



DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TX 78234-6000

REPLY TO
ATTENTION OF

OTSG/MEDCOM Policy Memo 10-015
15 MAR 2010

MCHO-CL-Q

Expires 15 March 2012

MEMORANDUM FOR Commanders, MEDCOM Regional Medical Commands

SUBJECT: Implementation of Rapid Response Systems (RSS)

1. References:

- a. Institute for Healthcare Improvement (IHI) website (<http://www.ihl.org/ih>).
- b. The Joint Commission (TJC) National Patient Safety Goal (NPSG) #16 (http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/08_hap_nps_gs.htm).
- c. The US Army Medical Command (MEDCOM), Quality Management Division (QMD), Patient Safety Web site (<https://www.gmo.amedd.army.mil/ptsafety/pts.htm>).
- d. Changes to the 2010 National Patient Safety Goals, *The Joint Commission Perspectives*, 29(10), 21.
- e. The Joint Commission Accreditation Standards Manual, 2010.

2. Purpose: To provide standardized implementation guidance for US Army MEDCOM rapid response systems (RRS).

3. Proponent: The proponent for this policy is the US Army MEDCOM, Office of the Assistant Chief of Staff for Health Policy and Services Directorate, Quality Management Division (QMD).

4. Applicability:

- a. This policy applies to all facilities providing care to patients in bedded facilities including inpatient and ambulatory facilities.
- b. This policy does not apply to neonatal intensive care patients.

5. Background:

a. The current literature states rapid response systems (RSS) are used to identify processes to expedite bedside care delivery to patients. The systems use specially trained clinicians to assess the patient's changing condition, thereby preventing or reversing clinical deterioration. The activation of the RRS, regardless of facility size,

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begins when specific vital sign parameters are met, the patient's level of consciousness changes or staff/family express concerns about a patient's clinical condition.

b. In July 2007, TJC released NPSG #16 to "improve recognition and response to changes in a patient's condition." Subgoal 16A required that "the organization selects a suitable method that enables healthcare staff members to directly request additional assistance from specially trained individual(s) when the patient's condition appears to be worsening." In 2009, TJC announced that as of January 2010, the requirements are located in the main body of the standards as follows: Moved 2009 NPSG#16 EPs 1-4 to new PC.02.01.19, EPs 1-4; moved EP 5 to HR.01.05.03, EP13; moved EPs 6 & 7 to PI.01.01.01, EP 39.

c. In formulating guidance for this memorandum, the MEDCOM used lessons learned from pilot projects conducted at Tripler Army Medical Center (TAMC) and Martin Army Community Hospital (MACH). Additional recommendations provided by a MEDCOM working group provided solutions to the new TJC standards.

6. Policy:

a. Each facility will implement RRS customized to the size of its own facility and mission in accordance with the parameters in (1)-(6) below. (Note: Ambulatory centers may design systems appropriate to their setting; however, TJC standards as described above in 5. b., are applicable only to hospitals or critical access hospitals.)

(1) The program design allows for a 24-hours-a-day, 7-days-a-week (24/7) response.

(2) There is consistency across the organization.

(3) Standardized activation parameters are identified.

(4) Staff members are empowered to activate the system without fear of retribution.

(5) An educational plan for activators, responders, patients, and Families is in place.

(6) Program effectiveness measures are in place.

b. Military treatment facility (MTF) personnel will ensure that RRS implementation adequately and effectively addresses the components described in paragraph 8 of this memorandum.

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c. MTF personnel will provide progress reports as well as measurements of program effectiveness to the MEDCOM Patient Safety Center as requested.

7. Responsibilities:

a. MTF Commanders will assign responsibility for oversight and coordination of RRS implementation and will establish a non-punitive culture for individuals who activate the system. Commanders will designate RRS champions, provide personnel, equipment, and educational resources to ensure success of the program.

b. The Chief, MEDCOM QMD will have overall responsibility for the program. Responsibilities include evaluate RRS program content for consistency and for MTF learning needs; and collate data and reports as requested by the regional medical commands, and as needed, for ongoing quality improvement activities.

c. The MTF Patient Safety Manager (PSM) will report, aggregate, and analyze data at the local facility. The PSM will have a collaborative role in the design and implementation plan developed by the RRS champions. The PSM may be assigned the task of evaluating the elements of program effectiveness.

