Risk Events and Medication Timeliness Policy

Purpose:

To ensure timely communication and documentation of critical events and medication administration issues, promoting patient safety, and transparency.

Scope

This policy applies to all staff responsible for administering medication and documenting patient care.

1. Risk Event Notification and Documentation

- For any incident requiring a **risk entry** (including but not limited to skin tears, falls, abrasions, bruises, or similar events), the following must be performed:
  - **Immediate notification** of:
    - The patient's **family or designated representative**
    - The **medical provider** responsible for the patient's care
  - **Documentation** in the **nurses' notes** that includes:
    - Description of the event
    - Time and date of occurrence
    - Actions taken
    - Confirmation that family and provider were notified (including time of notification)

2. Medication Administration Delays

- If any medication is administered **later than the scheduled time**:
  - The **medical team must be notified immediately**.
  - The delay and notification must be **documented in the nurses' notes**, including:
    - Medication name and scheduled time
    - Actual time of administration
    - Reason for delay
    - Name of the person notified and time of notification

Compliance

Failure to follow this policy may result in corrective action in accordance with organizational standards. Non-compliance may be reviewed by supervisory or regulatory bodies as appropriate.

Accurate Completion and Sign-Off of Treatment Records Policy

Purpose

To ensure all Licensed Practical Nurses (LPNs) accurately complete and sign off on treatment records according to established charting codes and documentation standards. This policy is intended to prevent incomplete, misleading, or falsified documentation, and uphold patient safety and regulatory compliance.

Scope

This policy applies to all LPNs responsible for administering, documenting, and verifying the completion of patient treatments.

Policy Statement

All Licensed Practical Nurses (LPNs) must accurately and truthfully complete and sign off on treatment records according to established charting codes, administration rules, and documentation standards. This policy is intended to prevent incomplete, misleading, or falsified documentation and uphold patient safety and regulatory compliance. Signing off on a treatment that was not completed, not fully performed, or not performed at all is considered falsification of documentation and is strictly prohibited.

Documentation Requirements

LPNs must:

1. Follow Chart Codes: Use only approved charting codes listed in the treatment record with corresponding administration details.

2. Sign Only After Completion: Sign off on treatments only after the treatment has been fully completed.

3. Never Pre-Sign or Batch Sign: Documentation must reflect real-time completion. Pre-signing, batch signing at the end of a shift, or signing without completion is not permitted.

4. Document with Accuracy: Ensure all entries, including exceptions or refusals, are accurately reflected using appropriate chart codes.

5. Notify as Required: Report any inability to complete a treatment—including equipment issues, patient refusal, or change in condition—to the charge nurse or supervisor.

This includes all treatments documented in electronic or paper medical records.

Treatments Covered

This policy includes, but is not limited to, the following treatments and associated orders:

- Skin sweeps and skin integrity checks
- Wound care
- CPAP/BiPAP therapy and related respiratory orders
- Oxygen use and adjustments
- Application of creams, ointments, and topical treatments
- Any other treatment orders listed in the patient’s record

Prohibited Actions

The following actions constitute falsification of documentation and are strictly prohibited:

- Signing off on treatments that were not completed
- Signing off without verifying completion
- Documenting care that was only partially performed as completed
- Pre-signing treatment records before performing care
- Documenting care performed by another staff member without proper authorization

Any staff found engaging in these behaviors may be subject to disciplinary action, up to and including termination, in accordance with facility policy and state regulations.

Acknowledgment

I acknowledge that I have read and fully understand these policies. I further acknowledge and agree that failure to comply with these policies may result in disciplinary action, up to and including termination, and may also carry legal or licensing consequences under applicable state and federal regulations. I understand that this acknowledgment will be kept in my personnel file. By signing below, I confirm my agreement, understanding, acceptance, and commitment to follow these policies.

Print Name and Title: ________________________________

Signature: ____

Date: ____