2024 VIZIENT CONNECTIONS SUMMIT

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Stayin' Alive: Keys to Sustaining Inpatient Mortality Improvement

Katherine Pavlovich, MPH, Director, Enterprise Analytics, UCSF Health
Donna Hays, BSN, Director, Clinical Documentation Integrity, UCSF Health
Madeline Chicas, MHA, CPHQ, Senior Quality Improvement Specialist, UCSF Health
My Nguy, RN, MSN, CPHQ, Director, Adult Quality Improvement, UCSF Health
Susan Nguyen, RN, MSN, Senior Quality Improvement Specialist, UCSF Health

Gordon E. Carr, MD, Chief Medical Officer, Banner UMC Tucson
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Learning Objectives

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- Explain the importance of tracking and reducing non-ICU code blue events.
- Discuss the impact of systemwide structures and processes on sustained success with inpatient mortality index.

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Failure to Rescue

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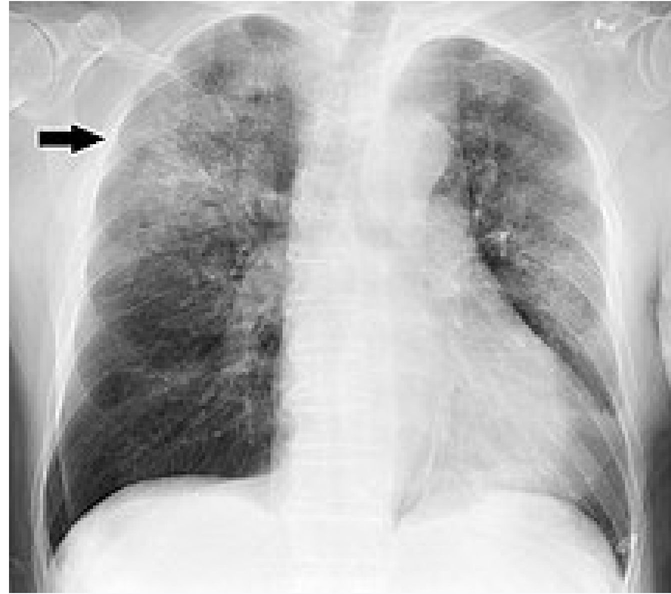

Admission

2100
Dyspnea &
tachycardia

2130
Lasix, nebs

0100
ABG 7.4/26/64/17
Lactate 4.6 (HH)

0200
Physician notified, No orders

1034
NRB, AMS

1200
Road trip to CT, Midazolam

Code Blue

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(Public Domain) "Chest Radiograph" by Mikael Häggström is used under public domain

Aren’t Codes Inevitable?

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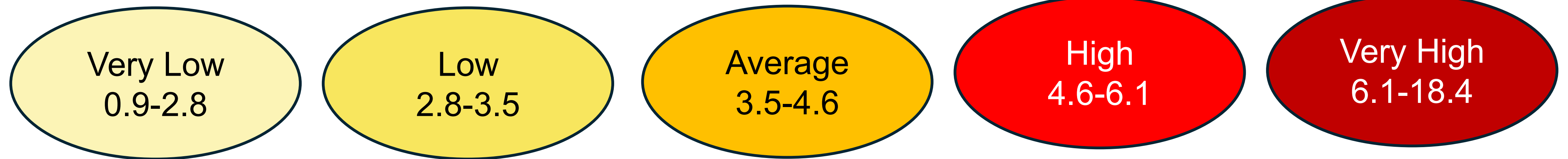

Chen, L. M., Nallamothu, B. K., Spertus, J. A., Li, Y., Chan, P. S., & American Heart Association’s Get With the Guidelines-Resuscitation (formerly the National Registry of Cardiopulmonary Resuscitation) Investigators (2013). Association between a hospital's rate of cardiac arrest incidence and cardiac arrest survival. JAMA internal medicine, 173(13), 1186–1195. https://doi.org/10.1001/jamainternmed.2013.1026

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Why did this patient die?

