My First Code Blue

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My heart was racing. *What do I do? Do I remember*? Everything was a blur. All I knew was that the patient flatlined. *Asystole. Vital signs absent*. I climbed up onto the bed and planted my shaking knees right next to my patient's limp arm. I thrust my hand into the carotid, felt for a pulse . . . waited . . . The only pulse I could feel was my own. I positioned my hands over the patient's chest. *Have I landmarked correctly?* I tentatively pressed down. *The laboratory dummies I practiced on seem so inadequate now!* The patient's chest barely moved. Rob Fuerté, my ICU preceptor, came up beside me. He urged me to press harder. My heart pounded faster and my body felt electrified by the adrenaline racing through it. I pressed down

harder. This time the patient's chest moved, but I felt it cracking under my hands. They'd taught us in school that you can break ribs, but I never imagined how unpleasant, how unsettling that would feel. I relaxed my muscles but definitely not my mind. I continued compressions.

Suddenly I realized my hands were wet. I could feel a soggy wetness through my gloves. I looked down and saw in horror that my patient's large intestine had been expelled from the wound over his abdominal cavity, by the force of my compressions. *Dehiscence—a splitting open of the wound*. I'd read about this in a textbook somewhere. Fluid was pouring out and along with each gush, long loops of large bowel. It seemed like I paused for only a moment to take in that shocking sight, but it must have been longer.

"Keep going," everyone shouted out, and I did.

That was the first time I participated in a cardiac arrest. Despite all my fears of doing something wrong, my patient actually made it, thanks to my efforts in this episode and the rest of his stay in the ICU.

I was still a nursing student when I helped save this patient's life. I was doing my final clinical placement in the ICU because I wanted to see whether, when I graduated from nursing school, critical care might be for me.

As a child I didn't plan on being a nurse. No young boy growing up in the 1970s would tell his grade school

teacher that he wanted to be a nurse when he grew up. I hope that times have changed since then, but I suspect that they haven't.

In high school, I was a geek, and most of my teachers thought I would go into some aspect of the then-new and promising field of computers. However, I saw those machines only as tools. I wanted to stay with something more real and connected to people. I thought that forensics was my calling but after half a year in college, I learned that a lab bench was not where I wanted to be. I toyed with the idea of pharmacy or medicine but after talking with many people, especially family members who were nurses, I decided nursing made more sense.

When I entered nursing, my intention was to go into rural or outpost nursing. I had grown up on a farm and looked forward to returning to a more rural lifestyle after finishing school. After my first year of nursing school, however, I failed to find a summer job in the city, so I volunteered at the local hospital in the intensive care unit. My volunteer work quickly became a paying job as a ward clerk. I had the opportunity to view the expertise and compassion of the ICU nurses, doctors, respiratory therapists, and a host of other professionals. I quickly discovered that critical care nursing was what I wanted to eventually do. I continued to work in the ICU, first as a ward clerk and later as hospital assistant, actually getting involved with patient care. Each experience seemed

to further show me that critical care was where I needed to be.

Working in the ICU has opened up many opportunities for me. It has presented me with some of the most challenging and amazing experiences of my life. I had an excellent preceptor in Rob Fuerté and the further luck of having a nurse manager, Maude Foss, who was open to the idea of having a student in the ICU, which was then a rarity (the prevailing belief at that time was that one should first acquire years of regular floor experience before graduating to the ICU). However, I knew exactly what I wanted. I was elated when, once I had graduated and become a nurse, Maude, who managed the ICU where I wanted to work, agreed to sponsor me to attend a critical care course and then to hire me, straight out of school.

I never expected the transition from student to nurse to be easy. There was an overwhelming amount to learn. During my first year, I was always lugging around at least three textbooks. I read most of them cover to cover, some a few times over. Surprisingly, the most challenging aspect of the transition was not my needing to acquire a tremendous amount of new knowledge or skill sets: rather, I encountered unexpected social pressures.

My being a new graduate caused quite a stir in my ICU. I didn't understand my coworkers' resistance to having a new grad working in the ICU. I heard whispers from coworkers whom I had grown to know and trust,

now questioning the appropriateness of hiring me, a new graduate, straight out of school. There was this sense that you had to "do your time" in the trenches, aka the floors, before becoming part of the elite team in the ICU. I think some people were waiting for me to make a major error—and I knew they'd be ready to show me up when I did. I give great credit however to the many colleagues who did support me. This was especially true of my preceptor, Rob, and my manager, Maude. They defended me and at the same time found clinical experiences appropriate for me at every stage of my learning curve. They helped me succeed in a sometimes hostile environment. In time, the whispers of doubt, which had sometimes seemed to me a muted roar that would never go away, faded. The fatal error that some were expecting, thankfully, never happened. I moved into a full-time position. I started the standard line of 12-hour shifts, alternating between days and nights every two weeks. Eventually, I gained the trust and respect of my coworkers, and they won mine.

As the years went by. I was able to shift my focus from acquiring the practical knowledge and many technical skills of the ICU, to learning about my patients' emotional and spiritual needs, and to those of their families.

In the ICU, we see patients and families at some of the worst times of their lives. We help them understand what is going on and support them as they make some complex decisions and deal with some difficult outcomes.

Today, I am at a point in my career where I split my time between bedside practice and my medical/nursing informatics business. Many people told me that I would not be able to do both—each requires such a different skill set. I've managed to do both for over five years now. Being both clinical and technical is an ideal work arrangement for me. It allows me to identify problems in the workplace and to come up with solutions that others may not see. To my mind, I've got the best of both worlds.