Describe how each step of the nursing process is operationalized in nursing practice throughout the organization.

The nursing process is an integral part of the fabric that comprises patient care at MGH. In all locations, the nurse assesses the patient, uses diagnostic reasoning to identify problems, creates a plan for nursing care that includes interventions and measurable patient care goals, and continually evaluates progress toward those goals. For the thirty-seven inpatient care units, the nursing process is evidenced in the standards describing the requirements for nursing documentation.

The Patient Care Services (PCS) model for nursing documentation provides a system to support the clinical decision-making that is the foundation of the nursing process. As stated in our Documentation Education Packet, “Nursing documentation is an essential component in the communication process that contributes to quality patient outcomes.” At present, nursing documentation is a manual system of written medical record forms used for inpatients and observation patients. The Standard for Documentation (attachment 6.5.a) describes the expectations around this documentation process. The standard outlines the basic requirements for the Staff Nurse (i.e., registered nurse) who is responsible for completion and documentation of the nursing process for all patients, and includes completion of:

- Admission Note
- Admission Assessment
- Problem / Intervention/ Outcome Sheet
- Progress Notes
- Treatment Record/One Time Treatment Record

The core components of this process have not changed significantly since MGH’s last evidence submission, however, through the Documentation/Communication Project improvements to the process have occurred. The Admission Assessment is now referred to as the Nursing Data Set Assessment with the first nine questions have been identified as “safety” questions that are required of all initial nursing assessments, regardless of the point of entry into the hospital (attachment 6.5.b). The revised standard also now requires problem-oriented progress notes rather than fully narrative documentation. An associated process change also requires that the on-coming and off-going Staff Nurses review the Nursing Data Set, Problem/Intervention/Outcome List, and most recent progress note at time change of shift report.
The multidisciplinary process for discharge documentation is fully automated and supports the final documentation for the hospitalized patient. The Discharge Documentation Module of the Provider Order Entry program was created several years ago to standardize the process, reduce redundancy, and coordinate the discharge process that involved more than one discipline. With the electronic system, there is a clear assignment of the responsibility for the components of discharge documentation. Data are entered only once and the discharge planning done by each discipline is housed in one place that is accessible to all care providers.

In other patient care areas, unit-specific documentation standards, processes and tools have been developed to support the nursing process. For example, in the Pre-admission Testing Area (PATA), Staff Nurses assess patients’ pre-operative needs, plan for pre-operatively testing, provide patient teaching about surgery, and begin to assess postoperative needs. The Preadmission Testing Area Perioperative Nursing Standards (attachment 6.5.e) describe how assessment, problem identification, interventions and evaluation are operationalized in this department.

In the Post Anesthesia Care Unit (PACU), the nursing process begins when a patient is received from the operating room and report is received from an anesthesia provider. The Post Anesthesia Care Unit Standards (attachment 6.5.f) describe the process for nursing assessment. It also includes documentation guidelines that require an admission note and use of the PACU flow sheet to document the nursing process. The admission assessment leads to identification of patient problems, which are often common or predictable for postoperative patients. For example, the PACU nursing assessment often leads to a diagnosis of pain, resulting in further assessment of the pain and creation of a plan of care to improve the patient’s comfort. Interventions often include administration of narcotics, which is followed by reassessment of the patient’s pain to determine the response to the interventions. ASPAN Clinical Practice Guidelines assist in the identification of appropriate interventions for postoperative pain, nausea/vomiting, and hypothermia, and ASPAN Guidelines for Discharge Criteria are used as part of the discharge evaluation.

On Blake 14, the Labor and Delivery unit, the components of the nursing process are documented using an electronic patient monitoring system called TraceView (OBTV). As described in the Policy and Procedure for Labor and Delivery:

- **Full nursing assessment will be completed in the OBTV system and will be updated with each visit during the current pregnancy.**
The policy continues to include the specific components of the physical and behavioral/psychosocial assessment, and patient education. It also states that:

- A plan of care will be developed with the patient and the OBCP

Progress toward identified plans is documented in specific areas depending on the outcome of the patient’s visit:

- Nursing documentation should be done on the triage form, the OBTV system, early pregnancy loss form and progress notes as appropriate.

