

The Chain of Command Protects Your Patients and You

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Purpose and Objectives

Purpose

The purpose of The Chain of Command Protects Your Patients and You is to alert nurses to situations that call for use of the chain of command and present assertive strategies for responding to these situations.

Objectives

1. Explain the purpose of a healthcare organization's chain of command policy and the nurse's role in pursuing the chain of command.
2. Identify situations in which the nurse's correct response is to pursue the chain of command.
3. Describe effective communication techniques to address patient safety issues.

Safety = Job #1

For healthcare organizations and for nurses and other healthcare professionals, nothing surpasses the importance of patient safety.

Inherent safety risks arise in the hospital environment and because of the conditions that bring patients to the hospital. Inpatient treatments, procedures, and medications all have potential to threaten patient safety.

The Nurse: First Line of Defense

The nurse is truly the first line of defense in protecting patients from risk.

Nurses spend more time with patients than other healthcare personnel. The nurse usually has continuity with the patient over the length of the hospital stay. Nurses notice subtle changes in their patients.

In addition to their own observations, nurses can instruct Patient Care Technicians (PCT) or other unlicensed assistive personnel (UAP) to be alert for specific indicators of deterioration and report such findings to the RN promptly.

To be effective as the first line of defense, the nurse promptly and assertively contacts the patient's provider to obtain orders or a visit to the patient, when assessment findings indicate a potential problem.

(Odell, 2010)

The Nurse as Safety Advocate

Healthcare organizations and consumer groups acknowledge risks in the healthcare setting and recommend that a patient identify an advocate to participate in care (National Patient Safety Forum [NPSF], 2014). Some

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organizations offer the services of professional patient advocates in the form of Patient Representatives, Patient Advocates, or Navigators to assist patients.

But regardless of who else may advocate for a patient, the nurse accepts responsibility for protecting patient safety.

As the Code of Ethics for Nurses states,

“The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient”
(ANA, 2010).

When the nurse calls a provider or supervisor for assistance in assuring patient safety, and does not receive a timely response, the nurse must pursue the chain of command.

The Nurse’s Liability

When a nurse fails to use knowledge, care, skill, or diligence and the patient is harmed as a result, the nurse can be held liable (Smalls, 2009). The courts have found nurses liable in situations in which a nurse could have prevented harm to a patient by persisting in obtaining a provider’s assessment or intervention.

Each healthcare organization formalizes a chain of command to identify the sequence of personnel to contact when the nurse cannot resolve concerns about patient safety or quality of care.

Nurses Fail to Protect Their Patient: An Example

A 5-day-old infant in the NICU had a yeast infection. The attending MD instructed the resident to order 5FC (flucytosine). The resident instead ordered the chemotherapeutic medication 5FU.

Nurses on 2 shifts observed the 5 rights, though not “right indication,” and administered 5FU.

A new nurse on the night shift called pharmacy to question the indication. The nurse also called the resident who insisted that the attending said to order that medication and demanded that the nurse give it.

This nurse then gave 5FU and the next morning the infant died.

The family brought a lawsuit, naming the resident, attending physicians, and hospital as defendants.

The hospital was sued because of the negligence of its nurses who failed to question the order to give 5FU.

(Smalls, 2009, p. 401)

Click on the 1st and 2nd buttons below to review the first and second opportunities that the nurse had to protect the infant.

The Nurse’s First Opportunity to Protect the Infant

Nurses on 2 shifts observed the 5 rights, though not “right indication,” and administered 5FU.

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Nurses need to know the indications, action, usual dose, pertinent precautions, adverse and toxic effects of all medications commonly administered on their units.

When they receive an order for an unfamiliar medication, nurses must secure this information before preparing and administering the medication.

The Nurse's Next Opportunity to Protect the Infant

A new nurse on the night shift called pharmacy to question the indication. The nurse also called the resident who insisted that the attending said to order that medication and demanded that the nurse give it.

Did this new nurse know about the chain of command? How could the nurse have acted differently?

This nurse could have:

1. Stated to the resident that the only indication she had found for 5FU was cancer treatment and in order to responsibly administer the medication, she needed to know the indication and expected effects in this infant's situation.
2. Stated that she was not comfortable administering this medication and would contact the attending to verify, if the resident continued to insist that she implement the order. Possibly the hospital's chain-of-command policy and procedure (P&P) would dictate that the nurse first report to the charge nurse who would then contact the attending, or pursue another sequence of contacts as the P&P directs.
3. Persistently pursued the chain of command as the P&P directs.

Escalating the Problem-Solving Process

"Nurses act with moral courage when they use the chain of command to share and discuss issues that have escalated beyond the problem-solving ability and/or scope of those immediately involved."

"Engaging the chain of command both ensures that the appropriate leaders know what is occurring and allows for initiating communication at the level closest to the event, moving the discussion upward as the situation warrants."

(LaSala & Bjarnason, 2010)

Using the chain of command when indicated not only protects specific patients, but also enhances the culture of safety. By pursuing the chain of command instead of ignoring an issue or working around the issue, the nurse raises organizational awareness of the issue and contributes to preventing similar situations in the future.

The Chain of Command Policy

Each healthcare organization establishes its own chain of command P&P to identify the sequence of personnel to contact in order to resolve a situation in which quality of care or safety is at risk.

P&P may also address:

- Examples of situations in which the P&P should be implemented
- Who may initiate the chain of command

- The timeframe within which a response should be received before proceeding to the next step in the chain of command
- Protection for a staff member who implements the policy in good faith
- Differences between emergent and non-emergent situations
- Documentation of use of the chain of command

The P&P may suggest that you validate your assessment and discuss your concerns with colleagues before initiating the chain of command, if time permits.

Identify these elements in your organization's chain of command P&P. Consult your immediate supervisor to clarify if necessary.

Think About It

What are the major risks for patients on your unit?

Certain specific post-operative complications, such as wound infection, bowel obstruction, urinary retention, pneumonia, venous thromboembolism (VTE), or others specific to the surgical procedure?

Toxicity or adverse effects related to a specific medication, especially opioids and anticoagulants?

Infection? Possible risk for sepsis?

Think about your patient population – the age group, the conditions, treatments, and medications that you commonly see.

What are the early warning signs of problems related to any of these risks?

Learn About Early Warning Signs

This course presents a few examples of common risk-for-deterioration situations, but by no means includes all the possibilities. Identify the greatest risks for your patient population and learn the early warning signs. Identify the assessment parameters that you will report to the patient's provider when you observe indications of deterioration.

Some situations that may present early warning signs include:

- Subdural hemorrhage or other internal bleeding, especially following trauma to a patient who is receiving anticoagulants
- Post-operative complications such as surgical site infection, sepsis, hemorrhage
- Thrombosis and embolism, especially venous thromboembolism (VTE), pulmonary embolism, and fat embolus following orthopedic surgery or long bone fracture
- Medication toxicity, especially opioid toxicity
- Impaired circulation in casted extremities
- Early signs of myocardial infarction (MI), cerebrovascular accident (CVA), worsening heart failure (HF), and renal failure
- Poor glycemic control

Risky Business: Anticoagulants

Many hospitalized patients receive anticoagulants. Use may increase as providers take more aggressive measures to prevent venous thromboembolism (VTE).

Anticoagulants are high-risk medications and have a narrow therapeutic window – a small range between the therapeutic dose and the toxic dose. There are important precautions associated with safe administration of anticoagulants and important patient teaching aspects of anticoagulant therapy.

Focus on risk-for-deterioration: Internal Bleeding and Subdural Bleeds

A fall or other trauma which may seem minor at the time of the occurrence, can cause excessive bleeding with the patient who is receiving anticoagulant therapy.

If a fall or trauma occurs, continue assessments at regular intervals beyond the time immediately following the injury:

- Assess neurological status, including level of consciousness.
- Assess for evidence of internal bleeding, specifically blood pressure and pulse.
- Compare assessment findings with previous findings for this patient. Is the situation improving or deteriorating?

VITAL Signs

Nurses often consider routine vital signs on stable patients to be a very basic nursing activity. Unlicensed personnel often take vital signs and blood glucose measurements.