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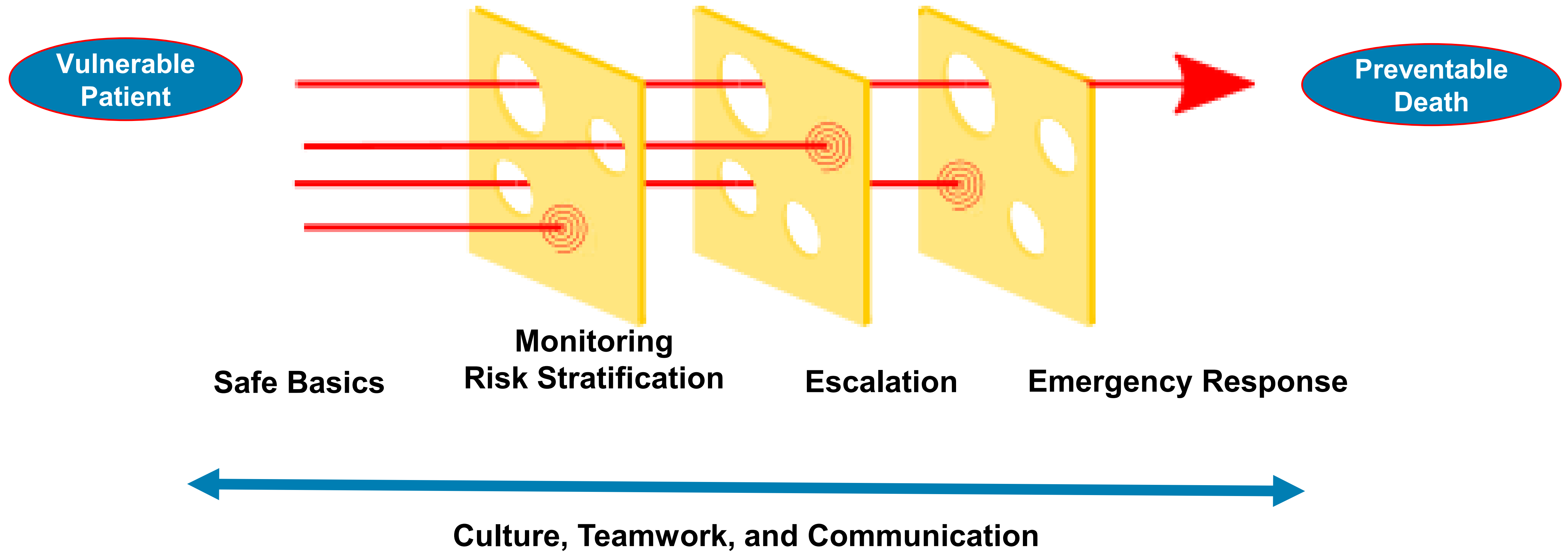

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(Public License) "The Swiss Cheese Model of Accident Causation" by Ben Aveling is used under a CC BY-SA 4.0 license, modified by adding labels

Why did this patient die?

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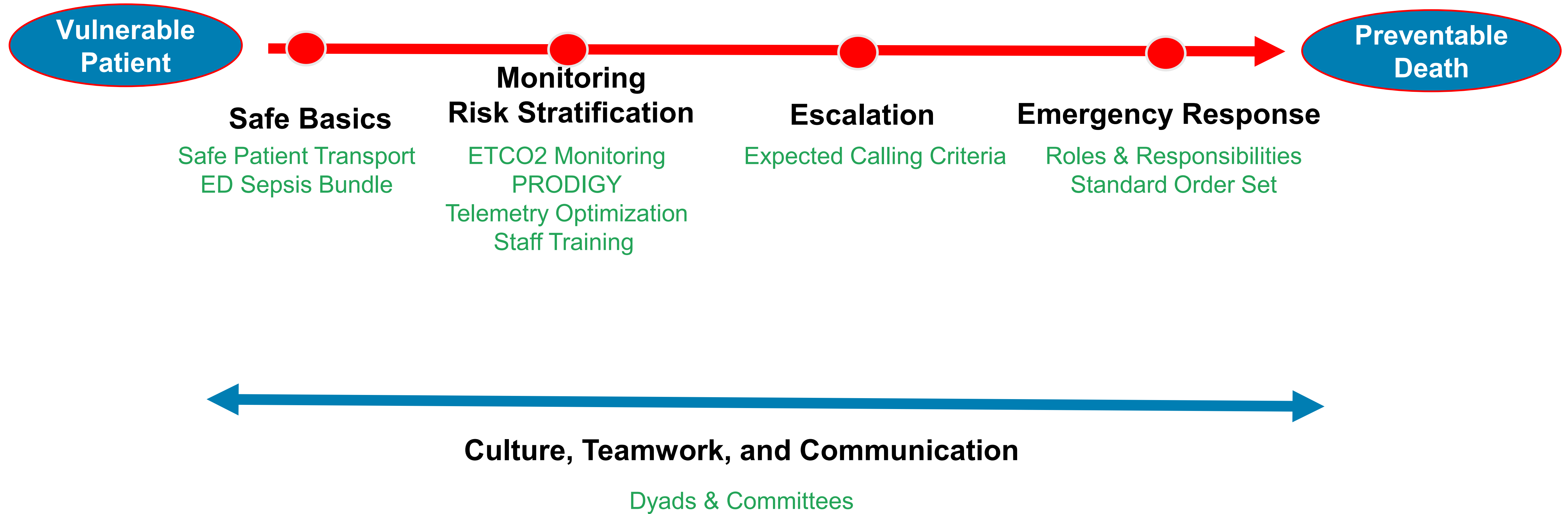

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Expected Rapid Response Team Calling Criteria (badge backer)

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Rapid Response Expected Adult Calling Criteria

Team member concerned about patient

HR change	<30 bpm or > 140 bpm
SBP change	< 80mm HG or > 200 mmHG
RR Change	< 8 or > 25 breaths per minute
Oxygen	Sustained increase in O2 needs
O2 Sat change	< 90% with O2 administration
ETCO2	> 55 after interventions
Mentation / GCS	Acute change in Mental status / Glasgow Coma Score change of > 2 pts
Neuro changes	New Seizure or S/S of Stroke

Additional reasons for calling: Acute significant bleeding, sudden onset or increase in pain, positive screen for sepsis/septic shock, failure to respond to treatment. Family member concern.

SBAR for Rapid Response

Situation:

- I Am Concerned!
- The Rapid Response was called because of (low BP, changes in HR, change in mental status, oxygen desaturation, etc.)
- The changes started at ....

Background/Assessment:

- Use phrases to explain concerns such as:
  "I feel uncomfortable because..."
  "This is a safety issue because..."
- Provide pertinent hospital course (why they are here, code status)
- What are the relevant vitals and assessments?

Recommendation

- What would you like to see done?
- Any additional diagnostics tests or labs?
- Any medications to give?
- What are next steps if patient doesn't improve?

Primary Nurse Role

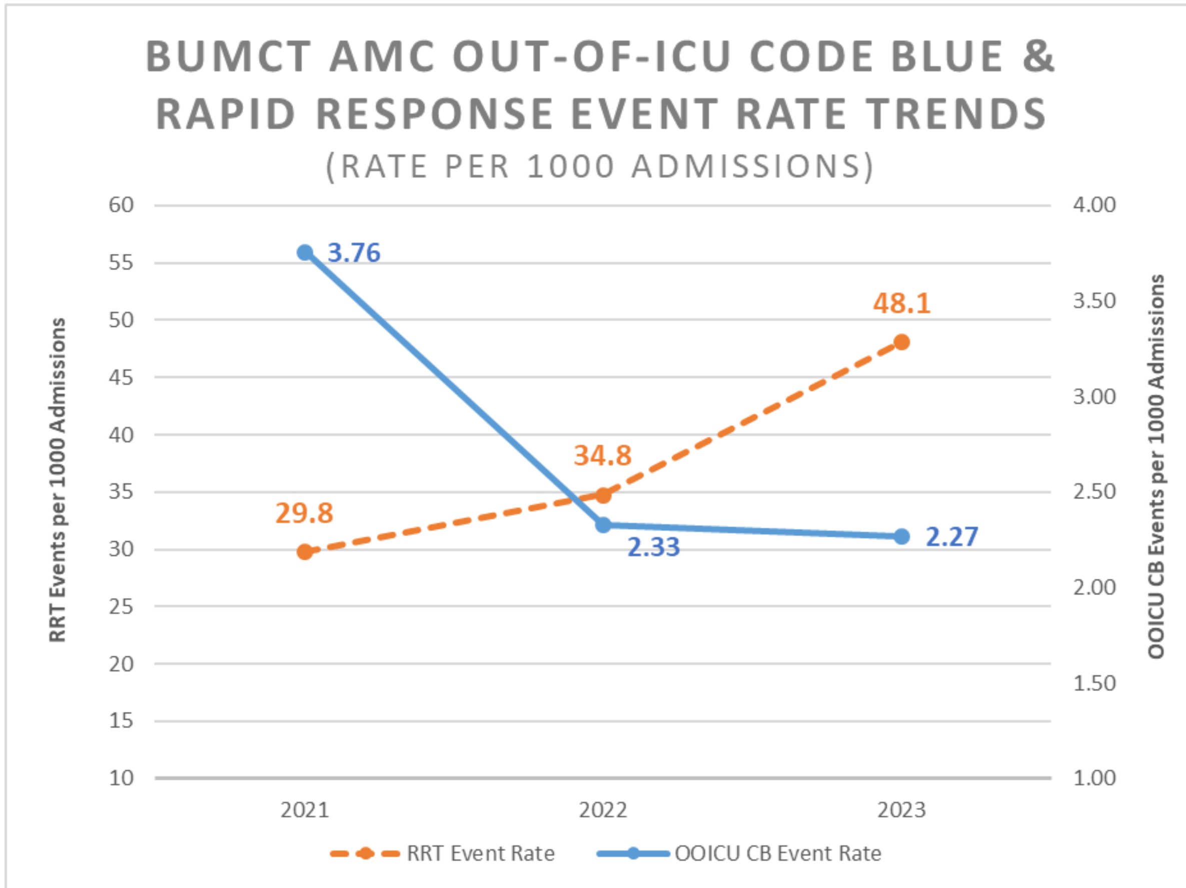
- Stay bedside for entire Rapid Response
- Communicate with RRT using SBAR
- Documents under "Critical Event" in Cerner
- If patient transitions to another unit, RN handoff

