

Patient Assessment Documentation Package (PADP)

C3-C1 Conversion Project

Admission – RN Assessment User Manual for NUPA Version 1.0



April 2012

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Office of Information and Technology (OIT)
Office of Enterprise Development (OED)

Revision History

Date	Revision	Description	Author
May 2010	1.0	Initial version for v1.0	CBeynon
August 2010	1.1	Add content	CBeynon
August 2010	1.2	Format content	CBeynon
September 2010	1.3	<ul style="list-style-type: none"> Split manual into three manuals <i>Admission – RN Assessment and Nursing Data Collection User Manual</i> Changed dates to October 	CBeynon
November 2010	1.3	<ul style="list-style-type: none"> Changed dates to November Updated topics to be the same as online help 	CBeynon
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December 2010	1.5	Removed the Nursing Data Collection section to create a 4th user manual <i>Admission – RN Assessment</i>	CBeynon
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Date	Revision	Description	Author
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Introduction

The Patient Assessment Documentation Package (PADP) Version 1.0 is a Veterans Health Information Systems and Technology Architecture (VistA) software application that enables Registered Nurses (RNs) to document, in a standardized format, patient care during an inpatient stay. Although the content is standardized for use across the VA system, some parameters can be set to support the unique processes at individual medical centers.

PADP interfaces directly with several VistA applications, including Computerized Patient Record System (CPRS), Clinical Reminders, Consult Tracking, Allergy/Adverse Reaction Tracking, Mental Health Assistant, Vitals, and Patient Care Encounter (PCE).

PADP is a Delphi application, which supports RNs in documenting patient care during an inpatient stay. It includes the following templates:

- Admission – RN Assessment allows RNs to document the status of the patient at admission.
- Admission – Nursing Data Collection allows Licensed Practical Nurses (LPNs) and other nursing staff, including the RN, to enter basic patient data, such as vitals and belongings at the time of admission.
- RN Reassessment allows RNs to document the condition of the patient on a regular basis and any time during the inpatient stay.
- Interdisciplinary Plan of Care interfaces with admission and reassessment data, and allows additional information to be entered by the RN and other health care personnel (physicians, social workers, chaplain, etc.). All clinical staff can enter information into the Plan of Care. The Plan of Care can be printed and given to the patient when appropriate.

PADP consists of a KIDS build, NUPA 1.0, and four (4) Delphi GUI templates in three executables.

1. The executable, **Admassess.exe**, contains the Admission - RN Assessment template and the Admission - Nursing Data Collection template.
2. The executable, **Admassess_Shift.exe**, contains the RN Reassessment template.
3. The executable, **Admassess_Careplan.exe**, contains the Interdisciplinary Plan of Care template.

Each template is associated with a note.

- The Admission - RN Assessment template is associated with the note: **RN Admission Assessment**
- The Admission - Nursing Data Collection template is associated with the note: **Nursing Admission Data Collection**
- The RN Reassessment template is associated with the note: **RN Reassessment**
- The Interdisciplinary Plan of Care template is associated with the note: **Interdisciplinary Plan of Care**

PADP adds to VistA, a new namespace (NUPA), four (4) Progress Notes, five (5) printouts, fourteen (14) files, thirty-six (36) parameters, and new health factors. The 5 printouts are:

1. The Daily Plan[®] is a health summary designed to be given to the patient and family
2. Plan of Care is a plan designed to guide the nursing staff
3. Discharge Plan is for discharge planners
4. Belongings is a list of patient belongings
5. Safe Patient Handling is designed to guide the transfer of a patient

Using Admission – RN Assessment

Registered Nurses (RNs) or ancillary nursing personnel use the Admission - RN Assessment template to document inpatient care in a standardized format. With the assessment template, you collect basic information associated with the patient at the time of admission, such as vitals, level of pain, skin condition, and status of respiration.

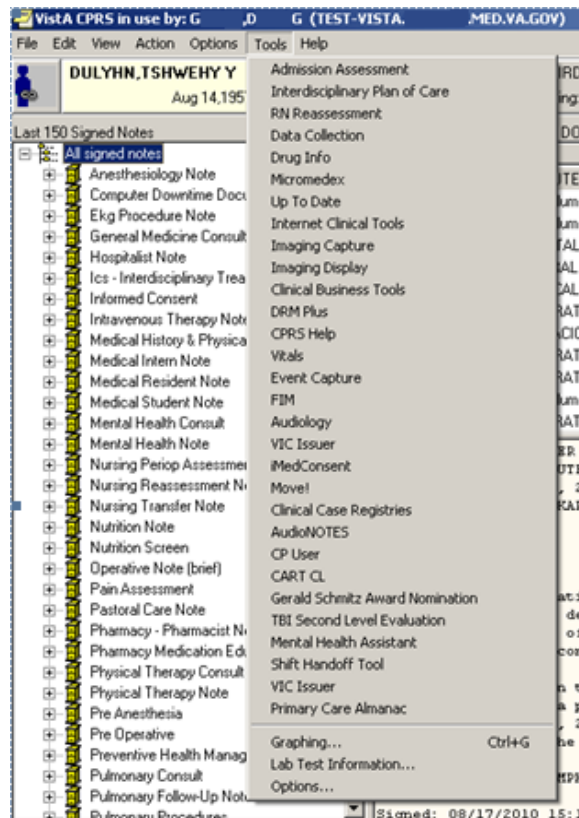
Opening Admission – RN Assessment

You access the Admission – RN Assessment through CPRS from the **Tools** menu.

1. Open CPRS.
2. Select a patient.
3. Click **Tools**.
4. Select **Admission Assessment**.

Enter a patient window automatically opens to the CPRS patient.

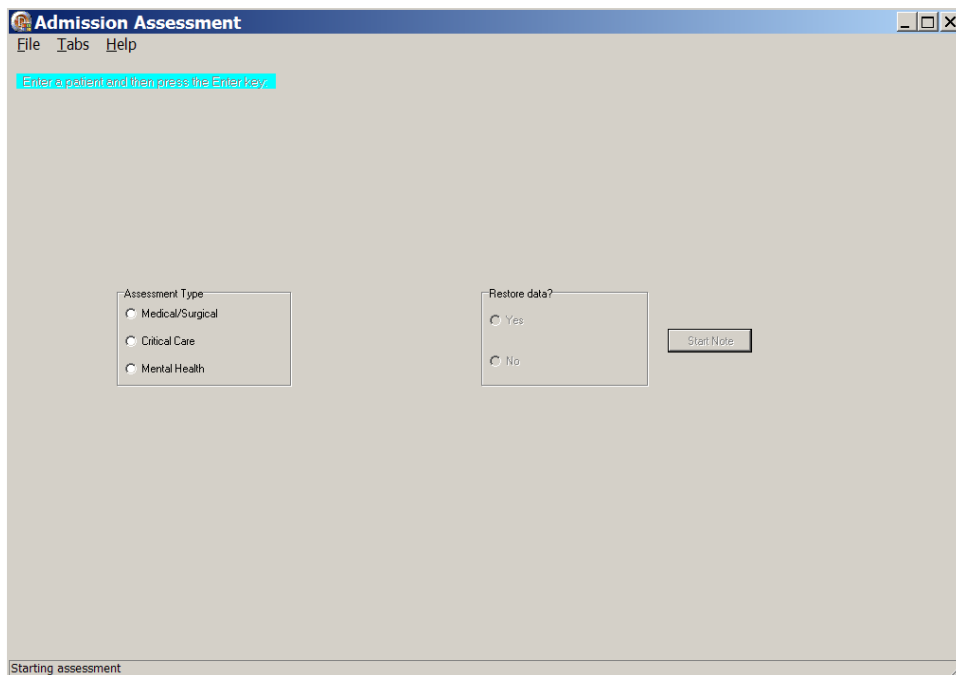
Note: You may have to re-enter your CPRS access and verify codes, depending on local site setup.



Access through CPRS

No Previously Saved Information

The Enter a patient window displays.

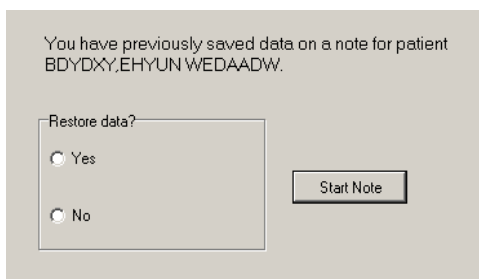


Admission – RN Assessment, Enter a patient window with no previously saved information

1. Select an Assessment Type.
2. Click **Start Note**.

The assessment template opens to the General Information tab for the CPRS patient.

Previously Entered Information Available for One Patient



Patient selection window with previously entered information available for one patient

Restore Patient's Data/No

If you previously entered data on one patient, you are prompted with: *You have previously saved data on a note for patient <PADPPATIENT,ONE >*.

1. Select an Assessment Type.
2. Select **No**.
The patient's information is deleted, but the Internal Entry Number (IEN) for the patient displays in the **Enter a patient** text box.
3. Click **Start Note**.
The template opens to the General Information tab and you can enter new data for that CPRS patient.
4. **Optional:** You can delete the IEN of that CPRS patient, enter the name of a different patient, and click **Start Note**.

Note: The Internal Entry Number (IEN) is a unique, computer-generated number that identifies a specific patient in your system. The IEN has no impact on the completed assessment, nor does it display again.

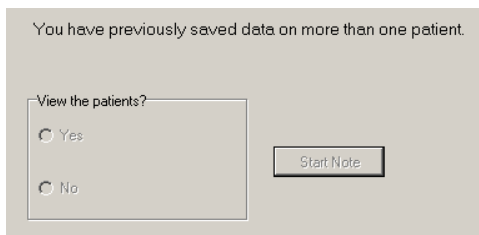
Restore Patient's Data/Yes

If you previously entered data on one patient, you are prompted with: *You have previously saved data on a note for patient <PADPPATIENT,ONE >*.

1. Select an Assessment Type.
2. Select **Yes**.
3. Click **Start Note**.
The template opens to the General Information tab for the CPRS patient with the data restored.

Previously Entered Information Available for Two or More Patients

If you have previously stored data from more than one patient, you are asked if you want to view a list of those patients.



You have previously saved data on more than one patient.

View the patients?

Yes

No

Start Note

Patient selection window with previously entered information available for more than one patient

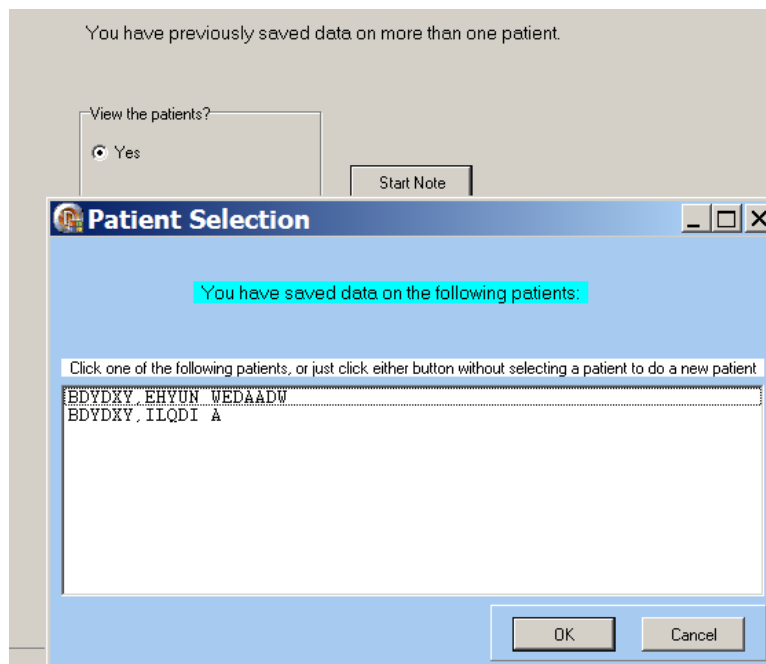
View the Patients ?/No

If you say **No**, the patient's name displays in the Enter a patient text box as a number that identifies the CPRS patient.

1. Select Assessment Type.
2. Click **Start Note**.
The template opens to the General Information tab.

View the Patients ?/Yes

1. Select **Yes**.
2. Select an Assessment Type.
Patient Selection window displays with a list of patients with saved data.



Patient Selection List

Patient on the List

1. Select a name.
2. Click **OK**.
The template opens to the General Information tab.

Patient not on the List

1. Click **Cancel**.
The number that represents your CPRS patient is in the Enter a patient text box.
2. Click the **Start Note**.
The template opens to the General Information tab.

The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main area is titled "GENERAL INFORMATION" and contains several sections of data entry fields:

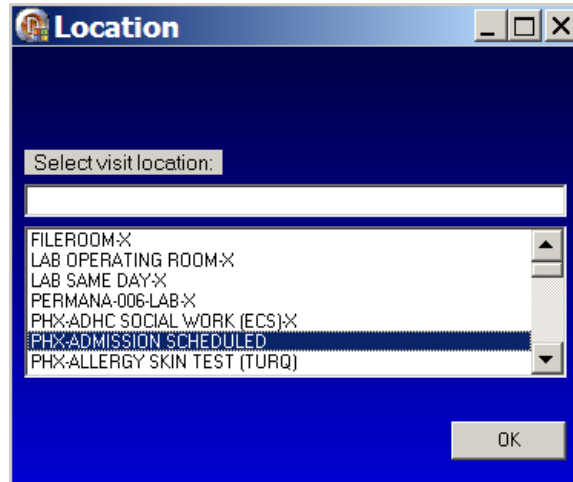
- GENERAL INFORMATION:** Includes a section for "Patient/family/support person able to respond to questions" with "Yes" and "No" radio buttons. It also has fields for "Why could no one respond" and "Other reason no one could respond". A dropdown menu for "Information obtained from" is open, showing options: "Patient" (checked), "Authorized surrogate", "Family/Support Person", "Medical Record", and "Other".
- Demographics:** Name: BDYDXY,ULN L; Age: 63; Sex: MALE; Race: WHITE, NOT OF HISP.
- Date/Time Patient Arrived on Unit:** 12/13/11, 16:46.
- Mode of arrival:** Radio buttons for "Ambulatory" (selected), "Stretcher/Gurney", and "Wheelchair".
- Admitted from:** Radio buttons for "Clinic", "Community Residential Care", "Emergency Department", "Home" (selected), "Nursing Home", "Shelter", "23 Hour Observation", and "Other".
- Admitting diagnosis:** ACROMIOPLASTY. A text box contains "pain free".
- Preferred Healthcare Language:** Radio buttons for "English" (selected), "Spanish", and "Other".
- Patient Identification band:** Radio buttons for "Patient arrived with identification (ID) band on" (selected), "ID Band applied on unit or clinic location", and "Patient arrived with Patient Identification Card".
- Special alert arm band:** A dropdown menu is open showing "None" (checked), "Allergy", "DNR/DNI", "Fall Risk", "Isolation", and "Other".

At the bottom, there is a "Go to radiogroup:" field with a dropdown menu set to "Mode of arrival" and a "Go" button. A status bar at the very bottom says "Looking up patient".

Admission – RN Assessment, General Information (Gen Inf) tab window, Gen I Page 1

Patient not yet Assigned to an Inpatient Bed

When a patient is not assigned an inpatient bed, a location pop-up automatically displays over the General Information window.



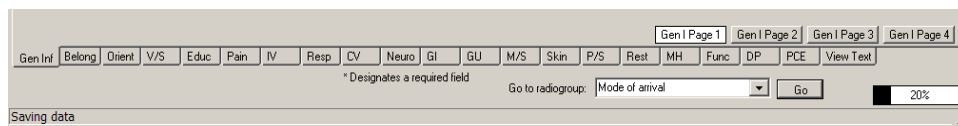
Location pop-up: Select visit location

1. Select a current patient location, i.e., outpatient clinic.
Navigate quickly to the current location by entering the first letter of the location.
2. Click **OK**.

Saving and Uploading Data

Auto Save

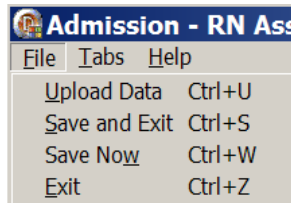
Data are saved automatically. Frequency of auto-save is set locally.



Saving data: percentage saved indicator
(bottom right corner of the window)

Manual Save

You can save data by using the File menu on any tab.

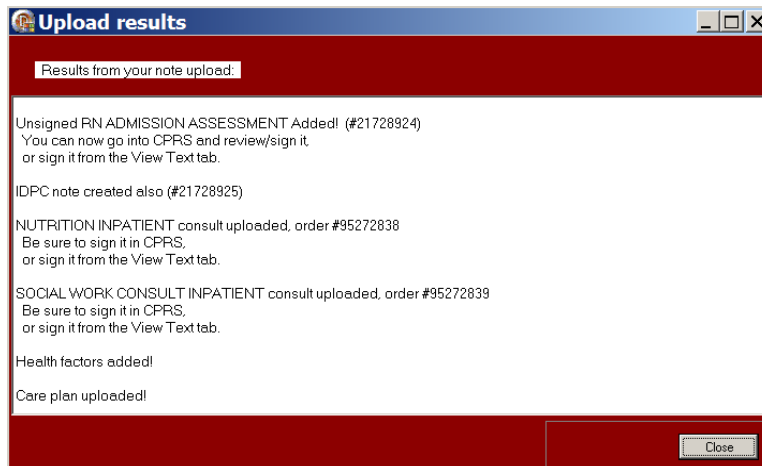


Admission – RN Assessment window, File menu

Upload Data

To create a note you must upload the data into VistA and CPRS:

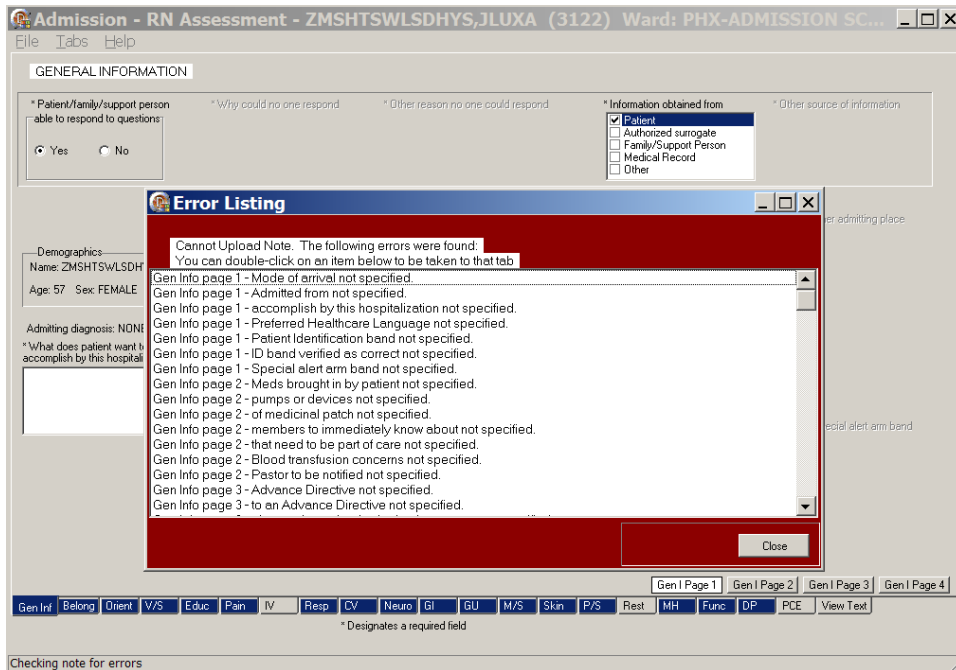
1. Open the File menu on any tab and select **Upload Data**.
Results from your upload display, verifying that the data are uploaded.



Admission – RN Assessment, Upload results window

Note: The *unsigned* note, selected consults, and PCE data/Health Factors are uploaded into CPRS and VistA.

2. If the information is incomplete, an Error Listing window displays indicating the pages within specific tabs that require attention.
 - The tabs with pages that require attention are blue.



Admission – RN Assessment, Error Listing window

- Once the pages are completed, the tab returns to gray.
 - i. Double-click an item to go to the page that requires attention.
 - ii. When all the errors are completed, select **Upload Data** again.

Save and Exit

To save data and temporarily leave the template:

1. Open the File menu on any tab.
2. Select **Save and Exit**.
3. When you reopen the template, your previously entered data is there.

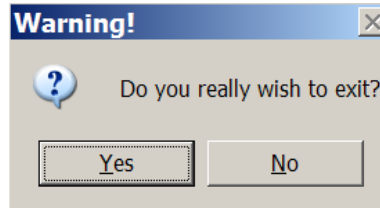
Save Now

To save data, but not close the template and continue to enter data:

1. Open the File menu on any tab.
2. Select **Save Now**.
3. Continue to enter data for the current patient.

Exit

1. From any tab, click **X** in the top right corner of the window.
Warning message displays.



Warning pop-up: Do you really wish to exit?

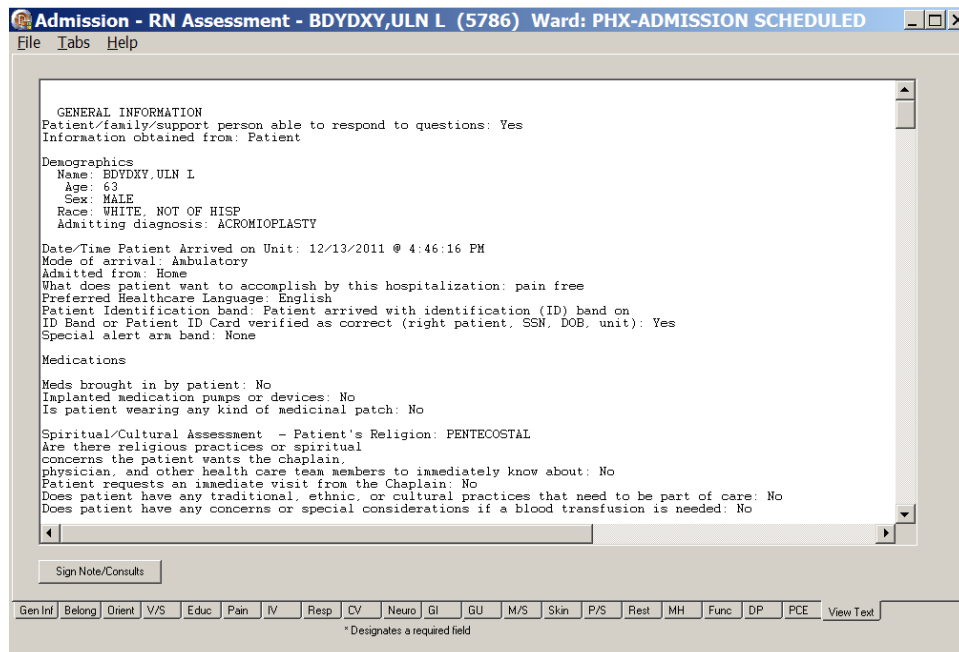
2. Click **Yes**.
- or
1. From any tab, open the File menu and click **Exit**.
Warning message displays.
 2. Click **Yes**.

Signing Notes

Go to CPRS to sign your **uploaded**, *unsigned* notes and consults.

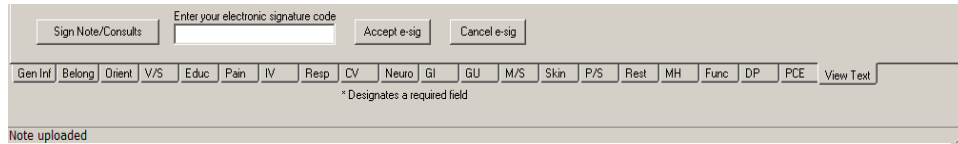
You can also sign *unsigned* notes **after the upload** from the View Text tab in the template.

1. Click **View Text**.



Admission – RN Assessment, View Text tab after upload

2. Click **Sign Note/Consults**.



Admission – RN Assessment with Sign Note/Consults button

- 3. Enter your electronic signature and click **Accept e-sig**.
- 4. To prevent the signing of an uploaded note, click **Cancel e-sig**.

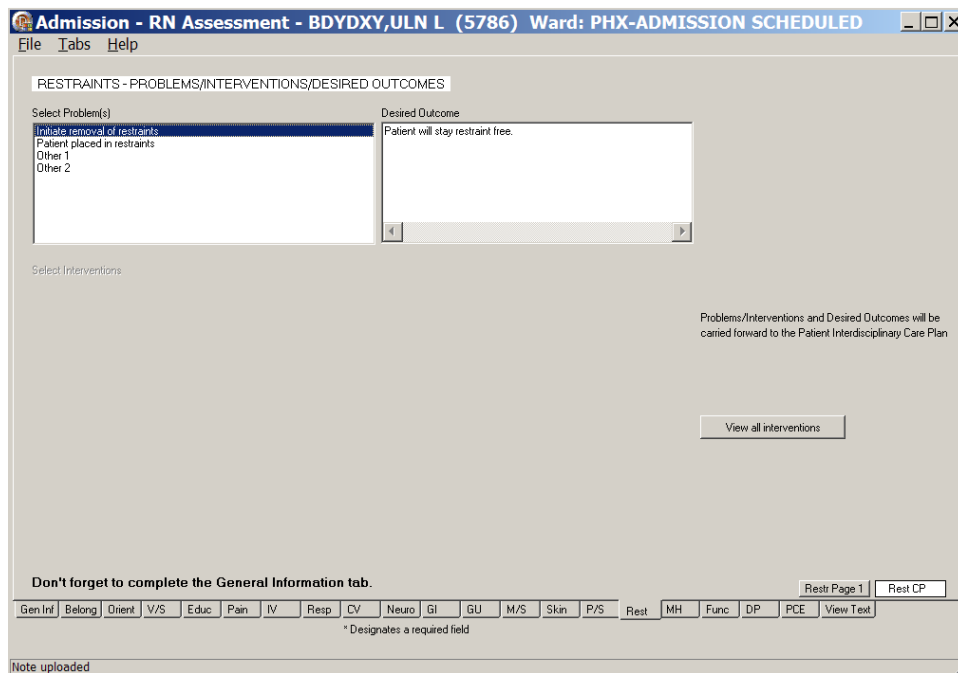
Note: If there is only a note to sign, the button is **Note**.
If there is a consult to sign, the button is **Sign Note/Consults**.

Working in a Care Plan

The Care Plan page for each section of the Admission – RN Assessment works the same way. The steps apply to each of the care plan (CP) pages. Creating a Rest CP is an example of how to work in any of the care plans.

Example – Creating a Rest CP

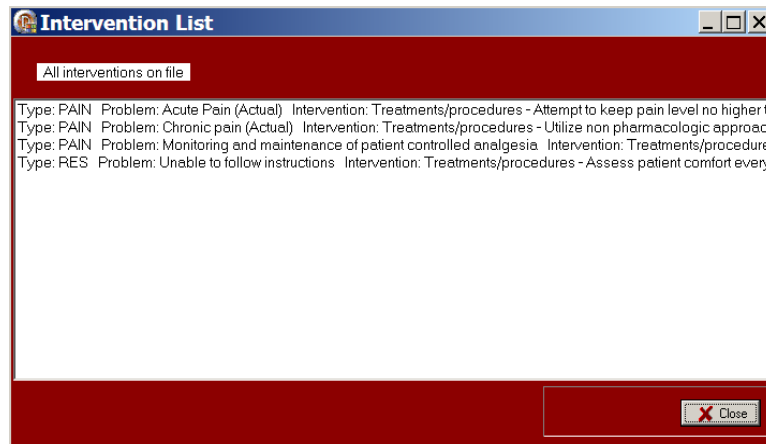
On Rest Page 1, select the **Restraints Initiated/maintained** check box. Click **Rest CP** to open the restraints care plan.



Admission – RN Assessment, <Restraints> - Problems/Interventions/Desired Outcomes, <Rest> CP window

Viewing Interventions Entered Previously during an Assessment

1. Click **<Rest> CP**.
Rest CP - the **<Restraints>** - Problems/Interventions/Desired Outcomes window displays.
2. Click **View all interventions** to view a list of interventions.
The Intervention List displays.



Rest CP window, Intervention List window

3. Click **Close**.

Entering Problems and Interventions

1. Select a problem in the **Select Problem(s)** list box.
The desired outcome and interventions for the selected problem display.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

RESTRAINTS - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES

Select Problem(s)

Desired Outcome

Select Interventions

Problems/Interventions and Desired Outcomes will be carried forward to the Patient Interdisciplinary Care Plan

Don't forget to complete the General Information tab.

Rest Page 1 Rest CP

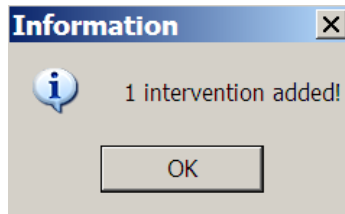
Gen Inf Belong Orient V/S Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text

* Designates a required field

Note uploaded

Admission – RN Assessment, <Restraints> - Problems/Interventions/Desired Outcomes <Rest> CP window

2. Select one or more interventions in the **Select Interventions** list box.
3. Click **Add/Change** to transfer the intervention to the care plan.
Information pop-up displays.



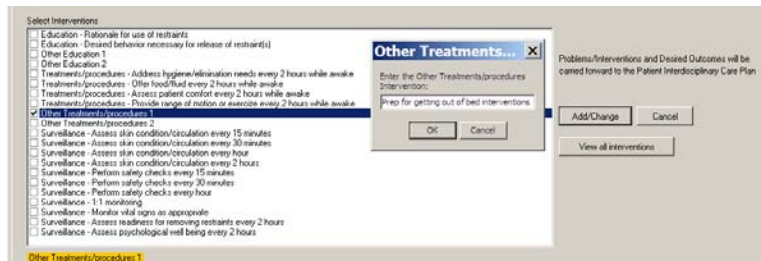
Information pop-up: 1 intervention added!

