A Rapid Response Team's Impact on Mortality Rates and Nursing Efficacy
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Problem:
Cardiopulmonary arrests of hospitalized patients are associated with increased mortality. Once an arrest occurs, patients have a 17% chance of survival. Eighty-four percent of patients show signs of deterioration up to 8 hours prior to the arrest (Hunt et al, 2009). This non-teaching, Magnet hospital implemented a Rapid Response Team (RRT) to assist in early treatment and prevention of cardiopulmonary arrests (code blue).

Evidence:
The Institute for Healthcare Improvement encourages hospitals to implement RRT’s. The Joint Commission recommends hospitals to have a method for recognizing and responding to changes in patients’ condition.

Strategy:
In 2005, the hospital’s Code Blue Committee implemented the RRT, which includes ACLS certified-critical care nurses and respiratory therapists.

Practice Change:
The RRT was fully implemented March 2006. The hospital lacks internal resources (residents/interns) for team staffing, and the RRT nurse has additional responsibilities, e.g., charge nurse and responding to code blues. To avoid intimidation, the RRT was encouraged to be supportive of staff initiating the call.

Evaluation:
Retrospectively, code blue and RRT events over 4.5 years have been identified – a time frame encompassing pre- and post-RRT implementation. Questionnaires addressing the RRT experience were distributed to RRT patients' primary nurses.

Results:
Prior to establishment of the RRT, 32 code blue events occurred in non-intensive hospital areas. Following implementation, non-intensive area code blue events decreased by 62.5%. After noting a overall downward trend in facility mortality over several years, code blue death outcome 1 year prior to and after RRT implementation was tracked. Fewer code blue deaths (17.3%) occurred following RRT implementation. Only 17% of the nurses who initiated a call to the RRT indicated they were intimidated by RRT members, while 94% stated the RRT involved them during the event and that they would utilize the RRT again.

Recommendations:
Family RRT initiation should be developed and implemented.
Lessons Learned:
Improved documentation of code blue and RRT events is crucial for evaluation of this process improvement initiative.

Bibliography:


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