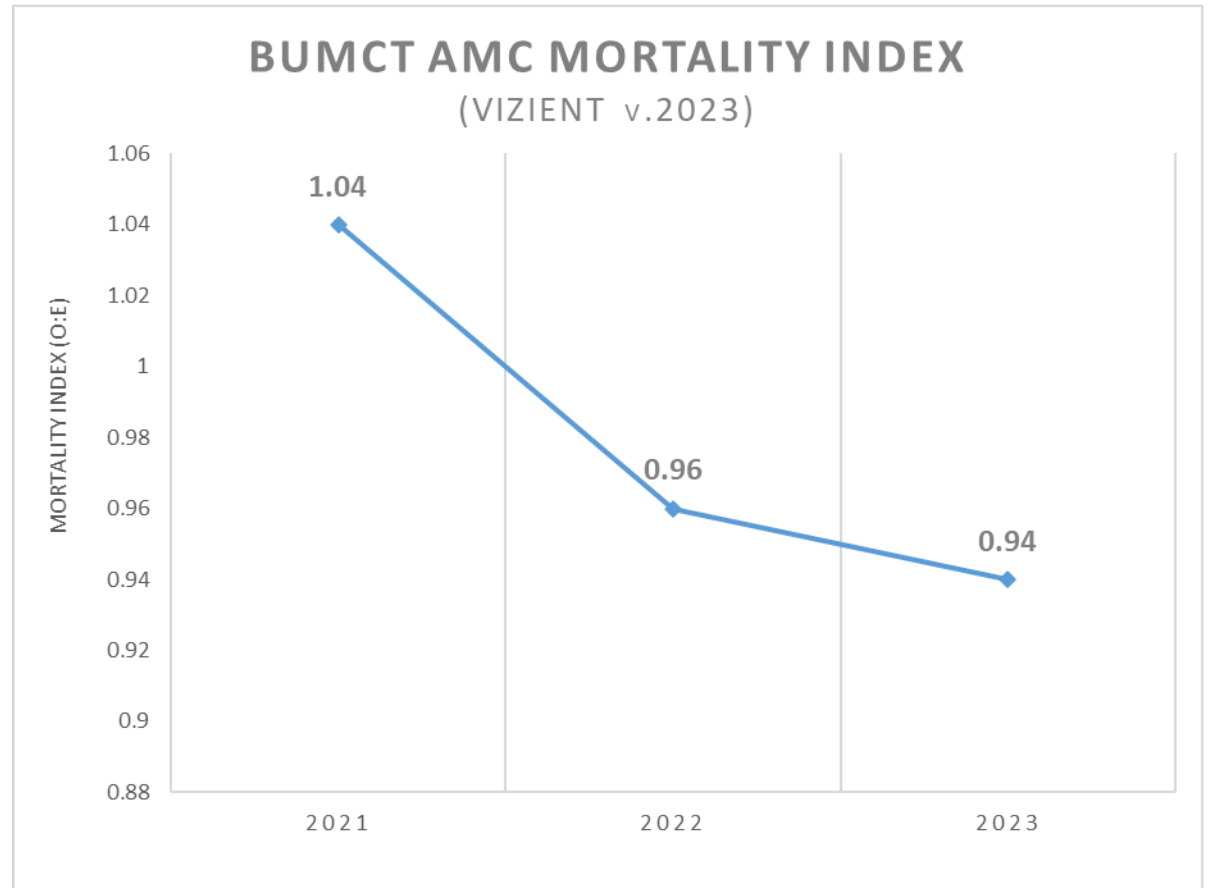
Who comes to the Rapid Response?