Examples of the OBTV tools used for documentation of the nursing process in Labor and Delivery are included in Force 13.6.
MASSACHUSETTS GENERAL HOSPITAL
Department of Nursing

TITLE: STANDARD FOR DOCUMENTATION: INPATIENT CARE UNITS

POLICY:
The patient record is the legal document of care provided and the patient’s response to that care. The documentary role of nursing is to record all nursing care and treatment and the effectiveness of nursing interventions. Documentation on the patient record is an essential means of communications with health team members.

All entries will include date, time, full name, and title or licensure. Entries will be written in black or blue ink.

1. An admission note will be written at the time of admission in the progress notes by the registered nurse admitting the patient. The admission note will include date and time of admission. The registered nurse will document the patient problems.

2. A nursing data set assessment, and an initial plan of care (problem, intervention, outcome sheet) will be completed for each patient by the admitting registered nurse. This data set must be completed within 24 hours of the time the decision to admit was made. However, if the patient is unable to provide information and the family is unavailable, the RN should check the box (last page of form) indicating that the patient is unable to provide information. The patient information should still be obtained and documented as soon as possible. All entries should be dated, timed and initialed.

3. For each patient there will be problems identified based on the nursing assessment. The problems may be written as nursing diagnoses and or medical diagnoses. For each problem there will be identified outcome(s). Diagnostic reasoning is the process used to reflect on information that the nurse utilizes to identify patient problems and design interventions toward achievement of outcomes.

4. A progress note will be written in a problem oriented format at least every twelve hours and/or when there is a transfer of accountability between nurses (eg. 4 hour shift, 8 hour shift or 12 hour shift), and as patient condition warrants, by the RN caring for the patient. Nursing notes will reflect reassessment of patient condition, planning, mutual goal setting, interventions, and patient progress toward goals. Patient response to nursing interventions for resolution of nursing diagnoses of collaborative problems will be the focus. Discharge planning will be reflected in the progress notes.

5. Nursing activities generated by the nursing and medical plan of care will be recorded on the Treatment Record and One Time Treatment Record).

6. Patient education will be identified on the problem/intervention/outcome form and documented in the progress notes.
7. A transfer note will be written when a patient is transferred from one unit to another by the nurse transferring the patient and a note will be written by the nurse accepting the patient. A brief notation will be made when a patient leaves and returns from a procedure.

8. A discharge note will be written on line at the time of discharge by the registered nurse discharging the patient. The note will include patient condition, person accompanying the patient, mode of transportation, prescriptions, and follow-up appointments scheduled. There will be a notation of resolution of problem (nursing diagnosis/collaborative problem) and plans for follow-up.

9. Clinical Associates, Unlicensed Nursing Students (while in their clinical rotation) and all other non-licensed personnel may document on specified forms those measurements and treatments performed within the scope of their position description or clinical rotation objectives. Clinical Associates and Unlicensed Nursing Students (while in their clinical rotations) may also write progress notes and transfer notes co-signed by the registered nurse caring for that patient.

10. Errors in documentation will be corrected by putting a single line through the incorrect information, writing “error”, dating and initialing. For an error that covers a larger area, a large parentheses may be put around the section in error, or an “X” mark through the area, write “error”, date and initial. No “whiteout”, cross outs, or erasures are permitted.

11. When an entry has been omitted and it is necessary to document after others have charted, the nurse should designate the note “late entry” and note the date and time of the omission.

Approved: Council on Practice 02/94
Approved: Nursing Executive Committee 04/94
Revised: Nursing Practice Committee 06/97
Revised: Nursing Practice Committee 09/02
Revise: Nursing Practice Committee 08/23/05
TITLE: NURSING ADMISSION DATASET FORM

STANDARD:
- Every patient is to have an Admission Dataset form completed by a Registered Nurse within 24 hours of admission to the hospital.
- The first nine questions on this form need to be completed at the initial entry point at MGH at the time the patient is admitted to the hospital.
- In addition, the remaining pattern areas need to be completed within 24 hours of admission. Initials of the RN, date and time must be documented in the spaces on the right hand side of each pattern area, (page 3-5), when this information is obtained.
- When a patient is unconscious, unable to speak; and family is not available to provide information to the nurse, note this on the last page of the data set. Check off appropriate box, and note signature, date and time of entry.
- The RN ensuring completedness of the Nursing Data Set, will sign, date and time in the provided space on the last page of the form.

PURPOSE:
The purpose of this dataset form is to gather data related to a patient’s health status and to be used to identify actual or potential problems an adult patient may have at admission or during hospitalization or at discharge.

INSTRUCTIONS FOR USE:
1. The first nine questions on the form will be completed by the admitting Registered Nurse at the initial point of entry for the patient.
2. The RN interviews the patient. If the patient is unable to answer questions, Information may also be obtained from the family or medical record. Indicate where the information was obtained. i.e. data from- the patient, family, medical record. Note where the information was obtained on top of first page.
3. After completing the first nine questions, the RN must sign, and document the date and time of completion.
4. After completion of each subsequent pattern area, the RN must provide his/her initials, date and time on the lines provided in the right hand box.
5. Document reason for hospitalization and pertinent past medical history.
6. Cognitive/Perceptual Pattern area: Complete all questions. Note the belongings and assistive devices the patient has brought with them to the hospital.
7. Pain Assessment: All patients are assessed for presence of pain upon admission. Use the pain scale provided to note level of pain. If this scale is not appropriate for the particular patient, refer to nursing procedure manual: Pain Assessment Guideline for appropriate tools.

8. Substance Abuse History: All patients are assessed for use of Alcohol, tobacco, and illicit drug use. Every patient receives the smoking cessation booklet upon admission. If the patient has used tobacco within the last year, consult the smoking cessation @ #6-7443.

9. Allergies: List patient allergies to medications, foods, and latex.

10. Skin Integrity: Document any skin breakdown, noting location and stage as appropriate.

11. FOR ALL: Screening questions that may indicate the need for a consult to one of the other health care professionals are included in the assessment form. Following are guidelines for using these screening questions:

   - *Nutrition/Metabolic Pattern Area*
     Consult to the dietician is required if the patient answers yes to any of the questions and/or if he has any of the diagnoses listed in the gray area. A physician’s order IS NOT necessary to consult the dietician.

     If consult is required, document patient’s name and room number of the dietician consult form located on all units.

   - *Activity/Exercise and Cognitive/Perceptual Pattern Area*
     Cues have been added to assist the RN in determining the need to consider a consult to physical or occupational therapy, or speech/language pathology. A physician’s order IS necessary for such consults.

   - *Value/Belief Pattern Area*
     Screening questions have been added to assist the RN in determining the need to consult the hospital Chaplain.

     If consult needed call chaplain office (number on assessment form) with patient information and note call placed on assessment form.

   - *Safety Pattern*
     Screening questions to identify patient at risk. If the patient answers “yes” to one or more of these questions, the nurse should discuss the situation with the social worker to determine need for further action.

     All consults to physical therapy, occupational therapy, speech/language pathology, dietetics and pastoral care will be responded to as soon as possible, but within 24 ours. If, after the form is completed, the RN obtains additional information, that information should be documented on the last page under “Additional Information”. The RN signs and dates the entry.
12. The remaining patterns areas will be completed within 24 hours of admission to the hospital. After completion of each subsequent pattern area, the RN must provide his/her initials, date and time on the lines provided in the right hand box.

13. The RN ensuring completedness of the Nursing Data Set, will sign, date and time in the provided space on the last page of the form.
MASSACHUSETTS GENERAL HOSPITAL
Department of Nursing

TITLE: NURSING PROBLEM/INTERVENTION/OUTCOME SHEET – INSTRUCTIONS FOR USE

STANDARD: Active problems will be identified based on nursing assessment of the patient’s physical, psychosocial and discharge planning needs. These problems will be identified upon admission and throughout the patient’s hospitalization based upon ongoing assessment of the patient’s needs and response to the plan of care. Problems may be identified and listed by other disciplines on the problem list. Problems identified by nurses may be written as nursing or medical diagnoses. Nurses utilize the process of diagnostic reasoning to identify the individualized needs of the patient, analyze and synthesize patient data, develop a plan of care with defined interventions to assist in meeting the goals of care.

When using either the preprinted, non-computer or online problem lists, the nurse should select specific interventions based upon individualized patient care needs. Nursing progress notes should reflect the patient’s response to these interventions and any changes required to the plan of care.

PURPOSE: To describe the patient’s active problems identified by the nurse and/or other interdisciplinary providers and serve as a basis for developing the patient’s plan of care.

INSTRUCTIONS FOR USE:

1. Each problem will be numbered, dated, and signed by the identifying RN.

2. Patient problems and outcomes will be identified:
   • Upon completion of the admission dataset form
   • Based upon ongoing patient assessment, changes in patient condition, and response to identified interventions.

3. Problems and outcomes may be identified by any RN caring for the patient using nursing diagnoses terminology or established medical diagnoses.

4. The problem list will be reviewed daily.

5. When a problem is resolved, the nurse will document the date with his/her initials under the column marked “resolv’d” on the problem list.

6. At the time of transfer or discharge, outstanding problems and current interventions will be summarized in the transfer or discharge note.
7. The Problem List should be filed in the appropriate section of the patient’s Medical Record.
TITLE: NURSING PROGRESS NOTES

STANDARD: Every patient will have a nursing progress note written reflecting progress toward goals. The note is to be completed by the end of the shift and will be handed off to oncoming nurse as part of the change of shift report.

PURPOSE:
1. To reflect patient's progress towards goals.
2. To document abnormal physiologic data and synthesize information. Normal physiologic data will be captured on the flow sheet.
3. To record patient response to nursing interventions.
4. To document plan that should be focused on during the next shift.
5. To document when nurses have provided educational information and materials to patients.

INSTRUCTIONS FOR USE:
1. The nurse caring for the patient will write a progress note at least every twelve hours, when there is a transfer of accountability between nurses, and prn as the patient condition warrants.
2. Each nursing progress note will be titled "Nursing" and will:
   - indicate date and time note is written
   - include complete signature and licensure.
   - be goal focused with emphasis on progress towards goals.
3. Progress Notes shall contain:
   - problem number and name as recorded on the patient's problem list
   - changes in patient condition
   - the patient’s response to interventions
   - progress toward and/or achievement of expected outcomes
   - any change in plan of care
   - assessment if a patient is ready to learn
   - record who was taught, the response to the learning and the follow up plan.
The American Society of PeriAnesthesia Nurses Standards of Perianesthesia Nursing Practice is used as a guideline for development of the unit standards and as a framework for clinical practice.

STANDARDS FOR PREOPERATIVE CARE

Standard I
Every patient will be assessed by a registered nurse prior their scheduled surgical procedure either in PRE-ADMISSION TESTING AREA or by phone assessment:

A. Data shall be collected to evaluate the patient’s readiness for surgery and to identify specific patient care management. Preoperative information shall include, but is not limited to:
   1) Nursing functional health pattern assessment (see documentation guidelines)
   2) Preoperative Teaching: preoperative care, postoperative care, patient understanding of perioperative experience and discharge planning.
   3) Understanding of procedure
   4) Completion of Health Care Proxy Questionnaire if applicable
   5) Availability of accompanying responsible adult for patients undergoing day surgical procedures. Availability of safe transport home/ responsible escort as applicable.
   6) Provision of information regarding Gray Family Waiting area.
   7) Discharge planning and anticipation of discharge needs that can include but is not limited to: responsible adult to transport home and assist as needed at home, preparation of the home, postoperative physical limitations, and postoperative supplies/equipment. Consult with case manager as appropriate. Provide information and guidance to the Blum Patient Family Learning Center.
   8) Appropriate referrals:
      a. Chaplain/Clergy consult if patient requests
      b. HAVEN program
      c. Nutrition
   9) Assess need for interpreter. Be sensitive to cultural-language preference, personal beliefs and restrictions.
   10) Allow patient and family time to verbalize concerns, additional questions and assure understanding of the perioperative experience.

