

Patient Assessment Documentation Package (PADP)

C3-C1 Conversion Project

RN Reassessment User Manual for NUPA Version 1.0



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Department of Veterans Affairs
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Revision History

Date	Revision	Description	Author
May 2010	1.0	Initial version for 1.0	CBeynon
August 2010	1.1	Add content	CBeynon
August 2010	1.2	Format content	CBeynon
September 2010	1.3	Split manual into three manuals <ul style="list-style-type: none">• RN Reassessment• User Manual	CBeynon
October 2010	1.4	Updated content	CBeynon
November 2010	1.5	Updated screen captures	CBeynon
December 2010	1.6	<ul style="list-style-type: none">• Changed dates• Pulled issues from this doc for team review	CBeynon
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Date	Revision	Description	Author
December 2011	1.14	<ul style="list-style-type: none"> • Changed dates to December 2011 • Changed <i>Admission – RN Reassessment to RN Reassessment</i> • Updated for build v15 • Updated for new assessment executables • Changed dates to January 2012 • Prepped for national release 	CBeynon
January 2012	1.15	<ul style="list-style-type: none"> • Changed NUPA 1.0 to NUPA Version 1.0 • Updated for build v16 • Changed dates to February 2012 	CBeynon
February 2012	1.16	<ul style="list-style-type: none"> • Updated Neuro tab • Updated the <i>Unable to Complete the Assessment</i> section 	CBeynon
March 2012	1.17	<ul style="list-style-type: none"> • Changed dates to March 2012 • Prepped for April national release • Changed dates to April 2012 • Added Appendix A: Reassessment Contingency Note 	CBeynon

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Introduction

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

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

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

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

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

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

Each template is associated with a note.

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

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

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

Using the RN Reassessment

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

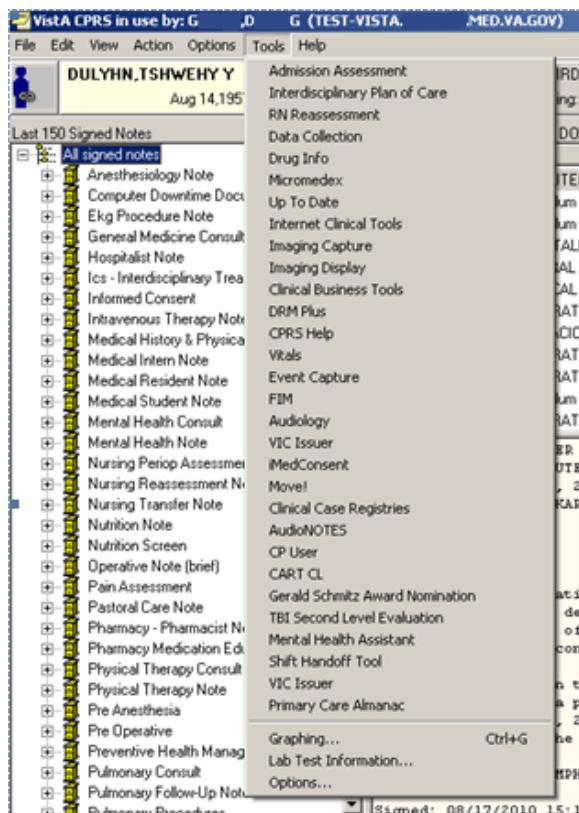
Opening RN Reassessment

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

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

Enter a patient window automatically opens to the CPRS patient.

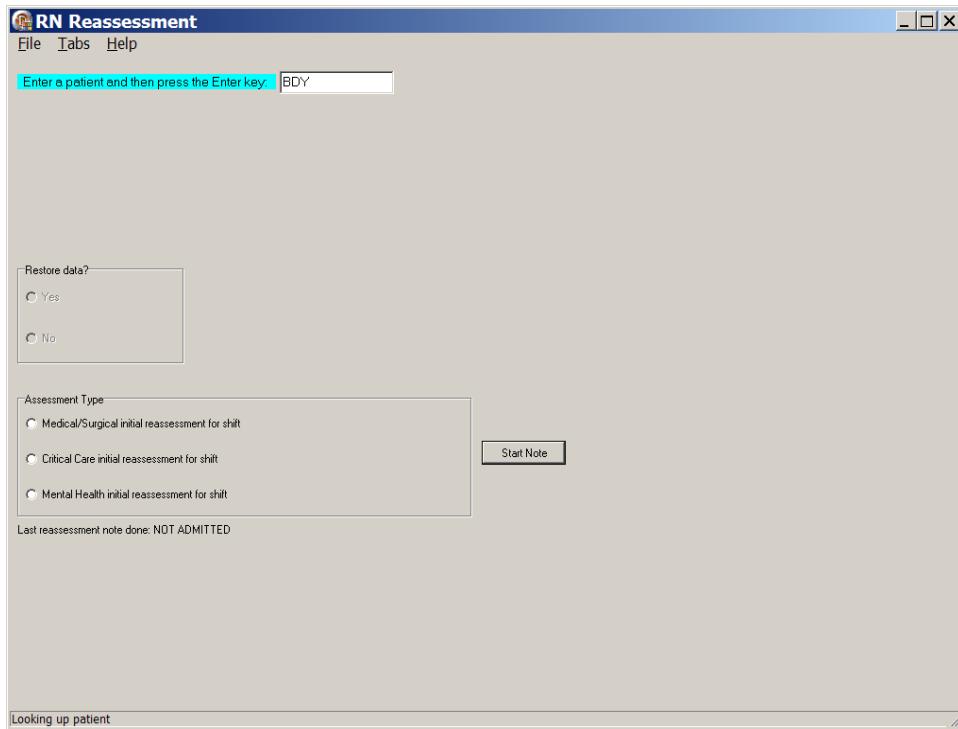
Note: You may have to re-enter your CPRS access and verify codes, depending on local site setup.



Access through CPRS

No Previously Saved Information

The Enter a patient window displays.

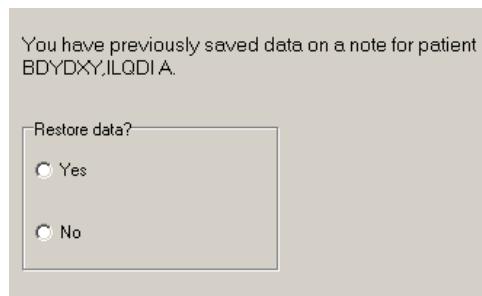


RN Reassessment, Enter a patient window with no previously saved information

1. Select an Assessment Type.
2. Click **Start Note**.

The reassessment template opens to the General Information tab for the CPRS patient.

Previously Entered Information Available for One Patient



Patient selection window with previously entered information available for one patient

Restore Patient's Data/No

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

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

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

Restore Patient's Data/Yes

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

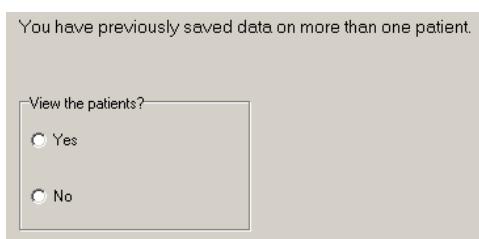
1. Select an Assessment Type.
2. Select **Yes**.
3. Click **Start Note**.

The template opens General Information tab for the CPRS patient with the data restored.

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

Previously Entered Information Available for Two or More Patients

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



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

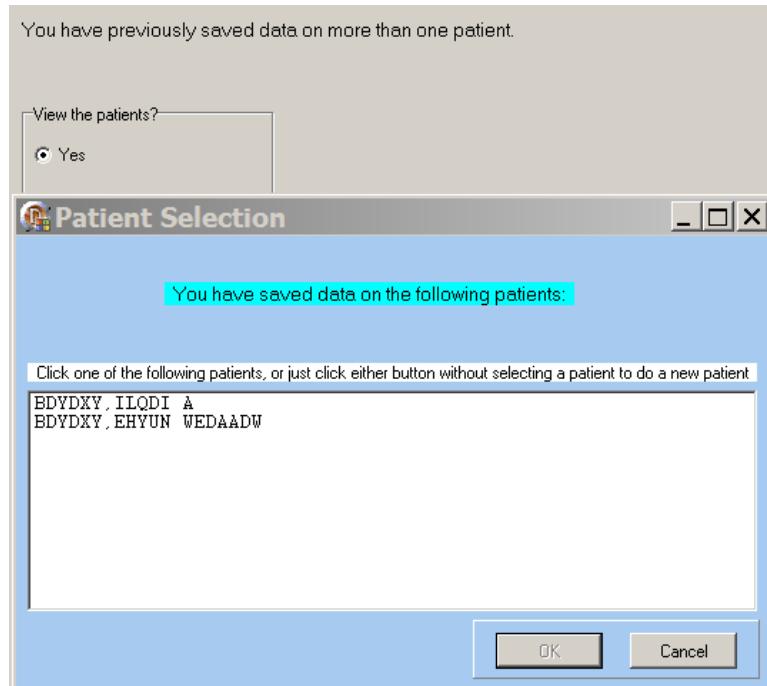
View the Patients?/No

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

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

View the Patients?/Yes

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



Patient SelectionList

Patient on the List

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

Patient not on the List

1. Click **Cancel**.

The number that represents your CPRS patient is in the Enter a patient text box.

2. Click the **Start Note**.

The template opens to the General Information tab.

The screenshot shows the RN Reassessment software interface. The title bar reads "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes "File", "Tabs", and "Help". The main window is titled "GENERAL INFORMATION".
Form fields:

- "Patient/family/support person able to respond to questions": Radio button group with "Yes" selected.
- "Why could no one respond": Text input field.
- "Other reason no one could respond": Text input field.
- "Information obtained from": Checkboxes for "Patient", "Authorized surrogate", "Family/Support Person", "Medical Record", and "Other".
- "Other source of information": Text input field.
- "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?': Text area.
- "Preferred Healthcare Language": Radio button group with "English" selected.
- "Other Language": Text input field.
- "What does patient want to accomplish by this hospitalization?": Text area.
- "Prior patient response": Text area.
- "Gen I Page 1" through "Gen I Page 4": Buttons for navigating between pages.
- "Designates a required field": Text.
- "Go to radiogroup: able to respond to questions": Drop-down menu.
- "Go": Button.
- "Performing assessment": Text at the bottom.

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

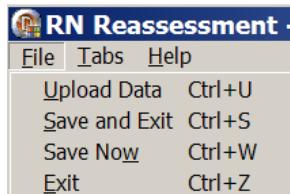
Data are saved automatically. Frequency of auto-save is set locally.



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.

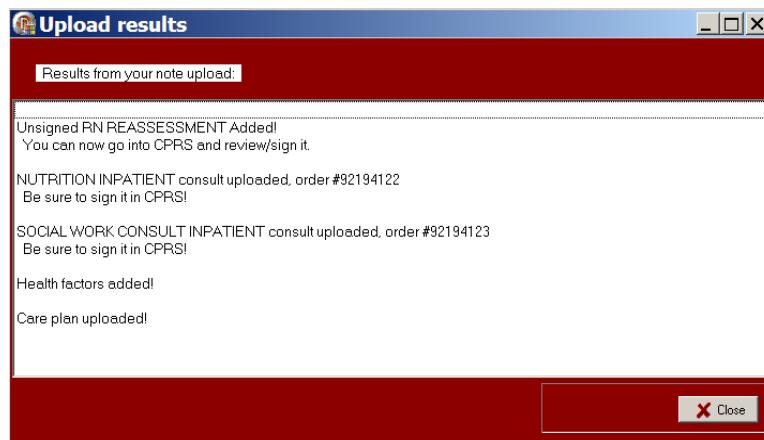


RN Reassessment window, File menu

Upload Data

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

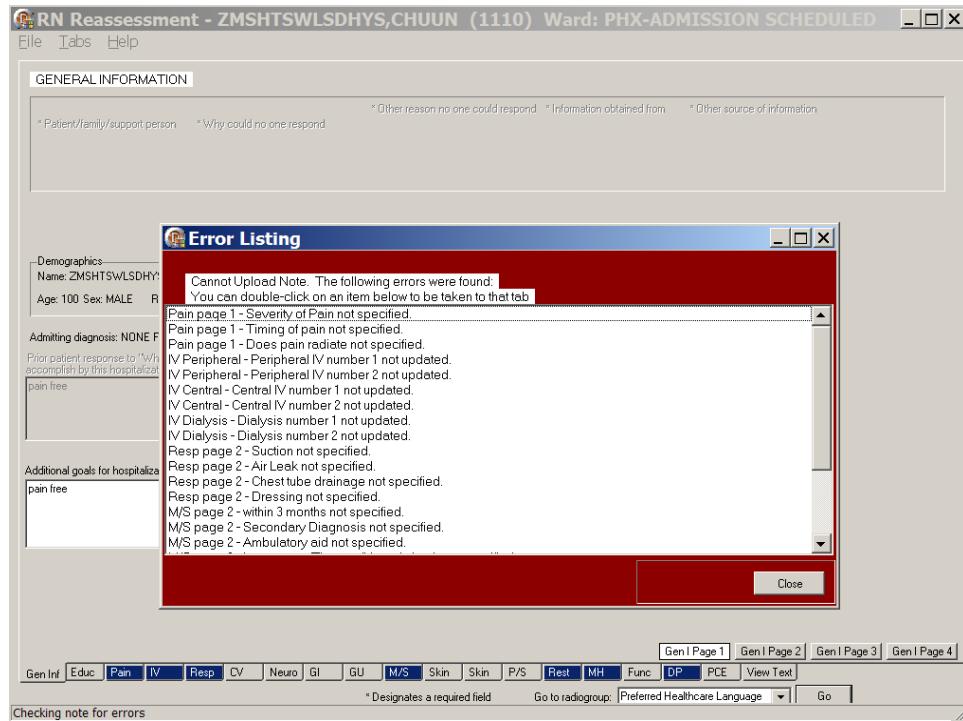
1. Open the File menu on any tab and select **Upload Data**.
Results from your upload display, verifying that the data is uploaded.



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.

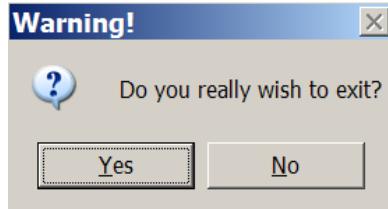
Save Now

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 the RN Reassessment software interface. The title bar reads "RN Reassessment - BDYDXY, ILQDI A (2902) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes File, Tabs, and Help. The main content area displays patient information under "GENERAL INFORMATION" and "Medications" sections. At the bottom of the screen, there is a toolbar with buttons for Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. A note at the bottom states "* Designates a required field" and "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 RN Reassessment software interface. It features a top bar with "Enter your electronic signature code" and three buttons: "Sign Note/Consult", "Accept e-sig", and "Cancel e-sig". Below this is a large empty text area for signatures. At the bottom, there is a toolbar with buttons for Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. A note at the bottom states "* Designates a required field" and "Uploading care plan. Cascade your windows if the program gets stuck".

RN Reassessment, Sign Note/Consult Button

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

Note: If there is only a note to sign, the button is **Note**.

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

Working in a Care Plan

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

RN Reassessment - 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 ENDED
NONE								

Problem/Intervention detail

Do not display resolved problems

[Add New Problem](#) [View history for this problem](#) [Add New Intervention to this problem](#)

[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

Educ Page 1 | Educ CP

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 DA
CV	Congestive Heart Failure (Actual)	2/3/11@1156	Prevention/minimization	New problem	Not on file	Education - Education	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/Potential)	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/Potential)	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 - Education	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 (Intervention Status Date)	Date on which the status of the intervention was evaluated

Updating an Existing Problem/Intervention

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

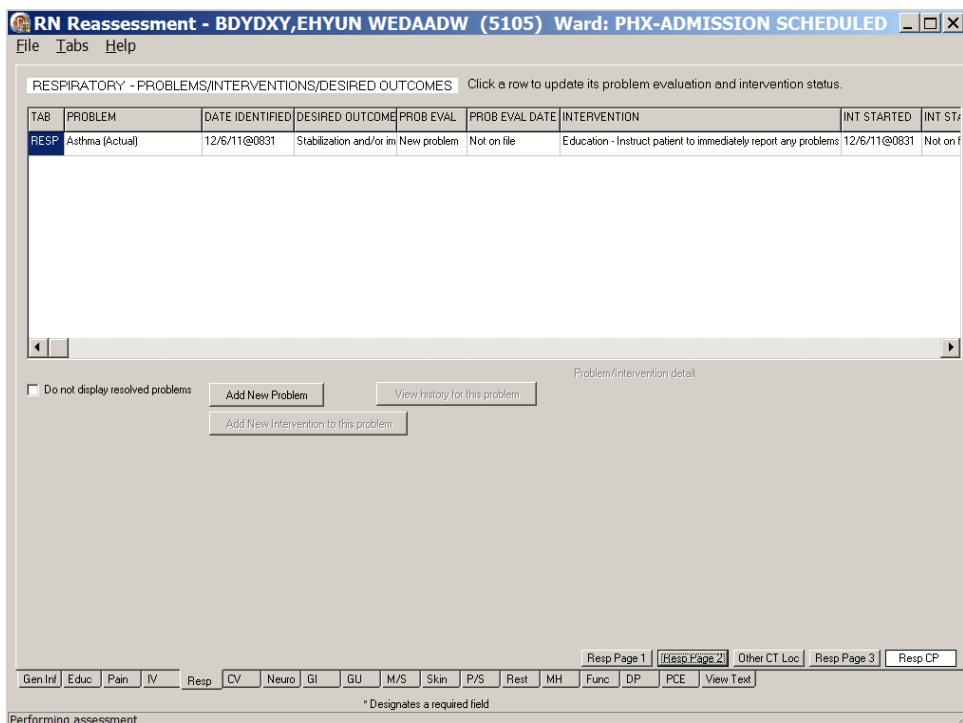


The screenshot shows a navigation bar at the top with tabs: Gen Inf, Educ, Pain, IV, Resp (which is bolded), CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text, Resp Page 1, Resp Page 2, Other CT Loc, Resp Page 3, and Resp CP. Below the navigation bar is a search bar with fields for "Performing assessment", "Go to radiogroup: Respiratory depth", and a "Go" button. A note indicates "* Designates a required field".

RN Reassessment, <Resp> tab

1. Click <Resp> CP.

The <Respiratory> - Problems/Interventions/Desired Outcomes window displays.



The screenshot shows a window titled "RN Reassessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION SCHEDULED". The main area displays a table of respiratory problems:

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

At the bottom of the window, there are buttons for "Do not display resolved problems", "Add New Problem", "View history for this problem", and "Add New Intervention to this problem". The bottom of the window features a navigation bar with tabs: Gen Inf, Educ, Pain, IV, Resp (bolded), CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text, Resp Page 1, Resp Page 2, Other CT Loc, Resp Page 3, and Resp CP. A note indicates "* Designates a required field".

