This Instruction implements Air Force Policy Directive 44-1, *Medical Operations*. This Instruction prescribes the training, procedures, and responsibilities essential in developing a coordinated team approach to cardiopulmonary resuscitation (CPR). This publication applies to all personnel assigned, attached, or under contract to the 59th Medical Wing (MDW) with the exception of personnel working at the 959th Medical Group at the San Antonio Military Medical Center and the 59th Training Group. This instruction does not apply to the Air National Guard or Air Force Reserve. This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by 10 U.S.C. 55, *Medical and Dental Care*, and E.O. 9397 (SSN). The applicable SORN F044 AF SG D, and Automated Medical/Dental Record System is available at: [http://dpclo.defense.gov/Privacy/SORNs.aspx](http://dpclo.defense.gov/Privacy/SORNs.aspx). Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication*. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) Air Force Manual 33-363, *Management of Records*, and disposed of IAW Air Force Records Information Management System Records Disposition Schedule. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

**SUMMARY OF CHANGES**

This publication has been revised. This rewrite of 59 MDWI 44-142 includes changed content and organization of the adult and pediatric code carts, changed code blue notification procedures,
a new code blue response team, changed code blue documentation, updated code carts and clarified life support certification and training requirements.

1. Responsibilities

1.1. Responsibilities at Joint Base San Antonio (JBSA) Lackland.

1.1.1. Resuscitation Working Group. The Resuscitation Working Group reports to the Executive Committee of the Medical Staff (ECOMS) and serves as the policy making body for the formulation, institution, and revision of policies and protocols for emergency response. The working group generally meets quarterly at the call of the chairperson. Membership includes multidisciplinary representation from Medicine, Nursing, Urgent Care Center (UCC), Emergency Medical Services (EMS), Pediatrics, Advanced Cardiac Life Support (ACLS) Program Director, Pharmacy, Process Improvement Advisor (PIA),
and a representative from the Division of Education and Training’s Life Support Office (LSO).

1.1.2. The JBSA Lackland Medical Response Center (MRC).

1.1.2.1. The MRC will provide information related to code blue events to Risk Management/Quality Improvement personnel, Patient Safety Office, and Resuscitation Working Group upon request for tracking purposes.

1.1.2.2. The MRC will also coordinate EMS activation and a facility wide overhead announcement to alert all staff regarding the situation. If EMS is not immediately available in house during a code blue situation, it will be the responsibility of the MRC to contact a local (San Antonio City) EMS service that can arrive more quickly.

1.1.3. The JBSA Lackland LSO.

1.1.3.1. As a representative of the 59 MDW Commander, the Education and Training Chief nominates candidates to the Military Training Network (MTN) for appointment as the Program Directors for MTN’s Life Support Programs.

1.1.3.2. Collaborates with group and squadron commanders to ensure organizational compliance with specified training requirements IAW Air Force and MTN directives.

1.1.3.3. Maintains an adequate amount of supplies and functional equipment to conduct training as required by program regulation (i.e. Military Training Network or equivalent).

1.1.3.4. Ensures the training site faculty, program directors and administrators remain compliant with the program guidance outlined in the MTN Handbook, current edition.

1.1.3.5. Coordinates resuscitation courses, schedules and executes mock code blue (MCB) evaluations and code cart inspections.

1.1.3.6. Plans training based on findings from both real and mock code blues. Ensures equipment for each training program is available and in good working order.

1.1.3.7. Updates training database with new basic life support (BLS), ACLS, pediatric advanced life support (PALS), and Neonatal Resuscitation Program (NRP) dates for personnel upon completion of course.

1.1.3.8. Completes end of course documentation IAW MTN/ American Heart Association (AHA) requirements.

1.1.3.9. Provides the Resuscitation Working Group with metrics as requested.

1.1.3.10. Forwards training reports to the MTN and/or American Academy of Pediatrics as applicable, and maintains records as outlined in the MTN Handbook.

1.1.3.11. Manages the following programs: Mock code blue and code cart inspection.

1.1.3.12. Conducts quality assurance inspections of all Automated External Defibrillators (AED)s within Wilford Hall Ambulatory Surgical Center (WHASC), at least annually.
1.2. Responsibilities at JBSA Randolph. Cardiac Life Support Function (CLSF) at Randolph is a function of the ECOMS. The Chief, Medical Staff (SGH) will appoint the members of the CLSF and serve as the advisor.

1.2.1. The CLSF is composed of the members listed below:

1.2.2. CLSF Director. The CLSF Director will:
   1.2.2.1. Report MCB issues to the ECOMS.
   1.2.2.2. Identify problems that merit attention of the CLSF.
   1.2.2.3. Monitor or review Code Blue exercises with the MCB Director.

1.2.3. MCB Director/Code Blue Quality Reviewer. The Mock Code Blue Director/Code Blue Quality Reviewer will:
   1.2.3.1. Coordinate all MCB exercises in the facility with Life Support Director.
   1.2.3.2. Coordinates with Chief Nurse representative to ensure staff members assigned a role in Adult or Pediatric Code teams have the required quarterly frequency of advanced life support training.
   1.2.3.3. Ensure all clinics undergo pediatric and adult MCBs quarterly.
   1.2.3.4. Provide the CLSF with the summary of MCB exercises.
   1.2.3.5. Review code blues that occur in the facility and report findings to the CLSF.

1.2.4. Crash Cart Coordinator. The Crash Cart Coordinator will:
   1.2.4.1. Coordinate and monitor the status of the crash carts throughout the facility.
   1.2.4.2. Conduct crash cart inventories on all areas maintaining a crash cart at least twice a year.

1.2.5. Chief Nurse Representative will:
   1.2.5.1. Provide updates to and review issues pertinent to Life Support training.
   1.2.5.2. Coordinate with MCB director to ensure staff members assigned a role in Adult or Pediatric Code teams have the required quarterly frequency of advanced life support training.

1.2.6. Primary Care Clinic Provider Representatives:
   1.2.6.1. Each primary care clinic [Family Health Clinic (FHC), Flight Medicine Clinic (FMC), Internal Medicine (IM), and Pediatrics] will be represented by a privileged provider at each function meeting.
   1.2.6.2. Will ensure that the Pediatric and FHC/FMC flights maintain a monthly roster of Rapid Response Team (RRT) and Code Blue team on-call and that team members will be ready to respond to a rapid response or code blue alert in the facility at all times during regular clinic hours. Team members listed on this on-call roster will appoint a substitute if they will be leaving the facility during the regular clinic hours.
1.2.6.3. Will ensure that the RRT or code blue team members will respond to all rapid response and code blue alerts throughout the entire MTF.

1.2.6.4. Will ensure training is accomplished by all members of the code blue/rapid response teams.

1.2.7. Dental Clinic Provider Representative will:

1.2.7.1. Ensure that the dental team is ready to provide immediate ACLS response during a code blue alert in the dental clinic until the code blue team members arrive on site. Dental team members listed on the on-call roster will appoint a substitute if he/she will be leaving the facility during the regular clinic hours.

1.2.7.2. Ensure that a dental technician/clerk performs daily crash cart checks and that the technician/clerk performing this duty will also be responsible for bringing the crash cart to any code blue events occurring on the second floor.

