

● NGN NCLEX 2026 · CLINICAL JUDGMENT · SAFETY & PRIORITIZATION

Rapid Response & Code Blue Team

Recognizing deterioration, preventing arrest, executing resuscitation.

CLUSTER	PRIORITY	NCSBN COMPETENCY	PATIENT POPULATION
Emergency Response	ABC / Safety	Clinical Judgment	All Acute Care Adults

 **Source Disclosure:** This topic is **not included** in Diane's uploaded reference notes for this project. Content below is compiled from external NCLEX-standard sources: *Saunders Comprehensive Review for the NCLEX-RN Examination, 9th ed. (2026)*; *AHA 2020 Guidelines for CPR and Emergency Cardiovascular Care (updates through 2024)*; *AACN Practice Alert: Rapid Response Teams*; *Lippincott Manual of Nursing Practice*.

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DEFINITION • OVERVIEW

What They Are & Why It Matters

*A Rapid Response Team is the **prevention team**. A Code Blue Team is the **rescue team**. The Rapid Response is the time-window you don't want to miss.*

Rapid Response Team (RRT / MET)

A dedicated team of experienced clinicians (typically an **ICU nurse + respiratory therapist + hospitalist/intensivist**) called to the bedside of a non-ICU patient who shows **early signs of clinical deterioration** — *before* cardiac or respiratory arrest occurs.

Goal: Identify and intervene during the 6–8 hour "deterioration window" that typically precedes arrest. Reduce code blues, ICU transfers, and mortality.

Code Blue Team

The **resuscitation team** activated for confirmed **cardiac arrest, respiratory arrest, or unresponsive patient with no pulse/breathing**. Composed of physicians, ICU/ED nurses, respiratory therapy, pharmacy, and a recorder.

Goal: Execute high-quality CPR + ACLS algorithm to achieve return of spontaneous circulation (ROSC).

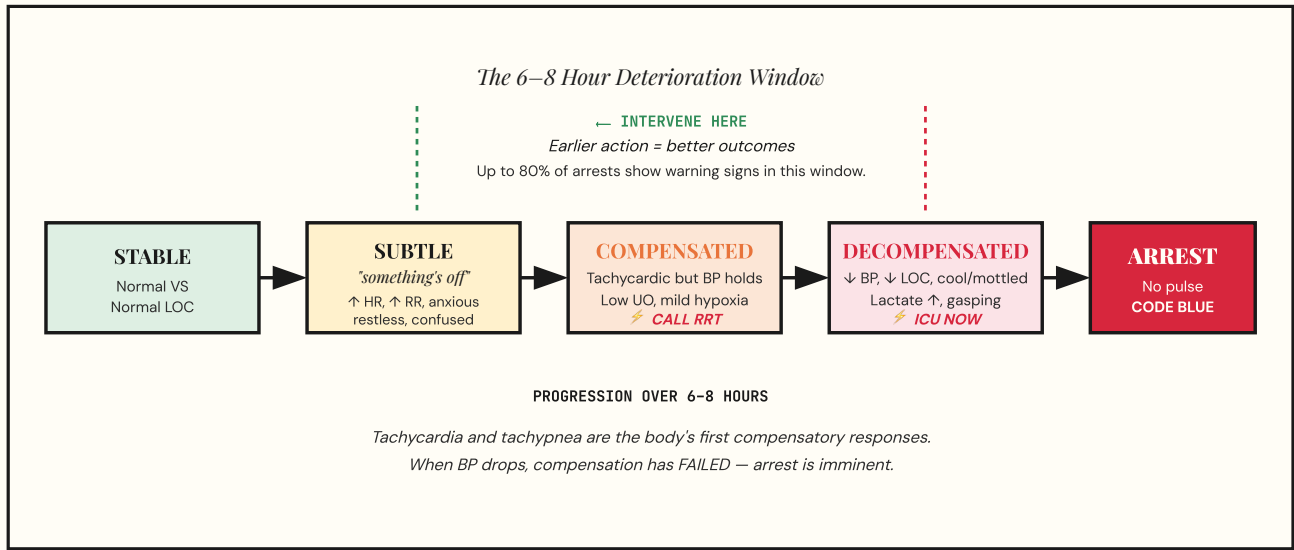
FEATURE	RAPID RESPONSE TEAM	CODE BLUE TEAM
Trigger	Patient is deteriorating but still <i>has a pulse</i>	Patient is in arrest — <i>pulseless</i> and/or apneic
Goal	Prevent the code	Rescue from the code
Activator	Any nurse, staff member, often family (most hospitals)	Any staff who finds an unresponsive/pulseless patient
Protocol	Assess, stabilize, transfer if needed	BLS → ACLS algorithm

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PATHOPHYSIOLOGY

The Deterioration Cascade

*Most arrests are **not sudden** — they are preceded by 6–8 hours of subtle deterioration. Catching the cascade early is the entire purpose of a Rapid Response system.*



Why It Cascades

- **Hypoxia / hypoperfusion** triggers sympathetic surge → tachycardia, tachypnea (compensation).
- The body *can compensate for hours* — BP often stays normal until very late.
- By the time BP drops or LOC declines, the patient is **already in shock**.
- Without intervention: organ failure → bradycardia → asystole or PEA.



The Critical Insight

A normal blood pressure does NOT mean a stable patient. A young patient can compensate with severe tachycardia for hours before crashing. *HR and RR change first; BP changes last.*

Trust your gut. "The patient just looks worse" is a valid Rapid Response trigger — and is one of the activation criteria at most institutions.

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ACTIVATION CRITERIA • SIGNS & SYMPTOMS

When to Call — Numbers That Trigger Action

If any one of these is present, the patient may need a Rapid Response. Don't wait for three.

RED FLAG = imminent arrest risk.

Rapid Response Activation Criteria

 Heart Rate < 40 or > 130 bpm	 Systolic BP < 90 mmHg	 Respiratory Rate < 8 or > 28 /min
 SpO₂ $< 90\%$ on O ₂	 LOC Change New confusion / ↓ GCS by 2+	 Urine Output < 50 mL in 4 hours
 Chest Pain New onset / unrelieved	 Seizure New or prolonged	 Nurse/Family Worried "Just looks worse" — VALID

Code Blue — Signs of Arrest

RED FLAG Cardiac Arrest • Unresponsive — no response to sternal rub • Pulseless — no carotid pulse in 10 sec • Apneic or only agonal gasps (NOT breathing) • Cyanosis, mottling, fixed/dilated pupils (late)	RED FLAG Respiratory Arrest • Apnea or RR < 6/min • Has a pulse but is not breathing effectively • Agonal respirations (gaspings) = treat as arrest • SpO₂ rapidly falling, cyanosis
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⚠ DO NOT Wait For All Criteria

NCLEX answer: **one criterion is enough**. Calling early is *never* wrong. The wrong answer is "monitor and reassess in 1 hour." If the patient has crossed any threshold — **call**.

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PRIORITY NURSING INTERVENTIONS

The ABC-Driven Action Plan

*Order matters. **Airway** → **Breathing** → **Circulation** → **Disability** → **Exposure**. Every NCLEX prioritization question maps to this hierarchy.*

A

AIRWAY — Open It, Keep It

- **Head-tilt/chin-lift** (no suspected trauma) or **jaw-thrust** (suspected C-spine injury)
- Suction visible secretions; remove obvious obstruction
- Place oral airway (OPA) if unconscious; nasal airway (NPA) if gag reflex intact
- **Prepare for intubation** — call respiratory therapy

B

BREATHING — Oxygenate & Ventilate

- If breathing: apply **non-rebreather at 15 L/min** (highest O₂ available)
- If apneic / agonal: **bag-valve-mask (BVM) at 10 breaths/min** (1 every 6 sec)
- Confirm chest rise; auscultate breath sounds bilaterally after intubation
- Attach continuous SpO₂ and waveform capnography (EtCO₂)

C

CIRCULATION — Pulse, Compressions, Access

- **Check carotid pulse ≤ 10 seconds**. No pulse = start CPR immediately
- **Compressions: rate 100–120/min · depth 2 inches (5 cm) · full recoil · 30:2 ratio**
- Switch compressor **every 2 minutes** (fatigue degrades quality)
- Establish 2 large-bore IVs (16–18 gauge) or **IO access** if IV fails
- Attach defibrillator/AED pads — **analyze rhythm** at next pulse check