But for the purpose of identifying early warning signs of a patient's deteriorating status, the nurse's assessment of vital signs and patterns in vital signs is absolutely VITAL, regardless of who takes the vital signs measurements (Odell, 2010).

Respiratory rate is considered the most sensitive marker for clinical deterioration and most poorly monitored, although small changes may be due to anxiety (Wolfenden, 2010).

Note! It is important for nurses to identify trends with vital signs, rather than just observe a single set of observations in isolation.

More Information: Early Warning Signs

Some organizations, particularly hospitals in the United Kingdom, use a standardized rating system, the Modified Early Warning Scores (MEWS). Total scores reflect nurses' ratings of a patient's:

- Temperature
- Systolic BP
- Pulse
- Respiratory Rate, Saturations, O2 liters per minute
- AVPU (Awake; Responds to Verbal Stimulation; Responds to Painful Stimulation; Unresponsive)

The MEWS protocol identifies specific actions for specific scores, ranging from:

- Score=8: Repeat MEWS after 3 – 5 minutes; have urgent conversation with the provider
- Score=4 - 7: Repeat MEWS after 5 – 10 minutes; call the provider; ask for visit within one hour
- Score=3: Reassess hourly, report to charge nurse, if score remains constant, call provider to visit
- Score= less than 3, but nurse is concerned: Assess hourly; report to charge nurse. If score increases or concern remains after 2 hours, call provider to visit.

(Wolfenden, 2010)

Think About It

What is your unit's typical assessment protocol?

Will it help you to detect early warning signs of a patient's deterioration?

Suppose you notice that a patient's level of consciousness is deteriorating. What additional data will you collect before contacting the patient's provider? Depending upon the patient's condition and history, any of the following may be important assessments in addition to temperature, BP, heart rate, and respiratory rate:

Neuro checks

Blood glucose

Hydration status

What other assessments might be pertinent?

Early Warning Signs

Early warning signs include the following:

- Cerebrovascular Accident (CVA)
- Myocardial Infarction (MI)
- Opioid Toxicity
- Pressure Ulcer
- Pulmonary Embolus (PE)
- Seizure
- Sepsis

Cerebrovascular Accident (CVA):

Patients at risk include those who have existing heart disease, arrhythmias, hypertension, atherosclerosis, thrombosis, or brain aneurysm.

Symptoms:

- Sudden numbness or weakness of the face, arm or leg (especially on one side of the body)
- Sudden confusion, trouble speaking or understanding speech
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination

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- Sudden severe headache with no known cause

(Medline Plus 2012a)

Myocardial Infarction (MI):

Patients at risk include those who have existing heart disease, arrhythmias, hypertension, atherosclerosis, or thrombosis.

Symptoms:

- Chest pain is the most common symptom of a heart attack. Pain may occur in only one part of the body, or may radiate from the chest to arms, shoulder, neck, teeth, jaw, belly area, or back.
- The pain can be severe or mild. The patient may describe:
 - A tight band around the chest
 - Bad indigestion
 - Something heavy sitting on your chest
 - Squeezing or heavy pressure
- Pain usually lasts longer than 20 minutes. Rest and nitroglycerin may not completely relieve the pain. Symptoms may also go away and reoccur.

Other symptoms of a heart attack may include:

- Anxiety
- Cough
- Fainting
- Light-headedness, dizziness
- Nausea or vomiting
- Palpitations
- Shortness of breath
- Sweating, which may be very heavy

(Medline Plus 2012b)

Opioid Toxicity

Any patient who is receiving opioids for pain relief is at risk for developing toxicity.

Symptoms include:

- Depressed respirations, very slow respiratory rate
- Decreased level of consciousness: extreme sleepiness, loss of alertness
- Constricted pupils

(Medline Plus 2012c)

Know your organization's protocol including use of naloxone (Narcan®)

Pressure Ulcers: Stage 1-2:

Identification of ANY stage of pressure ulcer requires prompt attention in order to institute immediate treatment and prevent further damage. Patients at risk include patients who are immobile, extremely thin, debilitated, poorly nourished, have devices or positioning needs that cause pressure, and other factors that create unrelieved pressure or make the patient vulnerable.

