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Any comments or suggestions regarding this publication are welcomed and should be forwarded to the attention of

STAR 2000 Documentation Team
McKesson
Mail Stop ATHQ-3302
5995 Windward Parkway
Alpharetta, GA 30005

Preface

This volume of documentation is one part of the *STAR Patient Care Reference Guide*. This volume, *Patient Assessment Module*, provides detailed information for the nursing assessment process, which is the nurse's initial step in evaluating the patient and planning care for the patient.

The information in this book corresponds to the order in which the various functions display on the STAR Patient Care system.

The *General Information Volume* is prerequisite reading for all other volumes of the *STAR Patient Care Reference Guide*. Successful use of the Patient Assessment Module depends on your knowledge of the concepts covered in the *General Information Volume*.

Documentation Conventions

Documentation for McKesson's STAR 2000™ line of products follows these conventions:

Revisions
Text revisions are indicated by a change bar in the left margin. Paragraphs that contain grammatical changes that do not affect content are not marked.

Canadian Documentation
This volume may include documentation for Canadian users of this product. Complete sections of Canadian text are identified by "CN" and "CN Only."

Key Names
Named keys, such as SHIFT, CTRL, ALT, and ENTER, are displayed in this document in uppercase (capital) letters. A symbol key is written as text in this document followed by the symbol in parentheses, such as hyphen (-) and asterisk (*).

Key Chords
Key chords are key entries that require you to hold down one or more keys (typically, CTRL, ALT, or SHIFT) before pressing another key. In this document, key chords are displayed as the names of each key in the chord separated by a hyphen (-) (for example, CTRL-ALT-DEL).

Enter
ENTER is a key on a computer keyboard used to complete an entry on a STAR system. (This key may also be referred to as NEW LINE or NL in the STAR system.)

Data Entries
Letters or words you enter in response to the system are displayed in **bold** letters in this document. For example: Enter **Y** for Yes or **N** for No.

Selecting an Entry
This document often instructs you to "select an entry." The method you use to select an entry depends on whether you are using STAR from a terminal or IBM-compatible personal computer. Entry methods include:

- Entering the option number
- Using your arrow keys to highlight the option and pressing ENTER
- Clicking on the option using a mouse or other pointing device (PC only)

For more information about these options, see the *General Information Volume*.

Prompts
System prompts are displayed at the bottom of many STAR screens when the system requests an entry or displays a message. In this document, these prompts are indented and the text italicized, as shown in the following example:

Enter patient name--

Field Characteristics

STAR product documentation provides field explanation codes, in addition to a narrative description for each field on a screen. These codes display the maximum length of your entry in the field, the type of entry you make in the field, and whether the field is required. This information displays in the following format:

- DISPLAY ONLY for a field you cannot edit.
- For X-YY-Z field types, where:
  - X is the maximum number of characters permitted in the field:
    - P for a field length determined by a Parameter
    - T for a field length determined by a Table
    - U for a field having an Undefined length
  - YY is the type of entry technique permitted in the field:
    - A for Letters only
    - AC for Letters and Punctuation only (no numbers)
    - AN for Numerals and Letters only (no punctuation)
    - C for Characters (including punctuation)
    - N for Numerals only
    - NC for Numerals and Punctuation only (no letters)
  - Z is the requirement indicator of the field:
    - C if an entry is Conditionally required or optional
    - O if an entry is Optional to complete the function
    - R if an entry is required to complete the function

      NOTE: Facilities can designate that certain fields be Required. STAR product documentation does not display R for fields designated as Required by a facility.
  - For YY-Z field types, where YY is:
    - DATE for a field subject to the date entry conventions described in the *General Information Volume*.
    - SPECIAL FORMAT for a field having data entry requirements not conforming to standard format. The field definition contains the specific data entry requirements for the field.
    - TABLE LOOKUP for a field that enables you to select from a displayed table. See the *General Information Volume* for more information regarding this entry technique.
    - TIME for a field subject to the time entry conventions described in the *General Information Volume*.

    NOTE: For use of the Z position in this format, refer to the explanations for Z under X-YY-Z.

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Introduction

The *Patient Assessment Module* provides the caregiver with a tool for evaluating and documenting the patient's health status, along with determining a nursing diagnosis and the patient's ongoing healthcare needs. The patient's assessment is described as a systematic method of data collection which includes consideration of biophysical, psychosocial, environmental, self-care, educational, and discharge planning factors.

The *Patient Assessment Module* contains the following chapters:

Chapter 1: Patient Assessment Process

This chapter explains the process of evaluating and documenting a patient's health status.

Chapter 2: Patient Assessment Maintenance

This chapter explains the maintenance procedures for the assessment process.

Chapter 3: Patient Assessment Output

This chapter describes the output that is used to aid and track the assessment process.

Appendix A: Information Windows

This chapter provides information on using Information Windows, which displays patients' medical information, physicians of record, and pharmacy information. These information windows are available through Order Management and Nursing functions.

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OVERVIEW

The Patient Assessment Module stores the collected data to provide a historical view of a patient's health status, and as an aid in determining the continuing plan of care. The module offers suggestions for appropriate plans of care based on the assessments.

The Patient Assessment Module provides the capability to build assessments that evaluate the patient's status in areas defined by the hospital. The assessment can be organized by groups of questions on a related topic. You build questions for each assessment and link possible responses to each question. The caregiver chooses from the list of responses when performing the assessment.

You can indicate for the system to skip related questions when the response means follow-up questions do not apply. Using the File Maintenance function, you can link Plan of Care elements, problems, and Patient Care Requirement (PCR) codes to the assessment response.

The system generates a Problem List with the patient's assessment. The system generates this list automatically from the problems linked to the patient's responses. The caregiver can also add problems to the list. The purpose of the Problem List is to enable caregivers to prioritize problems and track problem resolution. This feature is useful when the hospital uses problem-oriented charting systems. You are able to store ongoing problems identified during a patient visit in a Master Problem List. The system automatically adds these problems to the patient's Problem List whenever the patient is readmitted.

Patient Assessment is a function that can produce valuable clinical data. The Patient Assessment Module is integrated with other STAR Patient Care modules for maximum use of the data:

- For use with the Patient Acuity and Nurse Staffing module, you can attach a PCR value to an assessment response. The assessment automatically generates a value for use in determining nurse staffing and patient acuity.

- For use with the Care Planning and Documentation module, the user can attach a Plan of Care or any of the Plan of Care components to an assessment response. When the caregiver completes an assessment, the system displays a list of recommended Plans of Care. The recommendations provide an expert system that reinforces hospital standards of care.

The caregiver can select the Plan of Care or delete a Plan of Care if it is not appropriate for a specific patient. The caregiver has the option of going directly into the Plan of Care process. This capability saves time and eliminates keystrokes when the caregiver wants to immediately begin planning care for the patient.

The standards of care for each nursing station or specialty area determine who can perform an assessment, when assessments are to be performed, as well as how often

the caregiver performs an assessment. The hospital can allow departments to complete, view, or revise specific assessments. For example, Social Services, Dietary, or Physical Therapy can have specific assessments to complete. You can limit other departments to only viewing the assessment data.

TERMS AND CONCEPTS

ASSESSMENT
Assessment is the title of the questionnaire the caregiver uses to assess the patient's health status in a particular area, such as a Cardiovascular Assessment. The questions linked to the assessment are designed to assess the patient's health status for the particular area being assessed. You can print the assessment to bring to the patient's bedside by printing the Assessment Worksheet.

ASSESSMENT GROUP
Assessment Group is a heading under which related questions can be organized. For example, if the caregiver is doing a Review of Systems Assessment, there are groups of questions to be addressed on this topic. The questions dealing with the Central Nervous System may be one group, Respiratory functions may be another group, the Cardiovascular functions may be another group, and so on. Assessment Groups are a way to organize the flow of the assessment performed by the caregiver. Grouping of assessments is optional for the system, but may be required by your hospital.

ASSESSMENT ORDER
The Assessment Order is a nursing order linked to an assessment. The Assessment Order is an active order that prints on the Active Order Worksheet and the Patient Care Profile (PCP). The Assessment Order also generates an order notice that prints in the designated department or on the default printer for the nursing station when the order is placed. When an Assessment Order is linked to an assessment, the Assessment Order Update screen displays before you begin to enter the assessment. You can place an Assessment Order, edit active/pending order information, or view the last completed order before proceeding with the assessment.

ASSESSMENT QUESTION/RESPONSE
Assessment Question is the question or prompt to which the caregiver enters the patient's response or a comment. You select the response from a list of available responses. You can also enter a freeform comment. Questions can be built to require only one response or to enable multiple responses to the question. The same question can be used in multiple assessments. When you enter the response to the question in one assessment, the system automatically updates the response in any other assessments where the question is selected.

FLOWCHART

The Patient Assessment Module can function in different ways (described below) depending on how the Nursing Department builds the Assessment in File Maintenance:

1. Select the assessment.

2. If the assessment is linked to an assessment order, the Assessment Order Update screen displays. This screen enables you to add or edit active/pending orders or view the last completed order. An assessment order prints on the Active Order Worksheet and Patient Care Profile, and generates an Order Notice at the nursing station's default printer and in designated departments.

3. Select groups and/or questions.

4. Enter a response and/or comment for the questions. The system displays the questions for each group until all selected questions have displayed.

5. The system generates the following, depending on the responses: Problems, PCRs, and Plan of Care elements.

   - PCR values generated by the Assessment Response automatically update the Patient Acuity and Nurse Staffing Module with acuity information for this patient.

   - Problems associated with the response automatically generate a Problem List for the patient.

     NOTE: If your facility retains a Master Problem List, the system also adds ongoing Problems from previous visits. For more information refer to "MASTER PROBLEM LIST" on page 1-55. You can manually add to the Problem List using the Problem List function on the Plan of Care Process Menu. For more information refer to "MENU ACCESS" on page 1-10. You can view Problem Lists from previous visits using the View Problem List by Visit function. For more information refer to "VIEW PROBLEM LIST BY VISIT" on page 1-58.

   - Plan of Care elements associated with the response generate a list of Recommended Plans of Care/Outcomes.

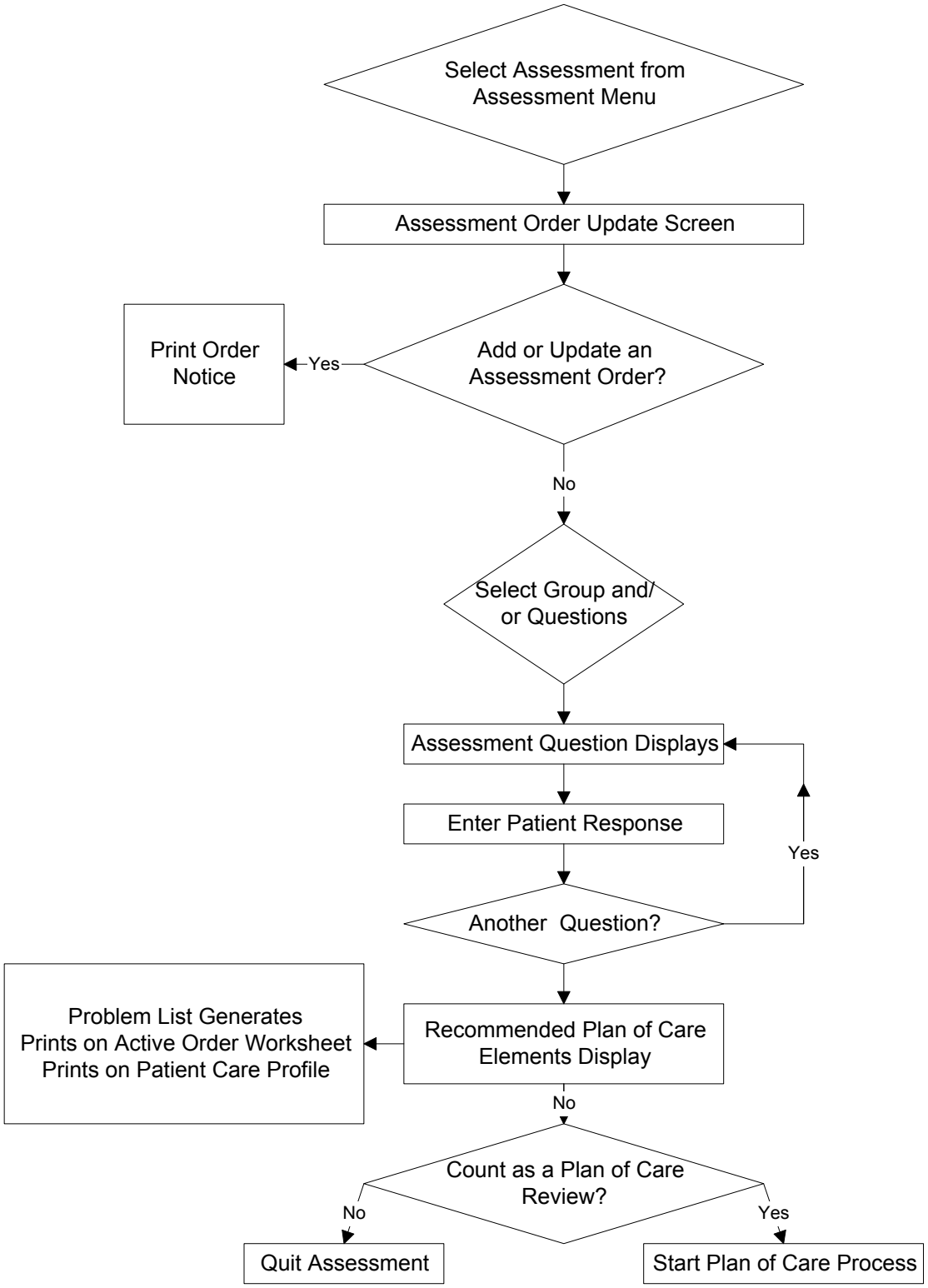
6. You have the following options:

   - Select from the list of Recommended Plans of Care/Outcomes and the Plan of Care process begins.

   - End the assessment process and the Plan of Care menu redisplays.

Figure 1.1 on page 1-7 illustrates the four possible flows of the Patient Assessment Module.

Figure 1.1 Flowchart of Patient Assessment Process



NOTES TO REMEMBER

Following are some helpful notes to remember when entering assessment data for a patient:

- A question can be part of more than one assessment. When you answer the question for one assessment, the system automatically enters the response for each assessment in which the question appears.

- When the response to a question eliminates the need to ask related questions, the system automatically skips the related questions (as built in File Maintenance).

- Enter assessment data in chronological order.

- Use the Add option to enter new assessment data for a patient.

- Use the Revise function's Revision option to correct an error made in charting, that is, an error made in data entry or data entered on the wrong patient. The Revision option is the equivalent of the manual system of crossing out the error and initialing.

- Use the Revise function's Late Entry option to enter assessment data that is out of chronological order.

- The system designates text you revise using the Revision option with *REV, and prints the date/time revised and the initials of the user who entered the last assessment (when the user is different from the user who originally entered the assessment).

