Patient Red Flags: Preventing Failure-to-Rescue
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**Problem:** Communication between caregivers and patient decline.

Teamwork and communication among nursing staff is essential for the detection and management of early warning signs of patient decline to prevent FTR. As registered nurses (RNs) in the Neuro-trauma Progressive Care Unit, we care for acutely injured patients who are at high risk for clinical decline. After review of unit-based quality indicators of FTR, we recognized the importance of timely communication of pertinent patient assessment data between all members of the healthcare team.

**Evidence:** After review of unit-based quality indicators of FTR, we recognized the importance of timely communication of pertinent patient assessment data between all members of the healthcare team.

**Strategy:** To help prevent FTR, we developed a quality improvement project titled “Patient Red Flags – Preventing Failure-to-Rescue.” Enhanced education for our nurse aides (NAs) emphasizes timely reporting of “patient red flags” and focuses on personal and team relationships to enhance communication. To avoid a delay in the communication of abnormal vital signs, we designed a system for timely reporting of abnormal vital signs by NAs so RNs could respond quickly to changes in patient status and implement necessary interventions.

**Practice Change:** Enhanced education practices for both the RN and the Nursing Assistant. Both staff are educated on Failure-to-Rescue as it relates to the job role. We developed specific educational in services for the RN and the NA. As a result of ongoing education for the NA we have developed new orientation practices as well. The NA orientee will have a structured orientation with an RN, as their preceptor, for a set amount of weeks and then transition to orient with another NA.

**Evaluation:** Following project implementation we demonstrated improved FTR patient outcomes including decreased numbers of unplanned transfers to the intensive care unit and for those transferred, a decrease number requiring mechanical ventilation. We also identified unit-specific FTR risk factors, allowing for increased staff vigilance with these subpopulations on the unit. We identified decrease in HAI’s and Nurse Sensitive Indicators. Patient satisfaction also increased. By enhancing the education of the NA along with recognizing they are an integral part of our team, through staff feedback and staff satisfaction we concluded increased accountability, teamwork and communication amongst all staff members.
**Recommendations:** Be very patient. Change takes time and work. Pilot each standard of change and let the staff be the leaders of that change.

**Lessons Learned:** As you transform care on the unit it is very important to keep in mind that transformation will work if the staff are committed to accepting the challenge. As manager’s we may see the problem but the staff need to recognize there is a need for change. If not all staff are on board you meet resistance and it becomes difficult. Persistence is the key to excellence.

**Bibliography:**

