Hospitals Urged to Form Rapid-Response Teams

In more than 2,000 hospitals to date, teams of trained clinicians take immediate action at the bedside.

BY BRUCE DIXON
Contributing Writer

CHICAGO — Expanded use of rapid-response teams should be a key element in efforts to reduce hospital mortality, speakers said at the annual meeting of the Society of Hospital Medicine.

"Few of us get good team training," said John Whittington, M.D., coordinator of clinical informatics and patient safety officer at OSF Healthcare System, based in Peoria, Ill. "A rapid-response team of clinicians brings critical care expertise to the bedside, where they can assess, stabilize, improve communication, educate, support and assist with patient transfer when necessary." As part of a systems approach to patient care, this SWAT approach helps to eliminate the cumbersome chain-of-command process.

Development of rapid-response teams is a cornerstone of the systems-based approach advocated by the "100,000 Lives Campaign" of the Institute for Healthcare Improvement, Cambridge, Mass. Supported by the American Medical Association and other private and public sector health care organizations, the campaign aims to prevent 100,000 unintended deaths by June 2006.

Other goals of the 100,000 Lives Campaign include delivery of evidence-based care for patients with acute MI, implementation of "medication reconciliation" to prevent prescribing errors, and use of science-based methods to prevent central-line infections, ventilator-associated pneumonia, and surgical-site infections.

More than 2,000 hospitals have joined the effort, Dr. Whittington said. "We decided that instead of a disease-specific focus, we'd go to a systems-specific focus to float the whole boat." By improving teamwork and communications, "you can improve the whole situation in a hospital."

"We can achieve a significant drop in all-cause mortality" by using rapid-response teams, he said. "You also see a significant drop in code rate per 1,000 discharges." By improving outcomes and job satisfaction, rapid-response teams also may boost employee retention levels and reduce costs.

Dr. Whittington cited an Australian study showing that 76% of cardiac arrests followed more than 1 hour of ongoing instability (Med. J. Aust. 1999;171:22-5). This and other studies identifying missed warning signs show that there are "burning opportunities" for rapid-response teamwork in hospitals, he said.

Terri Simmonds, R.N., director of critical care and patient safety at the Institute for Healthcare Improvement, said that a rapid-response team might be staffed with a respiratory therapist, an intensivist, a hospitalist, a resident, and a physician assistant, depending on a hospital's situation and resources.

But when it comes to creating such a team, "the devil is in the details," she said.

The clinicians who are assigned to the team must be ready to respond quickly, Ms. Simmonds said. "Many organizations set a minimum response time of 5-10 minutes, so that when the nurse on the floor activates the rapid-response team, she knows these individuals are going to show up in 5-10 minutes—and with smiles on their faces."

Members of the rapid-response team need access to proven protocols so that they can take immediate action, she added.

Ms. Simmonds and Dr. Whittington advocated use of the SBAR technique (situation, background, assessment, and recommendation), which was developed by a group at Kaiser Permanente of Colorado. SBAR improves patient care by providing a framework for communication between members of the health care team about a patient's condition.

"Nurses are taught not to make diagnoses, and doctors are taught to get right to the punchline," Dr. Whittington said. SBAR can encourage nurses to make recommendations that can improve the decision-making abilities of physicians who are willing to listen. ■

Americans Want Medical Error Reports

Nearly 6 years after an alarming Institute of Medicine report on hospital mortality, public trust in the nation's hospitals remains shaky, a spokesman for the American Hospital Association said at the meeting.

In that much-debated 1999 report, the IOM estimated that 45,000-98,000 U.S. patients were dying each year because of preventable medical errors.

"A lot of money and effort are being poured into patient safety, a lot of advocacy groups are inside our institutions, and a lot of hospitals are trying to create cultures of safety and all the rest, yet we have no data. … We have nothing that can assure the public that we're any safer today than we were 5 years ago," Richard H. Wade said. The public "is going to begin to ask questions such as: 'How do you oversee the medical franchise inside your walls? How well are doctors doing at policing and overseeing each other so that the quality of care you put before us can be trusted?' "

In a 2004 poll of 2,012 adults by the Kaiser Family Foundation, 55% of those asked were dissatisfied with the quality of the care they received in the hospital, he said. Also, 70% of those polled said they would have greater confidence in a hospital that voluntarily reported errors. One-third of the participants said they or a family member had experienced a preventable medical error during a hospital stay; of that group, 70% said they were never told about being the victim of an error.

