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

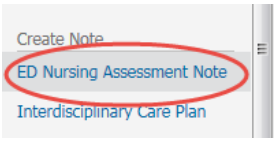
This process is followed when any visitor, staff member, or inpatient experiences a **Code Blue** or **medical emergency** and **must** be transported to the **ED post-resuscitation** for care.

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.

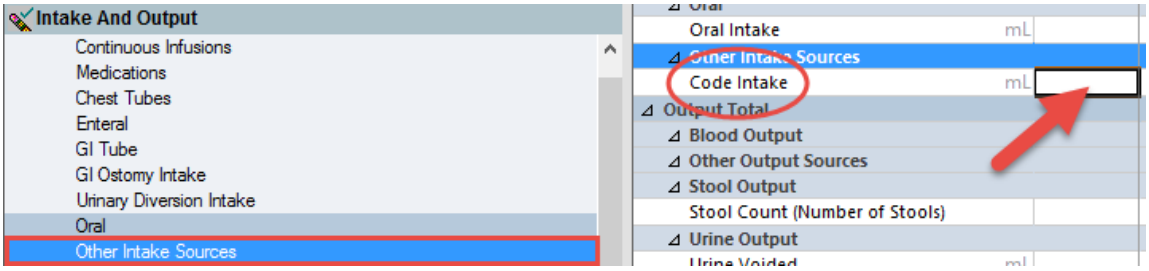
4. ED Provider enters Orders in the CIS and follows workflow for the management of the patient.
5. Follow CIS process to admit, transfer, discharge or for post-mortem care.
6. Back-enter required documentation into the CIS.

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).

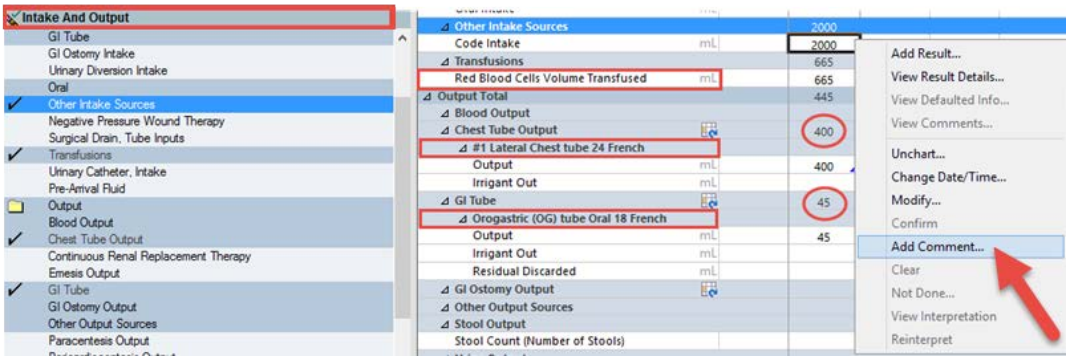


WARNINGS:

- 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** ☑ that states **Flag to cinlude in Interdisciplinary Summary** is automatically checked.
- The column header will now display a **flag** icon 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.



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.