Policies and procedures are guidelines and are not a substitute for the exercise of individual judgment. If you are reading a printed copy of this policy, make sure it is the most current by checking the on-line version.

TITLE
CLIN_190 RAPID RESPONSE TEAMS – ADULT AND PEDIATRIC

APPLICABILITY
The following Edward Hospital units:

<table>
<thead>
<tr>
<th>In-Patient Units</th>
<th>Other Units/Departments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTU 2, 7 and 8</td>
<td>Ambulatory and Surgical Care Center</td>
</tr>
<tr>
<td>Labor &amp; Delivery</td>
<td>Interventional Suites</td>
</tr>
<tr>
<td>Medical/Oncology</td>
<td>Endoscopy</td>
</tr>
<tr>
<td>Medical/Surgical</td>
<td>PACU</td>
</tr>
<tr>
<td>Mother Baby*</td>
<td>Pediatrics Special Procedures</td>
</tr>
<tr>
<td>Orthopedic/Spine</td>
<td>Radiology Specials</td>
</tr>
<tr>
<td>Pediatrics/PICU</td>
<td></td>
</tr>
<tr>
<td>Short Stay</td>
<td></td>
</tr>
</tbody>
</table>

*Adult RRT responds to issues involving mothers and the Pediatric RRT responds to issues involving newborns.

POLICY STATEMENT(S)
Provide a structure to mobilize resources and provide prompt clinical support for an unstable adult or pediatric patient in a non-critical care setting.

DEFINITION(S)

**Adult Rapid Response Team (RRT):** A team of designated professionals that may include a Critical Care Nurse, Respiratory Therapist, Pharmacist, Advance Practice Nurse or Hospitalist who respond to staff concerns about the change or substantive deterioration in a patient’s condition with the primary focus of assisting the bedside nurse with rapid assessment, communication and stabilization of the patient. Excludes obstetrical emergencies as outlined by the Emergency/Crash Cesarean Section Response Team.

**Pediatric Rapid Response Team (PRRT):** A team of designated professionals that may include a Pediatric Intensive Care Nurse, Neonatal Intensive Care Nurse, Respiratory Therapist, Pharmacist, and Pediatric Hospitalist who respond to staff concerns about the change or substantive deterioration in a pediatric patient’s condition (newborn to 17 years of age) with the primary focus of assisting the bedside nurse with rapid assessment, communication and stabilization of the patient.

**Hospitalist:** An in-house physician specialized in the management of adult inpatients.

**Pediatric Hospitalist:** An in-house pediatrician specialized in the management of inpatient pediatric patients.

**SBAR Communication Technique:** A format designed to expedite verbal communication in which the details are organized as follows: **Situation, Background, Assessment and Recommendations.**

PROCEDURE
I. **Guidelines when to call the Adult or Pediatric Rapid Response Team**
   A. The RRT/PRRT is called by a clinician when concerned about a significant change or
deterioration in a patient’s condition. The below listed conditions are guidelines for calling the Adult or Pediatric RRT that should be used in conjunction with the clinician’s judgment. The presence of these conditions will not always necessitate calling the RRT/PRRT if in the clinician’s judgment appropriate resources are present. The RRT/PRRT can be, but does not have to be, accessed if treatment of the patient’s deterioration would be inconsistent with the patient’s advance directives.

Criteria:
The clinician has the discretion to call the RRT/PRRT for any reason even if the below guidelines have not been met.

Adult Criteria
1. Acute change in heart rate less than 40 or greater than 130 BPM
2. Acute change in systolic blood pressure less than 90mmHg or greater than 200mmHg
3. Acute change in respiratory rate less than 8 or greater than 28 per minute
4. Acute change in saturation less than 90% despite oxygen therapy of two liters per nasal cannula
5. Acute change in conscious state or mental status
6. Acute change in neurological status

Infant/Pediatric Criteria (See appendix A for age specific guidelines)
1. Acute change in heart rate
2. Acute change in systolic blood pressure
3. Acute change in respiratory rate
4. Acute change in oxygen saturation and/or oxygen requirements.
5. Acute change in neurological status.

II. Mechanism for calling the Adult or Pediatric RRT
A. Activate the RRT/PRRT by dialing 75555 and request either the Adult Rapid Response Team or the Pediatric Rapid Response Team to the specific patient’s room number. The operator clarifies the specific team needed prior to terminating the phone call if not designated by the caller.
B. The operator sends an alpha-numeric page to the RRT or the PRRT members. An overhead page is used in the event that the alpha-numeric paging system is not functional.

III. Roles of the Care Team Members
A. Bedside Nurse:
1. Have chart available for RRT/PRRT when they arrive (as time permits).
2. Identify the specific concerns and work with the RRT/PRRT to assess the patient’s condition and identify actions which need to be taken.
3. Communicate with the primary care physician/consulting physician regarding the situation using the SBAR communication format.
4. Document the patient’s condition, actions taken, and patient’s response in nursing assessment, transfer to another unit and/or nursing notes as appropriate.
B. Critical Care Nurse/Pediatric Intensive Care Nurse/Neonatal Intensive Care Nurse:
1. Communicate with the bedside nurse about concerns regarding the patient.
2. Assess the patient and communicate findings with the bedside nurse. Assessment
may be focused or complete based on the patient’s presenting symptoms.

