Addendum 560-D: Surge Documentation (Program Flex) Guidelines

REQUEST FOR PROGRAM FLEX

For period 1/3/2021 to 3/31/2021

As part of an emergency response to COVID-19, LAC+USC Medical Center seeks a program flex to implement surge standards of nursing documentation, whereby nurses will document only the most critical information needed to provide an accurate picture of the patient condition, reflect the plan of care, and demonstrate the care provided. We request program flex for the following regulations:

Title 22, Section §70215, "Planning and Implementing Patient Care"

1. Ongoing patient assessments will continue to be performed as required by each unit's guidelines of care. However, documentation of these assessments will be made by exception. "By exception" means that a notation is made only when there is a deviation from baseline, deviation from normal limits, or an unexpected outcome.

2. Ongoing patient education will continue to be performed, as required by each unit's guidelines of care. Documentation in the medical record will be made by exception. However, discharge patient education will continue to be performed and documented for each patient as usual.

3. Documentation of formal nursing diagnosis and care plans in the medical record will be eliminated. This aligns with CMS's COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, which waives the requirements of 42 CFR §482.23(b)(4), which requires the nursing staff to develop and keep current a nursing care plan for each patient. Instead of having the nursing care plan noted in one designated section of the medical record, nursing staff will be allowed to document the elements of the care plan within the existing documentation throughout the medical record.

<u>Surge Documentation Guidelines</u>

1. Documentation of nursing care administered pursuant to each unit's guidelines of care will be restricted to the following:
   - Baseline assessment every shift (med-surg every 12 hours)
   - Patient reassessments by exception (ICU/PCU-every 4 hours)
     - May be done more frequently with more thorough assessment (e, g. neurology patient with intracranial pressure monitoring
   - Critical lab values/critical results not already documented
   - Vital signs
     - ICU/PCU- every 2 hours, with titration of drips, or significant change noted in patient condition
     - Med/Surg- every 4 hours or significant change in patient condition
   - Temperature- Every four hours and more frequently as needed

- Cardiac Rhythm, BP cuff location, FiO2, SpO2 location- St beginning of shift and with changes
- Pain assessment ICU/PCU-every 2 hours, Med/Surg- every 4 hours, after administration/ titration of analgesics
- Skin risk assessment- daily and prn
- Wound assessment- ICU/PCU-every 4 hours, Med/Surg- every 8 hours
- Fall risk assessment- daily and prn
- Ventilatory settings, artificial airway, respiratory modalities at beginning of shift and with changes
- Invasive IV lines and devices- At insertion and shift baseline. Ongoing assessment of invasive lines and devices will take place; documentation of care by exception
- Urine output
  - Every 2 hours in ICU, every 1 hour while on CRRT
  - Every 8 hours Med/Surg
- Administration of medications and treatments per policy
- Blood transfusions per policy
- Clinically relevant attending and consulting provider communication
- Restraint assessments and monitoring per policy
- End of shift summation including anything that, in the judgment of the nurse, would compromise patient safety if it were not documented
- Patient education at discharge. All other education will be done by exception (e.g. not provided)

2. Baseline System Assessment

More detailed assessment may be done for system based on diagnosis (e.g. more complete neuro assessment for neuro patients, for example GCS)		
System	Required Fields	If Applicable
Mental Status	• LOC • Orientation • Affect/behavior	• RASS (if on ventilator or receiving sedation)
Suicide Risk Assessment	• On admission and if issue arises during admission • If yes to having suicidal ideation, do full assessment and repeat Q 8 hours	
Neurological/ Pupils/ Neuromuscular Extremity/	• Pupils* • Extremity Strength* *(If stroke/neuro diagnosis- M/S)	

GCS		
Respiratory/ Artificial Airway/ Mechanical Ventilation/	• Respirations • Respiratory pattern • Breath sounds • Sputum, amount	
Cardiovascular/ Pulses/ Edema/ Neurovascular check/ Pacemaker	• Nail bed color (If respiratory or CV diagnosis- M/S) • Capillary refill- (If respiratory or CV diagnosis- M/S) • Pulses (peripheral only) • Edema	• Neurovascular checks • Pacemaker
Gastrointestinal	• Abdomen description • Abdomen palpation	• Emesis • Stool • GI tubes
Genitourinary	• Urinary elimination	• Urinary catheter
Integumentary/ Incision/Wound/ Skin Abnormality	• Four eyes check (admission only) • Skin color • Skin temperature • Skin integrity	• Incisions/ Wound/ Skin Abnormality
Tubes/ Drains	If applicable	
Braden	Yes	
Fall Risk Scale	Yes	

3. Admission Assessment
   Documented abbreviated history, including screening limited to situations that pose an immediate threat to the patient within 12 hours of admission
   - General Tab
     - Information related to family/patient representative
     - Ask patient what the reason is for coming to the hospital
   - Allergies- all sections
   - Transfusion history- Ask patient if blood transfusion is acceptable
   - Functional- Sensory deficits
   - Social History- tobacco, alcohol, substance abuse
   - Domestic violence screen- all sections
   - Nutritional Screening- all sections
   - Feeding history- all sections
   - Psychosocial stressors
     - Suicidal
     - Spiritual

- Initial infectious screening- If not done in ER
- Documentation that the patient is asked if a designated person (family member or representative) be notified of the patient's admission
- System assessment related to reason for admission
- Braden, Falls, and Pain assessments
- Home medications
- Weight, height
- Advance Directive

4. Other nursing care that is provided (including but not limited to activities of daily living, hygiene, routine catheter and ostomy care, repositioning, infection control practices, etc.), will continue to be performed as required by each unit's guidelines of care, but documentation will be done by exception (a note will be entered only if this not done)

Initial date approved: 1/6/2021	Reviewed and approved by: Professional Practice Committee Nurse Executive Committee Attending Staff Association Executive Committee	Revision Date: