

Patient Assessment Documentation Package (PADP)

C3-C1 Conversion Project

Interdisciplinary Plan of Care 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 <i>Interdisciplinary Plan of Care</i> <i>User Manual</i> Changed dates to October	CBeynon
October 2010	1.4	Updated according to comments from the WPR	CBeynon
November 2010	1.5	Prepped for release	CBeynon
February 2011	1.6	<ul style="list-style-type: none"> • Changed dates to February 2011 • Updated with comments from Judy 	CBeynon
March 2011	1.7	<ul style="list-style-type: none"> • Changed dates to April 2011 • Updated with Judy's comments 	CBeynon
April 2011	1.8	Updated RoboHelp with this file	CBeynon
May 2011	1.9	<ul style="list-style-type: none"> • Changed dates to May 2011 • Added (NUPA*1) namespace 	CBeynon
October 2011	2.0	<ul style="list-style-type: none"> • Added C3-C1 Conversion Project • Changed dates to October 2011 • Prepped for national release 	CBeynon
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December 2011	2.2	<ul style="list-style-type: none"> • Changed dates to December 2011 • Changed <i>Admission – RN Reassessment</i> to <i>RN Reassessment</i> • Updated for build v15 • Updated for new assessment executables • Changed dates to January 2012 • Prepped for national release 	CBeynon

Date	Revision	Description	Author
January 2012	2.3	<ul style="list-style-type: none"> • Changed NUPA 1.0 to NUPA Version 1.0 • Updated for build v16 • Changed dates to February 2012 	CBeynon
March 2012	2.4	<ul style="list-style-type: none"> • Changed dates to March 2012 • Prepped for April national release • Changed dates to April 2012 	CBeynon

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Introduction

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

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

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

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

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

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

Each template is associated with a note.

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

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

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

Using the Interdisciplinary Plan of Care

The Interdisciplinary Plan of Care contains the data collected during the assessment and reassessment - problems, interventions, and assessments of patient progress by any health care professional. All clinical staff can access and contribute to the Interdisciplinary Plan of Care.

The plan of care is initiated when the admission assessment is uploaded into CPRS and VistA. Once information is entered into the plan of care, the data can be uploaded into an *unsigned* Interdisciplinary Plan of Care note that must be signed in CPRS.

Note: *Sign* the Interdisciplinary Plan of Care note immediately after it is uploaded!

The first interdisciplinary plan of care uploaded after 12 midnight becomes a progress note. Additional updates during the following 24-hour period are uploaded as addenda to the first care plan uploaded after 12 midnight.

- You cannot add addenda to an Interdisciplinary Plan of Care note until the note is *signed*.
- After Midnight, a new note is automatically generated when the next plan of care is uploaded.
- If no updates are entered into the plan of care, the upload option is unavailable.

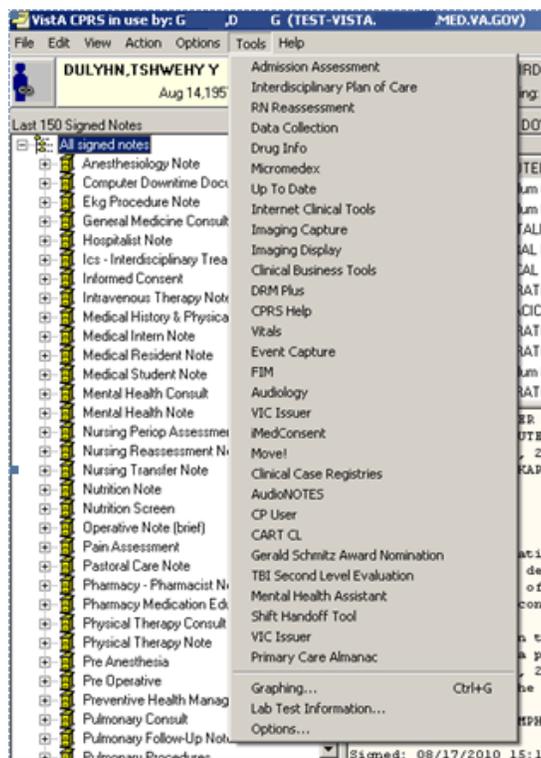
When initiated, the interdisciplinary care plan looks back 14 days. If there was a previous admission within those 14 days, the previously entered care plan is pulled forward into the new care plan.

Opening the Interdisciplinary Plan of Care

You access the Interdisciplinary Plan of Care through CPRS from the **Tools** menu.

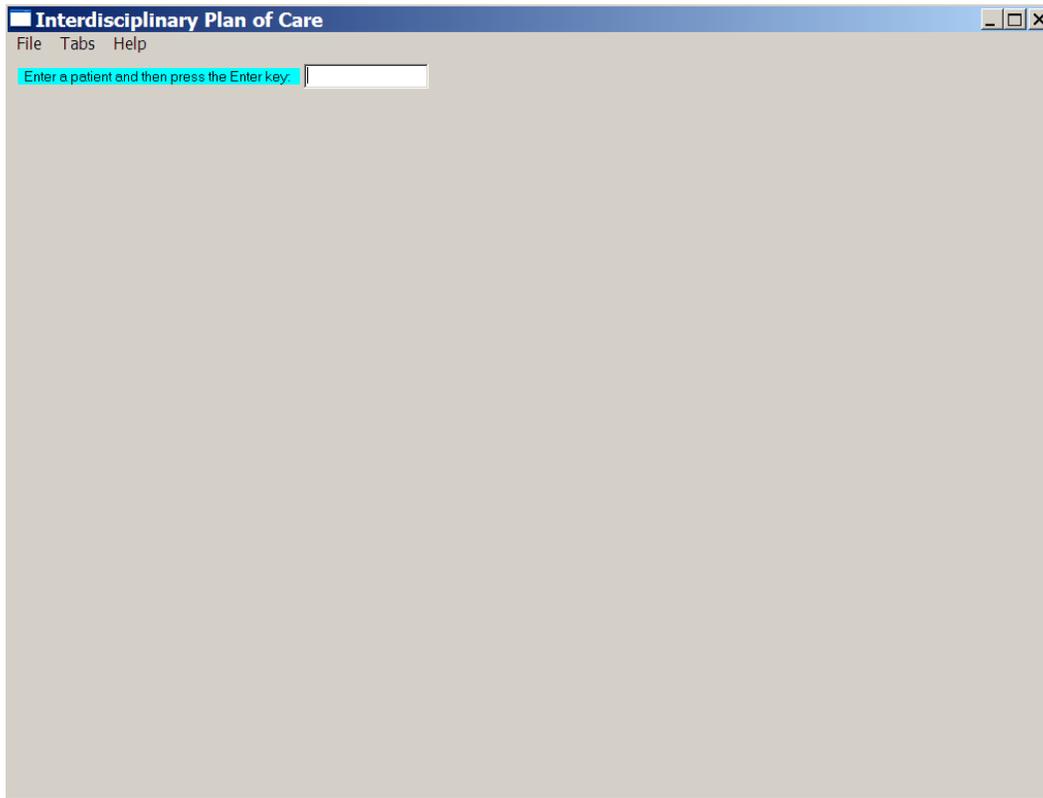
1. Open CPRS.
2. Select a patient.
3. Click **Tools**.
4. Select **Interdisciplinary Plan of Care**.
Enter a patient window automatically opens to the CPRS patient.

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



Access through CPRS

5. Type the patient name in the **Enter a patient** text box.



Interdisciplinary Plan of Care, Enter a patient window

6. Click **OK**.
Gen Inf 1 displays.

Interdisciplinary Plan of Care - ZMSHTSWLSDHYS, JEXIXALSH GRIFH (2537) Ward: Not An Inpatient

File Tabs Help

GENERAL INFORMATION

Background

*** LATEST CARE PLAN ***

Patient: ZMSHTSWLSDHYS, JEXIXALSH GRIFH

DOB: 06/09/1947

Ward: Not An Inpatient

Entered: JUL 26, 2011@12:47:15 by PADP CLINICIAN, ONE

Admitted: _____

Morse Fall Score

Morse score: 0 (APR 03, 2012@16:11)

Braden Score

Braden score: 15 (APR 03, 2012@16:11)

0 - 24: Patient is at low risk for falling.
25 - 44: Patient is at moderate risk for falling.
45 and higher: Patient is at high risk for falling.

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

Guardian: _____

Preferred Healthcare Language: _____

Suspected victim of abuse/neglect

Yes

No

* Cultural Practices Description

Cultural Practices

Yes

No

* Blood transfusion concerns

Blood transfusion concerns

Yes

No

* Advance directive location

Patient has an Advance Directive

Yes

No

* Special diet needs

Special diet needs

Yes

No

Gen Inf 1 Gen Inf 2 Educ Prob Func DP View CP

Go to radiogroup: _____ OK

* Designates a required field

Interdisciplinary Plan of Care, General Information Gen Inf 1 tab window

Saving and Uploading Data

The initial plan of care is generated using data entered on the Care Plan (CP) pages while documenting in the Admission - RN Assessment template.

Note: When you upload data from the Admission - RN Assessment and/or the RN Reassessment, that data is also sent to the Interdisciplinary Plan of Care.

Auto Save

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



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

Upload Data

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

1. Open the File menu on any tab and select **Upload Data**.

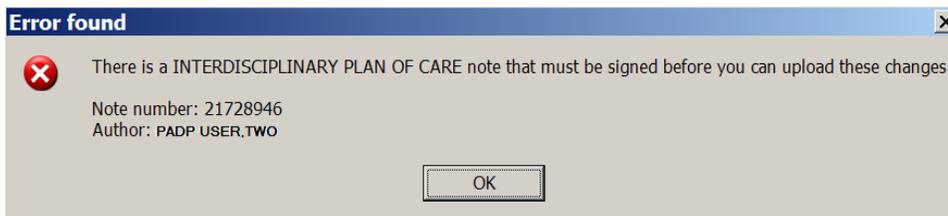
Warning pop-up displays.



Warning pop-up: You may not MAKE AN ADDENDUM for this unsigned
INTERDISCIPLINARY PLAN OF CARE (note #21728910)

2. Click **OK**.

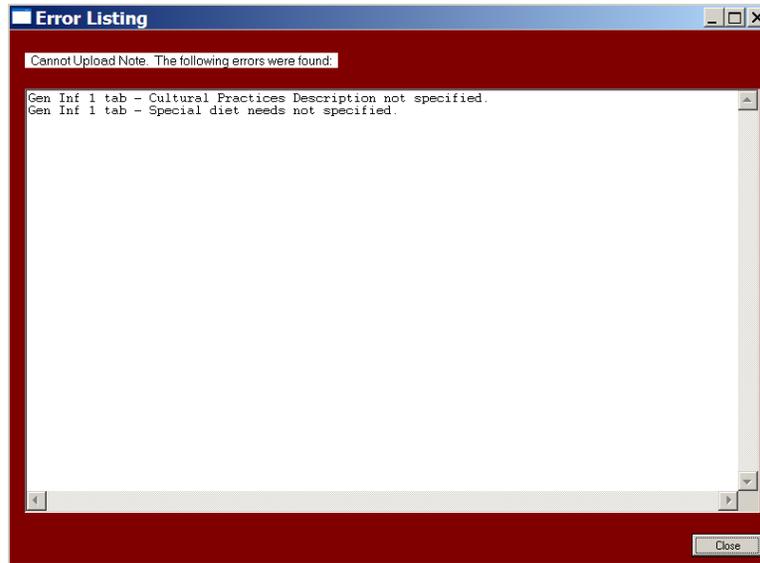
Error found message displays.



Error found: There is a Interdisciplinary plan of care note that must be signed
before you can upload these changes.

3. Click **OK**.

4. If required fields are incomplete, an Error Listing displays indicating the tab and issues that require attention.

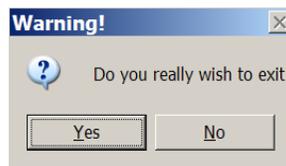


Error Listing window

5. Double-click an item to go to the tab that requires attention.
6. When all the errors are completed, select **Upload Data** again.

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**.

Working in the Template

1. To complete the template, move through the fields from left to right and then down.
2. Each field with an asterisk (*) must have an entry.
3. A field without an asterisk is optional.

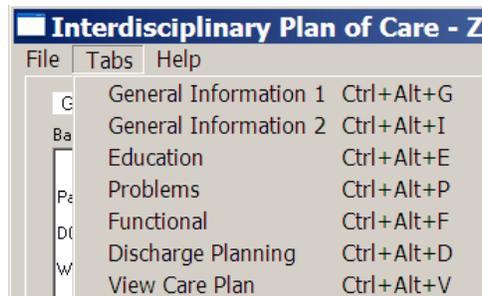
Moving through the Template with a Mouse

1. Click a tab at the bottom of any of the Interdisciplinary Plan of Care windows.
The selected tab opens.



Interdisciplinary Plan of Care tabs

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



Interdisciplinary Plan of Care, Tabs menu

Moving through the Template without a Mouse

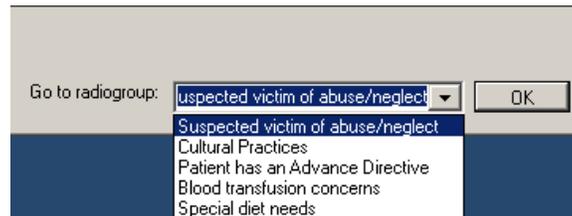
Ctrl-Alt Keys

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 1	Ctrl +Alt+G
General Information 2	Ctrl +Alt+I
Education	Ctrl +Alt+E
Problems	Ctrl +Alt+P
Functional	Ctrl +Alt+F
Discharge Planning	Ctrl +Alt+D
View Care Plan	Ctrl +Alt+V

Go to radiogroup

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



Go to radiogroup

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

Navigating the Interdisciplinary Plan of Care Tabs

The Interdisciplinary Plan of Care template has seven tabs.

General Information 1 (Gen Inf 1)

The Interdisciplinary Plan of Care template opens to the General Information 1 (Gen Inf 1) tab, the first tab at the bottom on the left. The Gen Inf 1 tab pulls information from the Admission – RN Assessment or a previous Interdisciplinary Plan of Care.

The Gen Inf 1 tab contains:

- Background
Pulled from the Admission – RN Assessment and other VistA files and cannot be edited
- Admitted
Date and time patient is admitted
- Morse Fall Score
Pulled from previously entered data and cannot be edited from the Plan of Care
- Braden Score
Pulled from previously entered data and cannot be edited from the Plan of Care
- Guardian
- Preferred Healthcare Language
- Suspected victim of abuse/neglect
- Cultural Practices
- Blood transfusion concerns
- Patient has an Advance Directive
- Special diet needs

The screenshot shows a software window titled "Interdisciplinary Plan of Care - BDYDXY,EHYUN WEDAADW (5105) Ward: Not An Inpatient". The window has a menu bar with "File", "Tabs", and "Help". The main content area is divided into several sections:

- GENERAL INFORMATION:** Includes a "Background" section with a "LATEST CARE PLAN" box containing patient details: Patient: BDYDXY,EHYUN WEDAADW, DOB: 07/23/1945, Ward: Not An Inpatient, and Entered: NOV 14, 2011 @ 12:43:34 by: RACPLINICAW,CNS.
- Admitted:** Contains "Morse Fall Score" (0 [DEC 06, 2011 @ 08:31]) and "Braden Score" (23 [DEC 06, 2011 @ 08:31]).
- Assessment Legend:** A table defining risk levels: 0-24 (Low risk), 25-44 (Moderate risk), 45+ (High risk), and 9 or below (Severe risk).
- Guardian:** A text field for the guardian's name.
- Preferred Healthcare Language:** A dropdown menu currently set to "English".
- Suspected victim of abuse/neglect:** Radio buttons for "Yes" and "No" (selected).
- Cultural Practices:** Radio buttons for "Yes" and "No" (selected).
- Blood transfusion concerns:** Radio buttons for "Yes" and "No" (selected).
- Patient has an Advance Directive:** Radio buttons for "Yes" and "No" (selected).
- Special diet needs:** Radio buttons for "Yes" and "No" (selected).

At the bottom, there is a navigation bar with buttons for "Gen Inf 1", "Gen Inf 2", "Edit", "Print", "Funct", "OP", and "View OP". A "Go to subgroup:" dropdown and an "OK" button are also present.

Interdisciplinary Plan of Care, General Information, Gen Inf 1 tab window

1. On the Gen Inf 1 tab, make changes if necessary.
2. Click **Gen Inf 2**.
Gen Inf 2 displays.

Example

If a **Patient has an Advance Directive**, you can change **No** to **Yes**. Advance directive location becomes available and because it is required, you can document the current location of Advance Directive.

General Information 2 (Gen Inf 2)

The General Information 2 tab pulls information from the Admission – RN Assessment or a previous Interdisciplinary Plan of Care. The Gen Inf 2 tab is read-only.

The Gen Inf 2 tab contains:

- Allergies
- Current Inpatient Meds (last 3 days)
- Precautions/Flags
- Current Active or Pending orders since yesterday
- Display only orders entered since yesterday (checked/unchecked)

Interdisciplinary Plan of Care - BDYDXY,EHYUN WEDAADW (5105) Ward: Not An Inpatient

File Tabs Help

GENERAL INFORMATION

Allergies

Current Inpatient Meds (last 3 days)

Precautions/Flags

- Dysphagia risk
- Eloperment risk
- Eloperment risk
- Eloperment risk
- Eloperment risk
- Fall risk
- Fall risk
- Fall risk
- Pressure sore

Current Active or Pending orders

ORDER TYPE	ITEM ORDERED	START DATE	ORDERED BY
NONE FOUND			

Display only orders entered since yesterday [unchecked]

Gen Inf 1 Gen Inf 2 Educ Prob Func DP View CP

* Designates a required field

Interdisciplinary Plan of Care, General Information, Gen Inf 2 tab window

Review the information in the Gen Inf 2 tab; no changes can be made on Gen Inf 2.

Education (Educ)

The Education tab pulls in previously entered information. You can change the responses, if the patient's condition requires education modifications.

The fields are like the Educational Assessment in the Admission - RN Assessment and the RN Reassessment.

- Patient/family/support person oriented
- Able to assess education
- Learns best by
- Prefers (method of learning)
- Readiness to learn
- Barriers to learning
- Knowledge of current illness, surgery, reason for hospitalization etc. as identified by patient
- Information provided to patient on the following topics

Interdisciplinary Plan of Care - BDYDX,Y,EHYUN WEDAADW (5105) Ward: Not An Inpatient

File Tabs Help

EDUCATION

Patient/family/support person oriented

Yes - patient oriented to unit
 Yes - family support person oriented to unit
 No - patient unable to respond and no family support person available

Able to assess education:

Yes
 No

Learns best by

Doing
 Hearing/Listening
 Reading
 Seeing

Prefers

Group Classes
 Includes Approach (A)
 Prefers support person to be included
 Computer based training

Readiness to learn

Ready to learn
 States not interested in learning
 States teaching not needed
 Impeded by current condition

Barriers to learning

None Identified
 Hearing
 Language
 Limited attention span
 Memory
 Pain
 Sedation/Lethargy
 Visual Impairment
 Other

Barriers to learning description

Knowledge of current illness, surgery, reason for hospitalization etc as identified by patient

None
 Limited
 Extensive

Information provided to patient on the following topics

BCMA
 Managing Your Pain
 Notification of the Joint Commission
 Patient Rights & Responsibilities
 Patient Safety Concerns
 Prevention of Falls
 Promotion of a Restraint Free Environment
 Other

* Other topic provided

Gen Inf 1 Gen Inf 2 Educ Prob Func DP View CP

Go to radiogroup: [dropdown] OK

* Designates a required field

Interdisciplinary Plan of Care, Education, Educ tab window

In the Educ tab, make changes if necessary.

Problems/Interventions/Desired Outcomes (Prob)

Problems are listed in the table on the Problems/Interventions/Desired Outcomes (Prob) tab. You can view:

- All problems for the current hospitalization of the patient, including resolved problems, or
- Only active problems

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DATE
CV	Abnormal Cardiac Rhythms (Actual)	12/16/11@0940	Prevention, recognition	No change/sta	12/16/11@0943	Surveillance - Monitor labs and oxygenatio	12/16/11@09	Continue	12/16/11@0943
RESP	Asthma (Actual)	12/6/11@0831	Stabilization and/or im	Improving	12/16/11@0932	Education - Assess patient's knowledge ar	12/16/11@09	Not on file	Not on file
						Surveillance - Assess patient's level of con	12/16/11@09	Not on file	Not on file
						Education - Instruct patient to immediat	12/6/11@083	Continue	12/16/11@0932

Interdisciplinary Plan of Care, Problems/Interventions/Desired Outcomes, Prob tab window

Note: To switch between the two views, select or clear the **Do not display resolved problems** check box.

Care Plan Table

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

Interdisciplinary Plan of Care, Problems/Interventions/Desired Outcomes table

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

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

Updating an Existing Problem/Intervention

1. Click a problem.
Problem evaluation and Intervention status become available.

The screenshot shows a software window titled "Interdisciplinary Plan of Care - BDYDXY,EHYUN WEDAADW (5105) Ward: Not An Inpatient". The window has a menu bar with "File", "Tabs", and "Help". Below the menu bar is a section titled "PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES" with a subtitle "Click a row to update it's problem evaluation and intervention status." Below this is a table with the following data:

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT ST
RESP	Asthma (Actual)	12/6/11@0831	Stabilization and/or imng	Deteriorating	12/15/11@1521	Education - Instruct patient to immediately report any problems	12/6/11@0831	Contini

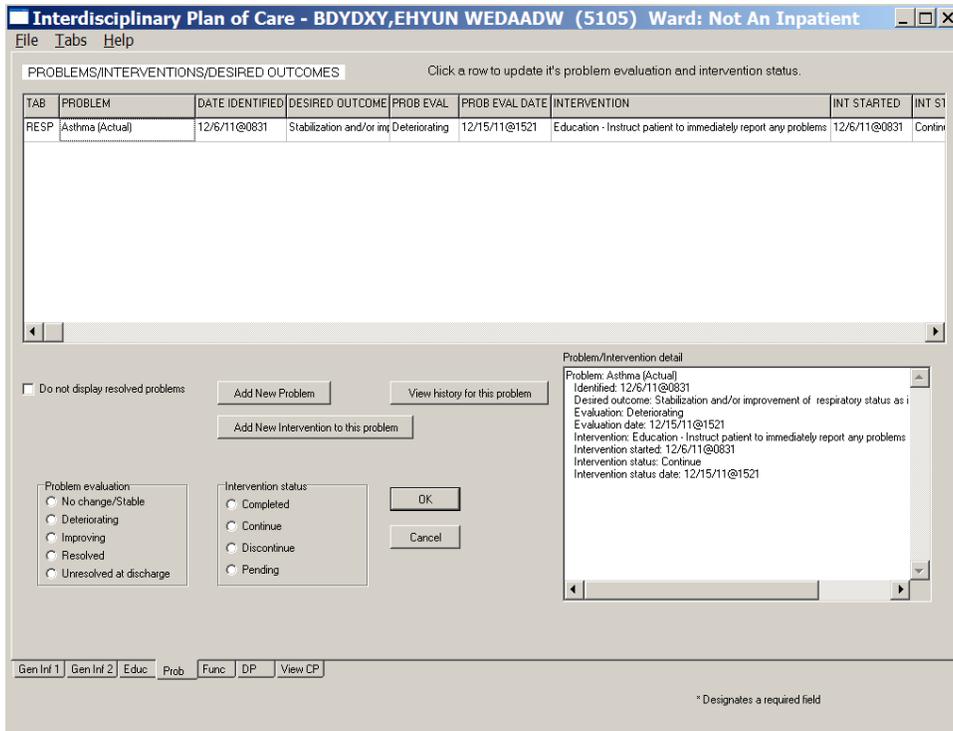
Below the table is a section titled "Problem/intervention detail" with several controls:

- Do not display resolved problems
- Buttons: "Add New Problem", "View history for this problem", "Add New Intervention to this problem"
- Problem evaluation section with radio buttons:
 - No change/Stable
 - Deteriorating
 - Improving
 - Resolved
 - Unresolved at discharge
- Intervention status section with radio buttons:
 - Completed
 - Continue
 - Discontinue
 - Pending
- Buttons: "OK", "Cancel"

At the bottom of the window, there is a navigation bar with buttons: "Gen Inf 1", "Gen Inf 2", "Educ", "Prob", "Func", "DP", "View CP". A small note at the bottom right says "* Designates a required field".

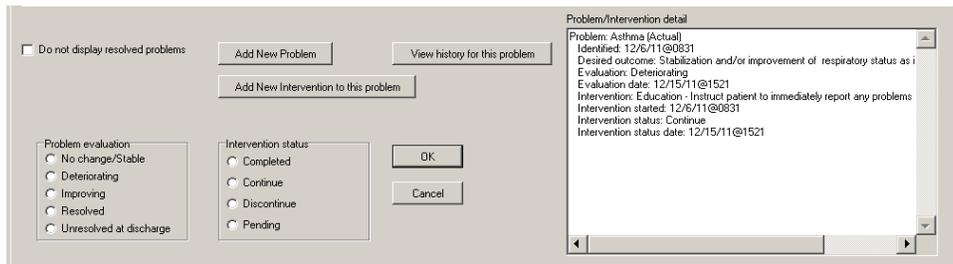
Interdisciplinary Plan of Care, Problems/Interventions/Desired Outcomes, Prob tab window
Problem evaluation and Intervention status available

2. Click the problem again to view its **Problem/Intervention detail**.
A summary of the problem displays with the specific intervention and statuses.



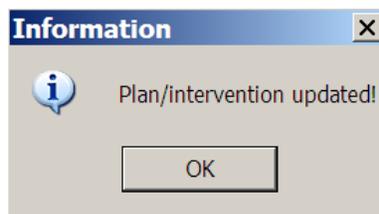
Interdisciplinary Plan of Care, Problems/Interventions/Desired Outcomes, Prob tab window
Problem/Intervention detail available

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



Problem evaluation, Intervention status, and Problem/Intervention detail

4. To delete entered data *before saving*, click **Cancel**.
5. Click **OK**.
Information pop-up displays.



Information pop-up: Plan/Intervention updated!

6. Click **OK** to complete the problem/intervention update.
7. To update additional problems/interventions, repeat steps 1-6, as necessary.
8. Review the care plan table.
The Prob Eval/Int Status are updated and the Prob Eval Date/Int Status Date are added.

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT ST
RESP	Asthma (Actual)	12/6/11@0831	Stabilization and/or imp	Improving	12/16/11@0932	Education - Instruct patient to immediately report any problems	12/6/11@0831	Continue

Interdisciplinary Plan of Care, Problems/Interventions/Desired Outcomes, Prob tab window with an updated problem

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

Problem History

Evaluation history DEC 16, 2011@09:32:51

Problem evaluation

Problems: Asthma (Actual)

Status: IMPROVING (DEC 16, 2011@09:32:54 by FADP USER,ONE)

Status: DETERIORATING (DEC 15, 2011@15:21:20 by FADP USER,ONE)

Intervention evaluation

Intervention: Education - Instruct patient to immediately report any problems that arise with

Int. Status: CONTINUE (DEC 16, 2011@09:32:54 by FADP USER,ONE)

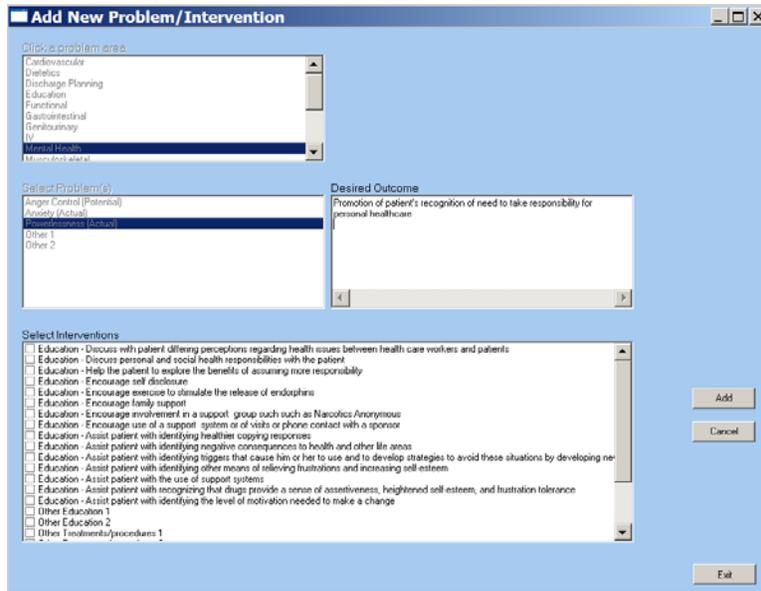
Int. Status: CONTINUE (DEC 15, 2011@15:21:20 by FADP USER,ONE)

Problem History window

10. Click **Close**.

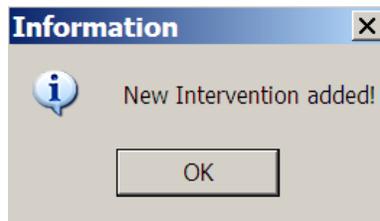
Adding a New Intervention for an Existing Problem

1. Click a problem.
2. Click **Add New Intervention to this problem**.
The Add New Problem/Intervention window displays with the area and problem selected.



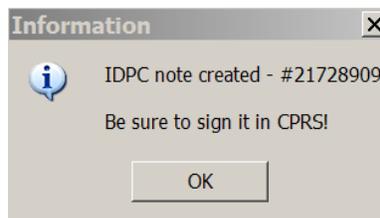
Add a New Problem/Intervention window

3. Select one or more interventions from the **Select Interventions** list box.
4. Click **Add**.
Information pop-up displays.



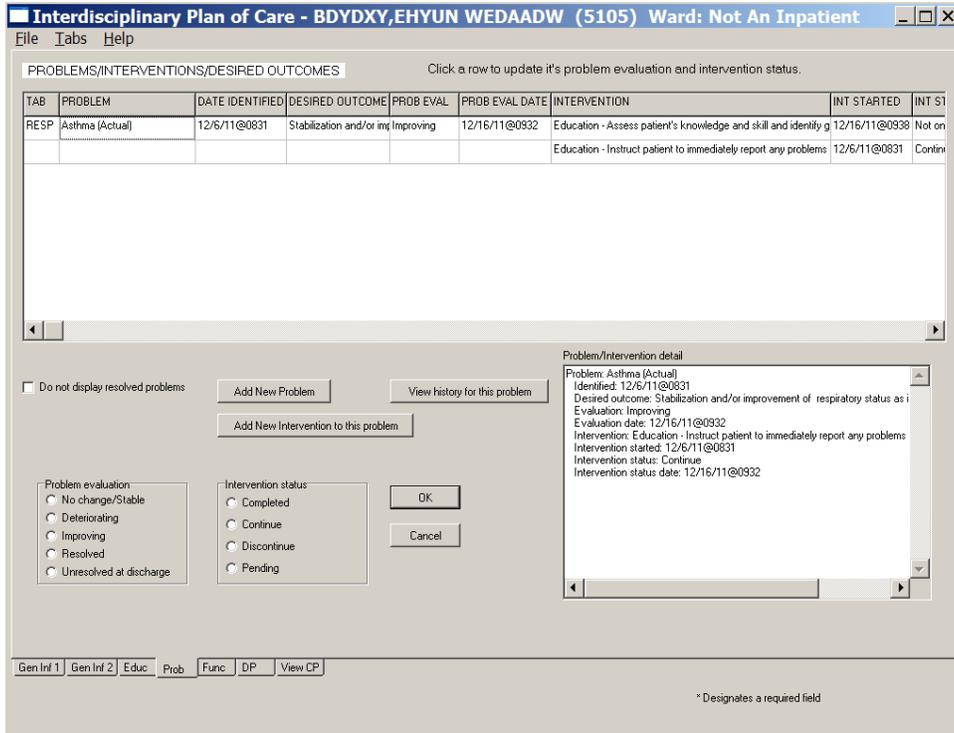
Information pop-up: New Intervention added!

5. Click **OK**.
6. Click **Exit**.
Information pop-up displays.



Information pop-up: IDPC note created - #(21728909)
Be sure to sign it in CPRS!

- Click **OK**.
Problems/Interventions/Desired Outcomes window redisplay with the new intervention.

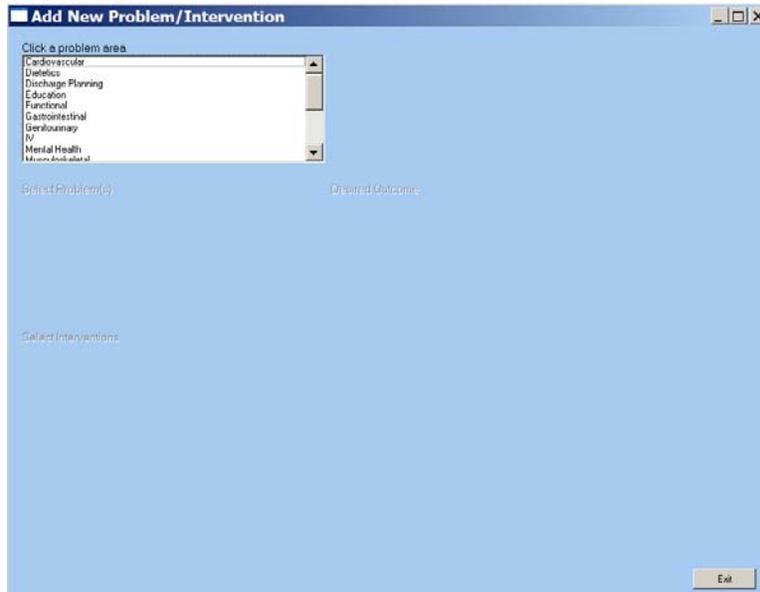


Interdisciplinary Plan of Care, Problems/Interventions/Desired Outcomes, Prob tab window with a new intervention added

- To add more interventions, repeat steps 1-7.

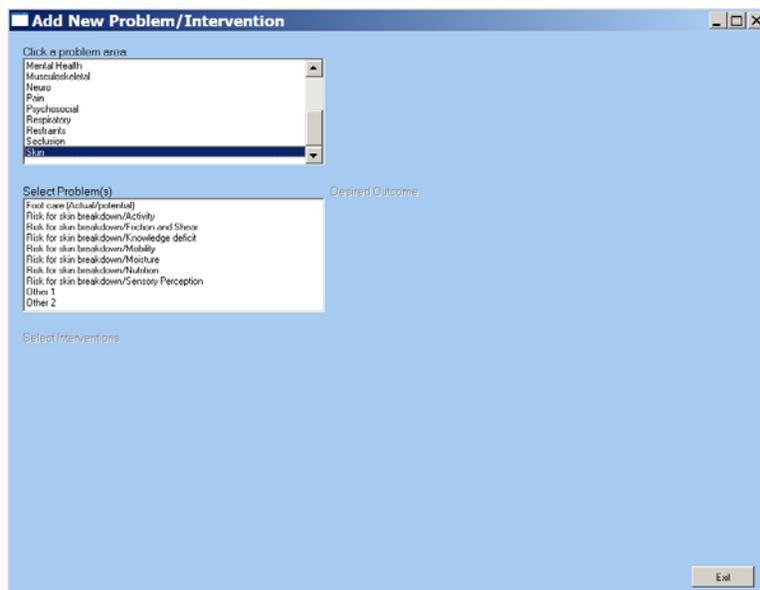
Adding a New Problem/Intervention

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



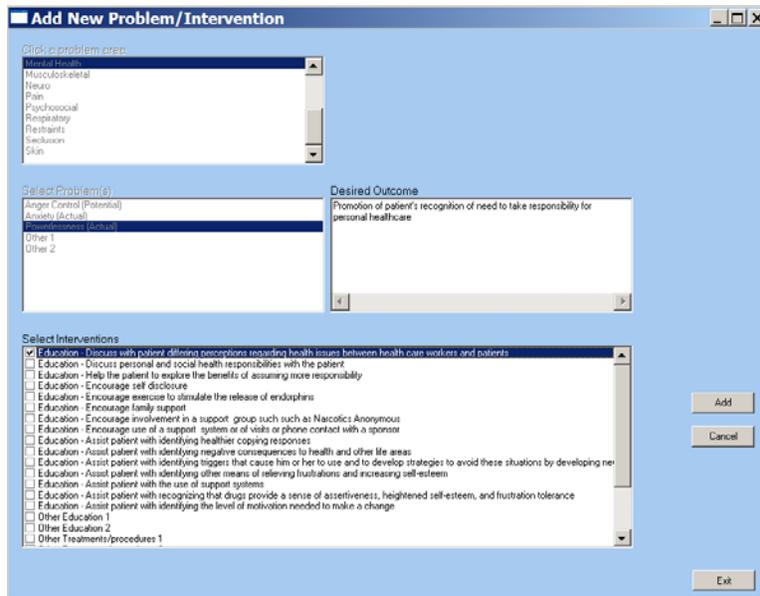
Add New Problem/Intervention window

2. Select an area from the **Click a problem area** list box.
The Select Problem(s) list box displays.



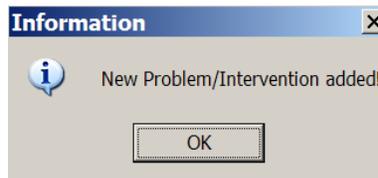
Add New Problem/Intervention window
Select Problem(s) available

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



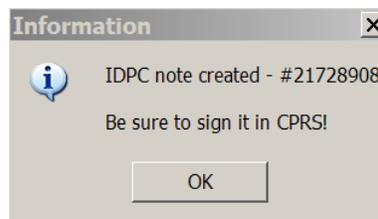
Add New Problem/Intervention window for problem/intervention options

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



Information pop-up: New Problem/Intervention added!

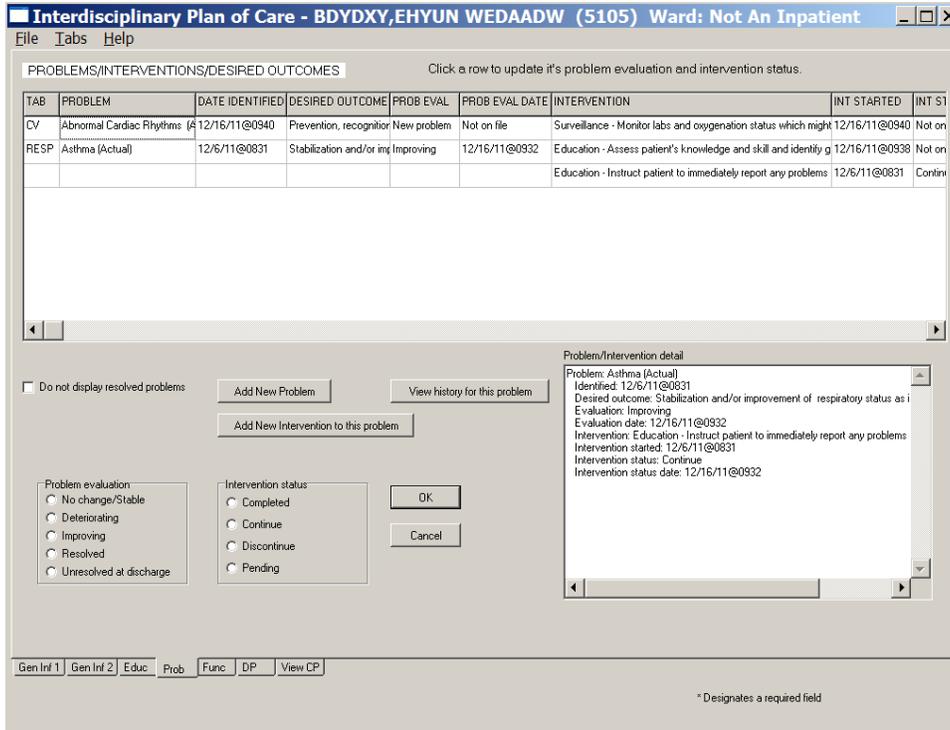
6. Click **OK**.
7. Click **Exit**.
Information pop-up displays.



Information pop-up: IDPC note created - #(21728908)
Be sure to sign it in CPRS!

8. Click **OK**.

Note: The Prob tab redisplay with the new problem and its related intervention(s) added to the table (grouped according to tab).



List of Problems/Interventions/Desired Outcomes with new problem added

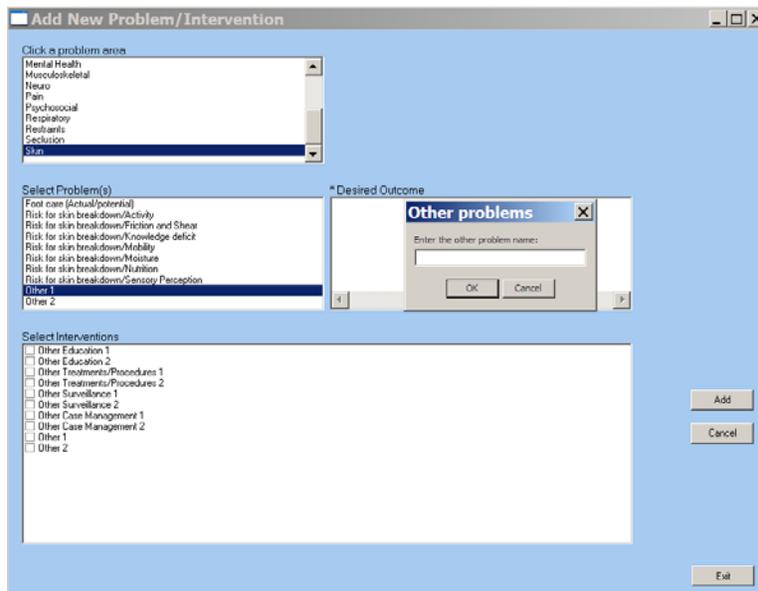
9. To add more problems/interventions, repeat steps 1-8, as necessary.

Other Problems

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

1. Select an *Other* problem in the **Select Problems** list box.

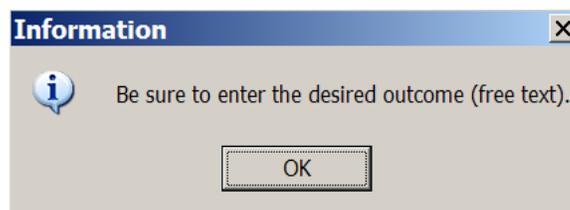
The *Other* problems pop-up displays.



Add New Problem/Intervention window with *Other* pop-up

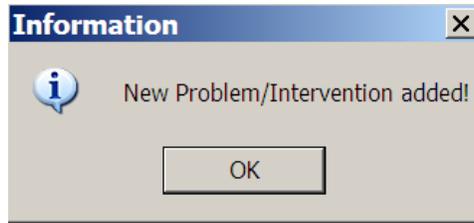
2. Type the *other* problem into the text box.
3. Click **OK**.

Information pop-up displays.



Information pop-up: Be sure to enter the desired outcome (free text).

4. Click **OK**.
5. Type a desired outcome into the **Desired Outcome** text box.
6. Select one or more interventions from the **Select Interventions** list box.
7. Click **Add**.



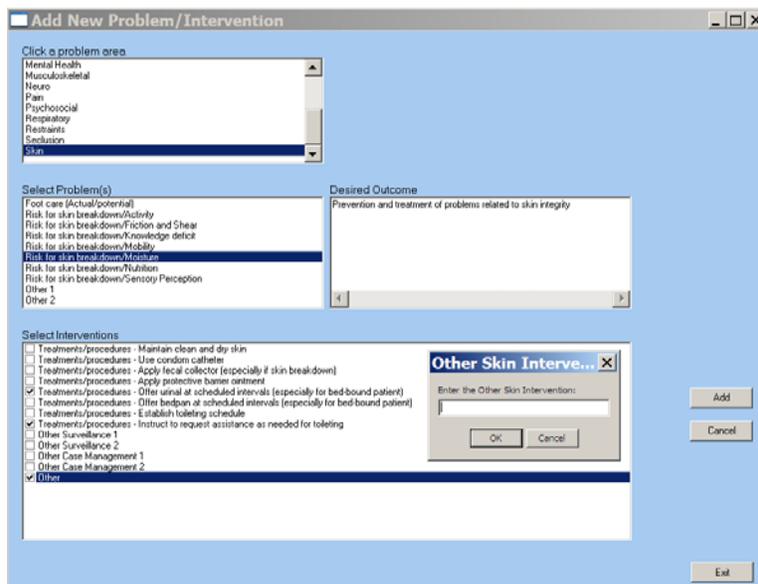
Information pop-up: New Problem/Intervention added!

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

Other Interventions

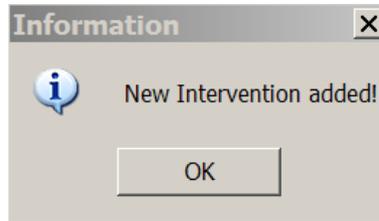
Some interventions generate a pop-up to enter interventions that are not on the predefined list.

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



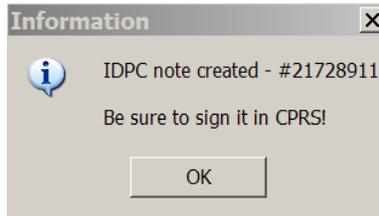
Add New Problem/Intervention window with Other pop-up

4. Click **Add** to transfer the intervention to the plan of care.
Information pop-up displays.



Information pop-up: New Intervention added!

5. Click **OK**.
6. Click **Exit**.
Information pop-up displays.



Information pop-up: IDPC note created - #(21728911)
Be sure to sign it in CPRS!

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

Functional (Func)

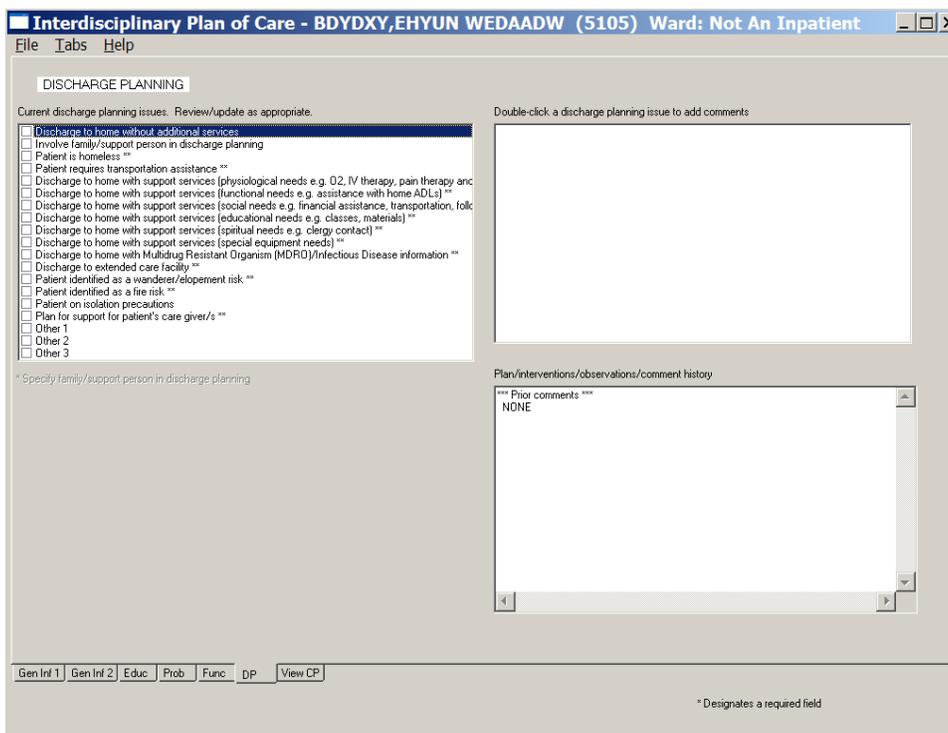
The Functional Assessment tab contains the information that you need to transfer a patient safely, using mechanical lifting devices and approved aids for lifting, transferring, repositioning, and moving patients.