1.2.7.3. During extended clinic hours, when dental clinic is closed, a staff member from the Optometry clinic will bring the crash cart from the dental clinic to the scene. Once the crash cart arrives on scene, any AED-trained personnel can use the AED until the appointed person (the defibrillator manager) arrives, who will take over control of the crash cart.

1.2.7.4. Will ensure training is accomplished by all members of the code blue teams.

1.2.8. Pharmacy Representative will:

1.2.8.1. Appoint a pharmacist on-call, in coordination with the Pharmacy Flight Chief, to respond to a code blue event.

1.2.8.2. Be the Pharmacy Chief designee who is responsible for inspecting and replacing outdated drugs in the crash carts during the last week of each month, and replacing any drugs used after code blue events.

1.2.8.3. Perform an annual review of the crash cart medication content approved by 59 MDW

1.2.9. Laboratory Representative will:

1.2.9.1. Ensure a laboratory technician will be available to respond to an RRT alert. A laboratory technician will respond to all code blue alerts.

1.2.9.2. Ensure laboratory specimens obtained during an RRT or code blue event are processed in the most expeditious method available in house.

1.2.9.3. Identify and provide recommendation for any additional laboratory process.

1.2.10. The CLSF will provide oversight for all significant resuscitation issues and will:

1.2.10.1. Review all instructions pertaining to BLS, ACLS, or PALS.

1.2.10.2. Review all code blues/RRT alerts and recommend follow up as needed.

1.2.10.3. Review all mock code blue/RRT exercises in the 359 MDG and recommend follow up as needed. A copy of each Mock Code Blue Evaluation form will be provided to the CLSF committee by the mock code director or designee.
1.2.10.4. Ensure all crash carts/Broselow bags are inspected and the cart contents list is reviewed annually by members of CLSF or a selected designee.

1.2.10.5. Ensure all personnel assigned to all clinical areas will attend crash cart training once a year.

1.2.10.6. Meet quarterly, at a minimum, or as needed. Documentation of the Function minutes will be reported to the ECOMS quarterly, and will include pertinent information regarding crash cart checks, MCB/RRT/Code Blue findings.

1.2.11. Flight commanders are responsible for ensuring that all personnel assigned to their areas, including clinic volunteers, are familiar with this instruction and their responsibilities.

1.2.12. The Flight Chiefs of FHC and Dental Clinic (or their designees) are responsible for the inspection and operational readiness of the crash carts that are positioned in their respective areas.

1.2.13. The Flight Chief of Pediatric clinic is responsible for the inspection and operational readiness of the Broselow bag.

1.2.14. The Pharmacy Chief (or designee), is responsible for inspecting and replacing outdated drugs in the crash carts during the last week of each month, and replacing any drugs used after code blue events.

1.2.15. After a Code Blue or MCB exercise, the crash cart custodian is responsible for ensuring that supplies are immediately restocked and the cart is immediately cleaned, sealed, and returned to its appointed location. Medications will be replaced by pharmacy staff as needed. The supplies and medication replacement should be accomplished immediately, before the close of business day.

2. Emergency Response Procedures.

2.1. Definition: A code blue is called for cardiac arrest or arrhythmia causing hemodynamic instability and actual or impending respiratory arrest or when additional resources are needed for timely management of patient care emergencies. Code blue emergencies require immediate activation of the EMS and a dedicated code blue response team (see below). Both EMS and the code blue team will respond to all code blue emergencies.

2.1.1. Cardiac events. Include ACLS defined pulseless rhythms and unstable rhythms. This requires either the lack of a pulse, loss of consciousness or rapid clinical deterioration and hypotension in the setting of an arrhythmia (abnormal heart rhythm).

2.1.2. Respiratory events: Include individuals not breathing, in severe respiratory distress or those with marked symptomatic and refractory hypoxia.

2.1.3. Patients found down and completely unresponsive or having witnessed seizures may require activation of the code blue team.

2.2. JBSA Lackland procedures for non-code blue medical emergencies. Call EMS ONLY and institute procedures per algorithm.

2.2.1. Cardiovascular events: Other rhythms, events or symptoms (such as chest pain or hemodynamically stable palpitations) may require emergent intervention but these events
do not necessarily merit activation of the code blue team. Attachment 2 gives the appropriate algorithm for addressing new chest pain.

2.2.2. Patients with new shortness of breath, hypoxia or difficulty breathing may require emergent intervention but these do not necessarily merit activation of the code blue team.

2.2.3. Other emergent events such as strokes, active myocardial ischemia with stable hemodynamics, critical lab values or critical radiology findings may require emergent intervention but these events do not necessarily warrant activation of the code blue team.

2.2.4. Any patient suspected of having a stroke within the previous 96 hours should be immediately transported to a facility capable of addressing and treating cerebral vascular accidents. The code blue team should not be activated unless the patient meets criteria as above. Attachment 3 gives the appropriate algorithm for addressing a new or suspected stroke.

2.3. JBSA Randolph procedures for non-code blue medical emergencies. Activate the RRT.

2.3.1. There are two types of RRT.

2.3.1.1. Pediatric RRT will respond to patients who are prepubescent. The team will consist of:

2.3.1.1.1. Pediatric provider on-call.

2.3.1.1.2. PALS-certified registered nurse (RN) from the on-call provider’s team.

2.3.1.1.3. One 7-level or advanced 5-level 4N technician.

2.3.1.2. Adult RRT will respond to patients who are pubescent and older. The team will consist of:

2.3.1.2.1. Adult provider on-call.

2.3.1.2.2. ACLS-certified RN from the on-call provider’s team.

2.3.1.2.3. One 7-level or advanced 5-level 4N technician.

2.3.1.2.4. The members of the RRT will be a subset of the corresponding Code Blue teams.

2.3.2. The appropriate RRT, adult or pediatrics, will be called when patients, visitors, or personnel, who are not under direct care of their Primary Care Manager team and are conscious and alert, are having medical urgent/emergent event (e.g., syncope but becomes alert immediately, presyncope, chest pain with diaphoresis). An RRT call will not be made if breathing has stopped, or there is no pulse. In these cases, a Code Blue will be activated.

2.3.3. When responding, the RRT will report to the designated area with a wheelchair, go-bag containing intravenous (IV) fluid and supplies (Attachment 4), and oxygen.

2.3.4. The adult patient will be stabilized and transported to the FHC Room 1C108, Critical Care Center (C3). Pediatric patients will be transported to the Pediatric treatment room, 1A209 (Treatment Room #1). The responding on-call provider will appropriately assess and manage the patient. If the patient cannot be safely discharged, EMS will be contacted for patient transport to a higher level of care. Per discretion of responding
provider, a 9-1-1 call will be placed if, and as soon as, the condition is identified as emergent.

2.3.5. All interventions provided by the RRT will be documented as a patient encounter in AHLTA. A copy of this documentation will also be submitted to the CLSF chairperson for review and evaluation.

2.3.6. If, at any time during the stabilization of the patient, the patient stops breathing or becomes pulseless, Code Blue should be activated and a 9-1-1 call should be made immediately.

2.4. Activation of Code Blue Team.

2.4.1. JBSA Lackland activation procedures. Personnel discovering any emergency will immediately call for help and activate the emergency response system by calling 9-1-1 from a landline phone. The clinic will also notify the Medical Control Center (MCC) if able to do so.

