VANDERBILT UNIVERSITY
MEDICAL CENTER

Standard Operating Procedure

eStar: Reduced Nursing Documentation During a Crisis – Emergency Department, Inpatient, and Outpatient	Category	Clinical Operations
	Effective Date	Month Year
	Approval Date	Month Year
	Supersedes	New

Applicable to: ☒ Adult Enterprise ☒ Pediatric Enterprise ☒ Behavioral Health Enterprise ☐ VUMC

This SOP correlates directly with the following VUMC policies:
Nursing Clinical Practice Guidelines - Adults, Children, and Neonates
Emergency Operations Plan Activation

I. Purpose:

To establish requirements for nursing documentation during a natural disaster, mass casualty, or pandemic crisis when severe staffing shortages impact Vanderbilt University Medical Center (VUMC).

II. Emergency Department:

A. Registration

Emergency Department (ED) Registration Staff or other designated screener who sees patient prior to registration asks the patient and documents the following:

1. Travel History;
2. Communicable Disease Screen; and
3. COVID Admission Screen.

If any of the above screen positive, a mask is immediately placed on the patient. For Infectious Diseases crisis, the patient is escorted to a designated area for evaluation and treatment.

B. Triage

The ED Triage nurse performs an abbreviated Mass Casualty Triage. All other Screenings in ASAP are not required unless patient-specific presentation warrants.

C. Required Documentation during Assessment

1. Chief complaint;
2. Vital signs: Temperature (temp), pulse/heart rate, respiratory rate (RR), blood pressure (BP), and peripheral capillary oxygen saturation (SpO2); and
3. Height, weight.
4. Allergies;

5. Medications taken at home prior to admission; and
6. History (only chronic diseases or co-morbidities relevant to reason for visit).

D. Initial Assessment

A focused assessment is performed based on chief complaint and presenting systems. Documentation of the assessment will be by exception. **Only Problems identified as Outside Expected Limits (OEL)** with any of these systems are documented; otherwise, documentation is not required.

E. Ongoing Re-assessment

1. Vital signs: (temperature, pulse/heart rate, RR, BP, and SpO2) – as ordered or appropriate for patient's clinical presentation.
2. Intake and Output as ordered – Clear pumps & document Shift totals end of each shift.
3. Blood Administration: No change in practice. Follow Blood Product Administration and Adult ED SOP - Blood Administration.
4. Any Care Category assessed as having a Problem on or since initial presentation to ED.

F. Lines-Drains-Airways (LDA), Incisions/Wounds, and Nursing Interventions

1. Location and type of all LDAs are documented at time of placement.
2. Incisions/wounds are documented at initial presentation.
3. Ongoing assessment and care of LDAs and incisions/wounds are performed per policy; however, documentation is performed only for exceptions (e.g., only abnormal assessment findings or exceptions to standard care procedures are documented).
4. Performance of ordered interventions is documented by the end of each shift.

G. Medications and Medication Administration

No change in practice. Medications/intravenous (IV) fluids continue to be administered and documented per VUMC policy: Medication Administration.

H. Wrap-up Documentation

Follow-up care prescribed and any educational materials provided are documented on After-Visit Summary (AVS).

III. Inpatient Areas:

A. Initial Screening

Screenings that require documentation upon admission by nurse or designee (if NOT already done at point of entry):

1. Communicable Disease Screen;
2. Travel History;
3. COVID Admission Screen;
4. Influenza Vaccine Screen; and
5. Pneumococcal Vaccine Screen.

All other screenings from the Admission Navigator or Screening Flowsheet Tab are documented only if patient presentation warrants.

B. Assessment of the following Care Categories is conducted as is currently standard practice: Cardiac, Respiratory, Neuro, GI, Renal/UR, Skin, Safety, Pain, and for ICU only, Vascular. **Only Care Categories identified as Outside Expected Limits (OEL) or having a Problem** are documented; otherwise, documentation is not required.

C. Documentation of the following **is required with initial** assessment following admission, within 1 to 2 hours of admission:

1. Vital signs: Temp, pulse/heart rate, RR, BP, and SpO2;
2. Height, weight;
3. Documentation of assessment of all other care categories and is not required unless patient specific presentation warrants;
4. History: Relevant history and co-morbidities that might impact care needed for present illness (if not identified at point of entry);
5. Allergies; and
6. Medications taken at home prior to admission.

D. Ongoing Re-assessment

1. Vital signs (temp, pulse/heart rate, RR, BP, SpO2): As ordered, or appropriate for patient's clinical presentation.
2. If Pain Problem, Pain reassessment before and after pain relief interventions; summary documentation of pain reassessments under Response to Care at end of each shift. (see example below)

E. Intake and Output (IF ordered/unit standard): Document totals end of each shift (minimum). More frequent documentation of some values may be warranted based on patient factors.

F. ICU: Assessments as per current standard. Documentation will be by exception with abnormal findings documented. Frequency of documentation will be based on patient acuity and orders (minimum assessment/reassessment 2X/shift; Vital Signs Q1h when titrating drips, Q2h for stable drips).

