Table 1. Final Evaluation Table

First Author (Year)	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied (and Their Definitions)	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Chan PS, et al. *Arch Intern Med* 2010;170(1): 18-26	None	SR Purpose: effect of RRT on HMR and CR • Searched 5 databases from 1950–2008 and "grey literature" from MD conferences • Included only 1) RCTs and prospective studies with 2) a control group or control period and 3) hospital mortality well described as outcome • Excluded 5 studies that met criteria due to no response to e-mail by primary authors	N = 18 out of 143 potential studies Setting: acute care hospitals; 13 adult, 5 peds Average no. beds: NR Attrition: NR	IV: RRT DV1: HMR (including DNR, excluding DNR, not treated in ICU, no HMR definition) DV2: CR	RRT: was the MD involved? HMR: overall hospital deaths (see definition) CR: cardio and/or pulmonary arrest; cardiac arrest calls	• Frequency • Relative risk	13/16 studies reporting team structure 7/11 adult and 4/5 peds studies had significant reduction in CR CR: • In adults, 21%–48% reduction in CR; RR 0.66 (95% CI, 0.54–0.80) • In peds, 38% reduction in CR; RR 0.62 (95% CI, 0.46–0.84) HMR: • In adults, HMR RR 0.96 (95% CI, 0.84–1.09) • In peds, HMR RR 0.79 (95% CI, 0.63–0.98)	Weaknesses: • Potential missed evidence with exclusion of all studies except those with control groups • Grey literature search limited to medical meetings • Only included HMR and CR outcomes • No cost data Strengths: • Identified no. of activations of RRT/1,000 admissions • Identified variance in outcome definition and measurement (for example, 10 of 15 studies included deaths from DNRs in their mortality measurement) Conclusion: • RRT reduces CR in adults, and CR and HMR in peds Feasibility: • RRT is reasonable to implement; evaluating cost will help in making decisions about using RRT • Risk/Benefit (harm): benefits outweigh risks