Review of Medical-Surgical Nurses' Rapid Response Team Experiences in a Hospital Setting

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Abstract

Background: The number of patients who need to be readmitted to the critical care unit (CCU) and hospital mortality and morbidity rates is reduced by the rapid response team (RRT). Before any signs of cardiac or pulmonary arrest-related deterioration appear, our team helps patients. The RRT's objectives include the rapid diagnosis and treatment of critically ill individuals. The RRT must also be on-site, accessible, and knowledgeable about situations to be ready to respond quickly. The concept of RRTs is considered to be well known among hospitals. The RRT differs from a team that reacts after a cardiac arrest because it intervenes before a patient has cardiac or respiratory arrest. What is presently known about medical-surgical nurses' experiences when they call an RRT to save a patient's life is included in this article. The author used a literature review as his method of choice. The Scopus search database yielded 22 papers, all original academic studies. After being examined and classified according to preset guidelines, only items in grades I and II were included.

Results: The years of experience and certificates a medical-surgical nurse has will determine whether or not she can decide whether to call the RRT. Knowledge and skills are also essential; some hospitals provide RRT training, while others do not. Together, bedside nurses and RRTs should provide high-quality care. The following challenges might affect how well patients are treated: To emphasize what nurses need RRTS to achieve to have a timely intervention, how information is delivered is essential.

Conclusion

Medical-surgical nurses request RRTs and depend on their knowledge to help save patients' lives. To provide the patient with care, RRTs and medical-surgical nurses must collaborate. It is essential to have substantial knowledge and communication skills to spot clinical signs that demand immediate care in a critically ill patient.

Keywords: Experiences, Hospital, Medical-Surgical Nurses Calling, Rapid Response

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Overview

Some hospitals develop measures to protect patients when a staff nurse notices symptoms of instability before cardiac arrest to prevent mortality and morbidity in severely ill patients. A critically ill patient may have a chance to survive if a nurse is assigned to them. Not every nurse expects their patient to have an arrest. However, several studies have demonstrated that hospital

staff can cause serious issues, including some instances like post-surgical infection, cardiac arrest code, and even death, by failing to recognize the early signs of patient deterioration, such as declining systolic pressure and abnormal breathing.[1]

A patient has the right to excellent medical care. Health services must be enhanced to offer patients high-quality care and achieve the intended outcomes. High-quality care also entails fewer readmissions to the intensive care unit (ICU) and the prevention of illness and infection, according to hospital management. Successful activities should be linked to monitoring to find problems and improve patient outcomes, according to a recommendation. A system called "the Rapid Response Team" has been established to deal with this issue. With the help of the Rapid Response Team, nurses may intervene when patients begin to deteriorate and exhibit signs of cardiopulmonary arrest, lowering the mortality and morbidity rates. In the US, 60% of hospitals have treated patients who have had a cardiac arrest. Other studies have shown that most worsening clinical signs in patients occur before a cardiac arrest. Healthcare professionals must be aware of the deteriorating signs in critically ill patients and have ready countermeasures. Not all appropriately trained healthcare personnel can recognize the signs of impending death. Hospitals must manage healthcare professionals and supply resources to accomplish and manage patient care and service results. Dr Don Berwick, who established the hospital in 1980, works with a team of dedicated individuals to redesign healthcare so that it is devoid of hold-ups, tedious duties, mistakes, and exorbitant expenses. Patient safety, improvement potential, person- and family-centred care, quality, cost, and value are just a few of the essential topics the IHI works on. The IHI seeks to improve patient-provider communication in both life and health. They strongly emphasise fairness, effectiveness, punctuality, efficiency, and safety.[2]

Quick Reaction Team: Lifesaving Methods

The 100,000 Lives Campaign was started in 2004 by The Institute of Health Care Improvement (2001) to reduce mortality and morbidity rates. With an initial focus on anticoagulants, sedatives, narcotics, and insulin, the objectives of this initiative are to put best practices into action, prevent pressure ulcers, reduce methicillin-resistant Staphylococcus aureus (MRSA) infection through control processes and policy, infection through fundamental changes in infection control processes, surgical complications by implementing changes in care, and harm from high-alert medications. By recommending the formation of a Rapid Response Team, they aided in achieving this goal to some extent (RRT).[3]

From December 2004 to June 2006, the program's goal was to save 100,000 lives. The Save 5 million Lives Campaign was then launched as a successor. Implementing the RRT was one of the six recommendations the Institute of Healthcare Improvement made in December 2006 for identifying patients experiencing pre-arrest prior to unplanned ICU admission. The tactics guiding the introduction of the RRT included:

1. Collaborating.
2. Bringing ICU-level patient care to the bedsides of critically ill patients.
3. Evaluating and acting to save patients' lives.