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 improvement New problem	Not on file		Education - Instruct patient to immediately report any problems	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 indicated
 Evaluation: New problem
 Evaluation date: Not on file
 Intervention: Education - Instruct patient to immediately report any problems
 Intervention started: 12/6/11@0831
 Intervention status: Not on file
 Intervention status date: Not on file

[Resp Page 1](#) | [Resp Page 2](#) | [Other CT Loc](#) | [Resp Page 3](#) | [Resp CP](#)

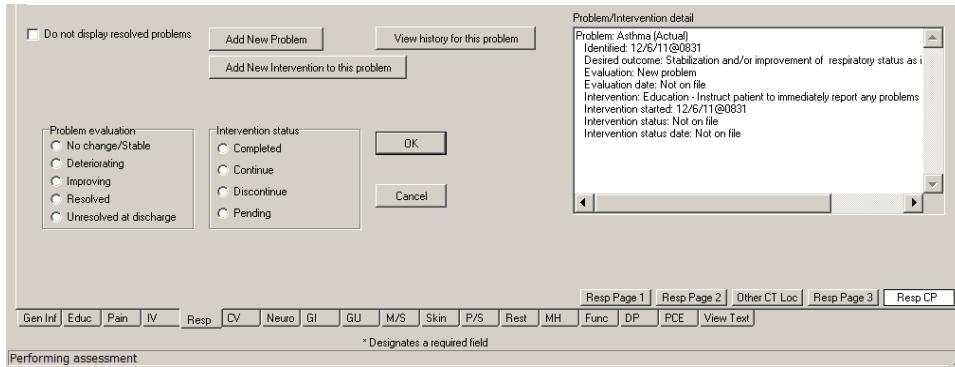
[Gen Inf](#) | [Educ](#) | [Pain](#) | [IV](#) | [Resp](#) | [CV](#) | [Neuro](#) | [GI](#) | [GU](#) | [M/S](#) | [Skin](#) | [P/S](#) | [Rest](#) | [MH](#) | [Func](#) | [DP](#) | [PCE](#) | [View Text](#)

* Designates a required field

Performing assessment

RN Reassessment, <Resp> CP window

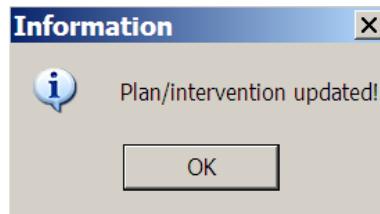
3. Select a problem evaluation and an intervention status for the selected problem.
Evaluate both the problem and the specific interventions each time you document.



Problem evaluation, Intervention status, and Problem/Intervention detail

4. Click **OK**.

Information displays.



Information : Plan/intervention updated!

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

6. Review the care plan table.

The Prob Eval/Int Status are updated and the Prob Eval Date/Int Status Date are added.

The screenshot shows a software window titled "RN Reassessment - BDYDXY,EHYUN WEDAADW (5105) Ward: PHX-ADMISSION SCHEDULED". The main title bar includes standard icons for minimize, maximize, and close. Below the title bar is a menu bar with "File", "Tabs", and "Help".

The main content area is titled "RESPIRATORY - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES". It contains a table with the following columns: TAB, PROBLEM, DATE IDENTIFIED, DESIRED OUTCOME, PROB EVAL, PROB EVAL DATE, INTERVENTION, INT STARTED, INT STATUS, and INT STATUS DAT.

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

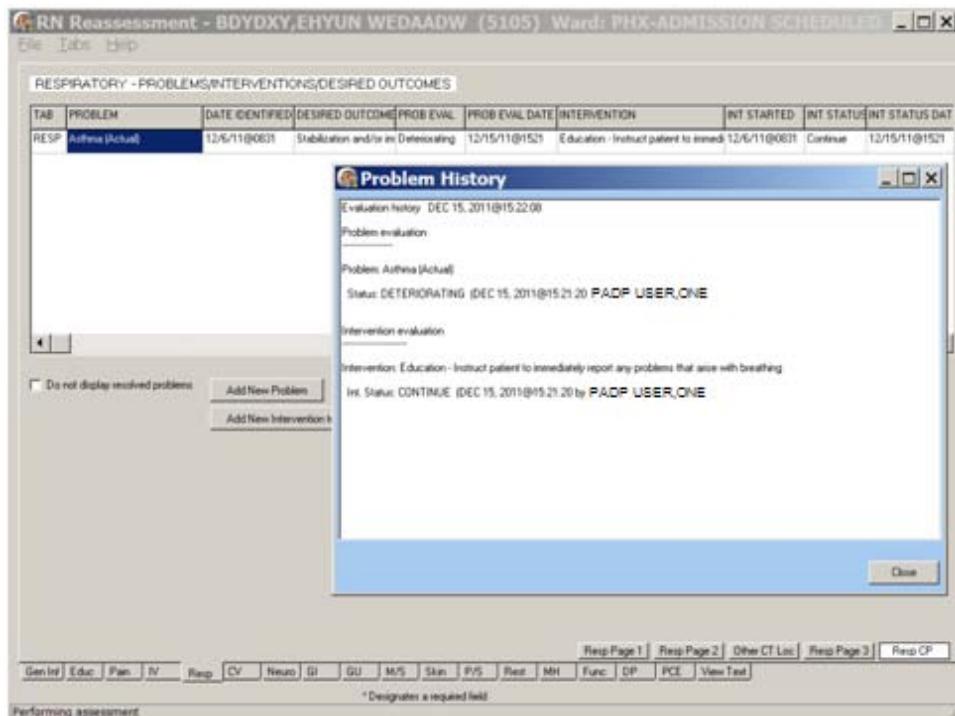
Below the table are several buttons: "Do not display resolved problems", "Add New Problem", "View history for this problem", and "Add New Intervention to this problem".

At the bottom of the window, there are navigation links: "Resp Page 1", "Resp Page 2", "Other CT Loc", "Resp Page 3", and "Resp CP". There is also a note: "* Designates a required field".

The status bar at the bottom displays "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.



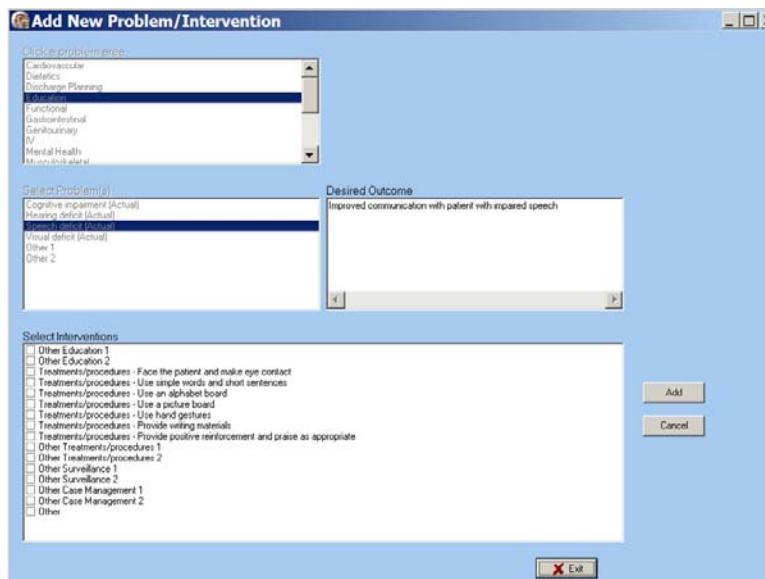
Problem History window

8. Click **Close**.

Adding a New Intervention for an Existing Problem

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

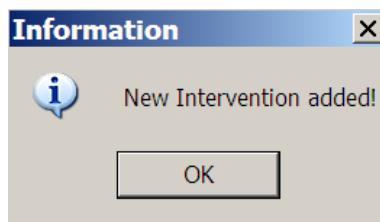
The Add New Problem/Intervention window displays with the area and problem selected.



Add New Problem/Intervention window

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

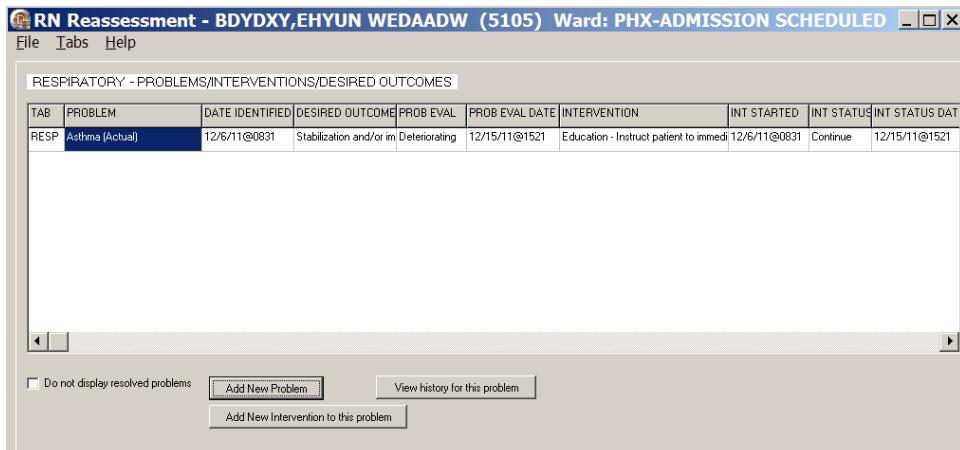
Information displays.



Information : New Intervention added!

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

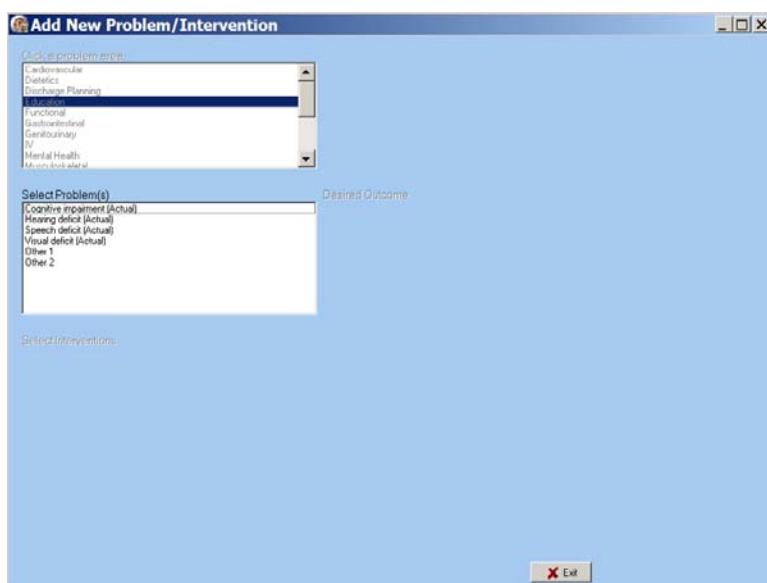
Adding a New Problem/Intervention



RN Reassessment, <Resp> CP window

1. Click Add New Problem.

Add New Problem/Intervention window displays.



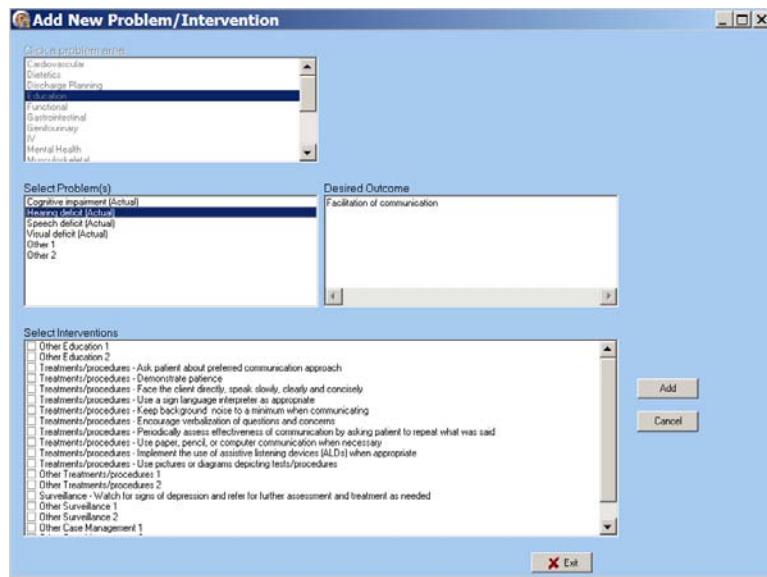
Add New Problem/Intervention window

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

2. Select a problem from the Select Problem(s) list box.

You can select only one problem at a time.

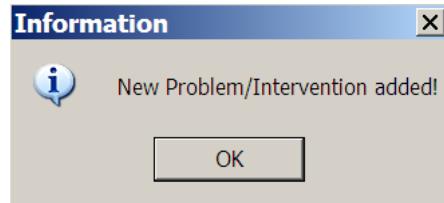
The Desired Outcome text box and the Select Interventions list box display.



Add New Problem/Intervention window for problem/intervention options

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

Information displays.



Information : New Problem/Intervention added!

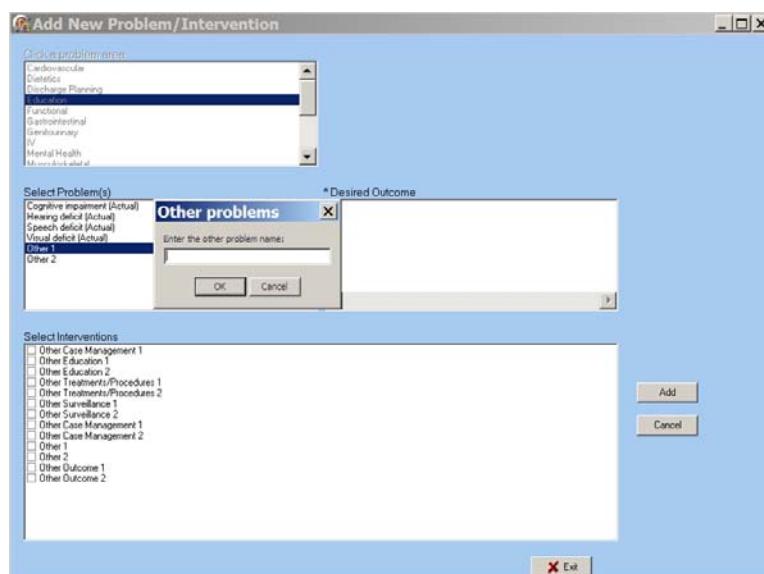
5. Click **OK**.
6. Click **Exit**.

Other Problems

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

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

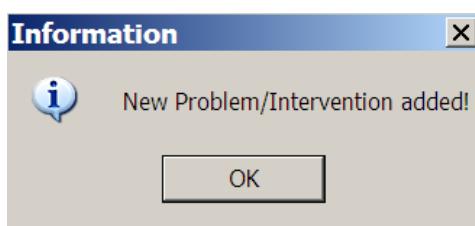
The *Other* problems displays.



Add New Problem/Intervention window with *Other*

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

Information displays.



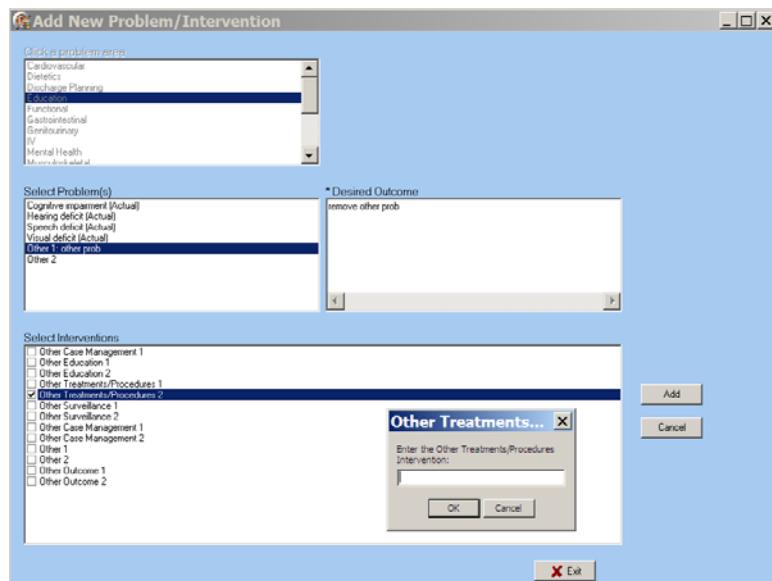
Information : New Problem/Intervention added!

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

Other Interventions

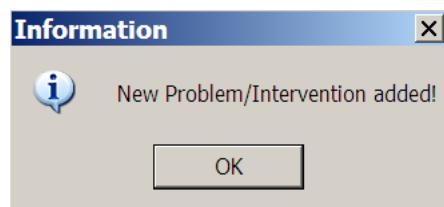
Some interventions generate a to enter interventions that are not on the predefined list.

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



Add New Problem/Intervention window with Other

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



Information : New Problem/Intervention added!

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

Working in the Consults

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

Example – Ordering a Chaplain Consult

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

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

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

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

Chaplain consult mandatory

Spiritual/Cultural Assessment - Patient's Religion: JEHOVAH'S WITNESSES

Are there religious practices or spiritual concerns the patient wants the chaplain, physician, and other health care team members to immediately know about? *Describe practices/concerns
Prior patient response: NO
 Yes No

Patient requests an immediate visit from the Chaplain
Prior patient response: NO
 Yes No

Does patient have any traditional, ethnic, or cultural practices that need to be part of care? *Describe practices
Prior patient response: NO
 Yes No

Does patient have any concerns or special considerations if a blood transfusion is needed? *Specify pastor or clergy
Prior patient response: NO
 Yes No

Does patient have a pastor or clergy who should be notified of this hospitalization?
Prior patient response: NO
 Yes No

Chaplain consult mandatory

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

2. Click <Chaplain Consult>.

The <INPATIENT CHAPLAIN> Consult window displays.

INPATIENT CHAPLAIN Consult

* Urgency: Routine

* Place of consult: Bedside

Provisional diagnosis: _____

* Reason for request:

* Patient will be seen as an:
 Inpatient Outpatient

* Provider: _____

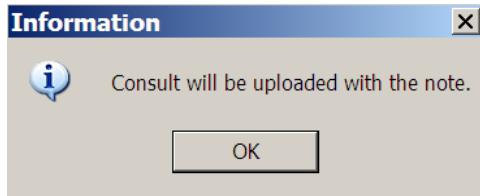
Person to notify: _____

Upload Consult 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.



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

Preferred Language
 English
 Spanish
 Other

* Other Language

Prior patient response: English

Additional goals for hospitalization

Prior patient response: English
Primary language

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

GENERAL INFORMATION	
Advance Directive Does patient have an Advance Directive? * Location of Advance Directive <input type="radio"/> Yes <input type="radio"/> No Prior patient response: NO	
Patient received info on Advance Directive <input type="radio"/> Yes <input type="radio"/> No Prior patient response: YES	
* Explain why patient did not receive info	
Does patient wish to initiate or make changes to an Advance Directive? <input type="radio"/> Yes <input type="radio"/> No	
Prior patient response: NO Social Work consult previously sent	

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

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

DISCHARGE PLANNING	
* Patient/family/support person able to respond to questions * Why could no one respond * Other reason no one could respond	
<input type="radio"/> Yes <input type="radio"/> No	
* Information obtained from * Other source of information <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Authorized surrogate <input type="checkbox"/> Family/Support Person <input type="checkbox"/> Medical Record <input type="checkbox"/> Other	
* Does patient have a legal/medical guardian (conservator)? <input checked="" type="radio"/> Yes <input type="radio"/> No	
* Specify guardian (conservator)	
* Employment Status <input type="radio"/> Presently employed <input type="radio"/> Unemployed <input type="radio"/> Retired <input type="radio"/> Disabled <input type="radio"/> Patient declines to answer	
* Relationship status <input type="radio"/> Co-habiting <input type="radio"/> Divorced <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Single <input type="radio"/> Widowed <input type="radio"/> Patient declines to answer	
* With whom does patient live <input type="radio"/> Alone <input type="radio"/> Family <input type="radio"/> Significant Other <input type="radio"/> Friend <input type="radio"/> Nursing Home <input type="radio"/> Assisted Living <input type="radio"/> Homeless <input type="radio"/> Patient declines to answer	
* Home environment <input type="checkbox"/> No identified problems <input type="checkbox"/> Stairs outside home <input type="checkbox"/> Stairs within home <input type="checkbox"/> Bed on main level <input type="checkbox"/> Full bathroom on main level <input type="checkbox"/> Bed & full bathroom on same floor (not main level) <input type="checkbox"/> Other architectural barriers (e.g. narrow doorways) <input type="checkbox"/> Patient declines to answer	
* Other architectural barriers <input type="checkbox"/> No equipment needed <input type="checkbox"/> Specialty bed <input type="checkbox"/> Specialty mattress <input type="checkbox"/> Ramp <input type="checkbox"/> Raised toilet seat <input type="checkbox"/> Safety bars <input type="checkbox"/> Other	
* Special Equipment Needed at Home * Other equipment needed	
* Transportation for Discharge <input type="radio"/> Own car <input type="radio"/> Friends/family <input type="radio"/> Bus <input type="radio"/> VA Shuttle <input type="radio"/> VA Travel <input type="radio"/> Other <input type="radio"/> Patient declines to answer	
* Other transportation for discharge	
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: Employment Status Go	

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

Navigating the RN Reassessment Tabs

The RN Reassessment template has 18 tabs.

General Information (Gen Inf)

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

The screenshot shows the RN Reassessment software interface. The title bar reads "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes "File", "Tabs", and "Help". The main content area is titled "GENERAL INFORMATION". It contains several input fields and dropdown menus:

- A radio button group for "Patient/family/support person able to respond to questions" with options "Yes" (selected) and "No".
- A dropdown menu for "Information obtained from" with options: Patient, Authorized surrogate, Family/Support Person, Medical Record, Other.
- A dropdown menu for "Other source of information" with options: Patient, Authorized surrogate, Family/Support Person, Medical Record, Other.
- A "Demographics" section showing Name: ZMSHTSWLSDHYS,CHUUN, Age: 100, Sex: MALE, Race: BLACK OR AFRICAN A.
- An "Admitting diagnosis" section stating "NONE FOUND".
- A "Prior patient response to 'What does patient want to accomplish by this hospitalization'" field.
- A "Preferred Healthcare Language" dropdown with options: English (selected), Spanish, Other.
- A "Other Language" field.
- A "Prior patient response" field.
- A "What does patient want to accomplish by this hospitalization" field.
- Navigation buttons at the bottom: Gen I Page 1, Gen I Page 2, Gen I Page 3, Gen I Page 4.
- Tab navigation buttons: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text.
- Help text: * Designates a required field, Go to radiogroup: able to respond to questions, Go.
- Status bar: 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
 EGGS
 PROCTER & GAMBLE

Yesterday's and Today's Orders

ORDERS YESTERDAY & TODAY - NONE FOUND

* Disposition of meds * Other Disposition

* Meds brought in by patient:

Yes
 No

* Implanted medication * Type of device/pump/medication * Is patient wearing any kind of medicinal patch?

Yes
 No

* Type of patch of medicinal 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

Prior patient response:

* 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.

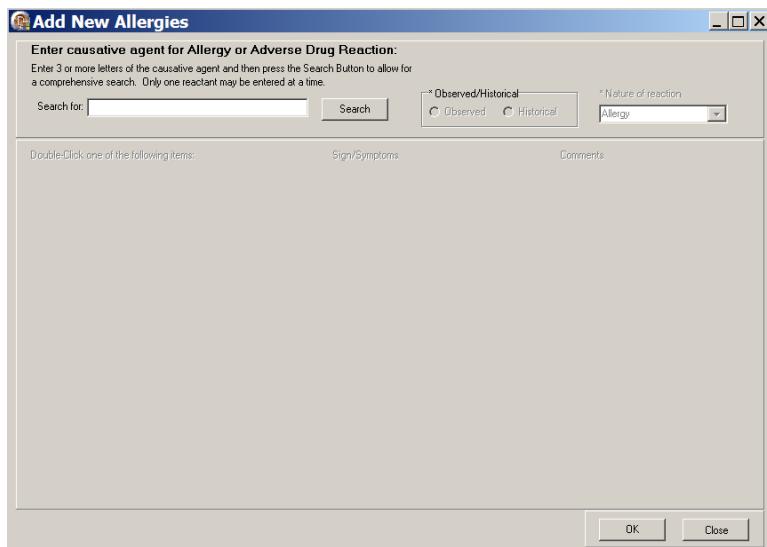
- Allergies are added on Gen I Page 2, in the Allergies text box.
- None of the fields on Gen I Page 2 is required during reassessment, provided a completed admission assessment is on file.

Adding an Allergy

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

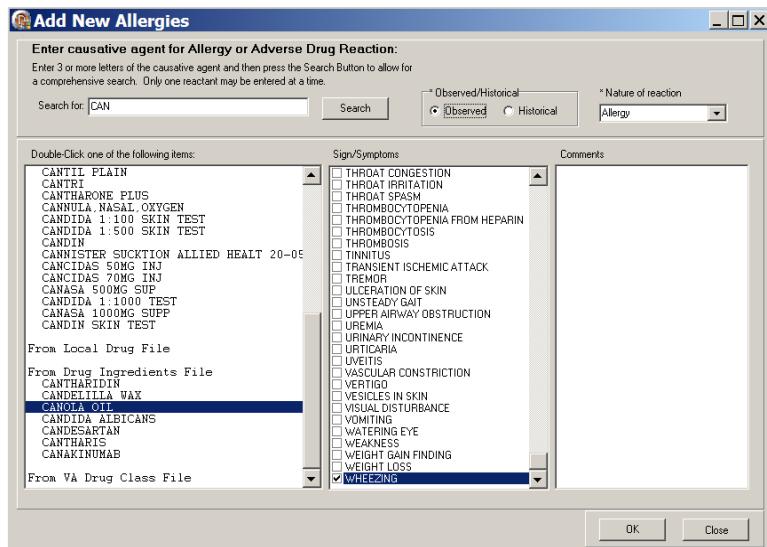
Note: Follow your local medical center policy with regard to adding allergies.

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 box displays.



Add New Allergies window with Sign/Symptoms available

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



Information : Allergy save done!

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

Initiating a Social Work Consult for Advance Directives

All of the consults in RN Reassessment work the same way; refer to the instructions in *Working in the Consults* on page 24.

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

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

GENERAL INFORMATION

* Does patient have an Advance Directive <input checked="" type="radio"/> Yes <input type="radio"/> No	* Location of Advance Directive <input type="text"/>	* Patient received info on Advance Directive <input type="text"/> <small>Prior patient response:</small>	* Explain why patient did not receive info <input type="text"/> <small>Prior patient response:</small>	* Does patient wish to initiate or make changes to an Advance Directive <input checked="" type="radio"/> Yes <input type="radio"/> No	<input type="button" value="Social Work Consult"/>
* Testing for MRSA brochure/equivalent information given to the patient/authorized surrogate <input checked="" type="radio"/> Yes <input type="radio"/> No		* Was the below Infection Control Education provided to the patient <input checked="" type="radio"/> Yes <input type="radio"/> No		Infection Control Education <input type="checkbox"/> Hand hygiene practices <input type="checkbox"/> Definition of MRSA, VRE, TB, and all resistant organisms <input type="checkbox"/> Spread of resistant organisms/prevention <input type="checkbox"/> Contact Precautions (as related to patient condition) <input type="checkbox"/> Respiratory Precautions (as related to patient condition) <input type="checkbox"/> Surgical site (as related to patient condition) <input type="checkbox"/> Other	
Prior patient response: <small>MRSA Nares swab performed</small>		Level of understanding <input type="checkbox"/> Prior response: <small>MRSA Nares swab performed on transfer with patient's agreement</small>		Precautions <input type="checkbox"/> Airborne <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Neutropenic	
Swab performed: <small>MRSA Nares swab performed on discharge with patient's agreement</small>		Prior response: <small>MRSA Nares swab performed on transfer with patient's agreement</small>		* Why wasn't it performed <input checked="" type="radio"/> Yes <input type="radio"/> No <small>MRSA Nares swab performed on discharge with patient's agreement</small>	
				* Why wasn't it performed <input checked="" type="radio"/> Yes <input type="radio"/> No <small>MRSA Nares swab performed on discharge with patient's agreement</small>	

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

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

The screenshot shows the 'RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' window. The 'File', 'Tabs', and 'Help' menu items are visible at the top. The main content area is titled 'GENERAL INFORMATION'. It contains three main sections: 'Advance Directive', 'Patient received info on Advance Directive', and 'Does patient wish to initiate or make changes to an Advance Directive'. The 'Social Work Consult' button is highlighted with a red border.

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

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

Changing Emergency Contact Information

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

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

The screenshot shows the RN Reassessment software interface. The title bar reads "RN Reassessment - BDYDXY, EHYUN WEDAADW (5105) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes "File", "Tabs", and "Help". The main window is titled "GENERAL INFORMATION".
Emergency contact information:
Contact: BDYDXY, EHYUN WEDAADW
Relationship: WIFE
Address: 9908 ROBIN NE.
FARM HILL, ID
Phone: 207-001-6182
Work Phone: QCYQFZS
General observations/comments:
A large text area for entering general observations and comments.
Support Person same as emergency contact:
 Support Person same as emergency contact
* Document the name and contact information of the patient's support person
Performing assessment:
A section for documenting the performing assessment.
Navigation:
Bottom navigation bar: Gen I Page 1, Gen I Page 2, Gen I Page 3, Gen I Page 4. The "Gen I Page 4" tab is selected. Below the tabs, a note says "* Designates a required field".

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

GENERAL INFORMATION

Emergency contact information

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

* Name (LN,FN):

* Relationship:

* Street Address 1:

Street Address 2:

Street Address 3:

* Zip Code:

Phone: Work Phone:

Support Person same as emergency contact

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

Emergency Contact and Support Person Information

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

Education (Educ)

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

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

The screenshot shows the 'EDUCATIONAL ASSESSMENT' tab of the RN Reassessment software. The window title is 'RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED'. The tab bar includes 'Gen Inf', 'Educ', 'Pain', 'IV', 'Resp', 'CV', 'Neuro', 'GI', 'GU', 'M/S', 'Skin', 'P/S', 'Rest', 'MH', 'Func', 'DP', 'PCE', and 'View Text'. The 'Educ' tab is selected.

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:**

*** Educational Level:**

- Grade school
- Junior high school
- High school
- College
- Graduate school
- Other
- Unable to answer
- Refuses to answer

*** Other education level:**

*** Has ability to read:**

- Yes
- No

*** Describe why unable to read:**

*** Has ability to write:**

- Yes
- No

*** Describe why unable to write:**

*** Learns best by:**

- Doing
- Hearing/Listening
- Reading
- Seeing

Prior patient response:

*** Barriers to learning:**

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

*** Describe identified barriers:**

*** Other barriers:**

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

- None
- Limited
- Extensive

Prior patient response:

*** Information provided to patient/support person on the following topics:**

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

*** Other topic provided:**

Joint Commission Phone Number: 1-800-994-6610

Performing assessment:

Buttons at the bottom:

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

Labels at the bottom:

- * Designates a required field
- Go to radiogroup:
- Go

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

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

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

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

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

Pain (Pain)

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

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

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

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

Is pain a problem for the patient/Yes

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

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

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

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

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

File Tabs Help

Pain Location #2		Pain Location #3	
* Pain Region None	* Quality of pain None	* Pain Region None	* Quality of pain None
* Other pain region	* Other quality of pain	* Onset of original pain (years, months)	* 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)	What makes pain worse	* Other provoking factor(s)
* Describe Pain Radiation		* Describe Pain Radiation	
What makes pain better	* Other palliative factor(s)	What makes pain better	* Other palliative factor(s)
* Rx/Otc Meds helping pain		* 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)?	
<input type="checkbox"/> More pain locations? <input type="checkbox"/> Designates a required field			
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			

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

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

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

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

5. **Optional:** Populate the Other Pain 2 page.
- Identify Pain Location #4/Pain Location #5 and document the behavioral indicators.
 - 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.

PAIN ASSESSMENT

* Is patient having any pain now?

No

Yes

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

None

* Other pain region

* Other quality of pain

Onset of original pain (years/months)

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

0

* Describe other timing of pain

* What makes pain worse

* Other provoking factor(s)

* What makes pain better

* Other palliative factor(s)

* Rx/Dic 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)?

* Does patient exhibit behavioral indicators related to pain

* Other behavioral indicator

Behavioral indicator(s) observed

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

* 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

The screenshot shows the RN Reassessment software interface. The top bar displays the title 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED' and standard menu options: File, Tabs, Help.

PAIN ASSESSMENT:

- * Is patient having any pain now?
 - Yes
 - No
 - Unable to respond to questions
- Explain if new occurrence: [Text Box]
- Patient has been placed on Palliative/Comfort Care since last patient assessment: [Check Box]

Pain Location #1:

- * Pain Region: None
- * Quality of pain: [Dropdown]
- * Other pain region: [Text Box]
- * Other quality of pain: [Text Box]
- Onset of original pain (years, months): [Text Box]

Severity of Pain: (0=None - 10=worst) [Dropdown]

Describe other timing of pain: [Text Box]

*** What makes pain worse:** [Text Box]

*** Other provoking factor(s):** [Text Box]

*** What makes pain better:** [Text Box]

*** Other palliative factor(s):** [Text Box]

*** Rx/Dic Meds helping pain:** [Text Box]

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

Behavioral Indicator(s) observed:

- * Does patient exhibit behavioral indicators related to pain? [Check Box]
- * Other behavioral indicator: [Text Box]
- None Observed
- Body Rigidity
- Crying
- Facial Grimacing
- Fainting
- Frightened Facial Expression
- Frowning
- Moaning
- Negative Vocalization
- Noisy Breathing
- Sad Facial Expression
- Unable to console, distract, or reassure
- Other

Areas of life affected by pain: [Text Box]

Comments for patient's life aspects: [Text Box]

Other pain location? [Text Box]

Navigation and Status:

- 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

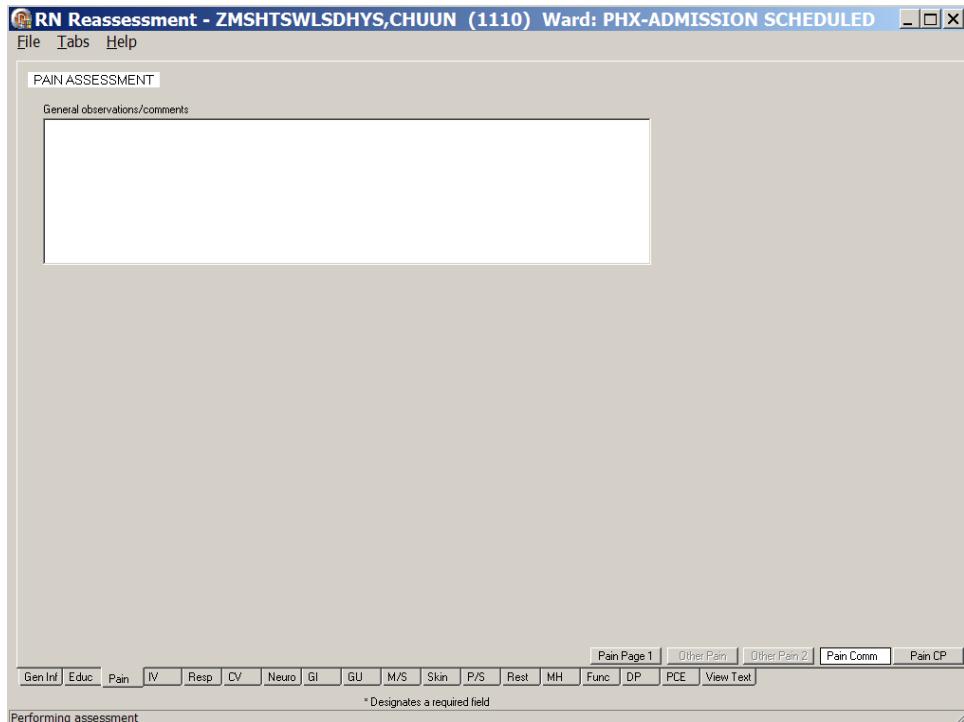
Performing assessment

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

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

2. Click **Pain Comm**.

Pain Comm displays.



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

3. Populate Pain Comm, if necessary.

Use the **General observations/comments** text box for additional information.

4. Click **Pain CP**.

Pain CP displays.

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

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									

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 1 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: 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

* Date/time inserted

* Other location

* Other size

* Other dressing condition

* Dressing type

* Other dressing type

* Site characteristics

* Drainage

* Other site appearance

* Describe patency

Dressing change
Last changed:
Dressing date/time change

Tubing change
Last changed:
Tubing date/time change

IV Discontinued

IV discontinute date/time

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 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.

The screenshot shows the RN Reassessment software interface. The title bar reads "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes File, Tabs, and Help. The main window is titled "IV" and contains a table with one row of data:

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

Below the table is a button labeled "Add New IV Location". A checkbox labeled "Show discontinued IVs also" is unchecked. The bottom section is a modal dialog titled "Edit Peripheral Line Site" with fields for Location, Date/time inserted, Other size, and Discontinued status. It also includes sections for Dressing change, Tubing change, and Site characteristics.

At the bottom of the screen, there is a navigation bar with tabs: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text, and IV Periph, IV Central, IV Dialysis, IV Comments, and IV CP. A note indicates that the IV tab is the active tab. A legend at the bottom says "* Designates a required field".

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

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

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

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

Add New IV Location

Show discontinued IVs also

Edit Peripheral Line site #1

* Location: Antecubital Right * Other location:

* Date/time inserted known: Yes No

* Date/time inserted:

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

* Other size:

IV Discontinued

IV discontinute date/time:

* Dressing: Clean, dry, intact Drainage Other

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

* IV patent: Yes No

* Other dressing condition: Bandaid Gauze Transparent Other None

* Dressing type: Other dressing type: No evidence of complications Drainage Pain Redness Swelling Other

* Site characteristics: 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

* Designates a required field

Performing assessment

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

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

New IV Lines

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

File Tabs Help

IV No IV/vascular access devices

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

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

Add New IV Location

Show discontinued IVs also

Edit Peripheral Line site #2

* Location Other location

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

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

IV Discontinued
 IV discontinue date/time

* Dressing change
 Last changed:
 Dressing date/time change

* Tubing change
 Last changed:
 Tubing date/time change

* Site characteristics
 Drainage
 Other site appearance
 Describe patency

* Other dressing condition
 Other dressing type
 Other/dressing type

* Other dressing type
 Other/dressing type

* Other site appearance
 Drainage
 Other site appearance
 Describe patency

* Describe patency
 Other/dressing type
 Other/dressing type

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 Periph window

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

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

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

Show discontinued IVs also

Edit Peripheral Line site #2

* Location: Forearm Right * Other location: Yes No
 Date/time inserted known

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

* Date/time inserted: Tubing change
 Last changed:
 Tubing date/time change

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

* Other size: IV Discontinued
 IV discontinute date/time

* Site characteristics: No evidence of complications Drainage
 Bandaid Pee Other
 Gauze Poop Redness
 Transparent Swelling Swelling
 Other Other

* Other site appearance: Describe patency

* IV patent: Yes No

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 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.

The screenshot shows the RN Reassessment software interface for managing central lines. The main title bar reads "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The window is titled "IV". A table lists one central line entry:

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

Below the table is a button labeled "Add New CL Location". The interface includes sections for "Edit Central Line Site" with dropdown menus for "Type" and "Location", and checkboxes for "Catheter impregnated" and "Central line discontinued". There are also sections for "Dressing change", "Tubing change", and "Site characteristics". At the bottom, there are "OK" and "Cancel edit" buttons, and a navigation bar with tabs like "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". A note at the bottom states "* Designates a required field".

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

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

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

File Tabs Help

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

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

Show discontinued Central Lines also

Edit Central Line site #2

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

* Catheter impregnated
 Yes
 No
 Unknown

* with antiseptic and/or antibiotic:
 Yes
 No
 Unknown

* Dressing:
 Clean, dry, intact
 Drainage
 Other

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

* Catheter power injectable:
 Yes
 No
 Unknown

* IV patent:
 Yes
 No

* Other dressing condition:
 Bandaged
 Gauze
 Transparent
 Other
 None

* Dressing type:
 Bandaged
 Gauze
 Transparent
 Other
 None

* Other dressing type:
 Bandaged
 Gauze
 Transparent
 Other
 None

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

* Drainage:
 No drainage

* Other site appearance:
 Redness

* Describe patency:
 Patent
 Non-patent

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 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.

The screenshot shows the RN Reassessment software interface. At the top, the title bar reads "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". Below the title bar, there are tabs for "File", "Tabs", and "Help". The main window is titled "IV" and contains a table with one row of data:

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

Below the table is a button labeled "Add New Dialysis Location". Underneath the table, there is a checkbox labeled "Show discontinued Dialysis access locations also".

The "Edit Dialysis access location #" section contains fields for "Type" (dropdown menu showing "None"), "Select Dialysis location" (dropdown menu showing "None"), "Other location" (text input field), "Other size" (text input field), "Dressing change" (checkbox), "Last changed" (text input field), "Dressing date/time change" (text input field), "Tubing change" (checkbox), "Last changed" (text input field), "Tubing date/time change" (text input field), "Other dressing condition" (checkbox), "Dressing type" (checkbox), "Other dressing type" (checkbox), "Site characteristics" (checkbox), "Drainage" (checkbox), "Other site appearance" (checkbox), "OK" button, and "Cancel edit" button.

At the bottom of the window, there are tabs for "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", "View Text", and "IV Periph", "IV Central", "IV Dialysis", "IV Comments", "IV CP". A note at the bottom states "* Designates a required field".

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

2. Populate IV Dialysis.

3. Click **Add New Dialysis Location**.

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

4. Select type and location.

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

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

File Tabs Help

IV

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

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

Show discontinued Dialysis access locations also

Edit Dialysis access location #2

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

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

* Other dressing condition: Bandaid Gauze Transparent Other None * Dressing type: No signs/symptoms of complication Bruise/hill present Bruise/hill not present Drainage Pain Redness Swelling * Site characteristics: * Drainage: * Other site appearance: OK Cancel edit

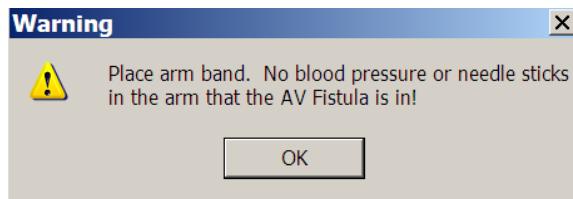
Gen Inf | Educ | Pain | IV | Resp | CV | Neuro | GI | GU | M/S | Skin | P/S | Rest | MH | Func | DP | PCE | View Text |

* Designates a required field

Performing assessment

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

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

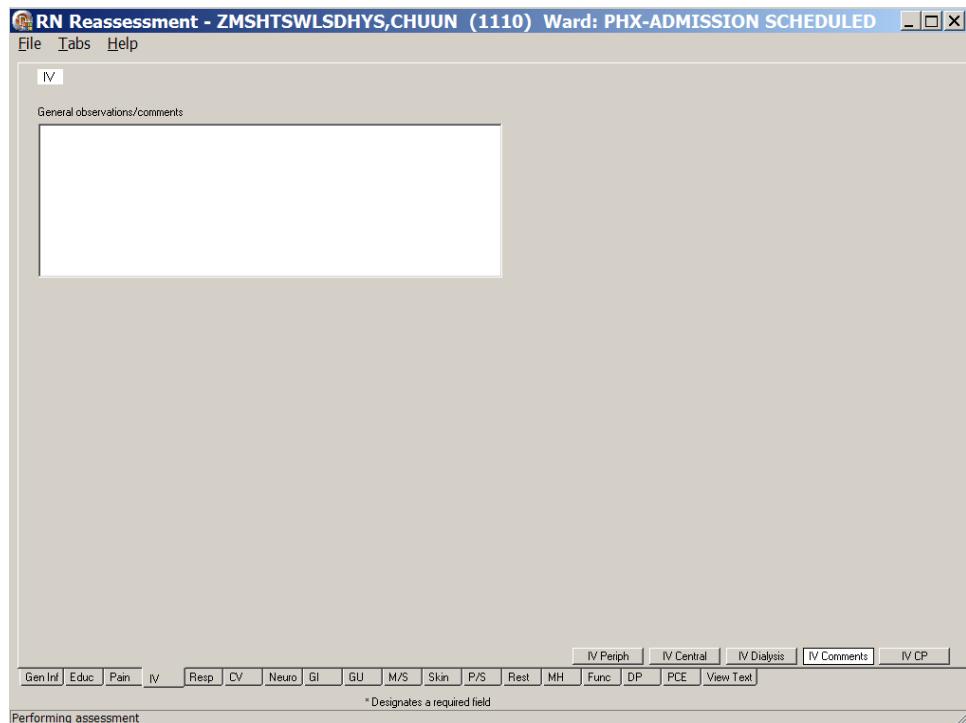


Warning: Place arm band.
No blood pressure or needle sticks in the arm that the AV Fistula or AV Graft is in!

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

General Observations/Comments – IV Comments

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



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

Care Plan - IV CP

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

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

File Tabs Help

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

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

Problem/Intervention detail

Do not display resolved problems

No change/Stable Deteriorating Improving Resolved Unresolved at discharge Completed Continue Discontinue Pending

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

Performing assessment

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

Respiratory (Resp)

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

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

The screenshot shows the RN Reassessment software interface for a patient named ZMSHTSWLSDHYS, CHUUN (1110) in the PHX-ADMISSION SCHEDULED ward. The window title is "RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The main panel is titled "RESPIRATORY ASSESSMENT".

Fields include:

- * Patient/family/support person able to respond to questions:
Yes (radio button selected)
- * Why could no one respond:
Other reason no one could respond
- * Other reason no one could respond:
Other
- * Information obtained from:
Patient (checkbox checked)
- * Other source of information:
Authorized surrogate, Family/Support Person, Medical Record, Other
- * Patient has a history of:
None reported, Asthma, COPD, Pulmonary Emboli, Pulmonary Fibrosis, Upper respiratory infections, TB, Other
- * Other history:
Other
- * Respiratory pattern:
Regular, Irregular - Agonal, Irregular - Cheyne-Stokes, Irregular - Kussmaul, Irregular - Other
- * Other respiratory pattern:
Other
- * Respiratory rate:
0
- * Respiratory depth:
Normal, Deep, Shallow
- * Chest movement:
Equal, bilateral, symmetrical, Abnormal
- * Abnormal Chest Movement:
Other
- * Work of breathing:
No difficulty observed, Dyspnea (shortness of breath), Nasal flaring, Gurgling, Purched Lips, Use of accessory muscles, Other
- * Other work of breathing:
Other
- * Cyanosis:
None, Central - tongue and lips, Peripheral - earlobes, fingertips, around lips
- * Breath sounds:
Absent, Crackles/Rales, Diminished/decreased, Rhonchi, Wheezing - expiratory, Wheezing - inspiratory
Options:
Clear (radio button selected), Abnormal
- * Stridor:
None
- * Pleural friction rub:
None

Buttons at the bottom:

- Resp Page 1, Resp Page 2, Other OT Loc, Resp Page 3, Resp CP
- Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text
- * Designates a required field
- Go to radiogroup: Respiratory depth
- Go

Performing assessment

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

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

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

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

RESPIRATORY ASSESSMENT

<input checked="" type="checkbox"/> Productive cough present Prior response: <input type="text"/>		* Sputum amount <input checked="" type="radio"/> Large <input type="radio"/> Moderate <input type="radio"/> Small Prior response: <input type="text"/>	* Sputum color <input type="checkbox"/> Bloody <input type="checkbox"/> Brown <input type="checkbox"/> Clear <input type="checkbox"/> Green <input type="checkbox"/> Pink 	* Other sputum color <input type="checkbox"/> Other	* Sputum consistency <input type="checkbox"/> Frothy <input type="checkbox"/> Mucous Plugs <input type="checkbox"/> Thick <input type="checkbox"/> Thin <input type="checkbox"/> Other	* Other sputum consistency <input type="checkbox"/> Other											
Chest tubes <input checked="" type="checkbox"/> Chest tubes present Prior response: NO <input type="text"/>		* Location 1 <input type="text"/>	* Suction <input type="checkbox"/> Suction * Other suction <input type="checkbox"/> Other suction	* Air Leak <input type="checkbox"/> Air Leak	* Chest tube drainage <input type="checkbox"/> Chest tube drainage	* Dressing <input type="checkbox"/> Dressing											
		Location 2 <input type="text"/>	* Suction <input type="checkbox"/> Suction * Other suction <input type="checkbox"/> Other suction	* Air Leak <input type="checkbox"/> Air Leak	* Chest tube drainage <input type="checkbox"/> Chest tube drainage	* Dressing <input type="checkbox"/> Dressing											
		<input type="checkbox"/> Other chest tube locations <input type="checkbox"/>															
Facility ordered oxygen <input checked="" type="checkbox"/> Facility ordered oxygen		* Liter flow <input checked="" type="radio"/> 1 L/Min <input type="radio"/> 2 L/Min <input type="radio"/> 3 L/Min <input type="radio"/> 4 L/Min <input type="radio"/> Other	* Other liter flow <input type="checkbox"/> Other liter flow	* Via <input checked="" type="radio"/> Bipap <input type="radio"/> Cpap <input type="radio"/> Cannula <input type="radio"/> Catheter <input type="radio"/> Mask <input type="radio"/> Other	* Other delivery method <input type="checkbox"/> Other delivery method	Oxygen saturation % <input type="text"/>	<input type="checkbox"/> Ventilator dependent - chronic * Ventilator dependent - chronic comments										
<input type="button" value="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 - ZMSHTWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED

RESPIRATORY ASSESSMENT

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

Productive cough present

Prior response:

Chest tubes

<input checked="" type="checkbox"/> Chest tube present	* Location 1	* Suction	* Air Leak	* Chest tube drainage	* Dressing
	Right Anterior	<input checked="" type="checkbox"/> Waterseal	<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> Clean, dry, intact
	Date/time inserted	<input type="button" value="20 cm"/>	<input type="checkbox"/> Slight bubbling on expiration	<input type="checkbox"/> Small	<input type="checkbox"/> Drainage
	12/08/11	<input type="button" value="10 cm"/>	<input type="checkbox"/> Large air leak on expiration	<input type="checkbox"/> Moderate	<input type="checkbox"/> Other
		<input type="button" value="Other"/>	<input type="checkbox"/> Air leak on inspiration/expiration	<input type="checkbox"/> Large	
			<input type="checkbox"/> Intermittent air leak	<input type="checkbox"/> Serous	
			<input type="checkbox"/> Crepitus present	<input type="checkbox"/> Seroanguinous	
				<input type="checkbox"/> Bloody	

Prior response: NO

Chest tube removed

Location 2	* Suction	* Air Leak	* Chest tube drainage	* Dressing
Right Posterior	<input checked="" type="checkbox"/> Waterseal	<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> Clean, dry, intact
Date/time inserted	<input type="button" value="20 cm"/>	<input type="checkbox"/> Slight bubbling on expiration	<input type="checkbox"/> Small	<input type="checkbox"/> Drainage
12/08/11	<input type="button" value="10 cm"/>	<input type="checkbox"/> Large air leak on expiration	<input type="checkbox"/> Moderate	<input type="checkbox"/> Other
	<input type="button" value="Other"/>	<input type="checkbox"/> Air leak on inspiration/expiration	<input type="checkbox"/> Large	
		<input type="checkbox"/> Intermittent air leak	<input type="checkbox"/> Serous	
		<input type="checkbox"/> Crepitus present	<input type="checkbox"/> Seroanguinous	
			<input type="checkbox"/> Bloody	

Chest tube removed

Other chest tube locations

Facility ordered oxygen

<input checked="" type="checkbox"/> Facility ordered oxygen	* Liter flow	* Via	Oxygen saturation %	<input type="checkbox"/> Ventilator dependent - chronic
	<input type="radio"/> 1 L/Min	<input type="radio"/> Bipap	<input type="button" value=""/>	<input type="checkbox"/> Ventilator dependent - chronic comments
	<input type="radio"/> 2 L/Min	<input type="radio"/> Cpap		
	<input type="radio"/> 3 L/Min	<input type="radio"/> Cannula		
	<input type="radio"/> 4 L/Min	<input type="radio"/> Catheter		
	<input type="radio"/> Other	<input type="radio"/> Mask		
		<input type="radio"/> Other		

Respiratory Consult

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

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

4. Populate Resp Page 2.
Complete all the fields with asterisks; they are required fields.
 - a. If the Respiratory Consult is set up at your site, use the Respiratory Consult button to order the consult, in accordance to the condition of the patient and the policy of your medical center.
 - b. Refer to the instructions in *Working in the Consults* on page 24.
 - c. Select the **Other chest tube locations** check box.
The Other CT Loc page is made available.
5. Click **Other CT Loc**.
Other CT Loc displays.
6. Populate Other CT Loc, CT locations 3 and 4, if necessary.
Complete all the fields with asterisks; they are required fields.

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

RESPIRATORY ASSESSMENT

Chest tubes

* Location 3
Right Posterior
Date/time inserted
12/08/11 16:12

* 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
Serous
Serosanguinous
Bloody

* Dressing
Clean, dry, intact
Drange
Other

* Other dressing

* Location 4

* Suction

* Other suction

* Air Leak

* Chest tube drainage

* Dressing

* Other dressing

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, 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
- * Type
 - Fenestrated
 - Non-fenestrated
 - Old stoma/no appliance
 - Other
- Trach recently inserted
- * Insertion date/time

* Size Known: Yes No

* Stoma appearance: No problems observed

- Redness
- Swelling
- Sutures
- Tissue breakdown present
- Other

* Other stoma appearance: Trach removed

* Removed date/time

* Dressing: Clean, dry, intact

* Other dressing: No dressing/open to air

Other

* Dressing change? Dressing date/time change

* Dressing type: Other dressing type

* Dressing date/time 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 or 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

Performing assessment

Resp Page 1 | Resp Page 2 | Other CT Loc | Resp Page 3 | Resp CP |
 Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text

* Designates a required field Go to radiogroup: Go

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

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

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

File Tabs Help

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

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

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

Problem/intervention detail

Problem evaluation	Intervention status
<input type="radio"/> No change/Stable <input checked="" type="radio"/> Deteriorating <input type="radio"/> Improving <input type="radio"/> Resolved <input type="radio"/> Unresolved at discharge	<input checked="" type="radio"/> Completed <input type="radio"/> Continue <input type="radio"/> Discontinue <input type="radio"/> Pending
<input type="button" value="OK"/> <input type="button" value="Cancel"/>	

Resp Page 1 | Resp Page 2 | Other CT Loc | Resp Page 3 | Resp CP
 Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text
 * Designates a required field Go to radiogroup: 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, Cardiovascular Assessment (CV) tab, CV Page 1 window

- Click **CV**.
CV Page 1 displays.
- Populate CV Page 1.
 - Complete all the fields with asterisks; they are required fields.
 - Use the **Extremities comments** text box for additional information, if necessary.
- 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		Dorsalis Pedis Pulse		Posterior Tibial Pulse	
Left	Right	Left	Right	Left	Right
<input type="button" value=""/>					

* Describe venous distension

Jugular Venous Distension:

Yes No

Homan's sign:

Negative Right Calf
 Positive Left Calf

Cardiac monitor:

Yes No

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

Cardiac devices

External pacemaker Permanent pacemaker

Implantable cardioverter/defibrillator (ICD) Other device

Prior cardiac monitor response: * Other cardiac monitor rhythm

T Wave:

General observations/comments

PR Interval:

QRS Duration:

QT Interval:

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 Distension 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 - ZMSHTSWLSDHYS,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 Intervention status

<input type="radio"/> No change/Stable	<input type="radio"/> Completed	<input type="button" value="OK"/>
<input type="radio"/> Deteriorating	<input type="radio"/> Continue	<input type="button" value="Cancel"/>
<input type="radio"/> Improving	<input type="radio"/> Discontinue	
<input type="radio"/> Resolved	<input type="radio"/> Pending	
<input type="radio"/> Unresolved at discharge		

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 Go

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.

The screenshot shows the RN Reassessment software interface for patient ZMSHTSWLSDHYS, ID 3122, in the PHX-ADMISSION SCHEDULED ward. The window title is "RN Reassessment - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED". The main tab selected is "NEUROLOGICAL ASSESSMENT".

Patient/family/support person able to respond to questions:

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

Patient has a history of:

- None reported
- CVA
- Multiple sclerosis
- Seizures
- Spinal cord injury
- Traumatic brain injury (TBI)
- Other

Spinal Cord Injury Level:

Orientation:

- Person, place, time, and situation
- Person, place, and time
- Person and place
- Person only
- Not oriented at all

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):

- 6 Obeys Commands
- 5 Localizes pain
- 4 Withdraws from pain
- 3 Flexes to pain
- 2 Extends to pain
- 1 No motor response

Total score: 0

Prior score: 0

Score is expressed as Eye (4) + Verbal (5) + Motor (6)

Glasgow score categories:

- 13-15 (normal result)
- 9-12 (correlates with moderate brain injury)
- 8 or less (correlates with severe brain injury)

Information obtained from:

- Patient
- Authorized surrogate
- Family/Support Person
- Medical Record
- Other

Other source of information:

Buttons at the bottom:

- 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

Links at the bottom:

- Neuro Page 1 | Neuro Page 2 | Neuro CP

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

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:

General observations/comments

* New sensations present
 Prior response:

* New comm device needed
 Prior response:

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

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											

Do not display resolved problems

Problem/intervention detail

Problem evaluation	Intervention status
<input type="radio"/> No change/Stable <input type="radio"/> Deteriorating <input type="radio"/> Improving <input type="radio"/> Resolved <input type="radio"/> Unresolved at discharge	<input type="radio"/> Completed <input type="radio"/> Continue <input type="radio"/> Discontinue <input type="radio"/> Pending
<input type="button" value="OK"/> <input type="button" value="Cancel"/>	

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 | Go |

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.

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

GI Device #1 * Type: None <input type="checkbox"/> New since last assessment Date/time <input type="checkbox"/> Removed since last assessment Date/time	GI Device #2 * Type: None <input type="checkbox"/> New since last assessment Date/time <input type="checkbox"/> Removed since last assessment Date/time
GI Device #3 * Type: None <input type="checkbox"/> New since last assessment Date/time <input type="checkbox"/> Removed since last assessment Date/time	GI Device #4 * Type: None <input type="checkbox"/> New since last assessment Date/time <input type="checkbox"/> Removed since last assessment Date/time

Gen Inf Educ Pain IV Resp CV Neuro GI GI Page 1 GI Dev GI Dev 2 GI Page 2 GI Page 3 GI CP

Performing assessment

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.

GASTROINTESTINAL ASSESSMENT

GI Device #1 * Type: Colostomy bag <input type="checkbox"/> New since last assessment Date/time <input type="checkbox"/> Removed since last assessment Date/time	GI device comments
---	--------------------

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

GI Device #5	GI device comments
* Type None	
<input type="checkbox"/> New since last assessment Date/time	
<input type="checkbox"/> Removed since last assessment Date/time	
GI Device #6	GI device comments
* Type None	
<input type="checkbox"/> New since last assessment Date/time	
<input type="checkbox"/> Removed since last assessment Date/time	
GI Device #7	GI device comments
* Type None	
<input type="checkbox"/> New since last assessment Date/time	
<input type="checkbox"/> Removed since last assessment Date/time	
GI Device #8	GI device comments
* Type None	
<input type="checkbox"/> New since last assessment Date/time	
<input type="checkbox"/> Removed since last assessment Date/time	

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

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

* Designates a required field

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Oral Screen Assessment - General <input type="checkbox"/> No problems/impairments <input type="checkbox"/> Assistance needed with oral hygiene <input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> All teeth present <input type="checkbox"/> Poor dentition <input type="checkbox"/> No dentition <input type="checkbox"/> Could not assess	Assessment - Mucous Membrane <input type="checkbox"/> Bleeding <input type="checkbox"/> Cyanotic <input type="checkbox"/> Intact <input type="checkbox"/> Lesions present <input type="checkbox"/> Pale <input type="checkbox"/> Pink	Nutrition screen * Description of patient <input type="radio"/> Well nourished <input type="radio"/> Obese <input type="radio"/> Emaciated * Appetite <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Unable to determine <input type="checkbox"/> Other
Height: 54 in [137.2 cm] (08/29/2009 10:43) Weight: 165.35 lb [75.2 kg] (12/15/2009 14:30) BMI: DEC 16, 2009@14:30:21		
Prior response: Diet History: * Does patient have any ethnic/cultural/ religious food preferences <input type="radio"/> Yes <input type="radio"/> No Prior response: * Does patient have any special diet needs <input type="radio"/> Yes <input type="radio"/> No Prior response: Prior food preferences		
* Unintentional weight loss or gain in the past month: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Prior response: Nutrition consult guidelines: <input type="checkbox"/> Patient on tube feeding or total parenteral nutrition <input type="checkbox"/> 5% unintentional weight gain or loss in past 30 days <input type="checkbox"/> Nausea/vomiting/diarrhea for greater than 3 days <input type="checkbox"/> Less than 50% usual intake for greater than 5 days <input type="checkbox"/> Dysphagia or dysphagia symptom		

[GI Page 1](#) | [GI Dev](#) | [GI Dev 2](#) | [GI Page 2](#) | [GI Page 3](#) | [GI CP](#)
[Gen Inf](#) | [Educ](#) | [Pain](#) | [IV](#) | [Resp](#) | [CV](#) | [Neuro](#) | [GI](#) | [GI](#) | [GU](#) | [M/S](#) | [Skin](#) | [P/S](#) | [Rest](#) | [MH](#) | [Func](#) | [DP](#) | [PCE](#) | [View Text](#)
 * Designates a required field Go to radiogroup: Go

Performing assessment

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

8. Populate GI Page 2.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. GI Page 2 contains the Nutrition Consult.
Refer to the instructions in *Working in the Consults* on page 24.
9. Click **GI Page 3**.
GI Page 3 displays.

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

File Tabs Help

GASTROINTESTINAL ASSESSMENT

Dysphagia screen	* Other reason unable to screen	Dysphagia risk factors
<input type="checkbox"/> Dysphagia screen <input type="checkbox"/> Able to screen <input type="checkbox"/> Unable - Patient on Ventilator <input type="checkbox"/> Unable - Patient unconscious <input type="checkbox"/> Unable - Other <input type="checkbox"/> N/A		* 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:
	<i>Wet gurgly voice</i>	<i>Drooling while awake</i>
		* Tongue deviation from midline
		Speech Consult
		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

10. Populate GI Page 3.
 - a. Complete all the fields with asterisks; they are required fields.
 - b. Use the **General observations/comments** text box for additional information.
 - c. GI Page 3 contains the Speech Consult.
Refer to the instructions in *Working in the Consults* on page 24.
11. Click **GI CP**.
GI CP displays.

RN Reassessment - ZMSHTSWLSDHYS,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									

Do not display resolved problems

Problem/intervention detail

Problem evaluation	Intervention status	OK
<input type="radio"/> No change/Stable <input type="radio"/> Deteriorating <input type="radio"/> Improving <input type="radio"/> Resolved <input type="radio"/> Unresolved at discharge	<input type="radio"/> Completed <input type="radio"/> Continue <input type="radio"/> Discontinue <input type="radio"/> Pending	<input type="button" value="OK"/>
		<input type="button" value="Cancel"/>

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

12. Update the GI CP, if necessary.

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

Genitourinary (GU)

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

The screenshot shows the RN Reassessment software interface for the Genitourinary (GU) tab. The window title is "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The main content area is titled "GENITOURINARY ASSESSMENT".

Key sections and fields visible:

- Patient/family/support person able to respond to questions:** Radio buttons for "Yes" (selected) and "No".
- Why could no one respond:** Text input field.
- Other reason no one could respond:** Text input field.
- Information obtained from:** Checkboxes for Patient (selected), Authorized surrogate, Family/Support Person, Medical Record, and Other.
- Other source of information:** Text input field.
- Patient has a history of:** Checkboxes for various medical conditions: None reported, Cancer, Diabetes, Dialysis - Peritoneal, Dialysis - Hemodialysis, Urinary tract disease, Neurogenic bladder, Sexually transmitted disease, TURP, Urinary tract infections, and Other.
- Voiding:** Radio buttons for Known (selected) and Unknown. A checkbox for Absorbency devices used.
- Intermittent catheterization frequency:** Radio buttons for No problems, Anuria, Oliguria, Polyuria, Frequency, Incontinence, Intermittent catheterization, Nocturia, Oliguria, Polyuria, Retention, Urgency, and Other.
- Other voiding:** Radio buttons for Known (selected) and Unknown.
- Urine:** Radio buttons for Color (Amber, Yellow, Bloody, Unable to evaluate, Other). Consistency (Normal, Concentrated, Dilute, Unable to evaluate).
- Odor:** Radio buttons for Foul smelling, None, and Unable to evaluate.
- Sediment:** Radio buttons for Yes, No, and Unable to evaluate.
- Abnormal discharge:** Radio buttons for None, Genital, and Unable to evaluate. A "Describe abnormal discharge" text input field.
- Prior response:** Text input field.
- Legend:** Asterisks (*) indicate required fields.
- Navigation:** Buttons for 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, and a "Performing assessment" button.
- Notes:** A note at the bottom states "* Designates a required field" and "Go to radiogroup: Color".

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.

The screenshot shows the RN Reassessment software interface. The title bar reads "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes "File", "Tabs", and "Help". The main window is titled "GENITOURINARY ASSESSMENT". It contains four separate sections for "GU Device #1", "GU Device #2", "GU Device #3", and "GU Device #4". Each section has a dropdown menu for "Type" (set to "None"), a "GU device comments" field, and two checkboxes: "Inserted since last assessment" and "Removed since last assessment", each with a "Date/time inserted" field below it. At the bottom of the window, there is a navigation bar with tabs: "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". The "GU Dev" tab is selected. Below the tabs, there is a note: "* Designates a required field".

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

Prior response

* Other device

Indwelling removed

Concerns voiced regarding sexual functioning

* Sexual Functioning concerns voiced

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

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

Prior response

* Other device

Indwelling removed

Concerns voiced regarding sexual functioning

* Sexual Functioning concerns voiced

Female patients

* Pregnancy

Approximate date

Approximate date

Approximate date

Male patients

Last prostate exam date

- Known
- Unknown
- No previous exam reported

Approximate date

Last PSA: - NONE FOUND

General observations/comments

GU Page 1 GU Dev GU Page 2 GU CP

Gen 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 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 - 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
- Urostomy bag
- Other

* Indwelling catheter size

Prior response

* Other device

Indwelling recently inserted Indwelling removed

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

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									

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 | 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

* Designates a required field

Performing assessment

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.

The screenshot shows the RN Reassessment software interface for the Musculoskeletal Assessment (M/S) tab. The window title is "RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes File, Tabs, and Help. The main content area is titled "MUSCULOSKELETAL ASSESSMENT".
Fields include:

- "Patient/family/support person able to respond": Radio buttons for Yes (selected) and No.
- "Why could no one respond": Text input field.
- "Other reason no one could respond": Text input field.
- "Information obtained from": Checkboxes for Patient (selected), Authorized surrogate, Family/Support Person, Medical Record, and Other.
- "Other source of information": Text input field.
- "Patient has a history of": A list of medical conditions with checkboxes.
 - 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": Text input field.
- "Body part(s) amputated": Text input field.
- "Range of Motion": Checkboxes for ROM - No apparent problem, Limited ROM - Right Upper Extremity, Limited ROM - Left Upper Extremity, Limited ROM - Right Lower Extremity, and Limited ROM - Left Lower Extremity.
- "Stated patient complaints": Text input field.
- "General observations/comments": Text input field.

At the bottom, there are tabs for M/S Page 1 (selected), M/S Page 2, and M/S CP. A footer bar includes Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text, and a note: "* Designates a required field".

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

2. Populate M/S Page 1.

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

3. Click M/S Page 2.

M/S Page 2 displays.

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

* Fall risk assessment indicated
 Yes No

* History of falling Describe previous falls and history

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

* Is patient on multiple meds to

Instructions for completing Morse Fall Scale

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

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

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

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

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

Total Morse score for Fall Risk: N/A

Prior score: Not assessed
 Date:

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

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

Gen 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

4. Populate M/S Page 2.

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

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

The screenshot shows the RN Reassessment software interface. The title bar reads "RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The main content area is titled "MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE". A radio button group for "Fall risk assessment indicated" has "Yes" selected. Below it, a question asks if there is a history of falling within 3 months, with options "No (0)" and "Yes (25)". A note says "Describe previous falls and history". Another section asks if the patient is on any meds that increase risk for falling or risk for injury with falls, with options "No (0)" and "Yes (25)". A note says "Other medication that increases risk". A section for "Secondary Diagnosis" has options "No (0)" and "Yes (15)". A section for "Ambulatory aid" has options "None, bedrest, wheelchair, other person (0)", "Crutches, cane, walker (15)", and "Furniture (30)". A section for "Gait/Transferring" has options "Normal, bedrest, immobile (0)", "Weak (10)", and "Impaired (20)". A section for "Intravenous Therapy/Heparin Lock" has options "No (0)" and "Yes (20)". A section for "Mental Status" has options "Oriented to own ability (0)" and "Diverestimates/Forgets Limitations (15)". On the right, instructions for completing the Morse Fall Scale are provided, along with detailed scoring for each category based on patient history and functional status. At the bottom, a note specifies the total score: "Total Morse score for Fall Risk: 0". It also includes a note about prior scores and the date of 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

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	Environment of Care Precautions	Other fall prevention interventions based upon clinical judgement
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	Place patient articles within easy reach Day lights 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)	

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

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

Do not display resolved problems

Problem/intervention detail

Problem evaluation:	Intervention status:
<input type="radio"/> No change/Stable <input type="radio"/> Deteriorating <input type="radio"/> Improving <input type="radio"/> Resolved <input type="radio"/> Unresolved at discharge	<input type="radio"/> Completed <input type="radio"/> Continue <input type="radio"/> Discontinue <input type="radio"/> Pending
<input type="button" value="OK"/> <input type="button" value="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

Performing assessment

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

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

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

Skin (Skin)

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

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

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

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

The screenshot shows the RN Reassessment software interface for patient ZMSHTWLSDHYS, CHUUN (1110) in the PHX-ADMISSION SCHEDULED ward. The window title is "RN Reassessment - ZMSHTWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The main focus is the "SKIN ASSESSMENT" tab. Key sections include:

- Patient/family/support person able to respond to questions:** Radio buttons for "Yes" (selected) and "No".
- Patient has a history of:** A list of skin conditions with checkboxes:
 - None reported
 - Acne
 - Athlete's foot
 - Burns
 - Cancer
 - Eczema
 - Herpes Simplex
 - Herpes Zoster (Shingles)
 - Injury/trauma
 - Pressure Ulcer
 - Promises
 - Rosacea
 - Sebaceous cysts
 - Other
- Predisposition for skin breakdown:** A list of conditions with checkboxes:
 - Amputee
 - Diabetes
 - Multiple Sclerosis
 - Neurological disease
 - Paraplegia
 - Paralysis
 - Quadriplegia
 - Spinal cord injury
- Risk Factors:** A list of factors with checkboxes:
 - None
 - Bariatric patient
 - Device-related pressure
 - Diabetes
 - End of life care
 - Hypoglycemia
 - Medication - Vasopressors
 - Refusing to turn/move secondary to pain
 - Too unstable for turns
 - Very low BMI (Body Mass Index)
 - Other
- Skin Inspection:** Fields for Skin Temperature (Warm, Hot, Cool, Cold) and Skin Moisture (Extremely dry, Dry, Moist, Diaphoretic).
- General observations/comments:** A large text area for additional notes.
- Buttons at the bottom:** Skin Page 1, Skin Pr UI 1, Skin Pr UI 2, Skin All 1, Skin All 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.
- Footers:** * Designates a required field, Go to radiogroup: Skin Patches, Go.

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

- Click **Skin**.
- Skin Page 1 displays.
- Populate Skin Page 1
 - Complete all the fields with asterisks; they are required fields.
 - 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 software interface. At the top, there are two checkboxes: 'Pressure ulcers' (which is checked) and 'Skin alterations'. Below this is a horizontal navigation bar with tabs: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text, Skin Page 1, Skin Pr Ul 1 (highlighted in blue), Skin Pr Ul 2, Skin Alt 1, Skin Alt 2, Skin Page 3, and Skin CP. Below the navigation bar is a note: '* Designates a required field'. Further down is a dropdown menu: 'Go to radiogroup: Skin Patches' and a 'Go' button. At the bottom left is the text 'Performing assessment'.

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 software interface with the title 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED'. The main area is titled 'SKIN ASSESSMENT'. It contains five sections labeled 'Pressure Ulcer #1', 'Pressure Ulcer #2', 'Pressure Ulcer #3', 'Pressure Ulcer #4', and 'Pressure Ulcer #5'. Each section has three dropdown menus: 'Location', 'Stage', and 'Status', followed by a 'Description of ulcer/dressing' input field. Below these sections is a link 'Click here for pressure ulcer staging information'. At the bottom is a horizontal navigation bar with tabs: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text, Skin Page 1, Skin Pr Ul 1 (highlighted in blue), Skin Pr Ul 2, Skin Alt 1, Skin Alt 2, Skin Page 3, and Skin CP. Below the navigation bar is a note: '* Designates a required field'. At the bottom left is the text 'Performing assessment'.

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

Pressure Ulcer Drop-downs

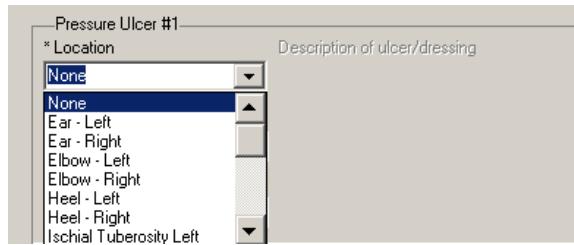
Pressure Ulcer #1

* Location

None

None
Ear - Left
Ear - Right
Elbow - Left
Elbow - Right
Heel - Left
Heel - Right
Ischial Tuberosity Left

Description of ulcer/dressing



Skin Assessment - Pressure Ulcer/Location

* Location

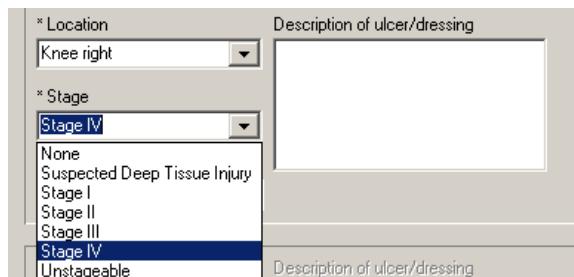
Knee right

* Stage

Stage IV

None
Suspected Deep Tissue Injury
Stage I
Stage II
Stage III
Stage IV
Unstageable

Description of ulcer/dressing



Skin Assessment - Pressure Ulcer/Stage

* Location

Knee right

* Stage

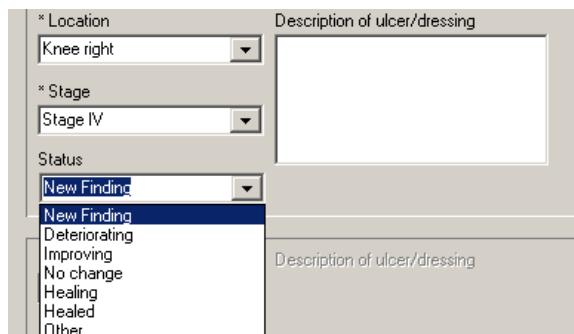
Stage IV

Status

New Finding

New Finding
Deteriorating
Improving
No change
Healing
Healed
Other

Description of ulcer/dressing



Skin Assessment - Pressure Ulcer/Status

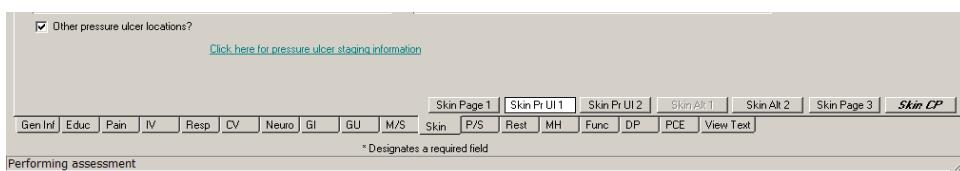
3. To enter more than six pressure ulcer locations, select the **Other pressure ulcer locations?** check box.

Skin Pr UI 2 displays.

