

Patient Assessment Documentation Package (PADP)

C3-C1 Conversion Project

RN Reassessment User Manual for NUPA Version 1.0



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Date	Revision	Description	Author
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Introduction

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

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

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

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

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

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

Each template is associated with a note.

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

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

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

Using the RN Reassessment

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

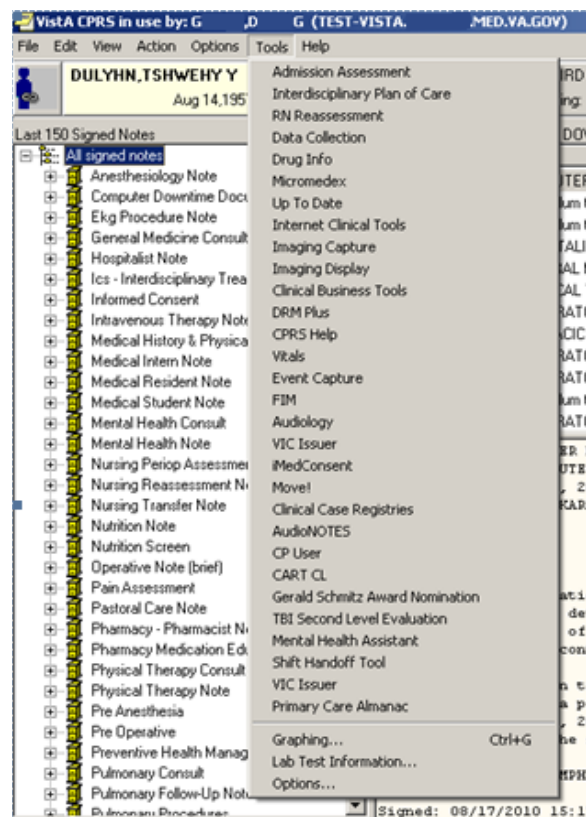
Opening RN Reassessment

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

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

Enter a patient window automatically opens to the CPRS patient.

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



Access through CPRS

No Previously Saved Information

The Enter a patient window displays.

The screenshot shows a window titled "RN Reassessment" with a menu bar (File, Tabs, Help). A text input field contains "BDY" with a prompt "Enter a patient and then press the Enter key:". Below this is a "Restore data?" section with radio buttons for "Yes" and "No". An "Assessment Type" section contains three radio buttons: "Medical/Surgical initial reassessment for shift", "Critical Care initial reassessment for shift", and "Mental Health initial reassessment for shift". A "Start Note" button is to the right. At the bottom, it says "Last reassessment note done: NOT ADMITTED" and a status bar at the very bottom says "Looking up patient".

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

The screenshot shows a dialog box with the text "You have previously saved data on a note for patient BDYDXY,ILQDIA." Below this is a "Restore data?" section with radio buttons for "Yes" and "No".

Patient selection window with previously entered information available for one patient

Restore Patient's Data/No

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

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

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

Restore Patient's Data/Yes

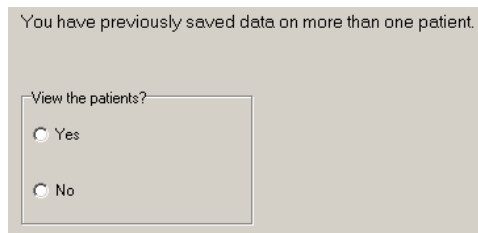
If you previously entered data on one patient, you are prompted with: *You have previously saved data on a note for patient <PADPPATIENT,ONE > m*

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

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

Previously Entered Information Available for Two or More Patients

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



You have previously saved data on more than one patient.

View the patients?

☐ Yes

☐ No

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

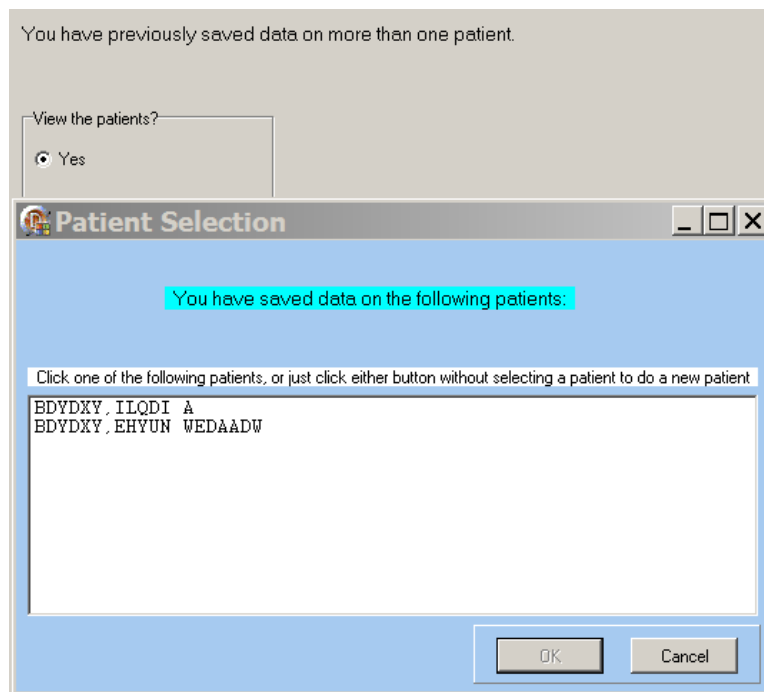
View the Patients?/No

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

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

View the Patients?/Yes

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



Patient 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.

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

At the top of the form, there are several sections:

- * Patient/family/support person able to respond to questions:** Radio buttons for "Yes" (selected) and "No".
- * Why could no one respond:** A text input field.
- * Other reason no one could respond:** A text input field.
- * Information obtained from:** Checkboxes for "Patient", "Authorized surrogate", "Family/Support Person", "Medical Record", and "Other".
- * Other source of information:** A text input field.

Below these, there is a section for **Demographics**:

- Name:** ZMSHTSWLSDHYS,CHUUN
- Age:** 100 **Sex:** MALE **Race:** BLACK OR AFRICAN A

Next is the **Admitting diagnosis:** NONE FOUND.

Below that, there is a section for *** Preferred Healthcare Language:** Radio buttons for "English" (selected), "Spanish", and "Other".

Below that, there is a section for *** What does patient want to accomplish by this hospitalization?** with a large text input area.

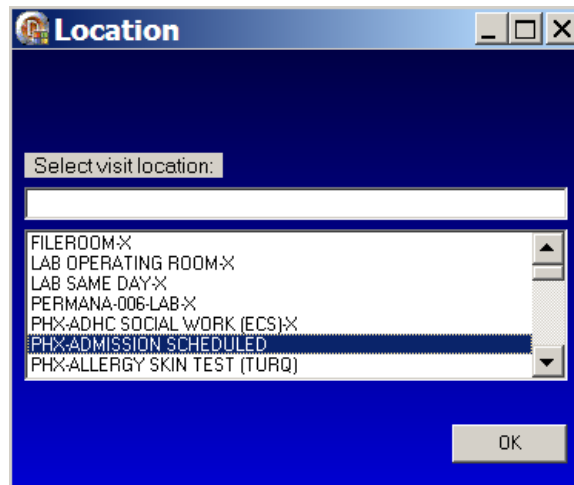
At the bottom of the form, there is a navigation bar with tabs: "Gen I Page 1", "Gen I Page 2", "Gen I Page 3", and "Gen I Page 4". Below the tabs, there is a row of buttons: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text".

At the very bottom, there is a status bar that says "Performing assessment".

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.



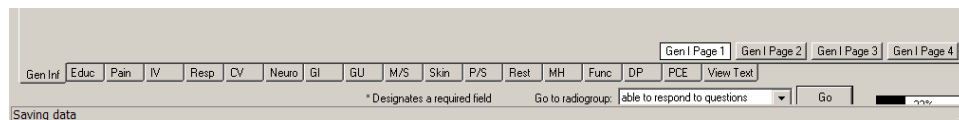
Location : Select visit location

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

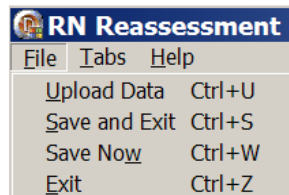
Data are saved automatically. Frequency of auto-save is set locally.



**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.

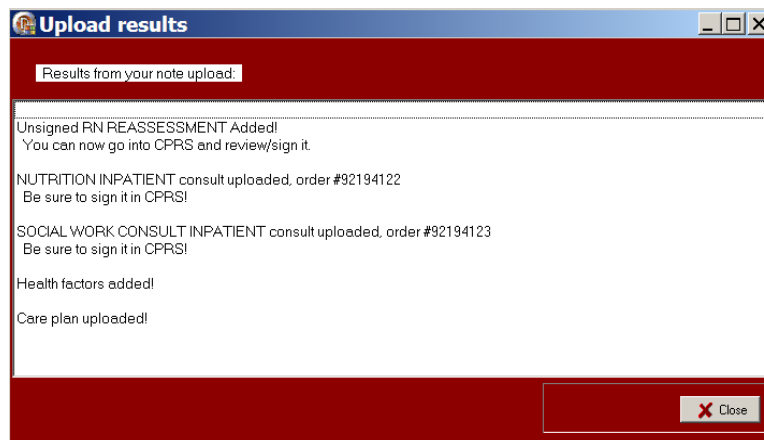


RN Reassessment window, File menu

Upload Data

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

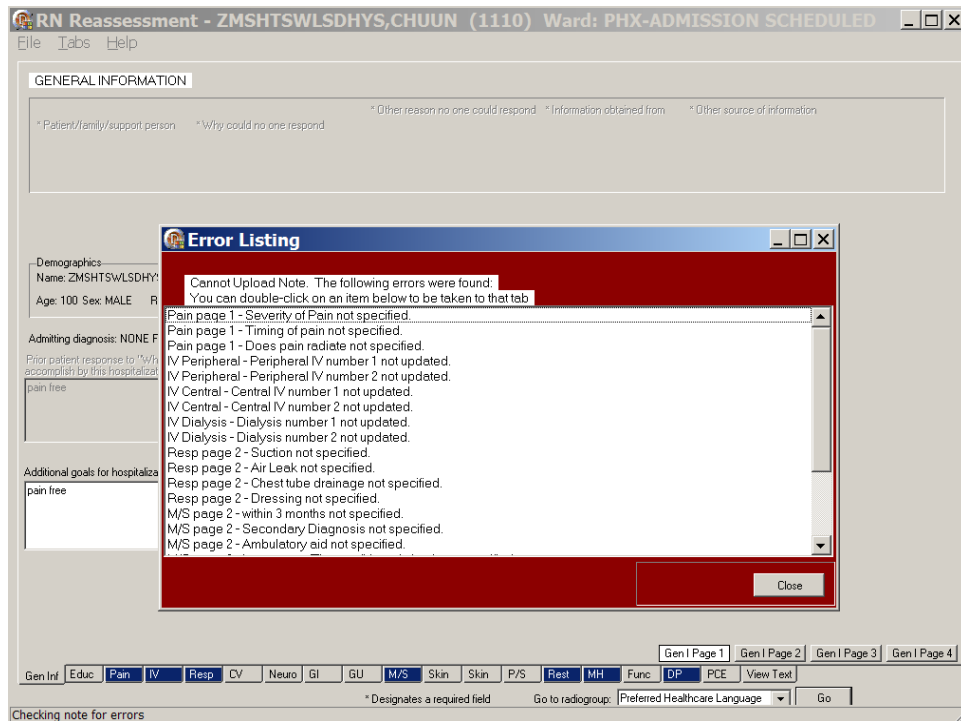
1. Open the File menu on any tab and select **Upload Data**.
Results from your upload display, verifying that the data is uploaded.



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.

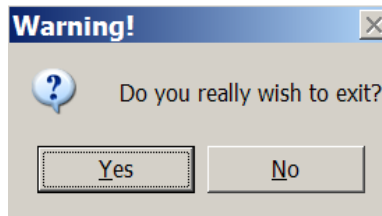
Save Now

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**.

The screenshot shows a software window titled "RN Reassessment - BDYDXY,ILQDI A (2902) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main content area displays a form with the following sections:

- GENERAL INFORMATION**
 - Patient/family/support person able to respond to questions: Yes
 - Information obtained from: Patient
 - What does patient want to accomplish by this hospitalization?: Improve lungs
 - Preferred Healthcare Language: English
- Medications**
 - Meds brought in by patient: No
 - Implanted medication pumps or devices: No
 - Is patient wearing any kind of medicinal patch: No
- Spiritual/Cultural Assessment**
 - Patient's Religion: ROMAN CATHOLIC CHURCH
 - Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about: No
 - Patient requests an immediate visit from the Chaplain: No
 - Does patient have any traditional, ethnic, or cultural practices that need to be part of care: No
 - Does patient have any concerns or special considerations if a blood transfusion is needed: No
 - Does patient have a pastor or clergy who should be notified of this hospitalization: No
- Advance Directive**
 - Does patient have an Advance Directive: No
 - Patient received info on Advance Directive: Yes
 - Does patient wish to initiate or make changes to an Advance Directive: No
- MRSA**
 - Testing for MRSA brochure/equivalent information given to the patient/authorized surrogate: Yes
 - Did the patient/authorized surrogate agree to MRSA Nares swab on admission/transfer/discharge: Yes
 - MRSA Nares swab performed: Yes
 - Was the below Infection Control Education provided to the patient: Yes
 - Infection Control Education: Hand hygiene practices
 - Level of understanding: Fair
 - Precautions: Contact
 - MRSA Nares swab performed on transfer with patient's agreement: Yes
 - MRSA Nares swab performed on discharge with patient's agreement: Yes

At the bottom of the form, there is a row of buttons: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "View Text" button is highlighted. Below the buttons, there is a small text: "* Designates a required field". At the very bottom, there is a status bar that says "Uploading care plan. Cascade your windows if the program gets stuck".

RN Reassessments, View Text tab after upload

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

The screenshot shows the same software window as the previous one, but with the "Sign Note/Consult" button highlighted. The "View Text" button is no longer highlighted. The rest of the form content is the same as in the previous screenshot.

RN Reassessment, Sign Note/Consult Button

- Enter your electronic signature and click **Accept e-sig**.
- 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 - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

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

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

☐ Do not display resolved problems

Add New Problem View history for this problem

Add New Intervention to this problem

Problem/Intervention detail

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

Educ Page 1 Educ CP

* Designates a required field

Performing assessment

**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 DATE
CV	Congestive Heart Failure (Actual)	2/3/11@1156	Prevention/minimization	New problem	Not on file	Education - Educational	2/3/11@1156	Not on file	Not on file
CV	Congestive Heart Failure (Actual)	2/3/11@1156	Prevention/minimization	New problem	Not on file	Other Treatments/procedures	2/3/11@1156	Not on file	Not on file
EDUC	Speech deficit (Actual)	2/3/11@1156	Improved communication	New problem	Not on file	Treatments/procedures	2/3/11@1156	Not on file	Not on file
EDUC	Speech deficit (Actual)	2/3/11@1156	Improved communication	New problem	Not on file	Treatments/procedures	2/3/11@1156	Not on file	Not on file
FUNC	Assistance with bathing and hygiene	2/3/11@1156	Facilitation of activities	New problem	Not on file	Treatments/procedures	2/3/11@1156	Not on file	Not on file
GI	Inadequate nutrition (Actual/Probable)	2/3/11@1156	Balanced dietary intake	New problem	Not on file	Treatments/procedures	2/3/11@1156	Not on file	Not on file
GI	Inadequate nutrition (Actual/Probable)	2/3/11@1156	Balanced dietary intake	New problem	Not on file	Treatments/procedures	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 - Educational	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/procedures	2/3/11@1156	Not on file	Not on file

RN Reassessment, Problems/Interventions/Desired Outcomes table

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

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

The screenshot shows the top navigation bar of the RN Reassessment application. It includes tabs for 'Resp Page 1', 'Resp Page 2', 'Other CT Loc', 'Resp Page 3', and 'Resp CP'. Below these are various clinical category tabs: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. A status bar at the bottom indicates 'Performing assessment' and a note '* Designates a required field'. A 'Go to radiogroup' dropdown menu is set to 'Respiratory depth' with a 'Go' button next to it.

RN Reassessment, <Resp> tab

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

The screenshot shows the 'RN Reassessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION SCHEDULED' window. The title bar includes 'File', 'Tabs', and 'Help' menus. The main content area is titled 'RESPIRATORY - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES' and contains a table with the following data:

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

Below the table, there are buttons for 'Add New Problem', 'View history for this problem', and 'Add New Intervention to this problem'. A checkbox labeled 'Do not display resolved problems' is also present. The bottom of the window shows the same navigation bar as the first screenshot, with 'Resp CP' now selected and highlighted.

RN Reassessment, <Resp> CP window

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

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

File Tabs Help

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

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

☐ Do not display resolved problems

Add New Problem View history for this problem

Add New Intervention to this problem

Problem evaluation:

☐ No change/Stable

☐ Deteriorating

☐ Improving

☐ Resolved

☐ Unresolved at discharge

Intervention status:

☐ Completed

☐ Continue

☐ Discontinue

☐ Pending

OK Cancel

Problem/Intervention detail

Problem: Asthma (Actual)

Identified: 12/6/11@0831

Desired outcome: Stabilization and/or improvement of respiratory status as i

Evaluation: New problem

Evaluation date: Not on file

Intervention: Education - Instruct patient to immediately report any problems

Intervention started: 12/6/11@0831

Intervention status: Not on file

Intervention status date: Not on file

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

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

* Designates a required field

Performing assessment

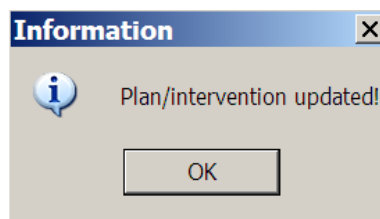
RN Reassessment, <Resp> CP window

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

The screenshot shows a software window titled "Performing assessment". At the top left, there is a checkbox labeled "Do not display resolved problems". Below this are two buttons: "Add New Problem" and "View history for this problem". In the center, there are two groups of radio buttons. The first group, labeled "Problem evaluation", includes options: "No change/Stable", "Deteriorating", "Improving", "Resolved", and "Unresolved at discharge". The second group, labeled "Intervention status", includes options: "Completed", "Continue", "Discontinue", and "Pending". To the right of these groups are "OK" and "Cancel" buttons. On the far right, there is a text area titled "Problem/Intervention detail" containing the following text: "Problem: Asthma (Actual)", "Identified: 12/6/11@0831", "Desired outcome: Stabilization and/or improvement of respiratory status as i", "Evaluation: New problem", "Evaluation date: Not on file", "Intervention: Education - Instruct patient to immediately report any problems", "Intervention started: 12/6/11@0831", "Intervention status: Not on file", and "Intervention status date: Not on file". At the bottom of the window is a horizontal menu with tabs: "Gen Int", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". Below the tabs, it says "Resp Page 1", "Resp Page 2", "Other CT Loc", "Resp Page 3", and "Resp CP". At the very bottom, it says "Performing assessment" and "* Designates a required field".

Problem evaluation, Intervention status, and Problem/Intervention detail

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



Information : Plan/intervention updated!

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

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

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

File Tabs Help

RESPIRATORY - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES

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

☐ Do not display resolved problems

Add New Problem View history for this problem

Add New Intervention to this problem

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

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

* Designates a required field

Performing assessment

RN Reassessment, <Resp> CP window

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

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

File Tabs Help

RESPIRATORY - PROBLEMS,INTERVENTIONS,DESIRED OUTCOMES

TAB	PROBLEM	DATE IDENTIFIED	DESIRED OUTCOME	PROB EVAL	PROB EVAL DATE	INTERVENTION	INT STARTED	INT STATUS	INT STATUS DAT
RESP	Asthma (Actual)	12/6/11@0831	Stabilization and/or no Deteriorating		12/15/11@1521	Education - Instruct patient to immediately report any problems that arise with breathing	12/6/11@0831	Continue	12/15/11@1521

Problem History

Evaluation history: DEC 15, 2011@15:22:08

Problem evaluation:

Problem: Asthma (Actual)

Status: DETERIORATING (DEC 15, 2011@15:21:20) P.A.D.P. USER, ONE

Intervention evaluation:

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

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

Close

☐ Do not display resolved problems

Add New Problem

Add New Intervention

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

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

* Designates a required field

Performing assessment

Problem History window

8. Click **Close**.

Adding a New Intervention for an Existing Problem

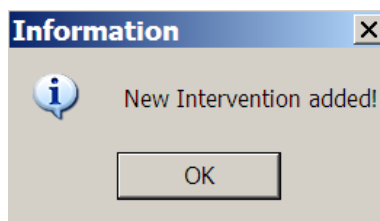
1. Click a problem.
2. Click **Add New Intervention to this problem.**

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

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

Do not display resolved problems ☐

Add New Problem View history for this problem

Add New Intervention to this problem

RN Reassessment, <Resp> CP window

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

Click a problem area

Cardiovascular
Diabetes
Discharge Planning
Education
Functional
Gastrointestinal
Genitourinary
IV
Mental Health
Musculoskeletal

Select Problem(s)

Control impairment (Actual)
Hearing deficit (Actual)
Speech deficit (Actual)
Visual deficit (Actual)
Other 1
Other 2

Desired Outcome

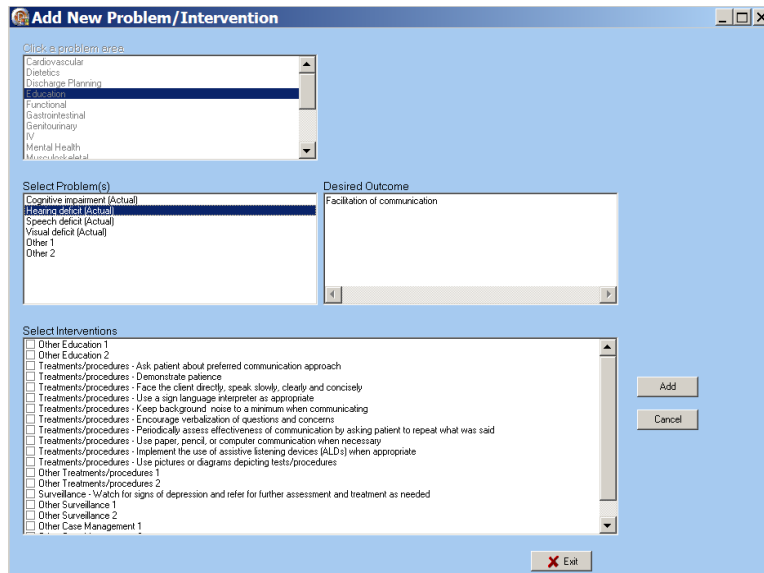
Select Interventions

Exit

Add New Problem/Intervention window

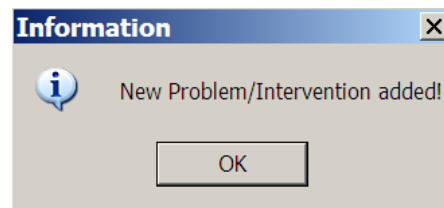
Note: The Respiratory area is auto selected, because you are in the Resp CP.

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



Add New Problem/Intervention window for problem/intervention options

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



Information : New Problem/Intervention added!

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

Other Problems

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

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

The *Other* problems displays.

Add New Problem/Intervention window with *Other*

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

Information displays.

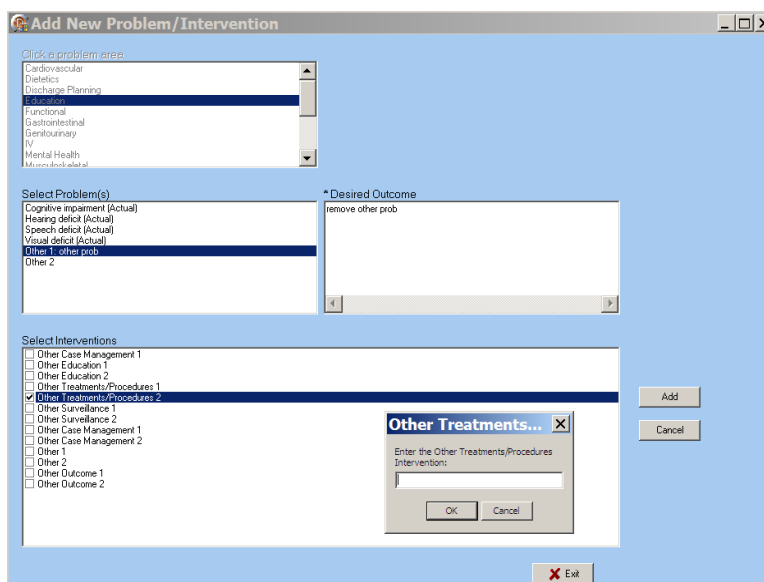
Information : New Problem/Intervention added!

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

Other Interventions

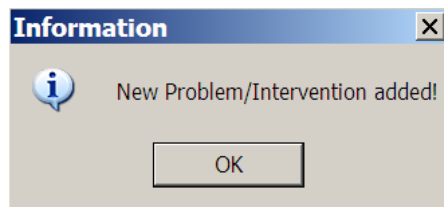
Some interventions generate a to enter interventions that are not on the predefined list.

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



Add New Problem/Intervention window with Other

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



Information : New Problem/Intervention added!

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

Working in the Consults

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

Example – Ordering a Chaplain Consult

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

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

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

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

Chaplain consult mandatory

The screenshot shows the 'Spiritual/Cultural Assessment' window for a patient whose religion is 'JEHOVAH'S WITNESSES'. It contains several questions with 'Yes' or 'No' radio button options. The 'Chaplain Consult' button is visible. A red banner message reads '*** Chaplain consult mandatory ***'. Other questions include: 'Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about?', 'Does patient have any concerns or special considerations if a blood transfusion is needed?', 'Does patient have a pastor or clergy who should be notified of this hospitalization?', and 'Does patient have any traditional, ethnic, or cultural practices that need to be part of care?'. Each question has a 'Prior patient response: NO' label.

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

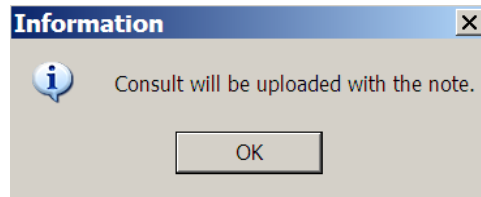
2. Click **<Chaplain Consult>**.

The **<INPATIENT CHAPLAIN>** Consult window displays.

The screenshot shows the 'INPATIENT CHAPLAIN Consult' window. It has a blue header with the title. Below the header are several fields: '* Urgency' (dropdown menu set to 'Routine'), '* Place of consult' (dropdown menu set to 'Bedside'), 'Provisional diagnosis' (text field), '* Reason for request' (large text area), '* Patient will be seen as an' (radio buttons for 'Inpatient' and 'Outpatient'), '* Provider' (text field), and 'Person to notify' (text field). At the bottom right are two buttons: 'Upload Consult' and 'Cancel'.

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.

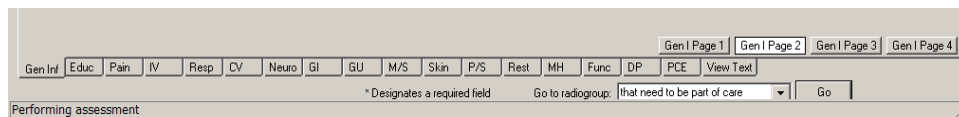
Working in the Template

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

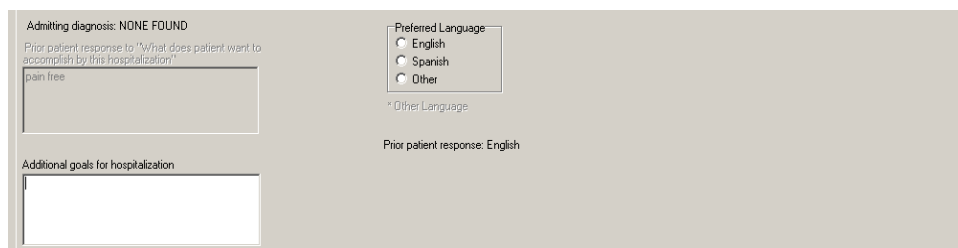
1. Use the Tab key to move to the bottom of the page.
 2. Use the arrow keys to move up/down in the **Go to radiogroup:** list.
 3. Click **Go**.
- or
1. Click the drop-down arrow in the **Go to radiogroup:** drop-down list.
 2. Select a radiogroup.
 3. Click **Go**.

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

File Tabs Help

GENERAL INFORMATION

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

* Why could no one respond:

* Other reason no one could respond:

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

* Other source of information:

Demographics
Name: ZMSHTSWLSDHYS,CHUUN
Age: 100 Sex: MALE Race: BLACK OR AFRICAN A

Admitting diagnosis: NONE FOUND
Prior patient response to "What does patient want to accomplish by this hospitalization":

* Preferred Healthcare Language: ☐ English ☐ Spanish ☐ Other

* Other Language:

* What does patient want to accomplish by this hospitalization:

Prior patient response:

Gen I Page 1 Gen I Page 2 Gen I Page 3 Gen I Page 4

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

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

Performing assessment

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

File Tabs Help

GENERAL INFORMATION

Medications/Allergies

Current Meds (last day)

*** Outpatient ***
 *** NONE FOUND ***
 *** IV ***
 *** NONE FOUND ***
 *** Unit Dose ***
 *** NONE FOUND ***

Allergies

BACTRIM DS
 PIROXICAM
 CODEINE
 LISINOPRIL
 MORPHINE
 EOS
 DOCTILITZONE

Yesterday's and Today's Orders

ORDERS YESTERDAY & TODAY - NONE FOUND

Add New Allergy

* Meds brought in by patient
☐ Yes
☐ No

* Disposition of meds
☐ Yes
☐ No

* Other Disposition
☐ Yes
☐ No

* Implanted medication
☐ Yes
☐ No

* Type of device/pump/medication
☐ Yes
☐ No

* Is patient wearing any kind
☐ Yes
☐ No

* Type of patch
☐ Yes
☐ No

Spiritual/Cultural Assessment - Patient's Religion: PROTESTANT, NO DENOMINATION

* Are there religious practices or spiritual
 concerns the patient wants the chaplain,
 physician, and other health care team
 members to immediately know about:
☐ Yes ☐ No

* Describe practices/concerns

* Patient requests an immediate
 Chaplain Consult

* Does patient have any traditional,
 ethnic, or cultural practices
 that need to be part of care
☐ Yes ☐ No

* Describe practices

Prior patient response:

* Does patient have any concerns
 or special considerations if a
 blood transfusion is needed:
☐ Yes ☐ No

* Describe concerns

* Does patient have a pastor or
 clergy who should be notified
 of this hospitalization:
☐ Yes ☐ No

* Specify pastor or clergy

Prior patient response:

Gen I Page 1 | Gen I Page 2 | Gen I Page 3 | Gen I Page 4

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

* Designates a required field

Go to radiogroup: that need to be part of care

Go

Performing assessment

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

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

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

Adding an Allergy

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

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

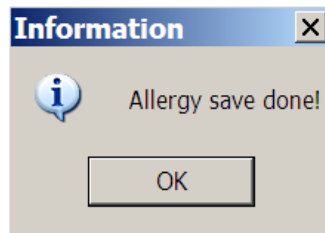
1. Click **Add New Allergy**.
The Add New Allergies window displays.

Add New Allergies window

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

Add New Allergies window with Sign/Symptoms available

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



Information : Allergy save done!

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

Initiating a Social Work Consult for Advance Directives

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

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

 The screenshot shows the 'RN Reassessment' application window for patient 'ZMSHTSWLSDHYS,CHUUN (1110)' in 'Ward: PHX-ADMISSION SCHEDULED'. The 'Gen I Page 3' tab is active, displaying the 'GENERAL INFORMATION' section. This section includes fields for 'Advance Directive' status, 'Location of Advance Directive', 'Patient received info on Advance Directive', and 'Does patient wish to initiate or make changes to an Advance Directive'. There are also sections for 'Infection Control Education' and 'Precautions'. At the bottom, there are tabs for 'Gen I Page 1', 'Gen I Page 2', 'Gen I Page 3', and 'Gen I Page 4'. The status bar at the bottom indicates 'Performing assessment'.

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

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

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

File Tabs Help

GENERAL INFORMATION

Advance Directive

* Does patient have an Advance Directive?

☐ Yes

☒ No

Prior patient response:

* Location of Advance Directive:

* Patient received info on Advance Directive?

☒ Yes

☐ No

Prior patient response:

* Explain why patient did not receive info.

* Does patient wish to initiate or make changes to an Advance Directive?

