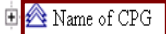



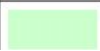
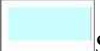



KBC DAILY DOCUMENTATION REMINDERS for NURSING

Tool	Profile The patient's story (Only one per visit) (Use the Enter Document icon)	Plan of Care (POC) (Flowsheet #1)		Assessment & Intervention Flowsheet (Flowsheet #2)	Education Outcome Record (Flowsheet #3)	Guideline Assessment / Outcome Evaluation (Flowsheet #4)		
		CPG Pt health issues and concerns. Clinical Practice Guideline Green = Guideline	Individual Statements Information that is unique to the patient's ongoing care	What you see and observe and what you do about what you see and observe	All Teaching/Education and detailed progress toward goals.	Guideline Assessment Signs and Symptoms of potential complications. Present or not.	Outcome Evaluation Global evaluation about Pts overall status and progress toward goals	Summary Statement Global statement about how the pt is progressing
Time Columns	Ongoing throughout hospital stay	Only one time column (number entries)		Add Time Columns at time of assessment/intervention	Add Time Columns at time education occurred	Add Time Columns at time of documentation		
Do When & Why	<ul style="list-style-type: none"> ▪ Initiate on admission; completed in 24 hrs (Med/Surg; PCU;ICU) ▪ Admission history and living document updated as information acquired 	<ul style="list-style-type: none"> ▪ Main CPG initiated on admission ▪ Other CPG if major concurrent illness ▪ May be D/C'd and new one added as patient's status changes 	<ul style="list-style-type: none"> ▪ Initiate by RN on admission and made individual prn by any member of the Health Care Team ▪ Communicate pts individual needs & interventions ▪ Co-morbid conditions ▪ Core Measures information ▪ Patient care needs ▪ Non time/date sensitive information 	Med/Surg: <ul style="list-style-type: none"> ▪ Head to Toe – every day ▪ Pain Assess. – every day ▪ Braden score – Daily; q 12 hrs if score ≤ 18 ▪ Morse Fall Scale – every shift ▪ IV site – every 2-4 hrs 	<i>Do Teaching Learning Assessment</i> on admission only Pt oriented <i>educational goal</i> on admission and as needed	Changes in pt condition &/or end of shift		
				PCU: <ul style="list-style-type: none"> ▪ Head to Toe – q 12 hrs ▪ Focus Reassessment. – q 4 hrs ▪ Pain Assessment – q 12 hrs ▪ Braden score – Daily; q 12 hrs if score ≤ 18 ▪ Morse Fall Scale – every shift ▪ IV site – every 2-4 hrs 	Document education as performed, recommended Each shift. Patients progress toward reaching education goals	Communicates trending of the pts overall condition and progress		
				ICU: <ul style="list-style-type: none"> ▪ Head to Toe – q 4 hrs ▪ Focus Reassessment. – q 2 hrs ▪ Pain Assessment – q 4 hrs ▪ Braden score – Daily; q 12 hrs if score ≤ 18 ▪ Morse Fall Scale – every shift ▪ IV site – every 2-4 hrs 	Open each plus sign to say what method and who was instructed	These are the evidenced-based signs and symptoms of potential complications from the CPG.	Improving, no change or declining.	<ul style="list-style-type: none"> ▪ Global statement about how the pt is progressing. ▪ Documents staff perception of the pts progress during the shift. Pts perceptions also. ▪ What leads you to say they are 'improving, no change or declining'

KBC DAILY DOCUMENTATION REMINDERS for NURSING

	Profile	POC	A & I	EDU	Guideline Assessment / Outcome Evaluation		
Key point(s)	<ul style="list-style-type: none"> Used to individualize the Plan of Care Questions are cues to deeper issues or concerns All disciplines contribute 	<ul style="list-style-type: none"> Always pick the name of the CPG next to the tent when initiating the POC  NOT the plus sign on the left. Clinical practice guidelines are updated q 2 years New guidelines are added – keep checking the start button for new guidelines over time. 	<p>Individualization about the patient identified from the profile about providing care.</p> <p>Individualization Examples:</p> <ul style="list-style-type: none"> Pt doesn't know about death of passenger in MVA Pt needs pills crushed and given with applesauce Pt likes to nap daily at 1pm Daughter Susan is family contact person Pt doesn't want to be seen without wig on by visitors 	<ul style="list-style-type: none"> WDL assessments are your whole assessment WDL except then only chart the exceptions Chart "per POC" at the end of each shift. Add indicated parameters for additional assessments (e.g. Foley catheter, suctioning,) Record mutual review of POC w/ pt/family R click to Modify Row Label for IV's, wounds, incisions, dressings, drains etc. IV's date goes in the Comment box 	<ul style="list-style-type: none"> Documentation of Education and detailed pt progress toward education goals. Communication to other providers education completed Start goal note with RN: CM: PT: etc. 	<ul style="list-style-type: none"> Details of assessment should be evident in the <i>Assessment & Intervention flowsheet</i>. This will only be present with Medical Surgical Guidelines 	<ul style="list-style-type: none"> Good place to include quote from pt about how they think they are progressing. Human response guidelines need to be captured in the summary statement Start Summary note with RN: CM: PT: etc.

TIPS

Notes	The following structured notes must be done as part of your documentation: Admission, Transfer, TimeOut, Restraint, & Electronic Downtime . You can use the Document Entry icon or R click in a data cell and select Enter Note to get to the Document Entry Worksheet and select the structured note. When using Physician Communication or Miscellaneous Notes , do not forget to type a Document Topic in that window at the top of the note.					
Abbreviations	KBC = Knowledge Based Charting (Interdisciplinary documentation tool) POC = Plan of Care CPG = Clinical Practice Guideline			SCM = Sunrise Clinical Manager (The whole document management system) WDL = Within Defined limits POCT = Point of care testing		
Flowsheet Colors	 CPG	 Screens - Scales	 WDL Statement	 Generic	 Late Parameter	
I&O	Be sure to R click and use cell comment to enter IVF rate at beginning of shift Frequency on Med/Surg floors = Every shift on pts with IV's, catheters, drains, fluid/electrolyte imbalance, Post-op, per MD order Frequency on all other floors = Every shift					
Vitals	Don't forget to add the parameter of O2 therapy for pt's with oxygen Add needed parameters e.g. Rhythm, Ectopy					

