



Getting Started Kit: Rapid Response Teams

How-to Guide

100,000 Lives Campaign

We invite you to join a Campaign to make health care safer and more effective — to ensure that hospitals achieve the best possible outcomes for all patients. IHI and other organizations that share our mission are convinced that a remarkably few proven interventions, implemented on a wide enough scale, can avoid 100,000 deaths between January 2005 and July 2006, and every year thereafter. Complete details, including materials, contact information for experts, and web discussions, are available on the web at <http://www.ihl.org/IHI/Programs/Campaign/>.

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■ **What Is a Rapid Response Team?**

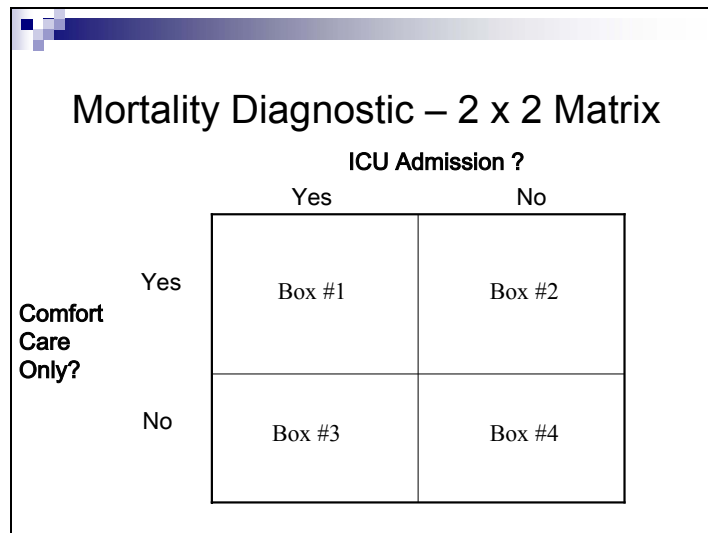
A Rapid Response Team (RRT) – known by some as the Medical Emergency Team – is a team of clinicians who bring critical care expertise to the patient bedside (or wherever it is needed).

■ **Why Do We Need Rapid Response Teams?**

People die unnecessarily every single day in our hospitals. It is likely that each clinician can provide an example of a patient who, in retrospect, should not have died during their hospitalization. The goal is to respond to a “spark” before it becomes a “forest fire.”

■ **Analyzing Hospital Deaths**

The purpose of this diagnostic is to get a clearer understanding of local conditions that contribute to mortality.



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These cases are often seen when retrospectively reviewing inpatient hospital deaths using a simple diagnostic tool called the “2 x 2 Matrix” – or “3 x 2 Matrix” for our colleagues in the United Kingdom. This diagnostic consists of analyzing the patient records for 50 consecutive patients who died in the hospital and placing them into one of the four boxes in the 2 by 2 Matrix. This is done by asking the following questions:

- Was the patient hospitalized for comfort care only?
- Was the patient initially placed into an intensive care unit?

If the answer is yes to both questions, the death is counted in Box 1. If the answer is no to the ICU but yes for comfort care, the death is counted Box 2. If the answer is yes to ICU but no to comfort care, the death is counted in Box 3. If the answer is no to both, then the death is counted in Box 4. Box 4 should be further analyzed by asking if there was any evidence of communication failures, planning failures, or failure to recognize a deteriorating patient condition, which often leads to situations of failure to rescue. Finally, deaths in Boxes 3 and 4 should be reviewed using the Global Trigger Tool (on the web at www.ihl.org), looking for any evidence of adverse events.

Mortality Diagnostic: Aggregate Results for 64 US Hospitals

	ICU Admission	No ICU Admission
Comfort Care	86 / 3175 3% (0-14%)	402 / 3175 13% (0- 40%)
Non Comfort Care	1161 / 3175 37% (10-72%)	1526 / 3175 48% (18-76%)

As of October 2004, 64 US hospitals have shared the results of their mortality reviews using the 2 x 2 Matrix. The table represents their data in aggregate. On average, 48% of all deaths are found in Box 4: patients who were admitted to a non-ICU setting and were not expected to die. Some percentage of the deaths in Box 4 are indeed unnecessary deaths – ones a Rapid Response Team can have an impact on.

Three Fundamental Problems

There is a large amount of variability in health care today. Numerous articles have shown that this variability exists across both quality and safety. Fairly recent work by Sir Brian Jarman, Emeritus Professor of Primary Health Care at Imperial College School of Medicine (London, UK), indicates that this variability exists in hospital mortality rates. Even when multiple risk factors and community factors are taken into consideration, there is no clear explanation for differences from hospital to hospital. And yet, an opportunity exists to reduce this variability by improving hospital care. During the past 18 months, work has been carried out to understand the causes of the problem and to develop potential improvement

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strategies. The conclusions from this work and a review of the literature are that three main systemic issues contribute to the problem:

- Failures in planning (including assessments, treatments, and goals)
- Failure to communicate (patient-to-staff, staff-to-staff, staff-to-physician, etc.)
- Failure to recognize deteriorating patient condition

These fundamental problems can often lead to a failure to rescue.

