**Basic Responsibility**

Licensed Nurses and Interdisciplinary Team (IDT)

**Purpose**

To provide consistent clinical documentation in the electronic medical record.

**Policy and Procedure**

(See following page)

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| **Category** | **Description** | **Instructions** |
| **General Charting** | Error Correction | * Vital Signs and Progress Notes: If you have made an error while typing or checking a box, you may correct/edit the error. * Observations and Events:   + If you have answered a question and made an error, you may edit it only **if you have not “saved” and/or marked your documentation “complete.”**   + If you have left a question/section unanswered and saved your documentation, you **may go back** and answer the question/section that was previously left unanswered.   + If you have saved and/or marked your documentation complete and realize that you have made an error, you may **not go back** and edit it. At this point, you must document the correction in a progress note and attach it to the Assessment or Event.   + If you have made an error, you may edit or invalidate your own Progress note. You must view the note and select Mark Invalid or Edit. Both options require a Correction Reason. |
| Date and time of entries | * It is important that you document in **REAL TIME** since every entry is date and time “stamped.” If you are documenting at 1:00 PM for something that occurred at 9:00 AM, you must **NOTE THE TIME THAT THE ENTRY, ASSESSMENT OR EVENT** occurred by changing the time on the entry at the top. If you do not do this then the time of the event will be the time that you documented it. **For legal purposes and your protection, it is absolutely necessary that you follow this policy.** |
| Late entry | * You will log on and create a progress note stating that this is a late entry. Select the correct date and time of entry and then click on the “yes” this is a late entry button. |
| Resident Name | * Will show up automatically whenever you are logged into a resident’s chart. |
| Signatures | * Each entry will be “stamped” with your name, date and time that the entry occurred. * All licensed staff will still need to sign the Master Signature Log. |

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| **Category** | **Description** | **Instructions** |
| **General Charting** | Issues to avoid | * Avoid extraneous remarks such as “foul mood” * Do not criticize, argue or complain about others. * Never speculate: for example, a resident is sitting at the side of the bed and you walk by the room. DON’T say resident attempting to get out of bed. ONLY document what you know as fact. * Do not use staff names refer to their position: STNA, DON, Unit Manager, etc. |
| Be specific | * There is no reason to use general terms, such as "good day, resting comfortably” just to have documentation. If you are going to attach a progress note to an event or assessment you must address the interventions and the resident’s reaction to those interventions. |
| Be objective | * Note facts only, not opinion * Describe the scene/event as if it were a “silent movie” let a picture tell the story * Always ask yourself how this would read in a court of law. |
| Be complete | Use the “sandwich” approach-action-reaction-action: something happens (action) you do something about it (reaction), the response to what you did (action)   * Include significant facts or data (what happened) * Describe your action (what was done to intervene) * Describe the resident's response (what was the outcome) |
| Be accurate | * Be sure the use of right and left are correct. This error is made more frequently than you might think. |

**MATRIX ELECTRONIC MEDICAL RECORDS DOCUMENTATION**

* **Most screens have a “teach me” button just below the folder tabs. The button looks like a computer monitor. Use this if you feel you need a general overview of an action. These overviews are not reflective of the Ohio Living documentation in the system or of our facility policies, which are more specific rather than general.**

