Patient Assessment Documentation Package (PADP)

C3-C1 Conversion Project

RN Reassessment User Manual for NUPA Version 1.0



April 2012

Department of Veterans Affairs Office of Information and Technology (OIT) Office of Enterprise Development (OED)

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		• User Manual	
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		Reassessment	

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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 the RN Reassessment

Registered Nurses (RNs) use the RN Reassessment template to document inpatient care in a standardized format at regular times and as needed. With the reassessment template, you collect information associated with new problems and with required physical assessment documentation, such as skin condition, respiratory, genitourinary, and gastrointestinal status.

Opening RN Reassessment

You access the RN Reassessment through CPRS from the **Tools** menu.

- 1. Open CPRS.
- 2. Select a patient.
- 3. Click **Tools**.
- 4. Select **RN Reassessment**.

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.

-2	/istA	CPRS ir	n use by	:G,	D	G (TEST-VI	STA.	.MED.VA	.GOV)
File	Edit	View	Action	Options	Tools	Help			
1	0	ULYH	N,TSHV	VEHY Y	Adr	mission Asses	sment		IRD
60			A	ua 14.195	Inb	erdisciplinary	Plan of Care	8	na
_					RN	Reassessmer	vt .		Ľ
Last	150 S	igned N	lotes		Dat	ta Collection			DO
8	5: A	l signed	notes		Dru	ig Info			
	•	Anest	hesiology	Note	Mic	romedex			TE
	P-1	Comp	uter Dow	ntime Doci	Up	To Date			lum
	P - B	EkgF	'tocedure	Note	Int	ernet Clinical	Tools		lum
	<u><u> </u></u>	Gene	ral Medici	ne Consult	Ima	aging Capture	1		TAL
	<u><u> </u></u>	Hospi	raist Note	e 	Ima	aging Display			AL
	부물	ICS - I	nteraiscip	enary i réa	Clin	ical Business	Tools		TAL
	뿌물	Inform	ed Lonse	ent Mat	DR	M Plus			BAT
	18	Mada	enous In	t Division	CPF	RS Help			CIC
	12	Medic	al history	γα Friysica Note	Vita	sls			RAT
	1 -	Made	al Reside	int Note	Eve	ent Capture			RAT
	1.8	Medic	al Studer	of Note	FIN	1			Lm.
	H _ H	Menta	al Health I	Consult	Au	fiology			RAT
	1 - 1	Menta	Health	Note	VIC	Issuer			
	<u>–</u>	Nursir	ng Periop	Assessme	Me	dConsent			A DTR
	<u>-</u>	Nursir	ng Reass	essment N	Mor	vel			2
	÷-1	Nursir	ng Transf	er Note	Cir	ical Case Rec	istries		KAJ
	<u>⊕</u> _ <u>∎</u>	Nutriti	on Note		Au	doNOTES			
	ė-1	Nutriti	ion Scree	n	CP	Liker			
	÷-1	Opera	stive Note	(brief)	CAL	PT CI			
1	÷-1	Pain/	Assessme	nt	Ger	ald Schmitz A	ward Nomin	ation	ati
	÷-1	Pasto	ral Care N	lote	TRI	Second Leve	Evaluation		de
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	P-1	Physic	cal Thera	py Consult	110	Tenuer			. L .
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	19	Pre 0	perative		Gra	phing		Ctrl+C	5 he
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	뿟쀨	Pulmo Pulmo	nary Lon	isur au Lle Mat	Opt	tions			HDH.
	18	Pulmo	mary Folk	ow-up Not	_	-	Signed:	08/17/201	10 15:1

Access through CPRS

No Previously Saved Information

The Enter a patient window displays.

@RN Reassessment	
<u>F</u> ile <u>T</u> abs <u>H</u> elp	
Enter a patient and then press the Enter key. BDY	
Restore data?	
C Yes	
C No	
Assessment Type	
C Medical/Surgical initial reassessment for shift	
C Critical Care initial reassessment for shift	it Note
C Mental Health initial reassessment for shift	
Last reassessment note done: NOT ADMITTED	
Looking up patient	

RN Reassessment, Enter a patient window with no previously saved information

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

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

Previously Entered Information Available for One Patient

You have previously saved data on a note for patient BDYDXY,ILQDI A.			
Restore data?			
C Yes			
C No			

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 > m*

- 1. Select an Assessment Type.
- 2. Select Yes.
- 3. Click Start Note.

The template opens General Information tab for the CPRS patient with the data restored.

Note: PADP does a search for previously entered assessments/reassessments within the last 12 hours.

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 d	ata on more than one patient.
View the patients?	
C Yes	
C No	

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.
- 3. The template opens to the General Information tab.

View the Patients?/Yes

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

You have previously saved data on more than one pa	atient.
View the patients?	
Patient Selection	
You have saved data on the following	ng patients:
Click one of the following patients, or just click either button witho	out selecting a patient to do a new patient
BDYDXY,ILQDI A BDYDXY,EHYUN WEDAADW	
,	OK Cancel

Patient SelectionList

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.

RN Reassessment - ZMSF File Tabs Help	TSWLSDHYS,CHUUN (1110)	Ward: PHX-ADMISSION SCHEDULED	<u>_ ×</u>
GENERAL INFORMATION			
* Patient/family/support person able to respond to questions r free r No	" Other reason no one could respond	Information obtained from Patient Authorized surrogate Family/Support Person Medical Record Other	
Demographics Name: ZMSHTSWLSDHYS,CHUUN Age: 100 Sex: MALE Race: BLACK OR AFRIC Admitting diagnosis: NONE FOUND Prior patient response to "What does patient want to accomplish by this hospitalization"	AN A	*	
"What does patient want to accomplish by this hospitalization"	C Other Chirdr Language Prior patient response:		
Gan lef Effus: Pain IV Bress IV	Neuro GI GII M/S Skin P/S Beet	Gen i Page 1 _ Gen i Page 2 _ Gen i Page 3 _ MH _ Func _ DP _ PTC _ View Text	Gen I Page 4
	* Designates a required field	So to radiogroup: able to respond to questions Go Go	

RN Reassessment, 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 automatically displays over the General Information window.



Location : 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.

RN Reassessment -					
<u>F</u> ile	<u>T</u> abs <u>H</u> el	р			
Up	oload Data	Ctrl+U			
Save and Exit Ctrl+S					
Sa	ive No <u>w</u>	Ctrl+W			
Ex	it	Ctrl+Z			

RN Reassessment window, File menu

Upload Data

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

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

🕼 Upload results	
Results from your note upload:	
Unsigned RN REASSESSMENT Addedl You can now go into CPRS and review/sign it.	
NUTRITION INPATIENT consult uploaded, order #92194122 Be sure to sign it in CPRS!	
SOCIAL WORK CONSULT INPATIENT consult uploaded, order #92194123 Be sure to sign it in CPRS!	
Health factors added!	
Care plan uploaded!	
	X Close

RN Reassessment, 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.

& RN Reassessm Eile <u>T</u> abs <u>H</u> elp	nent - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED	
GENERAL INFORMAT	TION	
* Patient/family/support pers	* Other reason no one could respond * Information obtained from * Other source of information rson * Why could no one respond	
	Gerror Listing	
Demographics Name: ZMSHTSWLSDHY! Age: 100 Sex: MALE R	Cannot Upload Note. The following errors were found: You can double-click on an item below to be taken to that tab Pain page 1 - Severity of Pain not specified.	
Admitting diagnosis: NONE F Prior patient response to "Wh accomplish by this hospitalizat	Pain page 1 - Timing of pain not specified. Pain page 1 - Does pain radiate not specified. IV Peripheral - Peripheral IV number 1 not updated. IV Peripheral - Peripheral IV number 2 not updated.	
pain free	IV Central - Central IV number 1 not updated. IV Central - Central IV number 2 not updated. IV Dialysis - Dialysis number 1 not updated. IV Dialysis - Dialysis number 2 not updated. Resp page 2 - Suction not specified.	
Additional goals for hospitaliza pain free	Pesp page 2 - Air Leek not specified. Pesp page 2 - Chest tube drainage not specified. Resp page 2 - Dressing not specified. M/S page 2 - within 3 months not specified. M/S page 2 - Ambulatory Diagnosis not specified. M/S page 2 - Ambulatory aid not specified.	
	Close	
	Gen I Page 1 Gen I Page 2 Gen I Page 3 Gen I	Page 4
Gen Inf Educ Pain IV	Resp CV Neuro GI GU M/S Skin Skin P/S Rest MH Func DP PCE View Test Designations accounted field Contractionneum Performed Healthouse accounts of Contractions	
Checking note for errors	Designales a requirea neixi di ti i i dalogroup, i riferirea reduncale canguage 🔹 di u	

RN Reassessment, 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 : 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.

RN Reassessment - BDYDXY, ILQDI A (2902) Ward: PHX-ADMISSION SCHEDULED	
<u>File Tabs H</u> elp	
	
GENERAL INFORMATION	
Information obtained from: Patient	_
What does patient want to accomplish by this hospitalization": Improve lungs Preferred Healthcare Language: English	
Medications	
Meds brought in by patient: No	
Implanted medication pumps or devices: No Is patient wearing any kind of medicinal match: No	
Spiritual (Cultural Accompany - Dation - Dollation - DOMAN CATUOLIC CUUDCU	
Are there religious practices or spiritual	
physician, and other health care team members to immediately know about: No	
Fatient 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 Does patient have a pastor or clergy who should be notified of this hospitalization: No	
Does patient have an Advance Directive: No	
Patient received info on Advance Directive: Yes Does natient wish to initiate or make changes to an Advance Directive: No	
Testing for MRSA brochure/equivalent information given to the patient/authorized surrogate: Yes	
MRSA Nares swab performed: Yes Use the balan Infection Control Education provided to the patient: Yes	
Infection Control Education: Hand hygiene practices	
Precautions: Contact	
MRSA Nares swab performed on transfer with patient's agreement: Yes MRSA Nares swab performed on discharge with patient's agreement: Yes	-
	Þ
Sign Note/Consult	
Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text	
* Designates a required field	n
uploading care plan. Cascade your windows in the program gets stuck	

RN Reassessments, View Text tab after upload

2. Click Sign Note/Consult.

	Sign Note/Consult	Ente	er your ele	etronic si	ignature (ode	Accept	e-sig	Can	cel e-sig]								_
Ger	n Inf Educ Pain	IV	Resp	CV	Neuro	GI	GU	M/S	Skin	P/S	Rest	мн	Func	DP	PCE	View Text	 		
Uploa	iding care plan.	Cascade	vour wi	ndows i	f the pr	ogram	" D aets stu	esignate: JCk	s a requin	ed field								005	

RN Reassessment, Sign Note/Consult 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(s) to sign, the button is Sign Note/Consult.

Working in a Care Plan

The Care Plan page for each section of the RN Reassessment works the same way. The steps apply to each of the care plan (CP) pages.

Ē	RN le	Rea Tabs	sses <u>H</u> elp	sme	nt - I	BDY	DXY,	EHY	UN V	VED/	AAD\	N (5	105)) Wa	ard:	РНХ∙	-ADM	ISSIO	N SCH	EDULED	_ [
	EDU	ICATIO	N-PR	OBLEM	IS/INTE	RVEN	ITIONS,	/DESIR	ED OU	тсом	ES	Click	a row to	updat	te its pro	oblem e	evaluati	on and inte	rvention st	atus.		
	TAB	PROBL	EM		D,A	TE IDEN	ITIFIED	DESIREI	Ο Ουτα	ME PRO	DB EVAL	PROE	EVAL D	ATE IN	TERVEN.	FION				INT STA	RTED	INT S
	NONE																					
	•																					
1	Do	not displ	ıy resol∨	ed proble	ems	Add N	ew Proble	em	this prob	View	r history fi	or this pro	blem			nterventi	on detail					
	ion Inf		Pain	1.07	Reen	0	Nouro	6	GU	14/0	Chin	D/C	Rest	мц	Euro	DB	DCE	Man Taut	Youd	Educ Page 11	Educ (P
<u>e</u>	ien inf	Educ	<u>r an</u>	<u></u>	<u>_ nesp</u>	<u> </u>		<u>_u</u>	<u>, uu</u> ×D	<u></u>			j <u>hest</u>	<u></u>		<u></u>	<u></u>					
Dave									- D	esignate	s a requir	euneid										

RN Reassessment, <Education> - Problems/Interventions/Desired Outcomes, <Educ> CP window

Care Plan Table

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DA
CV	Congestive Heart Failure (Actu	2/3/11@1156	Prevention/minimizatio	New problem	Not on file	Education - Educat	2/3/11@1156	Not on file	Not on file
CV	Congestive Heart Failure (Actu	2/3/11@1156	Prevention/minimizatio	New problem	Not on file	Other Treatments/p	2/3/11@1156	Not on file	Not on file
EDUC	Speech deficit (Actual)	2/3/11@1156	Improved communicati	New problem	Not on file	Treatments/proced	2/3/11@1156	Not on file	Not on file
EDUC	Speech deficit (Actual)	2/3/11@1156	Improved communicati	New problem	Not on file	Treatments/proced	2/3/11@1156	Not on file	Not on file
FUNC	Assistance with bathing and hy	2/3/11@1156	Facilitation of activities	New problem	Not on file	Treatments/proced	2/3/11@1156	Not on file	Not on file
GI	Inadequate nutrition (Actual/Po	2/3/11@1156	Balanced dietary intak	New problem	Not on file	Treatments/proced	2/3/11@1156	Not on file	Not on file
GI	Inadequate nutrition (Actual/Po	2/3/11@1156	Balanced dietary intak	New problem	Not on file	Treatments/proced	2/3/11@1156	Not on file	Not on file
GU	Diabetes - chronic (Actual)	2/3/11@1156	Not on file	New problem	Not on file	Education - Educat	2/3/11@1156	Not on file	Not on file
GU	Diabetes - chronic (Actual)	2/3/11@1156	Not on file	New problem	Not on file	Treatments/proced	2/3/11@1156	Not on file	Not on file
GU ∢	Diabetes - chronic (Actual)	2/3/11@1156	Not on file	New problem	Not on file	Treatments/proced	2/3/11@11	56	56 Not on file

RN Reassessment, Problems/Interventions/Desired Outcomes table

The width of each Care Plan column is adjustable. There are ten columns in the Care Plan (Problems/Interventions/Desired Outcomes) table.

Column	Description
Tab	Tab in which the problem was identified in a previous assessment Example The problems came from the Mental Health Assessment, MH tab
Problem	Problem of concern from a previous assessment
Date Identified	Date the problem was identified
Desired Outcome	Preferred resolution of the problem
Prob Eval (Problem Evaluation)	In relation to the problem, how are things going? a. No change/Stable b. Deteriorating c. Improving d. Resolved e. Unresolved at discharge
Prob Eval Date (Problem Evaluation Date)	Date on which the problem was last evaluated
Intervention	The <i>what to do</i> for the patient you identify, so that the problem will improve/get better/not get worse
Int Started (Intervention Started)	Date on which the intervention was initiated
Int Status (Intervention Status)	 In relation to the intervention, how should the staff proceed? a. Complete b. Continue c. Discontinue d. Pending (intervention was ordered but not started, such as a special bed or a lab test) e. Not on file (status not evaluated)
Int Stat Date (Intervention Status Date)	Date on which the status of the intervention was evaluated

Updating an Existing Problem/Intervention

All care plans are updated the same way. If problems are entered during a previous assessment, the CP page from any tab is bold and italicized.



RN Reassessment, <Resp> tab

1. Click **<Resp> CP**.

The <Respiratory> - Problems/Interventions/Desired Outcomes window displays.

RN <u>File</u>	l Reassessmen <u>T</u> abs <u>H</u> elp	t - BDY	DXY,	EHYUN W	EDAAD	N (5:	105)	Ward	: PHX	-ADM	ISSION SC	HEDULED	_ 🗆 ×
RES	SPIRATORY - PROBLE	MS/INTER	VENTIO	NS/DESIRED (UTCOMES	Click a	ı row to u	pdate its	problem	evaluatio	on and interventio	n status.	
TAB	PROBLEM	DATE IDE	NTIFIED	DESIRED OUTCOM	IE PROB EVAL	. PROB E	EVAL DAT		ENTION			INT STAR	TED INT ST
RESP	Asthma (Actual)	12/6/11@	0831	Stabilization and/or	im New probler	n Notion	file	Educatio	n - Instruct	patient to i	mmediately report any	problems 12/6/11@	0831 Not on f
I	_												
E D	o not display resolved problem	* Add 1	New Proble	em	View history f	or this prob	lem	rioue	nivi nuen ven	norr deten		1.0-0-01	Prov 60
Gen In	f Educ Pain IV	Resp CV	Neuro	GIGU	M/S Skin	P/S	Rest M	/H Fun	c DP	PCE	View Text		
				*De	signates a requi	red field							
Performi	ing assessment												

RN Reassessment, <Resp> CP window

2. Click a problem.

Problem evaluation, Intervention status, and Problem/intervention detail become available.

👰 RN	Reassessment	- BDYDXY,	EHYUN WE	DAADW	(5105)	Ward: PHX-ADMIS	SION SCH	HEDULE	
<u>F</u> ile	<u>T</u> abs <u>H</u> elp								
RES	SPIRATORY - PROBLEM	S/INTERVENTIO	NS/DESIRED OU	TCOMES	Click a row to u	pdate its problem evaluation ar	nd intervention	status.	
TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DAT	E INTERVENTION	INT STARTED	INT STATUS	INT STATUS DAT
RESP	P Asthma (Actual)	12/6/11@0831	Stabilization and/or im	New problem	Not on file	Education - Instruct patient to immed	i 12/6/11@0831	Not on file	Not on file
									Þ
	not display resolved problems toblem evaluation No change/Stable Deteriorating Improving Resolved Unresolved at discharge	Add New Probl Add New Inter Intervention stat. Completed Continue C Discontinue Pending	em , , , , , , , , , , , , , , , , , , ,	View history for	this problem	Problem/Intervention detail Problem: Astma (Actual) dentilied: 12/6/11/6/031 Desired outcome: Stabilization. E valuation: New problem E valuation: New problem E valuation: Adte: Not on File Intervention astatud: 12/6/11 (2) Intervention status: Not on File Intervention status: Not on File Intervention status: Not on File Intervention status: Adte: Not on	and/or improveme st patient to immed 0831 file	nt of respirator	y status as i y problems
Gen In	Educ Pain IV P	no CV Neuro		/S Skin	P/S Best I	Resp Page 1 Resp Page 2 H Euroc DP PCE View	Other CT Loc	Resp Page 3	3 Resp CP
Garm			*Desia	nates a required	field				
Performi	ng assessment								

RN Reassessment, <Resp> CP window

3. Select a problem evaluation and an intervention status for the selected problem. Evaluate both the problem and the specific interventions each time you document.

Do not display resolved problems Add New Problem View history for this problem Add New Intervention to this problem Add New Intervention to this problem Add New Intervention to this problem Problem evaluation Intervention status Intervention status Completed Deterionating Continue Discontinue Discontinue Discontinue Product at discharge Pending
Resp Page 1 Resp Page 2 Other CT Loc Resp Page 3 Resp CP Gen Infl Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text
* Designates a required field

Problem evaluation, Intervention status, and Problem/Intervention detail

4. Click **OK**.

Information displays.

Inform	nation X
(į)	Plan/intervention updated!
	ОК

Information : Plan/intervention updated!

5. Click **OK** to complete the problem/intervention.

Review the care plan table. The Prob Eval/Int Status are updated and the Prob Eval Date/Int Status Date are added.

RN ile <u>T</u>	Reassessmen abs <u>H</u> elp	t - BDYD)	ХҮ,ЕНҮ	'UN WE	DAADV	V (5105)	Wa	rd: PHX	-ADMIS	SION SCI	HEDULE	
RESP	IRATORY - PROBLE	MS/INTERVEI	NTIONS/DE	ESIRED OU	TCOMES							
TAB	PROBLEM	DATE IDENTI	FIED DESIRE	D OUTCOME	PROB EVAL	PROB EVAL D		RVENTION		INT STARTED	INT STATUS	INT STATUS DAT
RESP	Asthma (Actual)	12/6/11@083	31 Stabiliza	ition and/or im	Deteriorating	12/15/11@152	1 Educ	ation - Instruct	patient to imme	di 12/6/11@0831	Continue	12/15/11@1521
•												
🗖 Don	ot display resolved problem	S Add New	Problem	o this problem	View history fo	r this problem						
Gen Inf	Educ Pain IV		Neuro GI	GU M	/5 Skin	P/S Rest	MH	Resp Page 1	Hesp Page 2	Other CT Loc	Resp Page 3	B Resp CP
				* Desic	nates a requir	ed field						

RN Reassessment, <Resp> CP window

7. Click **View history for this problem** to view the history of the selected problem. The Problem History displays.

TAD PRODUCT	DA	TE DENTIFIED	DESIRED DU	ITCOME PROB EVAL	PROB EVAL DAT	EINTERVENTION	PV PV	T STARTED INT STA	TUSINT STATUS D
RESP Active (Actual)	12/	6/11@0831	Stabilization (end/tor in: Detexicsating	12/15/11@1521	Education - Instruct	r palient to immedi 12	/6/11@0E31 Continue	12/15/11@152
			9	Problem H	istory				_ 0 ×
 ▲ De not display musiked per 	territ	Add New Prob	Pro Pro S S Man Int Int Int Int Int Int Int Int Int In	blem evaluation blem Autona (Actual) auto: DETERIOPATIN evention evaluation evention: Education - 1. Status: CONTINUE	G (DEC 15, 2011) Instruct pallert to inte (DEC 15, 2011)(945.)	IS2120 PADP U edately report any pr 2120 by PADP U	ISER,ONE Internet that series with SER,ONE	beating	
									Dee

Problem History window

8. Click Close.

Adding a New Intervention for an Existing Problem

- 1. Click a problem.
- 2. Click Add New Intervention to this problem.

The Add New Problem/Intervention window displays with the area and problem selected.

Add New Problem/Intervention	n		_ 0
Cadovacula			
Dietetics	-		
Uncover Parring			
Functional			
anthomhestevil			
ientournay			
V dend of blandle			
renna meann Ann chuir alat al			
	Desired Outcome		
Coonitive incomment (Actual)	Impound comparing with nated with moving search		
fearing deficit (Actual)	ingen i su contra avalut i miri pateri miri sipateu specuri		
peech delicat (Actual)			
/isual deficit (Actual)			
Joner 1 Selar 3			
W11171-9-			
	201	and a	
	L.	1	
Select Interventions			
Other Education 1			
Other Education 2			
Treatments/procedures · Face the patient and make eye of	onlact		
Treatments/procedures - Use simple words and short sent	ences	A.44	1
Treatments/procedures - Use an aphabet board		1400	
Treatments/procedures - one a police board			
Treatments/procedures - Provide writing materials		Cance	
Treatments/procedures - Provide positive reinforcement ar	id praise as appropriate	10	
Other Treatments/procedures 1			
Other Treatments/procedures 2			
_ Other Surveillance 1			
Differ Case Management 1			
Other Case Management 2			
Other			
		E.a.	
		C.M.	

Add New Problem/Intervention window

- 3. Select an intervention from the **Select Interventions** list box for the selected problem.
- 4. Click **Add**. Information displays.



Information : New Intervention added!

- 5. Click **OK**.
- 6. Click **Exit**.

Adding a New Problem/Intervention

6	RN	Reassessment	- BDYDXY	EHYUN WE	DAADW	/ (5105) \	Ward: PHX-ADMISS	SION SCI	IEDULE	
E	le]	[abs <u>H</u> elp								
	RES	PIRATORY - PROBLEM	S/INTERVENTIO	ONS/DESIRED OU	TCOMES					
	TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DAT
	RESP	Asthma (Actual)	12/6/11@0831	Stabilization and/or im	Deteriorating	12/15/11@1521	Education - Instruct patient to immedi	12/6/11@0831	Continue	12/15/11@1521
		-								
Do not display resolved problems										
			Add New Prop			ans problem				
			Add New Inter	vention to this problem						

RN Reassessment, <Resp> CP window

1. Click Add New Problem.

Add New Problem/Intervention window displays.

Add New Problem/Intervention		- 0 >
ICCE problem eren Indersectar Serect Serect	-	
krzegowa wschonie una d wschonie una d wscholi w w V V		
elett Problem(s) contrive impartment (Actual) ferring detach (Actual) enext detick (Actual) fruid detick (Actual) fruid - 2 ferring - 2 fe	Desired Outcome	
	X Ext	

Add New Problem/Intervention window

Note: The Respiratory area is auto selected, because you are in the Resp CP.

 Select a problem from the Select Problem(s) list box. You can select only one problem at a time. The Desired Outcome text box and the Select Interventions list box display.

Add New Problem/Interv	ention		_ 0
ardovatcular	×		
etetica			
acharge Flanning			
unctional			
astroinkestinal			
enfourinary			
1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	and the second se		
ental Health Second of Matural	×		
and Parking (a)	Designation		
liect Problem(s)	Desired Unicome		
agnitive impairment (Actual)	Facilitation of communication		
peech deficit (Actual)			
sual deficit (Actual)			
ther 1			
ther 2			
	3 C	7	
	Constant of the second s		
elect Interventions			
Other Education 1		-	
Other Education 2			
Treatments/procedures - Ask patient about prefer	ed communication approach		
Treaments/procedures - Demonstrate pasence	mask slowly clearly and concisely	AH	
I I shatments (hipped) and . Eace the cleed deactly is	product and may, called a state of a state of a		
) Insaments/procedures - Face the client directly, s Tunalments/procedures - Use a sign language inter-	epreter as appropriate	7000	
Treatments/procedures - Face the client directly, 1 Treatments/procedures - Use a sign language inte Treatments/procedures - Keep background incise	rprefer as appropriate to a minimum when communicating		
Treatments/procedures - Face the client directly, 1 Treatments/procedures - Use a sign language inte Treatments/procedures - Keep background noise Treatments/procedures - Encourage verbalization	spreter as appropriate to a minimum when communicating of questions and concerns	Cancel	
Insaments/procedures - Face the client directly : Treatments/procedures - Use a sign language inte Treatments/procedures - Keep background incise Treatments/procedures - Periodically assess effect	spreter as appropriate to a minimum when communicating of questions and concerns tweness of communication by asking patient to repeat what was said	Cancel	
Instruments/procedures - Face the client directly, i Treatments/procedures - Use a sign language init. Treatments/procedures - Keep background noise Treatments/procedures - Periodically assess effect Treatments/procedures - Use paper, pencil, or cor Treatments/procedures - Use paper, pencil, or cor	speter as appropriate to a minimum when communicating of questions and concerns tweness of communication by asking patient to repeat what was said poter communication when necessary	Cancel	
Insomens/procedure: Face the clent directly, i Insoftments/procedure: Use a jog language rist Insoftments/procedure: Keep background noise Insoftments/procedure: Periodically assess effect Insoftments/procedure: Use paper, pencil, or con Insoftments/procedure: Use paper.	preter as appropriate to a minimum when communicating of quantions and concerns (whereas of communication by asting patient to repeat what was said inputer communication when necessary who flatment generation (ALD) when appropriate	Cancel	
Linements/procedures - Face the clerit directly, i Interfinents/procedures - Use angin language the Treatments/procedures - Keep background noise Treatments/procedures - Periodeal assess effect Treatments/procedures - Periodeal assess effect Treatments/procedures - Use paper, penc), or con Treatments/procedures - Use paper, penc), or Treatments/procedures - Use paper, penc), or Treatments/procedures - Use paper.	speter a appropriate of auxiliary and concerns of guestions and concerns inverses of communication by asking patient to repeat what was said applier communication when necessary attive fateraing devices (JAD) when appropriate depicting featurity devices applier common and the same spectra of the same applier communication of the same spectra applier common applier of the same spectra applier	Cancel	
Linemens/procedures - Face the clerid density, L Inethimeris/procedures - Use a sign language with Treatmens/procedures - Keep background noise Treatmens/procedures - Renorge verbalazion Treatmens/procedures - Periodically assess effect Treatmens/procedures - Use paper, penc), or co- treatmens/procedures - Implement the use of ass Treatmens/procedures - Implement the use of ass Other Treatment/procedures - 1 Billione Treatment/procedures - 2	preter a appropriate of questions and concerns of questions and concerns inverses of communication by aking patient to repeat what was said inputer communication when necessary infer lating device ULD 11 when appropriate depicting test/procedures	Cancel	
i reamens/piondues - Roac the client directly, reatment/piondues - Use a gain ginayage nit reatment/piondues - Reacage verbladdion Ineitment/piondues - Pionalage verbladdion Ineitment/piondues - Use pack percl, or con Tendiment/piondues - Use packet or dagaren Other Ineitment/piondues - Use packet or dagaren Other Ineitment/piondues - I Soundues - Multichton smort of diversion and in	speter as appropriate of quartitions and concerns of quartitions and concerns presents of council or the starting patient to resent what was said interesting the starting of the starting of the starting interesting devices (ALDS) when appropriate descripting the starting of the starting of a needed	Cancel	
incommers/procedures : - Pace the client density, - readments/procedures : - Use a gain gravage inter Teothments/procedures : - See background noise Treatments/procedures : - Procedures, assess effect Teothments/procedures : - Procedures, assess effect Treatments/procedures : - Tupement huse of ass Treatments/procedures : - Tupement huse of ass Treatments/procedures : - Tupement huse of ass Themaments/procedures : - Tupement of degrams Others Treatments/procedures : - Tupement of degrams of and Defess Treatments/procedure : - Tupement of degrams of a degrams	inseter a appropriate of questions and concerns. It is animum, when communicating of questions and concerns imputer communication when necessary interest lationing device ULD 31 when appropriate depicting test/stocedures effect for further assessment and treatment as needed	Cancel	
Incommers/pionoduse: Face the client density. Incommers/pionoduse: Use a sign impage the Teodiment/pionoduse: Use a sign impage the Teodiment/pionoduse: Pionoduse) assess effect Teodiment/pionoduse: Use pages, perci, or co- pionoduse (Clienter) and the sign impage Teodiment/pionoduse: Use pages, perci, or co- lotter Teodiment/pionoduse: Use pages, perci, or co- lotter Teodiment/pionoduse: Use pages, perci, or Client Teodiment/pionoduse; Use pages, perci, or Client Teodiment, perci, perci	speter as appropriate of auxiliary and communicating of auxiliary and communicating interest of communication by authors paired to repeat what was said interest therming devices (ALD 1) when appropriate depicting tests/succedues effect for lutter assessment and treatment as needed	Cancel	
incommers/pionoduse: - Roace the client density, - readments/pionoduse: - Use a gain gravage intri Teotiments/pionoduse: - Use a gain gravage intri readments/pionoduse: - Pionoduse, assess effect Teotiments/pionoduse: - Pionoduse, assess effect Teotiments/pionoduse: - Ingelment the use of ass Treatments/pionoduse: - Ingelment and use Differs Tavellinone 2 Differs Tavellinone 2	Instein a papopulate to a minimum when communicating to meass of communication by authors patient to repeat what was said paper communication when nocessary unitive latening devices IALD 31 when appropriate devicing the IALD sector and treatment as needed	Carcel	
Incommers/pionoduse: Face the client density. Incommers/pionoduse: Use a sign impage triat Teotherst/pionoduse: Use a sign witholicitom Teotherst/pionoduse: Pionoduse) assess effect Teotherst/pionoduse: Ingelenet the use of an Other Teotherst/pionoduse: Ingelenet the use of an Other Teotherst/pionoduse: Ingelenet the use of an Other Teotherst/pionoduse I Saveillance - Watch for upsis of depression and in Other Saveillance 1 Other Saveillance 1 Other Saveillance 1	instete a appropriate of auxiliary and communicating of auxiliary and communicating interest of communication by abing pole particular to a second second second second second particular to a second second second second second depicting test/bacedues after for lutter assessment and treatment as needed	Cancel	
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Add New Problem/Intervention window for problem/intervention options

- 3. Select an intervention from the **Select Interventions** list box.
- 4. Click **Add**. Information displays.

Inform	nation X
(į)	New Problem/Intervention added!
	ОК

Information : New Problem/Intervention added!

- 5. Click OK.
- 6. Click Exit.

Other Problems

Some problems generate a to enter problems that are not on the predefined list.

- 1. Select an *Other* problem in the **Select Problems** list box.
 - The Other problems displays.

Add New Problem/Inte	vention		1>
Gridon przibliem renzer. Cardovascuła Dieteksia Bioteksia Bioteksia Bioteksia Bioteksia Bioteksia Michael Hogith			
Select Pollow () Cognitive repained: (Actual) Heaving dates (Actual) Speech deficit (Actual) Viral deficit (Actual) Other 2	*Desired Outcome roblems X roblemname:		
Select Interventions Other Case Management 1 Other Education 2 Other Education 2 Other Structure 2 Other Structure 2 Other Case Management 2 Other Case Case Management 2 Other C		Add	
		X Est	

Add New Problem/Intervention window with Other

- 2. Type the *other* problem into the text box.
- 3. Click OK.
- 4. Type a desired outcome into the **Desired Outcome** text box.
- 5. Select one or more interventions from the **Select Interventions** list box.
- 6. Click **Add**. Information displays.



Information : New Problem/Intervention added!

- 7. Click **OK**.
- 8. Click Exit.
- 9. To add more *other* problems, repeat steps 1-8, as necessary.

Other Interventions

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

- 1. Select an *Other* intervention in the **Select Interventions** list box. The *Other* intervention displays.
- 2. Type the *other* intervention into the text box.
- 3. Click OK.

Add New Problem/Intervention		<u>_0×</u>
Glicken problem enve Endoverson problem enve Diretes Boschage Planang Richtonic Richtonic Richtonic Bornhaustenic W W Merstel Heath Mannehek auf all		
Select Problem(s) Cognitive measurert (Actual) Hearing defic (Actual) Vision (Actual Actual) Vision (Actual Actual) Other (Actual Actual) Other 2 Other 2	Desired Outcome temove after prob	
Select Interventions Other Exect Management 1 Other Execution 1 Other Execution 2 Ot	Other Treatments X Elite the Other Treatments/Procedures Districtions	Add Cancel
	X Ext	

Add New Problem/Intervention window with Other

4. Click **Add** to transfer the intervention to the care plan. Information displays.



Information : New Problem/Intervention added!

- 5. Click OK.
- 6. Click Exit.

Working in the Consults

All the consults in Reassessment 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**

Spiritual/Cultural Assessment - Patient's F	Religion: JEHOVAH'S WITNESS	SES			
Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about C Yes C No	Describe practices/concerns	Patient requests an immediate visit from the Chaplain Visit from the Chaplain Visit from the Chaplain No Prior patient response: NO	Chaplain Consult	Does patient have any traditional, ethnic, or cultural practices that need to be part of care C Yes C No	* Describe practices
Phor patient response: NU Does patient have any concerns or special considerations if a blood transfusion is needed 'Yes No Prior patient response: ND	Describe concerns	Chaplein consult man Does patient have a pastor or clergy who should be notified of this hospitalization C Yes C No rior patient response: ND	datory ****	Phor patient response: NU	

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

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

The <INPATIENT CHAPLAIN> Consult window displays.

MINPATIENT CHAPLAIN Consult	
*Urgency Routine	* Patient will be seen as an
* Place of consult Bedside	C Inpatient C Outpatient
Provisional diagnosis	* Provider
*Reason for request	
	Person to notify
	Ipload Consult K Cancel

INPATIENT CHAPLAIN Consult window

- a. Complete all fields with asterisks; they are required fields.
- b. Click Upload Consult.

Information displays indicating the consult is uploaded with the reassessment note.

Inform	ation X
į	Consult will be uploaded with the note.
	ОК

Information : Consult will be uploaded with the note.

3. Click **OK**.

On the Gen Inf tab, Gen I Page 2, under the Chaplain Consult button, Will Send displays.

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 with a Mouse

There are two ways to move from tab to tab within the template.

1. Click a tab at the bottom of any of the RN Reassessment windows. The selected tab opens.

Gen I Page 1 Gen I Page 2 Gen I Page 3 Gen I Page 3 Gen I Page 3	e 4
Gen Inf 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	

RN Reassessment tabs

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

@ R	N Reassessment -	BDYDXY,
<u>F</u> ile	<u>T</u> abs <u>H</u> elp	
	General Information	Ctrl+Alt+G
RE	Education	Ctrl+Alt+E
TAE	<u>P</u> ain	Ctrl+Alt+P
RES	ΙV	Ctrl+Alt+I
	<u>R</u> espiratory	Ctrl+Alt+R
	Cardiovascu <u>l</u> ar	Ctrl+Alt+L
	<u>N</u> eurological	Ctrl+Alt+N
	G <u>a</u> strointestinal	Ctrl+Alt+A
	Geni <u>t</u> ourinary	Ctrl+Alt+T
	<u>M</u> usculoskeletal	Ctrl+Alt+M
	<u>S</u> kin	Ctrl+Alt+S
	Psychosocial	Ctrl+Alt+Y
	Restraints	Ctrl+Alt+Z
	Mental <u>H</u> ealth	Ctrl+Alt+H
	<u>F</u> unctional	Ctrl+Alt+F
	<u>D</u> ischarge Planning	Ctrl+Alt+D
	P <u>C</u> E	Ctrl+Alt+X
	<u>V</u> iew Text	Ctrl+Alt+V

RN Reassessment window, 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
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 to radiogroup:	Mode of arrival	Go
	Mode of arrival Admitted from Primary Language	



- 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.

Viewing Previously Entered Data

Some of the information entered during the admission assessment or a reassessment is pulled forward to the current reassessment.

- Prior responses to many questions are embedded as read-only in the template. The responses do not show up in the new Progress Note.
- Although the prior response cannot be edited, in many places the information can be updated.

For example, the Primary Language is identified as English and can be updated.

Admitting diagnosis: NONE FOUND Prior patient response to "What does patient want to accomplish by this hospitalization" pain free	Preferred Language C English C Spanish C Other * Other Language
Additional goals for hospitalization	Prior patient response: English

Prior patient response: English Primary language For example, Advance Directive information was not requested in the previous assessment. Now the patient requests information on Advance Directives and a consult can be sent.

GENERAL INFORMATION				
Des palient have an * Location of Advance Directive Advance Directive Yes No Promotive teamores NO	Patient received info on Advance Directive C Yes C No Prior patient response: YE	* Explain why patient did not receive info	Does patient wish to initiate or make to an Advance Directive Yes No Prior patient response: NO	changes [Social Work Consult]
The pateric response. No	The pateric response. The		*** Social Work	consult previously sent ***

Prior response: No

Does patient wish to indicate or make changes to an Advance Directive

• Some data entered on one page in the template also displays on another page. Information entered on the Psychosocial tab, P/S Page 3 displays on the Discharge Planning tab shaded in yellow.

ISCHARGE PLANNING				
Patient/family/support person able to respond to questions	" 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
Does patient have a legal/ redical guardian (conservator)?) Yes) No led from P/S Page 3	* Specify guardian (conservator)	* Employment Status C Presently employed C Unenployed C Retired C Disabled C Patient declines to answ	* Describe employment status	* Relationship status Co-habitating Divorced Married Separated Single Widowed Patient declines to answer
With whom does patient live Alone Family Significant Other Friend Nursing Home Assisted Living Homeless Patient declines to answer	Home environment No identified problems Stais to enter home Stais to enter home Bed on main level Full bathroom on main level Bed & full bathroom on same floor (r Other architectural barris (e.g. nar Patient declines to answer	* Other architectural baniers not main level) now doorways	* Special Equipment Needed at HC No equipment needed Specially bed Specially matterss Ramp Raised toilet seat Safety bars Other	ome - Other equipment needed
Transportation for Discharge Own car Friends/Vamily Bus VA Shuttle VA Shuttle VA Travel Other Patient declines to answer	* Other transportation for discharge	General observations/commer	NS	
				DP Page 1 DP CP

RN Reassessment, Discharge Planning (DP) tab, DP Page 1 window

Navigating the RN Reassessment Tabs

The RN Reassessment template has 18 tabs.

General Information (Gen Inf)

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

<mark>Èile <u>T</u></mark>	Rea abs	sses <u>H</u> elp	sme	nt - i	ZMSI	HTSV	NLSI	DHY	s,ch	UUN	(11	.10)	Wai	rd: P	HX-A	DM:	ISSIO	N SCI	HEDU	LED	>
GENE	ERAL II	VFOR	IOITAN	N																	
* Patier able to (• Ye	nt/family o respon	/suppor d to que O No	t person stions			o one res	spond		Otherrea	son no o	ne could	respond	* Inform Pa Au Fai Me	nation obl tient thorized s mily/Supp rdical Rec ner	ained fro surrogate port Perso cord	m *	Other sourc	e of inform:	ation		
Demog Name: Age: 11 Admitting Prior patie accomplis	praphics ZMSHT 00 Sex: g diagno ent resp sh by this	SWLSD MALE sis: NON onse to ' s hospite	HYS,CH Race: IE FOUN What do lization''	UUN BLACK (D	DR AFRIC	CAN A			Pref C Er C Si C O	erred Hea nglish banish ther Languag	althcare I	Languag	e								
* What do accomplis	oes patie sh by thi	nt want s hospita	to Ilization''						Prior pat	ient resp	onse:										
																Genll	Page 1 _ G	ien I Page	2 <u>Gen I</u>	Page 3	Gen I Page 4
Gen Inf	Educ	Pain	<u>IV</u>	Resp	CV	Neuro	GI	GU	<u>M/S</u>	Skin	P/S	Rest	MH	Func	DP	PCE	View Te:	«		7	
erforming	g asses	sment						*	esignate:	s a requir	ed held		io to rad	iogroup:	able to r	espond	o questions	▼	Lio	1	

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 1 window

Gen I Page 1 contains information that is similar to its equivalent on the RN Assessment. It is previously entered information and is read-only.

- 1. Click Gen I Page 2.
 - Gen I Page 2 displays.
- 2. Populate Gen I Page 2, if necessary.
| *Meds brought in by patient
*Yes
No
Spinbus/Cultural Assessment - Patient's Religion: PROTESTANT, NO DENOMINATION
Are there religious practices or spinbal
ryproserve the patient was the chapter
or special case team
remethers to immediately know about
*Describe practices/concerns
*Describe patient have any traditional,
*Describe patient response:
*Describe concerns
*Describe concerns
*Describe notices
*Describe patient response:
*Describe concerns
*Describe notices
*Describe notices
*Describe concerns
*Describe notices
*Describe notices
* | NE FOUND | sterday's and Today's Orders
RDERS YESTERDAY & TODAY - | Veste
ORD | Allergies | dication/Altergies
* Outpatient ***
* Nothe FOUND ***
* IV ***
* UNE FOUND ***
* Unit Dose ***
* NONE FOUND *** |
|--|---------------------|---|------------------------|---|---|
| members to immediately know about Prior patient response: That need to be pat of care Prior patient response: Prior patient response: Prior patient response: * Does patient have any concients * Does patient have a pastron of Specify pastor or dergo * Does patient have any concients * Does patient have a pastron of Specify pastor or dergo * Does patient have any concients * Does patient have a pastron of Specify pastor or dergo * Does patient have any concients * One patient response: * Does patient tesponse: * One Prior patient response: Prior patient response: | * Type of patch | oump/medication * Is patient wearing any
of medicinal patch
C Yes
C No | an *Type of device/pum | di " Other Disposition * Implanted mode
pumps or devic
" Yes
No
PROTESTANT, NO DENOMINATION | * Disposition of med
* Pase
No
initual/Cultural Assessment - Patient's Religion: PF |
| ior patient response: Prior patient response: * Describe concerns * Descr | escribe practices | * Does patient have any traditional
ethnic, or cultural practices | te
Chaplain Consult | e practices/concerns * Patient requests an imm | e there religious practices or spiritual * Describe p
cerns the patient wants the chaplain,
sician, and other health care team |
| Prior patient response: Prior patient response: |) escribe practices | * Does patient have any traditional
ethnic, or cultural practices
that need to be part of care
C Yes C No | te
Chaplain Consult | e practices/concerns * Patient requests an imm
Prior patient response: | e there religious practices or spiritual * Describe p
cerns the patient wants the chaplain,
sician, and other health care team
embers to immediately know about-
* Yes C No |
| | Jesoribe practices | * Does patient have any traditional ethnic, or cultural practices that need to be part of care | te Cheplein Consult | Practices/concerns Prior patient requests an imm Prior patient response: concerns C | e there religious practices or spinitual "Describe p
cents the patient wants the chaptain,
scient, and other health care team
enthers to immediately know about-
'Yes 'No
* Describert teaponse:
* Describert |
| Gen [Pane 1] [Gen [Pane 2]] Gen [Pane | Jescribe practices | * Does patient have any traditional
ethnic, or cultural practices
that need to be part of care
Yes No
Prior patient response:
27 | te Cheplain Consult | Procession Prior patient requests an imm Prior patient response: concerns Clergy who should be notifie of this hospitalization Of this hospitalizatio | e there religious practices or spinitual " Cesoribe p
cens the palent wants the chaptain,
icitian, and other health care team
embers to immediately know about"
'Yes No
tpatient response:
" Does patient have any concerns
or special condications if a
" Disod transfusion in a ended
" Yes No |

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 2 window

Gen I Page 2 contains information that can be updated, as well as information that is read-only.

- Allergies are added on Gen I Page 2, in the Allergies text box.
- None of the fields on Gen I Page 2 is required during reassessment, provided a completed admission assessment is on file.

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.

iearch for:	Search	C Observed/Historical	* Nature of reaction Allergy	¥
dde-Click one of the following items:	Sign/Symptoms		rments	

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.

Enter causative agent for Allergy or Adv Enter 3 or more letters of the causative agent and then pre a comprehensive search. Only one reactant may be enter Search for: CAN	erse Drug Reaction: ss the Search Button to allow for sd at a time. Search Cbserved/Historic Cbserved C	al * Nature of reaction * Historical Allergy	•
Double Cick one of the following Hems: CANTIL FLAIN CANTEL CANTULA NEX FLUS CANUUCA NASAL CAYVEEN CANDIDA 1:100 SKIN TEST CANDIDA 1:100 SKIN TEST CANDIN CANCIDAS 50MG INJ CANCIDAS 50MG INJ CANCIDAS TOMG INJ CANCASA 1000MG DEP CANDIASA 1000MG DEP CANDIASA 1000MG DEP CANDIASA 1000MG DEP CANDASA 1000MG DEP CANDA	Sign/Symptoms THRDAT CONGESTION THRDAT CONGESTION THRDAT SPASMA THRDAT SPASMA THRDATONE SPASMA THRDMOD/TOPENIA FROM HEPAF ULCERATION OF SKIN ULTICARIA ULCERATION VETIS VECILES IN SKIN	Convnerks	

Add New Allergies window with Sign/Symptoms available

- 5. In the Observed/Historical box, select **Observed** or **Historical**.
- 6. In the Nature of reaction text box, select Allergy, Pharmacological, or Unknown.
- 7. Select one or more reported signs/symptoms.
- 8. Click **OK** and the allergy is saved in the Adverse Drug Reaction (ADR) file. Information displays to confirm the allergy is saved.

Inforn	nation 🗙
i)	Allergy save done!
	ОК

Information : Allergy save done!

- 9. Click **OK**.
- 10. Click Close.

Initiating a Social Work Consult for Advance Directives

All of the consults in RN Reassessment work the same way; refer to the instructions in *Working in the Consults* on page 24.

1. Click Gen I Page 3.

Gen I Page 3 displays.

RN Reassessment - ZMSHTS File Iabs Help	WLSDHYS,CHUUN (1110) Ward: P	HX-ADMISSION SCHEDULED
GENERAL INFORMATION		
Advance Directive		
* Does patient have an * Location of Advance Direct Advance Directive C Yes C No	ve "Patient received info on "Explain why patient did not Advance Directive	* Does patient wish to initiate or make changes to an Advance Directive C Yes C No
Prior patient response:	Prior patient response:	Prior patient response:
* Testing for MRSA brochure/equivalent information given to the patient/authorized surrogate C Yes C No	* Was the below Infection Control Education	
Prior response: * Did the patient/authorized surrogate agree to MRSA Nares swab on admission/transfer/discharge	Hand hygiene practices Definition of MRSA, VRE, TB, and all resistant organisms Definition of MRSA, VRE, TB, and all resistant organisms Drated of resistant organisms/prevention Ontact Precautions (as related to patient condition) Respiratory Precautions (as related to patient condition) Urgiest site (as related to patient condition) Other	
Prior patient response: Level of Level of	understanding Precautions	
	Airborne Contact Droplet Neutropenic	
"Why wasn't MRSA Nares swab performed MRSA Nares swab performed with potent's a With potent's a Yes C No MRSA Nares swab performed with potent's a MRSA Nares swab performed with potent's Nares swab performed with potential Yes States	wwb.performed on transfer sgreement Refused NA ab netformed on directory *"Why wasn't it performed	
with patient's a Vites (No f	ou pennine un auriege gement fretued NVA	Gen Pane 1 Gen Pane 2 Gen Pane 3 Gen Pane 4
Gen Inf 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:	to an Advance Directive Go
Performing assessment		//

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 3 window

- 2. Populate Gen I Page 3.
- 3. Make appropriate selections in the Advance Directive section.
 - If the patient wants to initiate or make changes to an Advance Directive, you are required to order a Social Work Consult.

RN Reassessment - ZMSHTSWL <u>File Iabs H</u> elp	SDHYS,CHUUN (1110)	Ward: PHX-ADMISSION SC	
GENERAL INFORMATION Advance Directive *Does patient have an *Location of Advance Directive Or Yes Or Yes No Prior patient response:	* Patient received into on Advance Directive G Yes C No Phior patient response:	elient did not. * Does patient wish to initiate or me to an Advance Directive C Yes C No Prior patient response. Social wor	ake changes Social Work Consult & consult mandatory

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 3 window, Social Work Consult Mandatory

Note: You cannot upload a Progress Note, unless you order the Social Work consult.

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.

RN Rea <u>File T</u> abs	i sses : <u>H</u> elp	smei	nt - I	BDYI	DXY,	EHY	UNV	VED/	٩AD	N (5	5105)) Wa	ard: I	РНХ	-ADM	IISSI	ION	SCH	IEDUL	ED	_ 🗆 >	<
GENERAL Emergency of Con Relation Add: Work PI	LINFOR contact info tact: B ship: W ress: 9 Fi none: 2 hone: Q	MATIC promation DYDXY, IFE 908 RC ARM HI 07-001 CYQFZS	HYUN BIN NH LL, II -6182	WEDAAI	DW	Cha	nge Conl	act			Ger	neral obs	ervations	/commer	nts							
Support P Document th	erson sam	e as eme	ergency (contact	he patier	t's supp	ort persor	1														
Gen Inf Educ	Pain	IV	Resp	<u>cv</u>	Neuro	<u>GI</u>	<u>GU</u> * D	M/S	Skin sarequi	P/S red field	Rest	MH	Func	DP	Gen I F	age 1	Gen IP ext	age 2	Gen I Pag	= 3 G	en IPage 4]
Performing asse	ssment																					

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 4 window

Emergency contac	t information		
Contact Relationship Address Phone	: BDYDXY,EHYUN : WIFE : 9908 ROBIN NE FARM HILL, ID : 207-001-6182	WEDAADW	Change Contact
Work Phone	: QCYQFZS		
* Name (LN,FN):			Save Contact
* Relationship:			
Street Address 1:			Cancel Contact
Street Address 2:			
Street Address 3:			
* Zip Code:			
Phone:		Work Phor	ne:
Support Person	same as emergency o	ontact	
Document the nar	ne and contact inform	ation of the patient	's support person

Emergency Contact and Support Person Information

- 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.

Education (Educ)

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

Educ Page 1 contains information that can be updated, but none of the fields on Educ Page 1 is required during reassessment.

Patient/family/support person * Why could n able to respond to questions	io one respond	* Other reason no one o	ould respond	* Information obtained from Patient Authorized surrogate Family/Support Person Medical Record Other	* Other source of inform
* Other education leve	4	[*] Has ability to read C Yes C No Prior patient response:	* Describe why unable to	reed C Yes C No Prior patient response:	* Describe why unable to
Grade Strold Junio high school High school College Graduate school Other Refuses to answer	Learns best by Doing Hearing/Listenin Reading Seeing	Prefers Group Classes Individual Approac Prefers support per Computer based tra	n (1:1) son to be included ining	 Readiness to learn Ready to learn States not interested in learning States teaching not needed Impeded by current condition 	
patient response: Saniers to learning *D escribe identified b Nore Identified Learning Language Limited attention span Memory Pain Sedation Lethargy Visual Impairment	erriers * Other barriers	* Knowledge of current reason for hospitaliza identified by patient C None C Limited C Extensive	* Info illness, surgery, on t ion etc as	Prior petient response: imation provided to patient/support person the following topics BCMA Managing Your Pain Notification of the Joint Commission Patient Rights 2 Responsibilities Patient Statey Concerns Prevention of Statey Prioration of a Restaint Free Environment Other	* Other topic provided
		Prior patient response:	Joint Cor	mmission Phone Number: 1-800-994-6610	Educ Page 1 Educ

RN Reassessment, Educational Assessment (Educ) tab, Edu Page 1 window

1. Click Educ.

Educ Page 1 displays.

2. Update Educ Page 1, if necessary.

3. Click Educ CP.

Educ CP displays.

RN <u>File</u>	Rea abs	ssessme <u>H</u> elp	nt -	ZMSI	HTS	WLSE	HYS	,JLU)	KA	(312	2)	War	d: Pŀ	IX-ADN	415510	N SC	CHEDU	ILED		
EDU	CATIO	I-PROBLEM	S/INTE	RVEN	TIONS	/DESIRI	ED OUT	LCOME:	3	Click	a row t	o upda	ate its pr	roblem eva	aluation and	l interve	ention stat	us.		
TAB	PROBL	EM	DA	TE IDEN	ITIFIED	DESIRED	OUTCO	MEPROB	EVAL	PROB	EVAL D	ATE	ITERVEN	ITION		INT	STARTED	INT STAT	JS INT :	STATU
NONE																				_
	1																			
Do Do	not displa	y resolved proble	ims	Add Ne	ew Probl	em /	his proble	View hi	istory fo	r this pro	blem									
Probl C N C D C Ir C F C U	em evalu lo chang reteriorati nproving lesolved Inresolve	ation e/Stable ng d at discharge		tervention Comple Continu Discon	n status eted ue tinue			OK Cancel												
																	Ec	luc Page 1	Educ	CP
Gen Inf	Educ	Pain IV	Resp	CV	Neuro	GI	GU	M/S	Skin	P/S	Rest	MH	Func	DP F	CE View T	「ext				
orformin	0.0000	remont			_		*De	signates a	a require	ed field	(ão to rac	diogroup:	Problem eva	aluation				_	

RN Reassessment, Educational Assessment (Educ) tab, Educ CP window

4. Update Educ CP.

Refer to the instructions in *Working in a Care Plan* on page 12.

Pain (Pain)

The Pain tab in reassessment is similar to the tab in the Admission - RN Assessment.

- If **Is pain is a problem for patient** was documented as **Yes** in the Admission RN Assessment, it is pulled into the RN Reassessment.
- If **Is pain is a problem for patient** was documented as **No** in the Admission RN Assessment, the reassessment pages work like those in Admission RN Assessment. If there is no pain at the time of the reassessment, all pain locations are unavailable.

AIN ASSESSMENT Is patient having any pain now Yes No			Pa * Pa Non	in Location in Region e	#1	Y	" Qualit	y of pain]			
• Unable to respond to questions	Patient on Paliat since last	has been place ve/Comfort Car patient assessi	e nent	* Severit (0=none	y of Pain - 10=wors	1) T				" Desc	of origina	pain (year	s, months) sin
			×9	/hat makes	: pain wors	e	* Othe	r provokin	g factor(s)) escribe Pi	in Radiation
Does patient exhibit behavioral dicators related to pain	* Other behavioral	indicator	~ V	/hat makes	: pain bette				rer paliativ	: factor(s)	×ţ	ix/Oto Me	is helping pa
	" Behavioral indicat	or(s) observed	4×	reas of life	affected b	y pain			ents for pat	ent's life a	spects * Wh to t	Pain at pain leve te patient (Goal (is acceptab)-10)? ▼
	🗖 0th	er pain location	?										
							Pain Pa	ige 1	Other Pain	Other	Pain 2	Pain Cor	nm Pair

RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window

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.

Complete all fields with asterisks; they are required fields. c.



RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window Is Patient having any pain now with Yes selected

2. When Pain Location #1 is complete and you have more pain locations to document, select the Other pain location ? check box.

Other Pain page displays.

Pain Location #2				-Pain Location	#3				
* Pain Region	* Quality of pain			* Pain Region		* Quality of pain			
* Other pain region	* Other quality of pain	Onset of original pa	in (years, months)	* Other pain re	gion	* Other quality of p	pain (Inset of original pa	in (years, months)
* Severity of Pain (0=none - 10=worst)		* Describe other tim	ing of pain	× Severity (0=none	v of Pain • 10=worst]			esoribe other timi	ng of pain
What makes pain worse	* Other provoking factor(s)		What makes p	ain worse	* Other provok	ing factor(s)		
		* Describe Pain F	adiation					' Describe Pain Ri	adiation
What makes pain better	* Other palliative factor(s) * Rx/Oto Med	is helping pain	What makes p	ain better	* Other pallia	tive factor(s)	* Rx/Oto Me	ds helping pain
Areas of Ife affected by pain	* Comments for patient's f	fe aspects <u>Pain (</u> "What pain ley to the patient (0	ioal el is acceptable 1707?	Areas of life af	fected by pain	* Comments fo	r patient's life a	spects Pain G *What pain lev to the patient (C	oal el is acceptable 110)?
			More pain I	ocations?					
					Pain Page	0ther Pain	Other Pain 2	2 Pain Comm	Pain CP

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

- 3. **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.

 When Pain Locations #2 and #3 are complete and you have more pain locations to document, select the More pain locations? check box. Other Pain 2 displays.

Pain Location #4 * Pain Region	* Quality of pain						Pain L * Pain	ocation # Region	5		* Quality	of pain				
None		-					None			Y			w.			
* Other pain region	* Other quality of pain		iset of orig	ginal pain	(years, n	nonths)	* Othe	pain reg	ion		* Other q	uality of pa	ain	Onset of	original pai	n (years, month
* Severity of Pain (0=none - 10=worst)			lescribe c	ther timin	g of pain			* Severit; (0=none	y of Pain • 10=wors	21) •				* Describ	e other timi	ng of pain
what makes pain worse	* Other provoking fa						What r	nakes pa	in worse			er provoki	ng factor(s)			
			* Descri	be Pain F	adiation									* Des	cribe Pain	Rediation
What makes pain better	* Other palliative	factor(s)	* Rx/C	Ito Meds	helping p	ain	Whatr	nakes pa	in better			Other pali	ative factor(s) * Fi	x/Otc Med	s helping pain
Areas of Ife affected by pain	* Comments for	areas of life	* What r to the	Pain Gr pain level patient (0	al is accep -10)?	table	Areas (of life affe	cted by p	ain		Comments	for areas of	life * What to the	Pain Go pain level patient (D	al is acceptable 10]?
					Y											Y
									Pain	Page 1	1 CTOR	er Pan	Other Pair	12 Pa	in Comm	Pain CF

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

- 5. **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.
- 6. 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

When No is selected on Pain Page 1, many fields are unavailable and no documentation is necessary.

PAIN ASSESSMENT Is patient having any pain now O Yes © No				Pair * Pair None * Other	Location Region	#1	Ŧ	* Qualit	y of pain	é nzin	~					
Unable to respond to questions xplain if new occurrence	Patie on Palli since la	nt has been p ative/Comfort ist patient ass	laced Care essment		* Severi (0=none	y of Pain -10=wor	st]			, brent		* Describe	other ti	ming of p	in	<u>,</u>
					nat make:	: pain wo	se	* Othe	er provok	ing factor			* De	escribe Pa	in Radia	ition
Does patient exhibit behavioral ndicators related to pain	* Other behavior	al indicator			nat makes	: pain bet	er			Ither palli	ative fac	tor(s)		v/Oto Med	ls helpin;	g pain
	" Behavioral indic	ator(s) observ	ed	* Are	eas of life	affected I	y pain			ments for	patient'	ife aspec	ots ≈`What to the	Pain I pain leve patient ((<u>iroal</u> I is accej I-10]?	ptable -
		ther pain loca	tion?											I		
								Pain Pa	age 1	filther P	Pain 1	Other Pai	n 2 1	Pain Con	- 1	Painf

RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window Is patient having any pain now/No

Explain if new occurence Pailed has been placed on Pailed/ve/Contont Care since last patient assessment is contact. State and the patient assessment is contact. State	PAIN ASSESSMENT T is patient having any pain now Yes No Unable to respond to questions		Pain Location #1 * Pain Region None * Other pain region	* Quality of pain * Other quality of pain	Onset of original pain (years, months)
*Whit makes per worse *Other provoking factor(s) *Describe Pain Radiation *Describe Pain Radiation *Describe Pain Radiation *Whit makes per worse *Other provoking factor(s) *Describe Pain Radiation *Whit makes per better *Other policitive factor(s) *RivDic Meds helping per Fidgeting Fidgeting Registre Vocalization *Whit makes per better *Other policitive factor(s) *RivDic Meds helping per *Areas of life affected by pain *What pain for patient's fife aspects *What pain for voting	Explain if new occurence	 Patient has been placed on Palliative/Comfort Care since last patient assessmen 	* Severity of Pain (0=none - 10=worst)		* Describe other timing of pain
Oescribe Pain Radiation **Describe Pain Radiation ***Describe Pain Radiation ***Describe Pain Radiation *********************************			* What makes pain worse	* Other provoking factor(s)	
Coes patient exhebit behavioral indicator related to pain Construction Conste					* Describe Pain Radiation
Control Underford Comments for patient's file aspects Comments for patien	* Does patient exhibit behavioral indicators related to pain	* Other behavioral indicator	" What makes pain better	* Other calliative	: factor(s) " Rx/Oto Meds heloing pain
Comments for patient's fire aspects Comments Comments for patient's fire aspects Comments Comments for patient's fire aspects Comments	Rody Rigidly Crying Facial Grimacing Fidgeting Fidghtened Facial Expression Frowning				
Other pein location?	L Moening			* Comments for pati	ent's life aspects
	Vocaling Vocalization Negative Vocalization Noisy Breathing Sad Facial Expression Unable to console, distract, or reassure Other	* Behavioral indicator(s) observed			Pain Goal "What pain level is acceptable to the patient (0:10)?
	Hopping Vocalization Hopp Brackhing Saf Facial Expression Unable to console, distract, or reassure Other	* Behavioral indicator(s) observed			Pain Goal * What pain revel is acceptable to the patient (0-107 *

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

RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window Is patient having any pain now/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 indicators 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.