☒ Yes

☐ No

Prior patient response:

Social work consult mandatory

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

File Tabs Help

GENERAL INFORMATION

Emergency contact information

Contact: BDYDXY, EHYUN WEDAADW
Relationship: WIFE
Address: 9908 ROBIN NE.
FARM HILL, ID
Phone: 207-901-6182
Work Phone: QCYQFZS

Change Contact

General observations/comments

☐ Support Person same as emergency contact

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

Gen I Page 1 | Gen I Page 2 | Gen I Page 3 | Gen I Page 4

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

* Designates a required field

Performing assessment

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

The screenshot shows a web form titled "GENERAL INFORMATION". Inside, there is a section for "Emergency contact information" which is currently expanded, displaying details for a contact named "SDYDKY, EHYUN WEDAADW", who is the "WIFE" of the patient, residing at "9908 ROBIN NE. FARM HILL, ID" with phone "207-001-6182" and work phone "QCYQFZS". To the right of this section is a "Change Contact" button. Below the emergency contact section are several input fields for a support person, marked with asterisks to indicate they are required: "* Name (LN, FN)", "* Relationship", "* Street Address 1", "Street Address 2", "Street Address 3", "* Zip Code", "Phone", and "Work Phone". To the right of these fields are "Save Contact" and "Cancel Contact" buttons. At the bottom, there is a checkbox labeled "Support Person same as emergency contact" and a text instruction: "* Document the name and contact information of the patient's support person". Below this instruction is a large, empty text area for documentation.

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

File Tabs Help

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

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

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

Add New Intervention to this problem

Problem evaluation:

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

Intervention status:

☐ Completed
☐ Continue
☐ Discontinue
☐ Pending

OK Cancel

Educ Page 1 Educ CP

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

* Designates a required field Go to radiogroup: Problem evaluation Go

Performing assessment

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

File Tabs Help

PAIN ASSESSMENT

* Is patient having any pain now
☒ Yes
☐ No
☐ Unable to respond to questions

Explain if new occurrence

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

* Pain Location #1

* Pain Region: **Head**

* Quality of pain

* Type of pain: ☐ Acute/surgical ☐ Chronic

* Other pain region

* Other quality of pain

Onset of original pain (years, months)

* Describe other timing of pain

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

* Timing of pain: ☐ Constant ☐ Intermittent ☐ Other

* What makes pain worse

☐ No identified triggers
☐ Bending
☐ Changes in temperature
☐ Changing position
☐ Coughing
☐ Deep breathing
☐ Exercise

* Other provoking factor(s)

* Does pain radiate: ☐ Yes ☐ No

* Describe Pain Radiation

* What makes pain better

☐ No identified relief factors
☐ Acupressure
☐ Acupuncture
☐ Assistive devices (cane, wheelchair)
☐ Brace/Support
☐ Chiropractic intervention
☐ Cold

* Other palliative factor(s)

* Rx/Otc Meds helping pain

* Does patient exhibit behavioral indicators related to pain

* Other behavioral indicator

* Behavioral indicator(s) observed

* Areas of life affected by pain

☐ No effect
☐ Anxiety
☐ Appetite
☐ Concentration
☐ Depression
☐ Energy level

* Comments for patient's life aspects

Pain Goal
 * What pain level is acceptable to the patient (0-10)?

☐ Other pain location?

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

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

* Designates a required field Go to radiogroup: Is patient having any pain now Go

Performing assessment

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

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

File Tabs Help

Pain Location #2
* Pain Region
None
* Quality of pain

* Other pain region
* Other quality of pain
Onset of original pain (years, months)

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

* Describe other timing of pain

What makes pain worse
* Other provoking factor(s)
* Describe Pain Radiation

What makes pain better
* Other palliative factor(s)
* Rx/Otc Meds helping pain

Areas of life affected by pain
* Comments for patient's life aspects
Pain Goal
* What pain level is acceptable to the patient (0-10)?

☐ More pain locations?

Pain Location #3
* Pain Region
None
* Quality of pain

* Other pain region
* Other quality of pain
Onset of original pain (years, months)

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

* Describe other timing of pain

What makes pain worse
* Other provoking factor(s)
* Describe Pain Radiation

What makes pain better
* Other palliative factor(s)
* Rx/Otc Meds helping pain

Areas of life affected by pain
* Comments for patient's life aspects
Pain Goal
* What pain level is acceptable to the patient (0-10)?

☐ More pain locations?

☐ More pain locations?

* Designates a required field

Performing assessment

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

File Tabs Help

Pain Location #4

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

Pain Location #5

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

Pain Page 1 **Other Pain 2** Other Pain 2 Pain Comm Pain CP

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

* Designates a required field

Performing assessment

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

File Tabs Help

PAIN ASSESSMENT

* Is patient having any pain now
☐ Yes
☒ No
☐ Unable to respond to questions

Explain if new occurrence

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

* Pain Location #1
* Pain Region: None
* Quality of pain:
* Other pain region:
* Other quality of pain:
Onset of original pain (years, months):
* Describe other timing of pain:
* Severity of Pain (0=none, 10=worst):
* What makes pain worse:
* Other provoking factor(s):
* Describe Pain Radiation:
* Does patient exhibit behavioral indicators related to pain:
* Other behavioral indicator:
* Behavioral indicator(s) observed:
* What makes pain better:
* Other palliative factor(s):
* Rx/Otc Meds helping pain:
* Areas of life affected by pain:
* Comments for patient's life aspects:
Pain Goal
* What pain level is acceptable to the patient (0-10)?

☐ Other pain location?

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

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

* Designates a required field Go to radiogroup: Is patient having any pain now Go

Performing assessment

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

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

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

File Tabs Help

PAIN ASSESSMENT

* Is patient having any pain now
☐ Yes
☐ No
☒ Unable to respond to questions

Explain if new occurrence
☐ Patient has been placed on Palliative/Comfort Care since last patient assessment

* Does patient exhibit behavioral indicators related to pain
☐ None Observed
☐ Body Rigidity
☐ Crying
☐ Facial Grimacing
☐ Fidgeting
☐ Frightened Facial Expression
☐ Frowning
☐ Moaning
☐ Negative Vocalization
☐ Noisy Breathing
☐ Sad Facial Expression
☐ Unable to console, distract, or reassure
☐ Other

* Other behavioral indicator
☐ Behavioral indicator(s) observed

* Pain Location #1
 * Pain Region: None
 * Quality of pain
 * Other pain region
 * Other quality of pain
 Onset of original pain (years, months)
 * Describe other timing of pain
 * Severity of Pain (0=none, 10=worst)
 * What makes pain worse
 * Other provoking factor(s)
 * Describe Pain Radiation
 * What makes pain better
 * Other palliative factor(s)
 * Rx/Otc Meds helping pain
 * Areas of life affected by pain
 * Comments for patient's life aspects

Pain Goal
 * What pain level is acceptable to the patient (0-10)?

☐ Other pain location?

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

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

* Designates a required field Go to radiogroup: Is patient having any pain now Go

Performing assessment

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

The screenshot shows a software window titled "RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main content area is titled "PAIN ASSESSMENT" and contains a large text box labeled "General observations/comments". At the bottom of the window, there is a navigation bar with tabs: "Pain Page 1", "Other Pain", "Other Pain 2", "Pain Comm" (which is selected), and "Pain CP". Below the navigation bar, there is a row of buttons: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". A status bar at the very bottom indicates "Performing assessment".

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

File Tabs Help

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

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

Problem/Intervention detail

☐ Do not display resolved problems

Add New Problem View history for this problem

Add New Intervention to this problem

Problem evaluation

☐ No change/Stable

☐ Deteriorating

☐ Improving

☐ Resolved

☐ Unresolved at discharge

Intervention status

☐ Completed

☐ Continue

☐ Discontinue

☐ Pending

OK

Cancel

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

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

* Designates a required field Go to radiogroup: Intervention status Go

Performing assessment

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

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

IV (IV)

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

No IV/Vascular Access Devices

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

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

File Tabs Help

IV ☒ No IV/vascular access devices

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

NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
NONE					

Add New IV Location

☐ Show discontinued IVs also

Edit Peripheral Line Site

* Location: None * Other location: * Other size: ☐ IV Discontinued
IV discontinue date/time:

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

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

OK Cancel edit

IV Periph IV Central IV Dialysis IV Comments IV GP

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

* Designates a required field

Performing assessment

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

Peripheral Lines - IV Periph

Existing IV Lines

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

NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
1	Antecubital Right	Unknown	16 G	NO	YES

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

File Tabs Help

IV ☐ No IV/vascular access devices

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

NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
1	Antecubital Right	Unknown	16 G	NO	YES

Add New IV Location

☐ Show discontinued IVs also

Edit Peripheral Line site #1

* Location: * Other location:

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

* Size: * Other size:

☐ IV Discontinued IV discontinue date/time:

* Dressing: ☐ Clean, dry, intact ☐ Drainage ☐ Other

☐ Dressing change Last changed: Clean, dry, intact Dressing date/time change:

☐ Tubing change Last changed: Tubing date/time change:

* Other dressing condition: * Dressing type: ☐ Bandaid ☐ Gauze ☐ Transparent ☐ Other ☐ None * Other dressing type:

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

* Drainage: * Other site appearance: * Describe patency:

☐ IV patent ☐ Yes ☐ No

OK Cancel edit

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

Performing assessment

* Designates a required field

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

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

New IV Lines

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

File Tabs Help

IV ☐ No IV/vascular access devices

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

NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
1	Antecubital Right	Unknown	16 G	NO	YES
2				NO	

Add New IV Location

☐ Show discontinued IVs also

Edit Peripheral Line site #2

* Location: * Other location:

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

* Size: * Other size:

☐ IV Discontinued

IV discontinue date/time:

☐ Dressing change: Last changed: Dressing date/time change:

☐ Tubing change: Last changed: Tubing date/time change:

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

OK Cancel edit

IV Periph IV Central IV Dialysis IV Comments IV CP

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

* Designates a required field

Performing assessment

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

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

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

File Tabs Help

IV ☐ No IV/vascular access devices

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

NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
1	Antecubital Right	Unknown	16 G	NO	YES
2				NO	

Add New IV Location

☐ Show discontinued IVs also

Edit Peripheral Line site #2

* Location: Forearm Right * Other location

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

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

☐ IV Discontinued IV discontinue date/time

* Dressing: ☒ Clean, dry, intact ☐ Drainage ☐ Other ☐ Dressing change Last changed: Dressing date/time change

* Tubing change Last changed: Tubing date/time change

* IV patent: ☒ Yes ☐ No

* Other dressing condition: ☐ Bandaid ☐ Gauze ☒ Transparent ☐ Other ☐ None * Other dressing type

* Site characteristics: ☒ No evidence of complications ☐ Drainage ☐ Pain ☐ Redness ☐ Swelling ☐ Other * Drainage * Other site appearance * Describe patency

OK Cancel edit

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

Performing assessment

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

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

File Tabs Help

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

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

Add New CL Location

☐ Show discontinued Central Lines also

Edit Central Line Site

* Type * Location * Catheter impregnated ☐

* Other location ☐ Central line discontinued

☐ Dressing change ☐ Tubing change * Date/time inserted Central line discontinue date/time

Last changed: **Last changed:**

Dressing date/time change Tubing date/time change

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

OK Cancel edit

IV Central IV Dialysis IV Comments IV CP

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

* Designates a required field

Performing assessment

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

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

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

File Tabs Help

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

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

Add New CL Location

☐ Show discontinued Central Lines also

Edit Central Line site #2

* Type: **Implanted port - Single Lumen** * Location: * Date/time inserted known: ☐ Yes ☐ No

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

* Catheter power injectable: ☐ Yes ☐ No ☐ Unknown

* IV patent: ☐ Yes ☐ No

* Dressing: ☐ Clean, dry, intact ☐ Drainage ☐ Other

☐ Dressing change Last changed: Dressing date/time change

☐ Tubing change Last changed: Tubing date/time change

* Central line discontinued: ☐ Central line discontinued date/time:

* Other dressing condition:

* Dressing type: ☐ Bandaid ☐ Gauze ☐ Transparent ☐ Other ☐ None

* Other dressing type:

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

* Drainage:

* Other site appearance:

* Describe patency:

OK Cancel edit

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

Performing assessment

* Designates a required field

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

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

Dialysis Ports - IV Dialysis

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

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

File Tabs Help

IV

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

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

Add New Dialysis Location

☐ Show discontinued Dialysis access locations also

Edit Dialysis access location #

* Type: * Select Dialysis location: * Other location: * Other size:

☐ Dressing change Last changed: Dressing date/time change:

☐ Tubing change Last changed: Tubing date/time change:

☐ Date/time inserted ☐ Dialysis catheter discontinued Discontinue date/time:

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

OK Cancel edit

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

* Designates a required field

Performing assessment

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

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

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.

The screenshot displays the 'RN Reassessment' software window. The title bar reads 'RN Reassessment - ZMSHTSWLS DHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED'. Below the title bar is a menu bar with 'File', 'Tabs', and 'Help'. The main content area is titled 'IV' and contains a large text box labeled 'General observations/comments'. At the bottom of the window is a navigation bar with various tabs: 'Gen Int', 'Educ', 'Pain', 'IV', 'Resp', 'CV', 'Neuro', 'GI', 'GU', 'M/S', 'Skin', 'P/S', 'Rest', 'MH', 'Func', 'DP', 'PCE', 'View Text', 'IV Periph', 'IV Central', 'IV Dialysis', 'IV Comments', and 'IV CP'. The 'IV Comments' tab is currently selected. A small note at the bottom of the navigation bar states '* Designates a required field'. The status bar at the very bottom indicates 'Performing assessment'.

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.

The screenshot shows the 'RN Reassessment' window for patient ZMSHTSWLSDHYS, JLUXA (3122) in Ward PHX-ADMISSION SCHEDULED. The 'IV - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES' tab is active. The window contains a table for tracking problems and interventions, with columns for TAB, PROBLEM, DATE IDENTIFIED, DESIRED OUTCOME, PROB EVAL, PROB EVAL DATE, INTERVENTION, INT STARTED, INT STATUS, and INT STATI. Below the table are buttons for 'Add New Problem', 'View history for this problem', and 'Add New Intervention to this problem'. There are also sections for 'Problem evaluation' (with radio buttons for No change/Stable, Deteriorating, Improving, Resolved, and Unresolved at discharge) and 'Intervention status' (with radio buttons for Completed, Continue, Discontinue, and Pending). At the bottom, there are tabs for IV Periph, IV Central, IV Dialysis, IV Comments, and IV CP, along with a 'Go to radiogroup' dropdown menu set to 'Intervention status' and a 'Go' button.

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

Problem/Intervention detail

☐ Do not display resolved problems

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

☐ Completed
☐ Continue
☐ Discontinue
☐ Pending

OK
Cancel

IV Periph IV Central IV Dialysis IV Comments IV CP

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

* Designates a required field Go to radiogroup: Intervention status Go

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.

- Click **Resp Page 2**.
Resp Page 2 displays.

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

File Tabs Help

RESPIRATORY ASSESSMENT

* Sputum color * Other sputum color * Sputum consistency * Other sputum consistency

☒ Productive cough present
Prior response:
Prior response:
Sputum amount:
Large
Moderate
Small
Sputum color:
Bloody
Brown
Clear
Green
Pink
Sputum consistency:
Frothy
Mucous Plugs
Thick
Thin
Other

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

Facility ordered oxygen:
☒ Facility ordered oxygen
Liter flow:
1 L/Min
2 L/Min
3 L/Min
4 L/Min
Other
Other liter flow:
Via:
Bipap
Cpap
Cannula
Catheter
Mask
Other
Other delivery method:
Oxygen saturation %:
Ventilator dependent - chronic:
* Ventilator dependent - chronic comments

Respiratory Consult

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

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

Performing assessment

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

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

File Tabs Help

RESPIRATORY ASSESSMENT

* Sputum color * Other sputum color * Sputum consistency * Other sputum consistency

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

Chest tubes:
☒ Chest tubes present
Prior response: NO
Location 1:
Right Anterior
Date/time inserted:
12/08/11 16:11
Suction:
Waterseal
20 cm
10 cm
Other
Other suction:
Air Leak:
None
Slight bubbling on expiration
Large air leak on expiration
Air leak on inspiration/expiration
Intermittent air leak
Crepitus present
Chest tube drainage:
None
Small
Moderate
Large
Serosanguinous
Bloody
Dressing:
Clean, dry, intact
Drainage
Other
Other dressing:
Location 2:
Right Posterior
Date/time inserted:
12/08/11 16:11
Suction:
Waterseal
20 cm
10 cm
Other
Other suction:
Air Leak:
None
Slight bubbling on expiration
Large air leak on expiration
Air leak on inspiration/expiration
Intermittent air leak
Crepitus present
Chest tube drainage:
None
Small
Moderate
Large
Serosanguinous
Bloody
Dressing:
Clean, dry, intact
Drainage
Other
Other dressing:
☐ Chest tube removed
☐ Other chest tube locations

Facility ordered oxygen:
☒ Facility ordered oxygen
Liter flow:
1 L/Min
2 L/Min
3 L/Min
4 L/Min
Other
Other liter flow:
Via:
Bipap
Cpap
Cannula
Catheter
Mask
Other
Other delivery method:
Oxygen saturation %:
Ventilator dependent - chronic:
* Ventilator dependent - chronic comments

Respiratory Consult

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

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

Performing assessment

**RN Reassessment, 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.

The screenshot shows the 'RN Reassessment - ZMSHTSWLSHDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'RESPIRATORY ASSESSMENT' tab is active, and 'Resp Page 2' is selected in the bottom navigation bar. The 'Chest tubes' section contains two rows for 'Location 3' and 'Location 4'. For 'Location 3', the 'Suction' dropdown is set to 'Right Posterior', and the 'Date/Time inserted' is '12/08/11 16:12'. The 'Other chest tube locations' checkbox is checked. The 'Air Leak' section has several options: 'None', 'Slight bubbling on expiration', 'Large air leak on expiration', 'Air leak on inspiration/expiration', 'Intermittent air leak', and 'Crepitus present'. The 'Chest tube drainage' section has options: 'None', 'Small', 'Moderate', 'Large', 'Serous', 'Serosanguinous', and 'Bloody'. The 'Dressing' section has options: 'Clean, dry, intact', 'Drainage', and 'Other'. The bottom navigation bar includes tabs for 'Gen Inf', 'Educ', 'Pain', 'IV', 'Resp', 'Resp CV', 'Neuro', 'GI', 'GU', 'M/S', 'Skin', 'P/S', 'Rest', 'MH', 'Func', 'DP', 'PCE', 'View Text', and 'Resp CP'. A status bar at the bottom indicates 'Performing assessment'.

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

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

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

File Tabs Help

RESPIRATORY ASSESSMENT

Tracheostomy:

☒ Tracheostomy present * Other trach type:

* Type: ☒ Fenestrated ☐ Non-fenestrated ☐ Old stoma/no appliance ☐ Other

* Size known: ☐ Yes ☒ No * Tracheostomy size:

☐ Trach recently inserted * Insertion date/time:

Stoma appearance:

☒ No problems observed ☐ Redness ☐ Swelling ☐ Sutures ☐ Tissue breakdown present ☐ Other

* Other stoma appearance:

☐ Trach removed * Removed date/time:

Dressing:

☒ Clean, dry, intact ☐ No dressing/open to air ☐ Other

* Dressing type: * Other dressing type:

☐ Dressing change? * Dressing date/time change:

Tobacco screen:

☐ Lifetime non-tobacco user ☒ Former tobacco user, but now quit ☐ Current tobacco user ☐ Patient declines to answer

* Type of tobacco used:

Prior response:

* Quit time frame:

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

* Approximate quit date:

Tobacco education:

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

Instructions for former usage:

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

General Observations/Comments:

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

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

* Designates a required field Go to radiogroup: Tobacco screen Go

Performing assessment

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

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

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

File Tabs Help

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

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

Problem/Intervention detail

☐ Do not display resolved problems

Problem evaluation:

☐ No change/Stable

☐ Deteriorating

☐ Improving

☐ Resolved

☐ Unresolved at discharge

Intervention status:

☐ Completed

☐ Continue

☐ Discontinue

☐ Pending

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

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

* Designates a required field Go to radiogroup: Intervention status Go

Performing assessment

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

File Tabs Help

CARDIOVASCULAR ASSESSMENT

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

* Why could no one respond
☐ No

* Other reason no one could respond
☐ No

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

* Other source of information
☐ No

* Patient has a history of
☐ None reported
☐ Anemia
☐ Angina
☐ Anticoagulant Therapy
☐ Arrhythmias
☐ CABG
☐ CAD
☐ CHF
☐ DVT
☐ Hypertension
☐ MI
☐ Peripheral Vascular Disease
☐ Other

* Other history
☐ No

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

* Edema
☒ Yes ☐ No

Facial
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Periorbital
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Right arm
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Left arm
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Right hand
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Left hand
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Sacral
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Right hip
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Left hip
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Right leg
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Left leg
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Pedal right
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

Pedal left
☐ Trace
☐ 1+ Pitting
☐ 2+ Pitting
☐ 3+ Pitting
☐ 4+ Pitting
☐ N/A

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

Extremities comments

Prior comments

Prior response:

Auscultation
 * Heart Rate

* Heart rhythm
☐ Regular
☐ Irregular

* Heart sounds
☐ Normal
☐ Abnormal

* Describe abnormal sound

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

CV Page 1 CV Page 2 CV CP

* Designates a required field Go to radiogroup: Heart rhythm Go

Performing assessment

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

File Tabs Help

CARDIOVASCULAR ASSESSMENT

Pulses

Radial Pulse: Left Right

Dorsalis Pedis Pulse: Left Right

Posterior Tibial Pulse: Left Right

* Describe venous distention

Jugular Venous Distention: ☐ Yes ☒ No

Prior response:

* Homan's sign: ☒ Negative ☐ Positive

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

* Cardiac monitor: ☒ Yes ☐ No

Cardiac devices:

☐ External pacemaker ☐ Permanent pacemaker

☐ Implantable cardioverter/defibrillator (ICD) ☐ Other device

* Other cardiac device

Prior cardiac monitor response: * Other cardiac monitor rhythm:

T Wave:

PR Interval:

QT Interval:

QRS Duration:

ST Segment:

General observations/comments

CV Page 1 CV Page 2 CV CP

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

* Designates a required field Go to radiogroup: Jugular Venous Distention Go

Performing assessment

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

File Tabs Help

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

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

Problem/Intervention detail

☐ Do not display resolved problems

Problem evaluation:

☐ No change/Stable

☐ Deteriorating

☐ Improving

☐ Resolved

☐ Unresolved at discharge

Intervention status:

☐ Completed

☐ Continue

☐ Discontinue

☐ Pending

CV Page 1 CV Page 2 CV CP

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

* Designates a required field Go to radiogroup: Intervention status

Performing assessment

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

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

File Tabs Help

NEUROLOGICAL ASSESSMENT

Motor
Instructions for performing motor assessment
Assess motor strength bilaterally. Have the patient flex and extend arm against your hand, squeeze your fingers, lift leg while you press down on the thigh, hold leg straight and lift it against gravity, and flex and extend foot against your hand. Grade each extremity using the scale below:
5+ - Active movement of extremity against gravity and maximal resistance
4+ - Active movement of extremity against gravity and moderate resistance
3+ - Active movement of extremity against gravity but NOT against resistance
2+ - Active movement of extremity but NOT against gravity
1+ - Slight movement (flicker of contraction)
0 - No movement

Right arm	Left arm	Right leg	Left leg
<input type="radio"/> 5+	<input type="radio"/> 5+	<input type="radio"/> 5+	<input type="radio"/> 5+
<input type="radio"/> 4+	<input type="radio"/> 4+	<input type="radio"/> 4+	<input type="radio"/> 4+
<input type="radio"/> 3+	<input type="radio"/> 3+	<input type="radio"/> 3+	<input type="radio"/> 3+
<input type="radio"/> 2+	<input type="radio"/> 2+	<input type="radio"/> 2+	<input type="radio"/> 2+
<input type="radio"/> 1+	<input type="radio"/> 1+	<input type="radio"/> 1+	<input type="radio"/> 1+
<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> N/A	<input type="radio"/> N/A	<input type="radio"/> N/A	<input type="radio"/> N/A

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

Speech/language
☐ Clear
☐ Abnormal - Slurred
☐ Abnormal - Aphasic
☐ Abnormal - Dysarthric
☐ Other
Prior response:
* Other speech/language

Pupils
☒ New lens implant/prosthesis
Prior response:
* Describe new lens implant/prosthesis:

Size
☐ Equal
☐ Right greater than left
☒ Left greater than right
☐ Other
Prior response:

* Other pupil size

Reactivity
Right eye
☐ Brisk reaction to light
☒ Some reaction to light (sluggish)
☐ No reaction to light
Prior response:

Left eye
☐ Brisk reaction to light
☐ Some reaction to light (sluggish)
☒ No reaction to light
Prior response:

☐ Sensations - New paresthesias or neuropathies present
Prior response:

* New sensations present

☐ Requires assistive new communication device to meet basic needs
Prior response:

* New comm device needed

General observations/comments

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

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

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

Performing assessment

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

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

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

File Tabs Help

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

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

Problem/Intervention detail

☐ Do not display resolved problems

Problem evaluation:

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

Intervention status:

- ☐ Completed
- ☐ Continue
- ☐ Discontinue
- ☐ Pending

Neuro Page 1 | Neuro Page 2 | Neuro CP

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

* Designates a required field Go to radiogroup: Intervention status

Performing assessment

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

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

Gastrointestinal (GI)

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

The screenshot shows the 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'GASTROINTESTINAL ASSESSMENT' tab is active. The form includes sections for patient history, abdominal assessment, bowel sounds, and bowel regimen. The 'Abdominal Assessment' section shows 'Distended' and 'Flat' as options, with 'Flat' selected. The 'Bowel sounds' section shows 'Present' as the selected option. The 'Bowel regimen' section shows 'Daily' as the selected option. The 'GI Page 1' window is displayed at the bottom of the form.

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

GI Device #5

* Type
None

GI device comments

☐ New since last assessment.
Date/time

☐ Removed since last assessment.
Date/time

GI Device #6

* Type
None

GI device comments

☐ New since last assessment.
Date/time

☐ Removed since last assessment.
Date/time

GI Device #7

* Type
None

GI device comments

☐ New since last assessment.
Date/time

☐ Removed since last assessment.
Date/time

GI Device #8

* Type
None

GI device comments

☐ New since last assessment.
Date/time

☐ Removed since last assessment.
Date/time

* Designates a required field

Performing assessment

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Oral Screen:

Assessment - General

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

Assessment - Mucous Membrane

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

Nutrition screen:

* Description of patient

- ☐ Well nourished
- ☐ Obese
- ☐ Emaciated

* Appetite

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

* Other appetite

Prior response:

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

Weight: 185.35 lb [75.2 kg] (12/16/2009 14:30)

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

Dietary History:

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

☐ Yes ☐ No

* Food preferences/Special diet needs

Prior response:

* Does patient have any special diet needs?

☐ Yes ☐ No

Prior response:

Prior food preferences

* Unintentional weight loss or gain in the past month

☐ Yes ☐ No ☐ Unknown

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

Prior response:

Nutrition consult guidelines:

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

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

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

* Designates a required field

Go to radiogroup: religious food preferences

Go

Performing assessment

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

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

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Dysphagia screen

* Dysphagia screen

☐ Able to screen

☐ Unable - Patient on Ventilator

☐ Unable - Patient unconscious

☐ Unable - Other

☐ N/A

* Other reason unable to screen

Dysphagia risk factors

* Diagnosis of new stroke, head and neck cancer, or traumatic brain injury

* Modified texture diet/ eating maneuvers (e.g. chin tuck, head turn)

* Unable to follow commands

Prior response:

Wet gurgly voice

Prior response:

Drizzling while awake

Prior response:

* Tongue deviation from midline

[Speech Consult]

General Observations/Comments

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

* Designates a required field

Go to radiogroup: Dysphagia screen

Go

Performing assessment

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

File Tabs Help

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

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

Problem/Intervention detail

☐ Do not display resolved problems

Problem evaluation:

☐ No change/Stable

☐ Deteriorating

☐ Improving

☐ Resolved

☐ Unresolved at discharge

Intervention status:

☐ Completed

☐ Continue

☐ Discontinue

☐ Pending

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

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

* Designates a required field

Performing assessment

**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 - ZMSHTSWLSDHYS,JLUXA (3122) Ward: FILEROOM-X

File Tabs Help

GENITOURINARY ASSESSMENT

Genitourinary Devices

* Current Devices

☐ None

☐ Continuous Ambulatory Peritoneal Dialysis

☐ Continuous Bladder Irrigation

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

☐ External catheter (condom)

☐ Indwelling urinary catheter

☐ Nephrostomy bag

☐ Suprapubic catheter

☐ Ureterostomy bag

☐ Other

* Indwelling catheter size

* Other device

☐ Concerns voiced regarding sexual functioning

* Sexual Functioning concerns voiced

Prior response

☐ Indwelling removed

Female patients

* Pregnancy

☐ Pregnant

☐ Possibly pregnant

☐ No possibility of pregnancy

☐ Lactating

☐ Patient declines to answer

Last mammogram

☐ Known

☐ Unknown

☐ No previous exam reported

Approximate date

Last menses

☐ Known

☐ Unknown

☐ Post menopausal

Approximate date

Last PAP Smear

☐ Known

☐ Unknown

☐ No previous exam reported

Approximate date

Male patients

Approximate date

Last PSA Results

General observations/comments

GU Page 1 GU Dev GU Page 2 GU CP

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

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

Performing assessment

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

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

File Tabs Help

GENITOURINARY ASSESSMENT

Genitourinary Devices

* Current Devices

☐ None

☐ Continuous Ambulatory Peritoneal Dialysis

☐ Continuous Bladder Irrigation

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

☐ External catheter (condom)

☐ Indwelling urinary catheter

☐ Nephrostomy bag

☐ Suprapubic catheter

☐ Ureterostomy bag

☐ Other

* Indwelling catheter size

* Other device

☐ Concerns voiced regarding sexual functioning

* Sexual Functioning concerns voiced

Prior response

☐ Indwelling removed

Female patients

* Pregnancy

Approximate date

Approximate date

Approximate date

Male patients

Last prostate exam date

☐ Known

☐ Unknown

☐ No previous exam reported

Approximate date

Last PSA: - NONE FOUND

General observations/comments

GU Page 1 GU Dev GU Page 2 GU CP

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

Performing assessment

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

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

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

Indwelling Catheter

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

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

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

File Tabs Help

GENITOURINARY ASSESSMENT

Genitourinary Devices

* Current Devices

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

* Indwelling catheter size

Prior response

☐ Indwelling recently inserted

☐ Indwelling removed

* Other device

☐ Concerns voiced regarding sexual functioning

* Sexual Functioning concerns voiced

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

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

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

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

File Tabs Help

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

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

Problem/Intervention detail

☐ Do not display resolved problems

Add New Problem View history for this problem

Add New Intervention to this problem

Problem evaluation

☐ No change/Stable

☐ Deteriorating

☐ Improving

☐ Resolved

☐ Unresolved at discharge

Intervention status

☐ Completed

☐ Continue

☐ Discontinue

☐ Pending

OK

Cancel

Diabetes Nurse Consult

GU Page 1 GU Dev GU Page 2 GU CP

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

Performing assessment * Designates a required field

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

File Tabs Help

MUSCULOSKELETAL ASSESSMENT

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

* Why could no one respond:

* Other reason no one could respond:

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

* Other source of information:

* Patient has a history of: ☐ None reported ☐ Amputation(s) ☐ Arthritis ☐ Back pain ☐ Cancer ☐ Cerebral Palsy ☐ Deformity(ies) ☐ Fibromyalgia ☐ Fractures ☐ Hip pain ☐ Muscle Atrophy ☐ Muscular Dystrophy ☐ Neck pain ☐ Other

* Describe other history:

* Body part(s) amputated:

* Range of Motion: ☐ ROM - No apparent problem ☐ Limited ROM - Right Upper Extremity ☐ Limited ROM - Left Upper Extremity ☐ Limited ROM - Right Lower Extremity ☐ Limited ROM - Left Lower Extremity

Stated patient complaints:

General observations/comments:

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

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

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

Performing assessment

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

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.

