When Nursing Assertion Stops

A Qualitative Study to Examine the Cultural Barriers Involved in Escalation of Care in a Pediatric Hospital

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KEYWORDS

• Code reduction • Rapid response teams • Nurse perception • Code barriers
• Rapid response team barriers • Pediatric nursing

KEY POINTS

- Nurses regarded rapid response team (RRT) calls as requests for a provider-to-provider consult such that initiation ought to be by the provider, not the nurse.
- RRT calls that do not lead to transfer of the patient to an ICU may be viewed as false alarms indicative of a failure of nursing clinical expertise.
- Nurses described physicians as wanting to try interventions on the floor first before calling an RRT, requiring excessive nursing time not appropriate to the medicine unit setting and contributing to delays in escalation of care.
- Nurses reported having strong assertion skills yet described clinical experiences in which "assertion" consisted of time spent attempting to convince physicians to call an RRT rather than calling the RRT themselves.

BACKGROUND

Reducing codes outside of ICUs has been a national and international focus in recent years. The term, code reduction, refers to clinical efforts to reduce the incidence of pulmonary and/or cardiac arrest that necessitates life-saving resuscitation. Code reduction involves a complex set of clinical activities, including early detection of signs and symptoms, communication among nursing and medical providers, and performance of clinical interventions to treat a patient's deterioration. Ideally,

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cardiopulmonary arrest would never occur on inpatient medical or surgical units because patients at risk of deterioration would be identified early and transferred to an ICU. Although rare, codes sometimes occur on the inpatient units. Many hospitals have implemented rapid response programs, known as RRTs or medical emergency teams, as an avenue for staff to escalate patient care needs. Rapid response program investments have not produced the level of reduction for code events that hospitals anticipated. This has generated interest in understanding barriers to success. The Medical Early Response Intervention and Therapy trial[1] found that rapid response system activation only occurred 30% of the time when clinical criteria were met in 250 cardiac arrests. A systematic review[2] demonstrated that failure to rescue rates vary between 8% to 16.9% and contributing causes may include failure to recognize clinical deterioration, failure to escalate, and failure to activate RRTs.

Nurses play a critical role in rapid response through identification of patient deterioration and communication of clinical changes. Nurses are trained to identify subtle changes and recognize signs of deterioration in the patient's condition.[3–6] Shearer and colleagues[7] found that failures in the system were most often not due to problems with recognition but instead due to challenges inherent in hospital cultures and clinical hierarchies. Roberts and colleagues[8] reported that nurses with lower self-efficacy often need consultation with another nurse to validate their concerns prior to activating an RRT, whereas the presence of self-efficacy can assist in overcoming challenges in hospital hierarchies.

Interdisciplinary hierarchies complicate nursing communication.[9] Some barriers to activating RRTs identified in the literature[5,8] include situations when nurses thought their patient was at risk but were uncomfortable going up the chain of command to preserve the relationship within the team. Nurses often solicit feedback and partner with other nurses to overcome this hierarchy.[8] Shearer and colleagues[7] found that RRTs may not be activated "because of the poor sensitivity and specificity of the activation criteria." A similar finding by Braaten revealed that clinicians require "justification" for RRT activation "to avoid false alarms."[6] Mathematical analysis of rapid response activation criteria's predictive sensitivity and specificity reveals that "33 calls would be needed to prevent one unplanned ICU transfer, cardiac arrest, or death. Nurses' attempts to minimize false-positive calls may help explain the low call rates for patients meeting RRT criteria."[10]

In previous studies[4,5,11] nurses were often alerted to deteriorating clinical condition because they perceived that something was wrong or they were "concerned about the patient." This feeling of concern was cited as more important than the measurement of vital signs.[11] Nurses have to synthesize all the evidence and determine when to call a provider or RRT. A nurse's decision to call for help was influenced by the ability to demonstrate confidence in knowledge of situations, strength of evidence of clinical deterioration, and the ability to balance and manage situations with the available resources.[11] Minick and Harvey[4] found that when nurses recognized small changes in a patient's condition they are more successful in getting physicians to act if they could describe these changes clearly when lacking objective data. Early warning score systems have allowed nurses to have tools for more objective reporting.[12,13] Nurses present evidence of and describe deterioration using intuitive knowing and objective findings.[12] In addition, nurses have to package the communication to persuade doctors to assess the patient.[11,12] If the doctor is not persuaded, this can result in a failure where the patient is not evaluated.[11] There needs to be more effort in understanding individual and bedside cultural issues that may prevent staff from activating an RRT and preventing a code event.