LAC+USC MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

Subject: **INPATIENT DOCUMENTATION GUIDELINES**	Original Issue Date : 8/91	Policy # **400**
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Departments Consulted:	Reviewed & Approved by:	Approved by:
	Professional Practice Committee Nurse Executive Committee Attending Staff Association Executive Committee	(signature on file) Nancy Blake Chief Nursing Officer

PURPOSE

To establish guidelines for nursing documentation in the inpatient care units in accordance with regulatory, accreditation, Medical Center and Department of Health Services Policies.

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

POLICY

Nursing documentation reflects the delivery of professional care, nursing process, and the status of the patient upon admission, progress through the hospitalization or course of treatment, transfers, and discharge. It shall include an initial assessment of the patient's complaints, a plan of care as supported by the diagnosis, interventions provided, an evaluation of the patient's responses to treatment, and progress toward desired outcomes.

PROCEDURE

Documentation Standards

Admission Forms

Upon admission the following documentation need to be initiated:

- Basic Admission
- Admission History
- Immunization Screen (e.g. Influenza, Pneumococcal and COVID-19 vaccine screen)
- Baseline Head to Toe Assessment must be initiated:
    - Acute care unit-within 4 hours of admission
    - ICU – within 1 hour of admission
    - Pediatric unit – within 1 hour of admission
- Interdisciplinary Plan of Care

Focus should be on obtaining detailed information on identified health problems that may require nursing interventions. Educational needs and discharge planning should be identified to help promote early discharge.

Basic Admission Information

The Basic Admission information form shall be completed by nursing staff within the first hour of admission.

- Ask the patient if he/she wants family notified of admission, the nurse must document the following:
  - Whether patient requests notification or declines
  - Notification method
  - If the patient is incapacitated, documentation must include what steps were taken to identify and provide notice to family member / representative.
  - If patient declines to have family notified of admission or designate a caregiver

Admission History Assessment and Discharge Planning

- The Admission History form shall be completed by the Registered Nurse. The LVN can assist in collecting data.

- The Admission History documentation shall be initiated within:

  - 4 hours of admission to an acute care unit
  - 1 hour of admission to a critical care unit 1 hour of admission to a pediatric unit

- Every attempt shall be made to complete all required sections of the admission history documentation. Additional history information may be added at any time. If unable to fully complete the Admission History, a reason must be stated in the documentation. Every attempt should be made to complete the Admission history documentation on ICU patients prior to being transferred to an acute care unit.

Baseline/Initial Head to Toe Assessment

The head to toe assessment on admission will be used as a baseline to plan patient care and track the progress of meeting the plans goals.

Any finding that indicates a problem exists must be included in the interdisciplinary plan of care (IPOC) and added as a problem in the *Admission History* under *Problem History section.*

The RN shall complete an examination of patient's body systems upon admission. Findings from physical examination shall be documented as follows:

- Check pertinent abnormal findings based on examination of patient
- Review abnormal findings and perform a focused assessment as needed to identify priority problem.
- Identify the patient's referral needs. The RN shall notify other disciplines regarding patient referrals.
- Complete the Falls Risk Scale (utilize appropriate tool for pediatrics) and implement care as outlined in the– Fall Prevention Nursing Policy #802

- Complete Skin Risk Assessment, a score of 16 or below on the Braden Scale and refer to the Pressure Injury Prevention and Management Nursing Clinical Standard.

- Complete a Suicide Risk Screen:
  - On all patients upon admission, for all patients on psychiatric legal holds, for all patients with chief complaint of emotional or behavioral disorder, when there is a change in risk for suicide, for example, change in status or change in diagnosis. Prior to discharge if previously identified as being at risk for suicide during current hospitalization.
  - If the patient answers "yes" to the suicide risk screen questions, then the RN will complete a detailed nursing suicide risk assessment, notify the provider and refer to the Suicidal Patient Nursing Clinical standard.

Interdisciplinary Plan of Care (IPOC)

RN responsibilities of IPOC

- The RN or other professional healthcare team member may initiate the IPOC. The care plan is individualized by the patient's diagnosis, needs, interventions, and desired outcomes.

- The RN reviews and documents in the IPOC at the end of every shift:
  - Status of Outcomes including reasons and actions for any variance.
  - Interventions provided
  - Any other pertinent information

- The RN shall document the time limits for the goals.

- The RN shall document the outcome of the goal upon resolution or discharge of the patient.

LVN responsibilities of IPOC

- The LVN participates in the implementation of the IPOC by assisting in the interventions and treatments.
- The LVN may document interventions provided and any other pertinent information in the IPOC.
- The LVN **may not** document on Status of Outcomes.

Documentation RESPONSIBILITY

Documentation entered should be reviewed for accuracy prior to signing off.

