Current Status: *Active*	**PolicyStat ID:** *3570727*
Implementation:	*1/1/2007*
Effective:	*12/12/2017*
Last Reviewed:	*12/12/2017*
Last Revised:	*12/12/2017*
Next Review:	*12/12/2018*
Owner:	*Deborah Watson: Chief Nursing Officer*
Policy Area:	*Patient Care Services*
References:	
Applicability:	*WA - Providence Mount Carmel Hospital* *WA - Providence St. Joseph's Hospital*

Providence St.Joseph Health

Rapid Response Team Activation

Policy

It is the policy of Providence Mount Carmel Hospital (PMCH) and Providence St. Joseph's Hospital (PSJH) to follow the Lippincott procedure titled **"Patient condition changes, recognizing and responding"** with regards to responding to changes in patient conditions that require immediate intervention from the Rapid Response Team (RRT). Below are additional items that are specific to our facilities and not covered by the Lippincott article.

It is the responsibility of all caregivers working at PMCH or PSJH to activate the RRT if they notice a sudden and unexplained deterioration in a patient's condition. Friends or family members of a patient also have the ability to activate the RRT since they are often the first to notice a change in the patient's condition. Friends or family members of the patient will activate the RRT by following the attached instructional posters, which will be placed in the patient rooms.

Activating the Rapid Response Team

To activate the RRT **as a caregiver**, page overhead by dialing **6010 at PMCH** or **211 at PSJH** and announce three times "Code Rapid Response" and the room number the team needs to respond to.

To activate the RRT as a **friend or family member:**

- **At PMCH** - call the Patient Access Reception Desk at 5500, ask to activate the Rapid Response Team, and give them the room number the team needs to respond to. The receptionist will then immediately announce the Rapid Response using the overhead pager.
- **At PSJH** - call the the Administrative Supervisor/Charge Nurse at 685-2060, ask to activate the Rapid Response Team, and give them the room number the team needs to respond to. They will then immediately announce the Rapid Response using the overhead pager, **unless it is for a Long Term Care resident.** If it is for a Long Term Care resident, the Administrative Supervisor/Charge nurse will instead perform an immediate assessment of the resident before activating the rest of the team.

Rapid Response Team Members

The RRT consists of, but is not limited to:

A. Attending Nurse

B. Administrative Supervisor

C. Respiratory Therapist

D. The Hospitalist or Emergency Department physician if called at PMCH, or the Emergency Department provider if called at PSJH.

Nurse Initiated Orders (NIO)

The following NIOs, approved by Medical Staff, are available to the RRT and may be implemented based on patient assessment. The nurse will notify the attending provider when this assessment is complete or as soon as clinically indicated.

For change in patient condition including but not limited to change in vital signs, mental status, arrhythmia or bradycardia, respiratory status, acute seizure, signs of stroke, acute coronary syndrome (ACS), sepsis, hyper/hypoglycemia, or new onset bleeding, the Rapid Response RN/Attending RN/ARNP/PA may perform the following:

a. Respiratory care consult

b. Apply nasal cannula oxygen and titrate to keep O2 saturation greater than 88%

c. Initiate continuous pulse oximetry

d. Suction set-up if needed

e. Establish IV access if not already in place, 2 sites if necessary (unless contraindicated by patient/resident written directives)

f. Initiate cardiac monitoring (except in Long Term Care Unit)

g. Monitor vital signs q5 minutes until stable, then q15 minutes x 4

h. STAT blood glucose

i. STAT CBC

j. STAT CMP

k. STAT H/H (for new acute evidence of bleeding)

l. STAT Lactic Acid q2 hours x 2, blood cultures x 2 (for suspicion of sepsis/septic shock)

m. STAT Troponin, total CK and CK-MB (cardiac enzymes)

n. STAT 12 lead EKG (for suspicion of Acute Coronary Syndrome characterized by chest pain, shortness of breath, jaw/arm pain, nausea and/or ST elevation on telemetry tracing)

o. STAT ABG (for respiratory distress characterized by new onset respiratory rate greater than 30 breaths/min, oxygen saturation less than 88%, signs of hypoxia or hypercapnia, new evidence of pulmonary congestion, severe shortness of breath, or altered level of consciousness with suspected respiratory cause)

p. STAT portable chest x-ray (to rule out pneumonia for suspicion of sepsis/septic shock)

q. Initiate 30ml/kg normal saline bolus x 1 to infuse as rapidly as possible for SBP <90mmHg or MAP <65mmHg (for suspicion of septic shock)

Documentation

The RRT activation will be documented by the attending nurse in the patient's electronic medical record.

APPROVING COMMITTEES AND COUNCILS

The following committees and councils have reviewed and approved this policy:

Committee or Council Name	Date
PMCH Medical Acute Committee	7-12-2017 Meeting
PSJH Medical Acute/Transitional Care Committee	10-5-2017 Meeting
PMCH Emergency Department Committee	7-7-2017 Meeting
PSJH Emergency Department Committee	10-6-2017 Ad Hoc
PMCH Professional Practice & Leadership Development Council	8-22-2017 Meeting
PSJH Nurse Practice Council	8-24-2017 Meeting
PMCH Medical Staff	Not required, per JoAnn Fox
PSJH Medcal Staff	9-19-2017 Meeting

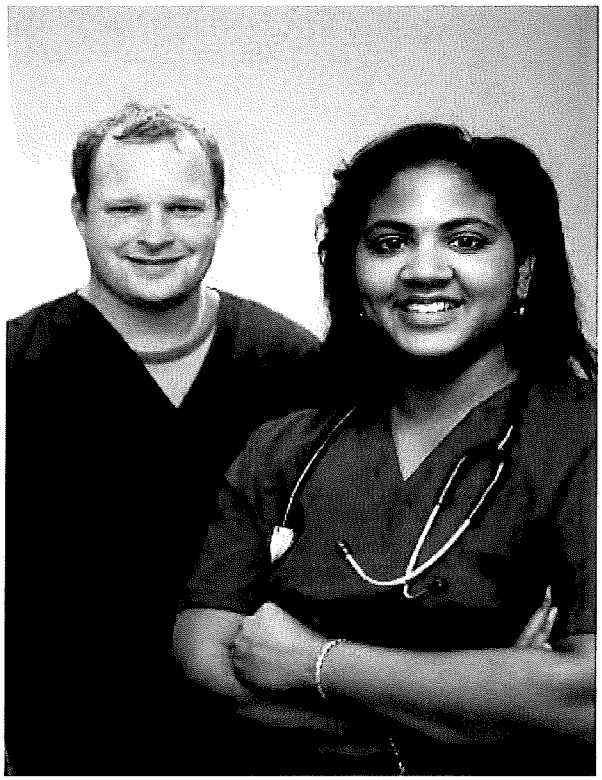
All revision dates: 12/12/2017, 5/10/2016, 11/1/2007

Attachments:

Rapid Response Team Poster PMCH.docx
Rapid Response Team Poster PSJH.docx

Approval Signatures

Step Description	Approver	Date
Chief Nursing Officer	Deborah Watson: Chief Nursing Officer	12/12/2017



Rapid Response Team

If you are concerned, we are concerned.

You know your loved one best. So if you notice a decline in condition:

- Alert the attending nurse immediately

If you do not receive the support you need:

- Dial **5500** and tell the receptionist you need the Rapid Response Team
- Give your location using the information at the bottom of this poster
- Let the attending nurse know the Rapid Response Team has been called as soon as possible

The Rapid Response Team, which includes an Administrative Supervisor and Respiratory Therapist, work with the attending nurse and provider to assess your loved one's condition, provide needed emergency care, and keep the admitting physician up to date about any changes. For more information please ask the attending nurse.

ROOM # _____