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

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

File Tabs Help

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

* Fall risk assessment indicated
☐ Yes ☒ No

* History of falling Describe previous falls and history

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

* Is patient on multiple meds to

Total Morse score for Fall Risk: N/A

Prior score: Not assessed
 Date:

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

Instructions for completing Morse Fall Scale

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

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

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

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

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

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

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

* Designates a required field Go to radiogroup: Fall risk assessment indicated Go

Performing assessment

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

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

File Tabs Help

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

* Fall risk assessment indicated
☒ Yes ☐ No

* History of falling within 3 months
☐ No (0) ☐ Yes (25)

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

* Secondary Diagnosis
☐ No (0) ☐ Yes (15)

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

* Intravenous Therapy/Heparin Lock
☐ No (0) ☐ Yes (20)

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

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

Total Morse score for Fall Risk: 0

Prior score: Not assessed
 Date:

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

Instructions for completing Morse Fall Scale

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

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

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

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

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

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

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

* Designates a required field Go to radiogroup: Fall risk assessment indicated Go

Performing assessment

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

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

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

File Tabs Help

MUSCULOSKELETAL - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES

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

Universal fall precautions. Institute on all patients

Patient Education Precautions

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

Environment of Care Precautions

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

Other fall prevention interventions based upon clinical judgement

Morse scores

No Morse scores on file

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

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

☐ Do not display resolved problems

Add New Problem View history for this problem

Problem/Intervention detail

Add New Intervention to this problem

Problem evaluation:

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

Intervention status:

- ☐ Completed
- ☐ Continue
- ☐ Discontinue
- ☐ Pending

OK Cancel

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

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

* Designates a required field Go to radiogroup: Problem evaluation Go

Performing assessment

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

- Update M/S CP, if necessary.

Refer to the instructions in *Working in a Care Plan* on page 12.

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

Skin (Skin)

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

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

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

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

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

File Tabs Help

SKIN ASSESSMENT

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

* Why could no one respond:

* Other reason no one could respond:

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

* Other source of information:

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

* Describe other:

Predisposition for skin breakdown

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

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

* Describe other:

Skin Inspection

* Skin Temperature: ☐ Warm ☐ Hot ☐ Cool ☐ Cold

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

* Describe other:

* Skin Turgor: ☐ Within Normal Limits ☐ Abnormal

* Skin Patches: ☐ Yes ☐ No

* Skin Patch Description:

General observations/comments:

☐ Pressure ulcers ☐ Skin alterations

Performing assessment

* Designates a required field

Go to radiogroup: Skin Patches

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

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

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.

The screenshot shows the 'RN Reassessment - ZMSHTSWLSHDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'SKIN ASSESSMENT' section is active, with 'Pressure ulcers' selected. The 'Skin Pr Ul 1' tab is highlighted in the tab bar. The interface includes a 'Go' button and a 'Performing assessment' status indicator.

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.

The screenshot shows the 'RN Reassessment - ZMSHTSWLSHDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'SKIN ASSESSMENT' section is active, and the 'Skin Pr Ul 1' tab is selected. The window displays six sections for documenting pressure ulcers, each with fields for Location, Stage, Status, and Description of ulcer/dressing. The 'Location' field is set to 'None' for all ulcers. The 'Status' field is also set to 'None' for all ulcers. The 'Description of ulcer/dressing' field is empty for all ulcers. The 'Skin Pr Ul 1' tab is highlighted in the tab bar. The interface includes a 'Go' button and a 'Performing assessment' status indicator.

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

Pressure Ulcer Drop-downs

Skin Assessment - Pressure Ulcer/Location

Skin Assessment - Pressure Ulcer/Stage

Skin Assessment - Pressure Ulcer/Status

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

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

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

File Tabs Help

OTHER PRESSURE ULCERS

Pressure Ulcer #7	Pressure Ulcer #8
* Location None	* Location None
* Stage None	* Stage None
Status None	Status None
Description of ulcer/dressing	Description of ulcer/dressing

Pressure Ulcer #9	Pressure Ulcer #10
* Location None	* Location None
* Stage None	* Stage None
Status None	Status None
Description of ulcer/dressing	Description of ulcer/dressing

Pressure Ulcer #11	Pressure Ulcer #12
* Location None	* Location None
* Stage None	* Stage None
Status None	Status None
Description of ulcer/dressing	Description of ulcer/dressing

Skin Page 1 | Skin Pr Ul 1 | **Skin Pr Ul 2** | Skin Alt 1 | Skin Alt 2 | Skin Page 3 | Skin CP

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

* Designates a required field

Performing assessment

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.

The screenshot shows the 'RN Reassessment' application window. At the top, there are checkboxes for 'Pressure ulcers' (unchecked) and 'Skin alterations' (checked). Below this is a tabbed interface with tabs for 'Skin Page 1', 'Skin Pr UI 1', 'Skin Pr UI 2', 'Skin Alt 1', 'Skin Alt 2', 'Skin Page 3', and 'Skin CP'. The 'Skin Page 1' tab is currently selected. Below the tabs is a horizontal menu with various system tabs: Gen Int, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. The 'Skin' tab is selected. At the bottom, there is a status bar that says 'Performing assessment' and a note '* Designates a required field'. There is also a 'Go to radiogroup: Skin Patches' dropdown and a 'Go' button.

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

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

The screenshot shows the 'RN Reassessment - BDYDXY, ILQDI A (2902) Ward: PHX-ADMISSION SCHEDULED' window. The 'SKIN ASSESSMENT' tab is active. It displays six skin alteration entry fields, labeled 'Skin Alteration #1' through 'Skin Alteration #6'. Each field contains a dropdown menu for 'Type' (set to 'None'), a dropdown menu for 'Location' (set to 'None'), a text input for 'Size', and a checkbox for 'Healed'. Below the entry fields is a horizontal menu with tabs for 'Skin Page 1', 'Skin Pr UI 1', 'Skin Pr UI 2', 'Skin Alt 1', 'Skin Alt 2', 'Skin Page 3', and 'Skin CP'. The 'Skin Alt 1' tab is currently selected. Below the tabs is a horizontal menu with various system tabs: Gen Int, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. The 'Skin' tab is selected. At the bottom, there is a status bar that says 'Performing assessment' and a note '* Designates a required field'.

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

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

Skin Alteration Drop-downs

* Type

Abrasion

Abrasion

Bite

Bruising

Burn

Crush Injury

Hematoma

Laceration

Penetrating Wound

Description of skin alteration

☐ Healed

Skin Assessment – Skin Alteration/Type

* Type

Abrasion

* Location

Abdomen - Right

Abdomen - Right

Abdomen - Left

Ankle - Right

Ankle - Left

Arm - Right, upper

Arm - Right, lower

Arm - Left, upper

Arm - Left, lower

Description of skin alteration

☐ Healed

Description of skin alteration

Skin Assessment – Skin Alteration/Location

* Type

Abrasion

* Location

Abdomen - Right

* Size

1 cm

Description of skin alteration

☐ Healed

Skin Assessment – Skin Alteration/Size

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

The screenshot shows a software window titled "RN Reassessment - ZMSHTSWLSHDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The window has a menu bar with "File", "Tabs", and "Help". The main area is titled "SKIN ASSESSMENT" and contains six identical forms for "Skin Alteration #7" through "Skin Alteration #12". Each form has the following fields:

- * Type: A dropdown menu with "None" selected.
- Description of skin alteration: A text field.
- * Location: A dropdown menu with "None" selected.
- * Size: A text field.
- Healed: A checkbox.

At the bottom of the window, there is a navigation bar with tabs for "Skin 1", "Skin Pr UI 1", "Skin Pr UI 2", "Skin Alt 1", "Skin Alt 2", "Skin Page 3", and "Skin CP". The "Skin Alt 2" tab is currently selected. Below the tabs, there is a row of buttons: "Gen Int", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "Skin" button is highlighted. At the very bottom, there is a status bar that says "Performing assessment" and a note "* Designates a required field".

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

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

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

File Tabs Help

SKIN ASSESSMENT **BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK**

* Skin assessment indicated
☐ Yes ☐ No

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

SENSORY SCORE:
☐ 1
☐ 2
☐ 3
☐ 4

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

MOISTURE SCORE:
☐ 1
☐ 2
☐ 3
☐ 4

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

ACTIVITY SCORE:
☐ 1
☐ 2
☐ 3
☐ 4

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

MOBILITY SCORE:
☐ 1
☐ 2
☐ 3
☐ 4

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

NUTRITION SCORE:
☐ 1
☐ 2
☐ 3
☐ 4

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

FRICTION SCORE:
☐ 1
☐ 2
☐ 3

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

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

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

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

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

Performing assessment

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

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

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

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

File Tabs Help

SKIN ASSESSMENT **BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK**

* Skin assessment indicated
☒ Yes ☐ No

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

Sensory Score:
☐ 1
☐ 2
☐ 3
☐ 4

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

Moisture Score:
☐ 1
☐ 2
☐ 3
☐ 4

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

Activity Score:
☐ 1
☐ 2
☐ 3
☐ 4

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

Mobility Score:
☐ 1
☐ 2
☐ 3
☐ 4

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

Nutrition Score:
☐ 1
☐ 2
☐ 3
☐ 4

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

Friction Score:
☐ 1
☐ 2
☐ 3

Total Score: 0
 Prior score: Not assessed
 Date:

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

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

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

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

Performing assessment

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

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

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

File Tabs Help

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

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

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

* Patient/caregiver education provided ☐ Yes ☐ No

* Education provided to * Other education provided to

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

Problem/Intervention detail

☐ Do not display resolved problems

Add New Problem View history for this problem

Add New Intervention to this problem

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

Intervention status ☐ Completed ☐ Continue ☐ Discontinue ☐ Pending

OK Cancel

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

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

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

Performing assessment

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

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.

The screenshot shows the 'RN Reassessment' application window for patient ZMSHTSWLSDHYS,CHUUN (1110) in the PHX-ADMISSION SCHEDULED ward. The 'PSYCHOSOCIAL ASSESSMENT' tab is active, displaying 'P/S Page 1'. The form includes several sections with radio button options and checkboxes:

- Patient/family/support person able to respond to questions:** Yes (selected), No.
- Why could no one respond?** (blank), **Other reason no one could respond?** (blank), **Other source of information:** (blank).
- Information obtained from:** Patient (checked), Authorized surrogate, Family/Support Person, Medical Record, Other.
- Patient has a history of:** None reported, Alcoholism, History of/ or treatment for mental health problems, History of depression, Other.
- Attitude:** Cooperative, Uncooperative, Other.
- Behavior:** Controlled, Uncontrolled, Other.
- Suspected Abuse/Neglect Screen:** Does patient report any of the following?
 - Verbal abuse:** Yes, No, Declines to answer.
 - Physical abuse:** Yes, No, Declines to answer.
 - Financial abuse:** Yes, No, Declines to answer.
 - Rape or sexual abuse:** Yes, No, Declines to answer.
 - Neglect:** Yes, No, Declines to answer.
- Based upon nursing assessment, is any of the following suspected?:** Verbal abuse, Physical abuse, Neglect (each with Yes, No, Declines to answer options).
- Based on nursing assessment, are others in the household possible victims of abuse or neglect by the patient?:** Yes, No, Unknown.

At the bottom, there is a 'Social Work Consult' button and a 'Performing assessment' status bar. Navigation tabs at the bottom include Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S (selected), Rest, MH, Func, DP, PCE, and View Text. A 'Go to radiogroup:' dropdown is set to 'Attitude'.

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

Suicide Risk Screen

Ask Patient

* Have you recently had thoughts about harming yourself?

☒ Yes
☐ No
☐ Declines to answer

Prior response:

* Have you rehearsed or practiced how to kill yourself?

☐ Yes
☒ No
☐ Declines to answer

Prior response:

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

☒ Yes
☐ No
☐ Declines to answer

Prior response:

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

☐ Yes
☒ No
☐ Declines to answer

Prior response:

* Describe plan

Prior plan:

* Describe means

Are there means available?

Prior response:

Prior means:

*** Notify provider ***
*** Keep patient under close observation ***

Comments relative to suicide

P/S Page 1 P/S Page 2 P/S Page 3 **OWA** P/S Page 4 P/S CP

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

* Designates a required field Go to radiogroup: harming yourself Go

Performing assessment

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

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

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

* Patient has a court-appointed legal guardian

☐ Yes ☒ No

Prior response:

* Specify guardian

* Patient has been legally committed

☐ Yes ☒ No

Prior response:

* Patient guardian response

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

☐ Yes ☒ No ☐ Unknown

Prior response:

* Patient has history of escape or elopement

☐ Yes ☒ No ☐ Unknown

Prior response:

* Patient is on legal observation status for Gravely Disabled

☐ Yes ☒ No

Prior response:

Date from where known

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

☐ Yes ☒ No

Prior response:

Prior escape/elopement response

[Social Work Consult](#)

Chemical Dependency Issues

* Alcohol use

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

Prior response:

* Date of last alcohol use

* Amount of last alcohol use

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

☐ Yes
☒ No
☐ Patient declines to answer

Prior response:

If Yes to use of recreational drugs, notify provider

* Date of last drug use

* Amount of last drug use

* Does patient have a medical marijuana card

☐ Yes ☒ No

Prior response:

Make Alcohol Treatment referral if patient is interested.

Contraband

* Contraband brought (in to/by) the patient

☐ Yes
☒ No

Prior response:

* Describe contraband

* Location of unremoved contraband

[Follow facility policy for contraband removal](#)

P/S Page 1 P/S Page 2 P/S Page 3 **OWA** P/S Page 4 P/S CP

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

* Designates a required field Go to radiogroup: appointed legal guardian Go

Saving data

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

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

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

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

Prior response: * Specify guardian:

Prior response: * Patient has history of escape or elopement: ☐ Yes ☒ No ☐ Unknown

Prior response: Date/From where if known:

Prior response: Prior escape/elopement response:

Social Work Consult

Will Send

Social work consult mandatory

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.

Chemical Dependency Issues:

Alcohol use:

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

* Date of last alcohol use:

* Amount of last alcohol use:

Prior response: Patient declines to answer any questions about alcohol use

* Type of recreational drugs used:

Does patient use recreational drugs:

* Date of last drug use:

* Amount of last drug use:

Prior response: No

If Yes to use of recreational drugs, notify provider

Does patient have a medical marijuana card: ☒ Yes ☐ No

Prior response: No

☒ Possibility of alcohol withdrawal

Notify provider

Make Alcohol Treatment referral if patient is interested.

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

File Tabs Help

Ask patient or observe

CIWA

***NAUSEA AND VOMITING:** "Feel sick to your stomach? Have you vomited?"

0 - No nausea and no vomiting
1 - Mild nausea with no vomiting
2 - Moderate nausea with no vomiting
3 - Moderate nausea with dry heaves
4 - Intermittent nausea with dry heaves
5 - Intermittent nausea with vomiting
6 - Intermittent nausea with vomiting
7 - Constant nausea, frequent dry heaves and vomiting

***TREMOR:** Arms extended and fingers spread apart

0 - No tremors
1 - Not visible, but can be felt fingertip to fingertip
2 - Moderate, with patient's arms extended
3 - Moderate, with patient's arms extended
4 - Moderate, with patient's arms extended
5 - Moderate, with patient's arms extended
6 - Moderate, with patient's arms extended
7 - Severe, even with arms not extended

***PARDOXYSMAL SWEATS**

0 - No sweat visible
1 - Barely visible sweating, palms moist
2 - Barely visible sweating, palms moist
3 - Barely visible sweating, palms moist
4 - Beads of sweat obvious on forehead
5 - Beads of sweat obvious on forehead
6 - Beads of sweat obvious on forehead
7 - Drenching sweats

***ANXIETY:** "Do you feel nervous?"

0 - No anxiety, at ease
1 - Mildly anxious
2 - Mildly anxious
3 - Mildly anxious
4 - Moderately anxious or guarded so anxiety is inferred
5 - Moderately anxious or guarded so anxiety is inferred
6 - Moderately anxious or guarded so anxiety is inferred
7 - Equivalent to acute panic states as in severe delirium/acute schizophrenia

***AGITATION**

0 - Normal activity
1 - Somewhat more than normal activity
2 - Somewhat more than normal activity
3 - Somewhat more than normal activity
4 - Moderately fidgety and restless
5 - Moderately fidgety and restless
6 - Moderately fidgety and restless
7 - Paces back and forth during most of the interview or

***TACTILE DISTURBANCES:** "Have you any itching, pins/needles, any burning, any numbness or feel bugs crawling on or under skin?"

0 - None
1 - Very mild itching, pins, needles, burning, numbness
2 - Mild itching, pins, needles, burning, numbness
3 - Moderate itching, pins, needles, burning, numbness
4 - Moderately severe hallucinations
5 - Severe hallucinations
6 - Extremely severe hallucinations
7 - Continuous hallucinations

***AUDITORY DISTURBANCES:** "Are you aware of sounds around you? Are they harsh or do they frighten you? Do you hear things that are disturbing to you or that you know are not there?"

0 - Not present
1 - Very mild harshness or ability to frighten
2 - Mild harshness or ability to frighten
3 - Moderate harshness or ability to frighten
4 - Moderately severe hallucinations
5 - Severe hallucinations
6 - Extremely severe hallucinations
7 - Continuous hallucinations

***HEADACHE:** "Does your head feel different? Does it feel like there's a band around your head?"

0 - Not present
1 - Very mild
2 - Mild
3 - Moderate
4 - Moderately severe
5 - Severe
6 - Very severe
7 - Extremely severe

***VISUAL DISTURBANCES:** "Does the light appear too bright? Is its color different? Does it hurt your eyes? Do you see things that are disturbing to you or that you know are not there?"

0 - Not present
1 - Very mild sensitivity
2 - Mild sensitivity
3 - Moderate sensitivity
4 - Moderately severe hallucinations
5 - Severe hallucinations
6 - Very severe hallucinations
7 - Extremely severe hallucinations

***ORIENTATION AND CLOUDING OF SENSORIUM:** "What day is this? Where are you? Who am I?"

0 - Oriented and can do serial additions
1 - Cannot do serial additions and is uncertain about the date
2 - Disoriented by date by no more than 2 calendar days
3 - Disoriented by date by more than 2 calendar days
4 - Disoriented for place and/or person

CIWA Score: 0

CIWA score interpretations
8 or Less= Minimal to mild withdrawal
9-15= Moderate withdrawal
16 or greater= Severe withdrawal

P/S Page 1 P/S Page 2 P/S Page 3 CIWA P/S Page 4 P/S CP

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

* Designates a required field

Go to radiogroup: "Feel sick to your stomach? Hav" Go

Performing assessment

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

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

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

File Tabs Help

PSYCHOSOCIALASSESSMENT

General observations/comments

P/S Page 1 P/S Page 2 P/S Page 3 CIWA P/S Page 4 P/S CP

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

* Designates a required field

Performing assessment

RN Reassessment, Psychosocial Assessment (P/S) tab, P/S Page 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 - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

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

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

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

Add New Intervention to this problem

Problem/Intervention detail

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

Intervention status
☐ Completed
☐ Continue
☐ Discontinue
☐ Pending

OK Cancel

P/S Page 1 P/S Page 2 P/S Page 3 QWA P/S Page 4 P/S CP

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

* Designates a required field Go to radiogroup: Intervention status Go

Performing assessment

**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

The screenshot shows a software window titled "RN Reassessment - VHLSE, JELUAHT ALRUHYJH (5326) Ward: 4CT". The window has a menu bar with "File", "Tabs", and "Help". The main area is titled "RESTRAINTS".

There is a checkbox labeled "Restraints Initiated/maintained". To its right is a section for "Date/time initiated" with radio buttons for "Known" and "Unknown", and a text field for "Initiated date/time".

Below this is a section for "Reason for restraint" with two radio buttons: "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" and "Patient's behavior is aggressive or violent presenting an immediate serious danger to his/her safety or that of others."

There are several text fields for justification and behavioral expectations, each with an asterisk indicating a required field. These include: "Justification for restraints", "Other justification", "Justification for restraints", "Other justification", "Behavioral expectations for termination of restraints", and "Other behavioral expectation".

At the bottom of the main area, there are fields for "Restrict Type", "Other Restrict", "Interventions tried to avoid restraint use", and "Other intervention".

At the bottom right of the main area, there is a text field for "Discontinued date/time".

At the bottom of the window, there is a tab bar with buttons for "Gen Int", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "Rest" button is highlighted. To the right of the tab bar are buttons for "Restr Page 1" and "Restr CP".

At the very bottom of the window, there is a status bar that says "Performing assessment" and a note "* Designates a required field".

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

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

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

File Tabs Help

RESTRAINTS

☒ Restraints Initiated/maintained

Date/time initiated: ☐ Known ☐ Unknown

Initiated date/time: _____

Reason for restraint

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

☐ Patient's behavior is aggressive or violent presenting an immediate serious danger to his/her safety or that of others.

* Justification for restraints: _____

* Other justification: _____

* Justification for restraints: _____

* Other justification: _____

Behavioral expectations for termination of restraints

☐ Follows simple directions

☐ Does not pull at lines/tubes

☐ Contracts for safety

☐ Denies homicidal ideation

☐ Denies self harm

☐ Denies suicidal ideation

☐ Displays no aggression to self/others

☐ Other: _____

* Other behavioral expectation: _____

*** Restraint Type**

☐ Ankle, Right, Locked

☐ Ankle, Right, Unlocked

☐ Ankle, Left, Locked

☐ Ankle, Left, Unlocked

☐ Blanket/Net

☐ Hand Mitt, Right

☐ Hand Mitt, Left

☐ Vest, Locked

☐ Vest, Unlocked

☐ Waist, Locked

☐ Waist, Unlocked

☐ Wrist, Right, Locked

☐ Wrist, Right, Unlocked

☐ Wrist, Left, Locked

☐ Wrist, Left, Unlocked

☐ Soft

☐ Leather/plastic/rubber

☐ Other: _____

* Other Restraint: _____

Interventions tried to avoid restraint use

☐ Bed alarm

☐ Camouflage lines/tubes

☐ Diversional activities

☐ Family at bedside

☐ Hourly rounding

☐ Laptop tray

☐ Low bed with mats

☐ Move closer to nurse's station

☐ Pain relief medicine

☐ Patient/family education

☐ Reality orientation

☐ Repositioning of lines/tubes

☐ Side rails, 3 or less

☐ Sitters

☐ Wedge cushion

☐ Other: _____

* Other intervention: _____

☐ Discontinued - desired outcome achieved

Discontinued date/time: _____

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

Restr Page 1 | Restr CP

* Designates a required field

Performing assessment

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

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

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

File Tabs Help

RESTRAINTS *** Notify provider ***

☒ Restraints Initiated/maintained * Date/time initiated
☐ Known Initiated date/time
☐ Unknown

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

* Justification for restraints * Other justification * Justification for restraints * Other justification Behavioral expectations for termination of restraints * Other behavioral expectation

☐ Pulling at tubes
☐ Promote medical healing
☐ Unable to follow commands
☐ Other

☐ Follows simple directions
☐ Does not pull at lines/tubes
☐ Contracts for safety
☐ Denies homicidal ideation
☐ Denies self harm
☐ Denies suicidal ideation
☐ Displays no aggression to self/others
☐ Other

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

☐ Ankle, Right, Locked
☐ Ankle, Right, Unlocked
☐ Ankle, Left, Locked
☐ Ankle, Left, Unlocked
☐ Blanket/Net
☐ Hand Mitt, Right
☐ Hand Mitt, Left
☐ Vest, Locked
☐ Vest, Unlocked
☐ Waist, Locked
☐ Waist, Unlocked
☐ Wrist, Right, Locked
☐ Wrist, Right, Unlocked
☐ Wrist, Left, Locked
☐ Wrist, Left, Unlocked
☐ Soft
☐ Leather/plastic/rubber
☐ Other

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

☐ Discontinued - desired outcome achieved
Discontinued date/time

Restr Page 1 Restr CP

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

* Designates a required field

Saving data

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

File Tabs Help

RESTRAINTS *** Notify provider ***

☒ Restraints Initiated/maintained * Date/time initiated
☐ Known Initiated date/time:
☐ Unknown

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

* Justification for restraints * Other justification * Justification for restraints * Other justification Behavioral expectations for termination of restraints * Other behavioral expectation

☐ Pulling at tubes
☐ Promote medical healing
☐ Unable to follow commands
☐ Other

☐ Follows simple directions
☐ Does not pull at lines/tubes
☐ Contracts for safety
☐ Denies homicidal ideation
☐ Denies self harm
☐ Denies suicidal ideation
☐ Displays no aggression to self/others
☐ Other

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

☐ Ankle, Right, Locked
☐ Ankle, Right, Unlocked
☐ Ankle, Left, Locked
☐ Ankle, Left, Unlocked
☐ Blanket/Net
☐ Hand Mitt, Right
☐ Hand Mitt, Left
☐ Vest, Locked
☐ Vest, Unlocked
☐ Waist, Locked
☐ Waist, Unlocked
☐ Wrist, Right, Locked
☐ Wrist, Right, Unlocked
☐ Wrist, Left, Locked
☐ Wrist, Left, Unlocked
☐ Soft
☐ Leather/plastic/rubber
☐ Other

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

☐ Discontinued - desired outcome achieved
Discontinued date/time:

Restr Page 1 Restr CP

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

Saving data * Designates a required field

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.
- Select a **Reason for restraint**.
 - 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 - ZMSHTSWLSHDHYS, JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED

File Tabs Help

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

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

☐ Do not display resolved problems

Add New Problem View history for this problem

Add New Intervention to this problem

Problem/intervention detail

Problem evaluation:

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

Intervention status:

- ☐ Completed
- ☐ Continue
- ☐ Discontinue
- ☐ Pending

OK Cancel

Restr Page 1 Restr CP

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

* Designates a required field Go to radiogroup: Problem evaluation Go

Performing assessment

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

File Tabs Help

MENTAL HEALTH ASSESSMENT

* Mood * Other mood

☐ Anxious
☒ Depressed
☐ Euphoric
☐ Irritable
☐ Labile
☐ Rapid mood swings
☐ Other

* Affect * Other affect

☒ Euphoric
☐ Flat
☐ Sad
☐ Other

* Behavior * Other behavior

☐ Aggressive
☒ Calm
☐ Hostile
☐ Inappropriate
☐ Intimidates others
☐ Restless
☐ Slaming doors
☐ Staff splitting
☐ Suspicious
☐ Use of profanity
☐ Yelling/shouting
☐ Other

Restraints/Behavioral Health Advance Directives

* Ask patient: "If you are placed in restraints, do you want us to notify someone?"

☐ Yes
☒ No
☐ Patient declines to answer
☐ Patient unable to answer

* Behavioral Health Advance Directives

☐ Behavioral Health Advance Directive copy on chart
☐ Behavioral Health Advance Directive copy not available
☐ Declined Behavioral Health Advance Directives
☐ Requested to given information on Behavioral Health Advance Directive
☒ Requested to given information on Behavioral Health Advance Directive

General observations/comments

MH Page 1 MH Page 2 MH CP

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

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

Performing assessment

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

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

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

File Tabs Help

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

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

Problem/Intervention detail

☐ Do not display resolved problems

Problem evaluation:

☐ No change/Stable

☐ Deteriorating

☐ Improving

☐ Resolved

☐ Unresolved at discharge

Intervention status:

☐ Completed

☐ Continue

☐ Discontinue

☐ Pending

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

MH Page 1 MH Page 2 MH CP

* Designates a required field Go to radiogroup: Intervention status Go

Saving data

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

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

Functional (Func)

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

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

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

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

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

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

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

File Tabs Help

FUNCTIONAL ASSESSMENT

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

* Patient's level of assistance
☒ Independent
☐ Partial Assist
☐ Dependent
 Prior response:

Assessment criteria and care plan for safe patient handling and movement
 An assessment should be made prior to each task if the patient has varying levels of ability to assist due to medical reasons, fatigue, medications, etc. When in doubt, assume the patient cannot assist with the transfer/repositioning.
 Height: 54 in (137.2 cm) (06/23/2009 10:43)
 Weight: 165.35 lb (75.2 kg) (12/16/2009 14:30)
 BMI: DEC 16, 2009@14:30:21

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

* Level of cooperation and comprehension
☒ Cooperative
☐ Unpredictable or varies
 Prior response:

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

General observations/comments

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

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

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

Performing assessment

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

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

FUNCTIONAL ASSESSMENT

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

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

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

Height: 54 in [137.2 cm] (06/23/2009 10:43)
 Weight: 165.35 lb [75.2 kg] (12/16/2009 14:30)
 BMI: DEC 16, 2009@14:30:21

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

* Level of cooperation and comprehension:
☐ Cooperative
☒ Unpredictable or varies

* Weight bearing capability:
☐ Full
☐ Partial
☐ None

* Bi-Lateral upper extremity strength:
☐ Yes
☐ No

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

Transfer/repositioning techniques comments

General observations/comments

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

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

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

Performing assessment

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

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

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

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

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

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

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

File Tabs Help

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

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

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

Add New Intervention to this problem

Problem evaluation:

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

Intervention status:

- ☐ Completed
- ☐ Continue
- ☐ Discontinue
- ☐ Pending

OK Cancel

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

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

* Designates a required field

Performing assessment

**RN Reassessment, 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.

The screenshot shows the 'RN Reassessment - ZMSHTSWLSHDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'DISCHARGE PLANNING' tab is active. The form contains several sections with radio buttons and checkboxes for data entry. The 'Does patient have a legal/medical guardian (conservator)?' section is highlighted in yellow, with 'Yes' selected. The 'Home environment' section is also highlighted in yellow. The 'General observations/comments' section is a large text area at the bottom right. The bottom of the window features a navigation bar with tabs for various assessment areas: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, ClWA, P/S, Rest, MH, Func, DP, PCE, and View Text. The 'DP' tab is currently selected. Below the navigation bar, there is a 'Performing assessment' section with a dropdown menu for 'Employment Status' and a 'Go' button.

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

File Tabs Help

DISCHARGE PLANNING - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES

* Problems, interventions, and desired outcomes identified in previous tabs have been discussed with the patient and/or family/support person and concurrence obtained. ☐ Yes ☐ No

* Why hasn't plan of care been discussed

Anticipated Discharge Plan Goals * Family/support person in discharge planning

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

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

Discharge Planning Consult Social Work Consult

Will Send

Telehealth Consult Home Care Consult

DP Page 1 DP CP

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

* Designates a required field Go to radiogroup: with the patient and/or family/sup Go

Performing assessment

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.

The screenshot shows the 'RN Reassessment' window for patient ZMSHTSWLSDHYS, CHUUN (1110) in Ward PHX-ADMISSION SCHEDULED. The 'Discharge Planning - Problems/Interventions/Desired Outcomes (DP)' tab is active. The form includes a section for 'Anticipated Discharge Plan Goals' with a list of checkboxes. The checkbox 'Patient requires transportation assistance **' is selected. A red banner at the bottom of the list states 'CONSULT REQUIRED'. To the right of the list are buttons for 'Discharge Planning Consult', 'Social Work Consult', 'Telehealth Consult', and 'Home Care Consult'. The 'Social Work Consult' button is highlighted with a red 'Will Send' label. At the bottom of the window, there is a navigation bar with tabs for various medical specialties (Gen Int, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, ClWA, P/S, Rest, MH, Func, DP, PCE, View Text) and a 'Go' button.

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

PCE Data (PCE)

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

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

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

The screenshot shows a software window titled "PCE DATA". It contains several sections:

- Inpatient Nursing PCE Information:** A list of topics including Advanced Directives Education, Basic Health Practices And Safety, Inpt Plan of Care Tx & Services, Nutr Intervention, Diet, and Oral Health, and Pain Education. A "Resolve" button is next to this list.
- Test (will be added to note):** A large empty text area for notes.
- Reminders Due (Display Only):** A table with two columns: "Reminders Due (Display Only)" and "Due Date".
- Buttons:** "Clinical Maintenance" and "Reminder Inquiry" are located to the right of the reminders table.
- Footer:** The word "Results" is at the bottom left.

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

RN Reassessment, PCE Data (PCE) tab

Reminders Due (Display Only)

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

Clinical Maintenance

1. Select a clinical reminder in the **Reminders Due** list box.
2. Click **Clinical Maintenance**.

Information displays in the **Maintenance Results** list box indicating when the reminder is due or was last done.

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

- PCE DATA:** Contains a list of 'Inpatient Nursing PCE Information' items: Advanced Directives Education, Basic Health Practices And Safety, Inpt Plan of Care Tx & Services, Nutr Intervention, Diet, and Oral Health, and Pain Education. A 'Resolve' button is located to the right of this list.
- Reminders Due (Display Only):** A table showing upcoming reminders.
- Maintenance Results:** A section for viewing the status and history of maintenance tasks.

Reminders Due (Display Only)	Due Date
CHF Weight Education	07/24/10
Diabetic Foot Exam Complete	10/09/10
Hemoglobin A1C	11/24/09
Influenza Vaccine	11/18/09
Microalbuminuria	02/21/09
PPD	08/01/10
Skin Integrity Screen OPT	DUE NOW

Buttons for 'Clinical Maintenance' and 'Reminder Inquiry' are located to the right of the reminders table.

Maintenance Results:

-STATUS- -DUE DATE- -LAST DONE-
DUE NOW 7/24/2010 7/24/2009
Frequency: Due every 1 year for all ages.
Cohort:

Clinical Maintenance

Reminder Inquiry

Click **Reminder Inquiry**.

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

The screenshot shows a software window titled "PCE DATA". It contains several sections:

- Inpatient Nursing PCE Information:** A list box containing: Advanced Directives Education, Basic Health Practices And Safety, Inpt Plan of Care Tx & Services, Nutr Intervention, Diet, and Oral Health, and Pain Education. A "Resolve" button is to its right.
- Reminders Due (Display Only):** A table with two columns: "Reminders Due (Display Only)" and "Due Date".

Reminders Due (Display Only)	Due Date
CHF Weight Education	07/24/10
Diabetic Foot Exam Complete	10/09/10
Hemoglobin A1C	11/24/09
Influenza Vaccine	11/18/05
Microalbuminuria	02/21/09
PPD	08/01/10
Skin Integrity Screen OPT	DUE NOW
- Topic def: CHF WEIGHT EDUCATION:** A section with two buttons: "Clinical Maintenance" and "Reminder Inquiry".
- Inquiry Results:** A list box showing "CHF WEIGHT EDUCATION" with "No. 55" to its right. Below it is a "Print Name:" label followed by "CHF Weight Education".
- Text (will be added to note):** An empty text area on the right side of the window.

Reminder Inquiry

Resolve Inpatient Nursing Clinical Reminders

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

The screenshot shows a window titled "PCE DATA". On the left, there is a list box labeled "Inpatient Nursing PCE Information" containing the following items: Advanced Directives Education, Basic Health Practices And Safety, Inpt Plan of Care Tx & Services, Nutr Intervention, Diet, and Oral Health, and Pain Education. To the right of this list box is a "Resolve" button. Further to the right is a text area labeled "Text (will be added to note)".

Resolve Inpatient Nursing Clinical Reminders

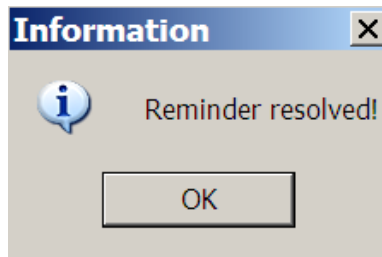
2. Click **Resolve**.
The Resolve Reminder Pain Risk, Mgmt, and Assessment window displays with items appropriate for the selected item.

The screenshot shows a window titled "Resolve Reminder Pain Risk, Mgmt, and Assessment". It contains two sections with radio button options. The first section, "Received?", has three options: "Patient had Pain Risk, Mgmt, and Assessment at this encounter", "Patient declined Pain Risk, Mgmt, and Assessment at this encounter", and "Pain Risk, Mgmt, and Assessment not applicable". The second section, "Level of Understanding", has five options: "Poor", "Fair", "Good", "Group - No Assessment", and "Refused". To the right of these options is a "Comment" text box. At the bottom right of the window are "Resolve" and "Cancel" buttons.

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.

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

GENERAL INFORMATION
Patient/family/support person able to respond to questions: Yes
Information obtained from: Patient

Does patient have an Advance Directive: No
Patient received info on Advance Directive: Yes
Does patient wish to initiate or make changes to an Advance Directive: Yes
Infection Control Education: None
Precautions: None

Emergency contact information:
Contact: ZMSHTSWLSDHYS,CHUUN
Relationship:
Address:
Phone:
Work Phone:

RESTRAINTS
Reason for restraint: Patient's behavior is aggressive or violent presenting an immediate serious danger to his/her safety
Justification for restraints: Agitated
Behavioral expectations for termination of restraints: Follows simple directions
Restraint Type: Ankle, Right, Locked
Interventions tried to avoid restraint use: Bed alarm

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

At the bottom of the window is a tab bar with the following tabs: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, CIWA, P/S, Rest, MH, Func, DP, PCE, and View Text. The "View Text" tab is currently selected. Below the tab bar, there is a status bar that says "Performing assessment" and a small note: "* Designates a required field".

RN Reassessment, View Text tab

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

Signing Note and Consults from within the Template

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

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

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

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

1. Click View Text.

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

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

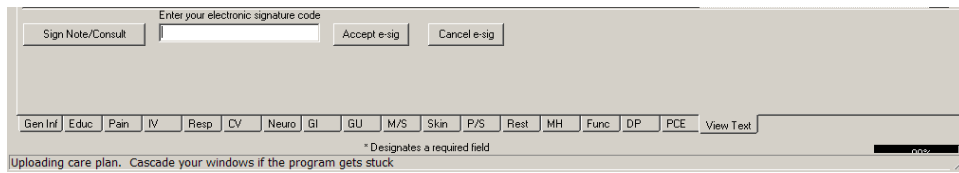
Below the form is a "Sign Note/Consult" button. At the bottom of the window is a tab bar with the following tabs: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. The "View Text" tab is currently selected. A status bar at the very bottom indicates "Performing assessment" and "00%".

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**.

The screenshot shows a software window titled "RN Reassessment - VHLSEJELUAHT ALRUHYJH (5326) Ward: 4CT". The window has a menu bar with "File", "Tabs", and "Help". The main content area is titled "GENERAL INFORMATION". It contains several sections: a section for "Patient/family/support person able to respond to questions" with radio buttons for "Yes" and "No"; a "Demographics" section with fields for Name, Age, Sex, and Race; an "Admitting diagnosis" section with the text "CHEST PAIN"; and a section for "What does patient want to accomplish by this hospitalization?". At the bottom, there is a navigation bar with tabs for "Gen I Page 1", "Gen I Page 2", "Gen I Page 3", and "Gen I Page 4". Below the tabs is a row of buttons for various assessment categories: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". At the very bottom, there is a status bar that says "Performing assessment" and a "Go to radiogroup:" dropdown menu with the text "able to respond to questions" and a "Go" button.

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

File Tabs Help

GENERAL INFORMATION

Medications/Allergies:

Current Meds (last day):

*** Outpatient ***	*** NONE FOUND ***
*** IV ***	*** NONE FOUND ***
*** Unit Dose ***	*** NONE FOUND ***

Allergies:

METOPROLOL
PEANUTS

Yesterday's and Today's Orders:

ORDERS YESTERDAY & TODAY - NONE FOUND
SOCIAL WORK CONSULT IN

Add New Allergy

* Disposition of meds * Other Disposition * Implanted medication * Type of device/pump/medication * Is patient wearing any kind * Type of patch

Spiritual/Cultural Assessment - Patient's Religion: ROMAN CATHOLIC CHURCH

Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about:

☐ Yes ☒ No

Prior patient response: NO

Describe practices/concerns

Does patient have any concerns or special considerations if a blood transfusion is needed:

☐ Yes ☒ No

Prior patient response: NO

Describe concerns

Does patient have a pastor or clergy who should be notified of this hospitalization:

☐ Yes ☒ No

Prior patient response: NO

Specify pastor or clergy

Does patient have any traditional, ethnic, or cultural practices that need to be part of care:

☐ Yes ☒ No

Prior patient response: NO

Describe practices

Chaplain Consult

Patient requests an immediate visit from the Chaplain:

☐ Yes ☒ No

Prior patient response: NO

Gen I Page 1 Gen I Page 2 Gen I Page 3 Gen I Page 4

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

* Designates a required field Go to radiogroup: that need to be part of care Go

Performing assessment

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

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

File Tabs Help

GENERAL INFORMATION

Advance Directive:

Does patient have an Advance Directive:

☐ Yes ☒ No

Prior patient response: NO

* Location of Advance Directive

Patient received info on Advance Directive:

☐ Yes ☒ No

Prior patient response: YES

* Explain why patient did not receive info

Does patient wish to initiate or make changes to an Advance Directive:

☐ Yes ☒ No

Prior patient response: NO

Social Work Consult

Will Send

Testing for MRSA brochure/equivalent information given to the patient/authorized surrogate:

☒ Yes ☐ No

Prior response: YES

Did the patient/authorized surrogate agree to MRSA Nares swab on admission/transfer/discharge:

☒ Yes ☐ No

Prior patient response: YES

MRSA Nares swab performed:

☒ Yes ☐ No

Swab performed: YES

* Why wasn't MRSA Nares swab performed

Was the below Infection Control Education provided to the patient:

☒ Yes ☐ No

Prior response: YES

Infection Control Education:

- ☒ Hand hygiene practices
- ☐ Definition of MRSA, VRE, TB, and all resistant organisms
- ☐ Spread of resistant organisms/prevention
- ☐ Contact Precautions (as related to patient condition)
- ☐ Respiratory Precautions (as related to patient condition)
- ☐ Surgical site (as related to patient condition)
- ☐ Other

Level of understanding:

☐ Poor ☒ Fair ☐ Good ☐ Refused

Precautions:

☐ Airborne ☒ Contact ☐ Droplet ☐ Neutropenic

Prior precautions:

Contact

Prior patient response: Fair

MRSA Nares swab performed on transfer with patient's agreement:

☐ Yes ☒ No ☐ Refused ☐ N/A

* Why wasn't it performed

MRSA Nares swab performed on discharge with patient's agreement:

☐ Yes ☒ No ☐ Refused ☐ N/A

* Why wasn't it performed

Gen I Page 1 Gen I Page 2 Gen I Page 3 Gen I Page 4

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

* Designates a required field Go to radiogroup: to an Advance Directive Go

Performing assessment

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

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

File Tabs Help

EDUCATIONAL ASSESSMENT

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

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

* Other reason no one could respond

* Information obtained from

* Other source of information

* Describe why unable to read

* Describe why unable to write

* Has ability to read

* Has ability to write

* Educational Level

* Other education level

Learns best by:

Prior patient response: Prefers

* Readiness to learn

Prior patient response:

* Barriers to learning

* Describe identified barriers

* Other barriers

* Knowledge of current illness, surgery, reason for hospitalization etc as

* Information provided to patient/support person on the following topics

* Other topic provided

Prior patient response:

Joint Commission Phone Number: 1-800-994-6610

Educ Page 1 Educ CP

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

* Designates a required field

Go to radiogroup: able to respond to questions

Go

Performing assessment

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

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

File Tabs Help

PAIN ASSESSMENT

* Is patient having any pain now: ☒ Yes ☐ No ☐ Unable to respond to questions

Explain if new occurrence

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

* Does patient exhibit behavioral indicators related to pain

* Other behavioral indicator

* Behavioral indicator(s) observed

☐ Other pain location?

* Pain Location #1

* Pain Region: Head

* Quality of pain: Aching

* Type of pain: Acute/Sharp ☒ Chronic

Onset of original pain (years, months)

* Describe other timing of pain

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

* Timing of pain: ☐ Constant ☐ Intermittent ☐ Other

* What makes pain worse: ☐ No identified triggers ☐ Bending ☐ Changes in temperature ☐ Changing position ☐ Coughing ☐ Deep breathing ☐ Exercise

* Other provoking factor(s)

* Does pain radiate: ☐ Yes ☒ No

* Describe Pain Radiation

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

* Other palliative factor(s)

* Rx/Dtc Meds helping pain

* Areas of life affected by pain: ☒ No effect ☐ Anxiety ☐ Appetite ☐ Concentration ☐ Depression ☐ Energy level

* Comments for patient's life aspects

Pain Goal

* What pain level is acceptable to the patient (0-10)? 0

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

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

* Designates a required field

Go to radiogroup: Is patient having any pain now

Go

Performing assessment

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

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

File Tabs Help

IV ☐ No IV/vascular access devices

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

NUMBER	LOCATION	DATE INSERTED	SIZE	DISCONTINUED	UPDATED
NONE					

☐ Show discontinued IVs also

Edit Peripheral Line Site

* Location: * Other location: * Other size: ☐ IV Discontinued

* Date/time inserted: IV discontinue date/time:

☐ Dressing change Last changed: ☐ Tubing change Last changed:

☐ Dressing date/time change: ☐ Tubing date/time change:

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

IV Periph IV Central IV Dialysis IV Comments IV CP

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

RESPIRATORY ASSESSMENT

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

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

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

* Patient has a history of: * Other history:

* Respiratory pattern: ☐ Regular ☐ Irregular - Agonal ☐ Irregular - Cheyne-Stokes ☐ Irregular - Kussmaul ☐ Irregular - Other

* Respiratory rate:

* Other respiratory pattern:

* Respiratory depth: ☐ Normal ☐ Deep ☐ Shallow

* Chest movement: ☐ Equal, bilateral, symmetrical ☐ Abnormal

* Abnormal Chest Movement:

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

* Other work of breathing:

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

* Breath sounds: ☐ Clear ☐ Abnormal

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

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

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

* Designates a required field Go to radiogroup: Respiratory depth Go

Performing assessment

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

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

File Tabs Help

RESPIRATORY ASSESSMENT

* Sputum color * Other sputum color * Sputum consistency * Other sputum consistency

☐ Productive cough present
Prior response:

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

Location 2 * Suction * Other suction * Air Leak * Chest tube drainage * Dressing * Other dressing

☐ Other chest tube locations

☐ Facility ordered oxygen * Other liter flow * Other delivery method * Oxygen saturation %
Prior response:

☐ Ventilator dependent - chronic
* Ventilator dependent - chronic comments

Respiratory Consult

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

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

RESPIRATORY ASSESSMENT

☐ Tracheostomy present * Other trach type * Stoma appearance * Other stoma appearance * Other dressing

* Tracheostomy size

☐ Trach removed * Removed date/time * Dressing change? * Dressing date/time change * Dressing type * Other dressing type

☐ Trach recently inserted * Insertion date/time

* Type of tobacco used

Instructions for former usage

Prior response:

* Approximate quit date
* Tobacco education

General Observations/Comments

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

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

CARDIOVASCULAR ASSESSMENT

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

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

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Patient has a history of:

* Other history:

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

* Edema:
☒ Yes ☐ No

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

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

Pedal right Pedal left Facial Periorbital Sacral

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

* Extremities:
☐ Warm
☐ Cool
☐ Capillary Refill Less than 3 Seconds
☐ Capillary Refill Greater than 3 Seconds

Extremities comments:

Prior comments:

Prior response:

Auscultation

* Heart Rate:

* Heart rhythm:
☐ Regular ☐ Irregular

* Heart sounds:
☐ Normal ☐ Abnormal

* Describe abnormal sound:

CV Page 1 CV Page 2 CV CP

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

* Designates a required field Go to radiogroup: Heart rhythm Go

Performing assessment

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

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

File Tabs Help

CARDIOVASCULAR ASSESSMENT

Pulses

Radial Pulse: Left Right

Dorsalis Pedis Pulse: Left Right

Posterior Tibial Pulse: Left Right

* Describe venous distention:
☐ Yes ☐ No

* Jugular Venous Distention:
☐ Yes ☐ No

Prior response:

* Cardiac monitor:
☐ Yes ☐ No

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

Cardiac devices:
☐ External pacemaker ☐ Permanent pacemaker
☐ Implantable cardioverter/defibrillator (ICD) ☐ Other device

* Other cardiac device:

Prior cardiac monitor response:

* Other cardiac monitor rhythm:

General observations/comments:

T Wave:

PR Interval:

QT Interval:

QRS Duration:

ST Segment:

CV Page 1 CV Page 2 CV CP

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

* Designates a required field Go to radiogroup: Jugular Venous Distention Go

Performing assessment

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

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

File Tabs Help

NEUROLOGICAL ASSESSMENT

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

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

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Patient has a history of:

* Spinal Cord Injury Level:

Orientation:

* Other neurological problem:

* Describe Spinal Cord Injury Level:

Prior response:

Level of Consciousness (Glasgow Coma Scale)

Eye response score:

Verbal response score:

Motor response score:

Total score: 0

Prior score:

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

Glasgow score categories

13-15 (normal result)

9-12 (correlates with moderate brain injury)

8 or less (correlates with severe brain injury)

Instructions for completing Glasgow Coma Scale

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

Best Eye Response: (4)

4. Eyes open spontaneously

3. Eye opening to verbal command

2. Eye opening to pain

1. No eye opening

C. Denotes closed eye or if patient is unable to open an eye due to swelling, nerve palsy or eye dressing

P. Indicates presence of pharmacological paralysis

Best Verbal Response: (5)

5. Oriented

4. Confused

3. Inappropriate words

2. Incomprehensible sounds

1. No verbal response

T. Indicates presence of an ET or Trach tube

D. Indicates patient aphasia

P. Indicates the presence of pharmacological paralysis

Best Motor Response: (6) (Best arm response)

