INTRODUCING RRS IN HEALTHY SYSTEM

Jorge Sinclair Avila

MD. FCCM. FCCP. FACP

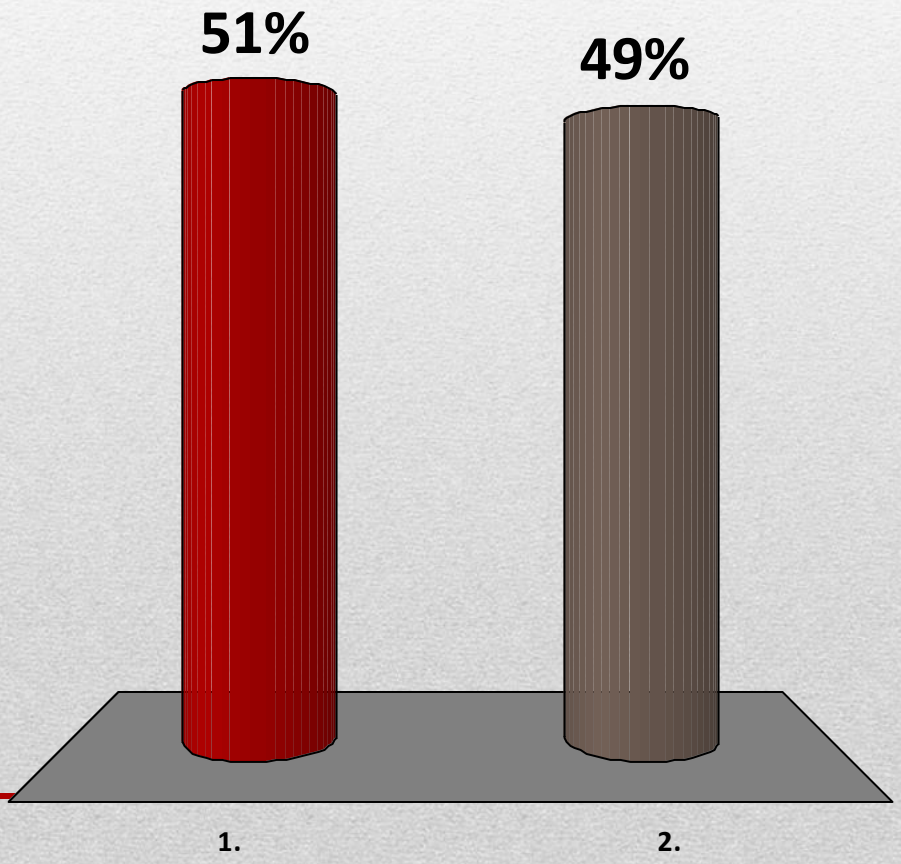
Director ICU Punta Pacifica Hospital/ Johns Hopkins Medicine

Associate Dean School of Medicine University of Panama

Past- President COCECATI

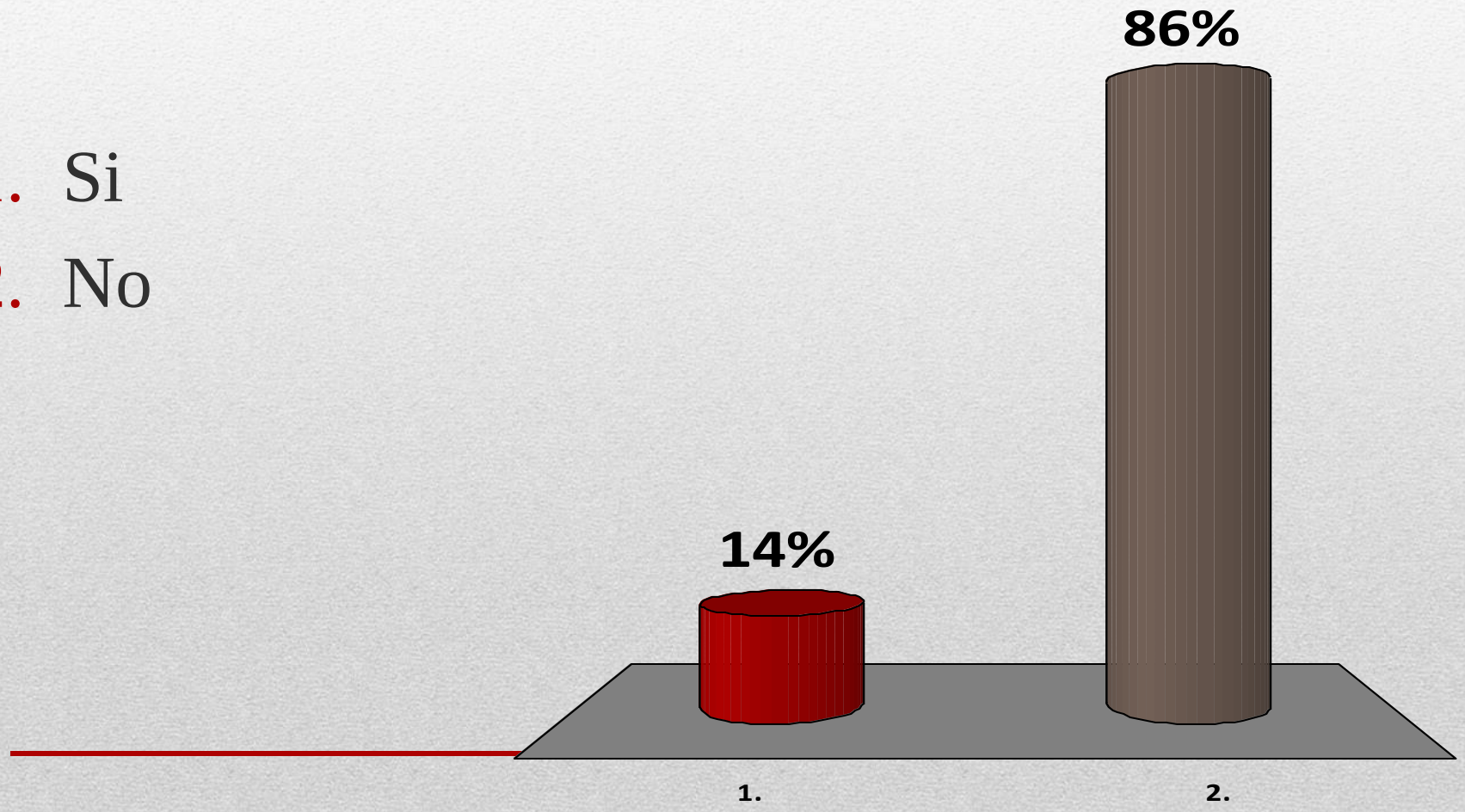
Sabe lo que son los equipos de respuesta rápida o sistemas de respuesta rápida ?
Si

1. Si
2. No



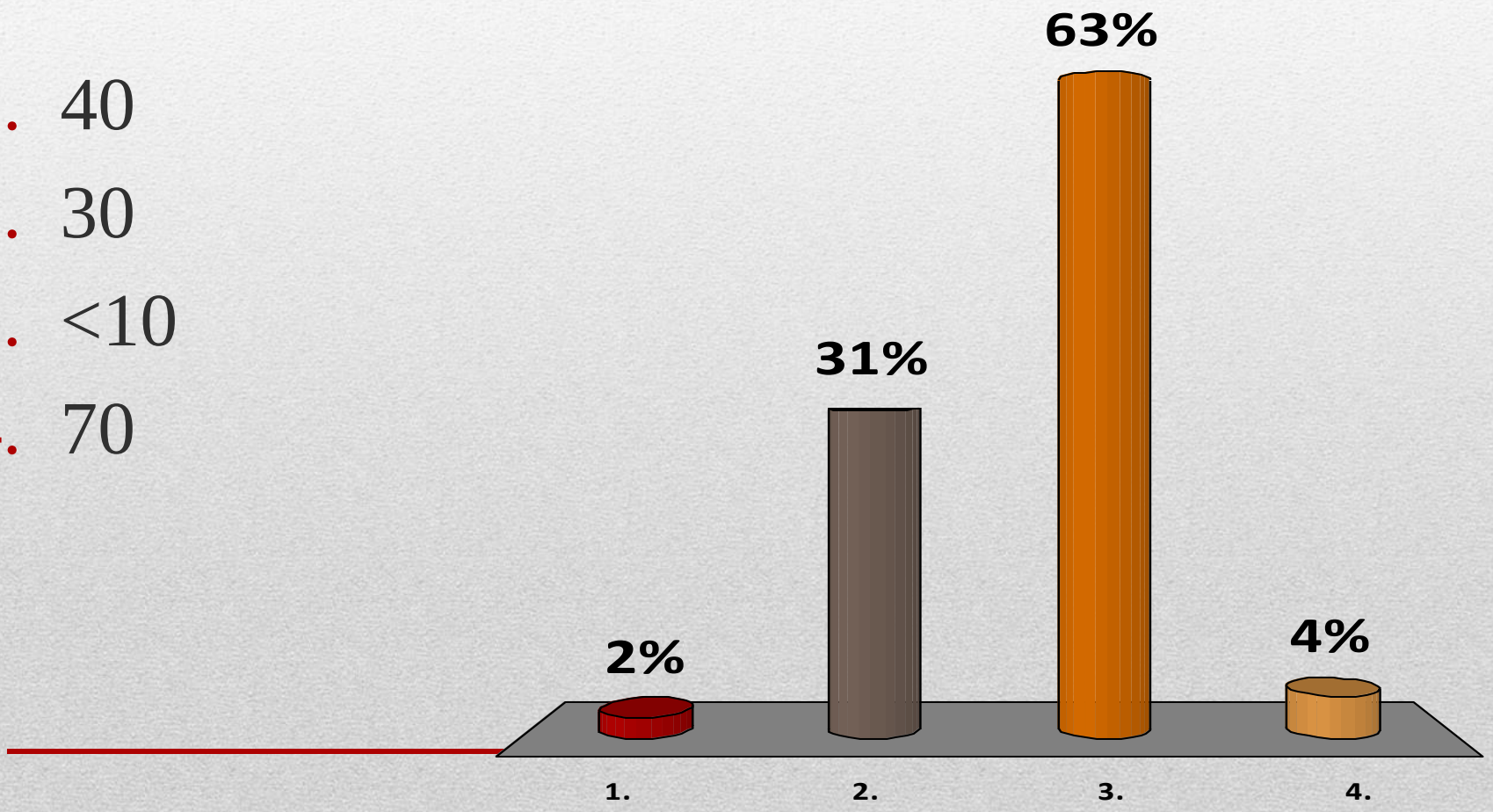
Su Institución cuenta con equipos o sistemas de respuesta rápida ?

1. Si
2. No



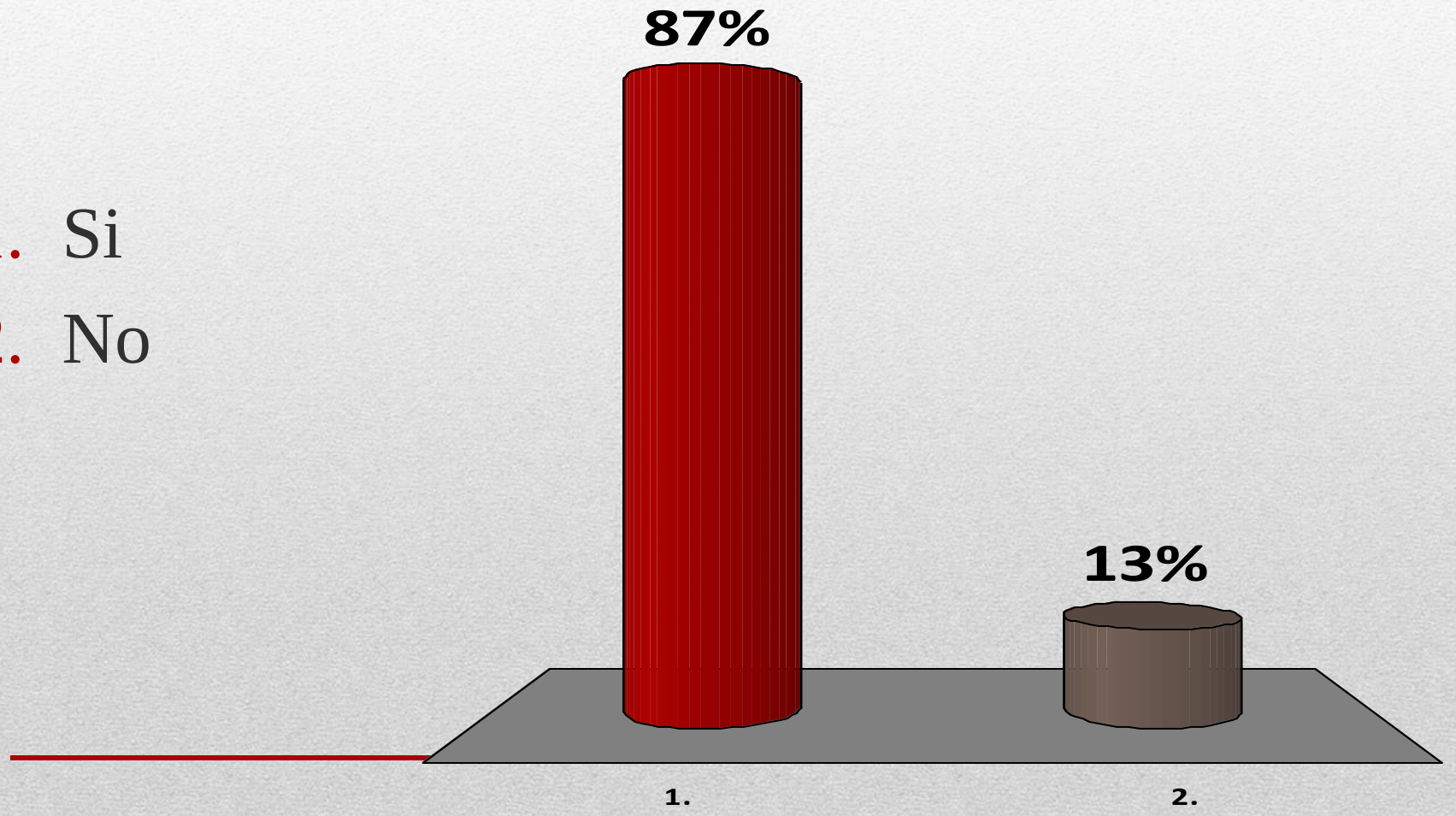
Sabe el % de códigos azules de su Institucion ?

1. 40
2. 30
3. <10
4. 70



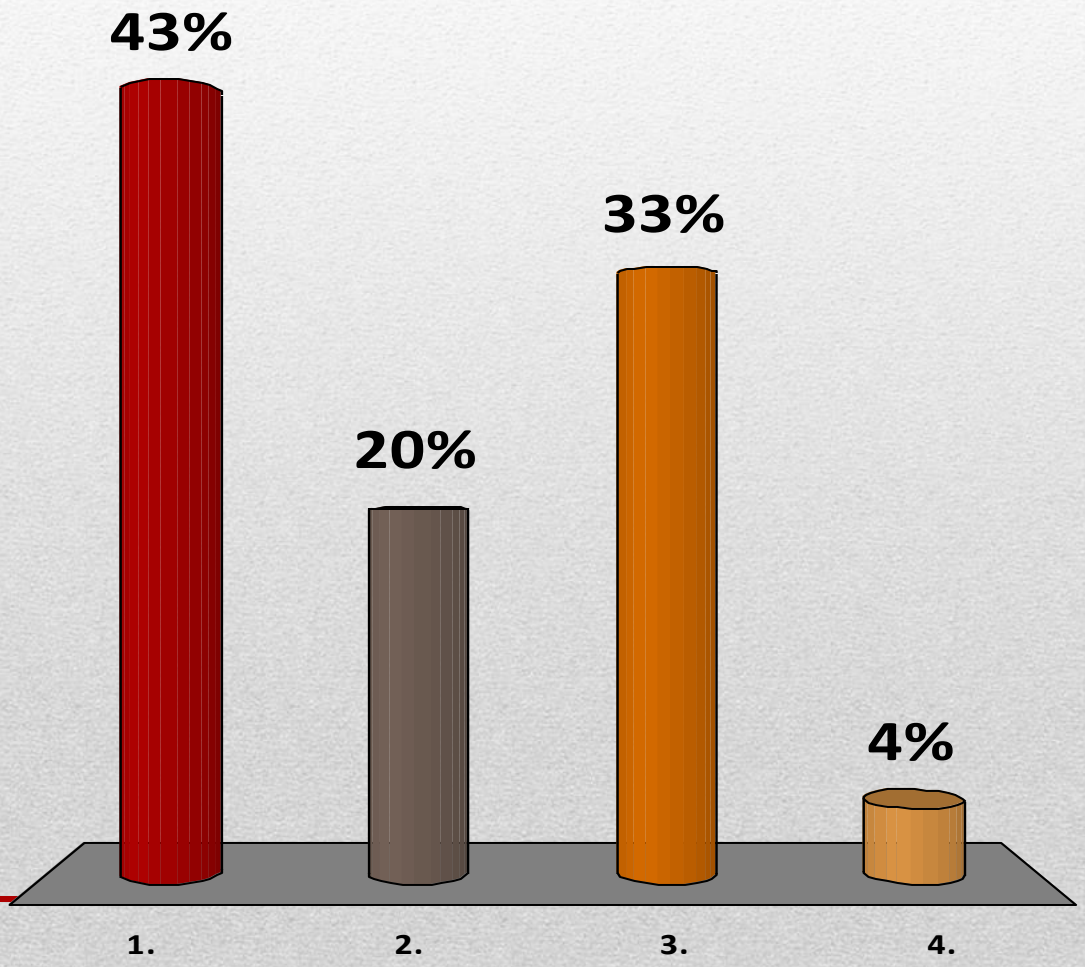
Considera Usted que en su Institución se podrían prevenir de manera más efectiva los casos de códigos azules ?

1. Si
2. No



Cual es el porcentaje de exito del manejo de códigos azules que usted ha manejado a la hora ,?

1. 50
2. 20
3. 10
4. 90



DISCLOSURE

Non Financial Relationship


HOSPITAL PUNTA PACÍFICA
2006 6 11

Overview RRT/ RRS

- Recognition and threatment of cfritical illness is often delay or inadecuate”
- Lack of effective institutions wide systems to facilitate early recognitions and rapid best practice
- Central America and Caribbean there are no evidence of RRS/ RRT
- Puerto Rico and Panama are just beginning

Sebat F. Johnson D.

Chest 2005; 127: 1729 – 1743

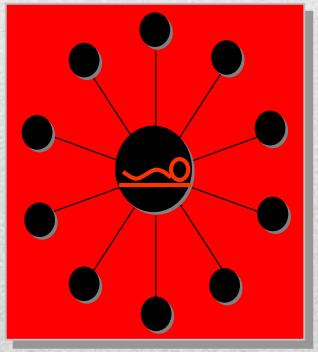
National Efforts to Recognize At-Risk Patients Sooner

- Institute of Health Improvement (IHI)
  - Has assisted in instillation of rapid response systems (RRS) in 2,000 hospitals
  - Developed a RRS Implementation manual
- Joint Commission will mandate RRS in all hospitals by 2008-2009
- STaRRT is first of its kind

S T a R R T

SHOCK TEAM and RAPID RESPONSE TEAM

From Shock to Start: A Multidisciplinary Approach to Implementing a Rapid Response System



Do We Recognize Critical Illness Early?

- Cardiac arrests and/or serious clinical deterioration are commonly preceded by warning signs

- Airway, breathing, and circulation management before admission to ICU is frequently suboptimal

- Franklin C. *Crit Care Med*. 1994;22:244-247
- McQuillan P. *BMJ*. 1998;316:1853-1858
- Buist MD. *Med J Aust.* 1999;171:22-25
- Garrard C. *BMJ*. 1998;316:1841-1842
- Hillman KM. *Intern Med J*. 2001;31:343-348

THESE DATA SHOW THAT WE DO NOT RECOGNIZE CRITICAL ILLNESS EARLY.

Why Implement an RRS?

A standardized and systematic approach to critical illness will lead to:

- Early Recognition
- Early Initiation of Best Practice

Improved Outcomes!

Outcome of Early Recognition RRT Results in Postoperative Patients

Bellomo, Crit Care Med 2004;32:916-921. Prospective controlled trial of effect of medical emergency team on postoperative morbidity and mortality rates (1,369 operations*)

- Adverse outcomes/1,000 surgical admissions
  - **Control 301**
  - **RRT 127**

*From the Department of Intensive Care and Department of Medicine, Austin &
Repatriation Medical Centre, Melbourne, Australia

Outcome of Early Recognition RRT Results in Postoperative Patients

- Relative risk reduction, 57.8%; $p < .0001$
  - Respiratory failure (RRR 79.1%; $p < .0001$)
  - Severe sepsis (RRR 74.3%; $p = .0044$)
  - Acute renal failure requiring renal replacement therapy (RRR 88.5%; p 0.0001)
- Significant decrease in the number of postoperative deaths (RRR 36.6%; $p = .018$)

Effect of Earlier Treatment of At-Risk Patients

Early and Rapid Administration of Respiratory Support, Fluid Administration and Goal Directed Hemodynamic Resuscitation

The New England
Journal of Medicine

EARLY GOAL-DIRECTED THERAPY IN THE TREATMENT OF SEVERE SEPSIS AND SEPTIC SHOCK

Emanuel Rivers, M.D., M.P.H.

Hospital mortality 46.5% decreased to 30.5% (p= 0.009)

Cycle of Shock

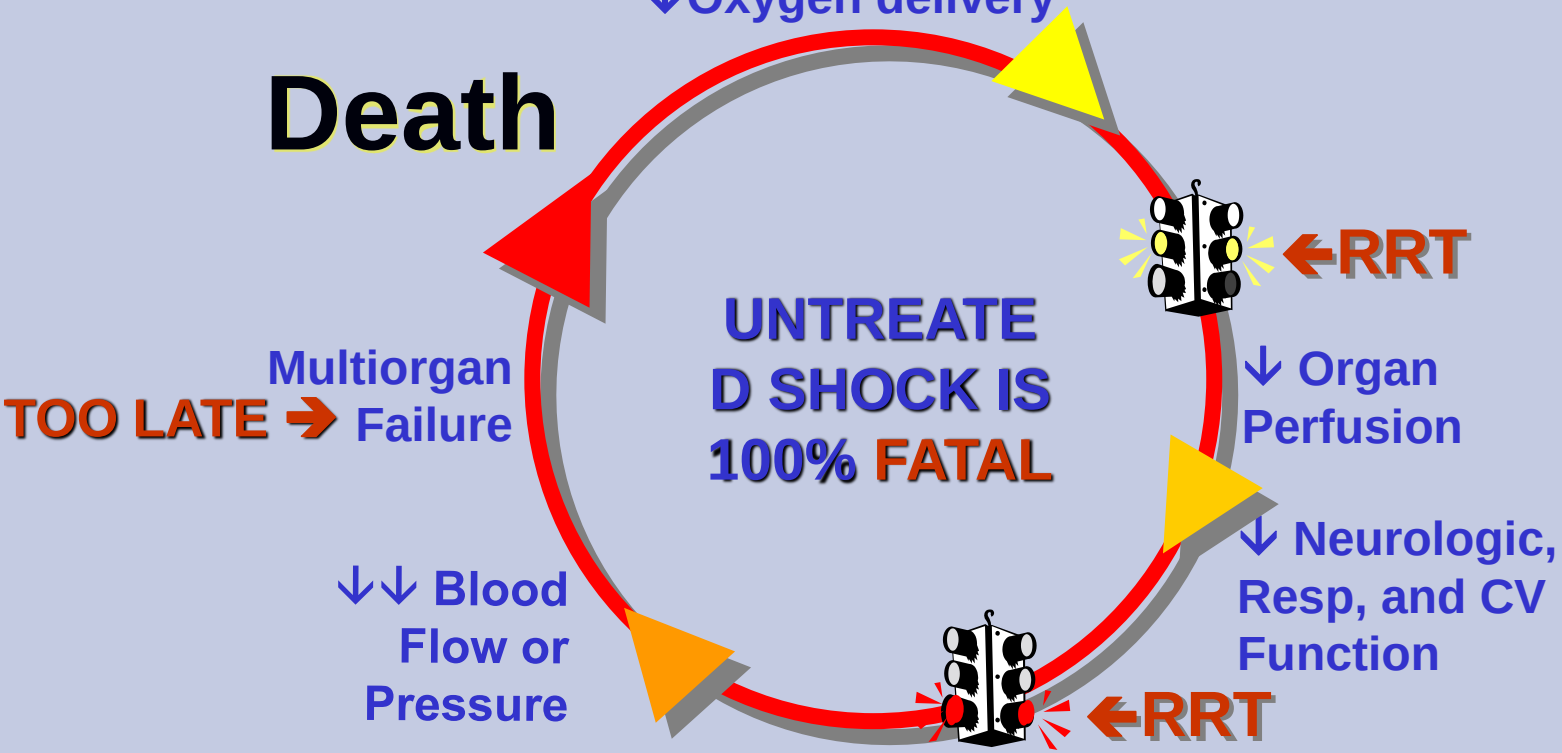
Respiratory Failure

Acute Change in Neurologic Status

1. Hypoxic
2. Hypovolemic
3. Septic
4. Cardiogenic
5. Anaphylactic

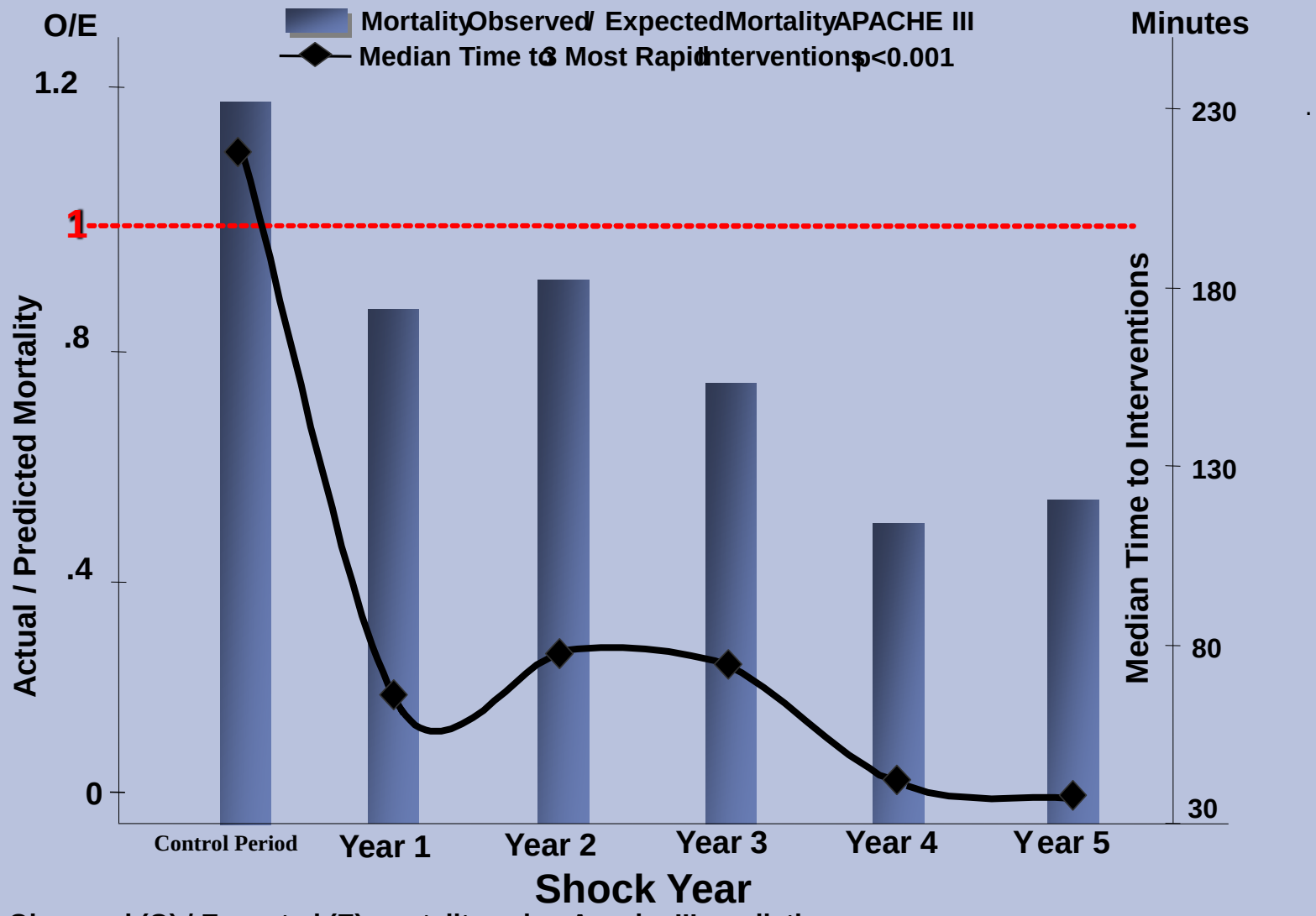
SHOCK

↓Blood Flow (C.O.) or
↓Blood Pressure or
↓Oxygen delivery



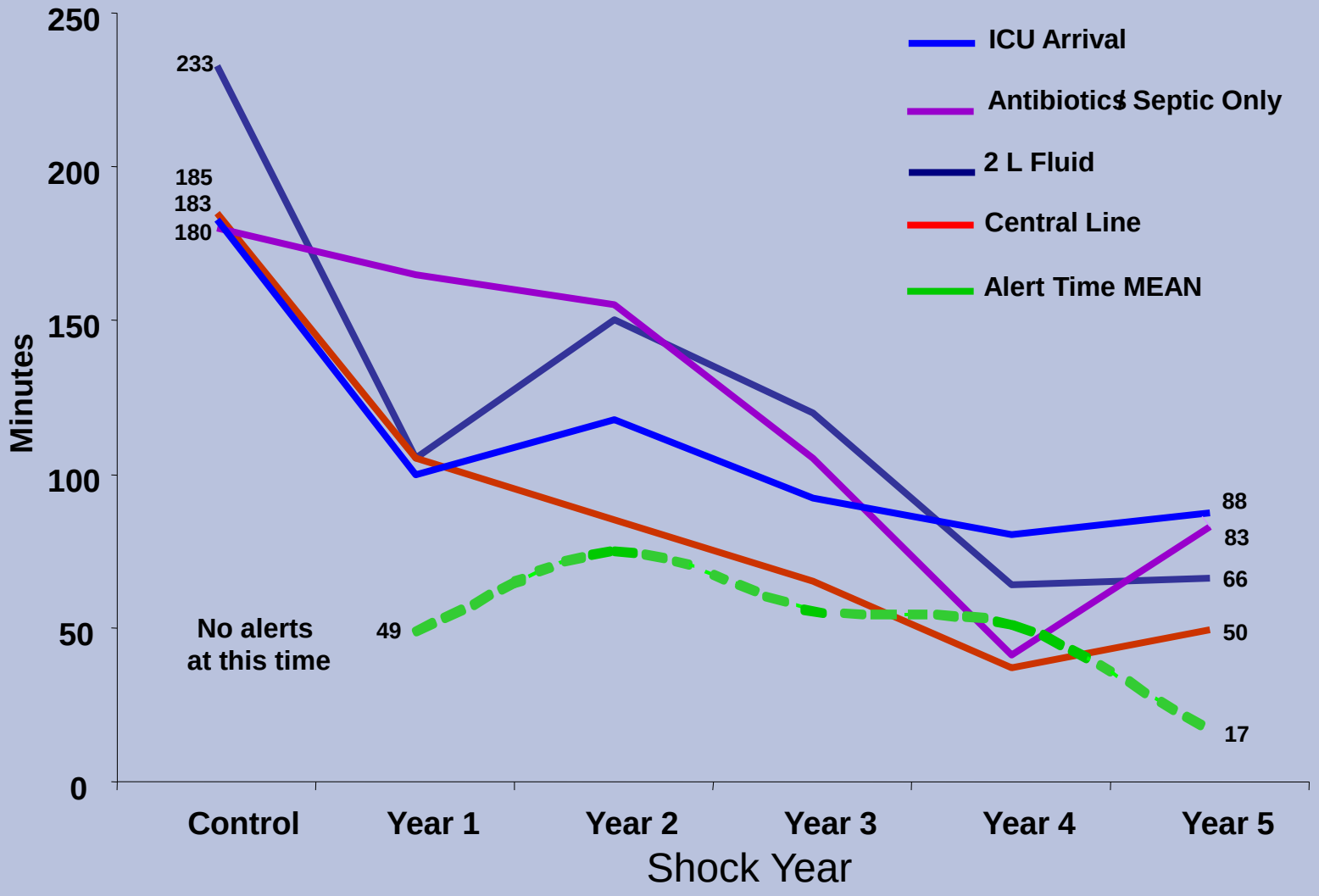
EARLIER RECOGNITION AND EARLY GOAL-DIRECTED THERAPY
WILL INTERRUPT THIS CYCLE

Adjusted Hospital Mortality vs. Median Time to 3 Most Rapid Interventions



Observed (O) / Expected (E) mortality using Apache III predictions
(O/E = 1 when observed mortality is equal to expected mortality)

Median Treatment Intervals



Goals RRT/ RRS

"A hospital wide programe that educates clinicians to identify early and rapidly treat life threatening conditions, with a team response and protocols based upon best practice guidelines will improve outcomes"

Policy and Procedure

Department: Nursing	
Effective Date:	Page 1 of 3
Subject/Title: Rapid Response System	Approved By and Title:
Dates of Review/Revision:	

I. **DEFINITION:**
   A. A hospital-wide system for early recognition and intervention in patients at high risk for decompensation, ie, patients developing cardiovascular, respiratory, or CNS instability
   B. RRS Structure
      1) Administration/Design Team: Oversees all functions
      2) Afferent: Event detection and response triggering
      3) Efferent: Crisis response, RRT/MET
      4) Quality Assurance: Data collection and analysis for process improvement

II. **PURPOSE:**
   A. To decrease morbidity or mortality rates among hospital patients
   B. To recognize early and stabilize quickly patients at risk for significant decompensation throughout the hospital, including ancillary departments, general wards, emergency department, recovery room and critical care units
   C. Establishment of an RRT made up of critical care-trained personnel who will be skilled in cardiovascular, respiratory, and neurologic assessment and emergency management

III. **POLICY:**
   A. **The RRT Alert** can be activated by any healthcare clinician who wishes to have his or her patient assessed by the RRT when the patient shows signs of instability as defined by the activation criteria. The RRT will be available 24 hours a day.
   B. **RRS Team Members:**
      1) ICU/CVICU RRT nurse
      2) Respiratory therapy staff member
      3) Clinical educator or clinical specialist or nursing supervisor
      4) Laboratory and radiology personnel
      5) MD (intensivist/hospitalist/ED-MD, as needed)
   C. **Bedside Nurses:** Will have completed 10 SOV/SBAR and RRS presentation and exams
   D. **RRT Nurse:** Will have completed 10 SOV/SBAR and RRS presentation and exams
   E. **RRT Respiratory Therapist**: Will have completed 10 SOV/SBAR and RRS presentations and exams, and anesthesia-supervised airway management and intubation skills

Key Element of RRS

- Reggard
  - Design
  - Country Culture
  - Acceptance of RRS
  - Integrating RRS

Key Element of RRS

I. A. Administration/ Design Team

- Planning
- Physicians or Non physicians = **Leaders** (Education activities)

B. RRS Phases

- Development
- Implementation
- Operations

Team Members

- Critical Care RN
- Respiratory Therapist
- Lab and Radiology as needed
- Nursing Supervisor


575
SÉPTICO
576
ENFERMERA JEFE
EXTINTOR
FIRE
PUSH HERE
PULL DOWN

Terms in RRT/ RRS

- **ACLS** (Advance Cardiac Life Support)
- **BLS** (Basic Life Support)
- **ATLS** (Advance Trauma Life Support)
- **FCCS** (Fundamental Critical Care Support)
- **ENLS** (Emergency Neurologyc Life Support)
- **MET** (Medical Emergency Team)
- **RRT** (Rapid Respond Team)

Key Element of RRS

II. Event detection and Response Triggering
The Afferent limb)

“The Biggest Challenge”

- Calling Criteria
- Softer Criteria

✓ **Barrers: Culture and Technology**

Activation

Any healthcare clinician can activate the STaRRT Alert

and the team will be available

24 hours a day

Team Activation Process

- Healthcare professional by criteria or who is worried about the patient in consultation with the patient's nurse
- Primary attending physician will be notified simultaneously with the activation
- Call ext. 7500, give room and bed number
- Once alert called, the care nurse will remain at the bedside and assist the team

Key Points to STaRRT

- Early recognition algorithm – 10 SOV
- Empowerment of frontline providers through education and protocol – AOV / VIPPS
- ***"STaRRT Alert"*** rapid response by STaRRT Team
- Goal-directed therapy and application of best practice
- Code status clarified
- Patient improved, remains on unit
- Rapid transfer to ICU or OR

Goals of the STaRRT Program

Earlier Identification of At-Risk Patients

10 SOV

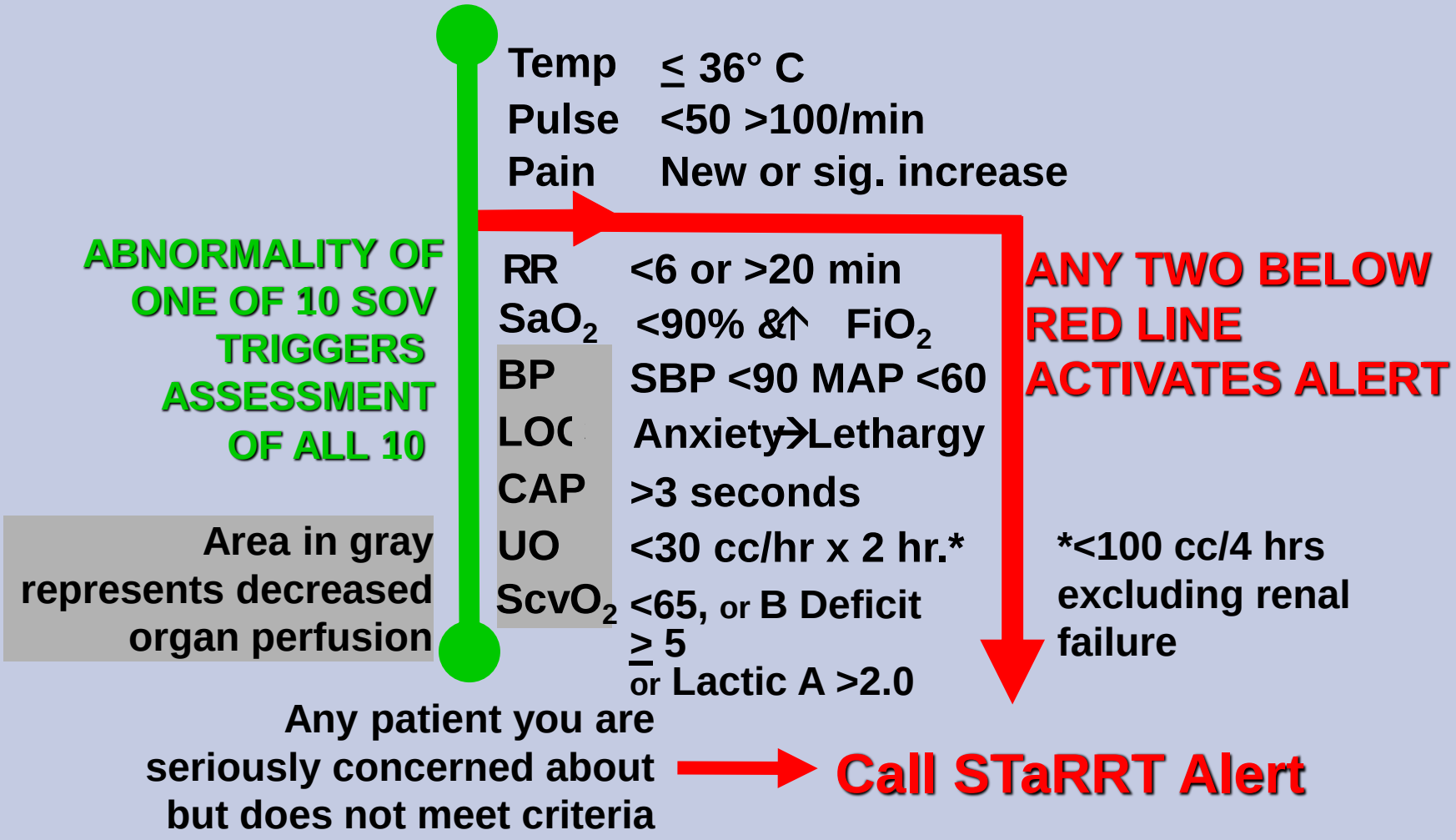
The Ten Signs of Vitality

The “Lady-in-Chief,” Florence Nightingale

- Temperature
- Pulse
- Respiratory rate
- Blood pressure
- Pain
- Level of consciousness
- Oxygen saturation
- Urine output
- Capillary refill
- $ScvO_2$ / SvO_2 or base deficit or lactic acid

