Introduction & Background

- Curbside Consults are a common part of the hospital culture – they are quick and easy for the caregiver, and provide free advice about the future direction of the patient's care.
- However, it provides suboptimal patient care. Without a formal record of this recommendation, it is hard for other team members (including nursing staff, therapists, and other consult services/residents) to understand the reasoning behind a decision. Further, decisions are made based on incomplete information.

- Medical Response Teams (MRTs) were started at CCHMC in 2005 in response to the Institute for Healthcare Improvement’s imperative and the desire to eliminate failure-to-rescue events. We implemented a MRT and significantly reduced mortality and morbidity.
- The role of an MRT is to provide an escalation of support when the patient experiences a deviation from the expected trajectory (i.e. hypoxia, seizures, tachycardia, etc.) or the nursing staff/parents become concerned and require additional support.
- Staff embraced the importance of the MRT.
- In 2009, a serious safety event (SSE) occurred at CCHMC due to communication error related to a curbside consult from the Pediatric Intensive Care Unit (PICU).

Aim

- To evaluate the effects of eliminating the PICU curbside consult and mandating activation of the MRT process for all PICU contact on MRT activations and preventable harm.

Methods

- Prior to October 2009, criteria for calling an MRT included automated triggers (PEWS) and nursing, physician, and family
  - Clinicians, primarily physicians, were able to freely contact the PICU fellow or attending on call to discuss a patient
  - As a result of the SSE, as of October 2009, all PICU consults were mandated to go through the MRT process
  - All patient transfers from the floor to the PICU need to go through the MRT process
  - Performance was benchmarked and additional training was provided as needed.

- Measures used:
  - Number of MRT preventable codes
  - Mortality and morbidity
  - Transfers to the PICU
  - Number of repeat MRTs called

Balancing Measures:

- Additional staff was provided in the PICU to manage the increased flow of patients, and a dedicated resource nurse was assigned for MRT response. This nurse had no other patient assignment for the day.
- There was continual reinforcement of goals and protocols by the Fellow and Attending staff in the PICU.

Results

- Curbside Consults of the PICU or PICU fellow were eliminated.
- Preventable Codes outside the ICUs were maintained at a low level.
- There was an increase in the number of MRTs and better communication between teams.
- The rate of transfer of patients to the ICU following MRT remained stable in a range of 55-60%

Conclusions

- MRT allows a team to come together to develop a comprehensive, universally agreeable plan to address acute issues.
- Eliminating Curbside Consults and mandating use of the MRT process is a manageable change.
- It does not result in either an increase, or a decrease in transfer rates following MRT.
- Historical data of total transfer rates needs to be compared to this cohort to see if there were differences in who and how patients were transferred
- The increased MRT rates may create increased demand on staffing, and require alternate staffing patterns (such as hiring a “Resource Nurse” who can respond without a concurrent patient assignment)
- Next steps include evaluating the reasons MRTs were called and what diagnoses were transferred at higher rates than others to evaluate efficiency, cost effectiveness, and adequacy of resource management.

Lessons Learned

- Change is hard. Reinforcement is key. Disruptive change isn’t effective, rather continuous evolution of a process is a key for the staff to embrace change.
- Developing consensus takes time
- Hospital leadership plays a key role in the success of these initiatives
- Without continual reinforcement, people can go back to their old ways

References:

1. Burben, Maritza; Ellen Larson; Angela Avendano; Barbara Sattler; Julie A. Toole; Rebecca Aliper; Mark R. Reed; Lisa Greenwalt; Maria H. Frank; Nicholas Sciabica; Philip Fung; Smriti Dhandhia; Barbara Lindsay; Nancy Moller; Manoj Patel; Jeff Zieren; Jessica Campbell; Mary A. Moler; Sarah A. Yolla; and Kristi A. Allen. “Implementation of a Pediatric Readmission Prevention Program Using Perioperative Readmission Consultations.” Journal of Hospital Medicine 5 (2010): 25-35. Print.