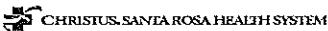
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SUBJECT: RAPID RESPONSE TEAM (RRT)		

PURPOSE

To describe the CHoSA Rapid Response Team, delineate the membership and their qualifications, outline the circumstances and process for activating the RRT, and detail the appropriate actions and interventions of the RRT.

This policy supports our commitment to the Core Values of Compassion and Clinical Excellence utilized in our Value Decision Making Model.

POLICY

1. The RRT is composed of a critical care RN and a respiratory therapist.
2. The RRT is activated by personnel in any inpatient or outpatient unit or ancillary area.
3. The nursing supervisor responds to the site of the call to assess the potential needs of the patient and team.

DEFINITION



Rapid Response Team (RRT): a team of clinicians who bring critical care expertise to the patient bedside or wherever it is needed.

PROCEDURE

1. To activate the RRT:
 - The Associate calls 4545 and provides the monitor technician with the room number and asks for the Rapid Response Team to be activated.
 - The monitor technician announces overhead in the Pediatric ICU that the RRT is to be activated for the acknowledged location.
 - The monitor technician contacts the nursing supervisor and informs them of the need for response.
 - Members of the RRT immediately respond to the site of the call.
2. Education and training requirements for the RRT:

A.

Registered Nurse	Respiratory Therapist
<ul style="list-style-type: none"> • Current BLS • Current ACLS/PALS • Critical care experience 2 years • Completion of RRT orientation 	<ul style="list-style-type: none"> • Current BLS • Current ACLS/PALS • Completion of RRT orientation

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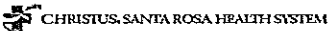
- B. The RRT orientation includes information regarding the SBAR format for communication, specific communication skills, and instruction relative to the approved interventions for specific patient problems.
- C. The facility nursing staff receive education and training relative to their role in summoning the RRT and expectations after their arrival. Education includes:
- Criteria for calling the RRT
 - Procedure for calling the RRT
 - Use of the “Situation-Background-Assessment-Recommendation (SBAR)” method for communicating appropriate information to the team.
4. When the RRT is activated, the patient’s physician/resident is immediately notified.
5. The nurse calling the RRT is a key member of the team, accompanying them to the patient’s bedside and offering whatever assistance is necessary. The nurse informs the RRT of the patient’s current status and reason for the call utilizing the SBAR format. **THE CRITICAL ACTION TEAM IS NOT THERE TO TAKE OVER AND ASSUME CARE OF THE PATIENT.**
6. Criteria for calling the Rapid Response Team:

Patient’s in Women’s Services

- Staff member is worried about any change in the patient’s condition
- Heart rate < 40 BPM or > 130 BPM
- Respiratory rate < 8 or > 30 with patient symptomatic
- Systolic blood pressure < 90 mmHg or > 200 mmHg with patient symptomatic
- Decrease in oxygen saturation < 90% despite oxygen therapy
- Change in level of consciousness

Pediatric Patients

- Staff member is worried about an acute change in the patient’s condition.
- Heart rate (unless otherwise specified on orders)
 - Newborn: <80 bpm or >200 bpm
 - 0-1 year: <80 bpm or >180 bpm
 - 1-8 years: <60 bpm or >180 bpm
 - >8 years: <60 bpm or >160 bpm



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- Respiratory rate (unless otherwise specified in orders)
 - 0-1 year: <20 or > 80
 - 1-8 years: <15 or > 40
 - > 8 years: <10 or > 35
 - Acute decrease in oxygen saturation <90% despite oxygen therapy
 - Systolic blood pressure
 - Infants age 1-12 months: SBP <60mm Hg
 - 1-10 years: < 70 mm Hg + (2 x age in years)
 - Children over 10years: SBP < 90 mm Hg
 - Acute change in level of consciousness
 - Increased work of breathing (as defined by retractions, head bobbing, nasal flaring and grunting) despite nebulizer treatments and/or increasing oxygen therapy
 - Poor perfusion with weak or absent distal pulses
7. The RRT and the patient's nurse keep the attending physician informed of any change in condition and the results of protocol interventions.
 8. The RRT remains with the patient and manages the change in condition for a maximum of 45 minutes. If the patient has not stabilized within that period of time, the nursing supervisor arranges for transfer of the patient to a higher level of care. The patient's attending physician is notified of the need for transfer.
 9. SBAR documentation of the event is done on the "Pediatric Rapid Response Team Record." The white copy is placed in the patient's medical record and the yellow copy is utilized for data collection and quality review. RRT data is reviewed quarterly by the Hospitalist Committee.
 10. Response protocols are delineated in order sets available on the intranet.
 11. Response protocols are reviewed and approved by appropriate medical staff. Protocols are presented to the CSRHC Medical Board for final approval.
 12. Outcome data relative to mortality, cardio-pulmonary arrest rate, and respiratory arrest rate are collected and reviewed by the PIPS committee.

PEDIATRIC EMERGENCY INTERVENTION PROTOCOLS

Acute Respiratory Distress

1. Notify attending physician or designee (resident or mid level provider).
2. Perform brief assessment/pertinent history to include vital signs. Place on cardiac monitor.
3. Place patient in high Fowler's position if not contraindicated.
4. Check oxygen saturation per pulse oximetry. Maintain continuous monitoring of oxygen

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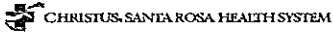
- saturation.
5. Obtain ABG/CBG on room air or existing oxygen.
 6. If no oxygen in place and saturation is <95%, apply oxygen if not contraindicated. Increase oxygen as necessary to keep SpO₂ > 95%.
 7. Suction, if indicated.
 8. Consider nebulizer treatment with wheezing and difficulty breathing as defined by tachypnea, increased work of breathing and oxygen requirement.
 - a) Albuterol sulfate 0.5% (5mg/ml) inhalation solution:
 - Children < 12kg – 0.3ml of Albuterol 0.5% inhalation solution in 2.2 ml normal saline
 - Children > 12kg – 0.5ml of Albuterol 0.5% inhalation solution in 1.5ml normal saline
 9. Obtain IV access if none available. Saline lock IV.
 10. Obtain STAT CXR.
 11. Monitor vital signs every 5 minutes.
 12. If intubation is required, call a Code Blue.
 13. If intubation is anticipated, initiate secondary response.
 14. Update attending physician/designee regarding results of interventions.

Change in Level of Consciousness

1. Notify attending physician/designee.
2. Perform brief neuro assessment/pertinent history to include vital signs and GCS.
3. If GCS is ≤8, call a Code Blue.
4. Obtain blood glucose level via bedside glucometer.
5. Check oxygen saturation per pulse oximetry. Maintain continuous monitoring of oxygen saturation.
6. If no oxygen in place and saturation is <95%, apply oxygen if not contraindicated. Increase oxygen as necessary based on pulse oximetry.
7. Obtain IV access if none available. Saline lock IV.
8. Monitor vital signs every 5 minutes.
9. Update attending physician/designee regarding results of interventions.

Shock State

1. Notify attending physician/designee.
2. Perform brief assessment/pertinent history to include vital signs.
3. Place patient on a cardiac monitor. Evaluate rhythm.
 - If sinus tachycardia and stable (normal BP and perfusion), contact attending physician/designee for orders
 - If sinus tachycardia with poor perfusion, infuse 20 ml/kg normal saline over 15 minutes and reassess. If perfusion still poor, repeat and activate secondary response
 - If supraventricular tachycardia (SVT) and stable (normal BP and perfusion), initiate secondary response

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- If ventricular tachycardia(VT) or unstable SVT, call Code Blue
 - If bradycardia and unstable, call Code Blue
 - If bradycardia and stable, contact attending physician/designee or initiate secondary response
4. Check oxygen saturation per pulse oximetry. Maintain continuous monitoring of oxygen saturation.
 5. If no oxygen in place and saturation is <95%, apply oxygen if not contraindicated. Increase oxygen as necessary based on pulse oximetry.
 6. Obtain IV access if none available.
 7. Obtain blood glucose level via bedside glucometer.
 8. Monitor vital signs every 5 minutes.
 9. Update attending physician/designee regarding results of interventions.

FOR PATIENTS IN WOMEN'S SERVICES



If available, the OB anesthesiologist should be present for any events that occur in Women's Services.

Acute Respiratory Distress

1. Crash cart to room and place patient on cardiac monitor. Follow ACLS guidelines.
2. Assess and maintain airway.
3. Continuous pulse oximetry. Initiate oxygen at 2 LPM; titrate to keep SPO₂ equal or greater than 93%
4. If intubation required, call Code Blue.
5. Perform brief assessment/pertinent history to include vital signs.
6. Place patient in high Fowler's position if not contraindicated.
7. Obtain ABG on room air or existing oxygen.
8. Suction, if indicated.
9. Obtain IV access and start normal saline at 20 mL/hr.
10. STAT CXR
11. Monitor VS every 5 minutes during the event.
12. Update attending physician regarding assessment, interventions and results.

Hypotension

1. Crash cart to room and place patient on cardiac monitor. Follow ACLS guidelines.
2. Perform brief assessment/pertinent history to include vital signs and urine output last 4 hours.
3. Continuous pulse oximetry. Initiate oxygen at 2 LPM; titrate to keep SPO₂ equal or greater than 93%
4. Consider reducing or discontinuing epidural infusion.
5. Obtain large bore IV access if none available. Initiate normal saline bolus of 250 mL and may repeat x1 if B/P remains less than 90 mmHg systolic.
6. Obtain fingerstick blood glucose.
7. Send stat H&H, CMP and lactic acid.

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8. STAT CXR
9. Monitor VS every 5 minutes during the event.
10. Update attending physician regarding results of assessments, interventions and results.

Seizure

1. Crash cart to room and place patient on cardiac monitor. Follow ACLS guidelines.
2. Assess and maintain airway. Suction at bedside. If respiratory distress, call Code Blue
3. Continuous pulse oximetry. Initiate oxygen at 2 LPM; titrate to keep SPO₂ equal or greater than 93%
4. Perform fingerstick glucose test.
5. Assess patient history and medication administration in last 24 hours. If patient on antiseizure medications, send blood level.
6. Obtain IV access and start normal saline at 20 mL/hr.
7. Consider the administration of Lorazepam (Ativan) 2mg IVP for continued seizure activity.
8. Monitor vital signs every 5 minutes during the event and include temperature.
9. Update attending physician regarding results of assessments, interventions and results.

REFERENCES/REGULATIONS/REQUIREMENTS

TJC requirement in 2008 – NPSG 315 for RRT

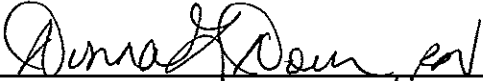
HISTORY

Adapted from CSR regional policy # CO-PM-07-55

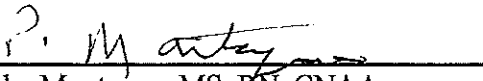
OFFICE OF PRIMARY RESPONSIBILITY

Chief Nursing Officer – Children's Hospital of San Antonio

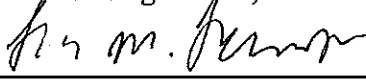
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