4. Click **OK**.
5. To add interventions for additional problems, repeat steps 1 through 4, as necessary.

Other Interventions

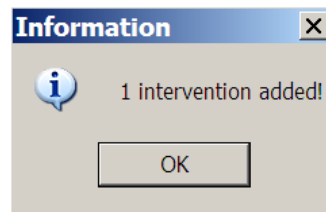
Some interventions generate a pop-up to enter interventions that are not on the predefined list.

1. Select an *Other* intervention in the **Select Interventions** list box.
The *Other* interventions pop-up displays.



Admission – RN Assessment, <Restraint> – Problems/Interventions/Desired Outcomes, <Rest> CP window,
Interventions: Other Treatments pop-up

2. Type the *other* intervention into the text box.
3. Click **OK**.
4. Click **Add/Change** to transfer the intervention to the care plan.
Information pop-up displays.



Information pop-up: 1 intervention added!

5. Click **OK**.
6. To add additional *other* interventions, repeat steps 1 through 5, as necessary.

Working in the Consults

All the consults in Admission – RN Assessment work the same way. The following steps apply to each of the consults. When a consult is required, a mandatory consult message is highlighted in **red**. Ordering a Chaplain Consult is an example of how to work in any of the consults.

Example – Ordering a Chaplain Consult

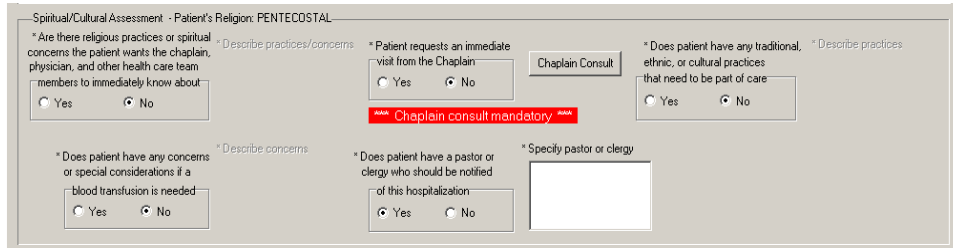
Order a Chaplain Consult from Gen Inf tab, Gen I Page 2 in the Spiritual/Cultural Assessment section.

The Chaplain Consult is mandatory when the patient answers **Yes** to any one of the following questions.

- Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about?
- Patient requests an immediate visit from the Chaplain?
- Does patient have a pastor or clergy who should be notified of this hospitalization?

1. Select **Yes** and a message indicating the consult is mandatory displays:

Chaplain consult mandatory

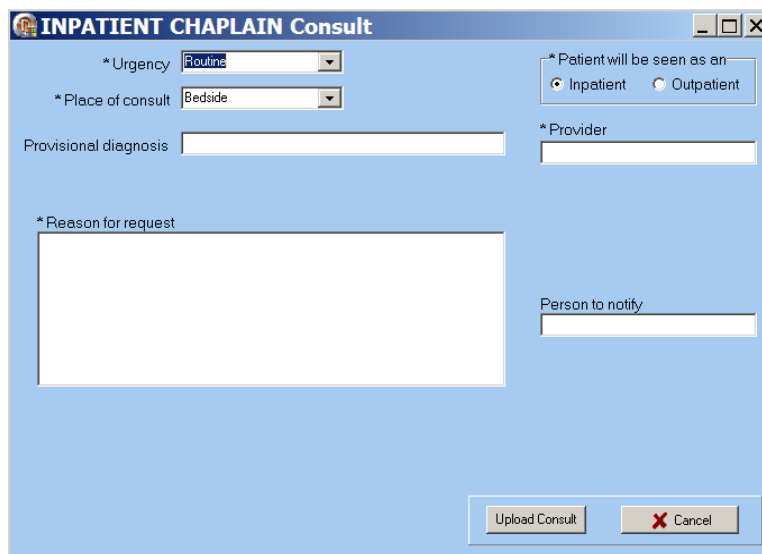


The screenshot shows a form titled "Spiritual/Cultural Assessment - Patient's Religion: PENTECOSTAL". It contains several questions with radio button options for "Yes" and "No". A red banner with the text "Chaplain consult mandatory" is displayed across the form. The questions include: "Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about?", "Patient requests an immediate visit from the Chaplain?", "Does patient have any traditional, ethnic, or cultural practices that need to be part of care?", "Does patient have any concerns or special considerations if a blood transfusion is needed?", "Does patient have a pastor or clergy who should be notified of this hospitalization?", and "Specify pastor or clergy".

Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 2 window
Spiritual/Cultural Assessment

2. Click **<Chaplain Consult>**.

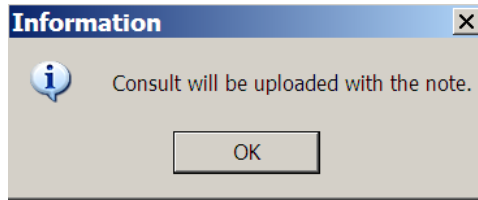
The **<INPATIENT CHAPLAIN>** Consult window displays.



The screenshot shows the "INPATIENT CHAPLAIN Consult" window. It has a blue header and contains the following fields: "Urgency" (dropdown menu set to "Routine"), "Place of consult" (dropdown menu set to "Bedside"), "Provisional diagnosis" (text input field), "Reason for request" (large text area), "Person to notify" (text input field), "Patient will be seen as an" (radio buttons for "Inpatient" and "Outpatient", with "Inpatient" selected), and "Provider" (text input field). At the bottom right, there are "Upload Consult" and "Cancel" buttons.

INPATIENT CHAPLAIN Consult window

- a. Complete all fields with asterisks; they are required fields.
- b. Click **Upload Consult**.
Information pop-up displays indicating the consult is uploaded with the RN Admission Assessment note.



Information pop-up: Consult will be uploaded with the note.

3. Click **OK**.
On the Gen Inf tab, Gen I Page 2, under Chaplain Consult, **Will Send** displays.

 A screenshot of a web-based form titled "Spiritual/Cultural Assessment - Patient's Religion: PENTECOSTAL". The form contains several sections with radio buttons and text boxes. The "Chaplain Consult" section is highlighted, showing a "Will Send" button in red. Other sections include "Are there religious practices or spiritual concerns...", "Patient requests an immediate visit from the Chaplain", "Does patient have any traditional, ethnic, or cultural practices...", "Does patient have any concerns or special considerations if a blood transfusion is needed", "Does patient have a pastor or clergy who should be notified", and "Specify pastor or clergy".

Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 2 window
Spiritual/Cultural Assessment

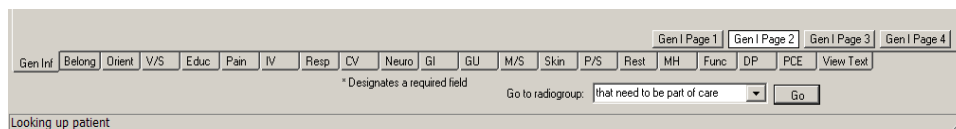
Note: Manage consults according to medical center policy. If nurses at your site do not order consults, upload a mandatory consult, but do not sign it.
The identified provider will be notified that there is a consult to sign.

Working in the Template

1. To complete the template, move through the fields from left to right and then down.
2. The active page displays first and the page tab is white.
3. Each tab across the bottom is subdivided into pages, which display on the right above the bar of tabs.
4. Each field with an asterisk (*) must have an entry.
5. A field without an asterisk is optional.
6. You must enter optional information where appropriate for the patient.

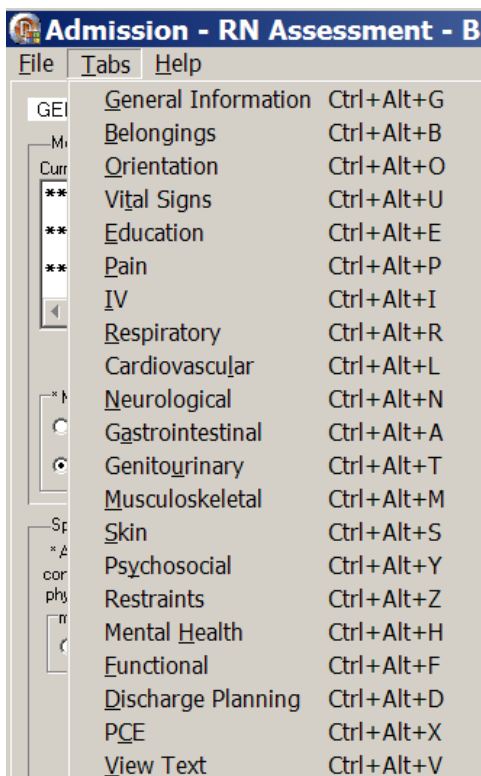
Moving through the Template using the Mouse

1. Click a tab at the bottom of any of the Admission – RN Assessment windows.
The selected tab opens.



Admission – RN Assessment tabs

2. Open the Tabs menu and select a tab from the list.
The selected tab opens.



Admission – RN Assessment, Tabs menu

Moving through the Template without a Mouse

Ctrl-Alt Keys

You can move from tab to tab using **Ctrl+Alt+<letter>**. The list contains the keys to use for each of the tabs.

Tab	Keys
General Information	Ctrl +Alt+G
Belongings	Ctrl +Alt+B
Orientation	Ctrl +Alt+O
Vital Signs	Ctrl +Alt+U
Education	Ctrl +Alt+E
Pain	Ctrl +Alt+P
IV	Ctrl +Alt+I
Respiratory	Ctrl +Alt+R
Cardiovascular	Ctrl +Alt+L
Neurological	Ctrl +Alt+N
Gastrointestinal	Ctrl +Alt+A
Genitourinary	Ctrl +Alt+T
Musculoskeletal	Ctrl +Alt+M
Skin	Ctrl +Alt+S
Psychosocial	Ctrl +Alt+Y
Restraints	Ctrl +Alt+Z
Mental Health	Ctrl +Alt+H
Functional	Ctrl +Alt+F
Discharge Planning	Ctrl +Alt+D
PCE	Ctrl +Alt+X
View Text	Ctrl +Alt+V

Go to radiogroup

The **Go to radiogroup:** is designed to navigate the templates with keyboard commands, when the mouse stops working during a patient assessment. It also satisfies the 508-compliant requirement, under Section 508 of the Rehabilitation Act, to be able to navigate the templates without using a mouse.



Go button

1. Use the Tab key to move to the bottom of the page.
 2. Use the arrow keys to move up/down in the **Go to radiogroup:** list.
 3. Click **Go**.
- or
1. Click the drop-down arrow in the **Go to radiogroup:** drop-down list.
 2. Select a radiogroup.
 3. Click **Go**.

Navigating the Admission – RN Assessment Tabs

The Admission – RN Assessment template has 21 tabs.

Note: For information on the Belongings and Orientation to Unit tabs, refer to the *Admission – Nursing Data Collection User Manual*.

General Information (Gen Inf)

The Admission – RN Assessment template opens to the General Information (Gen Inf) tab, the first tab at the bottom on the left.

1. Populate Gen I Page 1.
2. In the **Patient/family/support person able to respond to questions** box, select **Yes** or **No**.
 - If you select **Yes**, the application automatically enters **Yes** in each tab. You must also enter from whom the information is obtained.

The screenshot shows the 'Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED' window. The 'GENERAL INFORMATION' tab is active. The 'Patient/family/support person able to respond to questions' field is set to 'Yes'. The 'Information obtained from' dropdown is set to 'Patient'. The 'Demographics' section shows Name: BDYDXY,ULN L, Age: 63, Sex: MALE, Race: WHITE, NOT OF HISP. The 'Date/Time Patient Arrived on Unit' is 12/13/11 at 16:46. The 'Mode of arrival' is 'Ambulatory'. The 'Admitted from' is 'Home'. The 'Admission diagnosis' is 'ACROMIOPLASTY'. The 'Preferred Healthcare Language' is 'English'. The 'Patient Identification band' is 'Patient arrived with identification (ID) band on ID Band applied on unit or clinic location'. The 'Special alert arm band' is 'None'. The window has a menu bar (File, Tabs, Help) and a toolbar at the bottom with tabs for Gen I Page 1 through 4 and various assessment categories (Gen Inf, Belong, Orient, V/S, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text). A 'Go to radiogroup' field is also present.

Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 1 window
Patient/family/support person able to respond to questions/Yes

- If you select **No**, when a patient is unable to answer questions and there are no family members or others to contribute to the assessment, some of the fields will be unavailable. The unavailable questions are passed forward into the RN Reassessment to answer later, if possible.
- When you select **No**, you must manually select patient status on each tab.

3. Make appropriate selections on Gen I Page 1.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

GENERAL INFORMATION

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: Patient unable to communicate No family/support person present Other

* Other reason no one could respond: _____

* Information obtained from: _____

* Other source of information: _____

Demographics: Name: BDYDXY,ULN L Age: 63 Sex: MALE Race: WHITE, NOT OF HISP

* Date/Time Patient Arrived on Unit: 12/13/11 16:45

* Mode of arrival: Ambulatory Stretcher/Gurney Wheelchair

* Admitted from: Clinic Community Residential Care Emergency Department Home Nursing Home Shelter 23 Hour Observation Other

* Other admitting place: _____

Admitting diagnosis: ACROMIOPLASTY

* What does patient want to accomplish by this hospitalization: _____

* Other Language: _____

* Patient Identification band: Patient arrived with identification (ID) band on ID Band applied on unit or clinic location Patient arrived with Patient Identification Card

* ID Band or Patient ID Card verified as correct (right patient, SSN, DOB, unit):

* Special alert arm band: None Allergy DNR/DNI Fall Risk Isolation Other

* Other Special alert arm band: _____

Gen I Page 1 Gen I Page 2 Gen I Page 3 Gen I Page 4

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Performing assessment

Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 1, Patient/family/support person able to respond to questions/No

- Click **Gen I Page 2**.
Gen I Page 2 displays.
Allergies are added in the **Allergies** text box.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

GENERAL INFORMATION 2

Medications/Allergies

Current Meds: *** Outpatient *** NONE FOUND *** IV *** NONE FOUND *** Unit Dose *** NONE FOUND ***

Allergies: _____

Yesterday's and Today's Orders: ORDERS YESTERDAY & TODAY - NONE FOUND

Add New Allergy

* Disposition of meds: _____

* Other Disposition: _____

* Implanted medication pumps or devices: Yes No

* Type of device/bump/medication: _____

* Is patient wearing any kind of medicinal patch: Yes No

Spiritual/Cultural Assessment - Patient's Religion: PENTECOSTAL

* Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about: Yes No

* Describe practices/concerns: _____

* Patient requests an immediate visit from the Chaplain: Yes No

Chaplain Consult: _____

* Does patient have any traditional, ethnic, or cultural practices that need to be part of care: Yes No

* Describe practices: _____

* Does patient have any concerns or special considerations if a blood transfusion is needed: Yes No

* Describe concerns: _____

* Does patient have a pastor or clergy who should be notified of this hospitalization: Yes No

* Specify pastor or clergy: _____

Gen I Page 1 Gen I Page 2 Gen I Page 3 Gen I Page 4

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: _____ that need to be part of care [Go]

Performing assessment

Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 2 window

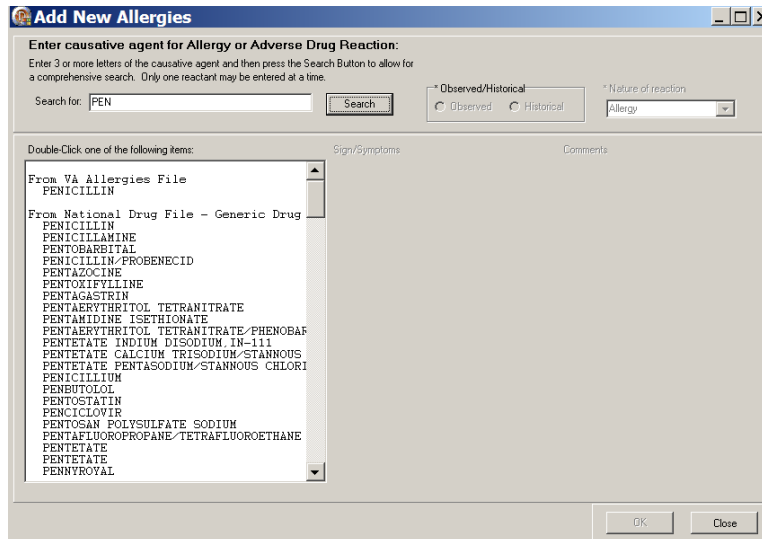
- Populate Gen I Page 2.

Adding an Allergy

Allergies/Adverse Reactions are uploaded immediately into the Allergy/Adverse Reaction Package when saved.

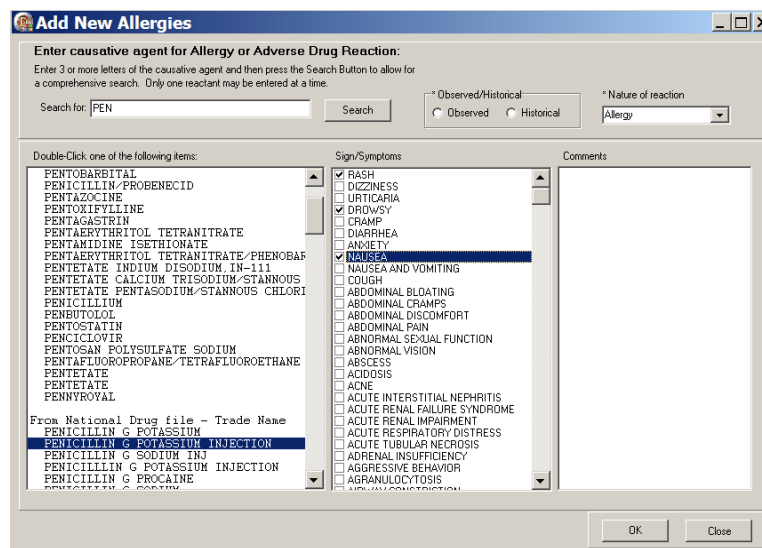
Note: Follow your local medical center policy with regard to adding allergies.

1. Click **Add New Allergy**.
The Add New Allergies window displays.



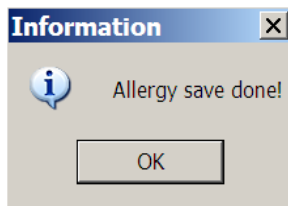
Add New Allergies window

2. Type 3-5 letters of the reported allergy into the **Search for** text box.
3. Click **Search**.
4. Double-click an allergy in the **Allergy** list.
The Sign/Symptoms list box displays.



Add New Allergies window with Sign/Symptoms available

5. In the **Observed/Historical** text box, select **Observed** or **Historical**.
6. In the **Nature of reaction** drop-down text box, select **Allergy**, **Pharmacological**, or **Unknown**.
7. In the **Signs/Symptoms** list, select the identified signs/symptoms.
8. Click **OK** and the allergy is saved in the Adverse Drug Reaction (ADR) file. Information pop-up displays to confirm the allergy is saved.



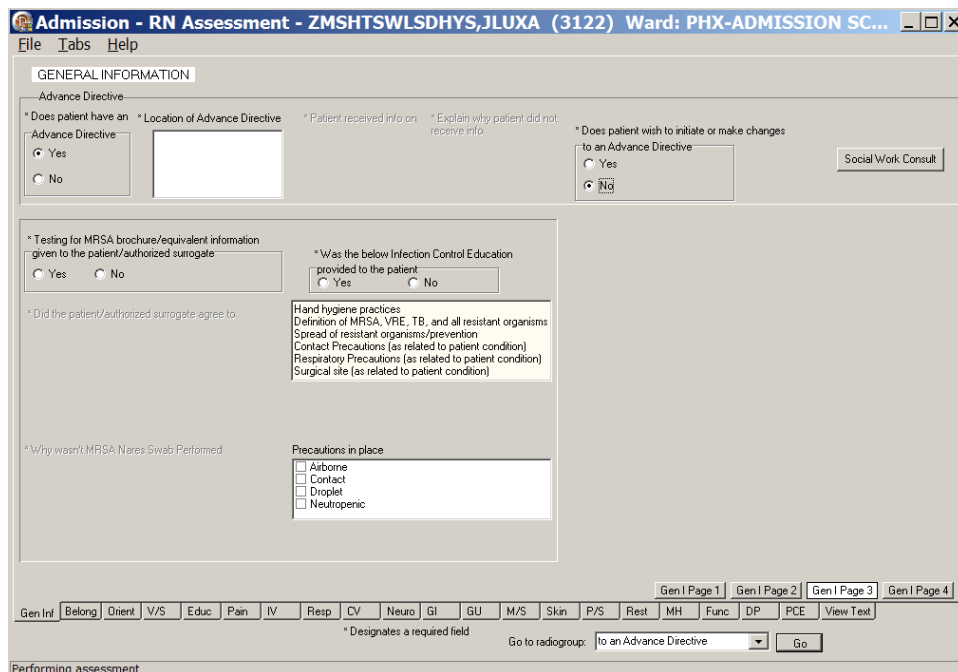
Information pop-up: Allergy save done!

9. Click **OK**.
10. Click **Close** to return to Gen I Page 2.

Initiating a Social Work Consult for Advance Directives

All of the consults in Admission – RN Assessment work the same way; refer to the instructions in *Working in the Consults* on page 15.

1. Click **Gen I Page 3**.
Gen I Page 3 displays with the Advance Direction section available.



Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 3 window
Advance Directive/Yes

2. Populate Gen I Page 3.

- Make appropriate selections in the Advance Directive section.
- If the patient wants to initiate or make changes to an Advance Directive, a Social Work Consult is required.

Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 3 window
Advance Directive/No

Documenting Infection Control Information

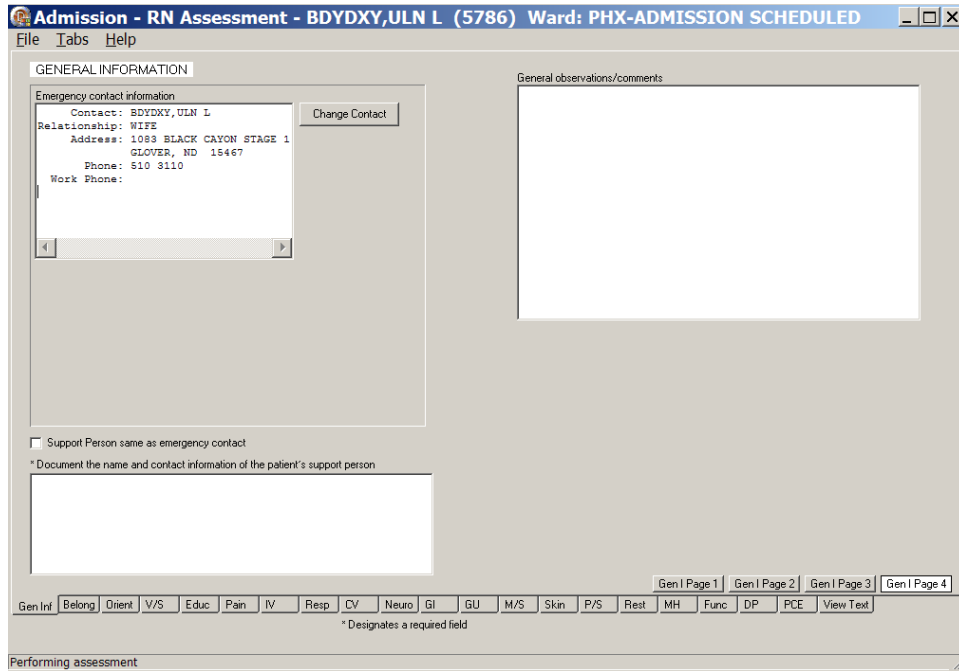
Infection Control Information/MRSA

1. Make appropriate selections in the Infection Control section.
2. Enter infection control and Methicillin-Resistant Staphylococcus Aureus (MRSA) collection information.

Changing Emergency Contact Information

1. Click **Gen I Page 4**.

Gen I Page 4 displays with the **Emergency contact information**, **Support person contact information**, and **General observations/comments** text boxes available for additional information.



Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 4 window

GENERAL INFORMATION

Emergency contact information

Contact: BDYDKY, ULN L
 Relationship: WIFE
 Address: 1083 BLACK CAYON STAGE 1
 GLOVER, ND 15467
 Phone: 510 3110
 Work Phone:

Change Contact

* Name (LN, FN): Save Contact

* Relationship: Cancel Contact

* Street Address 1:

Street Address 2:

Street Address 3:

* Zip Code:

Phone: Work Phone:

Support Person same as emergency contact

* Document the name and contact information of the patient's support person

Emergency Contact Information for patient and support person

2. To update the emergency contact information, click **Change Contact**.
The Emergency contact information section expands.
3. Complete all the fields with asterisks; they are required fields.
4. Click **Save Contact**.
5. To cancel the update, click **Cancel Contact** before you click **Save Contact**.
6. Document the name and contact information of the patient's support person.
It is required information.

Vital Signs (V/S)

The Vitals tab contains information about the patient's vital signs at admission. The vital signs include temperature, pulse, respiration, blood pressure, height, weight, pain, pulse oximetry, and circumference/girth.

Note: When you click **Upload Vitals**, vital signs are immediately uploaded into the Vitals package.

The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". Below the menu bar is a tab labeled "VITALS". The main area is divided into two columns. The left column is labeled "Last Vitals" and lists various vital signs: Temp, Pulse, Resp, B/P, Height, Weight, Pain, Pulse Ox, and Circumf. The right column is labeled "Vitals Date/Time:" and contains input fields for each vital sign, each with a "Click to enter qualifiers" link. The "Temp" field has a "Units" dropdown set to "C". The "Height" field has a "Units" dropdown set to "CM". The "Weight" field has a "Units" dropdown set to "KG". The "Pain" field has a dropdown set to "0". Below the input fields is a checkbox labeled "Vitals cannot be taken at this time or patient refused". At the bottom of the right column are two buttons: "Upload Vitals" (highlighted in red) and "Clear". Below the "Upload Vitals" button is a red box with the text "Vitals Not Uploaded". At the bottom of the window is a navigation bar with buttons for "Gen Inf", "Belong", "Orient", "V/S", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". Below the navigation bar is a "Go to radiogroup:" dropdown set to "Units" and a "Go" button. The status bar at the bottom left says "Performing assessment".

Admission – RN Assessment, Vitals (V/S) tab window

1. Click **V/S**.

Vitals (V/S) displays.

- Complete all the fields with asterisks; they are required fields.
- Click each **Click to enter qualifiers**, to select qualifiers for each of the vitals.

Note: Remember to enter units where appropriate.

Example

- Entering the temperature, depending on the type of thermometer used, select C for Centigrade or F for Fahrenheit.
- Entering the height and weight, depending on the instruments used, select CM or IN and KG or LB.

Qualifiers - Temp

Cuff Size

Location

- AXILLARY
- CORE
- ORAL
- RECTAL
- SKIN
- TEMPORAL
- TYMPANIC

Method

Position

Quality

Site

Save Qualifiers Cancel

Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - Temp

Qualifiers - Pulse

Cuff Size

Location

BILATERAL PERIPHERAL

Method

AFTER EXERCISE

Position

- LYING
- SEMIFOWLERS
- SITTING
- STANDING
- TRENDELENBURG

Quality

Site

LEFT

Save Qualifiers Cancel

Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - Pulse

Qualifiers - Resp

Cuff Size Location

Method Position

Quality Site

Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - Resp

Qualifiers - B.P.

Cuff Size Location

Method Position

Quality Site

Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - BP

Qualifiers - Height

Cuff Size Location

Method Position

Quality Site

ACTUAL

 ESTIMATED

 ESTIMATED BY ARM SPAN

 STATED

Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers – Height

Qualifiers - Weight

Cuff Size Location

Method Position

BED

 CHAIR

 LIFT SCALE

 STANDING WEIGHT

 WHEELCHAIR SCALE

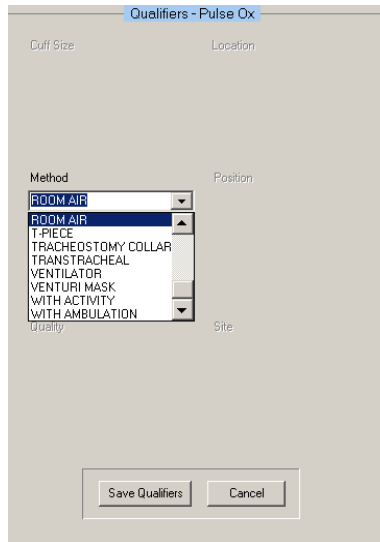
 WITH CAST OR BRACE

 WITH PROSTHESIS

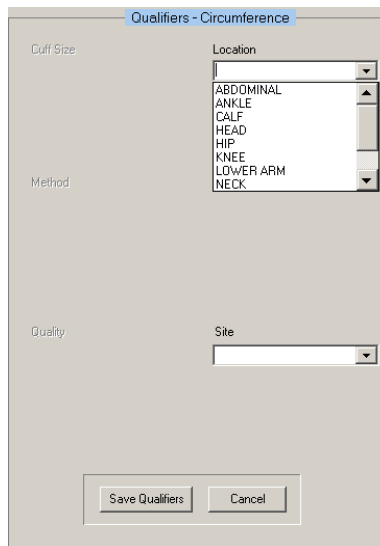
 WITHOUT PROSTHESIS

Quality Site

Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - Weight

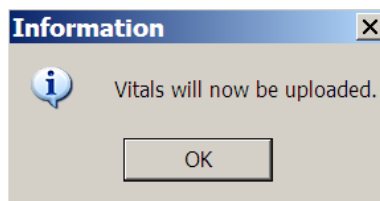


Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers – Pulse Ox



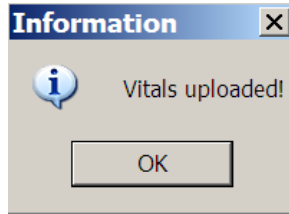
Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - Circumference

2. Click **Save Qualifiers**, after selecting qualifiers for the individual vitals.
3. To remove incorrect qualifiers entered in error, click **Cancel** before saving.
4. Click **Upload Vitals**.
Information pop-up displays.



