

Emergency – Code Blue/Trauma/Resuscitation

Code Blue documentation will remain on paper. Certain data elements will be back-entered into the Clinical Information System (CIS). The Code Blue record will be placed in the patient chartlet and scanned into the CIS upon patient discharge.

There are several components to the Code Blue workflow. The following reference guide will cover:

- Patient in ED.
- Any instance where the ED is acting as the "code bed" and an inpatient requires transfer to ED for care.
- Visitor, staff member or outpatient anywhere in hospital experiencing code blue/medical emergency
- Back-Entry of Documentation: Entering important data after a code event.



NOTE: Follow unit policy for calling and responding to Code Blue.

ED Patient

- 1. Document Code Blue events on paper (Code Blue Record, Trauma form, or Acute ED Record) or within the system via the Nursing Assessment Note.
- 2. Administer medications **without** barcode medication administration and document on appropriate paper form or in the system.
- 3. Notify diagnostic department for stat tests and enter orders in the CIS as appropriate.
- 4. Follow CIS process to admit, transfer or for post-mortem care.
- 5. Back-enter documentation into the CIS (see specific documentation below).

Code Bed- Inpatient or Outpatient/Staff/Visitor to ED

This process is followed when any visitor, staff member, or inpatient experiences a **Code Blue** or **medical emergency** and **must** be transported to the **ED post-resuscitation** for care.

- 1. Hospital's patient flow/charge staff will determine that the patient requires transport to the ED and a care space is arranged.
- 2. Code Blue team transports patient to the ED and provides handover to ED staff.
- 3. Triage, registration, or inpatient bed transfer processes occur per existing site policies.



- 4. ED Provider enters Orders in the CIS and follows workflow for the management of the patient.
- 5. Follow CIS process to admit, transfer, discharge or for post-mortem care.
- 6. Back-enter required documentation into the CIS.

Documentation

1. Use the **ED Nursing Assessment Note** type to document the event (located in the menu within the **Handoff Tool** tab)



- 2. Provider or delegate enters orders for *ongoing medications* (such as antibiotics, vasoactives, etc) into the CIS post event.
- 3. Clinician or team delegate enters Intake and Output into the CIS as 'Code Intake,' 'Code Output,' and Blood Product Volume in Interactive View and I&O (aka IView).

🗙 Intake And Output		21 0101	
		Oral Intake	mL
Continuous Infusions		A coner Intara Sources	
Medications		Code Intake	mL
Enteral		△ Output Total	
		⊿ Blood Output	
GITUDE		⊿ Other Output Sources	
GI Ostomy Intake Urinary Diversion Intake		⊿ Stool Output	
		Stool Count (Number of Stools)	
Oral Others Intelles, Serverses		⊿ Urine Output	
Other Intake Sources		Hate a Matula d	



WARNINGS:

- To flag a particular data field (or cell) within IView, you can right-click and Flag with Comment. However, after a Code Event you can also flag the entire column. Complete your documentation within IView, sign off on your charting by clicking the green checkmark, and then click on the time stamp 14:15 PST at the top of the column you would like to flag.
- The field will be outlined in black if you have done this successfully. Then, right-click on the time stamp field, select Flag Annotation. When the Flag Annotation window appears, comment as appropriate ex. Code Event. Notice how the checkbox I that states Flag to cinlude in Interdisciplinary Summary is automatically checked.
- The column header will now display a flag ricon and the flagged data will appear in the Flagged Events component of the Patient Summary.



- 4. Clinician or team delegate enters any other required data elements into the CIS.
- 5. Create dynamic groups for all tubes and lines inserted during resuscitation, add comments as required.

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	CIT.b.		d Other Intake Sources		2000	
		^	Code Intake	mL	2000	1.11D h
	GI Ostomy Intake		⊿ Transfusions		665	Add Kesult
	Unnary Diversion Intake		Red Blood Cells Volume Transfused	mL	665	View Result Details
	Oral		△ Output Total		445	View Defaulted Info
	Other Intake Sources		⊿ Blood Output			view berouted mitom
	Negative Pressure Wound Therapy		△ Chest Tube Output	12	(400)	View Comments
	Surgical Drain, Tube Inputs		A #1 Lateral Chest tube 24 French		000	100 ACC
	Transfusions		Output	mL	400	Unchart
	Urinary Catheter, Intake		Irrigant Out	ml	400	Change Date/Time
	Pre-Arrival Fluid		1 Cl Tube	FR.		Madifi
	Output			0.0	(45)	Modily
	Blood Output		△ Orogastric (OG) tube Oral 18 French			Confirm
	Chest Tube Output		Output	mL	45	Add Comment
	Continuous Renal Replacement Therapy		Irrigant Out	mL		Add commentai
Emesis Output	Emesis Output		Residual Discarded	mL		Clear
~	GI Tube		△ GI Ostomy Output			Not Done
	GI Ostomy Output		⊿ Other Output Sources			
	Other Output Sources		⊿ Stool Output			View Interpretation
	Paracentesis Output		Stool Count (Number of Stools)			Reinterpret
	B		and the second sec			

6. Clinician or team delegate will update **Medication Administration Record** in the CIS with the accurate non-ACLS medication administration times. Right-clicking on a column header will allow you to **Change Date/Time** for back-entering previous administrations.

E.g. Propofol infusion initiated during resuscitation - order is entered and actioned upon, administration time modified to the actual start time.

Provider Documentation of Event

1. Provider documents all procedures performed (such as Central line insertion, chest tube, etc.) and a **Resuscitation Note** into the CIS.



NOTE: Although not required, it is helpful to select the **Resuscitation Note** template within the **Documentation** section of the patient's chart for this purpose, especially for ED providers responding to inpatient Codes.

Note Type List Filter:	All (67) Favorites (4)	
All	*Note Templates	
*Type:	Name -	Description
	🚖 ED Note	ED Note
Title:	🔶 ED Note – WorksafeBC	ED Note – WorksafeBC
Resuscitation Note	🚖 ED Note Simple	ED Note Simple Template
	🔶 Resuscitation Note	Resuscitation Note Template
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