Cooper
University Hospital

Bridges to Excellence

A publication for nurses and healthcare professionals

SPRING 2008

Rapid Response Team

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From the Chief Nursing Officer

Elizabeth Bobulski, RN, BS, MPH • Senior Vice President of Patient Care Services and Chief Nursing Officer

Dear Colleagues,

Perhaps in our clinical practice there is no greater responsibility than keeping our patient's safe. In every setting the Nursing team works collaboratively with the Interdisciplinary team to identify the patient's needs and risks and to create a safe environment. Ultimately to create a culture of safety that resonates with all in an organization.

In this edition of "Bridges to Excellence" you will find many examples of the clinical team at its best. The advent of Rapid Response is one of the finest examples of sharing expertise to protect patients. The programs developed for Safe Patient Handling not only create safety and dignity in moving patients but they protect our valuable clinicians from injury. One of the articles discusses the "Good Catch" program at Cooper. It discusses the value of rewarding the team for the recognition of events that could lead to near misses. Reward openness, celebrate active participation… it is so vital to safety.

I hope you will enjoy exploring this issue and as always, let us know what you think. We appreciate your comments to any of our emails contained within.

Best regards,

Elizabeth Bobulski

Email comments to **Bobulski-liz@cooperhealth.edu**

Bridges to Excellence **Mission Statement:**

"To communicate and educate nurses and healthcare professionals to foster excellence in the delivery of patient care."

Cooper Nurses interested in authoring an article for a future edition of *Bridges to Excellence* may obtain submission guidelines by contacting **Yhlen-kathleen@cooperhealth.edu**

Good Catch Event Reporting

Suzanne Gould RN, MSN; Janette McFetridge RN, BSN

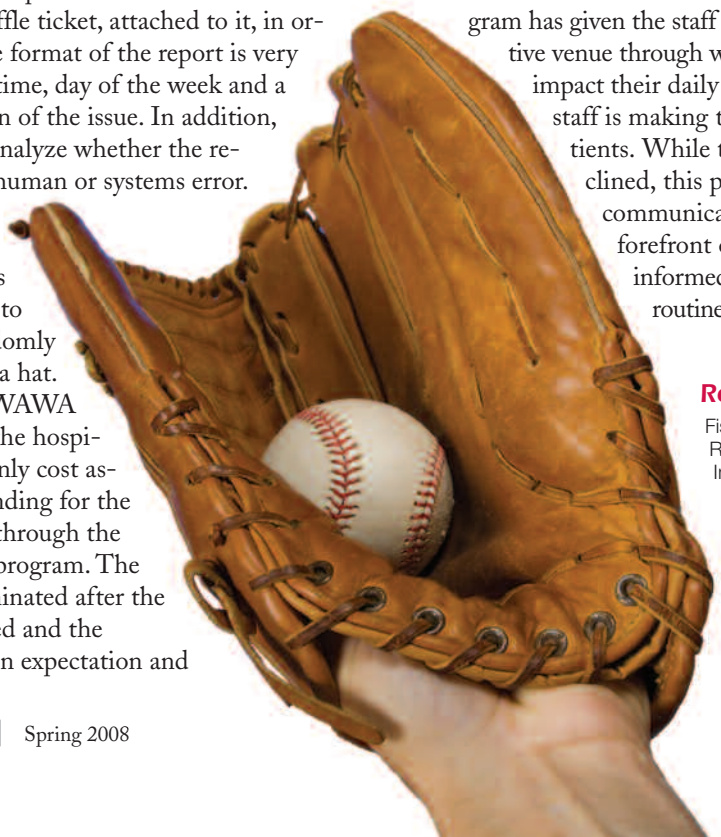
Non-punitive error reporting systems have been sited as one safety initiative directly responsible for saving up to 98,000 lives each year (Kohn, Corrigan, & Donaldson, 2000). Nurses often neglect reporting errors for fear of punishment, being label a "snitch," and retribution by their peers. In fact, in Cooper University Hospital's Intensive Care Unit (ICU) and Coronary Care Unit (CCU), only four incident reports were received in a four-year period of time, before the "Good Catch" program was initiated. The goal of the program was to increase the number of reports submitted, and to place a positive emphasis on the process. The challenge was changing the culture and making safety a priority.

The advent of this program was born out of our participation in the New Jersey Hospital Association Collaborative of Teaching Hospitals and the Institute of Medicine's (IOM) "100,000 Lives Campaign." Our leadership team adopted many of the protocols and recommendations that the campaign sited as necessary to keep patients safe from problems that are inherent in our healthcare system (Kohn, Corrigan, & Donaldson, 2000). The "Good Catch" program was selected because it is an anonymous, non-punitive error and near miss reporting system (Fish, Murphy, Olson, & Bowlinger, 2004). This does not replace mandatory incident reporting for such things as falls, elopement, and pressure ulcers, however it tends to complement this system and focus on processes, daily work habits, and potential problems encountered within the delivery system. The leadership team set up a drop box in each unit along with pre-printed report sheets. Each report has a numbered ticket, like a raffle ticket, attached to it, in order to maintain anonymity. The format of the report is very simplistic; it includes the date, time, day of the week and a space to write a brief description of the issue. In addition, there is space on the report to analyze whether the reported issue is thought to be a human or systems error. In order to offer incentive and foster participation in this new reporting system, staff members reporting an issue were eligible to win a prize. Each month a randomly selected ticket was pulled from a hat. Prizes included movie tickets, WAWA gift cards, and coffee cards for the hospital's café. The prizes were the only cost associated with this program. Funding for the prizes had been made possible through the hospital's Cooper Cares, grant program. The prize feature was gradually eliminated after the number of submissions increased and the process became hard-wired as an expectation and routine practice. Staff members from any discipline who provide care in ICU and CCU are encouraged to participate; including nurses, doctors, critical care technicians, respiratory therapists, dieticians, case managers, physical therapists, and occupational therapists.

