Rapid Response Systems and Impacts on Ward Work

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Outline

- Acute care nursing practice outside ICUs today
- Failure to rescue
- What events characterize a successful rescue? What skills are necessary?
- Thinking about workload and work design in systems context

Characteristics of Nursing Practice on Today's Acute Care Units

- High thresholds for admission, high thresholds for discharge—rising acuity on hospital units over past decades
- Constant interruptions
- Overstimulation/sensory overload
- Heavy documentation burden
- Often limited formal staff development initiatives
- Increasing initiatives related to safety and quality (initiative overload?)
- The work of admissions and discharges: "Churn" or patient turnover

Failure to Rescue

- Poor outcomes in patients with identified complications
- Both a measure/indicator:
  - Deaths among patients with complications
- … And a concept:
  - Poor outcomes preventable through earlier identification and/or treatment of problems

The Work of Rescue

- 1. Identification of the patient in trouble
- 2. Assembling additional people/resources (activation)
- 3. Mounting a timely and effective emergency response

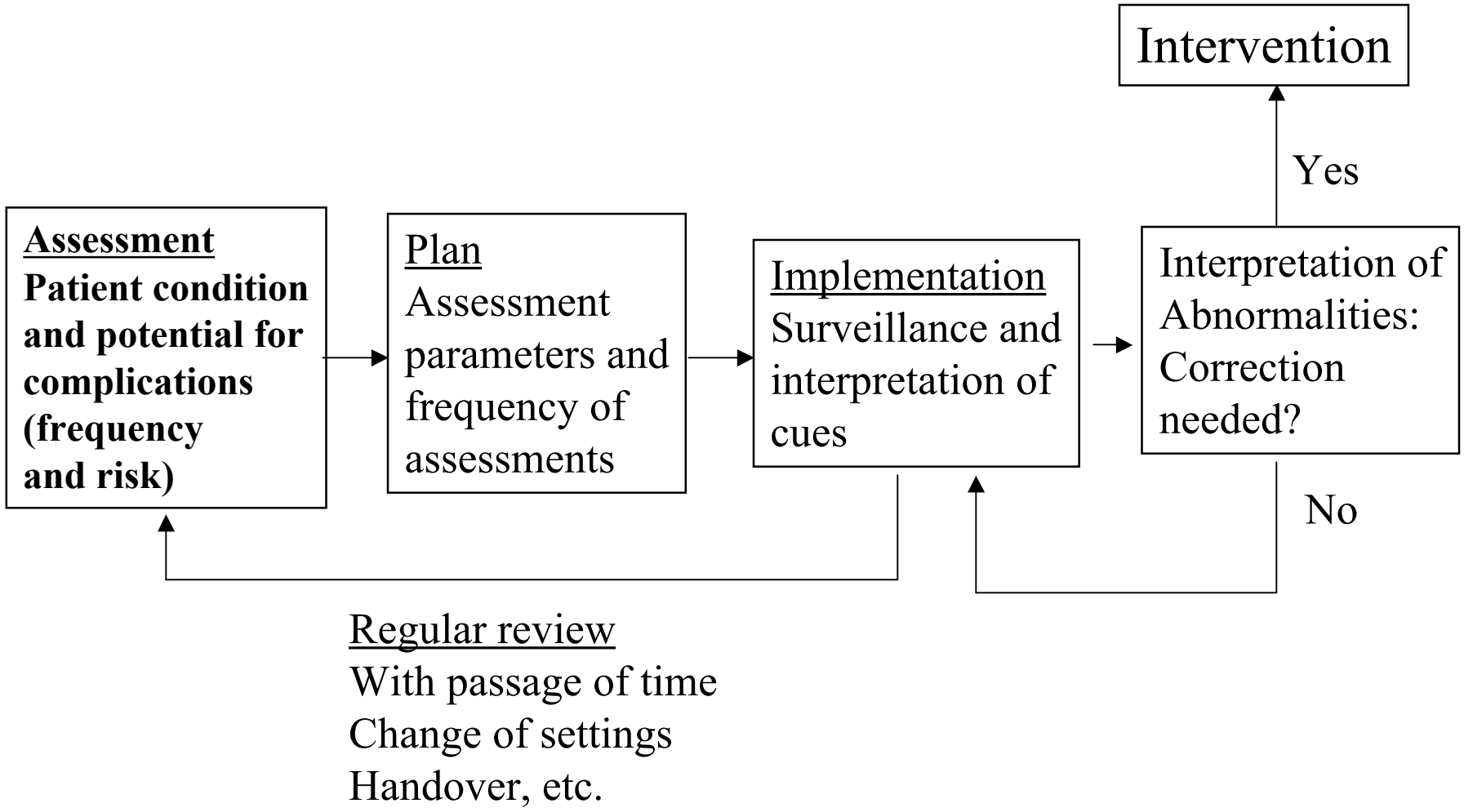
1+2=the afferent end of the RRS

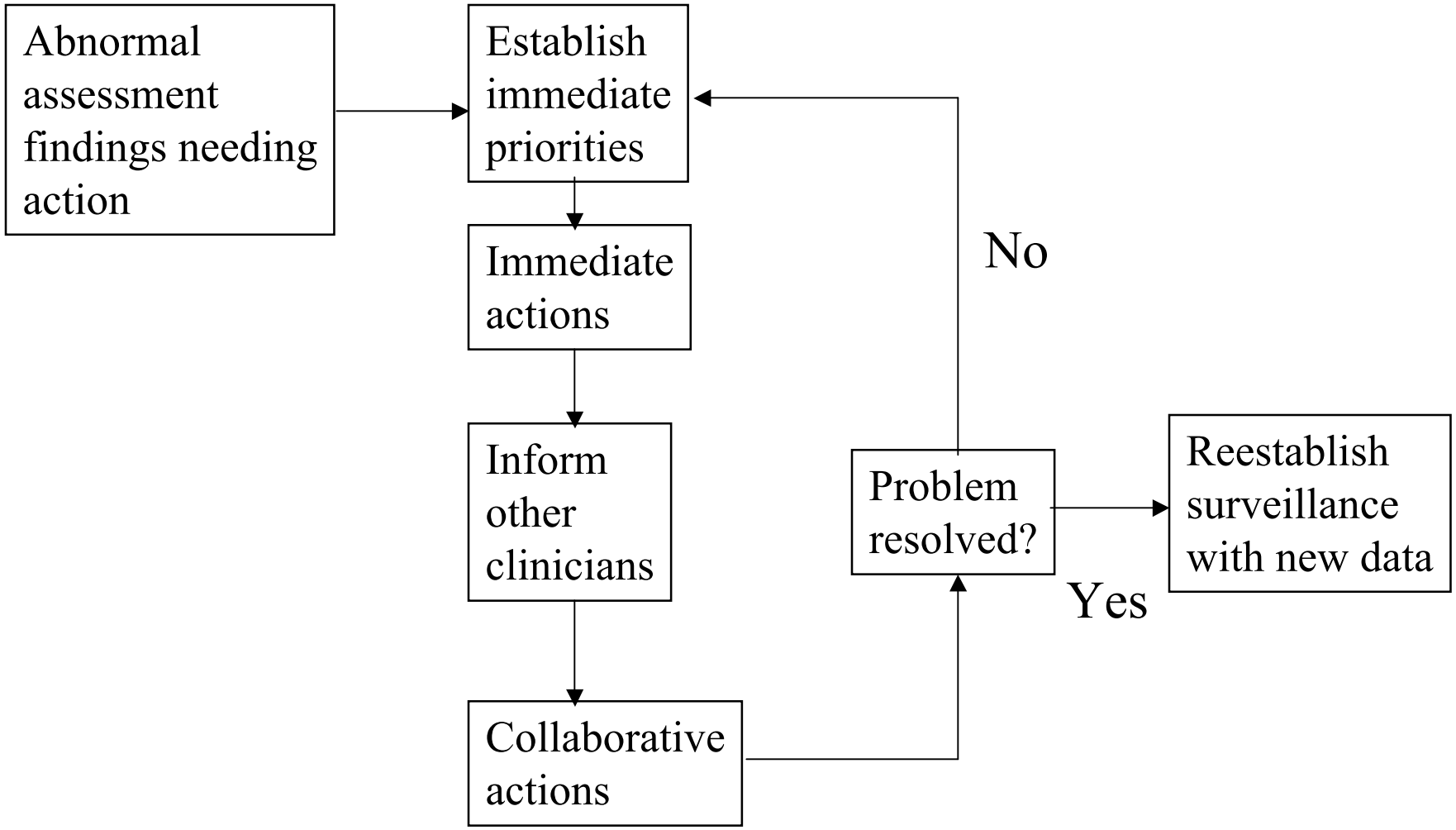
3=the efferent end of the RRS

1="surveillance"

2+3="rescue"

Surveillance in Practice





Intervention Phase

What could an RRS/MET intervention package reduce?

- Unnecessary delays in recognition related to reluctance to call
- Difficulty getting personnel to the bedside
- Delayed actions
- Ineffective responses (i.e. inappropriate or clumsy interventions)
- Slow escalation of the response
- Staff and responder stress

The Rub—Where Does Experience Come Into The Equation?

- "See one, do one, teach one …"
  - People learn by doing …
  - In the past, did staff learn at patients' expense?

VS.

- "Experience is a dear teacher, but fools will learn from no other."
  - Benjamin Franklin
    - Are there other ways of building these skills?

Do RRTs Build Staff Capacity?

- Learning opportunities
  - In theory the RRS members use their consultations for education/practice development and quality improvement
- But …
  - Workload issues (real/perceived) may preclude staff from participating in “teachable moments”
  - RRS members/staff behaviors may or may not favor involvement/debriefing
- … And what about other strategies for the development of foundational knowledge related to monitoring and rescue in basic/specialty/continuing education …
  - Better didactic teaching
  - Simulation, etc.

Where could we see problems over time post-RRT implementation?

- “Dumbing down” the interpretation of signs and symptoms for ward staff
  - Loss of “critical thinking”
  - Promotion of an attitude that this is others’ work
- Over time, perhaps a loss of capacity to intervene at even a basic level

Potential consequences of concentrating experience in the hands of a few?

- What becomes of ward clinicians' thinking processes? Their attitudes?
- Longer term/bigger picture implications for safety depending on sustainability? (e.g. with temporary RRS overloads … or longer-term scaling back of funding)?
- BUT
  - Was response capacity ever *consistently* good off critical care units?
  - And … do such considerations matter? Should they?

Broader Workload Implications

- Labor intensity of heavy monitoring and rescue efforts
  - RRS/METs as “relief staffing”?
    - Should we account for this somehow?
    - Is this a “workaround” for suboptimal staffing?

Questions

- What are the overall impacts of RRT implementation on staff capacities for monitoring and response?
  - What needs to be done above and beyond current RRS/MET packages?
- What is the overall impact on staff satisfaction?
- What are the implications for staff workload?
- Could these types of considerations (and variations in them across facilities) be responsible for agency-specific and system-wide “unintended consequences” of RRTs?
- Implications of these questions/answers for program development?