



Paris Community Hospital Family Medical Center

Policy Title: Rapid Response Team/ Code Blue	
Department/Scope: All Departments	Page 1 of 9
Replaces Policy Dates: See all electronic dates	Original Issue Date:11/19/2007
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PURPOSE:

- To outline Rapid Response Team's (RRT) duties, and to define the role of each team member.
- To list criteria to be utilized by the RRT team and other members as defined by the Code Blue or Rapid Response Team (RRT) called
- To improve patient outcomes by early identification of progressively deteriorating and/or clinically unstable by providing a dedicated multidisciplinary team that rapidly assesses and intervenes for each patient.

POLICY:

- The Rapid Response Team (RRT) of critically trained staff will assist with and evaluate any patient in the hospital who has clinically compromised values.
- The RRT may be summoned at any time by anyone in the hospital if there is a question or concern regarding the patient's condition.
- This team development is based on the Institute of Healthcare Improvement (IHI) campaign and NPSG's of TJC to save lives.
- The purpose of the team is to improve the clinical outcome of the patient who is clinically compromised or in a potentially critical situation, to use a proactive nursing assessment approach to clinical data, to communicate this data to the physician, and together determine the best ongoing treatment for the patient.
- There is a designed RRT for every shift that will respond to any Code Blue or RRT (patient in critical condition)
- The staff may announce overhead on the PA by dialing 88, or pressing code blue button in any area that has one, family may activate the RRT by dialing RRT (778)
- **For Code Blue events the hospital staff will begin cardiopulmonary resuscitation until the RRT arrives to manage the patient with Advanced Cardiopulmonary Life Support (ACLS/PALS) protocol or Pediatric Advanced Life Support (PALS).**
- If the physician has written an order for "Do Not Resuscitate", then a Code Blue will not be initiated but if needed staff may deploy the RRT for the patient, the patient/ family may also deploy the RRT by dialing the RRT= 778
- For RRT the *Situation, Background, Assessment and Recommendation (SBAR) either for Pediatric or Adult patients* tool will be utilized (Addendum attached). The staff may be trained in initial orientation on the use of SBAR and in an ongoing basis as per manager's discretion.

For Code Blue please utilize the code recording sheet (Addendum) as attached.

- Upon admission the patient or caregiver should be told by the staff, "If your medical condition changes you will need to use the call light, and call for your nurse immediately. If the response is not timely, you can dial 778 (RRT) and tell the hospital staff you need help." This information will also be communicated in patient areas in the hospital, in the welcome packet and upon admission to the hospital (Addendum attached).

*The RRT team may consist of: (those highlighted must attend)

1. Respiratory Care Practitioner (RCP) *if available
2. Hospital Supervisor *if available
3. Hospitalist/ ER physician from the ER (MD)
4. Lab technician *if available

5. Pharmacy department *if available
6. Anesthesia CRNA *if available
7. Department manager or designee *if available
8. Emergency Room experienced Registered Nurse (RN)
9. Direct Care Nurse caring for patient at the time of the incident if inpatient
10. This team will evaluate all patients under the RRT/ Code Blue/Pink situation.
11. The team may contact the patient's physician
12. The team may assist staff with the care of the patient until the critical situation and/or patient is stabilized.
13. ** RCP, Pharmacy department, departmental managers and designees, anesthesia, and house supervisor are not scheduled 24/7 at PCH, if they are present when a code is called they may be required or asked to assist.*

PROCEDURE:

