Disaster Nursing Clinical Documentation Plan During COVID-19 Surge Emergency

Effective only when the California Department of Public Health (CDPH) has approved this plan and the Hospital Command Center has separately and specifically activated this plan in writing and designated specific units subject to the plan, pursuant to the provisions below.

Who May Perform This Procedure:				**Population:**	
RN	**X**	**Ambulatory**		**Pediatrics**	**X**
LVN		**Inpatient**	**X**	**Adolescents**	**X**
HSA	x	**APS**		**Adults**	**X**
MA					
MUC					
HSR	x				
Techs	x				

I. POLICY

A. The Disaster Nursing Clinical Documentation Plan ("Plan") will be effective **only** when (a) the Hospital Command Center, in consultation with the Chief Nursing Officer and Nurse Executive at each hospital site, declares in writing that the Plan is activated and which units will be subject to the Plan; and (b) notice has been provided by the facility's designee to the California Department of Public Health (CDPH) and CDPH has approved the request. **Units that are not subject to the Plan as specifically activated by the Hospital Command Center in writing will continue usual and customary documentation per existing policy.**

B. The principal goal of the Plan when activated is to enable nursing staff to prioritize direct patient care at times of unusually high demand on nursing resources when modifications to clinical care documentation are necessary given the limited staff available to serve an unprecedented surge in COVID-19 patients who require care.

C. Nursing staff will follow the Plan outlined below when activated for the time frame and on the units designated in writing by the Hospital Command Center. The Hospital Command Center will designate which units are subject to the Plan when activated. The Chief Nursing Officer and Nurse Executive at each hospital site shall be responsible for the overall implementation and supervision of the Plan.

D. Nursing documentation under the Plan must still support safe and effective patient care and promote continuity of care among healthcare providers by communicating sufficient information. The Plan's documentation standards represent the minimum required documentation. When feasible, additional documentation above this minimum standard should be completed.

E. The Hospital Command Center, in consultation with the Chief Nursing Officer and Nurse Executive at each hospital site, will declare in writing when to end the activated Plan on each unit impacted.
F. The Plan shall be activated only when other attempts to obtain nursing personnel have been made and documented, and an assessment of the available resources including physical space, equipment, supplies, and personnel, indicate the need to implement the Plan.
G. All nurses working in units with modified standards will receive education on the documentation requirements and expectations under the Plan.

II. PURPOSE

A. To outline a process for reduced inpatient nursing documentation in the Electronic Health Record (EHR), provide initial and ongoing assessment guidelines, and define the scope and frequency of assessments and interventions based on patient needs.

III. PROCEDURE

1. Document at the beginning of each shift "COVID-19 Surge Documentation Reduction"
2. Admission/Initial Assessment
    a. Required Components
        i. Travel/Exposure/IP status of isolation precautions
        ii. COVID-19 screening
        iii. Advanced Directives
        iv. Suicide Risk
        v. Allergies
        vi. Vitals, Height, and Weight
        vii. Lines, Drains, Airways (as indicated)
        viii. Abuse Screening
        ix. Focused assessment
        x. Clinically relevant attending and consulting provider communication
        xi. Clinically relevant intake and output
        xii. Isolation precautions
        xiii. Invasive lines and tubes - lines, drains and airway (LDA) documented upon insertion or presentation. Ongoing assessment of LDAs will take place; documentation of care by exception (abnormal findings)
        xiv. Anything that, in the judgment of the nurse, would compromise patient safety if it were not documented
        xv. In addition, nurses will document a note at the end of each shift for clinically significant events if not documented elsewhere
3. Ongoing Assessments and Re-assessments to be completed during each shift. More frequent documentation may be needed based on provider orders.
    a. Vital Signs
        i. Intensive Care Units (ICU) – every 2 hours

ii. Progressive Care Unit (PCU) – every 4 hours and based on patient condition and provider orders
iii. Inpatient MedSurg care units – once a shift or q 8 hours, whichever is shorter

b. Fluid Balance/ Intake and Output
   i. ICU – every 2 hours
   ii. PCU – every 8 hours minimum, more frequent as per provider orders and patient condition
   iii. Inpatient MedSurg care units – once a shift

c. Systems Assessment
   i. ICU
      1. Every 8 hours
   ii. PCU
      1. Detailed assessment Q shift – Only document the exceptions. All else is within defined limits (WDL) unless otherwise noted.
      2. Focused assessment every 4 hours – Only document the exceptions. All else is WDL unless otherwise noted.
   iii. Inpatient Med/Surg care units
      1. Perform assessment Q shift – Only document the exceptions via nursing notes. All else is WDL unless otherwise noted.

d. Ongoing Assessment and Care
   i. Based on initial assessment and changes in patient condition.
   ii. Document by exception. "By exception" means that a notation is made only when there is a deviation from baseline, deviation from normal limits, or an unexpected outcome. If WDL, no need to expand documentation.
   iii. Complete documentation of ordered nursing interventions by end of shift.
   iv. Restraints will be documented and will include an attestation that the patient was checked every two hours and required elements of care were met.
   v. For constant observation, the note will attest to every 15-minute checks.

4. Ongoing patient education will continue to be performed, as required by each unit's guidelines of care. Documentation of this education in the medical record will be made by exception. However, discharge patient education will continue to be performed and documented for each patient as usual, as described below.
5. The RN shall document significant events using the EHR flowsheet or a plan of care note.
6. Care Plan documentation is not required unless pertinent to patient care. Specifically, Documentation of formal nursing diagnosis and care plans in the medical record will be eliminated. Instead of having the nursing care plan noted in one designated section of the medical record, nursing staff will be allowed to document the elements of the care plan within the existing documentation throughout the medical record.
7. Medication and Blood Administration
   a. Perform double checks and signatures for all high-risk medications. This may be done outside the room for infectious patients in isolation.
   b. RNs will administer medications following hospital policy.

c. All medication administration will be documented per hospital policy.

8. Discharge Documentation
   a. Use Discharge Navigator.
   b. Document completion of appropriate patient education.
   c. Ensure After Visit Summary is printed for patient.
9. Other nursing care that is provided (including but not limited to activities of daily living, hygiene, routine catheter and ostomy care, repositioning, infection control practices, etc.), will continue to be performed as required by each unit's guidelines of care, but documentation will be done by exception – for example, if a patient must be turned and repositioned Q2H, a note will be entered only if this is not done.

IV. REFERENCES

Centers for Medicare & Medicaid Services, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers* (Dec. 1, 2020), *available at* https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

Executive Department State of California, *Executive Order* 43-20 (Apr. 3, 2020), *available at* https://www.gov.ca.gov/wp-content/uploads/2020/04/4.3.20-EO-N-43-20.pdf.

California Hospital Association, *Requesting a Program Flex to Implement Surge Standards of Nursing Documentation,* *https://www.bing.com/search?q=california+hospital+association+requesting+program+flex+documentation+during+a+surge&src=IE-SearchBox&FORM=IENAE2*

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