

# *TeamSTEPPS*<sup>TM</sup>

*Team Strategies & Tools to Enhance Performance & Patient Safety*

## RAPID RESPONSE SYSTEMS



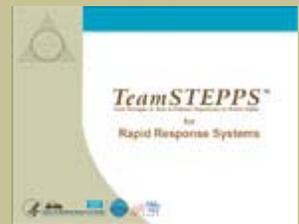
## INTRODUCTION

### SAY:

In recent years, the Agency for Healthcare Research and Quality and the Department of Defense have striven to optimize the lessons learned regarding multiple initiatives for reducing medical errors. These lessons learned have resulted in the marrying of two research and practice streams: 1) medical team training and 2) rapid response systems. This evidence-based module will provide insight into the core concepts of teamwork as they are applied to the rapid response system.

### INSTRUCTOR NOTE:

This module may be customized based upon the group's knowledge and experience with the Rapid Response System (RRS) and TeamSTEPPS™. For example, if the group has already implemented an RRS, it may be useful to include more discussion on the system in place rather than giving several examples of RRSs in different facilities. Similarly, depending on the amount of exposure to TeamSTEPPS, the group may need more or fewer slides with information on TeamSTEPPS.



### Slide



### MODULE TIME:

50 minutes



### MATERIALS:

- Flipchart and markers
- RRS Video (Successful and opportunity examples)

# OVERVIEW: WHAT IS A RAPID RESPONSE SYSTEM, ALSO CALLED AN RRS?



Slide

## SAY:

The RRS:

- Brings teams of critical care expertise to the patient bedside when other resources are lacking.
- Has a wide range of health care professionals coordinating efforts.
- Treats patients with early warning signs of acute clinical deterioration, namely cardiac arrest.
- Has a common goal of patient stabilization.

## INSTRUCTOR NOTE:

The following is background information on Rapid Response Teams (RRTs), which are a component of Rapid Response Systems (RRSs). You may choose to include this information based upon your group's experience level with RRTs, sometimes called Medical Emergency Teams.

## SAY:

A number of health care organizations have implemented Rapid Response Teams (RRTs), or Medical Emergency Teams, to address situations of acute patient deterioration while under hospital care. Groups of clinicians form RRTs, which bring critical care expertise to patients who require immediate treatment. Similar to the initiative to develop medical team training, the effort to establish RRTs in facilities across the Nation is a means of reducing the number of needless deaths associated with medical error. The Institute for Healthcare Improvement's 5 Million Lives campaign, which is a continuation of its initial 100,000 Lives campaign, calls for the establishment of Rapid Response Systems. IHI instituted its campaigns in response to the Institute of Medicine's *To Err Is Human* report that indicated that 98,000 deaths annually occur due to medical errors.<sup>1</sup> In particular, the goal of RRS implementation is to reduce the number of medical errors by decreasing the number of unmet patient needs prior to cardiac arrest.<sup>2</sup> RRSs are established to "respond to a 'spark' before it becomes a 'forest fire,'" thereby preventing failure to rescue.<sup>2</sup>

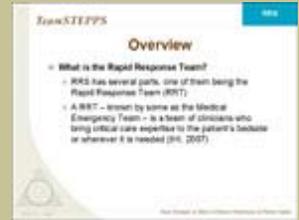
1. Kohn LT, Corrigan JM, and Donaldson MS. *To err is human*. Washington, DC: National Academy Press, 1999.

2. Baker D, Salas E, King H, Battles JB, and Barach P. The role of teamwork in the professional education of physicians: Current status and assessment recommendations. *Joint Commission Journal on Quality and Patient Safety*. 2005;31(4):185-202.

## OVERVIEW: WHAT IS RRT?

### SAY:

Rapid Response Teams (RRTs) are a part of the RRS. A RRT – known by some as a Medical Emergency Team – is a team of clinicians who bring critical expertise to the patient bedside (or wherever is needed). The RRT can have several different structures, customized to each institution. In this module, we will refer to members of the RRT as Responders.



### Slide

## WHY SHOULD YOU CARE?



Slide

### SAY:

Why should you care?

People die unnecessarily every day in our hospitals. It is likely that each of you can provide an example of a patient who, in retrospect, should not have died during a hospitalization. There are often clear early warning signs of deterioration.

Rapid Response is one of the Joint Commission's 2008 National Patient Safety Goals, and teamwork is critical to successful rapid response.

The evidence suggests that Rapid Response Systems work!

## DOES THE RRS WORK?

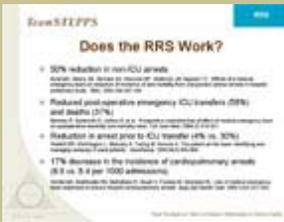
### SAY:

Research suggests that after implementing a Rapid Response System, hospitals experience a decrease in the number of cardiac arrests, deaths from cardiac arrest, number of days in ICU post arrest, number of days in the hospital after an arrest, and inpatient deaths.

The slide displays a table with the following data:

	before	after
No. of cardiac arrests	69	22
Deaths from cardiac arrest	37	16
No. of days in ICU post arrest	182	23
No. of days in hospital after arrest	1363	139
Inpatient deaths	302	232

### Slide



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### SAY:

Through implementing RRS initiatives, organizations have found positive results. Several examples of the promising findings are:

- 50% reduction in non-ICU cardiac arrests. (Buist MD, Moore GE, Bernard SA, Waxman BP, Anderson JN, Nguyen TV. Effects of a medical emergency team on reduction of incidence of and mortality from unexpected cardiac arrests in hospital: preliminary study. *BMJ*. 2002;324:387-390.)
- Reduced post-operative emergency ICU transfers (58%) and deaths (37%). (Bellomo R, Goldsmith D, Uchino S, et al. Prospective controlled trial of effect of medical emergency team on postoperative morbidity and mortality rates. *Crit Care Med*. 2004;32:916-921.)
- Reduction in cardiac arrest prior to ICU transfer (4% vs. 30%). (Goldhill DR, Worthington L, Mulcahy A, Tarling M, Sumner A. The patient-at-risk team: Identifying and managing seriously ill ward patients. *Anesthesia*. 1999;54(9):853-860.)
- 17% decrease in the incidence of cardiopulmonary arrests (6.5 vs. 5.4 per 1,000 admissions). (DeVita MA, Braithwaite RS, Mahidhara R, Stuart S, Foraida M, Simmons RL. Use of medical emergency team responses to reduce hospital cardiopulmonary arrests. *Qual Saf Health Care*. 2004;13(4):251-254.)

