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Bridging the Experience Gap: An ED Escalation Guide

Marcia Schram

Baptist Hospital of Miami, mschram@bellsouth.net

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Introduction

- More new graduates being hired as ED RNs
- Novice nurse challenges:
 - Difficulty with critical thinking, time management, prioritization - knowledge, skills, & critical thinking develop with experience
 - Common error - failure to recognize & intervene when patient is deteriorating
- **Possible solution: Early Warning System**
- SOS ED Escalation Guide to provide parameters for clinical deterioration

Literature Review

“According to Benner, a novice nurse is a beginner who must have rules from which to practice, as there is no experience from which to draw conclusions.” (Marble, 2009)

“Failing to recognize (deterioration)... a successful intervention can only happen if deterioration is detected early, recognized as important, communicated to appropriate team members, & care escalated rapidly.” (Wilson, S. et al, 2012)

Research Question

• In an adult Emergency Department (ED), will the introduction of an early warning system guide improve the recognition of critical symptoms in ED nurses with less than 2 years of experience?

Methodology

- SOS ED Escalation Guide - developed to be used as early warning system (EWS)
- Adapted from med-surg
- 3 levels of urgency based on VS parameters & Critical Symptoms
- Evaluated & revised by multiple ED-certified physicians & RNs
- Tested for effectiveness using quiz based on ESI handbook

	A Wait for EDP monitoring (45 min) notify monitoring	B Wait for EDP 1-15 min notify RN (15 min)	C Call for EDP notify RN (15 min)	CRITICAL SYMPTOMS
Systolic BP	90-100	90-100 or 101-120	101-120	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.
Diastolic BP	> 100	101-120	> 120	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.
Heart Rate	50-100	101-140	> 140	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.
Respiratory Rate	12-20	12-20	> 20	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.
SpO2	92-100	92-100	< 92	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.
CO level	16-20	16-20	> 20	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.
Temp	96-100	96-100	> 100	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.
LOC	Alert & Oriented	Alert & Oriented	Alert & Oriented	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.
Blood Sugar	70-100	70-100	> 100	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.
Symptoms	Stable	Stable	Stable	HR > 140, RR > 24, SpO2 < 92%, GCS < 15, etc.

- SOS Guide effectiveness:
 - Scenarios tested for reliability with experienced ED RNs
 - Quiz assesses prioritization based on 3 levels of urgency
 - 2 quizzes were given 1 week apart to ED RNs with varying experience
 - Quiz 1 (no Guide)
 - Quiz 2 (with Guide)

Results

- Higher quiz scores correlated with years of experience & clinical expertise
- **RNs with >1 year of ED experience:**
 - Consistent scores with & without availability of SOS Guide - Relied on their own judgment
- **RNs with < 1 year of ED experience:**
 - **25% improvement** in scores with SOS ED Escalation Guide
 - Increased confidence in reporting symptoms

Conclusions/Discussion

- Recognition of clinical deterioration & rapid intervention are vital
- Experience increases ability to assess & prioritize urgency of clinical presentations
- RNs with < 1 year of ED experience may not recognize/report critical symptoms promptly without parameters
- SOS Guide provides ED parameters

Implications for Practice

- An Early Warning System can be a valuable tool to help novice RNs to prioritize clinical symptoms
- The SOS Guide can be used by novice ED RNs to:
 - Increase confidence with assessments
 - Prioritize the urgency of clinical symptoms
 - Ensure pertinent clinical information is reported promptly to ED MDs

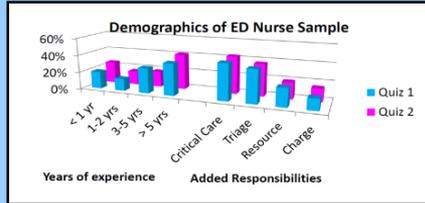
References

- References available upon request

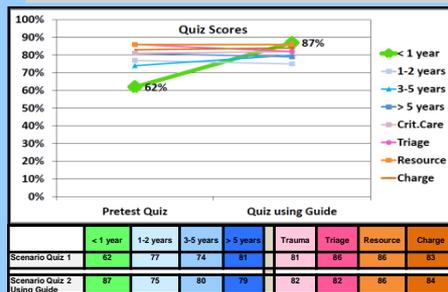
Scenario Sample – Choose Intervention (A, B, or C):

• A 44 year old female is vomiting small amounts of yellow fluid on arrival; per daughter, patient has been vomiting x 5 hours and has not been able to eat or take her insulin.
 • Blood sugar 363; BP 148/70, P 126, R 24, Temp 98.4 F, oral

A Routine- monitor: Wait for EDP evaluation <small>Start Advanced Nursing Intervention (ANI) protocols</small>	B STAT orders may be needed: Inform EDP and/or Resource RN	C Alert! Critical care needed: STAT call to EDP/ Charge RN
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Data Analysis



- Logs of real-time use in orientation
- Logs kept over a 3 week period
- Sample size: 46
- Level of severity based on SOS:
 - **24%, 46%, 30%**
- ED MDs notified & orders received: 93% of pts.
- Likert scale used to assess confidence in notifying MD about patient condition - score 3.98 out of 5

Scenario Quiz	<1 year	1-2 years	3-5 years	> 5 years	Trauma	Triage	Resource	Charge
Scenario Quiz 1	62	77	74	81	81	86	86	83
Scenario Quiz 2 (with Guide)	87	75	80	79	82	82	86	84