|  |  |
| --- | --- |
| **What To Chart And When To Chart It** | |
| **WHAT** | **WHEN** |
| Nursing Admission History and Screening Data | Within 24 hours of admission  May be collected in a shorter time frame based on the patient’s needs, or condition, or anticipated length of stay (LOS.) |
| In cases where it is not in the best interest of the patient to collect and document the entire data set at the time of admission, the following guidelines are followed | |
| Section 1 Data  Section 2 Data  Section 3 Data | Complete this section during the initial admission period  Collect and document data within the first 8 hours  Collect and document data within 24 hours of admission  Do not finalize until complete. Save as Draft & exit |
| Nursing Assessment | Complete documentation of the nursing assessment should be initiated as soon as possible at admission and/or:   1. The beginning of a shift 2. When the patient’s location changes 3. When the patient’s clinical condition changes |