FAILURE TO RESCUE PART I: CAN WE FAIL LESS AND RESCUE MORE?

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Alaska Hospital Association
May 2016
WHAT IS “FAILURE TO RESCUE”?
WHAT IS FAILURE TO RESCUE?

- Code Blue on the surgical floor for a patient who recently underwent knee surgery
- Patient on the medical floor who develops septic shock before we recognize a problem
- Post-partum patient who has a stroke days after delivery
FAILURE TO RESCUE

A measure of quality of care given in the hospital – the mortality rate for patients following the onset of a complication that the patient did not have at the time of admission.

Silber, Medical Care 1992;30:615-29.
WHY?

We fail as an organization to recognize early and respond appropriately to changes in a patient’s condition.

Johnston, M et.al Annal of Surg, 2014
PROGRESSIVE FAILURES

• Failure to recognize patient’s risk for mortality from complications

• Failure to recognize clinical deterioration in a timely manner

• Failure to respond to clinical deterioration

• Failure to learn from past cases
MULTI-PRONGED APPROACH PREVENTION

• Afferent Arm
• Efferent Arm
• Data Arm
• Leadership Arm
DRIVERS FOR PREVENTION OF FTR

Prevent FTR

Afferent Arm: Crisis detection

Implement standardized assessment tools to identify patients at risk of a serious event or complication. Develop standardized mechanisms for engaging patient family members in risk recognition.

Efferent Arm: Crisis response

Develop a protocol or process for obtaining resources quickly.

Data Driven Resources

Collection of input and feedback from providers, care teams, patients, and family members about experiences with and evaluations/reviews of events.

Leadership support

Implement and maintain a rapid response system structure
EFFERENT ARM: CRISIS RESPONSE

If your patient has a:
- respiratory rate >35 or <5
- systolic blood pressure <70
- heart rate >140 or <40
- EWS of 10 or more is unresponsive or fitting

OR you have serious clinical concerns about any patient regardless of their vital signs

YOUR PATIENT NEEDS A MET CALL NOW

DIAL 777

Medical Emergency Team

what to do: DIAL 777
what to say: "MET CALL"
THEN GIVE YOUR LOCATION & STAY WITH THE PATIENT

Medical Emergency Teams & Early Warning Scores are an essential part of the hospital’s mandatory patient safety system. If you are concerned about any patient, call for help immediately.
PURPOSE AND GOALS OF RAPID RESPONSE SYSTEM TEAMS (RRT)

Rapid response teams are expert clinicians who respond and provide interventional care to patients experiencing acute changes in their conditions. The goals of the team are to recognize early signs of patient deterioration and to prevent avoidable code events.
FOUR COMPONENTS OF A RAPID RESPONSE SYSTEM (RRS)

- Activators
- Responders
- Quality Improvement
- Leadership

RRS
ACTIVATORS

"Activators" - the person or persons who activate the RRS by calling the response team.

Activators can be:
• floor staff
• a patient
• a family member
• specialists
• anyone else sensing acute deterioration, including the patient or a family member
RESPONDERS

• After activation, Responders arrive at the bedside and assess the patient's situation.

• Responders coordinate with general care unit staff and the attending physician to provide treatment with the aim of stabilizing the patient.

• Responders determine patient disposition, which could include:
  - Transferring the patient to another critical care unit (e.g., ICU or CCU).
  - A handoff back to the primary nurse or primary physician.
  - Revising the treatment plan.
  - It is important to note that Activators may become Responders and assist in stabilizing the patient.
QUALITY IMPROVEMENT

• The **Quality Improvement Team** supports Activators and Responders by reviewing RRS events and evaluating data for the purpose of improving RRS processes.

LEADERSHIP

• The **Leadership Team** of the RRS supports the entire RRS by ensuring that changes in processes are implemented. The Administration Team can include organizational resources, support, and leadership.
EFFECTIVE IMPLEMENTATION STRATEGIES:

• Engage senior leadership support.
• Determine the best structure.
• Establish criteria for activation.
• Establish a simple process for activating the RRT.
• Provide education and training.
• Use standardized tools.
• Establish feedback mechanisms.
• Measure effectiveness.
STRUCTURE OF THE RESPONSE TEAM

- ICU RN, RT, Intensivist or Hospitalist
- ICU RN and Respiratory Therapist (RT)
- ICU RN, RT, Intensivist, Resident
- ICU RN, RT, Physician Assistant
- ED or ICU RN
KEY FEATURES OF RAPID RESPONSE TEAM MEMBERS

• Available
  – Must be onsite and accessible
• Critical care skills
  – Able to assess and respond
• Courteous
  – They must respond to every call with a smile on their face and a script that may include, “Thank you for calling. How can I help you?”
ESTABLISH CRITERIA FOR ACTIVATION

- Staff member is worried about the patient
- Acute change in heart rate <40 or >130 bpm
- Acute change in systolic blood pressure <90 mmHg
- Acute change in respiratory rate <8 or >28 per min
- Acute change in saturation <90% despite O2
- Acute change in conscious state
EDUCATION TO PHYSICIANS

- RRT does not replace immediate consult with physician
- Include the attending physician in RRT
- Linked to fewer codes and lower mortality
- Creates enhanced culture of safety for the patient
EDUCATION TO RRT MEMBERS

• Communication skills
  – SBAR
  – Professional, friendly

• Activation expectations
  – Timeliness
  – Provide non-judgmental, non-punitive feedback
  – Provide learning opportunity for the caregiver
EDUCATION TO PATIENTS AND FAMILY MEMBERS

• Family members and visitors may recognize deterioration in patients earlier than traditional staff members.
• Education may include posters placed in public areas, a brochure placed in the admission packet and a discussion during the admission process.
• The discussion should include a description and purpose of the team, as well as the mechanism for activation of the team.
FEEDBACK MECHANISMS AFTER AN RRT CALL

• Feedback information on patient outcome.
• Lessons learned hospital-wide.
• Use data to drive educational programs and proactive identification of at-risk patients.
• Share the success stories.
• Feedback mechanisms to the staff foster understanding of Rapid Response Teams and their benefits.
“Scientists have given a new name to the deaths that occur in surgery after something goes wrong—whether it is an infection or some bizarre twist of the stomach. They call them a “failure to rescue.” More than anything, this is what distinguished the great from the mediocre. They didn’t fail less. They rescued more.”

- Atul Gawande
- The New Yorker June 2012
RESOURCES


