
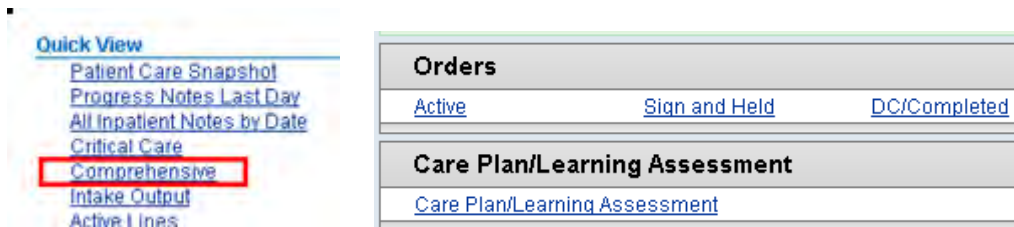


Student Nurse Clinical Documentation Requirements Guide for Nursing Instructors

Start of Shift

□ Review Patient Information

From the Summary Activity  Click on **Comprehensive Report**



- Orders to be Acknowledged
- Active Orders
- Nursing Orders to complete
- Orders needing specimen collection
- Verify lab collection status is correct for the patient
- Review care plan goals

□ Review Due Medications

From the Comprehensive report , scroll down to the medications section.



- Click Report hyperlink to review 3 day MAR report
Click the arrow to go directly to the MAR

Shift Documentation Requirements

The student enters their documentation using the  navigator.

- Vital signs
- Intake/Output
- LDA insertion/ discontinuation/assessments
- Wound assessments (if applicable)
- Daily Cares
- Medication Administration from the MAR
- Physical assessment in Patient Care Summary – the following sections **MUST** be **completed** each shift. Additional documentation is based on patient condition.
 - Cognitive/Perceptual/Neuro
 - Sleep/Rest Relaxation
 - Safety
 - Falls
 - Elopement (with RN)
 - HEENT
 - Cardiac
 - Peripheral Vascular
 - Respiratory
 - Nutrition
 - GI
 - GU
 - Musculoskeletal
 - Braden (daily on day shift)
 - Skin

- Document on Specialty flow sheets as indicated (examples: Neuro/LAM, Restraint, Stroke, etc)
 - Patient Education
 - **Review** Teaching Records
 - **Document** against teaching point when instruction has occurred
 - **Complete** any teaching titles in which all teaching points have been addressed
 - Document your End of Shift Summary note using the care plan note
- To review the student's documentation**

From the Patient Summary Activity, scroll to the bottom of Nurse Index report and click on the View-Only Flowsheet Data report.




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All Flowsheet Templates (all recorded)

- [Vitals I&O Summary Flowsheet](#)
- [Triage Plan Flowsheet](#)
- [IV-Airway Assess Flowsheet](#)
- [Wound Assessment/Care Flowsheet](#)
- [Specimen Collection Status Flowsheet](#)
- [Adult Patient Care Summary Flowsheet](#)
- [Adult Patient Profile Flowsheet](#)
- [Expected Discharge Flowsheet](#)

Select the flowsheet and corresponding date which contains the student's documentation. This is the easiest way to view flowsheet documentation.



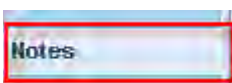
Row Name	10/23/12 0700	10/23/12 0659	10/23/12 0300	10/22/12 2300
Vitals I&O Summary				
Intake (ml)				
P.O.	--	125 mL -SC	--	--
IV Maintenance Volume (mL)	--	625 mL -SC	--	--
Vital Signs				
Temp	99.7 F (37.6 °C) -SC	--	100.1 F (37.8 °C) -SC	100.5 F (38.1 °C) -SC
Temp axc	Oral -SC	--	Oral -SC	Oral -SC
Pulse	84 -SC	--	82 -SC	85 -SC
Resp	24 -SC	--	20 -SC	20 -SC
BP	115/72 mmHg -SC	--	118/77 mmHg -SC	118/79 mmHg -SC
BP taken on	Left Upper Arm -SC	--	Left Upper Arm -SC	Left Upper Arm -SC
Patient Position	Supine -SC	--	Supine -SC	Supine -SC
Oxygen Therapy				
SpO2	99 % -SC	--	100 % -SC	98 % -SC
O2 Device	Nasal cannula -SC	--	Nasal cannula -SC	Nasal cannula -SC
Pain Assessment				
Pain Scale Used	Numeric -SC	--	Numeric -SC	Numeric -SC
Pain Rating	0 -SC	--	0 -SC	0 -SC
Pt's Tolerable Pain Goal	2 -SC	--	2 -SC	2 -SC

Co-signature Requirements

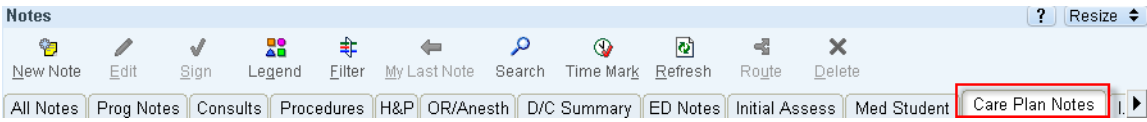
Per Froedtert policy all student documentation must be cosigned. This requirement is in place whether a student writes a note or not.

- Students document notes related to the patient's care plan progress in a Care Plan Note.**

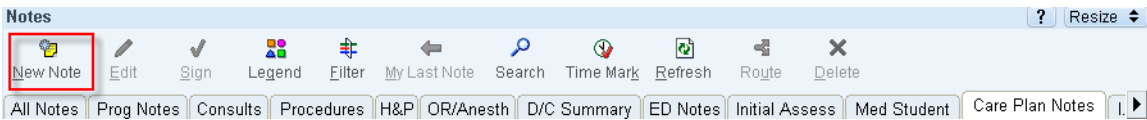
- Select the Notes Activity



- Click on the tab Care Plan Notes

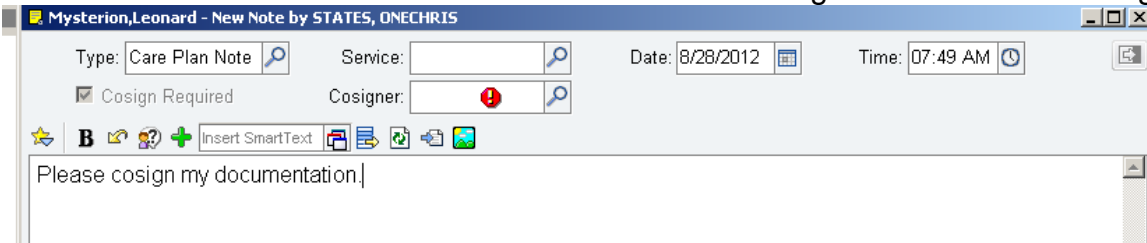


3. Click on New Note

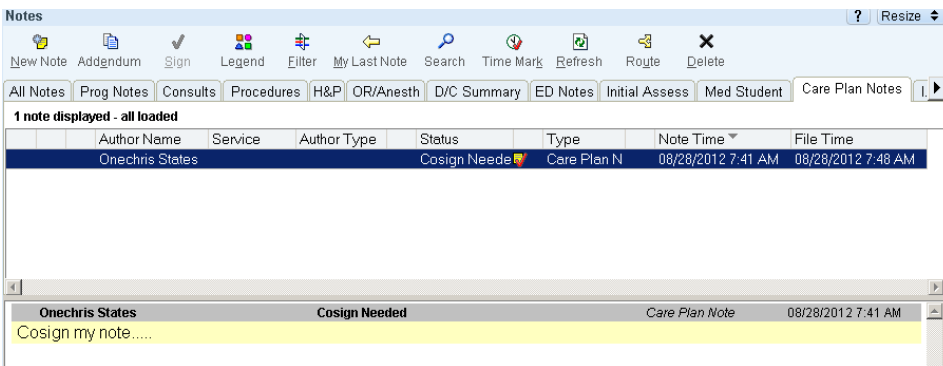


4. The note type will default to Care Plan Note. The student is required to add a cosigner. The cosigner can be the nursing instructor or the nurse caring for the patient. Decide who this is in collaboration with the instructor.

The student writes a note based on direction from nursing instructor. Student signs the note.

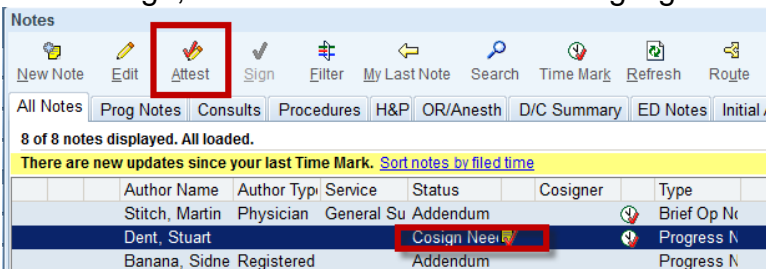


5. Once the student signs their note it will appear in the care plan notes tab as well as the All notes tab.



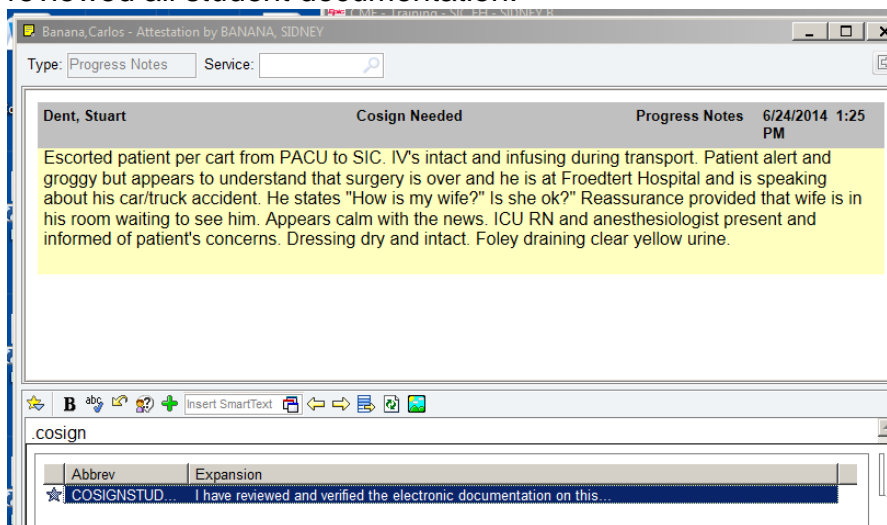
Cosign your student's documentation:

6. To cosign, click on the student note to highlight it. Click the **Attest** button.

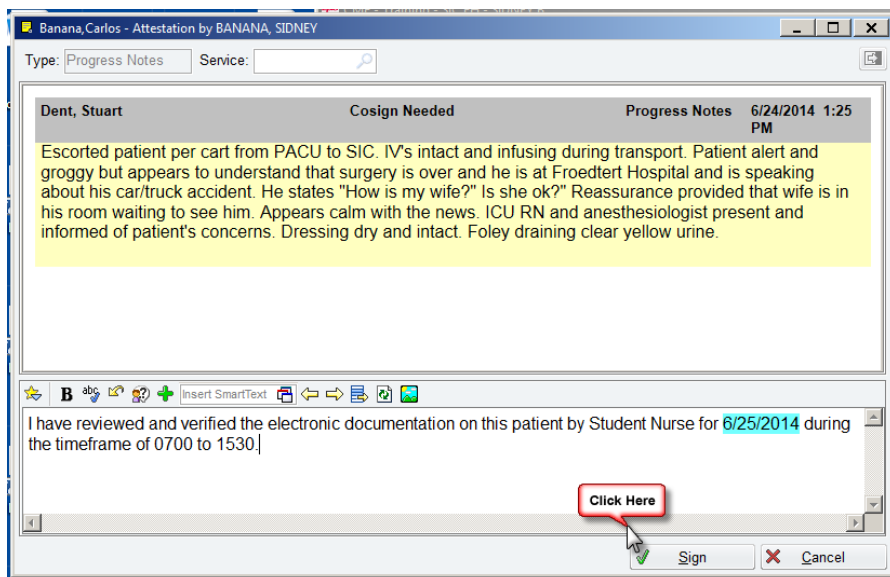


7. You may add additional information to the student's note in the free text field.

Then, enter the dot phrase titled **.cosign** and double click to enter text. This indicates you have reviewed all student documentation.



8. Enter text in the *** areas. You may add text before or after this statement also. SIGN the note!



9. The status of the note now changes to **Attested**.

	Author Name	Author Type	Service	Status	Cosigner	Type	Note Time	File Time
	Stitch, Martin	Physician	General Su	Addendum		Brief Op N	06/24/2014 2:31 PM	06/24/2014 2:33 PM
	Dent, Stuart			Attested	Banana, Si	Progress N	06/24/2014 1:25 PM	06/25/2014 10:34 AM
	Banana, Sidne	Registered		Addendum		Progress N	06/24/2014 1:00 PM	06/24/2014 5:40 PM
	Almndwhite, Al	Physician		Signed		Anesthesia	06/24/2014 12:55 PM	06/24/2014 12:56 PM

If your student does not write a note then the instructor must click new note from the All Notes tab. Select progress note and use **.cosign** to state they have reviewed the student's electronic documentation.

Cosign (Attest) your student's documentation at the end of their shift after you have reviewed it.