

Additional Tools

Rapid Response Team Frequently Asked Questions

Rapid Response Team Sample Policy

Rapid Response Team Evaluation – Caller perspective

Rapid Response Team Evaluation – RRT perspective

Condition H

Rapid Response Team Evaluation – Caller perspective

Rapid Response Team Evaluation – RRT perspective

Frequently Asked Questions (FAQ's) About The Rapid Response Team

When do you call a Rapid Response Team?

- The patient has a worrisome change in vital signs or level of consciousness
- The patient has no/inadequate response to ordered interventions
- You have alerted the patient's attending physician and charge nurse of your concerns and findings
- You feel uncomfortable with the situation

What will the Rapid Response Team want to know?

- What is happening with the patient (Situation, Background, Assessment, Recommendation)
- How they can assist

What are the expectations when the Rapid Response Team is used?

- They are consultants
- They will assist with assessment and management of the patient
- The floor staff will retain responsibility for:
 - Calling the patient's attending physician
 - Medications and interventions unless they require specialized skills
 - Documentation
- Floor staff and the Rapid Response Team will negotiate division of the work to be done
- Teaching will occur:
 - Assessment and critical thinking
 - Physiology and interventions
 - Assertiveness and interpersonal skills
 - Policies and procedures

What are the goals of the Rapid Response Team program?

- The patient will improve
- A patient transfer will be avoided
- Skills of floor staff will be improved
- Collegiality between departments will be improved

How will we know if this program is successful?

- Decreased codes
- Decreased ICU admissions from the floors
- Decreased patient deaths

Who is on the Rapid Response Team?

Rapid Response Team
(Authority to Intervene to Restore Patient Safety)

Policy Number:	Review/Revision #	New
Category:		
Site:	System	
Responsible for Review:	Director of Patient Safety	
Original Effective Date:	5/30/2006	
Review/Revision Date:		
Next Review Date:		

Purpose: To provide, in a timely manner, a team of critical-care trained staff, to assist with the assessment and treatment of a patient, whose condition is deteriorating.

Policy:

1. **All Children's employees, Children's Professional Staff, contracted staff, housestaff, students, volunteers, patients, parents, families, legal guardians, and visitors have the ability to unconditionally request urgent medical assistance for a patient perceived to be in distress without the advance consultation with housestaff or the patient's attending physicians if the attending physician is not physically present.** This departure from usual chain-of-command for medical care is intended to make sure that clinically deteriorating patients receive assistance before their conditions are an emergency.
2. Consultation with the patient's attending physician is expected after the patient has been assessed and stabilized.
3. Patient care personnel who recognize an acute deterioration in a patient's status and summon the Rapid Response Team shall stay with patient until the Rapid Response Team (RRT) arrives.
4. Patient care personnel are expected to stay with their patient throughout the RRT activation unless otherwise instructed by the team.

Key Words: Rapid Response Team, RRT, Stop the Line Rule, Chain of Command, patient safety, emergency intervention

Domain of Policy: All patients in all inpatient units on the Minneapolis and St. Paul Campuses

Responsibilities:

- a) Staff will be trained and responsible to implement the RRT according to procedural guidelines (Appendix A).
 - A. The RRT includes an PICU RN and a Respiratory Therapist (RCP) operating under the supervision of a PICU Intensivist.
 - B. The RRT provides:
 - Clinical expertise
 - Advanced assessment skills
 - Support for the nurse

Facilitates a more timely transfer to a higher level of care when needed.

- Criteria For RRT Activation**
- a) Staff are concerned about a patient.
 - b) Acute change in heart rate.
 - c) Acute change in systolic blood pressure.
 - d) Acute change in respiratory rate.
 - e) Acute change in respiratory effort.
 - f) Acute change in neurological status.
 - h) Patient fails to respond to treatment.
 - i) In addition, the following objective measures of clinical instability are provided as a general reference guide. Please Note that the numerical values do **NOT** need not be reached or exceeded before requesting a Rapid Response Team consultation. The most important activation criteria remains staff/family concern or intuition.

AGE	Abnormal Heart Rate (Beats/Minute)	Abnormal Resp Rate (Breaths/min)	Abnormal Systolic BP (mm Hg)
Neonate	<80 >200	<20 >75	<50
Infant (6 months)	<80 >200	<20 >70	<60
Toddler (2 years)	<65 >180	<16 >60	<65
Pre-school (5 yrs)	<50 >160	>50	<70
School age (7 yrs)	<50 >150	>45	<75
Adolescent	<40 >140	>40	<85

- Procedure:**
1. The patient care staff member who identifies that a patient meets any or all of the above listed criteria shall activates the Children’s RRT by calling the Pediatric Intensive Care Unit (PICU) and requesting the assistance of the Rapid Response Team:
 - MPLS PICU x5-6266
 - STP PICU x6-6310
 2. The Children’s RRT members respond to the activation throughout the inpatient units on the Minneapolis and St. Paul campuses.
 3. PICU staff member who answers the phone:
 - a) **Records** Caller’s Name and phone number, Patient’s Name, Location, Room Number, and time of request on *RRT Consultation Record*
 - b) **Informs** Caller that RRT is on its way. Asks caller to be prepared to discuss the Situation, Background, Their Assessment, and Their Recommendations. Asks the Caller to alert their charge nurse.
 - c) **Alerts** PICU Charge Nurse.
 4. The PICU Charge Nurse **Alerts** the Attending PICU Intensivist

of the request, and **Dispatches** the Rapid Response Team members (RN and RCP) to the requested location.

5. RRT RN and RRT RCP will:
 - a) Bring RRT documentation records.(Appendix B)
 - b) Activate Code Blue if necessary
 - c) Speak with the primary nurse to get the situation, background, and assessment of the patient.
 - d) Speak with the family/patient about the situation.
 - e) Assist with further assessment of the patient including patient's physical status, review of the medical record for pertinent history/lab findings.
 - f) Collaborate with PICU Intensivist to provide necessary medical interventions. The PICU Intensivist may elect to conduct own on site assessment as indicated.
 - g) Perform or recommend interventions authorized by the supervising Intensivist or approved protocol to support, stabilize, or transport the patient. (Appendix C)
 - h) Coordinate with the bedside nurse to ensure notification of the Patient's Attending Physician of the consultation request, the findings, any interventions, and the patient's disposition. If the patient is transferred into the PICU, the notification will occur by the PICU Intensivist.
 - i) Maintain documentation using the Rapid Response Consultation Record.
 - j) Stay with the patient until they are stable or assist with the transfer of the patient to a higher level of care.
 - k) Place the RRT Consultation Record into the patient's medical record.

6. The care-giving nurse will:
 - a) Provide information to the team when they present re: SBAR.
 - b) Notify the attending physician and communicate information about the RRT call and SBAR. (The physician may have already contacted but they should be notified of the team recommendations in the SBAR format).

201.00 Chain of Command for the Unstable / Stable Patient
108.00 Patient Rights and Responsibilities
201.00 Urgent Evaluation of Unstable Patient.

Review / New system policy:
Revision Dates:

Approval Group(s)

Group
Leadership
PCPC
PEC

Date

Appendix A: Rapid Response Team Activation Algorithm

If Patient's status unchanged from Baseline, Then patient's on-call physician is called for routine orders

If Patient is experiencing a Life Threatening Event (Cardiac or Respiratory Arrest), Then a Code Blue is activated

If Caregiver identifies or perceives a worrisome deterioration in the patient's clinical situation and the patient's attending physician is not physically present, Then a RRT consultation is made

Nurse, Resident, RCP. contacts PICU – Requests assistance of the Rapid Response Team (**MPLS** x5-6266 ; **STP** x6-6310)

PICU staff member who answers the phone

- 1) **Records** Caller's Name and phone number, Patient's Name, Location, Room Number, and time of request on RRT record
- 2) **Informs** Caller that RRT is on its way. Asks caller to be prepared to discuss the Situation, Background, Their Assessment, and Their Recommendations. Asks the Caller to alert their charge nurse.
- 3) **Alerts** PICU Charge Nurse.
- 4) **Pages** Attending MD, and RCP carrying code pager.

Charge Nurse **Alerts** Intensivist and **Dispatches** RN and RCP

RN and RCP respond to location requesting assistance

RRT RN and RRT RCP conduct assessments and

- 1) Activates Code Blue if necessary
- 2) Discusses Case with PICU Intensivist who may elect to conduct own on site assessment as indicated.
- 3) Performs appropriately authorized interventions to support, stabilize, or transport the patient.
- 4) Ensure notification of Patient's Attending Physician.
- 5) Maintain documentation
- 6) RRT returns to PICU

PICU Intensivist

- 1) Informed of RRT deployment
- 2) Receives RRT RN report.
- 3) Authorizes Interventions appropriate to meet patient needs.
- 4) Directly Evaluates patient and Dictates Medical Record Report as indicated.
- 6) Discusses patient with patient's attending physician if patient is transferred.



