Northern Light Health℠

Title: Patient Assessment, Education, and Documentation	
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Authors: VP & Chief Nursing Informatics Officer VP & Chief Nursing Officer	
Executive Sponsor: VP & Chief Nursing Officer	Final Approver: VP & Chief Nursing Officer
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APPLICABILITY

☐ Northern Light Health adopts the following (and any Attachment(s)) for all its Member Organizations, specifically including, but not limited to, those listed below:

☒ Northern Light Health adopts the following (and any Attachment(s)) for its Member Organizations selected below:

- ☐ Northern Light Acadia Healthcare
- ☐ Northern Light Acadia Hospital
- ☒ Northern Light AR Gould Hospital
- ☒ Northern Light Blue Hill Hospital
- ☒ Northern Light CA Dean Hospital
- ☒ Northern Light Eastern Maine Medical Center
- ☐ Northern Light Health Foundation
- ☐ Northern Light Health Home Office
- ☐ Northern Light Home Care & Hospice
- ☒ Northern Light Maine Coast Hospital
- ☐ Northern Light Mayo Hospital
- ☐ Northern Light Medical Transport
- ☒ Northern Light Mercy Hospital
- ☐ Northern Light Pharmacy
- ☒ Northern Light Sebasticook Valley Hospital
- ☐ Work Health
- ☐ Other (list): _____

SCOPE

This Policy applies to all nursing staff conducting a patient assessment, performing direct patient care, providing patient education, and/or documenting within the Electronic Health Record (EHR).

This Policy excludes patients cared for on the East Wing at CA Dean Hospital.

RELATED POLICIES/PROCEDURES

System Policy 29-026, Clinical Use of the Northern Light Health Electronic Health Record
System Policy 22-048, Clinical System Downtime

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DEFINITIONS

Block Charting: A method of documenting rapid titrations during an urgent or emergent situation without documenting the incremental titration adjustments.

Minimum Documentation Guidelines: Documentation expectations for each patient for the specific defined workflow or shift. These guidelines are the least amount of information required to tell the patient story. The patient condition, acuity, and interventions dictate the remaining information needed to describe the patient assessment, care, and services.

Northern Light Health Philosophy of Documentation: High-quality documentation is an integral component of care delivery. Comprehensive and accurate documentation ensures accurate communication and reflects the care, treatment and services provided by all members of the care team. Documentation is an essential element of safe, quality, evidence-based nursing practice and promotes positive patient outcomes. An important part of clinical care is complete and timely documentation.

Northern Light Health does not endorse documentation by exception. It is the expectation that all members of the clinical care team will document the care, treatment, and services provided to ensure the EHR accurately reflects the patients' assessment and acuity.

Documentation:

A. Communicates quality of care provided
B. Tells the "patient story"
C. Helps guide the patient's treatment plan
D. Contributes to the longitudinal patient record that drives decision-making and the future delivery of high-quality care
E. Improves patient outcomes
F. Reflects patient acuity
G. Is completed in near-real time unless patient circumstance dictates otherwise

Patient Story: The information (data, documentation, patient assessment) contained within the EHR that describes the patient condition and communicates plan of care. All members of the healthcare team contribute to the patient story.

Social Determinants of Health (SDOH): Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes.

Urgent/Emergent Situation: An urgent/emergent situation is defined as a patient who needs quick/immediate attention with medications to prevent harm to self or loss of life.

PURPOSE

A. To ensure the care, treatment, and services required to meet a patient's initial and continuing needs using an organized, systematic approach.
B. To provide documentation expectations that promote communication of the Patient Story, meet regulatory requirements, and reflect the assessment process and delivery of care.

POLICY

A. Supporting Patient Assessment and Prioritization of Care

1. A patient assessment documents the physical and psychosocial needs of the patient during the provision of healthcare services. A patient assessment requires critical thinking, data collection, and analysis to develop an integrated, interdisciplinary plan of care based on the patient's status, defined needs, and venue of care. Prioritization of patient needs should occur upon identification, followed by the delivery of appropriate care. Care delivery should involve the patient, the family/support structure, and the healthcare team.
2. Prioritization of care is an ongoing interdisciplinary method of determining appropriate decisions in order to deliver high quality, safe patient care. Using a collaborative interdisciplinary approach, the prioritization of care provides patients and staff the information required to make an appropriate assessment and deliver effective care.
3. Patient assessment and prioritization of care requires high-quality, accurate documentation completed in a timely fashion.

B. Documentation within the electronic health record (EHR) must align with the scope of practice for the individual entering the data and should be comprised of data elements that tell the Patient Story and provide the RN the information necessary to assess the patient condition.
C. Students performing a clinical rotation will document the care, treatment, and services provided; however, the healthcare team member responsible for the patient is ultimately responsible for the accuracy of the documentation. Validation of the student's documentation is completed on the Verify Documentation PowerForm.
D. Non RNs may collect data and communicate to the RN concerns requiring assessment.
E. Staff is expected to perform near-real-time documentation.
    1. Near-real-time documentation ensures alerts and algorithms, available within the EHR, fire promptly to notify of any potential untoward patient events and to calculate patient care hours.
    2. When near-real-time documentation is not possible, documentation will reflect both the actual time the event occurred and the actual time the documentation is completed.
F. General Requirements and Expectations
    1. Height (measured in centimeters), weight (measured in kilograms), and allergies are completed on admission/intake as they are a critical component of the ordering process.
    2. All documentation will include the date, time (military), full signature (first initial and last name), and credentials (e.g. RN, LPN, CNA, CMA). Within the EHR, the user sign-on is equivalent to the full signature with credentials and is date/time stamped at the time of the entry. Note: when using initials on a paper record, a full signature corresponding to the initials must be located on the form.
    3. Documentation within the medical record will use professional language with attention to proper spelling and punctuation. Unapproved abbreviations and text language are not permitted (see attachment - list of approved abbreviations.
    4. Paper documents within the medical record must include the patient's name and medical record number recorded on each page of the paper document.

5. When handwritten entries are required within the medical record, the writing must be legible and written in black or blue ink. The use of gel pens is discouraged.

G. Patient Plan of Care
    1. A plan of care will be initiated on all patients admitted or undergoing a procedure within 24 hours of admission/procedure and will reflect the individualized patient problems and expected outcomes.
    2. The plan of care will be reviewed each shift and updated to reflect any change in patient condition or care needs.

H. Patient and Family Education
    1. Patient and family education are essential in promoting positive patient outcomes. The opportunity to provide patient/family education begins at the time of admission and is ongoing until the time of discharge. The patient's lay caregiver must be included in the education process to meet the patient's needs following discharge.
    2. Any member of the healthcare team who provides information or instruction to patients and/or families/support system is required to document the education.
    3. Education documentation standards are intended to:
        a. Promote an interdisciplinary awareness of and approach to patient/family education;
        b. Identify factors that may influence patient's/family's ability to learn, preference for learning, and readiness to learn;
        c. Demonstrate the patient/family understanding of education provided related to disease process, medication management, and/or treatment plan.

I. Discharge
    1. Discharge planning is an integral and essential process of any hospitalization and begins with the initial assessment and continues to evolve throughout the care continuum.
    2. All patients will receive education and instructions regarding their ongoing plan of care upon discharge. Written education will be provided in the patient preferred language when available.

J. Block Charting for Medication Titration
    1. Block Charting of medication titration is only used in Emergent/Urgent situations for critical patients (including trauma) cared for a critical care or procedural area, or the ED.
    2. The Block Charting episode is limited to four hours and includes the following information:
        a. Start and End Time
        b. Start, Maximum, and End Rate
        c. Physiological parameters and goal evaluated during the charting block (e.g., Mean Arterial Pressure, heart rate, etc.)
    3. A new block must be started if the Emergent/Urgent event goes beyond 4 hours.

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K. Patient Expiration Documentation
    1. NEDS Automated Referral Process
        a. Required for both heartbeating and asystolic deaths before a call is placed to New England Donor Services.
        b. This documentation ensures information is electronically sent to NEDS prior to the confirmation call and that the case number flows back into the patient's EHR.
        c. NEDS documentation is also required for registrations workflow following a death.
    2. To ensure Registration has the appropriate information to complete requirements following a death and release the body to the funeral director or other approved individual, the following documentation is required for all deaths.
        a. Medical Examiner notified
        b. Family notified
        c. Autopsy
        d. Name of Funeral Home
        e. Belongings

L. Corrections and Late Entries
    1. All entries in the medical record are permanent. When corrections are required in the EHR, staff will use the "Unchart" function then select the reason for the change. On paper documents, a strikeout of the entry will be made with a single line, authenticating with date/time and legal signature.
    2. Should the need arise for late entry documentation, the entry will be completed as soon as possible after the actual event. Within the EHR, proxy charting functionality is used if the entry is made by someone other than the original caregiver.
    3. Required components of late entry documentation are:
        a. Notation that the documentation is a late entry;
        b. Inclusion of the actual date/time the event occurred;
        c. Current date, time, and signature of the person completing the late entry.

PROCEDURE

1. **Minimum Documentation Guidelines *are not all-inclusive,* nor do they represent all patient situations or care setting needs. Complete and accurate documentation is dependent upon the patient condition and care requirements and is based on critical thinking, the patient assessment, and the nursing process.**
2. Expectations:
    A. **Provider Notification:** Documentation should be completed each time a provider is contacted regarding a patient care event, need, or request.
    B. **CareCompass Task:** Should be utilized throughout the shift to drive care and documentation and be reconciled prior to the end of each shift to ensure all tasks (medication and patient care) are complete.

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C. **Activities of Daily Living:** Documentation will be completed anytime hygiene, activity, and/or nutrition activities are completed.
D. **Pre-Procedure:** Before a bedside procedure, invasive procedure, or surgery, clinical staff will complete pre-procedure documentation, including vital signs completed within 2-hours of surgery.
E. **Nursing Note:** Nursing notes are used to summarize any patient event or concern when discrete documentation cannot capture a need or further explanation is required.
    i. One note will be used for the entire hospital stay. When entering a note, a "new" Nursing Note PowerForm will be opened (**do not modify** a previously documented nursing note from Forms Browser.
    ii. Documentation will be completed in reverse chronological order meaning the the newest information will be documented at the top of the Form.
    iii. Each note must start with the Date and Time.
    iv. If the character limit is reached during the patient stay:
        a. Open a new Nursing note
        b. Delete all previous notes
        c. Start a new note
F. **Pain Reassessment Post Medication Administration:** Patients will be reassessed for pain within 30 minutes for an IV medication and within 1 hour after a PO medication is given.

3. **Minimum Documentation Guidelines Table of Content:**

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A. Adult Med-Surg/Intermediate Level of Care Minimum Assessment and Documentation Guidelines

Admission Assessment and Documentation ***Utilizing the Admission Workflow MPage*** ***Required within 24 hours of Admission***	**Patient Assessment and Documentation** **Every Shift *OR*** **as Ordered, Per Policy, or Change in Patient Condition**
Allergies	**Adult Systems Assessment iView Band**
Admission History Adult	Head to Toe Physical Assessment
Infectious Disease Risk Screening	Morse Fall Risk Scale
General Info	Braden Assessment
Interpreter Services – per patient need	Annotated Narrative Note
Advance Directive	bCAM for patients 65 years of age and older
CSSRS (Columbia Suicide Severity Rating Scale	BMAT (Bedside Mobility Assessment Tool)
Nutrition	**Adult Lines Devices Procedures iView Band**
Sexuality and Reproductive	Central Line Necessity
Spiritual / Visitors	Foley Catheter Necessity
Social History *(Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)*	**Adult Quick View iView Band**
Social Determinates of Health	Nursing Handoff/Transport Communication
Procedure History	**Patient Education iView Band**
Education Needs	Education related to disease process, medication regimen, pain management, and plan of care
Influenza Screening: *Sept. 1 to April 30*	**Other Required Assessment and Documentation** **as Ordered, Per Policy, or Change in Patient Condition**
Pneumococcal Screening	
Problem History	**Adult Systems Assessment iView Band**
Home Medications	Vital Signs
Adult Systems Assessment iView Band	Pain Assessment / Reassessment
Height and Weight	Wound/Incision/Pressure Injury
Vital Signs *(if using BMDI associate monitor)*	**Adult Lines Devices Procedures Band**
Pain Assessment / Reassessment	Line Placement, Assessment, Care, & Reconciliation
Head to Toe Physical Assessment	**Adult Quick View Band**
Morse Fall Risk Scale	Activities of Daily Living
Braden Assessment	BMAT
4-Eyed Assessment (per hospital policy)	**Restraint iView Band**
Any Wound or Pressure Injury POA	Restraint Assessment / Reassessment
bCAM for patients 65 years of age and older	**Intake and Output iView Band**
BMAT	I&O
Adult Lines Devices Procedures iView Band	**eMAR**
Any invasive line, tube, or drain POA	Medication Administration and Response
Adult Education iView Band	IV Start and Stop Times
Education related to admission, disease process and plan of care	**Plan of Care**
Other Admission Requirements	**Discharge Assessment and Documentation** ***Utilizing the Discharge Workflow MPage***
Plan of Care	Nursing Discharge Summary Form
Patient Pharmacy	Follow-up
On Admission, Prior to Procedures Requring Anesthesia or Moderate Sedation, Change in Level of Care, and a Signification Change in Clinical Condition	Patient Education
	Ensure Med Rec Completed
	Ensure IV Stop Times Documented
What Matters Documentation	Vital Signs within one hour of discharge

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B. **Adult Critical Care Minimum Assessment and Documentation Guidelines**

Admission Workflow ***Utilizing the Admission Workflow MPage*** ***Required within 24 hours of Admission***	**Patient Assessment and Documentation** **Every Shift *OR*** **as Ordered, Per Policy, or Change in Patient Condition**
Allergies **Admission History Adult** Infectious Disease Risk Screening General Info Interpreter Services – per patient need Advance Directive CSSRS (Columbia Suicide Severity Rating Scale) Nutrition Sexuality and Reproductive Spiritual / Visitors Social History *(Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)* Social Determinates of Health Procedure History Education Needs Influenza Screening: *Sept. 1 to April 30* Pneumococcal Screening **Problem History** **Home Medications** **Adult Critical Care Systems Assessment iView Band** Height and Weight Vital Signs *(if using BMDI associate monitor)* Pain Assessment / Reassessment Head to Toe Physical Assessment Morse Fall Risk Scale Braden Assessment 4-Eyed Assessment (per hospital policy) Any Wound or Pressure Injury POA CAM (Confusion Assessment Method) Assessment **BMAT (Bedside Mobility Assessment Tool)** **Adult Lines Devices Procedures iView Band** Any invasive line, tube, or drain POA **Adult Education iView Band** Education related to admission, disease process and plan of care **Other Admission Requirements** Plan of Care Patient Pharmacy	**Adult Critical Care Systems Assessment iView Band** Head to Toe Assessment Morse Fall Risk Scale Braden Assessment Annotated Narrative Note CAM (Confusion Assessment Method) Assessment **BMAT (Bedside Mobility Assessment Tool)** **Adult Lines Devices Procedures iView Band** Central Line Necessity Foley Catheter Necessity **Adult Quick View iView Band** Nursing Handoff/Transport Communication **Patient Education iView Band** Education related to disease process, medication regimen, pain management, and plan of care
	Focused Assessment every 4 hours *OR* **as Ordered, Per Policy, or Change in Patient Condition**
	Adult Critical Care Systems Assessment iView Band Vital Signs / Hemodynamic Monitoring Physical Assessment Pain Assessment / Reassessment Wound/Incision/Pressure Injury **Adult Lines Devices Procedures iView Band** Line Placement, Assessment, Care, & Reconciliation **Adult Quick View Band** Activities of Daily Living **Restraint iView Band** Restraint Assessment/Reassessment **Intake and Output iView Band** I&O **eMAR** Medication Administration and Response IV Start and Stop Times
	Discharge Workflow ***Utilizing the Discharge Workflow MPage***
	Nursing Discharge Summary Form Follow-up Patient Education Ensure Med Rec Completed Ensure IV Stop Times Documented
On Admission, Prior to Procedures Requring Anesthesia or Moderate Sedation, Change in Level of Care, and a Signification Change in Clinical Condition	
What Matters Documentation	

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C. Pediatric Critical Care Minimum Assessment and Documentation Guidelines

Admission Workflow ***Utilizing the Admission Workflow MPage*** ***Required within 24 hours of Admission***	**Patient Assessment and Documentation** **Every Shift *OR*** **as Ordered, Per Policy, or Change in Patient Condition**
Allergies	**Pediatric Critical Care Systems Assessment iView Band**
Admission History Pediatric	Head to Toe
Infectious Disease Risk Screening	Humpty Dumpty Fall Risk Scale
General Info	Braden QD Assessment
Interpreter Services – per patient need	Annotated Narrative Note
Advance Directive	**Pediatric Lines Devices Procedures iView Band**
CSSRS (Columbia Suicide Severity Rating Scale)	Central Line Necessity
Nutrition	Foley Catheter Necessity
Sexuality and Reproductive	**Pediatric Quick View iView Band**
Spiritual / Visitors	Nursing Handoff/Transport Communication
Social History *(Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)*	BMAT (Bedside Mobility Assessment Tool)
	Patient Education iView Band
Social Determinates of Health	Education related to disease process, medication regimen, pain management, and plan of care
Procedure History	
Education Needs	**Focused Assessment every 4 hours *OR*** **as Ordered, Per Policy, or Change in Patient Condition**
Influenza Screening: *Sept. 1 to April 30*	
Problem History	**Pediatric Critical Care Systems Assessment iView Band**
Home Medications	Vital Signs / Hemodynamic Monitoring
Adult Critical Care Systems Assessment iView Band	Physical Assessment
Height and Weight	Pain Assessment / Reassessment
Vital Signs *(if using BMDI associate monitor)*	Wound/Incision/Pressure Injury
Pain Assessment / Reassessment	**Pediatric Lines Devices Procedures iView Band**
Head to Toe Physical Assessment	Line Placement, Assessment, Care, & Reconciliation
Morse Fall Risk Scale	**Pediatric Quick View Band**
Braden Assessment	Activities of Daily Living
4-Eyed Assessment (per hospital policy)	**Restraint iView Band**
Any Wound or Pressure Injury POA	Restraint Assessment/Reassessment
Pediatric Lines Devices Procedures iView Band	**Intake and Output iView Band**
Any invasive line, tube, or drain POA	I&O
Pediatric Education iView Band	**eMAR**
Education related to admission, disease process and plan of care	Medication Administration and Response
	IV Start and Stop Times
Other Admission Requirements	**Discharge Workflow** ***Utilizing the Discharge Workflow MPage***
Plan of Care	
Patient Pharmacy	Nursing Discharge Summary Form
	Follow-up
	Patient Education
	Ensure Med Rec Completed
	Ensure IV Stop Times Documented

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D. Swing and Skilled Level of Care Minimum Assessment and Documentation Guidelines

Admission Assessment and Documentation ***Utilizing the Admission Workflow MPage*** ***Required within 24 hours of Admission***	**Within 5 Days of Admission** **Minimum Data Set (MDS) – Swing Bed PPS**
Allergies **Admission History Adult** Infectious Disease Risk Screening General Info Interpreter Services – per patient need Advance Directive CSSRS (Columbia Suicide Severity Rating Scale) Nutrition Sexuality and Reproductive Spiritual / Visitors Social History *(Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)* Social Determinates of Health Procedure History Education Needs Influenza Screening: *Sept. 1 to April 30* Pneumococcal Screening COVID-19 Screening **Problem History** **Home Medications** **Adult Systems Assessment iView Band** Height and Weight Vital Signs *(if using BMDI associate monitor)* Pain Assessment / Reassessment Head to Toe Physical Assessment Morse Fall Risk Scale Braden Assessment 4-Eyed Assessment (per hospital policy) Any Wound or Pressure Injury POA BMAT (Bedside Mobility Assessment Tool) **Adult Lines Devices Procedures iView Band** Any invasive line, tube, or drain POA **Adult Education iView Band** Education related to admission, disease process and plan of care **Other Admission Requirements** Plan of Care Patient Pharmacy	**Section B: Hearing, Speech and Vision** **Section C: Cognitive Patterns** **Section D: Mood** **Section E: Behavior** **Section G: Functional Status** **Section H: Bladder and Bowel** **Section J: Health Conditions**
On Admission, Prior to Procedures Requring Anesthesia or Moderate Sedation, Change in Level of Care, and a Signification Change in Clinical Condition	**Focused Patient Assessment and Documentation** **Once Every 24 Hours *OR*** **as Ordered, Per Policy, or Change in Patient Condition**
What Matters Documentation	**Adult Systems Assessment iView Band** Vital Signs Head to Toe Physical Assessment Morse Fall Risk Scale Braden Assessment BMAT (Bedside Mobility Assessment Tool) Annotated Narrative Note with documentation on progress towards goal **Adult Lines Devices Procedures iView Band** Central Line Necessity Foley Catheter Necessity **Adult Quick View iView Band** Activities of Daily Living Nursing Handoff/Transport Communication **Patient Education iView Band** Education related to disease process, medication regimen, pain management, and plan of care **Plan of Care**
	Other Required Assessment and Documentation **as Ordered, Per Policy, or Change in Patient Condition**
	Adult Systems Assessment iView Band Pain Assessment / Reassessment Wound/Incision/Pressure Injury **Adult Lines Devices Procedures Band** Line Placement, Assessment, Care, & Reconciliation **Restraint iView Band** Restraint Assessment / Reassessment **Intake and Output iView Band** I&O **eMAR** Medication Administration and Response IV Start and Stop Times
	Discharge Assessment and Documentation ***Utilizing the Discharge Workflow MPage***
	Nursing Discharge Summary Form Follow-up Patient Education Ensure Med Rec Completed Ensure IV Stop Times Documented Vital Signs within one hour of discharge

