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## Is Your Radiology Department Rapid Response Ready?



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Mock codes can be useful exercises to identify inadequacies in systems, standards of care, and teamwork that could be remediated in order to optimise patient care and safety, according to a report published in the *Journal of Radiology Nursing*. Using in situ mock codes can continue to provide practice for responders — both noncode team and code team members — so that they perform better during common emergency events.

Many code responses are often inadequate, depending on system integrity, team communication, and responder knowledge and experience. Responders often describe codes as “scary and intimidating”, regardless of whether they are nurses, physicians, respiratory therapists, or other members of the code team.

Sally Rudy, MSN, RN-BC, CHSE, a simulation educator at Penn State Hershey Clinical Simulation Center, and colleagues evaluated the effectiveness of using mock codes in a radiology area in a 550-bed teaching hospital. Staff responses in the first few minutes of a code are critical for patient survival; however, the code response in this expanding radiology department — where critical events happen often but do not always run smoothly — needed to be evaluated and remediated.

The clinical nurse educator (CNE) for radiology requested the mock codes to allow newly assigned staff to practise responding to critical events and to identify new emergency equipment locations. The radiology area in this busy academic medical centre has long been a maze of hallways and rooms, difficult to label and find. Hospital code teams, ad hoc groups of providers that include critical care physicians and nurses, anaesthesiologists, and others, often got lost trying to find codes in radiology. In addition, the code-call system was not standardised.

See Also: [Patient Emergencies in Radiology: How Frequent?](#)

Mock codes were run in different units in the radiology department. A total of 38 multidisciplinary responders participated in the mock codes, some from radiology and others from hospital code teams. Responder arrivals and actions were timed and evaluated for teamwork and standards of care. Effective team communication was lacking to some degree in all of the mock codes. In one of the events, a radiologist on the scene initially was the obvious team leader, but there was no clear handoff to the code team when they arrived. This created confusion about the team leader role for the remainder of the event.

Debriefing occurred after each session, and participants were asked to complete a post-session evaluation. The debriefing plan for the mock codes was to avoid highlighting individual incorrect actions but rather to focus on objective CPR (cardiopulmonary resuscitation) feedback, team communication, and effective team leadership to positively impact patient outcomes.

Significant systems, standards of care, and teamwork shortfalls were identified related to code paging, wayfinding, access to emergency equipment, team leadership, and CPR. Remedial discussions took place during debriefings, and corrective actions began after the sessions. Remediation included improvements in paging and wayfinding and the implementation of team training (including CPR) and emergency equipment reviews.

“The more mock codes were run, the more obvious it became that patient safety and outcomes might improve with ongoing simulated code response activities that looked at systems issues but that also addressed team communication and individual CPR effectiveness,” the authors note. “Staff are self-described as more confident and better prepared to deal effectively with emergency patient care events.”

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Published on : Tue, 15 Dec 2015