

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

Date	Revision	Description	Author
May 2010	1.0	Initial version for 1.0	CBeynon
August 2010	1.1	Add content	CBeynon
August 2010	1.2	Format content	CBeynon
September 2010	1.3	Split manual into three manuals <ul style="list-style-type: none"> • RN Reassessment • User Manual 	CBeynon
October 2010	1.4	Updated content	CBeynon
November 2010	1.5	Updated screen captures	CBeynon
December 2010	1.6	<ul style="list-style-type: none"> • Changed dates • Pulled issues from this doc for team review 	CBeynon
January 2011	1.7	<ul style="list-style-type: none"> • Changed dates to January 2011 • Updated with additional comments from Judy 	CBeynon
February 2011	1.8	Changed dates to February 2011	CBeynon
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Date	Revision	Description	Author
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January 2012	1.15	<ul style="list-style-type: none"> • Changed NUPA 1.0 to NUPA Version 1.0 • Updated for build v16 • Changed dates to February 2012 	CBeynon
February 2012	1.16	<ul style="list-style-type: none"> • Updated Neuro tab • Updated the <i>Unable to Complete the Assessment</i> section 	CBeynon
March 2012	1.17	<ul style="list-style-type: none"> • Changed dates to March 2012 • Prepped for April national release • Changed dates to April 2012 • Added Appendix A: Reassessment Contingency Note 	CBeynon

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Introduction

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

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

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

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

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

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

Each template is associated with a note.

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

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

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

Using the RN Reassessment

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

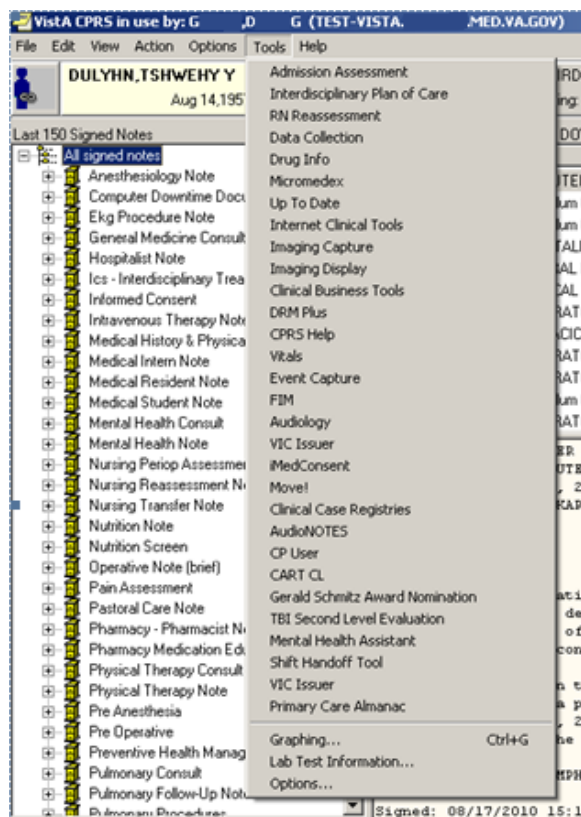
Opening RN Reassessment

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

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

Enter a patient window automatically opens to the CPRS patient.

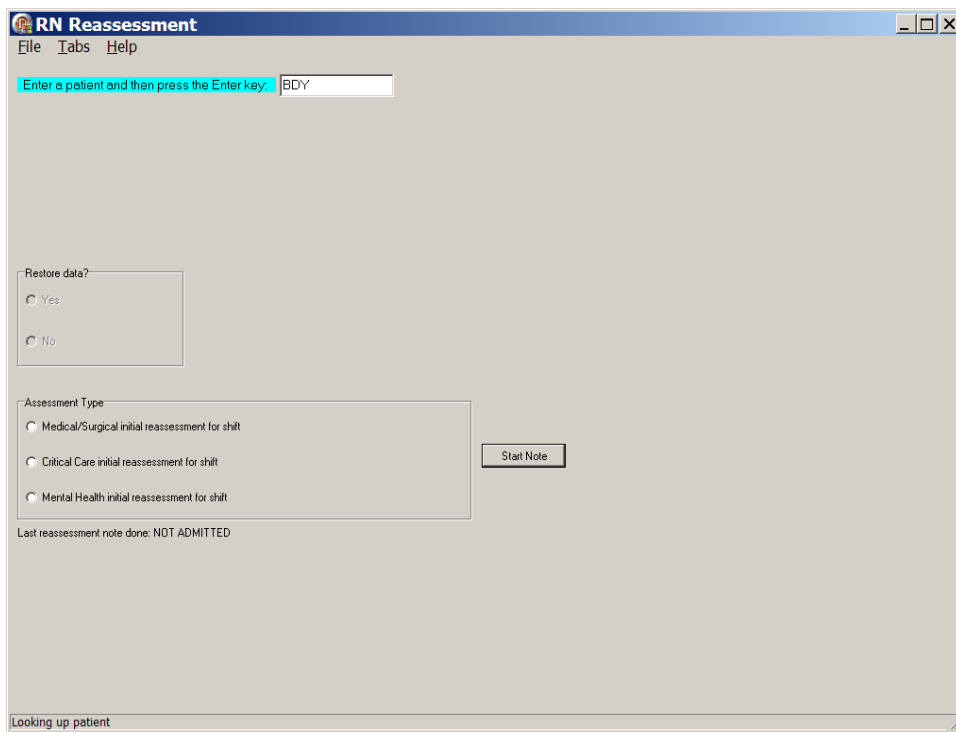
Note: You may have to re-enter your CPRS access and verify codes, depending on local site setup.



Access through CPRS

No Previously Saved Information

The Enter a patient window displays.

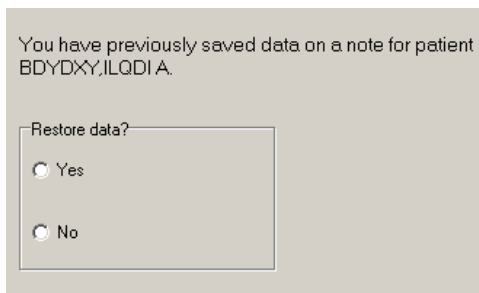


RN Reassessment, Enter a patient window with no previously saved information

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

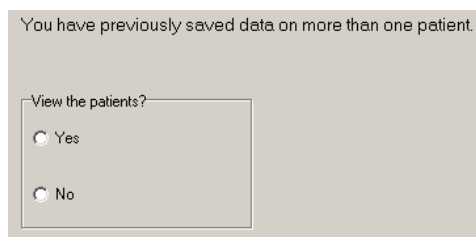
If you previously entered data on one patient, you are prompted with: *You have previously saved data on a note for patient <PADPPATIENT,ONE > m*

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.



You have previously saved data on more than one patient.

View the patients?

Yes

No

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

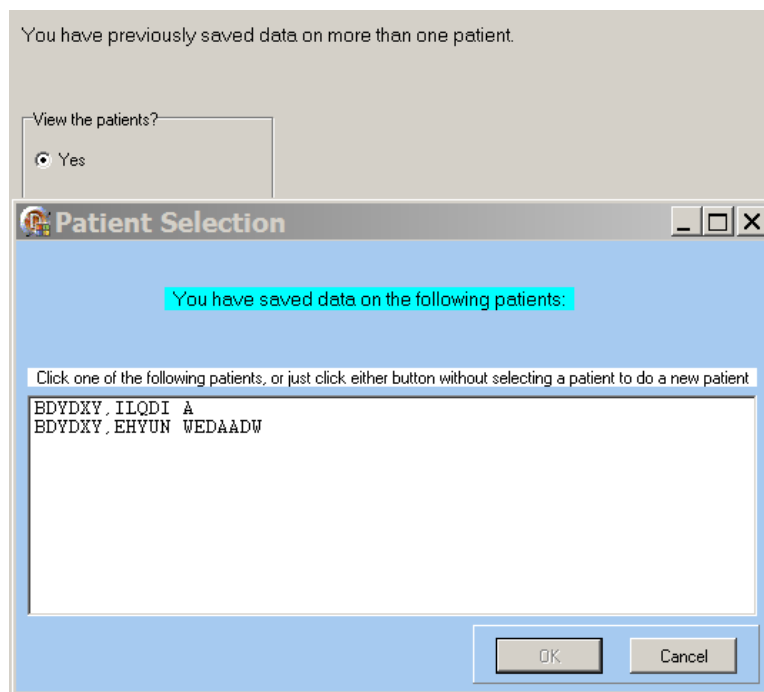
View the Patients?/No

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

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

View the Patients?/Yes

1. Select **Yes**.
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

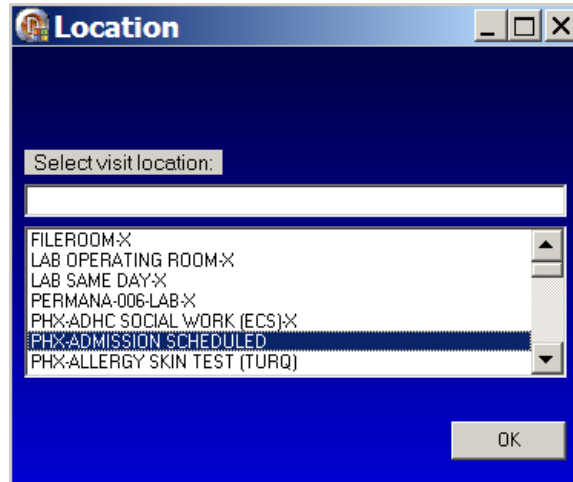
1. Click **Cancel**.
The number that represents your CPRS patient is in the Enter a patient text box.
2. Click the **Start Note**.
The template opens to the General Information tab.

The screenshot displays the 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'GENERAL INFORMATION' tab is active. The form includes several sections: 'Patient/family/support person able to respond to questions' with radio buttons for 'Yes' (selected) and 'No'; 'Information obtained from' with checkboxes for 'Patient', 'Authorized surrogate', 'Family/Support Person', 'Medical Record', and 'Other'; 'Demographics' with fields for Name, Age, Sex, and Race; 'Admitting diagnosis: NONE FOUND'; 'Preferred Healthcare Language' with radio buttons for 'English', 'Spanish', and 'Other'; and a text area for 'What does patient want to accomplish by this hospitalization?'. The bottom of the window features a navigation bar with tabs for 'Gen Inf', 'Educ', 'Pain', 'IV', 'Resp', 'CV', 'Neuro', 'GI', 'GU', 'M/S', 'Skin', 'P/S', 'Rest', 'MH', 'Func', 'DP', 'PCE', and 'View Text'. The 'Gen Inf' tab is selected. A status bar at the bottom indicates 'Performing assessment' and includes a 'Go to radiogroup' dropdown menu set to 'able to respond to questions' and a 'Go' button.

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

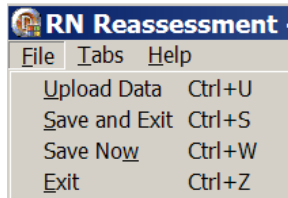
Data are saved automatically. Frequency of auto-save is set locally.



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.

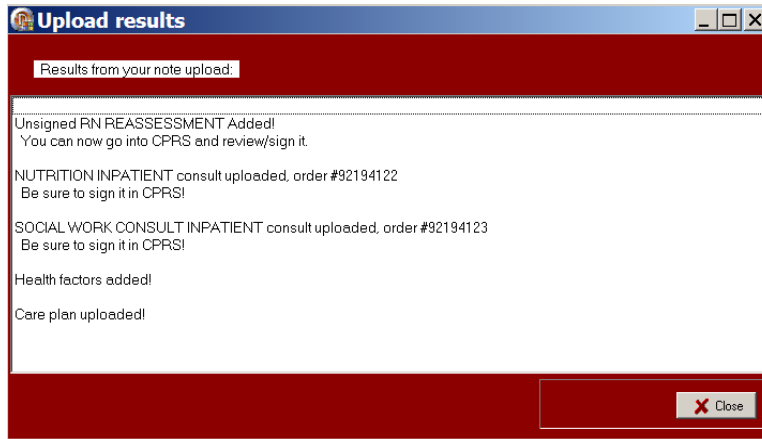


RN Reassessment window, File menu

Upload Data

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

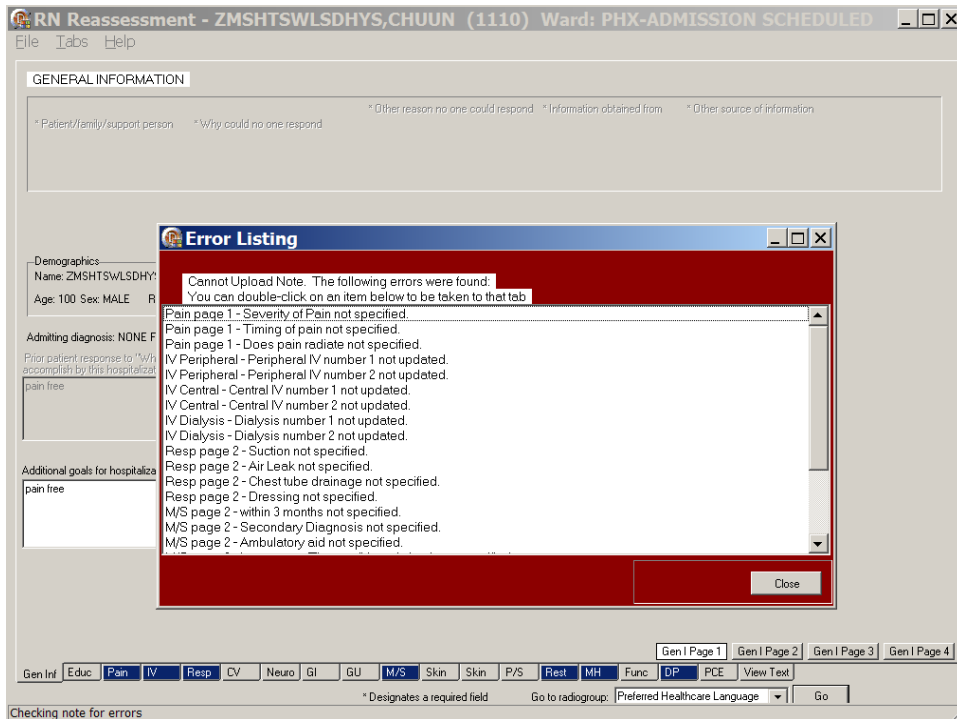
1. Open the File menu on any tab and select **Upload Data**.
Results from your upload display, verifying that the data is uploaded.



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.

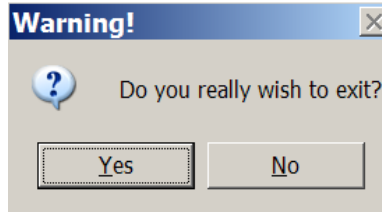
Save Now

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?

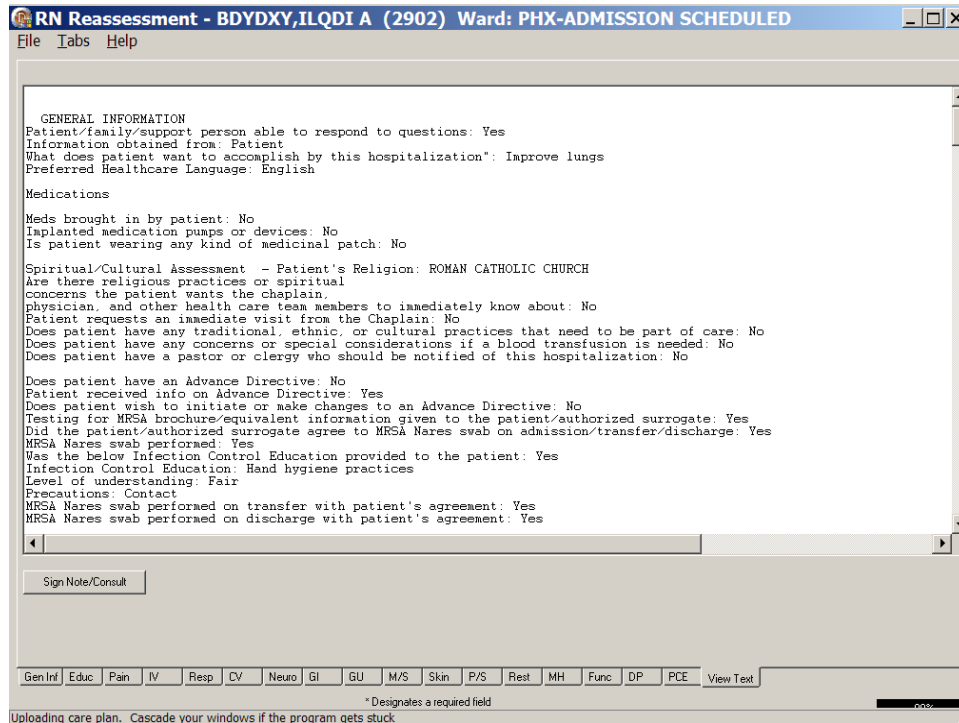
2. Click **Yes**.
- or
1. From any tab, open the File menu and click **Exit**.
Warning message displays.
 2. Click **Yes**.

Signing Notes

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

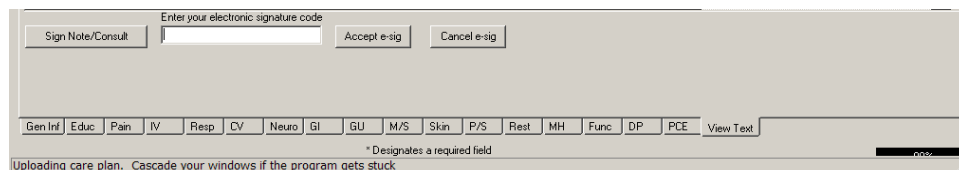
You can also sign *unsigned* notes **after the upload** from the View Text tab in the template.

1. Click **View Text**.



RN Reassessments, View Text tab after upload

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



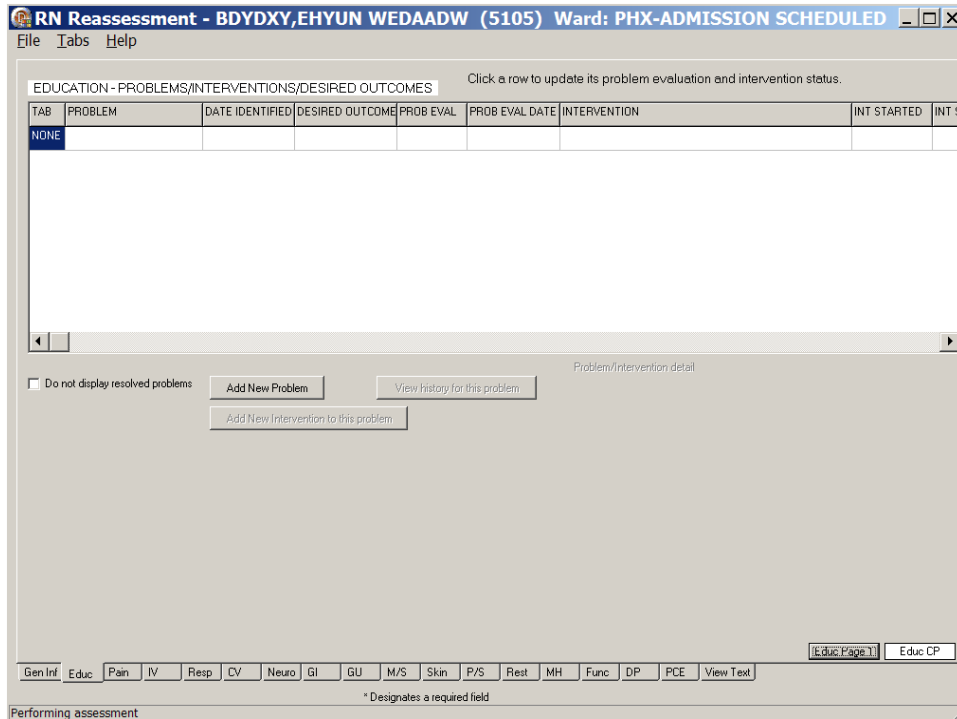
RN Reassessment, Sign Note/Consult Button

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 (Actual)	2/3/11@1156	Prevention/minimizati	New problem	Not on file	Education - Educat	2/3/11@1156	Not on file	Not on file
CV	Congestive Heart Failure (Actual)	2/3/11@1156	Prevention/minimizati	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 intake	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 intake	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

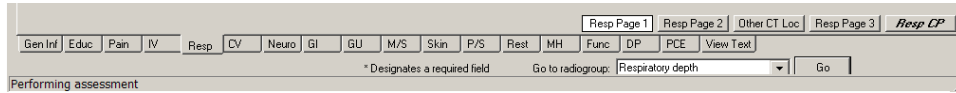
RN Reassessment, Problems/Interventions/Desired Outcomes table

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 <i>what to do</i> for the patient you identify, so that the problem will improve/get better/not get worse
Int Started (Intervention Started)	Date on which the intervention was initiated
Int Status (Intervention Status)	In relation to the intervention, how should the staff proceed? a. Complete b. Continue c. Discontinue d. Pending (intervention was ordered but not started, such as a special bed or a lab test) e. Not on file (status not evaluated)
Int Stat Date (Intervention Status Date)	Date on which the status of the intervention was evaluated

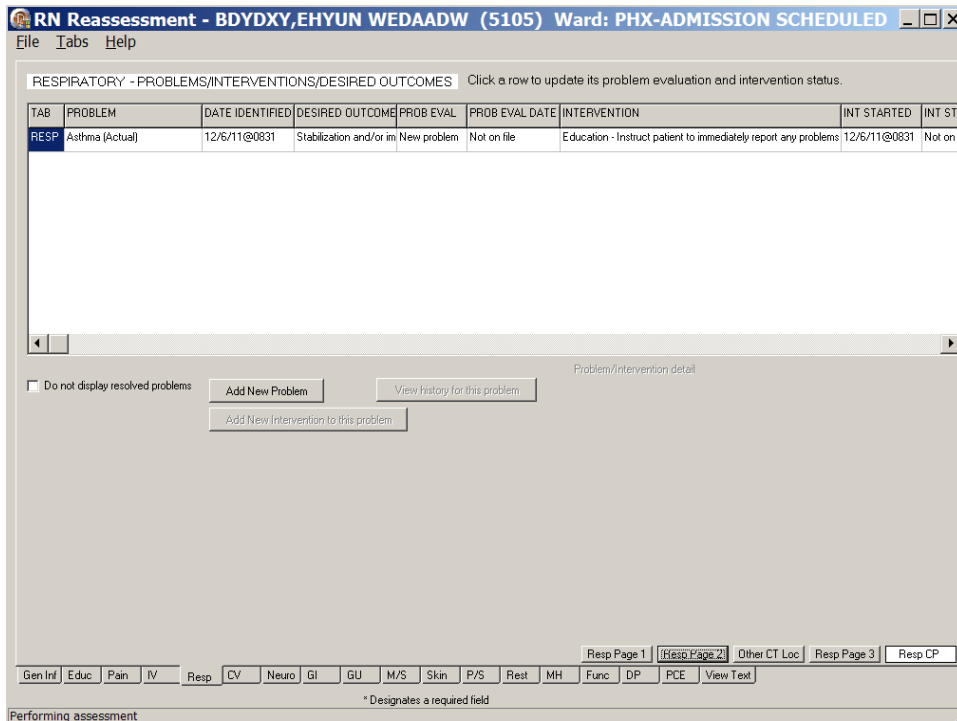
Updating an Existing Problem/Intervention

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



RN Reassessment, <Resp> tab

1. Click <Resp> CP.
The <Respiratory> - Problems/Interventions/Desired Outcomes window displays.



RN Reassessment, <Resp> CP window

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

RN Reassessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

RESPIRATORY - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES Click a row to update its problem evaluation and intervention status.