RRTs are employed in more than 25% of US hospitals to avert cardiac arrest, ICU readmissions, and mortality by providing early treatment to patients with acute, quickly deteriorating diseases.[4]

The fast reaction squad goes under a few different names.

Understanding the Rapid Response Teams' vocabulary is essential. The terms Patient at Risk Teams (PART), Critical Care Outreach Teams (CCOT), Medical Emergency Teams (METs), and Medical Emergency Response Teams have also been used to describe them (MERTs). Some of these terms are interchangeable in certain nations, like Australia, where RRT and MET have the same meaning. Like the MET, the RRT supports ill people before any symptoms that might lead to cardiac or respiratory arrest manifest. Both of the fundamental traits of an afferent limb, such as how the team is activated, and an efferent limb, such as the team's reaction, are preserved. There are a few differences between them: While the RRT is sometimes referred to as a nurse-led team, the MET is frequently a physician-led team. Since it is the

type that appears the most often in the literature, the author will refer to all of these terms together in this thesis as "Rapid Response Team."[5]

RRT calls are experiences, according to nurses. The qualifications and experiences of nurses. The majority of medical-surgical nurses were aware of how to call an RRT to enhance patient care. Nurses' evaluations of their degree of preparation have improved due to calling RRTs. The doctor had counselled against calling RRTs. Thus, other medical-surgical nurses had been hesitant to do so. Years of experience as ward nurses influenced whether to call an RRT when a patient was critically ill and needed help. Compared to nurses with 0–5 years of experience, those with 11 years or more of experience were more likely to contact RRTs without first speaking to charge nurses or the central team.[6]

Nurses with an associate's degree in nursing (AND; who studied nursing for two years) and less than or equivalent to three years of experience called at the request of another nurse (i.e., the nurse in charge) or a doctor are considered qualified when an RRT is requested for an urgent case. They called the RRT and compared this response to staff nurses with a bachelor of science in nursing (BSN), who have more than three years of experience and have studied nursing for four years, using the given criteria.[7]

A few experienced ward nurses alone requested an RRT without consulting the other nurses or physicians. The nurses decided whether or not to call an RRT based on their evaluation of the need for immediate assistance. Before reaching out to RRTs to gain the necessary support and validation, some bedside nurses were advised to trust their judgment. When unsure whether to contact an RRT, these nurses often consult other nurses and chat with them.[8]

Medical-surgical nurses collaborate to provide support during a call for RRTs when the bedside nurse shares the patient's understanding of the situation. Achieving role synergy is typified by RN-RN consultation, where what is done via interaction is more significant than what is completed through solo efforts; the RN in an RRT team provides the medical surgical nurse with the knowledge and skills essential for consultation. To prevent undesirable consequences during the rescue operation, RNs work together. A synergic role is an effective and educational tool for nurses and patients alike to assist junior and new graduate nurses and to get the whole picture of a patient who needs care and intervention. According to Wehbe-Janek et al. (2012), bedside nurses have used simulation exercises to increase their awareness of circumstances where patients need help. A high-fidelity simulator with accurate conditions was used to uncover valuable components for the nurse. The simulation program showed the relationship between the RRT and patient outcomes. Their ability to communicate more clearly was enhanced, and they felt more at ease in their roles and duties due to increased equipment familiarity. Such simulations have a considerable potential for effective learning when debriefing and reflective learning are used.[9]

The medical-surgical nurses' experiences indicate that when they began to worry about their patients, they chose to call an RRT because of their self-confidence. As they gained more information about the patient's state, they could decide if an RRT intervention was necessary. Whiledialing an RRT, nurses' feelings differed from nurse to nurse. Although some bedside nurses had positive thoughts about the RRT throughout the call, not all of the nurses did. Sometimes, they interacted amicably. A few nurses said that they were terrified when an RRT called them and chastised them. Other nurses, however, said that the need for RRT calls was due to inadequate medical supervision by physicians; many blamed this on young doctors and their inexperience and lack of training. However, a tiny proportion of medical-surgical nurses opted to call the doctor first rather than an RRT if there was an ill patient. Several bedside nurses allegedly threatened to phone the RRT if they could not contact the covering doctor.[10]

According to Jones et al. (2006), most ward nurses thought that calling for RRTs was done to help and manage a sick patient and averted cardiac arrest in 97% of cases. However, several nurses restricted their RRT calls due to a need for input on the treatment of their patients.[11]

Thoughts of nurses about the benefits of contacting RRTs

According to Wynn et al., there were three main reasons for calling RRTs from the viewpoint of the bedside nurses (2009). Nearly 78 percent of the nurses who participated in the survey (n=75) indicated they often contact an RRT when the patient's vital signs change quickly. The second explanation, 56% of respondents, was a steady decline in the patient's health. The third factor, which accounted for 35% of the cases, was that the physician's side had not offered a convincing response. According to studies that have been done, many nurses think that RRT helps critically ill patients when they display any early warning signs of deterioration. By providing a high level of competence and experience, pushing the assessment and treatment, and supplying high-level support, RRT assists the nurse in avoiding calling code blue to their medical-surgical ward. An RRT also moves the patient to the ICU level of care to guarantee their safety. According to the participating nurses' own experiences, RRTs may prevent mild anomalies from becoming severe, potentially deadly issues in critically ill patients and prevent cardiac or respiratory arrest.[12]

Nurses claim that the most crucial advantage of RRTs is their capacity to help fast deteriorating patients. The participants described the RRT as an additional pair of eyes to assess the situation. Critically ill patients get an early intervention to prevent cardiac or respiratory arrest, and all patients in life-threatening situations receive immediate treatment and support. RRTs also provide ward nurses backup support when they are concerned about or dissatisfied with their current medical treatment or when the ward doctor is unavailable. Thanks to technology, which also gives the ward nurse access to a medical expert experienced in addressing emergencies, they feel confident knowing there is always a backup.[13]

Most medical-surgical nurse participants reported that they call the RRT when there is a challenging medical-surgical issue. They also believed that calling the RRT may help to avert cardiac and respiratory arrest in an ill patient. A few nurses believed that summoning the RRT resulted from their lousy management.[14]

Knowledge and Skill of Bedside Nurses

According to a medical-surgical nurse, the RRT is a beneficial group that provides guidance, education, and continued follow-up for the patient's health. None of the nurses saw this team become discouraged during calls. They also felt certain because of the unit's culture of collaboration and preparedness to care for each other's patients during an RRT event since they knew they would get the assistance they needed.With only one phone call, nurses could immediately obtain help from RRT and the improved skills they had acquired via cooperation. They could even get more help without asking for permission. The hospitals utilized the RRTs to disperse the workload among the nurses. The assistance of medical-surgical nurses in contacting RRTs when they had critically ill patients enhanced their skills, expertise, and understanding of nursing practices. Remarkably fresh nursing graduates benefited from this since it gave them the chance to study the duties of RRTs. According to some brand-new nurses, calling the RRT was a supportive and collaborative experience that encouraged teamwork. Patients benefit from this team when quick decisions are made because, as numerous nurses noted, it offers them practical experience.[15]

According to Wehbe-Janek et al. (2012), the simulation-training program enhanced nurses' expertise and understanding in handling medical crises. An RRT assisted them in identifying their areas of weakness and learning from their mistakes or ignorance, mainly when it came to the uncomfortable challenges they had to overcome during certain suitable activities, including using an algorithm and a crash cart. Some nurses thought that by trading chores and ideas, the assessment process might go faster, improving the patient's health more quickly.[16]

Bedside nurses expressed satisfaction with the interaction with the RN RRTs and noted that the RRTs often gained knowledge and skill. Bedside nurses wanted to be actively engaged with the team to better care for their patients, and this was especially true after the RRT call was over and they had to attend to the patient who was still in the unit. When some patients' families thanked the nurses for their assistance and saving lives after an RRT call, they realized that the RRTs had deepened their admiration for the nurses.

According to the nurses' perspectives in this study, RRTs are valued, and their contributions to everyday work are advantageous. Support and empowerment for nurses are recommended advantages.[17]

Many medical-surgical nurses thought that understanding and being aware of the prerequisites for calling the RRT was essential to meeting the needs of the patients and identifying unstable individuals. Education is essential for creating the skills that can help patients.[18]

Nurses' acquaintance with the RRT call criterion

The bedside nurses tending to severely ill patients call for the RRT by the criteria based on their knowledge. According to nurses' experiences, vital knowledge experiences are essential for handling a crisis. According to medical-surgical nurses, using the team encourages trusting behaviour in an emergency (Leach & Mayo, 2013). RRT requirements. Nearly 84 percent of nurses stated the service improved the nursing environment, and nearly 90 percent of nurses said the RRT program improved patient care. When summoning an RRT, nurses were more likely to respect their limitations.[19]

According to the other nurses, RRTs have assisted them when they know the regulations, which has improved their practice. They also claimed that the nurse leader and their colleagues are behind them. The study's participants said they felt confident when they called an RRT. RRTs were discussed by the nursing staff in the medical-surgical profession during their annual competency assessment. A few persons said that their only knowledge of the RRT was the year of its invention. Participants felt that to know when and why they should call this team, newly minted nurses needed to understand more about RRTs.[20]

Communication Strategies for Calling an RRT

The fact that simulation training helps nurses develop their communication skills is an additional advantage. Several attendees complimented the RRT members' skillful and compassionate communication skills. To capture information during the event, bedside nurses and RRT members used SBAR, which provides information quickly and accurately. According to the participants, many of the RRT nurses provided emotional support. Others said they support bedside nurses and use humour to lighten up tense circumstances. A bedside nurse with poor experience must call the RRT in an emergency, whereas other nurses would call the doctor when they had a sick patient. To speak with the RRT and get additional information, 55.9% of the 351 participants indicated they would call the RRT even if they were worried about any changes in their vital signs.[21]

Frequently Occurring Challenges for Nurses Calling RRTs

Experiential and Understanding

Lack of knowledge and experience may cause uncertainty and uneasy feelings. Some bedside nurses find it challenging to exercise judgment and decide whether or not to summon an RRT when a medical-surgical nurse recognizes that a patient meets the criteria for doing so. Lack of knowledge will also lead to poor patient treatment. Some medical-surgical nurses were apprehensive about calling an RRT for concern that the RRT team would be critical of them when they answered the call.[22]

The conflict between the bedside nurse and the Rapid Response Team

Working as a team is essential to delivering high-quality care and protecting patients' lives. In the case of a dispute between the leading team and the RRTs or between the central team and the nurses, the bedside nurses felt that their plans for the patients were disrupted, resulting in fragmented care for the patient. It might be tough to decide which team the bedside nurse will help. According to a different study, these problems can be divided into two categories: direct challenges, where it is difficult to decide whether to call the RRT or not and indirect difficulties, where the RRT has been called and the question of who should take care of the patient while the RRT is on call out arises. Education Level Professionals who want to join RRTs must have more education, training, and understanding of the organization's core values. Another problem is the RRT staff's attitudes when responding to calls from the bedside nurses. A nurse participant noted that the person's angry tone of voice and communication style made the call-out

uninspiring. Traditional hierarchies and their linkages to physicians and managers limit the ability of registered nurses to make certain decisions during rescue operations. Other nurses who participated in the conversation indicated they were apprehensive about speaking with RRTs because they worried about their judgment. As a result of seeing the team's reaction and being leery of using the RRT again, other nurses were cautious of calling RRTs without the knowledge of the responsible nurses and physicians. Other nurses described situations where they wanted to call for RRTs but held off out of concern that they would seem to have neglected to treat the patients.[23]

Three studies found that communicating with RRT members over the phone who did not exhibit a supportive communication style was challenging. Participants thought the interviewers' body language and questioning techniques were rude and condescending. The bedside nurse also didn't think their conversation tone was encouraging. The nurse hesitated to call because she didn't know the institution's procedure for calling RRTs, which presented a puzzling barrier. According to Bagshaw et al. (2010) and Wehbe-Janek et al. (2012), nurses who want to call RRTs have extra challenges. They must suppress their desire to call the RRTs because they get frustrated with the treatment delay when physicians cannot examine their patients. Due to a lack of assistance from colleagues, nurses were compelled to work constantly, which lost essential time that might have been used to care for their patients. Several nurses mentioned increased communication as another advantage of simulation training since they were unfamiliar with open communication procedures. The simulation conveyed a lack of confidence and comfort in terms of feelings. Many nurses said they would consult a doctor before calling an RRT, while other nurses expressed worry that sure doctors could shout at them if they called the RRT. 84 percent of those questioned whether using an RRT system would increase their workload while caring for patients disagreed or strongly disagreed. Certain RRTs need further instruction to promote good communication between the team and employees caring for the patient because of their unfavorable attitudes.[24]

Conclusion

Medical-surgical nurses use their knowledge to make decisions while summoning RRTs to help save patients' lives. To care for patients, RRTs and medical-surgical nurses must collaborate. Both parties need to be aware and skilled communicators to swiftly provide treatment to a critically ill patient and notice the developing clinical signs that need action.

The experiences of bedside nurses familiar with the signs of a failing patient and aware of the prerequisites for contacting RRT have a vital role. The years of experience and educational credentials are crucial considerations when a nurse decides whether or not to contact the RRTs. The style and attitude of the RRT member and the bedside nurse can significantly influence how successfully they communicate. Finally, the patient needs support and protection from any adverse incidence while receiving medical care at a hospital. An RRT is a valuable tool that hospitals may use to educate staff members. When a patient is kept in the hospital due to a medical error, this team is necessary.

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Participant consent and ethical approval

No moral analysis is needed because no health-related information will be acquired. Data fabrication and forgery, privacy and confidentiality concerns, misconduct, dual publication, capitulation, and replication were all moral considerations that the author seriously considered when conducting this study.

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