

# Documentation

## Code Medication Documentation

1. A Code Blue sheet will be scanned to the Pharmacy.
2. Pharmacy will enter the med orders.
3. The RN documents the medications on the eMAR choosing Non-Admin and selecting Other – See Code Blue Sheet.
4. Then, the RN records on the **Shift Event Report** intervention in the Code section that the Code meds were documented on the eMAR.

Code	
Code Date	<input type="text"/>
Code Time	<input type="text"/>
Code Type	<input type="checkbox"/> Cardiac <input type="checkbox"/> Respiratory <input type="checkbox"/> STEMI <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Stroke <input type="checkbox"/> Unresponsive/Unknown
Code Meds Doc on eMAR	<input type="radio"/> Yes <input type="radio"/> No
Shift Event Comments	
Shift Event Comments	<input type="text"/>

Use this query to confirm the RN documented the Code med administrations on the eMAR