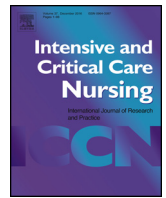




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Staff perceptions of a patient at risk team: A survey design

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ABSTRACT

Introduction: Whilst research demonstrates the benefits of critical care outreach, limited research describes staffs' perspective of these teams.

Objective: This study examined ward nurses' and doctors' perceptions of the service provided by a nurse-led 24 hours a day, seven days a week Patient at Risk team.

Design: Using an exploratory survey research design and a previously used instrument, data were collected between January and March (2016). The instruments' reliability was assessed using Cronbach's alpha ($\alpha = 0.90$).

Results: 339 participants, including 255 nurses and 84 doctors, completed the questionnaire (70.48% response rate). Most participants agreed the Patient at Risk team 1) were accessible and approachable, 2) recognised deterioration and reduced serious events, 3) provided ward staff teaching and coaching and 4) aided allied health referral and improved transfer of patients from critical care. More nurses than doctors perceived the team's role more positively in some aspects of the service they provided. Whilst most comments were positive, some comments identified improvements could be made to the service.

Conclusion: Ward nurses' and doctors' perceived the Patient at Risk team contributed to improving care of deteriorating ward patients. The instrument used in this study may be useful to other outreach teams to identify service improvements.

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Implications for clinical practice

- Limited literature exists on doctors' and nurses' perception of critical care outreach services
- Nurses' and doctors' viewed the critical care outreach service as approachable, available and one that improves care to the deteriorating patient
- More nurses than doctors perceived critical care outreach more positively in some aspects of the service they provide.
- The instrument used to assess the service demonstrated good reliability and is likely suitable for other critical care outreach teams to assess and re-evaluate their service.

Introduction

Critical care outreach services (CCOSs) are predominantly nurse-led and have a number of roles including: identifying and responding to ward patient deterioration; supporting ward staff, patients and their families immediately following discharge of

patients from critical care and training and education of ward staff (Athifa et al., 2011; Pedersen et al., 2014; Pirret et al., 2015).

Varying CCOS models exist both nationally and internationally. Some CCOSs respond to early warning score (EWS) triggers whilst others only provide follow-up of patients discharging from the intensive care unit (ICU) (Buist et al., 2007; Elliot et al., 2012; Pedersen et al., 2014). Whilst most nurses working in CCOSs are experienced in ICU (Subbe and Welch, 2013), some services include specifically trained ward experienced nurses (Pirret et al., 2015).

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Some CCOSs are fully staffed 24 hours a day, seven days a week (24/7) whilst others are not (Marsh and Pittard, 2012; Pedersen et al., 2014).

Whilst an increasing amount of research demonstrates the effectiveness of critical care outreach (CCO), there are significant gaps, both locally and internationally, on nursing and medical staffs' perceptions of these services. This paper shares the results of a survey evaluating nurses' and doctors' perceptions of a CCOS, referred to locally as the Patient at Risk Team (PART).

Background

Research examining ward nurses' perceptions of CCOSs demonstrate the value these services provide to the ward team. Common findings from these studies include a CCOS: 1) provides them with advice and support (Athifa et al., 2011; Chaboyer et al., 2005; Richardson et al., 2004; Salt, 2013; Valentine and Skirton, 2006), 2) enhances safer critical care discharge (Athifa et al., 2011; Baker-McClearn and Carmel, 2008; Chaboyer et al., 2005; McIntyre et al., 2012), 3) assists patient transfers to an appropriate area (Baker-McClearn and Carmel 2008; McIntyre et al., 2012; Valentine and Skirton 2006), 4) improves access to critical care services (Baker-McClearn and Carmel, 2008; McIntyre et al., 2012; Plowright 2006; Valentine and Skirton, 2006) and 4) provides education that enhances their knowledge and clinical expertise (Athifa et al., 2011; Chaboyer et al., 2005; McIntyre et al., 2012; Plowright, 2006; Richardson et al., 2004; Salt, 2013; Valentine and Skirton, 2006). Less common findings highlight outreach nurses role model skills and behaviours (Chaboyer et al., 2005; McIntyre et al., 2012; Valentine and Skirton, 2006), assist with not for resuscitation decisions (Baker-McClearn and Carmel, 2008) and increase ICU staffs' awareness of the ward situation (Athifa et al., 2011; Baker-McClearn and Carmel, 2008). All these factors enable CCOSs to assist ward nurses with formulating effective management plans and provide them with more knowledge, skills and confidence to manage sick and/or deteriorating patients (McIntyre et al., 2012; Salt, 2013).

