

**NYC HEALTH + HOSPITALS / ELMHURST
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL**

Originator: Nursing	Functions: Provision of Care (PC), Rights and Responsibilities (RI), Record of Care (RC)	Index No.: PTS 83
SUBJECT: RAPID RESPONSE TEAM (RRT)		
Status: ☐ New ☒ Revised	Date Issued: 8/1/06 Date Revised: 4/07, 6/09, 1/10, 3/13, 3/15, 3/17, 2/19 Date Reviewed: 1/12	

Patient Population	Neonate		Pediatric		Adolescent		Adult	√	Geriatric	√
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I. PURPOSE:

To describe functions of Rapid Response Team

Definition – A Rapid Response Team (RRT) is a team of expert critical care clinicians available to provide urgent and emergent care to non-ICU hospitalized patients with the intent of preventing or limiting hospital complications.

II. POLICY:

- NYC Health + Hospitals / Elmhurst maintains a multidisciplinary Rapid Response Team to reduce the instance of death or disability of non-ICU patients through early identification, assessment and stabilization of individuals with deteriorating medical conditions before the patient's condition requires resuscitation/code response.
- The Rapid Response Team (RRT) provides rapid and immediate intervention in order to promote better outcomes such as: reduced cardiac and/or respiratory arrests in the hospital, reduced or timelier transfers to ICU, and reduced number of hospital deaths or complications.
- The Rapid Response Team (RRT) will educate and support staff nurses, assist with physician communication and facilitate patient admission/transfer to a more appropriate level of care once the patient has been assessed and/or stabilized.
- NYC Health + Hospitals / Elmhurst's RRT provides service to inpatients in the Medical/Surgical units, Rehabilitation, Obstetrics (Post-Partum), and Psychiatric units. They also provide service to the Radiology Department and Admitted patients in the Emergency Department.
- RRT does not service the Pediatric (Medical or Psychiatry) Inpatient units nor the Ambulatory Care / Out-Patient Departments and /or employees.

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III. RESPONSIBILITY:

A. Nurse Practitioner (NP) – RRT Team Leader

- clearly identifies him/herself to other team members as the Team Leader
- determines the course of the patient's care during the team intervention
- directs the actions of all other team members
- determines the need for additional clinical resources (anesthesiologist, physician, intensivist) to participate in the RRT
- determines the subsequent disposition of the patient. If an intensive care or step-down transfer is deemed necessary, the NP communicates to the appropriate physician about the patient's condition and why the transfer is needed.
- retains responsibility for patient care until the clinical service responsible for that patient's care arrives
- ensures that all medical treatments and medications given to the patient are documented in the RRT record online
- completes and submits RRT PI documentation
- notifies the Primary Team and/or Attending of the proceedings and outcome of the team intervention after assessment and stabilization of the patient

B. Respiratory Therapist

- responds to every RRT call
- identifies him/herself on arrival as the Team Respiratory Therapist
- responds with necessary respiratory equipment
- documents interventions in Medical Record

C. Nurse Manager

- responds to RRT call when notified
- identifies him/herself to the RRT Leader as Nurse Manager
- facilitates bed assignment, including prioritization and overflow to designated areas

D. Patient's Assigned RN

- identifies him/herself to the RRT Leader
- provides clinical data to the RRT and to the subsequent clinical service whenever appropriate
- remains with the RRT to assist in patient care, to locate equipment, to call for additional assistance, etc.

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E. Primary Clinical Service

- responds to RRT call when notified
- identifies self as Primary Clinical Service
- receives SBAR communication from RRT and takes over clinical responsibilities

F. Additional RRT Team Members

- Telecommunications – receives request for RRT; activates group page
- Central Bed Listing – if transfer is required, facilitates bed assignment and preparation
- Additional Clinical Resources – for anesthesiologist, call Operator and request (ANESTHESIA STAT, with location), for STAT Radiological services call 43717

G. The RRT Committee is responsible for recommending and revising policies and procedures, and for monitoring activities related to the provision of rapid response teams.

IV. PROCEDURE

A. Criteria For Calling RRT:

1. Staff concerned or worried about a patient's condition
2. Patient or family is concerned or worried about a patient's condition
3. Respiratory
 - Respiratory rate less than 8 or greater than 30
 - New onset difficulty breathing that does not resolve within minutes
 - Pulse oximeter reading less than 90% for more than 5 minutes (unless patient is known to have chronic hypoxemia)
 - New requirement of the patient for greater than 50% oxygen to keep saturation about 90%
4. Cardiac
 - Unexplained acute chest pain
 - Heart rate less than 40 or greater than 140 with new symptoms; or any rate greater than 160/min
 - Blood pressure less than 90 or greater than 180 Systolic or 110 Diastolic with symptoms (neurological change, chest pain, difficulty breathing)
5. Acute Neurological Change