I. Rapid Response Team members and duties:

1. Duties to be performed
 - a. Crash Cart- ER RN, ED Manager(designee)
 - a. Pediatric code/RRT bring the Broselow bag
 - b. Will bring a crash cart to the Code/RRT if called in an area that does not provide a crash cart (see list of where carts are located to bring)
 - b. Team Lead duty- Hospitalist/ ER physician, House Supervisor, ED manager (designee)
 - c. Monitor duty- ED manager (designee), ED RN, House Supervisor, any manager
 - d. Medication duty- ED RN, Primary Nurse, unit manager,
 - e. Airway management- Hospitalist/ ER physician
 - f. Documenter/Recorder of event: ED RN, Primary RN, House Supervisor , any manager, see attachments RRT pediatric sheet (addendum E) RRT adult sheet (addendum F)
 - g. BLS/ACLS/PALS/PALS initiation- team lead, ED RN, ED Manager (designee)
2. Team Members role as defined by but not limited to:
 - a. The unit manager may respond to assist and may assist with debriefing of the RRT and ensure all proper paperwork and documentation is completed.
 - b. A Respiratory Care Practitioner who will respond to every "Condition" *code when available (as they are not scheduled 24/7)* will assist with providing respiratory interventions and securing patient's airway as defined by their job description.
 - c. The Hospital Supervisor, who will respond to every "Condition" *code when available (as they are not scheduled 24/7)*, will guide the team to work swiftly, will ensure documentation of the RRT code sheet is completed and may perform an RRT debriefing post RRT.
 - d. The Hospital Supervisor will collaborate with the ER Nurse RN and team for data collection and may assist in the assessment and implementation of any interventions necessary as ordered by the physician.
 - e. An ER experienced RN who will respond to every "Condition" code, will assess the patient and help with the implementation of the interventions as ordered by Hospitalist/ ER physician, may assist in calling the physician and receiving any orders, and may assist with transfer of the patient, if necessary, to a more acute hospital setting based on condition of patient and physician orders.
 1. ER RN may act as the team lead role in the absence of the Hospitalist/ ER physician
 2. In the event of a Pediatric RRT, the ER RN/ Manager / or House supervisor staff who is PALS certified may respond
 3. The ER RN will bring the pediatric Broselow bag
 4. May need to enact in the duty of administering medications as needed or required during code/RRT call.

- f. The Emergency Department/ Hospitalist/ ER physician (ED) will respond to any Code Blue or RRT
 1. If unable to respond due to an emergency situation in The ED, an ED nurse will notify the unit.
 2. The role of the physician is airway management, if needed by the condition of the patient/individual.
 3. The physician will direct the team in the care of the patient, based upon the SBAR.
- g. Anesthesia (CRNA) may need to respond while in-house (on duty) to RRT and Code Blue
- h. The RRT will work in collaboration with the Primary RN and staff to ensure that the patient is taken care of holistically.
 1. Ensure documentation is adequate via paper, electronic
- i. Role of the Primary Nursing Staff in RRT:
 1. Use of the *SBAR Tool* (See Addendums attached)
 2. Utilize the criteria established to call the RRT
 3. Primary Nurse will be available during RRT Code
 4. Work collaboratively with RRT and give a detailed quick report of patient
 5. Provide patient information and have patient chart and history available
 6. Use of Medication Administration Record
 7. Assessment of the RRT in the medical record
 8. Notify the family and physician
 9. The Primary nurse may need to remain close to help facilitate notification of physician and act as liaison with family.

● Initiation of RRT adult or child in response to an actual cardiac or respiratory arrest

- A. Identify that the person is breathless and/or pulseless.
- B. Summon help from the nearest source. One or more persons will immediately begin Cardiopulmonary Resuscitation (CPR) until the RRT arrives.
- C. One person should go to the nearest telephone and dial RRT 778 to access the hospital staff person or the person should push the code button located in areas where there is a code blue button.
- D. After calling 778, inform the PCH/FMC staff person there is a RRT and give the exact location of the patient
- E. The PCH/FMC staff may announce Code Blue via overhead page by dialing 88.
- F. The RRT may become the Code team with roles as defined
- G. The RRT may initiate the ACLS/PALS protocol if needed.
- H. The Primary nurse may need to remain close to help facilitate notification of physician and act as liaison with family.

● Reasons a team may be activated include but not limited to the following:

- Caregiver or family member is concerned about the patients clinical status
- Acute changes in VS from previously recorded or baseline parameters
- For any Stroke like symptoms
- For any suspicious chest pain
- Respiratory distress/ decrease in oxygen saturation
- Mental status change, changes the LOC, seizure activity
- Sudden onset or acute increase in pain
- Failure to respond to treatment

● Documentation Process:

1. The team is to utilize the approved RRT order set guide (the house supervisor/ or manager will provide a copy of the order set to be utilized during the RRT event)
2. RRT will be documented in computer with details surrounding the event and outcome by the primary nurse
3. After the RRT the team may need to participate in a debriefing
4. If a RRT is called in areas in the hospital or adjacent to the hospital that do not house Emergency carts, a certified ACLS/PALS employee will take an Emergency Cart from the Emergency Department. Use of the med/surg, OR, and ER crash cart are options to utilize for the ER RN: list non inclusive to
 1. Downstairs departments, Cafeteria, Purchasing, CSS etc.
 2. Wound center, Infusion Center, VSC, ER waiting, Front desk, Lab, Radiology, FMC, Cardiac stress unit
 3. Med/Surg crash cart is closest to PT department, Outpatient waiting area, MRI, and OR waiting area

● Data Collection: There is an RRT order set sheet that has necessary information that must be completed:

- Date
- Location
- Unit/Room if applicable
- Time called
- Time the RRT team arrived
- Reason for the RRT
- Who called the team, staff, patient or family
- Time the RRT ended
- Outcome of patient post RRT
 - Did they stay on the unit
 - Transfer to another unit
 - Change in code status
 - Other
- A copy of the RRT order set is copied and sent to the staff development office
- Staff Development/Education department role:
 - Review information
 - Audit information regarding code
 - Ensure timeliness of team arrival
 - Monitor outcome of patient immediately and post discharge--for readmission/or another RRT/ Code Blue call

RRT for a patient clinically compromised or in a potentially critical situation:

A. Criteria for initiation RRT for an adult patient (age 13 years and older) may include, **but are not limited to the following:**

1. Staff worried about patient
2. Change in heart rate less than 40 beats per minute (bpm) or greater than 130 bpm
3. Change in systolic blood pressure less than 90 millimeters (mm) Mercury (Hg)
4. Change in respiratory rate less than eight or greater than 28 breaths per minute
5. Change in oxygen saturation less than 90% despite oxygen usage
6. Change in level of consciousness
7. Change in urine output of less than 50 milliliters in four hours
8. Unknown seizure activity
9. Failure to respond to any treatment
10. Acute bleeding
11. Change in neurological status
12. Symptomatic hypovolemia

13. Symptomatic hypoglycemia blood glucose level <60 in adult patients especially with changes in mental status, confusion, slow to respond)

B. Criteria for initiation of RRT for a Pediatric patient (age 12 years and under) may include, but are not limited to the following:

1. Staff worried about patient
2. Change in heart or respiratory rates.
3. Change in oxygen saturation less than 90% despite oxygen usage
4. Change in level of consciousness
5. Change in output
6. Unknown seizure activity
7. Failure to respond to any treatment
8. Acute bleeding
9. Symptomatic hypoglycemia <40 in pediatric patients

If any patient's condition deteriorates in the presence of the RRT, then a Code Blue may be initiated by the RRT following ACLS/PALS protocol

Components of the RRT:

- a) Immediate Response
- b) Nonjudgmental
- c) Accessible and onsite
- d) Critical care skills
- e) ACLS/PALS certified staff available
- f) Quick assessment and evaluation of patient completed and documented

RRT Audit: *RRT Team Record sheet is on The Pulse under Forms*

The purpose of Audit: is to collect data on effectiveness of response to change or deterioration in a patient's condition, measures may include length of stay, response time for responding, changes in VS, arrest, code status etc.

1. Utilize the RRT Team Record Sheet
2. All copies go to the professional Development coordinator
3. This sheet is NOT part of the patients record, all information regarding the RRT call, must documented in the patients electronic record, or on downtime patient documentation records.
4. *The RRT Record sheet include written criteria for describing early warning signs or deterioration in patient medical condition and when staff or family should seek immediate attention. (the criteria are outlined as above and are NOT limited to just those warning signs, if as a staff person you need to assistance with a patient because of medical condition change, call the RRT immediately)
5. The RRT Team Record Sheet must include all the following and completed before turning in to the staff development office:
 - a. Date
 - b. Room
 - c. Unit
 - d. Time called
 - e. Time team arrived
 - f. Time RRT ended
 - g. Primary Reason for call
 - h. VS on arrival
 - i. Situation (free text what lead up to the event, describe in detail)
 - j. Background (any historical data including what is on the sheet be detailed)
 - k. Assessment (findings on the assessment, and ongoing assessment of the patient with times if necessary)
 - l. Recommendation/Interventions: what did the team decide to implement at the time (THESE are not orders, anything that requires an order must be written as an order, this is for documentation of the events and interventions utilized based on physician intervention).
 - m. If Medications were "ordered" please document the time, dose, route, dose and drug, these are to be documented electronically as they are to be given on any patient in that area.
 - n. Outcome- immediate disposition of the patient must be documented
 1. Additional outcomes are monitored for RRT's the patient will be monitored for 24 hour outcomes and discharge outcomes by staff development office.
 - o. Attending Physician name/ notification and any other physicians that joined the RRT.
 - p. Document the RRT team members including the primary care nurses present.
 - q. You may document any additional information or notes
 - r. Document your name, title and date.

