Nursing Documentation Policy – SAMPLE

Subject: Nursing Documentation
Number:
Effective Date:
Supersedes SPP No:
Approved by: (signature)
Distribution:

I. Purpose

The primary purpose of the patient record is for documenting evidence-based care of the patient. According to the American Association of Critical-Care Nurses (AACN), six elements of nursing care must be included in nursing documentation:

1. Assessment
2. Diagnosis
3. Outcomes identification
4. Planning
5. Implementation
6. Evaluation

II. Policy

Only persons authorized by the hospital’s policies to document in the medical record shall document. (This should be detailed in administrative policies and in the medical staff rules and regulations)

III. Procedures

1. Document all patient record entries at the time the treatment is rendered.
2. Every patient who is assessed and treated shall have a medical record.
3. Clearly identify the authorship of all entries.
4. Only acceptable abbreviations and symbols are permitted to be used (also see policy [insert name of relevant policy and procedures which address this for your organization]).
5. All entries into the medical record are considered to be permanent. No alteration or destruction of records is permissible at any time.
6. Correct errors in a paper document by drawing a single line in ink through the incorrect entry. The person making entry should write “amendment” at the top of the entry and include his/her legal signature or initials, title, discipline, date and time, along with the reason for the change. Do not use correction fluid, marker or other type of correction method which obliterates the original entry. Label a late entry as “late entry” and include the actual time and date the entry is made.
7. The electronic health record (EHR) is designed to track corrections or changes and note the date, time and the name of the person making the entry, all without destroying the original entry.
8. If a patient wishes to amend the information in the record, note it as a patient addendum, without any change to the original entry and identify it as an additional document appending the original patient record. Have the patient provide the rationale for the amendment in their amended notation.

9. All entries must be legible, complete, authenticated (signed) and dated promptly by the person making the entry (identified by name, title and discipline). This applies to all persons responsible for ordering, providing or evaluating the services furnished.

10. Authentication may include signatures, written initials or computer entry.

11. The record must contain information sufficient to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among healthcare providers.

12. The record must contain at least:
   a. Patient’s name, address, date of birth, name of any legally authorized representative
   b. Legal status of patients receiving mental health services
   c. Emergency care provided to the patient prior to arrival, if any
   d. Record and findings of patient assessment
   e. Conclusions or impressions from the medical history and physical examination
   f. Diagnosis or diagnostic impression
   g. Reasons for admission or treatment
   h. Goals of treatment and the treatment plan
   i. Evidence of known advance directives
   j. Evidence of informed consent
   k. Diagnostic and therapeutic orders
   l. All diagnostic and therapeutic procedures and test results
   m. All operative and other invasive procedures performed (using acceptable disease and operative terminology that includes etiology as appropriate)
   n. Progress notes made by the medical staff and other authorized individuals
   o. Reassessments and any revisions of the treatment plan
   p. Clinical observations
   q. Patient response to care
   r. Consultation reports
   s. All medications ordered and prescribed (inpatient)
   t. All dispensed medications (ambulatory or inpatient) on discharge
   u. Every dose of medication administered and any adverse drug reactions
   v. All relevant diagnoses established during the course of care
   w. Any referrals and communication made to external or internal providers and to community agencies
   x. Conclusions at termination of hospitalization
   y. Discharge instructions to patient and family
   z. Clinical resumes and discharge summaries, or a final progress note or transfer summary. The discharge summary contains:
      i. Reason for hospitalization
      ii. Significant findings
      iii. Procedures performed and treatment rendered
      iv. Patient’s condition at discharge
      v. Instructions to the patient and family

13. Review and comply with any department or unit-specific documentation requirements.

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References:
