Enhancing Practice
2022 Conference

20:20 Vision – Transforming Our Future Through Person-Centred Practices

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PRACTICE

an emancipatory practice development approach

Developing a safety culture on an acute care ward

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Enhancing Practice
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Nursing surveillance…why?

RNs keep patient safe through nursing surveillance [1]

Reduces risks, failure to rescue and patient mortality [2-4]

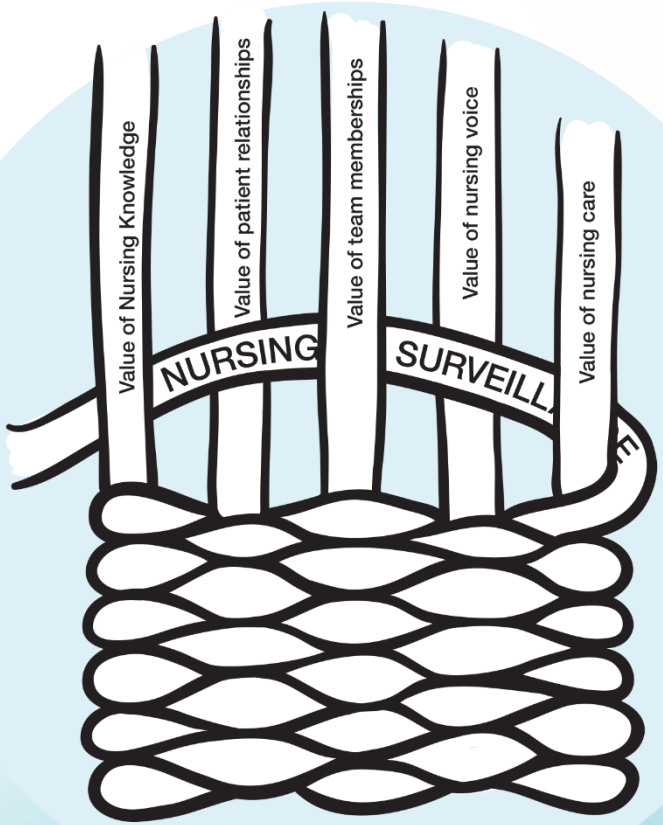
Inherently person-centred [5]

Ward culture [6-12]

RNs are well educated in assessment [13,14]

Contested area of practice [15-20]

Practice is suboptimal on general wards [20,21]



Why ePD?

Workplace culture and the complex environment of health care [3, 4, 12, 18]

Shared values [26]

Focused at the local level of practice [26, 27]

Systematic approaches [26,27]

Raise awareness [28]

Generate solutions [29]

Who?

