

Date:		Location Code:	
Pre-Code Diagnosis:		Admission Date:	
Time Code Called:	Time CPR Started	Time Code Ended:	
Event Witnessed:		<input type="checkbox"/> YES	<input type="checkbox"/> NO
CPR:			
• Initiated Immediately?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Backboard Placed?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Monitor Applied?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
• IV Started?		<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
Code Blue Care Arrived Promptly?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Code Team Responded Within <3 minutes?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Assigned RN gave brief history on patient including cardiopulmonary (including artificial airway) and code status?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Equipment/Supplies Present & Functioning			
• Ambu Bag		<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
• Suction Machine/Supplies		<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Endotracheal Intubation Tray/Supplies		<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
• Defibrillator/Monitor		<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Comments		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Essential Personnel Present?			
• Physician		<input type="checkbox"/> YES	<input type="checkbox"/> NO
• ACLS Certification Nurse		<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Respiratory Therapist		<input type="checkbox"/> YES	<input type="checkbox"/> NO
• House Supervisor		<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Chaplain		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was it clear who was responsible for running the code?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Adequacy of ventilation assessed (Auscultation or Capnography)?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cardiac compressions performed correctly & assessed for pulses?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Defibrillated using correct technique?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Reassessed for spontaneous pulse/respirations?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Attending MD notified?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Family/Emergency contact notified?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Outcome of Code?		<input type="checkbox"/> Complete Recovery <input type="checkbox"/> Survived with ↓ LOC <input type="checkbox"/> Death <input type="checkbox"/> Remained on Unit <input type="checkbox"/> Transferred to ICU <input type="checkbox"/> Made DNR after Code	

Submit to Quality Management  
Not Part of the Permanent Medical Record



**CODE BLUE EVALUATION**

Patient Identification: