OVERVIEW OF RAPID RESPONSE TEAMS

Recognising and Responding to Clinical Deterioration Workshop
Australian Commission on Safety and Quality in Health Care
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PROBLEM

- Deaths
- Cardiac arrests
- Admissions to ICUs

At least 70% preceded by abnormal observations and are potentially avoidable
WHY?

- Ageing hospital population
- Co-morbidities
- Dangerous interventions and therapies
- Silo based systems
- Medical specialisation
RAPID RESPONSE SYSTEMS

Expose the fragmentation in medical subspecialisation:

- Specialist nominally in charge of the patient
- But patient does not fit into a single organ construct
- No or outdated training in acute medicine

PATIENTS FALL BETWEEN THE CRACKS
RAPID RESPONSE SYSTEMS

- North America
- UK
- Scandinavia
- Europe

→ NSW / AUSTRALIAN ROLLOUT
CORE BUSINESS??
WHY HASN’T IT HAPPENED?

• System implementation across whole hospital is a relatively new challenge
• Does not belong in an existing silo
• Patient centred and therefore the usual advocacy is missing
• Needs funding
SUMMARY OF INTERNATIONAL EXPERIENCE

5 PILLARS – MINIMUM STANDARDS

1. Peak hospital committee and buy in – implementation, sustainability and monitoring.
2. Identify at-risk patient
3. Formal response
4. Key performance indicators
   - Defines the problem
   - Tracks the effectiveness
5. Education
   - Organisation
   - Basic awareness
   - High level resuscitation skills
HOW DO WE MAKE IT HAPPEN?

MINIMUM STANDARDS FOR:

• Identification of at-risk patients, eg NSW chart

• Response – 24/7 cover of at least 1 person with advanced resuscitation skills in every hospital
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NEXT STEPS

MINIMUM STANDARD PEAK HOSPITAL COMMITTEE AND “BUY IN”

• Administrative hospital head
• Senior clinicians
• Administrative support
EDUCATION

- Whole organisation awareness
- Evaluation programme aimed at frontline doctors/nurses, eg DETECT
- 24/7 advanced resuscitation - at least one person who can keep a seriously ill patient alive until the “cavalry” arrives + transport
KPIs

• Inexpensive
• Easy to collect
• Meaningful
• Standardised
• Linked to other patient safety activities, eg RCA, SAC, deaths

MUST BE AGGREGATED AND FED DOWN AS WELL AS UP

MOST IMPORTANT DRIVER OF SYSTEM
EMPOWERING NURSES

- Record vital signs (nurse)
- Calls (doctor)
- Monitor and act (nurse)
5TH ANNUAL INTERNATIONAL RRS/MET CONFERENCE – Copenhagen May 2009

• Clinicians
• Policy makers and politicians
• Epidemiologists
• Social scientists
• Patient advocate
LESSONS LEARNT FROM COPENHAGEN

• New system implementation very different from new drug/procedure
• Need understanding from non-medical areas (eg social scientists and organisational theorists)
• Need KPIs to track and drive implementation sustainability and effectiveness
• Data needs to be collated, packaged and targeted
  – Those involved in making it work
  – Those responsible for implementation and sustainability
• Good news stories for government/politicians
RAPID RESPONSE SYSTEMS HAVE AND WILL ENCOURAGE RE-EXAMINATION OF HISTORICALLY ENTRENCHED ACTIVITY

eg

• How and when to measure vital signs?
• Hierarchical and silo based approach to abnormal vital signs and observations
• Concept of general wards vs ICUs/ERs/ORs
• Conveyor belt approach to end-of-life care
TECHNOLOGY - REAL TIME, UNIVERSAL, NON-INVASIVE, WIRELESS MONITORING OF VITAL SIGNS

- Standardised response
- Triage criteria
- “Black box”
- Patient flow
RRSs - RE-EVALUATING THE ROLE OF ACUTE HOSPITALS

- End-of-life care
- Chronic illness
- Age related conditions
- Matching the patient with what the hospital can offer, ie appropriateness of admission
FEATURES

• Patient centred
• Integrated, accessible, equitable
• Works across silos
• Encourages clinicians / governments / administration / society to speak the same language
HEALTH

• POLICY

• Implementation