



▶ 1<sup>ST</sup> QUARTER AND FEBRUARY 2007 RESULTS ..... 1

○ February | ○ Issue 2 | ○ 2007



▶ SUPPORTING RESEARCH FOR RAPID RESPONSE TEAMS...2



▶ MEDCOM RRT CALLER RECOGNITION ..... 1

# TAMC Rapid Response Team

ADDRESSING THE NEEDS OF PATIENT SAFETY AND PATIENT CARE

1<sup>st</sup> Quarter (November 2006 – January 2007) and February 2007 Results

## Achieving patient care goals

On November 1, 2006, the Rapid Response Team was implemented at Tripler Army Medical Center. January 2007 was the end of the first quarter of operation. The program has been very successful.

Program success can be measured in several ways. One way is through an RRT Staff Evaluation Survey. A large percentage of callers agree that the Rapid Response Team made a difference in the patient's care and that the staff member is more confident in caring for patients because of the RRT.

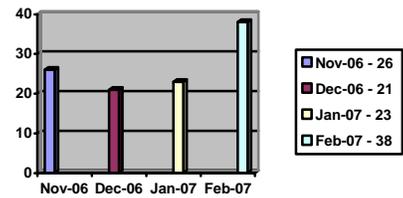
Based on the performance measures that are recommended by the Institute of Healthcare

Improvement (IHI) for RRTs, a second way in which success can be measured is in the number of RRT Calls. Tripler Army Medical Center is a 200+ bed hospital and a minimum of 20 calls per month are anticipated.

In November there were 26 calls, December 21 calls, and January 23 calls. The total was 70 RRT calls during the 1<sup>st</sup> Quarter of the program. From the 1<sup>st</sup> Quarter calls, 51% of patients were not transferred to a higher level of care, 29% transferred to ICU and 7% transferred to Progressive Care. The remaining 13% were sent to the Emergency Room or Admitted to a Ward.

In February there were 38 calls. Of these calls, 63% of patients were not transferred, 16% transferred to ICU, 13% transferred to Progressive Care and 8% transferred to other areas.

Total Calls for November 2006 through February 2007 are 108 calls.



*RRT Callers:  
Important  
Members of the  
Rapid Response  
Team*

## MEDCOM Recognizes RRT Callers

On January 25, 2007 MECOM gave special recognition to TAMC staff that had initiated an RRT Call from November '06 through January '07.

All RRT callers, and some wards, who had a high number of RRT calls, received certificates of appreciation from Marcia Harmon, Patient Safety Coordinator for Quality Management Division at U.S. Army MEDCOM. A Big Thank You to all TAMC staff who identified RRT patient criteria and activated an RRT Call.



# Call Early, Call Often

## Supporting Research for Rapid Response Teams

TAMC implemented the Rapid Response Team on November 1, 2006 to provide a safer patient environment. The bedside caregiver is required to activate the RRT when a patient meets call criteria. The team will respond within 5 minutes to a page.

The RRT is made up of an ICU Nurse, Respiratory Therapist, and an attending ICU physician. SBAR is used to provide a report to the RRT. The RRT assesses the patient, implement standing protocols, and consult with the on-call Intensivist. A plan of care is outlined, implemented, and a decision made to treat in place or move to higher level of care. The attending physician team will be notified by the bedside nurse or the RRT. At no time with the RRT circumvent the patient's attending physician team. The RRT serves only as an advocate for the patient and the bedside staff.

RRTs and medical emergency teams are used widely in Australia and Europe, and an increasing number of hospitals in the United States are developing and using them. Data on survival rates after cardiac arrest indicate that only 17% of patients who have an arrest survive to discharge. Yet, research has demonstrated that up to 80% of patients having an in-hospital cardiac arrest have signs of physiologic instability (commonly alterations in vital signs) in the 24 hours before the arrest. As a result, the formation and use of a RRT has been recently proposed as a nationwide strategy that hospitals should adopt to prevent avoidable deaths. The Institute for Healthcare Improvement (IHI) identifies the use of RRTs and medical emergency teams as interventions that are part of a 100,000 Lives Campaign to improve outcomes for patients and prevent avoidable deaths.

Excerpt from: *"Implementing a Rapid Response Team: Factors Influencing Success"*  
*Critical Care Nursing Clinics of N. America 18 (2006) 493-501*

The number of medical emergency teams and rapid response systems at the local, national and international level is exploding. What was a relatively unknown concept several years ago is now expected as a standard of care by many healthcare organizations. The first institutions to establish rapid response systems often faced cultural, educational, administrative and economic impediments. Change the culture and attitude of hospital staff and training them to call for help earlier was difficult at times.

Despite handicaps in standardizing terminology and team approaches, the common thread to all studies is a significant decrease in hospital and ICU mortality rates and length of stay, a decrease in the number of unexpected emergency admissions to the ICU, and a decrease in the ICU readmission rate.

For many clinicians, it is intuitive that if you respond to a patient in crisis earlier rather than later, the outcome will improve.

Excerpt from: *"Rapid Response Systems: Have They Made a Difference?"*  
*Society of Critical Care Medicine, The Intensive Care Professionals:*  
[http://www.sccm.org/SCCM/Publications/Critical+Connections/Archives/June+2006/Rapid\\_June06.htm](http://www.sccm.org/SCCM/Publications/Critical+Connections/Archives/June+2006/Rapid_June06.htm)

## Getting the most from the RRT: SBAR

**SBAR** stands for Situation, Background, Assessment, and Recommendation. It is a communication tool developed by the U.S. Navy that has been initiated in medical environments as a communication tool.

Use **SBAR** to report a critical situation to the RRT.

**Situation** – give details about patient and why you are at the bedside.

**Background** – details about patient history and events leading up to the RRT call.

**Assessment** – give details about your current assessment of patient and what you see as the problem.

**Recommendation** – say what you would like to see done with the patient (labs, chest x-ray, meds, transfer, etc.)

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