8. Procedures: This paragraph addresses the RRS components, educational requirements, and marketing initiatives involved in RRS implementation.

a. Components. Successful implementation of the RRS will require attention to each of the following four components: activation, RRS team/responders, interventions for stabilization of the patient, and outcome measures.

(1) Activation of the RRS.

(a) Activation criteria act as triggers for staff, patients, and Families to recognize changes in patient conditions that may indicate deterioration and necessitate calling the RRS team/responder to the bedside for further evaluation. All MTFs will adopt the standardized RRS activation criteria (enclosure 1). Activation criteria, specific for both adult and pediatric patients, will be included on the RRS Call Record (enclosure 2). As the evidenced-based practices are identified, additional triggers may be added at the direction of MEDCOM.

(b) Staff will call the RRS team/responder at the earliest sign of deterioration. Patients may demonstrate significant vital/clinical sign changes as many as eight hours pre-cardiopulmonary arrest. During observation if staff is uncomfortable with patient's condition, even in the absence of vital sign changes, the activator should be stressed as valid and encouraged as a trigger.

(c) Local policy will establish the mechanism for calling or alerting the RRS team/responder to the appropriate patient and location in a timely manner. Facilities are encouraged to keep the activation simple so that one call number is used throughout the facility to reach the responder. In addition, facilities should test the system through a central operator to ensure accurate communication of patient name and room number. Cell phone and beeper signals should be tested in every area of the facility.

(d) The expectation is that areas of patient care such as radiology, dialysis clinics, or other specialty areas are included in the activation plan. Ancillary personnel must be trained in the activation process.

(e) Families know the patient better and often recognize early changes in the patient's condition before changes are recognized by the healthcare staff. Patients and Families should be encouraged to activate the RRS through the staff on duty. Staff will activate the RRS at the patient's and/or family's request.

(f) Activation of the RRS is non-punitive. All RRS calls should be viewed as an opportunity for learning and improvement in assessment or critical thinking skills. Regardless of the trigger for the call or the presumed validity, all calls should be viewed as an opportunity to advocate for the patient's safety.

(2) RRS team/responders.

(a) The RRS may vary in design depending on the organization. In smaller facilities, the responder may be an individual; in larger facilities, a team may respond. The RRS structure includes consideration of responders who are available, accessible, and able to respond to a deteriorating patient condition. Common traits for team/responders include knowledge, skill, and judgment and ability to recognize and respond to staff, patients, or Families in crisis situations.

(b) The intent is to quickly bring to the bedside the intensive care unit (ICU) advanced skills of assessment, communication, and early interventions to prevent the patient's further deterioration. Response to activation requires the physical presence of the team/responder. Phone consultation will not suffice as an RRS response.

(c) The RRS must be designed to ensure a team/responder is available 24/7 for all areas of the facility. Local policy will dictate the handoff process for RRS team/responders to identify potentially unstable patients, perform equipment checks, and so forth. Ideally, the responder can be activated without jeopardizing other patients, i.e., activating a charge nurse.

(d) The RRS team/responder should be chosen and trained for the RRS role based on his/her willingness and ability to relate not only to patients and Families, but

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also to staff. Each activation should be met by a team/responder who agrees with the non-punitive, non-judgmental statement, "Thank you for calling the RRS, how might I help?" The responder training should include an attitude of cooperation that encompasses teaching and staff education.

(e) A "ramp-up" method for responders is recommended. An example of a "ramp-up" RRS is an ICU nurse assessing the patient at the bedside and evaluating which additional resources are needed. An example of a "ramp-down" system is the activation of a code blue team and release of code team members if they are not needed once the patient is assessed. (Note: Code blue teams activated for patient resuscitation are not part of the RRS.) The ramp-up approach is less burdensome to personnel and staffing. Standardization across the MTF is essential to ensure continuity, clarity, and metrics.

(f) Locally developed protocols and policies governing the actions of the responder should be within the responder's scope of practice.

(g) The RRS team/responder will be equipped with tools and protocols to quickly obtain an assessment that will facilitate treatment decisions. Equipment such as I-STAT machines, ECG access, STAT chest x-ray, IV orders, pulse oximeter, and oxygen flow devices are examples of needed equipment for responders.

(h) The RRS team/responder will assist and facilitate the assessment, early treatment, and, if needed, transfer of the patient. The RRS team/responder will not assume control or usurp primary team authority, but acts to support the primary team and encourage continuity of care.

