



What nurses involved in a Medical Emergency Teams consider the most vital areas of knowledge and skill when delivering care to the deteriorating ward patient. A nurse-oriented curriculum development project

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ABSTRACT

Introduction: Critical care nurses have been involved in Rapid Response Teams since their inception, particularly in medically led RRTs, known as Medical Emergency Teams. It is assumed that critical care skills are required to escalate care for the deteriorating ward patient. However, evidence to support critical care nurses' involvement in METs is anecdotal. Currently, little is known about the educational requirements for nurses involved in RRT or METs.

Objectives: We aimed to identify and describe what nurses involved in a MET consider the most vital areas of knowledge and skill when delivering care to the deteriorating ward patient.

Methods: An exploratory descriptive design was used and data was collected at a session of the Australian and New Zealand Intensive Care Society Rapid Response Team (ANZICS-RRT) Conference held at The Gold Coast, Australia in July 2015. All conference delegates were eligible to take part. Conference delegates totalled 293; 194 nurses, 89 doctors and 10 allied health professionals.

Data collection took place in three phases, over a 90-minute period. First, demographic data were collected from all participants at the start of data collection. These data were collected using paper-based surveys. Second, extended response surveys; that is, paper-based surveys that asked open-ended questions to elicit free text responses, were used to collect participants' individual responses to the question: "What are the specific theoretical knowledge, skills and behavioural attributes required in a curricula to prepare nurses to be high functioning members of a MET?"

Demographic, educational and work characteristics were descriptively analysed using SPSS (version 22). Participants perceptions of what knowledge, skills and attributes are required for nurses to recognise and respond to clinical deterioration were thematically analysed.

Results: Participants were predominantly female (88.3%, $n = 91$) with 54.4% ($n = 56$) holding a Bachelor of Nursing. Participants had a median of 20 years (IQR 16) experience as RNs, and a median of 14 years (IQR 13) experience in critical care. Participants formed part of METs frequently, with nearly half the cohort seeing clinically deteriorating patients more than once per day (37.9%, $n = 33$) or daily (10%, $n = 9$). Thematic analysis of survey responses revealed four main themes desired in Rapid Response Team Curricula: Clinical Deterioration Theory, Clinical Deterioration Skills, Rapid Response System Governance, and Professionalism and Teamwork.

Conclusions: We suggest that a curriculum that educates nurses on the specific requirements of assessing, managing and evaluating all aspects of clinical deterioration is now required.

1. Background

Rapid Response Systems (RRSs) were developed and implemented

to identify high-risk hospital patients early so that serious adverse events could be prevented and patient outcomes improved (De Jong et al., 2016). Rapid Response Systems are hospital-wide systems that

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provide a safety net for ward patients who suddenly deteriorate and develop complex care needs that may be outside the scope of clinical ward staff knowledge and skills (Hillman et al., 2014). An RRS has an afferent (case detection and response-triggering) limb and an efferent (response) limb for clinicians to successfully prevent deterioration or to respond appropriately to the deteriorating patient (Devita et al., 2006). The efferent arm of the RRS is called the Rapid Response Team (RRT). Rapid Response Teams can also be categorised as 'high-capability teams' and the 'ramp-up teams' (Devita et al., 2006). The Medical Emergency Team (MET) is an example of a high capability RRT. The MET usually consists of a medical officer and a critical care nurse (Devita et al., 2006). The MET members assess the patient and institute emergency therapy to stabilise the patient's clinical condition. Critical Care Outreach Team (CCORT) and/or the ICU liaison nurse are examples of a 'ramp-up team'. Although different RRTs exist, all are reliant on the contributions of experienced critical care nurses for patient safety (Boots et al., 2016; Devita et al., 2006). Nurses play an integral role in the development, implementation and evaluation of RRSs (Aitken et al., 2015; Considine et al., 2015; Massey et al., 2015; Maharaj et al., 2015).

Critical care nurses have been actively involved in RRSs since their inception, particularly in the form of medically led METs (Devita et al., 2004; Jones et al., 2015a). Recently, researchers have begun to evaluate the impact of nurse-led RRS (Jones et al., 2011; Scheer et al., 2012; Massey et al., 2015). There is currently a lack of knowledge about the role nurses play in RRTs and the educational requirements of nurses working in METs specifically. In addition to the critical care skills required to care for the deteriorating patient, recent research has revealed that deteriorating patients have other complex care needs that may be outside the scope of critical care nurses' expertise, for example, palliative care needs (Farley et al., 2015; Jones, 2014; Jones et al., 2013).

Thus, identification of the education requirements of nurses involved in METs is important, yet little is known about this important topic. Although examples of training needs for MET nurses have been developed for individual hospitals (Topple et al., 2016), there is no broad consensus, standardised curricula, agreed competencies, or well-defined scopes of practice for nurses who attend episodes of clinical deterioration as part of an RRT. Without this information, it is difficult to define and evaluate nurses' roles in, and impact on, MET functioning, let alone MET outcomes. Capacity planning for future MET nurses is problematic without such information, and consequently deteriorating patients may have unmet needs, negatively impacting on patient safety and quality care.

Given the unique nature of the MET or RRT, a lack of structured, formal education and training may leave nurses without a formal means of obtaining advanced knowledge and skills needed to care for this increasingly complex patient group (Currey et al., 2015; Jones, 2014; Jones et al., 2015c). Historically, specialist areas of clinical nursing practice have developed their own educational curricula, practice standards and clinical competencies (Gill et al., 2015; Jones et al., 2015b). Nurses working as part of METs have traditionally accessed formal critical care qualifications, and although these programs may offer important knowledge and skills, they do not necessarily provide the specialist knowledge required to care for a deteriorating ward patient. Currently, there is minimal information or knowledge available that explores or evaluates the educational needs, or the curricula requirements, of nurses involved in METs.

In this paper, we present the findings of a nurse-oriented curriculum development project conducted to identify and describe what nurses involved in a MET consider the most vital areas of knowledge and skill when delivering care to the deteriorating ward patient.

2. Methods

In this study we aimed to answer the following research questions:

1. What specific theoretical knowledge do nurses believe is required in a curricula to prepare nurses to be high functioning members of a MET?
2. What specific skills do nurses believe are required in a curricula to prepare nurses to be high functioning members of a MET?
3. What are the behavioural attributes nurses believe are required in a curricula to prepare nurses to be high functioning members of a MET?
4. What method of education delivery would nurses prefer for a MET curricula?

2.1. Design

An exploratory descriptive design was used to identify the curriculum content required for nurses to recognise and respond to clinical deterioration, and be a productive member of the Medical Emergency Team (MET). Ethics (IRB) approval was granted by Deakin University (92_2015).

2.2. Setting

This study was conducted in a session of the Australian and New Zealand Intensive Care Society Rapid Response Team (ANZICS-RRT) Conference held at The Gold Coast, Australia in July 2015. ANZICS is the peak medical body of intensive care physicians in Australasia. Conference registration was open to all health disciplines.

2.3. Sample

All conference delegates were eligible to take part in the study because by attending the conference an assumption was made that they had a role and a voice in RRS development. Conference delegates totalled 293; 194 nurses, 89 doctors and 10 allied health professionals. All conference delegates were invited to attend all sessions including nursing specific sessions. However only nurses attended the session where data collection for this study occurred. All attendees at the session were eligible to participate, and participants were asked to read a participant information sheet and sign an informed consent before data collection began. Members of the research team fielded questions with prospective participants.

2.4. Data collection

Data collection took place in three phases, over a 90 minute period. All participants took part in each data collection phase. Time was allocated to each phase of data collection to maximise completion. First, demographic data were collected from all participants at the start of data collection. Data were not collected regarding age or ethnicity. These data were collected using paper-based surveys. Second, extended response surveys; that is, paper-based surveys that asked open-ended questions to elicit free text responses, were used to collect participants' individual responses to the question: "What are the specific theoretical knowledge, skills and behavioural attributes required in a curricula to prepare nurses to be high functioning members of a MET?" Perceptions about the ways in which this education should be delivered were also sought and documented by participants. Finally, participants were requested to discuss their individual perceptions within groups that comprised 7–10 participants, and to document agreed content by the group on a single hard-copy page. In total 14 groups took part in the second data collection phase. Data from each of the 14 groups were discussed within and between groups by a facilitator. Ideas were shared and clarification was sought between groups. Groups made minor changes to their survey data as they saw fit once the facilitated discussion was complete. Once groups had discussed and reached final consensus about the knowledge, skills and behaviours required by registered nurses (RNs) to recognise and respond to clinical deterioration,

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