  For example, you enter *The abdomen is distended*, which prints on the Assessment Report in the following format:

```
01  :Is the patient's abdomen distended?
    The abdomen is distended.
```

  You realize you should have entered that the abdomen is *not* distended. You revise the assessment question. When you print the Assessment Report, the updated entry prints under the question. The entry you revised prints under the updated entry with a *REV designation, as shown in the following example:

```
01  :Is the patient's abdomen distended?
    The abdomen is not distended.
    *REV 02/16/93 10:30 from The abdomen is distended.
```

  You cannot suppress REV items from printing on the Assessment Report. Revised items do not print on the Assessment History Report since they do not indicate a valid change in the patient's status. The updated entry prints on the Assessment History Report.

- Use the following methods to move between questions within an assessment:
  - Enter **N** for Next at the prompt to accept the current response and move to the next Assessment Question.
  - Enter **P** for Previous at the prompt to accept the current response and move to the previous Assessment Question.

MENU ACCESS

To access the Patient Assessment function, display the Nursing main menu:

```
                General Hospital 2R1 Station ID Processor
                                                Mon May 15, 1996 02:52 pm
2R1 Station ID Input Options

            Option No.  Option
            ---------------------------------------
                1       Orders
                2       Diet Review
                3       Plan of Care Process
                4       Critical Pathways
                5       Vital Signs & Fluid Balances
                6       Revise Patient
                7       Patient History / Misc.
                8       Patient Print
                9       Station Print
               10       Nursing Management
               11       Staffing Functions
               12       Census
               13       Name Inquiry
               14       Send Message
               15       File Maintenance
               16       Hospital Employee File

Enter option number--
```

Select the Plan of Care Process option from the menu. The following prompt displays for you to identify the patient for whom you are doing the assessment:

Enter acct #, '-'bed code, first chars of name'-' [2N Census]
'C' for Census

You have the following options:

- Enter the patient's account number.
- Enter a hyphen (-) followed by the patient's bed code.
- Enter the beginning letters of the patient's name followed by a hyphen (-). The system displays a list of patients whose last names begin with these letters. Select the patient.
- Press ENTER to select the default nursing station's census of patients. The list of patients on the nursing station displays for your selection. The list includes the patient's first and last names and the room-bed occupied. This is the census of the primary nursing station of the CRT you are using.
- When your station has a secondary station, you can enter **C** to select a secondary station's census. The following prompt displays:

  Enter station code [2N]--

You can enter the secondary station or enter hyphen (-) to display a list of the available secondary stations. The primary nursing station is the default in the prompt. The census displays for the secondary station.

NOTE: If you press ENTER or enter **C** for census, a lowercase r by the room and bed number when the census is displayed indicates that the patient has PHI restrictions defined. PHI restrictions indicate with whom the patient's protected health information (PHI) should or should not be shared.

The Plan of Care menu displays after you identify the patient, as shown on the following screen:

```
                  General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN      F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51
            Option No.  Option
            ---------------------------------------
                1       Defining Characteristics
                2       Patient Assessment
                3       Recommended Plan of Care/Outcomes
                4       Plan of Care
                5       Discharge/Exp Outcome
                6       Problem/Exp Outcome
                7       Discharge Plan
                8       Intervention/Treatments
                9       ADL's / Misc.
               10       Problem List
               11       Display Patient Care Profile

 Print         12       Patient Care Profile
               13       Nursing Plan of Care
               14       Assessment Reports

Enter option number--
```

Select the Patient Assessment option. The following screen displays:

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN      F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51









Select Add(A), Revise(R) or View(V) Assessments [A]--
```

You have the following options:

- Enter **A** for Add, or press ENTER, to enter a new assessment for a patient. Add is the default. The procedure follows below.
- Enter **R** for Revise to revise an existing assessment (see "REVISE AN INCORRECT ASSESSMENT ENTRY" on page 1-29) or make a late entry (see "MAKE A LATE ASSESSMENT ENTRY" on page 1-32).
- Enter **V** for View to view a patient's existing assessment. Refer to "VIEW AN ASSESSMENT" on page 1-34 for the procedure.

ADD AN ASSESSMENT

The Assessment Menu

The Assessment menu displays when you enter **A** to add an assessment. The Assessment menu is a list of assessments from which you can select individual assessments to be done for a patient.

The following screen contains an example of a Patient Assessment menu. The hospital defines these assessments and builds the Patient Assessment menu using the Maintenance function described in "Chapter 2 - PATIENT ASSESSMENT MAINTENANCE", of this volume.

The Assessment menus are assigned to each station on the Station Parameters screen in File Maintenance, also explained in Chapter 2. When no menu has been assigned to this station, the system displays an error message stating *No Menu Available*.

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN      F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51

                                 Assessment Menu
( 1) ADMISSION ASSESSMENT
( 2) MED/SURG ASSESSMENT
( 3) NURSING HISTORY
( 4) NURSE CASE MANAGEMENT ASSESSMENT
( 5) REVIEW OF SYSTEMS
( 6) O/B ASSESSMENT
( 7) PEDIATRIC ASSESSMENT
( 8) ORTHOPEDIC ASSESSMENT
( 9) WELLNESS ASSESSMENT
(10) NEUROVASCULAR ASSESSMENT
(11) RESPIRATORY ASSESSMENT
(12) ABDOMINAL ASSESSMENT



Enter choices (e.g. 1,3,7-9) or `-`choices to remove--
                                 end selection(NL)
```

Selecting Assessments

Select the assessments you want to perform from the Assessment menu. You can enter multiple selections by using the comma (,) and the hyphen (-). For example, to select numbers 1, 2, 3, 4, 5, 8, and 10, enter them in the format: 1-5,8-10,12. The system displays selected assessments with flashing, highlighted numbers. You can remove any of the selections by entering a hyphen (-) followed by the range of number(s) you want to remove. For example, to remove 1, 8, 9, and 10, enter them in the following format:

-1,8-10.

NOTE: When you select an assessment for which you do not have the ability to enter data, the following error message displays:

Error: Not allowed to select!

After visually verifying your selections, press ENTER to begin the Assessment process. The following screen displays for you to enter the actual date and time of the assessment. You can use the standard date and time conventions, such as entering **T** for Today and **N** for Now. The user's full name automatically displays in the Assessed by field and cannot be edited.

```
                General Hospital Patient Assessment Processor
                                                    Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN      F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51

1 Date Assessed     2 Time Assessed     3 Assessed by
->                                        Damer,Mary









Enter date assessed--
```

NOTE: The system does not accept a date/time entry that is prior to the last entry for this assessment. The following error message displays:

Error: Cannot be earlier than last assessment!

For example, if the last assessment was 8:00 am, you need to enter a date and time later than 8:00 a.m. When you want to make a Late Entry, you need to revise the assessment. For more information refer to "MAKE A LATE ASSESSMENT ENTRY" on page 1-32.

Enter the date and time and accept the screen. When there is an assessment order linked to the assessment, the Assessment Order Update screen displays for you to add an order, update an active/pending order, or view the last completed order. You can press ENTER to continue the assessment. Refer to the "Assessment Order Update Screen" on page 1-36 for information.

After you continue the assessment, the following screen displays with the name of the first assessment you selected:

```
                General Hospital Patient Assessment Processor
                                                Mon May 15, 1996 09:20 am


Assessment: ADMISSION ASSESSMENT









Do you want to select questions (Y/N)? [N]--
```

The prompt that displays depends on whether or not there are groups set up for the assessments.

WHEN THERE ARE NO ASSESSMENT GROUPS:

The following prompt displays when there are no groups of related questions set up for this assessment:

Do you want to select questions (Y/N)? [N]--

The prompt displays for each assessment you selected.

