COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

CONFIDENTIAL: For purposes of Quality Assessment / Performance Improvement
INADMISSABLE IN ANY ADMIN, STATE or FEDRAL PROCEEDINGS
*****TO BE COMPLETED BY THE RN IN CHARGE AT THE TIME OF THE CODE, PRIOR TO END OF SHIFT****

Code Blue – Resuscitation and Outcome Review (EMS-001B)

Date of Code:	**RN in Charge of Code:**	**Physician Present:**

Prior to the Code

Code Status	**Yes**	**No**	**Clinical Status**	**Yes**	**No**	**Respiratory Status**	**Yes**	**No**
Was the patient a full code?			Was the patient stable?			Was patient on ventilator?		
Was this documented in the medical record?			Was the patient on Tele?			If yes, was patient weaning?		
Was a Rapid Response called?			Did the patient have IV access? Type:			If weaning, was this the initial wean episode?		

During the Code - Critique

Skill	**YES**	**NO**	**N/A**	**Comments / Areas to Improve**
Did the crash cart arrive promptly?				
Identification of code leader was prompt and appropriate				
Key positions were promptly assigned by code leader & appropriate for mix				
Code leader dismissed excess people/employees				
Was patient put on backboard or bed deflated?				
Attending physician notified?				
Physician in attendance/on phone?				
Pillow removed to open airway?				
Was CPR initiated immediately?				
Were monitor leads and defibrillation pads placed timely?				
Was the monitor changed to manual mode vs. AED mode?				
Was an IV line established?				
Did the code leader complete an assessment of EKG and algorithm?				
Was CPR resumed immediately between interventions?				
Were leads double checked in a systole?				
Was the correct algorithm/med and interventions followed?				
Did nurse/RT implementing interventions (meds/joules delivered/intubation) call out loudly after for a completed scribe?				
Did code leader call out interventions clearly and loudly?				
Did code leader maintain a leadership role throughout entire code? (hands off as much as possible)				
Did RT intubate patient successfully and in a timely manner? Should not take longer than 5mins. Total with bagging between each attempt				# of attempts:_____ # of people attempted:_____
Were ABG's and STAT CXR obtained?				
Did nurse/RT implementing interventions (meds/joules delivered/intubation) call out loudly after completed for scribe?				
Was the appropriate equipment immediately available **without** malfunction? (suction, oxygen, ambu bag, defibrillator)				
Documentation				
Was **thorough** documentation completed regarding the patient's assessment before, during and after the code? This should include: B/P readings, heart rate, respirations, cardiac rhythms (initial and changes), defibrillation (time and amount of joules), Transcutaneous pacing (rate, capture) and intubation)?				
Was the family notified?				

Code Start Time:	**Code End Time:**	**Final Disposition: ( ) Successful ( ) Transferred ( ) Expired**

What was the atmosphere of the code? ( ) Well Organized ( ) Fairly Well Organized ( ) Disorganized ( ) Chaotic

RN Signature:	**Date:**
DQM/CNO Signature:	**Date:**