Section 9 Clinical Policies **Subject 9. 13 General Procedures** **Policy 9.13.31 Activation of the Medical Surgical and Obstetrical Rapid Response Teams (RRT)**	02/05/07 –Originated 06/20/14 -Reviewed w/ Changes -Reviewed w/o Changes 06/20/14 – Effective Nursing - Author

Activation of the Medical Surgical and Obstetrical Rapid Response Teams (RRT)

Policy

The rapid response team (RRT) is committed to providing critical care resources to patients who may be in crisis. There are two separate teams: one to address the needs of medical and surgical (med/surg) patients and the other to respond solely to obstetrical (OB) patients.

A physician order is not required for a Rapid Response Activation, but all treatments and interventions require a physician's order.
Any healthcare provider may activate the Rapid Response Team.
No healthcare provider should discourage or prohibit the use of the Rapid Response Team.

Patient and/or Family Request
A patient or the patient's family may request the rapid response team to evaluate changes in a patient's condition. Information about the rapid response team is provided to patients/families in designated areas.

Non- inpatient

In the event medical attention is needed for an individual who is not an inpatient, employees of those areas should either: a.) call a code, or, b.) arrange for transportation to the Emergency Department (when applicable). If the rapid response team is available, they may assist with transporting to the Emergency Department.

Documentation

Accurate documentation of all Rapid Response Team activation will be maintained:

1. The Registered Nurse and Respiratory Therapist will document the initial activation on the area specific Rapid Response Flow Sheet.
2. Follow-up assessments and intervention will be documented on a progress note.
3. The Flow Sheet will be filed in the beginning of the Progress Notes Section of the medical record.
4. The Rapid Response Log Book will be maintained every shift by the Rapid Response nurse.

Activating a Med/Surg Rapid Response

When an adverse indicator is noted, the patient's physician shall be notified of changes indicating deterioration in the patient's condition. The nurse or other health care provider assigned to the patient may activate the Rapid Response Team to assist with assessment and timely treatment when a patient's condition is questionable or when a change

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Activating a Med/Surg Rapid Response, continued

in the patient's status falls within the following parameters:

1. Staff member concerned/worried about the patient.
2. Acute change in heart rate (less than 40 or greater than 130)
3. Acute change in systolic blood pressure (less than 90mm/Hg)
4. Acute change in respiratory rate (less than 8 or greater than 28) or threatened airway
5. Acute change in oxygen saturation (less than 90%)
6. Acute change in level of consciousness
7. Acute significant bleeding
8. Patient's oxygen requirements increase (50% or greater)
9. New, repeated, or prolonged seizures
10. Failure to respond to treatment for an acute problem/symptom
11. Acute change in urine output to less than 50ml in 4 hours

The primary responders of the Med/Surg Rapid Response Team include a Critical Care Nurse and a Respiratory Therapist. The nurse administrator will facilitate bed placement whenever needed. Their services are available 24 hours a day/7 days a week to inpatients in designated areas.

Responding to an Activation

The Med/Surg Rapid Response Team (RRT) members will carry pagers and will respond immediately to all calls to provide assistance to areas designated for RRT support. While carrying a RRT pager, team members are to remain on the hospital premises at all times and are individually responsible for assuring that their pager is functioning properly and answer test pages.

Designated patients/units

The Med/Surg Rapid Response Team will respond to activations on inpatients in designated units/areas on a "first come-first served basis". This includes adult medical/surgical non-ICU inpatient units.
In the event an inpatient from a designated area requires medical attention in an area other than their unit, the rapid response team, if available, may assist with transporting the patient back to their unit, and continue to assist with interventions if needed.

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Procedure for Calling a Med/Surg Rapid Response Activation

The following procedure is to be used when a Med/Surg rapid response activation is requested.

Responsibility	Action
Caller	All requests for the Rapid Response Team must be made through Operator Services. 1. Caller dials operator at extension 24000. Requests Rapid Response Team. Gives operator the following information: 2. Precise location (unit and building) 3. Caller's name and extension
Operator	Records the information and includes the date and time of the call. Activates the Rapid Response paging system designating exact location and extension.

Roles and Responsibilities for Med/Surg Activations

RRT RN Responsibilities

- Serves as the Team Leader and delegates responsibilities to other RRT responders.
- Assists the assigned health care providers with care of the patient including:
  a. Patient assessment
  b. Communication with medical team
  c. Providing interventions
  d. Evaluating the effectiveness of interventions
  e. Transporting patient if indicated to other care settings
  f. Resolving issues with Medical Team response
- Determines frequency, scope and duration of ongoing assessments of patients not transferred to the ICU or equivalent.
- Provides ongoing assessments of patients not transferred to the ICU or equivalent.
- Provides education and support to unit healthcare providers.
- Triage multiple requests for service
- Maintains monitoring equipment and supplies

RRT RT Responsibilities

1. Provides respiratory assessment and interventions.
2. Communicates with the medical team as it relates to respiratory care
3. Evaluates effectiveness of interventions
4. Documents activities
5. Assists the RRT RN as directed
6. Provides ongoing assessments of patients not transferred to the ICU or equivalent.

7. Provides education and support to unit healthcare providers

Roles and Responsibilities for Med/Surg Activations, continued

8. Maintains RRT oxygen tank
9. Notifies Respiratory Care Service when Code Cart is used

Nurse Administrator Responsibilities

1. Responds in-person or by phone to each activation
2. Provides assistance with resolution of issues
3. Assists with bed placement

Primary Nurse Responsibilities

1. Promptly activates Rapid Response Team when indicated.
2. Notifies primary medical team of rapid response activation.
3. Provides information to RRT and medical staff.
4. Remains present during the activation.
5. Assists RRT with obtaining supplies.
6. Actively participates in assessments and interventions.
7. Assumes total responsibility for care of the patient when requested by the RRT RN.

Primary Physician Team Responsibilities

1. Promptly responds to activation by phone or in-person.
2. Responds to request for in-person evaluation and/or care or determines alternate source of evaluation and/or care.

Multiple Activations

The Rapid Response Teams are an adjunct to patient care to support the primary nurse and operates on a "first-come-first served basis" The RRT RN will triage multiple activations to determine the most appropriate use of the team when possible. Options may include use of individual team members, transfer of care back to assigned primary nurse, or calling a Code 99.

Medical Response Issues

A response from a member of the assigned medical team is expected within 15 minutes from the original call/page. If the patient's medical team does not respond within the designated time frame, the RRT will use the physician chain of command to assure the patient's emergent needs are met.

The physician chain of command is identified as:

1. Resident in charge of the patient/resident on call
2. Chief resident, Faculty physician of the service/Clinical Medical Director
3. Department Chair
4. Inpatient: Chief Medical Director of Hospital Services

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5. Dean of Medicine

Testing of RRT Pagers

For the Med/Surg RRT , the hospital operator will activate all Rapid Response pagers as a functional test each morning and each evening. In the event of a Rapid Response at test time, the test will be deferred for one (1) hour.

In order to verify pager and personnel responsiveness, each Rapid Response responder **must** immediately call the paging operator at extension 24004 and identify their pager. If any required personnel fail to respond within fifteen (15) minutes, the operator will page the individual RRT pager of the non-responder. If there is still no response, the paging operator will contact the designated manager.

Obstetrical Rapid Response

Policy

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A physician order is not required for a Rapid Response Activation, but all treatments and interventions require a physician's order.
Any healthcare provider may activate the Rapid Response Team.
No healthcare provider should discourage or prohibit the use of the Rapid Response Team.

Patient and/or Family Request
A patient or the patient's family may request the rapid response team to evaluate changes in a patient's condition. Information about the rapid response team is provided to patients/families in designated areas.

Non- inpatient

In the event medical attention is needed for an individual who is not an inpatient, employees of those areas should either: a.) call a code, or, b.) arrange for transportation to the Emergency Department (when applicable). If the rapid response team is available, they may assist with transporting to the Emergency Department.

