Knowledge for nursing practice -

Management of the changing patient

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Assumptions

Graduates of accredited undergraduate nursing programs have had curricular content on the changing patient condition. However, not all programs are identical in what is taught and experienced in the clinical setting. Some assumptions about the nurse resident's pre-licensure preparation are outlined below. To avoid either duplicating content from nurse residents' undergraduate programs and/or omitting content essential for safe nursing care, these assumptions should be considered when designing nurse residency program workshops and seminars.

In 2021, AACN released new Essentials across ten domains that are broad, distinguishable areas of competence that constitute a descriptive framework for nursing practice when aggregated. It will take time for nursing schools to incorporate these new Essentials into their curriculum. For the Vizient/AACN Nurse Residency Program™ (NRP), we will provide context for the 2021 Essentials to bridge the gap as nursing schools transition.

2021 AACN Essentials

For this unit, assume that nurse residents can:
1.3 Demonstrate clinical judgment founded on a broad knowledge base
1.3a Demonstrate clinical reasoning
1.3b Integrate nursing knowledge and knowledge from other disciplines and inquiry to inform clinical judgment
1.3c. Incorporate knowledge for nursing and other disciplines to support clinical judgment
2.2 Communicate effectively with individuals
2.3 Integrate assessment skills into practice
2.3c. Perform a clinically relevant, holistic health assessment
2.3e. Distinguish between normal and abnormal health findings
2.3g. Communicate findings of a comprehensive assessment
2.4 Diagnose actual or potential health problems and needs
2.4a. Synthesize assessment data in the context of the individual's current preferences, situation and experience
2.4b. Create a list of problems/health concerns
2.4c. Prioritize problems/health concerns
2.4d. Understand and apply the results of social screening, psychological testing, laboratory data, imaging studies, and other diagnostic tests in actions and plans of care
2.5 Develop a plan of care

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2.5c. Prioritize care based on best evidence

2.5d. Incorporate evidence-based interventions to improve outcomes and safety

2.5e. Anticipate outcomes of care (expected, unexpected, and potentially adverse)

2.5f. Demonstration rationale for plan

2.6 Demonstrate accountability for care delivery

2.6b. Communicate care delivery through multiple modalities

2.6c. Delegate appropriately to team members

2.6d. Monitor the implementation of the plan of care

2.7 Evaluate outcomes of care

2.7a. Reassess the individual to evaluate health outcomes/goals

2.7b. Modify plan of care as needed

2.7c. Recognize the need for modifications to standard practice

2.9 Provide care coordination

c. Promote collaboration by clarifying responsibilities among individual, family and team members

d. Recognize when additional expertise and knowledge is needed to manage the patient

e. Provide coordination of care of individuals and families in collaboration with care team

6.1 Communicate in a manner that facilitates a partnership approach to quality care delivery

a. Communicate the nurse's roles and responsibilities clearly

b. Use various communication tools and techniques effectively

6.2 Perform effectively in different team roles, using principles and values of team dynamics

a. Apply principles of team dynamics, including team roles, to facilitate effective team functioning

b. Delegate work to team members based on their roles and competency

c. Engage in the work of the team as appropriate to one's scope of practice and competency

8.4 Use information and communication technology to support documentation of care and communication among providers, patients and all system levels.

a. Explain the role of technology in enhancing clinical information flows

b. Describe how information and communication technology tools support patient and team communications

c. Identify the basic concepts of electronic health, mobile health and telehealth systems in enabling patient care

d. Explain the impact of health information exchange, interoperability and integration of health care

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(American Association of Colleges of Nursing, 2021)

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Strategies for success

NRP Coordinators can consider accessing the following resources in advance of delivering content to nurse residents related to management of the changing patient. These resources are supplemental to the curriculum content provided here and may provide additional context and applicability for discussion about self-care management, education methods, and health literacy.

Clinical judgment assessment tools:

Tanner's Clinical Judgment Model & Lasater's Clinical Judgment Rubric (Lasater, 2007a ; Lasater et al., 2015; Tanner, 2006)

On the Vizient/AACN Nurse Residency Program™ website, there are customizable slide decks for presenting this topic.

See specialty case studies and simulations on the Vizient/AACN NRP website.

The PEARLS Healthcare Debriefing Tool was created to aid discussions after a clinical encounter or simulation scenario, enhancing clinical practice (Bajaj et al., 2018).

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Objectives

Seminar content, as well as clinical and other learning experiences, enable nurse residents to achieve the leadership skills needed to:

1. Apply parameters of the nurse's scope of practice in response to a change in the patient's condition as a member of the interprofessional team.

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Introduction

A nurse is responsible for recognizing and managing patients' changing conditions to prevent complications and ensure positive outcomes. Nurses collect patient data from multiple sources and analyze to coordinate care, implement care decisions, evaluate patient responses and communicate the information to other members of the health care team. The nursing process guides the nurse when gathering and analyzing information. It is an effective method of problem solving and provides a framework with which to make informed decisions regarding a patient's plan of care.

This curriculum content is intended to further enhance the nurse resident's knowledge and ability to critically assess and evaluate clinical changes and develop a plan of care based on sound clinical judgment and intervene when patient conditions are changing. The nurse resident will use evidence-based practices that apply standards of care, policies and procedures when caring for a patient whose condition is changing.

Critical thinking, clinical reasoning and clinical judgment

Nurses are natural innovators, required to question and explore new approaches to resolve challenging scenarios in both clinical and non-clinical settings. The nursing process of assessment, diagnosis, outcomes identification, planning, implementation and evaluation, is a critical thinking framework that provides structure to the dynamic challenges in nursing (American Nurses Association, 2021). Nursing students use the nursing process as a foundation for recognizing and understanding the evolution of symptoms and implications of changing clinical manifestations, and the expected nursing interventions required to effectively manage the changing patient.

Just as new graduate nurses transition from nursing students to professionals, they are also transitioning from growing theoretical knowledge to growing practical knowledge. Practical knowledge is built with clinical experience and is not always straightforward. Growing practical nursing knowledge requires the nurse to think about theoretical nursing knowledge in a different way, many times requiring the agility to consider what was once black and white with a different perspective (Tanner, 2006). This gray area thinking is frustrating to new graduate nurses because they crave structure and predictability as they are building confidence (Benner, 1982). Considering practice in a different way may involve examining the nursing process in a different way as well.

Many evidence-based approaches, tools and recommendations have been published with varying terms outlining each step of the problem-solving and patient care process. Often, the terms critical thinking, clinical judgment and clinical reasoning are used together, if not interchangeably. It is important to understand the differences to target growth for each.

Critical thinking

Critical thinking is the broad cognitive skill of analyzing, evaluating and synthesizing information to base decision-making on evidence and reasoning. It is the skill and framework necessary to make informed and thoughtful decisions. A nurse who is thinking critically begins with an open mind, removing biases and assumptions and considering alternative

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perspectives. They choose the priority concerns to focus on and ensure credibility of the information they are given, not taking it at face value. A critical thinker knows how to ask the right questions to obtain the information they need and differentiate applicable information (Persky et al., 2019; Sherman, 2022).

Clinical reasoning

Clinical reasoning is a more specific form of decision making that leverages clinical expertise and critical thinking abilities to achieve optimal patient outcomes. Clinical reasoning includes the intentional process of considering different options, evaluating them based on available evidence and selecting the most suitable. Additionally, it involves recognizing patterns, intuitively grasping clinical nuances and responding without explicit premeditation, which can be termed as practical reasoning (Tanner, 2006).

The enhancement of critical thinking and clinical reasoning skills occurs by repeatedly applying the essential knowledge learned in nursing school to actual patient care experiences with the support of a strong preceptor and mentor. The following are methods for growing critical thinking and clinical reasoning skills:

Listen to the patient and family!

"Being able to think critically enables nurses to meet the needs of patients within their context and considering their preferences" (Benner et al., 2008).

- **Assess your perspective and keep an open mind**: It is tempting to assume that the most apparent issue is responsible for the patient's deterioration. Nurses rely on their accumulated experiences to guide decision-making. Consider how one's perspective may affect their approach to a clinical situation. For instance, if a nurse went through the death of a loved one in a hospice setting, where the experience was peaceful and the family didn't display overt emotions, how might this nurse react when faced with a patient's family expressing more visible grief? Would this kind of reaction appear unusual?