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| **Category** | **Description** | **Instructions** |
| **Admission**  **\*All admission assessments are identified in the system by an asterisk** | Admission information to be completed within the **first 8 hours** | **Face Sheet:**   * Verify or add information on the Face Sheet   You can begin your admission documentation as follows:   * **OL Admission Observation-** This must be complete. No information can be omitted.   + A Progress Note with the following information: date, time of arrival, family/ friends present, reason for admission, general observations, resident’s response to admission and any other pertinent information that will not be captured in the Assessments, Events, VS, Orders, etc. * **Admission orders**:   + Orders are to be verified with the attending physician   + Enter all accompanying orders into the system   + See policy on entering and editing orders, titled **ELECTRONIC CLINICAL DOCUMENTATION: ORDERS** * **Pharmacy:** Orders go to the pharmacy electronically * **Diet order:** sent to dietary * **Admission Care Plan** to be started upon admission. * **Admission Pain Assessment** If a resident is in pain then complete the Pain Assessment within 24 hours * **Elopement:** there should be an elopement risk assessment done (Information obtained from and signed for by POA/family member) prior to admission. * **Medicare A:** Use all events that apply * **Therapy**: Therapists are required to check resident messages and/or email for rehab orders. |
| Complete within **24 hours of admission** | * 1st TB test completed * Johns Hopkins Fall Risk Assessment * Oral Cavity Assessment (if applicable) * Self-Administration of Medication Assessment (requires physician signature-**complete and print out**) * Pain/Discomfort Assessment (if triggered from Admission Assessment) * Safe Smoking Assessment (if applicable) * Skin Risk Assessment with Braden Scale * Personal effects inventory completed (A paper form, usually given to the family to compete and turn in) * Notification for glasses and dentures, etc. to be marked * Ancillary/ORBITS sheet in book |
| **Admission: Bowel and Bladder Assessment** | Complete within **24 hours of admission** | * Bowel & Bladder/Catheter Assessment |

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| **Category** | **Description** | **Instructions** |
| **Shift to Shift Report** | Nurses shift report | * The on-coming nurse will run the “Facility Activity Report” for purposes of shift documentation and nursing care. * Click on the “Facility” tab go to “Reports” under “Miscellaneous” click on “Facility Activity Report” select (at least) 1) Open Events, 2) Incomplete Assessments, 3) Orders”(for new and d/c orders) 4) Vital Signs Out of Range and 5) Active Wounds. Run the report. |
| **Change in condition or status** | Report significant adverse change in health status, such as illness, injury or death of resident **immediately** to:   * Hospice (if applicable) * Resident’s authorized representative * Attending physician | * If the resident is not being transferred to the hospital open an Event that describes the change in health status * Document that notifications were made * Document a progress note every shift until Event is closed. |
| **Death** | General progress note | Document the following in a or multiple Progress Note (s):   * No pulse, no BP * Notification of attending physician * Notification of resident's authorized representative * Notification of others as needed: coroner, chaplain, administrator, DON * Notification of funeral home * Time body released to funeral home * Location/ status of valuable items, such as glasses, dentures, jewelry, other belongings * Note order to release body to funeral home. * Mortician’s receipt from funeral home to cover what accompanied the deceased and that the body was released to them (paper document)- Leave this in the box/folder for Medical Records to file. |
| **Leaving AMA** | Leaving against medical advice | * This is a paper form, which can be printed off of the Ohio Living Intranet. Once this is completed, leave this in the box/folder for Medical Records to file. |
| **Medicare Skilled Charting** | Medicare Part A stays | * Complete the Focused Observation at least once every 24 hours. Complete a Progress Note on the shifts that did not complete one of the above. |

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| **Category** | **Description** | **Instructions** |
| **Medications** | PRN Psychoactive Medication use | Chart the following for all residents:   * Description of behavior before medication begun * Interventions tried and response before medication started and/or before PRN medication given (enter as Tasks in eMAR) * Presence of side effects of medication * Effectiveness of any new medication |
| All medications | * Complete all Tasks in eMAR, Prep and mark Administered after a medication has been administered * When the medication was not administered for whatever reason: resident refuses, is out of the building, etc. in eMAR indicate Not Administered and document the reason the medication was not administered.   + When a medication is not administered the physician MUST be notified. |
| PRN medications and treatments | * A reason must be listed in the order * Frequency must be listed in the order * Assess and chart the results of giving the PRN med or treatment * Do not accept dose range orders (i.e.: 1-2 for pain, must be 1 for mild pain, 2 for moderate to severe pain) |
| Additional documentation | * Add Tasks for pulse, BP, blood glucose, etc. as needed in eMAR |
| **Minor Skin Conditions** | Abrasions, lacerations (skin tears), rashes, burns | * Document in Wound Management |
| **Refusals of treatment and services** | General progress note | Open the Declination of Services Event when a resident or responsible party refuses treatment or services:   * Provision of education related to refusal, and consequences of refusal * Resident's response and level of understanding of consequences * Notification of physician according to policy * Notification of resident's authorized representative |

