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Perspective

Application of the Rapid Response System in General Wards: Clinical Observational Research

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DESCRIPTION

Recent years have seen an increase in the sudden deterioration of clinical signs and even unexpected fatalities in general wards due to the ongoing development of hospitals, the mismatch in the number of medical professionals, the fine tuning of specialties, and the increasingly complex spectrum of diseases. Many domestic and foreign nations have established various Rapid Response Systems (RRS), Clinical Emergency Response Systems (CERS), Medical Emergency Teams (MET), Critical Care Outreach Teams (CCOT), and so forth in order to quickly identify and respond to major adverse events (SAEs).

In the province of Henan, our hospital, the Zhengzhou Central Hospital, is a full-service facility with 2200 beds. Since January 2016, we have been developing Critical Rapid Outreach Teams (CROT) to help patients with SAEs have better outcomes. In this study, initial CROT case data were retrospectively examined, and solutions are discussed. RRS has been widely employed as a trustworthy technique for identifying clinical deterioration, responding to it, and lowering the likelihood of unanticipated hospital ICU admission. However, not all the calls were correct. In this study, it was found that 91.99% of the calls were effective and there was a certain waste of resources, which was consistent with Yang's report.

When an SAE occurs in a patient, it complies with the CROT requirement and calls right away. These team members can respond and deliver prompt, effective rescue care, transport patients to intensive care units, or higher medical institutions. The most activation was due to patients with organ dysfunction, need for advanced life support, and need to be transferred to ICU and organ function support.

The transfer rate to the ICU was just 68.27% in this study, though. Clinical data that were retrospectively analyzed revealed that the majority of patients who declined to be moved to the Intensive Care Unit (ICU) were over 75 years old, had several disorders, and had uncertain long-term prognoses. Second, the majority of calls are active-duty and patrol medical personnel, mostly non-bed doctors and responsible nurses, who are unaware of the families' true treatment intentions. Additionally, it implies that age and comorbidities are risk factors for unfavorable outcomes.

Early notice is therefore crucial for such patients. Currently, NEWS score is acknowledged as a reliable early-warning tool. However, physiological variables like age are not included in NEWS. However, the prognosis of patients who are transferred to the ICU is rarely researched. The incidence of call RRS transfer to the ICU has been frequently documented. The majority of activations were brought on by patients who required advanced life support, organ function support, transfer to the intensive care unit, and organ dysfunction support. In this study, the vasoactive medication, mechanical ventilation, and blood purification treatment utilization rates were above 80%, and the ICU patient fatality rate throughout hospitalization was 23.94%. Further investigation, in light of such a high fatality rate, showed that 80.28% (171 instances) of patients were transferred to ICU as a result of serious infection.

The stratification of risk for a severe infection can be determined using the SIRS diagnostic criteria and qSOFA score. This has been employed by Gershkovich as a hematologic tumor patient calling good sensitivity and specificity for RRS. Therefore, the introduction of a new scoring method merits further discussion based on the use of NEWS scoring. Building a rapid response system is crucial because rescuing in patients with acute adverse events from general wards is a weak point in medical safety. However, the activation standard and operation mode merit consideration in order to examine the operation effect, for which more data must be explored and studied.

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