



Delivered May 21, 2007
American Association of Critical-Care Nurses
National Teaching Institute and Critical Care Exposition, Atlanta, Georgia.

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POWered by INSIGHT

If you left your current position tomorrow, what *one* powerful insight would you be remembered for? If you don't think you've had that one powerful insight yet, try changing the question into the future tense. When you leave your current position, what one powerful insight do you *want* to be remembered for?

I'm asking you these questions because if we really commit to being powered by insight, answers to these tough questions will come more easily. We will answer not only with our words, but also with our actions. Congruence between words and actions is a critical element of being a skilled communicator. To just say the words, "I am powered by insight," and to *live* the words are very different things. I know I have to do both to fulfill my expectations of myself.

You know an insight is powerful when it changes your view of the world, the way you act and your impact on things that matter—like patient safety. Does this mean my *one* powerful insight has to be inventing the next big patient innovation like the ceiling lift or the balloon pump? While such aspirations are worthy, I have something more achievable in mind, but no less profound for our patients.

Here's an example of a brilliantly simple innovation that started as a powerful insight. It's called the No Interruption Zone and cost less than \$5 to implement.

The nurses at Sentara Leigh Hospital in Norfolk, Virginia established a No Interruption Zone around their Pyxis machine. They recognized that they were often distracted while getting medications. This zone was initially created by simply making a box on the floor using red masking tape, and making it clear that no nurse—ever—should be interrupted when getting patient medications.

The results from this powerful insight have been so significant to the nurses at Sentara Leigh that most of the units have adopted it. In fact, most of the units in all seven of the hospitals in the Sentara Healthcare system have adopted it. Now the red masking tape has been replaced with red tile to create a permanent No Interruption Zone.

Can you have, share and act on an insight like this?

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I know you can. I am certain that each of us in this room has at least one such powerful insight.

Imagine if each of us acted on our insight—just one each—to make our patients safer.

Imagine that.

That's power.

That's **our** power.

As every president of AACN does, I wondered what you would think of my theme and what it might mean to you. Learning from you this year has certainly been insightful.

I can't believe how many times I've heard the word "insight" used in the past 12 months, both purposefully and serendipitously. People who knew my theme would use the word "insight," realize what they said and chuckle—myself included! Is this word normally used so frequently—or am I noticing it more because it came to the forefront with the theme? Or, are we craving insight more? Are we ready to seek it out, capitalize on it and require it to transform our healthcare environment?

When I shared my theme for the first time at last year's NTI in Anaheim, I committed to ask two questions throughout my year as president and challenged you to do the same. The two questions were deceptively simple. They were: What is going well? What's not going well?

I say these questions are deceptively simple because we so seldom ask them—and even more seldom do we really want to hear the answers, especially to "what's not going well?"

I committed to asking these questions of all the nurses I met during my travels. I committed to asking my patients and their families; some of my colleagues, especially those I don't see eye to eye with; the person I report to; and physicians as well as the housekeepers, because they see everything. I suspected that I'd hear answers that would draw my attention to things I might be ignoring and that I'd start to see patterns and relationships I never noticed before. In other words, I expected and hoped that insights would form. And, fortunately, they did.

What did I learn? What insights did I gain?

My most surprising insight was that no matter whom I asked, I got the same answers. I really thought that the answers I would get from nurses would be different from those of a pharmacist or a housekeeper or a physician. But, you know, it seems our high points and low points, our concerns and victories are alike.

One colleague told me that he was struggling with the new computerized system our hospital implemented. He was working overtime to try to make things function properly. When we talked, he had been at the hospital well into the night before and was back that next day trying to tackle it all again. Despite the hours he invested doing manual work-arounds to make up for what the new system couldn't do, he said he felt like he'd been "kicked by his colleagues" all night long. He felt awful and defeated about not getting it all done, about letting his colleagues down, about letting patients down.

Does this sound familiar? I know I feel this way sometimes. Would you be surprised if I told you I heard this comment from a pharmacist? It could be any of us, couldn't it? I heard similar stories from nurses, physicians and administrators. If we want and fear the same things, why can't we work together to whip our common problems into shape?

Another surprising insight I had was that we healthcare professionals remain a pretty optimistic bunch—even amid the chaos that most of us work in. Although I expected the list of concerns to be twice as long as the "what is going well?" list, I found just the opposite. The people I asked were overwhelmed by change fatigue—the constant barrage of new initiatives being introduced. But they were also quick to talk about the good things they were doing to change their environments—especially at the unit and team levels.

Maybe that's because the unit—what experts call a microsystem—is a place we feel we can have greater impact. Whereas the macrosystem—the hospital—is a huge and infinitely complex system, our units are what we know best. Although the unit itself is a complex organization, it's not nearly as complex and daunting as the whole hospital—especially when you're trying to make a foundational cultural change like creating a healthier work environment.

Like those I asked, and like you, I struggle to make sense of the chaos in the hospital environment. Why, when tackling one issue, does it seem to grow into many other issues? The problem I started to tackle had no resemblance to the one I worked on in the end.

