**GUAM MEMORIAL HOSPITAL AUTHORITY**
**ADMINISTRATIVE MANUAL**

| APPROVED BY: | RESPONSIBILITY: | EFFECTIVE DATE: | POLICY NO. | PAGE |
|---|---|---|---|---|
| Joseph Verga, MS, FACHE<br>Hospital Administrator/CEO | Medical Staff<br>Nursing Services<br>Respiratory | 02/26/2013 | A-PS500 | 1 of 10 |
| **TITLE: RAPID RESPONSE TEAM** | | | | |
| **REVIEWED/REVISED:** 01/2013 | | | | |
| **ENDORSED:** NM 04/2012; Respiratory 07/2012; PSC 09/2012; P&T 01/2013; MEC 09/2012, EMC 10/2012 | | | | |

## PURPOSE

**The Rapid Response Team** — is a team of expert clinicians that can provide effective communication with the primary physician on the patient's status and work collaboratively with primary nurse clinician to continue to improve early recognition and response to changes in patient's condition. The goal is the reduction of Code 72 events through early intervention.

## POLICY

Two clinicians (Registered Nurse-RN/Respiratory Therapist-RT) will be identified at the beginning of every shift who will be responsible for responding to outpatient and in-house adult patients who meet criteria for Rapid Response Team activation. The clinicians selected for this assignment should all be Advance Cardiac Life Support (ACLS) trained Registered Nurses. The non-Intensive Care Unit (ICU)/non-Emergency Room (ER) clinicians (RN's) selected for this task will have successfully completed the recommended training program Essentials of Critical Care Orientation (ECCO) by the American Association of Critical Care Nurses (AACN) as well as a comprehensive clinical application/demonstration of skills.

## OVERVIEW

There is a significant amount of variability in both quality of care and the safety of patients in America's hospitals today. A review of the literature and our experience reveals that three main issues contribute to the problem:

**Failure in planning** (including patient assessments and treatment plans)
**Failure to communicate** (patient to staff, staff to staff, staff to physician, etc.)
**Failure to recognize** deteriorating patient condition

These fundamental problems can often lead to a ***Failure to Rescue.*** Establishing Rapid Response Teams can impact this state of affairs by identifying unstable patients and those patients likely to suffer cardiac or respiratory arrest. If identified in a timely fashion, cardiac or respiratory arrest can often be prevented.

### Early Warning Scoring System-

An Early Warning Scoring System can improve identification of patients who are at risk in a non-ICU setting. The Early Warning Scoring System consists of simple, practical methods of using routine physiological measurements to identify patients at risk. This system facilitates the timely attendance to all such patients by those possessing appropriate skills, knowledge, and experience.

An "Early Warning Scoring System" (EWSS) will be used to more reliably identify patients in trouble and trigger the appropriate response. Effective Early Warning Scoring Systems have two essential elements:

1. They use routine physiological measurements and observations to identify patients at risk, wherever the patient may be in the care system.

2. Members of the care team, with the appropriate skills, knowledge, and experience, respond as soon as patients at risk are identified.

**Early Warning System Criteria-**

The Early Warning Scoring System uses periodic observation of selected vital sign values. When one or more extreme values are noted, a predefined action is taken—for example, the Rapid Response Team is called.

The following are the parameters that will be utilized at Guam Memorial Hospital.

| | | |
|---|---|---|
| ■ Systolic Blood Pressure | **<90** | **>200** |
| ■ Respiratory Rate | **<8** | **>28** |
| ■ Heart Rate | **<51** | **>130** |
| ■ Saturation | **<88% with supplemental oxygen** | |
| ■ Urine Output | **< 0.5ml/kg/ hour over 8 hour period** | |
| ■ Conscious Level | **Not fully alert (change from baseline)** | |
| ■ **If a patient fulfills <u>one or more</u> of the above criteria <u>OR</u> you are worried about his/her condition, page the Rapid Response Team.** | | |
| ■ **A Rapid Response Team member MUST review the patient <u>within fifteen minutes from initial notification.</u>** | | |

**PROCEDURE:**

At the beginning of each shift, there will be two qualified clinicians to respond to the Rapid Response Team. There will be a primary Registered Nurse (RN)/Respiratory Therapist (RT) response member and a secondary RN/R.T. response member identified. At the end of the shift, the team members will give the Nursing Supervisor a written summary of all calls received during the shift and outcomes of each patient. The original RRT SBAR form shall be kept on file for statistics to be reviewed by Quality Management Director.

**Unit Nurses:**

The Unit Charge Nurse should be notified by the patient's primary nurse when the decision to notify the Rapid Response Team has been made. The operator will be provided with the patient's unit and room number, as well as the reporting nurse's name. The unit charge nurse or the primary nurse will dial **3-2222** to activate the Rapid Response Team.

**Operator:**

Once the information has been received from the nurse, the operator will page overhead "Rapid Response Team, unit and room number", three times. The primary RN responder designated will respond to the Rapid Response Team call, together with a Respiratory Therapist.

**Rapid Response Team:**

Once the Rapid Response Team call has been paged overhead, the Rapid Response Team member will respond and assess the patient (this should be within 15 minutes of the initial call). The initiating nurse will provide essential information to the team member. An assessment will then be done by the Rapid Response Team members and one of several actions may take place based on the patient findings and using the Rapid Response Team Interventional Protocol. If the patient is deemed unstable, then the Attending Physician will be notified immediately. If the Attending Physician can not be contacted, then the Emergency Room Physician must be contacted for immediate intervention. The team member (or the patient's primary nurse) will notify the on-call physician using the SBAR Process. All actions and interventions will be documented on the Rapid Response Team SBAR form. This will be a part of the patient's permanent record.

**Outcomes:**

The Quality Management Department, in coordination with the Nursing Department, will provide the following monthly outcome data for review by the Hospital Performance Improvement Committee on a quarterly basis in the first year of implementation:

i. # RRT calls/month
ii. % of calls requiring transfer to a higher level of care
iii. category of triggers for RRT calls
iv. # of successful RRT calls (not needing transfer to higher level of care)/ total # of calls

**Patient/Family Education:**

Patients and their family will be guided and educated on specific roles and responsibilities involved in the Rapid Response Team approach to patient care and intervention. It is important to offer anticipatory guidance to alleviate any fears or concerns the patient or family may have during an acute event.

Patient's family can serve as a resource in the plan of care as they may readily know the patient's change in status from baseline. They can collaborate with the primary nurse and the unit charge nurse to activate the Rapid Response Team should there be a worsening in the patient's condition and criteria for activation is met.

**RESCISSION**

Policy A-PS 500, *Rapid Response Team* of the GMHA Administrative Manual made effective September 21, 2009.

**ATTACHMENT(S)**

I. Guidelines for Using the SBAR Process.
II. SBAR Documentation Form
III. Rapid Response Team Protocols
IV. Inpatient Algorithm
V. Outpatient Algorithm

## ATTACHMENT I

**Guidelines for Communicating with Physicians Using the SBAR Process**

1. Notify the Attending Physician using the standard modalities (i.e. direct call or page, via hospital operator or overhead page). Wait no longer than five minutes between attempts. Before assuming that the physician you are attempting to reach is not responding, utilize all modalities.

2. Prior to calling the physician, follow these steps:

    - Have I seen and assessed the patient myself before calling?
    - Has the situation been discussed with resource nurse or preceptor?
    - Review the chart for appropriate physician to call.
    - Know the admitting diagnosis and date of admission.
    - Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me?
    - Have available the following when speaking with the physician:

        - Patient's chart
        - List of current medications, allergies, IV fluids, and labs
        - Most recent vital signs
        - Reporting lab results: provide the date and time test was done and results of previous tests for comparison.
        - Code status

3. When calling the physician, follow the SBAR process:

    **(S) Situation:** What is the situation you are calling about?
    - Identify self, unit, patient, room number.
    - Briefly state the problem, what is it, when it happened or started, and how severe.

