Allina Academic Affiliations
Excellian Documentation Guidelines for Nursing and Respiratory Therapy Students

Documentation in the medical record is critical to assure the patient's episode of care is appropriately recorded, to facilitate ongoing communication among the interdisciplinary team of healthcare providers, and to maintain a record of historical data for audit, future care reference, and research.

Allina Health strictly enforces that any clinical student performing cares for a patient must be able to document the care given in the Excellian record. This requires the student have their own secure Excellian access. In order to receive Excellian access, the student must successfully complete the appropriate Excellian course, either web-based or instructor-led depending on the clinical role.

IT IS NOT PERMISSIBLE TO HAVE A PRECEPTOR OR OTHER STAFF MEMBER DOCUMENT ON BEHALF OF THE CLINICAL STUDENT. This is considered fraudulent charting. It exposes the student, preceptor, and clinical department to enormous risk.

Student Documentation Guidelines

All nursing and respiratory therapy students will document in the:

- MAR (Medication Administration Record)
- Doc Flowsheet
- I & O
- Vital Signs Flowsheet
- Notes when applicable

MAR (Medication Administration Record):

- PLEASE USE PATIENT SUMMARY REPORT TO VIEW MEDS INSTEAD OF THE MAR. The MAR should only be used for documenting administration of meds. This is the same view as the MAR but allows other RNs to simultaneously chart on the patient's MAR if necessary
- Clinical Instructor/RN preceptor must document nursing student medications as "double checked" in the Excellian MAR (medication administration record). Clinical Instructor/RN preceptor will log in to Excellian and document each medication as "double checked" as the nursing student prepares/obtains the medication from the Automated Dispensing Cabinet [ADC]. The nursing student will then enter the patients' room and log into the patient's Excellian MAR. The nursing student will document each medication as administered as the patient takes the medication. A licensed RN/RT must be present in the patients' room and supervise the administration of all medications by a student nurse/respiratory therapist.
- The above process also is used for Respiratory Therapy students who administer medications.

Notes:

- All students should add an additional line to their signature (or create a SmartPhrase) that says, "Jane Doe, University of MN Student Nurse" to add to their note so that it accurately reflects what role they are in while performing nursing skills.

- The Clinical Instructor/RN Preceptor/RN assigned to the patient will enter a simple nursing note (using a SmartPhrase) to concur with the correct documentation the student entered.

Patient Care Plan and Patient Education

Student nurses can (and should) collaborate with professional staff and interdisciplinary team members to update and individualize the care plan to meet patient needs and expected outcomes. Students should not be "meeting" goals in the patient care plan. Note this function should be performed by a licensed nurse ONLY. Student nurses should work with their preceptor on patient education documentation.

Prohibited Charting Activities

Because the patient record is a legal document, there are certain activities that require a professional license and cannot be performed by a clinical student. These include:

- **Students may not acknowledge orders or take verbal or telephone orders.**
- **Students may not advance the plan of care.**

Clinical Instructor Documentation Guidelines

When clinical instructors are on site with students they will document the following:

- MAR – the instructor will double check the students' meds while the student is preparing/obtaining meds from the ADC. These meds will be documented in Excellian as double checked PRIOR to the administration of the medication by the student. Please note, you must click on the empty space in the cell in order to chart as double checked not the time the med is scheduled to be given.
- Enter a simple nursing note (you may use a SmartPhrase) to concur with the documentation that the student entered. You are not agreeing with the assessment per se, you are only agreeing the documentation was entered correctly.

RN assigned to the patient with a student

The staff RN retains the assessment, supervision of care and evaluation for each patient assigned to a student. The RN assigned to the patient will be responsible for documenting an assessment on the patient. The RN assigned to the patient will document per the update group that they agree with the student's charting or document their own additional assessment.