Overall, 92% of those polled said there should be public reporting of medical errors, up from 62% in a similar poll conducted in 2002.

None of this is lost on state and federal legislators who have drafted—or are drafting—legislation to make data on hospital medical errors open to public scrutiny, Mr. Wade noted. "Everybody wants to take charge of quality inside hospitals. … The government's trying to do it, and there's a lot of pressure to demonstrate the quality of care in the hospital."

"Why haven't hospitals taken the lead to do these things themselves? We're trying to accomplish these things, but it takes time," he said, pointing to the Hospital Quality Alliance sponsored by the AHA, the Association of American Medical Colleges, and the Federation of American Hospitals.

"We sat down 2 years ago and decided to begin to put data in front of the public," he said. The resulting Web site, www.hospitalcompare.com, offers data on hospital treatment of heart attack, heart failure, and pneumonia.

Laborist Movement Poised to Take Off in 10 U.S. Hospital Systems

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — Ten hospital systems in the United States have started or are about to start using "laborists"—physicians whose sole focus is managing the patient in labor—Louis Weinstein, M.D., reported at the annual meeting of the American College of Obstetricians and Gynecologists.

Using laborists makes sense, said Dr. Weinstein of Jefferson Medical College in Philadelphia. Laborists are expected to improve patient care and ease burnout among obstetricians.

The laborist profession offers obstetricians predictable and limited work hours, while reducing disruption of their office and operating room schedules. It also offers women in labor the benefit of prompt, continuous, and efficient care.

Dr. Weinstein demonstrated the laborist business model by calculating what it would cost a hospital to maintain 7-day, 24-hour coverage by a team of laborists. It would take four physicians, each working four 10.5-hour shifts each week. Dr. Weinstein assumed that the laborists would each earn $175,000 per year, and they would be given 1 week of CME time and 3 weeks of vacation annually. The hospital would have to provide a total of 12 weeks' vacation coverage for the time the laborists were away.

The laborists would receive benefits worth 28% of their salaries, and they would be covered under the hospital's liability policy at a cost of about $60,000 per laborist per year. The total annual cost to the hospital would be $1.2 million.

This scenario would make economic sense only in a hospital with at least 2,000 deliveries per year, he said. If laborists handled half of those deliveries at $1,200 per delivery, that would bring in $1.2 million/year, making the program "revenue neutral" from the hospital's perspective.

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Using laborists makes sense, Dr. Louis Weinstein of Jefferson Medical College in Philadelphia said.

But hospitals would come out ahead if the use of hospitalists improved patient safety such that even one lawsuit were avoided every 5 years, Dr. Weinstein said.

Beyond these economic calculations are the benefits to individual obstetricians and to the profession of obstetrics and gynecology. Dr. Weinstein pointed to studies showing a very high rate of burnout among ob.gyns., which he attributed in part to their hectic and unpredictable schedules and to work weeks well in excess of 40 hours.

Dr. Weinstein said he proposed the laborist model in 2003, patterning it after the rapidly growing hospitalist movement among internists (Am. J. Obstet. Gynecol. 2003;188:310-2). Some criticize the hospitalist movement for a disruption in care when the hospitalist becomes responsible for a patient, but studies have shown high patient satisfaction and significant reductions in resource utilization while maintaining good clinical outcomes.

Hospitalists themselves report high job satisfaction, a long-term commitment to remaining in the field, and the lowest burnout rates of any medical specialty.

For the laborist model to succeed, there must be buy-in by the medical staff. "Clearly, if everybody says, 'Well, I'm not going to let the laborist do *my* deliveries,' then it won't work," Dr. Weinstein said.

Additionally, laborists would have to receive respect from other ob.gyns. ■