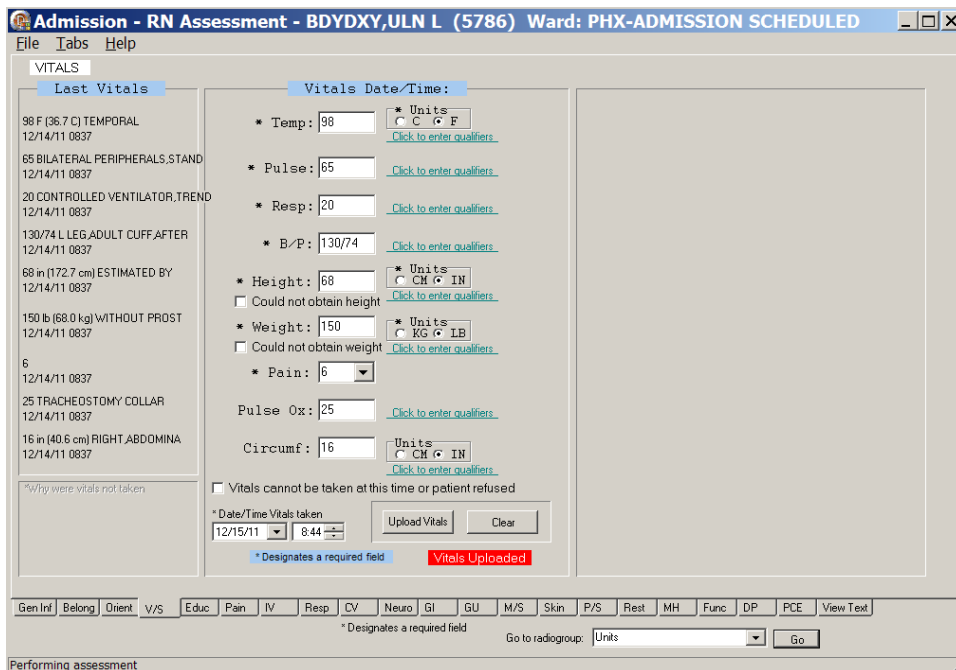
Information pop-up: Vitals will now be uploaded.

- a. Click **OK**.
Information pop-up displays.



Information pop-up: Vitals uploaded!

- b. Click **OK**.



Admission – RN Assessment, Vitals (V/S) tab window with Last Vitals

- If you select the **Vitals cannot be taken at this time or the patient refused** check box, enter a reason in the ***Why were vitals not taken** text box in the lower left corner of the page.

The screenshot shows the 'VITALS' tab window for patient ZMSHTSWLSDHYS, JEXJXALSH GRIFH (2537) in Ward 2CM. The 'Last Vitals' section on the left lists various vitals and measurements. The 'Vitals Date/Time' section on the right contains input fields for Temp, Pulse, Resp, B/P, Height, Weight, Pain, Pulse Ox, and Circumf, each with a 'Click to enter qualifiers' link. The 'Why were vitals not taken' section at the bottom left has a text box. The 'Vitals cannot be taken at this time or patient refused' checkbox is checked. Below it, the 'Date/Time Vitals taken' is set to 02/03/12 8:47. A red 'Vitals Not Uploaded' message is visible. The bottom of the window shows a navigation bar with tabs for Gen Inf, Belong, Orient, V/S, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. A 'Go to radiogroup' field is also present.

Admission – Nursing Data Collection, Vitals (V/S) tab window
Vitals cannot be taken at this time or patient refused

- If you select the **Could not obtain height** and/or the **Could not obtain weight** check boxes at time of assessment, enter a reason in the ***Why were vitals not taken** text box in the lower left corner of the page.

The screenshot shows the 'VITALS' tab window for the same patient. The 'Vitals Date/Time' section on the right now includes 'Units' dropdown menus for Temp (C, C, F), Height (C, M, FT, IN), and Weight (C, LB, P, LB). The 'Could not obtain height' and 'Could not obtain weight' checkboxes are checked. The 'Why were vitals not taken' text box is empty. The 'Vitals cannot be taken at this time or patient refused' checkbox is unchecked. The 'Date/Time Vitals taken' is 02/03/12 8:47. A red 'Vitals Not Uploaded' message is visible. The bottom of the window shows the same navigation bar and 'Go to radiogroup' field as the previous screenshot.

Admission – Nursing Data Collection, Vitals (V/S) tab window
Could not obtain height/Could not obtain weight

Education (Educ)

The Education Assessment tab contains an educational and a readiness to learn assessment. The Educational Assessment is unavailable when the patient cannot respond.

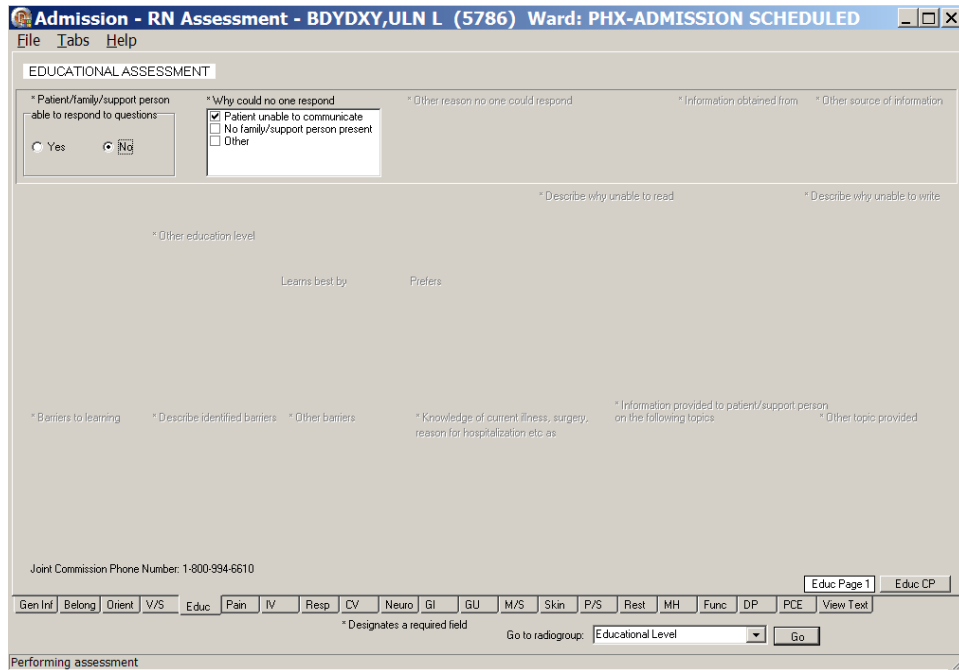
The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The main content area is labeled "EDUCATIONAL ASSESSMENT". It contains several sections of assessment questions:

- Response Ability:** "Patient/family/support person able to respond to questions" with radio buttons for "Yes" (selected) and "No".
- Information Source:** "Information obtained from" with checkboxes for "Patient", "Authorized surrogate", "Family/Support Person", "Medical Record", and "Other".
- Educational Level:** Radio buttons for "Grade school", "Junior high school", "High school", "College", "Graduate school", "Other", "Unable to answer", and "Refuses to answer".
- Ability to Read/Write:** Radio buttons for "Has ability to read" and "Has ability to write", each with "Yes" and "No" options.
- Learns best by:** Checkboxes for "Doing", "Hearing/Listening", "Reading", and "Seeing".
- Prefers:** Checkboxes for "Group Classes", "Individual Approach (1:1)", "Prefers support person to be included", and "Computer based training".
- Readiness to learn:** Radio buttons for "Ready to learn", "States not interested in learning", "States teaching not needed", and "Impeded by current condition".
- Barriers to learning:** Checkboxes for "None Identified", "Hearing", "Language", "Limited attention span", "Memory", "Pain", "Sedation/Lethargy", "Visual Impairment", and "Other".
- Knowledge of current illness:** Radio buttons for "None", "Limited", and "Extensive".
- Information provided:** Checkboxes for "BCMA", "Managing Your Pain", "Notification of the Joint Commission", "Patient Rights & Responsibilities", "Patient Safety Concerns", "Prevention of Falls", "Promotion of a Restraint Free Environment", and "Other".

At the bottom, there is a navigation bar with tabs for "Gen Inf", "Belong", "Orient", "V/S", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "Educ" tab is selected. Below the tabs is a "Go to radiogroup" field with a dropdown menu set to "Educational Level" and a "Go" button. The status bar at the very bottom says "Performing assessment".

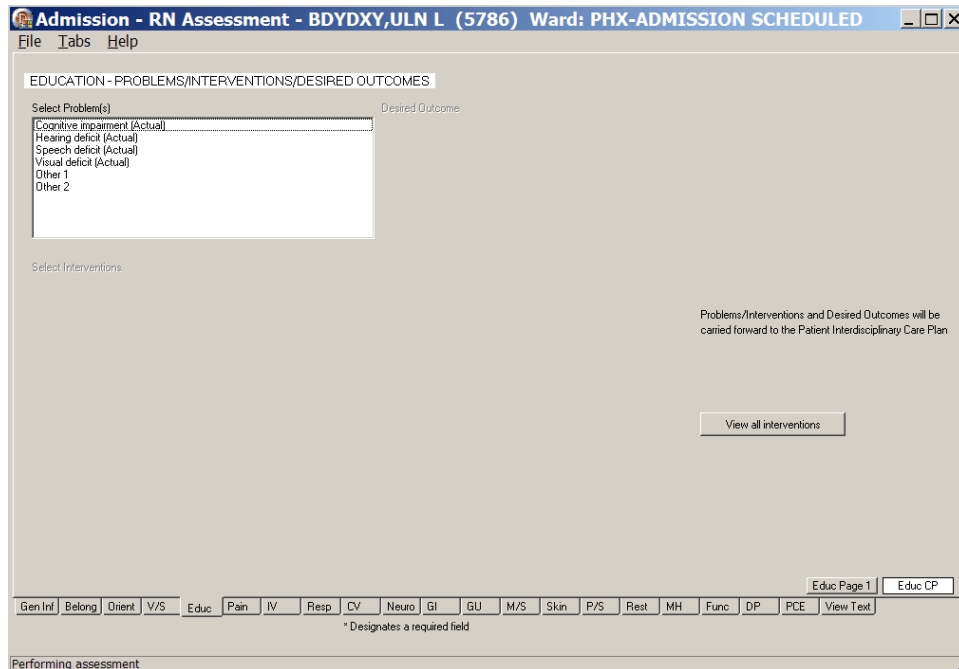
Admission – RN Assessment, Educational Assessment (Educ) tab, Educ Page 1 window
Patient/family/support person able to respond to questions/Yes

1. Click **Educ**.
Educ Page 1 displays.
2. Populate Educ Page 1.
Complete all the fields with asterisks; they are required fields.



Admission – RN Assessment, Educational Assessment (Educ) tab, Educ Page 1 window
Patient/family/support person able to respond to questions/No

3. Click **Educ CP**.
Educ CP displays.



Admission – RN Assessment, Education – Problems/Interventions/Desired Outcomes, Educ CP window

4. Populate Educ CP.
Refer to the instructions in *Working in a Care Plan* on page 11.

Pain (Pain)

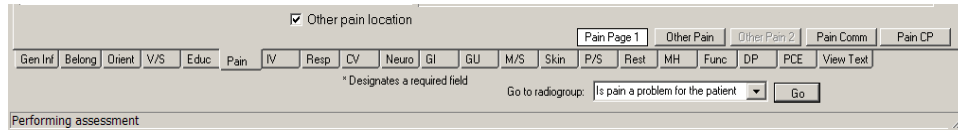
The Pain tab contains questions related to pain, pain location, and type of pain.

Admission – RN Assessment, Pain Assessment (Pain) tab, Pain Page 1 window
Is pain a problem for the patient/Yes

1. Click **Pain**.
Pain Page 1 displays.
2. Populate Pain Page 1.
 - a. Select a radio button in the **Is pain a problem for the patient** group. The fields that display vary depending on the response for this query.
 - Yes
 - No
 - Unable to respond to questions
 - b. Select a radio button in the **Is patient on Palliative/Comfort Care** group.

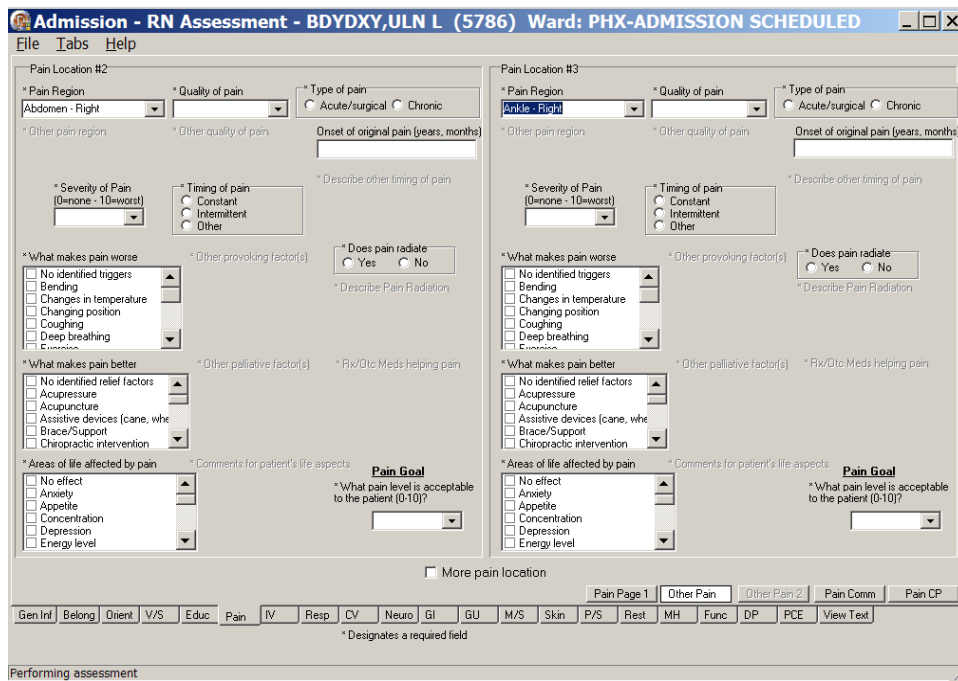
Is pain a problem for the patient/Yes

1. If a patient reports that pain is a problem (even if there is no pain currently), select **Yes**.
 - a. The Other Pain and Other Pain 2 pages are available when the patient identifies multiple pain locations. There are five pain location sections.
 - b. Identify Pain Location #1 and document the behavioral indicators.
 - c. Complete all fields with asterisks; they are required fields.
2. Pain Comm and Pain CP are always available, so you can enter comments or interventions, when appropriate.



Admission – RN Assessment, Pain Assessment (Pain) tab, Pain Page 1 window
Other pain location selected

3. When Pain Location #1 is complete and you have more pain locations to document, select the **Other pain location** check box.
The Other Pain page displays.



Admission – RN Assessment, Pain Assessment (Pain) tab, Other Pain window
Pain Location #2 and Pain Location #3

4. **Optional:** Populate the Other Pain page.
 - a. Identify Pain Location #2/Pain Location #3 and document the behavioral indicators.
 - b. Complete all fields with asterisks; they are required fields.
5. When Pain Locations #2 and #3 are complete and you have more pain locations to document, select the **More pain location** check box.
The Other Pain 2 displays.

Admission – RN Assessment, Pain Assessment (Pain) tab, Other Pain 2 window
Pain Location #4 and Pain Location #5

6. **Optional:** Populate the Other Pain 2 page.
 - a. Identify Pain Location #4/Pain Location #5 and document the behavioral indicators.
 - b. Complete all fields with asterisks; they are required fields.
7. If you require more than five pain locations, continue to document on the Pain Comm page in the **General observations/comments** text box.

Is pain a problem for the patient/No

The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main area is titled "PAIN ASSESSMENT".

On the left, there is a section "Is pain a problem for the patient" with three radio buttons: "Yes", "No" (selected), and "Unable to respond to questions". Below this is a text box for "Explain why patient unable to respond to questions".

To the right of this is a section "Complete Pain Location questions if pain is a problem for the patient". Below it is a section "Is patient on Palliative/Comfort Care" with four radio buttons: "Comfort Care", "Palliative Care" (selected), "No", and "Unknown".

The main area contains several fields for "Pain Location #1":

- "Pain Region" dropdown menu with "None" selected.
- "Quality of pain" dropdown menu with "None" selected.
- "Other pain region" text field.
- "Other quality of pain" text field.
- "Onset of original pain (years, months)" text field.
- "Describe other timing of pain" text field.
- "Severity of Pain (One none - 10 = worst)" dropdown menu.
- "What makes pain worse" text field.
- "Other provoking factor(s)" text field.
- "Describe Pain Radiation" text field.
- "What makes pain better" text field.
- "Other palliative factor(s)" text field.
- "Rx/Otc Meds helping pain" text field.
- "Areas of life affected by pain" text field.
- "Comments for patient's life aspects" text field.
- "Pain Goal" dropdown menu with "What pain level is acceptable to the patient (0-10)?" selected.

At the bottom, there is a navigation bar with tabs: "Pain Page 1" (active), "Other Pain", "Other Pain 2", "Pain Comm", and "Pain CP". Below the tabs is a row of buttons: "Gen Inf", "Belong", "Orient", "V/S", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", "View Text".

At the very bottom, there is a "Go to radiogroup:" dropdown menu with "Is pain a problem for the patient" selected, and a "Go" button.

Admission – RN Assessment, Pain Assessment (Pain) tab, Pain Page 1 window,
Is pain a problem for the patient/No

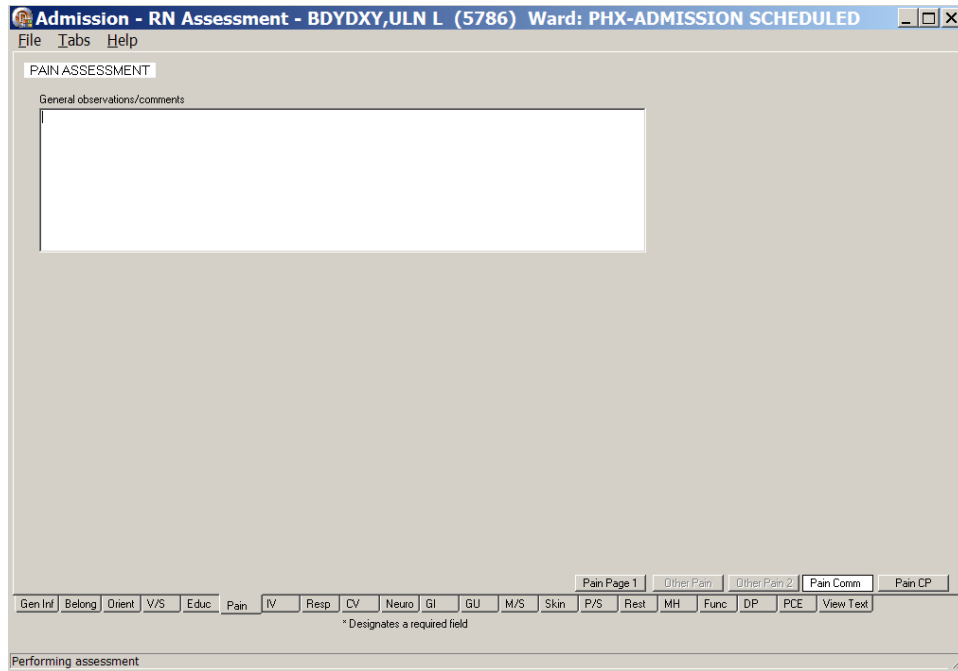
1. If the patient does not complain of pain, select **No**.
 - a. The Other Pain and Other Pain 2 pages are unavailable.
 - b. Many fields are unavailable.
2. Select a radio button in the **Is patient on Palliative/Comfort Care** group.

Is pain a problem for the patient/Unable to respond to questions

Admission – RN Assessment, Pain Assessment (Pain) tab, Pain Page 1 window
Is pain a problem for the patient/Unable to respond to questions

1. When **Unable to respond to questions** is selected on Pain Page 1
 - a. Type an explanation for unable to respond in the **Explain why patient unable to respond to questions** text box.
 - b. Select behavioral indications in the **Does patient exhibit behavioral indicators related to pain** list box.
 - c. Select a radio button in the **Is patient on Palliative/Comfort Care** group.

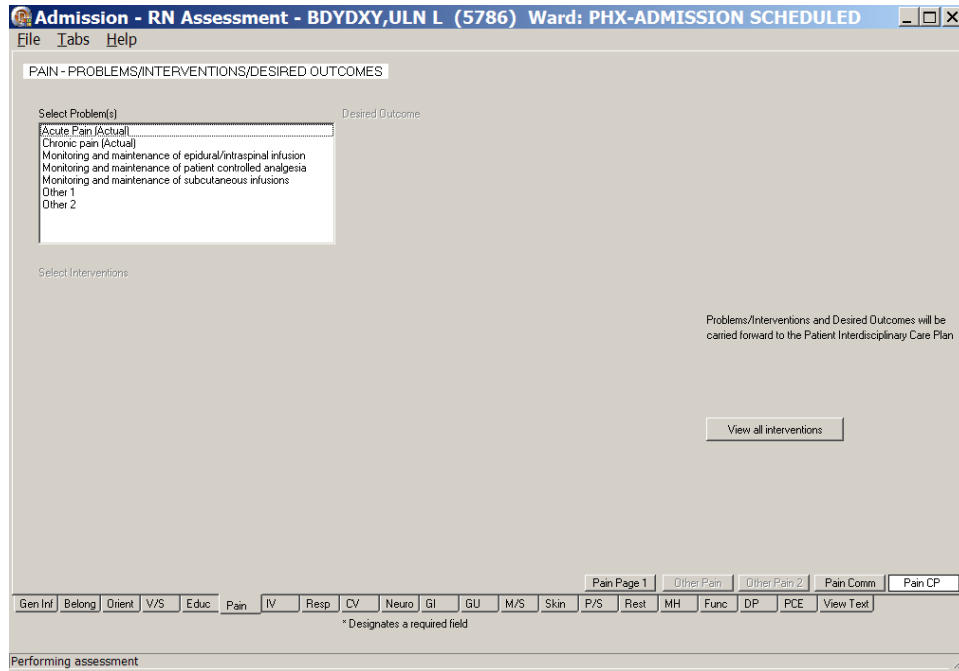
2. Click **Pain Comm**.
Pain Comm displays.



Admission – RN Assessment, Pain Assessment (Pain) tab, Pain Comm window

3. Populate Pain Comm, if necessary.
Use the **General observations/comments** text box for additional information.

- Click **Pain CP**.
Pain CP displays.



Admission – RN Assessment, Pain – Problems/Interventions/Desired Outcomes, Pain CP window

- Populate Pain CP.
Refer to the instructions in *Working in a Care Plans* on page 11.

IV (IV)

The IV tab contains information about IV devices, IV locations, and dialysis ports.

No IV/Vascular Access Devices

1. Click **IV**.
IV Periph displays.
2. If a patient has no IVs or dialysis access in place, select the **No IV/vascular access devices** check box and none of the IV pages or **Add New IV Location** are available.
3. Move to the next tab.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

IV No IV/vascular access devices

Select a peripheral line

NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
NONE					

Add New IV Location

Edit Peripheral Line Site

* Location: None

* Date/time inserted

* Other location

* Other size

Dressing change
Last changed:
Dressing date/time change

Tubing change
Last changed:
Tubing date/time change

IV Discontinued
IV discontinue date/time

* Other dressing condition * Dressing type * Other dressing type * Site characteristics * Drainage * Other site appearance * Describe patency

OK Cancel edit

IV Periph IV Central IV Dialysis IV Page 4 IV DP

Gen Inf Belong Orient V/S Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text

* Designates a required field

Performing assessment

Admission – RN Assessment, IV (IV) tab, IV Periph window
No IV vascular access devices selected

Peripheral Lines - IV Periph

1. Click **IV**.
IV Periph displays.
2. Populate IV Periph.
3. Click **Add New IV Location**.
The Location drop-down list box displays in the **Edit Peripheral Line site #1** section.

The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The "IV" tab is selected. At the top, there is a checkbox for "No IV/vascular access devices". Below this is a table with the heading "Select a peripheral line". The table has columns: NUMBER, LOCATION, DATE INSERTED, SIZE, DISCONTINUED, and UPDATED. The first row has the number "1" in the NUMBER column, and "NO" in the DISCONTINUED and UPDATED columns. To the right of the table is a button labeled "Add New IV Location".

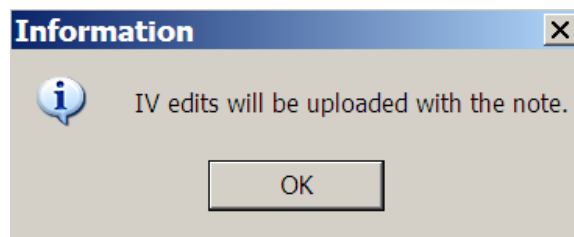
Below the table is the "Edit Peripheral Line site #1" form. It contains several sections:

- * Location:** A dropdown menu showing "Hand Right".
- * Date inserted known:** Radio buttons for "Yes" and "No".
- * Size:** Radio buttons for "16 G", "18 G", "20 G", "22 G", "Other", and "Unknown".
- * Dressing:** Radio buttons for "Clean, dry, intact", "Drainage", and "Other".
- * Site characteristics:** A list of checkboxes including "No evidence of complications", "Drainage", "Pain", "Redness", "Swelling", and "Other".
- * IV Discontinued:** A checkbox and a field for "IV discontinue date/time".
- * IV patent:** Radio buttons for "Yes" and "No".

 There are also "OK" and "Cancel edit" buttons at the bottom right of the form. At the bottom of the window, there is a navigation bar with tabs for "IV Periph", "IV Central", "IV Dialysis", "IV Page 4", and "IV CP". A status bar at the very bottom says "Performing assessment".

Admission – RN Assessment, IV (IV) tab, IV Periph window

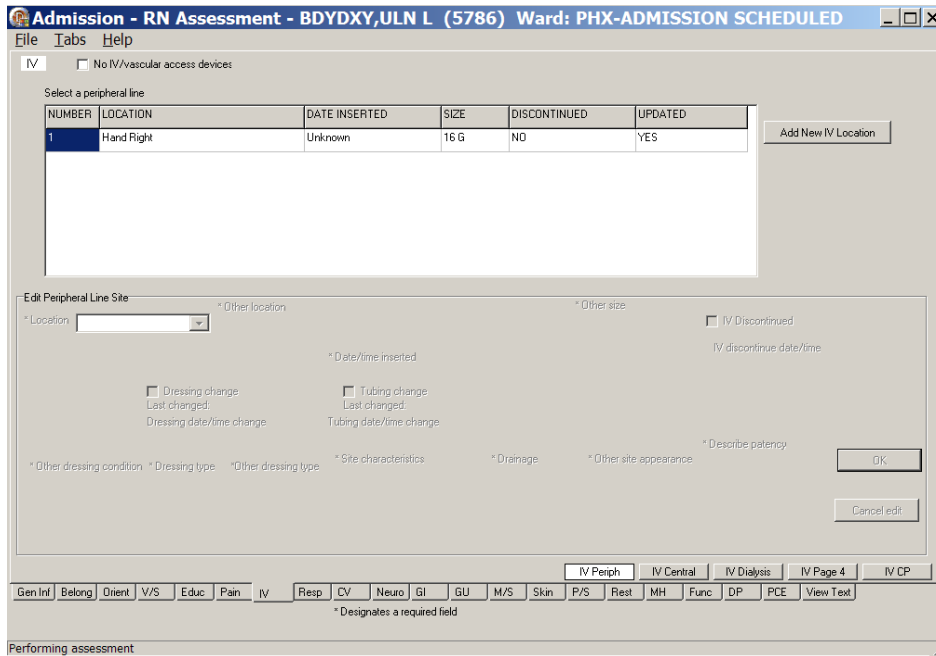
4. Select a location.
Additional fields become available.
5. Complete all the fields with asterisks; they are required fields.
6. To cancel entered data *before upload*, click **Cancel edit**.
7. To upload the data, click **OK**.
Information pop-up displays.



Information pop-up: IV edits will be uploaded with the note.

Note: The IV information is not uploaded until the RN Admission Assessment note is uploaded.

- Click **OK**.
IV Periph tab redisplay with a location added.



Admission – RN Assessment, IV (IV) tab, IV Periph window with a peripheral line location

- To add another IV location, repeat steps 1 through 8.

Note: There is no limit to the number of IV locations you can enter.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

IV No IV/vascular access devices

Select a peripheral line

NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
1	Hand Right	Unknown	16 G	NO	NO
2	Wrist Right	Unknown	16 G	NO	YES

Add New IV Location

Edit Peripheral Line Site

* Location * Other location * Other size IV Discontinued
 IV discontinue date/time

* Date/time inserted Dressing change
 Last changed: Tubing change
 Last changed: Dressing date/time change Tubing date/time change

* Other dressing condition * Dressing type * Other dressing type * Site characteristics * Drainage * Other site appearance * Describe patency

OK Cancel edit

IV Periph IV Central IV Dialysis IV Page 4 IV CP

Gen Inf Belong Orient V/S Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text

* Designates a required field

Performing assessment

Admission – RN Assessment, IV (IV) tab, IV Periph window with two peripheral lines added

Central IV Lines – IV Central

1. Click **IV Central**.
IV Central displays.
2. Populate IV Central.

The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". Below the menu bar is a section labeled "IV" with the instruction "Select a central line". This section contains a table with the following columns: NUMBER, TYPE, LOCATION, DATE INSERTED, DISCONTINUED, and UPDATED. The first row has the number "1" in the NUMBER column, and "NO" in the DISCONTINUED and UPDATED columns. To the right of the table is a button labeled "Add New CL Location".