Other pressure ulcer locations?
[Click here for pressure ulcer staging information](#)

Skin Page 1 | Skin Pr UI 1 | Skin Pr UI 2 | Skin All 1 | Skin All 2 | Skin Page 3 | Skin DP |
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, Skin Assessment (Skin) tab, Skin Pr UI 1 window
Other pressure ulcer locations? selected

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

File Tabs Help

OTHER PRESSURE ULCERS

Pressure Ulcer #7	Description of ulcer/dressing	Pressure Ulcer #8	Description of ulcer/dressing
* Location None		* Location None	
* Stage None		* Stage None	
Status None		Status None	
Pressure Ulcer #9	Description of ulcer/dressing	Pressure Ulcer #10	Description of ulcer/dressing
* Location None		* Location None	
* Stage None		* Stage None	
Status None		Status None	
Pressure Ulcer #11	Description of ulcer/dressing	Pressure Ulcer #12	Description of ulcer/dressing
* Location None		* Location None	
* Stage None		* Stage None	
Status None		Status None	

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

Performing assessment

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

4. Populate Skin Pr UI 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 software interface. At the top, there are two checkboxes: 'Pressure ulcers' (unchecked) and 'Skin alterations' (checked). Below the checkboxes is a horizontal menu bar with various 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 'Skin' tab is currently selected. To the right of the menu bar is a toolbar with buttons for Skin Page 1, Skin Pr UI 1, Skin Pr UI 2, Skin Alt 1, Skin Alt 2, Skin Page 3, and Skin CP. Below the menu bar is a status bar with the text 'Performing assessment'. At the bottom of the window is a message box stating '* Designates a required field' and 'Go to radiogroup: Skin Patches' with a dropdown arrow 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 software interface on the Skin Alt 1 tab. The window title is 'RN Reassessment - BDYDXY,ILQDI A (2902) Ward: PHX-ADMISSION SCHEDULED'. The main area contains six identical input fields for skin alterations, each labeled '#1' through '#6'. Each field has three dropdown menus for 'Type', 'Location', and 'Size', and a checkbox for 'Healed'. To the right of each field is a 'Description of skin alteration' text area. Below the input fields is a horizontal menu 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 'Skin' tab is selected. A status bar at the bottom left says 'Performing assessment'.

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	Description of skin alteration
Abrasion	<input type="checkbox"/> Healed
Abrasion	
Bite	
Bruising	
Burn	
Crush Injury	
Hematoma	
Laceration	
Penetrating Wound	

Skin Assessment – Skin Alteration/Type

* Type	Description of skin alteration
Abrasion	<input type="checkbox"/> Healed
* Location	
Abdomen - Right	
Abdomen - Right	
Abdomen - Left	
Ankle - Right	
Ankle - Left	
Arm - Right, upper	
Arm - Right, lower	
Arm - Left, upper	
Arm - Left, lower	

Skin Assessment – Skin Alteration/Location

* Type	Description of skin alteration
Abrasion	
* Location	
Abdomen - Right	
* Size	
1 cm	<input type="checkbox"/> Healed

Skin Assessment – Skin Alteration/Size

3. Click **Skin Alt 2**.

Skin Alt 2 displays.

The screenshot shows the RN Reassessment software interface. The main title bar reads "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes "File", "Tabs", and "Help". The active tab is "Skin Assessment". The main content area is titled "SKIN ASSESSMENT" and contains six sections for "Skin Alteration #7" through "#12". Each section has dropdown menus for "Type" and "Location", a text input field for "Size", and a checkbox labeled "Healed". Below these sections is a navigation bar with tabs: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin 1, Skin Pr/UIT 1, Skin Pr/UIT 2, Skin Alt 1, Skin Alt 2, Skin Page 3, and Skin CP. A note at the bottom of the navigation bar states "* Designates a required field".

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

4. Populate Skin Alt 2.

- Enter **Type**, **Location**, and **Size** for six (#7-#12) additional skin alterations.
The fields with asterisks are required fields.

- 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

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

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

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

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

Total Score: N/A

Prior score: Not assessed
 Date:

Risk Category

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 paraparesis 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.

Consult guide

Nutrition Consult **Wound Care Consult**

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[Skin Page 1] [Skin P/U 1] [Skin P/U 2] [Skin Alt 1] [Skin Alt 2] [Skin Page 3] [Skin CP]
 Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text
 * Designates a required field Go to radiogroup: Skin assessment indicated Go
 Performing assessment

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

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

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

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

File Tabs Help

SKIN ASSESSMENT BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

* Skin assessment indicated Yes No

SENSORY PERCEPTION: Ability to respond meaningfully to pressure-related discomfort	* Sensory Score: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	NUTRITION: Usual food intake pattern	* Nutrition Score: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
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	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		
MOISTURE: Degree to which skin is exposed to moisture	* Moisture Score: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	FRICITION AND SHEAR:	* Friction Score: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
1. CONSTANTLY MOIST: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	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		
ACTIVITY: Degree of physical activity	* Activity Score: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Total Score: 0	
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	Prior score: Not assessed Date: _____		
MOBILITY: Ability to change and control body position	* Mobility Score: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Risk Category:	
1. COMPLETELY IMMOBILE: Does not make even slight changes in body or extremity position without assistance.	Not at risk (19-23) At risk (15-18) Moderate risk (13-14) High risk (10-12) Severe risk (9 or below)		
<p>Copyright: Barbara Braden and Nancy Bergstrom, 1988. Reprinted with permission.</p> <p>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 deficit; or paraparesis or spinal cord injury exists, consider Wound Care Clinician alert.</p> <p>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.</p> <p>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.</p> <p>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 deficit; or paraparesis or spinal cord injury exists, consider Wound Care Clinician alert.</p> <p>Nutrition Consult Wound Care Consult</p>			
<p>Skin Page 1 Skin Pr/U1 1 Skin Pr/U1 2 Skin Alt 1 Skin Alt 2 Skin Page 3 Skin CP</p> <p>Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text</p> <p>* Designates a required field Go to radiogroup: Skin assessment indicated Go </p> <p>Performing assessment</p>			

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

- c. **Optional:** Order a Nutrition Consult and/or Wound Care Consult from Skin Page 3, if necessary.
 Refer to the instructions in *Working in the Consults* on page 24.
- 7. Click **Skin CP.**
 Skin CP displays.

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

File Tabs Help

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

PROBLEMS - RISK FOR SKIN BREAKDOWN

DESIRED OUTCOME - PREVENTION/TREATMENT OF PROBLEMS RELATED TO SKIN INTEGRITY

* Patient/caregiver education provided * Education provided to * Other education provided to

Yes
 No

Braden scores (Prior score:)
 No Braden score done this shift assessment.

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 Intervention status

No change/Stable Completed
 Deteriorating Continue
 Improving Discontinue
 Resolved Pending
 Unresolved at discharge

OK Cancel

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

Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin PVS 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 software interface for patient ZMSHTSWLSDHYS, CHUUN (1110) in the PHX-ADMISSION SCHEDULED ward. The focus is on the PSYCHOSOCIAL ASSESSMENT tab. Key sections include:

- Patient/family/support person able to respond to questions:** Radio buttons for Yes (selected) and No.
- Other reason no one could respond:** Text input field.
- Information obtained from:** Checkboxes for Patient (selected), Authorized surrogate, Family/Support Person, Medical Record, and Other.
- Other source of information:** Text input field.
- Patient has a history of:** Checkboxes for None reported, Alcoholism, History of/ or treatment for mental health problems, History of depression, and Other.
- Other history:** Text input field.
- Attitude:** Radio buttons for Cooperative, Uncooperative, and Other.
- Other attitude:** Text input field.
- Behavior:** Radio buttons for Controlled, Uncontrolled, and Other.
- Other behavior:** Text input field.
- Suspected Abuse/Neglect Screen:** A grid asking if the patient reports any of the following:
 - Verbal abuse: Yes (radio button selected), No, Declines to answer.
 - Physical abuse: Yes, No, Declines to answer.
 - Financial abuse: Yes, No, Declines to answer.
 - Neglect: Yes, No, Declines to answer.
 - Rape or sexual abuse: Yes, No, Declines to answer.
- Based upon nursing assessment, is any of the following suspected?** Checkboxes for Verbal abuse (Yes, No), Physical abuse (Yes, No), and Neglect (Yes, No).
- Prior response:** Text input field.
- Explain suspicions:** Text input field.
- On basis of nursing assessment, are others in the household possible victims of abuse or neglect by the patient?** Checkboxes for Yes, No, and Unknown.
- Explain about others in household:** Text input field.
- Social Work Consult:** Button.
- Navigation:** Buttons for 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, and Performing assessment.
- Notes:** Designates a required field (*), Go to radiogroup: Altitude, and Go button.

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

2. Populate P/S Page 1.

- There are no required fields on P/S Page 1.
- If the patient answers **Yes** to any of the abuse questions, a Social Work Consult is required. Refer to the instructions in *Working in the Consults* on page 24.

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

Notify provider and follow your state's reporting regulations

Based upon nursing assessment, is any of the following suspected?

- Verbal abuse
 - Yes
 - No
- Physical abuse
 - Yes
 - No
- Neglect
 - Yes
 - No

Prior response:

* Rape or sexual abuse

- Yes
- No
- Declines to answer

* Neglect

- Yes
- No
- Declines to answer

* Explain suspicions

Prior response:

Based upon 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 mandatory

- Social Work Consult

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.

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

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?

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

- Prior plan
- Are there means available

* Describe plan

* Describe means

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

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

- Prior response: * Have you tried to hurt or kill yourself in the past?
 - Yes
 - No
 - Declines to answer
- Prior response: * How have you tried to hurt or kill yourself in the past?
 - Prior response: * Are you feeling hopeless about the present or future e.g. feeling that there is no way out?
 - Yes
 - No
 - Declines to answer

Comments relative to suicide

P/S Page 1 | P/S Page 2 | P/S Page 3 | DWA | P/S Page 4 | P/S CP |

Gen Inf Educ Pain IV Resp CV Neuro GI GU M/S Skn 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

- Populate P/S Page 2.
 - The questions on P/S Page 2 are optional.
 - 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 - ZMSHTWLSDHYS,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:
 * Have you heard voices telling you to hurt or kill yourself?
 Yes
 No
 Declines to answer

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

* Describe plan

* Are there means available

* Describe means

Prior plan

Prior response:

Prior means

Comments relative to suicide

* Designates a required field

Go to radiogroup: harming yourself

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

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

Performing assessment

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

5. Click P/S Page 3.

P/S Page 3 displays.

RN Reassessment - 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 <input type="radio"/> Yes <input type="radio"/> No	* Patient has been legally committed <input type="radio"/> Yes <input type="radio"/> No	* Patient is considered a danger to him/herself or others <input type="radio"/> Yes <input type="radio"/> Unknown	* Patient is on legal observation status for Severely Disabled <input type="radio"/> Yes <input type="radio"/> No	* Patient lacks the cognitive ability to make relevant decisions (e.g. history of dementia, Alzheimer's or traumatic brain injury) <input type="radio"/> Yes <input type="radio"/> No
Prior response: * Specify guardian	Prior response:	Prior response:	Prior response:	Prior response: Date/from where known
Prior guardian response	Prior guardian response	Prior response: Escape or elopement <input type="radio"/> Yes <input type="radio"/> No	Prior response: Date/from where known	Prior response: Prior escape/elopement response
				Social Work Consult

Prior response:

Chemical Dependency Issues

* Alcohol use <input type="radio"/> Lifetime non-alcohol user <input type="radio"/> Patient declines to answer any questions about alcohol use <input type="radio"/> Patient has not used alcohol in the past 12 months <input type="radio"/> Patient is currently using alcohol or has within the past 12 months	* Date of last alcohol use * Amount of last alcohol use	* Does patient use recreational drugs (marijuana, cocaine, heroin etc) <input type="radio"/> Yes <input type="radio"/> No * Date of last drug use * Amount of last drug use
Prior response: * Type of recreational drugs used	* Does patient have a medical marijuana card <input type="radio"/> Yes <input type="radio"/> No	Prior response: If Yes to use of recreational drugs, notify provider
		<input type="checkbox"/> Possibility of alcohol withdrawal

Prior response:
Make Alcohol Treatment referral if patient is interested.

Contraband

* Contraband brought (in to/by) the patient <input type="radio"/> Yes <input type="radio"/> No	* Describe contraband	* Location of unremoved contraband
Prior response:		Follow facility policy for contraband removal

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 radiograph: appointed legal guardian

Go

Saving data

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

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

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

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

Alcohol use section

7. If there is the possibility of alcohol withdrawal, select the **Possibility of alcohol withdrawal** check box to display the CIWA page.
- Complete all the CIWA fields with asterisks; they are required fields.
 - 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?"		
	<input type="radio"/> 0 - No nausea and no vomiting <input type="radio"/> 1 - Mild nausea with no vomiting <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 - Intermittent nausea with dry heaves <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 - Constant nausea, frequent dry heaves and vomiting		
	* TREMOR: Arms extended and fingers spread apart		
	<input type="radio"/> 0 - No tremors <input type="radio"/> 1 - Not visible, but can be felt fingertip to fingertip <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 - Moderate, with patient's arms extended <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 - Severe, even with arms not extended		
	* PAROXYSMAL SWEATS:		
	<input type="radio"/> 0 - No sweat visible <input type="radio"/> 1 - Barely visible sweating, palms moist <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 - Beads of sweat obvious on forehead <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 - Drenching sweats		
	* ANXIETY: "Do you feel nervous?"		
	<input type="radio"/> 0 - No anxiety, at ease <input type="radio"/> 1 - Mildly anxious <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 - Moderately anxious or guarded so anxiety is inferred <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 - Equivalent to acute panic states as in severe delirium/acute schizophrenia		
	* AGITATION:		
	<input type="radio"/> 0 - Normal activity <input type="radio"/> 1 - Somewhat more than normal activity <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 - Moderately fidgety and restless <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 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"		
	<input type="radio"/> 0 - None <input type="radio"/> 1 - Very mild itching, pins/needles, burning, numbness <input type="radio"/> 2 - Moderate itching, pins/needles, burning, numbness <input type="radio"/> 3 - Moderately severe hallucinations <input type="radio"/> 4 - Moderately severe hallucinations <input type="radio"/> 5 - Severe hallucinations <input type="radio"/> 6 - Extremely severe hallucinations <input type="radio"/> 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?"		
	<input type="radio"/> 0 - Not present <input type="radio"/> 1 - Very mild harshness or ability to frighten <input type="radio"/> 2 - Mild harshness or ability to frighten <input type="radio"/> 3 - Moderate harshness or ability to frighten <input type="radio"/> 4 - Moderately severe hallucinations <input type="radio"/> 5 - Severe hallucinations <input type="radio"/> 6 - Extremely severe hallucinations <input type="radio"/> 7 - Continuous hallucinations		
	* 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?"		
	<input type="radio"/> 0 - Not present <input type="radio"/> 1 - Very mild sensitivity <input type="radio"/> 2 - Moderate sensitivity <input type="radio"/> 3 - Moderate sensitivity <input type="radio"/> 4 - Moderately severe hallucinations <input type="radio"/> 5 - Severe hallucinations <input type="radio"/> 6 - Very severe hallucinations <input type="radio"/> 7 - Extremely severe hallucinations		
	* HEADACHE: "Does your head feel different? Does it feel like there's a band around your head?"		
	Do not rate for dizziness or lightheadedness. Otherwise, rate severity		
	<input type="radio"/> 0 - Not present <input type="radio"/> 1 - Very mild <input type="radio"/> 2 - Mild <input type="radio"/> 3 - Moderate <input type="radio"/> 4 - Moderately severe <input type="radio"/> 5 - Severe <input type="radio"/> 6 - Very severe <input type="radio"/> 7 - Extremely severe		
	* ORIENTATION AND CLOUDING OF SENSORIUM: "What day is this? Where are you? Who am I?"		
	<input type="radio"/> 0 - Oriented and can do serial additions <input type="radio"/> 1 - Cannot do serial additions and is uncertain about the date <input type="radio"/> 2 - Disoriented by date by no more than 2 calendar days <input type="radio"/> 3 - Disoriented by date by more than 2 calendar days <input type="radio"/> 4 - Disoriented for place and/or person		
	CIWA Score: 0		
	CIWA score interpretations 0 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 Inf Educ Pain IV Resp CV Neuro GI GU M/S Skin P/S Rest MH Func DP PCE View Text			
<small>* Designates a required field</small> Go to radiogroup: <input type="text" value="*Feel sick to your stomach? Hav"/> Go			
Performing assessment			

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

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

General observations/comments

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
<small>* Designates a required field</small>
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, 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 the RN Reassessment software interface. The title bar reads "RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT". The menu bar includes "File", "Tabs", and "Help". The main window is titled "RESTRAINTS". It contains fields for "Date/time initiated" (with radio buttons for "Known" and "Unknown"), "Reason for restraint" (with radio buttons for "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 selfdestructive" and "Patient's behavior is aggressive or violent presenting an immediate serious danger to his/her safety or that of others."), "Justification for restraints" (radio buttons for "Other justification", "Other justification", "Other justification", and "Other behavioral expectation"), "Behavioral expectations for termination of restraints", "Justification for restraints" (radio buttons for "Other justification", "Other justification", and "Other behavioral expectation"), "Restraint Type" (radio buttons for "Other Restraint", "Interventions tried to avoid restraint use", and "Other intervention"), and "Discontinued date/time". At the bottom, there are tabs for "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". A note says "* Designates a required field". The status bar at the bottom left says "Performing assessment".

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

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

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

File **Tabs** **Help**

RESTRANTS

* Date/time initiated **Notify provider**

Restraints Initiated/maintained

* Reason for restraint

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

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

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

* 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
 Handouts
 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

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

Rest Page 1 Rest CP

Performing assessment

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

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

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

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

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

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

4. Click **Restr CP**.

Restr CP displays.

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

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

Rest Page 1 Rest 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.

The screenshot shows the RN Reassessment software interface for the Mental Health tab. The top menu bar includes File, Tabs, Help, and tabs for MENTAL HEALTH ASSESSMENT, 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 MENTAL HEALTH ASSESSMENT tab is active. The window contains several sections:

- Patient/family/support person able to respond to questions:** Radio buttons for Yes (selected) and No.
- Other reason no one could respond:** A dropdown menu with options like None reported, Bipolar, ECT, Homicidal intention, Major depression, PTSD (selected), Restraint, and Schizophrenia.
- Information obtained from:** A checkbox list including Patient (selected), Authorized surrogate, Family/Support Person, Medical Record, and Other.
- Prior response:** A dropdown menu with options like Threatening others, Hitting/kicking objects, Threatening to harm myself, Harming myself, Screaming or cursing, Running away (eloping), Drink or take drugs, Living (selected), Talking with others, and Other.
- Ask patient "What things or situations make you upset?"** A checkbox list including When my space gets invaded (selected), Excessive noise, An argument or altercation with family, partner, or friend, Separation/losses (death or breakup), Becoming homeless, Not being listened to, Hurt feelings, Physical Abuse, Sexual Abuse, Pain, Loss of control due to alcohol or drugs, When I don't get what I want, When I feel I have no power, and When my attempts at problem solving don't work.
- Prior response:** A dropdown menu with options like Listen to music, Talk with others, Exercise/Walk, Positioning body to feel calmer or more comfortable, Go to a quiet place, Distraction, Use relaxation techniques, Smoke, Pace, Pray, and Meditate.
- Ask patient "When you get upset, are you able to calm yourself?"** A checkbox list including Yes (selected), No, and Patient declines to answer.
- Other calming things:** A checkbox list including Listen to music, Talk with others, Exercise/Walk, Positioning body to feel calmer or more comfortable, Go to a quiet place, Distraction, Use relaxation techniques, Smoke, Pace, Pray, and Meditate.

At the bottom, there are buttons for 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, and a note that Designates a required field. There is also a Go to radiogroup button and a Go button.

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.

