HACKETTSTOWN REGIONAL MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

RAPID RESPONSE TEAM

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Effective Date:	**05/01/06**	**Policy No:**	**PC31**
Cross Referenced:		**Origin:**	**Patient Care Services**
Reviewed Date:	**05/09, 07/09, 11/12, 8/13**	**Authority:**	**Chief Nurse Executive**
Revised Date:	**6/2015**	**Page:**	**1 of 7**

PART I OF THE RAPID RESPONSE TEAM POLICY

SCOPE

All hospital staff and medical staff

PURPOSE

To define the structure and role of the Rapid Response Team (RTT) in the care of the adult patient. Hackettstown Regional Medical Center (HRMC) encourages the staff, patient and family to seek assistance when the patient's condition worsens.

POLICY

The Rapid Response Team:

- Consists of a team of clinicians who bring critical care expertise to the patient who becomes clinically unstable. (Hospitalist, Respiratory Therapist and Critical Care RN)
- May be summoned at any time by any hospital staff, patient and/or family member to assist in the care of a patient who appears to have a change in condition.
- Assessment and interventions are aimed at preventing a cardiac or respiratory arrest, if possible.
- Does not replace the attending and/or consulting physician(s). The unit staff will notify the physician when an RRT is called.
- Responds to inpatient and outpatient events. For a visitor event "Code Help" will be utilized.
- Following an outpatient RRT, if necessary and if patient consents, RRT member(s) will escort the outpatients to the Emergency Department. (except MOB I)

PROCEDURE

A. Criteria for Calling RRT

Whenever a patient is noted to have any of the following conditions not actively being treated by a physician or LIP, the staff member caring for the patient can mobilizes the RRT:

- Staff member is concerned regarding a change in the patient's condition.
- Acute change in heart rate to less than 50 or greater than 130 bpm.
- Acute changes in rhythm where patient is symptomatic or rhythms that are life threatening
- Acute change in systolic blood pressure less than 90mmHg or greater than 200mmHg.
- Acute change in respiratory rate to less than 8 or greater than 28 bpm.
- A sudden change in Sa02 less than 90%.
- An acute change/worsening in mental status or any acute neurological changes

  OR
- When a family member/friend of patient notices a serious change in patient's condition.

B. **Mechanism for Calling RRT**

The RRT is called by dialing 6000 from any internal phone. The caller will request the RRT and provide the location. The switchboard operator will overhead page the RRT, announcing the location. The following staff positions respond:

- Respiratory Therapy
- Rapid Response RN (Critical Care Experience)
- Hospitalist
- Administrative Supervisor
- Primary Care Nurse

C. Responders and Roles of RRT:

RAPID RESPONSE TEAM

1. Primary RN

- Provides initial situation, background and reason for call to the team
- Works with Rapid Response Team to assist with patient care, accessing needed medication and equipment.
- Administers medication as directed according to scope of practice
- Provides bedside electronic medical record to review results and eMAR
- Ensures Attending/Consulting Physician is notified of patient's change in condition
- Participates in Debriefing when RRT is completed

2. Rapid Response Nurse RN

Responds to location with DASH monitoring system (exception, Therapy Center in MOB I)

- Assesses patient for reason RR was called
- Applies DASH monitor and obtains baseline vital signs and ECG tracing
- Interprets vitals signs and ECG rhythm
- Oversees the nursing care of the patient during the event
- Administers medication or appropriately delegates medication to be administered within provider's scope of practice
- Documents events on the RRT record and initials any medications administered given by RRT nurse
- Ensures that medication administration by other providers, i.e. Physician, Respiratory Therapist or Primary Nurse is documented
- Scans RRT Record to Pharmacy (form is now the order sheet for the event)
- Assumes care of the patient during transport if moving to a higher level of care
- Participates in Debriefing when RRT is completed

3. Respiratory Therapist

- Provides an initial assessment of patient condition in conjunction with rest of team
- Manages airway and administers respiratory medications/treatments
- Assist in transferring the patient if O2 therapy is required
- Participates in debriefing when RR is completed
- Signs RRT Record as respiratory provider for the event
- Documents (Initials) respiratory treatments given on RRT record

