CLINICIAN FORM · RESUSCITATION

Code Blue Recording Flowsheet

Real-time documentation of CPR, defibrillation, ACLS medications & events — **Renal Care Unit, Rafael C. Lazatin Memorial Medical Center**

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[PATIENT LABEL] NAME · AGE · MRUN	DATE:	ROOM #:	TIME CODE CALLED:	TIME TEAM ARRIVED:
	CPR START TIME:	TEAM:		

MEDICATION DOSES: EPI 1 mg q3–5 min | AMIO 300 mg → 150 mg | LIDO 1–1.5 then 0.5–0.75 mg/kg | ADEN 6 mg → 12 mg (rapid IV push) | ATRO 1 mg q3–5 min (max 3 mg) | Ca gluconate 10% 1–2 g/10–20 mL (or $CaCl_2$ 1 g) | $NaHCO_3$ 50 mEq/50 mL
TREATMENT: CPR — Absent : 0 / Present : ✓ (×2-min rounds) | SHOCK — Biphasic : 120–200 J / Monophasic : 360 J | TIME in military format

TIME MILITARY	BP	HR	RHYTHM	O_2 SAT	PULSE ABS 0 / ✓	CPR ✓ /2MIN	SHOCK JOULES	EPI 1MG	AMIO 300/150	LIDO MG/KG	ADEN 6/12	ATRO 1MG	CA GLUC 1–2G	$NAHCO_3$ 50MEQ	COMMENTS BVM · INTUBATION · IV FLUIDS · PACING · CARDIOVERSION · LINES · LABS · ETC

Use alongside your institution's Code Blue policy and current AHA/ACLS guidelines. Verify all doses against local standing orders. Recording form for clinical documentation by trained personnel.

Code Blue Recording Flowsheet — continued

Recording grid · Event conclusion · Personnel on duty

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CODE BLUE EVENT CONCLUSION

Time event ended: _____

Patient outcome: ☐ ROSC achieved ☐ Expired / efforts terminated

Reason resuscitation ended: ☐ ROSC ☐ No benefit to continue

Family notification: ☐ At bedside ☐ By phone ☐ Unable to reach ☐ No family ☐ Pending

Name of person notified: _____

Relationship to patient: _____

PERSONNEL ON DUTY

PRIMARY NURSE	CHARGE NURSE	RECORDER
CPR STAFF	MEDICATION STAFF	RESPIRATORY THERAPIST
RESIDENT ON DUTY (ROD)	PHYSICIAN	ON-CALL NEPHROLOGIST

ACLS — Adult Cardiac Arrest

High-quality CPR + the dialysis circuit in parallel · epinephrine + rhythm-based pathway · treat reversible causes

START CPR — push hard & fast 100–120/min, depth 5–6 cm, full recoil · give O_2 · attach monitor / defibrillator

DIALYSIS ACTIONS (in parallel): STOP ultrafiltration · saline bolus 200–500 mL · return blood or clamp & disconnect — KEEP vascular access for drugs · think HYPERKALEMIA early

Rhythm shockable?

SHOCKABLE — VF / PULSELESS VT

SHOCK · biphasic 120–200 J (device-specific) · monophasic 360 J

▼

CPR 2 min · obtain IV / IO access

▼

Rhythm shockable? → **SHOCK**

▼

CPR 2 min · **Epinephrine 1 mg** IV/IO q3–5 min · consider advanced airway + capnography

▼

Rhythm shockable? → **SHOCK**

▼

CPR 2 min · **Amiodarone 300 mg** (then 150 mg) *or* Lidocaine 1–1.5 mg/kg · treat reversible causes

▼

ROSC? → post-cardiac-arrest care. If not, continue 2-min cycles.

NON-SHOCKABLE — ASYSTOLE / PEA

CPR 2 min · **Epinephrine 1 mg** IV/IO as soon as possible, q3–5 min · IV/IO access · advanced airway + capnography

▼

Rhythm shockable? → if YES, move to the shockable lane

▼

CPR 2 min · treat reversible causes (see below)

▼

ROSC? → post-cardiac-arrest care. If asystole persists despite treating reversible causes, consider termination per team decision.

Reversible causes — H's: HIGH-YIELD Hyper-/hypokalemia · Hypovolemia (over-UF → saline) · Hydrogen ion / acidosis · Hypoxia · Hypothermia · Hypocalcemia / hypomagnesemia

Reversible causes — T's: Thrombosis (MI / PE) · AIR EMBOLISM clamp venous line, left-lateral Trendelenburg · Tamponade · Tension pneumothorax · Toxins

If hyperkalemia suspected (missed sessions, Monday gap): empiric **Calcium gluconate 10% 1–2 g IV** (or $CaCl_2$ 1 g) → insulin 10 U + D50 25 g → salbutamol neb → ± bicarbonate → **emergency dialysis, low-K bath**. Calcium and bicarbonate must not share a line.

Unsure of the rhythm? See the companion **ACLS Cardiac Rhythm Recognition & Management Cheat Sheet** — williamriveromd.com/downloads/wgmr-acls-rhythm-recognition-cheatsheet.pdf

ACLS — Peri-arrest Rhythms & Hyperkalemic Arrest

Bradycardia · tachycardia (stability drives the path) · the dialysis-specific reversible cause

BRADYCARDIA W/ PULSE (HR < 50)

Identify & treat cause · airway, O_2 if hypoxic · monitor BP/SpO_2, IV, 12-lead ECG

▼

Symptomatic? hypotension · altered mental status · shock · ischemic chest pain · acute HF

▼

NO → monitor & observe

YES → **Atropine 1 mg** IV q3–5 min (max 3 mg)

▼

If ineffective: **transcutaneous pacing** AND/OR **Dopamine 5–20 mcg/kg/min** *or* **Epinephrine 2–10 mcg/min** IV

▼

Consider expert consult & transvenous pacing

Dialysis pearl: *hyperkalemia commonly causes bradycardia & AV block — give calcium gluconate, shift K^+, arrange HD.*

TACHYCARDIA W/ PULSE (HR ≥ 150)

Identify & treat cause · O_2 if hypoxic · monitor, IV, 12-lead ECG

▼

Symptomatic? hypotension · altered mental status · shock · ischemic chest pain · acute HF

▼

YES — UNSTABLE → **synchronized cardioversion** (sedate if able); if regular narrow, consider adenosine

▼

NO — STABLE → assess QRS width

▼

Wide QRS ≥ 0.12 s?

WIDE: adenosine only if regular & monomorphic · antiarrhythmic (amiodarone / procainamide / sotalol) · expert consult

NARROW: vagal · **Adenosine 6** → **12 mg** rapid push · β-blocker or CCB · expert consult

HYPERKALEMIC ARREST (DIALYSIS)

1 · STABILIZE — Calcium gluconate 10% 1–2 g IV/IO (or $CaCl_2$ 1 g, central/IO). Onset 1–3 min · protects heart · does NOT lower K^+.

▼

2 · SHIFT — Insulin 10 U + D50 25 g · **Salbutamol neb 10–20 mg** · ± **bicarbonate** (separate line). Monitor glucose.

▼

3 · REMOVE — Emergency HD, low-K bath (≈ 2.0 mEq/L) — the only definitive removal. Mobilize a machine early.

⚠ Calcium & bicarbonate must NOT share a line (precipitate). **Suspect** with missed sessions / peaked-T / wide-QRS / sine-wave / PEA.

After ROSC: *airway & BP · 12-lead ECG · treat cause · continue K^+ mgmt / dialysis · ICU transfer with documentation.*

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