Category/Stage I: Non-blanchable erythema

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” persons.

[National Pressure Ulcer Advisory Panel (NPUAP), 2007]

Category/Stage II: Partial thickness

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

*Bruising indicates deep tissue injury.

Pressure Ulcers: Stage 3-4:

Identification of ANY stage of pressure ulcer requires prompt attention in order to institute immediate treatment and prevent further damage. Patients at risk include patients who are immobile, extremely thin, debilitated, poorly nourished, have devices or positioning needs that cause pressure, and other factors that create unrelieved pressure or make the patient vulnerable.

Category/Stage III: Full thickness skin loss

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Category/Stage IV: Full thickness tissue loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.

[National Pressure Ulcer Advisory Panel (NPUAP), 2007]

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Pressure Ulcers: Additional Categories:

Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown

Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover” and should not be removed.

Suspected Deep Tissue Injury - depth unknown

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

[National Pressure Ulcer Advisory Panel (NPUAP), 2007]

Pulmonary Embolus:

Be aware that a number of conditions create risk for PE, including cancer, childbirth (amniotic embolus as well as blood clot), family history, long bone fractures and surgeries (fat embolus), MI, cardiac, neuro-, and orthopedic surgery, bedrest, severe injury, estrogen therapy.

Symptoms include:

- Chest pain
 - Under the breastbone or on one side
 - Most often feels sharp or stabbing
 - May also be described as a burning, aching, or dull, heavy sensation
 - Usually gets worse with deep breathing
 - Patient may bend over or hold his chest in response to the pain
- Sudden cough, possibly coughing up blood or bloody mucus
- Rapid breathing
- Rapid heart rate
- Shortness of breath that starts suddenly

Other symptoms that may occur:

- Anxiety
- Bluish skin discoloration (cyanosis)
- Clammy skin

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- Dizziness
- Leg pain, redness, or swelling
- Lightheadedness or fainting
- Low blood pressure
- Sweating
- Wheezing

(Medline Plus 2012d)

Seizure:

As well in neurological disease or injury, seizures may occur in electrolyte imbalance, hypoglycemia, withdrawal from alcohol or benzodiazepines, kidney or liver failure, very high blood pressure or body temperature.

Warning symptoms may include:

- Fear or anxiety
- Nausea
- Vertigo
- Visual symptoms (such as flashing bright lights, spots, or wavy lines before the eyes)

Specific symptoms depend on what part of the brain is involved. They occur suddenly and may include:

- Brief blackout followed by period of confusion
- Changes in behavior such as picking at one's clothing
- Drooling or frothing at the mouth
- Eye movements
- Grunting and snorting
- Loss of bladder or bowel control
- Mood changes such as sudden anger, unexplainable fear, panic, joy, or laughter
- Shaking of the entire body
- Sudden falling
- Tasting a bitter or metallic flavor
- Teeth clenching
- Temporary halt in breathing
- Uncontrollable muscle spasms with twitching and jerking limbs

Symptoms may stop after a few seconds, minutes, or continue for 15 minutes. They rarely continue longer.

(Medline Plus 2012e)

Sepsis:

Risk factors include post-surgical or other wound infection, (including pressure ulcers and IV sites and lines), immunocompromise, any infection can lead to sepsis.

A change in mental status and very fast breathing may be the earliest signs of sepsis.

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In general, symptoms of sepsis can include:

- Chills
- Confusion or delirium
- Fever or low body temperature (hypothermia)
- Hypotension
- Light-headedness due to low blood pressure
- Rapid heartbeat
- Shaking
- Skin rash
- Warm skin
- Bruising or bleeding may also occur

(Medline Plus 2012f)

Shock Alert: Which Patients are at Risk?

Shock requires immediate medical treatment and can get worse very rapidly.

With these patients be especially alert for indications of impending shock such as a pattern of decreasing blood pressure and increasing heart rate.

