

TITLE: Rapid Response Team		
FACILITY: St. Vincent's East	FUNCTION:	ORIGINATING DEPT: Nursing Administration
HOSPITAL SHARED POLICY? _X_ Yes ___ No		EFFECTIVE DATE:
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SCOPE: All Nursing, Respiratory, Pharmacy
PURPOSE: To provide care for patient's that are in acute distress using a team approach.
DEFINITIONS: <ol style="list-style-type: none"> 1. Rapid Response Team (RRT)-Team made up of the primary physician, Primary Nurse, Critical Care RN or Emergency RN, Respiratory Therapist, and a Family Practice Resident. 2. Code R- Over head announcement by the operator to activate the RRT 3. Protocols-Instructions approved by the Medical Executive Committee for the Nurses and Respiratory Therapist to follow when treating a patient. 4. Primary Unit- the unit that is assigned that day to cover Rapid Response calls. 5. Secondary Unit-The unit assigned that day to act as a back up for the primary unit, if they are unable to respond.
POLICY: The nurse caring for the patient experiencing acute changes will activate the RRT. The primary Nurse will still be the one in charge of the patient. The primary Physician should be contacted as quickly as possible as the RRT is activated.

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PROCEDURE:**I. How to Alert the Rapid Response Team (RRT)**

- A. The Primary Nurse will make every attempt to notify the Primary MD
- B. Primary RN will call 3500 and tell the operator to call a code R to that unit or floor.
- C. The Operator will call a code R over head with the location.
- D. The Critical Care RN or Emergency Department RN, who is assigned for that day, will bring the RRT Supply Box with them to the unit.
- E. The Respiratory Therapist will be paged by the Primary Nurse.
- F. Family Practice intern will be beeped by the team after an assessment is made and a determination of their assistance is needed. They will call the operator; ask for the Family Practice Resident to be paged on the code pager, with the numbers 111, followed by the room number.

II. Team Responsibilities

- A. Patient's Nurse
 - a. Assessment of patient's condition and determine if the RRT needs to be activated.
 - b. Call Primary MD about patient's condition and the rapid response team at the same time.
 - c. Page or ask someone to page Respiratory Therapy.
 - d. Report to RRT Nurse when they arrive and help with the documentation.
 - e. Communicate the code status of the patient.
 - f. The patient's nurse is still in charge of the patient and communicates the rapid response team's findings to the MD.
- B. Critical Care (CC) or Emergency Department (ED) RN
 - a. Respond to the page over head Code R to unit.
 - b. Provide advanced assessment and technical support. Act as an extra pair of hands and eyes. Use the SBAR or other assessment sheet to gather information and document patient's condition and interventions.
 - c. Follow protocols according to the situation
 - d. In conjunction with the other team members call the Family Practice Resident if needed.
 - e. Speak with primary care physician or Family Practice Physician if necessary.
- C. Respiratory Therapist
 - a. Assessment of respiratory system
 - b. Manage airway
 - c. Draw ABG's if needed, according to primary MD orders or protocol.
 - d. Respiratory treatments by protocol and as ordered
- D. Family Practice Physician
 - a. Help to critically assess the patient
 - b. Provide physician support and orders until primary MD can be reached.
- E. Documentation will be done on the Rapid Response Team Record.
 - a. The carbon copy will be given to the manager to forward to the Rapid Response Team Committee and the original placed on the chart.

III. Schedule for calls

- A. The managers from the Critical Care and Emergency areas will determine

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- a schedule of which units will be on call for the Rapid Response.
- B. A secondary unit will be designated to be on call, in case the primary unit is unable to respond.
- C. It will be up to the Charge Nurse of the primary unit to notify the secondary unit and talk with the charge nurse, and to notify the Nursing supervisor of any changes.
- D. If the secondary unit is busy and unable to respond then the Supervisor will designate a unit to respond and notify that unit.
- E. A schedule will be given to the Nursing Service office and Respiratory Department.