## NQF SAFE PRACTICES

### SAY:

In 2003 and in its 2006 update, the National Quality Forum identified Rapid Response Systems as a chief example of a team intervention serving the safe practice element of Team Training and Team Interventions.

To generate the greatest impact, teamwork-centered performance improvement initiatives or projects should target the work we do every day. The units and service lines selected should be prioritized based on the risk to patients and on the prevalence and severity of targeted adverse events. The interventions should address the frequency, complexity, and nature of teamwork and communication failures that occur in those areas. At a minimum, each year every organization should undertake at least two teamwork-centered intervention projects such as those such as the those we'll discuss in a moment.

Ideally, multiple teamwork-centered interventions should be undertaken in all areas of care.

#### ◆ Specific team performance improvement project information:

Organizations should select high-risk areas for performance improvement projects. These include emergency departments, obstetrics, intensive care units, operating rooms, and other procedural care units.

Performance targets should be identified with strategies to close known performance gaps. Performance improvement initiatives should have components of education, skill building, measurement, reporting, and process improvement.

#### ◆ Rapid response assessment:

Organizations should formally evaluate the opportunity for the RRS to address the issues of deteriorating patients across the organization. This evaluation should be undertaken once a year, even if this area is not chosen as a teamwork-centered intervention project. (NQF, 2006)



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**SAY:**

In addition to the NQF Safe Practices, the Joint Commission 2008 National Patient Safety Goals include the following goal:

Goal 16: Improve recognition and response to changes in a patient's condition.

16A. The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening.

## IMPLEMENTATION

### SAY:

The implementation of RRS involves:

- Identifying key staff for the response team.
- Establishing alert criteria and mechanisms.
- Educating staff.
- Using a structured documentation tool.
- Establishing feedback mechanisms.
- Measuring effectiveness.

The key to implementation, however, is to understand that the RRS is customizable and must fit your organization's needs and culture.

Useful resources for additional information on structuring and implementing RRS include:

- The Institute for Healthcare Improvement 100,000 Lives Campaign, *Getting Started Kit: Rapid Response Teams How-To Guide*. 2005.
- DeVita MA, Bellomo R, Hillman K, Kellum J, Rotondi A, Teres D, et al.: Findings of the First Consensus Conference on Medical Emergency Teams. *Critical Care Medicine*, 2006;34:2463.
- Delmarva Foundation. *Rapid Response System Collaborative*. RRS Collaborative Resource Materials. Princeton, NJ: The Robert Wood Johnson Foundation, 2006.



### Slide



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### **SAY:**

Structurally, the RRS can be divided into 4 coordinated groups:

- Activators – Those who activate the Rapid Response System by calling the response team.
- Responders – Those who are part of the response team.
- Quality Improvement – Supports Activators and Responders by reviewing RRS events and evaluating data for the purpose of improving RRS processes.
- Administration – Supports Activators and Responders by ensuring that changes in processes are implemented.

The following slides will go through each group in detail, highlighting their roles and responsibilities.

## ACTIVATORS

### SAY:

“Activators” refer to the person or persons who activates the RRS by calling the response team. Activators can be floor staff, a patient, a family member, specialists, or anyone else sensing acute deterioration. The patient or a family member may also serve as a kind of activator when they alert floor staff about acute deterioration.

Activators know when to call the response team by using the hospital’s pre-established RRS criteria. Team members from the nursing staff or floor staff are trained to monitor for fluctuations in any one of the indicators of acute cardiac distress, which are tied to criteria for making the call to activate the RRS. Criteria can include:

- Worry about the patient.
- Acute changes in heart rate  $<40$  or  $>130$  bpm.
- Acute changes in systolic blood pressure  $<90$  mmHg.
- Acute changes in respiratory rate  $<8$  or  $>28$  per min.
- Acute changes in saturation  $<90\%$  despite O<sub>2</sub>.
- Acute changes in conscious state.

The detection of any criterion relies heavily on a general care area provider’s ability to monitor the patient’s situation. Without situation monitoring, critical changes in patient status will not be identified.



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## RESPONDERS



Slide

### SAY:

After RRS activation, Responders arrive at the bedside and assess the patient's situation.

Responders coordinate with general care unit staff and the attending physician to provide treatment with the aim of stabilizing the patient. Responders determine patient disposition, which could include:

- Transferring the patient to another critical care unit (e.g., ICU or CCU).
- A handoff back to the primary nurse or primary physician.
- Revising the treatment plan.

It is important to note that Activators may become Responders and assist in stabilizing the patient.

## ACTIVATORS AND RESPONDERS

### SAY:

It is the responsibility of Activators to call Responders if a patient meets the calling criteria.

Responders must reinforce the Activators for calling.

Remember, there are no “bad calls.”

### ASK:

What is the difference in the following reactions? Which one is more likely to discourage the Activator from calling the Responders again?

### DO:

Read the following statements aloud or ask a participant to read it, and then discuss how the statements could be interpreted.

- “Why did you call?”

vs.

- “Thank you for calling. What is the situation?”

### INSTRUCTOR NOTE:

The first statement, depending on the tone can discourage the Activator from calling again. The second statement is more effective because it reinforces the Activator for calling and also asks about the situation.



### Slide



### Slide

### SAY:

The **Quality Improvement Team** supports Activators and Responders by reviewing RRS events and evaluating data for the purpose of improving RRS processes.

The **Administration Team** of the RRS supports the entire RRS by ensuring that changes in processes are implemented. The Administration Team can include organizational resources, support, and leadership.

## LET'S WATCH AN RRS IN ACTION

### SAY:

Let's watch the RRS in action. Pay special attention to see if they are maximizing teamwork.

### DO:

Play the video by clicking the director icon on the slide.

### DISCUSSION:

Discuss the video and what went wrong during this RRT call. Ask participants what could have been done to improve the call.

Possible discussion points:

- The nurse does not pay attention to roommate's input.
- Incomplete Situation-Background-Assessment-Recommendation between Activator and Responders.
- No positive reinforcement of RRS Activator.
- Incomplete check backs.
- Failed assertiveness.
- No debrief.



### Slide

 **VIDEO TIME:**  
7:18 minutes

 **MATERIALS:**

- RRS Opportunity Video



Slide

### SAY:

Let's look back at the challenges you described after watching the video. Did you describe any of the ones listed here?

- Lack of coordination
- Distractions
- Fatigue
- Workload
- Misinterpretation of cues
- Lack of role clarity
- Inconsistency in team membership
- Lack of time
- Lack of information sharing
- Hierarchy
- Defensiveness
- Conventional thinking
- Varying communication styles

These obstacles are common when dealing with teams in health care. They are only magnified when cutting across multiple teams. For example, consider the impact of varying communication styles when dealing with responding team members from three distinct units at your facility. These varying styles of communication can pose a host of information exchange problems when transitioning a patient.

Nonetheless, teamwork can help you overcome many of these. The key is using specific strategies that aid in performing team tasks. Before some specific strategies are presented, let's review the core tasks for all RRSs.

### INSTRUCTOR NOTE:

Before showing the next slide, ask the participants to define the basic core tasks that are common to the RRS performance cycle. Ask them to identify the basic elements of RRS action in any one given RRS call. After a brief discussion, show the following slide. Make sure that the participants are focusing on the system and not just the response team.

## NECESSARY TEAMWORK SKILLS

### SAY:

The core of the TeamSTEPPS model is composed of four teachable-learnable skills: leadership, mutual support, situation monitoring, and communication. The red arrows depict a two-way dynamic interplay between the four skills and the team-related outcomes. Interaction between the outcomes and skills is the basis of a team striving to deliver safe, quality care.

Encircling the four skills is the patient care team, which not only represents the patient and direct caregivers, but also those who play a supportive role within the health care delivery system.

Team competencies required for a high-performing team can be grouped into the categories of knowledge, skills, and attitudes (KSAs). Team-related knowledge results in a shared mental model. Attitudes result in mutual trust and team orientation. Adaptability, accuracy, productivity, efficiency, and safety are the outcome of a high-performing team.

Team members possessing strong leadership, situation monitoring, mutual support, and communication skills typically yield important team outcomes. The interrelationships are the foundation of a strong continuous improvement model: The knowledge, skills, and attitudes of teamwork complement clinical excellence and improve patient outcomes by utilizing feedback cycles and clearly defined tools to communicate, plan, and deliver better quality care.

**Knowledge:** Teams that have members with strong leadership, situation monitoring, mutual support, and communication capabilities yield important team outcomes like a shared awareness about what is going on with the team and progress towards its goal. Team members are also familiar with the roles and responsibilities of their teammates.

**Attitudes:** When you work in teams in which the members possess good leadership, situation monitoring, mutual support, and communication skills, team members are more likely to have a positive experience. You will enjoy working in teams and trust the intentions of your teammates.

**Performance:** You can adapt to changes in the plan of care. Team members know when and how to back up each other. You are more efficient in providing care. You have a plan and know who is supposed to do what and how they are supposed to do it. Finally, your team is safer, allowing it to more readily identify and correct errors if they occur.

No amount of teamwork can compensate for clinical and technical proficiency. The foundation of teamwork builds on technical proficiency and protocol compliance.



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### SAY:

The Rapid Response System requires some skills in addition to the core competencies we just discussed. Inter-team knowledge is defined as knowing and understanding the roles and responsibilities of each team within the RRS.

### ASK:

Consider for a moment the most recent RRS call you were a part of. Can you think of an example of inter-team knowledge?

How did the nursing staff know to call the response team and not other members of the general care area?

How did the response team know when and where to transition the patient to another care unit?

These are examples of inter-team knowledge. Inter-team knowledge ensures proper, coordinated treatment without duplication of effort or error.

## INTER-TEAM KNOWLEDGE

### SAY:

Inter-team knowledge is extremely beneficial for care team members who may serve on one or more teams during an RRS event. For example, when an Activator calls Responders into action, it is expected that the Activator may support the response team during treatment by providing insight on potential actions that the response team can pursue to stabilize the patient. If the patient is transferred, the Activator's insights may also assist the receiving care teams with further diagnostic and therapeutic activities. Providing these insights requires an understanding of the goals, tasks, and responsibilities of all units involved. Moreover, the Activator can adjust his or her role as the patient transitions from one care unit to another. For example, if the Activator was the nurse, his or her role could change from primary caregiver in the nursing unit to support staff with the Responders to transition coordinator within other care units. This Activator is able to span several teams within the RRS by possessing knowledge of different team roles and responsibilities (i.e., inter-team knowledge).

Think back to our example in the first video we watched.

Did the Responders know the role of the ICU team when making the decision to transition the patient there?

Did the Responders understand the role of the nursing staff in easing transition?



### Slide



### Slide

### SAY:

Transition support, or “boundary spanning,” is a behavioral skill that enables individuals to work effectively within different teams that comprise the RRS.

An example of transition support is an individual who serves on more than one team in an assembly line. For instance, if you were to examine how cars are made, you would find that a team member from the design team serves on the manufacturing team to ensure continuity of information exchange and proper interpretation of schematics. This person spans the boundaries of two or more teams within a system.

Similarly, during patient care delivery, transition support helps maintain continuity of care and ensures all key roles are filled from one unit to the next.

In the RRS, transition support involves being a liaison between two care units and providing role support.

## TRANSITION SUPPORT (“BOUNDARY SPANNING”)

### SAY:

In the context of the RRS, transition support applies to the liaison roles taken on by nurses or physicians who are assigned to the response team and who follow a patient from one care unit to the next during a rapid response event. It is often the case that these individuals will serve on more than one team in the RRS. For instance, the nurse may move along with the patient to the ICU. As such, this nurse has several responsibilities, including orienting all new team members on the current status of the patient. These duties, when carried out properly, can reduce duplication of effort, such as repeated tests for specific alert criteria. Transition support can also enhance the safety and effectiveness of patient transfers by ensuring critical patient information is accurately communicated.

Role support is best personified by a response team member (e.g., the respiratory therapist) who assists in role orientation by moving with the patient to the ICU. While in the ICU with the patient, the respiratory therapist can orient ICU team members, or the nurse responsible for activating the response team can assist in role orientation by taking on the role of data manager or bedside assistant.



### Slide

## EXAMPLE OF ONE RRS



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### SAY:

Let's look at one example of the RRS in action.

At a local university hospital, the response team consists of ICU physicians, ICU charge nurses, nurse practitioners, the RRS coordinator, and transportation staff. In addition, when dealing with a pediatric case, a chaplain, respiratory therapists, and security personnel are also included.

On-call response team staff members are alerted via a pager. Nursing staff alerts the RRS coordinator, and the RRS coordinator alerts the response team.

## EXAMPLE OF ONE RRS (continued)

### SAY:

The training of response teams at this university hospital includes:

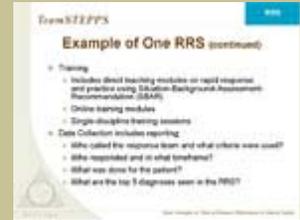
- Direct teaching modules on RRS and practice using SBAR.
  - At this particular medical center, response teams are given a 4-hour lecture-based training session with six practice scenarios. After each scenario, debriefing occurs with all members involved.
- Online modules.
  - All response teams that complete initial training are provided recurrence training through an online system.
- Non-interdisciplinary training sessions.
  - Staff from the three units that contribute to response team staff are not trained together. Intensive care staff (e.g., intensivists or hospitalists) are trained about RRT teamwork as one group. Nursing staff are trained as a group. Respiratory therapists are trained as a group. None of the training sessions are structured so that nurses, intensivists, and respiratory therapists are trained together.



**DISCUSSION:** Do you think that separate training is ideal for the RRS? How does your team coordinate training?

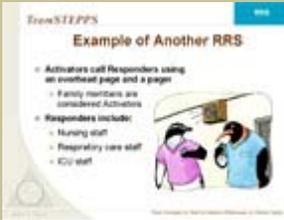
Finally, each time the response team is called, the following data are collected:

- Who called the response team and what criteria were used?
- Who responded and in what time frame?
- What was done for the patient?
- What are the response team's top five diagnoses?



### Slide

### EXAMPLE OF ANOTHER RRS



Slide

#### SAY:

At another university hospital, the response team comes from three pools:

- Nursing staff.
- Respiratory care staff.
- ICU staff.

The team typically consists of a nurse, a respiratory therapist, and an intensivist.

At this facility, response teams are activated using an overhead page system and a pager.

## EXAMPLE OF ANOTHER RRS (continued)

### SAY:

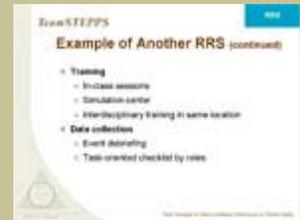
Training at this university hospital is comprised of:

- In-class sessions with lecture and practice role-plays.
- Scenario-based training exercises in a simulation center.
- Collocated training for staff from all three pools.

Data collection at this university includes:

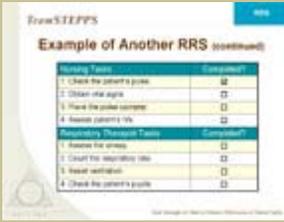
- Conducting event debriefing.
- RRS team members complete a task-oriented checklist against observations of others. They also view a video during the debrief session with the response team, the nurse, and other critical care staff as needed.

Let's look at the checklist example on the next slide.



### Slide

## EXAMPLE OF ANOTHER RRS (continued)



Slide

### SAY:

On this slide, we see an example of a task-oriented checklist used to assess whether a response team has performed their tasks. In this case, the checklist is used by the team to observe themselves on video after having worked on a group response team simulation scenario.

# EXERCISE I: LET'S IDENTIFY YOUR RRS STRUCTURE

### INSTRUCTOR NOTE:

After each phase of the next two “Exercise” slides has been completed, ask for volunteers to report their findings. Solicit responses from at least two facilities (or units if working at one facility).

### SAY:

Now that we have seen two examples of Rapid Response Systems in action, let's examine your RRS. In a group representing your facility, please think about the components of an RRS and identify how these are being carried out at your organization.

### DISCUSSION:

Answer the following questions:

Who are the Activators?

- What is the alert criteria?
- How are the Responders called?
- What do Activators do once the Responders arrive?

Who are the Responders?

- How many Responders arrive to a call?
- What is each person's role?

*Allot 5 minutes for this activity. Emphasize that the roles and responsibilities are customizable. Give examples: If a nurse, a doctor, and a respiratory therapist make up the response team, how would the responsibilities listed be distributed? If there are five to six people in the response team, how does this change the distribution of responsibilities?*



Slide



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### SAY:

While still in your groups, let's look at the barriers facing the RRS structure in your facility.



### DISCUSSION:

What are the common challenges facing your RRS?

Are there challenges during:

- Patient deterioration?
- System activation?
- Patient handoffs?
- Patient treatment?
- Evaluation of the response team?

