Beartooth Billings Clinic

POLICY MANUAL

Swing Bed

Nursing Documentation

Effective Date: November 18, 2010

Policy #: SBS003 COP C-0388

Approved: Director of Nursing

Reviewed / Revised : September 2013

SECTION TITLE : Nursing Documentation : Admission Assessment / Documentation – Admit and Ongoing

Purpose : To complete the admission assessment and ongoing documentation in order to develop a plan of care, as well as define specific nursing documentation procedures related to electronic health records.

Intent : It is the expectation that all nursing staff shall use the EMR when available to access and retrieve information, enter data, and respond to clinical decision support interventions at the point of care. Clinical decision support interventions refers to the specific alerts, reminders / icons, recommendations and other interventions that are generated from the system.
Point of care refers to the use of the EMR in close proximity to the patient, such as to support positive patient identification, obtain accurate and complete information or documentation, and appropriately communicate clinical findings.

Procedure :

- Upon admission to Acute Care, Swing Bed, and Observation each patient will be assessed by an RN to determine immediate needs and appropriate assignment of care.
- Certain aspects of data collection may be delegated to other qualified patient care personnel (i.e. VS, heights/weights, basic info) with the RN retaining responsibility for interpreting the data, identifying patient care need and completing and signing off on the assessment form.
- The Nursing Admission Assessment (body system assessment and patient history) shall be completed within 4 hours of admission. When appropriate, data from the patient's family or significant other is included in the assessment. More details related to mental / psychosocial, rehabilitation potential, and activities potential may be completed by other disciplines and found in other sections of the documentation in the medical record (notes, forms, power notes, etc.). I-View is the application in CERNER that is used for the body system assessment and the Ad Hoc forms –BTH Hospital Forms is where the Patient History form is located. (See screen shots attached, as reference).
- Re-assessment shall be completed and documented once per shift, or more frequently as condition warrants. This may delegated to other licensed staff with the RN retaining overall responsibility.
- A narrative note / free text shall be completed at the end of every shift, as well for the following situations :
  - Provider notification any time a patient's condition changes and / or requires intervention or additional attention.
  - Abnormal assessment findings.

- Abnormal lab or x-ray results.
- Inadequate analgesia or medication interventions
- Safety concerns.
- Patient falls of other unusual concerns.

- Care Plan - data from the admission assessment and continuing assessments shall be used to develop, review and revise the patient's plan of care. The initial nursing care plan shall be initiated within 24 hours of admission. The care plan shall be updated / kept current by ongoing assessments of patient's needs, the patient's response to interventions and changes in treatment plans. Care plans shall be initiated and updated for all Acute Care, Skilled Swing Bed, Hospice, and Intermediate Swing Bed patients. Refer to other policies for the initiation of multidisciplinary care conferences / care planning.
- Certified Nursing Assistants are authorized to document vital signs, height / weight, Intake and Output, patient care and activity functions (bathing, toileting, ambulation, ect.) meal and supplement intake, finger stick blood glucose results, and other patient care activities within their scope.
- Real time charting – every effort should be made to complete documentation as soon as possible after completing an assessment / nursing intervention. Late entry charting is possible with the EMR – ensure the correct date / time is entered at the start of documenting in the EMR.
- Remember to sign off on your documentation by hitting the " green " check mark. Some areas of CERNER may prompt you to do this, but not all and some documentation may be lost and have to be re-entered if you don't sign it off.

Computer Access / Security

- An individual's assigned computer password is equivalent to a signature, and the authorized user is accountable for anything done under his/her password.
- It is the responsibility of the authorized user to maintain the confidentiality of his/her password. No person with an assigned password may disclose the password to any person or attempt to learn another person's password, except that passwords may be disclosed to a person who is a known employee or agent of Billings Clinic IS Department if necessary to correct a problem or make an improvement to the authorized user's computer, relative to the EMR – CERNER.
- No terminal should be left unattended in a condition that would permit unauthorized access.
- Sign off the computer when completed with documentation. By signing off the next person who enters data will be required to identify themselves. Prior to data entry, make sure no one else is logged into the computer you are about to use as that person's name will be documented as doing any task you perform, in the permanent record.
- Authorized users are prohibited from executing a computer job or accessing confidential information, unless authorized to do so as part of their role.