4. Hospitalist

- RRT leader
- Evaluates patient to determine possible causes for the change in condition and orders initial interventions
- Communicates patient event, interventions and current status to the patient's attending/consulting physician(s). Determine patient's disposition and if necessary writes transfer orders
- Cosigns RRT record indicating medications and interventions listed were as ordered
- Participates in Debriefing when RRT is completed

5. Administrative Supervisor

- Controls the environment and dismisses non essential responders immediately
- Communicates with families/visitors if present at the time of the RRT
- Retrieves medication and equipment as directed by RRT members
- Proactively triages and facilitates bed availability if moving patient to another area
- Conducts debriefing immediately after event, and documents responder feedback
- Ensures RRT Record is complete and forwarded to Quality Department

6. Attending or Consulting Physician
   - Collaborates with Hospitalist to determine patient disposition, the need for further intervention and/or additional consultations.

D. Areas Covered

The RRT coverage areas include:

- Maternal Child (Fourth floor) (**non-obstetrical)**
- 3 South
- 3 North
- Progressive Care Unit (PCU)
- Intensive Care
- Same Day Surgery
- Minor Procedures
- Vascular Lab
- PACU
- Operating Room
- Cardiopulmonary Department
- Radiology Department
- Sleep Lab
- Lab Draw First Floor
- Lab Draw MOB II
- Dialysis Room (PCU)
- Infusion Center (MOB II)
- Registration Desks (first and second floors)
- Cancer Center (MOB II)
- Wound Healing Center (MOB II)
- Therapy Services and Cardiac Rehab (MOB I)

The following areas/patient population **will not** utilize RRT:

- Nursery/ Neonatal emergency
- Emergency Department
- Pediatrics

E. Documentation

1. The RRT Record will be available on a clipboard attached to the Dash 4000 monitor provided by the Critical Care RN.
2. The responding members of the RRT, (RN, RT and Physician) will sign their names in the appropriate area of the RRT Record.
3. The RRT Record will be completed by the Critical Care RN placed in the Progress Notes section of the patient's Medical Record.
4. A copy will be made of the RRT Record by the Administrative Supervisor who will then forward the record to the Quality Department, or the original can be scanned to the Quality Department prior to placement in the chart.
5. A debriefing will be conducted immediately post-RRT. The Administrative Supervisor will facilitate and document the feedback of the debriefing. The debriefing document will be forwarded with the Rapid Response Record.

RAPID RESPONSE TEAM

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PART II OF THE RAPID RESPONSE TEAM POLICY:
OB EMERGENCY RESPONSE TEAM

PURPOSE

To describe the process for mobilizing staff resources during obstetrical emergency situations in order to decrease risks of adverse outcomes.

POLICY

- The American College of Obstetricians and Gynecologists recommends that in an emergency, obstetrical units should be capable to initiating a cesarean section with 30 minutes of a decision.
  Although not every obstetrical emergency results in a cesarean section, it is necessary to quickly mobilize skilled personnel to the bedside the any emergent hence supporting a specialized RRT for OB.
- The OB emergency response team will bring their expertise to the bedside where they can assess, stabilize, improve communicate, educate, support and assist with patient transfer to OB/OR suite as necessary.
- If a further medical emergency exist with the post partum patient, a standard Rapid Response Team call or Code Blue will be initiated.
- If further medical emergency exist after the fetus is born, a Code White will be initiated.

A. Selected Maternal-Fetal Complications/Emergencies Appropriate for Team Response

Maternal	Fetal
Placental Abruption	Non-reassuring Fetal Heart Rate
Uterine Rupture	Prolapsed Umbilical Cord
Magnesium Sulfate Toxicity	Second Stage Fetal Intolerance
Eclampsia/Seizures	Shoulder Dystocia
Amniotic Fluid Embolism	
Vasa Previa	
Postpartum Hemorrhage	

B. Responders:

1. Any OB staff RN on duty
2. OB Tech
3. Respiratory Therapist.
4. Administrative Supervisor
5. The following respond if available in the building:
   - Any OB staff RN
   - OR Tech
   - Any OB Provider (Physician or Midwife)
   - OR staff in the building
   - Any Anesthesiologist
   - Any Pediatrician
   - Director of Women's Service

PROCEDURE

A. Procedure Steps

1. Whenever an Obstetrical patient is noted to have an emergent OB condition and additional assistance is required, the staff member or provider caring for the patient calls for an OB Emergency Response Team.
   NOTE: If full cardio-respiratory resuscitation is needed, a Code Blue or Code Pink must be called.

2. The OB Emergency Response Team is called by dialing 6000 from any internal phone. The caller will request OB Emergency Response Team and provide the location and give the room number.

3. The switchboard operator will overhead page the OB Emergency Response Team announcing the location.

4. Immediately following mobilization of the OB Emergency Response Team, the unit staff will notify the patient's provider (if not already present).

B. **Responders and Roles**

1. Primary OB RN
   - Provides background and assessment information for responders as necessary.
   - In absence of OB physician or midwife directs responders what measures may need to be taken for the patient.
   - Remains with patient and participates in emergency care measures.
   - Initiates nursing assessments, intervention and administers medication as ordered
   - Documents OB rapid response event and interventions

2. Other OB RNs, OB Techs (according to job description) – Implement emergency measures appropriate to the emergent condition, including but not limited to:
   - Obtains necessary medications from Pyxis or Pharmacy.
   - Assists with McRoberts or other maneuvers.
   - Manages prolapsed umbilical cord.
   - Assists with patient transport to OB OR.
   - Sets up OR for c-section.

3. Primary OB Provider (Physician/Midwife)
   - Directs staff by communicating treatment plan and providing orders for management of the emergent condition.

4. OB Providers (Physicians/Midwives)
   - In absence of primary OB provider, directs staff by communicating treatment plan and providing orders for management of the emergent condition.

5. Respiratory Therapist
   - In collaboration with the RRT provides an initial assessment of the patient's condition.
   - Assists with airway management and administers respiratory treatments/medications
   - Remains on stand-by for resuscitation of newborn, if necessary.
   - Assist with transferring the patient if necessary.

6. OR Staff
   - Sets up OB OR for emergency c-section. Scrubs, circulates as necessary.

7. Anesthesiologist
   - Prepares for emergency c-section if applicable.

8. Pediatrician
   - Prepares for emergency c-section if applicable. Performs resuscitation of newborn if necessary.

9. Director of Women's Service
   - Supports teams members and retrieves equipment/supplies
   - Facilitates patient flow if necessary

10. Administrative Supervisor
    - Controls the environment and dismisses non essential responders immediately
    - Communicates with families/visitors if present at the time of the RRT

- Retrieves medication and equipment as directed by RRT members
- Proactively triages and facilitates bed availability if moving patient to another area
- Conducts debriefing immediately after event, and documents responder feedback
- Ensures RRT Record is complete and forwarded to Quality Department

C. Documentation

1. The primary RN will document the OB Rapid response event and any interventions in the QS System in the Delivery section.
2. Documentation elements may include but are not limited to:
    a. Time and reason for OB Rapid Response call
    b. Interventions that were initiated and/or completed ie. Vital signs, medications administered, IV fluids started, McRoberts or other maneuvers.
    c. Patient disposition such as: Transfer to the OR
    d. Any additional personnel called to assist in care
    e. Notifications of any Providers caring for the patient.

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RAPID RESPONSE EVALUATION DATA

	Yes	No	Comments
Rapid Response called appropriately? (dialed 6000)			
Rapid Response announced x 3 by operator			
Was Rapid Response called within 24 hours of admission to hospital? (does not include transfer)			
Was the patient transferred to ICU or PCU			
Was the call appropriate?			
Was this unavoidable?			
Was the patient in the appropriate level of care at the time of RRT?			
If in the MOB I, was 911 called immediately after RRT called?			

Was equipment and medication available for use, if not stated what and why? (Going to the pyxis for medication is part of the process. Only if medication was not available in the pyxis on any of the units is problematic if pharmacy is not available) _____

In the teams' opinion (at least one nurse, physician and therapist should be present for debriefing at the same time, not individual debriefing) **did the rapid response run smoothly, why or why not?**

Could the outcome or process been improved? (Did the patient show signs of deterioration earlier? Did the patient have treatment ordered that was not started or not working? Did they patient have any recent abnormal labs?)

- ☐ **Black lock attached if Code Cart used** should not be used in RRT unless it progresses into a Code Blue)
- ☐ **Materials Management called**

COMPLETED BY: _____ DATE: _____

PATIENT NAME/LABEL

NOT A PERMANENT PART OF THE CHART **5/01/15**