Nursing Process Review: Utilizing a Consistent Approach to Evaluate Practice Breakdowns and Patient Safety

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INTRODUCTION

Nursing Process Review (NPR) was created mirroring physician peer review. NPR was to focus on significant events. A case review was completed by leadership which included reviewing the electronic health record and identifying gaps in the nursing process that may have contributed to the event. The team recognized the need for a whole systems approach that could organize data and improve analysis, and prevent future practice breakdown. Historically, the answer had been to take a quality management approach, and provide broad education and training. Conversely, a whole systems approach assesses the entire practice environment, and evaluates all the factors that may have contributed to a breakdown. This provided the team with specific information which could be utilized to improve the individual nurse's practice as well as the practice environment.

STRATEGY AND IMPLEMENTATION

A literature review for a theoretical framework was completed. The National Council of State Board of Nursing had implemented a framework that was utilizing a whole systems approach to evaluate practice breakdowns "Taxonomy of Error, Root Cause Analysis, and Practice Responsibility" (TERCAP) ®. NPR determined that this framework could provide the foundation to accomplish the purpose of the committee: "to create the infrastructure to review the practice environment, organizational culture and systems that may contribute to patient safety, while also addressing individual areas of growth which may have led to a practice breakdown." It was determined that NPR would be comprised of nursing leaders and clinical experts who could evaluate practice with a consistent framework focusing on patient safety. The process is as follows:

- Cases are referred for review
- APRNs are responsible for initial case review to identify concerns
- A meeting is scheduled with the APRN, the involved staff and the Nurse Manager
- Practice Breakdowns are determined through the interview process
- An action plan is formulated as needed
- A primary and secondary practice breakdown are assigned by the APRN and then validated for interrator reliability in NPR

EVALUATION

The modified TERCAP® provided specific, systematic information regarding the nursing staff prone to practice breakdowns: 80% had less than 1 year experience in the current unit and the most frequent practice breakdowns were clinical reasoning (lack of recognition of signs/symptoms/response to interventions) and intervention (lack of timely or skillful intervention). Additionally, the systemized approach added information about the practice environment that was previously lost in the review since only the electronic health record was evaluated for the nursing process. Furthermore, the new process illustrated that leadership and the staff had different perceptions of what contributed to the practice breakdown. (p value = 0.052). Other correlational statistical inferences between demographics, practice breakdown type and patient harm have not been shown to have statistical significance. However, it is hypothesized the population sample size is still too small.

RESULTS

2011 (Q2,Q3 & Q4)= 46 Interviews
2012 (Q1 & Q2)= 20 Interviews

Perception of Breakdown Factors	Nurse's Perception	Supervisor's Perception
Other	25	5
Nurse's high work volume/stress	14	4
Nurse's inexperience (ie w/ clinical event, procedure, treatment, or patient condition)	8	6
None	7	8
Nurse's lack of team support	9	6
Lack of adequate staff	7	0
Nurse's overwhelming assignment	4	2
No rest/meal breaks	2	0
Nurse's functional ability deficit	1	0
Nurse's lack of orientation/training	2	0
Nurse's conflict w/ other team members	2	0
Nurse's cognitive impairment	0	1
Nurse's fatigue/lack of sleep	0	2

Final Disposition of Practice Breakdown	2012	%	2011	%
Intervention	6	30%	7	18%
Clinical Reasoning	3	15%	16	42%
Professional responsibility/patient advocacy	3	15%	6	16%
Unknown	3	15%	0	0%
No Practice Breakdown	2	10%	2	5%
Attentiveness/Surveillance	1	5%	4	11%
Interpretation of provider orders	1	5%	2	5%
Prevention	1	5%	0	0%
Communicating Patient Data	0	0%	0	0%
Documentation	0	0%	1	3%

Secondary Practice Breakdown	2012	%	2011	%
Clinical Reasoning	4	20%	10	26%
Professional responsibility/patient advocacy	4	20%	4	11%
Attentiveness/Surveillance	1	5%	4	11%
Documentation	1	5%	1	3%
Intervention	2	10%	8	21%
Interpretation of provider's orders	0	0%	3	8%
Unknown/none	8	40%	8	21%

Clinical Reasoning	2012	%	2011	%
Clinical implications of patient signs, symptoms, and/or responses to interventions not recognized	9	41%	10	29%
Clinical implications of patient signs, symptoms, and/or interventions misinterpreted	6	27%	10	29%
Following orders/routines without considering specific patient	3	14%	5	14%
Other	1	5%	5	14%
Lack of knowledge	3	14%	3	9%
Inappropriate acceptance of assignment or accepting delegation beyond	0	0%	2	6%
Poor judgment in delegation and the supervision of other staff	0	0%	0	0%

Intervention	2012	%	2011	%
Did not provide timely intervention	7	37%	11	50%
Did not provider skillful intervention	8	42%	6	27%
Did not intervene for patient	3	16%	3	14%
Other	1	5%	2	9%
Intervened on wrong patient	0	0%	0	0%

Environmental Factors	2012	%	2011	%
Frequent interruptions/distractions	6	43%	7	28%
Other	2	14%	5	20%
Equipment failure	0	0%	4	16%
Multiple emergency situations	3	21%	1	4%
Increased noise level	0	0%	3	12%
Code Blue	0	0%	2	8%
Lack of adequate supplies/equipment	3	21%	1	4%
Similar/misleading labels (other than medications)	0	0%	1	4%
Poor lighting	0	0%	1	4%
Physical hazards	0	0%	0	0%

Backup/Support Factors	2012	%	2011	%
Lack of adequate provider response	7	54%	15	56%
Other	1	8%	4	15%
Lack of adequate response by ancillary departments	2	15%	3	11%
Forced choice in critical circumstances	0	0%	3	11%
Ineffective system for provider coverage	2	15%	2	7%
Lack of nursing expertise system for support	1	8%	0	0%

Staffing Issues	2012	%	2011	%
Other	2	17%	7	32%
Lack of supervisor/management support	3	25%	4	18%
Lack of clerical support	1	8%	3	14%
Lack of support nursing staff	1	8%	4	18%
Lack of other healthcare team support	3	25%	1	5%
Lack of appropriate skill mix	1	8%	2	9%
Lack of experienced RNs	1	8%	1	5%

IMPLICATIONS FOR PRACTICE

Action plans can be tailored for the individual nurse. Simulation scenarios have been developed based on actual events and nurses who had an identified area of growth have completed this training. A simulation "Boot Camp" has been initiated for all new hires as well as nurses who have worked less than one year on their unit.

System trends can be identified that require further action and processes implemented that improve patient safety. One such example has been to improve hand-off communication, bedside report involving the patient and their family has been instituted.

The environment becomes safer as nurses are supported in their role to prevent practice breakdowns or intervene before one occurs. One case illustrated a gap in the process of capturing patient documentation when in isolation. The patient record appeared incomplete and the assumption was the nursing process was lacking. In discovery through the interview process it was determined the nursing care was appropriate. However, the nurse was lacking adequate documentation resources in the room. The staff nurse was then empowered to come up with a solution to improve patient safety.

CONCLUSION

The whole systems approach has shifted the focus from quality management to the development of system wide changes. Targeted action plans have been developed to improve individual nursing practice. The ability to analyze and organize data in a meaningful way has lead to the development of meaningful education and system wide changes. The combination of these have improved patient safety throughout the institution.

REFERENCES

Benner, P. E., Malloch, K., & Sheets, V. (2010). *Nursing Pathways for Patient Safety.* Mosby Elsevier: St. Louis, MO

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