

XXXXXXXXX HOSPITAL CPR FLOW SHEET

Pt. Location _____

Addressograph _____

Date _____ Time Event Occurred _____ Time Code Announced _____ Time Code Ended _____

Event Witnessed: Yes No Pt. on Monitor Prior to Code: Yes No

Initial Condition:	Pt Conscious: <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Rhythm:	<input type="checkbox"/> VF/VT <input type="checkbox"/> Asystole <input type="checkbox"/> Bradycardia	<input type="checkbox"/> SR <input type="checkbox"/> VT w/ pulse <input type="checkbox"/> PEA (pulseless electrical activity) <input type="checkbox"/> Other _____
	Pt. Breathing: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Pt. w/ pulse: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Ventilation: Time Bag/Mask Ventilation Begun: _____ Intubation Time: _____ Tube Size: _____ # Attempts: _____ Intubated By: _____ Placement Checked By: _____ cm mark _____ <input type="checkbox"/> Bilateral Breath Sounds equal Time: _____	Compressions: Time Compressions Started: _____ Provider: <input type="checkbox"/> Nurse _____ <input type="checkbox"/> CNA _____ <input type="checkbox"/> MD _____ <input type="checkbox"/> RT _____ <input type="checkbox"/> Other _____ (Record initials of provider)
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IV Fluids: <input type="checkbox"/> IV infusing when code called (See MAR for specifics) Time Started: _____ Site: _____ Cath Size: _____ Started By: _____ Type/Amount Fld.: _____ Rate: _____	Time Started: _____ Site: _____ Cath Size: _____ Started By: _____ Type/Amount Fld.: _____ Rate: _____
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Time	Assessment					Interventions					Dose/ Joules	Initials	
	RHYTHM	BP	PULSE (Rate or "C")	RESPIRATION (Rate or "V")	Other/Comments	EPINEPHRINE	ATROPINE	BICARB	LIDOCAINE	DEFIB			Other Interventions

SR – Sinus Rhythm VF – Ventricular Fibrillation VT – Ventricular Tachycardia	Asy - Asystole Brady - Bradycardia	RHYTHM KEY 1° HB – 1 st degree heart block 2° HB – 2 nd degree heart block 3° HB – 3 rd degree/Complete heart block	PEA – Pulseless Electrical Activity A Fib- Atrial Fibrillation A Flutter – Atrial Flutter
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CODE CRITIQUE SHEET

**Detach and give to Nursing Supervisor.
To be completed by Nursing Supervisor (or
his/her designee – must be reviewed by
Nursing Supervisor).
Explain all unsatisfactory responses.
Forward to Nursing Process when complete.**

ADDRESSOGRAPH

1. Did Code Team Members arrive in a timely manner? Satisfactory Unsatisfactory

2. Did a physician arrive in a timely manner? Satisfactory Unsatisfactory

3. Was all equipment/supplies available and in working order? Satisfactory Unsatisfactory

4. Did team members know how to operate equipment/find supplies? Satisfactory Unsatisfactory

5. Was PPE worn appropriately? Satisfactory Unsatisfactory

Other Comments: _____

Critique Completed By: _____ Date _____ Time _____
 Administrative Nurse Supervisor Designee

NOT A PERMANENT PART OF THE MEDICAL RECORD. FORWARD TO NURSING PROCESS WHEN COMPLETE.