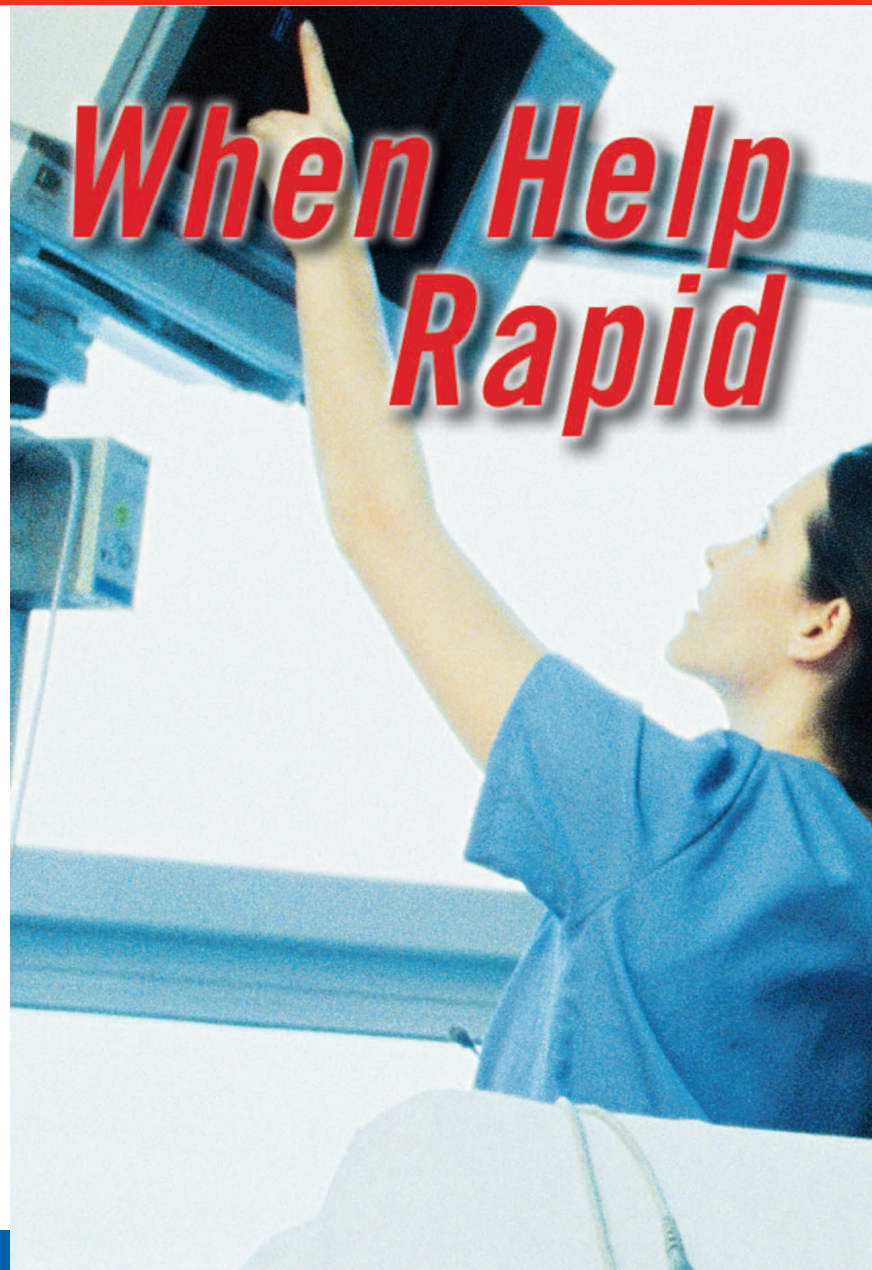


Every nurse has been in this position: A patient's vital signs are failing and he just doesn't look good.

In the past that meant, put a call into the physician and wait. Now it means summon the rapid response team and get the kind of immediate assistance necessary to keep a bad situation from getting worse.

by Debbie Bunch



Applying quality improvement methods used in business to health care is a slippery slope, as anyone working with patients can tell you. So when the first National Demonstration Project on Quality Improvement in Health Care was launched back in 1986 to explore the application of modern quality improvement methods to their industry, health care leaders were, no doubt, skeptical.

As the concept has matured over the years, however, hospitals have learned that what works in the wider world can work for them too. Nowhere has that been more evident than

in the initiatives established in 2004 by the Institute for Healthcare Improvement (IHI), the group that grew out of that initial demonstration project and is now driving major changes in the nation's hospitals.

Over the past two years, more than 3,000 hospitals — representing an estimated 75 percent of all U.S. hospital beds — have signed on to the IHI's 100,000 Lives Campaign, implementing six quality improvement changes in their facilities aimed at saving lives. (See sidebar for the complete list of changes.)

The AARC signed on as a campaign partner shortly after the initiative began; and from the

*Is Needed Fast,
Response Is on
the Scene*

IHI drives changes in hospitals, and respiratory therapists are key players

Goals of the 100k *lives* Campaign

SOME IS NOT A NUMBER. SOON IS NOT A TIME.

