Competencies in Action: Reflective Practice to Transform Quality and Safety in Pain Management

Gwen Sherwood, PhD, RN, FAAN, ANEF
Professor & Associate Dean for Practice and Global Initiatives
University of North Carolina at Chapel Hill School of Nursing
Co-investigator, Quality and Safety Education for Nursing (QSEN)
Gwen.sherwood@unc.edu

Learning with a Clear Purpose: Mindful Engagement

Why are you here?
What do you want to take with you?
What are you willing to invest?

Objectives

Examine the imperative to integrate quality and safety competencies in pain management nursing

Apply reflective practice to work experiences to develop mindful engagement to improve pain management outcomes

Demonstrate competencies in action to improve pain management outcomes

No Disclosures or conflict of interest for this presentation.
Take a piece of paper

• Follow my directions:

The subjectivity of pain affects providers and patients.

Beliefs about pain are a major factor in how both providers and patients respond to pain.

The Experience of Pain: A Cultural Transaction

What influences:

• Response to pain
• Perceptions of and about pain
• Communication about pain, to whom
• Behavior regarding pain
• Adherence to treatment
• Expectations and desired outcomes
Challenges in solving the puzzle of pain

- Teamwork
- Patient as partner
- Inadequate management
- Research
- Language
- Lack of OBG

Issues in Pain Control

- Health care system: Regulations, pain a low priority, cost-cutting measures, staffing.
- Health care professionals: Misinformation, biased attitudes, fear of addiction, fear of disciplinary action, lack knowledge and skill.
- Public/patients/families: Fear intensity, side effects and addiction, misinformation, cultural beliefs.

But evidence alone has not eliminated mismanagement

- JCAHO standards
- Clinical pathways and standards of care
- Pain Guidelines
- Research data
To change staggering reports of poor health care outcomes, the IOM developed Quality and Safety Competencies for all HC professionals.

All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics.

Health Professions Education
Institute of Medicine (2003)

---

Story: a great teacher:
Listen and Reflect

“It is hard to kill a healthy 15 year old.”

Helen Haskell

---

* https://search.yahoo.com/yhs/search?hspart=SGMedia&hsimp=yhscgmm_fb&fr=sgm&type=ss_search&enable_search=true&sp_pass=1&mp_pass=1&spred=1&srdfce=0&medications&patient%27s%20story
Tears to Transparency: The Story of Lewis Blackman (see YouTube)

What was the cascade of events that a healthy 15 year old died so unexpectedly?
Has it happened before? Can it happen again?
What are patient and family centered approaches that could have been applied?

“He died in the only place we could not call for help, in a hospital.”
Helen Haskell, Lewis’s mother

The IOM series of Quality Chasm reports seek to reframe health care to improve outcomes by focusing on 6 quality and safety competencies.

• The University of North Carolina at Chapel Hill School of Nursing
  • Leader to integrate the competencies in pre-licensure nursing education through the Quality and Safety Education for Nursing.
  • Each competency is defined with the required knowledge, skills and attitudes (KSAs). (Nursing Outlook, May/June 2007)
• www.qsen.org

Quality and Safety Competencies: IOM and QSEN

Patient centered care:
  Family as partner, accurate assessment
Teamwork and Collaboration:
  Communication, collaboration, trust
Evidence based standards:
  Best practices, asking why questions
Quality improvement:
  Process breakdowns, measure/close gaps
Safety:
  Check safety risks, error model, just culture
Informatics:
  Decision support, information sharing
1. Patient Centered Care Competency

Define:
Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.

Lewis: The unfolding case

- Accurate assessment based on individual patient is critical
- Low urine output
- Signs and symptoms repeatedly missed
- Fever; then temp dropped, heart rate up to 142 beats per minute
- Abdomen hard, skin pallor, sweating
- Mother asking for a veteran doctor

Patient Centered Care

- Treat patient and family as an ally
- Engage in care planning
- Provide continuum of care
Competency: Patient-Centered Care

Knowledge:
- Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiologic models of pain and comfort.