Rapid Response Team Consultation Record

Patient Name: _____ Room #: _____ Caller's Name: _____ Time of Call: _____

SITUATION Arrival Date: ____/____/____ Time: _____ RN: _____ RCP: _____

- Worrisome change in heart rate
- Worrisome change in systolic blood pressure
- Worrisome change in level of consciousness
- Worrisome change in O2 saturation
- Worrisome change in respiratory rate/effort
- Expressed Family Concern

BACKGROUND

Reason for this admission _____

Pertinent past med history _____

Interventions this admission _____

Current medications _____

ASSESSMENT Patient Weight: _____ KG

Vital Signs: *** Recorded on Back of Rapid Response Team Consultation Record ***

NL ABNL

- Airway** (drooling, congestion, stridor etc.): _____
- Breathing** (wheezing, rhonchi, retractions etc.): _____
- Circulation:** (Abnl rate, rhythm, color, refill etc.): _____
- Consciousness** (confused, agitated, somnolent etc.): _____
- Other: _____
- Other: _____

RECOMMENDATIONS

- CODE BLUE** initiated
- (REQUIRED) Discussed patient with Intensivist:** _____ **M.D.**, then (check all that apply):
 - Transferred patient to higher level of care
 - No change in level of care.
 - Evaluated directly by Intensivist
 - Other: _____

(REQUIRED) Patient's Attending notified by: _____ **at** _____ **hours**

- Interventions (check all that apply):**
- Apnea, Oximetry, or Cardiac Monitoring
 - Oxygen applied / increased
 - Oral / nasal airway
 - ECG
 - Other: _____
 - Other: _____
 - Chest X-ray
 - ABG/VBG
 - Oral / nasal / pharyngeal suctioning
 - Nebulizer treatment with albuterol/ racemic epi
 - IV Fluid Bolus _____

Additional documentation

- See Resuscitation Record
- See Intensivist Report
- See Physician Order Form

TEAM Departure Date: ____/____/____ Time: _____

Signature: _____ **RN** Signature: _____ **RCP**

Place in Progress Note Section

Place Patient Label Here

RESUSRCD

FREQUENT VITAL SIGNS	TIME:					
	Temp:					
	Site:					
	Pulse:					
	Respirations:					
	Systolic BP:					
	Diastolic BP:					
	FiO2:					
SaO2:						
INITIALS:						

Appendix C: Nursing Protocol

RESPIRATORY Nursing Protocols	CARDIOVASCULAR Nursing Protocols
<p>1. May start O₂ and titrate to saturation $\geq 92\%$.</p> <p>2. May obtain O₂ saturation per pulse Oximeter for change in respiratory status.</p> <p>3. May initiate continuous oximetry, apnea, and cardiac monitoring.</p> <p>4. May decrease nasal O₂ if patient denies shortness of breath, and is acyanotic with O₂ saturation \geq baseline on decreased settings.</p> <p>5. For a patient in respiratory distress who had previously ordered respiratory treatments, may call Respiratory Therapy for Respiratory Care Assessment and previously ordered treatment <u>STAT x1</u>. Must call physician for renewal/further orders (Respiratory Therapy will follow their policy pertaining to the 72-hour renewal reminder).</p> <p>6. For patient in respiratory distress, may order respiratory treatment x 1 of 3 ml. solution containing 2.5 ml. of NS and 0.5 ml (2.5 mg) albuterol to be nebulized over 7-8 minutes and notify physician.</p> <p>7. For patient's in respiratory distress may order and draw ABG or VBG testing one time.</p> <p>8. May obtain STAT chest x-ray with reading.</p> <p>9. May return to last stable ventilator setting if patient fails ventilator weaning as evidenced by: \uparrowRespiratory rate O₂ saturation ≤ 90 \downarrowLevel of consciousness \uparrowAnxiety Contact Respiratory Care. for Respiratory Care Assessment and to return patient to last stable ventilator setting.</p> <p>13. For patient in respiratory distress may initiate oral, nasal, pharyngeal suctioning.</p> <p>10. May initiate "Code Blue"</p>	<p>1. May insert a peripheral IV and/or keep open an existing IV with normal saline.</p> <p>2. May obtain STAT chest x-ray with reading.</p> <p>3. For Chest pain may: A. Obtain STAT 12 lead EKG and report results to supervising physician. B. May initiate cardiac monitoring (e.g.: Lead II) C. May initiate O₂ to keep saturation $\geq 92\%$. D. May monitor B/P-Pulse-Resp. every 5 minutes and document.</p> <p>4. For symptomatic hypotension (≥ 40mm Hg drop in systolic baseline), call supervising Intensivist STAT and may: A. Utilize MODIFIED Trendelenburg position by elevating legs and leaving head flat. DO NOT use Trendelenburg position as it may increase respiratory distress and cause refractory bradycardia or hypotension. B. Bolus with 250 cc's NS IV. C. Monitor B/P-Pulse-Resp. every 5 minutes and document until patient is no longer symptomatic, returns to baseline, or is transferred to a monitored bed. D. Use non-invasive automatic cuff or doppler stethoscope to monitor B/P. E. Remove topicals that may cause hypotension such as Nitroglycerin patch/paste, Duragesic, or Catapres patch. F. Hold oral antihypertensives until physician is consulted.</p> <p>5. For suspected/active bleeding may order and draw: 1) STAT CBC and send to lab 2) Type and screen and hold pending CBC results. If Hgb < 8, send type and screen to lab and set up 2 units packed cells</p> <p>6. May initiate "Code Blue"</p>

