

## PROBLEM/ISSUE

Implemented in 2006, Thomas Jefferson University Hospital (TJU) designed its RRT around intensive care unit registered nurses (ICU RNs). Over time, the Nursing Department realized the existing RRT design did not lend itself to efficient staffing and led to the following for ICU RNs:

- Away from units 45 minutes (average)
- Required to stay with patients until stable due to interventions or moved to a higher level of care
- ⇒ staffing shortages & increased demands on other nurses during nursing shortage.

The original RRT design, while theoretically strong, was not effective for the ICU RNs, throughout the hospital, or for patient care.

## GOAL

Redesign RRT to create a permanent team of RNs and an RRT focused on patient care and improving RRT process.

## CHANGES IMPLEMENTED

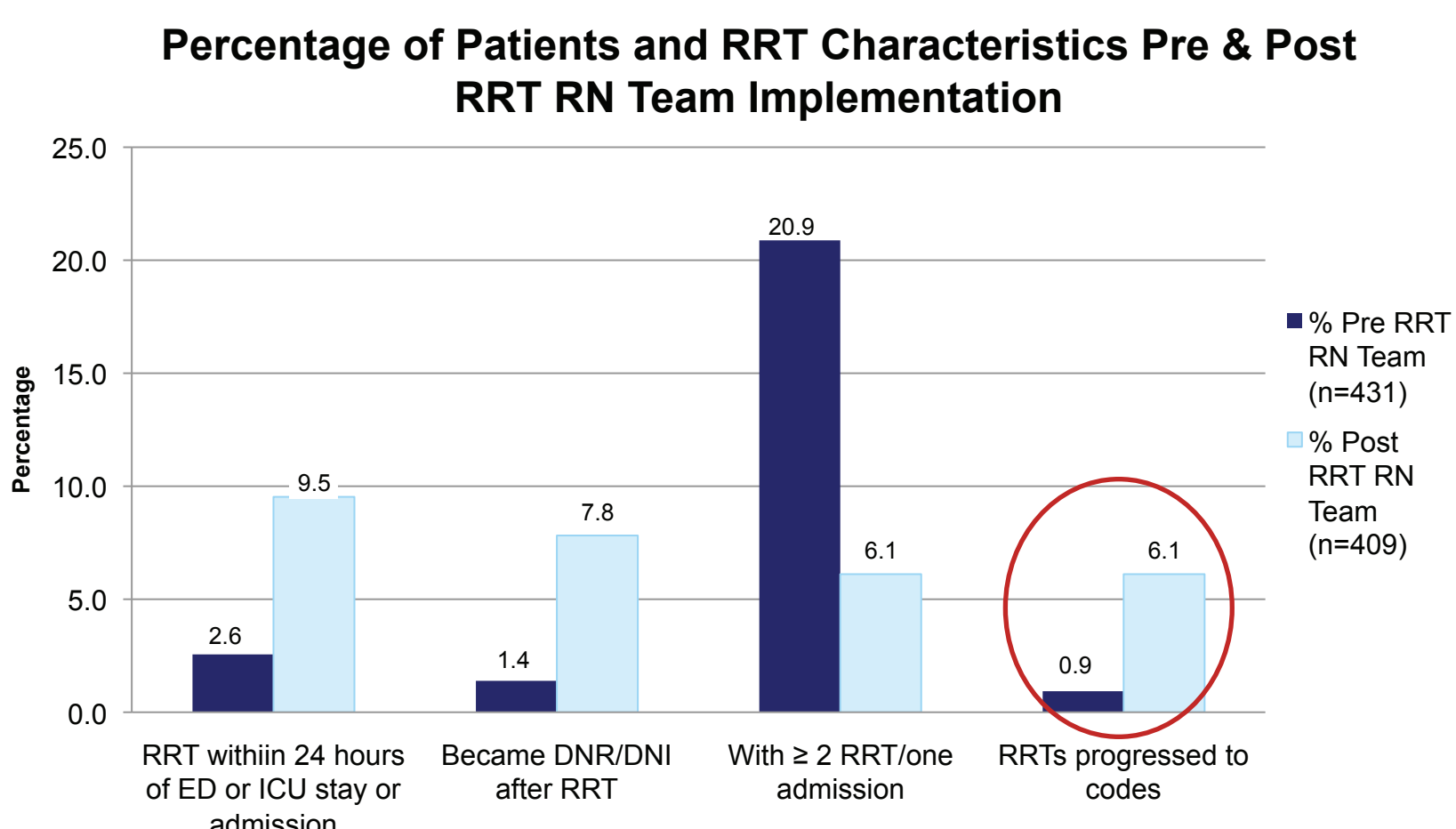
TJU nurses redesigned the RRT, creating a dedicated team of ICU RNs to function on the RRT. The RRT designated ICU RNs recognize critical situations early and impact patient care by intervening sooner. The primary roles are:

- Respond to non-ICU critical care emergencies.
- Round on each patient care unit a minimal of once per shift.
- Open communication between RN and physician.
- Focus rounds on nursing issues with patients.
- Functions as a resource nurse.
- Offer second opinion on patient assessments & interventions.
- Offer educational opportunities to the nursing staff in real time.
- Collect/record data.

## RESULTS

Now, the RRT RNs carry responsibility for data collection to monitor outcomes on RRTs. The RRT RNs follow both RRT case numbers and patients. The RRT RN team designed the outcome measures.

