

CODE BLUE AFTER ACTION REPORT

(For use of this form, see MEDDAC/DCC (Fort Meade) Regulation 40-24)

NOTE: This form is to be completed within 30 minutes of termination of the Code by the senior nurse and team leader physician involved and routed through the Code Blue Assessment Team within 24 hours of the resuscitation.

1. Patient's history/diagnosis:	2. Date:	3. Time:
	4. Unit:	

5. How was the Code Blue announcement made? Pager Public address system

6. Which members of the Code Blue Team responded to the announcement? *(A blank check box indicates the member did not respond.)*

On duty UCC physician On duty UCC RN Internist Anesthesia Svc staff member Respiratory therapist
 Nursing Services representative Pharmacist Pediatrician (for pediatric Codes only)

7. Type of arrest: Cardiac Respiratory Cardiopulmonary Other _____

8. Suspected cause of arrest: Myocardial Infarction Pulmonary Edema Dysrhythmia Drug Anesthesia
 Other _____

9. Procedure.

a. Recognized by: Nurse Corpserperson Physician Other _____

b. How recognized: No respiration No pulse Agonal gasps Unresponsiveness Alarm Monitor

c. Resuscitation was started by: Nurse Corpserperson Physician Anesthesia Other _____

d. Cardiac arrest recognized within: 1 minute 2 minutes 3 minutes 4 minutes Unknown

e. Effective CPR established within: 1 minute 2 minutes 3 minutes 4 minutes 5 minutes

f. Method of artificial ventilation: Mouth to mask Bag/mask Bag-ET tube

10. Results.

a. Resuscitation was: Successful Unsuccessful If successful, respirations were: Spontaneous None Intubated

b. Consciousness: Conscious Unconscious Semi-comatose

No.	ITEM(S)	PRESENT	ADEQUATE	INADEQUATE	SPECIFY
11	Monitor				
	ECG				
	Suction				
	Oxygen				
	Defibrillator				
	Resuscitator bags				
	Intubation equipment				
	Drugs				
	Other Supplies				

12. Patient identification:

13. Organization. Was the Code Blue Team Leader - Identified? Yes No Effective? Yes No

14. Was unit coverage adequate during the resuscitation? Yes No

15. What was the duration of the procedure? _____

16. What was the disposition of the patient? _____

17. Patient left in whose responsibility? _____

GENERAL COMMENTS

Team Leader:

Signature/Stamp:

Supervisor/Charge Nurse:

Signature:

RISK MANAGEMENT COMMITTEE FOLLOW UP

NOTE: Return this form to the Urgent Care Clinic after follow up procedure has been completed.

1. Condition 24 hours post-arrest: *(Check all that apply.)*

Neurological deficit Fractured ribs/sternum Pneumothorax Respiratory insufficiency Cardiogenic shock

Return to pre-arrest status Stable, but not in pre-arrest status Other

2. Survival: 24 hours 24-72 hours 1 week Discharged

3. Comments: