Purpose: To establish standards for nursing/interdisciplinary documentation of patient care in the patient's medical record in accordance with regulatory, accreditation, and Department of Health Services policies and standards.

To ensure that all pertinent information gathered and care delivered are documented in the patient's medical record in order to facilitate interdisciplinary communication and continuity of care.

Performed By:

1. RNs, LVNs, NAs, RAs, SNWs
2. Affiliating nursing students under the direction of an RN
3. Interdisciplinary team members

I. Policy Statements:

A. Nursing/interdisciplinary documentation reflects the delivery of patient care, the patient's status upon admission, progress through the hospitalization or course of treatment, transfer, and discharge. It shall include an initial assessment, diagnosis, interdisciplinary plan of care (IPOC), evaluation of the patient's responses to treatment, and progress toward established goals.

B. Patient goals will be collaborative, realistic, and measurable and are discussed with patient and family.

C. The RN will assess the patient upon admission, identify problems, and initiate appropriate IPOCs.

D. At a minimum, each patient is assessed and reassessed at regularly specified times related to the patient's course of treatment (refer to Attachment 1 for specifics).

E. RNs/LVNs and interdisciplinary team members will collaborate on the development of individualized care plans.

F. RNs/LVNs participate in the implementation of IPOCs, documentation of interventions and treatments, and care provided to the patient.

G. NAs, RAs, and SNWs participate in the implementation of the IPOCs as directed by the RN/LVN within their scope of practice.

H. RNs/LVNs shall document changes in the patient's condition in the medical record. In-depth narrative documentation is done under "Notes".

I. During the discharge and/or transfer planning process, the patient is notified of the reason for the discharge/transfer.

II. Policy Guidelines:

A. Documentation of Nursing Admission History/Physical Assessment

1. The nursing Physical Assessment is completed by an RN within four (4) hours of admission to an inpatient unit. Exception – Patients admitted to ICU will be assessed within one (1) hour.

2. The Nursing Admission History is completed by an RN within eight (8) hours of admission to an inpatient unit.

3. All sections of the Nursing Admission History/Physical Assessment will be completed for each patient with input from the patient, significant others, transferring facility, and/or previous medical records as appropriate.

4. As part of the assessment process, the patient and/or family are oriented to the immediate environment, equipment, unit rules, and patient's rights and responsibilities.

5. The Basic Admission Information section can be completed by licensed or unlicensed nursing staff.

6. Appropriate IPOCs will be initiated by an RN based on assessment findings.

7. Additional documentation during an admission includes but is not limited to:
    a. Morse Fall Scale or Humpty Dumpty Scale - Refer to DHS policy 311.101 : DHS System-wide Fall Prevention Program
    b. Braden Scale and four eyes skin check – Refer to DHS policy 321.007: DHS pressure injury prevention & wound management policy
    c. Immunization screen
    d. Suicide risk screen
    e. Patient education- Refer to nursing policy C206

B. Patient Daily Care Activities

1. Document daily patient care activities and provider notification in the medical record.

2. RNs/LVNs can delegate the responsibility for documenting in the "Daily Activities" to unlicensed staff.

Key Point: RNs and LVNs must review all documentation by the end of every shift for accuracy.

3. Orders are to be reviewed by an RN/LVN upon receipt of patient at change of shift and as prompted by medical record system.

4. New orders received during the shift will be marked as reviewed by an RN/LVN as prompted by the medical record system.

5. Some scheduled and recent orders will be tasked by the system. Tasked items will be opened, implemented, and documented in a timely manner.

C. Interdisciplinary Plan of Care (IPOC)

1. Admission/Transfers
    a. IPOCs will be initiated within eight (8) hours of admission.
    b. Upon transfer, the receiving nurse will review/update the IPOCs within eight (8) hours.

2. An IPOC may be initiated or discontinued anytime during hospitalization by an RN. An LVN may modify, resolve, or discontinue an IPOC as needed.

3. IPOC Documentation

    a. IPOCs will be reviewed and revised every shift as needed based on ongoing assessments and changes in patient condition.

    b. An IPOC is kept current based on the changing needs of the patient and patient's response to interventions.

    c. Postoperatively, the RN/LVN will review the IPOC and revise as necessary.

    d. Interdisciplinary team members will collaborate in updating the IPOC during team conferences.

    e. Problems are identified based on patient assessment.
        1) Contributing factors related to the problems are identified.

    f. Interventions
        1) Selected based on problem identified

2) All interventions that assist the patient in achieving the expected goal(s) are selected, reviewed, and signed.

g. Expected Goals
   1) Appropriate goals related to the problems are identified
   2) Goals are discussed with patient/family

h. Outcome Status
   1) The expected goals that were achieved, improved, or unchanged are documented under "outcomes" when discharging a patient or when discontinuing IPOC. This will be done for all IPOCs that were initiated.

Key Point: This does not to replace the discharge summary.

D. Narrative Documentation

1. Change in patient condition:
   a. Whenever a change in patient condition occurs, a narrative note is entered in the "Notes" indicating assessment, intervention, and evaluation.

2. Admission note:
   a. An admission note is only required when unable to complete the Nursing Admission History/Physical Assessment before the end of the shift on which the patient was admitted. A narrative note briefly describing the general condition of the patient is documented.

3. Transfer Documentation:
   a. A Transfer Summary is documented whenever a patient is transferred from one inpatient unit to another of the same DRG designation.
   b. A telephone or verbal report of patient's condition is provided via the SBAR form and by opening the SBAR section of the medical record and relaying pertinent information to the receiving licensed personnel.

Key Point: If the patient is transferred to a different DRG designation, the patient is discharged and readmitted. A discharge summary is documented.

   c. A Nursing Transfer Summary is documented in the "Notes" by the RN/LVN responsible for the patient during the actual transfer.

Key Point: If the patient is transferred to a higher level of care, the RN is to document the transfer note.

   d. A Nursing Transfer Summary will include:
      1) The reason for transfer
      2) The patient's present condition and brief history
      3) Any interventions completed or pending in relation to the reason for the transfer

4. Discharge Documentation:

   a. Discharge Summary:
      1) A nursing discharge summary is documented by the RN responsible on the day of discharge.

   b. Discharge Note:
      1) On the day of discharge, the RN/LVN will document a short discharge note in the "Notes" section to include the following:
         a) Date and time of discharge
         b) Destination
         c) Accompanied by whom
         d) Patient's general condition at the time of discharge

Key Point: Discharge Note can be waived if information is included in the discharge summary.

5. Leave of Absence (LOA)

    a. The RN/LVN will document a note to include:
        1) The reason for the LOA
        2) The patient's present condition and a brief history
        3) Any interventions completed or pending in relation to the LOA

E. Documentation of Ongoing Assessments

1. The RN and LVN are responsible for entering and validating nursing documentation in the medical record for their assigned patients.
2. Ongoing assessments will be completed and documented by an RN/LVN within four (4) hours from the start of every shift. The LVN will notify the RN of any pertinent findings. (Refer to table 2 for four (4) floating).
3. The RN covering the patients of the LVNs will go to the medical record and mark as reviewed after the LVN's documentation. If the RN identifies any discrepancies, the RN will document his/her own findings.
4. RNs will do a comprehensive assessment after patient's health condition changes (e.g., post-fall, post-seizure, sepsis).
5. Frequency of reassessments with changes/no changes are documented per unit's scope of care and based on patient condition..
6. The student nurse's documentation must be co-signed by the nursing instructor or supervising RN.

F. Post-Operative Documentation

1. Immediately upon receiving patients from the post-anesthesia recovery unit (PAR), the RN will obtain a post-operative report from the PAR nurse ***at the bedside***.

2. Only RNs may document post-operative assessments during the first 48 hours of the post-operative period.
    a. Portions of the data collection, e.g., vital signs, may be delegated to a LVN or NA.

3. Post-operative assessments will be completed:
    a. Initially, upon receipt of the patient from PAR

    b. For 72 hours after the initial post-operative assessment:
        1) Minimally, every two (2) hours x 24 hours, then every four (4) hours x 24hrs, then every eight (8) hours x 24 hours.

Key Point: This timeline may be extended if the patient's condition warrants (e.g., post-operative complications occurred requiring further monitoring, surgical procedures with a high risk for life-threatening complications extending beyond the 72-hour period).

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References:

Burke, K., & LeMone, P. (2019). Medical Surgical Nursing: Critical Reasoning in Patient Care. (7th Ed.) Upper Saddle River, New Jersey: Pearson Education.

BVNPT. (2022). *Vocational Nursing Practice Act with Rules and Regulations.* Sacramento, CA: Board of Vocational Nursing and Psychiatric Technicians.

Hankey, L. (2023). Proper documentation protects patients and your license. *American Nurse Journal*, *18*(8), 28–31. https://doi.org/10.51256/anj082328

The Joint Commission (2024). *Comprehensive Accreditation Manual for Hospitals*. PC.01.02.01, PC.01.02.03, PC.01.02.05, PC.01.02.07, RC.01.03.01.

Wong, C. (2023, June 22). *Understanding the 5 legal requirements for nursing documentation*. Experience Care: Long-Term Care EHR & Financial Software Solutions. https://experience.care/blog/5-legal-requirements-for-nursing-documentation/

07/2013 – New (Supersedes C134, C202, and C208 now archived).
09/2016 – Revised
01/2018 – Revised
03/2021 – Revised
08/2023 – Revised
01/2024 - Revised

Attachment 1 – Assessment Guidelines

Assessment Guidelines

Table 1 – Assessment/Reassessment Frequency Parameters (These assessments must be done at a minimum as described below)					
Parameters	ICU	PCU	Medical/Surgical	Pediatrics	Rehabilitation
Vital Signs	Q2h	Q4h	Q4h	Q8h	Q8h
Assessment	Q2h	Q8h	Q8h	Q8h	Q8h
IV site with Continuous infusion	Q2h	Q2h	Q2h	Q2h	Q2h
IV saline lock site	Q8h	Q8h	Q8h	Q8h	Q8h
Tubes/catheters	Q2h	Q8h	Q8h	Q8h	Q8h
Level of Activity	Q8h	Q8h	Q8h	Q8h	Q8h
Position	Q2h	Q2h	Q2h	Q2h	Q2h
Pain and response to meds	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

Table 2 – Head to Toe Assessment Times		
12- hour shift	Assessment	Reassessment
0700-1900	0700-1100	1500-1700
1900-0700	1900-2300	0300-0500
8 – hour shift	**Assessment**	
0700-1530	0700-1100	
1500-2330	1500-1900	
2300-0700	2300-0300	
4 – hour assignment	**Assessment**	
0700-1100 / 1900-2300	0700-1100 & 1900-2300	
1100-1500 / 2300-0300	Focused assessment as determined by RN based on clinical condition. Document narrative note with findings in the progress notes section titled “Focused Assessment”.	
1500-1900 / 0300-0700		

These times do not apply to the ICU. Assessments in this area must be done every two hours.
Every attempt will be made to document in real time but should not exceed 4 hours unless otherwise specified.

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