Patient Assessment Documentation Package (PADP)

C3-C1 Conversion Project

RN Reassessment User Manual for NUPA Version 1.0

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Department of Veterans Affairs
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Revision History

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August 2010	1.1	Add content	CBeynon
August 2010	1.2	Format content	CBeynon
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Date	Revision	Description	Author
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February 2012	1.16	• Updated Neuro tab • Updated the *Unable to Complete the Assessment* section	CBeynon
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Table of Contents

Introduction 1
Using the RN Reassessment 2
Opening RN Reassessment 2
No Previously Saved Information 3
Previously Entered Information Available for One Patient 3
Restore Patient's Data/No 4
Restore Patient's Data/Yes 4
Previously Entered Information Available for Two or More Patients 4
View the Patients?/No 5
View the Patients?/Yes 5
Patient not yet Assigned to an Inpatient Bed 7
Saving and Uploading Data 7
Auto Save 7
Manual Save 8
Upload Data 8
Save and Exit 9
Save Now 9
Exit 10
Signing Notes 11
Working in a Care Plan 12
Care Plan Table 13
Updating an Existing Problem/Intervention 14
Adding a New Intervention for an Existing Problem 19
Adding a New Problem/Intervention 20
Other Problems 22
Other Interventions 23
Working in the Consults 24
Working in the Template 26
Moving through the Template with a Mouse 26
Moving through the Template without a Mouse 27
Ctrl-Alt Keys 27
Go to Radiogroup 28
Viewing Previously Entered Data 28
Navigating the RN Reassessment Tabs 30
General Information (Gen Inf) 30
Adding an Allergy 31
Initiating a Social Work Consult for Advance Directives 33
Changing Emergency Contact Information 35
Education (Educ) 37
Pain (Pain) 39
IV (IV) 47
No IV/Vascular Access Devices 47
Peripheral Lines - IV Periph 48

Existing IV Lines 48
New IV Lines 50
Central IV Lines – IV Central 52
Dialysis Ports - IV Dialysis 54
General Observations/Comments – IV Comments 56
Care Plan - IV CP 57
Respiratory (Resp) 58
Cardiovascular (CV) 63
Neurology (Neuro) 66
Gastrointestinal (GI) 69
Genitourinary (GU) 75
Indwelling Catheter 78
Musculoskeletal (M/S) 80
Skin (Skin) 84
Documenting Pressure Ulcers 85
Pressure Ulcer Drop-downs 86
Documenting Skin Alterations 88
Skin Alteration Drop-downs 89
Psychosocial (P/S) 94
Restraints (Rest/Restr) 100
Mental Health (MH) 105
Functional (Func) 108
Discharge Planning (DP) 113
PCE Data (PCE) 116
Reminders Due (Display Only) 116
Clinical Maintenance 117
Reminder Inquiry 118
Resolve Inpatient Nursing Clinical Reminders 119
View Text (View Text) 121
Signing Note and Consults from within the Template 122
Unable to Complete the Assessment 124
Patient still cannot respond 125
Patient can respond 143
Updating the Reassessment Note 144
Glossary 145
Appendix A Reassessment Contingency Note 148

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

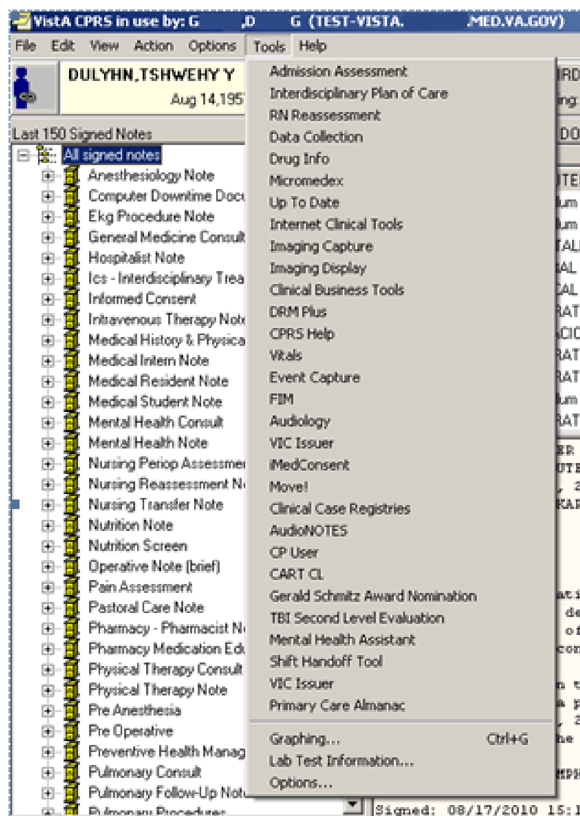
Registered Nurses (RNs) use the RN Reassessment template to document inpatient care in a standardized format at regular times and as needed. With the reassessment template, you collect information associated with new problems and with required physical assessment documentation, such as skin condition,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

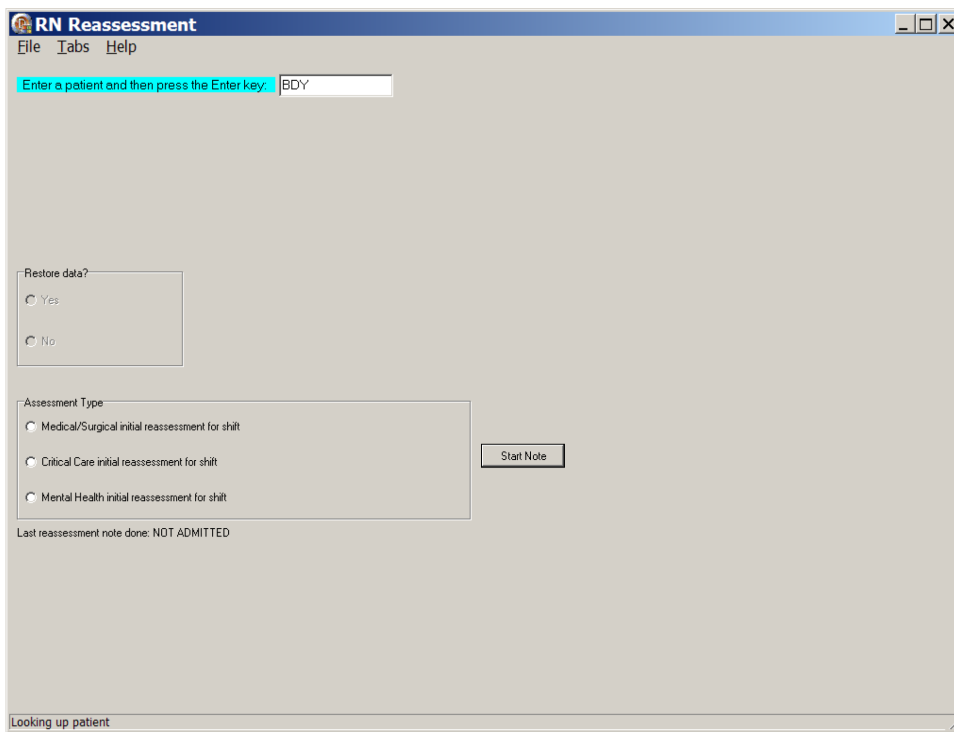
> **Note:** You may have to re-enter your CPRS access and verify codes, depending on local site setup.



Access through CPRS

No Previously Saved Information

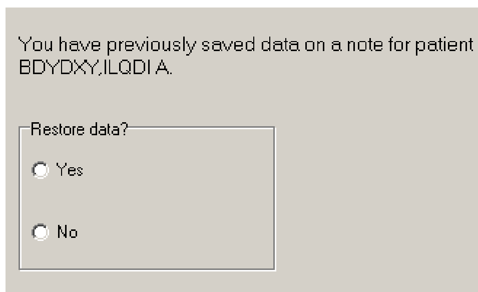
The Enter a patient window displays.



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



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

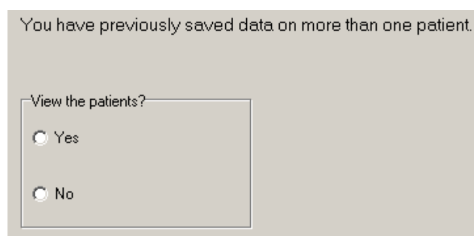
If you previously entered data on one patient, you are prompted with: *You have previously saved data on a note for patient <PADPPATIENT,ONE > m*

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.



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

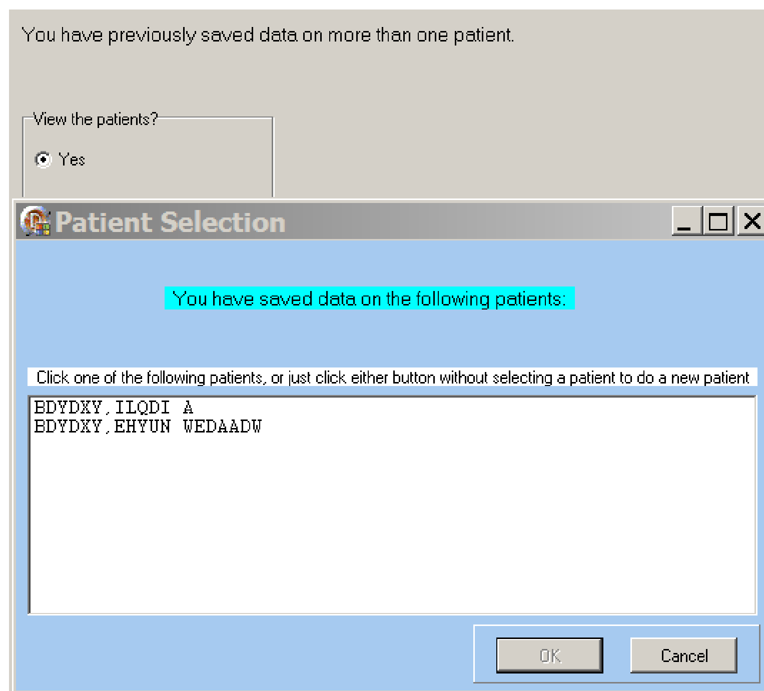
View the Patients?/No

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



Patient SelectionList

Patient on the List

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

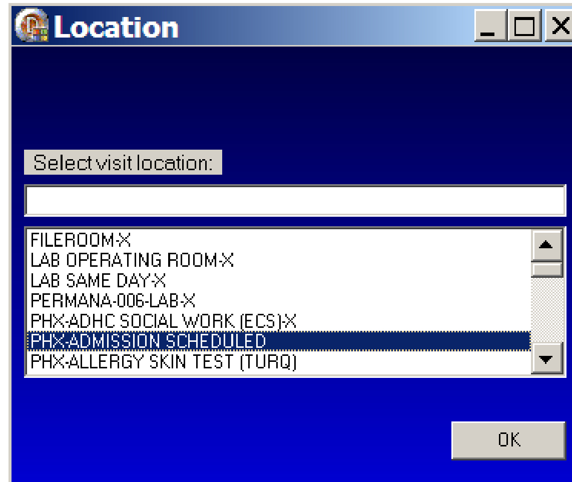
Patient not on the List

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, 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.



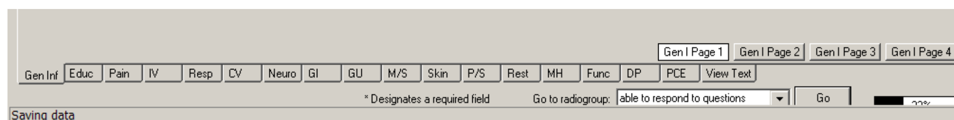
Location : Select visit location

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

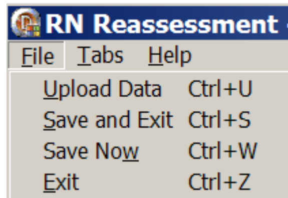
Data are saved automatically. Frequency of auto-save is set locally.



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.

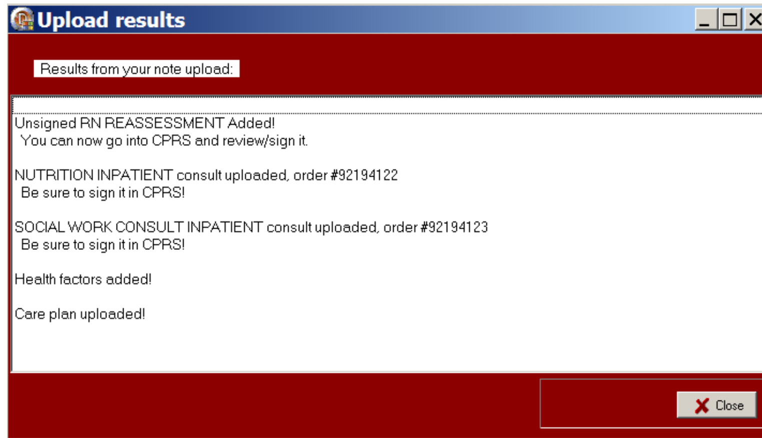


RN Reassessment window, File menu

Upload Data

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

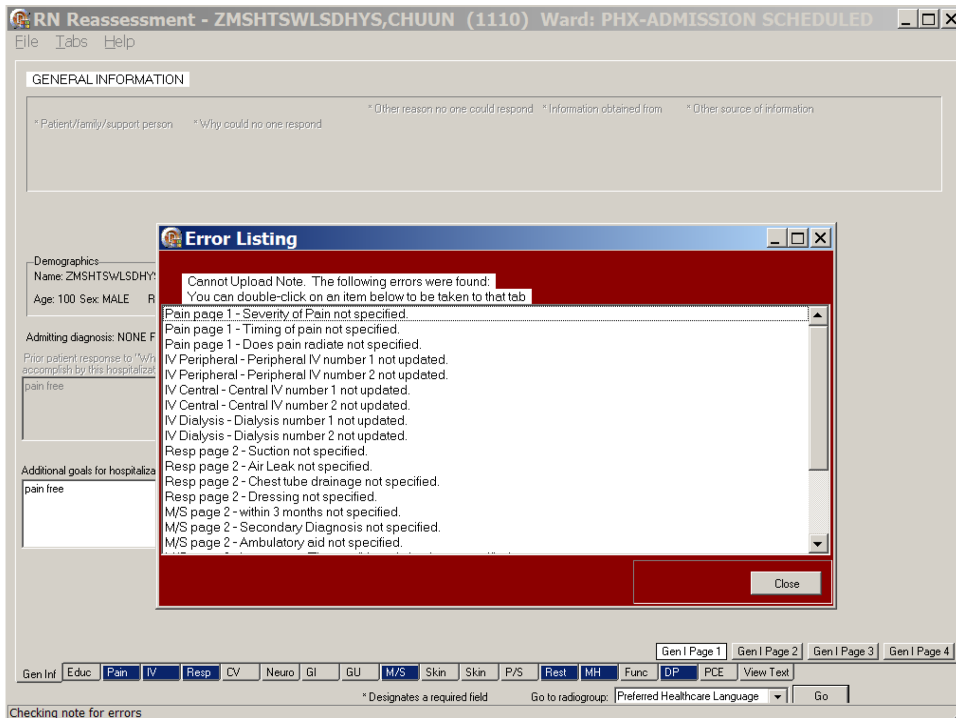
1. Open the File menu on any tab and select **Upload Data**.
   Results from your upload display, verifying that the data is uploaded.



