ORLANDO HEALTH®

1414 Kuhl Ave.
Orlando, Florida 32806
321.843.7000

Type of Policy:	**PATIENT CARE**	Category:	**PROVISION OF CARE TREATMENT AND SERVICES (PC)**

Title:	***RAPID RESPONSE TEAM***	Policy #:	**3390**
		Replaces #:	
Page:	1 of 3	Developed By:	Corporate Critical Care
Issue Date:	**5/07**	Approved By:	Patient Care Executive
Revision Dates:	5/13, 11/16, 2/20, 4/23		K Edmondson MSN, RN, NEA-BC

I. PURPOSE:

This policy establishes a consistent method for activating the Rapid Response Team (RRT) to respond, and quickly stabilize patients who have demonstrated signs of clinical deterioration.

II. DEFINITIONS:

A. Rapid Response Team (RRT): A designated group of experienced personnel, including a registered nurse and respiratory therapist with the specific purpose of providing early assessment and intervention for potential and/or actual physical deterioration or emergencies within the acute care hospital. Respiratory therapists are not part of the RRT at South Lake Hospital, Bayfront Health and Winnie Palmer Hospital.

B. Pediatric Early Warning Score (PEWS): Clinical manifestations that indicate rapid deterioration in pediatric patients, infancy to adolescence.

C. Deterioration Index – Epic-based tool that will alert clinicians when a patient's condition begins to deteriorate. This tool will enable staff to identify deterioration sooner and has the potential to prevent adverse outcomes and even death. .

D. Modified Early Obstetric Warning System (MEOWS): A physiologic scoring system that allows early recognition of physical deterioration in the peripartum patient.

III. POLICY:

It is the policy of Orlando Health that:

A. Any team member, patient, or family may initiate a call to the RRT, provided that a "Code Blue 90 or Code Blue 45" situation does not exist.

B. The patient's attending/managing physician shall be called STAT simultaneously with the activation of the call if the patient's condition warrants immediate medical attention.

C. If the patient's attending/managing physician is not readily available and the patient requires immediate medical care, the RRT shall notify a physician as applicable to the facility, or as per the physician notification chain of command process.

D. Nursing leadership shall determine the staffing patterns for the RRT at each facility.

E. A Rapid Response Team (RRT) shall respond to all registered patients in an Inpatient clinical area within the acute care hospital who exhibit signs or symptoms of physical deterioration or meet the criteria for initiating a response call. This includes:

1. Arnold Palmer Hospital outpatient clinic areas located within the acute care hospital.
2. Behavioral Health Inpatient unit at South Seminole Hospital.
    a. The RRT and/or Nursing Supervisor at South Seminole responding to an adolescent/child RRT call in Behavioral Health, will contact the ED Charge RN to come and evaluate the adolescent/child patient, if necessary.
3. At South Lake Hospital the ED Charge RN responds to Code Blue 45 with the RRT.

F. Once the RRT is activated, the bedside nurse and/or charge nurse will remain at the bedside and assist the team in the evaluation of the patient.

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IV. PROCEDURE:

A. Triggers to initiate a call to the RRT:
1. Worried about the patient.
2. Acute and sudden changes in vital signs (e.g., difficulty breathing, hypotension, tachycardia, bradycardia, or tachypnea).
3. Acute and changing respiratory status (e.g., low SaO_2 not responsive to oxygen therapy or increasing oxygen demand).
4. Acute change in neurological status (e.g., level of consciousness, motor and sensory function, behavior, seizures).
5. Clinical signs of stroke.
6. Uncontrolled bleeding or bleeding from an airway.
7. Indication of decreased perfusion (e.g., color changes, loss of pulse).
8. New onset of chest pain.
9. Positive severe sepsis screen or National Early Warning Score (NEWS) greater than or equal to 5, with a positive Stability Surveillance Screen (SSS). (Adult Hospitals)
10. Patient with orders for higher level of care requiring monitoring and/or treatment beyond the scope and/or knowledge level of the clinical area in which the patient resides.
11. Per Pediatric Early Warning Score (PEWS) algorithm at Arnold Palmer Hospital (APH)
12. Per Modified Early Obstetric Warning System (MEOWS) algorithm at Winnie Palmer Hospital (WPH), SLH and Bayfront Health.

B. The RRT, under leadership of the Rapid Response Nurse, will:
1. Assess the patient upon arrival to the clinical area and activate other members of the team when necessary. For South Seminole Behavior Health, refer to Attachment A.
2. Verify that the patient's attending/managing physician is called as appropriate.
3. Communicate with the patient's physician and provide information on the situation, background, assessment findings and recommendations.
4. Implement RRT protocol orders, if available/appropriate to facility.
5. Make arrangements with the Administrative Supervisor for transfer to a higher level of care, if needed.
6. Initiate a Code Blue 90/Code Blue 45 if cardiopulmonary arrest is imminent.
7. Call a Stroke Alert, if applicable.

V. DOCUMENTATION:

A. As appropriate in the Comprehensive Health Record.
B. Rapid Response Team Record (Form 0032-107484. Revised 11/14)

VI. REFERENCES:

A. Patient Care Policy and Procedure #0350, *Physician Notification Chain of Command*.

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B. Sebat, F. (2009). Society of Critical Care Medicine.: *Designing, implementing and enhancing a Rapid Response System.* Mount Prospect, IL

C. Lazzara, E.H., Benishek, L.E., Sonesh, S.C., Patzer, B., Robinson, P., Wallace, R., & Sala, E. (2014). The 6 "W's" of Rapid Response Systems [Abstract]. Critical Care Nursing Quarterly, 37 (2), 207-218.

D. NHS England, Royal College of Physicians, NHS Improvement. *Patient safety alert: Resources to support the safe adoption of the revised National Early Warning Score (NEWS2). NHS, 2018.*

E. Monaghan A. Detecting and managing deterioration in children. Paediatric Nurse. 2005; 17:32–5.

VII. ATTACHMENTS

A. South Seminole Hospital, Behavioral Health Process for RRT, one page

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Behavioral Health RRT

If a Behavioral Health (BH) nurse feels a BH patient may need a medical evaluation, please follow the process below:

a) RRT called by BH RN

b) RRT and Nursing Supervisor respond

c) RRT performs assessment

d) RRT or Nursing Supervisor will determine if the BH patient is being followed by Medicine

e) If the patient is currently being followed by IMG, RRT will notify Medicine to advise of patient condition and to receive any additional orders as deemed necessary

f) If the patient is not being followed by IMG and based upon RRT's assessment the patient may need further medical evaluation, RRT will call the ED MD via Ascom to discuss the situation. Based on this discussion, the ED doc will decide whether the patient is to be transferred to the ED. Most patients will likely be transferred but not necessarily all depending on the situation.

1) Behavioral health RN will call Psychiatrist and advise of patient situation and that ED MD was consulted and the disposition of the patient (e.g. transfer to ED or meds ordered and medicine consult placed etc.). If the Psychiatrist is still concerned, he/she should call and discuss the case with the ED doc.

2) Nursing Supervisor will contact ED Charge RN and provide report if patient is to be transferred to ED. The patient should not be brought to the ED until approved by the ED Mb and report call to ED charge nurse.

3) ED Charge will either assign an ED bed or will assign ED bed upon arrival to ED.