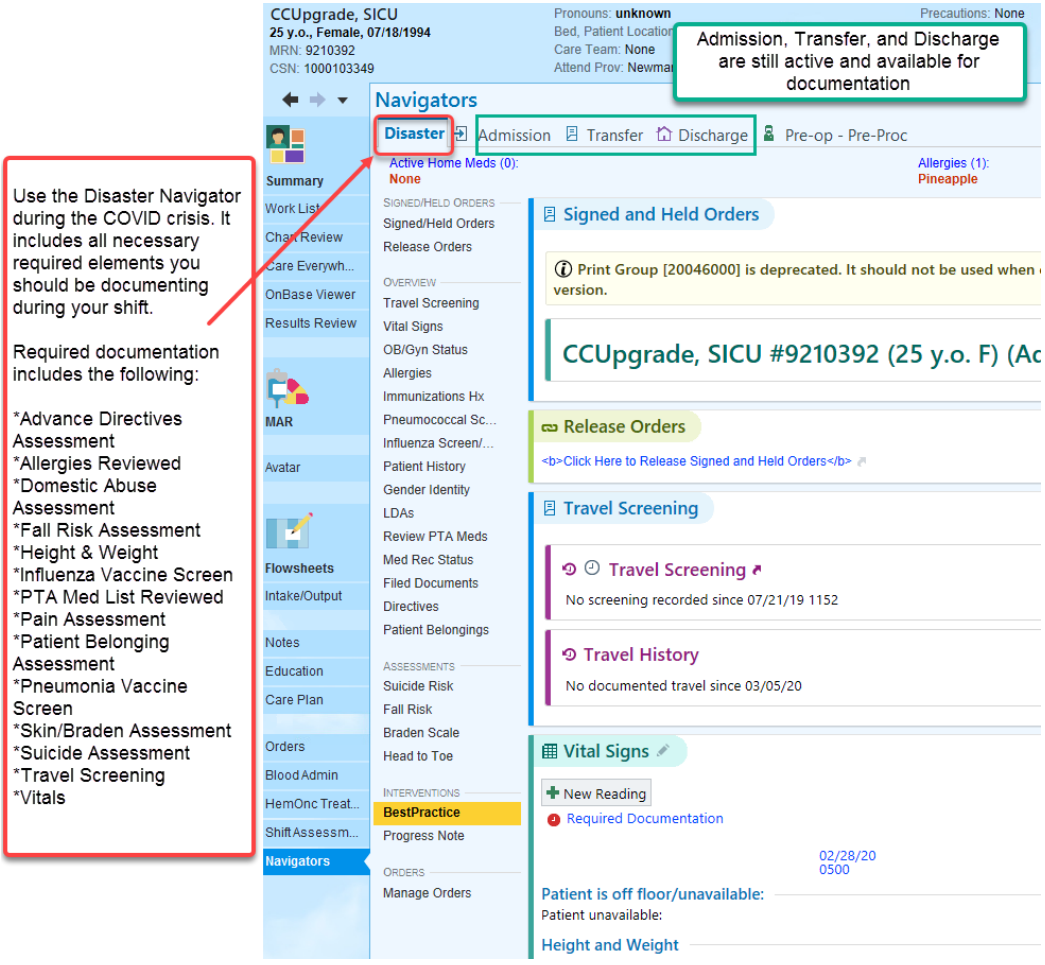
Application: ClinDoc
Release date: 4/5/2020

Inpatient Nursing Documentation Changes During COVID19

During the COVID19 Crisis, inpatient nursing required documentation will be decreased and streamlined. Documentation should be completed in the **Disaster Admission** Navigator.

Key Highlights

- Use of a new **Disaster Admission Navigator** with decreased admission documentation for all patients in Adult Med/Surg and ICU areas
- Current navigators will remain accessible and are available if an RN would like to document more than required
- Required documentation for Falls Score and Braden Scale has been changed from every shift to every 24 hours
- Removal of BPA logic that adds Care Plans
- Removal of automatic addition of First Dose Education for medications
- Care Plan and Education will be replaced by SmartText in RN Shift Note



WAIVING THE REQUIREMENT TO DEVELOP A CARE PLAN FOR EACH PATIENT

During the crisis, the use of Care Plans is not necessary. Since the education activity includes information added by the creation of a care plan, nurses will no longer be required to document in the Education activity. To support this change:

- All Best Practice Advisories (BPA) that recommend a Care Plan Template based on documentation or orders will be turned off
- Nurses will no longer document Care Plan Notes in the Care Plan section
- The RN Admit Note contains text for documenting that you have discussed a Plan of Care and Educated the patient
    - The plan section of the note includes the specific plan for the patient
- Nurses will document a Nursing Note at the end of each shift
- At discharge, skip the Care Plan and Education sections of the navigator