File	Tab	eas s F	ses Ielp	sme	nt - 2	ZMS	HTS	VLSI	DHYS	6,CH	UUN	(11	10)	War	d: Pl	HX-A	DMI	SSIC	ON SO	CHE	DULE		<u> </u>
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	-			NI																			
	aeneral (observ	ations	/commer	nts											_							
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Gen	Inf Edu	uc F	Pain	IV	Resp	CV	Neuro	GI	GU	M/S	Skin	P/S	Rest	мн	Pain Func	Page 1 DP	PCE	r Pain View T	ext 0	Pain 2	Pain Corr	m	Pain UP
									* D	esignate:	s a requir	ed field											
Perfor	ming as	ssessi	ment																				//.

RN Reassessment, Pain Assessment (Pain) tab, Pain Comm window

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

4. Click Pain CP.

Pain CP displays.

IRN	Reasse abs <u>H</u> elp	ssme	nt - Z	MSHTS	WLSI	DHYS,	JLUXA	(312	22) \	Nar	d: PH	X-AI	DMIS	SIO	n sc	HED	ULED	_	. <mark></mark> ×
PAIN	- PROBLEM	S/INTE	RVENTIO	ONS/DESIR	ED OUT	FCOMES		Click	a row to	o upda	ite its pro	oblem (e∨aluati	ion and	interve	ntion st	atus.		
TAB	PROBLEM		DAT	E IDENTIFIED	DESIRE	D OUTCOM	E PROB EVA	L PROE	EVAL D	ATE IN	TERVEN	TION			INT	STARTE	D INT ST	ATUS IN	NT STATU
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- Dor	not display resol	ved proble	ems	Add New Prob	lem	this problem	View history	for this pr	iblem		Problem/I	Intervent	ion detail						4
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Gen Inf	Educ Pain	IV	Resp	CV Neuro	GI	GU	M/S Skin	P/S	Rest	<u></u>	Pain Pa	ige 1	Other F	ain	Other Pai	in 2	Pain Comm	Pair	CP
rformin		•				* Des	ignates a requ	ired field	6	ào to rac	liogroup:	Interven	ition statu	s		•	Go		

RN Reassessment, Pain - Problems/Interventions/Desired Outcomes, Pain CP window

5. Populate Pain CP.

Refer to the instructions in Working in a Care Plan on page 12.

IV (IV)

On the IV tab, document new IV locations and Dialysis access, as well as update existing IV locations and Dialysis access.

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.

NONE Add New IV Locat NONE Add New IV Locat Show discontinued IVs also Image: Show discontinued IVs also It Perphetal Line Site * Other location • Other location * Other location • Date/time inserted IV Discontinued distributed • Date/time inserted IV Discontinued distributed • Date/time inserted IV discontinue date/time • Date/time change East changed: Dressing change East changed: Dressing date/time change Tubing date/time change Tubing date/time change * Other site. There dessing condition * Dressing type * Other change	Add New IV Location Add New IV Location Add New IV Location Add New IV Location Charge Tubing change Last change Tubing date/time change Tubing date/time change Tubing date/time change Tubing date/time change Carcel ed Carcel ed Carcel ed			DATE INSERTED	SIZE			
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	Cancel ed							
—								Cancel e

RN Reassessment, IV (IV) tab, IV Periph window No IV/vascular access device selected

Peripheral Lines - IV Periph

Existing IV Lines

If IVs were present at time of the Admission – RN Assessment or in previous reassessments, those IVs display on the IV tab.

Show discontinues in the site of the site	IDN bital Right	DATE INSERTED Unknown	512E	NO	YES	Add Ne	ew IV Location
Antecu Antecu Show discontin Response Line Site:	ondal Hight	Unknown	166	NU	YES		
Show discontin	and B (a plug						
it Peripheral Line Site	nen ivs gizo						
		-tion			* Other size		
ocation					O THE SIDE	🔲 IV Discontine	ued
	_	* Date/time inserted				IV discontinue d	ate/time
	Dressing change Last changed: Dressing date/time change	Tubing change Last changed: Tubing date/time chan	nge				
ther dressing conditio	n *Dressing type *Other dr	* Site characteristics	,	* Drainage * Ot	her site appearance * D	escribe patency	OK Cancel ed

RN Reassessment, IV (IV) tab, IV Periph window with an existing IV line

- 1. Populate IV Periph.
- 2. Select an existing IV and the edit fields for the selected IV are made available. Complete all the fields with asterisks; they are required fields.

RN Eile	l Rea : <u>T</u> abs	s sessment - Zl <u>H</u> elp	MSHTSWL	SDHYS,CHUU	N (11	10) W	ard: PH)	(-ADM)	SSION SC	HEDULED	
N		No IV/vascular access devic	es								
S	ielect a pe	ipheral line. Numbers may n LOCATION	ot be sequential if you	aren't showing D/Ced IV	(s.	Iniscor					
	1	Antecubital Bight		nknown	16.0	NO	I INOLD	YES		Add New IV Loca	stion
Fedit P *Loca C C	Show of eripheral Lation Ante ressing Clean, dry Drainage	iscontinued IVs also ine site #1 cubited Right ; intect Directing cha	Other location	* Date/time inserted Yes * Date/time inserted Tubing changed	known No]	Size 16 G 18 G 24 G 24 G 0 Other 9 Other 9 Other	* Other size	I V diş	"Discontinued continue date/time	
* Oth	Other er dressing	Dressing dete/tim condition * Dressing type Bandaid Gauze Transparent Other None	e change "Other dressing type	Tubing date/time cha * Site characteristics Drainage Pain Redness Swelling Other	omplications	* Drainage	* Other	site appearar	Ce * Describe pat		OK.
							IV Periph	IV Cer	tral IV Dialysi	is IV Comments	IV CP
Gen Inf	f Educ	Pain IV Resp 0	V Neuro GI	GU M/S Sk	in P/S	Rest MH	Func D	P PCE	View Text		
Performi	ing asses	sment		* Designates a re	quired held						

RN Reassessment, IV (IV) tab, IV Periph window with existing IV line

- 3. To cancel entered data *before upload*, click **Cancel edit**.
- 4. To upload updated information, click **OK**.

New IV Lines

V 🗖 🗌	No IV/vascular access devices rinheral line . Numbers may not be s	equential if you aren't showing D/C	ed IVs			
NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED	
1	Antecubital Right	Unknown	16 G	NO	YES	Add New IV Location
2				NO		
Show of	discontinued IVs also					
dit Peripheral L	ine site #2 × Other	location*Date/time inse	arted known	× Size	* Other size	_
location	•	C Yes * Date/time inset	C No ted	C 16G		V Discontinued
				C 20 G C 22 G C Other		IV discontinue date/time
	Dressing change	Tubing chan	ge	C Unknown		
	Last changed: Dressing date/time chan	ge Tubing date/time	e change			
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Other dressing	Last onengeo: Dressing date/time chan g condition * Dressing type *Othe	ge Tubing date/time r dressing type	e change tics	* Drainage * Othe	r site appearance " Dr	escribe patency
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Other dressing	Last cranged: Dressing dete/lime chan g condition * Dressing lype *Olhe	ge Tubing date/time r dressing type	e change tics	* Drainage * Olfre	r site appearance * Dr	escribe patency OK Cancel edit
Other dressing	Lest changes : Dressing date/time chan g condition * Dressing type * "Othe	ge Tubing deter/im r dressing type * Site characteria	e change tics	* Dreinage * Othe	r site appearance "Dr	escribe patency OK Cancel edit
Other dressing	Last changes . Dressing date/time chan g condition * Dressing type = *Othe	ge Tubing deter/im r dressing type * Site characteris	e change tics	" Drøinage " Othr	r site appearance "De	escribe patency OK Cancel edit
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RN Reassessment, IV (IV) tab, IV Periph window

5. Click Add New IV Location.

The Location drop-down list box displays in the **Edit Peripheral Line site #1** section.

- 6. Select a location and additional fields become available. Complete all the fields with asterisks; they are required fields.
- 7. To cancel entered data *before upload*, click **Cancel edit**.
- 8. To upload updated information, click **OK**.

R <u>F</u> ile	N Reas	s sessment · <u>H</u> elp	- ZMSHTSW	LSDHYS,CHUU	JN (11	10) War	d: PHX-	ADMISSI	ON SCHEDULE	D _ 🗆 X
IV		No IV/vascular access	s devices							
	Select a per	ipheral line. Numbers	may not be sequential if	you aren't showing D/Ced I	Vs.					
	NUMBER	LOCATION		DATE INSERTED	SIZE	DISCONTI	NUED	UPDATED		
	1	Antecubital Right		Unknown	16 G	NO		YES	Add New IV I	Location
	2					NO				
Edit *Lo	Show d Peripheral L acation Fore Dressing Clean, dry Drainage Other	iscontinued IVs also ine site #2 arm Right , intact Dressing de	* Other location T ng change ged: <i>Le / Time</i> change	*Date/time inserte C Yes C • Date/time inserted Tubing date/time ch Tubing date/time ch	d known No		e * (16 G 18 G 20 G 22 G Diher Jinknown	Ditter size	✓ IV Discontinued IV discontinue date/im ✓ IV patent ☞ Yest	YP
	ther dressing	condition * Dressing Bandai Gauze Transp Other None	type "Other dressing d arent	* Site characteristics ✓ No evidence of Orainage Pain Redness Swelling Other	complications			e appearance	Describe patency	OK Cancel edit
						[IV Periph	IV Central	IV DialysisIV Comme	nts VCP
Lien	ni Educ	Pain IV Re:	sp UV Neuro (ai <u>GU</u> M/S <u>S</u>	kan P/S	<u>Hest</u> MH	Func DP	PUE View	lext	
Perforn	ning asses	sment		- Designates a r	equired held					///

RN Reassessment, IV (IV) tab, IV Periph window with a peripheral line location

9. To add another IV location, repeat steps 6 through 8.

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

Central IV Lines – IV Central

1. Click IV Central.

IV Central displays.

NUMBER TYPE		LOCATION	DATE INSERTED	DISCONTINUED	UPDATED	
1 Tunn	eled catheter - Single Lumen	Radial Right	Unknown	NO	YES	Add New Cl. Landford
						Add New LL Location
Show discontin	nued Central Lines also					
Edit Central Line Site						the text in second text
* Туре	👻 🕆 Location					atheter impregnated
	* O ther location					
				Uentral line disc		
	Dressing change	Lubing change * Date	/time inserted	Central line discontinue	date/time	
	Last changed	Last changed:				
	Last changed: Dressing date/time change	Last changed: Tubing date/time change				
	Last changed: Dressing date/time change	Last changed: Tubing date/time change				
* Other dressing conditio	Last changed: Dressing date/time change	Last changed: Tubing date/time change type * Site characteristics	* Drainag	e * Others	ite appearance	* Describe patency
* Other dressing conditio	Last changed: Dressing date/lime change m * Dressing type * Other dressing	Last changed: Tubing date/time change type *Site characteristics	× Drainag	e × Others	ite appearance	* Describe patency
* Other dressing condition	Last changed: Dressing date/time change m * Dressing type * Other dressing	Last changed: Tubing date/time change type * Site characteristics	* Drainag	e * Other s	ite appearance	* Describe patency
* Other dressing conditio	Last changed: Dressing date/time change n * Dressing type * Other dressing	Last changed: Tubing date/time change type * Site characteristics	* Drainag	e * Other s	ite appearance	*Describe patency
* Other dressing conditio	Last changed Dressing date/time change n * Dressing type * Other dressing	Last changed: Tubing date/time change type * Site characteristics	* Drainag	e * Other s	ite appearance	* Describe patency
* Other dressing condition	Lat changed Dressing dete/time change in "Dressing type "Other dressing	Last changed. Tubrig date/time change type "Site characteristics	* Drainag	e * Others	ite appearance	* Describe patency
* Other dressing conditio	Last changed Dressing date/time change n * Dressing type * Other dressing	Last changed: Tubing date/time change type * Site characteristics	* Drainag	e * Other s	ite appearance	* Describe patency
* Other dressing conditio	Lat changed. Dressing dete/time change m * Dressing type * 0 ther dressing	Last changed: Tubing dite/time change type * Site characteristics	* Drainag	e * Others	te appearance	* Describe patency Cancel edit.
* Other dressing conditio	Last changed. Dressing date/time change m * Dressing type * Other dressing	Lat changed. Tubing date/time change type * Site characteristics	* Dreineg	e "Others	ite appearance	* Describe pelency Cancel edit
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* Other dessing condition	Last changed. Dressing date/time change n * Dressing type * Other dressing	Lat changed. Tubing dite/time change (ype * Site characteristics	* Dreineg	e "Others	te appearance	* Describe patency Cancel edit

RN Reassessment, IV (IV) tab, IV Central window

2. Populate IV Central.

3. Click Add New CL Location. The Type drop-down text box displays in the Edit Central Line site #1 section.

<mark>@ RN</mark> <u>F</u> ile <u>T</u>	Reasse abs <u>H</u> elp	ssment - ZMSHTSWLS	DHYS,CHUUN (1:	10) Ward:	PHX-ADMIS	SION SCH	
IV	Select a cer	ntral line. Numbers may not be sequential if y	ou aren't showing D/Ced Central Lin	es.			
	NUMBER	TYPE	LOCATION	DATE INSERTED	DISCONTINUED	UPDATED	
	1	Tunneled catheter - Single Lumen	Radial Right	Unknown	NO	YES	
	2				NO	NO	Add New CL Location
-Edi × T.	Show di: it Central Line s ype Implanted	scontinued Central Lines also ite #2 I port - Single Lumen v) ate/time inserted know Yes	רוא	× Cat	heter impregnated antiseptic and/or antibiotic
Ċ	Dressing Clean, dry, ir	* Other location	Tubing change * Date	No /time inserted	Central line disc	ontinued C Y date/time C Y	'es CNo CUnknown heter power injectable 'es CNo CUnknown
0	Drainage	Last changed: Dressing date/time change	Last changed: Tubing date/time change				*IV patent C Yes O No
	ther dressing c	ondition *Dressing type *Other dressing Bandaid Gauze Transparent None	* Site characteristics No evidence of c Drainage Pain Redness Swelling Other	* Draine	ge *Othersit	e appearance	* Describe patency Cancel edit
Gen Inf	Educ Pain	IV Resp CV Neuro GI	GU M/S Skin P/S	Rest MH Fi	/ Periph IV Central	IV Dialysis	V Comments V CP
Performin	g assessmen	nt	* Designates a required field				

RN Reassessment, IV (IV) tab, IV Central window

4. Select a type and a location.

Complete all the fields with asterisks; they are required fields.

- 5. To cancel entered data *before upload*, click **Cancel edit**.
- 6. To upload updated information, click **OK**.
- 7. To add another central line, repeat steps 3 through 6.

Dialysis Ports - IV Dialysis

1. Click IV Dialysis.

IV Dialysis displays.

1 Central	Venous Catheter (Dialysis cathete	e Arm - Right, upper	Unknown	16 G	NO	YES	Add New Dialysis Loca
Show discontinu	ed Dialysis access locations also						
Dialysis access locati	on #		cation * Other locati				* Other size
10		None					
	Dressing change			* Date/time in	nserted		🔲 Dialysis catheter disconti
	Last changed: Dressing date/time change	La:	Tubing change st changed:	Tubing dat	te/time change		Discontinue date/time
ner dressing condition	* Dressing type *Other dressin	ng type * Site characteristi	cs	* Drainage	* Other site app	sarance	OK
							Cancel edit

RN Reassessment, IV (IV) tab, IV Dialysis window

- 2. Populate IV Dialysis.
- Click Add New Dialysis Location. The Type and Select Dialysis location drop-down list boxes display in the Edit Dialysis access location #1 section.
- 4. Select type and location. Complete all the fields with asterisks; they are required fields.

RN <u>File</u>	l Rea <u>T</u> abs	I SSES <u>H</u> elp	sment	- ZMS	SHTS\	VLSDI	IYS,CH	UUN	(1110)	Wa	rd: P	РНХ-А	DMIS	SION	SCH	IEDULED	_ <u> </u>
IV																	
	Select a	dialysis I	ocation. Nur	nbers may n	ot be seque	ential if you a	aren't showing	D/Ced loca	tions.	ler	75	Inisco	NTINUED	Lupp.	ATED	т	
	1	Contra	- al Manaum Ca	thatar (Diali	uis asthata	Arm Diaht	upper	Unke		10	26	NO	INTINOED	VEC	ALED.		
	2	Cenu	ai verious ca	itrieter (Dialy		Allin - rught,	. upper	UNKI	UVWI	10	Ju	NO		NO		Add New	Dialysis Location
	2											NU		NU			
I *Typ enou C C	Show Dialysis ac le ssing Clean, dry Drainage Other	discontir cess loca er (Dialys , intact	ation #2 s catheter - T Last ch Dressing c	riple Lumen sissing chang anged: late/time ch	Non-tunne je	* 1e51 💌	Select Dialys None	is location Tubin	* Other loc] g change ed:	ation * Da	ate/time i	a te/time in: Yes inserted ate/time ch	serted know C No	n Size C 18 C 20 C 22 C 0 Ur	i G I G I G I her nknown	* Other size Dialysis ca Discontinue d	theter discontinued
	er dressin	g conditi	on * Dressing Band Gauz Trans Other None) type *0 aid parent	ther dressin	g type ×	Site characte No signs/ Bruit/thrill Drainage Pain Redness Swelling	ristics symptoms of present not present	complice		ainage	×	Other site a	ppearance			OK Cancel edit
Gen In	f Educ	Pain	<u>IV R</u>	esp <u>CV</u>	Neuro	GI	iU M/S	Skin	P/S Rest	MH	IV Peri Func	iph	V Central	IV Dialy	vsis	IV Comments	
Performi	ing acco	cemont					* Designate	s a required	field								
renorm	ing asse	sament															11

RN Reassessment, IV (IV) tab, IV Dialysis window

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.

Warni	ng 🗙
1	Place arm band. No blood pressure or needle sticks in the arm that the AV Fistula is in!
	ОК

Warning: Place arm band.

No blood pressure or needle sticks in the arm that the AV Fistula or AV Graft is in!

- 5. To cancel entered data *before upload*, click **Cancel edit**.
- 6. To upload updated information, click **OK**.
- 7. To add another dialysis access location, repeat steps 2 through 6.

General Observations/Comments – IV Comments

- 1. Click **IV Comments**. IV Comments displays.
- 2. Populate IV Comments. Use the **General observations/comments** text box for additional information.

RN Rea	ssessr Heln	nent - I	ZMS	HTSV	VLSI	DHY	S,CH	UUN	(11	10)	Wa	rd: Pl	HX-/	ADMI	SSIC	ON SC	CHEDU	LED		
Enc Table	Trub																			
IV																				
General obser	vations/com	nents								_										
												IV Peri	ph	IV Centr	al 🗌	IV Dialysis	IV Com	ments	IV CP	
Gen Inf Educ	Pain IV	Resp	CV	Neuro	GI	GU	M/S	Skin	P/S	Rest	MH	Func	DP	PCE	View T	ext				
Performing asses	ssment					* 0	esignate	s a requi	red field											

RN Reassessment, IV (IV) tab, IV Comments window

Care Plan - IV CP

- 1. Click **IV CP**. IV CP displays.
- 2. Update IV CP.
- 3. Add/update a problem evaluation and/or intervention status, if necessary. Refer to the instructions in *Working in a Care Plan* on page 12.

IV- TAB Pf NONE	PROBLEMS/INTEI	RVENTIONS/DESIR	RED OUTCOMES	PROB EVAL	Click a row to u	pdate its problem	evaluation and interv	vention status.	INT STATUS INT S
TAB Pf	ROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DAT	EINTERVENTION	1	NT STARTED	INT STATUS INT S
NONE									
• Do not	display resolved probles	ms Add New Prob Add New Inten	lem	View history for	this problem	Problem/Interver	tion detail		
Proble C N C D C Irr C R C U	em evaluation o change/Stable eteriorating proving esolved nresolved at discharge	Intervention statu C Completed C Continue C Discontinue C Pending		OK Cancel		IV Periph	IV Central V Dia	lysis IV Con	nments IV CP
Gen Inf E	duc Pain IV	Resp CV Neuro	GI GU M	/S Skin	P/S Rest M	IH Func DP	PCE View Text		
Performing	accoccmont		* Desig	inates a require	d field Go t	to radiogroup: Interve	ntion status	▼ Go	

RN Reassessment, IV – Problems/Interventions/Desired Outcomes (IV) tab, IV CP window

Respiratory (Resp)

In the Respiratory tab, update or add breathing information to reflect the condition of the patient during a current reassessment.

Responses from the previous assessment/reassessment are hard-coded into the reassessment, but the information is not transferred into the Progress Note of the current assessment.

Alle for espond or questions	* Other respiratory pattern	Conserved and the second and th
Verter has a bialogy of * Other History And me reported * Respiratory pattern OCPD Promovay Embolis Putmonay Embolis * Respiratory pattern Opper respiratory infections * Respiratory pattern Other * Respiratory respiratory respiratory rate Work of breathing * Other work of breathing * Other work of breathing * Other work of breathing	* Other respiratory pattern	* Respiratory depth Normal Deep Shallow * Chest movement Equal, bildered, symmetrical Abnormal
None reported Astma COPD Pulmoray Enboli Pulmoray Fibrois Upper repriatory infections TB Other * Respiratory rate ① ◆ * Other work of breathing * Other work of breathing	* Other respiratory pattern	-* Respiratory depth C Normal C Deep C Shallow -* Chest movement C Equal, bildered, symmetrical C Abnormal
* Respiratory rate		C Equal, bilateral, symmetrical C Abnormal
Thespiratory rate Vork of breathing Other work of breathing Other work of breathing		C Abnormal
And of breathing * Other work of breathing		
Nasal laring Cyanolis Dirhopnee Citos Conore Pursed Los Cestoy muscles Conore Other Central - to Other	ngue and lips earlobes, fingertips, around lips	
* Breath sounds Absent Crackles/Rales Diminished/decreased Rhonchi	Wheezing - expiratory	Wheezing - inspiratory
C Clear		C Stridor
C Abnormal		Pleural friction
		, , , , , , , , , , , , , , , , , , , ,
	Resp Page 1 Resp Page 2	Other CT Loc Resp Page 3 Resp

RN Reassessment, 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** 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.

RESPIRATOR	YASSESSMENT					
Productive of Prior response:	cough present	* Sputum ge derate all Free e:	color * Other spur		* Sputum consistency Frothy Mucous Plugs Thick Thin Other	* Other sputum consistency
-Chest tubes → Chest tubes pr Prior response: NC	resent * Location 1	* Suction	* Other suction	* Air Leak	* Chest tube drainage	* Dressing * Other dressing
	Location 2	" Suction	* Other suction	" Air Leak	" Chest tube drainage	* Dressing * Other dressing
C Other ches	at tube locations					
☐ Other ohes -Facility ordered o ▼ Facility ordered	t tube locations oxygen d oxygen C 1 L/Min C 2 L/Min C 3 L/Min C 3 L/Min C 0 Uher	* Other iter flow	°Via C Bipap C Cpap C Cantula C Catheter C Mask C Other	* Other delivery method	Oxygen saturation %	antilator dependent - chronic Bator dependent - chronic comments
☐ Other ches -Facility ordered ▼ Facility ordered	at tube locations xxygen C 1 L/Min C 2 L/Min C 3 L/Min C 0 ther	* Other Iter Nov	→ Via Bipap C Capap C Cambater Mask Other intory Consult	* Other delivery method	Oxygen saturation 2 Veri	entilator dependent - chronic Jator dependent - chronic comments Differ CT Loc Resp Page 3 Resp CF
☐ Other oftes Facility ordered ✓ Facility ordered	at tube locations xxygen C 1 L/Min C 2 L/Min C 3 L/Min C 4 L/Min C 0ther ain V Resp C	Other liter flow Resp V Neuro GI	· Via · Bipap · Capp · Capter · Mask · Other intony Consult GU M/S Skin	Other delivery method	Oxygen saturation % Vent	entilator dependent - chronic lator dependent - chronic comments Ditter CT Loc <u>Resp Page 3 Resp Cf</u> ex

RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 2 window

RESPIRAT	ORYA	SSESS	MENT																	
									her sputu	m color					outum con		° Other sputu	n consister		
Product	ive cougł	present																		
Prior respon	ise:																			
			Prior respo	onse:																
-Chest tubes																				
Chest tub Prior response	es preser e: NO	t * Lov Right A Date/tin 12/08/	cation 1 Interior me inserter /11	1 16:11		ction Vaterseal 20 cm 10 cm Other		her sucti		* Air Le No Slij La Air Into	rak ne ght bubbli rge air lea leak on ii ermittent epitus pre	ng on ex k on exp hspiration air leak sent	piration iration /expiratio		hest tube None Small Moderat Large Serous Serous	drainage e guinous	* Dressing Clean, o Drainag Other	e e	Other dress	ing
Chest tube	removed	Locatio Right F Date/tir 12/08/	n 2 Posterior me inserte	d 16:11	* Suc	ction Waterseal 20 cm 10 cm Dther	* 01	her sucti	m	* Air Le No Sli La Air Into Cre	ak ne ght bubbli ge air lea leak on ii ermittent epitus pre	ng on ex k on exp hspiration air leak sent	piration iration /expiratio		hest tube None Small Moderat Large Serous Serous Bloody	drainage e guinous	* Dressing Clean of Drainag Other	rv, intact e	Other dress	ing
-Facility orde	red oxyge dered oxy	n	* Liter flov C 1 L/M	r in	* Othe	r liter flow		* Via O Bip	ap	0ther	delivery (nethod	Oxyg	en satu	ation %	<mark>⊏ Ver</mark> *Ventil	ntilator depen ator depende	dent - chror nt - chronic	nic comments	
			C 3L/M C 3L/M C 4L/M C Other	in in				C Ca C Ca C Ma C Oth	nnula theter isk ner											
						Respir	atory Co	nsult												
															-					
													Resp P	age 1	Resp Pa	age 2	Other CT Loc	Resp Pa	ige 3 F	Resp C

RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 2 window Chest tube locations 1 and 2

4. Populate Resp Page 2.

Complete all the fields with asterisks; they are required fields.

- a. If the Respiratory Consult is set up at your site, use the Respiratory Consult button to order the consult, in accordance to the condition of the patient and the policy of your medical center.
- b. Refer to the instructions in Working in the Consults on page 24.
- c. Select the **Other chest tube locations** check box. The Other CT Loc page is made available.
- 5. Click **Other CT Loc**.

Other CT Loc displays.

6. Populate Other CT Loc, CT locations 3 and 4, if necessary. Complete all the fields with asterisks; they are required fields.

RN Reass <u>File Tabs H</u>	essment - 2 elp	ZMSH	TSWLS	SDHY	S,CH	UUN	(11	10)	War	d: Pl	HX-A	DMI	SSIC	ON SCH	IEDUL	.ED	<u>_ ×</u>
RESPIRATOR	Y ASSESSMENT																
Chest tubes	* Location 3 Bight Posterior Date/time inserte 12/08/11	.d 16:12 ↔	* Suction Waters 20 cm 10 cm	eal	Other sucti	on	* Air Le No Slin Air	aak me ght bubb rge airle leak on	ing on exp ak on exp nspiration	piration iration J/expiratio		est tube d None Small Moderat Large	rainage_	* Dressing Clean, Drainag Other	dry, intact ge	* Other dre	ssing
Chest tube rem	ved * Location 4		* Suction		Other sucti	on	* Air Le	ermittent epitus pre eak	air leak isent		× Che	Serous Serosan Bloody est tube d	guinous rainage	* Dressing		* Other dre	ssing
			1														
										Resp F	Page 1	Resp P	age 2	Other CT Loc	Resp F	Page 3	Resp CP
Gen Inf Educ Pa	in <u>IV Resp</u>	Resp	CV Neu	ro GI ×	GU Designates	J <u>M/S</u> sarequir	Skin ed field	<u>P/S</u>	Rest	MH	Func	J DP	PCE	View Text			

RN Reassessment, Respiratory Assessment (Resp) tab, Other CT Loc window Other CT locations, Location 3 and Location 4

7. Click Resp Page 3.

Resp Page 3 displays.

Trachecently inserted Track centry of the series of the s	Other trach type	* Size known Yes © No * Tracheostomy size	* Stoma appearance No problems observed Redress Svelling Svelling Stutues Tissue breakdown present Dither Trach removed * Removed date/rin	* Other stoma appearance Dressing ch * Dressing detex	* Dressing Clean, dy, intact No dressing/open to air Other * Dressing type ange? time change	* Other dressing * Other dressing type
* Tobacco screen C Lifetime non-tobacco user G Former tobacco user C Lurrent tobacco user Patient declines to answer * Tour toponse: * Quit time frame G Patient TATES that he/sl C Patient Quit tobacco more	iow quit he has quit within the than 12 months ago b	* Type of tobacco used past 12 months and now cr ut less than 7 years ago	onsiders his/herself a non-smoker	Instructions for A patient MUS1 consider thems If the patient he to state that the then classify pa General Obser	former usage STATE: that they quit within the elves a non-user. This cannot be s not used in X days/weeks/mon by have quit and consider themse tient as a current tobacco user. valions/Comments	e last 12 months, and nov the staff's conclusion. ths, but is not willing tves to be a non-user,
 realient qui tobacco more t proximate quit date: obacco education Patient states he/she not int Education not appropriate du Education net appropriate du Education with patient/sup Discussion with patient/sup Brochure/handouts provider 	rear / years ago erested in learning ab ue to patient condition oxygen and smoking port person re importa port person re importa to n tobacco use ces tion class or clinic	iout smoking cessation to fire potential nee of stopping smoking (st nee of not resuming smokin sation eed during hosnital stay or a	op using tobacco) g or tobacco use t discharge			
Referral to a smoking cessat Support of nicotine replacem	hent therapy if prescrib		~			

RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 3 window contains the Tobacco screen

8. Populate Resp Page 3, if necessary.

Complete all the fields with asterisks; they are required fields.

9. Click **Resp CP**.

Resp CP displays.

@ RN <u>F</u> ile 1	Reassessment <u>F</u> abs <u>H</u> elp	- ZMSHTS	WLSDHYS,:	JLUXA ((3122) Wa	ord: PHX-A	DMISSION	SCHEDU	JLED	
RES	PIRATORY - PROBLEM	S/INTERVENTIC	INS/DESIRED OU	JTCOMES	Click a row to up	date its problem	evaluation and ir	ntervention sta	tus.	
TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION		INT STARTED	INT STATUS	INT STATUS I
NONE										
					1	Problem/Interver	tion detail			Þ
1 00	nor display resolved problems	Add New Prob	em	View history for	this problem					
Pr C C C C	oblem evaluation No change/Stable Deteriorating Improving Resolved Unresolved at discharge	Intervention statu C Completed C Continue C Discontinue C Pending	IS	OK Cancel						
Gen Inf	Educ Pain IV Re	sp CV Neuro	GI GU M	1/S Skin	P/S Rest Mł	Resp Page 1	Resp Page 2	ther CT Loc R	esp Page 3	Resp CP
Performir	ng assessment		* Desig	gnates a require	d field Go to	radiogroup: Interve	ntion status	▼ G	•	

RN Reassessment, Respiratory - Problems/Interventions/Desired Outcomes (Resp) tab, Resp CP window

10. Update Resp CP, if necessary. Refer to the instructions in *Working in a Care Plan* on page 12.

Cardiovascular (CV)

Document the cardiovascular reassessment of a patient in the Cardiovascular tab.

ARDIOVASCULAR ASSESSMENT							
Patient/Tamily/support person able to respond to questions Yes No	spond	* Other reason no or	ne could respond	* Information obtain Patient Authorized surr Family/Support Medical Record Other	ned from ogate i Person d	* Other source of i	information
	Edema and L	ocations - Mark only t	he locations where e	edema is found			
Patient has a history of "Other history Anome reported Anome and the second sec	* Edema • Ves • No Sacral C Trace C 1+ Pitting C 2+ Pitting C 3+ Pitting C 4+ Pitting C N/A Prior resp.	Facial C Trace C 1+ Pitting C 2+ Pitting C 3+ Pitting C 4+ Pitting N/A Promesp. Right hip C 1+ Pitting C 2+ Pitting C 3+ Pitting C 4+ Pitting C 4+ Pitting C 4+ Pitting C 3+ P	Periorbial C Trace C 1+ Pitting C 2+ Pitting C 3+ Pitting C 4+ Pitting C N/A Priorresp Left hip C Trace C 1- Pitting C 2+ Pitting C 3+ Pitting C 4+ Pitting C 4+ Pitting C 3+	Right arm C Trace C Trace C 1+ Pitting C 2+ Pitting C 3+ Pitting C 4+ Pitting N/A Phorresp Right leg C 1+ Pitting C 3+ Pitting C 4+ Pitting C 4+ Pitting C 3+ Pitting C 4+ Pitting C 4+ Pitting C N/A Phorresp	Left arm C Trace C 1+ Pitting C 2+ Pitting C 3+ Pitting C 4+ Pitting C 4+ Pitting C 1+ Pitting C 2+ Pitting C 2+ Pitting C 3+ Pitting C 3+ Pitting C 3+ Pitting C 3+ Pitting C 4+ Pittin	Right hand C Trace C 1+ Pitting C 2+ Pitting C 3+ Pitting C 4+ Pitting C N/A Priorresp: Peddal right C Trace C 1+ Pitting C 2+ Pitting C 4+ Pitting C 4+ Pitting C 4+ Pitting C N/A Pitorresp:	Left hand C Trace C 1+ Pitting C 2+ Riting C 3+ Riting C 4+ Pitting C N/A Prior resp. Pedal left C Trace C 1+ Pitting C 2+ Riting C 3+ Riting C 3+ Riting C 4+ Pitting C N/A Prior resp.
Extremities Extremities commer	nts	Auscultation					
U Varm Cool Cool Capillary Refil Less than 3 Seconds Capillary Refil Greater than 3 Seconds Prior comments		* Heart Rate		* Heart rhythm C Regular C Irregular	 * Heart sounds O Normal O Abnormal 	* Describe abnorm	al sound
tior response:							
							- 1

RN Reassessment, 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.

RN Reassessment - ZMSH File Tabs Help	TSWLSDHYS,CHUUN (1110) Ward: P	HX-ADMISSION SCHEDULED
CARDIOVASCULAR ASSESSMENT	Dorsalis Pedis Pulse Posterior Tibis Left Right Left	al Pulse Right
* Describe venou "Jugular Venous Distemión C Yes C No Prior response:	s distension Homan's sign Negative Positive Prior response: Negative Prior response: I call rain resorted on Residue of foot	C No
Cardiac devices	Permanent pacemaker * Other cardiac device Other device	Prior cardíac montor response: * Other cardíac montor rhythm
General observations/comments		T Wave:
	PR Interval: QRS Duration:	QT interval: ST Segment:
Gen Inf Educ Pain IV Resp CV M	leuro Gi GU M/S Skin P/S Rest MH Func	CV Page 1 CV Page 2 CV CP
Performing assessment	*Designates a required field Go to radiogroup:	Jugular Venous Distensión ▼ Go

RN Reassessment, Cardiovascular Assessment (CV) tab, CV Page 2 window Cardiac monitor selected

- 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.
- 5. Click **CV CP**.

CV CP displays.

RN	Reassessme r [abs <u>H</u> elp	nt - i	ZMSH	TSV	VLSDH	YS,JI	LUXA	(312	2) \	Varo	d: PH	IX-AD	MISS	SION	SCH	EDUL	ED	_ [
CARI	DIOVASCULAR - PRO	OBLEM	IS/INTER	RVEN	TIONS/DE	SIRED	OUTCOM	IES	Click a	row to	update	its probl	em eval	uation e	und interv	vention s	status.		
TAB	PROBLEM	DA	TE IDENT	IFIED	DESIRED OU	TCOME	PROB EVAL	. PROB	EVAL D	ATE IN	TERVEN	TION		INT S	TARTED	INT STA	ATUS I	NT STATUS	6 DATE
NONE																			
•																			►
E Dev	not display resolved proble	-							. 1		Problem/	Interventio	n detail						
	not display resolved proble		Add New	v Proble	m	V	iew history f	or this pro	blem										
		_	Add Nev	v Interv	ention to this p	problem													
- 0.	alda a such a fair																		
C	No change/Stable		C Comp	on stat	us		OK												
0	Deteriorating Improving		C Conti	inue															
0	Resolved		C Pend	ing			ancel												
	- children at alcohargo																		
															CV Page	1 CV	Page 2		CP
Gen Inf	Educ Pain IV	Resp		Neuro	GI GU	J <u>M</u> /	S Skin	P/S	Rest	MH	Func	DP	PCE 1	View Text		-	-		
rformin	ng assessment					" Design	ates a requi	red held	G	o to rad	logroup:	priterventi	on status		▼	40	1		

RN Reassessment, Cardiovascular – Problems/Interventions/Desired Outcomes (CV) tab, CV CP window

6. Update the CV CP, if necessary. Refer to the instructions in *Working in a Care Plan* on page 12.

Neurology (Neuro)

Document the neurology reassessment of a patient in the Neurology tab.



RN Reassessment, 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.
| RN Reassessment - ZMSHTSWLSDHYS,JL
File Tabs Help | UXA (3122) Ward: | PHX-ADMISSIC | DN SCHEDULED |
|---|---|---|--|
| NEUROLOGICAL ASSESSMENT
Motor
Instructions for performing motor assessment
Assess motor strength bilateally. Have the palert like and extend am against
your hand, spacead that lingers; lik lay while you press down on the thigh:
hand, Brade each externity using the scale below.
S + Active movement of externity against gravity and maximal resistance
4 - Active movement of externity against gravity and moderate resistance
3 - Active movement of externity against gravity and moderate resistance
4 - Active movement of externity against gravity and moderate resistance
2 - Active movement of externity but NOT against gravity
1 - Sight movement (likes of contraction)
0 - No movement | Right am Left am C 5+ C 5+ C 4+ C 4+ C 2+ C 2+ C 1+ C 1+ C 0 C 0 C N/A Phor resp: | Right leg Left leg C 5+ C 5+ C 4+ C 4+ C 2+ C 2+ C 1+ C 0 C N/A C N/A Prior resp: Prior resp: | Speech/language
Clear
Abnormal - Stured
Abnormal - Aphasio
Abnormal - Dysathric
Other
Prior response:
* Other speech/language |
| Pupts
Very lens implant/prosthesis
Prior response:
* Describe new lens implant/prosthesis
* Describe new lens implant/prosthesis
* Other pupt
C Equal
C Right greater than light
C Other
Prior response: | Bight eye
C Brisk rea
C Some re.
C No react
Prior response | Ees
action to light
action to light (sluggish)
tion to light
x | Left eye
C Brisk reaction to light
C Some reaction to light
No reaction to light
Prior response: |
| * New sensations present.
Sensations - New paresthesias or neuropathies present device to mee
Prior response: Prior response: Prior response: | " New communication
at basic needs | device needed General obs | ervations/comments |
| Gen Inf Educ Pain IV Resp CV <u>Neuro GI GU M/S</u>
"Designal | Skin P/S Rest MH | Func DP PCE View
group: Right arm | Neuro Page 1 Neuro CP |
| Performing assessment | | | 11 |

RN Reassessment, Neurological Assessment (Neuro) tab, Neuro Page 2 window

- 4. Populate Neuro Page 2.

 - a. Complete all the fields with asterisks; they are required fieldsb. Use the General observations/comments text box for additional information.
- 5. Click Neuro CP.

Neuro CP displays.

R File	N I	Reassessment abs <u>H</u> elp	- ZMSI	HTS	WLSDH	YS,J	LUXA ((3122) \	Vard	l: PH)	(-ADMISSI	ON SCHE	DULED	_ 🗆 X
NE	EUI	ROLOGICAL - PROBLEM	S/INTER\	/ENTI	ONS/ DESI	REDOU	JTCOMES	Click a ro	nw to up	odate its	problem evaluat	ion and interve	ntion status.	
TAE	3	PROBLEM	DATE IDEN	TIFIED	DESIRED OU	тсоме	PROB EVAL	PROB EVAL D	TE INT	FERVENT	ON	INT STARTED	INT STATUS	INT STATUS DATE
NO	NE													
		·												
		1												Þ
	-	1									terrentien deteil			
Г	Doi	not display resolved problems	6 JU 81	D LI				this problem	F					
			Add Ne	SW FIOD	em		new miscory for	uns problem						
			Add Ne	ew Inten	vention to this p	problem								
	Pro	blem evaluation	Intervent	ion statu	15		OK							
	0	No change/Stable	C Comp	bleted			UK							
	č	Improving	C Conti	nue										
	C	Resolved	C Disco	ontinue		(Cancel							
	C	Unresolved at discharge	C Pend	ing										
_												Neuro Page 1	Neuro Page	2 Neuro CP
Lien	inf	Educ Pain IV Re	sp <u>CV</u>	Neuro		<u>м</u> /	S Skin	P/S Rest	мн	Func		ew lext		
Dorform	nin	a passagement				* Desigr	nates a require	d field G	o to radio	ogroup: II	ntervention status	▼	Go 📔	
renom	nin	y assessment												h

RN Reassessment, Neurological – Problems/Interventions/Desired Outcomes (Neuro) tab, Neuro CP window

6. Update Neuro CP, if necessary. Refer to the instructions in *Working in a Care Plan* on page 12.

Gastrointestinal (GI)

Document the gastrointestinal reassessment of a patient in the Gastrointestinal tab.

Patient/family/support person able to respond to questions © Yes C No	* Why could no one respon	d * Other reason in	o one could respond	 * Information obtained ✓ Patient Authorized surroga Family/Support Pe Medical Record Other 	from [×] Other sour te rson	ce of information
Patient has a history of "Of None reported Bleeding - Stool Constipation Diarthea Incontinence of stool Nausea Vorming Other	her history	Abdominal Assessment * Abdomen * Other a Distended Flat Guarding Non-tender Obese Rigid Round Soft Tender Other	abdominal assessment	Bowel sounds Present C A Present bowel soun Ornal C H " Last Bowel Movem C Known	Absent Ids Hypoactive C Hyper International Hyper Mathematical Hyper	Bowel sounds comments active * Date of Last Bowel Movement
Bowel regime* *Bowel pattern © Daily © Several times a week © Weekly © Other	Jther bowel pattern	* Laxative	name and frequency o	fuse	* Enema type na use	and frequency of use
Tior response: Oth Bowel program Bowel program schedule	er bowel program schedule	* Bowel care - start time	* Bowel c	are - completion time	Medicati	ion/treatment

RN Reassessment, 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.
- 3. Click **GI Dev**.

GI Page Dev displays.

RN Reassessment - ZMSHTSWLSDHYS,C File Tabs Help	HUUN (1110) Ward: PHX-ADMISSION SCHEDULED
GASTROINTESTINAL ASSESSMENT	
GI Device #1 * Type GI device comments Non: New since last assessment Date/rime	GI Device #2 * Type GI device comments None Statest essessment. Date/time
Removed since last assessment. Date//ime	Removed since last assessment Date/line
	GI Device #4
* Type GI device comments None None None Date/fime	* Type GI device comments None None New since last essessment Date/time
Femoved since last assessment Deter/ime	Removed since last assessment Date/line
Gen Inf Educ Pain IV Besn CV Neuro Gi Gi Gi	L M/S Skin P/S Best MH Func DP PCF View Text
*Design	nates a required field
erforming assessment	

RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Dev window GI Devices #1-#4

- If there are no previous devices, the fields are void.
- If the patient has a device at the time of the previous assessment, it displays in GI Device #1.

GASTROINTESTINAL ASSE	SSMENT
GI Device #1	GI device comments
Colostomy bag	
Date/time	
Removed since last assessment Date/time	

RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Dev window, GI Device #1

- 4. Populate GI Dev.
- Complete all the fields with asterisks; they are required fields.
- 5. Click **GI Dev 2**. GI Dev 2 displays.

RN Reassessment - ZMSHTSWLSDHYS,Cl File <u>T</u> abs <u>H</u> elp	HUUN (1110) Ward: PHX-ADMISSION SCHEDULED
GASTROINTESTINAL ASSESSMENT	
GI Device #5 * Type GI device comments None None Detervine	GI Device IIB Type GI device comments None New since last assessment Date/time
Removed since last assessment Date/time	☐ Removed since last assessment Date/time
GI Device #7	GI Device #8
* Type GI device comments None None None Comments Comments Date/time	* Type Gi device comments None
Removed since last assessment Date/lime	☐ Removed since last assessment. Date/ime
Gen Inf Educ Pain IV Reso CV Neuro GL GL M/S	GI Dev GI Dev 2 GI Page 2 GI Page 3 GI CP
*Design	
Performing assessment	

RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Dev 2 window GI Devices #5-#8

6. Populate GI Dev 2, if necessary.

Complete all the fields with asterisks; they are required fields.

7. Click **GI Page 2**. GI Page 2 displays.

RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ele Tabs Help GASTROINTESTINALASSESSMENT	Ward: PHX-ADMISSION SCHEDULED
Oral Screen Assessment - General Assessment - Mucous Membrane No problems /mpaiments Difficulty chewing Difficulty swallowing Attent present Poor dention No dention No dention	Nutrition screen * Appetite * Description of patient Good God God God God God God God God Go
Dietary History * Does patient have any ethnic/cultural/ * Food preferences/Special diet needs religious tood preferences C Yes C No Prior response: * Does patient have any carecial diet needs	Height: 54 in [137.2 cm] (06/29/2003 10.43) Weight: 155.35 ib [75.2 kg] (12/16/2003 14.30) BMI: DEC 16, 2009@14.30.21 *Unintentional weight loss of
Prior response: Prior food preferences	Yes No Unknown Prior response: Nuthion could guidelines So uniteritional weight gan of loss in past 30 days AsuaeAvoing/dather to greater than 3 days Less than 50% usual intake for greater than 5 days Dysphagia or dryphagia symptom
Gen Inf J Educ Pain IV Resp CV Neuro Gi GU M/S Skin P/S	age 1 Gi Dev 2 Gi Page 2 Gi Page 3 Gi CP Rett MH Func DP PCE View Text
Performing assessment	o to radiogroup: (religious food preferences VI) tao

RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 2 window

- 8. Populate GI Page 2.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. GI Page 2 contains the Nutrition Consult.
 - Refer to the instructions in Working in the Consults on page 24.
- 9. Click **GI Page 3**.

GI Page 3 displays.

RI Eile	l Rea <u>T</u> abs	<mark>isses</mark> <u>H</u> elp	sme	nt -	ZMS	HTS	VLSDH	YS,CH	UUN	(11	10)	War	d: Pl	IX-A	DMI	SSIC	on sc	HE	DULE	D	<u>_ </u>
GAS	STROIN	TESTI	NAL AS	SESS	MENT																
	Dysphag * Dyspha C Able C Unat C Unat C Unat C N/A	ia screer Igia scree to screer ble - Patie ble - Patie ble - Othe	n n ent on Ve ent uncor er	ntilator	* Othe	r reason u	nable to scree	en * Dia hear traun	qnosis of i I and neck Iatic brain	new strok : cancer, injury	<u>Dys</u> e. [*] Mi or eati chin	ohagia ris Idified ter Ig maneu tuck; her	<mark>sk factors</mark> kture diet vers (e.; ad turn)	: / g.	* Unable follow ca	e to ommand	8				
F	Prior respo	nse:						Prior re Wet g	esponse: jurgly voic	e	Prior i Drool	esponse: ng while	awake	Pi ×	rior respor Tonque a from midli	nse: leviation ne		. Survey	Speech C	onsult	
								Prior re	esponse:		Prior i	esponse:		Pr	ior respor	nse:					
Gen In	f Educ	Pain	11/	Resp	CV	Neuro	<u>GI</u> GI	GU	M/S	Skin	GI Pa P/S	ge 1	GI D	ev	GI Dev	/2 PCE	GI Page 2	2	GI Page	3	GI CP
Porformi	ing acco	comont						* Designati	es a requir	ed field	G	o to radio	ogroup:	Dysphagi	ia screen		•	1	Go		
enorm	ing asse	sament																			//

RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 3 window

10. 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 the Speech Consult.
 - Refer to the instructions in Working in the Consults on page 24.
- 11. Click GI CP.

GI CP displays.

RI Eile	l Reassess <u>T</u> abs <u>H</u> elp	ment - I	ZMSHTS	WLSDHYS,	JLUXA	(3122) V	Vard: PH	IX-ADMIS	SION SCH	EDULED	
G	ASTROINTESTI	NAL - PROE	BLEMS/INTER	VENTIONS/ DE	SIRED OUT	COMES Click	a row to upda	ate its problem	evaluation and in	itervention statu	8.
TAB	PROBLEM	DA	TE IDENTIFIED	DESIRED OUTCOM	PROB EVAL	PROB EVAL DAT	E INTERVENT	ION	INT STARTED	INT STATUS IN	T STATUS DATE
NONE											
•											▶
☐ Do	o not display resolved	problems	Add New Prob	vention to this problem	View history for	this problem					
	Problem evaluation No change/Stable Deteriorating Improving Resolved Unresolved at disc	harge	Intervention stat C Completed C Continue C Discontinue C Pending	15	OK Cancel						
						GI Pa	<u>je 1 GI [</u>	Dev GIDe	v 2 GI Page 2	GI Page 3	GI CP
Gen Ini	f <u>Educ</u> Pain <u>I</u>	Resp	CV Neur	GI GU	M/S Skin	P/S Rest	MH Func	DP PCE	View Text		
Deuferrei				* Des	ignates a requir	ed field					
renorm	ing assessment										//

RN Reassessment, Gastrointestinal – Problems/Interventions/Desired Outcomes (GI) tab, GI CP window

12. Update the GI CP, if necessary.

Refer to the instructions in Working in a Care Plan on page 12.

Genitourinary (GU)

Document the genitourinary reassessment of a patient in the Genitourinary tab. If a patient has a GU device documented in a previous assessment, the device displays in the current reassessment.

RN Reassessment File Tabs Help	t - ZMSHTSWLSDH	(S,CHUUN	(1110) Ward:	PHX-A	DMISSI	on schi	EDULED	
GENITOURINARY ASSES	SMENT								
* Patient/family/support person able to respond to questions © Yes © No	* Why could no one respond	* Other reason no	one could resp	ond	* Information	on obtained from ized surrogate 'Support Person al Record	* Other	source of informa	tion
* Patient has a history of	Voiding								
None reported Concer Diabetes Diabetes Diabris - Pentoneal Diabris - Hemodalysis Kiney disease Neurogenic bladder exauly transmitted disease Uningy tract infections Other	Voirig * Internit Voirig * Internit No problems Anuna Dribbing Polyuria Polyuria Retention Urgency Urfer * Last voided Known U	ent cathetenzation f	requency * I	Other voiding	Color C A C Y C C C C C C C C C C C C C C C C C C	mber fellow loody inable to evaluate ther istency formal Joncentrated Jilute Inable to evaluate	C None	er color	ble to evaluate
" Other history	* Date/ime.last voided: * Abnormal discharge © None © Genital © Unable to evaluate Prior response:	Describe abnormal	discharge		Sedii C Y C L	ment 'es lo Inable to evaluate	* Desor	ibe sediment	
						GU Page 1	GU Dev	GU Page 2	GU CP
Gen Inf Educ Pain IV F	Hesp UV Neuro GI GI	<u>GU M/S</u>	Skin P/S	Best MI	H Func	DP PCE	View Text		
Performing assessment		"Designates a requi	rea held	tao to radiogro	up: [Lolor		▼	uo	

RN Reassessment, Genitourinary Assessment (GU) tab, GU Page 1 window

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

4. Populate GU Dev.

Complete all the fields with asterisks; they are required fields.

GENITOURINARY ASSESSM	ENT												
GU Device #1 * Type (None ▼ □ Inserted since last assessment Date/time inserted	BU device comme	nts		-GU De * Type None □ Ins Date/ti	vice #2— erted sinc me inserte	e last ass :d	▼ essment	GiU de	evice con	nments			
Removed since last assessment Date/time				∏ Re Date/ti	moved sir me	ce last a	sessmer	ł					
GU Device #3				-GU De	vice #4—								
* Type (None • Inserted since last assessment Date/lime inserted	âU device comme	nts		* Type None Ins Date/ti	erted sinc me inserte	e last ass :d	▼ essment	GIU de	evice con	nments			
Removed since last assessment Date/time				∏ Re Date/ti	moved sir me	ce last a	sessmer	it					

RN Reassessment, Genitourinary Assessment (GU) tab, GU Dev window

5. Click GU Page 2.

GU Page 2 displays with the Indwelling Catheter field unavailable because there is no history of an indwelling catheter.

RN Reassessment - ZMSHTSWLSDHYS, JLUXA (3122) Ward: FILEROOM-X Elle Tabs Help	×
GENITOURINARY ASSESSMENT	
Contribute Arbeidson Periodes Content Vision Periodes Content Visio	
Female patients Last mammogram Last mammogram Last mammogram Last mammogram Last mammogram Last mammogram C Known C Unknown	
Mele patients	
GU Page 1 GU Dev GU Page 2 GU C Gen Inf 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: Last mammogram V Go	<u> </u>

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

Current Devices Current Devices None Continuous Ambulatory Peritoneal Dialysis Continuous Bladder Irrigation	* Indwelling catheter size	* Other device	Concerns voiced regarding sexual functioning
Continent Urinay Diversion (e.g.ileo-conduit) External calheter (condom) Indivelling urinay calheter Nephrostomy bag Ureterostomy bag Uther Cother	Prior repsonse	Indwelling removed	*Sexual Functioning concerns voiced
emale patients Pregnancy			
Approxim	iate date	Approximate date	Approximate date
Approxim Nale patients Last prostale exam date Approximate d	iate date	Approximate date	Approximate dete
Approxim Male patients	iete date. Iote	Approximate date General observations/comments	Approximate dote
Approxim Male patients Last prostate exam date C Known C Unknown No previous exam reported Last PSA: -NONE FOUND	iate date.	Approximete date General observations/comments	Approximete dete
Approxim Male patients Last prostate exam date C Known C Unknown C No previous exam reported Last PSA: -NONE FOUND	lete	Approximate date General observations/comments	Approximate date

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

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

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

Indwelling Catheter

If the presence of an indwelling catheter is documented, the size of the indwelling catheter is available when this data is **not** entered in a field that is pulled forward.

The size of the catheter can be entered in a previous reassessment on the GU Dev page in the **General observations/comments** text box.

RN Reassessment - ZMSHT	SWLSDHYS,CHUUN	(1110) Ward: PHX	-ADMISSION SCHEDULED	_ 🗆 X
<u>File Tabs H</u> elp				
GENITOURINARY ASSESSMENT				
Genitourinary Devices * Current Devices		* Other device		
None Continuous Ambulatory Peritoneal Dialysis Continuous Bladder Irrigation	* Indwelling catheter size		Concerns voiced regarding sexual functioning	
Continent Urinary Diversion (e.g.ileo-conduit) External catheter (condom)	Prior repsonse		* Sexual Functioning concerns voiced	
Indivening urnary catheter Nephrostomy bag Suprapubic catheter Ureterostomy bag Dither	Indwelling recently inserted	Indwelling removed		

RN Reassessment, Genitourinary Assessment (GU) tab, GU Page 2 window

This data is pulled forward to the next reassessment template when entered in an admission assessment or a previous reassessment.

7. Click GU CP.

GU CP displays.

TAB PROBLEM DATE IDENTIFIED DESIRED DUTCOME PROB EVAL PROB EVAL DATE INTERVENTION INT STARTED INT STATUS INT NONE INT INT <th>INT STATUS I</th>	INT STATUS I
NORE Image: Constraint of the second of	
Problem/Intervention detail Add New Froblem Add New Intervention to this problem	
Do not display resolved problems Add New Problem View history for this problem Add New Intervention to this problem	
Problem/Intervention detail Problem/Intervention detail Add New Problem Add New Intervention to this problem	
Do not display resolved problems Add New Problem View history for this problem Add New Intervention to this problem Add New Intervention to this problem	
Add New Intervention to this problem	
Problem evaluation Intervention status	
C Deteriorating	
C Improving C Discontinue Cancel	
C Resolved C Feeding	
Diabetes Nurse Consult	

RN Reassessment, Genitourinary – Problems/Interventions/Desired Outcomes (GU) tab, GU CP window

8. Update GU CP, if necessary.

Refer to the instructions in Working in a Care Plan on page 12.

Musculoskeletal (M/S)

Document the musculoskeletal reassessment of a patient in the Musculoskeletal tab.

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.

Alternizanys support person adels to respond to questions Paient has a history of None reported Amputation(s) Amputation(s) Anthritis Back pain Cancer Cancer Cancer Cancer Cancer Cancer Cancer Fractures Hip pain Muscela Aprophy Muscela Aprophy Muscela Aprophy Muscela Cystrophy	Why could no one response	na - Uth * Body part(s) at	n reason no one	Could respond * Informatic V Patien Author Formiy Medici Other * Range of FOM Cumite Limitec Limitec	n obtained from ized surrogate /Support Person al Record Motion No apparent problem (ROM - Right Upper Extremity IROM - Left Upper Extremity IROM - Right Upper Extremity	Uner source or information Stated patient complaints
Patient has a history of Nore reported Anputation(i) Anthritis Back pain Cancer Cerebral Paky Deformity(ies) Fractures Hip pain Muscla Aptrophy Muscula Dystrophy	* Describe ofher history	* Body part(s) ar	nputated	* Range of ROM Limited Limited Limited	f Motion No apparent problem BROM - Right Upper Extremity BROM - Left Upper Extremity BROM - Right Lower Extremity	Stated patient complaints
] Neck pain] Other					IROM - Left Lower Extremity	
				General of	servations/comments	

RN Reassessment, 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.

3. Click M/S Page 2.

M/S Page 2 displays.

MUSCULOSKE	LETAL AS: nent indicated	SESSN	IENT -	MORSE	E FAL	L SCALE							I	nstructions History of f	for comp	leting Mor	se Fall S	Scale		
* History of falling	Des	cribe pre	rvious fa	lis and his										Score as Score as before a physiolo to admis or her sc	0 if the p 25 if the p dmission gical falls sion. No core imme	atient has patient has or if there , such as l ote: If a pa idiately inc	not falle s fallen o was an irom seiz tient fall: reases b	n during the immediati sures or a sfor the f by 25.	e past thre e history n impaire irst time,	se month: of d gait prid then his
* Fracture Location	× () (her fracti	ure local	ion	H. T	ls patient c isk for fallin	m any me g or risk I	eds that for injury	increase with falls Oth	er medic	ation that	increase	:s risk	Secondary Score as chart. Score as patient's Use of mu the seco	diagnosi 0 if only o 15 if more chart; iltiple me indary dia	s: one medica e than one dications is agnosis (co	al diagno medica s implied o-morbid	osis is listi I diagnos I in the sc ity score)	ed on the is is listed cale as in	patient's I on the dicated by
		s patient	on multi	ple meds t										Ambulatory Score as assisted does nol Score as Score as for support.	aids: 0 if the p- by a nurs t get out - 15 if the j 30 if the j	atient walk se), uses a of bed at a patient use patient am	s withou wheelc all es crutch bulates	ut a walki hair, oris nes, a ca clutching	ing aid (e : on a bei ne, or a i ; onto the	ven if I rest and valker. furniture
														Intravenou Score as Score as heparin I	s therapy 0 is patie 20 if the j lock insei	: nt does no patient ha: ited.	ot have a s an intra	an IV or H avenous	teparin/9 apparatu	aline Loc s or a
														Gait: Score as walking	0 a norm with head	al gait whi d erect, arr	ch is cha ns swing	aracterize ging freelj	ed by the y at the s	patient ide, and
Total Morse Prior score: Not ass Date:	score for essed	Fall F	Risk: I	N/A		0 - 24 - 25 - 44 - 45 and h	Patient is Patient is igher - Pa	s at low i s at mod atient is	isk for fal erate risk at high ris	ing. Imp for falling k for falli	lement U). Implem ng. Imple	niversal F nent Univ ement Uni	Fall Prec ersal Fa iversal F	autions Il Precautio Fall Precaut	ns and p ions and	recautions precaution	based ins based	on identif d on iden	ied area tified area	of risk a of risk
																M/C Dag	- 1 []	4 IC D		NUC CD

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

4. Populate M/S Page 2.

Complete all the fields with asterisks; they are required fields.

5. **Optional:** To complete a Morse Scale, select **Yes** for **Fall risk assessment indicated**. If you select **Yes**, the fall risk assessment questions must be answered.

RN Eile	l Rea Tabs	sses <u>H</u> elp	sme	nt - 2	ZMS	HTSV	VLS	DHYS	6,CH	UUN	(11	110)	Wa	nrd: F	PHX-	ADMI	ISSIC	ON SO	CHED	DULEI)		×
MUS F* Fa	SCULOS all risk ass	SKELE" essment	TAL AS indicated	SESSN	/ENT -	MORS	E FALI	L SCALI								Instructions	s for comp	leting Mo	se Fall S	cale			
×H with C	Yes istory of fa hin 3 mon No (0) Yes (25)	C M alling ths	lo De	scribe pre	evious fa	lls and his										History of I Score as Score as before a physiolo to admis or her si	falling: 0 if the p 25 if the admission gical falls ssion. No core imme	atient has patient ha or if there , such as ote: If a pa diately ind	not faller s fallen d was an i from seiz tient falls treases b	n luring the p mmediate l ures or an s for the firs sy 25.	ast three history of impaired it time, th	months gait prior en his	^
* Fre	cture Loc	ation		ther fract	ure locat	ion		s patient (sk. for fallir	m any m ig or risk	eds that for injury	increase with fall: Of	: ter medic	ation th	at increas	ses risk	Secondary Score as chart. Score as patient's Use of m the seco	v diagnosi 0 if only o 15 if more chart; ultiple me ondary dia	s: one medic e than one dications i agnosis (c	al diagno • medica • s implied • morbidi	osis is listed I diagnosis in the scal ty score).	l on the p is listed o le as indio	atient's on the cated by	
C C	econdary No (0) Yes (15)	Diagnos	×	ls patieni	: on multi	ple meds										Ambulatory Score as assisted does no Score as Score as for	y aids: 0 if the p 1 by a nur: t get out 15 if the 30 if the	atient wall se), uses a of bed at patient us patient am	ks withou wheelc all es crutch bulates o	ut a walking hair, or is o nes, a cane clutching o	g aid (eve n a bed r e, or a wa nto the fi	en if est and Ilker. umiture	
	mbulatory None, be Crutches Furniture	aid drest, wl , cane, v (30)	heelchair valker (15	, other pe 5)	erson (0)			* Intrave C No (I C Yes)	nous The)) 20)	erapy/He	parin Lo	ck				support. Intravenou Score as Score as	us therapy 0 is patie 20 if the	: nt does ni patjent ha	ot have a s an intra	an IV or He avenous ap	parin/Sa iparatus	line Lock ora	
* G C C C	ait/Transl Normal, t Weak (1 Impaired	erring bedrest, i D) (20)	mmobile ((0)				* Mental O Drier O Dver	Status ited to ov estimate:	wn ability s/Forget	(O) s Limitatio	ons (15)				heparin Gait: Score as walking	lock inse 0 a norm with hea	ited. al gait whi derect, ar	ch is cha ms swing	aracterized jing freely a	by the pa at the sid	atient e, and	•
Prior Date	o tal Mo score: No c	rse sc it assess	ed	r Fall I	Risk: (1		0 - 24 - 25 - 44 - 45 and H	Patient i Patient i igher - P	s at low i s at mod atient is	iisk for fa erate risk at high ri	lling. Imp for fallin sk for fall	olement I g. Imple ng. Imp	Universal ment Uni lement U	Fall Pre versal F niversal	cautions all Precautio Fall Precau	ons and p tions and	recaution precautio	s based ons based	on identifie I on identifi 1/S Page 3	d area of ied area o	risk of risk 1/S CP	1
Gen Inf	Educ	Pain	IV	Resp	<u>cv</u>	Neuro	GI	GI	GU	M/S	Skin	P/S	Rest	мн	Fun	c DP	PCE	View Te		no rage.	<u> </u>	1/3 CF	
Performi	ng asse	ssment						× D	esignate	s a requi	red field		Go to ra	idiogroup:	: Fall ris	sk assessme	ent indica	ed 🔻	- (ào 📘			

RN Reassessment, Musculoskeletal Assessment (M/S) tab, M/S Page 2 window Morse Fall Scale

6. Click M/S CP.

M/S CP displays.

R File	N Rea Tabs	i <mark>sse</mark> s <u>H</u> elp	sme	ent - i	ZMSI	ITS\	NLSI	DHYS	6,JLU	JXA	(312	22) \	Naro	l: PH	IX-AI	OMISS	SION SCI	HEDULE	D _ 🗆 🗙
- Pi	USCULO ROBLEM -	DSKELE POTENT	ETAL - FIAL FOF	PROBL R FALLIN	EMS/IN G. DESIF	ITERV RED OU	'ENTIOI TCOME -	NS/DE: PREVEN	SIRED	OUTC	OMES /INJURY	ASSOCI	ATED W	/ITH FAL	LS		Other fall preventi based upon clinic	on intervention al judgement	2
P	niversal fal atient Educ Drient to su Purpose an	Iprecauti cation Pre rounding d use of i	ions. Ins ecaution: ps call light	stitute on a	all patient:	\$ 		Er P C	nvironme lace pat all light (lean up	ent of Carr ient article if applical spills imm	e Precau es within ble) in ea ediately	tions easy read sy reach	ch and ansv	wered pro	omptly	-			
F	Request as toileting, tr Purpose an	skiu siipµ sistance i ansfers) d use of i	for daily assistive	devices a	isuch as <u>c</u> and mobili	jetting o ty aides	ut of bed, if needed	N D N D N D N D N D N D N D N D N D N D	eep floo ock bed ock whe lodify en lace beo rovide p	r free of c wheels eelchair w wironmen d in low p roper ligh	clutter theels if a t for safe osition wl ting (nigh	pplicable transfer hen in be t lights)	ł				Morse scores No Morse s	cores on	file
Click	a row to	update M	e its pro	blem ev	/aluatio	n and i IFIED D	nterven	tion sta	tus. 1E PRO	B EVAL	PROB	EVAL DA	TEINTI	ERVENT	ION		INT STARTED	INT STATU	S INT STATUS DATE
NON																			
Do	Do not display resolved problems Add New Problem View history for this problem Problem Intervention detail																		
	Problem evaluation Intervention status Add New Intervention to this problem. No change/Stable Completed O betriating Continue O Improving Continue O Resolved Discontinue C Pending Cancel																		
Genl	nf Educ	Pain	<u>IV</u>	Resp		Neuro	GI	GU	M/S	Skin	P/S	Rest	<u></u>	Func	DP	PCE	M/S Page 1 View Text	M/S Page	2 M/S CP
Perforn	ning asse	ssment						* D	esignate	s a requir	ed field	6	ào to rad	iogroup:	Problem	evaluation		Go	-

RN Reassessment, Musculoskeletal – Problems/Interventions/Desired Outcomes (M/S) tab, M/S CP window

7. Update M/S CP, if necessary.

Refer to the instructions in Working in a Care Plan on page 12.

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

Skin (Skin)

Document the skin reassessment of a patient in the Skin tab. If a patient has pressure ulcers and skin alterations documented in a previous assessment, the information displays in the current reassessment.

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.

() RN <u>F</u> ile	I Rea <u>T</u> abs	sses <u>H</u> elp	sme	nt - I	ZMS	HTSV	VLSI	DHYS	6,CH	UUN	(11	10)	Wai	rd: P	HX-A	DMI	SSIC	N S	CHE	DULEI) [
SKI	N ASSE	SSME	١T																			
* Pal able	tient/family to respon Yes	/suppor d to que: O No	t person stions			l no one r	espond		* Otherr	eason no) one cou	ld respo	nd		* Infom Pal Au Far Me	nation obt tient thorized s mily/Supp dical Rec ner	tained from surrogate port Persor cord	1	,	Other sourc	e of info	rmation
* Patie	ent has a h	istory of			escribe a	ther		Prodice	orition fr	ar akin br	a ak down											
	one report che hlete's foc- urns ancer czema erpes Zosl jury/traum essure Uk soriasis osacea sbaceous iher	ed t er (Shing a ser cysts	gles)					Does pa Amp Diab Mult Neu Para Qua Spin	tient hav utee etes ple Scler ological plegia lysis draplegia al cord in	osis disease					* Risk Di Di Di Di Di Di Di Di	Factors one ariatric pa evice-rela abetic d of life of poalbum edication efusing to bo unstab any low Bh her	tient ted pressu care inemia · Vasopre i turn/mov le for turn: MI (Body N	ire ssors e second lass Inde	dary to p ∋x)	* Desc	ribe oth	er
Sk c ss c c	in Inspect kin Temp Warm kin Moistu Extremely Dry	on C Hot ire v dry	C C C M C D	ool C loist iaphoreti	Cold	* Skin O O O O O O	Color ormal for vanotic usky ushed undiced ottled ale her	ethnic gr	oup	Describe	other		× Skir C W Kir C Y	n Turgor √ithin No n Patche ′es ⊂	rmal Limit rs No	s 🔿 Ab * Skin Pe	onormal atch Desc	ription	Ge	neral observ	ations/c	comments_
Pr	essure ulc	ers	☐ Sk	in alterat	ons					Skir	Page 1	Skin	Pr UI 1	Skin	Pr UI 2	Skin	AILT	Skin A	lt 2	Skin Page	3	škin CP
Gen In	f Educ	Pain	IV	Resp	CV	Neuro	GI	GU	M/S	Skin	P/S	Rest	MH	Func	DP	PCE	View Te	ext				
								* D	esignate	s a requi	ed field		Go to rad	iogroup:	Skin Pa	tches		•	-11	Go		
Performi	ing asse	ssment																				11

RN Reassessment, 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.

Pressure ulcers	🥅 Skin alterat	ions																		
							Skin	Page 1	Skin	Pr UI 1	Skin F	r UI 2	Skin /	dt 1	Skin /	alt 2	Skin	Page 3	Skin	CP
Gen Inf Educ Pain	IV Resp		Neuro	GI	GU	M/S	Skin	P/S	Rest	MH	Func	DP	PCE	View 1	ext			-		
Performing accessment					* D	esignates	a require	ed field	G	io to radi	ogroup:	Skin Pal	tches			▼	Go	<u> </u>		



1. Click Skin Pr Ul 1.

Skin Pr Ul 1 displays.

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

RN Reassessment - ZMSHTSWLSDHYS,C Eile Tabs Help	HUUN (1110) Ward: PHX-ADMISSION SCHEDULED
SKINASSESSMENT	
Pressure Ulcer #1 Cocation Cocation Description of ulcer/dressing None	Pressure Ulcer #2 * Location Description of ulcer/dressing None
* Stage None	* Stage None
Pressure Ulcer #3	Pressure Ulder #4
Stage None None	None Stage None
Status None	Status None
Pressue Ulcet #5 Coation Description of ulcet/dressing None	Pressure Ulcer #B Construction of ulcer/dressing None
*Stage None Status None	* Stage None
Other pressure ulcer locations? Click here for pressure ulcer staging inform	ation
	Skin Page 1 Skin Pr UI 1 Skin Pr UI 2 Skin Alk 1 Skin Alk 2 Skin Page 3 Skin CP
Gen Inf Educ Pain IV Resp CV Neuro GI GU M/	/S Skin P/S Rest MH Func DP PCE View Text
* Design	nates a required field

RN Reassessment, Skin Assessment (Skin) tab, Skin Pr Ul 1 window

Pressure Ulcer Drop-downs

Γ	—Pressure Ulcer #1—— * Location	Description of ulcer/dressing	
	None	•	
	None Ear-Left Ear-Right Elbow-Left Elbow-Right Heel-Left Heel-Right Ischial Tuberosity Left	▲ 	

Skin Assessment - Pressure Ulcer/Location

* Location	Description of ulcer/dressing
Knee right 📃 💌	
* Stage	
Stage IV	
None Suspected Deep Tissue Injury Stage I Stage II	
Stage III	
Stage IV Unstageable	Description of ulcer/dressing

Skin Assessment - Pressure Ulcer/Stage

* Location	Description of ulcer/dressing
Knee right 🔹	
* Stage Stage IV	
Status	
New Finding	[
New Finding	
Deteriorating	
Improving	Description of ulcer/dressing
No change	presentation allocation and and a
Healing	
Healed	
Other	

Skin Assessment - Pressure Ulcer/Status

3. To enter more than six pressure ulcer locations, select the **Other pressure ulcer locations?** check box.

Skin Pr Ul 2 displays.

I	Ø Other pressure ulcer locations?										
	Click here for pressure ulcer staging information										
	Skin Page 1 Skin Pr UI 1 Skin Pr UI 2 Skin Alt 2 Skin Age 3 Skin CP										
	Gen Inf_Educ Pain IV Resp. CV Neuro GI M/S Skin P/S Rest MH Func DP PCE View Text										
	* Designates a required field										
F	Performing assessment										

RN Reassessment, Skin Assessment (Skin) tab, Skin Pr Ul 1 window Other pressure ulcer locations? selected

RN Reassessment - ZMSHTSWLSDHYS,CI File Tabs Help	HUUN (1110) Ward: PHX-ADMISSION SCHEDULED
OTHER PRESSURE ULCERS	Process Illey #0
Pressure Ulcer #/ * Location Description of ulcer/dressing None	Location Description of ulcer/diressing None T
* Stage None	* Stage None
Status None	Status None
Pressure Ulcer #9 *Location Description of ulcer/dressing None	Pressure Ulger #10 Coordination Description of ulger/dressing None
* Stage None	* Stage None
Status None	Status None
Pressure Ulcer #11 * Location Description of ulcer/dressing	Pressure Ulcer #12- *Location Description of ulcer/dressing
None 💌	None
Status	Sietus Nore
	Skin Page 1 Skin Pr UI 1 Skin Pr UI 2 Skin Alt 1 Skin Alt 2 Skin Page 3 Skin CP
Gen Int j Educ j Pain IV j Hesp CV Neuro GI GU M/S	Skin P/S Hest MH Func DP PDE View Text
* Designa	ates a required field
renorming assessment	

RN Reassessment, Skin Assessment (Skin) tab, Skin Pr Ul 2 window

- 4. Populate Skin Pr Ul 2.
 - a. Enter **Location**, **Stage**, and **Status** 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 Skin alterations and the Skin Alt 1 tab becomes available.





1. Click Skin Alt 1.

Skin Alt 1 displays.

RN Reassessment - BDYDXY,ILQDI A (29)	902) Ward: PHX-ADMISSION SCHEDULED	
<u>File T</u> abs <u>H</u> elp		
SKIN ASSESSMENT		
Skin Alteration #1	-Skin Alteration #2	
* Type Description of skin alteration	Vone Vescription of skin alteration	
* Location	* Location	
None	None	
* Size	* Size	
Skin Alieration #3	Skin Alteration #4	
* Type Description of skin alteration	* Type Description of skin alteration	
None	None V	
None	None	
* Size	× Size	
Healed	Healed	
Skin Alteration #5 Type Description of skin alteration	Skin Alteration #6 * Type Description of skin alteration	
None	None	
* Location	* Location	
* Size	× Size	
F Healed	E Healed	
	Skin Page 1 Skin Pr UI1 Skin Pr UI2 Skin Alt 1 Skin Alt 2 Skin Page 3	Skin CP
	Skin [773] nest MH Func DP [PCE] View Text]	
Performing assessment	and a required role	

RN Reassessment, 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) skin alterations. The fields with asterisks are required fields.
 - b. Enter a **Description for skin alteration**, if appropriate.

Skin Alteration Drop-downs

* Туре	Description of skin alteration
Abrasion 💌	
Abrasion 📃	1
Bite	4
Bruising	
Burn	
Crush Injury	4
Hematoma	
Laceration	Healed
Penetrating Wound	

 $Skin \ Assessment-Skin \ Alteration/Type$

* Туре	Description of skin alteration
Abrasion	
* Location	
Abdomen - Right	
Abdomen - Right	
Abdomen - Left Ankle - Right	Healed
Arm - Right, upper	
Arm - Right, lower Arm - Left, upper Arm - Left, lower	Description of skin alteration

Skin Assessment - Skin Alteration/Location

* Type Abrasion	Description of skin alteration
* Location Abdomen - Right	
* Size 1 cm	│ □ Healed

Skin Assessment - Skin Alteration/Size

3. Click Skin Alt 2.

Skin Alt 2 displays.

Chine Alexandree #7								litoration	HO										
* Type	Des	ription of	skin alte	ration			* Type				Descriptio	n of skin	alteratio	n					
None	•						None			•									
* Location	_						* Locati	on											
None	·						None			•									
* Size							* Size			—.									
1							1				Heale								
						_	Skin A	lteration	#10							1			
None	- Des	alpaion of		auch			None			-	Descriptio								
X I continu	_						XI conti			_									
None	-						None	UFI		-									
* Size	_						* Size			_									
		lealed									Heale								
- Chin Altoration #11								Iteration											
* Type	Desc	ription of	skin alter	ation			* Туре				Descriptio	n of skin	alteration						
None	•						None			-									
* Location							* Locati	on											
None	•						None			-									
* Size	_						* Size												
		lealed									Heale								
							c	kin 1		Priliti	Skie	21112	Skin	AFT 1	Skin	∆⊪2]	Skin Pa	ine 3	Skin CE
		-	_		1	1			JKIN		JART	1012	JKIN		_ 3Kin	MR Z	JAITE	903	JKIN UP

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

- 4. Populate Skin Alt 2.
 - a. Enter **Type**, **Location**, and **Size** for six (#7-#12) additional skin alterations. The fields with asterisks are required fields.
 - b. Enter a **Description of skin alteration**, if appropriate.
- 5. Click Skin Page 3.

Skin Page 3 displays.

RN Reassessment - ZMSHTSWLS File Tabs Help	SDHYS,CHU	UN (1110) War	d: PHX-ADMISSION SCHEDULED	<u> </u>
SKIN ASSESSMENT BRADEN SCALE FOR PF	EDICTING PRESS	SURE SORE RISK		
C Yes C No				
SENSORY PERCEPTION: Ability to respond meaningfully to pressure-related disconflot 1. COMPLETELY LIMITED: Unresponsive (does not moan, flinch, or grasp) to painful stimuli; due to diminished level of consciousness or sedation. OR limited ability to	* Sensory Score C 1 C 2 C 3 C 4	NUTRITION: Usual food in 1. VERY POOR: Never ea Rarely eats more than 1/3 o Eats 2 servings or less of pr product) per day. Takes flu	take pattern.	
MOISTURE: Degree to which skin is exposed to moisture 1. CONSTANTLY MOIST: Skin is kept moist almost com- by perspiration, urine, etc. Dampness is detected every tir patient is moved or turned.	* Moisture Score C 1 C 2 C 3 C 4	FRICTION AND SHEAR: 1. PROBLEM: Requires m assistance in moving. Con sliding against sheets is imp slides down in bed or chair,	oderate to maximum plete titing without costible. Frequently requiring frequent	
ACTMTY: Degree of physical activity 1. BEDFAST: Patient's confined to bed. 2. CHAIRFAST: Patient's ability to walk is severely limited Patient can't bear his own weight, or must be assisted into	* Activity Score C 1 C 2 C 3 C 4	Total Score: N/A Prior score: Not assessed Date: Risk Category Not at risk (19-23) At risk (19-23)	Concut guide (Ir patient has a Braden score of 12 or below; a Stage II or greater pressure ulcer is present; a history of pressure ulcers; encory or motor deficits; or paralysis or spinal cord injuny exists; consider Vound Care Chincina Alert. If patient has a Braden score of 16 or below; a history of pressure to be observation.	
MOBILITY: Ability to change and control body position. 1. COMPLET(IMMOBILE: Does not make even sight changes in body or extremity position without assistance.	Mobility Score C 1 C 2 C 3 C 4	Moderate risk (13-14) High risk (10-12) Severe risk (9 or below)	and/or a Braden Nutrition score of 1 or 2, consider a Nutrition alert III patient's accres in the mobility, activity or sensory scales and/or patient' has a motor deficit (le.g. amylece or spinal codi riyuty), a referral to physical therapy should be discussed with the interdisciplinay team.	
Copyright. Barbara Braden and Nancy Bergstom, 1988. Reprinted with permission.			Nutrition Consult Wound Care Consult	
	[Skin Page 11 Skin Pr UI 1	Skin Pr U12 Skin Alt 1 Skin Alt 2 Skin Page 3	Skin CP
Gen Inf Educ Pain IV Resp CV Neuro GI	GU M/S S	ikin P/S Rest MH	Func DP PCE View Text	
Performing assessment	* Designates a	required field Go to radi	ogroup: Skin assessment indicated 🔹 Go	
i chorning doctornent				11.

RN Reassessment, Skin Assessment (Skin) tab, Skin Page 3 window Braden Score for Predicting Pressure Sore Risk

Note: Braden Scale for Predicting Pressure Sore Risk is optional in the reassessment.

- 6. Populate Skin Page 3.
 - a. Select **Yes** to **Skin assessment indicated**, to complete the *Braden Scale for Predicting Pressure Sore Risk*.

Complete all the fields with asterisks; they are required fields.

b. Select **No** to **Skin assessment indicated**, to bypass the *Braden Scale for Predicting Pressure Sore Risk*.



RN Reassessment, Skin Assessment (Skin) tab, Skin Page 3 window Braden Score for Predicting Pressure Sore Risk Skin assessment indicated selected

- c. **Optional:** Order a Nutrition Consult and/or Wound Care Consult from Skin Page 3, if necessary. Refer to the instructions in *Working in the Consults* on page 24.
- 7. Click **Skin CP.** Skin CP displays.

Patient Assessment (NUPA) V.1 RN Reassessment User Manual

👰 R	N Rea	asses	smen	t - ZMSHT	SWLSDHY	(S,JLUXA	(3122) W	ard: PHX-AI	DMISSION SCHE	DULED	_ 🗆 ×
<u>F</u> ile	<u>T</u> abs	<u>H</u> elp									
S Pl P C C	KIN - PR ROBLEMS ESIRED O atient/care ducation p) Yes) No	OBLEM - RISK Fi IUTCOME egiver rovided	S/INTEP DR SKIN B PREVEN * Edu	VENTIONS/DE REAKDOWN TION/TREATMEN cation provided to	SIRED OUTCO	MES Click RELATED TO SKIN I In provided to	a row to update i NTEGRITY	ts problem evaluat B I	tion and intervention status. raden scores (Prior score:) No Braden score done assessment .	this shift	
TAB	PROBL	.EM		DATE IDENTIFIE	DESIRED OUTC	COME PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTE	D INT STATUS	INT STATUS
											•
								Problem/Interventi			
	io not disp	ılay resolvi	ed problems	Add New P	roblem	View history fo	or this problem				
	Problem e C Noch C Deteri C Improv C Resolv C Unres	valuation ange/Stal orating ving ved olved at d	ble ischarge	Complete Continue Continue Continue Continue	tatus J	OK Cancel					
Gen I	nf Educ	Pain		Resp CV No	suro GI GU	Skin M/S Skin	Page 1 Skin Pri	JII Skin PrUI2	Skin Alt 1 Skin Alt 2	Skin Page 3	Skin CP
					×	Designates a requir	ed field Go t	o radiogroup: educatio	on provided 🔹	Go	
Perforn	ning asse	essment									//.

RN Reassessment, Skin – Problems/Interventions/Desired Outcomes (Skin) tab, Skin CP window

8. Update Skin CP, if necessary. Refer to the instructions in *Working in a Care Plan* on page 12.

Psychosocial (P/S)

Document the psychosocial reassessment of a patient in the Psychosocial tab. This includes documentation for patients in restraints.

Directions for the Clinical Institute Withdrawal Assessment (CIWA) are on the CIWA page.

- 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.
- The CIWA Score is pulled forward to the P/S CP page to guide the entry of interventions.
- 1. Click **P/S**. P/S Page 1 displays.

RN Reassessm Eile <u>T</u> abs <u>H</u> elp	ent - ZMSHTS	WLSDHYS,CHU	JUN (1110) V	Vard: PHX-ADMISS	TON SCHEDULE	
PSYCHOSOCIAL ASSE	SSMENT					
* Patient/family/support personable to respond to question:	n *Why could no	o one respond * Other	reason no one could respon	Information obtained from Patient Authorized surrogate Family/Support Person Medical Record Other	* Other sc	urce of information
Patient has a history of None reported Accoholism History of/ or treatment for History of depression Uther	* 0	ther history	* Attitude C Cooperative C Uncooperative C Other Dire concerce	" Other attitude	* Behavior C Controlled C Uncontrolled C Uncontrolled C Other Differ concenses:	behavior
Suspected Abuse/Neglect Doesn Yetsal abuse Yes Declines to answer Prior response: *Rape or sexual abuse Yes Declines to answer Prior response:	Screen Screen Privicel abuse Ves No Screen No Screen No Screen Sc	ina2		Based upon nursin Verbal abuse Or Yes Or No Prior response * Explain surploans abuse or neglect by the Other Sectors Yes Or Nown Prior response:	a assessment, is any of the follow Physical abuse Yes No Prior response: nent, are others victims of ** Explain about patient?	ving suspected? Neglect Ores No Prior response:
Gen Inf Educ Pain IV	Resp CV Neuro	GI GU M/S	P/S Pag Skin P/S Rest M	e1 P/SPage2 P/SPage3 H Func DP PCE Vie	I CIWA P/S Page	4 P/S CP
Performing assessment		* Designates	a required field Got	o radiogroup: Attitude	▼ Go	

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

- 2. Populate P/S Page 1.
 - a. There are no required fields on P/S Page 1.
 - 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 24.

			r nor roopense.	1.101.1	ooponoo.	
Suspected Abuse/Neglect	Screen					
Does p	patient report any of the follow	<u>vinq?</u>		- Based upon nursing asses	ement is any of the fol	lowing suspected?
* Verbal abuse	* Physical abuse	* Financial abuse	N 1 - 474	Dased upon marsing asses	isinche, is driv or the for	iowing adaptotion:
Yes	Yes	C Yes	Notity provider and follow your	Verbal abuse	Physical abuse	Neglect
C No	C No	No	state's reporting regulations	C Yes C No	C Yes C No	C Yes C No
C Declines to answer	C Declines to answer	C Declines to answer		Prior response:	Prior response:	Prior response:
Prior response:	Prior response:	Prior response:		* Explain suspicions		
* Rape or sexual abuse C Yes	* Neglect					
No	C No					
C Declines to answer	C Declines to answer					
Prior response:	Prior response:		В	ased on nursing assessment, ar	e others	ut others in household
r norresponde.	r norresponde.			n the nousehold possible victims	or copiant app	ut others in nousenoid
	*** Socia	al Work Consult mandato	ry ***	C Yes	·	
	0.1114	in al		C No		
	Social Wo	rk Lonsuit		C Unknown		
			P	rior response:		

RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 1 window, Required Social Work Consult

Note: For emphasis, the notify provider, send consult, and follow your state's reporting regulations are highlighted in **red**.

3. Click P/S Page 2.

P/S Page 2 displays (Optional Suicide Risk - Ask Patient).

Ask Patient * Have you recently had thoughts about harming yourself	* Do you have a plan for			
* Have you recently had thoughts about harming yourself	* Do you have a plan for			
C Yes	how to do this	* Describe plan	Are there means available	* Describe means
C No				
O Declines to answer		Prior plan	r	Prior means
Prior response:	Prior response:	<u>^</u>	Prior response:	-
* Have you rehearsed or practiced how to kill yourself	* Have you heard voices telling to hurt or kill yourself		J	4 F
Prior response:	Prior response:		Comments relative to suici	ide
Prior response: * Have you tried to hurt or kill	Prior response: * How have you tried to hurt, or kill yourself in the past	" Are you feeling hopeless about the present or future e.g. feeling that I	Comments relative to suici he	ide
Prior response: * Have you tried to hurt or kill yourself in the past ◯ Yes	Prior response: " How have you tried to hurt or kill yourself in the past	* Are you feeling hopeless about It present or future e.g. feeling that I is no way out C Yes	Comments relative to suici	ide
Thior response: "Have you tried to hurt or kill yourself in the past " Yes " No	Prior response: * How have you tried to hurt or full yoursell in the past	* Are you feeling hopeless about th present or future e.g. feeling that is no way out ℃ Yes ℃ No	Comments relative to suici he	ide
Pior response: * Have you tried to hurt or kill yourself in the past ? Yes ? No ? Declines to answer	Prior response: * How have you tried to hurt or full yoursell in the past	" Are you feeling hopeless about th present or luture e.g. feeling that is no way out C Yes C No C Declines to answer	Comments relative to suici he	ide

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

- 4. Populate P/S Page 2.
 - a. The questions on P/S Page 2 are optional.
 - b. If a patient answers **Yes** to **Have you recently had thoughts about harming yourself**, you must **Notify provider** and **Keep patient under close observation**, according to medical center policy.

@ RN Reassessment - ZN <u>File Tabs H</u> elp	ISHTSWLSDHYS,C	HUUN (1110) V	Vard: PHX-ADMISSIC	ON SCHEDULED	<u> </u>
PSYCHOSOCIAL ASSESSMENT					
Suicide Risk Screen					
Ask Patient					
* Have you recently had thoughts about harming yourself	* Do you have a plan for how to do this	* Describe plan		* Describe means	
Yes	C Yes				
C No	No				
O Declines to answer	C Declines to answer	Prior plan		Prior means	
Prior response:	Prior response:		Prior response:		<u> </u>
* Have you rehearsed or practiced	* Have you heard voices telling			1	
how to kill yourself	you to hurt or kill yourself		1		
G No.	G No	**** Notify provid	er		
C o r i	C D C D	*** Keep patient	t under close observation 🚧		
U Declines to answer	U Declines to answer		Comments relative to suici	de .	
Prior response:	Prior response:				
* Have you tried to hurt or kill	* How have you tried to hurt or kill yourself in the past	* Are you feeling hopeless a present or future e.g. feelin is no way out	about the g that there		
Yes	ng	• Yes			
C No		C No			
O Declines to answer		C Declines to answer			
Prior response:	1	Prior response:			
		P/S Pag	je 1 P/S Page 2 P/S Page 3	CTWA P/S Page 4	P/S CP
Gen Inf Educ Pain IV Resp C	V Neuro GI GU M/	S Skin P/S Rest M	1H Func DP PCE View T	ext	
	* Design	ates a required field Go t	o radiogroup: harming yourself	▼ Go	
Performing assessment					11.

