

# Implementation of a Pre-Rapid Response Nurse

## *A Success Story*

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**T**hreats to the clinical safety of the hospitalized patient include those considered as a failure to rescue (FTR) event, described as a delay in the response to an adverse clinical presentation that may lead to deterioration of the patient. In 2004, the Institute of Healthcare Improvement's Saving 100,000 Lives campaign identified that deploying a rapid response team (RRT) to respond to and intervene on behalf of a patient who presents with a physiological change, but is not in an

arrest situation, was a strategy to save lives and is the norm in health care facilities today.<sup>1</sup> There are many models cited in the literature that a hospital can use for the operations of their RRT.<sup>2</sup> The purpose of this article is to present the positive outcomes achieved from a model that employs a full-time critical care RN who works in the "pre-rapid response" role. Challenges, lessons learned, and experiences with the implementation of a pre-rapid response nursing role are presented with the intent to provide guidance to other nurse leaders desiring to apply a similar nursing role to the structure of the RRT members in their facility.

### **BACKGROUND**

Failure to rescue events have been defined by the Agency for Healthcare Research as hospital deaths following adverse events that have been associated with a patient's deteriorating medical condition, and the health care team's ability to respond and ultimately the overall quality and safety of the hospital.<sup>3</sup> FTR deaths occur when clinicians fail to recognize signs of patient decline and fail to intervene in a timely manner. Signs and symptoms of impending cardiopulmonary arrest may be evident as early as 72 hours prior to the arrest.<sup>4</sup>

These events can lead to unplanned critical care admissions, cardiopulmonary arrest, and death. The occurrence of FTR events and delays in recognizing deterioration of a patient's clinical status were an impetus for the development of the RRT, with the intent to intervene once a change in a patient's status was identified and hopefully prevent an adverse event.

At the monthly multidisciplinary analysis of the rapid response (RR) and code blue events that occurred in our 207-bed acute care facility, the nursing leaders and advanced

**Figure 1. Clinical Resource Nurse Educator: Clinical Criteria**

- Bachelor of science in nursing (BSN)
- 2+ years critical care experience
- Charge RN experience preferred
- Preceptor RN experience preferred

cardiac life support committee continually looked for opportunities for improvement to include the composition of the RRT, and system issues that may affect the outcome of an event. The chief nursing officer proposed changing the infrastructure of the RRT to include a dedicated critical care registered nurse (RN) to intervene before the patient showed signs of deterioration. The primary rationale in consideration of adding this role is the frequency in which delay in identification is the possible cause of a patient becoming a FTR. Identification of inadequate nursing surveillance has been associated with poor patient outcomes.<sup>5</sup> In our facility, we focused on “inadequate” to include delay in recognition of an adverse change in a patient’s clinical status in the noncritical care areas, failure to seek help in a timely manner, as well as lack of clarity surrounding appropriate use of the RR system.

After intense review of all factors involved, the decision was made to implement a change in our RRT model to include an additional resource of pre-RRT nursing support, primarily for the medical surgical nursing team. The intent was not to change the original structure of the RRT at our facility, but rather to add the additional team member of a pre-RRT RN. Team members responding to a RR call would continue to include an intensive care unit (ICU) RN, the nursing supervisor (who also has critical care experience), and a respiratory therapist. Initial goals identified for the implementation of this innovative model were to improve patient outcomes by timely recognition of patient decline, and to have a decrease in the number of code blue events occurring outside the ICU. We also focused on this role to enhance nursing comfort and confidence with calling a RR in a timely manner.

## IMPLEMENTATION PROCESS

Utilizing the Iowa Model with feedback loop design, we first analyzed FTR, RR, and code blue event data as well as nursing satisfaction in relation to these events and the associated processes. This analysis brought awareness of gaps in our RR process and potential educational opportunities surrounding early identification and timely initiation of the RRT. These practice opportunities led to the development of the pre-RRT RN role. Organizational mission, vision, and values were in alignment with this quality improvement practice change, as well as the large amount of evidence surrounding the benefits of nursing surveillance, which eased the attainment of organizational support for the new role.

Implementation of new nursing roles may elicit theoretical, functional, and financial challenges to nursing leaders. In

the initial phases of implementation, cost center choice, and reporting structure were primary topics of discussion. It was decided that the clinical education department was the most appropriate cost center and that the pre-RR RN would report directly to this department manager, with the intent that this role would incorporate timely education to all areas outside critical care. The department manager would be responsible for orientation to this new role, progress monitoring, and result reporting.

In presenting the position to the finance team for approval and placement in the clinical education department, we focused on the expected outcomes related to a decrease in utilization of critical care beds and a decrease in code blue events. The content of the job description included education of the nursing team based on findings after an event, and patterns that have risen from clinical events that led to calling a RR on a patient. After much discussion, we decided to title the position according to the goals we identified to achieve with the role. With the intent of providing a system for the pre-RRT RN to use surveillance of clinical data to intervene on the care of a patient, we initially thought we would title the position as the “surveillance nurse,” but this nomenclature was not well received by the bedside nursing team. The initial questions raised concerns that the word *surveillance* was perceived negatively, meaning the team felt as though this position was created to “watch” them. Nursing “surveillance” was also tied to infection control surveillance and raised questions about the intended duties of this new role. The title was revised to be the clinical resource nurse educator (CRNE), which helped to categorize this new role as a resource for the team and was well received by the bedside nurse. In this process of role identification, we recognized and received feedback from stakeholders, not only the nursing team as mentioned previously, but also ancillary staff and physicians.

Clinical criteria for this role were determined (*Figure 1*) and the description created (*Figure 2*), preceding candidate selection.

The candidate chosen to fill this position was a seasoned critical care nurse who had been employed as a bedside caregiver in ICU with the facility for many years, and had skill in identifying the importance of collaborating with the multidisciplinary team in the care of the patient. This nurse possessed the needed nurturing qualities and had proven her ability to be an effective educator in her role as a preceptor in the ICU.

The next steps in implementation included working with the information technology team to create an early recognition report (ERR) that pulled clinical data from the electronic health record. The ERR data were sent electronically to the pre-RRT RN’s phone and desktop throughout the day. The intent of the ERR was to assist the pre-RRT RN in the identification of patients at risk for decline.<sup>6</sup> The clinical criteria sent to the devices matched the facility’s RR protocol:

- Respiratory rates <9 or >22 breaths/minute
- Heart rates <50 or >110 beats/minute

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