G. Blood Administration: No change in practice. Follow Blood Product Administration.

H. Any Care Category assessed as having a Problem on or since initial admission assessment.

I. LDA, Incisions/Wounds, and Nursing Interventions

1. Location and type of all LDAs are documented at time of placement.
2. Incisions/wounds (including pressure injuries) are documented at initial presentation. No dual assessment/co-sign required fir first assessment of pressure injuries.
3. Ongoing assessment and care of LDAs and incisions/wounds are performed per policy; however, documentation is performed only for exceptions (e.g., only abnormal assessment findings or exceptions to standard care procedures are documented).
4. Performance of ordered interventions is documented by the end of each shift.

J. Medications and Medication Administration

No change in practice. Medications/intravenous (IV) fluids continue to be administered and documented per VUMC policy: Medication Administration.

K. Plan of Care

1. Consists of the Problem List and Interventions from orders and unit standards. The Patient Problems that fall within the Nursing domain (Safety Risk – Falls, Suicide Risk, Restraint/Seclusion; Pain Control; Risk for Skin Breakdown) are the primary focus of the Nursing Care Plan.
2. At the end of each shift, a response to care/recommendations note is entered summarizing significant Problems addressed by Nursing Interventions and Patient Response.
   Examples: 1) "Pain score of 5 unchanged after 8AM Acetaminophen; pain score 1-2 after 1-time dose Acetaminophen/Hydrocodone." 2) "Patient followed safety plan with one exception when he got OOB w/o assist. No fall. Reinforce need to call for assist to toilet." 3) "Staying off of left side consistently all shift; area on left hip that was reddened is down to 4 X 5 cm."

L. Discharge Documentation

1. Document education provided and verify AVS, prescriptions, and appointments are given to patient/caregiver. Note: At a minimum, Discharge Instructions/AVS include: Medication changes (medications to start, stop, or continue), Signs and Symptoms to report with contact information for reporting, Activity/Diet Restrictions, and any post-discharge treatments to be done by patient/caregiver.

2. A COVID Discharge screen is documented at time of discharge to Home Health or Post-Acute Care Facility.

IV. Outpatient Areas:

A. Intake Documentation

1. Front Desk Staff perform and document the following abbreviated data collection prior to moving patient to ready for intake status:

   a. Travel History*;
   b. Communicable Disease Screen*; and
   c. COVID Admission Screen.

   If any of the above screen positive, a mask is immediately placed on the patient. For Infectious Diseases crisis, the patient is escorted to a designated area for evaluation and treatment.

   *Note: Travel History and Communicable Disease Screen may be done before patient enters building in an infectious disease pandemic scenario. If this is the case, it does not need to be repeated once patient arrives in clinic.

2. Screenings required to be documented upon admission by nurse/designee:
   a. Influenza Vaccine Screen; and
   b. Pneumococcal Screen.

   All other Screenings on the Intake Screen will be done only if patient presentation warrants.

3. Required assessment documentation during the visit should include:
   a. Reason for visit;
   b. Vital signs: Temp, pulse/heart rate, RR, BP, SpO2;
   c. Height, weight;
   d. Allergies;
   e. Medication Reconciliation: review patient medications;
   f. History – only chronic diseases or co-morbidities relevant to reason for visit; and
   g. Documentation of any ordered procedures performed by nursing.

B. Medications and Medication Administration

1. In clinics with barcode medication administration capabilities: Medications should continue to be administered and documented via standard Medication Administration policy.

2. In clinics without barcode medication administration capabilities: Medications will be documented on MAR or in Immunization Activity as applicable with manual verification of “5 Rights”.

C. Wrap-up Documentation

Follow-up care prescribed and any educational materials provided are documented in the AVS.

Note: Disruptions in supply chain associated with long-term crises may require alterations (e.g., if medications are not packaged with bar codes, barcode administration cannot be utilized and 5 Rights are verified by staff without technology assistance).

V. Lead Author and Content Experts:

Lead Authors: Karen Hughart, Sr. Director, Nursing Informatics
Patty Sengstack, Executive, Nursing Informatics

VI. Endorsement:

VUMC Nursing Informatics Committee	April, 2020
Clinical Operations Policy Committee	Month Year
Executive Policy Committee	Month Year

VII. References:

VUMC Policy Manual. (2020). Retrieved from https://vanderbilt.policytech.com.

Adult Emergency Department Category:
Adult ED SOP - Blood Administration

Clinical Practice Category:
Blood Product Administration
CL SOP - Pressure Injury Prevention and Treatment - Adult
CL SOP - Skin Care and Pressure Injury Prevention and Treatment - Pediatrics

Medication Management Category:
Medication Administration
MM SOP - Intravenous Medication Administration Nursing Clinical Practice Guidelines - Adults, Children, and Neonates
Medication Reconciliation
MM SOP - Medication Reconciliation: Emergency Department
MM SOP - Medication Reconciliation: Inpatient
MM SOP - Medication Reconciliation: Outpatient

Safety Category:
Emergency Operations Plan Activation