Patient Assessment Documentation Package (PADP)

C3-C1 Conversion Project

Admission – RN Assessment User Manual for NUPA Version 1.0

April 2012

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

Revision History

Date	Revision	Description	Author
May 2010	1.0	Initial version for v1.0	CBeynon
August 2010	1.1	Add content	CBeynon
August 2010	1.2	Format content	CBeynon
September 2010	1.3	• Split manual into three manuals *Admission – RN Assessment and Nursing Data Collection User Manual* • Changed dates to October	CBeynon
November 2010	1.3	• Changed dates to November • Updated topics to be the same as online help	CBeynon
December 2010	1.4	• Changed dates to December • Pulled issues from this doc for team review	CBeynon
December 2010	1.5	Removed the Nursing Data Collection section to create a 4th user manual *Admission – RN Assessment*	CBeynon
January 2011	1.6	• Changed dates to January 2011 • Updated with additional comments from Judy	CBeynon
February 2011	1.7	Changed dates to February 2011	CBeynon
March 2011	1.8	• Changed dates to April 2011 • Updated with Judy's comments	CBeynon
April 2011	1.9	Updated RoboHelp with this file	CBeynon
May 2011	2.0	• Changed dates to May 2011 • Added (NUPA*1) namespace	CBeynon
October 2011	2.1	• Added C3-C1 Conversion Project • Changed dates to October 2011 • Prepped for national release	CBeynon
November 2011	2.2	• Changed dates to November 2011 • Updated for build v14	CBeynon

Date	Revision	Description	Author
December 2011	2.3	• Changed dates to December 2011 • Changed *Admission – RN Reassessment* to *RN Reassessment* • Updated for build v15 • Updated for new assessment executables • Changed dates to January 2012 • Prepped for national release	CBeynon
January 2012	2.4	• Changed NUPA *1 to NUPA Version 1.0 • Updated for build v16 • Changed dates to February 2012	CBeynon
February 2012	2.5	• Updated the Neuro tab • Updated the Vitals tab • Updated the Psychosocial tab	CBeynon
March 2012	2.6	• Changed dates to March 2012 • Prepped for April national release • Changed dates to April 2012 • Added Appendix A: Assessment Contingency Note	CBeynon

Table of Contents

Introduction

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

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

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

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

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

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

Each template is associated with a note.

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

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

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

Using Admission – RN Assessment

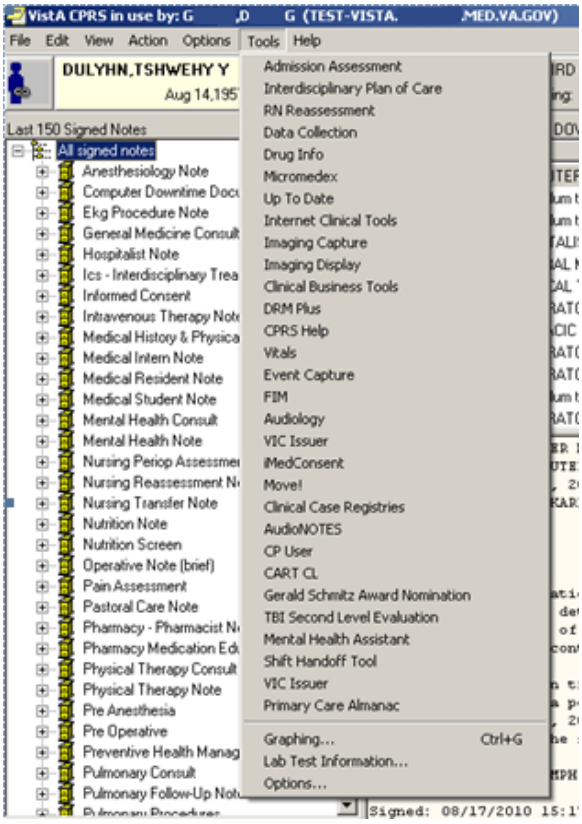
Registered Nurses (RNs) or ancillary nursing personnel use the Admission - RN Assessment template to document inpatient care in a standardized format. With the assessment template, you collect basic information associated with the patient at the time of admission, such as vitals, level of pain, skin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

Opening Admission – RN Assessment

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

1. Open CPRS.
2. Select a patient.
3. Click **Tools**.
4. Select **Admission Assessment**.
   Enter a patient window automatically opens to the CPRS patient.

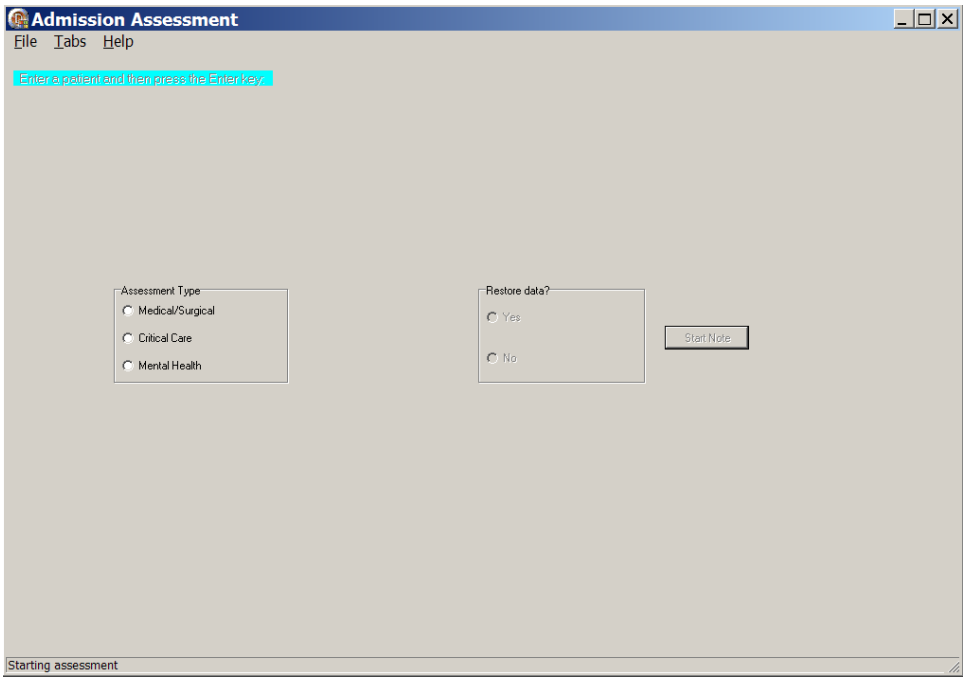
   Note: You may have to re-enter your CPRS access and verify codes, depending on local site setup.



Access through CPRS

No Previously Saved Information

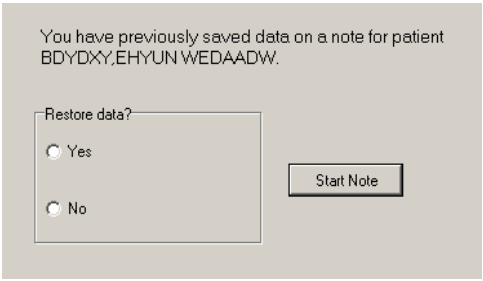
The Enter a patient window displays.



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

1. Select an Assessment Type.
2. Click **Start Note**.
   The assessment template opens to the General Information tab for the CPRS patient.

Previously Entered Information Available for One Patient



Patient selection window with previously entered information available for one patient

Restore Patient's Data/No

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

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

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

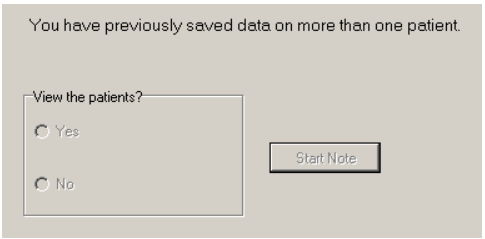
Restore Patient's Data/Yes

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

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

Previously Entered Information Available for Two or More Patients

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



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

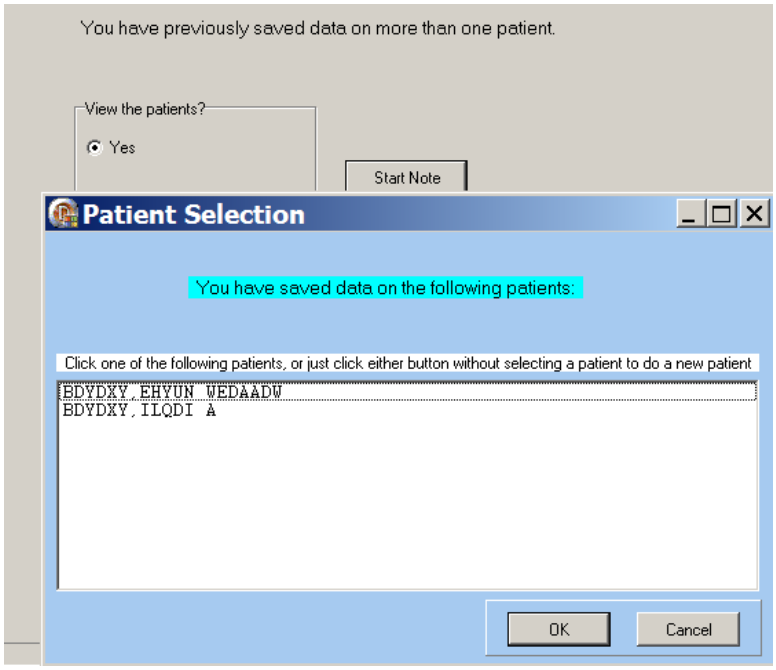
View the Patients?/No

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

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

View the Patients?/Yes

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



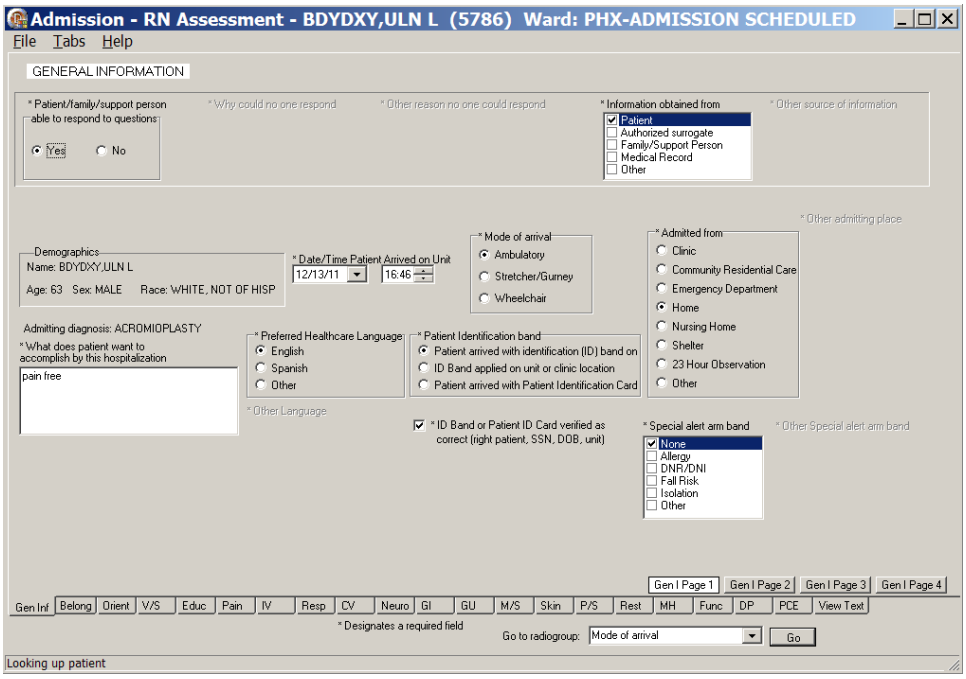
Patient Selection List

Patient on the List

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

Patient not on the List

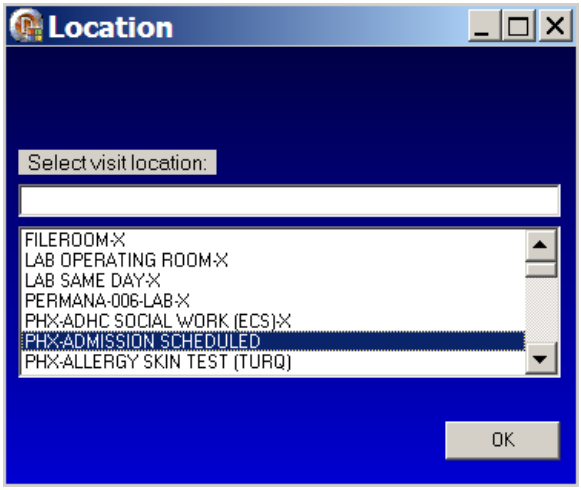
1. Click **Cancel**.
   The number that represents your CPRS patient is in the Enter a patient text box.
2. Click the **Start Note**.
   The template opens to the General Information tab.



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

Patient not yet Assigned to an Inpatient Bed

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



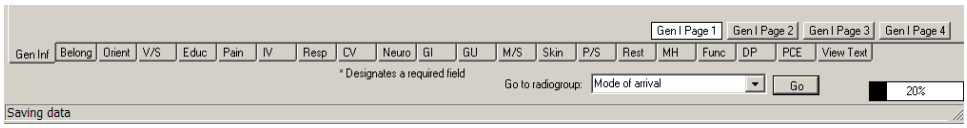
Location pop-up: Select visit location

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

Saving and Uploading Data

Auto Save

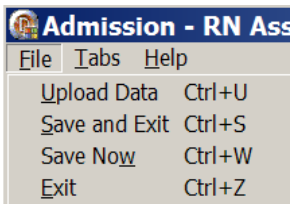
Data are saved automatically. Frequency of auto-save is set locally.



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

Manual Save

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

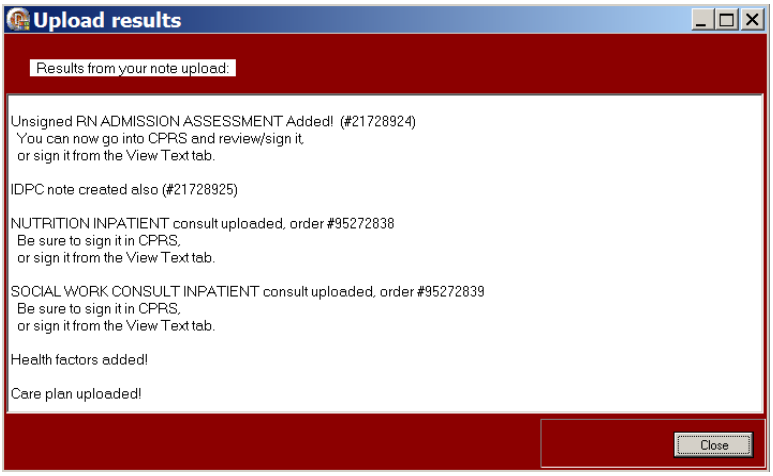


Admission – RN Assessment window, File menu

Upload Data

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

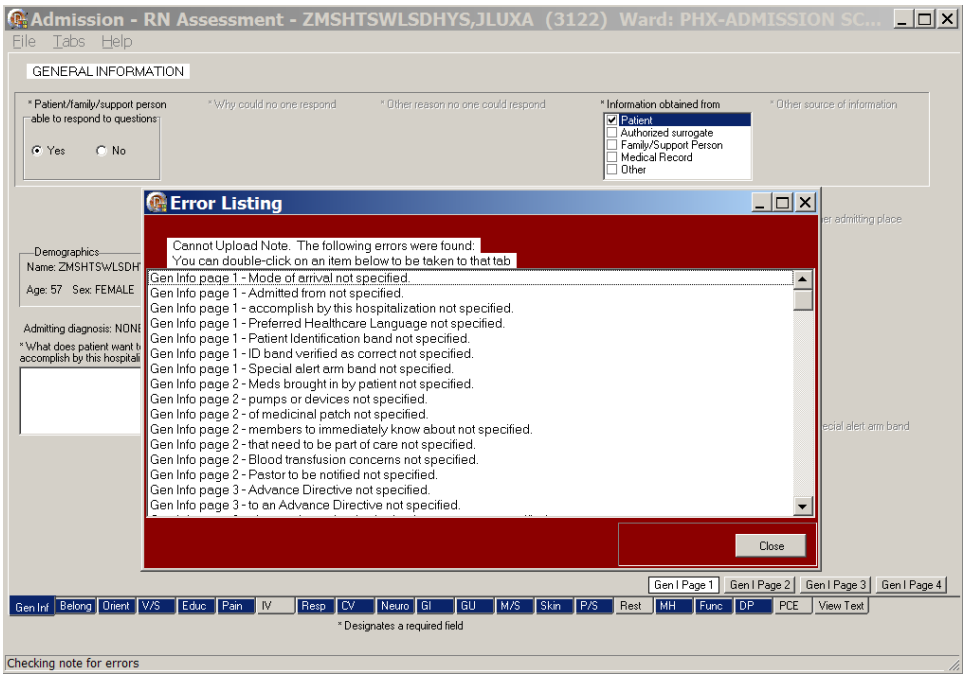
1. Open the File menu on any tab and select **Upload Data**.
   Results from your upload display, verifying that the data are uploaded.



Admission – RN Assessment, Upload results window

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

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



Admission – RN Assessment, Error Listing window

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

Save and Exit

To save data and temporarily leave the template:

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

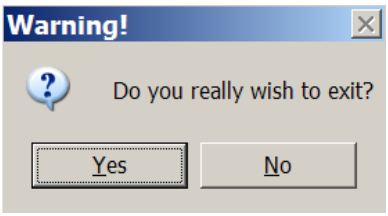
Save Now

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

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

Exit

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



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

2. Click **Yes**.

or

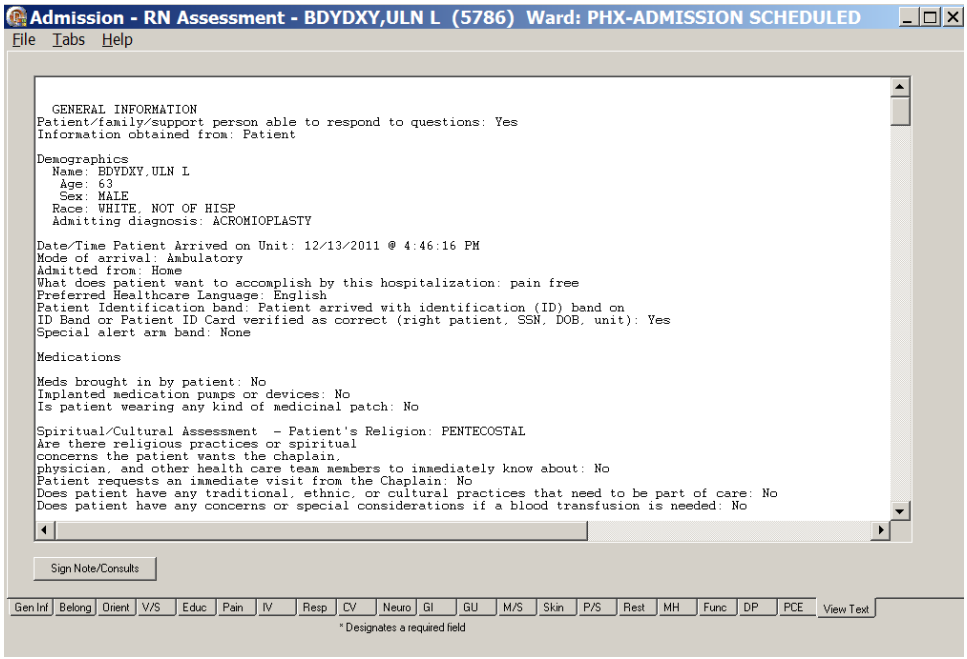
1. From any tab, open the File menu and click **Exit**.
   Warning message displays.
2. Click **Yes**.

Signing Notes

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

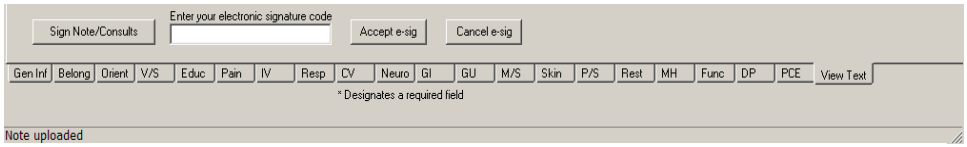
You can also sign *unsigned* notes **after the upload** from the View Text tab in the template.

1. Click **View Text**.



Admission – RN Assessment, View Text tab after upload

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



Admission – RN Assessment with Sign Note/Consults button

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

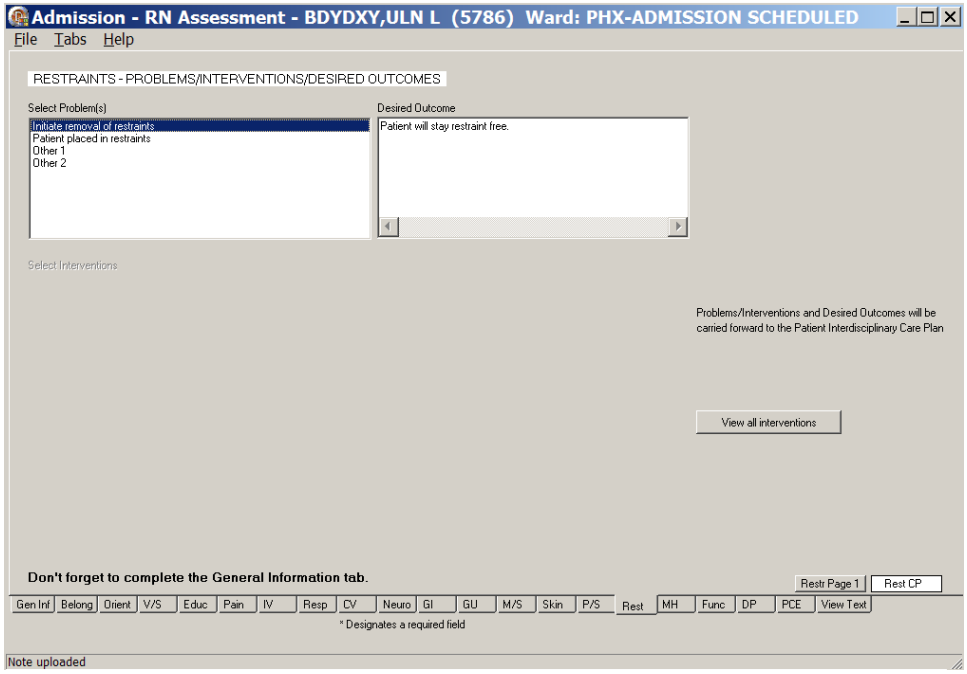
Note: If there is only a note to sign, the button is **Note**.
If there is a consult to sign, the button is **Sign Note/Consults**.

Working in a Care Plan

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

Example – Creating a Rest CP

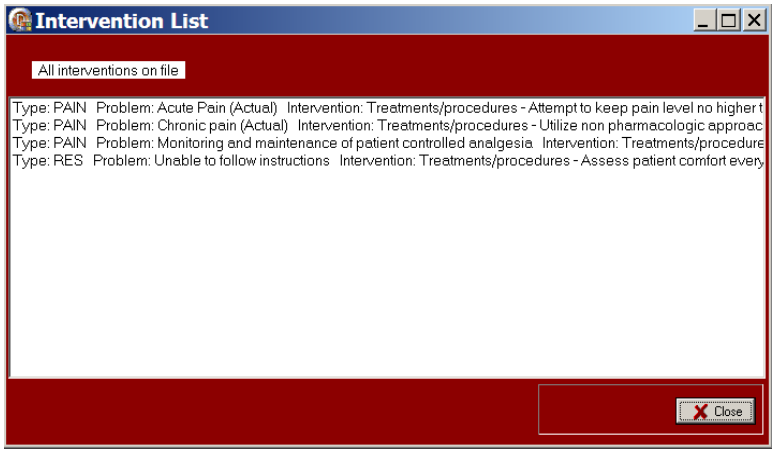
On Rest Page 1, select the **Restraints Initiated/maintained** check box. Click **Rest CP** to open the restraints care plan.



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

Viewing Interventions Entered Previously during an Assessment

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

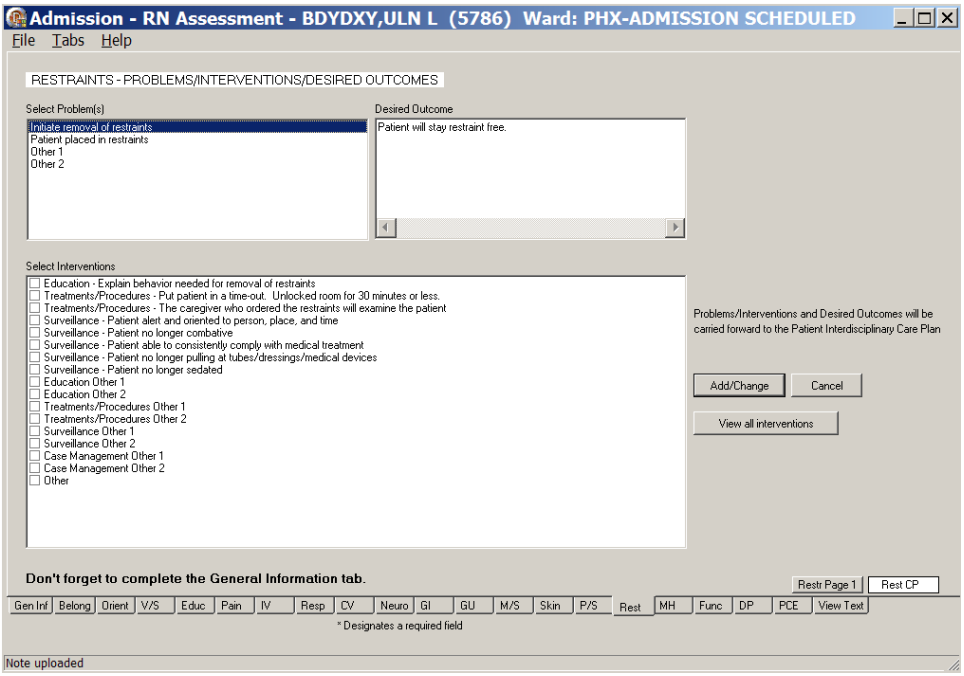


Rest CP window, Intervention List window

3. Click **Close**.

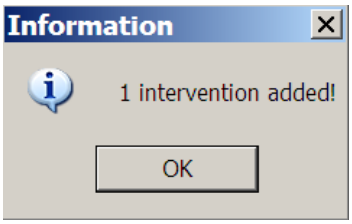
Entering Problems and Interventions

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



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

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



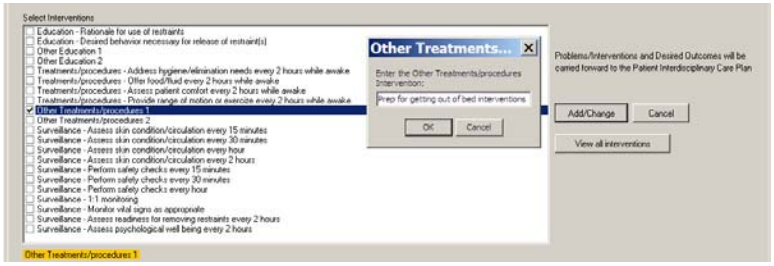
Information pop-up: 1 intervention added!

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

Other Interventions

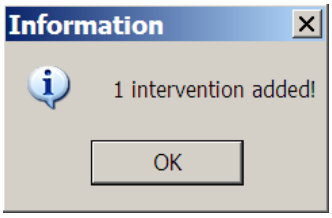
Some interventions generate a pop-up to enter interventions that are not on the predefined list.

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



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

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



Information pop-up: 1 intervention added!

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

Working in the Consults

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

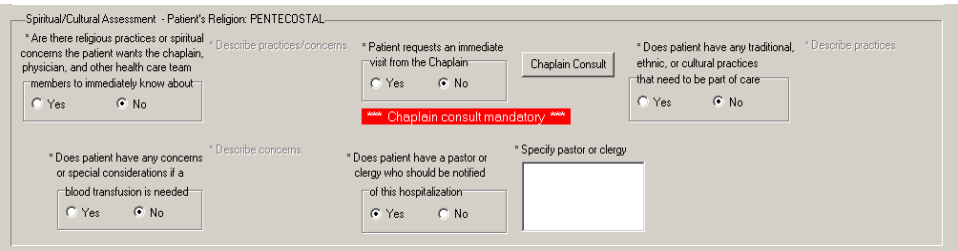
Example – Ordering a Chaplain Consult

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

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

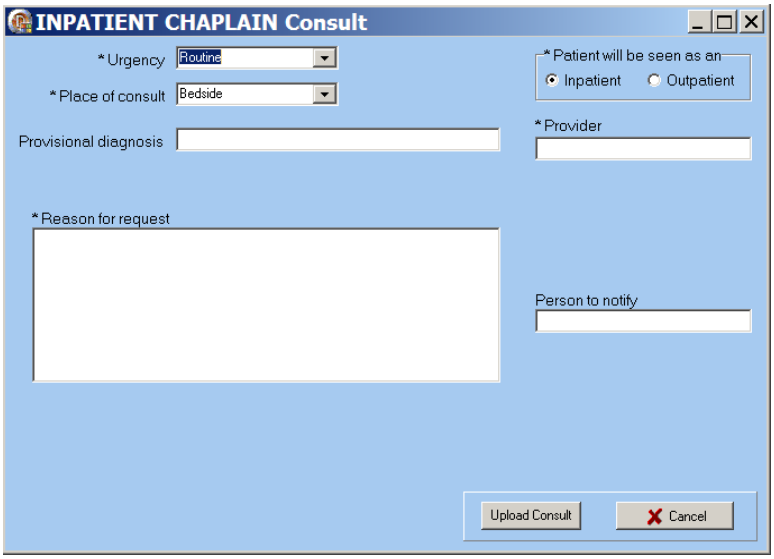
- Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about?
- Patient requests an immediate visit from the Chaplain?
- Does patient have a pastor or clergy who should be notified of this hospitalization?

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



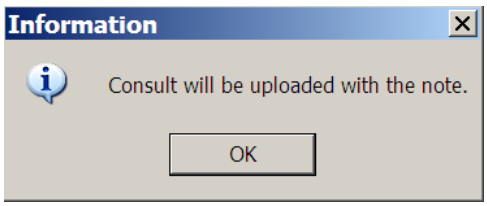
Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 2 window
Spiritual/Cultural Assessment

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



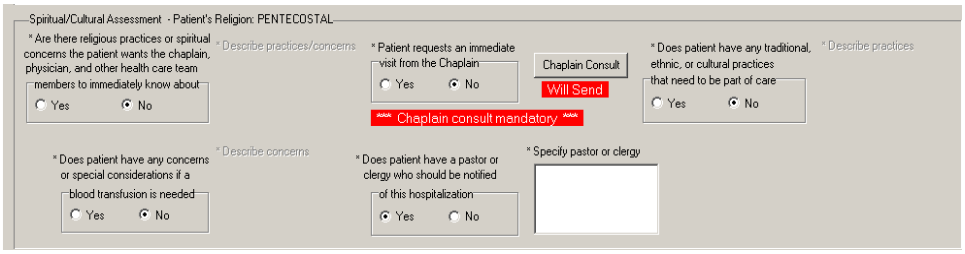
INPATIENT CHAPLAIN Consult window

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



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

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



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

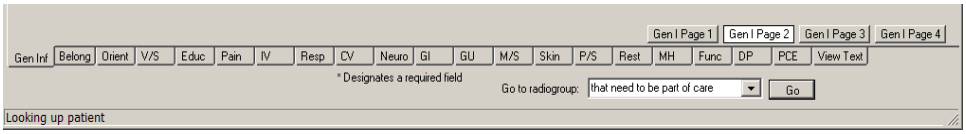
Note: Manage consults according to medical center policy. If nurses at your site do not order consults, upload a mandatory consult, but do not sign it.
The identified provider will be notified that there is a consult to sign.

Working in the Template

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

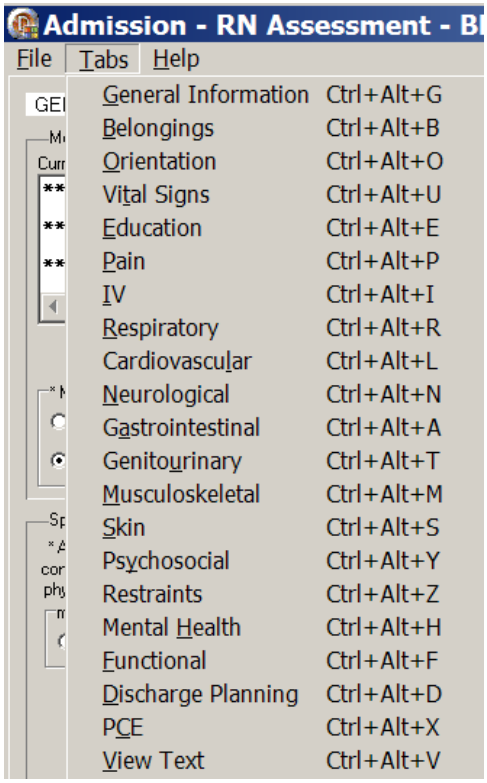
Moving through the Template using the Mouse

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



Admission – RN Assessment tabs

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



Admission – RN Assessment, Tabs menu

Moving through the Template without a Mouse

Ctrl-Alt Keys

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

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

Go to radiogroup

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

Go button

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

or

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

Navigating the Admission – RN Assessment Tabs

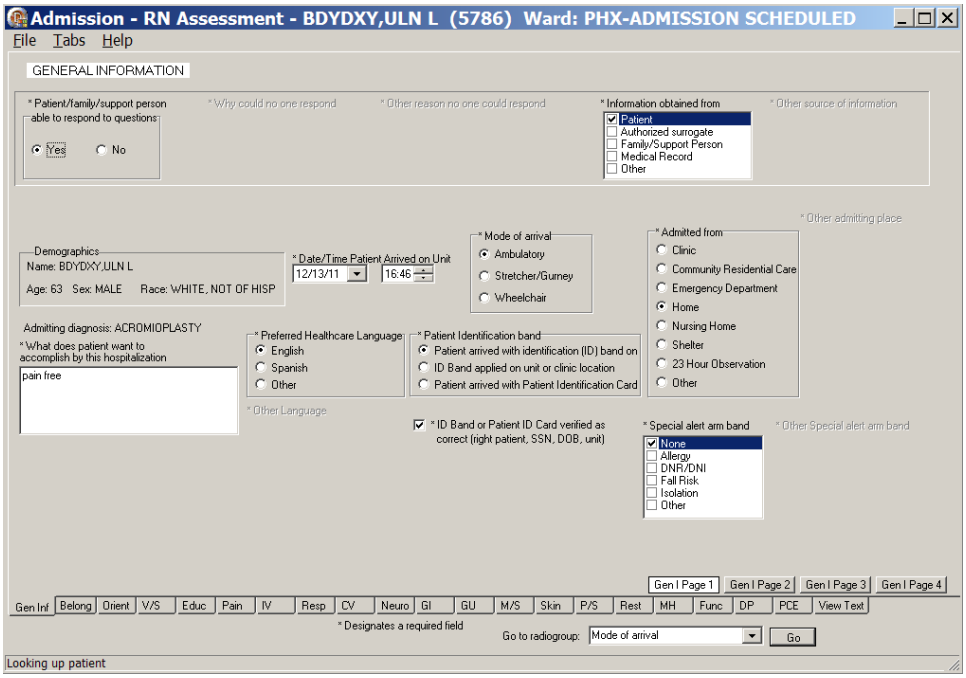
The Admission – RN Assessment template has 21 tabs.

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

General Information (Gen Inf)

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

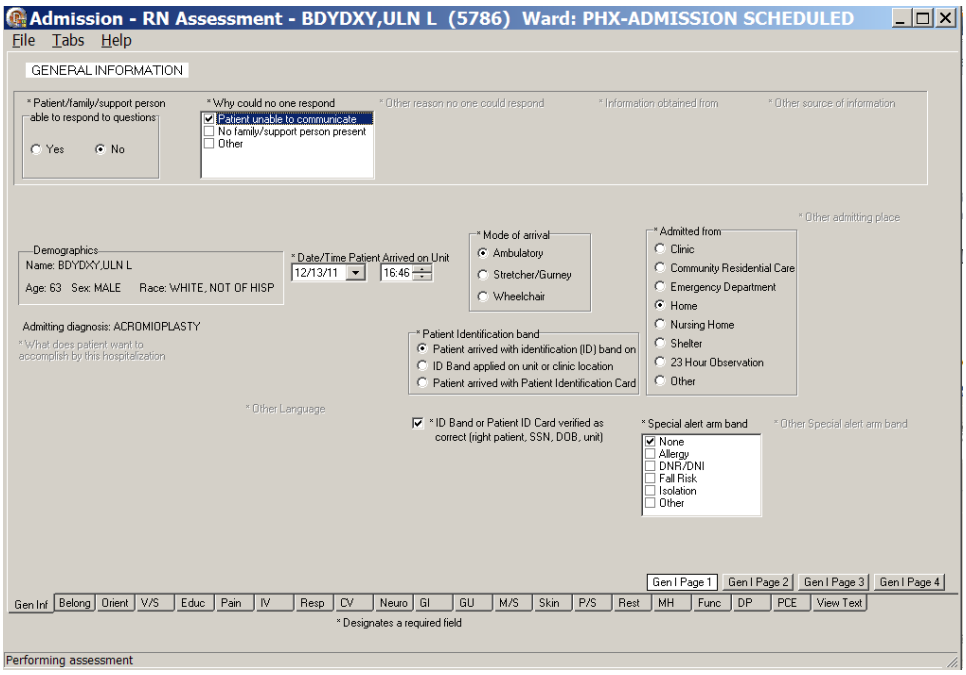
1. Populate Gen I Page 1.
2. In the **Patient/family/support person able to respond to questions** box, select **Yes** or **No**.
   - If you select **Yes**, the application automatically enters **Yes** in each tab. You must also enter from whom the information is obtained.



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

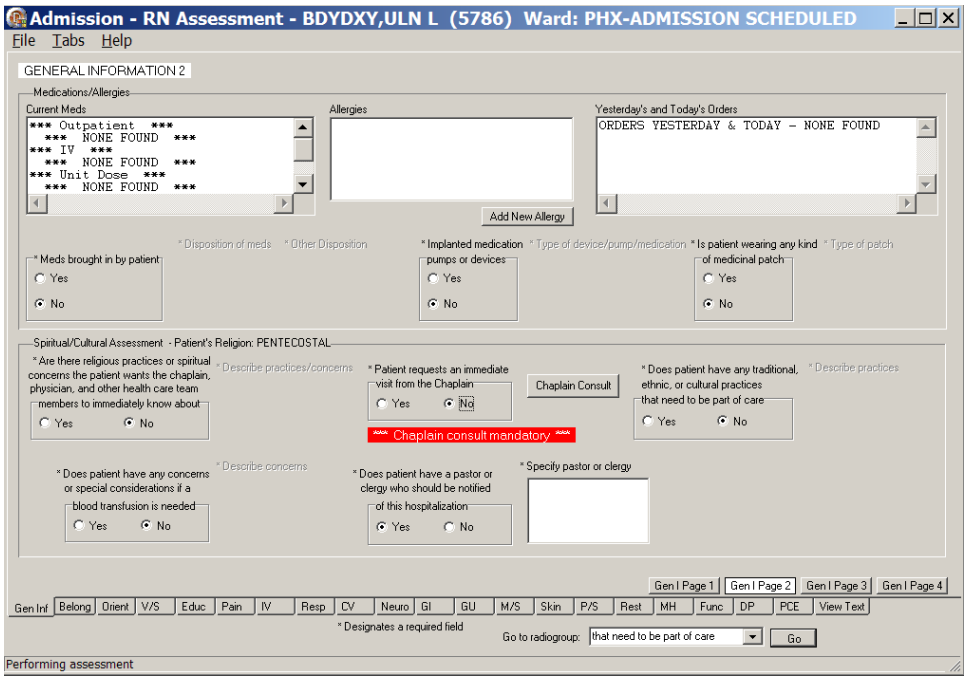
   - If you select **No**, when a patient is unable to answer questions and there are no family members or others to contribute to the assessment, some of the fields will be unavailable.
     The unavailable questions are passed forward into the RN Reassessment to answer later, if possible.
   - When you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

3. Make appropriate selections on Gen I Page 1.



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

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



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

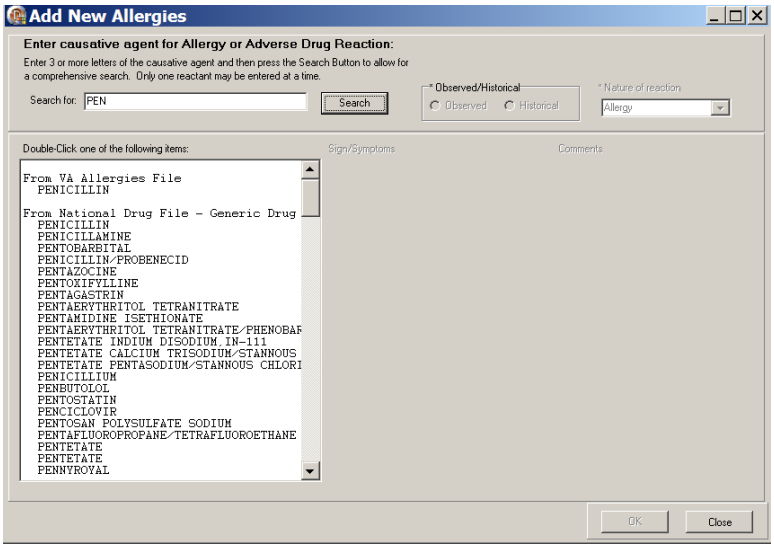
5. Populate Gen I Page 2.

Adding an Allergy

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

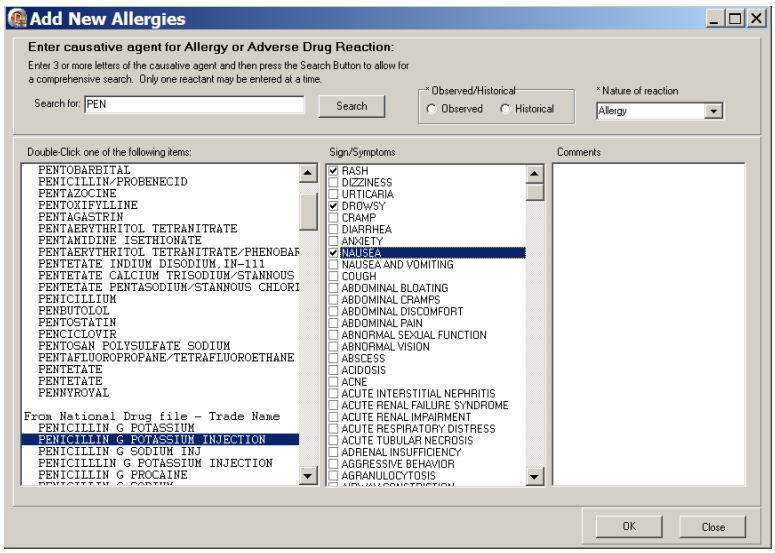
Note: Follow your local medical center policy with regard to adding allergies.

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



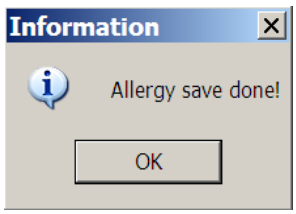
Add New Allergies window

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



Add New Allergies window with Sign/Symptoms available

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



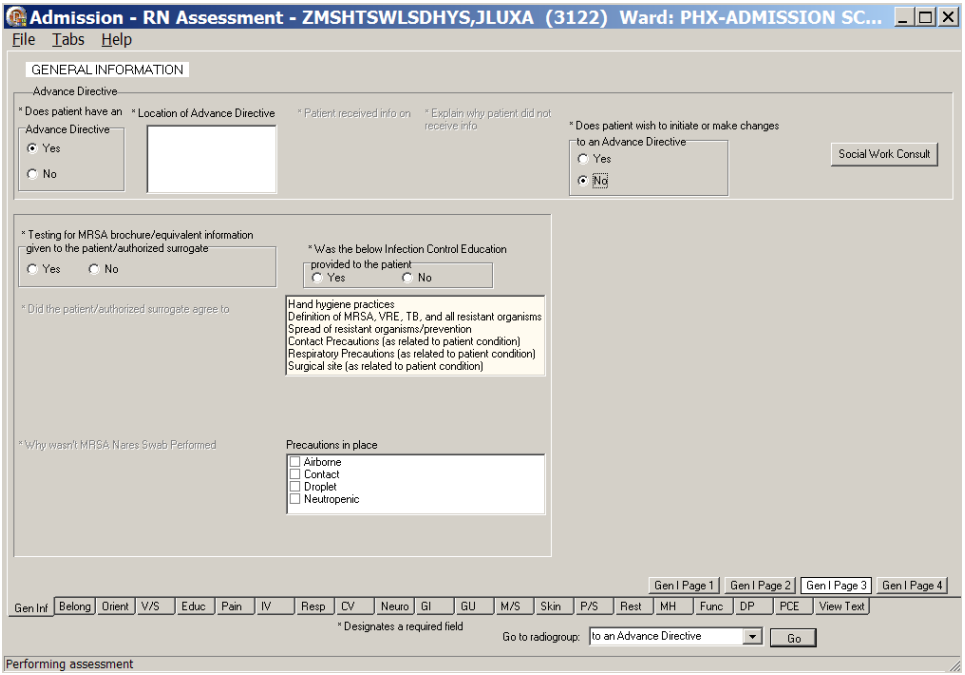
Information pop-up: Allergy save done!

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

Initiating a Social Work Consult for Advance Directives

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

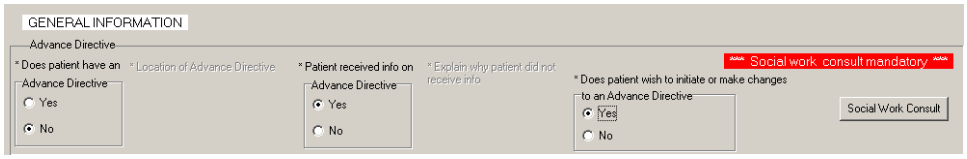
1. Click **Gen I Page 3**.
   Gen I Page 3 displays with the Advance Direction section available.



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

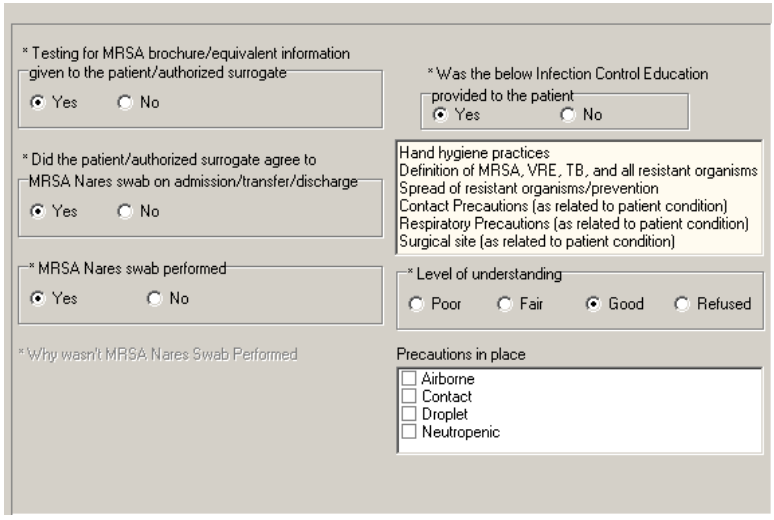
2. Populate Gen I Page 3.

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



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

Documenting Infection Control Information

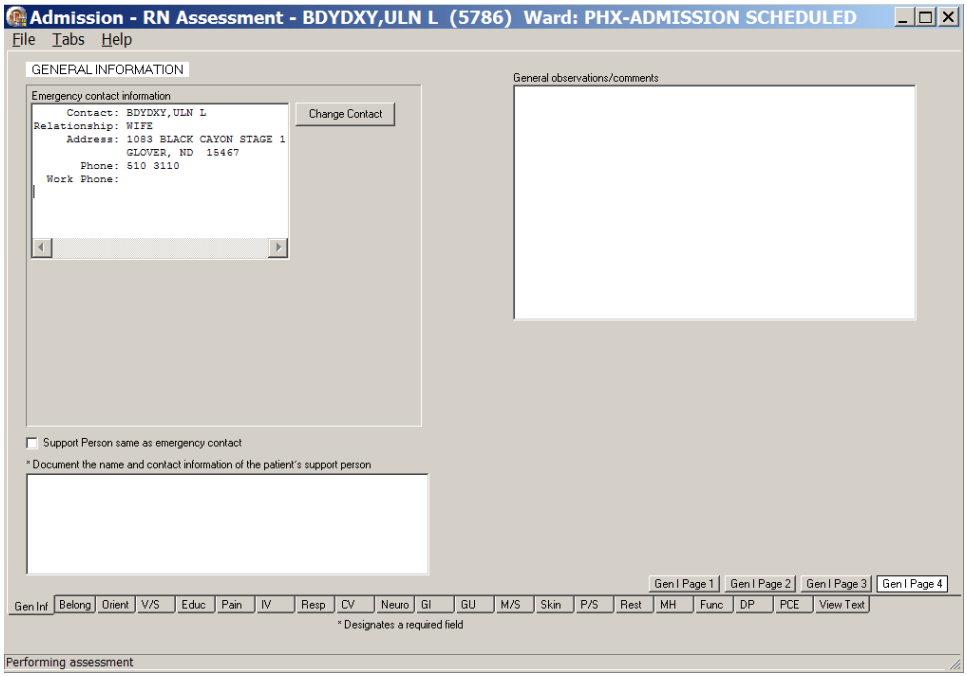


Infection Control Information/MRSA

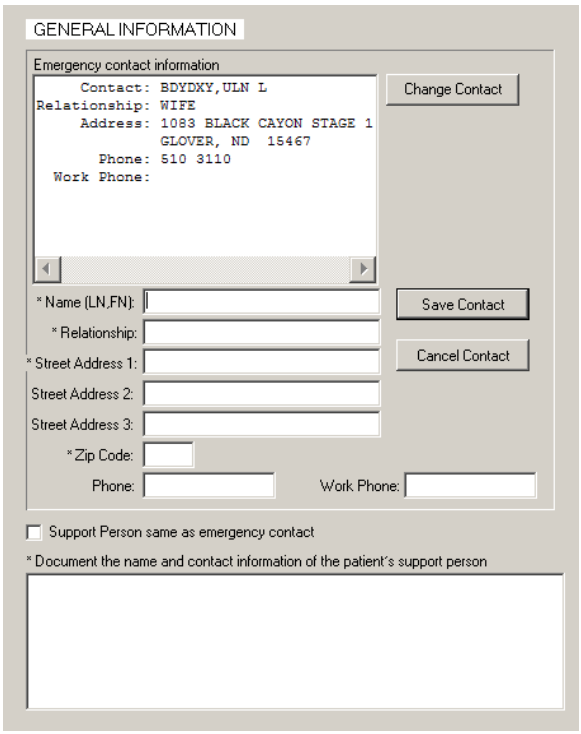
1. Make appropriate selections in the Infection Control section.
2. Enter infection control and Methicillin-Resistant Staphylococcus Aureus (MRSA) collection information.

Changing Emergency Contact Information

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



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



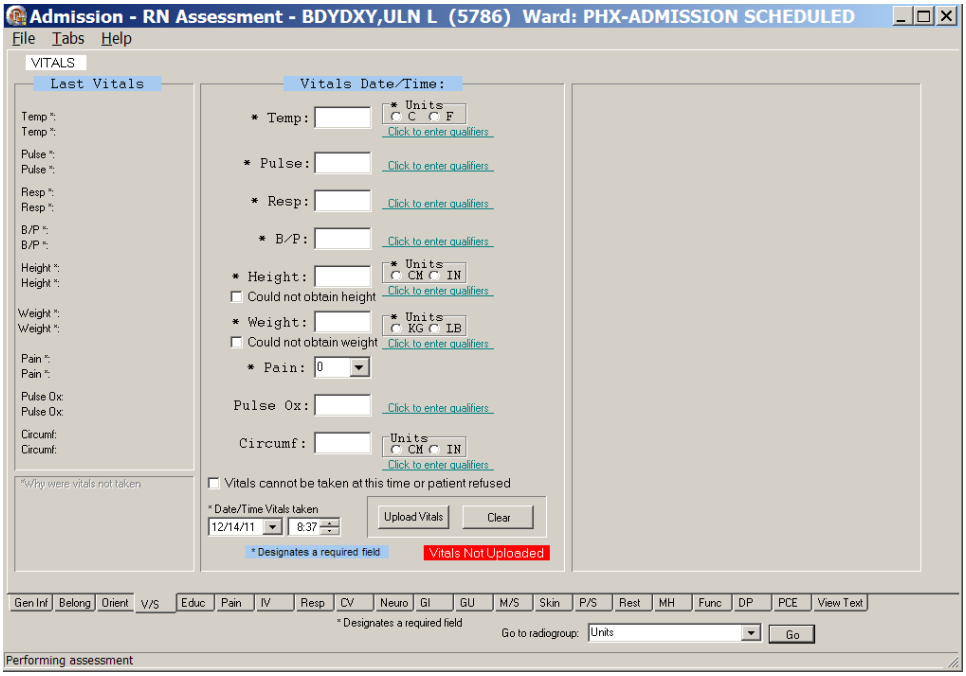
Emergency Contact Information for patient and support person

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

Vital Signs (V/S)

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

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



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

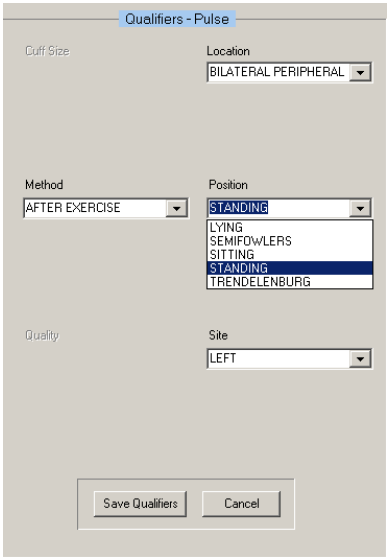
1. Click **V/S**.
   Vitals (V/S) displays.
   a. Complete all the fields with asterisks; they are required fields.
   b. Click each **Click to enter qualifiers**, to select qualifiers for each of the vitals.

   Note: Remember to enter units where appropriate.

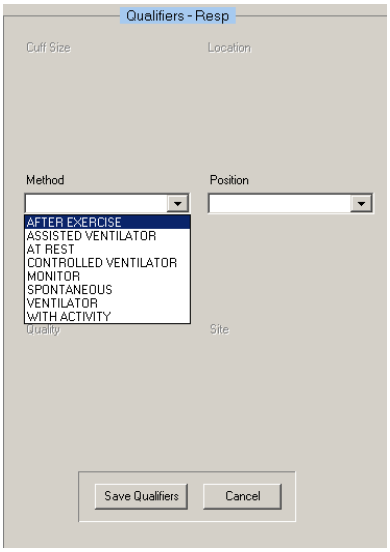
   Example

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

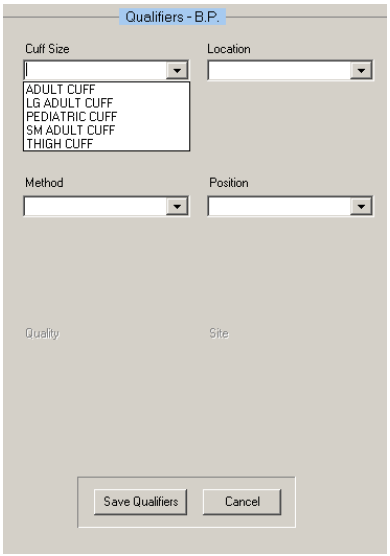
Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - Temp



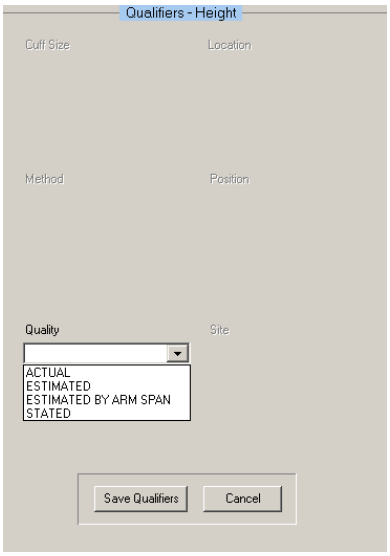
Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - Pulse



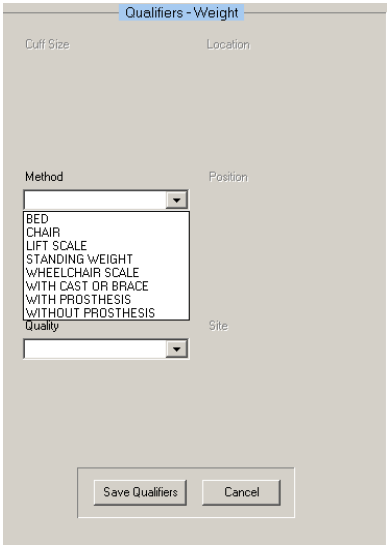
Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - Resp



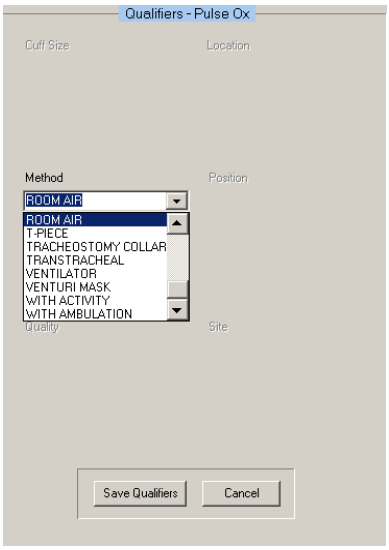
Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - BP



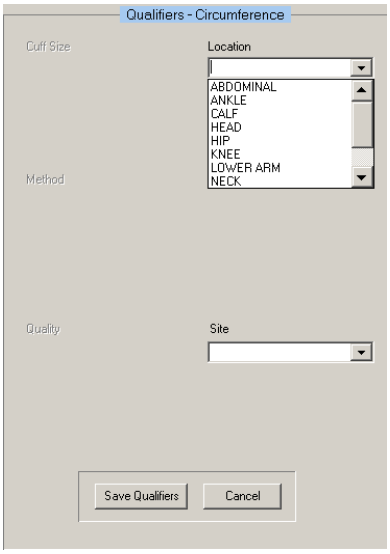
Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers – Height



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

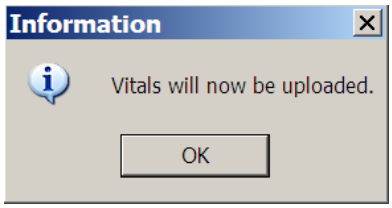


Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers – Pulse Ox



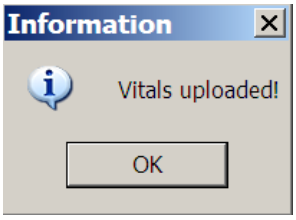
Admission – RN Assessment, Vitals (V/S) tab window, Qualifiers - Circumference

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



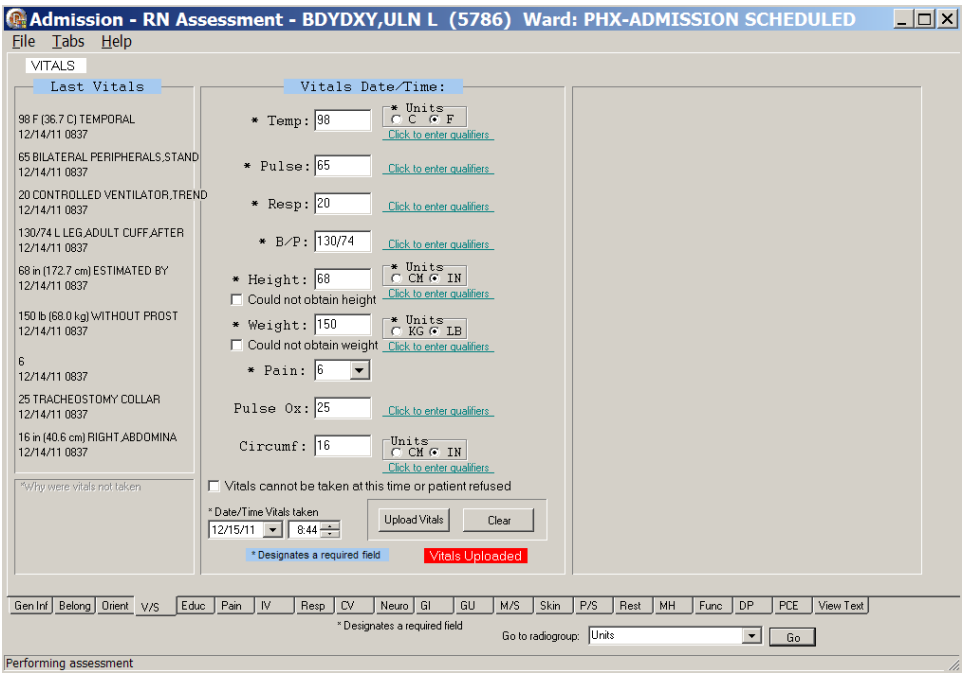
Information pop-up: Vitals will now be uploaded.

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



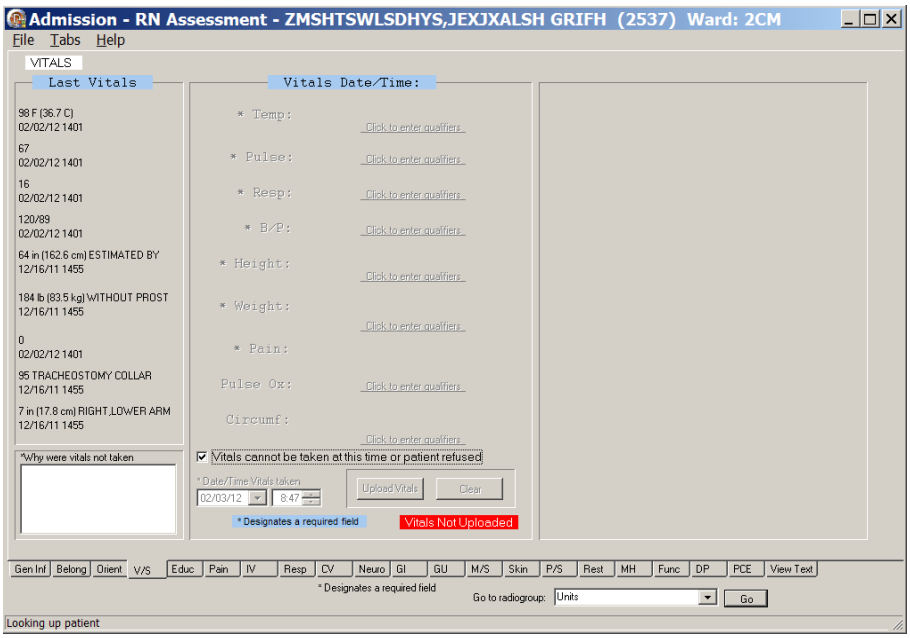
Information pop-up: Vitals uploaded!

b. Click **OK**.



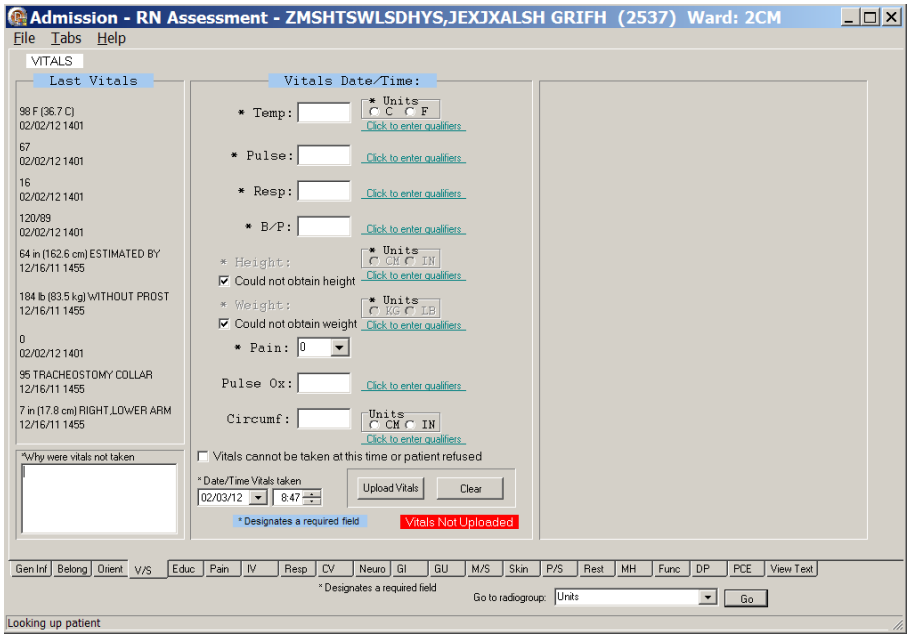
Admission – RN Assessment, Vitals (V/S) tab window
with Last Vitals

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



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

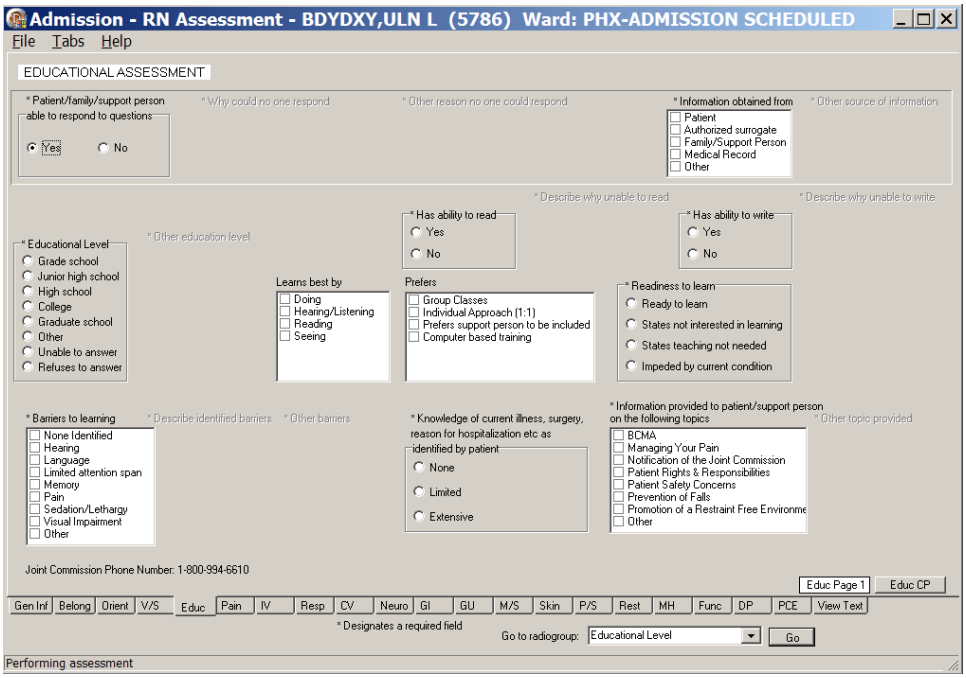
6. If you select the **Could not obtain height** and/or the **Could not obtain weight** check boxes at time of assessment, enter a reason in the ***Why were vitals not taken** text box in the lower left corner of the page.



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

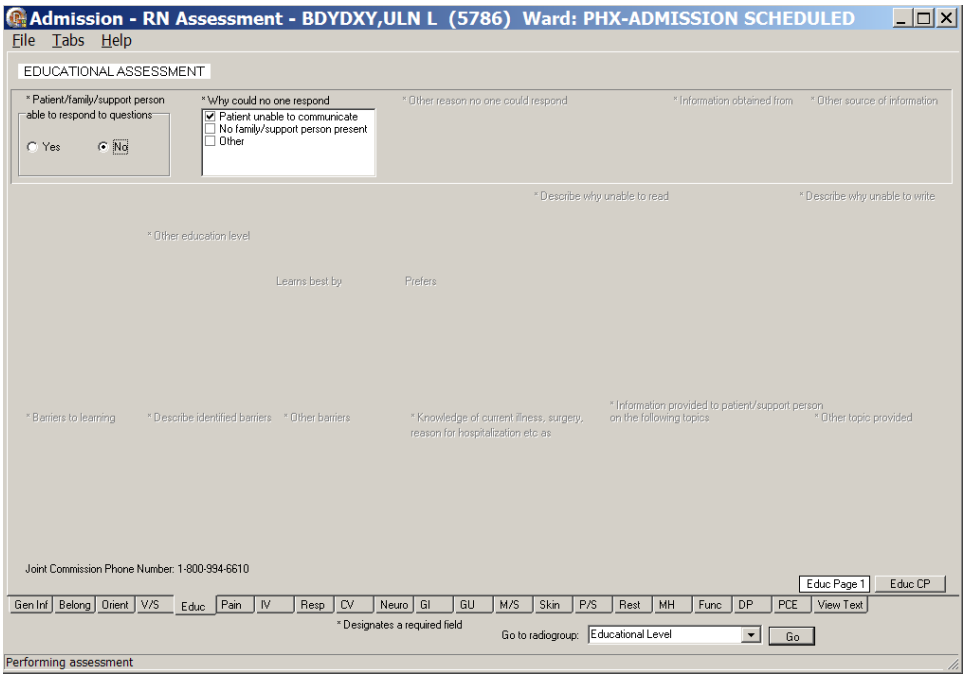
Education (Educ)

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



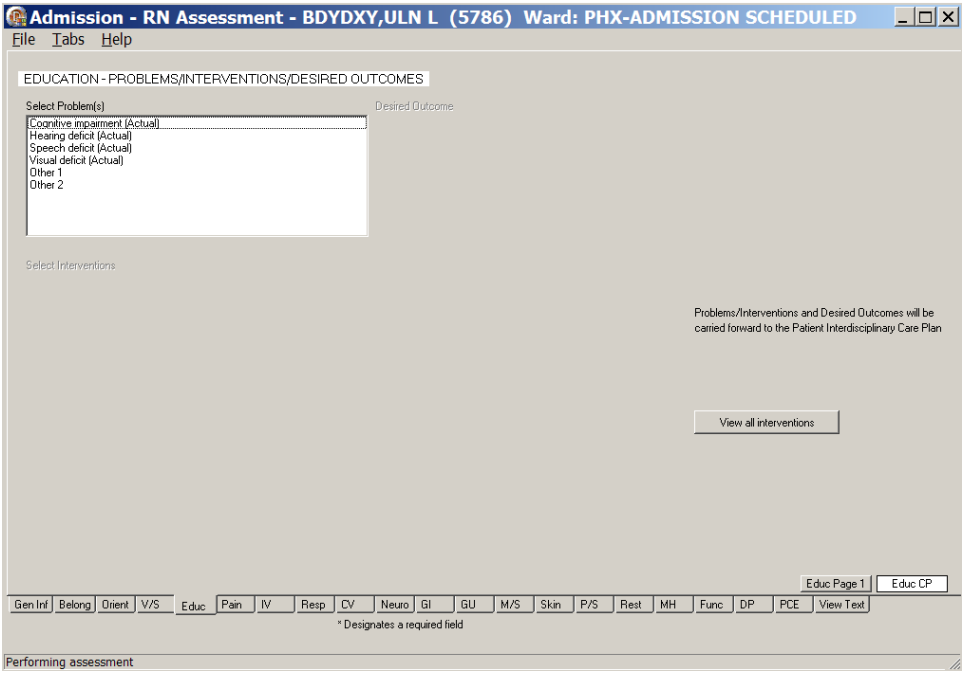
Admission – RN Assessment, Educational Assessment (Educ) tab, Educ Page 1 window
Patient/family/support person able to respond to questions/Yes

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



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

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

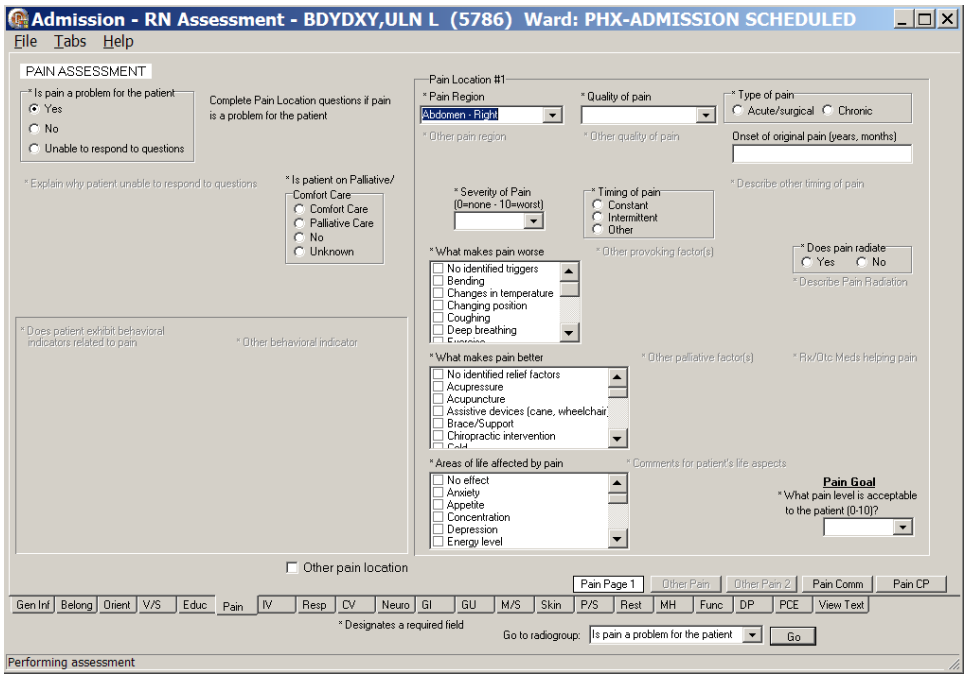


Admission – RN Assessment, Education – Problems/Interventions/Desired Outcomes, Educ CP window

