SCENARIO 1

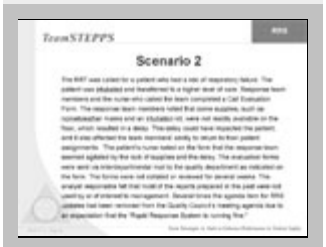
Slide

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?

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 on the floor, 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

Slide

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.

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 RRS 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:

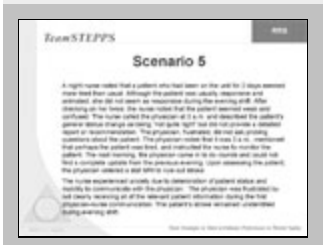
What could the Responders do if they run into this situation?

- 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



Slide

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.