

DEPARTMENT OF THE ARMY
HEADQUARTERS, WALTER REED ARMY MEDICAL CENTER
6900 Georgia Avenue, NW
Washington, DC 20307-5001

IM-1 Nursing Policy

23 August 2005

Inpatient Nursing Documentation

1. PURPOSE. To provide guidance for the assessment of patients and documentation of nursing care. To enhance interdisciplinary coordination and promote continuity of patient care. As the comprehensive screening and assessment policy for nursing, this policy is a supporting annex to WRAMC Regulation 40-104, Comprehensive Screening, Assessment, and Reassessment of Patients.

2. SCOPE. This policy applies to all nursing personnel and the documentation of health care through the electronic or hard copy medical records.

3. REFERENCES.

- a. AR 40-66, Medical Record Administration and Healthcare Documentation, 20 July 2004.
- b. AR 40-68, Clinical Quality Management, 26 February 2004.
- c. MEDCOM Circular 40-5 Inpatient Treatment Record Forms and Health Care Documentation, 4 August 2003.
- d. MEDCOM Circular 40-17 Surgical/Procedural Site Verification, 28 March 2005.
- e. WRAMC Reg 40-7, Use Of Physical Restraint In The Acute Medical And Surgical (Non-Psychiatric) Environment, 22 July 2004.
- f. WRAMC Reg 40-103, Comprehensive Pain Assessment and Management of Patients, August 2005.
- g. WRAMC 40-104, Comprehensive Screening, Assessment, and Reassessment of Patients, 1 July 2002.
- h. WRAMC Reg 40-105. Falls Prevention Protocol, 1 January 2005.
- i. WRAMC Clinical Information System User Training Manual, 15 Dec 1999.

This Nursing Policy supercedes NPOL IM-1 dated 20 Aug 2002.

- j. WRAMC CHCS Guide for Order Entry and the Clinical Desktop, 9th Ed, Feb 1996.
- k. American Nurses Association, Scope and Standards of Practice, 2004.
- l. Joint Commission on Accreditation of Healthcare Organization. 2005 Hospital Accreditation Standards, 2005.

4. DEFINITIONS.

- a. Clinical Information System (CIS): Electronic medical record used for documentation in the inpatient setting.
- b. Composite Health Care System (CHCS): Electronic medical record system used throughout WRAMC for inpatient and outpatient ancillary services.
- c. Expected Outcome (Goal): The planned observable/measurable change in the patient condition or behavior.
- d. Interdisciplinary Plan of Care: A written patient/family treatment plan, developed collaboratively with the health care team. The physician must determine the long and short term goals for care. Nursing staff and other disciplines individualize their plan of care to promote and obtain desired patient/family focused goals. In addition, the goals and plan of care must be evaluated by all members of the health care team as appropriate.
- e. Invasive Device: Any type of device that penetrates the skin or is placed in an orifice. Examples of invasive devices include foley catheters, intravenous lines, endotracheal tube, or nasogastric tube.
- f. Nursing Process: A method of problem solving that includes observing, recognizing and defining problems (assessment); arriving at possible solutions to problems and goal setting (planning); implementing proposed solutions (implementation); and evaluating the effectiveness of actions (evaluation).
- g. Nursing Orders: A prescription for nursing care written by registered nurses for nursing personnel delineating specific nursing interventions based upon actual or potential patient problems.
- h. Status board: A centralized screen within CIS that allows every member of the health care team to view the status of patients' involvement with supportive services, based on comprehensive assessment and functional screening.

5. RESPONSIBILITIES

- a. The **Deputy Commander for Nursing** provides direction and leadership for nursing documentation at WRAMC.
- b. The **Section Chiefs and Head Nurses** are responsible for ensuring staff education and compliance with standards, regulations, and policies. Nursing personnel are educated about the nursing documentation system in the initial nursing orientation, unit orientation, as well as other hospital training events.
- c. **Registered Nurses (RN)** are responsible for ensuring the accuracy, completeness and timeliness of all nursing documentation. In addition, they must documents assessment, goal setting, planning, care implementation, and reassessment/evaluation of care including patient progress toward desired goals/outcomes in accordance with all local and MEDCOM policies and regulations. The RN is responsible for providing professional supervision and review of nursing care and the appropriateness of all nursing documentation including ensuring the accuracy and completeness of patient data collected by nursing personnel other than an RN.
- d. **Licensed Practical Nurses/91WM6's** are responsible for documenting care in progress notes, and signs off on nursing/physician orders located in the CIS treatment/medication sheets and/or other authorized documentation forms. The LPN may collect data and document all pertinent information required to complete the admission note in collaboration with the RN. The LPN may also document the nursing plan for care daily using the interdisciplinary recommendations and physician goals/plans in collaboration with the RN.
- e. **Nursing Assistants/91W's** are responsible for providing and documenting care given by signing off on care provided on the CIS Vital Sign flow sheet, treatment sheet and/or other authorized documentation forms and electronic systems as directed by the team leader/supervisor.
- f. **Medical Support Assistants (MSA)** are responsible for ensuring that medical records are complete and in order to include, but not limited to, verification and countersignature of all orders and the verification of a completed nursing discharge note prior to submission to medical records. The medical records review checklist will be used as a guide.

6. POLICY:

- a. The required elements of documentation are based on the nursing process including assessment, goal setting, planning, implementation, and evaluation of the patient. At WRAMC, most inpatient medical information is documented in CIS and/or CHCS.

- b. The electronic medical record systems (CIS and CHCS) automatically place patient name, social security number, and registration information on all printed documents. Patient medical records other than those generated by CIS and CHCS will have a stamped addressograph impression for patient identification. If the addressograph is unavailable, the patient's name, family member prefix and sponsor's social security number will be handwritten on all hard copy documents.
- c. Nursing personnel are responsible for the accuracy and completeness of all nursing documentation. Documentation must be clear, concise, and consistent.
- d. Out of Sequence or Delayed Entries: On CIS, an entry may be made out of chronological order by simply entering the actual time the entry took place. The system will store the time of the actual recording. If using paper documents, note date and time of the entry followed by a statement that this recording is out of sequence (that is, a delayed entry).
- e. Documentation Errors: A documentation error cannot be erased, due to medical legal requirements. The nurse can edit the documentation error by using the edit command. The nurse can make a statement that the recording is an error, i.e., wrong patient, wrong entry, etc.
 - 1) If using paper documents, draw a single line through the error, note "error"; the reason for the error, and the initials of the writer followed by notation of the correct information.
 - 2) Do not obliterate errors. An adhesive label will **NEVER** be used to hide or correct documentation errors.
- f. A copy of the patient's Medication Administration Record (MAR) must be printed at the beginning of the shift in case of CIS downtime and/or to use as verification tool for medication administration.
- g. Unless otherwise directed, all handwritten documentation will be made in black or blue-black, non-erasable ink.
- h. Copying of medical records: The Patient Administration Department (PAD) provides official (authenticated) photocopying of medical records, and is the only activity authorized to do so.

7. PROCEDURE:

- a. Nursing documentation requirements are based on the nursing process including assessment, goal setting, planning, implementation, and evaluation. Specifically, documentation elements are listed below in Appendix A. More information for each specific element is addressed in the appendices Appendices B through D.

b. Transfer

- 1) All patients transferred from one unit to another or to the OR will have transfer notes written. The nurse who is transferring the patient completes a Transfer Out Note documenting the patient's condition and reviews the functional screening. Any patient needs/problems that remain open are annotated in the transfer summary.
- 2) All medication orders are discontinued at this time, and must be re-initiated for the gaining unit.
- 3) The gaining unit nurse must re-assess the patient, to include falls risk, skin breakdown risk, and pain. Findings are documented in the Transfer-In Note.
- 4) The gaining unit nurse reviews and updates the interdisciplinary plan of care and acknowledges new orders.