You have the following options:

- Enter **Y** for Yes when you want to select specific questions from the assessment. A list of questions built for the assessment displays for your selection. You can select one or more of the questions.
- Enter **N** for No, or press ENTER, when you want the system to automatically select the questions. The questions are defined for automatic selection in Assessment File Maintenance. Questions can be built for automatic selection in three ways:
  - For the initial assessment only.
  - For every assessment other than the initial assessment.
  - For all assessments performed on a patient (both initial and after).

The Assessment Question screen displays for you to enter the patient's response. To see this screen refer to "Enter Patient Data" on page 1-18.

WHEN THERE ARE ASSESSMENT GROUPS:

The following prompt displays when there are groups set up for this assessment:

Do you want to select groups(G), questions(Q), both(B) or none(NL)? [NL]--

The prompt displays for each assessment you selected.

You have the following options:

- Enter **G** for Groups when your hospital organizes assessments by groups of related questions. A list of groups displays for your selection, as shown in the following screen. You can select one or more of the Assessment Groups.
- Enter **Q** for Questions when you want to select specific questions from the assessment. A list of questions built for the assessment displays for your selection. You can select one or more of the Assessment Questions.
- Enter **B** for Both when you want to select specific questions from a specific group. First a list of assessment groups displays for your selection, as shown in the following screen. After you make your selection(s), a list of assessment questions for the group displays for your selection. You can select one or more of the Assessment Questions.
- Press ENTER, the default, when you want the system to automatically select the questions. The questions are defined for automatic selection in Assessment File Maintenance. Questions can be built for automatic selection in three ways:
  - For the initial assessment only.
  - For every assessment other than the initial assessment.
  - For all assessments performed on a patient (both initial and after).

When you enter **G** or **B**, the system displays a Group Screen listing the Assessment Groups, as shown on the following screen:

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN       F  02/14/15 2R15-1  DUNHAM,TOM R ENT 10 I/P 31

Assessment: SYSTEM REVIEW

Page:01                       Assessment Groups             ##=Current Choices
( 1) CARDIOVASCULAR
( 2) CENTRAL NERVOUS SYSTEM
( 3) GASTROINTESTINAL
( 4) MUSCLE/SKELETAL
( 5) GENITOURINARY
( 6) INTEGUMENTARY




Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                end selection(NL)
```

After you select the Groups or when you enter **Q**, a screen similar to the following displays with a list of Assessment Questions, as shown below:

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN       F  02/14/15 2R15-1  DUNHAM,TOM R ENT 10 I/P 31

Assessment: WELLNESS ASSESSMENT
     Group: HEALTH PERCEPTION MANAGEMENT
Page:01                       Assessment Questions          ##=Current Choices
( 1) GENERAL HEALTH?
( 2) HEALTH PAST YEAR?
( 3) HOW DO YOU STAY HEALTHY?
( 4) DO YOU SMOKE?
( 5) DO YOU DRINK?
( 6) MEDICATION?
( 7) DRUGS?




Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                end selection(NL)
```

The Assessment Question screen displays for the first question you selected from the list of questions or groups of questions you selected. The screen displays for each question you selected.

Enter Patient Data

After you select the group(s) and/or question(s), a screen displays for you to enter patient information for the first question, as shown on the following screen:

```
                General Hospital Patient Assessment Processor
                                                Mon May 15, 1996 09:20 am



Assessment/Group:   ADMISSION HISTORY DATA/SECTION 1
Date/time assessed: 02/16/09 15:33 #62345
 1 Question/Prompt
   |What is the patient's reason for admission                          |
   |                                                                    |
 2 Response                                          3 Last Date/Time Assessed
   ->                                                  05/15/93 8:00 #33233
 4 Comment
   |                                                                    |
   |                                                                    |
   |                                                                    |



Enter comment(C), next(N) or prev(P) [N]--
```

When the question has already been selected in a previous assessment, any existing response displays in the response field. The Last Date/Time Assessed field displays the date and time of the last assessment and the name of the user who selected the assessment question. When there is no existing response, the following message displays:

No Response Entries

Field Explanations

1. QUESTION/PROMPT (DISPLAY ONLY)
This field displays the question or prompt to assess the patient's health status. You cannot edit this field.

2. RESPONSE (2-N-R)
This field displays the current response. The bottom of the screen displays the available choices. You enter the selection number(s) of the response(s) to the question/prompt in this field. The response you enter prints on the Assessment Report. When the response is different from a previous response to this assessment, the response also prints on the Assessment History Report and the Assessment History Summary Report.

Various prompts can display, depending on how the Assessment Question is built in File Maintenance. Refer to "Answer Single-Response Questions" on page 1-20 for information on questions for which you select one response from a list of possible responses. Refer to "Answer Multiple-Response Questions" on page 1-21 for information on questions for which you can select more than one response.

When there is no response built for this question/prompt, the following prompt displays to enable you to enter a freeform comment:

Enter comment(C), next(N) or prev(P) [N]--

Refer to the Comment field for more information.

3. DATE/TIME LAST ASSESSED (DISPLAY ONLY)
The date and time of the last assessment displays in this field, along with the name of the user who performed the last assessment for this question. This field is blank when the question has not been previously selected. You cannot edit this field.

4. COMMENT (FREEFORM TEXT)
You can enter up to three lines of freeform text for any comment you want to enter in addition to the response. The Comment field can be required, optional, or skipped.

When the field is required, the system automatically positions the cursor in the Comment field. The editor screen displays with text editing options. You must enter a comment before you can exit the field or the following error message displays:

Error: Comment Required!

When the Comment is optional or skipped, the following prompt displays:

Enter comment(C), next(N) or prev(P) [N]--

You have the following options:

- Enter **C** for Comment when you want to enter a freeform comment. The cursor moves to the Comment field for you to make your entry.
- Enter **N** for Next to accept the current response and move to the next Assessment question.
- Enter **P** for Previous to accept the current response and move to the previous Assessment question.

When you enter **C** for Comment, the system positions the cursor in the Comment field where you can enter up to three lines of text. The following options display at the bottom of the screen:

Key	Function
F1 (Del Line)	Deletes the line where the cursor is positioned.
F2 (Ins Line)	Inserts a line above the line where the cursor is positioned.
F3 (Done)	Exits the text-entry screen.
F4 (Del Char)	Deletes the character where the cursor is positioned.
F5 (Ins Char)	Inserts a space in front of the character where your cursor is positioned. You can then enter the character you want to insert.

Once you enter a comment, the next assessment question displays.

ENTER MATERNITY PATIENT DATA

When you enter Assessment data for a maternity patient, the system displays an additional prompt when you are responding to an Obstetric History group. This prompt only appears the first time you enter the obstetric information for the patient. The system uses the number of Registerable Births from the patient's most recent maternity visit (if there is one) as the default response to the prompt. The default for the first visit (no previous maternity visits) is 0.

Enter the number of previous Registerable Births [3]--

Once this question has been answered, it does not display again. When you revise an existing assessment for a maternity patient, by editing an Obstetric History type, the option to revise the number of previous Registerable Births is again available.

You can either use or override the default response. After you enter the number of registerable births, the system brings up the selected obstetric history assessment groups the number of times you indicated. As you review/enter information, the system displays the total number of registerable births and which one you are currently editing to the right of the group description.

```
                  General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92044-00003   BARNES,BRENDA L    F  06/27/58 2G26-1  CHERECK,BOB  ALT 10 I/P 229

 Assessment/Group:   WELLNESS ASSESSMENT/HABITS        Reg Births: 4/1
 Date/time assessed: 01/28/09 18:41 #12700
  1 Question / Prompt
    |How have you complied with your special diet?                        |
    |                                                                      |
  2 Response                                          3 Last Date/Time Assessed
 -> YES                                                 01/28/09 18:41  #12700
  4 Comment
    |                                                                      |
    |                                                                      |
    |                                                                      |
 Page:01                              Responses                ##=Current Choices
 ( 1) YES
 ( 2) NO
 ( 3) NOT APPLICABLE

 Enter choice--
```

The system always displays and prints previous obstetric history in chronological order from one through twenty two, beginning with the earliest date.

