45th ANNUAL COURSE

Raising the Level of Concern;

Protecting your patients and you!

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Pre-meeting events: May 18-19

Orlando-Area, Florida

Disney's Coronado Springs Resort

SGNA

Objectives

1. Define failure to rescue and failure to escalate
2. Review malpractice data and implications for nursing
3. Identify barriers to escalation
4. Describe mitigation strategies to avoid escalation failures
5. Discuss case studies


What are we here
to discuss?

failure to escalate

“failure to act without delay if you believe there is a risk to patient.”

Raising and escalating concerns is a

fundamental responsibility

of all members of the healthcare team.

failure to rescue

“failure to rescue from a complication of an underlying illness or a complication of medical care.”

A ***measure*** of the ***providers response*** to adverse occurrences that developed on their watch.

Failure to Rescue/Escalate in Surgery

- FTR Rates varied between 8.0 and 16.9%.
  - Delayed escalation occurred in 20.7– 47.1% of patients and was associated with greater mortality rates in 4 studies ($P < .05$)
  - Higher hospital volume, communication failures, and lower nurse staffing have all been associated with higher failure-to-rescue rates.

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Johnston et al, 2015. A systematic review to identify the factors that affect failure to rescue and escalation of care in surgery *Surgery.* 157(4), 752-763.

Common themes from data on failure to escalate

- Lack of appreciation for clinical significance/decline
- Lack of sense of urgency in potentially critical situations
- Variations in knowledge, skills, willingness to escalate
- Communication disruptions, lack of team structure/function

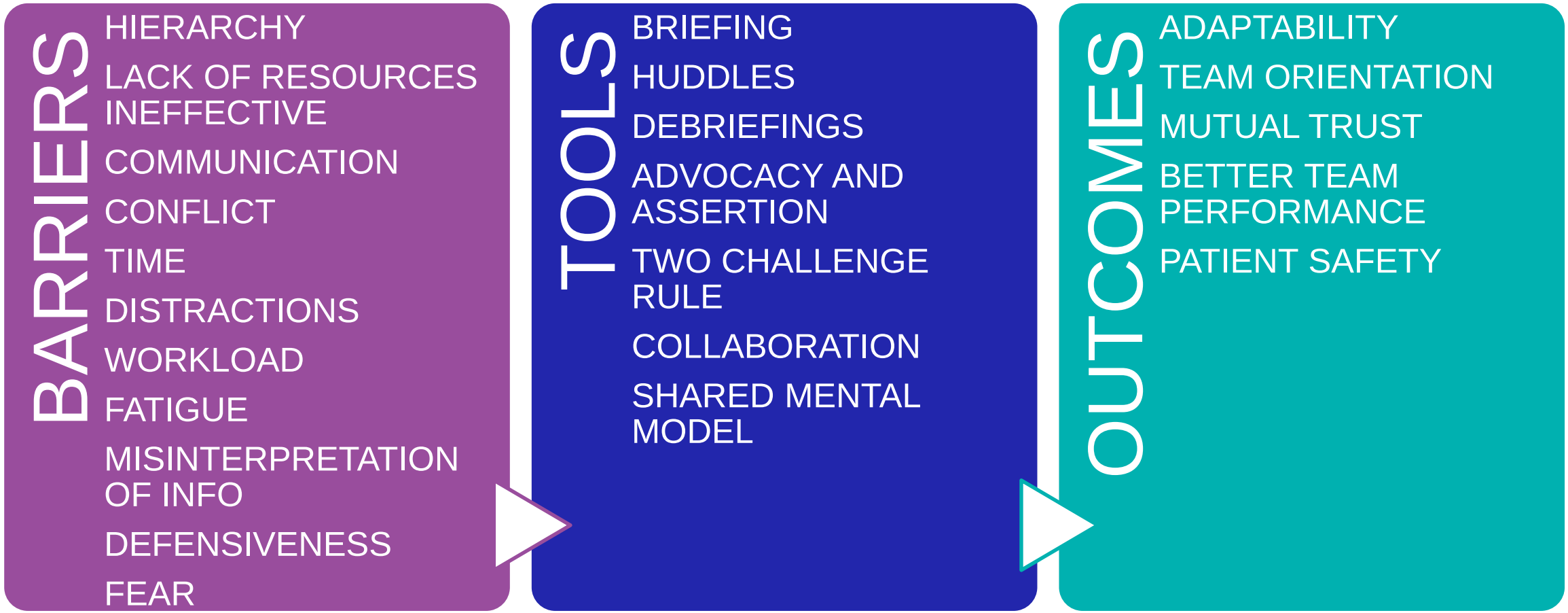
case study

Barriers to Escalation

- Hierarchical issues/Power gradients
- Unclear escalation protocols including not knowing “who” to contact
- Availability of senior staff
- Communication tools and information transfer
- Fear of negative response

Johnston, M. (2014). Escalation of care and failure to rescue: A multicenter multiprofessional qualitative study. *Surgery, 155(6), 989-994.*

How do we make this better?



Agency for Healthcare Research and Quality, AHRQ

Advocacy and Assertion

Advocate for the patient

- Invoked when team members' viewpoints don't coincide with that of the decision maker
- Assert a corrective action in a firm and respectful manner
  - Make an opening
  - State the concern
  - State the problem (real or perceived)
  - Offer a solution
  - Reach agreement on next steps
- SBAR type language

Two Challenge Rule

Invoked when an initial assertion is ignored…

- Speak assertively to voice your concern at least two times to ensure that it has been heard
- The person being challenged must acknowledge your concern
- If the outcome is still not acceptable:
  - Take a stronger course of action
  - Use supervisor or chain of command

Other thoughts…

Some factors that influence nurses recognition and response to patient deterioration:

- Knowing the patient
- Education
- Access to support
- Negative emotional response

Massey, D., Chaboyer, W., Anderson, V. (2016) What factors influence a ward nurses' recognition of and response to patient deterioration? An integrative review of the literature. *Nursing Open, 6-23.*

Knowing the patient

Strategies to help

Knowing specialized gastroenterology nursing care, anatomy and physiology

- Acquiring this knowledge through:
  - Mentoring
  - Preceptorships
  - Certification

Education

Strategies to help

- Deliberate practice – simulation
- Scenarios of high risk low frequency events
- Interprofessional teams to better understand each others roles
- Spaced learning

Access to support

Strategies to help

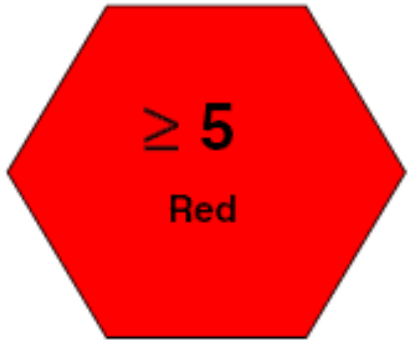
Improving systems to empower front line providers to act

- Educate staff to recognize early warning signals of clinical deterioration
- Develop trigger tools

MEWS (Modified Early Warning System)

	3	2	1	0	1	2	3
Respiratory Rate per minute		Less than 8		9-14	15-20	21-29	More than 30
Heart Rate per minute		Less than 40	40-50	51-100	101-110	111-129	More than 129
Systolic Blood Pressure	Less than 70	71-80	81-100	101-199		More than 200	
Conscious level (AVPU)	**U**nresponsive	Responds to **P**ain	Responds to **V**oice	**A**lert	New agitation Confusion		
Temperature (°c)		Less than 35.0	35.1-36	36.1-38	38.1-38.5	More than 38.6	
Hourly Urine For 2 hours	Less than 10mls / hr	Less than 30mls / hr	Less than 45mls / hr				

STRONGER TEAM *better care*

		
• Continue routine assessments	• Increase frequency of vital signes /CHEWS assessments • Notify charge nurse, physician, nurse practitioner or physician assistant • Discuss treatment plan with team • Consider higher level of care • Document interventions *Consider:* Intensive Care Unit Evaluation (page "EVAL," 3825)	• Physician, nurse practitioner or physician assistant evaluation at bedside • **Notify attending physician** • Discuss treatment plan with team • Document interventions *Consider:* Activating an Intensive Care Unit STAT (Rapid Response Team)
*** ICU STAT/CODE BLUE CAN BE ACTIVATED AT ANYTIME BY ANYONE*** **Use SBAR communication**		