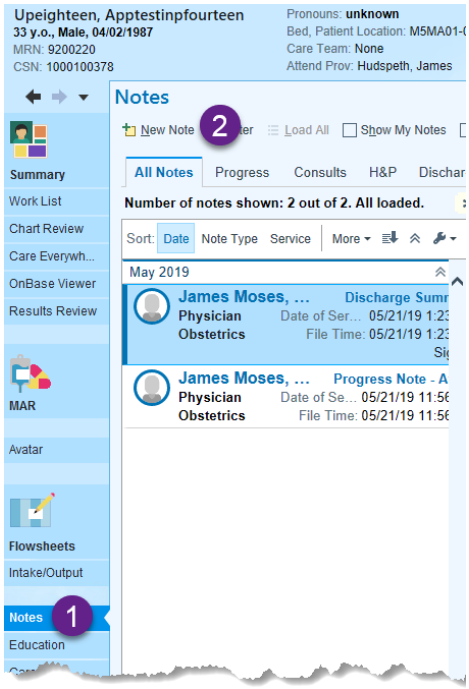
NURSING NOTE – MED SURG/CRITICAL CARE

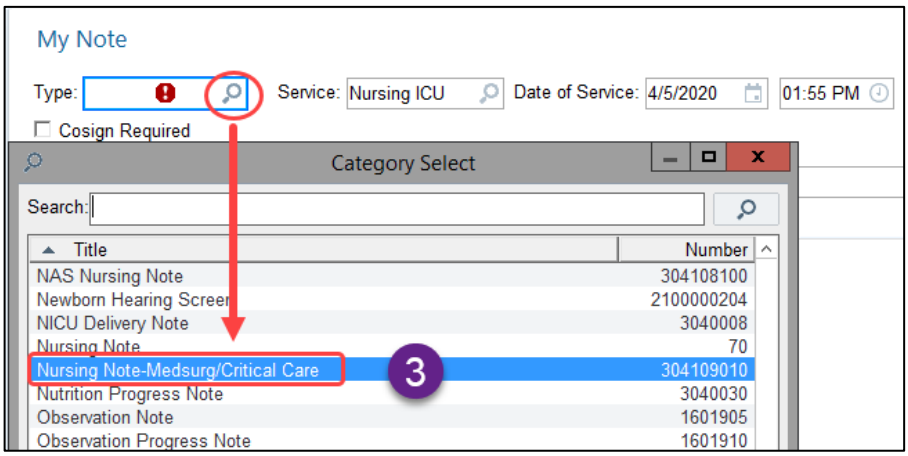
The new Nursing Note will include the following statements:

- The plan for the day was reviewed with the multidisciplinary team.
- The plan and patient education was provided verbally to the patient and/or family during the shift.
- Patient and/or family were accepting of this information and verbalized understanding.
- Any additional details and/or outstanding concerns are listed below.

CREATING A NURSING NOTE

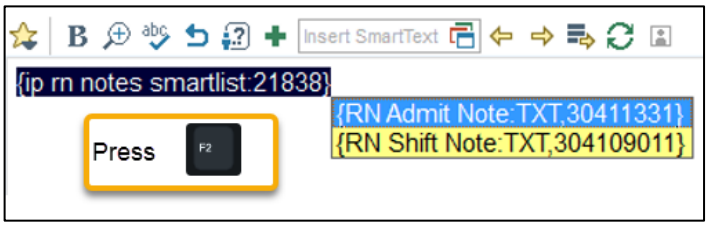
1. Go to the **Notes** Activity
2. Click **New Note**
3. Select the note type of **Nursing Note - Medsurg/Critical Care**