(i) Following the RRS call, the RRS team/responder is responsible for completing the RRS Call Record (enclosure 2). The RRS Call Record may be a part of the permanent medical record pending local/regional forms approval.

(j) The RRS Outcomes Review Form (enclosure 3) is a quality management tool designed to track RRS data and identify process improvement areas for education, communication, or facility issues. It is not a part of the clinical record; rather, it is a quality improvement document that is collected by the MTF quality management department for ongoing quality improvement initiatives.

(3) Interventions for stabilization.

(a) Interventions for patient stabilization include basic interventions for airway, breathing, and circulation support; diagnostic interventions; and medication administration based on protocols.

(b) The RRS Call Record (discussed in para (2) (i) above) reflects the current interventions.

(c) Additional interventions may be carried out consistent with the primary team/provider and hospital/facility protocols.

(4) Outcome measures. Measures to determine program effectiveness should be low burden, high value and must meet TJC requirements. Measuring the utility and effectiveness of the RRS interventions includes examining the RRS calls, RRS utilization, and surveillance of missed opportunities. Additional measures for utility and effectiveness may be added by facilities.

(a) Examining RRS calls. The impact on mortality and cardiac arrest rates that fall below 10 calls/1000 discharges is not the best indicator of a successful RRS initiative. Until rates reach 25-30 calls/1000 discharges, a positive impact may not be recognized.

(b) Utilization of the RRS. Facilities will track the number of times per month the RRS is activated. The facility should see an upward trend in the number of activations as the program is defined and improved. The number should be used as an indicator of program effectiveness and the program adjusted accordingly.

(c) Missed opportunities. Another outcome measure tracks whether or not opportunities for responding and rescuing are being missed. This measure is performed through retrospective chart audits.

(1) In larger facilities audits of medical records for the presence of activation criteria 8 and 24 hours prior to the event will be conducted for cardiac, respiratory, or cardiopulmonary arrests outside of the emergency room or ICU; number of patients returned to the ICU as a result of a deteriorating condition; and number of unanticipated ICU admissions.

(2) In smaller facilities where the number of codes or deaths are minimal and may not provide valuable data, the audits will consist of the number of patients transferred to a higher level of care/facility as a result of a deteriorating condition. Activation criteria should be audited at 8 and 24 hours prior to transfer. Excluded from audit are those patients transferred as a result of a need for increased diagnostic evaluation or for care not available at the smaller facility. If the smaller facility has an ICU, charts of patients returned to the ICU as a result of a deteriorating condition will be audited for activation criteria at 8 and 24 hours prior to return.

(d) Pediatric data. Facilities may want to capture the data locally for pediatric patients and report as separate from adult data.

(e) Added data. Additional measures of RRS success are suggested based on the MTF's process improvement or quality management requirements. Selection of additional measures is at the discretion of the commander and might include: staff satisfaction surveys, patient satisfaction surveys, ICU length of stay, nursing personnel turnover rates, or education/training need indicators for staff.

(f) TJC data requirements. TJC requires hospitals to collect data on the effectiveness of its response to change or deterioration in patient's condition.

b. Education. TJC's expectations require that formal education for urgent response policies and practices is conducted with personnel who may request assistance (activators) as well as for the personnel who may respond to those requests (responders).

(1) Education for the activators. Activators will have knowledge of activation criteria and the telephone numbers of personnel to activate the RRS.

(a) The activator must communicate a patient concern to the responder using a structured communication tool such as the Situation, Background, Assessment, Recommendation (SBAR) technique. Any variance from SBAR must be structured in approach, adopted by the facility as the communication tool, and be consistently used throughout the MTF.

(b) There must be reassurance that calling the RRS is proactive and non-punitive. Staff should be encouraged to activate, be rewarded for activation, and both give and receive feedback on the system design.

(c) There must be a clear understanding in the organization of the activation criteria, telephone number of personnel to activate, and examples of the SBAR communication technique (see para b(1)(a) above).

(d) Educational programs for staff activators include initial training, training for sustainment, and training for new personnel.

(2) Education for the responders.

(a) The format for the responder curriculum may vary from facility to facility dependent upon the staff responder's education and expertise. Options for training include formal group classes, one-on-one instruction, simulation exercises, or continuing education courses.

(b) A suggested curriculum design is included in enclosure 4. The responder curriculum builds on the critical care expertise of the provider. In addition to assessment and intervention protocols, the curriculum should include discussion

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regarding communication using a structured communication tool such as SBAR, interacting with Families and patients in crisis, and approaches to communication with providers.

c. Marketing. Success of the RRS includes extensive marketing and clear understanding of the RRS telephone numbers and activation criteria.

