MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

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Nursing Documentation of Care Guideline

Purpose

The purpose of this guideline is to outline nursing documentation standards and requirements related to patient care.

This guideline applies to all University of Michigan Health System nursing staff documenting patient care.

Definitions

A. **Care Plan Note (Patient Care Note)**: Narrative note documented in the patient's record by a registered nurse that is devoted to the patient's plan of care.

B. **Charting by Exception:** Term used to describe a documentation method where only deviations from defined assessment elements or, a variation from a standard of care is documented. The purpose is to reduce documentation effort.

C. **Co-signature**: A second signature added to documentation typically when the initial signer cannot independently document due to their scope of practice or safety checks put in place by the organization. The co-signature indicates that the co-signer has reviewed the documentation, believes it is accurate, complete, and/or reflects the care given by the initial documenter.

D. **Copy Forward:** The ability for patient care staff to copy forward assessment data in the electronic health record (EHR) from one time column to another as long as the current assessment aligns with the previous assessment data.

E. **Disposition**: Level of care patient is advised to seek based on symptom reporting and nursing assessment at the conclusion of the encounter.

F. **Electronic Signature**: The generation of a human-readable "mark" on an electronic document / record, which attests to the fact that the record / document was generated, reviewed, or endorsed by that individual solely authorized to use the mark. The electronic signature shall carry the same level of authority for the authentication of medical record reports within UMHS as an individual's handwritten signature.

G. **Encounter Summary**: An aggregate collection of details from a particular encounter which may include reason for visit or call, notes, assessment, disposition, care advice and protocols.

H. **Electronic Health Record (EHR)**: Digital version of a patient's medical chart. A patient's chart that is real time patient centered record that makes information available instantly and securely to authorized users.

I. **Graduate Nurse**: Person who has graduated from nursing school and is qualified to take state boards for a nursing license but has not yet obtained official RN licensure.

J. **Health Information Management (HIM):** Applies to health and health care and is the practice of acquiring, analyzing and protecting digital and traditional medical information vital to providing quality patient care.

K. **Monitor Capture**: Data transferred from the bedside monitor to the electronic medical record.

L. **Mutual Goal Setting**: Process that involves nursing staff partnering with patients and families to identify mutual goals.

M. **Narrative Note**: A note written by nurses to communicate a part of the patient's story during the time they cared for the patient.

N. **Medical Record:** Please see UMH Medical Record Requirements Policy (Includes Medical Record Form and Electronic Signature) 03-09-001

O. **Nursing Admission Process**: Elements that the nurse must complete for patients admitted or in anticipation of admission to an inpatient unit. These elements include completion of the patient's history (patient story), performance and documentation of a patient assessment, performance and documentation of multiple safety and risk screenings, review of information gathered from other members of the multidisciplinary team and development of mutual goal(s). All elements to be completed are outlined in the Nursing Inpatient Admission Process.

P. **Patient Assessment**: Assessment is a continuous process that uses multiple nursing skills. It consists of the purposeful collection, classification, and analysis of data from a variety of sources. The nurse must consider information about the patient's biophysical, psychological, sociocultural and spiritual background. The nurse uses this information for problem solving and decision making.

Q. **Patient Care Plan**: Describes the intentional plan around the care of the patient to facilitate achievement of mutual goals and desired outcomes.

R. **Patient/Family Education**: Education and verification of knowledge on disease management/self-care activities that the patient/family will need to perform to carry-out the treatment plan. Examples include medication use, diet, activity, equipment and pain management.

S. **Privileged Provider**: Licensed independent practitioners (i.e., MD, DO, Dentist, Psychologist) and advanced practice professionals under physician delegation (PAs, NPs, CNMs, CRNAs).

T. **Shift**: Length of time a nurse is to care for his or her patients. The shift for each patient's care ends when the nurse hands off to another nurse who will assume care for the patient. This does not include hand-offs for short periods of time such as lunch or leaving the unit to accompany another patient to a test.

