Lippincott Clinical Leaders: Rapid Response Teams

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Lisa Bonsall: Hello, and welcome to the Lippincott Clinical Leaders podcast. My name is Lisa Bonsall. I'm the Senior Clinical Editor for Lippincott NursingCenter. I'm joined today by Doctor Elizabeth Tomaszewski, the Clinical Content Editing Manager for Certification Review here at Wolters Kluwer. Beth has over 30 years of experience as a nurse and continues to practice as an acute care nurse practitioner in critical care. She also has nine years of experience as faculty and track director for the Adult Gerontology Acute Care Nurse Practitioner Program at Drexel University. Thank you for joining me today.

Beth Tomaszewski: Absolutely. Thank you.

Lisa Bonsall: So today we're going to talk about rapid response team calls. Let's start with the basics. What is an RRT call?

Beth Tomaszewski: So an RRT call, reasons can vary by facility, but essentially it's a way to rapidly gather a team together, to rescue a patient who's in danger of deterioration. Bringing a team together like that allows resources to be pulled and allocated to that patient to provide immediate evaluation and treatment to reduce morbidity and mortality.

Lisa Bonsall: What are some reasons that a nurse would call an RRT?

Beth Tomaszewski: So each facility has a different set of reasons why they would call certain codes, like some have stroke teams, some have rapids. In general, a rapid response can be called for any patient who appears to be deteriorating. The most important step is recognizing that deterioration. So some of the reasons might be an altered mental status. Maybe your patient became acutely confused or has acute mental status changes such as aphasia or hemiparesis, for example.

They may become acutely agitated, that would be of concern. They may be dyspneic or short of breath, have chest pain, low blood pressure or tachycardia. Some wild vital signs might be a reason that you might call a rapid. Suspicion of sepsis in some institutions, they call rapid responses for that, and in others they call sepsis alerts.

Falls, unwitnessed falls sometimes can be called as rapids, and things like seizures can be called as rapid responses if they're new onset, especially. So the most important thing, though is for a nurse to be able to trust their gut. It's one of those nursing senses that I think has gone by the wayside. We all look for the concrete signs and check boxes, but in the end, nurses have a gut feeling and if you don't feel like

your patient's doing well, and you have that slight inclination that they're going to deteriorate, you might be right. Just call the rapid.

Lisa Bonsall: So when a rapid is called, who typically comes?

Beth Tomaszewski: So each facility has a different makeup of their rapid response team. A lot of this stuff is facility dependent. But an example might be a provider, whether that provider comes from the ICU or the hospitalist service or the emergency room. It may be a physician, it may be a nurse practitioner, it may be a physician's assistant.

You'll oftentimes see an ICU or an ER nurse also respond in case there are advanced medications or procedures that need to be done for the patient. The bedside nurse of the patient is one of the most important members of the team, because they can give you an SBAR on that patient, and you're going to have a better idea of what was going on and how we got to that point. You may also see other members such as respiratory therapy, radiology technicians, phlebotomists, patient care technicians, the nursing supervisor. And in some cases, security also comes, you know, whether to do crowd control or if, there's an acutely agitated patient, it's getting a little out of hand that the medical team is having trouble corralling. But the main point is that everyone is there to help. Everyone is there to help the patient.

Lisa Bonsall: So how does this differ from calling a code blue?

Beth Tomaszewski: So that's a good question. Generally speaking, an RRT is for those patients who are in danger of deteriorating, whereas a code blue is called on those patients who have deteriorated, to the point where their life is in danger or they are lifeless. An RRT team might be a patient whose vital signs are measurable, they're responsive, their airway is patent, they’re breathing okay for the moment. They have palpable pulses. They have a sustainable vital sign, but they're in danger of that deterioration happening. Whereas a code blue, they may be unresponsive, they may be apneic. They may be pulseless. And that tends to need things to happen a lot more quickly than that of an RRT. But many of the team members are the same.

Lisa Bonsall: Thank you. Okay, so let's say an RRT is called and the team arrives. What's next? What should the nurse expect?

Beth Tomaszewski: So usually, the team leader will want to know what the concern is, what the patient is in the hospital for, any contributing factors that are leading up to that RRT. How did we get here? And it helps to get that background; a nurse can use an SBAR for that reason. It's a nice quick thing that they're used to delivering, and it provides a lot of the information that a leader would need to know how to treat that patient and evaluate that patient. Vital signs, blood glucose levels, that's one of the more popular things that I know I'll ask for, especially for somebody who has altered mental status. Before we're running off to CAT scan, we want to get that blood sugar.

It's interesting how when you ask for the same things as a leader, your staff get to know exactly what it is that you want. So that's that's one of those caveats I know that I personally like to have. You may also see things like EKGs, cardiac monitoring, IVs, medications. And all of this is happening while the leader of

the RRT is examining the patient and trying to figure out exactly how to best help that patient. They would expect further orders to stabilize the patient and maybe even transfer to a higher level of care.

And that is sometimes needed. And the SBAR should be given to that unit by the bedside nurse also to help continue that care of the patient. I keep talking about SBAR, it's: Situation Background Assessment and Recommendations. It's a quick way to give a sign out or a report to, someone who's asking for information on the patient. And we do have a lot of Lippincott NursingCenter articles on SBAR. So they're great. They're out there. Check them out.

Lisa Bonsall: Thank you, Beth. Can you sum this all up for us? What are the key points to remember about calling an RRT?

Beth Tomaszewski: Sure. So RRTs are used to prevent increased morbidity and mortality related to patient deterioration. It gets a team together to rapidly allocate resources to the evaluation and treatment of that patient. The biggest thing that I would want nurses to come away with is that they are the last line of defense for their patients, and they have to be able to identify that deterioration in the patient in order to be able to help, so that they can activate the team to intervene.

It's also important to know that if that patient does require a higher level of care as a result of that RRT, it shouldn't be viewed as a failure of the nurse. A lot of times the nurses take that personally, that they didn't take good enough care of their patients, and that's not the case at all. All patients are in the hospital for a reason, and the fact that you can identify a deteriorating patient is the most important thing, because you are able to get that patient the help that they need. Another thing that I believe strongly in is debriefing, not only after the cardiac arrest or code blues, but also after rapids too to help identify any kind of systems issues or, just to see what we did well and what we could do better.

Lisa Bonsall: Thank you so much. This has been a great conversation, Beth.

Beth Tomaszewski: Absolutely. Any time.

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