LAC+USC MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

SUBJECT:	Original Issue Date:	Policy #
DOCUMENTATION - AMBULATORY CARE, EMERGENCY Department AND URGENT CARE AREAS	08/91	**402**
	Supersedes: 07/2019	Effective Date: 08/22

Departments Consulted:	Reviewed & Approved by:	Approved by:
Emergency Department/Urgent Care Ambulatory Care Clinic	Professional Practice Committee Nurse Executive Council Attending Staff Association Executive Committee	(signature on file) Nancy Blake Chief Nursing Officer

PURPOSE

To establish guidelines for nursing documentation in the Ambulatory Care, Emergency Department and Urgent Care on the patient's medical record in accordance with regulatory, accreditation, Medical Center and Department of Health Services policies.

To ensure that all pertinent information gathered and care delivered is documented in the patient's health/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 presentation to the ambulatory care clinic, emergency room area or urgent care area. It shall include information to identify the patient, purpose for the visit, when applicable design the plan of care as supported by the diagnosis, the utilization of appropriate interventions, and facilitates the communication of the continuity of care by the multidisciplinary team.

Documentation Standards:

Upon the entry/intake, evaluation or treatment to the Ambulatory Care clinic, Emergency Department (ED), Psychiatric Emergency, or /Urgent Care Center, documentation shall be initiated refer to **Addendum A: Documentation Guidelines**.

Complete a Suicide Risk Screen on the following patients:

- Patients being evaluated or treated for behavioral health condition in the Emergency/Urgent Care/Ambulatory Care areas.
- Patients who are admitted from Hawkins, Metro.
- Patient on a legal hold or verbalizes suicide ideation during the course of care.

Discharge of the Homeless Patient:

Upon discharge from the ED/Urgent Care, patients identified as homeless must have their post discharge needs and destination documented in the electronic health record (EHR).

Documentation Guidelines:

- Document in accordance with Documentation Standards.
- All nursing documentation is completed on the appropriate form or section in the EHR.
- Entries shall be documented as soon as possible after each task, service, or observation and reflect the actual time of the event and the chronology of events.

RESPONSIBILITY:

Registered Nurse (RN)

The RN is responsible for documenting the care provided to patients in accordance to the nursing process. The RN documents the following:

- Assessment findings on presentation to the ambulatory care clinic, emergency department, psychiatric emergency or urgent care area.
- Analyses of assessment findings and the development of an individualized plan of care.
- Administration of medications, treatments, and comprehensive nursing interventions.
- Patient/family education provided according to patient/family needs and evaluation of responses to teaching as applicable.
- Review and follow –up on abnormal findings reported by LVN, CMA, and NA's and document in the EHR.

Licensed Vocational Nurse (LVN)

The LVN contributes to the care provided to patients according to the plan of care through subjective and objective data collection. The LVN participates in the implementation of the patient plan of care and documents the following:

- Information collected through patient interview
- Observations regarding patient condition
- Data collected from techniques of physical examination
- Administration of approved medications, treatments and nursing interventions
- Patient reactions to medications and treatments as observed and verbalized by patient
- Patient/family instruction and education as applicable.
- Any abnormal findings will be reported to the RN

Certified Medical Assistant (CMA)

The Certified Medical Assistant documents basic medical information in accordance with job description/duty statements that include the following:

- Patient's medical history
- Vital signs (Pain score: Wong-Baker or numerical scale only), weight, and height
- Any abnormal findings will be reported to the RN

Nursing Attendant (NA)

The Nursing Attendant documents performance of nursing procedures in accordance with job description/duty statements. The NA will document the following:

- Vital signs (Pain score: Wong-Baker or numerical scale only)
- Height, weight and head circumference.
- Any abnormal findings will be reported to the RN.

Scheduling of appointments may be made by RN, LVN, CMA, NA, and Clinic Clerk in accordance with their job description.

All staff will ensure accuracy of imprinted identification on medical records when working with them.

DOCUMENTATION DURING DOWNTIME

During downtime the following forms will be utilized:

- The Ambulatory Care Nursing Record and/or Clinic Record
- The Emergency Department/Urgent Care Database and Flow Record
- Individual nursing forms are completed in accordance with form guidelines.
- Entries recorded on paper must be legible and written with black ink and dated with month, date, year, and military time for each entry.
- Entries shall be documented as soon as possible after each task, service, or observation and reflect the actual time of the event and the chronology of events.
- Errors made using paper documents 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, labeled "error", dated timed, and initialed.
- It shall be signed with first initial, last name and category (RN, LVN, NA, CMA) on all entries corrected.
- Entries must never be erased or obliterated

Subject: **DOCUMENTATION – AMBULATORY CARE, EMERGENCY ROOM AND/OR URGENT CARE AREAS**	Effective Date: 08/22	Policy # **402**
	Initials: (signature on file)	

REFERENCE

California Code of Regulations, Title 22, Section 70527d
The Joint Commission Standards (Management of Information)
The Joint Commission (2018). *National patient safety goal for suicide prevention*.
LAC+USC Medical Center Policy #403, #412
#402 Nursing Policy Addendum A: Documentation Guidelines Documentation Guidelines in the Ambulatory care, Emergency /Psychiatric Department and Urgent Care Areas

REVISION DATES

1992, 1993, 1994, 1995, 1996, 1997, 02/99, 12/01, 12/04, 07/05, 10/06, 11/09, 07/19, 08/22

LAC+USC MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

SUBJECT:	Original Issue Date:	Policy #
#402 Nursing Policy Addendum A: Documentation Guidelines in the Ambulatory Care, Emergency /Psychiatric Department and Urgent Care Areas	Supersedes:	**402** Effective Date: 08/2022

Documentation shall be initiated, but is not limited to the following forms in the electronic health record:

Ambulatory Care Clinic:

- Ambulatory intake
- Fall Risk
- Domestic Violence Prevention
- Initial Infectious Screen
- Interdisciplinary patient/family record

Emergency Department (ED), Psychiatric Emergency and Urgent Care Clinic:

- ED Triage/ Intake, or ED Trauma Triage forms
- ED Vital signs & Pain
- Psych ED Triage
- Fall Risk
- Suicide Pre-Screen
- Violence Prevention
- Initial Infectious Screen