2.4.1.1. The 9-1-1 call at WHASC will be routed to the MRC. If it is determined there is a code blue emergency the MRC will simultaneously activate the EMS and notify the Medical Control Center. Additionally, an overhead announcement may be made overhead by the clinic area, in accordance with clinic procedures, though MCC will also make an overhead announcement if directly contacted. For additional details on chain of activation after calling 9-1-1, see Attachment 5.

2.4.1.2. The initial responder at WHASC will begin BLS. Subsequent responders will be responsible for retrieving crash cart or AED (see Attachment 6). Alternatively, the area in which the closest code cart is located may bring the cart to the location of the code as soon as they hear the overhead Code Blue announcement. Specifically, the individual who performed the daily crash cart check may bring the code cart to the location of the code.

2.4.1.3. If the patient is in a critical care area, such as (but not limited to) the Post Anesthesia Care Unit or operating room, the ALS Certified licensed provider(s) may choose to conduct the resuscitation without announcing a “code blue,” but they must immediately contact the MRC to arrange for patient transport. See Attachment 5.

2.4.1.4. The WHASC code blue team will respond to Code Blue scenarios located in WHASC and in the immediate vicinity (parking lot). The code blue team will not respond to Code Blue scenarios located at the AF Post Graduate Dental School, Dunn Dental clinic or Reid clinic. Personnel at AF Post Graduate Dental School, Dunn clinic or Reid clinic discovering an emergency will immediately call for help and activate the emergency response system by calling the Lackland Air Force Base emergency number (9-1-1).

2.4.2. JBSA Randolph activation procedures. A RRT or Code Blue response is activated by overhead page. The page should state “(Pediatric or Adult) Rapid Response Team to (appropriate location)” or “(Pediatric or Adult) Code Blue in (appropriate location).”

2.4.2.1. The person who identifies a cardiopulmonary arrest will initiate resuscitation and call for help.
2.4.2.2. The person who responds to the call for help will activate the in-house emergency response system by announcing via overhead page “Adult (or Pediatric) Code Blue to (appropriate location),” activate local EMS by calling 911, and assist with BLS until the code team arrives.

2.4.2.3. For either adult or pediatric code blue alerts at Randolph, a crash cart is brought to the scene by the one of the FHC front desk clerks for the crash cart on the 1st floor or by the dental clerk who performs the daily crash cart check for the crash cart on the 2nd floor. During extended clinic hours when dental clinic is closed, a staff member from the Optometry clinic will bring the crash cart from the dental clinic to the scene. Once the crash cart arrives on scene, any AED-trained personnel can use the AED until the appointed person (the defibrillator manager) arrives, who will take over control of the crash cart.

2.5. JBSA Lackland code team composition.

2.5.1. Team member composition is as follows:

2.5.1.1. Licensed active duty Medical Corp providers (2).
2.5.1.2. Anesthesiology (Anesthesiologist or CRNA) (1).
2.5.1.3. Nurse (1).
2.5.1.4. Pharmacist (1).
2.5.1.5. 4H cardiopulmonary technician or properly trained 4N technician (1).
2.5.1.6. Laboratory representative (1).
2.5.1.7. MDOG SGH (1).

2.5.2. All team members will hold a team-specific code pager for a single five day work week at a time. At the end of the week the team member will rotate off the code team and entrust the pager to the incoming code team participant. The MDOG SGH will be a continuous member of the code team.

2.5.3. The code team will be operational during standard clinic business hours. Code team members will be expected to be available and respond to code blue situations during this time.

2.5.4. For code blue medical emergencies on weekends, non-business days or outside of business hours, only EMS will be notified.

2.5.5. The Medical Corp providers, anesthesiology representatives, nurses, pharmacists and 4H technicians will be ACLS certified. The Medical Corp members will be chosen from the general 59 MDOG Medical Corp pool. The laboratory representative will be BLS certified and must be familiar with the oxygen and other resuscitation equipment to assist as needed.

2.5.6. All code team members, including pharmacy and laboratory representatives, must participate in quarterly hands on simulation lab or didactic training. Code team members will also be expected to participate in quarterly mock code training/drill in their respective clinics.
2.5.7. Any team member not able to fulfill their code team obligations must find a suitable replacement and submit the request at least one month prior to their assigned week to the head of the code blue team. Exceptions will be considered on a case by case basis.

2.5.8. The Resuscitation Committee will designate a head of the code blue team. This individual will be responsible for coordinating code team training and the on-call schedule, in collaboration with the points of contact (POC)s from each pool of team members (see below).

2.5.9. A POC will be selected from each pool of team members to represent their specific field (a nurse for the nurses, etc). This POC will be responsible for the pager rotation and on call schedule. The POC will report the call schedule to the head of the code blue response team and to the MDOG SGH.

2.5.10. Individual code team member responsibilities.

2.5.10.1. (2) Licensed medical corps providers: The first provider to arrive at the code blue will assume responsibility for the emergency situation. This physician will be the team leader and will take lead of the code from any other WHASC code blue team member that may be running the code upon the physician’s arrival. If the code is being directed by an ACLS certified physician that is not a part of the team, the first code blue team physician responder may assume control of the code or allow the initial provider to continue directing the code. This will be done at the discretion of the lead code team provider. The second provider will have a supportive role in the code. This provider’s responsibilities will include filling in for missing team members, clearing the area of onlookers, assuring proper documentation is being annotated, assuring the EMS paramedics have been notified, and assisting the team leader with directing the code. The code team leader will be responsible for the patient until the end of the code or until care is transitioned to EMS.

2.5.10.2. (1) Anesthesia. The primary role of the anesthesia representatives will be to secure and manage the airway. The anesthesia representatives will carry a ‘go bag’ to the code. The contents of the go bag are listed at the end of this document (see Attachment 7).

2.5.10.3. (1) Nurse: The primary role of the nurse representative is to obtain vascular access and administer medications.

2.5.10.4. (1) Pharmacy: These team members will be responsible for drawing up and preparing medications, assuring proper doses are ordered and administered, and verifying proper utilization of the pharmacologic resources during the emergency situation. The pharmacy team member will bring a ‘go bag’ that will be prepared and ready for use at all times. The bag will be stocked and maintained by the pharmacy. The pharmacy ‘go bag’ contents are listed at the end of this document in Attachment 8.

2.5.10.5. (1) 4H cardiopulmonary technician or properly trained 4N technician: The role of the 4H technician will be primarily airway support and management. The 4H technicians will be responsible for the assembling, administration of oxygen related supplies and equipment at the code. If the anesthesia representatives are not present
at the code then the 4H technician will be responsible for airway management. The 4H technician will carry a ‘go bag’ to the code. The contents of the go bag are listed at the end of this document in Attachment 9.

2.5.10.6. (1) Laboratory representative: All laboratory members will be BLS certified. The laboratory team member will bring a ‘go bag’ that will be prepared by the lab and ready for use at all times. The laboratory ‘go bag’ contents are listed at the end of this document in Attachment 10. The laboratory member will be responsible for running the glucometer and the ABG machine. If necessary, they may also be asked to act as a courier to run the blood samples to the main laboratory.

2.5.10.7. (1) MDOG SGH. The MDOG SGH will primarily assume the administrative role and assist in assuring the area is clear of bystanders and all proper procedures are followed. The MDOG SGH will also assure a post-code debriefing session is conducted.

2.6. JBSA Randolph code team composition and roles. There are two types of Code Blue Teams at Randolph, pediatric and adult.

2.6.1. Pediatric Code Blue team will respond to patients who are prepubescent. All members of the team should be PALS-certified or trained.

2.6.2. Adult Code Blue team will respond to patients who are pubescent and older. All members of the team should be ACLS-certified or trained.

2.6.3. The code team will consist of:

2.6.3.1. (1) Code team leader (CTL) – A provider from FHC, or if available, a FMC provider, can respond and assume the adult CTL. A provider from Pediatrics/FHC/FMC can respond and assume the pediatric CTL.

2.6.3.2. (1) Recorder – RN or any of the providers listed in the CTL role who has not assumed the CTL position.

2.6.3.3. (1) Medication manager – RN.

2.6.3.4. (1) Defibrillator manager – RN or 4N technician.

2.6.3.5. (1) Airway manager. Any clinical staff member skilled in bag-valve mask (BVM) ventilation or trained in the proper placement of Combitube. If patient requires more than basic airway management (BVM, nasopharyngeal tube, oropharyngeal airway) support or placement of advanced airway beyond Combitube, a provider listed in the CTL role who has not assumed the CTL position, and is competent in advanced airway placement should take over the role.

2.6.3.6. (2) Chest Compressor – any MDG staff member.

2.6.3.7. (1) Crowd controller – any MDG staff member.

2.6.4. The first provider at the scene will assume the role of CTL until the on-call code team arrives, when the designated CTL in the on-call team will assume the CTL role. When more than one provider is present, the most experienced provider will assume the CTL role and have overall responsibility for managing the code.
2.6.5. The medication manager (RN) will administer IV medications and solutions according to established ACLS/PALS protocols as directed by the CTL.

2.6.6. An appointed recorder will document care on the Cardiac/Respiratory Arrest Report.

2.6.7. Any 359 MDG personnel who have successfully completed the BLS/AED training may defibrillate using AED function of defibrillators prior to the arrival of a provider. The defibrillator manager will ensure appropriate rhythm strips are saved for documentation.

2.7. Transition to EMS care.

2.7.1. If the EMS team arrives prior to the code blue team, then EMS will immediately assume control of the code blue situation and for the care/resuscitation of the patient.

2.7.2. The code team leader will provide a warm hand-off report to the EMS transport team. All necessary documents will be provided to the transport team.

2.7.3. If the code blue team is running the code the patient will remain under the care of the code blue team until the team leader officially hands of the care of the patient to EMS. This transition should occur as rapidly as possible and can occur during compressions, administration of medication or without a secure airway. The code team leader may delay the hand off if it is deemed immediate transport could endanger the patient, but generally the handoff should proceed as quickly as possible.

2.8. JBSA Lackland Responsibilities after Resuscitation.

2.8.1. The senior person from the area/unit (or designee) will ensure the AED (if used) is taken to Biomedical Equipment Technician (BMET) for interrogation. The AED will be cleaned with an appropriate facility-approved (IAW manufacture’s recommendations) disinfecting agent (Sani-Wipes, etc.) after use on a victim and before taking to BMET.

2.8.2. A debrief will be conducted. The MDOG SGH ensures that this takes place and if needed, a supportive and consultative service with Mental Health personnel for all members involved in the cardiac arrest resuscitation will be requested.

2.8.3. The senior person at the scene along with the unit officer in charge (OIC) and medical director from the area/unit (or designee) will also participate in the post-code blue conference. If the unit OIC or medical director is not present for the code, the senior person will be responsible for ensuring that the 59 MDW Form 1280, Cardiac Respiratory Arrest Record, any rhythm strips, and a code blue critique memorandum for record (MFR) are given to the element medical director for review of documents and signature of the MFR. Copies of pertinent clinical documents will also become part of the patient’s medical record and will have also been provided to the medical transport team at the time of transfer.

2.9. JBSA Randolph Responsibilities after Resuscitation.

2.9.1. The CTL will review and complete the 59 MDW Form 1280 with input from other personnel present. The CTL will ensure that all documentation is completed in the patient’s record. A copy will be forwarded to the Code Blue Quality Reviewer and the SGH by close of business day.
2.9.2. The CTL will conduct a debrief and if needed, a supportive and consultative service with Mental Health personnel for all members involved in the cardiac arrest resuscitation will be requested.

3. **Mock Code Blue Program (MCBP).**

3.1. The MCB Program endeavors to ensure that all personnel are prepared to activate the emergency response system and adequately implement procedures to sustain the life of a victim until emergency personnel arrive.

3.2. MCB’s will occur at random times and locations throughout the clinics. Mock code blue exercise will be conducted in each clinic at least quarterly for all areas with a crash cart or the surrounding areas.

3.3. Upon completion of the Mock Code exercise, the evaluation team will conduct a debriefing for the code participants about their performance and pass/unsatisfactory status. MCBs are evaluated using 59 MDW Form 69, *Mock Code Blue Evaluation Sheet*.

3.4. Any code team with an unsatisfactory exercise will be retested on the same day. If on retest, the code team continues to demonstrate unsatisfactory performance, the team will coordinate with the MCB coordinator and schedule a retest within 30 days.

3.5. MCB trends and other actionable items will be reported to the Executive Committee of the Medical Staff.

3.6. **JBSA Lackland MCBP.** At Lackland there will be section/clinic-based MCBs as well as separate quarterly mock ACLS codes for the code blue team that will include participation by the paramedics.

3.6.1. The section/clinic-based MCB at Lackland will be conducted by the clinics using 59 MDW Form 69 under the authority of the Life Support Office. The results of MCBs will be reported to the Life Support Office which will report to the Resuscitation Working Group quarterly. For any clinics not reporting quarterly MCBs or clinics that have unsatisfactory MCB, the Life Support Office will provide no-notice MCBs in the clinics and report the results to the Resuscitation Working Group. For areas with AEDs only, the clinic will be required to perform BLS mock codes and identify the 2 closest crash carts to their location.

3.6.2. An unsatisfactory section/clinic based MCB at Lackland will be reevaluated in 30-45 days, during which time the unit/clinic is given the opportunity to conduct internal training. Unsatisfactory evaluations will also be disclosed to unit’s OIC/noncommissioned officer in charge and signatures obtained verifying receipt of information.

3.7. **JBSA Randolph MCBP.** The MCBs will involve both the clinics and the code blue team. Evaluators will consist of the following: a MDG staff member who is a BLS-instructor trainer and a member with ALS instructor experience.

3.7.1. Using the 59 MDW Form 69, the evaluator will record significant events and provide an overall critique of the mock code.

3.7.2. After each mock code, a debrief will be performed.
3.7.3. Each mock code exercise will be evaluated as overall "satisfactory" or "unsatisfactory".

3.7.4. A satisfactory evaluation implies:

3.7.4.1. Initial assessment, call for help, use of the crash cart, oxygen administration, use of the cardiac monitor, establishment of an IV access, and recording of events was successfully accomplished as required.