- SWAT RN or Critical Care RN
- Respiratory Therapist
- Nursing Supervisor
- Provider if available

HR= Heart Rate; SBP= Systolic blood pressure; RR= Respiratory Rate; O2= Oxygen; ETCO2= end tidal carbon dioxide

AMC Results





BUMCT=Banner UMC Tucson; RRT=Rapid Response Team; OOICU CB=Out of ICU Code Blue

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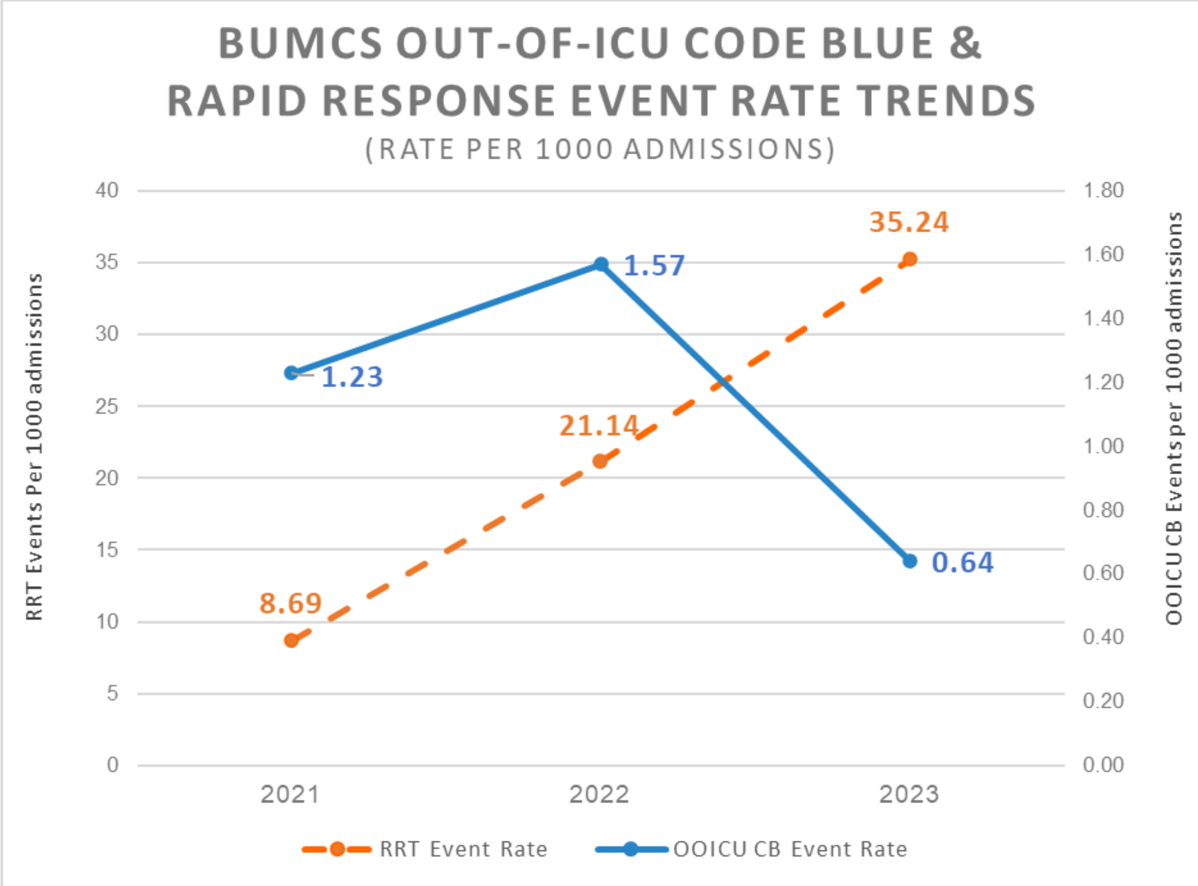
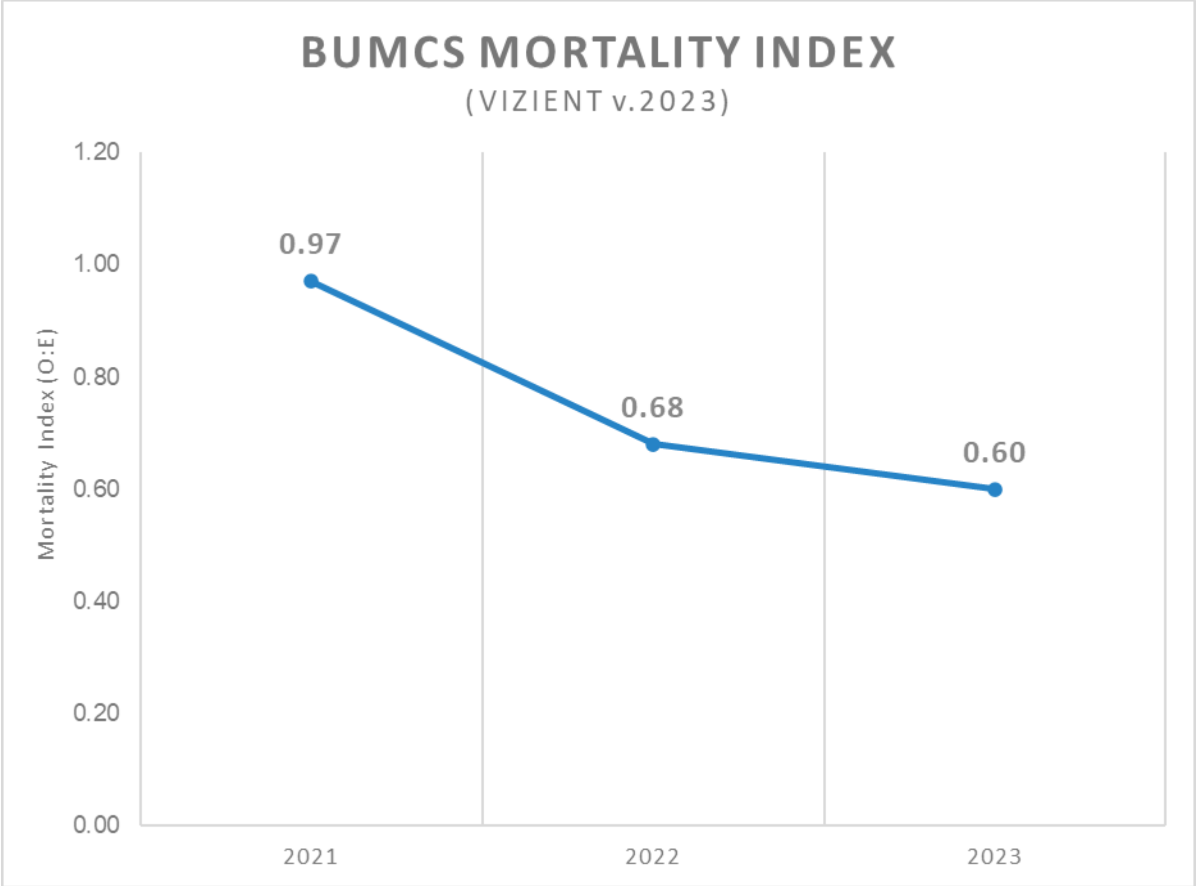
Community Results