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

Pain (Pain)

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

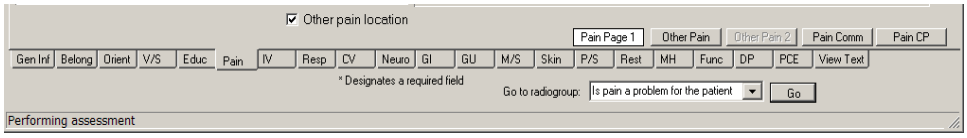


Admission – RN Assessment, Pain Assessment (Pain) tab, Pain Page 1 window
Is pain a problem for the patient/Yes

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

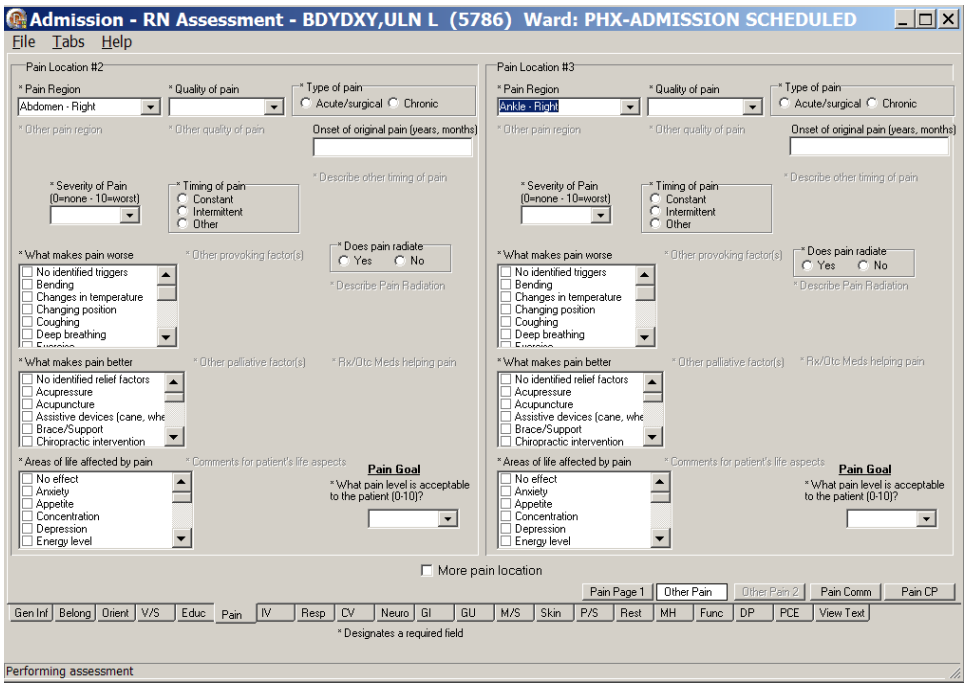
Is pain a problem for the patient/Yes

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



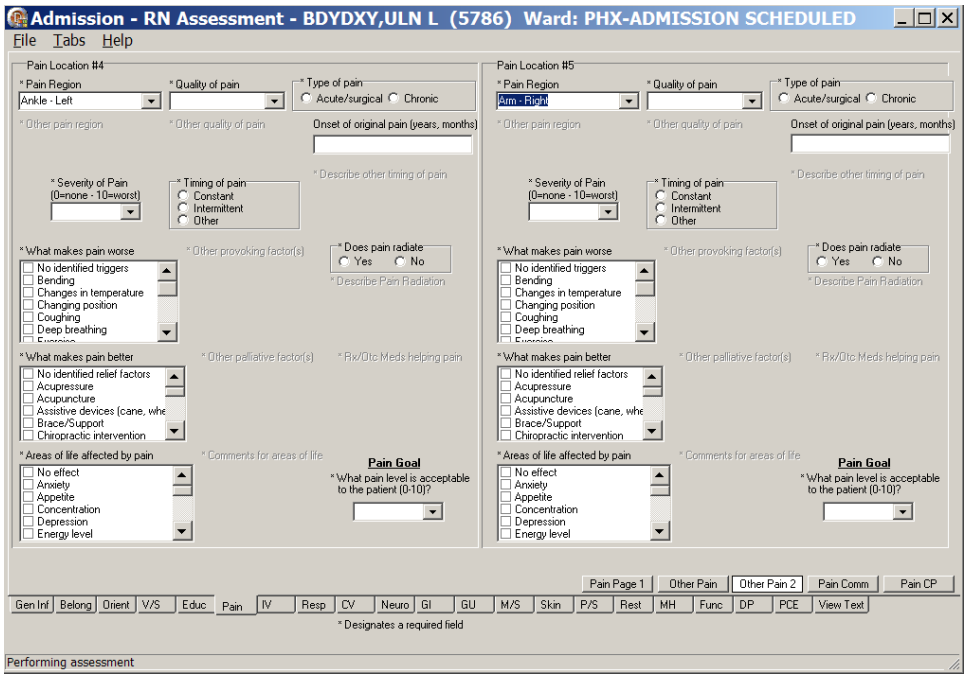
Admission – RN Assessment, Pain Assessment (Pain) tab, Pain Page 1 window
Other pain location selected

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



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

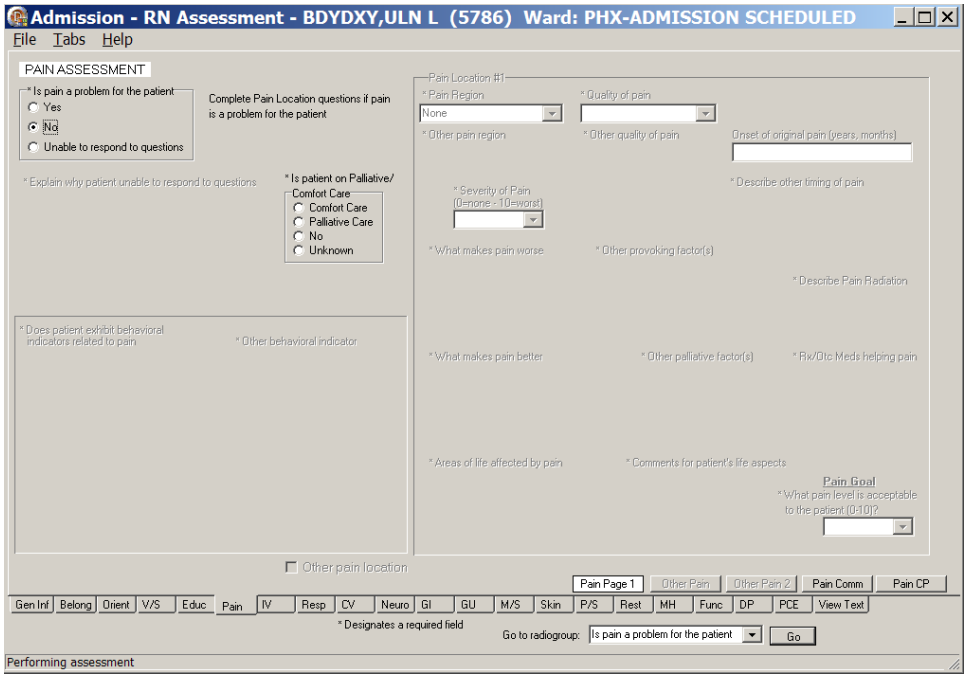
4. **Optional:** Populate the Other Pain page.
   a. Identify Pain Location #2/Pain Location #3 and document the behavioral indicators.
   b. Complete all fields with asterisks; they are required fields.
5. When Pain Locations #2 and #3 are complete and you have more pain locations to document, select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



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

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

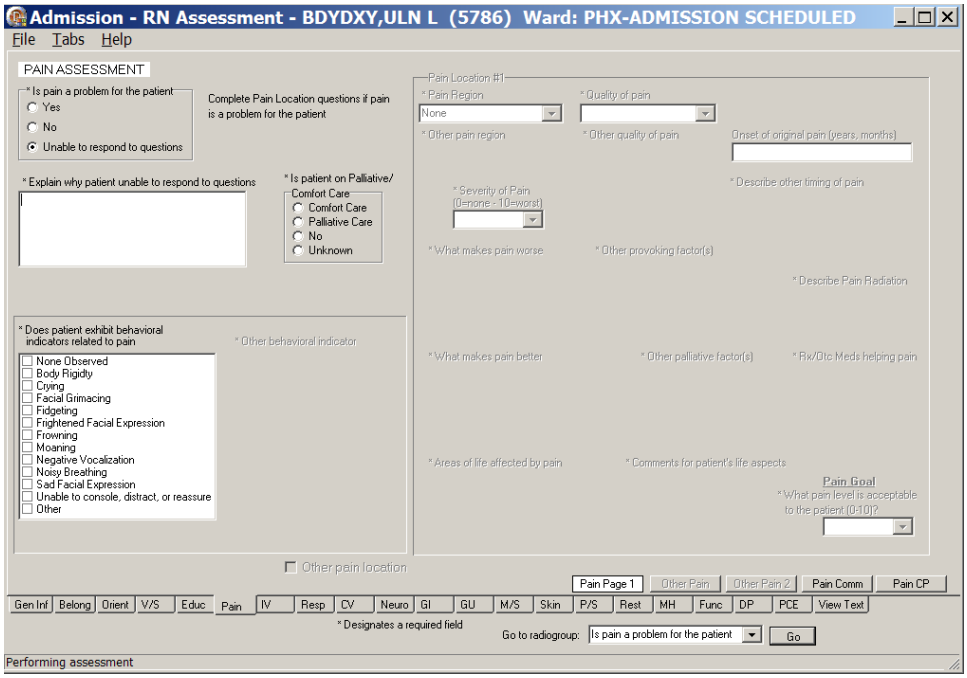
Is pain a problem for the patient/No



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

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

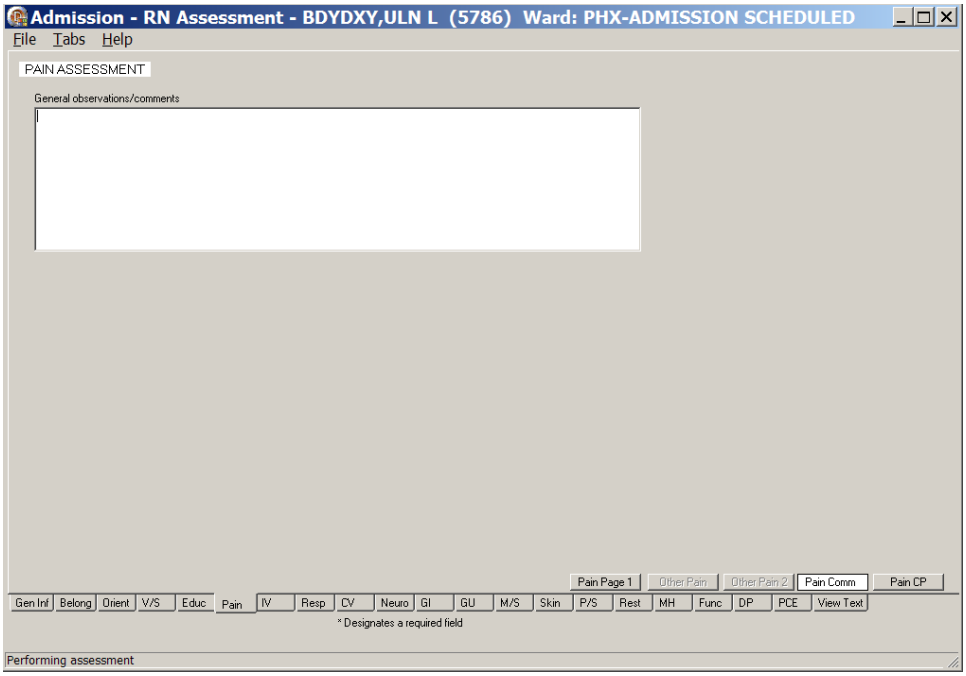
Is pain a problem for the patient/Unable to respond to questions



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

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

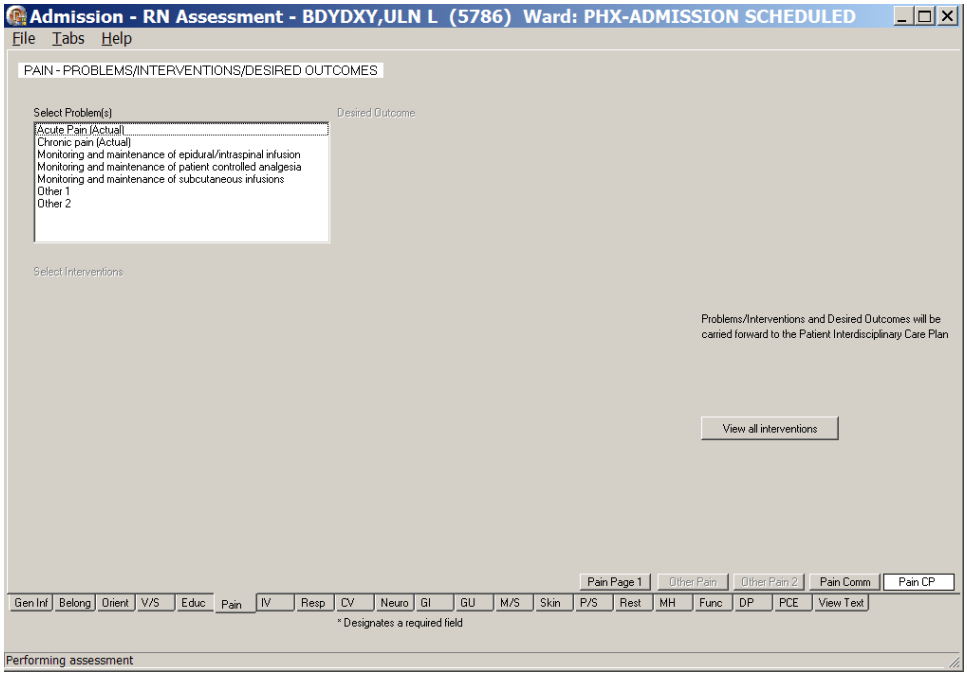
2. Click **Pain Comm**.
   Pain Comm displays.



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

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

4. Click **Pain CP**.
   Pain CP displays.



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

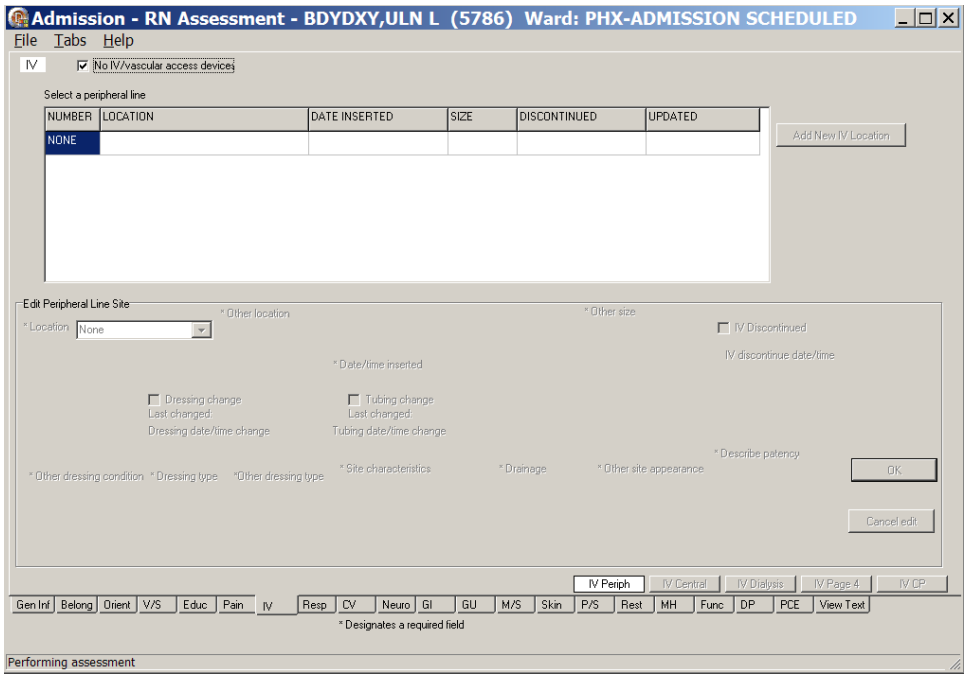
5. Populate Pain CP.
   Refer to the instructions in *Working in a Care Plans* on page 11.

IV (IV)

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

No IV/Vascular Access Devices

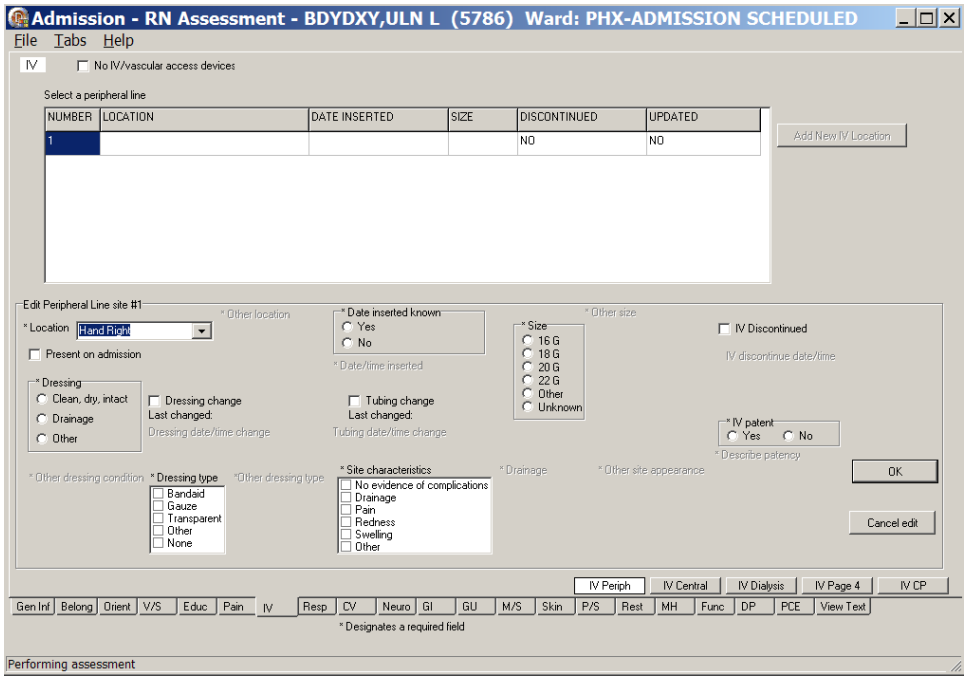
1. Click **IV**.
   IV Periph displays.
2. If a patient has no IVs or dialysis access in place, select the **No IV/vascular access devices** check box and none of the IV pages or **Add New IV Location** are available.
3. Move to the next tab.



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

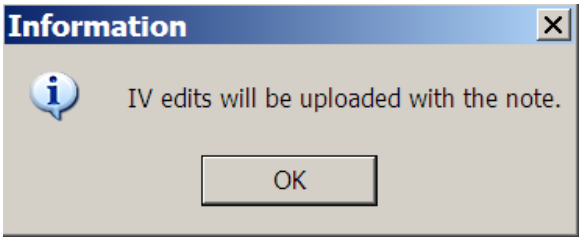
Peripheral Lines - IV Periph

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



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

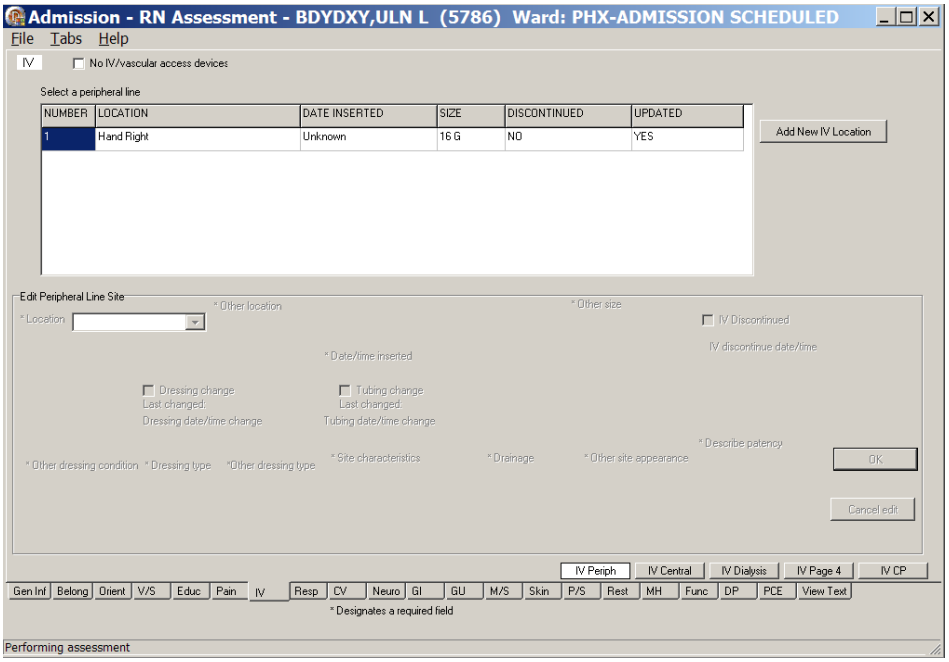
4. Select a location.
   Additional fields become available.
5. Complete all the fields with asterisks; they are required fields.
6. To cancel entered data *before upload*, click **Cancel edit**.
7. To upload the data, click **OK**.
   Information pop-up displays.



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

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

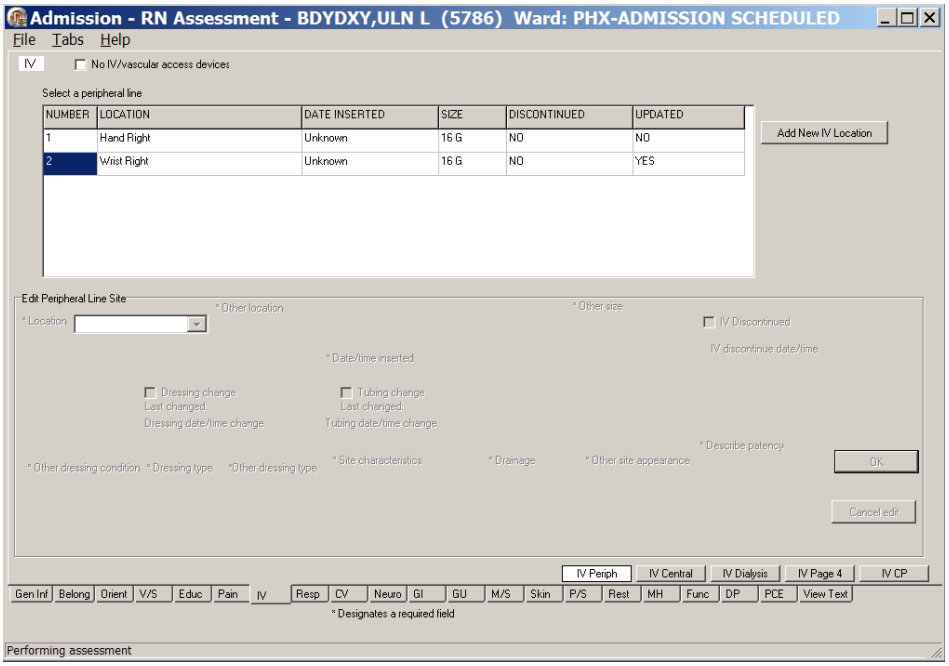
8. Click **OK**.
   IV Periph tab redisplays with a location added.



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

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

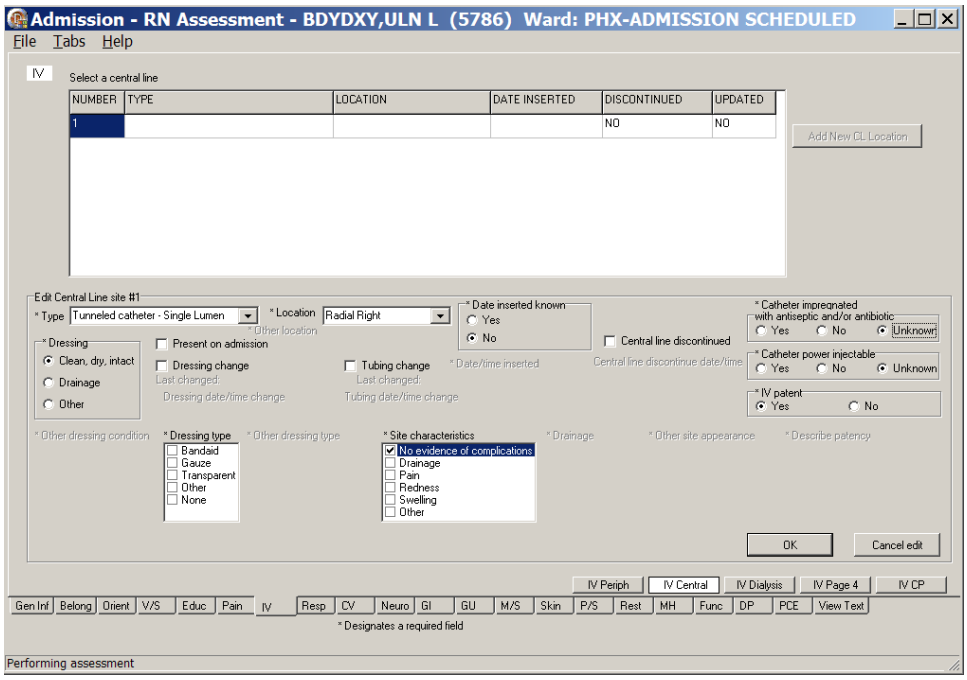
Note: There is no limit to the number of IV locations you can enter.



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

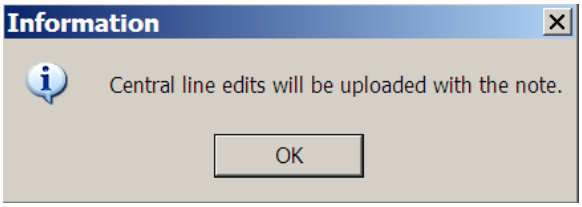
Central IV Lines – IV Central

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



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

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

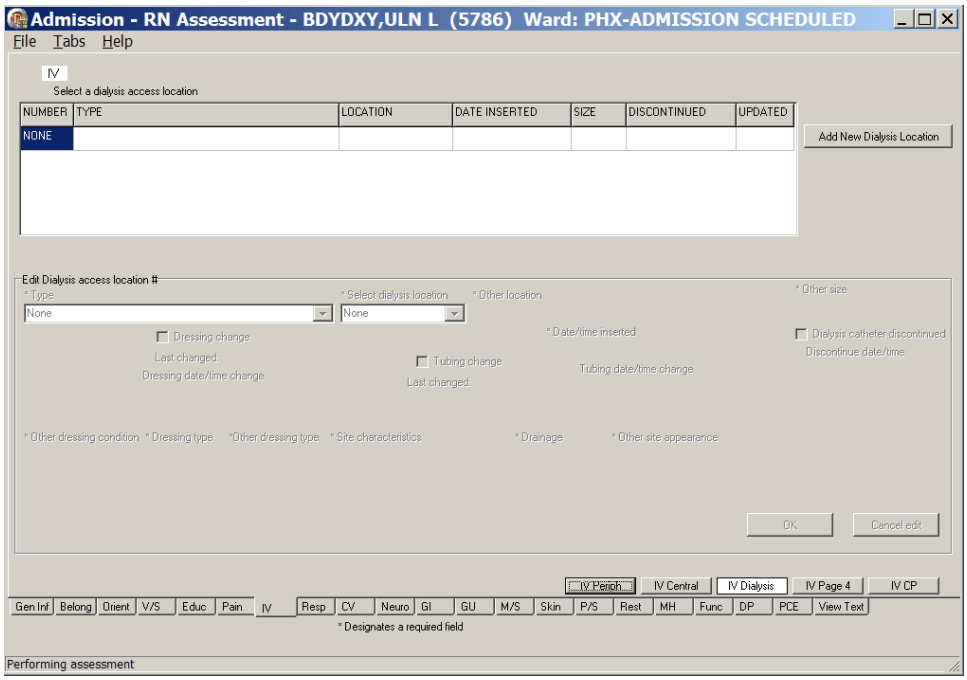


Information pop-up: Central line edits will be uploaded with the note.

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

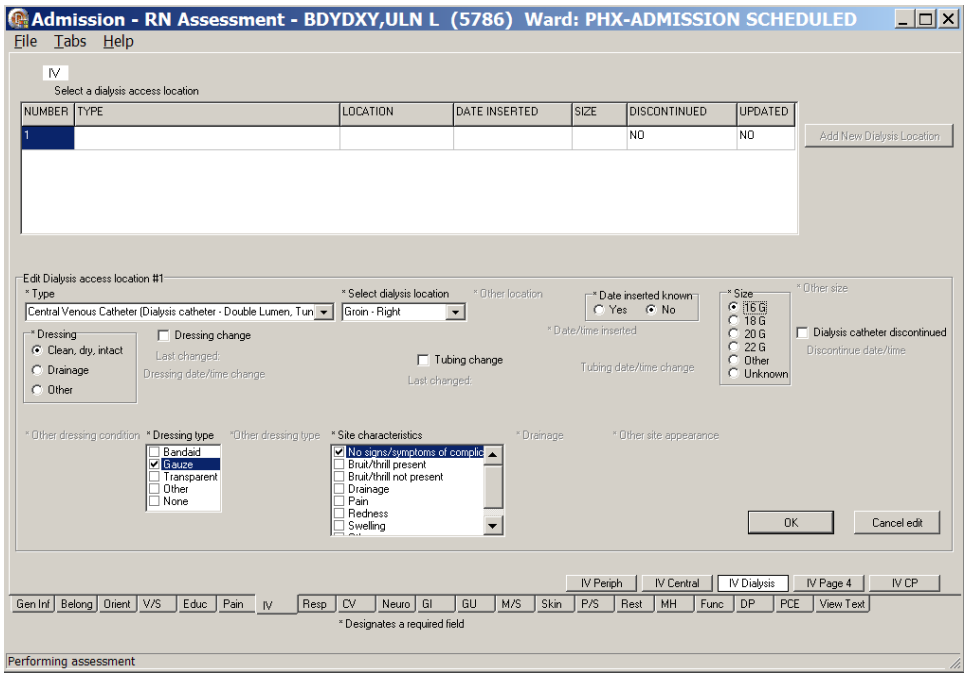
Dialysis Ports - IV Dialysis

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



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

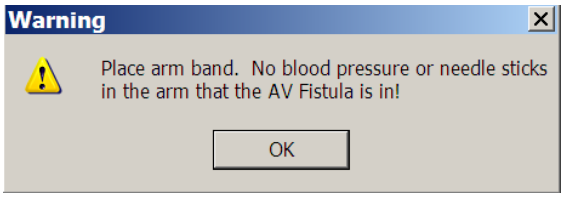
3. Click **Add New Dialysis Location**.
   The Type and Select Dialysis location drop-down list boxes display in the **Edit Dialysis access location #1** section.



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

4. Select a type and a location.

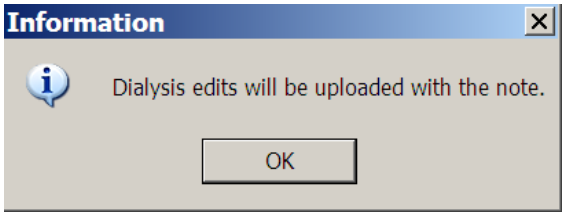
   Note: When you select **AV Fistula** or **AV Graft for Type**, a warning message displays to advise against using the patient's affected arm for BP or needle sticks. You must place an arm band on the affected limb to prevent any mishaps.



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

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

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

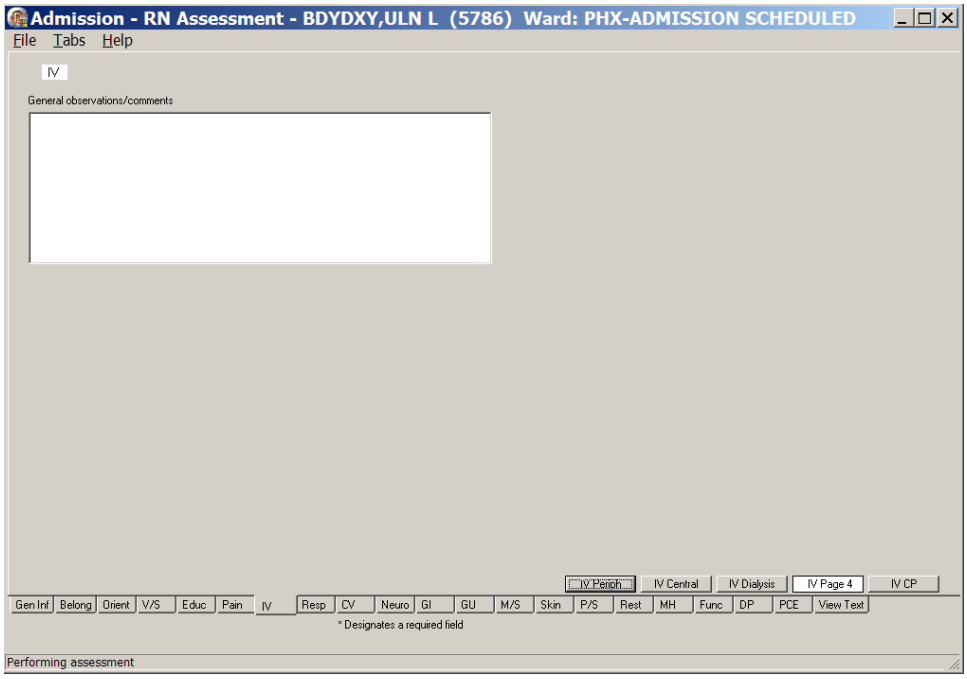


Information pop-up: Dialysis edits will be uploaded with the note.

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

General Observations/Comments – IV Page 4

1. Click **IV Page 4**.
   IV Page 4 displays.

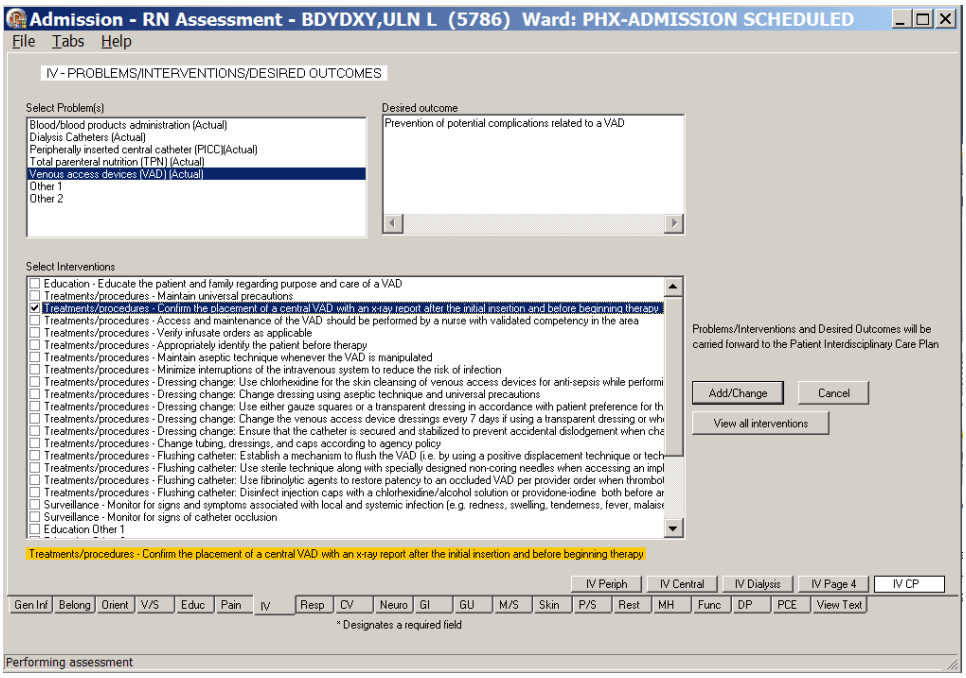


Admission – RN Assessment, IV (IV) tab, IV Page 4 window

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

Care Plan - IV CP

1. Click **IV CP**.
   IV CP displays.

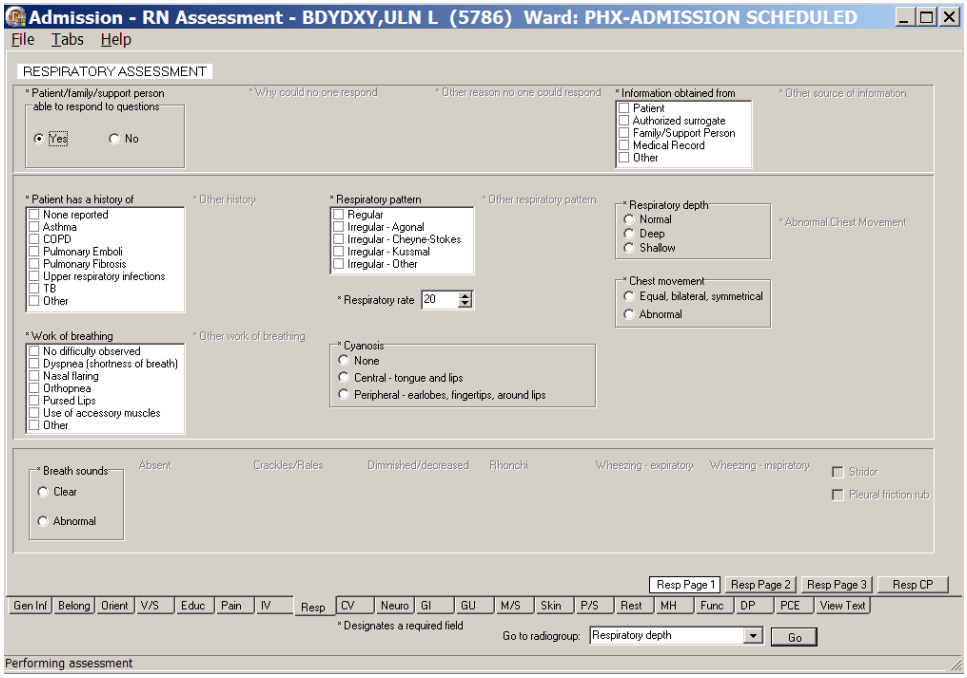


Admission – RN Assessment, IV – Problems/Interventions/Desired Outcomes, IV CP window

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

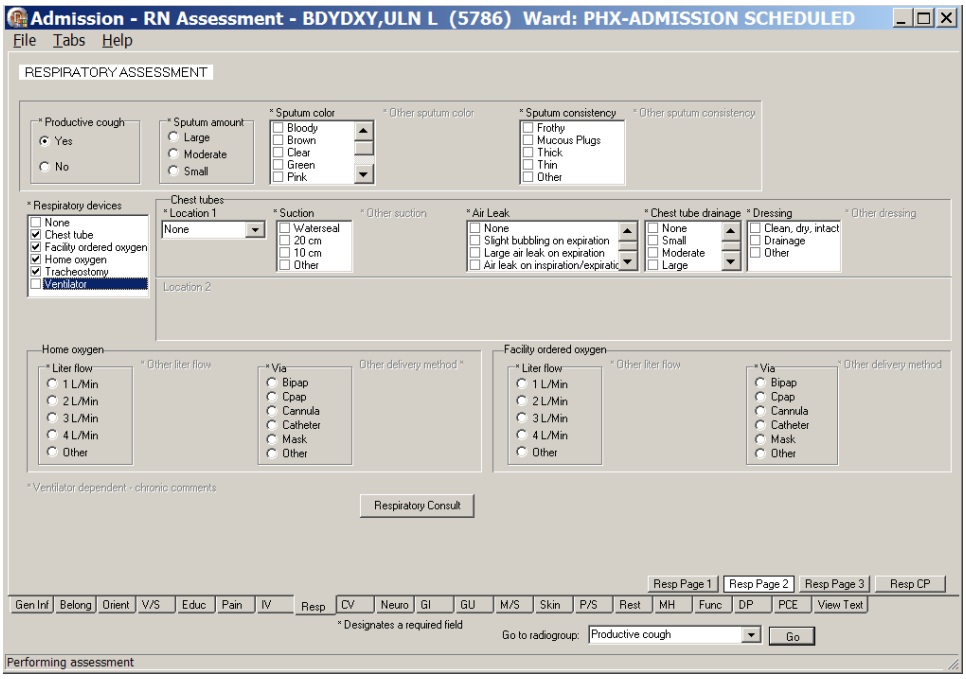
Respiratory (Resp)

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



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

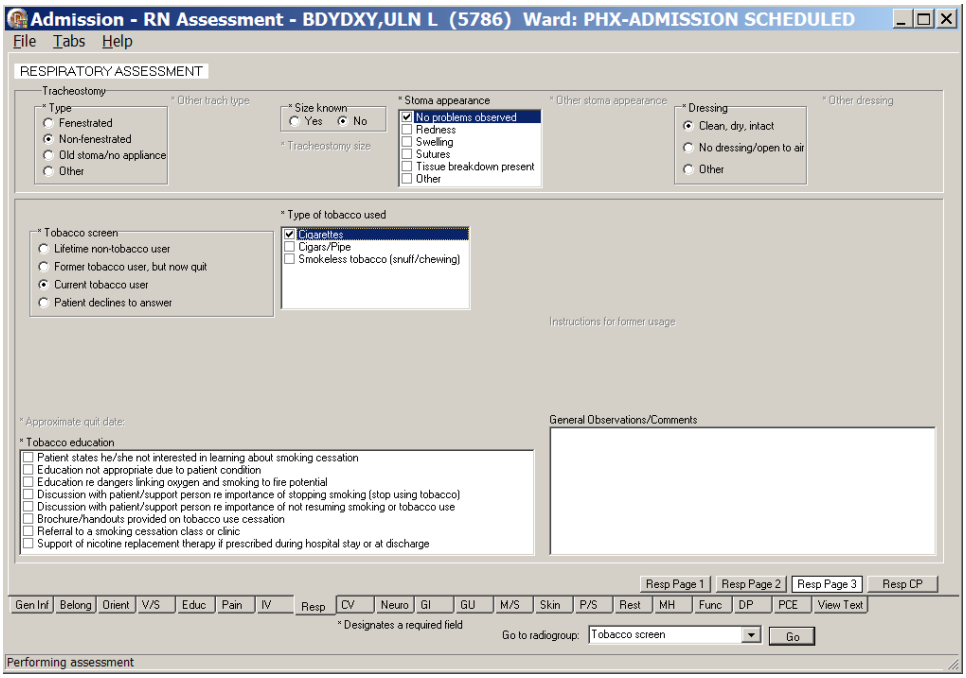
1. Click **Resp**.
   Resp Page 1 displays.
2. Populate Resp Page 1.
   a. Use the **Respiratory rate** text box to enter the patient's current respiratory rate.
   b. Complete all the fields with asterisks; they are required fields.
3. Click **Resp Page 2**.
   Resp Page 2 displays.



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

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

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

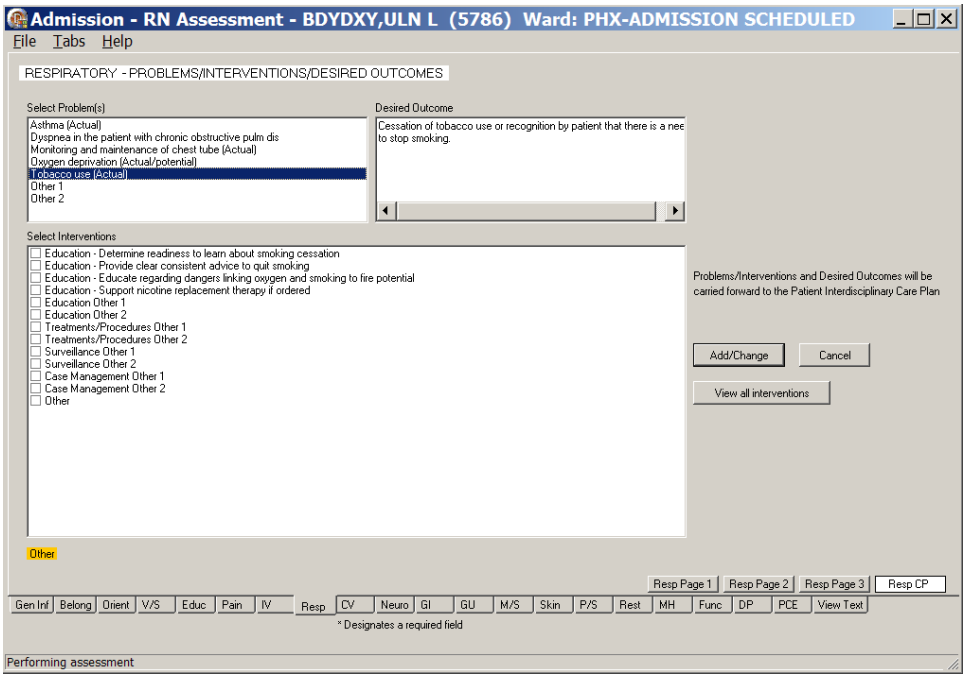


Admission – RN Assessment, Respiratory - Problems/Interventions/Desired Outcomes, Resp Page 3 window contains the Tobacco screen

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

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

7. Click **Resp CP**.
   Resp CP displays.

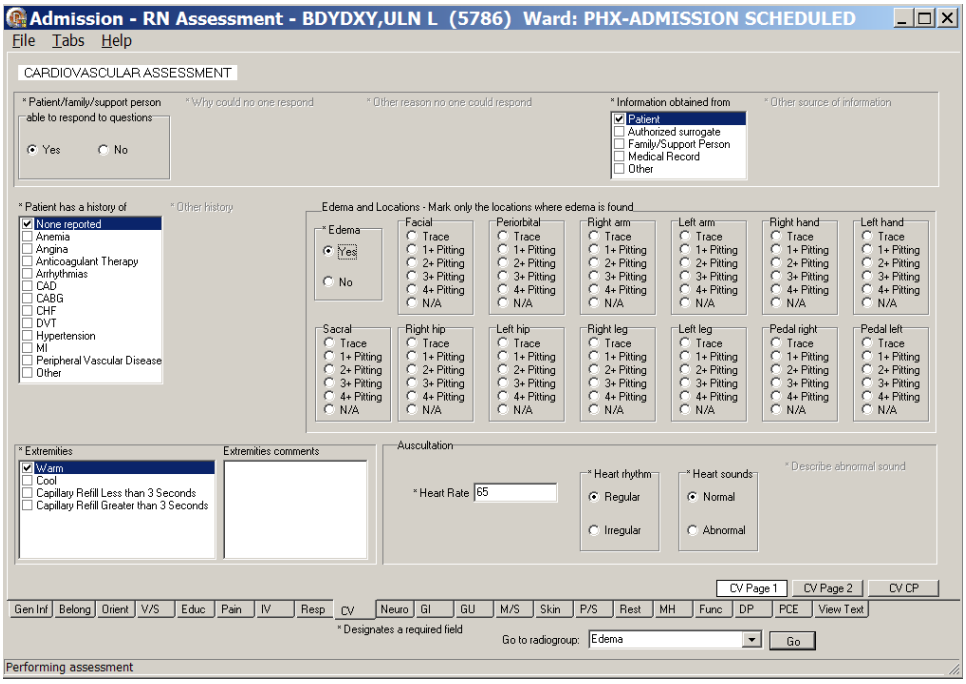


Admission – RN Assessment, Respiratory - Problems/Interventions/Desired Outcomes, Resp CP window

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

Cardiovascular (CV)

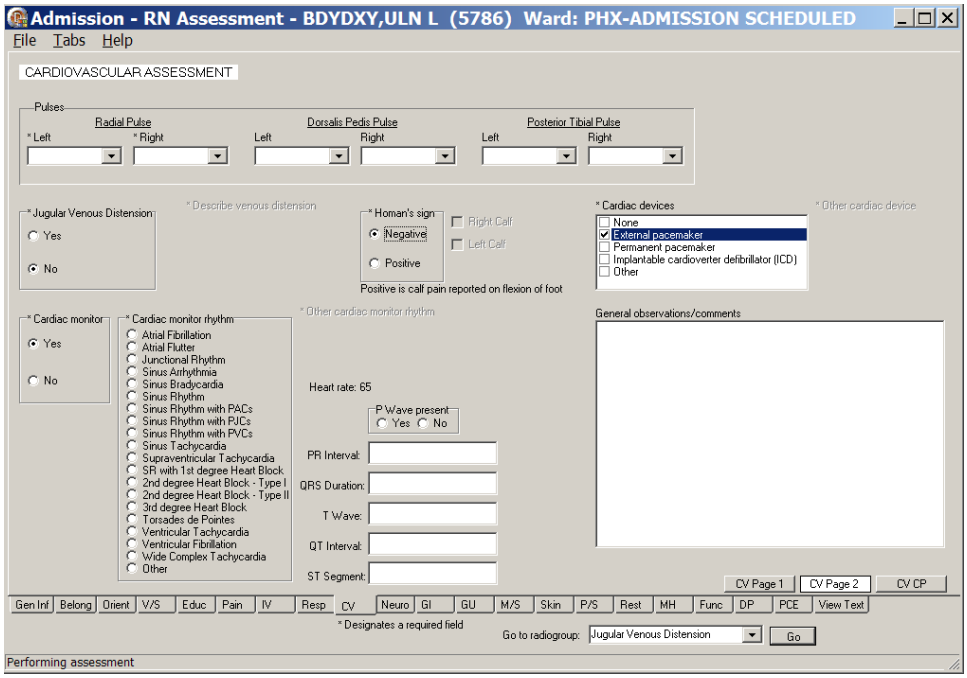
The Cardiovascular Assessment tab contains a history of the patient's cardiovascular health.



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

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

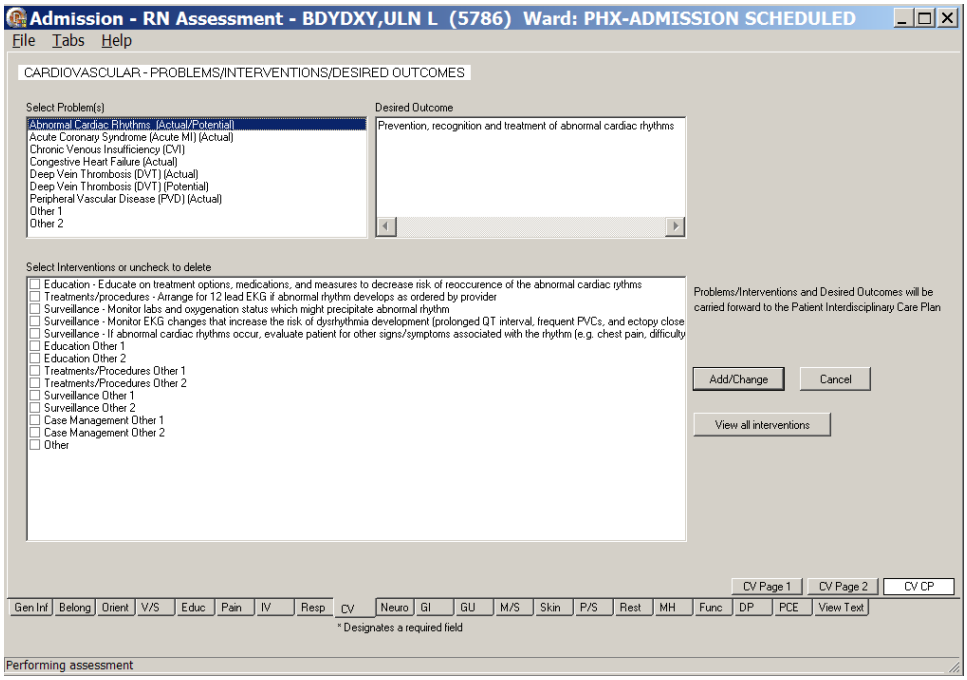
3. Click **CV Page 2**.
   CV Page 2 displays.



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

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

5. Click **CV CP.**
   CV CP displays.



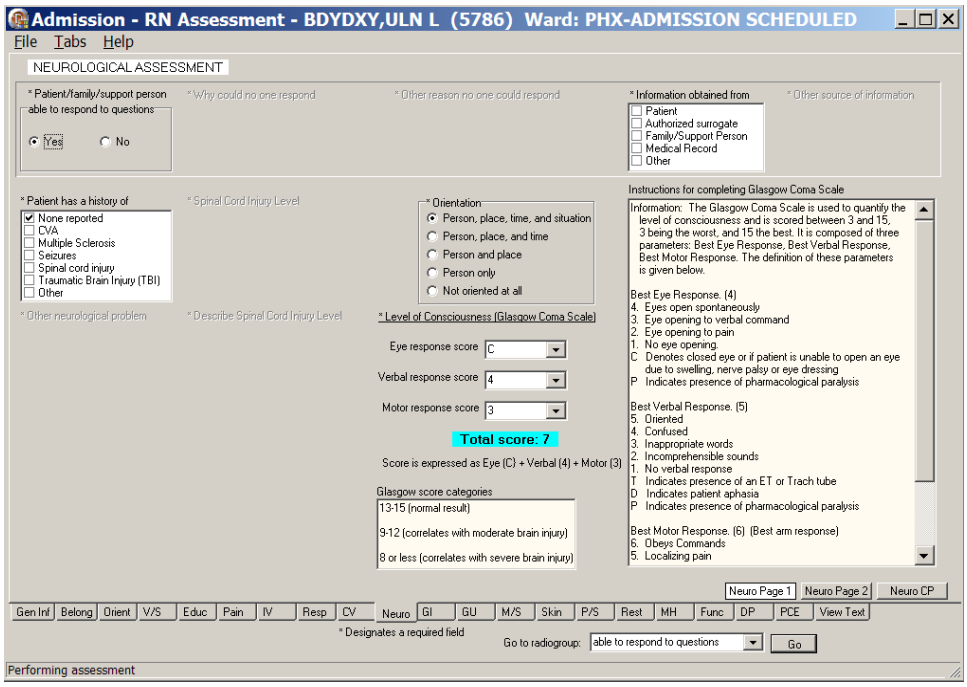
Admission – RN Assessment, Cardiovascular – Problems/Interventions/Desired Outcomes, CV CP window

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

Neurology (Neuro)

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

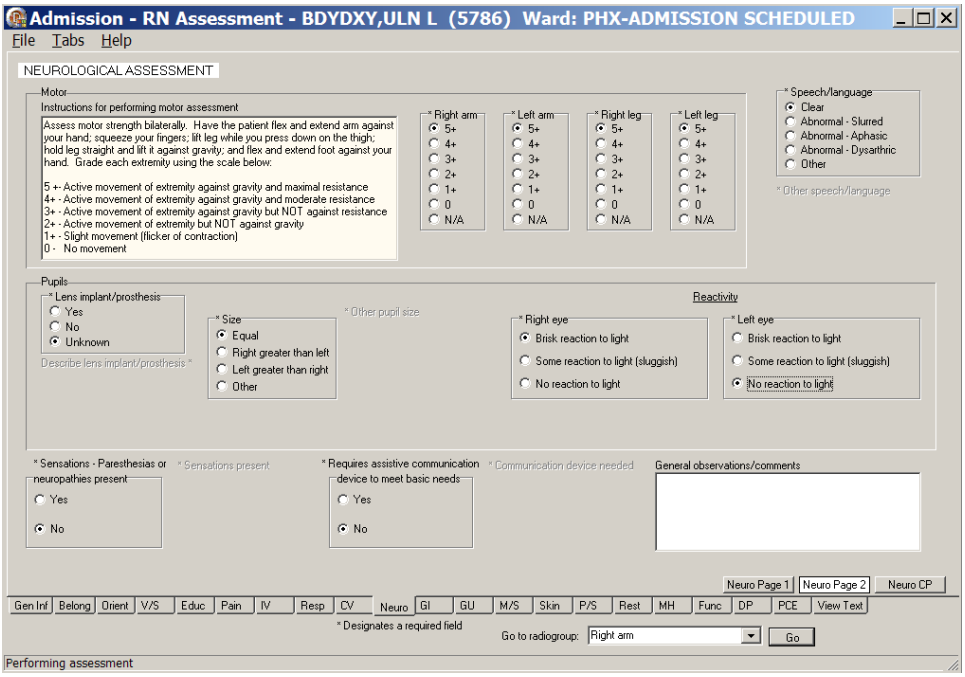
The directions for the *Glasgow Coma Scale* are on Neuro Page 1. The score is automatically calculated and transferred to the finished RN Admission Assessment note.



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

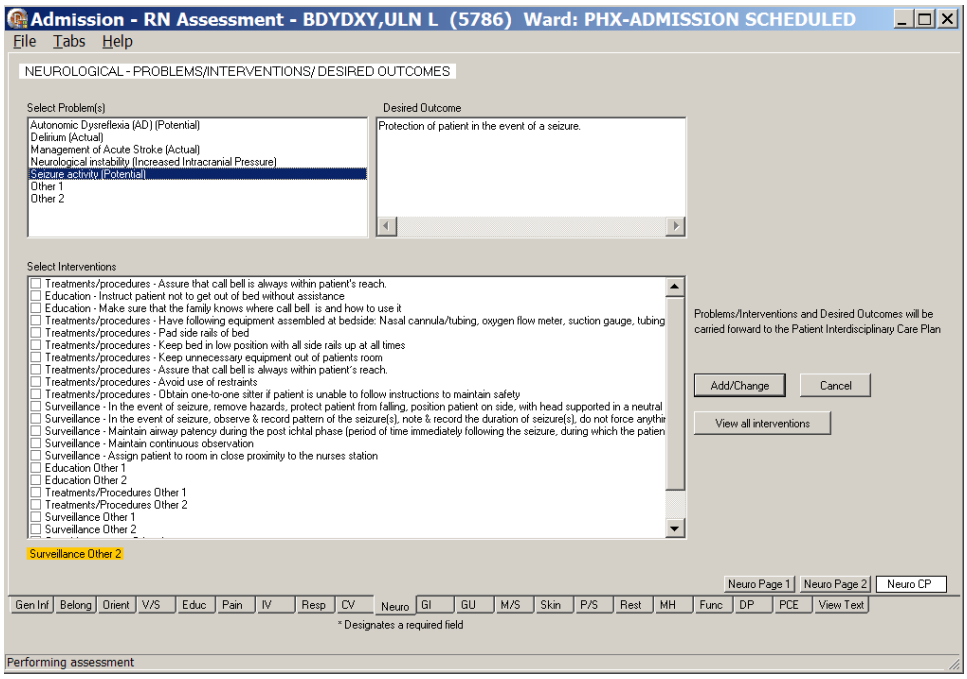
1. Click **Neuro**.
   Neuro Page 1 displays.
2. Populate Neuro Page 1.
   Complete all the fields with asterisks; they are required fields.

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



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

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



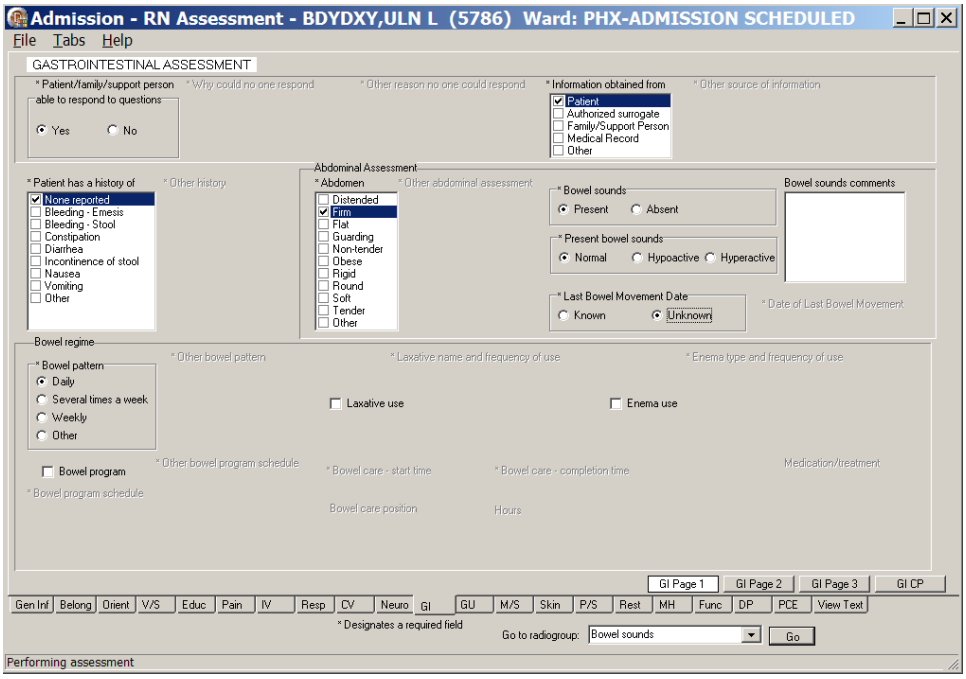
Admission – RN Assessment, Neurological Assessment (Neuro) tab, Neuro CP window

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

Gastrointestinal (GI)

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

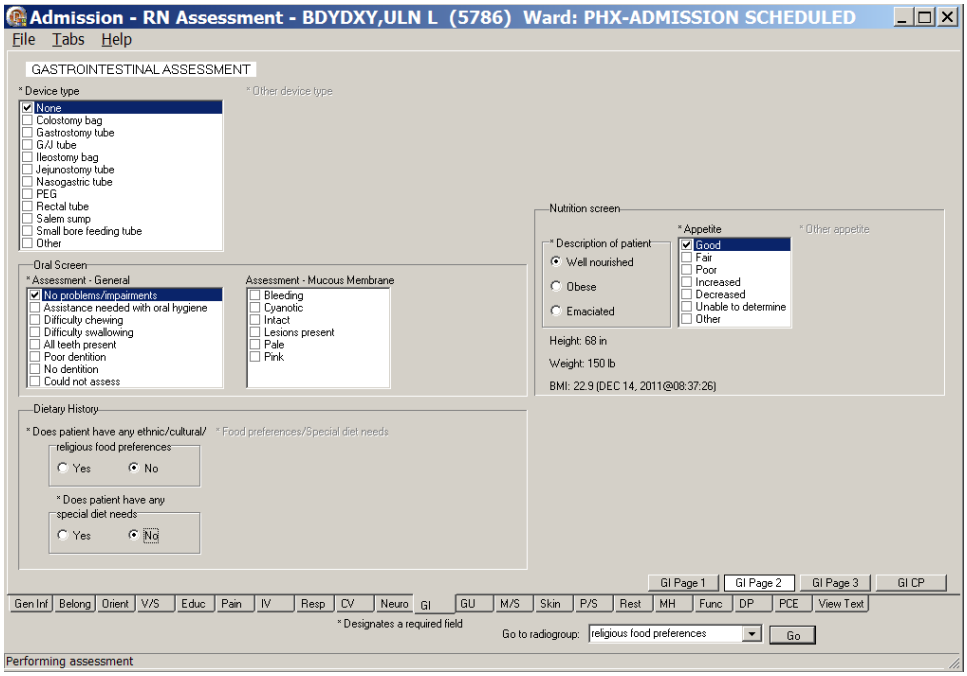
- On GI Page 3, when any items listed under the **Nutrition consult guidelines** are selected, a Nutrition Consult is required.
- On GI Page 3, when any Dysphagia question is answered with **Yes**, a Speech Consult is required.



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

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

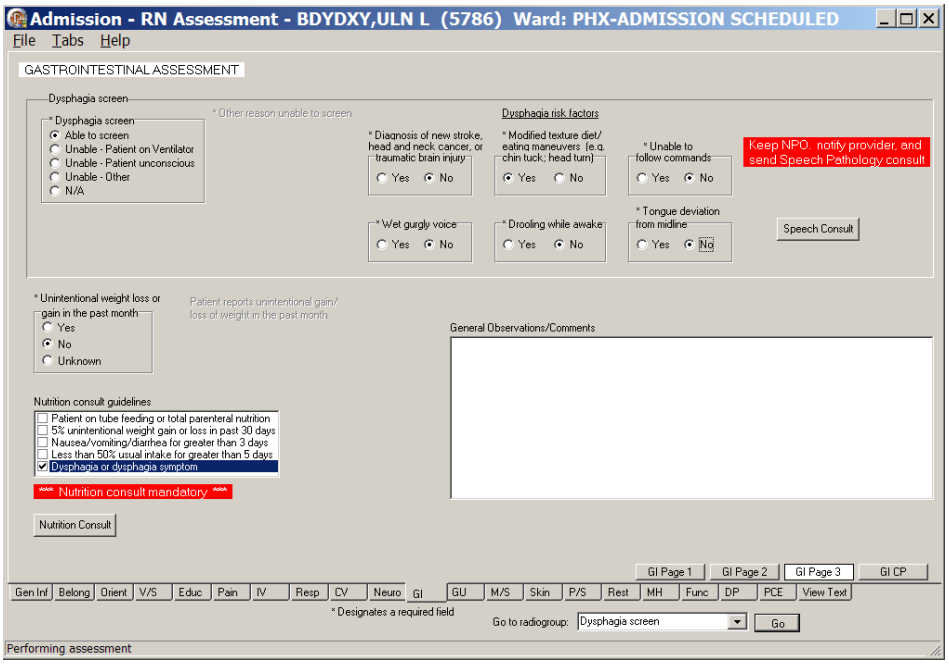
3. Click **GI Page 2**.
   GI Page 2 displays.



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

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

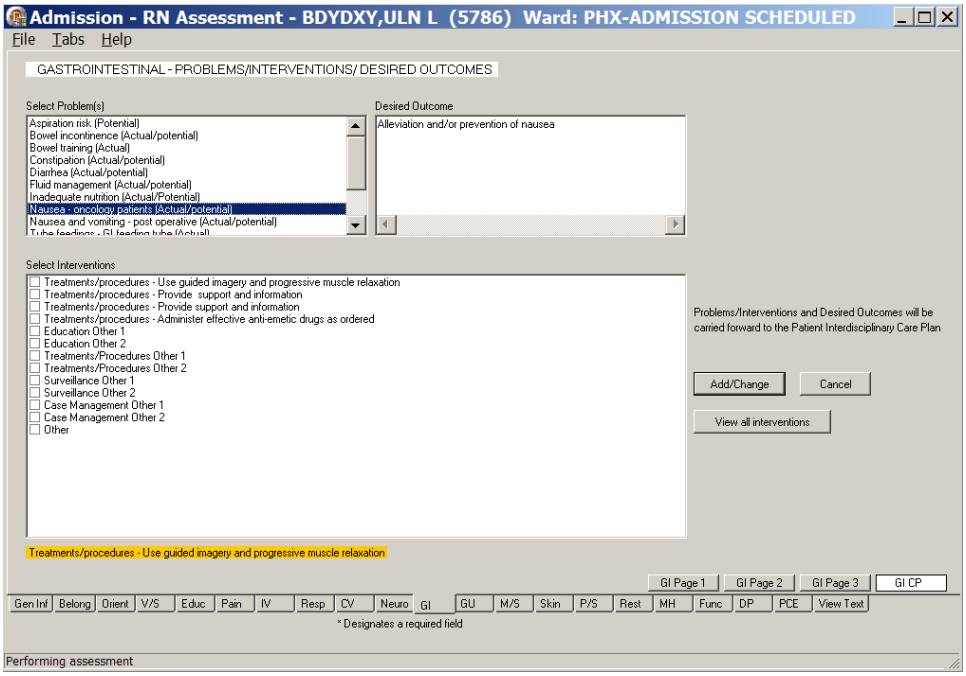
5. Click **GI Page 3**.
   GI Page 3 displays.



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

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

7. Click **GI CP**.
   GI CP displays.

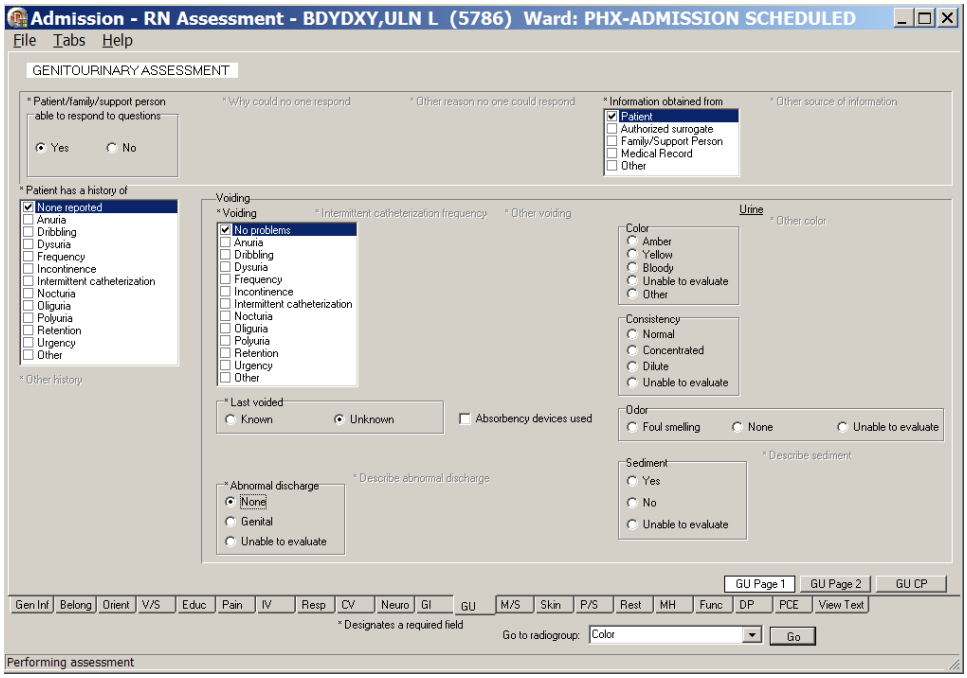


Admission – RN Assessment, Gastrointestinal – Problems/Interventions/Desired Outcomes, GI CP window

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

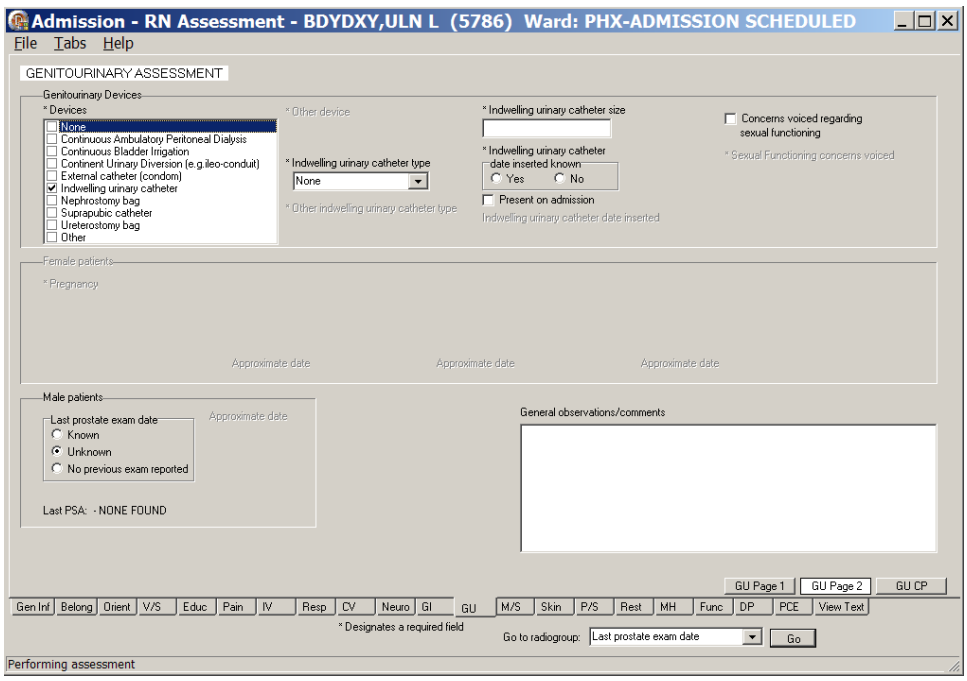
Genitourinary (GU)

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

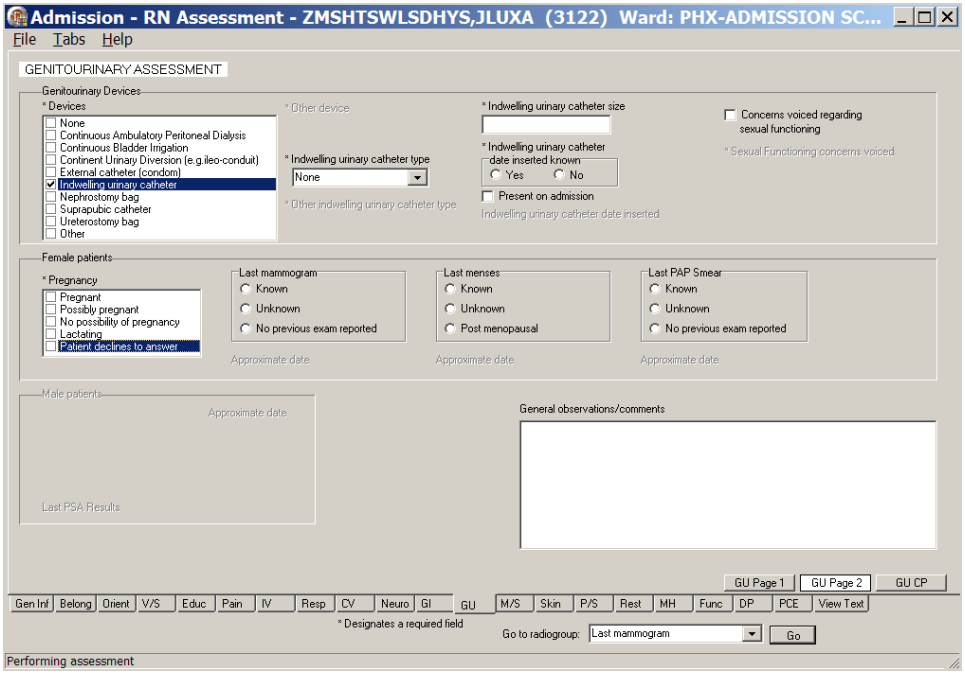


Admission – RN Assessment, Genitourinary Assessment (GU) tab, GU Page 1 window

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



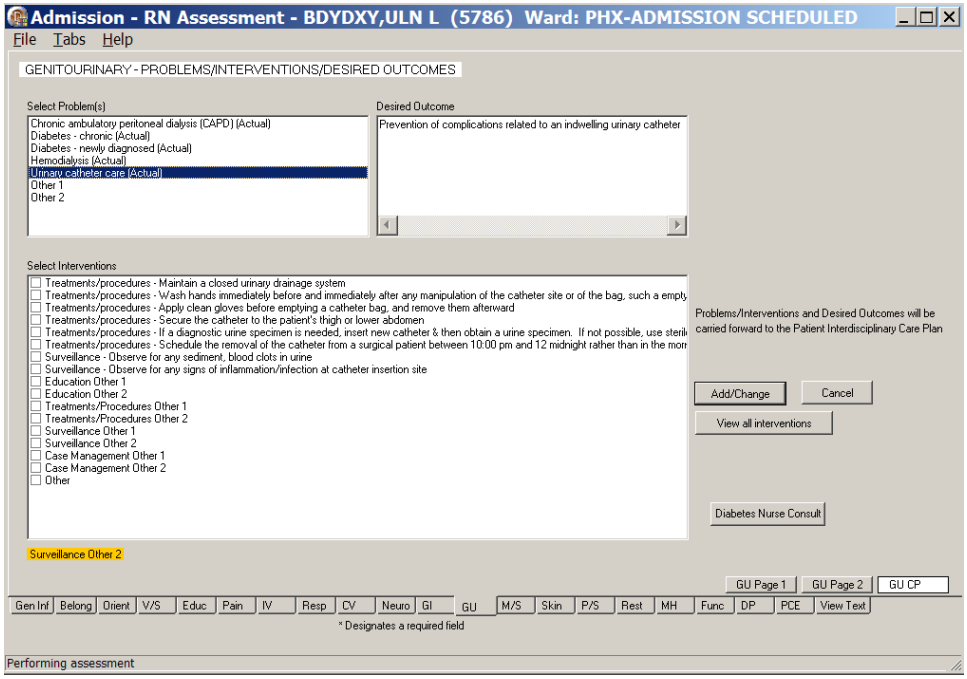
Admission – RN Assessment, Genitourinary Assessment (GU) tab, GU Page 2 window
Male patient information available



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

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

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



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

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

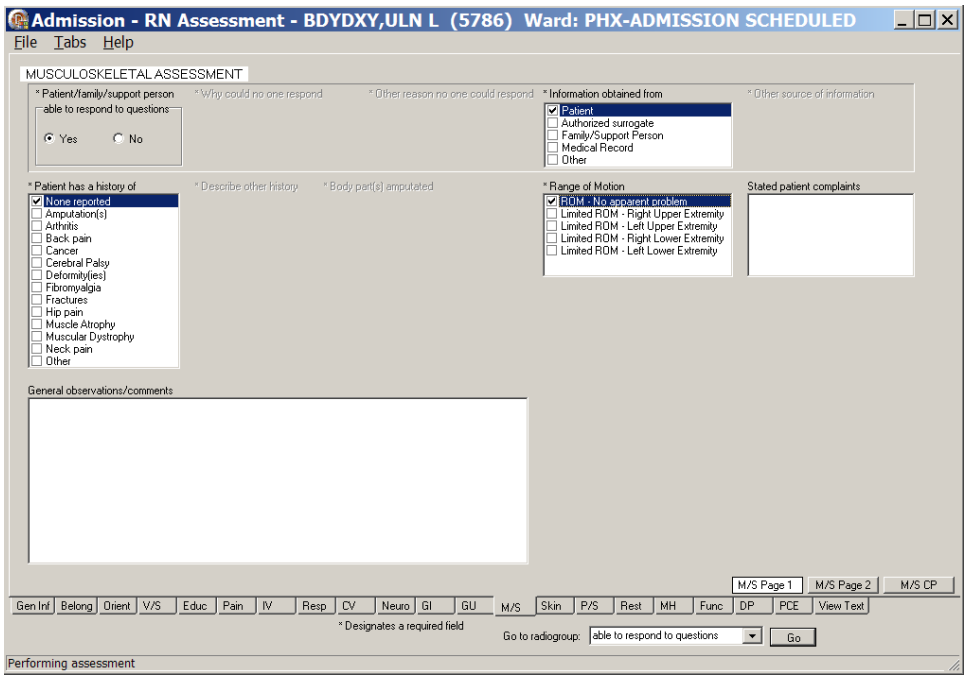
Musculoskeletal (M/S)

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

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

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

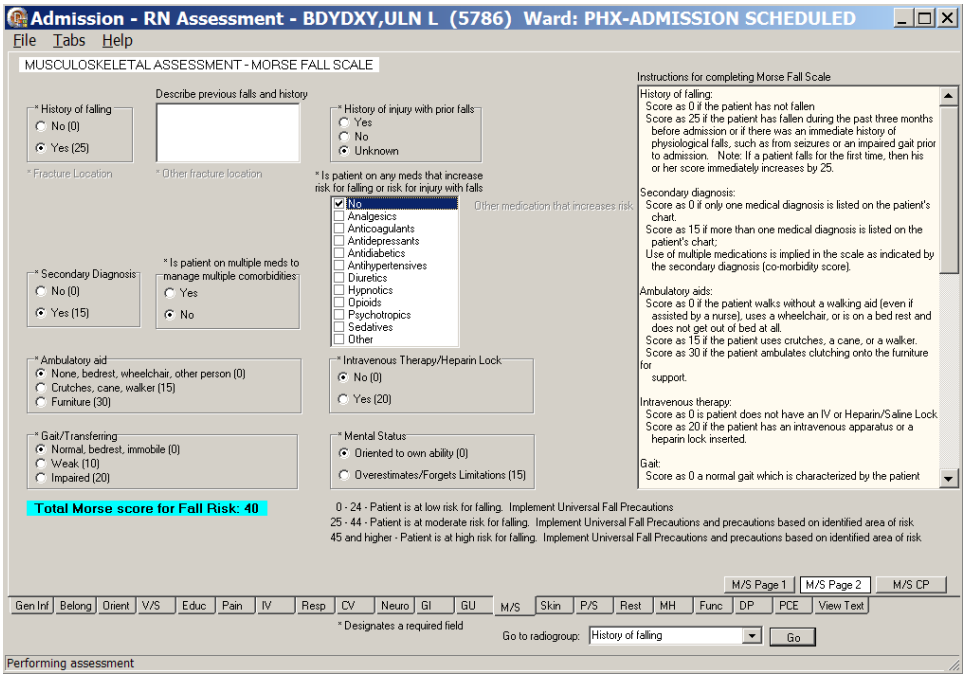
1. Click **M/S**.
   M/S Page 1 displays.



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

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

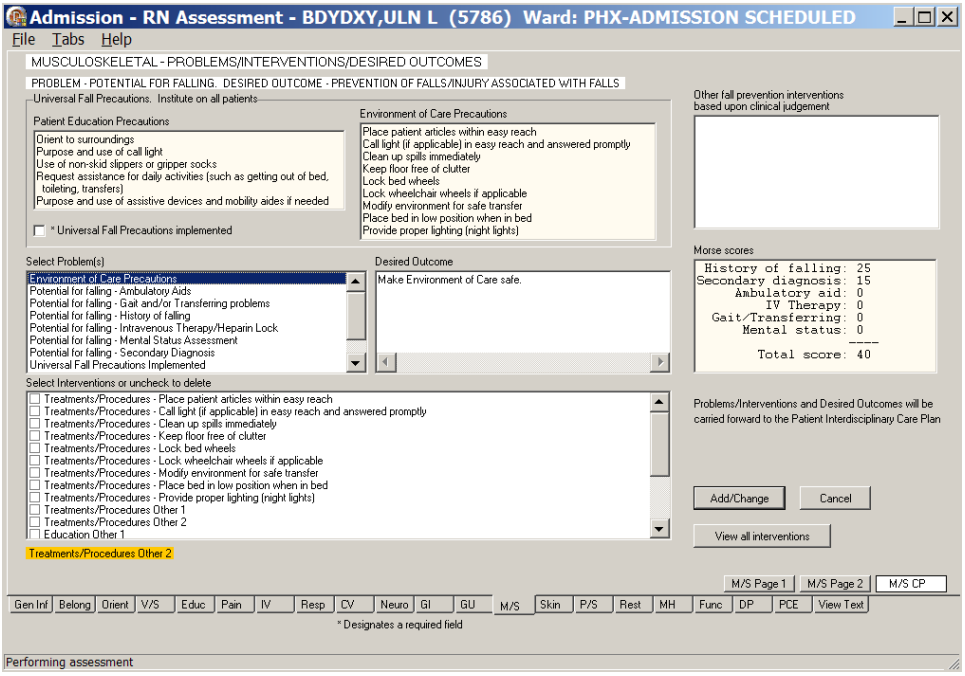
3. Click **M/S Page 2**.
   M/S Page 2 displays.



Admission – RN Assessment, 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. Click **M/S CP**.
   M/S CP displays.



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

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

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

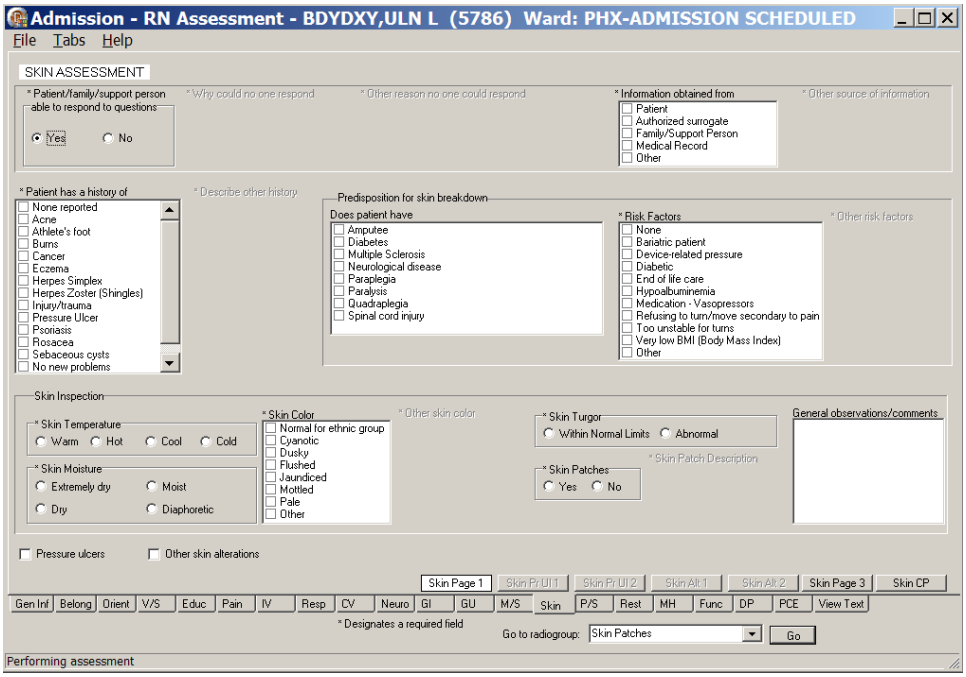
Skin (Skin)

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

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

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

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

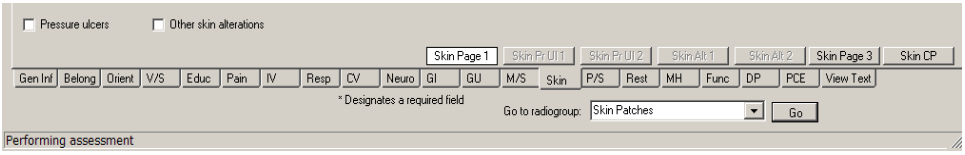


Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Page 1 window

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

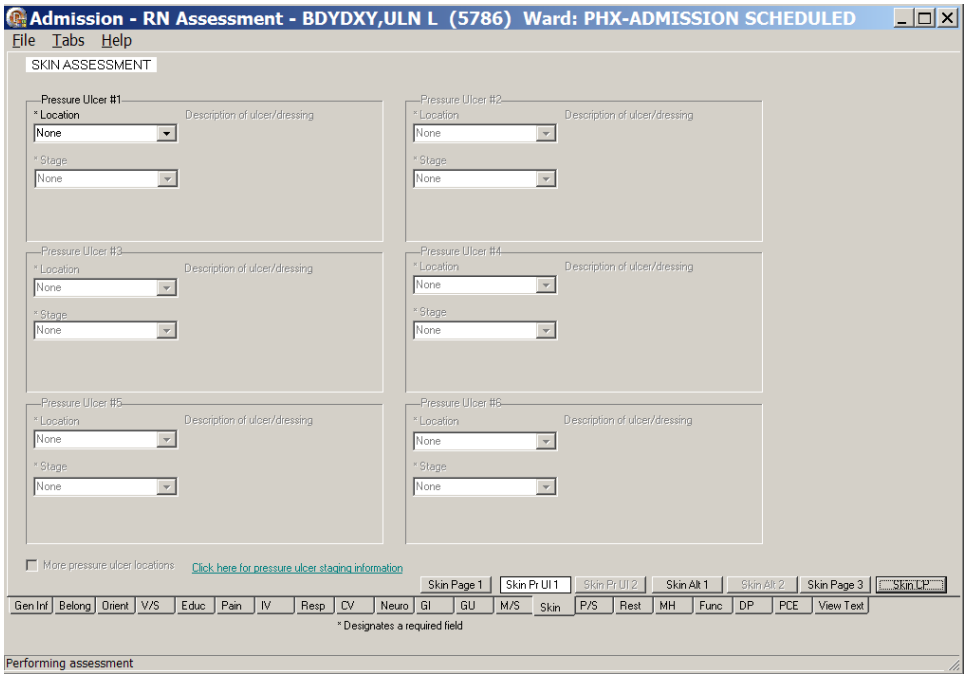
Documenting Pressure Ulcers

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



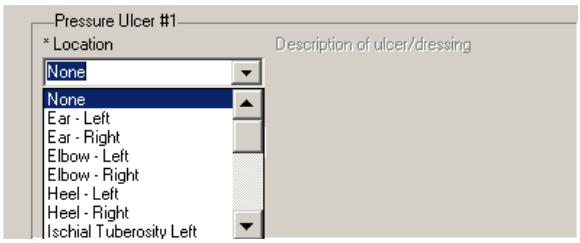
Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Page 1 window
Pressure ulcers selected

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

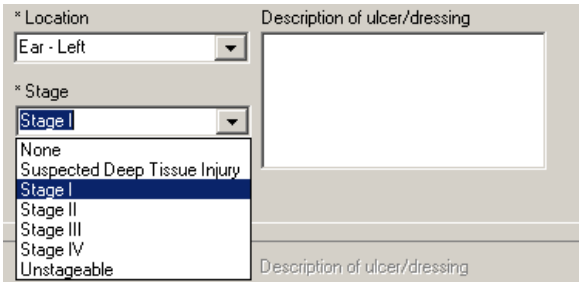


Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Pr Ul 1 window

Pressure Ulcer Drop-downs

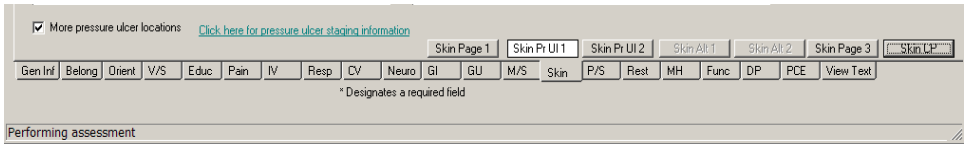


Skin Assessment - Pressure Ulcer #1/Location

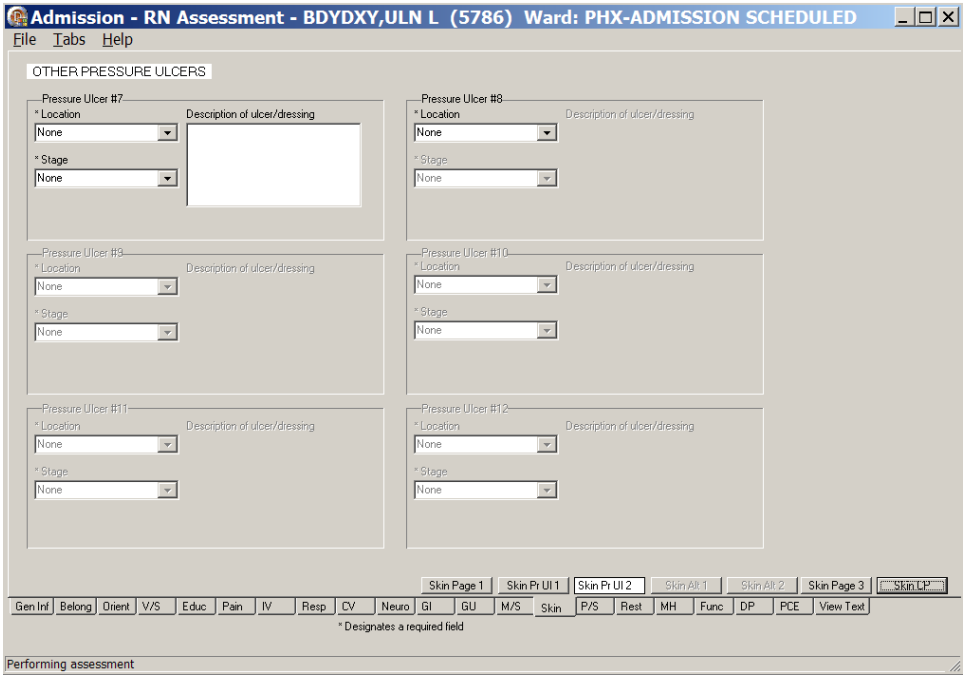


Skin Assessment - Pressure Ulcer #1/Stage

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



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

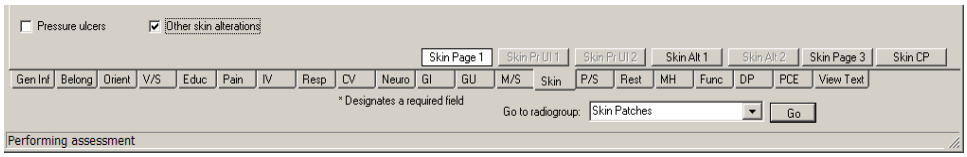


Admission – RN Assessment, Other Pressure Ulcers, Skin Pr Ul 2 window

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

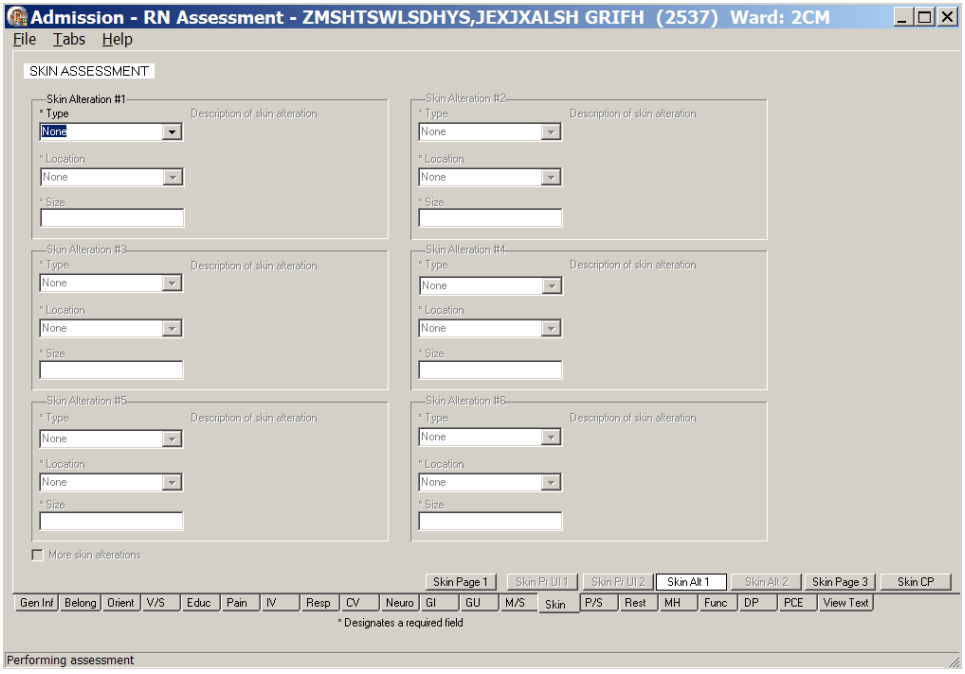
Documenting Skin Alterations

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



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

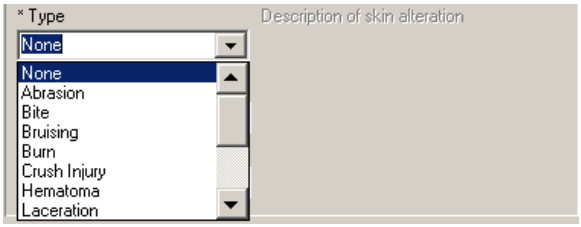
1. Click **Skin Alt 1**.
   Skin Alt 1 displays.



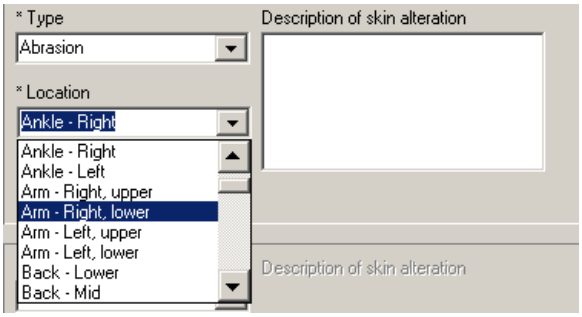
Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Alt 1 window
Skin Alterations #1-#6

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

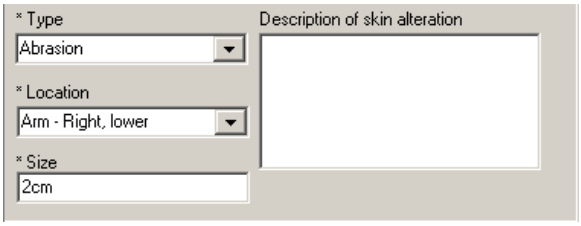
Skin Alteration Drop-downs



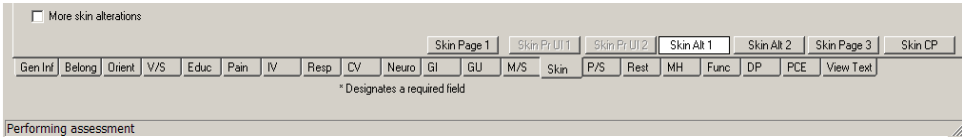
Skin Assessment – Skin Alteration #1/Type



Skin Assessment – Skin Alteration #1/Location

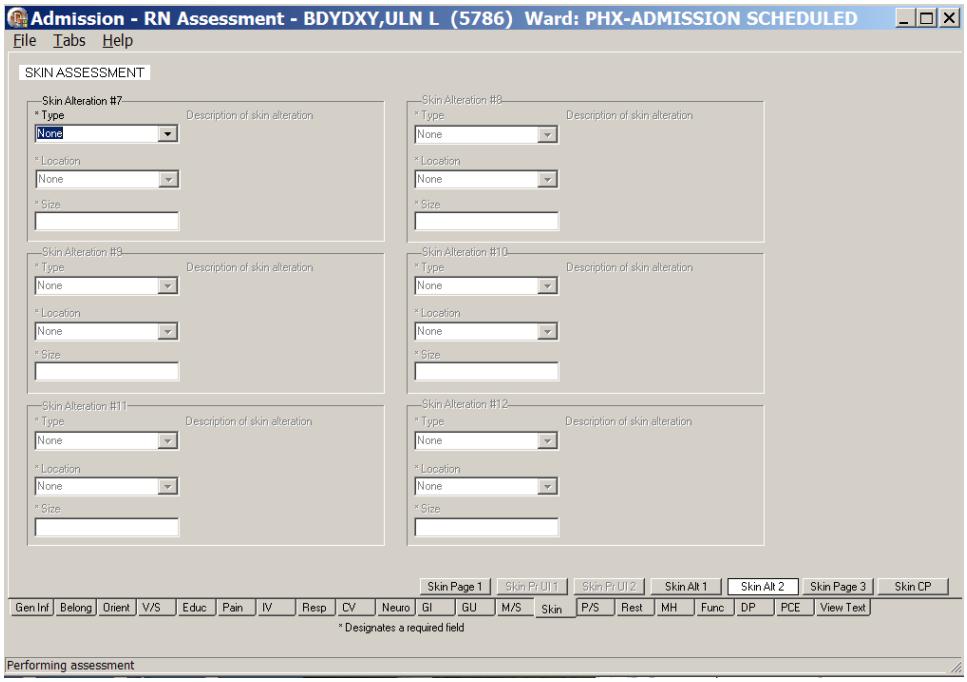


Skin Assessment – Skin Alteration #1/Size



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

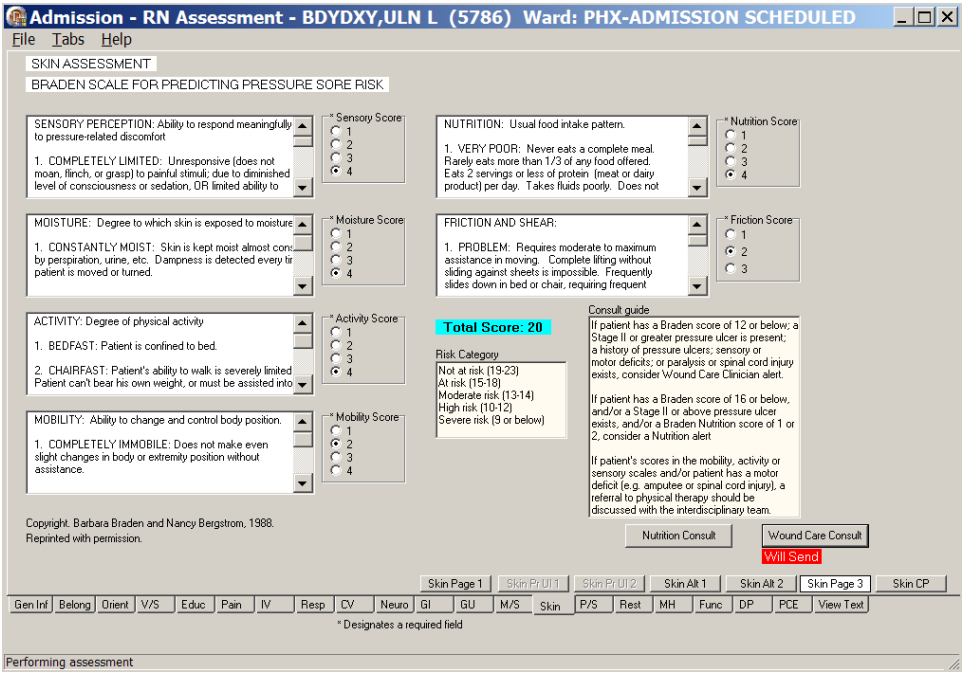
3. To enter more than six skin alterations locations, select the **More skin alterations** check box. Skin Alt 2 becomes available.
4. Click **Skin Alt 2**.
   Skin Alt 2 displays.



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

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

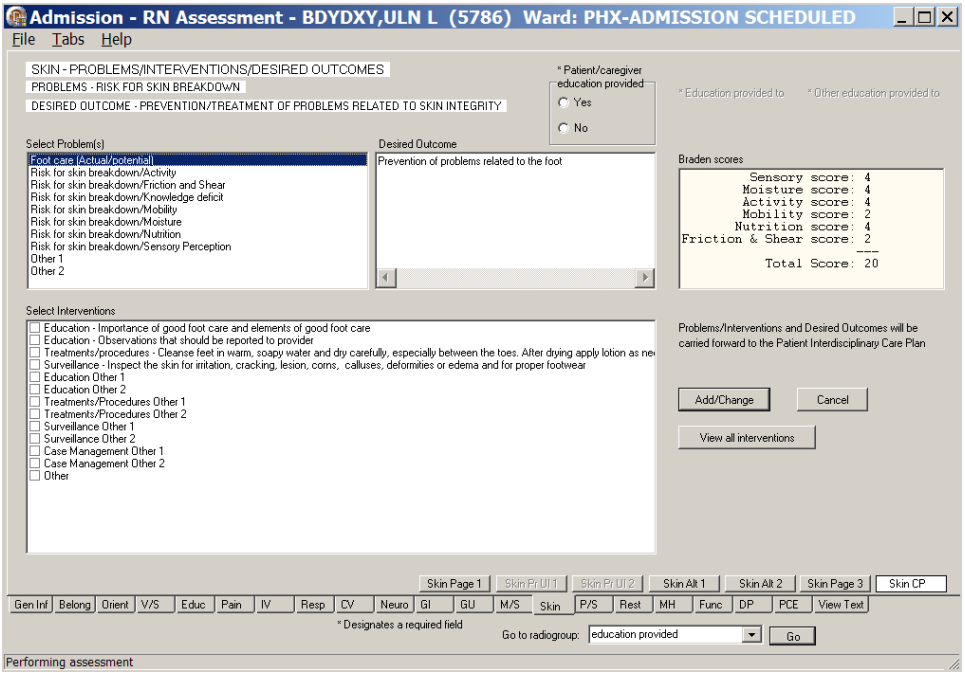
6. Click **Skin Page 3**.
   Skin Page 3 displays.



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

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

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



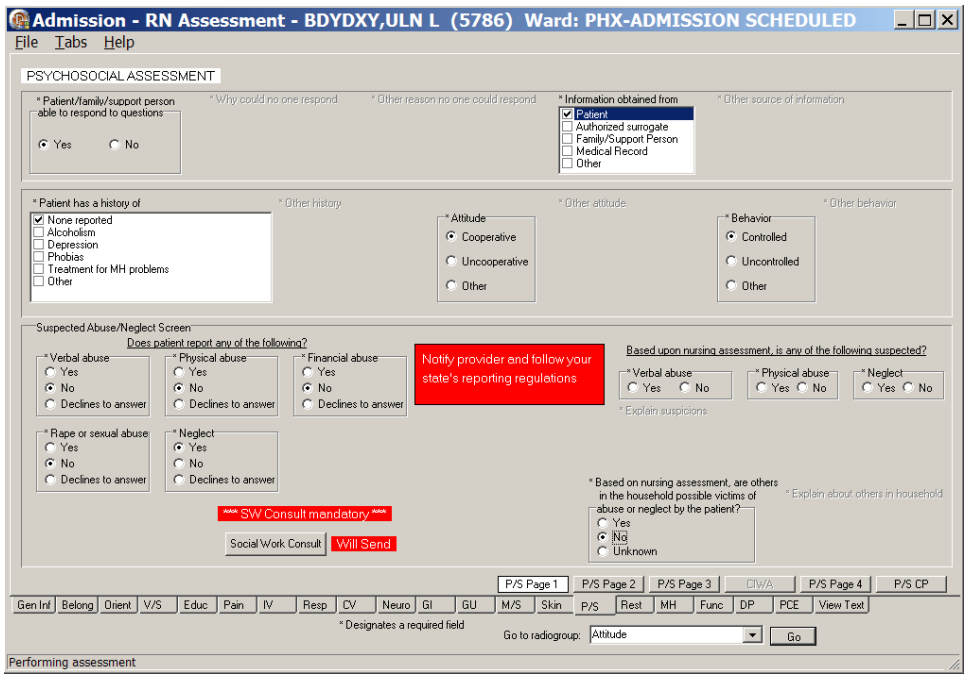
Admission – RN Assessment, Skin – Problems/Interventions/Desired Outcomes, Skin CP window

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

Psychosocial (P/S)

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

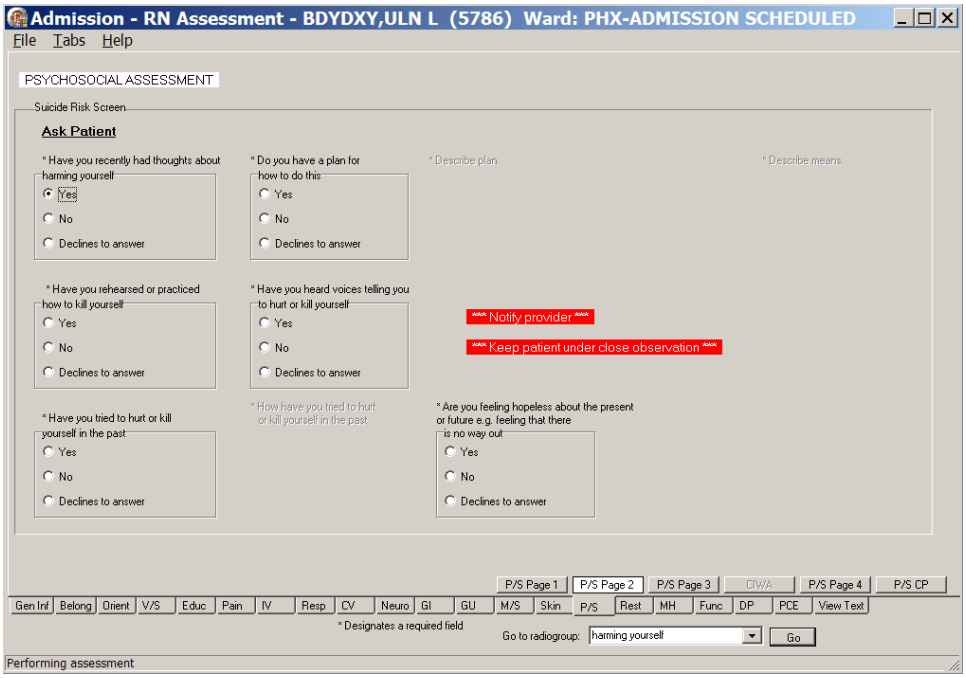
- Suicide Risk is on P/S Page 2.
- Questions concerning elopement, contraband, and chemical dependencies are on P/S Page 3.
- Directions for the *Clinical Institute Withdrawal Assessment (CIWA)* are on the CIWA page.
  a. The **CIWA Score** for the patient is calculated automatically as you select a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



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

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

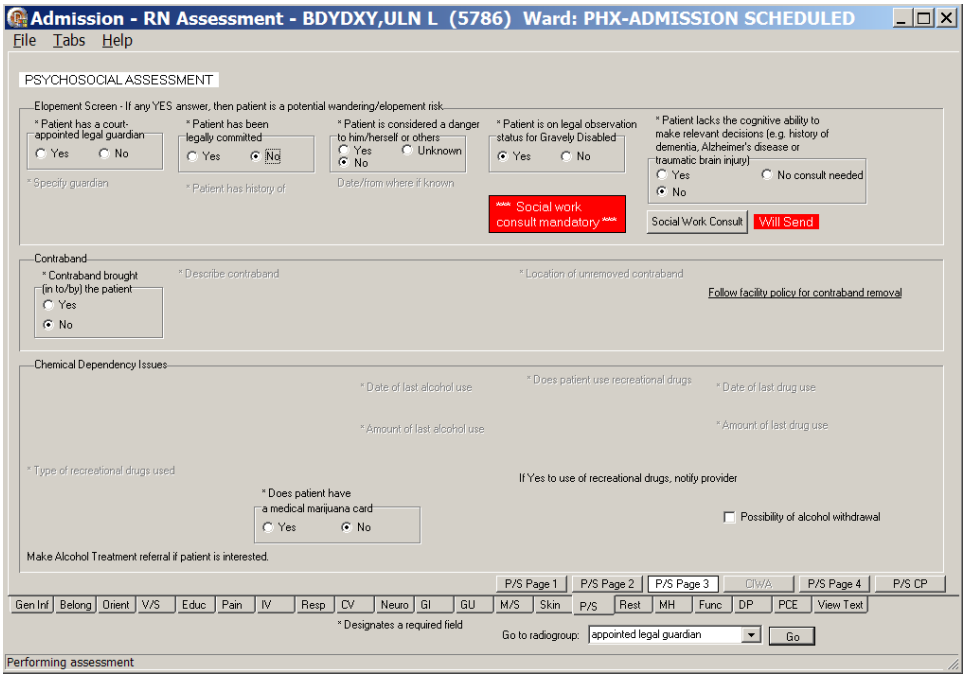
3. Click **P/S Page 2**.
   P/S Page 2 (Suicide Risk Screen - Ask Patient) displays.