3.7.4.2. Appropriate BLS/ACLS/PALS algorithms were adhered to.

3.7.4.3. Defibrillation was performed safely.

3.7.4.4. The team members assumed their proper roles.

3.7.5. An unsatisfactory evaluation implies at least one of the following:

3.7.5.1. Two or more of the above listed items were not accomplished.

3.7.5.2. There was a significant lack of knowledge regarding American Heart Association/American Red Cross BLS, ACLS or PALS guidelines.

3.7.6. Any code team with an unsatisfactory exercise will be retested on the same day. If on retest, the code team continues to demonstrate unsatisfactory performance, the team will coordinate with the MCB coordinator and schedule a retest within 30 days.

3.7.7. A copy of 59 MDW Form 69 will be sent to the chairperson of the CLSF. For a second unsatisfactory evaluation, the supervisor(s) of the personnel involved will address all discrepancies in writing to the flight commander, chairperson of the CLSF, and the SGH.

3.7.8. The results of each mock code will be discussed at the next CLSF meeting. Any concerns or recommendations that need to be further addressed will be reported to ECOMS.

4. Training Requirements.

4.1. AED training: Required for all personnel in patient care areas in accordance with AFI 44-102, Medical Care Management.

4.1.1. All personnel, including those in non-patient care areas, must be oriented to the location of the nearest AED and the procedures for activating the Emergency Response System.

4.2. All medical personnel who work in an area where a code cart is located must be oriented to, and be familiar with, the code cart, its location, its contents, the operation of all life support equipment, and their anticipated role in a code in accordance with their individual scope of practice.

4.3. BLS training: Military members, civilians, contract personnel and volunteers are required to maintain current certification in AHA Healthcare Provider BLS (or equivalent course based on published national guidelines for BLS) IAW AFI 44-102. The 59 MDW adheres to the guidelines of the AHA and the American Academy of Pediatrics for all life support programs.
4.3.1. Individuals with an expired BLS for Healthcare Providers certification must complete a BLS for Healthcare Providers course and will be prohibited from performing patient care until the training is complete.

4.4. ACLS certification is required by AFI 44-102 for any privileged healthcare provider (physician, resident physician, physician assistant, nurse practitioner or nurse anesthetist) assigned to the emergency department or urgent care center. In addition, ACLS certification is required by any privileged healthcare provider who provides moderate sedation or general anesthesia to adults (18 years and older), regardless of the clinical area where the care is being provided. All active duty licensed providers are also required to be ACLS certified, regardless of their assigned clinical area of care. This includes (but is not limited to) mental health, radiology, pediatric and ophthalmology, and dental providers.

4.4.1. ACLS training is required for nurses and optional for medical technicians who are assigned to the Emergency Department, Post Anesthesia Care Unit (PACU)/Operating Room, or UCC as well as EMS/RT techs, IDMTs, paramedics, and CCAT members. In addition, ACLS is required for any RN participating in moderate sedation procedures regardless of clinical area. All RNs assigned to Code Team will maintain ACLS.

4.5. PALS certification is required as per AFI 44-102, for any privileged healthcare provider (physician, resident physician, physician assistant, nurse practitioner, or nurse anesthetist) assigned to the emergency department or UCC. In addition, PALS certification is also required by any privileged healthcare provider who provides moderate sedation or general anesthesia to infants, children, and/or adolescents (before the 18th birthday) regardless of the clinical area where the care is provided. Dentists who provide moderate sedation or general anesthesia to pediatric patients must be PALS certified. The use of nitrous oxide alone or with local anesthetic does not require PALS certification.

4.5.1. PALS training is required for nurses, and optional for medical technicians, assigned to the Emergency Department, PACU/OR, or UCC as well as EMS/RT techs, IDMTs, paramedics, and CCAT members.

4.5.2. JBSA Randolph additional PALS requirement. At Randolph, all privileged providers, affiliate providers or IMA’s who provide patient care to pediatric patients will maintain PALS certification.

Table 4.1. Summary of Training Requirements for Privileged Healthcare Providers.

<table>
<thead>
<tr>
<th>Active Duty Provider</th>
<th>Civilian Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>Adults</td>
</tr>
<tr>
<td>AED, BLS, ACLS for all</td>
<td>AED, BLS for all; All privileged providers at 59 MDW require ACLS if treating adult patients. ACLS required if working in Urgent Care Center or Emergency Department or if providing moderate sedation or general anesthesia or if responding on code blue team.</td>
</tr>
<tr>
<td>PEDS</td>
<td>AED, BLS, ACLS for all; PALS if working in Urgent Care Center or Emergency Department or if providing moderate sedation or general anesthesia or if responding on code blue team.</td>
</tr>
<tr>
<td>Dentists</td>
<td>AED, BLS, ACLS for all</td>
</tr>
</tbody>
</table>

4.6. All personnel assigned to a code blue team will have ACLS and/or PALS certification.

4.7. New arrivals to the 59 MDW who have expired ACLS or PALS required certifications must complete the training at the first opportunity, as applicable to the individual’s situation. This must occur within 3 months and requires a waiver from MTF/CC IAW AF 44-102.

4.8. Active duty members, Reservists/National Guardsmen, DoD employees, and facility volunteers are eligible to attend WHASC Life Support Courses. Volunteers will receive a certificate of completion instead of a card. Contract personnel may attend WHASC classes only if their contract explicitly states the training is to be done by the 59 MDW.

4.9. Life Support course completion cards may be reissued if original card was lost or destroyed IAW guidance from the MTN.

5. **Code Blue Supplies and Equipment.**

5.1. Crash carts will be standardized throughout the Air Force Medical Service as outlined by Air Force Medical Operations Agency.

5.2. Crash cart contents will be maintained as specified in Attachment 11.

5.3. Crash Cart Notebooks will be stored on top of each cart and will contain the following:

5.3.1. Section 1: 59 MDWI 44-142 with Attachments.

5.3.2. Section 2: Daily/Monthly Crash Cart Checklist (59 MDW Form 2995 Daily/Monthly Code Cart Checklist). The completed daily/monthly checklist will be removed after 12 months and then archived for another 2 years, per The Joint Commission (TJC) standards.

5.3.3. Section 3: Lifepak 20 Operator’s Checklist. The completed checklist will be removed after 12 months and then archived for another 2 years, per TJC standards.

5.3.4. Section 4: 59 MDW Form 1280.

5.4. All carts and Broselow bag will be sealed with plastic locks. One lock will secure the entire crash cart. The lock will be removed only for a Code Blue, MCB, monthly inspection, or training. If a cart or Broselow bag is discovered without a lock, the contents must be inspected immediately. Items will be replaced if needed, and the cart/bag will be resealed. Plastic locks for the medication section of the cart will be kept in the pharmacy. Plastic locks for the remainder of the cart will be kept by the unit.
5.5. Crash carts will be inspected daily IAW the Daily/Monthly Crash Cart Checklist (59 MDW Form 2995). The monthly inventory of all drawers/items will be inspected during the first 5 days of each month. The monthly inventory inspection will include the Broselow bags and the Go-bags. Any items found to be inoperable or expired will be replaced immediately.

5.5.1. A complete inventory of the code cart is accomplished immediately after each code. All expired or missing items will be replaced promptly. The person completing the inventory must annotate the new lock number and sign the signature line of the checklist.