Neuroscience ward

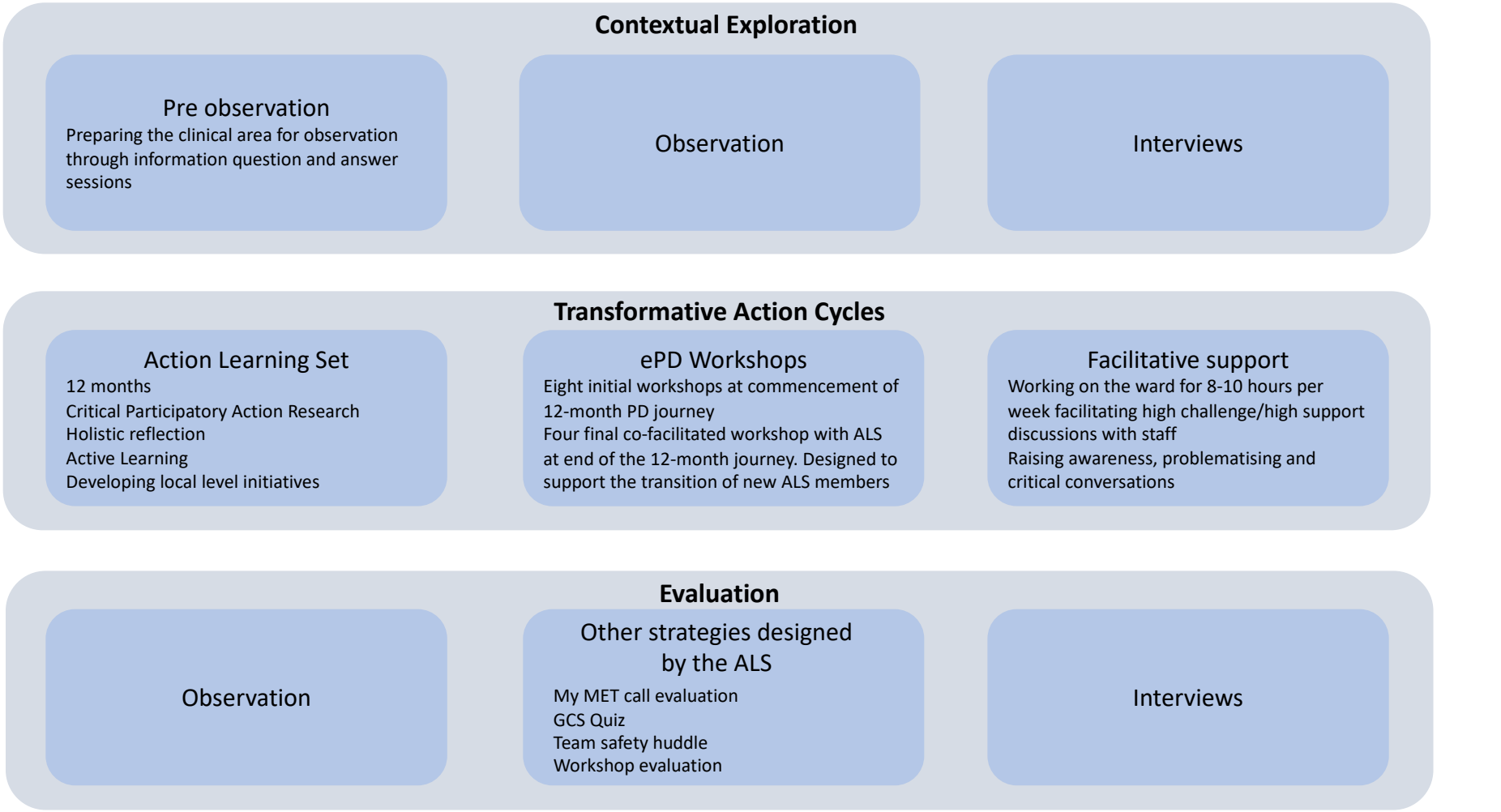
Collaborative partnership

Participants (RNs, ENs, MDT)

Ethics (HREC/17/MHS/35) and QUT (1700000417)

(HREC/17/MHS/139) and QUT (1800000246)

How did the journey unfold?

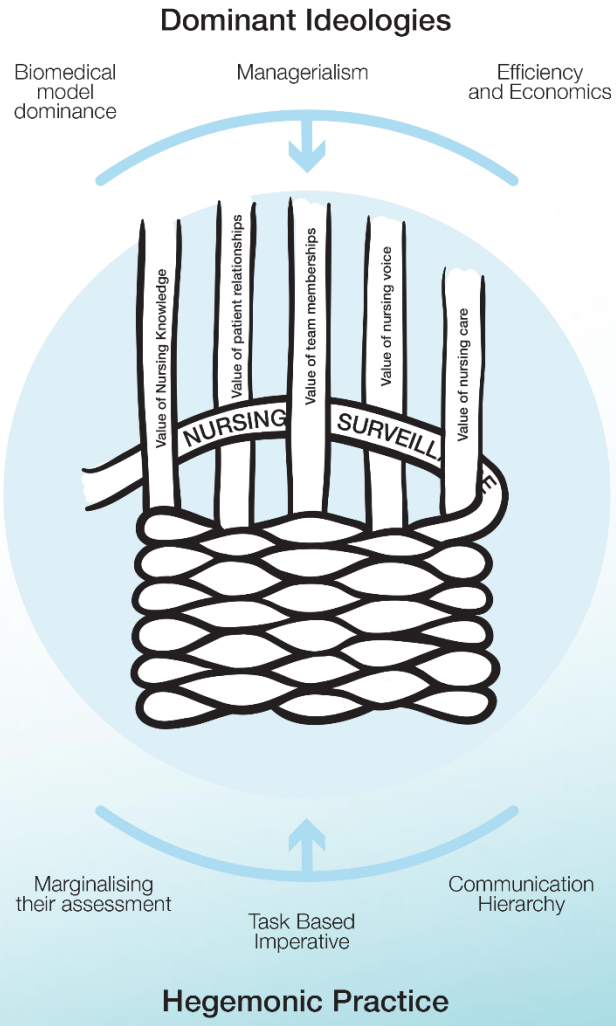


Model of nursing surveillance

Fabric supported by cultural values [5]

Vulnerable to distortion

Nursing surveillance invisible and unimportant



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ORIGINAL ARTICLE

WILEY Journal of Clinical Nursing

Strengthening nursing surveillance in general wards: A practice development approach

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Shared vision of keeping patients safe

PD workshops

Ways of working

Shared vision

Assessment stories displayed on the ward [31]

When my assessment made a difference

I arrived for a late shift and during handover came to an older patient who had a cardiac history.

They were an outlier from a medical ward. The patient looked unwell and had been transfered on room air. However, the patient was now on 3 litres of oxygen via the nasal prongs. The patient's heart rate was increased, and oxygen saturation decreased. The respirations were also increased. The patient looked like someone with a chest infection.

I contacted the doctor for a review. They stated they would review in the morning. I felt that this was something that needed to occur sooner and contacted ICU for a review. ICU was unwilling to review the patient. I contacted the treating doctor who stated that if the oxygenation saturation was still poor, I would need to call a MET call if no review was forth coming. I called a MET call. The patient was transfered to ICU with a chest infection.

I overheard handover between the morning and afternoon shifts stating that a patients GCS was 14-15 with prompting.

Knowing that a GCS should not require prompting I decided to perform a patient assessment to understand their true condition. Upon assessment I discovered the patients GCS to be 10 which I escalated to the registrar. The doctor was not concerned, stating that the patient had had a craniotomy were possibly tired. They did not review the patient.

Knowing that the patient had deteriorated compared to earlier in the day following my assessment and discussion with the patients' family, I asked the Occupational Therapist to perform a postop cognitive assessment to compare to pre-op. Her results were poor. With new objective data, I again contacted the registrar who, while seeming unconcerned asked for a head CT scan. Approximately half an hour later, the consultant arrived on the ward to review a different patient. I asked them if they were aware of this patients' current condition. They had not heard anything.

Upon review of the patient and their CT results, it was discovered that the patient had an increase in post-operative swelling and this was the cause of their decrease GCS.

My assessment and persistence in escalating my concerns resulted in the patient being started on appropriate course of corticosteroids. Their condition improved over the coming 12 hours.

I went to do observations on a patient who had an IDC insitu.

Her observations were stable however the patient stated that their IDC had not been draining overnight. I checked the IDC bag which had minimal drainage and checked the IDC tubing for any kinks that could be impeding the flow of urine. There were no kinks in the tubing. I assessed the patient for signs of dehydration. Their BP was within normal ranges and their mouth was moist. I also assessed for infection. Their temperature was below 37.5°. I then did a bladder scan and assessed the patients stomach. I noted the abdomen was distended, the patient was uncomfortable, and the scan revealed 1500 mls in the bladder.

I notified the team leader and was told to flush the IDC. I explained that I was unfamiliar with how to do this and was shown in the treatment room. I then flushed the IDC and manually removed approximately 1500mls. I reassured the patient and their family.

I notified the doctor of the blockage and then documented the incident in the patients chart. I notified the afternoon staff and suggested we do 4th hourly flushes to prevent the issue from reoccurring. The patient expressed that they felt her care had improved and was happy with the care I provided.

I had a patient who would come to the clinic every month. Each time it would be more and more difficult to get IV access.

The last time I saw the patient they were dehydrated, and it took six attempts by three different team members to IV access. I talked with the patient and found out they were becoming more and more distressed about their treatment due to the multiple attempts. They were concerned not only about the pain but also that the staff might be getting frustrated. I pulled some information regarding PICC insertions and had a conversation with her about the possibility of having one inserted. The patient was keen so I talked with her doctor and together we arranged for the patient to have a PICC inserted before their next treatment.

The patient was extremely grateful and is now coming in for their treatment every two weeks which they are no longer distressed about.

I observed my patient was deteriorating due to a decreasing GCS, crying out in pain, a raised temperature and cloudy, concentrated urine in their IDC.

I informed my team leader and contacted the patients doctor, collected some blood samples and a urine sample. I was with the doctor and informed them of my initial assessment. I was not happy with the new treatment plan. I spoke to a senior doctor and was able to ensure a more developed treatment plan which included further investigations and pain relief.

My assessment made a difference as I advocated on behalf of my patient. I prevented sepsis and made the patient more comfortable.

During a routine bedside handover, I noticed the patient had IV potassium on flow.