c. Transfers Under Special Conditions/Circumstances

- 1) The form used in documenting emergency situations involving the activation of the Red Bird Team, or any situation involving CPR or defibrillation: MEDCOM ERR Part 1 and Part 2. A WRAMC Form 1811 will be submitted for all codes.
- 2) MEDCOM Form 679-R (Test) Part 1 and Part 2 – ERR.
 - a) This form is found in the top drawer of the crash cart. Each unit should also have copies on file.
 - b) Once completed, the original copy should be placed in the patient's hospital record. A copy of the ERR is attached to the 1811 and submitted to the Performance Improvement Office and the CPR Committee for review.
 - c) All sections in Part 1 must be completed.
 - d) Part 2 is utilized to record cardiac rhythms, medications, IV fluids, defibrillation procedures, laboratory results, and hemodynamic information. It is important that specific ongoing rhythms and dosages are accurately recorded for legal documentation.
 - e) This record documents the code procedures and is evaluated to ensure adherence to established ACLS standards. The data must be written on this form.

f) Both the physician and the Redbird Nurse must sign the form. This is the official record of the physician's orders and the care provider's actions during the code; therefore contents must be reviewed and signed by both parties.

d. Discharge

- 1) The RN/LPN reviews care plans prior to patient discharge from the hospital.
- 2) The RN/LPN reviews discharge instructions with the patient/family, evaluating the level of understanding through methods such as demonstration/return demonstration and/or patient verbalization of instructions. Any handouts given to the patient are noted in the record, to include name and reference number.
- 3) The RN/LPN writes a discharge note (WR Nursing Discharge Note) to include: the patient's condition on discharge, understanding of discharge instructions, who accompanied the patient, and mode of transportation. Discharge notes written by an LPN must be co-signed by an RN.
- 4) The nurse reviews the Physician Discharge Summary with the patient. This note is signed in triplicate by the physician, the nurse, and the patient. The original note is filed in the inpatient chart, one copy is given to the patient, and one is filed in the outpatient record.
- 5) An LPN can provide discharge planning instructions. However, an RN must approve the discharge plan instructions. The RN must also cosign the discharge note.
- 6) **NOTE:** All orders in CIS must be discontinued prior to moving this record to discharge. To discontinue all active orders:
 - a) Go to the order entry screen and select all orders by choosing the top order, hold the shift key while selecting the last order.
 - b) After all orders have been highlighted, discontinue them.

8. Specialized Unit Documentation.

a. Short Stay /APV Nursing Documentation

- 1) Short stay patients are outpatients who remain at WRAMC for an ambulatory patient visit (APV) for a period of less than 24 hours.
- 2) In documenting the nursing process, the nurse selects the APV option in the admission note. An abbreviated history and physical assessment is performed.

Functional screening does not trigger a status board in CIS, but will appear in the physician progress note if the patient is subsequently admitted.

- 3) The nurse documents assessments and care throughout the APV, to include:
 - a) Admission/pre-procedural note
 - b) Intraoperative note
 - c) Post-procedural note
 - d) Transfer or discharge note as applicable (COL Eitzen will follow-up).
- 4) Each patient's status will be reassessed at least every shift and as needed based upon changes in the patient's condition. The RN, with participation of paraprofessional staff, is responsible for assessing the patient's status and recording changes as indicated.
- 5) If an APV patient is admitted to an inpatient unit, the RN must go back into the initial admission note and select the APV to Admission conversion box to convert the patient to inpatient status and initiate the comprehensive patient assessment process.

- b. Perioperative Nursing Documentation. Perioperative nursing documentation will be completed using the CIS generated and/or hard copy DA 5179 Preoperative/Postoperative Nursing Document and DA 5179-1 Intraoperative Document.

9. QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT.

- a. Chart checks will be conducted daily by the ward/unit RN. Orders written throughout the day will be compared with the orders reflected on the documentation flow sheets screens.
- b. Open inpatient medical records audits will be performed monthly by each inpatient ward . At least five audits per month will be turned into the designated mailbox in the DON copy room by the 20th of each month. Data will be aggregated by Medical Records as part of the ongoing accreditation readiness process. Head nurses are encouraged to keep a copy of the audits to use for peer review and/or for annual performance evaluations and performance improvement projects/in-services.

