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Owner:	*David Leslie: CNO*
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Documenting the Provision of Care

SCOPE:

All patient care areas within Presbyterian St. Luke's Medical Center and Rocky Mountain Hospital for Children that utilize Meditech to document a patient's Provision of Care (e.g. Pediatrics, PICU and all adult inpatient units except Mom/Baby).

PURPOSE:

To outline clinical documentation requirements that Presbyterian/St. Luke's Medical Center and Rocky Mountain Hospital for Children (P/SL& RMHC) have established to support coordinated, patient-centric care processes, including the assessment, plan of care and interventions, within an electronic documentation system environment.

POLICY:

P/SL strives for patient-centered care, where the patient is the primary decision-maker in their care. The patient's decisions and preferences are honored by the care team as reflected in the plan of care and the provision of care. For our pediatric patients in RMHC, we provide family-centered care where family decisions/ preferences are honored by the care team and where appropriate age and developmental comprehension levels are considered in all decision-making regarding the provision of care.

Patient-centered care is evidenced in interdisciplinary processes of care, care planning, and clinical documentation. The Clinical Care Classification (CCC) taxonomy, a component of SNOMED-CT, is the organizing framework for care planning and care documentation within the electronic health record.

Documentation in the electronic health record is focused on patient care activities, clinical decisions and patient response to care. Documentation elements must serve at least one of these purposes to be included:

- Necessary for patient care
- Required by regulatory or billing authority
- Needed for data reporting AND not overly burdensome to the care giving process

Key elements of the patient-centered electronic health record are:

A. History

B. Screening and risk assessment

C. Individual considerations for care

D. Assessment

E. Plan of care

F. Care Activities

History:

A. For inpatients, past medical history, allergies, immunizations, family medical history information and home medication list data collection is shared by clinical staff, including physicians. For outpatients, compiling a focused past medical history, allergies, immunizations and home medication list is a shared responsibility of the clinical staff, including physicians.

Recall functionality is used extensively in patient history to facilitate continuity of care. Recalled data is validated during the patient history process.

If patient or family is able to provide or validate history, the data collection is completed within 24 hours of admission or prior to any invasive treatment.

Screening and Risk Assessment:

Patient screening and risk assessment addresses each domain of the CCC framework: health behavior (safety), functional, physiological, and psychological components.

A. First point of care contact (POC) screening occurs upon arrival to the facility or as soon as the patient's condition allows. POC screening identifies patients with symptoms suggestive of a communicable disease. Patients with positive screens are provided with appropriate protective equipment immediately and placed into an appropriate treatment area as soon as possible.

B. Patients admitted to inpatient locations are also screened for current or prior history of MRSA. If screening is positive, patients are provided with appropriate protective equipment and placed into an appropriate treatment area as soon as possible.

C. Nutritional Screening is performed for inpatients and any outpatients with concerning symptoms. Positive screens are referred for nutritional evaluation.

D. Functional Screening is performed for inpatients and for any outpatients with concerning symptoms. Positive screens are referred for physical therapy evaluation.

E. Risk for falls is assessed for inpatients. Inpatients with positive screens are provided with appropriate supervision and fall prevention interventions. (Refer to Fall Prevention guidelines)

F. Suicide risk screening is performed for inpatients and emergency department patients with behavioral indicators. Patients with positive screens are provided with appropriate monitoring and referrals for psychiatric evaluation.

G. Abuse assessments/screenings will be performed for both inpatient and outpatients.

Positive screenings identify potential problems for the plan of care and/or identify the need for additional assessment by specialists to determine if a problem exists. Notification of positive screens are entered into the electronic documentation system. (i.e. order for specialists)

Individual Considerations for Care:

A. Individual Considerations for Care are identified during the history and assessment process. These findings are used by each member of the care team in planning and providing care for the individual patient throughout the episode of care.

1. Cultural / Spiritual considerations
2. Hearing / Sight impairments
3. Language Barriers/Preferred language for healthcare communication
4. Developmental level
5. Other respectful considerations (PTSD)
6. Legal considerations (organ donor, advanced directives, POA)
7. Need for assistive devices
8. Discharge planning needs
9. Educational needs and abilities

Assessment and Reassessment:

A. The initial assessment is done upon admission or initiation of service by a licensed professional. For inpatients, the initial assessment is completed per unit/ department standards.

The four domains of the CCC (Functional, Behavioral, Physiological and Psychological) provide the framework for initial assessment and reassessment.

Registered Nurses perform and document assessments. Nursing assistants may assist with assessment by collecting data and entering it into the clinical documentation record. RNs are responsible for reviewing and analyzing the data, drawing conclusions and taking appropriate actions.

A Within Defined Parameters/Limits (WDP/WDL) format is used for patient assessments and reassessments.

A. Documentation will indicate that the patient met the defined parameters OR
B. Documentation will describe variations from the defined parameters
C. The content of the WDP/WNL statement is visible to the clinician during documentation
D. "Recall" functionality is not used for patient assessment documentation
E. Routine care components, including environmental safety interventions that are defined in policies and procedures will be documented as a "bundle" using the WDP/WDL approach.

A Charting by Exception method of documenting findings is used based on clearly defined standards of practice and predetermined criteria for assessment findings and interventions. Blank boxes or spaces represent None, Absence of, or Not Applicable. Only significant findings or exceptions to the patient's baseline are documented in detail.

Reassessment frequency is defined by each inpatient and outpatient care area based on the usual course

of care for the patient population. Reassessment is also undertaken whenever a change in patient condition is identified and at key points in the treatment.

Reassessments are performed at key points in the treatment process, at change of shift, or at transition of caregiver or care unit.

Frequency of vital signs monitoring is defined by each care area. More frequent vital signs monitoring is required during and after procedures, in relation to specific medications or treatments, whenever a change in condition is identified, and within two hours prior to patient discharge.

Plan of Care:

A. The Plan of Care is with each professional involved in the patient's care contributing to the plan by identifying problems, establishing goals, setting timeframes, and prescribing interventions. Based on the comprehensive assessment and patient and family input, the appropriately credentialed clinician within each discipline will identify the problems that are the priority focus areas for this episode of care. The comprehensive list of interdisciplinary problems is derived from the CCC taxonomy.

   The clinician assigns an expected outcome and timeframe for each problem added to the Plan of Care. The expected outcome for each problem will either be to improve/resolve or to stabilize/maintain. For specific patient populations (rehabilitation, behavioral health), the clinician will add measurable goals to the expected outcome.

   For each problem added to the Plan of Care,the nurse will need to document re-assessment interventions. The interventions are derived from the CCC taxonomy and may reflect four action types:

   A. Assess / Monitor: Collect and analyze data on the health status
   B. Perform / Care: Perform a therapeutic action
   C. Manage / Refer: Coordinate care process
   D. Teach / Instruct: Provide knowledge and skill

   The Plan of Care is documented daily and updated as needed based on changes in the patient condition and progress toward identified outcomes or goals. Progress is documented as Improved, Stabilized, or Deteriorated, as defined by the CCC taxonomy. The daily focus/goal for the patient is identified at the beginning of the shift, usually during bedside handoff. The daily goals should be written on the white board at bedside to assure that all members of the care team, including the patient and their family are aware of the goals for the day.

Care Activities

A. **Routine Care** activities appear on the worklist for each patient. These interventions are not tied to problems or goals and are not a part of the Plan of Care. Routine care activities include:

   1. Admission history
   2. Assessment
   3. Vital signs/ht & wt measurements
   4. Safety/risk/regulatory

5. Intake & output
6. Pain management
7. Teach/Educate
8. Lines, Drains and Airways (LDA)
9. Activities of Daily Living (ADL): hygiene care/ meals/ ambulation (repositioning)

Discharge plan summarize key elements of post-discharge plan of care, including medications, diet, activity and follow-up, signs and symptoms when to notify physician care arrangements.

Patient Notes are used in a limited capacity to document unusual assessments or events that are not addressed in the standardized documentation.

Patient hand-offs follow a prescribed script with review of key elements of the electronic health record to assure a complete and thorough transfer of information and care responsibilities. For inpatient units, staff will review the patient status and pertinent elements of the treatment plan when transitioning care. Hand-off is a communication process and is not documented in the patient record.

Attachments

No Attachments

Approval Signatures

Approver	Date
Michelle Grimpo: VP of Quality	October 9th, 2020
David Leslie: CNO	September 28th, 2020
Michelle Robinson: Director of Risk and Patient Safety	September 28th, 2020
Michelle Grimpo: VP of Quality	September 23rd, 2020
Laura-Anne Cleveland: ACNO	September 23rd, 2020
Gregory Goerke: ACNO - Adults	August 5th, 2020
David Leslie: CNO	August 5th, 2020

Applicability

Presbyterian/St. Luke's Medical Center