The patient was making an unusual noise. They were on contact precautions. I entered the room to slow or stop the IV infusion. On entering the room I tried to speak with the patient. They patient was unable to talk back to me. On observation the patient appeared clammy, pale and cold to touch. The sheets were wet indicating a possible sweat. I attempted to clear the patients airway using suction which was not working. I was able to clear the patients mouth. The patient was still unable to verbalise. The vital signs were normal but the GCS was decreased.

On assessment the patient remained cold to touch on the feet, legs and chest. My previous findings for this patient were that this was unusual. I initiated a MET call. The patient was transferred to ICU requiring airway support with a low BP and GCS.

I was working a late shift. I walked into my patients room to check on them.

The patient had a history of a recent CVA post major surgery, looked distressed and was calling out in pain. I was unable to assess the patients level of pain as the patient did not speak English. I spoke with the patients son on the phone. They translated for me. The patient stated they had a lot of pain I their hip. As I assessed the patient, I noticed they were very pale and distressed.

The observations showed the oxygen saturations to be 87% on room air. I immediately commenced oxygen at 6 litres and voiced my concerns of the patients pain level and oxygenation. I initiated a MET call and the patient was reviewed by the MET team. A decision was made for the patient to remain on the floor with pain relief and high flow oxygen. I considered this to be unsafe for the patient. I called the neuro team and voiced my concerns.

The neuro team and ICU team reviewed the patient again. A new treatment plan was initiated. The patient was given IV Lasix and transferred to ICU. The patient was diagnosed and treated for sepsis. They recovered well and were transferred to rehab.

Upon handover, my patient was already in a critical condition with hypertension and had a 25mcg GTN patch insitu.

I received a thorough handover of actions that had been done for this patient and had begun to perform my set of vital and neurological observations. I documented a BP 180/90 (ACDS score of 2). I knew this needed immediate escalation as the patient had been admitted with a haemorrhagic stroke. I notified my concerns to the team leader and asked if it would be appropriate to call for a review.

I spoke with the doctor and communicated my concerns, knowledge of the patients' history and current medications. The response was to continue to monitor for 30 mins and the administer a 50 mcg GTN patch. I repeated these vital signs to assess for improvement or decline. I also communicated with the family members of her vital signs, what these meant and the plan. After an hour the vitals were still scoring an ACDs of 2 with the BP 180/90. I discussed this with the doctor who stated to continue to monitor.

I was unsatisfied with this response as my patient had a stroke and had already been hypertensive for a period of time. I saw the primary physician on the ward and asked them to review the patient. They reviewed the patient, asked for a nasogastric tube to be inserted and antihypertensives to be given. My colleague inserted the nasogastric tube and I observed so I would be confident in gaining this skill at the next opportunity. We administered the medications and the BP decreased to 120/70. The family were told of the improvement and felt much relieved and the patient began to respond more appropriately.

My patient was in the stroke unit as a newly diagnosed GBM. They had a GCS of 15 at the start of the shift.

Their speech, language and memory started to deteriorate. I spoke to the patient and asked some questions such as name and birthday. Their pupils were sluggish and decreased from a 4 to a 3 in size. I checked the progress notes. There was no information stating a fluctuating GCS. However, the patient did not seem their normal self.

I escalated my concerns to the Team Leader and doctor. An MRI was organised, and it was noted there had been further bleeding on the brain.

I arrived for a late shift and during handover came to an older patient who had a cardiac history.