Clinical Instability Prior to Arrest

Several studies indicate that patients often exhibit signs and symptoms of physiological instability for some period of time prior to a cardiac arrest:

- 70% (45/64) of patients show evidence of respiratory deterioration within 8 hours of arrest

Schein RM, Hazday N, Pena M, et al. Clinical antecedents to in-hospital cardiopulmonary arrest. *Chest*. 1990;98:1388-1392.

- 66% (99/150) of patients show abnormal signs and symptoms within 6 hours of arrest and MD is notified in 25% (25/99) of cases

Franklin C, Mathew J. Developing strategies to prevent in hospital cardiac arrest: analyzing responses of physicians and nurses in the hours before the event. *Crit Care Med*. 1994;22(2):244-247.

Franklin's article identified several warning signs present within six hours of arrest:

- MAP <70, >130 mmHg
- Heart rate <45, >125 per minute
- Respiratory rate <10, >30 per minute
- Chest pain
- Altered mental status

What Difference Can a Rapid Response Team Make?

	Before	After	
No of cardiac arrests	63	22	RRR 65% $P=0.001$
Deaths from cardiac arrest	37	16	RRR 56% $P=0.005$
No of days in ICU post arrest	163	33	RRR 80% $P=0.001$
No of days in hospital after arrest	1363	159	RRR 88% $P=0.001$
Inpatient deaths	302	222	RRR 26% $P=0.004$

MJA 2003; 179-7

- 50% reduction in non-ICU arrests

Buist MD, Moore GE, Bernard SA, Waxman BP, Anderson JN, Nguyen TV. Effects of a medical emergency team on reduction of incidence of and mortality from unexpected cardiac arrests in hospital: preliminary study. *BMJ*. 2002;324:387-390.

- Reduced post-operative emergency ICU transfers (58%) and deaths (37%)

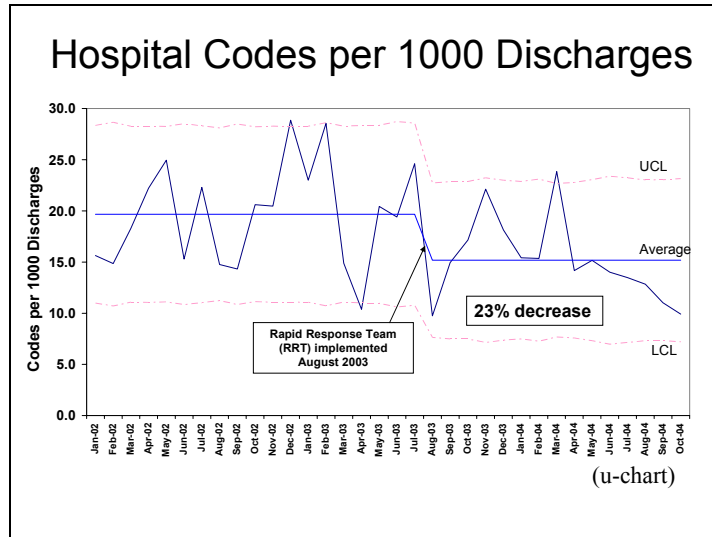
Bellomo R, Goldsmith D, Uchino S, et al. Prospective controlled trial of effect of medical emergency team on postoperative morbidity and mortality rates. *Crit Care Med*. 2004;32:916-921.

- Reduction in arrest prior to ICU transfer (4 % vs. 30 %)

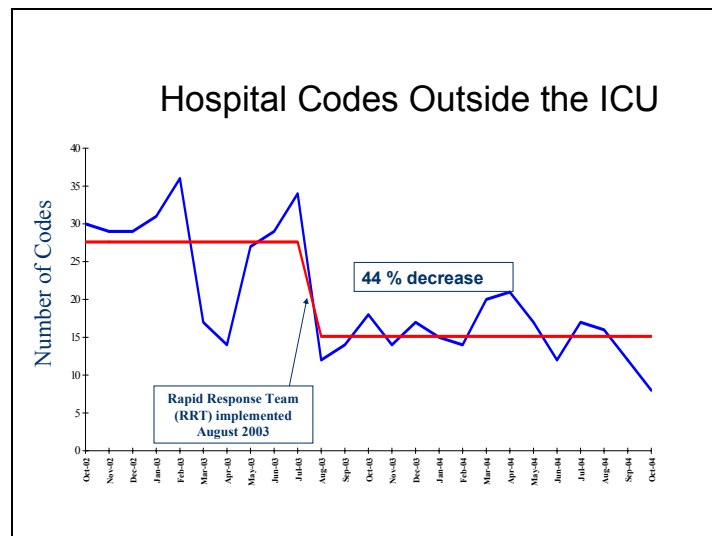
Goldhill DR, Worthington L, Mulcahy A, Tarling M, Sumner A. The patient-at-risk team: identifying and managing seriously ill ward patients. *Anesthesia*. 1999;54(9):853-860.