//original signed//
JOAN P EITZEN
COL, AN
Deputy Commander for Nursing

APPENDIX A

Nursing Documentation Requirements

Key Points about Documentation

1. Nurses may use the “copy forward” feature **only** for notes they have written themselves. The “copy forward” feature **cannot** be used for notes that they did not originally create.
2. Writing non-descriptive comments such as “see above note”, “continue with plan of care” or “unable to access” is **prohibited**. Nurses must provide clear and meaningful documentation that describes the patient’s status.
3. Patients admitted from Ward 66/67 do not have a full initial assessment. Nurses on inpatient units must complete the initial assessment for any patient that is admitted **from** Ward 66/67.

Documentation	Frequency	Comments	CIS Primary Location	CIS Alternate Location
WR Nursing Admission Assessment	On admission – within 24 hours	Must be done within 1 st 24 hours. Only one note allowed per chart. Must be signed by RN.	WR Nursing Admission Note	None
Initial Falls Risk Assessment (Morse Fall Scale)	On admission – within 24 hours	Found in WR Nursing Admission Note	WR Nursing Admission Note	None
Falls Risk Re-Assessment (Morse Fall Scale)	Unit transfers, change in patient status, or at least once per week (Sunday)	LPNs may do the falls risk reassessment.	WRAMC Falls Risk Assessment Note	None

This Nursing Policy supercedes NPOL IM-1 dated 20 Aug 2002.

Documentation	Frequency	Comments	CIS Primary Location	CIS Alternate Location
<p>Initial Wound / Skin Care Assessment (Braden Scale)</p> <hr/> <p>Wound/Skin Care Re-Assessment</p>	<p>On admission – within 24 hours</p> <ul style="list-style-type: none"> • Unit transfers • Change in patient status • During dressing changes • At least once per week (Sunday) 	<p>Found in WR Nursing Admission Note</p> <p>Reassessments may be completed by the LPN. Only one note may be opened per admission; do reassessments on same note.</p>	<p>WR Nursing Admission Note</p> <p>WRAMC Wound/Skin Care Assessment Note</p>	<p>None</p> <p>None</p>
<p>Initial Pain Assessment</p> <hr/> <p>Ongoing Pain Re-Assessment</p>	<p>On admission – within 24 hours Every Shift PRN</p> <p>At least 60 minutes after pain-relief interventions</p>	<p>Found in WR Nursing Admission</p> <p>Found on the Vital Sign Flowsheet</p>	<p>WR Nursing Admission Note</p> <p>Vitals Sign Flow Sheet</p>	<p>None</p> <p>Shift Nursing Assessment Note</p>
<p>Comprehensive Screening</p>	<p>On admission and updated PRN</p>	<p>Found in WR Nursing Admission Note (initial screening) and Shift Nursing Assessment (for changes in status). Initiates the Interdisciplinary Care Plan.</p>	<p>WR Nursing Admission Note</p>	<p>Shift Nursing Assessment Note</p>
<p>Shift Nursing Assessment</p>	<p>Every shift, within first 3 hours of shift beginning</p>	<p>Nurse should document plan of care for the shift that will best help meet medical goals.</p>	<p>New Shift Nursing Assessment Note</p>	<p>None</p>

Documentation	Frequency	Comments	CIS Primary Location	CIS Alternate Location
Shift Nursing Re-Assessment	Every Shift	Key assessment note for beginning of shift. Must be started within first 3 hours of shift. May also update Interdisciplinary Care Plan from this note.	Shift Nursing Assessment Note	None
Vital Signs	According to physician orders.	This is the primary screen for charting patient's physiologic status as well as other patient care interventions.	Vitals Sign Flow Sheet	None
Intake and Output (I & O)	According to physician orders.	If correctly filled out, will automatically calculate intake and output.	Intake and Output Screen	None
Treatments	According to physician orders.	This is the screen that is used to document non-medication treatments including nursing orders.	Treatment Screen	None
Medication Administration	According to physician orders.	Medications should be charted <u>after</u> given. Must use CIS terminal, or a copy of the Kardex or MAR for administration. Effects of new medications should be documented	Medication Screen (MAR)	None
Invasive Device Assessment	Every shift	All invasive devices must be assessed each shift, at a minimum.	Invasive Device Flowsheet	None
Patient/Family Education	Within 24 hours of admission and ongoing as needed	Educational barriers assessment is located within the WRAMC Nursing mission Note. Only 1 note; edit note to add comments	Patient Education Note	Treatment screen

