Patient Assessment Documentation Package (PADP)

C3-C1 Conversion Project

RN Reassessment User Manual for NUPA Version 1.0

April 2012

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

Revision History

Date	Revision	Description	Author
May 2010	1.0	Initial version for 1.0	REDACTED
August 2010	1.1	Add content	REDACTED
August 2010	1.2	Format content	REDACTED
September 2010	1.3	Split manual into three manuals • RN Reassessment • User Manual	REDACTED
October 2010	1.4	Updated content	REDACTED
November 2010	1.5	Updated screen captures	REDACTED
December 2010	1.6	• Changed dates • Pulled issues from this doc for team review	REDACTED
January 2011	1.7	• Changed dates to January 2011 • Updated with additional comments from Judy	REDACTED
February 2011	1.8	Changed dates to February 2011	REDACTED
March 2011	1.9	• Changed dates to April 2011 • Updated with Judy's comments	REDACTED
April 2011	1.10	Updated RoboHelp with this file	REDACTED
May 2011	1.11	• Changed dates to May 2011 • Added (NUPA*1*0) namespace	REDACTED
October 2011	1.12	• Added C3-C1 Conversion Project • Changed dates to October 2011 • Prepped for national release	REDACTED
November 2011	1.13	• Changed dates to November 2011 • Updated for build v14 • Changed dates to December 2011 • Updated for build v15 • Changed title to RN Reassessment	REDACTED

Date	Revision	Description	Author
December 2011	1.14	• 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	REDACTED
January 2012	1.15	• Changed NUPA 1.0 to NUPA Version 1.0 • Updated for build v16 • Changed dates to February 2012	REDACTED
February 2012	1.16	• Updated Neuro tab • Updated the *Unable to Complete the Assessment* section	REDACTED
March 2012	1.17	• Changed dates to March 2012 • Prepped for April national release • Changed dates to April 2012 • Added Appendix A: Reassessment Contingency Note	REDACTED

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 the RN Reassessment

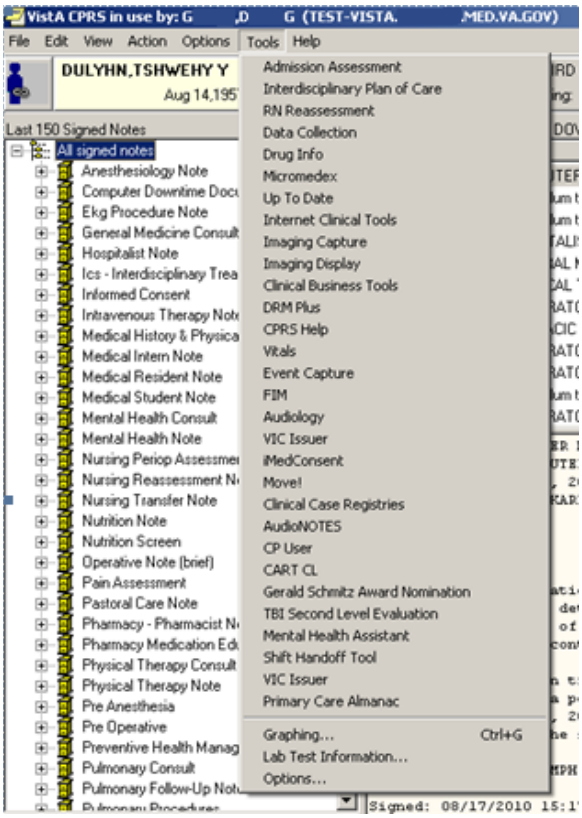
Registered Nurses (RNs) use the RN Reassessment template to document inpatient care in a standardized format at regular times and as needed. With the reassessment template, you collect information associated with new problems and with required physical assessment documentation, such as skin condition,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

Opening RN Reassessment

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

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

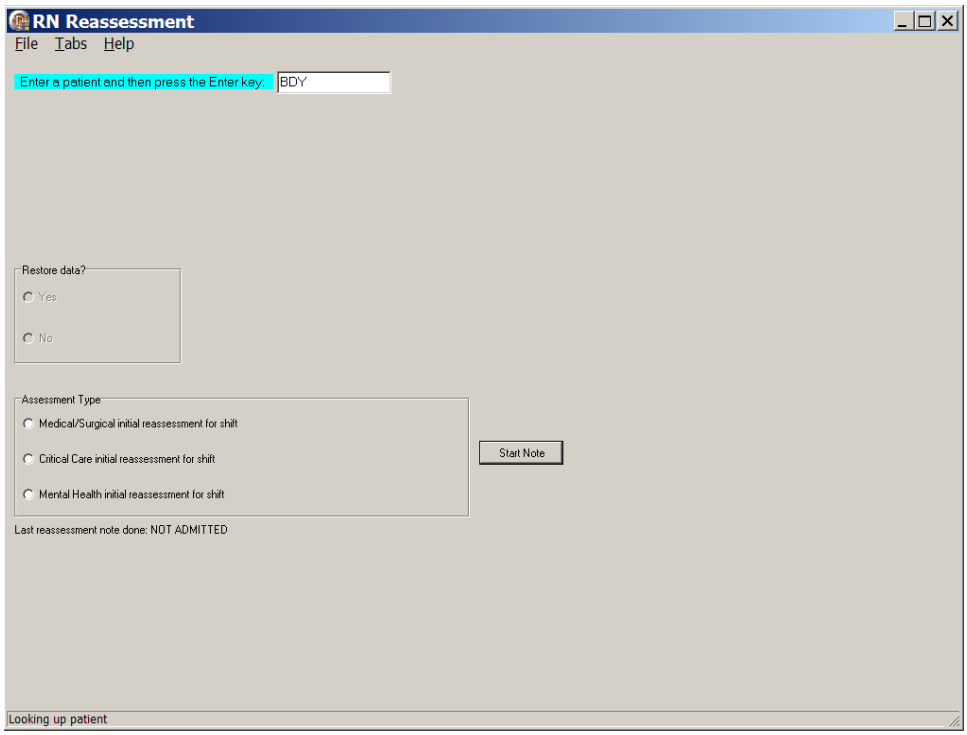
   Note: You may have to re-enter your CPRS access and verify codes, depending on local site setup.



Access through CPRS

No Previously Saved Information

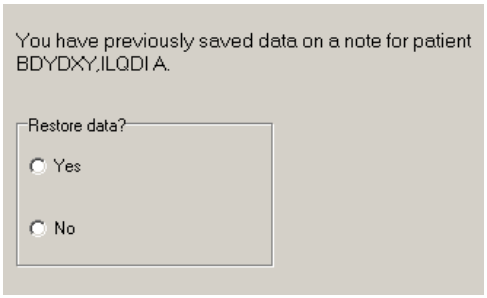
The Enter a patient window displays.



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

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

Previously Entered Information Available for One Patient



Patient selection window with previously entered information available for one patient

Restore Patient's Data/No

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

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

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

Restore Patient's Data/Yes

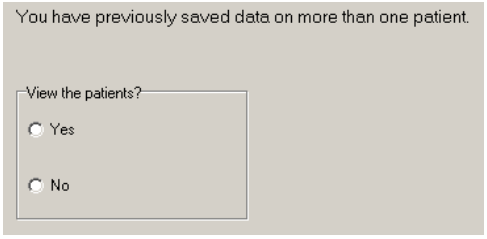
If you previously entered data on one patient, you are prompted with: *You have previously saved data on a note for patient <PADPPATIENT,ONE > m*

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

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

Previously Entered Information Available for Two or More Patients

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



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

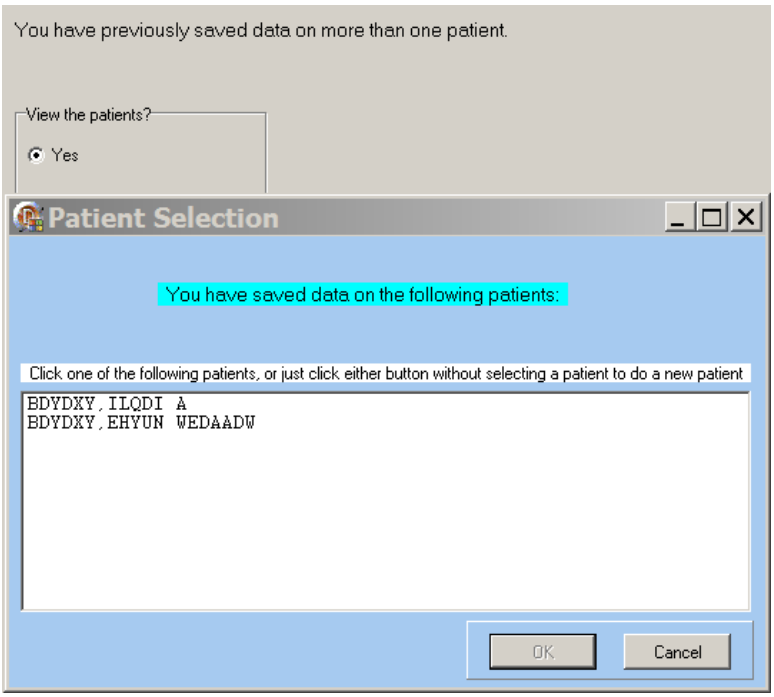
View the Patients?/No

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

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

View the Patients?/Yes

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



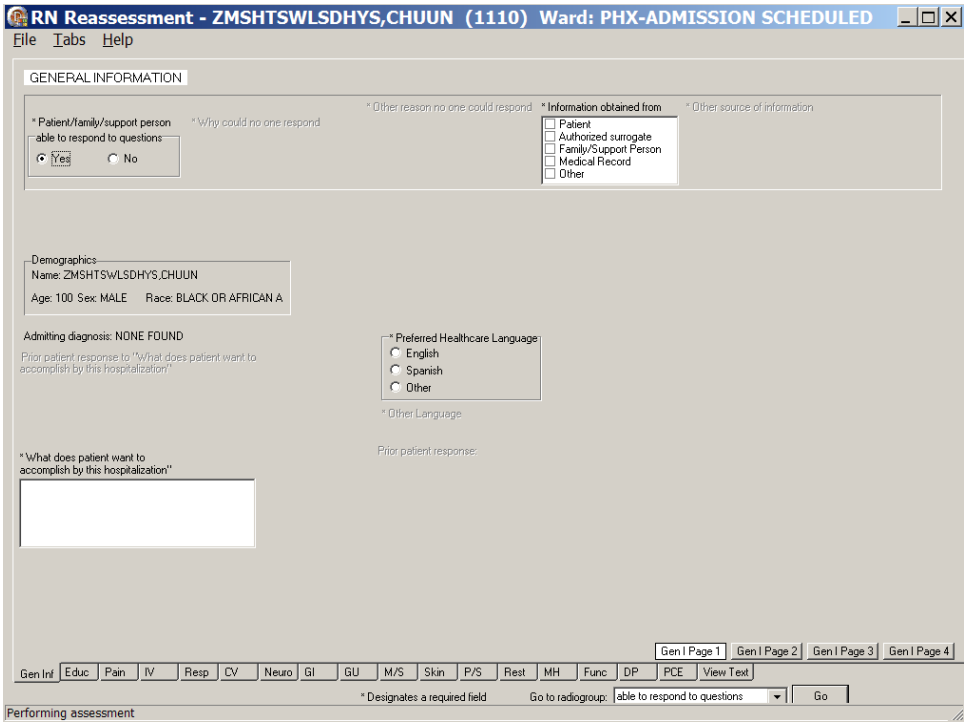
Patient Selection List

Patient on the List

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

Patient not on the List

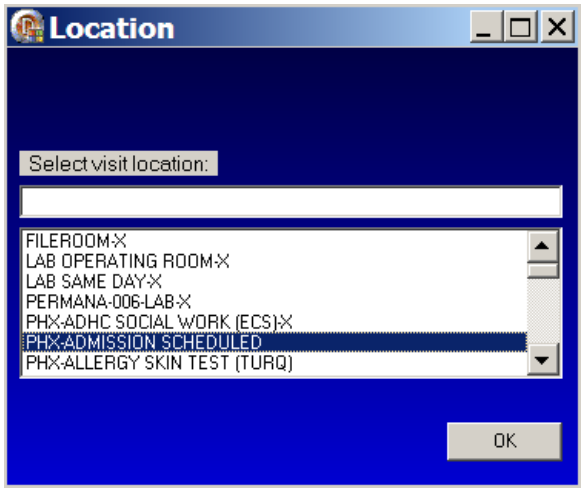
1. Click **Cancel**.
   The number that represents your CPRS patient is in the Enter a patient text box.
2. Click the **Start Note**.
   The template opens to the General Information tab.



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

Patient not yet Assigned to an Inpatient Bed

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



Location : Select visit location

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

Saving and Uploading Data

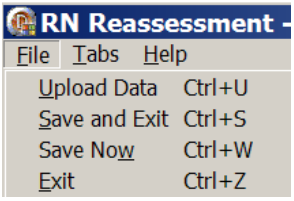
Auto Save

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

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

Manual Save

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

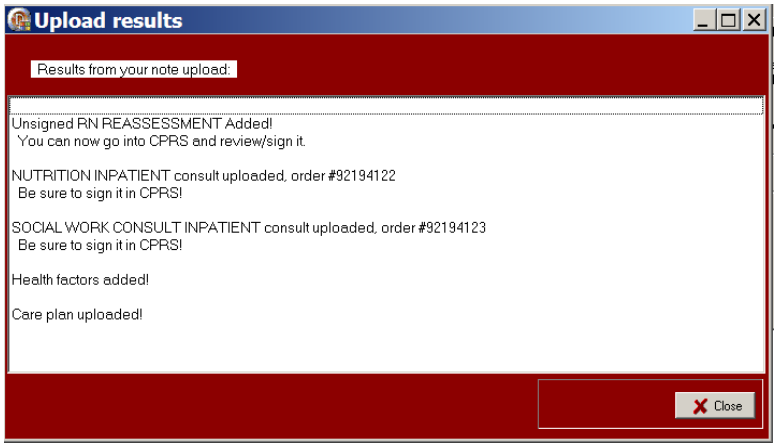


RN Reassessment window, File menu

Upload Data

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

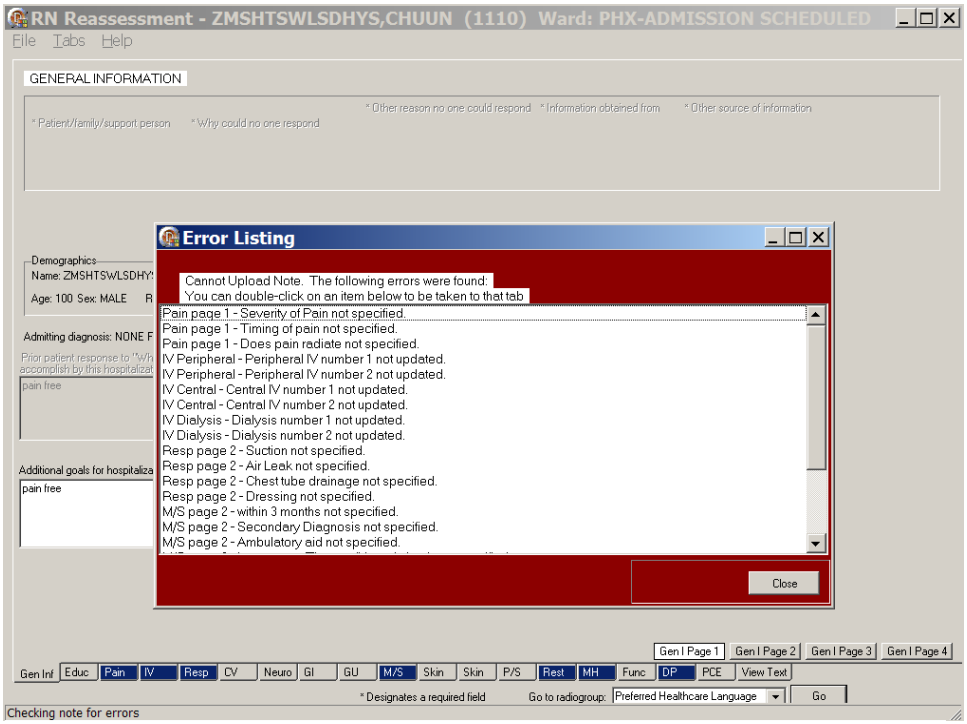
1. Open the File menu on any tab and select **Upload Data**.
   Results from your upload display, verifying that the data is uploaded.



RN Reassessment, Upload results window

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

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



RN Reassessment, Error Listing window

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

Save and Exit

To save data and temporarily leave the template:

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

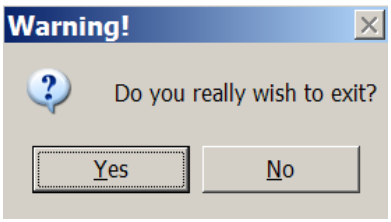
Save Now

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

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

Exit

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



Warning : Do you really wish to exit?

2. Click **Yes**.

or

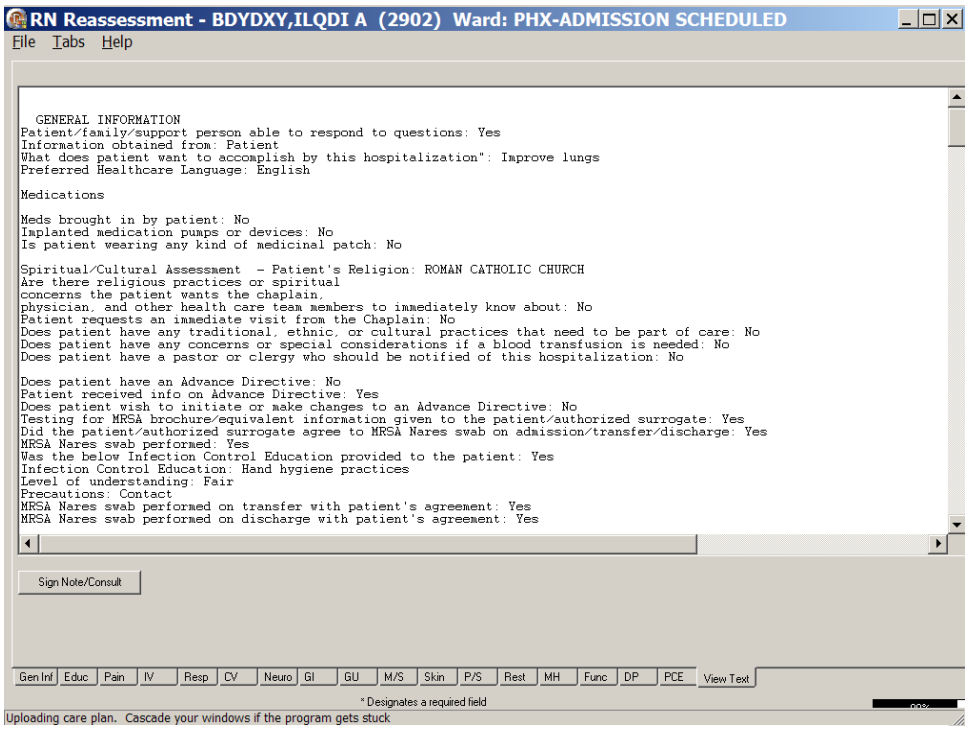
1. From any tab, open the File menu and click **Exit**.
   Warning message displays.
2. Click **Yes**.

Signing Notes

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

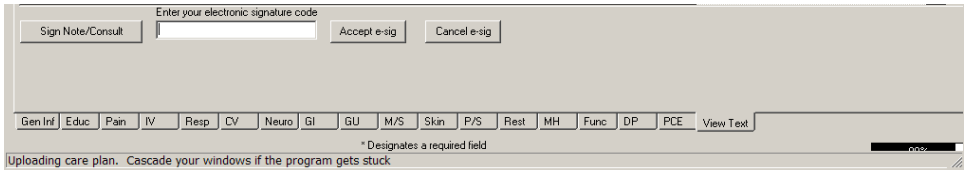
You can also sign *unsigned* notes **after the upload** from the View Text tab in the template.

1. Click **View Text**.



RN Reassessments, View Text tab after upload

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



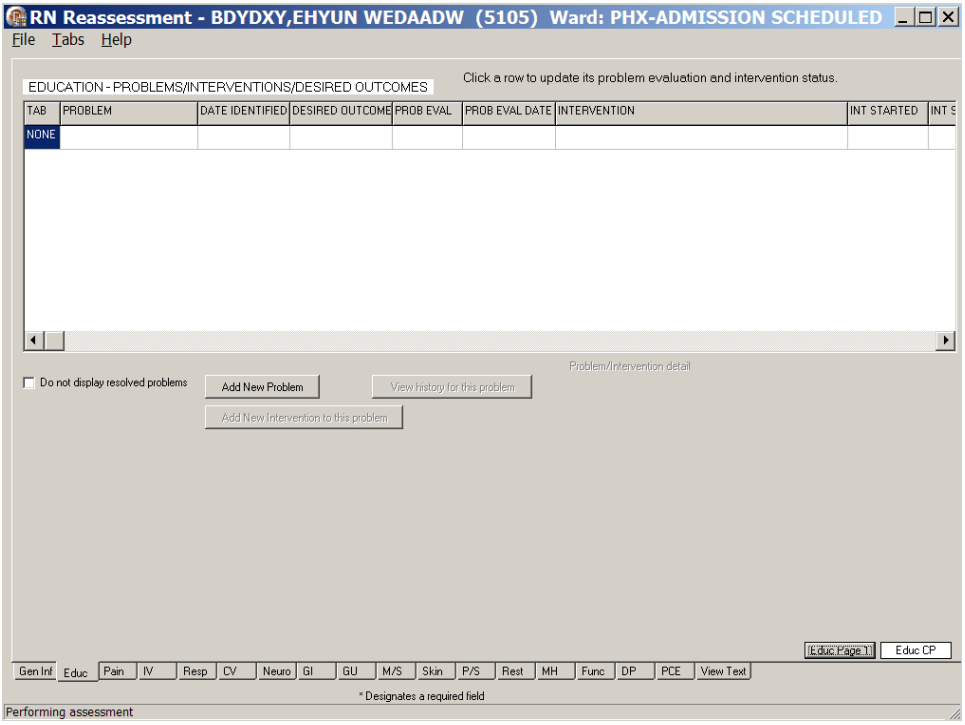
RN Reassessment, Sign Note/Consult Button

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

Note: If there is only a note to sign, the button is **Note**.
If there is a consult(s) to sign, the button is **Sign Note/Consult**.

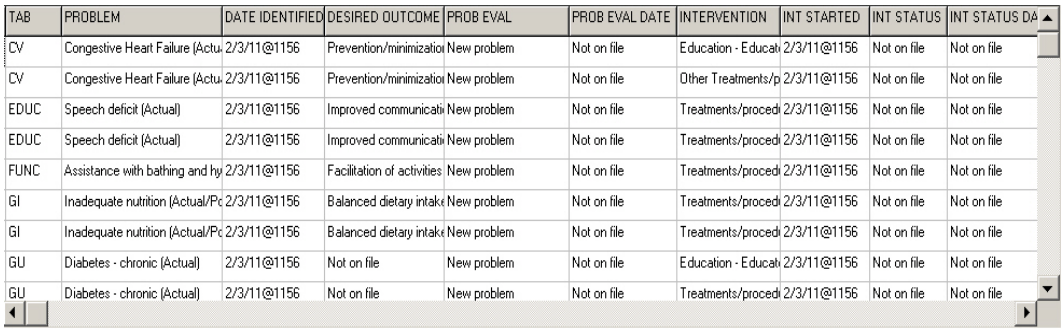
Working in a Care Plan

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



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

Care Plan Table



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

RN Reassessment, Problems/Interventions/Desired Outcomes table

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

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

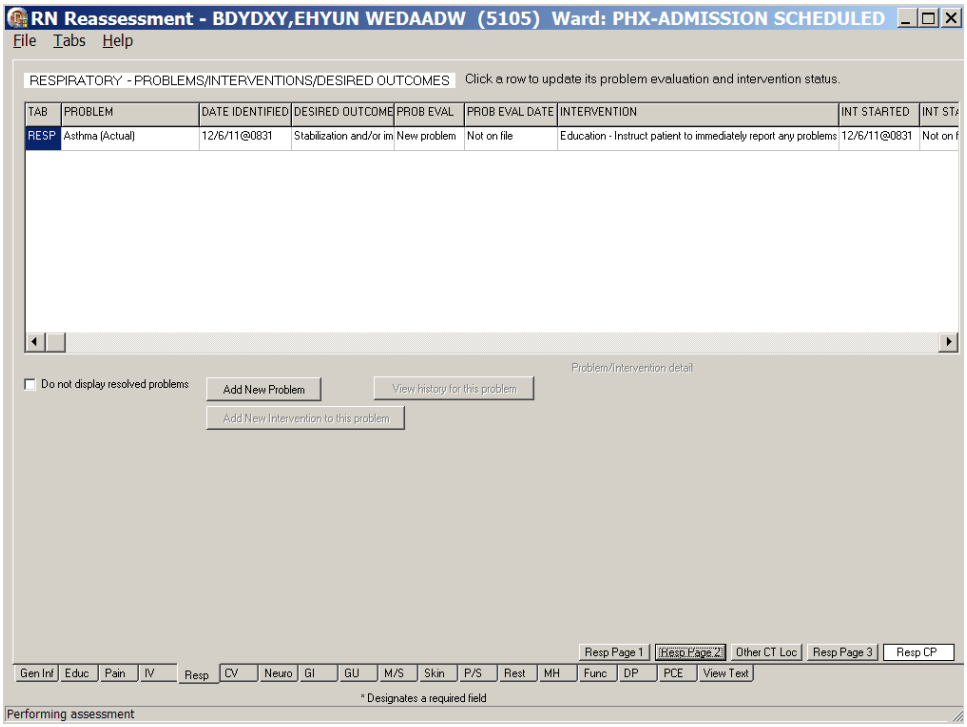
Column	Description
(Intervention Status Date)	

Updating an Existing Problem/Intervention

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

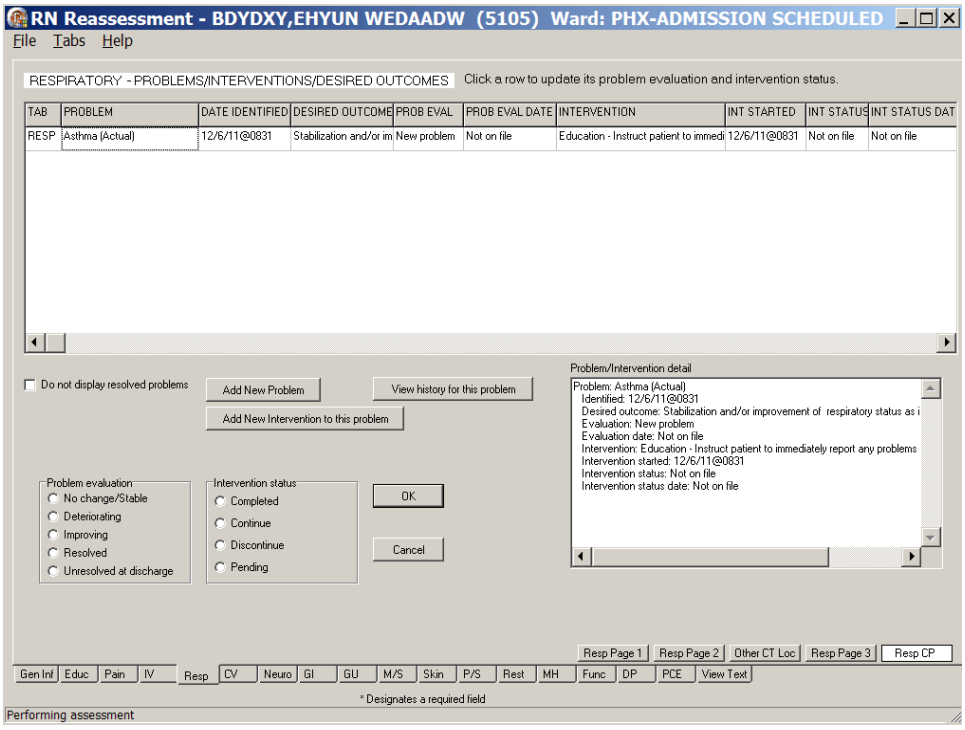
RN Reassessment, <Resp> tab

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



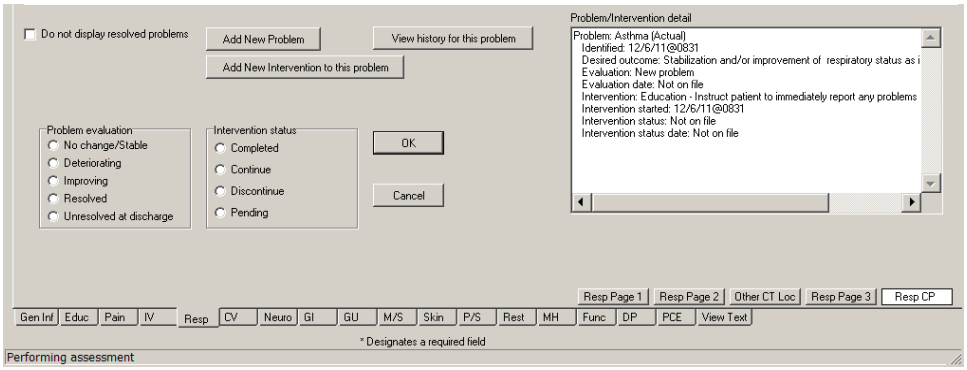
RN Reassessment, <Resp> CP window

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



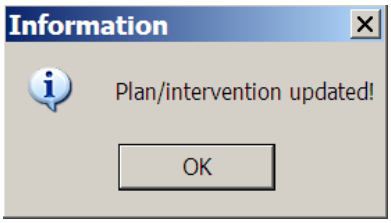
RN Reassessment, <Resp> CP window

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



Problem evaluation, Intervention status, and Problem/Intervention detail

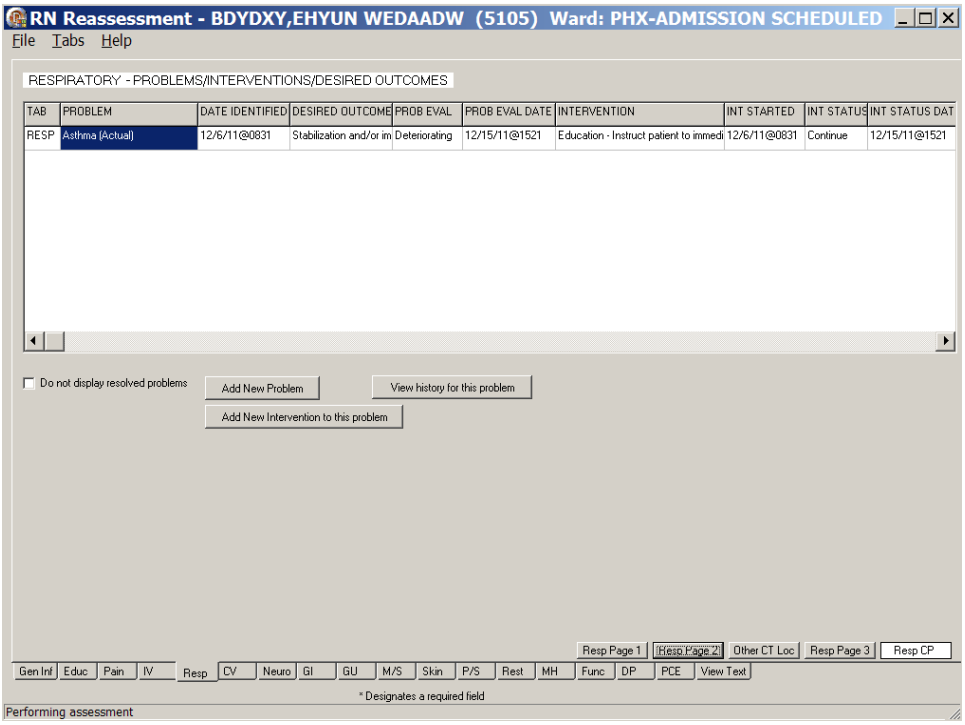
4. Click **OK**.
   Information displays.



Information : Plan/intervention updated!

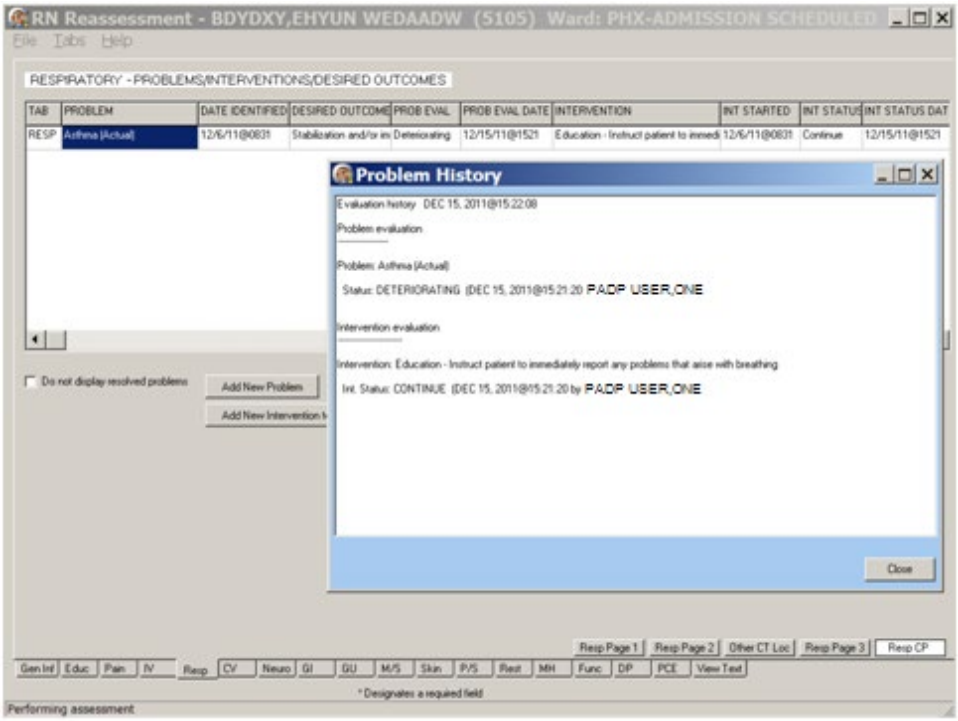
5. Click **OK** to complete the problem/intervention.

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



RN Reassessment, <Resp> CP window

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

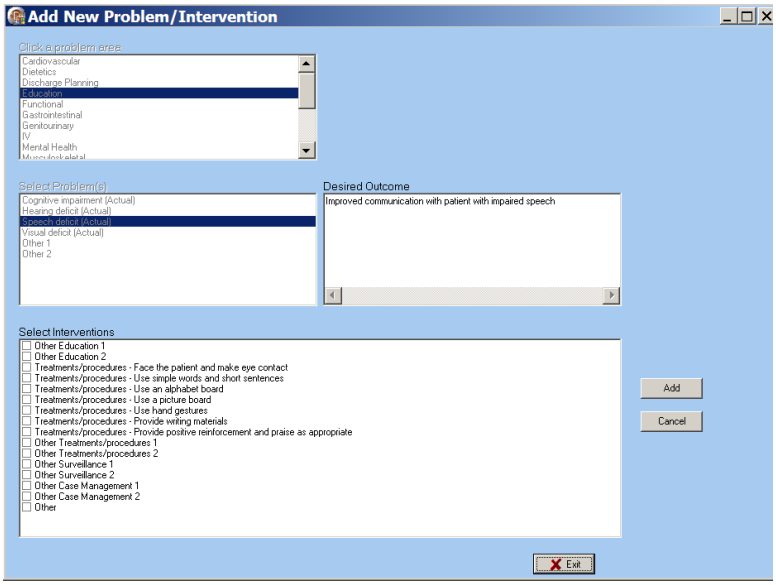


Problem History window

8. Click **Close**.

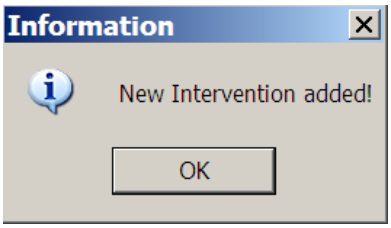
Adding a New Intervention for an Existing Problem

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



Add New Problem/Intervention window

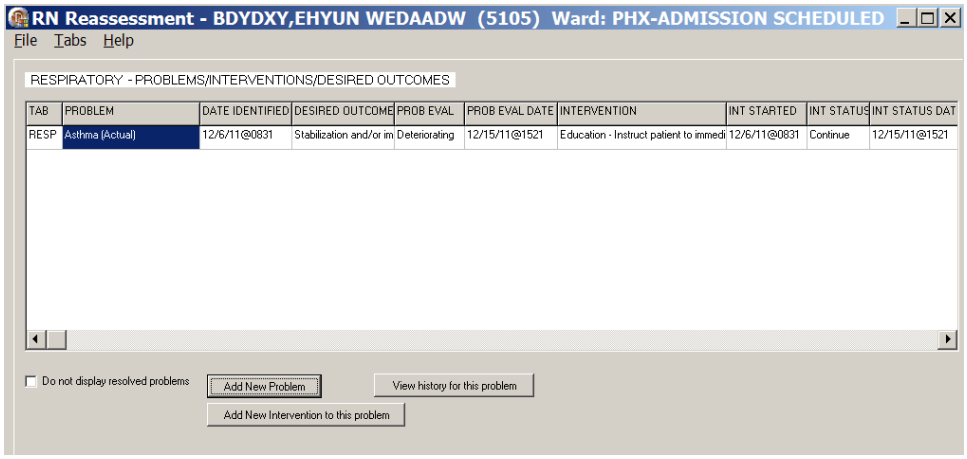
3. Select an intervention from the **Select Interventions** list box for the selected problem.
4. Click **Add**.
   Information displays.



Information : New Intervention added!

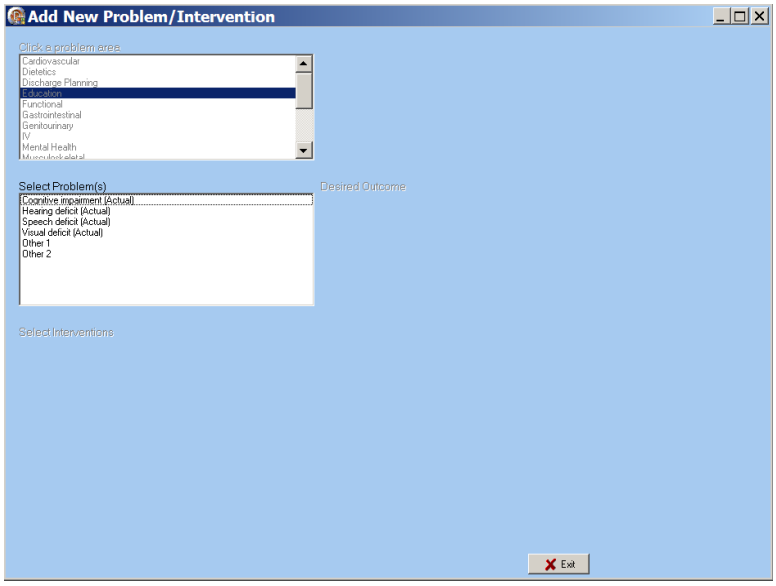
5. Click **OK**.
6. Click **Exit**.

Adding a New Problem/Intervention



RN Reassessment, <Resp> CP window

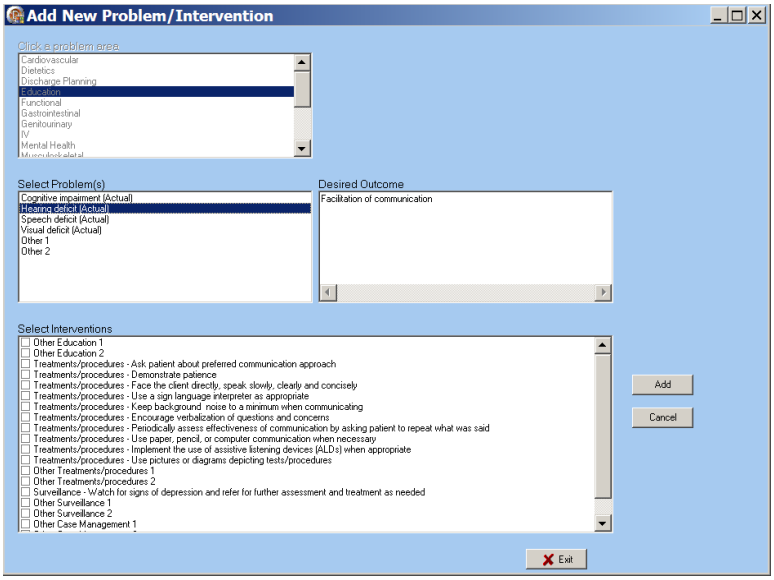
1. Click **Add New Problem**.
   Add New Problem/Intervention window displays.



Add New Problem/Intervention window

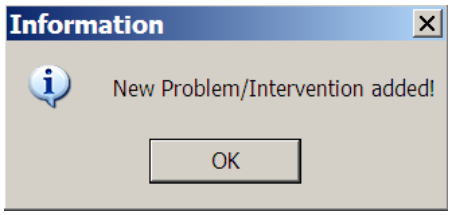
Note: The Respiratory area is auto selected, because you are in the Resp CP.

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



Add New Problem/Intervention window for problem/intervention options

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



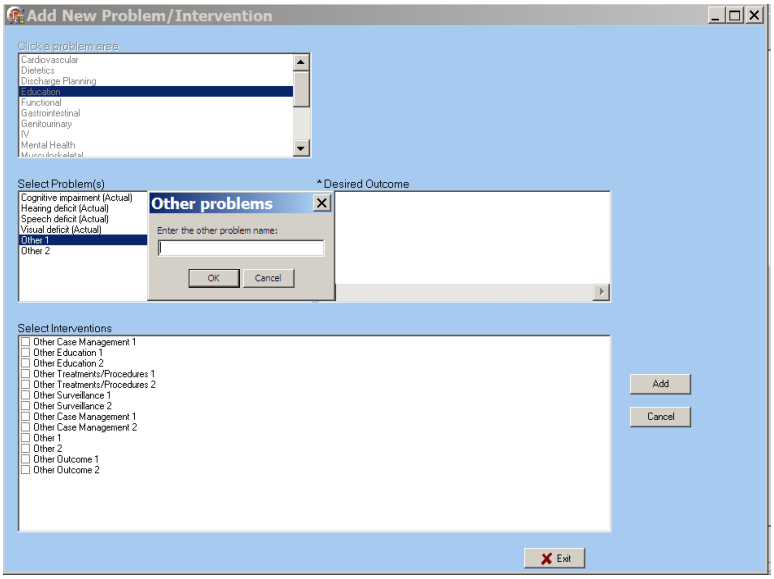
Information : New Problem/Intervention added!

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

Other Problems

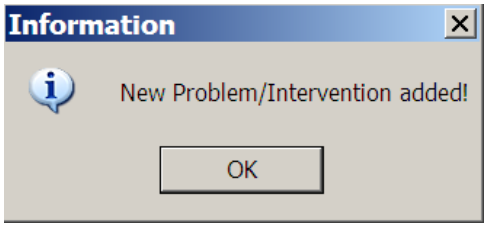
Some problems generate a to enter problems that are not on the predefined list.

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



Add New Problem/Intervention window with *Other*

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



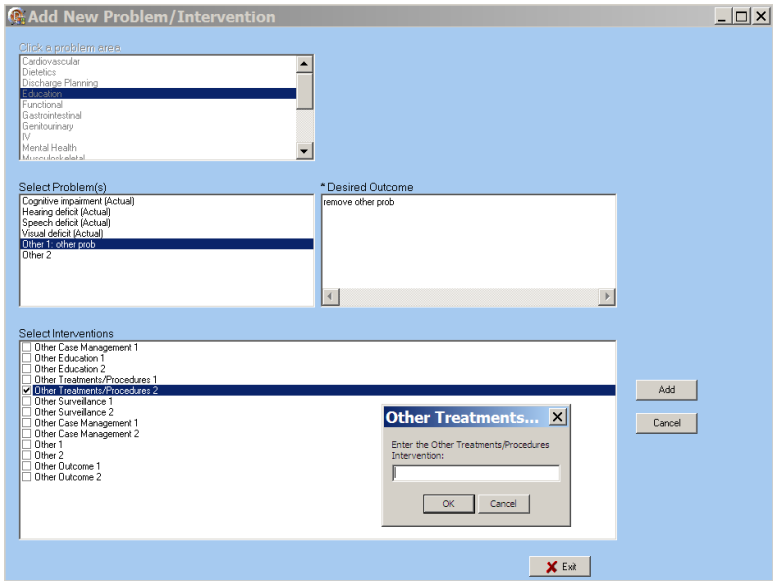
Information : New Problem/Intervention added!

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

Other Interventions

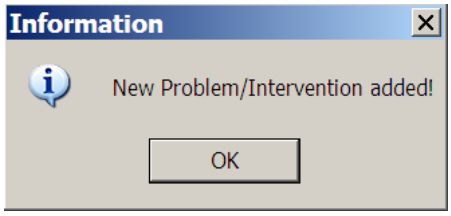
Some interventions generate a to enter interventions that are not on the predefined list.

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



Add New Problem/Intervention window with Other

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



Information : New Problem/Intervention added!

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

Working in the Consults

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

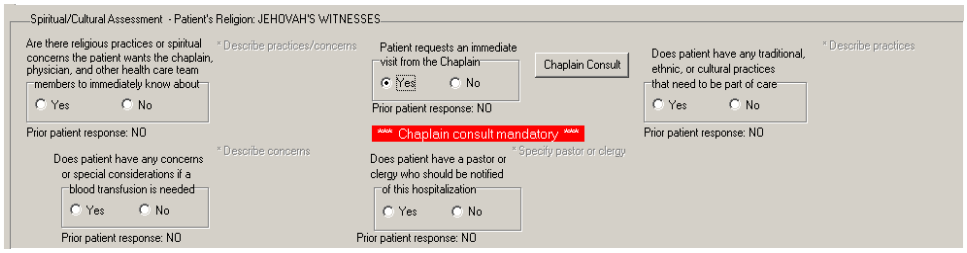
Example – Ordering a Chaplain Consult

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

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

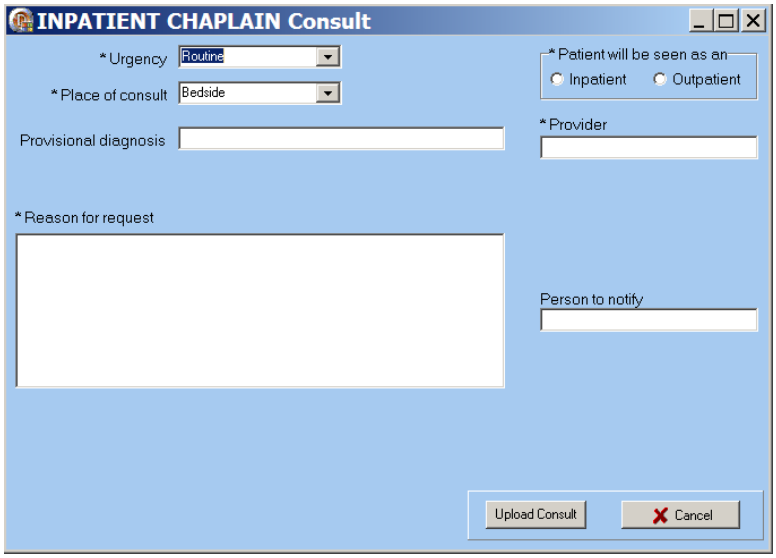
- Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about?
- Patient requests an immediate visit from the Chaplain?
- Does patient have a pastor or clergy who should be notified of this hospitalization?

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



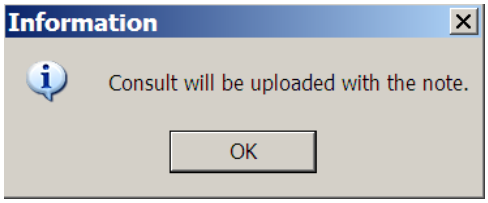
RN Reassessment, General Information (Gen Inf) tab, Gen I Page 2 window
Spiritual/Cultural Assessment

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



INPATIENT CHAPLAIN Consult window

a. Complete all fields with asterisks; they are required fields.
b. Click **Upload Consult**.
Information displays indicating the consult is uploaded with the reassessment note.



Information : Consult will be uploaded with the note.

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

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

Working in the Template

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

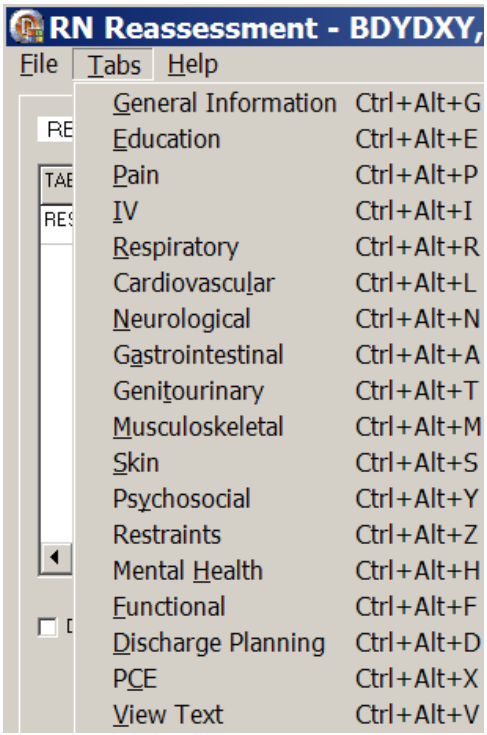
Moving through the Template with a Mouse

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

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

RN Reassessment tabs

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



RN Reassessment window, Tabs menu

Moving through the Template without a Mouse

Ctrl-Alt Keys

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

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

Go to Radiogroup

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

Go button

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

or

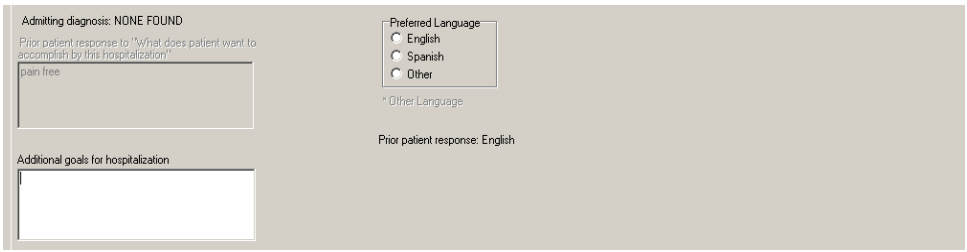
1. Click the drop-down arrow in the **Go to radiogroup:** drop-down list.
2. Select a radiogroup.
3. Click **Go**.

Viewing Previously Entered Data

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

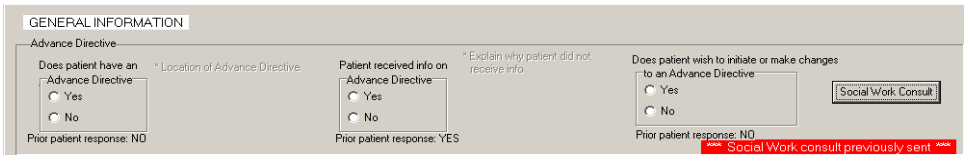
- Prior responses to many questions are embedded as read-only in the template. The responses do not show up in the new Progress Note.
- Although the prior response cannot be edited, in many places the information can be updated.

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



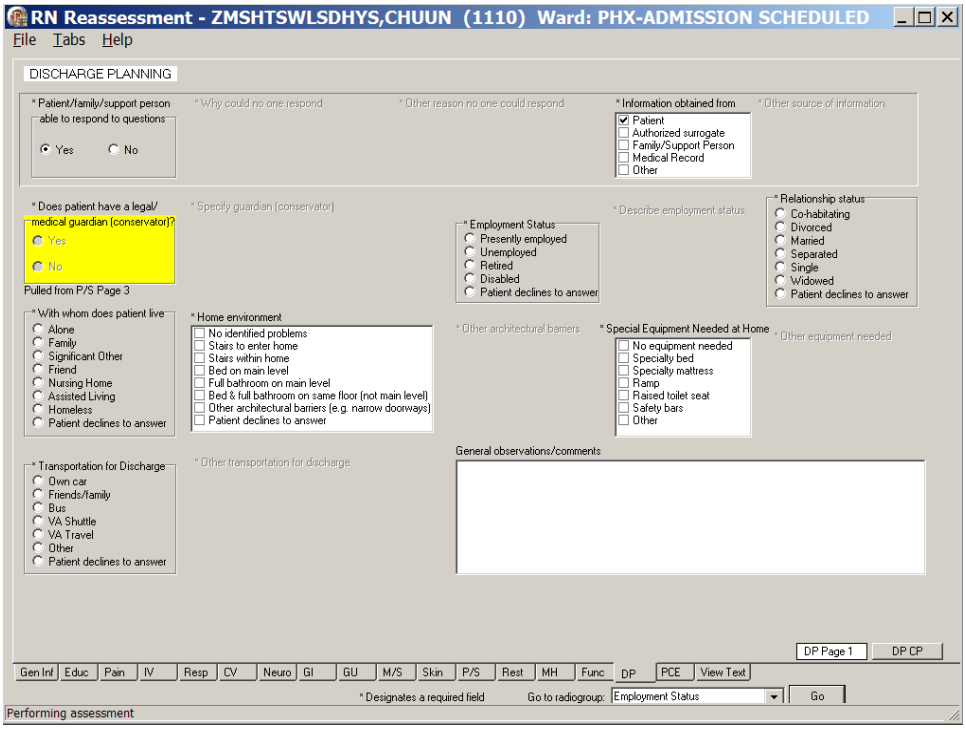
Prior patient response: English
Primary language

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



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

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



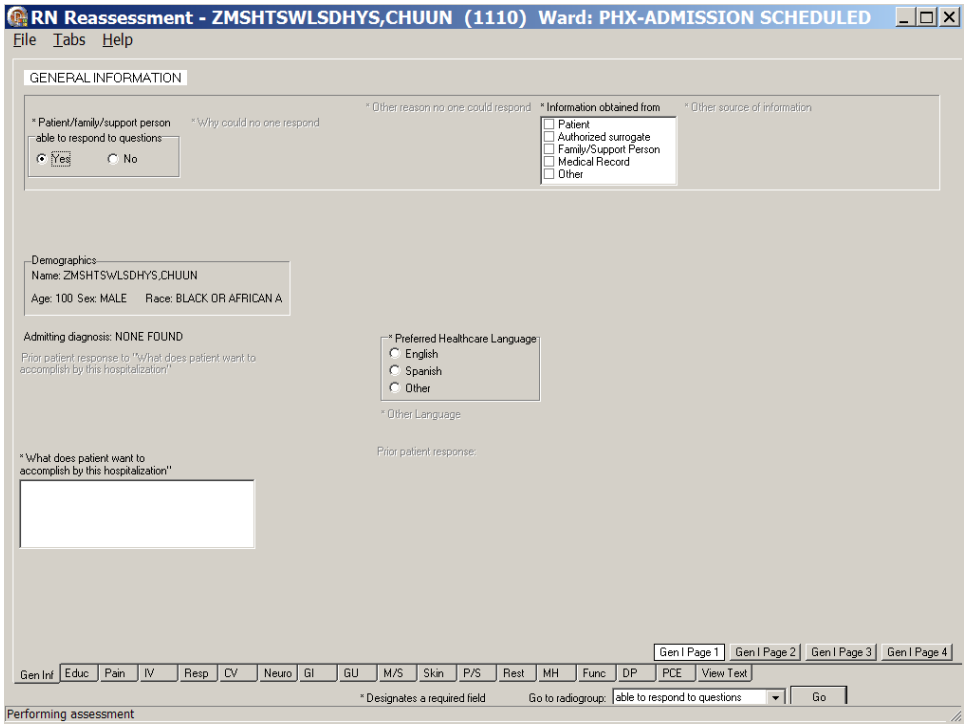
RN Reassessment, Discharge Planning (DP) tab, DP Page 1 window

Navigating the RN Reassessment Tabs

The RN Reassessment template has 18 tabs.

General Information (Gen Inf)

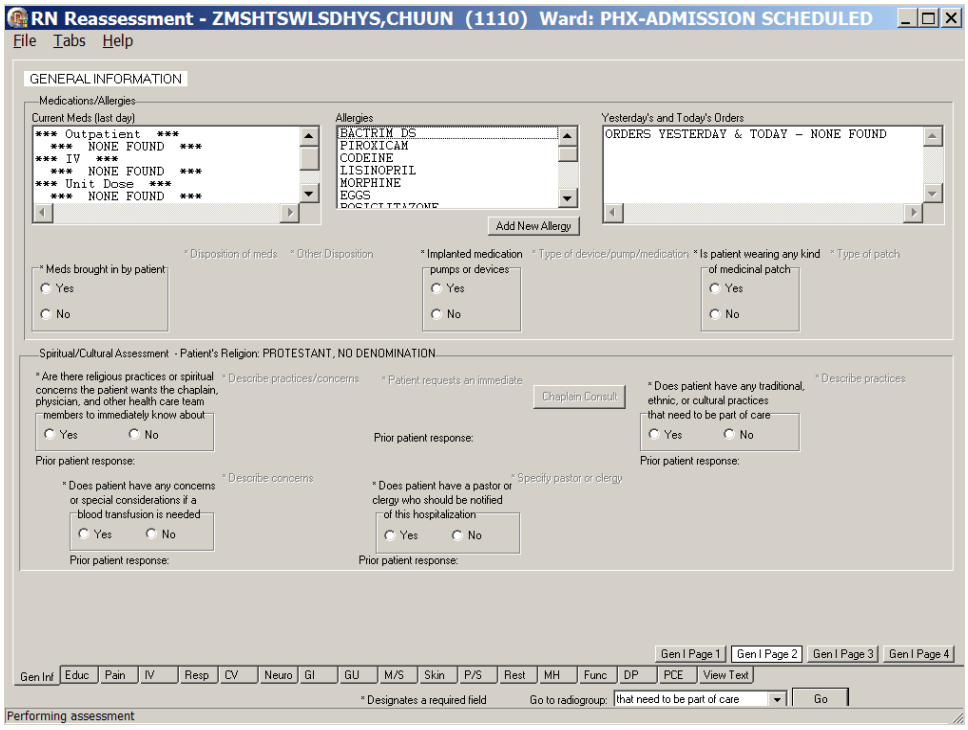
The RN Reassessment template opens to the General Information (Gen Inf) tab, the first tab at the bottom on the left.



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

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

1. Click **Gen I Page 2**.
   Gen I Page 2 displays.
2. Populate Gen I Page 2, if necessary.



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

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

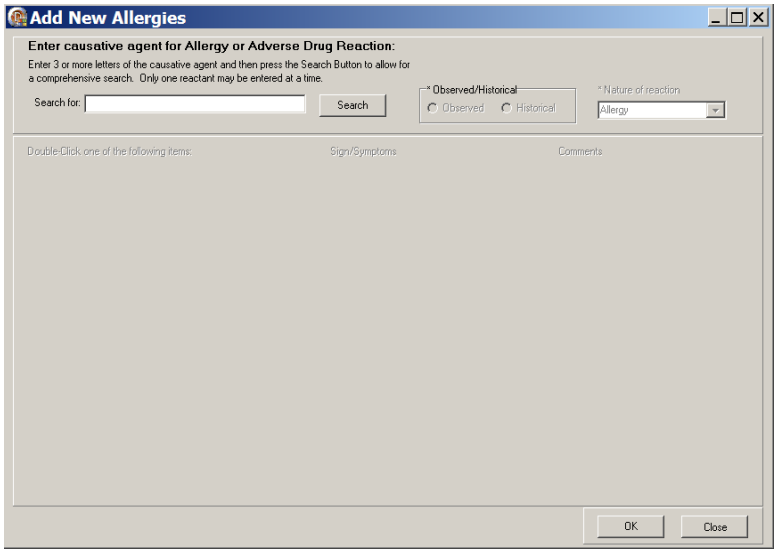
- Allergies are added on Gen I Page 2, in the Allergies text box.
- None of the fields on Gen I Page 2 is required during reassessment, provided a completed admission assessment is on file.

Adding an Allergy

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

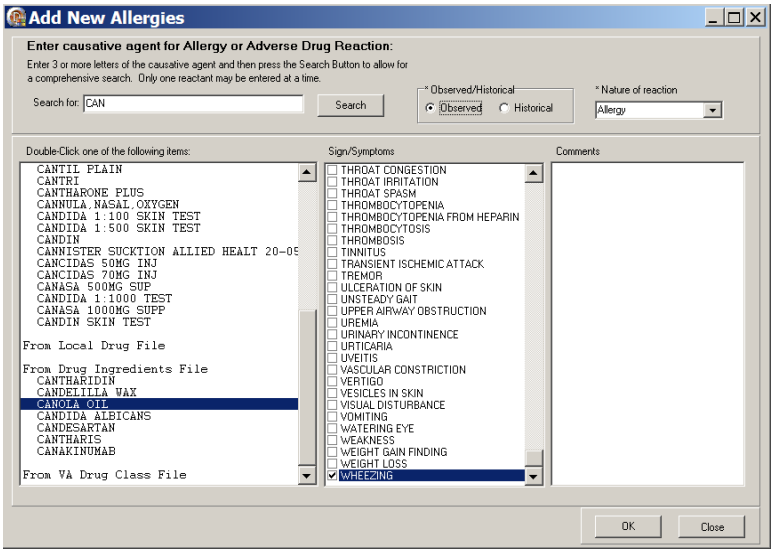
Note: Follow your local medical center policy with regard to adding allergies.

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



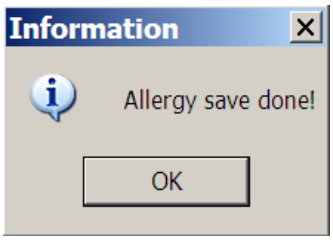
Add New Allergies window

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



Add New Allergies window with Sign/Symptoms available

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



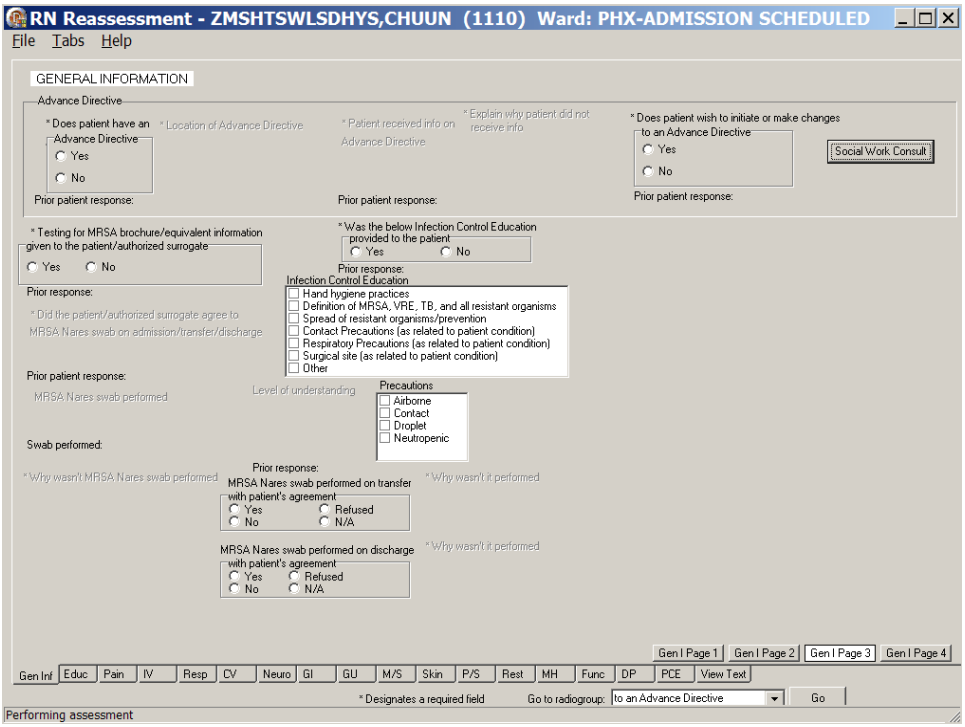
Information : Allergy save done!

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

Initiating a Social Work Consult for Advance Directives

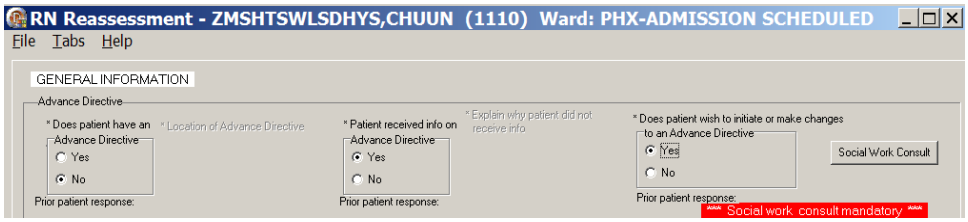
All of the consults in RN Reassessment work the same way; refer to the instructions in *Working in the Consults* on page 25.

1. Click **Gen I Page 3**.
   Gen I Page 3 displays.



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

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

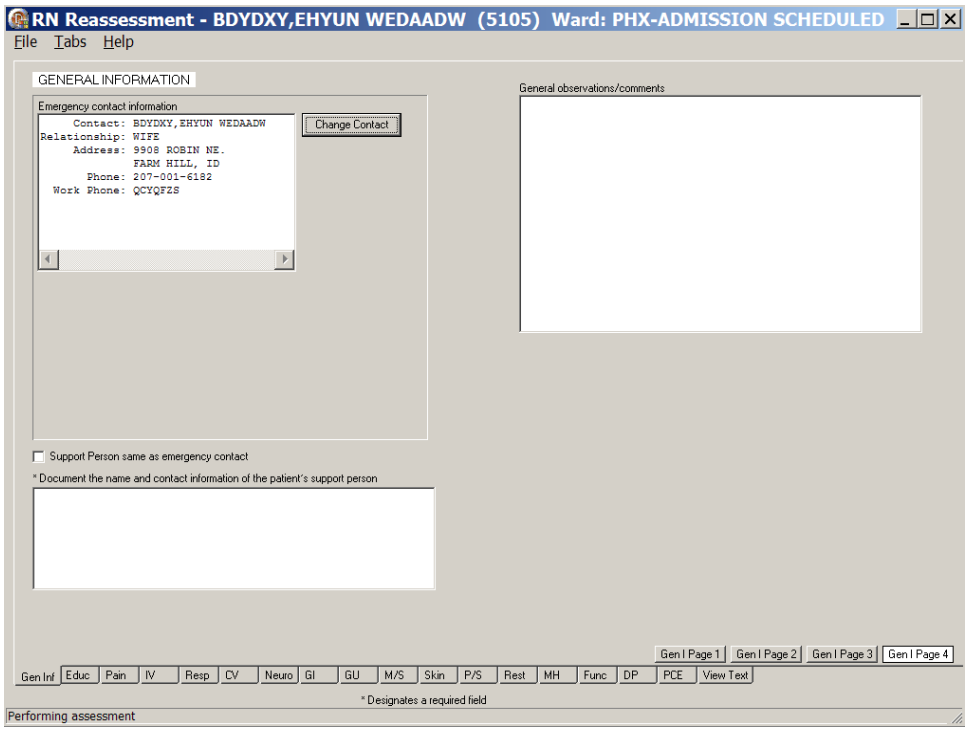


RN Reassessment, General Information (Gen Inf) tab, Gen I Page 3 window, Social Work Consult Mandatory

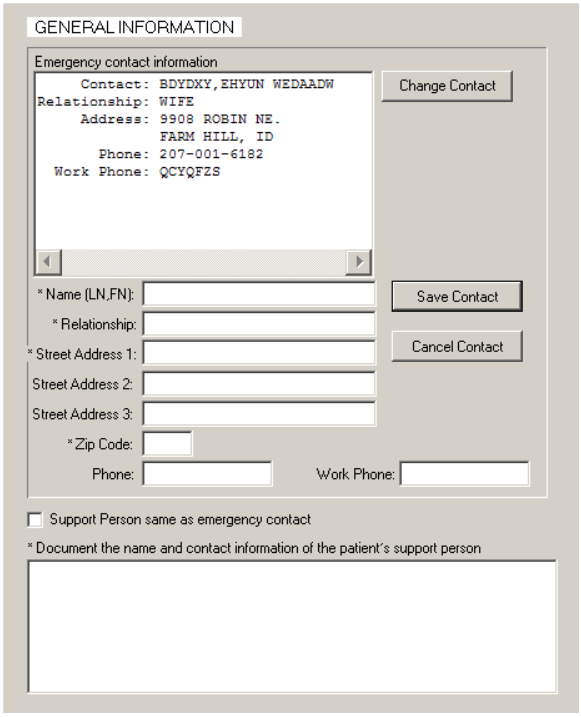
Note: You cannot upload a Progress Note, unless you order the Social Work consult.

Changing Emergency Contact Information

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



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



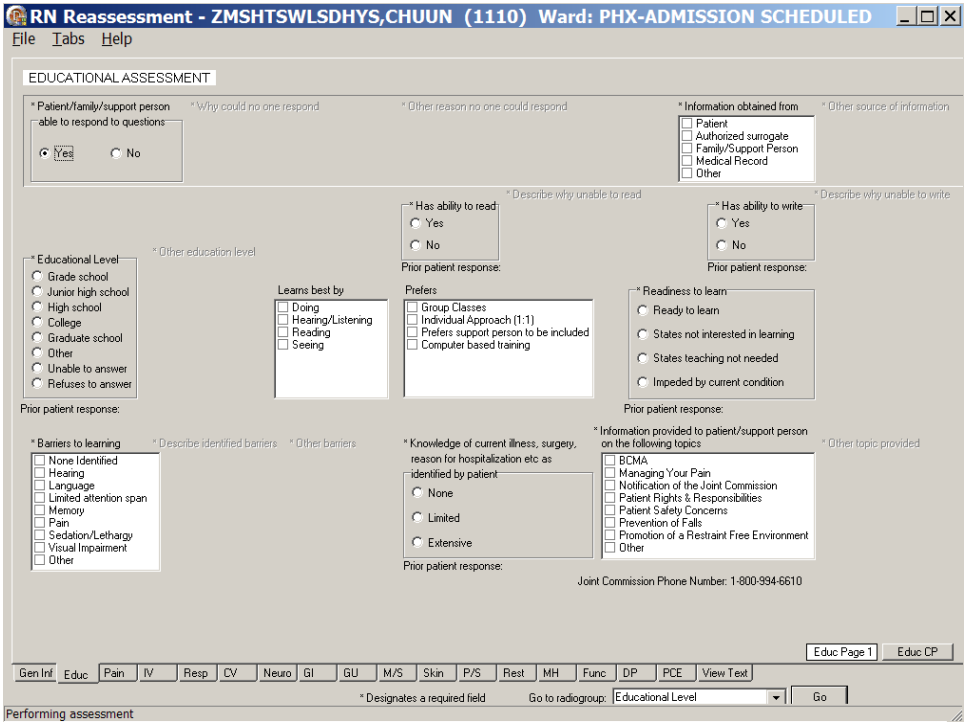
Emergency Contact and Support Person Information

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

Education (Educ)

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

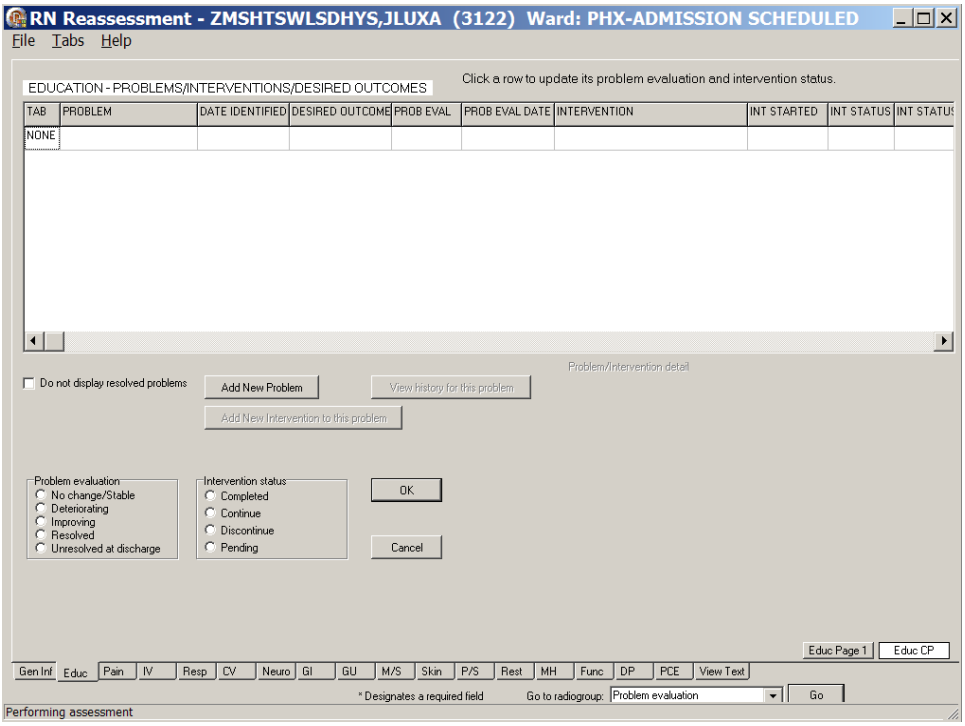
Educ Page 1 contains information that can be updated, but none of the fields on Educ Page 1 is required during reassessment.



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

1. Click **Educ**.
   Educ Page 1 displays.
2. Update Educ Page 1, if necessary.

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



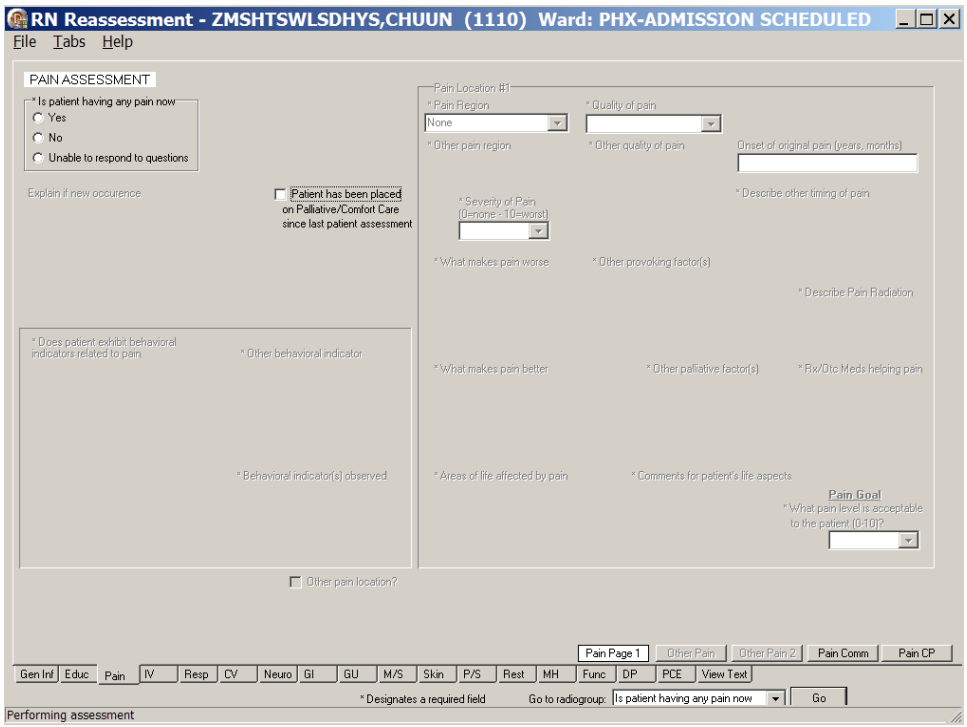
RN Reassessment, Educational Assessment (Educ) tab, Educ CP window

4. Update Educ CP.
   Refer to the instructions in *Working in a Care Plan* on page 12.

Pain (Pain)

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

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



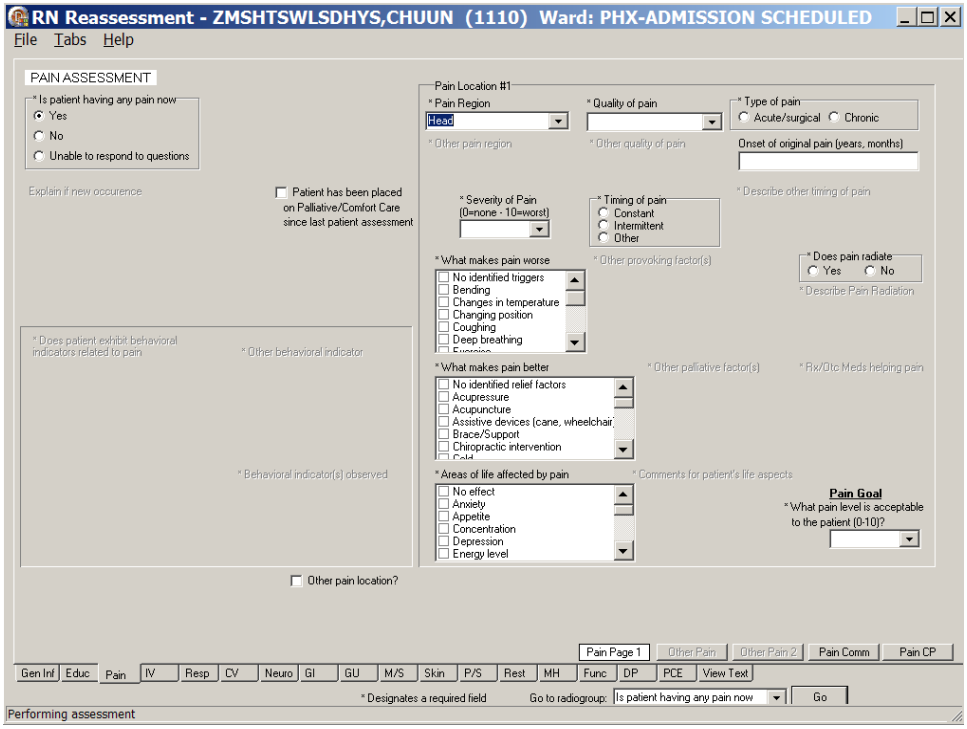
RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window

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

Is pain a problem for the patient/Yes

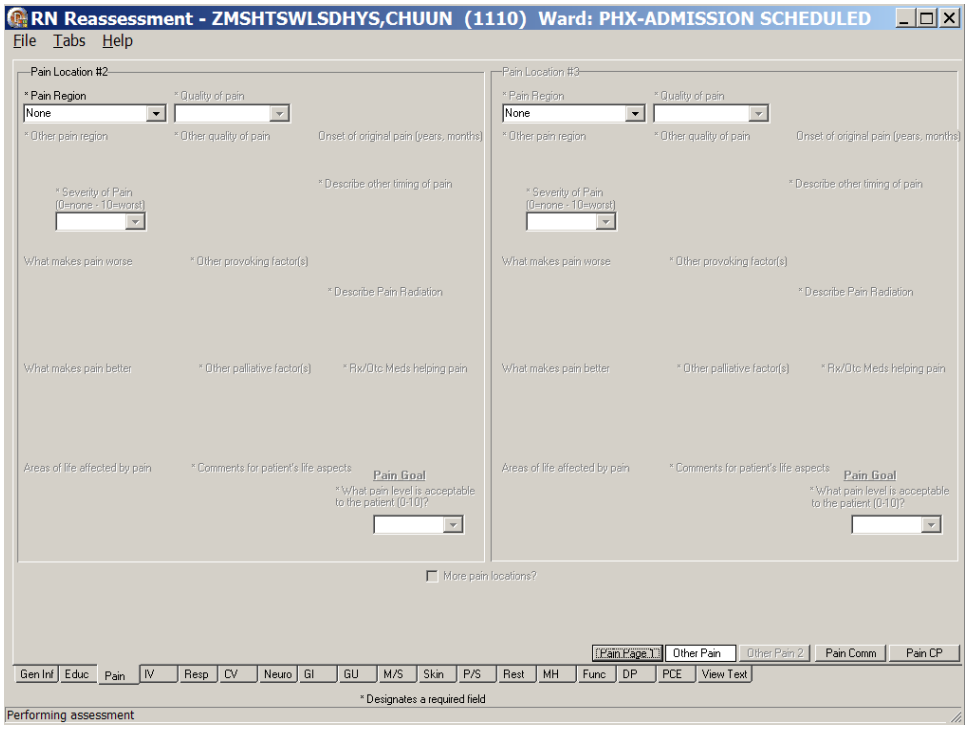
1. If a patient reports that pain is a problem (even if there is no pain currently), select **Yes**.
   a. The Other Pain and Other Pain 2 pages are available when the patient identifies multiple pain locations. There are five pain location sections.
   b. Identify Pain Location #1 and document the behavioral indicators.

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



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

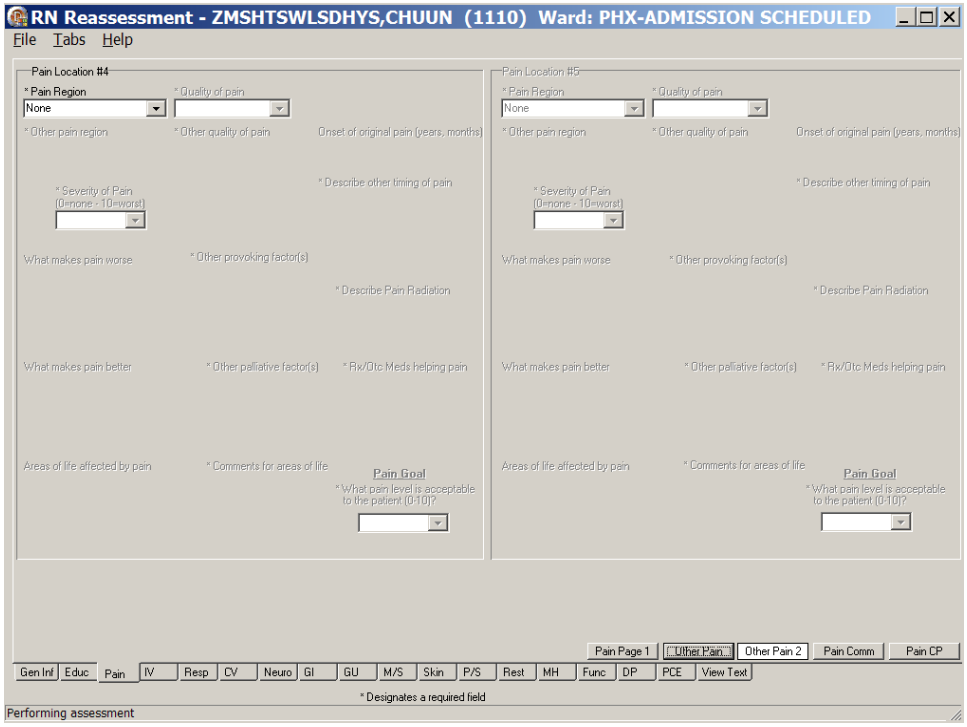
2. When Pain Location #1 is complete and you have more pain locations to document, select the **Other pain location ?** check box.
   Other Pain page displays.



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

3. **Optional:** Populate the Other Pain page.
   a. Identify Pain Location #2/Pain Location #3 and document the behavioral indicators.
   b. Complete all fields with asterisks; they are required fields.

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

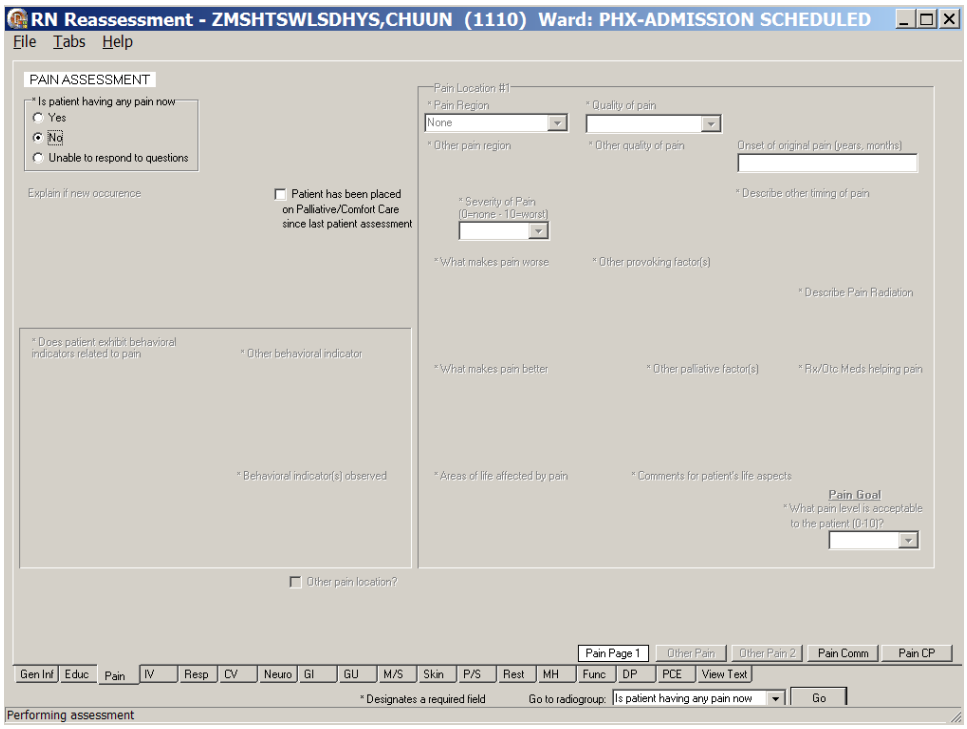


RN Reassessment, Pain Assessment (Pain) tab, Other Pain 2 window
Pain Location #4 and Pain Location #5

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

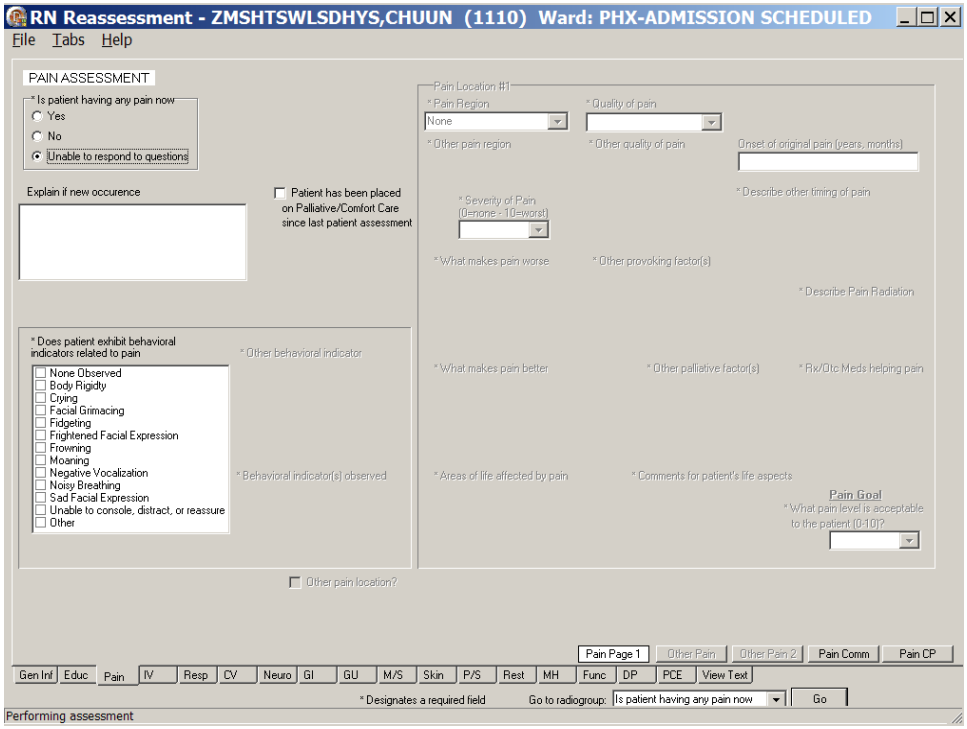
Is pain a problem for the patient/No

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



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

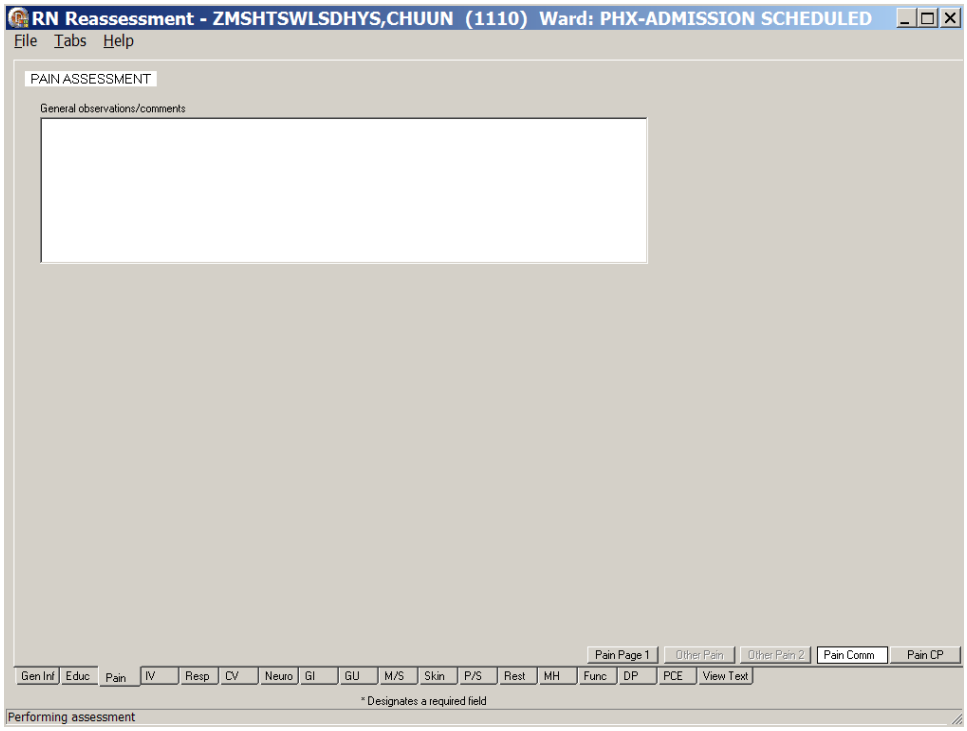
Is pain a problem for the patient/Unable to respond to questions



RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window
Is patient having any pain now/Unable to respond to questions

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

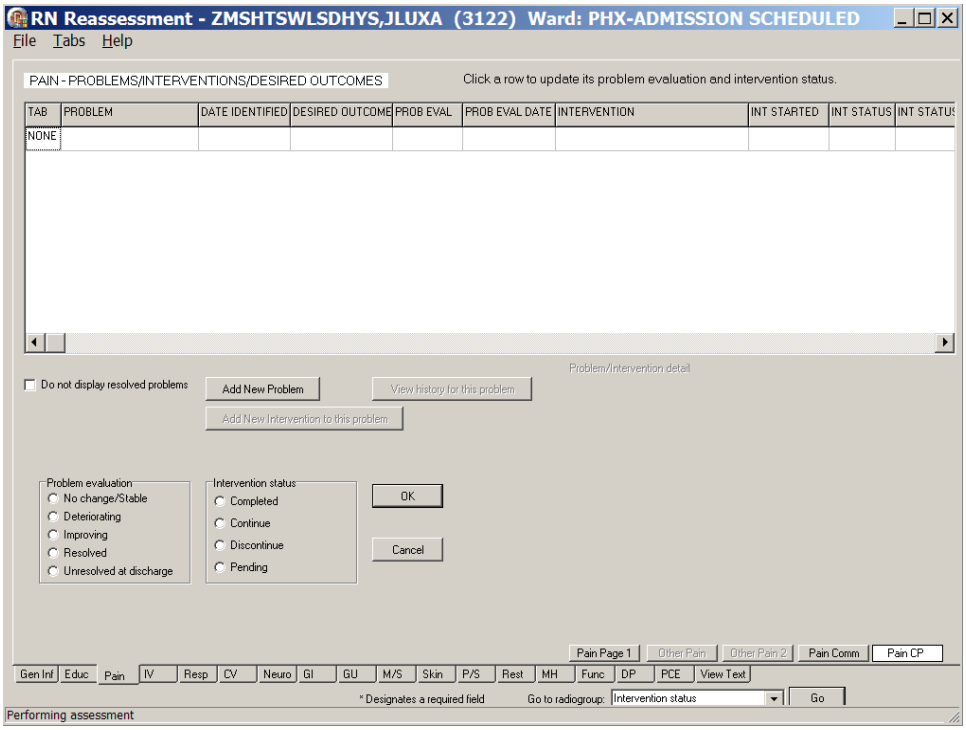
2. Click **Pain Comm**.
   Pain Comm displays.



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

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

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



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

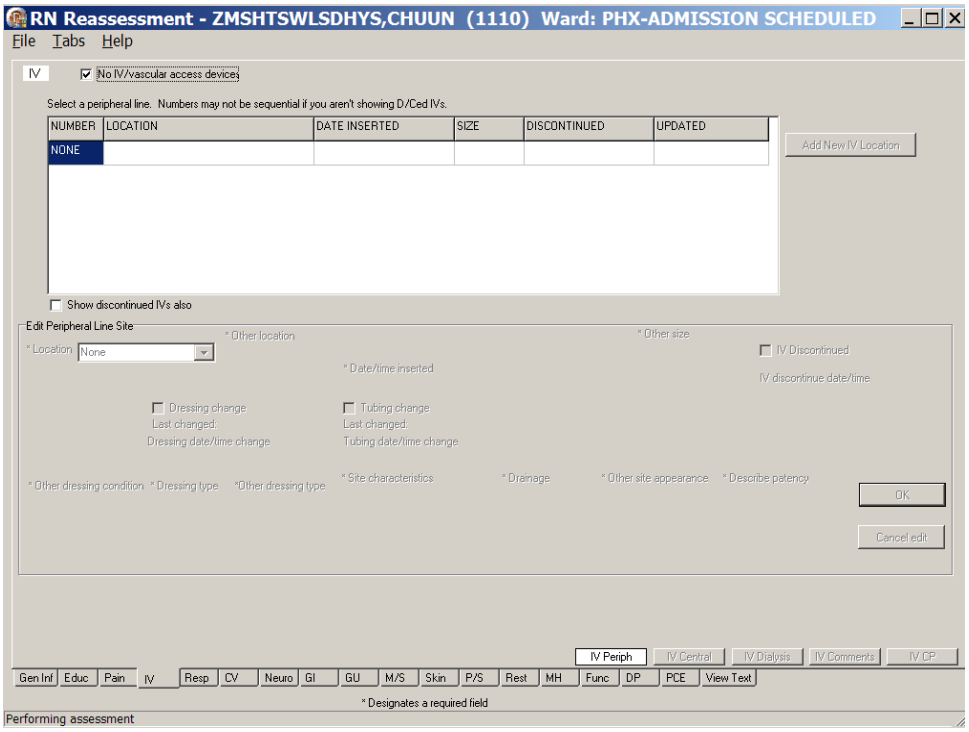
5. Populate Pain CP.
   Refer to the instructions in *Working in a Care Plan* on page 12.

IV (IV)

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

No IV/Vascular Access Devices

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

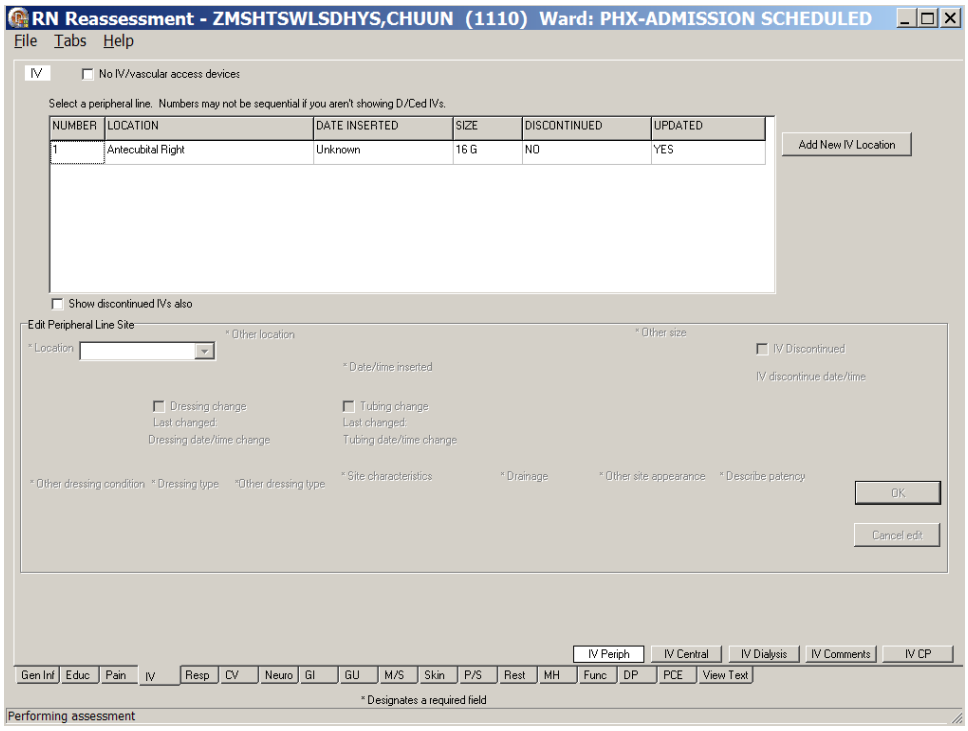


RN Reassessment, IV (IV) tab, IV Periph window
No IV/vascular access device selected

Peripheral Lines - IV Periph

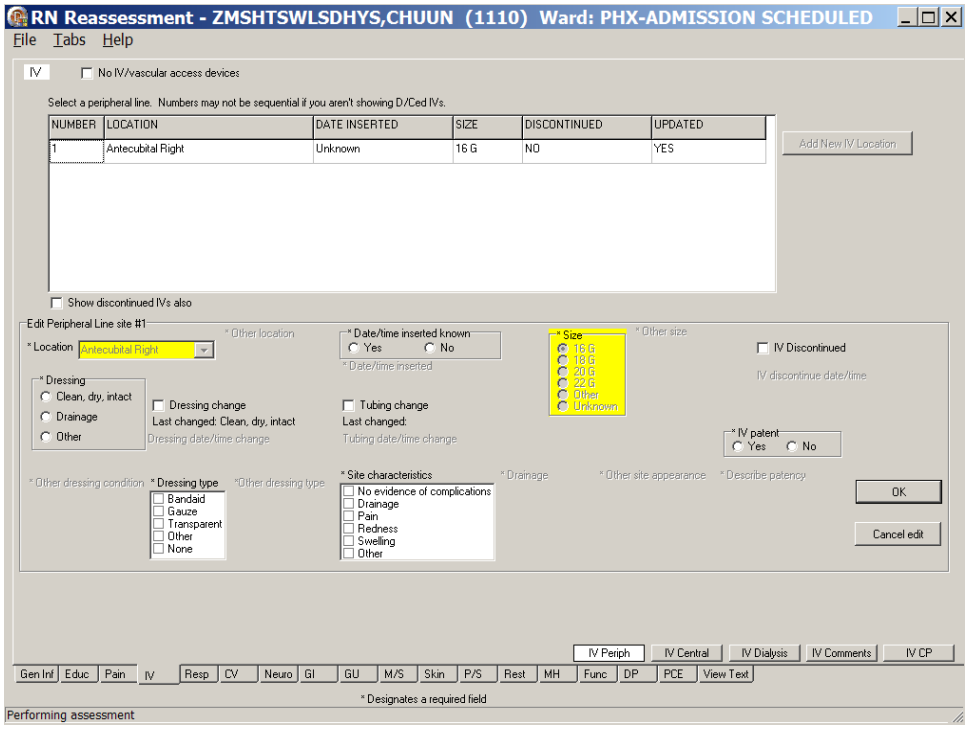
Existing IV Lines

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



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

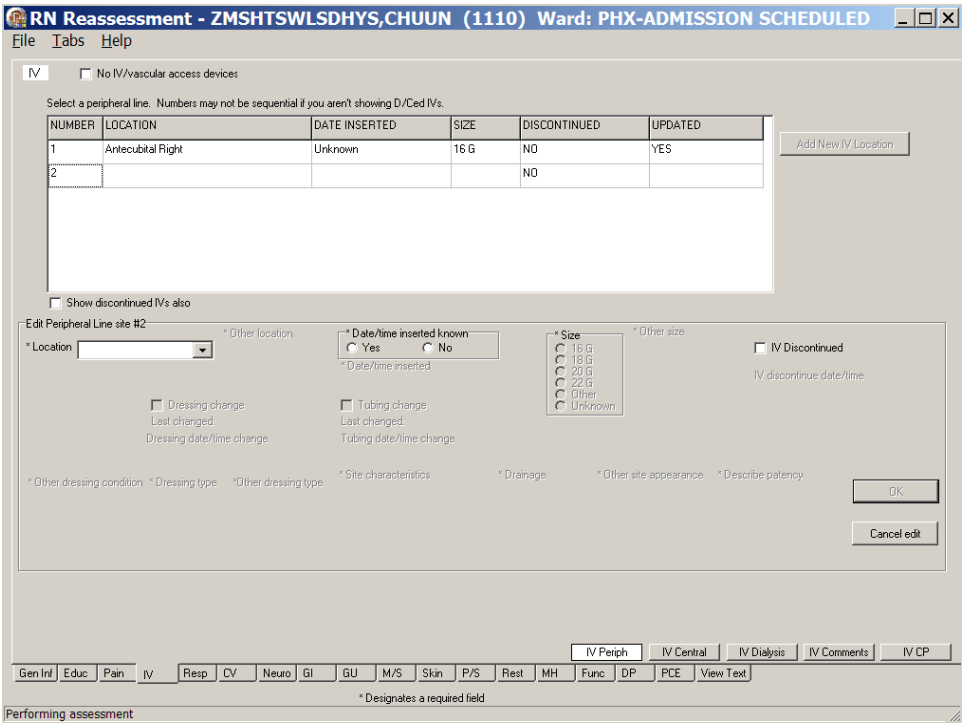
1. Populate IV Periph.
2. Select an existing IV and the edit fields for the selected IV are made available. Complete all the fields with asterisks; they are required fields.



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

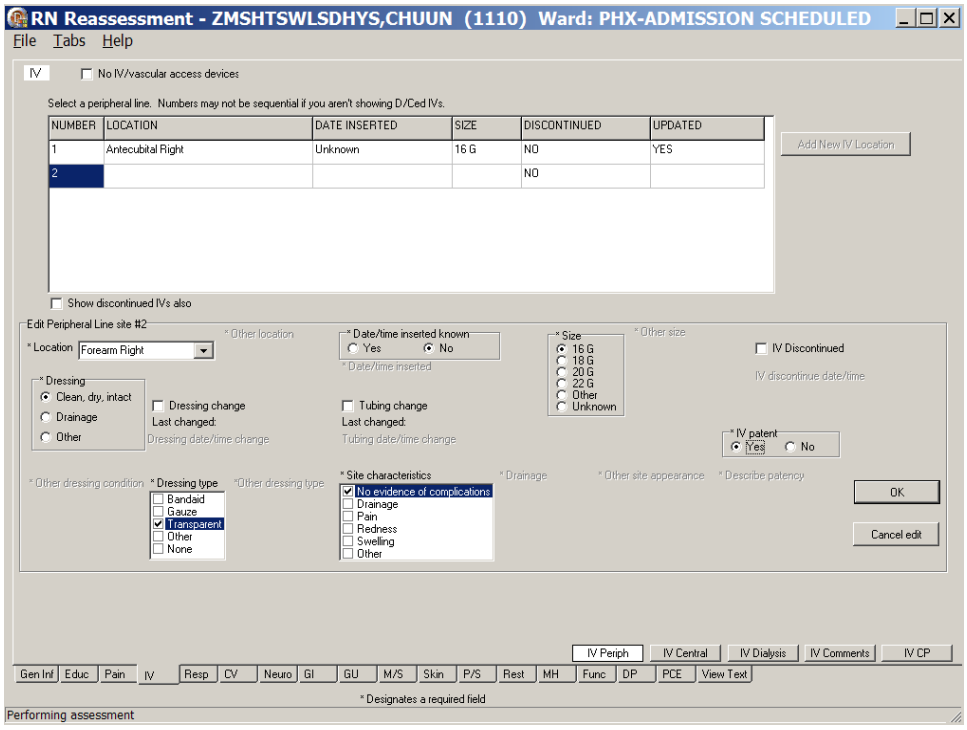
3. To cancel entered data *before upload*, click **Cancel edit**.
4. To upload updated information, click **OK**.

New IV Lines



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

5. Click **Add New IV Location**.
   The Location drop-down list box displays in the **Edit Peripheral Line site #1** section.
6. Select a location and additional fields become available.
   Complete all the fields with asterisks; they are required fields.
7. To cancel entered data *before upload*, click **Cancel edit**.
8. To upload updated information, click **OK**.



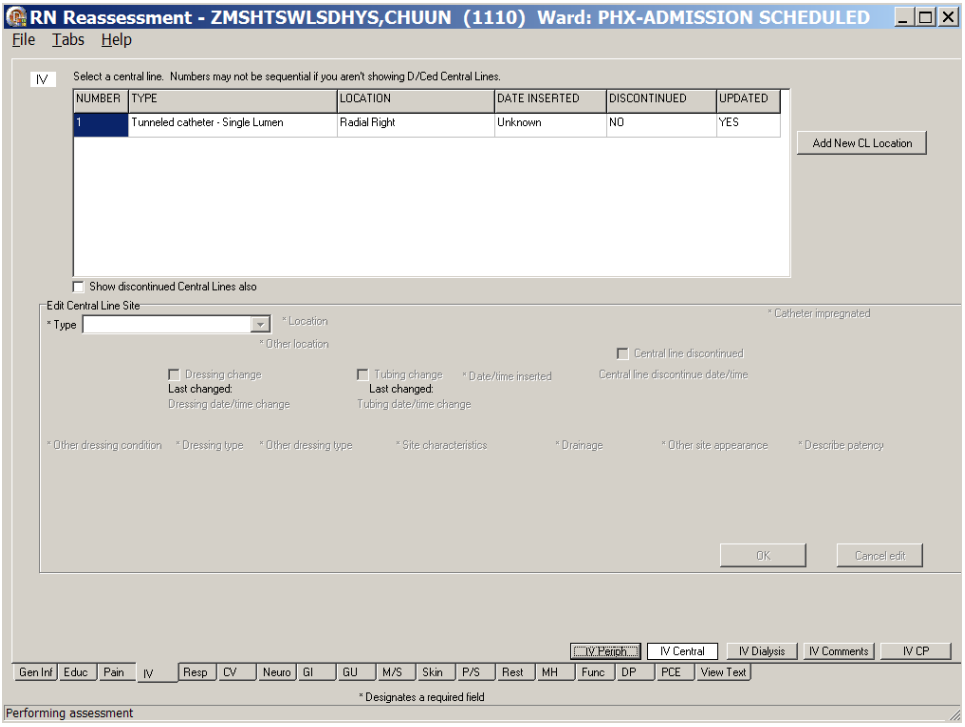
RN Reassessment, IV (IV) tab, IV Periph window with a peripheral line location

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

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

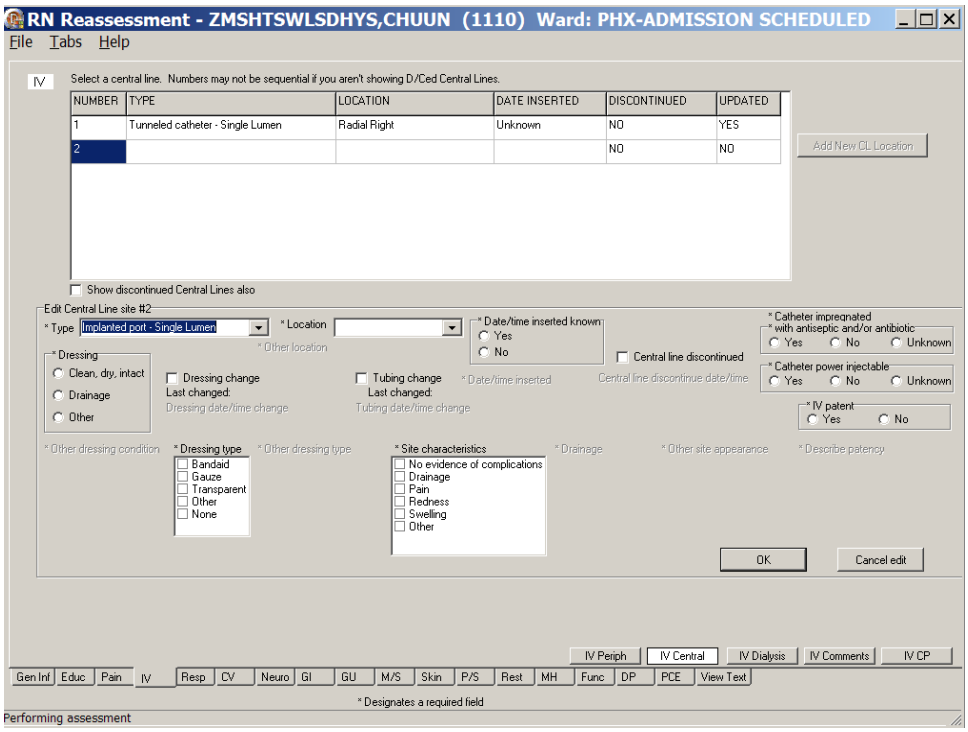
Central IV Lines – IV Central

1. Click **IV Central**.
   IV Central displays.



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

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

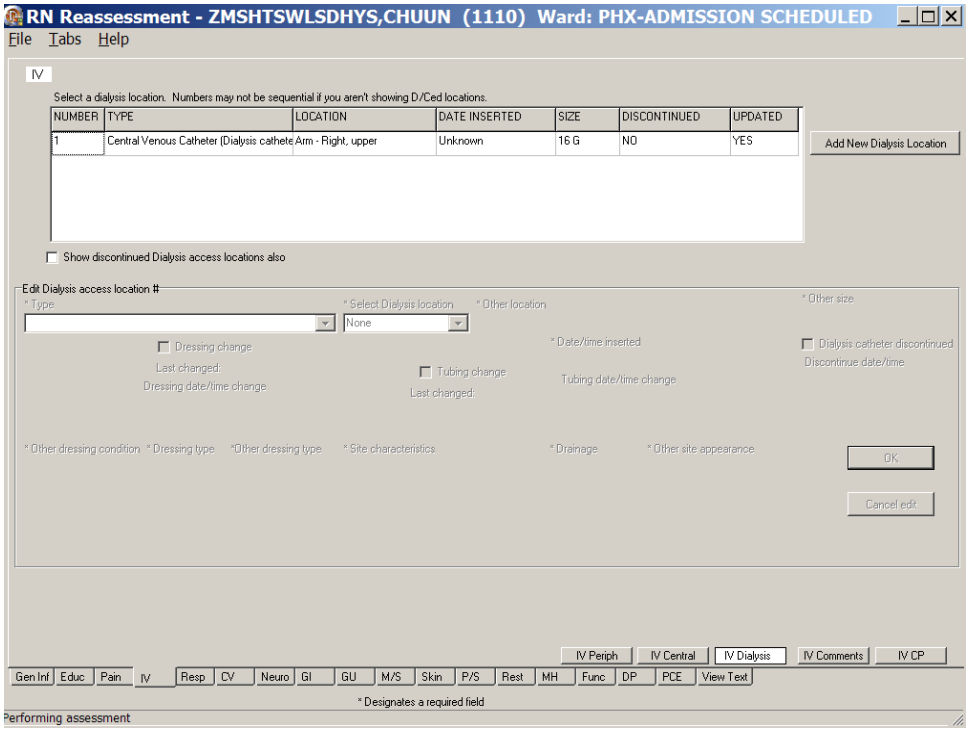


RN Reassessment, IV (IV) tab, IV Central window

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

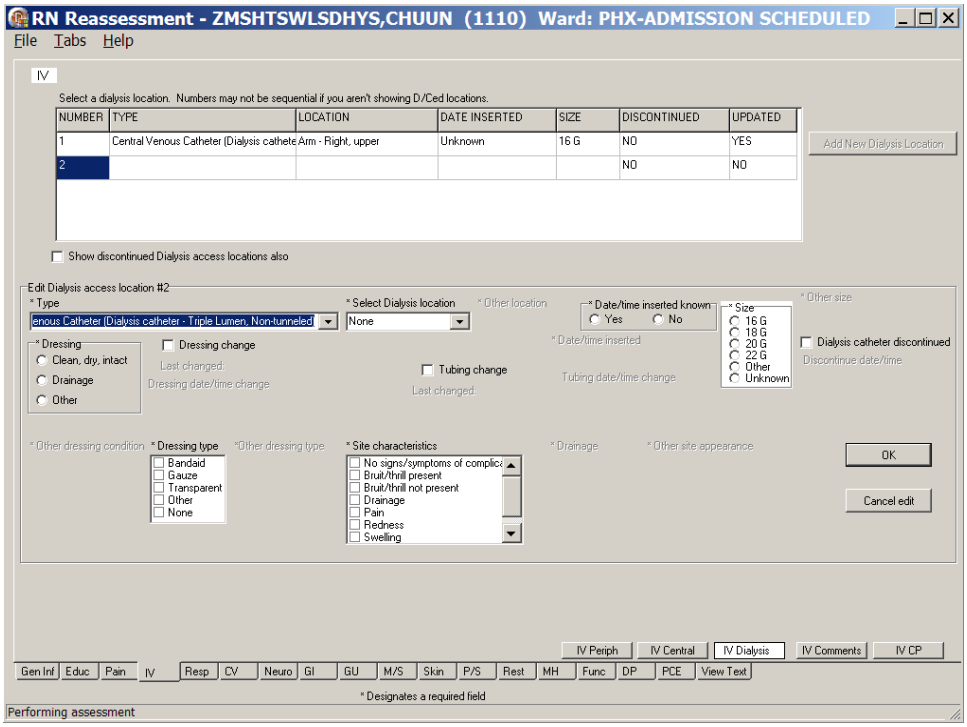
Dialysis Ports - IV Dialysis

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



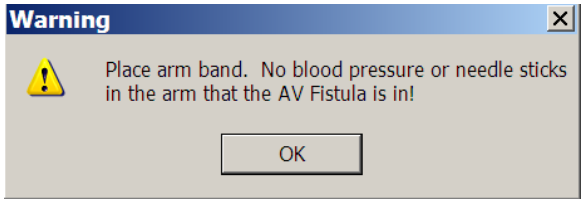
RN Reassessment, IV (IV) tab, IV Dialysis window

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



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

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

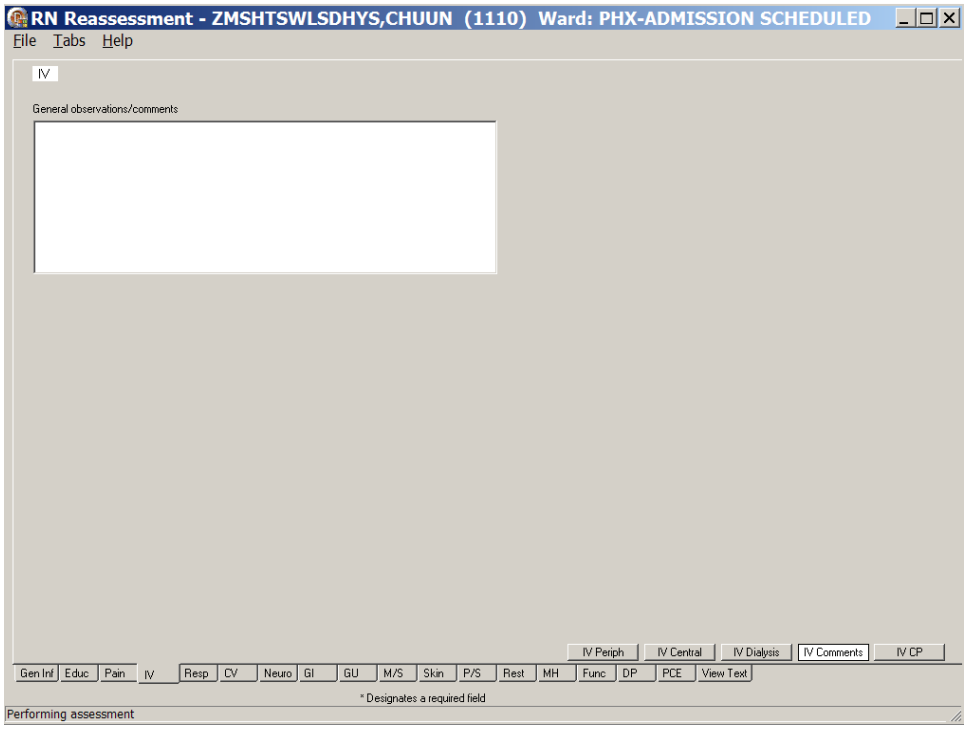


Warning: Place arm band.
No blood pressure or needle sticks in the arm that the AV Fistula or AV Graft is in!

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

General Observations/Comments – IV Comments

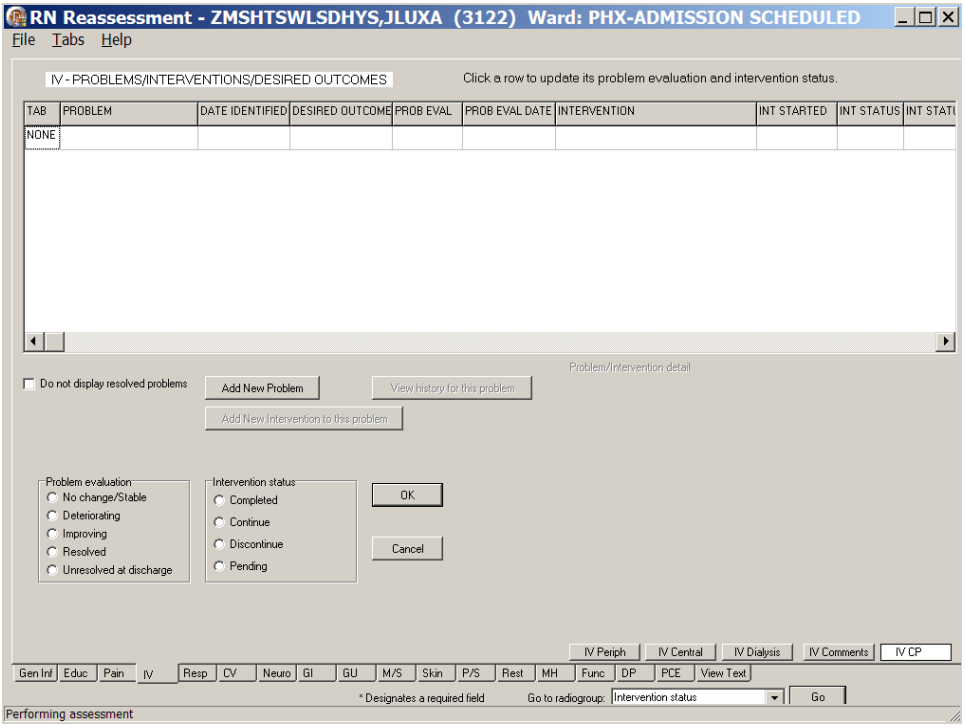
1. Click **IV Comments**.
   IV Comments displays.
2. Populate IV Comments.
   Use the **General observations/comments** text box for additional information.



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

Care Plan - IV CP

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

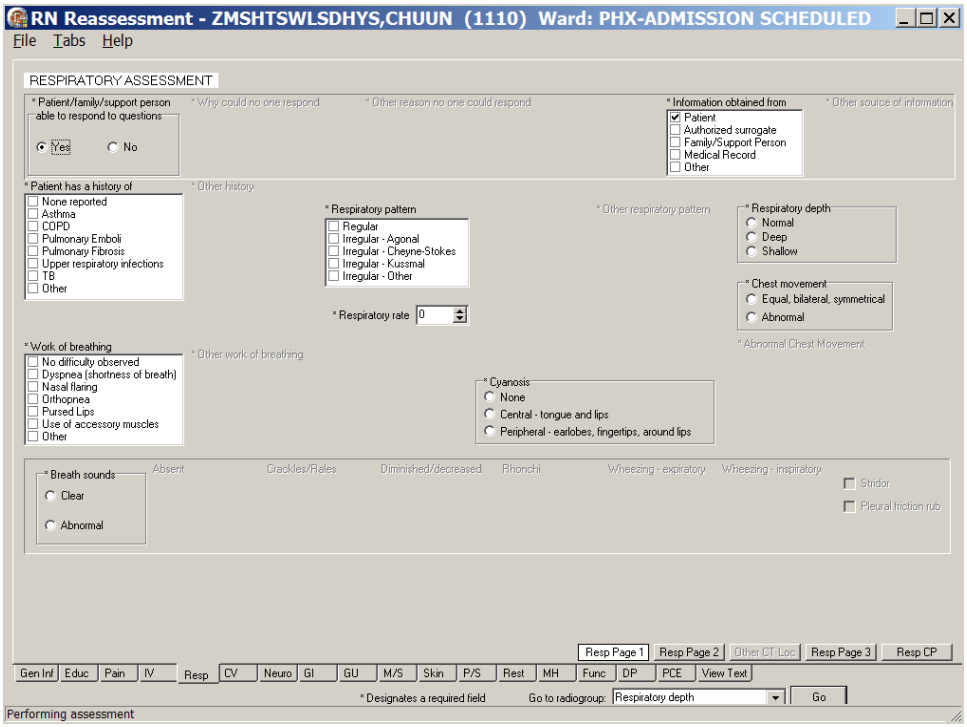


RN Reassessment, IV – Problems/Interventions/Desired Outcomes (IV) tab, IV CP window

Respiratory (Resp)

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

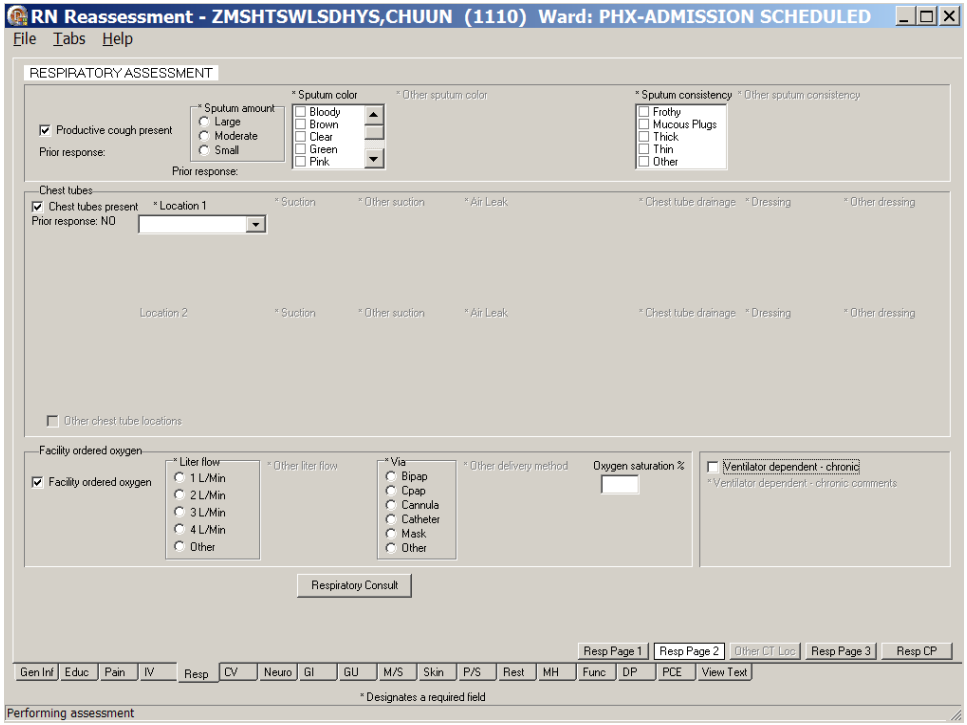
Responses from the previous assessment/reassessment are hard-coded into the reassessment, but the information is not transferred into the Progress Note of the current assessment.



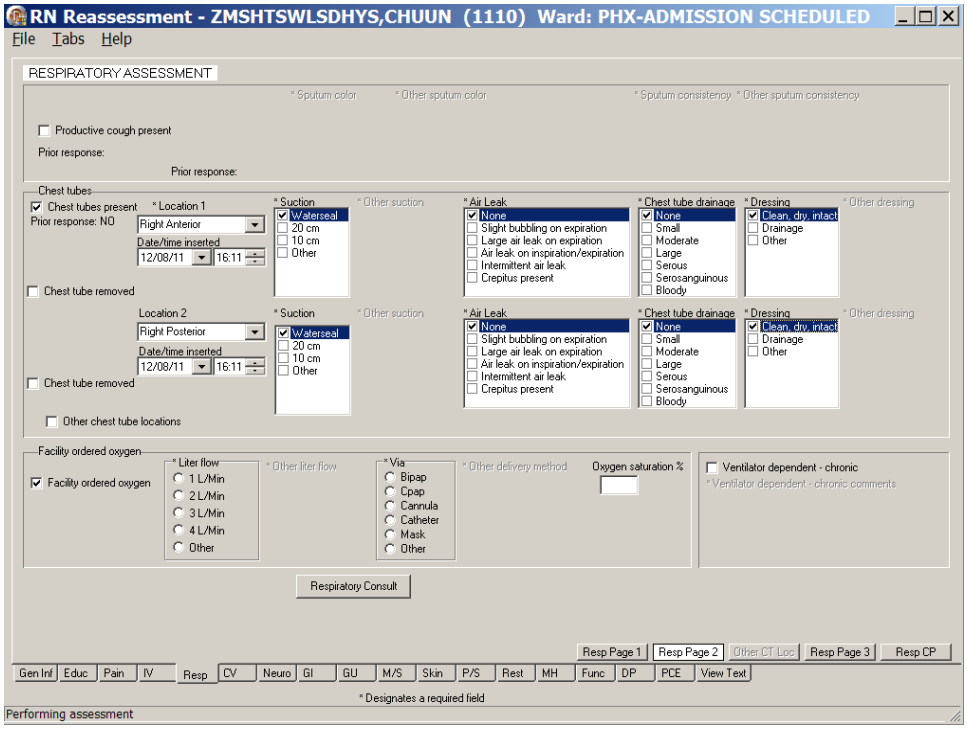
RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 1 window

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

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

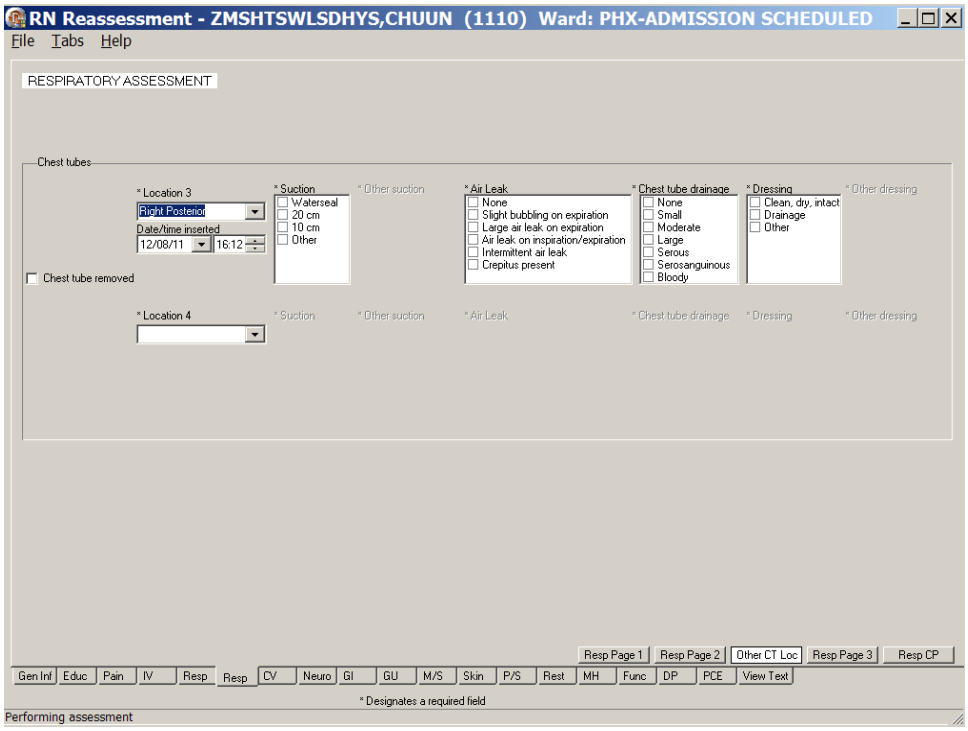


RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 2 window



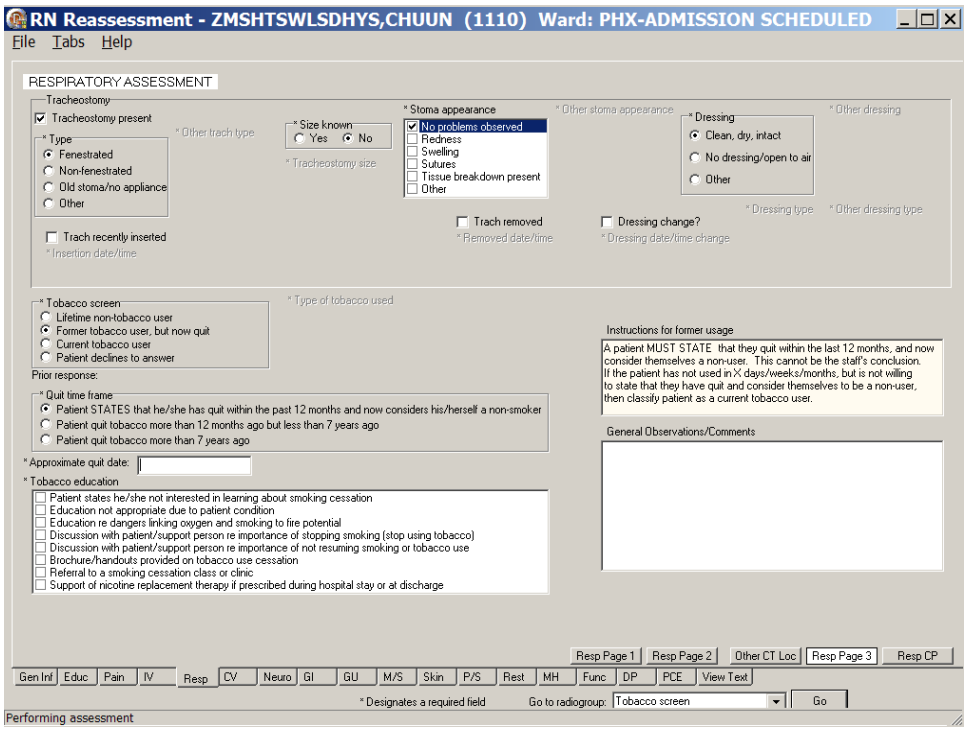
RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 2 window
Chest tube locations 1 and 2

4. Populate Resp Page 2.
   Complete all the fields with asterisks; they are required fields.
   a. If the Respiratory Consult is set up at your site, use the Respiratory Consult button to order the consult, in accordance to the condition of the patient and the policy of your medical center.
   b. Refer to the instructions in *Working in the Consults* on page 25.
   c. Select the **Other chest tube locations** check box.
      The Other CT Loc page is made available.
5. Click **Other CT Loc**.
   Other CT Loc displays.
6. Populate Other CT Loc, CT locations 3 and 4, if necessary.
   Complete all the fields with asterisks; they are required fields.



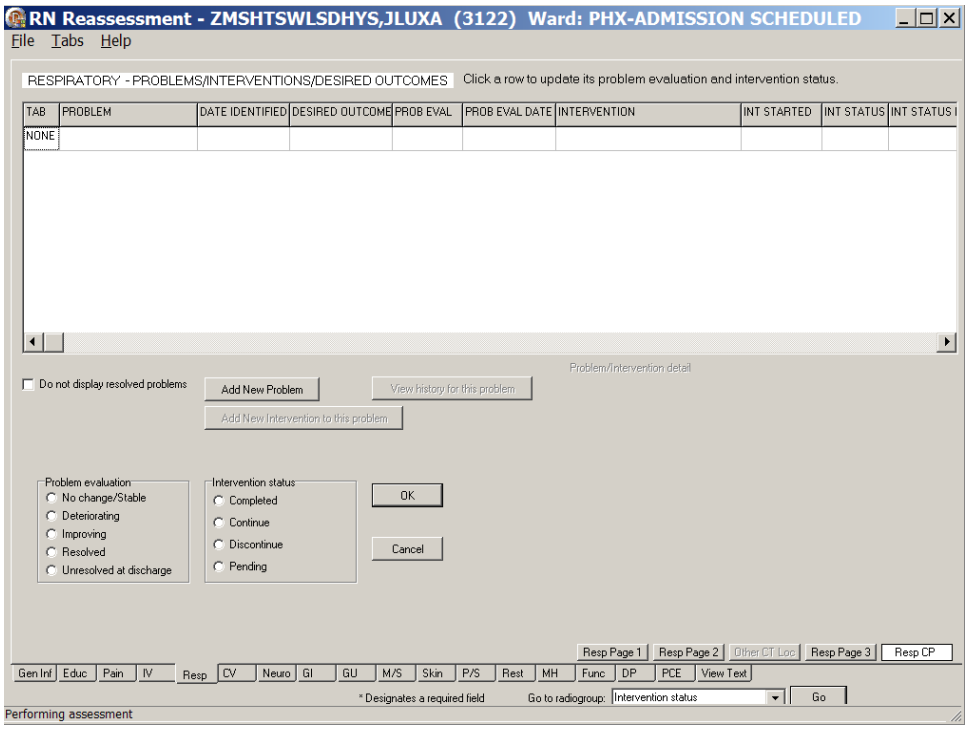
RN Reassessment, Respiratory Assessment (Resp) tab, Other CT Loc window
Other CT locations, Location 3 and Location 4

7. Click **Resp Page 3**.
   Resp Page 3 displays.



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

8. Populate Resp Page 3, if necessary.
   Complete all the fields with asterisks; they are required fields.
9. Click **Resp CP**.
   Resp CP displays.