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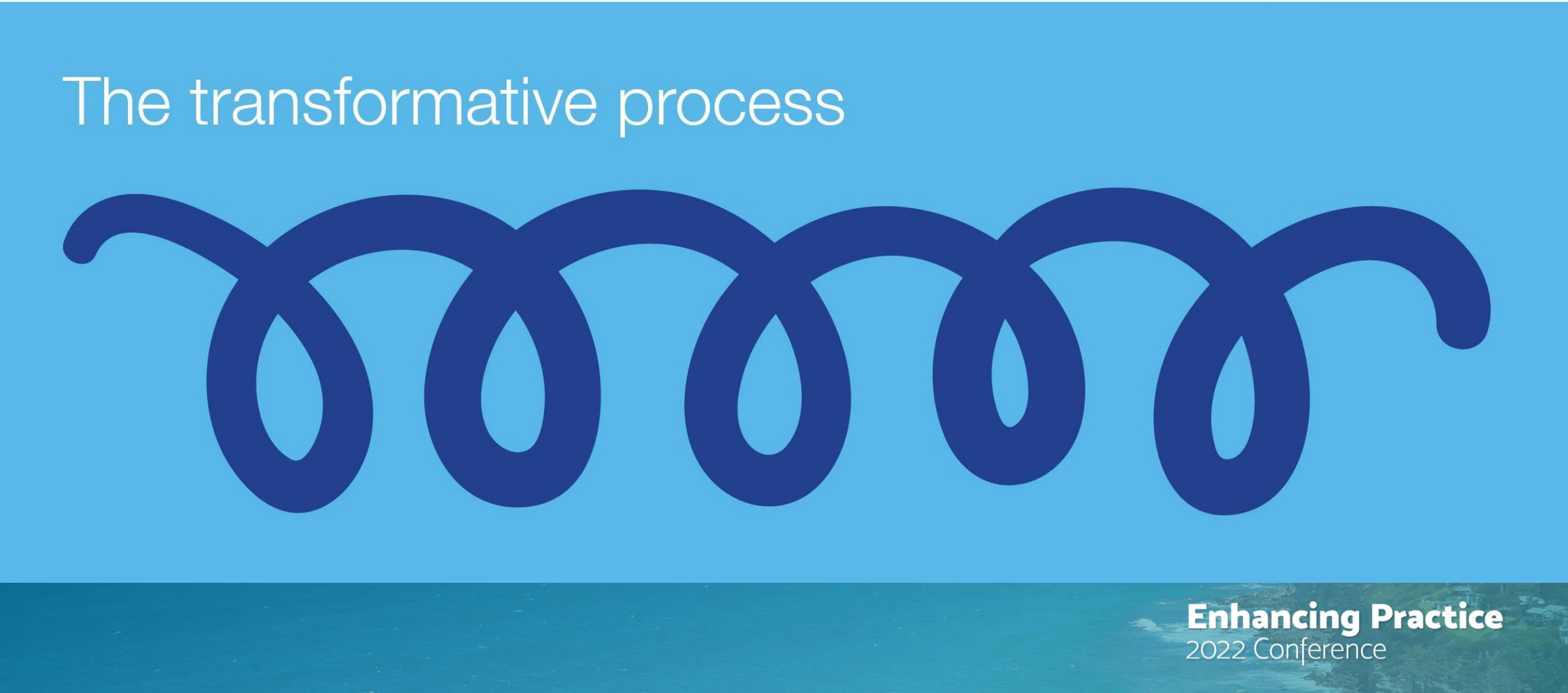
Working with an action learning set