    **(B) Background**: Pertinent background information related to the situation should include the following:
    - The admitting diagnosis and date of admission
    - List of current medications, allergies, IV fluids, and labs
    - Most recent vital signs
    - Lab results: provide the date and time test was done and results of previous tests for comparison
    - Other clinical information
    - **Code status**

    **(A) Assessment**: What is the nurse's assessment of the situation?

    **(R) Recommendation**: What is the nurse's recommendation or what does he/she want?

    Examples:
    - Notification that patient has been admitted
    - Patient needs to be seen now
    - Order change

4. Document the change in the patient's condition and physician notification.

Guam Memorial Hospital Authority
850 Gov. Carlos Camacho Road
Tamuning, Guam 96911

# RRT-SBAR FORM

ATTACHMENT II

## S

**SITUATION**

**I am calling about**_____

**The patient's Code status is:**_____

**The problem I am calling about is:**_____

(e.g. I AM CONCERNED AND WORRIED THAT SOMETHING IS WRONG WITH THE PATIENT)

**The most current vital signs are:** **Date :** _____ **Time:**_____

Blood Pressure_____/_____, Pulse_____, oxygen saturation _____

Respiration_____, Temperature_____

**I am concerned about the:**

| | | |
|---|---|---|
| Blood pressure because it is | over 200 systolic or | less than 90 systolic or 30 mmHg below usual |
| Pulse because it is | over 130 or | less than 40 and symptomatic |
| Respiration because it is | less than 8 or | over 30 |
| Temperature because it is | less than 96 or | over 104 |
| Urine output because it is | less than 25ml/hr or 200ml/8hrs | |
| $O_2$ saturation because it is | less than 88% on _____ /liters nasal cannula or _____ | |

Other:_____

## B

**BACKGROUND**

**The patient's mental status is:**

Alert and oriented to person, place, and time, cooperative and calm
Confused, agitated, combative
Lethargic but conversant and able to follow commands
Stuporous, or _____
Comatose, Eyes closed Not responding to stimulation.

**The skin is:**

___Warm and dry _____Pale ____Mottled
___ Diaphoretic _____Extremities are cold ____Extremities are warm

**The patient is not or is on oxygen.**

The patient has been on_____ (l/min) or (%) oxygen for _____ minutes (hours)
The oximeter is reading _____ %
The oximeter does not detect a good pulse and is giving erratic readings.

## A

**ASSESSMENT**

**This is what I think the problem is:**_____

"SAY WHAT YOU THINK IS THE PROBLEM"

**The problem seems to be cardiac infection neurologic respiratory**
**I am not sure what the problem is but the patient is deteriorating.**
**The patient seems to be unstable and may get worse, we need to do something.**

## R

**RECOMMENDATION**

**From Physician** _____

_____Transfer the patient to Critical Care _____Talk to family about Code status
_____Come to see the patient at this time _____Ask a consultant to see patient now
_____Other :_____

**Are any tests needed:**

Do you need any tests like : CXR ABG EKG CBC Chem7 Blood Sugar by Accucheck____
Others:_____

**If a change in treatment is ordered then ask:**

How often do you want vital signs?
How long do you expect this problem will last?
If the patient does not get better when would you want us to call again?

## Signatures

**Primary Nurse:**_____ **Actual Time Rapid Response Team was activated :** _____

**RN Rapid Response Team Member:**_____ **Date:**_____ **Time responded:** _____

**RN Rapid Response Team Member:** _____ **Date:**_____ **Time responded:** _____

**Hospital Nursing Supervisor:** _____ **Date:**_____ **Time responded:**_____

**Respiratory Therapist: :** _____ **Date:** _____ **Time responded:** _____

**Physician:**_____**Transferred to:** _____**or remained in same room: Yes or No**

PATIENT LABEL

ATTACHMENT III

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850 Gov. Carlos Camacho Road
Tamuning, Guam 96911

# RAPID RESPONSE TEAM PROTOCOLS

**PURPOSE:** To provide clinical support and medical intervention for patients experiencing a decline in clinical status that needs immediate medical attention.