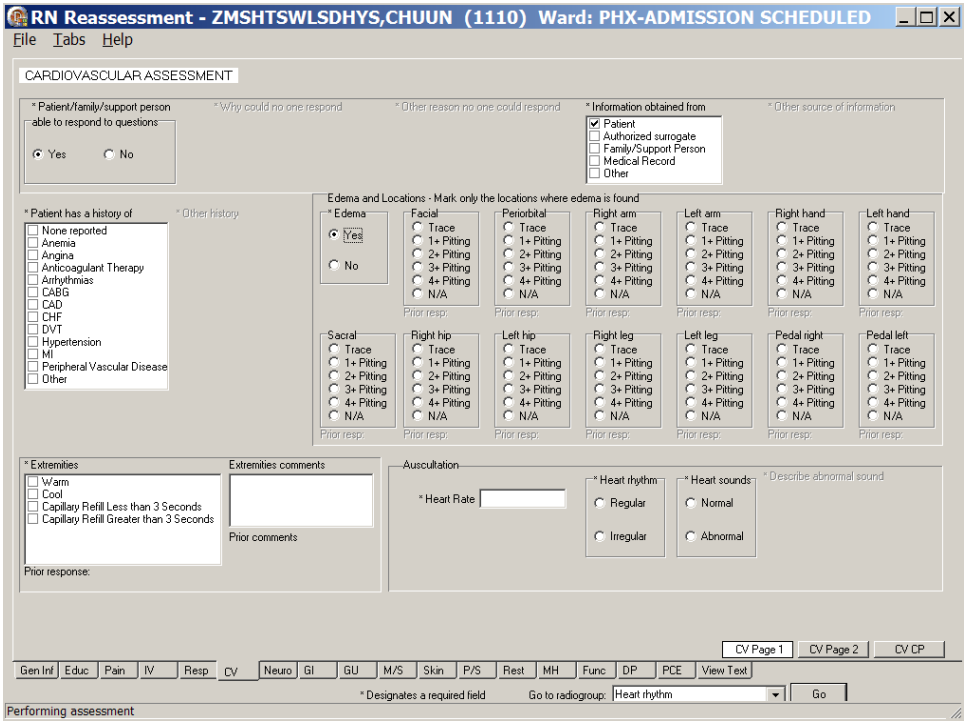


RN Reassessment, Respiratory – Problems/Interventions/Desired Outcomes (Resp) tab, Resp CP window

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

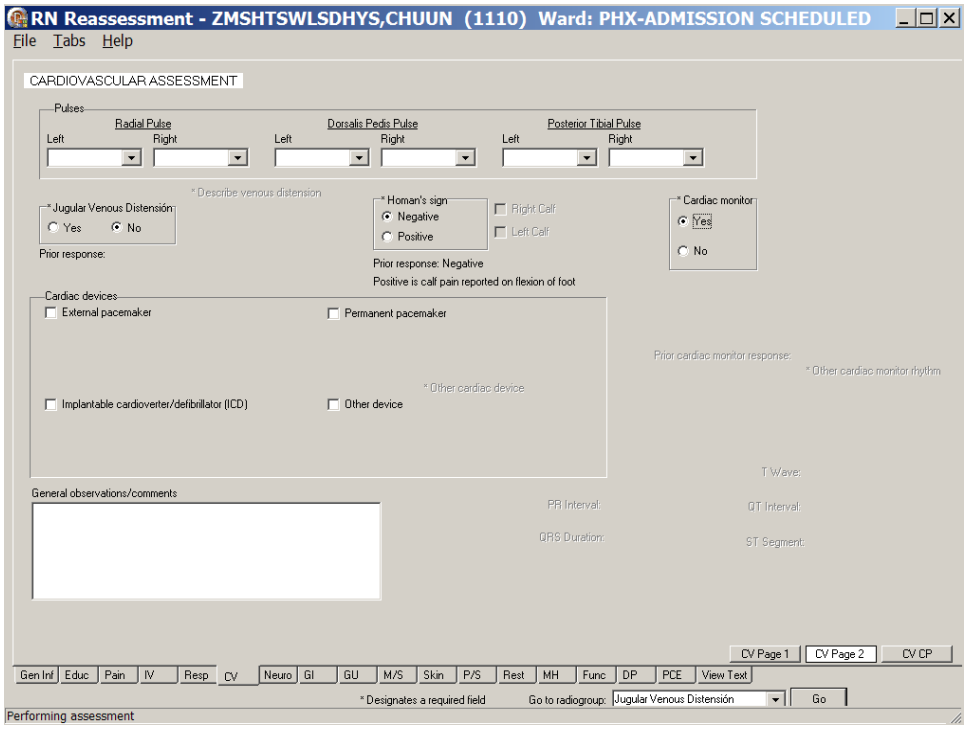
Cardiovascular (CV)

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



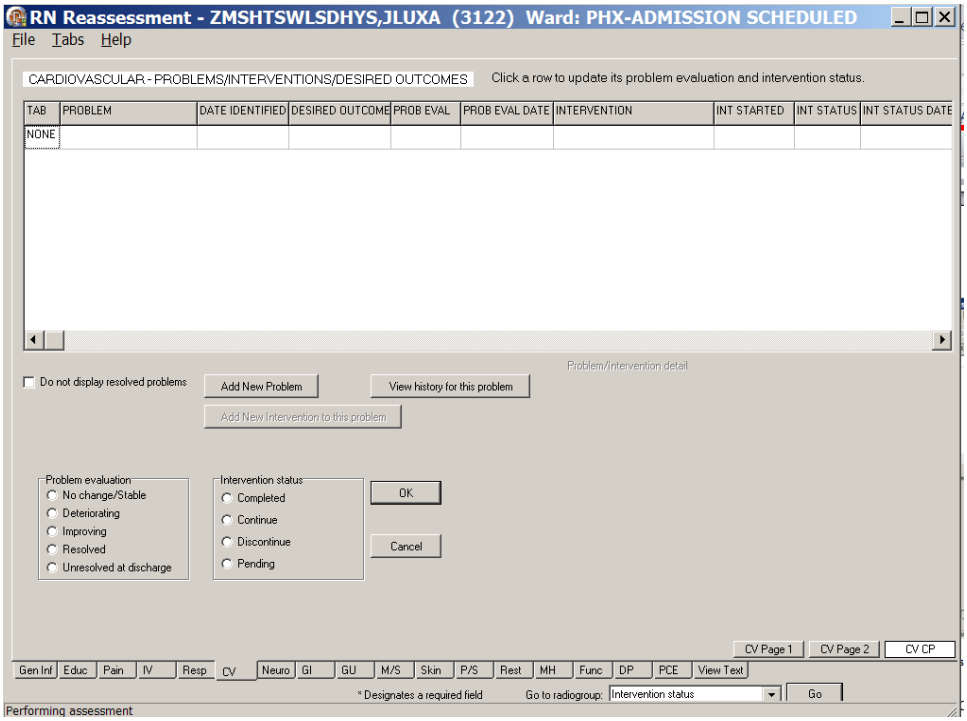
RN Reassessment, Cardiovascular Assessment (CV) tab, CV Page 1 window

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



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

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

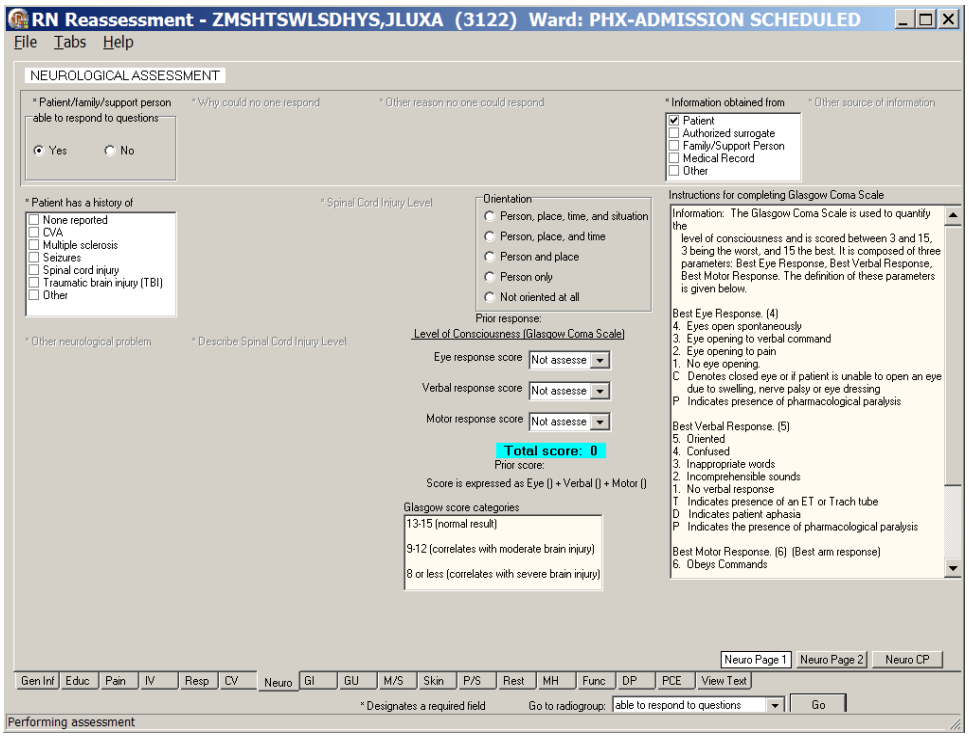


RN Reassessment, Cardiovascular – Problems/Interventions/Desired Outcomes (CV) tab, CV CP window

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

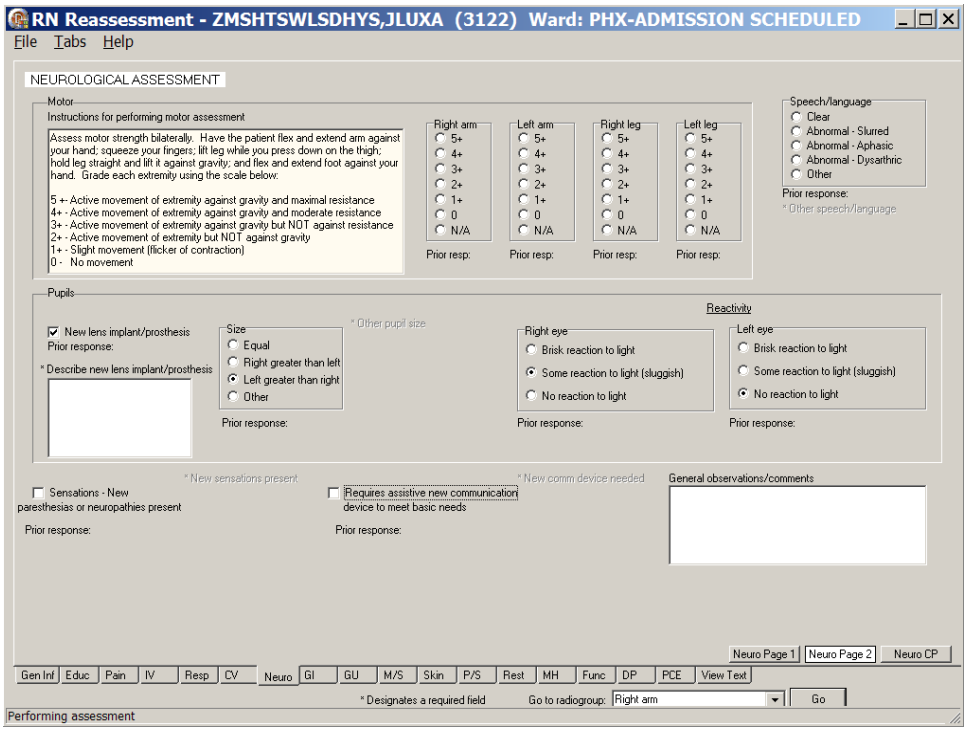
Neurology (Neuro)

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



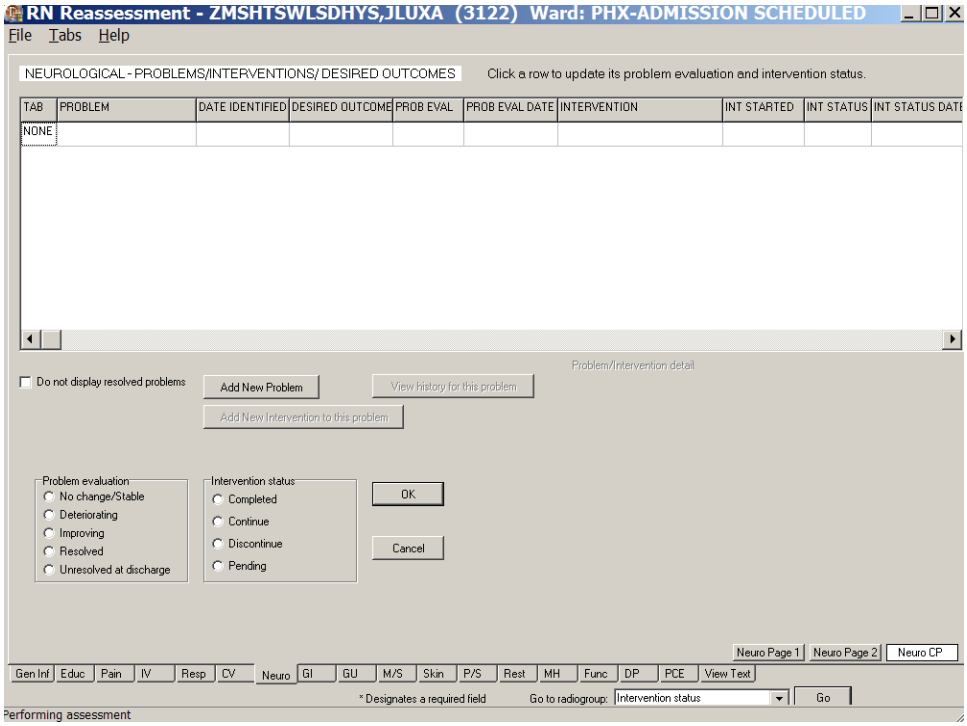
RN Reassessment, Neurological Assessment (Neuro) tab, Neuro Page 1 window

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



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

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

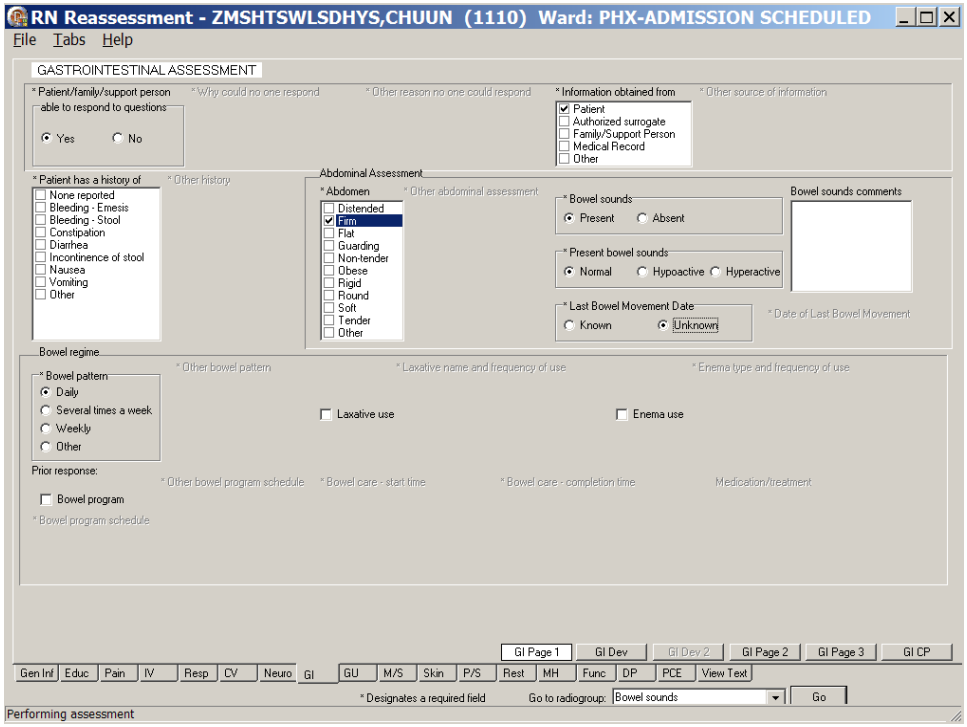


RN Reassessment, Neurological – Problems/Interventions/Desired Outcomes (Neuro) tab, Neuro CP window

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

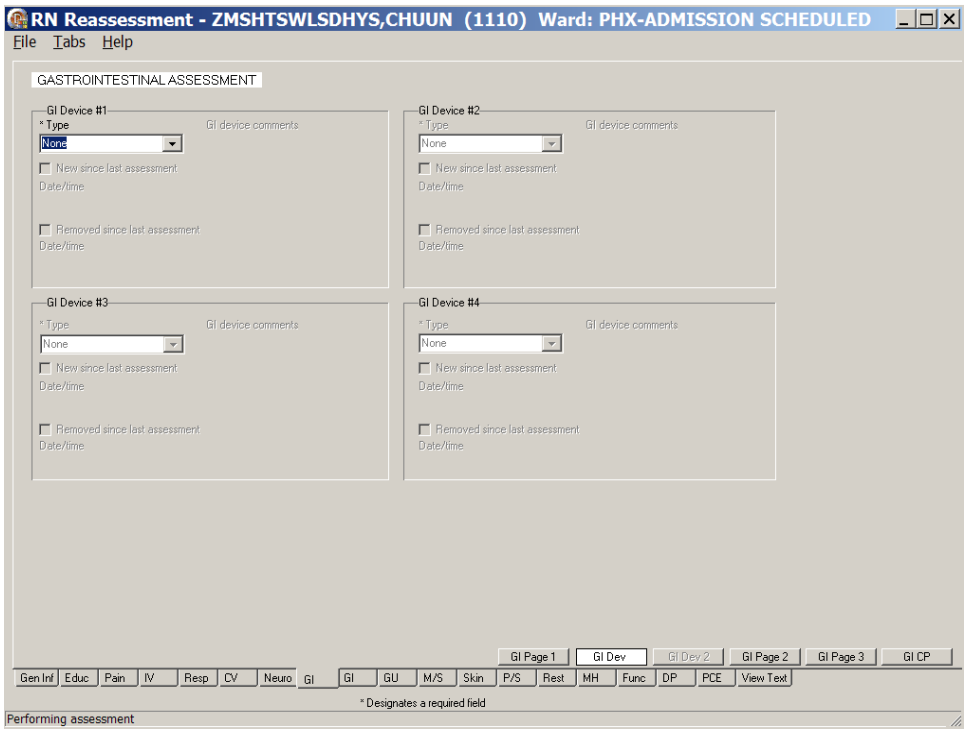
Gastrointestinal (GI)

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



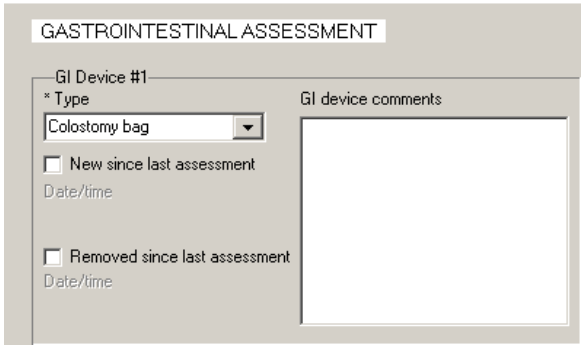
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 1 window

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



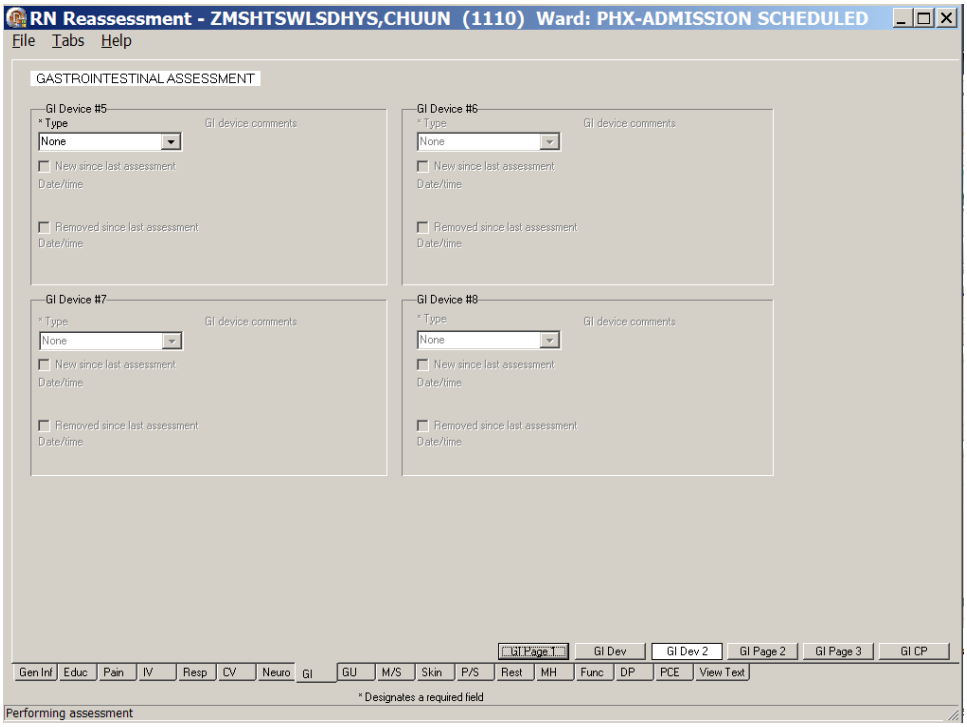
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Dev window
GI Devices #1-#4

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



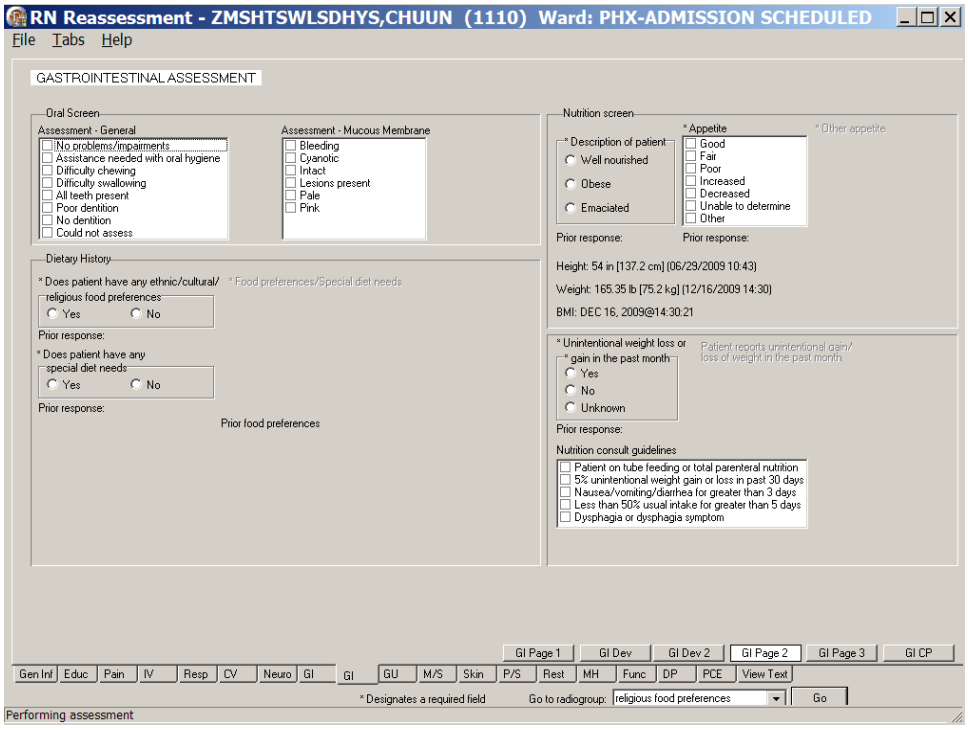
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Dev window,
GI Device #1

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



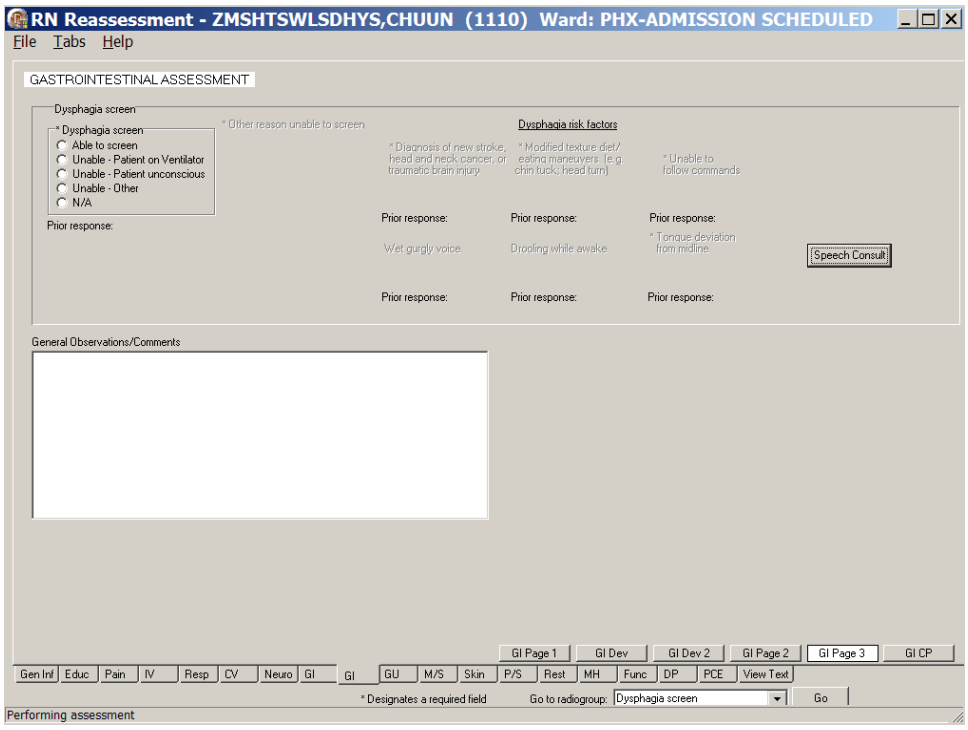
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Dev 2 window
GI Devices #5-#8

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



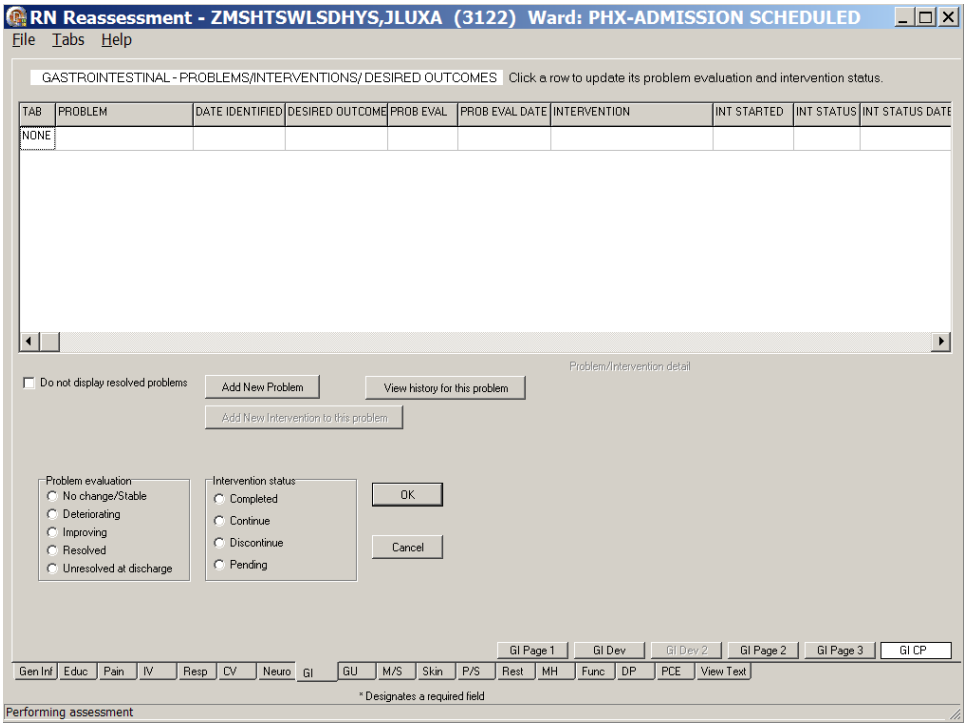
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 2 window

8. Populate GI Page 2.
   a. Complete all the fields with asterisks; they are required fields.
   b. GI Page 2 contains the Nutrition Consult.
      Refer to the instructions in *Working in the Consults* on page 25.
9. Click **GI Page 3**.
   GI Page 3 displays.



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

10. Populate GI Page 3.
    a. Complete all the fields with asterisks; they are required fields.
    b. Use the **General observations/comments** text box for additional information.
    c. GI Page 3 contains the Speech Consult.
       Refer to the instructions in *Working in the Consults* on page 25.
11. Click **GI CP**.
    GI CP displays.

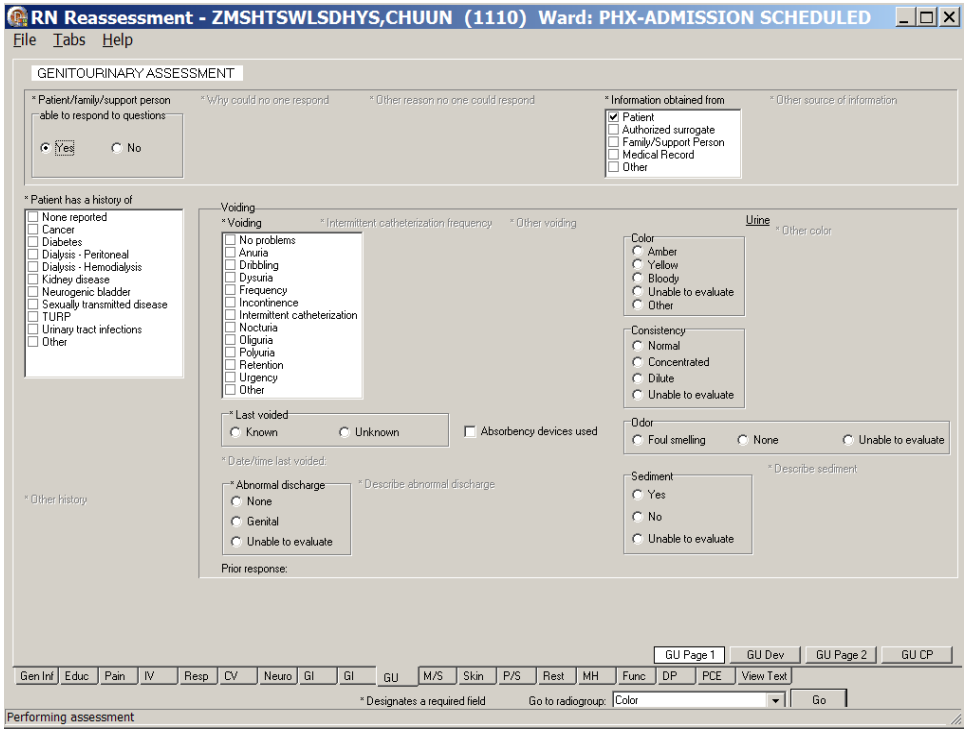


RN Reassessment, Gastrointestinal – Problems/Interventions/Desired Outcomes (GI) tab, GI CP window

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

Genitourinary (GU)

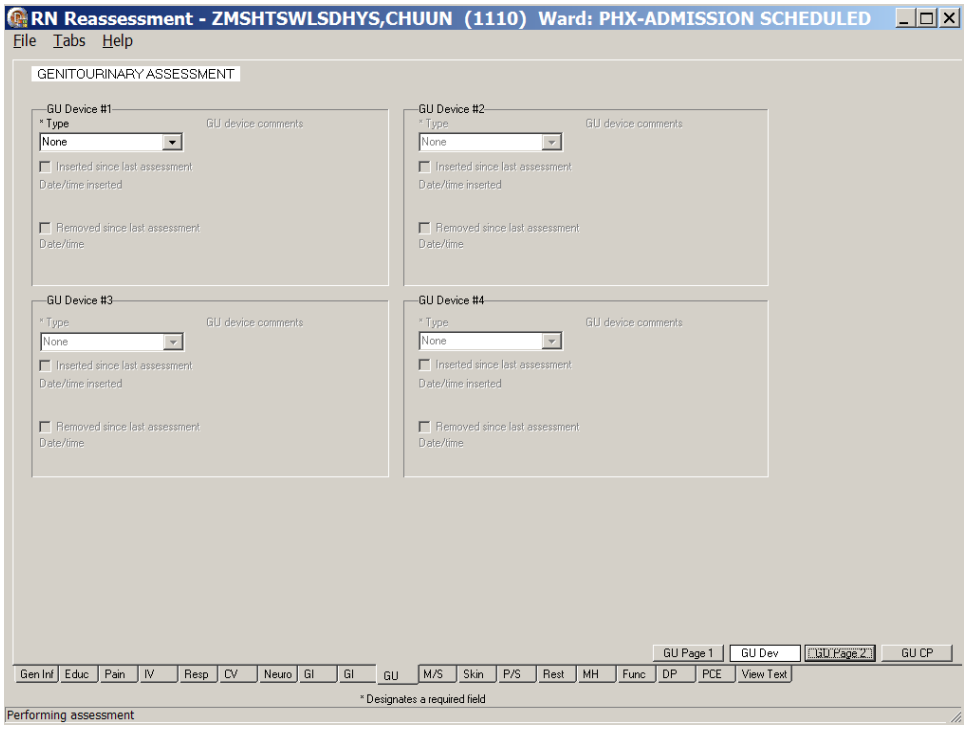
Document the genitourinary reassessment of a patient in the Genitourinary tab. If a patient has a GU device documented in a previous assessment, the device displays in the current reassessment.



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

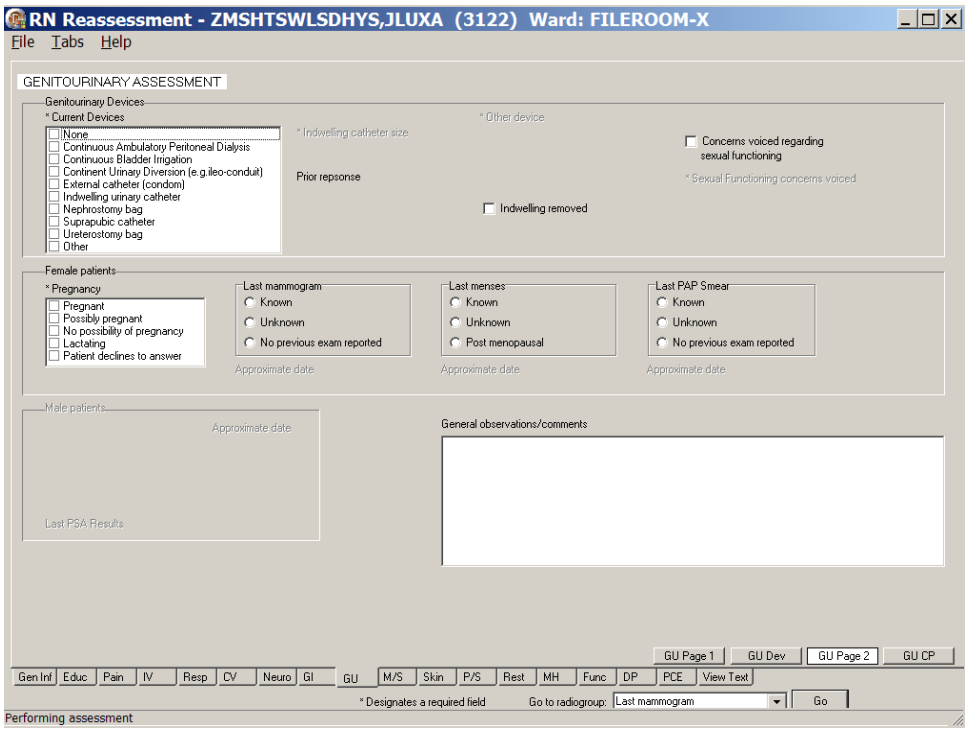
1. Click **GU**.
   GU Page 1 displays.
2. Populate GU Page 1.
   Complete all the fields with asterisks; they are required fields.
3. Click **GU Dev**.
   GU Dev displays.

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

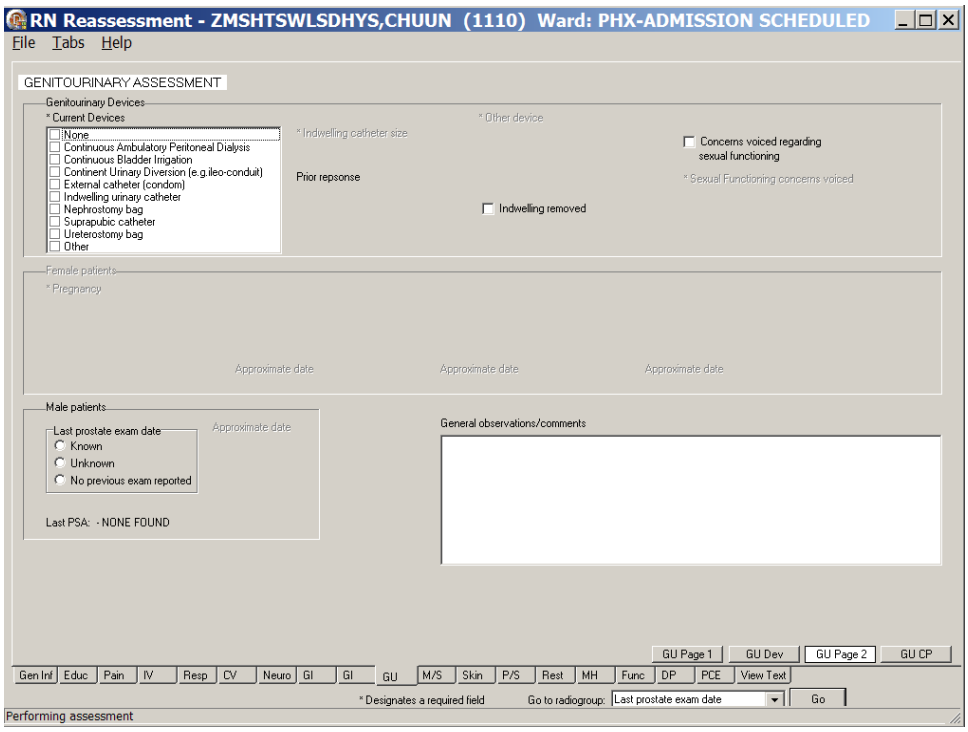


RN Reassessment, Genitourinary Assessment (GU) tab, GU Dev window

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



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



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

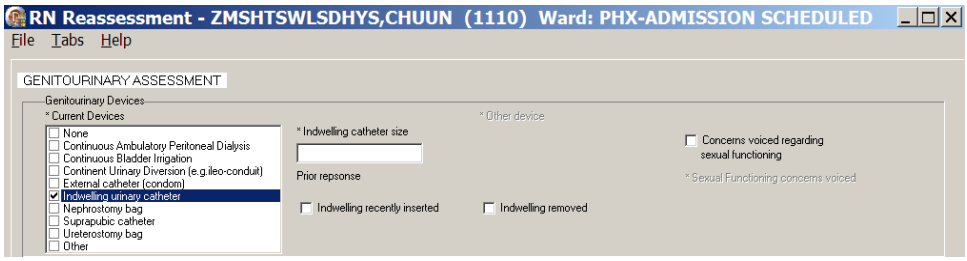
Note: The sex-specific questions (male/female) are optional. The exception is for female patients; the pregnancy responses are required.

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

Indwelling Catheter

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

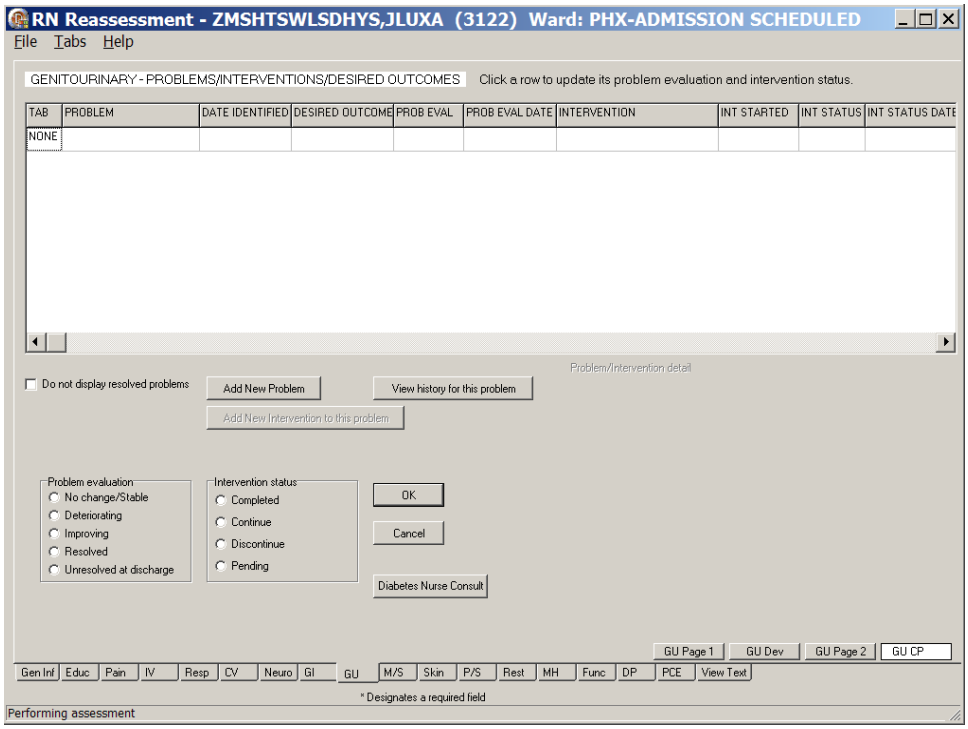
The size of the catheter can be entered in a previous reassessment on the GU Dev page in the **General observations/comments** text box.



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

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

7. Click **GU CP**.
   GU CP displays.



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

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

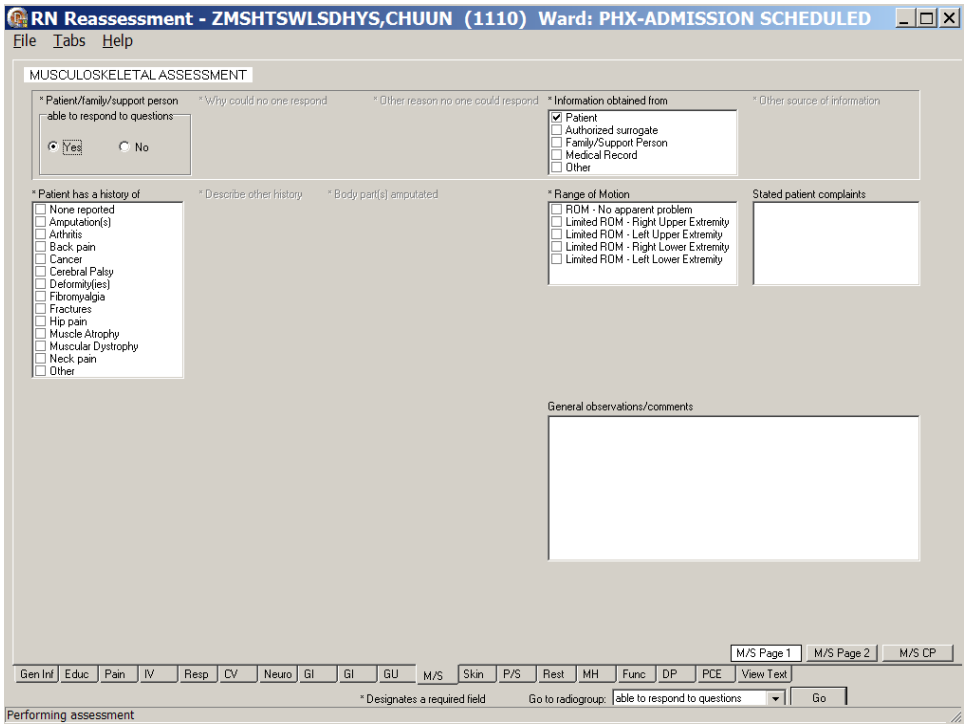
Musculoskeletal (M/S)

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

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

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

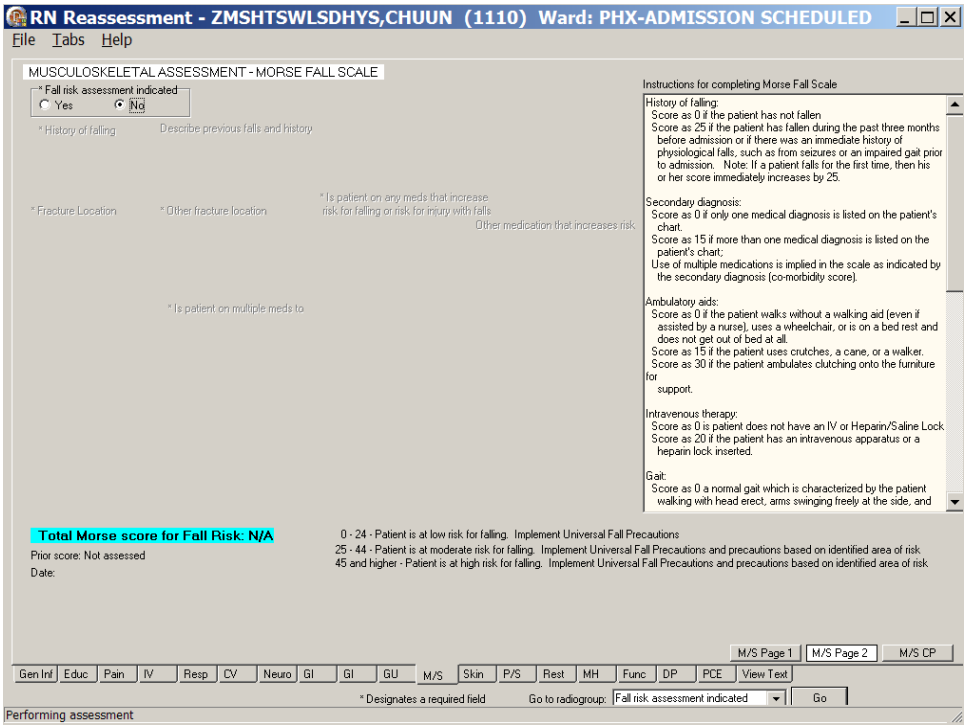
1. Click **M/S**.
   M/S Page 1 displays.



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

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

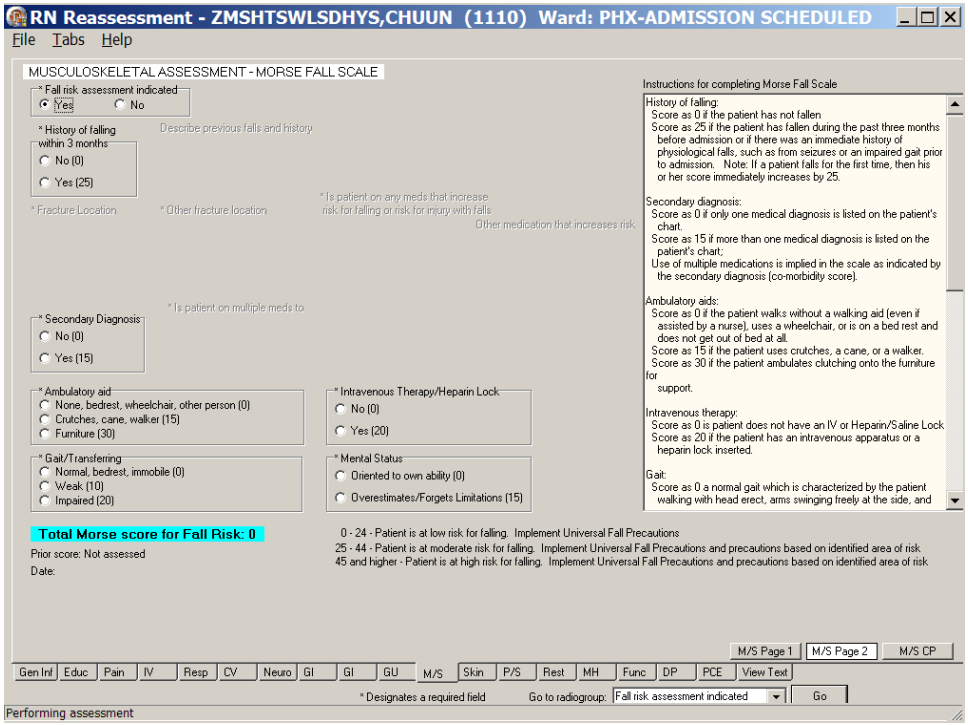
3. Click **M/S Page 2**.
   M/S Page 2 displays.