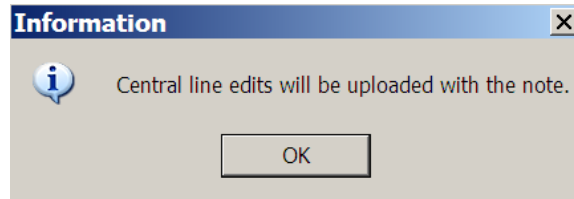
Below the table is the "Edit Central Line site #1" section. It contains several fields and checkboxes:

- * Type: Tunneled catheter - Single Lumen
- * Location: Radial Right
- * Date inserted known: Yes (selected), No
- * Catheter impregnated with antiseptic and/or antibiotic: Yes, No, Unknown
- * Dressing: Clean, dry, intact (selected), Drainage, Other
- * Present on admission: Yes, No
- * Tubing change: Yes, No
- * Catheter power injectable: Yes, No, Unknown
- * IV patent: Yes (selected), No
- * Dressing type: Banded, Gauze, Transparent, Other, None
- * Site characteristics: No evidence of complications (checked), Drainage, Pain, Redness, Swelling, Other

At the bottom of the window is a navigation bar with buttons for "IV Periph", "IV Central" (highlighted), "IV Dialysis", "IV Page 4", and "IV CP". Below the navigation bar is a status bar with various assessment categories: "Gen Inf", "Belong", "Orient", "V/S", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", "View Text". A note at the bottom states "* Designates a required field".

Admission – RN Assessment, IV (IV) tab, IV Central window

3. Click **Add New CL Location**.
The Type and Location drop-down list boxes display in the **Edit Central Line site #1** section.
4. Select a type and a location.
5. Complete all the fields with asterisks; they are required fields.
6. To cancel entered data *before upload*, click **Cancel edit**.
7. To upload the data, click **OK**.
Information pop-up displays.



Information pop-up: Central line edits will be uploaded with the note.

8. Click **OK**.
9. To add another central line, repeat steps 1 through 8.

Dialysis Ports - IV Dialysis

1. Click **IV Dialysis**.
IV Dialysis displays.
2. Populate IV Dialysis.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

IV

Select a dialysis access location

NUMBER	TYPE	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
NONE						

Add New Dialysis Location

Edit Dialysis access location #

* Type: None * Select dialysis location: None * Other location: * Other size:

Dressing change Last changed: Dressing date/time change

Tubing change Last changed: Tubing date/time change

* Date/time inserted: * Dialysis catheter discontinued Discontinue date/time:

* Other dressing condition: * Dressing type: * Other dressing type: * Site characteristics: * Drainage: * Other site appearance:

OK Cancel edit

IV Periph IV Central IV Dialysis IV Page 4 IV CP

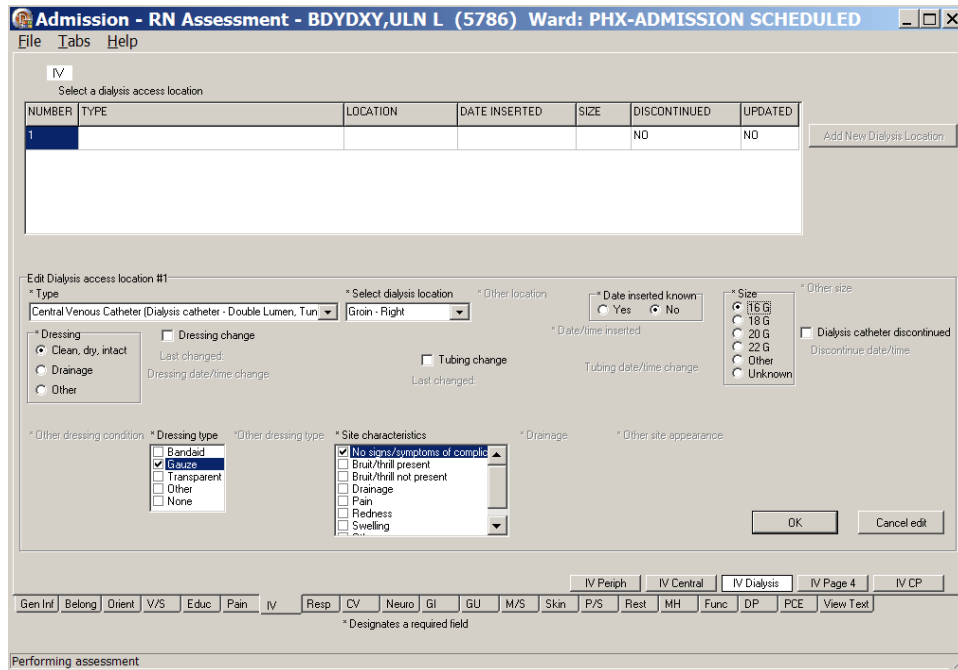
Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Performing assessment

Admission – RN Assessment, IV (IV) tab, IV Dialysis window
with no Dialysis location

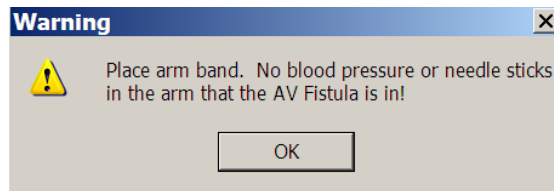
3. Click **Add New Dialysis Location**.
The Type and Select Dialysis location drop-down list boxes display in the **Edit Dialysis access location #1** section.



Admission – RN Assessment, IV (IV) tab, IV Dialysis window with Edit Dialysis access location #1

4. Select a type and a location.

Note: When you select **AV Fistula** or **AV Graft** for **Type**, a warning message displays to advise against using the patient’s affected arm for BP or needle sticks. You must place an arm band on the affected limb to prevent any mishaps.

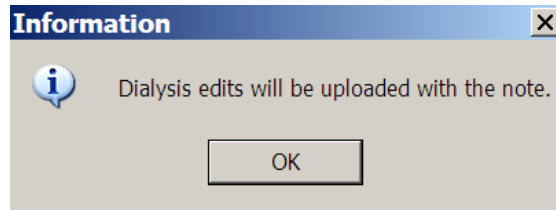


Warning pop-up:

Place arm band. No blood pressure or needle sticks in the arm that the AV Fistula is in!

5. Complete all the fields with asterisks; they are required fields.
6. To cancel entered data *before upload*, click **Cancel edit**.

- To upload the data, click **OK**.
Information pop-up displays.

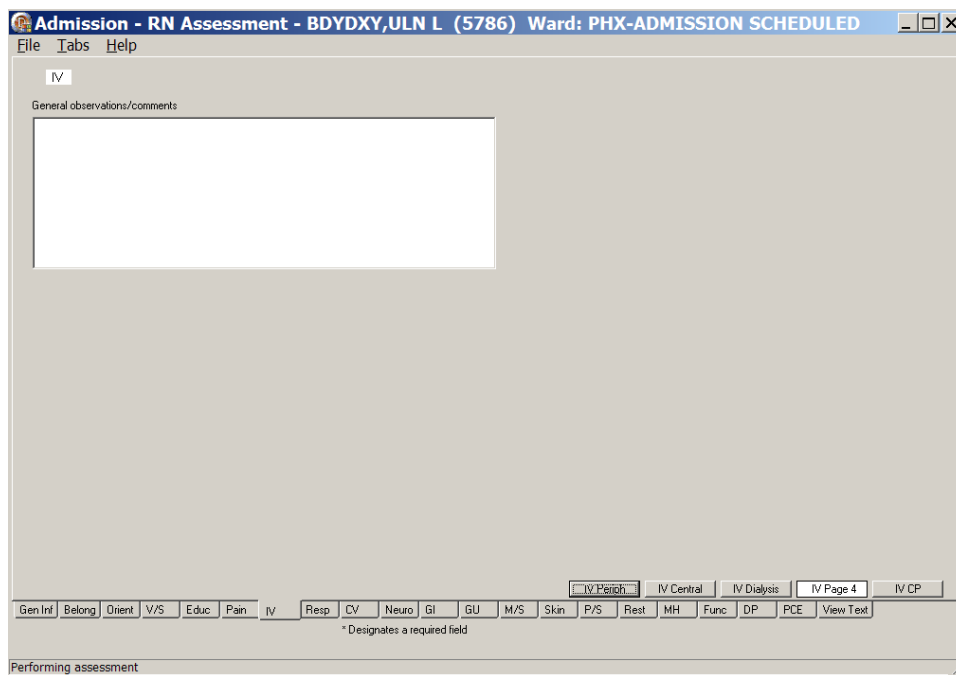


Information pop-up: Dialysis edits will be uploaded with the note.

- Click **OK**.
- To add another dialysis access location, repeat steps 1 through 8.

General Observations/Comments – IV Page 4

- Click **IV Page 4**.
IV Page 4 displays.

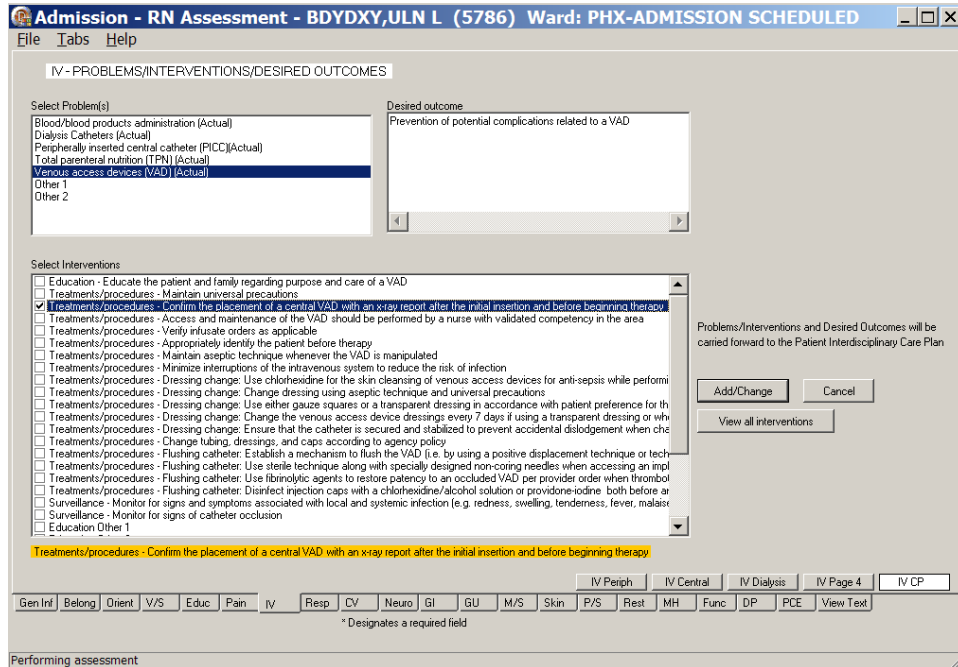


Admission – RN Assessment, IV (IV) tab, IV Page 4 window

- Populate IV Page 4.
Use the **General observations/comments** text box for additional information.

Care Plan - IV CP

1. Click IV CP.
IV CP displays.



Admission – RN Assessment, IV – Problems/Interventions/Desired Outcomes, IV CP window

2. Populate IV CP.
3. Add/Change problems/interventions, if necessary.
4. Refer to the instructions in *Working in a Care Plan* on page 11.

Respiratory (Resp)

The Respiratory Assessment tab contains an assessment of the patient's breathing at admission.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

RESPIRATORY ASSESSMENT

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: * Other reason no one could respond: * Information obtained from: Patient Authorized surrogate Family/Support Person Medical Record Other

* Other source of information:

* Patient has a history of: None reported Asthma COPD Pulmonary Emboli Pulmonary Fibrosis Upper respiratory infections TB Other

* Other history:

* Respiratory pattern: Regular Irregular - Agonal Irregular - Cheyne-Stokes Irregular - Kussmal Irregular - Other

* Other respiratory pattern:

* Respiratory rate: 20

* Respiratory depth: Normal Deep Shallow

* Abnormal Chest Movement:

* Chest movement: Equal, bilateral, symmetrical Abnormal

* Work of breathing: No difficulty observed Dyspnea (shortness of breath) Nasal flaring Orthopnea Flared Lips Use of accessory muscles Other

* Other work of breathing:

* Cyanosis: None Central - tongue and lips Peripheral - earlobes, fingertips, around lips

* Breath sounds: Absent Crackles/Rales Diminished/decreased Rhonchi Wheezing - expiratory Wheezing - inspiratory Stridor Pleural friction rub

Clear Abnormal

Resp Page 1 Resp Page 2 Resp Page 3 Resp CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: Respiratory depth Go

Performing assessment

Admission – RN Assessment, Respiratory Assessment (Resp) tab, Resp Page 1 window

1. Click **Resp**.
Resp Page 1 displays.
2. Populate Resp Page 1.
 - a. Use the **Respiratory rate** text box to enter the patient's current respiratory rate.
 - b. Complete all the fields with asterisks; they are required fields.
3. Click **Resp Page 2**.
Resp Page 2 displays.

Admission – RN Assessment, Respiratory Assessment (Resp) tab, Resp Page 2 window

4. Populate Resp Page 2.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. When **Home oxygen** is selected under Respiratory device, the Respiratory Consult is available. Order a consult according to your medical center policy.
 - c. Refer to the instructions in *Working in the Consults* on page 15.

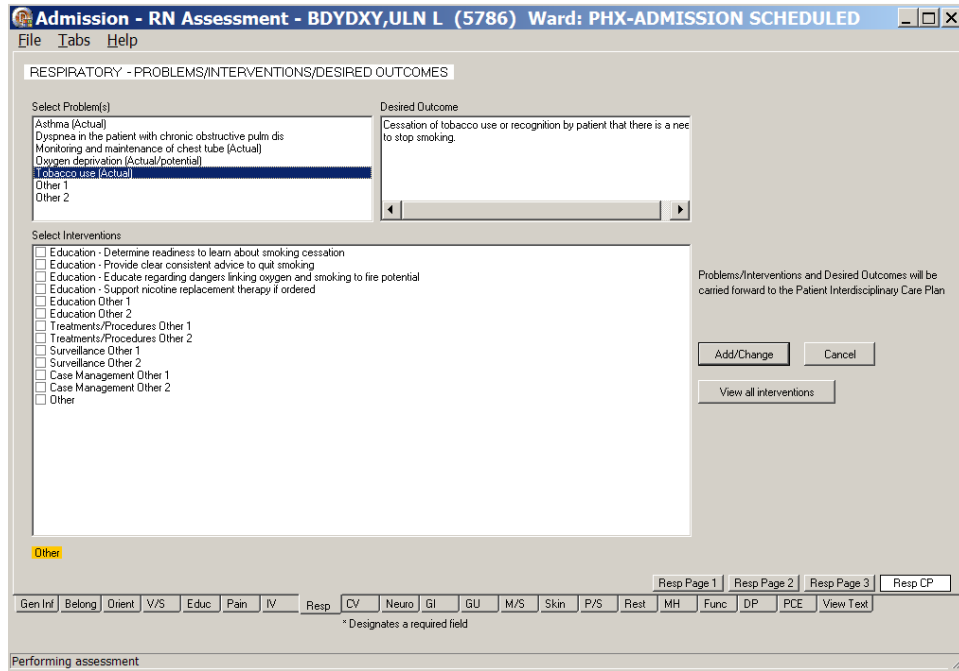
5. Click **Resp Page 3**.
Resp Page 3 displays.

Admission – RN Assessment, Respiratory - Problems/Interventions/Desired Outcomes, Resp Page 3 window contains the Tobacco screen

6. Populate Resp Page 3.
 - a. If the patient has a tracheostomy, complete fields with asterisks; they are required fields.
 - b. Complete the Tobacco fields with asterisks; they are required fields.

Note: Health Factors are deposited into PCE for Clinical Reminder resolution and/or cohort identification.

- Click **Resp CP**.
Resp CP displays.



Admission – RN Assessment, Respiratory - Problems/Interventions/Desired Outcomes, Resp CP window

- Populate Resp CP.
Refer to the instructions in *Working in a Care Plan* on page 11.

Cardiovascular (CV)

The Cardiovascular Assessment tab contains a history of the patient's cardiovascular health.

The screenshot shows the 'CARDIOVASCULAR ASSESSMENT' window. Key sections include:

- Patient/Family/support person able to respond to questions:** Radio buttons for 'Yes' (selected) and 'No'.
- Information obtained from:** Checkboxes for 'Patient' (checked), 'Authorized surrogate', 'Family/Support Person', 'Medical Record', and 'Other'.
- Patient has a history of:** A list of conditions with checkboxes, including 'None reported' (checked), Anemia, Angina, Anticoagulant Therapy, Arrhythmias, CAD, CABG, CHF, DVT, Hypertension, MI, Peripheral Vascular Disease, and Other.
- Edema and Locations:** A grid of radio buttons for 'Yes' or 'No' across various body parts: Facial, Periorbital, Right arm, Left arm, Right hand, Left hand, Sacral, Right hip, Left hip, Right leg, Left leg, Pedal right, and Pedal left.
- Extremities:** Checkboxes for 'Warm' (checked), 'Cool', 'Capillary Refill Less than 3 Seconds', and 'Capillary Refill Greater than 3 Seconds'.
- Auscultation:** A text field for 'Heart Rate' (65), radio buttons for 'Regular' (selected) and 'Irregular' under 'Heart rhythm', and radio buttons for 'Normal' (selected) and 'Abnormal' under 'Heart sounds'.

Admission – RN Assessment, Cardiovascular Assessment (CV) tab, CV Page 1 window

1. Click **CV**.
CV Page 1 displays.
2. Populate CV Page 1.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **Extremities comments** text box for additional information, if necessary.

3. Click **CV Page 2**.
CV Page 2 displays.

The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The main content area is labeled "CARDIOVASCULAR ASSESSMENT". It features several sections:

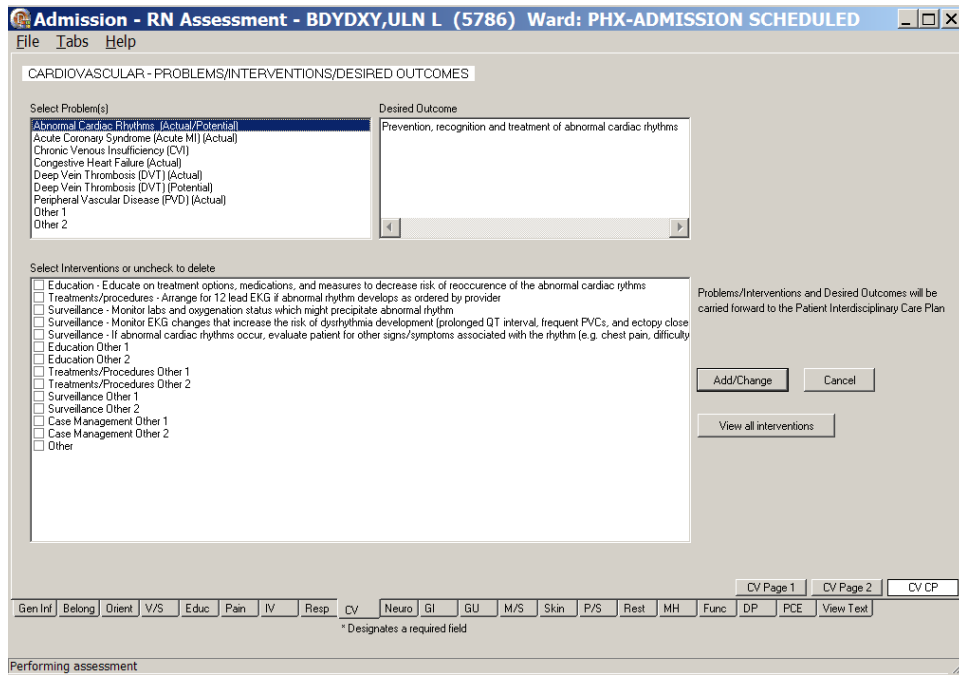
- Pulses:** Three groups of dropdown menus for "Radial Pulse", "Dorsalis Pedis Pulse", and "Posterior Tibial Pulse", each with "Left" and "Right" options.
- Jugular Venous Distention:** Radio buttons for "Yes" and "No".
- Homan's sign:** Radio buttons for "Negative" (selected) and "Positive", with checkboxes for "Right Calf" and "Left Calf".
- Cardiac devices:** A list with checkboxes for "None", "External pacemaker" (checked), "Permanent pacemaker", "Implantable cardioverter defibrillator (ICD)", and "Other".
- Cardiac monitor:** Radio buttons for "Yes" (checked) and "No".
- Cardiac monitor rhythm:** A list of rhythm types with checkboxes, including Atrial Fibrillation, Atrial Flutter, Junctional Rhythm, Sinus Arrhythmia, Sinus Bradycardia, Sinus Rhythm, Sinus Rhythm with PACs, Sinus Rhythm with PJC's, Sinus Rhythm with PVC's, Sinus Tachycardia, Supraventricular Tachycardia, SR with 1st degree Heart Block, 2nd degree Heart Block - Type I, 2nd degree Heart Block - Type II, 3rd degree Heart Block, Torsades de Pointes, Ventricular Tachycardia, Ventricular Fibrillation, Wide Complex Tachycardia, and Other.
- ECG Parameters:** Fields for "Heart rate: 65", "P Wave present" (Yes/No), "PR Interval:", "QRS Duration:", "T Wave:", "QT Interval:", and "ST Segment:".
- General observations/comments:** A large text area for notes.

 At the bottom, there is a navigation bar with tabs for "Gen Inf", "Belong", "Orient", "V/S", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "CV" tab is active. Below the navigation bar, there is a "Go to radiogroup:" dropdown menu set to "Jugular Venous Distention" and a "Go" button. The status bar at the very bottom reads "Performing assessment".

Admission – RN Assessment, Cardiovascular Assessment (CV) tab, CV Page 2 window

4. Populate CV Page 2.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** text box for additional information.

- Click CV CP.
CV CP displays.



Admission – RN Assessment, Cardiovascular – Problems/Interventions/Desired Outcomes, CV CP window

- Populate CV CP.
Refer to the instructions in *Working in a Care Plan* on page 11.

Neurology (Neuro)

The Neurological Assessment tab contains an assessment of brain related issues and includes instructions for assessing the patient's level of consciousness.

The directions for the *Glasgow Coma Scale* are on Neuro Page 1. The score is automatically calculated and transferred to the finished RN Admission Assessment note.

The screenshot shows the 'NEUROLOGICAL ASSESSMENT' window. Key fields include: 'Patient/family/support person able to respond to questions' (Yes selected), 'Patient has a history of' (None reported selected), 'Orientation' (Person, place, time, and situation selected), and 'Level of Consciousness (Glasgow Coma Scale)' (Eye response score: C, Verbal response score: 4, Motor response score: 3, Total score: 7). The 'Instructions for completing Glasgow Coma Scale' section provides detailed information on how to score the scale. The bottom of the window shows a navigation bar with tabs for 'Neuro Page 1', 'Neuro Page 2', and 'Neuro CP', and a 'Go to radiogroup' dropdown menu.

Admission – RN Assessment, Neurological Assessment (Neuro) tab, Neuro Page 1 window

1. Click **Neuro**.
Neuro Page 1 displays.
2. Populate Neuro Page 1.
Complete all the fields with asterisks; they are required fields.

3. Click **Neuro Page 2**.
Neuro Page 2 displays.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

NEUROLOGICAL ASSESSMENT

Motor

Instructions for performing motor assessment
Assess motor strength bilaterally. Have the patient flex and extend arm against your hand; squeeze your fingers; lift leg while you press down on the thigh; hold leg straight and lift it against gravity; and flex and extend foot against your hand. Grade each extremity using the scale below.

5+ - Active movement of extremity against gravity and maximal resistance
4+ - Active movement of extremity against gravity and moderate resistance
3+ - Active movement of extremity against gravity but NOT against resistance
2+ - Active movement of extremity but NOT against gravity
1+ - Slight movement (licker of contraction)
0 - No movement

* Right arm
 5+
 4+
 3+
 2+
 1+
 0
 N/A

* Left arm
 5+
 4+
 3+
 2+
 1+
 0
 N/A

* Right leg
 5+
 4+
 3+
 2+
 1+
 0
 N/A

* Left leg
 5+
 4+
 3+
 2+
 1+
 0
 N/A

* Speech/Language
 Clear
 Abnormal - Sttered
 Abnormal - Aphasic
 Abnormal - Dysarthric
 Other
* Other speech/language

Pupils

* Lens implant/prosthesis
 Yes
 No
 Unknown
Describe lens implant/prosthesis *

* Size
 Equal
 Right greater than left
 Left greater than right
 Other

* Other pupil size

Reactivity

* Right eye
 Brisk reaction to light
 Some reaction to light (sluggish)
 No reaction to light

* Left eye
 Brisk reaction to light
 Some reaction to light (sluggish)
 No reaction to light

* Sensations - Paresthesias or neuropathies present
 Yes
 No

* Sensations present

* Requires assistive communication device to meet basic needs
 Yes
 No

* Communication device needed

General observations/comments

Neuro Page 1 | **Neuro Page 2** | Neuro CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

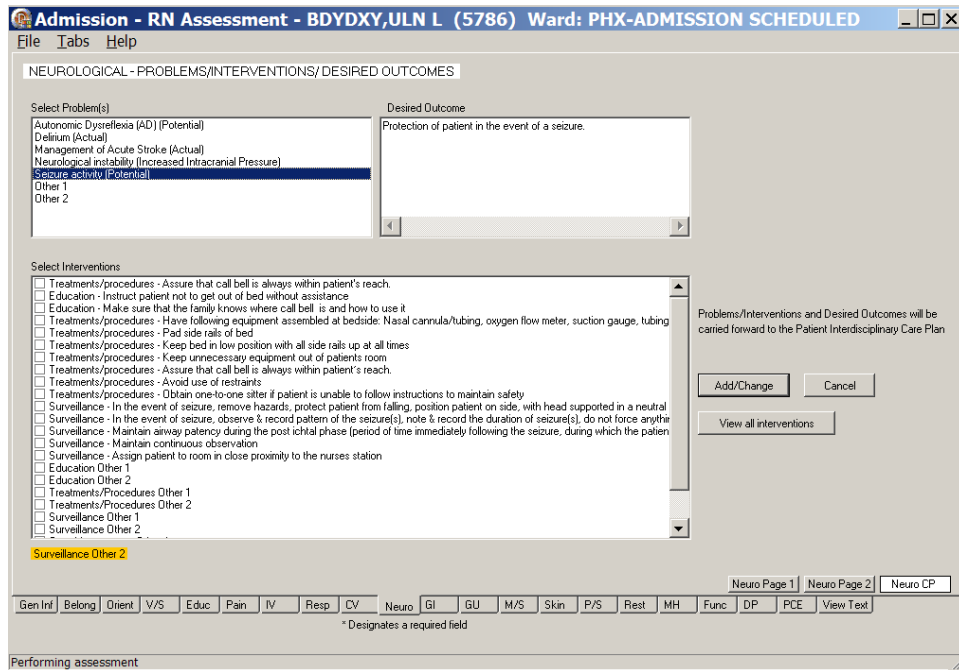
* Designates a required field

Go to radiogroup: Right arm [Go]

Performing assessment

Admission – RN Assessment, Neurological Assessment (Neuro) tab, Neuro Page 2 window

4. Populate Neuro Page 2.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** text box for additional information.
5. Click **Neuro CP**.
Neuro CP displays.



Admission – RN Assessment, Neurological Assessment (Neuro) tab, Neuro CP window

6. Populate Neuro CP.

Refer to the instructions in *Working in a Care Plan* on page 11.

Gastrointestinal (GI)

The Gastrointestinal Assessment tab contains abdominal and bowel assessments, a nutrition screening, and a dietary history.

- On GI Page 3, when any items listed under the **Nutrition consult guidelines** are selected, a Nutrition Consult is required.
- On GI Page 3, when any Dysphagia question is answered with **Yes**, a Speech Consult is required.

The screenshot shows the 'GASTROINTESTINAL ASSESSMENT' window. At the top, it says 'Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED'. Below that are 'File', 'Tabs', and 'Help' menus. The main area is divided into several sections:

- Patient/family/support person able to respond to questions:** Radio buttons for 'Yes' (selected) and 'No'.
- Information obtained from:** Checkboxes for 'Patient' (checked), 'Authorized surrogate', 'Family/Support Person', 'Medical Record', and 'Other'.
- Abdominal Assessment:** Includes 'Abdomen' (Distended, Flat, Guarding, Non-tender, Obese, Rigid, Round, Soft, Tender, Other) and 'Other abdominal assessment'.
- Bowel sounds:** Radio buttons for 'Present' (selected) and 'Absent'. Below it, radio buttons for 'Normal' (selected), 'Hypoactive', and 'Hyperactive'.
- Bowel sounds comments:** A text area for notes.
- Bowel regime:** Radio buttons for 'Daily' (selected), 'Several times a week', 'Weekly', and 'Other'. Includes checkboxes for 'Laxative use' and 'Enema use'.
- Bowel program:** Includes 'Bowel program' checkbox, 'Bowel program schedule', 'Bowel care - start time', 'Bowel care - completion time', and 'Medication/treatment'.

At the bottom, there are tabs for 'GI Page 1', 'GI Page 2', 'GI Page 3', and 'GI CP'. A navigation bar contains various system tabs like 'Gen Inf', 'Belong', 'Orient', 'V/S', 'Educ', 'Pain', 'IV', 'Resp', 'CV', 'Neuro', 'GI', 'GU', 'M/S', 'Skin', 'P/S', 'Rest', 'MH', 'Func', 'DP', 'PCE', and 'View Text'. A 'Go to radiogroup:' dropdown is set to 'Bowel sounds' with a 'Go' button. The status bar at the very bottom says 'Performing assessment'.

Admission – RN Assessment, Gastrointestinal Assessment (GI) tab, GI Page 1 window

1. Click **GI**.
GI Page 1 displays.
2. Populate GI Page 1.
Complete all the fields with asterisks; they are required fields.

- Click **GI Page 2**.
GI Page 2 displays.

Admission – RN Assessment, Gastrointestinal Assessment (GI) tab, GI Page 2 window

- Populate GI Page 2.
Complete all the fields with asterisks; they are required fields.

5. Click **GI Page 3**.
GI Page 3 displays.

The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The main content area is labeled "GASTROINTESTINAL ASSESSMENT".

Dysphagia screen:

- * Dysphagia screen
 - Able to screen
 - Unable - Patient on Ventilator
 - Unable - Patient unconscious
 - Unable - Other
 - N/A
- * Other reason unable to screen

Dysphagia risk factors:

- * Diagnosis of new stroke, head and neck, cancer, or traumatic brain injury: Yes No
- * Modified texture diet/ eating maneuvers (e.g. chin tuck, head turn): Yes No
- * Unable to follow commands: Yes No
- * Wet gurgly voice: Yes No
- * Drooling while awake: Yes No
- * Tongue deviation from midline: Yes No

Unintentional weight loss or gain in the past month:

- Yes
- No
- Unknown

Nutrition consult guidelines:

- Patient on tube feeding or total parenteral nutrition
- 5% unintentional weight gain or loss in past 30 days
- Nausea/vomiting/diarrhea for greater than 3 days
- Less than 50% usual intake for greater than 5 days
- Dysphasia or dysphagia symptom

General Observations/Comments: (Empty text box)

Warnings:

- Keep NPO, notify provider, and send Speech Pathology consult (Red box)
- Nutrition consult mandatory (Red box)

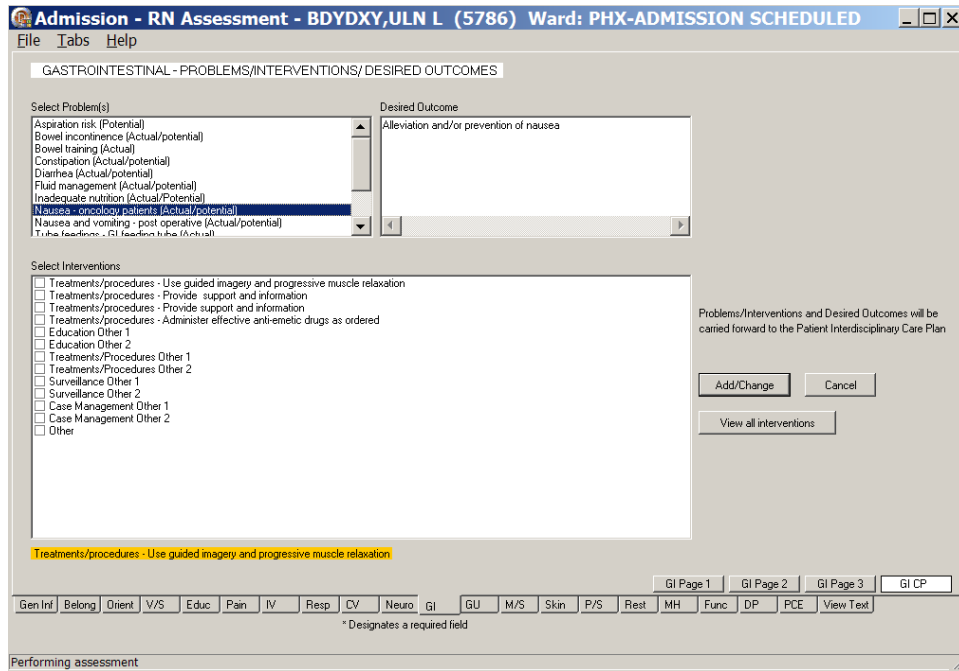
Navigation:

- Buttons: GI Page 1, GI Page 2, GI Page 3, GI CP
- Bottom menu: Gen Inf, Belong, Orient, V/S, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text
- * Designates a required field
- Go to radiogroup: Dysphagia screen
- Go button

Admission – RN Assessment, Gastrointestinal Assessment (GI) tab, GI Page 3 window

6. Populate GI Page 3.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** text box for additional information
 - c. GI Page 3 contains Speech Consult and Nutrition Consult.
Refer to the instructions in *Working in the Consults* on page 15.

- Click **GI CP**.
GI CP displays.



Admission – RN Assessment, Gastrointestinal – Problems/Interventions/Desired Outcomes, GI CP window

- Populate **GI CP**.
Refer to the instructions in *Working in a Care Plan* on page 11.

Genitourinary (GU)

The Genitourinary Assessment tab contains information about the quality and quantity of urine. Questions about urine are optional because patients may not be able to void at time of the assessment.

The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The main content area is labeled "GENITOURINARY ASSESSMENT". It contains several sections of questions and options:

- Information obtained from:** Radio buttons for "Patient", "Authorized surrogate", "Family/Support Person", "Medical Record", and "Other".
- Voiding:** A list of voiding problems with checkboxes: Anuria, Dribbling, Dysuria, Frequency, Incontinence, Intermittent catheterization, Nocturia, Oliguria, Polyuria, Retention, Urgency, and Other. A "Last voided" section has radio buttons for "Known", "Unknown", and "Absorbency devices used".
- Urine:** Radio buttons for "Color" (Amber, Yellow, Bloody, Unable to evaluate, Other), "Consistency" (Normal, Concentrated, Dilute, Unable to evaluate), "Odor" (Foul smelling, None, Unable to evaluate), and "Sediment" (Yes, No, Unable to evaluate).
- Abnormal discharge:** Radio buttons for "None", "Genital", and "Unable to evaluate".

At the bottom, there is a navigation bar with tabs for "GU Page 1", "GU Page 2", and "GU CP". A "Go to radiogroup:" dropdown menu is set to "Color" with a "Go" button next to it.

Admission – RN Assessment, Genitourinary Assessment (GU) tab, GU Page 1 window

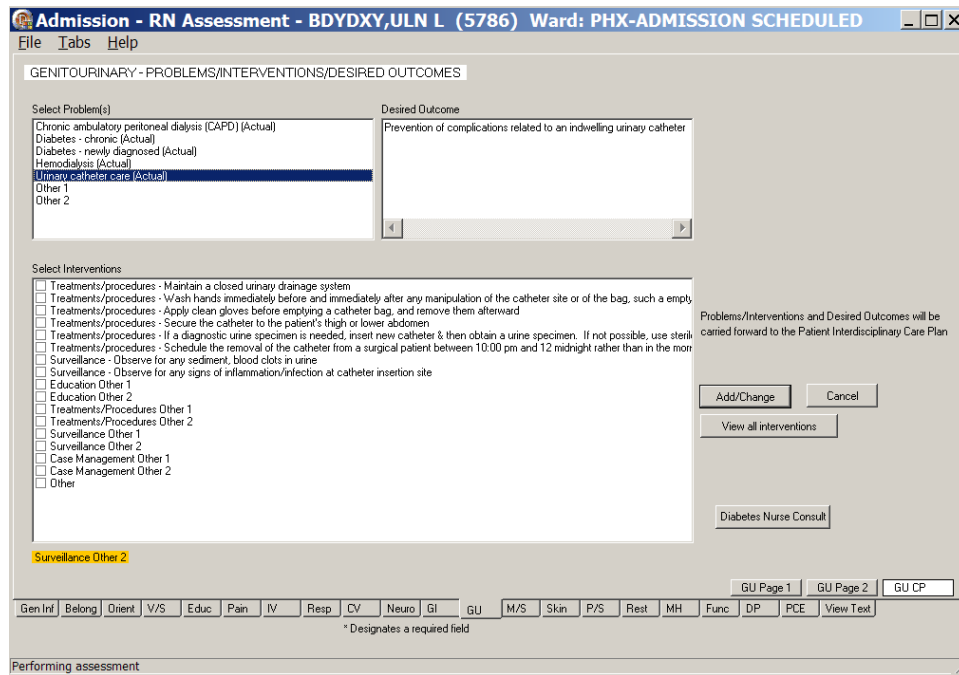
1. Click **GU**.
GU Page 1 displays.
2. Populate GU Page 1.
Complete all the fields with asterisks; they are required fields.
3. Click **GU Page 2**.
GU Page 2 displays.

Admission – RN Assessment, Genitourinary Assessment (GU) tab, GU Page 2 window
Male patient information available

Admission – RN Assessment, Genitourinary Assessment (GU) tab, GU Page 2 window
Female patient information available

Note: The sex-specific questions (male/female) are optional. The exception is for female patients; the pregnancy responses are required.

4. Populate GU Page 2.
 - a. When a patient has genitourinary devices, additional fields are made available.
 - b. Complete all the fields with asterisks; they are required fields.
 - c. Use the **General observations/comments** text box for additional information.
5. **Optional:** If the Women's Health Consult is set up at your site, the button displays on GU Page 2; refer to the instructions in *Working in the Consults* on page 15.
6. Click **GU CP**.
GU CP displays.



Admission – RN Assessment, Genitourinary – Problems/Interventions/Desired Outcomes, GU CP window

7. Populate GU CP.
Refer to the instructions in *Working in a Care Plan* on page 11.

Musculoskeletal (M/S)

The Musculoskeletal Assessment tab contains information about the patient's muscular and skeletal history.

Directions for the *Morse Fall Scale* are on M/S Page 2. The directions are only on the template and are not transferred into the completed Progress Note.

- The **Total Morse** score for fall risk for the patient is calculated automatically as you select responses for history of falling, secondary diagnosis, ambulatory aid, gait/transferring, and marital status.
- The Morse Score is pulled forward to the M/S CP page to guide the entry of interventions.

1. Click **M/S**.
M/S Page 1 displays.

The screenshot shows the 'MUSCULOSKELETAL ASSESSMENT' form. Key sections include:

- Information obtained from:** Patient (checked), Authorized surrogate, Family/Support Person, Medical Record, Other.
- Range of Motion:** ROM - No apparent problem (checked), Limited ROM - Right Upper Extremity, Limited ROM - Left Upper Extremity, Limited ROM - Right Lower Extremity, Limited ROM - Left Lower Extremity.
- Stated patient complaints:** Empty text box.
- General observations/comments:** Large empty text box.

Navigation buttons at the bottom: M/S Page 1, M/S Page 2, M/S CP. A 'Go to radiogroup' dropdown is set to 'able to respond to questions' with a 'Go' button.

Admission – RN Assessment, Musculoskeletal Assessment (M/S) tab, M/S Page 1 window

2. Populate M/S Page 1.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** text box for additional information.

- Click **M/S Page 2**.
M/S Page 2 displays.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

Describe previous falls and history

* History of falling
 No (0)
 Yes (25)

* History of injury with prior falls:
 Yes
 No
 Unknown

* Is patient on any meds that increase risk for falling or risk for injury with falls
 No
 Analgesics
 Anticoagulants
 Antidepressants
 Antidiabetics
 Antihypertensives
 Diuretics
 Hypnotics
 Opioids
 Psychotropics
 Sedatives
 Other

* Secondary Diagnosis:
 No (0)
 Yes (15)

* Is patient on multiple meds to manage multiple comorbidities:
 Yes
 No

* Ambulatory aid:
 None, bedrest, wheelchair, other person (0)
 Crutches, cane, walker (15)
 Furniture (30)

* Intra-venous Therapy/Heparin Lock:
 No (0)
 Yes (20)

* Gait/Transferring:
 Normal, bedrest, immobile (0)
 Weak (10)
 Impaired (20)

* Mental Status:
 Oriented to own ability (0)
 Overestimates/Forgets Limitations (15)

Total Morse score for Fall Risk: 40

0 - 24 - Patient is at low risk for falling. Implement Universal Fall Precautions
 25 - 44 - Patient is at moderate risk for falling. Implement Universal Fall Precautions and precautions based on identified area of risk.
 45 and higher - Patient is at high risk for falling. Implement Universal Fall Precautions and precautions based on identified area of risk.

Instructions for completing Morse Fall Scale

History of falling:
 Score as 0 if the patient has not fallen
 Score as 25 if the patient has fallen during the past three months before admission or if there was an immediate history of physiological falls, such as from seizures or an impaired gait prior to admission. Note: If a patient falls for the first time, then his or her score immediately increases by 25.

Secondary diagnosis:
 Score as 0 if only one medical diagnosis is listed on the patient's chart.
 Score as 15 if more than one medical diagnosis is listed on the patient's chart.
 Use of multiple medications is implied in the scale as indicated by the secondary diagnosis (co-morbidity score).

Ambulatory aids:
 Score as 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on a bed rest and does not get out of bed at all.
 Score as 15 if the patient uses crutches, a cane, or a walker.
 Score as 30 if the patient ambulates clutching onto the furniture for support.

Intravenous therapy:
 Score as 0 if patient does not have an IV or Heparin/Saline Lock.
 Score as 20 if the patient has an intravenous apparatus or a heparin lock inserted.

Gait:
 Score as 0 a normal gait which is characterized by the patient

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

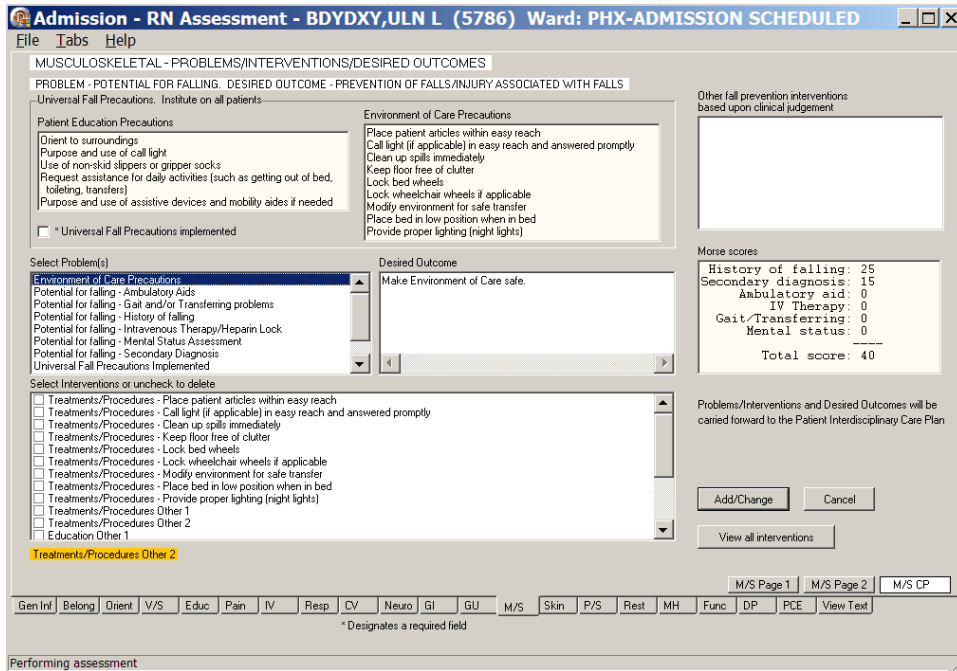
* Designates a required field
 Go to radiogroup: History of falling [Go]

Performing assessment

Admission – RN Assessment, Musculoskeletal Assessment (M/S) tab, M/S Page 2 window

- Populate M/S Page 2.
Complete all the fields with asterisks; they are required fields.

- Click **M/S CP**.
M/S CP displays.



Admission – RN Assessment, Musculoskeletal – Problems/Interventions/Desired Outcomes M/S tab,
M/S CP window

- Populate M/S CP.
Refer to the instructions in *Working in a Care Plan* on page 11.

Note: *Universal Fall Precautions* must be completed for all patients.

Skin (Skin)

The Skin Assessment tab contains information about the condition of the patient's skin – pressure ulcers and skin alterations.

Directions for the *Braden Scale for Predicting Pressure Sore Risk* are on Skin Page 3.

- The **Total Score** for the patient is calculated automatically as you select scores (1-4) for sensory perception, moisture, activity, mobility, nutrition, and friction and shear.
- The Braden Score is pulled forward to the Skin CP page to guide the entry of interventions.

Skin CP contains patient/caregiver skin care education, including risk for skin breakdown and prevention/treatment of problems related to skin integrity.

Admission - RN Assessment - BDYDX,Y,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

SKIN ASSESSMENT

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond:

* Other reason no one could respond:

* Information obtained from: Patient Authorized surrogate Family/Support Person Medical Record Other

* Other source of information:

* Patient has a history of: None reported Acne Athlete's foot Burns Cancer Eczema Herpes Simplex Herpes Zoster (Shingles) Injury/Trauma Pressure Ulcer Psoriasis Psoriasis Psoriasis Sebaceous cysts No new problems

* Describe other history:

Predisposition for skin breakdown:

Does patient have: Amputee Diabetes Multiple Sclerosis Neurological disease Paraplegia Paralysis Quadraplegia Spinal cord injury

* Risk Factors: None Bariatric patient Device-related pressure Diabetic End of life care Hypoalbuminemia Medication - Vasopressors Refusing to turn/move secondary to pain Too unstable for turns Very low BMI (Body Mass Index) Other

* Other risk factors:

Skin Inspection:

* Skin Temperature: Warm Hot Cool Cold

* Skin Moisture: Extremely dry Moist Dry Diaphoretic

* Skin Color: Normal for ethnic group Cyanotic Dusky Flushed Jaundiced Mottled Pale Other

* Other skin color:

* Skin Turgor: Within Normal Limits Abnormal

* Skin Patches: Yes No

* Skin Patch Description:

General observations/comments:

Pressure ulcers Other skin alterations

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: Skin Patches Go

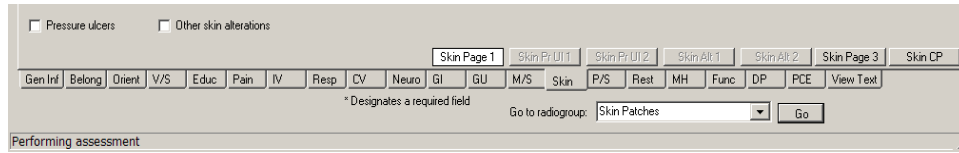
Performing assessment

Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Page 1 window

1. Click **Skin**.
Skin Page 1 displays.
2. Populate Skin Page 1.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** text box for additional information.

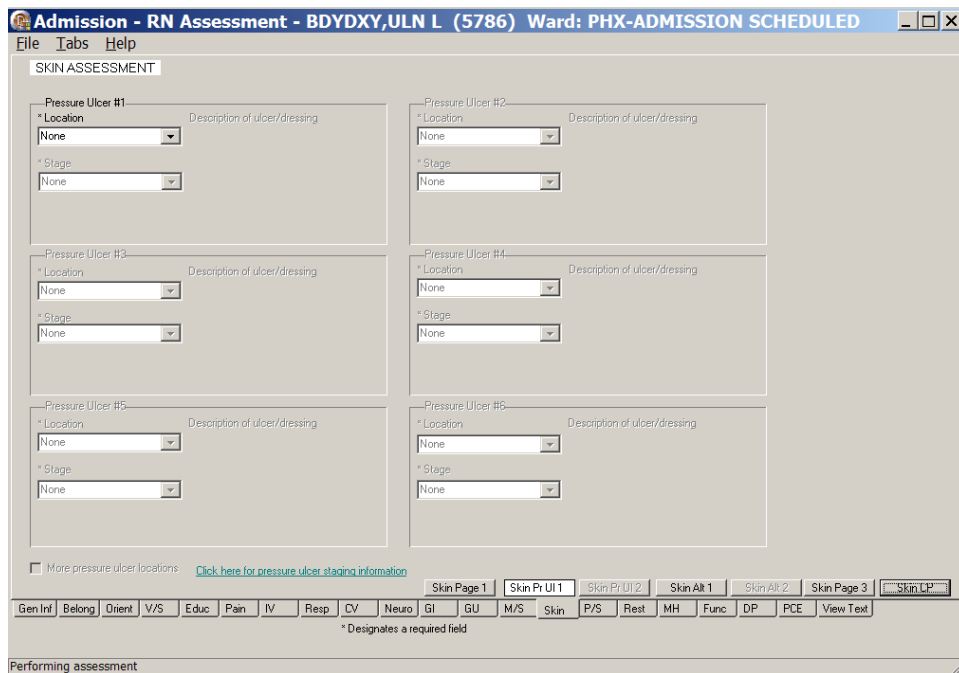
Documenting Pressure Ulcers

From the Skin Page 1 tab, select **Pressure ulcers** and the Skin Pr Ul 1 tab becomes available.



Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Page 1 window
Pressure ulcers selected

1. Click **Skin Pr Ul 1**.
Skin Pr Ul 1 displays.
2. Populate Skin Pr Ul 1.
 - a. Enter **Location** and **Stage** for up to six pressure ulcer locations.
The fields with asterisks are required fields.
 - b. Enter a **Description of ulcer/dressing**, if appropriate.



Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Pr Ul 1 window

Pressure Ulcer Drop-downs

Pressure Ulcer #1

* Location: None (selected), Ear - Left, Ear - Right, Elbow - Left, Elbow - Right, Heel - Left, Heel - Right, Ischial Tuberosity Left

Description of ulcer/dressing

Skin Assessment - Pressure Ulcer #1/Location

* Location: Ear - Left

* Stage: Stage I (selected), None, Suspected Deep Tissue Injury, Stage II, Stage III, Stage IV, Unstageable

Description of ulcer/dressing

Skin Assessment - Pressure Ulcer #1/Stage

- To enter more than six pressure ulcer locations, select the **More pressure ulcer locations** check box. Skin Pr UI 2 becomes available.

More pressure ulcer locations [Click here for pressure ulcer staging information](#)

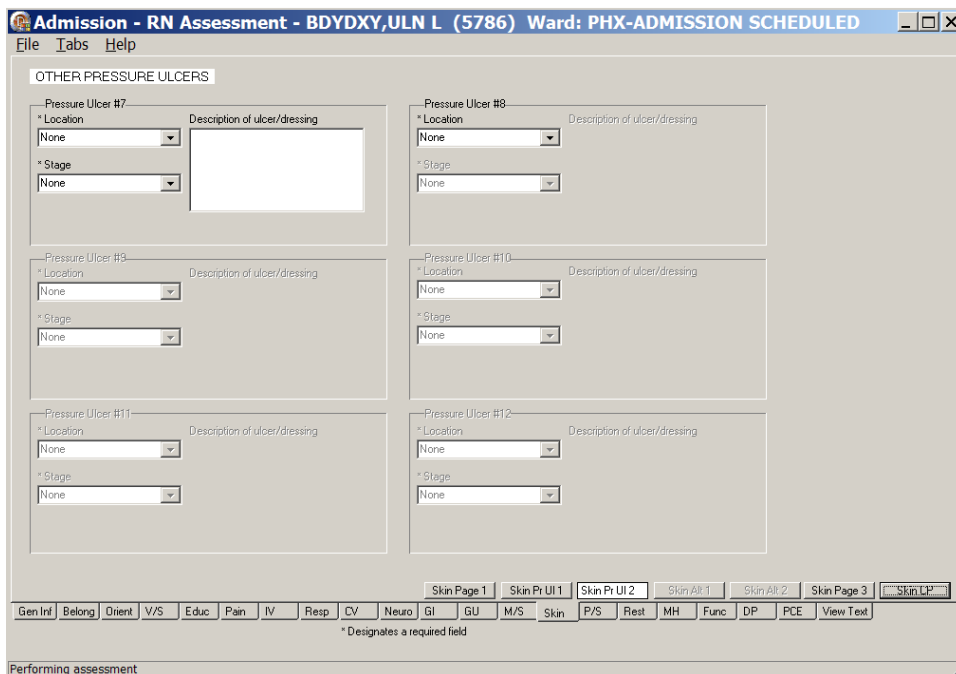
Skin Page 1 | Skin Pr UI 1 | **Skin Pr UI 2** | Skin Alt 1 | Skin Alt 2 | Skin Page 3 | Skin LP

Gen/Int | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Performing assessment

Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Pr UI 1 window
More pressure ulcer locations selected

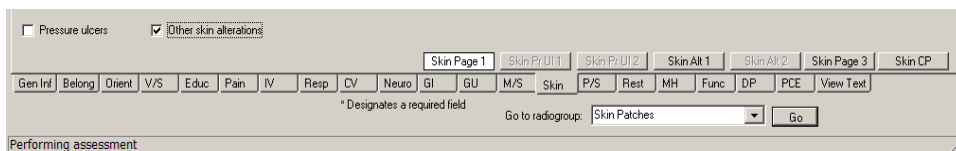


Admission – RN Assessment, Other Pressure Ulcers, Skin Pr Ul 2 window

4. Click **Skin Pr Ul 2**.
Skin Pr Ul 2 displays.
5. Populate Skin Pr Ul 2.
 - a. Enter **Location** and **Stage** for six additional pressure ulcer locations.
The fields with asterisks are required fields.
 - b. Enter a **Description of ulcer/dressing**, if appropriate.

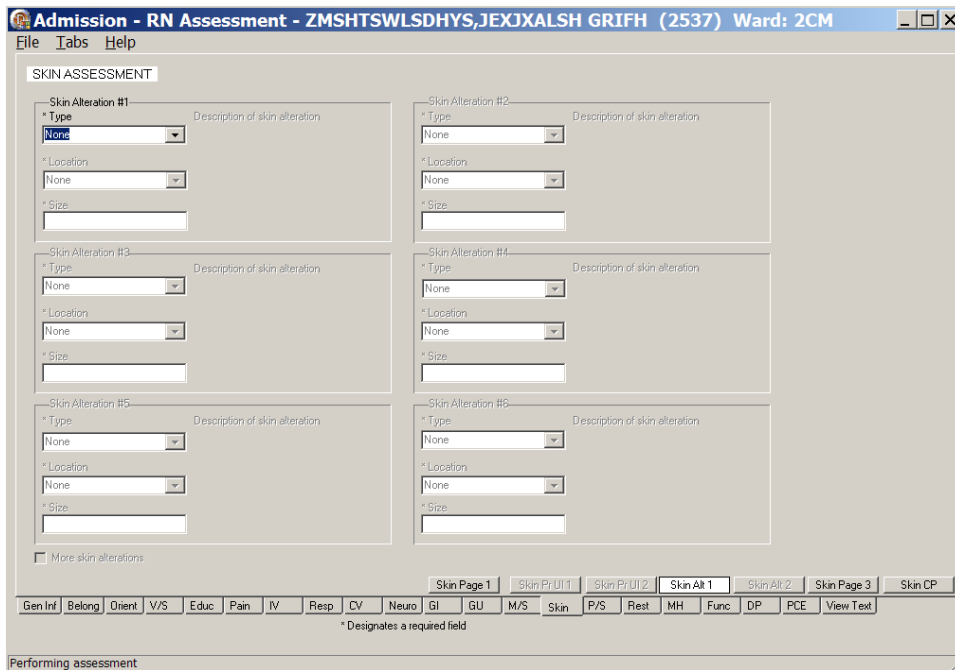
Documenting Skin Alterations

From the Skin Page 1 tab, select **Other skin alterations** and the Skin Alt 1 tab becomes available.



Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Page 1 window
Other skin alterations selected

1. Click **Skin Alt 1**.
Skin Alt 1 displays.



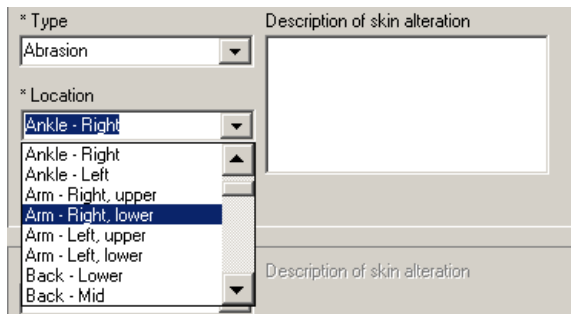
Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Alt 1 window
Skin Alterations #1-#6

2. Populate Skin Alt 1.
 - a. Enter **Type**, **Location**, and **Size** for up to six (#1-#6) other skin alterations. The fields with asterisks are required fields.
 - b. Enter a **Description of skin alteration**, if appropriate.

Skin Alteration Drop-downs



Skin Assessment – Skin Alteration #1/Type



Skin Assessment – Skin Alteration #1/Location

* Type: Abrasion
 * Location: Arm - Right, lower
 * Size: 2cm
 Description of skin alteration: [Empty text box]

Skin Assessment – Skin Alteration #1/Size

More skin alterations
 Skin Page 1 | Skin Pr/U1 | Skin Pr/U2 | Skin Alt 1 | Skin Alt 2 | Skin Page 3 | Skin CP
 Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text
 * Designates a required field
 Performing assessment

Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Alt 1 window
 More skin alterations selected

3. To enter more than six skin alterations locations, select the **More skin alterations** check box. Skin Alt 2 becomes available.
4. Click **Skin Alt 2**.
 Skin Alt 2 displays.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED
 File Tabs Help
 SKIN ASSESSMENT
 Skin Alteration #7: Type: None, Location: None, Size: [Empty]
 Skin Alteration #8: Type: None, Location: None, Size: [Empty]
 Skin Alteration #9: Type: None, Location: None, Size: [Empty]
 Skin Alteration #10: Type: None, Location: None, Size: [Empty]
 Skin Alteration #11: Type: None, Location: None, Size: [Empty]
 Skin Alteration #12: Type: None, Location: None, Size: [Empty]
 Skin Page 1 | Skin Pr/U1 | Skin Pr/U2 | Skin Alt 1 | Skin Alt 2 | Skin Page 3 | Skin CP
 Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text
 * Designates a required field
 Performing assessment

Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Alt 2 window
 Skin Alterations #7-#12

5. Populate Skin Alt 2.
 - a. Enter **Type**, **Location**, and **Size** for up to six (#7-#12) additional skin alterations. The fields with asterisks are required fields.
 - b. Enter a **Description of skin alteration**, if appropriate.

6. Click **Skin Page 3**.
Skin Page 3 displays.

Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Page 3 window
Braden Scale for Predicting Pressure Sore Risk

7. Populate Skin Page 3.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Order a Nutrition Consult and/or Wound Care Consult, if necessary.
Refer to the instructions in *Working in the Consults* on page 15.

8. Click **Skin CP**.
Skin CP displays.

Admission – RN Assessment, Skin – Problems/Interventions/Desired Outcomes, Skin CP window

9. Populate Skin CP.
 - a. If you gave skin education information to the patient or caregiver, you must select **Yes** for **Patient/caregiver education provided**.
 - b. Refer to the instructions in *Working in a Care Plan* on page 11.

Psychosocial (P/S)

The Psychosocial Assessment contains information about abuse-verbal, physical, financial, sexual, and neglect. During admission, each patient receives a comprehensive psychosocial assessment.

- Suicide Risk is on P/S Page 2.
- Questions concerning elopement, contraband, and chemical dependencies are on P/S Page 3.
- Directions for the *Clinical Institute Withdrawal Assessment (CIWA)* are on the CIWA page.
 - a. The **CIWA Score** for the patient is calculated automatically as you select a response level for nausea/vomiting, tremor, paroxysmal sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache, and orientation/clouding of sensorium.
 - b. The CIWA Score is pulled forward to the P/S CP page to guide the entry of interventions.

The screenshot shows the 'PSYCHOSOCIAL ASSESSMENT' window. Key sections include:

- Information obtained from:** Radio buttons for Patient (selected), Authorized surrogate, Family/Support Person, Medical Record, and Other.
- Patient has a history of:** Checkboxes for None reported, Alcoholism, Depression, Phobias, Treatment for MH problems, and Other.
- Attitude:** Radio buttons for Cooperative, Uncooperative, and Other.
- Behavior:** Radio buttons for Controlled, Uncontrolled, and Other.
- Suspected Abuse/Neglect Screen:** Multiple sections with radio buttons for Yes, No, and Declines to answer. A red box highlights the instruction: "Notify provider and follow your state's reporting regulations".
- Based upon nursing assessment, are others in the household possible victims of abuse or neglect by the patient?:** Radio buttons for Yes, No, and Unknown.
- Buttons:** 'Social Work Consult' and 'Will Send'.
- Navigation:** Tabs for P/S Page 1, P/S Page 2, P/S Page 3, CIWA, P/S Page 4, and P/S CP.

Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 1 window

1. Click **P/S**.
P/S Page 1 displays.
2. Populate P/S Page 1.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. If the patient answers **Yes** to any of the abuse questions, a Social Work Consult is required.
 - Refer to the instructions in *Working in the Consults* on page 15.
 - For emphasis, the notify provider, send consult, and follow your state's reporting regulations will be highlighted in **red**.

3. Click **P/S Page 2**.
P/S Page 2 (Suicide Risk Screen - Ask Patient) displays.

Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 2 window
Have you secretly had thoughts about hurting yourself/Yes

4. Populate P/S Page 2.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. If the patient answers **Yes** to **Have you secretly had thoughts about hurting yourself**, you must **Notify provider** and **Keep patient under close observation**.

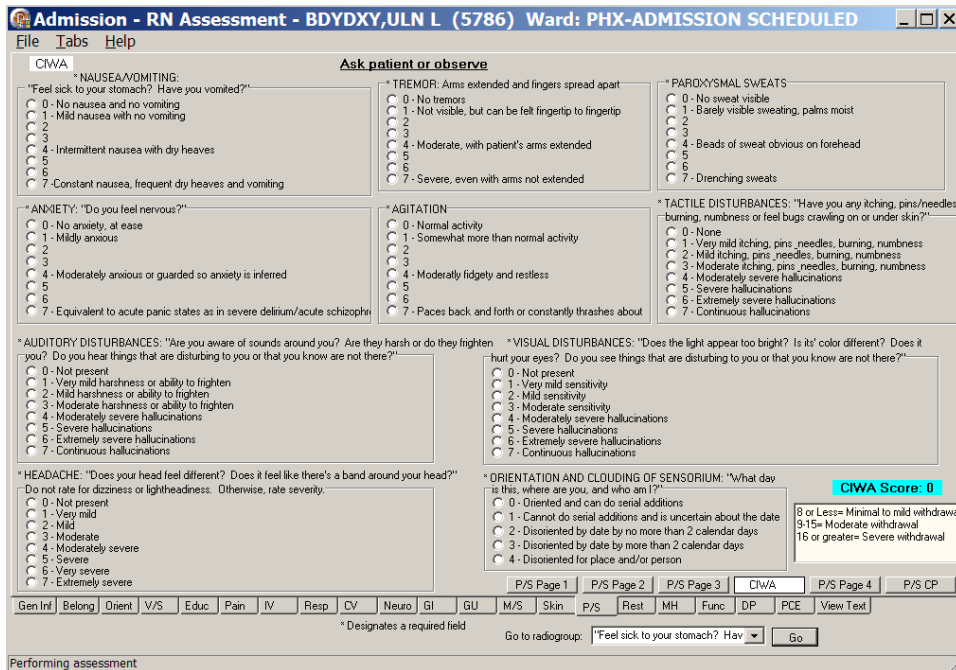
5. Click **P/S Page 3**.
P/S Page 3 displays.

Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 3 window

6. Populate P/S Page 3.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Answer **Yes** to any of the Elopement Screen questions and a **Social Work Consult** is required.
 - The patient is a potential wandering/elopement risk.
 - Refer to the instructions in *Working in the Consults* on page 15.
 - c. P/S Page 3 contains the **Alcohol use** section.

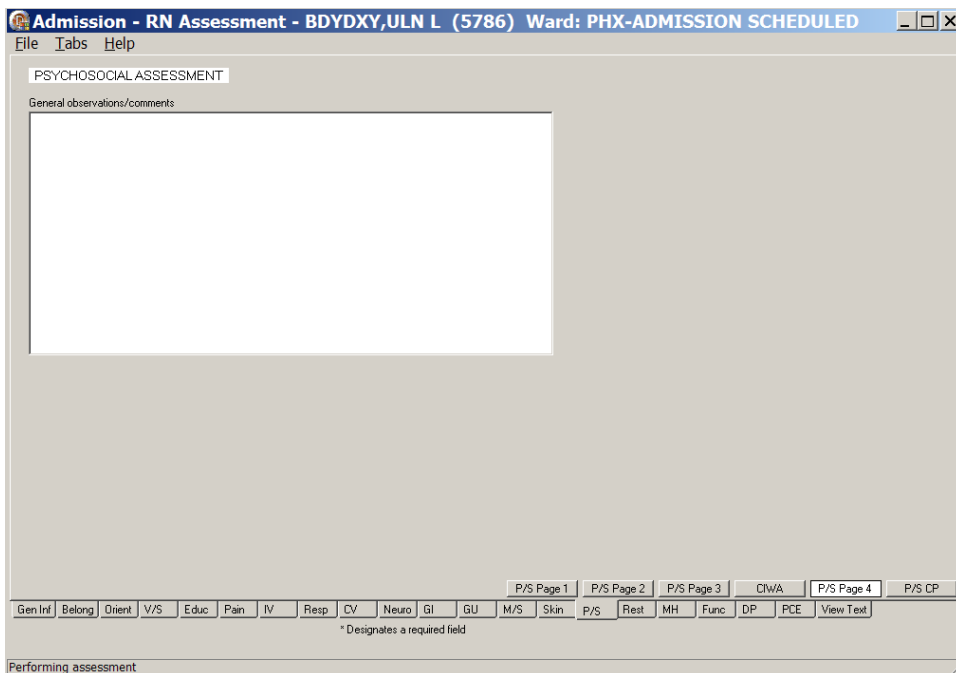
Alcohol use section

7. If there is the possibility of alcohol withdrawal, select the **Possibility of alcohol withdrawal** check box to display the CIWA page.
 - a. Complete all the CIWA fields with asterisks; they are required fields.
 - b. Alert the physician of the possibility of alcohol withdrawal.



Admission – RN Assessment, Psychosocial Assessment (P/S) tab, CIWA window

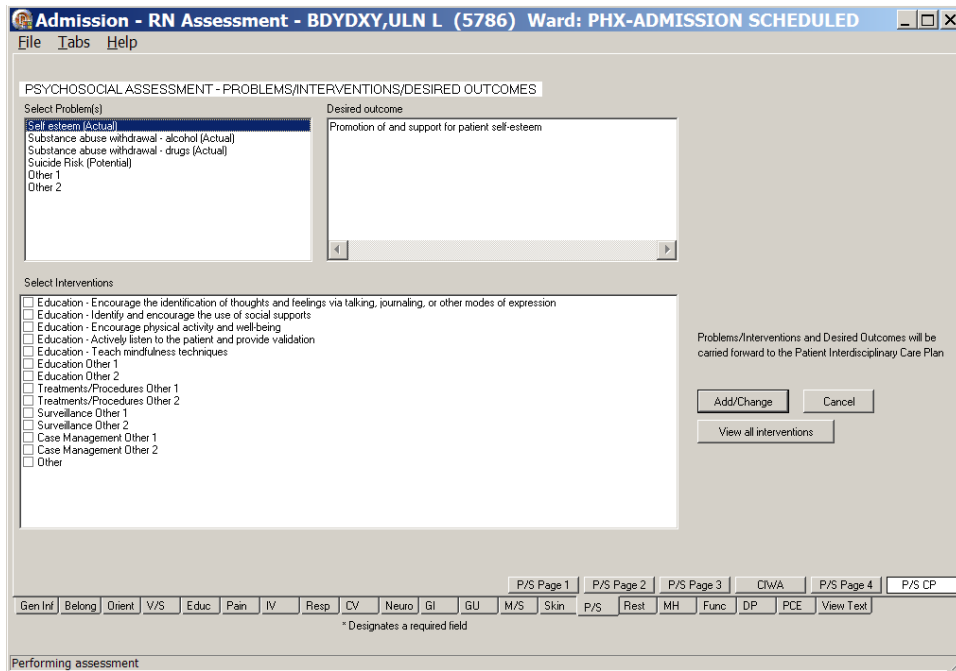
8. Click **P/S Page 4**.
P/S Page 4 displays.



Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 4 window

9. Populate P/S Page 4.
Use the **General observations/comments** text box for additional information.

- Click **P/S CP**.
P/S CP displays.



Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S PC window

- Populate P/S CP.
Refer to the instructions in *Working in a Care Plan* on page 11.

Restraints (Rest/Restr)

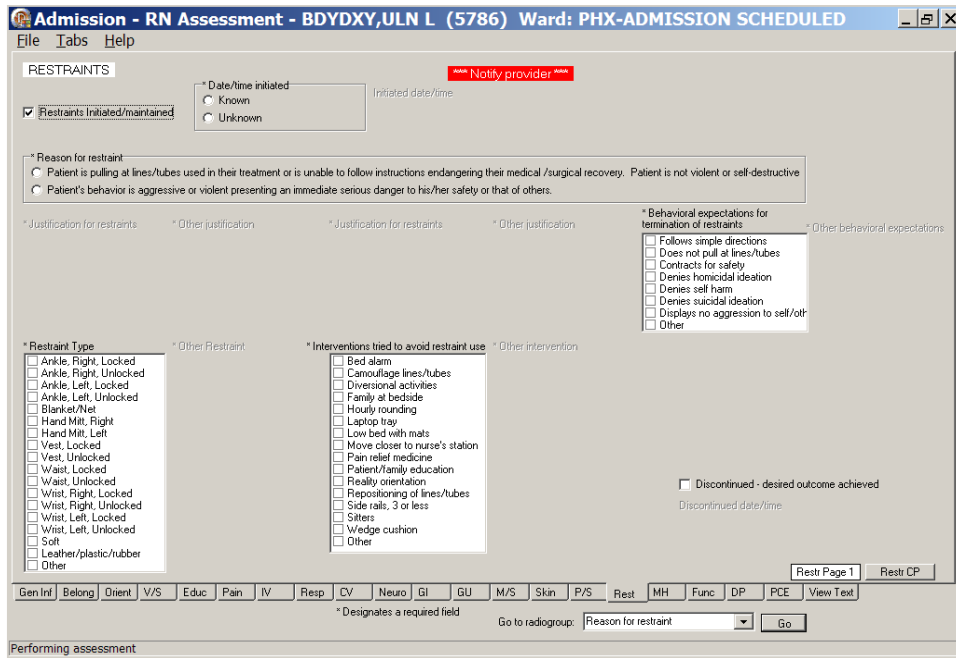
There are two categories of restraints.

- Patient is pulling at lines/tubes used in their treatment or is unable to follow instructions, endangering their medical/surgical recovery. Patient is not violent or self-destructive
- Patient's behavior is aggressive or violent presenting an immediate, serious danger to his/her safety or that of others

The screenshot shows a software window titled "Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main content area is titled "RESTRAINTS" and contains a checkbox labeled "Restraints Initiated/maintained". Below this checkbox are several fields for justification and behavioral expectations, including "* Justification for restraints", "* Other justification", "* Behavioral expectations for termination of restraints", and "* Other behavioral expectations". There are also fields for "* Restraint Type", "* Other Restraint", "* Interventions tried to avoid restraint use", and "* Other intervention". At the bottom of the window, there is a navigation bar with tabs for "Rest" and "Restr CP", and a "Go to radiogroup" dropdown menu set to "Reason for restraint".

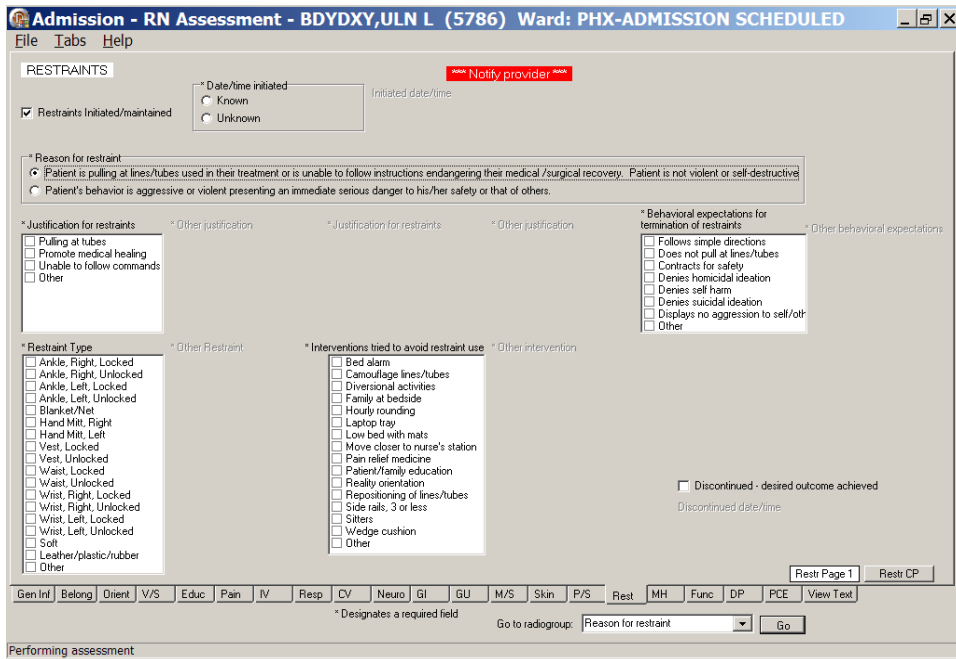
Admission – RN Assessment, Restraints (Rest) tab, Restr Page 1 window

1. Click **Rest**.
Restr Page 1 displays.
2. Select the **Restraints Initiated/maintained** check box.
The reasons for restraint become available.



Admission – RN Assessment, Restraints (Rest) tab, Restr Page 1 window with restraints initiated/maintained

- a. When you select, **Patient is pulling at lines/tubes used in their treatment or is unable to follow instructions endangering their medical/surgical recovery. Patient is not violent or self-destructive**, the following window displays.



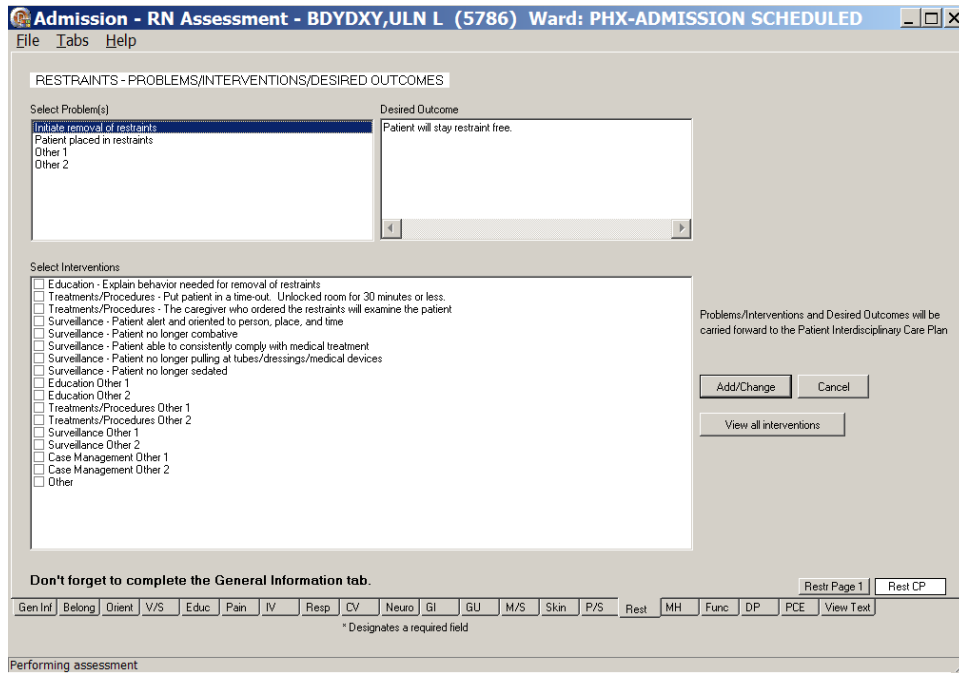
Admission – RN Assessment, Restraints (Rest) tab, Restr Page 1 window Patient is pulling at lines/tubes used in their treatment or is unable to follow instructions endangering their medical/surgical recovery. Patient is not violent or self-destructive selected

- b. When you select, **Patient's behavior is aggressive or violent presenting an immediate serious danger to his/her safety or that of others**, the following window displays.

Admission – RN Assessment, Restraints (Rest) tab, Restr Page 1 window
 Patient's behavior is aggressive or violent presenting an immediate serious danger to his/her safety
 or that of others selected

3. Populate Restr Page 1.
- Select a **Reason for restraint**.
 - Complete all the fields with asterisks; they are required fields.
 Questions are based on standards for documenting seclusion or restraint.

- Click **Restr CP**.
Restr CP displays.



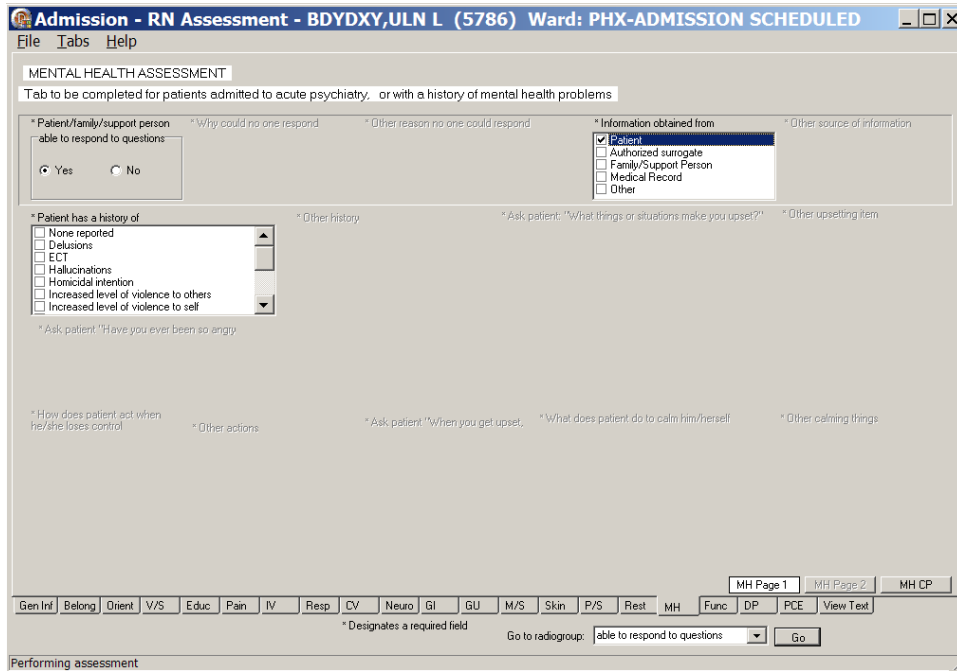
Admission – RN Assessment, Restraints - Problems/Interventions/Desired Outcomes, Restr CP window

- Populate Restr CP.
Refer to the instructions in *Working in a Care Plan* on page 11.

Mental Health (MH)

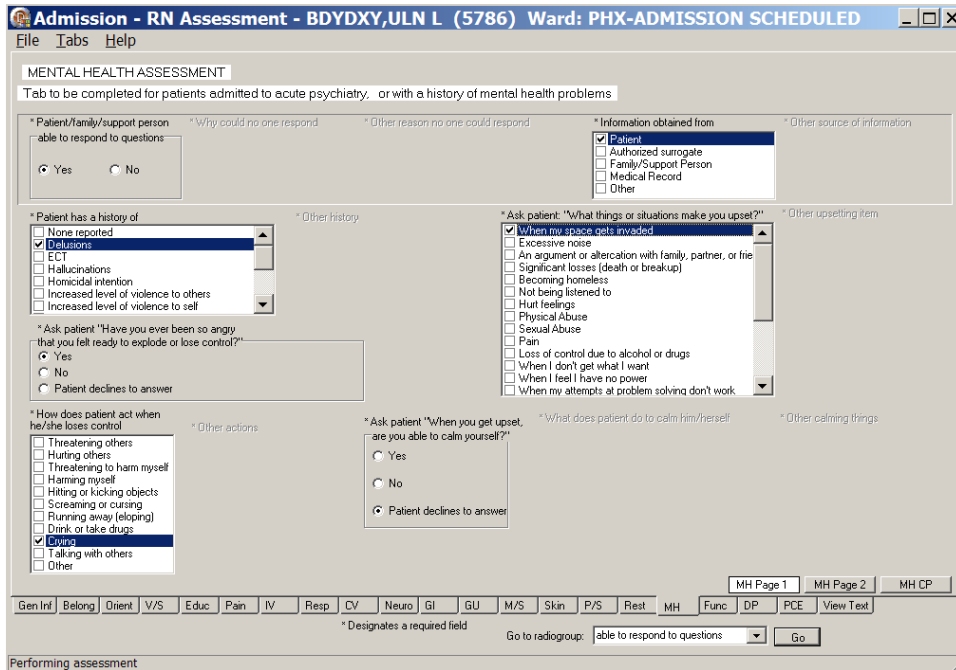
The Mental Health Assessment tab contains the patient’s mental health history.

1. Click **MH**.
MH Page 1 displays.
 - a. For patients not admitted to acute psychiatry and do not have a history of specific major mental illnesses, MH Page 2 is unavailable.



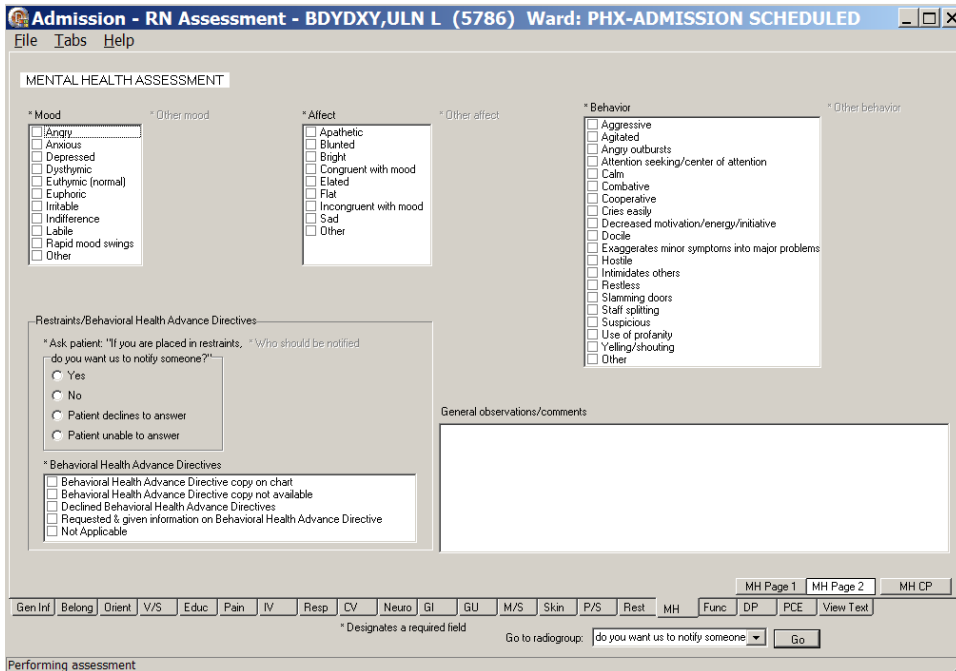
Admission – RN Assessment, Mental Health Assessment (MH) tab, MH Page 1 window when patient is not admitted to acute psychiatry

- b. For patients admitted to acute psychiatry or have a history of a major mental illness, MH Page 2 is available and must be completed.



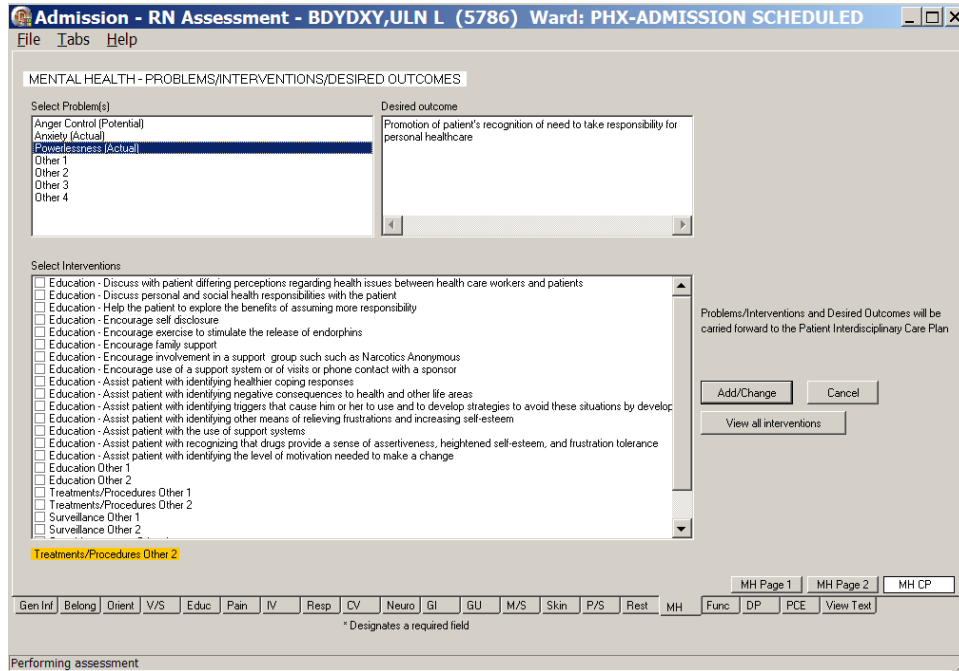
Admission – RN Assessment, Mental Health Assessment (MH) tab, MH Page 1 window when patient is admitted to acute psychiatry

2. Populate MH Page 1.
Complete all the fields with asterisks; they are required fields.
3. Click **MH Page 2**.
MH Page 2 displays.



Admission – RN Assessment, Mental Health Assessment (MH) tab, MH Page 2 window

4. Populate MH Page 2.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** text box for additional information.
5. Click **MH CP**.
MH CP displays.



Admission – RN Assessment, Mental Health Assessment (MH) tab, MH CP window

6. Populate **MH CP**.
Refer to the instructions in *Working in a Care Plan* on page 11.

Functional (Func)

The Functional Assessment tab contains information about the patient's independence/dependence in activities of daily living.

Directions for the *Katz Index of Independence in Activities of Daily Living* are on Func Page 1. The **Total Score** for the patient is calculated automatically as you select Independence/Dependence for six activities.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

FUNCTIONAL ASSESSMENT

* Patient/family/support person able to respond to questions
 Yes No

* Why could no one respond
* Other reason no one could respond
* Information obtained from
 Patient
 Authorized surrogate
 Family/Support Person
 Medical Record
 Other
* Other source of information

Instructions for completing Katz Index of Independence in Activities of Daily Living

Bathing:
1 - Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area, or disabled extremity
0 - Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.

Dressing:
1 - Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.
0 - Needs help with dressing self or needs to be completely dressed.

Toileting:
1 - Goes to toilet, gets on and off, arranges clothes, cleans genital area without help
0 - Needs help transferring to the toilet, cleaning self or uses bedpan or commode

Transferring:
1 - Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable
0 - Needs help in moving from bed to chair or requires a complete transfer

Continence:
1 - Exercises complete self control over urination and defecation
0 - Is partially or totally incontinent of bowel or bladder

Feeding:
1 - Gets food from plate into mouth without help. Preparation of food may be done by another person.
0 - Needs partial or total help with feeding or requires parenteral feeding.

Bathing
 Independence - 1 point
 Dependence - 0 points

Dressing
 Independence - 1 point
 Dependence - 0 points

Toileting
 Independence - 1 point
 Dependence - 0 points

Transferring
 Independence - 1 point
 Dependence - 0 points

Continence
 Independence - 1 point
 Dependence - 0 points

Feeding
 Independence - 1 point
 Dependence - 0 points

Total Score: 0
6 = High (Patient independent); 0 = Low (Patient very dependent)

Refer to provider for evaluation if patient has a Katz score of 4 or less OR a decrease in the level of independence and changes have occurred within the past month.

Assist patient with
 Ambulating
 Bathing
 Dressing
 Feeding
 Toileting
 Transferring

Did patient have a decrease in the level of independence within the past 30 days:
 Yes
 No
 Unable to determine

Func Page 1 | **Func Page 2** | Func Page 3 | Func CP

Gen Inf | **Belong** | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | **Func** | DP | PCE | View Text

* Designates a required field
Go to radiogroup: Bathing Go

Performing assessment

Admission – RN Assessment, Functional Assessment (Func) tab, Func Page 1 window

1. Click **Func**.
Func Page 1 displays.
2. Populate Func Page 1.
Complete all the fields with asterisks; they are required fields.

Note: Refer to provider for evaluation, if patient has a Katz score of 4 or less, or a decrease in the level of independence and changes have occurred within the past month.

3. Click **Func Page 2**.

Func Page 2 displays.

- If the patient is independent and cooperative, no additional entries are necessary on Func Page 2.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

FUNCTIONAL ASSESSMENT

Instructions for assessing the patient's level of assistance
Independent (Patient performs task safely, with or without staff assistance, with or without assistive devices)
Partial Assist (Patient requires no more help than stand-by, cueing, or coaching, or caregiver is required to lift no more than 35 lbs. of a patient's weight)
Dependent - Patient requires nurse to lift more than 35 lbs. of the patient's weight, or is unpredictable in the amount of assistance offered.

* Patient's level of assistance
 Independent
 Partial Assist
 Dependent

Assessment criteria and care plan for safe patient handling and movement
An assessment should be made prior to each task; if the patient has varying levels of ability to assist due to medical reasons, fatigue, medications, etc. When in doubt, assume the patient cannot assist with the transfer/repositioning.

Height: 68 in
Weight: 150 lb
BMI: 22.9 [DEC 14, 2011@08:37:26]

Instructions for assessing patient's level of cooperation and comprehension
Cooperative (may need prompting; able to follow simple commands)
Unpredictable or varies (patient whose behavior changes frequently should be considered as "unpredictable"); not cooperative; or unable to follow simple commands

* Level of cooperation and comprehension
 Cooperative
 Unpredictable or varies

Applicable conditions likely to affect transfer/repositioning techniques
Transfer/repositioning techniques comments

General observations/comments

Func Page 1 | Func Page 2 | Func Page 3 | Func CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field
Go to radiogroup: Patient's level of assistance Go

Performing assessment

Admission – RN Assessment, Functional Assessment (Func) tab, Func Page 2 window when the patient is independent

- If the patient is dependent and completely uncooperative, additional entries are necessary on Func Page 2.

Admission – RN Assessment, Functional Assessment (Func) tab, Func Page 2 window when the patient is dependent

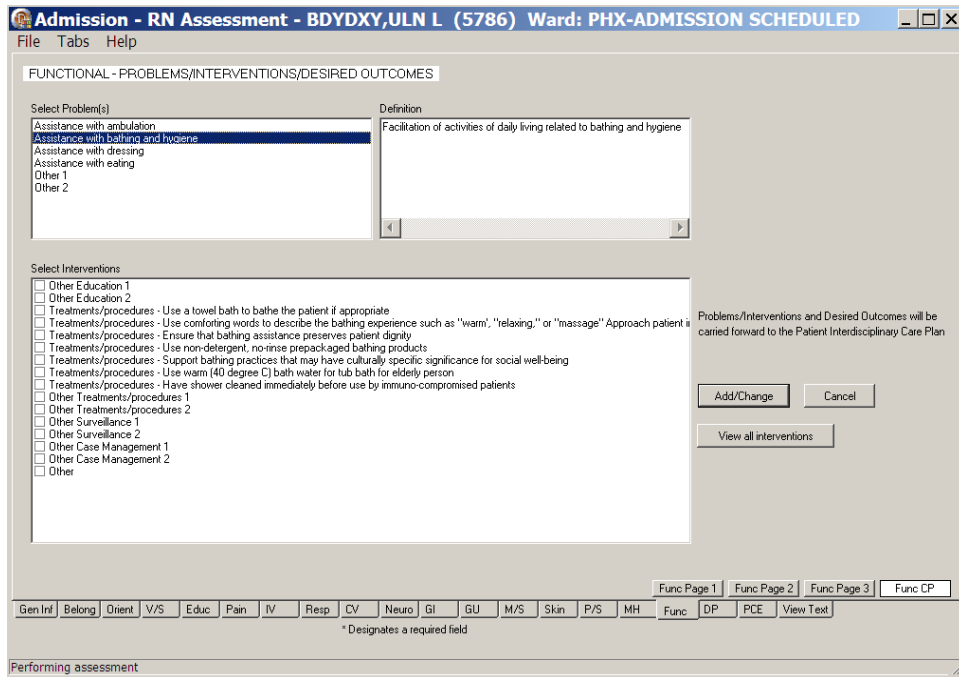
4. Populate Func Page 2.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** text box for additional information.

5. Click **Func Page 3**.
Func Page 3 displays.

Admission – RN Assessment, Functional Assessment (Func) tab, Func Page 3 window

6. Populate Func Page 3.
 - a. Complete the fields as necessary.
 - b. Click **Print**.
 - c. Print Func Page 3 and give it to the staff handling the move of the patient.

- Click **Func CP**.
Func CP page displays.



Admission – RN Assessment, Functional Assessment (Func) tab, Func CP window

- Populate Func CP.
Refer to the instructions in *Working in a Care Plan* on page 11.

Discharge Planning (DP)

The Discharge Planning tab contains information about home environment, living arrangements, and special equipment, if required for discharge.

Information about the legal/medical guardian is pulled from the question asked in P/S Page 3. You cannot edit it from the DP tab. If the information is not correct, return to P/S Page 3 to correct.

The screenshot shows the 'DISCHARGE PLANNING' window with the following fields and options:

- * Patient/family/support person able to respond to questions:** Radio buttons for Yes (selected) and No.
- * Why could no one respond:** Text field.
- * Other reason no one could respond:** Text field.
- * Information obtained from:** Checkboxes for Patient (checked), Authorized surrogate, Family/Support Person, Medical Record, and Other.
- * Does patient have a legal/medical guardian (conservator)?** Radio buttons for Yes and No (selected). Below it, text reads 'Pulled from P/S Page 3'.
- * Specify guardian (conservator):** Text field.
- * Describe employment status:** Radio buttons for Presently employed, Unemployed, Retired, Disabled, and Patient declines to answer.
- * Relationship status:** Radio buttons for Co-habiting, Divorced, Married, Separated, Single (selected), Widowed, and Patient declines to answer.
- * With whom does patient live:** Radio buttons for Alone, Family, Significant Other, Friend, Nursing Home, Assisted Living, Homeless, and Patient declines to answer.
- * Home environment:** Checkboxes for No identified problems (checked), Starts to enter home, Starts within home, Bed on main level, Full bathroom on main level, Bed & full bathroom on same floor (not main level), Other architectural barriers (e.g. narrow doorways), and Patient declines to answer.
- * Other architectural barriers:** Text field.
- * Special Equipment Needed at Home:** Checkboxes for No equipment needed (checked), Specialty bed, Specialty mattress, Ramp, Raised toilet seat, Safety bars, and Other.
- * Other equipment needed:** Text field.
- * Transportation for Discharge:** Radio buttons for Own car, Friends/family, Bus, VA Shuttle, VA Travel, Other, and Patient declines to answer.
- * Other transportation for discharge:** Text field.
- General observations/comments:** A large text area for notes.

At the bottom, there is a navigation bar with tabs for Gen Inf, Belong, Orient, V/S, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. A 'Go to radiogroup:' dropdown is set to 'Employment Status' with a 'Go' button next to it.

Admission – RN Assessment, Discharge Planning (DP) tab, DP Page 1 window

1. Click **DP**.
DP Page 1 displays.
2. Populate DP Page 1.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** for additional information.

3. Click **DP CP**.
DP CP displays.

Admission – RN Assessment, Discharge Planning – Problems/Interventions/Desired Outcomes,
DP CP window

4. Populate DP CP.
 - a. Complete the fields as necessary.
Refer to the instructions in *Working in a Care Plan* on page 11.
 - b. Complete a Social Work Consult or Discharge Planning Consult, if required.
Refer to the instructions in *Working in the Consults* on page 15.
 - c. **Optional:** Complete a Telehealth Consult or a Home Care Consult, if set up by your medical center.

Note: If an item in the **Anticipated Discharge Plan Goals** list box contains **, a Social Work Consult or Discharge Planning Consult is required.

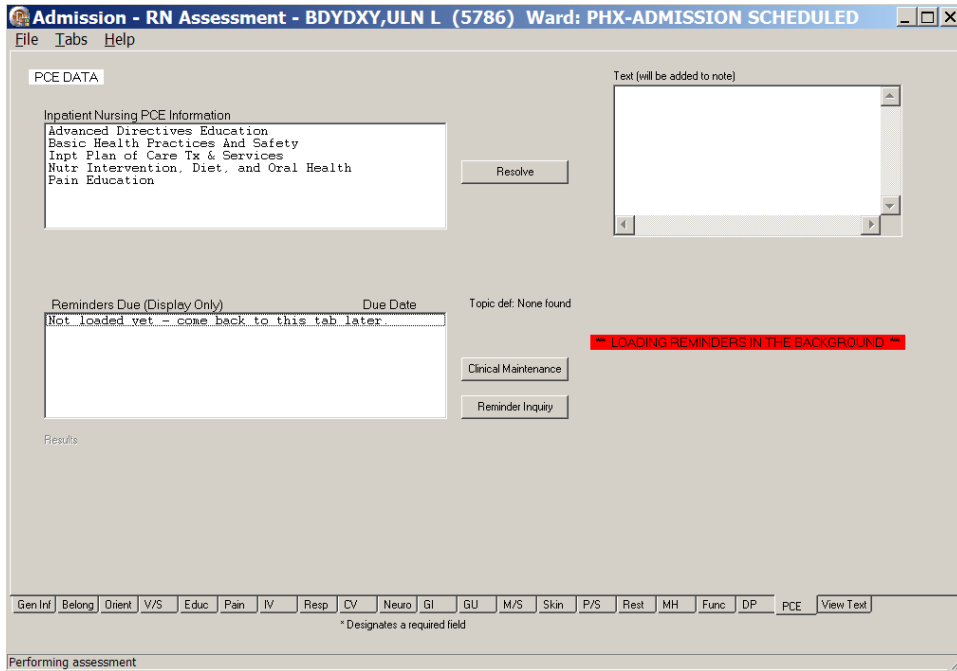
PCE Data (PCE)

The PCE (Patient Care Encounter) Data tab is **optional** and may not be set up at your medical center. The PCE tab includes a list of all clinical reminders due for the patient.

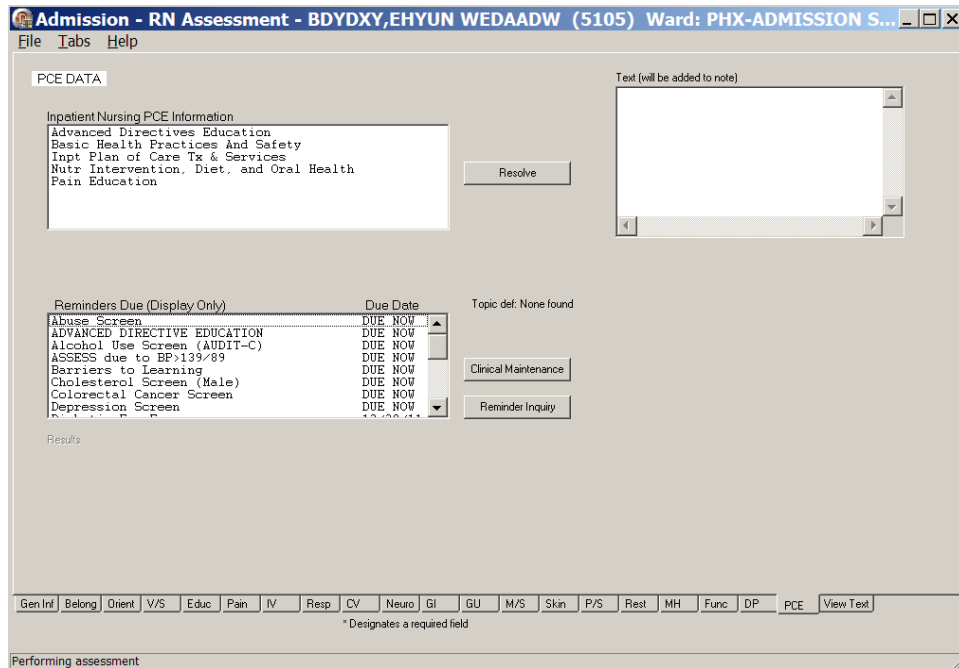
Note: The clinical reminders must be set up by your facility.

Use the PCE tab to document specific clinical reminders completed by the inpatient nurse at admission.

1. Click **PCE**.
PCE tab displays.



Admission – RN Assessment, PCE Data (PCE) tab window with reminders loading



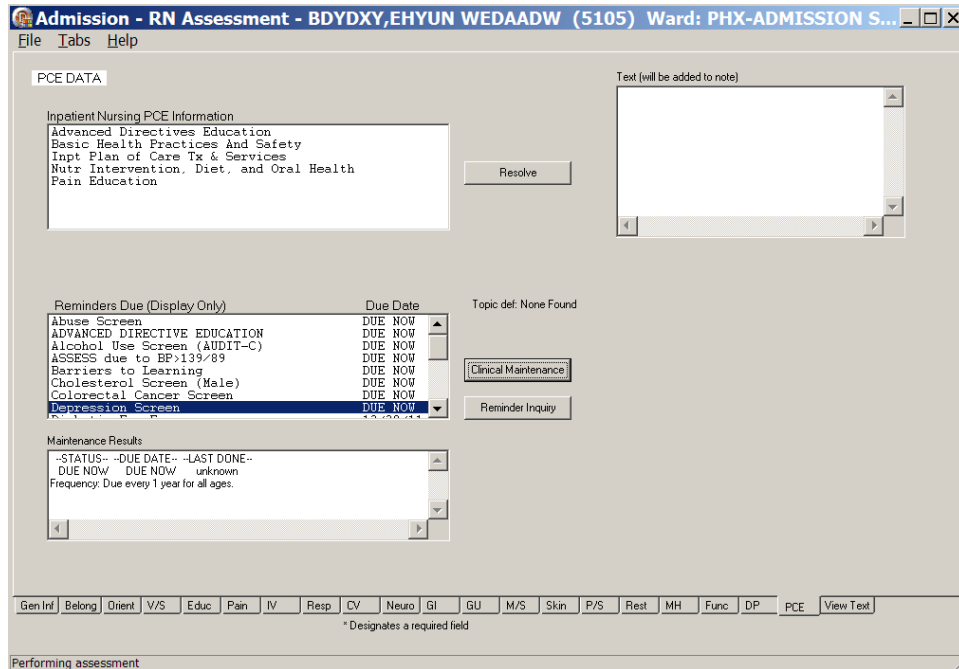
Admission – RN Assessment, PCE Data (PCE) tab window after reminders are loaded

Reminders Due (Display Only)

The list of all clinical reminders due for the patient is for display only. You cannot take action on the clinical reminders from within the assessment template.

Clinical Maintenance

1. Select a clinical reminder in the **Reminders Due** list box.
2. Click **Clinical Maintenance**.
Information about when the reminder is due or was last done, displays in the **Maintenance Results** list box.

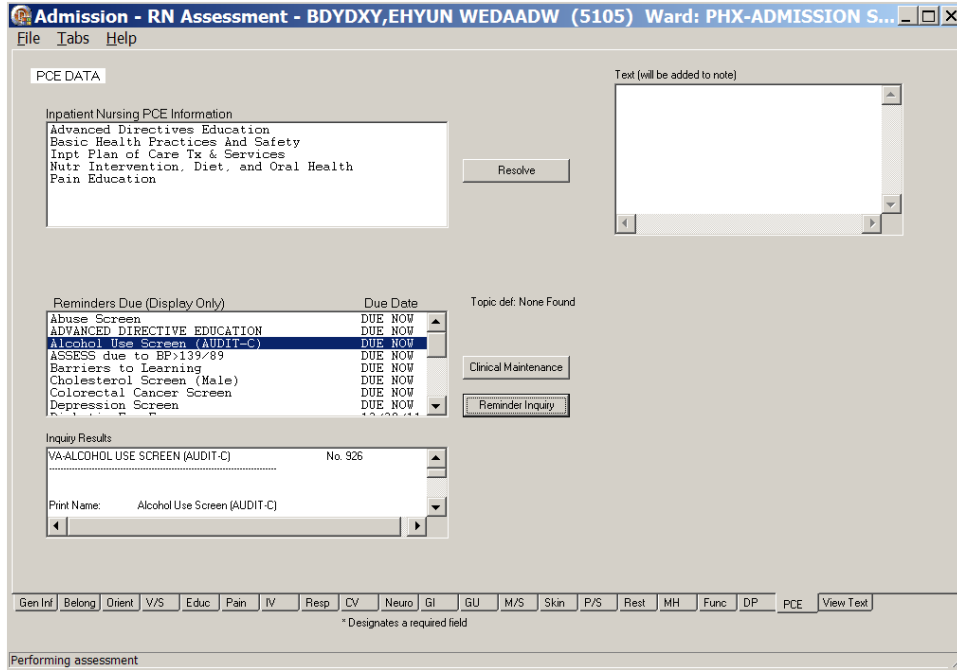


Clinical Maintenance

Reminder Inquiry

Click **Reminder Inquiry**.

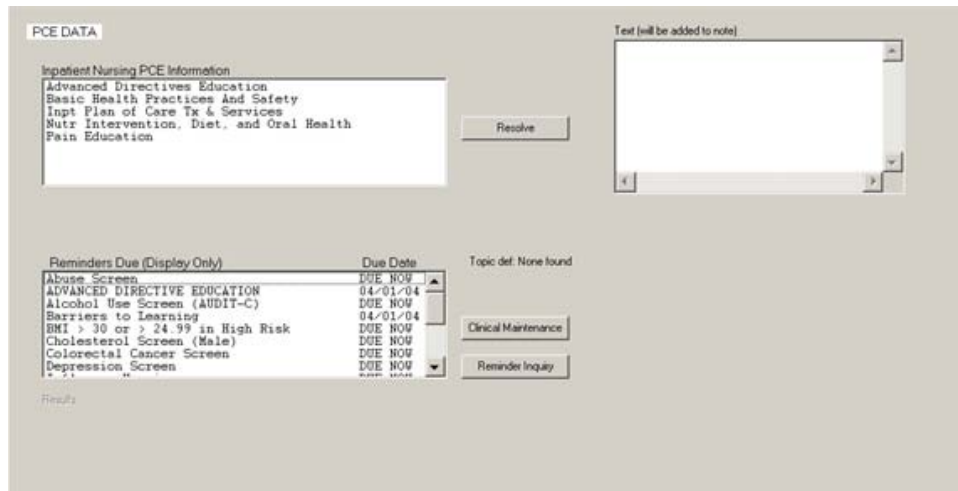
Information about the logic of the selected reminder displays in the **Inquiry Results** list box.



Reminder Inquiry

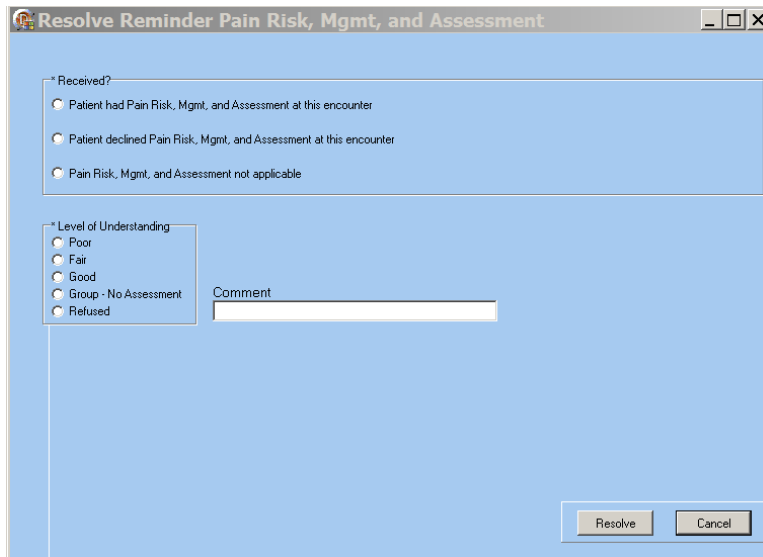
Resolve Inpatient Nursing Clinical Reminders

1. Select an item in the **Inpatient Nursing PCE Information** list box.



PCE Data, Resolve Inpatient Nursing Clinical Reminders

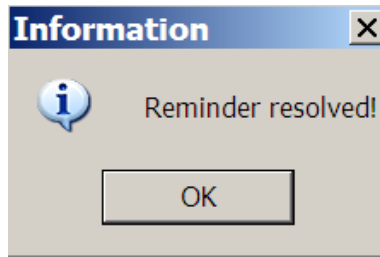
2. Click **Resolve**.
The Resolve Reminder Pain Risk, Mgmt, and Assessment window displays with items appropriate for the selected item.



Resolve Reminder Pain Risk, Mgmt, and Assessment window

3. Select a radio button from **Received?**
4. Select an item from **Level of Understanding**.

5. Click **Resolve**.
Information pop-up displays indicating the reminder is resolved.



Information pop-up: Reminder resolved!

6. Click **OK**.
The text that is added to the Progress Note displays in the **Text (will be added to note)** text box.



Text (will be added to note)

View Text (View Text)

The View Text tab is a review of all the information entered for a patient during the admission assessment.

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

GENERAL INFORMATION
Patient/family/support person able to respond to questions: Yes
Information obtained from: Patient

Demographics
Name: BDYDXY,ULN L
Age: 63
Sex: MALE
Race: WHITE, NOT OF HISP
Admitting diagnosis: ACROMIOPLASTY

Date/Time Patient Arrived on Unit: 12/13/2011 @ 4:46:16 PM
Mode of arrival: Ambulatory
Admitted from: Home
What does patient want to accomplish by this hospitalization: pain free
Preferred Healthcare Language: English
Patient Identification band: Patient arrived with identification (ID) band on
ID Band or Patient ID Card verified as correct (right patient, SSN, DOB, unit): Yes
Special alert ara band: None

Medications

Meds brought in by patient: No
Implanted medication pumps or devices: No
Is patient wearing any kind of medicinal patch: No

Spiritual/Cultural Assessment - Patient's Religion: PENTECOSTAL
Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about: No
Patient requests an immediate visit from the Chaplain: No
Does patient have any traditional, ethnic, or cultural practices that need to be part of care: No
Does patient have any concerns or special considerations if a blood transfusion is needed: No

Sign Note/Consults

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Admission – RN Assessment View Text tab window

1. Click **View Text**.
The View Text window scrolls through the admission assessment for review.
2. Review the patient admission assessment.

Signing Note and Consults from within the Template

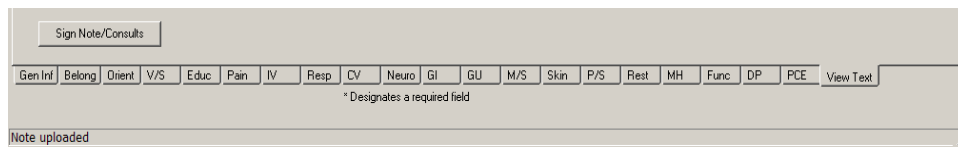
During the assessment, you may be prompted to enter a mandatory consult, which will be uploaded with the assessment note.

Note: Manage consults according to medical center policy. If nurses at your site do not order consults, upload a mandatory consult, but do not sign it.
The identified provider will be notified that there is a consult to sign.

Go to CPRS to sign your **uploaded**, *unsigned* notes and consults.

You can sign *unsigned* notes **after the upload** from the View Text tab in the template.

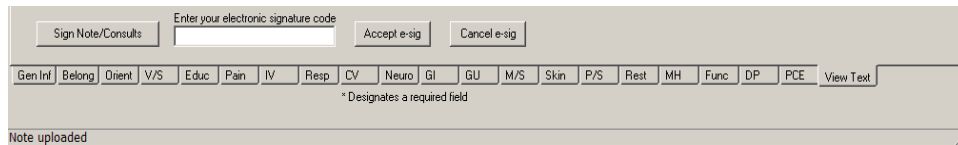
1. Click **View Text**.



Admission – RN Assessment with Sign Note/Consults button

2. Click **Sign Note/Consults**.

If the button does not display, upload again.



Admission – RN Assessment with Sign Note/Consults button

Note: If there is only a note to sign, the button is **Note**.

If there is a consult to sign, the button is **Sign Note/Consults**.

3. Enter your electronic signature and click **Accept e-sig**.

Information pop-up displays, *Note signed!*.

4. Click **OK**.

5. To prevent the signing of an uploaded note, click **Cancel e-sig**.

Note: It is safer to go to CPRS, read the note in CPRS, and sign the note in CPRS.

- An unsigned note can be edited.
- A signed note cannot be edited.

Patient Unable to Respond

An incomplete admission assessment is filed when the patient cannot respond to admission assessment questions and there is no caregiver available to provide the necessary data.

The following screen captures are examples of the tabs when **No** is selected for **Patient/family/support person able to respond to questions**.

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

GENERAL INFORMATION

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: Patient unable to communicate No family/support person present Other

* Other reason no one could respond

* Information obtained from

* Other source of information

Demographics: Name: BDYDXY,EHYUN WEDAADW Age: 66 Sex: MALE Race: BLACK OR AFRICAN A

* Date/Time Patient Arrived on Unit: 11/07/11 13:43

* Mode of arrival: Ambulatory Stretcher/Gurney Wheelchair

* Admitted from: Clinic Community Residential Care Emergency Department Home Nursing Home Shelter 23 Hour Observation Other

* Other admitting place

Admitting diagnosis: NONE FOUND

* What does patient want to accomplish by this hospitalization

* Patient Identification band: Patient arrived with identification (ID) band on ID Band applied on unit or clinic location Patient arrived with Patient Identification Card

* ID Band or Patient ID Card verified as correct (right patient, SSN, DOB, unit):

* Special alert arm band: None Allergy DNR/DNI Fall Risk Isolation Other

* Other Special alert arm band

* Other Language

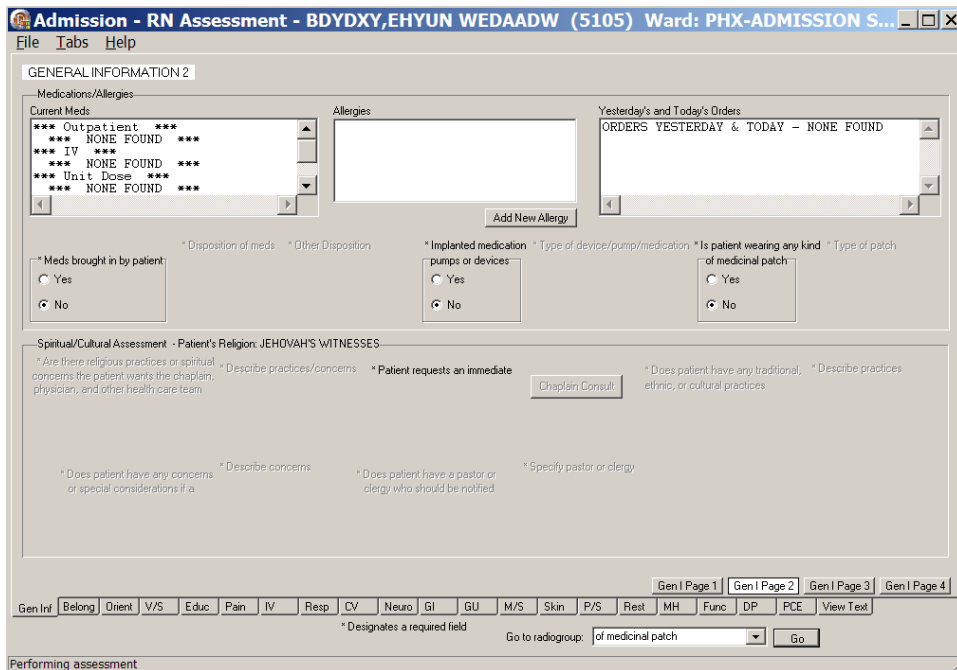
Gen I Page 1 Gen I Page 2 Gen I Page 3 Gen I Page 4

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

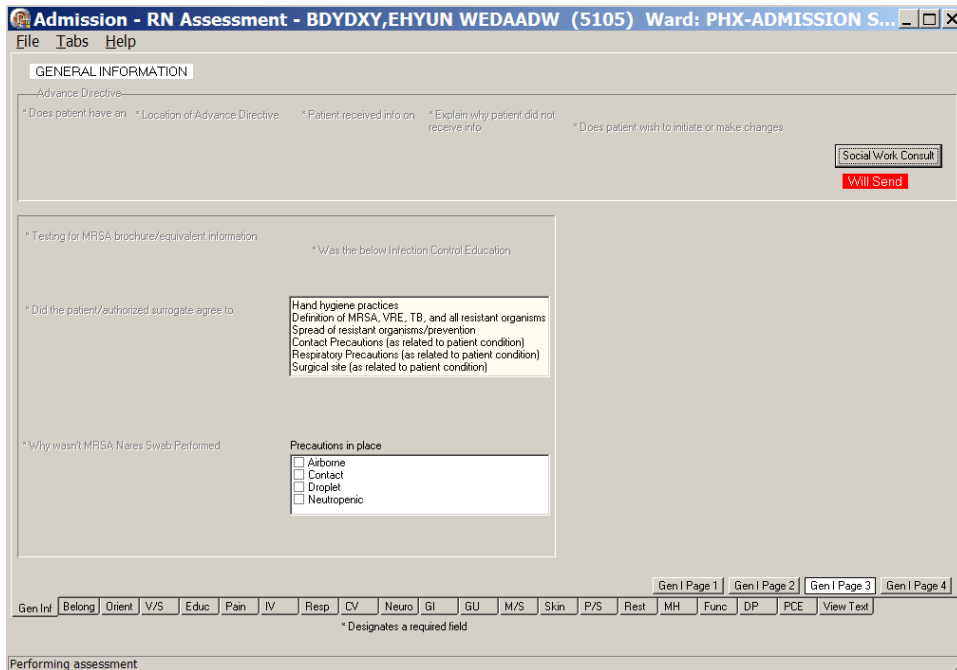
* Designates a required field

Performing assessment

Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 1 window



Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 2 window



Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 3 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