**Rapid Response Team protocols are to be initiated and used until the Attending Physician is available. If the patient condition deteriorates despite the interventions, and the Attending Physician has not yet responded, it may be necessary to alert the Emergency Room physician.**

**SUPPORTIVE DATA:**

- SYMPTOMATIC HEART RATE GREATER THAN 130 AND/OR RHYTHM CHANGES
- SUSPECTED PULMONARY STATUS DETERIORATION
- SYMPTOMATIC HEART RATE LESS THAN 60
- SYSTOLIC BLOOD PRESSURE LESS THAN 90 OR MAP LESS THAN 60
- UNCONTROLLED CHEST PAIN
- CHANGE IN MENTAL STATUS
- SEIZURES
- HEMORRHAGE/EXCESSIVE BLEEDING
- STROKE SYMPTOMS

**CONTENT:**

**A. SYMPTOMATIC HEART RATE GREATER THAN 130 AND/OR RHYTHM CHANGES PROTOCOL**

The Rapid Response Team may initiate any of the following:

1. Cardiac monitoring
2. Pulse oximetry
3. Oxygen to maintain the saturation above 92%. If the patient has a history of Chronic Obstructive Pulmonary Disease (COPD), maintain the saturation at 88-90%.
4. Establish IV access.
5. Normal Saline bolus, up to 500 ml IV (if indicated)
6. 12 Lead EKG
7. Chem 7, CBC, Magnesium level

**B. SUSPECTED PULMONARY STATUS DETERIORATION PROTOCOL**

The Rapid Response Team may initiate any of the following:

1. Stat arterial blood gas
2. Pulse oximetry
3. Oxygen to maintain the saturation above 92%. If the patient has a history of COPD, maintain the saturation at 88-90%
4. Cardiac monitoring
5. Chest X-ray
6. Establish IV access
7. Nebulized Albuterol 2.5 mg one time treatment by Respiratory Therapist
8. Bipap as tolerated, settings to be determined by Respiratory Therapist
9. Prepare for intubation

**C. SYMPTOMATIC HEART RATE LESS THAN 60 PROTOCOL WITH HYPOTENSION**

The Rapid Response Team may initiate any of the following:

1. Cardiac monitoring
2. Pulse oximetry
3. Oxygen to maintain saturation above 92%. If the patient has a history of COPD, maintain the saturation at 88-90%
4. Establish IV access
5. 12 Lead EKG
6. Transcutaneous pacing
7. Dopamine 5-20 mcgs/kg/min IV infusion

**D. (SYMPTOMATIC) SYSTOLIC BLOOD PRESSURE LESS THAN 90 OR MAP LESS THAN 60 PROTOCOL**

The Rapid Response Team may initiate any of the following:

1. Cardiac monitoring
2. Pulse oximetry
3. Oxygen to maintain the saturation above 92%. If the patient has a history of COPD, maintain the saturation at 88-90%
4. Establish IV access
5. Normal Saline to keep vein open
6. Normal saline bolus, up to 500 ml IV
7. Chem 7
8. Dopamine 5-20 mcgs/kg/min infusion to keep MAP above 65

**E. UNCONTROLLED CHEST PAIN PROTOCOL**

The Rapid Response Team may initiate any of the following:

1. Stat 12 Lead EKG. This needs to be seen by a physician immediately. (if no physician available, have someone take the EKG to the ER physician).
2. Cardiac Monitor
3. Pulse oximetry
4. Oxygen
5. Establish IV access
6. Normal Saline to keep vein open
7. Cardiac enzymes, Troponin
8. CBC, Chem 7, PT/INR, PTT (unless obtained within the last 24 hours)
9. Nitroglycerin 0.4mg sublingually. May repeat every 5 minutes up to 3 doses
10. Morphine Sulfate 2 mg IV every 5 minutes up to 5 doses for pain unrelieved by NTG

**F. CHANGE IN MENTAL STATUS PROTOCOL**

The Rapid Rseponse Team may initiate any of the following:

1. Cardiac monitoring
2. Pulse oximetry
3. Oxygen to maintain the saturation above 92%. If the patient has a history of COPD, maintain the saturation at 88-90%
4. Establish IV access
5. Normal Saline to keep vein open
6. Fingerstick blood sugar, if blood sugar less than 60mg/dl, give D50Water one ampule IV push
7. 12 Lead EKG
8. Narcan 0.2mg IV for suspected opiate overdose, may repeat 0.2mg every 2 minutes up to 0.4mg
9. Romazicon 0.2mg IV over 15 seconds for suspected benzodiazepine overdose, may repeat 0.2mg every one minute up to 1 mg.

**G. SEIZURE PROTOCOL**

The Rapid Response Team may initiate any of the following:

1. Cardiac monitoring
2. Pulse oximetry

3. Oxygen to maintain saturation above 92%. If the patient has a history of COPD, maintain the saturation at 88-90%
4. Establish IV access
5. Normal Saline to keep vein open
6. Fingerstick blood sugar, if blood sugar less than 60mg/dl, give D50Water one ampule IV push
7. Lorazepam 1mg IV every 5 minutes times 3, up to 3 mg for seizures

## H. HEMORRHAGE/EXCESSIVE BLEEDING PROTOCOL

The Rapid Response Team may initiate any of the following:

1. Cardiac monitoring
2. Pulse oximetry
3. Oxygen to maintain saturation above 92%. If the patient has a history of COPD, maintain the saturation at 88-90%
4. Establish IV access (preferably a large bore)
5. Normal Saline to keep vein open
6. Normal Saline bolus, up to 500 ml IV
7. CBC, Chem 7, PT/INR, PTT, type and screen. If the patient is hemodynamically unstable (heart rate greater than 120 or blood pressure less than 90), change the type and screen to type and cross match 2 units packed red blood cells (PRBC)
8. 12 Lead EKG

## I. STROKE SYMPTOM PROTOCOL

The Rapid Response Team may initiate any of the following:

1. Cardiac monitoring
2. Pulse oximetry
3. Oxygen to maintain the saturation above 92%. If the patient has a history of COPD, maintain the saturation at 88-90%
4. Establish IV access
5. Normal Saline to keep vein open
6. CBC, Chem 7, PTT,PT/ INR
7. 12 Lead EKG
8. Fingerstick blood sugar, if blood sugar less than 60 mg/dl, give D50Water one ampule IV push
9. Prepare patient for CT scan

*ATTACHMENT IV*

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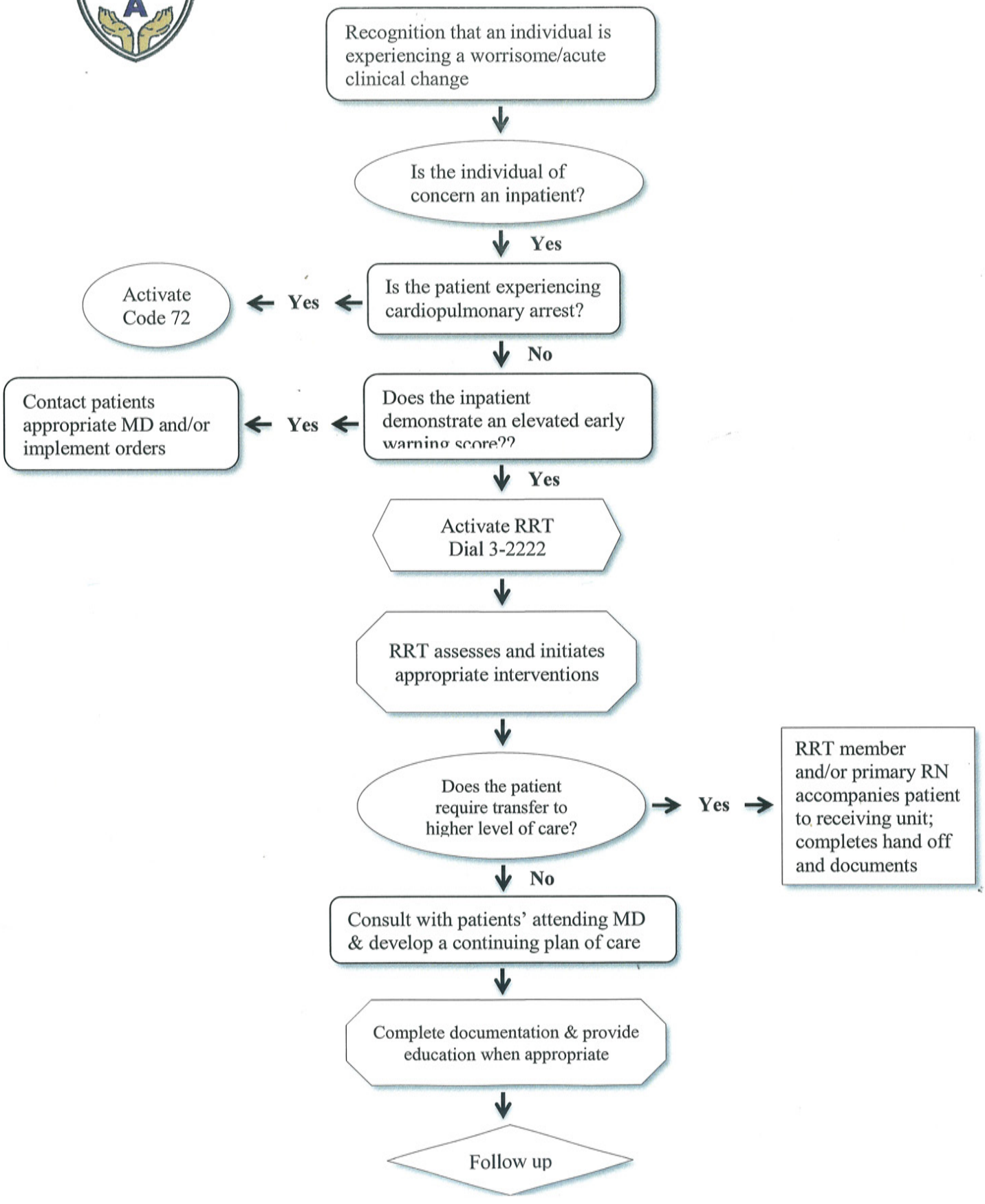
**Inpatient Algorithm**



*ATTACHMENT V*

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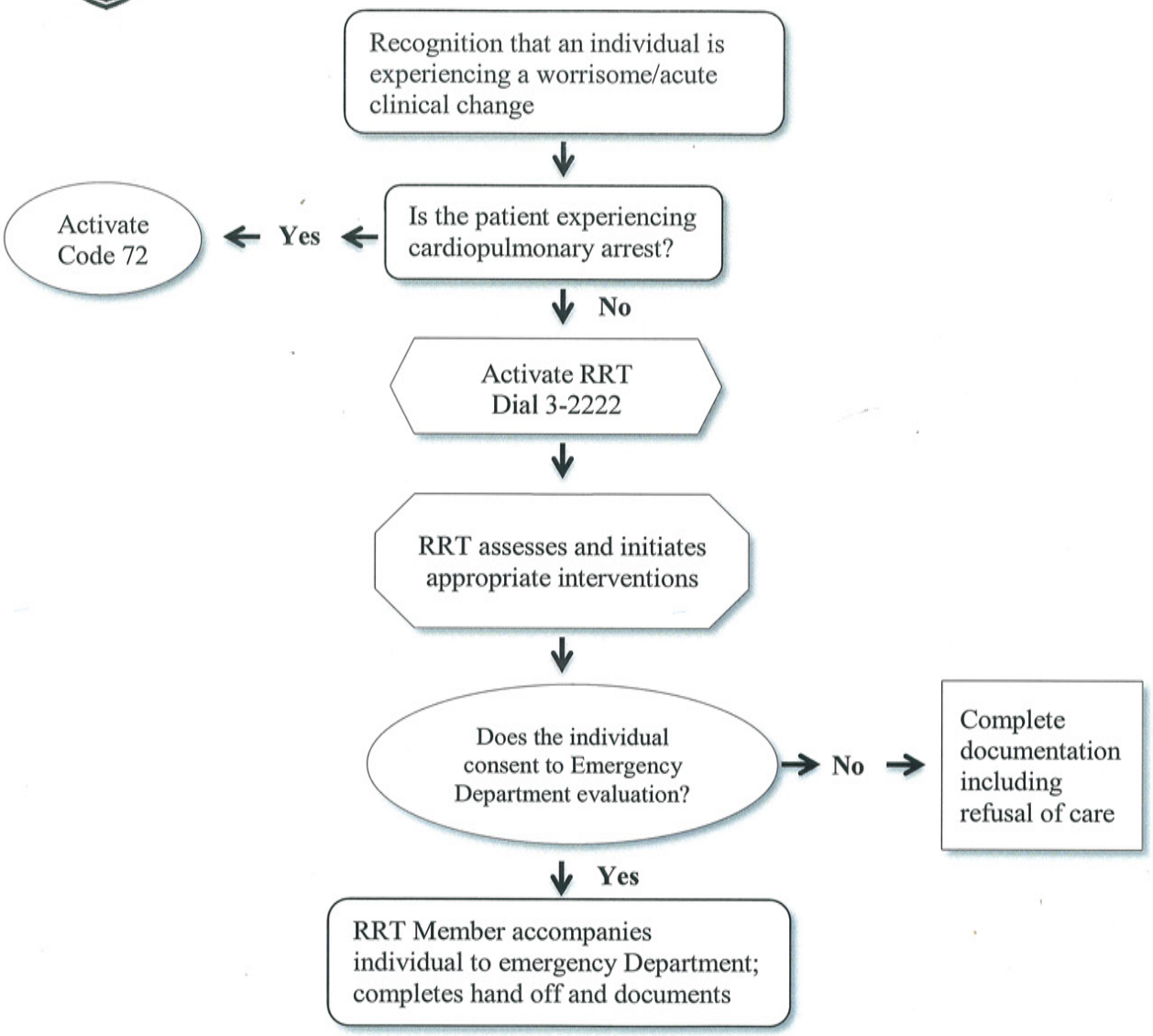
**Out Patient Algorithm**



**GUAM MEMORIAL HOSPITAL AUTHORITY**
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and endorsed the following:

☐ Bylaws
☐ Rules and Regulations
✓ Policies and Procedures

Submitted by
Department/Committee: Nursing Services Department
Title: Rapid Response Team
Policy Number (if applicable) A-PS500

| | Date | Signature |
|---|---|---|
| Reviewed | 4/25/2012 | |
| Approved | 4/25/2012 | |
| Title | Christine Tuquero, MSN, RN<br>Assistant Administrator of Nursing Services, Acting | |
| Reviewed | 7/20/2012 | |
| Approved | 7/20/2012 | |
| Title | Angie Gaminde, RRT/NPS<br>Respiratory Department, Chief Respiratory Therapist | |
| Reviewed | 9/14/12 | |
| Approved | 9/14/12 | |
| Title | Steven Baacke<br>Patient Safety Copmmittee Chairperson | |
| Reviewed | | |
| Approved | 9/28/12 | |
| Title | Jonathan Sidell, MD<br>Medical Executive Committee, President | |
| Reviewed | 10/23/12 | |
| Approved | JOSEPH VERGA<br>~~REY M. VEGA~~, Hospital Administrator/CEO, Interim | |
| Title | Chairman, Executive Management Council | |

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REVIEW AND ENDORSEMENT CERTIFICATION
PAGE 2

The signatories on this document acknowledge that they have reviewed and approved the following:

□ Bylaws Submitted by: Nursing Services Department

□ Rules & Regulations Policy No./Title: A-PS500 Rapid Response Team

☑ Policies & Procedures

| | Date | Signature |
|---|---|---|
| Reviewed | | |
| Endorsed | 01/16/13 |  |
| Title | Thomas Shieh, MD<br>Pharmacy & Therapeutics Committee Chairperson | |

| | Date | Signature |
|---|---|---|
| Reviewed | | |
| Endorsed | | |
| Title | | |

| | Date | Signature |
|---|---|---|
| Reviewed | | |
| Endorsed | | |
| Title | | |

| | Date | Signature |
|---|---|---|
| Reviewed | | |
| Endorsed | | |
| Title | | |

***Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer.**