CHRISTUS. SANTA ROSA Health System	PRIMARY FUNCTION: NURSING – **Nursing Clinical Practice**	POLICY# CO-NU-00-55
	EFFECTIVE DATE: 9/2006	PAGE 1 OF 3
LAST REVIEW DATE: 11/2010	REVISION DATE: 11/2010, 05/2015	
SUBJECT: **RAPID RESPONSE TEAM (RRT)**		

PURPOSE

To describe the CSRHC 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.

POLICY

1. The RRT will be composed of a critical care/ED RN and a respiratory therapist.

2. The RRT may be activated by personnel in any inpatient or outpatient unit or ancillary area.

3. The nursing supervisor will respond to the site of the call to assess the potential needs of the patient and team..

PROCEDURE:

1. To activate the RRT:
   - Associate will call:
     - 4-8888 at the Westover Hills and Medical Center campus
     - 3-8888 at the New Braunfels campus
   - Provide the operator with the room number and ask the operator to call the Rapid Response Team code pager or page the team overhead (as appropriate for the specific campus)
   - Members of the appropriate RRT will immediately respond to the site of the call.

2. Calls to the operator activating the RRT may not be cancelled.

3. Education and training requirements for the RRT:

A.

Registered Nurse	Respiratory Therapist
• Current BLS • Current ACLS/PALS • Critical care experience 2 years • Completion of RRT orientation	• Current BLS • Current ACLS/PALS • Completion of RRT orientation

B. The RRT orientation will include 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 will receive education and training relative to their role in summoning the RRT and expectations after their arrival. Education will include:

- 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 arrives, the patient's chart, medication administration record (MAR) and current documentation will be immediately available. The patient's physician/resident will also be immediately notified by the patient's staff nurse.

5. The nurse calling the RRT will become a key member of the team, accompanying them to the patient's bedside and offering whatever assistance is necessary. THE RAPID RESPONSE TEAM IS NOT THERE TO TAKE OVER AND ASSUME CARE OF THE PATIENT.

6. Criteria for calling the adult Rapid Response Team:
   - 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
   - Decrease in urine output < 50 ml over 4 hours
   - Chest pain
   - Change in level of consciousness/acute seizure activity

7. The RRT and the patient's nurse will keep the attending physician informed of any change in condition and the results of protocol interventions.

8. The RRT will remain with the patient and manage the change in condition for a maximum of 45 minutes. If the patient has not stabilized within that period of time, the PFC/nursing supervisor will be notified of the need to transfer the patient to a higher level of care. The patient's attending physician will also be notified of the need for transfer.

9. Response protocols will be delineated in printed protocol/order format. The RRT will access the protocol, indicating the interventions performed. The protocol will be placed in the physician order section of the medical record for physician signature.

10. Protocols will be reviewed annually by members of the Resuscitation Committee and appropriate medical staff committees. Revisions will be based on a review of outcome data and evidence-based practice recommendations. Protocols will be presented to the CSRHC Medical Board for final approval.

11. Outcome data relative to subsequent cardiopulmonary arrest rate, and discharge outcomes will be collected and reviewed by the PIC and the Resuscitation Committee.

CHRISTUS. SANTA ROSA Health System	PRIMARY FUNCTION: NURSING – Nursing Clinical Practice	POLICY# CO-NU-00-55
	EFFECTIVE DATE: 9/2006	PAGE 3 OF 3
LAST REVIEW DATE: 11/2010	REVISION DATE: 11/2010, 05/2015	
SUBJECT: **RAPID RESPONSE TEAM (RRT)**		

DEFINITIONS

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

HISTORY

New policy effective 09/2007, revised to reflect addition of CSR-NB and CSR-WH 8/2009. Revised November, 2010 to reflect protocol review. Revised 2015 to reflect emergency numbers.

APPROVAL:

Ken Haynes, CEO

Patricia Toney MSN, RN

Patricia Toney, MSN, RN, CNE