Documentation	Frequency	Comments	CIS Primary Location	CIS Alternate Location
Progress	PRN	General purpose note to cover issues that are not addressed in other templates.	Progress Note	Any place that an asterisk can be placed
Other				
Restraint	Complete restraint order on initiation and every 24 hours in accordance with WRAMC Regulation No. 40-7	RN may complete in absence of Licensed Independent Provider (LIP)	WRAMC Restraints Note Restraint Flowsheet. (Must be created by adding a row)	None
Command Interest	Daily (Night Shift) as needed At least once daily by 0200 hours.	This note does not print to patient's chart, but it used only for command report.	WRAMC Command Interest Note	None

Appendix B

Nursing Assessment and Reassessment

WR Nursing Admission Note

1. A nursing admission note is completed within 24 hours of admission by an RN, to include reason for admission, history and physical findings, advance directives, religious/cultural considerations, psychosocial considerations, age-specific criteria, functional screen and source of information.
2. An LPN may complete the history section; however an **RN must complete the assessment.**
3. With the patient's consent, the patient's family should be included in the assessment and planning process. The patient's family must be included if they are providing care at home, e.g., administering medications, preparing food, participating in dressing changes, etc.
4. If the patient is unable to provide information within the first 24 hours of admission, family members or the significant other may be included to begin the history. Outpatient records may also be useful in providing information. If the patient is unable to provide the necessary information, a statement to this effect must be noted on the WR Admission Nursing Note in the comment section.

Falls Risk Assessment

1. Patients are assessed for risk of falling on admission. The assessment is documented via the Morse Fall Scale, found within the WR Nursing Admission Note.
2. The RN is responsible for the initial falls risk assessment and documentation, while subsequent assessments may be performed and documented by the LPN. Falls risk is reassessed weekly, upon transfer from another unit (including the OR) and with any status change via the WR Falls Risk Assessment Note. The reassessment should be done every Sunday at a minimum.
3. A Morse score of 45 or higher qualifies the patient for the Falls Protocol. The RN may also place other patients on the Falls Protocol based on his/her professional assessment. Falls prevention monitoring is continuous and each shift is responsible for actions to prevent falls and documentation in CIS in accordance with WRAMC Regulation 40-105.
4. Patients identified as being a falls risk will have fall orders initiated. A green armband will be placed on the patient's wrist. A "green star" will be placed at the head of the patient's bed and census board to indicate patient is a falls risk.

This Nursing Policy supercedes NPOL IM-1 dated 20 Aug 2002.

Pressure Ulcer Risk Assessment

1. Patients are initially assessed for risk of skin breakdown on admission via the Braden Scale Skin Assessment, found in the WR Nursing Admission Note. The RN is responsible for this assessment and documentation.
2. Skin breakdown risk is reassessed weekly, upon transfer and with change in status of integument. The reassessment is documented in the WR Wound/Skin Care Flow sheet. The reassessment should be done every Sunday at a minimum. Subsequent physical assessments may be performed and documented by the LPN.
3. A Braden Scale score of less than or equal to 15 (≤ 15) indicates the patient is at risk for skin breakdown. Patients identified at risk for pressure sores will have individualized nursing orders for skin care plan initiated and followed. A Nursing Initiated Order (NIO) will be written to indicate an appropriate turning schedule, position of turn (Example: left side, right side, back) and the appropriate sleep surface, e.g., Softcare, ZONEAIRE. In the event that a patient cannot tolerate a certain position, an annotation should be made in the nursing order a sign posted at the bedside.
4. A Braden Scale score of between 10-15 indicates a medium risk for developing pressure ulcer and requires documentation of prevention activities on the Wound-Skin Care Flowsheet in CIS.