Quality management expert Paul Plsek talks about hospitals as being complex, adaptive systems. He explains that a complex adaptive system is an organism that is constantly adapting based on the "relationships and responses of the individuals." In such systems, relationships are vital because interactions between people affect outcomes. Structures and processes are highly linked, but so are patterns of the culture that must be recognized and acknowledged. This is where that idea of microsystems comes in. Each unit, or microsystem, has a unique culture. Thus, a hospitalwide implementation of any new program or process is nearly impossible. If we

began looking at implementation unit by unit, rather than using the usual one-size-fits-all approach, we'd see better results.

Too often, we want to ignore beliefs, traditions, power differentials and conflict, but they are an ingrained part of the system. When I think of some of the recent implementations we've done at my hospital, I realize how vital it is that the implementation be adapted for each unit. If we don't take this microsystem approach, it can feel like we're being steamrolled into change that may not be in our patients' best interests. One hundred percent standardization isn't always a good thing.

We found this out recently at my hospital when we implemented a quality improvement process to standardize supplies on all units. The goal was to standardize the supply location and restocking procedure. The initial approach was piloted on the telemetry unit. The assumption was that we could then roll out the exact same approach for all the other units. It wasn't that simple.

Let me explain. I work as a clinical nurse specialist for three distinctly different units on two different campuses. At the university campus, I work in a medical ICU and surgical ICU. At the community campus, I work in a medical-surgical ICU that also admits high-risk obstetric and behavioral health patients. Add in another cardiovascular ICU at the university hospital that shares staff with the surgical ICU. And the cardiovascular ICU is covered by another clinical nurse specialist.

In this standardization project, of course, we recognized that we would need different types and par levels of supplies, but we didn't realize how much the resupply process would need to differ between units. Workflow patterns, patient admission patterns and available space in the patient rooms all affected supply availability differently on each unit. As usual, the timeline for rollout was aggressive, with no allowance for stopping the implementation if things weren't working. While the new process was an initial improvement for our university surgical ICU, this was not the case in the medical ICU or in the community medical-surgical ICU.

It took weeks of data collection before there was recognition that the process that was implemented wasn't working. The data were first collected and compiled manually. Realizing that the data on paper didn't tell the whole story, staff used video to expand the understanding of project leaders regarding what wasn't working. Our initial lack of recognition that the cultures and work patterns vary significantly from unit to unit provided us with a powerful insight.

You may be hearing some familiar themes from the AACN Healthy Work Environment Standards—the need for collaboration, communication and strengthening of relationships. Effective decision making is dependent on nurses being involved in decisions that affect our practice. Often, when someone says, “But we're different,” we try

to refute it rather than acknowledging the fact that every unit culture is different and instead explore the ways we could adapt to address the differences.

These concepts seem obvious on the surface. So why are we finding it so hard to effectively improve our environments? I don't think it will surprise you that one of the major barriers is time. What might surprise you, though, is that there is growing evidence to support what we all complain about—that there is simply not enough time to do all that we want and need to do.

Visionary nurse leader Karlene Kerfoot recently wrote about the need for slack time in organizations. “Unless we have slack time in our organizations,” she writes, “we will lack agility, retention of key personnel or an ability to invest in the future by rethinking present processes.” Healthcare professionals aren't the only ones yearning for “thinking time.” Genius—even the everyday genius of ideas like tape around the Pyxis machine—takes thinking time. Time when we aren't in full reaction mode.

In his book *How to Think Like Leonardo da Vinci*, Michael Gelb shares his learning about what da Vinci did that made him the greatest genius of all time. There was a quote by da Vinci that I found surprising. It was unexpected because da Vinci was one of the busiest men in history, the most prolific inventor and artist we've ever known.

He said, “It is ... a good plan every now and then to go away and have a little relaxation; for when you come back to the work your judgment will be surer, since to remain constantly at work will cause you to lose the power of judgment.”

I share this quote with you because the power of good and clear judgment is vital to us as nurses. It is the essence of what we do as knowledge workers.

Our role is not simple.

Our patients are really sick.

We don't work on an assembly line doing exactly the same thing every day, knowing exactly what the result of our actions will be.

Our patients count on us to maintain good judgment and the energy we need to be a part of solving our most complex problems. We can't fulfill this promise if we are allowing ourselves to work in constant crisis mode.

It will take some doing to build in that much-needed slack time in our organizations. In the meantime, we must immediately begin employing a new strategy to maintain our good judgment every day. I call it stopping for a “thought pause.”

A thought pause requires us to take a moment to *think* rather than *do*. To use our knowledge and the knowledge of our colleagues. To ask the right questions before we take action—especially high-risk actions like giving medications. To rise above the task for a moment to be sure we're thinking of the bigger picture, the whole patient. What does a thought pause look like?

It might mean taking a moment before you give a dose of furosemide to think through why you're giving it to this particular patient. Ask yourself, "Have I checked potassium levels?" "Have I checked the dosage?" "Have I evaluated the patient's current fluid status?" New nurses do this all the time. They ask themselves, "Why am I doing this?" "Is it the right thing?" If they don't know, they ask a more experienced colleague. Remember those days? Maybe there's something to be learned by going back to our early mindset.

