SWEDISH MEDICAL CENTER

NURSING DOCUMENTATION

Clinical Policy and Procedure	
Approved: October 2015	**Next Review:** October 2018
Clinical Area: Inpatient units	
Population Covered: All bedded inpatients	
Campus: Ballard, Cherry Hill, Edmonds, First Hill, Issaquah	**Implementation Date:** July 2010

Related Policies, Procedures, and Job Aids:

Advance Directives and CPR Preference
Fall Prevention
Fall Prevention and Safety: Pediatric
Nursing Documentation in the Emergency Department
Pain Management
Pain Management: Neonatal
Patient Rights
Skin Care: Pressure Ulcer Prevention and Management

Purpose

To outline the minimum documentation requirements for registered nurses (RN) caring for inpatients.

Policy Statement

RNs complete documentation on each patient as outlined in this procedure. Based on the patient's condition, situation, and complexity, clinical judgment and critical thinking are employed to determine the need for additional data collection and/or more frequent monitoring and documentation.

Assessments and interventions are completed before documentation. Swedish Medical Center accepts RN use of "Time Note Filed" functionality in Epic to reflect actual assessment time(s) if/when necessary.

LIP Order Requirement

None.

Responsible Persons

Registered nurse (RN).

Prerequisite Information

None.

PROCEDURE

Responsible Person	Steps
RN	**STANDARD ADMISSION DOCUMENTATION** **Must be entered in the chart within 12 hours of admission:** • Physical assessment, using appropriate vital signs flowsheet(s) and assessment flowsheet(s) ▪ Allergies ▪ Height, weight ▪ Prior to admission (PTA) medications. • Skin assessment, using Skin Risk Screening Tool, and assessment on flowsheet in the Skin/Wound Group • Fall assessment, using Fall Risk Screening Tool on appropriate flowsheet • Family/Patient representative notification of inpatient admission
RN	**Must be entered in the chart within 24 hours of admission:** • Admission screen, using Admission Navigator or admission screen flowsheet. • Learning assessment in Patient Education Activity, including ability and readiness to learn, and addition of appropriate topics. • Plan of care, including goals and interventions, based on assessment. • Admission note as a summary of patient's admission status.
RN	**Document at least once per shift, including but not limited to:** • Physical assessment and reassessment based on patient's condition. **NOTE:** May use "within defined limits" in those groups marked "WDL." If patient assessment findings are not within defined limits, the nurse documents the part of the assessment that is not within defined limits. ▪ Vital signs and monitored parameters ▪ Pain assessment ▪ Assessment of pertinent systems' status ▪ Skin status ▪ Fall risk status ▪ Psychological or psychosocial status • Nursing care and responses to interventions, as applicable: ▪ Wounds, dressings ▪ Lines, drains, airways (LDA) ▪ Pain management ▪ Medications ▪ Intake & output (I&O) ▪ Interventions ▪ Activity, mobility ▪ Skin care ▪ Hygiene and personal care

	• Patient education
	  ▪ Topics as appropriate, in Patient Education Activity
	  ▪ Patient and/or family/caregiver, as appropriate
	• Plan of care
	  ▪ Document plan of care "review" once per shift by noting any progress toward goals.
	  ▪ Update goals, progress, and interventions as appropriate every 24 hours.
	• Nursing progress note, using "Progress Note" template.
	• Event note, if appropriate, using "NSG Unexpected Event Note" template to describe any unexpected or unplanned event and /or a serious change in patient's condition.

RN	**Required discharge documentation:** • Discontinue LDA as appropriate. • Resolve or complete Patient Education Teaching Points. • Document educational handouts provided to patient/family, including medication list and educational materials. Confirm patient/family/caregiver understanding in the After Visit Summary. • Resolve or complete Plan of Care. • Discharge Note

Definitions

None.

Forms

Electronic Medical Record Forms/Flowsheets:

- Admission Navigator or Admission Flowsheet
- Flowsheets (various, department dependent)
- Nursing Care Flowsheet (various, department dependent)
- Plan of Care
- Patient Education Activity
- RN Discharge Navigator
- Progress Note
- NSG Unexpected Event Note
- After Visit Summary

Supplemental Information

Documentation facilitates communication among health care team members, promotes continuity of care, and serves as the legal record of care provided.

Documentation includes information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patient's outcomes and of responses to nursing care.

The patient's record reflects assessments performed by the nurse. The documented assessment forms a baseline for developing nursing diagnoses and planning patient care. The record reflects the plan of care, which is an ongoing process beginning when the nurse identifies the patient's nursing problem list and the nursing interventions that will address the patient's problems.

Documenting nursing interventions promotes continuity of patient care and improves communication. The patient's record specifies what nursing interventions were performed by whom, when, and where and patient's response to interventions.

Regulatory Requirement

CMS. 482.13 – Patient Rights; 482.23 – Nursing Services; 482.24 – Medical Record Services; 482.43 – Discharge Planning.

DNV. NS.3 – Nursing Services; Patient Rights; MR.7 – Medical Records Service; DC.1 – Discharge Planning.

DOH. WAC 246-320-141 – Patient Rights and Organizational Ethics; WAC 246-320-166 – Management of Information; WAC 246-320-226 – Patient Care Services.

The Joint Commission. PC 01.02.01; PC 01.02.03; PC 01.03.01; PC 02.01.01; PC.02.01.21; RC 01.01.01; RC 02.01.01; RI.01.01.03.

References

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

STAKEHOLDERS

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