

Addendum: Documentation Guidelines

Inpatient Visits:

- I. The following assessments will be completed and documented in the patient's medical record within the first eight hours of admission to a non-critical care unit and within two hours of admission to a special care unit:
 - A. Vital Signs, Weight and Height
 - B. Pain Assessment
 - C. Allergy Assessment
 - D. Nutritional Assessment
 - E. Functional Assessment
 - F. Medication History
 - G. Communicable Disease History
- II. A physical, psychological and social status assessment based on the patient's presenting condition (includes protocol needs, and patient population specific needs) is completed within the first 24 hours. The patient's initial learning and discharge needs are also assessed.
- III. Re-assessments will occur at least every 24 hours or more frequently as specified by the patient's condition, or by the physician or unit leadership. Re-assessments include vital signs and other assessments driven by the needs of the protocol, the patient's current condition, and any patient population specific needs.
- IV. An assessment must be done if the need for transfer is based on a change in a patient's condition. The transferring unit performs an assessment of the patient's condition prior to the transfer and the receiving unit assesses the patient's condition upon receiving the patient.
- V. Potential discharge needs are assessed throughout the patient's admission and a note is entered by the nurse at the time of discharge.
- VI. Special Patient Population Needs:
 - A. Additional special patient needs assessments (e.g., age specific, potential abuse, suicide, elopement, etc.) are done as needed.

Outpatient/Day Hospital Visits:

- I. There are five different types of patient visits that occur in the outpatient clinics and/or in the day hospitals. The documentation requirements for each type of visit are different.
- II. **Screening Visit:** Patient is seen to determine if they meet the protocol requirements.
 - A. Vital Signs, Weight and Height
 - B. Any assessments needed by the PI to assist in the protocol screening process
- III. **First Protocol Visit:** This is the first visit after the patient has been placed on the protocol. For some patients this may be their first visit.
 - A. Vital Signs, Weight and Height
 - B. Pain Assessment
 - C. Allergy Assessment
 - D. Medication History
 - E. Communicable Disease History

- F. Physical, psychological and social status assessment based on the patient's presenting condition (includes protocol needs, presenting condition and patient population specific needs).
- G. Learning and/or discharge needs identified (includes need for community resources), referral for ancillary services (e.g., social work or spiritual ministry referrals).
- H. Any interventions and the patient's response.
- I. Additional special patient needs assessments (e.g., age specific, potential abuse, suicide, elopement, etc.) are done as needed.

IV. Protocol Follow Up:

- A. Vital Signs
- B. Communicable Disease history
- C. Review of Issues from Prior Visit
- D. Protocol Requirements
- E. Assessments Based on Presenting Condition

V. Procedure Treatment Visit:

- A. Vital Signs
- B. Communicable Disease history
- C. Review of Issues from Prior Visit
- D. Protocol Requirements
- E. Assessments Based on Presenting Condition