IV. RRT Supply Box

There will be 7 Rapid Response boxes that will be locked and checked daily. They will be kept in each Critical Care unit and Emergency Department. Two will be kept in Central Supply. Items to be placed in a toolbox to carry to the RRT calls are:

- A. Respiratory
 - 1. Pulse oximeter x1
 - 2. Nasal cannula x 1
 - 3. Non-rebreather mask x 1
 - 4. Flow Meter with Christmas tree x 1
 - 5. Nebulizer set up x 1
 - 6. Oral airways
 - 7. ABG kits neonatal x 3
- B. IV equipment
 - 1. Angio-caths at least 2 of the following 22 angios, 20 angios and 18 angios.
 - 2. Heplock / saline lock x 1
 - 3. IV start kit x 1
 - 4. 1000cc Normal Saline with tubing x 1
 - 5. 10cc NS flushes x 3
 - 6. Syringes 12cc x 3 3cc syringes with 20 gauge needles x 3
 - 7. Needles 20 gauge x 3
- C. Paper work
 - 1. Rapid response Team Report
 - 2. List of Phone numbers
 - 3. SBAR sheets
- D. Other
 - 1. Electrodes x 3
 - 2. Quick Combo pads x 1
 - 3. Suction Kit x 3
 - 4. Blood pressure cuff x 1
 - 5. Tape 2 inch micro pore x 1
 - 6. Bag with Lab tubes
 - a. Blue, lavender, gold, and red topped, one of each
 - 7. Butterfly needles 19 gauge x 2
 - 8. Bio hazard bags x 2

9. Alcohol preps
 10. Gauze 4x4 - 6
- E. Drugs
1. Narcan
 2. D50W
 3. SL NTG
 4. Aspirin
 5. Albuterol, Atrovent, Mucomyst
- F. Replacement of the box when used
1. Place patient's stickers on the tabs
 2. Secure with Blue Lock
 3. Take to pharmacy for the drugs to be removed.
 4. Take remainder of the box to central supply to replace supplies used on patient.
 5. Pick up replacement box and take to unit.
 6. Central well notify Pharmacy when the box is stocked and ready to be closed.
 7. Pharmacy will bring the drugs to be placed in the restocked Rapid Response Box and secure the box with a yellow lock.

IV. PROTOCOLS

A. UNIVERSAL- For all patients

1. Obtain brief history using the rapid response assessment sheet
2. Contact MD. If unable to contact Primary MD immediately then page the Family Practice Resident on call if needed.
3. Assess Oxygenation.
 - a. Place pulse ox on patient
 - b. Respiratory will place O2 as needed to maintain an O2 saturation greater than 90%
4. Place patient on monitor
5. Place an IV.
6. Assess vital signs (BP, Heart rate and rhythm, pulse, respiration rate, temperature, level of consciousness, and last blood sugar).
7. Assess recent medication history
8. Have patient's chart in the room.
9. Ensure the Primary MD is notified

B. CHEST PAIN

1. Assess chief complaint
 - a. Location
 - b. Chronology
 - c. Quantity
 - d. Quality
 - e. Aggravating Symptoms
2. Assess Vital Signs

3. Oxygen start at 2 Liters/minute to be increased by respiratory therapist according to SPO₂
4. Run stat 12 lead EKG
5. Have patient chew an ASA 325mg tablet if not dosed in the last 12 hours (obtain from Pyxis)
6. Administer NTG 1/150 sub lingual every 5 minutes x 3. (Only if BP is >100mmHG systolic)
7. Obtain IV access
8. Initial Troponins and cardiac enzymes will be drawn.
9. Ensure MD is aware of change in status

C. Respiratory Failure/Pulmonary Edema

1. Obtain brief history using assessment sheet
2. Assess vital signs
3. Pulmonary assessment note O₂ sat and work of breathing
4. If RN and RT agree, may begin treatment with Albuterol, Atrovent or Mucomyst as needed.
5. Assess level of consciousness
6. Raise head of bed to 30 degrees if not contraindicated
7. Stat ABGs if SPO₂ saturation below 90%
8. Obtain a STAT portable chest X-Ray
9. Start O₂ by respiratory therapy to increase O₂ sats above 90%. COPD patients may be treated differently
10. Provide emotional support to patient
11. Observe for cardiac rhythms
12. Ensure MD is aware of status and ABGs.