## RRS EXECUTION

### SAY:

Core tasks common to the execution of every RRS range from detection of patient deterioration warning signs to evaluation of RRS performance.

The first task occurs where urgent unmet patient care needs are **detected** by Activators (e.g., nursing staff) in the primary care unit. This task is followed by the **activation** of the RRS. Following the activation of the RRS, the response team is responsible for **response, assessment, and stabilization**. Once the response team has provided treatment, they must determine the **disposition** of the patient. This could include transferring the patient to another acute care unit if he or she requires further treatment or completing a handoff back to the general care area if the patient has been stabilized. The final task for any RRS is **evaluation** of the response team's performance.

The RRS requires teams within the system to perform critical tasks which require team members to possess specific team knowledge, skills, and attitudes (KSAs) competencies. These KSAs are the foundation of TeamSTEPPS. Moreover, in the case of the RRS, team members must employ these KSAs across teams when moving a patient from one treatment unit to another. These transitions in care represent an extended responsibility for all members of the RRS. Further, they represent a need to demonstrate competency in team skills above and beyond those simply required to perform as an effective team member within a single team.

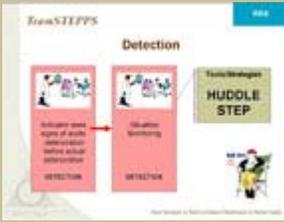
### SAY:

We're going to walk through each phase of RRS execution, focusing on the relevant TeamSTEPPS tools that can be used in each phase. Keep in mind the video that we watched earlier in terms of these phases and what tools might have been used to promote teamwork.



Slide

## DETECTION



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### VIDEO TIME:

2:25 minutes



### MATERIALS:

- RRS Team Success Video Clip: STEP

### SAY:

Now let's focus on the detection aspect of the RRS.

In the RRS, situation monitoring is most important in the detection stage. Family members, nursing staff, and other care units must assess the patient's status prior to and while engaging in patient care.

For the detection phase of the RRS, situation monitoring is the most important team competency. Care providers and family members must continually maintain awareness of the patient's status.

A useful TeamSTEPPS tool for monitoring a situation is the STEP assessment. When conducting an assessment for acute deterioration in patients, the key is to take the RRS criteria and apply them to the patient monitoring portion of the STEP tool.

### SAY:

Let's take a look at the STEP being used to monitor a patient's status.



### DO:

Play the video by clicking the director icon on the slide.

## DETECTION: STEP ASSESSMENT

### SAY:

Here we see how the STEP assessment applies to the Detection stage. When you review the status of the patient, you are required to examine the patient's condition and vital signs. If you are reviewing in conjunction with the alert criteria set for calling the response team, you can answer the subsequent question: Is it time to activate the RRS?

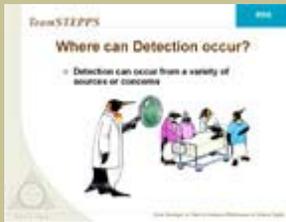
### ASK:

- How would you customize the STEP assessment for your RRS?
- In the video, what would Activators observe by using the STEP assessment?



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### WHERE CAN DETECTION OCCUR?



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#### **SAY:**

Detection can come from a variety of sources, including the following:

- The patient.
- Patient care team members.
- Family members.
- A “gut feeling.”

## RRS ACTIVATION

### SAY:

When the RRS is activated, the general care team must exchange information with the response team when they arrive. The Situation Background Assessment Recommendation communication protocol tool also known as the SBAR is a useful TeamSTEPPS tool for facilitating information exchange regarding a patient's status.

### ASK:

Specifically, think of a recent RRS call that you were a part of.

- Did the person who activated the RRS present the patient to the response team using an SBAR format?
- What was the situation?
- What background was provided?
- What was the assessment?
- What was the recommended strategy?

### SAY:

Let's take a look at the SBAR being used to monitor a patient's status.

### DO:

Play the video by clicking the director icon on the slide.



Slide



### VIDEO TIME:

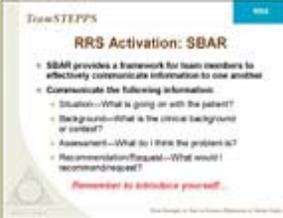
0:32 minutes



### MATERIALS:

- RRS Team Success Video Clip: SBAR

## SBAR PROVIDES...



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### KEY POINTS:

- SBAR stands for: Situation– Background– Assessment– Recommendation.
- The SBAR is one technique that can be used to standardize communication, which is essential for developing teamwork and fostering a culture of patient safety.
- SBAR creates a consistent format for information to be sent and creates an expectation for information to be received.

### SAY:

The SBAR technique provides a standardized framework for members of the healthcare team to communicate about a patient's condition. You may also refer to this as the ISBAR where “I” stands for Introductions.

SBAR is an easy-to-remember, concrete mechanism that is useful for framing any conversation, especially a critical one requiring a clinician's immediate attention and action. SBAR originated in the U.S. Navy submarine community to quickly provide critical information to the captain. It provides members of the team with an easy and focused way to set expectations for what will be communicated and how. Standards of communication are essential for developing teamwork and fostering a culture of patient safety. In phrasing a conversation with another member of the team, consider the following:

- Situation—What is happening with the patient?
- Background—What is the clinical background?
- Assessment—What do I think the problem is?
- Recommendation—What would I recommend?

SBAR provides a vehicle for individuals to speak up and express concern in a concise manner.

### ASK:

Give me some examples of communication exchanges between caregivers in your unit (doctor-to-doctor, nurse-to-doctor, or nurse-to-nurse).

# RESPONSE, ASSESSMENT & STABILIZATION

### SAY:

All four TeamSTEPPS skills are important in the analysis and response tasks.

- Leadership in the form of resource management and decisionmaking.
- Situation monitoring regarding team and environmental changes.
- Mutual support in the form of task assistance, conflict resolution, and team coordination (i.e., advocacy and assertion).
- Communication in the form of information exchange between and among team members.

Useful TeamSTEPPS tools during analysis and response include:

- A **brief** to develop a shared understanding of the patient's presenting problem and a plan of action regarding the patient's treatment.
- A **team huddle** to reestablish situational awareness, problem solve, and readjust the plan if necessary.
- A **check back** or **call out** to ensure closed-loop communication.
- **CUS** words when team members are concerned about a course of action chosen by the RRT.

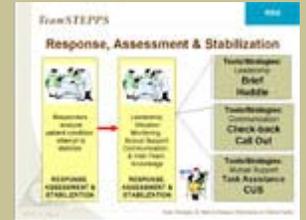
### SAY:

Let's take a look at the one of these tools being used in the response, assessment, and stabilization phase of the RRS.

### DO:



Choose the video clip for SBAR, Team Huddle, STEP or CUS. Play the video by clicking the director icon on the slide.



### Slide



### VIDEO TIME:

2:43 minutes



### MATERIALS:

- RRS Team Success Video Clip: SBAR, Team Huddle, STEP or CUS



### Slide

## SAY:

Huddles represent ad hoc meetings among the care team. They assist with ensuring that everyone on the team is “on the same page” or has a shared mental model. During a team huddle, response team members could:

- Discuss critical issues and emerging events.
- Anticipate outcomes and likely contingencies.
- Set up contingencies for sending the patient to ancillary care units.
- Set up contingencies for a handoff back to the general care area (i.e., keeping the patient in current location).
- Assign resources for the patient.
- Express concerns as needed.

TeamSTEPPS presents a briefing checklist for guiding team huddles.

## ASK:

How would you structure a huddle after you have been called together as a response team?

**RESPONSE, ASSESSMENT & STABILIZATION: CUS****SAY:**

How do you express concern or conflicting opinions?

The best way is to use CUS words.

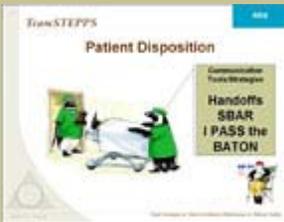
- I am CONCERNED.
- I am UNCOMFORTABLE.
- This is a SAFETY issue.

**ASK:**

How often do you hear these words in the RRS? Is it often?

How would you use these words to encourage advocacy and assertion in your RRS?

**Slide**



Slide



### VIDEO TIME:

1:17 minutes



### MATERIALS:

- RRS Opportunity Video Clip: Incomplete Handoff

### SAY:

Transitions in care rely almost exclusively on the exchange of information. Appropriate TeamSTEPPS tools for information exchange and effective Handoffs include **SBAR** and **I PASS the BATON**. These are particularly useful when handing off a patient from one unit to another.

We will go over SBAR and I PASS the BATON in detail. While we do so, keep in mind where in the “patient disposition” phase each tool might be used.



### INSTRUCTOR NOTE:

The SBAR may be more useful when Responders first arrive to present the patient situation, whereas I PASS the BATON may be useful when the patient is being transferred to a different unit.

### DO:



Choose the video clip for SBAR, Handoff or I PASS the BATON. Play the video by clicking the director icon on the slide.

## PATIENT DISPOSITION

### SAY:

When the response team arrives, the team analyzes the situation to determine the patient disposition. Sometimes this can mean transfer to the ICU, but this is not always the case. This transition of care can include:

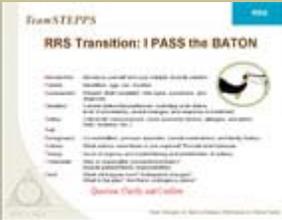
- Transferring the patient to another unit.
- A handoff back to the primary nurse or primary physician.
- A handoff to a specialized team (cardiac team, code team, stroke team, etc.).
- A revised plan of care.

### SAY:

As you can see, when the Responders arrive, the patient is not necessarily transferred to a different group. Disposition can include staying in the general care area with a handoff back to the primary nurse or physician.



### Slide



Slide



**SAY:**

“I PASS the BATON” is an option for structured handoffs.

**I Introduction**—Introduce yourself and your role/job (include patient).

**P Patient**—Name, identifiers, age, sex, location.

**A Assessment**—Presenting chief complaint, vital signs, symptoms, and diagnosis.

**S Situation**—Current status/circumstances, including code status, level of uncertainty, recent changes, response to treatment.

**S Safety Concerns**—Critical lab values/reports, socio-economic factors, allergies, alerts (falls, isolation, etc.).

**THE**

**B Background**—Co-morbidities, previous episodes, current medications, family history.

**A Actions**—What actions were taken or are required? Provide brief rationale.

**T Timing**—Level of urgency and explicit timing and prioritization of actions.

**O Ownership**—Who is responsible (nurse/doctor/team)? Include patient/family responsibilities.

**N Next**—What will happen next? Anticipated changes? What is the plan? Are there contingency plans?

 **DISCUSSION:**

How was I PASS the BATON utilized in this physician to physician example?

- Physician shift change (responsibility).
- Evolving patient condition.
- Sharing of information for better decisionmaking between care leaders.

## RRS EVALUATION

### SAY:

The purpose of the Evaluation phase of the RRS is to understand and improve performance throughout the entire system.

Appropriate debriefing is the key to understanding and improving performance. TeamSTEPPS includes a checklist for conducting a proper debrief.

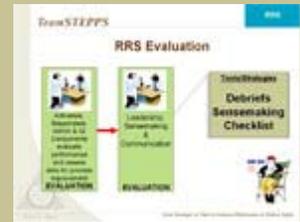
During the debrief the goal is to make sense of the situation and what happened – what Battles, et al., has referred to as “sensemaking.” The keys for effective sensemaking can be found in the Battles, et al., *Health Services Research* report.

### SAY:

Let’s take a look at the one of these tools being used in the response, analysis, and stabilization phase of the RRS.

### DO:

Choose the video clip for SBAR, Team Huddle, STEP, or CUS. Play the video by clicking the director icon on the slide.



### Slide



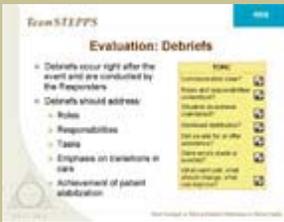
### VIDEO TIME:

1:08 minutes



### MATERIALS:

- RRS Team Success Video Clip: Debrief



Slide

### INSTRUCTOR NOTE:

The institution may want to substitute their Debrief Checklist on this slide.

### SAY:

Responders conduct typical debriefs right after the event to give teams an opportunity to conduct a self examination. Teams typically examine their teamwork by discussing their coordination, mutual support efforts, resource management, conflict resolution, etc. Debriefs play a key role in identifying opportunities for improvement. For example,

- What went well and how can we ensure it always goes well?
- What went wrong and how can we change the RRS to prevent recurrence?

RRS debriefs should also address:

- Roles.
- Responsibilities.
- Tasks.
- Emphasis on transitions in care.
- Achievement of patient stabilization.

### SAY:

Be mindful that we all suffer from a self-serving bias at times of self evaluation. The key to growth through self evaluation is to be honest with yourself. Debriefs should not be punitive in nature.

For additional learning and growth, RRS debriefs could be coupled with a recording of a simulated response team event. Reviewing the recording with a debrief checklist will yield valid evaluations and growth.

### ASK:

What other criteria would you add to your debrief checklist?

## SYSTEM EVALUATION: SENSEMAKING

### SAY:

Sensemaking supports the QI function of the RRS by helping teams make sense of uncommon events and prescribe a course of action for future events.

Sensemaking reviews are typically conducted after an event, much like a debrief. However, the goal of the sensemaking review is to see the “big picture” when looking at all RRS events. This can help uncover any patterns or trends, as well as strategies for dealing with events in the future.

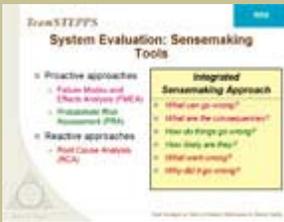
### ASK:

Think back to a time when you and your RRS teammates were involved in a strange or unusual response team call.

- How was the RRS call resolved? What collective perspective was adopted?
- Was a course of action prescribed for similar situations in the future?



Slide



Slide

**SAY:**

Sensemaking can take on many forms. It can take on the form of proactive approaches for risk and hazard assessment when the QI and Administration teams are reviewing RRS calls.

**Failure Modes and Effects Analysis (FMEA)**

This answers questions like:

- What can go wrong?
- What are the consequences?

**Probabilistic Risk Assessment (PRA)**

This addresses the process by which things can go wrong and how likely they are to happen by answering the following questions:

- How do things go wrong?
- How likely are they to go wrong?

**Root Cause Analysis (RCA):**

Sensemaking can also take a reactive approach. This is typically indicative of an attempt to uncover what might have gone wrong during an uncommon event. This is typical of debriefing but involves a much more detailed analysis of outcomes and possible reasons.

- What happened?

An **integrated approach** for sensemaking proves to be most useful for evaluation, especially in the RRS. An integrated approach would attempt to answer all the questions covered under an FMEA, PRA, and RCA.

## RRS VIDEO

### SAY:

Let's look back at our example. Is the team able to apply strategies successfully?

Let's think back to the RRS we saw in action earlier.

Let's see if they have been able to apply TeamSTEPPS tools and strategies to their situation.

### DO:

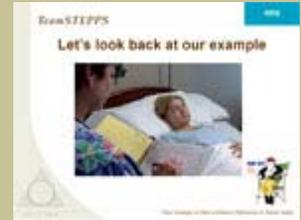
Play the video by clicking the director icon on the slide.

### DISCUSSION:

Briefly discuss the video and what changes the team made to make this call a success.

Strategies to look for:

- Nurse's STEP assessment.
- Nurse's huddle with patient and roommate.
- SBAR between Activator and Responders.
- Positive reinforcement of RRS Activation.
- Check backs throughout.
- CUS words when nurse is concerned; Responder's respect of CUS words.
- Task assistance at the end.



Slide

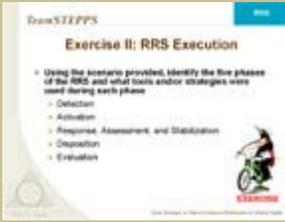
### VIDEO TIME:

8:22 minutes

### MATERIALS:

- RRS Team Success Video

## EXERCISE II



Slide

### INSTRUCTOR NOTE:

The following slides may be customized for the group. It may be effective to pass out the scenarios and have participants split up into groups to discuss each scenario.

### SAY:

Now let's look at five examples and see if we can identify which tools or strategies were used by the RRT and other RRS members.

See if you can identify situations where a tool could have been used to ease performance.

## SCENARIO 1

The nurse called the RRT to a patient who exhibited a reduced respiratory rate. The team was paged via overhead page. Within several minutes, team members arrived at the patient's room; however, the respiratory therapist did not arrive. After a second overhead page and other calls, the respiratory therapist arrived, stating that he could not arrive sooner due to duties in the ICU. This critical team member did not ascribe importance to the rapid response call and failed to provide a critical skill during a rapid response event. As a result, there was a delay in the assessment of the patient's airway and intervention pending arrival of the response respiratory therapist.

Discussion points might include:

- Why might have the respiratory therapist been late? (E.g., he did not have leadership, support or resources to make sure there was back-up support to leave; the situation did not seem important)
- What can the response team and/or the Administrative Team do to demonstrate the importance of the RRS?
- If one of the Responders expected to arrive does not show up, what is the contingency plan?



### Slide

## SCENARIO 2



### Slide

The RRT was called for a patient who had a risk of respiratory failure. The patient was intubated and transferred to a higher level of care. Response team members and the nurse who called the team completed a Call Evaluation Form. The response team members noted that some supplies, such as nonrebreather masks and an intubation kit, were not readily available in the room, which resulted in a delay. This delay could have impacted the patient, and it also affected the team members' ability to return to their patient assignments. The patient's nurse noted on the form that the response team seemed agitated by the lack of supplies and the delay. The evaluation forms were sent via interdepartmental mail to the quality department as indicated on the form. The forms were not collated or reviewed for several weeks. The analyst responsible felt that most of the reports prepared in the past were not used by or of interest to management. Several times the agenda item for RRS updates had been removed from the Quality Council's meeting agenda due to an expectation that the "Rapid Response System is running fine."

Discussion points might include:

- What might management see if the response team evaluations are reviewed?
  - A review of the findings could have resulted in solutions, such as preparing a supply kit for the response team or ensuring that units are adequately and regularly stocked with items that have been used regularly during rapid response calls.

## SCENARIO 3

A family member noticed the patient seemed lethargic and confused. The family member alerted the nurse about these concerns. The nurse assured the family member that she would check on the patient. An hour later, the family member reminded the nurse, who then assessed the patient. The nurse checked the patient's vital signs. She did not note any specific change in clinical status, though she agreed that the patient seemed lethargic. At the family member's urging, the nurse contacted the physician, but the conversation focused on the family member's insistence that the nurse call the physician rather than conveying a specific description of the patient's condition. Based on the unclear assessment, the physician did not have specific instructions. The physician recommended additional monitoring.

Another nurse on the floor suggested calling the RRT, which she heard had helped with this type of situation on another floor. The first nurse missed the training about the new RRS, which was not discussed in staff meetings. Based on her colleague's recommendation, the nurse called the RRT via the operator. The overhead page stated the unit where assistance was needed but not the patient's room number. The operator forgot to take down all of the usual information because he missed lunch and was distracted. The team arrived on the floor but had to wait to be directed to the appropriate room. Once there, the RRT received a brief overview from the nurse, who left the room shortly afterward. The responders conducted an assessment of the patient and identified that the patient was overmedicated.

Discussion points might include:

- What might the nurse have done to address the family concerns?
  - The family can play a role in monitoring the status of the patient; the nurse could have huddled with the family.
  - Family can be educated about the RRS.
- What procedures could be put into place to avoid the confusion of what room the response team should go to?
  - Checklists to ensure that the RRS activation process is consistent.



### Slide

## SCENARIO 4



### Slide

The RRT was called to the outpatient (OP) area for a report of a patient with a seizure. The usual or expected set of supplies was not available for the team in the OP area. The RRT arrived and assessed the patient. As part of the assessment, the team ordered a stat lab. The lab technician working with the OP area had not heard of the RRT and refused to facilitate a stat lab because he was unfamiliar with having this need in an OP area. The RRT members were frustrated but did not challenge the lab technician. The patient was taken to the Emergency Department.

Discussion points might include:

What could the Responders do if they run into this situation?

- Two-challenge rule.
- CUS words.

How can the administration team help with this issue?

- Training for everyone that could be involved in the RRS.

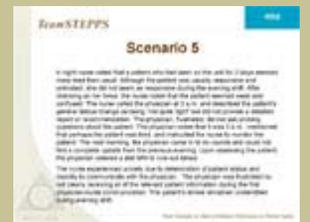
## SCENARIO 5

A night nurse noted that a patient who had been on the unit for 2 days seemed more tired than usual. Although the patient was usually responsive and animated, she did not seem as responsive during the evening shift. After checking on her twice, the nurse noted that the patient seemed weak and confused. The nurse called the physician at 3 a.m. and described the patient's general status change as being "not quite right" but did not provide a detailed report or recommendation. The physician, frustrated, did not ask probing questions about the patient. The physician noted that it was 3 a.m., mentioned that perhaps the patient was tired, and instructed the nurse to monitor the patient. The next morning, the physician came in to do rounds and could not find a complete update from the previous evening. Upon assessing the patient, the physician ordered a stat MRI to rule out stroke.

The nurse experienced anxiety due to deterioration of patient status and inability to communicate with the physician. The physician was frustrated by not clearly receiving all of the relevant patient information during the first physician-nurse communication. The patient's stroke remained unidentified during evening shift.

Discussion points might include:

- What tools or strategies could the nurse have used when calling the doctor?
  - CUS words.
  - Activating the RRS.



### Slide

## TeamSTEPPS™ CITATIONS

**TeamSTEPPS Instructor Guide.** [TeamSTEPPS™: Team Strategies & Tools to Enhance Performance and Patient Safety; developed by the Department of Defense and published by the Agency for Healthcare Research and Quality.] AHRQ Publication No. 06-0020. Rockville (MD): Agency for Healthcare Research and Quality; September 2006.

**TeamSTEPPS Pocket Guide.** [Team Strategies & Tools to Enhance Performance and Patient Safety; developed by the Department of Defense and published by the Agency for Healthcare Research and Quality.] AHRQ Publication No. 06-0020-2. Rockville (MD): Agency for Healthcare Research and Quality; June 2006.

**TeamSTEPPS Multimedia Resource Kit.** [TeamSTEPPS: Team Strategies & Tools to Enhance Performance and Patient Safety; developed by the Department of Defense and published by the Agency for Healthcare Research and Quality.] AHRQ Publication No. 06-0020-3. Rockville (MD): Agency for Healthcare Research and Quality; September 2006.

**TeamSTEPPS Guide to Action.** [TeamSTEPPS: Team Strategies & Tools to Enhance Performance and Patient Safety; developed by the Department of Defense and published by the Agency for Healthcare Research and Quality.] AHRQ Publication No. 06-0020-4. Rockville (MD): Agency for Healthcare Research and Quality; September 2006.

**TeamSTEPPS Poster.** [TeamSTEPPS: Team Strategies & Tools to Enhance Performance and Patient Safety; developed by the Department of Defense and published by the Agency for Healthcare Research and Quality.] AHRQ Publication No. 06-0020-5. Rockville (MD): Agency for Healthcare Research and Quality; September 2006.

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