I. POLICY STATEMENT

- To enhance early recognition of and response to a decline in a patient’s condition, CHN has a system for associates, patients, or visitors to request assistance from specially trained individuals when there is an actual decline, or a perception by associates, the patient, or the patient’s family that the patient’s condition has declined or is declining. The Rapid Response Team is designed to assist in non-critical areas of the hospital with assessment and treatment of life-threatening conditions or potential non-threatening conditions. The Rapid Response Team responds to both inpatient and outpatient units within the hospital.

(See attached Addendum for Site Specific information)

- Rapid Response Team may be activated by any associate, the patient, or the patient’s family

- Patients and family members are educated regarding the availability of a rapid response team or process and how to access or request activation of the team / process. This education may occur at time of admission, initial assessment, and/or during the patient’s stay

- The attending physician remains in charge of the patient’s care unless care is delegated to another physician

- Activation of the Rapid Response Team is not intended to bypass regular communication with the patient’s physician or to remove the attending physician as the director of the patient’s care

II. PURPOSE

This policy describes the scope, roles, and responsibility of the Rapid Response Team. It also provides a guide for the activation of the rapid response process at CHN and defines the collaboration between the staff caring for the patient and the Rapid Response Team.

III. DEFINITIONS

RRT – Rapid Response Team

Rapid Response Team – a team of specially trained health care personnel that responds to calls from patient care areas, for assistance with an actual or perceived decline in a patient’s condition. The goal of the team is to bring critical care expertise to the patient when needed, to avoid or, if necessary, to facilitate the timely transfer of patients to a higher level of care, to provide early and rapid intervention in order to reduce the occurrence of respiratory or cardiac arrest, and ultimately to minimize adverse or unanticipated patient outcomes.

(See attached Addendum for Site Specific team members)

SBAR – (Situation – Background – Assessment – Recommendation)

SBAR provides a framework for communication among members of the health care team. It allows for consistent and focused process of communicating essential information about patients’ status, condition, or plan for care among all members of the health care team.
IV. ROLES AND RESPONSIBILITIES (when Rapid Response is activated)

Patient’s nurse, clinical leader, or charge nurse
- Provides pertinent background information related to the patient’s condition to the Rapid Response Team and the primary care physician
- Notifies the physician of the patient’s deteriorating condition and that a Rapid Response has been activated
- Assists the Rapid Response Team with monitoring, interventions, and treatments (e.g. vital signs monitoring, vascular access, IV fluid administration, medication administration, suctioning, etc.).
- Gathers supplies and medications that are requested by the Rapid Response Team members
- Documents the symptoms of deterioration that results in activation of the Rapid Response
- Documents the event, interventions and outcomes in the patient record
- Provides support for the patient’s family

Rapid Response Team RN(s)
- Receives report from the initiating nurse, patient, or family member
- Conducts assessments of the patient and the situation
- Initiates rescue interventions per physician orders and/or per approved protocols
- Communicates with the primary care physician regarding the patient’s condition and needs
- Consults with critical care or emergency physicians as needed
- Facilitates the timely transfer of the patient to a higher level of care as needed
- Debriefs and evaluates the event with the initiating nurse, patient, or family member
- Provides education to associates

Clinical Supervisor/Resource Nurse (or designee)
- Manages the environment
- Facilitates communication with the family, among the team, and with physicians
- Assists with monitoring, interventions, and treatments
- Provides support for the patient’s family
- Facilitates patient transfer and placement

Respiratory Therapist
- Provides respiratory assessment, airway support and management, respiratory treatments and blood gas monitoring as ordered or per protocol.

V. SPECIAL CONSIDERATIONS
NOTE: Activation of the Rapid Response Team does NOT in any way replace immediate consultation with the patient’s attending physician.

VI. PROCESS
Activation of Rapid Response Team MAY include but is not limited to the following:
   a. Perceived or actual decline in patient’s condition by any associate, by the patient, or by the patient’s family member(s)
   b. Failure to respond to prescribed treatment regimen
   c. Chest Pain
   d. Acute change in conscious state (Altered Mental Status, decreased Level of Consciousness, or other alterations in consciousness).
   e. Seizures or other neurological concerns (i.e. possible brain attacks/strokes/TIAs)
   f. Onset of Agitation/Delirium
   g. Acute change in heart rate to less than 40 or greater than 130 bpm
   h. Acute change in systolic blood pressure to less than 90 mmHg or greater than 180
   i. Acute change in respiratory rate to less than 8 or greater than 28 per minute
   j. Acute change in O2 Saturation to less than 90% despite supplemental oxygen
k. O2 Saturation decrease by 10% on any FiO2
l. Acute change in Urinary Output to less than 50 ml in 4 hours
m. Intake exceeds output by greater than 1000 ml over past 24 hrs
n. Acute significant bleeding