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

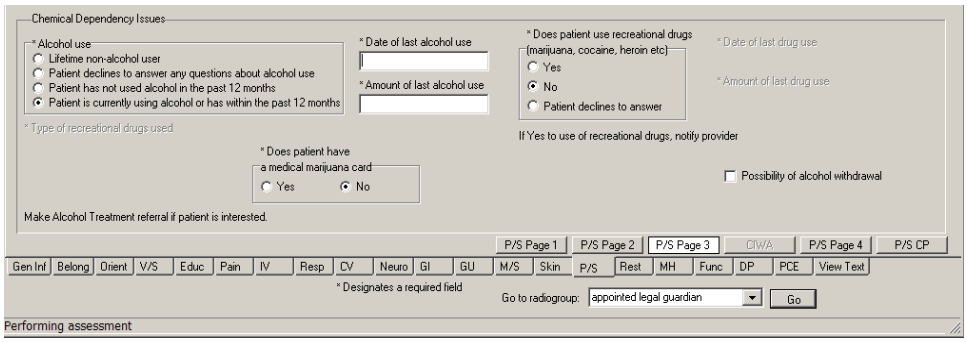
4. Populate P/S Page 2.
   a. Complete all the fields with asterisks; they are required fields.
   b. If the patient answers **Yes** to **Have you secretly had thoughts about hurting yourself**, you must **Notify provider** and **Keep patient under close observation**.

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



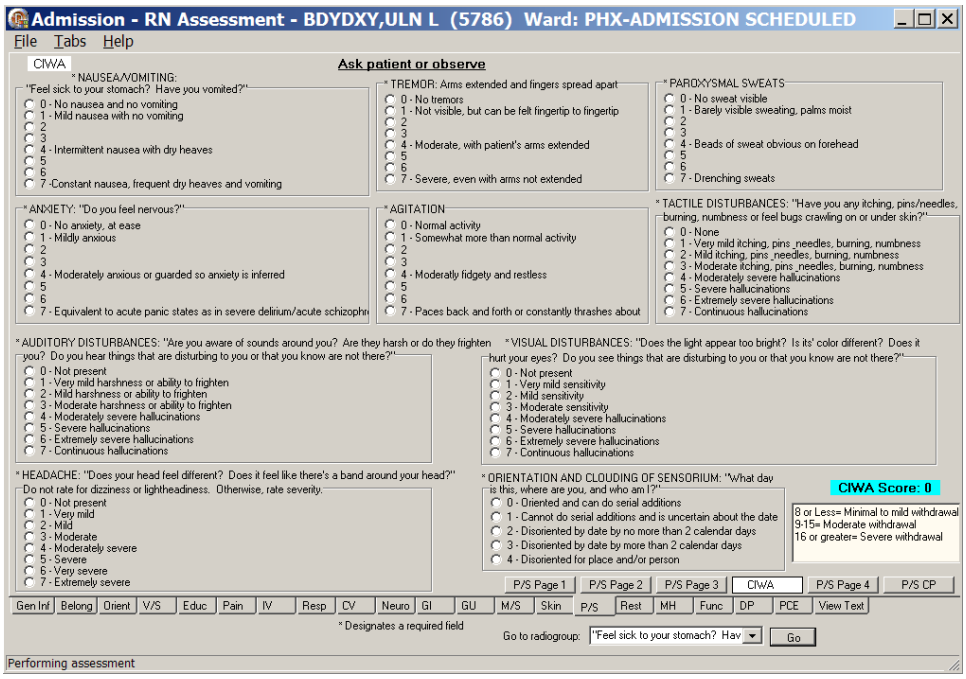
Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 3 window

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



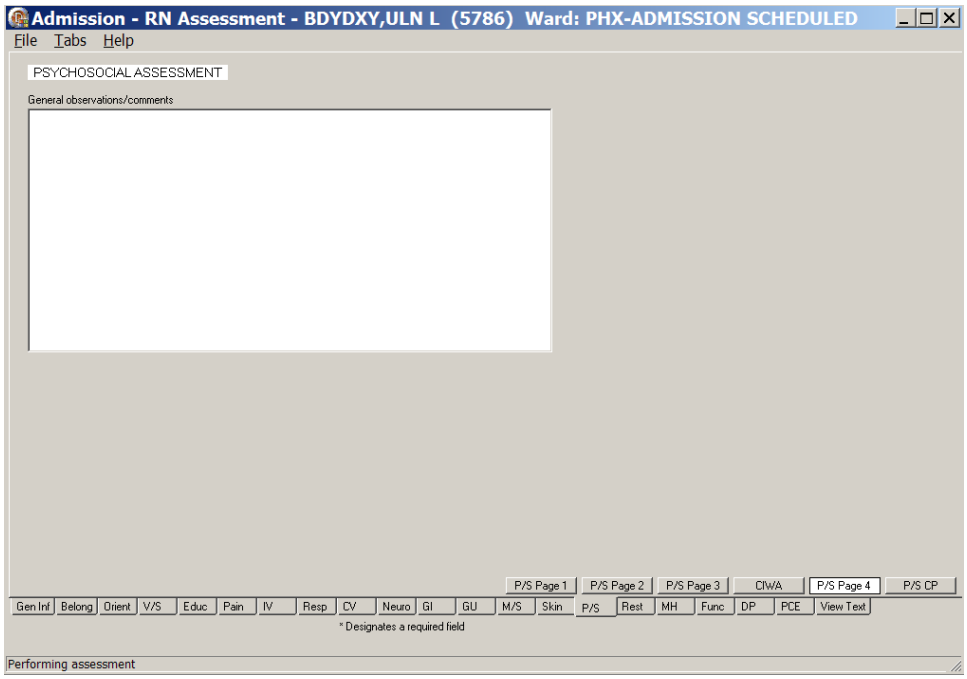
Alcohol use section

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



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

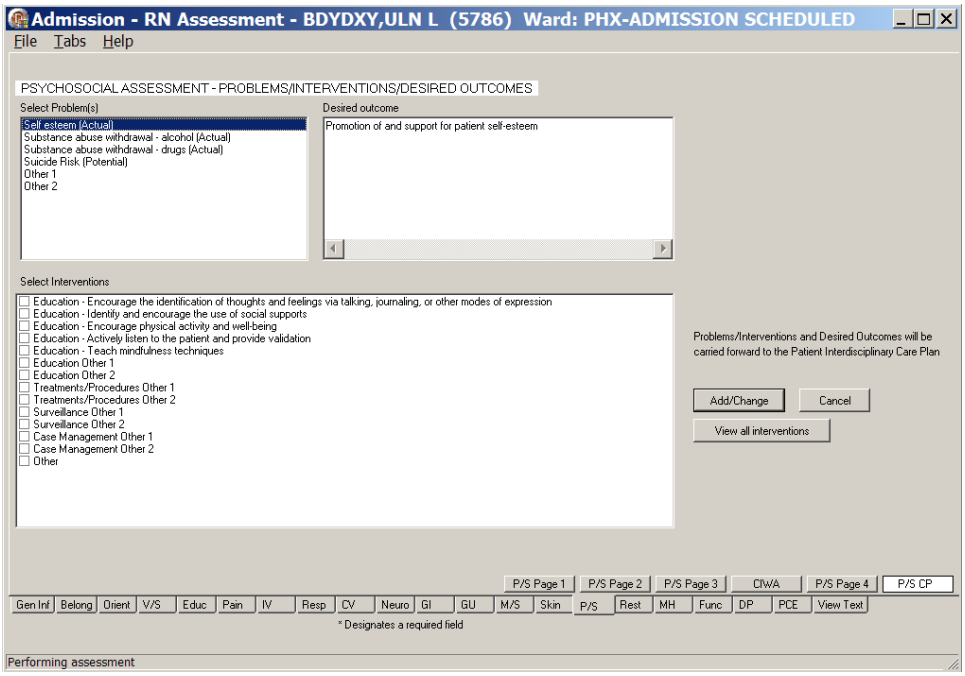
8. Click **P/S Page 4**.
   P/S Page 4 displays.



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

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

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



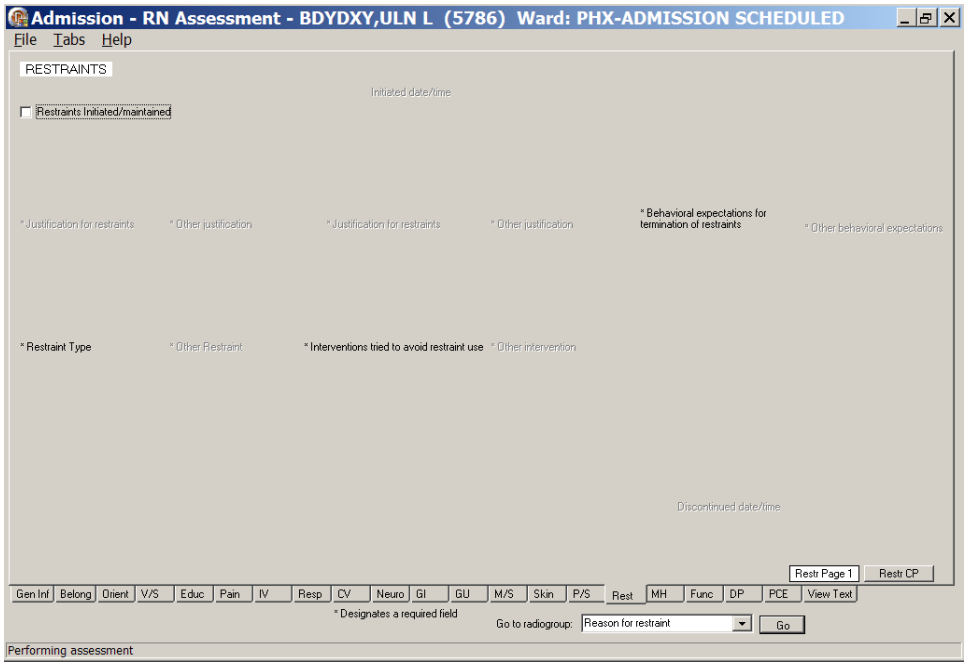
Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S PC window

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

Restraints (Rest/Restr)

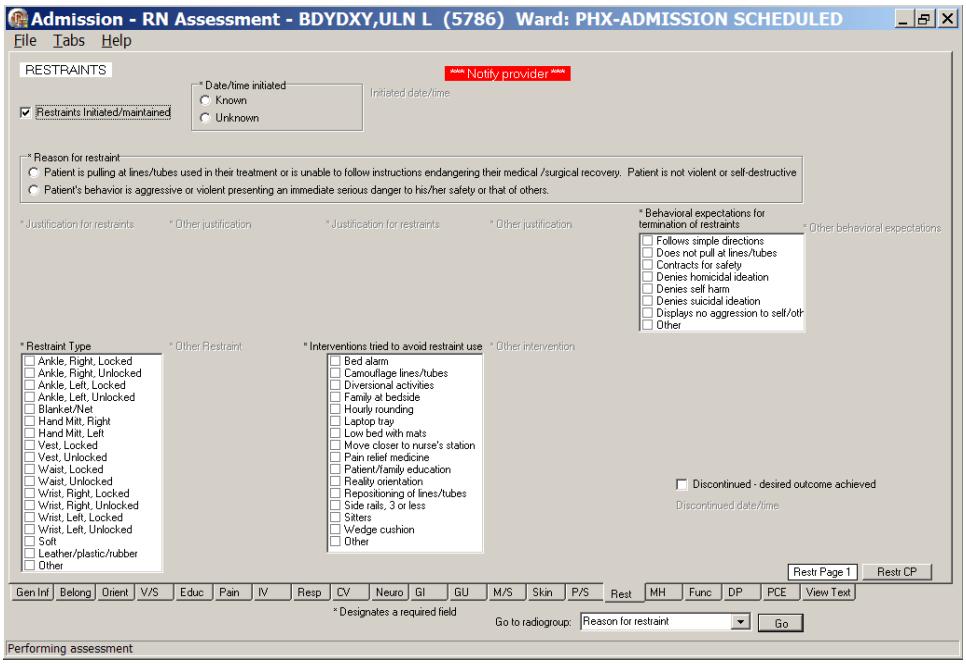
There are two categories of restraints.

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



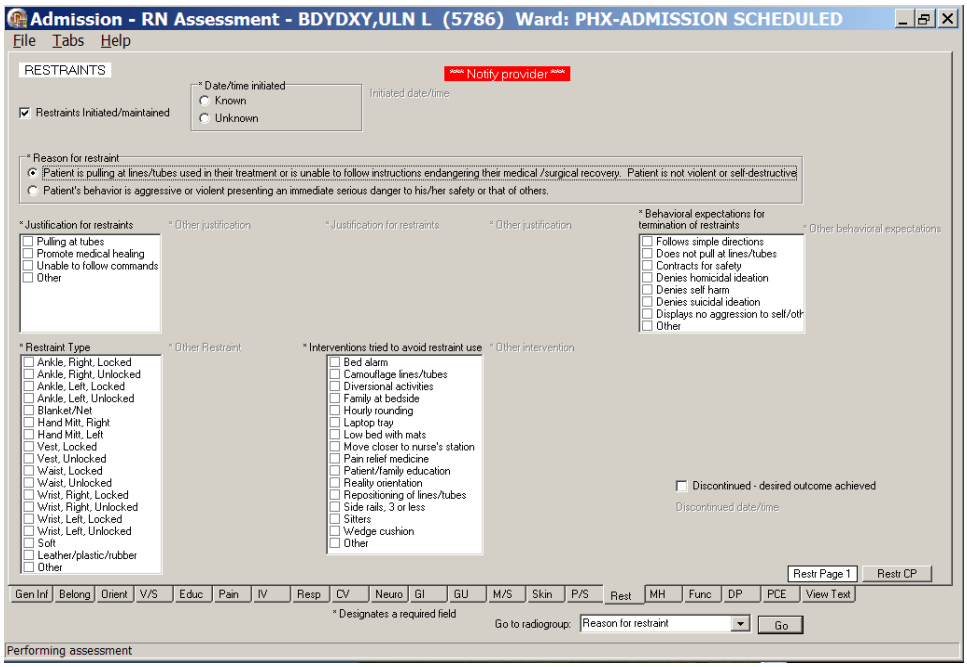
Admission – RN Assessment, Restraints (Rest) tab, Restr Page 1 window

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



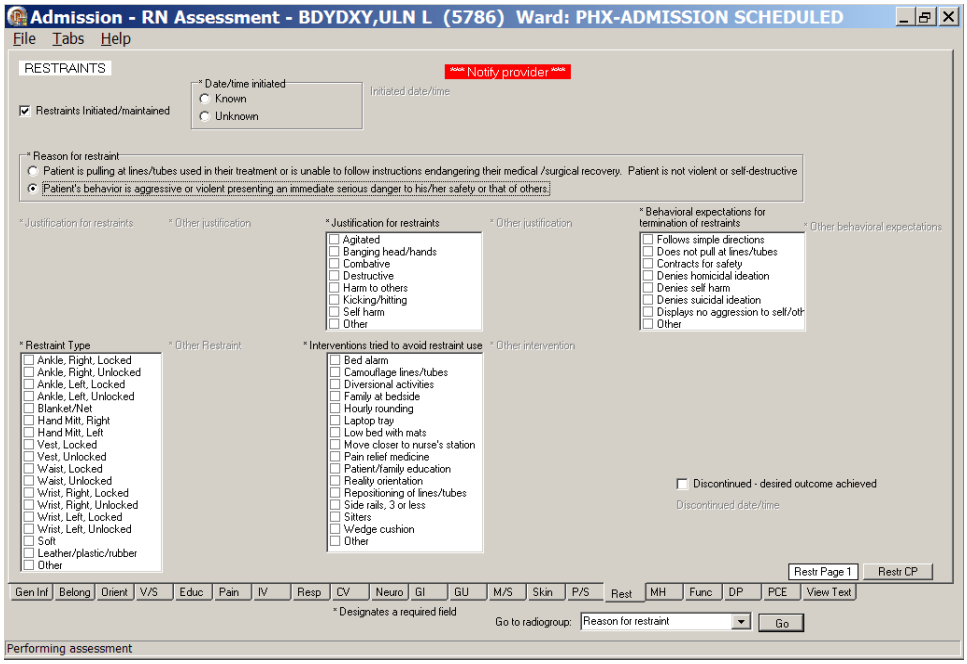
Admission – RN Assessment, Restraints (Rest) tab, Restr Page 1 window
with restraints initiated/maintained

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



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

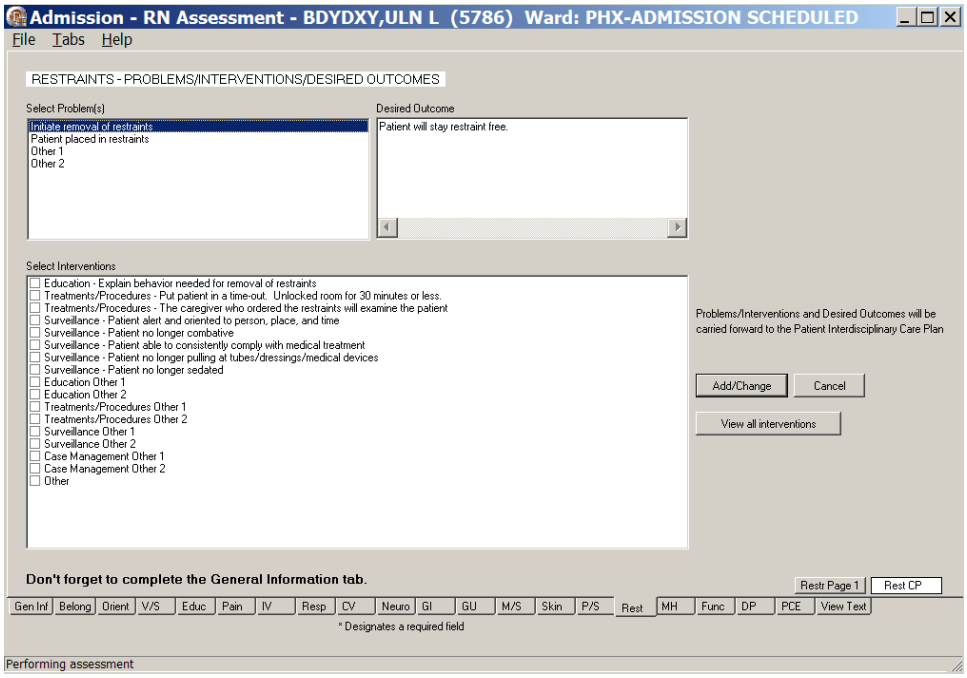
b. When you select, **Patient's behavior is aggressive or violent presenting an immediate serious danger to his/her safety or that of others**, the following window displays.



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

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

4. Click **Restr CP**.
   Restr CP displays.



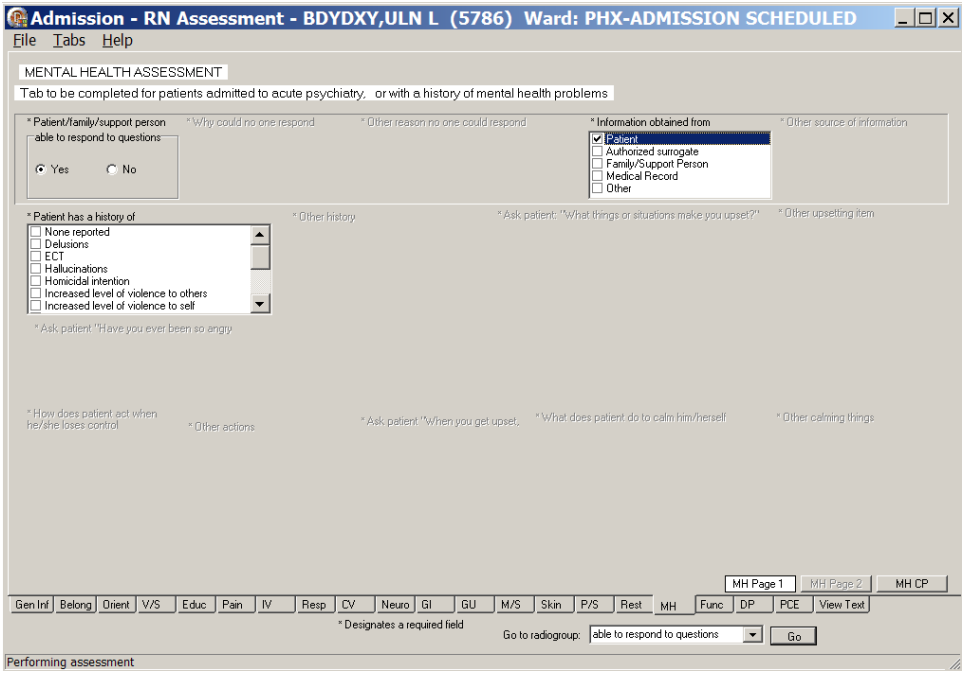
Admission – RN Assessment, Restraints - Problems/Interventions/Desired Outcomes, Restr CP window

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

Mental Health (MH)

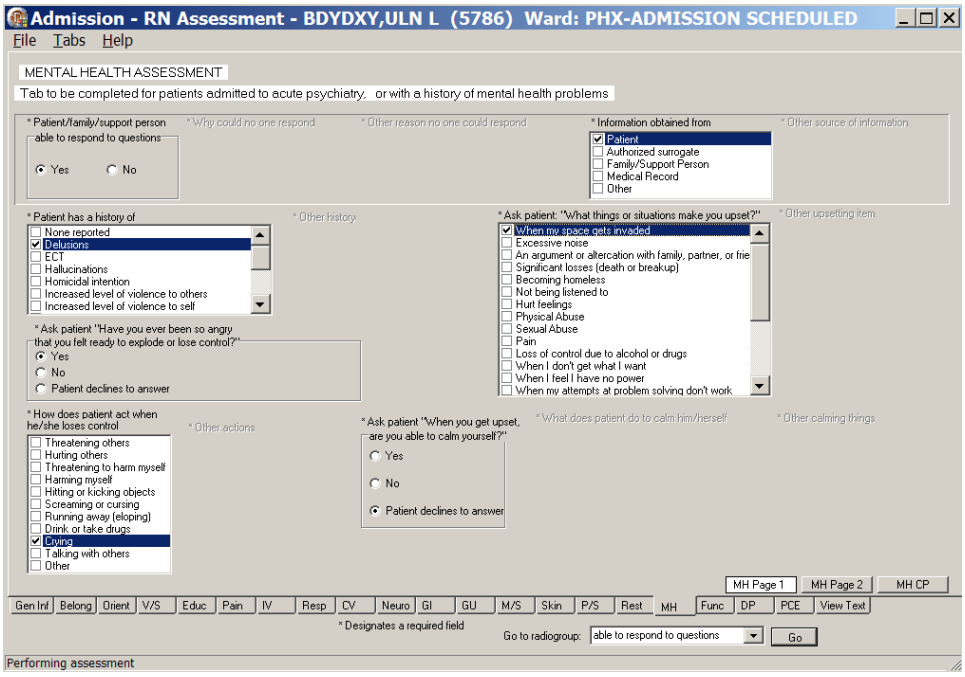
The Mental Health Assessment tab contains the patient's mental health history.

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



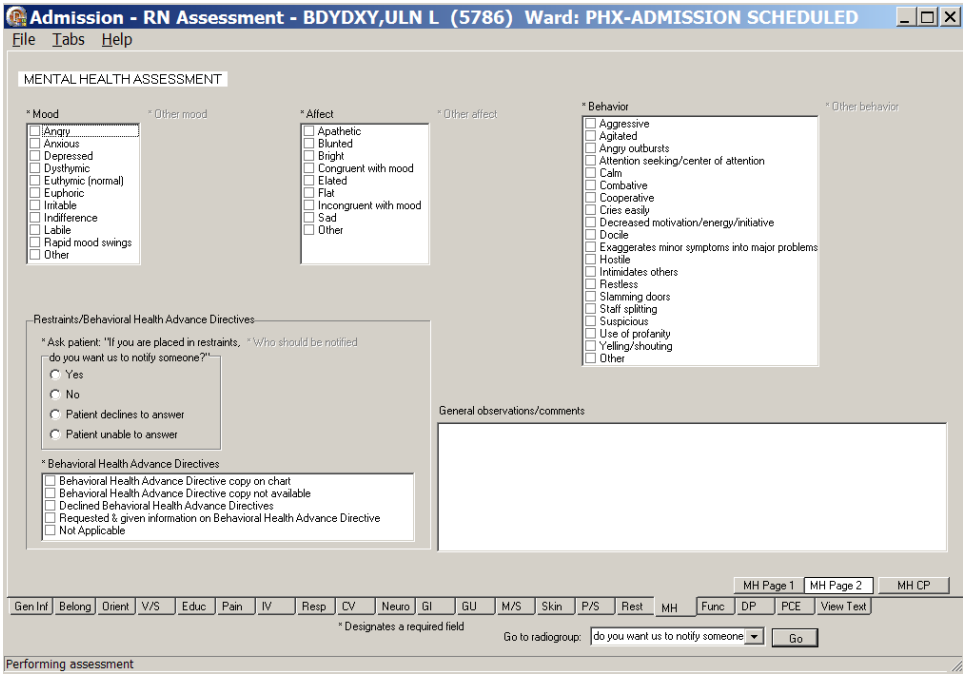
Admission – RN Assessment, Mental Health Assessment (MH) tab, MH Page 1 window when patient is not admitted to acute psychiatry

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



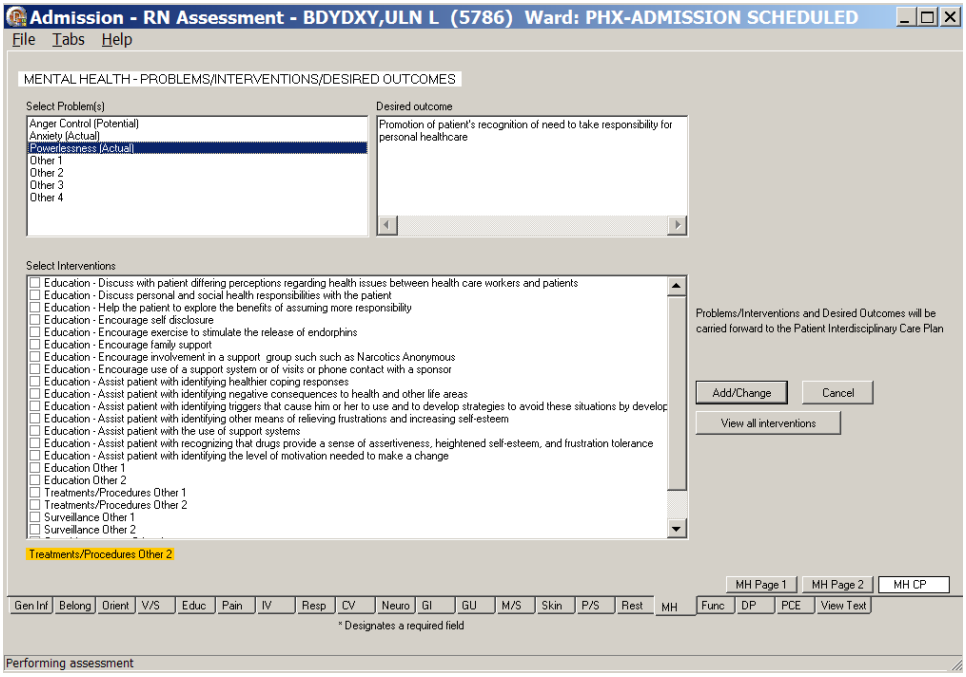
Admission – RN Assessment, Mental Health Assessment (MH) tab, MH Page 1 window when patient is admitted to acute psychiatry

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



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

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



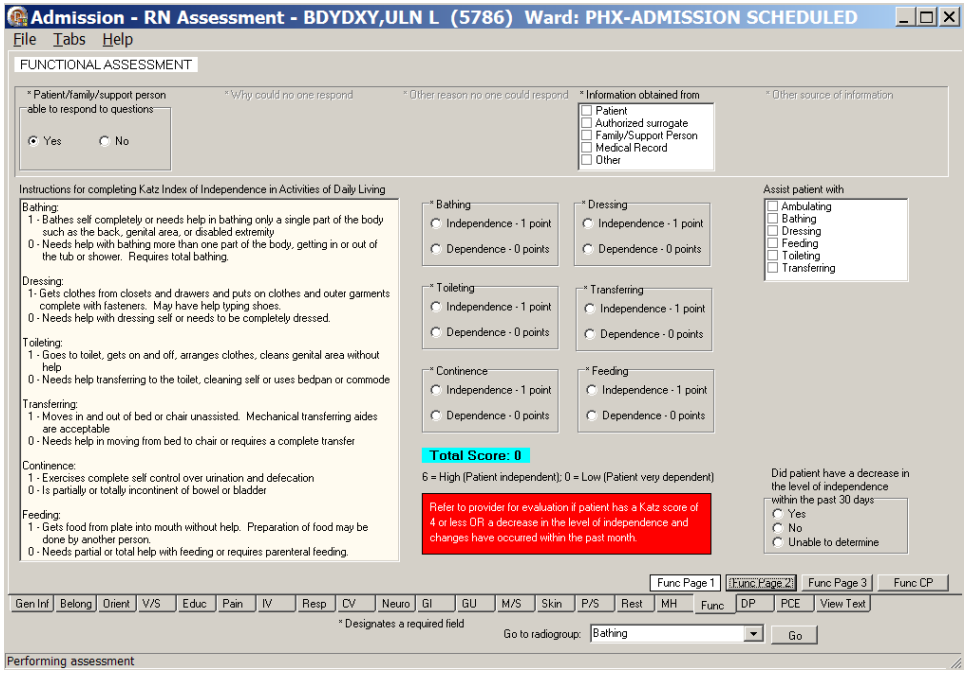
Admission – RN Assessment, Mental Health Assessment (MH) tab, MH CP window

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

Functional (Func)

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

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

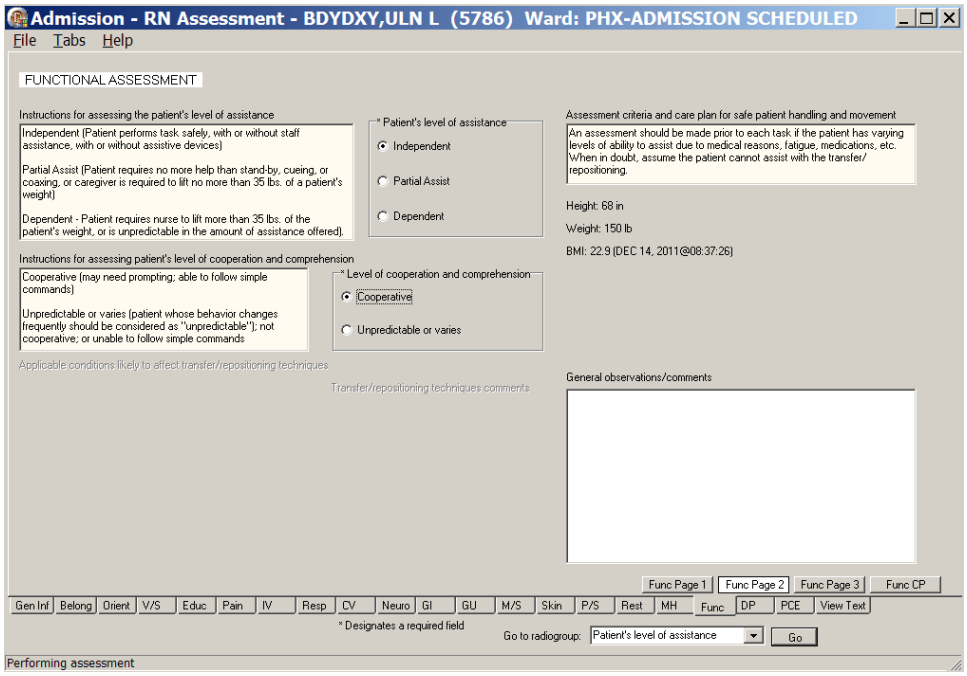


Admission – RN Assessment, Functional Assessment (Func) tab, Func Page 1 window

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

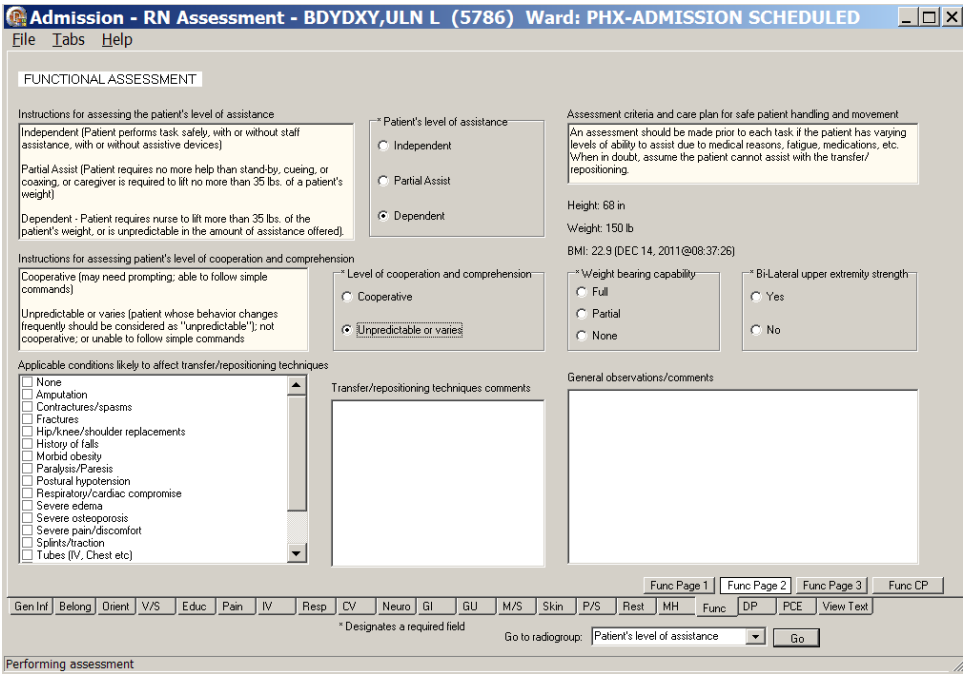
   Note: Refer to provider for evaluation, if patient has a Katz score of 4 or less, or a decrease in the level of independence and changes have occurred within the past month.

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



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

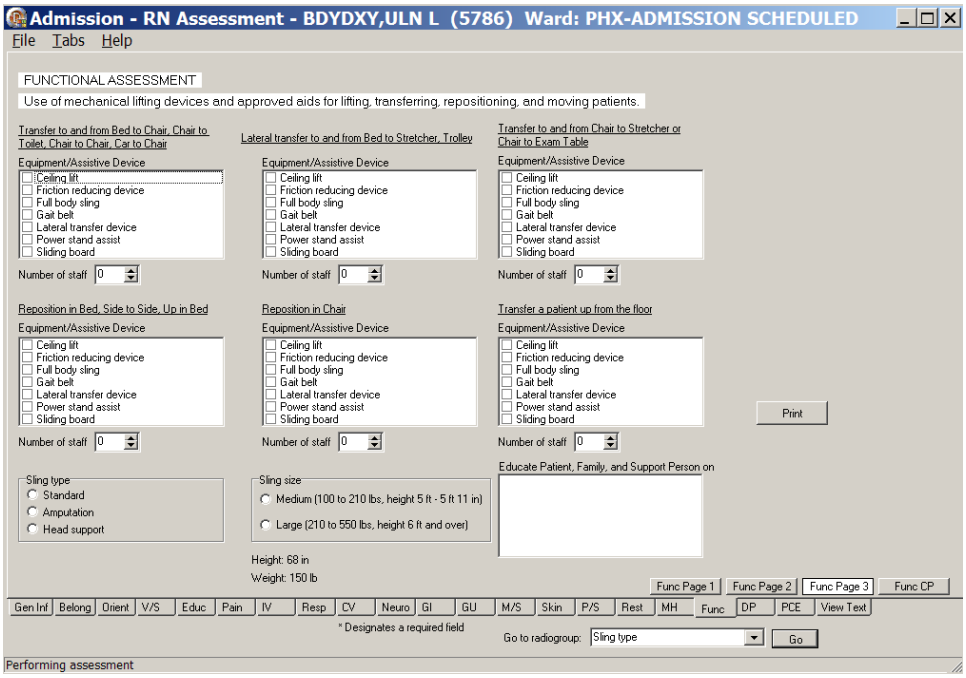
- If the patient is dependent and completely uncooperative, additional entries are necessary on Func Page 2.



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

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

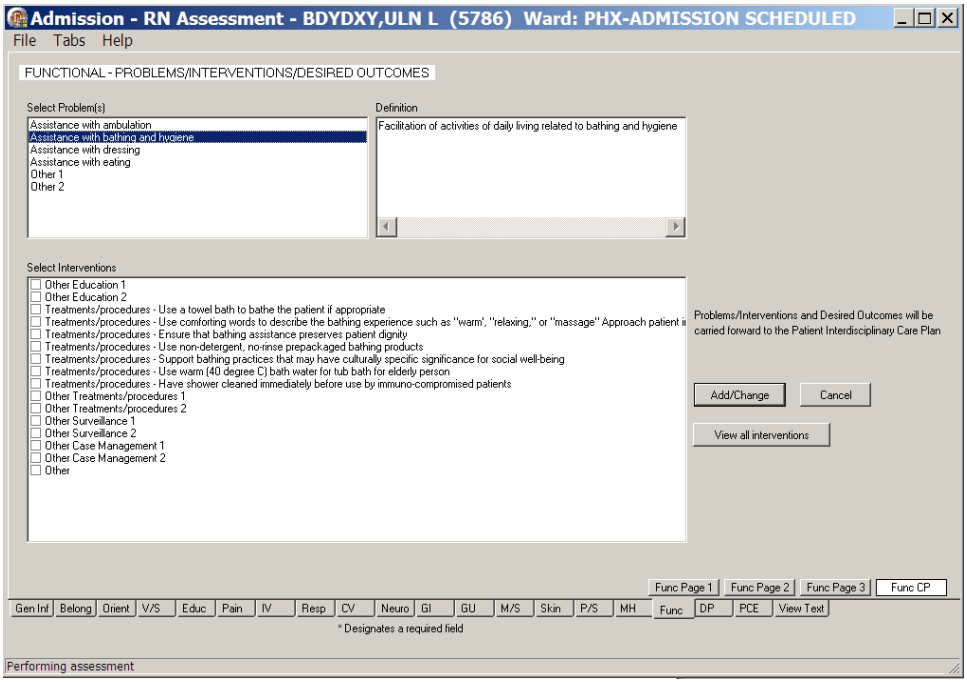
5. Click **Func Page 3**.
   Func Page 3 displays.



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

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

7. Click **Func CP**.
   Func CP page displays.



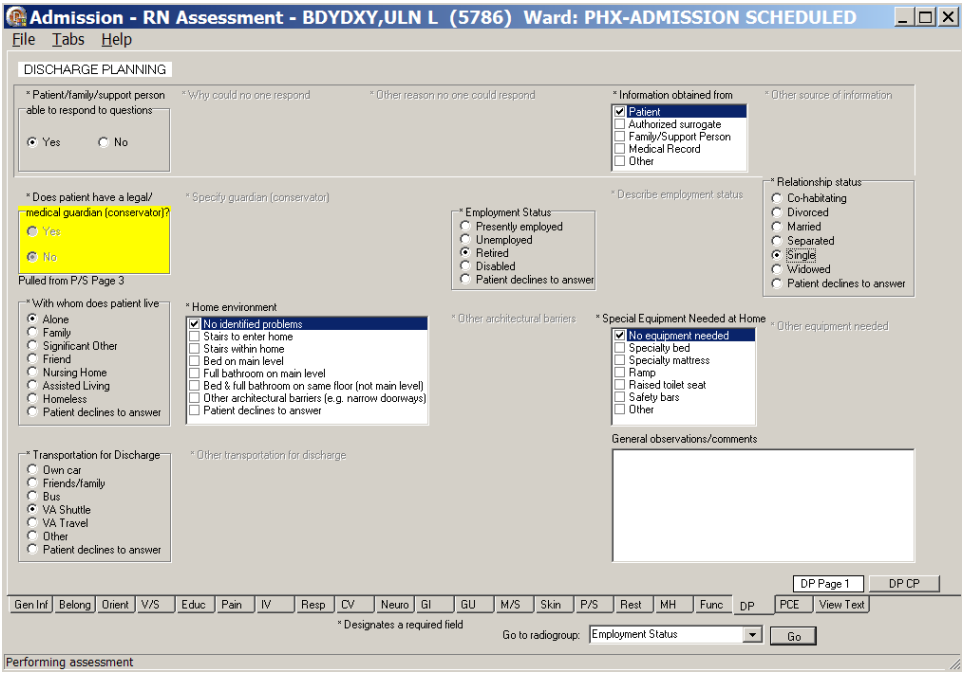
Admission – RN Assessment, Functional Assessment (Func) tab, Func CP window

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

Discharge Planning (DP)

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

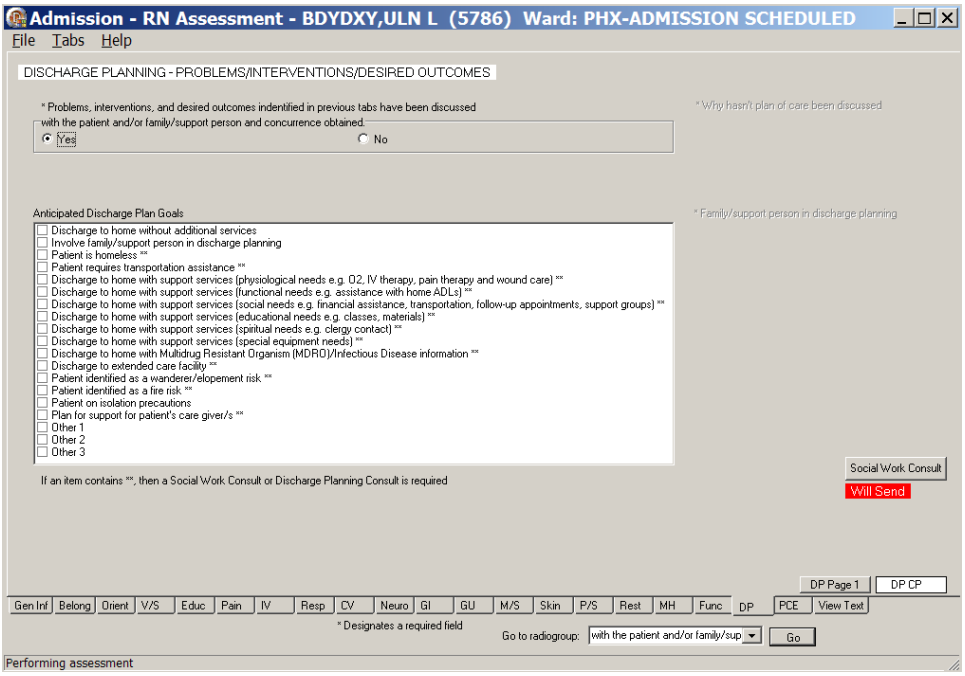
Information about the legal/medical guardian is pulled from the question asked in P/S Page 3. You cannot edit it from the DP tab. If the information is not correct, return to P/S Page 3 to correct.



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

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

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



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

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

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

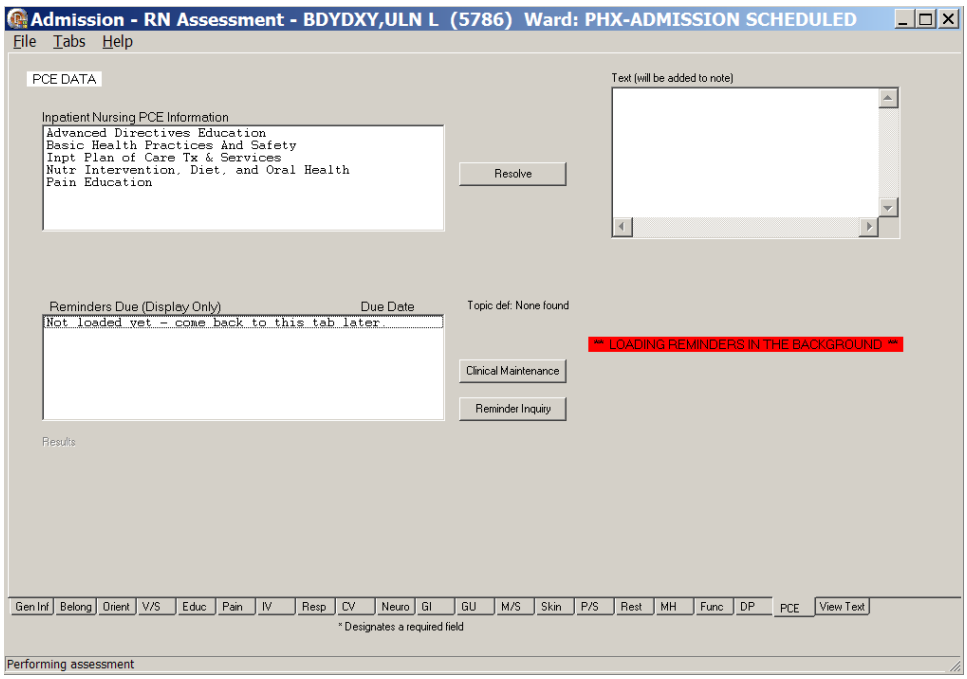
PCE Data (PCE)

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

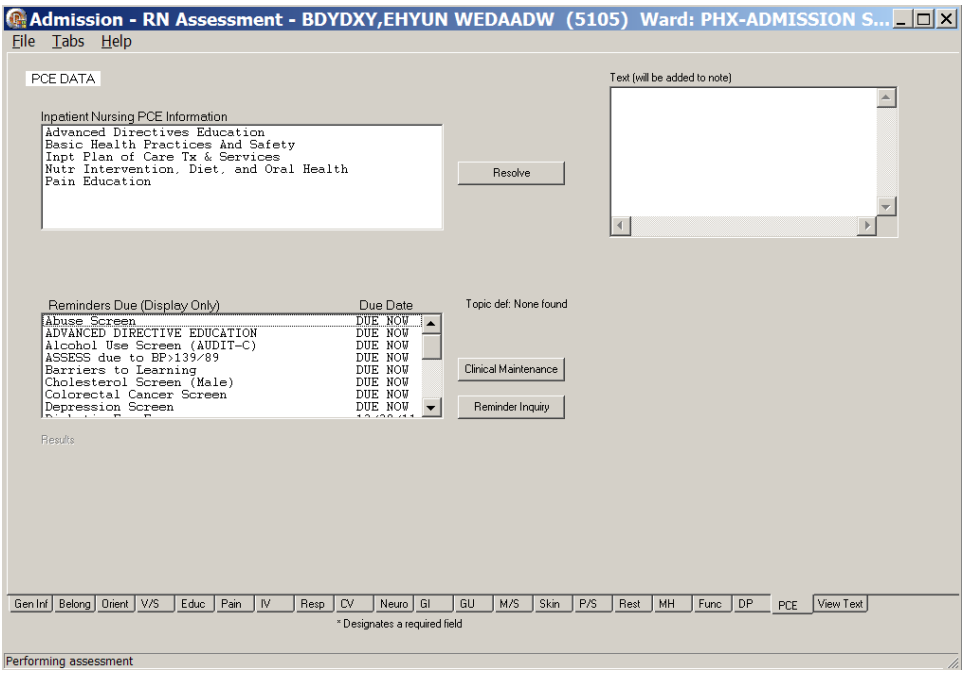
Note: The clinical reminders must be set up by your facility.

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

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



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



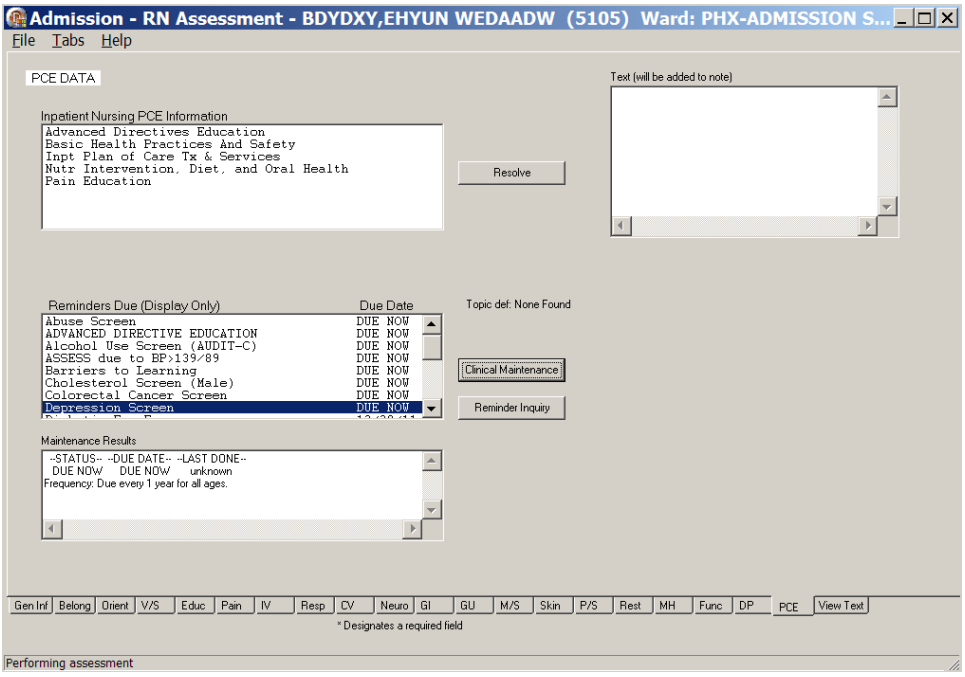
Admission – RN Assessment, PCE Data (PCE) tab window after reminders are loaded

Reminders Due (Display Only)

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

Clinical Maintenance

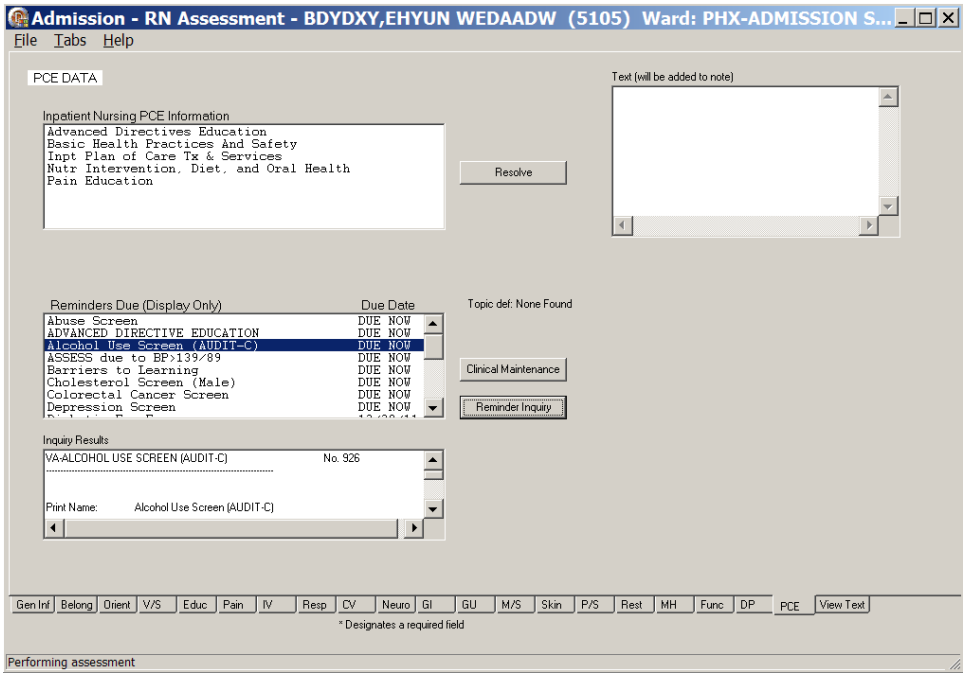
1. Select a clinical reminder in the **Reminders Due** list box.
2. Click **Clinical Maintenance**.
   Information about when the reminder is due or was last done, displays in the **Maintenance Results** list box.



Clinical Maintenance

Reminder Inquiry

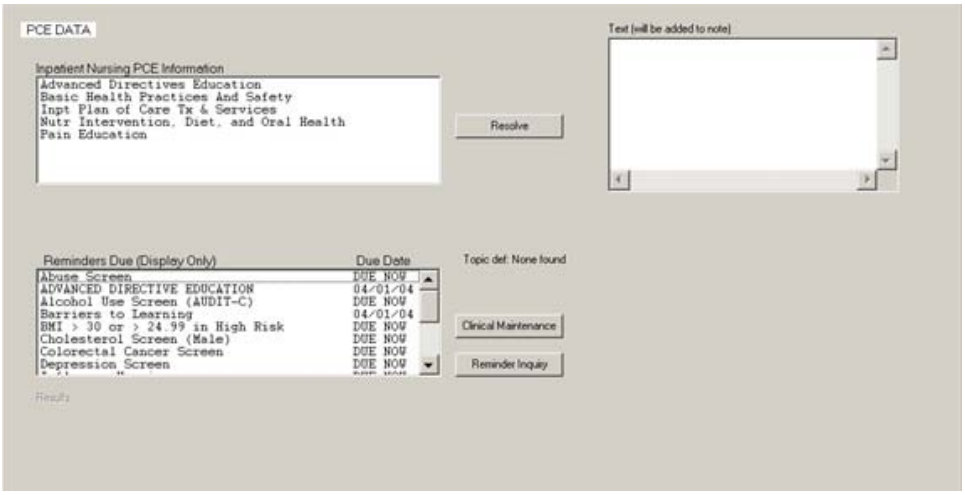
Click **Reminder Inquiry**.
Information about the logic of the selected reminder displays in the **Inquiry Results** list box.



Reminder Inquiry

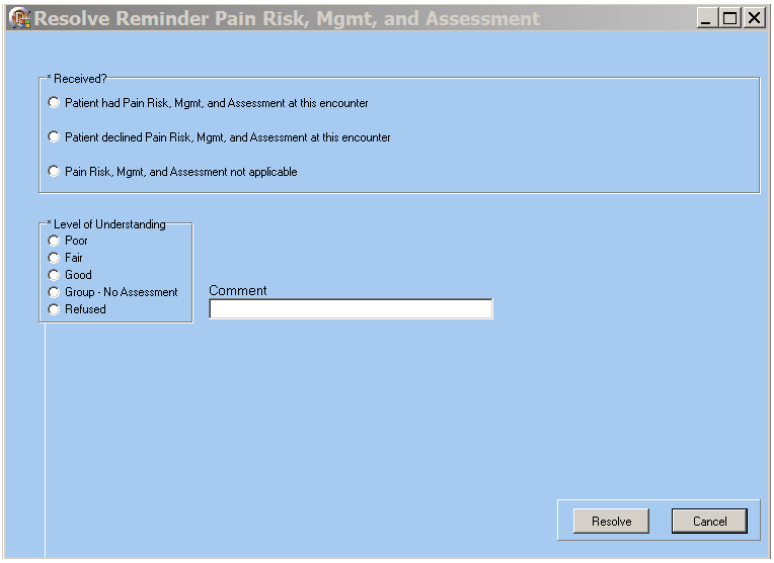
Resolve Inpatient Nursing Clinical Reminders

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



PCE Data, Resolve Inpatient Nursing Clinical Reminders

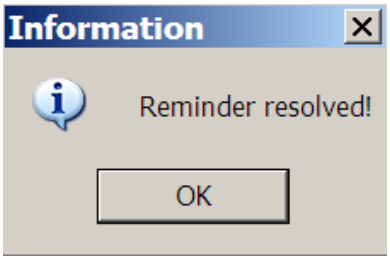
2. Click **Resolve**.
   The Resolve Reminder Pain Risk, Mgmt, and Assessment window displays with items appropriate for the selected item.



Resolve Reminder Pain Risk, Mgmt, and Assessment window

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

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



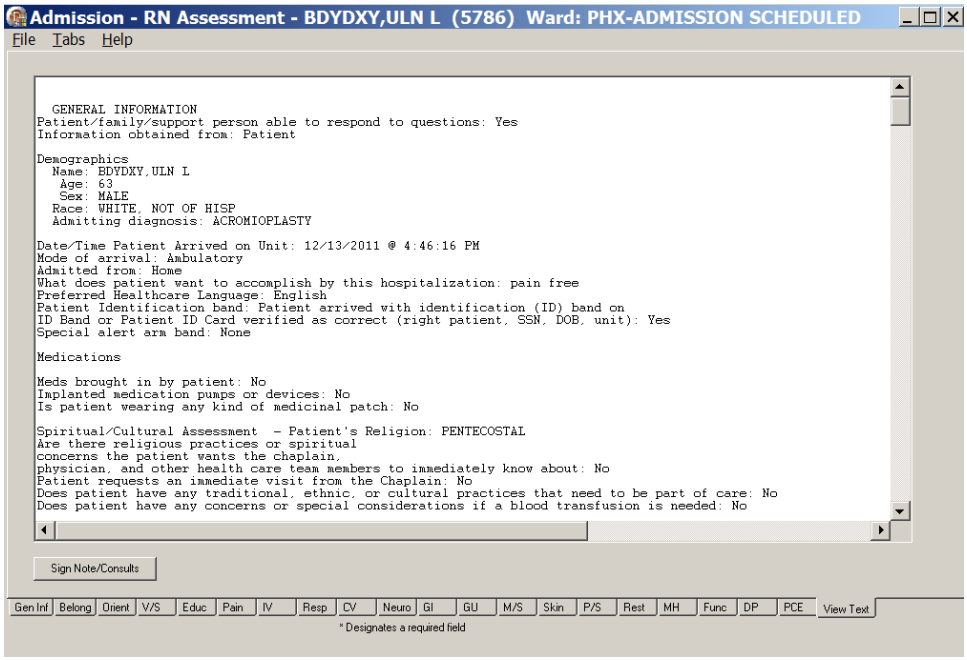
Information pop-up: Reminder resolved!

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

Text (will be added to note)

View Text (View Text)

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



Admission – RN Assessment View Text tab window

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

Signing Note and Consults from within the Template

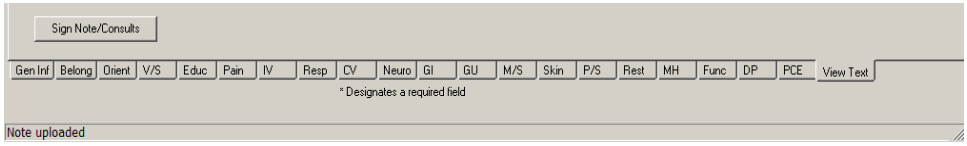
During the assessment, you may be prompted to enter a mandatory consult, which will be uploaded with the assessment note.

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

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

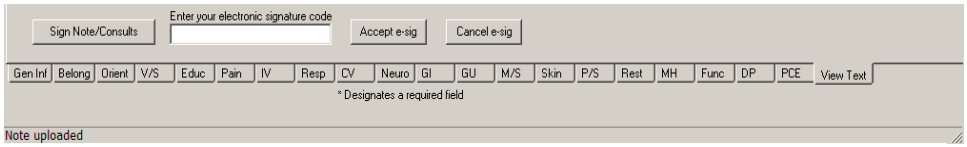
You can sign *unsigned* notes **after the upload** from the View Text tab in the template.

1. Click **View Text**.



Admission – RN Assessment with Sign Note/Consults button

2. Click **Sign Note/Consults**.
   If the button does not display, upload again.



Admission – RN Assessment with Sign Note/Consults button

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

3. Enter your electronic signature and click **Accept e-sig**.
   Information pop-up displays, *Note signed!*.
4. Click **OK**.
5. To prevent the signing of an uploaded note, click **Cancel e-sig**.

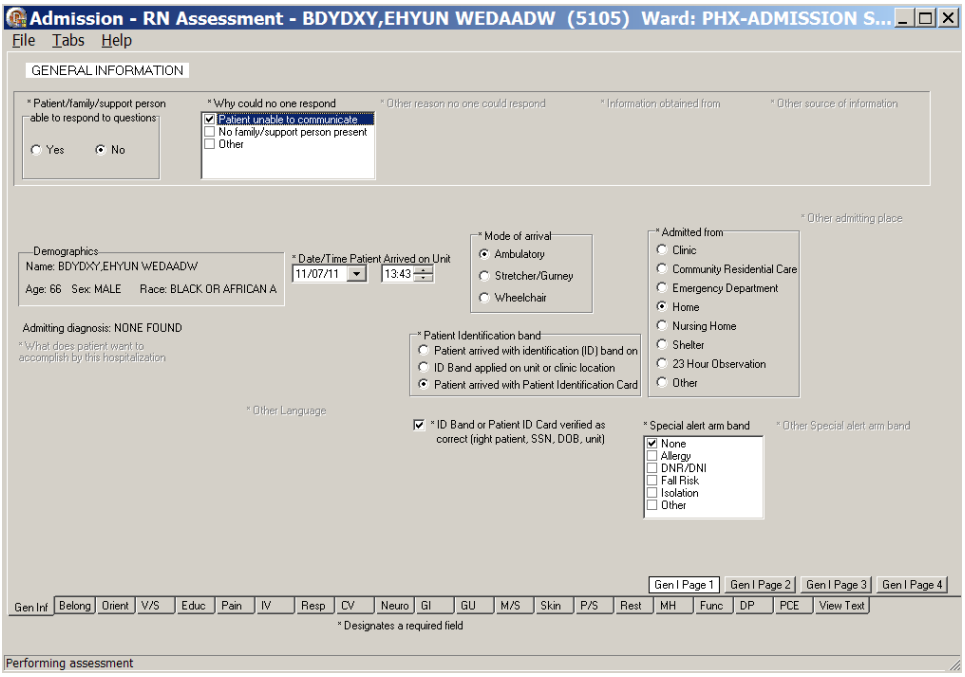
Note: It is safer to go to CPRS, read the note in CPRS, and sign the note in CPRS.

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

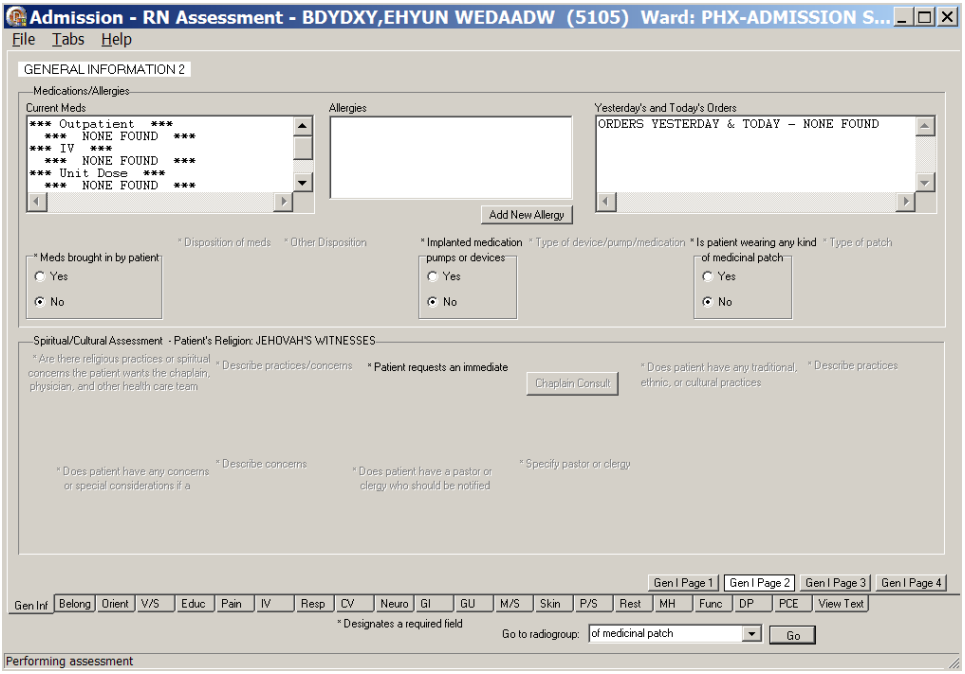
Patient Unable to Respond

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

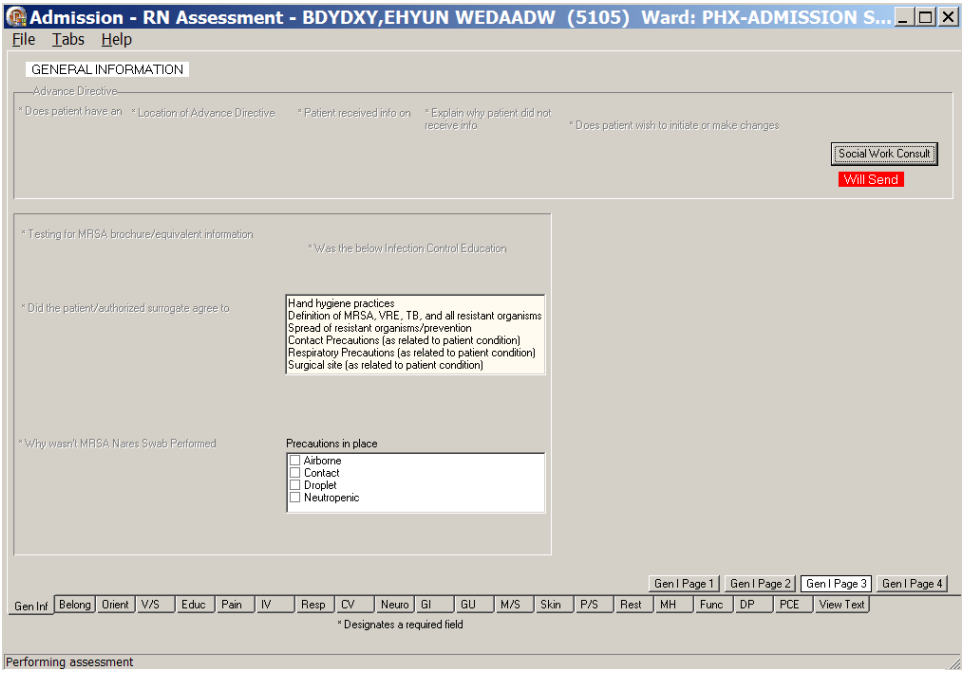
The following screen captures are examples of the tabs when **No** is selected for **Patient/family/support person able to respond to questions**.



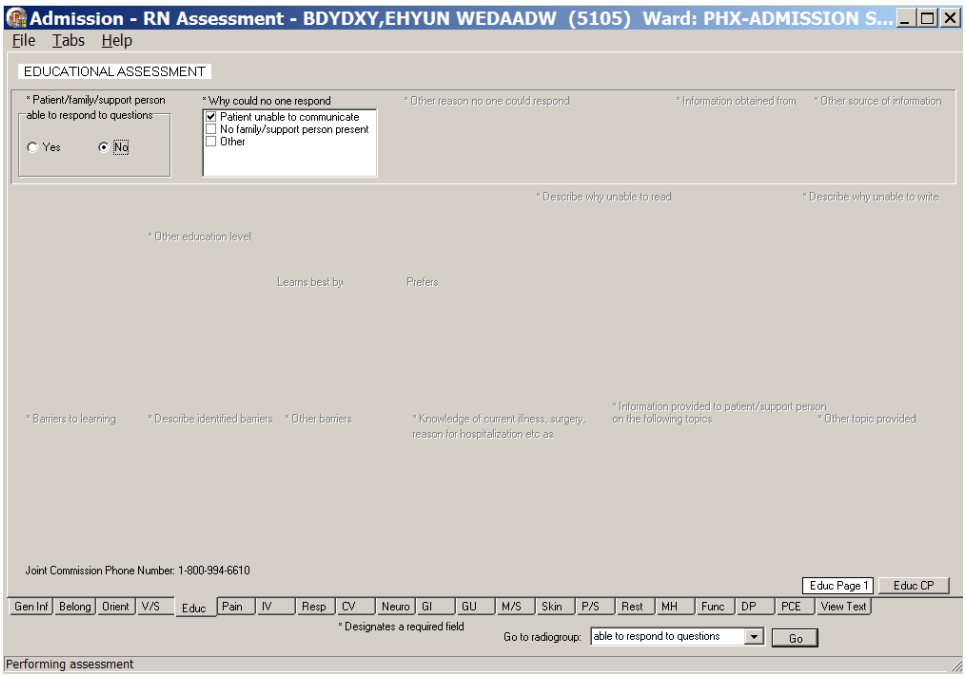
Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 1 window



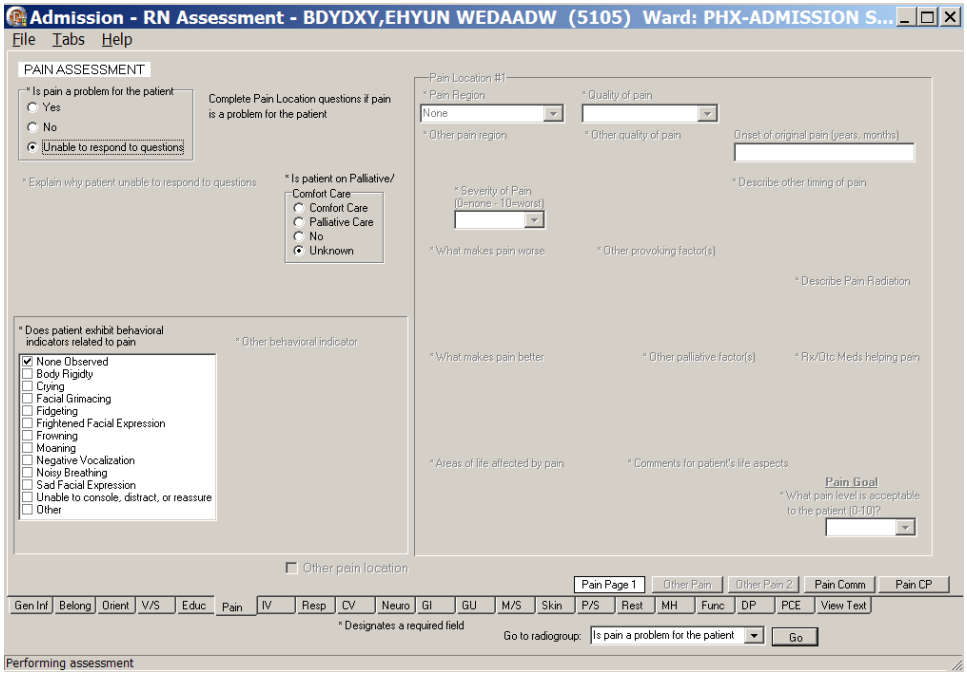
Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 2 window



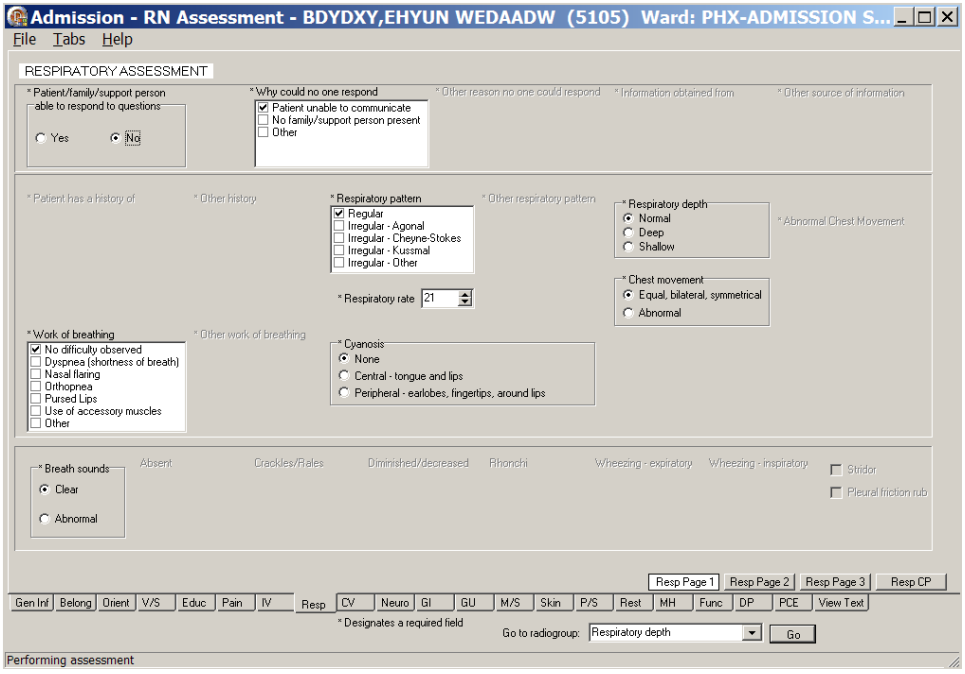
Admission – RN Assessment, General Information (Gen Inf) tab, Gen I Page 3 window



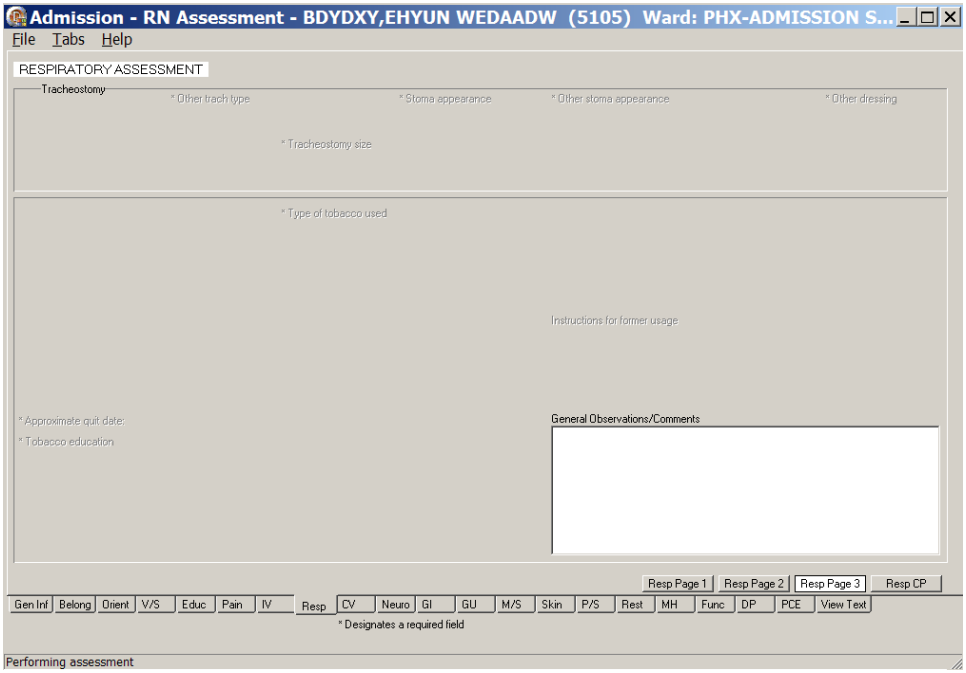
Admission – RN Assessment, Educational Assessment (Educ) tab, Educ Page 1 window



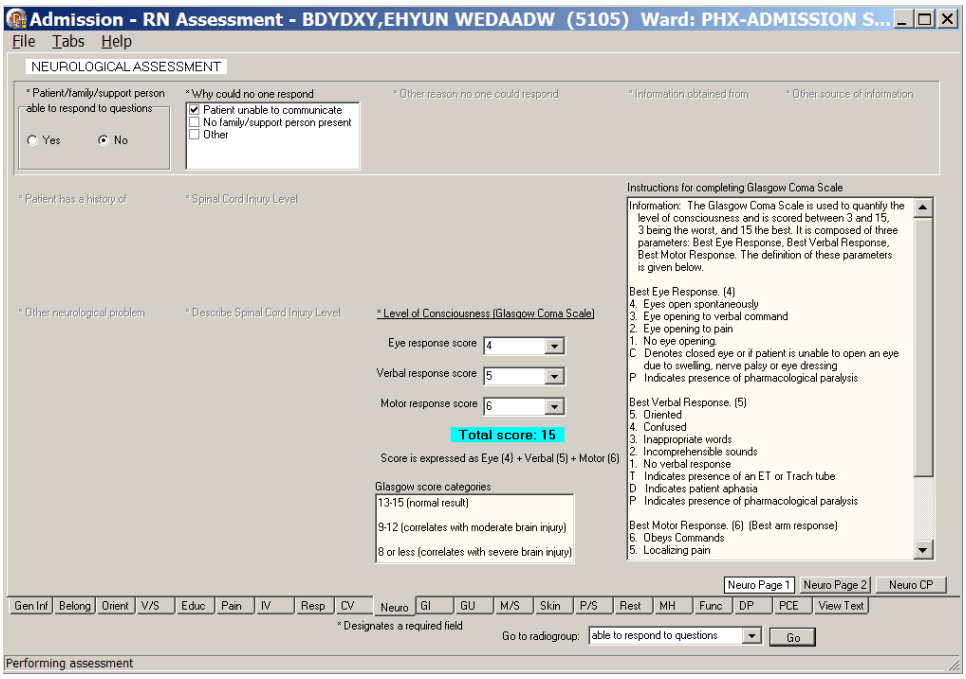
Admission – RN Assessment, Pain Assessment (Pain) tab, Pain Page 1 window



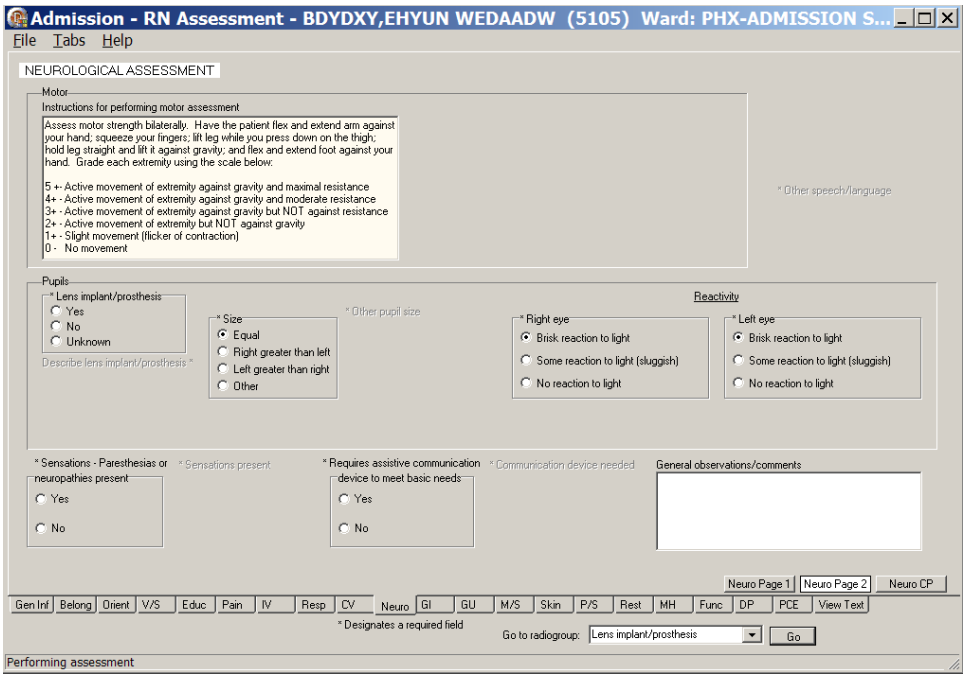
Admission – RN Assessment, Respiratory Assessment (Resp) tab, Resp Page 1 window



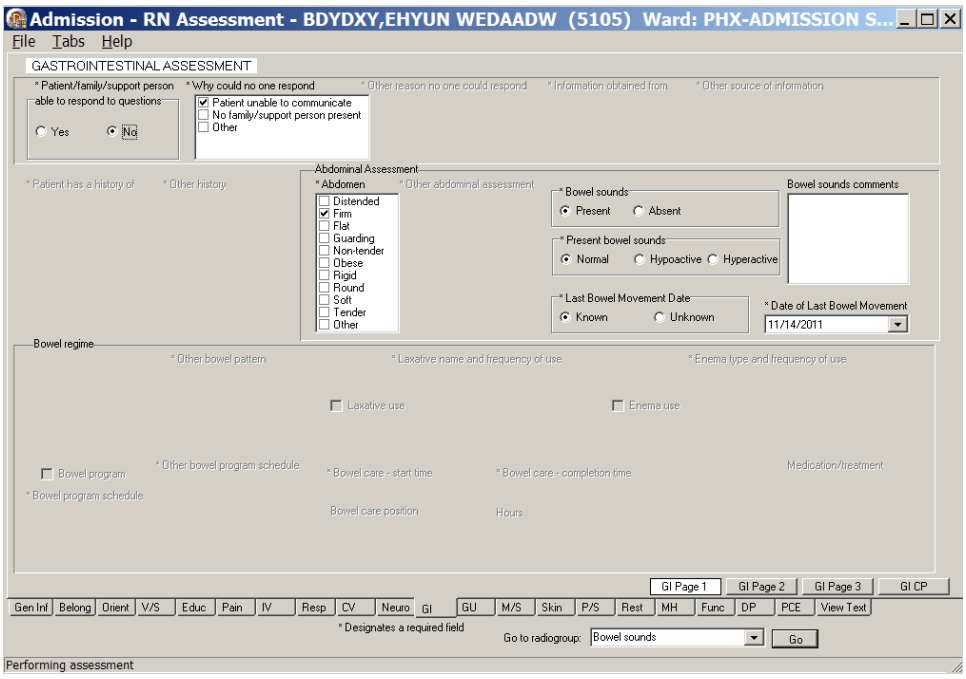
Admission – RN Assessment, Respiratory Assessment tab, Resp Page 3 window



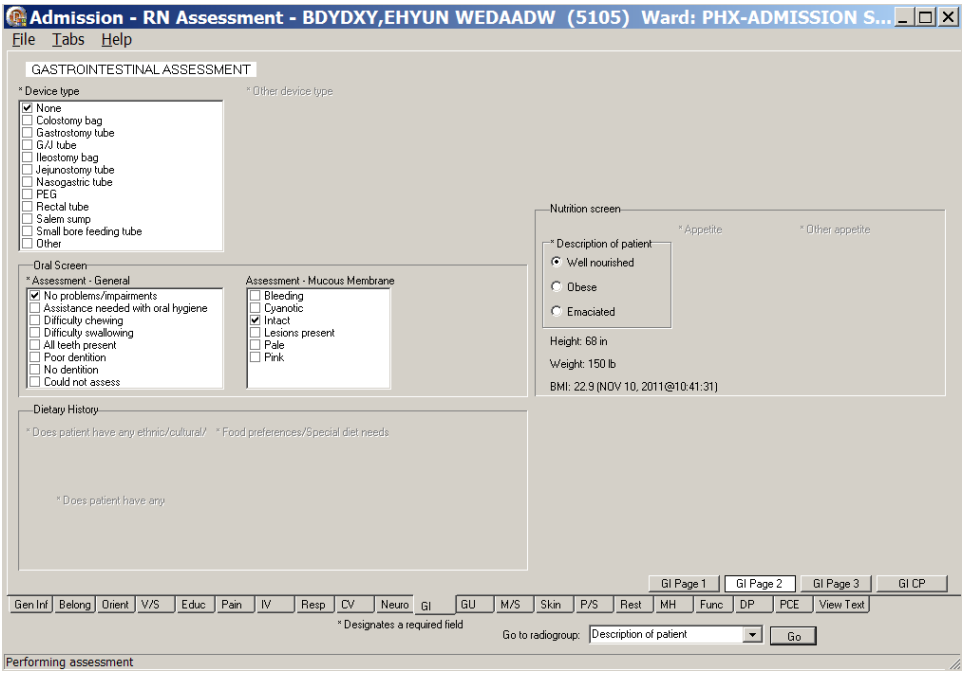
Admission – RN Assessment, Neurological Assessment (Neuro) tab, Neuro Page 1 window



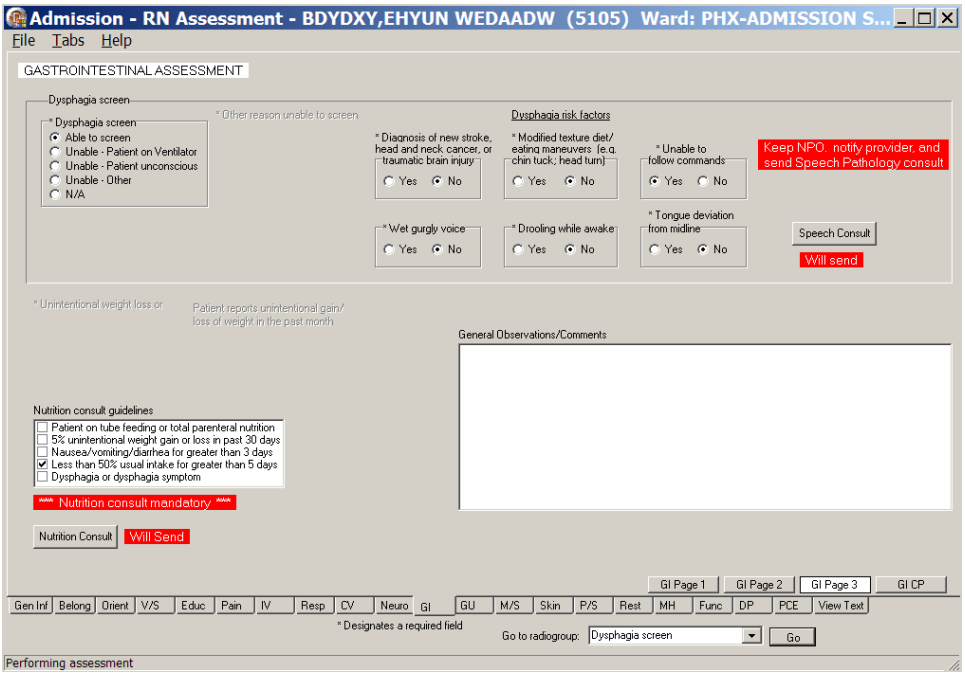
Admission – RN Assessment, Neurological Assessment (Neuro) tab, Neuro Page 2 window



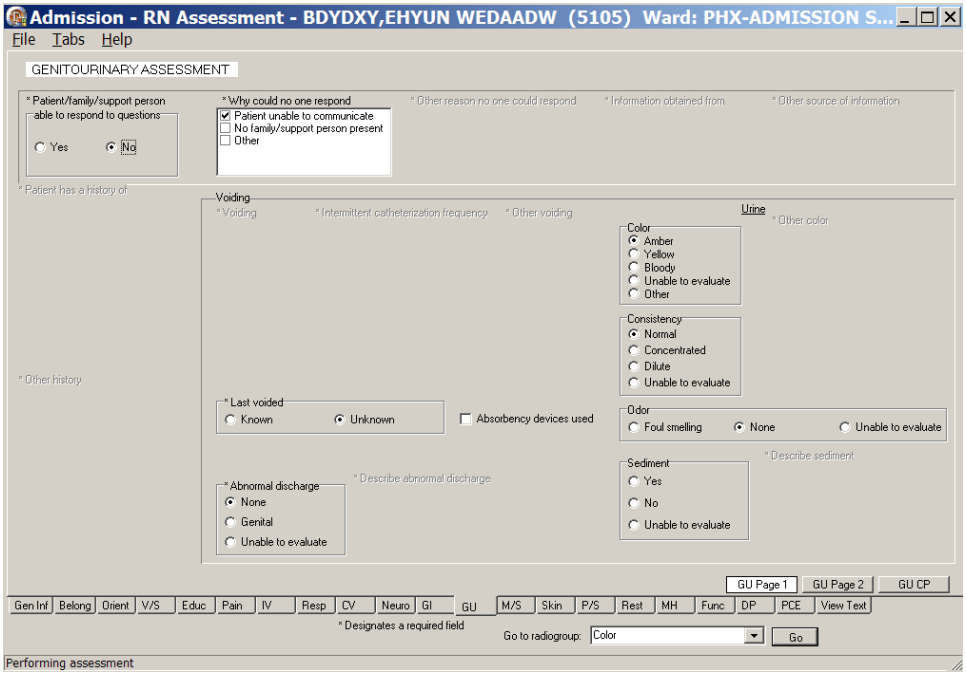
Admission – RN Assessment, Gastrointestinal Assessment (GI) tab, GI Page 1 window



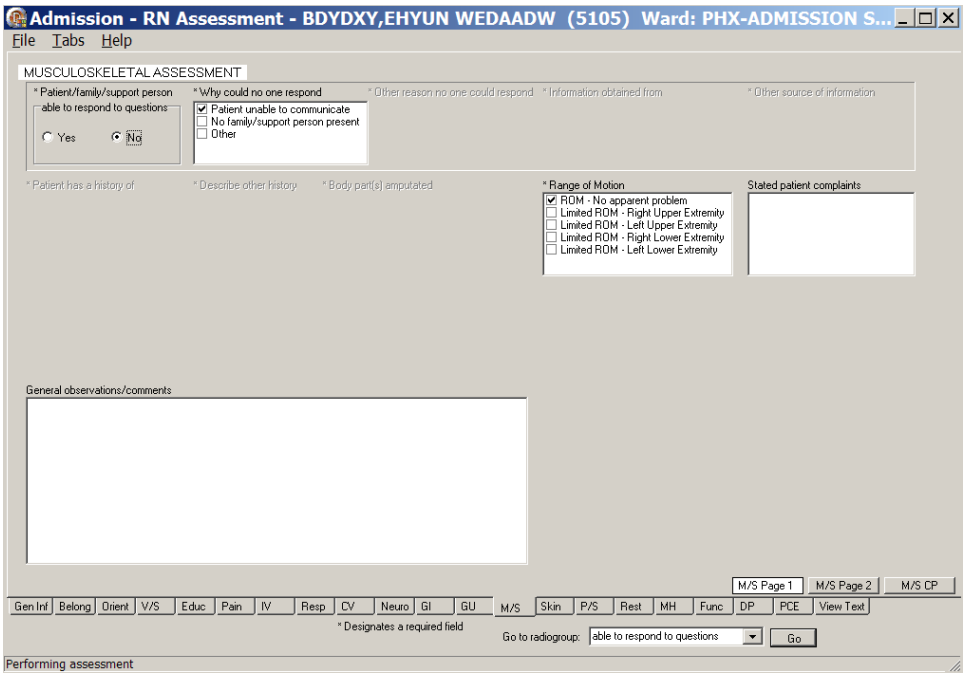
Admission – RN Assessment, Gastrointestinal Assessment (GI) tab, GI Page 2 window



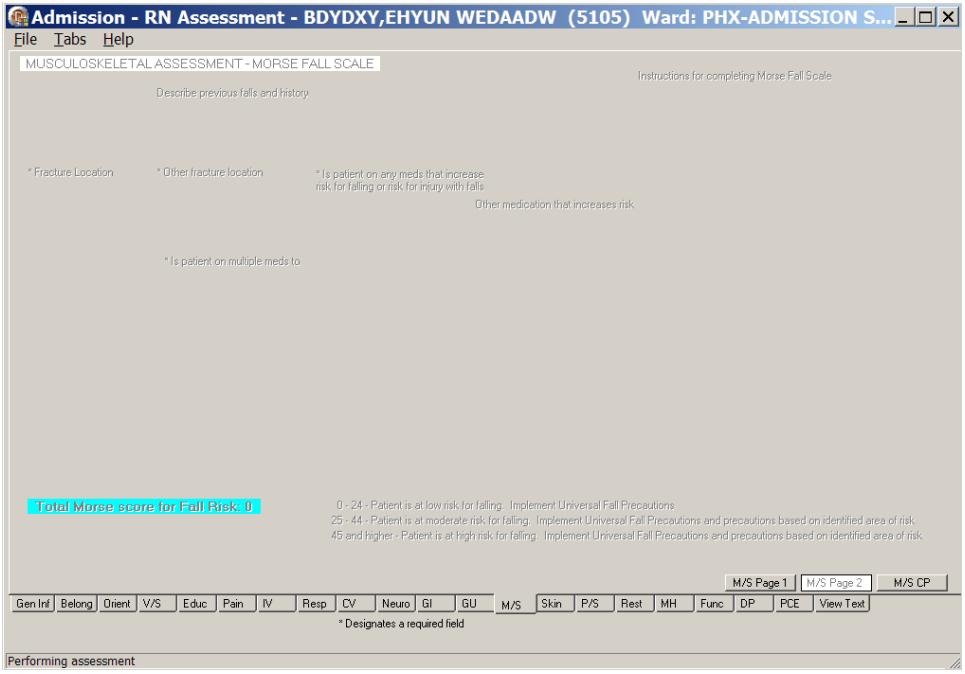
Admission – RN Assessment, Gastrointestinal Assessment (GI) tab, GI Page 3 window



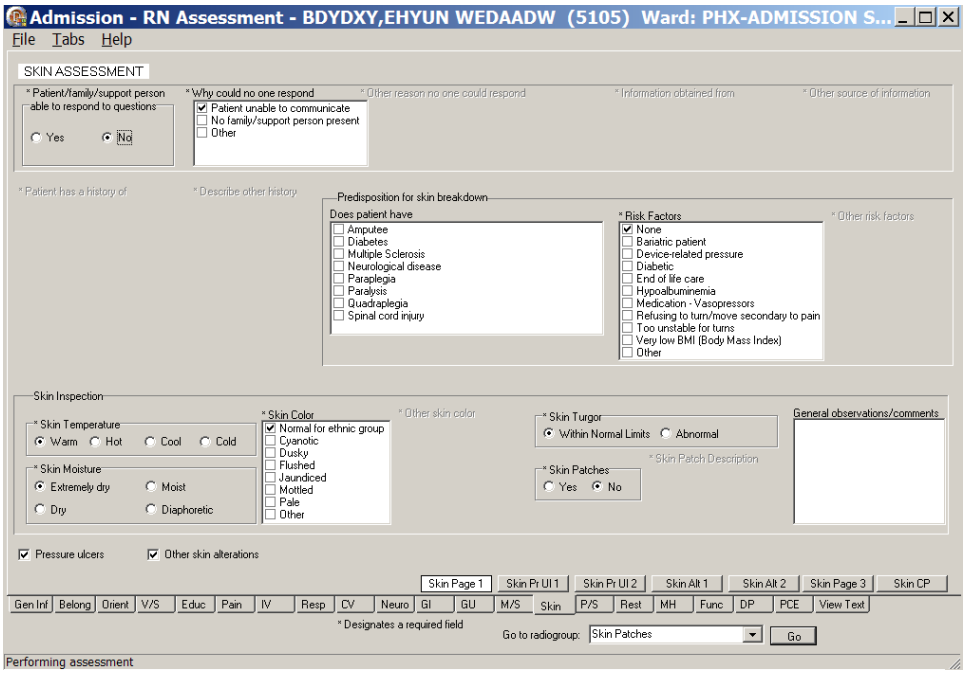
Admission – RN Assessment, Genitourinary Assessment (GU) tab, GU Page 1 window



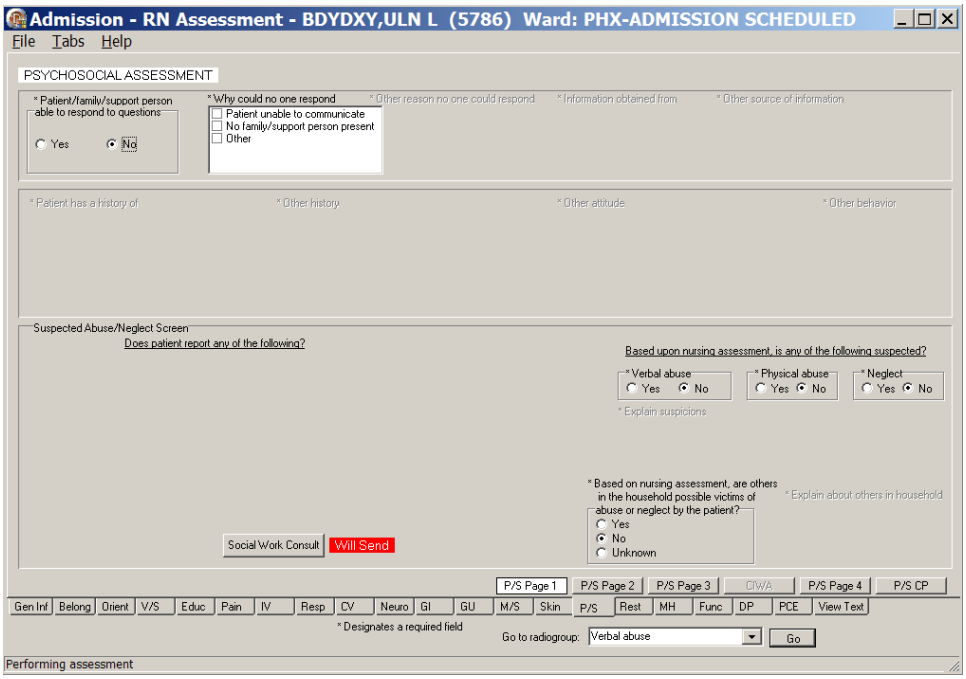
Admission – RN Assessment, Musculoskeletal Assessment (M/S) tab, M/S Page 1 window



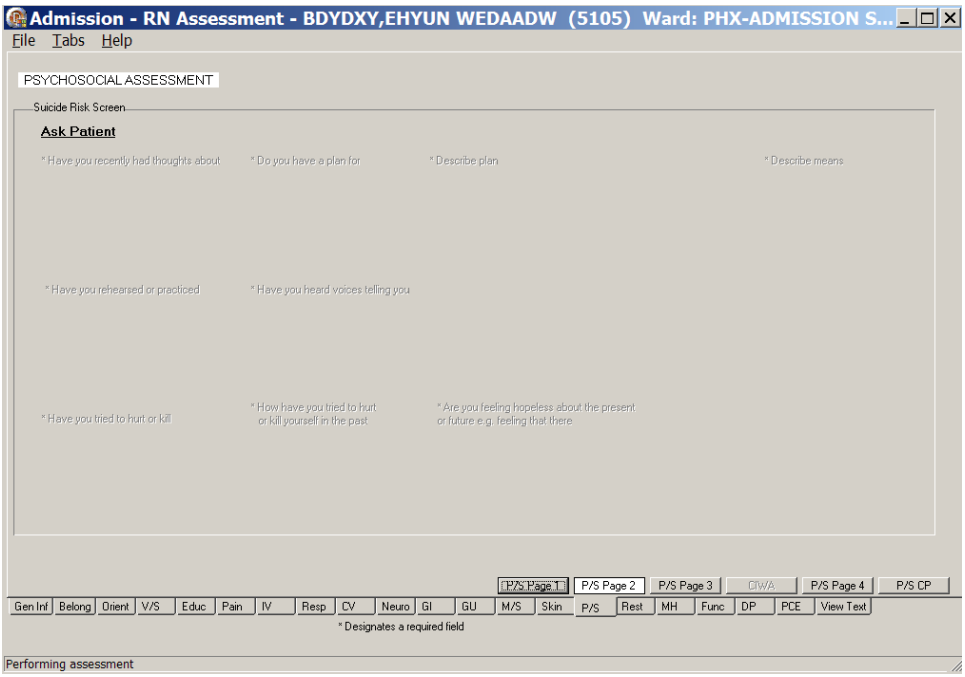
Admission – RN Assessment, Musculoskeletal Assessment (M/S) tab, M/S Page 2 window



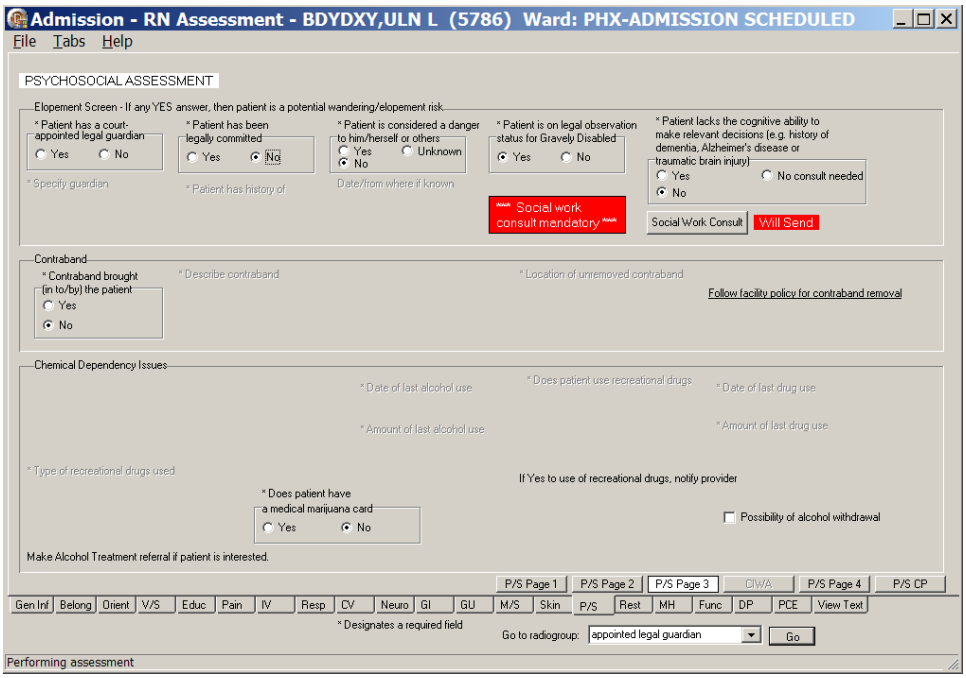
Admission – RN Assessment, Skin Assessment (Skin) tab, Skin Page 1 window



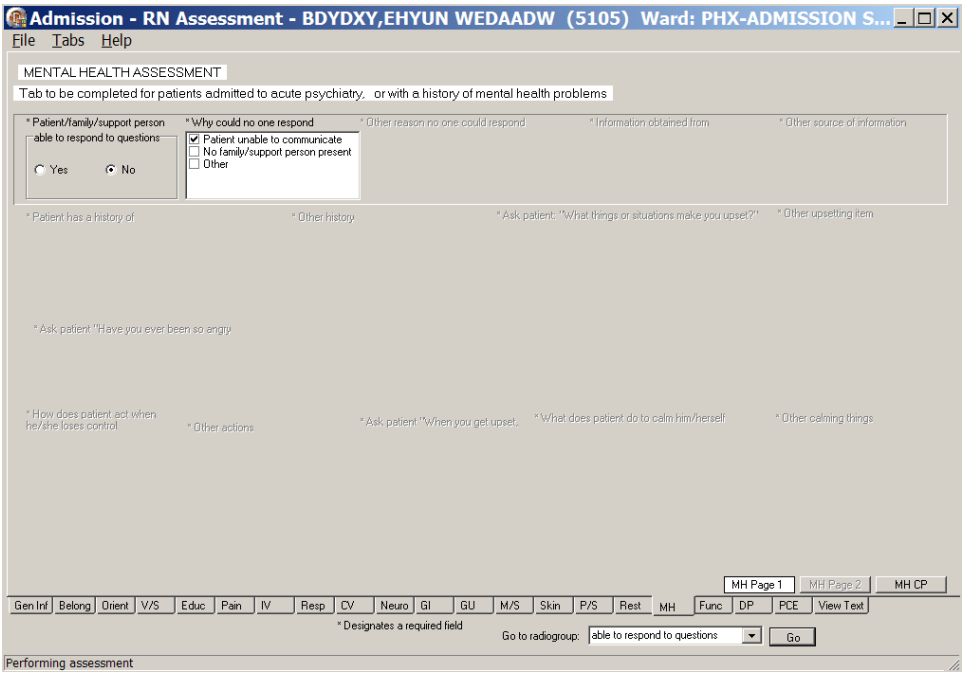
Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 1 window



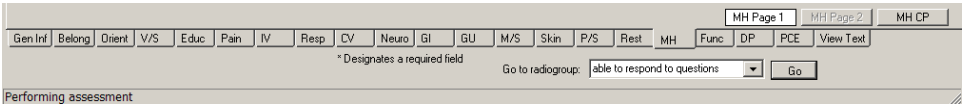
Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 2 window



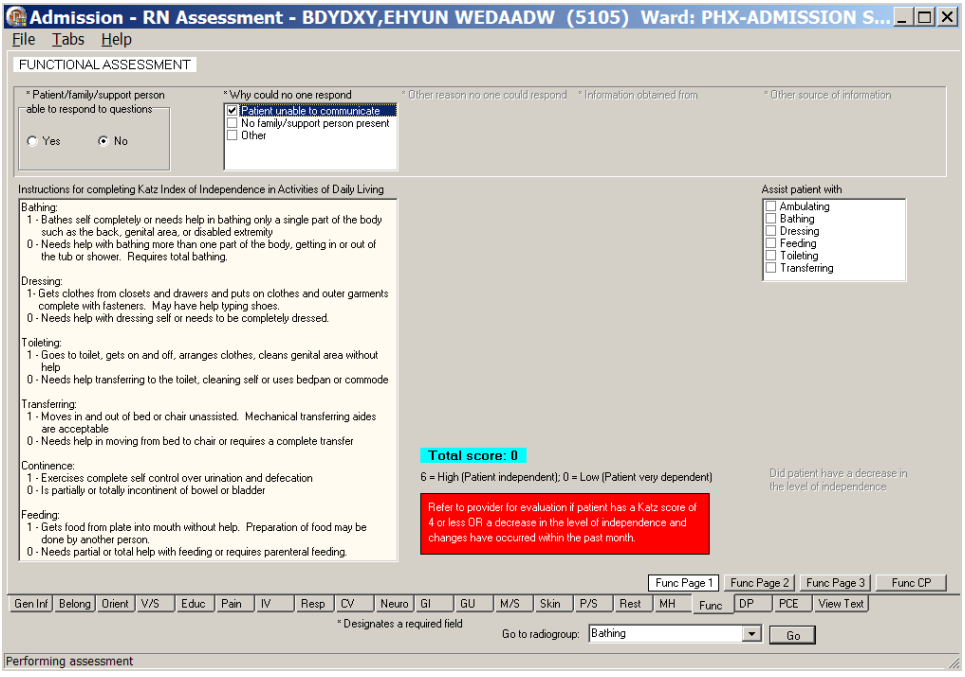
Admission – RN Assessment, Psychosocial Assessment (P/S) tab, P/S Page 3 window



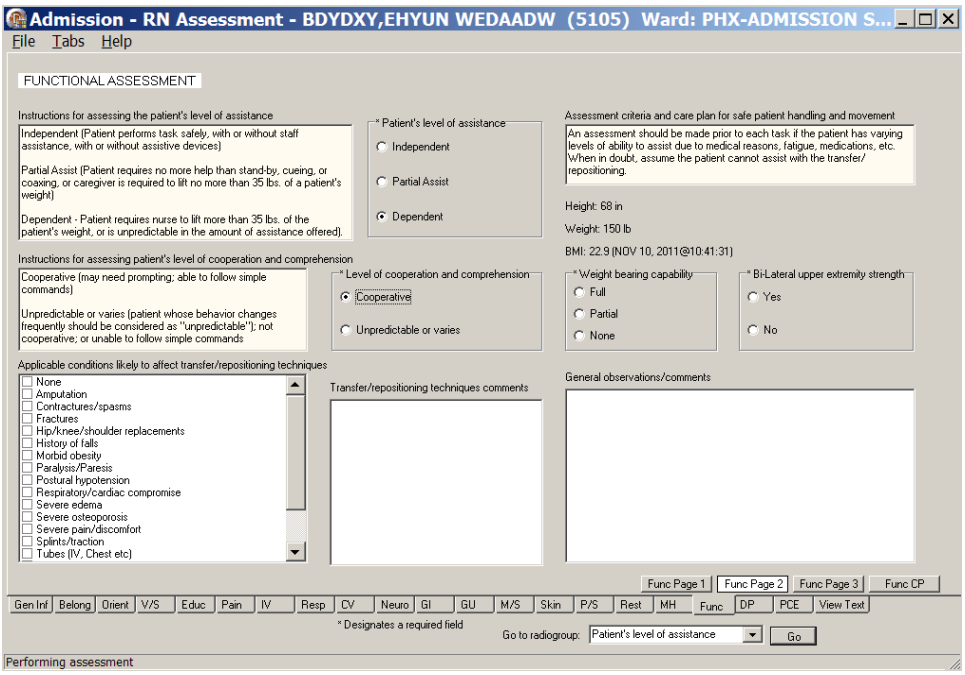
Admission – RN Assessment, Mental Health Assessment (MH) tab, MH Page 1 window



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



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



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

Glossary

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

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

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

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

Documentation for NUPA Version 1.0 is also available on

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

Appendix A
Assessment Contingency Note

Assessment Contingency Note.pdf

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