Clinical Reflection #2

Reflecting on my first code blue brings back a flood of emotions and valuable lessons learned in real time. I remember that day clearly. One of our first patients was a diabetic who had undergone a below-knee amputation and was struggling with respiratory issues. He was in our care from the start of the shift. He had been triaged to B pod, and despite testing positive for Flu A, he was waiting for a bed upstairs for further observation. Throughout the day, I noticed his oxygen levels would occasionally dip into the 70s before correcting itself. At the time, both the nurse and I chalked it up to sensor issues, possibly influenced by his position during sleep.

There were moments that felt off. I recall him waking from a deep sleep and softly saying, “help me!” Although his wife tried to reassure him, that moment still sent a shiver down my spine. Later, when he asked for help to sit up because he felt he couldn’t breathe comfortably, the nurse and I didn’t initially suspect anything more than his usual discomfort. Yet, just minutes before the code, he repeated that same request to the oncoming nurse.

I was nearby, assisting another nurse with a Foley insertion, when I suddenly heard the commotion, the nurse’s urgent call for help and the unmistakable sound of the code blue siren. I was told by the nurse to go help. Despite feeling nervous about jumping in, I took the initiative to help with chest compressions during the resuscitation. The atmosphere was intense; everyone was focused and working in perfect synchrony. In those moments, the importance of teamwork, clear communication, and relying on each other’s strengths became incredibly apparent to me.

After about ten minutes, when the patient regained a pulse and we began preparing him for transfer to the ICU, I couldn’t shake the feeling that there had been warning signs earlier in the day. Later that night, I looked into the fluctuating oxygen levels and our observations, and it made me wonder if the patient might have been experiencing a pulmonary embolism—a thought that I overheard the team mentioning that was their suspicion as well.

This experience has deeply influenced my perspective on patient care. It highlighted to me the importance of not dismissing early, subtle cues, and highlighted the critical nature of every team member’s role during a code. I’m grateful for the opportunity to have been a part of such a well-coordinated effort, and I carry the lessons from that day with me as I continue to grow in my clinical practice.