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

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

PSYCHOSOCIAL ASSES	SMENT			
Elopement Screen - If any Yf * Patient has a court- appointed legal guardian G Yes O No Prior response: * Specify guardian	S answer, then patient is a poten * Patient has been legally committed Yes © No Prior response: Prior guardian response	ial wandering/elopement risk. ** Patient is considered a danger to him/breef or others ** Original of the second Prior response: ** Patient has history of ** patient has history	* Patient is on legal observation status for Gravely Disabled Yes No Prior response: D ste/from where if known	* Patient lacks the cognitive ability to make relevant decisions (e.g. history of dementia, Alzheimer's or traumatic brain injury) • Yes <u>No</u> Prior response: Prior response: Prior escape/elopement response
Chemical Dependency Issue * Alcohol use C Lifetime non-alcohol user C Patient declines to answu C Patient has not used alco C Patient is currently using	s er any questions about alcohol use hol in the past 12 months alcohol or has within the past 12 n	* Date of last alcohol use * Amount of last alcohol use	* Does patient use recreati (marijuana, cocaine, heroir C Yes C No	ional drugs * Dete of last drug use * Amount of last drug use
Prior response: * Type of recreational drugs us	ed * Does patie a medical m C Yes Prior response	ent have arijuana card O No 8:	C Patient declines to ans Prior response: If Yes to use of recreational	wer drugs, notify provider Possibility of alcohol withdrawe
Pior response: * Type of recreational drugs un Make Alcohol Treatment referr Contraband brought (in tot/by the patent C Yes Pior response:	ed * Does pair a medical m ? Yes Prior respons al if patient is interested. * Describe contraband	ent have arijuana card © No e:	Patient declines to ans Prior response: If Yes to use of recreational * Location of unremoved co	wer drugs, notify provider Possibility of alcohol withdrawe ntreband Follow facility policy for contraband removal

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

- 6. Populate P/S Page 3.
 - a. The questions are all optional; update, if necessary.
 - b. If a patient answers **Yes** to any of the Elopement Screen questions, a Social Work Consult is required.

Refer to the instructions in Working in the Consults on page 24.

Ē	RN Reassessme le <u>T</u> abs <u>H</u> elp	nt - ZMSHTSWLS	SDHYS,CHUUN (11	110) Ward: PHX-A	ADMISSION SCHE	
	PSYCHOSOCIAL ASSES Elopement Screen - II any YES "Patient has a court- appointed legal guardian "Gr Yes - C No Prior response: "Specify guardian	SMENT S answer, then patient is a potent "Patient has been legally committed Or Yes Or No Prior response: Prior guardian response	ial wandering/elopement risk ** Palient is considered a danger to kinn/esreell and the source ** of the source of the source ** Palient has history of ** palient has history of ** palient has history of ** of the source ** of the source of the source ** of the source of the source of the source ** of the source o	* Patient is on legal observation status for Gravely Disabled C Yes C No Prior response: Date/from where if known	* Patient lacks the cognitive abi decisions (e.g. history of dement or traumatic brain injury) © Yes © No Pitior response. Pitior response.	ily to make relevant Alzheimer's Social Work Consult Will Send Social Work consult mandatory

RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 3 window, Social work consult mandatory

c. P/S Page 3 contains the Alcohol use section.

Chemical Dependency Issues			
Alcohol use	* Date of last alcohol use	Does patient use recreational drugs	* Date of last drug use
Patient declines to answer any questions about alcohol use Patient has not used alcohol in the past 12 months Patient is currently using alcohol or has within the past 12 months	* Amount of last alcohol use		* Amount of last drug use
Prior response: Patient declines to answer any questions about alcohol us	se		
* Type of recreational drugs used Does patient have		Prior response: No	
a medical marijuana	card	If Yes to use of recreational drugs, notify pr	ovider
	No		Possibility of alcohol withdrawal
			Notify provider
Prior response: No			
Make Alcohol Treatment referral if patient is interested.			

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.

RN Reassessment - ZMSHTSWLSDHYS,CHUUN	(1110) Ward: PHX-A	DMISSION SCH				
Citwa Ask patient or ob "Yeel tick to your stomach? Have you vonited?" *TREMOR: A C 0. No ause and no voniting C 0. No ten C 1. Multinussee and no voniting C 1. No ten C 2 Status	ISERVE rms extended and fingers spread apart rors ble, but can be felt fingertip to fingertip	* PAROXYSMAL SWEATS C 0- No sweat visible C 1- Barely visible sweating, palms moist C 2				
C 4 - Intermittent nausea with div heaves C 4 - Modera C 5 5 5 C 7 - Constant nausea, frequent div heaves and vomiting C 5	ite, with patient's arms extended	C 3 4 - Beads of sweat obvious on forehead C 5 C 6 C 7 - Drenching sweats				
ANGETY: "Do you feel nervous?" O -Normail AGITATION O -Normail I-Middenately anxious or guarded so anxiety is inferred S C - S C C - S C - S C C - S C	activity hat more than normal activity ally fidgety and restless back and forth during most of the interview or	* TACTILE DISTURBANCES any burning, any numbress C 0 - None C 1 - Very mild tiching, pins 2 - Mild tiching, pins ner C 3 - Moderately severe ha C 5 - Severe hallucination C 6 - Extremely severe ha C 7 - Continuous hallucination	: "Have you any itching, pins/heedles, or feel bugs crawling on or under skin' s needles, burning, numbness deles, burning, numbness s needles, burning, numbness allucinations s lucinations lions			
*AUDITORY DISTURBANCES: "Are you aware of sounds around you? Are they harsh or do the you? Do you hear things that are disturbing to you or that you know are not there?" 0 • Not present 1 • Vey mild harshness or ability to frighten 2 • Mid harshness or ability to frighten 3 • Moderate harshness or ability to frighten 5 • Severe halucinations 5 • Severe halucinations 6 • Extremely severe halucinations	ey lighten • VISUAL DISTURBANCES.*T hut your eyes? Do you see things th 0. • Not present 1. • Vey mail sensitivity 2. • Moderale sensitivity 3. • Moderale sensitivity 5. • Noderale sensitivity 5. • Veys evere hallucinations 6. • Veys evere hallucinations 7. • Externely severe hallucinations	oes the light appear too bright hat are disturbing to you or that ons	(? Is its' color different? Does it you know are not there?"⊣			
*HEADACHE: "Does your head feel different? Does it feel like there's a band around your he Do not rate for disziness or lightheadness. Dithewise, rate seventy. C 0. Not preent C 1. Very mid C 2. Mode C 4. Moderately sevene C 5. Sevene C 6. Very severe C 7. Extremely severe	*ORIENTATION AND CLOUDING DI this? Where are you? Who am? C 0 -0 intented and can do serial ad C 1 - Carnot do serial additions and C 2 - Disoriented by date by more th C 3 - Disoriented by date by more th C 4 - Disoriented by date by more th	SENSORIUM: "What day ditions d is uncertain about the date te than 2 calendar days han 2 calendar days person	CIWA Score: 0 CIWA score interpretations 8 or Less= Minimal to mild withdrawa 9-15= Moderate withdrawal 16 or greater= Severe withdrawal			
Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin * Designates a require * Designates a require *	P/S Page 1 P/S Page 2 CIW/A Rest MH Func DP ed field Go to radiogroup: "Feel sick	P/S Page 3 CIWA PCE View Text to your stomach? Hav v	P/S Page 4 P/S CP			
Controlling descentant						

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

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

RN Reasses <u>File</u> Tabs <u>H</u> elp	sment - ZMSHTSWL	SDHYS,CHUUN (1:	L10) Ward: PHX-ADMISSI	ON SCHEDULED
PSYCHOSOCIAL	ASSESSMENT			
General observations/	comments			
			D/C Dana 1 D/C Dana 2 D/C Dana 2	CINA DE Des A
Gen Inf 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				

RN Reassessment, 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.

10. Click **P/S CP**.

P/S CP displays.

RI	N Reas	sessme	ent -	ZMS	HTS	NLSI	DHY	s,jlu	XA	(31	22)	War	d: PH)	X-AD	MISS	ION	SCHE	DUL	ED	<u>_ ×</u>
Lue		īeih																		
PSY	снозосі	AL ASSES:	SMENT	- PRO	BLEMS	/INTEF	RVENT	IONS/D	ESIRE	D OUT	гсоме	S (Click a ro	w to up	date its p	roblem	evaluatio	on and	interventio	n status.
TAB	PROBLEM		DA	TE IDEN	TIFIED	DESIRED	OUTCO	DME PROF	B EVAL	PROB	EVAL D	ATE IN1	FERVENTION	ON			INT STA	RTED	INT STATU	S INT STAT
NONE																				
•																				Þ
	_												Problem/in	nterventio	m detail					
E D	o not display i	resolved probl	ems	Add N	ew Proble	em		View	history f	or this pr	oblem									
				Add N	ew Interv	ention to	this prot	blem												
-F	Problem evalu	ation		Intervent	ion statu:	s														
İ	🔿 No chang	e/Stable		C Comp	pleted			OK												
	 Detenorat Improving 	ng		C Conti	inue															
	C Resolved			C Disco	ontinue r			Cano	:el											
	C Unresolve	d at discharge		() Penc	ling															
Genlin	€ Educ E	Pain IV	Been	Inv	Neuro	G	GU	M/S	Skin		P/ Best	S Page 1	Euro	Page 2	P/S Pag	je 3	CIWA	P/9	Page 4	P/S CP
Genin			J mesp	<u></u>	<u></u>	<u></u>	<u>- 40</u> ×r)esignates	a requir	ed field		Go to rac	finaroun: Ti	nterventi	on status	ICHT / EM	-	Go	1	
Perform	ing assess	ment											3 40- 10							

RN Reassessment, Psychosocial Assessment –Problems, Interventions, Desired Outcomes (P/S) tab, P/S CP window

11. Update P/S CP, if necessary.

Refer to the instructions in Working in a Care Plan on page 12.

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

Èile <u>T</u>abs <u>H</u>elp	ent - \	VHLS	SJE,J	ELU/	AHT	ALR	UHY:	JH (532(5) W	/ard	4CT						_	
RESTRAINTS	ed []	Date/time) Known) Unknos	e initiated wn			Initiated	i dete/tin	ne											
* Reason for restraint C Patient is pulling at lines/t C Patient's behavior is aggre	ubes used i essive or vic	n their tre dent presi	atment or enting an	is unable immedial	e to follo te seriou	w instruct s danger	tions end to his/he	angering er safety o	their mea or that of	ical /suŋ others.	gical reco	overy. Pa	tient is r	not violen	t or self-destru	uctive			
* Justification for restraints	* Other ju	ustification			* Justific	ation for r	estraints		* Other	justificat	ion	Be ter	haviora minatior	l expecta n of restra	tions for ints		* Other br	ehavioral	expectatio
*Restraint Type	* Other F	lestraint		Inte	ervention	s tried to	avoid res	straint use	• * Other	interven	tion								
														Disconti	nued date/tim	e			
Gen Inf Educ Pain IV	Resp		Neuro	GI	GU	M/S	Skin	Skin	<u>P/S</u>	Rest	MH	Func	DP	PCE	View Text	R	estr Page 1	Re	estr CP
erforming assessment					* D	esignate:	s a requir	ed field											

RN Reassessment, 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.



RN Reassessment, Restraints (Rest) tab, Restr Page 1 window with restraints initiated/maintained selected

a. When you select, **Patient is pulling at lines/tubes ...**, the following window displays.



RN Reassessment, 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
b. When you select, **Patient's behavior is aggressive or violent ...**, the following window displays.

RN Reassessme	ent - VHL	SJE,JEL	UAHT ALR	ИНҮЈН	(5326	5) W	/ard:	4CT						×
RESTRAINTS	d C Unkn	ne initiated n own	Initiate	ed date/time	Notify pr	ovider '	in the second							
* Reason for restraint Patient is pulling at lines/tu Patient's behavior is aggre	bes used in their tr ssive or violent pre	reatment or is ur senting an imm	nable to follow instru ediate serious dange	ctions endangerin r to his/her safety	g their mec or that of (lical /surj others.	gical reco	overy. Pa	itient is n	ot violent	or self-destri	uctive		
* Justification for restraints Pulling at tubes Promote medical healing Unable to follow commands Dither	* Other justificati	on	* Justification for	restraints	* Other	justificat	ion	Beter	havioral mination Does n Contrac Denies Denies Denies Denies Display Other	expectati of restrain s simple di tot pull at l cts for safe homicida self harm suicidal in s no aggr	ons for ints lines/tubes ety l ideation deation ession to se	lf/others	" Other behavioral expecta	ition
* Restraint Type Anibe, Right, Locked Anibe, Right, Unlocked Anibe, Lett, Locked Anibe, Lett, Unlocked Blanken/Net Hand MK, Right Vest, Locked West, Locked West, Locked Wist, Enght, Locked Wist, Enght, Unlocked Wist, Enght, Unlocked Wist, Lett, Unlocked Wist, Lett, Unlocked	* Other Restraint		Interventions tried to Bed alarm Camoullage Diversional 4 Family at bet Houdy roum Laptop tray Low bed with More closer Pain refer Repositionin Side rafs, 3 Sitters Wedge cut	a avoid restraint us lines/tubes activities dside fing h mats to nurse's station edicine edicine y education tation g of lines/tubes or less nion	e *Other	interven	tion			Discontin	ntinued - de	sired outo	come achieved	
Gen Inf Educ Pain IV	Resp CV	Neuro GI	GU M/S	Skin Skin	<u>P/S</u>	Rest	MH	Func	DP	PCE	View Text	Res	tr Page 1 Restr CP	
			* Designate	es a required field										
Saving data														11.



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

4. Click **Restr CP**.

Restr CP displays.

@ RI <u>F</u> ile	N Rea Tabs	sses: <u>H</u> elp	smei	nt - 2	ZMSH	HTS	WLSI	DHYS	S,JLU	XA	(312	22)	War	d: PH	IX-AD	MISS	ION	SCHE	DUI	LED	_	
R	ESTRAI	NTS-P	ROBLE	MS/IN	TERVE	INTIO	NS/DES	SIRED (OUTCO	MES		Click e	ı row to	update	e its prob	lem evalı	uation a	and interve	ention	status.		
TAB	PROBI	.EM		DA	TE IDEN	ITIFIED	DESIRED	о оптсо	DME PROI	B EVAL	PROB	EVAL D	ATE IN	ITERVEN	ITION			INT START	ED I	NT STAT	US INT :	STATUS
NOM	IE																					
<	o not displ	ay resolve	d probler	ns	Add Ne Add Ne	ew Proble	em		View	history fo	or this pro	blem	1		Vinterventid	on detail						Þ
	Problem ev C No cha C Deteric C Improv C Resolv C Unresc	valuation- inge/Stab rating ed Ived at dis	le scharge		Intervent C Comp C Conti C Disco C Pend	tion statu pleted inue ontinue ding	ş		OK Cance	el												
Gente	of Educ	Pain	IV	Besp		Neuro	GI	GU	M/S	Skin	P/S	Bart	МН	Euro	DP	PCE V	/iew Tevt		Hestr	Page 1	Rest C	<u>Р</u>
		<u>, an</u>						* De	esignates	a requir	ed field	mest	Go to rac	diogroup:	Problem (evaluation	1011 1040		Go			
Perform	ning asse	ssment																				

RN Reassessment, Restraints – Problems/Interventions/Desired Outcomes (Rest) tab, Restr CP window

5. Update Restr CP, if necessary. Refer to the instructions in *Working in a Care Plan* on page 12.

Mental Health (MH)

The Mental Health tab is completed for patients admitted to acute psychiatry, or when any patient reports a new mental health problem.

RN Reassessme Eile Tabs Help	nt - 2	ZMSI	ITSV	VLSDHY	S,CHU	JUN	(11	10)	War	'd: P	HX-A	DMI	SSIC	ON SC	HED	DULED	_	
MENTAL HEALTH ASSES	SMEN	г																
Tab to be completed for pa	atients e	dmitted	l to acu	te psychiatry,	or with a	a history	/ of me	ntal he	alth pro	blems								
* Patient/family/support person able to respond to questions	* Why) one res	pond *	Other reas	on no oni					* In	formation Patient Authoriz Family/S Medical Other	obtained ed surrog iupport P Record	from ate erson	* 01	ter source o		ation
Patent has a history of None reported Bipda ECT ECT Homicidal intention Migor depression Graduate and the set of the set	* Other	gy iol?''			* Other H * Ask p r you C Yo C No Phior resp	ristory balient "W u able to (s) tient decli ponse:	/hen you calm you	Ask pa	tient: "W men my signature argument arg	hat thing soce gelt to railer soce gelt to railer soce soce soce and to due to soce and the due soce and the due sociationin to to a que sociationin so relax: moke ace ray editate	ps or situa s invaded cation wi eath or br a to alcohol a to alcohol a to alcohol a catal I want o power at problem cohers g batiet o cohers g cohers g cohers g cohers g cohers g cohers cohers g cohers coher	tions makes th family, performed to the seakup) or drugs is solving of the seakup) feel calm	e you up partner, c don't work him/hers	set?" file elf	* Other	upsetting ite Other calmi	m ng thing	75 74 CP
Gen Inf Educ Pain IV	Resp	CV	Neuro	GI GU	M/S	Skin	CIWA	P/S	Rest	мн	Func	DP	PCE	View Te:	kt			
Performing assessment				× [lesignates	a require	d field	(ào to radi	ogroup:	able to r	espond to	question	ns 💌] 0	io		//

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

1. Click MH.

MH Page 1 displays.

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

3. Click MH Page 2.

MH Page 2 displays.

RN Reassess File Tabs Help	ment - ZM	ISHTSWLSDHY	S,CHUUN	(1110)	Ward: P	PHX-ADMISSIO	N SCHEDU	
MENTAL HEALTH A	SSESSMENT							
Kood Angy Angy Angy Angu Opticised Untifyinic Untifyinic Untifyinic Untifyinic Untifyinic Untificience Unt	* Other mood Health Advance Dire placed in restraints, tify someone ?'	* Alfect Adjestreide Adjestreide Adjestreide Baight Ealwed Choraguert Sad Other Ctives Who should be notified	with mood	Other affect	Bet	navior Vagressive Vagressive Vagressive Vagressive Vagressive Social search Combarive Combarive Comparitive Combarive Comparitive Combarities Combarit	tention /initiative into major problems	(Other behavior
Prior response: *Behavioral Health Ar	dvance Directives	- 						
Behavioral Health Behavioral Health Declined Behavioral Requested & give Not Applicable	Advance Directive of Advance Directive of ral Health Advance I n information on Beh	copy on chart copy not available Directives avioral Health Advance Direc	ive					
						_	MH Page 1 MH	Page 2 MH CP
Gen Inf Educ Pain	IV Resp CV	Neuro GI GU	M/S Skin	CIWA P/S	Rest MH	Func DP PCE	View Text]
Performing assessment					rourogroup.	1		•

RN Reassessment, 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.

<mark>@ RN</mark> <u>F</u> ile	Reassessment Tabs <u>H</u> elp	- ZMSHTS	WLSDHYS,	JLUXA ((3122) W	ard: PHX-AD	MISSION SCH	EDULED	
MEN	ITAL HEALTH - PROBLE	MS/INTERVENT	IONS/DESIRED	OUTCOMES	Click a row to	update its problem	evaluation and intervent	ion status.	
TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOM	E PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DATE
NONE									
▼ □ Do	not display resolved problems	Add New Probl	em	View history for	this problem	Problem/Interventio	n detail		Þ
	oblem evaluation No change/Stable Deteriorating Improving Resolved Unresolved at discharge	Intervention statu C Completed C Continue C Discontinue C Pending		OK Cancel					
Gen Inf	∫ <u>Educ Pain IV Re</u> ata	sp <u>CV Neuro</u>	GI GU I	M/S Skin ignates a require	<u>P/S Rest</u> M d field Go te	H Func DP	MH Page 1 PCE View Text on status	MH Page 2	MH CP

RN Reassessment, Mental Health Assessment (MH) tab, MH CP window

6. Update MH CP, if necessary.

Refer to the instructions in Working in a Care Plan on page 12.

Functional (Func)

Document the functional (bathing, dressing, toileting, transferring, continence, and feeding) reassessment of a patient in the Functional tab.

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.



RN Reassessment, Functional Assessment (Func) tab, Func Page 1 window

1. Click Func.

Func Page 1 displays.

- 2. Update Func Page 1, if necessary. The fields are optional.
 - **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.

RN Reassessment - ZMSHTSWLSDF File Tabs Help	HYS,CHUUN (1110) W	ard: PHX-ADMISSION SCHEDULED
FUNCTIONAL ASSESSMENT		
Instructions for assessing the patient's level of assistance Independent (Patient pedients task safe), which or without staff assistance, with or without assistive devices) Patial Assist (Patient requires no more help than stand-by, cueing, or coasing, or caregiver is required to lift no more than 35 bits, of the patient's weight, or is unpredictable in the amount of assistance offer Instructions for assessing patient's level of cooperation and comprehe Cooperative (may need prompting, able to follow simple commands) Unpredictable or varies (patient whose behavior charges frequent) should be considered as "unpredictable"); not	" "	Assessment ciretia and care plan to sale patient handing and movement An assessment to hould be made point to each task if the patient has vaying levels of ability to assist due to medical reasons, falgue, medications, etc. When in double, assume the patient cannot assist with the transfer/ repositioning. Height: 54 in [137.2 cm] (06/29/2009 10.43) Weight: 165.35 b [75.2 kg] (12/16/2009 14.30) BMI: DEC 16, 2009@14.30.21
cooperative; or unable to follow simple commands	Prior response:	Prior response: Prior response:
Population contractor framely to officer during the proposition in grant market.	ng techniques comments	bservations/comments
Gen Inf Educ Pain IV Resp CV Neuro GI G	3U M/S Skin ClWA P/S Re	Func Page 1 Func Page 2 Func Page 3 Func CP st MH Func DP PCE Vrew Text
Performing assessment	* Designates a required field Go to	radiogroup: Patient's level of assistance 💌 Go

RN Reassessment, 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.

№ RN R <u>File</u> <u>T</u> ab	leasse os <u>H</u> elp	ssme	nt - 2	ZMSI	HTSV	VLSD	HYS	,CH	UUN	(11	.10)	Wa	rd: P	HX-A	ADMI	SSIC	N SCI	HED	JLED	_ [
File Jab	Constructions of the second se	SSIMIC SS	ENT ENT i task safe sistive de sistive de to lift r unde to lift r	evel of as eley, with vices) help than to more the to follow behavioon to follow to follow	sistance or without non 35 lb th of assist eration an simple changes changes de'l; not dialoning te	t staff , cueing . of a pati- tance offet	or ent's ered]. erson C Co C Di Prior ress ning tech	Price Price Price appredict.	Patient's Patient's Patial	level of a andent Assist and com arises	Gene Gene	m ral obse	Assessm An asse levels of when in repositio Weight: BH! C Full C Full C Full C Full Phior resp Phior resp	ent citteri ssment si ability to ability to	ia and carr hould be a sasiti dui- sasiti dui- (75.2 kg) g capability s	e plan for vade priori te medic patient d /23/2000: (12/16/2 21	safe palien to each ta each ta ta ta ta ta ta ta ta ta ta ta ta ta t	t handling sk if the p fatigue, n t with the eral upper	g and move attent has a tended atoms	t	
Gen Inf Ed	duc Pain	IV	Resp	CV	Neuro	GI	GU	M/S	Skin	CIWA	P/S	Rest	мн	Func	Func Pag	e 1 F	unc Page 2 View Text	Func	Page 3	Func C	<u>P</u>
							* De	esignate	s a requi	red field	(ão to rac	liogroup:	Patient's	s level of a	ssistance	-	Go			
Performing a	assessmen	t																			

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

- 4. Update Func Page 2, if necessary.
 - 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.



RN Reassessment, Functional Assessment (Func) tab, Func Page 3 window

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

7. Click Func CP.

Func CP page displays.

RN <u>F</u> ile	Reassessme Tabs <u>H</u> elp	nt - ZMS	HTS	WLSI	OHYS,	JLUXA	(312	22) \	Nard	i: PH	IX-AI	DMIS	SI 0	N SCHE	DULED	_ 🗆 ×
FUN	CTIONAL - PROBLEI	VIS/INTERVE	NTION	S/DESIF	RED OUT	COMES	Click	a row to	updat	te its pro	oblem	evaluati	on and	l intervention	status.	
TAB	PROBLEM	DATE IDE	NTIFIED	DESIRED	OUTCOM	E PROB EVAL	L PROB	BEVAL D	ATE INT	TERVEN	TION			INT STARTE	D INT STATUS	INT STATUS D.
NONE																
↓ □ Do		ems Add N Add 1	lew Probl	lem	this problem	View history I	for this pro	oblem	F	Problem/I	Intervent	ion detail				×
	oblem evaluation No change/Stable Deteriorating Improving Resolved Unresolved at discharge	Con Con Con Con Con So Con Con So Con Con So Con Con So Con So Con So Con Con So Con Con Con Con Con Con Con Con Con Co	ntion statu npleted tinue continue ding	15		OK Cancel										
												Func P	age 1	Func Page 2	Func Page 3	Func CP
Gen Inf	Educ Pain IV	Resp CV	Neuro	GI	GU	4/S Skin	P/S	Rest	MH	Func	DP	PCE	View 1	ext		
Performin	ng assessment				* Des	gnates a requi	ired field									

RN Reassessment, Functional – Problems/Interventions/Desired Outcomes (Func) tab, Func CP window

8. Update Func CP, if necessary. Refer to the instructions in *Working in a Care Plan* on page 12.

Discharge Planning (DP)

Document the discharge reassessment for a patient in the Discharge Planning tab.

e Tanz Heib				
DISCHARGE PLANNING				
Patient/family/support person able to respond to questions	* Why could no one respond	* Other reason no one could respond	* Information obtained from V Patient Authorized surrogate Family/Support Person Medical Record Other	* Other source of information
* Does patient have a legal/ medical guardian (conservator)? © Yes © No ulled from P/S Page 3	* Specify guardian (conservator)	⁺ Employment Status C Presently employed C Unemployed C Retired C Disabled C Patient declines to answ	* Describe employment status	Relationship status Co-habitating Divorced Marined Separated Single Widowed Patient declines to answer
"With whom does patient live C Alone C Family Significant Other C Friend Nursing Home C Assisted Living Homeless C Homeless	* Home environment No identified problems Stairs to enter home Stairs within home Bed on main level Bed a full bathroom on main level Ded & full bathroom on same floor Other architectural barries (e.g. na Patient declines to answer	* Other architectural barriers (not main level) arrow doorwaye)	* Special Equipment Needed at Ho Decuipment needed Specially bed Parap Raised toilet seat Safety bars Other	me * Other equipment needed
* Transportation for Discharge © Own car © Friends/Tamily © Bus © VA Shuttle © VA Travel © Other © Other © Patient declines to answer	* Other transportation for discharge	General observations/comme	ents	
				DP Page 1

RN Reassessment, Discharge Planning (DP) tab, DP Page 1 window

1. Click **DP**.

DP Page 1 displays.

- 2. Populate PD Page 1, if available.
 - a. If a DP Page 1 was completed during the admission assessment, none of the fields are active.
 - b. Use the General observations/comments for additional information.

Note: The presence of the guardian and name of the legal guardian are pulled forward and can be edited on P/S Tab, Page 3.

3. Click **DP CP**.

DP CP displays.

RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-AL File <u>T</u> abs <u>H</u> elp	DMISSION SCHEDULED
DISCHARGE PLANNING - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES	
* Problems, interventions, and desired outcomes indentified in previous tabs have been discussed "Why hearh plan of care been dis with the patient and/or family/support person and concurrence obtained. C Yes C No	scussed
Anticipated Discharge Plan Goals	* Family/support person in discharge planning
Patient is homeless ** Patient equires transportation assistance ** Discharge to home with support services (physiological needs e.g. 02, IV therapy, pain therapy and wound care) ** Discharge to home with support services (succional needs e.g. 02, IV therapy, pain therapy and wound care) ** Discharge to home with support services (social needs e.g. assistance, transportation, follow-up appointments, support groupe) Discharge to home with support services (social needs e.g. classes, materials) ** Discharge to home with support services (social needs e.g. classes, materials) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Discharge to home with support services (social equators remed) ** Patient identified as a file risk	** Discharge Planning Consult / Social Work Consult /
If an item contains **, then a Social Work Consult or Discharge Planning Consult is required	Telekeath Consult
Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin CTWA P/S Rest MH Func	DP Page 1 DP CP
* Designates a required field Go to radiogroup: with the pa	atient and/or family/sup Go

RN Reassessment, Discharge Planning – Problems/Interventions/Desired Outcomes (DP) tab, 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 12.
 - b. Complete a Social Work Consult or Discharge Planning Consult, if required. Refer to the instructions in *Working in the Consults* on page 24.

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.

RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED
IDISCHARGE PLANNING - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES * Problems, interventions, and desired outcomes indervisitied in previous tabs have been discussed * Why heavit plan of care been discussed * Why heavit plan of care been discussed * Why heavit plan of care been discussed * Yes
Anicipated Discharge Plan Goals Charge to hone without additional services Charge to hone without additional services Charge to hone without additional services Charge to hone with support services (dyusioplical needs e.g. assistance with home ADLs]** Discharge to hone with support services (dyusioplical needs e.g. assistance with home ADLs]** Discharge to hone with support services (dyusioplical needs e.g. class; materials)** Discharge to hone with support services (dyusioplical needs e.g. class; materials)** Discharge to hone with support services (dyusioplical needs e.g. class; materials)** Discharge to hone with support services (dyusioplical needs e.g. class; materials)** Discharge to hone with support services (spinual needs) = Discharge to hone with support services (spinual needs) = Discharge to hone with support services (spinual needs) = Discharge to hone with support services (spinual needs) = Discharge to hone with support services (spinual needs) = Discharge to hone with support services (spinual needs) = Discharge to hone with support services (spinual needs) = Discharge to more with support services (spinual needs) = Discharge to mere with support services (spinual needs) = Discharge to mere with support services (spinual needs) = Discharge to mere with support services (spinual needs) = Discharge to mere with services (spinual needs) = Discharge to mere with services (spinual needs) = Discharge to extend the initiation assistance needs) = Discharge to mere with services (spinual needs) = Discharge Planning Consult Social Work Consult Discharge Planning Consult Social Work Consult Discharge Planning Consult Social Work Co
If an item contains ", then a Social Work Consult or Discharge Planning Consult is required
* Designates a required field Go to radiogroup: [with the patient and/or family/sup +] Go

RN Reassessment, Discharge Planning – Problems/Interventions/Desired Outcomes (DP) tab, DP CP window, Consult Required

PCE Data (PCE)

The PCE (Patient Care Encounter) Data tab is optional and may or may not be set up at your medical center. The PCE tab includes a list of all clinical reminders due for the patient, as well as specific nurse Clinical Reminders.

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

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

atient Nursing PCE Information			-
Venced Directives Education smic Health Fractices And Safety upt Plan of Care Tx & Services itr Intervention, Diet, and Oral Healt in Education	h	Resolve	
)
eminders Due (Display Only) Nuse Screen WANCED DIRECTIVE EDUCATION Cobol Use Screen (AUDIT-C) Triers to Learning	Due Dote DUE NO9 04/01/04 DUE NO9 04/01/04	Topic del: None Jourd	

RN Reassessment, PCE Data (PCE) tab

Reminders Due (Display Only)

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

Clinical Maintenance

1. Select a clinical reminder in the **Reminders Due** list box.

2. Click Clinical Maintenance.

Information displays in the **Maintenance Results** list box indicating when the reminder is due or was last done.

CE DATA		Text (will be added to note)	-
npetent Nursing PCE Information Advanced Directives Education Basic Health Practices And Safety Inpt Plan of Care Tx & Services Nutr Intervention, Diet, and Oral He Pain Education	alth	Resolve	ے ا
Reminders Due (Display Only)	Due Date	Topic det. CHF WEIGHT EDUCATION	
Diabetic Foot Exam Complete Hemoglobin AlC	10/09/10 11/24/09 11/18/05		
Microalbuminuria PPD Skin Integrity Screen OPT	02/21/09 08/01/10 DUE NOU	Clinical Maintenance Reminder Inquiry	
Antienze vectore Microslbusinuria PPD Skin Integrity Screen OPT Mantenance Result	02/21/09 08/01/10 DUE NOV	Clinical Maintenance Rieminder Inquity	
Initemente veccane Nicrosolbusinuria Sto Kain Integrity Screen OPT feriense Result -STATUSDUE DATELAST DONE- OUE NOW 72A/2010 72A/2000 Finguncy Due very 1 yes to 14 ges.	02/21/09 08/01/10 DUE NOU	Clinical Maintenance Reminder Inquity	
An Lawesta Factane Bicrosolbusinaria Ego Skin Integrity Screen OPT Hardenance Result -STATUSOUE DATELAST DDNE- DUE NOW 724/2010 7/24/2009 Finguncy: Due wey 1 year for all ages. Echot	02/21/09 08/01/10 DUE NOU	Clinical Maintenance Reminder Inquity	

Clinical Maintenance

Reminder Inquiry

Click Reminder Inquiry.

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

CE DATA		Text (will be added to note)	
npotentNursing PCE Information Advanced Directives Education Basic Health Practices And Safety Inpt Plan of Care Tx & Services Nutr Intervention, Diet, and Oral He Pain Education	116	Resolve	
Reminders Due (Display Only) <u>CHF Weight Education</u> Diabetic Foot Exas Complete Henorichin ALC	Due Date 07/24/10 10/09/10 11/24/09	Topic det. CHF WEIGHT EDUCATION	
Influenza Vaccine Microalbuainuria PPD Skin Integrity Screen OPT	11/18/05 02/21/09 08/01/10 DOE NOW	Clinical Mantenance Reminder Inquity	
Influenza Vaccine Microalbuminuria PPD Skin Integrity Screen OPT Ngay Reads Derweigert EDUCATION No. 1	11/18/05 02/21/09 09/01/10 DUE NOV	Clinical Maintenance Besinder Inquity	
Influenza Vaccine Microalbusinuria PPD Skin Integrity Screen OPT Ingaig Result DHF wEIGHT EDUCATION No 1 Pint Name DHF Weight Education	11/18/05 02/21/09 08/01/10 DUE NOU	Clinical Maintenance Reminder Inquity	

Reminder Inquiry

Resolve Inpatient Nursing Clinical Reminders

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

PCE DATA		Text (will be added to note)	
Inpatient Nursing PCE Information Advanced Directives Education Basic Health Practices And Safety Inpt Plan of Care Tx & Services Nutr Intervention, Diet, and Oral Health Pain Education	Resolve	× ×	

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.

Received? Detiont had Pain Pick, Mar	t and Associations at this enseranter		
 Fallerit nau Fairfrisk, mgi 	r, and Assessment at this encounter		
C Patient declined Pain Risk,	Mgmt, and Assessment at this encounter		
O Pain Risk, Mgmt, and Asse	sment not applicable		
* Level of Understanding			
C Poor			
🔿 Fair			
C Good			
C Group - No Assessment	Comment		
C Refused			

Resolve Reminder Pain Risk, Mgmt, and Assessment window

- 3. Select an item from **Received**?
- 4. Select an item from Level of Understanding.

5. Click **Resolve**.

Information displays indicating the reminder is resolved.



Information : 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.

PCE DATA	Text (will be added to note)
Inpatient Nursing PCE Information	Nutr Intervention, Diet, and Oral Health Nutrition/Oral Health Education not applicable
Advanced Directives Education Basic Health Practices And Safety	
Nutr Intervention, Diet, and Oral Health	
	*

Text (will be added to note)

View Text (View Text)

The View Text tab is a review of all the information added/updated for a patient during the reassessment.

RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED	_ 🗆 X
<u>File Tabs Help</u>	
	^
GENERAL INFORMATION Patient/family/support person able to respond to questions: Ves	
Information obtained from: Patient	
Does patient have an Advance Directive: No Patient received info on Advance Directive: Yes	
Does patient wish to initiate or make changes to an Advance Directive: Yes Infection Control Education: None	
Frequency contact information:	
Contact: ZMSHTSWLSDHYS,CHUUN Relationship:	
Address:	
Phone: Work Phone:	
RESTRAINTS Reason for restraint: Patient's behavior is aggressive or violent presenting an immediate serious danger to his/her	r safeti
Justification for restraints: Agitated Behavioral expectations for termination of restraints: Follows simple directions	
Restraint Type: Ankle, Right, Locked Interventions tried to avoid restraint use: Bed alarm	
EDITORATIONAL RECEIPTION	
Patient/family/support person able to respond to questions: Yes	
4	•
Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin CIWA P/S Rest MH Func DP PCE View Text	
* Designates a required field	
renorming assessment	

RN Reassessment, View Text tab

1. Click View Text.

The View Text window scrolls through the admission reassessment for review.

2. Review the patient admission reassessment.

Signing Note and Consults from within the Template

During the assessment, you may be prompted to enter mandatory consults that will be uploaded with the reassessment 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 also sign *unsigned* notes after the upload from the View Text tab in the template.

1. Click View Text.

RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDUL File Tabs Help	
GENERAL INFORMATION Patient/family/support person able to respond to questions: Yes Information obtained from: Patient What does patient want to accomplish by this hospitalization": pain free Preferred Healthcare Language: English	_
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: PROTESTANT, NO DENOMINATION Are there religious practices or spiritual concerns the patient vants the chaplain. physician, and other health care team members to immediately know about: No Patient requests an immediate visit from the Chaplain: No Dees patient have any traditional, ethnic, or cultural practices that need to be part of care: No Dees patient have any concerns or special considerations if a blood transfusion is needed: No Dees patient have any econterior of care the should be notified of this hospitalization: No	
Does patient have an Advance Directive: No Patient received info on Advance Directive: Yes Does patient vish to initiate or make changes to an Advance Directive: Yes Testing for MKSA brochure/equivalent information given to the patient/authorized surrogate: No Was the below Infection Control Education provided to the patient. No Infection Control Education: None Precoutions: None MKSA Nares swab performed on transfer with patient's agreement: N/A MKSA Nares swab performed on discharge with patient's agreement: N/A	
Emergency contact information: Contact: ZMSHTSULSDHYS CHUUN	
	•
Sign Note/Consult	
Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text	
* Designates a required field	00%
Performing assessment	

RN Reassessments, View Text Tab after Upload

2. Click Sign Note/Consult.

If the button does not display, upload again.

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/Consult**.



RN Reassessment, Sign Note/Consult Button

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

Unable to Complete the Assessment

An incomplete admission assessment is filed when the nurse is unable to complete an assessment because the patient cannot respond to admission assessment questions and there is no caregiver available to provide the necessary data. The reassessment that opens after the assessment is signed, allows you to enter the missing data.

- 1. Open RN Reassessment. Gen Inf tab, Gen I Page 1 displays,
- 2. Select Yes or No for Patient/family/support person able to respond to questions.

RN Reassessment - VHLSJE,JELUA File Tabs <u>H</u> elp	HT ALRUHYJH (5326) Ward: 4CT	<u>_ ×</u>
GENERAL INFORMATION		
* Patient/family/support person * Wiry could no one respond able to respond to questions C Yes C No	* Other reason no one could respond * Information obtained from * Other source of information	1
Demographics Name: VHLSJE JELUAHT ALRUHYJH Age: 69 Sex: MALE Race: DECLINED TO ANSWER Admitting diagnosis: CHEST PAIN Prior patient response to "What does patient want to according the york in properlation"		
	* Offner Language	
What does patient want to accomptish by this hospitalization"	Prior patient response:	
Gen Inf Educ Pain IV Resp. CV Neuro GI	Gen IPage 1 Gen IPage 2 GU M/S Skin P/S Rest MH Func DP PCE View Text	Gen1Page 3 Gen1Page 4
	* Designates a required field Go to radiogroup: able to respond to questions	Go
rforming assessment		

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 1 window

Patient still cannot respond

1. If the patient still cannot respond, select **No** and select a reason(s) ***Why could no one respond**.

RN Reassessment - VHLSJE,JELUA File Tabs Help	HT ALRUHYJH (5326) Ward: 4СТ	_ 🗆 X
GENERAL INFORMATION		
* Patent/family/support person * Why could no one respond ble to respond to questions C Yes C Yes C No * Bol pamily/support patient control to communic at C Yes C Yes C No * Bol pamily/support patient costs • Bol patient	* Other reason no one could respond * Information obtained from * Other source of information	
Demographics Name: VHLSJEJELUAHT ALRUHYJH Age: 69 Sex: MALE Race: DECLINED TO ANSWER Admitting deposits: CHEST PAIN Price patient: response to "What Addes patient want to accomplish by this hospitalization"		
	* Other Language	
What does patient want to accomplish by this hospitalization?	Prior patient response:	
Gen Inf Educ Pain IV Resp CV Neuro GI	Gen I Page 1] Gen I Page 2] Gen I Page 3] GU M/S Skin P/S Rest MH Func DP PCE View Text	Gen I Page 4
aving data	* Designates a required field Go to radiogroup: able to respond to questions 👻 Go	

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 1 window with *Why could no one respond

- 2. Continue through the reassessment tabs and pages.
- 3. Complete all the fields with asterisks; they are required fields.
- 4. Upload the information.

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

ile <u>T</u> abs <u>H</u> elp	BDYDXY,ILQ	DI A (2902) Ward: Pl	IX-ADMISS	ION SCHEDULED	>
GENERAL INFORMATION					
metucadur/regres Current Meds (last day) *** Outpatient *** *** NONE FOUND *** *** NONE FOUND *** *** NONE FOUND ***	×	Allergies INETOPROLOL PEANUTS Add Ne	Vestero ORDE SOCI	lay's and Today's Diders RS YESTERDAY & TODAY - AL WORK CONSULT IN	NONE FOUND
Spiritual/Cultural Assessment - Patier Are these religious practices or spiritua concerns the patient wants the cheate physician, and other heath care team members to minedately hraw about	vosuorriotimeds Uther L xts Religion: ROMAN CATH 	HOLIC CHURCH Patient requests an immediate Visit from the Chaplain C Yes C No	Type or device/pump	Does patient have any traditional, ethnic, or cultural practices [that need to be part of care	 * Describe practices
C Yes No Prior patient response: NO Does patient have any concern- or special considerations if a	* Describe concerns	Prior patient response: ND Does patient have a pastor or ^{* Sp} clergy who should be notified	ecify pastor or clergy	C Yes C No Prior patient response: ND	
blood transfusion is needed C Yes Yes No Prior patient response: NO		Of this hospitalization Of Yes O No Prior patient response: ND			
Gen Inf Educ Pain IV Resp	· CV Neuro Gi	GU M/S Skin P/S Rest	<u>MH</u> Func Df	Gen i Page 1 9 PCE View Text	Gen I Page 3 Gen I Page 4

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 2 window

RN Rea <u>File</u> Tabs	sses <u>H</u> elp	sme	nt - I	BDYI	DXY,	[LQD]	[A (29	02)	War	d: PH	IX-A	DMIS	SSI 0	N SC	HEDU	JLED			<u>_ 🗆 ×</u>
GENERAL	INFOR	MATIC	N																
Advance Dir	ective																		
Does patier Advance C Yes © No Prior patient re	nt have a Directive esponse:	n *Lo NO	ication o	Advanc	e Directiv	re 	Patient receive Advance Dire © Yes © No Prior patient resp	d info on ctive ponse: YE	* Expl rece	ain why p ive info	atient dic	í not	Does to C Prio	patient (an Adva Yes No patient (vish to initia nce Directiv esponse: N	te or make re O	changes 	Social Wo	rk Consult
Testing for MR given to the pat	SA broch ient/auth	iure/equ orized su	ivalent in rrogate	formation		V [Vas the below provided to th Yes	nfection le patient C	Control E No	ducation									
• Yes C	NO				In	F fection Cor	'rior response: ` ntrol Education	res											
Did the patient MRSA Nares s	YES /authoriz wab on a No	ed surroş admissior	jate agre /transfer	e to /discharg		Hand hy Definition Spread o Contact I Respirato Surgical	giene practices n of MRSA, VR if resistant orga Precautions (as ory Precautions site (as related	E, TB, an nisms/pre related ti (as relate to patient	d all resis evention patient d to patie condition	itant orgai condition ent condit n)	nisms I ion)								
Prior patient res	ponse: Y	ES			l evel of	Uther	fing Preca	utions	Pri	or precau	tions								
MRSA Nares s	wab perf	ormed			C Poor Fair C Goor	unuerstant	Airt	orne itact plet		ontact									
Swab performe	± YES				C Refu	sed		utropenic											
* Why wasn't MF	RSA. Nare	:s swab (performer	MRS/ with p © Ye © No	Prior resp A Nares s atient's a es p	onse: Fair wab perfor greement C R C N	med on transfe efused /A		vwasn't i	t performe	d								
				MRSA I with p I Ye C No	Nares sw atient's a es C p C	ab perform greement 'Refused 'N/A	ed on discharg	e *\v/hj	ı wasn't if	t performe	d								
														Gen IP	age 1 G	en IPage 2	Genl	Page 3	Gen I Page 4
Gen Inf Educ	Pain	IV	Resp	CV	Neuro	GI	GU M/S	Skin	P/S	Rest	мн	Func	DP	PCE	View Tex	t			
							* Designate	s a requi	ed field	- <u> </u>	io to radi	iogroup:	to an Ad	vance Di	rective	-	Go	1	
Performing asses	ssment																		

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 3 window

RN Reassessment - VHLSJE, JELUAHT A	LRUHYJH (5326) W	ard: 4CT	
EDUCATIONAL ASSESSMENT			
Patient/Iamily/support person Why could no one respond able to respond to questions Petern unable to communicate No family/support person present Dither	* Other reason no one could respond	* Information obtained from	* Other source of information
	* Describe why	unable to read	* Describe why unable to write
		* Has ability to write	
* Other education level			
* Educational Level	Prior patient response:	Prior patient response:	
Learns best by	Prefera	* Readiness to learn	
Prior patient response:		Prior patient response:	
* Baniers to learning * Describe identified baniers * Other baniers	*Knowledge of current illness, surgery, reason for hospitalization etc as	* Information provided to patient/support person on the following topics	* Other topic provided
	Prior patient response:	Joint Commission Phone Number: 1-800-994-6610	
		[Educ Page 1 Educ CP
Gen Inf Educ Pain IV Resp CV Neuro GI GU I	M/S Skin P/S Rest MH	Func DP PCE View Text	
* Desi	ignates a required field Go to radio	group: able to respond to questions 🔹	Go

RN Reassessment, Educational Assessment (Educ) tab, Educ Page 1 window



RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window

RN Rea	assessment - BD Help	YDXY,ILQI	DIA (2902)	Ward: F	HX-AI	OMISSIO	ON SCHE	DULED		<u>_ ×</u>
	No IV/vascular access device									
Colorit or	nonvisional line. Numbers non net	e In a convential if your	ward shawing D /Cad D/a							
NUMBER	R LOCATION	De sequential il you a	TE INSERTED	SIZE	DISCONTIN	NUED	UPDATED			
NONE									Add New IV Location	n
Show	v discontinued IVs also									
Edit Peripheral	I Line Site	Ither location					ther size	-		
* Location	one 🔻		* Date/time inserted						liscontinued	
								IV disco	intinue date/time	
	🗖 Dressing chan	je	Tubing change							
	Last changed: Dressing date/time	change	Last changed: Tubing date/time change							
* Other dressin	ng condition * Dressing type *	Other dressing type	* Site characteristics		inage	* Other site	appearance *	Describe pater	ncy	ок
									Car	cel edit
									1.000	
Gen Inf Educ	Pain N/ Beso DV	Neuro GI	GIL M/S Skin	P/S Bes	т мн	IV Periph	IV Central	Text Text	IV Comments	IV UP
			* Designates a requir	ed field						
Performing asse	essment		2 2.1.ghadoo a roqui							

RN Reassessment, IV (IV) tab, IV Periph window

RESPIRAT Patient/famil able to respo C Yes	ORY ASSI y/support per nd to question	SSMENT	y could no Patient una No family/s Other	one resp ble to cor upport pe	ond nmunicate rson present	* Other read	ion no one d	could respond		* Information	n obtained from * C	ther source of information
'atient has a l	iistory of	× 08	er history		* Resp Re Ine Ine Ine * Res	iratory pattern igular igular - Agona igular - Cheyn igular - Kussm igular - Other spiratory rate	I e-Stokes al		* Otherrespi	ratory pattern	* Respiratory depth C Normal C Deep C Shallow * Chest movement C Equal, bilateral, s C Abnormal	ymmetrical
Vork of breat No difficulty Dyspnea (sl Nasal flaring Orthopnea Pursed Lips Use of acce Other	ning observed nortness of br g essory muscle	eath) s	er work of	breathing				× Cyanosis ⊂ None ⊂ Central - ti ⊂ Peripheral	ingue and lips - earlobes, fingertips, ar	ound lips	* Abnormal Chest Mov	ement
-* Breath so C Clear C Abnorm	unds	Absent		Crackle	s/Rales	Diminish	ed/decreas	ed Rhonchi	Wheezin	g - expiratory	Wheezing - inspiratory	Strider Bleural friction rub

RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 1 window

ESPIRATORY ASSESSMENT						
☐ Productive cough present Prior response: Prior response:		or * Other spi	utum color	* Sputum con	sistency * Other sputum co	
Chest tubes Chest tubes present "Location 1 ior response: NO	* Suction	* Other suction	* Air Leak	* Chest tube	drainage * Dressing	* Other dressing
Location 2	* Suction	* Other suction	* Air Leak	* Chest tube	drainage * Dressing	* Other dressing
Cither chest tube locations						
Other ohest tube locations acility ordered oxygen Facility ordered oxygen	* Other liter flow		* Other derivery method	Oxygen saturation %	Ventilator dependent * Ventilator dependent - c	- chronic chronic comments
C Other chest tube locations actility ordered oxygen	* Other Ree flow Respiral	ary Consult	* Other delivery method	Oxygen seturation %	Ventilator dependent * Ventilator dependent - C	chronic comments

RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 2 window

RN Reassessme	ent - \	/HLS	SJE,J	ELUA	HT A	LRUH	IYJH ((532	5) V	Vard: 4	ICT						_	s ×
<u>-</u> ile <u>T</u> abs <u>H</u> elp																		
	SMENT																	
-Tracheostomy	DIVICIN																	
Tracheostomy present	* Other tr	ach type					a appearanc	e		ther stoma ap	opearar	nce			2	" Other dress	sing	
			×Ţ	racheost	omy size													
Trach recently inserted * Insertion date/time							Tra * Remo	ch remove ved date/	ed /time	Dr * Dres	essing sing da	change? ite/time cl	hange	* Dressing t	ype '	" Other dress	ing type	
				ype of to	bacco us	ed												
											uctions	for former	r usage					
Prior response:																		
										Gene	eral Ob:	servations	s/Comm	ents				
* Approximate quit date:																		-
										,								
	_									Resp Page	1 B	esp Page	2	Other CT Loc	Res	p Page 3	Resp CF	
Gen Inf Educ Pain IV	Resp		Neuro	GI	GU	M/S Sk	in P/S	Rest	<u> MH</u>	Func D	P.	PCE	View Te	ext				
rforming assessment					* Des	signates a re	quired field											
a second second																		

RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 3 window

'atient/family/support person	* Why could no a	one respond	* Other reason no	o one could respond	* Information obt	ained from	* Other source	of information
le to respond to questions	✓ Patient unabl ✓ No family/sup ☐ Other	e to communicate aport person present						
ient has a history of C) ther history	Edema and I * Edema C Yes C No	Locations - Mark on Right arm	ly the locations where Left arm	edema is found Right hand	Left hand	Rightleg	Left leg
			u Prior resp: Pedal right	Prior resp: Pedal left	Prior resp: Facial	Prior resp. Periorbital	Prior resp: Secrel	Prior resp:
		Prior resp:	Prior resp:	Prior resp:	Prior resp:	Prior resp:	Prior resp:	Prior resp:
remities Warm Cool Capillary Refill Less than 3 Seco Capillary Refill Greater than 3 Se	Extremities co nds conds Prior commen	mments ts	Auscultation	B	* Heart rhythm C Regular C Irregular	Heart sounds Normal Abnormal	* Describe abno	rmal sound

RN Reassessment, Cardiovascular Assessment (CV) tab, CV Page 1 window

RN Reassessment - VHLSJE,JELUAI File Tabs Help	HT ALRUHYJH (5326) Ward:	4CT _ 공 X
CARDIOVASCULAR ASSESSMENT Pulses Left Right Left	a <u>lis Pedis Pulse</u> Right Left Rij V V V	Pulse ph
* Describe venous distension Yes No Prior response:	Fight Celf Left Celf	Cardiac monitor C Yes C No
Cardiac devices	Prositive is call pain reported on flexion of foot Permanent pacemaker	
Implantable cardioverter/defibrillator (ICD) Implantable cardioverter/defibrillator (ICD)	* Other cardiac device Uther device	Prior cerdiec monitor response: * Other cerdiec monitor rhythm
		T Wave:
General observations/comments	PR Interval:	QT Interval:
	QRS Dureton:	ST Segment
Gen Inf Educ Pain IV Resp CV Neuro GI C	M/S Skin P/S Rest MH Func * Designates a required field Go to radiogroup: J	CV Page 1 CV Page 2 CV CP DP PCE View Text ugular Venous Distensión V Go
Performing assessment		

RN Reassessment, Cardiovascular Assessment (CV) tab, CV Page 2 window



RN Reassessment, Neurological Assessment (Neuro) tab, Neuro Page 1 window

RN Reassessment - VHLSJE, JELUAHT ALRUHYJH (5326) Ward: 4CT	_ & ×
Eile Iabs Help	
Assess motor stroph bilated. Assess motor stroph bilated. Have the paint flaw, and extend arm against your hand, squeeze your finger; it lies will see via extend arm against hold ag atraph and it it against gavity, and the send extend foot against your hand. Grade each externity using the scale below. 5 + Active movement of externity against gavity and maximal resistance 4 + Active movement of externity against gavity and maximal resistance 2 + Active movement of externity against gavity and maximal resistance 2 + Active movement of externity against gavity and maximal resistance 2 + Active movement of externity against gavity and maximal resistance 2 + Active movement of externity against gavity and the scientistance 2 + Active movement of externity against gavity and the scientistance 2 + Active movement of externity against gavity and the scientistance 2 + Active movement of externity against gavity and the scientistance 2 + Active movement of externity built of against gavity 1 + - Slight movement (licks of contraction) 0 - No movement Prior resp: Prior resp: Prior resp: Prior resp: Prior resp: Prior resp: Prior resp: 2 + Active movement of externity built of against gavity 3 + Active movement of externity built of against gavity 4 + - Slight movement (licks of contraction) 9 + Prior resp: Prior resp: Prior resp: 4 + - Active movement of externity built of against gavity 4 + - Slight movement (licks of contraction) 9 + Prior resp: Prior resp: 4 + - Active movement of externity built of against gavity 4 + - Slight movement 4 + - Active movement of externity built of against gavity 4 + - Slight movement (licks of contraction) 5 + - Active movement of externity built of against gavity 5 +	
Pupts Beachinty Image: New lens implant/prosthesis Size * Other pupil size Prior response: C gual * Describe new lens implant/prosthesis C left greater than left * Describe new lens implant/prosthesis C left greater than left * Describe new lens implant/prosthesis C left greater than left * Describe new lens implant/prosthesis C left greater than left * Describe new lens implant/prosthesis C left greater than left * Describe new lens implant/prosthesis No reaction to light * Describe new lens implant/prosthesis No reaction to light * Describe new lens implant/prosthesis Phior response:	
"New sensations present "New sensations present "New comm device needed General observations/comments General observations/comments General observations/comments Device to meet basic needs Prior response:	
Gen Inf Educ Pain IV Resp. CV Neuro GGI GU M/S Skin P/S Rest MH Func. DP PCE View Text	Neuro CP
= vesignares a required reid Go to radiogroup: jove ▼ GO ■	

RN Reassessment, Neurological Assessment (Neuro) tab, Neuro Page 2 window

SASTROINTESTINAL ASSESSMENT Second and the commerce of the reason no one could respond in information detained from information in the commerce of the reason no one could respond in information detained from information information Pedient has a history of information commerce of the reason no one could respond information detained from information Pedient has a history of information commerce of the reason no one could respond information detained from information Pedient has a history of information commerce of the reason no one could respond information detained from information Pedient has a history of information commerce of the reason no one could respond information detained from information detai	RN Reassessment - VHLSJE,JEI Ele <u>T</u> abs <u>H</u> elp	UAHT ALRUHYJH (5326) V	Vard: 4CT	_ & ×
* Petert/fenkly/seport person * Why could no one respond * Other rescor no one could respond * Information distinct from * Other source of information * Patert/fenkly/seport person present * Potert/fess a history of * Other has a history of the has a history of history has a history of history has history of history has a history of history has history has a	GASTROINTESTINAL ASSESSMENT			1
	Patient/lamily/support person Able to respond to questions Ves Yes No Iamily/support person Other	d * Other reason no one could respond * In unicate in present	formation obtained from * Other source of information	
Bowel patern * Other bowel patern * Other bowel program schedule Devel program schedule * Bowel care - start time Bowel care - concletion time * Bowel care - concletion time * Bowel program schedule GI Page 1 GI Dev GI Page 2 GI Page 3 GI CP Server A * Designates a required field Go to radiogroup: Bowel sounds Go	* Patient has a history of * Other history	Abdommal Assessment Abdomen Other abdominal assessment Firm Firm Guteranded Guterande Guterande Round Round Sott Firm Fireder Cuterande	Bowel sounds Bowel sounds commen Present Absent Last Bowel Movement Date Known C Unknown	ts ient
Bowel pattern Child David pattern Construction in the call of the pattern of of the	Bowel regime × Other bowel pattern	× Lavative name and frequency of rice	* Enema time and frequency of use	
Phior response: * Other bowel program schedule: * Bowel page - start time: * Bowel page - completion time: Medication/treatment. Bowel program schedule: * Bowel page - start time: * Bowel page - completion time: Medication/treatment. * Bowel program schedule: * Bowel page - start time: * Bowel page - completion time: Medication/treatment. * Bowel program schedule: * Bowel page - start time: * Bowel page - start time: Medication/treatment. * Bowel program schedule: * Bowel page - start time: * Bowel page - start time: Medication/treatment. Git Page 1 Git Dev: Git Dev: Git Dev: Git Page 2 Git Page 3 Git CP an Int/ Educ: Pain IV Resp. CV Neuro: Git Dev: Bowel page 3 Git CP feature: * Designates a required field Go to radiogroup: Bowel page 3 Git CP		Laxative use	Enema use	
GIPage 1 GIDev 2 GIPage 2 GIPage 3 GICP Den Inf 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. Bowel sounds V Go	Prior response: Bowel program achedule Bowel program achedule	* Bowel care - start time * Bowel care - c	completion time Medication/treatment	
* Designates a required field Go to radiogroup: Bowel sounds 💌 Go	Gen Inf] Educ Pain IV Resp CV Neuro Gi	GiPoge 1 GU M/S Skin P/S Rest MH	GIDev GIDev 2 GIPage 2 GIPage 3 Func DP PCE View Text	GICP
torming assessment	erforming assessment	* Designates a required field Go to rad	diogroup: Bowel sounds 🛛 🗸 Go	

RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 1 window

RN Reassessment - VILSJE, JELUARI A	ALRUHYJH (5326) Ward: 4CT	_ 8 2
CASTONITESTINAL ASSESSMENT		
CAST TO REPORT AND A SESSIVERT		
-GI Device #1	- GI Device #2-	
None	None	
New since last assessment	New since last assessment	
Date/ime	Date/ime	
Removed since last assessment	Removed since last assessment	
Date/time	Date/time	
GI Device #3	GI Device #4	
* Type GI device comments	* Type GI device comments	
None	None	
New since last assessment	New since last assessment	
Dete/ime	Date/ime	
 Removed since last assessment 	Removed since last assessment	
Date/ime	Date/time	
	GIPage 1 GIDev GIDev 2 GIPage 2 GIPa	age 3 GICP
Inf Educ Pain IV Resp LV Neuro GI GU	M/S Skin P/S Hest MH Func DP PDE View Text	

RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Dev window

RN Reassessment - VHLSJE, JELUAHT ALRUHYJH (5326)	Ward: 4CT
GASTROINTESTINALASSESSMENT	
Oral Screen Assessment - Mucous Membrane Assessment - General Assessment - Mucous Membrane Bleeding Openotic Difficulty chewing Difficulty washowing Difficulty washowing Difficulty washowing Al tech present Pale Pool Centrion Pink No dentition Fink	Nutrition screen* Appetite * Other
Dietay Histoy * Does pelient have any ethnic/cultural/ * Food preferences/Special diet needs.	Height: 56.25 in [168.3 cm] (03/11/2011 03:14) Weight: 229.94 lb [104.5 kg] (06/22/2011 12:30) BMI: 36.9 IJUN 22, 2011@12:30.48)
Phor response: * Does patient have any	Unintentional weight loss of Patientreopts wrintentional agin/ loss of weight in the past month
Prior response: Prior food preferences	Pilor response: Nutrition consult guidelines Patent on tube feeding of total parenteral nutrition 5% unienterional weight gain or loss in past 30 days 5% unienterional weight gain or loss in past 30 days Less than 5% unaul rinks for greater than 3 days Less than 5% unaul rinks for greater than 5 days Dysphagia or dysphagia symptom
Gen Ind Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest 1	e 1 GI Dev GI Dev 2 GI Page 2 GI Page 3 GI CP 4 HH Func DP PCE View Text
* Designates a required field Go I erforming assessment	to radiogroup: Description of patient 🔍 Go

RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 2 window

RN Reassessment - VHLSJE,JELUAH	T ALRUHYJH (5	326) Ward: 4	СТ	_ & ×
GASTROINTESTINAL ASSESSMENT				
Dysphagia screen Dysphagia screen Able to screen Unable - Patient un Ovenilator Unable - Patient unconscious	* Diagnosis of new stroke, head and neck cancer, or traumatic brain injury	Dysphagia risk factors * Modified texture diet/ eating maneuvers (e.g. chin tuck; head turn)	* Unable to follow commends	
Phior response:	Prior response: Wet gurgly voice	Prior response: Drooling while awake	Prior response: * Tonque deviation from midine Speech Consult)	
	Prior response:	Prior response:	Prior response:	
Gentral Educ I Pain IV I Resn I TV I Neuro ci (Gil		GiPage1 GiDev	GIDev.2 GIPage 2 GIPage 3	GICP
	Designates a required field	Go to radiogroup: Dyst	shagia screen 🗸 Go	
erforming assessment				

RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 3 window

RN Reassessment <u>File T</u> abs <u>H</u> elp	t - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT	BX
GENITOURINARY ASSES	SMENT	
* Patient/family/support person able to respond to questions	* Why could no one respond * Other reason no one could respond * Information obtained fram * Other source of information ♥ Patient unable to communicate ♥ No family/support person present Other	
* Patient has a history of	Voiding Line "Voiding "Intermittent catheterization frequency "Other voiding Color Anber Yellow Bloody Bloody Bloody Consistency Normal Consistency Consistency Normal Date Consistency Consistency Constency Constency	
* Other History	Control of the sector of	
Gen Inf Educ Pain IV F	Resp. CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text	
Performing assessment	* Designates a required field Go to radiogroup: Color 👻 Go	

RN Reassessment, Genitourinary Assessment (GU) tab, GU Page 1 window

GENITOURINARY ASSESSI	MENT					
GU Device #1 Type None	GU device comments	GU Device #2 * Type None Inserted since last assess Date/lime inserted	GU device or ment	amments		
Removed since last assessment Date/time		Removed since last asse Date/time	sment			
-GU Device #3		 GU Device #4				
Type None Inserted since last assessment Date/time inserted	GU device comments	* Type None Inserted since last assess Date/time inserted	GU device co ment	omments		
Removed since last assessment Date/time		Removed since last asse Date/time	isment			
				GU Page 1 GL	J Dev GU Page 2	GU CP

RN Reassessment, Genitourinary Assessment (GU) tab, GU Dev window

RN Reassessment - VHLSJE	JELUAHT ALRUH	IYJH (5326) Ward: 40	CT	_ 8 ×
<u>File Labs Help</u>				
GENITOURINARY ASSESSMENT				
Current Devices Current Devices	* Indweling catheter size	* Other device	Concerns voiced reparding	
Continuous Ambulatory Peritoneal Dialysis Continuous Bladder Irrigation Continent Urinary Diversion (e.g.ileo-conduit) External catheter (condom)	Prior repsonse		sexual functioning * Sexual Functioning concerns voiced	
Indwelling urinary catheter Nephrostomy bag Suprapublic catheter Ureterostomy bag Other		Indwelling removed		
Female patients				
* Pregnancy				
Approxima	e date	Approximate date	Approximate date	
Male natients				
Approximate da	e	General observations/comments		
Last PSA: 10/14/10 @ 0819 0.74				
			GU Page 1 GU Dev GU Page 2	GUCP
Gen Inf Educ Pain IV Resp CV Neu		kin P/S Rest MH Func DP	PCE View Text	
Performing assessment	* Designates a ri	equired held		

RN Reassessment, Genitourinary Assessment (GU) tab, GU Page 2 window



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

Fall risk assessment in Yes ONo	AL ASSESSMENT - MORSE F dicated	ALL SCALE	Instructions for completing Morse Fall Scale History of falling:
* History of falling	Describe previous falls and history		Score as 0 if the patient has not tailen Score as 2 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 secures or an imparted galt pilor to admission. Note: If a patient falls for the first time, then his or her score immediately increases by 25.
Tracture Location	* Other fracture location	* Is patient on any meds that increase risk for falling or risk for incury with falls Other medication that increa	Seconday diagnosis: Scate as 0 if only one medical diagnosis is listed on the patient's chart. Scate 15 fit more than one medical diagnosis is listed on the Use of multiple medications is implied in the scale as indicated by the secondary diagnosis (co-mobidity score).
	* Is patient on multiple meds to		Ambulatory addr. 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 no get out of bed at all. Score as 15 if the patient uses clutches, a cane, or a walker. Score as 30 if the patient ambulates clutching onto the furniture for support.
			Intravenous therapy: Score as 0 is palient does not have an IV or Heparin/Saline Lock. Score as 20 if the palient has an intravenous apparatus or a heparin lock inserted.
			Gait: Score as 0 a normal gait which is characterized by the patient walking with head erect, arms swinging freely at the side, and
Total Morse sco ior score: Not assessed ate:	re for Fall Risk: N/A	0 - 24 - Patient is at low risk for falling. Implement Universa 25 - 44 - Patient is at moderate risk for falling. Implement Ur 45 and higher - Patient is at high risk for falling. Implement U	al Fail Precautions niversal Fail Precautions and precautions based on identified area of risk Universal Fail Precautions and precautions based on identified area of risk

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



RN Reassessment, Skin Assessment (Skin) tab, Skin Page 1 window

RN Reassessment - VHLSJE, JELUAHT ALRUHYJH (5326) Ward: 4CT	3 ×
SKIN ASSESSMENT BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK	
SENSORY PERCEPTION Ability to respond meaningfully	
MOISTURE: Degree to which skin is exposed to moisture 1. CONSTANTLY MOIST: Skin is kept moist almost con- by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	
ACTIVITY: Degree of physical activity ACTIVITY: Degree of physical activity BEDFAST: Patient is confined to bed. CHARFAST: Patient is confined to bed. CHARFAST: Patient's ability to valk is severely limited /ul>	
[Stim Page 1] Skim Pr UII 1 Skim AP 1	
* Designates a required field Go to radiogroup: Skin assessment indicated 👻 Go	

RN Reassessment, Skin Assessment (Skin) tab, Skin Page 3 window

Part P PSYCHOSOCIAL ASSESSMENT **Other seguent and the respond **Other secure of Promition **Other secure of Promitin secure of Promition	RN Reas	ssess Holp	ment	VHL	SJE,J	ELUAH	T ALF	RUHY	JH (5326) W	/ard:	4CT						_ & >
**Patert/family/support person adde to respond a questions	PSYCHOSO	ICIAL AS	SESSME	νT															
Patient History * Other History * Other Johnson * Other Johnson Patient History of Prior response: Prior response: Prior response: Suspected Abure/Neglect Screen Dest patient response: Prior response: * Explain about, others in household due to register by the patient? * Explain about, others in household due to register by the patient? * Explain about, others in household due to register by the patient? * Explain about, others in household due to register by the patient? * Explain about, others in household due to register by the patient? * Explain about, others in household due to register by the patient? * Explain about, other	* Patient/family. able to respon	/support p nd to quest (* Na	erson tions	* Wh	y could no ('atient unab lo family/su Ither	one respond le to commun pport person j	icate present	ther reason	no one o		nd	* Inform		ined from			* Othe	source of infor	mation
Prior response:	* Patient has a hi	istory of				er history)ther attit	ude					her behavior	
Description response: Pior response: Based upon nursing assessment, is and of the following suspected? Prior response: Pior response: Pior response: Pior response: Prior response: Pior response: * Explain suspicions Prior response: Pior response: * Explain statut others in household abuse or neglect by the pairs? Prior response: Pior response: * Explain statut others in household abuse or neglect by the pairs? Prior response: Pior response: * Explain statut others in household abuse or neglect by the pairs? Prior response: Pior response: * Explain statut others in household abuse or neglect by the pairs? Pior response: Pior response: * Explain about others in household abuse or neglect by the pairs? Pior response: Pior response: * Explain about others in household abuse or neglect by the pairs? Pior response: Pior res		hune Aleah	ect Screen					I	Prior resp	onse:					Prior	response:			
Prior response: Pior response: Based on nursing assessment, are offners in the household opsale within of abure or neglect by the palent? Social Work Consult Social Work Consult P/S Page 1 P/S Page 2 P/S Page 3 CIWA P/S Page 4 P/S CP ninf 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; Verbal abuse V Go	Prior response	<u>Do</u> e	<u>es patient re</u> Prior re	<u>ort any of</u> ponse:	the followin	<u>a?</u> Prior response	e:						Base Verba © Y Prior re * Expla	d upon nu al abuse es O sponse: in suspició	nsing asses No	Physical	ny of the fo abuse C No onse:	Neglect Veglect Ves C Prior respon	ed? No
P/S Page 1 P/S Page 2 P/S Page 3 OWA P/S Page 4 P/S CP m In/ 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; Verbal abuse v Go	Prior response	8:	Prior re	ponse:	ocial Work	Consult						Ba in C C Priv	sed on nu the house buse or n Yes No Unkno or respon	ursing ass shold pos reglect by wm se:	essment, ai sible victim the patient	re others s of *1	Explain ab	out others in ho	usehold
*Designates a required field Go to radiogroup: Verbal abuse V Go	en Inf Educ	Pain	IV Ret		Neuro	61 61	M/S	Skip	- P/C	P/S P	age 1	P/S P	age 2	P/S Pa	je 3	CIWA	P/S Pa	ige 4 P/1	CP
						0	* Designa	ites a requi	ed field	G	o to radi	group:	Verbal at	ouse		•	Go		

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

PSYCHOSOCIAL ASSESSMENT Suicide Risk Screen Ask Patient *Here you recently had throughts about * Do you have a plan for how to do this Prior response: Prior response: *Here you referenced or practiced * Have you head voices tellin how to kill yourseft Prior response: * Have you head voices tellin how to kill yourseft Prior response: * Have you head voices tellin how to kill yourseft Prior response: * Have you thied to host or kill * Have you thied to host or kill or kill yourseft in the past * Have you thied to host or kill or kill yourseft in the past Prior response: * Prior response: *	LRUHYJH (5326) Ward: 4CT	×
Subide Risk Screen Ask Patient * Have you recently had thoughts about * Do you have a plan for how to do this Prior response: Prior response: * Have you released or practiced how to kill yourself * Have you head voices telling to hust or kill yourself Prior response: Prior response: * Have you tried to hust or kill Prior response: Prior response: Prior response: * Have you tried to hust or kill * How have you tried to hust or kill yourself in the past Prior response: Prior response: * Have you tried to hust or kill * How have you tried to hust or kill yourself in the past Prior response: Prior response: Prior response: Prior response:		
Ask Patient * Have you recently had thoughts about * Do you have a plan for how to do this Prior response: Prior response: * Have you released or practiced how to kill yourself * Have you head voices telling to hust or kill yourself Prior response: Prior response: Prior response: Prior response: Prior response: Prior response: * Have you head to hust or kill * How have you head to hust or kill yourself in the past Prior response: Prior response: Prior response: Prior response: Prior response: Prior response: Prior response: Prior response:		
" Have you recently had thoughts about * Do you have a plan for how to do this Prior response: Pilor response: * Have you reheased or practiced how to kill yourself Prior response: Pilor response: * Have you hied to hurt or kill Prior response: * How have you hied to hurt or kill yourself in the past Prior response: * How have you hied to hurt or kill yourself in the past Prior response: * How have you hied to hurt or kill yourself in the past Prior response: * How have you hied to hurt or kill yourself in the past Prior response: * How have you hied to hurt or kill yourself in the past		
Prior response: Prior response: * Have you refeared or practiced how to kill yourself * Have you heard voices tellin to hut or kill yourself Prior response: Prior response: * Have you tried to hut or kill * How have you tried to hut or kill yourself Prior response: * How have you tried to hut or kill yourself	* Describe plan * Desc Ave there means available	cribe means
Prior response: Prior response: * Have you reheated or practiced how to kill yourself * Have you head voices telling to hut or kill yourself Prior response: Prior response: * Have you tried to hurt or kill * How have you tried to hurt or kill yourself in the past Prior response: * How have you tried to hurt Prior response: * How have you tried to hurt	Prior plan Prior p	means
" Have you reheased or practiced how to kill yoursel? " Have you head voices tellin to hurt or kill yoursel? Prior response: " How have you tried to hurt or kill yoursel? How have you tried to hurt or kill or kill yoursel? How have you tried to hurt or kill yoursel?	Prior response:	
Prior response: Prior response: * Have you tried to hurt or kill * How have you tried to hurt or kill or kill you sell in the past Prior response: Prior response:		
* Have you tried to hurt or kill * Hove have you tried to hurt or kill or kill yourpell in the past	Comments relative to suicide	
Prior response:	* Are you feeling hopeless about the present or lature e.g. feeling that there	
Senter Fabro Davin IV Beron IV Neuro GI GII	Prior response:	
Sen Inf Educ Pain IV Been DV Neuro GI GI		
Gen Inf Educ Pain IV Beso CV Neuro GL GL	P/S Page 2 P/S Page 3 CIWA	P/S Page 4 P/S CP
	M/S Skin P/S Rest MH Func DP PCE View Text	
*De	ignates a required field	

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

le <u>T</u> abs	<u>H</u> elp	ent - VHL	SJE,JEL	UAHT ALRUHY	JH (5326) Ward: 4C		
PSYCHOS	OCIAL ASSES	SMENT					
Elopement S * Patient has appointed le C Yes Prior response * Specify gual	Screen - If any YE is a court- egal guardian © No e: irdian	S answer, then p * Patient ha: legally comn Yes Prior response Prior guardian	atient is a poten s been nitted C No c response	tial wandering/elopement risk- * Patient is considered a to him/herself or others- C Yes Unkno Prior response: * Patient has history of	danger "Patient is on legal observation status for Gravely Disabled "Yes No Prior response: Date/from where if known	* Patient lacks the cognitive ability decisions (e.g. history of dementia or traumatic brain injury) Yes No Prior response: Prior escape/elopement response	to make relevant "Alzheimer's Social Work Consult)
				Prior response:			
Chemical De	ependency Issue	;					
"Alcohol use	e			* Date of last alcoho	ol use * Does patient use recrea	ational drugs * Date of last drug u	se
Prior response * Type of reor	e: reational drugs us	ed	* Does pati a medical n C Yes Prior respons	ent have narijuana card C No e:	Prior response: If Yes to use of recreations	l drugs, notify provider □ Pos	sibility of alcohol withdrawal
Prior response * Type of recr Make Alcohol	e: reational drugs us I Treatment referr	ed al if patient is inte	* Does pati a medical n C Yes Prior respons rested.	ent have narijuana card Ĉ No e:	Prior response: If Yes to use of recreations	l drugs, notify provider 🗖 Pos	sibility of alcohol withdrawal
Prior response * Type of reor Make Alcohol — Contraband- * Contraband- (in to/by) ti — Yes — No	e: reational drugs us I Treatment referr L and brought the patient	ed al if patient is inte * Describe co	* Does pati a medical n C Yes Prior respons rested.	ent have narijuana card C No e:	Prior response: If Yes to use of recreations * Location of unremoved o	al druge, notify provider Pos	sibility of alcohol withdrawal
Prior response * Type of reor Make Alcohol Contraband. * Contraba (in to/by) ti C Yes C No Prior respon	e: reational drugs us I Treatment referr and brought the patient	ed al if patient is inte *Describe co	* Does pati a medical n C Yes Prior respons ested.	ent have narijuana card C No e:	Prior response: If Yes to use of recreations * Location of unremoved o	al druge, notify provider Pos	ibility of alcohol withdrawal
Prior response * Type of reor Make Alcohol Contraband * Contraband * Contraband * Contraband * Contraband * Contraband * Contraband * Contraband * Contraband * Nor Prior response * Nor Prior response * Nor * N	e reational drugs us I Treatment referr and brought the patient	ed I il patient is inte * Describe co	* Does pati endical n Prior respons ested. traband	ent have nariyuana card C No e:	Prior response: If Yes to use of recreations * Location of unremoved of P/S Page 1 P/S Page 2	il drugs, notity provider Pos ontraband Follow facility policy fo	ibility of alcohol withdrawal r contraband removal P/S Page 4
Prior response * Type of recr Make Alcohol Contraband * Contraband * Contraband * Contraband * Contraband * Contraband * Contraband * Contraband * One * No Prior response * No Prior response * No * No	e: reational drugs us I Treatment referr and brought the patient nse: Patin IV	ed al if patient is inte "Describe co	* Does pati emedical n Yes Prior respons ested. traband	ent have narijuana card C No e: 	Prior response: If Yes to use of recreations * Location of unremoved o P/S Page 1 P/S Page 2 P/S Rest MH Func DP	al druge, notify provider Pos ontraband Follow facility policy fo P/S Page 3	ability of alcohol withdrawal contraband removal P/S Page 4 P/S CP

RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 3 window
RN Reassessmer File Tabs Help	nt - BDYDXY,IL	QDIA (2902) Ware	i: PHX-ADMISS	SION SCHEDULED	
RESTRAINTS	* Date/time initiated C Known C Unknown	Initiated date/time	lotify provider ***		
* Reason for restraint C Patient is pulling at lines/tube C Patient's behavior is aggressi	s used in their treatment or is u ve or violent presenting an imm	nable to follow instructions endangering ediate serious danger to his/her safety o	their medical /surgical recove or that of others.	ry. Patient is not violent or self-destructive	
* Justification for restraints *	Other justification	* Justrication for restraints	* Other justification	Behavioral expectations for termination of restraints Does not pall at lines/tubes Orntracts for safety Derries self harm Derries self harm Derries self harm Displays no aggression to self/othe Other	[•] Other behavioral expectation
Restraint Type Ankle, Right, Locked Ankle, Right, Unlocked Ankle, Lett, Locked Ankle, Lett, Unlocked Blanket/Net Hand Mit, Left Yest, Locked West, Unlocked West, Unlocked West, Unlocked West, Unlocked West, Unlocked West, Unlocked Witt, Left, Locked Witt, Left, Unlocked Witt, Left, Unlocked	Other Restraint	Interventions tried to avoid restraint use Bed alarn Cancollage ines/tubes Diversional activities Family at bedide Hourly rounding Laptop trie Conv bed with mater Move closen to russe's station Pain relief medicine Painer (Tamily education Painer (Tamily education Painer), go prine/tubes Side rail, go thes Side rail, go thes Side rail, go thes	• Other intervention	Discontinued - desired o Discontinued date/time	utcome achieved
Gen Inf Educ Pain IV	Resp CV Neuro Gi	GU M/S Skin P/S *Designates a required field	Rest MH Func [P PCE View Text	iestr Page 1 Restr CP

RN Reassessment, Restraints (Rest) tab, Restr Page 1 window

* Patient/Tamily/support person * W * Patient/Tamily/support person * W * Dable to respond to questions W © Yes • No	NT admitted to acute psychiatry hy could no one respond Patient unable to communicate	, or with a history of men Other reason no one could re	tal health problems		
Tab to be completed for patients *Patient/family/support person able to respond to questions C Yes No	admitted to acute psychiatry hy could no one respond Patient unable to communicate	, or with a history of men Other reason no one could re	tal health problems		
*Patient/family/support person *W able to respond to questions	hy could no one respond Patient unable to communicate	Other reason no one could re			
	No ramiy/support person present Other			* Information obtained from	* Other source of information
" Patient has a history of		* Other history	Ask patient: "What things or	situations make you upset?"	* Other upsetting item
" Ask patient "Have you ever been so a	angry				
Prior response: "How does patient act when * OI he/she loses control	her actions	" Ask patient "When you	get upset, ≚What does pat	ient do to calm him/herself	" Other calming things
		Prior response:			
Gen Inf Educ Pain IV Resp	CV Neuro GI GU	M/S Skin P/S	Rest MH Func D	MH Pag	e1 MH Page 2 MHILP
rforming accordment	*	Designates a required field	Go to radiogroup: abl	e to respond to questions	- Go

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

RN Reassessment - VHLSJE, JELUAHT ALF	RUHYJH (5326) Ward: 4CT	_ & ×
<u>File Tabs H</u> elp		
FUNCTIONAL ASSESSMENT		
* Palent/lamily/support person *'Why could no one respond rable to respond to questions Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate Image: Palent unable to communicate </th <th>Other reason no one could respond * Information obtained from</th> <th>* Other source of information</th>	Other reason no one could respond * Information obtained from	* Other source of information
Instructions for completing Katz Index of Independence in Activities of Daily Living		Assist patient with
Bathing: 1: Bathes self completely or needs help in bathing only a single part of the body such as the back, gential 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.		Ambulating Bathing Dressing Feeding Toineting Transfermon
Dressing: 1 - Gets clothes from closets and drawers and puts on clothes and outer garments complete with lasteners. May have help typing shoes. 0 - Needs help with dressing self or needs to be completely dressed.		
Toileing: 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	T	
Continence: 1 - Exercises complete self control over urination and defecation 0 - Is partially or totally incontinent of bowel or bladder	Prior score: 0 Prior score: 6 = High (Patient independent); 0 = Low (Patient very dependent)	Did patient have a decrease in the level of independence
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.	Heter to provider for evaluation if patient has a har score of 4 or less DR a decrease in the level of independence and changes have occurred within the past month.	Prior response:
	Less David Them	Ware 72 Euro Page 2 Euro PD
Gen Inf Educ Pain IV Resp CV Neuro GI GII M/S	Skin P/S Best MH Func DP PCF View Text	et.age.e. renerage.o rune ci
* Designa	ates a required field Go to radiogroup: able to respond to questions	▼ Go
erforming assessment		

RN Reassessment, Functional Assessment (Func) tab, Func Page 1 window

RN Reassessment - VHLSJE,JELU	AHT ALRUHYJH (5326)	Ward: 4CT	_ 8
e <u>T</u> abs <u>H</u> elp			
UNCTIONAL ASSESSMENT			
Instructions for assessing the patient's level of assistance		Assessment criteria and care plan for safe patient handling and movement	
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, cuein	C Independent	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.	g
coaxing, or caregiver is required to lift no more than 35 lbs. of a p	atient's C Partial Assist		
weignij	C Description	Height: 66.25 in [168.3 cm] (03/11/2011 09:14)	
Dependent - Patient requires nurse to lift more than 35 lbs. of the patient's weight, or is unpredictable in the amount of assistance of	offered).	Weight: 229.94 lb [104.5 kg] (06/22/2011 12:30)	
·	Prior response:	BMI: 36.9 (JUN 22, 2011@12:30:48)	
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	0	
pplicable conditions likely to affect transfer/repositioning techniqu	es Prior response:	Prior response: Prior response:	
Transter/reposi	aning rearing as comments		
n Inf Educ Pain IV Resp CV Neuro Gi	GU M/S Skin P/S Rest Mi	Func Page 1 Func Page 2 Func Page 3 Func H Func DP PCE View Text	nc CP
	* Designates a required field Go to	radiogroup: Patient's level of assistance Go	
ming assessment			

RN Reassessment, Functional Assessment (Func) tab, Func Page 2 window

RN Reassessment - VH	ILSJE, JELUAHT ALRUHYJH	(5326) Ward: 4CT	_ & ×
<u>F</u> ile <u>T</u> abs <u>H</u> elp			
			1
FUNCTIONAL ASSESSMENT			
Use of mechanical lifting devices an	d approved aids for lifting, transferring, repos	sitioning, and moving patients.	
Transfer to and from Bed to Chair, Chair to Toilet, Chair to Chair, Car to Chair Equipment/Assistive Device	Lateral transfer to and from Bed to Stretcher, Trolley Equipment/Assistive Device	<u>Transfer to and from Chair to Stretcher or</u> <u>Chair to Exam Table</u> Equipment/Assistive Device	
Ceiling lift Friction reducing device Full body sting Cast belt Lateral transfer device Power stand assist Stiding board	Ceiling lift Frietion reducing device Full body sing Gait belt Lateat lansfer device Power stand assist Stidip board	Callerg lift Friction reducing device Galt body sing Jate It conster device Over stand assist Stang board	
Number of staff 0	Number of staff 0	Number of staff 0	
Reposition in Red, Side to Side, Up in Red Equipment/Assistive Device Celling fith Friction reducing device Full body sing Gat belt Devier stand assist Silding board Number of staff Silning board	Besosition in Chail Couptment Assistive Device Performance of the second seco	Irander a patient up from the floor Equipment/Assistive Device Ceining fit Friction reducing device Full body sing Gat belt Lateral transfer device Cover stand assist Vumber of staf Caucate Patient, Family, and Support Person on	
C Standard C Amputation C Head support	Medium (100 to 210 lbs, height 5 ft - 5 ft 11 in) Large (210 to 550 lbs, height 6 ft and over) Prior response:		
	Height: 5625 in (1683 cm) (03/11/2011 09:14) Weight: 223.94 lb (104.5 kg) (06/22/2011 12:30)	Func Page 1 Func Page 2 Func Page 3	Func CP
Gen Inf Educ Pain IV Resp C	/ Neuro GI GU M/S Skin P/S	B Rest MH Func DP PCE View Text	
	* Designates a required fie	ld Go to radiogroup: Sling type 🗾 Go	
Performing assessment			

RN Reassessment, Functional Assessment (Func) tab, Func Page 3 window

DISCHARGE PLANNING																	
* Patient/family/support person able to respond to questions C Yes C No	* Why could no or Patient unable No family/supp Other	ne respond to communica iort person pre	ite sent		her reas		e could re	spond			ation obtain	ed from	* Other	source of i	nformation		
*Does patient have a legal/ medical guardian (conservator)? © Yes © Ho Pulled from P/S Page 3	* Specify guardian	(conservator)								* Descrit	e employm	ent status					
	* Home environme	nt				* Other a	rchitectur	al barrier	s ×S	pecial Ec	quipment N	eeded at H	ome _{* Ot}	ner equipri	ient neede		
	* Other transporta	ion for dischar	ge			General	observati	ons/com	ments								
														DP Pag	pe 1	DP CP	1
en Inf Educ Pain IV	Resp CV Ne	euro Gi	GU	M/S	Skin	P/S	Rest	MH	Func	DP	PCE	View Text					_

RN Reassessment, Discharge Planning (DP) tab, DP Page 1 window

RN Reassessment - VHLSJE, JELUAHT ALRUHYJH (5326) Ward: 4CT	_ 8	×
<u>File Tabs Help</u>		
DISCHARGE PLANNING - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES		
* Problems, interventions, and desired outcomes indentified in previous tabs have been discussed * Why hasn't plan of oare been discuss	ed	
Anticipated Discharge Man Goals	* Hamiy/support person in discharge planning	
Involve family tupport periods in discharge planning Patient requires transportation assistance " Discharge to home with support services (physiological needs e.g. 02, IV therapy, pain therapy and wound care) " Discharge to home with support services (physiological needs e.g. 02, IV therapy, pain therapy and wound care) " Discharge to home with support services (post-off needs e.g. 02, IV therapy, pain therapy and wound care) " Discharge to home with support services (post-off needs e.g. 02, IV therapy, pain therapy and wound care) " Discharge to home with support services (post-off needs e.g. assistance with home ADLs) " Discharge to home with support services (post-off needs e.g. classes, material) " Discharge to home with support services (post-off needs e.g. assistance with services (post-off needs e.g. assi	Discharge Planning Consult Social Work Consult	
If an item contains **, then a Social Work Consult or Discharge Planning Consult is required		
	Telehealth Consult Home Care Consult	
Gen Inf 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		

RN Reassessment, Discharge Planning (DP) tab, DP CP window

Patient can respond

1. If the patient can respond, select **Yes** and select where the ***Information obtained from**.

RN Reassessment - VHLSJE, JELU	AHT ALRUHYJH (5326) Ward: 4CT	<u>_ & ×</u>
GENERAL INFORMATION		
* Patient/Tamily/support person * Why could no one respond able to respond to questions • Yes • No	* Other reason no one could respond * Information obtained from	ation
Demographics Name: VHLSIEJIELUAHT ALRUHYJH Age: 63 Sex: MALE Race: DECLINED TO ANSWER Admiting diagnosis: CHEST PAIN Prior patient response to "What does patient went to accomplish by this hosphalization"	 [→] Preferred Healthcare Language [→] English [→] Spanish [→] Other 	
" What does patient want to accomplish by this hospitalization"	* Uther Language Prior patient response:	
Gen Inf Educ Pain IV Resp CV Neuro Gi	Gen i Page 1 Gen i Page GU M/S Skin P/S Rest MH Func DP PCE View Text	2 Gen I Page 3 Gen I Page 4
Performing assessment	* Designates a required field Go to radiogroup: able to respond to questions 🗸	Go

RN Reassessment, General Information (Gen Inf) tab, Gen I Page 1 window

- 2. Continue through the reassessment tabs and pages.
- 3. Complete all the fields with asterisks; they are required fields.

Note: For the content of the template, refer to the User Manual for *Admission – RN Assessment*.

4. Upload the information.

Updating the Reassessment Note

PADP provides you with the ability to document simple updates during a tour of duty. You do not have to re-enter a completed reassessment every time you document. For another tour of duty, just return to the reassessment template and update information.

- 1. In CPRS, open the Tools menu and select **RN Reassessment**. RN Reassessment opens to the CPRS patient.
- 2. If the patient had a reassessment completed within the last 24 hours, the following screen displays providing several choices for **initial reassessment for shift** and **update reassessment (full reassessment completed previously on current shift)**.

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RN Reassessment window with Assessment Types

Note: The template that opens is identical to the initial RN Reassessment with one exception-there are no required fields.

- 3. Move to the tab that requires updating. For example, to document that an IV was discontinued:
 - a. Click IV.
 - b. Select an IV to discontinue.
 - c. Select the **IV discontinued** check box.
- 4. Open the File menu and select **Upload Data**. Data is uploaded.
- 5. Sign note in CPRS or from the View Text tab.

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 AssessmentCIWA
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
СР	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

Term	Definition
IV Dialysis	IV Dialysis ports
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
МН	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

Term	Definition
SNOMED – CT	Systemized Nomenclature of Medicine Clinical Terms
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 Admission – RN Assessment, 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 Reassessment Contingency Note



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