Because our environments are complex and because our role is comprehensive, we find it difficult to isolate and focus on the highest priorities—like pausing to think. Often, we don't implement vital changes until the pain has become unbearable or a major medical error has occurred.

We know waiting to treat a patient's pain until it reaches a "10" is unacceptable. Not only does it cause unnecessary suffering and a tremendous waste of the patient's valuable energy, it is now significantly more difficult to get the pain under control than if we had addressed it when it was a "4" or a "5." Why then do we ignore our own "pain" until it reaches a "10," when mandatory and urgent change is required?

Some would say that change won't occur until the pain of not changing is greater than the pain of the change itself. I challenge that assumption. We must listen to the "whispers" of discomfort and treat them before they get to be full-blown agony.

What do I mean by "whispers"? I mean those first hints that something isn't right.

Remember the Oucher pain scale? I know those of you in pediatrics do. It's used to engage pediatric patients in helping us to assess their level of pain so that we can treat it effectively.

Of course, treating our psychological pain looks different than treating our patients' physical pain. Where their analgesic is fentanyl or morphine, our analgesic is engagement. Unless we take the initiative to describe the pain, identify its source and participate in creating solutions, we won't find lasting relief.

To gain the insight needed, we must give ourselves the necessary time and space. Insight requires self-reflection and inquiry. What is the true problem or process to be addressed? What role am I playing in the problem? How are my beliefs and expectations facilitating or hindering me from finding a solution? How can the perspectives of

others enrich the solution pool?

I can almost hear your voices out there saying, "But I am only one person. How can I possibly impact problems as big as the ones we're facing?"

Do you remember the butterfly effect from Nancy Molter's presidential speech at the 1994 NTI? The butterfly effect is a concept in chaos theory, which asserts that small variations in a particular place or time can make a large impact on the end result. The original butterfly effect refers to the idea that a butterfly's wings might create small changes at just the right time and place, triggering such a significant atmospheric chain of events as to cause or prevent a tornado.

Simply by being an AACN member or by attending NTI, you are in a position to prevent tornadoes. Imagine if we all did our small part in solving a devastating problem. Take adverse patient outcomes from improper placement of nasogastric tubes, for example. The simple, small act of using AACN practice alerts, like the one on Verification of Feeding Tube Placement, puts you in a position to prevent a common cause of harm, including death, in your patients. Imagine how this effect is amplified when you share a practice alert with your colleagues at a staff meeting, through your unit council or whatever effective system you have for sharing innovations in patient care. Often, we don't implement vital changes like this until the pain has become unbearable or a major medical error has occurred.

Change begins with the momentum created by one or two people—I see this in my units, don't you? You don't have to be Leonardo da Vinci to make a remarkable contribution to patients. You don't have to be a formal volunteer to move AACN's mission forward. Sharing what we learn—the work that AACN has done for nurses like you and me who want to use the latest evidence in our practice—is the most valuable contribution we can make.

We are not cogs in a machine.

We are not a service that just comes with the bed.

We as nurses are the creators and sharers of insights that ensure our patients' wishes are honored—that they are not in pain and that they are better for the care we provide.

AACN's vision is of a healthcare system driven by the needs of patients and their families. If this vision is to be realized, we must assume power and responsibility for fixing those things that have the public convinced they are in danger when they enter the hospital. We will know we have succeeded when we have loved ones in the hospital and don't feel like we need to be there to watch over them every minute of their stay.

What can you or I—just one person, one butterfly—do right to ensure there is never another tornado on our units? To ensure that our patients and their families are free of unnecessary fear? What you learn and share could very well be the catalyst for that one powerful insight that you'll be remembered for long after you've moved on.

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Acknowledgments

This presentation would not have been possible without the insights and support of the AACN and AACN Certification Corporation boards of directors, the AACN National Office staff and each of the following individuals and groups. I am extremely grateful for their generous contributions of time and thought.

Ayesha Ali, Marian Altman, AVW AudioVisual, Mike Ballew, Connie Barden, Debbie Brinker, Denise Buonocore, Robyn Bushinski, Damon Cottrell, Cathy Dunn, Matt Edens, Freeman Decorating Company, Ellen French, Tim Fromm, Caryl Goodyear-Bruch, Debby Greenlaw, Beth Hammer, Dave Hanson, Susan Helms, Wanda Johanson, Roberta Kaplow, Karlene Kerfoot, Ramón Lavandero, Rebecca Long, Paula Lusardi, Beth Martin, Carol Melman, Julie Miller, Nancy Molter, Patricia Gonce Morton, Jodi Mullen, Kim Nesbitt, Jackie Newis, Kristine Peterson, Marilyn Petterson, Kevin Reed, Maria Shirey, Jon Shirley, Mary Stahl, Lisa Valencia-Villaire, Judy Wilkin, Janice Wojcik, Dana Woods, Dale Yuhas and the nurses at Sentara Hospital, Norfolk, Va.