Registered Nurse (RN)

The RN is responsible for documenting the care provided to patients in accordance to the nursing process. The RN documents but not limited to the following:

- Assessment findings on initial admission and ongoing assessments/reassessments of patients.
- Analyses and linkage of assessment findings with the IPOC.
- Analyses and follow-up of data collected by other personnel.
- Development of the IPOC in collaboration with the health team.
- Administration of medications, treatments and comprehensive nursing interventions
- Patient/family education provided according to patient/family needs and evaluation of responses to teaching.
- Referrals and Discharge Planning.
- Evaluation of the patient's condition, responses to desired outcomes and interventions in the IPOC.
- The Registered Nurse shall review abnormal findings (including data reported by the LVN and NA) and evaluate if intervention is required.

Licensed Vocational Nurse (LVN)
The LVN documents participation in patient care and implementation of assigned duties in accordance with the LVN scope of practice and job duties. The LVN contributes to the initial and ongoing assessments/reassessments of patients through data collection and documents the following:

- Collected subjective and objective data through patient interview.
- Observations regarding patient condition.
- Patient reactions to medications and treatments as observed and verbalized by patient.
- Any abnormal findings will be reported to the RN.

The LVN participates in the implementation of the IPOC and documents:

- Administration of approved medications, treatments and nursing interventions
- Incidental Patient/family instructions and/or demonstration of nursing procedures

The Nursing Attendant (NA)
The Nursing Attendant (NA) documents performance of nursing procedures in accordance with job description. Nursing Attendant (NA) responsibilities can include but not limited to:

- Documenting (e.g. vital signs (the nursing attendant will document patient's stated pain score using Wong-Baker or numerical scale only) restraint monitoring, intake/output)
- Assisting in daily living activates (ADLs).
- Any abnormal findings will be reported to the RN.

Clerk
The Nursing Unit Clerk ensures the accuracy of printed (or labeled) identification on medical records, and enters discharge clinic appointments in accordance with job description.

BASELINE/INITIAL HEAD TO TOE ASSESSMENT

A baseline/initial head to toe assessment shall be completed:

- When accepting a new patient
- When a patient returns from the OR/procedural areas

Reassessments

Reassessments are completed as follows:

- Every 4 hours (except Perinatal)
- Perinatal every 8 hours
- To determine a patient's response to care
- With change in a patient's condition or diagnosis

Nursing Notes

- The RN/LVN shall document incidental events in the *Notes s*ection under the menu bar in the EHR.

End of Shift Summation (EOSS)

- The RN/LVN is required to document an End of Shift Summation.

Discharge Planning

- The RN shall be responsible for discharge planning of the patient. The LVN participates in the preparation of the patient for discharge including patient education and aggregation of patient's supply needs for post discharge care.

- The initial discharge planning section is initiated upon admission. The ongoing discharge planning is completed, as patient's discharge is determined. Discharge planning ends once patient's discharge readiness (section in inpatient discharge) is complete.

- The RN is responsible in completing the *Nursing Discharge Summary* prior to patient discharge.

Documentation General Rules for Non- Electronic Medical Records (includes Downtime forms)

- All patient record forms shall be labeled with patient name, Medical Record Number (MRN) number, Financial Identification Number (FIN), unit, and bed number.

- Entries must be legible and written with black ink and dated with month, date, year, and military time for each entry.

- Only approved abbreviations shall be used in documentation.

- Entries shall accurately reflect assessments, plan of care and interventions that were carried out for the patient. Document as soon as possible after completion of observations, assessments, tasks, services, or interventions and reflect the actual date/ time, the chronology of events and care provided.

- Late entries: (notes written out of the sequence with prior existing notes) are acceptable only if the information is designated as a "*Late Entry*." The note must identify the date and time it was actually written and "Late Entry" for date and time of task, service, or observation. No future charting is allowed.

- Errors shall be corrected by the individual who wrote or is writing the note by drawing a single line through the error such that it remains legible, dated, timed, and initialed. It shall be signed with first initial, last name and category (RN, LVN, NA) on all entries corrected. Entries must never be erased or obliterated.

- Individual nursing forms are completed in accordance with forms guidelines.

- Nursing documentation is completed on the appropriate forms.

REFERENCE

California Code of Regulations, Title 22, Sections 70749, 70223(f-h)
Joint Commission Standards (Management of Information)
LAC+USC Healthcare Medical Center #403
LAC+USC Healthcare Medical Center Policy #910

REVISION DATES

92, 93, 95, 96, 97, 05/98, 02/99, 12/01, 11/04, 07/05, 10/06, 11/07, 07/08, 01/14, 07/15, 03/18, 06/18, 10/21