

## OBJECTIVE

Improve patient safety by increasing comfort of the Neonatal Intensive Care Unit (NICU) staff in code situations

## BACKGROUND

- Patient resuscitation can cause anxiety and stress for the RNs in the NICU.
- Opportunities to practice patient resuscitation occurred through mock codes offered only through Neonatal Resuscitation Program and the Children's Hospital Competency Assessment and Validation Expo (CAVE).
- These mock events focused on the resuscitation of the neonate immediately after delivery. Realistically, this only impacts a small percentage of Neonatal Intensive Care Unit (NICU) staff.
- In addition, these mock events were intended for staff members to participate once/year and staff had given feedback that they felt intimidated when they participated.

## SETTING

- NICU at the Monroe Carell Jr. Children's Hospital at Vanderbilt consists of 98 beds, offering Level IV care to critically ill infants.
- Average shift staffing : 39 RNs, 4 Shift Leaders, and 5 Provider Teams
- Average daily patient census: 85 infants
- All bedside RNs have to be prepared to resuscitate or help resuscitate their infant or infant in their pod at any time without notice.

## IMPLEMENTATION

- Researchers state that practicing resuscitation, specifically simulation-based education, increases knowledge, skills, and comfort related to resuscitation.
- The NICU Pediatric Assessment Response Team (PART) Committee formed as a collection of nurses with a strong compassion for staff education and resuscitation of the smallest patients.
- The NICU PART Committee began to meet regularly and identified opportunities for improvement of resuscitation through staff feedback.
- It was discovered that over 50% of staff respondents rated themselves as having moderate, low, or very low level of comfort regarding performing the skills necessary for resuscitation.
- Through this feedback, the committee has increased mock code opportunities by 5 events and 8 possible time slots at each event, tailored scenarios to bedside situations (versus post-delivery), and scenarios are led by peers (members of the committee) to appear less intimidating.

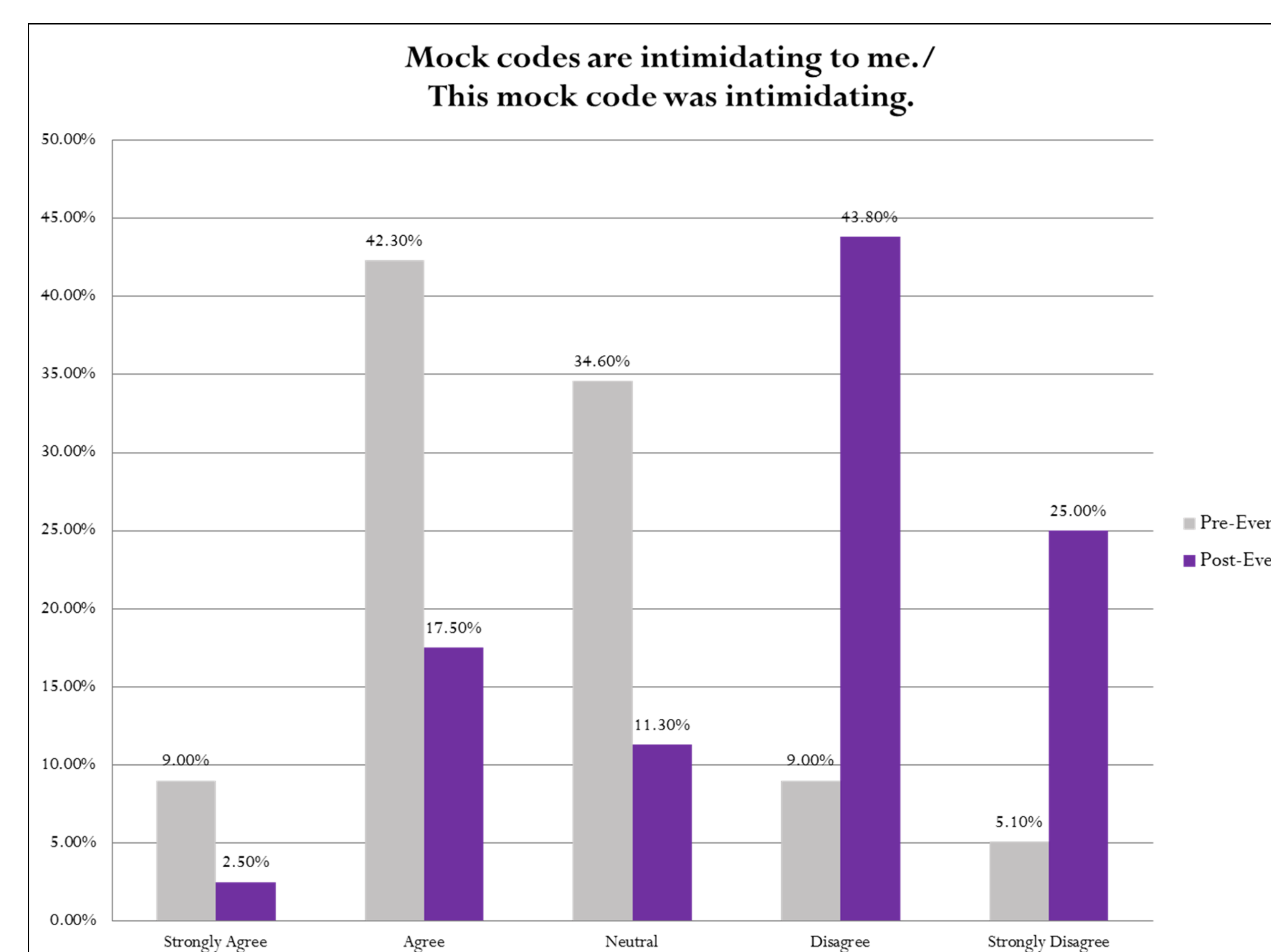
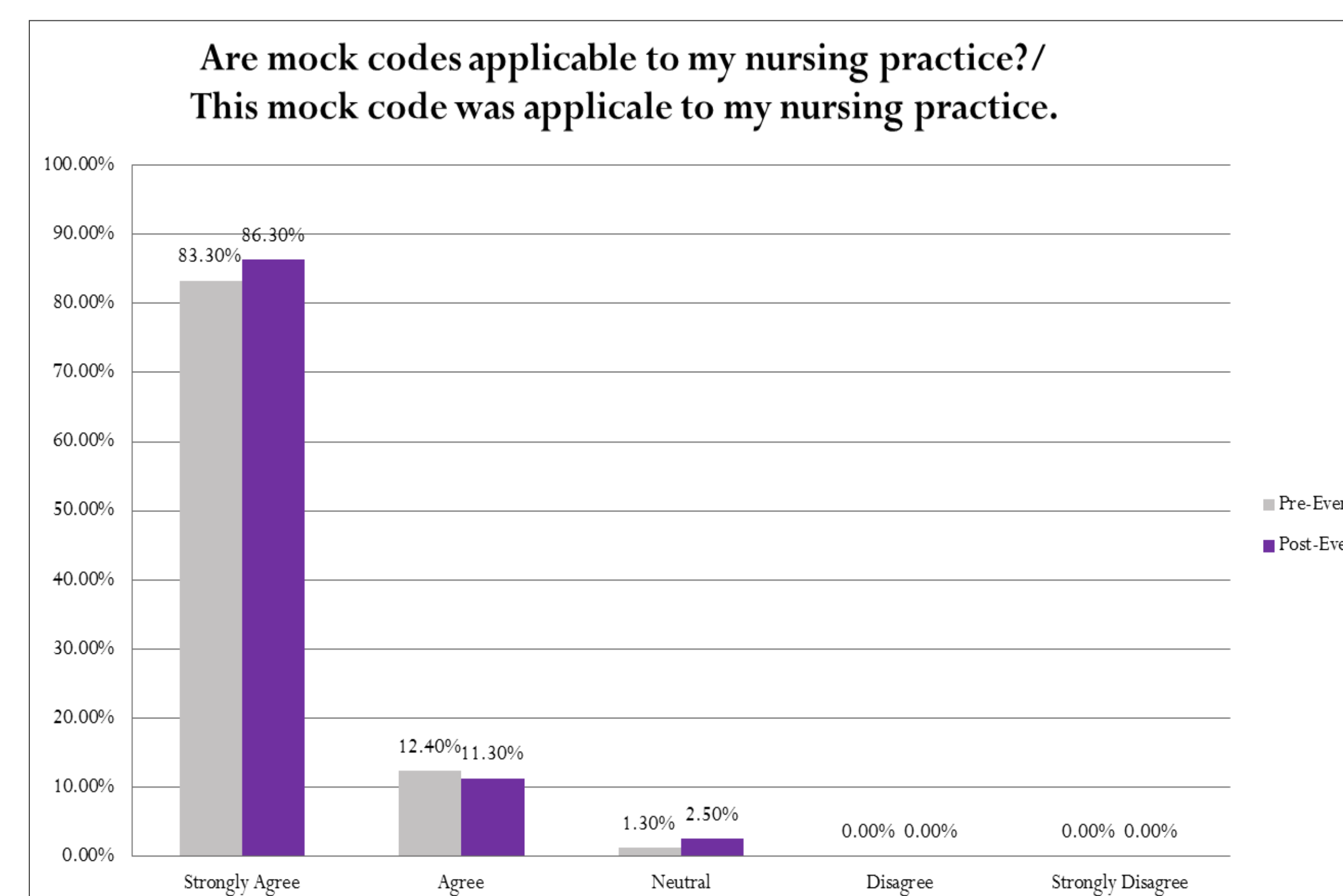
## OUTCOMES AND LESSONS LEARNED

