Rapid Response Teams in Hospitals Increase Patient Safety

Matthew Grissinger, RPh, FASCP

Many hospitals are now familiar with the concept of rapid response teams (RRTs), one of six initiatives that comprised the Institute for Healthcare Improvement’s (IHI’s) “100,000 Lives Campaign.” The idea is simple: any health care worker can bypass the typical chain of command and call what is essentially a medical “SWAT team” to quickly assess a patient and intervene when lifesaving care may be needed. Unlike the traditional “code” team, the RRT intervenes before the patient experiences respiratory or cardiac arrest. The results have been impressive, with reductions in cardiac arrests, deaths, and length of hospital stay.

The University of Pittsburgh Medical Center (UPMC) Shadyside and Children’s Hospital appears to be the first facility in the U.S. to have invited patients and families to call for a RRT to address unresolved concerns about their safety and health. Upon admission, patients and family members are invited to pick up any phone in the hospital to report a patient and intervene when lifesaving care may be needed.1 Unlike the traditional “code” team, the RRT intervenes before the patient experiences respiratory or cardiac arrest. The results have been impressive, with reductions in cardiac arrests, deaths, and length of hospital stay.2

Sorrel King had no doubt that access to a RRT would have saved her daughter’s life, because the errors that caused her death were easily correctable.4 Similarly, we have no doubt that a RRT could have reduced harm resulting from other life-threatening medication errors.

One mistake that helped spark the modern patient safety movement—an overdose of cyclophosphamide administered to Boston Globe reporter Betsy Lehman in 1994—brought widespread public attention to medical errors.6–8 Mrs. Lehman received an entire course of chemotherapy each day for four consecutive days at Dana–Farber Cancer Center. Both she and her husband repeatedly stated that something was not right after the first dose, but their concerns were dismissed as the expected toxicity of the chemotherapy. Sadly, on the day she was to be discharged, Betsy even phoned a friend and left a message: “I’m feeling very frightened, very upset. I don’t know what’s wrong, but something’s wrong.”9 She died an hour later.

If either Betsy or her husband had been able to call a RRT when she first experienced symptoms of the overdose, would she have survived? Deploying a different group of health practitioners, whose primary roles were to listen, be objective, and be responsive, might have resulted in a better outcome if the error had been caught when the patient and her husband first expressed concerns.

Between July 2005 and March 2006, Shadyside received 20 calls, mostly from patients.5 All calls were judged to have been appropriately initiated, and the hospital considers each call a learning experience.3 In fact, it is recognized that even though something interfered with communication between the patient, family, and staff, individuals should not be blamed. Condition H is considered an additional opportunity to step in before a tragedy occurs. However, Shadyside also believes that the program has caused staff members to ramp up their communication with patients. Patients say they feel

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Increase Patient Safety

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much safer knowing they can get immediate attention if they feel they need it.4
UPMC has been expanding Condition H to other facilities within its network, and other hospitals in the U.S. are gearing up to empower patients to call a response team. This intervention may truly be one of the most important ways that health care systems can make patients an equal partner in their care and safety.

REFERENCES


The reports described in this column were received through the ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP Web site (www.ismp.org) or communicated directly to ISMP by calling 1-800-FAIL-SAFE or via e-mail at ismpinfo@ismp.org.