Interdisciplinary Plan of Care, Functional Assessment (Func) tab window

1. Select one or more for each type of transfer, type of device, and number of staff needed.
2. Select a sling type and sling size, if necessary.
3. Click **Print**.
4. Print the information and give it to the staff handling the transfer.

Discharge Planning (DP)

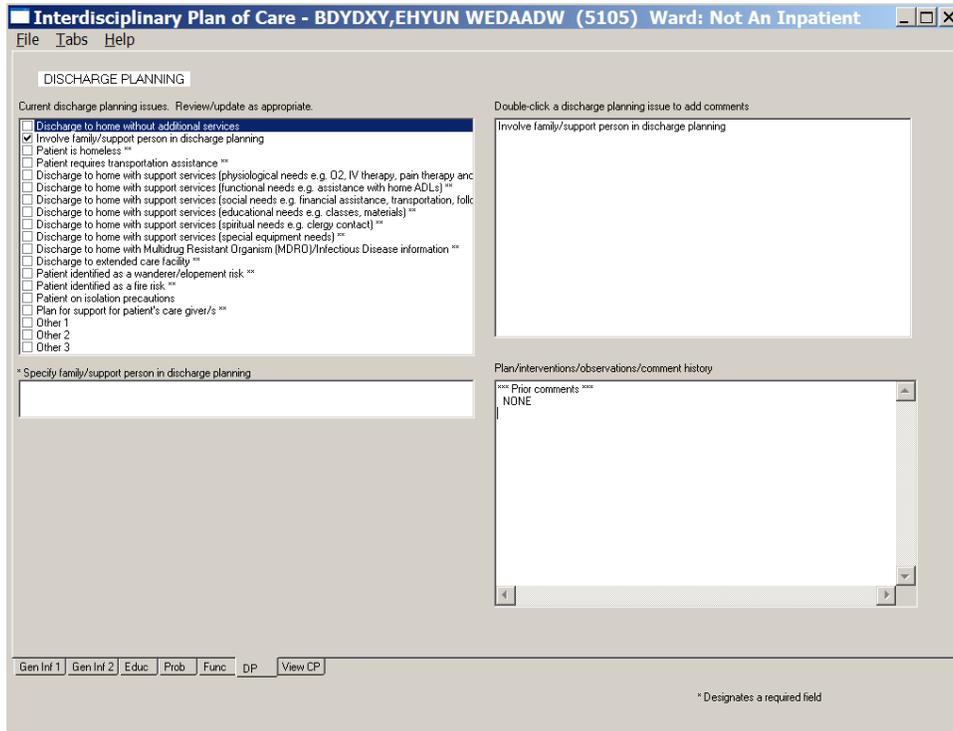
The Discharge Planning tab contains issues pulled forward into the list of **Current discharge planning issues**, identified previously in the Admission – RN Assessment or older plans of care.



Interdisciplinary Plan of Care, Discharge Planning (DP) tab window

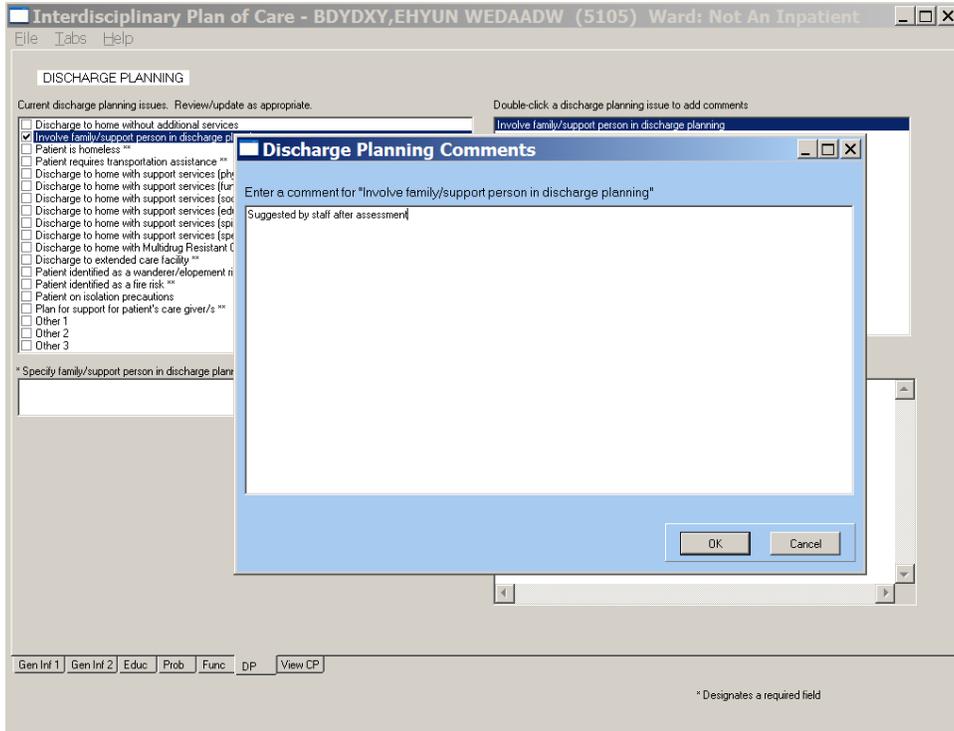
1. Select one or more items in the **Current discharge planning issues** list box. As you select an item, it moves to the comment text box on the right.

2. Review the discharge planning issues and modify, as appropriate, based on the current situation.



Interdisciplinary Plan of Care, Discharge Planning (DP) tab window
Involve family/support person in discharge planning selected

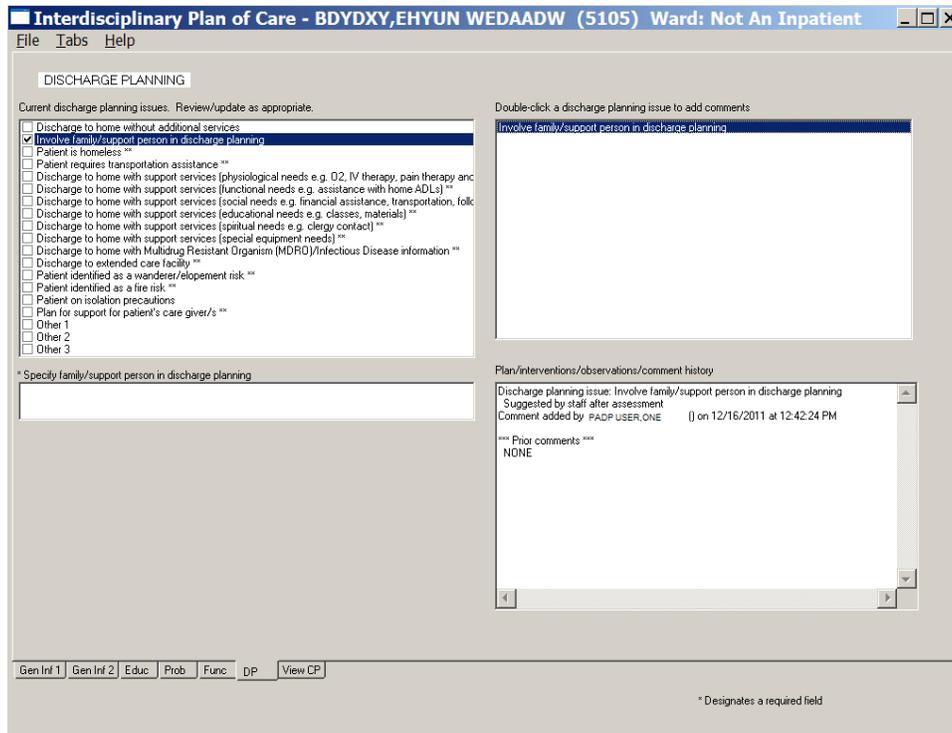
- To add comments for a selected discharge issue, double-click the discharge planning issue. Discharge Planning Comments window displays.



Discharge Planning Comments window

- Add a comment for the selected issue.

- Click **OK**.
Comments display in the **Plan/interventions/observations/comments history** along with the associated discharge planning issue and the name of the staff that entered the comment.