### Outcomes:

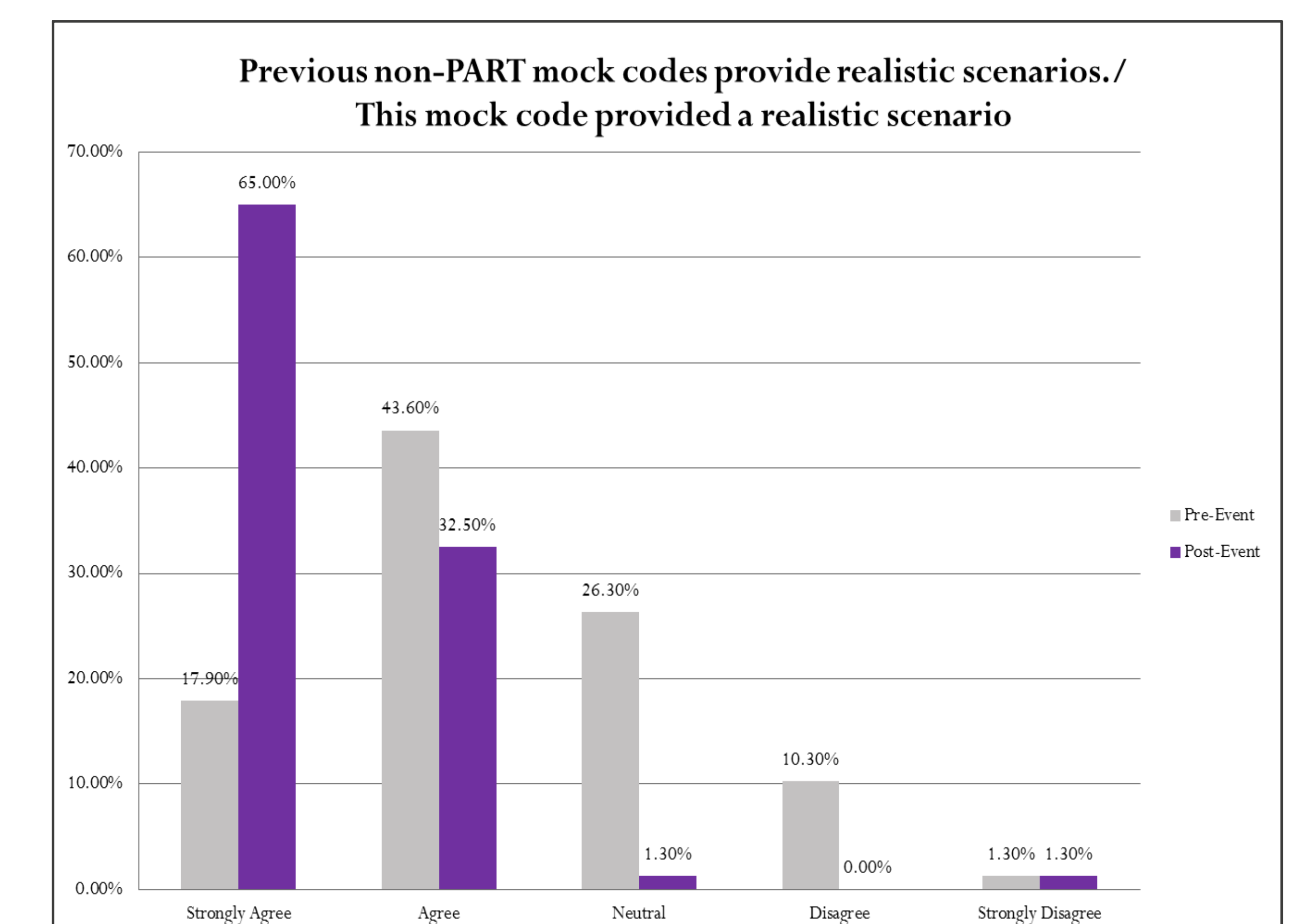
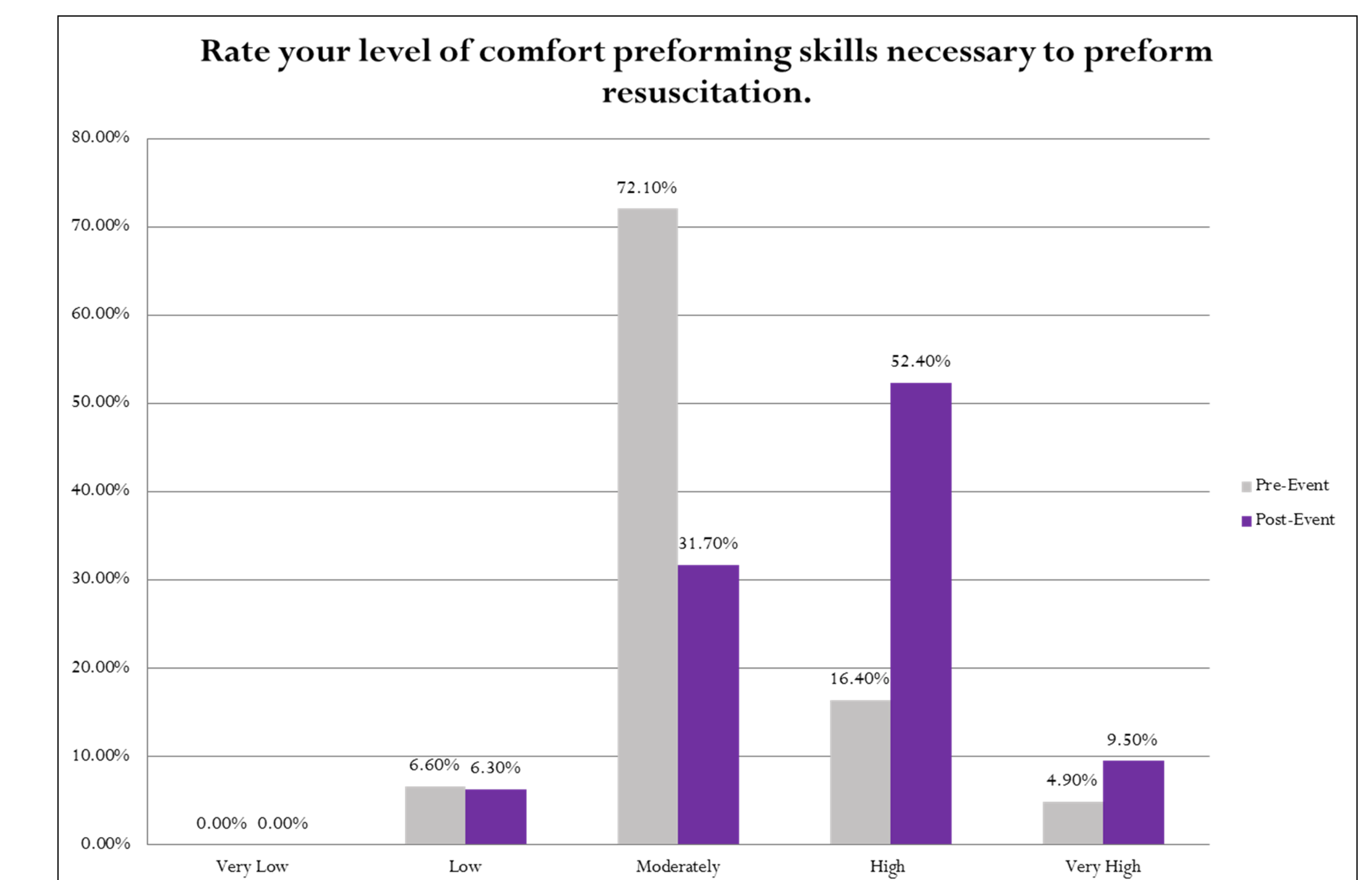
- 80 participants
- 42.5% from nights/57.5% from days
- 10 people went through more than once (some 3 times)
- Saw a positive shift in attitudes towards mock code being less intimidating, increase in comfort levels, and that the scenarios were more relatable.

### Lesson's Learned:

- In addition to mock event, team will have mandatory skills session to practice individual skills often encountered in mock codes: bagging, drawing up meds, and setting up respiratory supplies
- Need to work on flow of the event, timing, supplies, and recruiting



## OUTCOMES AND LESSONS LEARNED



## NEXT STEPS

2018

- Flow changes: complete mock code first then do skills session
- Goals: work on filling roles and closed loop communication. [Surveys participants fill impacted goals for 2018]
- Each member of PART Team will have the opportunity to lead the event in order to allow more flexibility for members.
- Continue to offer opportunities to practice code skills through interdisciplinary events along with PART events.

- Arx, D. V., & Pretzlaff, R. (2010). Improved Nurse Readiness Through Pediatric Mock Code Training. *Journal of Pediatric Nursing*, 25, 438-440. <http://dx.doi.org/10.1016/j.pedn.2009.09.006>
- Kane, J., Pye, S., & Jones, A. (2011). Effectiveness of a Simulation-Based Educational Program in a Pediatric Intensive Care Unit. *Journal of Pediatric Nursing*, 26, 287-294.