ANSWER SINGLE-RESPONSE QUESTIONS

When there is only one response to a question, a list of the possible responses built for the question/prompt displays for your selection, as shown on the following screen:

```
                General Hospital Patient Assessment Processor
                                                Mon May 15, 1996 09:20 am



Assessment/Group:   ADMISSION HISTORY DATA/SECTION 1
Date/time assessed: 02/16/09 15:33 #62345
 1 Question/Prompt
   |TIME ARRIVED AND MODE OF TRANSPORTATION                              |
   |                                                                     |
 2 Response                                      3 Last Date/Time Assessed
 ->CARRIED                                         05/15/93 8:00 #33233
 4 Comment
   |________ TIME ARRIVED                                               |
   |                                                                     |
   |                                                                     |
Page:01                          Responses
( 1) WHEELCHAIR
( 2) AMBULATORY
( 3) STRETCHER

Enter choice, NL for [CARRIED]--
```

The following prompt displays:

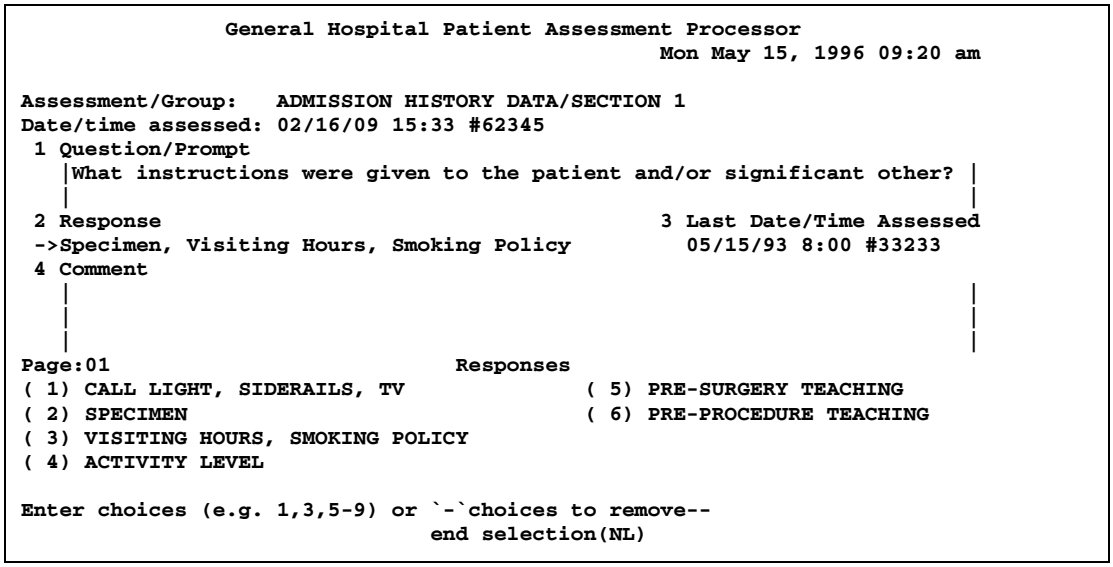
Enter choice, NL for [FIRST RESPONSE]--

The first time you select this Assessment Question, a default displays in the prompt. The default is the first response that was built for the question in File Maintenance. This response is usually the most common response. When a previous response was entered for this assessment, the selection is highlighted and you only need to press ENTER to select the same response.

The Comment field of a Single-Response Question is linked to the response. This means that when you change the response, the system deletes any entry in the Comment field. The system positions the cursor in the Comment field for you to enter a different response.

ANSWER MULTIPLE-RESPONSE QUESTIONS

When you can choose more than one response for a question, a list displays of the possible responses built for the question/prompt. You can select one or more responses, as shown on the following screen:



The following prompt displays:

Enter choices (e.g. 1,3,5-9) or `-`choices to remove--
end selection(NL)

This prompt enables you to choose multiple responses from the list using the selection numbers. You can also remove responses that have been selected by preceding the selection number(s) with a hyphen (-).

The Comment field of a Multiple-Response Question is linked to the question. This means that when you select different responses, the Comment field does not change.

QUIT AN ASSESSMENT

You can quit an assessment before completing all of the questions you have selected. You can enter a period (.) and press ENTER to display the following prompt:

Quit Assessment? [N]--

This prompt also displays when you leave a PC prior to completing the questions for an assessment and there is no activity for several minutes.

You have the following choices:

- Enter **Y** for Yes when you want to quit the assessment. The entries you have already made are stored with the assessment. When you want to finish the assessment, you must use the Revise option to make a Late Entry. For more information refer to "MAKE A LATE ASSESSMENT ENTRY" on page 1-32.

  NOTE: When you use the Revise function's Late Entry option to complete the assessment, the system does not designate the answers as corrected entries (REV). The system reports the answers as if they were entered during the initial assessment.

- Enter **N** for No when you want to continue the assessment.

COMPLETE THE ASSESSMENT

Recommended Plans of Care

The system displays each Assessment Question you selected or that was automatically selected. After you complete the Assessment, the system displays the Recommended Plans of Care, as in the following screen example:

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
92147-00002   LITNER,FRANK S    M  12/31/87 6407-1  ABRAHAM,JENNIALT 10 I/P 358


Page:01    File Type Code Recommended Plan of Care/Outcomes ##=Current Choices

( 1)          PC     0025 NS HEALTH MAINTENANCE, ALTERATION
( 2)          PC     1010 COPING, INEFFECTIVE INDIVIDUAL
( 3)          PC     2008 SKIN INTEGRITY IMPAIRED ACTUAL
( 4)          PO     4098 SENSORY, HEARING ALTERATION









Count as a PC Review? (Y/N) [N]--
                                 end selection(NL)
```

The system lists the Plan of Care elements set up in Standard File Maintenance for the response(s) given by the patient. The following prompt displays:

Count as a PC Review? (Y/N) [N]--

The prompt asks if you want your review of the Plan of Care to count as an official Plan of Care Review. You have the following options:

- Enter **N** for No when you do not want review the recommended Plans of Care. The system redisplays the Plan of Care menu.
- Enter **Y** for Yes when you want to select or view the recommended Plans of Care. The system prompts you to select or delete a Plan of Care element:

Enter select(S) or delete(D) plan of care elements or NL--
next page (/)

You have the following options:

- Enter **S** to select a Plan of Care element.
- Enter **D** to delete a Plan of Care element.
- Press ENTER to display the prompt to accept the screen.

NOTE: You can also access the Plans of Care linked to an assessment by selecting the Recommended Plan of Care/Outcomes function from the Nursing main menu.

After you specify a Plan of Care element to select or delete, the system displays "Select" or "Delete" next to the Plan of Care element, as shown on the following screen.

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY        F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 71

Page:01    File Type  Code  Recommended Plan of Care/Outcomes ##=Current Choices
( 1)           PC     4003  TISSUE PERFUSION-ALTERATION
( 2)           PC     4004  BREATHING PATTERNS, INEFFECTIVE
( 3)  Select   PC     4007  MOBILITY, IMPAIRED PHYSICAL
( 4)           PC     6018  NUTRITION, ALT IN, LESS THAN REQ
( 5)           PO     4044  KNOWLEDGE OF NUTRITIONAL REQUIEM
( 6)           PO     4097  SENSORY, VISION ALTERATION
( 7)           PO     4098  SENSORY, HEARING ALTERATION
( 8)           PO     4124  COMPLY WITH MEDICATION SCHEDULE
( 9)           PO     7777  LEVEL OF CONSCIOUSNESS IMPAIRED
(10)  Select   PC     1001  POTENTIAL FOR INJURY
(11)           PC     1010  COPING, INEFFECTIVE INDIVIDUAL
(12)           PC     2003  ORAL MUCUS MEMBRANES, ALT IN
(13)           PC     2007  SKIN INTEGRITY IMPAIRED, POTENTIAL

Accept screen? (Y/N)--  |
```

Press ENTER when you finish selecting or deleting Plans of Care.

