



Title: CARDIOPULMONARY RESUSCITATION (CPR) PROCEDURE, DOCUMENTATION AND QUALITY IMPROVEMENT	Procedure
Patient Age Group: <input type="checkbox"/> N/A <input checked="" type="checkbox"/> All Ages <input type="checkbox"/> Newborns <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult	

DESCRIPTION/OVERVIEW

Cardiopulmonary resuscitation is a combination of artificial respiration and artificial circulation that should be started immediately when respiratory and/or circulatory arrest occurs. The purpose of cardiopulmonary resuscitation (CPR) and its documentation is to maintain life support of vital organs by means of artificial respiration and artificial circulation and to accurately document treatment and outcome of cardiopulmonary arrest.

REFERENCES

Emergency Carts/Defibrillators/Transport Boxes
 Basic Life Support Kits & CPR Emergency Preparedness in Offsite Ambulatory Locations
 Cardiopulmonary Resuscitation in the Special Care Nurseries
Circulation. Volume 112(24) Supplement, 13 December 2005, pp IV-6-IV-11
 AHA (2006). Textbooks on BLS, ACLS, PALS.
 Perry, A.G., & Potter, PA (2004). Clinical Nursing skills & Techniques. St. Louis: Mosby

AREAS OF RESPONSIBILITY

All direct patient care givers in Clinical Settings.

PROCEDURE

1. Emergency carts are stocked according to the Emergency Cart/Defibrillator Policy.
2. Off-site ambulatory clinics and behavioral health components have BLS kits/AED's that are stocked and maintained according to the Basic Life Support Kits and CPR Emergency Preparedness in Offsite Ambulatory Locations.
3. Available physicians respond to a Dr. Heart.
 - a. For components with a Code Team, the senior resident physician on the code team is responsible for the medical care and management of the situation.
 - b. In ambulatory clinics or behavioral health facilities, the senior medical clinician is responsible for the medical care and management of the situation until EMS arrives.
4. The Code Team is trained in age-appropriate Advanced Life Support.
 The Code Team is comprised of, but not limited to:
 - Senior MICU resident physician
 - Senior ICU RN
 - Secondary ICU RN (when available)
 - Respiratory Therapist
 - Administrative Supervisor
 - Pharmacist

Pediatric Team for Pediatric Patient

- PICU resident
- PICU staff nurse

Anesthesia Support

- OR Charge Nurse to alert the O.R. Anesthesia personnel if assistance is needed
 - L&D Charge Nurse to alert O.B. Anesthesia personnel if OR is unable to respond.
5. The patient's nurse should provide the team with history, allergies, condition and recent events.
 6. The unit charge nurse assists with logistics and equipment support.
 7. It is a physician's decision to stop resuscitative efforts.
 8. All nursing personnel are expected to know the location of the emergency equipment and how to institute emergency measures.
 9. Initiate Basic Life Support (BLS) per American Heart Association guidelines and alert Advanced Life Support personnel per component policy.
 10. When a Dr. Heart is called per component policy, the staff person initiating the call should not hang up until the operator gives permission to do so. The operator must be made aware when it is a pediatric code situation.
 11. The code team is alerted by communications via an overhead page and code pager.
 12. A barrier device is to be used to protect against exposure to body fluids.
 13. Initial therapy should be administered per Basic Life Support (BLS) guidelines.
 13. Definitive therapy should be administered per Pediatric Advanced Life Support (PALS)/Advanced Cardiac Life Support (ACLS) guidelines by the Code Team.
 14. For Code Team responses, the procedure for documentation on the Cardiopulmonary Resuscitation form follows:
 - 14.1. Affix patient sticker to form.
 - 14.2. Indicate date, unit, patient diagnosis, service, time of arrest, and if and when code team was called.
 - 14.3. Briefly state history related to code, if code was witnessed, etiology of arrest and time CPR was started.
 - 14.4. Indicate time ventilation was initiated, method used and if patient was intubated prior to arrest.
 - 14.5. Record time, type of intervention, patient status and responses in appropriate columns. This includes medication doses, IV drips initiated, defibrillation, cardiac rhythm, vital signs, LOC and if CPR in progress. Documentation should occur at least every five minutes including quality of pulse with and without CPR.
 - 14.6. Record drug dosages administered in the appropriate box. Using check marks or indicating one amp given is not acceptable. Record medication infusion rates.
 - 14.7. Record ABG results, time drawn and site. Record labs drawn and results.
 - 14.8. Indicate time CPR stopped, outcome, total time of resuscitation and patient disposition (transferred to ICU, OMI).
 - 14.9. Complete signature boxes and print name.
 - 14.9.1. Person recording code.
 - 14.9.2. Code team members.
 - 14.10. Place original form with rhythm strips in the patient chart.

