

# 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

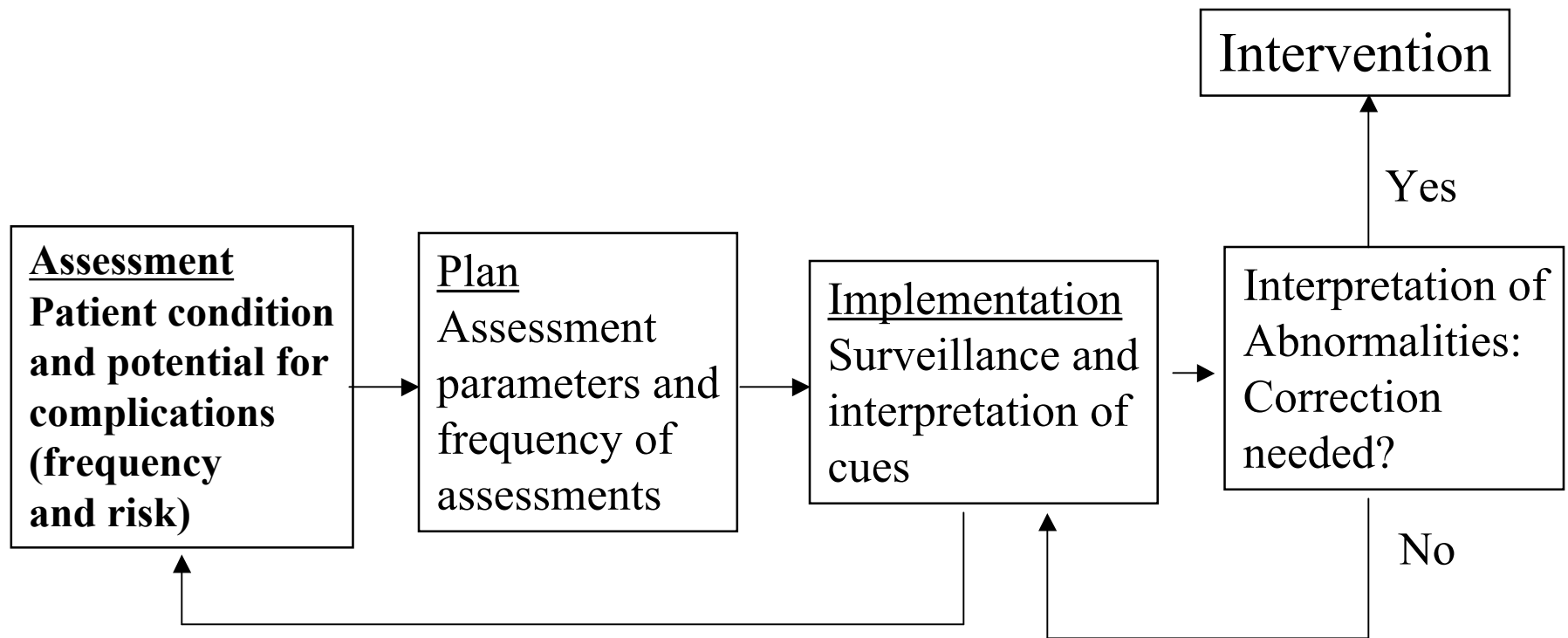
1+2=the afferent end of the RRS

3=the efferent end of the RRS

1="surveillance"

2+3="rescue"

# Surveillance in Practice



Regular review  
With passage of time  
Change of settings  
Handover, etc.

Abnormal  
assessment  
findings needing  
action

Establish  
immediate  
priorities

Immediate  
actions

Inform  
other  
clinicians

Collaborative  
actions

Problem  
resolved?

Reestablish  
surveillance  
with new data

No

Yes

## 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?