- 1 Activate a Rapid Response Team at the first sign that a patient's condition is worsening and may lead to a more serious medical emergency.
- 2 Prevent patients from dying of heart attacks by delivering evidence-based care, such as appropriate administration of aspirin and beta-blockers to prevent further heart muscle damage.
- 3 Prevent medication errors by ensuring that accurate and continually updated lists of patients' medications are reviewed and reconciled during their hospital stay, particularly at transition points.
- 4 Prevent patients who are receiving medicines and fluids through central lines from developing infections by following five steps, including proper hand washing and cleaning the patient's skin with chlorhexidine.
- 5 Prevent patients undergoing surgery from developing infections by following a series of steps, including the timely administration of antibiotics.
- 6 Prevent patients on ventilators from developing pneumonia by following four steps, including raising the head of the patient's bed between 30 and 45 degrees.



beginning, respiratory therapists have played a key role in the most prominent of the initiatives — the development of “rapid response teams” to quickly address the needs of patients who are rapidly failing outside of the ICU. Teaming up with nurses and sometimes physicians and pharmacists, therapists are rushing to the bedsides of patients in need, delivering the timely care necessary to stop deteriorating conditions in their tracks.

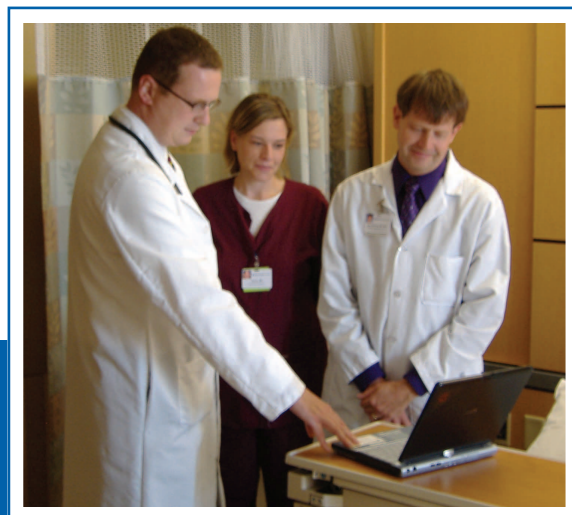
RTs answer the call

Respiratory therapists owe their key involvement on these teams to the fact that most cases involving a rapid decline outside of the ICU have a respiratory component. “Most critical events in a hospital relate to or have a component of a compromised respiratory status, so it is a natural fit to have a therapist as part of the team,” says Joe Rohling, BS, RRT, manager of respiratory therapy and transport services at Saint Clare’s Hospital in Weston, WI. The facility has had a team in place since it first opened its doors last year. “Many times a therapist is the first call for additional assessment or assistance with patients whose status is deteriorating,” notes Rohling.

As a brand new facility, Rohling says implementation of the rapid response team concept at Saint Clare’s was a given, and inclusion of an RT on the team along with an ICU registered nurse (RN) was never in question. Richard Bailey, MD, FACP, who played a key role in the development of the team, agrees. “Being a new organization, we had an overall young staff and wanted to do everything possible to have the people succeed in their roles.” They examined the models that worked, and all had a respira-



Just a few of Blessing Hospital's Rapid Response Team members were able to sit long enough for this photo. (Back row, from left): Dorothy Bybee, RN, director critical care; Rod Poling, CRT; Lisa Surratt, RN; Teresa Ashley, CRT; and Dwayne Goodwin, CRT. (Front row, from left): Kelly Smyser, RN; Jolene Beaber, RRT; Lynnette Baughman, CRT; and Cheryl Reardon, CRT.



Richard Bailey, MD, FACP (left), medical director, inpatient care and hospitalist services; Jennifer Stankowski, RN; and Joe Rohling, BS, RRT; collaborated on the development of the Rapid Response Team at Saint Clare's Hospital.

tory therapist as part of the team. At Saint Clare's, the RT and RN respond to the initial call, then call in a hospitalist if the situation warrants.

The decision was made in the beginning to have a respiratory therapist on the team because we wanted to have as many support people as we could to stabilize and possibly transfer the patients as appropriate, as well as to facilitate teaching and education of those who request the rapid response team, says Jennifer Stankowski, RN, who headed the team formation.

The Saint Clare team includes all the respiratory therapists on staff. Rohling says, "Besides BLS*, all therapists maintain an ACLS* and NRP* certification."

* BLS = basic life support; ACLS = advanced cardiac life support; NRP = neonatal resuscitation program; PICC = peripherally inserted central catheter

Team configuration varies

Saint Clare's is just one example of how hospitals are using respiratory therapists on these teams. "RTs perform highly skilled levels of care here, such as protocols, intubation, and arterial and PICC* line insertion, and are already relied upon for critical thinking skills, so it was a given for us," says Christine Lager, BA, RRT, supervisor of pulmonary services at West Allis Memorial Hospital/Aurora Health Care in West Allis, WI. Her hospital initiated its team — dubbing it the "STAT Team" — in September of 2005, staffing it with a critical care unit (CCU) RN and an RT.

At Bethesda Memorial Hospital in Boynton Beach, FL, Sheryle Barrett, BA, RRT, educational coordinator for respiratory care,

co-chaired (along with the ICU manager) the intra-hospital committee charged with developing her hospital's team. (They call their's the "BEE Team," for Bethesda Emergency Evaluation.) "Our first meeting was in March of 2005, and we started the actual service in May 2005. The goal was to create a systematic approach to promote early and appropriate intervention in the care of critically ill patients to decrease the number of codes, mortality, and ultimately, costs."

The team consists of the RT charge therapist and unit charge nurse. "This was decided because of two issues," explains Barrett. "These positions do not routinely have a patient assignment and their going to the call would be least disruptive to patient care, and indi-



Sheryle Barrett and other BEE Team members at Bethesda Memorial Hospital are identified with a “bee” on their name badge. Their outcomes data show an inverse proportion of bees to codes — the more bees, the less codes.



Saint Clare’s Rapid Response Team includes Joe Rohling, BS, RRT (left), Kristin Henrickson, RRT; Laurie Dunk, CRT; Sandy Elsen, RRT; Judy Liegl, CRT; Renee Babbitts, RRT; Richard Bailey, MD, FACP; and Jennifer Stankowski, RN.



viduals who are in these positions are there because they have a high level of assessment skills.” However, therapists who are working on the floor where the call originates are asked to respond as well to ensure the most timely response; and generally speaking, any respiratory therapist close to the call responds to lend a hand.

The team at Blessing Hospital in Quincy, IL, which averages about 20 calls per month, also uses the charge respiratory therapist as the key team member along with a critical care RN, says Jolene Beaber, RRT, respiratory care department manager. “We decided to use the respiratory charge person, and we also trained a few more people because we recognized that there might be times when there could be more than one rapid response called at a time.” All the therapists who participate must have ICU experi-

ence and competencies and good patient assessment and communication skills, notes Beaber.

Rebecca Young, RRT, manager of cardiopulmonary services at Citrus Memorial Health System in Inverness, FL, says the team at her hospital currently consists of a CCU RN and an RT, with the respiratory therapist called in when a respiratory condition is involved. “The nurse is called and goes to the patient to make an assessment. He or she then calls the RT if it is believed to be a respiratory problem,” she says.

The hospital has been collecting outcomes since implementation of the program and estimates that mortalities have been reduced by 17 percent per 1,000 discharges, codes outside of the CCU have declined by 44 percent, and successful codes — defined as returning the patient to spontaneous circulation — have increased by 95 percent.

Similar results have been seen at the other facilities, which have noted a significant decline in the number of codes since their teams began, a reduction in the mortality rate, and a greater percentage of patients being stabilized on the floors. The number of calls has increased as well, as floor nurses have become more comfortable with the concept.

Respiratory therapists welcome the role

All of these managers say implementing their teams was a fairly smooth process, with therapists generally excited to be playing a key role. Joe Rohling says therapists at his hospital were “happy and eager to be a part of this team,” noting that because the team was started when the hospital opened, there weren’t any issues to overcome concerning workload.

Dr. Bailey credits the hospital’s

therapists with playing a valuable role on the team, noting, “Our hospital is very fortunate to have the highly skilled therapists that we do.”

Sheryle Barrett and Christine Lager say therapists at their hospitals were already providing a “rapid response” in situations where it was warranted, so making the concept official through the team fit right into the work ethic and was never an issue. “For years we have unofficially responded to calls by nursing to take a look at their patients pre-coding,” says Barrett. “The team gives official recognition of this; and as we have also developed an RT protocol for us to use, we can do ABGs, treatments, oxygen set-ups, and order x-rays immediately without having to wait for a call to the doctor. This relieves worry about what you can and can’t do and just lets you take care of the patient.”

Lager says her therapists welcomed the new system as a way to

put a name to what they were already doing on an individual basis as well. “The transition to a process was very natural for us, so it was readily accepted without question and implementation was very smooth.”

In the spotlight

What’s been good for patient care in facilities that have adopted the rapid response team concept has been equally good for RT morale. Indeed, inside facilities and out, rapid response teams have garnered much attention, with recognition from administration and news coverage in the local press. “The spotlight that has been put on this program has been very positive,” says Jolene Beaber. “Anytime that you can be a part of something positive that is being celebrated, it elevates morale and recognition from others.”

Lager says the respiratory thera-

pists’ involvement on the team in her hospital has helped educate nurses and physicians about the importance of respiratory therapy professionals. “The nursing staff actually has an opportunity to see us use our knowledge and critical thinking skills, which can’t help but build some respect for the profession,” she says. “We have gained respect for our skills and decision-making abilities with physicians also... Our RTs feel like they finally are getting to do what they went to school for.”

But the bottom line for everyone involved in these teams and all the other IHI initiatives is probably summed up best with a quote from Donald Berwick, MD, MPP, president and CEO of the Institute for Healthcare Improvement. “The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them.” 🙏