- **Know the norm**: Repetitive exposure to patients that are within normal limits lays a foundation for recognition of abnormal findings.

- **Ask questions**: If something doesn't add up, question it. If you don't have enough information, keep asking! If you can't find the answer yourself, ask someone else such as a preceptor or other experienced nurse.

- **Engage in predictive thinking**: An effective strategy for enhancing critical thinking is to make predictions about patient outcomes in relation to the care provided. For example, if you administer 50mEq of potassium, what increase in their total potassium levels do you expect? When you communicate a patient's changing condition to a healthcare provider, what orders do you anticipate in response? A patient's hemoglobin a1C has significantly increased from a previous visit. What could be factors contributing to the increase and what plan of care modifications would be indicated based on the result? By recording these predictions and their outcomes, you can rapidly accumulate a bank of experiences, thereby accelerating the development of critical thinking skills.

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Clinical judgment

Clinical judgment is action-oriented and takes the information obtained using critical thinking, then clinical reasoning and applies it to the scenario at hand. Clinical judgment includes consideration of patient preferences, availability of resources, health history and other factors, to come to a decision on the correct action to take (Tanner, 2006). It is focused on the evaluation process required for nurses to engage in clinical decision-making (Lasater, 2007a).

Tanner's Model of Clinical Judgment (2006) is a framework for breaking down clinical judgment to focus on each step in the process. The model calls out four aspects of clinical judgment:

- **Noticing**: Noticing is not an automatic result of assessing a patient but is also influenced by the nurse's expectations of the situation. The nurse's knowledge of the patient, similar cases, exposure to excellent practice, the culture of the care setting, complexity of the work environment and overall nursing knowledge will collectively shape their ability to notice changes in the patient's condition. For example, a nurse who is working with a team to perform a procedure on a patient will have a set of expectations based on previous experiences, if any.

- **Interpreting**: After noticing, the nurse must use their clinical reasoning skills to generate hypotheses and perform additional assessments until a suitable interpretation supporting the collected data emerges.

- **Responding**: Once the nurse solidifies their interpretation, they use further clinical reasoning skills to respond in the appropriate manner.

- **Reflecting**: Reflecting-in-action involves the nurse's ability to continually assess and interpret how a patient is responding to their nursing interventions and adapt accordingly. Reflecting-on-action involves deliberate reflection following the event. Reflection is crucial in the development of clinical knowledge and clinical judgment.

Establishing a foundation of knowledge to support the development of nursing practice is challenging and takes time. In a supportive environment, every situation presents an opportunity for learning. Debriefing and time spent in reflection after a challenging patient situation is crucial for validating that you're learning at an appropriate pace, but also so that you can learn from each scenario. Through reflection, nurses gain insights from the experience, enabling them to differentiate between sound decisions and regrettable ones. This process adds to their clinical knowledge, thereby affecting their ability to notice, interpret and respond appropriately (Lasater, 2007b; Monagle et al., 2018; Wiles, Simko, & Schoessler, 2013).

The changing patient

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Recognizing a changing patient

Early detection and interventions are key elements for patient safety. There are two ways to categorize changes in a patient: objective and subjective. Objective changes encompass measurable data, including changes in vital signs or mental status, sudden and significant increase in pain level or quality and critical lab results. Objective data is the beginning of the story, but critical thinking is needed to be able to understand the full picture. Subjective changes typically involve a patient or family report that there has been a change. It can be more difficult to act based on subjective data alone, so perseverance is important in these situations.

Often, new graduates understand that a patient is changing, whether it be because of a gut feeling (also called nursing intuition), family report or small amount of data. With a lack of experience, it is difficult to ascertain appropriate next steps or relevant data to communicate. Gathering pertinent information and resources and communicating the change are important next steps in ensuring the patient is safe and the interprofessional team has the information needed to collaborate on a plan of care.

Observing trends is another way to recognize that a patient is in decline. Often, patients are in decline for hours, and even days, before they have an event that alerts the nurse. When reviewing a patient's chart, take into consideration the past few hours and days' worth of results. If a blood pressure has been declining, oxygen usage increasing, or agitation has been building, these are all trends of decline. It should be noted that the opportunity to notice decline in the outpatient setting can be limited.

What are the steps to take if concerned that a patient is unstable? Review the organization's policy and identify the appropriate nursing actions and resources to use.

