

Queen's Medical Center, Honolulu

Rapid Response Team (RRT) Evaluation Form

Date of Event: _____ Time of Event: _____ Place of Event (*Dept/Unit of Patient*): _____

Patient Name: _____ Medical Record #: _____ Acct #: _____
 (6 digit) (8 digit)

X Please answer the following questions with respect to the RRT Event.

X The Primary Nurse of the patient should complete this form and return it within 24 hours

X Please answer each question and mark your responses with an "X" when appropriate

#	Question	Disagree Strongly 1	Disagree Slightly 2	Neutral 3	Agree slightly 4	Agree Strongly 5
1	The RRT arrived in a timely manner					
2	The RRT nurse was knowledgeable and efficient in assessing and implementing care needs					
3	The RRT respiratory care therapist was knowledgeable and efficient in assessing and implementing care needs.					
4	Communication to and from the RRT nurse and/or respiratory care therapist was effective in facilitating the delivery of care.					
5	The RRT was courteous and helpful.					
6	Patient outcome was improved because of RRT assistance.					
7	I worked collaboratively with the RRT and the attending physician/resident.					
8	In working with the RRT I feel more comfortable and confident in managing patient in pre or potential crisis.					
9	The RRT helped me to learn something new or something I should have done.					
10	The RRT helped me to see or understand the "big picture" on managing the patient's care.					
11	EDUCATION: <i>(Briefly describe what you learned)</i>					
12	PROCESS IMPROVEMENT: <i>(Briefly describe a change in a patient care process that could help improve patient care)</i>					
13	ADDITIONAL COMMENTS:					

Primary Nurse (Print name) _____ (Signature) _____

Please return completed form to Nurse Manager, QET 4C within 24 hours of event.

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