Applying Situational Awareness to Your Operational Practices, Your Team and Yourself

Cagney Martin
khsb4bang@gmail.com

What is **Situational Awareness?**

The **practice** and **mindset** of actively monitoring your surroundings to spot potential hazards or risks—so you can quickly act to stop any escalation and mitigate harm.

BANG!

is the **BAD** stuff that happens to you or your organization.

Before the Boom

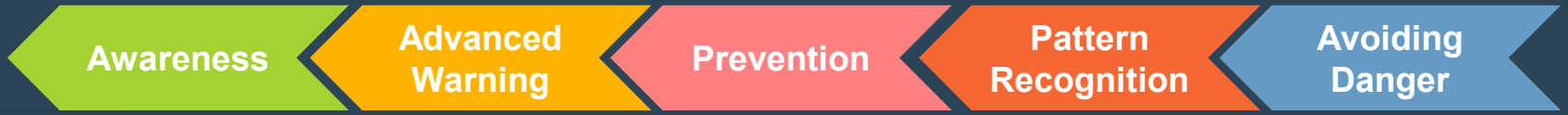
We **predict** and can **prevent**.
We are **proactive** and **mitigate** risks and dangers to **avoid** them altoghter.
We are **intentional**!

Some Day Soon!

We respond and react to the Bang.
We are in recovery mode.
We “should have known.”
We might expereince trauma.
Act quickly.

In Healthcare, we tend to sit over here!

Let's Hang on the Left Side for Awhile



What did you know and when did you know?
And WHAT THE HECK DID YOU DO ABOUT IT?

Awareness

is a key ingredient in success. If you have it, teach it, if you lack it, seek it.

Michael B Kitson

Identifying Risks + Increased Awareness = Prevention of “Bangs”

How does your organization identify risks?
Where does your awareness of future “Bangs” come from?
What things put you at risk?

Population outliers	Frequent population problems	Past survey citations	QAPI data	Top 10 citations
Agency staff	Turnover	Event reports/near misses	“Stuff” that happens at other places	Hazard vulnerability assessment

Awareness

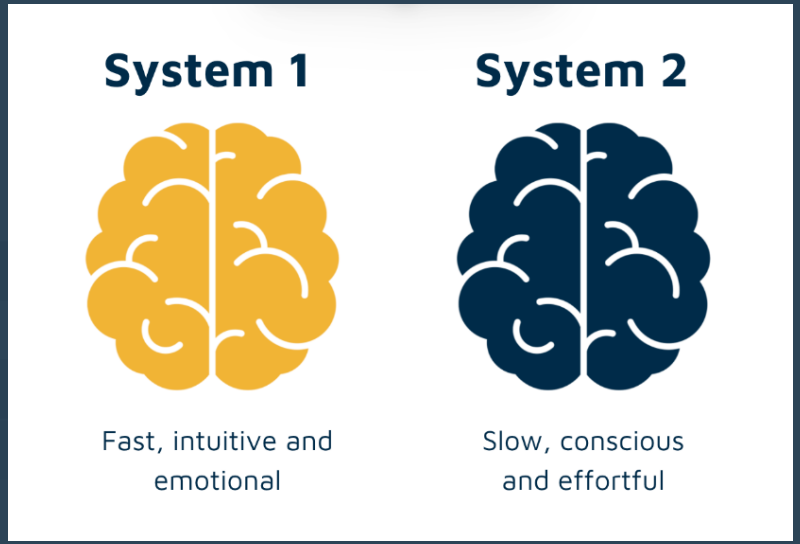
Let's Start by Evaluating Ourselves

COOPER'S COLOR CODE

WHITE	Unprepared and unready to take action.
YELLOW	Prepared, alert, and relaxed. Good situational awareness.
ORANGE	Alert to probable danger. Ready to take action.
RED	Action mode. Focused on the emergency at hand.
BLACK	Panic. Breakdown of physical and mental performance.

Awareness

How Do We Process Information?



Filter It Out!

So much stuff! Can't pay attention.

