Rapid Response Team Training: Using Interprofessional Simulation As A Guide For Responders

Michelle I. Schweinfurth, DNP, RN, CCRN; Amy Taylor, BSN, CCRN; John Brinson, RRT

University of Mississippi Medical Center; 2500 North State, Jackson, MS 34921 • 601-984-5559 • mschweinfurth2@umc.edu

Introduction

ICU charge nurses (CNs) often function as a vital member of a Rapid Response Team (RRT) when called upon to evaluate a patient who shows clinical deterioration on an adult ward. How to function as a member of this team is not included in any unit-based charge nurse training at the University of Mississippi Medical Center (UMMC); nor is it a part of competency for a respiratory therapist. Therefore, staff are unprepared to respond to a rapid response call.

Solution: Develop an orientation program, using an interprofessional collaborative partnership with simulation colleagues, to provide training to ICU CNs. The authors developed a competency tool to be used for orientation of both new and substituting CNs and therapists.

Objectives

1. State the purpose of a RRT in a hospital setting
2. Identify competency skills needed by RRT members
3. Indicate how interprofessional simulation training can be used to improve partnerships between the RRT members

The authors met with the UMMC Interprofessional Simulation and Education Center to set the schedule. Three scenarios were written: one for Code Stroke, Code STEMI and a Seizure in a visitor in a waiting room. Two of the scenarios involved a trip to triage and management of a stroke or STEMI; these two scenarios were included since they are not frequent reasons for RRT calls. To aid the realism of each scenario, a confederate patient was used rather than a high-fidelity mannequin, and a medical-surgical unit nurse educator played the role of the staff nurse who activated the RRT. The goal during each scenario was for the ICU nurse to achieve the minimum passing competency.

Background

The groundbreaking 100,000 lives campaign launched by the Institute for Healthcare Improvement (IHI) in December 2004 contained a set of six evidence-based healthcare interventions that have been shown to improve standards of care. Deploying RRTs at the first sign of patient decline is one of these interventions (Bierwirth, Cullen, McCann & Heithecker, 2006). In support of the IHI campaign, and to coincide with its national Patient Safety Goals (2008), the UMMC developed guidelines and implemented a RRT in the adult hospital in November 2006. The UMMC RRT is comprised of a critical care registered nurse and a registered respiratory therapist. The ICU charge nurse acts as a back up team member. This is shared amongst the four adult ICUs on a weekly rotating call schedule. There are an average of 45 adult rapid response calls each month at UMMC. In preparation for this training, background information about Rapid Response systems, the UMMC Code Blue RRT policy and activation criteria were provided to the ICU CNs via PowerPoint using the Healthcare learning system.

Materials and Methods

The competency tool outlined baseline performance criteria that all RRT members needed to possess, and was based on the adult RRT record that makes use of the SBAR documentation format. Incomplete documentation is a frequent issue with actual patient events. Tracking outcomes is a reportable item to TJC, and thus a challenge for the UMMC Code Blue committee. Thus, consistent and accurate documentation was a key part to emphasize on the orientation competency tool.

Two additional competency forms were written from the original one; to measure competency of RRT events of Code Stroke and Code STEMI.

Results

Three sessions were held with 14 of 18 nurses completing the orientation training. Those who were unable to attend had conflicts due to night shift rotation. Several of the nurses were familiar on the SBAR form during the scenario, looking at the chart, but not writing any information down. Based on clinical experience, 6 of the nurses quickly suspected stroke or STEMI and fell into typical protocol for management. However they were unfamiliar how to escalate the call to expedite patient care, or where to locate center core within the charting system. Almost all of the nurses left completions of the SBAR rapid response form for the very end of the scenarios. Emphasis on accurate completion of vital signs and all sections of this form was stressed to all. Several stated that charting at the end was out of habit to get all the needed information first, as well as not being familiar with the form.

Follow Up After Training

The Code Blue Committee held a routine Monthly training – I week later as a follow-up to an in-service on one of the Medical-Surgical floors in the Women’s hospital. The STEMI scenario was utilized with a confederate patient. The ICU nurse who responded on the RRT was one of the orientees who had attended the training just one-week prior. Our sessions on that day was so good he believed it was a real event (she had been the stroke patient in his scenario for the earlier training). His actions that day in ordering a 12-lead ECG and aspirin were right in alignment with the order set. Once we revealed 15 minutes into the scenario (rather than the tech final saying that it was a mock) – he told us how much that earlier training helped him know what to do.

Conclusions

Staff nurses and residents are encouraged to make Rapid Response calls when a patient condition has changed, and the expert opinion of an ICU nurse or respiratory therapist can help to stabilize the patient. Placing a backup charge nurse into the role of the ICU RRT member with little or no training on the paperwork or RRT protocols puts patients at risk. This orientation training will now become a standard part of the required competencies for the nurse (and therapist) to complete in order to participate on the RRT at UMMC. Consideration for review of current RRT members has been made for mastery of skills.

Acknowledgements

The authors would like to thank the UMMC Interprofessional Simulation and Education Center staff for their time and contributions to this training project: Dr. Ann Lemons, Dr. McHale, Ms. Patrick Patton, Dr. Chambler Mayes, and Dr. Danielle Patton.

References