After you accept the screen, the system displays the selected Plan of Care on the Plan of Care screen, as shown on the following screen:

```
                    General Hospital Plan of Care Processor
PC: TISSUE PERFUSION-ALTERATION                    Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90164-00002   LINSKI,ELLEN      F  03/17/10 1202-1  DUNHAM,TOM R OTH 10 I/P 139

               Prob/Exp Outcome  TISSUE OXYGENATION, ADEQUATE

                              PB: TISSUE PERFUSION, DECREASED:RELATED
                                  TO_____________
                              GL: THE CUSTOMER WILL RETURN TO A LEVEL OF
                                  ADEQUATE TISSUE OXYGENATION

               Intervention      MAINTAIN B/P, P, R

                                : MAINTAIN
                                  B/P >_______, P <_______, RESP <_______


 Press NL to continue viewing or `A` to activate this Plan of Care--
```

The following prompt displays:

Press NL to continue viewing or 'A' to activate this plan of care--

You can press ENTER to view the Plan of Care, or you can enter **A** to activate the plan of care.

After you activate or delete a Plan of Care, the title of the Plan of Care does not display on the Recommended Plan of Care List the next time you display the list for this patient.

Impact

When you enter the Delete option and accept the screen, the Plan of Care title no longer displays as a selection on the previous screen.

When you enter the Select option and accept the screen, the system moves into the Plan of Care Process function described briefly below, where you can view or activate Plans of Care/Outcomes.

For more information on the Plan of Care Process, refer to the *Care Planning and Documentation Module* of the *STAR Patient Care Reference Guide*.

Menu Access to Plan of Care Process

When you want to access Recommended Plan of Care/Outcomes through the menu, and not directly from the Patient Assessment Process, select Plan of Care Process from the Nursing main menu.

```
                General Hospital 2R1 Station ID Processor
                                                  Mon May 15, 1996 02:52 pm
2R1 Station ID Input Options

           Option No.  Option
           ---------------------------------------
               1       Orders
               2       Diet Review
               3       Plan of Care Process
               4       Critical Pathways
               5       Vital Signs & Fluid Balances
               6       Revise Patient
               7       Patient History / Misc.
               8       Patient Print
               9       Station Print
              10       Nursing Management
              11       Staffing Functions
              12       Census
              13       Name Inquiry
              14       Send Message
              15       File Maintenance
              16       Hospital Employee File

Enter option number--
```

The next screen prompts you to identify the patient for whom you are reviewing the Recommended Plan of Care/Outcomes.

Enter acct #, '-'bed code, first chars of name'-' [1E Census]--
'C' for Census

You have the following options:

- Enter the patient's account number.
- Enter a hyphen (-) followed by the patient's bed code.
- Enter the beginning letters of the patient's last name. The system displays a list of patients whose last names begin with these letters. Select the correct patient. (The selection becomes more specific with every letter that you add.)
- Press ENTER to select the default nursing station's census of patients. The list of patients on the nursing station displays for your selection. The list includes the patient's first and last names and the room-bed occupied.

  This is the census of the primary nursing station of the CRT you are using.
- When your station has a secondary station, you can enter **C** to select a secondary station's census. The following prompt displays:

  Enter station code [1E]--

You can enter the secondary station or enter hyphen (-) to display a list of the available secondary stations. The primary nursing station is the default in the prompt. The census displays for the secondary station.

The Plan of Care menu displays after you identify the patient:

```
                  General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN       F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51
            Option No.  Option
            ----------------------------------------
                1       Defining Characteristics
                2       Patient Assessment
                3       Recommended Plan of Care/Outcomes
                4       Plan of Care
                5       Discharge/Exp Outcome
                6       Problem/Exp Outcome
                7       Discharge Plan
                8       Intervention/Treatments
                9       ADL's / Misc.
               10       Problem List
               11       Display Patient Care Profile

 Print         12       Patient Care Profile
               13       Nursing Plan of Care
               14       Assessment Reports

 Enter option number--
```

Select the Recommended Plan of Care/Outcomes option. The list of Recommended Plan of Care/Outcomes display from the Plan of Care elements linked to an assessment response during the process of building the standard files. The responses you select for the patient generate the list of Recommended Plan of Care/Outcomes that display. To view the screen refer to “Recommended Plans of Care” on page 1-24.

REVISE AN INCORRECT ASSESSMENT ENTRY

You can correct any entries you make for an assessment. The system lists all the dates that the assessment was completed for the patient's visit. You select the date when you made the error in charting. The error may be during data entry or data that was entered on the wrong patient. The Revision option is the equivalent of the manual system of crossing out the error and initialing.

NOTE: Use the Revision function's Late Entry option when you want to finish an assessment that you quit, or to enter an assessment with an assessment date/time prior to the current assessment's date/time. Refer to "MAKE A LATE ASSESSMENT ENTRY" on page 1-32 to view this procedure.

The system designates text you revise with the abbreviation *REV, and prints the date/time revised and the initials of the user who entered the last assessment (when the user is different from the user who originally entered the assessment).

For example, you enter *The abdomen is distended*, which prints on the Assessment Report in the following format:

```
01  :Is the patient's abdomen distended?
    The abdomen is distended.
```

You realize you should have entered that the abdomen is *not* distended. You revise the assessment question. When you print the Assessment Report, the updated entry prints under the question. The entry you revised prints under the updated entry with a *REV designation, as in the following example:

```
01  :Is the patient's abdomen distended?
        The abdomen is not distended.
    *REV 02/16/93 10:30 from The abdomen is distended.
```

You cannot suppress REV items from printing on the Assessment Report. Revised items do not print on the Assessment History Report since they do not indicate a valid change in the patient's status. The updated entry prints on the Assessment History Report.

Refer to "MENU ACCESS" on page 1-10 for the procedure to display the following prompt:

Select Add(A), Revise(R) or View(V) Assessments [A]--

Enter **R** to Revise the assessment. The Assessment Menu displays with the list of available assessments. Select the assessment that you want to correct. The system displays the date and time of the existing assessments at the bottom of the screen, as shown on the following screen:

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN       F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51

                                  Assessment Menu
( 1) ADMISSION ASSESSMENT
( 2) MED/SURG ASSESSMENT
( 3) NURSING HISTORY
( 4) NURSE CASE MANAGEMENT ASSESSMENT
( 5) REVIEW OF SYSTEMS
( 6) O/B ASSESSMENT
( 7) PEDIATRIC ASSESSMENT
( 8) ORTHOPEDIC ASSESSMENT
( 9) WELLNESS ASSESSMENT
(10) NEUROVASCULAR ASSESSMENT

Page:01                          Assessment Dates
( 1) 02/16/09 2110
( 2) 02/16/09 1620
( 3) 02/16/09 1017
( 4) 02/16/09 2008
( 5) 02/16/09 1530

Select Assessment to revise or (NL) to add late-entry--
```

The most recent assessment displays first. The following prompt displays:

Select Assessment to revise or (NL) to add late-entry--

Enter the selection number of the assessment date you want to revise. The prompt displays for you to select Groups and/or Questions. For information on how to select groups or questions refer to "Selecting Assessments" on page 1-13.

NOTE: When you revise an existing assessment that contains an Obstetrical History assessment, the system displays the following prompt if the patient is a maternity patient:

Enter the birth to revise--

This prompt enables you to switch assessments from one registerable birth to another. For example, if you accidently entered birth #4 as birth #3, you can simply revise the two with the correct numbers, rather than having to delete and re-enter the information.

Once you select the groups/questions you want to correct, the screen displays the first question you selected, as shown on the following screen:

```
               General Hospital Patient Assessment Processor
                                                 Mon May 15, 1996 09:20 am

Assessment/Group:   WELLNESS ASSESSMENT/HEALTH PERCEPTION MANAGEMENT
Date/time assessed: 02/16/09 15:33 #62345
 1 Question/Prompt
   |How has your general health been?                                    |
   |                                                                     |
 2 Response                                      3 Last Date/Time Assessed
-> GOOD                                            05/15/93 8:00 #33233
 4 Comment
   |Deteriorating                                                        |
   |                                                                     |
   |                                                                     |
Page:01                              Responses              ##=Current Choices
( 1) GOOD
( 2) FAIR
( 3) POOR
( 4) EXCELLENT

Enter choice--
```

The cursor is in the Response field. The response entered during the last assessment displays in the field. The list of available choices display at the bottom of the screen. The system highlights the current choice(s) as the default. When only one response is allowed, select the choice you want to make. When this is a multiple-response question, remove selection of the incorrect response(s) by entering hyphen (-) and the selection number(s) and then enter the correct response(s).

The Comment field of a Single-Response Question is linked to the response. This means that when you change the response, the system deletes any entry in the Comment field and positions the cursor in the field for you to enter a different comment. The Comment field of a Multiple-Response Question is linked to the question. When you select different responses, the Comment field does not change, although you can change the entry in the field, if necessary.

MAKE A LATE ASSESSMENT ENTRY

There may be times when you need to add a late entry to an assessment or add an assessment that you performed on a date/time prior to the current assessment. You can use the Late Entry option to add this assessment information.

The system defines a Late Entry as any assessment that is entered out of chronological order. The system designates the entry by printing *Late Entry* on the Assessment Report, along with the date/time and user name of the late entry.

Refer to "MENU ACCESS" on page 1-10 for the procedure to display the following prompt:

Select Add(A), Revise(R) or View(V) Assessments [A]--

NOTE: Do not select **A** to add the assessment information. When you enter a date or time that is earlier than the last assessment entered, the following error message displays:

Error: Cannot be earlier than last assessment!

Enter **R** to Revise the assessment. The Assessment menu displays with the list of available assessments. Select the assessment to which you want to add the late entry. The system displays the date and time of the existing assessments at the bottom of the screen, as shown on the following screen:

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN       F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51

                                 Assessment Menu
( 1) ADMISSION HISTORY
( 2) ASSESSMENT HISTORY
( 3) NURSING HISTORY
( 4) NURSE CASE MANAGEMENT ASSESSMENT
( 5) REVIEW OF SYSTEMS
( 6) REVIEW OF SYSTEMS QUESTIONNAIRE
( 7) SYSTEM REVIEW
( 8) SYSTEMS REVIEW 1
( 9) WELLNESS ASSESSMENT
Page:01                         Assessment Dates
( 1) 02/16/09 2110
( 2) 02/16/09 1620
( 3) 02/16/09 1017
( 4) 02/16/09 2008
( 5) 02/16/09 1530

Select Assessment to revise or (NL) to add late-entry--
```

The most recent assessment displays first. The following prompt displays:

Select Assessment to revise or (NL) to add late-entry--

Press ENTER to add a late entry. The following screen displays for you to enter the actual date and time of the assessment. You can use the standard date and time conventions, such as enter **T** for Today and **N** for Now. The user's full name automatically displays in the Accessed by field and cannot be edited.

```
                General Hospital Patient Assessment Processor
                                                    Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN       F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51

1 Date Assessed     2 Time Assessed     3 Assessed by
->                                        Damer,Mary









Enter date assessed--
```

NOTE: When you enter a date that is not prior to the current assessment, the system displays the following prompt:

Assessment will become current. OK to proceed? [N]--

Enter **Y** for Yes when you want to add the assessment as a late entry. Enter **N** for No when you do not want to proceed with the assessment. The Plan of Care Menu redisplays. The assessment process is the same as for adding an Assessment: an Assessment Order Update screen displays when there is an Assessment Order linked to the assessment, then the prompt displays to select questions or groups of assessments. Refer to "ADD AN ASSESSMENT" on page 1-13 for more information.

Output

On the Assessment Report, the system prints the date and time you entered for when the assessment was performed (prior to the current assessment). On the same line, the system prints the words *Late Entry* and the actual date/time you entered the assessment.

VIEW AN ASSESSMENT

You can view all or part of a patient's assessment when you do not want to print a report. This enables you to view a particular assessment of the patient's health status or to compare the patient's current status with one on a previous date.

Refer to "MENU ACCESS" on page 1-10 for the procedure to display the following prompt:

Select Add(A), Revise(R) or View(V) Assessments [A]--

Enter **V** to View the assessment. The Assessment menu displays with the list of available assessments. Select the assessment for which you want to view. The system displays the date and time of the existing assessments at the bottom of the screen, as shown on the following screen:

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN      F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51

                                 Assessment Menu
( 1) ADMISSION HISTORY
( 2) ASSESSMENT HISTORY
( 3) NURSING HISTORY
( 4) NURSE CASE MANAGEMENT ASSESSMENT
( 5) REVIEW OF SYSTEMS
( 6) REVIEW OF SYSTEMS QUESTIONNAIRE
( 7) SYSTEM REVIEW
( 8) SYSTEMS REVIEW 1
( 9) WELLNESS ASSESSMENT
Page:01                          Assessment Dates
( 1) 02/16/09 2110
( 2) 02/16/09 1620
( 3) 02/16/09 1017
( 4) 05/15/93 2008
( 5) 05/15/93 1530

Select Assessment to view--
```

The most recent assessment displays first. The following prompt displays:

Select Assessment to view--

Select the assessment you want to view. The prompt displays for you to select specific groups and/or questions. For more information refer to "Selecting Assessments" on page 1-13.

NOTE: When you view an existing assessment for a maternity patient, the system displays the following prompt before advancing to the screen that displays question details:

Enter the birth to view--

You must specify the birth that corresponds to the assessment you want to view in order to access the associated questions. After you enter the birth information, the question details display in the order in which you selected them.

After you select the questions, the system displays the detail screen for each question, with the following prompt:

Enter next(N) or prev(P) question [N]--

You have the following choices:

- Enter **N** for Next to display the next question.
- Enter **P** for Previous to display the previous question.

After you view the last question, the Plan of Care menu redisplays.

ASSESSMENT ORDERS

Assessment Order Update Screen

The Assessment Order Update screen displays the last completed order and the active/pending orders associated with the assessment you selected. This screen displays if an assessment order is linked to an assessment in File Maintenance.

```
                General Hospital Patient Assessment Processor
                                                    Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI, ELLEN     F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 56

Last Completed Order:

 No. Dept  Ord#  Date/Time/Shift to do     Description ('~'=recurring)
 1   S       64  02/17/09  10:13am  1      Assessment History Order

Active/Pending Orders:

 No. Dept  Ord#  Date/Time/Shift to do     Description ('~'=recurring)
 2   L       70  02/18/09  11:05am  1      Neuro Assessment Order


                          No more active orders!
Enter # to update, add(A), continue assessment (NL) [NL]-- |
```

You have the following options:

- Enter the selection number from the No. column to update an active/pending order or view the last completed order.
- Enter **A** to Add a new assessment order.
- Press ENTER to continue the assessment.
- Enter slash (/) to display the next page of active/pending orders, when additional active/pending orders exist. You do not receive this message when no additional pages exist; instead, the system displays the message *No More Active Orders!*

REVIEW A COMPLETED ASSESSMENT ORDER

You cannot update a completed assessment order, but you can review the last completed order. After you enter the number of the last completed order (No. 1), the system displays the following screen for you to review the information.