The screenshot shows the RN Reassessment software interface for the Mental Health Assessment (MH) tab, specifically MH Page 2. The window title is "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The main content area is divided into several sections:

- MENTAL HEALTH ASSESSMENT** section:
 - * Mood**: Options include Angry, Anxious, **Depressed** (selected), Dysthymic, Euthymic (normal), Euphoric, Irritable, Indifference, Lable, Rapid mood swings, and Other.
 - * Affect**: Options include **Sapientic** (selected), Blunted, Bright, Congruent with mood, Elated, Flat, Incongruent with mood, Sad, and Other.
 - * Behavior**: Options include **Calm** (selected), Aggressive, Agitated, Angry outbursts, Attention seeking/center of attention, Demanding, Delusional, Cooperative, Cries easily, Decreased motivation/energy/initiative, Docile, Exaggerates minor symptoms into major problems, Hostile, Intimidates others, Pacing, Slamming doors, Staff splitting, Suspicious, Use of profanity, Yelling/shouting, and Other.
- Restraints/Behavioral Health Advance Directives** section:
 - * Ask patient: "If you are placed in restraints, do you want us to notify someone?" Options: Yes, No, Patient declines to answer (selected), and Patient unable to answer.
 - * Who should be notified: A dropdown menu.
 - Prior response: A dropdown menu showing options like Behavioral Health Advance Directive copy on chart, Behavioral Health Advance Directive copy not available, Declined Behavioral Health Advance Directives, Requested & given information on Behavioral Health Advance Directive, and **Not applicable** (selected).
- General observations/comments**: A large text input field.
- Bottom navigation and status**:
 - Buttons: MH Page 1, MH Page 2 (highlighted), MH CP.
 - Links: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, CIWA, P/S, Rest, MH, Func, DP, PCE, View Text.
 - Text: * Designates a required field, Go to radiogroup: do you want us to notify someone, Go.
 - Status: Performing assessment.

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

4. Populate MH Page 2.

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

5. Click **MH CP**.

MH CP displays.

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

File Tabs Help

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

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

Problem/intervention detail

Do not display resolved problems

Problem evaluation Intervention status

<input type="radio"/> No change/Stable	<input type="radio"/> Completed	<input type="button" value="OK"/>
<input type="radio"/> Deteriorating	<input type="radio"/> Continue	<input type="button" value="Cancel"/>
<input type="radio"/> Improving	<input type="radio"/> Discontinue	
<input type="radio"/> Resolved	<input type="radio"/> Pending	
<input type="radio"/> Unresolved at discharge		

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: Intervention status Go

Saving data

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

6. Update MH CP, if necessary.

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

Functional (Func)

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

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

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.

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 within the past 30 days:
 Yes
 No
 Unable to determine

Prior response:

Performing assessment

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: Bathing Go

Func Page 1 Func Page 2 Func Page 3 Func CP

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

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

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

3. Click **Func Page 2**.

Func Page 2 displays.

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

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

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.

Prior response:

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

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:

Transfer/repositioning techniques comments

Prior response:

Prior response:

General observations/comments

Applicable conditions likely to affect transfer/repositioning techniques

Transfer/repositioning techniques 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 independent

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

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

File Tabs Help

FUNCTIONAL ASSESSMENT

Instructions for assessing the patient's level of assistance

[Independent (Patient performs task safely, with or without staff assistance, with or without assistive devices)]
[Partial Assist (Patient requires no more help than stand-by, cueing, or 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] [06/29/2009 10:43]
Weight: 165.35 lb [75.2 kg] [12/16/2009 14:30]
BMI: DEC 16, 2009@14:30:21

Instructions for assessing patient's level of cooperation and comprehension

[Cooperative (may need prompting; able to follow simple commands)]
[Unpredictable or varies (patient whose behavior changes frequently should be considered as "unpredictable"); not cooperative; or unable to follow simple commands)]

* Level of cooperation and comprehension

Cooperative
 Unpredictable or varies

Prior response:

* Weight bearing capability

Full
 Partial
 None

Prior response:

* Bi-Lateral upper extremity strength

Yes
 No

Prior response:

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.

The screenshot shows the RN Reassessment software interface. The main title bar reads "RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes "File", "Tabs", and "Help". The "FUNCTIONAL ASSESSMENT" tab is selected, displaying the "Use of mechanical lifting devices and approved aids for lifting, transferring, repositioning, and moving patients." section. This section contains three main transfer categories: "Transfer to and from Bed to Chair, Chair to Toilet, Chair to Chair, Chair to Chair", "Transfer to and from Bed to Stretcher, Trolley", and "Transfer to and from Chair to Stretcher or Chair to Exam Table". Each category has a list of equipment/assistive devices (e.g., Ceiling lift, Friction reducing device, Full body sling, Gait belt, Lateral transfer device, Power stand assist, Sliding board) and a "Number of staff" input field. Below these are sections for "Reposition in Bed, Side to Side, Up in Bed" and "Reposition in Chair", each with similar lists and staff count fields. A "Transfer a patient up from the floor" section is also present. On the right side, there is a "Print" button and a "Educate Patient, Family, and Support Person on" section. At the bottom, there are tabs for "Func Page 1", "Func Page 2", "Func Page 3", and "Func CP", along with other navigation buttons like "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "CIWA", "P/S", "Rest", "MH", "Func", "DP", "PCE", "View Text", and a note about designating required fields. The status bar at the bottom left says "Performing assessment".

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

6. Populate Func Page 3.

- Complete the fields, if necessary.
- Click **Print**.
- 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 - ZMSHTSWLSDHYS,JLUXA (3122) Ward: PHX-ADMISSION SCHEDULED

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

* 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.

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

- Click **DP**.
DP Page 1 displays.
- Populate PD Page 1, if available.
 - If a DP Page 1 was completed during the admission assessment, none of the fields are active.
 - 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.

The screenshot shows the RN Reassessment software interface. The title bar reads "RN Reassessment - ZMSHTSWLSDHYS, CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The menu bar includes "File", "Tabs", and "Help". The main window is titled "DISCHARGE PLANNING - PROBLEMS/INTERVENTIONS/DESIRED OUTCOMES". A note at the top states: "*Problems, interventions, and desired outcomes identified in previous tabs have been discussed *Why hasn't plan of care been discussed with the patient and/or family/support person and concurrence obtained." Below this are two radio button options: "Yes" and "No".

Anticipated Discharge Plan Goals:

- Discharge to home without additional services
- Involve family/support person in discharge planning
- Patient is homeless
- Patient needs 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 Multi-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 given/s **
- Other 1
- Other 2
- Other 3

* Family/support person in discharge planning

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

Buttons at the bottom right include: "Discharge Planning Consult", "Social Work Consult", "Will Send", "Telehealth Consult", "Home Care Consult", "DP Page 1", and "DP CP".

At the very bottom, there are links for "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "CIWA", "P/S", "Rest", "MH", "Func", "DP", "PCE", "View Text", and a note: "* Designates a required field Go to radiogroup: with the patient and/or family/sup ▾ Go".

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

4. Populate DP CP.
- Complete the fields as necessary.
 Refer to the instructions in *Working in a Care Plan* on page 12.
 - Complete a Social Work Consult or Discharge Planning Consult, if required.
 Refer to the instructions in *Working in the Consults* on page 24.

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

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

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 with the patient and/or family/support person and concurrence obtained?

Yes No

Anticipated Discharge Plan Goals

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. grocery delivery or 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 in 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 **CONSULT REQUIRED**

* Family/support person in discharge planning

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, 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.

Reminder	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 shows the Clinical Maintenance window with the following sections:

- PCE DATA**: A list of Inpatient Nursing PCE Information items 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 present.
- Text (will be added to note)**: An empty text area for notes.
- Reminders Due (Display Only)**: A table listing clinical reminders with their due dates:

	Due Date
CHF Weight Education	02/24/10
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 topic definition box.
- Clinical Maintenance** and **Reminder Inquiry** buttons.
- Maintenance Results**: A table showing the status, due date, and last done date for the selected reminder:

STATUS - DUE DATE - LAST DONE -
DUE NOW 7/24/2010 7/24/2009

Frequency: Due every 1 year for all ages.
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 interface for a 'Reminder Inquiry'. At the top left is a 'PCE DATA' section containing a list of 'Inpatient Nursing PCE Information' such as 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 next to this list. To the right is a large text area labeled 'Text (will be added to note)' with a scroll bar. Below the PCE DATA is a 'Reminders Due (Display Only)' section listing various medical topics with their due dates: 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), and Skin Integrity Screen OPT (DUE NOW). To the right of this list is a 'Topic def.' section titled 'CHF WEIGHT EDUCATION' with 'Clinical Maintenance' and 'Reminder Inquiry' buttons. At the bottom left is an 'Inquiry Results' section showing a single entry: 'CHF WEIGHT EDUCATION' with 'No 55' next to it. Below this is a 'Print Name' field containing 'CHF Weight Education'.

Reminder Inquiry

Resolve Inpatient Nursing Clinical Reminders

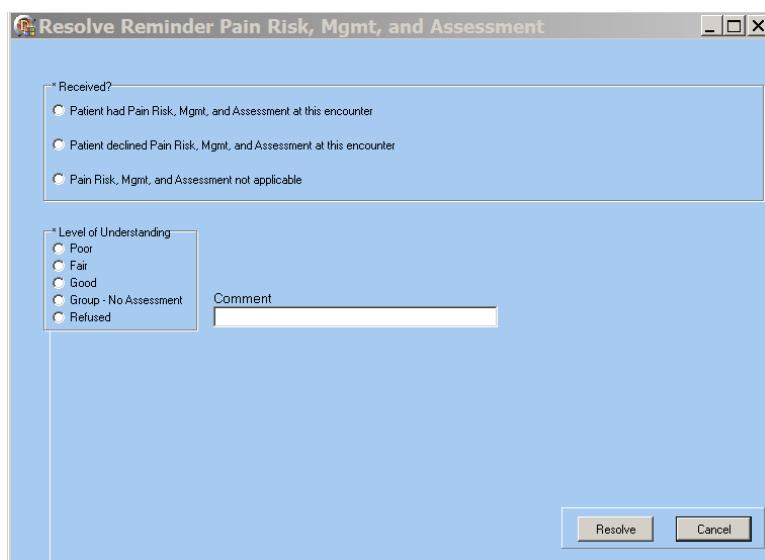
1. Select an item in the **Inpatient Nursing PCE Information** list box.



Resolve Inpatient Nursing Clinical Reminders

2. Click **Resolve**.

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

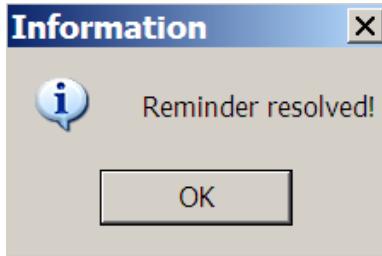


Resolve Reminder Pain Risk, Mgmt, and Assessment window

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

5. Click **Resolve**.

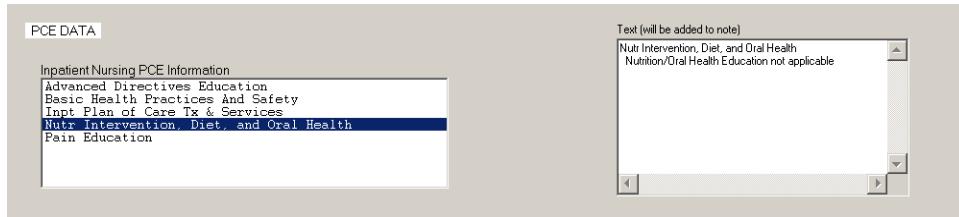
Information displays indicating the reminder is resolved.



Information : Reminder resolved!

6. Click **OK**.

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



Text (will be added to note)

View Text (View Text)

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

The screenshot shows a computer window titled "RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED". The main content area displays patient information under several sections: GENERAL INFORMATION, RESTRAINTS, and EDUCATIONAL ASSESSMENT. The GENERAL INFORMATION section includes fields for advance directives, infection control education, and emergency contact information. The RESTRAINTS section details reasons for restraint, behavioral expectations, and restraint types. The EDUCATIONAL ASSESSMENT section shows patient's ability to respond to questions. At the bottom, a navigation bar lists various assessment categories like Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, CIWA, P/S, Rest, MH, Func, DP, PCE, and View Text. A note indicates that the View Text tab is designated as a required field. The status bar at the bottom says "Performing assessment".

RN Reassessment, View Text tab

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

Signing Note and Consults from within the Template

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

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

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

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

1. Click View Text.

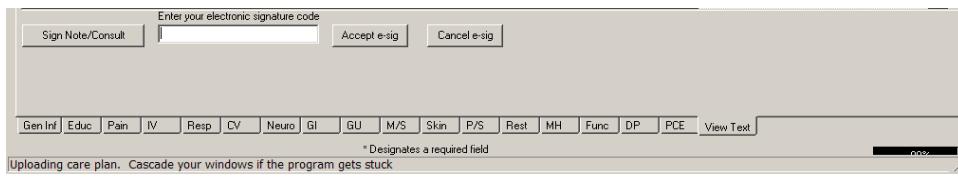
The screenshot shows the 'RN Reassessment' software interface. The title bar reads 'RN Reassessment - ZMSHTSWLSDHYS,CHUUN (1110) Ward: PHX-ADMISSION SCHEDULED'. The main window displays a 'View Text' tab containing patient information and a 'Sign Note/Consult' button. The information includes general patient details, medications, spiritual/cultural assessments, and infection control education. At the bottom, a navigation bar lists categories like Gen Inf, Edu, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, and View Text. A note indicates that '*' designates a required field.

RN Reassessments, View Text Tab after Upload

2. Click Sign Note/Consult.

If the button does not display, upload again.

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



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 the RN Reassessment software interface. The title bar reads "RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT". The menu bar includes File, Tabs, and Help. The main window has a "GENERAL INFORMATION" section. In this section, there is a question "Patient/family/support person able to respond to questions" with two radio button options: "Yes" (selected) and "No". Below this, there are fields for Demographics: Name: VHLSJE,JELUAHT ALRUHYJH, Age: 69, Sex: MALE, Race: DECLINED TO ANSWER. There is also a field for Admitting diagnosis: CHEST PAIN. A note below states: "Prior patient response to 'What does patient want to accomplish by this hospitalization?'" and "What does patient want to accomplish by this hospitalization?". At the bottom of the window, there are tabs for Gen I Page 1, Gen I Page 2, Gen I Page 3, and Gen I Page 4. The Gen Inf tab is selected. A note at the bottom says "* Designates a required field".

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

Patient still cannot respond

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

The screenshot shows the RN Reassessment software interface. The title bar reads "RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT". The menu bar includes "File", "Tabs", and "Help". The main window has a "GENERAL INFORMATION" tab selected. In the "Demographics" section, the name is listed as "VHLSJE,JELUAHT ALRUHYJH", age is 69, sex is MALE, and race is DECLINED TO ANSWER. The "Admitting diagnosis" is listed as "CHEST PAIN". Below this, there is a section for "Prior patient response to 'What does patient want to accomplish by this hospitalization?'" and "What does patient want to accomplish by this hospitalization?". At the bottom of the window, there are tabs for "Gen Inf", "Educ", "Pain", "IV", "Resp", "CV", "Neuro", "GI", "GU", "M/S", "Skin", "P/S", "Rest", "MH", "Func", "DP", "PCE", and "View Text". There are also buttons for "Gen I Page 1", "Gen I Page 2", "Gen I Page 3", and "Gen I Page 4". A note at the bottom indicates "* Designates a required field".

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**.

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

* 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?

Prior patient response: NO

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

Prior patient response: NO

Patient requests an immediate visit from the Chaplain

Prior patient response: NO

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

Prior patient response: NO

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

Prior patient response: NO

* Describe concerns * Specify pastor or clergy

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

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

Performing assessment

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

GENERAL INFORMATION

Advance Directive

Does patient have an Advance Directive

Prior patient response: NO

* Location of Advance Directive

Patient received info on Advance Directive

Prior patient response: YES

* Explain why patient did not receive info

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

Prior patient response: NO

Social Work Consult Will Send

Testing for MRSA brochure/equivalent information given to the patient/authorized surrogate

Prior response: YES

Did the patient/authorized surrogate agree to MRSA Nares swab on admission/transfer/discharge?

Prior patient response: YES

MRSA Nares swab performed

Prior patient response: No

Swab performed: YES

* Why wasn't MRSA Nares swab performed

MRSA Nares swab performed on transfer with patient's agreement

Prior response: Fair

Level of understanding

- Poor
- Fair
- Good
- Refused

Precautions

- Airborn
- Contact
- Droplet
- Neutropenic

Prior precautions

Was the below Infection Control Education provided to the patient?

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

Prior response: Fair

* Why wasn't it performed

MRSA Nares swab performed on discharge with patient's agreement

Prior response: Refused

* Why wasn't it performed

MRSA Nares swab performed on discharge with patient's agreement

Prior response: No

* Why wasn't it performed

* Designates a required field Go to radiogroup: To an Advance Directive Go

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

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:	* Why could no one respond	* Other reason no one could respond	* Information obtained from	* Other source of information
<input type="radio"/> Yes	<input checked="" type="checkbox"/> Patient unable to communicate	<input type="checkbox"/> No family/support person present	<input type="checkbox"/> Other	

* Describe why unable to read * Describe why unable to write
 * Has ability to read * Has ability to write

* Educational Level Prior patient response: Prior patient response:
 Learns best by Prefers * Readiness to learn

Prior patient response: Prior patient response:
 * Barriers to learning * Describe identified barriers * Other barriers * Knowledge of current illness, surgery, or the topics on the following topics
 reason for hospitalization etc as * Information provided to patient/support person * Other topic provided

Prior patient response: Joint Commission Phone Number: 1-800-934-6610

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 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?	Pain Location #1		
<input checked="" type="radio"/> Yes	* Pain Region	* Quality of pain	* Type of pain
<input type="radio"/> No	Head	Aching	<input checked="" type="radio"/> Acute/Chronic
<input type="radio"/> Unable to respond to questions	* Other pain region	* Other quality of pain	* Onset of original pain (years, months)

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

* What makes pain worse * Timing of pain * Describe other timing of pain
 No identified triggers Constant Describe other timing of pain
 Binding Intermittent
 Change in temperature Other
 Changing position * Other provoking factor(s)
 Coughing * Does pain radiate
 Deep breathing Yes No
 * Describe Pain Radiation

* What makes pain better * Other palliative factor(s) * Rx/Dic Meds helping pain
 No identified relief factors Rx/Dic Meds helping pain
 Acupuncture * What pain level is acceptable to the patient (0-10)?
 Acupressure 0
 Assistive devices (cane, wheelchair, brace/support, Chiropractic intervention, etc.)
 Energy level

* Areas of life affected by pain * Comments for patient's life aspects

No effect * What pain level is acceptable to the patient (0-10)?
 Anxiety 0
 Appetite * Pain Goal
 Concentration * What pain level is acceptable to the patient (0-10)?
 Depression 0
 Energy level

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

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

* Date/time inserted: * Other size: IV Discontinued
 IV discontinue date/time

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

IV Periph IV Central IV Dialysis IV Comments IV CP

Gen 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

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

File Tabs Help

RESPIRATORY ASSESSMENT

* Patient/family/support person able to respond to questions * Why could no one respond * Other reason no one could respond * Information obtained from * Other source of information

Yes No

* 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 Intercostal recession Pursed Lips Use of accessory muscles Other

* Other work of breathing * Cyanosis None Central - tongue and lips Peripheral - earlobes, fingertips, around lips

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

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

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

* Designates a required field Go to radiogroup: Respiratory depth Go

Performing assessment

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

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

RESPIRATORY ASSESSMENT

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

Productive cough present

Prior response:

