



Best Practices in Hospital Resuscitation Response Teams

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Team Debrief vs Simple Feedback

- Teams who debrief together perform better on subsequent codes
- Feedback is often geared toward correcting actions
- Effective Debriefing is focusing on correcting the through process that leads to the action

Elements of an Effective Code Debrief

- Debrief takes longer, but helps develop a deeper understanding
- The hallmark to constructive debrief is a learner centered self analysis
- Active participation and discussion
- The Goal is to gather information on how the code progressed,
- Summarize and Analyze information
- Create an accurate record of event
- Summarize goals for future improvement

Effective Communication within a Code Team

Closed Loop Communication:

- When a team member gives an order, team member confirms that order
- Team leader makes sure team member understood task before assigning additional tasks
- Clear messages - use concise clear language, prevents misunderstandings
- Speak in a tone that is loud enough to understand, yet calm and confident

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Clear Roles and Responsibilities

- Teams function more smoothly when everyone knows their job
- The team leader clearly defines and delegates tasks of each member according to areas of skill and competence
- Every member of the team should know their limitations and team leader should be aware of them
- Ask for assistance and advice early, not when situation deteriorates

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Knowledge Sharing

- Is a critical component of effective team performance
- Team leader should ask for good ideas for a differential diagnosis and frequently ask for observations from team members about possible oversights
- Team members should freely share ideas

Constructive Intervention

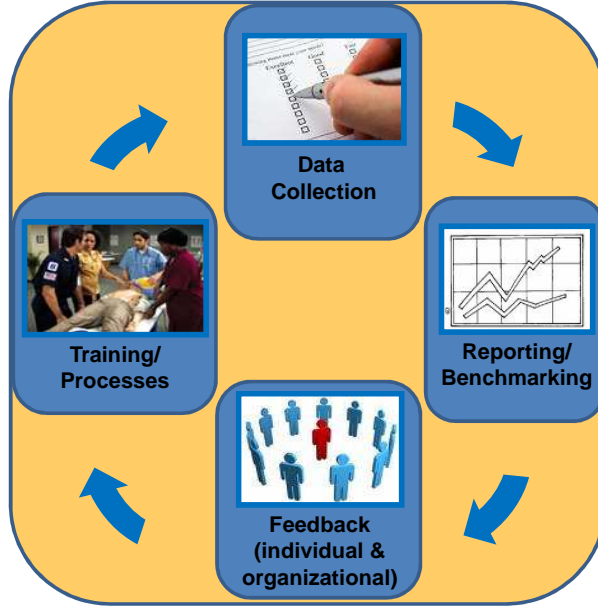
- Team leader or member may correct actions that are incorrect or inappropriate (drug, dosage or intervention)
- If so, be tactful and professional with your colleague
- Mutual respect of team members is key

Summarizing and Reevaluation

- Summarizing out loud, assists in maintaining ongoing record of treatment,
- Acts as a way to reevaluate patients status, interventions performed, and where the team is within the algorithm of care

Resuscitation Measures/Goals to Consider

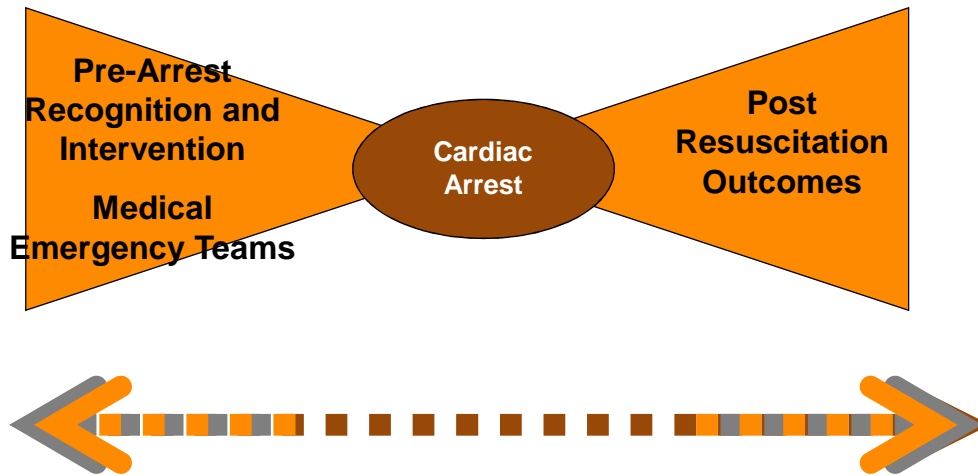
Developing A Culture Of High Quality Resuscitation



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“Bow Tie” of Resuscitation



Moving Hospitals Toward A Performance Improvement Approach For In-Hospital Cardiac Arrest

Five Key Metrics Based On Data Of What Matters

1. Increase Survival to Discharge
2. Decrease Time to Defibrillation
3. Decrease Unmonitored/Unwitnessed Arrests
4. Decrease Time to Chest Compressions
5. Confirmation of Endotracheal Tube Placement

Percent pulseless cardiac events monitored or witnessed

- Percent of events in Adult or Pediatric patients who were monitored or witnessed at the time of arrest.
- Monitored status includes continuous ECG, apnea monitor, apnea-bradycardia monitor and pulse oximetry.
- Witnessed status is the direct observation of onset of the cardiopulmonary arrest by someone (family, lay bystander, employee or health care professional).

Strategies to Improve

- Review most recent sets of vitals and nurses notes to see if there were any clues or changes in the patient that were either not caught or weren't followed up on.
- Analyze the availability of monitored beds in your facility
- Evaluate the appropriateness of patient placement within the medical center
- Addition of "flex" beds and/or staff to accommodate patients with short term increased acuity needs
- Flexible visiting - allowing families to stay with loved ones if desired in an effort to facilitate notification of rapid changes in patient condition
- Visibility of high acuity patients close to nursing stations

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Time to first chest compressions ≤ 1 min in adult and pediatric patients, and newborn/neonates ≥ 10 minutes old

Date/Time the need for chest compressions (or defibrillation when initial rhythm was VF or Pulseless VT) was FIRST recognized

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Strategies to Improve

- Increase the number of mock codes or simulations being performed on each unit
- Stress the importance that any member of the medical staff should start chest compressions
- Encourage the practice: "Change in LOC + no or weak pulse=start compressions"
- Stress in mock simulations that it is fine to start compressions if the patient has a change in LOC and no pulse is felt in the first several seconds. Do not delay compressions (i.e. attempt to identify pulse with Doppler)
- Provide/require CPR training for **all** hospital staff allowing whoever finds the patient to start chest compressions.

Device confirmation of correct endotracheal tube placement

Percent of events with an endotracheal tube placement which was confirmed to be correct.

Strategies to Improve

- Analyze the availability of airway confirmation devices in your facility.
- Evaluate airway confirmation device or devices used in your facility for ease of use and reliability. Consider other options as needed.
- Ensure all code carts (crash carts) have adapter to confirm placement once intubation occurs. Ensure adaptors are not expired and are checked during code cart inspections as dictated in hospital policy
- Ensure code leader asks for confirmation of endotracheal delivery device.
- Change arrest records to require documentation of airway confirmation other than auscultation and/or chest x-ray.

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Time to first shock \leq 2 min for VF/pulseless VT first documented rhythm

Percent of initially pulseless events with VF/pulseless VT first documented rhythm with time to first shock \leq 2 minutes.

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Strategies to Improve

- Assess Defibrillators and Code Carts for Standardization. Various defibrillator types may account for delayed times due to unfamiliarity of equipment.
- Defibrillators include stand-alone automated external defibrillators (AEDs) and AED mode in manual defibrillators.
- Ensure that stand-alone AEDs and/or AED mode in manual defibrillators are available throughout the facility.
- Early defibrillation should be available in geographically isolated parts of the hospital where code team response times are long.
- All BLS personnel must be trained to operate, be equipped with, and permitted to operate a defibrillator if, in their professional duties, they are expected to respond to cardiac arrests.

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Code/Crash Cart Specific Suggestions:

- Determine the “owner” of code carts, responsible for content and restocking
- Carts should be re-stocked after each code & checked for outdated equipment, AED pads, drugs etc. by an assigned code team member
- Do not lock carts in closet or rooms, it delays access.
- Check to make sure cart supplies aren't being pilfered
- Use laminated lists attached with everything on that cart & when it was last updated (use same list on every cart)
- Cart placement in ED, surgical areas, birthing centers, cath lab and ICUs, etc., according to their floor plans.

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QUESTIONS?