VII. DOCUMENTATION
Documentation of the Rapid Response Team’s assessments and interventions must include:
- Time of activation
- Physician notification
- Primary reason for activation (include patient’s clinical condition, signs and symptoms, etc.)
- Interventions that were initiated, including medications
- Patient’s response to interventions
- Patient outcome and disposition
- Physician orders on the Physician Order Sheet
- Signatures of the patient’s nurse, RRT RN, respiratory therapist, physician (if present)
- Completion of the RRT documentation forms
- Documentation in the patient’s medical record to include all of the above

VIII. TRANSFER TO A HIGHER LEVEL OF CARE
If the patient’s attending physician or physician present at the rapid response orders the patient to be transferred to a higher level of care, the clinical supervisor/resource nurse, or designee will notify the receiving unit of an impending admission.
- Patient is assigned a bed on the appropriate unit
- Patient is accompanied by a certified ACLS nurse
- Patient’s nurse or designee accompanies patient to the receiving unit to provide hand off communication, utilizing SBAR
- Transport monitor is used during transport
- Patient’s medical record is completed by the patient’s nurse and RRT team members as appropriate
- Physician orders are documented on the physician order sheet

IX. If the patient is stabilized and not transferred, the Rapid Response Nurse or designee will collaborate with the patient’s nurse regarding the plan of care for the patient to prevent further deterioration.

X. DEBRIEFING AND EVALUATION
A debriefing and evaluation of the rapid response activation, team, and interventions may be conducted at a reasonable time after the event.
- Debriefing may be initiated by the RRT nurse and includes, at a minimum, the patient’s nurse
- Evaluation of call may include
  - Who participated in the RRT
  - What interventions were necessary
  - Contact with the patient’s physician, including time of notification
  - Was the problem resolved
  - Were plans and/or goals established for maintaining the patient
  - Was the patient transferred
  - Was documentation complete on all forms and in the medical record
  - What education is necessary for any or all staff involved
XI. Rapid Response Reviews
Rapid Response reviews may include both qualitative and quantitative indicators to assess the impact of the Rapid Response Team on patient outcomes. These may include

- Qualitative
  - Was the patient stabilized with the RRT interventions
  - Was the patient transferred to a higher level of care
  - Was the family notified/supported during the event

- Quantitative
  - Number of RRT called per unit, day, or month
  - Reasons for calls

XII. REFERENCES


XIII. APPROVAL

<table>
<thead>
<tr>
<th>Committee/Department</th>
<th>Original Approval</th>
<th>1st Review</th>
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Addendum # 1

ST. JOSEPH’S HOSPITAL

Rapid Response Team SJH Rapid Response Team Members:
1. Critical Care Clinical Nurse Lead or Charge Nurse
2. Respiratory Therapist
3. Clinical Nurse Supervisor/or designee

Hospital Areas for Rapid Response
1. Main Hospital
2. O’Reilly Care Center
3. Perinatal Assessment Center

<table>
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<tr>
<th>PROCESS</th>
<th>KEY POINTS</th>
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| **Activation of RRT** | • Dial “911” ask for Rapid Response Team and provide the patient’s room number  
• Operator will notify House Supervisor/Designee on dedicated “Code Cell Phone”  
• House Supervisor/Designee broadcast to the team using Vocera “Urgent broadcast rapid response team”  
• Patient’s nurse or clinical lead will provide a detailed report of the patient’s condition and concerns to RRT  
Patient’s nurse will remain with the patient throughout the assessment and interventions by the RRT. |
| **RRT Arrival** | • Any associate, the patient, or the patient’s family, may activate the RRT in response to concerns related to the patient’s condition  
• Patients and their family members may ask any hospital associate to activate the RRT  
• Patients and family will be educated about contacting the patient’s nurse or any clinical associate for concerns related to the patient’s condition  
• The education is documented on the Interdisciplinary Teaching Record  
• When the RRT is activated by the patient or a family member, the RRT nurse will obtain information regarding their concern.  
• If the concern is non clinical in nature, the information will be given to the unit manager or a designee for further follow up.  
• Approved protocols will be initiated including:  
  • Cardiac  
  • Pulmonary  
  • Level of consciousness  
• The attending physician remains the director of the patient’s care unless delegated to another physician. |
| **Documentation** | • All sections of the RRT documentation form must be completed  
• A copy of the completed form will be forwarded to the quality office.  
• Reviews will be completed by committee and appropriate follow up will be documented. |

Rapid Response Team
Page 5 of 7
CSM Rapid Response (RR) Team Members:
1. Critical Care RN or Critical Care Charge Nurse
2. Respiratory Therapy Charge plus another RT
3. Clinical Nurse Supervisor

Hospital Areas for Rapid Response
1. Main Hospital

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| **Activation of RRT** | • Contact number for the RR Nurse is 349-5148 and/or Vocera “call the RR Nurse”
|                       | • The RR Nurse uses the Vocera command “Urgent Broadcast RR Team” and states reason and location of call Patient’s nurse or clinical lead provides a detailed report of the patient’s condition and concerns to RRT
|                       | • Patient’s nurse remains with the patient throughout the assessment and interventions by the RRT |
| **RRT Arrival**       | • Associate or family identifies the patient is experiencing one or more of the “Call Criteria” and contacts the RR Nurse
|                       | • The use of the “Urgent Broadcast” alerts the entire team of a patient in need
|                       | • Patients and family are educated about contacting the patient’s nurse or any clinical associate for concerns related to the patient’s condition
|                       | • The education is documented on the Interdisciplinary Teaching Record
| **Documentation**     | • The RR Nurse and/or Respiratory Therapist releases the Respiratory Therapist and contacts on an as needed basis based on patient needs after initial assessment completed
|                       | • The bedside RN continues to be accessible to RR Team
|                       | • The RR Nurse and/or Respiratory Therapist continues to notify patient’s physician of patient’s change in condition
|                       | • If the patient’s physician cannot be reached, the RR Nurse uses the Assessment Rescue Team Orders and Protocols to manage the care of the patient
|                       | • The RR Nurse and/or Respiratory Therapist documents the patient assessment and interventions on the RR Team Documentation Record
|                       | • The RR Nurse and/or Respiratory Therapist leaves the original (white) copy of the RR Team Documentation Record in the patient’s chart under “Progress Notes” |
**HOLY CROSS HOSPITAL**

**RRT PROCESS**

**HCH Rapid Response Team Members:**
1. Emergency Department (ED) physician
2. Emergency Department (ED) charge nurse or designee
3. Cardiopulmonary tech

**Hospital Area for Rapid Response**
1. Main Hospital

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<tr>
<th>PROCEDURE</th>
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<tr>
<td><strong>Activation of RRT</strong></td>
<td>• ED charge nurse or designee, and/or physician and/or cardiopulmonary tech respond to the unit within 15 minutes</td>
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<td>• Staff nurses activate RRT by calling the ED charge nurse and/or cardiopulmonary tech</td>
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<tr>
<td>• Call the ED charge nurse on Vocera at 88-3400 Nurse 1 (or at ext. 8020)</td>
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<tr>
<td>• Cardiopulmonary tech can be reached on Vocera at 88-3400 Holy Cross Cardio</td>
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<tr>
<td>• ED charge nurse alerts the ED physician</td>
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<td>• Patient/family may request that the RRT be activated if they have concern regarding patient status</td>
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<tr>
<th><strong>RRT Arrival</strong></th>
<th><strong>SBAR is used for communication among team members</strong></th>
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<tr>
<td>• Team members assess the patient’s condition and make recommendations for care</td>
<td>• Staff nurse, ED nurse or ED physician may do the notification</td>
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<tr>
<td>• ED physician orders treatment for the patient</td>
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<tr>
<td>• Staff nurse becomes part of the team and provides patient information</td>
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<td>• The patient’s attending physician is notified of the change in the patient’s condition</td>
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<tr>
<td>• In the absence of a physician, treatment recommendations by the ED nurse and cardiopulmonary tech are called to the attending physician</td>
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<th><strong>Documentation</strong></th>
<th><strong>All sections of the RRT documentation form must be completed</strong></th>
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<td>• RRT nurse and the patient’s nurse document details of the patient’s condition prompting the RRT call</td>
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<tr>
<td>• Documentation includes assessment findings, interventions ordered and implemented, and patient’s response to treatment</td>
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