Bridge the Gap

Scan, filter, delete.

System 1 or 2

Unconscious/automatic vs. Slow/complex

Problems with Awareness- Distractions!

In 2015 a study claimed that the average attention span **dropped to 8 seconds**, down from 12 seconds!

"I'm surprised we don't have **more** med and charting errors"

Is your smart phone making you less smart?

Problems with Awareness – The Myth of Multitasking

You're really just doing a whole bunch of things…poorly, all at the same time.

What happens when we try to "pay attention" to two things at once is the brain give its neuronal attention to one thing… then the other… then back to the first – never are we able to give simultaneous attention to two things.

You can't really use both well at the same time.

Awareness Tools

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Pressure Ulcer/Injury Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- ☐ Did your wound develop in the facility? If so, do you know how it occurred?
- ☐ Has staff talked to you about your risk for the wound and how they plan to reduce the risk?
- ☐ How are they treating your wound?
- ☐ Is the wound getting better? If not, describe.
- ☐ How has your wound caused you to be less involved in activities you enjoy?
- ☐ How has your wound caused a change in your mood or ability to function?
- ☐ How did the facility ensure you had a choice in h would be treated?
- ☐ How often are dressings changed or treatment a
- ☐ Does your wound hurt? Do you have pain with the dressings are changed? If so, what does sta
- ☐ What types of interventions are done to help t about specific interventions (e.g., positioned redistribution devices or equipment).
- ☐ If you know the resident refused care: Did s other options of treatment or did staff provi on what might happen if you do not follow

Staff Interviews (Nursing Aides, Nurse, DON, Attending Practitioner):

- ☐ What, when, and to whom do you report changes in skin condition?
- ☐ Does the resident have a PU? If so, where is it located?
- ☐ How are you made aware of the resident's daily care needs?
- ☐ What PU interventions are used?
- ☐ Does the resident have pain? If so, how is it being treated?
- ☐ Has the resident had weight loss, dehydration, or acute illness? If so, what interventions are in place to address the problem?
- ☐ Is the resident currently on any transmission-based precautions?
- ☐ Has there been a change in the resident's overall function and mood?
- ☐ Ask about any observation concerns.
- ☐ Is the resident at risk for the development of PU/PI?
- ☐ How and how often is the resident's skin assessed and where is it documented?
- ☐ When did the current PU/PI develop? What caused the PU/PI?
- ☐ Are ordered nutritional interventions implemented (e. supplements and hydration)?
- ☐ What do you do if the resident refuses c
- ☐ Is the PU/PI improving?
- ☐ How is pain related to the PU/PI asses
- ☐ How do you inform other staff and th
- ☐ How do you monitor staff to ensure t planned interventions?
- ☐ How do you determine the appropri
- ☐ If there are systemic concerns: Wh procedures regarding care, treatm for pressure ulcers?
- ☐ Is the resident's treatment effecti any changes in the PU/PI?
- ☐ How do you monitor the reside
- ☐ How is the effectiveness of wc measures evaluated? And how

Form CMS 20078 (April 2024)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Behavioral and Emotional Status Critical Element Pathway

Resident, Family and/or Resident Representative Interview:

- ☐ Is the facility aware of your/the resident's current conditions or history of conditions or diagnoses?
- ☐ How did the facility involve you/the resident in developing the care plan, including implementing non-pharmacological interventions and goals and identifying triggers that may cause fear or re-traumatize the resident?
- ☐ What non-pharmacological approaches to care are used to help with the resident's mood? Are they effective? If not, describe.
- ☐ How did the facility ensure approaches to care reflect your/the resident's choices and cultural preferences?