5.5.2. The pharmacist (or a designee) will inspect required medications monthly IAW the Crash Cart Medication List (Attachment 12). Outdated (or soon to be outdated) medications will be replaced as needed.

5.6. Each duty section will be responsible for initial and annual crash cart training for all personnel assigned to their section. The status of annual crash cart training will be reported to the LSO (at Lackland) or CLSF (at Randolph).

5.7. Quality Assurance Code Cart Inspection Program. The LSO will implement a Quality Assurance Program of the code carts within the 59 MDW by maintaining a list of all code cart locations and conduct annual no-notice inspections using 59 MDW Form 66, Life Support Code Cart Inspection Record. Any discrepancies must be addressed and/or corrected the day of inspection. The inspection results will be forwarded to the appropriate unit personnel at the discretion of the LSO. Code cart inspection data will also be reported to the Resuscitation Working Group.

5.8. Locations of Code Carts.

5.8.1. JBSA Lackland Code Cart Locations. Code carts at Lackland are strategically located to provide basic and advanced life support in the event of a code. Attachment 6 lists the current locations of ACLS carts.

5.8.2. JBSA Randolph Code Cart Locations.

5.8.2.1. Family Health Clinic: Located in Room 1C108, C3. This cart responds to all Code Blue activities on the first floor.

5.8.2.2. Dental Clinic: Located in north Dental Clinic Hallway. This cart responds to all Code Blue activities on the second floor.

5.9. Automated External Defibrillators.

5.9.1. The Public Access Defibrillation Program evaluates non clinical areas for placement of AEDs for use by non-medical personnel as well as conducting training related to maintenance and inspection requirements.

5.9.2. Requests for AED placement within WHASC. These requests will be brought before the Resuscitation Working Group for approval by the Chairman.

5.9.2.1. Once authorized by the Chairman, a AF Form 601, Equipment Action Request is submitted to the Medical Equipment Management Office by the requesting area/unit.
5.9.2.2. Medical Equipment Custodians (or designees) are responsible for the maintenance and monthly checks of all AEDs on their respective accounts. AED management training is conducted and tracked by Life Support Office.

5.9.2.3. The Life Support Office will conduct quality assurance inspections of all AEDs within WHASC, at least annually.

5.9.2.4. Each AED will contain all items listed in Attachment 13 “WHASC AUTOMATED EXTERNAL DEFIBRILLATOR (AED) SUPPLY PACK” in order to be “serviceable”.

5.9.2.5. Replacement supplies or batteries are obtained through Medical Logistics Customer Support.

5.9.2.6. In the event that an AED is used for a victim of a medical emergency, BMET will interrogate the used AED at the next available opportunity and have AED Patient Report/Code Summary printed and available for the area/unit within 4 working days for use in the post code blue critique session. A replacement AED will be provided to the area during interrogation/repair from a section with less criticality or from where there are other AEDs or code carts close by, at the discretion of the Life Support Office.

JOSEPH R. RICHARDS, Colonel, USAF, MC
Chief of the Medical Staff, 59th Medical Wing
Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References
AFPD 44-1, Medical Operations, 9 June 2016
AFI 44-102, Medical Care Management, 17 March 2015
AFI 44-119, Medical Quality Operations, 16 August 2011
American Heart Association Standards
The Joint Commission (TJC) Standards
Neonatal Resuscitation Manuals, 2011

Prescribed Forms
59 MDW Form 66, Life Support Code Cart Inspection Record
59 MDW Form 69, Mock Code Blue Evaluation
59 MDW Form 1280, Cardiac Respiratory Arrest Record
59 MDW Form 2995, Daily/Monthly Code Cart Checklist

Adopted Forms
AF Form 601, Equipment Action Request
AF Form 847, Recommendation for Change of Publication

Abbreviations and Acronyms
AAR—After Action Report
AED—Automated External Defibrillator
ALS—Advanced Life Support
ACLS—Advanced Cardiac Life Support
AHA—American Heart Association
BLS—Basic Life Support
BMET—Biomedical Equipment Technician
BVM—Bag-Valve Mask
C3—Critical Care Center
CLSF—Cardiac Life Support Function
CPR—Cardiopulmonary Resuscitation
CTL—Code Team Leader
ECOMS—Executive Committee of the Medical Staff
EMS—Emergency Response System
FHC—Family Health Clinic
FMC—Flight Medicine Clinic
IAW—In Accordance With
IV—Intravenous
JBSA—Joint Base San Antonio
LSO—Life Support Office
MCB—Mock Code Blue
MCBP—Mock Code Blue Program
MDG—Medical Group
MDW—Medical Wing
MFR—Memorandum for Record
MRC—Medical Response Center
MTN—Military Training Network
NRP—Neonatal Resuscitation Program
OIC—Officer in Charge
PACU—Post Anesthesia Care Unit
PALS—Pediatric Advanced Life Support
PIA—Process Improvement Advisor
POC—Point of Contact
RM—Risk Management
RN—Registered Nurse
RRT—Rapid Response Team
TJC—The Joint Commission
UCC—Urgent Care Center
WHASC—Wilford Hall Ambulatory Surgical Center
Attachment 2

JBSA LACKLAND CHEST PAIN PROTOCOL

Figure A2.1. JBSA Lackland Front Desk Chest Pain Protocol.
Figure A2.2. JBSA Lackland Treatment Room Chest Pain Protocol.

Patient complains of chest pain

Patient has dyspnea, nausea, or dizziness in last 72 hours?

Yes

Obtain vitals and EKG (if you have the ability to obtain EKG)

Call 911 for ambulance
Tell them NOT to activate CODE TEAM
Notify MD
Initiate treatment protocol to the extent possible in your clinic.**
If not available in your clinic, EMS will initiate tx protocol.
** Do NOT send to UCC

Unstable vitals or EKG changes? *

Yes

Obtain brief history
Place on monitor
Get MD to evaluate further
** Do NOT send to UCC

If you feel pt should be further evaluated but does not require ambulance transport, you can recommend family member drive them to an Emergency room.
If you do not have EKG ability but pt is symptomatic, then call 911 for ambulance ride.
Tell them NOT to activate CODE TEAM

No

Current chest pain or pain in last 72 hours?

Yes

Make appt with PCM within 7 days

No

* Examples of unstable patient:
- HR >120 or <50
- RR >25
- SO2 <90% on baseline O2
- SBP >180 or <90
- DBP >110
- ST elevations or depressions on EKG
- New LEBB
- Patient appears to be in distress by nursing judgment

** Active chest pain treatment protocol:
- Give ASA 325 mg
- Give nitroglycerin 0.4 mg sublingual every 5 minutes x 3
  - Do not give if BP <90/50
- If SO2 <90%, place on oxygen
- Place on cardiac monitor
- Monitor vitals every 10 minutes
- Start IV
Attachment 3

JBSA LACKLAND STROKE PROTOCOL

Figure A3.1. JBSA Lackland Front Desk Stroke Protocol.
Figure A3.2. JBSA Lackland Treatment Room Stroke Protocol.

* Examples of Stroke symptoms:
  - Unilateral weakness
  - Slurred speech
  - Unintelligible speech
  - Unable to understand spoken language
  - Facial drooping
  - Marked confusion
  - Inability to walk, vertigo
  - Poor coordination
  - Difficulty swallowing
  - All symptoms should be new/recently developed symptoms.

