

# PEER

*Professionals Evolving Through Education and Research*

## Rapid Response Teams: Improving Care and Saving Lives

### **Background**

Rapid Response Teams (RRT) are surging in popularity across the country. They originated in Australia several years ago and were developed to identify those patients whose conditions were beginning to deteriorate in order to intervene early and aggressively. The program was extremely successful in reducing mortality and improving survival from codes. As a result the Institute for Healthcare Improvement (IHI) has recommended that all U.S. hospitals implement these teams. And U.S. hospitals have listened. In just a few years, the number of rapid response teams in this country has grown from 50 to over 1,500. An additional 700 hospitals have pledged to initiate the teams. (IHI, retrieved 2007).

### **How Effective are Rapid Response Teams?**

The short answer — VERY effective. IHI (retrieved June, 2006) cited data from the original Australian RRT study indicating:

- A 65% decrease in cardiac arrests
- A 56% decrease in deaths from cardiac arrest
- An 80% decrease in the number of days in ICU
- An 88% decrease in the number of days of hospitalization following cardiac arrest
- A 25% decrease in mortality

Similarly where RRTs have been implemented in the US, 16 to 25% drops in mortality rates have occurred. For example, Tallahassee Memorial Healthcare Center implemented their RRT in 2003. Since that time, they have seen a 16% decrease in overall hospital mortality, a 33% decrease in the number of codes called, and a 55% decrease in the number of codes outside of the ICU (Repasky & Pfeil, 2005).



### **What Makes the Teams Effective?**

The IHI has studied the causes of higher than necessary mortality rates and has concluded that there are 3 main issues leading to the problem. These issues are:

1. Failures in planning (including assessments, treatments, and goals)
2. Failure to communicate (patient to staff, staff to staff, staff to physician, etc.)
3. Failure to recognize deteriorating patient condition. (IHI, retrieved June, 2006)

The teams are structured to address each of these areas. With respect to planning, teams help staff assess the patient and facilitate the process of obtaining treatment. Communication is facilitated by using standardized language and forms to relay information to physicians. Finally, indicators of patient deterioration are used as criteria for calling the team.

### **How do the Teams Actually Work?**

At a minimum, each team consists of a critical care nurse and a respiratory therapist. The teams may also include physicians and other support staff. Because time is

of the essence, team members need to be able to respond quickly when called by staff.

When arriving on a unit the team's role is to provide support and consultation. The team doesn't take over the care of the patient, but instead helps the nurse understand what is going on and supports the nurse during communication with the doctor as needed. Communication from the team to the staff needs to be constructive and non-punitive. Because the purpose of the team is consultation and support, the effectiveness of the team depends on establishing a trusting relationship between the staff and team.

#### ***What are the Responsibilities of the Unit Staff?***

Unit staff members need to be able to recognize the signs of distress and also need to feel comfortable enough to call the team anytime they have the "gut" feeling that something isn't right. Staff members need to feel assured that there are no inappropriate calls to the team. Upon arrival of the team, staff works with the team to address the patient's problems and to make appropriate contacts to physicians or other services throughout the hospital.

#### ***What are Hospitals Saying about the Program?***

The response to the teams has been extremely positive. Anecdotal comments include statements such as "One of my nurses told our Chief Nursing Officer that the Rapid Response Team is one of the best things she's ever done for nursing and for patients" and "If we said today we were going to get rid of the Rapid Response Team, we'd probably have a mutiny on our hands," (IHI, 2006). Some nurses are even saying that they will only work at hospitals that have Rapid Response Teams.

#### ***What are we doing at Methodist?***

Rapid response teams will be started at both campuses of Methodist Hospitals in June, 2007. Each team will consist of an ICU nurse and a Respiratory Therapist. Criteria for calling the team are:

- New changes in heart rate - less than 45 or greater than 125 beats per minute
- New changes in respiratory rate – less than 10 or greater than 30
- New change in systolic blood pressure – rise or decrease of 30 mmHg or greater
- New change in mental status
- Chest pain or
- Intuitive sense from nurse that something is going wrong with the patient.

When the nurse determines that the criteria for calling the team are present, he or she will call the operator via "22" and will ask the operator to activate RRT to room "X." The operator will announce three times "Rapid Response Team to room "X." The RRT will arrive on the unit and collaborate with the primary nurse while performing an assessment of the patient and the situation. The team will then intervene in accordance with an established RRT protocol. The primary nurse will collaborate with the RRT and contact the patient's physician to inform him/her of the patient's status and to receive further orders as indicated. The SBAR format will be used to communicate with the physician. Finally, the primary nurse will document interventions and assessment findings in the medical record.

It is hoped that implementing an RRT program at our hospital will also result in improved mortality rates, decreased numbers of codes and increased survival from codes. So, the next time you have a patient that is deteriorating or you have the feeling that something's not quite right, remember to call the RRT.

#### ***References***

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