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| **Category** | **Description** | **Instructions** |
| **Restorative**  **Evaluations** | Complete as needed | ALL RESTORATIVE DOCUMENTATION IS IN PAPER FORMAT   * Must be completed / approved by an RN. * Nursing Restorative Programs can be written for the following areas and do not require physician's orders:   + Range of Motion   + Active Range of Motion   + Training and Skill Practice   + Bed Mobility   + Transfer   + Walking   + Dressing or Grooming   + Eating or Swallowing   + Amputation/ Prosthesis Care   + Splint or Brace Assistance   + Specific Toileting Programs   + Communication * Must include initial status * Must include measurable goal. Use of percentages is a suggested format. To be faxed into the system |
| **Restorative Documentation** | Nurse progress and STNA documentation | * Education of NA to provide restorative care completed and documented in training records * Nurse reevaluates each program quarterly * Nurse or aide to document progress monthly * NA to initial daily provision of restorative care. Documentation must show 15 minutes of services at least 6 times/week for credit as a restorative program * Toileting programs do not need to show the 15 minutes, but completion of the program does need to be documented daily. To be scanned into the system. |
| **Transfer or Discharge** | * Room to room * To hospital or another health care facility * To home | Document the following in a Progress Note attached to the Transfer Event, Discharge or if these do not pertain- document just a general Progress Note.  TRANSFER:   * If emergency transfer to a hospital, use the Transfer Event and document all that occurred leading up to the emergency transfer. * Family/ friends present * Method of giving caregiver's information on caring for resident. (phone call to nurse, verbal report to unit nurse, discharge summary given to caregiver)   DISCHARGE:   * Complete the Discharge Plan and Instructions Assessment * If going home, describe who was given home going instructions, and if instructions were understood * Complete the discharge medication reconciliation process according to the Medication Reconciliation Upon Discharge policy   ROOM CHANGE   * If room change, document that the resident and responsible party were notified. |
| **Unusual incidents and accidents** | All Significant Events: i.e.: falls, injuries, abuse, elopements, theft, equipment failure, hostile and/or dangerous family members/staff etc. | * Complete an incident report, in RISKWATCH * Notify the physician and family as applicable * Notify the supervisor or on-call manager if there has been a significant incident or a potentially dangerous one. * Open the proper, corresponding Event for each incident. |
| **Vital Signs** | Document on the Vital Signs page | * Every event requires VS, All Events trigger VS documentation. The Event will take you to the VS page when you click on vital signs within the event. * Whenever VS are required you are required to a full set of vital signs this includes: blood pressure, pulse, respiration and **temperature** |
| **Wounds** | Wounds:   * Pressure * Venous ulcers * Arterial ulcers * Diabetic ulcers * Surgical | All wounds to be documented in Wound Management   * Measure on admission, initially and weekly * Describe type of tissue, exudate, odor, peri wound, and presence of tunneling * Note all preventive skin care interventions (pressure redistributing mattress, devices, protective barrier creams, etc. * Document Q shift until Event is resolved. * Charge nurse or designee to document wound in Wound Management section of EMR |
| **Weights** | * Complete as ordered | Weights are documented in “Vital Signs”   * Check that height and weight were charted on admission * Chart all weights on the vital signs page * Chart the scale that is used for each weight * **Reweigh if it is > or < 5 lbs. from the previous weight** * Dietary technician will notify the physician, and resident's authorized representative for significant changes of   > 5% in one month and/or >10% in six months |