- A patient who has heart failure or has had an MI
 - Risk for cardiogenic shock
- A patient who has suffered blood loss due to injury, surgery, or childbirth; A patient who has internal bleeding due to an injury or post-operative complication; A patient who is dehydrated
 - Risk for hypovolemic shock
- A patient who has known allergies or is receiving antibiotic therapy, especially for the first time
 - Risk for anaphylactic shock, caused by a severe allergic reaction
- A patient who has an infection or is at risk for infection such as a wound infection
 - Risk septic shock, less frequently, toxic shock syndrome associated with infection
- A patient who has damage to the nervous system, such as a spinal cord injury
 - Neurogenic shock
- A patient who is receiving medications that treat hypertension, cardiac medications, opioids, or other medications that may significantly reduce heart function or blood pressure

(Medline Plus 2012g)

Shock Alert: Watch for Early Signs

Early signs of shock include:

- A pattern of decreasing blood pressure and weak, rapid pulse
- Rapid, shallow respirations
- Lightheadedness, confusion, dizziness

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- Agitation, restlessness

Depending on the specific cause and type of shock, symptoms may include:

- Bluish lips and fingernails
- Chest pain
- Pale, cool, clammy skin
- Low or no urine output
- Profuse sweating, moist skin
- Unconsciousness

(Medline Plus 2012g)

An Early Warning of Heart Failure

Your patient experienced a myocardial infarction 2 days ago. This morning you notice increased pedal edema and you hear rales in his lungs. You call the patient's provider to report these early indications of heart failure. After 30 minutes you have received no response.

According to your organization's P&P, you should initiate the chain of command because the provider has not responded within 30 minutes.

Per P&P, you report the situation to the charge nurse. He calls the provider and receives no response within 30 minutes. Your patient is becoming dyspneic.

The charge nurse reports the situation to the Nurse Manager, who decides that in this situation, having waited for a total of one hour for the provider to respond, it is time to move up the chain of command and call the CNO.

The CNO contacts the Chief Medical Officer rather than continuing to pursue the unresponsive provider. Within 15 minutes, the patient's provider has called to give medication orders and states that he will visit the patient within the hour.

Patterns and Trends - Be on the Lookout

Be alert for subtle changes in your patients' vital signs, level of conscious, pain level, and other assessment parameters specific to each patient's condition and treatment.

Always evaluate your assessments in the light of previous findings. Emphasize patterns and trends in your hand-off communication.

Is the patient getting better or worse? If worse, what additional data do you need to collect before contacting the patient's provider.

Experienced nurses develop expertise in recognizing deterioration even before vital signs may indicate a problem. This assessment ability, "knowing the patient" (Odell, 2010) has great value in early detection of deterioration.

The patient's family members or other visitors who know the patient well may also alert the nurse to subtle changes based upon their own "knowing the patient." Enlist this important source by encouraging family members or visitors to call for the nurse immediately if they are concerned about the patient (Odell, 2012).

An Urgent Situation

Your patient is receiving treatment for new onset atrial fibrillation. She suddenly experiences dyspnea and chest pain.

What will you do?

Your patient is exhibiting symptoms of acute myocardial infarction (AMI). Call for your organization's Rapid Response Team. In compliance with your organization's P&P, contact the Rapid Response Team in situations of extreme urgency that require immediate specialized assistance.

The Rapid Response Team (RRT)

The Institute for Healthcare Improvement (IHI) introduced the 100,000 Lives Campaign, a patient safety initiative. The first nationwide initiative was from Jan 2005- June 2006, and annually thereafter (IHI, 2014). IHI proposed the Rapid Response Team as one of the six initiatives in the campaign.

Any healthcare staff member can bypass the typical chain of command and call what is essentially a medical "SWAT team" to quickly assess a patient and intervene when lifesaving care may be needed.

Unlike the traditional "code" team, the RRT intervenes before the patient experiences respiratory or cardiac arrest.

Use of RRTs have resulted in reductions in cardiac arrests, deaths, and length of hospital stay (Grissinger, 2010).

RRTs typically include medical, nursing, and allied health personnel specialized in critical care or emergency medicine.