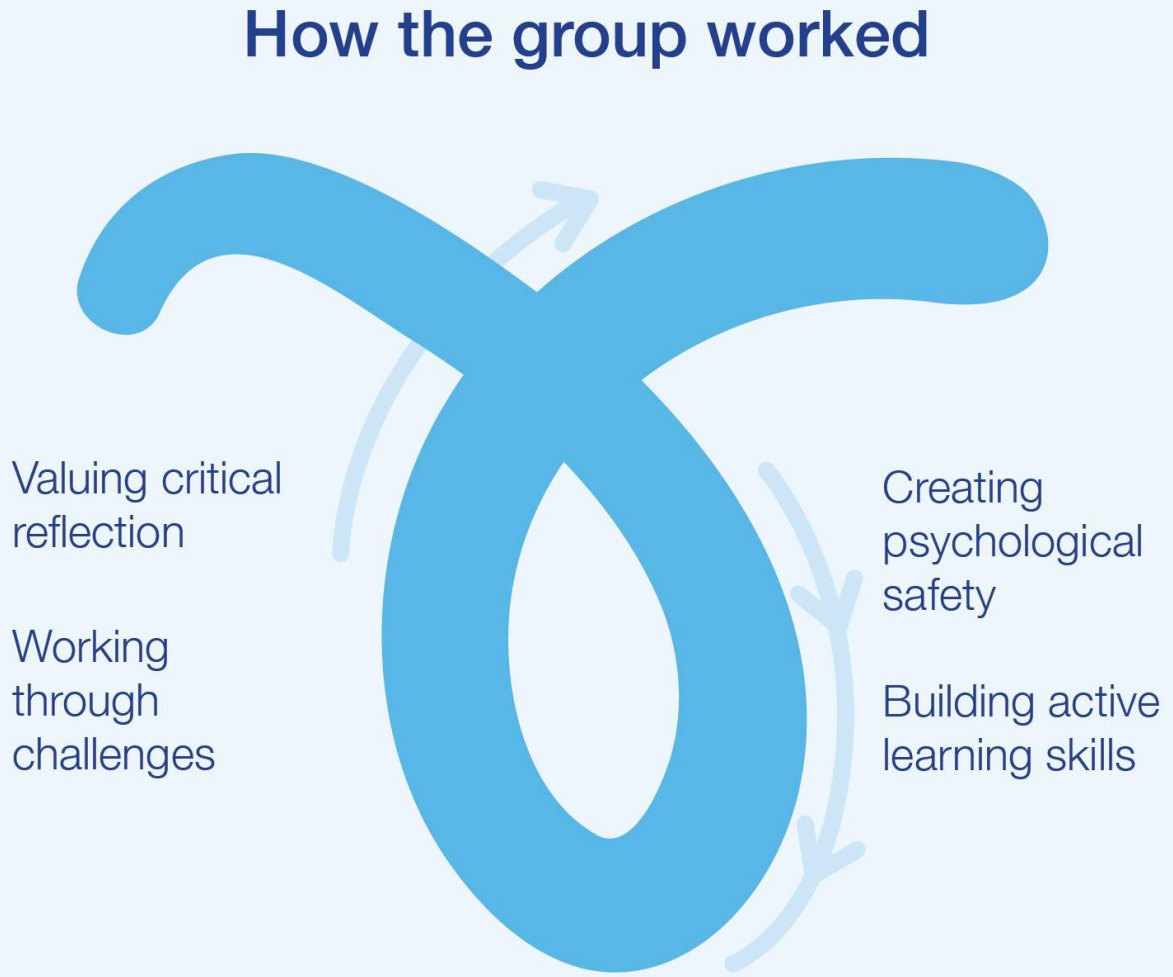


The ALS

Established a shared sense of purpose [32]

Connecting with them [33]

Making visible practice contradictions



The My MET call series

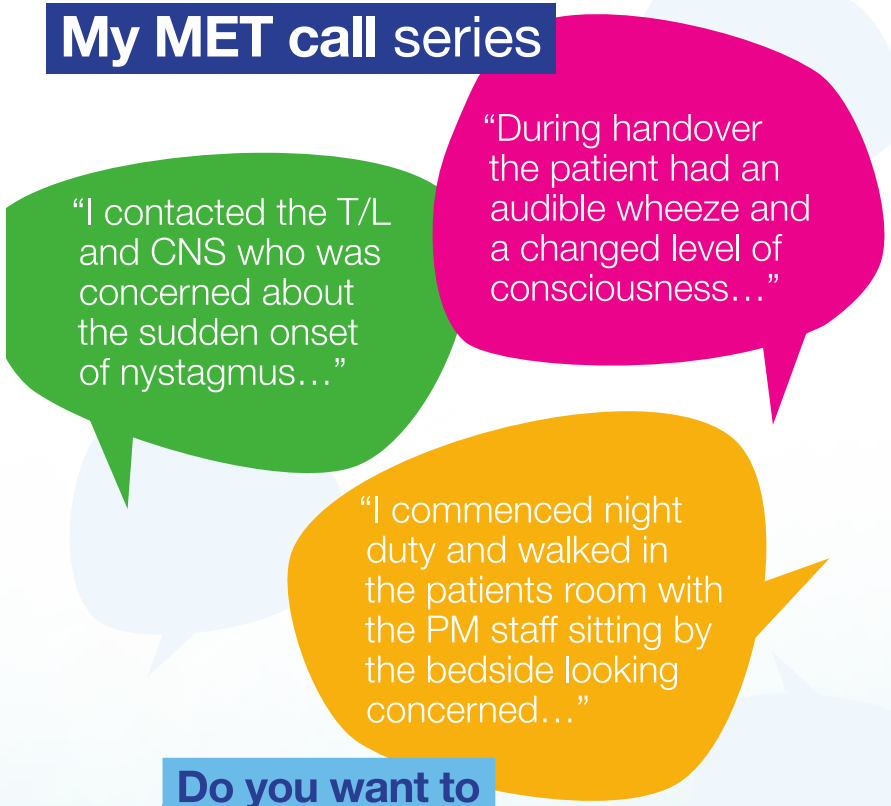
Exploring practice in the *moment* and reflecting [32]

Making visible practice contradictions

Living *Habermas* in practice [29]

Modelling the way and co-constructing practice

My MET call series



Do you want to know more?