6. Obeys Commands

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

Neuro Page 1 Neuro Page 2 Neuro CP

* Designates a required field

Go to radiogroup: Go

Performing assessment

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

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

File Tabs Help

NEUROLOGICAL ASSESSMENT

Motor

Instructions for performing motor assessment

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

5+ Active movement of extremity against gravity and maximal resistance

4+ Active movement of extremity against gravity and moderate resistance

3+ Active movement of extremity against gravity but NOT against resistance

2+ Active movement of extremity but NOT against gravity

1+ Slight movement (flicker of contraction)

0 No movement

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

Pupils

☐ New lens implant/prosthesis

Prior response:

* Describe new lens implant/prosthesis:

Size

☐ Equal

☐ Right greater than left

☐ Left greater than right

☐ Other

* Other pupil size:

Prior response:

Reactivity

Right eye

☐ Brisk reaction to light

☐ Some reaction to light (sluggish)

☐ No reaction to light

Prior response:

Left eye

☐ Brisk reaction to light

☐ Some reaction to light (sluggish)

☐ No reaction to light

Prior response:

☐ Sensations: New paresthesias or neuropathies present

Prior response:

* New sensations present:

☐ Requires assistive new communication device to meet basic needs

Prior response:

* New comm device needed:

General observations/comments

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

Neuro Page 1 Neuro Page 2 Neuro CP

* Designates a required field

Go to radiogroup: Go

Performing assessment

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

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

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

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

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Patient has a history of:

* Other history:

Abdominal Assessment

* Abdomen: ☐ Distended ☐ Firm ☐ Flat ☐ Guarding ☐ Non-tender ☐ Obese ☐ Rigid ☐ Round ☐ Soft ☐ Tender ☐ Other

* Other abdominal assessment:

* Bowel sounds: ☐ Present ☐ Absent

* Last Bowel Movement Date: ☐ Known ☐ Unknown

* Date of Last Bowel Movement:

Bowel sounds comments:

Bowel regime

Bowel pattern:

* Other bowel pattern:

* Laxative name and frequency of use:

* Enema type and frequency of use:

☐ Laxative use ☐ Enema use

Prior response: ☐ Bowel program

* Other bowel program schedule:

* Bowel care - start time:

* Bowel care - completion time:

Medication/treatment:

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

* Designates a required field

Go to radiogroup: Go

Performing assessment

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

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

GI Device #1

* Type: None

GI device comments:

☐ New since last assessment

Date/time:

☐ Removed since last assessment

Date/time:

GI Device #2

* Type: None

GI device comments:

☐ New since last assessment

Date/time:

☐ Removed since last assessment

Date/time:

GI Device #3

* Type: None

GI device comments:

☐ New since last assessment

Date/time:

☐ Removed since last assessment

Date/time:

GI Device #4

* Type: None

GI device comments:

☐ New since last assessment

Date/time:

☐ Removed since last assessment

Date/time:

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Oral Screen

Assessment - General

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

Assessment - Mucous Membrane

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

Nutrition screen

* Appetite * Other appetite

* Description of patient:

- ☐ Well nourished
- ☐ Obese
- ☐ Emaciated

Prior response: Prior response:

Height: 66.25 in [168.3 cm] [03/11/2011 09:14]
Weight: 229.94 lb [104.5 kg] [06/22/2011 12:30]
BMI: 36.9 [JUN 22, 2011@12:30:48]

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

Prior response:

Nutrition consult guidelines

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

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

* Designates a required field Go to radiogroup: Description of patient Go

Performing assessment

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

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Dysphagia screen

* Dysphagia screen

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

* Other reason unable to screen

Dysphagia risk factors

* Diagnosis of new stroke, head and neck cancer, or traumatic brain injury

* Modified texture diet/ eating maneuvers (e.g. chin tuck; head turn)

* Unable to follow commands

Prior response: Prior response: Prior response:

Wet gurgly voice Drooling while awake * Tongue deviation from midline

Prior response: Prior response: Prior response:

General Observations/Comments

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

* Designates a required field Go to radiogroup: Dysphagia screen Go

Performing assessment

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

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

File Tabs Help

GENITOURINARY ASSESSMENT

* Patient/family/support person able to respond to questions:
☐ Yes ☒ **NG**

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

* Other reason no one could respond: _____

* Information obtained from: _____

* Other source of information: _____

* Patient has a history of:

Voiding
 * Voiding: ☐ Intermittent catheterization frequency: _____ * Other voiding: _____

Urine
 * Other color: _____

Color:
☐ Amber
☐ Yellow
☐ Bloody
☐ Unable to evaluate
☐ Other

Consistency:
☐ Normal
☐ Concentrated
☐ Dilute
☐ Unable to evaluate

* Last voided:
☐ Known ☐ Unknown ☐ Absorbency devices used

* Date/time last voided: _____

* Describe abnormal discharge:
☐ Abnormal discharge
☐ None
☐ Genital
☐ Unable to evaluate

* Describe sediment:
☐ Sediment
☐ No
☐ Unable to evaluate

Odor:
☐ Foul smelling ☐ None ☐ Unable to evaluate

Prior response: _____

GU Page 1 GU Dev GU Page 2 GU CP

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

* Designates a required field Go to radiogroup: Color Go

Performing assessment

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

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

File Tabs Help

GENITOURINARY ASSESSMENT

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

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

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

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

GU Page 1 GU Dev **GU Page 2** GU CP

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

GENITOURINARY ASSESSMENT

Genitourinary Devices

* Current Devices

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

* Indwelling catheter size

* Other device

☐ Concerns voiced regarding sexual functioning

* Sexual Functioning concerns voiced

Prior response

☐ Indwelling removed

Female patients

* Pregnancy

Approximate date

Approximate date

Approximate date

Male patients

Approximate date

Last PSA: 10/14/10 @ 0819 0.74

General observations/comments

GU Page 1 GU Dev GU Page 2 GU CP

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

MUSCULOSKELETAL ASSESSMENT

* Patient/family/support person able to respond to questions

☐ Yes ☒ No

* Why could no one respond

- ☒ Patient unable to communicate
- ☐ No family/support person present
- ☐ Other

* Other reason no one could respond

* Information obtained from

* Other source of information

* Patient has a history of

* Describe other history

* Body part(s) amputated

* Range of Motion

- ☐ ROM - No apparent problem
- ☐ Limited ROM - Right Upper Extremity
- ☐ Limited ROM - Left Upper Extremity
- ☐ Limited ROM - Right Lower Extremity
- ☐ Limited ROM - Left Lower Extremity

Stated patient complaints

General observations/comments

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

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

* Designates a required field

Go to radiogroup: able to respond to questions Go

Performing assessment

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

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

File Tabs Help

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

* Fall risk assessment indicated
☐ Yes ☐ No

* History of falling Describe previous falls and history

* Fracture Location * Other fracture location

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

* Is patient on multiple meds to

Total Morse score for Fall Risk: N/A

Prior score: Not assessed
 Date:

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

Instructions for completing Morse Fall Scale

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

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

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

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

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

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

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

* Designates a required field Go to radiogroup: Fall risk assessment indicated Go

Performing assessment

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

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

File Tabs Help

SKIN ASSESSMENT

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

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

* Other reason no one could respond

* Information obtained from

* Other source of information

* Patient has a history of

* Describe other

Predisposition for skin breakdown

Does patient have

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

* Risk Factors

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

* Describe other

Skin Inspection

* Skin Temperature
☐ Warm ☐ Hot ☐ Cool ☐ Cold

* Skin Moisture
☐ Extremely dry ☐ Moist
☐ Dry ☐ Diaphoretic

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

* Describe other

* Skin Turgor
☐ Within Normal Limits ☐ Abnormal

* Skin Patches
☐ Yes ☐ No

* Skin Patch Description

General observations/comments

☐ Pressure ulcers ☐ Skin alterations

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

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

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

Performing assessment

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

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

File Tabs Help

SKIN ASSESSMENT **BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK**

* Skin assessment indicated
☐ Yes ☐ No

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

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

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

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

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

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

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

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

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

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Nutrition Consult Wound Care Consult

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

Performing assessment

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

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

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

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

* Other history:

* Other attitude:

* Other behavior:

* Patient has a history of:

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

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

* Explain suspicions:

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

* Explain about others in household:

Social/Work Consult

P/S Page 1 P/S Page 2 P/S Page 3 CIWA P/S Page 4 P/S CP

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

Performing assessment

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

Suicide Risk Screen

Ask Patient

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

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

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

Prior response: Prior response: Comments relative to suicide:

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

Prior response: Prior response:

P/S Page 1 P/S Page 2 P/S Page 3 QIWA P/S Page 4 P/S CP

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

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

* Patient has a court-appointed legal guardian: ☐ Yes ☐ No
Prior response: * Specify guardian:

* Patient has been legally committed: ☐ Yes ☐ No
Prior response: Prior guardian response:

* Patient is considered a danger to him/herself or others: ☐ Yes ☐ No ☐ Unknown
Prior response: * Patient has history of:

* Patient is on legal observation status for Gravely Disabled: ☐ Yes ☐ No
Prior response: Date/from where if known:

* Patient lacks the cognitive ability to make relevant decisions (e.g. history of dementia, Alzheimer's or traumatic brain injury): ☐ Yes ☐ No
Prior response: Prior escape/elopement response: [Social Work Consult](#)

Prior response:

Chemical Dependency Issues

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

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

Make Alcohol Treatment referral if patient is interested:

Contraband

* Contraband brought (in to/by) the patient: ☐ Yes ☐ No
Prior response: * Describe contraband: * Location of unremoved contraband: [Follow facility policy for contraband removal](#)

P/S Page 1 P/S Page 2 P/S Page 3 QIWA P/S Page 4 P/S CP

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

* Designates a required field Go to radiogroup: appointed legal guardian Go

Performing assessment

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

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

File Tabs Help

RESTRAINTS *** Notify provider ***

☒ Restraints Initiated/maintained

* Date/time initiated
☐ Known
☐ Unknown
 Initiated date/time

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

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

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

* Restraint Type * Other Restraint

☐ Ankle, Right, Locked
☐ Ankle, Right, Unlocked
☐ Ankle, Left, Locked
☐ Ankle, Left, Unlocked
☐ Blanket/Net
☐ Hand Mitt, Right
☐ Hand Mitt, Left
☐ Vest, Locked
☐ Vest, Unlocked
☐ Waist, Locked
☐ Waist, Unlocked
☐ Wrist, Right, Locked
☐ Wrist, Right, Unlocked
☐ Wrist, Left, Locked
☐ Wrist, Left, Unlocked
☐ Soft
☐ Leather/plastic/rubber
☐ Other

Interventions tried to avoid restraint use * Other intervention

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

☐ Discontinued - desired outcome achieved
 Discontinued date/time

Restr Page 1 Restr CP

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

MENTAL HEALTH ASSESSMENT

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

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

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

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

* Patient has a history of * Other history Ask patient: "What things or situations make you upset?" * Other upsetting item

* Ask patient "Have you ever been so angry"

Prior response:
 * How does patient act when he/she loses control * Other actions * Ask patient "When you get upset, what does patient do to calm him/herself" * Other calming things

Prior response:

MH Page 1 MH Page 2 MH CP

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

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

Performing assessment

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

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

File Tabs Help

FUNCTIONAL ASSESSMENT

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

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

* Other reason no one could respond:

* Information obtained from:

* Other source of information:

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

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

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

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

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

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

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

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

Total score: 0
Prior score: 6 = High (Patient independent); 0 = Low (Patient very dependent)
Refer to provider for evaluation if patient has a Katz score of 4 or less OR a decrease in the level of independence and changes have occurred within the past month.

Did patient have a decrease in the level of independence:

Prior response:

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

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

Performing assessment

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

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

File Tabs Help

FUNCTIONAL ASSESSMENT

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

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

Prior response:

Assessment criteria and care plan for safe patient handling and movement
An assessment should be made prior to each task if the patient has varying levels of ability to assist due to medical reasons, fatigue, medications, etc. When in doubt, assume the patient cannot assist with the transfer/repositioning.
Height: 66.25 in [168.3 cm] [03/11/2011 09:14]
Weight: 229.94 lb [104.5 kg] [06/22/2011 12:30]
BMI: 36.9 (JUN 22, 2011@12:30:48)

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

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

Prior response:

Applicable conditions likely to affect transfer/repositioning techniques:

Transfer/repositioning techniques comments:

General observations/comments:

Func Page 1 Func Page 2 Func Page 3 Func CP

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

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

Performing assessment

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

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

File Tabs Help

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

Transfer to and from Bed to Chair, Chair to Toilet, Chair to Chair, Car to Chair
Equipment/Assistive Device
☐ Ceiling lift
☐ Friction reducing device
☐ Full body sling
☐ Gait belt
☐ Lateral transfer device
☐ Power stand assist
☐ Sliding board
Number of staff: 0

Lateral transfer to and from Bed to Stretcher, Trolley
Equipment/Assistive Device
☐ Ceiling lift
☐ Friction reducing device
☐ Full body sling
☐ Gait belt
☐ Lateral transfer device
☐ Power stand assist
☐ Sliding board
Number of staff: 0

Transfer to and from Chair to Stretcher or Chair to Exam Table
Equipment/Assistive Device
☐ Ceiling lift
☐ Friction reducing device
☐ Full body sling
☐ Gait belt
☐ Lateral transfer device
☐ Power stand assist
☐ Sliding board
Number of staff: 0

Reposition in Bed, Side to Side, Up in Bed
Equipment/Assistive Device
☐ Ceiling lift
☐ Friction reducing device
☐ Full body sling
☐ Gait belt
☐ Lateral transfer device
☐ Power stand assist
☐ Sliding board
Number of staff: 0

Reposition in Chair
Equipment/Assistive Device
☐ Ceiling lift
☐ Friction reducing device
☐ Full body sling
☐ Gait belt
☐ Lateral transfer device
☐ Power stand assist
☐ Sliding board
Number of staff: 0

Transfer a patient up from the floor
Equipment/Assistive Device
☐ Ceiling lift
☐ Friction reducing device
☐ Full body sling
☐ Gait belt
☐ Lateral transfer device
☐ Power stand assist
☐ Sliding board
Number of staff: 0

Print

Educate Patient, Family, and Support Person on

Sling type:
☐ Standard
☐ Amputation
☐ Head support

Prior response:
Height: 66.25 in [168.3 cm] (03/11/2011 09:14)
Weight: 229.94 lb [104.5 kg] (06/22/2011 12:30)

Sling size:
☐ Medium (100 to 210 lbs, height 5 ft - 5 ft 11 in)
☐ Large (210 to 550 lbs, height 6 ft and over)

Prior response:

Func Page 1 Func Page 2 Func Page 3 Func CP

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

* Designates a required field Go to radiogroup: Sling type Go

Performing assessment

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

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

File Tabs Help

DISCHARGE PLANNING

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

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

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

* Does patient have a legal/medical guardian (conservator)?
☒ Yes ☐ No

* Specify guardian (conservator): * Describe employment status:

* Home environment: * Other architectural barriers: * Special Equipment Needed at Home: * Other equipment needed:

* Other transportation for discharge:

General observations/comments:

DP Page 1 DP CP

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

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

Performing assessment

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

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

File Tabs Help

DISCHARGE PLANNING - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES

* Problems, interventions, and desired outcomes identified in previous tabs have been discussed * Why hasn't plan of care been discussed

Anticipated Discharge Plan Goals

* Family/support person in discharge planning

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

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

Discharge Planning Consult Social Work Consult

Telehealth Consult Home Care Consult

DP Page 1 DP CP

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

Performing assessment

* Designates a required field

RN Reassessment, 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**.

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

Under "GENERAL INFORMATION", there are several sections:

- * Patient/family/support person able to respond to questions:** Radio buttons for "Yes" (selected) and "No".
- * Why could no one respond:** A text area.
- * Other reason no one could respond:** A text area.
- * Information obtained from:** A list box with "Patient" (selected), "Authorized surrogate", "Family/Support Person", "Medical Record", and "Other".
- * Other source of information:** A text area.

Below these sections, there is a "Demographics" section with the following information:

- Name: VHLSEJELUAHT ALRUHYJH
- Age: 69 Sex: MALE Race: DECLINED TO ANSWER

There is also an "Admitting diagnosis: CHEST PAIN" section.

At the bottom of the window, there is a "Prior patient response to 'What does patient want to accomplish by this hospitalization?'" section with a text area.

The bottom of the window features a navigation bar with tabs: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "Gen Inf" tab is currently selected.

At the very bottom, there is a status bar that says "Performing assessment".

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.pdf

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