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DAT
RESP	Asthma (Actual)	12/6/11@0831	Stabilization and/or im	New problem	Not on file	Education - Instruct patient to immedi	12/6/11@0831	Not on file	Not on file

Do not display resolved problems

Add New Problem View history for this problem

Add New Intervention to this problem

Problem evaluation:
 No change/Stable
 Deteriorating
 Improving
 Resolved
 Unresolved at discharge

Intervention status:
 Completed
 Continue
 Discontinue
 Pending

OK Cancel

Problem/Intervention detail
 Problem: Asthma (Actual)
 Identified: 12/6/11@0831
 Desired outcome: Stabilization and/or improvement of respiratory status as i
 Evaluation: New problem
 Evaluation date: Not on file
 Intervention: Education - Instruct patient to immediately report any problems
 Intervention started: 12/6/11@0831
 Intervention status: Not on file
 Intervention status date: Not on file

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

Performing assessment

RN Reassessment, <Resp> CP window

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

The screenshot shows a software window titled "Performing assessment". At the top left, there is a checkbox "Do not display resolved problems" and two buttons: "Add New Problem" and "View history for this problem". Below these are two more buttons: "Add New Intervention to this problem" and "OK".

There are two sections of radio buttons for selection:

- Problem evaluation:**
 - No change/Stable
 - Deteriorating
 - Improving
 - Resolved
 - Unresolved at discharge
- Intervention status:**
 - Completed
 - Continue
 - Discontinue
 - Pending

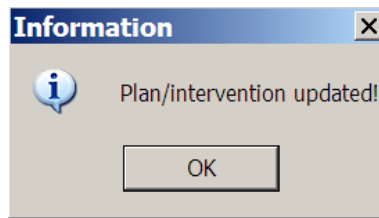
At the bottom right, there is a "Cancel" button. A "Problem/Intervention detail" window is open, showing the following text:

```
Problem: Asthma (Actual)
Identified: 12/6/11@0831
Desired outcome: Stabilization and/or improvement of respiratory status as i
Evaluation: New problem
Evaluation date: Not on file
Intervention: Education - Instruct patient to immediately report any problems
Intervention started: 12/6/11@0831
Intervention status: Not on file
Intervention status date: Not on file
```

At the bottom of the main window, there is a navigation bar with tabs: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", "View Text". Below the tabs, it says "* Designates a required field".

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.

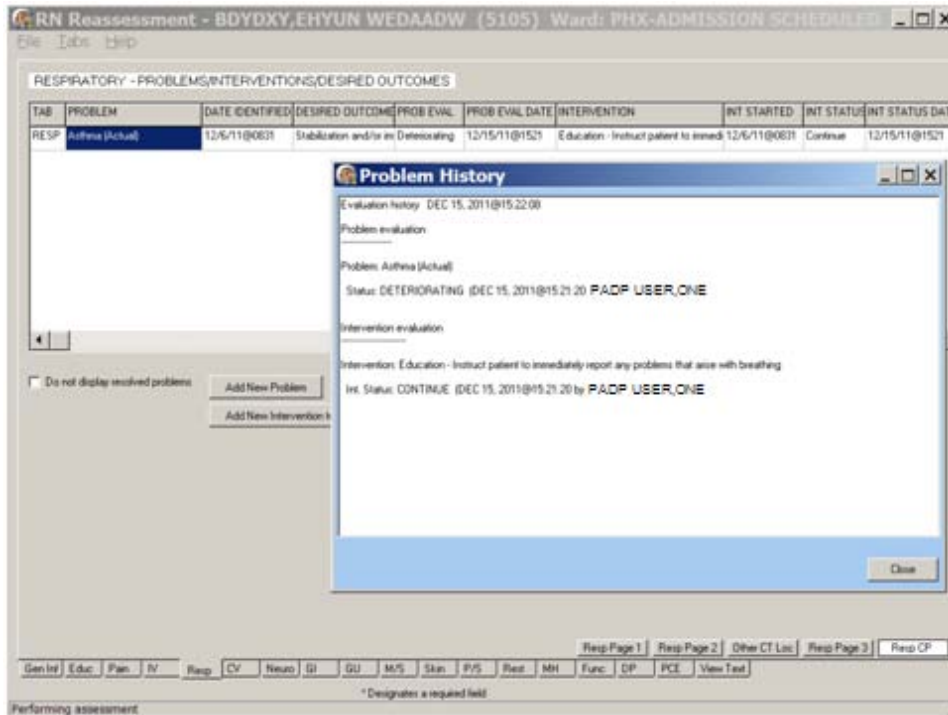
The screenshot shows a software window titled "RN Reassessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION SCHEDULED". The main content area is titled "RESPIRATORY - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES" and contains a table with the following data:

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DAT
RESP	Asthma (Actual)	12/6/11@0831	Stabilization and/or im	Deteriorating	12/15/11@1521	Education - Instruct patient to immedi	12/6/11@0831	Continue	12/15/11@1521

Below the table, there are several control buttons: "Do not display resolved problems" (checkbox), "Add New Problem", "View history for this problem", and "Add New Intervention to this problem". At the bottom of the window, there is a navigation bar with tabs for "Gen/Int", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "Resp" tab is currently selected. A status bar at the bottom left indicates "Performing assessment" and a note at the bottom center states "* Designates a required field".

RN Reassessment, <Resp> CP window

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

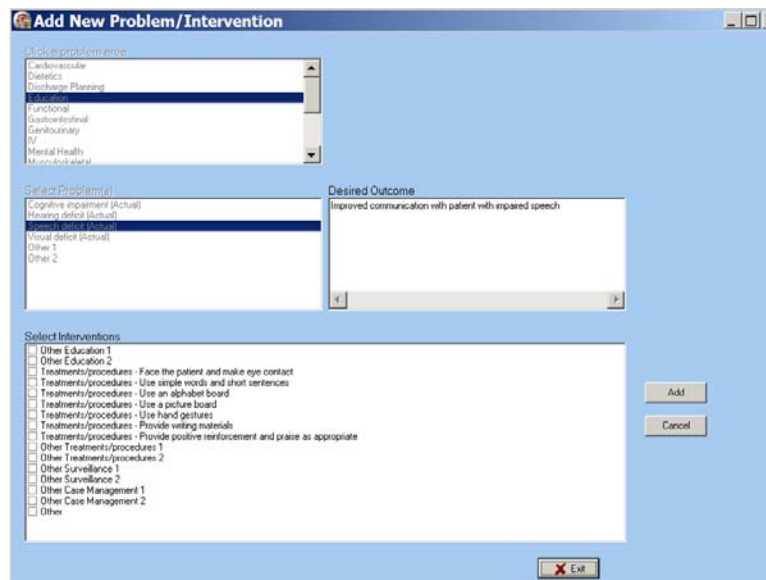


Problem History window

- Click **Close**.

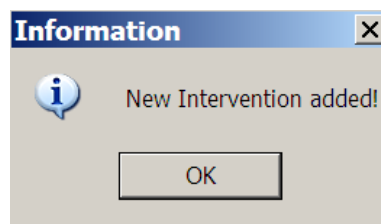
Adding a New Intervention for an Existing Problem

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

RESPIRATORY - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DAT
RESP	Asthma (Actual)	12/6/11@0831	Stabilization and/or im	Deteriorating	12/15/11@1521	Education - Instruct patient to immedi	12/6/11@0831	Continue	12/15/11@1521

Buttons: Do not display resolved problems, Add New Problem, View history for this problem, Add New Intervention to this problem

RN Reassessment, <Resp> CP window

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

Add New Problem/Intervention

Click on problem area:

- Cardiovascular
- Diabetes
- Discharge Planning
- Education**
- Functional
- Gastrointestinal
- Genitourinary
- IM
- Mental Health
- Musculoskeletal

Select Problem(s):

- Cognitive impairment (Actual)
- Hearing deficit (Actual)
- Speech deficit (Actual)
- Visual deficit (Actual)
- Other 1
- Other 2

Desired Outcome:

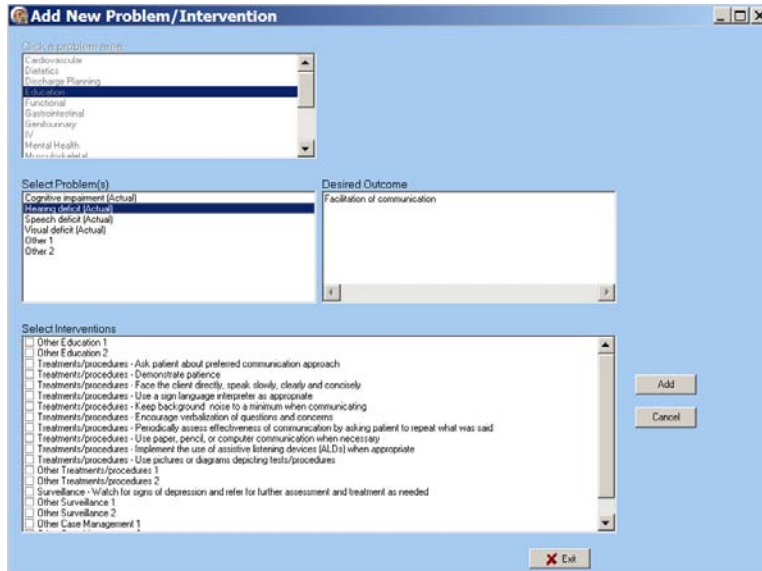
Select Interventions:

Exit

Add New Problem/Intervention window

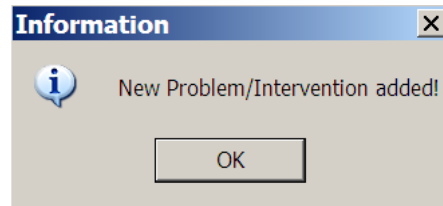
Note: The Respiratory area is auto selected, because you are in the Resp CP.

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.



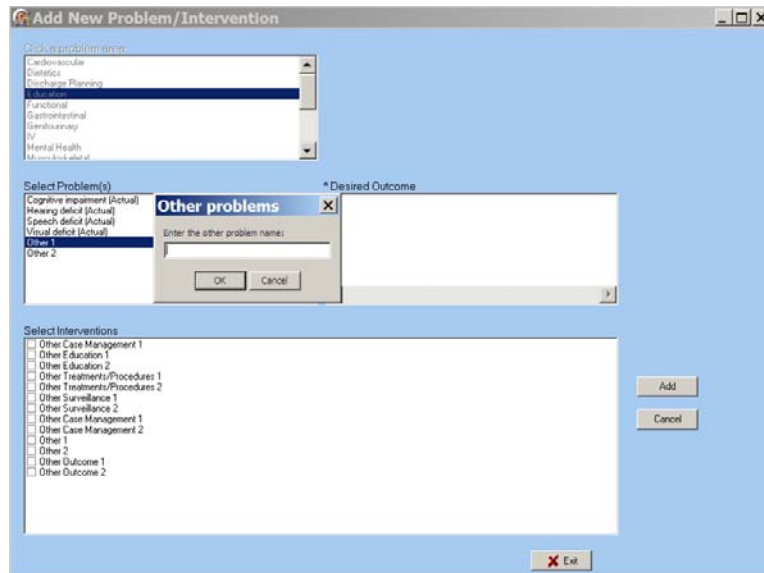
Information : New Problem/Intervention added!

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

Other Problems

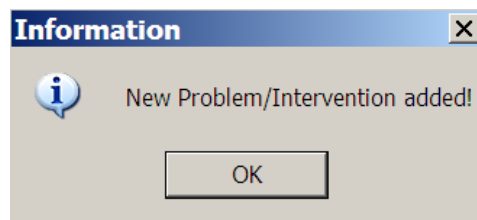
Some problems generate a to enter problems that are not on the predefined list.

1. Select an *Other* 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.



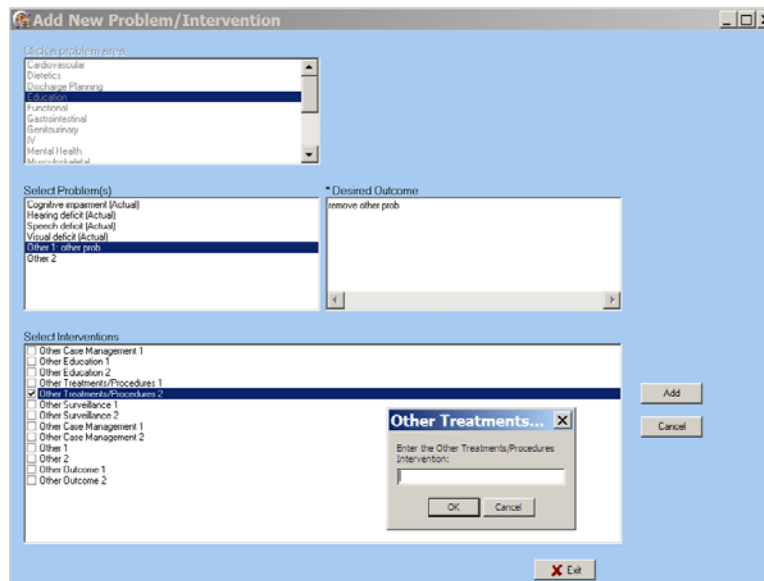
Information : New Problem/Intervention added!

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

Other Interventions

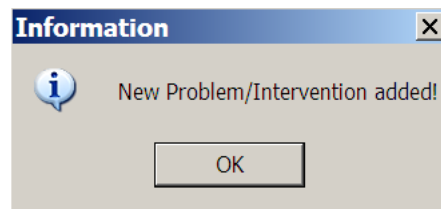
Some interventions generate a to enter interventions that are not on the predefined list.

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

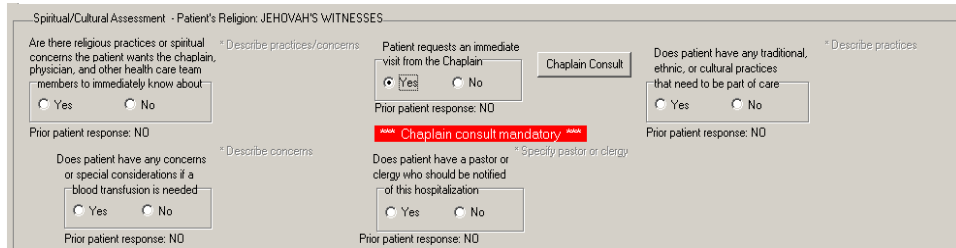
Order a Chaplain Consult from Gen Inf tab, Gen I Page 2 in the Spiritual/Cultural Assessment section.

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



The screenshot shows a form titled "Spiritual/Cultural Assessment - Patient's Religion: JEHOVAH'S WITNESSES". It contains several questions with radio button options for "Yes" and "No".

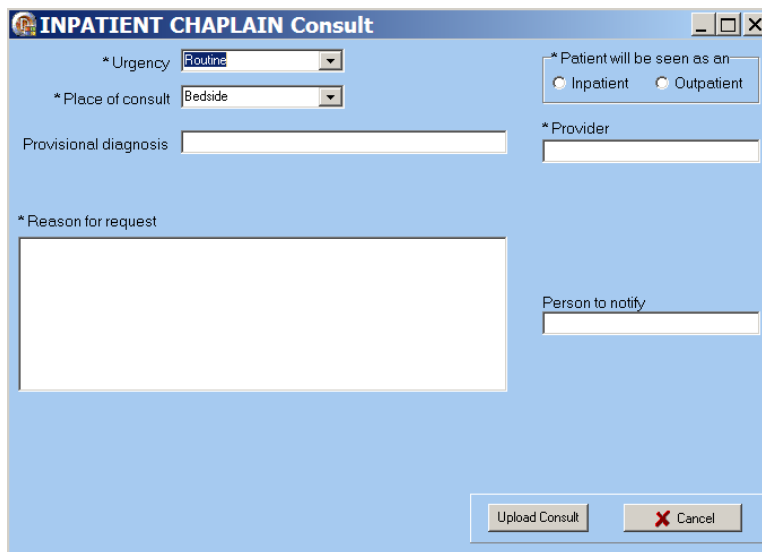
- Question 1: "Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about?" - The "Yes" option is selected. Below it, a red message reads "*** Chaplain consult mandatory ***".
- Question 2: "Does patient have any traditional, ethnic, or cultural practices that need to be part of care?" - The "No" option is selected.
- Question 3: "Does patient have any concerns or special considerations if a blood transfusion is needed?" - The "No" option is selected.
- Question 4: "Does patient have a pastor or clergy who should be notified of this hospitalization?" - The "No" option is selected.

Each question has a "Prior patient response: NO" label below it. A "Chaplain Consult" button is visible between the first and second questions.

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.

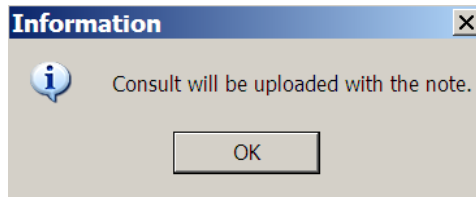


The screenshot shows the "INPATIENT CHAPLAIN Consult" window. It has a blue header and contains the following fields:

- * Urgency: Routine (dropdown menu)
- * Place of consult: Bedside (dropdown menu)
- * Patient will be seen as an: Inpatient (radio button selected), Outpatient (radio button)
- * Provider: (text input field)
- Provisional diagnosis: (text input field)
- * Reason for request: (large text area)
- Person to notify: (text input field)
- Buttons: "Upload Consult" and "Cancel" (with a red X icon)

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

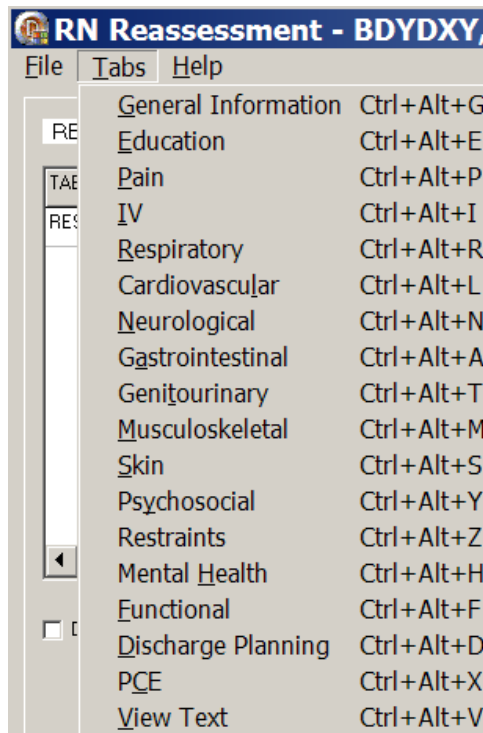
There are two ways to move from tab to tab within the template.

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

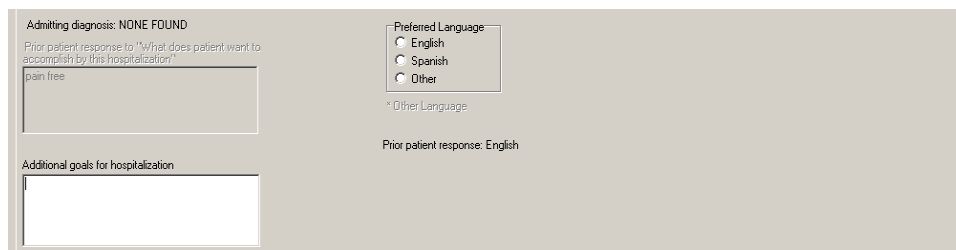
1. Use the Tab key to move to the bottom of the page.
 2. Use the arrow keys to move up/down in the **Go to radiogroup:** list.
 3. Click **Go**.
- or
1. Click the drop-down arrow in the **Go to radiogroup:** drop-down list.
 2. Select a radiogroup.
 3. Click **Go**.

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.

GENERAL INFORMATION

Advance Directive

Does patient have an Advance Directive? Yes No
 * Location of Advance Directive

Patient received info on Advance Directive? Yes No
 * Explain why patient did not receive info

Does patient wish to initiate or make changes to an Advance Directive? Yes No
 [Social Work Consult]

Prior patient response: NO
 Prior patient response: YES
 Prior patient response: NO
 Social Work consult previously sent

Prior response: No
 Does patient wish to indicate or make changes to an Advance Directive

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

RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

DISCHARGE PLANNING

* Patient/family/support person able to respond to questions: Yes No
 * Why could no one respond * Other reason no one could respond

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

* Does patient have a legal/medical guardian (conservator)? Yes No
 * Specify guardian (conservator)
 Pulled from P/S Page 3

* Employment Status: Presently employed Unemployed Retired Disabled Patient declines to answer
 * Describe employment status

* Relationship status: Co-habiting Divorced Married Separated Single Widowed Patient declines to answer

* With whom does patient live: Alone Family Significant Other Friend Nursing Home Assisted Living Homeless Patient declines to answer
 * Home environment: No identified problems Stairs to enter home Stairs within home Bed on main level Full bathroom on main level Bed & full bathroom on same floor (not main level) Other architectural barriers (e.g. narrow doorways) Patient declines to answer
 * Other architectural barriers

* Special Equipment Needed at Home: No equipment needed Specialty bed Specialty mattress Ramp Raised toilet seat Safety bars Other
 * Other equipment needed

* Transportation for Discharge: Drive car Friends/family Bus VA Shuttle VA Travel Other Patient declines to answer
 * Other transportation for discharge

General observations/comments:

DP Page 1 DP CP

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

* Designates a required field Go to radiogroup: Employment Status Go

Performing assessment

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.

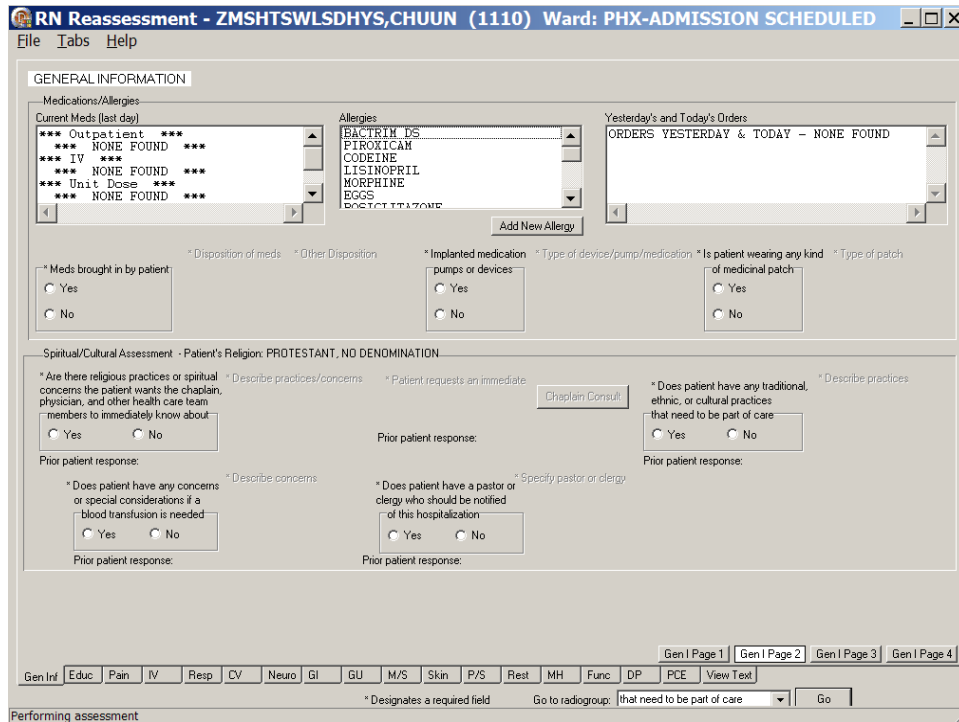
The screenshot shows a web-based application window titled "RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main content area is titled "GENERAL INFORMATION" and contains several sections:

- Response Information:** Includes fields for "Patient/family/support person able to respond to questions" (radio buttons for Yes/No), "Why could no one respond", "Other reason no one could respond", "Information obtained from" (checkboxes for Patient, Authorized surrogate, Family/Support Person, Medical Record, Other), and "Other source of information".
- Demographics:** A box containing "Name: ZMSHTSWLSDHYS, CHUUN", "Age: 100 Sex: MALE", and "Race: BLACK OR AFRICAN A".
- Admitting diagnosis:** "NONE FOUND".
- Prior patient response:** A section for "Prior patient response to 'What does patient want to accomplish by this hospitalization?'", including a "Preferred Healthcare Language" section with radio buttons for English, Spanish, and Other, and a text input field.
- Bottom Navigation:** A row of tabs: "Gen I Page 1", "Gen I Page 2", "Gen I Page 3", and "Gen I Page 4". Below this is a horizontal menu with tabs for "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text".
- Footer:** "Performing assessment" and "Go to radiogroup: able to respond to questions" with a "Go" button.

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.

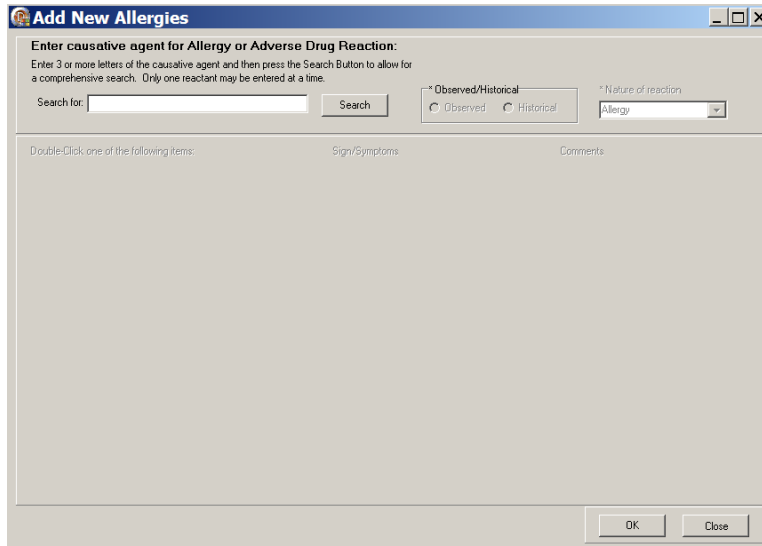
- Allergies are added on Gen I Page 2, in the Allergies text box.
- None of the fields on Gen I Page 2 is required during reassessment, provided a completed admission assessment is on file.

Adding an Allergy

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

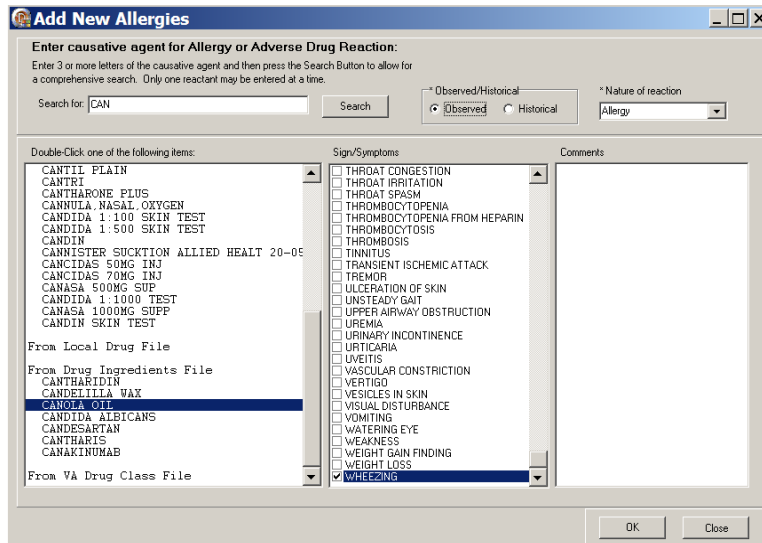
Note: Follow your local medical center policy with regard to adding allergies.

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



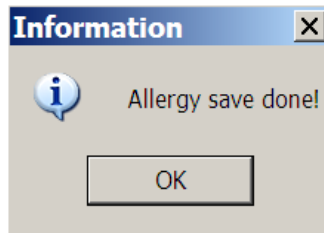
Add New Allergies window

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 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.

 A screenshot of the 'RN Reassessment - ZMSHTSWLSHDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' software window. The window title bar includes the patient name and ward information. Below the title bar is a menu bar with 'File', 'Tabs', and 'Help'. The main content area is titled 'GENERAL INFORMATION' and contains several sections of form fields:

- Advance Directive**: Includes radio buttons for 'Yes' and 'No', a 'Social Work Consult' button, and a 'Prior patient response' field.
- Testing for MRSA brochure/equivalent information**: Includes radio buttons for 'Yes' and 'No', and a 'Prior patient response' field.
- MRSA Nares swab on admission/transfer/discharge**: Includes radio buttons for 'Yes' and 'No', and a 'Prior patient response' field.
- Swab performed**: Includes radio buttons for 'Yes' and 'No', and a 'Prior patient response' field.
- Why wasn't MRSA Nares swab performed**: Includes radio buttons for 'Yes', 'No', 'Refused', and 'N/A', and a 'Prior patient response' field.
- MRSA Nares swab performed on discharge**: Includes radio buttons for 'Yes', 'No', 'Refused', and 'N/A', and a 'Prior patient response' field.
- Infection Control Education**: Includes a list of checkboxes for '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)', and 'Other'.
- Precautions**: Includes a list of checkboxes for 'Airborne', 'Contact', 'Droplet', and 'Neutropenic'.

 At the bottom of the window, there is a navigation bar with tabs for 'Gen I Page 1', 'Gen I Page 2', 'Gen I Page 3', and 'Gen I Page 4'. Below the navigation bar is a status bar with the text 'Performing assessment' and a 'Go' button.

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.

The screenshot shows a software window titled "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main content area is titled "GENERAL INFORMATION" and contains the "Advance Directive" section. This section includes three columns of questions, each with radio button options for "Yes" and "No", and a "Prior patient response:" label below each. The first column asks "Does patient have an Advance Directive?". The second column asks "Patient received info on Advance Directive". The third column asks "Does patient wish to initiate or make changes to an Advance Directive?". A "Social Work Consult" button is located to the right of the third column. At the bottom right of the form, there is a red error message: "Social work consult mandatory".

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

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

Changing Emergency Contact Information

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

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

The screenshot shows a software window titled "RN Reassessment - BDYDX, EHYUN WEDAADW (5105) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main content area is divided into two sections: "GENERAL INFORMATION" and "General observations/comments".

The "GENERAL INFORMATION" section contains a sub-section titled "Emergency contact information" with the following details:

- Contact: BDYDX, EHYUN WEDAADW
- Relationship: WIFE
- Address: 9908 ROBIN NE. FARM HILL, ID
- Phone: 207-001-6182
- Work Phone: QCYQFZS

There is a "Change Contact" button next to the contact information. Below this section is a checkbox labeled "Support Person same as emergency contact" which is currently unchecked. A note below the checkbox reads: "* Document the name and contact information of the patient's support person". Below the note is a large empty text box for entering support person information.

The "General observations/comments" section is a large empty text box on the right side of the window.

At the bottom of the window, there is a navigation bar with tabs for "Gen I Page 1", "Gen I Page 2", "Gen I Page 3", and "Gen I Page 4". Below the tabs is a row of buttons for various assessment categories: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". A note at the bottom center states "* Designates a required field". The status bar at the very bottom indicates "Performing assessment".

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

GENERAL INFORMATION

Emergency contact information

Contact: BDYDKY, EHYUN WEDAADW
 Relationship: WIFE
 Address: 9908 ROBIN NE.
 FARM HILL, ID
 Phone: 207-001-6182
 Work Phone: QCYQFZS

Change Contact

* Name (LN, FN):

* Relationship:

Street Address 1:

Street Address 2:

Street Address 3:

* Zip Code:

Phone: Work Phone:

Save Contact

Cancel Contact

Support Person same as emergency contact

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

Emergency Contact and Support Person Information

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

Education (Educ)

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

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

The screenshot shows the 'EDUCATIONAL ASSESSMENT' window. The title bar reads 'RN Reassessment - ZMSHTSWLSHDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED'. The menu bar includes 'File', 'Tabs', and 'Help'. The main content area is divided into several sections:

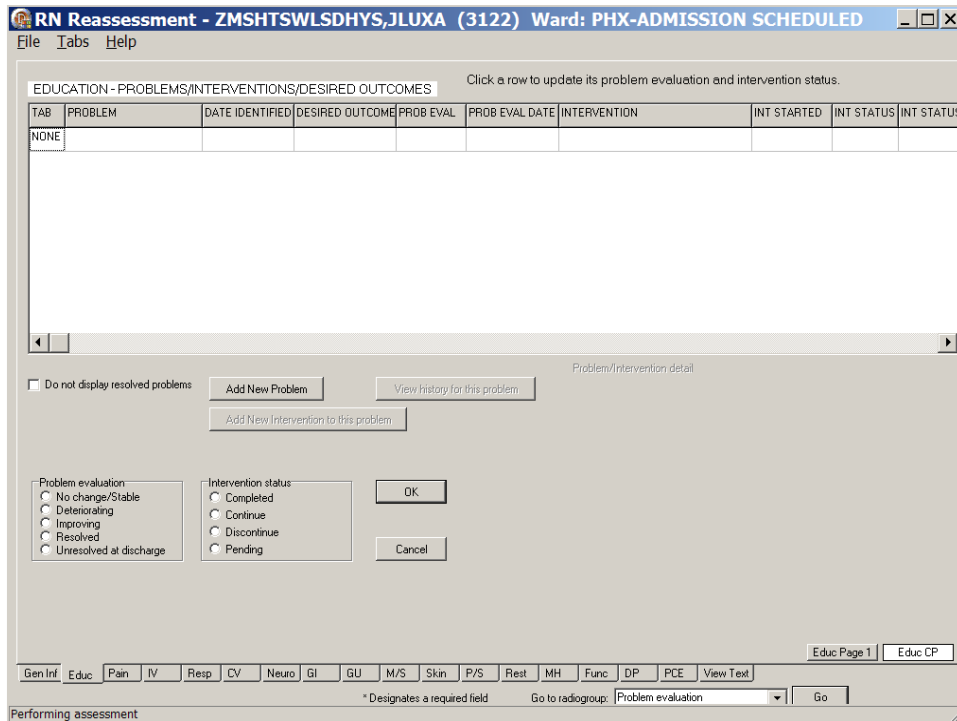
- Top Section:** 'Patient/family/support person able to respond to questions' with radio buttons for 'Yes' (selected) and 'No'. To the right, 'Information obtained from' includes checkboxes for 'Patient', 'Authorized surrogate', 'Family/Support Person', 'Medical Record', and 'Other'.
- Left Section:** 'Educational Level' with radio buttons for 'Grade school', 'Junior high school', 'High school', 'College', 'Graduate school', 'Other', 'Unable to answer', and 'Refuses to answer'. Below it, 'Learns best by' has checkboxes for 'Doing', 'Hearing/Listening', 'Reading', and 'Seeing'.
- Middle Section:** 'Has ability to read' and 'Has ability to write' with radio buttons for 'Yes' and 'No'. Below each is a 'Prior patient response:' field. 'Readiness to learn' has radio buttons for 'Ready to learn', 'States not interested in learning', 'States teaching not needed', and 'Impeded by current condition'.
- Bottom Section:** 'Barriers to learning' with checkboxes for 'None Identified', 'Hearing', 'Language', 'Limited attention span', 'Memory', 'Pain', 'Sedation/Lethargy', 'Visual Impairment', and 'Other'. 'Knowledge of current illness, surgery, reason for hospitalization etc as identified by patient' has radio buttons for 'None', 'Limited', and 'Extensive'. 'Information provided to patient/support person on the following topics' includes checkboxes for 'BCMA', 'Managing Your Pain', 'Notification of the Joint Commission', 'Patient Rights & Responsibilities', 'Patient Safety Concerns', 'Prevention of Falls', 'Promotion of a Restraint Free Environment', and 'Other'.

At the bottom, there is a navigation bar with tabs for 'Gen Inf', 'Educ', 'Pain', 'IV', 'Resp', 'CV', 'Neuro', 'GI', 'GU', 'M/S', 'Skin', 'P/S', 'Rest', 'MH', 'Func', 'DP', 'PCE', and 'View Text'. The 'Educ' tab is active. Below the tabs is a 'Performing assessment' status bar with a 'Go to radiogroup' dropdown set to 'Educational Level' and a 'Go' button. A footer note states '* Designates a required field'.

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.

The screenshot shows a software window titled "RN Reassessment - ZMSHTSWLSHDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The "PAIN ASSESSMENT" tab is selected, and the "Pain Page 1" sub-tab is active. The "Is patient having any pain now" radio button is set to "Yes". The "Pain Location #1" section is filled out with "Head" in the "Pain Region" dropdown. Other sections include "Quality of pain", "Type of pain" (Acute/surgical), "Severity of Pain" (0=none - 10=worst), and lists of factors that make pain worse or better. The "Pain Goal" section is also visible. The bottom of the window shows a navigation bar with tabs for "Gen/Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text".

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.

The screenshot displays the 'RN Reassessment - ZMSHTSWLSHDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. It features two side-by-side forms for 'Pain Location #4' and 'Pain Location #5'. Each form contains several required fields marked with an asterisk (*):

- Pain Region** (dropdown menu, currently set to 'None')
- Quality of pain** (dropdown menu)
- Other pain region** (text input)
- Other quality of pain** (text input)
- Onset of original pain (years, months)** (text input)
- Severity of Pain (None-10 Worst)** (dropdown menu)
- Describe other timing of pain** (text input)
- What makes pain worse** (text input)
- Other provoking factor(s)** (text input)
- Describe Pain Radiation** (text input)
- What makes pain better** (text input)
- Other palliative factor(s)** (text input)
- Rx/Otc Meds helping pain** (text input)
- Areas of life affected by pain** (text input)
- Comments for areas of life** (text input)
- Pain Goal** (dropdown menu)
- What pain level is acceptable to the patient (0-10)?** (dropdown menu)

At the bottom of the window, there is a navigation bar with tabs: 'Pain Page 1', 'Other Pain 1', 'Other Pain 2' (selected), 'Pain Comm', and 'Pain CP'. Below the navigation bar is a row of medical specialty checkboxes: Gen Int, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. A status bar at the very bottom indicates 'Performing assessment' and a note '* Designates a required field'.

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.

The screenshot displays the 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'PAIN ASSESSMENT' section is active, with the 'Is patient having any pain now' radio button set to 'No'. The 'Pain Location #1' dropdown is set to 'None'. The 'Quality of pain' dropdown is set to 'None'. The 'Severity of Pain' dropdown is set to 'None (0) to worst (10)'. The 'Pain Goal' dropdown is set to 'None'. The 'Behavioral indicator(s) observed' field is empty. The 'Pain Page 1' tab is selected, and the 'Pain' sub-tab is active. The 'Go to rediogroup' dropdown is set to 'Is patient having any pain now'.

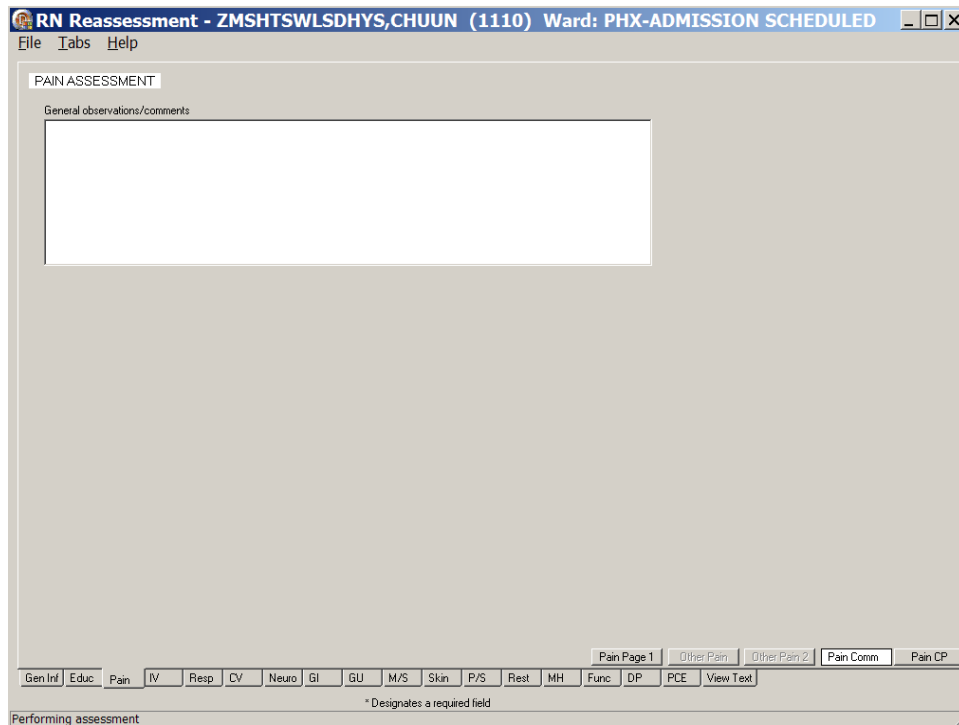
RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window
Is patient having any pain now/No

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.

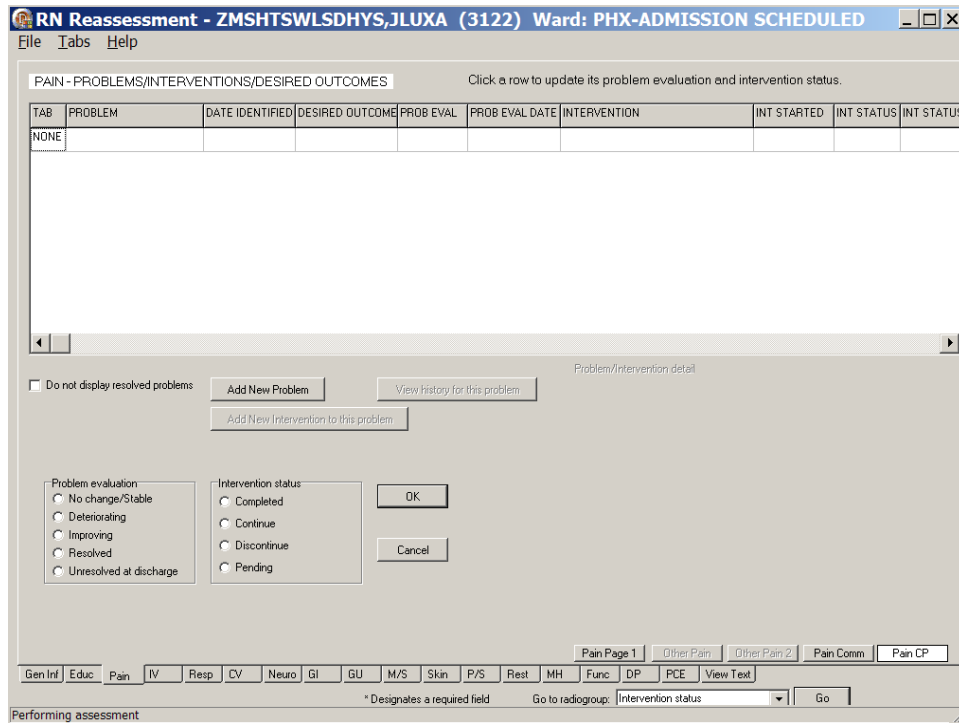
2. Click **Pain Comm**.
Pain Comm displays.



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 - ZMSHTSWLSDHYS, CHUUN (1110) 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

* Date/time inserted

* Other size

Dressing change
Last changed:
Dressing date/time change

Tubing change
Last changed:
Tubing date/time change

IV Discontinued
IV discontinue date/time

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

OK

Cancel edit

IV Periph IV Central IV Dialysis IV Comments IV CP

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

* Designates a required field

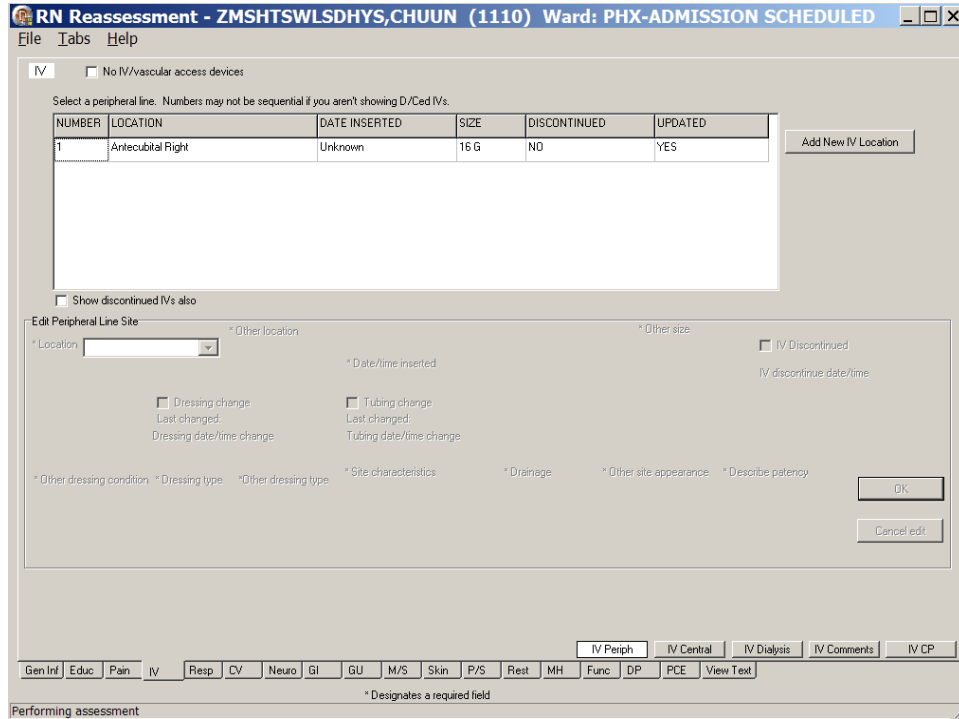
Performing assessment

RN Reassessment, IV (IV) tab, IV Periph window
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 - ZMSHTSWLSDHYS,CHUUN (1110) 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
1	Antecubital Right	Unknown	16 G	NO	YES

Add New IV Location

Show discontinued IVs also

Edit Peripheral Line site #1

* Location: Antecubital Right Other location

* Date/time inserted known: Yes No Other size

* Date/time inserted: IV Discontinued

* Dressing: Clean, dry, intact Dressing change Tubing change IV Discontinued

Drainage Last changed: Clean, dry, intact Last changed: IV Discontinued

Other Dressing date/time change: Tubing date/time change: IV Discontinued

* Other dressing condition: Bandaid Gauze Transparent Other None

* Dressing type: Bandaid Gauze Transparent Other None

* Other dressing type:

* Site characteristics: No evidence of complications Drainage Pain Redness Swelling Other

* Drainage:

* Other site appearance:

* Describe patency:

IV patent: Yes No

OK Cancel edit

IV Periph IV Central IV Dialysis IV Comments IV CP

Gen Int 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 with existing IV line

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

New IV Lines

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
1	Antecubital Right	Unknown	16 G	NO	YES
2				NO	

Show discontinued IV's also

Edit Peripheral Line site #2

* Location * Other location

* Date/time inserted known Yes No * Date/time inserted

* Size * 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

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

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 - ZMSHTSWLSDHYS,CHUUN (1110) 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
1	Antecubital Right	Unknown	16 G	NO	YES
2				NO	

Add New IV Location

Show discontinued IVs also

Edit Peripheral Line site #2

* Location: Forearm Right * Other location

* Date/time inserted known: Yes No * Date/time inserted

* Size: 16 G 18 G 20 G 22 G Other Unknown * Other size

IV Discontinued IV discontinue date/time

* Dressing: Clean, dry, intact Dressing change Tubing change IV patent Yes No

Drainage Last changed. Dressing date/time change Last changed. Tubing date/time change

* Other dressing condition * Other dressing type

* Dressing type: Bandaid Gauze Transparent Other None

* Site characteristics: No evidence of complications Drainage Pain Redness Swelling Other

* Drainage * Other site appearance * Describe patency

OK Cancel edit

IV Periph IV Central IV Dialysis IV Comments IV CP

Gen Int 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 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.

IV Select a central line. Numbers may not be sequential if you aren't showing D/Ced Central Lines.

NUMBER	TYPE	LOCATION	DATE INSERTED	DISCONTINUED	UPDATED
1	Tunneled catheter - Single Lumen	Radial Right	Unknown	NO	YES

Show discontinued Central Lines also

Edit Central Line Site

* Type * Location * Catheter impregnated

* Other location Central line discontinued

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

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

IV Periph IV Central IV Dialysis IV Comments IV CP

Gen Int 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 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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

IV Select a central line. Numbers may not be sequential if you aren't showing D/Ced Central Lines.

NUMBER	TYPE	LOCATION	DATE INSERTED	DISCONTINUED	UPDATED
1	Tunneled catheter - Single Lumen	Radial Right	Unknown	NO	YES
2				NO	NO

Add New CL Location

Show discontinued Central Lines also

Edit Central Line site #2

* Type: * Location: * Date/time inserted known: Yes No

* Dressing: Clean, dry, intact Drainage Other

Dressing change Last changed: Dressing date/time change

Tubing change Last changed: Tubing date/time change

Central line discontinued

* Catheter impregnated with antiseptic and/or antibiotic: Yes No Unknown

* Catheter power injectable: Yes No Unknown

* IV patent: Yes No

* Other dressing condition:

* Dressing type: Bandaid Gauze Transparent Other None

* Site characteristics: No evidence of complications Drainage Pain Redness Swelling Other

* 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

Performing assessment

* Designates a required field

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

4. Select a type and a location.
Complete all the fields with asterisks; they are required fields.
5. To cancel entered data *before upload*, click **Cancel edit**.
6. To upload updated information, click **OK**.
7. To add another central line, repeat steps 3 through 6.

Dialysis Ports - IV Dialysis

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

IV

Select a dialysis location. Numbers may not be sequential if you aren't showing D/Ced locations.

NUMBER	TYPE	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
1	Central Venous Catheter (Dialysis cathete	Arm - Right, upper	Unknown	16 G	NO	YES

Add New Dialysis Location

Show discontinued Dialysis access locations also

Edit Dialysis access location #1

* Type: [None] * Select Dialysis location: [None] * Other location: [] * Other size: []

Dressing change
Last changed: [] Dressing date/time change: []

Tubing change
Last changed: [] Tubing date/time change: []

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

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

OK
Cancel edit

IV Periph IV Central **IV Dialysis** IV 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 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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

IV

Select a dialysis location. Numbers may not be sequential if you aren't showing D/Ced locations.

NUMBER	TYPE	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
1	Central Venous Catheter (Dialysis cathete Arm - Right, upper		Unknown	16 G	NO	YES
2					NO	NO

Add New Dialysis Location

Show discontinued Dialysis access locations also

Edit Dialysis access location #2:

* Type: Venous Catheter (Dialysis catheter - Triple Lumen, Non-tunneled) * Select Dialysis location: None * Other location: * Date/time inserted known: Yes No * Size: 16 G 18 G 20 G 22 G Other Unknown * Other size: Dialysis catheter discontinued Discontinue date/time:

* Dressing: Clean, dry, intact Dressing change Last changed: Tubing change Last changed: * Date/time inserted: * Date/time inserted: * Tubing date/time change: * Other dressing condition: * Dressing type: Bandaid Gauze Transparent Other None * Other dressing type: * Site characteristics: No signs/symptoms of complica Bruit/thrill present Bruit/thrill not present Drainage Pain Redness Swelling * Drainage: * Other site appearance: OK Cancel edit

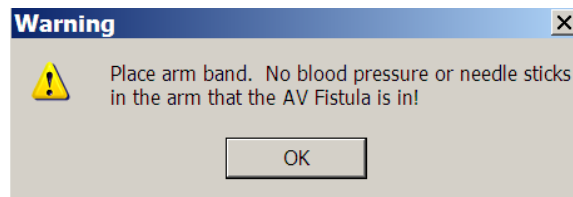
Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text

* Designates a required field

Performing assessment

RN Reassessment, IV (IV) tab, IV 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.



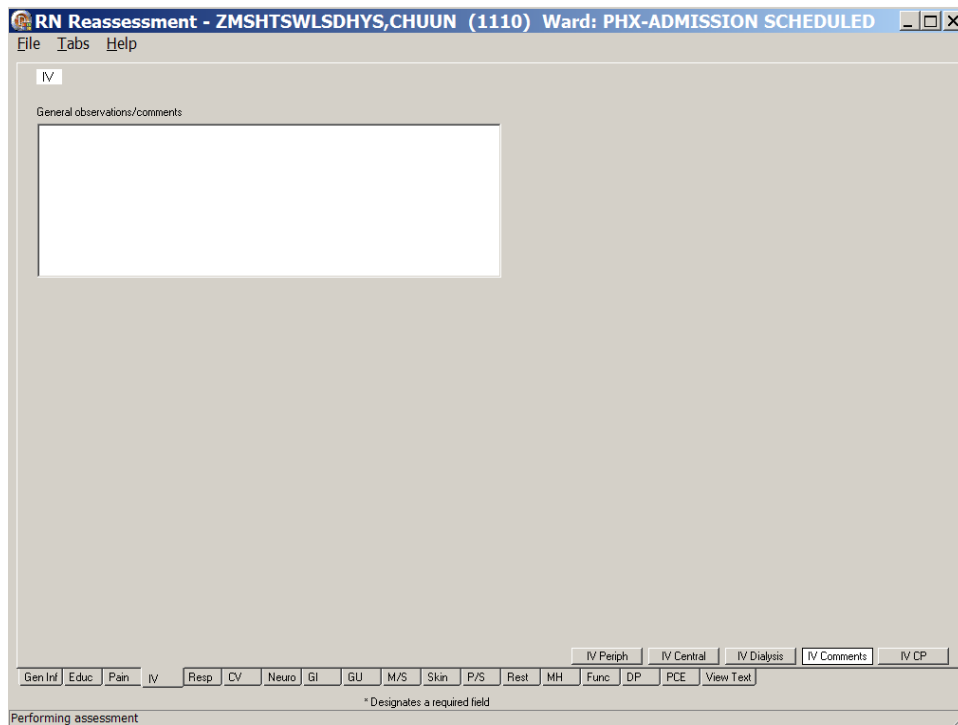
Warning: Place arm band.

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.

IV - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES

Click a row to update its problem evaluation and intervention status.

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATI
NONE									

Do not display resolved problems Add New Problem View history for this problem
 Add New Intervention to this problem

Problem evaluation:
 No change/Stable
 Deteriorating
 Improving
 Resolved
 Unresolved at discharge

Intervention status:
 Completed
 Continue
 Discontinue
 Pending

IV Periph IV Central IV Dialysis IV Comments IV CP

Gen Int 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: Intervention status Go

Performing assessment

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.

The screenshot shows the 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'RESPIRATORY ASSESSMENT' tab is active. The interface includes several sections for data entry:

- Patient/family/support person able to respond to questions:** Radio buttons for 'Yes' (selected) and 'No'.
- Why could no one respond:** Fields for '* Why could no one respond' and '* Other reason no one could respond'.
- Information obtained from:** Checkboxes for 'Patient' (checked), 'Authorized surrogate', 'Family/Support Person', 'Medical Record', and 'Other'.
- Patient has a history of:** Checkboxes for 'None reported', 'Asthma', 'COPD', 'Pulmonary Emboli', 'Pulmonary Fibrosis', 'Upper respiratory infections', 'TB', and 'Other'.
- Respiratory pattern:** Checkboxes for 'Regular', 'Irregular - Agonal', 'Irregular - Cheyne-Stokes', 'Irregular - Kussmaul', and 'Irregular - Other'. A '* Respiratory rate' spinner box is set to 0.
- Respiratory depth:** Radio buttons for 'Normal', 'Deep', and 'Shallow'.
- Chest movement:** Radio buttons for 'Equal, bilateral, symmetrical' and 'Abnormal'.
- Work of breathing:** Checkboxes for 'No difficulty observed', 'Dyspnea (shortness of breath)', 'Nasal flaring', 'Orthopnea', 'Pursed Lips', 'Use of accessory muscles', and 'Other'.
- Cyanosis:** Radio buttons for 'None', 'Central - tongue and lips', and 'Peripheral - earlobes, fingertips, around lips'.
- Breath sounds:** Radio buttons for 'Clear' and 'Abnormal'. A dropdown menu shows 'Absent', 'Crackles/Rales', 'Diminished/decreased', 'Rhonchi', 'Wheezing - expiratory', and 'Wheezing - inspiratory'. Checkboxes for 'Stridor' and 'Pleural friction rub' are also present.

At the bottom, there are navigation buttons for 'Resp Page 1', 'Resp Page 2', 'Resp Page 3', and 'Resp CP'. A status bar at the very bottom indicates 'Performing assessment' and includes a 'Go to radiogroup' dropdown set to 'Respiratory depth'.

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

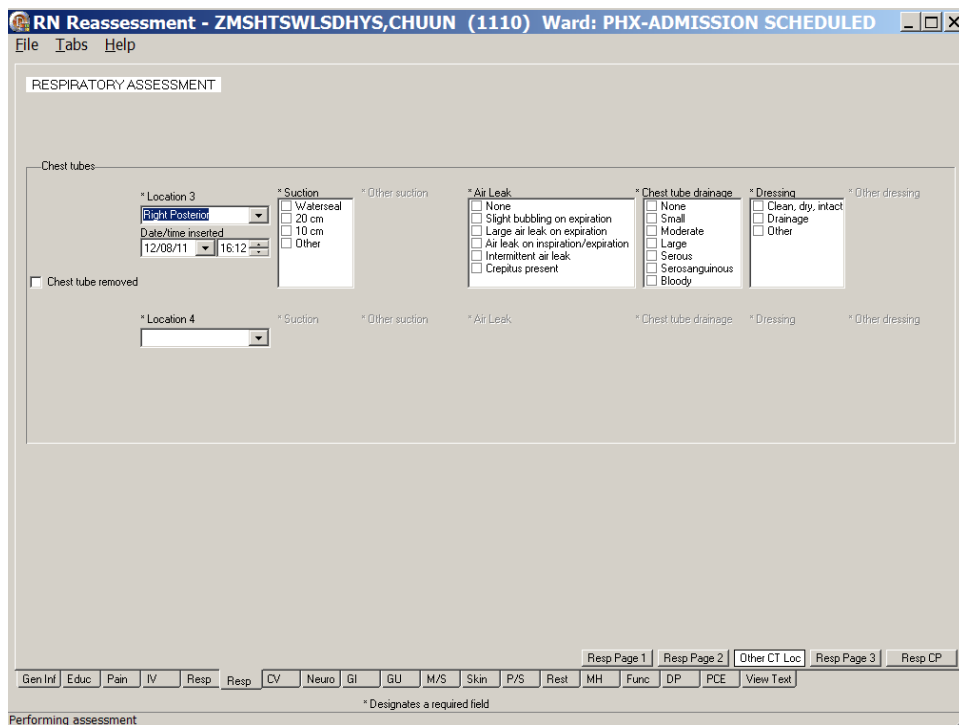
1. Click **Resp**.
Resp Page 1 displays.
2. Populate Resp Page 1.
 - a. Use the **Respiratory rate** box to enter the patient's current respiratory rate.
 - b. Complete all the fields with asterisks; they are required fields.

- 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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

RESPIRATORY ASSESSMENT

Tracheostomy:

Tracheostomy present * Other trach type: * Size known: Yes No * Tracheostomy size: * Stoma appearance: No problems observed Redness Swelling Sutures Tissue breakdown present Other * Other stoma appearance: * Dressing: Clean, dry, intact No dressing/open to air Other * Other dressing: * Dressing type: * Other dressing type:

Trach recently inserted * Insertion date/time: Trach removed * Removed date/time: Dressing change? * Dressing date/time change:

* Tobacco screen: Lifetime non-tobacco user Former tobacco user, but now quit Current tobacco user Patient declines to answer * Type of tobacco used:

Prior response:

* Quit time frame: Patient STATES that he/she has quit within the past 12 months and now considers his/herself a non-smoker Patient quit tobacco more than 12 months ago but less than 7 years ago Patient quit tobacco more than 7 years ago

* Approximate quit date:

* Tobacco education:

Patient states he/she not interested in learning about smoking cessation
 Education not appropriate due to patient condition
 Education re dangers linking oxygen and smoking to fire potential
 Discussion with patient/support person re importance of stopping smoking (stop using tobacco)
 Discussion with patient/support person re importance of not resuming smoking or tobacco use
 Brochure/handouts provided on tobacco use cessation
 Referral to a smoking cessation class or clinic
 Support of nicotine replacement therapy if prescribed during hospital stay or at discharge

Instructions for former usage
A patient MUST STATE that they quit within the last 12 months, and now consider themselves a non-user. This cannot be the staff's conclusion. If the patient has not used in X days/weeks/months, but is not willing to state that they have quit and consider themselves to be a non-user, then classify patient as a current tobacco user.

General Observations/Comments

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: Tobacco screen | Go

Performing assessment

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 - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

RESPIRATORY - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES Click a row to update its problem evaluation and intervention status.

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS I
NONE									

Problem/intervention detail

Do not display resolved problems

Problem evaluation:

No change/Stable

Deteriorating

Improving

Resolved

Unresolved at discharge

Intervention status:

Completed

Continue

Discontinue

Pending

Resp Page 1 Resp Page 2 Other CT Log Resp Page 3 Resp CP

Gen Int 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: Intervention status Go

Performing assessment

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

- 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.

The screenshot shows a software window titled "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The window contains a "CARDIOVASCULAR ASSESSMENT" form. The form is divided into several sections:

- Response Information:** Includes fields for "Patient/family/support person able to respond to questions" (Yes/No), "Why could no one respond", "Other reason no one could respond", "Information obtained from" (Patient, Authorized surrogate, Family/Support Person, Medical Record, Other), and "Other source of information".
- History:** "Patient has a history of" section with checkboxes for Anemia, Angina, Anticoagulant Therapy, Arrhythmias, CABG, CAD, CHF, DVT, Hypertension, MI, Peripheral Vascular Disease, and Other.
- Edema and Locations:** A grid of checkboxes for edema locations: Facial, Periorbital, Right arm, Left arm, Right hand, Left hand, Sacral, Right hip, Left hip, Right leg, Left leg, Pedal right, and Pedal left. Each location has radio buttons for Trace, 1+ Pitting, 2+ Pitting, 3+ Pitting, 4+ Pitting, and N/A, along with a "Prior resp." field.
- Extremities:** Checkboxes for Warm, Cool, Capillary Refill Less than 3 Seconds, and Capillary Refill Greater than 3 Seconds. Includes an "Extremities comments" text box and a "Prior response:" field.
- Auscultation:** A "Heart Rate" input field, radio buttons for "Heart rhythm" (Regular, Irregular), and radio buttons for "Heart sounds" (Normal, Abnormal). A "Describe abnormal sound" text box is also present.

At the bottom, there are navigation buttons for "CV Page 1", "CV Page 2", and "CV CP". A status bar at the very bottom shows "Performing assessment" and a "Go to radiogroup:" dropdown menu set to "Heart rhythm".

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

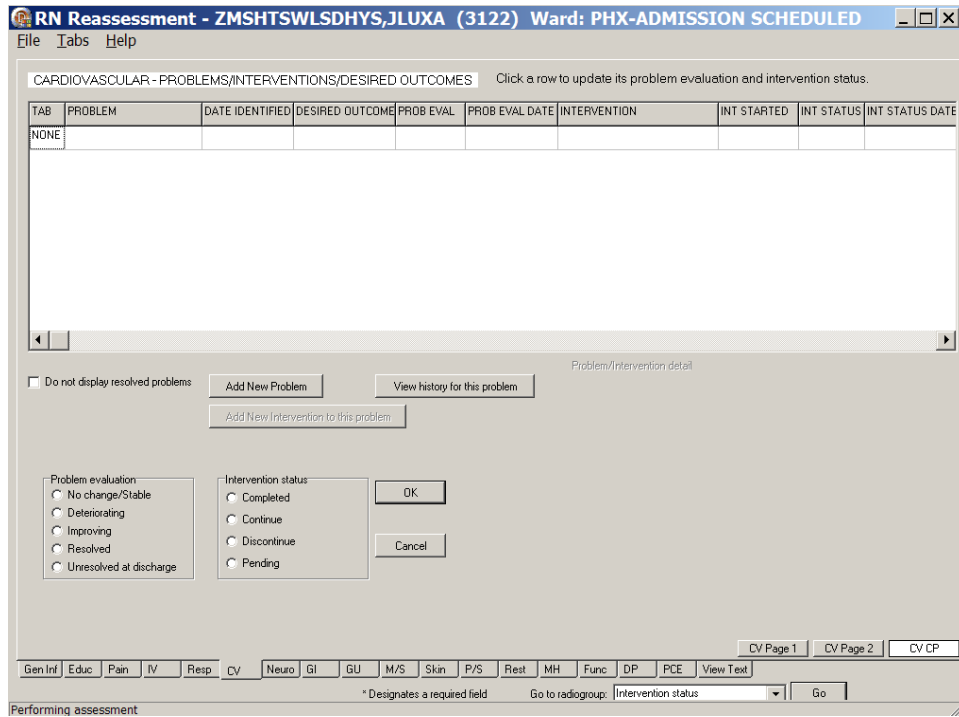
1. Click **CV**.
CV Page 1 displays.
2. Populate CV Page 1.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **Extremities comments** text box for additional information, if necessary.
3. Click **CV Page 2**.
CV Page 2 displays.

The screenshot shows the 'CARDIOVASCULAR ASSESSMENT' window in the RN Reassessment software. The window title is 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED'. The interface includes the following sections:

- Pulses:** Three columns for 'Radial Pulse', 'Dorsalis Pedis Pulse', and 'Posterior Tibial Pulse', each with 'Left' and 'Right' dropdown menus.
- Jugular Venous Distention:** Radio buttons for 'Yes' and 'No'. A note: '* Describe venous distention'.
- Homan's sign:** Radio buttons for 'Negative' (selected) and 'Positive'. Checkboxes for 'Right Calf' and 'Left Calf'. A note: 'Positive is calf pain reported on flexion of foot'.
- Cardiac monitor:** Radio buttons for 'Yes' (selected) and 'No'. A note: '* Cardiac monitor'.
- Cardiac devices:** Checkboxes for 'External pacemaker', 'Permanent pacemaker', 'Implantable cardioverter/defibrillator (ICD)', and 'Other device'. A note: '* Other cardiac device'.
- General observations/comments:** A large text area for notes.
- ECG Parameters:** Fields for 'PR Interval:', 'QT Interval:', 'QRS Duration:', and 'ST Segment:'.
- Navigation:** 'CV Page 1', 'CV Page 2' (selected), and 'CV CP' tabs. A 'Go to radiogroup:' dropdown menu with 'Jugular Venous Distention' selected and a 'Go' button.

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.

The screenshot shows a software window titled "RN Reassessment - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED". The main content area is titled "NEUROLOGICAL ASSESSMENT". It contains several sections:

- Information obtained from:** Radio buttons for "Patient" (selected), "Authorized surrogate", "Family/Support Person", "Medical Record", and "Other".
- Orientation:** Radio buttons for "Person, place, time, and situation", "Person, place, and time", "Person and place", "Person only", and "Not oriented at all".
- Level of Consciousness (Glasgow Coma Scale):** Three dropdown menus for "Eye response score", "Verbal response score", and "Motor response score", all set to "Not assessed".
- Total score:** A red box displays "Total score: 0".
- Glasgow score categories:** A list showing "13-15 (normal result)", "9-12 (correlates with moderate brain injury)", and "8 or less (correlates with severe brain injury)".
- Instructions for completing Glasgow Coma Scale:** A scrollable text area explaining the scale and defining parameters like Best Eye Response, Best Verbal Response, and Best Motor Response.

At the bottom, there is a navigation bar with tabs for "Neuro Page 1", "Neuro Page 2", and "Neuro CP". A status bar at the very bottom indicates "Performing assessment".

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

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

RN Reassessment - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

NEUROLOGICAL ASSESSMENT

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

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

Right arm: 5+, 4+, 3+, 2+, 1+, 0, N/A
 Left arm: 5+, 4+, 3+, 2+, 1+, 0, N/A
 Right leg: 5+, 4+, 3+, 2+, 1+, 0, N/A
 Left leg: 5+, 4+, 3+, 2+, 1+, 0, N/A

Speech/language
 Clear
 Abnormal - Slurred
 Abnormal - Aphasic
 Abnormal - Dysarthric
 Other
 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
 * Other pupil size
 Prior response:

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:

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

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

General observations/comments

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

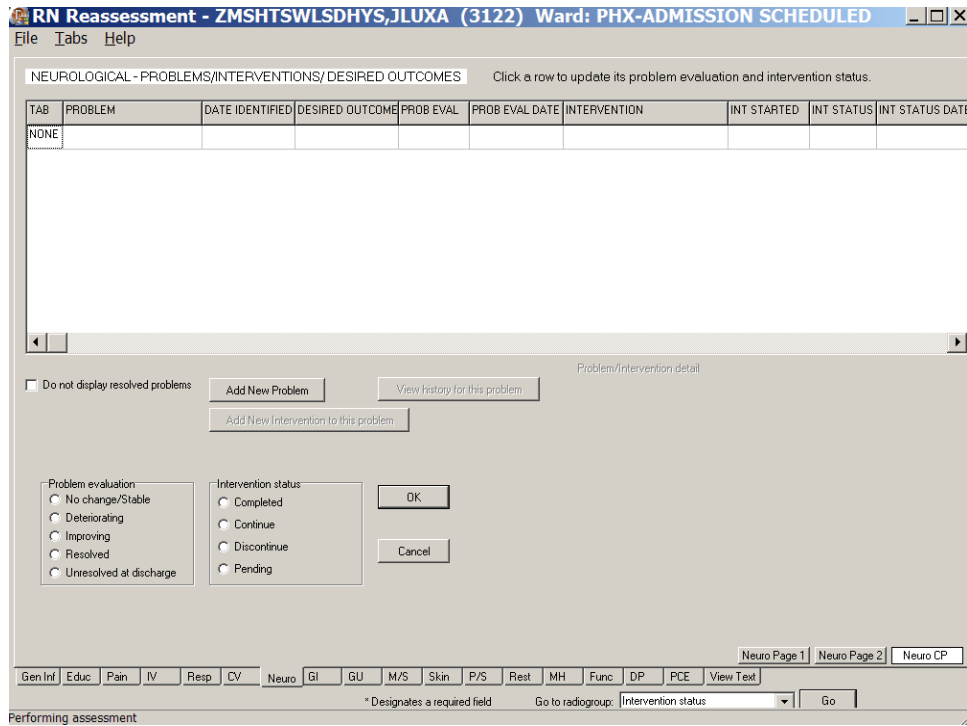
Neuro Page 1 | **Neuro Page 2** | Neuro CP

* Designates a required field Go to radiogroup: Right arm Go

Performing assessment

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.

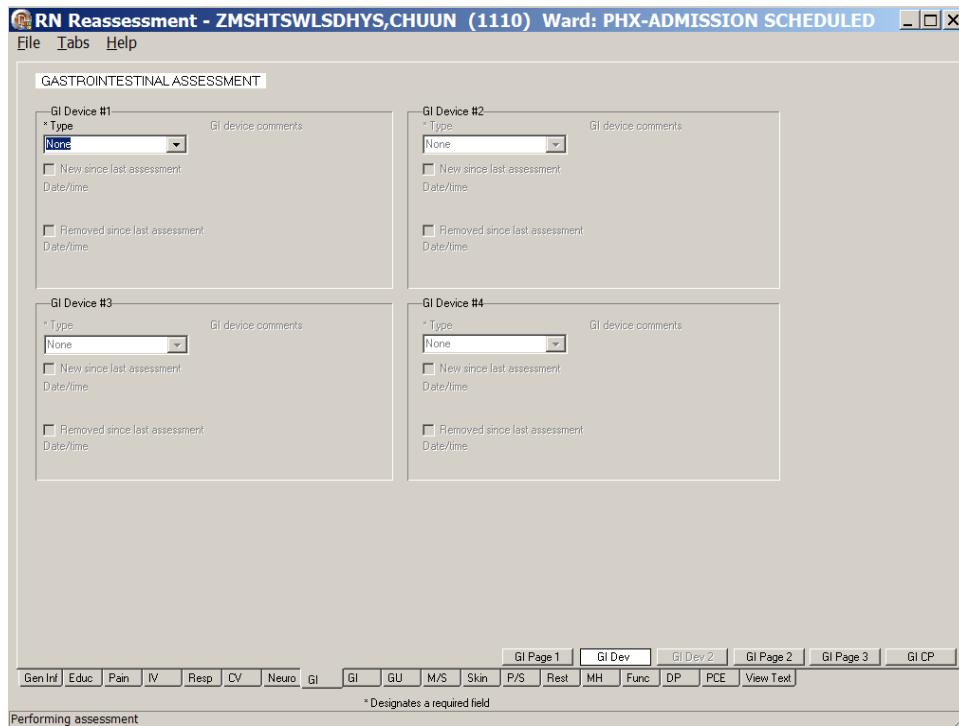
The screenshot displays the 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The main content area is titled 'GASTROINTESTINAL ASSESSMENT'. It features several sections for data entry:

- Patient/family/support person able to respond to questions:** Radio buttons for 'Yes' and 'No'.
- Information obtained from:** Checkboxes for 'Patient' (checked), 'Authorized surrogate', 'Family/Support Person', 'Medical Record', and 'Other'.
- Patient has a history of:** Checkboxes for 'None reported', 'Bleeding - Emesis', 'Bleeding - Stool', 'Constipation', 'Diarrhea', 'Incontinence of stool', 'Nausea', 'Vomiting', and 'Other'.
- Abdominal Assessment:** Checkboxes for 'Distended', 'Firm' (checked), 'Flat', 'Guarding', 'Non-tender', 'Obese', 'Rigid', 'Round', 'Soft', 'Tender', and 'Other'.
- Bowel sounds:** Radio buttons for 'Present' (checked) and 'Absent'. Below, radio buttons for 'Normal' (checked), 'Hypoactive', and 'Hyperactive'.
- Last Bowel Movement Date:** Radio buttons for 'Known' and 'Unknown' (checked).
- Bowel regime:** Radio buttons for 'DAILY' (checked), 'Several times a week', 'Weekly', and 'Other'.
- Laxative and Enema use:** Checkboxes for 'Laxative use' and 'Enema use'.
- Prior response:** Checkboxes for 'Bowel program'.
- Medication/treatment:** A text field for entering medication details.

At the bottom, there is a navigation bar with tabs for 'GI Page 1', 'GI Dev', 'GI Dev 2', 'GI Page 2', 'GI Page 3', and 'GI CP'. Below the navigation bar is a status bar with 'Performing assessment' and a 'Go to radiogroup' dropdown menu set to 'Bowel sounds'.

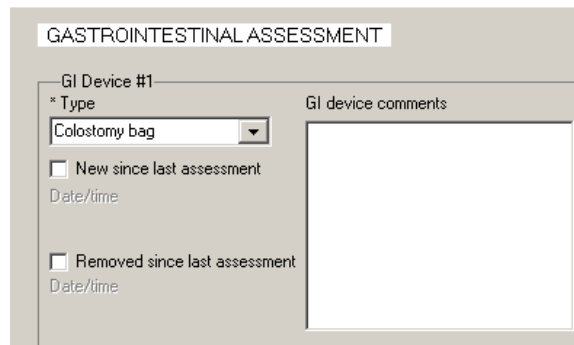
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 1 window

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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Oral Screen

Assessment - General

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

Assessment - Mucous Membrane

- Bleeding
- Cyanotic
- Inlact
- Lesions present
- Pale
- Pink

Nutrition screen

* Description of patient

- Well nourished
- Obese
- Emaciated

* Appetite

- Good
- Fair
- Poor
- Increased
- Decreased
- Unable to determine
- Other

* Other appetite

Prior response: Prior response:

Height: 54 in [137.2 cm] (06/29/2009 10:43)
 Weight: 165.35 lb [75.2 kg] (12/16/2009 14:30)
 BMI: DEC 16, 2009@14:30:21

Dietary History

* Does patient have any ethnic/cultural/ religious food preferences/ special diet needs?

Yes No

Prior response:

* Does patient have any special diet needs?

Yes No

Prior response: Prior food preferences

* Unintentional weight loss or gain in the past month

- Yes
- No
- Unknown

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

Prior response:

Nutrition consult guidelines

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

GI Page 1 GI Dev GI Dev 2 **GI Page 2** GI Page 3 GI CP

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

* Designates a required field Go to radiogroup: religious food preferences Go

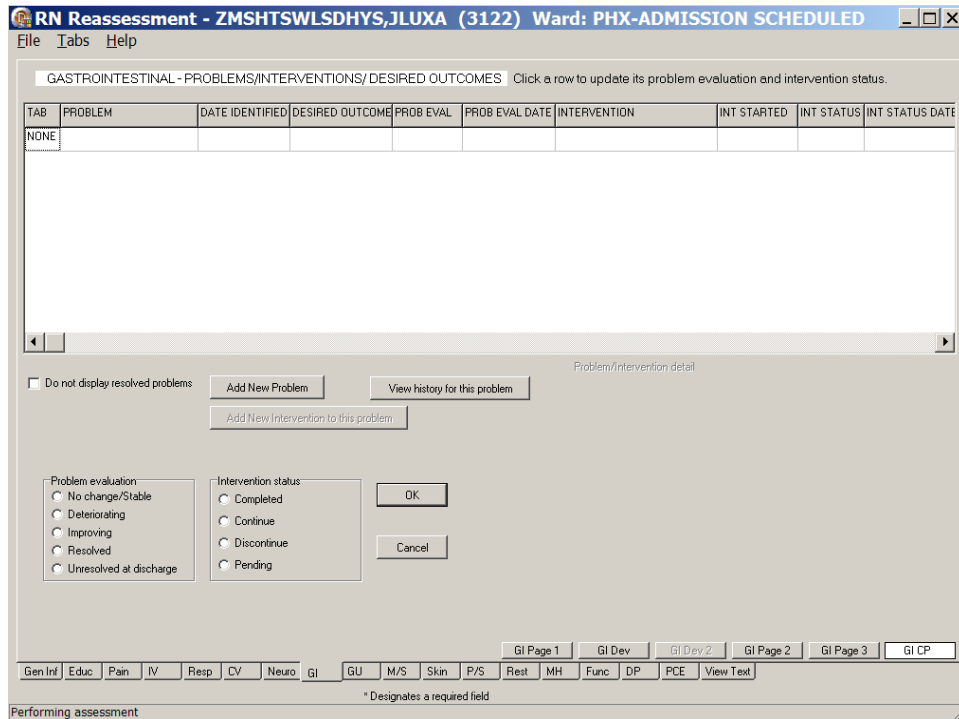
Performing assessment

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.

The screenshot shows the 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The main title bar includes 'File', 'Tabs', and 'Help'. The window content is titled 'GENITOURINARY ASSESSMENT'. It features several sections of assessment questions and options:

- Patient/family/support person able to respond to questions:** Radio buttons for 'Yes' (selected) and 'No'.
- Information obtained from:** Checkboxes for 'Patient' (checked), 'Authorized surrogate', 'Family/Support Person', 'Medical Record', and 'Other'.
- Patient has a history of:** A list of conditions with checkboxes: Cancer, Diabetes, Dialysis - Peritoneal, Dialysis - Hemodialysis, Kidney disease, Neurogenic bladder, Sexually transmitted disease, TURP, Urinary tract infections, and Other.
- Voiding:** A list of voiding issues with checkboxes: No problems, Anuria, Dysuria, Frequency, Incontinence, Intermittent catheterization, Nocturia, Oliguria, Polyuria, Retention, Urgency, and Other.
- Last voided:** Radio buttons for 'Known' (selected) and 'Unknown', and a checkbox for 'Absorbency devices used'.
- Date/time last voided:** A text input field.
- Abnormal discharge:** Radio buttons for 'None' (selected), 'Genital', and 'Unable to evaluate'.
- Urine characteristics:** Sections for 'Color' (radio buttons: Amber, Yellow, Bloody, Unable to evaluate, Other), 'Consistency' (radio buttons: Normal, Concentrated, Dilute, Unable to evaluate), 'Odor' (radio buttons: Foul smelling, None, Unable to evaluate), and 'Sediment' (radio buttons: Yes, No, Unable to evaluate).
- Prior response:** A text input field.

At the bottom, there is a navigation bar with tabs for 'GU Page 1', 'GU Dev', 'GU Page 2', and 'GU CP'. Below the tabs is a status bar with 'Performing assessment' and a 'Go' button.

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 - ZMSHTSWLSHDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

GENITOURINARY ASSESSMENT

GU Device #1

* Type: None GU device comments:

Inserted since last assessment. Date/time inserted:

Removed since last assessment. Date/time:

GU Device #2

* Type: None GU device comments:

Inserted since last assessment. Date/time inserted:

Removed since last assessment. Date/time:

GU Device #3

* Type: None GU device comments:

Inserted since last assessment. Date/time inserted:

Removed since last assessment. Date/time:

GU Device #4

* Type: None GU device comments:

Inserted since last assessment. Date/time inserted:

Removed since last assessment. Date/time:

GU Page 1 GU Dev GU Page 2 GU CP

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

* Designates a required field

Performing assessment

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

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

RN Reassessment - ZMSHTSWLSDHYS,JLUXA (3122) Ward: FILEROOM-X

File Tabs Help

GENTOURINARY ASSESSMENT

Genitourinary Devices

* Current Devices

None
 Continuous Ambulatory Peritoneal Dialysis
 Continuous Bladder Irrigation
 Continent Urinary Diversion (e.g. ileo-conduit)
 External catheter (condom)
 Indwelling urinary catheter
 Nephrostomy bag
 Suprapubic catheter
 Ureterostomy bag
 Other

* Indwelling catheter size

* Other device

Concerns voiced regarding sexual functioning
 Sexual Functioning concerns voiced

Prior response

Indwelling removed

Female patients

* Pregnancy

Pregnant
 Possibly pregnant
 No possibility of pregnancy
 Lactating
 Patient declines to answer

Last mammogram

Known
 Unknown
 No previous exam reported

Approximate date

Last menses

Known
 Unknown
 Post menopausal

Approximate date

Last PAP Smear

Known
 Unknown
 No previous exam reported

Approximate date

Male patients

Approximate date

Last PSA Results

General observations/comments

GU Page 1 GU Dev GU Page 2 GU CP

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

* Designates a required field Go to radiogroup: Last mammogram Go

Performing assessment

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

RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

GENTOURINARY ASSESSMENT

Genitourinary Devices

* Current Devices

None
 Continuous Ambulatory Peritoneal Dialysis
 Continuous Bladder Irrigation
 Continent Urinary Diversion (e.g. ileo-conduit)
 External catheter (condom)
 Indwelling urinary catheter
 Nephrostomy bag
 Suprapubic catheter
 Ureterostomy bag
 Other

* Indwelling catheter size

* Other device

Concerns voiced regarding sexual functioning
 Sexual Functioning concerns voiced

Prior response

Indwelling removed

Female patients

* Pregnancy

Approximate date

Approximate date

Approximate date

Male patients

Last prostate exam date

Known
 Unknown
 No previous exam reported

Approximate date

Last PSA: - NONE FOUND

General observations/comments

GU Page 1 GU Dev GU Page 2 GU CP

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

* Designates a required field Go to radiogroup: Last prostate exam date Go

Performing assessment

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

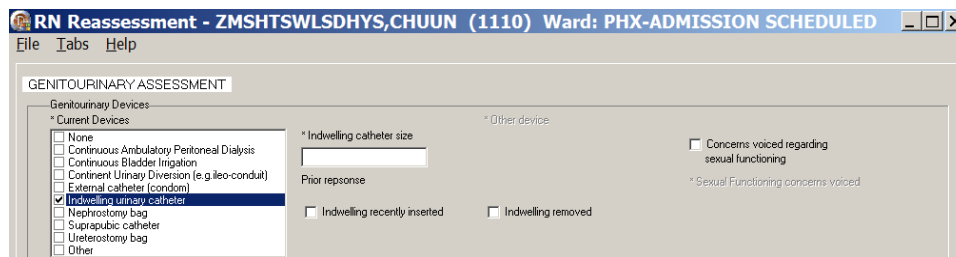
Note: The sex-specific questions (male/female) are optional. The exception is for female patients; the pregnancy responses are required.

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.



The screenshot shows a software window titled "RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main content area is titled "GENITOURINARY ASSESSMENT". Under "Genitourinary Devices", there is a section for "* Current Devices" with a list of options: "None", "Continuous Ambulatory Peritoneal Dialysis", "Continuous Bladder Irrigation", "Continent Urinary Diversion (e.g. ileo-conduit)", "External catheter (condom)", "Indwelling urinary catheter" (which is selected with a checkmark), "Nephrostomy bag", "Suprapubic catheter", "Ureterostomy bag", and "Other". To the right of this list is a text input field labeled "* Indwelling catheter size" and a "Prior response" label. Below these are two checkboxes: "Indwelling recently inserted" (checked) and "Indwelling removed". Further right, there are two more checkboxes: "* Other device" and "Concerns voiced regarding sexual functioning". A note at the bottom right says "* Sexual Functioning concerns voiced".

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.

- Click **GU CP**.
GU CP displays.

The screenshot shows the 'RN Reassessment - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED' window. The main area is titled 'GENITOURINARY - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES' and contains a table with the following columns: TAB, PROBLEM, DATE IDENTIFIED, DESIRED OUTCOME, PROB EVAL, PROB EVAL DATE, INTERVENTION, INT STARTED, INT STATUS, and INT STATUS DATE. The table currently shows a single row with 'NONE' in the PROBLEM column. Below the table are several controls: a checkbox for 'Do not display resolved problems', buttons for 'Add New Problem', 'View history for this problem', and 'Add New Intervention to this problem'. There are also two groups of radio buttons for 'Problem evaluation' (No change/Stable, Deteriorating, Improving, Resolved, Unresolved at discharge) and 'Intervention status' (Completed, Continue, Discontinue, Pending). 'OK' and 'Cancel' buttons are present, along with a 'Diabetes Nurse Consult' button. At the bottom, there is a navigation bar with tabs for 'GU Page 1', 'GU Dev', 'GU Page 2', and 'GU CP'. The 'GU CP' tab is currently selected. A footer bar shows various clinical categories like Gen/Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. The status bar at the very bottom indicates 'Performing assessment'.

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

- 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 - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

MUSCULOSKELETAL ASSESSMENT

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

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

* Patient has a history of * Describe other history * Body part(s) amputated
 None reported
 Amputation(s)
 Anthritis
 Back pain
 Cancer
 Cerebral Palsy
 Deformity(ies)
 Fibromyalgia
 Fractures
 Hip pain
 Muscle Atrophy
 Muscular Dystrophy
 Neck pain
 Other

* Range of Motion * Stated patient complaints
 ROM - No apparent problem
 Limited ROM - Right Upper Extremity
 Limited ROM - Left Upper Extremity
 Limited ROM - Right Lower Extremity
 Limited ROM - Left Lower Extremity

General observations/comments

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

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

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

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

2. Populate M/S Page 1.

- Complete all the fields with asterisks; they are required fields.
- Use the **General observations/comments** text box for additional information.

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

RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

* Fall risk assessment indicated
 Yes No

* History of falling Describe previous falls and history

* Fracture Location * Other fracture location * Is patient on any meds that increase risk for falling or risk for injury with falls Other medication that increases risk

* Is patient on multiple meds to

Instructions for completing Morse Fall Scale

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

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

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

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

Gait:
 Score as 0 a normal gait which is characterized by the patient walking with head erect, arms swinging freely at the side, and

Total Morse score for Fall Risk: N/A

Prior score: Not assessed
 Date:

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

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

Gen/Int 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: Fall risk assessment indicated Go

Performing assessment

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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

* Fall risk assessment indicated
 Yes No

* History of falling within 3 months
 Describe previous falls and history.
 No (0) Yes (25)

* Fracture Location * Other fracture location * Is patient on any meds that increase risk for falling or risk for injury with falls
 Other medication that increases risk.

* Secondary Diagnosis * Is patient on multiple meds to
 No (0) Yes (15)

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

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

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

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

Total Morse score for Fall Risk: 0
 Prior score: Not assessed
 Date:

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

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

Gen Int | 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: Fall risk assessment indicated Go

Performing assessment

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 - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

MUSCULOSKELETAL - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES

PROBLEM - POTENTIAL FOR FALLING. DESIRED OUTCOME - PREVENTION OF FALLS/INJURY ASSOCIATED WITH FALLS

Universal fall precautions. Institute on all patients:

Patient Education Precautions

- Orient to surroundings
- Purpose and use of call light
- Use of non-skid slippers or gripper socks
- Request assistance for daily activities (such as getting out of bed, toileting, transfers)
- Purpose and use of assistive devices and mobility aides if needed

Environment of Care Precautions

- Place patient articles within easy reach
- Call light (if applicable) in easy reach and answered promptly
- Clean up spills immediately
- Keep floor free of clutter
- Lock bed wheels
- Lock wheelchair wheels if applicable
- Modify environment for safe transfer
- Place bed in low position when in bed
- Provide proper lighting (night lights)

Other fall prevention interventions based upon clinical judgement

Morse scores

No Morse scores on file

Click a row to update its problem evaluation and intervention status.

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DATE
NONE									

Do not display resolved problems

Problem/Intervention detail

Problem evaluation:

- No change/Stable
- Deteriorating
- Improving
- Resolved
- Unresolved at discharge

Intervention status:

- Completed
- Continue
- Discontinue
- Pending

M/S Page 1 | M/S Page 2 | M/S 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: Problem evaluation

Performing assessment

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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

SKIN ASSESSMENT

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

* Why could no one respond:

* Other reason no one could respond:

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

* Other source of information:

* Patient has a history of: None reported Acne Athlete's foot Burns Cancer Eczema Herpes Simplex Herpes Zoster (Shingles) Injury/trauma Pressure Ulcer Prioniasis Rosacea Sebaceous cysts Other

* Describe other:

Predisposition for skin breakdown:

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

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

* Describe other:

Skin Inspection:

* Skin Temperature: Warm Hot Cool Cold

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

* Describe other:

* Skin Turgor: Within Normal Limits Abnormal

* Skin Patches: Yes No

* Skin Patch Description:

General observations/comments:

Pressure ulcers Skin alterations

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

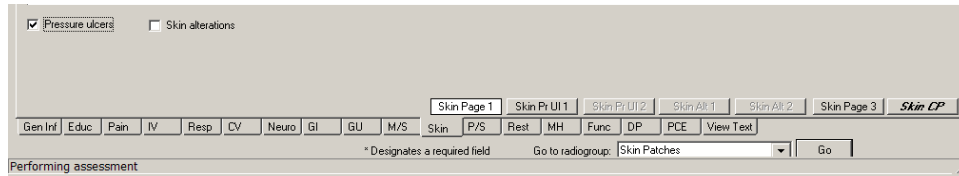
Performing assessment

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.

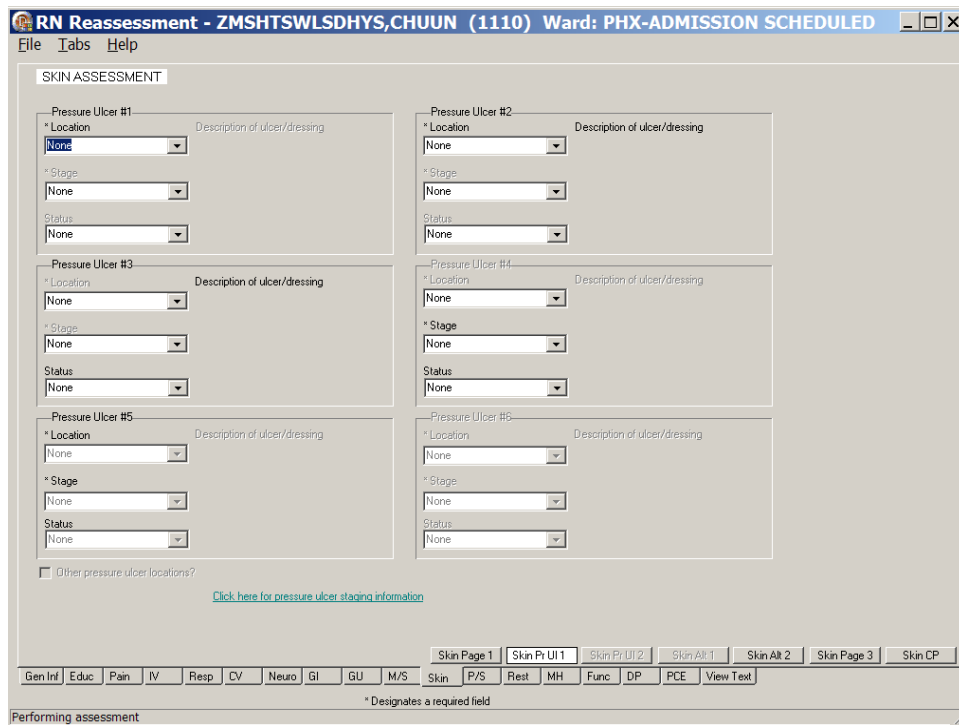
Documenting Pressure Ulcers

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

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

Skin Pr UI 2 displays.

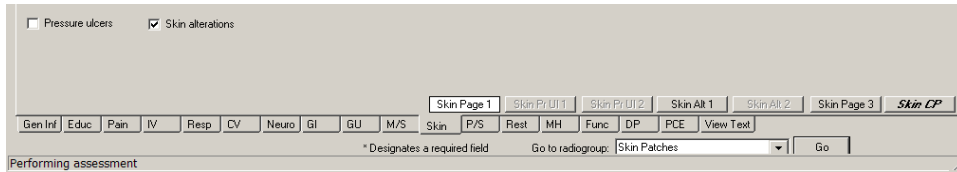
RN Reassessment, Skin Assessment (Skin) tab, Skin Pr UI 1 window
Other pressure ulcer locations? selected

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.

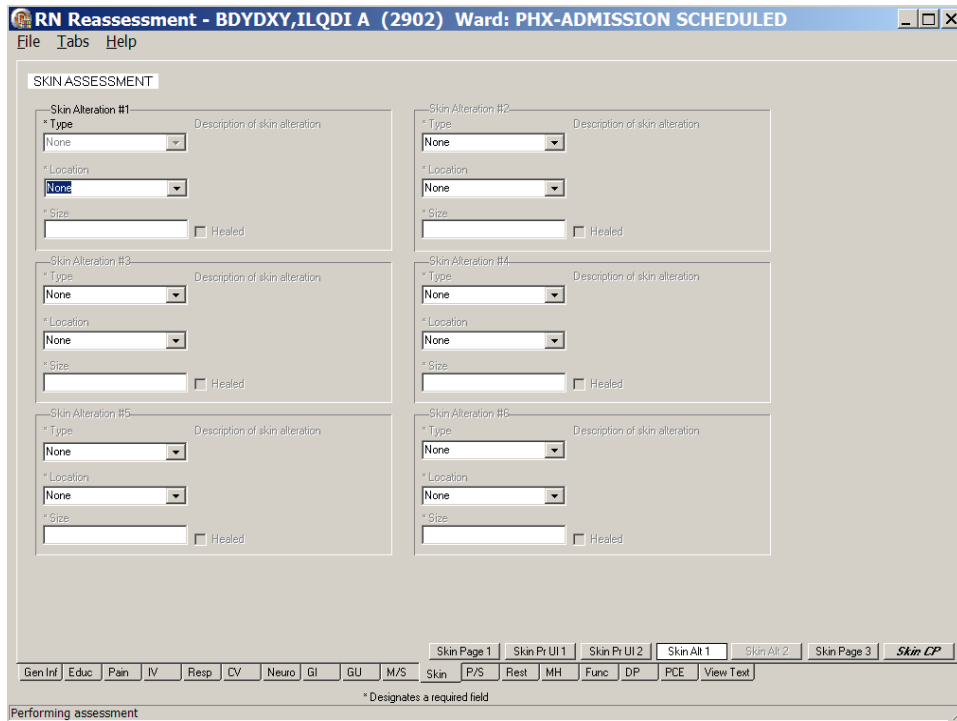
Documenting Skin Alterations

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

* Type
Abrasion
Abrasion
Bite
Bruising
Burn
Crush Injury
Hematoma
Laceration
Penetrating Wound

Description of skin alteration

Healed

Skin Assessment – Skin Alteration/Type

* Type
Abrasion

* Location
Abdomen - Right
Abdomen - Right
Abdomen - Left
Ankle - Right
Ankle - Left
Arm - Right, upper
Arm - Right, lower
Arm - Left, upper
Arm - Left, lower

Description of skin alteration

Healed

Description of skin alteration

Skin Assessment – Skin Alteration/Location

* Type
Abrasion

* Location
Abdomen - Right

* Size
1 cm

Description of skin alteration

Healed

Skin Assessment – Skin Alteration/Size

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

The screenshot shows a software window titled "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The main area is labeled "SKIN ASSESSMENT" and contains six identical forms for "Skin Alteration #7" through "#12". Each form has a "Type" dropdown menu (set to "None"), a "Location" dropdown menu (set to "None"), a "Size" text input field, and a "Healed" checkbox. A "Description of skin alteration" label is present but empty. At the bottom, a navigation bar includes buttons for "Skin 1", "Skin Pr/U 1", "Skin Pr/U 2", "Skin Alt 1", "Skin Alt 2", "Skin Page 3", and "Skin CP". Below the navigation bar is a row of medical specialty abbreviations: Gen/Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text. A status bar at the very bottom indicates "Performing assessment" and a note "* Designates a required field".

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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

SKIN ASSESSMENT BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

* Skin assessment indicated:
 Yes No

SENSORY PERCEPTION: Ability to respond meaningfully to pressure-related discomfort

1. COMPLETELY LIMITED: Unresponsive (does not moan, flinch, or grasp) to painful stimuli; due to diminished level of consciousness or sedation, OR limited ability to

+ Sensory Score:
 1
 2
 3
 4

MOISTURE: Degree to which skin is exposed to moisture

1. CONSTANTLY MOIST: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.

+ Moisture Score:
 1
 2
 3
 4

ACTIVITY: Degree of physical activity

1. BEDFAST: Patient is confined to bed.
 2. CHAIRFAST: Patient's ability to walk is severely limited. Patient can't bear his own weight, or must be assisted into

+ Activity Score:
 1
 2
 3
 4

MOBILITY: Ability to change and control body position.

1. COMPLETELY IMMOBILE: Does not make even slight changes in body or extremity position without assistance.

+ Mobility Score:
 1
 2
 3
 4

NUTRITION: Usual food intake pattern.

1. VERY POOR: Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy product) per day. Takes fluids poorly. Does not

+ Nutrition Score:
 1
 2
 3
 4

FRICITION AND SHEAR:

1. PROBLEM: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent

+ Friction Score:
 1
 2
 3

Total Score: N/A
 Prior score: Not assessed
 Date:

Risk Category
 Not at risk (19-23)
 At risk (15-18)
 Moderate risk (13-14)
 High risk (10-12)
 Severe risk (9 or below)

Consult guide
 If patient has a Braden score of 12 or below, a Stage II or greater pressure ulcer is present, a history of pressure ulcers; sensory or motor deficits; or paralysis or spinal cord injury exists, consider Wound Care Clinician alert.
 If patient has a Braden score of 16 or below, and/or a Stage II or above pressure ulcer exists, and/or a Braden Nutrition score of 1 or 2, consider a Nutrition alert.
 If patient's scores in the mobility, activity or sensory scales and/or patient has a motor deficit (e.g. amputee or spinal cord injury), a referral to physical therapy should be discussed with the interdisciplinary team.

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Nutrition Consult Wound Care Consult

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

* Designates a required field Go to radiogroup: Skin assessment indicated Go

Performing assessment

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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

SKIN ASSESSMENT BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

* Skin assessment indicated
 Yes No

SENSORY PERCEPTION: Ability to respond meaningfully to pressure-related discomfort

1. COMPLETELY LIMITED: Unresponsive (does not moan, flinch, or grasp) to painful stimuli; due to diminished level of consciousness or sedation, OR limited ability to

* Sensory Score:
 1
 2
 3
 4

MOISTURE: Degree to which skin is exposed to moisture

1. CONSTANTLY MOIST: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.

* Moisture Score:
 1
 2
 3
 4

ACTIVITY: Degree of physical activity

1. BEDFAST: Patient is confined to bed.
 2. CHAIRFAST: Patient's ability to walk is severely limited. Patient can't bear his own weight, or must be assisted into

* Activity Score:
 1
 2
 3
 4

MOBILITY: Ability to change and control body position.

1. COMPLETELY IMMOBILE: Does not make even slight changes in body or extremity position without assistance.

* Mobility Score:
 1
 2
 3
 4

NUTRITION: Usual food intake pattern.

1. VERY POOR: Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy product) per day. Takes fluids poorly. Does not

* Nutrition Score:
 1
 2
 3
 4

FRICITION AND SHEAR:

1. PROBLEM: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent

* Friction Score:
 1
 2
 3

Total Score: 0

Prior score: Not assessed
 Date:

Risk Category
 Not at risk (19-23)
 At risk (15-18)
 Moderate risk (13-14)
 High risk (10-12)
 Severe risk (9 or below)

Consult guide
 If patient has a Braden score of 12 or below, a Stage II or greater pressure ulcer is present, a history of pressure ulcers; sensory or motor deficits; or paralysis or spinal cord injury exists, consider Wound Care Clinician alert.
 If patient has a Braden score of 16 or below, and/or a Stage II or above pressure ulcer exists, and/or a Braden Nutrition score of 1 or 2, consider a Nutrition alert.
 If patient's scores in the mobility, activity or sensory scales and/or patient has a motor deficit (e.g. amputee or spinal cord injury), a referral to physical therapy should be discussed with the interdisciplinary team.

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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: Skin assessment indicated Go

Performing assessment

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 - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

SKIN - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES Click a row to update its problem evaluation and intervention status.

PROBLEMS - RISK FOR SKIN BREAKDOWN Braden scores (Prior score:)

DESIRED OUTCOME - PREVENTION/TREATMENT OF PROBLEMS RELATED TO SKIN INTEGRITY No Braden score done this shift assessment.

* Patient/caregiver education provided: Yes No

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS
NONE									

Do not display resolved problems

Buttons: Add New Problem, View history for this problem, Add New Intervention to this problem

Problem/Intervention detail

Problem evaluation: No change/Stable, Deteriorating, Improving, Resolved, Unresolved at discharge

Intervention status: Completed, Continue, Discontinue, Pending

Buttons: OK, Cancel

Navigation: Skin Page 1, Skin Pr.U.1, Skin Pr.U.2, Skin Alt.1, Skin Alt.2, Skin Page 3, Skin CP

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

* Designates a required field Go to radiogroup: education provided Go

Performing assessment

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

- 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.

The screenshot shows the 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'PSYCHOSOCIAL ASSESSMENT' tab is active, and 'P/S Page 1' is selected. The form contains several sections with radio button options and checkboxes:

- Information obtained from:** Patient (checked), Authorized surrogate, Family/Support Person, Medical Record, Other.
- Attitude:** Cooperative, Uncooperative, Other.
- Behavior:** Controlled, Uncontrolled, Other.
- Suspected Abuse/Neglect Screen:** Verbal abuse, Physical abuse, Financial abuse, Rape or sexual abuse, Neglect.
- Based upon nursing assessment, is any of the following suspected?:** Verbal abuse, Physical abuse, Neglect.
- Based on nursing assessment, are others in the household possible victims of abuse or neglect by the patient?:** Yes, No, Unknown.

A 'Social Work Consult' button is visible below the abuse/neglect questions. The bottom of the window shows a navigation bar with tabs for 'P/S Page 1' through 'P/S CP', and a 'Go' button.

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 - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

Suicide Risk Screen

Ask Patient

* Have you recently had thoughts about harming yourself?

Yes
 No
 Declines to answer

Prior response:

* Do you have a plan for how to do this?

Yes
 No
 Declines to answer

Prior response:

* Describe plan

Prior plan:

* Describe means

Are there means available?

Prior response:

Prior means:

* Have you rehearsed or practiced how to kill yourself?

Yes
 No
 Declines to answer

Prior response:

* Have you heard voices telling you to hurt or kill yourself?

Yes
 No
 Declines to answer

Prior response:

* How have you tried to hurt or kill yourself in the past?

Prior response:

* Are you feeling hopeless about the present or future e.g. feeling that there is no way out?

Yes
 No
 Declines to answer

Prior response:

Comments relative to suicide

P/S Page 1 | P/S Page 2 | P/S Page 3 | Q/W/A | P/S Page 4 | P/S 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: harming yourself Go

Performing assessment

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

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

RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

Elopement Screen - If any YES answer, then patient is a potential wandering/elopement risk

* Patient has a court-appointed legal guardian?

Yes No

Prior response: *Specify guardian

* Patient has been legally committed?

Yes No

Prior response: Prior guardian response

* Patient is considered a danger to him/herself or others?

Yes No Unknown

Prior response: * Patient has history of escape or elopement?

Yes No Unknown

Prior response:

* Patient is on legal observation status for Gravely Disabled?

Yes No

Prior response: Date/From where if known

* Patient lacks the cognitive ability to make relevant decisions (e.g. history of dementia, Alzheimer's or traumatic brain injury)?

Yes No

Prior response: Prior escape/elopement response

Social Work Consult

Chemical Dependency Issues

* Alcohol use?

Lifetime non-alcohol user
 Patient declines to answer any questions about alcohol use
 Patient has not used alcohol in the past 12 months
 Patient is currently using alcohol or has within the past 12 months

Prior response:

* Date of last alcohol use

* Amount of last alcohol use

* Does patient use recreational drugs (marijuana, cocaine, heroin etc)?

Yes
 No
 Patient declines to answer

Prior response: If Yes to use of recreational drugs, notify provider

* Date of last drug use

* Amount of last drug use

* Type of recreational drugs used

* Does patient have a medical marijuana card?

Yes No

Prior response:

Make Alcohol Treatment referral if patient is interested.

Possibility of alcohol withdrawal

Contraband

* Contraband brought (in to/by) the patient?

Yes
 No

Prior response:

* Describe contraband

* Location of unremoved contraband

Follow facility policy for contraband removal

P/S Page 1 | P/S Page 2 | P/S Page 3 | Q/W/A | P/S Page 4 | P/S 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: appointed legal guardian Go

Saving data

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

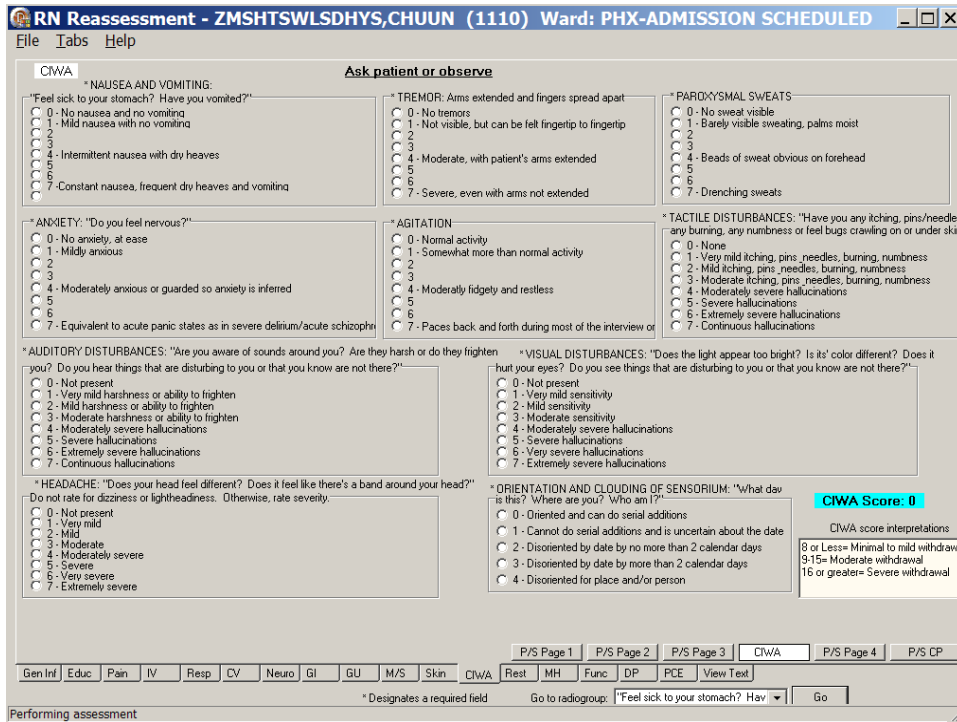
6. Populate P/S Page 3.
 - a. The questions are all optional; update, if necessary.
 - b. If a patient answers **Yes** to any of the Elopement Screen questions, a Social Work Consult is required.
Refer to the instructions in *Working in the Consults* on page 24.

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.

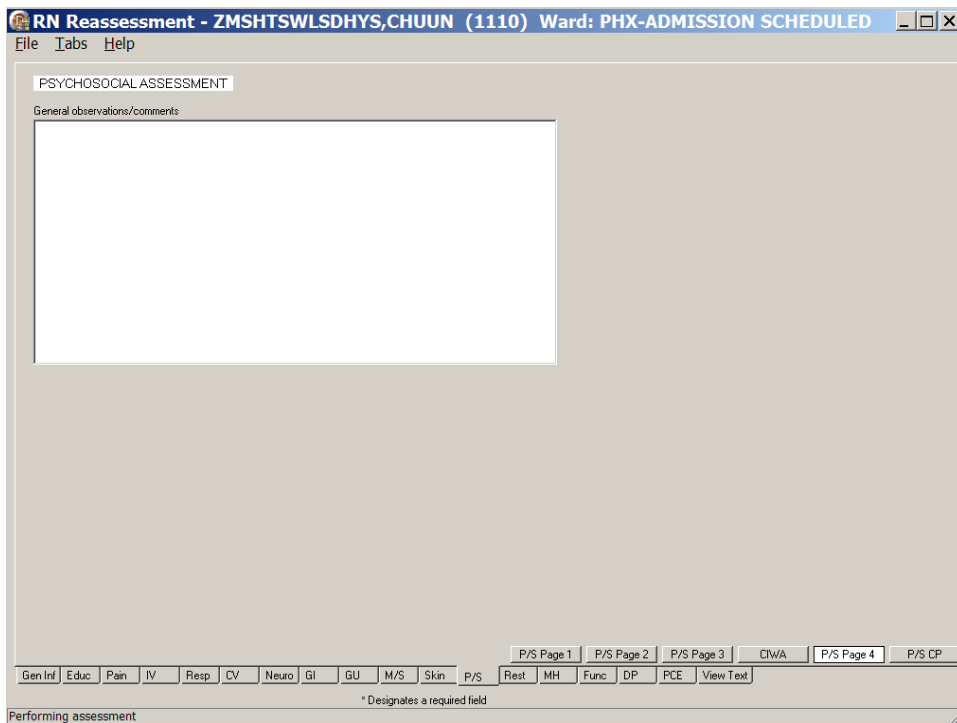
Alcohol use section

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.



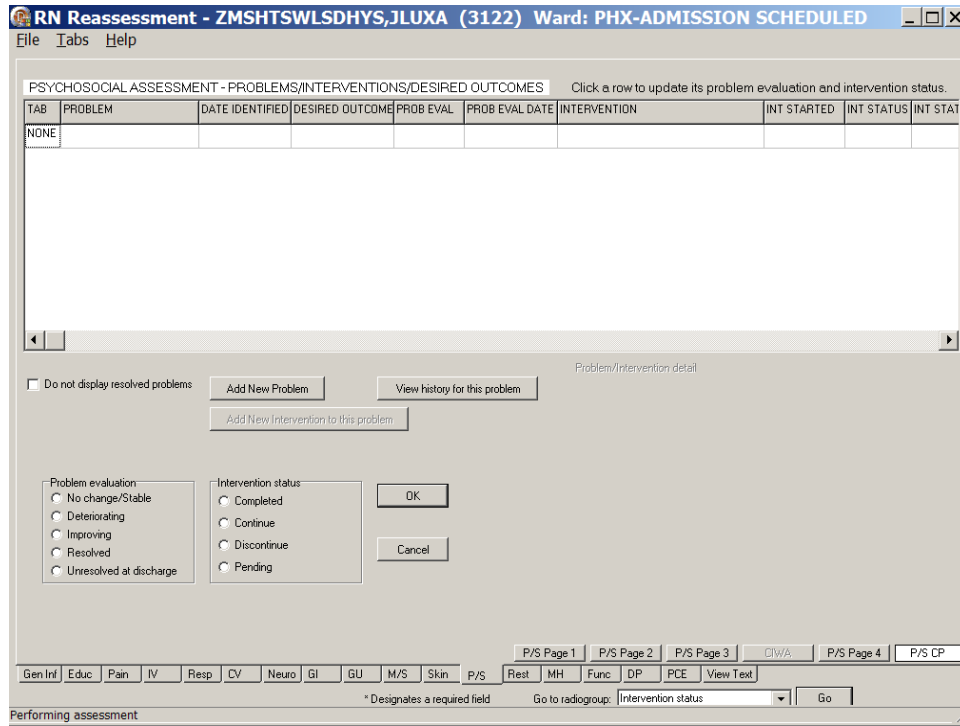
RN Reassessment, Psychosocial Assessment (P/S) tab, CIWA window

- 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

RESTRANTS

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 * Other behavioral expectation

* Restraint Type * Other Restraint Interventions tried to avoid restraint use * Other intervention

Discontinued date/time

Rest 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

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 ***

* Date/time initiated
 Known
 Unknown
 Initiated date/time: _____

Restraints Initiated/maintained

* 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 * Other behavioral expectation

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

* Restraint Type * Other Restraint Interventions tried to avoid restraint use * Other intervention

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
 Solt
 Leather/plastic/rubber
 Other

Bed alarm
 Camouflage lines/tubes
 Diversional activities
 Family at bedside
 Hourly rounding
 Laptop tray
 Low bed with mate
 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

Discontinued - desired outcome achieved
 Discontinued date/time: _____

Restr Page 1 Restr CP

Gen Int 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

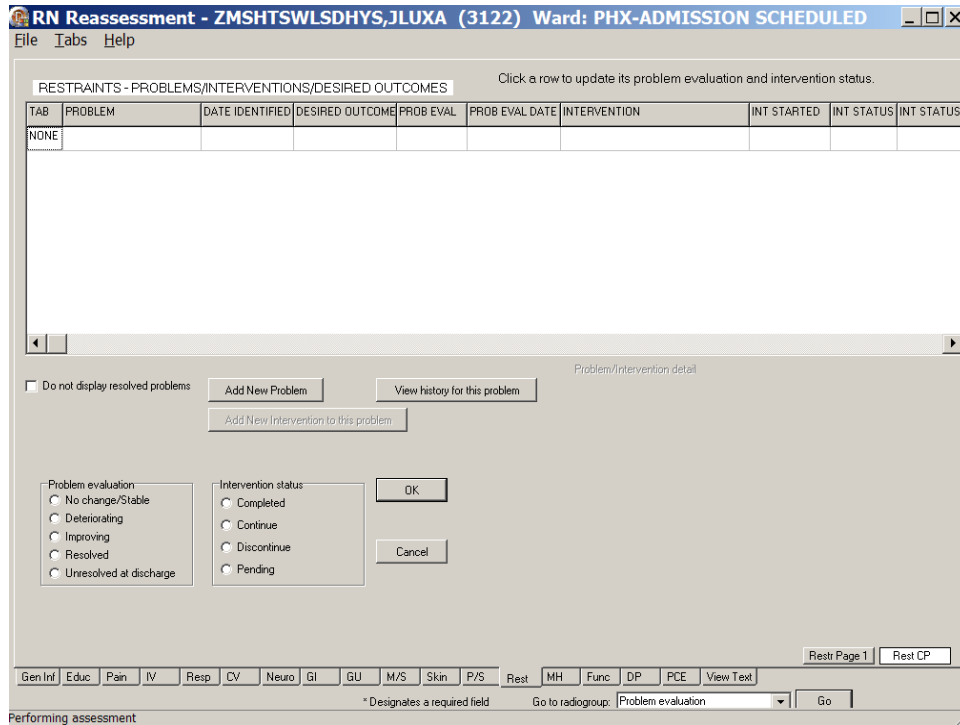
Patient is pulling at lines/tubes used in their treatment or is unable to follow instructions endangering their medical/surgical recovery. Patient is not violent or self-destructive

- 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.

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



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

- 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.

File Tabs Help

MENTAL HEALTH ASSESSMENT

Tab to be completed for patients admitted to acute psychiatry, or with a history of mental health problems

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

* Why could no one respond: Other reason no one could respond

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

* Other source of information

* Patient has a history of: None reported Bipolar ECT Homicidal intention Major depression PTSD Restraint Schizophrenia

* Other history

Ask patient: "What things or situations make you upset?": Violence or people's invaded Excessive noise An argument or altercation with family, partner, or friend Significant losses (death or breakup) Becoming homeless Not being listened to Hurt feelings Physical Abuse Sexual Abuse Pain Loss of control due to alcohol or drugs When I don't get what I want When I feel I have no power When my attempts at problem solving don't work

* Other upsetting item

* Ask patient "Have you ever been so angry that you felt ready to explode or lose control?": Yes No Patient declines to answer

Prior response:

* How does patient act when he/she loses control? Threatening others Hurting others Threatening to harm myself Harming myself Hitting or kicking objects Screaming or cursing Running away (eloping) Drink or take drugs Drunken Talking with others Other

* Other actions

* Ask patient "When you get upset, are you able to calm yourself?": Yes No Patient declines to answer

Prior response:

* What does patient do to calm him/herself? Listen to music Talk with others Exercise/Walk Positioning body to feel calmer or more comfortable Go to a quiet place Distraction Use relaxation techniques Smoke Pace Pray Meditate

* Other calming things

MH Page 1 MH Page 2 MH CP

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

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

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 - ZMSHTSWLSHDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

MENTAL HEALTH ASSESSMENT

* Mood * Other mood * Affect * Other affect * Behavior * Other behavior

Anxious
 Depressed
 Dysphoric
 Euphoric
 Irritable
 Indifference
 Labile
 Rapid mood swings
 Other

Apathetic
 Blunted
 Bright
 Congruent with mood
 Elated
 Flat
 Incongruent with mood
 Sad
 Other

Aggressive
 Agitated
 Angry outbursts
 Attention seeking/center of attention
 Calm
 Combative
 Cooperative
 Cries easily
 Decreased motivation/energy/initiative
 Docile
 Exaggerates minor symptoms into major problems
 Hostile
 Intimidates others
 Restless
 Slamming doors
 Staff splitting
 Suspicious
 Use of profanity
 Yelling/shouting
 Other

Restraints/Behavioral Health Advance Directives

* Ask patient: "If you are placed in restraints, do you want us to notify someone?"
 Yes
 No
 Patient declines to answer
 Patient unable to answer

Prior response: []

* Behavioral Health Advance Directives
 Behavioral Health Advance Directive copy on chart
 Behavioral Health Advance Directive copy not available
 Declined Behavioral Health Advance Directives
 Requested & given information on Behavioral Health Advance Directive
 Not Applicable

General observations/comments

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

MH Page 1 MH Page 2 MH CP

* Designates a required field Go to radiogroup: do you want us to notify someone Go

Performing assessment

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 - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

MENTAL HEALTH - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES Click a row to update its problem evaluation and intervention status.

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DATE
NONE									

Do not display resolved problems

Problem/Intervention detail

Problem evaluation:
 No change/Stable
 Deteriorating
 Improving
 Resolved
 Unresolved at discharge

Intervention status:
 Completed
 Continue
 Discontinue
 Pending

Gen Int 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: Intervention status Go

Saving data

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

- 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 - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

FUNCTIONAL ASSESSMENT

Instructions for assessing the patient's level of assistance

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

Partial Assist (Patient requires no more help than stand-by, cueing, or 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)

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)

Applicable conditions likely to affect transfer/repositioning techniques

Transfer/repositioning techniques comments

* 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: 54 in [137.2 cm] (06/29/2009 10:43)

Weight: 165.35 lb [75.2 kg] (12/16/2009 14:30)

BMI: DEC 16, 2009@14:30:21

* Level of cooperation and comprehension:

Cooperative

Unpredictable or varies

Prior response:

Prior response:

Prior response:

General observations/comments

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

Gen Int | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | ClWA | 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 when the patient is independent

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

RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

FUNCTIONAL ASSESSMENT

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

* Patient's level of assistance
 Independent
 Partial Assist
 Dependent

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

Height: 54 in [137.2 cm] (06/29/2009 10:43)
 Weight: 165.35 lb [75.2 kg] (12/16/2009 14:30)
 BMI: DEC 16, 2009@14:30:21

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

Level of cooperation and comprehension
 Cooperative
 Unpredictable or varies

* Weight bearing capability
 Full
 Partial
 None

* Bi-Lateral upper extremity strength
 Yes
 No

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

Transfer/repositioning techniques comments

General observations/comments

Gen/Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin CWA 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 when the patient is dependent

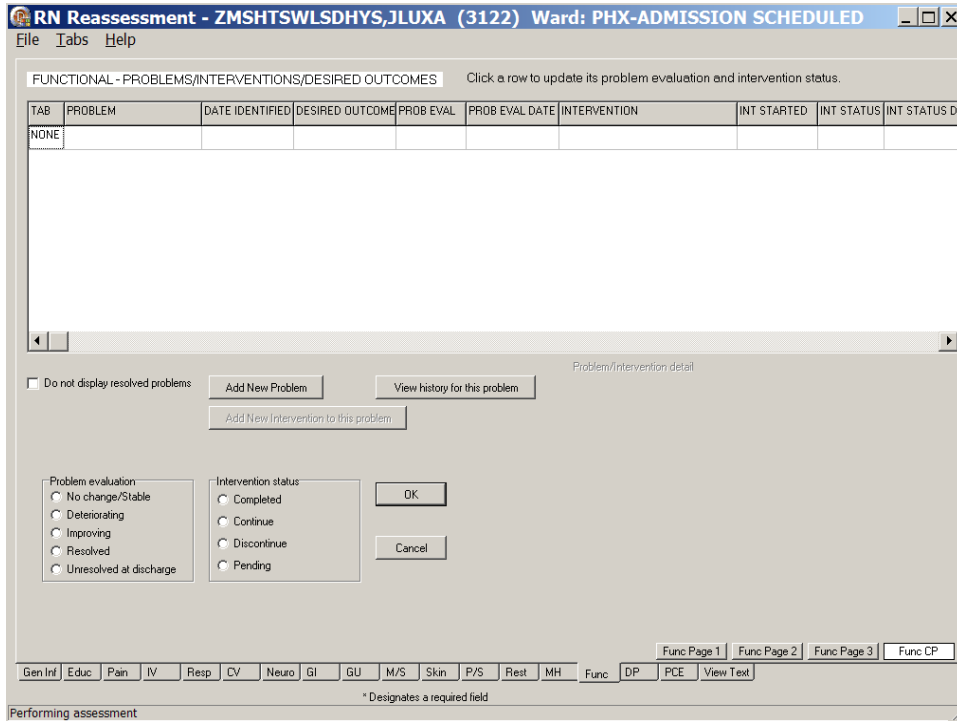
4. Update Func Page 2, if necessary.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** text box for additional information.

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.

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



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

- 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.

The screenshot shows the 'DISCHARGE PLANNING' window for patient ZMSHTSWLSDHYS, CHUUN (1110) in the PHX-ADMISSION SCHEDULED ward. The window is divided into several sections for data entry:

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

At the bottom, there is a navigation bar with tabs for 'Gen Int', 'Educ', 'Pain', 'IV', 'Resp', 'CV', 'Neuro', 'GI', 'GU', 'M/S', 'Skin', 'CIWA', 'P/S', 'Rest', 'MH', 'Func', 'DP' (selected), 'PCE', and 'View Text'. A 'Go to radiogroup' dropdown is set to 'Employment Status'.

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

1. Click **DP**.
DP Page 1 displays.
2. Populate DP 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.

The screenshot displays the 'RN Reassessment' software interface. The window title is 'RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED'. The main content area is titled 'DISCHARGE PLANNING - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES'. It includes a section for 'Anticipated Discharge Plan Goals' with a list of checkboxes, some marked with double asterisks (**). A red banner at the bottom of the list says 'CONSULT REQUIRED'. To the right of the list are buttons for 'Discharge Planning Consult', 'Social Work Consult', 'Telehealth Consult', and 'Home Care Consult'. A 'Will Send' button is also present. The bottom of the window shows a navigation bar with tabs for various medical specialties and a 'Go' button.

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.

Reminders Due (Display Only)	Due Date
Abuse Screen	DDE NOV
ADVANCED DIRECTIVE EDUCATION	04/01/04
Alcohol Use Screen (AUDIT-C)	DDE NOV
Barriers to Learning	04/01/04
BMI > 30 or > 24.99 in High Risk	DDE NOV
Cholesterol Screen (Male)	DDE NOV
Colorectal Cancer Screen	DDE NOV
Depression Screen	DDE NOV

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.

The screenshot displays a software interface for clinical maintenance. It is divided into several sections:

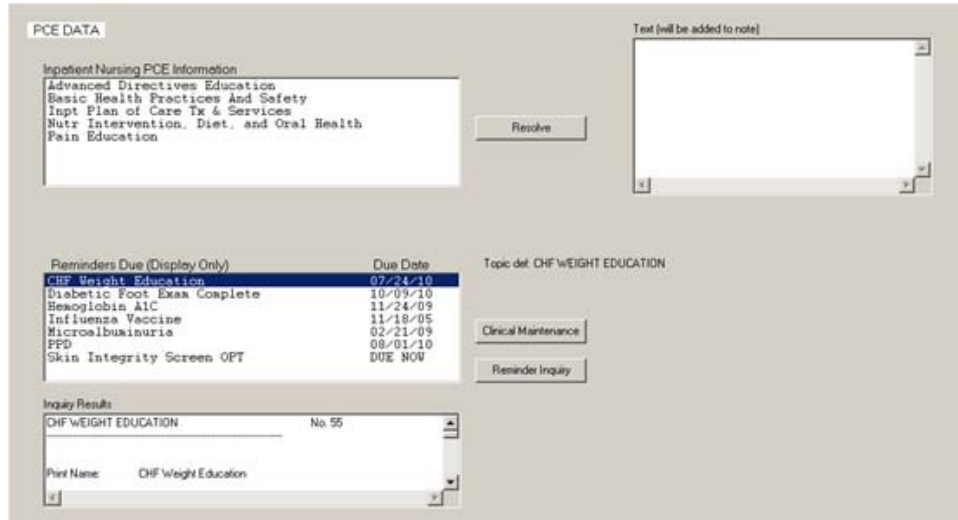
- PCE DATA:** A box titled "Inpatient Nursing PCE Information" containing a list of topics: Advanced Directives Education, Basic Health Practices And Safety, Inpt Plan of Care Tx & Services, Nutr Intervention, Diet, and Oral Health, and Pain Education. A "Resolve" button is located to the right of this box.
- Reminders Due (Display Only):** A table with two columns: "Reminders Due (Display Only)" and "Due Date". The first row is highlighted in blue and shows "CHF Weight Education" with a due date of "07/24/10". Other reminders include Diabetic Foot Exam Complete (10/09/10), Hemoglobin A1C (11/24/09), Influenza Vaccine (11/18/09), Microalbuminuria (02/21/09), FPD (08/01/10), and Skin Integrity Screen OPT (DOE NOW).
- Maintenance Results:** A text area showing details for the selected reminder: "-STATUS--DUE DATE--LAST DONE-", "DUE NOW 7/24/2010 7/24/2009", "Frequency: Due every 1 year for all ages.", and "Cohort:". A "Clinical Maintenance" button is positioned to the right of this section.
- Text (will be added to note):** An empty text box for adding notes, with a "Reminder Inquiry" button below it.

Clinical Maintenance

Reminder Inquiry

Click **Reminder Inquiry**.

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



Reminder Inquiry

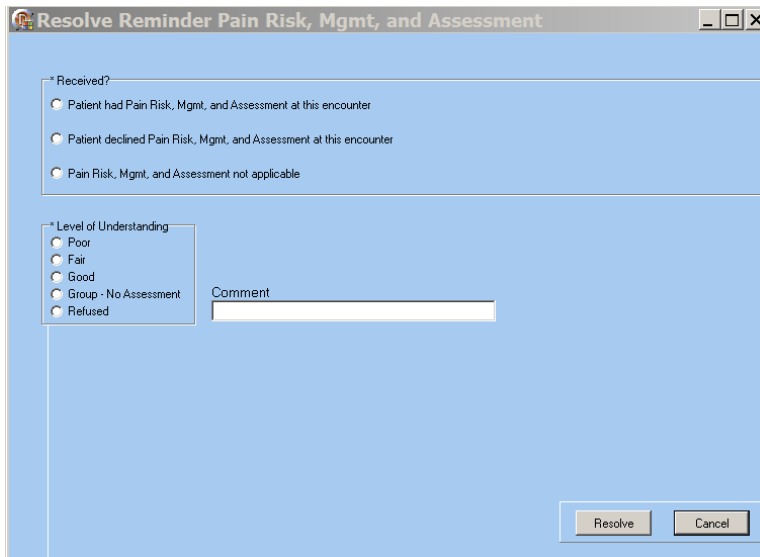
Resolve Inpatient Nursing Clinical Reminders

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.

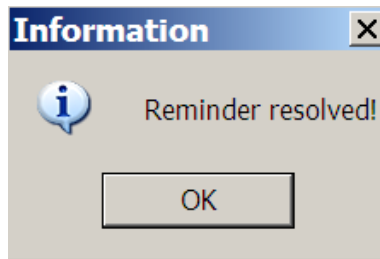


Resolve Reminder Pain Risk, Mgmt, and Assessment window

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.

File Tabs Help

RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

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 CWA 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

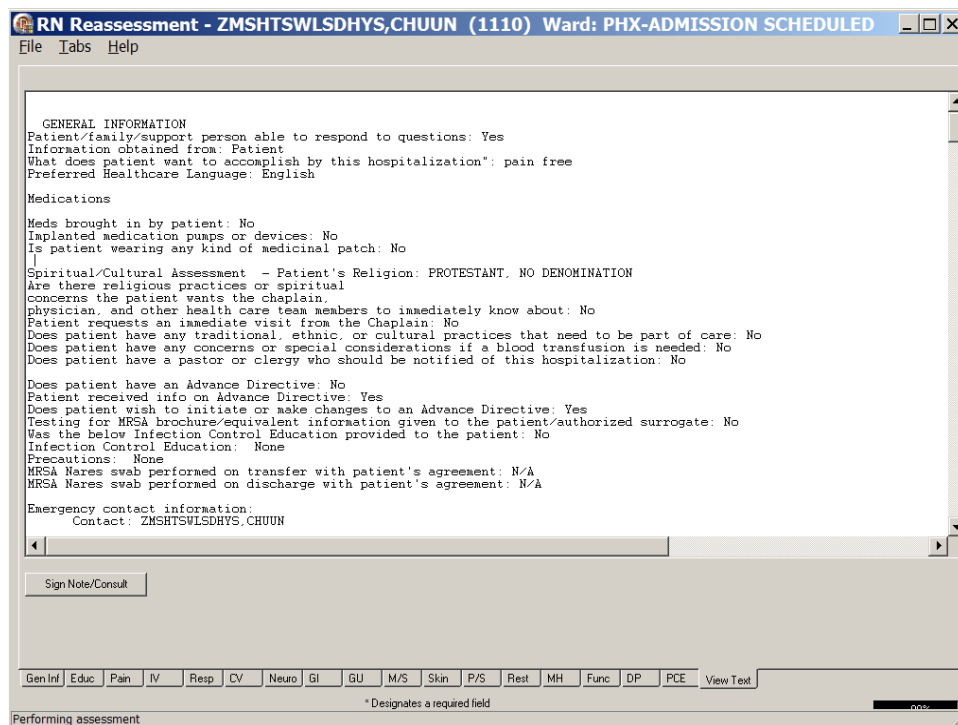
During the assessment, you may be prompted to enter mandatory consults that will be uploaded with the reassessment note.

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**.



The screenshot shows a software window titled "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main content area displays a text-based assessment form with the following sections:

- GENERAL INFORMATION**
 - Patient/family/support person able to respond to questions: Yes
 - Information obtained from: Patient
 - What does patient want to accomplish by this hospitalization: pain free
 - Preferred Healthcare Language: English
- Medications**
 - Meds brought in by patient: No
 - Implanted medication pumps or devices: No
 - Is patient wearing any kind of medicinal patch: No
- Spiritual/Cultural Assessment** - Patient's Religion: PROTESTANT, NO DENOMINATION
 - Are there religious practices or spiritual concerns the patient wants the Chaplain, physician, and other health care team members to immediately know about: No
 - Patient requests an immediate visit from the Chaplain: No
 - Does patient have any traditional, ethnic, or cultural practices that need to be part of care: No
 - Does patient have any concerns or special considerations if a blood transfusion is needed: No
 - Does patient have a pastor or clergy who should be notified of this hospitalization: No
- Advance Directive**
 - 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
- MRSA**
 - Testing for MRSA brochure/equivalent information given to the patient/authorized surrogate: No
 - Was the below Infection Control Education provided to the patient: No
 - Infection Control Education: None
 - Precautions: None
 - MRSA Nares swab performed on transfer with patient's agreement: N/A
 - MRSA Nares swab performed on discharge with patient's agreement: N/A
- Emergency contact information:**
 - Contact: ZMSHTSWLSDHYS,CHUUN

At the bottom of the window, there is a "Sign Note/Consult" button and a row of tabs: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "View Text" tab is currently selected. A status bar at the bottom indicates "Performing assessment" and includes a note: "* Designates a required field".

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**.

Enter your electronic signature code

Sign Note/Consult Accept e-sig Cancel e-sig

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

Uploading care plan. Cascade your windows if the program gets stuck

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**.

The screenshot shows a software window titled "RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT". The window has a menu bar with "File", "Tabs", and "Help". The main content area is titled "GENERAL INFORMATION" and contains several sections:

- A section for "Patient/family/support person able to respond to questions" with radio buttons for "Yes" and "No".
- A "Demographics" section with fields for Name (VHLSJE,JELUAHT ALRUHYJH), Age (69), Sex (MALE), and Race (DECLINED TO ANSWER).
- An "Admitting diagnosis" section with the text "CHEST PAIN".
- Two text input areas for "Prior patient response to 'What does patient want to accomplish by this hospitalization?'" and "Other Language".

At the bottom of the window, there is a navigation bar with tabs for "Gen I Page 1", "Gen I Page 2", "Gen I Page 3", and "Gen I Page 4". Below this is a row of buttons for various assessment categories: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "Gen Inf" button is currently selected. To the right of these buttons is a dropdown menu labeled "Go to radiogroup:" with "able to respond to questions" selected, and a "Go" button. The status bar at the bottom left reads "Performing assessment".

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

Patient still cannot respond

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

The screenshot shows the 'RN Reassessment - VHSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT' window. The 'GENERAL INFORMATION' tab is active. Under the heading '*Why could no one respond', the following options are listed: 'Patient unable to communicate' (checked), '*No family/support person present' (checked), and 'Other' (unchecked). The 'Patient/family/support person able to respond to questions' section has 'No' selected. Demographics include Name: VHSJE,JELUAHT ALRUHYJH, Age: 63, Sex: MALE, and Race: DECLINED TO ANSWER. The admitting diagnosis is CHEST PAIN. The bottom navigation bar includes tabs for Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. The 'Gen I Page 1' tab is selected.

