Patient Outcomes

Paula Hartman MSN, RN, ANP, CNE
Caroline Sims PhD, RN
Patient outcomes

What is important and why do we measure them?
Objectives

The new graduate nurse will
1. Be able to differentiate critical thinking, clinical reasoning, and clinical judgment
2. Gain an understanding of what nurse sensitive outcomes are and why they are important in healthcare
3. Integrate knowledge of nurse sensitive measures and outcomes into their practice of nursing
4. Communicate and collaborate with members of the interprofessional team, the patient and the patient’s support persons to promote positive patient outcomes
5. Assimilate professional boundaries, patient advocacy, and patient education in practice as a professional nurse
6. Identify and implement appropriate methods to prioritize patient care
Pre-test

1. The “R” in SBAR stands for
   a) Recommendation
   b) Read back
   c) Repeat
   d) Reconcile

2. The nurse who shares personal information with the patient may be crossing professional boundaries
   a) True
   b) False

3. Which of the following may be considered when prioritizing patient care
   a) Patient preference
   b) Maslow’s hierarchy of needs
   c) Anticipation of future problems
   d) All of the above
Pre-test

4. Which of the following is the best example of a nurse demonstrating patient engagement behavior?
   a) Distributing information on a need-to-know basis
   b) Asking the patient for input in deciding plan of care
   c) Neglecting to teach the patient how to complete own dressing change
   d) Omitting bedside rounds due to time constraints

5. The nurse acts as a patient advocate when she/he makes decisions for the patient
   a) True
   b) False
Pre-test

6. Which of the following can be considered a violation of professional boundaries
   a) Supporting a patient in her decision to stop treatment
   b) Sharing your own personal experiences with illness with the patient
   c) Becoming politically active
   d) Avoiding posting anything on social medial that violates patient-nurse privilege

7. An interpretation or conclusion about a patient’s needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient’s response is the definition of
   a) Clinical reasoning
   b) Clinical judgment
   c) Critical thinking
   d) Problem solving
Pre-test

8. Critical thinking embedded in nursing practice defines
a) Clinical reasoning
b) Clinical judgment
c) Critical thinking
d) Problem solving

9. Which of the following are considered nurse sensitive indicators?
   a) Patient satisfaction
   b) Falls
   c) Catheter associated urinary tract infections (CAUTI)
   d) All of the above

10. The acronym SMART refers to nursing outcome measures. What does the “S” stand for?
   a) Singular
   b) Simple
   c) Specific
   d) Synthesize
Outcomes defined

In ANA’s The Essential Guide to Nursing Practice (2012) outcomes are defined as,

“an individual’s, family’s, or community’s state, behavior, or perception that can be measured along a continuum and is responsive to nursing interventions.”

p. 63

- How do we know what we do is really meeting the needs and expectations of our patients?
- Only by having clear definitions around the expectations and measurement of those expectations.
- The outcomes drive then what we as nurses do to support our patients needs.
Why are outcomes so important?

- Nurses need to be able to evaluate the effectiveness of their practice and interventions
- Analysis of outcomes drives nursing practice change as well as healthcare organizational change
- Quality and safety in healthcare have been raised as major issues since the Institute of Medicine (IOM) began publishing results of their research in the Quality Chasm series in the early 2000’s
- Payers are increasingly basing reimbursement on demonstrated outcomes

- Outcomes are publicly posted on the internet. Search Hospital Care at www.medicare.gov and see what you find about our facility and our competitors. How does this data impact the choices our patients make?
- Nursing can make a difference in this data.
- We must know what outcomes are being measured and identify ways that we as nurses improve those outcomes.
How do we measure outcomes of nursing care? **SMART**

Outcomes measured should be

**Specific**
- clearly understand what is being measured

**Measurable**
- everyone has clarity around how well anticipated outcomes were met

**Achievable**
- based on the practice of all team members

**Realistic**
- can be achieved given the situation and resources available

**Time-framed**
- by when will the outcome be met

- This is also from ANA’s *The Essential Guide to Nursing Practice*. Remember this acronym. Know what it is that is being measured. If you are not clear, ask questions until you do.

- Understand how it is measured. If a patient feels weak while walking and is lowered to the floor, does that constitute a fall?

- How will you achieve the measure? If your unit/department is not meeting expected outcomes, what are the opportunities for improvement?

- We as nurses have accountability for breaking down the barriers to exemplary professional practice. If the outcome seems unrealistic seek feedback from your nurse manager or clinical leader (such as an APN) for better understanding and direction.

- Know the time frame in which the outcomes must be met (are they monthly or quarterly?) and any time frames related to the measure itself (ex. discontinuation of foley catheters within 48 hours).

- Be knowledgeable, take accountability, demonstrate excellence in professional nursing practice.
• For years nurses have spoken to “critical thinking”. We all felt we knew what it was and how to define it. (ask for definitions from the group).

• In the literature there are many definitions. The literature surrounding critical thinking was discussed including the multiple facets of this concept with components such as confidence, self reflection, inquisitiveness, logical reasoning, and reflection (Scheffer & Rubenfeld, 2000; Zori & Morrison, 2009).

• Critical thinking is very focused on rational decision making given a specific set of data (i.e. diagnosis, vital signs, laboratory results, etc.), but does not reflect the significance of the individual patient characteristics or circumstances or the nurse’s engagement with the patient.

• The literature suggests that critical thinking is seen as contributing to clinical reasoning (Pesut and Herman, 1999; Facione and Facione, 2008).

• Pesut and Herman (1999) defined clinical reasoning as, “the reflective, concurrent, creative, and critical thinking embedded in nursing practice,” (p. 4). They also describe the clinical reasoning process as supporting the ability to make clinical decisions to achieve the desired outcome.

• Tanner (2006) described clinical reasoning similarly to Pesut and Herman while also including deliberate processes of idea generation, comparing alternatives to the evidence and choosing the best option in order to support clinical judgment.
In a review of 191 studies Tanner (2006) identified five conclusions about clinical judgment:

Clinical judgments are more influenced by what nurses bring to the situation than the objective data about the situation at hand;

• Sound clinical judgment rests to some degree on knowing the patient and his or her typical pattern of responses, as well as an engagement with the patient and his or her concerns;

• Clinical judgments are influenced by the context in which the situation occurs and the culture of the nursing care unit;

• Nurses use a variety of reasoning patterns alone or in combination; and

• Reflection on practice is often triggered by a breakdown in clinical judgment and is critical for the development of clinical knowledge and improvement in clinical reasoning.

• Clinical judgment is about the action the nurse identifies based on the clinical reasoning, understanding of the patient and their specific situation (cultural, family, fiscal resources, psycho-social, etc), and evidence based practice.
Clinical reasoning and clinical judgment

SO...

CLINICAL REASONING is how you think through what is best for your patient and CLINICAL JUDGMENT is how you act on that thought process!
Why are they important?

CLINICAL REASONING and CLINICAL JUDGMENT both directly impact the care we deliver and therefore the outcomes for our patients.

If they impact the care we deliver they also impact the outcomes of the care. They are also important as we think through how we can influence the outcomes within our areas specific to the standards set. Clinical reasoning and clinical judgment are core to the professional practice of nursing.
Nurse-sensitive indicators

- Measures and indicators that reflect the impact of nursing actions on outcomes (ANA, 2009)
- Are being publicly reported which impacts patient and other customers’ confidence
- Payers are looking at payment based on nurse sensitive measure outcomes
- Nurse sensitive outcome measures include hospital acquired conditions as well as patient experience measures

What are nurse sensitive indicators?

- Nursing-sensitive indicators identify structures of care and care processes, both of which in turn influence care outcomes.
- Nursing-sensitive indicators are distinct and specific to nursing, and differ from medical indicators of care quality
  http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No3Sept07/NursingQualityIndicators.html
- They reflect the impact of nursing actions and as such reflect levels of nursing clinical excellence. They are the outcomes that nurses, within our own scope of practice, can directly influence.
- Patient outcomes that are determined to be nursing sensitive are those that improve if there is a greater quantity or quality of nursing care.
Nurse-sensitive hospital-acquired conditions

- Falls - under this category there is further definition around level of injury
- Pressure ulcers - there is further breakdown related to staging. Stage III and Stage IV are state reportable events
- Pediatric pain management
- Pediatric IV infiltration
- Central Line Associated Blood Stream Infection (CLABSI)
- Catheter Associated Urinary Tract Infection (CAUTI)

• Discuss each of these indicators and what control the registered nurse has over the outcomes.
• What can the nurse do to improve outcomes for the patients?
Other nurse-sensitive measures

- Patient satisfaction
- Nursing satisfaction (both our nurse leaders as well as peer nurses impact nurses’ satisfaction with their work environment)
- BSN rates
- Certification rates
- Nursing turnover rates

These are often included in discussions around nurse sensitive indicators as they are highly nursing leadership driven and have been shown to impact the clinical nurse sensitive indicators.
**New nurse’s role in patient outcomes**

- Know and follow nursing practice guidelines
- Seek resources for complex patient issues
- Demonstrate lifelong learning: continuing education, formal education to advance your degree, planning ahead to be prepared for certification
- Stay informed about outcomes measured in your organization
- Participate in teams focusing on evidence based improvement
- Hold yourself and peers accountable to best practices

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How do you know what nursing practice guidelines exist in your specialty?

Who would you turn to in a complex situation (*preceptors, mentors, advanced practice nurses, etc speak about processes within your organization*)?

What are the resources for CEs and organized as well as self directed learning in this organization? (*Be prepared to discuss facility specific resources*)

Where/how will you receive information about how we are doing related to these measures? (*Be prepared to discuss facility specific resources*)

(Describe/discuss teams that focus on improving outcomes in your organization)

We must hold ourselves and our peers accountable. (*Refer to the Code of Ethics for Nurses with Interpretive Statements (2015); especially Provisions 3 & 5*)
Path to positive patient outcomes

- Excellent communication
- Professional boundaries
- Engaging the patient, family and caregivers
- Nurse as advocate
- Prioritization of care
Interprofessional communication

- The World Health Organization (WHO) recognized that better teamwork between health professionals improves patient outcomes
- QSEN competency - function effectively within nursing and inter-professional teams, fostering open communication, mutual respect and shared decision-making to achieve quality patient care
- Share knowledge with each other, no hoarding or withholding information

The new nurse may fall short in the area of interprofessional communication if not given enough opportunity to practice this skill while in school.

The institution is tasked with socializing the novice nurse to the role as well as creating a safe collaborative space where all feel welcome.

According to the study *Silence Kills: The Seven Crucial Conversation for Health Care*, the prevalent culture of poor communication and collaboration among health professionals is significantly related to continued medical errors and staff turnover. Additionally, a lack of adequate support systems, skills, and personal accountability results in communication gaps that can cause harm to patients.

7 areas broken rules: short cuts, mistakes, lack of support, incompetence, poor teamwork, disrespect and micromanagement (Maxfield 2005)
Patient hand-off

- The process of accurate presentation and acceptance of patient-related information from one caregiver to another using effective communication

- It is estimated that 80% of serious medical errors occurs due to a miscommunication during a hand-off
  (Joint Commission)

- **SBAR** provides a consistent method for hand-off communication that is clear, structured and easy to use
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<th><strong>I-SBAR-R</strong></th>
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<tr>
<td><strong>Introduce</strong></td>
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<tr>
<td>• yourself and the patient</td>
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<td><strong>Situation</strong></td>
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<td>• give your assessment and why you are concerned</td>
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<td><strong>Background</strong></td>
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<td>• give any pertinent background</td>
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<td><strong>Assessment</strong></td>
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<td>• state what you think the problem is or state you are unsure of the problem but the patient is deteriorating</td>
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<td><strong>Recommendation</strong></td>
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<td>• receive or offer a recommendation from the provider</td>
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<td><strong>Read back</strong></td>
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<td>• clarify or ask questions</td>
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Gather all the information and write down all pertinent information.
Professional boundaries

- Nursing tops national polls of the most widely respected and trusted professions

- The therapeutic relationship protects the patient’s dignity and autonomy and allows the nurse to apply their professional knowledge, skills, abilities and experiences towards meeting the health needs of the patient

- The power of the nurse comes from the nurse’s professional position and access to sensitive private information. The nurse must make every effort to respect the power imbalance and ensure a patient-centered relationship (NCSBN)
Boundary crossings/violations

- Disclosing excessive personal information to the patient
- Making comments on social media that breach patient confidentiality
- Are likely to occur when there is confusion between the needs of the nurse and those of the patient
- Sexual misconduct is an extreme form of boundary violation and includes any behavior that is seductive, sexually demeaning, harassing or reasonable interpreted as sexual by the patient (NCSBN)

Warning signs and examples

- Discussing intimate or personal issues with a patient
- Engaging in behaviors that could reasonably be interpreted as flirting
- Believing that you are the only one who truly understands or can help the patient
- Speaking poorly about colleagues or your employment setting with the patient and/or family
- Meeting a patient in settings besides those used to provide direct patient care or when you are not at work.
Care prioritization

The nurse must prioritize the patient’s needs (nursing diagnoses) to decide how best to provide care
The patient's need for food, oxygen, must be met prior to meeting the need for belonging.
Tools (continued)

- Patient preference

  Patient centered nursing direct the nurse to first meet the needs that the patient thinks are most important, as long as the order does not interfere with other vital therapies

- Anticipation of future problems

  Provide nursing interventions to prevent problems from occurring, such as repositioning q2h  (Taylor, 2015)

Patient preference - allow them to make a phone call before you start the bath.
Prioritizing the care of several patients

Care for the following first

- Acute
- Unstable
- Unpredictable

Ask yourself is this symptom new, unstable or unpredictable. If you answer “yes” to any of those questions, that need should be made a priority.

Acute - the patient with c/o of a new episode of abdominal pain vs diabetic with c/o neuropathic pain

Unstable - patient will sudden drop in B/P vs patient with slow chronic a fib

Unpredictable - a confused 75 year old patient vs a 40 year old 2 day post lap cholecystectomy who rates his pain as a 5 on a 0-10 scale
Patient and family teaching

Patient education focuses on
- Preparation for receiving care
- Preparation before discharge
- Documentation of patient education activity

Factors affecting patient learning
- Age and developmental level
- Family and support networks
- Cultural influences and language deficits
- Health literacy (Taylor, 2015)

- Patients and families that have “buy in” to their care, will have better outcomes. Nurses can facilitate “buy in” through education.
- Age and developmental level - Malcom Knowles
- adult learning principle
- as people mature, their self concept is likely to be more independent
- Previous experience of the adult is a rich resource for learning.
- An adult readiness to learn is often related to a developmental task or a social role.
- Most adult orientation to learning is that material should be useful immediately
- Family
- Help family find resources and help demonstrate how to problem solve
- Cultural influences
- Understand the core values of the patient or group, supply informational materials in their native language
- Health literacy
- Lack of understanding of basic health information
Patient and family advocacy

The nurse as a patient/family advocate actively promotes the patient’s rights to autonomy and free choice

- Assess the need for advocacy
- Communicate with other healthcare team members
- Provide patient and family teaching
- Assist and support patient decision making
- Serve as a change agent in the healthcare system
- Participate in health policy formulation
Examples of a nurse as an advocate

- Act as an intermediary between the patient and the family or the patient and medical profession
- Helping the family navigate the healthcare system - access to services
- Support the decision making but do not make the decisions for them
- Whistle-blowing
- Politically active

(Taylor, 2015)

Whistle blowing is a warning from a present or past member of an organization to the public concerning a serious wrongdoing or danger created or masked by the organization.
Patient engagement

- Occurs when patients and families become actively involved in their own care

- Meaningful outcomes such as quality, safety and costs are more effective if the patient is engaged in his/her own care

- Being alienated from the care process causes a loss of one’s dignity and respect  
  (Bo-Linn, 2012)

Example: Empowering patients to become active participants in their fall prevention care during hospitalization. Inpatients could receive fall prevention information tailored to their risk for falling as well as their physical and psychosocial characteristics (Heuy-Ming Tzeng 2014)
Strategies for patient engagement

- Rounding on patients
- Communication – keeping the patient informed
- Asking the patient about their preferences
- Teach-back of skills
- Encouraging the patient to ask questions

(Wetzel, 2011) and (Zeis, 2014)
Perfection is not attainable, but if we chase perfection we can catch excellence

Vince Lombardi

every patient deserves excellence
Post-test

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