The Educational Curriculum for RRS

Anne Lippert
Danish Institute for Medical Simulation

Anne.Lippert@regionh.dk
Danish Institute for Medical Simulation
The main center for simulation in the Capital Region Of Denmark
Conflicts of interest: None to declare
Content:

- Why do we train the teams? – the needs
- Diverse teams – diverse training
- Simulation based training – what can it offer?
- Evaluation and feedback – possibilities after the introduction of a regional Database
What are the tasks we need to prepare the teams for?

- Working in a different environment
- Creating a team amongst strangers
- Having a structured approach to the patient
- Using appropriate medical knowledge
- Helping and educating staff on the wards
- Taking decisions, sometimes life and death – even end – of life decisions
- Making a plan – and getting it across
- Follow-up?
Very diverse rapid response teams

- Nurse from ICU – "hotline" to an ICU doctor
- Nurse and doctor from ICU
- Anesthesia nurse

- Sometimes defined together with ward nurse and doctor

- Some hospitals don’t have a RRT – call the ICU physician directly (anesthesiologist)
Diverse teams - diverse training???

Possible subjects of interest:
• Scoring system – or calling criteria
• A systematic approach to examine the patient
• Specific treatment/care knowledge
• Situational awareness
• Decision making
• Team function – leadership and followership
• Communication
• Handover
Diverse teams -

Need training on different levels, but also team training
Diverse teams - diverse training

• From no training to 8 hours and training together with ward staff for the deteriorating patient
• Supervision and feedback for the nurses
• Feedback in cases of cardiac arrest (doctors only)
• 2-3 annual theme sessions, brush up and improvement discussions
• Bed-site training and supervision (nurses mostly)
Diverse teams - diverse training

Nurse-led teams:
- ABCDE approach to patients
- Communication - SBAR
- Documentation
- Peer- to peer supervision

Doctor-led teams:
- Nurses more training than doctors in ABCDE
- Communication - SBAR
- Documentation
- Simulation and debriefing
What is not trained?

- Decision making – biases
- Who benefits from ICU?
- Sequelae after ICU stay
- End – of – life decision making and conversations
Various kinds of bias

• Anchoring og Confirmation bias – see only what we want to see
• Attribution error – The patient is to ”blame” (alcohol, obesity etc)
• Availability error – seen many times before
• Triage Cueing – tentative diagnoses, ”Geography is destiny”
• Representativeness restraint – avoids thinking about alternative, rare manifestations
• Search satisfying – stops when one possible answer is found
• Outcome bias –likes diagnoses with a beneficial outcome
• Aggregate bias – I don’t need to follow guidelines, my patients /situations are different
• Etc…..

Ref: ”How doctors think”, Jerome Groopman, M.D. 2008
Ref: Pat Croskerry: The Importance of Cognitive Errors in Diagnosis and Strategies to Minimize Them”. Acad Med 2003;78: 775-780
Situational awareness

• Not realizing – or wanting to realize – the seriousness of the situation

• Perceptual error

Failure to perceive clinical events: an under-recognised source of error
Author: Paul R. Greig Helen Higham Anna C. Nobre
DOI: http://dx.doi.org/doi:10.1016/j.resuscitation.2014.03.316
Resuscitation 2014
Hierarchy

Speak up for the patient – just do it!

• Very easy to say (and mean in earnest) – but veeery difficult to do
• What does it take to minimize hierarchy in patient safety sensitive situations?
• A change in culture – how?
• Training - together - simulation
An example of a curriculum

Program in Herlev University Hospital
For the ICU staff:
• Intro – the goal of RRT and the tasks
• ABCDE – a workshop
• Respect and feedback – a workshop on communication
• Documentation – our new database
• Simulation – scenarios and debriefings
An example of a curriculum

Program in Herlev University Hospital

For the ward staff:

• Intro – the goal of EWS and the MET
• EWS and ABCDE – theory and a workshop
• Simulation – scenarios and debriefings

• BUT THEY DO NOT TRAIN TOGETHER !!!
Full scale simulation

Training a realistic scenario (patient case) in realistic settings with no real patient involved

The scenario is followed by a debriefing of the participants
Simulation offers:

- Drills, know your role and your tasks
- An opportunity to reflect on own behaviour
- Training non-technical skills (safe communication, situation awareness, leadership, co-operation, task management, use of relevant resources etc.)
Simulation offers:

- Safe surroundings – no patient is harmed
- Medical knowledge and Non-technical skills are trained
- Scenarios that can be customized to the actual participants
Reflection

- Enable the learners to identify and build on their existing knowledge
- Enable the learners to identify deficits in their knowledge
- Enable the learners to generalize from a particular experience and apply their new knowledge
- Learners are likely to feel more ownership of insights that emerge from their own discoveries
Simulation based education-concrete experiences

Citations from ViEWS education 2012, post simulation scenario:

• Nurse Jane: ”Now I see that it gives me a tool and language in common with the doctors – the doctor will be more willing to see the patient”

• Doctor Katja: ” Improved common language, no longer the vague: I think Jensen is in a bad shape….. But rather: ”Jensen has a ViEWS score of 6 compared to this morning’s 2, he is doing worse in RF and oxygen saturation and I even increased the O2 supply. I need you to come straight away, please”. This will make me much more inclined to go there.”
Transfer into practice
A qualitative study of nursing students of transfer to practice:
1. Memory (enhancing storage and retrieval of knowledge)
2. Mnemonics as transfer tools
3. Recognizing similar situations
4. Emotional responses

Lessons learned: use simulated patients and increase stress

Medical emergency teams

- Simulation enhances team-performance in a simulated environment

DeVita MA et al 2005 in Qual Saf Health Care
NTS in Pediatric emergency teams

• In-situ training of technical as well as non-technical skills in a pediatric intensive care unit increased comfort and preparedness and decreased anxiety in a "real" multidisciplinary team

What should be done more:

- Training the team together
- Training human factors (Elaine Bromiley video)
- Prevention/mitigating human error

https://app.box.com/s/5ri1gm5pcpem1wdl2cek

Youtube.com Just a Routine Operation
DATA drives knowledge

A database offers new possibilities:

• Use it for feedback to the nurses and doctors – who are especially interested when statistics is involved
• Several RRT calls before ICU admission
• Time lag
• Calls without a plan
• Is the entire team assembled (doctors on wards may be missing)
• Use it for the administration – number of calls – time used - resources
Thank You