Chellell et al. (2006) were the only study we identified that evaluated nurses' and doctors' perception of a CCOS. Using observation and interviews, they identified outreach nurses' specialty and organisational knowledge and clinical expertise enabled them to holistically assess patients, liaise with different team members to ensure patients received timely physical interventions and treatment decisions, ensured patients' treatments and investigations were carried out and supported inexperienced medical and nursing staff.

Research measuring ward nurses' perception of CCOSs utilise a number of methods, such as semi-structured interviews (Baker-McClearn and Carmel, 2008; Chaboyer et al., 2005), focus groups (Athifa et al., 2011) and locally designed surveys and questionnaires (Plowright, 2006; Richardson et al., 2004; Salt, 2013; Valentine and Skirton 2006). Rather than focusing on questions reflecting local CCOS delivery, the questionnaire utilised by McIntyre et al. (2012) focuses on general questions, some of which were used to assess nurses' perceptions of a medical emergency team (MET) (Bagshaw et al., 2010; Jones et al., 2006). Utilising a standardised questionnaire, such as that described by McIntyre et al. (2012), enables evaluation and re-evaluation of the service to identify service improvements or setbacks and comparisons between services in different organisations and has the potential to assess both nurses' and doctors' perception of the service.

Method

The study used a survey design to explore ward nurses' and doctors' perceptions of the services provided by our PART.

Our study included a questionnaire consisting of two parts. Part one collected demographic data whilst part two included an instrument to examine nurses' and doctors' perceptions of the PART. This instrument was previously used by McIntyre et al. (2012) when evaluating ward nurses' attitudes towards an ICU Nurse Consultant Service. Our study reworded the instrument so the term PART replaced the term ICU Nurse Consultant. The instrument was piloted prior to the study, which resulted in rewording of question 14 to aid comprehension. The instrument consisted of 19 questions using a five point Likert-type scale: strongly agree, agree, uncertain, disagree, and strongly disagree. These 19 questions measured staffs' perceptions of the PART service in four areas: 1) accessibility and approachability, 2) skills in recognising patient deterioration and reducing serious event, 3) skills in teaching/coaching staff to manage sick patients, and 4) activating allied health referrals and improving patient transfer from the ICU and high dependency care unit (HDU) to the ward. The instrument provides an opportunity for staff to add comments on the best and worst aspects of the service (McIntyre et al., 2012).

Ethical considerations

The New Zealand National Health and Disability Ethics Committee deemed the study did not require their formal ethical approval as it was a low risk observational study. The study received approval from the Hospital Research Office. Completion of the survey implied consent. Participant anonymity and confidentiality were maintained throughout the study.

Setting

Our hospital has 990 beds and a critical care unit which consists of 12 ICU beds and six HDU beds. The hospital has a well-established aggregated early warning scoring system (EWSS) and a two-tiered response system 24/7. The two-tiered response system consists of a nurse-led PART that responds to lower threshold early warning score (EWS) triggers and a physician-led MET that responds to higher threshold EWS triggers. The PART also follows up all patients discharged from the ICU and HDU and forms part of the MET; the MET also serves as the cardiac arrest team.

Two PART nurses are on duty 24/7 with a further PART nurse often rostered 1030am to 1030pm weekdays to accommodate peak workload. Research demonstrates the EWSS increased the number of MET calls by 156% (Robb and Seddon 2010) and the PART team contributed to a 50% reduction in ward cardiac arrests and reductions in hospital length of stay and direct ward admissions to ICU (Pirret et al., 2015). The wards activate approximately 950 MET calls per year and the PART receives just over 3700 referrals annually.

Participant selection

Purposeful sampling recruited registered nurses, house officers and registrars working in acute wards in our hospital. In New Zealand a house officer is a doctor in their first two years of training post their medical graduation whilst a registrar is in specialty training, which can occur in their third year post medical graduation. The acute wards included: seven medical wards; four surgical wards; three women's health wards, which included gynaecology and maternity wards; two orthopaedic wards and one plastic surgery ward. Nursing and medical staff in the ICU and HDU; coronary care unit; emergency department; national burns unit; and

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