Rolling Out the Rapid Response Team

The pilot phase begins.

This is the 10th article in a series from the Arizona State University College of Nursing and Health Innovation's Center for the Advancement of Evidence-Based Practice. Evidence-based practice (EBP) is a problem-solving approach to the delivery of health care that integrates the best evidence from studies and patient care data with clinician expertise and patient preferences and values. When delivered in a context of caring and in a supportive organizational culture, the highest quality of care and best patient outcomes can be achieved.

The purpose of this series is to give nurses the knowledge and skills they need to implement EBP consistently, one step at a time. Articles will appear every other month to allow you time to incorporate information as you work toward implementing EBP at your institution. Also, we've scheduled "Chat with the Authors" calls every few months to provide a direct line to the experts to help you resolve questions. See details opposite.

In March's evidence-based practice (EBP) article, Rebecca R., our hypothetical staff nurse, Carlos A., her hospital's expert EBP mentor, and Chen M., Rebecca's nurse colleague, conducted their stakeholder kickoff meeting to explain to rapid response team (RRT) members and stakeholders the details of their plan to implement an RRT at their institution. At the meeting, the stakeholders were engaged and supportive, offering valuable feedback and suggestions to enhance the project. By the end of the meeting, all RRT members and their respective managers committed to participate. No major changes were made to any of the draft documents; however, one minor adjustment was made when the advanced practice nurse (APN) hospitalist suggested that the EBP team include all the systemic inflammatory response syndrome (SIRS) criteria in the RRT protocol.

Among the many commitments made by stakeholders to move the project forward were the following:

- The Finance Department representative offered, during the discussion of RRT project outcomes, to determine the cost per day of unplanned ICU admissions (UICUA) and to create a report to establish the baseline average length of stay for the UICUA in their hospital (for a list of outcomes, see Table 1 in "Implementing an Evidence-Based Practice Change," March).

- The Health Information Management Systems/Medical Records Department representative committed to create a data documentation tool to facilitate the collection from completed RRT records of the following: code rates outside the ICU, RRT response time and duration, UICUA, and RRT events that prevent ICU stays.

- The vice president of medical affairs and the APN hospitalist agreed to notify the hospital's medical staff of the RRT project in a letter and in the staff's monthly newsletter; they also agreed to address any questions medical staff might have about the project.

- The Quality/Performance Improvement Department director suggested that she, Carlos, Rebecca, Chen, and the project's pilot unit quality council representative have a follow-up meeting to organize the outcomes data collection and reporting processes needed to demonstrate the success of the project.

After the meeting, Rebecca, Chen, and Carlos reviewed how it went and were pleased by what they had accomplished as a team. Now they're ready to begin the RRT implementation, guided by their overall plan and by the project timeline they'd created earlier.

PREPARING FOR THE RRT PILOT LAUNCH

As they get ready to initiate the pilot project, Rebecca, Chen, and Carlos refer to the EBP Implementation Plan (see Figure 1 in "Following the Evidence: Planning for Sustainable Change," January) to determine their next steps. They already identified their own clinical unit as the RRT pilot unit and involved their nurse manager and clinical educator, so they've completed checkpoint six. Now they prepare a "to do" list of the activities they need to complete prior to the RRT pilot launch (see 'To Do' List for RRT Pilot Rollout).

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Rebecca and Chen attend their unit's upcoming staff meetings to introduce the evidence-based RRT project to the staff nurses. They ask the unit's clinical educator, Susan B., to attend too, so she can share the schedule for the RRT education program; that way, staff can plan to attend one of the in-services before the RRT project begins. At the staff meetings, the EBP team explains the project, the reasons for and importance of the pilot phase that will take place on their unit, and expresses appreciation for their colleagues' support.

Although the staff is supportive of the project, they're concerned about being the "test" unit. The EBP team acknowledges these concerns and, after the staff meetings are over, discusses them with the unit's nurse manager, Pat M. Carlos suggests that they implement the RRT only on the day shift for the first week of the project so that Rebecca and Chen can be available to the staff during the first RRT calls. He says the presence of the EBP champions during initial RRT implementation on the unit is critical, because they can

- provide expertise and education.
- support their staff colleagues.
- monitor RRT response time.
- observe interactions between the RRT and staff.
- obtain immediate feedback about the RRT process.
- identify any problems with the RRT process.
- speak with any resisters to the RRT project.
- work with the nurse manager (or other departmental leadership) to address resistance.
- make timely adjustments to the RRT process, if needed.
- provide immediate feedback to the RRT and staff.

Pat agrees and commits to using the small number of budgeted per diem staff hours needed to allow Rebecca and Chen to adjust their work hours during the first week of the rollout.

Rebecca meets with the Quality/Performance Improvement Department director and quality council representative to make a plan for outcomes data collection, analysis, and reporting. At the meeting, the quality department director describes a tool her department uses to present outcomes data, called a "dashboard." Resembling the dashboard of a car, the tool schematically portrays the status of a number of quality initiatives and how they're progressing toward meeting their goals; it makes it possible to get a comprehensive and concise picture of many critical performance indicators at a glance. They discuss the project outcomes to be measured, how they'll obtain the raw data, and the estimated amount of RRT data they can expect. The quality department director and council representative agree that the volume of data seems relatively small, and they offer to enter the raw data into the clinical unit's quality/performance improvement database so it can be included on the dashboard if Rebecca and Chen forward it to them by the 15th of each month. Rebecca and Chen enthusiastically commit to this monthly timeframe.

Next, Rebecca and Chen meet with the Clinical Informatics Department nurse, Karen H., to discuss creating a data documentation tool for staff and RRT members to use that can be accessed from the electronic medical record. They describe the RRT project to Karen and share the protocol with her. After reviewing the documents and getting answers to her questions, Karen recommends that rather than create a whole new tool for this project, they modify their current code blue documentation tool. Karen and the team review the code sheet together and agree that modifying the current tool makes sense because

- it's more efficient than creating a new tool.
- it'll be easier for staff to learn the revised tool since it's based on one with which they're already familiar.

Karen commits to creating the documentation tool, but tells Rebecca and Chen that it'll be at least two weeks before she can begin because there are many other informatics projects ahead of theirs in the queue. This two-week delay isn't a problem for Rebecca and Chen. They have designed flexibility into their implementation plan; therefore, this wait will not push back the rollout. The RRT documentation tool is delivered in two weeks as promised, so Susan B., the clinical

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'To Do' List for RRT Pilot Rollout

- Attend pilot unit staff meetings
- Create poster and/or flyer to inform staff of rollout date
- Order "RRT Launch" buttons
- Meet with Quality/Performance Improvement Department director and unit-based quality council representative
- Meet with Clinical Informatics Department to develop electronic data documentation tool
- Make sure collecting outcomes measures is possible
  - o Finance Department follow-up
  - o Health Information Management Systems/Medical Records Department follow-up
- Check with RRT members to make sure they're ready to go

educator, is able to include it in the in-services, which are conducted on schedule.

Days before the RRT pilot's official rollout, Rebecca, Chen, and Carlos meet to review their final preparations, check in with Pat, the nurse manager, and Susan, the clinical educator, and post the RRT rollout flyers around the unit (see *RRT Rollout Flyer*). Rebecca and Chen tell Carlos they want to create a "spirit of celebration" on the morning of the rollout to get people excited about it. They decide to bring breakfast and give out "RRT Launch" buttons on rollout day. Carlos agrees that it's a great idea to try to make the first day of a new process positive and memorable. He particularly likes the idea of giving out buttons that will serve as visual triggers that something new and exciting is about to happen.

THE RRT PILOT ROLLOUT

On the first day of the rollout, Rebecca, Chen, and Carlos are on the unit before the day shift begins. They decorate the lounge, invite the staff to enjoy a complimentary breakfast when they take their break, and give every staff member a button to remind them to spread the word that it's RRT Launch Day.

A patient is stabilized. Although the first three days begin

and end with no RRT calls, on the fourth day, while Rebecca is working, one of her nurse colleagues, Jessica T., approaches and asks her to come and look at a patient she thinks is decompensating. As they proceed to the patient's room, they take a copy of the RRT protocol from the nurse's desk as a guide. Jessica, the bedside nurse, assesses her patient and determines that the patient meets the criteria for calling the RRT. She follows the RRT protocol step-by-step, while Rebecca stays close by to support her. The team arrives within five minutes and there is a flurry of activity. Jessica and the RRT all work together to care for the patient. As a result of their timely interventions, the patient is stabilized and remains on the unit.

After most of the RRT members leave, Jessica, Rebecca, and the ICU nurse on the RRT sit together for a few minutes to debrief the RRT call and experience.

The ICU nurse tells Jessica what a great job she did assessing and caring for her patient. Jessica appreciates the compliment and feels good about the RRT intervention and outcome. Rebecca tells both nurses how well they shared their knowledge and skills to turn a potentially challenging situation into a wonderful learning experience. The nurses express to Rebecca how satisfying it was to know they were giving this patient the best care possible. Rebecca is pleased by how well the RRT process worked and how positive the experience was for everyone involved. Rebecca calls Carlos and Chen to share with them the great success of their first RRT consult. The EBP team is happy the first test of the RRT intervention is over and that it was a success!

As a result of the RRT's timely interventions, the patient is stabilized and remains on the unit.

A patient codes. The RRT pilot continues to proceed well until its third week, when Chen arrives at work and finds that a patient coded on the unit the day

RAPID RESPONSE TEAM
STARTS AUGUST 1, 2011

Key Points to Remember:
An RRT consult can be initiated by any bedside clinician.
The RRT will arrive within five minutes (or less) of the call.
The full RRT protocol is posted at the nurses' station and in the policy book.

RRT consult procedure:
1. **Assess** patient using the RRT protocol.
2. If any RRT criteria are identified, **initiate** the RRT consult by **calling 5-5555.** The operator will request your location, the patient's name, the patient's location, and the reason for RRT activation.
3. **Provide** the RRT with information about the patient using the SBAR reporting protocol.

While waiting for the RRT to arrive:
Initiate any/all of the following actions:
- Call for a colleague to help you.
- Set up oxygen apparatus.
- Set up suction apparatus.
- Call for the code cart to be brought to the area.
- Communicate with the patient's family (if present); tell them what you're doing and why and that someone will be there shortly to help them.
- Obtain proper documentation tools to be used during the RRT consult.

When the RRT arrives:
1. **Provide** information using SBAR.
2. **Participate** in the care of your patient and remain with the patient and the RRT.
3. **Assist** the RRT as needed.
4. **Document** activities, interventions performed, and patient responses to interventions.
5. **Ensure** that the patient's family is informed of the situation at reasonable intervals.
6. **Assist** in arranging for transfer of the patient to a higher level of care if indicated, and **provide** a detailed report to the receiving nurse, using SBAR.

If you have any questions, please contact **Rebecca or Chen @ x1234.**
Thank you for your support of this evidence-based initiative!

before and was transferred to the ICU; the RRT was never utilized. Chen contacts Carlos and shares this information and her concerns with him. Carlos offers to review the patient's chart that afternoon with the APN hospitalist to determine if this patient had been an appropriate RRT candidate and what, if any, follow-up would be appropriate.

Carlos meets with Rebecca, Chen, and Pat, the nurse manager, the following day to discuss his findings. He informs them that the patient was indeed an appropriate candidate for an RRT consult; however, there's no clear indication in the documentation as to why the RRT wasn't called by the staff nurse who cared for the patient that day. They decide that Pat and Rebecca will talk with the staff nurse, Joanne S., to hear why, from her perspective, the RRT consult wasn't initiated. When Pat and Rebecca meet with Joanne, they ask her first whether she had attended an RRT in-service and had known the RRT was available.

"Yes, I went to the in-service," Joanne says, "but I never thought about the new RRT thing the other day." She continues: "I've

been a nurse for 25 years and I know when a patient is going bad, how to call a code, and that our ICU is always there when needed." In response to Rebecca's further questions: was there a particular reason Joanne chose not to use the RRT, would she be willing to use it in the future, and what would be helpful in encouraging her to use it in the future, Joanne responds, "I'm not opposed to new ideas; after all, there's a new idea on this unit every day, for goodness' sake! I might use this new team someday, but I have to see how it works for other people first. I'm just not sure about it yet."

Pat M. recognizes that this is a critical moment in the EBP project implementation process where she, as nurse manager, needs to provide leadership. She recalls a list of key strategies Carlos had shared with her regarding the manager's role in the successful implementation of an EBP project (see *Managers' Key Strategies to Promote Successful Implementation of an EBP Project*). She utilizes several of these strategies in her discussion with Joanne, particularly those that focus on her expectations of

both leadership and staff. Joanne agrees to review the RRT criteria and protocol. Rebecca reminds Joanne that the purpose of the RRT is to improve patient outcomes. Joanne says she'll try to remember to use it next time.

After the meeting with Joanne, Pat and the EBP team meet and agree that this missed opportunity wasn't related to the RRT process. Instead, it concerned a single individual who seemed to be resistant to a change in practice. They decide that there's no need to follow up with the entire staff at this time, and that Rebecca will check in with Joanne in a few days. Carlos reminds the team that resistance to change is common and that paying timely, direct attention to situations like Joanne's is an effective strategy to get and keep everyone on board with an evidence-based project. Carlos congratulates Pat and the EBP team on their handling of this situation.

While they're together, the team uses this opportunity to review how the project is proceeding overall and to update their EBP Implementation Plan. After they check off several items in checkpoints seven, eight, and

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Managers' Key Strategies to Promote Successful Implementation of an EBP Project

1. Become an expert on the EBP project and activities implemented on the unit.
2. Communicate information about the EBP project with staff as early and often as possible.
3. Encourage staff feedback about the EBP project.
4. Speak positively about the EBP champion(s) and the EBP project.
5. Demonstrate, through actions, support of the EBP champion(s) and the EBP project.
6. Set clear expectations for staff regarding the EBP project and related activities.
7. Provide support and resources to staff as the EBP project is implemented and integrated.
8. Be present and available to staff during critical phases of EBP project implementation.
9. Hold staff accountable to the EBP project and related activities.
10. Provide timely follow-up or redirection if evidence-based activities are not carried out (whether it be by an individual or group).
11. Acknowledge staff efforts toward successful implementation of the EBP project (highlight specific staff if possible).
12. Celebrate milestones during the EBP project.

nine, such as addressing stakeholder concerns, launching the project, and reviewing its progress, they turn back to Pat and ask her for any feedback on the launch. She says that she's been talking with the nursing staff and attending physicians regularly over the past three weeks and is excited to share with the team that the feedback has been overwhelmingly positive. Pat believes that the team's extensive planning has been critical to the project's success. Pat ends by saying, "In my opinion, there have been no real problems or major setbacks."

Rebecca tells the team that she has communicated with both the Health Information Management Systems/Medical Records Department director and the Finance Department manager, and they've been successful in collecting the data they committed to collect at the kickoff meeting. Chen has been following up on how well the electronic data documentation tool has been working for the staff and RRT members. Some minor adjustments were made on the tool by the clinical informatics team over the three-week pilot; however, overall, the tool has worked very well. The EBP team agrees that the success of the experience on the pilot unit has made them confident about rolling out the program hospital-wide. They make a special note to continue to monitor the RRT processes as utilization of the RRT in the hospital increases. As the final step in the pilot, the EBP team contacts each of the key stakeholders to obtain feedback about the pilot and inform them of the hospital-wide rollout.

THE HOSPITAL-WIDE ROLLOUT
When the EBP team meets to plan the hospital-wide rollout, they discuss the feedback they received from stakeholders, pilot unit leadership, and staff. They

confirm that each member of the RRT is prepared for the hospital-wide rollout to begin. Carlos then leads the team through a structured discussion of how they'll roll out the RRT protocol to all hospital units. They determine that to replicate their pilot unit success, they'll need the buy-in of the nurse manager and clinical educator on every unit and to identify an RRT staff nurse champion on each unit. The EBP team decides to request time to introduce the project and present the proposed timeline at next month's nurse manager, clinical educator, and EBP council meetings in order to finalize the hospital-wide rollout plan with these key individuals.

When Rebecca and Chen attend the council meetings, they find that most of the participants are already aware of the RRT project, as it has received much attention and praise throughout the hospital over the past several months. The nurse managers are eager to adopt the program on their units, and they commit to support and promote the project. They also ask some excellent questions. The pediatric manager asks, "Will the RRT respond to pediatric patients and newborns in the nursery?" The obstetrics manager asks, "Will the RRT respond to obstetric patients who are having nonobstetrical clinical problems?" The endoscopy suite manager asks, "Can we call the RRT

for outpatients?" Rebecca and Chen don't have immediate answers for all of these questions. They tell the nurse managers that they'll take their questions back for the whole EBP team to discuss and promise they'll have answers within a week. The clinical educators are very supportive of the project and Susan B. has already begun to work with them to plan their staff in-services. The EBP council representatives are also quite positive: they tell Rebecca and Chen that they've discussed the RRT project and unanimously decided they'll be "the best RRT champions ever." The EBP team is pleased with the enthusiasm and support from every group. They feel confident about proceeding

To replicate their pilot unit success, they'll need the buy-in of the nurse manager and clinical educator on every unit and to identify an RRT staff nurse champion on each unit.

with the EBP implementation process and rolling out the RRT hospital-wide.

Join the EBP team next time to learn the results of the hospital-wide rollout, how outcomes data were collected and evaluated, and about their plans to disseminate the results of their experiences so others can learn from them. ▼

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