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SCOPE

North Memorial Health Hospital (NMHH) and Maple Grove Hospital (MGH)

PURPOSE

To provide standard assessment and documentation expectations for care team members documenting in the electronic health record (EHR).

POLICY

1. Customers are assessed by multiple disciplines based on customers care needs, type of setting and type of care provided.
2. All customers have an initial assessment by RNs including screens for potential referral to other disciplines.
3. Each discipline completes an initial assessment and all ongoing assessments are based on the following:
    a. Customers diagnosis
    b. Customer/family needs
    c. Desire for care
    d. Response to previous care or treatment
    e. Care setting
4. Documenters using the EHR are advised to avoid indiscriminately copying, pasting, or altering another person's progress note or flowsheet row information.
    a. Documenters are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported or reused.
    b. If any information is imported or reused from a prior note, the documenter is responsible for its accuracy and medical necessity.
5. Documentation should be done at the time care is given as the entries are all date and time stamped.
    a. A "late entry" note may be important for customer care and as a communication tool.

PROCEDURE

1. Complete initial physical assessment including pain assessment and vital signs per specific care center/department guidelines.
2. The initial nursing assessment will include but not be limited to:
    a. Allergies
    b. Admitting problem
    c. History of pain and current status
    d. Preexisting or other conditions (i.e. Pregnancy, COPD, Diabetes)
    e. Current mediations (what time last does, including any illicit drugs)
    f. Activities of Daily Living (ADL) needs

g. Dietary requirements/preferences

ADMISSION NAVIGATOR

1. Complete Admission Navigator within twenty four (24) hours of admission.
    a. Screen for problems/conditions which trigger a need for more focused assessments by nursing and/or other disciplines.
    b. When the navigator is initiated in one department but not completed, the admitting RN on the next department is to review the admission navigator and complete any sections not addressed as part of the admission process.
2. Assess and document education needs upon admission, which includes the following:
    a. Barriers to learning
    b. Methods of desired learning
    c. Involvement of family
    d. Information needs
    e. Factors affecting learning including cultural, religious, and motivation
3. Complete re-assessments based on population specific parameters, customer/family needs, desire for care, response to previous care or treatment and care setting.
4. Customers receiving end-of-life care will have a grief assessment including social, spiritual and cultural variables.

PLAN OF CARE

1. An individualized plan of care and customer education is developed and documented within 24 hours of admission and includes goals and interventions.
2. The care plan is reassessed and individualized to the customer once between the hours of 0700-1900 and also 1900-0700 and with condition changes, and includes the following:
    a. Goals which are consistent with the provider's plan for medical care
    b. Nursing interventions
    c. Evaluation of customer's progress toward the goals
    d. Reflection of findings on assessments, both physiological and psychosocial factors
    e. Discharge planning
    f. Interdisciplinary assessments (as applicable)
3. The care team member documents the customer's progress toward meeting the plan of care goals which have been the focus of care.
4. The care plan and customer education is resolved when goals are met, teaching completed or customer is discharged or transferred.

PROGRESS NOTES

1. Progress notes are used for documenting changes in condition or updates.

FLOWSHEET ROWS

1. Flowsheet rows being copied to the next or last column is allowed for selected assessment and flowsheet rows.
    a. Care must be taken to change values to reflect the changes in team member's observation.

2. Provider notifications including critical values will be documented on clinical flowsheets.

CUSTOMER EDUCATION

1. Education and training is provided to the customer and their family based on assessed needs.
2. Customer education and training is provided by all disciplines involved in the customer's care, treatment, and services.
3. RN communicates and educates the customer about follow-up care prior to transfer or discharge.
4. The customer and family educational process includes the assessment of their learning needs, preferences and readiness to learn. Considerations shall be given to:
   a. Barrier to learning
   b. Factors that affect learning
   c. Language
   d. Learning preferences
   e. Special topics
5. Customer education is required:
   a. Upon admission
      i. RN will initiate the Customer and Family Learning Assessment within 12 hours of admission and document in EPIC.
   b. Ongoing
      i. RN will document education in EPIC education tab.
      All other disciplines will document education as appropriate.
      ii. RN will review education needs daily and as customer's condition/outcomes change. Documentation will occur upon performance of education.
      iii. Elements of Medication Education* include:
         1. Medication name
         2. Dose
         3. Route of administration
         4. Intended use
         5. Expected action
         6. Potential side effects
         *Pharmacy is available as an additional resource to educate customers about their medications.
   c. At discharge
      i. The interdisciplinary team, including RNs, will provide education on the following:
         1. Review discharge instructions/education with the customer/family
         2. Assess and confirm customer's understanding of safe and effective use of discharge medications:
            a. Medication name, dose, route of administration, the intended use, and expected action.
            b. Significant side effects, interactions (food-drug/drug-drug), or therapeutic contraindications and how to avoid and respond to them.
            c. Special directions and precautions, including what to do in case of a missed dose at home.
            d. Proper storage, disposal and expiration.
         3. All education points in the education section of EPIC are to be resolved at discharge.

6. Resources for Customer Education Materials
    a. Emergency Room/Emergency Care Center and Inpatient: MicroMedex is utilized for customer and medication education in English and Spanish. This resource can be accessed via EPIC tools.
    b. Video On-Demand: These are educational videos that can be assigned based on the educational needs of the customer.
    c. Multilingual eXchange: This resource can be utilized when you need customer education materials translated into another language. This resource can be accessed via EPIC tools.
        i. Click on Multilingual eXchange link and log into the website:
            1. Log in Name: mmic
            2. Password: mmic
    d. Specialty Packets/Binders: There are educational packets available for specialty teaching/instruction.
        i. Examples: CHF, Ostomy Care, and Admission Folders.
        ii. Nutrition Care Manual for inpatient diet education can be accessed via intranet under patient education materials.

7. Documenting Customer Education
    a. ER/ECC:
        i. In a progress note and/or
        ii. In the Discharge/Admit Assess Outcome Assessment
    b. Surgical Services/PCC/PACU/Endo
        i. Documentation Flow sheets under Learning Assessment/Customer Education
    c. In-Patient Units (RN, Therapies, Nutrition Services, etc.)
        i. Select the Education Tab
        ii. Select The Manage Education Tab
        iii. Pick the Education Topic and Document:
        Learner - Readiness - Method -Response

DEFINITIONS

Care Team Member: a licensed or certified team member that develops plans of care or provides education and can document these tasks as part of their role.

REFERENCES

Assessment, Interdisciplinary (MGH)

Assessment, Interdisciplinary (NMHH)

TABLE OF REVISIONS

Date	Description of Change(s)
5.2018	Updated the policy to clarify when the care plan is reassessed and individualized. Updated ED/ECC resources to MicroMedex. Added hyperlink to reference.