Pediatric Rapid Response System Education

UNC Hospitals
North Carolina Children's Hospital
What Happens When…

• you know there is something *just not right* with a patient and you need some additional help to evaluate the situation?

• your knowledge base tells you that some action needs to be taken, but you are reluctant to be overly aggressive calling for help – *maybe you’re wrong and it’s nothing*?
What Happens When...

• A patient is deteriorating and requiring multiple urgent interventions and you are not able to keep up with the orders – you know the patient needs care urgently but you only have 2 hands...
Has this ever happened to you?

If not, it will at some point in your career.
At UNC Hospitals, we have a process that will get help to the scene when you need it.

The Rapid Response Systems

The patient will get the care and treatment required in a timely manner - possibly before a bad situation becomes worse.
In this presentation – you will learn about the Pediatric Rapid Response System

We also have an Adult Rapid Response System at UNC Hospitals
Please ask your supervisor for details
This process encourages the nurse, physician, respiratory therapist, and all other staff to call the Pediatric Rapid Response Team (PRRT).

We want **YOU** to call for help before the situation becomes an emergency. A subset of the pediatric code team (PICU fellow, Pediatric Admitting Officer, PICU RN, RT) will respond immediately. **THE STANDARDS FOR CALLING THE PEDIATRIC CODE TEAM HAVE NOT CHANGED.**
If you are concerned, please call 6-4111 for the “Pediatric Rapid Response Team”

Calling criteria:

• Staff or family member is worried about the patient
  (A “gut feeling” is more than enough!)
• Acute change in heart rate
• Acute change in systolic BP
• Acute change in respiratory rate
• Acute change in $O_2$ saturation
• Mental status changes
• New or prolonged seizure
• Patient with difficult to control pain or agitation
It is important to stress the following to all personnel:

When you call this emergency, if everyone arrives and you determine that the problem can easily be rectified - you have achieved the ultimate purpose of the plan. *It was not a call or time wasted!*

*There should never be a negative response to this call nor should we second guess the caller of the Pediatric Rapid Response Team*

*We must partner to create a culture where it is easier to call for help*
Case 1 Presentation

• An infant is admitted early afternoon with new onset pneumonia. At 21:45, the nurse notes the patient to be “irritable” and reassesses the patient at 22:05 at which time the heart rate is noted to be 220-230.

• The resident is called to the bedside and arrives at 22:10. The patient is assessed and examined by the resident in the presence of the nurse and over the next 20 minutes the patient is noted to be “grey and desaturating”.
Case 1 Presentation

- At 22:30, the patient experiences a cardiac arrest and the code team is called. The patient receives CPR and is taken to the ICU after successful intubation.
- In this situation, it would have been appropriate to call the PRRT at the first recognition of instability. At least 25 minutes elapsed during which time the team could have been assessing the patient with the physicians and nurse assigned to the patient.
Case 2 Presentation

• Patient is a 7 month old ex-premature infant with a history of congenital heart disease.

• He has been hospitalized for several weeks for management of congestive heart failure and failure to thrive.
Case 2 Presentation

• At 0400, the nurse finds him to have HR of 170, RR 90, saturations 93% on RA and he is febrile. The nurse contacts the resident who assesses the patient and recommends monitoring, obtaining a blood culture and starting antibiotics.
Case 2 Presentation

• The patient continues to have an elevated RR and HR and the nurse makes frequent assessments. When the attending physician examines the patient at 09:45, the patient is found to be in severe respiratory distress with poor perfusion and is emergently transferred to the ICU.
Case 2 Presentation

• Immediately after the patient arrives in the ICU, he suffers respiratory arrest and requires intubation.
• An echocardiogram reveals severe cardiac dysfunction.
• Three hours after transfer to the ICU, the patient suffers a cardiac arrest and does not have return of spontaneous circulation.
Case 2 Presentation

• In this situation, it would have been appropriate to call the PRRT at the first recognition of instability.

• At least 5 hours elapsed during which time the team could have been assessing the patient with the physicians and nurse assigned to the patient.
Culture Change

• *There should never be a negative response to this call nor should we second guess the caller of the Pediatric Rapid Response Team.*

• There are no False Alarms

• We must partner to create a culture where it is easier to call for help.
Situational Briefing (SBAR) techniques are used in communication.

It is important to effectively communicate with the team as they arrive to the patient’s location.

* **Situation:** who you are and your relationship to the patient
* **Background:** what is the patient’s diagnosis and brief clinical synopsis of current problem?
* **Assessment:** what is your assessment of the problem?
* **Recommendation:** what recommendation do you have for the team? (this may be as simple as you would like the team to evaluate the patient)
Situational Briefing Example

**Situation**
“My name is Lynn; I am the resident/RN/RT for Joey. He is a 3 year old admitted with an asthma exacerbation”

**Background**
“He has required more treatments this evening and even though he seems to be breathing ok he just seems confused and not acting right”

**Assessment**
“I’m really worried about his mental status”

**Recommendation**
“I think he needs to be evaluated by the rapid response team now”

*This technique can allow important information to be shared with the team so appropriate, safe care can be delivered quickly.*
Team Members

• The PRRT is composed of the ICU responders and the primary team responsible for the patient.
• The primary nursing and physician staff are expected to be part of the team.
• If the primary physicians are not able to attend at the bedside at the time of the team’s arrival, the ICU responders will communicate with them by phone.
Team Members

• Please do not respond to the call if you are not a member of the PRRT unless you are the patient’s physician, nurse, or RT

• Extra staff responding to codes and rapid response team calls causes large crowds and confusion
Questions

1. Who can call the Pediatric Rapid Response Team?
   A. The patient’s nurse after he/she contacts the patient’s primary medical team
   B. Any medical staff member after he/she contacts the patient’s primary medical team
   C. Anyone who needs the team including a patient’s family – the patient’s primary medical team does not need to be contacted first
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Questions

2. How do you activate the Pediatric Rapid Response Team?
   A. Call the Pediatric ICU charge nurse
   B. Call the hospital emergency number 6-4111 and ask for the Pediatric Rapid Response Team
   C. Call the Pediatric ICU fellow
Questions

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A. Call the Pediatric ICU charge nurse

B. Call the hospital emergency number 6-4111 and ask for the Pediatric Rapid Response Team

C. Call the Pediatric ICU fellow
Questions

3. Can a patient’s family call the team?
   A. No
   B. Only if a staff member calls for them
   C. Yes, there is a mechanism and education program in place in for family members to call the Pediatric Rapid Response Team
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4. Is it appropriate to give feedback that a pediatric rapid response call should not have been made?

A. Yes, when it is a false alarm
B. Never, there are no false alarms in this system
C. Only when the primary team was not contacted first
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A. Yes, when it is a false alarm
B. Never, there are no false alarms in this system
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Questions

5. Where does the team respond?
   A. Only in the Children’s Hospital inpatient areas
   B. The inpatient and outpatient Children’s Hospital areas
   C. ANYWHERE in the UNC Hospitals (in and out of Children’s) where a child needs the team including clinics, lobbies, radiology, and all other hospital building areas
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Questions

6. Can you call the Pediatric Rapid Response Team for a pediatric visitor?
   A. No, the team can only be called for patients.
   B. Yes, the team can be called for a pediatric visitor anywhere in UNC Hospitals
   C. Only in the Children’s Hospital
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Questions

7. Can you be told not to call the team or be reprimanded by anyone for calling the team?
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No! If you feel that you have been reprimanded by anyone you should report this to your supervisor or to the responding ICU physician or nurse. They can assist with disagreements regarding the need for the team. Remember, there are no false alarms and this is all about the patient!