- Open the smartlist by selecting F2
- Select the appropriate note type

(Admit Note, Plan of Care) by double clicking your selection

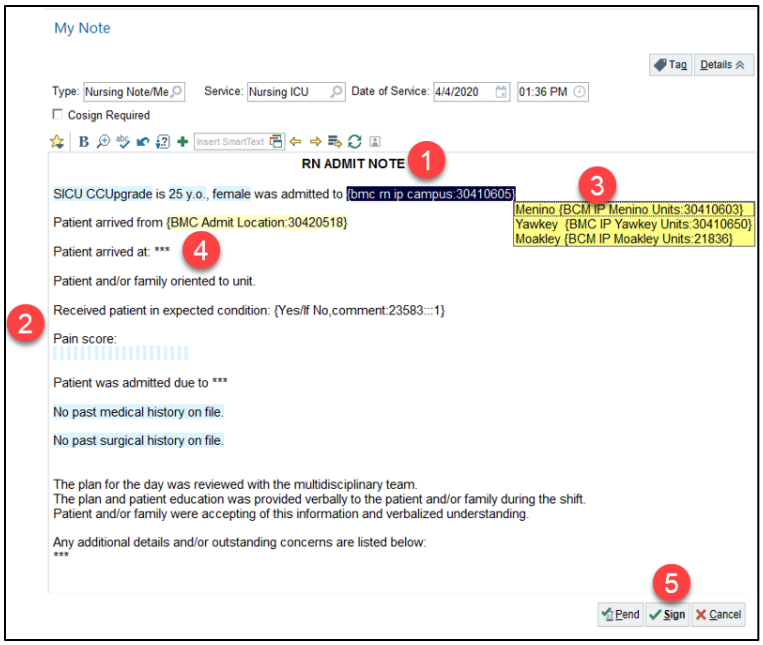


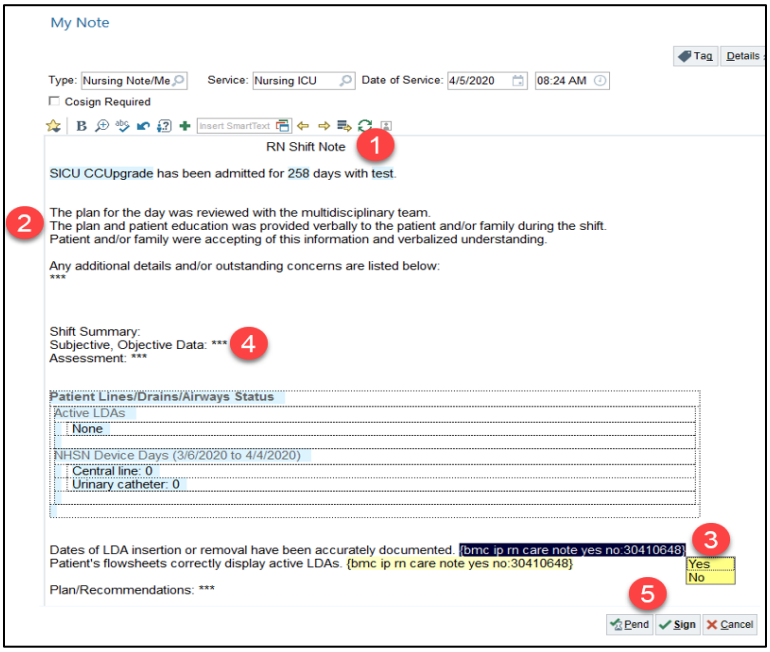
1. The appropriate heading will display in the body of the note
2. Text will auto populate to help streamline your documentation
3. Complete SmartLists throughout your note
4. The *** is a wildcard which is a placeholder for additional documentation.

Remember you cannot sign your note if SmartTools are left unfinished (lists or *)**

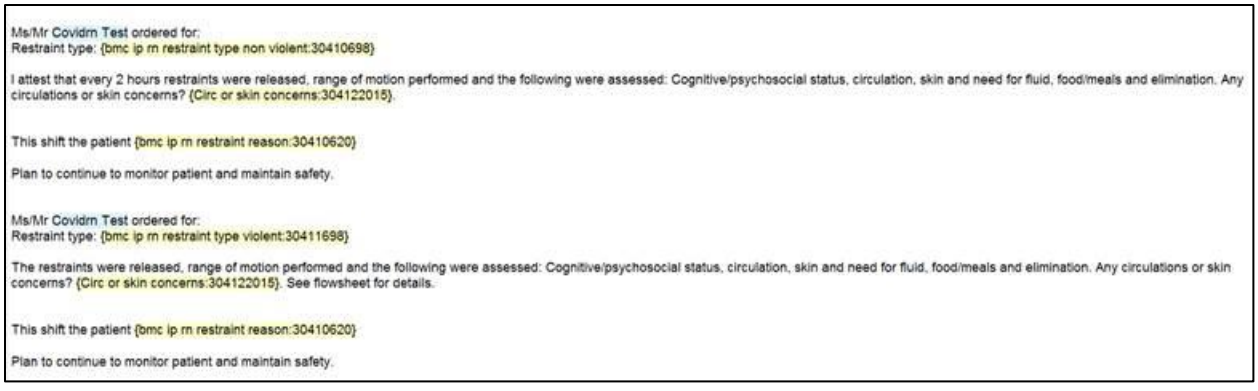
5. Click Sign

"F2 will see you through" – Use F2 to navigate through all of the SmartTools to complete your note





- Restraint documentation is embedded in the Shift Note. If there are no restraints, delete this section:



- If your patient is in Med/Surg and on telemetry, you do not need write a separate note about telemetry. If appropriate you can add information to your Nursing Note. You should still document on the strip and place it in the chart.

- If the patient falls, use the **IP RN Falls Event Note** SmartText in your note: