CLINTON REGIONAL HOSPITAL	POLICY AND PROCEDURE	NUMBER NS 507
	MANUAL Nursing Service	EFFECTIVE DATE
	SUBJECT Documentation Guidelines	REVISED REVIEWED

1.0 PURPOSE

1.1 To provide guidelines for nursing documentation in the medical record.

2.0 POLICY

2.1 The admitting RN initiates the plan of care after the patient assessment, with interventions and reassessment appropriately documented by the patient care nurse.

2.2 Each patient will be assessed by an RN on admission, at least once per shift, and if there is a significant change in patient's status.

2.3 The RN who does the initial assessment will be responsible for initiating the treatment plan of care for that patient.

2.3.1Reassessment will be done routinely every shift there after by an LPN or RN. If assessed by LPN, the RN shall co-sign the assessment that he/she agrees with the LPN assessment.

2.3.2 An LPN may revise the treatment plan of care after an RN has initiated it. The LPN may add new foci and chart on those the RN has identified.

2.3.3 Patient care narrative notes are organized according to the following categories:

- Time/Data: Subjective and/or objective information pertaining to the concern.
- Action: Immediate or future nursing actions based on the nurse's assessment/evaluation of the patient's status.
- Response: description of patient's responses to any part of the medical or nursing care.

2.4 The following are to be addressed in the narrative section using the above DAR format:

2.4.1 Admitting and/or discharge note.

2.4.2 Concern or significant change in patient condition (include notification of physician and their response).

2.4.3 Any abnormal assessment that requires detailed narrative documentation to ensure clarity.

2.4.4 With each data recorded there may not be a need to chart in all three categories, But this does provide more complete documentation.

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2.5 Ensure documentation of patient education and discharge teaching.

2.7 All new licensed staff and Nurse Aid/Nurse Techs will be required to receive orientation to the charting system.

3.0 High acuity patients who require constant monitoring, intensive interventions, or life-saving procedures. These patients may be in intensive care units or emergency departments.

3.1 Documentation must be completed immediately after any critical intervention or at the time of the event.

3.2 Progress notes for high-acuity patients (including emergency care and ICU) must be updated at least every 30 minutes or after a significant change in condition.

3.3 Vital signs should be documented immediately after measurement or within the patient's acuity time frame. Every hour for high acuity unless specified otherwise.

4.0 Patients who require ongoing monitoring but are stable and do not require intensive care. These patients are typically on medical or surgical wards.

5.0 Patients who are stable and require minimal intervention or monitoring. These patients are usually in observation status or post-acute care.

Administrator/CEO	Revised & Approved By
Original Signatures on file in Nursing Administration	