

## Documentation Guidelines : A summary of when to document what

### Admission

- Complete Admission History in StarPanel within 24 hrs. of admission
- Assess ALL Care Categories, noting baseline status. If using WEL& OEL enter an annotation with supporting information.
- Document Care Contact & VUMC general & unit specific orientation in Education Tab

### Beginning of Shift

- Assess Care Categories in **ALL CAPS** + others based on problems or risk for problems
- Denote Priority Problems for shift w/ **!!** & set goals for each priority problem.
- Document Interventions in real time or near real time through the shift.

### Focused Re-assessment

- Document either "unchanged" or "unchanged except" & denote changes for OEL, problems, risk for problems or based on orders &/or nursing judgment. DO NOT document on those wnl.
- ICU – at least two more times during the shift
- Acute Care – at least once during the shift

### Pre-Procedure or Transfer

- Focused reassessment, note new, resolved, or unchanged problems
- Summarize response to care focus on priority problems; Identify issues for f/u by receiving nurse; avoid duplication
- Enter interventions, vitals, I&O, & meds

### End of shift

- Summarize response to care focus on priority problems; Identify issues for f/u by receiving nurse; avoid duplication
- Ensure all assessment, interventions, vitals, I&O, meds documentation is up-to-date

### Discharge

- Summarize response to care, focus on unresolved problems and action plan post discharge; avoid duplication
- Ensure all assessments, interventions, vitals, I&O, meds documentation is up-to-date

# Nursing Documentation Guidelines

**Mosby**



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