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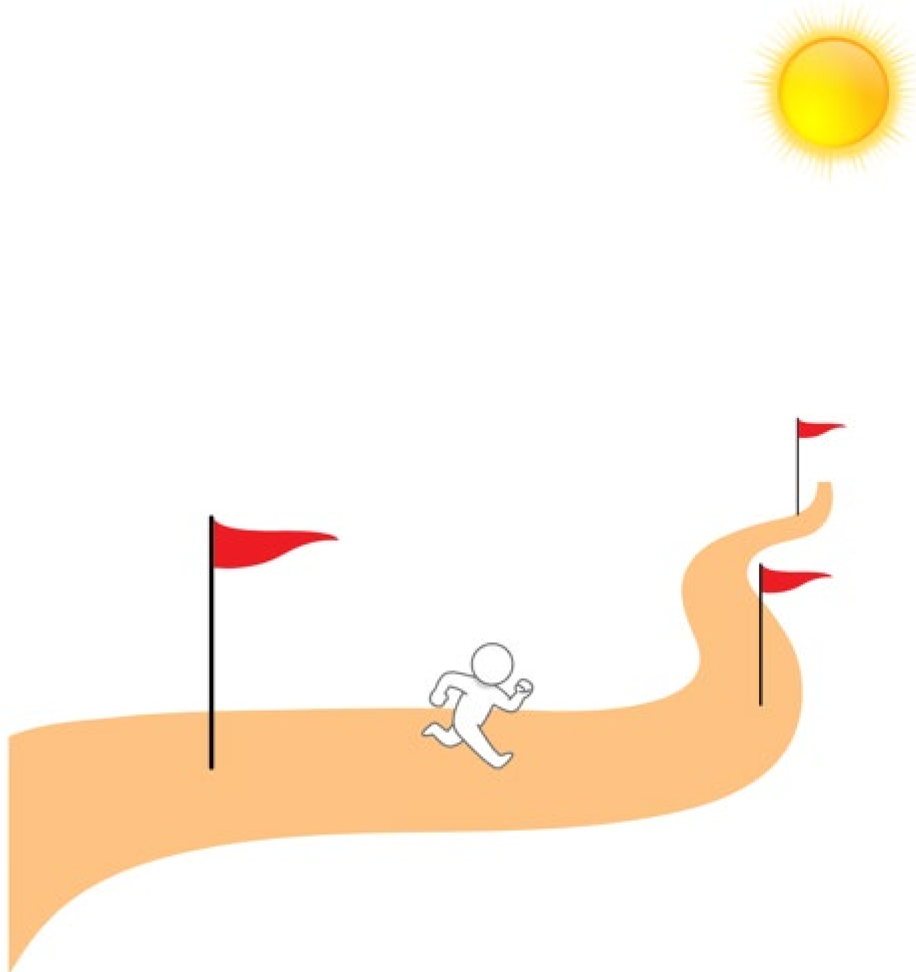
When Meeting Goal is Not Enough



DOCUMENTATION
- CDI Partnerships
- Risk model analysis
- EMR tools

Clinical Outcomes Huddle

REPORTING
- Mortality dashboard
- Data visibility
- Service line O:E

QUALITY CARE
- Real Time Mortality quality review
- System issues
- Care Opportunities

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Outcomes

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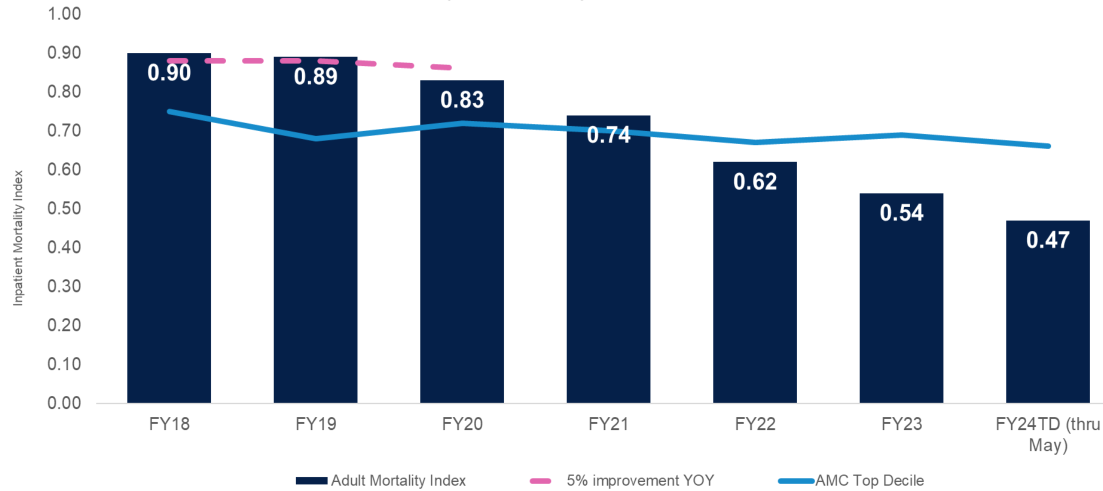
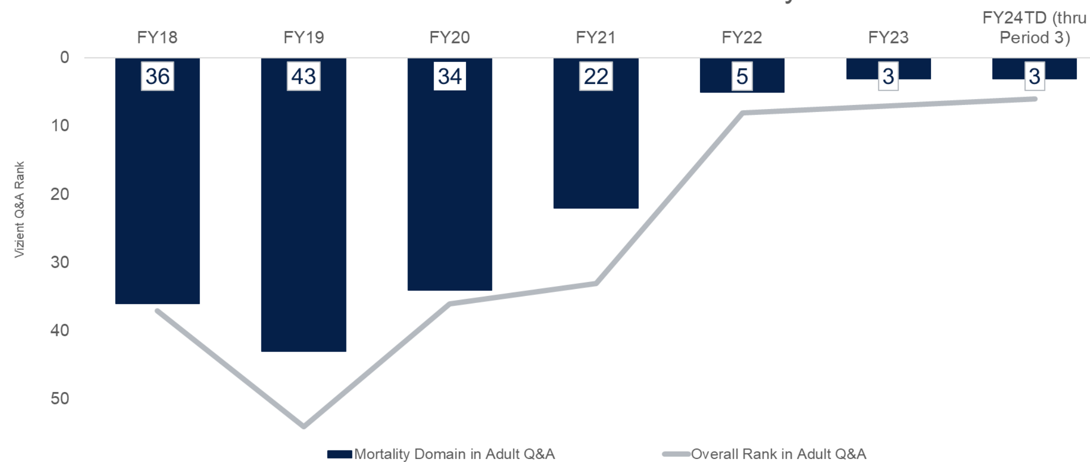
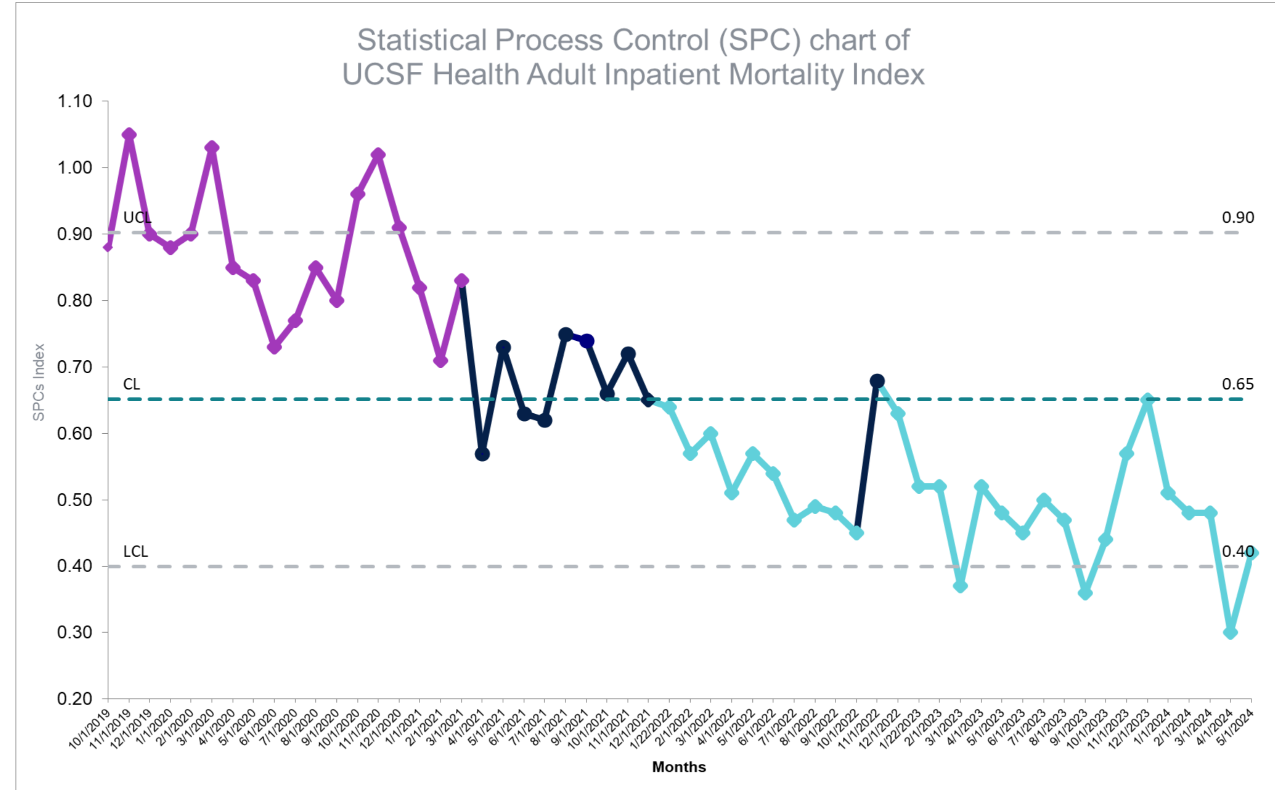




Source of all data: UCSF Health



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Lessons Learned

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- Failure to Rescue (FTR) is not inevitable
- Prevention relies on teamwork and a proactive approach
  - Process
  - Culture
- Multidisciplinary team-based learning drives culture change
- The Inpatient Chain of Survival is a good framework to guide improvement efforts
- Rapid Response Team (RRT) calling criteria can optimize RRT utilization and reduce cardiac arrests

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Lessons Learned

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Clinical, operational, and intra-quality partnerships

Data infrastructure and governance

“Improving Clinical Outcomes” meeting

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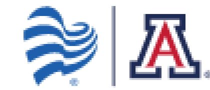
Key Takeaways



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- Safe basics
- Monitoring and risk stratification
- Escalation
- Emergency response
- Foundational culture and leadership

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Key Takeaways

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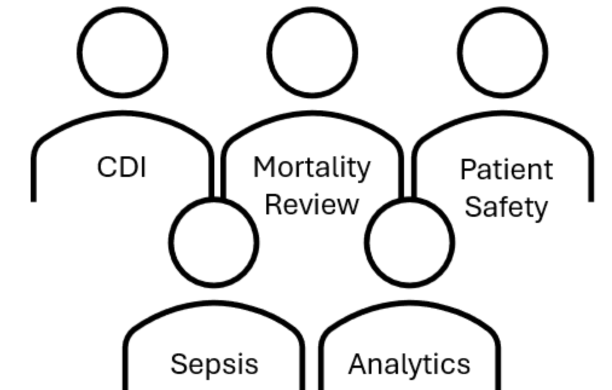
- **Embrace aspirational goals to drive excellence**
- **Connect with others working on mortality**
  - Real Time Mortality Review, Sepsis Mortality, Patient Safety, Clinical Documentation Integrity, Analytics
  - Clinical partnerships for documentation, education, and shared goals
- **Simplify and standardize**
  - What reports are generated/what data are being shared?
  - Where can we streamline and automate processes?



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Questions?

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