

## POLICY

Rapid Response is designed to provide early and rapid assessment and intervention to patients when their condition is deteriorating or the caregiver is concerned about the patient's medical condition.

Family Initiated Rapid Response is designed to provide families with tools to address any serious concerns they have that they believe cannot wait or have not been adequately addressed by their physician or nurse in order to provide early and rapid assessment and intervention to patients when their condition is deteriorating or the family member is concerned about the patient's medical condition.

## SCOPE

1. The Rapid Response Team responds to all calls on EvergreenHealth property for patients.
  - a. This policy does not encompass the care of pediatric or NICU population, with the exception of a Family Initiated Rapid Response.
  - b. The Family Initiated Rapid Response is intended to be called in all areas of EvergreenHealth property.
2. Responders to calls in outpatient locations (e.g. CPC, DI recovery, presurgical clinic) will notify the attending physician and transfer the patient to Emergency Department after being assessed for further evaluation and treatment.

## SUPPORTIVE DATA

Most patients who have a cardiac arrest in the hospital have identifiable signs of deterioration prior to their arrest. The Institute for Healthcare Improvement's goal for implementing Rapid Response is to prevent deaths in patients who are progressively failing outside the CCU. The Rapid Response process has been proven to improve patient outcomes.

Family members or friends at the bedside may be the first to notice subtle signs that may indicate an impending emergency.

## PURPOSE

The purposes of the Rapid Response are to improve patient outcomes by the following avenues:

1. Support the patient, family and bedside nurse as contributing members of the healthcare team by bringing together a team of expert personnel who can provide rapid assessment and intervention, facilitate timely transfer to a higher level of care as necessary, and thus prevent medical crises and reduce mortality.
2. Facilitate ongoing confidence and trust between patients' family members and hospital staff. It is the expectation of the medical staff leadership and the hospital that all primary attendings or covering physicians will respond to calls from the Rapid Response team within the time frames defined in the hospital policy and Medical Staff Rules and Regulations.
3. Enhance knowledge, skills and critical thinking of staff nurses as they work with Rapid Response teams in evaluating their patients.
4. Improve patient outcomes by providing a forum for process review via committee meetings.

## TEAM MODEL AND RESPONSIBILITIES

1. Primary RN (RN caring for patient) - Available to provide information about patient.
2. Charge RN - Records Rapid Response or assigns recorder position, facilitate communication between department staff and rapid response team.
3. Rapid Response RN: ED RN/CCU RN or Rapid Response Stat RN trained to respond to Rapid Responses - Team leader and facilitator of care.

- a. Collaborate with primary RN to assess patient and formulate immediate plan of care, assist primary RN SBAR communication with attending physician.
  - b. Implement appropriate interventions and diagnostics based on the patients current order set and the Rapid Response order set.
  - c. Assist with transfer to higher level of care if appropriate.
  - d. Ensure documentation is complete upon completion of Rapid Response.
4. Respiratory Therapist - Maintains airway, obtains EKG and other responsibilities within scope of practice.
  5. Nursing Supervisor (“705”), Clinical Nurse Manager of unit - manage bed placement, facilitate transfer and support staff caring for patient.
  6. “Attending Physician” (herein referring to primary attending or on-call attending physician) - Be available in person, by phone or by proxy via on-call physician to respond to the needs of the patient as recommended by the Rapid Response Nurse.
  7. Hospitalist - Be available for consult from primary attending for urgent bedside needs.

## PROCEDURE

### Initial Notification

1. RN, caregiver or family member recognizes change in patient’s condition and need for a Rapid Response. Clinical indications for rapid response may include:
  - a. Signs or symptoms of new stroke
  - b. Acute mental status change
  - c. Heart rate <40 or >130
  - d. Respiratory rate <8 or >28
  - e. Systolic blood pressure < 90 mm Hg
  - f. Oxygen saturation <90%
  - g. Urine output <50 mL in four hours
  - h. Caregiver is worried or concerned about the patient
  - i. MEWS score of 6 or greater
  - j. Positive Sepsis Alert
  - k. Patient family member is alerted to a serious concern that cannot wait or has not been adequately addressed by the patient’s physician or nurse.
    - i. If they notice that your family member’s condition is severe or worsening quickly.
    - ii. If there is a medical emergency and a doctor or nurse is not in the room.
2. RN, caregiver or family dials 1199 from an in-house hospital phone and gives the following information:
  - a. Tell the operator that this is a rapid response call
  - b. If the rapid response is being called for sepsis: tell the operator, "Rapid Response: Sepsis"
  - c. Room number or location
  - d. Caller’s name and patient name and call back number
  - e. Cause for concern, if initiated by a family member
3. If the Rapid Response Team has not arrived in 3-5 minutes, repeat page.

### Assessment

1. For Family Initiated Rapid Response in Pediatrics and NICU:
  - a. There is no order set.
  - b. Family rapid response team for Pediatrics/NICU includes Stat nurse, Pediatric RT, NICU Charge nurse and Pediatric Charge nurse.
  - c. Stat nurse will facilitate the conversation with the family and patient care team but will not perform patient assessments or treatments.
2. For Family Initiated Rapid Response to all areas of the hospital EXCEPT Pediatrics and NICU: Hospital staff will follow guidelines as below.

3. Primary RN or Charge RN brings crash cart, Rapid Response Record (paper version for downtimes and areas where Cerner is not used) and patient's chart to the bedside (if necessary). Primary RN remains at bedside to provide patient information regarding reason for Rapid Response call. Information should be given in SBAR format if possible.
4. Initial responders will maintain safe patient environment and provide easy access to patient and the medical record. Suggested activities include:
  - a. Obtain vital signs and have automatic vital sign machine at bedside.
  - b. Bring crash cart to patient's bedside.
  - c. Attach 3-lead heart monitor to patient.
  - d. Set up oxygen therapy and suction if necessary.
  - e. Open patient's chart on bedside computer or have paper chart readily available.
  - f. Initiate Rapid Response Power Plan (sign with attending MD name as "standing orders/protocol - cosign").
5. When Rapid Response team arrives, they will introduce themselves. Primary RN will provide report of patient's current condition and relevant background. Rapid Response RN assesses patient and provides indicated interventions according to the Rapid Response Standing Orders.

## Physician Notification

1. Rapid Response RN facilitates report to the patient's primary attending or covering attending physician. Provides Rapid Response team assessments for the patient, using SBAR format.
2. It is expected that the patient's attending physician will be available to respond to the bedside if, after discussion with the Rapid Response team member, it is determined that the patient's condition warrants in-person assessment or treatment. The patient's attending physician may consult additional services, as deemed necessary based upon the patient's condition, by personally placing a direct call to the appropriate consultant (i.e. hospitalist, cardiology, etc.).
3. If the Rapid Response RN is unable to reach the patient's primary attending in a timely manner and the Rapid Response RN feels the condition indicates a more urgent assessment is indicated, they may contact the on-call hospitalist physician for assistance until the attending physician can be reached. If a hospitalist becomes involved in the patient's care, they will notify the attending physician with the status of the patient.
4. All physicians with privileges at EvergreenHealth are expected to respond to Rapid Response team pages within 15 minutes. Appropriate medical staff action will be pursued for those physicians who do not respond to calls on their patients in a timely manner or ignore a Rapid Response team request for assistance at the bedside.
5. **Rapid Response CVA specific considerations:** when rapid response RN has identified one or more of the following criteria and has initiated CVA specific response;
  1. Sudden numbness/weakness face, arm, leg - one sided
  2. Sudden aphasia/trouble speaking/understanding
  3. Sudden vision loss - one or both eyes
  4. Sudden vertigo/one sided discoordination
  5. Sudden severe headache with no known cause
  - 0700-1700 Monday - Friday Neurohospitalist will be paged to consult at bedside, in addition to patients primary physician for consultation for further definitive stroke care.
  - 1700-0700 weekdays/24 hours holidays - For hospitalists patients - page hospitalist to bedside per rapid response policy. For NON-Hospitalist patients, page cross cover (triage) hospitalist to come to bedside for consult. Neurology will be paged for phone consult.

## DOCUMENTATION

1. Rapid Response team will document physician orders, physician responding to event, assessments and interventions in Cerner. The [Rapid Response Record](#) (NUR 750) will be used for downtime and areas not using Cerner.
2. Primary RN will document reason for Rapid Response call, time team called, and any patient transfer in the patient's medical record, and ensure that the order has been placed in Cerner and the actual rapid response has been documented in IVIEW or on the rapid response form from the crash cart.

3. Medications administered during a Rapid Response will be immediately recorded in Cerner or on the paper [Rapid Response MAR \(MAR 380\)](#).

## COMPLETION

Rapid Response shall be recorded as “complete” when a plan of care and disposition is communicated by the primary physician and all members of the Rapid Response team communicate that they no longer need assistance with any of their continued roles with the patient’s plan of care.

## FOLLOW UP

1. Rapid Response RN will follow up as appropriate on previous shift response calls for patients who remain outside the Critical Care Unit.
2. Off-going Rapid Response RN will provide handoff to oncoming Rapid Response RN.

## SIMULTANEOUS RAPID RESPONSE

If there is a rapid response in progress and another rapid response is called, the following guidelines have been established:

1. The Rapid Response RN is the primary responder, but if a second code or rapid response is called the CCU charge nurse will respond.
2. Respiratory Therapy has multiple therapists assigned to the adult areas as well as the manager. If all adult RT resources are unavailable, call the NICU RT for support.
3. The nursing supervisor can help facilitate any calls for additional resources. They can also reassign staff from one event to the next as necessary.

## COMMITTEE

Quality improvement projects will be initiated based on trends in rapid response data by the Rapid Resonse Committee.

## REFERENCE

1. 1000K Lives Campaign: Rapid Response Teams Getting Started Toolkit. Institute for Healthcare Improvement, 2005.
2. Partnering With Patients, and Families to Design a Patient- and Family-Centered Health Care System," (p-p 19, 72, 76, 79, 113) <http://www.ipfcc.org/pdf/PartneringwithPatientsandFamilies.pdf> by the Institute for Patient- and Family-Centered Care
3. "Delivering Great Care: Engaging Patients and Families as Partners," retrieved from IHI.org ( <http://www.ihl.org/resources/Pages/ImprovementStories/DeliveringGreatCareEngagingPatientsandFamiliesasPartners.aspx> )
4. <http://www.josieking.org>

## References

| Reference Type                               | Title   | Notes                           |
|--|---|---------------------------------|
| <b>Documents referenced by this document</b> |   |                                 |
| Referenced Documents                         | <a href="#">Rapid Response Record - NUR 750</a>   | Rapid Response Record - NUR 750 |
| Referenced Documents                         | <a href="#">Rapid Response MAR - MAR 380</a>  | Rapid Response MAR - MAR 380    |
| Referenced Documents                         | <a href="http://www.ihl.org/resources/Pages/ImprovementStories/DeliveringGreatCareEngagingPatientsandFamiliesasPartners.aspx">http://www.ihl.org/resources/Pages/ImprovementStories/DeliveringGreatCareEngagingPatientsandFamiliesasPartners.aspx</a> |                                 |
| Referenced Documents                         |   |                                 |

<http://www.ipfcc.org/pdf/PartneringwithPatientsandFamilies.pdf>

Referenced Documents

<http://www.josieking.org>

Applicable Documents

Rapid Response Record - NUR 750

Applicable Documents

Rapid Response MAR - MAR 380

Applicable Documents

Rapid Response

Applicable Documents

Rapid Response Feedback Form

Applicable Documents

Rapid Response Family Information Sheet

Referenced Documents

RN TPA Checklist

Referenced Documents

Rapid Response CVA/Stroke Algorithm

Referenced Documents

NIHSS Cards

**Documents which reference this document**

Referenced Documents

Patient Management and Documentation on Oncology, Ortho/Spine/Neuro and Medical/Surgical

Referenced Documents

Clinical Alarm Management

Rapid Response

**Signed by**

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