Skills:
- Assess presence and extent of pain and suffering
- Assess levels of physical and emotional comfort
- Elicit expectations of patient & family for relief of pain, discomfort, or suffering
- Initiate effective treatments to relieve pain and suffering in light of patient values, preferences and expressed needs

Attitudes:
- Recognize personally held values and beliefs about the management of pain or suffering
- Appreciate the role of the nurse in relief of all types and sources of pain or suffering
- Recognize that patient expectations influence outcomes in management of pain or suffering

Questions for Patient centered care:
- What would have been the most important thing you could have done for Lewis and his mother?
- What unique cultural or personal situations influenced?
- How could the team have communicated more effectively with this patient and family?
  - (Day & smith, 2007).

2. Evidence-based practice Competency:

Define:
Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care
Unanswered questions in Lewis’s case:
What do you need to know about the analgesics you administer?

Medication orders for Ketorelac: Black Box warns “administration carries many risks and should be monitored.”

Managing Pain: What were warning signs?
- Low urine output?
- Assessing vital signs? HR 142
- Pain management: a gasp, stated “worst pain imaginable.”

Evidence Based Practice
- Ask questions about practice.
- Search for best practices and clear decisions.
- Compare actual care and best practices.
- Close gaps in Quality measures

OSEN
3. Quality Improvement competency:
Define
- Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems
Quality Improvement

Question dysfunction, normalization of deviance, seek evidence based decisions

Ask questions about evidence for a particular problem

Learn the language and strategies of QI

Quality Improvement questions in Lewis’s case:

- No bed on surgical unit
- Put on oncology
- It was the week end.

What happens when patients are not cared for by those trained for their care?

What are standard protocols for asking for help?

What are week end protocols?

4. Informatics competency:

Define:

Use information and technology to communicate, manage knowledge, mitigate error, and support decision making
Decision support tools

How can technology applications improve and help manage care?

What tools and strategies can search for health care information and data?

How do I apply EBP to evaluate web based information and help patients and families evaluate information?

5. Teamwork and collaboration competency:

Define:

Function effectively in nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care

Teamwork and Collaboration

Use personal strengths to foster effective team functioning (EQ)

Shift leadership as needed

Include patient and family as team members

Integrate quality and safety science in communicating across diverse team members
Evaluate Gaps in Lewis’s care

- Patient/family were not part of planning care
- No consultation between nurses and residents or discussion about signs and symptoms
- Nurses assumed pain due to gas without further inquiry
- Lack of communication with attending physician and other consultations

Brief: Plan
- Anticipate outcomes and likely contingencies
- Assign resources

Huddle: Problem Solve
- Hold ad hoc, “touch-base” meetings to regain situation awareness
- Discuss critical issues and emerging events
- Express concerns

Debrief: Reflect and Improve
- What went well?
- What can we do better?

6. Safety Competency:

Define:

Minimize risk of harm to patients and providers through both system effectiveness and individual performance
Transform systems approach for a culture of quality and safety
- Mitigating possibility of process breakdowns
- Lessening unintended outcomes: Death or illness resulting from care, unrelated to original cause

A safety mindset
- Safety belongs to everyone but begins with me

Characteristics: Safety science
- Awareness of actions that may put patients at risk for error
- Implement, work with system alerts for safety
- Seek solutions to broken processes and evaluate short cuts
- Work with patient and family and team members as safety allies

Safety Culture
- Results from group values, attitudes, beliefs and competencies
  - Shares collective commitment and mindset
  - Pursue safety goals over obstacles
  - Willing to report near misses & adverse events
- Just Culture: learn from events
  - Replace blame with system design
In Lewis’s case, how did providers....

- Communicate across the care team to share critical information
- Call for help as patient deteriorates
- Consider the possibility of error
- Assess and evaluate pain
- Consider alternatives in a back up plan?

---

**Monday AM**
- 8:30 – 10:15 unable to obtain BP, search for five blood pressure cuffs assuming equipment failure, 12 attempts on arms and legs

**Monday noon:**
- Lab techs can only get a small sample of blood
- Speech becomes slurred, “it’s going black.”
- Seizure, cardiac arrest, resuscitation unsuccessful
- Autopsy: perforated ulcer, bled to death

---

Reason’s Swiss Cheese Model

*Defenses prevent error*

- What is your role in the defense against errors?

http://patientsafetyed.duhs.duke.edu/module_e/swiss_cheese.html
Error: someone did other than what they should have done which led to an undesirable outcome

Normal Human errors
- Slips, lapses
- Forgetful
- Distraction

At-Risk behavior
- Fails to recognize risk
- Reasonable expectations not met
- Outside the rules that usually are ok

Reckless conduct
- Conscious disregard for rules
- Creates dangerous situation

Near Misses

Human factors influence pain management

Health professional
- Background and experience
- Attitudes toward pain and analgesics
- Language
- Interaction with patients and families

Patients and families
- Past experience with pain
- Attitudes toward pain and analgesics
- Language
- Interaction with health professionals
- Access to health care

Analysis of Poor Pain Management in Acute Care Settings (Starck, McNeill, Sherwood, Thomas, 2001)

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Primary Responsible Party</th>
<th>Description of Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and documentation</td>
<td>Nurse</td>
<td>Not specifically and optimally assessed</td>
</tr>
<tr>
<td></td>
<td>Nurse</td>
<td>Not recorded/documented; language issues</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>Shows less change or less frequently (a range to intended dose)</td>
</tr>
<tr>
<td>Treatment and Management</td>
<td>Nurse</td>
<td>Shows less change or less frequently (a range to intended dose)</td>
</tr>
<tr>
<td></td>
<td>Nurse</td>
<td>Shows less change or less frequently (a range to intended dose)</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>Does not respond or decline when requested</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>Language issues</td>
</tr>
<tr>
<td>Patient education</td>
<td>Patient</td>
<td>&quot;Need to save for when really needed&quot;</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>&quot;Need to save for when really needed&quot;</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>&quot;Need to save for when really needed&quot;</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>&quot;Need to save for when really needed&quot;</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>&quot;Need to save for when really needed&quot;</td>
</tr>
</tbody>
</table>
Actions in a Safety Culture

Daily debriefings: empower staff discussions to identify potential errors
- Look back: Review last 24 hours events
- Look ahead: Anticipate issues
- Follow-up: Issue status reports

Best practices
- Reflect and learn from experience: Share failures and successes

Safety Mindset to improve pain management

- What is the risk of my actions?
- What are system alerts or safe guards to prevent the next error?
- How is safety compromised when I take short cuts in care?
- How do I handle uncertainty about care decisions?

Errors in Pain Assessment Practices

Failure to
- Credit the patient's self report
- Use a valid and reliable assessment scale
- Use culturally or language appropriate instruments
- Document/report consistently

Faulty interpretation of assessment information
- Severity of pain intensity
- Severity of pain related interference
Errors in Treatment

Errors in analgesic choice
- Inappropriate use of meperidine (Gordon et al, 2002)
- Analgesic strength does not match pain severity
- Provider and patient fear of opioids

Errors in scheduling

Errors in route choice, avoiding IM route

Errors related to the use of adjuncts
- Pharmacologic
- Non-Pharmacologic

Errors in patient education

Failure to
- Correct myths/misinformation about pain and pain management
- Inform patients re realistic expectations for pain control
- Educate patients re pain management approaches available to them
- Provide culturally or language appropriate instructions re pain management

Best practice

Systems would be designed that make it impossible, or extremely difficult, to not attend to patients’ pain.

- Develop protocols for pain management to improve standard of care
- Identify patients who are high risk for inadequate pain management to assure appropriate assessment/management
- Design systematic outcome measures
3 components in a System Approach to Effective Post-Op Pain Management in diverse populations

Assessment and Documentation

Education for providers and patients, families

Treatment and Management

Team based

Quality monitoring

Reflective Practice and Mindful Engagement: Listening to the Patient

• Count how many times the team in white passes the ball?

• http://www.youtube.com/watch?v=1D07neiB7H1

Do we see and hear what we expect to see and hear?

• Task orientation
• Situation monitoring
• Situational Awareness

Assessing pain includes multiple factors

- intensity
- education
- type of pain
- expectations
- satisfaction
Assessing pain: What are the patient’s expectations about pain?

“Unrecognized pain is untreated pain.”
C. Cleland (JAMA, 1998)

- What is the patient’s pain relief goal?
  - On a scale (0 – 10)
  - In terms of function
    - Wants to reduce pain interference on sleep, work, walking, mood, other...
  - Document relief goal

Relies on patient self-report!

Untreated pain is medical error

Assessing pain: Meaning

Research indicates patients assign meaning to pain. How patients interpret the meaning or role of pain influences their responses. Providers can assist patients in recognizing the meaning of their pain.

- Is the disease worsening?
- Is it inevitable with disease or surgery?
- Is it distracting from treatment for disease?
- Does it signal need for medication?
- What are fears related to medication?
Pain Management Documentation

- Post-surgical monitoring.
- Education of patients, families and care providers on assessment, pharmacological and non-pharmacological management.
- Policies and procedures established through interdisciplinary planning.

Quantifying the Effectiveness of Pain Management

Pain Management Index (PMI): a formula to evaluate effectiveness of pain management. Cleeland, 1992

- **Worst Pain Rating:**
  - 10 to 7 = 3
  - 6 to 4 = 2
  - 3 to 1 = 1

- **Analgesic rating:**
  - Strong opioid = 3
  - Weak opioid = 2
  - Non-opioid = 1

- **Negative number = poor management**
- **Positive number = adequate treatment**

Assessing Effectiveness

- Is the individual comfortable and able to do desired activities?
- Are the patient and family satisfied with pain management?
- Did the patient achieve pain relief goals?
- Was hospital length of stay affected?
Standardize protocols to apply evidence based best practices:

- Administer appropriate medication for pain intensity
- Provide around the clock vs prn scheduling for initial postoperative pain management
- Use oral or IV route whenever possible, not IM
- Do not use IM Demerol unless specifically indicated
- Consider non-pharmacological, adjunct therapies
- Manage analgesic Side Effects

Education

Provide culturally and language appropriate instruction to patient/family, providers

- Collaborate with patients/families, especially high risk
- Set expectations; identify and correct misinformation
- Use all forms of media for instruction
- Establish unit experts as resources for patients and staff
Do you agree or disagree with these common beliefs about pain and pain treatment?

- Everyone responds to pain in the same way.
- You can judge a person’s pain by various body movements and signs.
- Patients who take narcotics (opioids) for pain are highly likely to become addicted.
- One should save pain medicine for when it is really needed.
- Pain represents punishment for bad deeds.
- Good patients do not complain about pain.

All are myths, unproven by scientific evidence!

How do you rate yourself as a provider in managing pain outcomes?

- Involve patients in all aspects of care.
- Honor patients’ right to appropriate pain related care.
- Assess all patients for pain.
- Know policies and procedures for safe and appropriate use of pain management approaches.
- Monitor during the postoperative period.
- Educate patients about discharge planning.
- Continuous assessment to monitor performance.

A proposed systems approach

- Assessment and Documentation
  - Use standard numeric scales
  - Identify/monitor high risk
  - Provide culturally and language appropriate tools
  - Assess periodically as 5th VS
  - Reassess after analgesic interventions
  - Red flag high severity patients
- Treatment and Management
  - Use appropriate analgesics
  - Schedule analgesics for post-op, cancer pain
  - Monitor high-risk pts closely
  - Use adjunct pharm and non-pharm approaches
  - Avoid I&I’s & meperidine
- Patient Education
  - Focus on priority of pain management
  - Foster collaboration with patient/family
  - Provide education, culturally sensitive, language appropriate care, written and verbal

McNeill, Sherwood, Stark, 2003
Reflective Practice: Mindful Engagement
Developing situational awareness

What do I need to know to accomplish my purpose?
What do I need to be able to do?
How do my attitudes shape my choices?

Competency:
• Knowledge
• Skills
• Attitudes

Best practice: Partnerships ...
System designs would make it difficult to avoid attending to patients’ pain.
Errors of mismanaged pain can reach Zero!

... client, family, & health provider for education and collaboration.

Nurses’ work redefined

A Quality Safe Culture: A new way of thinking about practice

Engages in their work with the patient as the focus
Encourages inquiry
Applies evidence based standards and interventions
Investigates outcomes and critical incidents from a system perspective
Continually seek to improve care
Learning with a Clear Purpose: Mindful Engagement

What are your next steps?

What can you take with you to begin using from today's session?

What needs to change to implement IPE?

What are your next steps?