Before collecting data, nurses should first determine if the patient is stable or unstable, and call for help, if needed. In most ambulatory care settings, this will involve calling 911 and notifying the onsite provider. Completing the primary assessment of ABCD: airway, breathing, circulation and disability will help determine stability. New graduate nurses should ask for help for the next steps if unsure at this stage by activating the care area's emergency response protocol. The nurse should never leave the patient if there is a concern for instability. Care of the patient needing immediate care is discussed in more detail below.

Gather information and resources

Patient assessment is necessary to fill in the gaps in information. Clinical judgment is key in knowing the type of assessment to perform. There are three main assessment types to help the nurse in gathering information:

- **Doorway assessment**: The doorway assessment, or 60 second assessment, allows the nurse to quickly identify key elements of the patient's condition observable without much effort. Examples of what a nurse might assess in 60 seconds include level of consciousness, speech, respiratory pattern, level of agitation, pacing, pain, color or pallor, bedside monitors, pumps or devices, and safety checks such as bed alarms or side rails. Often, a 60-second doorway assessment can lead to a gut feeling or spark in nursing intuition.

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- **Problem focused assessment**: Problem-focused assessments are most often the next step following recognition of a health issue. This exam focuses on the specific body system(s) in which the changes have occurred, including new signs and symptoms. This targeted approach to assessment streamlines the information gathering process, avoiding unnecessary collection of irrelevant data. In the ambulatory setting, this may include performing an assessment over the telephone such as during telephone triage. The disposition of the patient is determined following this assessment. For example, does the patient need to go to the Emergency Department or schedule a same day appointment?

- **Complete head to toe assessment**: This comprehensive assessment is usually conducted upon admission or initiation of care to create a thorough baseline assessment for the patient.

After the assessment, ensure that all necessary information required to communicate the concern has been gathered. Key items required for communication of the patient status are code status or advance directive, recent vital signs, current medications, including any recent changes, lab and test results, and the patient's last known normal. Evaluating the trends of these findings is essential as a single result may not be significant. Involving the family in the conversation may be helpful, especially if they were present when the change occurred.

Once the assessment is complete, the nurse uses clinical judgment to decide on the appropriate actions. At this time, they may begin to delegate to other nurses, nursing assistants or other unlicensed assistive personnel while preparing the patient for the next intervention or transfer to a higher level of care. Table 1 highlights expected next steps according to affected body system, but always follow the organization's policies and protocols.

Table 1: Expected nursing interventions for emergent alterations

Affected body system	Expected interventions
Respiratory system	Maintain airway, administer oxygen, raise the head of the bed or exam table or place patient in a sitting position. If indicated, ensure suction is available, continually assess vital signs, continuous pulse oximetry and end tidal carbon dioxide monitoring if available, blood gases and applicable labs
Cardiovascular system	12-lead echocardiogram (EKG), assessment for dysrhythmias, chest pain or shortness of breath, monitor electrolytes, continuous vital signs and cardiac monitoring if available, lab work, administer medications per policy
Neurological system	Maintain airway, monitor for changes in level of consciousness, frequent neurological exams, continually assess vital signs, blood glucose, stroke or seizure protocols if applicable
Psychosocial	Assess for signs of agitation, aggression or self-harm, ensure safety of self and others, implementing de-escalation techniques, administering medications per policy
Obstetrical	Maintain airway, continually assess vital signs, continuous pulse oximetry and fetal monitoring, oxygen if applicable, anticipate expedited delivery, maintain IV infusion through large bore IV, begin treatment protocols per policy if applicable

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Communication of the changing patient

Timely communication of a change in patient condition is critical for interprofessional collaboration for patient safety. The nurse, as the primary advocate for the patient at the point of care, holds a pivotal role in this process. Even if the etiology of the problem is unknown or important information is missing, the nurse must be able to effectively communicate the situation. This includes prompt notification of the care team as well as thorough documentation. Depending on the organization or shift, the nurse may be speaking to an on-call provider or new care team that is unfamiliar with the patient.

Some common communication pitfalls include:

- **Too many superfluous details**
- **Notifying provider before obtaining all necessary information**
- **Not including a recommendation**

What is the difference between a concise SBAR report and handoff communication?

The Interprofessional Communication chapter contains content for SBAR and I-PASS tools as well as best practices for using assertive communication and chain of command (Haig et al., 2006; Shahid & Thomas, 2018; Starmer et al., 2013; Vizient Inc., 2024).

Documentation of the event should occur as quickly as possible. Many documentation elements, such as vital signs, can be delegated. Sometimes, newly licensed nurses are nervous to document vital signs outside of normal range, opting to chart a normal value after treatment (e.g., charting oxygen level after applying nasal cannula). It is important to document the observed value, even if it is outside normal range to communicate the full picture to the care team. The nurse should take care to document the provider notified, the concern communicated, any response or action taken because of the communication, the patient's response to treatment when indicated, patient and family teaching and other pertinent information.

Managing yourself in chaotic situations

In a learning environment, simulated activities are a valuable means to refine the skills necessary for appropriate response to patient events. While simulation is highly effective in providing opportunities to practice skills and build clinical knowledge, the impact of stress in a real-world setting cannot be overstated (Norris et al., 2023). The brain's response under stress is not the same as the brain in a non-stressful situation. When stressed, the amygdala can override the prefrontal cortex, causing anxiety and scattered thoughts. It can cause situational paralysis and uniquely reduce the brain's ability to quiet distractions (Park et al., 2016). Possessing the tools to refocus on the situation is essential for

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ensuring patient safety. The following are some ways to decrease the occurrence of situational paralysis in a changing patient scenario.

- **Mindfulness techniques**: Whether it is taking physical movement, deep breathing, a mantra, or any other mindfulness activity, it is important to understand an approach that works to refocus.
- **Exposure**: Take advantage of changing patient scenarios by participating whenever possible.
- **Plan**: Higher acuity patients require extra caution, so when assessing your patients and noticing trends, identify which patient is at the most risk for decline. What would happen if they were to decline? How would they present? What would the next steps be? In the ambulatory setting, the nurse may educate the patient and family on identifying health changes and developing a response plan.
- **Manage the environment**: Assess the number of personnel in the room, unneeded equipment, belongings and noise. Also, review the organization's policy for family presence during emergencies. It is important that the family be taken care of during an emergency, and understanding the policy can ensure that the process is efficient.
- **Perseverance:** Being in chaotic situations can be unsettling, and not everyone naturally thrives in emergencies. In such circumstances, whether facing chaos or experiencing situational paralysis, the dedication to persist is crucial, not only for ensuring patient safety but also for clinical knowledge and personal growth (Seibert, 2021).
- **Debriefing:** After involvement in a decompensating patient scenario, it is important to spend time in a group and individually identifying what went well and what could have gone better. Identifying and addressing learning opportunities can prevent them from occurring again.

Management of a patient needing immediate care

If upon the assessment, it is determined that the patient is unstable and is in immediate need of care, the nurse must decide the appropriate next actions. Rapid response teams (RRTs), code teams, behavioral health teams and emergency medical services (EMS) exist to support resuscitation and decision-making when needed. Not all ambulatory care settings with have access to these response teams, but all personnel should be familiar with an alternative plan for intervention based on available resources.

- **Rapid response team:** The rapid response team was created as a catalyst for early identification and intervention for deteriorating patients outside of the ICU. Support for these teams stems from the knowledge that patients often deteriorate over time and exhibit changes before a patient goes intro cardiopulmonary distress. The RRT is often made up of a critical care nurse and respiratory therapist, with a physician as backup if needed (AHRQ, 2019). Refer to the organization's policy for rapid response to review criteria for calling and team members.

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- **Code team:** The code team responds to cardiac arrest, airway emergencies or other events depending on organizational policy. The team is expanded from the rapid response team, adding physicians, pharmacists, and other professionals according to the setting.

- **Behavioral emergency response team:** The behavioral emergency response team includes team members who have been trained to assist in the safe management of situations in which a person's behavior poses a risk to themselves or others using evidence-based techniques. The team responds with the goal of de-escalating, ensuring safety and providing care or support to the individual in crisis.

- **Emergency medical services:** Some care settings rely on EMS as their emergency response plan when immediate medical care and transportation to a higher level of care is required.

Barriers to calling for help

It is important to address that making the decision to activate a rapid response, code blue, or behavioral response team can be challenging, even when comprehensive data has been collected and an SBAR has been prepared. Common barriers are listed below.

- **Fear of being wrong**: There is always a possibility of making a mistake. However, if there is compelling information or strong intuition that something is wrong, as the patient's advocate, it is the role of the nurse to notify the care team.

- **Rejection, disagreement or indifference**: This situation is distinct from the fear of being wrong because the primary issue here is that the nurse feels as if the concern is not being acknowledged. In this situation, it is important to use assertive language to clearly communicate the concern, ensuring that the person comprehends. It is acceptable to request an explanation to gain a better understanding of why a provider is choosing not to take immediate action (Clayton, 2019). The Interprofessional Communication chapter contains content on using the chain of command, which nurses should be familiar with at their organizations.

- **Lack of confidence**: This is where a thoughtful SBAR and assessment and a supportive preceptor can be very beneficial. The new graduate can also validate concerns with another nurse or charge nurse before making a call to a provider.

(Burke, Downey & Almoudaris, 2022; Murray, Sundin & Cope, 2020; Tilley & Spencer, 2020)

During the event

Once the team has been notified, the primary nurse should stay with the patient and begin to appropriately delegate roles to other nurses and any assistive personnel as the emergency response team is arriving. The nurse should be ready to

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communicate the patient's situation and background to the team upon arrival and should have the chart open, ready to communicate any other pertinent information as necessary.

For a newly licensed nurse, recognizing personal strengths, weaknesses and competency is essential for self-advocacy in this role. For example, the nurse should inform the team if assigned to operate the cardiac defibrillator when training has not occurred. Assigning roles at the beginning of the shift is a common practice of charge nurses for clarity in the event of a code.

Depending on the event, nurses should adhere to the organization's policy, scope of practice guidelines and national guidelines for appropriate care for the patient.

Post event

Following a patient event where intervention is required, the nurse must consider the appropriate next steps. The organization's policy or standard work will outline the appropriate next steps. A preceptor, mentor, charge nurse or house supervisor are resources that can be used to guide a newly licensed nurse through the process.

Documentation

Following any code scenario, regardless of its nature, documentation of the event is critical. The accurate recording of the event in the appropriate areas in the electronic health record is essential for communicating the event to the care team. Various electronic health records have special alerts in system that can be used to alert the care team to the event. Many times, separate paper or electronic forms require completion and signatures as well. Post-code documentation ensures that critical information is accessible to all relevant healthcare professionals for informed decision-making and ongoing patient care. The nurse should adhere to organizational policy and request assistance when needed to ensure completion of these documents.

Debriefing

Debriefing after an event, regardless of the type is an important practice for nurses. Immediately following an event, or hot debriefing, is a type of debriefing that occurs shortly after the code event. It is conducted while the participants' memories and emotions are still fresh and can provide real-time feedback on the event. The purpose of a hot debrief is to examine the code, assess the team's response, identify strengths and weaknesses and discuss areas for communication and clinical performance improvement. The PEARLS Healthcare Debriefing Tool was created to aid discussions after a clinical encounter or simulation scenario, enhancing clinical practice (Bajaj et al., 2018).

Plan of care

After a patient has a code event of any kind, the plan of care may need to be modified. There may be medication changes, new activity restrictions, transfer to a different level of care or a change in goals among others. It is important

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that these changes in the plan of care are properly documented and communicated to the care team. Nurses can do this by ensuring proper EMR documentation, patient and family education and thorough shift reporting.

Self-care

Debriefing after events is also important for self-care and the wellness of the care team. In 2020, the AHA added a recommendation for debriefing after a cardiac arrest event for rescuers to the Guidelines for CPR and ECC (AHA, 2020). This is important because of the emotional distress and posttraumatic stress related to managing clinical emergencies. Team debriefings can serve as a platform to acknowledge stressors associated with caring for patients near death or experiencing clinical emergencies.

An example of The Pause:

"Could we stop and honor this patient who was alive prior to coming in here, who was loved by others, who loved others, who had a life—and also take the moment to honor all the efforts we put into caring for the patient? I ask that we hold the space, to honor this patient in your own way and in silence."

The Pause is a practice developed by Jonathan Bartels, a registered nurse, which is implemented after the death of a patient, with the goal of offering closure and respect to the health care team and the patient (2014). It serves as a moment to mark the significance of this event and allows for personalization without imposing beliefs on others. Any member of the team can request a Pause and many teams are committed to offering it after a patient death. The Pause involves a brief period of silence to honor the person who has passed and the efforts of the medical team.

Nurses have a critical role to recognize and manage changing patient conditions to ensure optimal outcomes and prevent complications. Support, experience and time are required to grow the skills of critical thinking and clinical reasoning to improve clinical judgment for making decisions in complex patient care scenarios.

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References

Agency for Healthcare Research and Quality. (2019). Rapid response systems. https://psnet.ahrq.gov/primer/rapid-response-systems#:~:text=Rapid%20response%20teams%20represent%20an,%2C%20cardiac%20arrest%2C%20or%20death.

American Association of Colleges of Nursing. (2021). *The essentials: Core competencies for professional nursing education*. Retrieved April 13, 2023, from https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

American Heart Association. (2020). *Highlights of the 2020 American heart association guidelines for CPR and ECC*. https://cpr.heart.org/-/media/CPR-Files/CPR-Guidelines-Files/Highlights/Hghlghts_2020_ECC_Guidelines_English.pdf

American Nurses Association. (2021). *Nursing: Scope and standards of practice, 4th edition.*

Bajaj, K., Meguerdichian, M., Thoma, B., Huang, S., Eppich, W., Cheng, A. (2018). The PEARLS healthcare debriefing tool. *Academic Medicine*, 93(2), 336. https://doi.org/10.1097/ACM.0000000000002035

Bartels, J. B. (2014). The pause. *Critical Care Nurse, 34*(1), 74-75. http://dx.doi.org/10.4037/ccn2014962

Benner, P., (1982). From novice to expert. *American Journal of Nursing*, 82(3), 402–407.

Benner, P., Hughes, R.P., & Sutphen, M. (2008). Clinical reasoning, decision making, and action: Thinking critically and clinically. In R.G. Hughes (Ed.) *Patient safety and quality: An evidence-based handbook for nurses* (pp. 1-87 - 1-109). Agency for Healthcare Research and Quality.

Black Parker, C., Calhoun, A., Wong, A. H., Davidson, L., & Dike, C., (2020). A call for behavioral emergency response teams in inpatient hospital settings. AMA Journal of Ethics, 22(11), E956-964. doi: 10.1001/amajethics.2020.956.

Burke, J. R., Downey, C., & Almoudaris, A. M. (2022). Failure to rescue deteriorating patients: A systematic review of root causes and improvement strategies. *Journal of Patient Safety*, 18(1), e140–e155. https://doi.org/10.1097/PTS.0000000000000720

Clayton, W.R. (2019). Overcoming barriers impeding nurse activation of rapid response teams. *OJIN: The Online Journal of Issues in Nursing*, 24(3), https://doi.org/10.3912/OJIN.Vol24No03PPT22

Embler, P. (2021). Imparting clinical judgment leading to sound clinical decision-making and patient advocacy. Health. https://www.wolterskluwer.com/en/expert-insights/imparting-clinical-judgement#:~:text=Clinical%20judgment%20is%20the%20accumulation,patient%20outcomes%3B%20clinical%20decision%20making

Fink R. (2000). *Pain* assessment: The cornerstone to optimal pain management. *Proceedings (Baylor University. Medical Center)*, *13*(3), 236–239. https://doi.org/10.1080/08998280.2000.11927681

Haig, K.M., Sutton, S., & Whittington, J. (2006). SBAR: A shared mental model for improving communication between clinicians. Joint Commission Journal on Quality and Patient Safety, 32(3), 167-175. https://doi.org/10.1016/s1553-7250(06)32022-3

Lasater, K. (2007a). Clinical judgment development: Using simulation to create an assessment rubric. *Journal of Nursing Education*, 46(11), 496-503. https://doi.org/10.3928/01484834-20071101-04

Lasater, K. (2007b). High-fidelity simulation and the development of clinical judgment: Students' experiences. *Journal of Nursing Education*, 46(6), 269-276. https://doi.org/10.3928/01484834-20070601-06

