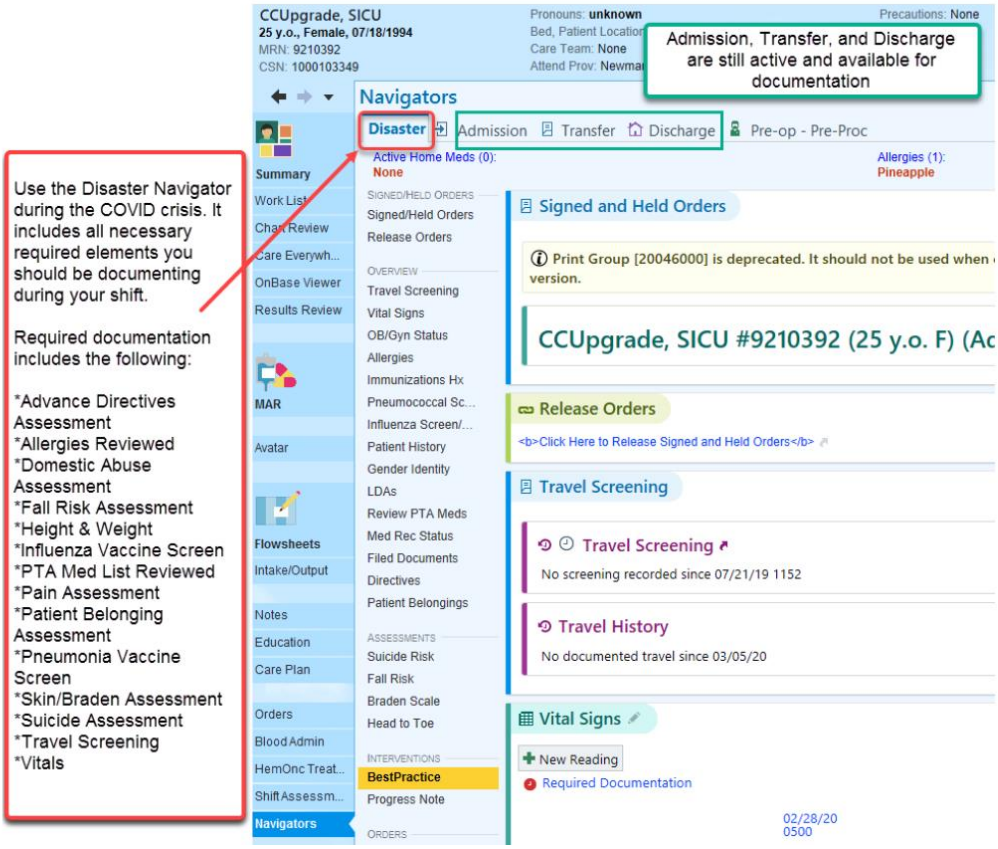
Inpatient Nursing Documentation Changes During COVID19

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

New Disaster Navigator



WAIVING THE REQUIREMENT TO DEVELOP A CARE PLAN FOR EACH PATIENT

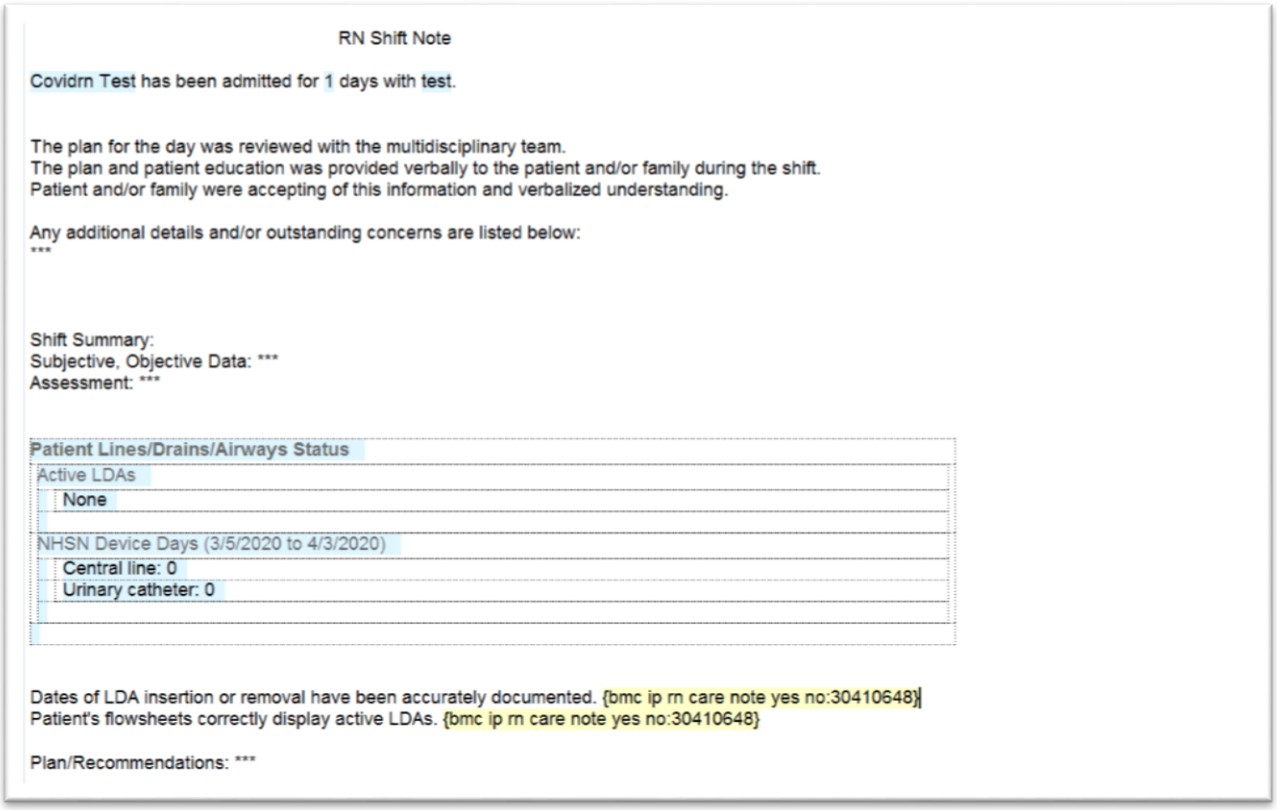
During the crisis, the use of Care Plans is not necessary. Since the education activity includes information added by the creation of a care plan, nurses will no longer be required to document in the Education activity. To support this change:

- 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.**



RN Shift Note

Covidrn Test has been admitted for 1 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 (3/5/2020 to 4/3/2020)

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: ***

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

Ms/Mr Covidrn Test ordered for:
Restraint type: {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 Covidrn Test ordered for:
Restraint type: {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

For more information and step by step instructions there is a tip sheet you can find here: https://share.bmc.org/emerge/COVID19%202020/Epic%20IPRN%20Documentation%20Changes%20COVID19.pdf