To promote patient safety and to address a 2008 Joint Commission (TJC) National Patient Safety Goal (NPSG) healthcare organizations developed RRT. The NPSG did not specifically mandate RRT, but required hospitals to implement systems to enable staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening (AHRQ, 2010). TJC retired this NPSG after most hospitals had achieved the goal.

More Information: Rapid Response Team Criteria

Organizations establish guidelines and criteria for contacting the Rapid Response Team. Some organizations educate patients and families about the Rapid Response Team and encourage them to contact the team if indicated. Click [here](#) to view criteria that organizations commonly include in their guidelines and criteria (AHRQ, 2010).

Any staff member may call the team if one of the following criteria is met.

Heart rate: greater than 140 beats/minute or less than 40 beats/minute

Respiratory rate: greater than 28 breaths/minute or less than 8 breaths/minute

Systolic BP: greater than 180 mmHg or less than 90 mmHg

O₂ Saturation: less than 90% with supplementation

Mental Status: acute change in mental status

Urine Output: less than 50 mL over 4 hours

Concern: staff member has significant concern about a patient's condition

Additional criteria used by some organizations:

- Chest pain unrelieved by NTG
- Threatened airway
- Seizure
- Uncontrolled pain

Think about It

What situations have brought the Rapid Response Team to your unit?

Were there any early indications of the patient's deteriorating condition?

If so, what was or could have been reported to the patient's provider?

What would you have done if you did not receive a timely response from the provider?

Empowering Patient and Family

At the University of Pittsburgh Medical Center (UPMC) Shadyside and Children's Hospital, staff encourage patients and families to call for a RRT to address unresolved concerns about their safety and health.

Staff instruct patients and family members to pick up any phone in the hospital to report a Condition H (for "help") if they:

- Fear something is seriously wrong and have expressed their concerns without validating or recognizing its potential importance.
- Experience a communication failure with the staff.
- Become confused about the patient's care.
- Need to know where to voice concerns.
- Feel something about the patient's condition is "just not right."

(Grissinger, 2010)

Additional Threats to Safety and Quality

In addition to early warning signs of a patient's deterioration, inadequate staffing may threaten patient safety. Three of the American Association of Critical Care Nurses (AACN) Standards for Establishing and Sustaining Healthy Work Environments (2005) identify the need for safe staffing and the nurse's responsibility to persist in communicating and collaborating to resolve staffing and clinical issues:

- Staffing must ensure the effective match between patient needs and nurse competencies.
- Nurses must be as proficient in communication skills as they are in clinical skills.
- Nurses must be relentless in pursuing and fostering true collaboration.

(AACN, 2005)

Studies have identified concerns about patient care at end of life, and particularly futile treatment, as the #1 ethical issue for nurses (RN.com, 2012). When nurses raise these concerns using the chain of command, ethics committees, and other appropriate resources, the organizational culture becomes more sensitive to these important concerns.

When Staffing Places Patients at Risk

When you come on duty, you see that your unit has an unusually high number of fresh post-operative patients on this 7:00 PM – 7:00 AM shift. The unit is staffed as it is for most 7:00 PM – 7:00 AM shifts during the week, but with more fresh post-op and unstable patients, you think an additional RN is needed to give safe care.

You tell the charge nurse of your concerns. She tells you that she doesn't want to bother the supervisor because she knows the supervisor is trying to solve a staffing problem in the Emergency Department. She says she'll help out if she can.

You tell her that the situation is not safe and that she really needs to get an additional RN. She says, "I think we can handle it."

What will you do?

Getting Additional Help

You cannot risk participating in an unsafe situation just because the charge nurse is unwilling to ask the supervisor for additional help. You need to pursue the chain of command.

Tell the charge nurse that you will contact the supervisor because you cannot accept your assignment and you believe that the assignments of the other RNs are also unsafe because of the acuity of the patients and the number of patients assigned to each nurse.

Then contact the supervisor. Staffing is a priority for off-shift supervisors. The supervisor has a view of the staffing situation throughout the hospital and can reassign qualified staff to meet patient care needs. The supervisor also has access to the organization's float pool and temporary staffing resources.

Refusing to accept an unsafe assignment not only protects patients, but also calls attention to a problem and may help to prevent a recurrence of a similar situation in the future.

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A Need to Advocate for Your Patient

Your 90-year-old patient has pneumonia, C. diff infection, and worsening heart failure. She has a stage IV pressure ulcer on her sacrum. You observe signs of impending death, including difficulty swallowing, disinterest in food, increasing incontinence, and decreasing body movements. She is often restless and anxious.

Her son, for whom she has signed permission to receive her healthcare information, visits frequently and attempts to feed her, telling her “You’ve got to eat, Mom, to build yourself up so you can go home and climb the stairs up to your room.”

She often chokes on the food he attempts to feed her.

You tell him that you are concerned about her safety and that her difficulty swallowing creates a risk for choking and worsening pneumonia.

He tells you that she has to eat and get stronger so that she can go home and resume her normal activities. He says that her doctor told him she’s getting better.

You decide to ask her doctor to speak to her son and clarify his mother’s prognosis and current status. You believe that your patient deserves measures to manage her symptoms, a peaceful death, and that her son needs an opportunity to prepare for her death.

Advocating with Your Patient’s Provider

You call your patient’s doctor and state your observations and concerns. You ask him to clarify the situation with her son and order palliative care services. He says, “I’ve seen patients die faster with these hospice approaches. I’m not ready to tell her son to give up hope.”

You reiterate that you are especially concerned about her son’s insistence on feeding her, the need for comfort measures, and an opportunity for her son to prepare for her death.

The doctor tells you that he’ll tell her son to let the nurses feed his mother, but he plans to let it go at that.

What will you do next?

Advocating for Your Patient

You might consult with your staff nurse colleagues to validate your concerns. And then, after considering their input, pursue the chain of command.

You follow your organization’s P&P, which typically indicates the charge nurse as the first link in the chain.

Let’s suppose that the charge nurse says, “We’ll never get anywhere with that doctor, just forget about it and make our patient as comfortable as possible.”

You feel very strongly that palliative measures need to be ordered and that the patient’s son needs more accurate information.

The P&P identifies the Nurse Manager or Supervisor as the next contact in the chain of command. You bring your concerns to your Nurse Manager. The Nurse Manager contacts the doctor and expresses the concerns

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about quality of care. The doctor agrees to refer the patient to the palliative service and to be more candid with the patient's son about her prognosis.

Resolving Concerns at the Lowest Level

Although the chain of command specifies a hierarchical sequence of personnel to contact to resolve a problem, problems are best resolved at the lowest level with individuals directly involved.

Therefore, in this advocacy situation, the Nurse Manager communicated directly with the provider involved. Only if the situation remained unresolved after that communication would the Nurse Manager take further steps in the chain of command. The Nurse Manager's next step would be to contact the Chief Nursing Officer (CNO) or administrator on call if the CNO were not accessible.

The CNO would also attempt to resolve the situation with the provider involved, but if unsuccessful, the CNO would pursue chain of command by contacting the Chief of Staff or Chief Medical Officer for assistance in resolving the issue.

SBAR: A Communication Guide

Situation, Background, Assessment, Recommendations

The SBAR tool serves as a helpful guide for communicating concern about a patient's condition to the provider.

Some have expanded the "R" to also include rationale and ratification – that is, justifying and asking for endorsement of a course of action.

But the guide can be effective only when the nurse alertly identifies indicators of deterioration and assertively contacts the provider.

When beginning to use SBAR, some nurses have found it helpful to share their planned SBAR communication with a more experienced nurse colleague to refine the communication.

(IHI, 2014)

SBAR: Not only for Reporting to a Provider

Situation, Background, Assessment, Recommendations

Many healthcare organizations use SBAR as a protocol for hand-off communication. Use of SBAR can help you clarify your observations and recommendations and communicate them concisely.

Some organizations have incorporated SBAR into the electronic medical record.

SBAR has also proven helpful when communicating concerns to managers, administrators, and when formulating an ethical concern.

Many nurses are accustomed to a narrative style of communication, but providers and organization leaders seem to receive the SBAR communication better since it focuses only on pertinent details and recommended actions.