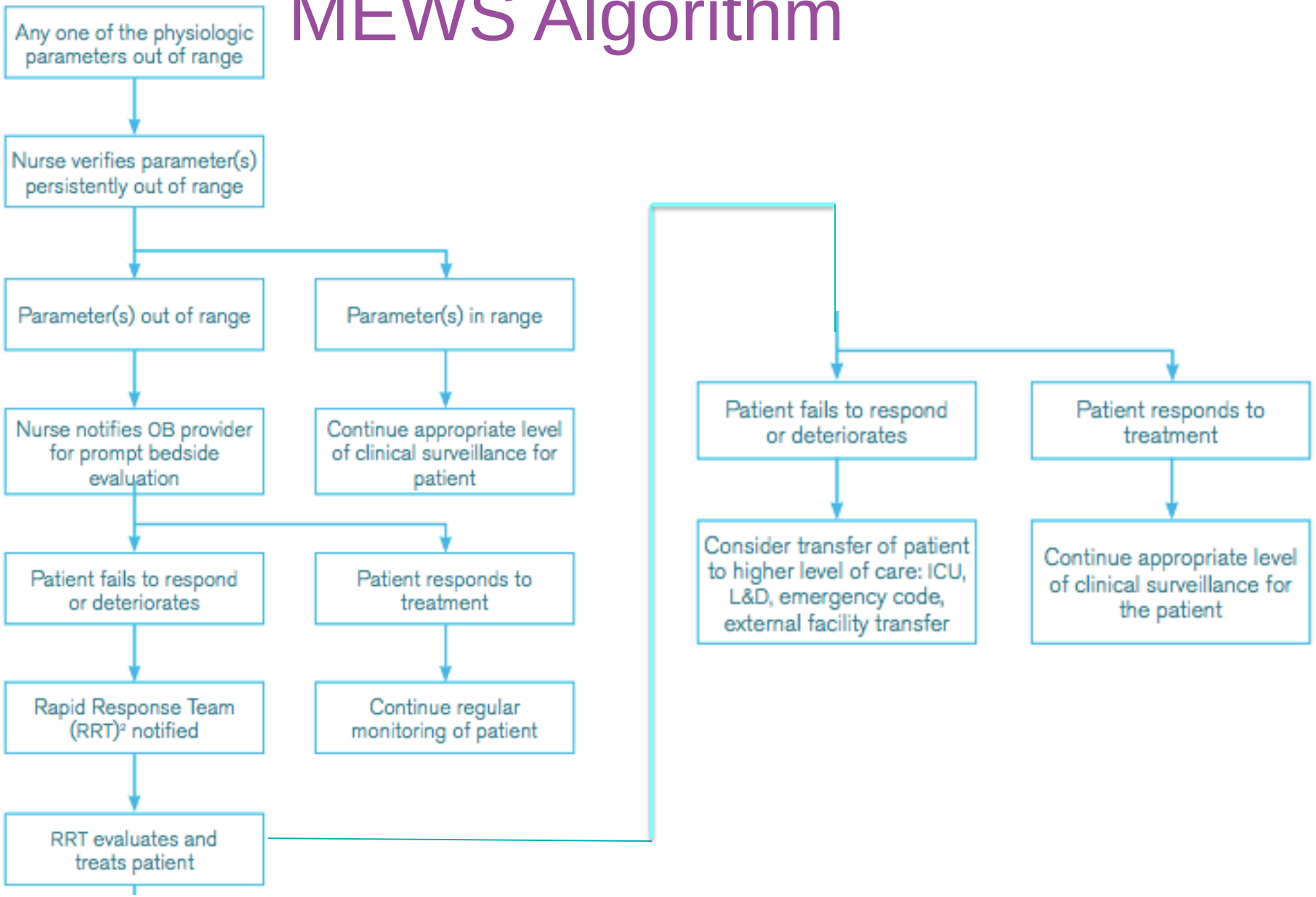
Maternal Early Warning System (MEWS)

MEWS TRIGGER CRITERIA*

parameter	value
systolic BP (mm Hg)	< 80 or > 160
diastolic BP (mm Hg)	> 105
heart rate (beats per min)	< 50 or > 120
respiratory rate (breaths per min)	< 10 or > 30
oxygen saturation % (room air, at sea level)	< 95
oliguria (mL for > 2 hours); for catheterized patients	< 30
maternal agitation, confusion, unresponsiveness	if any present
preeclampsia, with patient reporting non-remitting headache or shortness of breath	if either present

https://www.rmf.harvard.edu/Clinician-Resources/Guidelines-Algorithms/2017/OB-Guideline-Files/Appendix-C-Maternal-Early-Warning-System

MEWS Algorithm



Negative Emotional Response

Strategies to help

Establish a “Culture of Safety”

- Create an environment of just culture
- No fear of retaliation
- No fear of speaking up with concerns

How?

- Simulation and Team Training
- Conduct joint multi-disciplinary Mortality and Morbidity rounds
- Support professional, collegial team relationships

"Dealing with concerns should **not** be focused on **judging and accusing**; instead it should involve exploring an issue in an open, **transparent** manner to allow for timely evidence, **solutions** and recommendations."

McSherry, R., McSherry W. (2015) A model to support staff in raising concerns. *Nursing Times*; 111: 8, 15-17.

Is this feasible in the procedural setting?

Endoscopy non-technical skills research

- Twenty-three participants attended
- Patient safety knowledge improved significantly 43%-55% ($P \leq 0.001$) following training
- 12/41 (29%) of the safety attitudes items significantly improved in the areas of perceived patient safety knowledge and awareness
- Both qualitative and quantitative global course evaluations were positive
- Qualitative evaluation included mandating team training for endoscopy teams

Matharoo, et al. (2014). Endoscopic non-technical skills team training: The next step in quality assurance of endoscopy training. *World Journal of Gastroenterology*.14; 20(46): 17507-17515. DOI: 10.3748/wjg.v20.i46.17507

Endoscopy non-technical skills research

- Assess staff perceptions of using simulation team training in endoscopy
- Simulation of endoscopy-based scenarios to teach crisis resource management skills
- Perceptions were positive from nurses and associates

Heard, L., et al., (2011). Perceptions of Simulation-Based Training in Crisis Resource Management in the Endoscopy Unit. *Gastroenterology Nursing*. 34(1):42-48..

Discussion:

- What initiatives have been done in your organization to address escalation issues?
- Successes/Challenges?
- Lessons learned?

Thank you!

For questions or more information:
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