

Requesting a Program Flex to Implement Surge Standards of Nursing Documentation

The California Hospital Association has been asked how a hospital can request a program flex for nursing documentation. To do this, the hospital must complete the [CDPH Form 5000A](#), submit it to CHCQdutyofficer@cdph.ca.gov, and copy [the local CDPH District Office](#). CHA has developed the following information and sample language to help hospitals fill out the form. (If the hospital needs CDPH to approve the request within eight hours, the hospital should put the word “URGENT” in the subject line of the email.)

Here’s how to complete various parts of the CDPH form:

“Approval Request”

Check the box marked “Other”

“What regulation are you requesting program flexibility for?”

Answer: Title 22, Sections 70215(d) and 70749(a)(6)(4)

“Justification for the Request”

Check the first box, which says, “A disease outbreak”

“Additional Information”

Each hospital will need to carefully review the sample language below. The hospital must make a choice in paragraph 2 at the bottom (see yellow highlighting below). Once that choice is made, the language that is not chosen should be deleted. In addition, the hospital must revise the CHA sample language as necessary to fit its unique circumstances. CHA is providing this language as a starting point only to help hospitals consider various options.

BACKGROUND

During public health emergencies, the standards for documenting nursing care provided may have to change. While the primary goal is to maintain usual standards of care as much and for as long as possible, surge standards of documentation may need to be implemented if resources are scarce. The American Nurses Association, The Joint Commission, and the Centers for Medicare & Medicaid Services all recognize that during surge conditions, patient care should take precedence over documentation.

POLICY STATEMENT FOR SURGE DOCUMENTATION STANDARDS

- The intent of modified documentation standards is to allow nurses to prioritize direct patient care in the event of patient surge and diminished resources to meet patient care needs.
- The priorities of documentation are to support safe and effective patient care and communicate information among health care team members to promote continuity of care.
- Only the chief nursing officer (CNO) or designee can authorize the implementation of modifications to usual documentation standards based on patient census and nurse availability. The CNO may choose to implement modified standards for a service line or an individual unit(s) (such as the ICU).

- The surge standards will remain in place until the CNO or designee revokes them. The CNO shall revoke the surge standards when available nursing resources are sufficient to carry out the usual and customary documentation standards.
- The surge standards represent the minimum required documentation. When feasible, additional documentation above the minimum standard should be completed.
- The time period that the surge documentation standards are in effect should be noted in the patient's medical record or the hospital's policies and procedures.

REQUEST FOR PROGRAM FLEX

As part of its COVID-19 response, our hospital seeks a program flex to implement surge standards of nursing documentation, whereby nurses will document only the most critical information needed to provide an accurate picture of the patient condition, reflect the plan of care, and demonstrate the care provided. We request program flex for the following regulations:

Title 22, Section §70215 — “Planning and Implementing Patient Care”

- 1) Ongoing patient assessments will continue to be performed as required by each unit's guidelines of care. However, documentation of these assessments will be made by exception. “By exception” means that a notation is made only when there is a deviation from baseline, deviation from normal limits, or an unexpected outcome.
- 2) Ongoing patient education will continue to be performed, as required by each unit's guidelines of care. Documentation in the medical record will be made by exception. However, discharge patient education will continue to be performed and documented for each patient as usual.
- 3) Documentation of formal nursing diagnosis and care plans in the medical record will be eliminated. This aligns with CMS's [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#), which waives the requirements of 42 CFR §482.23(b)(4), which requires the nursing staff to develop and keep current a nursing care plan for each patient. Instead of having the nursing care plan noted in one designated section of the medical record, nursing staff will be allowed to document the elements of the care plan within the existing documentation throughout the medical record.

Title 22, Division 5, Chapter 1, §70749 (a) (6) (A) — “Patient Health Record Content”

- 1) Documentation of nursing care administered pursuant to each unit's guidelines of care will be restricted to the following:
 - Patient assessments by exception
 - Abnormal findings and clinical status changes (e.g., lungs that are clear to auscultation are documented if the patient had crackles previously)
 - Critical lab values/critical results not already documented
 - Vital signs, including pain assessment
 - Administered medications and treatments (including blood transfusions)
 - Invasive lines and tubes - lines, drains and airway (LDA) documented upon insertion or presentation. Ongoing assessment of LDAs will take place; documentation of care by exception (abnormal findings)
 - Clinically relevant attending and consulting provider communication
 - Clinically relevant intake and output
 - Key patient information (e.g. height, weight, allergies, advance directives, home medications, admission intake form)
 - Restraint assessments and monitoring
 - Patient education at discharge

- Isolation precautions
 - Anything that, in the judgment of the nurse, would compromise patient safety if it were not documented
 - In addition, nurses will document a note at the end of each shift for clinically significant events if not documented elsewhere.
- 2) Other nursing care that is provided (including but not limited to activities of daily living, hygiene, routine catheter and ostomy care, repositioning, infection control practices, etc.), will continue to be performed as required by each unit's guidelines of care, but documentation will be done: **[HOSPITAL CHOOSES ONE OF THE FOLLOWING OPTIONS]**
- a. By exception – for example, if a patient must be turned and repositioned Q2H, a note will be entered only if this is not done.
 - b. In an end-of-shift note – for example, the note would state that “the patient was turned and positioned Q2H as per policy,” rather than having nurses document every two hours throughout the shift.
 - c. Hybrid – for example, activities of daily living and hygiene will be documented by exception, but routine ostomy care and repositioning will be documented in an end-of-shift note rather than documenting throughout the shift. Hospitals will want to list which activities are documented by exception and which are documented in the end-of-shift note.

The hospital's CNO or designee has the authority to initiate surge standards of documentation, taking into consideration patient census and nurse availability. Based on this assessment, the CNO may implement modified standards for a service line or an individual unit(s) (such as the ICU). Surge documentation will remain in place until revoked by the CNO or designee. All nurses working in units with modified standards will receive education on the surge documentation requirements and expectations.