6. RRT Debriefing/ opportunities if any identified/ recognized
 - a. Immediately post RRT call assessments and interventions are completed and outcome of patient is determined, the house supervisor or unit manager may lead the team into a quick discussion of the case to determine that all pertinent information was documented and completed during the RRT and to see if there is an opportunity to ensure that flow of the event was successful
 - b. Documentation of any opportunities will be forwarded to staff development specialist for the RRT audit and/or identification of any educational needs

7. See attachments for SBAR documentation and communication for adult and pediatric conditions/ the code blue documentation sheet *the RRT order set can be accessed from the house supervisor, manager, and forms folder on The Pulse.

PCH/FMC-SBAR report to physician about an Adult-critical situation

S	<p><u>Situation</u> I am calling about <patient name and location>. The patient's code status is <code status>. The problem I am calling about is _____ I am afraid the patient is going to arrest.</p> <p>I have just assessed the patient personally: _____</p> <p>Vital signs are: Blood pressure _____ / _____, Pulse _____, Respiration _____ and Temperature _____</p> <p>I am concerned about the potential VS readings of and of any symptomatic: Blood pressure because it is over 200 _____ or less than 90 or 30 mmHg below usual. Heart rate because it is over 130 or less than 40. Respiration because it is less than 8 or over 28. Temperature _____</p>
B	<p><u>Background</u> The patient's mental status is: Alert and oriented to person, place and time. Confused and cooperative or non-cooperative. Agitated or combative. Lethargic but conversant and able to swallow. Stuporous and not talking clearly and possibly not able to swallow. Comatose. Eyes closed. Not responding to stimulation.</p> <p>The skin is: Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm</p> <p>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.</p>
A	<p><u>Assessment</u> This is what I think the problem is: <say what you think is the problem> The problem seems to be: cardiac, hypoglycemic, sepsis, neurological, 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.</p>
R	<p><u>Recommendation</u> I suggest or request that you: <say what you would like to see done>. Transfer the patient to critical care. Come to see the patient at this time. Talk to the patient or family about code status. Ask for a consultant to see the patient now.</p> <p>Are any tests needed: Do you need any tests like: CXR, ABG, EKG, CBC, or BMP? Others?</p> <p>If a change in treatment is ordered then ask: How often do you want vital signs? Is there anything else you would like to be done at this time? I will call you back in _____ (amount of time).</p>