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 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.

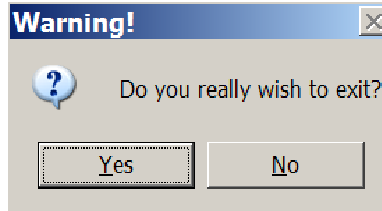
Save Now

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

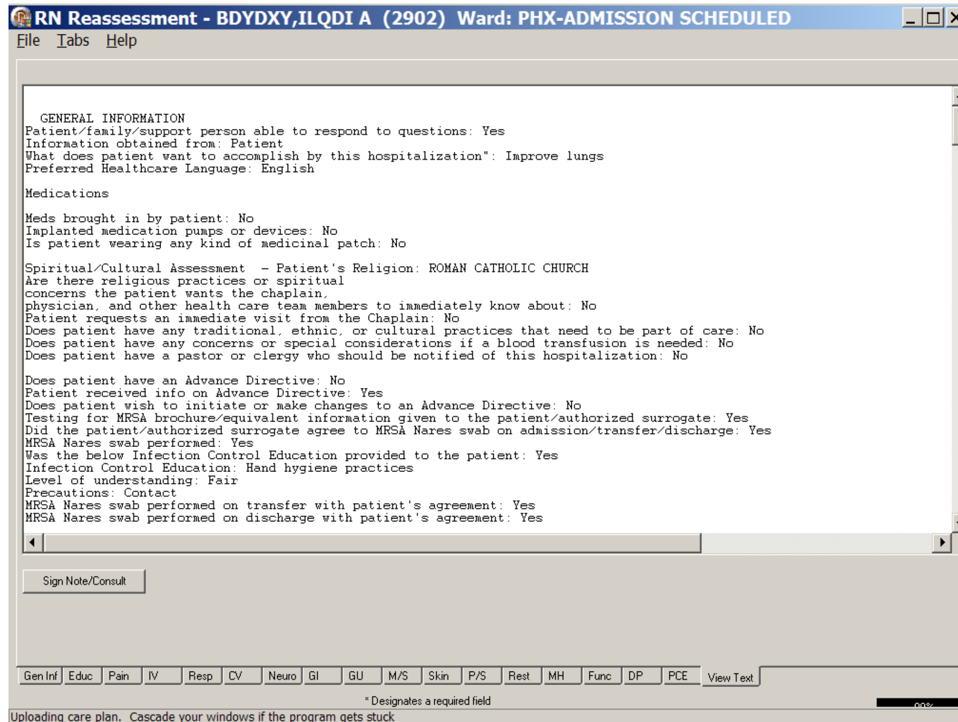
1. From any tab, open the File menu and click **Exit**.
   Warning message displays.
2. Click **Yes**.

Signing Notes

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

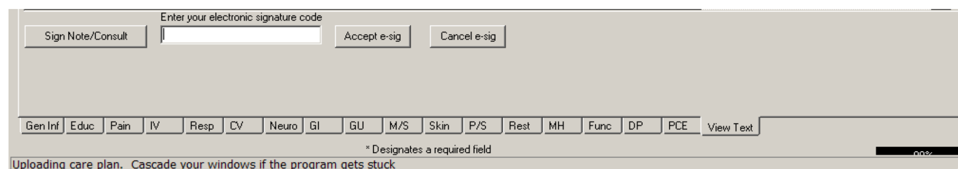
You can also sign *unsigned* notes **after the upload** from the View Text tab in the template.

1. Click **View Text**.



RN Reassessments, View Text tab after upload

2. Click **Sign Note/Consult**.



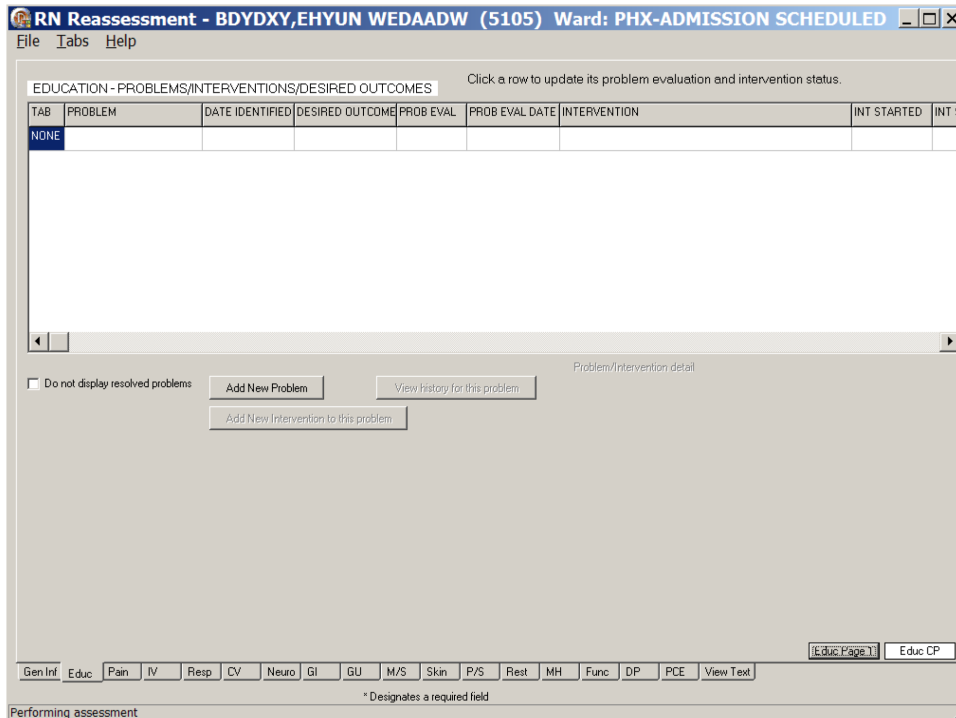
RN Reassessment, Sign Note/Consult Button

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.



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/Pc	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/Pc	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

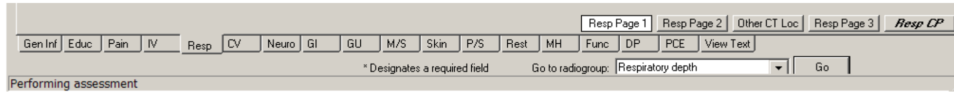
RN Reassessment, Problems/Interventions/Desired Outcomes table

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 *what to do* 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

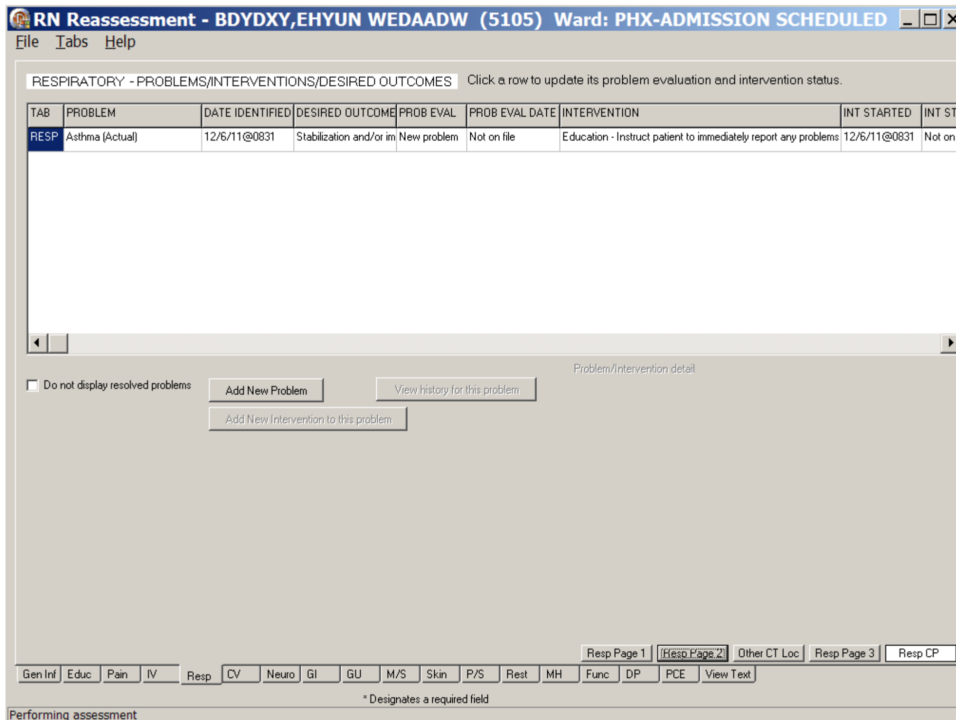
Updating an Existing Problem/Intervention

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 Reassessment, <Resp> CP window

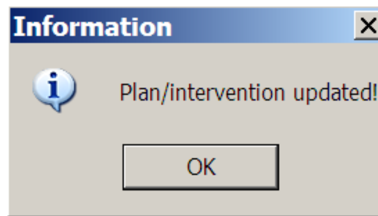
2. Click a problem.
   Problem evaluation, Intervention status, and Problem/intervention detail become available.

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.

Problem evaluation, Intervention status, and Problem/Intervention detail

4. Click **OK**.
   Information displays.



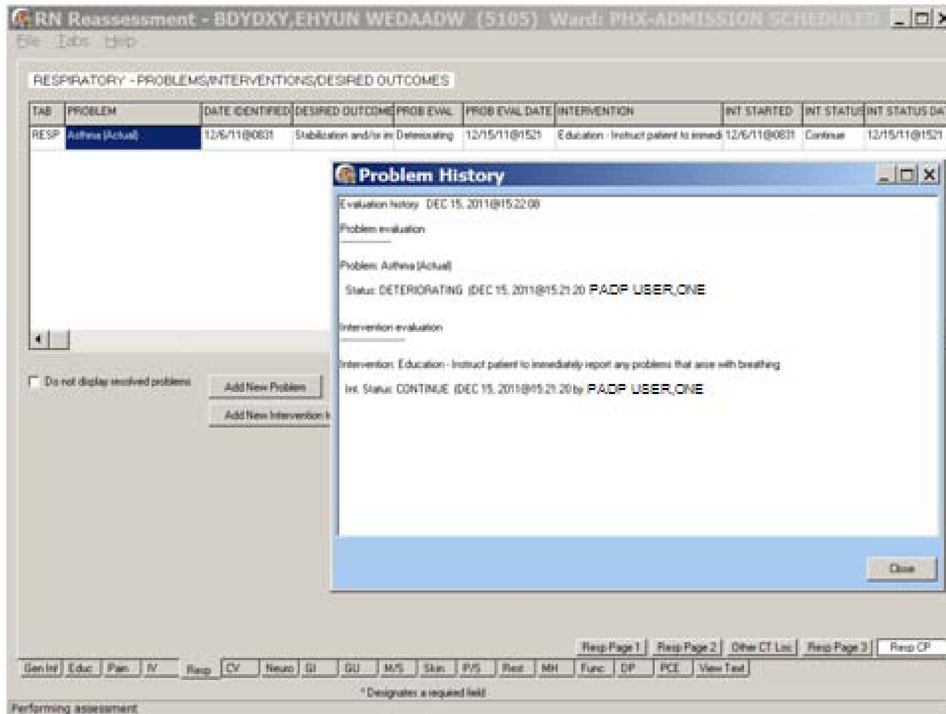
Information : Plan/intervention updated!

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

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

RN Reassessment, <Resp> CP window

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

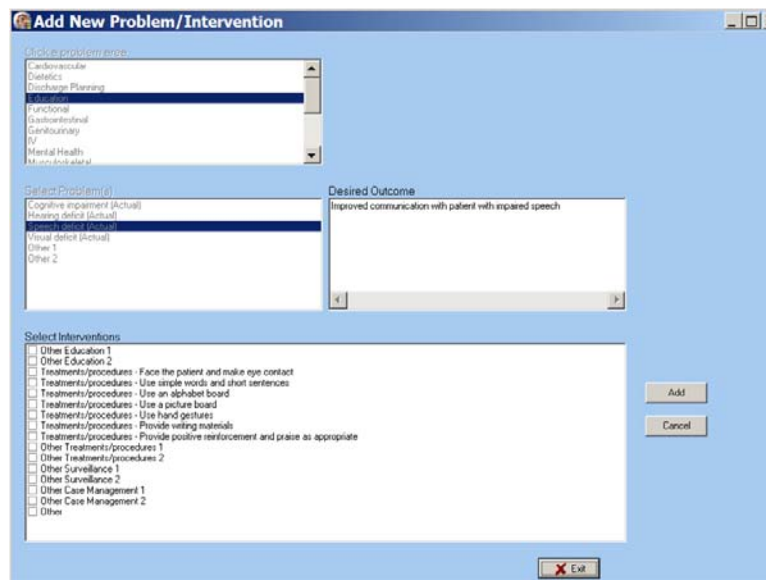


Problem History window

8. Click **Close**.

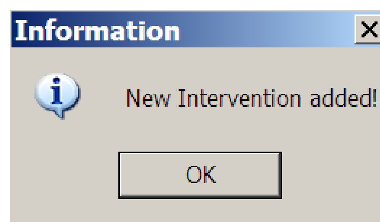
Adding a New Intervention for an Existing Problem

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 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

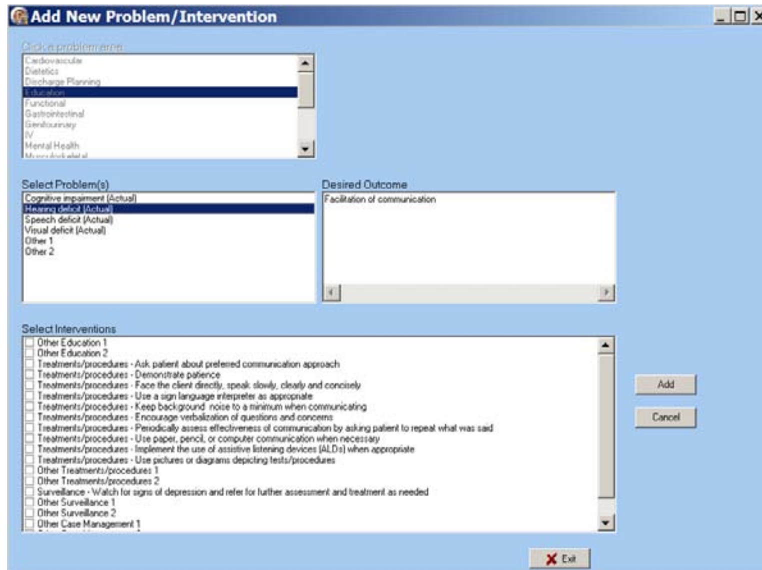
RN Reassessment, <Resp> CP window

1. Click **Add New Problem**.
   Add New Problem/Intervention window displays.

Add New Problem/Intervention window

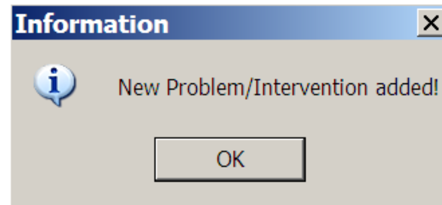
Note: The Respiratory area is auto selected, because you are in the Resp CP.

