

DOCUMENTATION DURING COVID-19

Documentation is an ongoing means of communication among healthcare professionals. The medical record serves as the legal document in the event of a negative outcome/claim. Thorough documentation is critical to the facility's success to support proper assessment and care and services were provided to the resident.

Just the Facts:

Factual - make sure all entries represent the facts

Actual - record all entries as they happen, with the date and time of the entry

Complete - make sure all entries are complete

Timely - Document all events as close as possible to the time they occurred

Sensible - take care that all entries make sense and the reader understands what was written

Medical Record Documentation:

- All notifications to the physician; include the physicians name and the date/time of the notification.
- All notifications to the legal decision maker, include the person's name and the date/time of the notification.
- Utilize the nursing process when documenting:
 - Assessment of the resident
 - O Diagnosis nursing diagnosis such as SOB, pain, etc.
 - Plan what is the plan based on the assessment such as notify the physician etc.
 - Implementation implement the plan such as administer a medication, transfer to the hospital, etc.
 - o Evaluation evaluate the resident after the plan is implemented.

Facility Documentation

- Development and updates to policies
- Dates of Implementation of interventions to prevent the spread of infection:
 - When non-essential visitors were restricted
 - Education to staff and residents on policy changes
 - o Communal activities were put on hold and individual activities were initiated
 - Screening of staff and essential HCP was implemented
 - Mandatory, universal use of face masks
 - o Communications to residents and, family members and staff
 - Challenges faced by the facility such as shortages of PPE and efforts taken by the facility to solve those challenges.
 - Notifications provided to, or communications with, government entities, including local health departments, state licensing agencies, etc., regarding COVID-19. Include the name and title of the individual communication occurred with.

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This policy and procedure is not intended to replace the informed judgment of individual physicians, nurses or other clinicians nor is it intended as a statement of prevailing community standards or minimum standards of practice. It is a suggested method and technique for achieving optimal health care, not a minimum standard below which residents necessarily would be placed at risk.