PROBLEM: Patients who experience deterioration not recognized in a timely manner evidence adverse events and/or death.

EVIDENCE: 24% of acute care units initiated code blues. 27% initiated medical emergencies. Rapid response teams (RRT) have been shown to decrease mortality and arrests.

STRATEGY: The RRT was an initiative to enhance safety and patient outcomes for those exhibiting clinical deterioration. Rollout included timelines, team composition, clinical call parameters, education, documentation, pilot initiation, and outcome monitoring. The team includes: nursing, medicine, surgery, intensive care, respiratory therapy, psychiatry, spinal cord, and administration. SBAR and the Huddle formats adopted from TeamSTEPPS™ including patient and family education strategies complement the comprehensive effort.

PRACTICE CHANGE: The RRT deployed an ICU nurse and a respiratory therapist to the site where a deteriorating clinical situation was recognized. Patient outcomes improved by equipping people to access resources early. The RRT enhanced the timeliness of the team response decreasing out of ICU codes, saving lives, and improving patient satisfaction with care.

EVALUATION: Noteworthy multi-service improvements are realized in several crucial patient outcome measures before and after the activation of the RRT: a reduced number of cardiac arrests, medical emergencies, and deaths from cardiac arrest outside of the ICU. Weekly huddles have drastically improved communication.

RESULTS: Evidence indicates a decline in the frequency of unexpected cardiac arrest after the initiation of a RRT. All patients that received RRT services had an improved survival rate. Additionally, weekly huddles have dramatically improved communication.

RECOMMENDATIONS: On-going evaluations of the team processes are continuing to support the sustainability of this system improvement. Team composition, micro-system re-education, and effective communication skills have continued to prepare patients to RRT arrival where the teams function effectively to improve patient outcomes.

LESSONS LEARNED: System-wide change involving multiple disciplines and numerous people requires time, lots of dedicated people, and processes that will facilitate success. The ongoing weekly huddles provide a mechanism for sharing successes and strategizing missed opportunities.
BIBLIOGRAPHY: