Sigma’s 30th International Nursing Research Congress
The I.C.a.R.U.S. Program: Phase 1
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Purpose: The healthcare system is ever-changing and multifaceted, patients are presenting to healthcare providers with more complex illnesses and shorter hospital stays. These patients require competent collaborative interprofessional care to have successful outcomes. Interprofessional education is thought to improve efficiency and patient safety. Interprofessional education is now widely being developed and used throughout the world as evidence finds that it leads to more positive interactions, cost-effective, and patient-centered care. Interprofessional education also leads to increased competency and self-efficacy of those involved and saves time in times of emergency. Facilities that train together are more likely to have excellent communication, clearly defined roles, improve understanding of scope of practice, and better satisfactions scores from the patients and staff. This collaborative type of education can enhance quality, safety, and efficiency for the healthcare system. Interprofessional education can be delivered through a variety of methods including but limited to simulation, role playing, rounding, and evidence-based projects. For these reasons and many others there is a large drive to establish Interprofessional education (IPE) within healthcare facilities. Commitment to professional excellence also includes a drive to improve patient outcomes by improving communication and teamwork which will lead to better patient outcomes and efficiency. This will help systems to become even more of an example of what excellence in patient care should be to the world. The purpose of the I.C.A.R.U.S. program is to meet the complex and multifaceted demands in patient care by improving communication and teamwork between the nurses and the physicians, starting with the medical and nursing residents.

Methods: Phase one of the I.C.A.R.U.S. program involves conducting mock codes with the medical and nursing residents and surveying them after the experience. The mock codes occur once or twice a month and all participants and observers are asked for feedback about the experience and ways to improve for the future. The nursing residents were later rounded on to see if there were any changes to their confidence when interacting with the physicians.

Results: The program is not completed and is in its early stages but after the first few sessions the medical and nursing residents verbalized that they wanted more activities like the mock codes and that they felt they had a greater understanding of the other professional. They felt more comfortable communicating with each other.

Conclusion: Phase one of the I.C.A.R.U.S. program is still in the early stages but it showed leadership and members of the healthcare team that there is a need and a desire for these types of activities. It also has thus far improved communication between the medical and nursing residents as well as between the nursing residents and the attending physicians. The mock code improved team work and communication for the staff that participated. The mock code experience improved understanding of roles and communication for participants and observers as well.
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Keywords:
experiential learning, interprofessional and nurses

References:


Abstract Summary:
How can we improve communication at the start of the nurse-physician relationship? Is there a way to start role delineation and communication excellence at the beginning? The participants who view this poster will learn about the concept of phase one the I.C.A.R.U.S. program, an IPE concept to improve communication.

Content Outline:

1. Introduction:
   Communication is a key issue that affects many healthcare facilities throughout the world. The problem largely lies in the miscommunication between physicians and nurses. Often words and intent are misconstrued and without correction it may lead to poor patient outcomes. The point of the I.C.A.R.U.S. program is to improve that communication at the beginning. This involves joining medical and nursing residents in various activities.

1. Body
2. Main Point #1 There is an obvious problem with communication between physicians and nurses in healthcare facilities.
3. Supporting point #1 Deficient communication may create a feeling of acrimony between the professions.
4. a) Nurses are reluctant to call physicians
5. b) Physicians sometimes do not understand why nurses are calling and are angry
6. Supporting point #2 the communication and professional relationship between these two professions has a direct impact on the quality of patient care.
7. a) If a physician isn't properly notified of a patient issue it may lead to a delay in patient care
8. b) A sentinel event may occur due to a medical error if orders are not verified or clarified.
9. Main Point #2 Medical residents and nursing residents are not so different in their experiences upon leaving their academic institutions.
10. Supporting point #1 They are both adult learners with mostly textbook knowledge when they start their residencies
11. a) Depending on the type of academic institution they may have limited exposure to many clinical situations such as a code blue
12. Supporting point #2 They both are learning from a senior medical professional in their field
13. a) The medical residents have grand rounds, while the nurses are precepted
14. Main Point #3 There is evidence that shows that structured active or experiential strategies can help improve teamwork and communication.
15. Supporting point #1 In 2006 six academic institutions with health professionals programs saw the issue with interprofessional collaborative practice
16. a) The IPEC was formed with the goal to create and grow an interprofessional healthcare team
17. Supporting point #2 Simulation is through to be a powerful tool to reinforce collaboration
18. a) The I.C.A.R.U.S. program phase one uses mock code blues to increase coordination, communication, and efficiency amongst the different professions.

III. Conclusion: In conclusion the medical residents and the nurses attested on the survey that communication was much clearer and they had an understanding of the knowledge base and intent of the other professionals. In addition, before this activity there was a degree of separation between the two groups, now they freely engage in casual conversation and seek help from each other. The nurse residents also verbalized more confidence in their interactions with physicians. There appears to be a beautiful
exchange of knowledge and ideas. This is only phase one of the I.C.A.R.U.S. program and its only in the earliest of stages but more activities are to come.

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**Author Summary:** Keondra Rustan serves as Clinical Educator, Informaticist, and Simulation Developer at Eisenhower Health. She is an experienced nurse who has served as a staff educator as well as a nurse faculty member. She is a member of several professional organizations and is dedicated to advancing education. She is currently responsible for training faculty/staff and ensuring that new technologies are integrated properly at her facility.