McLaren
OAKLAND

CODE BLUE WORKSHEET

ENCOUNTER#:

Date:	Time:	Type: ☐ Resp ☐ Cardiac	Location: ☐ Pre-Hospital
Time of arrest:	Time CPR Initiated:	☐ Bystander ☐ EMS ☐ McLaren Oakland Staff	

Dr. _____ Arrival Time: _____ RT: _____ /

Anesthesia Provider: _____ ACLS RN: _____ RN: _____

Nurse Supervisor: _____ Scribe: _____ Other: _____

☐ BVM	☐ Capnography	☐ Post Rapid Response	☐ Lucas Device at: _____ ☐ N/A _____

Intubated by:	# Attempts:	ETT Size:	Lip Line:	☐ Placement Confirmed

IV Access: ☐ Existing ☐ Started: size _____ site _____ Presenting rhythm: ☐ VF ☐ VT ☐ AS ☐ PEA

MEDICATION	DOSE	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME
Epiniphrine	1 mg per amp										
Epiniphrine	1 mg per amp										
Amiodarone	300 mg										
Amiodarone	150 mg										
Sodium Bicarb	50 m per amp										
50% Dextrose	25 grams per amp										
Calcium Chloride	1 gram per amp										
Mag Sulfate	2 grams										
Lidocaine	100 mg per amp										
Adenosine	6 mg										
Adenosine	12 mg										
Atropine	1 mg per amp										

CPR OUTCOME

☐ Survived (ROSC > 20 min)	☐ Dr. _____	☐ Family Notified Time: _____
Transferred to: _____	Notified Time: _____	☐ Spiritual Care Contacted: _____
BP: _____ HR: _____ RR: _____	☐ Attending: _____	☐ Gift of LIfe Contacted: _____
Rhythm: _____ GCS: _____	Notified Time: _____	☐ Medical Examiner Contacted: _____
☐ Patient Expired	☐ Intubation medications ordered and documented in MAR	☐ ECG strips printed/scanned to chart
TOD: _____		

Physician:	Signature:	Date:	Time:
RN Recorder:	Signature:	Date:	Time:

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ENCOUNTER#:

TIME	RHYTHM	Defib/Joules	NURSE'S NOTES	BP	HR	RR	etCO2

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Advice for Team Debriefing:

1. Try to find a quiet, isolated place. Anyone present during the event may lead the debriefing. Debriefing leader should start by thanking team members for being present.
2. STATE: " The purpose of debreifing is to improve the quality of medical care."
3. STATE: " We will briefly review the patient's summary and then we can discuss what went well and what could have gone better. Please feel free to ask any questions."
4. STATE: "All information discussed during the debreifing is confidential."
5. Please limit debriefing to ten minutes.

Fill out this section **BEFORE** the debriefing Team discusses whether to do a debrief.

1. Patient FIN	
2. Date (MM/DD/YY):	
3. Location in Hosptial:	
4. Team Leader:	
5. Debriefing Documenter:	

6. If debriefing did not occur please state reason(s) why:

- ☐ Time constraints
- ☐ Team dispersion
- ☐ Team change
- ☐ Team decline
- ☐ Other pt care issues

7. Event Type:

- ☐ Medical (ED/Floor/ICU)
- ☐ Trauma

8. Circumstances:

- ☐ Cardiac event
- ☐ Respiratory event

9. Involved Disciplines:

- ☐ ALS Provider
- ☐ Anesthesia
- ☐ Respiratory
- ☐ ICU/ED RN
- ☐ Nursing Supervisor
- ☐ RN
- ☐ Security

Fill out this section DURING the Debriefing. (Person completing this form is *not* the person leading the debriefing).

1. Debriefing Start Time: ☐

2. What went well during our care for the patient? Why? *Please select all that apply and add comments as necessary.*

☐	Clinical care (ex. Airway, access, CPR)
☐	Team work
☐	Communication
☐	Leadership
☐	Response Time
☐	Equipment available and functional
☐	Other (please specify):

3. What could have improved during our care for the patient? *Please select all that apply and add comments as necessary.*

☐	Clinical care (ex. Airway, access, CPR)
☐	Team work
☐	Communication
☐	Leadership
☐	Response Time
☐	Equipment available and functional
☐	Other (please specify):

4. Could this event have been predicted or prevented?

5. Was family notified? ☐ Yes | If no, why?

Debrief Stop Time ☐

*** For quality Purposes Only. DO NOT place in Medical Record.**