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Sample Results

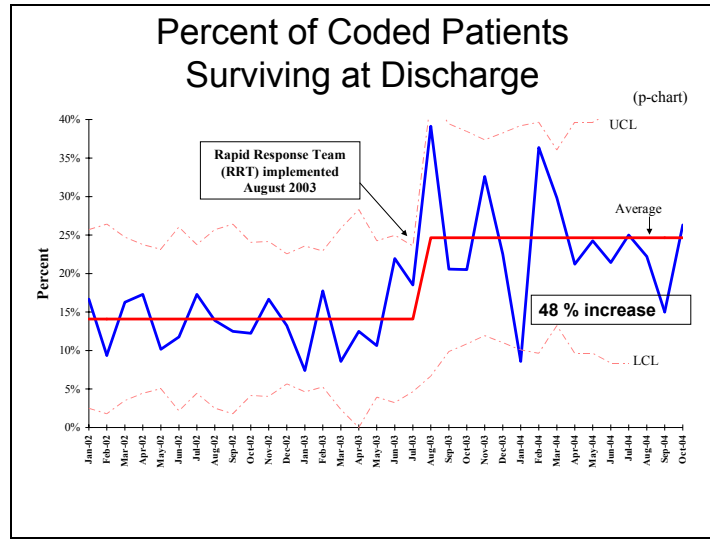


This chart represents one hospital's results after implementing a Rapid Response Team. This hospital is a 750-bed non-teaching community hospital. Their RRT consists of a critical care nurse and respiratory therapist, with intensivist backup. They have seen a 23% decrease in their overall code rate per 1,000 discharges.

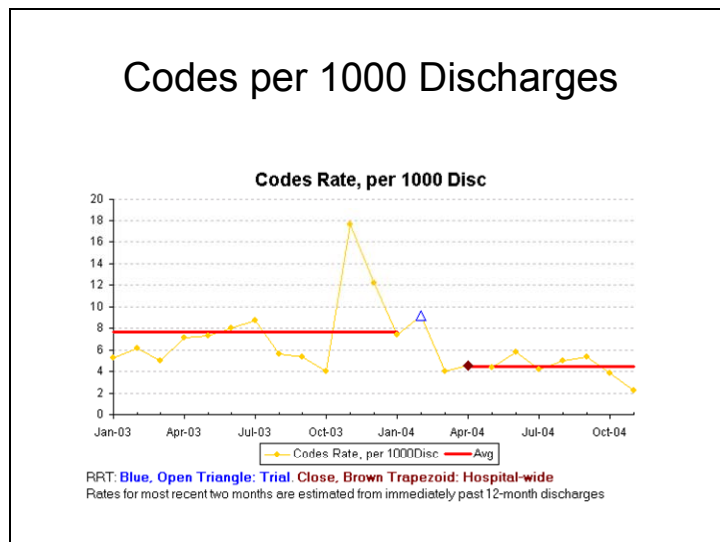


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The same organization observed a 44% decrease in the codes occurring outside their ICU. Their hypothesis: Patients were being identified prior to cardiac arrest and either never coded at all or were moved to the ICU prior to their arrest.



This same hospital saw a 48% increase in the percentage of coded patients surviving at discharge. Once again, their hypothesis: Patients who coded did so in a monitored setting such as an ICU, thereby increasing the likelihood of their surviving.



Another organization, a smaller community non-teaching hospital with an average daily census of around 225 patients, has seen similar results in their overall reduction in codes per 1,000 discharges.

What Is the Role of the Rapid Response Team?

- Assess
- Stabilize
- Assist with communication
- Educate and support
- Assist with transfer, if necessary

The Rapid Response Team has several key roles. The team assists the staff member in assessing and stabilizing the patient's condition and organizing information to be communicated to the patient's physician. The Rapid Response Team member also takes on the role of educator and support to the staff. Initially, organizations may fear that the introduction of the Rapid Response Team will lessen the clinical skills of the non-ICU staff. In fact, quite the opposite appears to be true. In their role as educators, the Rapid Response Team nurses have a unique opportunity to educate the non-ICU staff at the time of the call, assembling the various pieces of clinical information and pulling the pieces of the puzzle together. If the circumstances warrant, the Rapid Response Team assists with the patient transfer to a higher level of care.

Rapid Response Team Considerations

Prior to testing and implementation of a Rapid Response Team, organizations may wish to consider the following:

- Engage senior leadership support.
- Determine the best structure for the team.
- Provide education and training.
- Establish criteria and mechanism for calling the RRT.
- Use a structured documentation tool.
- Establish feedback mechanisms.
- Measure effectiveness.

Engage Senior Leadership Support

Engage senior leadership (executive and physician) support and buy-in, i.e., “We are going to do this; this is important and the right thing to do for our patients.”

- Make an explicit organizational commitment to establishing the RRT.
- Educate the medical staff about the benefits of RRT and put the myths to rest.
- Craft a very clear and widely disseminated communication message from senior leadership.

Determine the Best Structure for the Team

First, who will comprise the Rapid Response Team? Our experience shows that multiple models work well, including the following:

- ICU RN and Respiratory Therapist (RT)
- ICU RN, RT, Intensivist, Resident
- ICU RN, RT, Intensivist or Hospitalist
- ICU RN, RT, Physician Assistant

Select each member (physician, RN, RT) of the RRT team carefully. The physician team member should be one who is respected by both nurses and physicians and perceived as a good communicator and team player.

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In every model, there are three key features of the team members:

- The team members must be available to respond immediately when called, and not be constrained by competing responsibilities.
- They must be onsite and accessible.
- They must have the critical care skills necessary to assess and respond.

Organizations should examine their current resources and culture when choosing the Rapid Response Team members and build on existing relationships and practice patterns, e.g., hospitalist program, less than 24 x 7 intensivist coverage, etc. Staff must feel comfortable calling the Rapid Response Team. Care should be taken when choosing team members in order to maximize their capabilities as educators and responders.

Organizations are able to muster resources when patients progress to a cardiac arrest. The challenge is to find resources to *prevent* such cardiac arrests from occurring in the first place.

Provide Education and Training

Medical Staff: Educate the medical staff about the benefits of RRT and dispel the myths.

Benefits:

- Fast and accurate critical patient assessment 24 x 7
- Clear and concise communication using SBAR (Situation, Background, Assessment, Recommendation) method of communicating
- Link to fewer codes and lower mortality

Myths:

- RRT is not intended to take the place of immediate consultation with the physician if needed. After consultation with the RRT, a call is placed to the appropriate physician.

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The intention is to help patients in the time window of clinical instability and not to replace physician involvement in that process.

RRT Members: The RRT members should receive education and training together. Training includes the following:

- Advanced critical care training (ACLS) as needed. Most ICU RNs and RTs will likely have training already. Organizations should determine which standing protocols the RRT will have available for use during the call.
- SBAR (Situation, Background, Assessment, Recommendation) method of communicating and receiving communications about patient condition (details available on www.ihl.org)
- Communication skills, including responding in a professional and friendly manner
- Setting appropriate expectations, including responding in a timely manner (e.g., within 5 minutes every time the RRT is called); providing non-judgmental, non-punitive feedback to the person that initiated the call to the RRT

Nursing Staff: Nursing staff should receive education and training on the following:

- Criteria and procedures for calling, how to notify the team
- Communication and teamwork skills – use of SBAR, appropriate assertion, and critical language skills
- Appropriate expectations – call even if you’re unsure. “It’s better to call than not.” Some organizations have set the expectation that nurses “will call when any criteria are met” – and *not* calling may have repercussions.

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- The team that responds will do so in a non-judgmental, non-punitive way.
- Have information available for the team, such as the chart, medication administration record (MAR), previous assessments, etc.
- The person who calls the RRT should become a key member of the team and assist the RRT; the RRT is not there to take over and assume care of the patient.

Nursing staff education can take the form of a “traveling road show” to each nursing unit, either as they join the pilot or at the beginning. Nursing managers and educators may want to gather staff together and do a debriefing of a code or critical event that “could have happened last night on this unit.” Providing a brief description of how the RRT could have assisted the staff and prevented the event from occurring may accelerate learning.

Establish Criteria and Mechanism for Calling the RRT

Criteria for Calling the RRT: Each organization should determine which criteria will be used to call a Rapid Response Team, and educate the staff accordingly.

Example criteria include:

- 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
- Acute change in urinary output to <50 ml in 4 hours

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There are at least two different approaches to the use of criteria. The first is to educate staff on the criteria and encourage them to call the RRT when any are met or when they are worried about the patient, even though the patient may not meet any criteria. Another approach is to mandate the staff to call the RRT when any criteria are met, thereby setting a different expectation.

Tip: After piloting the Rapid Response Team, be sure to educate all hospital employees on the criteria, including radiology, endoscopy, etc.

Mechanism for Calling the RRT:

- Use a beeper, with or without overhead page.
- Encourage staff to dial in the patient’s room number.
- If not in a patient room, dial in the extension for the RRT Team to call back for a location.

Use a Structured Documentation Tool

Communication and Documentation

- Embed SBAR
- Record the interventions and reasons for call
- Use data to drive educational programs

Missouri Baptist Medical Center
RAPID RESPONSE TEAM RECORD

Form fields include: Patient, Room #, Location, Time of Call, Event Location, Primary Reason for Call, Assessment, Interventions, SBAR, Disposition, and a barcode at the bottom.

Examples of documentation forms are available; there is no need to reinvent the wheel. (You can download this “Rapid Response Team Record” on www.IHI.org)

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The SBAR communication technique can be embedded into the process by including it on the documentation form. The team can use the form to capture and organize information about the patient's condition prior to calling the physician. The documentation form captures information on reasons for the RRT call, as well as the types of interventions required. This information can be used for planning purposes and to drive nursing and medical staff educational programs.

Establish Feedback Mechanisms

- Feedback information on patient outcome.
- Look for lessons learned hospital-wide.
- Use data to drive educational programs.
- Share the success stories.

It is important to create feedback mechanisms to the staff to foster understanding of RRTs and their benefits. Particularly during the initial stages of establishing the team, organizations find it useful to tell the stories of patients who were rescued by the team. These stories are useful in garnering support for the team. Organizations should examine RRT data for lessons learned and patterns and trends, for example, respiratory events related to narcotics. The information gained from the RRT calls can also be used to inform the overall educational plan for the organization.

Measure Effectiveness

Use these three key measures to evaluate the effectiveness of the Rapid Response Team:

- Codes per 1,000 Discharges
- Codes Outside the ICU
- Utilization of Rapid Response Team

See Appendix C for the measurement information forms (MIFs), which contain detailed information about these measures.

Organizations may wish to collect data on additional measures, such as post-cardiac arrest ICU bed utilization, staff satisfaction with the Rapid Response Team, percent of coded patients surviving at discharge, and safety culture survey data.

Using the Model for Improvement

In order to move this work forward, IHI recommends using the Model for Improvement. Developed by Associates in Process Improvement, the Model for Improvement is a simple yet powerful tool for accelerating improvement that has been used successfully by hundreds of health care organizations to improve many different health care processes and outcomes.

The model has two parts:

- Three fundamental questions that guide improvement teams to 1) set clear aims, 2) establish measures that will tell if changes are leading to improvement, and 3) identify changes that are likely to lead to improvement.

- The Plan-Do-Study-Act (PDSA) cycle to conduct small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.

Implementation: After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale — for example, for an entire pilot population or on an entire unit.

Spread: After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or to other organizations.

You can learn more about the Model for Improvement on www.IHI.org

Other Possible Benefits of Rapid Response Teams

In addition to fewer codes and lower mortality, there may be other possible benefits of the Rapid Response Team, although they require further study. Other possible benefits might include:

- Better outcomes
- Improved relationships
- Improved satisfaction
 - Nursing
 - Physician
 - Patient
- Impact on nursing retention
- Financial benefits

Tips when getting started:

- Be tolerant of “false alarms.” Staff should be praised for calling even if, after assessment, the patient condition did not appear to warrant calling the RRT.
- Get the word out – initially and continuously. Communicate, communicate, and communicate! You cannot do enough of this. Particularly in the beginning, get the word out often and continuously. Be systematic and relentless with your communication.
- The power of sharing the RRT stories with medical and nursing staff cannot be underestimated.
- Maintain continuous awareness and reinforcement of RRT through hospital publications, newsletters, etc.

Appendix A

Rapid Response Team Education Checklist

Medical Staff Education

- General information
- Benefits
- Myths

RRT Education

- ACLS or advanced critical care training
- SBAR (Situation, Background, Assessment, Recommendation)
- Communication skills
- Appropriate expectations
 - Importance of responding in a timely manner
 - Importance of providing non-judgmental, non-punitive feedback to call initiator

Nursing Staff Education

- Criteria for calling
- Notification process
- Communication and teamwork skills
 - SBAR, Assertiveness / Critical Language
- Appropriate expectations
 - Importance of calling even when unsure
 - Non-judgmental, non-punitive nature of the RRT
 - Have information available for RRT (chart, medication administration record, etc.)
 - Role as a member of the team

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Appendix B

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Reports from the Field

Intervention: Rapid Response Teams

Organization: Missouri Baptist Medical Center
St. Louis, MO

Contact: John E. Krettek Jr., M.D., Ph.D.
Vice President Medical Affairs and Chief Medical Officer
jkrettek@bjc.org

Date: 2/8/05

At Missouri Baptist Medical Center, we have had our Rapid Response Team active now for a year. The team does not respond to the ED, the Cardiac Cath Lab, or the ICUs; the latter are staffed by intensivists 24/7. The team is comprised of a Physician Assistant, an ICU nurse and a respiratory therapist. They carry beepers and when an RRT call is made they respond in person. There is thus no "discussion" only response. Our response time is 1.5 minutes. All members arrive and then it is determined who should remain depending on the patient's condition. 70% of our calls are respiratory in nature and often the other members may leave. A significant part of the educational process occurs at this point; the ICU nurse is a resource for the floor nurse and during the initial 3 months we actually had the nurse who had called the RRT complete a survey and the response was 100% overwhelmingly positive that we stopped the survey. The nurses on the floor appreciate the teaching from the high level ICU nurse which is done in a positive rather than a critical fashion, so that it is important to educate the ICU nurses ahead of time about the crucial nature of their role as mentor and educator. Since 35% of our RRT patients are transferred to a higher level of care, the second education piece is feedback to the nurse on the floor of the patient's condition. We also on a monthly basis provide information to the nursing directors, managers and assistant nurse managers at a leadership meeting about the statistics related to RRT versus Codes. Our "discharge from hospital" statistic for RRT is 82%, while for Codes only 17%. This enhances their appreciation for what they personally can do as the initiator of the RRT call.

In short:

- 1) Pre-implementation education of the participant about their roles as both responder and educator; this minimizes the tendency for someone to say the RRT should not have been called or that a nurse is "stupid" in situations that are not critical
- 2) Contemporaneous education about the pathophysiology and the importance of early recognition and reaction rather than waiting to "be sure" and risking a patient in worse condition or code status

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3) Feedback to the individuals involved about the value to the patient of a particular RRT call and their role in improving the care of their specific patient

4) Education of the organization with your own statistics and what the RRT has done to improve the care of your own patients.

The focus is on the patient and the outcome rather than on the attitudes and activities of individual caregivers.

5) There are two parallel tracks;

a) One is that the physicians appreciate the immediate nature of the response and they are called either by a member of the RRT or preferably by the patient's own nurse, who is now more knowledgeable, to provide them a synopsis rather than the physician finding out the next time that she/he visits the patient.

b) Since these are usually "floor" patients it is also desirable to include some education, by the floor nurse, the ICU nurse, or the PA to the family about what is going on. We have had families comment on how impressed by the way that the situation was handled and the rapid response and the fact that they feel much safer knowing that the RRT is available.

One of our Board members actually called me to see if we had such a team after the WSJ article and I simply had him read a little closer and identify that the Missouri Baptist hospital and Nancy Sanders were actually his own organization.

APPENDIX C: MEASURE INFORMATION FORMS

Measure Information Form:
Codes per 1000 Discharges

Intervention(s): Rapid Response Teams

Definition: The number of codes per 1000 inpatient discharges

Goal: Reduce by 50%

Matches Existing Measures: N/A

CALCULATION DETAILS:

Numerator Definition: Total inpatient codes

Numerator Exclusions:

- Codes occurring in the emergency department

Denominator Definition: Total inpatient discharges

Denominator Exclusions:

- Stillbirths
- Deaths in the emergency department (ED) of ED-only patients

Measurement Period Length: 1 month

Definition of Terms:

- Code: Patients requiring cardiopulmonary resuscitation or intubation
- Emergency department-only patient: A patient receiving care in the emergency department who has not been admitted to the hospital

Calculate as: (numerator / denominator) x 1000; as a number of codes per 1000 inpatient discharges

Comments:

Stillbirths and ED-only deaths are generally not considered inpatient discharges; we have noted them explicitly for clarification.

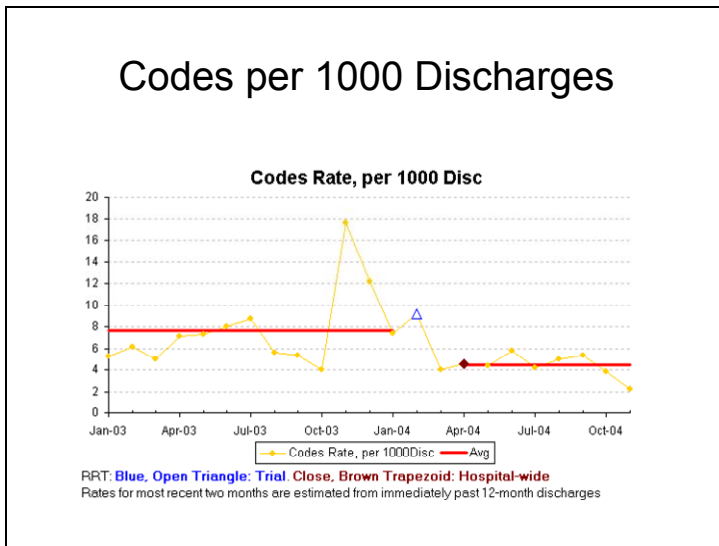
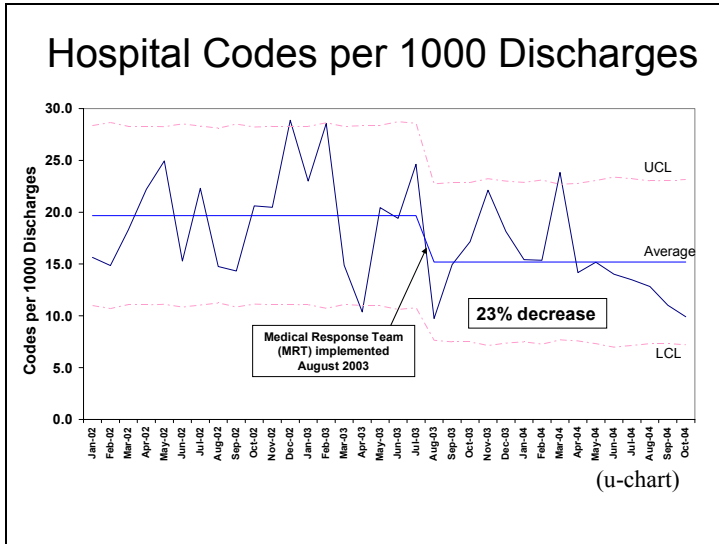
COLLECTION STRATEGY:

Obtain numerator and denominator from hospital information systems or other reliable sources on a monthly basis as soon as discharge and death data are available.

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Sampling Plan: N/A

SAMPLE GRAPH:



Measure Information Form: Percent of Codes Outside ICU

Intervention(s): Rapid Response Teams

Definition: Percent of all codes occurring outside the ICU

Goal: Decrease the overall incidence of codes occurring outside the ICU.

Matches Existing Measures: N/A

CALCULATION DETAILS:

Numerator Definition: In-hospital codes that occur outside the ICU

Numerator Exclusions:

- Codes occurring in the ED

Denominator Definition: All in-hospital codes

Denominator Exclusions:

- Codes occurring in the ED

Measurement Period Length: 1 month

Definition of Terms:

- Code: Patients requiring cardiopulmonary resuscitation or intubation
- ED: Emergency department

Calculate as: (numerator / denominator); as a percentage

Comments:

The purpose of the rapid response team is to support the hospital personnel outside of the ICU and the ED. Therefore, we would expect the early intervention of the Rapid Response Team to decrease the number of patients who are coding within your facility outside of the ICU and ED.

We do not include ED codes because the Rapid Response Team is generally used to support and help all areas of the hospital except for the ED and ICU. Since the Rapid Response Team will not impact codes in the ED, we exclude them.

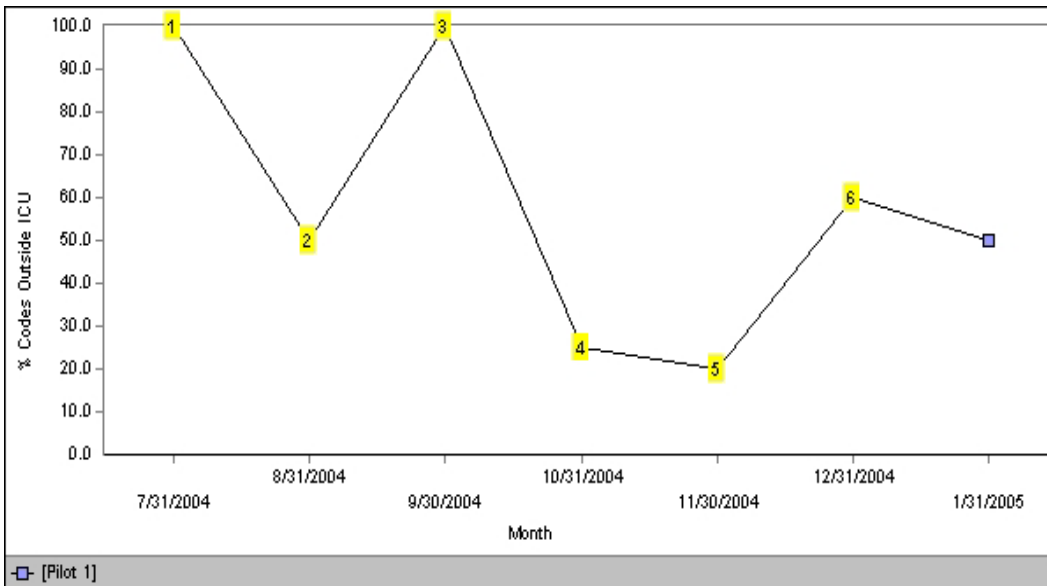
DATA COLLECTION STRATEGY:

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Each month, determine the location each code occurs from code logs and records. Establish a process to identify all calls to the Rapid Response Team. One possible data collection strategy: Each call to the RRT should result in the completion of a documentation form or record. These records should be kept in a central location (paper log book, electronic record, etc.) and serve as the source of the data.

Sampling Plan: Sampling is not appropriate for this measure.

SAMPLE GRAPH:



Measure Information Form: Utilization of Rapid Response Team

Intervention: Rapid Response Teams

Definition: Number of calls to the Rapid Response Team

Goal: Increase the use of the Rapid Response Team over time. (This is an organization-specific measure; it is not suggested to compare across organizations, so there is no absolute goal.)

Matches Existing Measures: N/A

CALCULATION DETAILS:

Numerator Definition: Number of calls to the Rapid Response Team

Numerator Exclusions: None

Denominator Definition: N/A

Denominator Exclusions: N/A

Measurement Period Length: Typically this is done in monthly increments, but teams might find it useful initially to track this information weekly (i.e., period of 1 week, every week; measuring calls per week). Once your team is well established, you can move the measurement period to monthly (i.e., period of 1 month, every month; measuring calls per month). Data submitted to IHI should be aggregated to monthly.

Definition of Terms:

- Rapid Response Team: A team of clinicians who bring critical care expertise to the bedside (or wherever it's needed)

Calculate as: numerator; as a number of calls

Comments:

The numerator includes all calls to the Rapid Response Team.

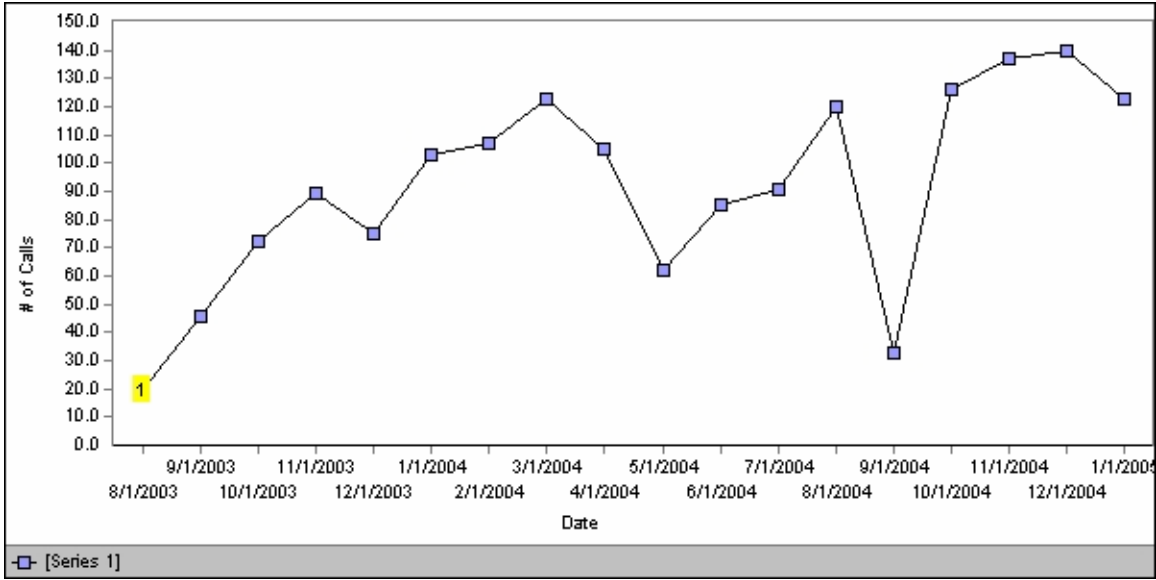
COLLECTION STRATEGY:

Establish a process to identify all calls to the Rapid Response Team. One possible data collection strategy: Each call to the RRT should result in the completion of a documentation form or record. These records should be kept in a central location (paper log book, electronic record, etc.) and serve as the source of the data.

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Sampling Plan: Sampling is not appropriate for this measure.

SAMPLE GRAPH: UTILIZATION OF RAPID RESPONSE TEAM



DATA COLLECTION AND ANALYSIS TOOLS:

Rapid Response Team Record