D

DISABILITY / DEFIBRILLATION

- Assess LOC (AVPU or GCS); check **blood glucose** (hypoglycemia is reversible!)
- Check pupils — fixed/dilated suggests prolonged anoxia or herniation
- **Shockable rhythm (VF / pulseless VT):** defibrillate at 200 J biphasic, resume CPR *immediately*
- **Non-shockable (asystole / PEA):** continue CPR + epinephrine; do *not* shock

E

EXPOSURE / EVERYTHING ELSE

- Fully expose patient (preserving dignity); look for bleeding, rash, trauma, medication patches
- Review the **H's & T's** — reversible causes (see Memory Boosters)
- Communicate using **SBAR** to the responding team
- Assign a **recorder** — accurate timing of meds, shocks, rhythm changes is critical
- Consider family presence (evidence-supported; many units now allow it)

✓ Universal "First Action" on NCLEX

Patient found unresponsive: **(1) Check responsiveness** → **(2) Call for help / activate code** → **(3) Open airway, check breathing & pulse simultaneously (≤10 sec)** → **(4) Begin CPR if no pulse** → **(5) Defibrillate as soon as**

available.

Compressions before ventilations: C-A-B (per 2020 AHA guidelines for adult arrest of cardiac origin).

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PHARMACOLOGY · ACLS CODE CART

Drugs You Must Know Cold

High-yield code drugs. Memorize doses, indications, and what they will not fix. NCLEX loves "which drug do you anticipate?"

Epinephrine

SYMPATHOMIMETIC · $\alpha + \beta$ AGONIST

INDICATION

Any cardiac arrest rhythm: **VF, pVT, asystole, PEA**

DOSE

1 mg IV/IO push every 3–5 min during arrest

MECHANISM

↑ HR, ↑ contractility, ↑ vasoconstriction → coronary & cerebral perfusion during CPR

NURSING

Flush with 20 mL NS, raise extremity. **NEVER** mix with bicarb (deactivates).

Amiodarone

CLASS III ANTIDYSRHYTHMIC

INDICATION

Refractory VF / pulseless VT after 2nd shock + epinephrine

DOSE

300 mg IV/IO bolus first dose · 150 mg second dose · max 2.2 g/24 hr

MECHANISM

Prolongs action potential; stabilizes irritable ventricular myocardium

NURSING

Monitor for hypotension, bradycardia post-ROSC. Long half-life. **Lidocaine** = alternative if amio unavailable.

Atropine

ANTICHOLINERGIC

INDICATION

Symptomatic bradycardia with pulse (NOT for asystole/PEA per 2010+ guidelines)

DOSE

1 mg IV every 3–5 min · max 3 mg

MECHANISM

Blocks vagal tone → ↑ HR

NURSING

If ineffective: prepare for **transcutaneous pacing**. Watch for paradoxical bradycardia with doses < 0.5 mg.

Sodium Bicarbonate

ALKALINIZER

INDICATION

Specific situations only: **hyperkalemia, TCA overdose, prolonged arrest with documented acidosis**

DOSE

1 mEq/kg IV (typical 50 mEq)

MECHANISM

Buffers metabolic acidosis

NURSING

Routine use in arrest is **NOT recommended**. NEVER in same line as epinephrine, calcium, or catecholamines.

Calcium Chloride

ELECTROLYTE

INDICATION

Hyperkalemia, hypocalcemia, calcium-channel blocker overdose, magnesium toxicity

DOSE

500–1000 mg IV slow push (central line preferred)

MECHANISM

Stabilizes cardiac membrane in hyperkalemia

NURSING

Tissue necrosis if extravasated — use central line if possible. Monitor for bradycardia.

Adenosine

ANTIDYSRHYTHMIC • AV NODE BLOCKER

INDICATION

Stable narrow-complex SVT (patient has a pulse — not arrest)

MECHANISM

Briefly blocks AV node → resets rhythm

DOSE

6 mg rapid IV push, then 20 mL flush. Repeat 12 mg if no conversion.

NURSING

Warn patient: brief asystole, flushing, "sense of doom" — passes in seconds. Push as *fast* as possible into port closest to patient.



Drug Delivery Rules During Code

- **Push fast, flush with 20 mL NS**, raise the extremity 10–20 sec — gets drug to central circulation
- Preferred route order: **IV → IO → ET tube** (ET doses are 2–2.5× IV; rarely used now)
- Do NOT pause compressions to push drugs — continue CPR through administration
- Document **time given** for every drug — the recorder owns this

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NCLEX TEST TRAPS

Wrong vs. Right — Don't Get Fooled

Every trap below has cost students points. Learn the right answer pattern.

~~✗ WRONG~~

~~"Notify the provider and wait for orders."~~

~~The patient has SBP of 84 and HR of 142.~~



✓ RIGHT

"Activate the Rapid Response Team." One criterion is enough. RRT does not require an order.

~~✗ WRONG~~

~~"Reassess vital signs in 30 minutes."~~

~~Patient now has new confusion + RR of 30.~~



✓ RIGHT

"Call Rapid Response now." New altered LOC + tachypnea = active deterioration. Don't watch it — act on it.

~~✗ WRONG~~

~~"Defibrillate asystole."~~

~~Patient is in asystole on the monitor.~~



✓ RIGHT

"Continue CPR; give epinephrine 1 mg IV." Asystole and PEA are NOT shockable rhythms. Only VF and pVT get the shock.

~~✗ WRONG~~

~~"Stop CPR to administer epinephrine."~~



✓ RIGHT

"Continue compressions during drug push." Minimize CPR interruptions. The pulse check is the only acceptable pause — and only every 2 minutes.

~~✗ WRONG~~

~~"Push atropine for asystole."~~



✓ RIGHT

"Atropine is for symptomatic bradycardia with a pulse." It was removed from the asystole/PEA algorithm in 2010. Epinephrine + CPR is the answer.

~~✗ WRONG~~

~~"Agonal gasps mean the patient is still breathing."~~



✓ RIGHT

"Agonal gasps are NOT effective respirations." Treat as apnea — begin CPR.

~~✗ WRONG~~

~~"Check pulse for 30 seconds before starting CPR."~~



✓ RIGHT

"Maximum 10 seconds for pulse check." Beyond 10 sec, brain perfusion suffers. If unsure — start CPR.

✗ ~~WRONG~~

~~"Normal BP means the patient is stable."~~



✓ RIGHT

"HR and RR change *before* BP." A compensating patient may have a normal BP and still be in early shock. Trend the vital signs.

7

PATIENT & FAMILY EDUCATION

Empowering Bedside Advocacy

*Many hospitals now allow **patients and families** to call Rapid Response themselves ("Condition H" or "Family-Activated RRT"). Teaching is part of safe care.*



For the Family

- "You can call Rapid Response if you feel something is seriously wrong — even if staff say otherwise. Dial [unit-specific number]."
- Warning signs to call about: sudden confusion, trouble breathing, unrelieved pain, "they just don't look right."
- Family presence during a code is supported by evidence — you may be offered the option to remain. A staff member will stay with you.
- After resuscitation: the team will explain what happened and next steps once the patient is stabilized.



For the Recovering Patient (Post-ROSC)

- Memory loss around the event is normal and expected.
- Targeted temperature management (cooling 32–36 °C × 24 hr) may be used to protect the brain.
- Expect ICU admission, possible mechanical ventilation, and cardiac monitoring.
- Cardiac rehab, advance care planning (code status discussion), and possibly an ICD (implantable defibrillator) may be discussed.



Discharge / Advance Care Planning

- Confirm **code status** (Full code · DNR · DNI) is documented and discussed with family
- Provide written advance directives / POLST forms as appropriate
- Teach CPR / hands-only CPR to family of high-risk patients
- Reinforce medication compliance — many arrests follow med non-adherence (heart failure, anti-arrhythmics)

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MEMORY BOOSTERS • MNEMONICS

Patterns That Stick



The H's — Reversible Causes

- H** Hypovolemia
- H** Hypoxia
- H** Hydrogen ion (acidosis)
- H** Hyper-/Hypokalemia
- H** Hypothermia
- H** Hypoglycemia

Always check a glucose during a code — it's quick and reversible.



The T's — Reversible Causes

- T** Tension pneumothorax
- T** Tamponade (cardiac)
- T** Toxins (drug overdose)
- T** Thrombosis — pulmonary (PE)
- T** Thrombosis — coronary (MI)
- T** Trauma

If PEA is unexplained, run the H's and T's mentally — the cause is usually there.



