



## Who we are...

Since 1989, Med League Support Services, Inc. has aided attorneys in 38 states. We perform these services:

- Analyze medical records
- Develop case chronologies
- Screen malpractice cases for merit
- Prepare PowerPoint presentations for settlement negotiations or trial
- Locate nursing & physician experts
- Prepare pain and suffering reports
- Transcribe handwriting
- Prepare life care plans
- Assist with demonstrative evidence
- Prepare medical illustrations
- Assist with preparation of demand letters and settlement brochures

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## RRTs: Douse the spark before it becomes a forest fire

Imagine this scene: You are visiting your elderly father in the hospital when you notice his speech is becoming slurred and he is less awake than usual. Concerned, you call his nurse into the room. She assesses your father, then picks up the phone and requests an emergency response team. A team of professionals enter the room, assess and stabilize your father, and arrange for him to be transported to the ICU with a tentative diagnosis of rule out stroke. Your father's attending physician is called as the team is completing its assessment. The critical care nurse on the team pulls the floor nurse aside to congratulate her on her astute assessment. The process from start to finish has taken 20 minutes.

Rapid response teams (RRTs) were started in Australia several years ago, and have been implemented in large numbers of American and Canadian hospitals and elsewhere in the world after 2005. The genesis of rapid response teams is rooted in the recognition that unnecessary deaths occur in hospitals every day. Early recognition of warning signs of impending medical deterioration reduces some of these deaths. In one study published 17 years ago, as many as 70% of patients showed evidence of respiratory deterioration within 8 hours of a respiratory/cardiac arrest. <sup>1</sup> A study

published 13 years ago reported that as many as 66% of patients showed abnormal signs and symptoms within 6 hours of an arrest; the physician was notified only 25% of the time. <sup>2</sup>

The composition of RRTs varies from hospital to hospital. A team typically consists of 2-3 people who are assigned to flexible responsibilities within the facility. The team may consist of respiratory therapists, physician assistants, nurse practitioners, critical care nurses, intensivist (critical care doctors), hospitalists (physicians employed within a facility to provide inpatient care) or residents. The team's role is to assess and stabilize the patient, assist with communication with the attending physician, educate and support the nursing staff and family, and assist with transfer to another level of care, if needed.

Without rapid response teams, nurses who recognize ominous changes in the status of their patients are forced to contact the attending physician and wait for a return call. Should an attending physician

refuse to deal with or minimize the concerns of the nurse, the nurse has to use the chain of command within a facility - in effect, to go over the head of the attending physician with the assistance of nursing administration, to find a physician who will respond. This is a slow and difficult process. RRTs have the capability of bypassing the attending physician to turn what can be a 2-3 hour long process into a 5-10 minute arrival to the patient's bedside. The use of a team within a facility empowers the staff nurse, and provides a safety net for both the nurses and the patients. (Refer to box for



typical criteria for calling a RRT.) Implementation of RRTs has reduced cardiac arrests, deaths, the number of unexpected emergency admissions to ICU, and the length of a hospital admission for cardiac arrest survivors. RRTs build teamwork and spread knowledge and skills throughout the hospital. "The goals of the team are to provide immediate detection and diagnosis, to treat patients early, and to mitigate harm by turning adverse events into 'near misses'. The system is designed to protect the patient from further harm and to allow for recovery from possible medical errors and system deficiencies." <sup>3</sup>

The benefits seem obvious - why doesn't every hospital have an RRT? If the Institute for Healthcare Improvement had its way, every one would. The use of RRTs is one of the cornerstones of the 5 Million Lives Campaign, which is aimed at preventing 5 million incidents of medical harm over 2 years (December 2006 to December 2008) by use of patient safety measures that have been proven to save lives. Implementation of RRTs has stirred initial resistance to change in some facilities. Some physicians have resisted the development of RRTs, fearing that a call to the team will be viewed as a sign of inadequate medical care. In one facility, resistant physicians were upset that the nursing staff could invite another physician to get involved with their patient. Some even went as far as to write formal orders that the rapid response team could not look at their patients. Such orders were ignored. <sup>4</sup> Despite initial resistance, it is clear that RRTs are spreading and they are saving lives.



### Key points for attorneys

1. Many hospitals have now adapted the RRT concept to the needs of specific patients. There are trauma teams, chest pain teams, stroke teams, shock teams, and obstetrical teams.
2. Some facilities have begun encouraging patients and family members to activate a rapid response team when they do not feel their concerns are being adequately addressed.
3. Soon it will be argued that having an RRT is the standard of care.
4. Whether or not a team is in place, failure to recognize early changes in a patient's condition causes many deaths.
5. Inquire if a hospital has a RRT before someone you love is electively admitted.

1. Schein, R, Hazday, N, Pena, M et al. Clinical antecedents to in-hospital cardiopulmonary arrest. *Chest* 1990: 98: 1388-1392.
2. Franklin, C, Matthew, J. Developing strategies to prevent in-hospital cardiac arrest: analyzing responses of physicians and nurses in the hours before the event. *Critical Care Medicine*. 1994; 22 (2): 244-247.
3. Baldisseri, M. Rapid Response Systems: Have They Made a Difference? *Critical Connections*, June 2006, online at [www.sccm.org/SCCM/Publications](http://www.sccm.org/SCCM/Publications).
4. Staff education, 'tough love' key to RRT success, *HealthCare Benchmarks and Quality Improvement* 11/01/06.

### Typical criteria for calling the RRT

- A staff member is concerned or worried about the patient
- Acute change in heart rate (less than 40 or greater than 130 beats per minute)
- Acute change in systolic blood pressure (less than 90 mm/Hg)
- Acute change in respiratory rate (less than 8 or greater than 24 breaths per minute) or threatened airway obstruction
- Acute changes in blood oxygen saturation (less than 90% despite oxygen)
- Fractional inspired oxygen (FiO<sub>2</sub> for a patient on a ventilator) of 50 % or greater
- Acute changes in mental status (delirium, confusion, decreased awareness)
- Acute significant bleeding
- Urine output less than 50 cc in 4 hours
- New, repeated, or prolonged seizures
- Failure to respond to treatment for an acute problem or symptom

**Patricia Iyer MSN RN, LNCC, Mary Ann Shea JD RN, and Barbara Levin BSN RN ONC LNCC** presented a symposia at the International Council of Nurses Conference in Yokohama, Japan on May 31, 2007, on education of nurses about RRTs and dealing with unexpected changes in patient's conditions. Their second symposia described the consequences of a medical error. An estimated 3,400 nurses from 109 countries attended the conference.