2. 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/Intervention window for problem/intervention options

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



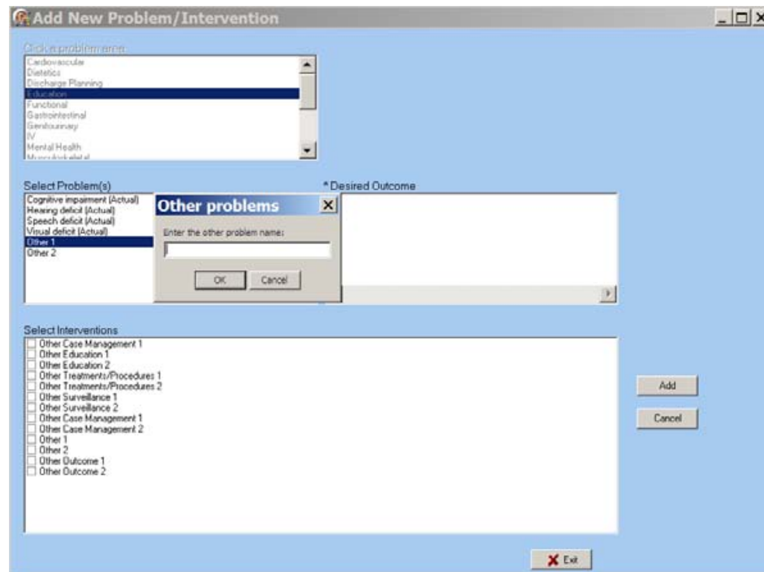
Information : New Problem/Intervention added!

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

Other Problems

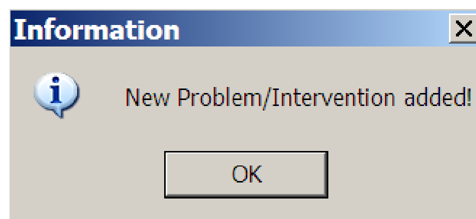
Some problems generate a to enter problems that are not on the predefined list.

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



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.



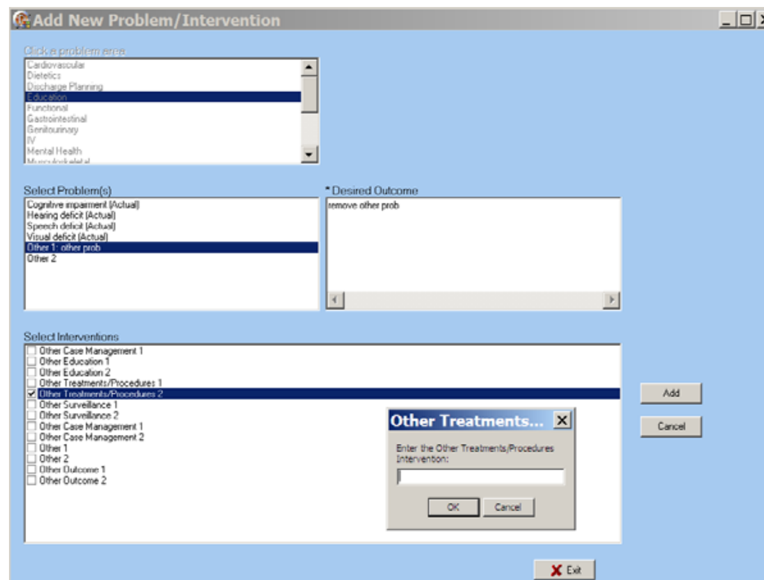
Information : New Problem/Intervention added!

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

Other Interventions

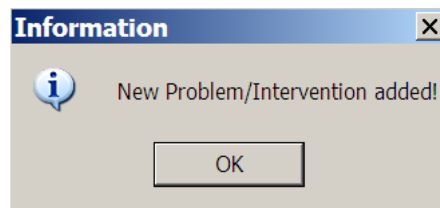
Some interventions generate a to enter interventions that are not on the predefined list.

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 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.

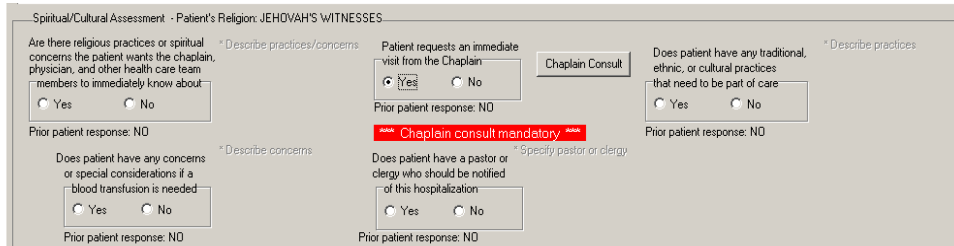
Example – Ordering a Chaplain Consult

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.

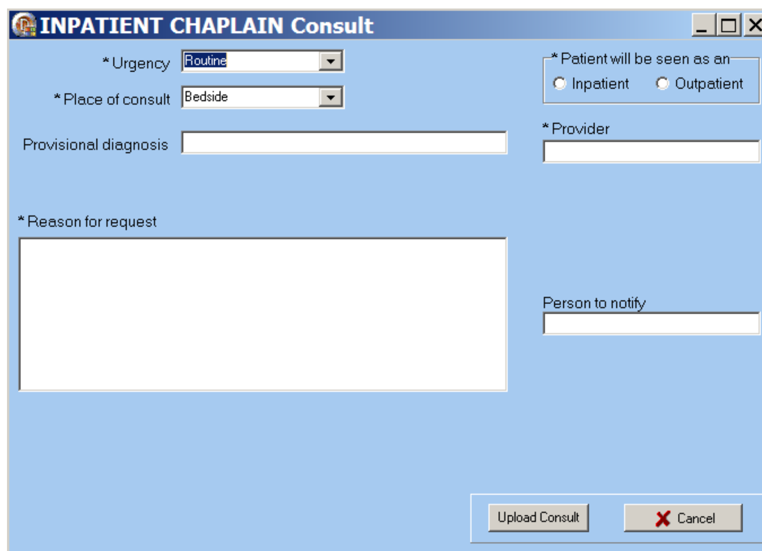
- Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about?
- Patient requests an immediate visit from the Chaplain?
- Does patient have a pastor or clergy who should be notified of this hospitalization?

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



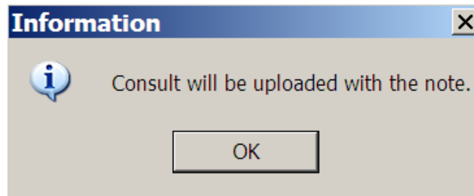
RN Reassessment, General Information (Gen Inf) tab, Gen I Page 2 window
Spiritual/Cultural Assessment

2. Click **<Chaplain Consult>**.
   The <INPATIENT CHAPLAIN> Consult window displays.



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.



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.

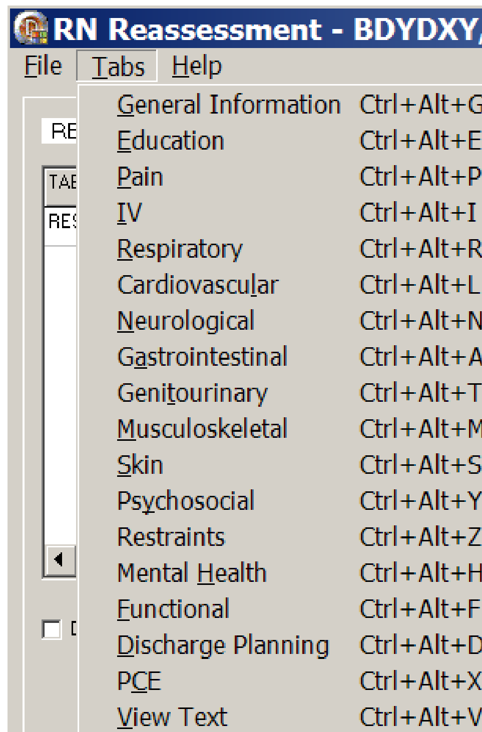
Moving through the Template with a Mouse

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.

RN Reassessment tabs

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



RN Reassessment window, Tabs menu

Moving through the Template without a Mouse

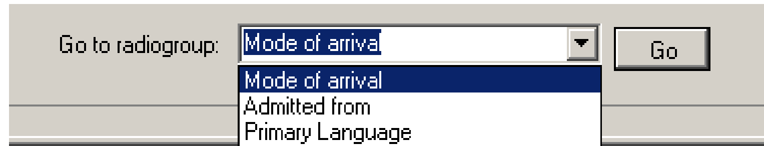
Ctrl-Alt Keys

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 button

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

or

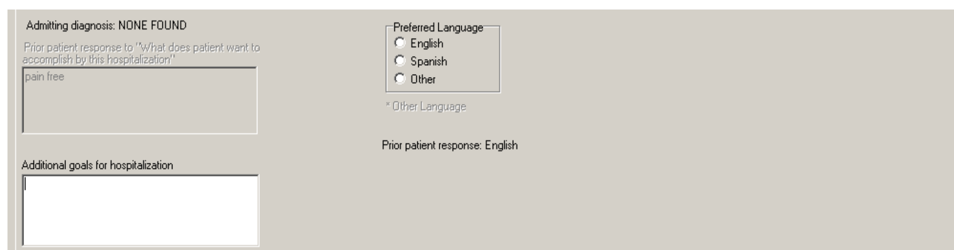
1. Click the drop-down arrow in the **Go to radiogroup:** drop-down list.
2. Select a radiogroup.
3. Click **Go**.

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.



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.

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.

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

Navigating the RN Reassessment Tabs

The RN Reassessment template has 18 tabs.

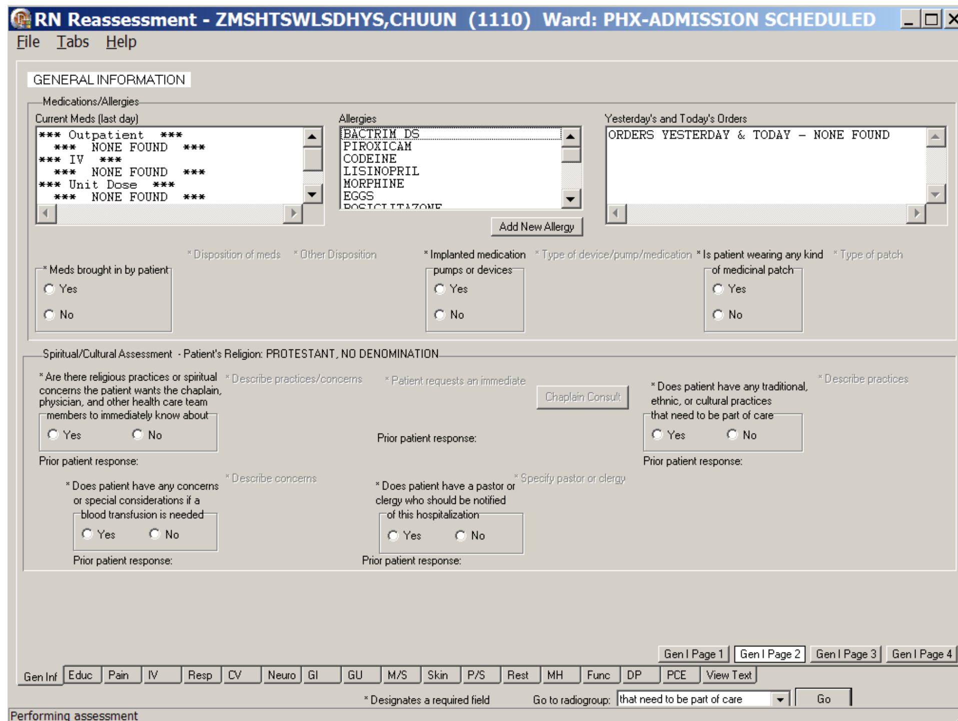
General Information (Gen Inf)

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

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.



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.

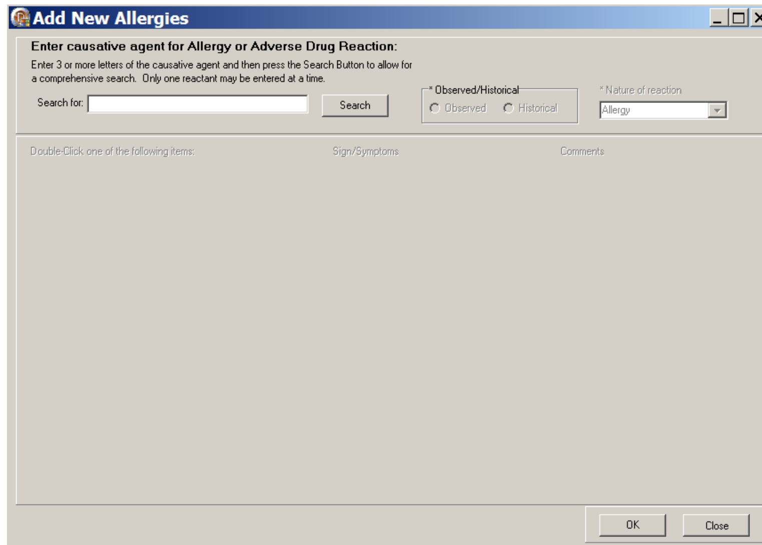
- Allergies are added on Gen I Page 2, in the Allergies text box.
- None of the fields on Gen I Page 2 is required during reassessment, provided a completed admission assessment is on file.

Adding an Allergy

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

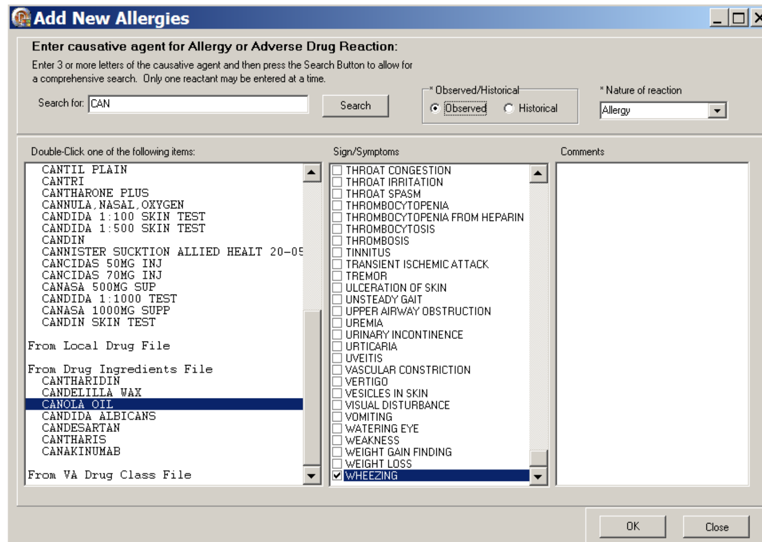
> **Note:** Follow your local medical center policy with regard to adding allergies.

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



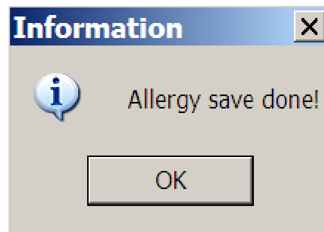
Add New Allergies window

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



Add New Allergies window with Sign/Symptoms available

5. In the Observed/Historical 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.



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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED
File Tabs Help
GENERAL INFORMATION
Advance Directive
* Does patient have an Advance Directive
Yes
No
Prior patient response:
* Location of Advance Directive
* Patient received info on Advance Directive
* Explain why patient did not receive info
Prior patient response:
* Does patient wish to initiate or make changes to an Advance Directive
Yes
No
Prior patient response:
Social Work Consult
* Testing for MRSA brochure/equivalent information given to the patient/authorized surrogate
Yes No
Prior response:
* Did the patient/authorized surrogate agree to MRSA Nares swab on admission/transfer/discharge
Prior patient response:
MRSA Nares swab performed
Swab performed:
* Why wasn't MRSA Nares swab performed
* Was the below Infection Control Education provided to the patient
Yes No
Prior response:
Infection Control Education
Hand hygiene practices
Definition of MRSA, VRE, TB, and all resistant organisms
Spread of resistant organisms/prevention
Contact Precautions (as related to patient condition)
Respiratory Precautions (as related to patient condition)
Surgical site (as related to patient condition)
Other
Level of understanding
Precautions
Airborne
Contact
Droplet
Neutropenic
Prior response:
MRSA Nares swab performed on transfer with patient's agreement
Yes Refused
No N/A
* Why wasn't it performed
MRSA Nares swab performed on discharge with patient's agreement
Yes Refused
No N/A
* Why wasn't it performed
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 | 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, 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 Reassessment, General Information (Gen Inf) tab, Gen I Page 4 window

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)

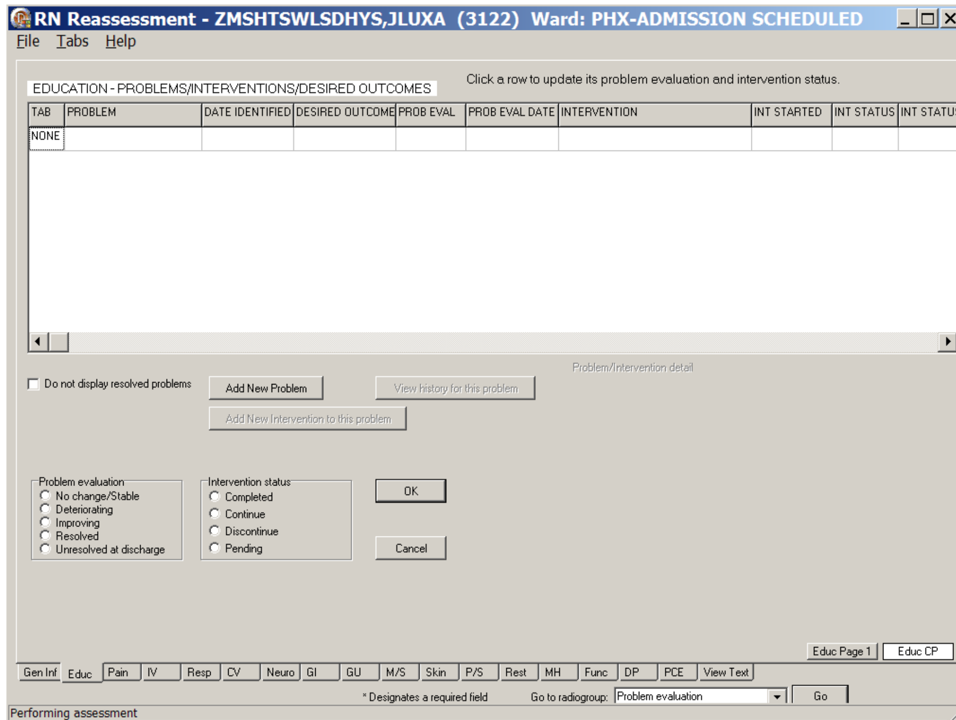
The Education Tab contains the educational assessment and a readiness to learn. The Educational Assessment is unavailable when the patient cannot respond.

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

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 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.

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.

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

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.

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.

4. 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.

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.

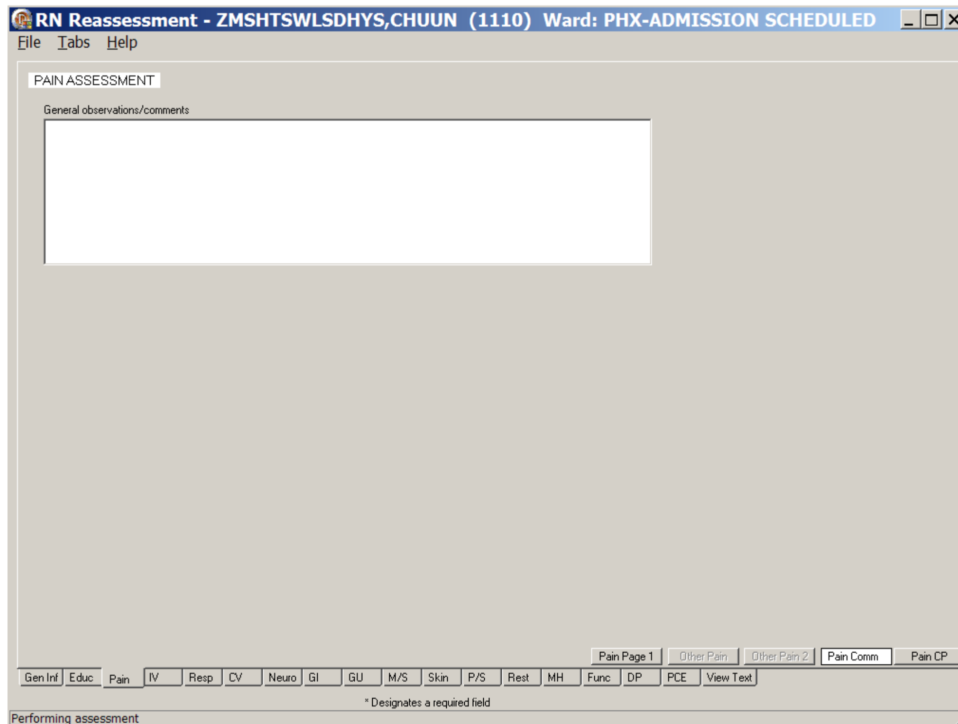
RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window
Is patient having any pain now/No

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.

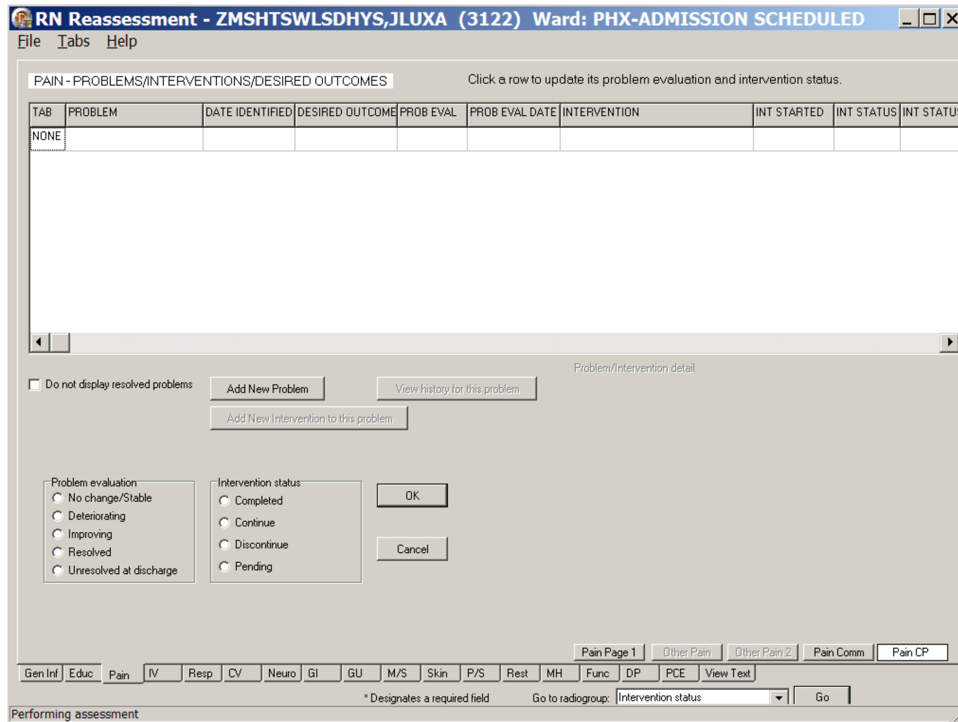
2. Click **Pain Comm**.
   Pain Comm displays.



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.



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

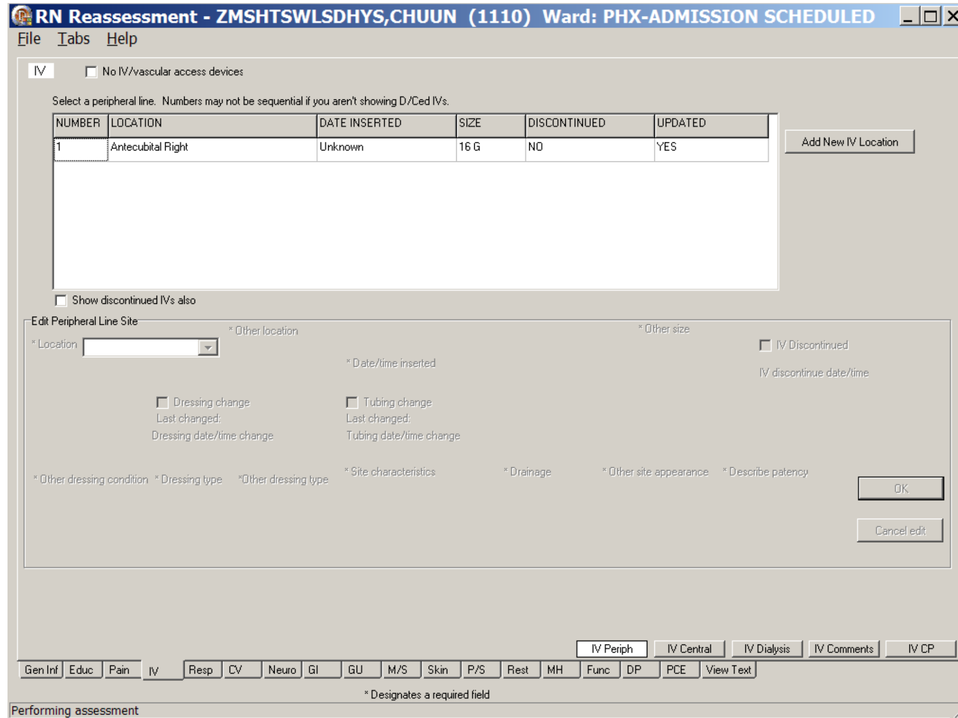
1. Click **IV**.
   IV Periph displays.
2. If a patient has no IVs or dialysis access in place, select the **No IV/vascular access devices** check box and none of the IV pages or Add New IV Location are available.
3. Move to the next tab.

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.



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 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

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**.

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.

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.

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

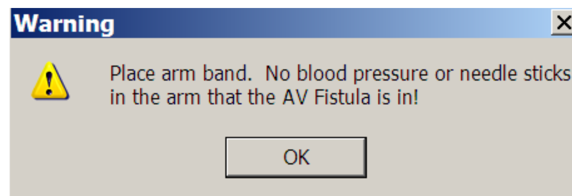
1. Click **IV Dialysis**.
   IV Dialysis displays.

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

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

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.

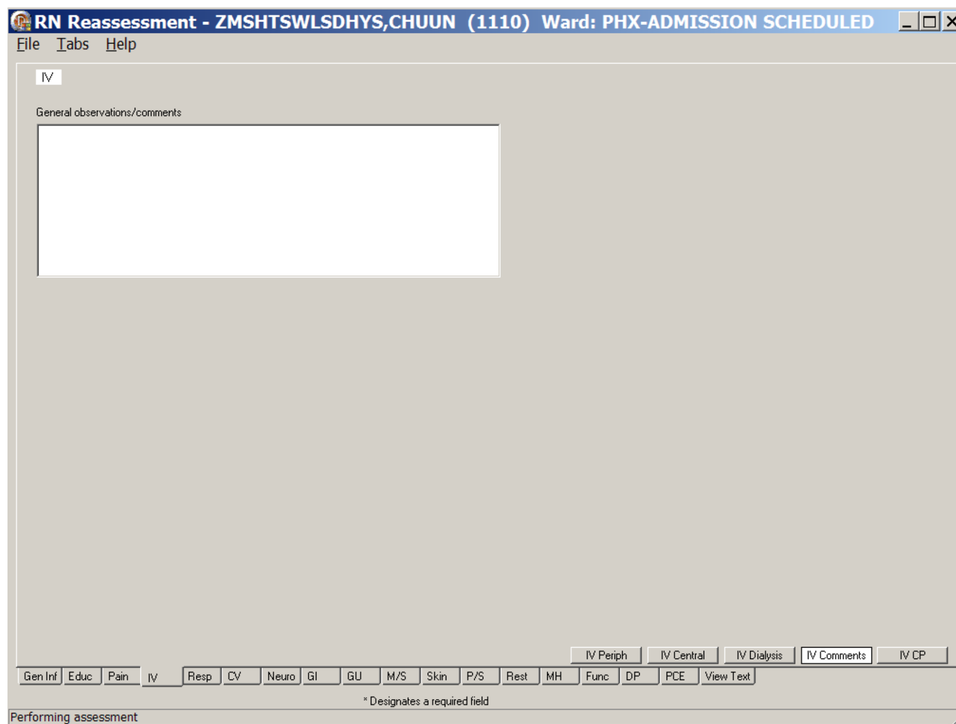


Warning: Place arm band.
No blood pressure or needle sticks in the arm that the AV Fistula or AV Graft is in!

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 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.

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.

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

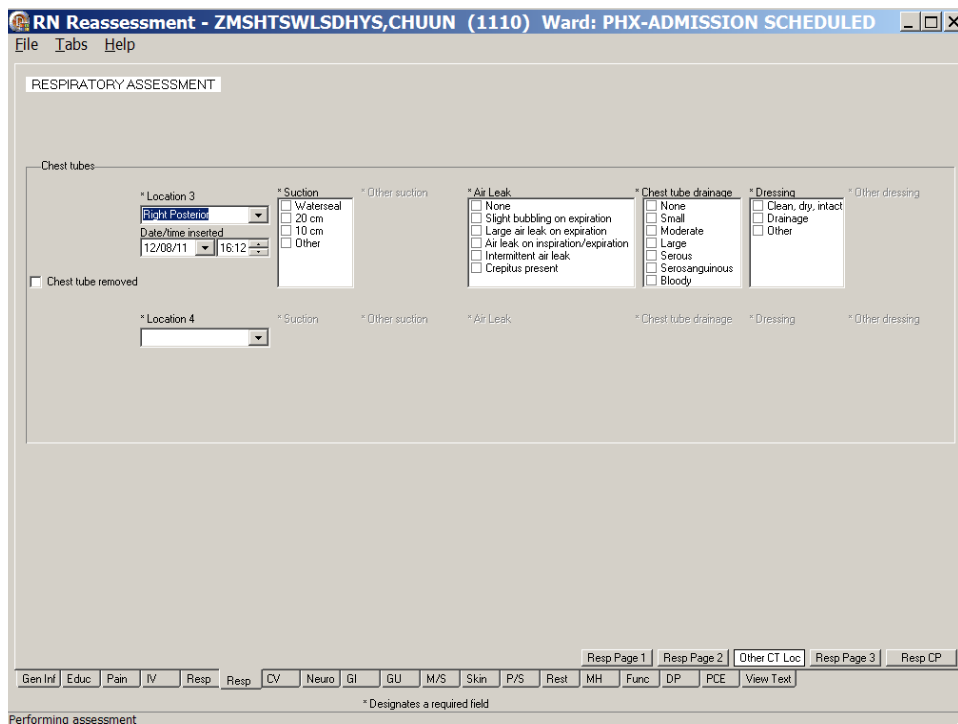
1. Click **Resp**.
   Resp Page 1 displays.
2. Populate Resp Page 1.
   a. Use the **Respiratory rate** box to enter the patient's current respiratory rate.
   b. Complete all the fields with asterisks; they are required fields.

3. Click **Resp Page 2**.
   Resp Page 2 displays.

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

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 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.

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 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)

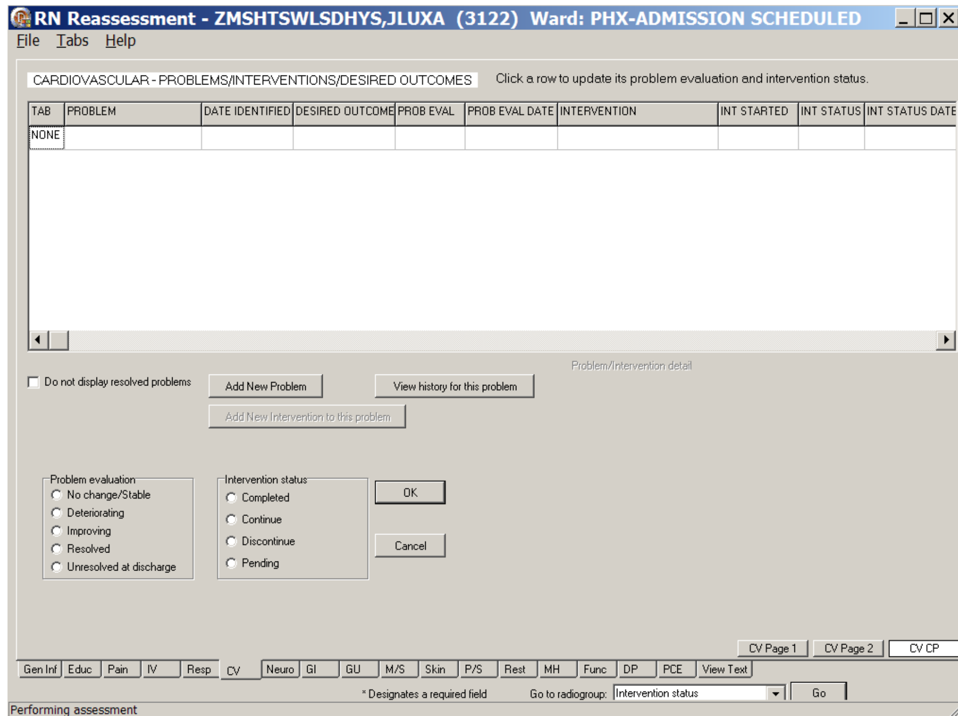
Document the cardiovascular reassessment of a patient in the Cardiovascular tab.

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, 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 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)

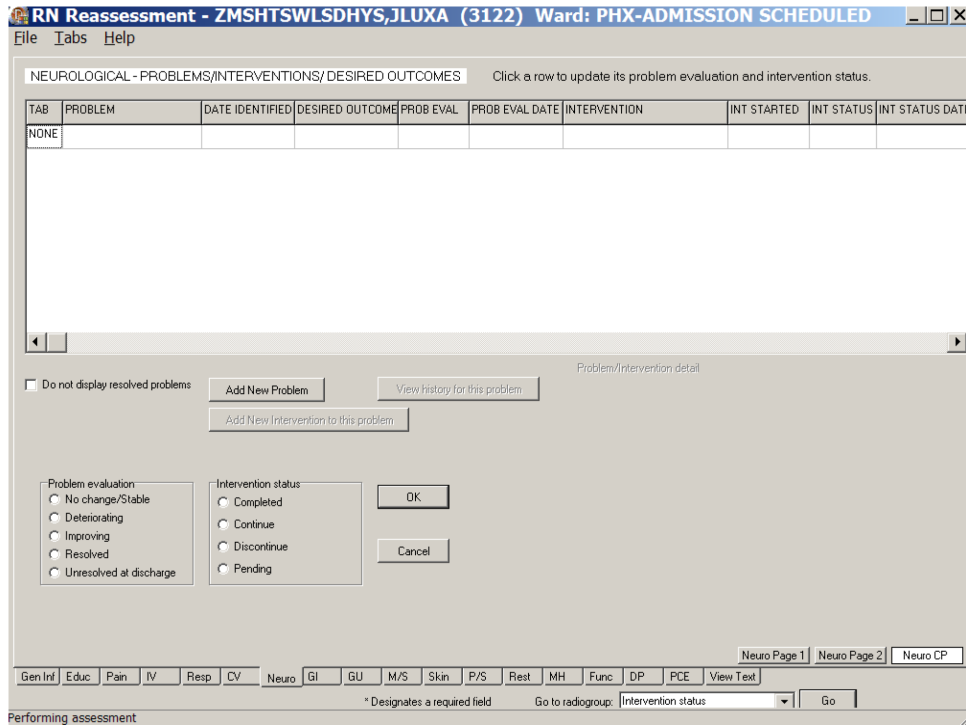
Document the neurology reassessment of a patient in the Neurology tab.

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

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



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

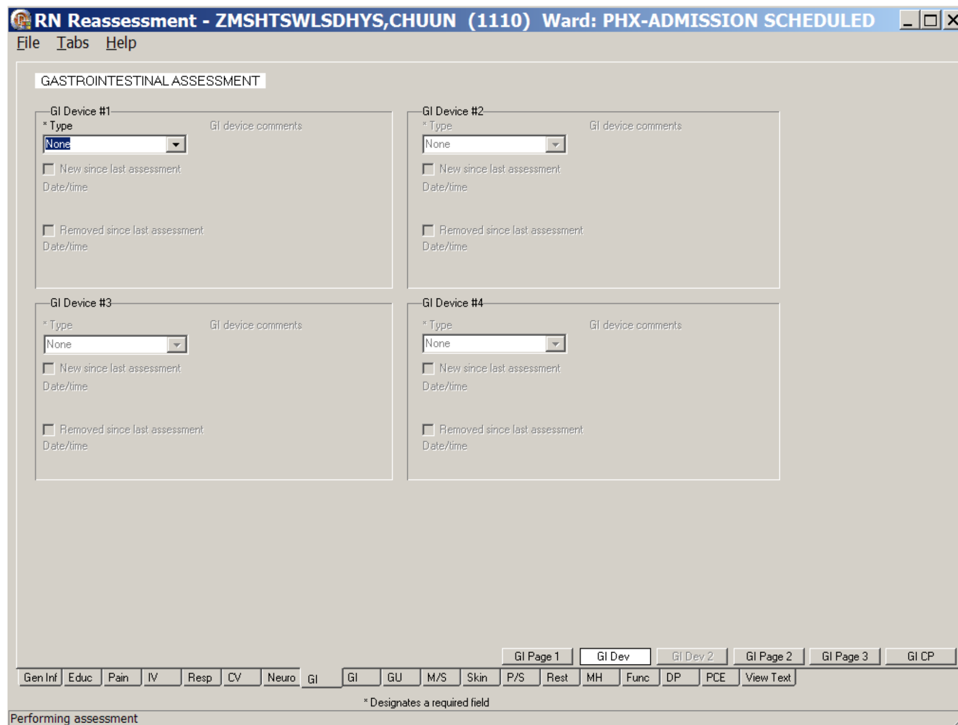
6. Update Neuro CP, if necessary.
   Refer to the instructions in *Working in a Care Plan* on page 12.

Gastrointestinal (GI)

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

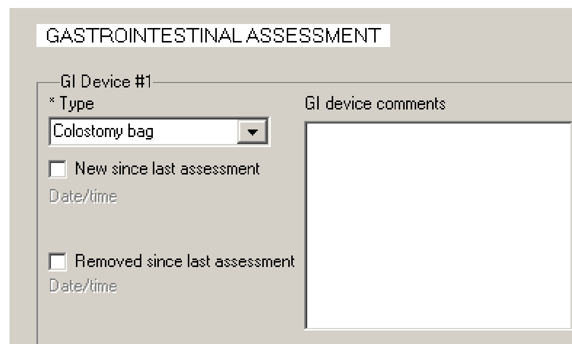
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 1 window

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, 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.



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

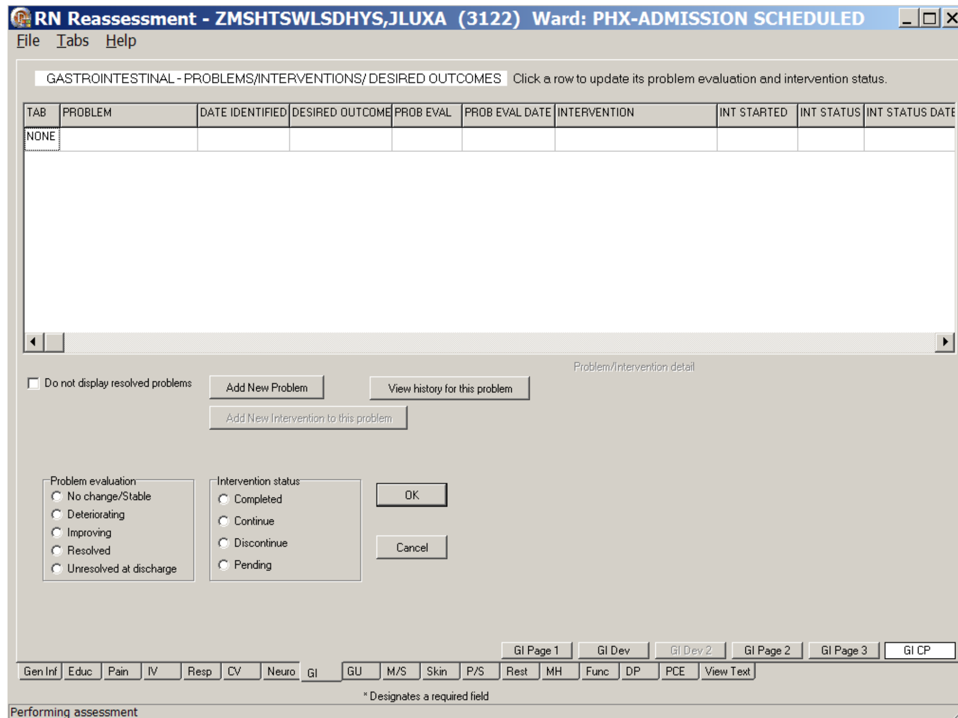
6. Populate GI Dev 2, if necessary.
   Complete all the fields with asterisks; they are required fields.
7. Click **GI Page 2**.
   GI Page 2 displays.

RN Reassessment, 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.

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.



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

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

4. Populate GU Dev.
   Complete all the fields with asterisks; they are required fields.

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

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

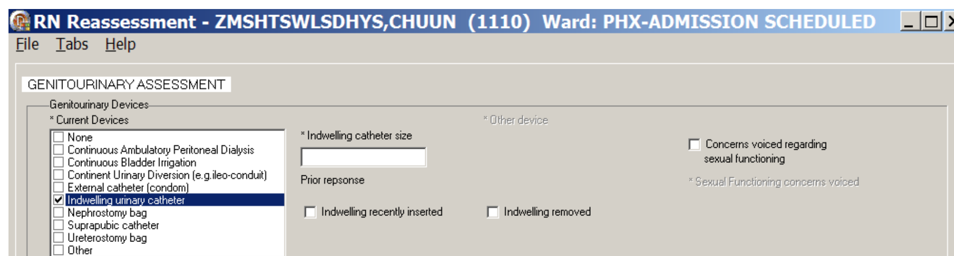
Note: The sex-specific questions (male/female) are optional. The exception is for female patients; the pregnancy responses are required.

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, 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.

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.

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.

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

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

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.

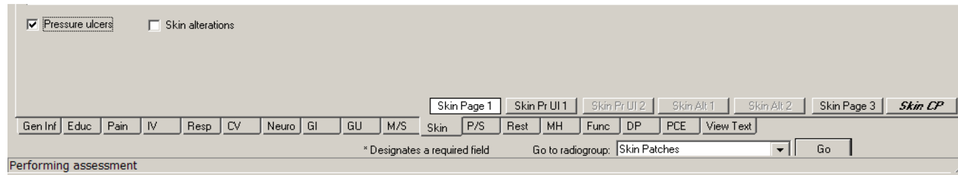
Skin CP contains patient/caregiver skin care education, including risk for skin breakdown and prevention/treatment of problems related to skin integrity.

RN 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.

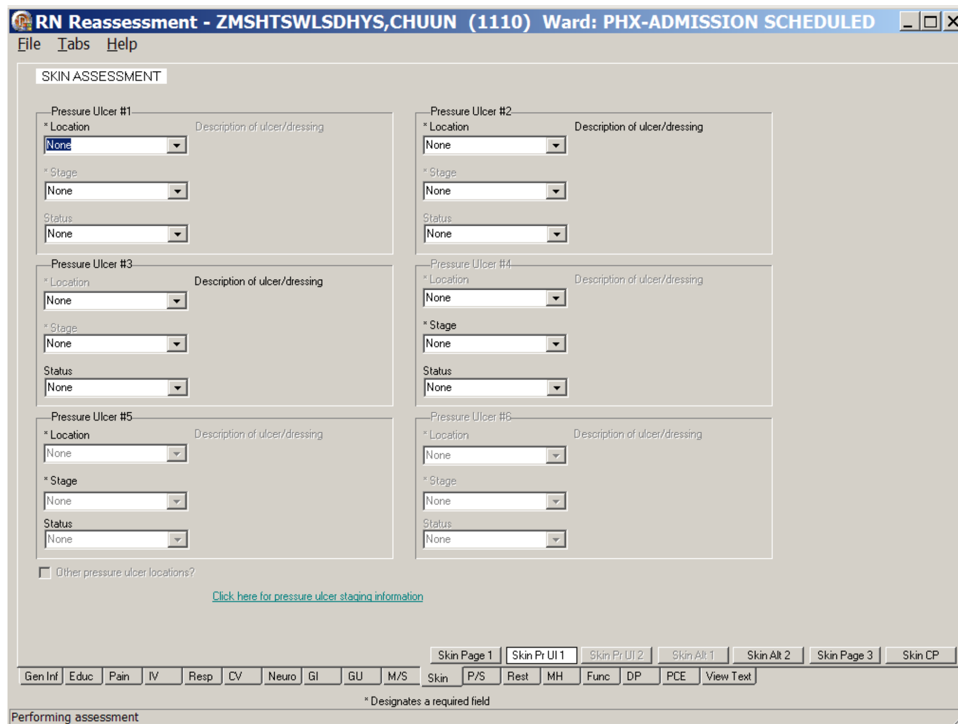
Documenting Pressure Ulcers

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



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

1. Click **Skin Pr Ul 1**.
   Skin Pr Ul 1 displays.
2. Populate Skin Pr Ul 1.
   a. Enter **Location**, **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, Skin Assessment (Skin) tab, Skin Pr Ul 1 window

Pressure Ulcer Drop-downs

Skin Assessment - Pressure Ulcer/Location

Skin Assessment - Pressure Ulcer/Stage

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.

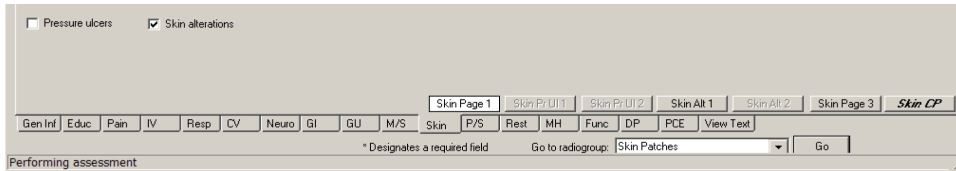
RN Reassessment, Skin Assessment (Skin) tab, Skin Pr Ul 1 window
Other pressure ulcer locations? selected

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.

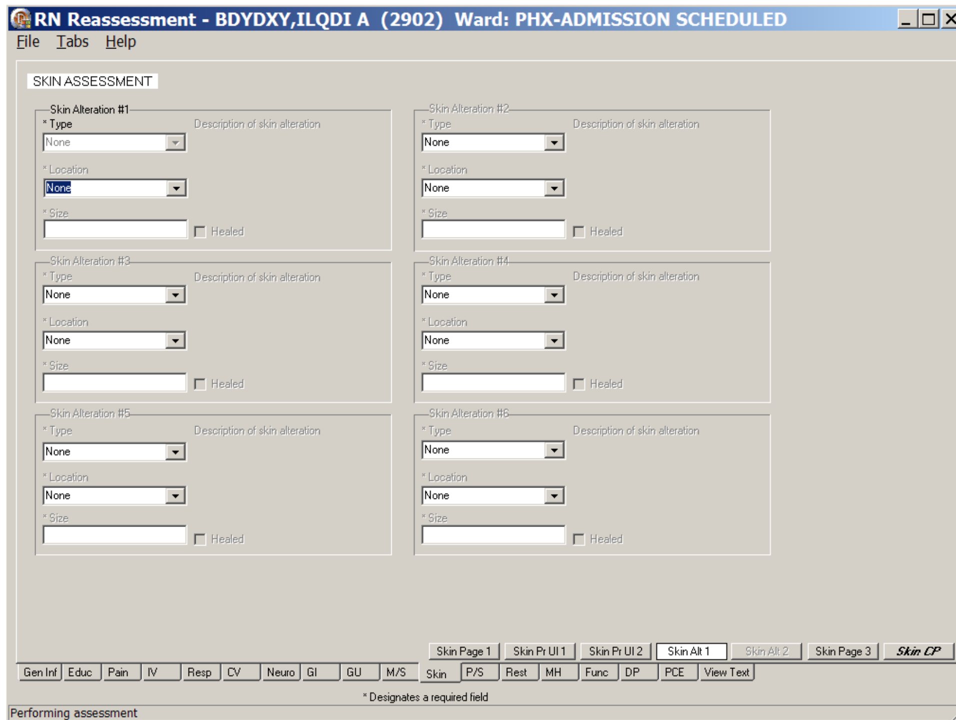
Documenting Skin Alterations

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



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

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



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

Skin Assessment – Skin Alteration/Type

Skin Assessment – Skin Alteration/Location

Skin Assessment – Skin Alteration/Size

3. Click **Skin Alt 2**.
   Skin Alt 2 displays.

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, 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.

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 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.

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).

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

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

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

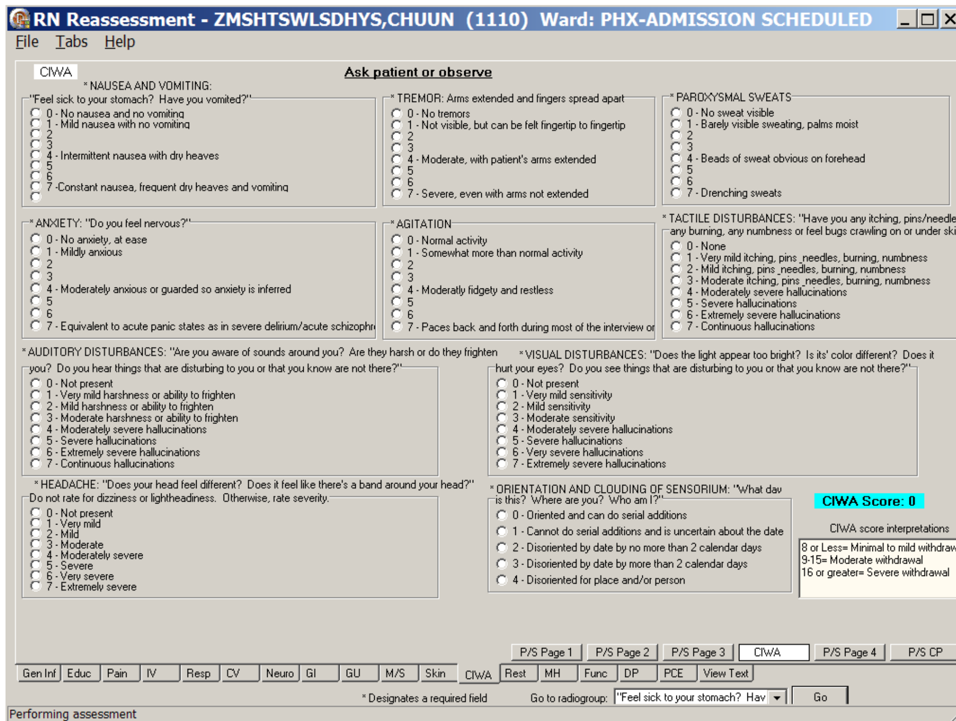
6. Populate P/S Page 3.
   a. The questions are all optional; update, if necessary.
   b. If a patient answers **Yes** to any of the Elopement Screen questions, a Social Work Consult is required.
   Refer to the instructions in *Working in the Consults* on page 24.

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.

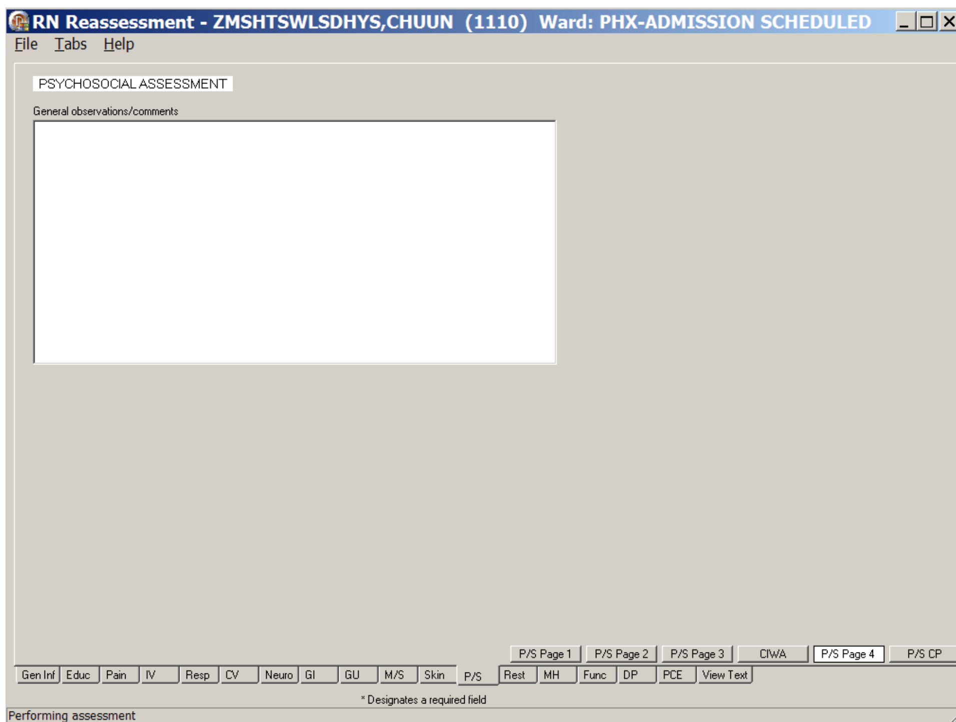
Alcohol use section

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.



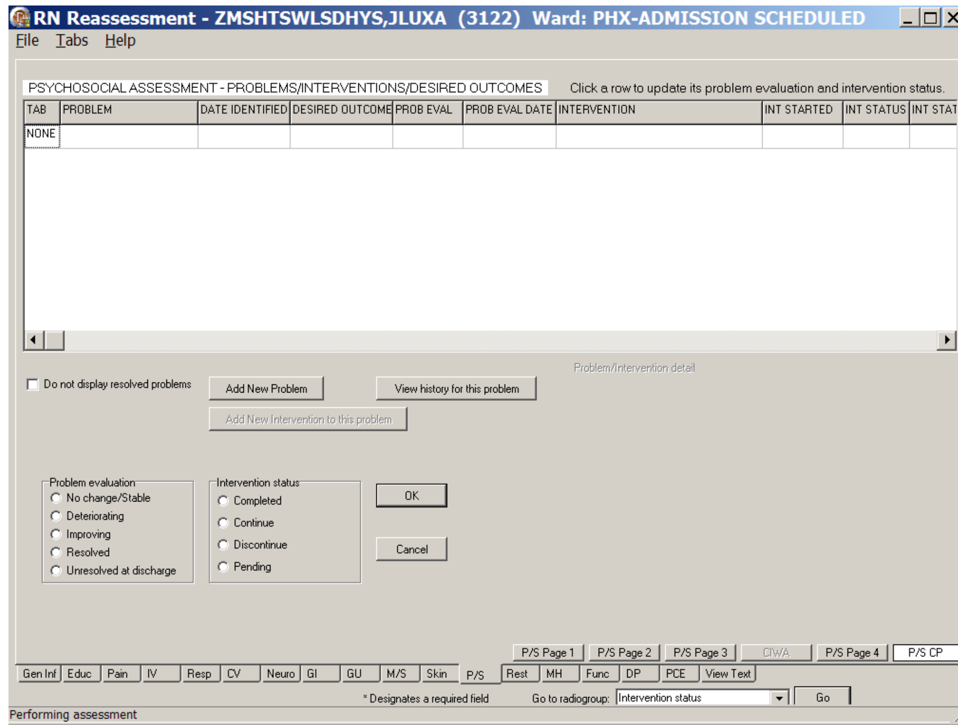
RN Reassessment, Psychosocial Assessment (P/S) tab, CIWA window

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



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.



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

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 - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

RESTRAINTS

*** Notify provider ***

☑ Restraints Initiated/maintained

* Date/time initiated
- Known
- Unknown

Initiated date/time

* Reason for restraint
- 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.

* Justification for restraints | * Other justification | * Justification for restraints | * Other justification

Behavioral expectations for termination of restraints
- Follows simple directions
- Does not pull at lines/tubes
- Contracts for safety
- Denies homicidal ideation
- Denies self harm
- Denies suicidal ideation
- Displays no aggression to self/others
- Other

* Other behavioral expectation

* Restraint Type
- Ankle, Right, Locked
- Ankle, Right, Unlocked
- Ankle, Left, Locked
- Ankle, Left, Unlocked
- Blanket/Net
- Hand Mitt, Right
- Hand Mitt, Left
- Vest, Locked
- Vest, Unlocked
- Waist, Locked
- Waist, Unlocked
- Wrist, Right, Locked
- Wrist, Right, Unlocked
- Wrist, Left, Locked
- Wrist, Left, Unlocked
- Soft
- Leather/plastic/rubber
- Other

* Other Restraint

Interventions tried to avoid restraint use
- Bed alarm
- Camouflage lines/tubes
- Diversional activities
- Family at bedside
- Hourly rounding
- Laptop tray
- Low bed with mats
- Move closer to nurse's station
- Pain relief medicine
- Patient/family education
- Reality orientation
- Repositioning of lines/tubes
- Side rails, 3 or less
- Sitters
- Wedge cushion
- Other

* Other intervention

☐ Discontinued - desired outcome achieved

Discontinued date/time

Restr Page 1 | Restr CP

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

* Designates a required field

Performing assessment

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.

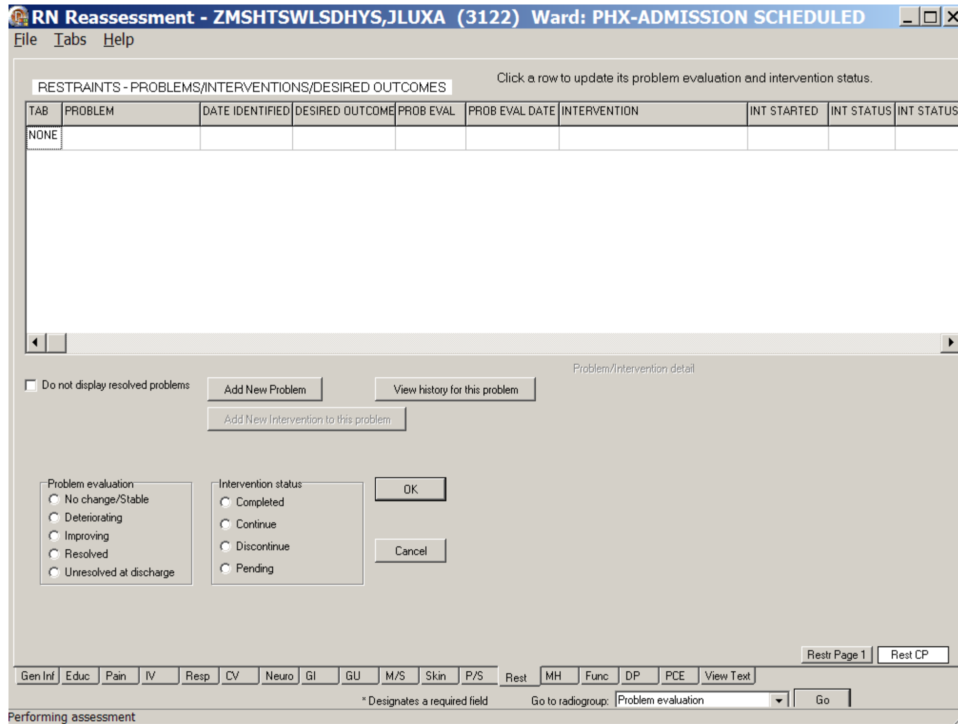
RN Reassessment, Restraints (Rest) tab, Restr Page 1 window
Patient is pulling at lines/tubes used in their treatment or is unable to follow instructions endangering their medical/surgical recovery. Patient is not violent or self-destructive

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

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

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.



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 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 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.

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

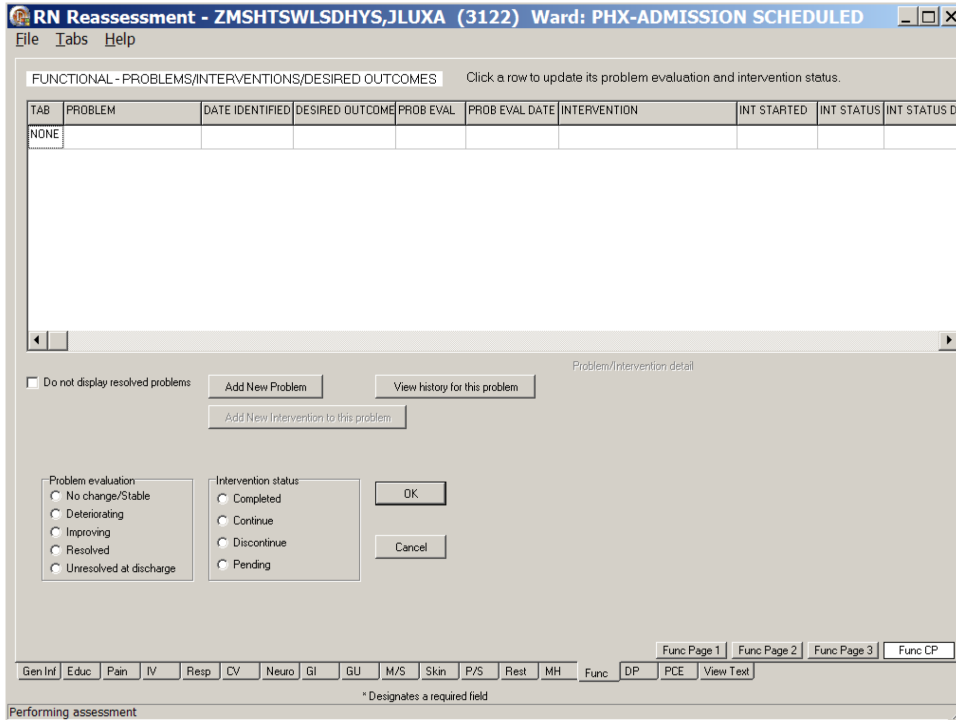
4. Update Func Page 2, if necessary.
   a. Complete all the fields with asterisks; they are required fields.
   b. Use the **General observations/comments** text box for additional information.

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 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.

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, 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, 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.

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.

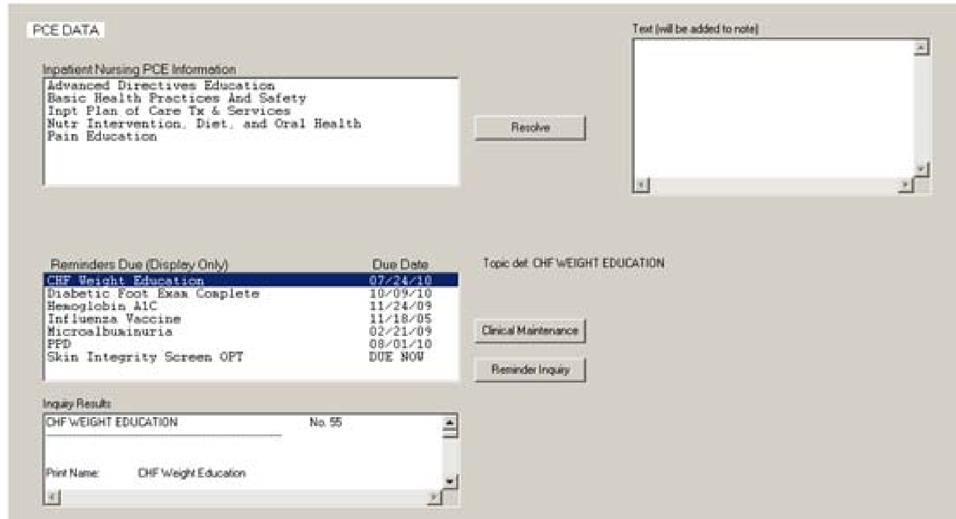
Clinical Maintenance

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.

Clinical Maintenance

Reminder Inquiry

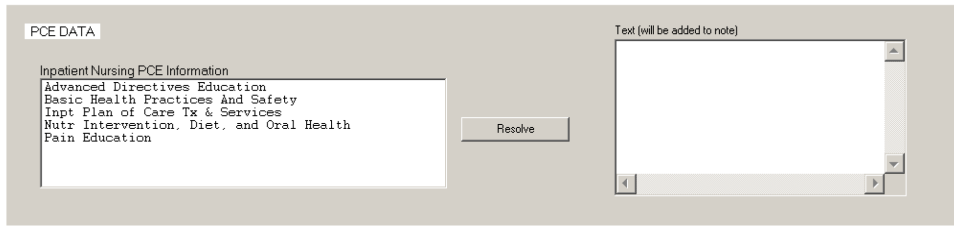
Click **Reminder Inquiry**.
Information displays in the **Inquiry Results** list box about the logic of the selected reminder.



Reminder Inquiry

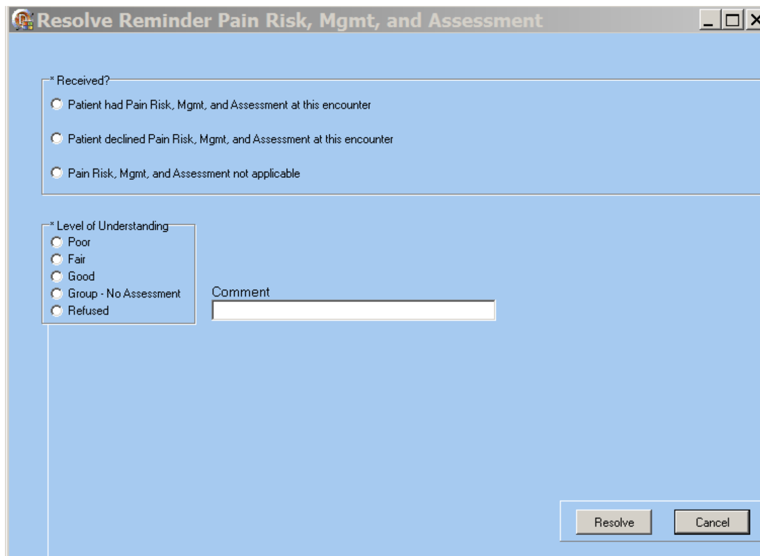
Resolve Inpatient Nursing Clinical Reminders

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



Resolve Inpatient Nursing Clinical Reminders

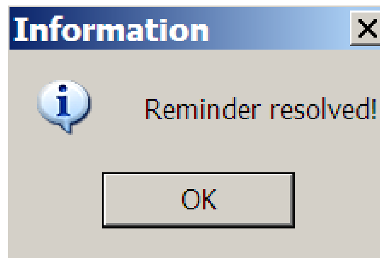
2. Click **Resolve**.
   The Resolve Reminder Pain Risk, Mgmt, and Assessment window displays with items appropriate for the selected item.



Resolve Reminder Pain Risk, Mgmt, and Assessment window

3. Select 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.

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
File  Tabs  Help

  GENERAL INFORMATION
Patient/family/support person able to respond to questions: Yes
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
Precautions:  None

Emergency 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 safety
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


  EDUCATIONAL ASSESSMENT
Patient/family/support person able to respond to questions: Yes
Information obtained from: Patient

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
Performing 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

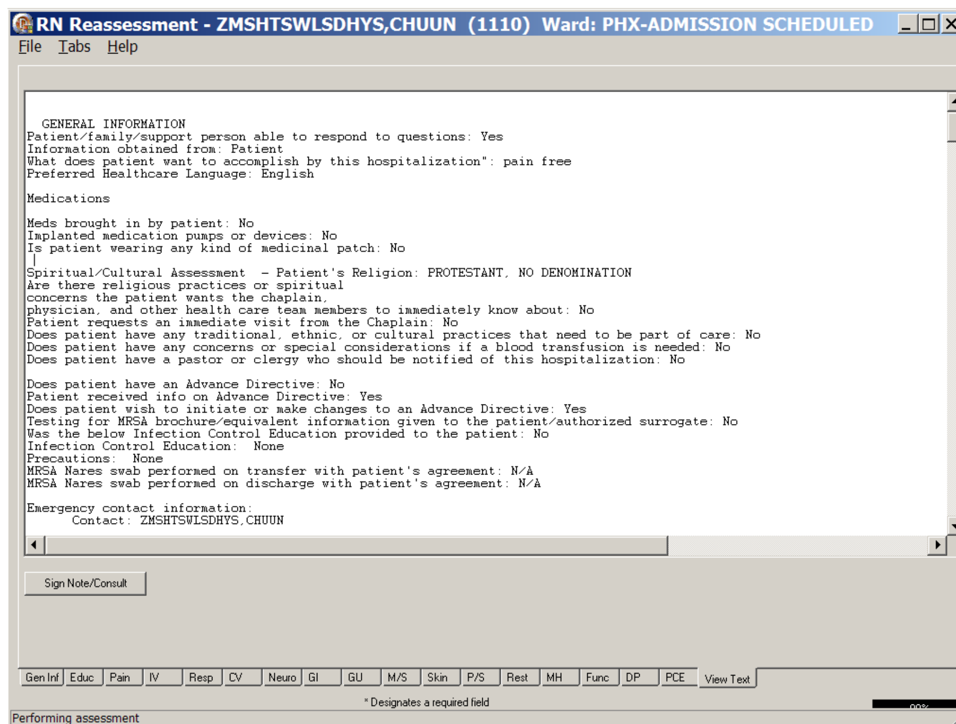
During the assessment, you may be prompted to enter mandatory consults that will be uploaded with the reassessment note.

> **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 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, 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, 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**.

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

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

RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

EDUCATIONAL ASSESSMENT

* Patient/family/support person able to respond to questions: Yes / No
* Why could no one respond: Patient unable to communicate; No family/support person present; Other
* Other reason no one could respond
* Information obtained from
* Other source of information
* Describe why unable to read
* Describe why unable to write
* Has ability to read
* Has ability to write
* Other education level
* Educational Level
Prior patient response:
Prior patient response:
Learns best by
Prefers
* Readiness to learn
Prior patient response:
Prior patient response:
* Barriers to learning
* Describe identified barriers
* Other barriers
* Knowledge of current illness, surgery, reason for hospitalization etc as
* Information provided to patient/support person on the following topics
* Other topic provided
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 | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text

* Designates a required field Go to radiogroup: able to respond to questions Go

Performing assessment

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

RN Reassessment - BDYDXY,ILQDI A (2902) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

PAIN ASSESSMENT

* Is patient having any pain now: Yes / No / Unable to respond to questions
Explain if new occurence
Patient has been placed on Palliative/Comfort Care since last patient assessment
Pain Location #1
* Pain Region: Head
* Other pain region
* Quality of pain: Aching
* Other quality of pain
* Type of pain: Acute/surgical / Chronic
Onset of original pain (years, months)
* Severity of Pain (0=none - 10=worst)
* Timing of pain: Constant / Intermittent / Other
* Describe other timing of pain
* What makes pain worse: No identified triggers; Bending; Changes in temperature; Changing position; Coughing; Deep breathing; Exercise
* Other provoking factor(s)
* Does pain radiate: Yes / No
* Describe Pain Radiation
* Does patient exhibit behavioral indicators related to pain
* Other behavioral indicator
* What makes pain better: No identified relief factors; Acupressure; Acupuncture; Assistive devices (cane, wheelchair; Brace/Support; Chiropractic intervention; Cold
* Other palliative factor(s)
* Rx/Otc Meds helping pain
* Behavioral indicator(s) observed
* Areas of life affected by pain: No effect; Anxiety; Appetite; Concentration; Depression; Energy level
* Comments for patient's life aspects
Pain Goal
* What pain level is acceptable to the patient (0-10)? 0
Other pain location?