3. Identify necessary actions based on the assessment.
4. Implement interventions for which standing orders/protocols exist or communicate with the APN, Hospitalist, or Primary Physician to obtain orders as necessary.
5. Assist the bedside nurse with communication using the SBAR format when contacting the primary care physician/consulting physician.
6. Complete the Adult/Pediatric Rapid Response Team Record, distribute the original to the patient chart and retain a copy for Adult/Pediatric RRT data tracking purposes.
7. Coordinate events during the Adult/Pediatric RRT’s presence.

C. Advance Practice Nurse (APN)/Hospitalist:
   1. Communicate with the bedside nurse, critical care nurse, pediatric intensive care nurse, neonatal intensive care nurse, and share any patient specific information the APN/Hospitalist may have.
   2. Assess the patient and work with critical care nurse, pediatric intensive care nurse, neonatal intensive care nurse and bedside nurse to identify necessary actions for the patient.
   3. Initiate orders as appropriate based on assessment and scope of practice.
   4. Communicate with the Primary Care Physician any changes in patient condition/status, treatment, etc.
   5. Hospitalists respond 1700-0700 Monday through Friday and weekends/holidays 24 hours. APNs respond to calls on their patients when they are on campus and available.

D. Respiratory Therapist:
   1. Assess airway.
   2. Implement interventions for which standing orders/protocols exist or communicate with the APN or Hospitalist to obtain orders as necessary.
   3. Monitor the effectiveness of oxygen therapy and changes in therapy.

E. Pharmacist:
   1. Communicate with team pertinent drug information and treatment recommendations based on patient’s clinical status and availability of the medications.
   2. Calculate medication dosages and administration rates.
   3. Distribute medications ordered for patient.

F. Primary Care Physician/Consulting Physician:
   1. Communicate changes in patient condition/status, treatment, etc. to the Primary Physician/Consulting physician.

CROSS REFERENCE(S)
CLIN_050, Do Not Resuscitate (DNR) Order
CLIN_120, Advance Directives
6055_001, Emergency/Crash Cesarean Section Response Team

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Previous Policy No.: NA
Policy Creation Date: 12/05/2005
Most Recent Review/Revised Date: 06/04/2012
Approved by: Edward Medical Executive Committee, 02/15/2006
Appendix A Infant/Pediatric Criteria age specific guidelines

### Normal Vital Signs: Heart Rate

<table>
<thead>
<tr>
<th>Age</th>
<th>Awake Rate</th>
<th>Sleeping Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn-3 months</td>
<td>85-205</td>
<td>80-160</td>
</tr>
<tr>
<td>3 months-2 years</td>
<td>100-190</td>
<td>75-160</td>
</tr>
<tr>
<td>2-10 years</td>
<td>60-140</td>
<td>60-190</td>
</tr>
<tr>
<td>Greater than 10 years</td>
<td>60-100</td>
<td>50-90</td>
</tr>
</tbody>
</table>

### Normal Vital Signs: Respiratory Rate

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>30-60</td>
</tr>
<tr>
<td>Toddler</td>
<td>24-40</td>
</tr>
<tr>
<td>Preschooler</td>
<td>22-34</td>
</tr>
<tr>
<td>School age</td>
<td>18-30</td>
</tr>
<tr>
<td>Adolescent</td>
<td>12-16</td>
</tr>
</tbody>
</table>

### Normal Vital Signs: Blood Pressure - Hypotension

<table>
<thead>
<tr>
<th>Age</th>
<th>Systolic Blood Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-28 days (neonate)</td>
<td>Less than 60</td>
</tr>
<tr>
<td>1-12 months (infant)</td>
<td>Less than 70</td>
</tr>
<tr>
<td>1-10 years</td>
<td>Less than 70 + (age in years x 2)</td>
</tr>
<tr>
<td>Greater than 10 years</td>
<td>Less than 90</td>
</tr>
</tbody>
</table>

### Signs of Respiratory Distress

- Increased respiratory rate
- Nasal Flaring
- Retractions
- Grunting
- Color Changes
- Diaphoresis
- Wheezing
- Acute change in oxygen saturation and/or oxygen requirements

### Early Signs of Shock

- Increased heart rate from baseline
- Poor systemic perfusion: capillary refill greater than 2 seconds
- Possible increased BP
- Fever or hypothermia
- Tachypnea
- Increased or decreased WBC, or increased bands

### Signs of Neurological Status Change

- Irritability
- New onset/prolonged seizure activity
- High pitched cry
- Headache
- Vision changes: nystagmus, sunset eyes, disconjugate gaze
- Nausea & vomiting
- Altered level of consciousness