Some suggest "ISBAR," with "I" representing introduction to emphasize the importance of introducing yourself before beginning the SBAR communication.

(IHI, 2014)

The SBAR Tool

Situation

- Assess the patient.
- Discuss the situation with the Charge Nurse.
- Have the patient's record in hand.
- Determine how urgent the situation is: immediate, or can it wait?
- Identify which Healthcare Provider to call.
- Call and identify yourself, your unit, and the patient.
- State the problem you are calling about, "I'm calling because I'm concerned about . . ."

Background

- Check:
 - Recent Healthcare Provider orders
 - Standing orders
 - Healthcare Provider progress notes
 - Previous shift nurses' notes
- State why the patient is in the hospital and a brief synopsis of treatment to date.
- State:
 - Relevant assessment data: VS, pain level, labs, I&O, any significant pattern
 - Relevant physical assessment findings
 - Patient's mental status if relevant
 - Code status if critical situation
 - Allergies

Assessment

- Give your conclusions. "Might be" or "Could be" may be helpful, a diagnosis of the problem is not necessary.
- Relate your assessment findings to the problem.
- State again why you called: What is your concern?
- Identify how severe the problem is.

Recommendations

- State what you think would be helpful or needs to be done. What orders do you need?
 - Medications?
 - Diagnostic test? ECG?
 - Transfer to a higher level of care such as ICU?
 - MD evaluation?
 - Consultant evaluation?
- Read back any orders.
- Summarize conversation.
- Clarify monitoring or follow-up instructions, such as frequency of vital signs.
- Clarify under what circumstances to call back.

DOCUMENT _____

- Enter orders according to policy.
- Date and time of call.
- Who you spoke with.
- Brief summary of your report and Healthcare Provider's response.

SBAR for the Receiver

SBAR provides a structure for the sender of communication and also suggests attitudes and actions for a receiver of communication that maximize the effectiveness of the communication.

	Sender	Receiver in response to each step
S	Situation	Set aside assumptions
B	Background	Be attentive
A	Assessment	Ask questions
R	Recommendation	Reflect
R	Rationale	Respond
R	Ratification	Ratify

(IHI, 2014)

Assertiveness

Effective communication, especially in urgent situations, requires not only clarity, but also assertiveness.

Assertiveness begins with identifying clearly and specifically what you need and then asking for it in a courteous, professional manner.

Begin the communication by introducing yourself and the reason for the contact, such as “I need to give you an update...,” or “I am concerned about your patient Mr...”

With use of SBAR you will conclude with the specific orders or other response that you need, but a general statement of the reason for your contact is an assertive approach.

Remember your responsibility to advocate for your patient’s safety and high quality of care and to persist until the concern is resolved. Honor this responsibility and recognize that it is more important than fear of contacting an intimidating provider. Consult with your nursing colleagues to validate your concerns and plan your communication.

Documentation

Follow your organization’s P&P for documenting initiation of the chain of command.

P&P typically direct you to document the initiation of the chain of command and outcome

- Name of the person contacted with date and time.
- Assessment of the notification.
- Orders or directions received.

A Documentation Example

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If the nurse had initiated the chain of command in the NICU situation presented previously in this course, Nurse Attorney Smalls recommends this documentation:

4:00 p.m. 5FU ordered

4:15 p.m. Dr. Resident called and order for 5FU discussed and clarified times two.

On the MAR, the nurse could have indicated that she did not give the medication and noted:

4:30 p.m. Dr. Attending called.

4:35 p.m. Charge nurse at bedside

(Smalls, 2009)

Smalls emphasizes that documentation should not criticize the actions of another, or blame another individual. Simply report the facts which include the issue, the individuals notified, the time frames, and the outcome.

Conclusion

The Chain of Command Protects Your Patients and You has presented information to alert nurses to situations that call for use of the chain of command and has presented assertive strategies for responding to these situations.

After studying the course, you have learned:

The purpose of a healthcare organization's chain of command policy and the nurse's role in pursuing the chain of command.

Situations in which the nurse's correct response is to pursue the chain of command.

Effective communication techniques to address patient safety issues.

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