Initiating an Obstetrical

A physician order is not required for a Rapid Response Activation, but all treatments and interventions require a physician's order.

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Rapid Response

Any healthcare provider may activate the Rapid Response Team.
No healthcare provider should discourage or prohibit the use of the Rapid Response Team.

Initiating an Obstetrical Rapid Response, continued

When an adverse indicator is noted, the patient's physician shall be notified of changes indicating deterioration in the patient's condition. The nurse or other health care provider assigned to the patient may activate the Rapid Response Team to assist with assessment and timely treatment when a patient's condition is questionable or when a change in the patient's status falls within the following parameters:

1. Staff member concerned/worried about the patient
2. Acute Significant Bleeding
   a. Uncontrolled, significant bleeding R/T for example, but not limited to, placenta previa, postpartum hemorrhage, placental abruption.
3. Vital Sign changes
   a. Acute changes in baseline BP
   b. Acute change in heart rate
   c. Persistent $SpO_2 < 90\%$
   d. Acute change in respiratory rate or threatened airway
4. Prolonged or new onset of seizures
5. Acute changes in conscious state
6. Precipitous delivery of viable infant

The primary responders of the OB RRT shall include the Labor and Delivery Charge RN and/or a designated Critical Care OB nurse. Their services are available 24 hours a day/7 days a week to inpatients in designated areas.

Responding to an Activation

The OB RRT members shall respond immediately to all overhead pages to provide assistance to areas designated for OB RRT support. Members of the team shall remain on the hospital premises at all times. If a team member must leave Labor and Delivery, then another person shall be designated to respond to the OB RRT overhead pages during the interim time period.

Designated patients/units

The OB Rapid Response Team shall respond to activations on inpatients on the Antepartum and Postpartum floors for Obstetrical related issues.

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Procedure for Calling an OB Rapid Response Activation

The following procedure is to be used when a rapid response activation is requested.

Responsibility	Action
Primary Nurse	Provide ongoing assessment and determine need for OB RRT Activate OBRRT by overhead paging 155-0 and state "OB Rapid Response Team to Unit ____Room ___" Provide report to team upon arrival using SBAR **S**ituation: What is going on with the patient
Primary Nurse	**B**ackground: OB history **A**ssessment: What does the nurse think the problem is? **R**ecommendation: What does the nurse think the patient needs immediately? For imminent delivery, **Call x 24000** and state: **"I have a neonatal code on Unit ____ Room____."** *Primary RN shall remain with the patient until situation is resolved or patient is transferred to Labor and Delivery.

Documentation

Accurate documentation of all Rapid Response Team activation will be maintained:

1. The Registered Nurse and Respiratory Therapist will document the initial activation on the area specific Rapid Response Flow Sheet.
2. Follow-up assessments and intervention will be documented on a progress note.
3. The Flow Sheet will be filed in the beginning of the Progress Notes Section of the medical record.
4. The Rapid Response Log Book will be maintained every shift by the Labor and Delivery charge nurse.

Multiple Activations

The Rapid Response Teams are an adjunct to patient care to support the primary nurse and operates on a "first-come-first served basis" The RRT RN will triage multiple activations to determine the most appropriate use of the team when possible. Options may include use of individual team members, transfer of care back to assigned primary nurse, or calling a Code 99.

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A response from a member of the assigned medical team is expected within 15 minutes from the original call/page. If the patient's medical team does not respond within the designated time frame, the RRT will use the physician chain of command to assure the patient's emergent needs are met.

The physician chain of command is identified as:

1. Resident in charge of the patient/resident on call
2. Chief resident, Faculty physician of the service/Clinical Medical Director
3. Department Chair
4. Inpatient: Chief Medical Director of Hospital Services
5. Dean of Medicine

Testing of RRT Pagers

For the OB RRT the overhead paging system shall be tested each Tuesday and Friday morning and night shift, and documented in the L&D Charge RN logbook.

In the event that the overhead paging system is not functioning properly, the primary RN shall page the L&D charge nurse or call L&D and speak with the L&D charge nurse directly.