(1) Materials. Examples of materials to convey activation criteria, telephone numbers to call, and reminders for staff to activate are available in the RRS Tool Kit on the MEDCOM QMD Patient Safety Website (www.qmo.amedd.army.mil/ptsafety/pts.htm).

(2) Education for providers.

(a) The organization should educate the medical staff on the evidence-based and regulatory components of the RRS. Staff education may involve one-on-one conversations with providers. RRS champions and the MTF leadership will act as change agents.

(b) RRS provides the opportunity to improve patient safety and care. Providers must know that the activation of the RRS is non-punitive for both the activator and the responder. The RRS is not intended to usurp the physician's treatment plan. Exclusion of patients from RRS activation criteria should be on a case-by-case basis and be the exception rather than the rule. For example, if a patient consistently has a systolic blood pressure less than 90mmHg, the provider is aware and the patient demonstrates no changes in condition, activation of the RRS would not be warranted. The provider may request exclusion of blood pressure as an indication for RRS activation and document his/her rationale.

9. Protected information. The data collected through the RRS is considered Title 10, US Code § 1102, protected quality improvement information.

FOR THE COMMANDER:

4 Encls


HERBERT A. COLEY
Chief of Staff

Rapid Response System Activation Criteria

1. Activation criteria act as triggers for staff, patients, and families to recognize changes in patient conditions that might indicate deterioration and call the RRS responder to the bedside for further evaluation.
2. The Institute for Healthcare Improvement (IHI) has outlined activation criteria in the RRS "How to Guide for Rapid Response Systems". The RRS Working Group agreed to accept the criteria as listed in #3.
3. The adult criteria for activation will be reflected on the Rapid Response Call Record:
 - a. Respiratory Rate less than 8
 - b. Respiratory Rate greater than 24
 - c. SpO₂ less than 90% with oxygen
 - d. Systolic Blood Pressure below 90mmHg
 - e. Heart Rate less than 40
 - f. Heart Rate greater than 130
 - g. Acute change in conscious state
 - h. Family concerns
 - i. Staff concerns about patient condition
4. The pediatric criteria for activation are recommended by IHI in the Pediatric Supplement and the RRS Working group. For facilities with pediatric patients the RRS Call Record will reflect:
 - a. the table below which lists criteria for activation to represent general age categories and vital signs generally accepted and noted in the pediatric literature.

AGE	Abnormal Heart Rate (Beats/Minute)	Abnormal Resp Rate (Breaths/min)	Abnormal Systolic BP (mm Hg)
Neonate	< 80 or > 200	< 20 or > 75	< 60
6 mos	< 80 or > 200	< 20 or > 75	< 60
2 yrs	< 65 or > 180	<16 or > 60	< 65
5 yrs	< 50 or > 160	> 50	< 70
7 yrs	< 50 or > 150	> 45	< 75
Adolescents	< 40 or > 140	> 40	< 85

- b. Staff concerns or "intuition"
- c. Parental concerns
- d. Acute Mental Status changes



Enclosure 2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA		
For use of this form, see AR 40-85; the proponent agency is the Office of The Surgeon General.		
REPORT TITLE Rapid Response Team Adult and Pediatric Call Record	OTSG APPROVED (Date) (YYYYMMDD)	
Date Admit: _____ Time Admit: _____	Responding RRT Team Members	
Admission Dx: _____	RRT RN _____	
Rank/First Name/Last Name _____	RT Resp Therapist _____	
Staff Activating: _____	Notified Primary MD _____	Notified RRT MD _____
Location: _____	Phone _____ Bedside _____	Phone _____ Bedside _____
Date: _____ Time of Call: _____	Time _____	Time _____
Arrival Time: _____ Departure Time: _____	Name of Primary MD _____	Name of RRT MD _____
Adult RRT - Reasons stated by staff that made the call (circle all that apply & enter value of vitals prior to RRT):		
RR < 8 _____	SpO2 < 90% with O2 _____	HR < 40 _____
RR > 24 _____	SBP < 90 mmHg _____	HR > 130 _____
Acute Mental Status Change _____	Family Concerned _____	
Staff Concerned: _____		
Peds RRT - Reasons stated by staff that made the call (circle all that apply & enter value of vitals prior to RRT):		
Low Respiratory Rate _____	Low Heart Rate _____	SpO2 < 90% with O2 _____
High Respiratory Rate _____	High Heart Rate _____	Abnormal BP _____
Acute Mental Status Change _____	Family Concerned _____	
Staff Concerned: _____		
Observations at time of arrival		
RR _____ SpO2 _____ LOC _____	Monitory/Rhythm _____	
HR _____ BP _____ Other: _____		
RRT Problem Identification: _____		
Interventions		
Airway/Breathing		
Oral Airway/Nasal Trumpet _____	Bag-valve mask _____	Oxymask _____ liters/min.
Nasal cannula _____	Suctioned _____	Non-Rebreather _____
Nebulizer Treatment _____	Ventilation from trach _____	Simple Face Mask _____
Circulation		
IV Access Y or N _____	Pre-existing _____	Placed by RRT _____
_____ 1st site _____ gauge	_____ IV Fluid ml	_____ 2nd site _____ gauge _____ IV Fluid ml
Diagnostic Enter value		
ECG _____	ABG _____	CXR _____ Glucose _____
Medications		
Albuterol _____	Narcan _____ mg	Romazicon _____ mg
Atrovent _____	D50W _____ amps	Lasix _____ IV or _____ oral dosage
		NTG _____ tab or _____ spray
Other: CODE Blue Activated Time: _____		Additional Comments: _____
Final Assessment		
RR _____	SpO2 _____	LOC _____
HR _____	BP _____	Other: _____
RRT Call Outcomes		
Transferred to ED _____	Remained in Room _____	Pre-existing DNR Order _____
Transferred to ICU _____	Transferred to _____	Date of DNR Order: _____
Transferred to Prog _____	another Hospital: _____	DNR suggested by RRT _____
Transferred/admitted to Ward _____	Died during RRT event _____	DNR documented by RRT _____
PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)
PATIENT'S IDENTIFICATION (For typed or written entries give: Name -last, first, middle; grade; date; hospital or medical facility)		
<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART		
<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (Specify)		
<input type="checkbox"/> DIAGNOSTIC STUDIES		
<input type="checkbox"/> TREATMENT		

Rapid Response Team Adult and Pediatric Call Record - Page 2

Notes

PATIENT'S IDENTIFICATION (For typed or written entries give Name last, first, middle, gender, date, hospital or medical facility)

RRT Outcomes Review Form

(To be completed by the RRT Coordinator)

<input type="checkbox"/> RRT Activated Date / / Time Activated: : Time Arrived: : Location:	<input type="checkbox"/> RRT NOT Activated Date / / Time: : Location:	Hospital in which Event Occurred <input type="checkbox"/> TAMC <input type="checkbox"/> MACH
Classification of Primary Event: (check <u>one</u> box <u>only</u>) <input type="checkbox"/> Cardiac Arrest and Died at the time of event with NO prior DNR order <input type="checkbox"/> Cardiac Arrest and survived at time of event (but not admitted to ICU) with NO prior DNR order <input type="checkbox"/> Cardiac Arrest and admitted to ICU with no prior DNR order <input type="checkbox"/> Unplanned ICU admission (no preceding Cardiac Arrest) <input type="checkbox"/> Death with NO prior DNR order (and no preceding Cardiac Arrest) <input type="checkbox"/> RRT activation with none of the above		RRT History <input type="checkbox"/> Previous RRT this admission <input type="checkbox"/> Previous RRT call within 24 hrs of this event