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

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: Is patient having any pain now Go

Performing assessment

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

RN Reassessment - BDYDXY,ILQDI A (2902) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

IV | No IV/vascular access devices

Select a peripheral line. Numbers may not be sequential if you aren't showing D/Ced IVs.

NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
NONE					

Add New IV Location

Show discontinued IVs also

Edit Peripheral Line Site

* Location: None | * Other location | * Date/time inserted | * Other size | IV Discontinued | IV discontinue date/time

Dressing change | Last changed: | Dressing date/time change | Tubing change | Last changed: | Tubing date/time change

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

OK | Cancel edit

IV Periph | IV Central | IV Dialysis | IV Comments | IV CP

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, IV (IV) tab, IV Periph window

RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

RESPIRATORY ASSESSMENT

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

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

* Other reason no one could respond | * Information obtained from | * Other source of information

* Patient has a history of | * Other history

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

* Other respiratory pattern

* Respiratory depth: Normal; Deep; Shallow

* Respiratory rate 0

* Chest movement: Equal, bilateral, symmetrical; Abnormal

* Abnormal Chest Movement

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

* Other work of breathing

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

* Breath sounds: Clear; Abnormal

Absent | Crackles/Rales | Diminished/decreased | Rhonchi | Wheezing - expiratory | Wheezing - inspiratory | Stridor | Pleural friction rub

Resp Page 1 | Resp Page 2 | Other CT Loc | Resp Page 3 | Resp CP

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: Respiratory depth | Go

Performing assessment

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

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

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

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

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

RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

NEUROLOGICAL ASSESSMENT

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

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

* Other reason no one could respond
* Information obtained from
* Other source of information

* Patient has a history of
* Spinal Cord Injury Level
Orientation

* Other neurological problem
* Describe Spinal Cord Injury Level

Prior response:
Level of Consciousness (Glasgow Coma Scale)

Eye response score: Not assesse
Verbal response score: Not assesse
Motor response score: Not assesse

Total score: 0

Prior score:

Score is expressed as Eye () + Verbal () + Motor ()

Glasgow score categories
- 13-15 (normal result)
- 9-12 (correlates with moderate brain injury)
- 8 or less (correlates with severe brain injury)

Instructions for completing Glasgow Coma Scale

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

Best Eye Response. (4)
4. Eyes open spontaneously
3. Eye opening to verbal command
2. Eye opening to pain
1. No eye opening.
C Denotes closed eye or if patient is unable to open an eye due to swelling, nerve palsy or eye dressing
P Indicates presence of pharmacological paralysis

Best Verbal Response. (5)
5. Oriented
4. Confused
3. Inappropriate words
2. Incomprehensible sounds
1. No verbal response
T Indicates presence of an ET or Trach tube
D Indicates patient aphasia
P Indicates the presence of pharmacological paralysis

Best Motor Response. (6) (Best arm response)
6. Obeys Commands

Neuro Page 1 | Neuro Page 2 | Neuro CP

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: able to respond to questions   Go

Performing assessment

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

RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

NEUROLOGICAL ASSESSMENT

Motor

Instructions for performing motor assessment

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

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

Prior resp: Prior resp: Prior resp: Prior resp:

Prior response:
* Other speech/language

Pupils

[ ] New lens implant/prosthesis
Prior response:
* Describe new lens implant/prosthesis

Size
( ) Equal
( ) Right greater than left
( ) Left greater than right
( ) Other

Prior response:

* Other pupil size

Reactivity

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

Prior response:

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

Prior response:

* New sensations present
[ ] Sensations - New paresthesias or neuropathies present
Prior response:

* New comm device needed
[ ] Requires assistive new communication device to meet basic needs
Prior response:

General observations/comments

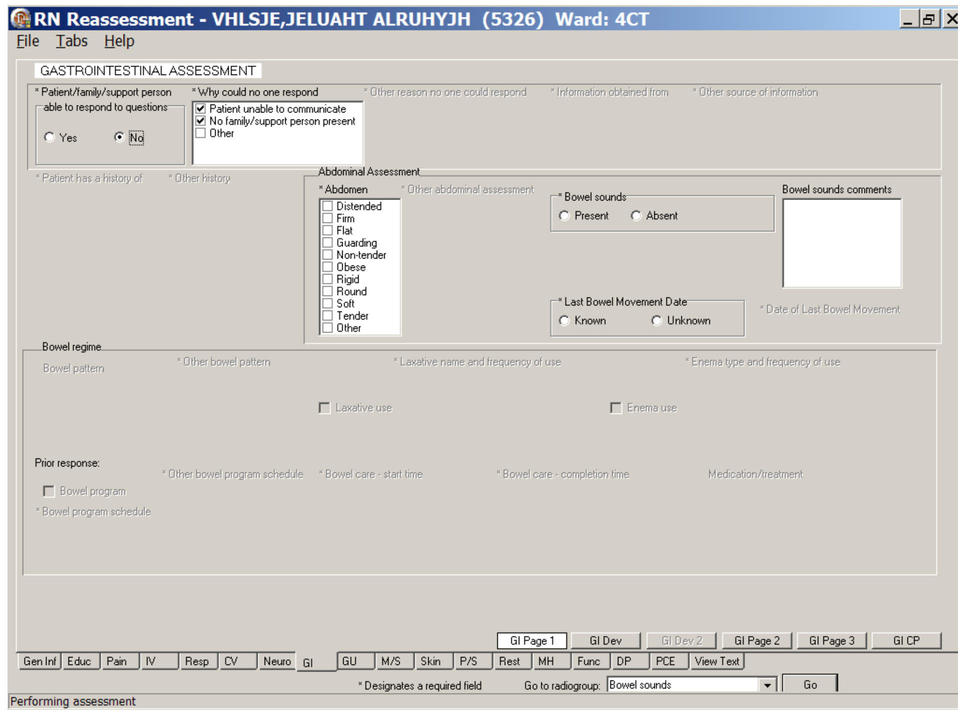
Neuro Page 1 | Neuro Page 2 | Neuro CP

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

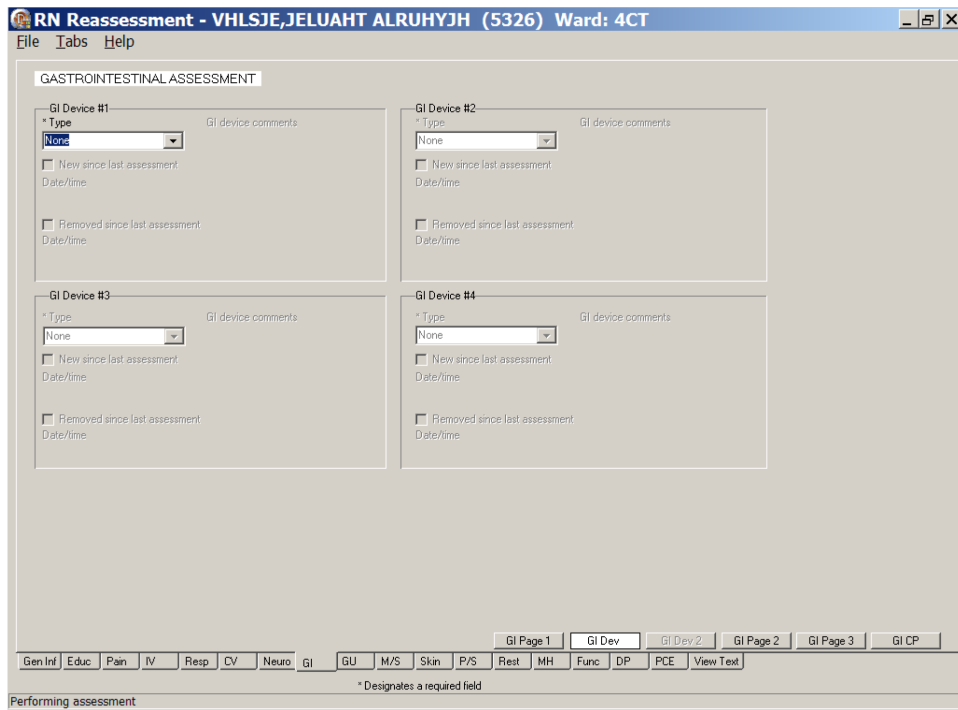
* Designates a required field   Go to radiogroup: Size   Go

Performing assessment

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



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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

FUNCTIONAL ASSESSMENT

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

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

* Other reason no one could respond · * Information obtained from · * Other source of information

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

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

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

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

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

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

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

Assist patient with: Ambulating; Bathing; Dressing; Feeding; Toileting; Transferring

Total score: 0

Prior score:

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

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

Did patient have a decrease in the level of independence

Prior response:

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

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: able to respond to questions · Go

Performing assessment

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

RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

FUNCTIONAL ASSESSMENT

Instructions for assessing the patient's level of assistance

Independent (Patient performs task safely, with or without staff assistance, with or without assistive devices)

Partial Assist (Patient requires no more help than stand-by, cueing, or coaxing, or caregiver is required to lift no more than 35 lbs. of a patient's weight)

Dependent - Patient requires nurse to lift more than 35 lbs. of the patient's weight, or is unpredictable in the amount of assistance offered).

* Patient's level of assistance: Independent / Partial Assist / Dependent

Prior response:

Assessment criteria and care plan for safe patient handling and movement

An assessment should be made prior to each task if the patient has varying levels of ability to assist due to medical reasons, fatigue, medications, etc. When in doubt, assume the patient cannot assist with the transfer/repositioning.

Height: 66.25 in [168.3 cm] (03/11/2011 09:14)

Weight: 229.94 lb [104.5 kg] (06/22/2011 12:30)

BMI: 36.9 (JUN 22, 2011@12:30:48)

Instructions for assessing patient's level of cooperation and comprehension

Cooperative (may need prompting; able to follow simple commands)

Unpredictable or varies (patient whose behavior changes frequently should be considered as "unpredictable"); not cooperative; or unable to follow simple commands

* Level of cooperation and comprehension: Cooperative / Unpredictable or varies

Prior response: · Prior response: · Prior response:

Applicable conditions likely to affect transfer/repositioning techniques

Transfer/repositioning techniques comments

General observations/comments

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

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

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

Performing assessment

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

RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

FUNCTIONAL ASSESSMENT

Use of mechanical lifting devices and approved aids for lifting, transferring, repositioning, and moving patients.

Transfer to and from Bed to Chair, Chair to Toilet, Chair to Chair, Car to Chair

Lateral transfer to and from Bed to Stretcher, Trolley

Transfer to and from Chair to Stretcher or Chair to Exam Table

Equipment/Assistive Device: Ceiling lift, Friction reducing device, Full body sling, Gait belt, Lateral transfer device, Power stand assist, Sliding board

Number of staff 0

Reposition in Bed, Side to Side, Up in Bed

Reposition in Chair

Transfer a patient up from the floor

Equipment/Assistive Device: Ceiling lift, Friction reducing device, Full body sling, Gait belt, Lateral transfer device, Power stand assist, Sliding board

Number of staff 0

Print

Sling type: Standard, Amputation, Head support

Prior response:

Sling size: 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: 66.25 in [168.3 cm] (03/11/2011 09:14)

Weight: 229.94 lb [104.5 kg] (06/22/2011 12:30)

Educate Patient, Family, and Support Person on

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

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: Sling type Go

Performing assessment

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

RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

DISCHARGE PLANNING

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

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

* Other reason no one could respond

* Information obtained from

* Other source of information

* Does patient have a legal/ medical guardian (conservator)?: Yes, No

Pulled from P/S Page 3

* Specify guardian (conservator)

* Describe employment status

* Home environment

* Other architectural barriers

* Special Equipment Needed at Home

* Other equipment needed

* Other transportation for discharge

General observations/comments

DP Page 1 | DP CP

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: able to respond to questions Go

Performing assessment

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

RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT

File Tabs Help

DISCHARGE PLANNING - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES

* Problems, interventions, and desired outcomes indentified in previous tabs have been discussed

* Why hasn't plan of care been discussed

Anticipated Discharge Plan Goals

* Family/support person in discharge planning

- [ ] Discharge to home without additional services
- [ ] Involve family/support person in discharge planning
- [ ] Patient is homeless **
- [ ] Patient requires transportation assistance **
- [ ] Discharge to home with support services (physiological needs e.g. O2, IV therapy, pain therapy and wound care) **
- [ ] Discharge to home with support services (functional needs e.g. assistance with home ADLs) **
- [ ] Discharge to home with support services (social needs e.g. financial assistance, transportation, follow-up appointments, support groups) **
- [ ] Discharge to home with support services (educational needs e.g. classes, materials) **
- [ ] Discharge to home with support services (spiritual needs e.g. clergy contact) **
- [ ] Discharge to home with support services (special equipment needs) **
- [ ] Discharge to home with Multidrug Resistant Organism (MDRO)/Infectious Disease information **
- [ ] Discharge to extended care facility **
- [ ] Patient identified as a wanderer/elopement risk **
- [ ] Patient identified as a fire risk **
- [ ] Patient on isolation precautions
- [ ] Plan for support for patient's care giver/s **
- [ ] Other 1
- [ ] Other 2
- [ ] Other 3

If an item contains **, then a Social Work Consult or Discharge Planning Consult is required

Discharge Planning Consult | Social Work Consult | Telehealth Consult | Home Care Consult

DP Page 1 | DP CP

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, 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.

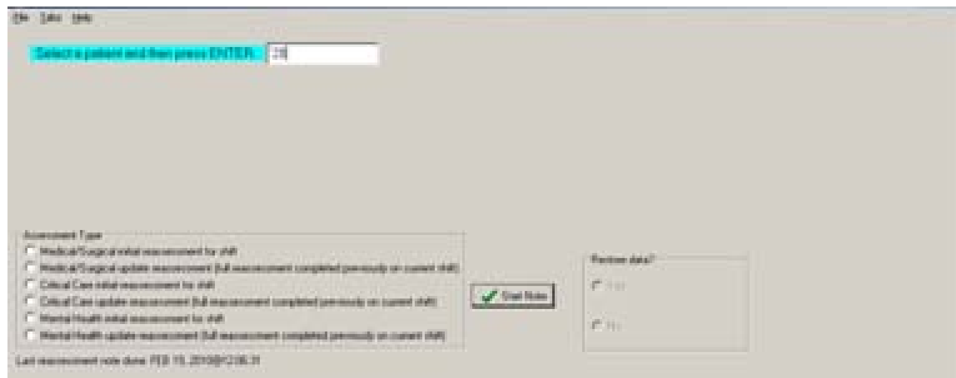
Note: For the content of the template, refer to the User Manual for *Admission – RN Assessment*.

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)**.



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

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

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

Reassessment Contingency Note.pd

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