COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

RAPID RESPONSE TEAM FLOWSHEET (EMS-003F)

Date: _____ Room#/Location: _____ Time Called: _____ Arrival Time: _____ Event Ended: _____

Primary Reason for Call:

☐ Staff concerned/worried
Specify: _____
☐ HR less than 40 OR >130 ☐ Uncontrolled pain
☐ SBP less than 90 mmHg ☐ HR greater than 130
☐ Acute change in LOC ☐ RR greater than 25
☐ RR less than 8 ☐ FiO_2 50% or greater
☐ SpO_2 less than 90% ☐ Seizures
☐ Acute Significant Bleed ☐ Urine output < 30ml for 2 consecutives
☐ Failure to respond to tx ☐ Acute change in LOC
☐ Shock_____

Immediate Interventions:

RT	RN
☐ Oral airway/Nasal airway	☐ IV Fluid Volume Adjustment
☐ Suctioning	☐ Cardiac Monitoring
☐ Nebulizer Treatment	☐ O_2
☐ Intubated	☐ CPR
☐ NPPV	☐ Defibrillation
☐ Bag Mask	☐ IV access
☐ O_2 Mask/Nasal	☐ Ordered PRN Medications
☐ ABG	☐ _____
☐ _____	☐ _____
☐ No Intervention	☐ No Intervention

Protocols Initiated:

□ Rapid Response Hypotension Protocol
□ Rapid Response Respiratory Distress Protocol
□ Rapid Response Unresponsive Patient Protocol
□ Hypoglycemia Protocol/Hyperglycemia Protocol
□ Shock Protocol

Medication(s): _____
_____
_____
_____

Other Interventions

Specify: _____
_____
_____
_____

Outcome: ☐ Stayed in room ☐ Expired
☐ Transferred: _____
☐ Other: _____
☐ Notified Provider: _____ Time: _____
(Name)

RRT Signatures:

RN: _____
RN: _____
RT: _____
Other: _____

Situation:
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Background: _____
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Assessment:
Temp_____BP_____HR____RR_____SpO_2____GCS____
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See back for additional Vital signs & documentation

Recommendation: _____

RRT - HYPOTENSION PROTOCOL

- □ Obtain Vital Signs & recheck Q 5 min
- □ Obtain IV access
- □ Position in Trendelenburg position
- □ Check most current lab & I/O
- □ Check current MAR to include BP meds & narcotics (note dose and time of last dose)
- □ Hold all BP meds and Notify Provider immediately.
- □ Notify MD

RRT – RESPIRATORY DISTRESS PROTOCOL

- □ Obtain O_2 Saturation (SAT) and vital signs q 15 minutes
- □ Elevate HOB to 45 degrees
- □ If O_2 SAT <90%, place on Nasal Cannula @ 2 LPM and titrate until SAT >92%
- □ If O2 SAT remains <90%, obtain ABG's & CXR
- □ If distress resolved, monitor O2 SAT
- □ Check current labs results (ABG)
- □ Notify Provider

RRT- HYPOGLYCEMIC MANAGEMENT PROTOCOL

If less than 40 mg/dL call **RAPID RESPONSE** and

- Assess patient situation and select appropriate treatment sequence from the options below:

Treatment Sequence A: Patient is conscious and able to swallow

- Administer ***one*** of the following carbohydrates:
  - 3 Glucose tablets (primary treatment of choice)
    OR
  - 4 ounces of orange juice (IF NOT A RENAL PATIENT)
    OR
  - 8 ounces of skim / 2 percent milk
    OR
  - 4 ounces of a regular soft drink
- ***Notify provider***
- Repeat finger stick blood glucose 15 minutes post treatment. If result ***STILL 60 mg/dL or LESS,*** repeat treatment above and ***notify provider*** for additional orders

Treatment Sequence B: Patient is unable to swallow
If no IV access:

- Administer Glucagon 1mg subcutaneously (use insulin syringe)
- **Insert saline lock if not present**
- Obtain finger stick blood glucose 15 minutes after subcutaneous Glucagon. If result ***60 mg/dL or LESS*** and **if IV access has been obtained**, give D50W 50 mL IVP (25 grams) and ***notify physician***

If patient has IV access:

- Give D50W 50 mL (25 grams) IV push.
- **Recheck FSBS in 10 minutes.** If result ***60 mg/dL or LESS, notify provider*** for additional orders

RRT- UNRESPONSIVE PATIENT PROTOCOL

- □ Obtain Neuro check, GCS, Vital Signs q 15 minutes
- □ If O_2 SAT <90%, place on O_2 2L NC
- □ If Hyper/Hypoglycemia Suspected
- □ Check Blood Glucose
- □ Obtain IV access
- □ Check most recent MAR
- □ Notify MD
- □ If suspected CVA, notify Provider

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FOLLOW-UP REPORT (To be done within 24 hours):

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Signature:
_____

Date/Time: _____

RRT-SHOCK PATIENT

- □ Assess and maintain a patent airway
- □ Place oxygen via mask at 10-15 liters per minute
- □ Assess level of consciousness
- □ Assess Glasgow Coma Scale
- □ Place on cardiac monitor and obtain baseline rhythm
- □ Obtain initial vital signs
- □ Control obvious external bleeding
- □ Initiate intravenous lines with large-bore catheters using normal saline
- □ Obtain venous blood for Clinical Laboratory per Provider Orders
- □ Type and cross for possible transfusion per Provider Orders
- □ If available, check glucose and H&H per Provider orders
- □ Obtain baseline electrocardiogram
- □ Continuously monitor the patient's:

- □ Temp <96.8F > 100.9 F
- □ HR <50 or > 90
- □ SBP < 90
- □ MEAN BP < 65
- □ RR < 10 or > 20
- □ O2 Sat < 90%
- □ Acute change in LOC

TIME	Temp	Pulse	RR	BP	SpO_2	Cardiac Monitor	IV titration Drug: _______	IVF Intake	Urine Output	BS	SSI	Nurse Initials

PATIENT LABEL