** Active stoke treatment protocol
  - Give ASA 325 mg (if patient able to swallow)
  - If SO2 <90%, place on oxygen
  - Place on cardiac monitor
  - Monitor vitals every 10 minutes
  - Start IV

Patient complains of stroke-like

Symptoms progressive or onset in the past 96 hours

Symptoms new within past 6 hours

No

Make appt with PCM within 7 days

Obtain vitals, EKG, assess mental status and airway

Yes

Obtain brief history
Place on monitor
Get MD to evaluate further

Unstable vitals, airway or EKG changes?

Yes

Call 911 for ambulance
Tell them NOT to activate CODE TEAM

Notify MD
Initiate treatment protocol to the extent possible in your clinic.

If not available in your clinic, EMS will initiate tx protocol.

Do NOT send to UCC

No

Do NOT send to UCC
### Attachment 4

**JBSA RANDOLPH GO-BAG CONTENT LIST OF MEDICAL SUPPLIES**

Figure A4.1. JBSA Randolph Go-Bag Content List of Medical Supplies.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>QUANTITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cravats</td>
<td>4</td>
</tr>
<tr>
<td>Tape</td>
<td>2.2.2</td>
</tr>
<tr>
<td>Bandage Scissors</td>
<td>1</td>
</tr>
<tr>
<td>Sharps Container</td>
<td>1</td>
</tr>
<tr>
<td>Masks</td>
<td>2</td>
</tr>
<tr>
<td>Gloves</td>
<td>Box</td>
</tr>
<tr>
<td>Alcohol Pads</td>
<td>20</td>
</tr>
<tr>
<td>Ice Packs</td>
<td>3</td>
</tr>
<tr>
<td>Tongue Blades</td>
<td>15</td>
</tr>
<tr>
<td>Safety Pins</td>
<td>5</td>
</tr>
<tr>
<td>Safety Glasses</td>
<td>1</td>
</tr>
<tr>
<td>Pocket mask</td>
<td>1</td>
</tr>
<tr>
<td>Pencils</td>
<td>2</td>
</tr>
<tr>
<td>Pens</td>
<td>2</td>
</tr>
<tr>
<td>Nasopharyngeal Airway set</td>
<td>1</td>
</tr>
<tr>
<td>Ace Bandages</td>
<td>2 each (2, 4, 6)</td>
</tr>
<tr>
<td>Flashlight</td>
<td>1</td>
</tr>
<tr>
<td>Sterile 2x2</td>
<td>10</td>
</tr>
<tr>
<td>Sterile 4x4</td>
<td>10</td>
</tr>
<tr>
<td>Sterile eyepads</td>
<td>5</td>
</tr>
<tr>
<td>Non-adherent Dressing</td>
<td>5</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>1</td>
</tr>
<tr>
<td>BP Cuff</td>
<td>1</td>
</tr>
<tr>
<td>O2 Tubing</td>
<td>1</td>
</tr>
<tr>
<td>O2 Mask</td>
<td>1</td>
</tr>
<tr>
<td>Nasal Canula</td>
<td>2</td>
</tr>
<tr>
<td>IV Start Kit</td>
<td>2</td>
</tr>
<tr>
<td>IV Bag (0.9% NS)</td>
<td>1</td>
</tr>
<tr>
<td>IV Tubing</td>
<td>2</td>
</tr>
<tr>
<td>IV Catheter</td>
<td>2 each (16, 18, 20, 22g)</td>
</tr>
<tr>
<td>Surgilube</td>
<td>1</td>
</tr>
</tbody>
</table>
Figure A5.1. JBSA Lackland Activation of the Code Team.

Activation of the Code Team

- Call 9-1-1*
- Dial 292-9462 from any phone to make overhead announcement

*Must be from a land-line, otherwise call will get routed to the city.

- Medical Response Center (MRC) 292-1800
- Medical Control Center (MCC/HARPS) 292-5990
- Emergency Medical Services (EMS)

- Activate web-based code blue pager system (TEXT PAGE)
- Facility wide announcement overhead

Attachment 5

JBSA LACKLAND ACTIVATION OF THE CODE TEAM
Table A6.1. List of Code Cart Locations.

<table>
<thead>
<tr>
<th>FLOOR</th>
<th>RM</th>
<th>Location</th>
<th># Adult Carts</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>B175</td>
<td>CT SCAN</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>UCC</td>
<td>UCC</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>BF20</td>
<td>Cardio Rehab</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>1G02</td>
<td>Allergy/Immunization</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>1B35</td>
<td>Oral Surgery</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>1N46</td>
<td>Interventional Radiology</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2D17</td>
<td>PACU</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2M16</td>
<td>OR Area</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3A31, 3A33 &amp; 3A47</td>
<td>Cardiology Clinic</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>6A55</td>
<td>Pulmonary Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Off Site</td>
<td>Rm 21</td>
<td>P Graduate Dental Clinic</td>
<td>2</td>
</tr>
<tr>
<td>Off Site</td>
<td>A213 A113</td>
<td>DUNN DENTAL</td>
<td>2</td>
</tr>
</tbody>
</table>

In addition to the Code team Go-Bags, the following locations have Go-Bags for immediate urgent response: EMS (5), Reid PIT (x1), Flight Medicine for IFE (x5)

Note: Please note there are no code carts on the 4th, 5th, 7th, 8th or 9th floors. If a code occurs on the 4th floor, an ACLS cart from the cardiology clinic should be obtained. If a code occurs on the 5th, 7th, 8th or 9th floors the ACLS cart from pulmonary should be obtained.
Attachment 7

**JBSA LACKLAND CONTENTS OF ANESTHESIA GO BAG**

Table A7.1. JBSA Lackland Contents of Anesthesia Go Bag.

<table>
<thead>
<tr>
<th></th>
<th>ADULT</th>
<th></th>
<th>PEDIATRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ET Tubes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.5</td>
<td>LMA</td>
<td></td>
<td>3.5</td>
</tr>
<tr>
<td>7.0 (X2)</td>
<td>Air Q3.5</td>
<td></td>
<td>4.0</td>
</tr>
<tr>
<td>7.5 (X2)</td>
<td>4.5</td>
<td></td>
<td>4.5</td>
</tr>
<tr>
<td>8.0</td>
<td></td>
<td></td>
<td>5.0</td>
</tr>
<tr>
<td><strong>STABILIZER BAR</strong></td>
<td></td>
<td></td>
<td>5.5</td>
</tr>
<tr>
<td><strong>FIBEROPTIC HANDLE AND BLADES</strong></td>
<td></td>
<td></td>
<td><strong>STYLET</strong></td>
</tr>
<tr>
<td><strong>ESCHMAN</strong></td>
<td></td>
<td></td>
<td><strong>ANGIOCATH</strong></td>
</tr>
<tr>
<td>30 CC SYRINGES</td>
<td>10 CC SYRINGES</td>
<td></td>
<td>22G</td>
</tr>
<tr>
<td>5 CC SYRINGES</td>
<td>3 CC SYRINGES</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IV START KITS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18G ANGIOCATHS</td>
<td>20G ANGIOCATHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Airways</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal Airways</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26F</td>
<td>32F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28F</td>
<td>34F NASAL AIRWAYS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SALINE FLUSHES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ET Tubes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.0 CUFFED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STYLET</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24G</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ORAL AIRWAYS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NASAL AIRWAYS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20F</td>
<td>22F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FIBEROPTIC BLADES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MCGRATH Video laryngoscope</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table A8.1. Contents of Pharmacy Go Bag.

<table>
<thead>
<tr>
<th>Medication/Supply</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenosine 6mg/2ml Ansyr syringe</td>
<td>3</td>
</tr>
<tr>
<td>Amiodarone (50mg/ml) 3ml vial</td>
<td>3</td>
</tr>
<tr>
<td>Atropine 1mg (0.1mg/ml) LifeShield 10ml syringe</td>
<td>2</td>
</tr>
<tr>
<td>Calcium Chloride 10% LifeShield 10ml syringe</td>
<td>1</td>
</tr>
<tr>
<td>Dextrose 50% (0.5g/ml) LifeShield 50ml syringe</td>
<td>1</td>
</tr>
<tr>
<td>Diazepam 5mg/ml 2ml carpoject</td>
<td>1</td>
</tr>
<tr>
<td>Epinephrine 1mg (0.1mg/ml) LifeShield 10ml syringe</td>
<td>2</td>
</tr>
<tr>
<td>Etomidate 40mg/20ml</td>
<td>1</td>
</tr>
<tr>
<td>Flumazenil 0.5mg/5ml (0.1mg/ml) vial</td>
<td>2</td>
</tr>
<tr>
<td>Lidocaine 2% (20mg/ml) Ansyr syringe</td>
<td>2</td>
</tr>
<tr>
<td>Magnesium Sulfate 50% (1gm/2ml) vial</td>
<td>2</td>
</tr>
<tr>
<td>Naloxone 1mg/ml Luer-jet syringe</td>
<td>1</td>
</tr>
<tr>
<td>Needle Hypodermic Safety Glide 18 X 1.5 gage</td>
<td>4</td>
</tr>
<tr>
<td>Sodium Bicarbonate 8.4% (1 mEq/ml) LifeShield syringe</td>
<td>1</td>
</tr>
<tr>
<td>Sodium Chloride 0.9% 10ml syringe</td>
<td>4</td>
</tr>
<tr>
<td>Syringe HYPO 10ml Luer Lock w/o needle</td>
<td>3</td>
</tr>
<tr>
<td>Vasopressin 20 units/ml vial</td>
<td>2</td>
</tr>
<tr>
<td>Vecuronium 10mg vial</td>
<td>1</td>
</tr>
</tbody>
</table>
Attachment 9

**JBSA LACKLAND CONTENTS OF 4H GO BAG**

Table A9.1. JBSA Lackland Contents of 4H Go Bag.

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portable Oxygen Tank (1500 psi)</td>
<td>1</td>
</tr>
<tr>
<td>Portable Suction Unit</td>
<td>1</td>
</tr>
<tr>
<td>Portable Pulse Ox</td>
<td>1</td>
</tr>
<tr>
<td>Suction Tubing</td>
<td>1</td>
</tr>
<tr>
<td>Yankauers</td>
<td>2</td>
</tr>
<tr>
<td>Adult/Pedi Non-rebreather Masks</td>
<td>4</td>
</tr>
<tr>
<td>Adult/Pedi Nasal Cannulas</td>
<td>4</td>
</tr>
<tr>
<td>Nebulizers</td>
<td>4</td>
</tr>
<tr>
<td>Albuterol</td>
<td>5</td>
</tr>
<tr>
<td>Footballs</td>
<td>5</td>
</tr>
<tr>
<td>Christmas Trees</td>
<td>5</td>
</tr>
<tr>
<td>O2 Extension Tubing</td>
<td>4</td>
</tr>
<tr>
<td>Gloves L</td>
<td>5</td>
</tr>
<tr>
<td>2” Tape</td>
<td>2</td>
</tr>
<tr>
<td>Trauma Shears</td>
<td>2</td>
</tr>
<tr>
<td>Disposable Pulse Ox</td>
<td>4</td>
</tr>
<tr>
<td>Manual BP Bag</td>
<td>1</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>2</td>
</tr>
<tr>
<td>Transfer Checklist</td>
<td>5</td>
</tr>
<tr>
<td>Documentation Forms</td>
<td>5</td>
</tr>
<tr>
<td>ACLS Algorithm</td>
<td>2</td>
</tr>
<tr>
<td>Pocket Mask</td>
<td>2</td>
</tr>
<tr>
<td>Pen Light</td>
<td>2</td>
</tr>
<tr>
<td>Adult/Child/Infant BVM</td>
<td>1</td>
</tr>
</tbody>
</table>
Attachment 10

JBSA LACKLAND CONTENTS OF LABORATORY GO BAG

Table A10.1. Contents of Laboratory Go Bag.

<table>
<thead>
<tr>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccutainer tubes (Blue, Pink, Purple, Green, Red, and Yellow)</td>
</tr>
<tr>
<td>Tourniquet</td>
</tr>
<tr>
<td>Tape</td>
</tr>
<tr>
<td>Coban</td>
</tr>
<tr>
<td>10 mL syringes</td>
</tr>
<tr>
<td>5 mL syringes</td>
</tr>
<tr>
<td>Butterfly needles, 23g</td>
</tr>
<tr>
<td>Newborn Sampling Incision Device</td>
</tr>
<tr>
<td>Alcohol Prep Pads</td>
</tr>
<tr>
<td>Gauze</td>
</tr>
<tr>
<td>Vaccutainer Hubs</td>
</tr>
<tr>
<td>21 g Needles</td>
</tr>
<tr>
<td>Fingerstick tubes-gold and purple</td>
</tr>
<tr>
<td>59 MDW Form 120, Standard Lab Request</td>
</tr>
<tr>
<td>iSTAT instrument</td>
</tr>
<tr>
<td>E-G7 Blood gas cartridges</td>
</tr>
<tr>
<td>iSTAT Printer (plugged in)</td>
</tr>
<tr>
<td>Five sets of gloves</td>
</tr>
<tr>
<td>Small Sharps container</td>
</tr>
<tr>
<td>Transfer Checklists</td>
</tr>
<tr>
<td>Documentation Forms</td>
</tr>
<tr>
<td>ACLS Algorithm Cards</td>
</tr>
</tbody>
</table>
Attachment 11

CRASH CART CONFIGURATION CHART: FRONT/BACK

Figure A11.1. Crash Cart Configuration Chart: Front/Back

[Diagram of crash cart configuration with labels for each item]
Attachment 12

MEDICATION DRAWER CONTENTS

Figure A12.1. Medication Drawer Contents.
Attachment 13

JBSA LACKLAND WHASC AUTOMATED EXTERNAL DEFIBRILLATOR (AED)
SUPPLY PACK

A13.1. The following items will be included with each AED:
   A13.1.1. One adult and one pediatric set of defibrillator pads.
   A13.1.2. One adult pocket mask with a one-way valve.
   A13.1.3. One disposable safety razor.
   A13.1.4. Two pairs of non-latex gloves.
   A13.1.5. One red biohazard plastic bag.

A13.2. Any items with expiration dates must be within their dates. Replace any expired items immediately.