U. **Student nurse**: A student enrolled in a diploma, associate degree, baccalaureate, or graduate degree nursing program.

V. **Validation**: Method for confirming data transfer from a physiological monitor or device (vital signs, ventilator data etc.) into the electronic medical record.

W. **Within Defined Limits (WDL)**: Specific type of documentation by exception related to a patient assessment.

Procedures/Actions

A. Principles of nursing documentation

1. Documentation of nursing care is recorded in the medical record and is reflective of the care provided by nursing staff.
2. Nursing care documented in the medical record will be accurate, complete, and legible.
3. Nursing care will be documented in real time, as close to the time that care was provided and information obtained as possible. Documentation will not be recorded in advance of care being provided.
4. Each entry will contain a date, time and signature of the nurse recording the documentation.
    a. Electronic nursing documentation that is not automatically time stamped and signed when the documentation is entered will have an electronic signature signed by the RN within 30 days of the patient encounter or by discharge. https://michmed-clinical.policystat.com/policy/6411559/latest/
5. Nursing documentation will provide a chronological time line of nursing care provided.
6. Each nursing role (e.g. RN, LPN, Unlicensed Assistive Personnel, nursing student, graduate nurse) will document care delivered that is within the scope of their practice.
7. Only abbreviations approved by UMHS will be used in the medical record; MedAbbrev
8. Fields and/or variables that do not pertain to the patient's care/condition can be left blank.
9. Physiologic patient information (e.g. vital signs) captured by monitors or other data captured by pieces of equipment that are pulled into the nursing documentation sections of the patient's medical record will be validated/confirmed by the RN or provider.
10. Copy forward function may be used as available in the EHR. The nurse must review, edit and ensure the accuracy of data copied forward.
11. Documentation on paper will be completed using a blue or black ink pen.
12. Changes, additions and deletions to nursing documentation will be made in accordance with the UMH Medical Record Requirements Policy
13. The inpatient licensed practical nurse (LPN) will document their care provided to patients. An RN will collaborate with the LPN in documentation of a care plan note regarding mutual goal setting, analysis of the interventions performed and the patient response, and the plan moving forward. The RN will review, edit and co-sign patient care notes entered by the LPN.
14. In the ambulatory care setting LPN documentation is not reviewed or co-signed by the RN.
15. Nursing Student and Graduate Nurse Documentation
    a. A designated RN and/or Faculty will supervise care provided by student nurses. The RN or Faculty will review and co-sign all documentation entries by the student nurse.
    b. The RN preceptor will oversee care and cosign all documentation completed by a graduate nurse.
    c. The graduate nurse will not pass medication or document on the medication administration record (MAR). Nursing Medication Administration
16. Electronic documentation templates and paper forms utilized by nursing must meet requirements established by UMHS Health Information Management (HIM). UMH Medical Record Requirements Policy

B. Documenting nursing care and assessments.

1. UMHS Nursing uses a combination of documentation methods:
    a. Charting by exception (WDLs) for assessment only
    b. Documenting changes
    c. Set, periodic documentation
    d. Encounter documentation
2. For each encounter within UMHS a patient will have documentation using the appropriate form and system for the respective area (inpatient, outpatient, ambulatory care, procedure areas).
3. Documentation of assessments, interventions and education will reflect the time they are completed.
4. WDL's can be utilized to document assessments when the definition is immediately available for the documenting clinician and the clinician has assessed all elements within the definition.
5. The frequency by which the assessment or care will be documented should align with the corresponding policy, guideline, or standard of care for the unit/area.
6. The inpatient nurse will follow the guideline for Nursing Inpatient Admission Process to complete all required documentation for admission of a patient.
    a. Additional pertinent information about the patient will also be collected and documented as deemed appropriate by the RN
7. Nursing care surrounding the application of medical devices, initiation of treatments, or interventions, will be documented at the time they are applied or initiated and according to the following:
    a. On-going therapies or treatments (e.g. application of sequential compression devices, orthopedic device application) will be documented at the beginning of each nurse's shift, with any changes (e.g. removal, change in limb, etc.) or during the home visit.
    b. Exceptions to this are interventions governed by regulatory agencies and/or UMHS policies that require more frequent documentation of the device, treatment or intervention (e.g. restraints, blood transfusion).

C. Plan of Care

1. The patient will have a plan of care that is reflective of the data gathered and includes sources such as provider notes, orders, nursing notes, allied health notes and information obtained from the patient/family. The plan of care will be applicable and appropriate to the venue where the patient is receiving care.
    a. Inpatient Setting
        i. The plan of care will also include evidence-based care plans that are the most relevant to the patient/family and their clinical condition.
        ii. The anticipated end date for those evidence-based care plans will be appropriate for the patient/family and their clinical scenario.
            - When the anticipated end date is known, it should be entered.
            - When not known and for certain care plans, the time of transfer and/or time of discharge is appropriate to use.
            - Care plans will be resolved when they are no longer applicable to the patient.
        iii. The progress to the patients plan of care should be documented every shift for inpatients

and daily and as needed for patients cared for at home.

2. The discussion and plan of care related to substantial changes in patient care should be documented in the medical record.
3. A note reflective of the patient's response to care provided and progress in the care plan will be entered into the medical record as appropriate for where the patient is receiving care.
    a. Outpatient and ambulatory care nursing notes will correspond with patient encounters and interventions that are recommended or performed.
        i. Additional information from the EHR including flow sheets, vital signs, smart forms, goals or patient instruction may be brought into the documentation.
        ii. The outpatient nurse will update the EHR as needed with new patient information including demographics, allergies, medication review, and preferred patient pharmacy.
    b. Procedure areas will document nursing care, interventions and patient responses corresponding to the time the patient is in their care.
    c. Inpatient notes will reflect progress in the care plan and will be entered into the medical record to communicate to all members of the health care team the mutual goal(s) for the day and stay. The note will focus on the patient's response to interventions performed and the plan moving forward. The frequency of the note will be driven by the nurse's assessment of the patient's condition and the patient's response to interventions, at minimum daily.

D. Patient/Family Education and Leave on Pass
    1. Nurses will document patient/family education in the medical record. Documentation will include the patient/family response and retention of information provided as well as contact information for concerns/questions after discharge. UMH Patient and Family Education Policy and Procedure 03-07-020
    2. Leave on Pass: When a patient leaves the hospital for a temporary period of time on a provider's written order (a leave on pass) the patient's status is assessed and documented. On return from leave, a focused reassessment of status, including the patient's reported adherence to medication or other therapeutic plan will be documented.

Exhibits

References

A. References
The Joint Commission
Press Ganey
Wong D, & Hockenberry M. Nursing Care of Infants and Children. St Louis: Mosby; 2003.

B. Search Terms: Nursing Documentation, Nursing Plan of Care, Nursing note

Related Policies/Guidelines/Standards/ Procedures

A. UMH Patient and Family Education Policy and Procedure

B. UMH Medical Record Requirements Policy 03-09-001

C. Nursing Medication Administration

D. Nursing Inpatient Admission Process

Author(s), Consultant(s)

Nursing Documentation Committee

Reviewed and Approved by:

Evidence-Based Nursing Standards Committee, April, 2014; September 2016; August 26, 2020; January 7, 2022 (Hospital Care at Home verbiage only)
Chief Nurse Executive: August 28, 2020; January 7 (Hospital Care of Home verbiage only)

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Original guideline documents are held by the Evidence-Based Nursing Standards Committee. Direct questions to Nurse-EBS_Administration@med.umich.edu.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
CNE Delegate	Lori Wenzel: Admin Specialist Inter Health	01/2022
EBS Delegate	Lori Wenzel: Admin Specialist Inter Health	01/2022
Policy Owner	Denise Roberts: Clinical Nurse Specialist	12/2021

Applicability

UMHS Clinical