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Lasater, K., Nielsen, A. E., Stock, M., & Ostrogorsky, T. L. (2015). Evaluating the clinical judgment of newly hired staff nurses. *Journal of Continuing Education in Nursing*, 46(12), 563-571. doi:10.3928/00220124-20151112-09

Loughlin, P. C., Sebat, F., & Kellett, J. G., (2018). Respiratory rate: The forgotten vital sign- make it count!. *The Joint Commission Journal on Quality and Patient Safety,* 44(8). https://doi.org/10.1016/j.jcjq.2018.04.014

Monagle, J.L., Lasater, K., Stoyles, D., & Dieckmann, N. (2018). New graduate nurse experiences in clinical judgment: What academic and practice educators need to know. *Nursing Education Perspectives*, 39(4), 201-207. https://doi.org/10.1097/01.NEP.0000000000000336

Murray, M., Sundin, D., & Cope, V. (2020). A mixed-methods study on patient safety insights of new graduate registered nurses. *Journal of Nursing Care Quality*, 35(3), 258–264. https://doi.org/10.1097/NCQ.0000000000000443

Norris, H., New, K., Miller, B., Kramer, M., Fultz, J., Arthur, C., Smoot, B., & Rogers, A. (2023). Preparing new graduate nurses for patient rescue: An experimental quantitative study. *Journal for Nurses in Professional Development*, 39(2), E20–E24. https://doi.org/10.1097/NND.0000000000000840

Park, J., Wood, J., Bondi, C., Del Arco, A., & Moghaddam, B. (2016). Anxiety evokes hypofrontality and disrupts rule-relevant encoding by dorsomedial prefrontal cortex neurons. *The Journal of Neuroscience*, 36(11), 3322–3335. https://doi.org/10.1523/JNEUROSCI.4250-15.2016

Persky, A. M., Medina, M. S., & Castleberry, A. N. (2019). Developing critical thinking skills in pharmacy students. *American Journal of Pharmaceutical Education*, 83(2). https://doi.org/10.5688%2Fajpe7033

Seibert, S. A. (2021). Problem-based learning: A strategy to foster generation Z's critical thinking and perseverance. *Teaching and Learning in Nursing*, 16(1), 85–88. https://doi.org/10.1016/j.teln.2020.09.002

Shahid, S. & Thomas, S. (2018). Situation, background, assessment, recommendation (SBAR) communication tool for hand-off in healthcare—A narrative review. Safety in Health 4(7). https://doi.org/10.1186/s40886-018-0073-1

Sherman, R. (2022, August 4). Helping new nurses with critical thinking skills. *Emerging RN Leader*. https://emergingrnleader.com/helping-new-nurses-with-critical-thinking-skills/

Starmer, A.J., Sectish, T.C., Simon, D.W., Keohane, C., McSweeney, E., Chung, E.Y., Yoon, C.S., Lipsitz, S.R., Wassner, A.J., & Harper, M.B. (2013). Rates of medical errors and preventable adverse events among hospitalized children following implementation of a resident hand-off bundle. Journal of the American Medical Association 310(21), 2262-2270. doi: 10.1001/jama.2013.281961.

Tanner, C.A. (2006). Thinking like a nurse: A research based model of clinical judgment in nursing. *Journal of Nursing Education,* 45(6), 204-211. https://doi.org/10.3928/01484834-20060601-04

Thim, T., Krarup, N. H., Grove, E. L., Rohde, C. V., & Løfgren, B. (2012). Initial assessment and treatment with the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach. *International journal of general medicine*, *5*, 117–121. https://doi.org/10.2147/IJGM.S28478

Tilley, M., & Spencer, K. (2020). Perceived barriers to rapid response team activation among nurses. *AJN, American Journal of Nursing*, 120(7), 52–60. https://doi.org/10.1097/01.NAJ.0000688220.05900.7c.

Vizient Inc. (2024). *Vizient AACN nurse residency program curriculum.* Retrieved February 28, 2024, from https://www.vizientinc.com/my-dashboard/my-tools/nurse-residency-program/nurse-residency-program-curriculum

Wiles, L.L., Simko, L.C., & Schoessler, M. (2013). What do I do now?: Clinical decision making by new graduates. *Journal for Nurses in Professional Development*, 29(4). 167-172. doi: 10.1097/NND.0b013e31829aeab3

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