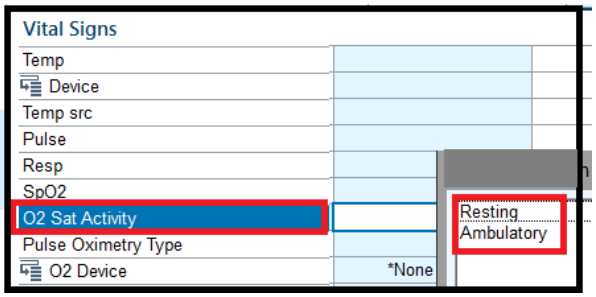
Different section

EPIC UPDATES

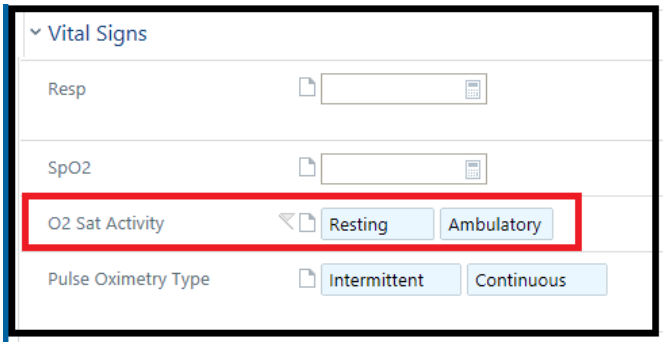
New row for O2 Sat documentation

This new row will indicate whether the pulse ox was taken ambulatory it is assumed if it is not documented on the O2 sat was taken at rest. This is especially useful for ILI and ED as it is being used to model whether a patient is more likely to come back with worsening COVID after being discharged.

Inpatient



ED



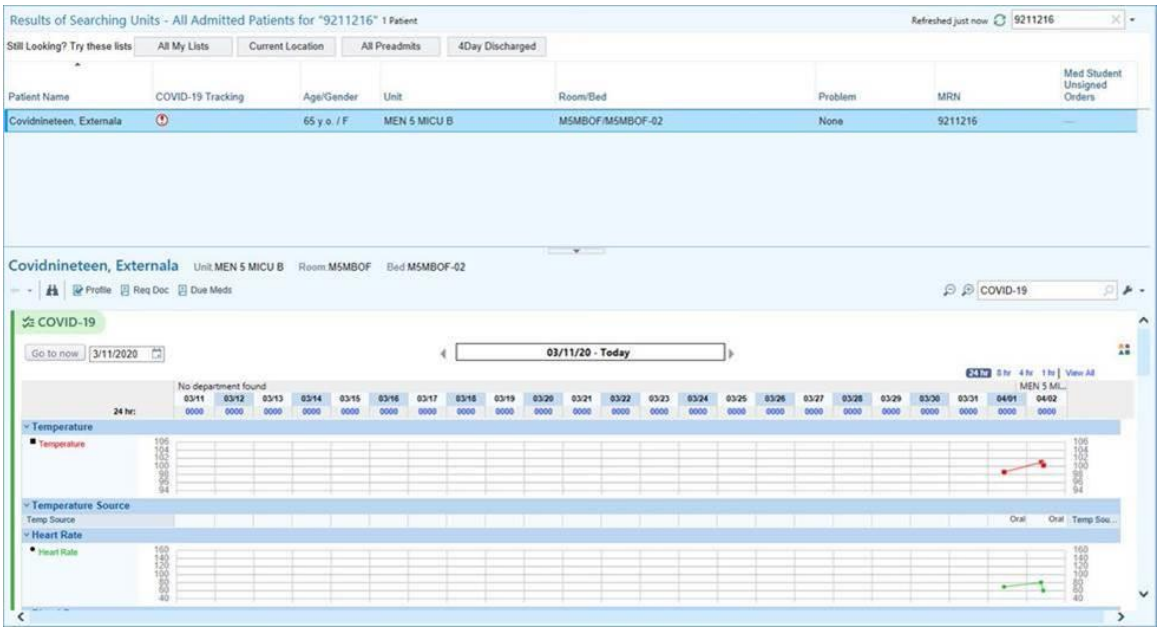
New COVID-19 Accordion Report

This report includes The report contains:

- Vitals
- Labs
- Meds
- Vent settings
- ABG/VBG
- Imaging results (last 7 days – cross encounters)
- Covid Orders and results (last 60 days – cross encounters)
- Comp resp panel (last 60 days – cross encounters)
- Micro results (last 21 days – cross encounters)

It can be accessed from below the patient lists or in the patient summary by searching or wrenching in COVID-

Patient list view:



From summary activity: