# Nursing Documentation

## Inpatient EHR during
## COVID – 19 SURGE PLAN

4/24/2020

**GUIDELINE STATEMENT:** This document guides nursing documentation for inpatients and observation patients in anticipation of the emergent needs associated with the COVID-19 pandemic. **The Chief Nursing Officer (CNO) will designate when this policy is implemented for specific units**. The current nursing documentation policy(s) remains in effect until the CNO designates this policy effective to a specific unit. The policy will be implemented until the CNO renders it inactive on unit.

**BACKGROUND:** MedStar Health remains committed to maintaining appropriate numbers, types, and qualifications of staff to respond to the immediate needs and care of its patients. There may be, however, times of unusually high demand on nursing resources which require flexible medical record documentation to enable staff to prioritize direct patient care.

**PERSONNEL:** RN and nursing assistant/technician documentation for hospitalized inpatients.

**PROCEDURE:**

A. Appendix A outlines suggested documentation practices to be followed when the CNO has declared that a specific unit or area is operating on the Covid-19 Emergency Documentation Plan.

1. **Nursing staff completes the documentation of focused patient assessments, abnormal findings, vital signs, administered medications and treatments, clinically relevant intake and output, and key patient information such as height, weight, allergies, and advanced directives.**
    - **a.** Focused patient assessments include the body system related to the presenting problem or current concern. For example: Neuro, Cardiac, Respiratory, and renal assessments for the COVID – 19 patients.
    - **b.** RN's perform comprehensive physical assessment per standard practice, but only document a focused assessment plus any abnormalities noted in the comprehensive assessment
    - **c.** Medication administration will occur using 2 patient identifiers in accordance with local policy. Medications should be administered using Positive Patient ID (PPID) whenever possible. In the event PPID is inaccessible for any reason, the nurse will review the order for the correctness of drug name, dosage form, frequency, route, time of administration and document the administration on the MAR. Medication timing should occur in accordance with local policy.
    - **d.** Lines, drains, airway, and wounds are documented upon insertion or presentation. Ongoing assessment and care will still occur, but only exceptions to care and assessment are documented. (ex. Flushing of lines and cap changes are not documented).
    - **e.** Vital signs documentation should occur as timely as possible. Documentation of vital signs may occur by another caregiver if necessary and documented to reflect the time the actual vital was taken.
    - **f.** For patients on Cardiac ECG monitoring, document every shift and with any changes in cardiac rhythm.
    - **g.** For patients on Ventilators, Ventilator settings will be documented every shift and with any changes.
    - h. Care of and assessment of patients requiring restraints should continue to follow the Restraint and Seclusion policy. As directed by CNO, if necessary, documentation

of such assessments and care can be reduced to once per 12 hour shift and by exception. Ideally however, restraint documentation continues.

i. Performance of ordered interventions is documented by the end of shift.

2. Additional documentation is completed when feasible and does not take priority over providing essential direct nursing care. Examples of this type of documentation include head to toe assessments, screenings, and psychosocial assessments. Clinical judgment is used during this time to conduct similar assessments at the bedside and to guide appropriate interventions.
3. Nursing care planning and patient education still occurs in practice but is not required to be documented during Covid-19 surge conditions.

B. Write one note per shift stating:"COVID-19 Surge Crisis Charting in Effect", which will guide the expectations of those reading the chart retrospectively. Include a brief summary of pertinent care provided and patient condition for the shift.
C. Documentation of notification for Critical results are required as per current critical result policy.
D. Nurses will use clinical judgement regarding other documentation based on the needs of each patient and the unit until standard operations can be safely resumed.
E. In line with standard documentation policy:
    1. All entries are to be signed, dated, and timed to include the actual date and time the intervention was completed. An automated date, time and signature of the user will correspond with the actual entry in the Electronic Medical Record (EMR) regardless of any changes made to time columns or other time/date entry.
    2. Manual documentation entries must include date, time, and have a legible signature or initials with credentials. A legible signature and credentials must correspond with initials to accurately identify the author. Indicate the actual date and time of documentation with any noted late entries and/or addendums. In addition, include the actual date and time the intervention was completed.
    3. Clinical documentation should use military time for consistency within the medical record.
    4. Documentation of a focused nursing assessment is completed at least once per shift on all inpatient units. The scope and frequency of any further assessment will be based on the patient's diagnosis, the patient's reason for care, treatment and services, and the patient's response to care.
    5. Pain assessment documentation occurs in accordance with the administrative pain management policy
    6. Errors in the paper medical record (if in use) will be crossed out with a single line and "correction" written next to it. This correction must be signed, dated, and timed. Initials are acceptable if full signature with initials is already present in document. White-out is prohibited.
    7. Errors in the electronic medical record require a "correction" comment be entered with pertinent details about the reason for the correction if applicable.

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APPENDIX A: ◊ Only for use on units where activated by CNO

| Tier 1 - Must be completed | Tier 2: Complete if Feasible/Relevant |
|---|---|
| Allergies | Full Assessment |
| Nursing Documentation Orderset | Fall Assessment a minimum of once per shift- Critical Care ONLY |
| Admission Database | IMOC rounding PowerForm |
| Vitals/Pain Assessment | Purposeful Rounding |
| Dosing Height/Weight | IPOCs |
| Focused Assessment - | Daily Education |
| Skin/Skin Abnormalities on discovery and at least once a shift. | Patient Belongings |
| Braden Scale | Activities of Daily Living (ADL's) |
| Advance Directives | |
| Fall Assessment- Med/Surg units | |
| Orders/Tasks - Nurse Review, follow, complete | |
| Depression/Suicide Screening | |
| I&O | |
| Meds / IV Drips | |
| Blood Transfusions | |
| Lines/Tubes/Drains/Devices upon insertion/application and at least once a shift | |
| Sitter documentation | |
| Restraints per policy | |
| One note per shift stating "COVID19 Surge in effect" | |
| Critical Value Notification | |
| Interventions/Procedures - by end of shift | |
| Discharge Process/Education | |

References: This policy is in alignment with CERNER Disaster Policy Recommendations.