Interruptions to Nursing Practice: How nurses are affected and what can be done.

excellence collaboration

integrity innovation

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SickKids

Healthier children. A better world.

Overview

1. Background
   - Patient Safety
   - Patient Safety at Sickkids
   - Patient Safety in Pediatrics
   - Patient Safety in Nursing
2. Clinical Comments & Questions
3. (Participatory) Action Research
4. Collaboration
5. The research: How are nurses affected?
6. Opportunites for nursing practice: What can be done.

Patient Safety

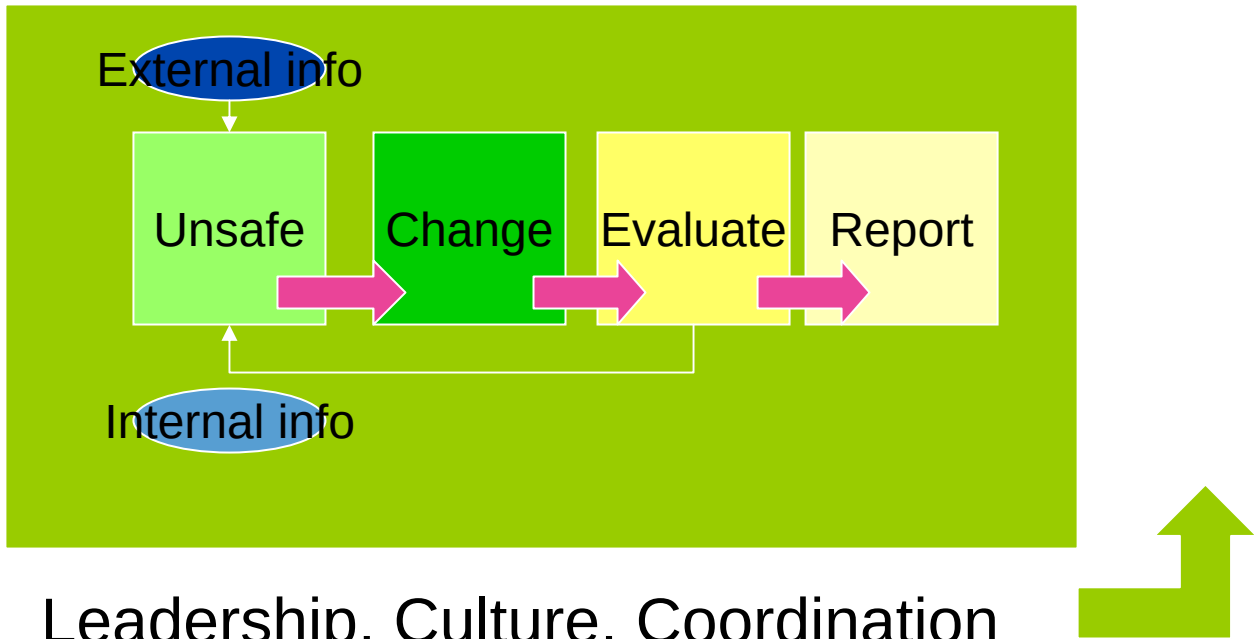
"Freedom from accidental injury as a result of medical care or medical errors." IOM

- Focus on system a source of many errors (Leape, 1997)

- Focus on improving systems of care delivery (IOM Reports,
  - Too Err is Human: Building a Safer Health System, 1999, &
  - Crossing the Quality Chasm: A New Health System for the 21st Century, 2001)

Patient Safety at SickKids

- The Patient Safety Blueprint (2002 +) was launched with the following conceptual framework



Stevens, Matlow, & Laxer, (2006)

Patient Safety in Pediatrics

Fernadez & Gillis-Ring, 2003

- Unique Aspects of Care
  - Communication
  - Disease
  - Size – dynamic, physical & physiological
  - Medication dosing

- Epidemiology
  - Poor reporting, limited studies

Patient Safety in Pediatrics

- High Risk Areas
  - ER, NICU, PICU & Oncology
- Taxonomy of Error
  - Active & Latent Factors

Patient Safety in Pediatrics

- Miller & Zhan's 4D's, (2004)
  - developmental change
  - dependence on adults
  - different disease epidemiology
  - demographic characteristics

Patient Safety & Nursing

- Nurses are highly concerned about quality
- Nursing work is about “Keeping Patients Safe” (2004)
- What impacts nurses work, by extension, impacts patient safety
- Some studies of nurse staffing, skill mix and patient outcomes (Aiken, et al, 2001; Blegen, Goode,& Reed, 1998; McGillis Hall et al. 2001; Needleman, Buerhaus, Mattke, Steward, & Zelevinsky, 2001)
- GAP = studies of nursing work environments & patient safety in pediatrics

Critical of the Patient Safety Movement

- Is it just another Bandwagon? as asked Storch (2005) in Nursing Leadership

  - "Jumping on the bandwagon of patient safety neglects the root causes of error & the lack of patient & nurse safety."

Storch: "Cult of Efficiency"

- Storch (2005) advocates a focus on staffing & patient outcomes & warns of a "cult of efficiency"
- Cut backs, constraints, the business model, & corporate ideology
- Results in shifts in workload, an increased mechanistic approach, less time with patients, nurses compensating for reductions in other services
- Invisibility of nursing work…does anybody notice?

Clinical Comments & Questions

"it's too busy"

"it's chaotic"

"so much going on"

"over worked"

"easily distracted"

"it's unsafe"

"patients are at risk"

"pulled in different directions"

"moral distress"

"no time"

"everybody needs something"

- Led to a focus on the work environment

- What could we do to raise awareness & visibility of important nursing work, make visible the challenges, the frustrations and the potential risk in day to day situations?

- How could we come up with a plan to do thing differently?

- How could we makes real change to real problems?

(Participatory) Action Research

- "Aims to contribute to the practical concerns of people in an immediate problematic situation to further the goals of social science simultaneously." (O'Brien, 2001)

- Contextual

- Knowing, learning, doing…PAR leads us to ask some important questions about using research
  - Why do the research?
  - Who will benefit?
  - Who uses the information & what for?
  - What is worth researching? (www.NSCALL.net)

Participatory Action Research

- It is a style of research *with & not for*, defined by need for action & focused on creating knowledge that is put into practice

- A strong tool for improving programs & practice, for assisting with the scholar – practitioner gap

- Has it's origins in experimental psychology, Kurt Lewin (1940's) and others…Lewinian Action – a reflection spiral

Participation Action Research

- A Guiding Principle = decisions are best implemented by the people who make them

- Assists in building capacity by reducing intellectual dependence and developing praxis (critically informed committed action)

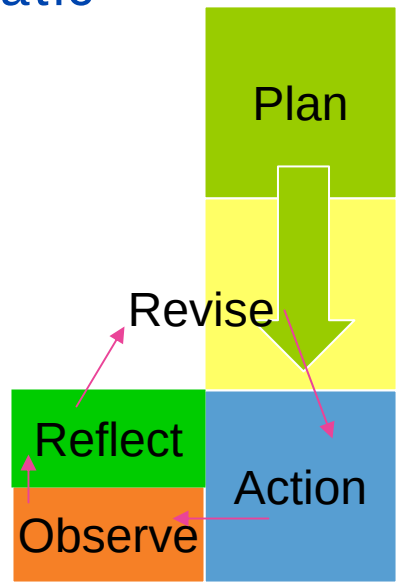
- Praxis (term used by Aristotle)…the art of acting upon the conditions one faces in order to change them

Participation Action Research

- May help with
  - Innovations
  - Rethinking old patterns

PAR Model

Simple schematic



MacIsaac, 1995

Collaboration

Strong desire to advance:

- Evidence based, professional practice environment
- Connections with academic partners in designing practical solutions
- Contributions to nursing at the local, organizational and profession levels
- Bring research to life with staff & learn new ways to approach problems

Collaboration

Process Steps:

- Sought out an Academic expert

- Discussed areas of mutual interest based on clinical questions…..“interruptions”
  - What gets in the way of nursing doing their work and potentially impacts patient care?
  - What is the work environment like for pediatric nurses in an academic setting?

- Set up stakeholder meetings to explore concepts and research potential

Collaboration

- Study designed to help identify potential solutions to practical, day to day problems
- Primary Investigator lead proposal development and research process
- Site Investigator assisted with internal navigation: REB & links to staff
- Research Manager aligned with Clinical Mangers for data collection
- Attention to front line nurses engagement & participation

The research

- Designed to learn more about the idea of interruptions in pediatric nurses' work
- Engaged nurses in examining their work and the context (environment) in which they work
- Used work observation & focus group techniques

Interruptions: How nurses are affected.

- Intrusions

"an unexpected encounter initiated by another person that interrupts the flow and continuity of an individual's work and brings that work to a temporary halt"

- Distractions

"psychological reactions triggered by external stimuli or secondary activities that interrupt focused concentration on a primary task...irrelevant to the task at hand."

Opportunities for Nursing Practice: What can be done.

- Transform work process to reduce interruptions.

- Consider patient care interruptions in relation to Family Centred Care…the data encourages us to consider how we manage interruptions in the context of assessment & procedures.

Opportunities for Nursing Practice: What can be done.

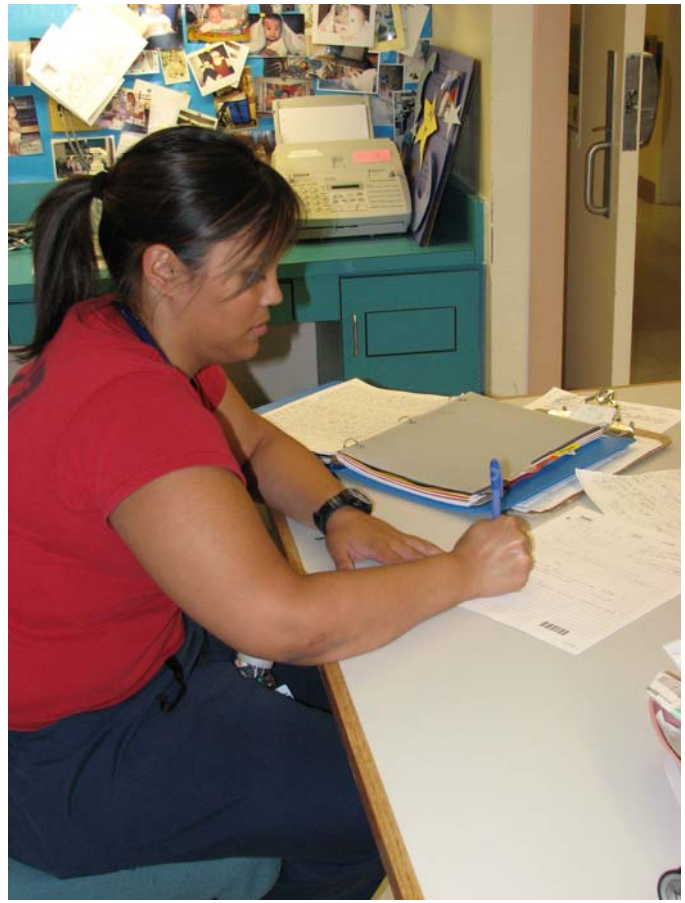
- Demonstrate more respect for each other…role model to reduce nurse to nurse interruptions!

- Cultivate a new language. New terminology can help categorize interruptions & shift conversations from workload concerns to patient care concerns.

- More (P)AR!

Opportunities for Nursing Practice: What can be done.

- Advance local change initiatives
  - Nurse to nurse interruptions
  - Nurse organization for procedures
  - Medication administration
  - Report time
  - Documentation
  - Interruption rules



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