SUBJECT: **CODE BLUE/MEDICAL EMERGENCY RESPONSE DOCUMENTATION**

Policy No.: **C205.20**

Effective Date: **12/1989**

Purpose of Procedure: To document a Code Blue, Rapid Response, Code Assist, Code Stroke

Physicians Order Required: No

Performed by: RN

Procedural Steps:

Patient Record Documentation

1. For Code Blue, Code White, Code Assist, and Rapid Response, the CPR/Rapid Response form will be used for documentation
    A. The form can be re-copied for clarity and legibility
    B. The required names and signatures of the Team Leader Physician and Team Leader RN must appear on the final copy
    C. The full name of the Recorder must be present in the final copy
2. For Code Stroke, the Code Stroke Report form will be used for documentation.

3. If a patient is transferred to the ICU or expires, notify the operator.
   KEY POINT: If the patient expires, the physician who pronounces the patient dead completes the "Notification of Death" form on medical record under expiration record and determines whether or not it is a coroner's case.

4. Include the following information in the Progress Notes
    A. Initial condition of the patient and time of discovery.
    B. Time the "Code Blue" was initiated.
    C. Refer to the CPR/Rapid Response Report form for detailed information.
    D. All EKG strips generated during the code; should be attached to the Progress Note.
    E. Condition and disposition of the patient at the end of the Code Blue.
    F. Initiation of Targeted Temperature Management
       KEY POINT: If the patient expires, include the time the patient was pronounced and by whom, notification of family, and post-mortem care. Include the confirmation number from tissue donation and eye donor referral for cardiac death.

       Example:

       Patient found unconscious and without pulse at 1645. Code Blue initiated (see CPR/Rapid Response Report form). Patient pronounced dead at 1730 by Dr. James. Family notified (specify family member's

name and telephone number). Post-mortem care given. Organ Procurement Organization called and confirmation number (xxxx) obtained. Mortuary called. Valuables ready for pick-up by family.

5. The Evaluation forms must be completed after Each event. The evaluation form and a copy of the appropriate report form must be submitted to the ICU Nurse Manager within 24 hours.
   KEY POINTS:
   - Complete sections I through III on the Code Blue Evaluation form.
   - All Code Blue Evaluation forms are reviewed by the CPR Committee.
   - **DO NOT** place the Evaluation forms in the patient's record after completion
   -

6. An event notification is completed for every Medical Emergency Code (see Event Notification Reporting Process procedure in Hospital Administrative Policy Manual - Administrative B704).

Attachments:

1. **CPR Rapid Response Report**
2. **Code Stroke Report**
3. **Code Blue Evaluation**
4. **Rapid Response Evaluation**
5. **Code Assist Evaluation**
6. **Code Stroke Evaluation**

Revised By: Ramon Enage RN, CCRN
Reviewed By: Angelica S. Lopez MSN, RN, AGCNS-BC
References:

AACN. (2017). *AACN procedure manual for high acuity, progressive and critical care* (7th ed.). (D. L. Wiegand, Ed.) St. Louis: Elvevier.

12/89 – Revised
12/90 – Revised
12/93 – Revised (formerly #C221)
03/97 – Revised
11/99 – Revised
12/02 – Revised
02/06 – Revised
06/07 – Revised
06/10 – Revised
04/12 – Revised
09/15 – Revised
11/16 – Revised
09/18 – Reviewed
03/22 - Revised

Date:	Event Time:	Event Location:	CPR Start Time:	CPR Started By:

How Patient Recognized

Circle one: Code Blue / White
Rapid Response
Code Assist

- ☐ No Pulse
- ☐ No Respirations
- ☐ No Response
- ☐ Cardiac Monitor
- ☐ Seizure
- ☐ Other:_____

Blood Glucose:_____ mg/dl

Intubation

Time:_____
Size:_____
Type: ☐ ETT ☐ LMA
Placement:_____cm at lip

Confirmation:
- ☐ Auscultation
- ☐ Colorimetric ETCO2
- ☐ Waveform Capnography

Codes

Cardiac Rhythms:
A = Asystole P = PEA VF = Vent Fib
SB = Sinus Brady NSR = Normal Sinus
ST = Sinus Tach VT = Vent Tach

Medication Routes:
IV = Intravenous
IO = Interosseous
ET = Endotracheal

O_2 Delivery System:
B = Bag mask
NC = Nasal Cannula
NR = Non-Rebreather

Electrical Therapy:
A = AED
C = Cardioversion
D = Defibrillation

Mental Status: A = Awake L = Lethargic NR = No response

		Time						
Assessment & Vital Signs	Heart Rate (bpm)							
	Pulse Present (Y = Yes N = No)							
	Cardiac Rhythm							
	Blood Pressure							
	SpO_2 (%)							
	Mental Status							
BLS & Treatments	CPR in Progress							
	Multi-function Pads Placed							
	End Tidal CO2 Monitor Placed							
	Automatic Compression Device Placed							
	Electrical Therapy (Joules/AED)							
	Pacing (mA/Rate)							
	Oxygen Delivery System (FiO_2)							
	Intubated							
	IV Access							
Medications Dose/Route (IV/IO/ET)	Epinephrine 1:10,000 1mg/10mL							
	Amiodarone 150 mg/3mL							
	Lidocaine 100mg/5mL							
	Dextrose 50% (25gm/50mL)							
	Sodium Bicarbonate 8.4% (50mEq/50mL)							
Infusions	Epinephrine Drip 1:1000 1mg/mL mcg/min							
	Lidocaine Drip 2g/500mL D5W mg/min							
	0.9% NS							

MD Team Leader (Signature):	MD:	Resp. Therapist:	RN Recorder:
RN Team Leader (Signature):	RN:	Other:	Other:

Targeted Temperature Management ☐ Yes ☐ No

Disposition of Patient:_____ Time:_____

Page_____of_____

FILE IN MEDICAL RECORD
PAGE 2 OF 1

PATIENT INFORMATION
MRN
NAME
DOB/GENDER
FIN

T-R0928ENURI

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
DEPARTMENT OF NURSING

Policy C205.20 Attachment 2

Date: _____ Time Called ICU: _____ Patient Location: _____Primary MD: _____

Neurological changes noted: _____
Last Known Well Time (LKWT): _____ Patient's dosing weight: _____kg

NIHSS Score: _____ Time:_____ RN: _____ NIHSS Score:_____ Time: _____ MD:_____

Contact Neurology Resident and ASTK Attending
(and Intensivist if after hours)
Neurology Resident Phone number: 562-466-2000

May initiate prior to MD arrival
But should not delay CT scan or tPA

Vital signs: Time: _____ HR:_____RR:_____T:_____ Blood Glucose:_____

O2 Sat:_____ (Start O2 if below 94%) _____L/min Oxygen delivery system:_____

BP q 10 minutes:

Time:_____BP:____/____, Time:_____BP:____/____, Time:_____BP:____/____, Time:_____BP:____/____,

Time:_____BP:____/____, Time:_____BP:____/____, Time:_____BP:____/____, Time:_____BP:____/____.

IV Access: (Bilateral antecubital access with 18g) Rt. Antecubital time:_____Lt. Antecubital time:_____

Initiate IV NS at 100mL/hr: Time:_____ Site:_____

Send labs stat: CBC, PT/PTT/INR, Type and Screen, BMP, Troponin Time sent:_____

Call a Code Stroke as directed by MD

Yes	**No**
Call 544 - Time activated:_____	Monitor Patient & Follow MD orders - Transfer to ICU

STAT CT Time Completed: _____ Candidate for thrombolytic therapy? YES NO
BP must be below 185/110
IV Antihypertensive administered: Med Name:_____Dose:_____Time:_____RN Initials:_____
MD to obtain informed consent if between 3-4.5 hours from LKWT Consent obtained? YES NO
Total Dose to be administered (bolus and infusion):_____
Time of bolus administration:_____Dose:_____ RN Initials _____
Time infusion initiated: _____ Dose:_____ RN Initials _____

USC Stroke Line – 323-442-6111

MD Team Leader:					
	Full Name	Signature	RN Initials	Full Name	Signature
RN Initials	Full Name	Signature	RN Initials	Full Name	Signature

PATIENT INFORMATION
MRUN
NAME
DOB/GENDER

FILE IN MEDICAL RECORD

CODE STROKE REPORT
(01/2022)

CODE BLUE EVALUATION

Date:_____ Time Code initiated:_____ Unit/Location:_____

(Write name and check discipline)	RN	LVN	NA	MD	Other (Title)	Other (Title)
Discovered by:						
Persons responding to code were:						

I. Adequate Initiation of CPR	Yes	No	N/A	Comments
A. Code Blue page immediate, audible and understandable				
B. Airway/ventilations managed appropriately				
C. Crash cart available				
D. Cardiac board in place within two (2) minutes				
E. Adequate compressions given				
F. Multifunctional defibrillator electrodes placed and rhythm monitored				
G. IV/IO access obtained				
H. 15L O_2 given via NC during intubation				
I. Number of intubation attempts				

II. Adequate Nursing/Code Team Response	Yes	No	N/A	Comments
A. Team recorder identified				
B. CPR Coach Identified				
C. MD on scene/at bedside				
D. Emergency/ACLS/Crash Cart/Medications/Supplies readied				
E. Infection control maintained/ All necessary PPE worn by team members				

III. Equipment	Yes	No	N/A	Comments
A. All equipment available and functioning				
B. All equipment used properly				
C. $ETCO_2$ Monitor placed				

Section below to be completed by Critical Care Committee Chair or Physician Designee

IV. Quality of Medical Management	Yes	No	N/A	Comments
A. Drugs administered timely and in appropriate doses/intervals				
B. Reasonable treatment modalities performed/ACLS protocols followed				
C. Code managed appropriately				
D. Team Debriefing Completed				

Patient Disposition: ☐ **Remained on unit** ☐ **Transferred to:**_____ ☐ **Expired** ☐ **Other:**____

Evaluator Signature: RN_____ Date:_____

Evaluator Signature: MD_____ Date:_____

Comments:_____

PATIENT INFORMATION
MRUN
NAME
DOB/GENDER

SUBMIT COMPLETED FORM AND ATTACHMENTS TO ICU NURSE MANAGER WITHIN 24 HOURS

RAPID RESPONSE EVALUATION

Date:_____ Time Code initiated:_____ Unit/Location:_____

(Write name and check discipline)	RN	LVN	NA	MD	Other (Title)	Other (Title)
Discovered by:						
Persons responding to code were:						

II. EARLY WARNING SIGNS	Yes	Comments
J. Acute change in vital signs		
K. Acute drop in oxygen level		
L. Acute change in mental status		
M. Significant concern about patient's clinical status		

III. Adequate Nursing/Code Team Response	Yes	No	N/A	Comments
F. Team recorder identified				
G. MD on scene/at bedside				
H. Effective communication				
I. ECG leads placed and rhythm monitored				
J. Emergency/ACLS/Crash Cart/Medications/Supplies readied				
K. Infection control maintained/ All necessary PPE worn by team members				

IV. Equipment	Yes	No	N/A	Comments
D. All equipment available and functioning				
E. All equipment used properly				

Section Below to be Completed by Critical Care Committee Chair or Physician Designee

V. Quality of Medical Management	Yes	No	N/A	Comments
E. Drugs administered timely and in appropriate doses/intervals				
F. Reasonable treatment modalities performed				
G. Code managed appropriately				
H. Rapid Response Team Call was appropriate				

Patient Disposition: ☐ **Remained on unit** ☐ **Transferred to:**_____ ☐ **Progressed to Code Blue** ☐ **Expired** ☐ **Other:**_

Evaluator Signature: _____ Date:_____

Evaluator Signature: MD_____ Date: _____

Comments:_____

_____

SUBMIT COMPLETED FORM AND ATTACHMENTS TO ICU NURSE MANAGER WITHIN 24 HOURS

PATIENT INFORMATION
MRUN
NAME
DOB/GENDER

RAPID RESPONSE EVALUATION
NUMBER (01/2022)

CODE ASSIST EVALUATION

Completed by Administrative Nursing Supervisor

Date:_____ Time Code initiated:_____ Unit/Location:_____

		Yes	No	Comments
Reason for Activation	Acute Change in vital signs			
	Acute drop in blood oxygen level			
	Acute Change in Mental Status			
	Significant concern about patient's clinical status			
	Injury			
	Seizure			
	Other:			
Code Assist Team Response time	Time Called:			
	ICU RN Arrival Time:			
Interventions	Blood Sugar Level checked			
	Peripheral IV			
	Medications given			
	IV Fluids			
	Defibrillation			
	Cardiac rhythm check			
	Did the team have all necessary supplies/ equipment?			
	Was the team able to contact intensivist when needed?			
Disposition of Patient	Paramedics- Time: _____			
	Code Blue – Time:_____			
	Admitted to: _____ Time:_____			
	Transfer to Clinic – Time:_____			

Completed by: _____ Ext. _____ Date: _____ Time: _____

PATIENT INFORMATION

MRN

NAME

DOB/GENDER

FIN

SUBMIT COMPLETED FORM AND ATTACHMENTS TO ICU NURSE MANAGER WITHIN 24 HOURS

CODE STROKE EVALUATION

Date:_____ Time Code initiated:_____ Unit/Location:_____

(Write name and check discipline)	RN	LVN	NA	MD	Other (Title)	Other (Title)
Discovered by:						

III. Adequate Team Response	Yes	No	N/A	Comments
N. Team members responded in a timely manner				
a. ICU RN				
b. Neurology Attending Physician				
c. Neurology Resident				
d. Intensivist (after hours only)				
e. Pharmacist				
f. ICU RN				
g. CT scan suite readied in a timely manner				
h. Team communicated effectively				
O. Emergency/ACLS/Medications/Supplies readied				
P. Infection control maintained/All necessary PPE worn by team members				

IV. Adequate Initiation	Yes	No	N/A	Comments
A. Code Stroke page immediate, audible and understandable				
L. Code Stroke protocol followed				

V. Equipment	Yes	No	N/A	Comments
F. All equipment available and functioning				
G. All equipment used properly				

Section below to be completed by Neurology Attending or Physician Designee

VI. Quality of Medical Management	Yes	No	N/A	Comments
I. Drugs administered timely and in appropriate doses/intervals				
J. Reasonable treatment modalities performed				
K. Code managed appropriately				

Patient Disposition:

_____

Evaluator Signature: RN_____ Date:_____

Evaluator Signature: MD_____Date:_____

Comments:_____

_____

SUBMIT COMPLETED FORM AND ATTACHMENTS TO ICU NURSE MANAGER WITHIN 24 HOURS

PATIENT INFORMATION

MRUN

NAME

DOB/GENDER