

**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

Use the Disaster Navigator during the COVID crisis. It includes all necessary required elements you should be documenting during your shift.

Required documentation includes the following:

- \*Advance Directives Assessment
- \*Allergies Reviewed
- \*Domestic Abuse Assessment
- \*Fall Risk Assessment
- \*Height & Weight
- \*Influenza Vaccine Screen
- \*PTA Med List Reviewed
- \*Pain Assessment
- \*Patient Belonging Assessment
- \*Pneumonia Vaccine Screen
- \*Skin/Braden Assessment
- \*Suicide Assessment
- \*Travel Screening
- \*Vitals

CCUpgrade, SICU  
 25 y.o., Female, 07/18/1994  
 MRN: 9210392  
 CSN: 1000103349

Pronouns: unknown  
 Bed, Patient Location  
 Care Team: None  
 Attend Prov: Newma

Precautions: None

**Admission, Transfer, and Discharge are still active and available for documentation**

**Navigators**

**Disaster** Admission Transfer Discharge Pre-op - Pre-Proc

Active Home Meds (0): None Allergies (1): Pineapple

**Signed and Held Orders**

Print Group [20046000] is deprecated. It should not be used when version.

**CCUpgrade, SICU #9210392 (25 y.o. F) (Ac**

**Release Orders**

Click Here to Release Signed and Held Orders

**Travel Screening**

**Travel Screening**

No screening recorded since 07/21/19 1152

**Travel History**

No documented travel since 03/05/20

**Vital Signs**

New Reading

Required Documentation

02/28/20 0500

Patient is off floor/unavailable:

Patient unavailable:

Height and Weight

## 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

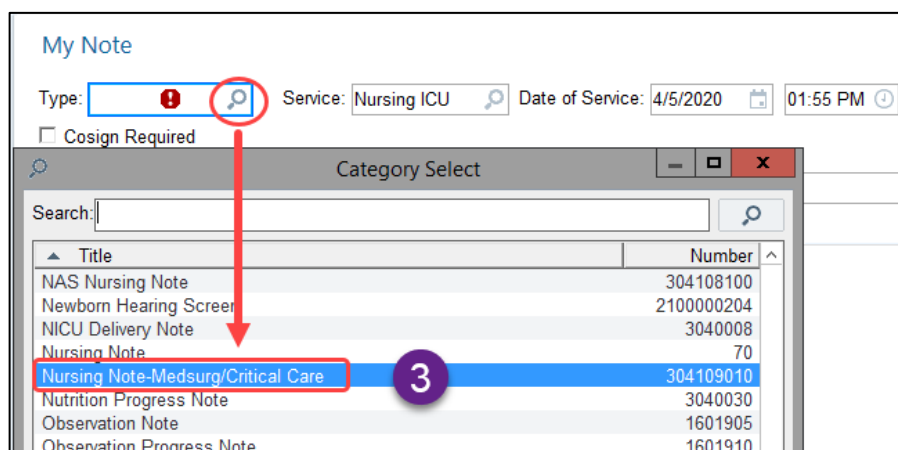
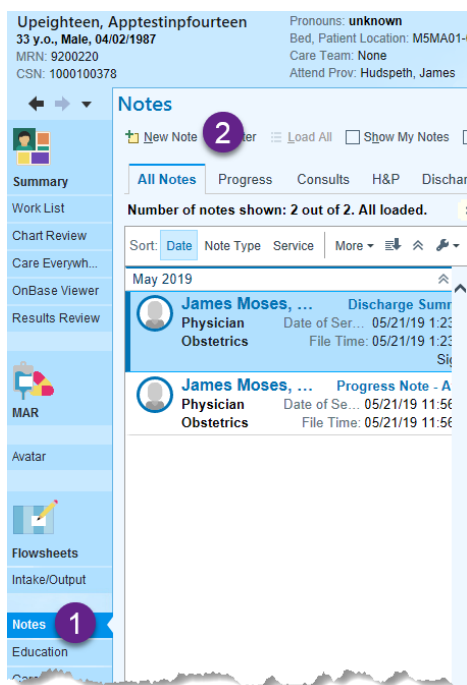
## NURSING NOTE – MED SURG/CRITICAL CARE

The new Nursing Note will include the following statements:

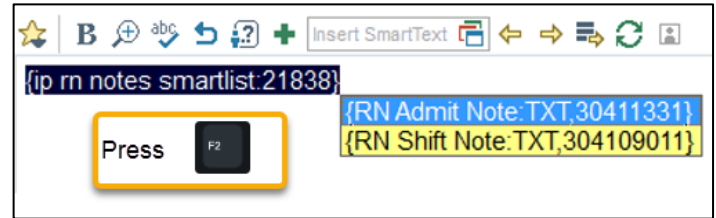
- The plan for the day was reviewed with the multidisciplinary team.
- The plan and patient education was provided verbally to the patient and/or family during the shift.
- Patient and/or family were accepting of this information and verbalized understanding.
- Any additional details and/or outstanding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



- The appropriate heading will display in the body of the note
  - Text will auto populate to help streamline your documentation
  - Complete SmartLists throughout your note
  - The \*\*\* is a wildcard which is a placeholder for additional documentation.
- Remember you cannot sign your note if SmartTools are left unfinished (lists or \*\*\*)**
- Click Sign

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

My Note

Type: Nursing Note/Me Service: Nursing ICU Date of Service: 4/4/2020 01:36 PM

☐ Cosign Required

Insert SmartText

**RN ADMIT NOTE**

SICU CCUpgrade is 25 y.o., female was admitted to [bmc ip rn campus:30410805]

Patient arrived from [BMC Admit Location:30420518]

Patient arrived at: \*\*\*

Patient and/or family oriented to unit.

Received patient in expected condition: (Yes/If No,comment:23583:::1)

Pain score: [Progress bar]

Patient was admitted due to \*\*\*

No past medical history on file.

No past surgical history on file.

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: \*\*\*

End Sign Cancel

My Note

Type: Nursing Note/Me Service: Nursing ICU Date of Service: 4/5/2020 08:24 AM

☐ Cosign Required

Insert SmartText

**RN Shift Note**

SICU CCUpgrade has been admitted for 258 days with test.

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: \*\*\*

Shift Summary: Subjective, Objective Data: \*\*\* Assessment: \*\*\*

Patient Lines/Drains/Airways Status

Active LDAs: [None]

NHSN Device Days (3/6/2020 to 4/4/2020): Central line: 0 Urinary catheter: 0

Dates of LDA insertion or removal have been accurately documented. [bmc ip rn care note yes no:30410648]

Patient's flowsheets correctly display active LDAs. [bmc ip rn care note yes no:30410648]

Plan/Recommendations: \*\*\*

End Sign Cancel

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

Ms/Mr Covidm Test ordered for: [bmc ip rn restraint type non violent:30410698]

I attest that every 2 hours restraints were released, range of motion performed and the following were assessed: Cognitive/psychosocial status, circulation, skin and need for fluid, food/meals and elimination. Any circulations or skin concerns? [Circ or skin concerns:304122015]

This shift the patient [bmc ip rn restraint reason:30410620]

Plan to continue to monitor patient and maintain safety.

Ms/Mr Covidm Test ordered for: [bmc ip rn restraint type violent:30411698]

The restraints were released, range of motion performed and the following were assessed: Cognitive/psychosocial status, circulation, skin and need for fluid, food/meals and elimination. Any circulations or skin concerns? [Circ or skin concerns:304122015]. See flowsheet for details.

This shift the patient [bmc ip rn restraint reason:30410620]

Plan to continue to monitor patient and maintain safety.

- 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:

