Rapid Response at Northwest Hospital
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Planning & Education

- Planning for our Rapid Response program began back in 2006
- Staff educated on when and why to call a Rapid Response
  - Used our “COW’s” to provide a power point presentation to each unit
  - Had messages displayed on flat screens throughout the hospital
  - Inservices for RRT team members
Implementation

- Rapid Response Team went live March 2007
- To date we have had over 400 RRT calls
Why Condition H at Northwest?

- Best Practice
- Patients have evolved over the past decade into better educated and better informed consumers of health care, and may already be aware of the service from other hospitals
- Families can be helpful in identifying acute changes not readily seen by primary care staff
Why Condition H at Northwest?

• To improve Press-Ganey scores associated with
  – Improved communication between patient and care team
  – Improved patient outcomes
  – Improved communication between individual care providers
Families & Rapid Response Planning

• Discussions around Families and RRT with the RRT Committee initially began October 2007

• November 2007 meeting decided on an April 1\textsuperscript{st}, 2008 target for a Families and RRT role out date

• December 2007 our committee head left the hospital
Families & Rapid Response Planning

- By April 2008, still ironing out kinks with the RRT (i.e.: how to call one, when to call one, overburdened ICU staff)
- Met a lot of resistance from staff (especially in ICU) related to families calling Rapid Responses
- With the support of the VP of Nursing and the Critical Care Committee final decision made to implement family involvement in Rapid Response
Families & Rapid Response Planning

• RRT committee decided to initiate this process with a 2 month pilot in July and August on the IMC unit
• Hospital role out September 22nd
Implementation

- 2 month pilot on our 16 bed IMC unit
- Unit chosen because manager volunteered
- Education
  - Inservices given to staff
  - Talking points were available
  - A brochure to reinforce the talking points for the patients were given out
  - Laminated poster placed in patient rooms
  - A poster was left in the nurses station area with all the information above and points for documentation
  - Nurses instructed to document patient teaching on our IDPOC (show IDPOC)
Documentation for tracking

![Rapid Response Team Form](image)

**Situation**

- **Date/Time Called:**
- **Time Arrived:**
- **Minutes on Unit:**

**Reason for Call:**
- Staff Concerned
- Seizures
- HR change <60 or >120
- Rapid deterioration
- FiO2 > 50%
- SpO2 < 90% on O2
- Airway compromise
- RR <10 or >30
- SBP +/- 30% from baseline
- SBP < 90mmHg
- Abrupt dyspnea
- Arrhythmias

**Person Initiating RRT:**

**RRT Initiated by Patient/Family:** Yes

**Background**

**Events Leading to Activation of RRT:**

**Assessment**
Challenges During Pilot

• Making sure the nurses did not feel like they were being penalized
• Dispelling fears that families were going to “abuse” the service
• Decreasing the pressure ICU/RRT nurses felt due to the perceived notion that there were going to be many more RRT calls with the implementation of this process.
Over Coming Challenges

- Education, Education, Education
- Support from Management
Hospital Wide Implementation

- Same as for pilot, a few changes due to the future roll out of our Clin Doc II at the end of this month.
- Educators and Clinical Leaders assisted with hospital wide education
Current Challenges

- Advertisement
- Patient and Family education – difficulty tracking whether or not this is being done
- Little resistance from staff, especially since there had been no calls from families or patients during the pilot period
Conclusion

- RRT committee needs to re-evaluate how effective the education was and discuss how to monitor whether or not the education is actually being done.
- We still have had no families or patients initiate a Rapid Response since implementation of this program.
- Thank you for your time and attention.