Policy Analysis Project

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The analysis of certain policies within healthcare should require constant evaluation to improve specific patient outcomes. Nursing leaders within the healthcare organization should act as champions in the inquiry, review, potential change, dissemination, and evaluation of healthcare policies. A crucial step in the analysis of certain policies may require interviewing identified nursing leaders who may be able to offer insight on specific organizational needs through an effective organizational assessment.

An interview with Lieutenant Commander (LCDR) name of interviewee was conducted on November 3, 2016 at Naval Hospital Twenty-nine Palms. LCDR last name of interviewee is an Emergency Room/Critical Care Clinical Nurse Specialist (CNS) and Adult Nurse Practitioner (NP) with 18 year of nursing experience. LCDR last name of interviewee (personal communication, November 3, 2016) graduated with his Master of Science in Nursing from the University of Los Angeles in 2009, and has been stationed at Naval Hospital Twenty-nine Palms, as the Department Head for the emergency room, for the last 18 months. The purpose of the interview was to identify a current issue within the hospital, review the policy related to the issue, and decide on a potential DNP project related to the identified issue. The rationale for initiating the interview is associated with the need to identify a potential policy issue that directly affects patient care outcomes within the organization. The following paper will outline the identified policy-related issue through a detailed organizational assessment using Bardach’s (2012) guide for policy analysis.

**Description of Policy Issue**

Naval Hospital Twentynine Palms has established a dedicated Cardiopulmonary Resuscitation (CPR) Committee with the responsibility of forming a plan for CPR procedures to facilitate prompt notification, documentation, and intervention during CPR events. The current policy requires mock code blue training to take place once per month by both the inpatient and clinical nursing staff, and may need to be increased to twice per month as identified during the interview. The issue is related to the lack of nursing experience, Advanced Cardiac Life Support (ACLS) training, and current staffing shortages, which contribute to the need to increase the amount of required code blue training drills from once per month to twice per month.

The American Heart Association (AHA) set forth the “Get with the Guidelines” initiative, which states that once a patient is found to be pulseless CPR should be initiated within less than one minute and the use of defibrillation should be within less than two minutes (Get with The Guidelines®-Resuscitation Overview, 2016). The current policy does not reference or include the AHA guidelines, and during the interview, it was revealed that the current Code Blue Critique Worksheet does not list the specific times associated with CPR and defibrillation as well.

**Interview Examples**

During the interview with LCDR last name of interviewee (personal communication, November 3, 2016), it was noted that a lack of knowledge by the inpatient nursing staff was recently discovered concerning the Rapid Response Team (RRT) and how to properly use the team to help prevent clinical deterioration while caring for patients in the inpatient setting. The CPR Committee policy describes the current role of the RRT and provides standardized parameters for the clinical nursing staff to use daily. However, there have been concerns in the past with the inpatient nursing staff not utilizing the RRT effectively, which may be a result in the lack of training associated with understanding the clinical significance of the RRT (first initials and last name of interviewee, personal communication, November 3, 2016) .

Another example discussed during the interview was the lack of available educational resources in the form of a Nursing Leader or CNS who could be available to assist the inpatient nursing staff with questions or concerns each day of the week (day shift, night shift, and over the weekend). This concern is a result in the lack of available Nursing Leaders who are also CNSs or Nursing Educators who would be able to support the inpatient nursing staff during an emergent situation (first initials and last name of interviewee, personal communication, November 3, 2016). The current CPR policy does not mention the need of such clinical leadership, but does provide information on the RRT and their availability during an emergency.

**Practice Examples**

During a recent un-announced mock code-blue drill on the Multi-Service Ward (MSW), the inpatient nursing staff responded to a mock code-blue drill but was not in line with the current AHA guidelines for providing CPR and defibrillation. Again, the current CPR plan policy generated by the CPR Committee does not provide explicit guidance about both CPR initiation time and defibrillation time for patients in cardiac arrest. Regarding current practice, there is also an initiative to have all inpatient nursing staff complete and become certified in ACLS as well. This initiative was discussed during the interview, and could be used as a leadership incentive to provide an increase in the number of ACLS classes that are currently offered within the hospital.

Another practice-related example reviewed during the interview was lack of guidance included in the Code Blue Critique Worksheet. The worksheet outlines the steps to assessing a patient in need of CPR, but does not mention the times associated with initiating CPR or defibrillation in a patient who presents with a shockable pulseless rhythm. Changing the current policy by adding the recommended times for both CPR and defibrillation could help remind the inpatient nursing staff about the importance of providing CPR within one minute and defibrillation (as needed) within less than two minutes. This change in policy can provide inpatient nursing staff with additional training as needed.

**Presentation of Policy Analysis**

A practical guide to policy analysis should be used to help identify areas of improvement, or change, with a specific policy. Bardach (2012), details an eight-fold process that can be used when evaluating policies and policy changes. The process includes defining a problem, gathering evidence, constructing alternatives, selecting the criteria, projecting the outcomes, confronting trade-offs, deciding, and finally telling your story (Bardach, 2012).

**Define the Problem**

The identified problem that was discussed during the interview involved the Multi-Service Ward (MSW) and the lack of CPR and ACLS training in the form of mock code blue drills. In line with the lack of training, it was also discussed and noted that there was a lack of documented code blue drill training sessions as well. The current hospital policy (initiated by the CPR Committee) recommends conducting a documented code blue drill once per month on both the night and day shift. During the interview, it was also noted that the CPR Committee’s involvement with ensuring the documented drills were being completed was also missing. This lack of training and involvement from both the CPR Committee and the inpatient nursing staff may impact the ability of the nursing staff to effectively provide BLS and ACLS care to patients in an emergency.

**Assemble Some Evidence**

The American Heart Association (AHA) establishes specific guidelines for both BLS and ACLS, and healthcare professionals are required and encouraged to become certified in both life support trainings (Saramma, Raj, Dash, & Sarma, 2016). Therefore, providing support to continuous training efforts will help ensure nurses are familiar with the guidelines set for by the AHA. Successfully completing an ACLS course does not necessarily guarantee long-term proficiency (Nielsen, 2015). The CPR Committee at Naval Hospital Twentynine Palms (NHTP) is aware of the current evidence associated with both BLS and ACLS, and the current policy needs a revision to improve available training options, continuous practice, and involvement (from the committee) to ensure the nursing staff is confident and competent when caring for patients in an emergency.

The AHA has also provided guidance through the Get with The Guidelines initiative, which provides evidence-based guidelines for CPR (start compressions within less than one minute) within the inpatient hospital setting (Get with The Guidelines®-Resuscitation Overview, 2016).

**Construct Alternatives**

If changes to the current policy are not revised, then the nursing staff on the MSW may not be able to provide high-quality patient care during an emergency. The alternative to not revising the policy is to ensure all nursing staff are knowledgeable regarding BLS, but instruction should be provided to ensure the nursing staff is practicing current AHA guidelines to provide CPR within less than one minute (name of interviewee, personal communication, November 3, 2016). In the hospital setting, nurses are usually the ones who initiate CPR in an emergency, and should fully understand the basis of CPR to effectively provide appropriate care (Bukiran, Erdur, Ozen, & Bozkurt, 2014). Therefore, an alternative to not revising the policy to include the AHA Get with The Guidelines initiative could be to ensure adequate BLS training is provided for the inpatient nursing staff.

**Select the Criteria**

The current policy affects all nurses and Hospital Corpsmen within the hospital. Therefore, a change to the policy will influence how both nurses and Hospital Corpsmen provide CPR during an emergency. Nurses are required to hold a bachelor’s degree in nursing, and the Hospital Corpsmen are required to complete both Basic Hospital Corpsmen “A” School and Hospital Corpsmen Skills Basic (HMSB). At a minimum, the nursing staff is required to hold a current BLS card, which is good for two years. The annual mandatory training and two-year recertification requirements are not enough to help prepare healthcare workers to provide high-quality CPR (Everett-Thomas, Yero-Aguayo, Valdes, Valdes, & Shekhter, 2016).

**Project the Outcomes**

If changes are made to the current CPR Committee policy to require the inpatient nursing staff to complete two mock code blue drills twice per month (to include the recommended CPR and defibrillation start times from the AHA), the expected outcomes would provide an increase in confidence and competence among the nursing staff resulting in better patient care outcomes. Implementing effective policy changes and tools for assessment can help researchers and evaluators critically evaluate program and group performance (Everett-Thomas, Yero-Aguayo, Valdes, Valdes, & Shekhter, 2016). The evaluation of the projected outcomes can provide a foundation of data that could be used to effectively make changes to current policies related to life support initiatives in the future.

**Confront the Trade-offs**

If the current CPR policy is changed, there will mostly likely be positive outcomes in learning for the inpatient nursing staff. The nursing staff should develop an increase in confidence and competence regarding the safe and effective treatment of patients in emergency situations. The more familiar a team is with the roles identified in BLS and ACLS can lead to greater confidence in knowing the skills and limitations, which can lead to the identification of learning opportunities and needed training (Lanfranchi, 2013). Another apparent trade-off could be linked to the necessary training time required to increase the nursing staff’s confidence in both BLS and ACLS, which could impact working hours that would have otherwise been dedicated to patient care. Therefore, allowing a flexible training program would be more acceptable when attempting to increase a formal knowledge base (Saramma, Raj, Dash, & Sarma, 2016).

**Decide**

The decision to change the current CPR Committee policy will help increase awareness for the need to be more engaged in practicing BLS-type code blue scenarios (LCDR Closas, personal communication, November 3, 2016). This decision will involve key members of the CPR Committee to include the Quality Management Department, staff ER physician, inpatient RN, Staff Education and Training, and the Anesthesia Department to name a few. Several nurses report that responding to a code blue instills a certain level of both fear and anxiety (Castro, Milagros, & Briones, 2014). However, deciding to change the current policy, and providing an opportunity to train more often, may result in a decrease in the amount of fear and anxiety felt by nursing staff when working with a patient in an emergency.

**Tell Your Story**

As the decision to make changes to the current CPR Committee policy develop, the inpatient nursing staff is patiently waiting to receive any additional training to better provide emergency medical care while working in the MSW as needed. LCDR Last name of interviewee (personal communication, November 3, 2016) stated that the need to make changes to the current policy could not have come at a better time, as there is a significant need to increase the training efforts in both BLS and ACLS for our nursing staff. As new nursing staff members, continuously check-in to the hospital, the need to provide high-quality training in the form of mock code blue drills is vital to the successful resuscitation of patients who may be suffering from an in-hospital cardiac arrest.

**Conclusion**

In conclusion, the time to make effective changes to the current CPR Committee’s policy related to the frequency of mock code blue drills, and implementing the recent AHA Get with The Guidelines initiatives is now. After reviewing and discussing the policy with LCDR Last name of interviewee (personal communication, November 3, 2016), it became clear how important it is that the inpatient nursing staff at Naval Hospital Twentynine Palms be well-trained in both BLS and ACLS. This unique opportunity to make an effective change to the current policy will hopefully provide the nursing staff with an opportunity to become comfortable and competent when caring for any patient in an emergency. As a DNP-prepared leader in nursing, one must be able to assess the need for change (policy or otherwise), make effective team decisions on how to implement such changes, and evaluate the success of the changes to provide high-quality patient care.

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