Assessment Using 10 SOV : Results in Earlier Identification and Treatment of Critical Illness

Inclusion Criteria for Calling a STaRRT Alert



Key Element of RRS

III. Team Respponse and Intervention
(The Efferent Line)

- ❑ Appropriated Personnel
- ❑ Appropriated Equipment

✓ Mandatory

- ❖ Trainning
- ❖ Experience
- ❖ Monitoring equipment
- ❖ Life saving intervention
- ❖ Triage

Assessment and Treatment

- STaRRT nurse and respiratory therapist will assess the patient and mobilize other team members as needed
- Nurse and RT responder will initiate STaRRT protocols as indicated
- Team will use this opportunity to reinforce SBAR communication, 10 SOV assessment, and AOV and VIPPS interventions
- STaRRT nurse and RT will document the assessment and treatment on the RRT record

Standardized Best Practice

Weil MH, Shubin H. *JAMA*. 1969;207:337-340

ACLS of Early Critical Illness/ Shock

V entilation/oxygenation

I nfusion of VOL

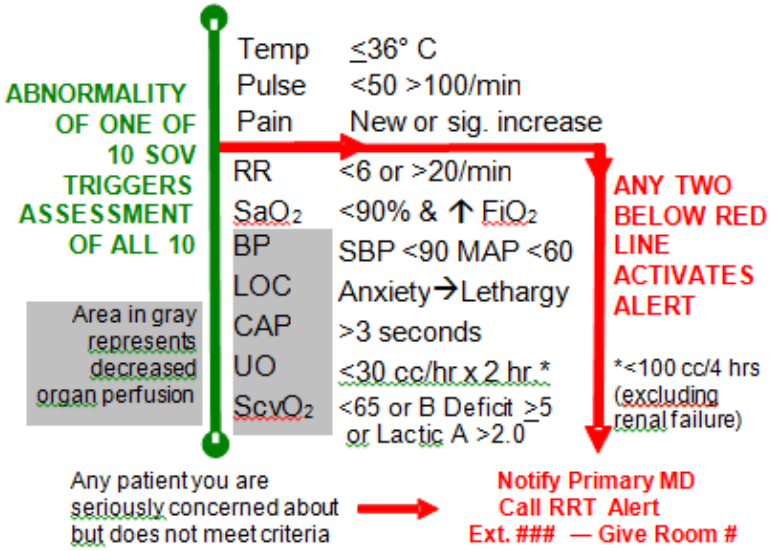
P ressors / Pump

P harmacy

S pecific

RRS PROGRAM

10 SIGNS OF VITALITY FOR CALLING RRT ALERT



EXCLUSION CRITERIA

1. Trauma as cause of shock.
2. Patients who are not candidates for aggressive treatment by preexisting diagnosis, advanced directives or DNR.

TO ACTIVATE A RRT ALERT

Notify Primary Physician

DIAL ### — Give Room #

RRS PROGRAM

RRS PATIENT LAB

A **FOR ALL PATIENTS**

1. ABG.
2. Bedside H/H, Lytes.
3. 12 Lead EKG.
4. Chest x-ray.
5. If sepsis suspected or temp is < 36° or > 38°, or antibiotics to be started: CBC w/diff, 2 blood cultures, sputum GS/CS, U/A & urine GS/CS if >5 WBC/HPF.

B **FOR PATIENTS WITH DECREASED ORGAN PERFUSION**

6. Serum lactate x 2, 4 hrs apart.
7. Metabolic & liver panel.
8. Type & screen.
9. D.I.C. screen.
8. Amylase / Lipase.
10. LDH, PO_4.

Follow Up / Debriefing

- STaRRT RN will conduct a de-briefing session:
  - With unit charge nurse and care nurse
  - Identification of opportunities for reward, improvement and education
  - Feedback will be forwarded to the Unit Supervisor, Director of Nursing, and Code Blue Committee

RRT **RN**
Data Collection Tool
1 of 2

ADDRESSOGRAPH

Please: (1) Address each item and explain any items with missing data (2) All time entries are to be in military time (3) Print legibly full names for all staff and physicians

Hospital ☐--- ☐---	Unit:	Room #:
RRT Alert Date:	Time:	Called by (full name):
RRT **RN** arrival time:		RRT **RT** arrival time:
History / Situation:		
Diagnosis on Admission:		Primary MD:
☐Primary MD or ☐On Call MD notified Dr._____		Time:_____ Called by:_____
Time On Call MD responded:		☐Did not respond within 30 minutes
Intensivist called ☐Yes ☐No Dr:	Time:	Response time:

Inclusion Criteria
Check criteria met

ABNORMALITY OF ONE OF 10 SOV TRIGGERS ASSESSMENT OF ALL 10

Area in gray represents decreased organ perfusion

- ☐ Temp — <36° C
- ☐ Pulse — <50 >100/min
- ☐ Pain — New or sig. Increase
- ☐ RR — <6 or >20/min
- ☐ SaO_2 — <90% & ↑FIO_2
- ☐ BP — SBP <90 MAP <60
- ☐ LOC — Anxiety / Lethargy
- ☐ CAP — >3 seconds
- ☐ UO — <30 cc/hr x 2 hr, <55, or B Def ≥ 5 or, Lactic A <2.0
- ☐ $ScvO_2$

ANY TWO BELOW RED LINE ACTIVATE'S ALERT

☐ Does not meet above criteria, but identified to be at high risk for neurologic, respiratory or cardiovascular decompensation

☐ Acute Seizure

☐ Acute Stroke Findings:

* < 100 cc /4 hrs (excluding renal failure)

Vital Signs:								
Time:	Pulse:	RR:	BP:	CAP refill:	sec	SaO_2:	LOC:	UO:
Time:	Pulse:	RR:	BP:	CAP refill:	sec	SaO_2:	LOC:	UO:
Time:	Pulse:	RR:	BP:	CAP refill:	sec	SaO_2:	LOC:	UO:
Time:	Pulse:	RR:	BP:	CAP refill:	sec	SaO_2:	LOC:	UO:

☎ FAX THIS COMPLETED FORM TO ### ASAP

☞ PUT ORIGINAL FORM IN BACK OF EKG/CARDIOLOGY SECTION OF PATIENT'S CHART

RRT **RN**
Data Collection Tool
2 of 2

ADDRESSOGRAPH

Glasgow Coma Score (required):		LOC/Sedation Scale (0-5)	0 = Awake / Alert, cooperative 1 = Anxious / Agitated 2 = Drowsy, but easy to arouses by verbal stimulation to a cooperative state		3 = Frequently drowsy, arouses to physical stimulation 4 = Somnolent, difficult to arouse 5 = Unarousable	
3-15	6	5	4	3	2	1
EYES	N/A	N/A	Opens eyes spontaneously	Opens eyes in response to voice	Opens eyes in response to painful stimuli	Does not open eyes
VERBAL	N/A	Oriented, converses normally	Confused, disoriented	Utters inappropriate words	Incomprehensible sounds	Makes no sounds
MOTOR	Obeys command	Localizes painful stimuli	N/A	Flexion of extremities upon painful stimuli	Extension of extremities upon painful stimuli	No movement to pain

☐No ☐Yes Narcan given. Dose(s): ☐ ### Notified (required)

☐No ☐Yes Romazicon given. Dose(s): ☐ ### Notified (required)

RRT Lab ☒A panel drawn Date/Time: ☐B panel drawn Date/Time:

Fluid bolus amt: Date/Time:

☐Central line or ☐(2) 16 ga IVs Date/Time:

☐$ScvO_2$ or ☐ SvO_2 % Sat Time:

☐1°Antibiotic given:

Date/Time:

☐Levophed Date/Time started: ☐Dopamine Date/Time started:

☐Epinephrine Date/Time started: ☐Dobutamine Date/Time started:

☐Tridal Date/Time started: ☐Nipride Date/Time started:

I/O Prior 24 hours is: I= O=

Shock Type: ☐Hypoxic ☐Hypovolemic ☐Septic/Distributive ☐Cardiogenic ☐Obstructive ☐Anaphylactic

☐Other (describe) _____

Patient ☐Coded ☐Resuscitation limited ☐Improved; remained on floor Transferred to ☐ICU / ☐OR Date/Time:

RRT Alert time completed: Alert called off by (full name):

Family notified ☐Yes ☐No Time: Relationship: Called by

Event reviewed with unit staff ☐Yes ☐No

Bedside Nurse (full name): Charge RN (full name):

RRT **RN** (full name): RRT **RT** (full name):

Exclusion criteria:

☐Trauma as cause of critical illness

☐Patients who are not candidates for aggressive treatment by pre-existing diagnosis, advanced directive or DNR.

Comments:

RRT RT
Data Collection Tool

ADDRESSOGRAPH

Please address each item and explain any items with missing data. All time entries are to be in military time.

RRT Alert Date:	Time:	Called by (full name):
Hospital ☐--- ☐---	Unit:	Room #:
STaRRT **RT** arrival time:		Primary MD:
Bedside RN (full name):		Charge RN (full name):
RRT **RN** (full name):		RRT **RT** (full name):
Diagnosis on Admission:		

Respiratory therapy arrived time_____ O_2 SAT _____ ☐ N/C ☐ Venti Mask ☐ Rebreather Mask

Airway Open ☐ Yes ☐ No Airway placed _____

Gag present ☐ Yes ☐ No Respiratory Pattern: ☐ Regular ☐ Irregular ☐ Apnea ☐ Prolonged expiration

☐ Audible wheezing ☐ Use of accessory muscles

Cough ☐ Non effective ☐ Effective ☐ Non productive ☐ Productive sputum amount / Color _____

Breath Sounds (R) _____ (L) _____

O_2 by _____

Respiratory Rx _____

Ventilatory Support by _____ Time _____

ABG O_2 SAT _____ PO_2_____ PCO_2 _____ pH _____ Base Deficit ____ Time Drawn _____

History / Situation

Interventions / Medications

Event reviewed with unit staff ☐ Yes ☐ No

Comments:

☎ FAX THIS COMPLETED FORM TO ### ASAP

☞ PUT ORIGINAL FORM IN BACK OF EKG/CARDIOLOGY SECTION OF PATIENT'S CHART

PLEASE JOIN US

10 SOV ▶ SBAR ▶ RRS

NURSING INITIATIVE MEETING

WEDNESDAY APRIL 11TH 2 – 4 PM

HOSPITAL CONFERENCE ROOM

RRS

10 SOV

SBAR


Rapid Response System
ACTIVATION CRITERIA FOR CALLING A
RRT ALERT
ABNORMALITY OF ONE OF THE 10 SOV TRIGGERS ASSESSMENT OF ALL 10
Temp
≤36° C
Pulse
<50 >100/min
Pain
New or sig. increase
RR
<6 or >20/min
SaO2
<90% & ↑ FiO2
BP
SBP <90 MAP <60
LOC
Anxiety / Lethargy
CAP
>3 seconds
UO
<30 cc/hr x 2 hr.*
ScvO2
<65 or B Deficit ≥ 5 or Lactic A > 2.0
ANY TWO BELOW RED LINE ACTIVATES ALERT
Area in gray represents decreased organ perfusion
*<100cc / 4hrs (excluding renal failure)
Any patient you are seriously concerned about but does not meet criteria
Call Primary Physician
Call STaRRT Alert
ext. 7500, Give Room #
CRITERIA FOR MOBILIZATION OF RAPID RESPONSE TEAM
HOSPITAL LOGO
RRT PROGRAM
HOSPITAL NAME

SBAR COMMUNICATION

SITUATION	• Acute problem	• Age / Gender
	• Time of onset	• Identify yourself / Location
	• Patient's name	• Current vital signs
BACKGROUND	• Date / Reason for admit	• I/O 24 hrs
	• Code status / Resuscitation limits	• Meds
	• Diagnosis / PMHx	
ASSESSMENT	• 10 SOV / PEx	• Your thoughts for possible cause of problem
	• New & pertinent old lab	
RECOMMENDATION	• Your suggested interventions	
	• Order sheet available	

HOSPITAL LOGO

RRT PROGRAM

HOSPITAL NAME

COMING SOON

RRS

RAPID RESPONSE SYSTEM

AN INTEGRATED SYSTEM OF CARE FOR PATIENTS AT-RISK

We are looking for RNs with 2 years minimum ICU experience and working 1 clinical shift per week to join us in training for the RRs Program

If you are interested, please contact:
Critical Care Educator or Director

HOSPITAL LOGO

RRS PROGRAM
HOSPITAL NAME

RRT Activation Card
Worn by Nursing Staff

FRONT

RRT ALERT / ACTIVATION CRITERIA
10 Signs of Vitality

ABNORMALITY OF ONE OF 10 SOV TRIGGERS ASSESSMENT OF ALL 10

Temp	≤36° C
Pulse	<50 >100/min
Pain	New or sig. increase
RR	<6 or >20/min
SaO_2	<90% & ↑FiO_2
BP	SBP <90 MAP <60
LOC	Anxiety / Lethargy
CAP	>3 seconds
UO	≤30 cc/hr x 2 hr.*
$ScvO_2$	<65 or B Deficit > 5 or Lactic A >2.0

ANY TWO BELOW RED LINE ACTIVATES ALERT

*<100cc/4 hrs excluding renal failure

Any patient you are seriously concerned about but does not meet criteria → Call Primary MD Call RRT Alert—ext. ### Give Room #

SBAR COMMUNICATION

S = Situation	Reason for call, acute problem
B = Background	Reason for adm, current Dx, PmHx, I/O, meds, chart available
A = Assessment	10 SOV, PEx
R = Recommendation	Your suggested interventions. Order sheet available

BACK

AOV / VIPPS / RESUSCITATION

V **A**irway → **O**xygen → **V**entilation
Ventilate, assure adequate airway, oxygenate SaO_2 >90%

I Rapidly infused crystalloid or colloid, except pulmonary edema

P Pressors MAP >60 & assess the pump. JVD/CVP, stethoscope, EKG, cardiac echo?

P Pharmacology, i.e., bronchodilators, steroids, antibiotics, anticoagulants, NTG, APC, etc.

S Specific interventions, endoscopy, surgical consult, etc.

Decreased organ perfusion; resuscitation & lab

RRT PATIENT LAB

- ABG
- H/H, Lytes STAT
- 12 lead EKG
- CXR
- If sepsis suspected or temp is < 36° or > 38°, or antibiotics to be started: CBC w/diff, 2 blood cultures, sputum GS/CS, U/A & urine GS/CS
- Serum lactate x 2, 4 hrs apart
- Metabolic & liver panel
- Type and screen
- CPK/Troponin
- D.I.C. screen
- Amylase / Lipase
- LDH, PO_4

RRT

Retrospective

Data Collection Tool

1 of 1

ADDRESSOGRAPH

RRT Alert Date: Time:	Called by (full name):
Hospital ☐--- ☐--- Unit:	Room #:
Bedside Nurse (full name):	Charge RN (full name):
RRT RN (full name):	RRT RT (full name):
Time Zero (on retrospective review-criteria met):	ER Triage Date / Time (if applicable):
Diagnosis on Admission:	
Primary MD:	
Worst vital sign in 24 hrs of patient first meeting criteria: SaO_2: on FiO_2: P: RR: BP: GCS:	
☐No ☐Yes Narcan given. Dose(s):	
☐No ☐Yes Romazicon given. Dose(s):	
☐No ☐Yes Verify RT form completed: If not, explanation:	

Confirmatory criteria met in first 24 hrs: ☐ Romazicon or Narcan administered ☐ Needed airway assistance i.e., oral/nasal airway or tracheal suction ☐ Significant ↑ in FiO_2 requirement i.e., ≥5L N/C ☐ Ventilatory assistance BiPAP or Ambu Bag ☐ ≥500 cc of fluid in the first hr or ≥ 4 LF in first 24H	☐ Blood transfusion ☐ Intravenous drug Rx or electrocardioversion for SVT or VT ☐ Lactic acid > 2 or $ScvO_2$ <65 or B Deficit ≥ -5 ☐ Death as a result of hemodynamic or respiratory instability ☐ Patient code status changed to limited resuscitation ☐ Transfer to ICU

Shock Type: ☐Hypoxic ☐Hypovolemic ☐Septic/Distributive ☐Cardiogenic ☐Obstructive ☐Anaphylactic

☐Other (describe) _____

☐ Request Medical Review (forward copy of this form to Quality Assurance) ☐Patient is a readmission to ICU

During this admission:

☐ Code Blue Date/Time: _____ Outcome: _____

☐ Mortality Date/Time: _____ _____

☐ Other: _____

Comments: _____

_____

APACHE III score :	APACHE Diagnosis:	Date/Time :
Form Completed by:		Date:

All time entries are to be in military time.

Nursing Pre and Post Survey

SBAR Communication, 10 SOV, and Rapid Response Team Initiatives

To assist in assessing and improving nurse satisfaction and patient care, please respond to the following statements indicating your level of agreement using a scale from 1-5, with 1 indicating strong agreement and 5 indicating strong disagreement.

The majority of the time the following apply	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. I believe I possess the necessary patient assessment skills to allow me to evaluate a patient who may be deteriorating clinically.	1	2	3	4	5
2. The majority of physicians feel that I perform patient assessments that are sufficient to address issues requiring physician contact	1	2	3	4	5
3. I believe I use effective communication skills when calling physicians about my patients.	1	2	3	4	5
4. I believe I have all pertinent information together and organized prior to calling a physician.	1	2	3	4	5
5. I am able to answer most questions related to the issue without asking the physician to wait.	1	2	3	4	5
6. I believe the majority of physicians appreciate it when I call them about my concerns related to their patients.	1	2	3	4	5
7. I believe I would benefit from more education related to assessment skills for at-risk patients	1	2	3	4	5
8. I believe I would benefit from more education regarding effective communication skills	1	2	3	4	5
9. I feel that I deliver good care to my patients.	1	2	3	4	5
10. I believe my input regarding patient care is valued by the physician.	1	2	3	4	5
11. I believe I am viewed by the majority of physicians as a valuable member of the patient care team	1	2	3	4	5
12. I generally work in the following unit(s): (may circle more than one): a. Critical Care b. Medical Unit c. Surgical Unit d. Cardiac Telemetry e. Central/Nephrology Unit f. ER g. Labor & Delivery/ Postpartum h. Pediatrics					

You will be re-surveyed after the program is fully operational. Your input is valued. Thank you.

Suggestions/Comments:

_____

_____

_____

_____

Physician Pre and Post Survey

SBAR Communication, 10 SOV, and Rapid Response Team Initiative

In the interest of improving patient care in our hospitals, please respond to the following statements indicating your level of agreement using a scale from 1 to 5, with 1 indicating strong agreement and 5 indicating strong disagreement.

The majority of the time the following apply	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The majority of nursing staff possesses adequate assessment skills and uses these skills when caring for my sickest patients.	1	2	3	4	5
2. The majority of nurses have most pertinent information together and organized prior to calling me.	1	2	3	4	5
3. The majority of nurses are able to answer most of my questions regarding a patient whose clinical status has changed without substantial delay.	1	2	3	4	5
4. The majority of nursing staff are skilled in using effective communication when calling me about my sickest patients.	1	2	3	4	5
5. I encourage the nursing staff to call me about concerns related to my patients.	1	2	3	4	5
6. My sickest patients receive very timely and appropriate nursing assessment and care at our facility.	1	2	3	4	5
7. I generally have at any given time in the hospital: a. 0-1 patients/week b. 2-5 patients/week c. >5 patients/week					
8. I see the majority of my patients in the following units: (may circle more than one): a. Critical Care b. Medical Unit c. Surgical Unit d. Cardiac Telemetry e. Central/Nephrology Unit f. ER g. Labor & Delivery/ Postpartum h. Pediatrics					

You will be re-surveyed after the program is fully operational. Your input is valued. Thank you.

Suggestions/Comments:

_____

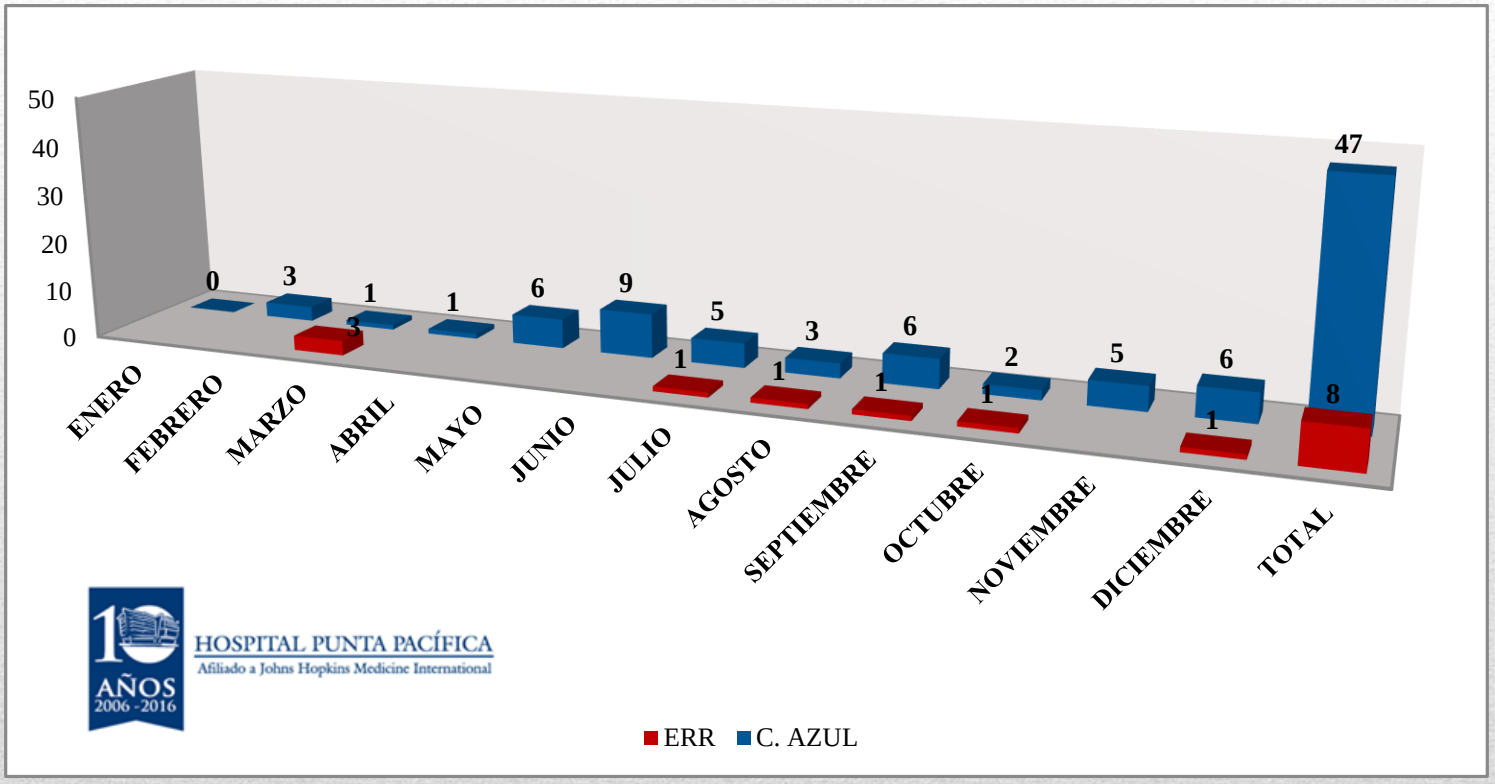
_____

_____

_____

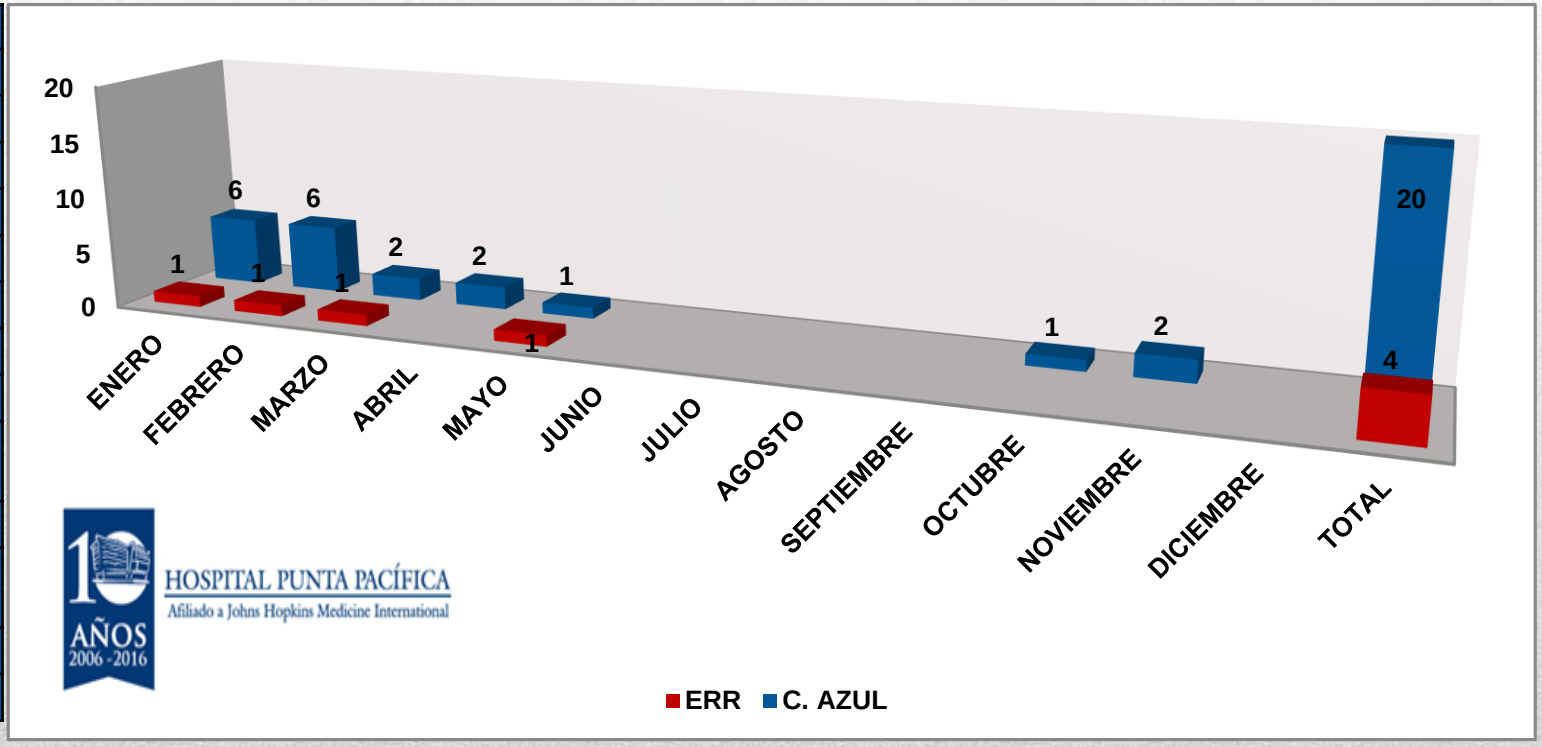
RESUMEN DE CODIGOS ERR Y CODIGO AZUL DEL 2013-2016

	AÑO 2103	ERR	C. AZUL
1	ENERO		0
2	FEBRERO		3
3	MARZO	3	1
4	ABRIL		1
5	MAYO		6
6	JUNIO		9
7	JULIO	1	5
8	AGOSTO	1	3
9	SEPTIEMBRE	1	6
10	OCTUBRE	1	2
11	NOVIEMBRE		5
12	DICIEMBRE	1	6
	TOTAL	8	47



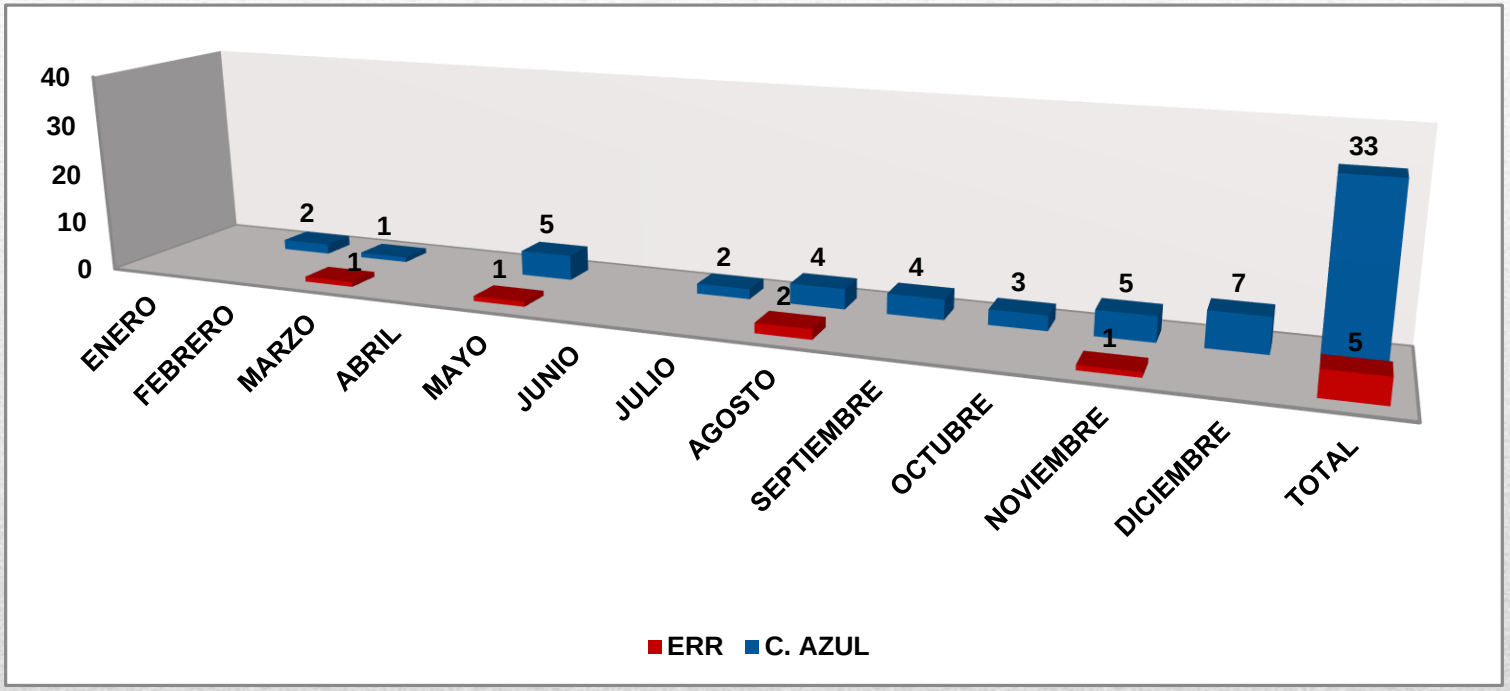
RESUMEN DE CODIGOS ERR Y CODIGO AZUL DEL 2013-2016

