

**PROCEDURE FOR: Code Blue Documentation**

- POLICY:**
1. A written account of code events, in sequence, will be maintained by a nurse throughout all Code Blue situations. This record will include the therapeutic interventions employed and the response of the victim to these efforts. It will also include medication(s) given and by whom.
  2. The John Dempsey Hospital CPR Report Form (HCH-1036) will be used to document all Code Blues, paged or unpagged, except in clinical areas that maintain an electronic code record (i.e. Emergency Department), or areas for which Paramedic/EMS is designated as primary response.
  3. The CPR Report Form will serve as both the order sheet and medication administration record (MAR) for the code event.

**EQUIPMENT:** HCH-1036: CPR Report Form and clip board (located in the top compartment of the adult code cart)

**PROCEDURE:**

**ACTION**

**POINTS OF EMPHASIS**

1. The RN will document all interventions and the patient's response, noting the time initiated and time achieved. (See attached Appendix - Critical Elements of Code Blue Documentation.) If orders are given by someone other than the responsible MD, document initials in box next to the order. If a medication is given by staff other than the identified medications RN, put their initials in the box next to the corresponding medication.
  2. At the completion of the code, the recording nurse, medication RN and responsible MD sign page 2 of the CPR Report Form. If staff other than the responsible MD or medication RN give orders or give meds, those persons also need to sign and initial at the end of the form.
  3. The physician/LIP conducting the code completes the second page of the CPR
2. The Form must include account of the following:
    - Demographics
    - Participants
    - Time of arrest
    - Time CPR initiated
    - Time of intubation/by whom?
    - Monitoring to include:  
Rhythm; BP; Pulses (present / absent);  
skin color / temp / moisture; verbal / motor / pupillary responses;
    - Defibrillation attempts (# joules and post-defibrillation rhythm)
    - Lines: type (peripheral / central);  
location; solution infusing; if new,  
name of person inserting line)
    - Medications (include type, dose,  
route, and effect)
    - Procedures performed in connection  
with code: pacemaker, chest tube, NG  
insertion, etc.
    - Lab Specimens: type and results

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Report Form and signs the document.

4. The CPR report is in duplicate. When completed, the original copy of the CPR Report Form is placed in the progress notes section of the patient record. The yellow copy is to be forwarded to the Nursing Manager of the unit where the code occurred, or the Administrative Nursing Supervisor.
4. If resuscitative efforts were initiated in the field, a copy of the Paramedic/EMS pre-hospital care records should accompany the CPR report.

**APPROVAL:** Nursing Standards Committee  
CPR Committee

**EFFECTIVE DATE:** 8/22/86

**REVISION DATES:** 10/88, 12/90, 11/97, 10/00, 10/03, 9/07, 7/08, 2/10