Staff Interviews (Interdisciplinary team (IDT) members including social services) across Various Shifts:

- ☐ What are the underlying causes (e.g., history of trauma, mental disorder) of the resident's behavioral expressions or indications of distress, specifically included in the care plan?
- ☐ What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility-specific guidelines/protocols? What is the rationale for each intervention?
- ☐ How do you meet the resident's needs and provide emotional support to a resident who is having difficulty coping with change, loss or coping with stressful events?
- ☐ How do you provide or arrange for needed mental and psychological counseling services?
- ☐ How are the interventions monitored?
- ☐ How do you ensure care is consistent with the care plan?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How do you know a resident is a trauma survivor and what do you need to do differently for that resident?
- ☐ How are the resident's individual needs being met through person-centered approaches to care?
- ☐ What are your or the resident's concerns, if any, regarding the resident's mood or history of trauma?
- ☐ Have you or the resident had a change in mood? If so, please describe.
- ☐ What interventions is the resident receiving for the resident's mood? Are the interventions effective? If not, describe.
- ☐ How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?
- ☐ How did the facility determine cultural preferences which should be honored while the resident is in the facility?
- ☐ What types of behavioral health training have you completed?
- ☐ How do you identify and support individual resident's needs?
- ☐ How do you monitor for the implementation of the care plan and changes in the resident's condition?
- ☐ How are changes in both the care plan and condition communicated to the staff?
- ☐ How often did the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?
- ☐ Ask about any other related concerns the surveyor has identified.

Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.

FORM CMS–20067 (10/2023)

Advanced Warning

‘Everyone has a plan until they get punched in the mouth.’

Mike Tyson

Advanced Warning

- **Automation**: leads to complacency, reduced vigilance, and changes in the quality of feedback provided to the human operator.
- **De-Escalation**. SA can give staff tools to identify:
  - Early recognition of escalating behavior and warning signs or situations that may lead to assaults;
  - Ways to recognize, prevent or diffuse volatile situations or aggressive behavior, manage anger;

Before engaging, assess personal readiness by asking yourself the following:

SELF-CHECK	CONSIDER	TIPS
What's happening?	What is being requested? What is the underlying issue? What is going on at this point in time?	Gather information from others when needed. Stay calm.
What's going on with me?	What is your state of mind? Be mindful of your triggers and emotions.	Know when to step away or ask for help. Have a code word so others know when to intervene.
What's going on around me?	Is the environment stressful? Are other residents or family members present?	Keep a safe distance. Move the discussion to a private area when possible.

Prevention

In an emergency, **people do not rise to the occasion**—they drop to their lowest level of training. If they are unprepared, **fear will bring about panic** and system two thinking will shut down and greatly reduce problem-solving abilities.

It Could Happen to You!

- A tornado touches down in Wisconsin on a February afternoon.
- On a Saturday, a fire breaks out in the laundry room of your facility.
- A visitor, who appears intoxicated, demands to see a resident
- A recently termed coworker, shows up pounding on the front door
- Cleaning chemicals were left out, unlocked and a resident ingested them
- A surveyor finds a missing resident in the employee locker room, trapped.
- Two residents with dementia, one consenting, one who can’t, engage in sexual activity.

Prevention

Prevention thur Orienation & Onboarding

How does Orientation and Onboarding increase an employee's Situational Awareness?

Are your employees prepared for what you expect them to do? Or are we throwing them into a job with the hopes they know how to do it?

Problems with Prevention

Demonstrating Competence	Do they really know?
Everyday Adverse Events	Skin, falls, resident relationships
Confirmation Bias	What do they think they know or expect to see?
Short Cuts	I'd do it right when the surveyors are here

Pattern Recognition

Pattern Recognition

Pattern Recognition – Change in Condition

- The general read, the initial scan and the detailed scan
  - Intuition, baseline and **deviations**
- What is normal…for the situation?
- If you are not monitoring the baseline, you will not recognize the presence “disturbances.”
- How well can you “**Read the Room**?” What’s your gut feeling?

Pattern Recognition Problems

Doing the same task over and over can lead to boredom.

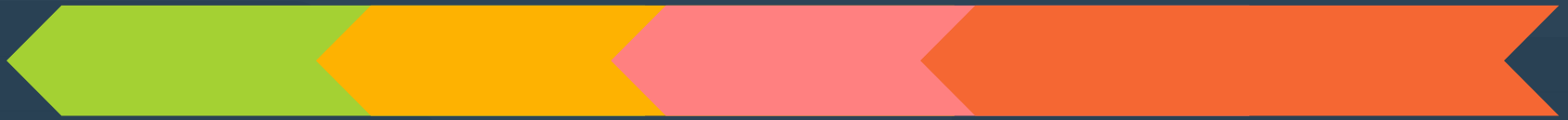
The task becomes automatic which can lead you to miss unexpected stimuli.

Some nurses have done the same job for years.

Consequently, they may stop looking for hazards around them.

- Mind scripts: Every time we do a task, our mind creates a script. A script is a memory that helps us get things done.
    - 9 medications per person, 30-40 steps
- Challenge the team to be ready for the “what if’s

Avoiding Danger



Problems with Avoiding Danger- Perceptions

Past Experiences

We act on information based on our knowledge. When something looks like what we are familiar with, we may react as if it were the same

Normalcy Bias

Occurs during a crisis, causes us to disregard any signs or warnings
We WANT and NEED things to be OK, so we don't accept that the stimulus we're receiving representing a threat. Thus we don't prepare.

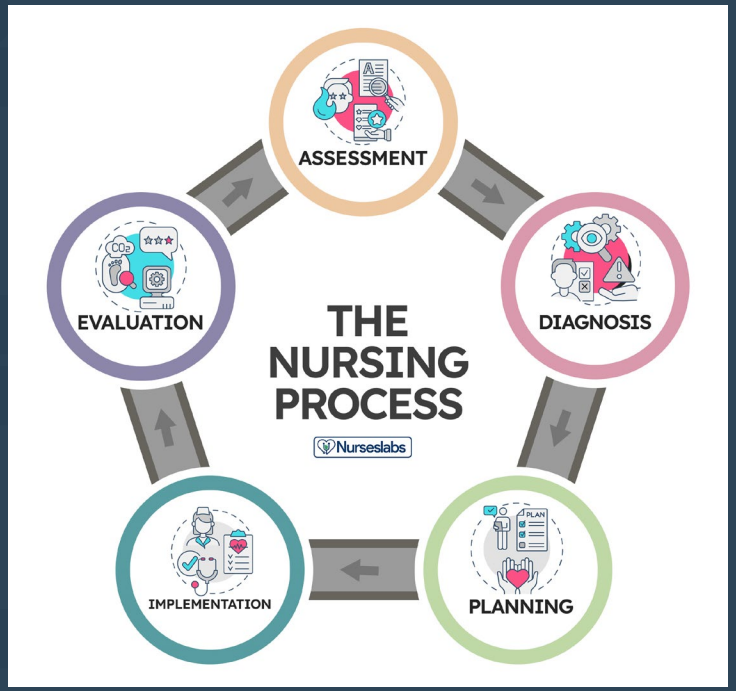
- Nothing has ever happened when I do this, so nothing is likely to happen
- Change "It can't happen here or it won't be that bad" to "Why NOT here?

