Restructuring Rapid Responses: A Collaborative Process for improved team communication and patient safety

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Background/Introduction

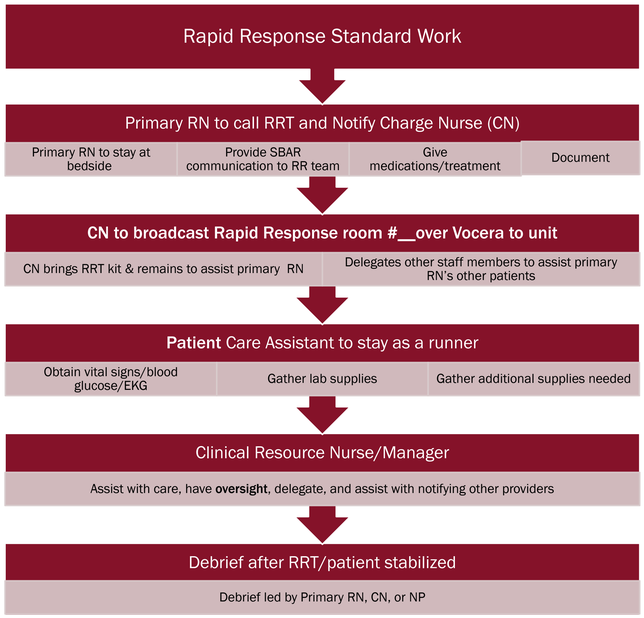
- Joint Commission National Patient Safety requirements for a Rapid Response Team (RRT) was developed to assess and treat patients' worsening conditions prior to cardiac or respiratory arrest, reduce unplanned ICU transfers, and increase clinical nurse support
- Although implementation of rapid response systems (RRS) has improved patient safety in hospitals, standard work varies across hospitals, and collaborative communication process is limited
- Studies have indicated unit nurses fear being criticized for unnecessary RRT calls, are concerned about conflict between RRT and nursing staff with no resolution of patient symptoms
- In this 358-bed community hospital, Rapid responses were called, but appeared silent upon RRT arrival due to limited staff availability, support, and visibility
- There was limited communication to the RRT when patients were deteriorating, limited knowledge of patient condition due to lack of communication during hand-off reports, lack of feeling psychologically safe with reporting concerns of possible deteriorating conditions

Purpose/Objectives/Hypothesis

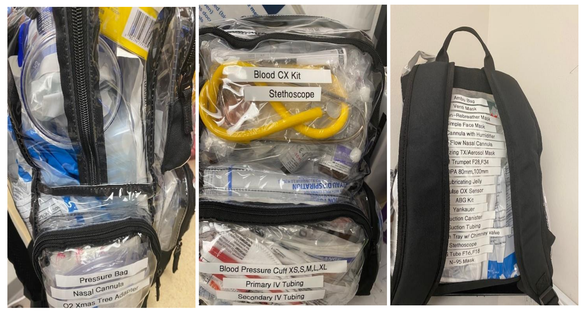
- Communication and cooperation play a significant role during RRT member-user interactions
- The clinical stressors and time stressors of RRT calls can threaten the working relationship between users and members, which may hinder successful resolution of RRT calls
- It was hypothesized that improving RRT member- Nurse Practitioner/staff RN collaboration would improve communication, psychological safety, and ultimately improve patient safety by preventing in hospital cardiac arrest.

Method

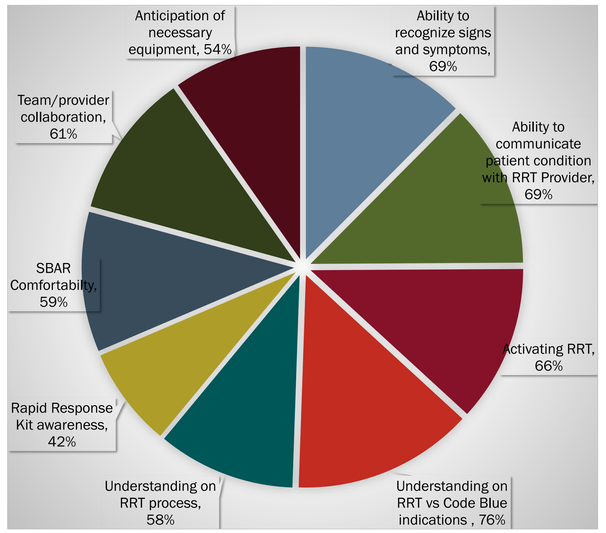
- Initial Education included TEAMSTEPPS class for Nurse Practitioner (NP). Time was allowed to thoroughly review the imperative concerns, and brainstorm to determine an appropriate avenue for improved communication and patient safety.
- Workgroup meeting with RRT-NP, IMU, Med-Surg, and Observation charge nurses
- Interprofessional rounds with a special focus on EPIC Deterioration Index (EDI), Sepsis, and previous RRT calls were initially specific to IMU and night shift
- Debriefings were held in all Med-Surg units, after RRT completion
- Collaboration training held for nurse residents, new employees, and shared governance committee
- Survey provided to staff on each unit for random survey, provided to new employees, and nurse residents, at the end of the collaborative lecture



Rapid Response Kits



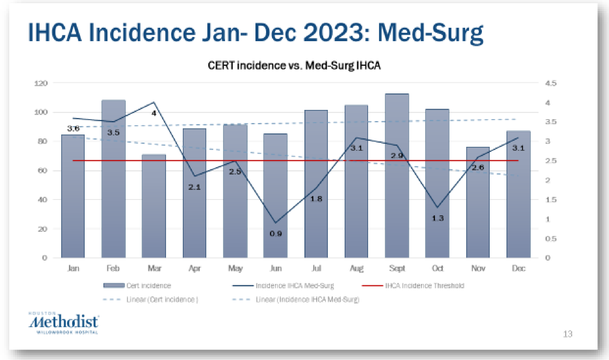
Rapid Response Assessment Survey (N=163)



Results

- Real-time debriefings have allowed improved psychological safety, critical thinking, communication, mutual respect, trust between team members, and decreased frustration. Additionally, it allowed suggestions for:
  - Standard work
  - Rapid response bag/kit with appropriate items for RRT, including items necessary tailored to the facility for the most common RRT calls
  - Ordering STAT meds for improved timeliness
  - RRT call awareness
- While communication with the team on the unit has increased team collaboration and improved patient safety, we continue to strive for higher psychological safety among all members

Results



Future Actions

- While IHCA has decreased and communication has improved, we will need to continue to teach all current staff, new employees, increase dayshift rounding on all units, and consistently provide debriefings with tangible data sheets
- Additionally, providing reminders of standard work, such as badge buddies will be valuable tool in the future
- TEAMSTEPPS planned for all staff members
- Post Survey will need to be completed, as well as new surveys for new hires post-orientation

Acknowledgments

- Acute Care Managers and Charge Nurses
- Night-shift shared governance committee members
- Hospital Educators

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