"Good Catches" are collected and reviewed each month by the Clinical Manager. The issues are categorized by topic (i.e.: equipment, medications, laboratory, procedure, throughput, patient, miscellaneous) and reported to the Performance Improvement Team and then to the Vice President of Regulatory Affairs. In addition, the numbers of "Good Catches" are reported monthly at the ICU Quality Assurance Committee and the CCU Committee meetings, as part of a benchmark report card used by the leadership team to evaluate outcomes. Issues which require immediate attention are addressed with the manager of that department. If a hospital-wide issue is discovered, it is brought to the Director and/or the Vice President of that department for review and follow-up. Occasionally, issues are addressed at hospital-based committees, by Risk Management, or at staff meetings if appropriate. The program started in 2005, that year there were 122 issues reported, in 2006 there were 96, and in 2007 there were 44 reports.

There have been many measurable results. The leadership team has been able to change processes, identify deficiencies, and build collaborative relationships with other departments including Pharmacy, Lab and the Biomedical Department. The staff has taken the time to address matters and initiate change. The negative perception of reporting has been eradicated. The "Good Catch" program has given the staff a sense of empowerment and a positive venue through which they can voice concerns that impact their daily practice. More importantly, the staff is making the environment safer for the patients. While the actual number of reports has declined, this program has opened the door to communication and has brought safety to the forefront of delivering care. Keeping managers informed, in a timely manner has become routine and is recognized as a "Good Catch."

The "Good Catch" program has given the staff a sense of empowerment and a positive venue through which they can voice concerns that impact their daily practice.



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The Importance of Families in the Post Anesthesia Care Unit

Mary Louise Kenney, RN, CAPA

"Historically, Post Anesthesia Care Units (PACU) have been closed units" (Sullivan, 2001, p.29).

It was believed that patients recovered better without the disruption of visitors. Today, that thinking has changed and families are encouraged to participate in the recovery process. Some nurses are still resistant to this change in practice. They view visitors as an unnecessary burden placed on them. "As a previously invisible staff, the nurse's behaviors and practice were suddenly on display to the public" (Smykowski & Rodriguez, 2003, p.7). Families are an extension of the patient and need to be reunited with their loved ones as soon as possible to reduce stress and aid in the recovery process.

Patients, visitors, and nursing staff benefit from having families in the PACU. The benefit for the patient is that they will see a familiar face and feel comforted and secure (Om, 2008). The benefit for the family is that they will know that their loved one is alive and in a safe environment. The staff can also benefit from families in the PACU. Visitors have been seen as helpful in some aspects of patient care (Sullivan, 2001). Visitors are able to assist with relieving stress and providing reassurance so the patient does not feel alone. They can also provide the nurse with important insight into the patient's personality and preferences. Finally, while the family is with the patient in the PACU, the nurse can initiate post op teaching and discharge instructions. This is an added benefit to the staff because it allows for a smoother transition of the patient from the facility to their home. "Family-centered care leads to better health outcomes, wiser allocation of resources and greater patient and family satisfaction" (Kamerling, et.al, 2008, p5).

Several barriers to visitation in the PACU have been identified. "Despite the evidence that supports family visitation in the PACU, visitation remains a controversial issue for nurses" (Sullivan, 2001, p.29). Various reasons for this behavior among nurses have been documented. Some nurses do not perceive visitation as important to family members (Tuller et al, 1997). These nurses may be uncomfortable with a change in traditional practice. Traditionally PACU nurses are not familiar with working in front of the family and may feel awkward. Concerns over maintaining patient privacy and confidentiality are another issue for nurses. Additionally, patient recovery areas in the PACU are usually small, confined spaces leaving little room for additional people. Finally, visitors may come into the unit, may be disruptive and unprepared for the experience (Smykowski & Rodriguez, 2003).

Solutions exist to improve family participation in the PACU. Education is the first step. Patients, families and staff need training and instruction regarding the appropriateness of including families in the PACU. Patients need to know that their families will be invited back to join them as soon as it is safely possible. Families need to know that the patients in the PACU need a quiet environment so they can rest and recover from surgery. The staff needs to know that including families in the PACU is the standard of care. First we have to help the staff confront and embrace the change. Many health care facilities have unit-based committees. It is the

responsibility of the unit-based committee to improve the family visitation process. The following educational strategies for implementing a visitation protocol can be used (Smykowski & Rodriguez, 2003). Reviewing the current literature will help the staff identify benefits in family visitation. Encourage the staff to verbalize their concerns and reluctance to change. Reassure the staff that family visitation has shown to enhance patient recovery and ease anxiety and fear. Empowering the PACU nurse to take control of the family visitation will benefit the staff, patient and their families.

Advances in technology have created a more educated health care consumer. This will have a significant impact on nursing care and the nursing profession. Patients are aware that their families should be included in the recovery process. "There is a growing volume of nursing research that supports family visitation in the PACU" (American Society of PeriAnesthesia Nurses, 2003, p.303). It is an integral part of patient recovery and consistent with recommendations of the Joint Commission on Accreditation of Healthcare Organizations (Ninger, 2003). "As PeriAnesthesia nurses, we have the responsibility to evaluate our research findings and incorporate them into our practice" (Sullivan, 2001, p30). PACU nurses need to own this practice and should be accountable for meeting the needs of the patient and the family to provide the best care available (Smykowski & Rodriguez, 2003).

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Safe Patient Handling:
Protecting Patients, Protecting Caregivers

Kathleen Yhlen, RN, BSN, CNA; Christina Hunter RN, BSN, OCN; Norma Rowello, RN

Providing quality patient care includes providing a safe environment for both the patient and the caregiver. Nurses now place an increased value on safe patient handling evidenced-based practice, by role-modeling its importance in the hospital environment (Chiverton & Witzel, 2008). Safe patient handling programs are being increasingly accepted by healthcare organizations to prevent work-related injuries to caregivers while providing a safe environment for the patient (Nelson et al., 2007).

Typically, body mechanics and lifting techniques are taught as a means to counteract the physical stress of manually handling patients,(de Castro, Hagan, & Nelson, 2006). The reality of nursing care includes high-risk tasks such as lifting a magnitude of weight and sustained awkward positions used to provide care, such as bending over chairs, or beds while the back is flexed. In addition, nurses are caring for patients that are sometimes unpredictable in nature, with higher acuity levels, including elderly and bariatric patients (de Castro et al., 2006).

Some of the essential elements of safe handling programs include policies, assessment of patient care areas, staff training and education, and investment in patient handling equipment and devices. Safe patient handling programs benefit patients by reducing the potential for injury and increasing comfort levels. The benefits to nurses include a reduction in musculoskeletal injuries, a safe workplace to practice, decreased fatigue, and increased job satisfaction.

Program development

In a joint effort, Cooper University Hospital (CUH) and the Health Professionals and Allied Employees (HPAE) Local 5118, the union representing Cooper's registered nurses, created a task force to plan, develop, implement, and evaluate a safe patient handling program. The multidisciplinary task force included representatives from Patient Care Services Administration, Physical Therapy, Risk Management, Environmental Services, Human Resources, Environmental Safety, Nursing Education, Staff Nurses, and HPAE. In addition to promoting the safety and comfort of patients, Cooper's healthcare providers who assist in the transferring and repositioning of patients were a priority for the task force.

In an effort to provide education to the task force, eight members traveled to Kalieda Healthcare in Buffalo, New York, for a site visit. Kalieda had successfully implemented a safe patient handling program. The group saw first-hand the equipment being utilized by hospital. In addition, Kalieda shared implementation strategies, policies and procedures, and their lessons learned.

Next, the task force sent two staff nurses and the Director of Physical Therapy to the 7th Annual Safe Patient Handling and Movement Conference in Lake Buena Vista, Florida. The conference provided cutting edge research, best practices, hands-on workshops, equipment demonstrations, training techniques, and information on how to develop safe patient handling programs.

Implementation/Education

After returning from the conference, the task force decided that in order to successfully implement a program, the frontline healthcare providers needed to be involved. A train the trainer approach was agreed upon to reach the frontline staff. The managers of each patient care area along with the task force identified "unit champions." The unit champions receive education and training to train the staff on their respective units. An application was submitted for a federally funded grant program, and was awarded from the U.S. Department of Labor, to develop a comprehensive education and training program designed to prevent back and musculoskeletal injuries. The Occupational Training and Education Consortium (OTEC), a New Brunswick-based program within the School of Labor and Management Relations at Rutgers, The State University of New Jersey, provided the education and training for Coopers' frontline trainers. Over the past ten years, OTEC worked with a wide range of New Jersey industries including healthcare, to create education programs to help frontline workers develop the knowledge and skills to effectively participate in health and safety decisions and help facilities develop the in-house capacity and organizational infrastructure to sustain a culture of health and safety.

> Developing safe patient handling policies and procedures, educating and training health care providers, and utilizing patient safe handling equipment are essential elements in delivering quality patient care.

A two-day workshop was held at CUH. The agenda for the first day of the workshop included myths and facts about safe patient handling, implementing a safe lift program, equipment needs assessment and planning, and hands–on practice with equipment. Day two included putting safe patient handling strategies into practice, creating a culture of safe patient handling, recommendations for policies, identifying and analyzing key implementation issues, and developing and presenting talking points. After attending the workshop the attendees stated that they were able to identifying problems, explain evidenced-based health and safety practices, develop strategies for overcoming barriers, and plan how to implement new practices.

Choosing the right tools and equipment

Vendors from several companies offering safe patient lift tools and equipment were invited to an all-day equipment fair at the hospital. Direct patient caregivers, managers, and educators were invited to see demonstrations and evaluate and make recommendations for which tools and equipment would best meet the needs of the patients for which they cared. The first tool unanimously re-

quested was the non-friction slider sheet. This nylon sheet coated with silicone assists with the transfer of patients from bed to stretcher and facilitates positioning the patient in bed.

A medical-surgical unit was chosen to pilot the slider sheets. The unit educator trained the unit's champions and they in turn trained the remainder of the staff. In order to raise excitement a contest was devised for the staff person who "slides" the most. An evaluation tool for the sheet doubled as a way of keeping track of who was using the sheet. In just a few weeks the responses were overwhelmingly positive. Comments included "we were able to transfer a patient that was over 500 pounds with ease," "my back felt no pain," "we transferred a patient with burns and the patient stated an increase in comfort," and "we need less staff to transfer bariatric patients." When the pilot was completed three additional patient care units received the slider sheets and were trained. As a result of the successful pilot, slider sheets have been ordered for the remainder of the hospital.

The first lesson learned from using the slider sheets was that the sliders needed to be available at every bedside. Originally the sheets were placed in the clean utility room. Accessibility was an important determining factor whether staff would use the sheets. Another lesson learned was the necessity of maintaining a small par level on the unit in the event that sheets were sent to the laundry. Finally, when the unit champions met resistance among staff they found approaching those staff members

The benefits to nurses include a reduction in musculoskeletal injuries, a safe workplace to practice, decreased fatigue, and increased job satisfaction.

directly and re-training them was necessary. The reason for resistance was mutual – it was one extra step and it takes more time to place the sheet under the patient. The champions continued to demonstrate the ease of use and explained the legislation and rationale behind using safe handling equipment.

Celebration

On December 5, 2007 Cooper University Hospital and Health Professionals & Allied Employees officially kicked off the joint initiative, "Protecting Patients, Protecting Caregivers." This placed Cooper at the forefront of an effort to utilize safe patient handling equipment by caregivers. Together they proudly unveiled the new initiative before frontline caregivers, legislators, and media from both Pennsylvania and New Jersey.

This incredible undertaking is a one of a kind in a New Jersey hospital. Working together, Cooper and HPAE have taken the lead in developing a model program. Staffs throughout the organization were extremely excited about this collaborative initiative with HPAE and the opportunity to be part of a program which enhances the safety of the work environment and patient care.

While HPAE and Cooper had been working on the Safe Patient Handling initiative, a Cooper physician and NJ Assemblyman Dr. Herb Conaway introduced a bill requiring all NJ hospitals to implement programs like the one developed at Cooper. HPAE members testified on behalf of the bill, which successfully became a law in New Jersey.

The legislation was signed by Governor Corzine on January 3, 2008!

Next Steps

Additional equipment has been delivered to pilot on two patient care units. The new equipment will assist staff to safely position and transfer patients to and from the bed, stretcher, or chair. Each clinical area will be assessed for specific equipment needs based on patient population. Once staff on the unit feels comfortable with the education process and new equipment, the remaining clinical areas will receive equipment and training.

Developing safe patient handling policies and procedures, educating and training health care providers, and utilizing patient safe handling equipment are essential elements in delivering quality patient care. Safe patient handling programs are evidenced-based practices, increasingly being incorporated into healthcare settings, to provide patients with safety and comfort while reducing injuries and providing safe workplaces for nurses to practice.

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Cooper's First Responders:
Adult Rapid Response Team

Laura Decker RN, BSN, CCRN; Mary Jo Cimino RN, BSN, CCRN; Kimberly Aimone RN, BSN

Problem

Rapid response teams were born from the national 100,000 lives campaign. In 2004, the Institute for Healthcare Improvement (IHI) claimed that over 100,000 lives were lost in the United States alone from preventable errors; errors not only during administration and ordering of medication, but from what is now being been called failure to rescue. Therefore, the IHI challenged the healthcare community to create a culture of safety to achieve the best possible outcomes for patients (McFarlan & Hensley, 2007).

The Institute of Healthcare Improvement cites that 66% of patients show abnormal signs and symptoms within six hours of arrest and the doctor is notified in only 25% of cases. "Failure to recognize changes in a patient's condition until major complications, including death, have occurred is referred to as failure to rescue (Table 1). The phrase 'failure to rescue' is not intended to apply negligence or wrongdoing. Failure to rescue is a measure of an overall performance of a hospital with respect to caregivers' ability to recognize and react autonomously" (Thomas, Force, Rasmussen, Dodd, & Whildin, 2007, p. 20).

Table 1 **Adult Warning signs within six hours of an event include:**

- MAP<70 or >130 mmHg
- Heart Rate <45 or >125 per minute
- Respiratory rate <10 or >30 per minute
- Chest pain
- Altered mental status

Solution

One of the campaign's recommendations was to implement rapid response teams. A rapid response team (RRT) is a team of clinicians who bring critical care expertise to the patient in need. The RRT provides a system of care for clinically unstable patients in the general hospital population. This system adheres to the principles of early detection and response to specific indicators of clinical deterioration. Although the response team is the most obvious component of these systems, these teams are only one part of a much more comprehensive system-wide response (International Liaison Committee on Resuscitation, 2007).

In 2005, Cooper University Hospital (CUH) decided to join the IHI's 100,000 Lives Campaign. Once the decision was made to proceed, a planning committee was put into place. The RRT committee first needed to create a core group of healthcare practitioners to respond when needed. The designated first responders included a critical care fellow, a critical care nurse, and a respiratory therapist. Next, the committee needed to specify which appropriate patient care areas the first responders would respond to. Besides the obvious in-house patients, the RRT would also respond to the GI Lab, Echo Lab, Radiology, and Dialysis departments. Finally, after a brief trial period on a medical-surgical unit, the RRT committee made a decision to formally implement the team.

The next order of business was to develop the inclusion criteria for staff to determine when it was appropriate to call the RRT. With this in mind, the planning committee felt that criteria should include some additional 'warning signs' since there was no one single standardized data set available (Table 2).

Lessons Learned

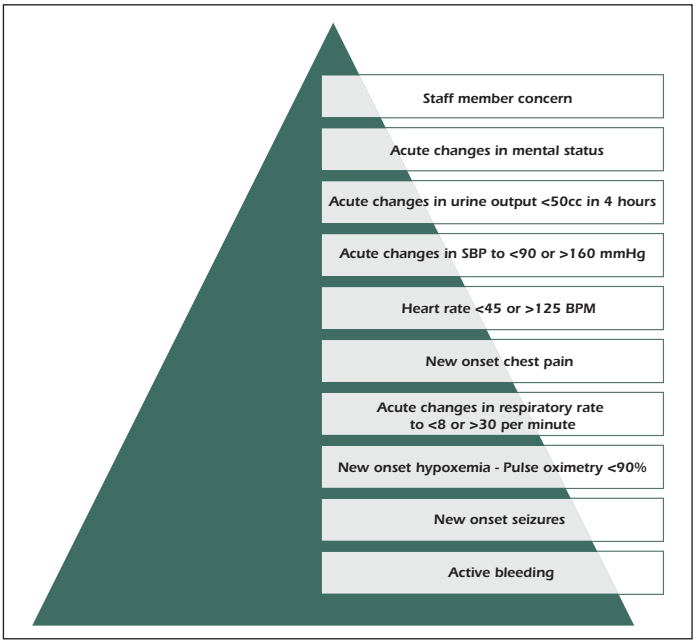
Communication or rather lack thereof, was an initial pitfall. In healthcare's fast-paced environments, it is imperative to give clear and concise information specifically during shift report, patient transfers, and critical events. In fact, the Joint Commission has issued a new requirement in association with its National Patient Safety Goal 2, which states that facilities must implement a standardized approach to handoff communications (IHI, n.d.).

In an effort to improve patient outcomes and avoid a failure to rescue situation, the committee recommended that nurses and physicians use the anagram SBAR when communicating.

- **S** – ***Situation:*** What is happening at the present time?
- **B** – ***Background:*** What are the circumstances leading up to this situation?
- **A** – ***Assessment:*** What do I think the problem is?
- **R** – ***Recommendation:*** What should we do to correct the problem?

