



Featured Article

Inside the Debriefing Room: Multidisciplinary Rapid Response Team Training Findings Revealed

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KEYWORDS

simulation;
high-fidelity;
rapid response teams;
multidisciplinary;
medical emergency
team;
ACLS;
advanced
cardiopulmonary life
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RRT;
interdisciplinary
communication;
patient safety training;
professional
development;
staff education;
failure to rescue

Abstract

Background: Research indicates that, despite the intent to save lives through rapid response teams (RRTs), mortality and morbidity outcome data are variable. A reason for that may be a lack of proficient and consistent training and education.

Objectives: To determine whether high-fidelity simulation is an effective instructional method for interdisciplinary RRT training.

Methods: Multidisciplinary health care team members participated in high-fidelity simulation scenarios, were evaluated by the instructors during the simulation, and then were given the opportunity to give informal and formal feedback.

Results: The results of an anonymous survey sent to all participants showed that a majority who completed the online survey (91.4%) found this instructional method to be either very effective or somewhat effective for teaching in the hospital setting. The majority of participants (63.6%) indicated that high-fidelity simulation was their preferred method of learning when compared with case studies, online learning modules, or classroom/lecture. Major themes and opportunities identified for additional training were communication, assessment skills, teamwork, critical thinking, cardiopulmonary resuscitation skill retention, and timely initiation of RRT calls.

Conclusions: This pilot study supports the current literature detailing the effectiveness of high-fidelity simulation and perceived learner outcomes. During crisis situations, there are significant communication barriers that can derail care providers from providing the most optimal care to the patient. As a result of debriefing, it was found that derogatory comments made by the RRT members during previous rapid response calls significantly impacted how early subsequent rapid responses were called by some participants.

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For more than a decade, rapid response teams (RRTs) have become a standard for preventing in-hospital patient deaths by rescuing patients that are showing clinical signs of deterioration (McCannon, Hackbarth, & Griffin, 2007). The Institute of Health Care Improvement has established

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the standard that clinicians rapidly respond to hospitalized patients that are experiencing an acute decline in their condition (Institute for Healthcare Improvement, 2000). RRTs are composed of critical care or emergency room staff who respond to an acute change in a hospitalized patient, any time,

Key Points

- Lack of consistent education is cited as a factor contributing to RRTs variable results.
- HFS is an evidence based tool with potential to increase effectiveness of RRTs.
- Debriefing revealed that previous negative RRT experiences decrease the likelihood of RRTs being called early, or even at all.

day or night. Expected outcome results include decreased cardiopulmonary arrests and improved mortality and morbidity. Actual outcome results have been mixed; the reasons for the discrepancy are multifaceted (Huff, 2011). One potential cause is the lack of consistent and effective training for both the non-critical care staff who initiates a RRT call and for the critical care team who respond to the call. Critical elements to the success of RRTs include recognizing signs of acute deterioration, correct interpretation of data,

and timely initiation of interventions. A best practice solution must be found to educate both the nurses who call rapid responses and the responding critical care team. High-fidelity simulation is well-documented as an effective, best practice learning strategy. A literature review revealed that there was a gap in the body of knowledge surrounding high fidelity simulation and RRT training (Cant & Cooper, 2009).

Literature Review

Thomas, VanOyen, Rasmussen, Dodd, and Whildin (2007) described one hospital's experience with implementing a RRT at Delnor-Community Hospital in Chicago. They described failure to rescue as a situation where hospital staff failed to recognize deterioration in a patient's condition that led to additional complications or even death. The authors identified three major reasons why failure to rescue occurred: (1) breakdown in communication among providers, (2) failure to recognize signs of decline, and (3) either incorrect assessment or inappropriate interventions to treat the findings (Thomas et al., 2007). The project team utilized this information to plan and implement their RRT process. They were able to reduce the number of code blues by 56% and decrease the number of code blues outside of the intensive care unit from 1.22 per 1,000 discharges to 0.63 per 1,000 discharges (Thomas et al., 2007). During the implementation of the RRT, education was a key measure that led to their success. The education was intensive, directed at multiple care providers and ongoing. The focus was on critical thinking and active listening. Practice sessions were also included in the

educational roll out plan. The dedication to education at Delnor reflected a best practice for other hospitals wishing to implement or improve RRTs. The practice sessions used to train the staff that were mentioned in this study, did not utilize high-fidelity simulation. Therefore, an opportunity exists to build on the work of Thomas and associates (2007) by integrating high fidelity simulation for increased realism.

Stollendorf-Meur (2008) discussed the challenges that health care organizations have when attempting to implement the recommendations for a RRT. Current data surrounding the ability of RRT to decrease morbidity and mortality are not consistent. This variation may be explained by the wide diversity in the members of the RRT, processes, policies surrounding the RRT, and the lack of consistency in training and education. Opportunities exist to improve processes, standardization and training through presenting evidence based best practice solutions.

Marshall et al. (2011) focused on the reasons staff do not activate a RRT. One of the barriers identified by the authors was lack of recognition of pending clinical deterioration. In addition, an interprofessional barrier was identified as lack of trust between non-critical care nurses and RRT members. Previous negative experiences increased the likelihood that the non-critical care nurses would not call a rapid response in the future. Other reasons for not activating the RRT were mentioned in a theoretical framework describing the cognitive and sociocultural barriers. Marshall et al. (2011) published this article based on their research of barriers and theoretical framework surrounding RRTs. At the time of publication, the actual study results were not available.

The Calvary Health Care Launceston Hospital in Australia is an acute care hospital where high-fidelity simulation was implemented in the training of RRTs (Williams & Chong, 2010). Williams and Chong chose high-fidelity simulation to provide experience with medical emergencies in a safe environment, the opportunity to experience rare but important medical events, and the opportunity for immediate feedback through the debriefing process. In addition, team building and student satisfaction with this instructional method were noted to be advantages. After implementing high-fidelity simulation with RRT training, the hospital experienced remarkable outcomes with actual patients including an increased ability of the team to recognize and intervene in critical events, confidence in managing deterioration, and decreased patient transfers. The literature review reveals that there is very limited research related to RRT training that is multidisciplinary and also utilizes high-fidelity simulation.

Methods/Implementation Plan

Introduction and Site Selection

In the summer of 2012, St. Mary Corwin Medical Center in Pueblo, CO formed a partnership with Pueblo Community

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