

Reducing Unplanned Adverse Events on a Trauma Unit by Improving Critical Thinking



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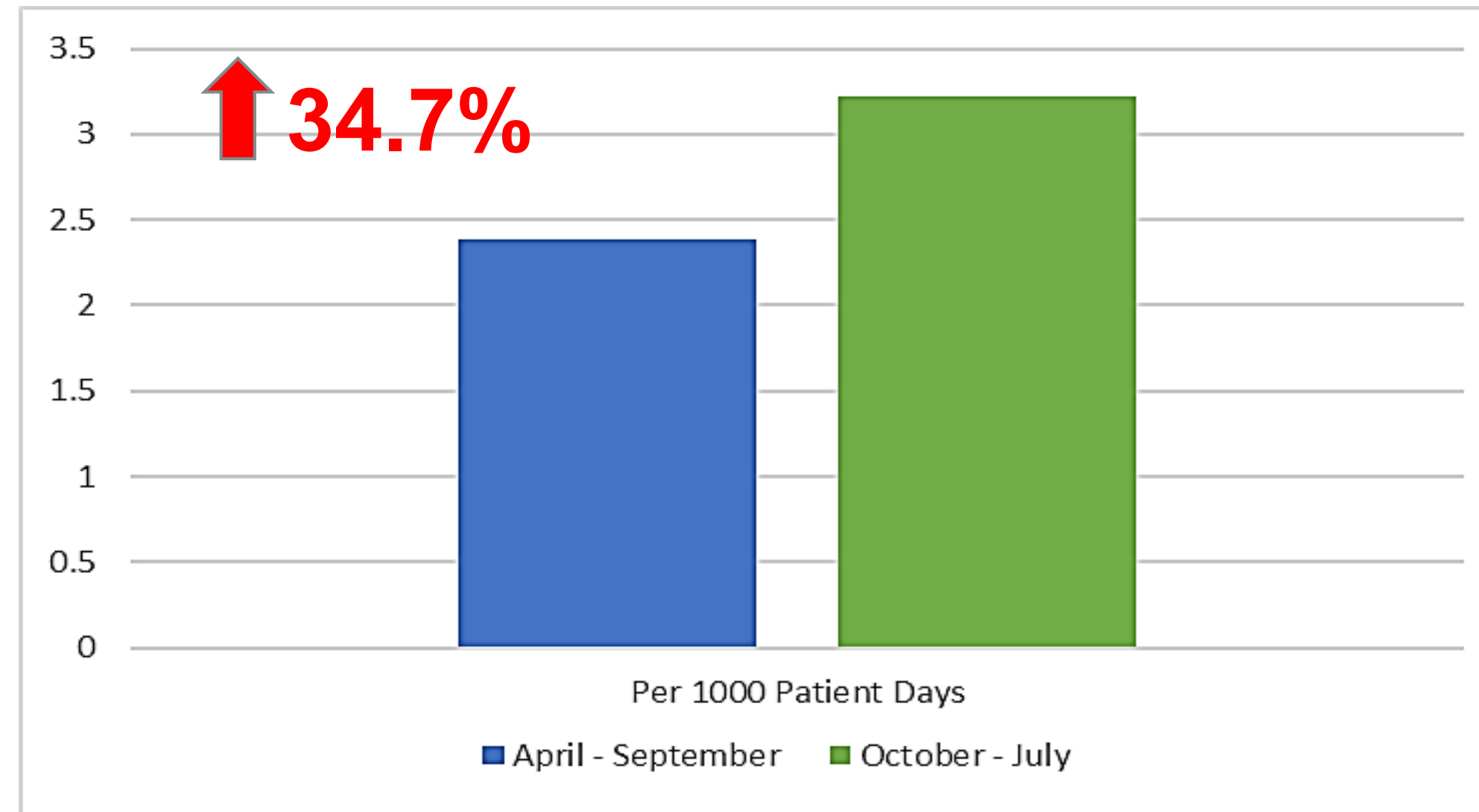
Background

- Clinical deterioration of patients in the hospital is an ongoing concern.
- Gaps exist in nursing documentation, assessment knowledge, and nurse-provider communication.
- Opportunities were identified for education related to patient findings that warrant a call to the provider versus a call for the Rapid Response Team.

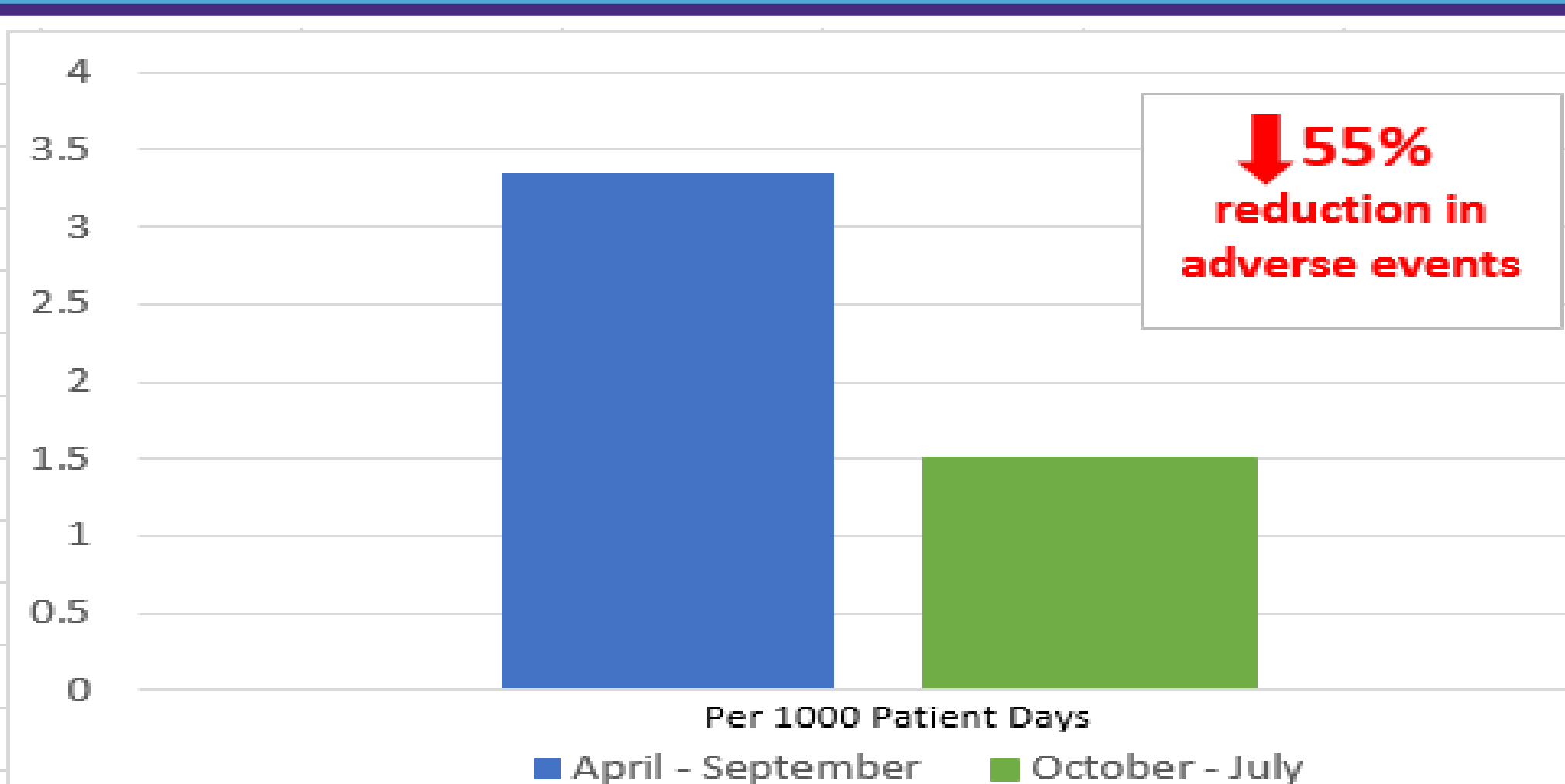
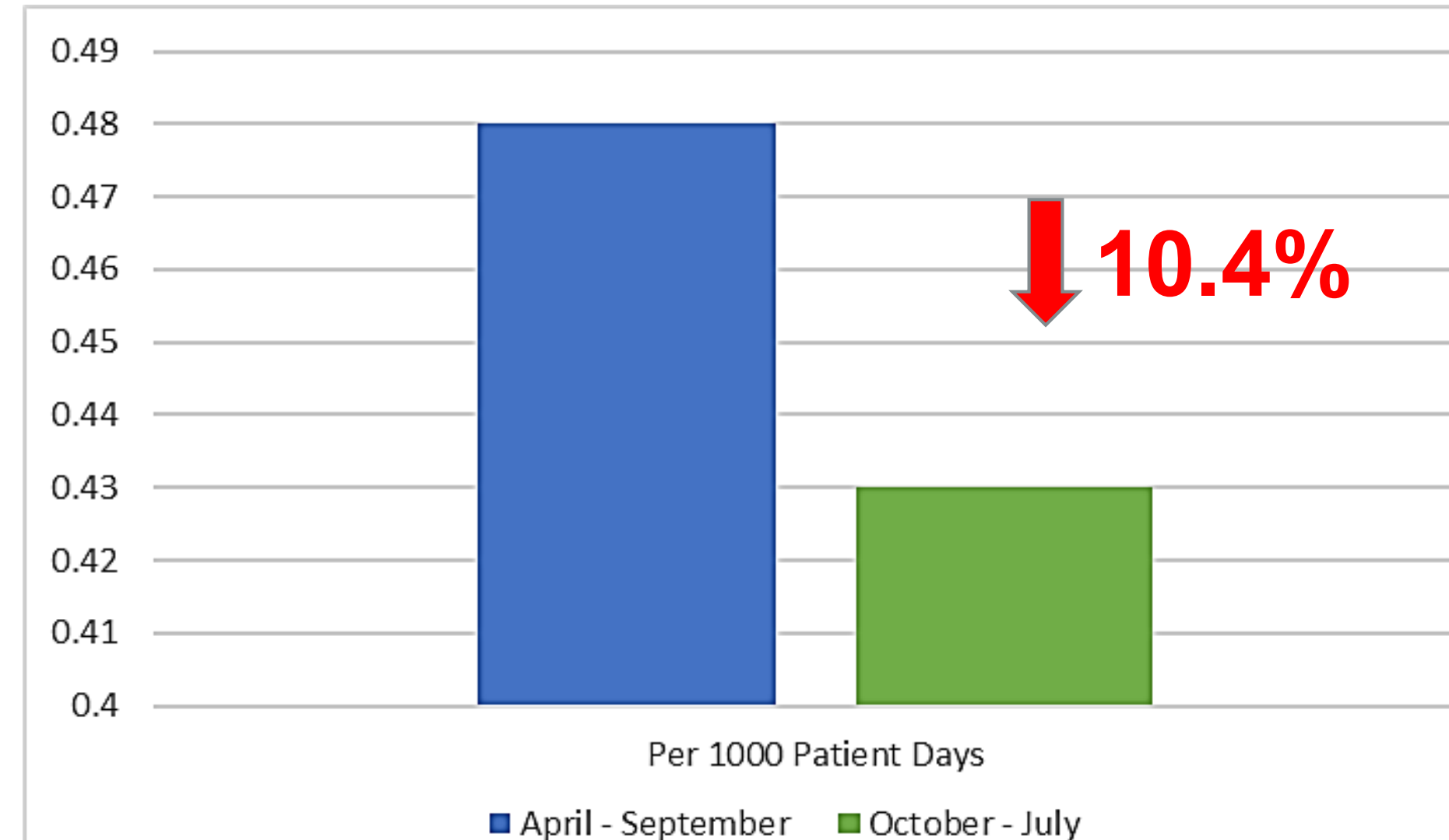
Methods

- Monthly, CNLs presented case studies of actual patients who had deteriorated on Trauma Unit. Discussion with staff about findings and necessary interventions followed.
- Assessment skills for each body system were reviewed in accordance with Texas Health Policy.
- Education was provided on bedside documentation and appropriate findings that warrant immediate provider notification.

Rapid Response – Main 3 Trauma



RRT → Code Blue Main 3 Trauma



Conclusion

- 35% increase in Rapid Response Team events.
- 10% reduction in RRT converted to Code Blue events.
- 55% reduction in unplanned adverse events
- RNs reported improved assessment skills and broader understanding of body system after case study discussion.
- Nurses reported improved nurse to provider communications and increased nursing confidence when communicating with physicians.
- Improved nursing documentation.
- More subtle changes in patient status assessed, documented, and intervened on by staff.

Key Finding - Sustainment

- Immediate education involving case studies of actual patients who had UAE provided the relevancy and emotional impact necessary for sustained learning