RRT criteria present before the event <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Up to 8 hrs before</th> <th style="text-align: center;">Up to 24 hrs before</th> <th style="text-align: center;">(check both if present in both time periods)</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Airway Threatened</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Respiratory Arrest</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>RR < 5</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>RR > 24</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>SpO2 < 90% w/O2</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Prior Cardiac Arrest</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>HR > 140</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>HR < 40</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>SBP < 90 mmHg</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Staff Concern</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Patient/Family Concern</td></tr> </tbody> </table>	Up to 8 hrs before	Up to 24 hrs before	(check both if present in both time periods)	<input type="checkbox"/>	<input type="checkbox"/>	Airway Threatened	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Arrest	<input type="checkbox"/>	<input type="checkbox"/>	RR < 5	<input type="checkbox"/>	<input type="checkbox"/>	RR > 24	<input type="checkbox"/>	<input type="checkbox"/>	SpO2 < 90% w/O2	<input type="checkbox"/>	<input type="checkbox"/>	Prior Cardiac Arrest	<input type="checkbox"/>	<input type="checkbox"/>	HR > 140	<input type="checkbox"/>	<input type="checkbox"/>	HR < 40	<input type="checkbox"/>	<input type="checkbox"/>	SBP < 90 mmHg	<input type="checkbox"/>	<input type="checkbox"/>	Staff Concern	<input type="checkbox"/>	<input type="checkbox"/>	Patient/Family Concern	Transfer History <input type="checkbox"/> Transferred from another hospital facility within 24 hours preceding an RRT call Facility: Date/Time of transfer: <input type="checkbox"/> Transferred from a critical care area within 24 hrs preceding a RRT call Date/Time of transfer: Transferred from: <table style="width: 100%; margin-left: 40px;"> <tr> <td><input type="checkbox"/> PACU</td> <td><input type="checkbox"/> ICU</td> </tr> <tr> <td><input type="checkbox"/> ED</td> <td><input type="checkbox"/> CCU</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Same Day Surgery</td> </tr> </table>	<input type="checkbox"/> PACU	<input type="checkbox"/> ICU	<input type="checkbox"/> ED	<input type="checkbox"/> CCU	<input type="checkbox"/> Same Day Surgery	
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Staff Survey completed: Yes No

RRT Coordinator Signature: _____

Date Completed: / /

Suggested RRS Curriculum Design

1. Education and Training for RRS responders
 - a. Selection of responders should be based on knowledge, skills, judgment and attitude consistent with the responder's scope of practice.
 - b. Curricula for RRS should be designed to fit the system of the facility.
 - c. Suggested outline for education and training of responders
 - 1). Facility's model for RRS – ramp up; roles of responders
 - 2) Goals of RRS – prevent failure to rescue; prevent communication breakdown; alter care in response to patient deterioration; support critical thinking, judgment, and knowledge for staff in recognition of changing patient conditions.
 - 3) Identify criteria for RRS activation (See Enclosure 1)
 - 4) Outline process for RRS notification in facility
 - 5) Define criteria for success as responder
 - a). Thank you for calling – how can I help?
 - b). Nurture, mentor, coach and assure staff that call is important
 - c). Share knowledge, judgment, and attitude with staff
 - d). Rapid assessment of patient's clinical status
 - e). Interventions within scope of practice to stabilize patients
 - f). SBAR (Situation, Background, Assessment, Recommendation) communication with primary provider and/or ICU provider
 - g). Assisting with transfer
 6. Outline process in place if RRS requires "Code" response
 7. Discuss RRS standing orders and situations where standing orders can/should be implemented.
 8. Discuss equipment available for response
 9. Discuss documentation
 10. Discuss /simulate strategies for the most common patient presentations, interventions, and concerns:
 - a). Sepsis
 - b). Hypotension (hypovolemia v Not r/t hypotension)
 - c). Hypertensive urgency/crisis
 - d). Hypoglycemia
 - e). Acute mental status changes
 - f). Situational toxicology
 - g). Chest pain/ Ischemic changes/ Acute MI
 - h). Stroke
 - i). Respiratory distress
 - j) Medication administration
 - k). Families concerned or in crisis
 11. Debriefing RRS calls

2. Education and Training for Staff Activation

- a. Benefits of RRS: patient safety, improved quality, education and learning
- b. Identify RRS in facility and RRS responder responsibilities.
- c. Identify activation criteria – emphasize staff and patient/family concern
- d. SBAR (Situation, Background, Assessment, Recommendation) communication in activation
- e. Non-punitive, non judgmental activation
- f. Outline process for RRS activation – number to call
- g. Case analysis for RRS activation
- h. Materials for Staff - Examples: saturate facility with criteria for activation and activation number such as badge cars, posters, magnets, phone stickers, etc.
- i. Ongoing educational materials - Examples; newsletters, thank you for activating letters, showcase success stories from staff and patients/families.
- j. Newcomer Orientation
- k. Debriefing process following activation – what happened, what went well, what could be done better next time.
- l. Identify trends for education and training –example – how to administer oxygen

3. Patient and Family Education

- a. Develop process to notify patient and family members about RRS and how to activate within the facility. Examples: brochures, fliers, posters, inpatient guidebook, facility website.
- b. Distribute widely: admission, same day surgery, patient room, newsletter, commander town hall meeting.
- c. Identify trends from patient satisfaction surveys.