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E. Women's Health: Obstetric Observation or Admission Minimum Assessment and Documentation Guidelines

Admission Workflow ***Utilizing the Triage/Ante/Labor Workflow MPage***	**Patient Assessment and Documentation** **Every Shift *OR*** **as Ordered, Per Policy, or Change in Patient Condition**
OB Triage (Outpatient/Observation iView Band	**Labor and Delivery iView Band**
Fetal Monitoring Annotations per FetaLink	Fetal Monitoring Annotations per FetaLink
FHR Monitoring	FHR Monitoring
Contraction Information	Contraction Information
Vital Signs	Vital Signs
Hypertension Management (as applicable)	Hypertension Management (as applicable)
Activities of Daily Living	Activities of Daily Living
Environmental Safety Management	Environmental Safety Management
OB Subjective Data	OB Subjective Data and OB General Information
OB General Information	Cervical Exam (as applicable)
Cervical Exam (as applicable)	Membranes Status
Membranes Status	Obstetrical Bleeding
Obstetrical Bleeding (as applicable)	Pain Assessment / Reassessment
Pain Assessment / Reassessment	IV Drips (as applicable)
IV Drips (as applicable)	Psychosocial OB
Psychosocial OB	Domestic Violence
Domestic Violence	Nursing Handoff (as applicable)
Provider Notification	Maternal Charges
Nursing Handoff (as applicable)	PPH Risk Assessment
Maternal Charges	**OB Systems Assessment**
Admission	Head to Toe Physical Assessment
Maternal Fetal Triage Index (MFTI)	Morse Fall Risk Scale
Height/Dosing Weight	**OB Special Assessment iView Band (as applicable)**
Admission History OB PowerForm	Mechanical Cervical Ripening
ID Risk Screening including ID Risk Screening OB	Obstetrical Bleeding
General Info	Amnioinfusion
Subjective Data	Nursing TOLAC Checklist
Prenatal Info	Blood Product Transfusion
PPH Risk Assessment	Hypertension Management (as applicable)
Shoulder Dystocia Screening Tool	Seizure Assessment
CSSRS (Columbia Suicide Severity Rating Scale)	Fetal Neonatal Bereavement
Advance Directive	CIWA and/or COWS
Obstetrical History	Warming/Cooling
Birth Plan/Requests	**Adult Lines Devices Procedures iView Band**
Antepartum Note	Line Placement, Assessment, Care, & Reconciliation
Spiritual	**Intake and Output iView Band**
Social History *(Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)*	I&O (as applicable)
Social Determinates of Health	**OB Education iView Band**
Anesthesia/Sedation (when applicable)	Antenatal Education
Transfusion Reaction, OB (as applicable)	L&D Patient Education including post-partum hemorrhage, and hypertension/pre-eclampsia
Nutrition	**IV Start and Stop Times**
Education Needs	**Results Copy After Delivery and Every Shift**
Influenza Screening: *Sept. 1 to April 30*	**Induction of Labor**
Pneumococcal Screening	**Triage/Ante/Labor MPage**
Allergies	Patient Safety Checklist/Assessments
Home Medications	**Oxytocin**: Oxytocin in Use Checklist
Admission Workflow MPage	**TOLAC**: Nursing TOLAC
Allergies	**Epidural**: Pain Management OB
Home Medications	

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F. Women's Health: Postpartum Minimum Assessment and Documentation Guidelines

Patient Assessment and Documentation **Every Shift *OR*** **as Ordered, Per Policy, or Change in Patient Condition**
Recovery and Postpartum
PPH Risk Assessment
OB Systems Assesment
Vital Signs
Activities of Daily Living
Environmental Safety Management
Obstetrical Bleeding
Pain Assessment / Reassessment
IV Drips (as applicable)
Psychosocial OB
Domestic Violence
Provider Notification
Nursing Handoff (as applicable)
Maternal Charges
Head to Toe Assessment
Morse Fall Risk Scale
OB Special Assessment iView Band (as applicable)
Obstetrical Bleeding
Amnioinfusion
Blood Product Transfusion
Hypertension Management (as applicable)
Seizure Assessment
Fetal Neonatal Bereavement
CIWA
COWs
Warming/Cooling
Adult Lines Devices Procedures iView Band
Line Placement, Assessment, Care, & Reconciliation
Intake and Output iView Band
I&O (as applicable)
OB Education iView Band
Postpartum Education, pain management and plan of care
eMAR
Medication Administration and Response
IV Start and Stop Times
Results Copy every shift
Discharge Workflow ***Utilizing the Discharge Workflow MPage***
Discharge Summary Form
Follow-up
Patient Education
Ensure Med Rec Completed
Ensure IV Stop Times Documented

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G. Women's Health: Newborn Minimum Assessment and Documentation Guidelines

Admission Workflow ***Utilizing the Admission Workflow MPage***	**Patient Assessment and Documentation** **Every Shift *OR*** **as Ordered, Per Policy, or Change in Patient Condition**
Allergies	**Newborn Systems Assessment Band**
Admission History Newborn	Vital Signs
Infectious Disease Risk Screening	Measurements
General Info	Head to Toe Physical Assessment
Birth History	Umbilicus Assessment
Ballard Score	Humpty Dumpty Fall Risk Assessment
Family History	**Newborn Quick View Assessment**
Social History	Newborn ADLs
Feeding Plan	Breastfeeding Assessment (when applicable)
Education Needs	LATCH Score (when applicable)
Discharge Planning	Parental Involvement
Newborn Delivery Data Band	**Complete a Result Copy**
Newborn Delivery Data	**Other Required Assessment and Documentation as Ordered, Per Policy, or Change in Patient Condition**
Newborn Exam	
Security tags	Newborn I&O
Complete First Result Copy	N-PASS or NAS Eat Sleep Console
	eMAR
	Medication Administration and Response
	Plan of Care
	Newborn Lines Devices and Procedure Band
	IV Site Assessment (every hour if applicable)
	Discharge Workflow ***Utilizing the Discharge Workflow MPage***
	Result Copy
	Discharge Summary Form
	Follow-up
	Patient Education
	Ensure Med Rec Completed
	Ensure IV Stop Times Documented

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H. **NICU Minimum Assessment and Documentation Guidelines**

Admission Workflow ***Utilizing the Admission Workflow MPage***	**Other Required Assessment and Documentation as Ordered, Per Policy, or Change in Patient Condition**
Allergies **Admission History NICU** Infectious Disease Risk Screening General Info Birth History Family History Social History Social Determinates of Health Feeding History Educational Needs DC Planning **NICU Systems Assessment iView Band** Vital Signs Pain Assessment / Reassessment Physical Assessment 4-Eyed Assessment (per hospital policy) Humpty Dumpty Fall Risk Assessment **NICU Lines Devices Procedures iView Band** Any invasive line, tube, or drain POA **Newborn Neonate Patient Education iView Band** Education related to admission, disease process, pain management, and plan of care **Other Admission Requirements** Plan of Care	**NICU Systems Assessment iView Band** Vital Signs / Hemodynamic Monitoring I&O Pain Assessment / Reassessment NPASS Feeding Method Umbilical Assessment Wound/Pressure Injury **NICU Lines Devices Procedures iView Band** Line Assessment, Care, & Reconciliation **NICU Quick View iView Band** Activities of Daily Living **Intake and Output iView Band** I&O **eMAR** Medication Administration and Response IV Start and Stop Time
Patient Assessment and Documentation **Every Shift *OR*** **as Ordered, Per Policy, or Change in Patient Condition**	**Discharge Workflow** ***Utilizing the Discharge Workflow MPage***
NICU Systems Assessment iView Band NICU Physical Assessment Braden QD Annotated Narrative Note **NICU Lines Devices Procedures iView Band** Central Line Necessity Foley Catheter Necessity **NICU Quick View iView Band** Nursing Handoff/Transport Communication **Newborn Neonate Patient Education iView Band** Education related to disease process, medication regimen and plan of care **Pediatric Family Interaction Form** Parental Involvement	Nursing Discharge Summary Form Follow-up Patient Education Ensure Med Rec Completed Ensure IV Stop Times Documented Vital Signs within one hour of discharge **Other Discharge Assessment and Documentation** Patient Pharmacy Hearing Screen Newborn Blood Spot Car seat Challenge Primary Care Physician Immunization status Congenital Heart Defect Screening

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I. Pediatric Minimum Assessment and Documentation Guidelines

Admission Workflow ***Utilizing the Admission Workflow MPage***	**Patient Assessment and Documentation** **Every Shift *OR*** **as Ordered, Per Policy, or Change in Patient Condition**
Allergies **Admission History Pediatric** Infectious Disease Risk Screening General Info Interpreter Services – per patient need CSSRS (Columbia Suicide Severity Rating Scale) *ages 10 and greater* Nutrition Breast/Formula Feeding Sexuality and Reproductive Spiritual / Visitors Social History *(Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)* Social Determinants of Health Procedure History Education Needs Influenza Screening: *Sept. 1 to April 30* **Problem History** **Home Medications** **Pediatric Systems Assessment iView Band** Height and Weight Vital Signs Pain Assessment / Reassessment Head to Toe Head to Toe Physical Assessment Humpty Dumpty Fall Risk Scale BradenQD Assessment 4-Eyed Assessment (per hospital policy) Any Wound or Pressure Injury POA **Pediatric Lines Devices Procedures Band** Any invasive line, tube, or drain POA **Patient Education Band** Education related to admission, disease process, pain management, and plan of care **Problem History** **Home Medications** **Other Admission Requirements** Plan of Care Patient Pharmacy	**Pediatric Systems iView Assessment Band** Head to Toe Physical Assessment Humpty Dumpty Fall Risk Scale BradenQD Assessment Annotated Narrative Note **Pediatric Lines Devices Procedures iView Band** Central Line Necessity Foley Catheter Necessity **Pediatric Quick View iView Band** Nursing Handoff/Transport Communication BMAT **Patient Education Band** Education related to disease process, medication regimen, pain management, and plan of care **Other Required Assessment and Documentation** **as Ordered, Per Policy, or Change in Patient Condition** **Pediatric Systems iView Assessment Band** Vital Signs Pain Assessment / Reassessment Wound/Incision/Pressure Injury **Pediatric Lines Devices Procedures iView Band** Line Assessment, Care, & Reconciliation **Intake and Output iView Band** I&O **eMAR** Medication Administration and Response IV Start and Stop Times **Plan of Care** **Discharge Workflow** ***Utilizing the Discharge Workflow MPage*** Discharge Summary Form Follow-up Patient Education Ensure Med Rec Completed Ensure IV Stop Times Documented Vital Signs within 1 hour of discharge

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J. ED Minimum Assessment and Documentation Guidelines

<table>
<tr><th>Triage Assessment and Documentation</th><th>Other Required Assessment and Documentation
as Ordered, Per Policy, or Change in Patient Condition</th></tr>
<tr><td>ED Triage
Chief Complaint
Infectious Disease Screening
Prearrival Interventions
Triage Assessment
Triage Interventions (when applicable)
CSSRS (Columbia Suicide Severity Rating Scale)
Behavioral Health Complaints)
Allergies
KINDER1 Fall Risk Assessment
Preferred Spoken Language
Stroke Symptoms when applicable
Vital Signs
Height and Weight
Pain Assessment / Reassessment
Patient Acuity
ED Intake
Social History (Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)
Social Determinates of Health (yearly)</td><td>ED Systems Assessment iView Band
Focused Assessment
Vital Signs
Pain Assessment / Reassessment
ED Lines Devices Procedures iView Band
Line Assessment, Care, & Reconciliation
ED Interventions iView Band
Interventions performed during the ED visit
Intake and Output iView Band
I&O
Restraint iView Band
Restraint Assessment/Reassessment
eMAR
Medication Administration and Response
IV Start and Stop Times
Care Plan and Nursing Histories
Must be started/completed within 24 hours for patients admitted and waiting for beds</td></tr>
<tr><td>On Admission, Prior to Procedures Requring Anesthesia or Moderate Sedation, Change in Level of Care, and a Signification Change in Clinical Condition</td><td>Discharge Workflow
Utilizing the Discharge Workflow MPage</td></tr>
<tr><td>What Matters Documentation</td><td>Follow-up
Patient Education
Ensure Med Rec Completed
Ensure IV Stop Times Documented
Vital Signs within 1 hour of discharge</td></tr>
</table>

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K. **Peri-Op: Minimum Assessment and Documentation Guidelines**

PAT Workflow
Utilizing the Preprocedure Workflow MPage

Pre-Admission Assessment PowerForm
- Infectious Disease Risk Screening
- Allergies
- Home Medications
- General Info
- Interpreter Services – per patient need
- Height/Dosing Weight
- Advance Directive
- CSSRS Screen (Columbia Suicide Severity Rating Scale) *ages 10 and greater*
- Nutritional Screen
- Sexuality and Reproductive
- Spiritual / Visitors
- Problem History
- Social History *(Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)*
- Social Determinates of Health
- Spiritual / Visitors
- Procedure History
- Education Needs
- Influenza Screening (in person visit only)
- Pneumococcal Screening (in person visit only)
- Anesthesia/Sedation
- Preprocedure Instructions
- Tests

Pre-op Workflow
Utilizing the Admission Workflow MPage

Preprocedure Checklist PowerForm
- ***Validate Documentation for PAT patients***
- Infectious Disease Screening, Allergies, Admission History, Problem History, & Home Medication

Documentation Required on Admission
- Height/Dosing Weight
- Plan of Care
- Pre-Procedure Time Out

Periop Systems Assessment
- Vital Signs
- Pain Assessment / Reassessment
- Morse (adult) or Humpty Dumpty (peds) Fall Risk
- Isolation
- Neurological Assessment
- Cardiovascular Assessment
- Respiratory Assessment
- Pressure Injury Risk Assessment
- 4-Eyed Assessment (per hospital policy)
- Any Wound or Pressure Injury POA

Periop Lines Devices Procedures Band
- Any invasive line, tube, or drain

Intake and Output iView Band
- I&O

Adult Education Band
- Education related to admission, disease process, pain management, and plan of care

Other Admission Requirements
- Plan of Care & Patient Pharmacy

Intraop Workflow
Utilizing the Perioperative Documentation MPage and Perioperative Documentation Toolbar

Case Segments as applicable
- Case Attendees
- Case Time
- Cautery
- Delays
- Dressing/Packing
- Fire Risk
- General Care Data
- Hair Removal
- Medication
- Patient Care Devices
- Patient Positioning
- Performance Indicators
- Safety Checklist – Sign In, Time Out, & Sign Out
- Skin Assessment
- Skin Prep
- Surgical Procedure
- Transport
- Pick List Quantities

Periop Lines Devices Procedures iView Band
- Any invasive line, tube, or drain

Implant History
Implant including lot number

PACU Workflow
Utilizing Periop Tracking and Peri-Op Summary MPage

Acuity Levels and Times

Periop Quick View IView Band
Patient Arrival / Departure
- Vital Signs
- Pain Assessment / Reassessment
- Sedation Assessment
- Modified Aldrete
- PADS
- Cardiovascular Assessment
- Respiratory Assessment
- Neuro Assessment

Periop Lines Devices Procedures iView Band
Any invasive line, tube, or drain

Intake and Output iView Band
I&O

Discharge Workflow
Utilizing the Discharge Workflow MPage

Follow-up
Patient Education
Ensure Med Rec Completed
Ensure IV Stop Times Documented
Vital Signs within 1 hour of discharge

On Admission, Prior to Procedures Requring Anesthesia or Moderate Sedation, Change in Level of Care, and a Signification Change in Clinical Condition

What Matters Documentation

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12. Nursing Facility/Custodial Care Assessment and Documentation Guidelines

Nursing Facility level of care pertains to patients who are physically in an acute care bed and no longer at an acute level of care. *This is considered the same admission with same FIN. Progress notes indicate change in level of care per UR policy.*

In determining whether an individual is receiving **custodial care,** the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.

Custodial Care *is defined as:*

1. Care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care.
2. Serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.
3. personal care that does not require the continuing attention or supervision of trained, medical or paramedical
4. Maintenance care provided by family members, health aides or other unlicensed individuals after an acute medical event, including behavioral health events, when an individual has reached the maximum level of physical or mental function.

Admission Workflow **Utilizing the Admission Workflow MPage**
All admission requirements as outlined in the Med/Surg Intermediate Level of Care Guidelines are completed during the acute phase of the hospitalization
Discharge Assessment and Documentation ***Utilizing the Discharge Workflow MPage***
Nursing Discharge Summary Form Follow-up Patient Education Ensure Med Rec Completed
On Admission, Prior to Procedures Requring Anesthesia or Moderate Sedation, Change in Level of Care, and a Signification Change in Clinical Condition
What Matters Documentation

Patient Assessment and Documentation once *every 7 days* and as Necessary or Change in Patient Condition unless otherwise ordered
Adult Systems Assessment iView Band Morse Fall Risk Scale Braden Assessment BMAT (Bedside Mobility Assessment Tool) Annotated Narrative Note **Adult Lines Devices Procedures iView Band** Line Placement, Assessment, Care, Necessity & Reconciliation as applicable Foley Catheter Necessity **Adult Systems Assessment iView Band** Wound/Incision/Pressure Injury **Adult Quick View Band** Activities of Daily Living
Patient Assessment and Documentation *Weekly* and as Necessary or Change in Patient Condition
Patient Education iView Band Education related to self-care, mobility, and fall prevention **Plan of Care**
Patient Assessment and Documentation *as Necessary* or Change in Patient Condition
Adult Quick View Band Nursing Handoff/Transport Communication
Patient Assessment and Documentation *as Ordered, Per Policy* or Change in Patient Condition
Restraint iView Band Restraint Assessment / Reassessment **Intake and Output iView Band** I&O **eMAR** Medication Administration and Response IV Start and Stop Times

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13. **Ambulatory Regulatory and Social Determinants of Health (SDOH) Documentation Requirements**

Primary Care	Specialty Practices
Every Visit Weight Medication History Medication Administration (when applicable) Education related to reason for visit, disease process, pain management, and plan of care **Annually and as Patient Condition Warrants** Advance Directives Abuse/Neglect Screening Fall Risk Learning Needs Assessment Primary Language Social Determinants of Health *(all questions & Abuse/Neglect)* **Per Policy** Depression Screening Nutrition Assessment Pain Assessment **Pre-Procedure** Time-Out/Universal Protocol	**Every Visit** Medication History Education related to reason for visit, disease process, pain management, and plan of care **Annually and as Patient Condition Warrants** Abuse/Neglect Screening Advance Directive**s** Fall Risk Primary Language Social Determinants of Health *(all questions & Abuse/Neglect)* **Per Policy** Depression Screening Nutrition Assessment Pain Assessment **Pre-Procedure** Time-Out/Universal Protocol

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14. **Ambulatory Surgery: Minimum Assessment and Documentation Guidelines**

PAT Workflow
Utilizing the Preprocedure Workflow MPage

ASC Pre-Admission Assessment PowerForm
- General Admission Info
- Interpreter Services – per patient need
- Advance Directive
- CSSRS Screen (for ages 10 and greater)
- Social Determinates of Health
- Infectious Disease Risk Screening
- Subjective Review of Systems
- Pain Assessment as applicable
- Height/Dosing Weight
- Anesthesia/Sedation
- Education Needs
- Anticipated Discharge Needs
- Preprocedure Instructions

Allergies
Problem History
Social History *(Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)*
Implant History
Procedure History
Home Medications

Pre-op Workflow
Utilizing the Preprocedure Workflow MPage

ASC Preprocedure Checklist PowerForm
- Completion of any of the above noted data not completed during the PAT process
- Meds to Beds Program
- Total Joint Site Prep if applicable
- Perioperative Protocols