The data show that RRTs increased within 24 hours of ED and ICU stays and direct admission. The team believes this is due to increased staff comfort in calling RRTs. Similarly, the team also believes the increase in RRTs becoming codes is related to early staff calls for RRTs.



The most important finding, to date, is a large increased in the number of RRTs progressing to codes. This demonstrates a significant shift toward more appropriate calling of codes and demonstrates success for this team.

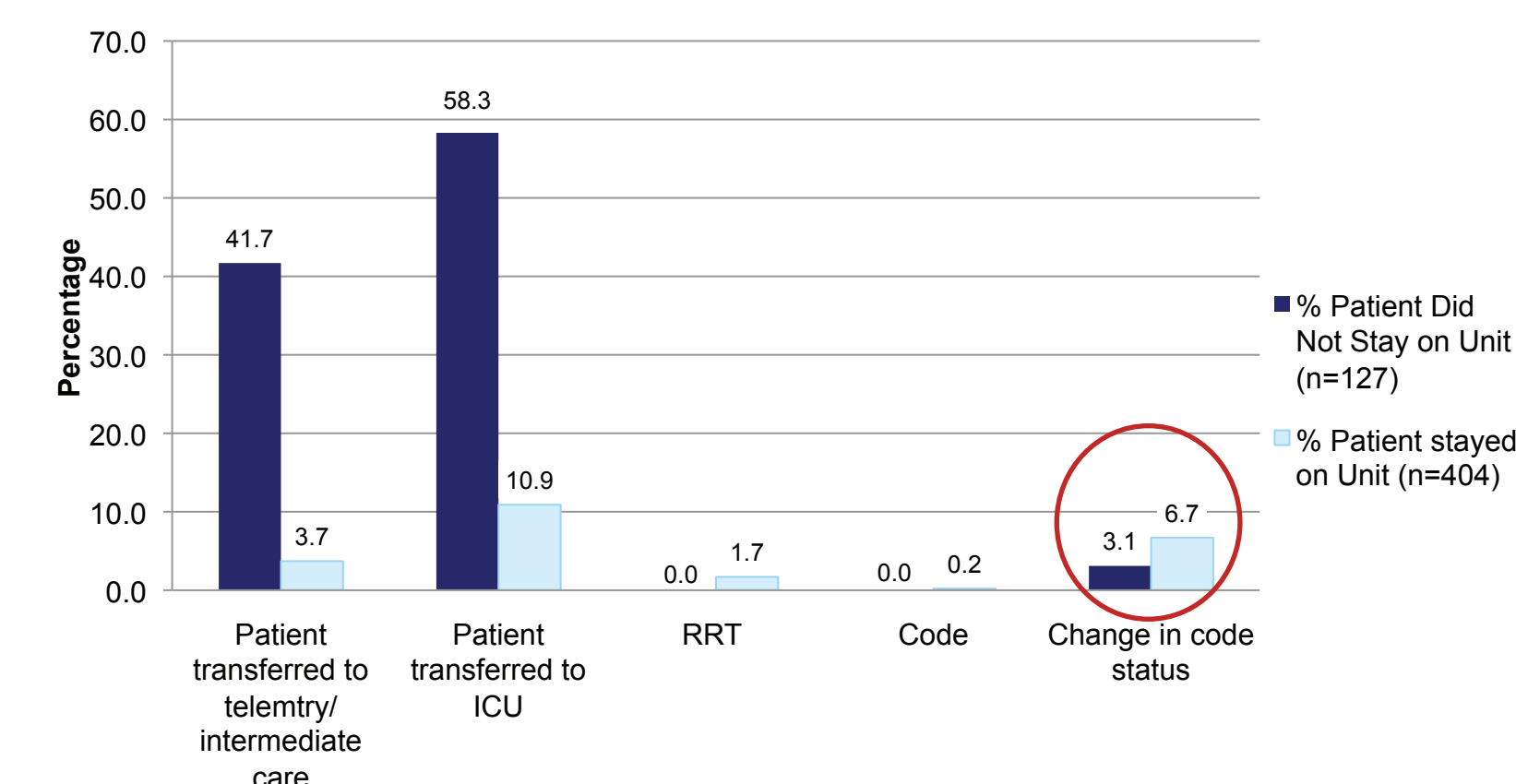
The data also show an increase in patient cases becoming DNR/DNI during and after RRTs. The number of patients with two or more RRTs on one admission decreased dramatically from 20.9% to 6.1%.

Data were also collected on patients maintained on the RRT RN rounding list. From 9/11/2012 through 4/12/2012, data were collected on 531 patients. These data show RRT RNs performed physical assessments on 72.5% (385) of these patients and performed nursing interventions on 41.4% (220) of these patients. Without critical intervention and proactive critical thinking by the RRT RNs, patients on the rounding list could have become RRTs.

## RESULTS

These data also show fewer patients staying on the unit were transferred to higher levels of care and more patients staying on the unit had a change in code status.

**RRT RN Patient Rounding List Patient Outcomes, 9/11-4/12/2012**



## LESSONS LEARNED

Several key lessons were learned:

- Tackling culture change is an important part of RRT redesign, including reframing the perception that RRT calls are negative. This improved RRT call times.
- If RNs are not called away from patient care assignments, unit and nurse stressors are reduced.
- RRT process can be improved with dedicated RNs who are familiar with emergency equipment
- RRT RNs serve as champions for the RRT process and improve communication and willingness to call RRTs. The care team now works toward common goals with the RRT.
- Significant change in code status with patient rounding.
- Database development and data collection/management are important.

## ACKNOWLEDGEMENTS

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