D. Seizures

1. Assess signs/symptoms of seizure (length, progression, form it takes)
2. Obtain vital signs
3. Neuro assessment
4. Seizure precautions
 - a. Bed in low position
 - b. Side rails up and padded
 - c. Do not restrain
 - d. Turn patient on side when able
 - e. Keep warm
5. Obtain blood sugar

E. Adult Diabetic Emergency Therapy

1. Perform STAT blood sugar with hospital bedside glucose testing equipment
2. Assess level of consciousness
3. If Blood Sugar less than 70
 - a. Give 4 ounces of unsweetened orange juice or 3 glucose tablets
 - b. Recheck the glucose levels in 10-15 minutes.
 - c. If still less than 70 repeat above and recheck blood sugar in 10 minutes

- until glucose is stabilized above 70
- d. After the blood glucose is stabilized above 70, if the next mealtime or snack is more than one hour away, give a snack, which is the equivalent of one (1) starch and one (1) meat exchange. Example: Eight (8) ounces of skim milk or six (6) saltine crackers and one (1) tablespoon of peanut butter (**Note** if patient has any food allergies).
 - e. Notify the physician as ordered and document the blood sugar results, treatment, and patient's symptoms on the Diabetes Flow Sheet
4. Treating insulin reactions in the conscious patient who is NPO
 - a. Check the blood glucose using the hospital bedside blood glucose testing equipment when reaction symptoms occur.
 - b. If blood sugar is less than 70 give 50 cc of D50W IV push over three (3) minutes.
 - c. Recheck blood glucose in 10-15 minutes using the hospital bedside blood glucose testing equipment.
 - d. Notify the physician as ordered and document the blood sugar results, treatment, and patient's symptoms on the Diabetes Flow Sheet.
 5. Treating the unconscious or semi-conscious patient having an insulin reaction.
 - a. When reaction symptoms occur, check the blood glucose using the hospital bedside blood glucose testing equipment and notify the laboratory to draw a stat blood glucose.
 - b. If the blood glucose is less than 70 by the bedside blood glucose testing equipment, give 50 cc D50W IV push over three (3) minutes.
 - c. Recheck the blood glucose in ten (10) minutes with the bedside blood glucose testing equipment and if the result is less than 70 verify by lab that the blood glucose is still less than 70.
 - d. Notify the physician of the blood glucose results, treatment given and request further treatment orders.
 - e. If unable to reach the physician, if the blood glucose is less than 70, start an IV of D5W at 125 cc/ hr and continue to check the blood glucose every ten (10) minutes until the blood glucose is above 70 or the patient is alert and able to take treatment by mouth.
 - f. Once a blood glucose of over 100 is maintained, continue to monitor blood glucose every 30 minutes times one (1) and then as ordered.
 - g. After blood glucose is stabilized above 100, if able to take PO nourishment and the next mealtime is more than one (1) hour away, give the equivalent of one (1) starch and one (1) protein exchange by mouth. Example: Give eight (8) ounces of skim milk and three (3) saltine crackers and one (1) tablespoon peanut butter (**Note** if patient has any food allergies).
 - h. Document blood sugar results, treatments and patient's symptoms on the Diabetes Flow Sheet.

F. Gastrointestinal Bleeding

1. Assess abdominal pain vs. chest pain
2. Assess bowel sounds and presence of pain
3. Assess nausea, vomiting, coffee ground emesis, dark tarry stools, bright red blood, change in level of consciousness
4. Raise head of bed
5. Obtain STAT hemoglobin & hematocrit, and BMP. Draw blue top and gold top for possible coagulation studies and type and cross match if the MD later orders one.
6. Provide O2 to keep sat above 90%
7. Two large bore IVs

G. ACUTE HYPOTENSION

1. Assess Vital signs
2. Assess level of consciousness
3. Assess for last dose of pain reliever, sedation, antihypertensive drug, or any other drug that may affect blood pressure
4. Ensure head of bed is flat with possible Trendelenberg position if needed
5. Start large bore IV
6. Start 250cc normal saline bolus (Listen to breath sounds for crackles). After the first saline infusion is complete and no failure is present and blood pressure does not improve start another 250 cc normal saline bolus.
7. Place Foley
8. Obtain 12 lead EKG
9. Draw stat CBC. Also draw a gold top for possible BMP later.
10. Start O2 to maintain saturations above 90%

H. Narcotic Over Sedation with Respiratory Depression

1. Assess last dose of Narcotic
 - a. Time given
 - b. Dose given
 - c. Route given
 - d. Level of consciousness
2. Assess present
 - a. Level of consciousness
 - b. Respiratory effort
 - c. Respiratory rate
 - d. O2 sat.
 - e. Vital signs
3. Give Narcan .05 to .2 mg IV every 2 minutes until the desired level of reversal is reached.
4. Remain at bedside until level of reversal is reached and maintained.

REFERENCES:

Institute for Healthcare Improvement. "How to Establish a Rapid Response Team". 100,000 Lives Campaign. Accessed 10/24/06. Accessed at http://www.ihl.org/ihl .
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