


Name of Policy: <u>Rapid Response Team</u> Policy Number: 3364-100-45-05 Department: Hospital Administration Approving Officer: Vice President & Executive Director Chief of Staff Responsible Agent: Vice President & Executive Director Scope: The University of Toledo Medical Center and its Medical Staff	 Effective Date: 10/22/2008 Initial Effective Date: 11/8/2006
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy	<input type="checkbox"/> Minor/technical revision of existing policy <input checked="" type="checkbox"/> Reaffirmation of existing policy

(A) Policy Statement

The Rapid Response Team (RRT) is a response team comprised of an ICU RN Charge Nurse and a Respiratory Therapist, including the Administrative Coordinator weekdays 7 pm – 7 am and 24 hours on weekends/holidays. The team is activated when there is a concern regarding an inpatient’s condition. The response time goal of the RRT is 5 minutes or less. The RRT will be used for all areas other than the ED, cath lab, OR, PACU and critical care areas.

(B) Purpose of Policy

The purpose of the RRT is to quickly provide a multidisciplinary team approach to assess a patient whose condition is deteriorating. The goal is to reduce the number of cardiopulmonary arrests outside of the ICU, reduce the number of critical patient events outside the ICU and ultimately reduce the number of unplanned transfers to the ICU.

(C) Procedure

1. Preparation & Education:

A. RRT members will have excellent assessment and communication skills in addition to the following qualifications:

- 1) Provide clinical expertise, advanced assessment skills, and support for the bedside nurse.
- 2) ICU Nurse: ACLS certified with minimum of one year critical care experience. Functions in the charge nurse or lead nurse role and assists in education of others.
- 3) Registered or Certified Respiratory Therapist with a minimum of 1 year critical care experience.

B. When the primary nurse notices that a patient is deteriorating, they will notify the charge or lead nurse of their unit who will quickly assess the patient and if the charge nurse agrees they will activate the RRT.

Symptoms/triggers of a deteriorating condition include (but are not limited to):

- 1) Nurse uncomfortable with patient’s condition
- 2) Systolic blood pressure < 90
- 3) Heart rate < 40 or > 130 or 20% change from baseline
- 4) Respiratory distress, change in breathing pattern, or threatened airway (respiratory rate < 8 or > 28, an acute change in O₂ saturation, or O₂ saturation < 90% despite O₂).
- 5) Acute/significant change in level of consciousness
- 6) Acute/significant bleed
- 7) Color change – pale, dusky, gray or blue (of patient or extremity)
- 8) New, repeated, or prolonged seizures
- 9) Failure to respond to treatment for an acute problem/symptom

2. When the primary nurse and/or charge nurse believes that a patient needs more immediate intervention based on the above criteria, he/she will page the RRT by calling the operator at 2222 and identifying the patient’s room number. The operator will text page the RRT to the appropriate room.

3. The primary nurse or designee will also initiate contact with the appropriate physician.


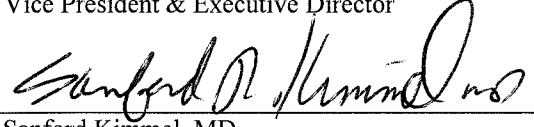
4. Upon arrival of RRT members at patient’s bedside:

- A. Obtain report from the primary nurse
 - B. Assess patient – sick or not sick
 - C. Rapid decline vs. stable problem
 - D. Identify problem, i.e., circulatory, respiratory, neurological, other.
5. Determine how much time you have to deal with the patient's condition and call a Code Blue if you need help quickly, need a physician to respond quickly, or the patient goes into respiratory or cardiac failure or arrest.
6. Roles & Responsibility
- A. Primary Nurse
 - 1) Collect pertinent patient information including chart, nursing notebook and have available in room for RRT to review.
 - 2) Provide background information to RRT on patient's condition.
 - 3) Remain with patient.
 - 4) Assist RRT as needed
 - B. ICU Nurse:
 - 1) Receives necessary background information and assessment from primary nurse
 - 2) Performs complete assessment.
 - 3) Administers treatment as prescribed.
 - 4) Speaks with family/patient about the situation
 - 5) Facilitates timely transfer to ICU if necessary.
 - C. Respiratory Therapist
 - 1) Provides advanced respiratory assessment
 - 2) Provides immediate O₂ therapy/ treatments.
 - D. Administrative Coordinator (if 7 pm – 7 am, weekend or holiday)
 - 1) Provides expertise in patient flow
 - 2) Facilitates proper bed placement for patient based on acuity and assessed needs.
7. Follow Rapid Response Team order set
- A. Stabilize patient's airway
 - B. Increase O₂ from baseline, consider face mask, non-rebreather or suctioning
 - C. Put patient on telemetry or cardiac monitor if not already in place
 - D. Begin ACLS protocol if symptomatic arrhythmia detected
 - E. EKG if heart rate abnormal or chest pain.
 - F. Start IV access if one not in place, consider placing second line and drawing labs if possible.
 - 1) Labs: CBC, CMP, PT, PTT, INR, Troponin, CK, CKMB if cardiac injury suspected. BNP if CHF suspected.
 - G. Portable chest x-ray
 - H. NG if abdominal distention or vomiting, unless contraindicated.
 - I. Foley catheter if not already present, and/or contraindicated
 - J. If temperature > 101 and no work up within 24 hours, obtain blood culture, Urinalysis with C&S and sputum C&S.
 - K. Discuss Lasix IV with physician
 - L. Fingerstick blood sugar. Discuss results and treatment with physician.
 - M. 0.9 NS 500 ml bolus for hypotension if patient not in congestive heart failure

- N. Naloxone if patient received opioids recently or narcotic overdose suspected.
- O. Arterial blood gases if indicated for change in O₂ saturation
- P. Albuterol 2.5 mg if bronchospasm suspected.
- Q. Transfer patient to ICU as indicated by patient's condition at any time on this intervention list.

8. Documentation

- A. ICU nurse to report all actions taken and findings to patient's physician using SBAR tool.
- B. Document assessments and interventions on special report sheet in patient chart.
- C. Complete the RRT SBAR tool every time the team is activated and place white copy in the progress notes of the patients' chart, and send the yellow copy to Quality Management for tracking purposes
- D. The RRT record is completed and signed by the RRT members.

<p>Approved by:</p> <div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="text-align: center;">  <hr style="width: 80%; margin: 0 auto;"/> <p>Mark Chastang Vice President & Executive Director</p> </div> <div style="text-align: center;"> <p>10/08</p> <hr style="width: 80%; margin: 0 auto;"/> <p>Date</p> </div> </div> <div style="display: flex; justify-content: space-between; align-items: flex-end; margin-top: 10px;"> <div style="text-align: center;">  <hr style="width: 80%; margin: 0 auto;"/> <p>Sanford Kimmel, MD Chief of Staff</p> </div> <div style="text-align: center;"> <p>10/24/08</p> <hr style="width: 80%; margin: 0 auto;"/> <p>Date</p> </div> </div> <p><i>Review/Revision Completed By:</i> HAS Rapid Response Team Chief of Staff</p>	<p>Review/Revision Date: 10/22/2008</p>
<p>Next Review Date: 10/1/2011</p>	
<p>Policies Superseded by This Policy: 7-45-05</p>	

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.