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The Critical Thinking Toolkit

Fostering Critical Thinking Skills in the Front Line

Nursing Executive Center

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Nursing Executive Center Publication Information

The Critical Thinking Toolkit (29692)
Fostering Critical Thinking Skills in the Front Line

Orientation to the Toolkit

Nearly all nursing leaders report that today's fast-paced and task-oriented care environment can prevent bedside nurses from thinking critically about their patient's needs and nursing care—all too often resulting in suboptimal care. Expanded course offerings during new-graduate nurse orientation are no doubt an excellent starting place for bolstering critical thinking skills. But mounting evidence indicates they are not sufficient. The reach of such courses typically is too limited in timing and scope to overcome the myriad roadblocks to critical thinking that all nurses face in today's complex care environment. Moreover, the challenge of equipping nurses to think critically is scaling. Nurses long recognized as strong critical thinkers are increasingly finding themselves challenged as the care environment becomes ever more complex due to ongoing protocolization, rising patient acuity, and decreasing length of stay.

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Problem Recognition

Section Goal: To help participants anticipate, recognize, and clearly communicate signs of emerging problems

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This Toolkit contains 16 targeted exercises to enhance bedside nurse performance on five core components of critical thinking. The exercises are designed for nurses at every career stage—tenured nurses as well as new graduates. To complement didactic training and reflect adult learning theory, the exercises are highly interactive. Activities participants will be asked to conduct include role-playing, structured peer feedback, targeted patient observation, and guided self-reflection. Ideally, the managers, educators, and preceptors deploying the toolkit should first identify their frontline nurses' most pressing improvement needs and then prioritize the most relevant exercises. To assist with this mapping, each section begins with a brief overview of the targeted critical thinking competency and supporting tools. Additionally, each tool contains a user guide, evaluation criteria, and prompts for facilitated discussion.

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Center Resources

While this toolkit is designed to be a stand-alone resource, the Center further supports institution efforts to further critical thinking through resources listed below:

- **Critical Thinking Diagnostic** Assesses individual performance across 25 critical thinking competencies
- **Best Practices** Targeted strategies for overcoming bedside nurse task-focused tunnel vision
- **Onsite Consultation** Presentation by Center faculty at member institution
- **On-Call Expert Support** Direct access to Center experts on advancing and assessing critical thinking

Section I

Problem Recognition

Section Goal: To help participants anticipate, recognize, and clearly communicate signs of emerging problems

- Tool #1: Change in Patient Status Exercise
- Tool #2: "Unusual" Patient Progression Exercise
- Tool #3: Unit-Level Problem Identification and Prioritization Exercise
- Tool #4: Root Cause Analysis
- Tool #5: In-the-Moment Safety Concern Scripting

Introduction

Starting Questions

The scripting below is designed to help facilitators provide participants with an overview of the context and aim of the toolkit section on Problem Recognition.

1. What are the key elements of Problem Recognition?

Problem Recognition has three key elements:

- The ability to anticipate likely problems
- The ability to recognize signs of an emerging problem
- The ability to clearly communicate real-time concerns about an emerging problem

2. Why is Problem Recognition important for bedside nurses?

Problem Recognition is the foundation of all quality improvement efforts—without a recognized problem there would be little incentive to change current practice.

As a result, bedside nurses with strong problem recognition skills have the opportunity to improve the safety and quality of care delivered to their individual patients, as well as groups of patients on their unit. When caring for individual patients, strong problem recognition skills allow bedside nurses to identify early signs of patient deterioration and the need for corrective action. When considering the unit as a whole, strong problem recognition skills enable bedside nurses to identify evidence of underlying unit-level problems and opportunities for improvement.

3. How will the exercises in this section help improve Problem Recognition?

The first two exercises in this section focus on the first two elements of Problem Recognition: anticipating and recognizing signs of emerging problems. In these exercises participants practice identifying emerging problems for individual patients—including recognizing changes in patient status or departures from an expected disease progression.

The next two tools shift the focus from identifying emerging problems for a single patient to identifying problems at the unit (or system) level. These exercises provide two approaches for practicing systems-thinking and problem solving: participants are first asked to identify potential risks or improvement opportunities on their unit, and are then asked to conduct a root cause analysis on a specific incident in which non-optimal care was delivered (or nearly delivered).

The final exercise focuses on the third element of Problem Recognition: clear and timely communication about emerging problems. In this exercise participants use scenarios to practice clearly expressing their concerns to other care team members.

Overview of Tools for Problem Recognition

Tool #1: Change in Patient Status Exercise

Overview: The goal of this exercise is to prepare bedside nurses to identify potential changes in patient status through guided observations and analysis of stable and unstable patients.

Type of Exercise: Observational activity

Tool #2: "Unusual" Patient Progression Exercise

Overview: The goal of this exercise is to enable bedside nurses to detect emerging clinical patterns worthy of concern. The worksheet assists participants by increasing knowledge of the "typical" characteristics of a defined patient population.

Type of Exercise: Investigative activity requiring research and collaboration

Tool #3: Unit-Level Problem Identification and Prioritization Exercise

Overview: The goal of this tool is to provide bedside nurses with an opportunity to apply systems thinking to daily unit practice. The tool provides participants with a framework and structured activities for elevating problem recognition skills from an individual patient to the unit's broader patient population.

Type of Exercise: Investigative activity

Tool #4: Root Cause Analysis

Overview: The goal of this tool is to guide staff members through a written root cause analysis of a specific incident in which non-optimal patient care was delivered in order to identify opportunities for unit improvement.

Type of Exercise: Root cause analysis

Tool #5: In-the-Moment Safety Concern Scripting

Overview: The goal of this tool is to help staff nurses appropriately voice their concerns when witnessing a potentially unsafe practice. This tool provides detailed scripting and advice on communicating with other members of the care team about potentially unsafe practices.

Type of Exercise: Scripting and written exercise

Tool #1: Change in Patient Status Exercise

Overview: The goal of this exercise is to prepare bedside nurses to identify potential changes in patient status through guided observations and analysis of stable and unstable patients.

Type of exercise: Observational activity

Staff resources required: None

Time required: Approximately one hour per week over four weeks; 30 minutes for concluding discussion

Targeted skill: Early identification of potential changes in patient status

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This tool is most applicable for less experienced staff members who do not routinely anticipate changes in patient status.

II: Share this exercise with participating staff members and agree upon a deadline. The Center recommends setting a deadline of four to five weeks after sharing the exercise with participants. Establish regular check-ins across the exercise period to answer staff questions.

III: Assess the exercise using the Evaluation Guide on page 7. Use the Discussion Guide to initiate a conversation about participants' experiences completing the exercise and their comfort level in detecting potential changes in patient status.

Tool #1: Change in Patient Status Exercise

Step One: Among patients commonly seen on your unit, select a diagnosis pathway that has a predictable range of vital signs. Write the diagnosis below.

Selected Diagnosis: _____

Step Two: Observe patients with this condition in the course of your daily practice over the coming month and then record the top five answers to the questions below.

Typically, what are the earliest clinical signs that the patient's condition is improving? (If applicable, list exact ranges of vital signs.)

1. _____
2. _____
3. _____
4. _____
5. _____

Typically, what are the earliest clinical signs that the patient's condition is deteriorating? (If applicable, list exact ranges of vital signs.)

1. _____
2. _____
3. _____
4. _____
5. _____

What are the most likely clinical triggers that would lead to further deterioration?

1. _____
2. _____
3. _____
4. _____
5. _____

When a patient with this condition deteriorates, what are the most dangerous consequences?

1. _____
2. _____
3. _____
4. _____
5. _____

Tool #1: Change in Patient Status Exercise

Step Three: Please complete the chart below by recording the anticipated range of values for each clinical indicator according to the listed patient condition. Note any typical patient lab values and record additional symptoms that would confirm the patient's condition in the far-right column.

	Indicator	Minimum Value	Maximum Value	Applicable Labs	Minimum Value	Maximum Value	What additional observable patient symptoms would confirm this condition?
Condition Remains Stable	HR:	_____	_____	_____	_____	_____	
	RR:	_____	_____	_____	_____	_____	
	Oxy%:	_____	_____	_____	_____	_____	
	Temp:	_____	_____	_____	_____	_____	
	Pain Level:	_____	_____	_____	_____	_____	
	BP:	_____	_____	_____	_____	_____	
Condition Improves	HR:	_____	_____	_____	_____	_____	
	RR:	_____	_____	_____	_____	_____	
	Oxy%:	_____	_____	_____	_____	_____	
	Temp:	_____	_____	_____	_____	_____	
	Pain Level:	_____	_____	_____	_____	_____	
	BP:	_____	_____	_____	_____	_____	
Condition Deteriorates	HR:	_____	_____	_____	_____	_____	
	RR:	_____	_____	_____	_____	_____	
	Oxy%:	_____	_____	_____	_____	_____	
	Temp:	_____	_____	_____	_____	_____	
	Pain Level:	_____	_____	_____	_____	_____	
	BP:	_____	_____	_____	_____	_____	

Step Four: Please discuss the questions below with your manager, an educator, or a peer, and record the top three answers in the spaces below.

If you suspect you are seeing early signs of patient deterioration, what additional information should you gather to confirm your suspicions?

1. _____

2. _____

3. _____

If a patient's condition is beginning to deteriorate, what actions can you take to stabilize the patient?

1. _____

2. _____

3. _____

Facilitator Resources

Tool #1: Change in Patient Status Exercise

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the spectrum may indicate a greater opportunity for improvement.

Selection of appropriate diagnosis for this exercise

☐	☐	☐	☐
Diagnosis is one of the most common or acute conditions cared for by the participant	Diagnosis is regularly treated on unit but not among most acute	Diagnosis is occasionally treated on unit	Diagnosis is rarely, if ever, present on unit

Accuracy of clinical indicator ranges

☐	☐	☐	☐
All clinical indicator ranges are accurate and specific	Some sections of clinical indicator ranges are accurate and specific, but others may be vague	Clinical indicator ranges are vague and do not provide sufficient detail from which to make decisions	Clinical indicator ranges are inaccurate and/or incomplete

Thoroughness of action steps to stabilize a patient

☐	☐	☐	☐
Action steps accurately reflect urgency of intervention and indicate appropriate course of action	Action steps may depend on peer or physician intervention	Action steps do not appropriately prioritize most urgent steps	Action steps not applicable to chosen diagnosis

Comments:

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences completing the exercise and their comfort level in detecting potential changes in patient status.

1. How hard was it to determine the range of standard values for each vital sign?
2. When you collected information on vital signs for stable and unstable patients, were you surprised by any of the information?
3. Which was easier, finding ranges for the clinical indicator or determining the nursing interventions to stabilize a patient? What does that tell you about the extent to which you rely on your instincts in nursing practice?

Tool #2: "Unusual" Patient Progression Exercise

Overview: The goal of this exercise is to enable bedside nurses to detect emerging clinical patterns worthy of concern. The worksheet assists participants by increasing knowledge of the "typical" characteristics of a defined patient population.

Type of exercise: Investigative activity requiring research and collaboration

Staff resources required: Access to nursing literature and unit clinical experts

Time required: Ten hours over one month for observation, research, and collaboration with peers; 30 minutes for concluding discussion

Targeted skill: Differentiating "typical" and "non-typical" patient characteristics and progression for a selected patient population

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

This tool was developed by nursing leaders at Baylor Health System for use during new hire orientation. At the conclusion of orientation, all new hires present their work to their peers.

I: Select frontline staff members to complete this exercise. This tool is most applicable for newer staff members or those caring for a new patient population.

II: Share this exercise with participating staff members and agree upon a deadline. The Center recommends setting a deadline of four to five weeks after sharing the exercise with participants. Establish regular check-ins to answer staff questions.

III: Assess the exercise using the Evaluation Guide on page 13. Use the Discussion Guide to initiate a conversation about participants' experiences completing this exercise and their ability to detect an "unusual" progression for their selected patient population.

Tool #2: "Unusual" Patient Progression Exercise

Step One: Select a patient condition that commonly presents on your unit and for which you commonly deliver care. Write the selected diagnosis in the space below.

Selected Diagnosis: _____

Step Two: Across the coming month, observe patients on your unit with this condition (including patients with the condition who are not in your patient assignment). As you observe these patients, record the typical characteristics of the disease and the patient population in the table below.

Most Common Presentation	
Gender	
Age range & any age-specific care considerations or accommodations needed	
Cultural care considerations or accommodations needed	
Cognitive status (e.g., cognitive impairment such as dementia)	
Method of admission (e.g., elective, via ED)	
Typical length of stay on unit	
Usual discharge disposition (e.g., home, home with home care, another facility)	

Tool #2: "Unusual" Patient Progression Exercise

Step Three: Use your observations to complete the following form.

Patient Needs	Key Characteristics/ Areas of Interest to Ask About	Profile of the Population in General
Stability	• Vital signs, labs, tests, cardiac rhythms/ arrhythmias, or assessment results that typically deviate from the norm • Critical results (labs, ABGs, or EKG) that specifically apply to this patient population • Types of meds or treatments used in response to these deviations/abnormals/critical results	
Complexity	• Key system assessments including psychosocial needs, patient/family dynamics • Specialty assessments commonly used (e.g., pain, skin, fall, sedation, restraints, etc.) • Usual type of IV access, incisions, dressings seen • Any specialty equipment or devices used • Any required isolation and/or specialized infection prevention or control methods	
Vulnerability	• Commonly encountered factors that can put this population at risk or create safety issues (e.g., sedation, fall/wandering, weight gain/loss, NPO/ poor intake, restraints, immunosuppressed, etc.) • Pain management for this population • Any communication and/or sensory limitations such as non-English speaking, aphasic, blind, glasses/contacts, deaf/HOH, hearing aid • Nursing interventions and precautions to prevent or minimize these risks	
Resiliency	• How well this population progresses along the health care continuum and recovers or returns to pre-hospital baseline/functioning • Commonly encountered population/family coping abilities, anxieties, fears, concerns, questions, needed info related to the condition/ status	

Tool #2: "Unusual" Patient Progression Exercise

Step Three: Use your observations to complete the following form.

Patient Needs	Key Characteristics/ Areas of Interest to Ask About	Profile of the Population in General
Predictability	• Typical progression for this population during the stay on the unit • Commonly used plans of care, physician orders/order sets, SDMOs, consults, carepaths, ordered procedures/exams/tests including any associated preps and special consents, etc. • Commonly needed/ordered consults (e.g., other medical specialists, PT, OT, psych, etc.) • Commonly ordered medications including doses, expected effects, pre-/post-administration assessments/monitoring, needed education, potential side effects or adverse reactions, considerations or accommodations needed based on population's age, other medications being given, or other comorbid conditions	
Participation in Care	• Activity level based on condition and/or physical ability, amount of assistance required for care • Population's ability to participate in care/do self-care such as ADLs • Any special safe patient handling equipment required	
Participation in Decision Making	• Level of involvement or ability of population to make decisions about care • Any advanced directive, end-of-life, or palliative care issues encountered with this population	
Resource Availability	• Population's support network (e.g., family, social, community, spiritual, financial, etc.) • Learning needs and commonly used patient education materials • Discharge planning needs (e.g., social work/ care coordination consults, home care, placement in other facility, equipment needed after discharge, etc.)	

Tool #2: "Unusual" Patient Progression Exercise

Step Four: Draw upon the information recorded in Step Three, as well as your personal observations, to answer the questions below.

What are the top five most common psychosocial issues that this patient population faces?

1. _____
2. _____
3. _____
4. _____
5. _____

What are the top five most common ways patients deviate in any way from your defined "normal"?

1. _____
2. _____
3. _____
4. _____
5. _____

What are the top five ways care requirements changed for "non-typical" patients?

1. _____
2. _____
3. _____
4. _____
5. _____

Facilitator Resources

Tool #2: "Unusual" Patient Progression Exercise

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the spectrum may indicate a greater opportunity for improvement.

Selection of appropriate diagnosis for this exercise

☐	☐	☐	☐
Diagnosis presents frequently on unit	Diagnosis not uncommon on unit	Diagnosis rarely, if ever, presents on unit	Specific diagnosis not selected

Accuracy of disease presentation

☐	☐	☐	☐
All key vitals and patient demographic data are correct	Data is mostly correct; may contain some vague statements	Some data is missing or vague; may contain minor inaccuracies	Moderate to major inaccuracies

Comprehensiveness of identified patient needs

☐	☐	☐	☐
Demonstrates clear understanding of patient clinical needs	Demonstrates understanding of clinical condition, if not individual needs	Information is missing, vague, or non-specific; may contain minor inaccuracies	Moderate to major inaccuracies; demonstrates clear development need

Comments:

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences completing this exercise and their ability to detect an "unusual" progression for their selected patient population.

1. What considerations led you to select the patient population to research?
2. How "alike" were the patients within your selected patient population? What surprised you about the amount of patient variability (or lack thereof)?
3. What information could you gather on your own? What information did you have to gain through other sources?
4. Which providers were the most helpful to you as you completed this exercise?
5. Which component of the exercise did you find the most useful for detecting early deviations from the anticipated patient progression? Why?

