

 <p>Connecticut Valley Hospital Nursing Policy and Procedure</p>	<p>SECTION B: THE NURSING PROCESS</p> <p>CHAPTER 7: NURSING PLAN OF CARE PROCESSES</p> <p>Policy and Procedure: 7.5 Integrated Progress Notes</p>
<p>Authorization: Nursing Executive Committee</p>	<p>Date Effective: May 1, 2018 Scope: Registered Nurses</p>

Standard of Practice:

The Registered Nurse (RN) documents nursing assessments, interventions, education, and patient response to nursing actions in accordance with professional standards related to the Nursing Process. All documentation adheres to Nursing Discipline requirements and the Hospital's Operational and Health Information Management Policies and Procedures for entries in the patient's medical record.

Standard of Care:

The patient can expect that information which reflects his/her progress in achieving short-term objectives and long-term goals, significant changes in his/her behavior or clinical condition, and/or potential elevation of risk will be documented in the medical record.

Policy:

The attainment of long-term goals, short-term objectives and other significant information shall be documented in the Integrated Progress Notes of the patient's medical record. Specifically, the patient's response to individualized nursing interventions.

The RN will document on the Injury Assessment Form for closed skin injuries such as fractures, or the Wound Care Flowsheet for wounds such as abrasions, skin tears, pressure ulcers, etc.

Procedure:

Documentation Schedule for the Registered Nurse

- On **Admission** to hospital: Daily for seven (7) days: Reference the last page of the Admission Nursing Assessment
- Weekly from the 2nd through 8th week (by first or second shift): Reference the Integrated Treatment Plan that includes short-term objectives with a nursing service/intervention.
- Monthly from the 9th week thereafter: Reference the Integrated Treatment Plan that includes short-term objectives with a nursing service/intervention.

- On **Transfer** within the hospital: Daily for seven (7) days, then Weekly for the next 30 days, then Monthly: Reference the Integrated Treatment Plan that includes short-term objectives with a nursing service/intervention.

Documentation Requirements for Registered Nurses

I. Routine Progress Note

Content Description

- **First Section**
 - A holistic discussion of how the patient is progressing in treatment
- **Second Section (Each short-term objective (Recovery & Medical) with a nursing intervention must be addressed)**
 - Write the word “Objective.”
 - Write a word or a few to identify which short-term objective you are referencing such as “Restoration to Competency” or” Hypertension.” The purpose for doing this is to identify which short-term objective is being referenced from the treatment plan.
 - Include specific data in the note
 - Number of times the behavior was observed, B/P range, etc.
 - Was the objective met, or not, are you recommending a modification of the short-term objective utilizing the criteria for measuring the short-term objective.
 - Address the next short-term objective with a nursing intervention until ALL have been addressed.
 - Sign your name and clearly print your name.

II. Treatment Notes and Alternative Treatment

Content Description

- These are recordings in the medical record that indicate the provision of, and a patient’s response to, a specific modality such as group therapy, individual therapy and/or any other specialized therapy ordered and prescribed in the plan of care.
- Examples include:
 - Group notes
 - Individual Health Teaching notes
 - Discipline specific engagements treatment notes
 - MHA providing specific engagement activities (CVH-674)
 - RN providing alternative treatment interventions for patients not attending a prescribed nursing group
- Treatment notes must include the following

- **Topic:** Describe the information that was reviewed and an overview of the content of the group/discussion
- **Understanding of the topic:** Describe the patient's demonstrated understanding of the content of the group/discussion (or the lack thereof).
- **Response:** The patient's response to the content provided.
- **Participation:** Describe the patient's participation in group (specifically describing patient's comments- include client quotes where appropriate and objective data regarding behaviors (e.g. number of times the behavior was observed, etc.)
- **Progress toward the Objective:** Describe the purpose of the treatment in terms of what the patient is supposed to get out of the group and what they are getting from the group - Describe revisions to the treatment intervention based on your assessment of the patient's progress.

Process

- All treatment notes must be labeled "**Treatment Note.**" This allows for a clear identification of the documentation related to delivery of a treatment intervention and for ease of identification.

Frequency

- There must be a treatment note in the medical record for every treatment (e.g., group therapy, one-on-one, etc.) prescribed in the treatment plan whether provided or not.
- Registered Nurses are to write **SEPARATE** Treatment Notes after every individual session they conduct based on the Active Treatment individual Intervention in the RMS - these are **not part of the monthly progress note.** (ex. if the active intervention is to meet weekly with the patient the RN would document and Label as Treatment Note weekly to discuss the Topic, understanding, response, participation and progress toward the objective)

Incidental (Special) Progress Note Entry Requirements

- **Significant changes** in behavior requiring special interventions such as:
Patient returned from Absent Without Leave (AWOL) status; significant changes in psychiatric status; assaultive behavior; suicide attempt; suicidal gestures or expressions of self-harm; special observations; restraint or seclusion episode; experience of/or exposure to trauma; possession of non-permissible items that are considered dangerous for that patient or the milieu; suspected substance use; inappropriate sexual behaviors; any illegal activities conducted by patient; significant increase in symptoms; persistent refusal of treatment interventions; level placed on hold; other specified by clinician.
- **Significant changes** in physical condition such as:
Patient received treatment at an acute care hospital to include inpatient admissions to the hospital and treatment received through the Emergency Department; significant change in medical condition; new medical condition of diagnosis; deterioration in medical status; medication reaction; if indicated by Fall Risk Assessment Process; other specified by clinician.

- Changes in observational status.

Documentation Schedule/Requirements for Licensed Practical Nurses, Mental Health Assistants and Forensic Treatment Specialists

- Once each shift for seven (7) days.
- Once weekly from day eight (8) to day thirty (30), by 1st or 2nd shift or Primary Nursing Contact (PNC)
- Once weekly by PNC and third shift thereafter.
 - Significant event
 - Response to admission process
 - Adaptation to ward routines
 - Ability to follow simple direction
 - Ability to perform activities of living.
 - Socialization with others.
 - Participation in scheduled activities.
 - Dietary intake.
 - Sleeping patterns.
 - Verbalized concerns.

Integrated Progress Note Instructions

1. All relevant progress notes will be referenced to the short-term objective in the current MTP/TPR.
2. Verify proper identification on the progress sheet (patient name, MPI#).
3. Record date, time, discipline, and information in blue or black ink.
4. Document in chronological order. Entries out of sequence must be identified as “late entry”.
5. Bracket an incorrect entry, draw a single line through it, write “error”, within the brackets, sign and date the error. ***Never erase or obliterate an entry using whiteout, magic marker, eraser mate pens, pencils, etc.***
6. Any blank lines on a Progress Note sheet, preceding or following an entry, may need to have a diagonal line or an “X” drawn through them.
7. Write neatly and legibly, sign name and classification. Print name and title clearly next to signature.
8. Document significant observations and treatment events (both psychiatric and medical).
9. A description of the patient’s response to nursing interventions will be documented daily until the condition is resolved or is integrated into the Master Treatment Plan (MTP). The MTP then guides the specific frequency of assessments and treatment response.

10. Record and identify all patient education provided. Any staff who provide education will utilize one or more of the following to determine comprehension.
 - a. Ask the patient to repeat or paraphrase instructions or key points presented.
 - b. Ask the patient to demonstrate the specific skill taught.
 - c. Ask the patient to identify one specific action they will take.
 - d. If problems are identified with reference to the patient's understanding, this should be noted along with planned actions to re-teach the material.
11. Describe the status of nursing interventions for the physical health problems identified in the MTP, in the weekly/monthly RN Summary Notes, or as indicated.
12. Document physician notification of any physical or behavioral health related concerns, data reported and physician recommendations
13. Use only approved abbreviations. (see HIM P&P 6.4)
14. Record facts, not interpretations.