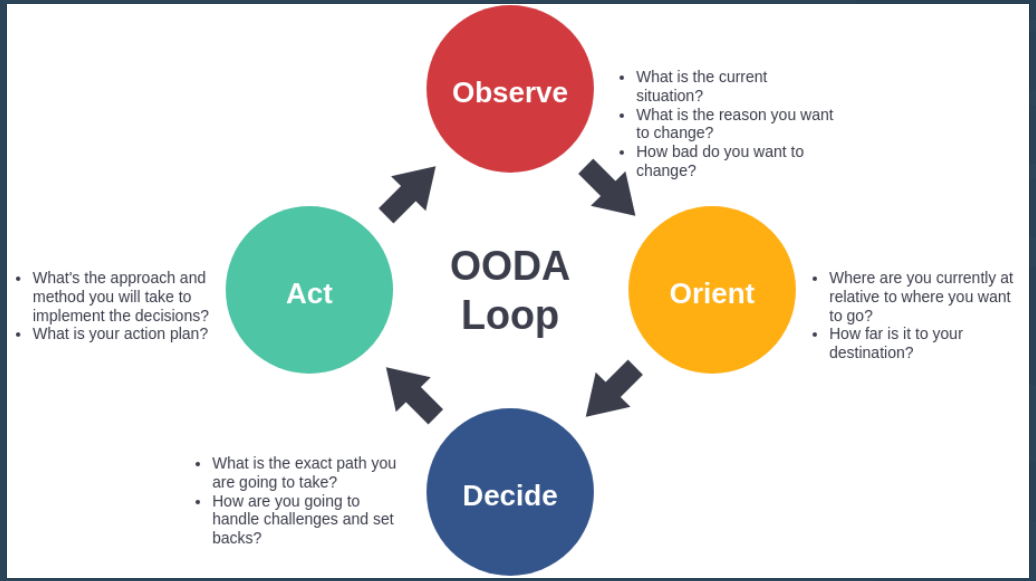
“In a moment of decision,
the best thing you can do is the right thing,
the worst thing you can do is NOTHING.”
U.S. President Theodore Roosevelt

Mental Practice	Physical Practice
Body won’t go where the mind hasn’t been.	Your muscles don’t learn from verbal instruction.

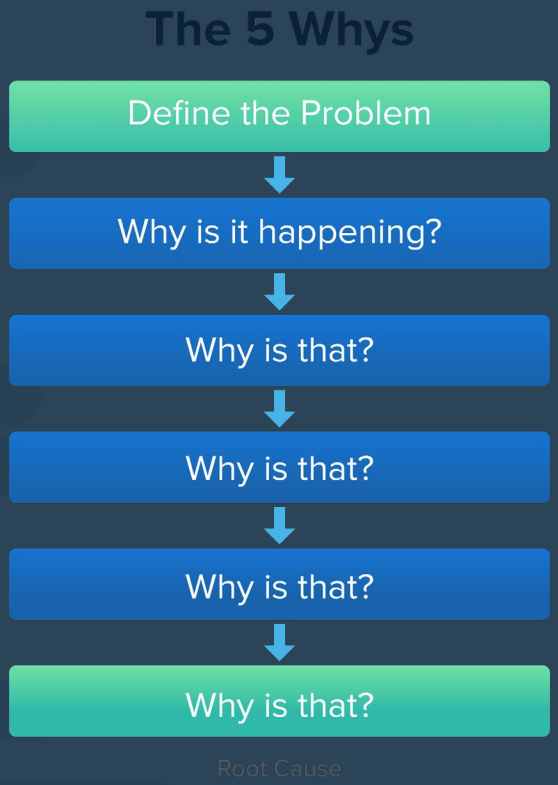
What would you do if you walked in a resident room, and they had hung themselves.

Situational Awareness & the Nursing Process





Situational Awareness & QAPI



Think about a common scenario and then ask yourself “What if?”

- A visitor comes to see a resident
  - What if the visitor is angry?
  - What if the visitor is intoxicated?
  - What if the person at the front desk doesn’t know what to do?
  - What if they start throwing furniture?

Spice It Up!

Use it as a stand-alone topic

Add it to new employee orientation

Give old training a new look!

Room of Horrors or Escape Rooms

Change up your drills and audits, ask “what ifs”

Relate it to your staff’s families

Take It Home!

1 in 4 girls and **1 in 6 boys** have been sexually abused before the age of 18.[4]

Every 11 minutes
one person dies by suicide in the US.

- Hard or Soft targets
- Teenagers' brains
- Unusual actions, uncomfortable behaviors
- Knowing your exits
- Watching people’s hands not their faces

When “Bangs” Happen Here, We....

Every team and organization will have
“Bangs.”
How you prepare and react will
determine where you end up.

Thanks for paying attention in a world full of barriers to awareness and BANGs!

Cagney Martin: khsb4bang@gmail.com

Awareness → Advanced Warning → Prevention → Pattern Recognition → Avoiding Danger