A) Policy Statement

The Nursing Process will be evident throughout nursing documentation including: assessment, identification of priority problems, planned interventions, actual interventions, and evaluation of patient responses. Nursing care is guided by the nursing process and documentation is based on biopsychosocial health care concepts, relevant clinical research, and standards of care and practice.

B) Purpose of Policy

The nursing process is a framework for providing and documenting nursing practice.

C) Procedure

1. Problems are identified based upon assessment data within twenty-four hours of admission.

2. The list of problems should be formulated from the nursing assessment, patient and family input, multidisciplinary patient care conferences, and referrals or past medical records when applicable.

3. The mutual plan of care should be revised based on the patient’s response to care and changes in condition or diagnosis.
   a. The Registered Nurse (RN) is responsible for maintaining the problem list and associated planning, interventions, and evaluations.
   b. All nursing staff are encouraged to contribute to the nursing process.
   c. Revision or update of the problems, planned interventions, and evaluation of patient responses should be made under the supervision of the RN.

4. Current problems are listed on the Mutual Plan of Care.

5. Implementation of the nursing process and progress toward expected outcomes are reflected in the electronic medical record (EMR).
Policy 3364-110-07-05
Nursing Process Documentation
Page 2

|-----------------------|------|------|------|------|------|------|------|------|------|

Next Review Date: 5/2018

Policies Superseded by This Policy: