Rapid Response

Crenshaw Community Hospital
Education Department

What is a Rapid Response?

Rapid Response

A rapid response is called when a patient or a visitor is recognized as showing a negative change in condition.

Rapid Response

Any hospital staff may call a rapid response by announcing over the hospital intercom three times:

“Rapid response to room XXX, rapid response to room XXX, rapid response to room XXX.”

Rapid Response

Criteria for calling a rapid response may include, but is not limited to, any of the following:

- Heart rate less than 50 BPM or symptomatic
- SBP less than 90 mmHg or symptomatic
- Respiratory Rate less than 8/min or symptomatic
- SpO2 less than 85% and symptomatic
- Acute bleed
- Heart rate greater than 130 BPM
- Acute mental status change or neurological deficit
- Respiratory rate greater than 30
- Seizure
- Staff, patient, or caregiver feels that there has been an acute negative change in the patient's condition, even if they are not sure what is happening

Rapid Response

A rapid response can also be called if the nurse just thinks “something is just not right with my patient.”

Rapid Response

In response to the overhead page, a nurse and the Physician from the Emergency Department, will respond to the location called to assess the patient.

Rapid Response

The primary nurse should have the patient's chart at bedside and be able to update the Rapid Response team as to the patient's previous condition and why the rapid response was called.

Rapid Response

Visitors to the facility that are involved in accidents or sudden deterioration in condition should be taken to the Emergency Department if possible.

Rapid Response

The entire rapid response event should be documented on the Rapid Response Form, with a copy being sent to Risk Management.

Rapid Response

The goal of the Rapid Response process is to try to arrest the patient's deteriorating condition BEFORE having to call a Code Blue.

Rapid Response

At any point, the team may choose to proceed with a Code Blue call if the patient's condition warrants the call.

Rapid Response

For a rapid response team to be most effective, the primary nurse must make certain that he/she has a full knowledge of the patient's baseline condition, so that changes in that condition can be noticed as early as possible.

Rapid Response

The primary nurse should follow the standard SBAR report to give the rapid response team the information needed to make the best decisions regarding the patient.

Rapid Response

S: What is the **situation**?
B: What is the patient's **background**?
A: Assessment - What is your **assessment** of the patient's condition?
R: Recommendation: What is your **recommendation** for the Plan of Care?

Rapid Response

Once the patient's condition is determined to be stable, the Primary Physician must be notified and updated on the event and the patient's condition.

Rapid Response

After the patient is stable, there will be a debriefing of the health care providers to discuss the event and determine if any further action to safeguard the patient is warranted.

Rapid Response

Additionally, during the debriefing, any opportunities for education for staff will be forwarded to the Director of Education.