Perioperative Documentation
- Case Attendance
- Case time
- PNDS Evaluation

ASC PACU Recovery View
- Vital Signs
- Pre-Procedure Time Out
- Equipment/Devices if applicable
- Morse (adult) or Humpty Dumpty (peds) Fall Risk
- Pain Assessment / Reassessment
- Respiratory Assessment
- Cardiovascular Assessment
- Integumentary Assessment
- Peripheral IV

Adult Education Band
- Education related to admission, disease process, pain management, and plan of care

Intraop Workflow
Utilizing the Perioperative Documentation MPage and Perioperative Documentation Toolbar

Case Segments as applicable
- Case Attendees
- Case Time
- Cautery
- Counts Verification
- Delays
- Dressing/Packing
- Fire Risk Assessment
- General Care Data
- Hair Removal
- Irrigation
- Medication
- Patient Care Devices
- Patient Positioning
- Performance Indicators
- PNDS Evaluation
- Safety Checklist – Sign In, Time Out, & Sign Out
- Skin Assessment
- Skin Prep
- Surgical Procedure
- Transport

Pick List

PACU Workflow
Utilizing ASC Recovery and Discharge Workflow MPage

ASC PACU Recovery View
PACU Phase I/II Record Case Segments
- Acuity Level
- Case Attendance
- Case Times
- Delays
- PNDS Evaluation

ASC PACU Recovery View
- Vital Signs
- Pain Assessment / Reassessment
- Sedation Assessment
- Modified Aldrete
- Airway Management
- PADS
- Incision/Wound/Skin
- Cardiovascular Assessment
- Respiratory Assessment
- Neuro Assessment
- Integumentary Asessment
- Any invasive line, tube, or drain
- Activities of Daily Living

I&O
ASC Recovery and Discharge Workflow MPage
- Follow-up
- Home Medications
- Patient Education
- Surginet Discharge Instructions
- Ensure IV Stop Times Documented

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15. **Endoscopy: Minimum Assessment and Documentation Guidelines (excludes MOs documenting in a hybrid state)**

PAT Workflow
Utilizing the Preprocedure Workflow MPage

ASC Pre-Admission Assessment PowerForm
- General Admission Info
- Interpreter Services – per patient need
- Advance Directive
- CSSRS Screen (for ages 10 and greater)
- Social Determinates of Health
- Infectious Disease Risk Screening
- Subjective Review of Systems
- Pain Assessment as applicable
- Height/Dosing Weight
- Anesthesia/Sedation
- Education Needs
- Anticipated Discharge Needs
- Preprocedure Instructions

Allergies
Problem History
Social History *(Tobacco, Alcohol, Substance Use, Abuse/Neglect, Vaping)*
Implant History
Procedure History
Home Medications

Pre-op Workflow
Utilizing the Preprocedure Workflow MPage

ASC Preprocedure Checklist PowerForm
- Completion of any of the above noted data not completed during the PAT process
- Meds to Beds Program
- Total Joint Site Prep if applicable
- Perioperative Protocols

Perioperative Documentation
- Case Attendance
- Case time
- PNDS Evaluation

ASC PACU Recovery View
- Vital Signs
- Pre-Procedure Time Out
- Equipment/Devices if applicable
- Morse (adult) or Humpty Dumpty (peds) Fall Risk
- Pain Assessment / Reassessment
- Respiratory Assessment
- Cardiovascular Assessment
- Integumentary Assessment
- Peripheral IV

Adult Education Band
- Education related to admission, disease process, pain management, and plan of care

Intraop Workflow
Utilizing the Perioperative Documentation MPage and Perioperative Documentation Toolbar

Case Segments as applicable
- Case Attendees
- Case Time
- Cautery
- Counts Verification
- Delays
- Dressing/Packing
- Fire Risk Assessment
- General Care Data
- Hair Removal
- Irrigation
- Medication
- Patient Care Devices
- Patient Positioning
- Performance Indicators
- PNDS Evaluation
- Safety Checklist – Sign In, Time Out, & Sign Out
- Skin Assessment
- Skin Prep
- Surgical Procedure
- Transport

Pick List

PACU Workflow
Utilizing ASC Recovery and Discharge Workflow MPage

ASC PACU Recovery View
PACU Phase I/II Record Case Segments
- Acuity Level
- Case Attendance
- Case Times
- Delays
- PNDS Evaluation

ASC PACU Recovery View
- Vital Signs
- Pain Assessment / Reassessment
- Sedation Assessment
- Modified Aldrete
- Airway Management
- PADS
- Incision/Wound/Skin
- Cardiovascular Assessment
- Respiratory Assessment
- Neuro Assessment
- Integumentary Asessment
- Any invasive line, tube, or drain
- Activities of Daily Living

I&O
ASC Recovery and Discharge Workflow MPage
- Follow-up
- Home Medications
- Patient Education
- Surginet Discharge Instructions
- Ensure IV Stop Times Documented

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Sutton, D. E., Fogel, J. R., Giard, A. S., Gulker, L. A., Ivory, C. H., & Rosa, A. M. (2020). Defining an essential clinical dataset for admission patient history to reduce nursing documentation burden. *Applied Clinical Informatics*, 1-10. doi:10.1055/s-0040-1713634

ATTACHMENTS

List of Approved Abbreviations, included at the end of this Policy

This document was approved by the committee(s) noted below on the date(s) as noted:

Leadership Council, 9/22/2021, 4/4/2023
Nurse Leadership Council, 9/14/2021, 4/19/2022, 3/15/2023, 6/11/2024, 7/7/2025, 3/10/2026
Clinical Policy Committee, 9/16/2021, 3/23/2022, 10/25/2022, 2/28/2023, 5/10/2024 (via electronic vote), 6/27/2025 via email, 2/24/2026
CNIO Operations, 4/25/2025, 2/13/2026
CNIO Council, 4/29/2024
rNIO Operations, 9/10/2021, 3/4/2022, 6/17/2022, 1/20/2023

List of Approved Abbreviations

General

Ad lib - As Desired
AMA - Against Medical Advice
c/o - Complains of
DC or d/c – Discharge or Discontinue
DNaR – Do Not attempt Resuscitation
DNR - Do Not Resuscitate
DOA - Dead on Arrival
DOB - Date of Birth
(e)MAR – (electronic) Medication Administration Record
h/o – History of
H&P – History and Physical
HPI - History of Present Illness
Hx - History
OT - Occupational Therapist
PCP - Primary Care Provider
PPE - Personal Protective Equipment
pt - Patient
PT - Physical Therapist/Therapy or Prothrombin Time
R/O – Rule out
R/T - Related to
S/P – Status post

Activity

ADL - Activities of daily living
AROM - Active Range of Motion
HOB - Head of bed
NWB – Non-weight bearing
OOB – Out of bed
ROM - Range of motion
WBAT – Weight bearing as tolerated
W/C – Wheelchair

Assessment Data

Abd - Abdomen
ACL - Anterior cruciate ligament
AV - Atrioventricular
BG - Blood Glucose
BLE - Bilateral Lower Extremity
BM - Bowel Movement
BP - Blood Pressure
BPM - Beats Per Minute
BUE - Bilateral Upper Extremity
CNS - Central Nervous System
CSF - Cerebrospinal Fluid
CSM - Circulation, Sensation, Motion
DOE - Dyspnea on Exertion
EBL – Estimated blood loss
EENT - Ears, Eyes, Nose and Throat
GCS - Glasgow Coma Scale
GI - Gastrointestinal
GU - Genitourinary
GYN - Gynecology
HA – Headache
HEENT - Head, Ears, Eyes, Nose, and Throat
HOH – Hard of hearing
HR - Heart Rate
I&O - Intake and output
LBBB- Left bundle branch block
LLE - Left Lower Extremity
LMP - Last Menstrual Period
LOC- Level of Consciousness
LUE - Left Upper Extremity
LUQ - Left Upper Quadrant
MAP - Mean Arterial Pressure or Mean Airway Pressure
N/V - Nausea / vomiting
NG – Nasogastric
NSR - Normal Sinus Rhythm
OB - Obstetrics
Obs - Observation
OG - Orogastric
PAC- Premature Atrial Contraction
PERRLA - Pupils Equal, Round, Reactive to Light and Accommodation
PIP - Peak Inspiratory Pressure
PVC- Premature Ventricular Contraction
RA - Room Air
RBBB- Right bundle branch block
REM - Rapid Eye Movement
RLQ - Right Lower Quadrant
RLE - Right Lower Extremity
RUE - Right Upper Extremity
RUQ - Right Upper Quadrant
SOB - Shortness of breath

SR – Sinus Rhythm
SVC - Superior Vena Cava
SVT - Supraventricular tachycardia
VF- Ventricular fibrillation
VS - Vital signs
VT- Ventricular tachycardia

Diagnostic/Lab Studies

ABG - Arterial Blood Gas
ALT - Alanine Aminotransferase
Angio - Angiogram
AST - Aspartate Aminotransferase
BMP - Basic Metabolic Panel
BUN - Blood Urea Nitrogen
C&S - Culture and Sensitivity
Cath – Catheter(ization)
CBC - Complete blood count
CK - Creatine Kinase
CMP - Complete Metabolic Panel
CPK - Creatine Phosphokinase
CRP - C-Reactive Protein
CT (scan)- Computed Tomography (scan)
CXR - Chest X-Ray
ECG/EKG - Electrocardiogram
EEG - Electroencephalogram
ERCP - Endoscopic Retrograde Cholangiopancreatography
ESR - Erythrocyte Sedimentation Rate
FOBT - Fecal Occult Blood Test
FSH - Follicle-Stimulating Hormone
GBS - Group B Streptococcus
GFR - Glomerular Filtration Rate
H&H - Hemoglobin and Hematocrit
hCG - Human Chorionic Gonadotropin
Hct - Hematocrit
HDL - High Density Lipoprotein
Hgb - Hemoglobin
IgG - Immunoglobulin G
IgM - Immunoglobulin M
LDL - Low Density Lipoprotein
LFT - Liver Function Test
LP - Lumbar Puncture
MRI - Magnetic Resonance Imaging
PCR - Polymerase Chain Reaction
PFT - Pulmonary Function Test
PTT - Partial Thromboplastin Time
RBC - Red Blood Count
Stat - At once, immediately
TSH - Thyroid-Stimulating Hormone
UA - Urinalysis
US - Ultrasound
VBG - Venous Blood Gas
WBC - White Blood Count

Medical/Procedure History

AAA - Abdominal Aortic Aneurysm
ADHD - Attention deficit hyperactivity disorder
ARF - Acute renal failure
AIDS- Acquired immune deficiency syndrome
AKA - Above Knee Amputation
AKI - Acute kidney injury
AMI - Acute myocardial infarction
ARDS - Acute respiratory distress syndrome
BKA - Below Knee Amputation
BPH - Benign Prostatic Hypertrophy
CABG - Coronary Artery Bypass Graft
CAD - Coronary Artery Disease
CHF - Congestive Heart Failure
CMV - Cytomegalovirus
COPD - Chronic Obstructive Pulmonary Disease
CVA - Cerebrovascular accident or stroke
D&C - Dilation and Curettage
DIC - Disseminated Intravascular Coagulation
DJD - Degenerative Joint Disease
DM - Diabetes Mellitus
ETOH - Alcohol
DVT - Deep Vein Thrombosis
dx - Diagnosis
ESRD - End Stage Renal Disease
Fx - Fracture

Medical/Procedure History, cont.

GERD - Gastroesophageal Reflux
Hep B - Hepatitis B
HIV - Human Immunodeficiency Virus
HTN – Hypertension
I&D - Incision and Drainage
IBS - Irritable bowel syndrome

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IDDM - Insulin dependent diabetes mellitus
IVF - In Vitro Fertilization
MDRO - Multidrug-Resistant Organism
MI - Myocardial Infarction
MRSA - Methicillin-Resistant Staphylococcus Aureus
ORIF - Open Reduction/Internal Fixation
PE - Pulmonary embolism
PFO - Patent Foramen Ovale
PMH - Past Medical History
PMS - Premenstrual Syndrome
PNA - Pneumonia
PROM - Premature Rupture of Membrane
PTL - Preterm Labor
PVD - Peripheral Vascular Disease
RLS - Restless Leg Syndrome
SIDS - Sudden infant death syndrome
STD - Sexually Transmitted Disease
STI – Sexually Transmitted Infection
TBI - Traumatic Brain Injury
TB - Tuberculosis
TIA - Transient Ischemic Attack
UTI - Urinary Tract Infection
VRE - Vancomycin-Resistant Enterococci

Medications/Devices/Treatments

ARB - Angiotensin Receptor Blocker
ASA - Acetylsalicylic Acid (aspirin)
BiPAP - Bilevel Positive Airway Pressure
CPAP: Continuous Positive Airway Pressure
CPR - Cardiopulmonary resuscitation
ECMO - Extracorporeal membrane oxygenation
ECT - Electroconvulsive Therapy
ETT - Endotracheal Tube
FFP - Fresh Frozen Plasma
Gtt(/min) - Drops (per minute)
IM - Intramuscular
IV - Intravenous
IVPB - intravenous Piggyback
IVP - Intravenous Push
KCL - Potassium Chloride
KVO - Keep Vein Open
MDI - Metered-Dose Inhaler
MMR - Measles, Mumps, Rubella
NaCl - Sodium Chloride
NC - Nasal Cannula
NPO - Nothing by mouth
NS - Normal Saline
O2 - Oxygen
Oint. - Ointment
OTC - Over the counter
PCA - Patient-Controlled Analgesia
PICC - Peripherally inserted central catheter
PO - By mouth
PN – Parenteral Nutrition
PPN – Peripheral Parenteral Nutrition
PRN – As needed
SCD – Sequential compression device
SL - Sublingual
Supp - Suppository
TF - Tube Feeding
TPN - Total Parenteral Nutrition
Trach – Tracheostomy
VAD – Ventricular Assist Device or Vascular Access Device

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