AÑO 2104	ERR	C. AZUL
ENERO	1	6
FEBRERO	1	6
MARZO	1	2
ABRIL		2
MAYO	1	1
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		1
NOVIEMBRE		2
DICIEMBRE		
TOTAL	4	20



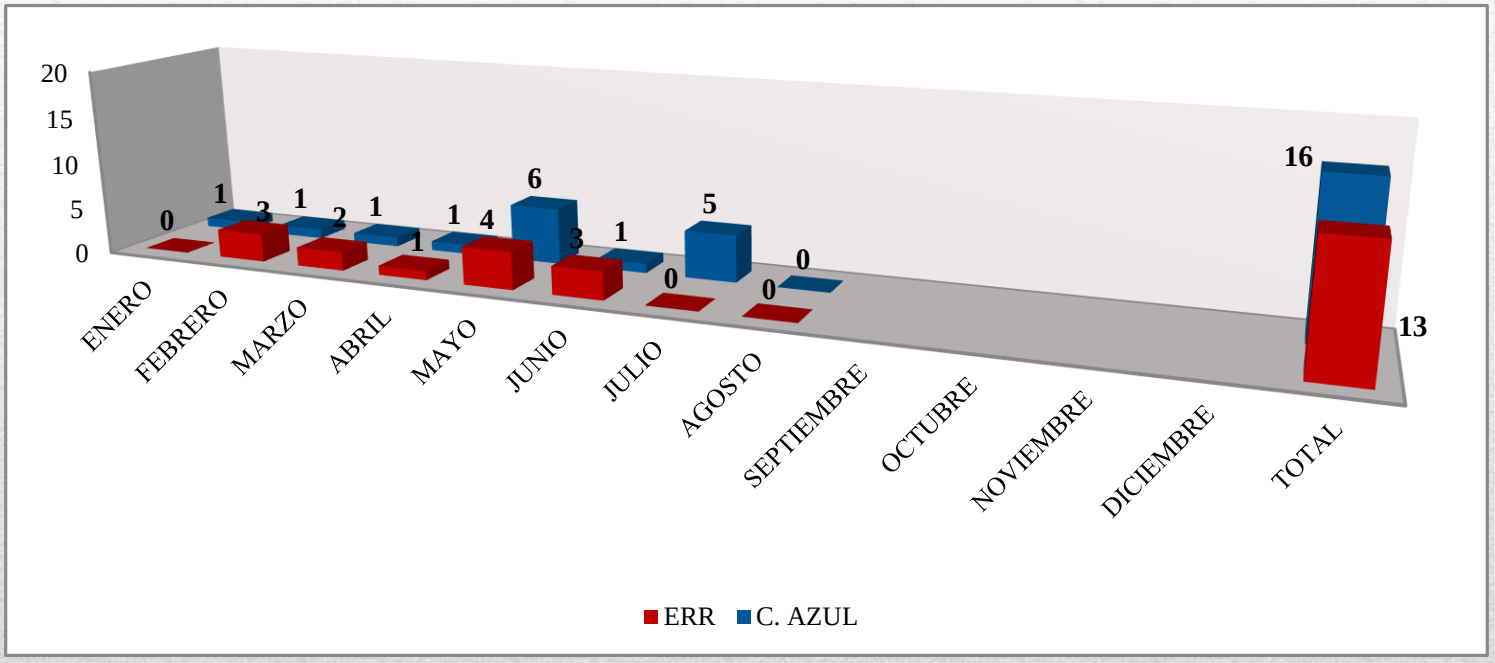
RESUMEN DE CODIGOS ERR Y CODIGO AZUL DEL 2013-2016

AÑO 2105	ERR	C. AZUL
ENERO		
FEBRERO		2
MARZO	1	1
ABRIL		
MAYO	1	5
JUNIO		
JULIO		2
AGOSTO	2	4
SEPTIEMBRE		4
OCTUBRE		3
NOVIEMBRE	1	5
DICIEMBRE		7
TOTAL	5	33



RESUMEN DE CODIGOS ERR Y CODIGO AZUL DEL 2013-2016

AÑO 2106	ERR	C. AZUL
ENERO	0	1
FEBRERO	3	1
MARZO	2	1
ABRIL	1	1
MAYO	4	6
JUNIO	3	1
JULIO	0	5
AGOSTO	0	0
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		
TOTAL	13	16



Implementation of RRS

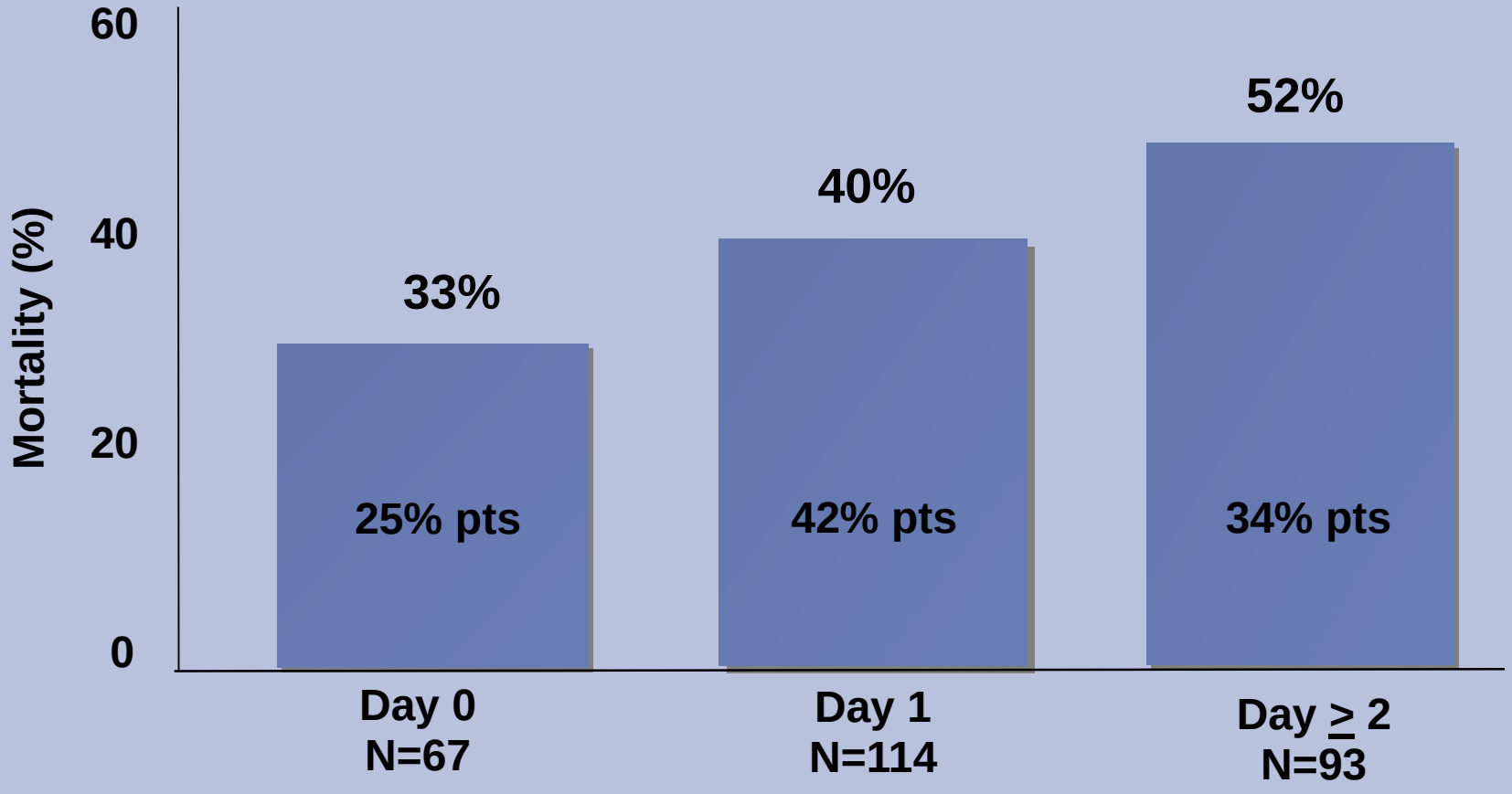
Summary

I. Pre implementation considerations
   - Stakeholder support (Securing)
II. Pre implementation data (Gathering)
III. Criteria forRRS activation (Identifying)
IV. RRS Team Composition (Design)
V. RRS Education Topics (Conducting education and trainning)
VI. Timeline for implementation (Establishing)
VII. Colecting data to monitoring the effectiveness of the RRS

Implementation of RRS Summary

“THANK YOU”

Mortality / Timing of APC Administration in 274 patients



A post-marketing retrospective analysis

How Will the RRS Work at FRHG?