- 14.11. Submit copy of form and rhythm strips to department head or designee for review. Department head will forward to unit code committee member or nursing leadership co-chair of the CPR committee via for committee review.
15. Family presence is given at the discretion of the “Code” team (see Attachment I).

AGE OR DEVELOPMENTAL VARIATIONS

- Infant code situations in the Special Care Nursery are managed as per the area code policy.
- The Special Care Nurseries response team also manages newborn nursery and Mother Baby Unit neonatal emergencies.
- Pediatric Dr. Hearts at UH are specifically managed by the pediatric code team who are summoned when the operator (dial 44) is alerted that the situation involves a pediatric patient. The Pediatric Intensive Care Unit (2-2351) is the home for the pediatric code team members.

UNIT OR AREA SPECIFICS

- When a Dr. Heart is called at the Cancer Center, the Code Team responds.
- At UH, to summon the resuscitation team referred to as “Dr. Heart”, dial 44. Tell the operator the type of emergency (Dr. Heart), the unit location, the room number, and if it’s an adult or pediatric code.
- Offsite Clinics will provide BLS/CPR and call 911, Albuquerque Police.
- Children’s Psychiatric Center and the Psychiatric Center will provide BLS/CPR and call 911 (Campus) Police, who will summon an ambulance. At Children's Psychiatric Center and the Psychiatric Center, yearly staff competency verification includes verification of BLS skills.
- Carrie Tingley Hospital will call on overhead page (#56) and announce a Dr. Heart. Appropriate staff will respond and initiate basic life support. A 911 call will be placed immediately for transport to Children’s Hospital/University Hospital, or ER of patient’s choice as appropriate for the patient’s age.
- Crash carts are available on inpatient units or in the in-hospital clinics. Bag/valve/mask units are available throughout the hospital and in patient rooms.

DOCUMENTATION

1. The resuscitation record is a permanent part of the patient’s medical record and its’ completion is essential.
2. Copies of the resuscitation record with rhythm strips and resuscitation follow-up sheet are to be forwarded to the CPR Committee. The Unit Manager of the Unit where the arrest occurred will ensure the resuscitation record is forwarded to the CPR Committee.
 - White copy remains on the patient’s chart
 - Pink copy to the unit director
 - Yellow copy to the CPR committee

3. The CPR Committee will review all arrest records from University Hospital except those in Neonatal Areas, OR and ED Trauma.
4. Timed rhythm strips are to be attached to the form in a manner that will allow them to be copied.
5. *All columns are used to chronologically record the succession of events in a logical manner so that the arrest is accurately documented. This is to allow for evaluation by the CPR Committee.*
6. The resuscitation record is ordered from the standardized registry, p-200211, pages 1 & 2. Record date, time, sequence of events, physician in charge, medications administered intubations if necessary, defibrillation, patient outcome and disposition. Code sheet should be completed and signed by RT, MD, RN and person completing the record.

EXAMPLE: 3/22/93, 1600. Patient found on floor. Unresponsive and without spontaneous respiration or pulse. “Dr. Heart” paged. CPR initiated. Code terminated at 1700 per Dr. A. See code sheet for details. B. Jones, RN.

DEFINITIONS

Code – a cardiopulmonary arrest, and/or a patient who has become highly unstable and is in imminent risk of “coding”.

BLS Kit – the name for the toolkit that houses emergency supplies.

Crash Cart – the other name for an emergency cart.

SUMMARY OF CHANGES

This document includes recommendations for Family Presence.

There is a format change without other substantive changes.

KEY WORDS

Dr. Heart, CPR, Code Team, Crash Cart, Defibrillators, Codes, Emergency Carts.

RESOURCES/TRAINING

Resource/Dept	Internet/Link
Clinical Education	Learning Central
BATCAVE	Website

DOCUMENT APPROVAL & TRACKING

Item	Contact	Date	Approval
Owner	CPR Committee		
Consultant(s)	Clinical Education		
Nursing Officer	Chief Nursing Officer		Y
Medical Director/Officer	[Name, Department (or Chief Medical Officer)]		[Y or N/A]
Human Resources	[Name], HR Administrator, [UNMH or UNM]		[Y or N/A]
Finance	[Name, Title], [UNMH or HSC]		[Y or N/A]
Legal	[Name, Title], [UNMH or HSC]		[Y or N/A]
Official Approver	Judy Spinella, MBA, MSN, RN, Chief Nursing Officer		Y

Official Signature		10/12/06
2nd Approver (Optional)		
Signature		[Day/Mo/Year]
Effective Date		[Day/Mo/Year]
Origination Date		[Month/Year]
Issue Date	Clinical Operations Policy Coordinator	

ATTACHMENTS:

Attachment 1: Guidelines for Family Presence

Attachment 2: Quality Assurance Activities and Database

ATTACHMENT 1: Guidelines for Family Presence

1. Family presence during a “Code” situation is at the discretion of the team. This is not a requirement and each situation, patient circumstance and family must be evaluated individually.

2. Providing the option to families to be present during code situations is recommended and supported by the literature from the American Heart Association along with multiple professional organizations including the Emergency Nurses Association, the American Association of Critical Care Nurses, and the Society of Critical Care Medicine.
 - A. Surveys and research indicate that family members with no medical background have reported that being at a loved one’s side during the final moments of life was comforting. Furthermore, family members report that it helped them to adjust to the death of their loved one. Several retrospective reports indicate that family members who are given the option to be present report they felt they had a sense of helping their loved one.

 - B. It is appropriate to ask family members of patient’s in code situations if they would like to present during the resuscitation efforts especially if the family expresses an interest and a member of the code team or patient care staff can be available to provide support during the situation. It is also appropriate to allow family members to stay during resuscitation efforts based on the discretion of the team.

 - C. If family members are violent or emotionally volatile, they should not be present and should have someone from the health care team to provide them with information as the event is occurring.

ATTACHMENT 2: Quality Assurance Activities and Database

1. The CPR Committee meets monthly to review all codes except those in Neonatal Areas, the OR and ED trauma.
2. The codes are reviewed for medical management, systems issues and other variances. Variances are investigated by the CPR committee, or forwarded to other committees as appropriate.
3. The code information is entered into the database, which is housed in the Emergency Medicine department.
4. Trends are analyzed every six months and as needed.
5. The Executive Director of Education, Research & Practice or his/her designee makes dissemination of trends and/or educational programs for nursing/respiratory therapy to the Nursing Senior Leadership and the Education Subcommittee. Clinical Education uses the database to design educational offerings for clinical staff when performance issues are identified. Competence maintenance may include, but is not limited to, mock codes and annual competencies as well as CPR/BLS, ILS, NRP, PALS, ACLS certification courses. Nurse members of the code team receive additional orientation and training as required.
6. The Medical Director of the Committee makes dissemination of trends and/or educational programs for house staff to the Quality Management committee and ultimately, the Medical Executive Committee. The Medical Director or his/her designee meets monthly with the oncoming physician code team members to review roles, responsibilities and the emergency cart contents.
7. Systems issues or opportunities for improvement are addressed on an as needed basis by working with the appropriate entities.
8. Code Committee members include representatives from:
 - Medical Director Chair-Attending from Emergency Medicine
 - Medical Director Chair-Attending from Critical Care Medicine
 - Nursing Director-Executive Director for Education, Research & Practice
 - Administrative Supervisor
 - Clinical Educators
 - Heart Station
 - Pharmacy
 - Respiratory Therapy
 - Quality Outcomes/Quality Management
 - Unit Representative:
 - CNS's/RN Spec or UBE from Inpatient Med-Surg Units/SAC/ICU