Tool #3: Unit-Level Problem Identification and Prioritization Exercise

Overview: The goal of this tool is to provide bedside nurses with an opportunity to apply systems thinking to daily unit practice. The tool provides participants with a framework and structured activities for elevating problem recognition skills from an individual patient to the unit's broader patient population.

Type of exercise: Investigative activity

Staff resources required: None

Time required: Approximately five hours across one week for problem surfacing; 30 minutes for concluding discussion

Targeted skill: Systems thinking, problem recognition, and problem prioritization

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This tool is most applicable for high-performing staff members who have the capacity to perform observation and analysis in the course of their daily practice.

II: Share this exercise with participating staff members and agree upon a deadline. The Center recommends setting a deadline of one to two weeks after sharing the exercise with participants. Establish regular check-ins across the exercise period to answer staff questions.

III: Assess the exercise using the Evaluation Guide on page 17. Use the Discussion Guide to initiate a conversation about participants' experiences completing the exercise and their surfaced problems.

Tool #3: Unit-Level Problem Identification and Prioritization Exercise

Step One: Spend one week closely observing your practice and the practice of others on your unit. Your goal is to identify potentially inefficient processes, near-misses, and circumstances in which you or your peers struggle to deliver safe care.

Step Two: Answer the questions below based on your observations. Be as specific as possible.

1. Were there incidents of patient harm or near misses? If so, record them below.
   Sample: Elderly patient fell after receiving Klonopin
   a. _____ e. _____
   b. _____ f. _____
   c. _____ g. _____
   d. _____ h. _____

2. Based on your observations, can you predict how the next incidents of patient harm (or near misses) will occur?
   Sample: Pressure ulcer in peds patient with spine injury
   a. _____
   b. _____
   c. _____

3. What care processes take longer than they should?
   Sample: Locating supplies for IV insertion
   a. _____
   b. _____
   c. _____

4. Do any potential emergency situations lack defined protocols? Which ones?
   Sample: Emergency CT scan
   a. _____
   b. _____
   c. _____

5. For which policies or protocols do staff struggle to reach 100 percent compliance?
   Sample: Hand washing prior to entering patient rooms
   a. _____
   b. _____
   c. _____

6. What generates the greatest number of complaints from patients, physicians, or staff members about your unit?
   Sample: Patients dissatisfied with discharge education according to Press Ganey surveys
   a. _____
   b. _____
   c. _____

Tool #3: Unit-Level Problem Identification and Prioritization Exercise

Step Three: Review your answers to the previous six questions. Use the prompts below to identify the problems that have the greatest impact on care quality and write the three biggest problems on the blank lines below.

Which of the problems address:

- needs of a high-risk patient population?
- the greatest unit quality concerns?
- persistent staff cultural concerns?
- care processes that are more dangerous than others?
- institutional strategic goals that the unit is falling short on?
- care process that you are passionate about improving?

Sample: Documentation of Joint Commission Core Measures in the EMR

a. _____

b. _____

c. _____

Step Four: Write the problems you identified in Step Three in the table below.

Step Five: For each problem, use the scale in the table to rate its likelihood of occurring, its severity, and its likelihood of detection.

Step Six: Multiply the three scores to get a single Risk Priority Score for each problem.

Problem	Likelihood of occurrence (1=rare, 10=frequent)		Severity of consequence (1=minor, 10=catastrophic)		Likelihood of detection (1=extremely likely, 10=extremely unlikely)		Risk Priority Score
Sample: Physician fails to use full drape during central line insertion	8	x	7	x	2	=	112
		x		x		=	
		x		x		=	
		x		x		=	

Step Seven: Use the Risk Priority Score to identify the highest-scoring problem. Verify that the problem can be inflected by a change in practice. If the problem is not actionable, move to the next-highest-scoring problem until you find one that is actionable. List that problem below.

Key Problem:

_____

_____

_____

Tool #3: Unit-Level Problem Identification and Prioritization Exercise

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the spectrum may indicate a greater opportunity for improvement.

Originality of surfaced problems

☐ All problems surfaced highlight previously hidden quality concerns	☐ Surfaced problems typically reiterate current ongoing initiatives, with some original ideas	☐ No ideas identified outside of current unit initiatives	☐ Unable to identify even current unit improvement ideas

Importance of surfaced problems

☐ Surfaced problems target critical unit performance concerns	☐ Surfaced problems align with unit priorities	☐ Surfaced problems focus on narrow area of nurse's individual practice	☐ Surfaced problems have no impact on unit operations

Relevance of identified highest-priority problem

☐ Identified problem highlights one of unit's most pressing concerns	☐ Identified problem closely aligns with unit priorities	☐ Identified problem has some impact on unit operations	☐ Identified problem has little applicability beyond one staff member

Actionability of identified highest-priority problem

☐ Identified problem can be readily inflected by change in nursing practice or support system	☐ Identified problem requires stakeholder buy-in from other units	☐ Identified problem is extremely general and broad	☐ Identified problem virtually impossible to solve

Comments:

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences completing the exercise and their surfaced problems.

1. What surprised you the most when you observed the unit?
2. How hard was it for you to identify potential quality improvement opportunities?
3. Why did you select your identified problem as the most important problem to tackle?
4. How does your identified Key Problem impact your daily practice?

Tool #4: Root Cause Analysis

Overview: The goal of this tool is to guide staff members through a written root cause analysis of a specific incident in which non-optimal patient care was delivered in order to identify opportunities for unit improvement.

Type of exercise: Root cause analysis

Staff resources required: None

Time required: One hour for brainstorming; 30 minutes for concluding discussion

Targeted skill: Root cause analysis

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select individuals to complete this exercise. The tool is applicable for all staff members. This tool is not intended to replace your institution's formalized root cause analysis process after significant events.

II: Share this exercise with participating staff members and agree upon a deadline. The deadline should be one to two weeks after sharing the tool with participants. The Center recommends checking in twice with participants during the exercise; once after participants select an event to analyze and a second time at the halfway point of the exercise to answer questions.

III: Assess the exercise using the Evaluation Guide on page 23. Use the Discussion Guide to initiate a conversation about participants' experiences completing the exercise and developing a root cause analysis.

Tool #4: Root Cause Analysis

Step One: In the space below, record a specific clinical situation in which you delivered (or nearly delivered) non-optimal patient care.

Sample Event: Medication dosage near miss: almost gave 10 times recommended dose of morphine. Unit was very busy. I had used solution 10 times stronger by accident. The nursing aide who checked calculations caught the concentration error.

Your Event: _____

_____

_____

Step Two: In the table below, list all other providers that were involved (even indirectly) in your selected situation.

Additional Care Providers Involved (Sample List)	Additional Care Providers Involved
• Nurse	• _____
• Physician	• _____
• Unit-based pharmacist	• _____
• Nursing assistant	• _____

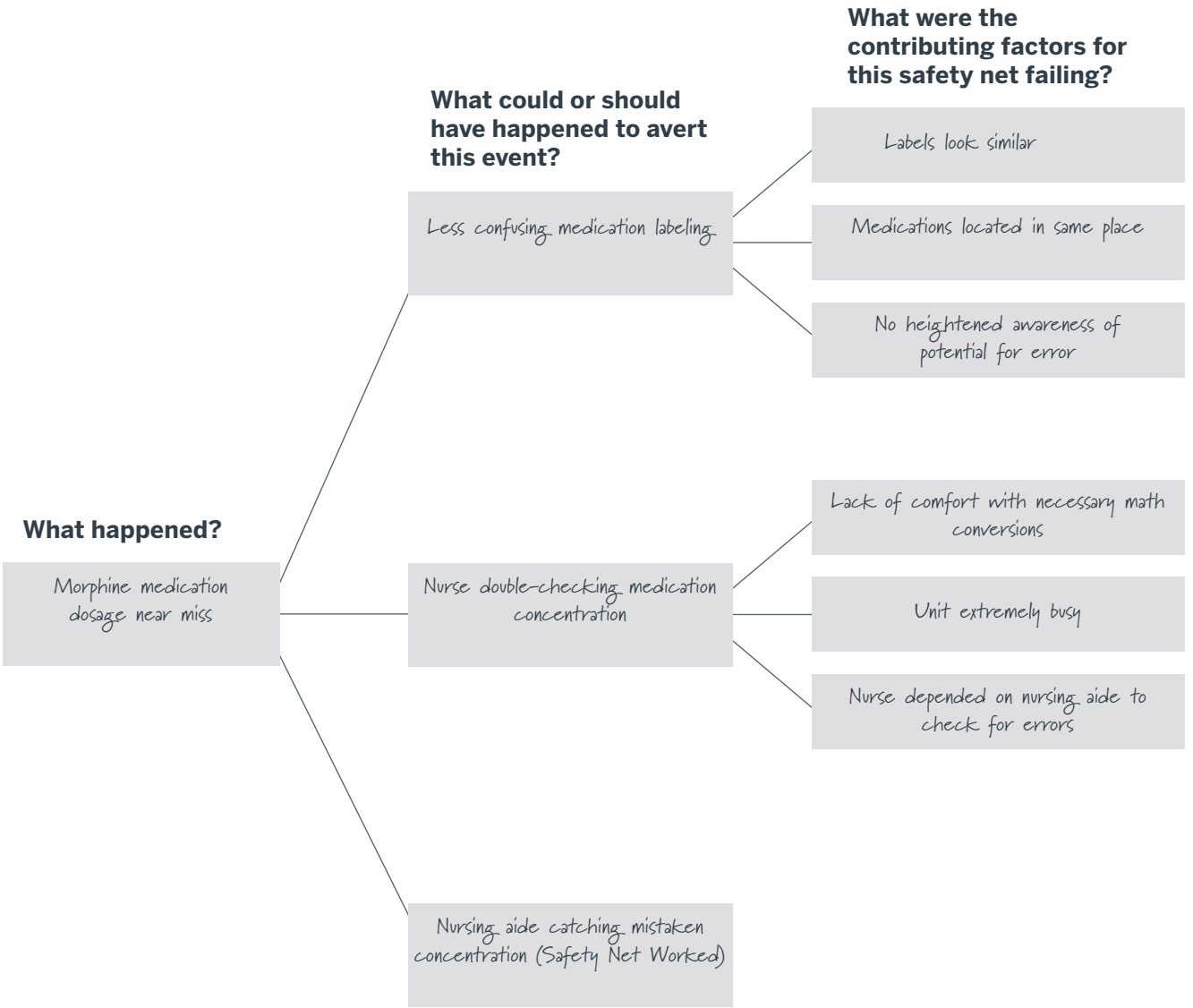
Step Three: In the table below, list the key events of your identified clinical situation. Include the events that led up to the situation, events during the situation, and events directly resulting from the identified situation.

Additional Care Providers Involved (Sample List)	Additional Care Providers Involved
1. Pharmacist stocks Pixys system with varying doses of morphine	1. _____
2. Doctor writes order for morphine based on patient pain levels	2. _____
3. I mistakenly took higher dose concentration	3. _____
4. I calculated necessary dilution factor	4. _____
5. Nursing aide checks calculations to verify correct dosage; caught medication error	5. _____
	6. _____
	7. _____
	8. _____
	9. _____
	10. _____

Tool #4: Root Cause Analysis

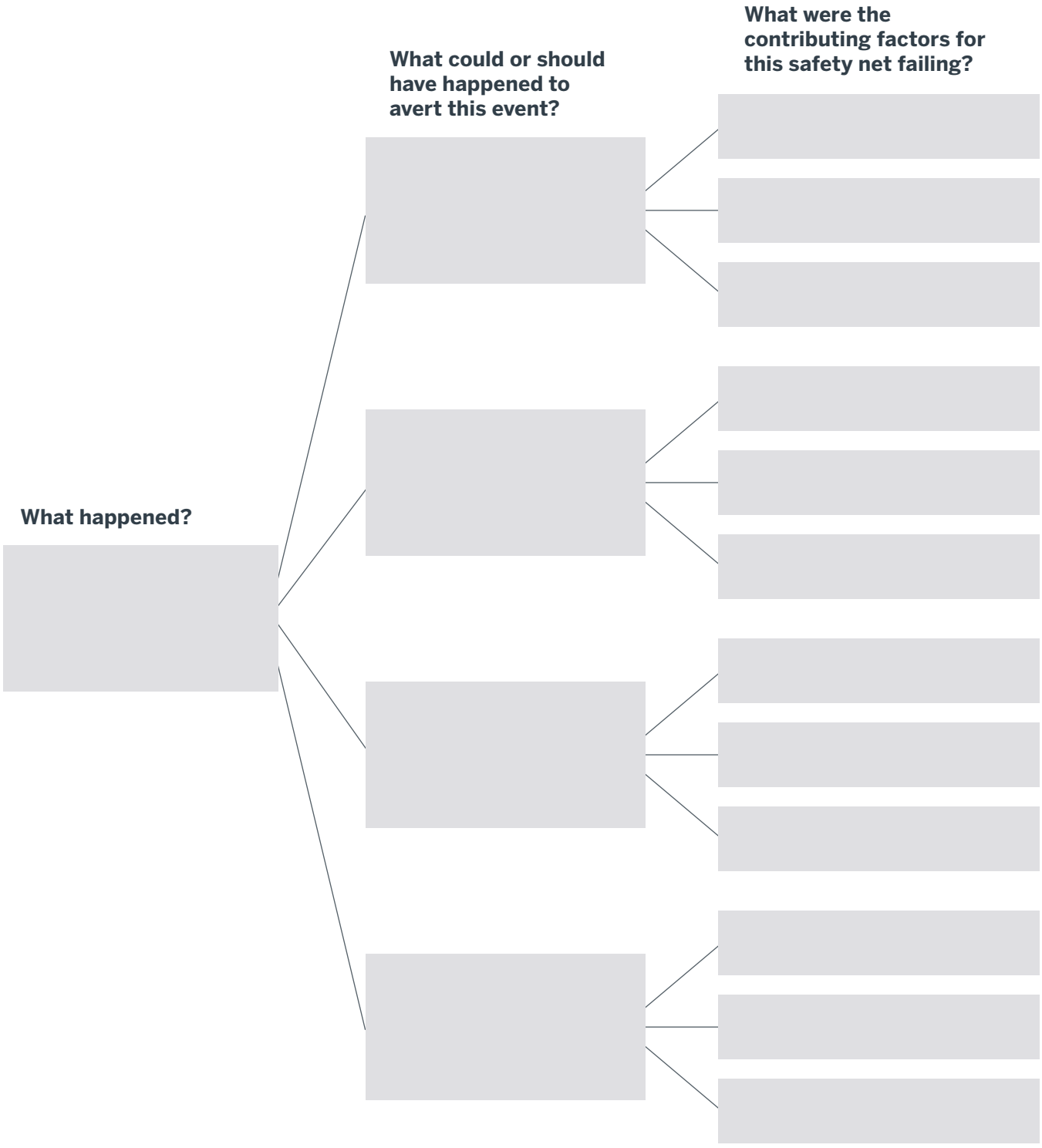
Step Four: In the blank root cause tree on the following page, write your identified clinical situation in the box labeled: "What happened?" Then review the key events listed in Step Three and fill in the blank boxes labeled: "What could or should have happened to prevent the situation?" Next fill in the blank boxes labeled: "What were the contributing factors for this safety net failing?" For guidance, a sample root cause tree is provided below.

Sample Root Cause Tree



Tool #4: Root Cause Analysis

Root Cause Tree



Tool #4: Root Cause Analysis

Step Five: Review your completed root cause tree and list each contributing factor (the factors written in the boxes in the right-hand column of the root cause tree) in the table below. For each contributing factor, list between one and three specific actions that could prevent the contributing factor from recurring in the future.

Contributing Factor	Potential Corrective Action(s)
Labels look similar	• High-alert tag placed on all morphine vials • Medication concentrations listed in large fonts with different colors

Facilitator Resources

Tool #4: Root Cause Analysis

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the spectrum may indicate a greater opportunity for improvement.

Selection of appropriate incident for this exercise

☐	☐	☐	☐
Incident was personally meaningful to participant and involved the participant in a significant way	Incident involved participant in a significant way	Incident occurred on the unit but did not directly involve the participant	Incident did not occur on the unit and did not involve the participant

Comprehensiveness of root cause tree

☐	☐	☐	☐
Root cause tree explores all potential options for unit improvement	Root cause tree focuses on key areas for unit improvement	Root cause tree narrowly focuses on one area of unit operations but not the most important	Root cause tree does not delve into unit improvement efforts

Comprehensiveness of potential corrective actions

☐	☐	☐	☐
Potential corrective actions reflect wide array of potential unit improvement opportunities	Potential corrective actions reflect targeted unit improvement opportunities	Potential corrective actions are narrowly focused on select improvement opportunities	Potential corrective actions do not reflect opportunities for unit improvement

Actionability of potential corrective actions

☐	☐	☐	☐
Potential corrective actions can be immediately implemented on the unit	Potential corrective actions can be implemented with the assistance of major stakeholders on the unit	Potential corrective actions require significant stakeholder buy-in and high effort levels	Potential corrective actions are outside the unit's span of control

Comments:

_____

_____

_____

_____

_____

Tool #4: Root Cause Analysis

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences completing the exercise and developing a root cause analysis.

1. Did you uncover any other unanticipated factors that contributed to your identified situation?
2. What was the most surprising finding of your Root Cause Analysis? Why?
3. How often do you think the underlying causes of your identified situation occur? How can we prevent them from happening?
4. Are there other specific clinical situations that you still remember and think about weeks or months later? Have you conducted a Root Cause Analysis on these events? What do you think you would find?

Tool #5: In-the-Moment Safety Concern Scripting

Overview: The goal of this tool is to help staff nurses appropriately voice their concerns when witnessing a potentially unsafe practice. This tool provides detailed scripting and advice on communicating with other members of the care team about potentially unsafe practices.

Type of exercise: Scripting and written exercise

Staff resources required: A peer with whom to practice the scripted language

Time required: 30 minutes for exercise completion; 30 minutes for concluding discussion

Targeted skill: Proactive and clear communication regarding patient safety concerns

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Sample Communication Framework	Frontline Nurse/ Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This exercise is applicable for all staff members, particularly those who are hesitant to speak up about quality concerns.

II: Share this exercise with participating staff members. There is a sample communication framework included in the tool, but you may substitute a framework from your institution if it is available.

III: Assess the exercise using the Evaluation Guide on page 28. Use the Discussion Guide to initiate a conversation about participants' experiences completing the exercise and their ability to speak up regarding safety concerns.

Tool #5: In-the-Moment Safety Concern Scripting

Sample Communication Framework

The communication framework shown below was implemented by Pitt County Memorial Hospital in North Carolina. Pitt County deployed the tool as part of communication campaign known internally as "AAA." The goal of the campaign was to enable bedside caregivers to clearly speak up when they identified potential patient safety issues by using the escalating strategies of "asking," "advocating," and "asserting." Staff use the key words below to signal to other providers their level of perceived urgency.

The "AAA" framework can be especially effective when standardized across an institution and direct care providers. Standardization ensures that caregivers share a common vocabulary to discuss potential patient safety concerns and can increase staff willingness to speak up.

Step	Key Word	Sample Scripting	Associated Action
1. Ask	Confused	"I am confused and need clarification about_____." (Questioner must specify a particular concern.)	Team member explains rationale behind actions or lack thereof; it is the questioner's responsibility to keep asking questions until their questions are answered and they are satisfied the situation is safe.
2. Advocate	Uncomfortable	"I am uncomfortable with _____ I do not believe it is in the patient's best interest." (Questioner must specify a particular concern and recommend action steps.)	Team member stops what they are doing if it is a non-emergent situation to reevaluate patient needs; it is the questioner's responsibility to advocate for the clinical and psychosocial needs of the patient.
3. Assert	Scared	"I am scared about this patient care situation. We need to stop what we are doing now and reevaluate." (Questioner must specify a particular concern and recommend action steps.)	Unless it is a life-or-death situation, all team members stop their actions to reassess whether there are safety concerns; it is the questioner's responsibility to assert their concerns if current practice may result in patient harm.

Tool #5: In-the-Moment Safety Concern Scripting

Step One: For each situation listed below, circle the appropriate level of urgency for speaking up in the moment and alerting other caregivers to the potential for harm. For each scenario, write the language you would use to share your concerns.

Situation	Urgency Level (Circle One)	Your Scripting
Individual does not wash hands prior to entering a patient room	• Ask provider • Voice concern for patient • Stop the line	Hi Jane. Did you wash your hands before entering the patient's room? Hey Joe, Patient A may have the flu. Can I ask you to be extra careful and wash your hands before and after leaving her room?
Individual misses necessary portion of care protocol	• Ask provider • Voice concern for patient • Stop the line	
Peer appears to be missing early signs of patient deterioration	• Ask provider • Voice concern for patient • Stop the line	
Patient's room or nursing station is dirty or disorganized	• Ask provider • Voice concern for patient • Stop the line	
Peer or physician is being abusive to staff member or patient	• Ask provider • Voice concern for patient • Stop the line	
The pharmacy may have sent the wrong dose of a medication you are about to administer	• Ask provider • Voice concern for patient • Stop the line	
You are unsure what the physician is currently doing for your patient	• Ask provider • Voice concern for patient • Stop the line	
Your patient does not appear to be improving along the typical care path	• Ask provider • Voice concern for patient • Stop the line	

Tool #5: In-the-Moment Safety Concern Scripting

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the spectrum may indicate a greater opportunity for improvement.

Selection of appropriate level of urgency and need for in-the-moment intervention

☐	☐	☐	☐
All selected urgency levels are correct and ably advocate for patient needs	Stated urgency levels mostly accurate but tend to favor higher urgency levels	Selected urgency levels tend to favor low urgency levels	Selected urgency levels do not reflect potential patient quality concerns

Accuracy of disease presentation

☐	☐	☐	☐
All scripting is realistic and reflective of patient and provider needs	Scripting is realistic but may be lengthy	Scripting is stilted or not sufficiently assertive to communicate concerns	Scripting is brusque and not appropriate for real-life situations

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences completing the exercise and their ability to speak up regarding safety concerns.

1. How does the way in which you express your concerns change depending on who you are speaking to?
2. Has there ever been a time when you have been hesitant to speak up? What made you hesitate?
3. When is it hardest for you to speak up?
4. What would make you more likely to speak up in a similar situation in the future?

Section II

Clinical Decision Making

Section Goal: To help participants surface multiple solutions to a given problem, assess each solution on the strength of its supporting evidence, and select the most appropriate solution

- Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise
- Tool #7: Concept Mapping Exercise
- Tool #8: Solution Assessment and Trade-Off Exercise

Introduction

Starting Questions

The scripting below is designed to help facilitators provide participants with an overview of the context and aim of the toolkit section on Clinical Decision Making.

1. What are the key elements of Clinical Decision Making?

Clinical Decision Making has three key components:

- The ability to surface multiple solutions to a given problem
- The ability to assess the strength of evidence supporting the different solutions surfaced
- The ability to assess the applicability of potential solutions (or interventions) to a specific problem or patient need

2. Why is Clinical Decision Making important for bedside nurses?

Strong Clinical Decision Making enables bedside nurses to deliver safe and effective patient care by considering multiple potential solutions for meeting a patient's need (or goal), assessing the strength of the evidence supporting each potential solution, and then selecting the intervention best suited to the individual patient.

3. How will the exercises in this section help improve Clinical Decision Making?

The first exercise in this section targets all elements of Clinical Decision Making by asking participants to develop an evidence-based proposal for improving unit practice. In the exercise, participants are asked to access nursing research, evaluate the strength of each study's evidence, and assess the applicability of each study's key conclusion or recommendation.

The second and third exercises in this section advance Clinical Decision Making by asking participants to closely assess the rationale underlying the interventions delivered to current patients. In the second exercise, participants use concept mapping to develop a holistic picture of a single patient's needs and generate multiple potential nursing interventions to meet these needs. In the third exercise, participants practice applying a framework for evaluating multiple nursing interventions in order to select the intervention which best meets patient needs.

Overview of Tools for Clinical Decision Making

Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise

Overview: The goal of this tool is to provide frontline nurses with practice in accessing nursing research studies and a framework for analyzing studies and assessing their applicability. At the conclusion of the exercise, participating staff members are asked to develop a proposal to improve a unit process or protocol based on their analysis of relevant research studies.

Type of Exercise: Written exercise requiring research

Tool #7: Concept Mapping Exercise

Overview: The goal of this tool is to better enable bedside nurses to build holistic pictures of their patients. This tool provides a replicable framework and method for organizing ideas around a central patient diagnosis in order to draw connections between seemingly unrelated symptoms. These new connections can enable the identification of previously overlooked patient needs or nursing interventions.

Type of Exercise: Observational and written exercise

Tool #8: Solution Assessment and Trade-Off Exercise

Overview: The goal of this tool is to assist bedside nurses in identifying instances in which a patient's condition has multiple potential treatments and to provide a framework that aids in selection of the most appropriate interventions.

Type of Exercise: Reflection-based exercise

Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise

Overview: The goal of this tool is to provide frontline nurses with practice in accessing nursing research studies and a framework for analyzing studies and assessing their applicability. At the conclusion of the exercise, participating staff members are asked to develop a proposal to improve a unit process or protocol based on their analysis of relevant research studies.

Type of exercise: Written exercise requiring research

Staff resources required: Access to nursing research studies (either online or in hard copy)

Time required: Five to ten hours over one month for reviewing research studies; two hours across one week for developing a proposal to change unit practice; 30 minutes for concluding discussion

Targeted skill: Accessing nursing research and analyzing study applicability

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. The tool is not suitable for individuals still mastering basic clinical concepts as they will have insufficient knowledge to isolate unit improvement opportunities. These individuals will be better served by focusing on the skills reinforced by Tool #7: Concept Mapping Exercise and Tool #8: Solution Assessment and Trade-Off Exercise.

II: Share this worksheet with participating staff members and agree upon a deadline. The Center recommends setting a deadline of four to five weeks after you first share the exercise with participants and checking in with participants twice during the exercise. Check in for the first time after participants select a subject for their research (See Step One in the accompanying Staff Exercise) and a second time when participants are halfway to their deadline. Please note that this tool may be used in conjunction with Tool #3: Unit-Level Problem Identification and Prioritization Exercise in order for participants to identify a problem.

III: (optional) This exercise contains a final section (Step Seven) in which participants develop a proposal based on their literature review for improving a unit process. If desired, this exercise can be shared with participants without including the final step focused on proposal development.

IV: Assess the exercise using the Evaluation Guide on pages 38 and 39. Use the Discussion Guide to initiate a one-on-one conversation about participants' experiences with this exercise and their ability to analyze nursing research studies.

Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise

Step One: Select a unit process or problem to research using the evidence-based practice methodology outlined in this tool. Note: for assistance in selecting a process or improvement opportunity, please see Tool #3: Unit-Level Problem Identification and Prioritization Exercise in Section I of this toolkit. Write your selected process or problem below.

Selected Process: _____

Step Two: Search nursing studies to locate studies that focus on your selected process or problem. The journals and associations listed below may be useful sources of nursing research studies. In the table below and on the following page, check the box in the third column if you searched the listed nursing journal or organization, and check the box in the fourth column if you found it to be a helpful resource.

Journal	Website	Searched	Useful
American Journal of Critical Care (AJCC)	http://ajcc.aacnjournals.org		
American Journal of Nursing (AJN)	http://journals.lww.com/ajnonline		
Annals of Emergency Medicine	www.annemergmed.com		
Annals of Internal Medicine	www.annals.org		
AORN Journal	http://aornjournal.org		
Archives of Internal Medicine	http://archinte.ama-assn.org		
CIN: Computers, Informatics, Nursing	https://journals.lww.com/cinjournal		
Evidence-Based Nursing	http://ebn.bmjjournals.com		
Journal for Healthcare Quality	www.nahq.org/journal		
Journal of Clinical Nursing	www.wiley.com/bw/journal.asp?ref=0962-1067		
Journal of Nursing Administration (JONA)	http://journals.lww.com/jonajournal		
Journal of Nursing Care Quality	http://journals.lww.com/jncqjournal		
Journal of Nursing Education	www.journalofnursingeducation.com		
Journal of Nursing Scholarship	www.wiley.com/bw/journal.asp?ref=1527-6546		
Journal of Professional Nursing	www.professionalnursing.org/		
Journal of the American Medical Association (JAMA)	http://jama.ama-assn.org		
Medical Care	http://journals.lww.com/lww-medicalcare		
MedSurg Nursing	www.medsurgnursing.net		
Modern Healthcare	www.modernhealthcare.com		
New England Journal of Medicine (NEJM)	http://content.nejm.org		
Nurse Educator	http://journals.lww.com/nurseeducatoronline		
Nursing	http://journals.lww.com/nursing		
Nursing Administration Quarterly (NAQ)	http://journals.lww.com/naqjournal		
Nursing Outlook	www.nursingoutlook.org		
Nursing Spectrum	www.nurse.com		
Pediatrics	http://pediatrics.aappublications.org		

Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise

Organization	Website	Searched	Useful
Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.gov		
American Association of Critical-Care Nurses (AACN)	www.aacn.org		
American Nurses Association (ANA)	www.nursingworld.org		
Association of periOperative Registered Nurses (AORN)	www.aorn.org		
Institute for Healthcare Improvement (IHI)	www.ihi.org		
National Council of State Boards of Nursing (NCSBN)	www.ncsbn.org		
National Guideline Clearinghouse	www.guideline.gov		
National Institute for Clinical Evidence (NICE)	www.nice.org.uk		
National Library of Medicine	www.nlm.nih.gov		
Nursing Executive Center	www.advisory.com/nec		

Step Three: When you identify a relevant research study, closely examine the strength of the study's data and analysis. For each relevant study, answer the yes or no questions below.

Note: For definitions of bolded terms, see the box on the following page. While "Yes" answers do not necessarily invalidate a study, they may limit its applicability.

	Selected Study Title Abbreviations									
	Study #1 _____ _____ _____	Study #2 _____ _____ _____	Study #3 _____ _____ _____	Study #4 _____ _____ _____	Study #5 _____ _____ _____	Study #6 _____ _____ _____	Study #7 _____ _____ _____	Study #8 _____ _____ _____	Study #9 _____ _____ _____	Study #10 _____ _____ _____
Did the data come from an **administrative data set**?										
Were the **data aggregated** across long periods of time, different facilities, or different sources?										
Was the study's "**n**," or were subsets within the study's "**n**," lower than 30?										
Did the study data come from a survey source, increasing the results' vulnerability to respondent error or flawed recall?										
Did the study rely on **proxy variables**?										
Was the study **confounded** by variables not controlled for in the statistical analysis?										
Did the study use **hospital-level**, rather than unit-level data?										
Were the data narrowly limited to select DRGs, a particular geographic region, or a specific time period that may limit their applicability to your hospital's or unit's situation?										
Were the variables **operationally defined** in a way that could compromise their applicability to your hospital's or unit's situation?										

Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise

Definition of Terms

- **Administrative data set**: Data used primarily for billing purposes, which may be unreliable when repurposed to quantify occurrences of clinical events
- **Data aggregation:** Averaging of variables across time, facilities, or sources, which may mask significant fluctuations in variables such as staffing levels or patient census
- **"n":** Total number of study subjects in the entire data set or a data subset; "n"s lower than 30 typically considered too low to achieve statistical significance
- **Proxy variable:** Substitution of closely related variable or modeled variable for the actual variable (e.g., using patients cared for on last shift to approximate ratios), which may compromise the results' real-world applicability
- **Confounding:** Failure to account for variables that might influence tested outcomes (e.g., patient acuity or LOS)
- **Hospital-level data:** Data aggregated and analyzed across disparate unit and patient types, which may limit the applicability of findings
- **Operational definition:** How a variable is defined; failure to understand a study's operational definitions may lead to overgeneralization of results (e.g., defining "care quality" as an absence of patient falls or medication errors)

Step One: After completing the previous chart, in the table below list the potential strategies for improving your selected process (or potential solutions to your problem) described in the studies you reviewed. For each potential strategy, also include a brief description, critical supporting evidence, and the study limitations you identified in the previous table.

#	Strategy	Supporting Evidence	Source	Study Limitations
ex	Joint Bedside Report: Nurses collaboratively turn, assess and examine patients during shift handoff	Eliminated unit-acquired pressure ulcers since 2007	Nursing Executive Center, Safeguarding Against Nursing Never Events	Results only from one institution
1				
2				
3				
4				
5				
6				
7				
8				

Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise

Step Five: In the table below, list up to eight strategies or solutions you identified through your literature review that you believe would be an effective improvement (or solution) to your identified process or problem. Once you have listed each strategy, use the scales in the table below to rate each strategy on its impact on the identified problem, impact on unit workflow, and anticipated cost. Multiply these numbers together to get a single number that represents the item's overall applicability and viability.

Practice	Impact on Identified Problem 3=Completely fixes 2=Solves part but not all 1=Solves small portion		Impact on Unit Workflow 3=Little to no impact 2=Some impact on workflow 1=High impact on workflow		Cost of Practice 3=No cost 2=Fits unit budget 1=Fits department budget		Overall Applicability and Viability (product of middle three columns)
Joint Bedside Report	3	x	1	x	3	=	9
1.		x		x		=	
2.		x		x		=	
3.		x		x		=	
4.		x		x		=	
5.		x		x		=	
6.		x		x		=	
7.		x		x		=	
8.		x		x		=	

Step Six: List the three strategies or solutions with the highest scores for overall **applicability and viability.**

1. _____
2. _____
3. _____

Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise

Step Seven: Review the three practices listed on the previous step. Use your judgment and the input of your peers to select the practice that appears to be the best fit for your unit and complete the proposal below. The goal of the proposal is to assist you in presenting your identified solution to your manager, educator, or practice council in order to obtain approval and necessary resources for implementing it on your unit.

What is the process you are hoping to improve (or problem you are hoping to solve)?:

_____

_____

Why is this problem worth addressing? (Select supporting evidence is listed below):

Patient population: _____ Mortality rate: _____

Frequency on unit: _____ Morbidity rate: _____

Current performance: _____ Time to complete task: _____

National benchmark: _____ Cost of problem: _____

Nurse frustration level: _____ Impact on patient satisfaction: _____

What is the proposed process improvement strategy (or solution)?:

_____

_____

Why is this the best strategy?