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: _____

* Has ability to read: _____ * Describe why unable to read: _____

* Has ability to write: _____ * Describe why unable to write: _____

* Educational Level: _____ * Other education level: _____

Learns best by: _____

Prior patient response: Prefers: _____

* Readiness to learn: _____

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 occurrence: _____

Patient has been placed on Palliative/Comfort Care since last patient assessment

* Does patient exhibit behavioral indicators related to pain: _____ * Other behavioral indicator: _____

* Behavioral indicator(s) observed: _____

Other pain location?: _____

Pain Location #1

* Pain Region: Head

* Quality of pain: Aching

* Type of pain: Acute/surgical Chronic

* Other pain region: _____

* Other quality of pain: _____

Onset of original pain (years, months): _____

* Describe other timing of pain: _____

* Severity of Pain (0=none - 10=worst): _____

* Timing of pain: Constant Intermittent Other

* 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: _____

* What makes pain better: No identified relief factors Acupressure Acupuncture Assistive devices (cane, wheelchair) Brace/Support Chiropractic intervention P-14

* Other palliative factor(s): _____

* Rx/Otc Meds helping pain: _____

* 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

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					

Show discontinued IVs also

Edit Peripheral Line Site

* Location: * Other location:

* Date/time inserted: * Other size:

Dressing change Last changed: Tubing change Last changed:

Dressing date/time change Tubing date/time change

IV Discontinued IV discontinue date/time:

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

IV Periph IV Central IV Dialysis IV Comments IV CP

Gen Int 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 - Kussmaul Irregular - Other

* Other respiratory pattern:

* Respiratory rate:

* Respiratory depth: Normal Deep Shallow

* Chest movement: Equal, bilateral, symmetrical Abnormal

* Abnormal Chest Movement:

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

* Other work of breathing:

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

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

Clear Abnormal

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

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

File Tabs Help

RESPIRATORY ASSESSMENT

Productive cough present
 * Sputum color * Other sputum color * Sputum consistency * Other sputum consistency
 Prior response: Prior response:

Chest tubes
 Chest tubes present * Location 1 * Suction * Other suction * Air Leak * Chest tube drainage * Dressing * Other dressing
 Prior response: NO
 Location 2 * Suction * Other suction * Air Leak * Chest tube drainage * Dressing * Other dressing
 Other chest tube locations

Facility ordered oxygen
 Facility ordered oxygen * Other liter flow * Other delivery method Oxygen saturation %
 Ventilator dependent - chronic
 * Ventilator dependent - chronic comments

Respiratory Consult

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

Gen Int 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, Respiratory Assessment (Resp) tab, Resp Page 2 window

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

File Tabs Help

RESPIRATORY ASSESSMENT

Tracheostomy
 Tracheostomy present * Other trach type * Stoma appearance * Other stoma appearance * Other dressing
 * Tracheostomy size
 Trach recently inserted * Insertion date/time
 Trach removed * Removed date/time
 Dressing change? * Dressing type * Other dressing type
 * Dressing date/time change
 * Type of tobacco used
 Instructions for former usage

Prior response:

* Approximate quit date:
 * Tobacco education

General Observations/Comments

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

Gen Int 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, Respiratory Assessment (Resp) tab, Resp Page 3 window

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

File Tabs Help

CARDIOVASCULAR 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

Edema and Locations - Mark only the locations where edema is found

* Edema
 Yes No

Right arm Left arm Right hand Left hand Right leg Left leg

Prior resp. Prior resp. Prior resp. Prior resp. Prior resp. Prior resp.

Pedal right Pedal left Facial Periorbital Sacral

Prior resp. Prior resp. Prior resp. Prior resp. Prior resp. Prior resp.

Extremities
 Warm
 Cool
 Capillary Refill Less than 3 Seconds
 Capillary Refill Greater than 3 Seconds

Extremities comments

Prior comments

Prior response:

Auscultation

* Heart Rate

* Heart rhythm
 Regular Irregular

* Heart sounds
 Normal Abnormal

* Describe abnormal sound

CV Page 1 CV Page 2 CV CP

Gen Int 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: Heart rhythm Go

Performing assessment

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

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

File Tabs Help

CARDIOVASCULAR ASSESSMENT

Pulses

Radial Pulse Dorsalis Pedis Pulse Posterior Tibial Pulse

Left Right Left Right Left Right

* Jugular Venous Distension
 Yes No

* Describe venous distension

* Cardiac monitor
 Yes No

Prior response:

Prior response: Negative
 Positive is call pain reported on flexion of foot

Cardiac devices

External pacemaker Permanent pacemaker

Implantable cardioverter/defibrillator (ICD) Other device

* Other cardiac device

Prior cardiac monitor response:

* Other cardiac monitor rhythm

General observations/comments

T Wave:

PR Interval:

QT Interval:

QRS Duration:

ST Segment:

CV Page 1 CV Page 2 CV CP

Gen Int 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: Jugular Venous Distension Go

Performing assessment

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: Patient unable to communicate No family/support person present Other

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Patient has a history of:

* Spinal Cord Injury Level:

Orientation:

* Other neurological problem:

* Describe Spinal Cord Injury Level:

Prior response:

Level of Consciousness (Glasgow Coma Scale)

Eye response score:

Verbal response score:

Motor response score:

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

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

Neuro Page 1 | Neuro Page 2 | Neuro CP

* 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:

Pupils

New lens implant/prosthesis

Prior response:

* Describe new lens implant/prosthesis:

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

* Other pupil size:

Reactivity

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

Prior response:

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

Prior response:

Sensations - New paresthesias or neuropathies present

Prior response:

* New sensations present:

Requires assistive new communication device to meet basic needs

Prior response:

* New comm device needed:

General observations/comments

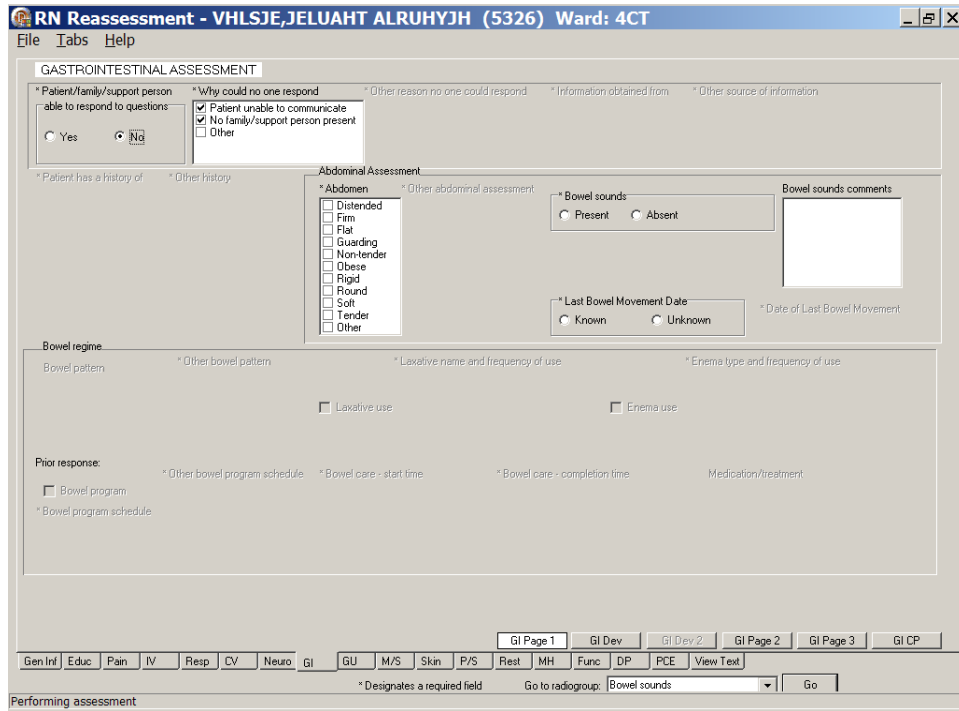
Gen Int Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text

Neuro Page 1 | Neuro Page 2 | Neuro CP

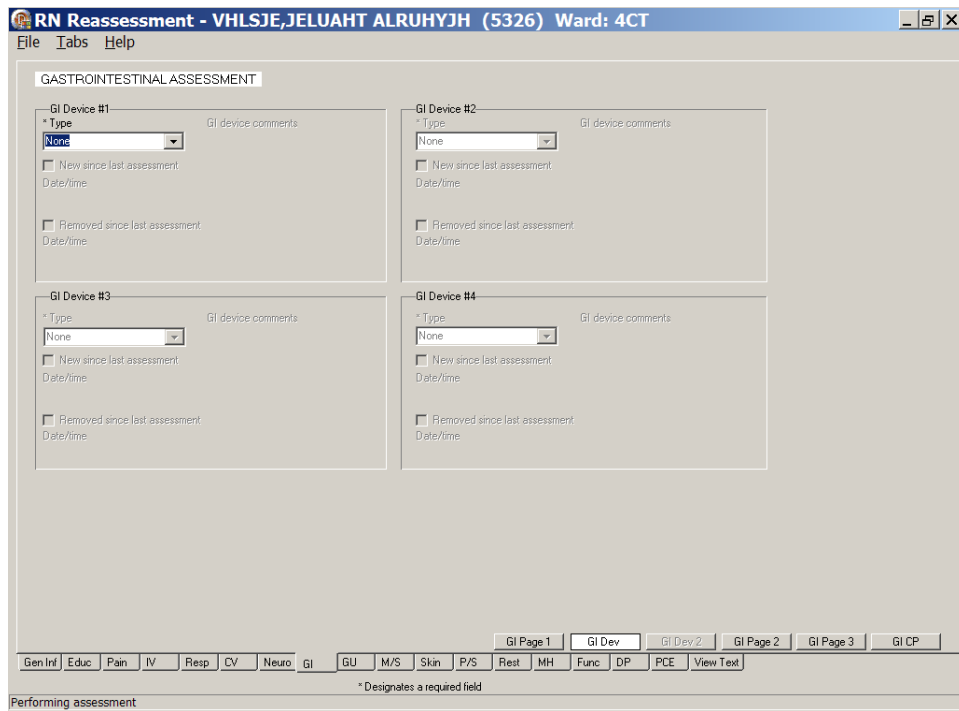
* Designates a required field Go to radiogroup: Size Go

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Oral Screen

Assessment - General

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

Assessment - Mucous Membrane

- Bleeding
- Cyanotic
- Intact
- Lesions present
- Pale
- Pink

Nutrition screen

*Appetite *Other appetite

* Description of patient:

- Well nourished
- Obese
- Emaciated

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

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

Prior response:

Nutrition consult guidelines

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

GI Page 1 GI Dev GI Dev 2 GI Page 2 GI Page 3 GI 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: Description of patient Go

Performing assessment

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

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Dysphagia screen

* Dysphagia screen * Other reason unable to screen

- Able to screen
- Unable - Patient on Ventilator
- Unable - Patient unconscious
- Unable - Other
- N/A

Dysphagia risk factors

- * Diagnosis of new stroke, head and neck cancer, or traumatic brain injury
- * Modified texture diet/ eating maneuvers (e.g. chin tuck; head turn)
- * Unable to follow commands

Prior response: Prior response: Prior response:

Wet gurgly voice Drooling while awake * Tongue deviation from midline

Speech Consult

General Observations/Comments

GI Page 1 GI Dev GI Dev 2 GI Page 2 GI Page 3 GI 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: Dysphagia screen Go

Performing assessment

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

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

File Tabs Help

GENITOURINARY ASSESSMENT

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

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

* Other reason no one could respond

* Information obtained from

* Other source of information

* Patient has a history of

Voiding
 Voiding
 Intermittent catheterization frequency
 Other voiding

Urine
 Color
 Amber
 Yellow
 Bloody
 Unable to evaluate
 Other

Consistency
 Normal
 Concentrated
 Dilute
 Unable to evaluate

Odor
 Foul smelling
 None
 Unable to evaluate

Sediment
 Yes
 No
 Unable to evaluate

* Last voided
 Known Unknown Absorbency devices used

* Date/time last voided:

* Abnormal discharge
 None
 Genital
 Unable to evaluate

* Describe abnormal discharge:

* Describe sediment:

Prior response:

GU Page 1 GU Dev GU Page 2 GU CP

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

* Designates a required field Go to radiogroup: Color Go

Performing assessment

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

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

File Tabs Help

GENITOURINARY ASSESSMENT

GU Device #1
 Type
 None
 GU device comments:
 Inserted since last assessment
 Date/time inserted:

 Removed since last assessment
 Date/time:

GU Device #2
 Type
 None
 GU device comments:
 Inserted since last assessment
 Date/time inserted:

 Removed since last assessment
 Date/time:

GU Device #3
 Type
 None
 GU device comments:
 Inserted since last assessment
 Date/time inserted:

 Removed since last assessment
 Date/time:

GU Device #4
 Type
 None
 GU device comments:
 Inserted since last assessment
 Date/time inserted:

 Removed since last assessment
 Date/time:

GU Page 1 GU Dev GU Page 2 GU CP

Gen Int 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, Genitourinary Assessment (GU) tab, GU Dev window

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

File Tabs Help

GENTOURINARY ASSESSMENT

Genitourinary Devices

* Current Devices

None Indwelling catheter size Other device

Continuous Ambulatory Peritoneal Dialysis Concerns voiced regarding sexual functioning

Continuous Bladder Irrigation Sexual Functioning concerns voiced

Continent Urinary Diversion (e.g. ileo-conduit)

External catheter (condom)

Indwelling urinary catheter

Nephrostomy bag

Suprapubic catheter

Ureterostomy bag

Other

Prior response Indwelling removed

Female patients

* Pregnancy

Approximate date

Approximate date

Approximate date

Male patients

Approximate date

General observations/comments

Last PSA: 10/14/10 @ 0819 0.74

GU Page 1 GU Dev GU Page 2 GU 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, Genitourinary Assessment (GU) tab, GU Page 2 window

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

File Tabs Help

MUSCULOSKELETAL ASSESSMENT

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

* Why could no one respond

Patient unable to communicate

No family/support person present

Other

* Other reason no one could respond

* Information obtained from

* Other source of information

* Patient has a history of

* Describe other history

* Body part(s) amputated

* Range of Motion

ROM - No apparent problem

Limited ROM - Right Upper Extremity

Limited ROM - Left Upper Extremity

Limited ROM - Right Lower Extremity

Limited ROM - Left Lower Extremity

Stated patient complaints

General observations/comments

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

Gen/Inf 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, Musculoskeletal Assessment (M/S) tab, M/S Page 1 window

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

File Tabs Help

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

* Fall risk assessment indicated
 Yes No

* History of falling Describe previous falls and history

* Fracture Location * Other fracture location
 * Is patient on any meds that increase risk for falling or risk for injury with falls
 * Other medication that increases risk

* Is patient on multiple meds to

Total Morse score for Fall Risk: N/A

Prior score: Not assessed
 Date:

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

Instructions for completing Morse Fall Scale

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

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

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

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

Gait:
 Score as 0 a normal gait which is characterized by the patient walking with head erect, arms swinging freely at the side, and

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

Gen Int 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: Fall risk assessment indicated Go

Performing assessment

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

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

File Tabs Help

SKIN ASSESSMENT

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

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

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

* Patient has a history of * Describe other

Predisposition for skin breakdown

Does patient have

- Amputee
- Diabetes
- Multiple Sclerosis
- Neurological disease
- Paraplegia
- Paralysis
- Quadriplegia
- Spinal cord injury

* Risk Factors

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

* Describe other

Skin Inspection

* Skin Temperature
 Warm Hot Cool Cold

* Skin Moisture
 Extremely dry Moist
 Dry Diaphoretic

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

* Describe other

* Skin Turgor
 Within Normal Limits Abnormal

* Skin Patches
 Yes No

* Skin Patch Description

General observations/comments

Pressure ulcers Skin alterations

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

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

* Designates a required field Go to radiogroup: Skin Patches Go

Performing assessment

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

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

File Tabs Help

SKIN ASSESSMENT BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

* Skin assessment indicated
 Yes No

SENSORY PERCEPTION: Ability to respond meaningfully to pressure-related discomfort
 1. COMPLETELY LIMITED: Unresponsive (does not moan, flinch, or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR limited ability to
 * Sensory Score
 1
 2
 3
 4

MOISTURE: Degree to which skin is exposed to moisture
 1. CONSTANTLY MOIST: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.
 * Moisture Score
 1
 2
 3
 4

ACTIVITY: Degree of physical activity
 1. BEDFAST: Patient is confined to bed.
 2. CHAIRFAST: Patient's ability to walk is severely limited. Patient can't bear his own weight, or must be assisted into
 * Activity Score
 1
 2
 3
 4

MOBILITY: Ability to change and control body position.
 1. COMPLETELY IMMOBILE: Does not make even slight changes in body or extremity position without assistance.
 * Mobility Score
 1
 2
 3
 4

NUTRITION: Usual food intake pattern.
 1. VERY POOR: Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy product) per day. Takes fluids poorly. Does not
 * Nutrition Score
 1
 2
 3
 4

FRICION AND SHEAR:
 1. PROBLEM: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent
 * Friction Score
 1
 2
 3

Total Score: N/A
 Prior score: Not assessed
 Date:

Risk Category
 Not at risk (19-23)
 At risk (15-18)
 Moderate risk (13-14)
 High risk (10-12)
 Severe risk (9 or below)

Consult guide
 If patient has a Braden score of 12 or below, a Stage II or greater pressure ulcer is present, a history of pressure ulcers, sensory or motor deficits, or paralysis or spinal cord injury exists, consider Wound Care Clinician alert.
 If patient has a Braden score of 16 or below, and/or a Stage II or above pressure ulcer exists, and/or a Braden Nutrition score of 1 or 2, consider a Nutrition alert.
 If patient's scores in the mobility, activity or sensory scales and/or patient has a motor deficit (e.g. amputee or spinal cord injury), a referral to physical therapy should be discussed with the interdisciplinary team.

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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: Skin assessment indicated Go

Performing assessment

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

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

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

* Other reason no one could respond

* Information obtained from

* Other source of information

* Patient has a history of

* Other history

* Other attitude

* Other behavior

Suspected Abuse/Neglect Screen
 Does patient report any of the following?
 Prior response: Prior response: Prior response:

Based upon nursing assessment, is any of the following suspected?
 Verbal abuse: Yes No
 Physical abuse: Yes No
 Neglect: Yes No
 Prior response: Prior response: Prior response:

* Explain suspicions

Based on nursing assessment, are others in the household possible victims of abuse or neglect by the patient?
 Yes
 No
 Unknown
 Prior response:

* Explain about others in household

P/S Page 1 P/S Page 2 P/S Page 3 OWA P/S Page 4 P/S 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: Verbal abuse Go

Performing assessment

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

Suicide Risk Screen

Ask Patient

* Have you recently had thoughts about: * Do you have a plan for how to do this * Describe plan * Describe means

Are there means available

Prior response: Prior response: Prior plan: Prior response: Prior means

* Have you rehearsed or practiced how to kill yourself * Have you heard voices telling to hurt or kill yourself

Prior response: Prior response: Comments relative to suicide

* Have you tried to hurt or kill * How have you tried to hurt or kill yourself in the past * Are you feeling hopeless about the present or future e.g. feeling that there

Prior response: Prior response:

P/S Page 1 | P/S Page 2 | P/S Page 3 | Q/W/A | P/S Page 4 | P/S CP

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

Elopement Screen - If any YES answer, then patient is a potential wandering/elopement risk-

* Patient has a court-appointed legal guardian: Yes No * Patient has been legally committed: Yes No * Patient is considered a danger to him/herself or others: Yes No Unknown * Patient is on legal observation status for Gravelly Disabled: Yes No * Patient lacks the cognitive ability to make relevant decisions (e.g. history of dementia, Alzheimer's or traumatic brain injury): Yes No

Prior response: * Specify guardian Prior response: Prior guardian response Prior response: * Patient has history of Prior response: Date/from where if known Prior response: Prior escape/elopement response

Prior response:

Chemical Dependency Issues:

* Alcohol use * Date of last alcohol use * Does patient use recreational drugs * Date of last drug use

* Amount of last alcohol use * Amount of last drug use

Prior response: * Type of recreational drugs used * Does patient have a medical marijuana card: Yes No Prior response: If Yes to use of recreational drugs, notify provider Possibility of alcohol withdrawal

Prior response:

Make Alcohol Treatment referral if patient is interested.

Contraband:

* Contraband brought (in to/by) the patient: Yes No * Describe contraband * Location of unremoved contraband

Prior response: [Follow facility policy for contraband removal](#)

P/S Page 1 | P/S Page 2 | P/S Page 3 | Q/W/A | P/S Page 4 | P/S CP

Gen Int | 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: appointed legal guardian Go

Performing assessment

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

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

File Tabs Help

RESTRAINTS *** Notify provider ***

Restraints Initiated/maintained Date/time initiated: Initiated date/time

Known Unknown

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:**

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

Restraint Type:

Ankle, Right, Locked

Ankle, Right, Unlocked

Ankle, Left, Locked

Ankle, Left, Unlocked

Blanket/Net

Hand Mit, Right

Hand Mit, 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

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

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 P/S Rest MH Func DP PCE View Text

* Designates a required field

Performing assessment

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

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

File Tabs Help

MENTAL HEALTH ASSESSMENT

Tab to be completed for patients admitted to acute psychiatry, or with a history of mental health problems

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:

Ask patient: "What things or situations make you upset?":

Other upsetting item:

Ask patient: "Have you ever been so angry":

Prior response:

How does patient act when he/she loses control:

Other actions:

Ask patient: "When you get upset, what does patient do to calm him/herself":

Other calming things:

Prior response:

MH Page 1 MH Page 2 MH 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, 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 tying shoes.
0 - Needs help with dressing self or needs to be completely dressed.

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

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

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

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

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 coaching, or caregiver is required to lift no more than 35 lbs. of a patient's weight)

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

Patient's level of assistance: Independent Partial Assist Dependent

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: 223.94 lb [104.5 kg] (06/22/2011 12:30)
BMI: 36.9 (JUN 22, 2011@12:30:48)

Prior response:

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:

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

General observations/comments:

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: 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

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

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

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

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

Educate Patient, Family, and Support Person on

Slings
 Standard
 Amputation
 Head support
Prior response:

Slings
 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]

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

* 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 identified 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 Int Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text

Performing assessment * Designates a required field

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**.

GENERAL INFORMATION

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

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

Demographics: Name: VHLSJE,JELUAHT ALRUHYJH Age: 69 Sex: MALE Race: DECLINED TO ANSWER

Admitting diagnosis: CHEST PAIN

* Preferred Healthcare Language: English Spanish Other

* What does patient want to accomplish by this hospitalization?

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

Go

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

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

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

4. Upload the information.

Updating the Reassessment Note

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

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

The screenshot shows a software window titled "RN Reassessment" with a search bar at the top that says "Select a patient and then press ENTER". Below the search bar is a section titled "Assessment Type" containing six radio button options: "Medical/Surgical initial reassessment for shift", "Medical/Surgical update reassessment (full reassessment completed previously on current shift)", "Critical Care initial reassessment for shift", "Critical Care update reassessment (full reassessment completed previously on current shift)", "Mental Health initial reassessment for shift", and "Mental Health update reassessment (full reassessment completed previously on current shift)". To the right of these options is a green "Get Note" button. Further right is a "Review Data" section with two empty input fields. At the bottom left, it says "Last reassessment note date: FEB 15, 2010@12:06:31".

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.pdf

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