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"Who called this code?"

Aluem Tark, RN, BSN

I had just finished my AM patient assessments on a beautiful Saturday morning. Our often-busy floor, the pediatric oncology/bone marrow transplant unit, was calm and peaceful. I had just sat down to begin charting when I noticed a coworker seemed very distressed. Wondering what could be wrong, as the floor was quiet, I asked, "What happened?"

My coworker told me that a patient's condition had rapidly deteriorated while she was taking care of him a couple of days ago, and she was still feeling emotionally distressed from it. A seasoned nurse with years of experience, she had quickly recognized some red flags that indicated things were not right. With the warning signs there, she notified the medical care team without hesitation. The situation eventually turned into a code. Additional team members came to assess and intervene, including physicians, a respiratory therapist, a PICU fellow, and a charge nurse, and a code cart was readied. Fortunately, the patient was breathing on his own and was transferred to PICU for closer observation.

My coworker's distress was not caused by the change in her patient's condition, however; it was the result of a comment she overheard. One of the responders to the code criticized my coworker's actions, saying, "Who called the code? This was unnecessary!" The story reminded me of a similar experience I had had, and its effect on me was similar to my coworker's distress.

I heard such a comment for the first time 3 years ago. I was a new graduate shadowing one of the most experienced nurses in the unit as part of my staff-nurse orientation. We were caring for a patient who had received a bone marrow transplant. The patient was fighting hard but was weakened by his illness and given a very slight chance of surviving. He was connected to at least five different medication infusion pumps—an overwhelming situation in the eyes of a new grad nurse. On the second day, the patient seized in bed, and the situation quickly turned into an emergency. My preceptor stayed in the room with the patient, and as physicians rushed in, I ran for the code cart wheeling it in as fast as I could. The patient was transferred to PICU, where he passed away several days later.

As I was packing up the patient's remaining belongings, I heard two health care providers talking about what had just happened. One of them commented, "Who would call a code for *that*? We didn't even use anything from the code cart!" I was stunned and could not speak; I just stood there silent. I started questioning our actions: calling for help, bringing the cart to the room, and assisting by providing necessary medical information as asked. I wondered whether I had overreacted to the situation, as they described. I even felt embarrassed, as if I had made a huge mistake.

I finished my orientation and began working on my own. As a bedside nurse, I faced other emergent situations, and each time, I took a moment to weigh the situation. I made sure to look back on all the choices and interventions that were made, either by the medical team or by myself, and all the strengths and weaknesses I experienced while an emergent situation was acute. The more I look back, the more I believe that the statement I heard during my

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very first code was both inappropriate and unprofessional. As health care providers, we are trained to develop skill sets for recognizing problems and taking the necessary steps to produce positive patient outcomes. But we also learn that circumstances can turn grim fast, often without warning.

We cannot always accurately predict what will happen in any given situation, but we can prepare for the worst. That preparation can take many forms, such as notifying the medical care team when any warning signs manifest, seeking additional help when your instinct tells you something is not right, or simply bringing the code cart closer to the patient when rapid changes are taking place.

Classifying a clinician's decision to call a code as *unnecessary* or labeling a decision to seek help as *overreacting* can very well put someone's life in jeopardy. In addition, it does not facilitate the process of having additional help available if it really is needed. Each time I think about that very first experience, I wish I could be in that situation again. I wish I had had the courage to turn around, look those colleagues in the eyes, and advocate for my decision by letting them know no interventions are unnecessary when it comes to a patient's care, especially when the patient's condition deteriorates or changes suddenly. If we put ourselves in the patient's or the families' shoes, can you possibly say an intervention was unnecessary?

I assured my coworker that her decision to call a code and seek appropriate help was the best decision a bedside nurse could make. I shared my own experience with her. We related to each other's story, comforted each other, and lifted each other's spirits. Later, I thought of other nurses or caregivers who do their best in an uncertain situation and felt either unappreciated or even hurt by a careless comment made in regard to their care decisions. Although we might try to ignore such comments, they affect us and make us question ourselves, or our abilities. We should remember that caring for our patients may include advocating for our care decisions. When facing criticism, just advocate for your patient care and leave your doubts at the door. Remember, one positive action can bring about powerful change in the workplace. ■

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