

2005 Showcase in Excellence Awards Recipient

Banner Thunderbird Medical Center – “Critical Rescue Team”



Testimonial of Value of the AZ State Quality Awards Program

Banner Thunderbird Medical Center is proud to have been selected as a 2005 Showcase in Excellence Award recipient. The AQA process provides organizations opportunities for constructive feedback from external sources experienced in process improvement.

Highlights of Organizational Process:

The ability to provide safe patient care at Banner Thunderbird remains an essential focus throughout the organization and remains consistent with Banner Health’s mission of making a difference in people’s lives through excellent patient care. The 2nd annual HealthGrades (2005) American hospitals found 1.18 million patient safety incidents throughout 2001, 2002, and 2004, with an annual Medicare cost of \$3 billion dollars. A major factor within this study was safety incidents related to failure to rescue and contributes to over 60,000 deaths every year in Medicare patients under the age of 75. Failure to rescue was first identified from research done by Aiken, et al. (2002), Clarke & Aiken (2003) and relates to nurses who fail to recognize or fail to act on signs and symptoms of deterioration noted in patient status.

The first step in the process consisted of assessment of the problem and correlation to the situation as it is and recognizing the barriers or problems to implement a change. Assessment of this nature requires having the right individuals who could give a realistic assessment of the problem. The steering team at Banner Thunderbird consisted of: the critical care clinical nurse specialist, the critical care intensivist (physician), the medical director of the hospital, staff nurses, critical care and nursing unit directors, pharmacist, case management, and quality assurance specialist. Key to this process was a needs assessment done using validated tools of research. The team utilized a tool from the Institute of Healthcare (IHI) to evaluate possible improvements in failure to rescue.

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Type of work: Patient safety

Workforce: 20

Assessment also needed to be consistent with core values of Banner Health in considering people or our customers, excellence, and measurable outcomes to the program. The development of the rapid response team included assessment in meeting the needs of all customers including physicians, payors, nurses, and most importantly the patient. Two areas of concern in the assessment phase consisted of communication of assessment needs to physicians and additional resources for the bedside nurse when the patient is showing signs of deterioration.

The second step was to develop a plan of *tactical change* from what is, to what is to be. Planning requires intensive research of evidence based practice and research of other successful programs as a methodology in implementing change. An extensive literature search revealed medical models in which physicians led the initiative and team. Rapid response teams were found primarily in teaching facilities where there were an abundance of interns and residents present on a 24/7 basis. Community hospitals found frequent problems in starting up programs without the support of 24-hour physician coverage. Therefore, Banner Thunderbird decided to take a nursing approach: where nurses would take the primary leadership role in the development, implementation, and assessment of the program. This team identified and recruited members of the rapid response team, which included experienced critical care nurses, respiratory therapist, and critical care physicians (intensivists). A collaborative approach was taken among all these specialties in developing education programs and outcome measures. The planning phase recognized the need to develop a communication tool, which defines expectations for what and when information is to be communicated in a timely manner. An effective tool found within the literature is the SBAR method and was developed by Dr. Michael Leonard in Greeley Colorado. Note pads were developed to be distributed throughout the hospital facility (see below).

The last and final stage consisted of continued evaluation and renewal of the program. Banner Thunderbird prides itself in being a learning organization and continues to assess and reassess programs that have been developed. An essential component in this process is to build in feedback loops to provide knowledge, which can be used to improve the program and/or identify barriers. The final stage also included renewal, which has been repeated with additional education to both medical and nursing staff. The rapid response concept is presented in the orientation process for all employees (including physicians). The renewal process also involves a recognition program to single out individuals who have contributed to the rapid response team success.

The rapid response process improvement at Banner Thunderbird remains an ongoing process and requires continued dedication of all stakeholders. The outcome measures demonstrate the need to consider the rapid response team concept as an important patient safety goal, which is weaved into the foundation of complex healthcare organizations. The rapid response team concept is enhancing the culture of a learning organization and enhancing the ability to provide high reliable patient care. While the concept of a rapid response team is not new, the way in which our community-based hospital with limited resources has organized, implemented, and embraced our Critical Rescue Team provides a resource to other hospitals.