RASE to a Solution: *A Systematic Way to Make Effective Practice Changes*

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As a result of the dynamic nature of healthcare reform, many hospitals are being led to reduce expenditures. At the bedside, in our offices, and as leaders, we are frequently being asked to increase efficiency, reduce cost, and "do more with less."[1] The cost of educating staff is no exception and warrants analysis. In an effort to move away from costly educational initiatives without supportive data, one is challenged with evaluating and negotiating educational needs. The ongoing question of whether undesirable patient outcomes are related to knowledge deficiencies or staff compliance will always exist, but we no longer have the resources to waste on searching for solutions.

An extensive needs assessment is not routinely performed when a perceived hole exists in a certain area of healthcare.[2] Instead, many professional development and or healthcare professionals rely on annual assessments of nurses to identify areas of need.[3] Clinical nursing leaders and educators are often caught "putting out fires" and offering quick solutions for ongoing problems. Sustainable solutions are needed to ensure quality patient outcomes. A lack of a systematic approach can lead to overtraining, undertraining, or just the wrong type of training in the healthcare setting and, subsequently, a waste of resources, both time and money.

After careful reflection of many interventions made as an educational and clinical leader over the past several years, I am proposing a simple method to think through practice issues and guide healthcare education RASE:

- Recognize the issue
- Assess the depth of the problem
- Supply an intervention
- Evaluate for effectiveness

The thoughts behind such a systematic approach to providing education to healthcare providers have come from both a look into the literature as well as anecdotal approaches to education delivery. While working at 2 large academic institutions, I have been able to sort through various implementations in hindsight and try and understand why one may have worked and another may have failed. In my experience, the educational initiatives tend to have success when implemented using a systematic approach. A focused approach can lead to success.[3] My introduction to the concept of RASE is just one way to organize your thoughts and plan an event; it is applicable to all areas of educational intervention when responding to a gap or need.

In reviewing the staff development and professional nurse literature, much of it speaks to the identification of needs of new graduate nurses, nursing students, and the needs of our patients; the identification of processes surrounding everyday needs in the clinical setting are less available. One recent example is that of McKibbin et al.,[4] who in 2011, utilized a systematic approach when planning emergency preparedness training for nurses in an emergency department in South Carolina. This approach allowed the group to tailor the education to meet the needs of the nursing staff in an efficient manner. This level of educational efficiency is vital in order to successfully contribute to cost containment in our dynamic healthcare setting.[1] Because many healthcare leaders are now sharing throughout the country, the idea of aligning our quest for competent and safe care delivery in hospitals must now be united with the financial implications of every decision.

The following example is specific to a women's and children's population in regard to clinical significance; however, the application of RASE is applicable to any setting when reviewing gaps and or needs related to education. The example is strong because it included many levels of nurse leaders providing input into the plan of education in response to an identified need recognized by other disciplines.

This example is in response to the use of an infant scoring tool used by both a women and children's inpatient setting, known as the Modified Finnegan Neonatal Abstinence Score Tool (M-FNAST). Currently, approximately 225,000 infants are exposed to illicit substances every year.[5] This exposure leads to withdrawal symptoms typically known as "neonatal abstinence syndrome." The nurses caring for these patients utilize the M-FNAST scoring tool to wean the infants off of medications suppressing their withdrawal symptoms. The correct use of the tool allows for better patient outcomes as well as decreased inpatient days (*Appendix*).

RECOGNIZE THE ISSUE

Nurse practitioners (NPs) and physicians (MDs) who follow up on this tool *recognized* an influx in patients requiring the use of this tool and a gap in education related to proper use of the tool. According to the literature, between 2000 and 2009, antepartum opioid use increased from 1.19 to 5.63 per 1000 live births.[6] These providers were also part of a statewide initiative that was looking into the care of patients with neonatal abstinence syndrome. These NPs and MDs reached out to the clinical nurse education specialist (myself) and the clinical nurse specialist, as well as some key unit leaders in each of the pediatric and newborn areas. The increased use of the tool combined with some practice inconsistencies led to a small taskforce being formed to further recognize the current situation related to the tool.

I think it is important to note here that a deficit, an inconsistency, or a need for practice change can come from any discipline able to recognize it. Interprofessional teams work to provide quality care to all patients and I think we must commit to recognizing areas of improvement in each other's practices in order to truly succeed. Therefore, the fact that NPs and MDs helped recognize the inconsistencies with the influx of the tool was received with great support by nurse leaders asked to participate.

ASSESS THE DEPTH OF THE PROBLEM

Despite the general recognition of a need for further education on the M-FNAST tool, there were no baseline data to support the inconsistencies. There were anecdotal discussions between disciplines that warranted more education, as well as national discussions regarding the increase in opiate-dependent newborns being born with needs for intervention. In sticking with my attempt to RASE to the problem, I felt it necessary to truly assess the depth of the problem.

In looking at any situation, assessing the depth of the problem first entails figuring out what to actually assess. If there are deficits in patients' pain management, for example, one may audit pain documentation to try and assess the depth of the problem. Are pain medications being followed up on? Are non-pharmacologic pain management tools being used and/or documented? In this case, I felt that measuring the inter-rater reliability of the M-FNAST tool without providing any education to staff first would help truly assess the depth of the problem (and even if there was one!).

Using a short 6-minute example video exam of a withdrawing infant requiring scoring on the M-FNAST, I determined that the inter-rater reliability of nurses using the tool was 88%. I did this by showing the video to 60 random participants who anonymously tracked their score on paper. I collected and docu-

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