Franciscan HEALTH
Dyer • Hammond • Munster

Nursing Documentation Checklist

Items highlighted in yellow must be charted multiple times in an 8 to 12-hour shift.

Items in red are new and/or of special concern.

Required Charting	Room	Room	Room	Room	Room	Room
Nursing Assessment: • Initiated – Within 2 hours (Med Surg), 1 hour (IMCU), 15 minutes (ICU) of arrival to unit • Completed – Every shift (Med Surg), every 4 hours (IMCU), every 2 hours (ICU) – all units per policy and change in patient condition						
• Braden Scale – Minimally every 24 hours; on admission/transfer, change in patient condition • If the patient has a wound(s), an LDA must be added and a photograph taken upon admission. Wound(s) and appropriate interventions are documented every shift.						
IV Sites: • Every 2 hours for IV infusions/Once per shift for IV locks						
Daily Cares/Safety: • Repositioning – Every 2 hours for Braden Scale Score less than or equal to 18 (turns). Also include heels up, head of bed, and specialty mattress once per shift. • Once per shift for Braden Scale Score greater than 18 (non-turns)						
• SIRS – Upon presentation to facility (ED or direct admit) and PRN						
• VTE Screening – Every shift (ex. SCDs, TED hose, pharmacological interventions)						
Pain: • Assessed on admission, once per shift and as patient condition warrants, or new onset • Utilize appropriate pain scale and include pain intensity/level, pain type, pain location/orientation, pain descriptors, pain frequency, and onset.						
• Reassessed within 1 hour of pain medication administration						
Intake/Output: • Minimally once per shift – Document at end of shift and PRN (ex: 1800, 0600) and include IV infusions, urine, stool, etc.						

Care Plan and Education:
• Care Plan – Minimally every 24 hours and change in patient condition
  • Must be specific to patient (ex: CHF, COPD, Pneumonia)
  • Problems must include Knowledge Deficit and Pain
  • If applicable: Aspiration Risk, Risk for Impaired Skin Integrity, Restraints
  • Care plan for Hester Davis: Refer to Hester Davis protocol						

• Education – Minimally every 24 hours and change in patient condition • Must be specific to patient with teach-back once per shift						
Flu/Pneumonia Vaccine Screening: • Completed on admission/transfer						
• Document refusal/contraindications. If criteria met, vaccine/s ordered for 0900 the next morning, unless ICU prior (prior to discharge).						

Required Charting	Room	Room	Room	Room	Room	Room
Hester Davis: • HD Fall Risk Assessment – Within 4 hours of admission, once per shift, change in condition, and post fall						
• Implement individualized fall indicators/interventions (ex: non-skid slippers, fall band, mat, and signage).						
• Care Plan – Initiated upon initial assessment based on categories patient scored 2 or greater. Review and document progression minimally once per calendar day. • Interventions must be documented once per shift. Interventions documented in the care plan will carry over into the flowsheet. Note: If fall occurs, complete HD Flowsheet, Huddle Form, sig. event note, and incident report.						
Mobility: • Prior Mobility Level – Within 4 hours of admission						
• Stability and Current Mobility Level – Within 4 hours of admission, once per shift (minimum twice per day), change in condition and/or level of care						
• Mobility Goal – Once per shift (minimum twice per day)						
• Highest Mobility Level Activities Performed – Minimum three times per day						

Restraints:
• Restraint Order – "Yes" on initiation and when obtaining a new order
  • Non-violent – Re-ordered once per calendar day
  • Violent (Critical Care Areas Only) – Re-ordered every 4 hours (18+ adult)						

• Restraint Alternative – On initiation and when obtaining a new order						
• Clinical Justification – On initiation and when obtaining a new order						
• Education – All 4 rows on initiation and when obtaining a new order						
• Restraint Type – Upon initiation, when obtaining a new order, and discontinuation						
• Q2H Monitoring – Non-Violent and Violent – All rows on initiation and every 2 hours						
Restraint Monitoring Q 15 Mins – Violent – All 5 rows on initiation and every 15 minutes						
• Criteria Met for Discontinuation – Both rows on discontinuation (will auto-populate)						
Notes – Both on initiation and discontinuation utilizing appropriate restraints smart phrase(s); A 1-hour face-to-face assessment/note is required for violent restraints.						
Restraints Care Plan – Documented on daily (minimally)						
Restraints Patient Education – Documented on daily (minimally)						
Admission: • Admission Navigator – Completed within 18 hours of admission • Special attention to: Notification of Admission, Braden Scale, Aspiration Risk, Diabetes Compliance, HD Fall Risk, Lay Caregiver, Stool Screening, SIRS Screen, and Suicide Risk. Verify Columbia Suicide Severity Rating Scale was completed in ED. If not, complete upon admission.						
• 2 RN Skin Co-Sign (in integumentary section or note using smart phrase)						
Discharge: • Discharge planning screen completed						
• AVS completed with appropriate patient instructions						
• At least one follow-up appointment scheduled; If RN is unable to schedule appointment, document patient will make his/her own appointment in the AVS.						
• Discharge form utilized for patients being discharged to an ECF (prescriptions included for Class II medications)						