Impact on workflow: _____

_____

_____

Cost: _____

Cost of comparable solutions: _____

Previously demonstrated impact: _____

_____

_____

_____

Predicted impact on unit: _____

_____

_____

Improvements or savings achieved by implementing the practice (Include potential impact on patient care quality, time, money, staff member frustration): _____

_____

_____

Strength of evidence: _____

_____

_____

Strategy for piloting the practice (or process improvement): _____

_____

_____

Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the spectrum may indicate a greater opportunity for improvement.

Selection of appropriate process (or problem) to research

☐ Identified process is vital for advancing unit priorities	☐ Identified process is important for advancing unit priorities	☐ Identified process has some impact on unit operations	☐ Identified process has little applicability beyond one staff member

Comprehensiveness of identified solutions

☐ Solutions comprehensively target all facets of identified problem	☐ Solutions address leading facets of identified problem	☐ Solutions target only narrow subset of identified problem	☐ Few, if any solutions offered

Thoroughness of search methods

☐ Displays an exceptional grasp of a wide array of nursing literature and available resources	☐ Displays solid grasp of nursing literature and available resources	☐ Displays breadth but not depth of searching ability	☐ Displays perfunctory searching

Originality of identified solutions

☐ Solutions offer insightful and creative methods for addressing the problem	☐ Solutions are based on solid evidence of previous impact	☐ Many included solutions are status quo or have already been tried	☐ All identified solutions already implemented on unit

Practicality of identified solutions

☐ All solutions highly applicable to current unit situation	☐ Majority of solutions require stakeholder buy-in	☐ Solutions show promise but require additional detail work	☐ Majority of solutions cannot be implemented

Tool #6: Evidence-Based Nursing Practice Analysis and Application Exercise

Comments:

_____

_____

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a one-on-one conversation about the participants' experiences with this exercise and their ability to analyze and apply nursing research studies.

1. How long did it take you to select the process you wanted to research? What were some of the other processes you considered? What was the ultimate deciding factor?
2. How many studies did you review before deciding on your preliminary list of potential solutions? Which resources and studies were the most helpful?
3. How often were you concerned about a study's data quality or replicability? What were your main concerns about the studies? Were you surprised about how often you were concerned? Why?
4. What criteria (other than impact on problem, impact on workflow, and cost) do you think we should use to evaluate potential solutions? Do you understand why those were the three that were chosen?
5. (Optional) What was hard about writing a proposal for the unit practice council? Are you thinking about actually presenting it? If not, what is stopping you? If so, how do you think it will be received?

Tool #7: Concept Mapping Exercise

Overview: The goal of this tool is to better enable bedside nurses to build holistic pictures of their patients. This tool provides a replicable framework and method for organizing ideas around a central patient diagnosis in order to draw connections between seemingly unrelated symptoms. These new connections can enable the identification of previously overlooked patient needs or nursing interventions.

Type of exercise: Observational and written exercise

Staff resources required: None

Time required: Approximately two hours for exercise completion; 30 minutes for concluding discussion

Targeted skill: Concept mapping

Tool contents and intended audience:		
	Tool Implementation Guide	Manager/Educator
	Staff Exercise	Frontline Nurse
	Evaluation Guide	Manager/Educator
	Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This tool is applicable for all staff members and can be conducted individually or as a group exercise.

II: Share this exercise with participating staff members and set a deadline for completion. The deadline should be one to two weeks after you first share the exercise with participants. The Center recommends checking in with participants twice during the exercise; first after participants select a subject for their concept maps (See Step One in the accompanying Staff Exercise), and a second time when participants are halfway to their deadline.

III: (optional) If participants are completing this exercise as a group activity, the facilitator should prepare for the discussion by selecting a patient by following Step One in the accompanying Staff Exercise. Once a patient is selected, write the patient's pertinent clinical data and psychosocial needs on individual post-it notes and place them in random order on a wall or easel. Ask participants to review the notes and arrange the post-it notes into logical groups. Next, encourage participants to arrange (and rearrange) the post-it notes until everyone is satisfied with the groupings. Proceed with Step Six of the exercise.

IV: Assess the exercise using the Evaluation Guide on pages 45 and 46. Use the Discussion Guide to initiate a conversation about participants' experiences with the exercise and the information they uncovered through their concept map.

Tool #7: Concept Mapping Exercise

Step One: Select one of the most acute or complex patients you are currently caring for. Write the patient's specific diagnosis below.

Diagnosis: _____

Step Two: List your selected patient's symptoms. These symptoms should encompass both objective and subjective data and observations. Sample presenting symptoms are listed below, but feel free to add additional symptoms based on the patient's condition.

- Anxiety/depression
- Hypo-/hypertension
- Dementia
- Elimination
- Glucose control
- Hypoperfusion
- Immobility
- Infection
- Numbness
- Nutritional intake
- Pain
- Paralysis
- Respiratory changes
- Skin breakdown
- Vision problems

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Step Three: Turn to the blank concept map on the following page. Write your selected patient's diagnosis at the center of the blank concept map in the box labeled "Diagnosis with Patient Data."

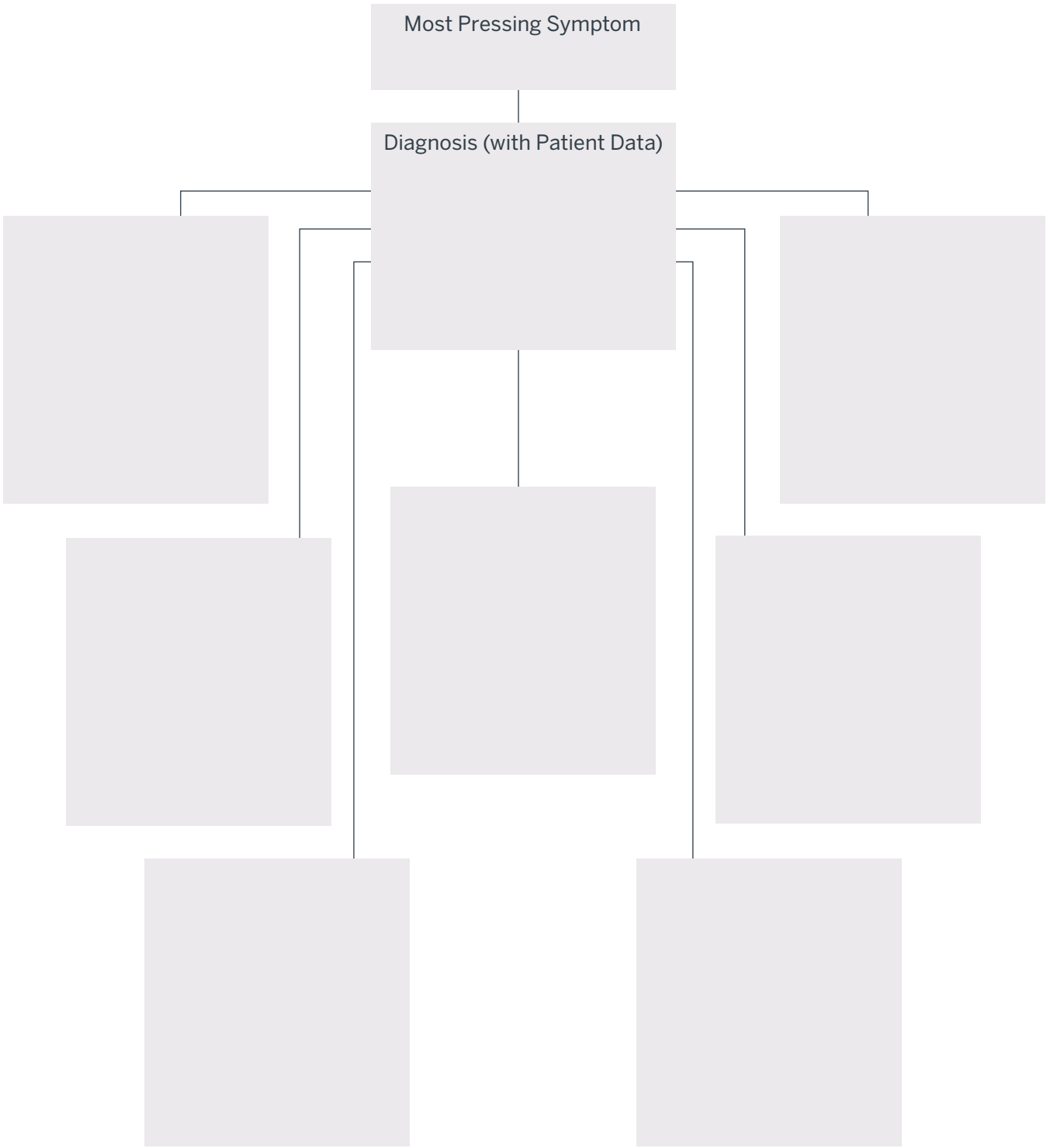
Step Four: Review the symptoms listed in Step Two and select the single most pressing symptom. Write this symptom in the blank box at the top of the concept map. Write the remaining symptoms listed in Step Two at the top of the remaining blank boxes in the concept map. For additional guidance, a sample completed concept map is provided on page 43.

Step Five: For each symptom listed on the concept map, write the relevant clinical evidence supporting the symptom underneath the symptom in the box. For example, if you wrote the symptom "anxiety" you might list the supporting clinical evidence of "irritability, restlessness, and tension." For additional guidance, a sample completed concept map is provided on page 43.

Step Six: Identify the connections between related symptoms or clinical data. Use a different-colored pen (or draw dotted-lines) to visually represent these connections. When appropriate, draw arrows to indicate a causal relationship. For additional guidance, a sample completed concept map is provided on page 43.

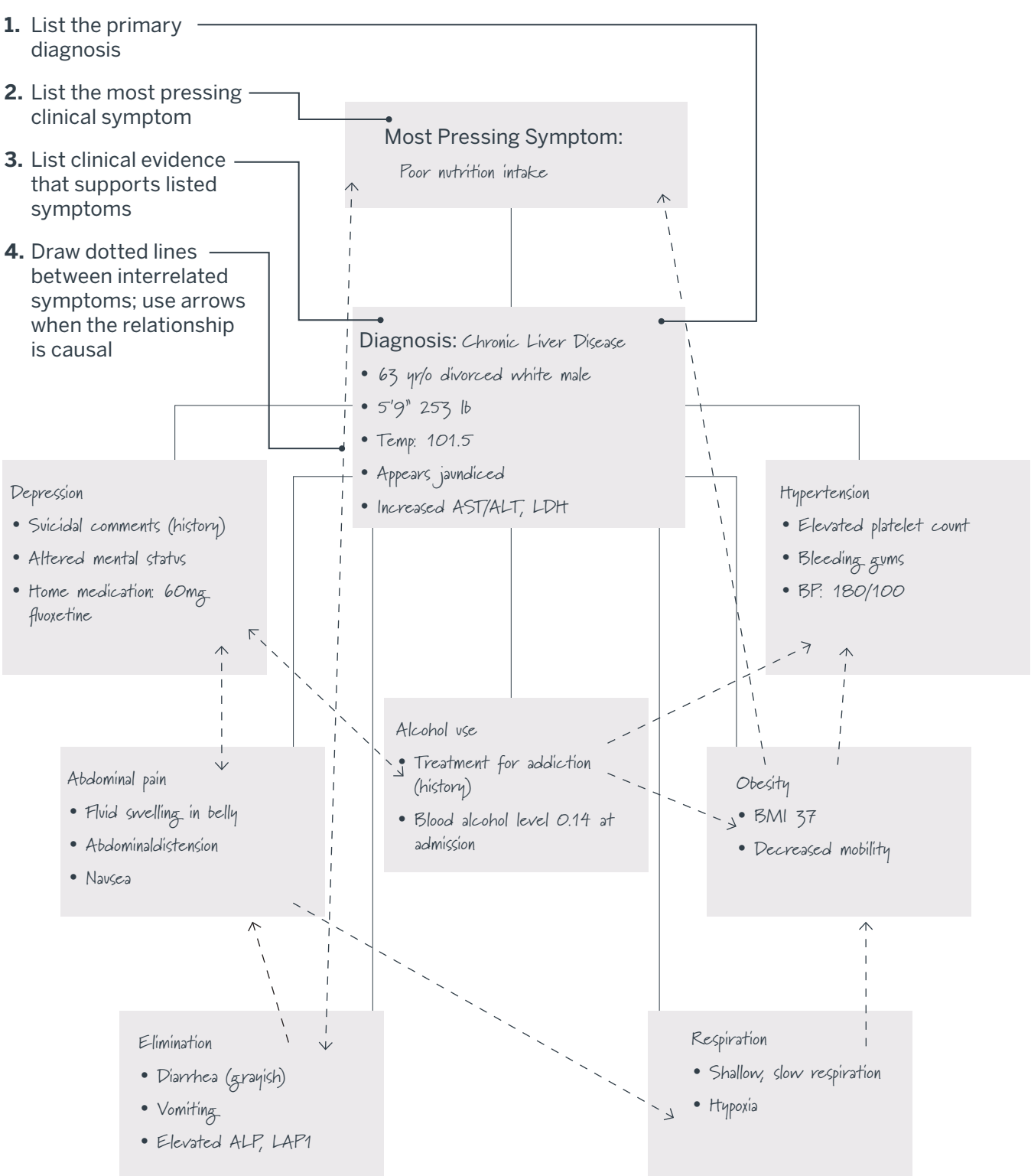
Tool #7: Concept Mapping Exercise

Concept Map



Tool #7: Concept Mapping Exercise

Sample Completed Concept Map



Tool #7: Concept Mapping Exercise

Step Seven: List the symptoms from your concept map in the table below. For each symptom listed on your concept map, write the appropriate nursing intervention. For each intervention, list the data you will collect (or strategy you will use) to evaluate if the intervention is having the intended effort.

Patient Symptom	Nursing Interventions	Key Data (or Strategy) to Evaluate the Efficacy of Intervention
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Facilitator Resources

Tool #7: Concept Mapping Exercise

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the evaluation scale may indicate a greater opportunity for improvement.

Selection of patient with a condition appropriate for the exercise

☐ Patient is most acute or complex on the unit	☐ Patient is not among the most complex on the unit	☐ A general patient condition is selected with few patient-specific details	☐ Selected condition is not reflective of patients cared for on the unit

Inclusion of all relevant clinical and psychosocial data

☐ All relevant clinical data and observations are included	☐ All relevant clinical data is included but some subjective observations may be missing or vague	☐ Some relevant clinical data is excluded	☐ Relevant clinical data is missing and/or incorrect

Appropriate grouping of concepts in concept map

☐ Clinical data is accurately grouped in manageable concepts	☐ Concepts accurately reflect patient condition but may be too granular or broad for decision making	☐ Concepts are vague and not particularly meaningful	☐ Little logic in clinical data grouping

Appropriate linking of concepts in concept map

☐ Concepts are linked in clear and insightful ways	☐ Obvious linkages are made, but some subtle signs may be missed	☐ Linkages are non-specific and vague	☐ Linkages missing or incomprehensible

Ability to articulate reasoning behind concept map

☐ Clearly articulates reasoning behind decisions underlying each step, shows clear forethought and analysis	☐ Displays good decision making but cannot clearly articulate why those decisions were made	☐ Has not thought through all ramifications for the patient	☐ Generally muddled, confused, or unable to explain their thought process

Tool #7: Concept Mapping Exercise

Comments:

_____

_____

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences with the exercise and the information they uncovered through their concept map.

1. When you built your concept map, did you find it easier to start by listing broad symptoms and then adding supporting clinical evidence? Or was it easier to start by listing individual clinical indicators and then organizing these into symptoms? What does this suggest about your approach to problem solving?
2. Did you learn anything surprising when you drew connections between your patient's symptoms or clinical data? What surprised you? Why?
3. Did you learn anything new about the patient's condition or nursing needs as a result of this exercise? What did you learn?
4. Did this exercise help broaden your thinking about your patient's potential comorbidities or broader care needs? How?
5. Next time you care for a patient with a similar diagnosis or symptoms, will you do anything differently as a result of this exercise? Why or why not?

Tool #8: Solution Assessment and Trade-Off Exercise

Overview: The goal of this tool is to assist bedside nurses in identifying instances in which a patient's condition has multiple potential treatments and to provide a framework that aids in selection of the most appropriate interventions.

Type of exercise: Reflection-based exercise

Staff resources required: None

Time required: 30 minutes for exercise completion, 30 minutes for concluding discussion

Targeted skill: Identifying and assessing multiple potential interventions

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This tool is most applicable for experienced bedside nurses.

II: Share this exercise with participating staff members and agree upon a deadline. The deadline should be one to two weeks after you first share the exercise with participants. The Center recommends checking in with participants twice during the exercise; a first time after participants select a subject for the exercise (See Step One in the accompanying Staff Exercise), and a second time when participants are halfway to their deadline.

III: Staff members may need assistance in selecting a diagnosis that provides a significant opportunity for evaluating potential interventions. Suggested patient populations are listed below. However, please do not feel limited to this list.

- Patient at high risk for a fall
- Patient being weaned from a ventilator
- Patient with bouts of psychosis
- Patient with chronic pain
- Patient with emerging sepsis
- Patient with pressure ulcer

IV: Assess the exercise using the Evaluation Guide on page 52. Use the Discussion Guide to initiate a one-on-one conversation about participants' experiences with this exercise and their ability to identify and assess multiple potential interventions.

Tool #8: Solution Assessment and Trade-Off Exercise

Step One: Identify a patient diagnosis commonly seen on your unit that can be treated through multiple care pathways or nursing interventions. Write the diagnosis on the line below.

Sample Patient Diagnosis: Patient has a pressure ulcer

Your Patient Diagnosis: _____

Step Two: List all potential nursing interventions for your selected condition on the lines below. Include those you know of (but have not personally performed) as well as those you have performed.

Sample interventions:

1. Use skin protective ointment on denuded skin
2. Use underpads that wick incontinence moisture away from skin
3. Encourage mobility and ambulation
4. Manage glucose levels
5. Ensure fluid intake is approximately 1,500 mL per day
6. Keep the head of bed below 30 degrees
7. Consider indwelling catheter use

Interventions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

Step Three: After listing the interventions above, observe two of your peers treating patients with the same condition. If your peers perform interventions not already on the list, please add them.

Tool #8: Solution Assessment and Trade-Off Exercise

Step Four: List your identified interventions in the blank table on the following page. If you have more interventions than available space, list the interventions most commonly performed on your unit. For each intervention, list the patient type for which the intervention is most commonly performed. For each intervention, list the rationale underlying the decision to provide the listed intervention to the specified patient type. A sample table is provided below.

Nursing Intervention	Patient type(s) for which this intervention is most applicable	Why is this intervention preferable for this patient type?	What factors would lead you to select this intervention over others?
1. Use skin protective ointment on denuded skin	- All with minor denudation - Patients with score of 2 or below on Moisture section of Braden scale	Provides protective barrier preventing further skin erosion	• Patient is functional and mobile • Skin largely intact
2. Use wicking underpads	- Patients with score of 2 or below on Moisture section of Braden scale	Pads wick moisture from skin, reducing moisture friction	• Patient is incontinent or extremely sweaty, making standard moisture management difficult
3. Encourage mobility and ambulation	- All patients who are able - Patients with score of 2 or below on Activity or Mobility section of Braden scale	Mobility improves circulation and removes pressure on key areas of the body	• Patient is uncomfortable in heel lift devices or lying down • Pressure ulcers not present on patient feet or heels
4. Manage glucose levels	- Patients with score of 2 or below on Nutrition section of Braden scale	Appropriate glucose levels protect the integrity of the skin and discourage infection	• Patient is diabetic and is showing signs of other skin breakdown
5. Ensure fluid intake is approximately 1,500 mL per day	- Patients with score of 2 or below on Nutrition section of Braden scale	Fluids prevent dehydration, which may lead to further skin erosion	• Patient unable to feed themselves • I+O unusually low
6. Keep the head of bed below 30 degrees	- All patients with sacral pressure ulcers - Patients with score of 2 or below on Friction or Shear section of Braden scale	Decreased head of bed elevation reduces pressure on sacrum	• Patient is not on a ventilator
7. Consider indwelling catheter use	- Patients with score of 2 or below on Moisture section of Braden scale - Patients with score of 2 or below on Activity or Mobility section of Braden scale	Indwelling catheter decreases urine and moisture on sheets	• Patient is incontinent, making standard moisture management more difficult

Tool #8: Solution Assessment and Trade-Off Exercise

Nursing Intervention	Patient type(s) for which this intervention is most applicable	Why is this intervention preferable for this patient type?	What factors would lead you to select this intervention over others?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Tool #8: Solution Assessment and Trade-Off Exercise

Step Five: Reflect on the rationales underlying the decisions to treat different patient types with different interventions that you listed in the previous table. Beyond the initial diagnosis, identify between one to three pieces of additional clinical information that helped inform your decision making.

Sample additional clinical information:

1. Braden scale indicates moisture and nutrition are likely high-risk
2. Patient is obese

Pertinent clinical information for selected condition:

1. _____
   _____
2. _____
   _____
3. _____
   _____

Facilitator Resources

Tool #8: Solution Assessment and Trade-Off Exercise

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the evaluation scale may indicate a greater opportunity for improvement.

Selection of appropriate diagnosis for this exercise

☐	☐	☐	☐
Diagnosis commonly presents on unit in different patient populations	Diagnosis commonly presents on unit for single patient population	Diagnosis sometimes presents on unit for assorted patients	Diagnosis rarely presents on unit

Comprehensiveness of listed interventions

☐	☐	☐	☐
List of interventions reflects entire gamut of potential care pathways	List of interventions reflects most pertinent care pathways	List of interventions reflects only a single care pathway	List of interventions does not correlate with selected diagnosis

Accuracy of criteria used to decide which intervention is most suited to each patient population

☐	☐	☐	☐
Criteria are accurate and specific	Criteria are accurate but vague	Criteria have minor inaccuracies	Criteria are missing or grossly inaccurate

Comments:

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a one-on-one conversation about the participants' experiences with this exercise and their ability to identify and assess multiple potential interventions.

1. When you observed your peers, did you observe any significant variations in practice? What were they?
2. Did this variation surprise you? Why or why not?
3. The goal of this exercise is to examine the trade-offs we make (consciously or unconsciously) when we select one potential nursing intervention over another. Had you previously been aware of these types of decisions in your daily practice?
4. How often do you use the alternative nursing interventions you identified? Are there opportunities to use them more often?
5. What do you think accounts for this variation in practice?

Section III

Prioritization

Section Goal: To help participants sequence multiple actions according to importance and urgency and delegate appropriate actions

- Tool #9: Delegation Decision Tree
- Tool #10: Individual Patient Goal Prioritization Exercise
- Tool #11: Patient Assignment Prioritization Scenarios

Introduction

Starting Questions

The scripting below is designed to help facilitators provide participants with an overview of the context and aim of the toolkit section on Prioritization.

1. What are the key elements of Prioritization?

Prioritization has three key elements:

- The ability to sequence multiple action-steps according to importance and urgency
- The ability to decide which action-steps to delegate and which to personally perform
- The ability to delegate (selecting the correct person to perform the action-step, clearly articulating the action-step, and confirming completion)

2. Why is Prioritization important for bedside nurses?

To deliver safe and effective care to their assigned patients, bedside nurses must be able to effectively prioritize multiple action-steps for multiple patients to ensure actions are performed in their order of importance. Due to the intensity of nursing workload, to accomplish all important action steps—and avoid burnout—bedside nurses must also be able to effectively identify which actions can be delegated and then effectively delegate them.

3. How will the exercises in this section help improve Prioritization?

The first two exercises in this section target individual elements of Prioritization. The first exercise seeks to improve participants' comfort and effectiveness in delegation. It provides participants with a framework to inform their decision-making on delegation, and then provides an opportunity to apply the framework to specific scenarios. The second exercise seeks to improve participants' ability to appropriately sequence their interventions for a single patient across a single shift. Participants practice evaluating the importance and urgency of needed nursing interventions for a single patient.

The final exercise builds upon the previous exercises by asking participants to apply multiple elements of prioritization. In this exercise participants sequence interventions for multiple patients with competing care needs and then decide which action-steps can be delegated.

Overview of Tools for Prioritization

Tool #9: Delegation Decision Tree

Overview: The goal of this tool is to improve bedside nurses' ability to delegate effectively to appropriate care team members. This tool provides participants with a framework for delegation decisions and an opportunity to apply the framework to common patient care tasks.

Type of Exercise: Thought exercise

Tool #10: Individual Patient Goal Prioritization Exercise

Overview: The goal of this tool is to assist bedside nurses in prioritizing nursing interventions for an individual patient across the patient's length of stay.

Type of Exercise: Thought exercise

Tool #11: Patient Assignment Prioritization Scenarios

Overview: The goal of this tool is to improve bedside nurses' ability to prioritize across multiple patients with competing care needs. In this exercise participants practice prioritizing multiple patients and making potentially difficult delegation decisions.

Type of Exercise: Thought exercise

Tool #9: Delegation Decision Tree

Overview: The goal of this tool is to improve bedside nurses' ability to delegate effectively to appropriate care team members. This tool provides participants with a framework for delegation decisions and an opportunity to apply the framework to common patient care tasks.

Type of exercise: Thought exercise

Staff resources required: None

Time required: One hour for exercise completion; 30 minutes for concluding discussion

Targeted skill: Delegation

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Sample Delegation Decision Tree	Frontline Nurse/ Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

The list of patient care responsibilities included in this tool was developed by administrators at Westside Regional Medical Center in Plantation, Florida. The chief nursing officer and her team identified responsibilities for each care team member. Nursing leaders shared the resulting list with all direct care providers in order to clarify responsibilities and improve delegation.

I: Select frontline staff members to complete this exercise. This tool is applicable for all staff members, particularly those who struggle with delegation.

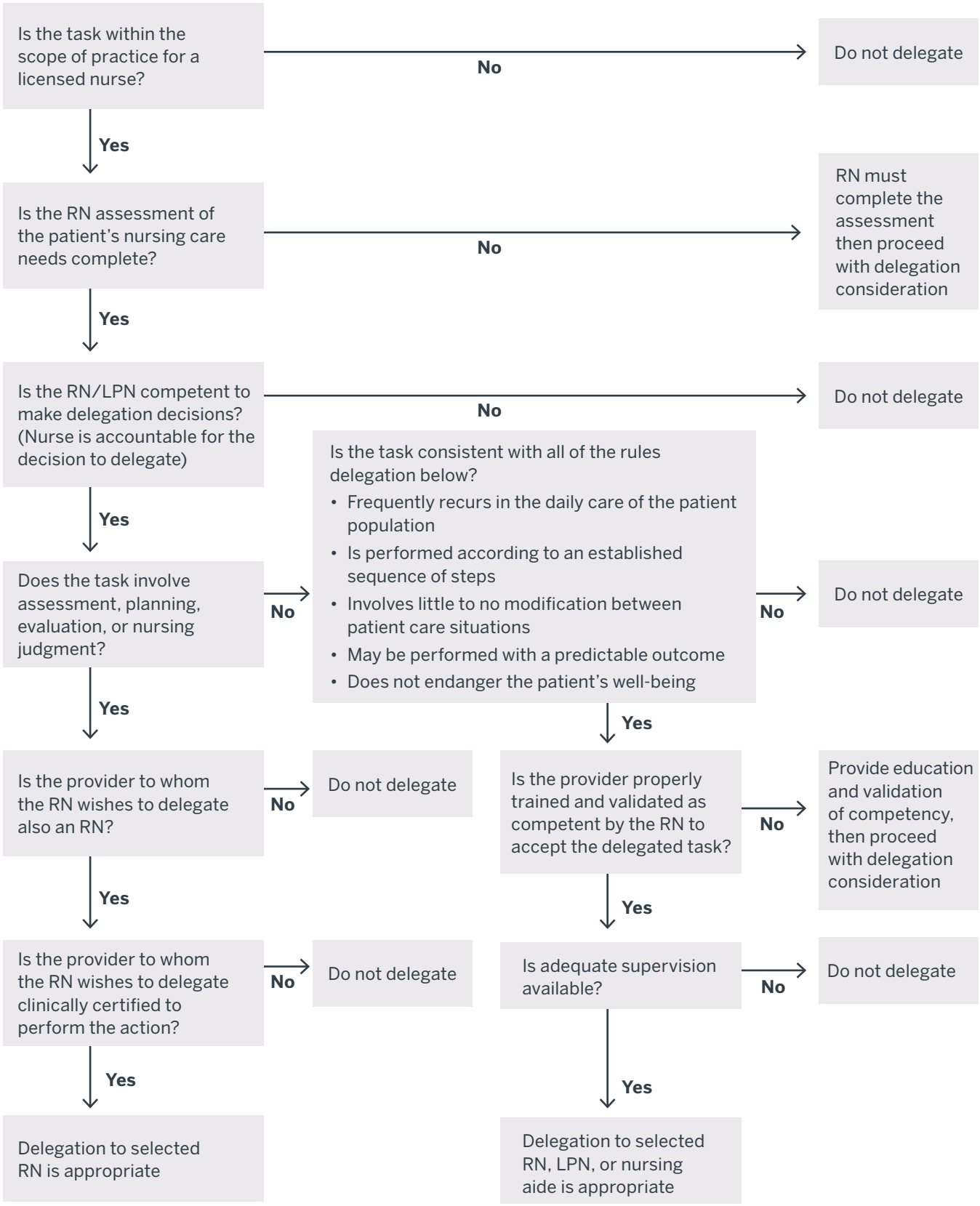
II: Examine the sample Delegation Decision Tree in this exercise to determine if it is consistent with your state laws regarding nursing scope of practice and your institution's policies. If appropriate for your institution, provide the Delegation Decision Tree to participants to assist them with the following exercise. The decision tree included in this tool is based on decision trees developed by the North Carolina Board of Nursing (available at www.ncbon.com).

III: Share this exercise with participating staff members and set a deadline for exercise completion. The Center recommends a deadline of one week after you first share the exercise with participants.

IV: Assess the exercise using the Evaluation Guide on page 60. Use the Discussion Guide to initiate a one-on-one conversation about participants' experiences completing the exercise and delegation practices.

Tool #9: Delegation Decision Tree

Sample Delegation Decision Tree



Tool #9: Delegation Decision Tree

Step One: For each responsibility listed below, circle the provider(s) who can perform the task within their scope of practice.

Step Two: For each responsibility listed below, write a brief explanation of your rationale for selecting the circled providers. (Sample rationales are provided on the Delegation Decision Tree on the preceding page.)

Responsibility	Provider	Rationale
Formulates patient plan of care	• RN • LPN • Nursing aide • None of the above	
Performs admissions, discharge, and transfer assessments of all patients	• RN • LPN • Nursing aide • None of the above	
Provides/documents patient and family education	• RN • LPN • Nursing aide • None of the above	
Performs IV care	• RN • LPN • Nursing aide • None of the above	
Provides treatments and medications to assigned patients	• RN • LPN • Nursing aide • None of the above	
Performs phlebotomy, if certified	• RN • LPN • Nursing aide • None of the above	
Answers call lights in a timely manner	• RN • LPN • Nursing aide • None of the above	
Assists with patient toileting needs	• RN • LPN • Nursing aide • None of the above	
Completes vital signs	• RN • LPN • Nursing aide • None of the above	
Coordinates imaging appointments based on physician orders and plan of care	• RN • LPN • Nursing aide • None of the above	

Tool #9: Delegation Decision Tree

Responsibility	Provider	Rationale
Inserts Foley, if certified	• RN • LPN • Nursing aide • None of the above	
Turns patients at least every two hours	• RN • LPN • Nursing aide • None of the above	
Bathes/assists in bathing of patients	• RN • LPN • Nursing aide • None of the above	
Provides mouth care	• RN • LPN • Nursing aide • None of the above	
Changes linens	• RN • LPN • Nursing aide • None of the above	
Monitors diet/fluid restrictions, posts sign on door if needed	• RN • LPN • Nursing aide • None of the above	
Ambulates patient per physician order	• RN • LPN • Nursing aide • None of the above	
Performs initial patient assessment	• RN • LPN • Nursing aide • None of the above	
Performs ordinary wound care	• RN • LPN • Nursing aide • None of the above	
Updates physicians on patient status	• RN • LPN • Nursing aide • None of the above	
Assists with codes	• RN • LPN • Nursing aide • None of the above	
Calls the rapid response team	• RN • LPN • Nursing aide • None of the above	

Facilitator Resources

Tool #9: Delegation Decision Tree

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the evaluation scale may indicate a greater opportunity for improvement.

Appropriateness of selected provider for delegated task

☐	☐	☐	☐
All delegation decisions are in accordance with the decision tree and state laws	Some responsibilities are unnecessarily completed by a nurse, but vast majority of responsibilities are delegated correctly	Responsibilities delegated to too many providers; lack of specificity inhibits decision-making	Some responsibilities which should only be completed by an RN are delegated to unlicensed staff members

Thoroughness of rationale underlying delegation decision making

☐	☐	☐	☐
All rationales are correct and thorough, accounting for scope of RN practice	All rationales are correct but some may be vague	Rationales are mostly correct but are likely too vague to indicate clear thought processes	Some rationales missing, vague, or incorrect

Comments:

_____

_____

_____

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a one-on-one conversation about the participants' experiences completing the exercise and delegation practices.

1. What tasks that you ordinarily perform are difficult to delegate? Why?
2. What tasks are the easiest to delegate? Why?
3. What tasks used to be difficult to delegate are now easy to delegate? What changed? How did you become more comfortable?
4. In this exercise, you received a delegation decision tree. How similar is this decision tree to the thought process you usually follow when delegating?
5. How do you follow up on delegated tasks to ensure they were completed and performed correctly?
6. What additional unit resources would help you delegate more effectively?
7. Which members of the unit are the most effective at delegation? What do they do that makes them so effective?

Tool #10: Individual Patient Goal Prioritization Exercise

Overview: The goal of this tool is to assist bedside nurses in prioritizing nursing interventions for an individual patient across the patient's length of stay.

Type of exercise: Thought exercise

Staff resources required: None

Time required: One hour for exercise completion; 30 minutes for concluding discussion

Targeted skill: Prioritizing patient care needs

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select staff members to complete this exercise. This tool will be of greatest benefit to nurses who have difficulty prioritizing their responsibilities across a shift.

II: Share this exercise with participating staff members and agree upon a deadline. The Center recommends setting a deadline of one to two weeks after sharing the tool with participants. If desired, conduct this exercise as an interactive group discussion. If participants complete the exercise individually, check in with participants at the halfway point to answer any questions.

III: Assess the exercise using the Evaluation Guide on pages 66 and 67. Use the Discussion Guide to initiate a conversation about participants' experiences completing this exercise and current prioritization practices.

Tool #10: Individual Patient Goal Prioritization Exercise

Step One: Select a patient for whom you are currently providing care and who is expected to remain on the unit for at least one more day. With this patient in mind, complete the table below.

<table>
<tr><td rowspan="2">Patient Name</td><td>Age:</td><td>Weight:</td></tr>
<tr><td>Room Number:</td><td></td></tr>
<tr><td rowspan="5">Patient Diagnosis</td><td>Pain:</td><td>Temperature:</td></tr>
<tr><td>Fluid Status:</td><td>Blood Pressure:</td></tr>
<tr><td>Blood Sugars:</td><td>Pulse:</td></tr>
<tr><td>Lab Values:</td><td>Respiratory Rate:</td></tr>
<tr><td>Procedures:</td><td>Pulse Oximetry:</td></tr>
<tr><td>Referrals (circle):
• PT/OT
• Social Work
• Home Care
• Other</td><td>RN Concerns:</td><td>Physician Concerns:</td></tr>
<tr><td colspan="3">Discharge Education Needs:</td></tr>
<tr><td colspan="3">Anticipated Discharge Date:</td></tr>
</table>

Tool #10: Individual Patient Goal Prioritization Exercise

Step Two: List the nursing interventions the patient will likely require during his or her stay on the table below. Be sure to include the anticipated date of each intervention as well as any required advance steps.

Intervention	Advance steps (optional)	Today?	Later date?
Patient receives contrast CT	• Schedule CT • Administer contrast	yes	

Tool #10: Individual Patient Goal Prioritization Exercise

Step Three: Looking at the previous table, identify the nursing interventions that must be performed in your next shift. For each intervention, determine the approximate time it should be performed and write the intervention in the appropriate time slot in the table below. Once you have ordered the interventions chronologically, list any likely follow-up steps and the team members who can assist you.

Time	Responsibility	Assisting Care Team Member (Optional)	Follow-Up Action
11 a.m.	Patient needs contrast CT	None	Update physician on results

Time	Responsibility	Assisting Care Team Member (Optional)	Follow-Up Action
7			
8			
9			
10			
11			
12			
1			
2			
3			
4			
5			
6			
7			

Tool #10: Individual Patient Goal Prioritization Exercise

Step Four: Looking at the table completed in Step Two, identify the patient care responsibilities that will be completed on future shifts. In the table below, list the approximate shift of each future intervention. Once you have ordered the interventions chronologically, list any likely follow-up steps and the team members who can assist.

Day	Responsibility	Assisting Care Team Member (Optional)	Follow-Up Action
Next Shift	• Schedule CT • Administer contrast	N/A	No

Day	Responsibility	Assisting Care Team Member (Optional)	Follow-Up Action
Next shift			
Tomorrow			
2-4 days from now			
5 days or more from now			

Facilitator Resources

Tool #10: Individual Patient Goal Prioritization Exercise

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the evaluation scale may indicate a greater opportunity for improvement.

Thoroughness of outlined patient information

☐ Patient clinical data clearly and thoroughly displays strong understanding of broader clinical and psychosocial needs	☐ Patient clinical data accounts for all clinical needs but may neglect broader psychosocial needs	☐ Patient clinical data reflects most urgent clinical needs but may be vague and have minor inaccuracies	☐ Patient clinical data is missing or inaccurate

Accuracy of prioritization decisions

☐ Care responsibilities appropriately prioritized across shift and stay	☐ Care responsibilities appropriately prioritized across shift and stay, although there may be overreliance on either the current shift or rest of stay	☐ Care responsibilities not well prioritized across stay	☐ Prioritization of care responsibilities shows lack of prioritization skills

Specificity of shift plan

☐ Shift plan shows clear forethought about busy times during the shift and need for flexibility while still clearly mapping patient goals	☐ Shift plan is detailed but may not reflect some broader realities on the unit (such as peak census time, rounding times, etc.)	☐ Shift plan does not reflect the true extent of patient interventions across the day	☐ Shift plan is largely unrealistic

Thoroughness of subsequent care planning

☐ Subsequent care planning delineates patient care needs across the extent of the stay and sets a clear timeline for accomplishment	☐ Subsequent care planning delineates most patient care needs across the extent of the stay	☐ Subsequent care planning is vague or not sufficiently specific to guide care planning	☐ Subsequent care planning displays little forethought of patient needs and goals

Facilitator Resources

Tool #10: Individual Patient Goal Prioritization Exercise

Comments:

_____

_____

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences completing this exercise and current prioritization practices.

1. How difficult was it to plan your interventions across the shift? How much of the difficulty was due to the events beyond your control (e.g., changing patient condition)? How much of the difficulty was due to trouble prioritizing and executing tasks within your control?
2. Looking across the shift, are there periods that you anticipate being busier than others? Are there any actions you can perform preemptively to make that time period less busy?
3. Did this exercise make you think differently about your patient's needs across the entirety of his or her stay? Are there any tasks that can be completed earlier to make discharge or transfer easier?
4. What are the most difficult responsibilities for you to accomplish during the shift? Are there other members of the care team who can help you?
5. Can you think of a time that you effectively planned all of your interventions across a shift or a patient's length of stay? What helped you plan effectively? How could you replicate your success?

Tool #11: Patient Assignment Prioritization Scenarios

Overview: The goal of this tool is to improve bedside nurses' ability to prioritize across multiple patients with competing care needs. In this exercise participants practice prioritizing multiple patients and making potentially difficult delegation decisions.

Type of exercise: Thought exercise

Staff resources required: None

Time required: 30 minutes per scenario (3 total scenarios); 30 minutes for concluding discussion

Targeted skill: Prioritizing patient care needs; delegation

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This tool is most applicable for staff members who have difficulty prioritizing their patient care responsibilities.

II: Select one or more of the following three scenarios to share with participants and set a deadline for completion. The Center recommends allocating approximately two weeks for completion of all scenarios. Check in with participants after completion of the first scenario to answer any questions.

III: (optional) Supplement existing exercises by developing additional scenarios based on your unit's patient population. Unit-specific scenarios may be most useful in helping staff members make difficult trade-offs between competing patient care needs.

IV: Assess the exercise using the Evaluation Guide on page 72. Use the Discussion Guide to initiate a conversation about participants' experiences completing the exercise and ability to prioritize multiple competing responsibilities.

Tool #11: Patient Assignment Prioritization Scenarios

Scenario One

Step One: Read the patient situations listed below. For each situation, list the action steps you would personally perform, then list the action steps you would delegate to another team member.

Patient Situation	Nurse-Completed Responsibilities	Delegated Responsibilities
58-year-old male recovering after bypass surgery hits his call button	Double-check recent pain control	Call button needs to be answered
47-year-old female diabetic recovering after foot amputation needs to be bathed		
36-year-old female recovering from mastectomy will be discussed in rounds in 15 minutes		
52-year-old male recovering after gastric bypass surgery needs blood drawn for lab tests		
59-year-old male recovering after bypass surgery has just been cleared for discharge		
64-year-old female recovering after hip replacement has been transferred from the PACU and is being boarded in the hallway while awaiting a bed		

Step Two: In the chart below, list the actions identified in Step One according to their urgency. List the most urgent items first.

	Nurse-Completed Responsibilities in Order of Urgency	Delegated Responsibilities in Order of Urgency	To Whom? (circle)
1			• Nursing aide • Peer • Charge nurse
2			• Nursing aide • Peer • Charge nurse
3			• Nursing aide • Peer • Charge nurse
4			• Nursing aide • Peer • Charge nurse
5			• Nursing aide • Peer • Charge nurse

Tool #11: Patient Assignment Prioritization Scenarios

Scenario Two

Step One: Read the patient situations listed below. For each situation, list the action steps you would personally perform, then list the action steps you would delegate to another team member.

Patient Situation	Nurse-Completed Responsibilities	Delegated Responsibilities
51-year-old male with renal failure is running a fever with a depressed respiratory rate; the physician has ordered labs taken and an update when you receive the labs		
27-year-old recently admitted male with hepatitis C and history of drug abuse is repeatedly crying out in pain and pressing his call button; he has not been prescribed pain relievers		
41-year-old female with unspecified abdominal pain has been sleeping long enough to cause her family concern; she is scheduled for a CT scan in 60 minutes		
33-year-old female with lupus is being admitted to the unit after undergoing a seizure		
One of your peers is being floated to another unit and you are asked to take one of her patients		
Your shift is over in 90 minutes		
The pharmacy has sent up the latest order of medications for your patients		

Step Two: In the chart below, list the actions identified in Step One according to their urgency. List the most urgent items first.

	Nurse-Completed Responsibilities in Order of Urgency	Delegated Responsibilities in Order of Urgency	To Whom? (circle)
1			• Nursing aide • Peer • Charge nurse
2			• Nursing aide • Peer • Charge nurse
3			• Nursing aide • Peer • Charge nurse
4			• Nursing aide • Peer • Charge nurse
5			• Nursing aide • Peer • Charge nurse

Tool #11: Patient Assignment Prioritization Scenarios

Scenario Three

Step One: Read the patient situations listed below. For each situation, list the action steps you would personally perform, then list the action steps you would delegate to another team member.

Patient Situation	Nurse-Completed Responsibilities	Delegated Responsibilities
76-year-old man with sepsis after bowel reconstruction appears to be deteriorating quickly, including increasing temperature, changed mental status, and rapid pulse; the patient and the patient's family have a limited ability to communicate in English and ring his call bell frequently		
35-year-old female in coma after car accident needs to be turned; all monitors are steady (and have been for the last two hours), but the physician has requested that you check her vitals every 15 minutes		
Multidisciplinary rounds on the unit start in 60 minutes, including physicians, RT, PT, pharmacy, and your nurse manager		
Pharmacy has delivered medications for your patients		
You have a break coming in two hours and no one is assigned to take your patients while you are out		

Step Two: In the chart below, list the actions identified in Step One according to their urgency. List the most urgent items first.

	Nurse-Completed Responsibilities in Order of Urgency	Delegated Responsibilities in Order of Urgency	To Whom? (circle)
1			• Nursing aide • Peer • Charge nurse
2			• Nursing aide • Peer • Charge nurse
3			• Nursing aide • Peer • Charge nurse
4			• Nursing aide • Peer • Charge nurse
5			• Nursing aide • Peer • Charge nurse

Facilitator Resources

Tool #11: Patient Assignment Prioritization Scenarios

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the evaluation scale may indicate a greater opportunity for improvement.

Appropriateness of delegation decisions

☐ Staff member performs most sensitive actions and delegates responsibilities to most appropriate member of the care team	☐ Delegates some responsibilities but may take on responsibilities that should be carried out by other team members	☐ Unable to delegate; feels compunction to take on too much	☐ Some responsibilities which should only be completed by an RN are delegated to unlicensed staff members

Comprehensiveness of identified patient care responsibilities

☐ All critical responsibilities listed; staff member anticipates potential future needs	☐ Majority of patient needs adequately accounted for but may not be thorough	☐ Some patient needs are vague or missing	☐ Inaccurate or inadequate patient needs outlined

Appropriateness prioritization among competing responsibilities

☐ Clearly prioritizes most urgent patient needs	☐ Appropriately sequences most responsibilities	☐ Displays limited knowledge of how urgently certain care tasks are needed	☐ Has no clear view of what needs to be completed most urgently

Comments:

_____

_____

_____

_____

_____

_____

Facilitator Resources

Tool #11: Patient Assignment Prioritization Scenarios

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences completing the exercise and ability to prioritize multiple competing responsibilities.

1. Which scenario was the most challenging? Why?
2. If you could change the most difficult scenario in one way in order to make the delegation decisions less challenging, how would you change it? Why?
3. How realistic were the scenarios? Can you think of a similar time when you had a lot to do and had to make difficult choices about what tasks to personally perform and which to delegate?
4. What are the hardest things for you to delegate? Who can be the most challenging to delegate to? Why?
5. Do competing responsibilities ever make you feel overwhelmed? Are there things that other members of the care team can do to help you when this happens?
6. Describe a time in which you had many competing responsibilities and you effectively decided which to delegate and which to perform. What process did you use to make your decisions? What helped you make decisions effectively?

Section IV

Clinical Implementation

Section Goal: To help participants recognize and tailor care to unique patient circumstances and clearly communicate the care delivered to team members

- Tool #12: Plan of Care Customization Exercise
- Tool #13: SBAR Template and Role-Play

Introduction

Starting Questions

The scripting below is designed to help facilitators provide participants with an overview of the context and aim of the toolkit section on Clinical Implementation.

1. What are the key elements of Clinical Implementation?

Clinical Implementation has three key elements:

- The ability to recognize how a specific situation may differ from the norm
- The ability to respond (or adapt care) to the identified difference
- The ability to clearly communicate actions taken to others

2. Why is Clinical Implementation important for bedside nurses?

Clinical Implementation is the step of translating thought into action. To deliver safe and effective care, bedside nurses must be able to move beyond enacting a single "one size fits all" solution and instead recognize and tailor their actions to their patients' specific and unique needs.

Clinical Implementation also includes the component of clear communication. Clear communication improves both care quality and patient safety. It improves care quality by ensuring that all care team members have the ability to respond to a complete and accurate understanding of the patient's condition. Clear communication also improves patient safety by reducing the likelihood of miscommunication between care team members and resulting errors.

3. How will the exercises in this section help improve Clinical Implementation?

The first exercise targets participants' performance on the first two elements of Clinical Implementation. In this exercise participants are asked to recognize unique patient needs and adapt plans of care to accommodate the identified needs. The second exercise targets the third element of Clinical Implementation: clear communication. In this exercise participants practice applying the SBAR communication framework to specific clinical scenarios.

Overview of Tools for Clinical Implementation

Tool #12: Plan of Care Customization Exercise

Overview: The goal of this tool is to assist bedside nurses in incorporating unique patient, family, and community needs into plans of care. The tool prompts participating staff members to evaluate how their care plans would change based on individual patient needs.

Type of Exercise: Thought exercise

Tool #13: SBAR Template and Role-Play

Overview: The goal of this exercise is to equip bedside nurses to use the SBAR communication framework to communicate clearly and concisely with physicians and other providers.

Type of Exercise: Written exercise and role-play

Tool #12: Plan of Care Customization Exercise

Overview: The goal of this tool is to assist bedside nurses in incorporating unique patient, family, and community needs into plans of care. The tool prompts participating staff members to evaluate how their care plans would change based on individual patient needs.

Type of exercise: Thought exercise

Staff resources required: None

Time required: One hour for exercise; 30 minutes for concluding discussion

Targeted skill: Tailoring plans of care to reflect individual patient needs

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This tool is applicable for all staff members.

II: Share this exercise with participating staff members and agree upon a deadline. The Center recommends setting a deadline of approximately one week after sharing the tool with participants. Check in with participants halfway through the designated deadline in order to answer any questions.

III: Assess the exercise using the Evaluation Guide on page 82. Use the Discussion Guide to initiate a conversation about participants' experiences with the exercise and their ability to customize plans of care to individual patients.

Tool #12: Plan of Care Customization Exercise

Step One: Select a patient you would like to focus on in this exercise. (Any current patient can be selected, although a patient with unique circumstances will be especially appropriate.) With this patient in mind, complete the table below.

Stage	Patient Data
Assessment What are the key presenting symptoms?	
Diagnosis What is the primary nursing diagnosis?	
Planning What is the care plan?	
Implementation How will unique patient circumstances influence your care plan?	
Evaluation How will you evaluate the efficacy of your nursing interventions?	

Tool #12: Plan of Care Customization Exercise

Step Two: Review the unique patient situations listed below. For each patient situation, list how the situation might change the nursing process you outlined in the previous table. Please note that the specified circumstance may not impact all steps of your nursing process.

	Patient circumstance #1: Patient is homeless and is likely to struggle with follow-up care.	**Patient circumstance #2: Patient has serious depression and is generally unresponsive to conversation.**
A		
D		
P		
I		
E		

	Patient circumstance #3: The patient may have been given a serious drug overdose on the previous shift.	**Patient circumstance #4: The patient does not speak English and appears to be continually agitated.**
A		
D		
P		
I		
E		

Tool #12: Plan of Care Customization Exercise

	Patient circumstance #5: The patient appears to have an unusual rash unconnected with his or her diagnosis and denies its existence.	Patient circumstance #6: The patient is a devout Mennonite with religious objections to receiving certain types of care.
A		
D		
P		
I		
E		

Step Three: After completing the previous step, answer the questions below:

List between one and three specific ways in which the listed patient circumstances might make it more challenging to recognize signs of patient deterioration.

_____

_____

_____

_____

_____

List two to four ways in which you might identify a patient who is impacted by one of the circumstances listed above.

_____

_____

_____

_____

_____

Facilitator Resources

Tool #12: Plan of Care Customization Exercise

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the evaluation scale may indicate a greater opportunity for improvement.

Thoroughness of original ADPIE

☐ Original ADPIE provides a clear and accurate picture of what has been (and will be) done for the patient	☐ Majority of steps of original ADPIE provide an accurate picture of patient care pathway	☐ Original ADPIE provides broad enough overview of patient condition to complete exercise meaningfully	☐ Original ADPIE is too vague to guide decision making

Specificity of solutions for unique patient circumstances

☐ Solutions are correct and specific, providing clear guidance to oncoming staff	☐ Solutions are correct but somewhat vague	☐ Solutions are not detailed or may be missing information on select parts of the nursing process	☐ Solutions contain some inaccurate information or are too vague to guide decision making

Creativity of solutions for unique patient circumstances

☐ Solutions account for broad spectrum of patient needs above and beyond specific needs of the condition or the unique patient circumstances	☐ Solutions account for all clinical and psychosocial needs as strictly defined by the condition and unique patient circumstances	☐ Solutions thoroughly account for needs of unique patient circumstances but may disregard how the circumstances may interact with the underlying diagnosis	☐ Solutions do not display insight into the clinical needs of patients with these unique circumstances

Comments:

_____

_____

_____

_____

_____

_____

Facilitator Resources

Tool #12: Plan of Care Customization Exercise

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences with the exercise and their ability to customize plans of care to individual patients.

1. How often have you encountered the unique patient circumstances listed in this exercise? What are some other unique patient circumstances you have seen on this unit? How have they changed the way you deliver care?
2. Which situation would be the most challenging for you? Why?
3. What is the most challenging patient situation you have encountered? How did the situation impact your care delivery?
4. Do you think these unique patient circumstances would have a significant impact on the way you deliver care? Why?
5. How difficult was it for you to use ADPIE to structure your thinking? On a typical workday, what structure or framework do you use to keep track of each patient's unique needs?

Tool #13: SBAR Template and Role-Play

Overview: The goal of this exercise is to equip bedside nurses to use the SBAR communication framework to communicate clearly and concisely with physicians and other providers.

Type of exercise: Written exercise and role-play

Staff resources required: A peer, manager, or educator to serve as a partner for role-play exercises

Time required: 30 minutes for written exercise; 30 minutes for role-play; 30 minutes for follow-up discussion

Targeted skill: Communication with physicians using SBAR

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
SBAR Template	Frontline Nurse
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This tool is applicable for all staff members. This exercise can be completed by staff members working in pairs or in a group.

II: Share this exercise with participating staff members. The Center recommends allocating participants approximately two hours to complete this exercise. Ask participants to prepare for the role-play by completing the scenario sheets provided on pages 86 and 87 and sharing the completed sheets with their partner.

III: Use the SBAR sheet completed by participants to guide the role-play. As a role-play partner, put yourself in the shoes of the provider the nurse is contacting. Based on your own experience, ask questions that the provider would ask in the specified situation. Sample questions are provided below.

- Are there secondary diagnoses?
- How does this change the patient's care pathway?
- How urgent is the situation?
- What are the patient's vital signs?
- What do you think the problem is? Why?
- What is your recommendation?
- Why is that your recommendation?
- Why should I follow your recommendation?

IV: Assess the exercise using the Evaluation Guide on page 88. Use the Discussion Guide to initiate a conversation about participants' experiences with the exercise and comfort with SBAR.

Tool #13: SBAR Template and Role-Play

SBAR Template

The SBAR template below is used by providers at University Hospital in Cincinnati, Ohio, to ensure they communicate clearly, comprehensively, and concisely. This SBAR template is similar to those deployed at other institutions across the country. If applicable, you may use your own institution's template for this exercise.

Critical Thinking Pocket Guide…

When calling physicians:

1. Have I seen and assessed this patient myself before I call?
2. Have I reviewed the patient's active orders?
3. Do I have at hand:
   - The chart
   - List of current meds, IV fluids, labs, and most recent vital signs
   - If reporting lab work, date and time this test was done and results of previous tests for comparison
   - Code status
4. Have I read the most recent physician progress notes and notes from the previous shift's staff?
5. Is there a need to discuss this call with my supervisor?
6. When ready to call, remember to identify:
   - Self, unit, patient, room #
   - The admitting diagnosis and date of admission
   - Briefly, the problem, what it is, when it happened or started, and how severe it is
7. What do I expect to happen as a result of this call?
8. Document whom you spoke to, time of call, and summary of conversation

SBAR report to physician about critical situation

S

Situation

I am calling about <patient name and location>.
The patient's code status is <code status>.
The problem I'm calling about is_____.
I am afraid the patient is going to arrest.

I have just assessed the patient personally:
Vital signs are:
Blood pressure ____/____, Pulse ____, Respiration ____ and Temperature ___
I am concerned about the:
Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual.
Pulse because it is over 140 or less than 50.
Respiration because it is less than 5 or over 40.
Temperature because it is less than 96 or over 104.

B

Background

The patient's mental status is:
Alert and oriented to person, place, and time
Confused and cooperative or non-cooperative
Agitated or combative
Lethargic but conversant and able to swallow
Stuporous and not talking clearly and possibly not able to swallow
Comatose. Eyes closed. Not responding to stimulation.

The skin is:	Warm and dry	Diaphoretic
	Pale	Extremities are cold
	Mottled	Extremities are warm

The patient is not or is on oxygen.
The patient has been on ____ (l/min) or (%) oxygen for ____ minutes (hours)
The oximeter is reading ____ %
The oximeter does not detect a good pulse and is giving erratic readings.

A

Assessment

This is what I think the problem is: <say what you think is the problem>
The problem seems to be
cardiac infection neurologic respiratory _____
I am not sure what the problem is but the patient is deteriorating.
The patient seems to be unstable and may get worse;
we need to do something.

R

Recommendation

I suggest or request that you <say what you would like to see done>
Transfer the patient to critical care.
Come to see the patient at this time.
Talk to the patient or family about code status.
Ask the on-call family practice resident to see the patient now.
Ask for a consultant to see the patient now.
Are any tests needed:
Do you need any tests like CXR, ABG, EKG, CBC, or BMP?
Others?
If a change in treatment is ordered then ask:
How often do you want vital signs?
How long do you expect this problem will last?
If the patient does not get better, when would you want us to call again?

Tool #13: SBAR Template and Role-Play

Step One: Select three of your current patients and write their primary diagnoses and key clinical data in the table below. For each patient, read the specified scenario and then use the SBAR format to create a script that communicates the specified concern.

Patient Clinical Data	Scenario	Scripting	
Sample: *48-year-old white male recovering comfortably for 12 hours after scheduled triple bypass*	Your patient has reported a surprising spike in pain. You have called the physician to report this change.	S	*The patient has experienced a spike in pain from a level 4 to a level 8 across the past two hours.*
		B	*The patient is a 48-year-old white male recovering from triple bypass. His pain levels and vitals had been normal until approximately two hours ago. The patient is not responding to traditional pain medications.*
		A	*The patient's pulse, blood pressure, and respiration levels are all elevated and there is additional tenderness in the abdomen.*
		R	*I recommend the patient be prescribed a stronger pain reliever and undergo radiology scans to verify that there is no internal bleeding.*
	The patient has becoming increasingly despondent and depressed. You are communicating this to the patient's physician on the unit.	S	
		B	
		A	
		R	

Tool #13: SBAR Template and Role-Play

Patient Clinical Data	Scenario	Scripting	
	An ancillary staff member is about to transport your patient to radiology.	S	
		B	
		A	
		R	
	You are concerned that your patient may be deteriorating. You have called the physician to discuss potential action steps.	S	
		B	
		A	
		R	

Step Three: Give a copy of the completed table to your role-play partner (the manager or educator facilitating this exercise). Your partner will conduct a role-play exercise with you in which they will step into the shoes of the caregiver you are contacting. Initiate a conversation in SBAR format based on the previous scenarios. Respond to their questions using SBAR to structure your answers.

Step Four: After the role-play exercise, answer the following reflection questions on your own.

Did my partner fully understand what I was saying? Was I misunderstood at any point?

Did I leave out any information on the SBAR form? If so, why?

Was I unprepared for any of the questions I received?

Tool #13: SBAR Template and Role-Play

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the evaluation scale may indicate a greater opportunity for improvement.

Clarity of communication in SBAR format

☐	☐	☐	☐
All SBAR elements are clearly and concisely communicated	All SBAR elements are communicated; some portions may not be concise	All SBAR elements are communicated; some portions may not be clear	Some SBAR elements are missing

Ability to clearly and concisely answer follow-up questions

☐	☐	☐	☐
All follow-up questions are addressed clearly and concisely	All follow-up questions are addressed clearly but not as concisely as possible	Most follow-up questions are addressed clearly	Most follow-up questions are not addressed clearly

Comments:

_____

_____

_____

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a conversation about the participants' experiences with the exercise and comfort with SBAR.

1. What do you find easiest about the SBAR format? Why?
2. What do you find most challenging about the SBAR format? Why?
3. Have you observed any providers on the unit using SBAR effectively? What do you think makes them so effective?
4. How often do you use SBAR in your communications with physicians? How often do you use SBAR in handoffs to other providers? Why?
5. Have you ever faced a situation in which the other provider was impatient or confused? How did you respond?
6. What training or additional information would help you use SBAR more routinely?

Section V

Reflection

Section Goal: To help participants analyze their current and past practice in order to learn from identified strengths and improvement opportunities

- Tool #14: Peer Feedback Request Exercise
- Tool #15: Individual Self-Assessment and Development Plan
- Tool #16: Clinical Narrative Exercise

Introduction

Starting Questions

The scripting below is designed to help facilitators provide participants with an overview of the context and aim of the toolkit section on Reflection.

1. What are the key elements of Reflection?

Reflection has three key elements:

- The ability to accurately recall past practice
- The ability to dispassionately analyze past practice in order to identify strengths and improvement opportunities
- The ability to incorporate identified strengths and improvement opportunities into current practice

2. Why is Reflection important for bedside nurses?

Reflection enables bedside nurses to continually advance their practice by learning from past experience. Structured reflection (facilitated through the exercises in this section) can jump-start this learning process by assisting participants in accurately assessing their current practice and identifying specific strengths and opportunities for improvement.

3. How will the exercises in this section help improve Reflection?

The first tool will enable participants to identify strengths and improvement opportunities by soliciting concrete feedback from peers. The tool provides scripting and a feedback request guide to ensure that peer feedback is specific and actionable.

The second and third tools provide participants with the opportunity to assess their current practice by respectively completing the Center's Critical Thinking Diagnostic and a clinical narrative. Both exercises include an opportunity for participants to identity specific strengths and opportunities for improvement. The second exercise includes the creation of an individual development plan to help participants develop concrete goals and an action plan for the upcoming year.

Overview of Tools for Reflection

Tool #14: Peer Feedback Request Exercise

Overview: The goal of this tool is to provide bedside nurses with scripting and techniques for soliciting concrete feedback from peers.

Type of Exercise: Discussion and guided self-reflection

Tool #15: Individual Self-Assessment and Development Plan

Overview: The goal of this tool is to lead bedside nurses through a structured assessment of their own practice in order to identify specific improvement goals and develop concrete action steps for achieving them.

Type of Exercise: Written self-reflection

Tool #16: Clinical Narrative Exercise

Overview: The goal of this tool is to provide bedside nurses with a structured opportunity for reflecting on the care they delivered to a specific patient. The reflection is designed to increase self-awareness and facilitate identification of personal strengths and improvement opportunities

Type of Exercise: Clinical narrative composition

Tool #14: Peer Feedback Request Exercise

Overview: The goal of this tool is to provide bedside nurses with scripting and techniques for soliciting concrete feedback from peers.

Type of exercise: Discussion and guided self-reflection

Staff resources required: Peer(s) willing to provide concrete feedback

Time required: 30 minutes for feedback preparation; 30 minutes for peer discussion; 30 minutes for post-discussion reflection

Targeted skill: Soliciting concrete peer feedback

Tool contents and intended audience:		
	Tool Implementation Guide	Manager/Educator
	Staff Exercise	Frontline Nurse
	Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select individuals to complete this exercise. The tool is applicable for all staff members.

II: Share this exercise with participating staff members and agree upon a deadline. The expected deadline should be one to two weeks after sharing this exercise with participants. The Center recommends checking in with participants at the halfway point to ensure participants have found a peer who has agreed to provide feedback.

III: (Optional) If a significant portion of unit staff members will be participating in soliciting and delivering peer feedback, it may be efficient to provide unitwide education on delivering peer feedback. To aid creation of a unitwide education module, key teaching points are provided below.

Guidelines for providing peer feedback:

- After you are asked to provide feedback, spend 30 to 45 minutes reflecting on your peer's performance. Write down all of your feedback on paper. If necessary, rewrite the feedback to ensure it is constructive rather than critical.
- Balance positive feedback and potential development objectives.
- Be honest—the object of the exercise is to highlight opportunities to improve.
- When providing feedback, avoid superlatives and exaggeration.
- Consider providing feedback along each of the following vectors: patient service, teamwork (including prioritization and delegation), communication, assessment skills, clinical decision making, and unit contribution.
- When possible, provide concrete examples
- Hold all feedback and conversations in strict confidence.

IV: Use the Discussion Guide on page 97 to initiate a conversation about participants' experiences completing the exercise. Due to the focus of this tool, there is no Evaluation Guide.

Tool #14: Peer Feedback Request Exercise

Step One: The first step in receiving actionable feedback from peers is to clarify your own goals and motivation for seeking feedback. To help define your goals for seeking peer feedback, answer the questions below.

What aspects of your practice would you like feedback on?

_____ _____

_____ _____

_____ _____

How detailed would you like the feedback to be?

_____

_____

_____

How could peer feedback help you improve your nursing practice?

_____

_____

_____

Step Two: The second step in receiving actionable feedback is to solicit feedback from a peer with direct knowledge of your practice. Write the name of a peer you believe would be well-positioned to provide feedback in the space below.

Peer:_____

Answer the questions below to confirm that your selected peer is well-positioned to provide you with actionable feedback. More than one "no" answer indicates you should select a different peer.

Question	Yes	No
Is this someone you can trust to give you honest and thorough feedback?		
Is this someone you can trust to keep performance feedback confidential?		
Is this someone you have worked with closely across the past several weeks, months, or years?		
Is this someone with whom you maintain a strictly professional (rather than personal) relationship?		
Is this someone whose performance you believe meets or exceeds your own?		
Is this someone who has sufficient clinical experience to identify growth areas?		
Is this someone you can trust to be constructive with feedback rather than confrontational?		
Is this someone whose opinions you respect?		

Tool #14: Peer Feedback Request Exercise

Step Three: After identifying a peer in Step Two, use the sample scripting below to request feedback.

Sample Scripting

"Hi [peer's name]. I have enjoyed working closely with you across the past [time frame], and I have come to respect your clinical judgment. I am hoping to improve [your goals], and I was hoping to get feedback on how I can improve. Would you have 30 minutes or so to sit down with me across the next week?"

Step Four: After your peer agrees to provide feedback, give your peer a short Feedback Request Guide in which you list the specific areas of your practice you are seeking feedback on and your goals for the conversation. A sample Feedback Request Guide is provided on the following page.

Step Five: Meet with your selected peer in a quiet and neutral space. Use your Feedback Request Guide and the questions below to prompt your peer for specific feedback.

- What do I do particularly well? Can you think of a specific patient situation when you were impressed with my practice?
- How often do I seem overwhelmed? Do you have any tips on how I can better multitask when the unit is particularly busy?
- I do my best to provide quality patient care every day. Have you seen any way I can improve my nursing practice?
- Sometimes I need help deciding what to delegate and when. Do you have any advice on additional tasks that I can delegate? Have you seen me delegate anything I shouldn't?
- Sometimes I have difficulty communicating with physicians. Do you have any advice on how I can improve my communication skills? What did you do to improve your ability to communicate with physicians?

Keys to a Successful Discussion

Do's	Don'ts
Ask for specific examples whenever possible—the more specific information you receive, the better you can understand your opportunities for improvement	Don't become defensive—there is a reason your peer is providing the feedback; try to understand their viewpoint
Conduct the conversation in a quiet, private place	Don't interrupt your peer
Ask for concrete advice on how to improve	Don't be satisfied with only positive feedback—everyone has an opportunity to improve
If you become upset, explain why to your peer using "I feel" statements	Don't attack your peer—providing honest feedback is just as difficult as receiving it

Tool #14: Peer Feedback Request Exercise

Tool in Action

This Feedback Request Guide was developed by the Weinberg ICU at Johns Hopkins University Hospital. During the annual performance review process, all staff members on the unit solicit feedback from two peers using the form below.