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

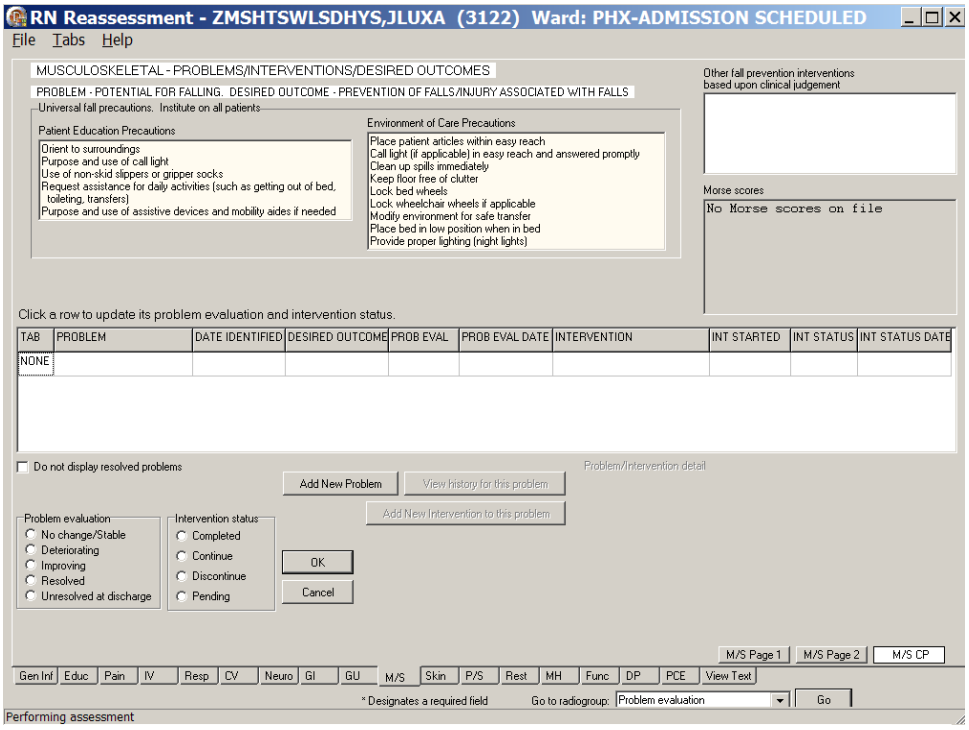
4. Populate M/S Page 2.
   Complete all the fields with asterisks; they are required fields.

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



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

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



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

7. Update M/S CP, if necessary.
   Refer to the instructions in *Working in a Care Plan* on page 12.

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

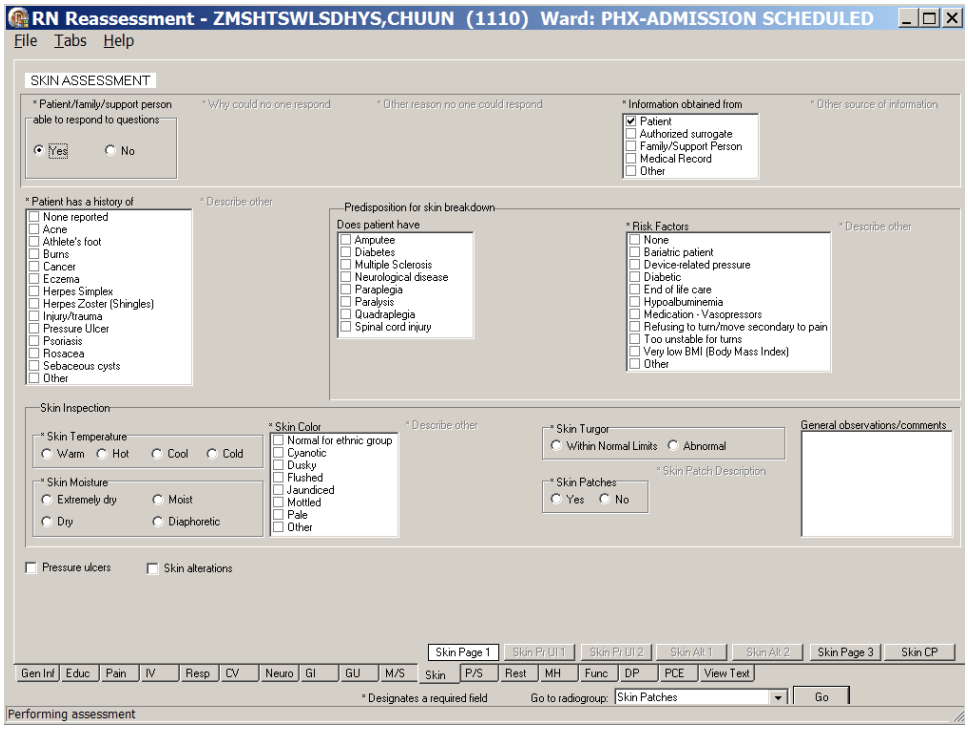
Skin (Skin)

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

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

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

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

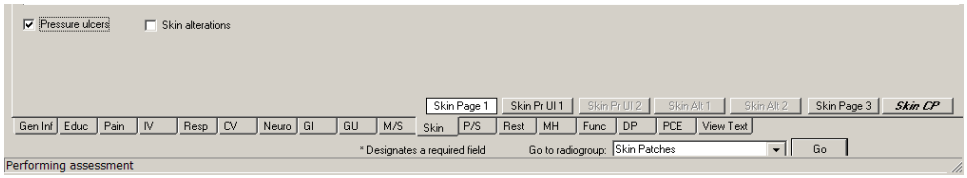


RN Reassessment, Skin Assessment (Skin) tab, Skin Page 1 window

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

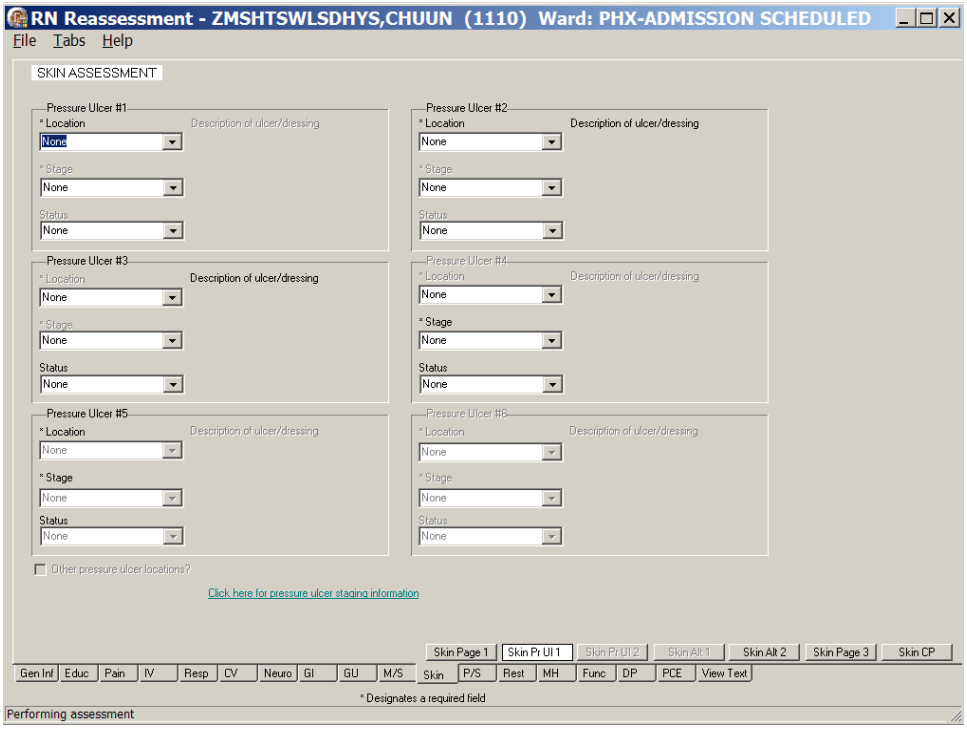
Documenting Pressure Ulcers

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



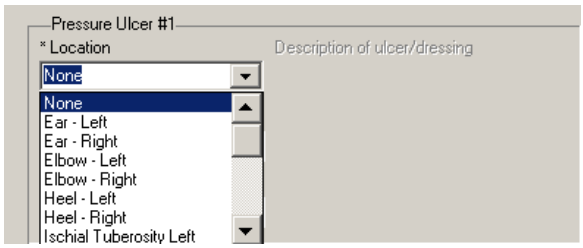
RN Reassessment, Skin Assessment (Skin) tab, Skin Page 1 window
Pressure ulcers selected

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

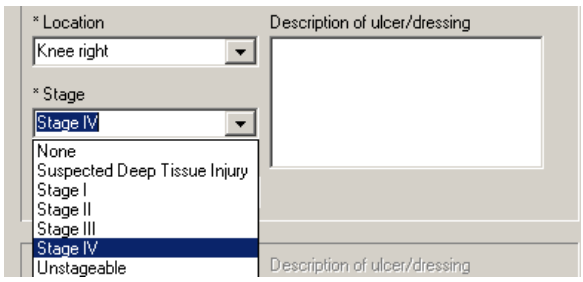


RN Reassessment, Skin Assessment (Skin) tab, Skin Pr Ul 1 window

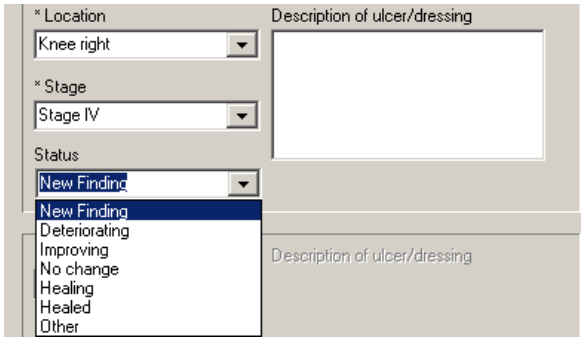
Pressure Ulcer Drop-downs



Skin Assessment - Pressure Ulcer/Location

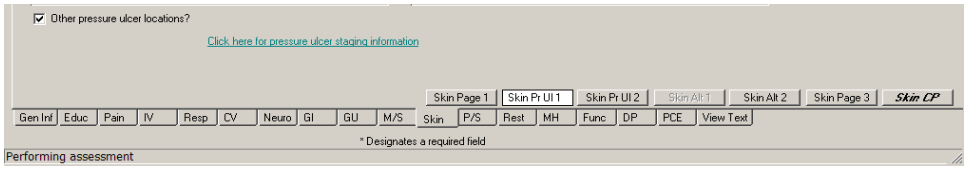


Skin Assessment - Pressure Ulcer/Stage

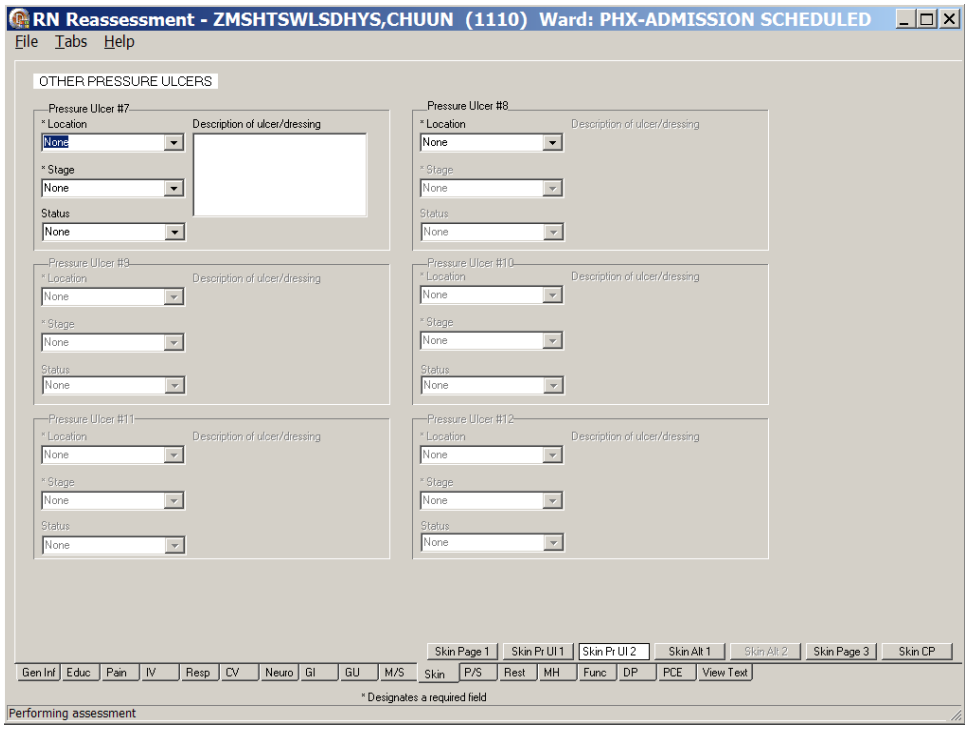


Skin Assessment - Pressure Ulcer/Status

3. To enter more than six pressure ulcer locations, select the **Other pressure ulcer locations?** check box.
   Skin Pr Ul 2 displays.



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

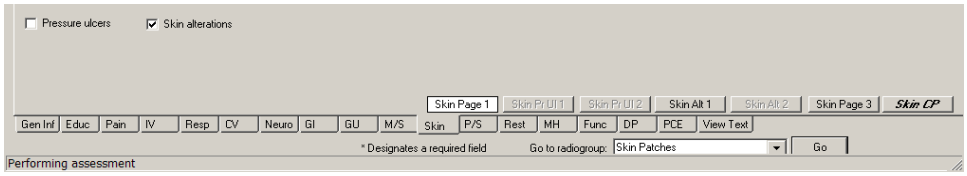


RN Reassessment, Skin Assessment (Skin) tab, Skin Pr Ul 2 window

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

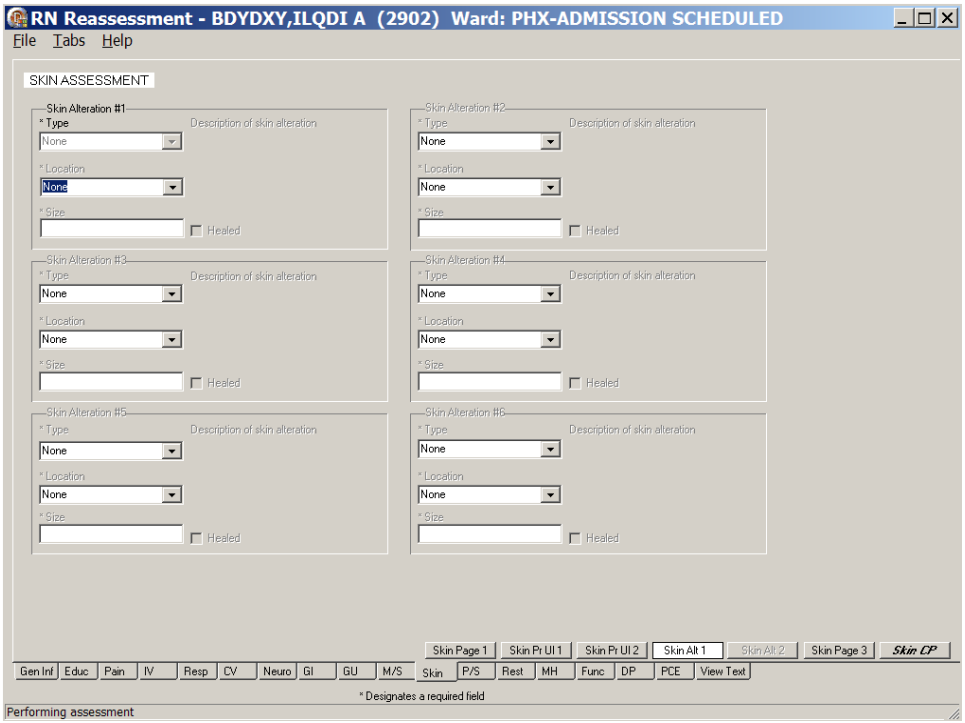
Documenting Skin Alterations

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



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

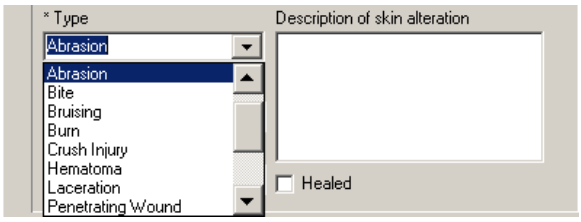
1. Click **Skin Alt 1**.
   Skin Alt 1 displays.



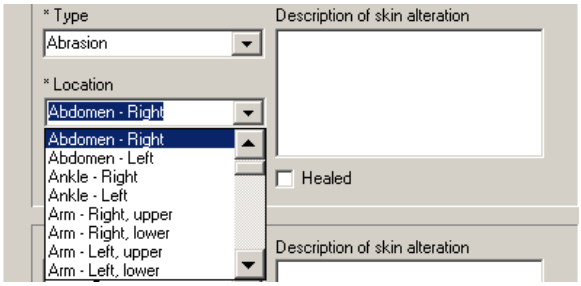
RN Reassessment, Skin Assessment (Skin) tab, Skin Alt 1 window
Skin Alterations #1-#6

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

Skin Alteration Drop-downs



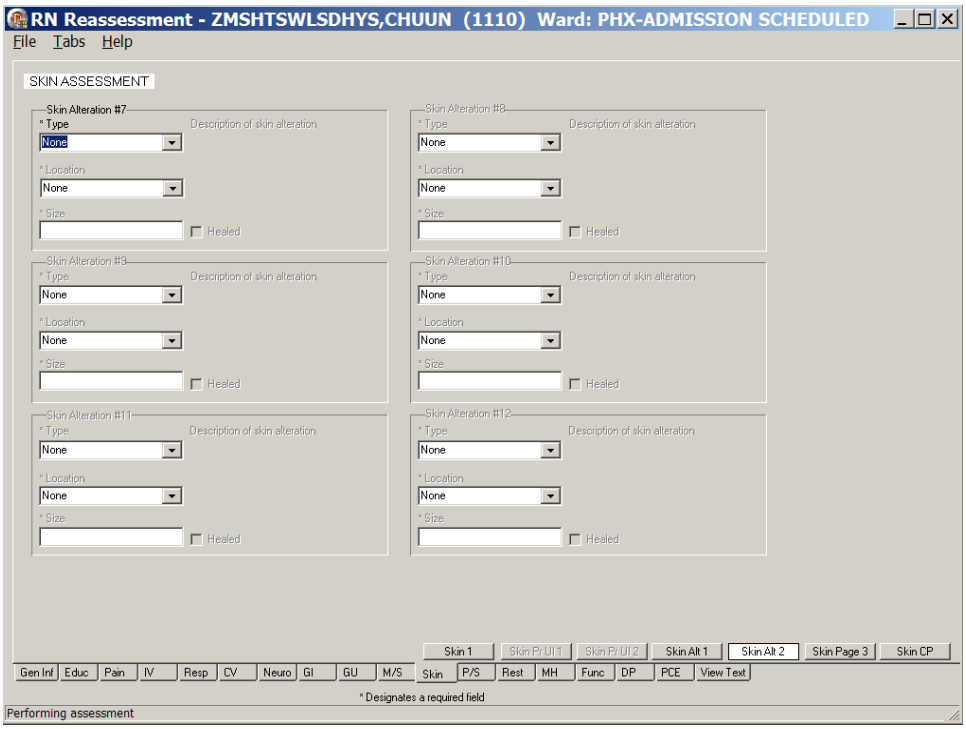
Skin Assessment – Skin Alteration/Type



Skin Assessment – Skin Alteration/Location

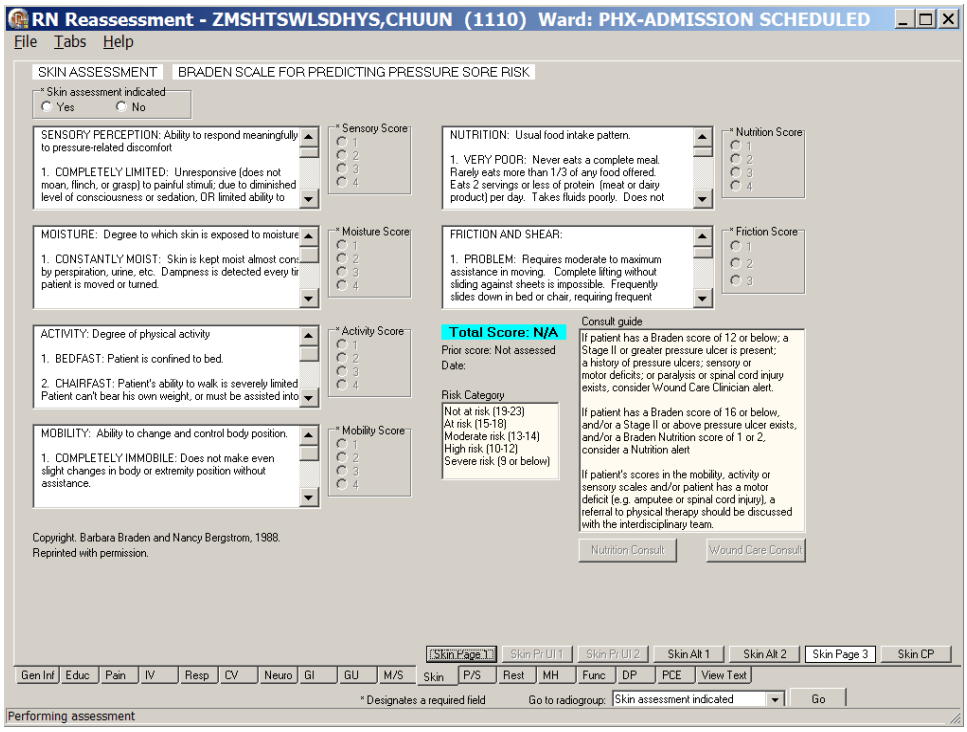
Skin Assessment – Skin Alteration/Size

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



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

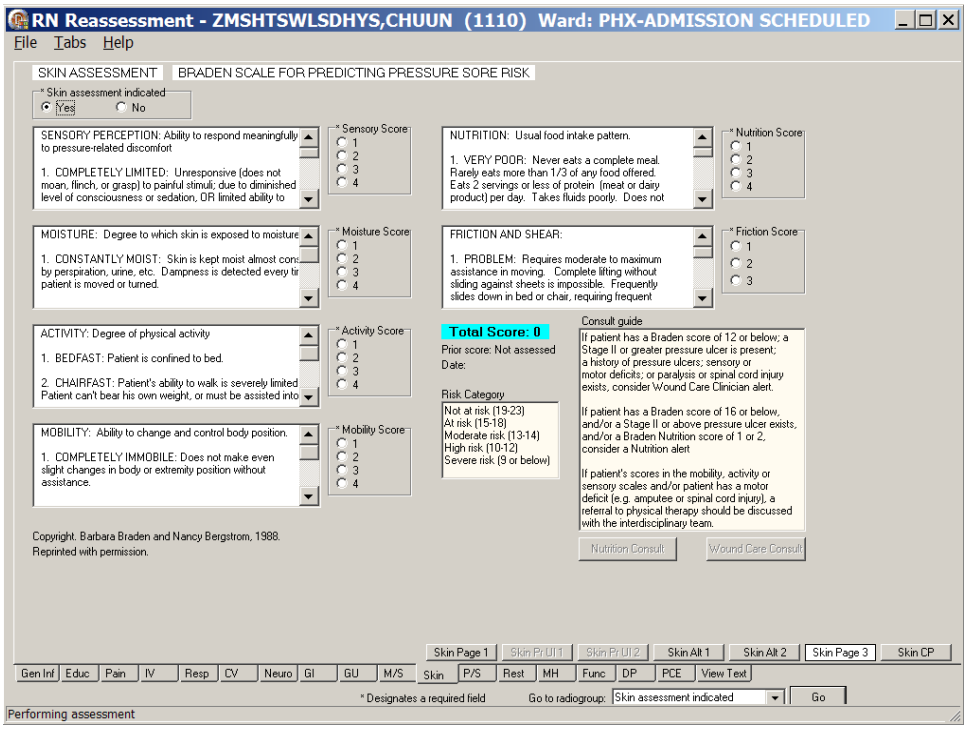
4. Populate Skin Alt 2.
   a. Enter **Type**, **Location**, and **Size** for six (#7-#12) additional skin alterations. The fields with asterisks are required fields.
   b. Enter a **Description of skin alteration**, if appropriate.
5. Click **Skin Page 3**.
   Skin Page 3 displays.



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

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

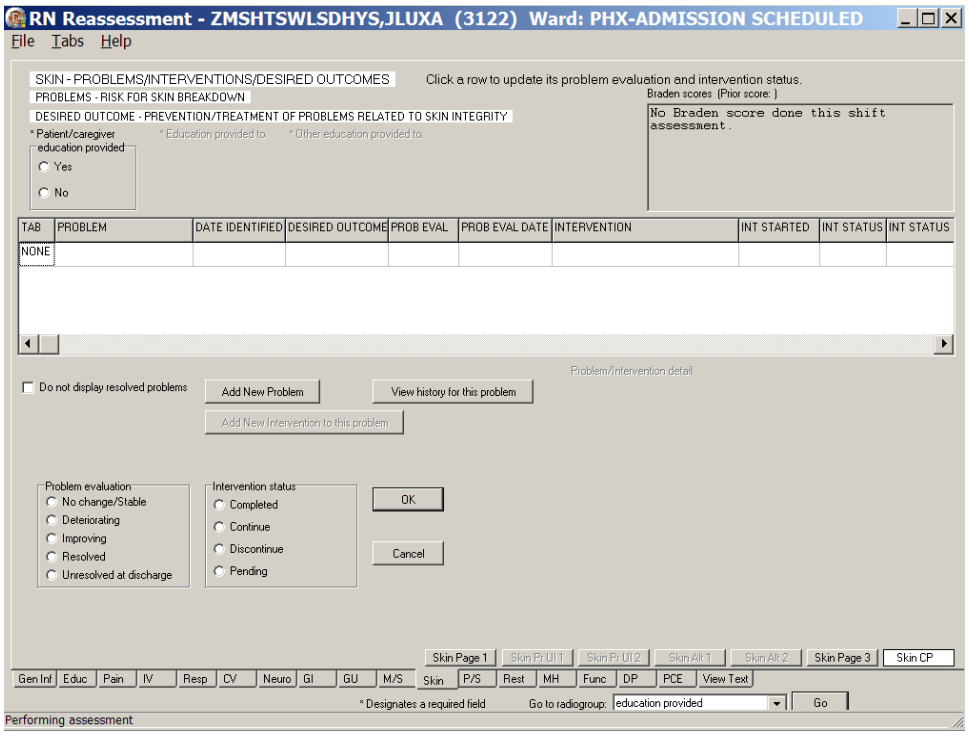
6. Populate Skin Page 3.
   a. Select **Yes** to **Skin assessment indicated**, to complete the *Braden Scale for Predicting Pressure Sore Risk*.
      Complete all the fields with asterisks; they are required fields.
   b. Select **No** to **Skin assessment indicated**, to bypass the *Braden Scale for Predicting Pressure Sore Risk*.



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

c. **Optional:** Order a Nutrition Consult and/or Wound Care Consult from Skin Page 3, if necessary. Refer to the instructions in *Working in the Consults* on page 25.

7. Click **Skin CP.**
   Skin CP displays.



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

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

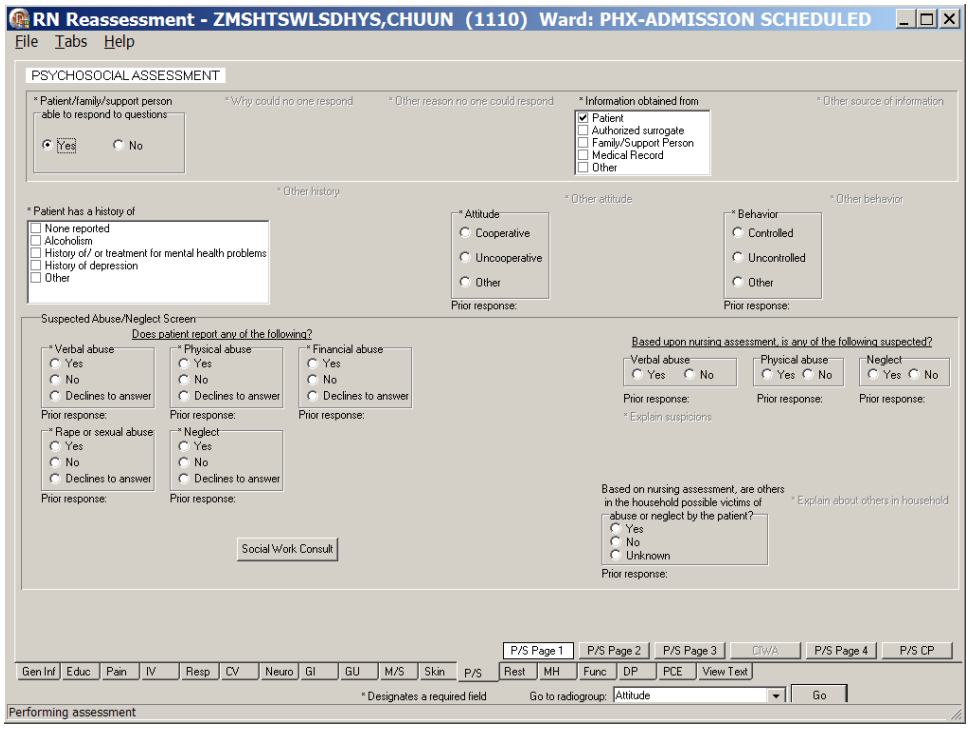
Psychosocial (P/S)

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

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

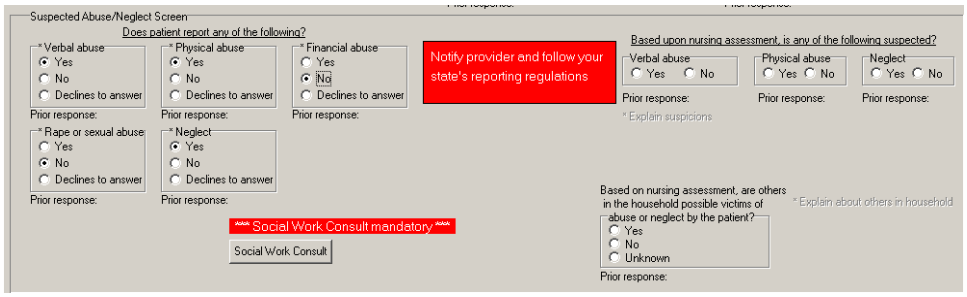
- The **CIWA Score** for the patient is calculated automatically as you select a response level for nausea/vomiting, tremor, paroxysmal sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache, and orientation/clouding of sensorium.
- The CIWA Score is pulled forward to the P/S CP page to guide the entry of interventions.

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



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

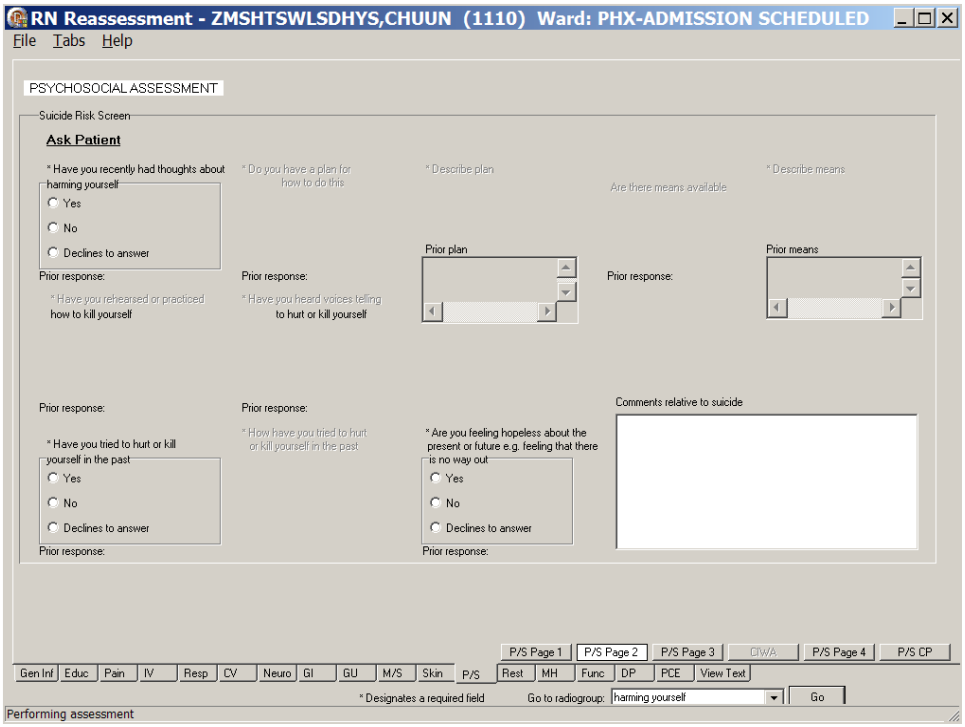
2. Populate P/S Page 1.
   a. There are no required fields on P/S Page 1.
   b. If the patient answers **Yes** to any of the abuse questions, a Social Work Consult is required. Refer to the instructions in *Working in the Consults* on page 25.



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

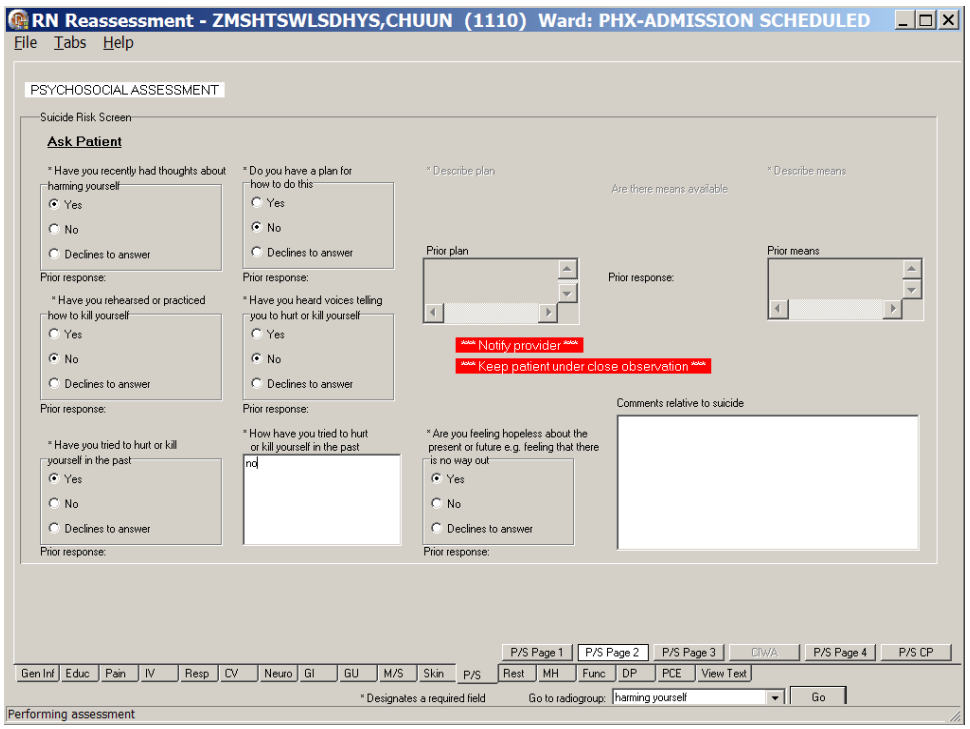
Note: For emphasis, the notify provider, send consult, and follow your state's reporting regulations are highlighted in **red**.

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



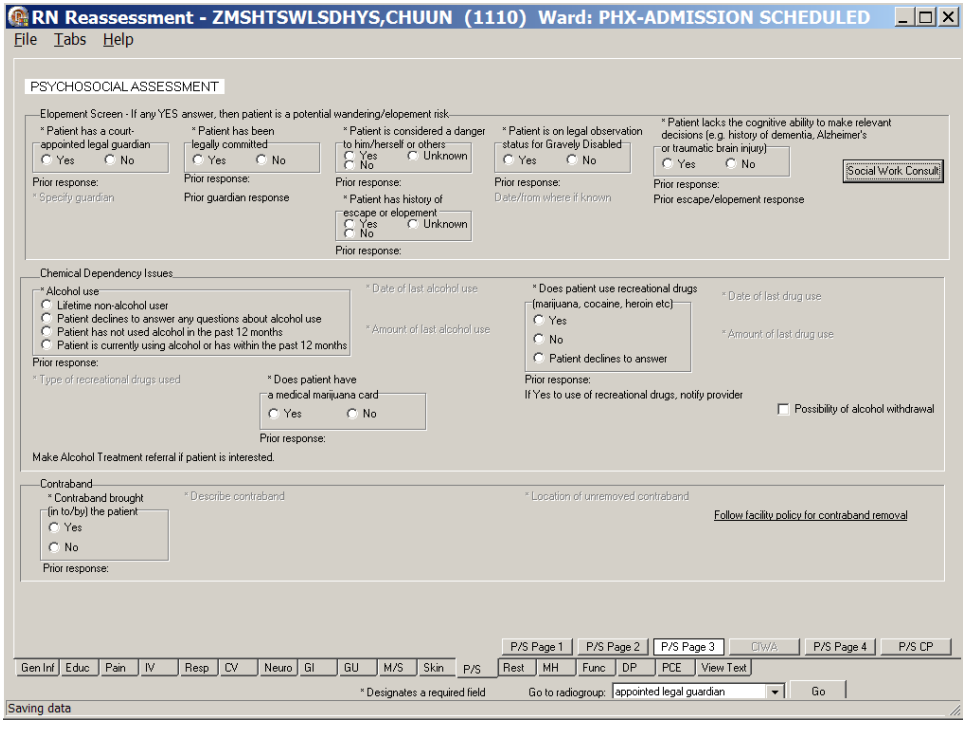
RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 2 window

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



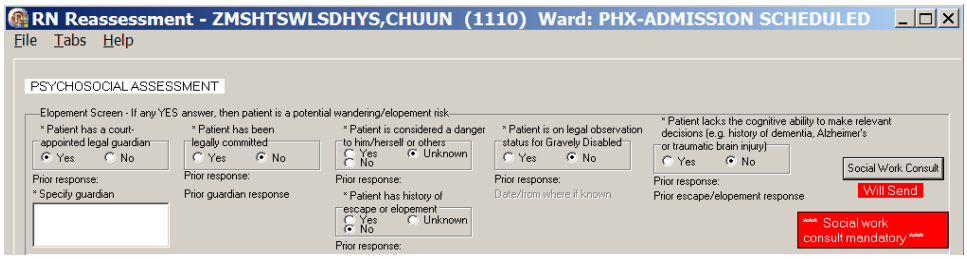
RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 2 window

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



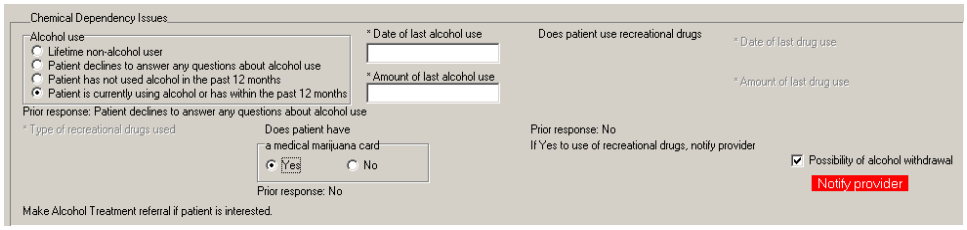
RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 3 window

6. Populate P/S Page 3.
   a. The questions are all optional; update, if necessary.
   b. If a patient answers **Yes** to any of the Elopement Screen questions, a Social Work Consult is required.
      Refer to the instructions in *Working in the Consults* on page 25.



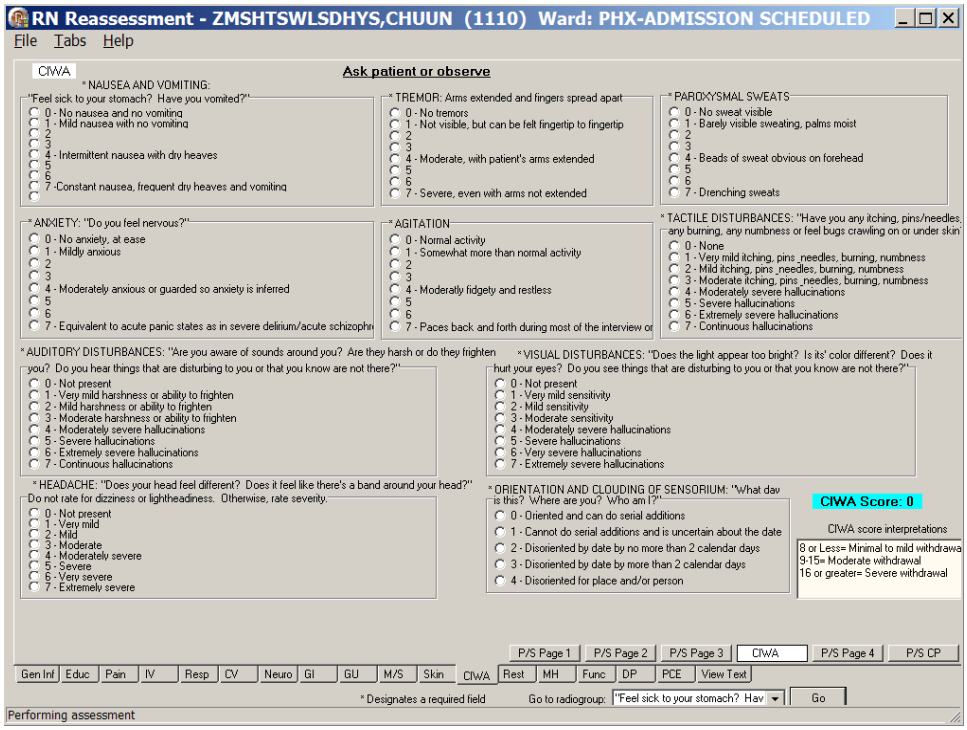
RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 3 window, Social work consult mandatory

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



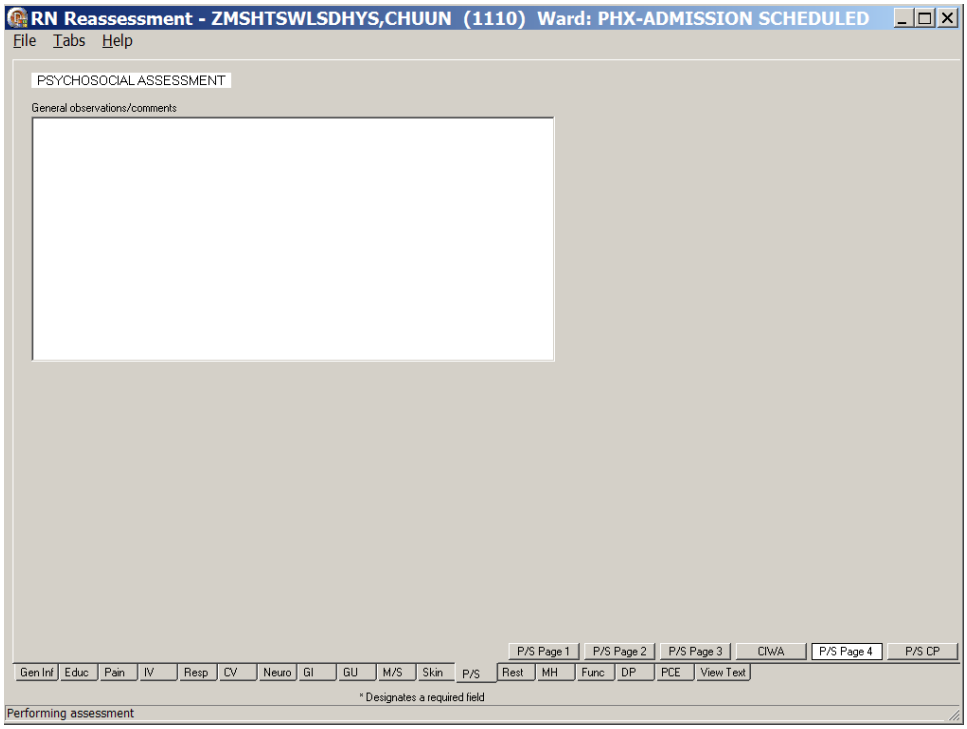
Alcohol use section

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



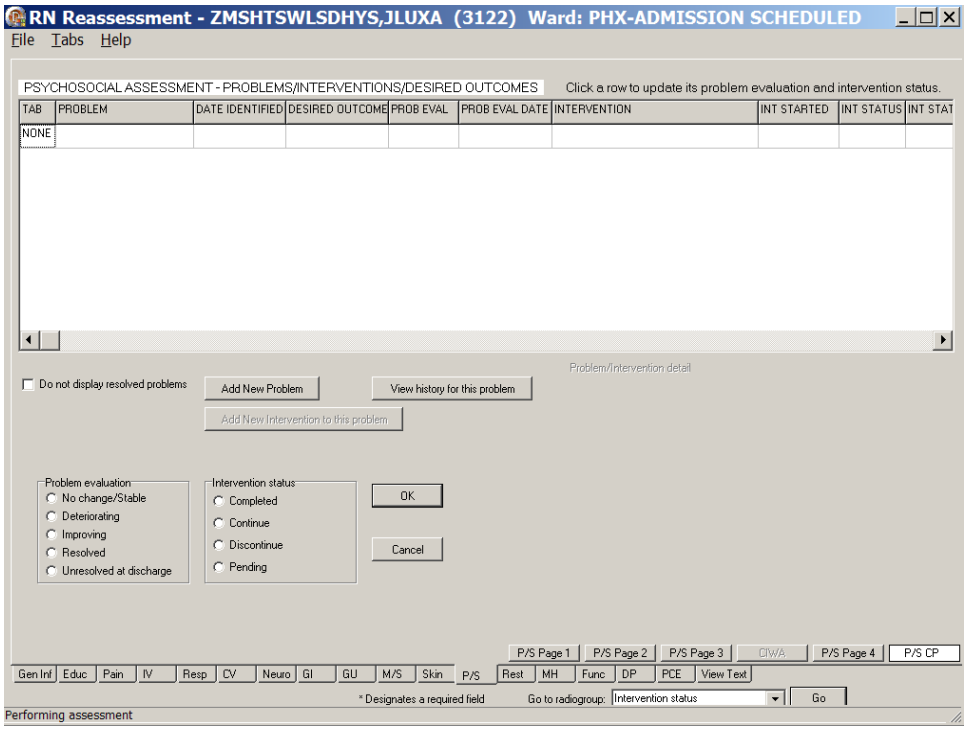
RN Reassessment, Psychosocial Assessment (P/S) tab, CIWA window

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



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

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



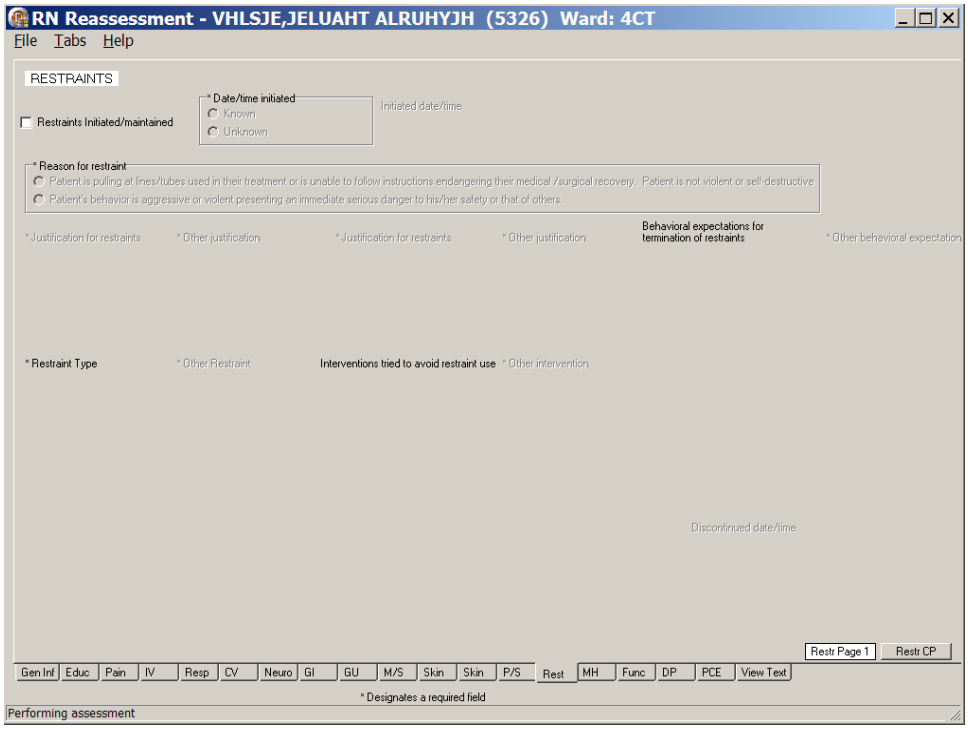
RN Reassessment, Psychosocial Assessment –Problems, Interventions, Desired Outcomes (P/S) tab, P/S CP window

11. Update P/S CP, if necessary.
    Refer to the instructions in *Working in a Care Plan* on page 12.

Restraints (Rest/Restr)

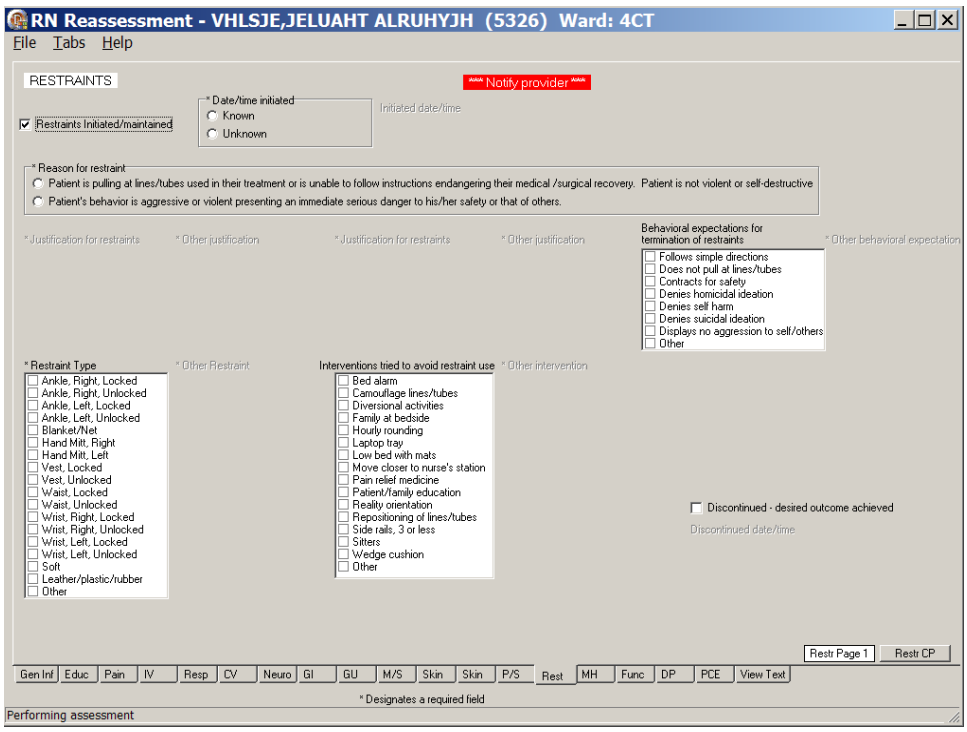
There are two categories of restraints.

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



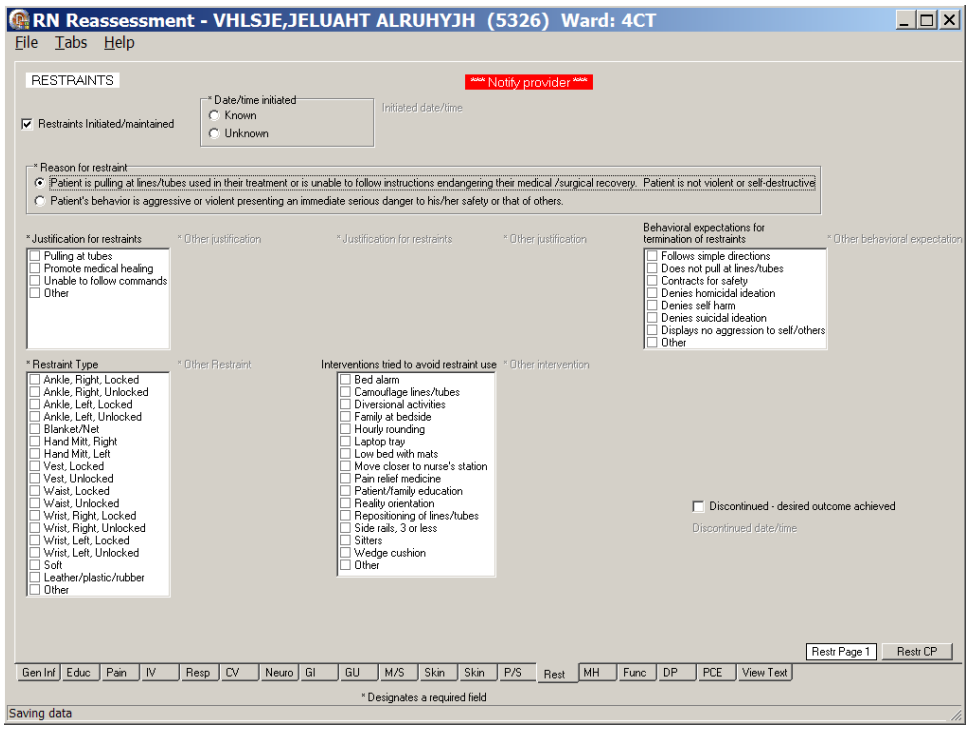
RN Reassessment, Restraints (Rest) tab, Restr Page 1 window

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



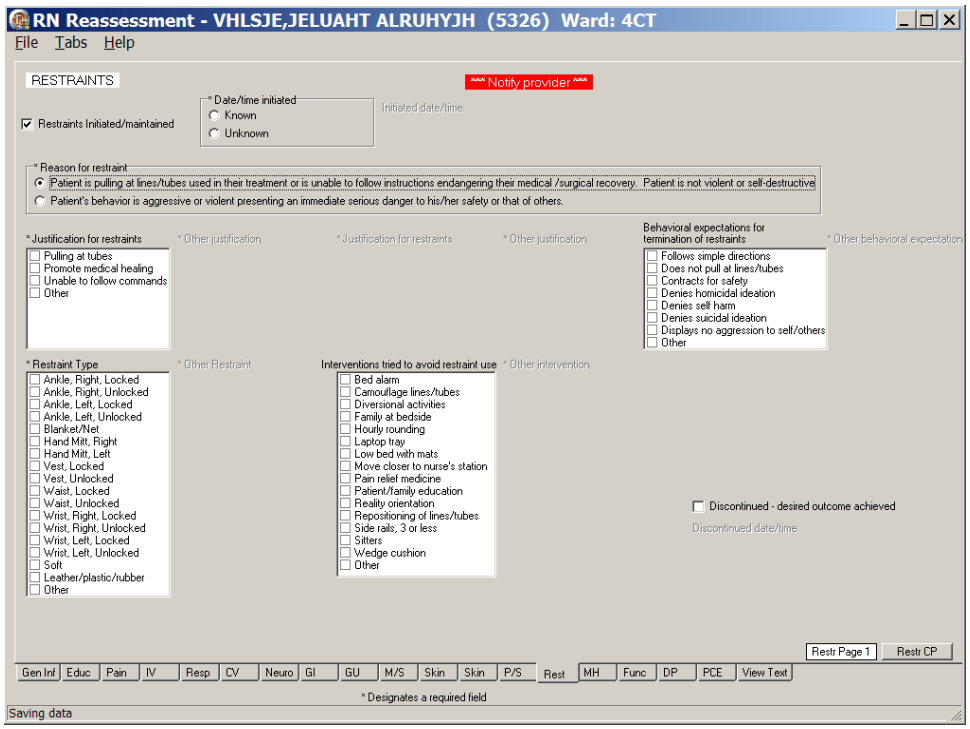
RN Reassessment, Restraints (Rest) tab, Restr Page 1 window with restraints initiated/maintained selected

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



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

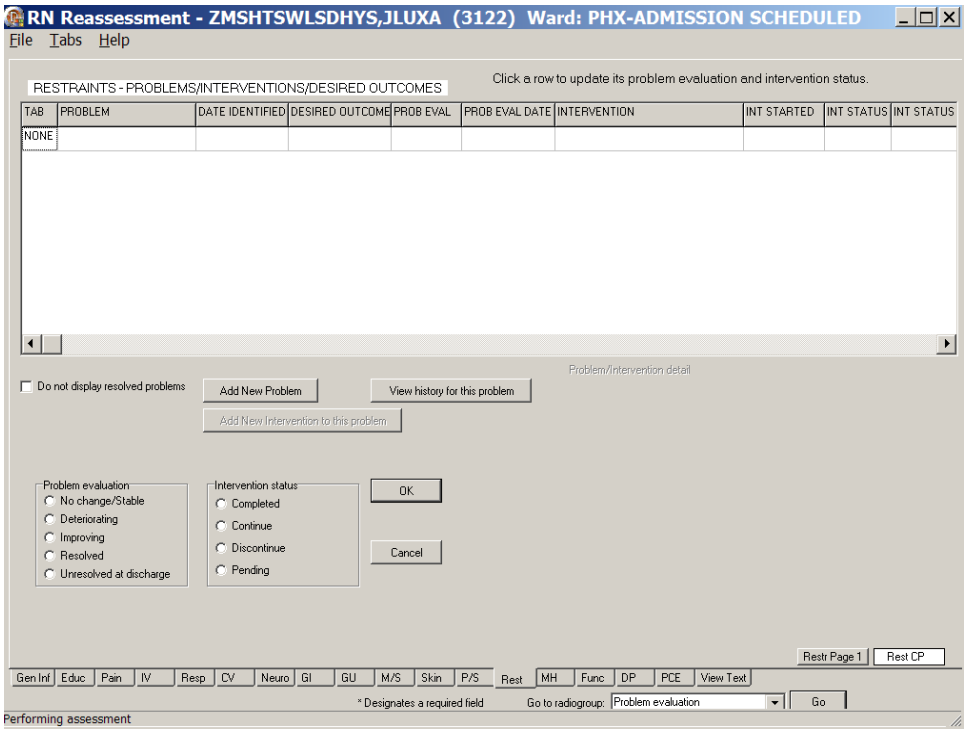
b. When you select, **Patient's behavior is aggressive or violent …**, the following window displays.



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

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

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

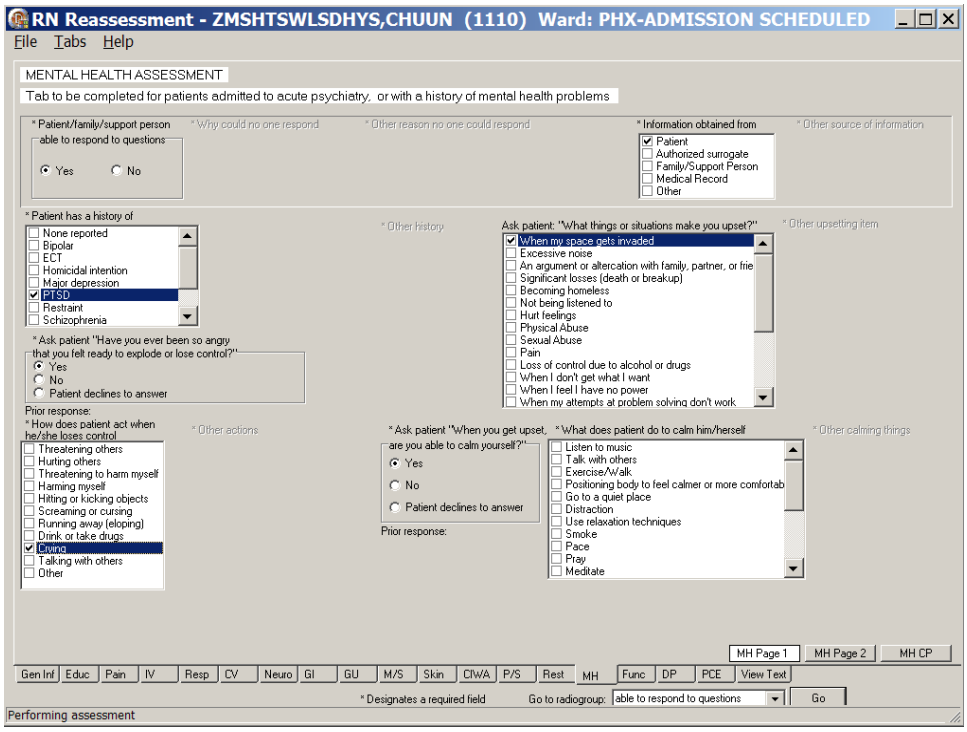


RN Reassessment, Restraints – Problems/Interventions/Desired Outcomes (Rest) tab, Restr CP window

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

Mental Health (MH)

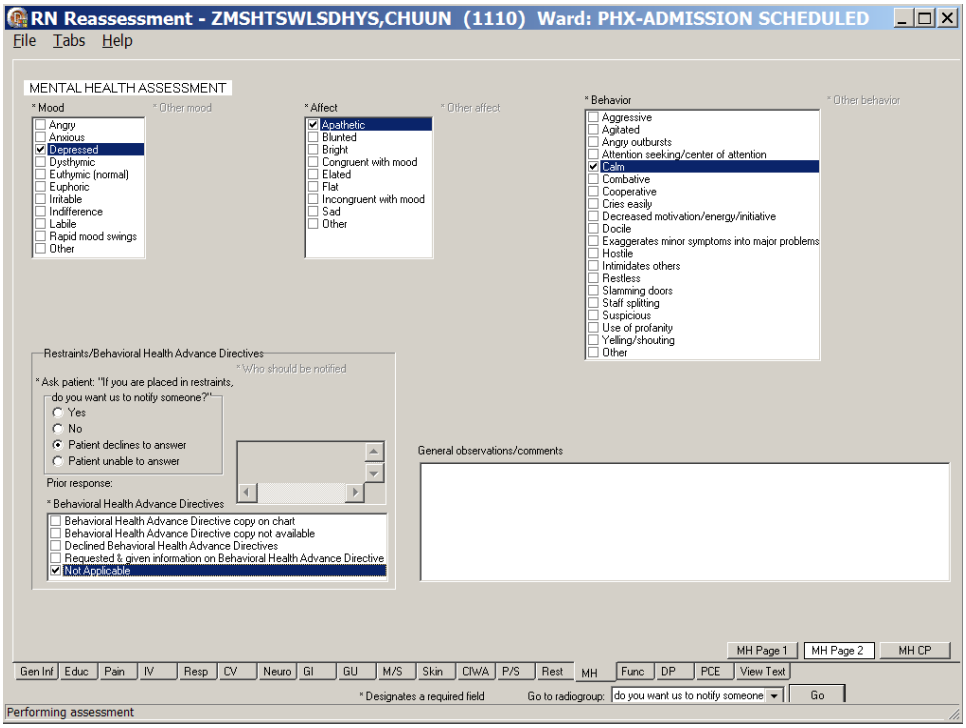
The Mental Health tab is completed for patients admitted to acute psychiatry, or when any patient reports a new mental health problem.



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

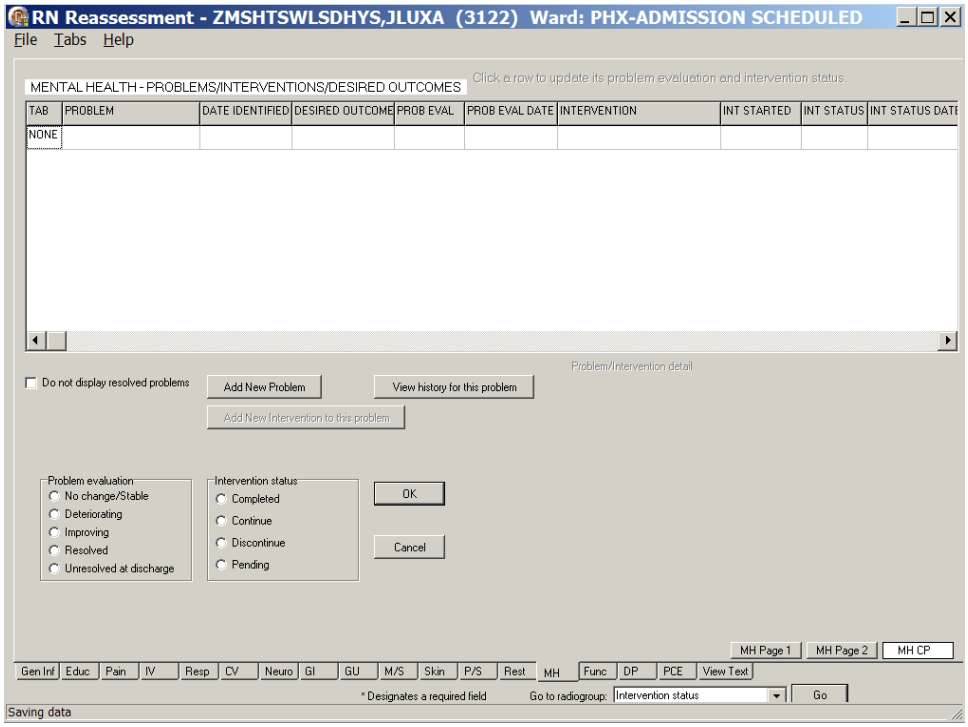
1. Click **MH**.
   MH Page 1 displays.
2. Populate MH Page 1.
   Complete all the fields with asterisks; they are required fields.

3. Click **MH Page 2**.
   MH Page 2 displays.



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

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



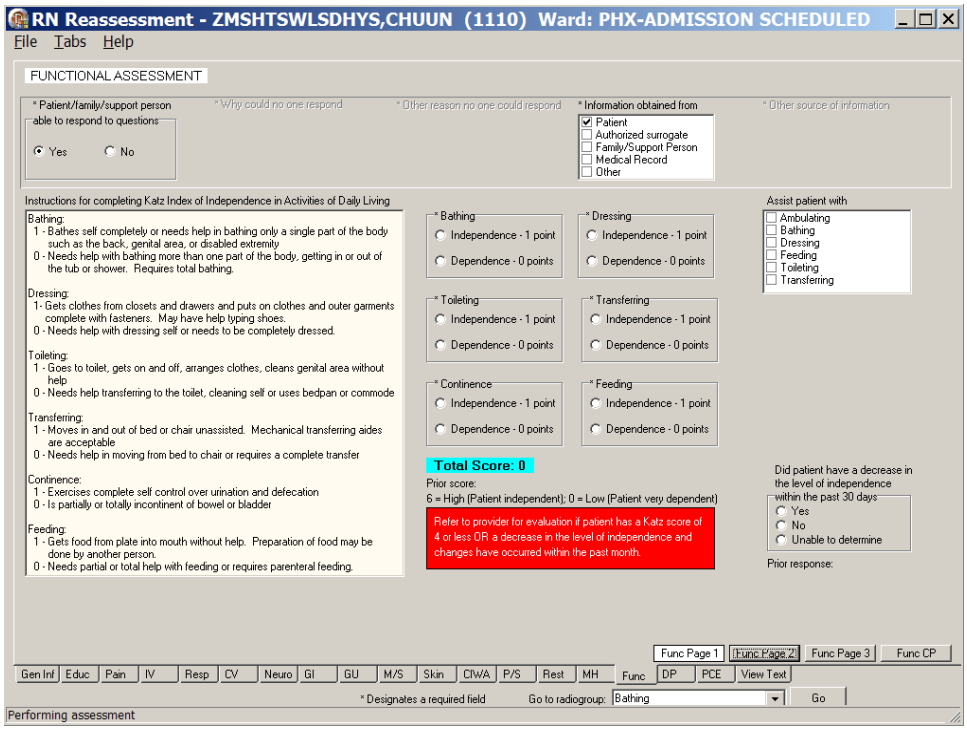
RN Reassessment, Mental Health Assessment (MH) tab, MH CP window

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

Functional (Func)

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

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

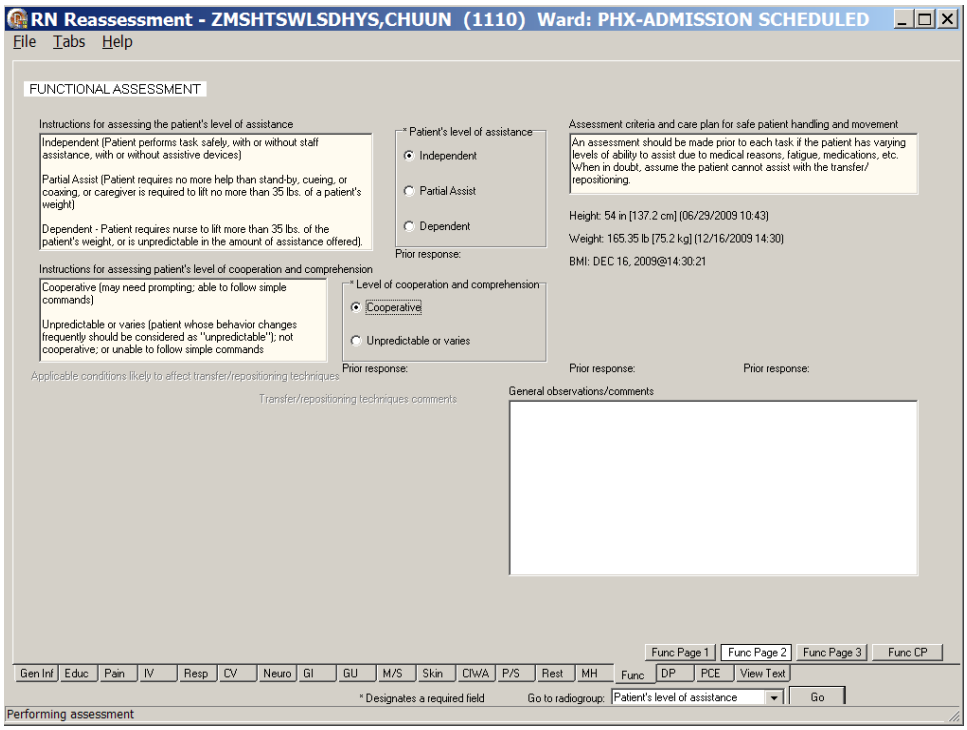


RN Reassessment, Functional Assessment (Func) tab, Func Page 1 window

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

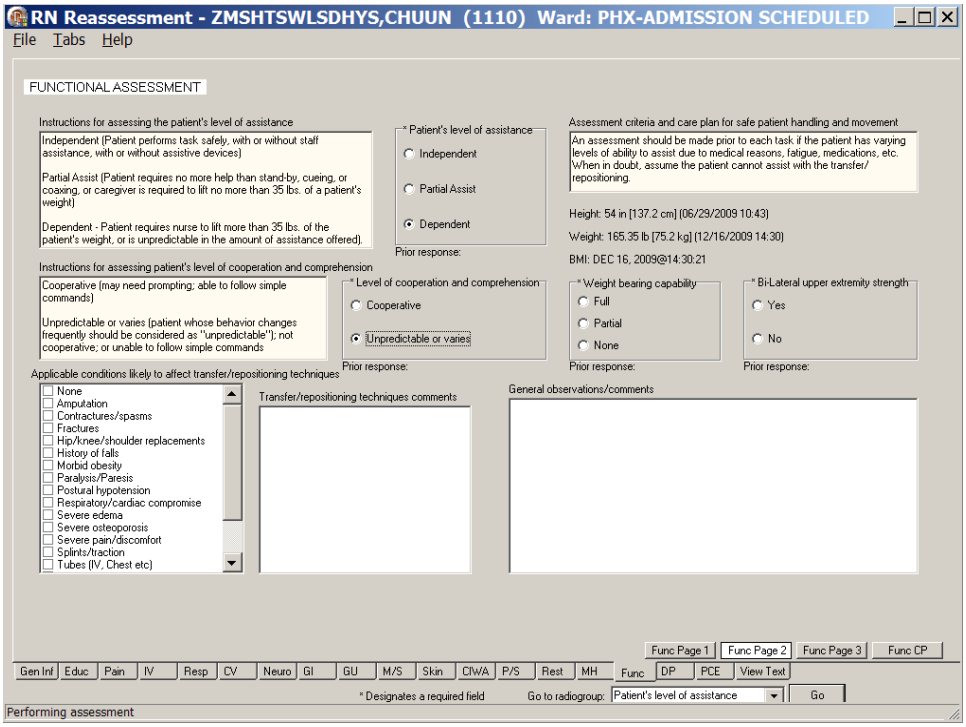
   Note: Refer to provider for evaluation, if patient has a Katz score of 4 or less, or a decrease in the level of independence and changes have occurred within the past month.

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



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

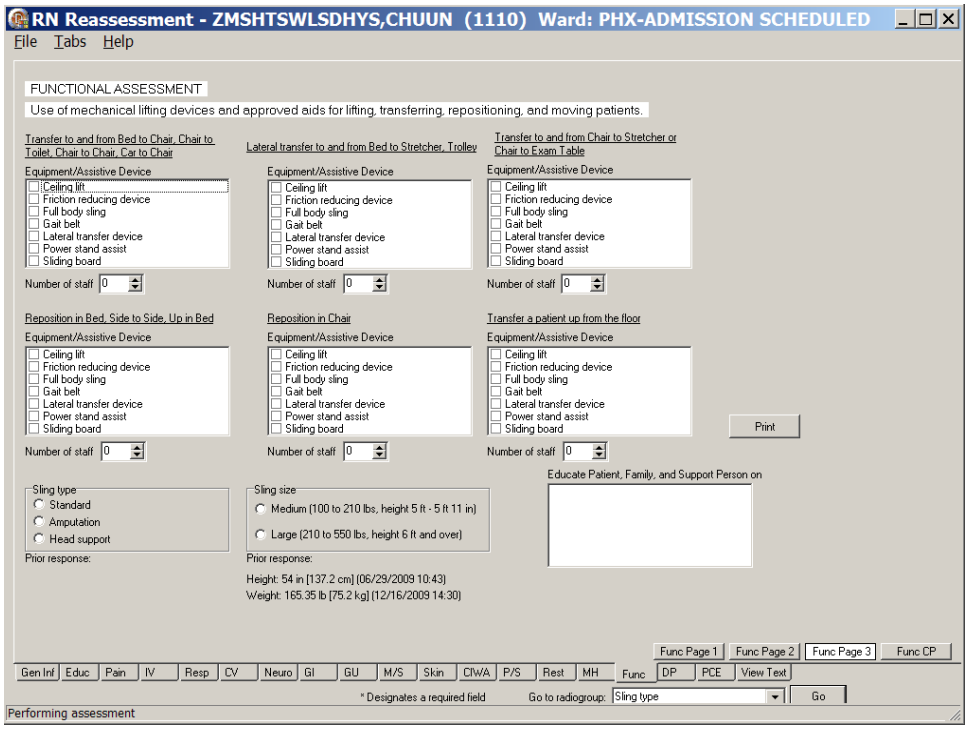
- If the patient is dependent and completely uncooperative, additional entries are necessary on Func Page 2.



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

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

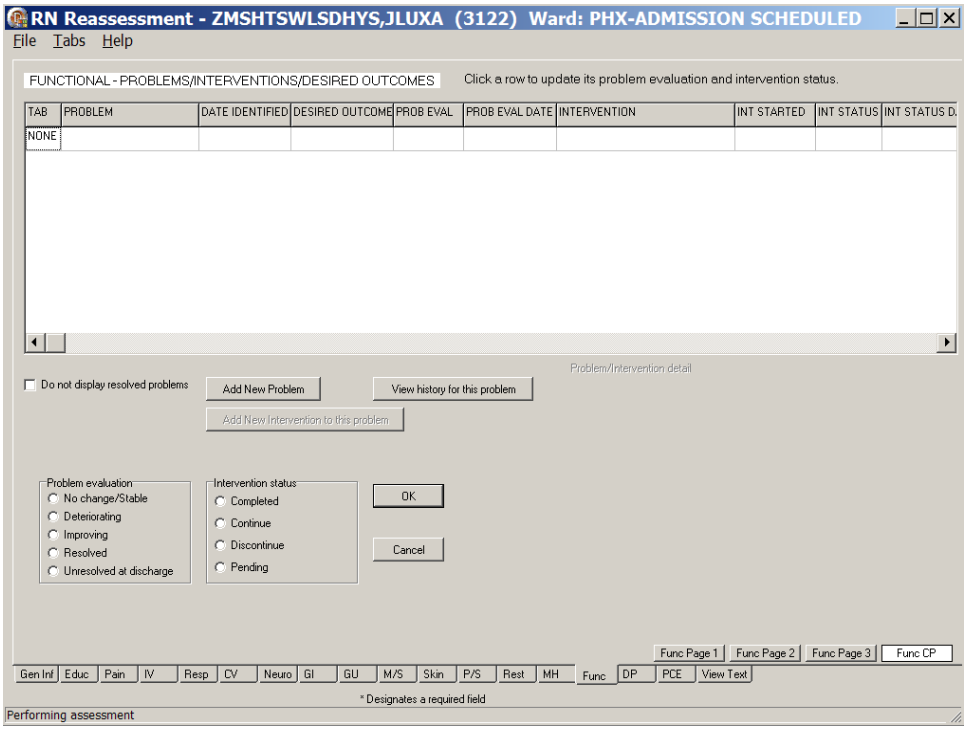
5. Click **Func Page 3**.
   Func Page 3 displays.



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

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

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

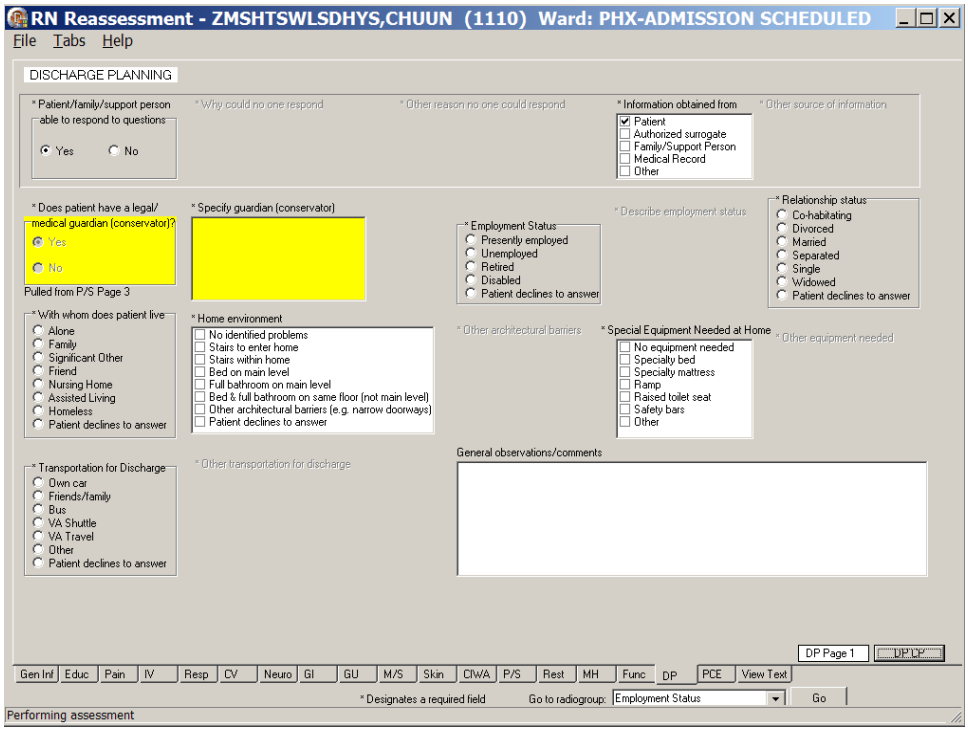


RN Reassessment, Functional – Problems/Interventions/Desired Outcomes (Func) tab, Func CP window

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

Discharge Planning (DP)

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

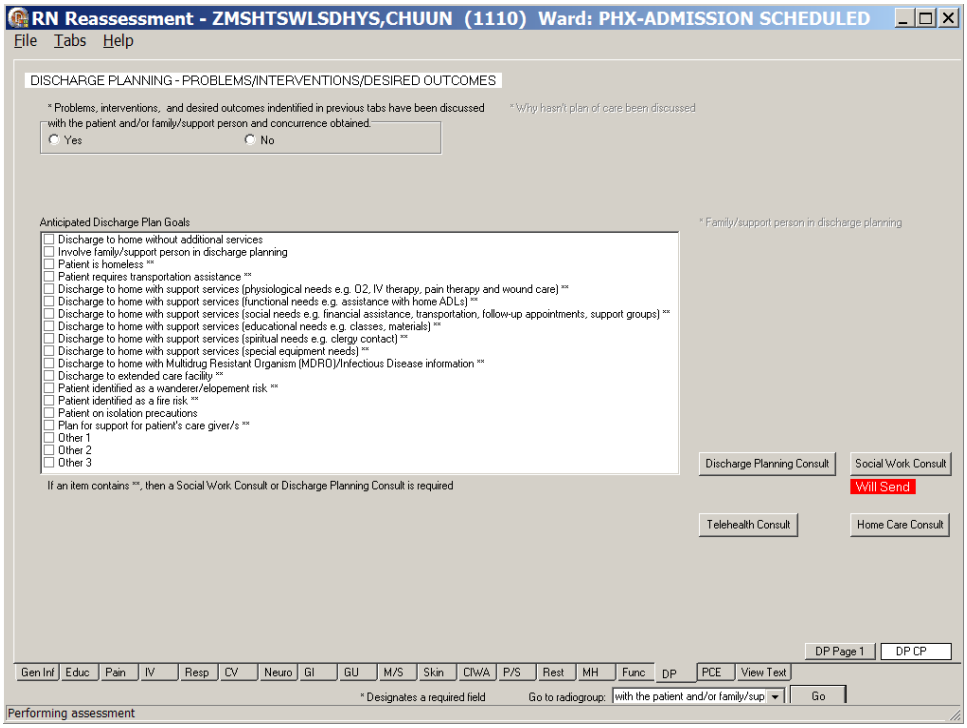


RN Reassessment, Discharge Planning (DP) tab, DP Page 1 window

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

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

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

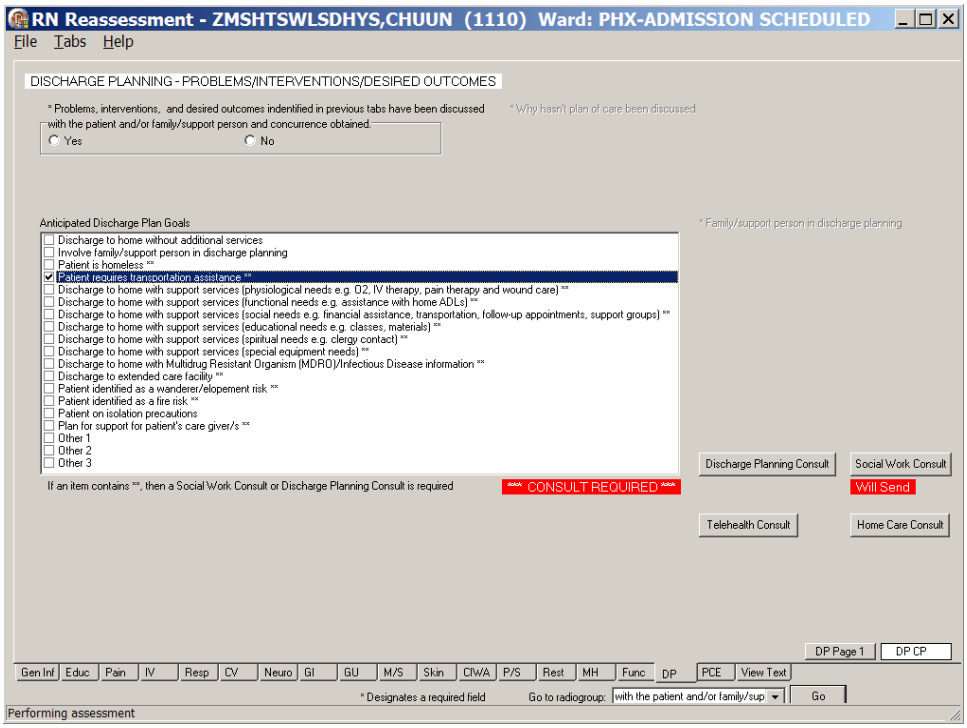


RN Reassessment, Discharge Planning – Problems/Interventions/Desired Outcomes (DP) tab, DP CP window

4. Populate DP CP.
   a. Complete the fields as necessary.
      Refer to the instructions in *Working in a Care Plan* on page 12.
   b. Complete a Social Work Consult or Discharge Planning Consult, if required.
      Refer to the instructions in *Working in the Consults* on page 25.

c. **Optional:** Complete a Telehealth Consult or a Home Care Consult, if set up by your medical center.

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



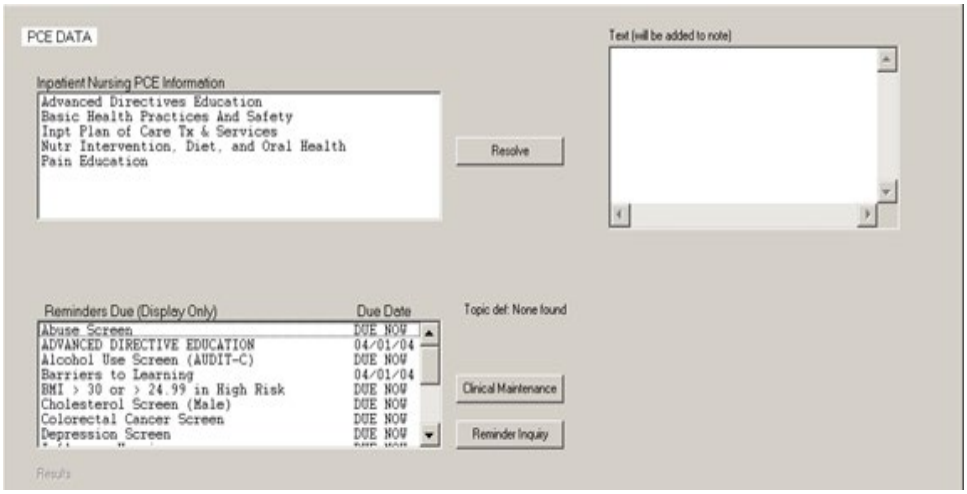
RN Reassessment, Discharge Planning – Problems/Interventions/Desired Outcomes (DP) tab, DP CP window, Consult Required

PCE Data (PCE)

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

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

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



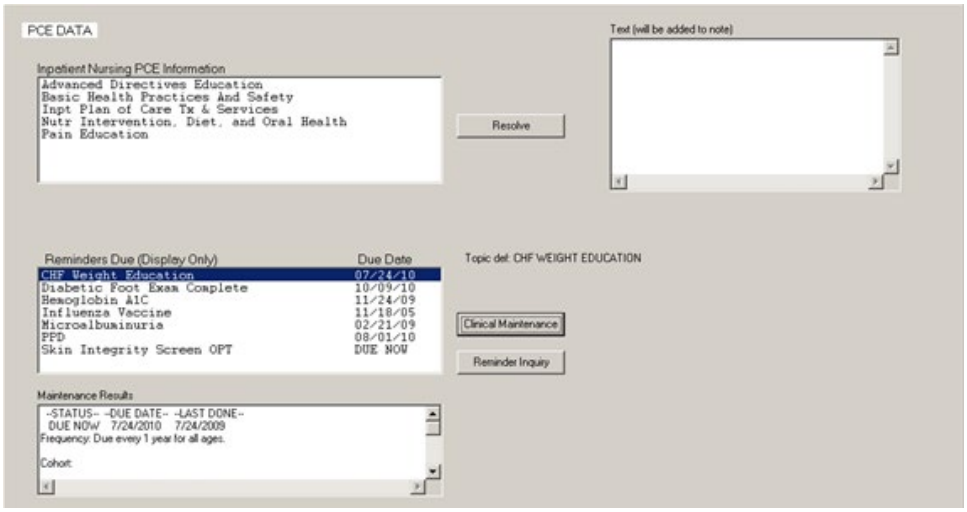
RN Reassessment, PCE Data (PCE) tab

Reminders Due (Display Only)

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

Clinical Maintenance

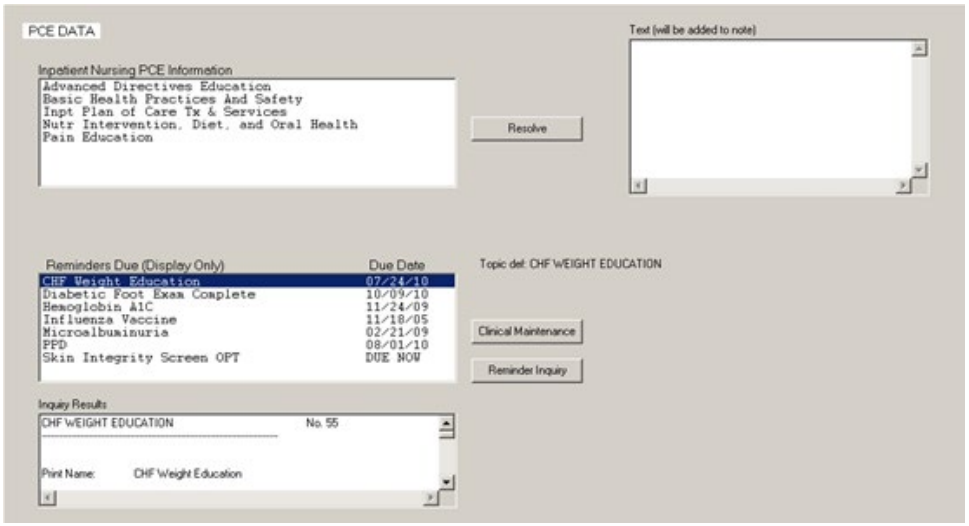
1. Select a clinical reminder in the **Reminders Due** list box.
2. Click **Clinical Maintenance**.
   Information displays in the **Maintenance Results** list box indicating when the reminder is due or was last done.



Clinical Maintenance

Reminder Inquiry

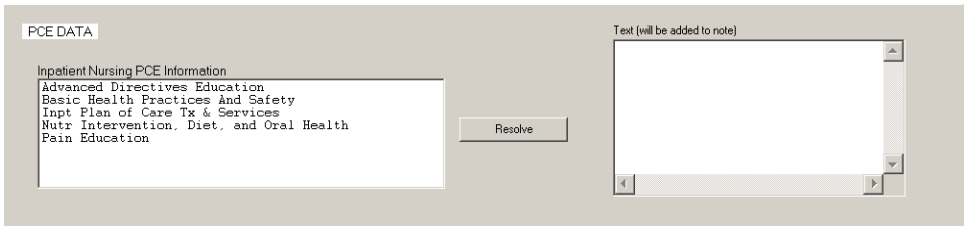
Click **Reminder Inquiry**.
Information displays in the **Inquiry Results** list box about the logic of the selected reminder.



Reminder Inquiry

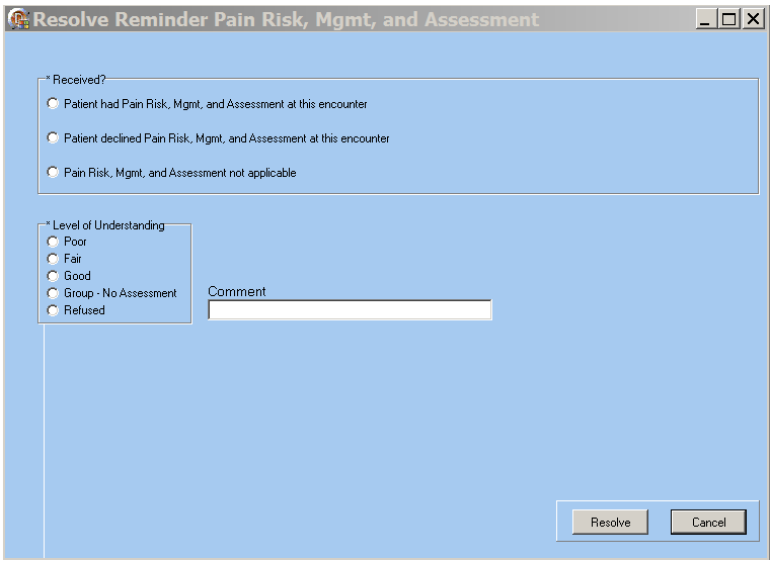
Resolve Inpatient Nursing Clinical Reminders

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



Resolve Inpatient Nursing Clinical Reminders

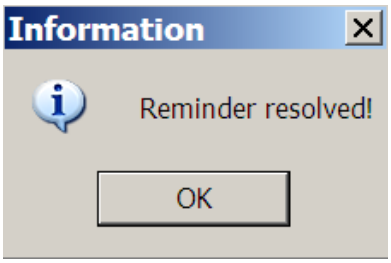
2. Click **Resolve**.
   The Resolve Reminder Pain Risk, Mgmt, and Assessment window displays with items appropriate for the selected item.



Resolve Reminder Pain Risk, Mgmt, and Assessment window

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

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



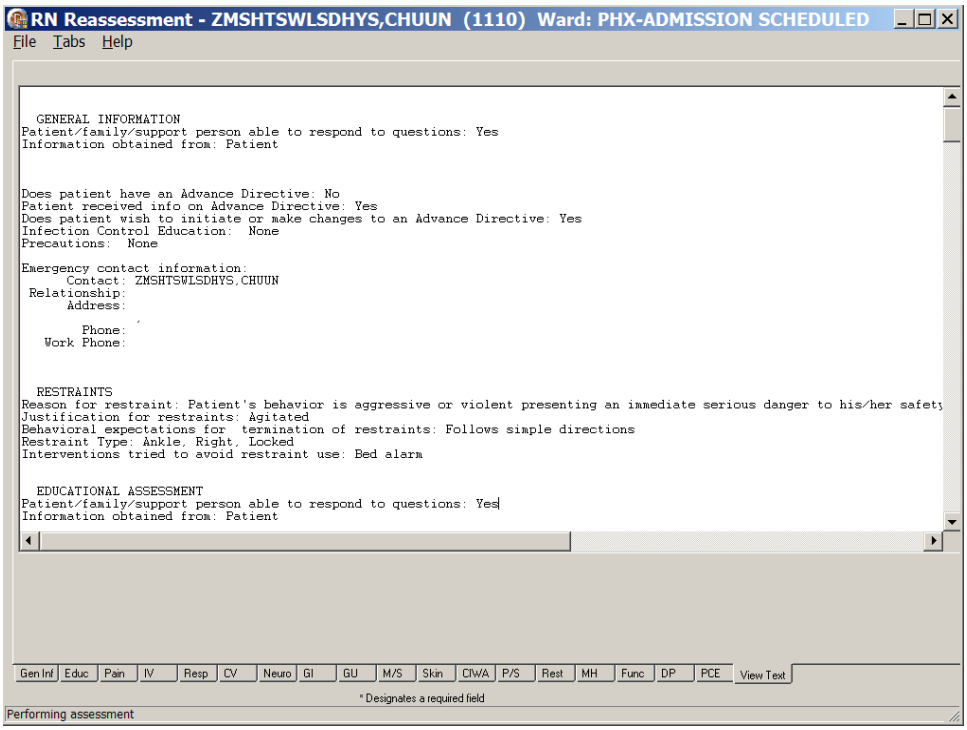
Information : Reminder resolved!

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

Text (will be added to note)

View Text (View Text)

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



RN Reassessment, View Text tab

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

Signing Note and Consults from within the Template

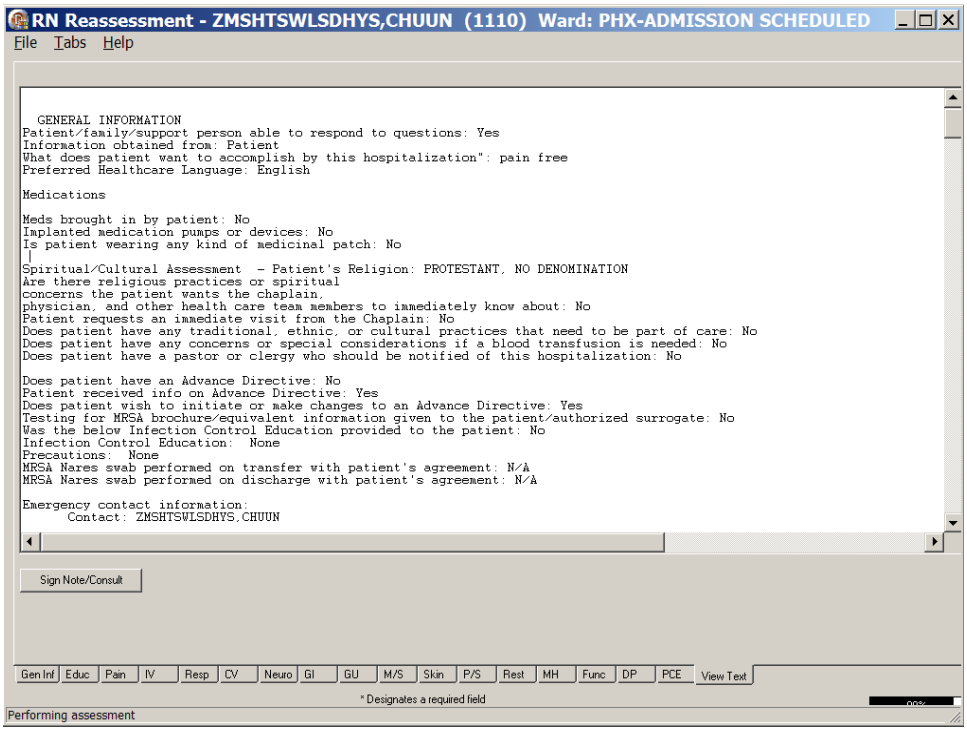
During the assessment, you may be prompted to enter mandatory consults that will be uploaded with the reassessment note.

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

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

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

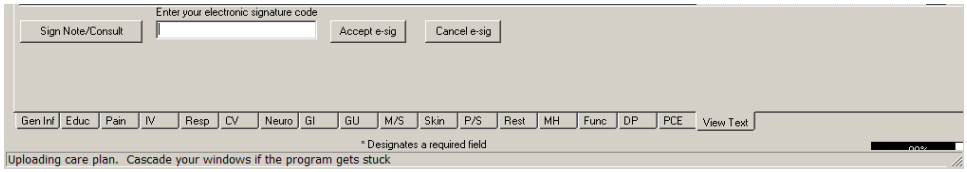
1. Click **View Text**.



RN Reassessments, View Text Tab after Upload

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

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



RN Reassessment, Sign Note/Consult Button

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

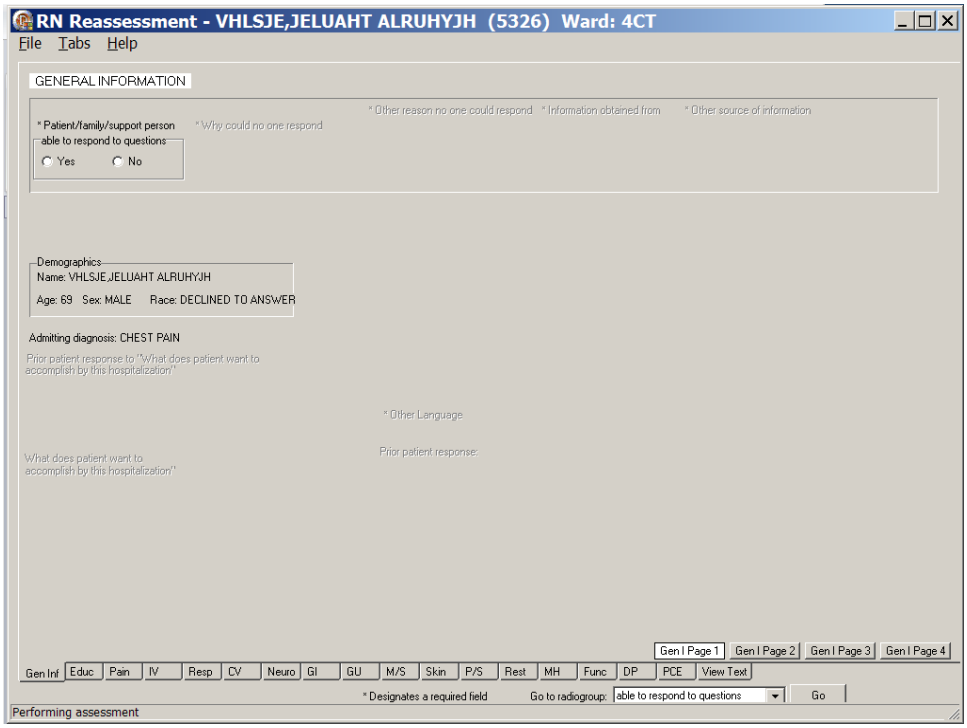
Note: It is safer to go to CPRS, read the note in CPRS, and sign the note in CPRS.

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

Unable to Complete the Assessment

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

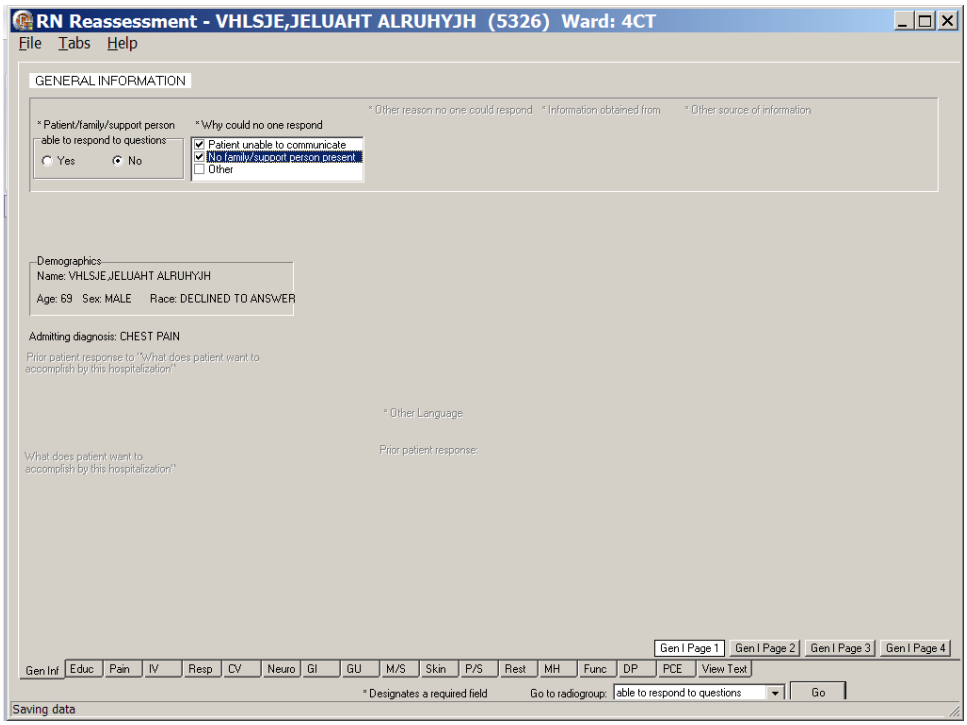
1. Open RN Reassessment.
   Gen Inf tab, Gen I Page 1 displays,
2. Select **Yes** or **No** for **Patient/family/support person able to respond to questions**.



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

Patient still cannot respond

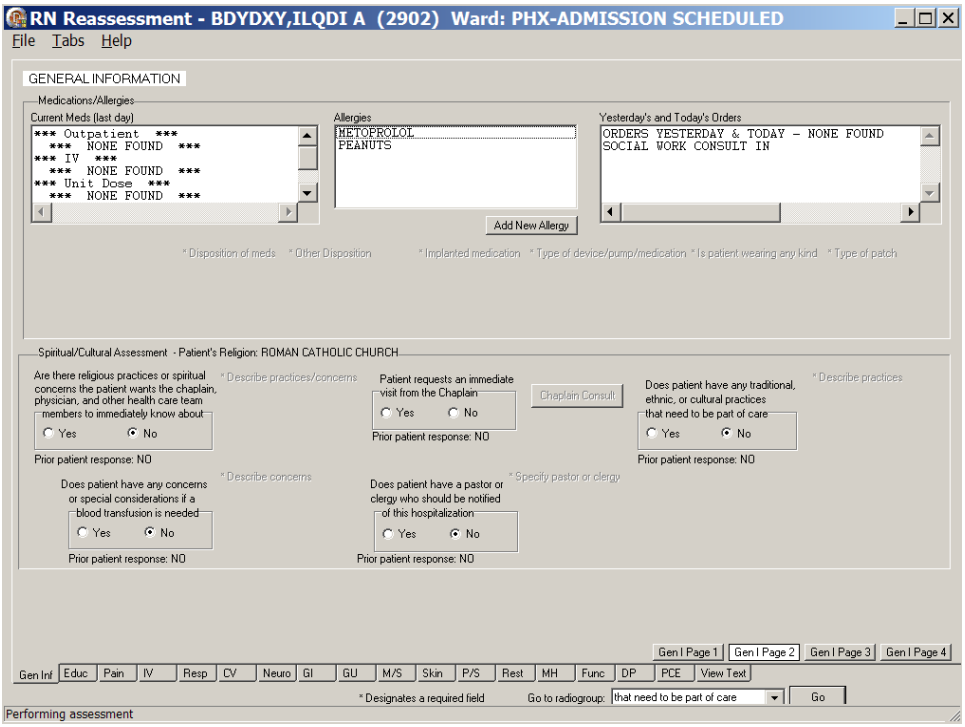
1. If the patient still cannot respond, select **No** and select a reason(s) ***Why could no one respond**.



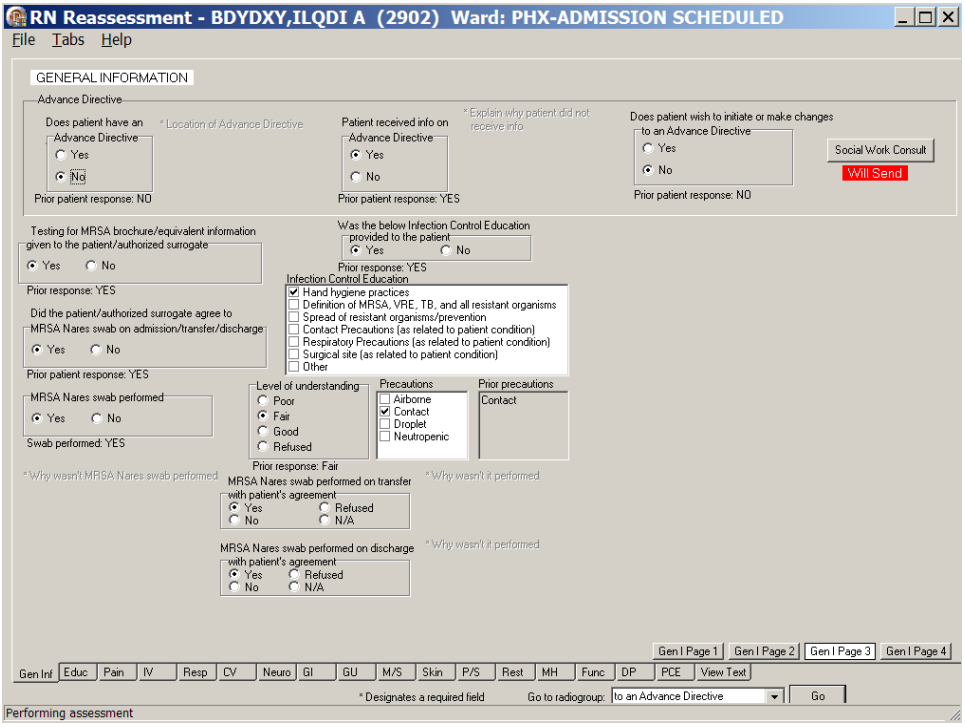
RN Reassessment, General Information (Gen Inf) tab, Gen I Page 1 window with *Why could no one respond

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

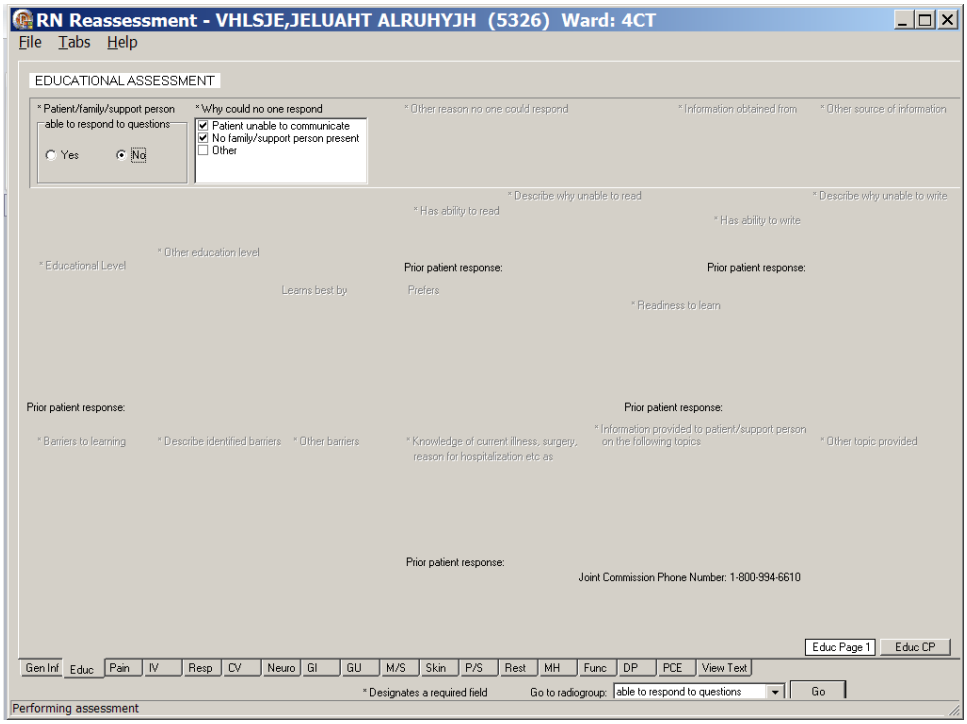
The following screen captures are examples of the tabs when **No** is selected for **Patient/family/support person able to respond to questions**.



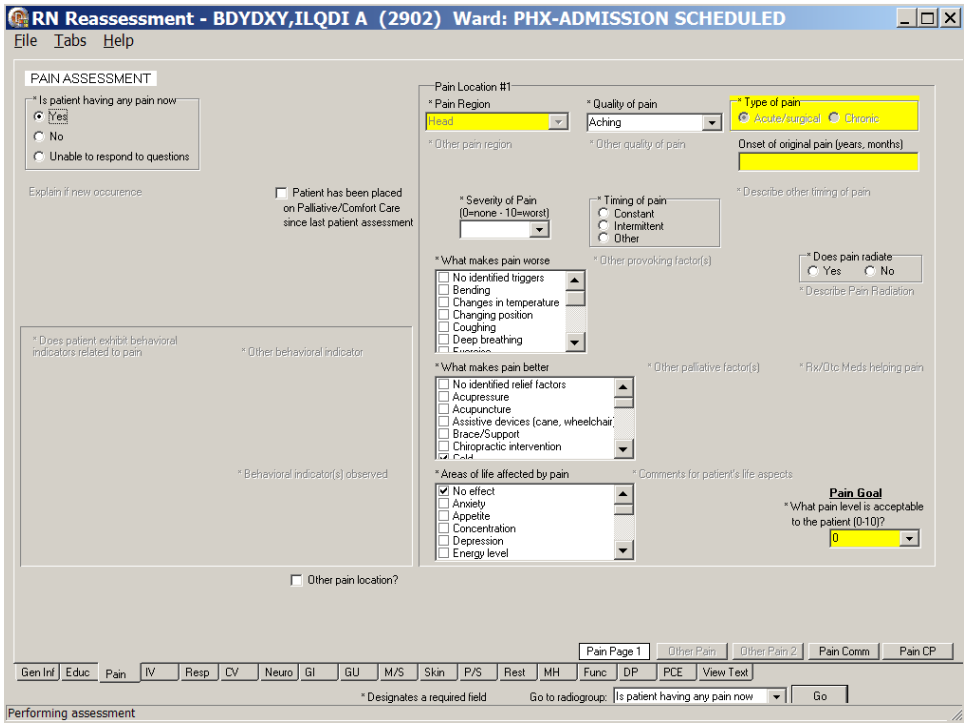
RN Reassessment, General Information (Gen Inf) tab, Gen I Page 2 window



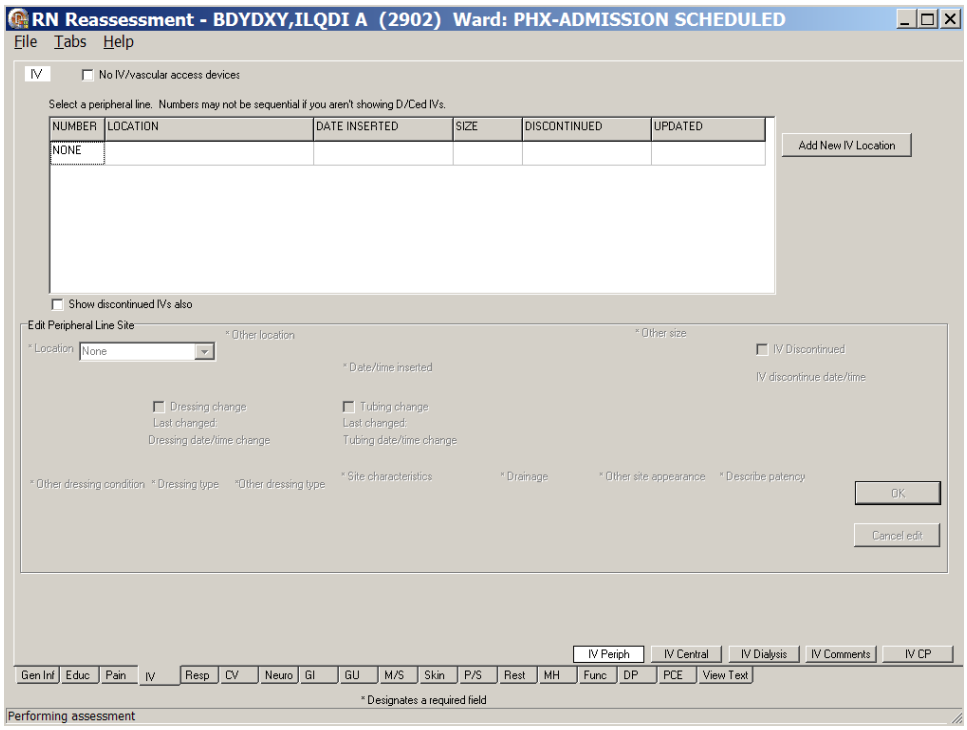
RN Reassessment, General Information (Gen Inf) tab, Gen I Page 3 window



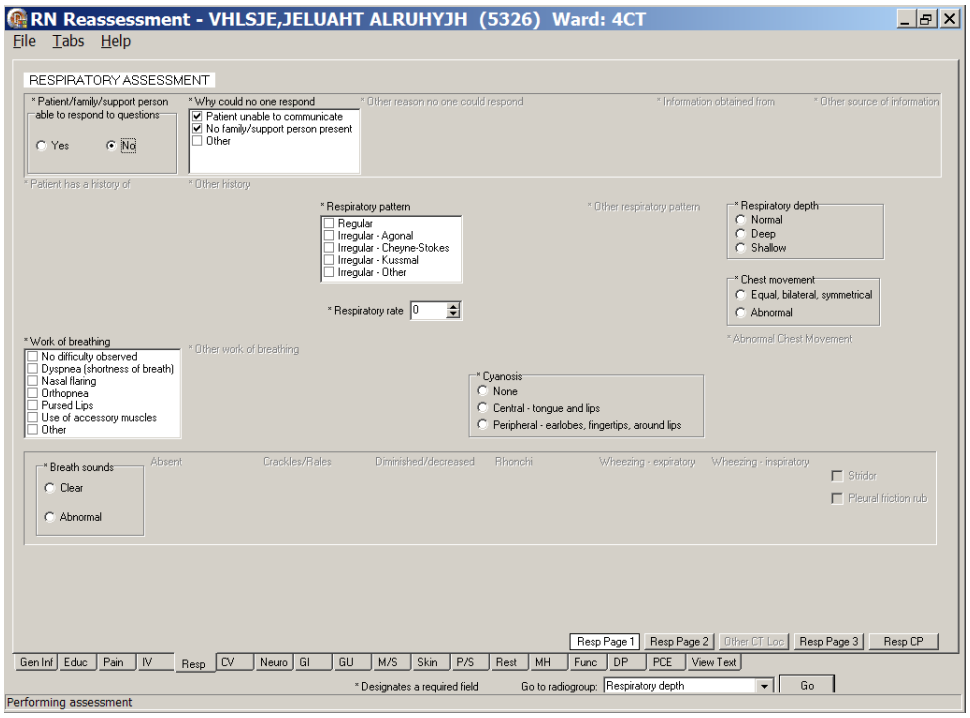
RN Reassessment, Educational Assessment (Educ) tab, Educ Page 1 window



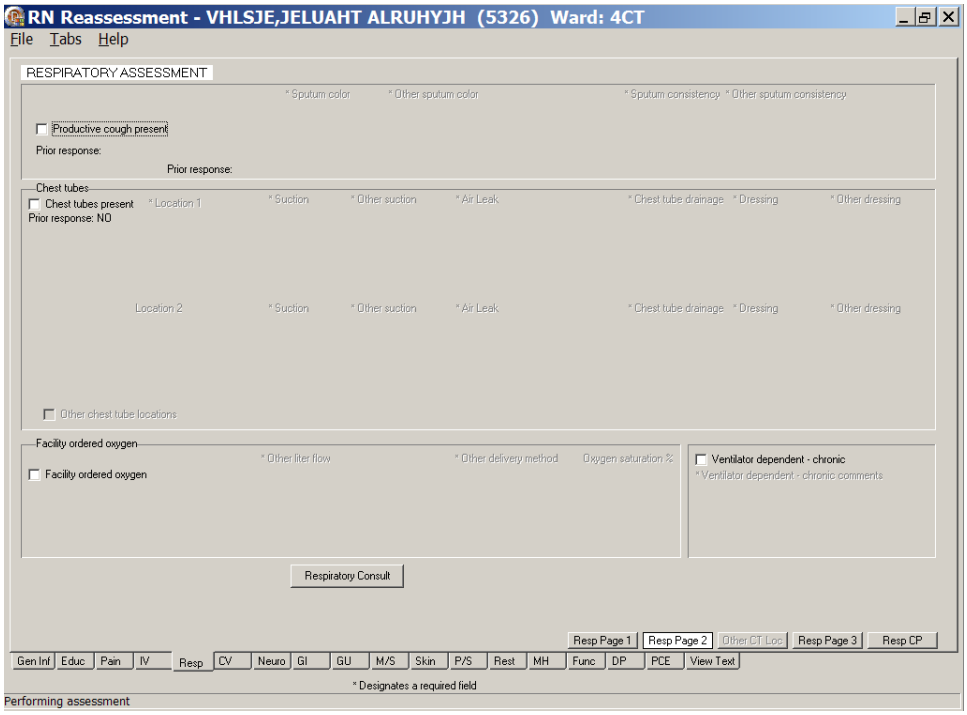
RN Reassessment, Pain Assessment (Pain) tab, Pain Page 1 window



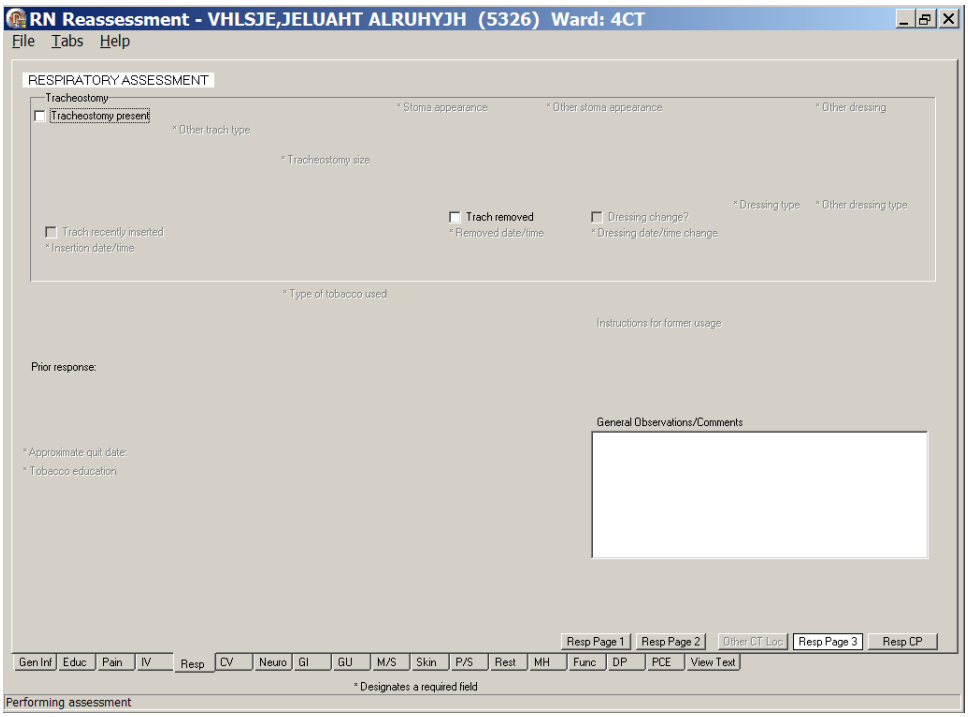
RN Reassessment, IV (IV) tab, IV Periph window



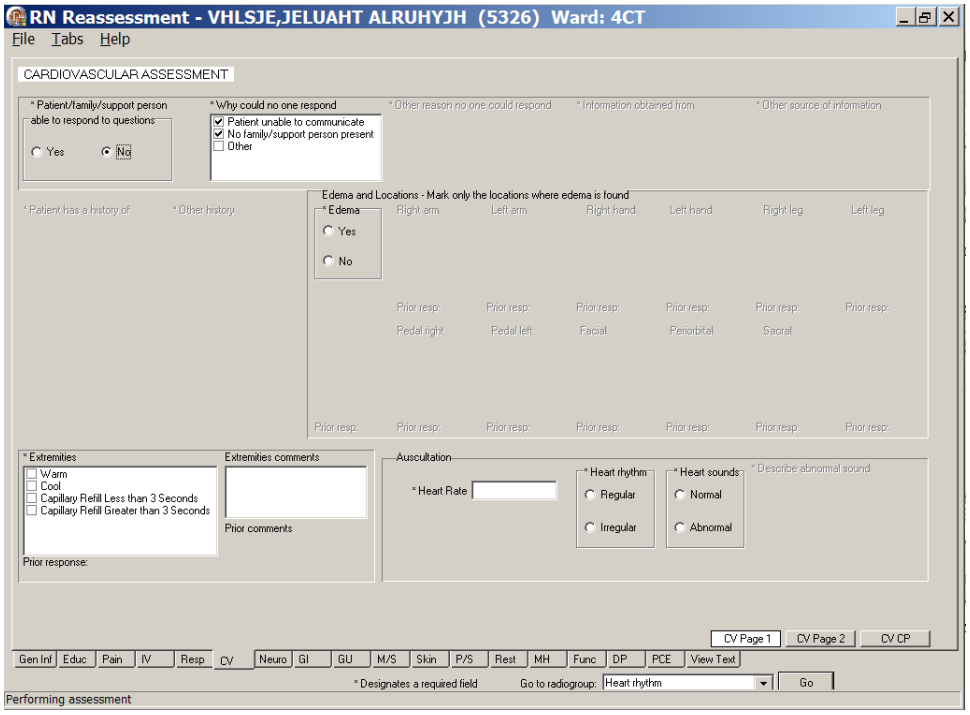
RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 1 window



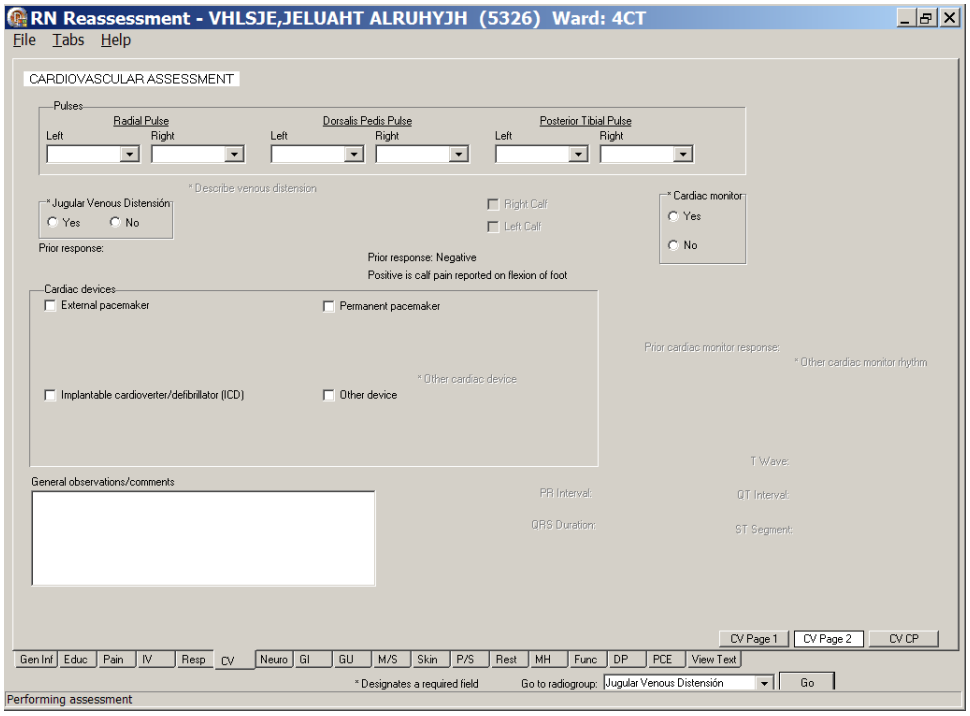
RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 2 window



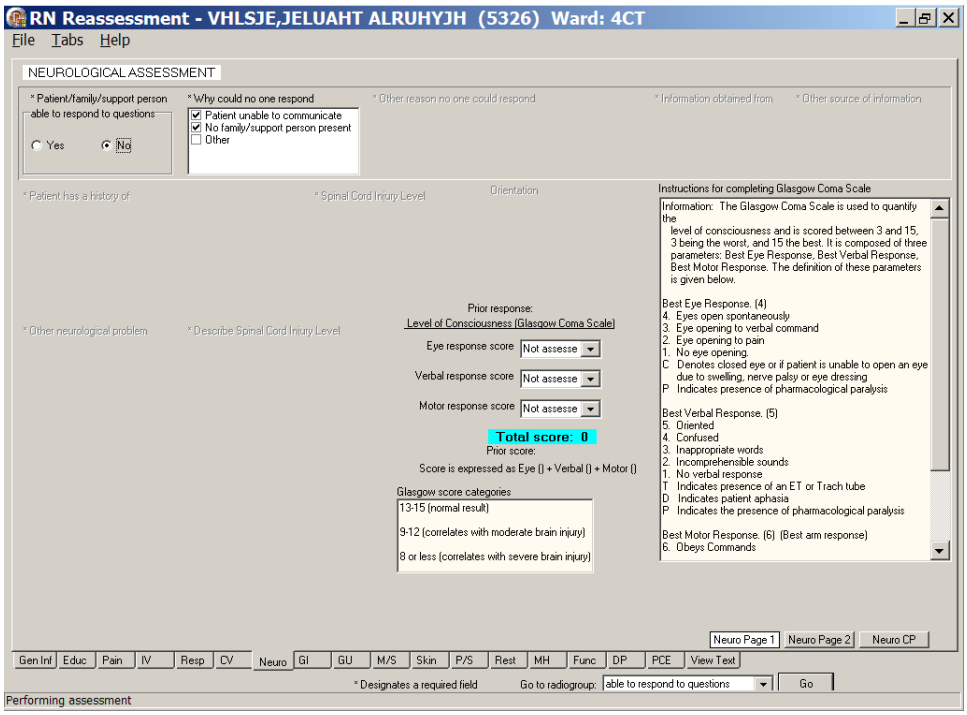
RN Reassessment, Respiratory Assessment (Resp) tab, Resp Page 3 window



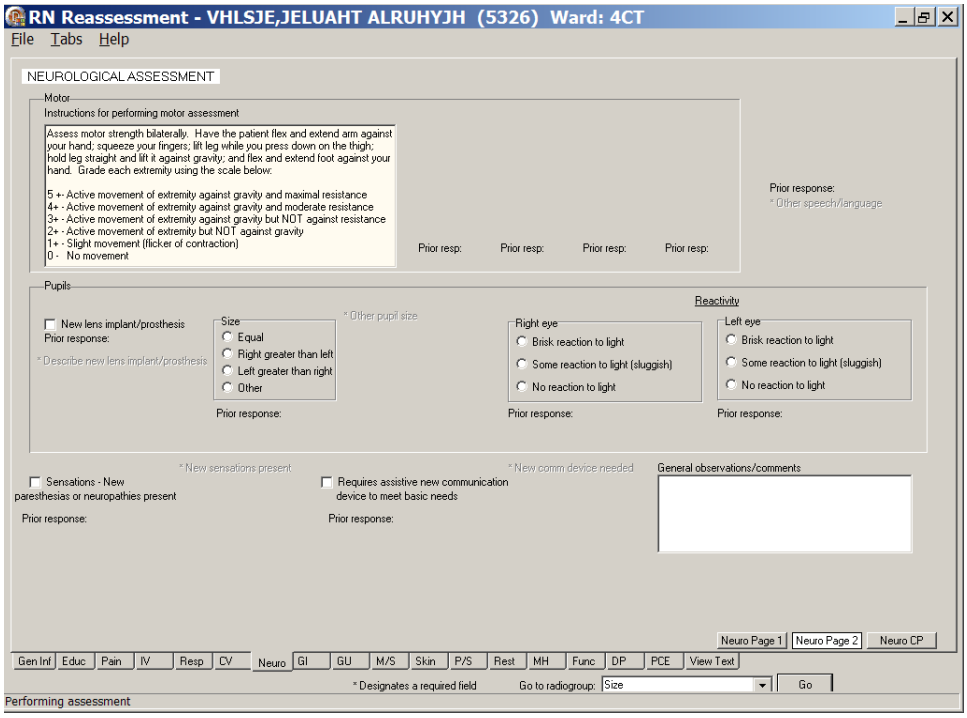
RN Reassessment, Cardiovascular Assessment (CV) tab, CV Page 1 window



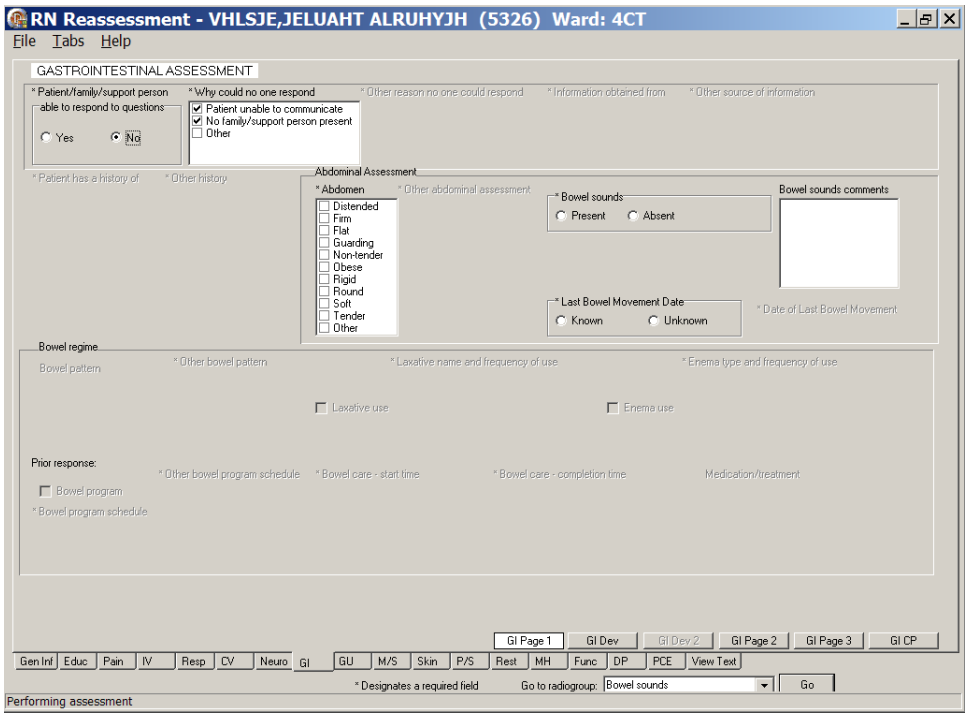
RN Reassessment, Cardiovascular Assessment (CV) tab, CV Page 2 window



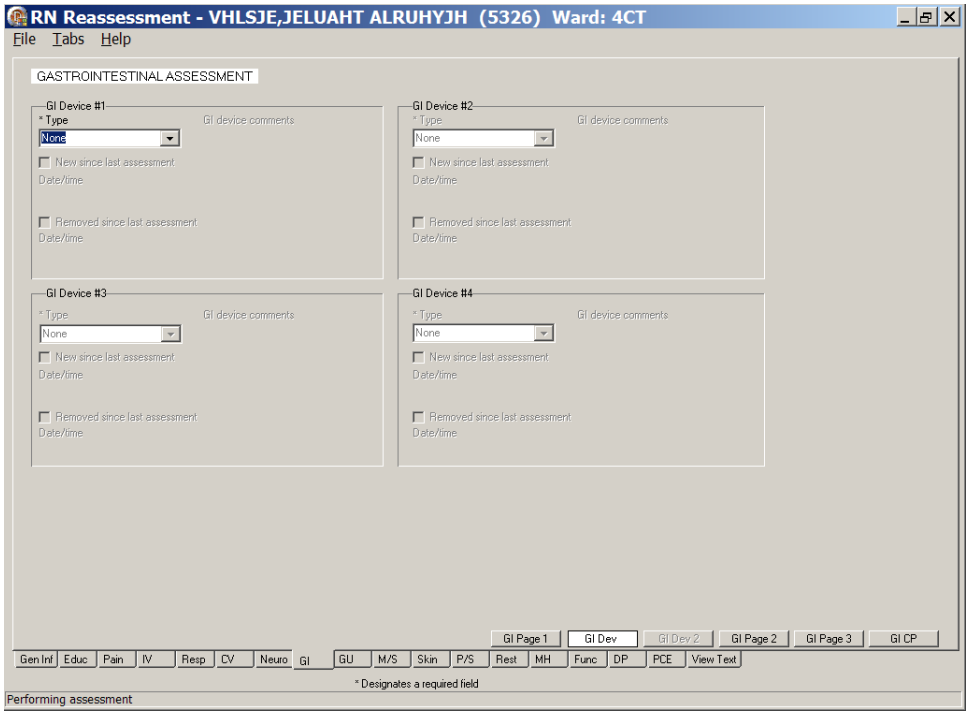
RN Reassessment, Neurological Assessment (Neuro) tab, Neuro Page 1 window



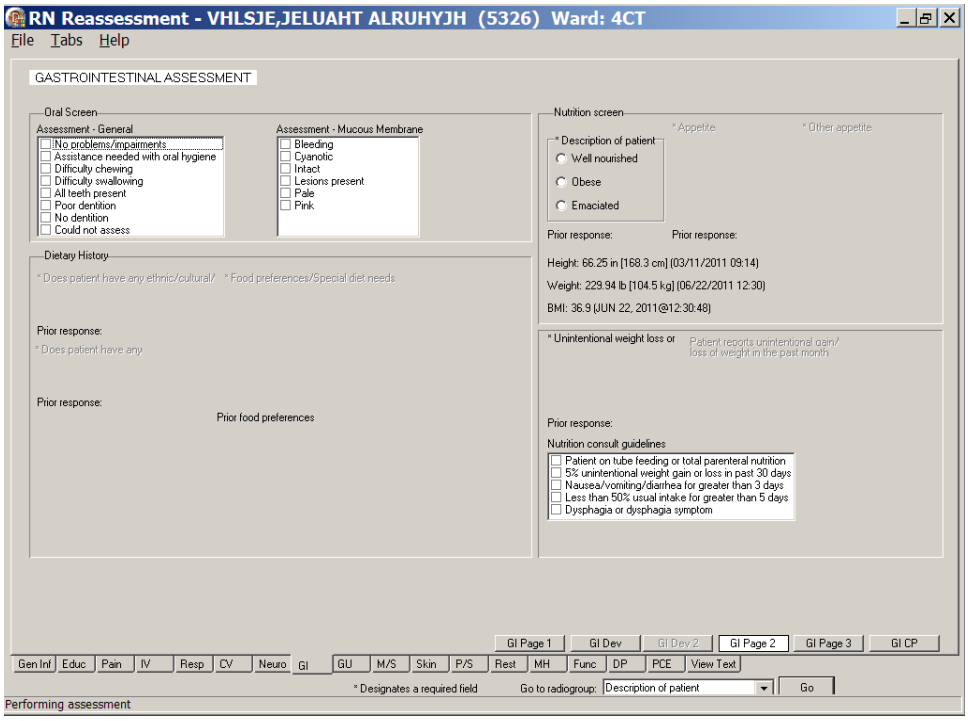
RN Reassessment, Neurological Assessment (Neuro) tab, Neuro Page 2 window



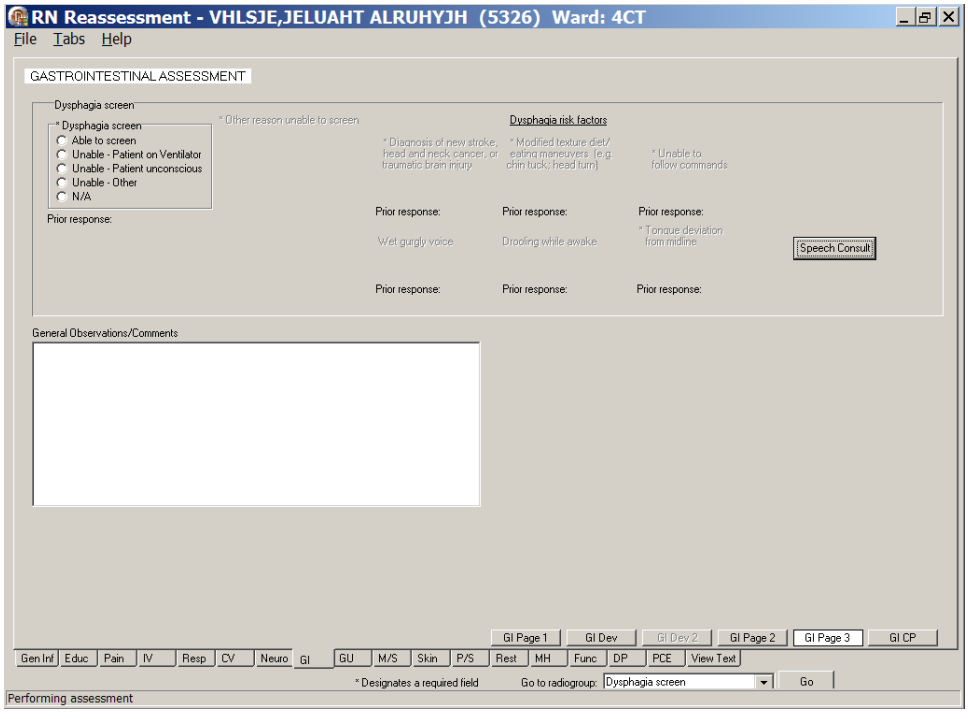
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 1 window



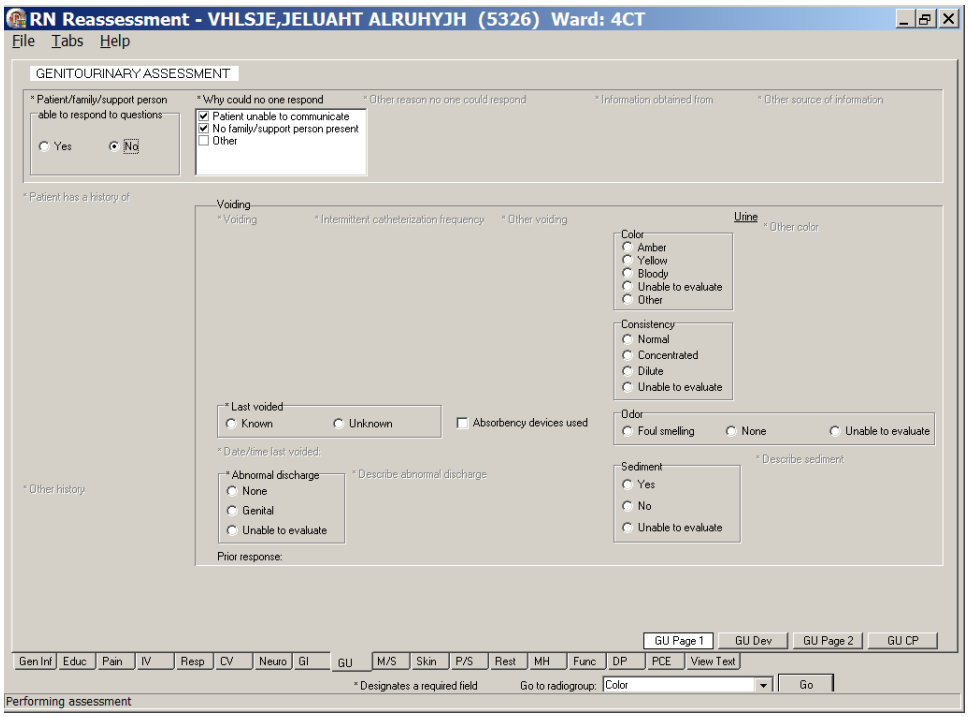
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Dev window



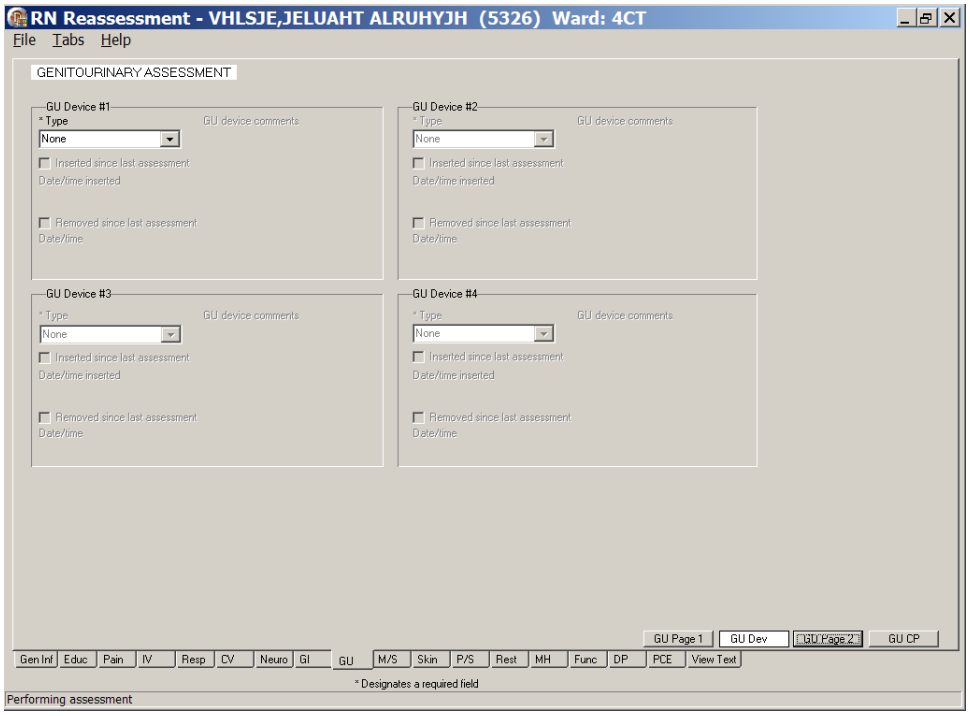
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 2 window



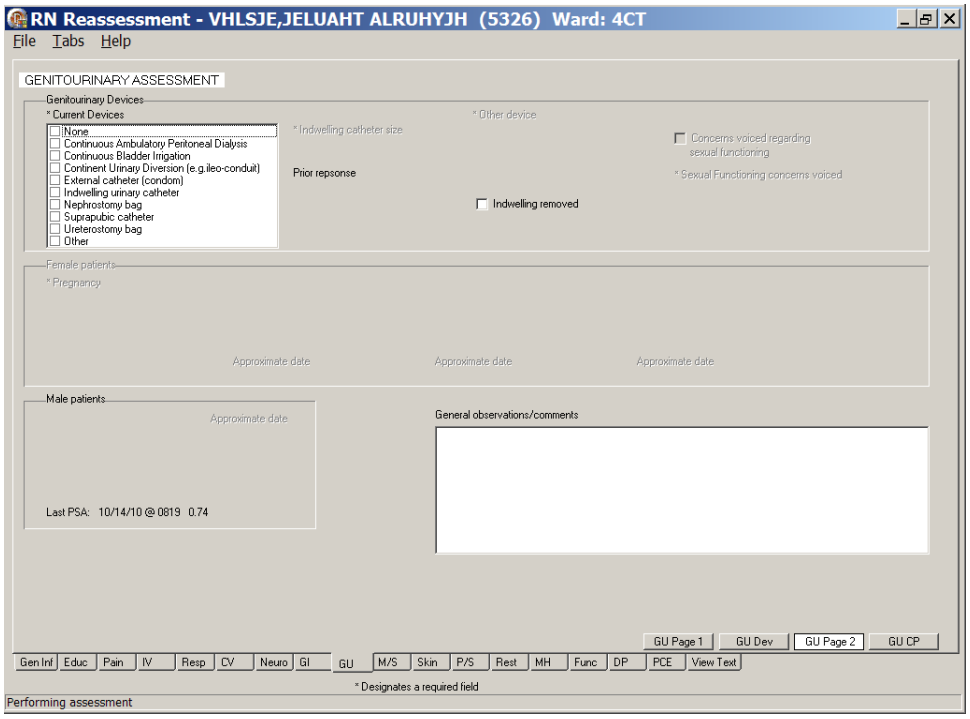
RN Reassessment, Gastrointestinal Assessment (GI) tab, GI Page 3 window



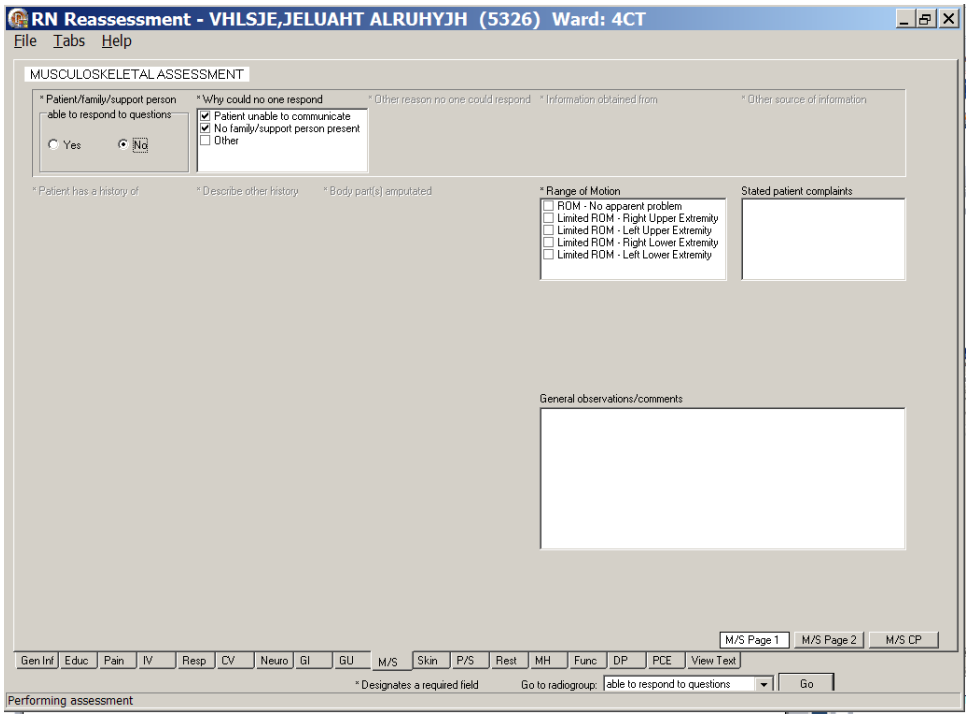
RN Reassessment, Genitourinary Assessment (GU) tab, GU Page 1 window



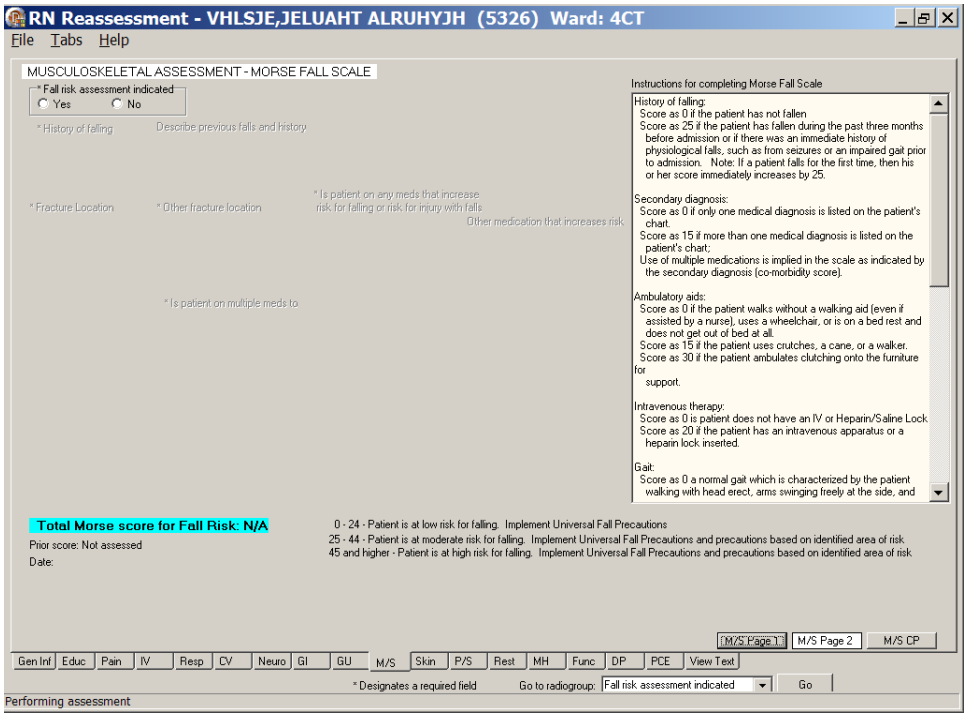
RN Reassessment, Genitourinary Assessment (GU) tab, GU Dev window



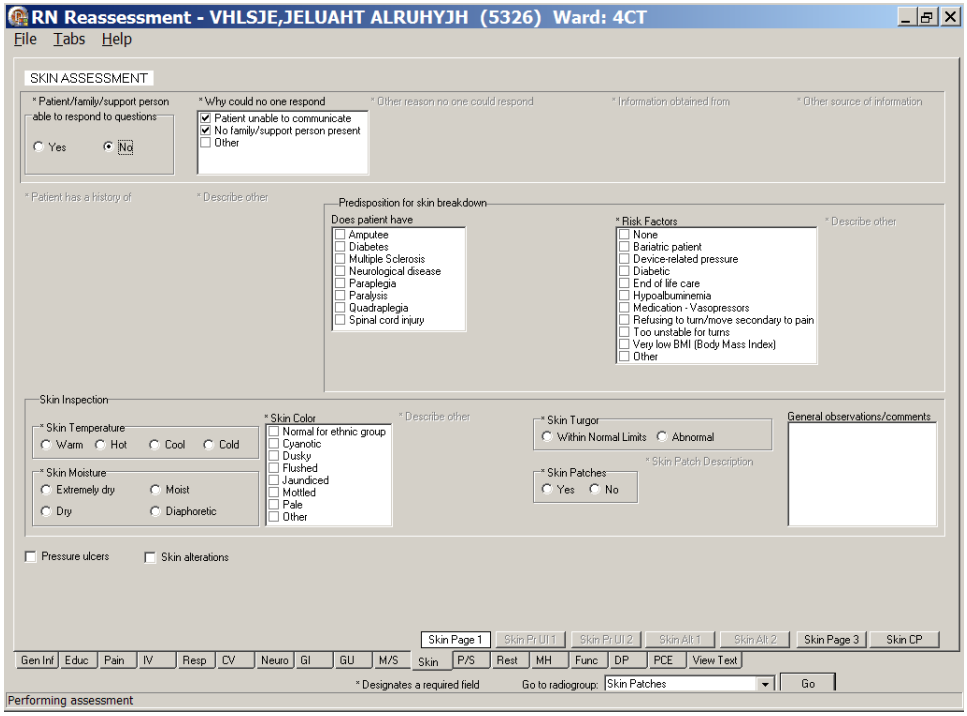
RN Reassessment, Genitourinary Assessment (GU) tab, GU Page 2 window



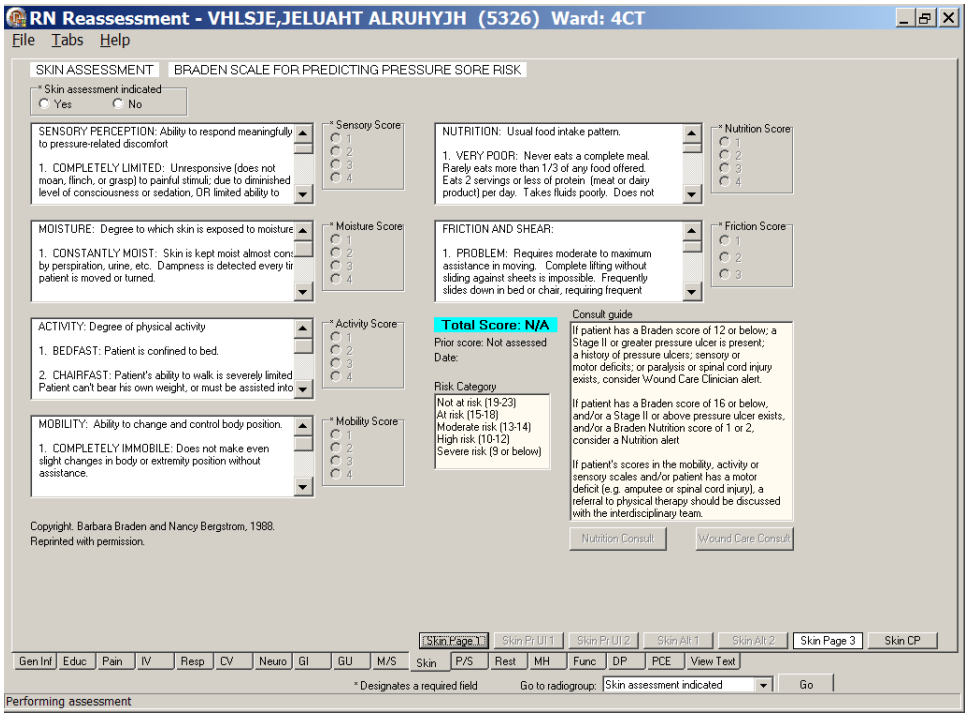
RN Reassessment, Musculoskeletal Assessment (M/S) tab, M/S Page 1 window



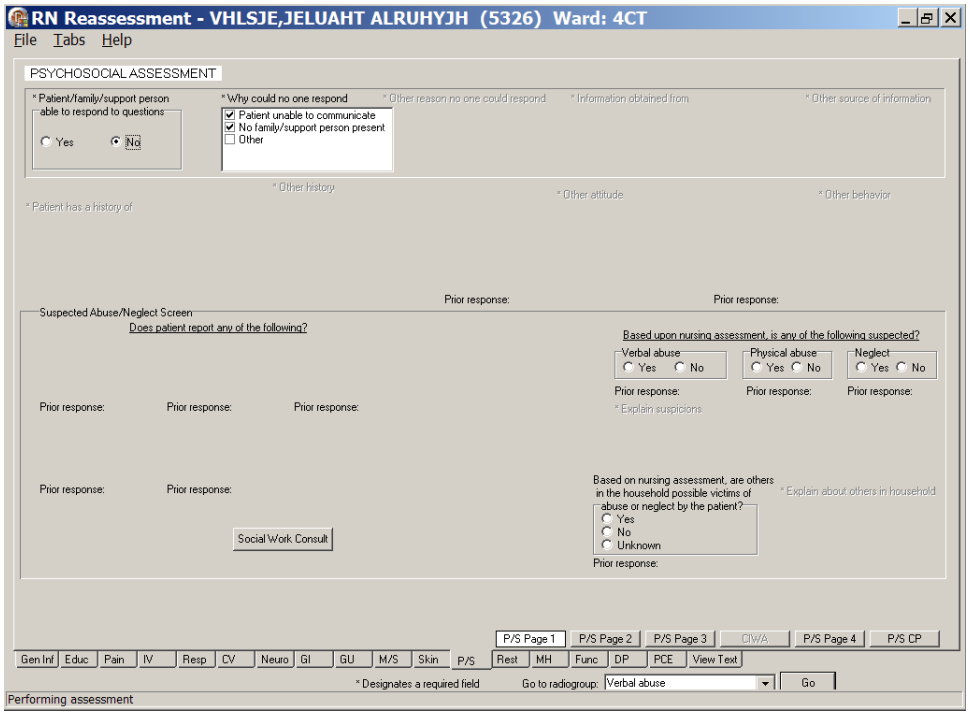
RN Reassessment, Musculoskeletal Assessment (M/S) tab, M/S Page 2 window



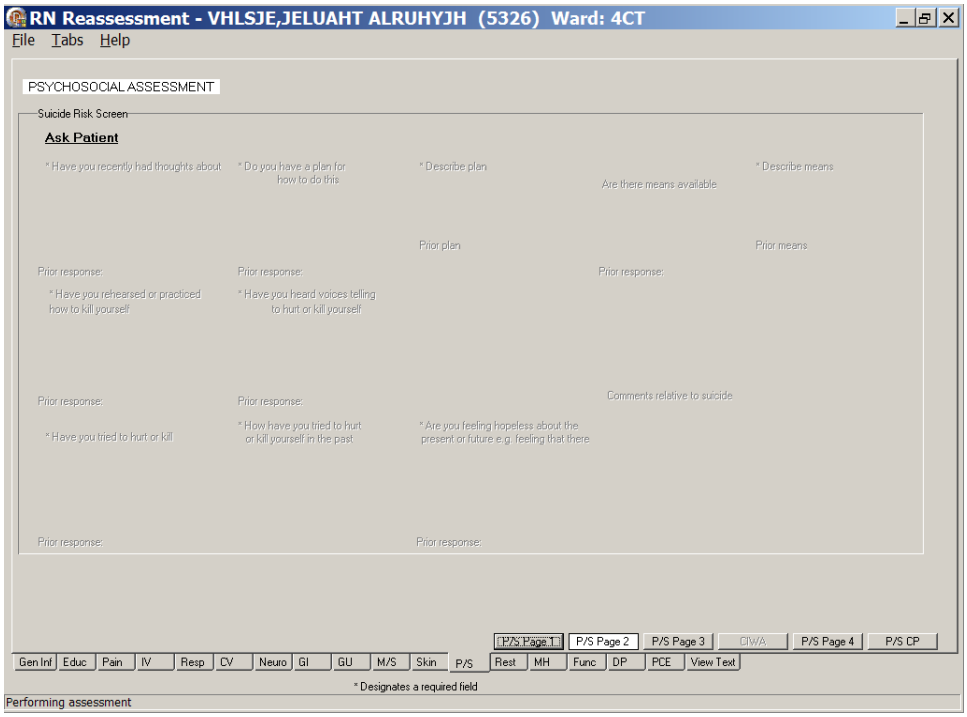
RN Reassessment, Skin Assessment (Skin) tab, Skin Page 1 window



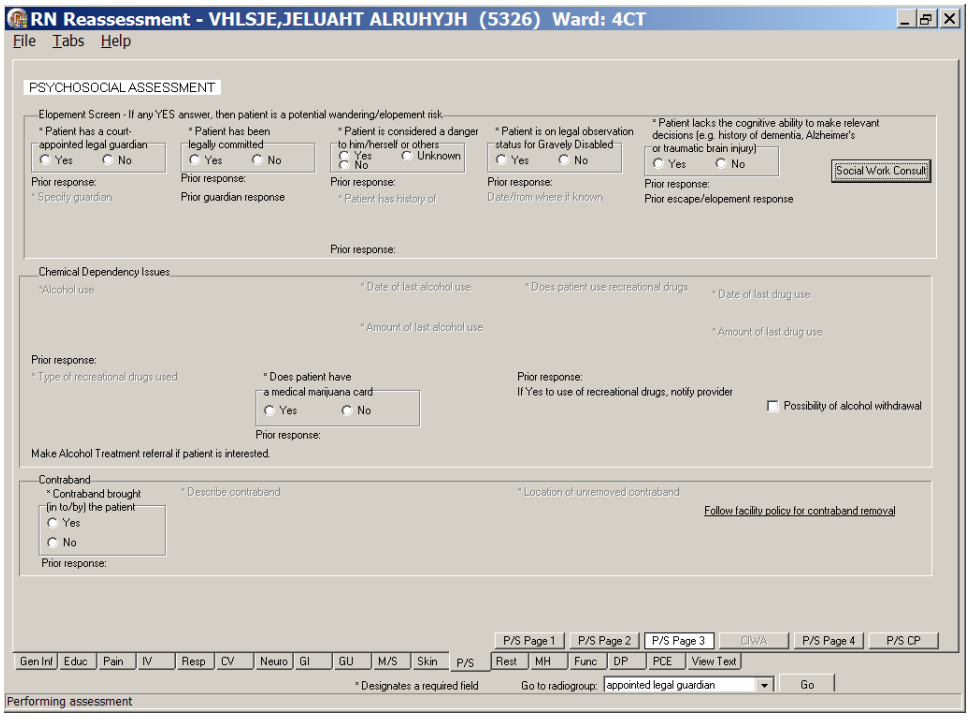
RN Reassessment, Skin Assessment (Skin) tab, Skin Page 3 window



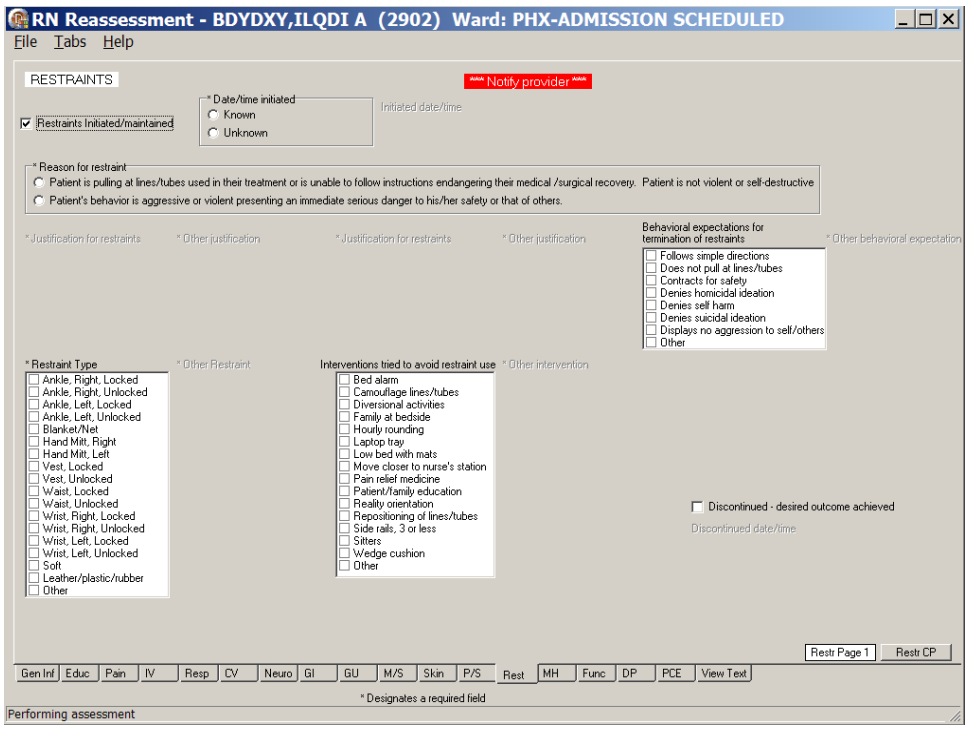
RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 1 window



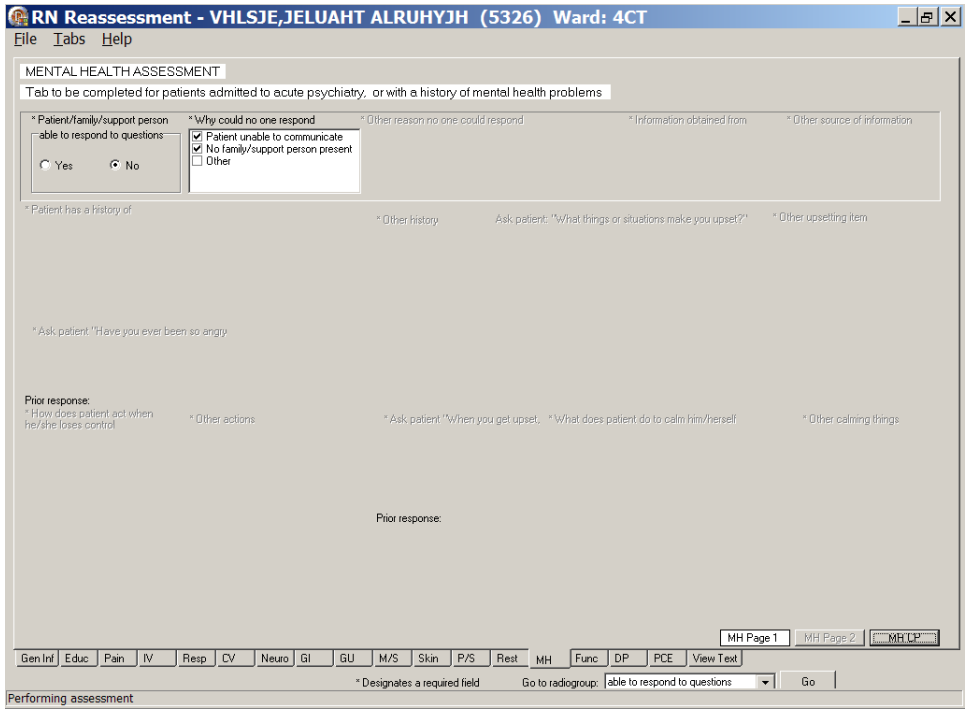
RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 2 window



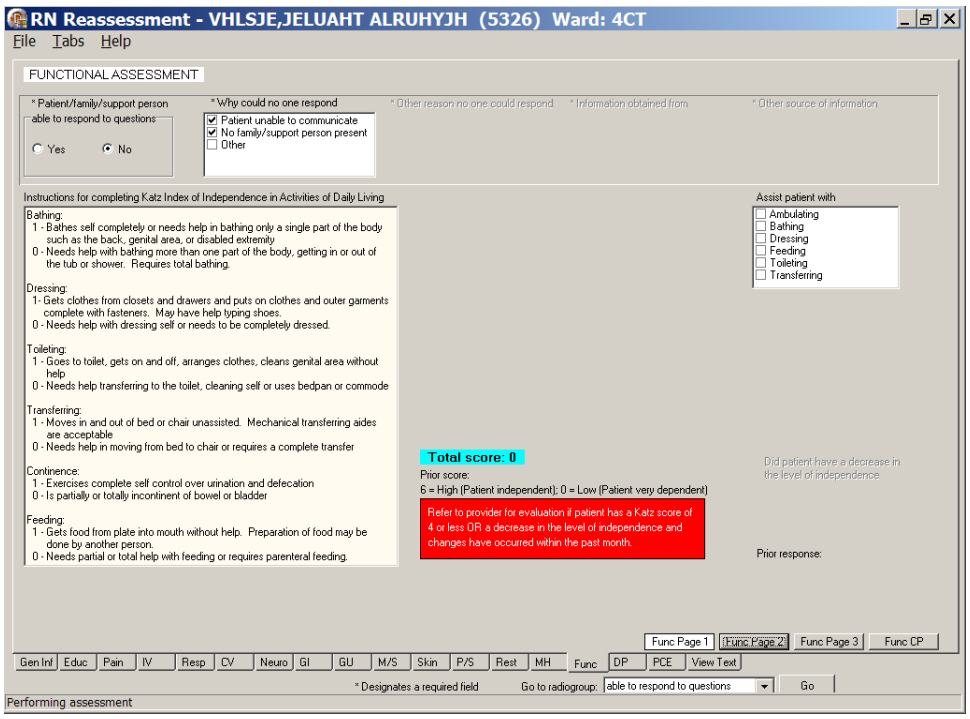
RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 3 window



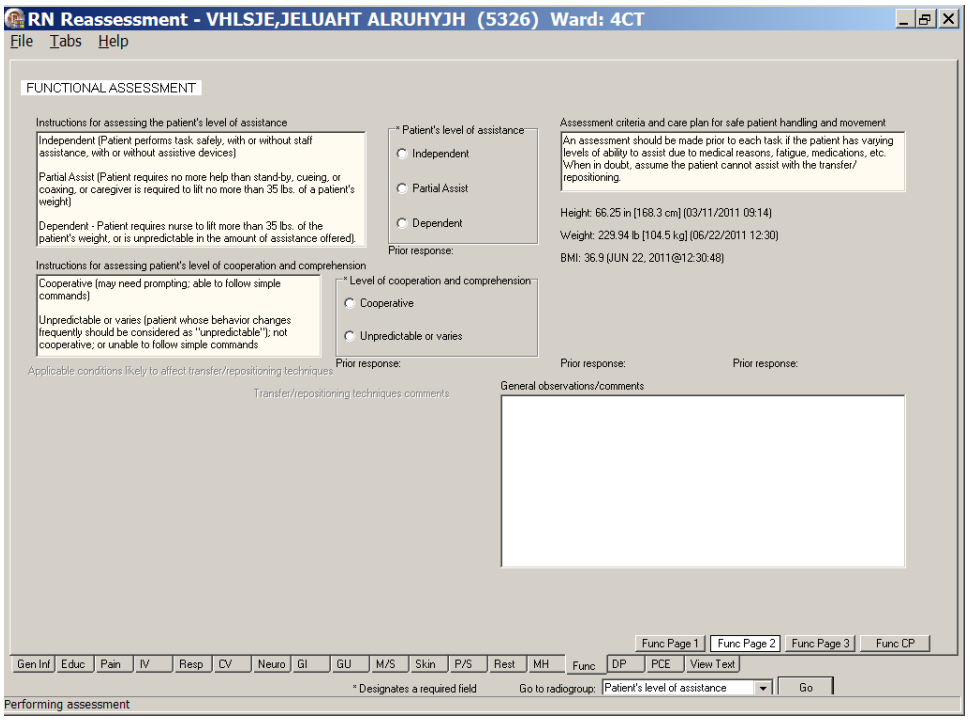
RN Reassessment, Restraints (Rest) tab, Restr Page 1 window



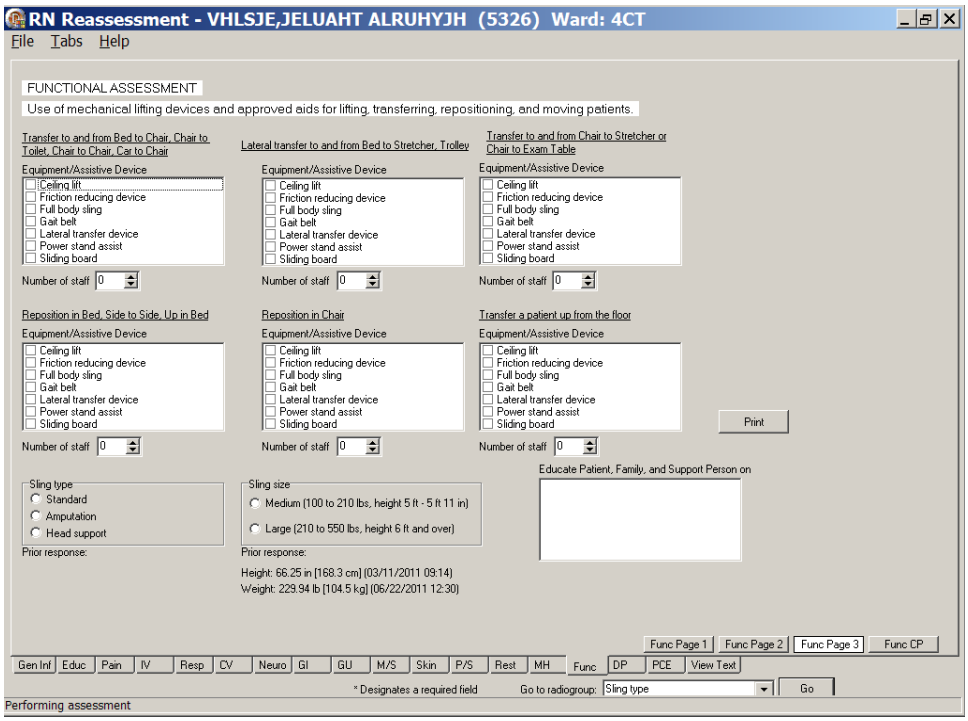
RN Reassessment, Mental Health Assessment (MH) tab, MH Page 1 window



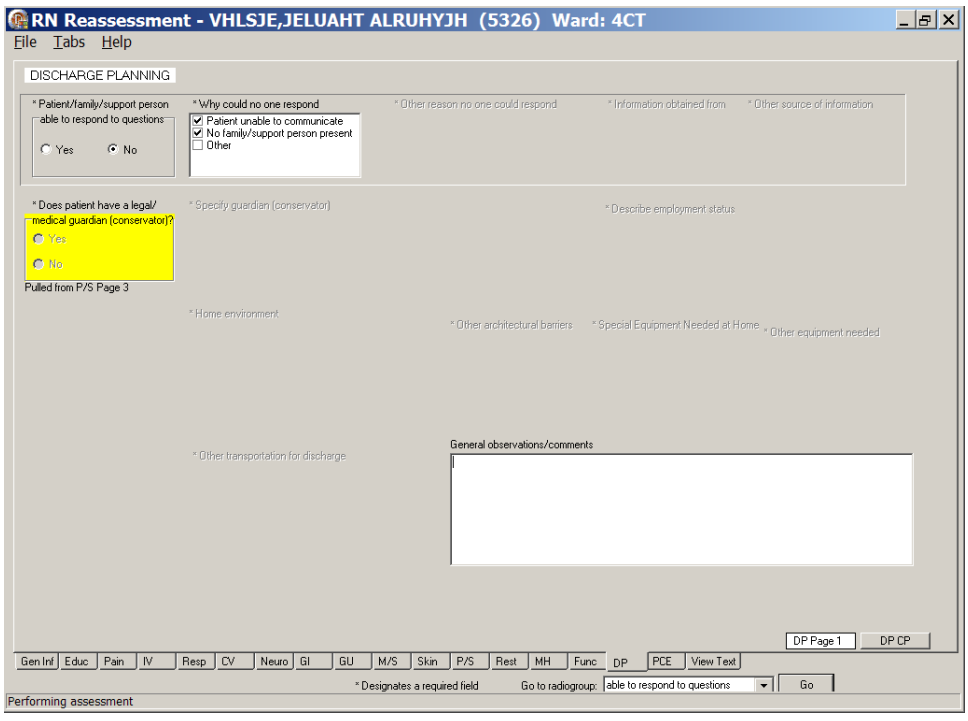
RN Reassessment, Functional Assessment (Func) tab, Func Page 1 window



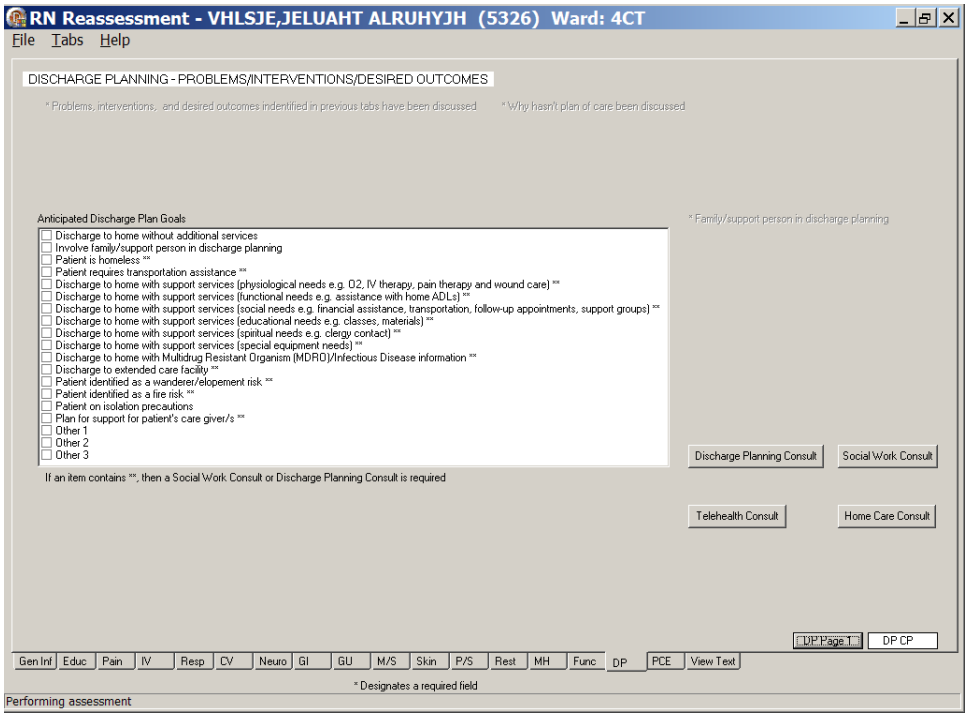
RN Reassessment, Functional Assessment (Func) tab, Func Page 2 window



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



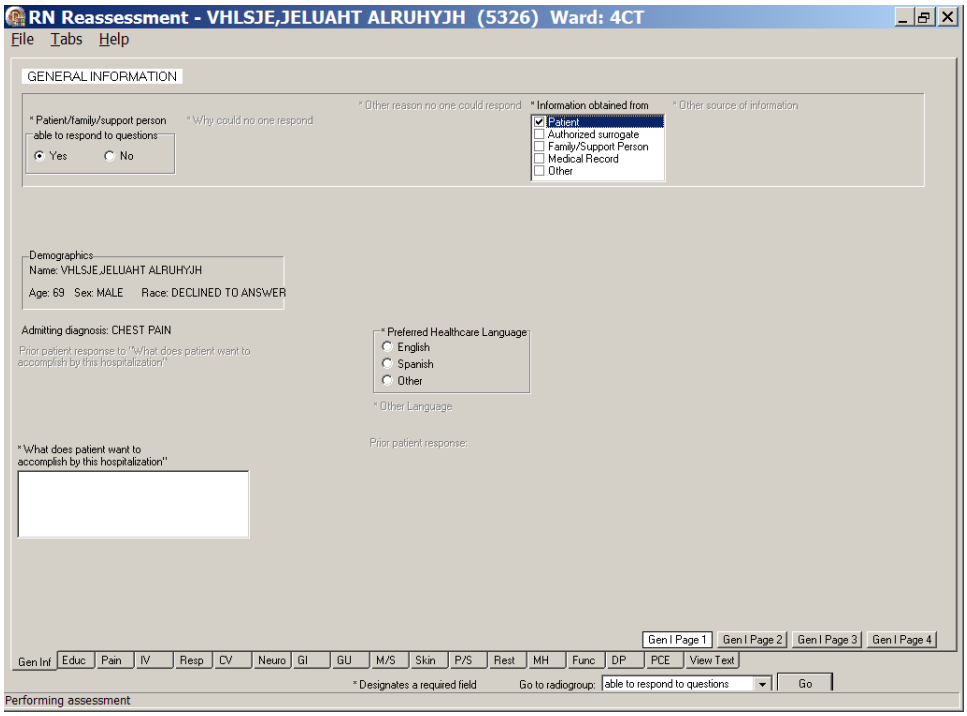
RN Reassessment, Discharge Planning (DP) tab, DP Page 1 window



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

Patient can respond

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



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

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

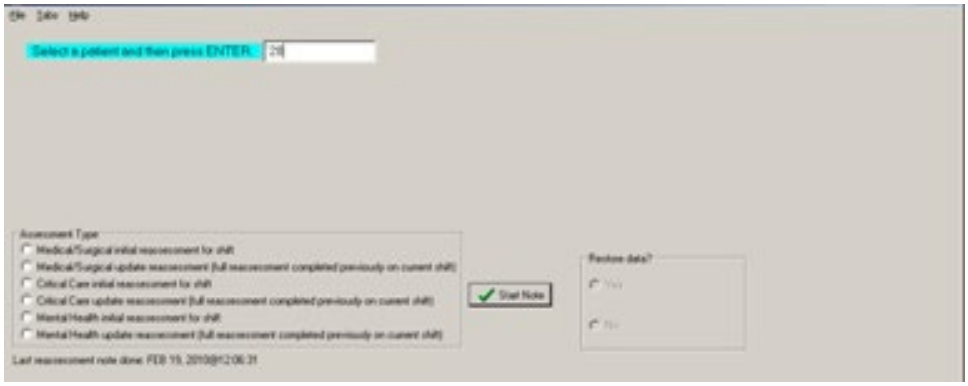
   Note: For the content of the template, refer to the User Manual for *Admission – RN Assessment*.

4. Upload the information.

Updating the Reassessment Note

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

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



RN Reassessment window with Assessment Types

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

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

Glossary

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

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

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

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

Documentation for NUPA Version 1.0 is also available on

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

Appendix A
Reassessment Contingency Note

Reassessment Contingency Note.pd

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