

FAILURE TO RESCUE: HOW SIMULATION CAN HELP TRANSITION TO PRACTICE

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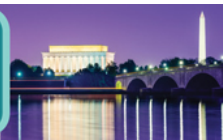
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DISCLOSURES

Conflict of Interest

- Sabrina Beroz (Content expert and speaker) reports no conflict of interest.
- Tonya Schneidereith (Content expert and speaker) reports no conflict of interest.
- Nancy Sullivan (Content expert and speaker) reports no conflict of interest.
- Crystel Farina (Content expert and speaker) reports no conflict of interest.
- Julia Greenawalt (INACSL Conference Administrator & Nurse Planner) reports no conflict of interest
- Leann Horsley (INACSL Lead Nurse Planner) reports no conflict of interest

Successful Completion

- Attend 100% of session
- Complete online evaluation

LEARNING OUTCOMES

Upon completion of this educational activity, participants will be able to:

- 1. Discuss the impact of failure to rescue on patient outcomes.**
- 2. Explore designing simulations aimed at failure to rescue (surveillance and taking).**
- 3. Develop a curriculum map aligning failure to rescue with nurse residency programs.**

FAILURE TO RESCUE

The Agency for Healthcare Research and Quality (AHRQ) has defined failure to rescue as:

“a measure of the degree to which providers responded to adverse occurrences that developed on their watch. It may reflect the quality of monitoring, the effectiveness of actions taken once early complications are recognized, or both” (AHRQ, 2013, para. 1).

IMPACT ON PATIENT CARE

- **The cost attributable to medical errors in 2010 was \$19.5 billion and the total cost per error was \$13,000 (AHRQ, 2013).**
- **Less than one-third of the patients with pneumonia or sepsis and less than one-half of the patients with acute renal failure, gastrointestinal hemorrhage, or deep vein thrombosis/pulmonary embolism received an intervention within one day of the availability of signs and symptoms (Cuny, 2005).**

WHAT IT MEANS FOR PRACTICE

- **Failure to rescue is one outcome measure used to examine quality of care in hospitalized patients.**
- **Two concepts, surveillance and taking action, have been identified as necessary in preventing failure to rescue events (Clarke & Aiken, 2003).**
- **Novice nurses, who are working on time management and priority setting skills, are at risk for not recognizing the subtle cues of patient deterioration.**

THE NOVICE NURSE

Literature review conducted to identify factors that influence graduate nurse's preparedness for recognizing and responding to a deteriorating patient.

- 1. Clinical support from colleagues in escalating care.**
- 2. Lack of nurse experience in interpreting signs of deterioration.**
- 3. Overwhelming workload as a barrier to adequate assessment and recognition.**
- 4. Holistic assessment as a need to go beyond vital signs.**
- 5. Variety of past experiences.**
- 6. Lack of available resources.**

New graduates were found to lack overall experience because of lack of exposure and knowledge and skill-- all barriers to recognition of deterioration and appropriate management.

(Purling & King, 2012)

SIMULATION DESIGNS: CRITICAL ELEMENTS

- **Recognition of changes in patient status**
- **Taking initiative**
- **Tracking multiple responsibilities**
- **Ability to prioritize**
- **Anticipate risk**
- **Delegation of tasks.**

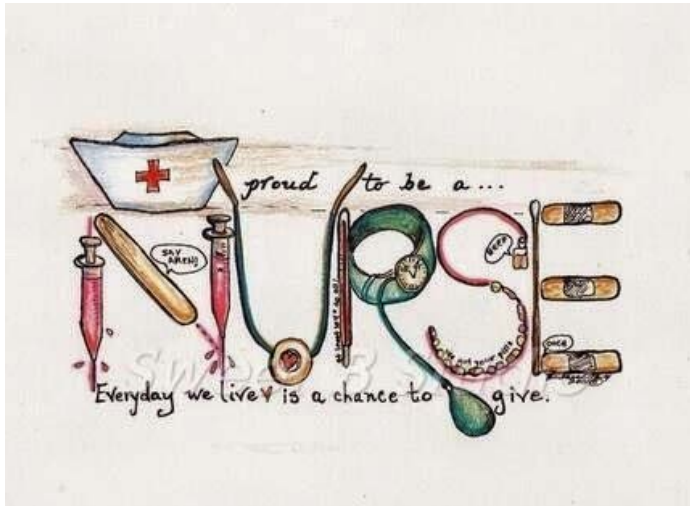
(Berkow et al., 2009)

KEY AREAS FOR DEBRIEFING

Core concepts found in simulation scenarios across academic and practice nurse educators (MCSRC 2016):

- **QSEN Competencies: Safety, Team collaboration. Communication, Informatics, Patient-Centered Care and EBP.**
- **Professionalism**
- **Ethics/caring**
- **Delegation**
- **Interprofessional collaboration**
- **Scope of practice**

EVALUATION OF CRITICAL ELEMENTS



Changes in patient status

Taking initiative

Multiple responsibilities

Prioritization

Anticipate risk

Delegation



EXAMPLES



CURRICULUM MAPPING

Alignment grid

Sample curriculum map

Collaborative work

CURRICULUM ALIGNMENT

Program/Institution Course	Program Outcome	Course Outcome	Concept	Simulation Title with Learning Outcomes

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