PEER INPUT

WICU PERFORMANCE REVIEW

NAME:_____ EVALUATOR:_____

DATE DUE TO: _____ DATE COMPLETED: _____

Instructions: Please write the "gist" of the person's strengths and areas for development in each of the sections. Be as specific as possible. Describe behaviors versus using labels. Do not write only "good" descriptions. No one can grow from that.

I. CLINICAL PRACTICES

A. Assessment: (thoroughness, depth, identification of changes in the patient, "picture" given to MDs, ability to assist others with their assessment, problems are identified with outcome statements)
B. Planning: (prioritization, individualization of care, communication of plan to all)
C. Implementation: (documentation, facilitation of plan to be followed, handling of emergencies, proactive approach, patient/family teaching, follow through on plans, completeness of discharge process)
D. Evaluation: (updating, modifying plan)
E. Problem solving/decision making: (unitwide versus own patient assignment focus, ability to adjust assignments based on priorities, decisions made willingly and with comfort, able to present sound rationale for decisions)
F. Organization: (answers others alarms, call lights, use of down time, ability to handle changes/disruptions, quality of report-trends, hints, etc, handling of the charge nurse role)

II. TEAM CONTRIBUTION

A. Communication (approachability, openness, congruency of verbal and non-verbal, objectivity, use of proper chain of command, handling conflicts, ability to deal with issues versus the person)
B. Contributes constructively to problem solving, goal formation, conflict resolution and negotiations to maximize team performance
C. Delegates aspects of care to appropriate personnel, will follow-up with +/- feedback

III. SERVICE STANDARDS

A. Customer Service (responds quickly and appropriately to customer requests, anticipates customer needs and initiates actions to meet those needs)
B. Self-Management (presents a positive image, carries out responsibilities in a timely fashion, annual updates, CPR, self learning/tests of new protocols)
C. Ownership/Accountability: (follows up on issues/problems, holds peers accountable when practice does not meet standard, contributes to group six-week focus)

The three special contributions or aspects she/he brings to the team/unit are:

1.
2.
3.

The three things she/he is most valued for as a co-worker are:

1.
2.
3.

The three areas I feel she/he could work on or develop to be more effective in their personal performance in the work of our team or in the function of the unit are:

1.
2.
3.

Tool #14: Peer Feedback Request Exercise

Step Six: Use the form below to record the specific feedback you receive from your peer.

Competency	Areas of Strength	Opportunities for Improvement
Assessment		
Planning		
Implementation		
Evaluation		
Problem Solving		
Organization		
Communication		
Constructive Unit Contribution		
Delegation		
Customer Service		
Self-Management		
Accountability		

Step Seven: Use the questions below to reflect on the feedback you received and to think about how you may use this feedback to improve your practice.

- How closely does the feedback align with what I think my strengths are?
- How accurate do I believe my identified development objectives are?
- What can I do in the near future to address the highlighted development objectives?
- Who on the unit can I look to for assistance or as a role model?

Facilitator Resources

Tool #14: Peer Feedback Request Exercise

Discussion Guide

Use the following Discussion Guide to initiate a conversation about the participants' experiences completing the exercise.

1. How do you anticipate changing your practice in response to the feedback you received from your peers?
2. Was the feedback you received surprising in any way? How?
3. How do you think the feedback you received from peer(s) differs from the feedback you receive during performance reviews or check-ins? How is each type useful for your development?
4. What do you think would be the most difficult part of delivering feedback to a peer? How could you prepare for such a conversation?
5. What, if anything, will you do differently the next time you seek feedback from a peer?

Tool #15: Individual Self-Assessment and Development Plan

Overview: The goal of this tool is to lead bedside nurses through a structured assessment of their own practice in order to identify specific improvement goals and develop concrete action steps for achieving them.

Type of exercise: Written self-reflection

Staff resources required: None

Time required: One hour for exercise; 30 minutes for concluding discussion

Targeted skill: Self-assessment and creation of Individual Development Plan

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select individuals to complete this exercise. The tool is applicable for all staff members. As part of the annual review process, some institutions ask staff members to complete an Individual Development Plan in order to identify goals (and concrete steps for achieving them) in the coming year.

II: Share this exercise with participating staff members and agree upon a deadline. The deadline should be one to two weeks after sharing the tool with participants.

III: (Optional) If a significant portion of unit staff members will be participating in this exercise, it may be efficient to provide unitwide education on creating Individual Development Plans. To aid creation of a unitwide education module, key teaching points are provided below.

- The self assessment activity is for your own benefit—it behooves you to be as honest and thoughtful as possible.
- Think critically about the direction you want to take your career. This is an opportunity to set short-term goals that will shape your larger goals.
- This exercise will not be used or incorporated in your performance evaluation in any way. It is solely for your own development.

IV: Assess the exercise using the Evaluation Guide on page 105. Use the Discussion Guide to initiate a one-on-one conversation about participants' experiences completing the exercise and their Individual Development Plans.

Tool #15: Individual Self-Assessment and Development Plan

Step One: Use the scale below to rate your current performance level for each skill listed in the table. In the right column, provide between one and three supporting examples of times that you performed each skill at the rated level.

5 = I perform this skill effectively with every patient.

4 = I am generally able to perform this skill but may not do so for every patient.

3 = I do not perform this skill as well as I wish I could.

2 = I sometimes struggle to perform this skill.

1 = I often struggle to perform this skill.

Competency	Skill	Score	Supporting Examples
Problem Recognition	Accurately anticipate changes in patient status		
	Accurately recognize changes in patient status		
	Consistently recognize unsafe practices by self and others		
	Proactively voice concerns about unsafe practices by self and others		
	Proactively identify unit- or hospital-based improvement opportunities		
Clinical Decision Making	Effectively explore multiple solutions to a given problem		
	Consistently demonstrate understanding of rationale for following (or departing from) established protocols and policies		
	Consistently demonstrate understanding of potential clinical implications of interventions		
	Proactively ask peers and experts for assistance when needed		
	Proactively consult further resources (e.g. literature, evidence-based tools, etc.) to improve patient care		

Tool #15: Individual Self-Assessment and Development Plan

5 = I perform this skill effectively with every patient.

4 = I am generally able to perform this skill but may not do so for every patient.

3 = I do not perform this skill as well as I wish I could.

2 = I sometimes struggle to perform this skill.

1 = I often struggle to perform this skill.

Competency	Skill	Score	Supporting Examples
Prioritization	Appropriately prioritize the most urgent patients		
	Appropriately sequence care for an individual patient		
	Appropriately sequence indirect care responsibilities across the shift		
	Appropriately delegate responsibilities		
	Consistently demonstrate accountability for delegated responsibilities		
Clinical Implementation	Consistently develop plans of care that reflect the most current evidence-based practices and protocols		
	Consistently develop plans of care that reflect patient, family, and community needs		
	Effectively implement nursing interventions included in plan of care		
	Proactively adjust plan of care according to patient needs, preferences, and cultural considerations		
	Clearly communicate plan of care to other care team members		

Tool #15: Individual Self-Assessment and Development Plan

5 = I perform this skill effectively with every patient.

4 = I am generally able to perform this skill but may not do so for every patient.

3 = I do not perform this skill as well as I wish I could.

2 = I sometimes struggle to perform this skill.

1 = I often struggle to perform this skill.

Competency	Skill	Score	Supporting Examples
Reflection	Appropriately apply knowledge of past experiences to present situations		
	Consistently reevaluate assumptions to draw conclusions based on nursing evidence		
	Proactively initiate collegial dialogue around nursing practice		
	Proactively debrief following errors or near misses		
	Appropriately adjust own practice based on others' feedback		

Tool #15: Individual Self-Assessment and Development Plan

Step Two: Review the supporting examples you listed in the previous table. For each of the five competencies listed below, list three examples that demonstrate your strengths and three examples that illustrate your opportunities for further development.

Competency	Strengths	Development Opportunities
Problem Recognition	• • •	• • •
Clinical Decision Making	• • •	• • •
Prioritization	• • •	• • •
Clinical Implementation	• • •	• • •
Reflection	• • •	• • •

Tool #15: Individual Self-Assessment and Development Plan

Step Three: Review the strengths and development opportunities you identified in the previous table and identify three development opportunities that you will focus on improving in the coming year.

1. _____
2. _____
3. _____

Step Four: Brainstorm a list of potential strategies for improving your performance in your three identified improvement opportunities. The table below offers recommended strategies for each competency.

	Learn by Doing	Learn from Others	Learn from Training
Problem Recognition	• Track signs of anticipated clinical deterioration to determine how often your predictions are accurate	• Shadow a nurse educator or senior peer • Discuss common clinical symptoms with unit physicians	• Complete exercises in this toolkit • Participate in simulation exercises offered at your institution • Discuss training opportunities with your direct manager
Clinical Decision Making	• Review nursing research or your unit's standard plans of care and protocols to determine best practice	• Form a journal club to discuss best practices with peers • Participate on unit-based practice councils	• Complete exercises in this toolkit • Participate in simulation exercises offered at your institution • Discuss training opportunities with your direct manager
Prioritization	• Create a written plan of tasks to accomplish during a shift and order them by importance • Meet with your extender staff to seek feedback on improving delegation skills	• Discuss delegation practices with peers or an educator • Observe peers' delegation and prioritization skills	• Complete exercises in this toolkit • Participate in simulation exercises offered at your institution • Discuss training opportunities with your direct manager
Clinical Implementation	• Debrief with peers or physicians following challenging clinical scenarios • Write formal plans of care for each of your patients and ask a manager to evaluate them	• Observe peers performing various clinical interventions in different circumstances • Seek additional unit clinical or operational responsibilities	• Complete exercises in this toolkit • Participate in simulation exercises offered at your institution • Discuss training opportunities with your direct manager
Reflection	• Set aside dedicated time to reflect on your performance at the close of each shift	• Solicit feedback on your performance from others	• Complete exercises in this toolkit • Participate in simulation exercises offered at your institution • Discuss training opportunities with your direct manager

Tool #15: Individual Self-Assessment and Development Plan

Step Five: In the table below, list your top three development objectives and the strategies you will pursue to improve your performance on these objectives in the coming year. For each strategy, list your anticipated timeline and any required resources or needed support.

Personal Development Objectives	Actions	Timeline	Resources/Support

Facilitator Resources

Tool #15: Individual Self-Assessment and Development Plan

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the evaluation scale may indicate a greater opportunity for improvement.

Appropriateness of self-improvement action steps

☐	☐	☐	☐
Action steps reflect real opportunities for improvement	Action steps represent improvement opportunities but may not be specific	Action steps are either too aggressive or too basic	Action steps are superficial, vague, or missing

Appropriateness of timeline for achieving goals

☐	☐	☐	☐
Timeline is realistic and appropriate for selected goals	Timeline is ambitious but achievable	Timeline is unrealistic	Timeline is missing

Comments:

_____

_____

_____

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a one-on-one conversation about the participants' experiences completing the exercise and their Individual Development Plans.

1. How aggressive are the goals you set for yourself? Do you think you will be able to achieve them this year? Why or why not?
2. Which goal will be the greatest "stretch" for you to achieve? What strategies did you use in the past to achieve other ambitious goals? Will these strategies help you achieve this new goal?
3. What assistance or education would help you achieve your goals? What help can I (or others on the unit) provide to help you achieve your goals?
4. How often do you do a holistic assessment of your practice? Which aspect of the exercise was most challenging? Which was the most helpful? Did you learn anything surprising about your practice?

Tool #16: Clinical Narrative Exercise

Overview: The goal of this tool is to provide bedside nurses with a structured opportunity for reflecting on the care they delivered to a specific patient. The reflection is designed to increase self-awareness and facilitate identification of personal strengths and improvement opportunities.

Type of exercise: Clinical narrative composition

Staff resources required: None

Time required: Two hours for composition of narrative; 30 minutes for concluding discussion

Targeted skill: Self-awareness; identification of personal development opportunities

Tool contents and intended audience:

Tool Implementation Guide	Manager/Educator
Staff Exercise	Frontline Nurse
Evaluation Guide	Manager/Educator
Discussion Guide	Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This tool is applicable for all staff members.

II: Share this exercise with participating staff members and agree upon a deadline. The Center recommends checking in with participants twice during the exercise, first after participants select a subject for their narratives (See Step One in the accompanying Staff Exercise), and second when participants are halfway to their deadline. The deadline should be one to two weeks after you first share the exercise with participants.

III: Assess the exercise using the Evaluation Guide on page 109. Use the Discussion Guide to initiate a one-on-one conversation about participants' experiences completing the exercise and their clinical narrative.

Tool #16: Clinical Narrative Exercise

Step One: In this exercise you will be asked to write a clinical narrative (a personal account of a recent clinical situation or a patient you cared for). The clinical situation you select should be one in which you were called upon to think creatively to meet your patient's needs and should also provide a clear example of your current nursing practice. Think of a potential subject for your clinical narrative and write it below.

Selected clinical narrative subject:

_____

_____

_____

_____

Answer each of the following questions with your proposed subject in mind. One or more "no" answers indicates that you may need to select a new subject.

Topic Refinement Question	Yes	No
Does the subject have a defined beginning and end?		
Did the subject have any significant meaning to you in your practice?		
Does the subject display a clear picture of your practice?		
Did the subject require any creative thinking beyond normal practice?		

Step Two: Once you have used the criteria in Step One to select a subject, use the framework below to outline your clinical narrative.

Situation	• What was the patient's exact clinical situation? • What else was happening on the unit at the time? • What was the initial warning sign that alerted you to the uniqueness of the situation?
Thoughts	• What was your initial reaction to the situation? • What was the mental reasoning process you went through? • Why has this situation had lasting meaning for you?
Actions	• What actions did you take in response to the situation? • How did you decide on those specific actions? • What did others do in response to your actions? • How did you communicate your actions to the rest of the care team?
Results	• What could you have done differently in that situation? • What were the results of your actions? • How did the patient or their family react to the situation?

Step Three: Use your outline to write a one- to two-page clinical narrative on a separate sheet of paper.

Tool #16: Clinical Narrative Exercise

Step Four: Evaluate your own narrative by circling the criteria below that best describe your narrative. Your narrative's overall "stage" is determined by the stage associated with the majority of the criteria you circled. (These criteria are loosely based on Patricia Benner's Novice to Expert model. Please note: the majority of narratives will fall into Stage Three.)

Stage	Criteria
One	• Narrative shows tendency to rely on protocols • Narrative shows reliance on peers to evaluate patient symptoms • Narrative draws very little on past experience to guide decision making • Narrative shows little customization based on patient needs
Two	• Narrative shows provider gave clinically competent care with some assistance • Provider relied on experience or teaching to recognize patient symptoms
Three	• Narrative shows provider gave clinically competent care independently • Narrative displays knowledge of patient goals beyond the single patient diagnosis • Narrative clearly outlines provider's thought process • Narrative displays purposeful planning and decision making • Narrative shows ability to recognize most pertinent aspects of patient clinical situation
Four	• Narrative shows ability to evaluate the appropriateness of selected protocols, deviating when necessary • Narrative displays ability to observe entirety of patient situation while focusing on most pertinent aspects • Narrative shows awareness of patient normals and how the individual patient varies from expected • Narrative shows customization of the plan of care to target specific patient clinical or psychosocial needs
Five	• Narrative shows appropriate reliance on instinct while still outlining clear reasoning process • Narrative shows ability to recognize short-term and long-term implications of interventions • Narrative does not rely on protocols to provide excellent care • Narrative displays authoritative knowledge of clinical diagnosis

Step Five: With your narrative in mind, answer the questions below to identify future improvement opportunities.

What could you have done differently to achieve a better patient outcome?

_____

_____

_____

What can you do to improve clinical quality for the future?

_____

_____

_____

What specific improvements would help you progress to the next stage?

_____

_____

_____

Facilitator Resources

Tool #16: Clinical Narrative Exercise

Evaluation Guide

Use the evaluation criteria below to assess participants' exercises. For each criterion, check the box with the text that most closely describes the participant's work. Check marks on the right-hand side of the evaluation scale may indicate a greater opportunity for improvement.

Thoroughness of reflection in the narrative

☐	☐	☐	☐
Narrative notes in-depth opportunities for unit and personal improvement	Narrative notes general improvement opportunities	Narrative does not suggest improvement opportunities	Narrative blames others exclusively for identified problems

Appropriateness of selected narrative topic

☐	☐	☐	☐
Narrative topic is personally meaningful to the participant	Narrative topic is reflective of a deviation in normal practice patterns	Narrative topic is reflective of normal practice patterns	Narrative topic is not reflective of unit practice

Comments:

_____

_____

_____

_____

_____

_____

Discussion Guide

Use the Discussion Guide below to initiate a one-on-one conversation about the participants' experiences completing the exercise and their clinical narrative.

1. What was the most challenging part of writing the narrative? Why?
2. What did you think about the evaluation criteria? At what "stage" did you personally assess your narrative? At what stage would you generally assess your daily practice? Why?
3. What did you learn about your own practice through the exercise of writing a clinical narrative? How might you approach a similar situation differently in the future?
4. Is there any assistance that the unit can provide to better support nurses facing a similar situation or challenge in the future?