

PROCEDURE FOR: Documentation: Standard Care Plan (SCP)

- POLICY:
1. On a daily basis, each RN or LPN is responsible for initiating, reviewing, updating and/or revising the individualized SCP for each assigned patient. This review will be documented on the Inpatient Daily Chart Check form.
 2. If the LPN initiates the SCP on admission, an RN must validate and co-sign the SCP.
 3. All documentation on the SCP must be done in ink.

PROCEDURE:

- | <u>ACTION</u> | <u>POINTS OF EMPHASIS</u> |
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| 1. Each page of the SCP form must be stamped with the patient addressograph card in designated area. | |
| 2. Each individual who documents on the form must write his/her initials and signature in the designated box in the upper left hand corner of each page on which they document. | |
| 3. As patient care problems are activated, document the date, and the initial of the RN or LPN who activated the problem in the "Started" columns next to the problem statement. | |
| 4. Interventions/protocols are initiated by writing the date of initiation and the RNs or LPNs initials in the "Started" column next to the specific intervention/protocol initiated. | 4. Check the nursing web page for the most current list of active protocols. |
| 5. Modifications of interventions/protocols are written under that intervention. | |
| 6. Additional interventions/active protocols, not preprinted on the SCP form, can be added in the blank spaces under the appropriate problem. | |
| 7. Nursing interventions/protocols are discontinued by documenting the date and RN or LPN initials in the "Resolved" column next to the specific intervention. | |

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ACTION

POINTS OF EMPHASIS

8. As problems are resolved, document the date and RN or LPN initials in the "Resolved" columns next to the problem statement.

8. For units not using Charting by Exception, a Progress Note should be written in focus format documenting patient response to care and resolution of each problem.

For units using Charting by Exception: A Progress Note should be written documenting resolution of problems when problem resolution cannot be determined by information on the Flowsheet.

APPROVAL: Nursing Standards Committee

EFFECTIVE
DATE: 8/90

REVISION
DATES: 12/93, 1/96, 9/97, 11/99, 11/02, 4/03, 10/06, 7/09

REVIEWED
DATES: 12/08