PCH/FMC-Pediatric SBAR report to physician about a Pediatric critical situation

S	<p><u>Situation</u> I am calling about <patient name and location> _____. The patient's code status is <code status> _____. The problem I am calling about is _____.</p> <p>I am afraid the patient is going to arrest. I have just assessed the patient personally:</p> <p>Vital signs are: Blood pressure <u> </u>/<u> </u> , Pulse <u> </u> , Respiration <u> </u> and Temperature <u> </u></p> <p>I am concerned about the:</p>
B	<p><u>Background</u> The patient's mental status is:</p> <ul style="list-style-type: none"> • Alert and oriented to person, place and time. Confused and cooperative or non-cooperative. Agitated or combative. • Lethargic but conversant and able to swallow. • Stuporous and not talking clearly and possibly not able to swallow. Comatose. Eyes closed. Not responding to stimulation. <p><u>Pediatric Assessment:</u> Normal vital signs <u>guidelines</u> for the following age groups:</p> <p><u>I. Age: infant up to six months</u> Heart rate (HR) 80 to 160 beats per minute (bpm) Respiratory rate (RR) 25 to 45 breaths per minute Systolic blood pressure (B/P) – not applicable Diastolic B/P – not applicable Oxygen saturation (O2sat): room air greater than 96% Rectal temperature 98 to 99.5° Fahrenheit (F)</p> <p><u>II. Age: six months to three years</u> HR 70 to 120 bpm RR 20 to 40 breaths per minute Systolic B/P 72 to 110 millimeters (mm) of Mercury (Hg) Diastolic B/P 36 to 70 mm Hg O2sat room air greater than 96% Rectal temperature 98.6 to 99°</p> <p><u>III. Age: Preschool</u> HR 60 to 90 bpm RR 25 to 30 breaths per minute Systolic B/P 72 to 113 mm Hg Diastolic B/P 39 to 74 mm Hg O2sat room air greater than 96% Oral temperature 96.5 to 99°</p> <p><u>IV. Age: School age to 12 years</u> HR 50 to 90 bpm RR 15 to 20 breaths per minute Systolic B/P 72 to 126 mm Hg Diastolic B/P 40 to 78 mm Hg</p>
A	<p><u>Assessment</u> This is what I think the problem is: <say what you think is the problem> _____.</p> <p>The problem seems to be: cardiac, infection, neurological, respiratory _____.</p> <p>I am not sure what the problem is but the patient is deteriorating. _____</p> <p>The patient seems to be unstable and may get worse; we need to do something.</p>
R	<p><u>Recommendation</u> I suggest or request that you: <say what you would like to see done> _____.</p> <p>Transfer the patient to critical care. Come to see the patient at this time.</p> <p>Talk to the patient or family about code status. Ask for a consultant to see the patient now.</p> <p>Are any tests needed: _____</p> <p>Do you need any tests like: CXR, ABG, EKG, CBC, or BMP? Others? _____</p> <p>If a change in treatment is ordered then ask: -How often do you want vital signs? How long do you expect this problem to last: _____ If the patient does not get better when would you want us to call again?</p>

PCH/FMC-Cardiopulmonary Arrest Flow Sheet

Date: _____ Time: _____ Facility Code Location: _____ Witnessed Arrest: YES / NO

Initial Assessment:	Event	Time	Event	Time
Responsive: <input type="checkbox"/> Yes <input type="checkbox"/> No	Code Alarm Initiated: _____		External Pacer Time: ____ Rate/MA _____	
Respiration: <input type="checkbox"/> Absent <input type="checkbox"/> Present	CPR Initiated: _____		Pacer Applied by: _____	
Pulse: <input type="checkbox"/> Absent <input type="checkbox"/> Present	Doctor Arrived: _____		Time	IV Solution
Initial Rhythm: _____	Intubation: _____			Drip Rate
IV Access Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Intubated by: _____			
IV Obtained Time: _____	ETT Size: ____mm / Taped at: ____cm			
	End Tidal Co2 Checked: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Vital Signs every 5 minutes

Time	HR	RR	BP	SP02	Time	HR	RR	BP	SP02	Time	HR	RR	BP	SP02

Time	Bolus Medication Dosage								IV Infusion (ml / hour)					Comments: ie IV placement, Chest Tube, Foley Cath, Response to Interventions	
	Rhythm	Defib/Cardio Joules	Amiodarone	Atropine	Epinephrine	Other	Sodium Bicarb	Vasopressin	Amiodarone	Dopamine	Dobutamine	Epinephrine	Other		

***** Medications are given IV, if other document in comments

Outcome

Resuscitation Ended _____ Successful Expired
 Family Notified _____ Time _____
 Attending MD Notified _____ Time _____
 Disposition _____ Time _____
 Gift of Hope 1-800-545-4438 Time _____
 Gift of Hope Referral Number _____
 Coroner Notified _____ Time _____

Signature of Code Physician: _____
 Signature of Recording RN/LPN: _____
 Signature of Lead Code RN: _____

PCH Code Blue: updated: 04/2014

Continued: PCH/FMC Code Blue Nurses Notes:

EKG Rhythm Key

A = Asystole
D5W AF = Atrial Fibrillation
NS
AFI = Atrial Flutter
P = PEA
1:1000
SB = Sinus Bradycardia
SR = Sinus Rhythm
ST = Sinus Tachycardia
SVT = Supraventricular Tachycardia
VF = Ventricular Fibrillation
VT = Ventricular Tachycardia

IV Infusion Dosage Key/ Guide

Amiodarone Drip 225mg/125cc
Dobutamine Drip 250mg/250cc
Dopamine Drip 400 mg/250cc NS
Epinephrine

Code Attended By: Names of all staff involved: legible
please.