EDUCATIONAL ASSESSMENT

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: Patient unable to communicate No family/support person present Other

* Other reason no one could respond: _____

* Information obtained from: _____

* Other source of information: _____

* Describe why unable to read: _____

* Describe why unable to write: _____

* Other education level: _____

Learns best by: _____ Prefers: _____

* Barriers to learning: _____ * Describe identified barriers: _____ * Other barriers: _____

* Knowledge of current illness, surgery, reason for hospitalization etc. as: _____

* Information provided to patient/support person on the following topics: _____ * Other topic provided: _____

Joint Commission Phone Number: 1-800-994-6610

Educ Page 1 Educ CP

Gen Inf | Belong | Orient | V/S | Educ | **Pain** | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: able to respond to questions [Go]

Performing assessment

Admission – RN Assessment, Educational Assessment (Educ) tab, Educ Page 1 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

PAIN ASSESSMENT

* Is pain a problem for the patient: Yes No Unable to respond to questions

Complete Pain Location questions if pain is a problem for the patient

* Explain why patient unable to respond to questions: _____

* Is patient on Palliative/Comfort Care: Comfort Care Palliative Care No Unknown

* Pain Location #1: * Pain Region: None * Quality of pain: _____

* Other pain region: _____ * Other quality of pain: _____ Onset of original pain (years, months): _____

* Severity of Pain (None - 10 worst): _____ * Describe other timing of pain: _____

* What makes pain worse: _____ * Other provoking factor(s): _____

* Describe Pain Radiation: _____

* What makes pain better: _____ * Other palliative factor(s): _____ * Rx/OTc Meds helping pain: _____

* Does patient exhibit behavioral indicators related to pain: None Observed Body Rigidity Crying Facial Grimacing Fidgeting Frightened Facial Expression Frowning Moaning Negative Vocalization Noisy Breathing Sad Facial Expression Unable to console, distract, or reassure Other

* Other behavioral indicator: _____

* Areas of life affected by pain: _____ * Comments for patient's life aspects: _____

* Other pain location:

Pain Goal: * What pain level is acceptable to the patient (0-10)? _____

Pain Page 1 Other Pain Other Pain 2 Pain Comm Pain CP

Gen Inf | Belong | Orient | V/S | Educ | **Pain** | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: Is pain a problem for the patient [Go]

Performing assessment

Admission – RN Assessment, Pain Assessment (Pain) tab, Pain Page 1 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

RESPIRATORY ASSESSMENT

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: Patient unable to communicate No family/support person present Other

* Respiratory pattern: Regular Irregular - Agonal Irregular - Cheyne-Stokes Irregular - Kussmal Irregular - Other

* Respiratory rate: 21

* Respiratory depth: Normal Deep Shallow

* Chest movement: Equal, bilateral, symmetrical Abnormal

* Work of breathing: No difficulty observed Dyspnea (shortness of breath) Nasal flaring Orthopnea Pursed Lips Use of accessory muscles Other

* Cyanosis: None Central - tongue and lips Peripheral - earlobes, fingertips, around lips

* Breath sounds: Clear Abnormal

Resp Page 1 | Resp Page 2 | Resp Page 3 | Resp CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: Respiratory depth [Go]

Performing assessment

Admission – RN Assessment, Respiratory Assessment (Resp) tab, Resp Page 1 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

RESPIRATORY ASSESSMENT

* Tracheostomy:

* Tracheostomy size:

* Type of tobacco used:

Instructions for former usage:

* Approximate quit date:

* Tobacco education:

General Observations/Comments:

Resp Page 1 | Resp Page 2 | Resp Page 3 | Resp CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Performing assessment

Admission – RN Assessment, Respiratory Assessment tab, Resp Page 3 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

NEUROLOGICAL ASSESSMENT

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: Patient unable to communicate No family/support person present Other

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Patient has a history of:

* Spinal Cord Injury Level:

* Other neurological problem:

* Describe Spinal Cord Injury Level:

* Level of Consciousness (Glasgow Coma Scale)

Eye response score:

Verbal response score:

Motor response score:

Total score: 15

Score is expressed as Eye (4) + Verbal (5) + Motor (6)

Glasgow score categories

13-15 (normal result)

9-12 (correlates with moderate brain injury)

8 or less (correlates with severe brain injury)

Instructions for completing Glasgow Coma Scale

Information: The Glasgow Coma Scale is used to quantify the level of consciousness and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.

Best Eye Response: (4)

4. Eyes open spontaneously

3. Eye opening to verbal command

2. Eye opening to pain

1. No eye opening

C. Denotes closed eye or if patient is unable to open an eye due to swelling, nerve palsy or eye dressing

P. Indicates presence of pharmacological paralysis

Best Verbal Response: (5)

5. Oriented

4. Confused

3. Inappropriate words

2. Incomprehensible sounds

1. No verbal response

T. Indicates presence of an ET or Trach tube

D. Indicates patient aphasia

P. Indicates presence of pharmacological paralysis

Best Motor Response: (6) (Best arm response)

6. Obeys Commands

5. Localizing pain

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup:

Performing assessment

Admission – RN Assessment, Neurological Assessment (Neuro) tab, Neuro Page 1 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

NEUROLOGICAL ASSESSMENT

Motor

Instructions for performing motor assessment

Assess motor strength bilaterally. Have the patient flex and extend arm against your hand; squeeze your fingers; lift leg while you press down on the thigh; hold leg straight and lift it against gravity; and flex and extend foot against your hand. Grade each extremity using the scale below:

5+ Active movement of extremity against gravity and maximal resistance

4+ Active movement of extremity against gravity and moderate resistance

3+ Active movement of extremity against gravity but NOT against resistance

2+ Active movement of extremity but NOT against gravity

1+ Slight movement (flicker of contraction)

0- No movement

* Other speech/language:

Pupils

* Lens implant/prosthesis: Yes No Unknown

Describe lens implant/prosthesis:

* Size: Equal Right greater than left Left greater than right Other

* Other pupil size:

Reactivity

* Right eye: Brisk reaction to light Some reaction to light (sluggish) No reaction to light

* Left eye: Brisk reaction to light Some reaction to light (sluggish) No reaction to light

* Sensations - Paresthesia or neuropathies present: Yes No

* Sensations present:

* Requires assistive communication device to meet basic needs: Yes No

* Communication device needed:

General observations/comments:

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup:

Performing assessment

Admission – RN Assessment, Neurological Assessment (Neuro) tab, Neuro Page 2 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

GASTROINTESTINAL ASSESSMENT

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: Patient unable to communicate No family/support person present Other

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Patient has a history of:

* Other history:

Abdominal Assessment

* Abdomen: Distended Firm Flat Guarding Non-tender Obese Rigid Round Soft Tender Other

* Other abdominal assessment:

* Bowel sounds: Present Absent

* Present bowel sounds: Normal Hypoactive Hyperactive

* Bowel sounds comments:

* Last Bowel Movement Date: Known Unknown

* Date of Last Bowel Movement: 11/14/2011

Bowel regime

* Other bowel pattern:

* Laxative name and frequency of use:

* Enema type and frequency of use:

Laxative use Enema use

Bowel program * Other bowel program schedule:

* Bowel program schedule:

* Bowel care - start time:

* Bowel care - completion time:

Medication/treatment:

Bowel care position:

Hours:

GI Page 1 GI Page 2 GI Page 3 GI CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: Go

Performing assessment

Admission – RN Assessment, Gastrointestinal Assessment (GI) tab, GI Page 1 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

GASTROINTESTINAL ASSESSMENT

* Device type: None Colostomy bag Gastrostomy tube G/J tube Ileostomy bag Jejunostomy tube Nasogastric tube PEG Rectal tube Salem sump Small bore feeding tube Other

* Other device type:

Oral Screen

* Assessment - General: No problems/impairments Assistance needed with oral hygiene Difficulty chewing Difficulty swallowing All teeth present Poor dentition No dentition Could not assess

Assessment - Mucous Membrane: Bleeding Cyanotic Intact Lesions present Pale Pink

Nutrition screen

* Description of patient: Well nourished Obese Emaciated

* Appetite:

* Other appetite:

Height: 68 in

Weight: 150 lb

BMI: 22.9 (NOV 10, 2011@10:41:31)

Dietary History

* Does patient have any ethnic/cultural/

* Food preferences/special diet needs:

* Does patient have any:

GI Page 1 GI Page 2 GI Page 3 GI CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: Go

Performing assessment

Admission – RN Assessment, Gastrointestinal Assessment (GI) tab, GI Page 2 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Dysphagia screen

* Other reason unable to screen

Dysphagia screen

Able to screen

Unable - Patient on Ventilator

Unable - Patient unconscious

Unable - Other

N/A

* Diagnosis of new stroke, head and neck cancer, or traumatic brain injury:

Yes No

* Modified texture diet/ eating maneuvers (e.g. chin tuck, head turn):

Yes No

* Unable to follow commands:

Yes No

Keep NPO, notify provider, and send Speech Pathology consult

* Wet gurgly voice:

Yes No

* Drooling while awake:

Yes No

* Tongue deviation from midline:

Yes No

Speech Consult

Will send

* Unintentional weight loss or Patient reports unintentional gain/loss of weight in the past month

General Observations/Comments

Nutrition consult guidelines

Patient on tube feeding or total parenteral nutrition

5% unintentional weight gain or loss in past 30 days

Nausea/vomiting/diarrhea for greater than 3 days

Less than 50% usual intake for greater than 5 days

Dysphagia or dysphagia symptom

*** Nutrition consult mandatory. ***

Nutrition Consult Will Send

GI Page 1 GI Page 2 GI Page 3 GI CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: Dysphagia screen Go

Performing assessment

Admission – RN Assessment, Gastrointestinal Assessment (GI) tab, GI Page 3 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

GENITOURINARY ASSESSMENT

* Patient/family/support person able to respond to questions:

Yes No

* Why could no one respond:

Patient unable to communicate

No family/support person present

Other

* Other reason no one could respond

* Information obtained from

* Other source of information

* Patient has a history of

Voiding

* Voiding

* Intermittent catheterization frequency

* Other voiding

Urine

* Other color

Color:

Amber

Yellow

Bloody

Unable to evaluate

Other

Consistency:

Normal

Concentrated

Dilute

Unable to evaluate

Odor:

Foul smelling

None

Unable to evaluate

* Other history

* Last voided:

Known Unknown

Absorbency devices used

* Abnormal discharge

None

Genital

Unable to evaluate

* Describe abnormal discharge

Sediment

* Describe sediment

Yes

No

Unable to evaluate

GU Page 1 GU Page 2 GU CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: Color Go

Performing assessment

Admission – RN Assessment, Genitourinary Assessment (GU) tab, GU Page 1 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

MUSCULOSKELETAL ASSESSMENT

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: Patient unable to communicate No family/support person present Other

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Patient has a history of:

* Describe other history:

* Body part(s) amputated:

* Range of Motion: ROM - No apparent problem Limited ROM - Right Upper Extremity Limited ROM - Left Upper Extremity Limited ROM - Right Lower Extremity Limited ROM - Left Lower Extremity

Stated patient complaints:

General observations/comments:

M/S Page 1 M/S Page 2 M/S CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: able to respond to questions

Performing assessment

Admission – RN Assessment, Musculoskeletal Assessment (M/S) tab, M/S Page 1 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

Describe previous falls and history:

Instructions for completing Morse Fall Scale

* Fracture Location:

* Other fracture location:

* Is patient on any meds that increase risk for falling or risk for injury with falls:

Other medication that increases risk:

* Is patient on multiple meds to:

Total Morse score for Fall Risk: 0

0 - 24 - Patient is at low risk for falling. Implement Universal Fall Precautions.
 25 - 44 - Patient is at moderate risk for falling. Implement Universal Fall Precautions and precautions based on identified area of risk.
 45 and higher - Patient is at high risk for falling. Implement Universal Fall Precautions and precautions based on identified area of risk.

M/S Page 1 M/S Page 2 M/S CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Performing assessment

Admission – RN Assessment, Musculoskeletal Assessment (M/S) tab, M/S Page 2 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

SKIN ASSESSMENT

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: Patient unable to communicate No family/support person present Other

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Patient has a history of:

* Describe other history:

Predisposition for skin breakdown

Does patient have:

- Angiulce
- Diabetes
- Multiple Sclerosis
- Neurological disease
- Paraplegia
- Paralysis
- Quadraplegia
- Spinal cord injury

* Risk Factors:

- None
- Bariatric patient
- Device-related pressure
- Diabetic
- End of life care
- Hypoalbuminemia
- Medication - Vasopressors
- Refusing to turn/move secondary to pain
- Too unstable for turns
- Very low BMI (Body Mass Index)
- Other

* Other risk factors:

Skin Inspection:

* Skin Temperature: Warm Hot Cool Cold

* Skin Moisture: Extremely dry Moist Dry Diaphoretic

* Skin Color: Normal for ethnic group Cyanotic Dusky Flushed Jaundiced Mottled Pale Other

* Other skin color:

* Skin Turgor: Within Normal Limits Abnormal

* Skin Patches: Yes No

* Skin Patch Description:

General observations/comments:

Pressure ulcers Other skin alterations

Skin Page 1 | Skin Pr UI 1 | Skin Pr UI 2 | Skin Alt 1 | Skin Alt 2 | Skin Page 3 | Skin CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field

Go to radiogroup: Skin Patches

Performing assessment

Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Page 1 window

Admission - RN Assessment - BDYDXY,ULN L (5786) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

* Patient/family/support person able to respond to questions: Yes No

* Why could no one respond: Patient unable to communicate No family/support person present Other

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Patient has a history of:

* Other history:

* Other attitude:

* Other behavior:

Suspected Abuse/Neglect Screen

Does patient report any of the following?

Based upon nursing assessment, is any of the following suspected?

Verbal abuse: Yes No

Physical abuse: Yes No

Neglect: Yes No

* Explain suspicions:

Based on nursing assessment, are others in the household possible victims of abuse or neglect by the patient?

Yes No Unknown

* Explain about others in household:

Social Work Consult

P/S Page 1 | P/S Page 2 | P/S Page 3 | DWA | P/S Page 4 | P/S CP

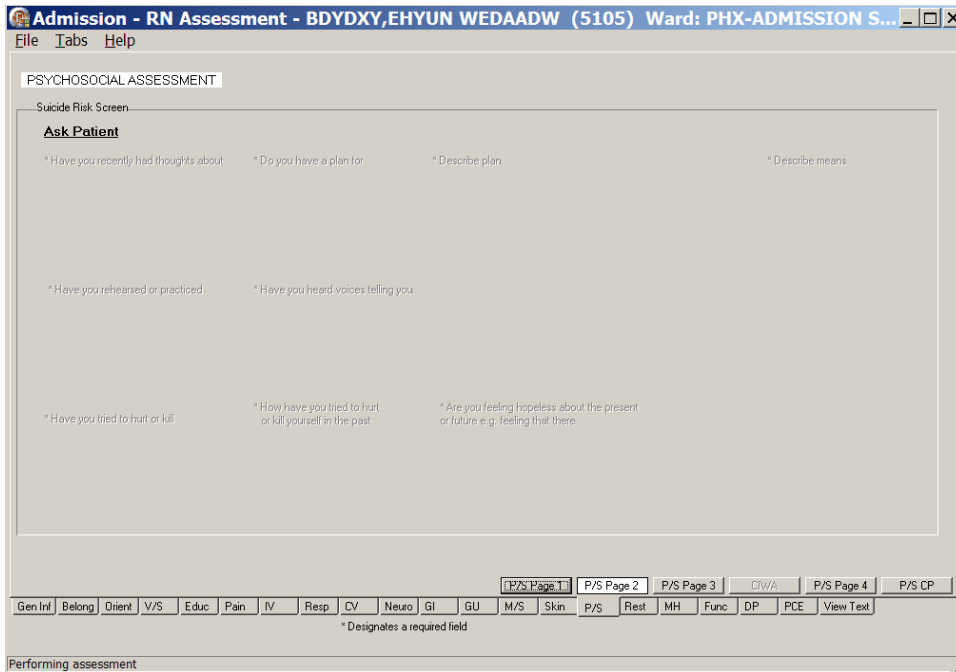
Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

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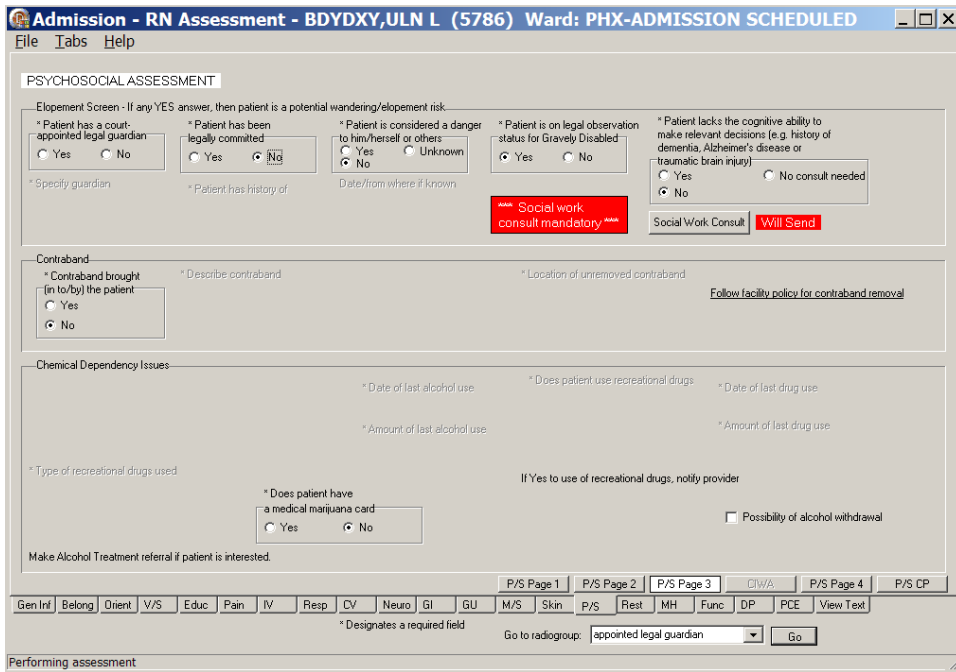
Go to radiogroup: Verbal abuse

Performing assessment

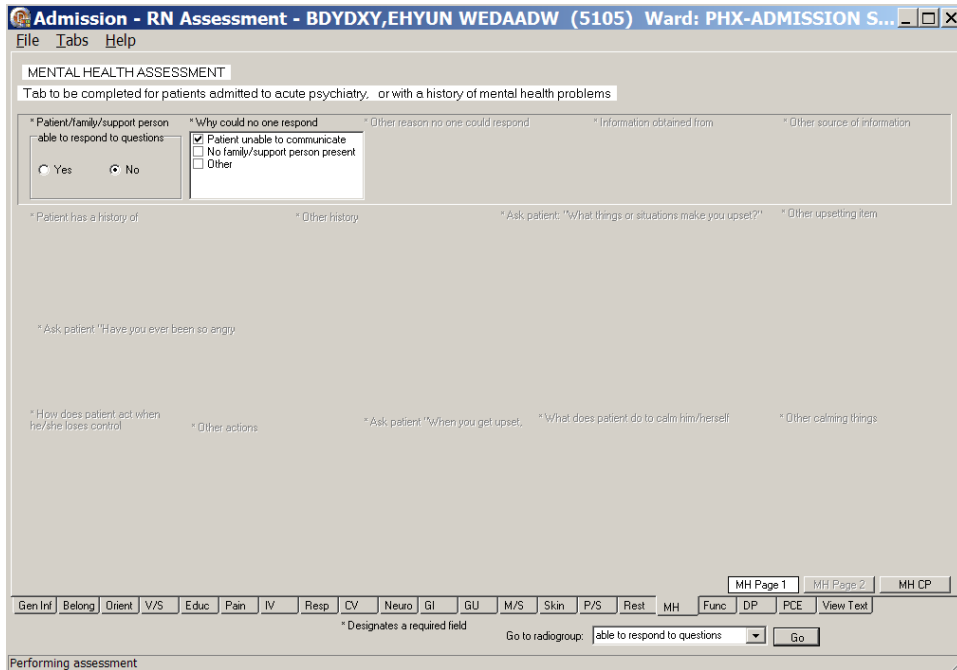
Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 1 window



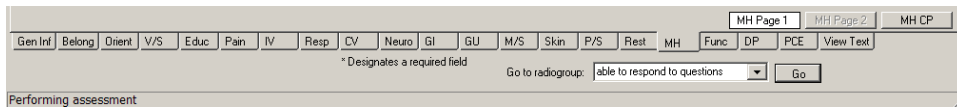
Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 2 window



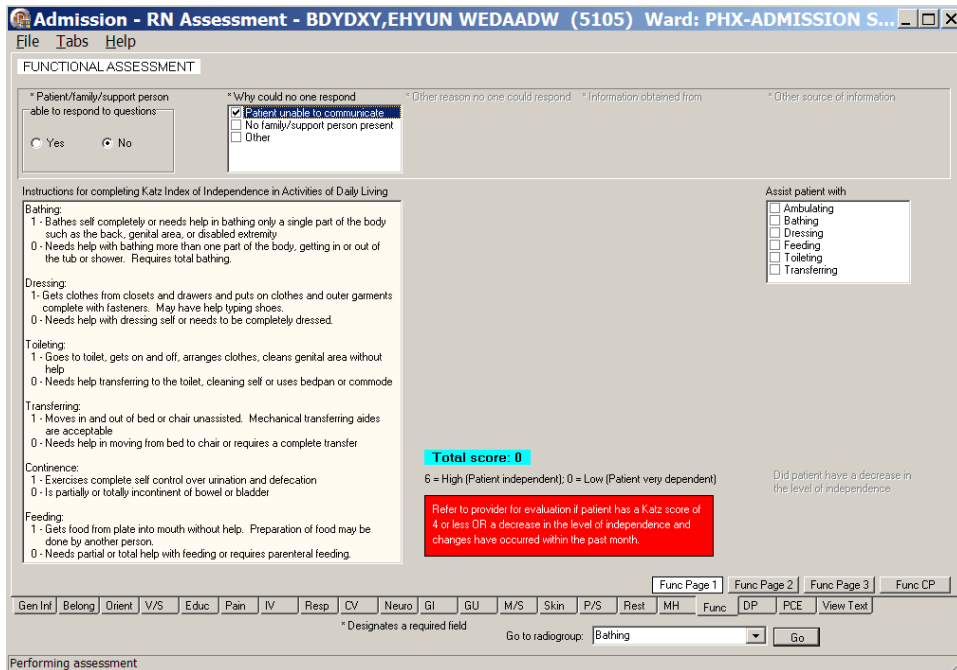
Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 3 window



Admission – RN Assessment, Mental Health Assessment (MH) tab, MH Page 1 window



Admission – RN Assessment, Mental Health Assessment (MH) tab, MH Page 2 is unavailable



Admission – RN Assessment, Functional Assessment (Func) tab, Func Page 1 window

Admission - RN Assessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION S...

File Tabs Help

FUNCTIONAL ASSESSMENT

Instructions for assessing the patient's level of assistance
 Independent (Patient performs task safely, with or without staff assistance, with or without assistive devices)
 Partial Assist (Patient requires no more help than stand-by, cueing, or coaching, or caregiver is required to lift no more than 35 lbs. of a patient's weight)
 Dependent - Patient requires nurse to lift more than 35 lbs. of the patient's weight, or is unpredictable in the amount of assistance offered)

→ Patient's level of assistance
 Independent
 Partial Assist
 Dependent

Assessment criteria and care plan for safe patient handling and movement
 An assessment should be made prior to each task if the patient has varying levels of ability to assist due to medical reasons, fatigue, medications, etc. When in doubt, assume the patient cannot assist with the transfer/repositioning.

Height: 68 in
 Weight: 150 lb
 BMI: 22.9 (NOV 10, 2011@10:41:31)

Instructions for assessing patient's level of cooperation and comprehension
 Cooperative (may need prompting; able to follow simple commands)
 Unpredictable or varies (patient whose behavior changes frequently should be considered as "unpredictable"); not cooperative; or unable to follow simple commands)

→ Level of cooperation and comprehension
 Cooperative
 Unpredictable or varies

→ Weight bearing capability
 Full
 Partial
 None

→ Bi-Lateral upper extremity strength
 Yes
 No

Applicable conditions likely to affect transfer/repositioning techniques

- None
- Amputation
- Contractures/spasms
- Fractures
- Hip/knee/shoulder replacements
- History of falls
- Morbid obesity
- Paralysis/Paresis
- Postural hypotension
- Respiratory/cardiac compromise
- Severe edema
- Severe osteoporosis
- Severe pain/discomfort
- Splints/traction
- Tubes (IV, Chest etc)

Transfer/repositioning techniques comments

General observations/comments

Func Page 1 | Func Page 2 | Func Page 3 | Func CP

Gen Inf | Belong | Orient | V/S | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field
 Go to radiogroup: Patient's level of assistance [Go]

Performing assessment

Admission – RN Assessment, Functional Assessment (Func) tab, Func Page 2 window

Glossary

Term	Definition
ADPAC	Automated Data Processing Application Coordinator
ART	Adverse Reactions Tracking
BCE	Bar Code Expansion
BCE-PPI	Bar Code Expansion-Positive Patient Identification
BCMA	Bar Code Medication Administration
Belong	Belongings
CAC	Clinical Application Coordinator
CIWA	Clinical Institute Withdrawal Assessment.--CIWA
Class 1 (C1)	Software produced inside of the Office of Enterprise Development (PD) organization
Class 3 (C3)	Also known as Field Developed Software Refers to all VHA software produced outside of the Office of Enterprise Development (PD) organization
CMS	Centers for Medicaid and Medicare Services
COTS	Commercial Off the Shelf
CP	Care Plan
CPRS	Computerized Patient Record System
CV	Cardiovascular Assessment
Delphi	Programming language used to develop the CPRS chart
DFN	Data File Number
DP	Discharge Planning
Educ	Educational Assessment
Func	Functional Assessment
Gen Inf	General Information tab
GI	Gastrointestinal Assessment
GU	Genitourinary Assessment
GUI	Graphical User Interface
ICD	International Classification of Diseases
ICN	The patient's national identifier, Integration Control Number
IDPA	Interdisciplinary Patient Assessment - involves multiple disciplines responsible for assessing the patient from their perspective and expertise.
IDPC	Interdisciplinary Plan of Care - The entry of treatment plans by multiple disciplines to meet JCAHO requirements
IV	Intravenous
IV Central	Central IV lines
IV Dialysis	IV Dialysis ports

Term	Definition
IV Periph	IV Peripheral lines
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LPN	Licensed Practical Nurse
M/S	Musculoskeletal Assessment
MAS	Medical Administration Service
MH	Mental Health Assessment
MRSA	Methicillin-Resistant Staphylococcus Aureus
NAA	Nursing Admission Assessment
Neuro	Neurological Assessment
NHIA	Nursing Healthcare Informatics Alliance
NPAT	National Patient Assessment Templates
NUPA	Namespace assigned to the Patient Assessment Documentation Package (PADP) by Database Administrator
OED	Office of Enterprise Development
OERR	Order Entry Results Reporting
OIT	Office of Information and Technology
ONS	Office of Nursing Services
Orient	Orientation to Unit
P/S	Psychosocial Assessment
PADP	Patient Assessment Documentation Package
Pain	Pain Assessment
PC	Plan of Care
PCE	Patient Care Encounter
PD	Product Development
PHR	Patient Health Record
Prob	Problems/Interventions/Desired Outcomes tab in the RN Reassessment
Resp	Respiratory Assessment
Rest (or Restr)	Restraints
RN	Registered Nurse
RPC	Remote Procedure Call
RSD	Requirements Specification Document
Section 508	Under Section 508 of the Rehabilitation Act, as amended (29 U.S.C. 794d) Public Law 106-246 (http://va.gov/accessible) agencies must provide employees and members of the public who have disabilities access to electronic and information technology that is comparable to the access available to employees and members of the public who are not individuals with disabilities
Skin	Skin Assessment
SNOMED – CT	Systemized Nomenclature of Medicine Clinical Terms

Term	Definition
TIU	Text Integration Utilities Program All text in CPRS is stored in TIU
TJC	The Joint Commission
V/S	Vital Signs
VA	Department of Veterans Affairs
VAMC	Department of Veterans Affairs Medical Center
VANOD	VA Nursing Outcomes Database
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture An enterprise-wide information system built around an electronic health record used throughout the Department of Veterans Affairs medical system.
Vital Qualifiers	Provide detail in to the unit of measurement used with the vital signs. Height in inches or centimeters? Weight in pounds or kilograms?

For additional PADP information, refer to the user manuals for *RN Reassessment, Admission – Nursing Data Collection*, and *Interdisciplinary Plan of Care*.

Documentation for NUPA Version 1.0 is also available on

- VA Software Documentation Library in the Clinical Section
<http://www4.va.gov/vdl/>
- PADP SharePoint for NUPA Version 1.0
http://vaww.oed.portal.va.gov/programs/class3_to_class1/padp/field_development

Appendix A

Assessment Contingency Note



Assessment
Contingency Note.pdf

During system downtimes, print a copy of the attached *Assessment Contingency Note* and use it to perform an *Admission RN Assessment*.