Abstract

A small community hospital in northern California implemented a practice improvement project in critical care units to optimize best practices surrounding a “code blue” event. In-Hospital Cardiac Arrest (IHCA) is a high-risk process of care that requires tremendous resources to deliver an efficient, safe, and cost-effective service. The code blue recorder sheet summarizes the whole patient care event; this necessitates careful documentation. As a risk anticipator, the unit clinical nurse leader identified suboptimal variation in the code blue documentation were critically low. A literature review revealed best practices with an emphasis on documentation after a microsystem assessment. This led to a practice change project and targeted educational intervention for code blue recorders. Fifteen staff members were identified from every shift to cover all IHCA events. Baseline data indicated that the completion and accuracy of the code blue documentation were critically low. A literature review revealed best practices with an evidenced-based educational approach including thorough assessment and responsiveness to staff learning needs and preparedness, enhancing knowledge and building confidence to impact patient care outcomes. Results of the educational intervention demonstrated significant improvements in team member confidence in the skills specific to their role and responsibilities. Completion and accuracy data indicated that the rate improved from the baseline of 17% to 67% over the two-month period of training. Clearly, in high acuity and high-risk events such as IHCA, unit leaders need to carefully define the division of labor, role clarity, staff learning needs to implement, and maintain best practices in code blue documentation.

Keywords: in-hospital cardiac arrest, focused training, recorder, documentation

Specific Aim

The Critical Care Unit will optimize the completion and accuracy of the code blue recorder sheet documentation to 90% by July 31, 2017.

Global Aim Statement

We aim to improve the completion and accuracy of the documentation for all in-hospital cardiac arrest (IHCA) events. The process begins when Code Blue is announced via overhead pager indicating the location of the patient identified as having respiratory, cardiac or both (also known as cardiopulmonary) arrest. The process ends after the code blue recorder sheet is completed. By working on this process, the educational intervention in conjunction with the revised code blue recorder sheet contents will lead into the improvement of the assigned team member as the Code Blue Recorder to complete the recorder sheet correctly and accurately according to the sequence of the IHCA event, in compliance with American Heart Association (AHA) standard guidelines.

Why do we need a Code Team?

- Efficient and safe
- Saves lives
- Reverse clinical death
- Limb disability

The Recorder

- Document the entire resuscitation process
- Knowledgeable of the ACLS algorithm
- Reminds the Team Leader of the time, name and dose of last medication administered
- Document cardiac rhythm and code summary strips
- Document airway management
- Complete Vital signs documentation
- Document start and end time of the event
- Indicates patient disposition
- Obtains Team Leader signature
- Completes the critique form

The benefits of a complete code blue recorder sheet:

- Data help determine performance improvement priorities
- Data collected are used to monitor the stability of existing processes
- Data will help determine if AHA guidelines are being followed
- It provides information that can guide continuing care for the patient
- It helps to answer questions the family may have about the event, reducing the risk for litigation

How to be an effective team?

- Be organized
- Well-trained with knowledge and skill
- Able to apply standardized process
- Effective communication
- Practice to maintain drills
- Clear identification of team member roles and responsibilities

Power Point Presentation

Kotter’s 8 Step Change Model

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