Pain Assessment

1. Patients are assessed for pain on admission and asked at what pain level they would require intervention in accordance with WRAMC Regulation 40-103. The initial pain assessment and intervention score is documented in the WR Nursing Admission Note.
2. Pain is assessed IAW WRAMC Regulation 40-103, but generally with vital signs at a minimum. Patient's who receive any type of pain-relief intervention will be reassessed within 60 minutes. The patient's pain, as well as responses to PRN pain medications and comfort measures, will recorded on the I & O Flowsheet and MAR in CIS.

Shift Nursing Assessment

1. The patient's status is assessed and documented at least once every shift (defined as a nurse assigned to a patient for 4 or more hours) using the Shift Assessment Note which includes a review of systems, pain assessment and functional screen update. This note should be done within 3 hours of start of shift.
2. Any updates to the interdisciplinary screening can be made within this note.

3. Nurses may use the “copy forward” feature **only** for notes they have written themselves. The “copy forward” feature **cannot** be used for notes that they did not originally create.

Progress Note. A Progress Note may also be used for any additional documentation of the patient’s progress. Any significant changes in physical, psychosocial or mental status that cannot be addressed within the flowsheets should be documented in the Progress Note. Do not edit the original Shift Nursing Assessment to reflect those status changes.

Appendix C

Plan for Patient Care**Interdisciplinary Care Planning**

Interdisciplinary Care Planning provides a collaborative approach to patient care. All team members view the patient's interdisciplinary plan of care via the CIS template visible in each discipline's shift note.

Interdisciplinary Care Planning starts with the Comprehensive Screening for Comprehensive Assessment is performed on admission in accordance with WRAMC Regulation 40-104, and documented in the WR Nursing Admission Note. The RN is responsible for initial comprehensive assessments (including functional screening) and documentation. Subsequent functional screenings are performed during the nursing shift assessment with updates to the comprehensive assessment documented in the nursing shift note by the RN or LPN.

The patient's needs for consultation by Infection Control, Physical Therapy, Behavioral Health, Speech Therapy, Social Services, Discharge Planning, Pharmacy, and Nutrition are displayed on the unit status board. The patient status board serves as a means of interdisciplinary communication, as it is displayed on the CIS progress note for each discipline with the current consultation status and progress annotated.

The physician/provider initiates consults as necessary for Physical Therapy, Behavioral Health, and Speech Therapy. The RN/LPN may independently consult Social Services, Discharge Planning, Pharmacy, and Nutrition.

Appendix D

Implementation of Patient Care Patient Care Flowsheets**Orders Screen**

Orders entered by the physician are displayed on the Orders Screen. Nursing staff are prompted when they sign on to CIS if new orders are pending. Nursing staff needs to check for new orders at the start of the shift and prior to giving change of shift report, as well as at least every four hours if not logging into CIS more frequently during patient care.

An RN must acknowledge all new orders electronically in CIS. The acknowledgement activates the order and serves as part of the system of checks and balances designed for patient safety. Alteration of original orders is not allowed for nursing personnel.

The RN may (should) initiate nursing orders for identified nursing needs on the order sheet. Nursing initiated orders are identified with "NIO".

Vital Signs Flowsheet

Vital signs are performed and documented according to the physician's order or the minimum requirements of the ward/unit if not otherwise specified.

The pain scale can be accessed through the Vital Sign screen to record patients' pain as well as responses to PRN pain medications and comfort measures. Patient's response to pain medication will be charted on the MAR.

Oxygen saturation values will be documented on the vital sign flow sheet. Include source and percentage of oxygen, using choices listed on the pick list in CIS.

Blood glucose levels (finger sticks) are recorded on the vital sign flow sheet.

The graph section can also be utilized to annotate the start and completion times of procedures and medications, including Vital Signs, respiratory status, pain assessment/reassessment, restraint monitoring, etc. If the I & O sheet is filled out correctly, those data will also appear on this screen.

Treatment Flowsheet

The RN, LPN, and Nursing Assistant are responsible for electronically signing off treatments performed. The RN reviews documentation to ensure accuracy and completion.

The Treatment Flow Sheet is used for diagnostics and treatments such as serial labs and specimens, sequential compression devices, daily weights, patient turn schedules.

blood glucose levels via finger stick, dressing changes, incentive spirometry, and other non-medication treatments.

A series of treatments such as serial lab draws should be annotated with the number of the series, (e.g., lab draw #1, #2, #3) until completed.

Orders that are time specific and/or at intervals will be listed as such in the hour column (e.g., turn patient q2hrs or use of sequential compression devices should be listed at 0200, 0400,0600, etc.), and signed off when completed.

Orders that are in effect the entire shift (e.g., diet; activity; and DNR/DNI status) may be signed off at the beginning of each shift.

Orders that are not time specific and are provided episodically throughout the shift (e.g. patient education or emotional support) may be signed off at the end of the shift and should have accompanying documentation in the corresponding section of CIS.

Intake & Output Flowsheet

I&O records are maintained from 0001-2400 hours daily.

All fluids are to be measured and recorded using the metric system. Accuracy of recordings is essential and requires vigilance.

Daily weights are recorded on this screen with the most recent weight recorded appearing in the upper left corner of this screen.

When recording I&O in CIS, enter only the numeric measurement in the documentation box. The unit of measure is designated at the beginning of each line. Entering units of measure in the documentation box will result in failure to include the volume in the running total.

Nurses will write a nursing order to add rows for specific drains, tubes, etc. on the I & O Flowsheet for in order to accurately record intake and output.

Rows will be added as needed to the flowsheet.

Medication Administration Record (MAR)

The “five rights” of medication administration (Right patient, drug, dose, route, and time) must be checked at the patient’s bedside via a login on a CIS terminal in the room or by checking against a copy of the patient’s Kardex or MAR from CIS.

Each medication administered will be initialed by the RN/LPN or provider administering it at the time of the administration of the medication.

Whenever a treatment or medication is held or not given as ordered, the event and circumstances are documented by selecting the "hold med" function key.

PRN medications must be followed up with an evaluation of the effectiveness of the medication given. Effectiveness of pain medications/interventions will be documented on the Pain Scale, located in the Vital Sign Screen. All other PRN medication effectiveness will be documented via the Medication Screen.

All unexpected or untoward patient responses to medications as well as medications not administered require documentation by making a note in the MAR. This note will appear in the Progress Note.

Invasive Device Flowsheet

The Invasive Device Screen should be utilized for all invasive devices that are initiated at the bedside or perioperatively and will be managed at the unit/ward level. This screen should be used for devices such as foley catheters, JP drains, IVs, NG tubes, OG tubes, tracheostomies, etc.

The screen is initiated at the time of insertion of the invasive device and updated each shift throughout the hospital stay, documenting device, size, condition, and annotating change(s) or discontinuation of the device.

Patient Education Note

Patient Education is initiated within the first 24 hours of admission and documented in the interdisciplinary Patient Education Note. Education is based upon assessment of the patient's needs, abilities, learning preferences, and readiness to learn. Upon admission the following sections of the note are completed: Education Assessment, Diagnosis/Disease Process/Disease Management, Procedures/Treatments, and Medications.

Identify the patient's teaching issues/topics based on the assessment and identified discharge planning needs, and use the education note to document the following: (a) date and time of instruction, (b) what was taught, (c) the patient/family's response/understanding and ability to use and apply the information, and (d) educational materials given to the patient/family.

Patient education is documented in the interdisciplinary Patient Education Note throughout the hospital stay to include, but not limited to, follow-up teaching and reinforcement of education, rationale for tests and/or procedures (videos, pamphlets), potential food and drug interactions, and discharge instructions.