Interdisciplinary Plan of Care, Discharge Planning (DP) tab window

View Care Plan (View CP)

The View Care Plan (View CP) tab allows you to view and print three different perspectives of the Plan of Care.

1. The Daily Plan®

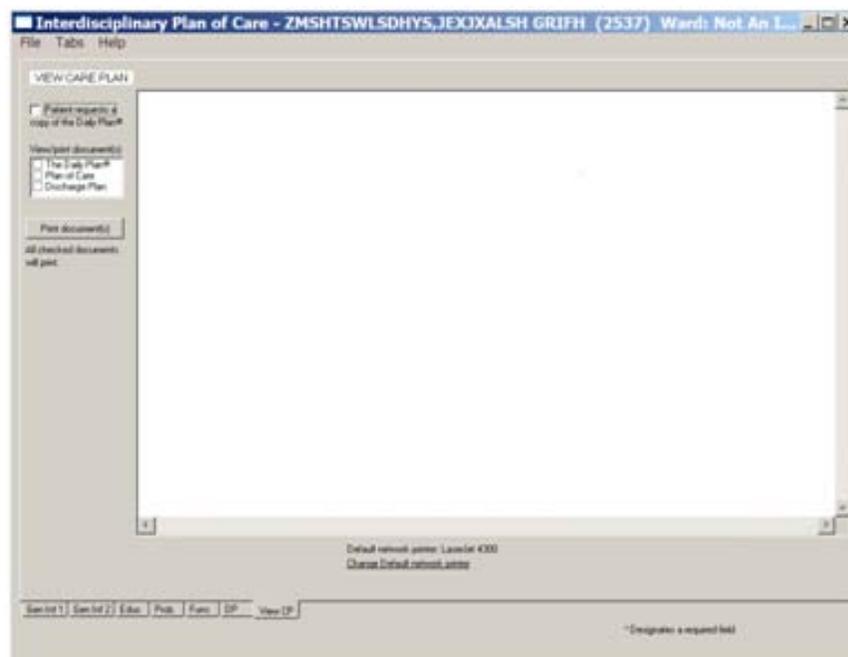
The Daily Plan® is a summary of current orders for nurses, or other clinicians, to review daily with the patient, as appropriate. The RN can print a copy of The Daily Plan® for the patient by selecting the **Patient requests a copy of The Daily Plan®** check box. The daily plan should be re-evaluated after each reassessment because patient status may change.

2. Plan of Care

The Plan of Care contains general information and problems/interventions from the Interdisciplinary Plan of Care, Prob tab.

3. Discharge Plan

The Discharge Plan contains information about home environment, living arrangements, special equipment, and other needs.



View Care Plan window: View/print documents menu

The Daily Plan®

Interdisciplinary Plan of Care - BDYDXY,EHYUN WEDAADW (5105) Ward: Not An Inpatient

File Tabs Help

VIEW CARE PLAN

Patient requests a copy of the Daily Plan®

View/print document(s)

Latest Care Plan®

Plan of Care

Discharge Plan

Print document(s)

All checked documents will print.

The Daily Plan for BDYDXY,EHYUN WEDAADW
Date: 12/16/2011 1:07:23 PM

GENERAL INFORMATION

*** LATEST CARE PLAN ***

Patient: BDYDXY,EHYUN WEDAADW
DOB: 07/23/1945
Ward: Not An Inpatient
Entered: NOV 14, 2011@12:43:34 by PADP,USER,ONE

Special diet needs: No

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

Allergies: None

Current Inpatient Meds (last 3 days): None

Current Active or Pending orders since yesterday
ORDER TYPE: NONE FOUND
ITEM ORDERED:
START DATE:
ORDERED BY:

Default network printer:
[Change Default network printer](#)

Gen Inf 1 Gen Inf 2 Educ Prob Func DP View CP

* Designates a required field

Interdisciplinary Plan of Care, Daily Plan

The Daily Plan® is a health summary that contains the following General Information components for the Latest Care Plan:

- Patient Name
- DOB (Date of Birth)
- Ward
- Entered (date/time)
- Special diet needs
- Next of kin
 - a. Contact
 - b. Relationship
 - c. Address
 - d. Phone
 - e. Work phone
- Allergies
- Current Inpatient Meds (last 3 days)
- Current Active or Pending orders since yesterday
 - a. Order type
 - b. Item ordered
 - c. Start date
 - d. Ordered by
 - e. Appointments in the next year

Plan of Care

Interdisciplinary Plan of Care - BDYDXY,EHYUN WEDAADW (5105) Ward: Not An Inpatient

File Tabs Help

VIEW CARE PLAN

Patient requests a copy of the Daily Plan®

View/print document(s)

The Daily Plan®

Gen Info

Discharge Plan

Print document(s)

All checked documents will print.

Plan of Care for BDYDXY,EHYUN WEDAADW
Date: 12/16/2011 1:12:29 PM

GENERAL INFORMATION

*** LATEST CARE PLAN ***

Patient: BDYDXY,EHYUN WEDAADW
DOB: 07/23/1945
Ward: Not An Inpatient
Entered: NOV 14, 2011@12:43:34 by PADP USER,ONE

PROBLEMS

PROBLEM: 12/16/11@0940
DATE IDENTIFIED: Prevention, recognition and treatment of abnormal cardiac rhythms
DESIRED OUTCOME: No change/stable
PROB EVAL: 12/16/11@0943
PROB EVAL DATE: Surveillance - Monitor labs and oxygenation status which might precipitate abnormal
INTERVENTION: 12/16/11@0940
INT STARTED: Continue
INT STATUS: 12/16/11@0943
INT STATUS DATE:

PROBLEM: 12/6/11@0831
DATE IDENTIFIED: Stabilization and/or improvement of respiratory status as it relates to asthma
DESIRED OUTCOME: Improving
PROB EVAL: 12/16/11@0932
PROB EVAL DATE: Education - Assess patient's knowledge and skill and identify gaps
INTERVENTION: 12/16/11@0938
INT STARTED: Not on file
INT STATUS: Not on file

Default network printer:
[Change Default network printer](#)

Gen Inf 1 Gen Inf 2 Educ Prob Func DP View CP

* Designates a required field

Interdisciplinary Plan of Care, Plan of Care

The Plan of Care includes General Information components for the Latest Care Plan:

- Patient
- DOB (Date of Birth)
- Ward
- Entered (date/time)
- Problems
 - a. Problem
 - b. Date identified
 - c. Desired outcome
 - d. Prob eval (evaluation)
 - e. Prob eval (evaluation) date
 - f. Intervention
 - g. Int (intervention) started
 - h. Int (intervention) status
 - i. Int (intervention) status date

Discharge Plan

Interdisciplinary Plan of Care - BDYDXY,EHYUN WEDAADW (5105) Ward: Not An Inpatient

File Tabs Help

VIEW CARE PLAN

Patient requests a copy of the Daily Plan*

View/print document(s)

The Daily Plan*

Plan of Care

Discharge Plan

Print document(s)

All checked documents will print.

Discharge Plan for BDYDXY,EHYUN WEDAADW
Date: 12/16/2011 1:04:58 PM

GENERAL INFORMATION

*** LATEST CARE PLAN ***

Patient: BDYDXY,EHYUN WEDAADW
DOB: 07/23/1945
Ward: Not An Inpatient
Entered: NOV 14, 2011@12:43:34 by PADD USER,ONE

DISCHARGE PLANNING

Current discharge planning issues. Review/update as appropriate.:
Involve family/support person in discharge planning
*** Prior comments ***
NONE

Default network printer:
[Change Default network printer](#)

Gen Inf 1 Gen Inf 2 Educ Prob Func DP View CP

* Designates a required field

Interdisciplinary Plan of Care, Discharge Plan

The Discharge Plan includes General Information components for the Latest Care Plan:

- Patient
- DOB (Date of Birth)
- Ward
- Entered (date/time)
- Discharge Planning
 - a. Current discharge planning issues
 - b. Prior comments

Glossary

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

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

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

For additional PADP information, refer to the user manuals for *Admission - RN Assessment, RN Reassessment*, and *Admission - Nursing Data Collection*.

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