Jersey City Medical Center Rapid Response Team (RRT)

JCMC Rapid Response Team	Activation Criteria	Methods to Activate	Methods to Document	Communication SBAR
Rapid Response Team Members: Critical Care/ ED RN Respiratory Therapist Transporter Assigned Senior Resident & Intern Nursing Supervisor Quality Improvement representative **Rapid Response Team (RRT) members are skilled in:** ACLS Critical Care Experience Expert in rapid assessment and intervention **Why use RRT?** It has been shown to decrease: • Number of codes • ICU admissions from floor • Patient deaths ER RN, will respond to all first floor RRTs. If the patient is an inpatient, a second over head announcement "Rapid Response Team B" is made and ICU RN will respond	• Intuitive sense that something is wrong • Decrease in LOC or Acute changes in LOC • New onset of agitation/restlessness • Slurred Speech • Sudden loss of movement or weakness of face, arm or leg • Acute changes in RR <8 or >28 per min • Stridor/noisy breathing • Increase work of breathing • Sat<90% • Acute changes in the heart rate <50 or >120 bpm • Acute changes in systolic BP <90mmHg • New onset of chest pain • Seizures • Significant bleeding • No improvement in condition despite treatment • Potential serious medication errors • S/P fall with evidence of any of the following: head injury, any complaints of pain, obvious injury or deformity • Inability to contact or communicate with physician. This does not exclude the attempts to contact the primary physician but can assist in a rapid response to meet the needs of a changing condition of a patient; visitor or employees • When in doubt, contact RRT • Patient screened positive for severe sepsis or septic shock • EWSS>2	**Dial 8 tell operator to activate the RRT and give patient location** Tell RRT what is happening and how they can assist (SBAR) RRT will assist with assessment and management of patient. Primary nurse will be responsible to begin SBAR, meds, and interventions **RRT interventions may include:** Physical Assessment 02 stat EKG monitoring VS monitoring	Critical Care RN will assess and document patient's findings and all intervention on the RRT form. The primary nurse will document patients status leading to activation of RRT, followed by "see rapid response notes for interventions" MD team leader will document assessment and intervention in progress notes All patients will be screened for severe sepsis/septic shock, standing order are to be initiated if needed	Purpose of SBAR: provide clear concise, pertinent information to all members of the team **Situation:** Reason for initiation of RRT: [] Acute change in: [] Respiratory status [] Vital signs [] Cardiac status [] Mental status [] FALL [] MEWS score [] Other **Background:** admission diagnosis, past medical history, allergies, surgery/procedures **Assessment**: VS, 02 sat, Fio2, Abn lab results, EKG, recent CXR, pertinent physical exam **Recommendation/Response**: Recommendation- to suggest to MD and or/orders from MD Response- Patient Condition in response to interventions