GUIDELINE STATEMENT: This document guides nursing documentation for inpatients 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, including ICU vs. medical surgical, and when it terminates. Policy 87-025 'Documentation in the Inpatient Medical Record' remains in effect until the CNO designates this policy (20-003) effective. The policy will be implemented until the CNO renders it inactive.

BACKGROUND: Penn Presbyterian Medical Center remains committed to maintaining sufficient 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 documentation for hospitalized inpatients.

PROCEDURE:

A. The required documentation column within Penn Chart does not reflect the documentation required while this policy is in effect. 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 (ex. Pulmonary assessment with care to document accurate respiratory rate, lung sounds, and oxygen flow/ventilator settings).
        - **b.** RN's perform comprehensive physical assessment per standard practice, but only document a focused assessment plus any abnormalities noted in the comprehensive assessment (ex. Column full of WDL's is not required under this policy).
        - **c.** Lines, drains, airway, and wounds (LDAs) are documented upon insertion or presentation. Ongoing assessment and care of LDA's will still occur, but only exceptions to care and assessment are documented. (ex. Flushing of lines and cap changes are not documented, sites that are WDL are not documented)
        - d. Care of and assessment of patients requiring restraints should continue to follow policy 11.134 Management of Restraints and Seclusion. 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.
        - e. 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 judgement 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 in Effect", which will guide the expectations of those reading the chart retrospectively.

C. 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.

D. 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 patients 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 11.199.All entries to the EMR shall be saved as required by the document or flowsheet.
6. Errors in the paper medical record 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.

REVISIONS/REVIEWS

All Policies Reviewed Annually

Penn Medicine

PENN PRESBYTERIAN MEDICAL CENTER
Department of Nursing and Patient Care Services

CLINICAL PRACTICE GUIDELINE MANUAL

	Tier 1	Tier 2	Tier 3
Description	**Required - Must be completed**	**Complete if feasible**	**Not Required Unless Acutely Pertinent to the Patient**
	Write one note per shift stating: "COVID-19 Surge in Effect"		
Admissions Documentation	Allergies	Reconcile Meds Activity**	History***
	Arrival/Arm band	Review PTA Meds	Travel screening
	Associate Devices (ICU)	Psychosocial	Language
	Vitals/Pain (Special emphasis on correct respiratory rate and oxygen flow)	Patient Identity	Care Plan
	Height/Weight	Screenings Flowsheet	Education
	Focused assessment (head to toe section)	Language	Patient Belongings
	LDA (with existing wounds)	Immunizations	
	Release all relevant signed and held orders		
Required Doc	Advanced Directives Assessment	Aspiration Risk Assessment	Pre-op Hospitalization Living Assessment
	Orders – acknowledge, follow, complete, release	Nutrition Assessment	Learning Assessment
	Suicide Risk Assessment (patients admitted for behavioral health indication or with clinical suspicion)	Depression Screening	
		Domestic Abuse Assessment	
		Fall Assessment	
		Functional Assessment	
		Psychosocial	
		Social History	
Flowsheets	I/O (if relevant to patient condition; include TEN)		Care plan daily
	Focused physical assessment and any abnormal findings of full assessment.		Education Daily
	eMAR – Document med admin. Perform bar coding unless it impedes patient care		
	Blood Transfusion		
	LDA – (lines, drains, airways, wounds upon insertion/presentation, after that only document by exception)	Braden Scale Unchanged wound, line, drain, airway assessments and care	
	Continuous Observation (1:1 safety or suicided)		
	Restraints (at least once per 12 hour shift & by exception)	Restraints full documentation	

*Braden Scale is Tier 2

**Ensure completion prior to discharge by some discipline

***Utilize provider documentation to guide care