Chest tubes

Chest tubes present * Location 1 * Suction * Other suction * Air Leak * Chest tube drainage * Dressing * Other dressing

Prior response: NO

Location 2 * Suction * Other suction * Air Leak * Chest tube drainage * Dressing * Other dressing

Other chest tube locations

Facility ordered oxygen * Other liter flow * Other delivery method Oxygen saturation %

Facility ordered oxygen

Ventilator dependent - chronic
*Ventilator dependent - chronic comments

Respiratory Consult

Performing assessment

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

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

* Designates a required field

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

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

RESPIRATORY ASSESSMENT

Tracheostomy

Tracheostomy present * Stoma appearance * Other stoma appearance * Other dressing

* Other trach type

* Tracheostomy size

Trach recently inserted * Insertion date/time

Trach removed * Removed date/time * Dressing change? * Other dressing type

* Dressing date/time change

* Type of tobacco used

Instructions for former usage

Prior response:

* Approximate quit date:
* Tobacco education

General Observations/Comments

Performing assessment

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

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

* Designates a required field

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

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:

* Extremities: Warm Cool Capillary Refill Less than 3 Seconds Capillary Refill Greater than 3 Seconds Extremities comments: Prior comments: * Auscultation: * Heart rhythm: Regular Irregular * Heart sounds: Normal Abnormal * Describe abnormal sound: Prior response: * Designates a required field Go to radiogroup: Heart rhythm Go 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

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 distension: Right Calf Left Calf

* Jugular Venous Distension: Yes No

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

* Cardiac monitor: Yes No

External pacemaker: Permanent pacemaker: Prior cardiac monitor response: * Other cardiac monitor rhythm: Other device: Implantable cardioverter/defibrillator (ICD)

General observations/comments: PR Interval: QT Interval: GRS Duration: ST Segment: T Wave:

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

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

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

* Information obtained from: * Other source of information

* Patient has a history of: * Spinal Cord Injury Level: Orientation

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)

- Eyes open spontaneously
- Eye opening to verbal command
- Eye opening to pain
- 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)

- Oriented
- Confused
- Inappropriate words
- Incomprehensible sounds
- 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)

- Obey Commands

Prior response: Level of Consciousness (Glasgow Coma Scale)

Eye response score: Not assess

Verbal response score: Not assess

Motor response score: Not assess

Total score: 0

Prior score:

Score is expressed as Eye (E) + Verbal (V) + Motor (M)

Glasgow score categories

13-15 (normal result)
9-12 (correlates with moderate brain injury)
8 or less (correlates with severe brain injury)

* Other neurological problem: * Describe Spinal Cord Injury Level: * Designate a required field

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

Performing assessment

Go to radiogroup: Able to respond to questions Go

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: * Other pupil size: Right eye: Left eye: * Other speech/language

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

* Describe new lens implant/prosthesis: Prior response: Right eye: Prior response: Left eye: Prior response: General observations/comments

Sensations - New paresthesias or neuropathies present: Prior response: * New sensations present: Prior response: * New comm device needed: Prior response: General observations/comments

Requires assistive new communication device to meet basic needs: Prior response: Prior response: General observations/comments

* Designate a required field Go to radiogroup: Size Go

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

Performing assessment

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

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

GASTROINTESTINAL ASSESSMENT

* Patient/family/support person able to respond to questions * Why could no one respond * Other reason no one could respond * Information obtained from * Other source of information

Yes No

* Patient has a history of * Other history

Abdominal Assessment

* Abdomen * Other abdominal assessment

Distended Firm Flat Guarding Non-tender obese Hard Round Soft Tender Other

* Bowel sounds * Bowel sounds comments

Present Absent

* Last Bowel Movement Date * Date of Last Bowel Movement

Known Unknown

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: * Other bowel program schedule * Bowel care - start time * Bowel care - completion time Medication/treatment

Bowel program Bowel program schedule

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

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

* Designates a required field Go to radiogroup: Bowel sounds Go

Performing assessment

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

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

GASTROINTESTINAL ASSESSMENT

GI Device #1 **GI Device #2**

* Type **GI device comments**

None New since last assessment Date/time

Removed since last assessment Date/time

GI Device #3 **GI Device #4**

* Type **GI device comments**

None New since last assessment Date/time

Removed since last assessment Date/time

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

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

* Designates a required field

Performing assessment

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

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

GASTROINTESTINAL ASSESSMENT

Oral Screen

Assessment - General	Assessment - Mucous Membrane
<input type="checkbox"/> No problems/impairments	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Assistance needed with oral hygiene	<input type="checkbox"/> Cyanotic
<input type="checkbox"/> Difficulty chewing	<input type="checkbox"/> Intact
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Lesions present
<input type="checkbox"/> All teeth present	<input type="checkbox"/> Pale
<input type="checkbox"/> Poor dentition	<input type="checkbox"/> Pink
<input type="checkbox"/> No dentition	
<input type="checkbox"/> Could not assess	

Dietary History

* Does patient have any ethnic/cultural? * Food preferences/Special diet needs

Prior response:

* Does patient have any?

Prior response: Prior food preferences

Nutrition screen

* Description of patient

Well nourished
 Obese
 Emaciated

* Appetite

* Other appetite

Prior response: Prior response:

Height: 66.25 in [168.3 cm] (03/11/2011 09:14)
Weight: 229.94 lb [104.5 kg] (06/22/2011 12:30)
BMI: 36.9 (JUN 22, 2011@12:30:48)

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

Prior response: Nutrition consult guidelines

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

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

Gen Inf Educ Pain IV Resp CV Neuro Gl 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

GASTROINTESTINAL ASSESSMENT

Dysphagia screen

* Dysphagia screen	* Other reason unable to screen
<input type="radio"/> Able to screen	
<input type="radio"/> Unable - Patient on Ventilator	
<input type="radio"/> Unable - Patient unconscious	
<input type="radio"/> Unable - Other	
<input type="radio"/> N/A	

Prior response:

Dysphagia risk factors

* Diagnosis of new stroke, head and neck cancer, or traumatic brain injury * Modified texture diet/earthing 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:

Speech Consult

General Observations/Comments

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

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

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

Performing assessment

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

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

File Tabs Help

GENITOURINARY ASSESSMENT

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

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

* Information obtained from
 Other source of information

* Patient has a history of
 Voiding * Intermittent catheterization frequency * Other voiding

Urine * Other color
 Color
 Amber
 Yellow
 Bloody
 Unable to evaluate
 Other

Consistency:
 Normal
 Concentrated
 Dilute
 Unable to evaluate

Odor:
 Foul smelling None Unable to evaluate

* Last voided
 Known Unknown Absorbency devices used

* Date/time last voided:
 Abnormal discharge * Describe abnormal discharge
 None
 Genital
 Unable to evaluate

* Describe sediment:
 Yes
 No
 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 _____

Prior response _____

Indwelling removed

Concerns voiced regarding sexual functioning

* Sexual Functioning concerns voiced

Female patients:

* Pregnancy: _____

Approximate date _____ Approximate date _____ Approximate date _____

Male patients:

Approximate date _____ General observations/comments _____

Last PSA: 10/14/10 @ 0819 0.74

GU Page 1 GU Dev GU Page 2 GU CP

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

* Designates a required field

Performing assessment

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

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

File Tabs Help

MUSCULOSKELETAL ASSESSMENT

* Patient/family/support person able to respond to questions _____

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

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

* 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

Performing assessment

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

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

MUSCULOSKELETAL ASSESSMENT - MORSE FALL SCALE

* Fall risk assessment indicated
 Yes No

* History of falling Describe previous falls and history

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

* Is patient on multiple meds to

Instructions for completing Morse Fall Scale

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

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

Ambulation aid:
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.

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

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

Total Morse score for Fall Risk: N/A

Prior score: Not assessed
Date:

[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

SKIN ASSESSMENT

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

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

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

* Patient has a history of
 Describe other

Predisposition for skin breakdown

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

* Risk Factors
 None
 Bariatric patient
 Device-related pressure
 Diabetic
 End of life care
 Hypoalbuminemia
 Medication: Vasodilators
 Patient unable to 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

* Skin Turgor
 Within Normal Limits Abnormal

* Skin Patches
 Yes No

General observations/comments

[Skin Page 1] [Skin Pr/Ult 1] [Skin Pr/Ult 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

Skin Assessment **BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK**

* Skin assessment indicated
 Yes No

SENSORY PERCEPTION: Ability to respond meaningfully to pressure-related discomfort		NUTRITION: Usual food intake pattern	
<input type="radio"/> 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 move		<input type="radio"/> 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	
<input type="radio"/> 2. SENSITIVELY LIMITED: Partially responsive to pain		<input type="radio"/> 2. POOR: Eats less 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	
<input type="radio"/> 3. MODERATELY LIMITED: Partially responsive to pain		<input type="radio"/> 3. FAIR: Eats less 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	
<input type="radio"/> 4. UNLIMITED: Fully responsive to pain		<input type="radio"/> 4. GOOD: Eats a complete meal. Eats 2 servings or more of protein (meat or dairy product) per day. Takes fluids well.	

MOISTURE: Degree to which skin is exposed to moisture		FRICTION AND SHEAR:	
<input type="radio"/> 1. CONSTANTLY MOIST: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.		<input type="radio"/> 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	
<input type="radio"/> 2. BEDFAST: Patient is confined to bed.		<input type="radio"/> 2. MODERATE: Requires some assistance in moving. Complete lifting without sliding against sheets is difficult. Frequently slides down in bed or chair, requiring frequent	
<input type="radio"/> 3. CHAIRFAST: Patient's ability to walk is severely limited. Patient can't bear his own weight, or must be assisted into chair.		<input type="radio"/> 3. FAIR: Requires some assistance in moving. Complete lifting without sliding against sheets is difficult. Frequently slides down in bed or chair, requiring frequent	
<input type="radio"/> 4. UNLIMITED: Patient can walk and change position freely.		<input type="radio"/> 4. GOOD: Requires minimal assistance in moving. Complete lifting without sliding against sheets is possible. Rarely slides down in bed or chair.	

ACTIVITY: Degree of physical activity		Total Score: N/A	
<input type="radio"/> 1. BEDFAST: Patient is confined to bed.		Prior score: Not assessed	
<input type="radio"/> 2. CHAIRFAST: Patient's ability to walk is severely limited. Patient can't bear his own weight, or must be assisted into chair.		Date:	
<input type="radio"/> 3. MODERATELY ACTIVE: Patient can walk and change position freely, but has difficulty with activities of daily living.		Risk Category	
<input type="radio"/> 4. UNLIMITED: Patient can walk and change position freely.		Not at risk (19-23) At risk (15-18) Moderate risk (13-14) High risk (10-12) Severe risk (9 or below)	

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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 15 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., amputation or spinal cord injury), a referral to physical therapy should be discussed with the interdisciplinary team.

Nutrition Consult **Wound Care Consult**

Navigation: Skin Page 1 | Skin Pr UI 1 | Skin Pr UI 2 | Skin Al 1 | Skin Al 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 assessment indicated Go

Performing assessment

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

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

Psychosocial Assessment

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

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

Patient unable to communicate
 No family/support person present
 Other

* Other history * Other attitude * Other behavior

* Patient has a history of:

Prior response: Prior response: Prior response:

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 Physical abuse Neglect
 Yes No Yes No Yes No

Prior response: Prior response: Prior response:
 * Explain suspicions

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

Prior response: Prior response:
 Social Work Consult

Navigation: 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: Verbal abuse Go

Performing assessment

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

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

File Tabs Help

PSYCHOSOCIAL ASSESSMENT

Suicide Risk Screen

Ask Patient

* Have you recently had thoughts about... * Do you have a plan for how to do this? * Describe plan * Describe means
Are there means available

Prior response: Prior response: Prior response:
* Have you rehearsed or practiced how to kill yourself? * Have you heard voices telling to hurt or kill yourself?

Prior response: Prior response: Prior response:
* 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:

Comments relative to suicide

Performing assessment

[P/S Page 1] [P/S Page 2] [P/S Page 3] [DWA] [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

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

Prior response: * Specify guardian Prior response: * Prior guardian response Prior response: * Patient has history of...
 Prior response: Date/from where if known Prior response: Prior escape/elopement response 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: If Yes to use of recreational drugs, notify provider Possibility of alcohol withdrawal

Prior response: Make Alcohol Treatment referral if patient is interested.

Contraband

* Contraband brought in to/by the patient * Describe contraband * Location of unremoved contraband
 Yes No Follow facility policy for contraband removal

Prior response:

Performing assessment

[P/S Page 1] [P/S Page 2] [P/S Page 3] [DWA] [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

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

* Date/time initiated Notify provider

Restraints Initiated/maintained Known Unknown Initiated date/time

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

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

Follows simple directions
 Does not pull lines/tubes
 Oriented 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 Discontinued - desired outcome achieved Discontinued date/time

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 side
 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
 Positioning/education
 Reality orientation
 Repositioning of lines/tubes
 Side rails, 3 or less
 Sitters
 Wedge cushion
 Other

Rest Page 1 Rest 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 * Why could no one respond * Other reason no one could respond * Information obtained from * Other source of information

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

* 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:	* Why could no one respond	* Other reason no one could respond	* Information obtained from	* Other source of information
<input type="radio"/> Yes <input checked="" type="radio"/> No	<input checked="" type="checkbox"/> Patient unable to communicate <input checked="" type="checkbox"/> No family/support person present <input type="checkbox"/> Other			

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, clearing 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

Total score: 0

Prior score:
5 = High (Patient independent); 0 = Low (Patient very dependent)

Did patient have a decrease in the level of independence?

Assist patient with

- Ambulating
- Bathing
- Dressing
- Feeding
- Toileting
- Transferring

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.

Prior response:

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

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

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

Performing assessment

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

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

File Tabs Help

FUNCTIONAL ASSESSMENT

Instructions for assessing the patient's level of assistance

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

Partial/Assist (Patient requires no more help than stand-by, cueing, or coaxing, or caregiver is required to lift no more than 35 lbs. of a patient's weight)

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

Instructions for assessing patient's level of cooperation and comprehension

Cooperative (may need prompting, able to follow simple commands)

Unpredictable or varies (patient whose behavior changes frequently should be considered as "unpredictable"); not cooperative; or unable to follow simple commands

* 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)

* Level of cooperation and comprehension

- Cooperative
- Unpredictable or varies

Prior response: Prior response: Prior response:

General observations/comments

Transfer/repositioning techniques 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, Cart to Chair

Equipment/Accommodation Device

- Ceiling lift
- Friction reducing device
- Full body sling
- Gait belt
- Lateral transfer device
- Power stand assist
- Sliding board

Number of staff

Lateral transfer to and from Bed to Stretcher, Trolley Chair to Exam Table

Equipment/Accommodation Device

- Ceiling lift
- Friction reducing device
- Full body sling
- Gait belt
- Lateral transfer device
- Power stand assist
- Sliding board

Number of staff

Transfer to and from Chair to Stretcher or Chair to Exam Table

Equipment/Accommodation Device

- Ceiling lift
- Friction reducing device
- Full body sling
- Gait belt
- Lateral transfer device
- Power stand assist
- Sliding board

Number of staff

Reposition in Bed, Side to Side, Up in Bed

Equipment/Accommodation Device

- Ceiling lift
- Friction reducing device
- Full body sling
- Gait belt
- Lateral transfer device
- Power stand assist
- Sliding board

Number of staff

Reposition in Chair

Equipment/Accommodation Device

- Ceiling lift
- Friction reducing device
- Full body sling
- Gait belt
- Lateral transfer device
- Power stand assist
- Sliding board

Number of staff

Transfer a patient up from the floor

Equipment/Accommodation Device

- Ceiling lift
- Friction reducing device
- Full body sling
- Gait belt
- Lateral transfer device
- Power stand assist
- Sliding board

Number of staff

Educate Patient, Family, and Support Person on

Print

Prior response:

Height: 66.25 in [168.3 cm] (03/11/2011 09:14)
Weight: 229.94 lb [104.5 kg] (06/22/2011 12:30)

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

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

* Designates a required field Go to radiogroup: Sling type Go

Performing assessment

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

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

File Tabs Help

DISCHARGE PLANNING

* Patient/family/support person able to respond to questions

Yes No

* Why could no one respond

Patient unable to communicate
 No family/support person present
 Other

* Other reason no one could respond

* Information obtained from

* Other source of information

* Does patient have a legal/medical guardian (conservator)?

Yes
 No

* Specify guardian (conservator)

* Describe employment status

Pulled from P/S Page 3

* 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

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 (emotional 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 need) **
 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 **
 Plan on isolation precautions
 Plan for support for patient's care giver/s **
 Other 1
 Other 2
 Other 3

* Family/support person in discharge planning

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

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, 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 the RN Reassessment software interface. The title bar reads "RN Reassessment - VHLSJE,JELUAHT ALRUHYJH (5326) Ward: 4CT". The menu bar includes "File", "Tabs", and "Help". The main window is titled "GENERAL INFORMATION". It contains several input fields and dropdown menus:

- * Patient/family/support person able to respond to questions: Radio buttons for "Yes" (selected) and "No".
- * Why could no one respond: A dropdown menu with options like "Other reason no one could respond", "Other source of information", and "Information obtained from".
- * Information obtained from: A dropdown menu with options: Patient (selected), Authorized surrogate, Family/Support Person, Medical Record, and Other.
- Demographics: Name: VHLSJE,JELUAHT ALRUHYJH, Age: 69, Sex: MALE, Race: DECLINED TO ANSWER.
- Admitting diagnosis: CHEST PAIN.
- Prior patient response to "What does patient want to accomplish by this hospitalization": A large text area.
- * Preferred Healthcare Language: Radio buttons for English (selected), Spanish, and Other.
- * Other Language: A dropdown menu.
- * What does patient want to accomplish by this hospitalization: A large text area.
- Prior patient response: A large text area.
- Buttons at the bottom: Gen Inf, Educ, Pain, IV, Resp, CV, Neuro, GI, GU, M/S, Skin, P/S, Rest, MH, Func, DP, PCE, View Text, Gen I Page 1, Gen I Page 2, Gen I Page 3, Gen I Page 4.
- Notes: * 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

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

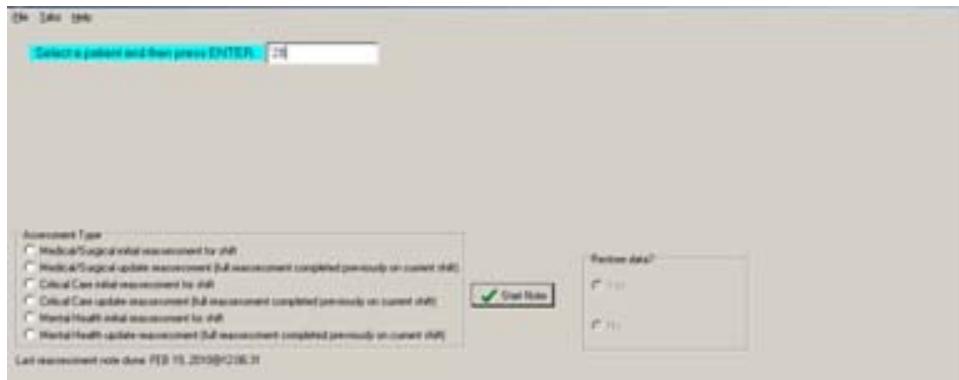
Note: For the content of the template, refer to the User Manual for *Admission – RN Assessment*.

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*.