

Department of Developmental Services

NURSING STANDARD

96.3 NURSING DOCUMENTATION

- A. The RN shall utilize the Nursing Process (**#NS 09.1**) in the provision of nursing care.
- B. All nursing documentation shall be entered into the individual's health record or master file.
- C. Licensed nurses (LPN's/RNs) shall use Focus charting for all documentation. Focus charting is a method of organizing information (**see Nursing Documentation Guidelines**).
- D. Upon admission or for any change of condition, an RN shall document a nursing assessment and action plan of care within a 24 hour period, or as determined by the RN, but not to exceed two working days.
- E. At the time of re-admission of a client from either an acute or long-term care facility the RN must document a re-assessment of the client's health care status/needs within a 24 hour period or as determined by the RN, but not to exceed two working days following discharge.
- F. A Licensed nurse shall document all nursing interventions and care provided for each individual, including telephone communications.
- G. A Licensed nurse shall document an evaluation of identified nursing needs when an individual's health status changes and/or as specified by regulation.
- H. A Licensed nurse shall document communication with community health care providers, (i.e. hospitals, clinics, physicians, and ER's etc.).
- I. When an individual moves to another residential facility, the RN shall document an evaluation of all health care needs, including history, current status and recommendations as part of the transition process.
- J. LEGALLY ACCEPTED DOCUMENTATION STANDARDS SHALL INCLUDE:
 - 1. All entries shall be documented in blue or black ink.
 - 2. When documenting, the licensed nurse shall sign off the entry with the date, time, first initial, last name and title (e.g. date, time, first initial, last name, title).
 - January 1, 2010, 10 a.m., J. Smith, LPN
 - 3. Charting corrections shall be made by drawing a single line through the incorrect statement/word, writing "omit" and initialing above the statement/word, and then entering the correct documentation.
 - 4. When an addendum is needed, the following shall be documented next to the current date: time, first initial, last name and title as follows:
 - current date and time
 - focus
 - addendum to notes of date and time of happening
 - signaturee.g. 1/1/10 2 p.m. addendum to notes of January 1, 2010 10 a.m., J. Smith, LPN
 - 5. When a late entry is needed, the following needs to be documented:
 - current date/time
 - focus
 - entry for date and time of happening
 - signature.e.g. 1/3/10 9 a.m. late entry for January 1, 2010, 10 a.m., J. Smith, LPN

Formulated: October 1, 1996

Approved:

Revised: December 21, 2010