FLOYD MEDICAL CENTER
POLICY AND PROCEDURE MANUAL
PATIENT CARE SERVICES

TITLE: Rapid Response Team (RRT)	Policy No.: PCS-14-001
Purpose: To provide interventions required for sudden and/or acute changes in a patient's condition in a timely and appropriate manner. To reduce the number of emergency transfers, cardiac arrests and deaths (in non-ICU patients) by intervening with a specially trained team before there is a medical emergency.	**Developed Date:** 1/06 **Review Date:** 7/07, 2/09, 7/11 **Revised Date:** 5/09, 3/12, 5/12, 4/14, 10/14, 6/15, 4/18
Policy: The Rapid Response Team comprised of members of the Code Blue Team will respond to all overhead "Rapid Response" pages.	**Review Responsibility:** Executive VP Chief of Patient Services/CNO, Nursing Leadership, Critical Care Committee; Executive Committee of the Medical Staff
Expected Outcomes: By immobilizing a team approach to intervene before patients have complete demise and respiratory/cardiac arrest, patient outcomes will improve.	
Reference Standards: Best Practice Protocols, IHI 100,000 Lives Campaign, Nurse Management 2005; Nursing 2006 (volume 36, number 12), 2008 Handbook of Emergency Vascular Care AHA	

Procedure

ACTIONS	KEY POINTS
1. A sudden and/or acute change in an **adul**t patient's condition requires the need for an immediate assessment by the nurse. If intervention is indicated, the nurse will call the Rapid Response Team via the operator. **The Emergency Department staff and Inpatient Code Team will respond to all Rapid Responses in the Imaging Services area on 2nd floor.** If it is determined that the patient is not an inpatient (i.e. ECC patient or other Outpatient), the Emergency Department staff will direct the Rapid Response. If it is determined the patient is an inpatient, the inpatient Rapid Response team will direct the Rapid Response. **Note:** Staff at Willowbrooke at Floyd will call 911 and provide care and treatment to the patient until EMS arrives.	1. Signs/symptoms of emerging crisis include, but are not limited to: ♦ Acute change or deterioration ♦ Heart < 40 ♦ Systolic BP <90 ♦ Respiratory Rate <8 ♦ FIO_2 >50% ♦ O_2 Sat <90% despite O_2 ♦ Failure to respond to treatment ♦ Acute change in mental status ♦ Urine Output <50 ml in 4 hours ♦ Heart Rate >130 ♦ Complaints of Shortness of Breath ♦ Respiratory Rate >30 ♦ Paresis/weakness ♦ Seizures ♦ Stupor ♦ Sepsis ♦ Complaints of chest pain ♦ Stroke

ACTIONS	KEY POINTS
2. A sudden and/or acute change in a **pediatric** patient's condition requires the need for an immediate assessment by the nurse. If intervention in indicated, the nurse will call a Rapid Response via the operator and will notify the pediatric resource nurse.	2. Signs/symptoms of emerging crisis include but are not limited to: ♦ Acute change or deterioration ♦ Heart rate: Newborn – 3 months <85 or >200 3 months – 2 years <100 or >190 2 years – 10 years <60 or >140 Greater than 10 years <60 or >100 ♦ Respiratory rate: Infant <30 or >60 Toddler <24 or >40 Preschooler <22 or >34 School Age <18 or >30 Adolescent <12 or >16 ♦ Blood Pressure: 1 year to 10 years: systolic <70 plus age in years x 2 10 years and older: systolic <90 ♦ FIO_2 >50% ♦ O_2 sat <90% despite O_2 ♦ Failure to respond to treatment ♦ Acute change in mental status ♦ Urine Output: Neonate 1 ml/kg per hour Child <1 ml/kg per hour Adolescent <0.5 ml/kg per hour ♦ Shortness of breath, respiratory distress, grunting, nasal flaring, retractions, decreased muscle tone in infants ♦ Paeresis/weakness ♦ Seizures ♦ Stupor ♦ Sepsis
3. The nurse will call the operator by dialing 1 2 3. For an **adult rapid** r**esponse**, the operator will use the overhead paging system to call a "Code RRT to room # ___ and will follow up with a phone call to the ICU, Respiratory Therapist and Medical Resident.	3. Having a designated team to respond in an expedient manner will decrease delays in patient crisis intervention. The Rapid Response team is comprised of designated Medical Residents, Critical Care Nurses, Respiratory Therapists, Patient's Primary Nurse, Unit Charge Nurse and House Resource Nurse.

ACTIONS	KEY POINTS
For a **pediatric rapid response**, the operator will use the overhead paging system to call a "Code RRT Pediatrics room # ___ and will follow up with a phone call to the NICU.	
4. Upon arrival, the team will complete an assessment of the patient.	4. Assessment will include vital signs, O_2 sat, Bedside Blood Glucose (BBG), and temperature, if indicated, and issues regarding patient's problems (reason RRT was called), stroke assessment and sepsis screen.
5. The RRT will make recommendations /interventions for the patient based on the assessment.	5. Recommendations/interventions are, but not limited to: ♦ Oral airway, suction respiratory treatments ♦ O_2 (cannula, mask, bipap) ♦ Intubate ♦ ABG, Chest X-ray, comprehensive chemistry, CBC ♦ IV fluid bolus, blood ♦ Central line placement ♦ Cardioversion, defibrillation ♦ CPR, ACLS ♦ EKG, CT Scan ♦ Stat medications ♦ No intervention ♦ Remain on current unit ♦ Transfer to Critical Care Unit ♦ Initiate Stroke Alert
6. A member of the RRT or the patient's nurse will notify attending MD of event.	6. MD will be notified of change in patient's condition, interventions and recommendations.
7. The critical care nurse will complete event log and place it on the chart. One copy will be routed to Critical Care for data collection. One copy will be routed to the Clinical Manager of the unit where the event occurred for review.	7. RRT event log is a part of the patient's permanent record and RRT event will be reviewed for performance improvement opportunities.

ACTIONS	KEY POINTS
8. Patients, families and caregivers are provided a handout upon admission regarding their role in alerting the nurse of changes in the patient's condition.	8. Changes in the patient's condition noted by the family/caregiver may be a warning sign of an impending problem. Patients, families and caregivers are encouraged to vocalize concerns to the nurse, who will assess the patient and call a rapid response, if indicated.