(continued on page 10)

Table 2 **Criteria for activating the Rapid Response Team**



Back (l-r): M.J. Cimino, RN; K. Heinkel, RN; Dr. S. Ahmed; Dr. I. Ahmed; Dr. J. Williams; K. O'Brien, RN; K. Pardee, RRT; **Middle:** Dr. R. Nahra; D. McGinly, RRT; R. Gruber, RN; D. Dilger, RN; **Front:** C. Clarke, RN; Dr. A. Spevetz; O. Davidson, RN; Dr. R. P. Dellinger; L. Burgess, RN (PHOTO BY GREG STAMAN, RN)

(continued from page 9)

"SBAR creates a shared mental model for effective information transfer by providing a standardized structure for concise factual communications among clinicians — nurse-to-nurse, doctor-to-doctor, or between nurse and doctor" (IHI, n.d.).

The assumption for this system of care is that resuscitation of unstable patients is more likely to succeed if activated as soon as possible after clinical instability is discovered, and in particular before the patient arrests. As previously stated, the goal is to prevent death and decrease the amount of admissions to intensive care units by rapidly treating a patient who exhibits early warning signs. When a nurse identifies a patient who is deteriorating, he or she can simply use his or her intuition, or check to see if the patient meets specific criteria of instability, and then call in the hospital's RRT to evaluate the patient.

Outcomes

Initially, rapid response was only offered for certain hours of the day. The RRT is now available 24 hours a day, thus creating an even safer environment for patients. Many indicators are tracked in order to adequately measure the various ways the RRT has impacted the adult acute care population including time of the call, the amount of time it takes for the RRT to respond to the floor, and the immediate treatment and disposition of the patient after the assessment has been provided. Data collection has shown an increase in the number of RRT calls and a decrease in the numbers of codes. (Table 3)

Table 3 Average Monthly RRT/Codes

	Monthly Average Number of Codes	Monthly Average Number of RRT Calls
2006	35	2.5
2007	29	7.25

Presently, the majority of patients are subsequently transferred to a monitored critical care unit such as the ICU or CCU. It is our intent and goal, however to be able to treat the patients and have them remain on the floor after they have been stabilized. This is one of the major goals of the RRT, and in order to accomplish this, the staff, house-wide need to be educated in the early warning signs preceding an event and the reasons to initiate a rapid response call. From a patient safety perspective, the earlier the rapid response call, the better the outcome. Every call is important, no matter how 'minor' it might seem.

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Institute for Healthcare Improvement. (n.d.). *Effective Teamwork as a Care Strategy: SBAR and Other Tools for Improving Communication between Caregivers*. Retrieved February 1, 2008, from www.IHI.org

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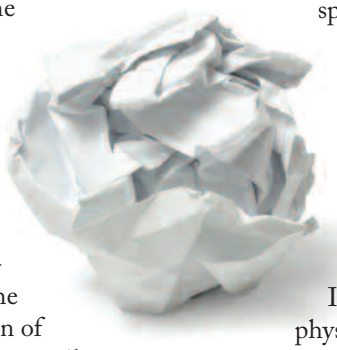
Imperfect Design

Frances Paul, RN, BSN, CPHQ, HEM

I was not a nurse yet when I first challenged the status quo in healthcare. Well, it was not as vast as "healthcare", but it felt like an act of bravery in the little world of a small diploma nursing school.

During my senior surgical rotation in the operating room, I observed a rhinoplasty. I had, in my last case, contaminated a large sterile table of instruments with a glove wrapper so I was assigned to observe this case instead of touching anything in the room. I felt like a toddler on a time-out.

The Operating Room (OR) team bantered back and forth, assistants anticipated instrument requests like mind readers and there was an easy flow to the room. I was gazing at the patient's uneven nares when the surgeon announced that the case was over. Given my recent lack of credibility, I knew what I was about to say was a risk. I rationalized by thinking "You do not need to be a doctor to know even from uneven". I coughed (under my mask of course) an attention getting "Ahem", and told the surgeon that if he stood at the head of the table where I was, he would see that the patient's nose was not even. The room fell silent. I hoped he would agree so I would not become their first student nurse Darwin Award recipient. The surgeon came to the head of the table and much like a golfer crouching to line up a putt, he examined his work. "Sure enough, you are right" he said, and proceeded to correct the problem. Whew!



Years later, I realized that that was my start in becoming a patient advocate. I also realized that the surgeon was a good one who simply forgot to look at his work from all angles. He was after all, human. He was smart though, because he ignored the messenger and focused on the message; the condition of the patient's nose. That patient's crooked nose (and my sterile technique breach) became a professional life metaphor for a constant reminder that we are by design, *all of us*… imperfect. That seemingly small reality leveled the playing field in the OR that day and gave me the leverage I needed to open my mouth.

The often cited Institute of Medicine's "To Err is Human" report on medical error made a variety of suggestions to reduce medical mistakes. Since most human error is induced by system failure, most of their recommendations were process design changes to guide and support the clinician and organization. The overwhelming truth though is that even the most sophisticated process is designed by an imperfect human and is not fool proof. There will always be human error. Given *that* reality, how will *you*, the most important variable in the safety equation, *design you?* Here are three questions for you to ask.

"Do I know ***why*** *I am doing what I'm doing?"* Do you remember those horrific care plans from freshman year in nursing school? They required the scientific rationale for every procedural step which forced students to learn the connection between their actions and the impact on the patient. I should have paid better attention to them because *what was absolute torture then, was actually the strongest mental exercise for critical thinking that I had in all my education.* Knowing why means you know the science, understand the effect on the patient when you do (or do not) perform a task and have relevance to drive you to remember and comply. The Joint Commission standards list their *intent* with each standard because it's not enough just to *tell* a clinician to do something. The simple task of "check the patient identification" tells you nothing. However, when it is explained that the purpose of checking the patient identification is actually a verification process that matches the correct patient with the correct task, (e.g. correct patient receives the correct medication), *that tells you the why.*

"Am I really listening to the patient?" I remember working on a medical-surgical floor as new graduate nurse. A patient told me he just "didn't feel right." His vital signs and exam were normal. Given my new nurse status and confirmation that I was not perfect (from the OR debacle and a few other student mishaps) I was afraid I was missing something. I continued talking to him trying to gain some concrete information. Finally, I asked if he ever felt like this before and he said when he had gastrointestinal bleeding a few years ago. Bingo! We got him on a bedpan and he produced a melanotic stool. Back then we did not have rapid response teams (and we would get in trouble for calling the code team for a non-code) and most transfers to Intensive Care Unit (ICU) were emergencies. We ended up with a controlled transfer to the unit under the care of more experienced nurses that knew how to pre-empt his impending shock. In this case, I found the information that I needed by listening, not looking.

"How will I feel later if I do nothing now?" I was a more experienced nurse when I ran into a physician that would leave town for a few days and not see his patients or provide physician coverage for his inpatients. Upon his return, he would write daily progress notes for the days that he was out of town. We did not have Ethics or Compliance lines back then (that I knew of) so my only option was a face-to-face discussion with leadership about the lack of patient care and medical record falsification. I was not supported and I quit. I found a better job and overwhelming guilt. I realized that I had not tried hard enough and allowed my fear to get in the way of taking action on to a higher level. About a year later, I learned about the Office of the Inspector General and reported the incident to them. I wondered how many patients suffered in the meantime because I did not push the issue.

My student nurse OR rotation was my stepping point into understanding that the limits and unpredictabilities created by our human imperfections have a critical impact on the lives of others. Good process design is essential for creating a safe patient care environment, but should support not substitute for critical thinking. Know why you do what you do, listen to understand and speak up when something is not right.

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Code Blue: *Are You Prepared?*

Don Everly, RN, MSN, MBA, CCRN, CCNS, PCCN

You are working on a medical-surgical floor and walk into your patient's room to answer his call-light. Mr. Johnson, a 68-year-old patient who was admitted to your floor last night, informs you that he is feeling lightheaded and nauseated. As you begin to take his vital signs, you notice that he becomes unresponsive. You shake him to check for arousal and there is no response. This is the first time you have witnessed a patient go unresponsive right in front of your eyes and your only thought is "what just happened?"

Loudly, you yell out to the nurses' station seeking help and another nurse quickly enters the room. As your co-worker approaches Mr. Johnson, she notices that his eyes are closed and he does not appear to be breathing. She instructs you to lower his head of the bed and "check his ABC's." Overwhelming thoughts run through your mind. You take a deep breath and force yourself to relax. You lower the head of the bed and tilt Mr. Johnson's head back to open his airway and check to see if he is actually breathing. The thought now going through your mind is that you only ever did this before in Basic Life Support (BLS) courses and it was on a plastic mannequin. Now you are performing this on a real person. A real person that was just speaking to you seconds before.

You remember – "Look, Listen & Feel" for breathing and determine that Mr. Johnson is not breathing. Now the adrenaline is really pumping throughout your body. You turn to your co-worker and cry out "call a Code and get the crash cart in here now!" Again, you are trying to calm yourself and think aloud "ABC." Mr. Johnson's airway is open, and he is not breathing, so you quickly put your fingers on his neck to check for a carotid pulse. After a ten second check, you do not feel a pulse. Your next thought is "where is everyone?"

You hear your co-worker telling the unit secretary to call a code and see the crash cart being pushed into the room by another nurse. Next, the nurse opens up the last drawer of the crash cart and removes the ambu bag and runs over to the oxygen outlet on the wall to connect the tubing. The technician is moving furniture out of the room to help free up space for needed equipment and personnel. Running to the back of the crash cart, you obtain the CPR board and place it under the patient. The charge nurse turns on the LIFEPAK 20 monitor on top of the crash cart and peels off the pads to place on the patient's chest. The monitor begins talking and you hear "apply pads to patient's bare chest." The charge nurse calmly informs everyone to not touch the patient, as the monitor needs to analyze the patient. The monitor is now echoing her words and saying, "do not touch patient." After a few seconds, the monitor says "shock advised…charging…stay clear of patient." The charge nurse waves her arm over the patient's chest to ensure that no one is touching the patient and she states that she is going to shock the patient and yells "all clear." She pushes the red SHOCK button on the monitor and you see the patient's arms and thorax area twitch forcefully as the energy is being delivered to the heart. After that shock, the monitor begins talking again and says, "Begin CPR."

Immediately, you perform CPR with 30 chest compressions and 2 ventilations given by another nurse via the ambu bag. As sweat is running down your forehead from performing chest compressions, you ask yourself "where is the code team?" You heard the operator announce CODE BLUE overhead and yet it seems like that was announced hours ago, even though it has only been about four minutes that the patient became unresponsive. Looking around the room, you notice there are only your four nurses from the floor, none of which has ever taking an Advanced Cardiac Life Support (ACLS) course. All of a sudden, you hear and see about 15 white coats running into the room. You hear another voice state, "I am the intensive care nurse (ICU) nurse" and with a great sigh of relief, you think that your role is now over and the ICU nurse will be able to save this patient's life.

The Medical Admitting Resident (MAR) calmly identifies himself as the Team Leader and the ICU nurse reaches into the 2nd drawer of the crash cart and gets the pink CODE TEAM LEADER sticker for the MAR to wear on his lab jacket. The MAR asks the nurses what events lead to calling the Code Blue and, because of the commotion in the room, realizes that no one heard him. He politely asks that only those present who have an actual role in this code to remain in the room. He again asks the nurses what happened to the patient. As Mr. Johnson's nurse, you give a detailed report of the events leading up to the code and the past medical history of the patient.

> Each code you encounter is your chance to save a life. Remember to stay calm. Take a deep breath and let your nursing skills take over.

The charge nurse is starting to write down all of this information on the code record and the ICU nurse opens up the door to the LIFEPAK 20 monitor so that the patient's heart rhythm can be observed. The MAR orders for chest compressions to be stopped so he can look at the patient's heart rhythm. The rhythm appears to be an organized rhythm on the monitor so he asks a resident to check for a pulse, but no pulse can be palpated. The MAR announces, "The patient is in pulseless electrical activity (PEA), resume CPR and give 1mg of epinephrine."

The ICU nurse announces aloud to the recording nurse that 1 mg of epinephrine has just been given. The recording nurse writes down the time and dose of this drug, but questions the team on what is PEA. The coronary care unit (CCU) fellow, whose role it is to oversee the code and answer any questions, informs the team that PEA stands for Pulseless Electrical Activity.

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He further states that it is possible to view organized electrical on the cardiac monitor, yet assessment of the patient reveals no palpable pulse.

After 2 minutes of CPR, the MAR asks for chest compressions to be stopped, so the rhythm on the monitor can be assessed. The rhythm still appears to be an organized one, but at a slightly faster rate. He asks for a pulse to be checked. While the resident is checking for a femoral pulse, anesthesia successfully intubates the patient and informs the recording nurse that it is a "size 8.0 ET tube being taped at 22 cm."

The resident then yells out "I feel a bounding pulse." The MAR informs the code team to stop chest compressions and continue assisting ventilations. The CCU fellow is conversing with the Bed Coordinator to determine if a critical care bed is available for this patient in either ICU or CCU. The MAR informs the nursing staff to contact the patient's attending physician and contact information for the patient's family members, so they can be informed about the sudden change in the patient's condition.

The CCU fellow then announces for no one to leave yet and asks for the door to the room to please be shut, so a debriefing can occur. He begins to thank everyone for their successful efforts in saving this patient's life and he asks everyone how they felt the code ran. The charge nurse speaks up first and thanks the MAR for asking those who did not have a role in this code to please leave so that the room was not overwhelmed with too many people. The ICU nurse then thanks the medical-surgical team for having the crash cart already in the room, having the patient already hooked up to the monitor and oxygen. You thank everyone who came to the room, as you inform everyone that this was the first time you had a patient code right in front of your eyes and have never taken ACLS, so did not know how to run a code. The MAR then states it was the quick response from these medical-surgical nurses who really saved this patient's life. He continues to say that it was the good BLS skills that the nurses performed which were needed to help save this patient's life. It was the quick response of getting the crash cart and utilization of the AED that most likely saved this patient's life; the sooner the defibrillation, the greater the chance of recovery. Each minute that defibrillation is delayed; the chance of restoring a perfusing rhythm is reduced by about 7% to 10%.

Medical-surgical nurses do not need ACLS in order to run the first few minutes of this patient's cardiac arrest. If they were

to take an ACLS course, they would learn that "Good ACLS begins with Good BLS." And that is what they did – GOOD BLS. Typically, the initial rhythm in sudden cardiac arrest is ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT). The most effective initial treatment for either arrhythmia is electrical defibrillation, which rapidly delivers large amounts of electricity to depolarize the myocardium and help to restore the heart to a stable, organized rhythm.

Automated External Defibrillators (AED) are now located on every crash cart on every medical-surgical unit at Cooper University Hospital. These AEDs are within the LIFEPAK 20 monitors and should be utilized before the code team arrives. Non-critical care nurses can easily operate AEDs, as the AED mode of the LIFEPAK 20 automatically verbalizes the simple steps of operation. With an AED, someone who is inexperienced at interpreting cardiac rhythms can prepare and deliver defibrillatory shocks based on information provided by the AED.

Knowing the steps that you learned in your last BLS course is as easy as ABC. Each code you encounter is your chance to save a life. Remember to stay calm. Take a deep breath and let your nursing skills take over. Even though you are working at a fast pace during a code, a calm look will assure others in the room that you are not flustered by the situation. This builds trust and communicates confidence and ability. You can come "out of your comfort zone" and help in a code, no matter what your role may be. As chaotic as it may seem during the code, each team member has a specific job. ***Are you prepared for the next code?***

REFLECTIONS:

A Lifetime Love Affair

Peggy Burgoyne, CRNA, MS

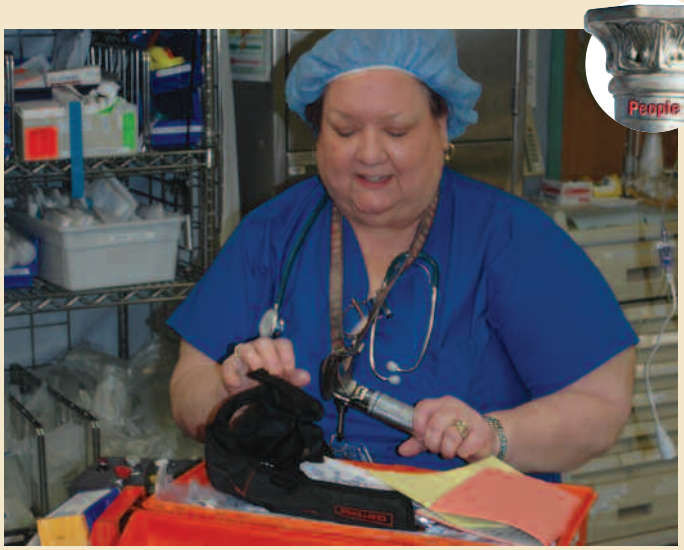
At the tender age of 24, I made two smart choices. I married my husband, Paul and I entered nurse anesthesia school. With his support and faith in me, I successfully completed the program. Both of these choices have given me a wonderful life. I have a deep passionate love for them both for the past 32 years.

After I graduated from nursing school, I worked in the intensive care unit at Germantown Hospital. This job included recovering patients after anesthesia on off hours, as post anesthesia care units were only open eight hours a day, Monday through Friday. The nurse anesthetists instructed me on how to care for their patients. One nurse anesthetist, Sarah Allen Murphy, always encouraged me to become a nurse anesthetist. She would say "If I can do it, you can do it." I admired her greatly, and so I prepared to do so. I then took a job at The Medical College of Pennsylvania's (MCP) Post-anesthesia Care Unit. I knew that would give me even closer scrutiny as to my future goals. I worked closely for and with the nurse anesthetists and anesthesia students. I applied to several schools and decided to attend MCP's program. I thank Sarah and others like her who have challenged me.

The nurse anesthesia program which I attended was 24 months long, with two weeks vacation a year. We were required to do in-house call every third night and every third weekend Friday to Monday. Classes were held three times a week at the end of the OR schedule. My instructors often joked that Anesthesia was 20% science and 80% skill. The actual event of giving an anesthetic was compared to flying a plane, with induction and emergence, compared to take-off and landing. We were told anesthesia was 80% boredom and 20% sheer terror. Times have changed. The science of anesthesia and the intricate supporting equipment and pharmaceuticals have made it a brave new world. Today, many programs are 24 to 27 months in length and some longer, depending on the type of advanced degree awarded. My lifetime has been spent reading, learning and growing in my profession with the help of my patients, my co-workers, and my students.

My day starts at Cooper saying hi to my co-workers and thanking them for coming to work. I check my assignment and prepare my work area. First, I do a system check on my anesthesia machine, check and sign the quality improvement binder to signify that the assessment was completed and turn on the monitors. I prepare my anesthetic medications, standard resuscitation drugs and any special pharmaceutical infusions required for the procedures. These drugs are meticulously labeled with date, time and concentration. Anesthetists can be found anywhere in the hospital, providing anesthesia services for medical, surgical, diagnostic, or resuscitative procedures; anywhere from the roof at the helipad to receive incoming wounded, to the basement for radiological procedures and everywhere in between. Cooper University Hospital's anesthesia department is filled with gifted dedicated professionals who work with a sense of purpose and a smile.

After the work environment is prepared, I greet my patient. You will hear me say, "Hello I am Peggy Burgoyne, your nurse anesthetist. I will be providing your anesthesia today. I need to examine your chart, have you answer a few questions, examine your airway and listen to your chest. I will then explain the anesthesia and answer any questions you might have about this explanation." At this time, I explain the types of medications I will use to induce sleep, alleviate discomfort, prevent nausea and vomiting and give a sense of well being. I also explain in basic terms what type of monitoring I provide to maintain safety during the surgical journey. I discuss the awareness monitor and how it informs me as to when their brain is awake, sedated or asleep. Explanations are vital to any patient and their family.



(PHOTO BY GREG STAMAN, RN)

I have been blessed to have been part of two volunteer medical mission groups, serving the poor around the world. I administered anesthesia to children in Ecuador and El Salvador with Healing the Children. I provided anesthesia services to adults in Ghana, Africa, with International Healthcare Volunteers. I will hold these people and all of my patients in my heart forever.

Each day I strive to be the best nurse anesthetist I can be. My goal is to take each patient through the journey of their anesthetic safely, pain free, and without nausea or recall. Sometimes this can be a real challenge, due to the surrounding events and pre-existing condition of the patient. I thank those who have come before me and have made this possible.

At this point in my professional career, I am teaching my replacements. This is a special commitment to me. During the day I am fortunate to work with nurse anesthesia students, anesthesia residents and residents and fellows from critical care areas developing their airway skills. It is a blessing and a joy to be part of this experience. Someone did it for me! And I can say with pride they did a good job. I have been coming to work at Cooper for 20 years. They have been the happiest years of my anesthetic career. I marvel at the skills of the surgeons that I work with as they attempt to alleviate pain and disease and teach a new generation of surgeons that will someday replace them. All healthcare professionals teach each other and so do our patients. They teach us to believe in ourselves and to work with each other to provide the care that our patients require. They teach us how to live and when the time comes, how to die. I am grateful to all the patients that have been kind enough to let me be part of their life's experience. It has been a trip well worth the price of admission. That is why I love nurse anesthesia.

Email comments to **Burgoyne-Peggy@cooperhealth.edu**

Professional News

DEGREES:

Ed Hatton, RN, MSN, NP (Family)
Staff Nurse TICU,
Wilmington University

Eileen Cabalo, RN, BSN
Assistant Clinical Manager,
Clinical Educator
Obstetric Units
University of Delaware

PRESENTATIONS:

Kathleen Yhlen, RN, BSN
Clinical Nurse Educator
Caring For Patients Who Refuse Blood Transfusion: Challenge or Dilemma?
Presented for the Southern New Jersey Perinatal Cooperative February 27, 2008, Voorhees, NJ

Dominic Parone, RN
Staff Nurse Emergency Department
Poster Presentation: Implementation of an Emergency Nursing Journal Club.
Presented at the Emergency Nurses Association 30th Annual Emergency Care Conference
March 12-14, 2008 Atlantic City, NJ

Lorene Pugh, RN and **Beth Sherman, RN**
Staff Nurses Emergency Department
Poster Presentation: Unit Based Council.
Presented at the Emergency Nurses Association
30th Annual Emergency Care Conference
March 12-14, 2008 Atlantic City, NJ

APPOINTMENTS:

Cheryl Koehl, RN, MSN, APN
Clinical Nurse Educator
Appointed to the Education Committee of the Emergency Nurses Association

Michelle Colligan, RN
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AWARDS:

Carol Jones, RN
Staff Nurse Neonatal Intensive Care Unit
2008 March Of Dimes Reality Award for Apprentice Nurse Recipient

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Suzanne Gould, RN, MHA, CCRN, Mary Jo Cimino, RN, BSN and David R. Gerber, MD
Packed Red Blood Cell Transfusion in the Intensive Care Unit: Limitations and Consequences American Journal of Critical Care 2007 16(1): 39-48. Selected for the Daily Publication at The National Teaching Institute and Critical Care Exposition (first week of May 2008 Chicago, Illinois)

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Debra Hood, RN . . . . . Peds
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Kerry Myers, RN, CPN . . . . . Peds
Jannine Rousseau, RN, BSN, CPN . . PICU
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