Name of Policy:	**Rapid Response Team**	THE UNIVERSITY OF TOLEDO **MEDICAL CENTER**
Policy Number:	3364-100-45-05	
Department:	Hospital Administration	
Approving Officer:	Chief Medical Officer	
Responsible Agent:	Chief of Staff	
Scope:	The University of Toledo Medical Center and its Medical Staff	**Effective Date:** 05/01/2021 Initial Effective Date: 11/8/2006

_____ New policy proposal	_____ Minor/technical revision of existing policy	
_____ Major revision of existing policy	__X__ Reaffirmation of existing policy	

(A) Policy Statement

It is the policy of the Medical Staff and the University of Toledo Medical Center that healthcare providers follow the procedures set forth in this document.

(B) Definitions

The Rapid Response Team (RRT) is comprised of an Intensive Care Unit (ICU) Nurse (RN), a Respiratory Therapist, and House Supervisor.

(C) Purpose of Policy

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 reduce the number of unplanned transfers to the ICU.

The RRT 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 inpatient areas including post-anesthesia care unit (PACU).

(C) Procedure

1. Activating the RRT
    a. The primary nurse, charge nurse or family member may activate the RRT.
    b. The RRT is activated by calling the operator at x2222 and identifying the patient's room number. The operator will text page the RRT to the appropriate room.
    c. The primary nurse will notify the charge or lead nurse that RRT has been activated.
    d. The primary nurse or charge nurse will contact the attending physician or his/her designee.

2. Triggers to activate the RRT and signs/symptoms of a deteriorating condition include:
    a. Nurse uncomfortable with patient's condition;
    b. Systolic blood pressure < 90;
    c. Heart rate < 40 or > 130 or 20% change from baseline;
    d. Respiratory distress, change in breathing pattern, or threatened airway (respiratory rate < 8 or > 28, an acute change in O_2 saturation, or O_2 saturation < 90% despite O_2);
    e. Acute/significant change in level of consciousness;
    f. Acute/significant bleeding;
    g. Color change – pale, dusky, gray or blue;
    h. New, repeated, or prolonged seizures;
    i. Failure to respond to treatment for an acute problem/symptom.

3. Actions of the RRT
    a. Obtain report from the primary nurse.
    b. Quickly assess patient- subjective and objective.
    c. Determine tempo of change and determine the need for Code Blue.
    d. Identify the problem (e.g., circulatory, respiratory, neurological, other).

4. Roles and Responsibilities
    a. Primary Nurse:
        i. Collect pertinent patient information including chart and have available in room for RRT to review;
        ii. Provide background information to RRT on patient's condition;
        iii. Remain with patient;
        iv. Assist RRT as needed.

    b. ICU Nurse:
        i. Receives necessary background information and assessment from primary nurse;
        ii. Performs complete assessment;
        iii. References Rapid Response Team guidelines in the order entry system and implements appropriate guidelines;
        iv. Administers treatment as prescribed;
        v. Speaks with family/patient about the situation;
        vi. Facilitates timely transfer to ICU if necessary.

    c. Respiratory Therapist:
        i. Provides advanced respiratory assessment;
        ii. Provides immediate O_2 therapy/ treatments.

    d. House Supervisor:
        i. Provides expertise in patient transfer and transport;
        ii. Facilitates proper bed placement for patient based on acuity and assessed needs.

5. Documentation
    a. ICU nurse reports 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.

6. Follow up on previous rapid response alerts
    a. Current RRT team to receive a sign out report from previous RRT team.
    b. Current RRT team to round on the rapid response patients from previous shift.

7. Modified Early Warning System (MEWS)
    a. The MEWS program runs every hour on the hour.
    b. For each bedded patient it retrieves the most recent Systolic Blood Pressure, Heart Rate, Respiratory Rate, Temperature, O2 sat, Oxygen source (FiO2) , and Level of consciousness as documented by nursing.
    c. With these values it assigns a score (Points) based on the following table:

Points	3	2	1	0	1	2	3
SBP	≤ 90	91-100	101-110	111-219			≥ 220
Temp (°F)	≤ 95		95.1-96.8	96.9-100.4	100.5-102.2	≥ 102.3	
HR	≤ 40		41-50	51-90	91-110	111-130	≥ 131
RR	≤ 8		9-11	12-20		21-24	≥ 25
O₂ Sat	≤ 91 %	92-93 %	94-95 %	≥ 96 %			
FiO2				Room Air		Suppl O₂	
Alertness				Awake, alert			Altered*

* Altered = stuporous, lethargic, obtunded, unresponsive, or comatose

d. If the cumulative score for a patient is 8 or higher, the program will send an email to the House Supervisor's pager with the following exceptions:
  i. If the patient is in a bed identified as "Intensive Care" an alert will not be sent.
  ii. If the patient has had previous alerts sent and the House Supervisor marked the patient as "Snoozed" an alert will not be sent.

Approved by: /s/ 06/11/2021 Michael Ellis, M.D. Date Chief Medical Officer /s/ 06/11/2021 Andrew Casabianca, M.D., D.M.D. Date Chief of Staff *Review/Revision Completed By:* *HAS* *Rapid Response Team* *Code Blue Committee* *Chief of Staff*	**Review/Revision Date:** 10/22/2008 9/29/2010 6/1/2013 5/1/2016 6/10/2019 5/1/2021 **Next Review Date:** 5/1/2024

Policies Superseded by This Policy: 7-45-05