IDENTIFICATION:

In today’s healthcare environment, there is an imperative that patient safety be improved. The 1999 IOM report “To Err is Human,” which revealed that health care mistakes kill up to 98,000 people a year, served as a “wake up call” to the international healthcare community. Quality organizations, such as the Institute for Healthcare Improvement (IHI), The Joint Commission (TJC) and others, have embarked on initiatives like the 100,000 Lives Campaign, which is now the 5 Million Lives Campaign, and a widespread endorsement of the National Patient Safety Goals (NPSG’s).

Of the numerous strategies promoted by these safety initiatives, the development of rapid response teams (RRT) has been widely adopted, not just in the U.S., but also internationally. Although there have been limited randomized trials, there is a proliferation of literature describing the clinical value of RRT implementation. In general, studies have reported decreased in incidence of arrest by 50-65%, decreased deaths from CPR by 56%, decreased ICU length of stay by up to 80%, as well as other positive outcomes. It has become widely accepted that RRT has provided a mechanism by which the nurse can get help quickly to the bedside of patients who are clinically deteriorating, and thus, prevent codes. This concept has now been integrated as a requirement into the Joint Commission’s NPSG’s for 2009.

Although many discussions had occurred, our organization had not developed a rapid response team. There were numerous reasons for this, one of which was that we have many clinical nursing resources for staff, as well as residents, interns, and midlevels to support the attending physician staff. In addition, our facility’s code survival data exceeds the national benchmarks.

In the current economic situation, individuals, businesses, as well as healthcare systems, are compelled to do more with less. Our challenge was how to meet the 2009 NPSG’s, specifically related to managing deteriorating patients, without negatively affecting the budget.

PROCESS:

A thorough review of the literature had been done initially to provide an analysis to Administration regarding the state of rapid response systems. In addition, several meetings occurred to discuss whether or not to implement an RRT, and implications for patient safety and cost to the hospital. With the groundwork having been done, another meeting, including frontline nursing and physician staff, occurred to brainstorm alternatives to meet the NSPG standard, once it was clear that having a specific team was not an option. This team remained in place to develop a solution.

SOLUTION:
The team identified three critical elements needed in developing a process for improving management of deteriorating patients:

- Recognition
- Communication
- Response

A process was developed that included a tool for nurses to help identify signs of clinical deterioration, a standard “language” and method for communicating to the provider, and expected timeframe for provider response to be at the bedside within 10 minutes. The team included key physicians from the Department of Medicine as “champions,” and two patient care units were identified for the pilot, one general med-surg, and the other intermediate care unit (IMC). Managers and nurses from these units were added to the implementation team.

The pilot of our new process, “Urgent Evaluation,” was to begin in 8/08, with anticipated house-wide implementation targeted by 12/08. The process to be piloted was as follows:

- Nurse identifies deteriorating patient
- Provider is paged with “911” added to the callback number
- Provider answers page within 5 minutes
- Nurse says “I have an Urgent Evaluation for _______”
- Provider to the bedside in 10 minutes
- APN and charge nurse notified for support, enabling the nurse to stay with the patient

In preparation for the pilot, similar education was developed both for nursing and providers, with the belief that accountability for provider response could be expected only if the process is understood. One-on-one meetings with physician chiefs of services also occurred, and were successful in obtaining support for the process. Standardized tools for documentation and tracking data were developed, as well as a schedule for ongoing team meetings during the pilot phase. These meetings were instrumental in identifying and discussing issues, making adjustments in the process, solving problems immediately, and tracking data.

The following indicators were tracked during the pilot:

- # calls per week/time of day
- Reasons for calls
- Provider response times
- Patient disposition
- Patterns in recent (8 hrs) admissions from ED/transfers from critical-care
- Unplanned admissions/returns to critical-care
- Codes

The first 3 months of pilot data (34 events) revealed that the physician responses were within expected timeframes from 75 – 96% of the time. On the monitored unit (IMC), all patients were managed and maintained on the unit, while on the general unit, all patients were transferred to a higher level of care. There were no codes on the general unit during this timeframe.

Pilot data was reported to administrative and clinical staff in hospital meetings, and a plan was created to implement the process house-wide during November and December.
Additional data is currently being compiled, and a mechanism to correlate this with hospital code data is being developed. An oversight process of frequent unit-level meetings to track data and issues is in place to continue reinforcing and monitor quality, and a committee is being established for ongoing oversight.

Response by nurses has been positive, citing clarity in how to obtain help quickly, an improvement in provider response, and a sense of being able to provide the care needed to the patient. Providers, who were worried about nurses calling when it was not urgent, have commented that they are “cautiously” optimistic about the process.

The hope is that trust is strengthening as communication improves, and nursing and providers are both at the bedside to provide the best care and keep the patient safe.