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6. Acute loss of consciousness

- New onset lethargy or difficulty walking
- Seizure
- Slurred speech
- Sudden loss of movement or weakness of face, arm or leg
- Unexplained agitation for more than 10 minutes
- Syncope/near syncope

7. Fall

6. Other

- Failure to respond to treatment
- Acute change in color of an extremity or the whole patient (pale, dusky, gray or blue)
- Any other change in condition of serious concern to any provider, including lack of a **prompt** (2 pages within 15 minutes with no response) or satisfactory response from the responsible physician
- Bleeding

B. RRT Notification

1. Any EHC employee, patient or family may call for the RRT within the Hospital.

Note: Non-clinical employee calling the RRT may use criterion “worried about the patient.” Clinical staff when using this criterion should, however, be ready to give additional objective parameters when the RRT arrives.

2. Call **41911** clearly identify self and a call back number and state “RRT is needed in (specify floor, unit, and room # if applicable).”
3. Telecommunications will initiate a group page.
4. Standardized method utilized by clinical personnel when handing-off care to the RRT upon their arrival is **SBAR** (**S**ituation, **B**ackground, **A**ssessment and **R**ecommendation).

C. Response

1. Each departmental RRT responder must arrive to the area with equipment/treatments necessary to appropriately treat patients.
2. Team members must remain at the bedside until the RRT NP/or Primary Clinical Service indicates that their services are no longer required. The Team Leader or Primary Clinical Service has sole authority to determine that the patient is stable and that the incident is concluded.
3. Transfer of RRT coverage: If for any reason, any scheduled Rapid Response Team member cannot be available immediately to respond to a request for

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intervention, they are responsible to delegate that responsibility to another provider and notify telecommunications of that person's name and pager number. The designated RRT replacement must then respond to all RRT requests during that shift until responsibility is either transferred to the original team member or to the designated team member on the next shift.

D. Interventions Will Include But Not Limited To:

1. Airway/Breathing: oral airway, suctioning, oxygen mask, nebulizer treatment, non-invasive positive pressure ventilation (NPPV), intubation, bag mask ventilation, ABG, Chest X-ray
2. Circulation: intravenous fluid bolus, EKG, defibrillation, transfusion, CPR.
3. Immediate transfer to appropriate level of care after consultation and/or coordination with Primary Clinical Service.

E. Documentation

1. The RRT will document on the Rapid Response Team Record online.

F. Termination of Rapid Response Team Care

The RRT event will be terminated when:

1. the patient's condition is stabilized
2. an unstable patient is transferred to the appropriate unit
3. interventions are no longer needed
4. the primary care physician or designee arrives and assumes responsibility for continued patient management.

G. Performance Improvement (PI)

1. Ongoing monitoring of RRT performance will include review of individual evaluation forms, as well as aggregate analysis for tracking and trending purposes (comparisons of mortality rates, number of codes, etc.).
2. RRT data is presented during Medicine PI Committee Quarterly meetings will review conclusions, recommendations and actions.
3. Concurrent review of Team 700 arrest codes outside the ICU is conducted to evaluate and determine missed opportunities:
 - a. to recognize first signs of deterioration
 - b. to identify system issues
 - c. to effectively communicate among providers
 - d. outcomes of these codes outside the ICU will also be reviewed to determine whether such codes are preventable.
4. A database will be maintained by the Nursing Department.

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VIII. REFERENCES:

American Nurses Association (ANA), Standards for Organized Nursing Services, Washington, D.C, 2010.

Hospital Accreditation Standards (HAS): PC.02.01.19, EPs 1-4; RI.01.02.01, EP 20; RC.01.01.01.

IX. ATTACHMENTS:

None.

X. CONTROLS:

This policy will be reviewed every two years by the Nursing department with the concurrence of Internal Medicine, Medical Staff, Administration, Risk Management, and Quality Management.

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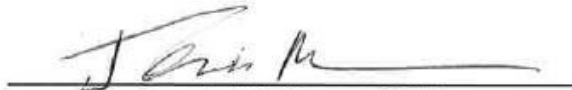
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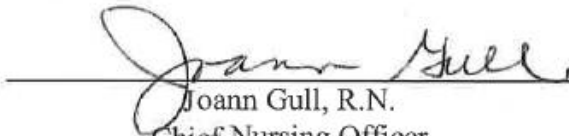
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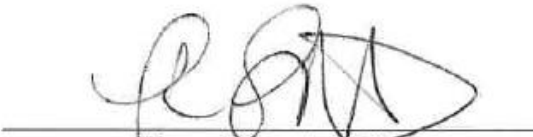
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