

Anatomy of a Code

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Only someone who works as a nurse or who has been in a code knows what it is like. The shifting, crazy changes would overwhelm anyone else. In the interests of letting students, prospective nurses, and those who have never been in a code know what it is like, here is a rundown of most of the experiences I had during a typical code a few years ago. ACLS has changed since then and anything missed was because I was involved in other aspects of the care.

You're standing at your computer, charting on your patients. The end of the shift is nearing, and you really want to get this done so that you can get home. As you are typing, you hear a loud snoring noise coming from your patient's room. Suddenly alert, you abandon your computer and walk quickly toward the source of the sound.



It's coming from the room where your patient, an 82 year old man with COPD, was expecting to go home today. You flip on the light, and he's slumped in his bed, his face blue, his dentures hanging out of his mouth. From the door, you call his name, but he doesn't respond. He just keeps making that snoring, gurgling sound.

Gloves. You put them on quickly, your hands shaking. No matter how many times you've been through this, your hands still shake. It comes from the adrenaline of knowing that a life is at stake. With the gloves on, you enter the room and shake the patient by the shoulder. His eyes are at half mast, the part you can see is milky white. His lips are the color of a bruise.

Immediately, you grab the CPR handle and lower his bed to a flat position. You can't leave the bedside, so you call for some help. Coworkers appear at the door while you check for breathing and a pulse. He has the snoring respirations, but they are getting fewer. You can't feel a pulse.

One of your coworkers runs to get the crash cart. As you open up the patient's gown, tearing away the snapped shoulders, you notice that the patient has stopped breathing. A pulse check still shows nothing, so you get on the chest for compressions. You lace your hands, straighten your elbows, and piston your hips as you press down onto the sternum. It gives under your assault, bowing and cracking with each thrust.

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You can hear the cart coming down the hall, the rattle of the wheels that seem worse than any grocery store cart. The compressions are wearing you out, but another coworker appears across the bed. He nods at you, and takes over the compressions.

Suddenly, the room is full. The crash cart is beside the bed, and multiple sets of gloved hands work over the body. Telemetry leads are placed. The blood pressure cuff is wrapped to the upper arm. The shock pads are put at the top right and bottom left of the rib cage. All are plugged into the cart as your coworker hands off compressions to someone else. The patient is rolled and a backboard is placed under his shoulders.

Respiratory takes over the airway as the monitor clicks on. Compressions are halted, and asystole is confirmed. The doctor strides into the room, and she politely but firmly asks for a report. This is your patient, so it is your responsibility to run down the situation for the doctor. You have five patients, though. Do you remember enough about this patient to give an accurate history? Your brain is spinning.

You reach for your notes while watching the respiratory team use the bag valve mask to give respirations. Already someone else is on the chest, pumping out compressions. Frantically, you search for the patient's history and find your notes. The history is sketchy from when you took report at the start of the shift, but you know enough to get by.

The doctor nods as you tell her how you found the patient. One of your coworkers has gotten an IV started, and the doctor immediately orders a dose of epi. Pharmacy hovers just outside the door, and you can see the pharmacist pulling up the medicine. The nurse from the ICU picks up the recording clipboard and starts to write down the actions of the team.

As the epi is getting ready, the doctor orders a score of lab tests. A phlebotomist winds his way into the melee and finds an open part of the patient's arm. It is too late to draw from the started IV. This is hospital policy. You hear the snap of a tourniquet, and the epi is handed to you.

You announce that you are about to administer the epi. The phlebotomist gets his vein and draws a handful of brightly topped tubes, the blood like red lacquer in the glass. You announce the epi is in, flush it fast, and watch the recorder mark it down.

It has been a while since there was a pulse and rhythm check. You aren't sure how long, but the doctor says it is time. You go with it. Everyone backs off the patient, including respiratory. You check for a pulse, find none. The monitor looks like a squiggly line. You know that's vfib.

The doctor announces a shock, and you press the button on the AED to fire it up. The machine analyzes the rhythm, announces a shock is advised, and winds up like a siren going up a hill. Everyone backs up, holding their hands up. You ensure everyone is clear, and when the machine beeps, you press the shock button.

The patient twitches in his bed, his body arching slightly off the mattress. Immediately, compressions are continued for a cycle. At this point, the chart has been brought to the room, and although you knew your patient was on dialysis, you didn't know that he missed it before coming into the hospital.

Back inside the patient's room, the compressions are halted for a rhythm check. Still no pulse. Still vfib. The shock procedure continues again, and another person takes over compressions. By this time, the anesthesiologist has arrived. She comes into the room, and the bed is moved away from the back wall. The headboard is removed.

While the new doc gets ready to intubate the patient, the blood work results come back. It shows that the patient's potassium is sky high, explaining why he coded. Following the Hs and Ts, you and the team have discovered why the patient coded.

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You watch as the anesthesiologist tilts the patient's head back, grabs the laryngoscope, and smoothly slides the tube in. The respiratory therapist begins bagging the tube, and you listen for bilateral breath sounds. Perfect. Got it on the first try.

As the airway is secured, the doctor orders the standard treatment for high potassium. She orders 15 units of regular insulin IV push, and pharmacy is already handing you the syringe. You push the insulin into the IV port, and immediately hear the doctor call for dextrose. Flush, push the dextrose. Next bicarb comes at you, and you push that in, too. Check the rhythm.

The patient has converted to tachycardia, but at least he has a pulse now. The ventilator is brought into the room, and the ICU nurses prepare for transport. A travel monitor is connected to the leads, and the bed is pushed from the room, a cadre of support personnel following in its wake.

For the first time in half an hour, you breathe. You look around the room, and it is covered with discarded wrappers, a whole bevy of syringes, and disposable gloves that were tossed on the floor in the emergency. Your coworkers look as tired as you feel. You sign off on the recorder's sheet in a daze, and you give report to the ICU nurse that is now in charge of your patient.

Everyone works to get the room back into decent shape. The crash cart is put back in position, and the routine for checking the cart is gone through. It takes a while, but you have to replace several items. Then you write up an incident report so your manager knows what happened.

In all of this time, your other four patients have been out of your mind. Smacking yourself in the forehead, you run to check on them, but your coworkers have already answered their bells, administered a few meds, and taken some to the bathroom. You thank them profusely, and check on your patients anyway.

End of shift looms. Your replacement is on her way down the hall, and you still haven't finished charting. With a mixture of relief and anxiety, you give report on the remaining four patients. The adrenaline still hasn't worn off, so you go to the bathroom, sit on the toilet, and cradle your head in your hands.

You saved a life today, but now you can cry about it. When you are through, you march back out to the desk, sit in the most comfy chair you can find, and chart as quickly as possible. You have to get done and get out of here because you're going to do it all again tomorrow.