Rapid Response Team Evaluation

Requester Feedback

1. The team responded promptly (within 15 minutes) Yes No

2. The team was respectful of my need for help Very much Somewhat Not at all

1. The team provided education and/or helpful Very Much Somewhat Not at all
clinical hints to help me in my practice

2. The Patient's outcome was impacted by Positively Not Sure Negatively
this process

3. My overall satisfaction with the rapid response team was...
 Very satisfied Somewhat satisfied Not satisfied

4. What else might improve this service? _____

Return completed forms to Scan Central via inner office mail, MS 17-750

Do no photocopy this form.

For more blank forms, call 5-6617



Rapid Response Team Evaluation

Team Member Feedback

1. The charge nurse effectively facilitated my deployment to where help was needed Very much Somewhat Not at all
2. Shifting my work assignment to accommodate my role on the team was... Smooth OK Chaotic
3. When I arrived in the patient care area it was clear who was requesting assistance. Yes No
4. When I arrived in the patient care area it was clear which patient needed by clinical assessment. Yes No
5. I was helpful to the person requesting our assistance Agree Don't Know Disagree
6. I would rate this experience on the Rapid Response Team as.... Very good OK Bad
5. I have the following suggestions for improving the Rapid Response Team: _____

Return completed form to Scan Central via intern office mail at MS 17-750

Do not photocopy this form.

For more blank forms, call Scan Central at 5-6617



Condition H

At UPMC Shadyside Hospital, we are building the hospital of the future with the help of patients and families we care for. We believe in teamwork and ask that you be a part of our team when visiting your loved ones.



UPMC Shadyside
Part of UPMC Presbyterian Shadyside
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For questions regarding Condition H:
Beth Kuzminsky – 412-623-3954

Condition H

(Condition HELP)



Josie King Call Line
3-3131



The Josie King Story

Josie King, an 18 month old little girl, died from medical errors at John's Hopkins Children Center in 2001. Josie was the sister of Jack, Rely, and Eva and beloved daughter of Tony and Sorrel. She died as a result of a series of hospital errors and poor communication.

"Listening to Sorrel King tell her tragic story left a lasting impression with me-- 'if I would have been able to call a Rapid Response Team, I can't help but think Josie would be here today.'—providing the highest quality care for patients and their families is UPMC Shadyside's history. I knew that we had to bring a family life line (Condition H) to our patients."

*Tami Merryman
Vice President
Patient Care Services
UPMC Shadyside*

Condition H

At UPMC Shadyside, we are leading the national focus on eliminating system problems that affect delivery of care. As a response to providing the best care to our patients, we created a Josie King Call Line -- **Condition H**. Josie's mother, Sorrel King, worked with UPMC Shadyside to design how this valuable resource will work in health care

UPMC is dedicated to making the hospital a safe place for patient care to happen.

Condition H was created to address the needs of the patient in case of an emergency or when the patient is unable to get the attention of a healthcare provider. This call will provide our patients and families an avenue to call for immediate help when they feel they are not receiving adequate medical attention.

When to call

1. If a noticeable medical change in the patient occurs and the health care team is not recognizing the concern.
2. If after speaking with a member of the healthcare team (i.e. nurses, physicians), you continue to have serious concerns on how care is being given, managed, or planned.

To access Condition H, please call 3-3131 and place your call light on. The operator will ask for caller ID, room number, patient name and patient concern. The operator will immediately activate a "Condition H" where a team of medical professionals are alerted and will arrive in the room to assess the situation. Additional clinical supports will be called in as needed.

In offering our families the Condition H option, we want you to know that you are our partners in care. If you have any questions, please discuss them with one of our healthcare providers.