B. Preoperative phone calls will be made to select patients according to Same Day Surgery Unit guidelines. The registered nurse shall collect data described above, if applicable, and review the preoperative information with the patient including, but not limited to:
   1. NPO Guidelines
   2. Medications
      • Medications presently taking including herbs, supplements and over the counter.
      • Medications to take the day of surgery as instructed by MD.
3. Arrival time and location day of surgery
4. Gray Family Waiting Area: location and liaison RN role
5. Escort status for Same Day Surgical patients
   • Responsible adult
   • Must come up to SDSU unit to pick up patient
   • Contact information for escort
   • Arrival time
7. Limited luggage.
8. Discharge teaching/planning
   • Explain post-op instructions (especially if patient is to be discharged home same day as surgery.)
   • Pain management
   • Home supports systems: Case Manager consult
   • Prescriptions
     If the patient has a pharmacy card—suggest they bring it with them if they would like to have their postoperative prescription filled here or on the way home.
9. Allow patient and family time to verbalize concerns, additional questions and assure understanding of the perioperative experience.

Standard II: Perioperative Plan of Care

The perioperative nurse develops and coordinates the implementation of a dynamic nursing plan of care based upon an individualized patient’s assessment. The nursing plan of care guides each nurse to provide interventions in a manner congruent with the patient’s needs and goals, ongoing assessment, and patient progress is monitored through nursing outcome criteria. The perioperative nurse will collaborate with the patient, family, parents or guardian of pediatric patients, and significant other to develop this individualized plan of care. The plan of care may include, but is not limited to: physician orders, clinical protocols, and standards of care. Evaluation of the nursing plan of care is directed toward achievement of the desired nursing outcomes and patient’s readiness to meet discharge criteria from the perioperative settings.

Documentation standards are consistent and follow the standards set forth in NPM 2.11-NPM 2.22
POST ANESTHESIA CARE UNIT

Standards for Post Anesthesia Care: The American Society of PeriAnesthesia Nurses standards of postanesthesia care are used as a guideline for development and as a framework for clinical practice in this unit.

STANDARD I

A Post Anesthesia Care Unit (PACU) or an area, which provides equivalent postanesthesia care, shall be available to receive patients after anesthesia care. All patients who receive anesthesia shall be admitted to the PACU or its equivalent except by specific order of the staff anesthesiologist responsible for the patient’s care.

STANDARD II

A patient transported to the PACU shall be accompanied by a member of the Anesthesia Care team who is knowledgeable about the patient’s condition. The patient shall be continually evaluated and treated during transport with monitoring and support appropriate to the patient’s condition. A member of the anesthesia care team shall remain with the patient until the RN has taken responsibility for the nursing care of the patient.

Standard III

Upon arrival in the PACU, the patient shall be re-evaluated and a verbal report given to the responsible PACU nurse by the member of the Anesthesia Care team who accompanies the patient. Report shall include, but not limited to:

1. Relevant preoperative status and medications
2. Anesthesia technique, anesthetic agents and other intra-operative medications
3. Length of time anesthesia administered, time reversal agents given.
4. Type of procedure.
5. Estimated blood/fluid loss and replacement
6. Complications occurring during the anesthesia course, treatment and response
7. Emotional status and response

Standard IV

Upon admission to the post-anesthesia care area, a registered nurse will assess each patient. The initial assessment will include, but not limited to:

1. Integration of preoperative data and transfer of care data.
2. Vital signs: airway patency/status, respiratory status, oxygen saturation, blood pressure, heart rate and rhythm, temperature and pain level.
3. Intravenous site, Fluid therapy and patency of infusions
4. Level of Consciousness
5. Pressure readings of invasive monitoring lines if applicable
Attachment 6.5.f continued

6. Position of the patient
7. Condition and color of the skin
8. Patient safety needs
9. Neurovascular: peripheral pulses and sensation of extremity
10. Condition of dressings, description of drainage if applicable
11. Condition of suture lines if no dressing.
12. Drainage tubes; types, patency, output
13. Neurological assessment as appropriate to the procedure

Standard V
The Patient’s condition shall be evaluated continually in the PACU:
1. The patient shall be observed and monitored by methods appropriate to the patient’s medical condition and at intervals outlined below (see Standard VII: Documentation guidelines). Particular attention should be given to monitoring oxygenation, ventilation, and circulation. During recovery from all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed during Phase 1 recovery.
2. An accurate written report of the PACU period shall be maintained via the PACU flowsheet. Use of appropriate PACU scoring system is utilized for each patient on admission, at appropriate intervals prior to discharge, and at the time of discharge.
3. General medical supervision and coordination of patient care in the PACU should be the responsibility of an anesthesiologist.

Standard VI
Discharge criteria: Per ASPAN standard, data is collected and recorded to evaluate the patient status for discharge. This criterion is used as a guideline for discharge. Final discharge evaluation is based on sound clinical judgment and in consultation with the PACU anesthesiologist. The following elements should be considered and evaluated prior to discharge:
1. Airway patency, respiratory function and oxygen saturation
2. Stability of vital signs, including temperature and lab values.
3. Level of consciousness and muscular strength
4. Patency of tubes, catheters, drains, intravenous lines
5. Skin color and condition
6. Intake and output
7. Comfort Pain score level less than 5, or negotiated with patient
8. Anxiety
9. Child-Parent/significant other interactions

Standard VII
Documentation guidelines:
1. All patients shall have an admission note upon arrival to the PACU:
   a. all notes shall be dated and timed
The note should include any assessment that is not documented on the PACU flowsheet. Specific detail to surgical site assessment, present pain assessment and interventions and any other patient needs that are identified and addressed are documented in the PACU admission note.
Attachment 6.5.f continued

b. Unusual post-op events shall have a narrative nursing progress note and flowsheet documentation.
   a. the narrative should include:
      1. the event
      2. treatment management
      3. resulting outcome of effect
      4. names of those present
      5. others informed of the event
      6. time and date of the complication
      7. a reassessment narrative with resolution

2. All patients (except those in the PACU overnight area), staying 2 hours or more hours shall have a narrative nursing progress note every 2 hours until discharge criteria met. Continued patient evaluations in regards to surgical site re-assessment, nausea/vomiting or pain issues are documented at a minimum of every two hours and interventions initiated are addressed.

3. PACU overnight patients shall follow the SICU Standards of Practice.

4. All patients shall have a nursing discharge progress note prior to leaving the PACU.
   a. the narrative will include:
      1. the time and date
      2. patient condition (specific documentation as to surgical site continued reassessment, ongoing pain assessment and effectiveness of present pain management, nausea/vomiting)
      3. Patient destination
      4. Name of chaperone accompanying patient

5. The PACU flowsheet shall serve as the PACU assessment documentation.
   a. Every 15 minutes for the first hour.
      1. After the first hour, every 30 minutes x 2 hours
      2. Then every 60 minutes until discharge
   b. The PACU flowsheet shall serve as a guideline for patient assessment and progress back to baseline.
      1. The Aldrette Score is a guide for patient assessment and readiness for discharge. A score of 10 is not required for the patient to meet discharge criteria based on the individual patient's baseline.
   b. The PACU flowsheet shall serve as Pain documentation and resulting outcome.
      1. If pain score greater than 5 on discharge, additional documentation is needed on the discharge progress note.
Standard VIII:

Care and Management of the Patient undergoing Electroconvulsive therapy (ECT) in the PACU.

A. Patients undergoing ECT in the PACU will follow the above PACU standards of care with the following exceptions:

1. Documentation will be utilization of ECT Interdisciplinary flowsheet.
2. Documentation of any unusual events will be consistent with PACU standards of notation in the Progress notes.
3. Discharge criteria will be consistent with the above PACU standard. Ambulatory/Day ECT patients will be discharged through the Same Day Surgery unit and discharge criteria will be consistent with SDSU discharge criteria.

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