SBAR — Code/RRT Communication

- S** Situation — what's happening now
- B** Background — diagnosis, brief history
- A** Assessment — VS, what you found
- R** Recommendation — what you need



Shockable vs Non-Shockable

Shockable (defib): VF + pVT

"Very Fast" rhythms get the shock"

Non-shockable (CPR + epi): Asystole + PEA

"Flat" or "fake" rhythms — drugs only



The "30:2 - 2 - 2" Rule for CPR

- **30:2** = 30 compressions to 2 breaths (single rescuer adult)
- **2** inches deep (5 cm)
- **2** minutes between rhythm checks / compressor swaps

"30-2-2-2: Rate is 100-120/min · No more than 10 seconds for pulse check."



C-A-B (Adult Cardiac Arrest)

Compressions first → **A**irway → **B**reathing

Adult cardiac arrest = compressions before airway. (Pediatrics & respiratory arrest still emphasize early ventilation.)

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NCJMM • CLINICAL JUDGMENT SCENARIO

Six-Step Walk-Through

SCENARIO: A 68-year-old client is post-op day 2 from an open abdominal surgery on a medical-surgical unit. The night shift reported the patient was "a little restless." At 0700, your initial assessment finds: BP 96/58 (was 128/72 at midnight), HR 124 (was 88), RR 26 (was 18), SpO₂ 89% on 2 L NC, temp 100.8 °F, and the patient is now mildly confused and oriented to person only. Lungs have new fine crackles in the bases. Urine output for the last 4 hours is 60 mL total.

1

RECOGNIZE CUES

RED CUES: Drop in SBP from 128 → 96. HR rise 88 → 124. RR rise 18 → 26. SpO₂ 89% (below 90% threshold). New altered LOC. Low urine output (< 30 mL/hr × 4 hr). Low-grade fever. New crackles. *Multiple Rapid Response criteria met simultaneously.*

2

ANALYZE CUES

Pattern fits early septic shock vs. pulmonary embolism vs. fluid overload / heart failure. Post-op day 2 + fever + tachycardia + tachypnea + hypotension + crackles + altered LOC = **SIRS / sepsis with developing organ dysfunction**. PE is a competing concern given post-op state.

3

PRIORITIZE HYPOTHESES

#1: Sepsis / septic shock (highest acuity, time-sensitive — every hour delay ↑ mortality).
#2: Pulmonary embolism (post-op risk factor).
#3: Fluid overload (less likely given hypotension and tachycardia, but crackles fit).

4

GENERATE SOLUTIONS

Activate Rapid Response Team immediately. Increase O₂ to non-rebreather 15 L/min. Establish second large-bore IV. Anticipate: lactate, blood cultures × 2, CBC, CMP, ABG, troponin, CXR, EKG. Prepare for IV fluid bolus (30 mL/kg crystalloid) and broad-spectrum antibiotics within the first hour ("Hour-1 Bundle"). Notify surgical team. Place patient on continuous monitoring.

5

TAKE ACTION

Call RRT (does not require provider order). Apply NRB at 15 L/min. Reposition supine with legs elevated if tolerated. Place second 18-gauge IV. Draw labs and blood cultures BEFORE starting antibiotics (if possible without delaying treatment beyond 45 min). Begin 1L NS bolus. Document precise times. Use SBAR to communicate with the RRT lead and the on-call surgeon.

6

EVALUATE OUTCOMES

Desired outcomes within 1 hour: SBP > 90 (or MAP > 65), HR trending down, RR < 24, SpO₂ > 94%, improved LOC, urine output > 30 mL/hr. **Worsening trends** (rising lactate, persistent hypotension, falling LOC) → escalate to ICU, anticipate vasopressors (norepinephrine first-line), possible intubation. Continue reassessment every 15 minutes during transfer.

Diane's NGN NCLEX 2026 Visual Study Library

TOPIC 19 • RAPID RESPONSE & CODE BLUE TEAM • EMERGENCY RESPONSE CLUSTER

SOURCES: SAUNDERS COMPREHENSIVE REVIEW 9TH ED. • AHA 2020 ACLS GUIDELINES • AACN PRACTICE ALERTS