Do you have a story to share?

Come to the My MET Call sessions

during in-service or ask to share your story.

PD research

The My MET call series

…better understand the importance of my job as a nurse, how important my clinical judgement is, I know my patient better than anyone, my voice is important and it matters. (ALS member)

A shared GCS

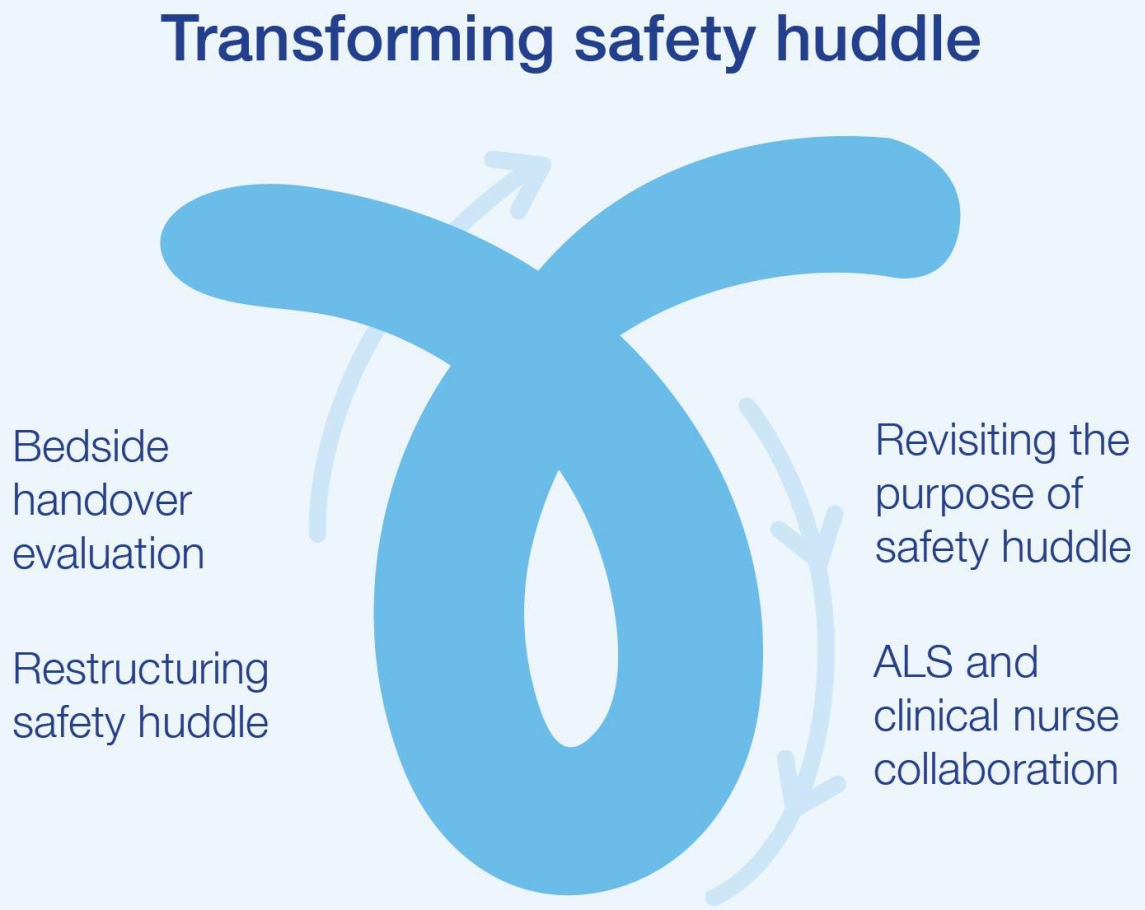

WHAT WAS THIS
PERSON'S GCS?


A shared GCS
Second video quiz
Collective GCS assessment at handover
Shared under-standing of GCS assessment: video quiz
Assessment conversations at handover

A shared GCS

“I just waited till they came to the bedside and encouraged them to do a GCS at handover. The GCS had changed, the patient went for a scan and is now having surgery”. (ALS workshop)

Transforming the safety huddle



Owning practice change

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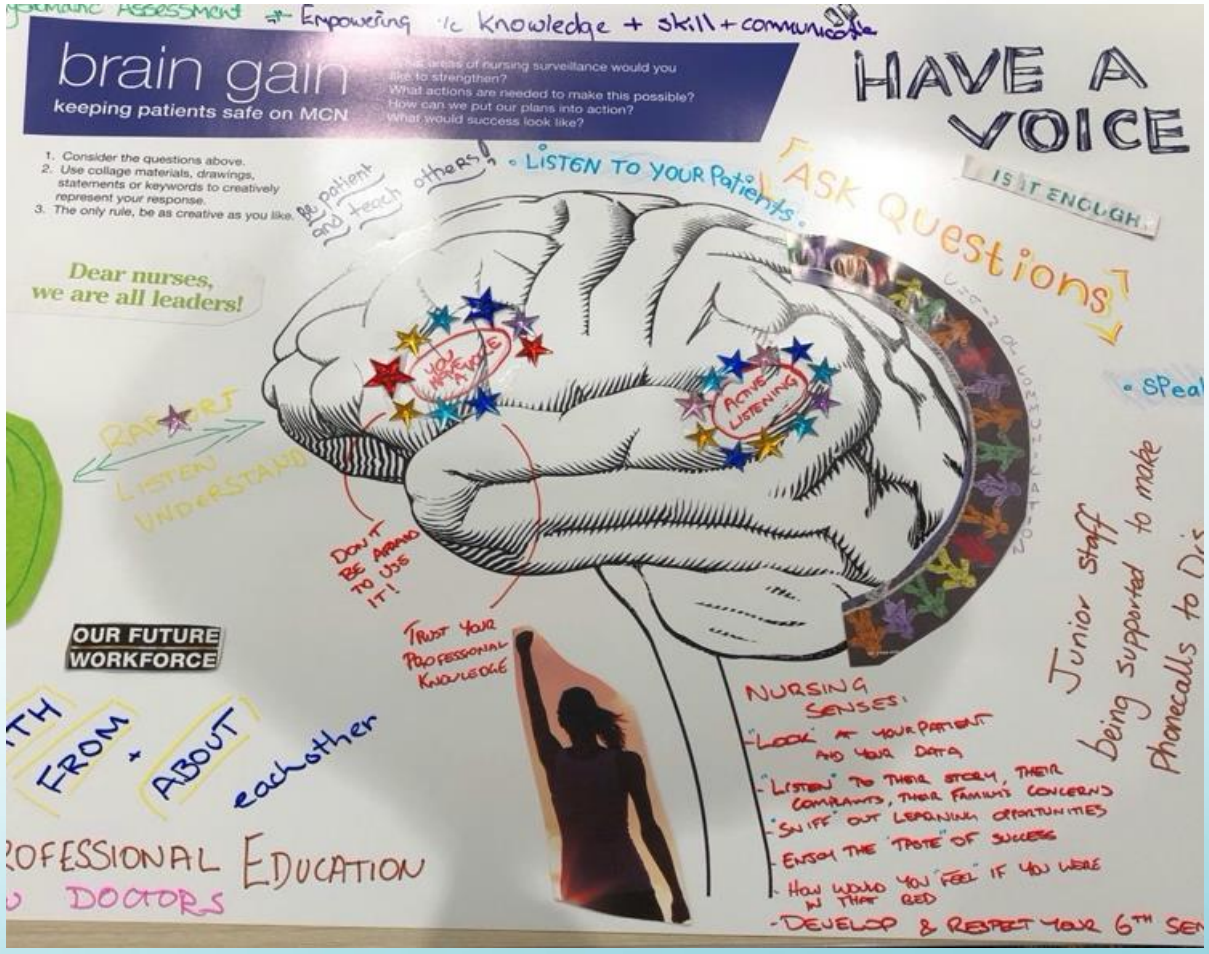
ORIGINAL ARTICLE

Building safety cultures at the frontline: An emancipatory Practice Development approach for strengthening nursing surveillance on an acute care ward

Jacqueline Peet PhD, RN, Senior Research Assistant[1] | Karen A. Theobald PhD, RN, Associate Professor[1] | Clint Douglas PhD, RN, Conjoint Professor[1,2,3]



Learning is the change

“We are probably not in a position to change all the doctors practice independently. But what we can do is change our practice and empower our staff. I would not have had the confidence to do what I do now, 12 months ago”.

Further insights…

Navigating the challenges of emancipation in an acute care setting requires facilitators who work with critical intent

Collaboration between the facilitator and the ward guides bottom-up change as they work with uncertainty

Practice change sustainability is built through clinical leadership and learning cultures at the front line

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