```
                General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 71

 1 Assessment                                  2 Print      3 Initials
   0101 REVIEW OF SYSTEMS (GRP)                             EM
 2 Priority            3 Request Date    6 Request Time   7 Request Shift
   Shift 1               02/17/09          07:00am          Daytime
 8 Recurring           9 Stop Date      10 Stop Time     11 Interval
   No                    02/17/09          11:00am
12 Ordering Physician          13 Shifts to Print        14 Print Order Notice
   17 ZELLER, HECTOR C




Next order (NL) or /NL to continue assessment [NL]--
```

You have the following options:

- Press ENTER to display the next order.
- Enter a slash (/) and press ENTER to continue the assessment. The system displays the first question of the Assessment Groups or Assessment Questions you selected.

Field Explanations

The patient's Account Number, Name, Sex, Birthdate, Room, Attending Physician, Medical Service and Status display across the top of the screen.

1. ASSESSMENT (DISPLAY ONLY)
The Assessment Order code and descriptive name display in this field.

2. PRINT (DISPLAY ONLY)
This field displays whether or not this order prints on the Patient Care Profile. *Yes* displays if it prints on the PCP; *No* displays if it does not print on the PCP.

3. INITIALS (DISPLAY ONLY)
The initials of the individual who entered the order display in this field.

4. PRIORITY (DISPLAY ONLY)
The order's priority, relating to when the order needs to be done, displays in this field. For example, Shift 1 or Now may display in this field.

5. REQUEST DATE (DISPLAY ONLY)
This field displays the date the order has been requested to begin.

6. REQUEST TIME (DISPLAY ONLY)
This field displays the time the order has been requested to begin.

7. REQUEST SHIFT (DISPLAY ONLY)
This field displays the shift on which this order has been requested to begin.

8. RECURRING (DISPLAY ONLY)
This field displays whether or not this is a recurring order. *Yes* displays if it is a recurring order; *No* displays if it is not a recurring order.

9. STOP DATE (DISPLAY ONLY)
The date the recurring order discontinues displays in this field.

10. STOP TIME (DISPLAY ONLY)
The time the recurring order discontinues displays in this field.

11. INTERVAL (DISPLAY ONLY)
This field displays the time interval between recurrences of the order, when this is a recurring order. For example if this field displays 4 HR 0 MIN, it means to perform the assessment every four hours between the Request Date/Time and the Stop Date/ Time.

12. ORDERING PHYSICIAN (DISPLAY ONLY)
The physician or caregiver who requested this order displays in this field.

13. SHIFTS TO PRINT (DISPLAY ONLY)
This field displays the shifts for which this order prints on the Patient Care Profile: *1* for Shift 1, *2* for Shift 2, and *3* for Shift 3.

14. PRINT ORDER NOTICE (DISPLAY ONLY)
This field displays whether or not an Assessment Order Notice prints.

Impact

You can only review a completed order through this screen. You cannot make any changes to a completed order. This function has no impact on the system.

Update an Active/Pending Order

You can update an active or pending order from the Assessment Order Update screen, as shown on the following screen:

```
                General Hospital Patient Assessment Processor
                                                    Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN       F  02/14/15 2R15-1  DUNHAM,TOM R ENT 10 I/P 31

Last Completed Order:

 No. Dept  Ord#  Date/Time/Shift to do     Description ('~'=recurring)
 1   S       64  02/17/09  10:13am  1      Assessment History Order

Active/Pending Orders:

 No. Dept  Ord#  Date/Time/Shift to do     Description ('~'=recurring)
 2   L       70  02/18/09  11:05am  1      Neuro Assessment Order




                          No more active orders!
Enter # to update, add(A) continue assessment (NL) [NL]-- |
```

You have the following options:

- Enter the selection number from the No. column to update an active/pending order or view the last completed order.
- Enter **A** to Add a new assessment order.
- Press ENTER to continue the assessment.
- Enter a slash (/) to display the next page of active/pending orders, when additional active/pending orders exist. You do not receive this message when no additional pages exist; instead, the system displays the message *No More Active Orders!*

If you select an active or pending order from the list, the following Order Detail screen displays.

The Assessment Order Detail screen is similar to the screen that displays for completed orders. This screen does not include the fields that display information regarding when and who completed the order, since the order is still active/pending.

```
               General Hospital Patient Assessment Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 71

 1 Assessment                                  2 Print      3 Initials
   0101 REVIEW OF SYSTEMS (GRP)                             EM
 4 Priority            5 Request Date    6 Request Time   7 Request Shift
   Shift 1               05/17/93          07:00am          Daytime
 8 Recurring           9 Stop Date      10 Stop Time     11 Interval
   No                    05/17/93          11:00am
12 Ordering Physician          13 Shifts to Print        14 Print Order Notice
   17 ZELLER, HECTOR C


Complete(C), Cancel(D), Next order (NL) or /NL to continue assessment [NL]--
```

You have the following options:

- Enter **C** to complete the active or pending order. The system displays the Assessment Order Detail screen for the next order on the list and provides the update options.
- Enter **D** to cancel, or delete, the active or pending order. The system displays the Order Detail screen for the next order on the list and provides the update options.
- Press ENTER to display the next active or pending order in the list.
- Enter a slash (/) to continue the assessment. The system displays the first question of the Assessment Groups or Assessment Questions you selected.

Field Explanations

The patient's Account Number, Name, Sex, Birthdate, Room, Attending Physician, Medical Service and Status display across the top of the screen. You cannotedit these fields on an Assessment Order.

1. ASSESSMENT (DISPLAY ONLY)
The Assessment Order code and descriptive name display in this field.

2. PRINT (DISPLAY ONLY)
This field displays whether or not this order prints on the Patient Care Profile. Yes displays if it prints on the PCP; *No* displays if it does not print on the PCP.

3. INITIALS (DISPLAY ONLY)
The initials of the individual who entered the order.

4. PRIORITY (DISPLAY ONLY)
The order's priority, relating to when the order needs to be done, displays in this field. For example, *Shift 1* or *Now* may display in this field.

5. REQUEST DATE (DISPLAY ONLY)
This field displays the date the order has been requested to begin.

6. REQUEST TIME (DISPLAY ONLY)
This field displays the time the order has been requested to begin.

7. REQUEST SHIFT (DISPLAY ONLY)
This field displays the shift on which this order has been requested to begin.

8. RECURRING (DISPLAY ONLY)
This field displays whether or not this is a recurring order. *Yes* displays if it is a recurring order; *No* displays if it is not a recurring order.

9. STOP DATE (DISPLAY ONLY)
The date the recurring order discontinues displays in this field.

10. STOP TIME (DISPLAY ONLY)
The time the recurring order discontinues displays in this field.

11. INTERVAL (DISPLAY ONLY)
This field displays the time interval between recurrences of this order, when this is a recurring order. For example if this field displays 4 HR 0 MIN, it means to perform the assessment every four hours between the Request Date/Time and the Stop Date/ Time.

12. ORDERING PHYSICIAN (DISPLAY ONLY)
The physician or care provider who requested this order displays in this field.

13. SHIFTS TO PRINT (DISPLAY ONLY)
This field displays the shifts for which this order prints on the Patient Care Profile: *1* for Shift 1, *2* for Shift 2 and *3* for Shift 3.

14. PRINT ORDER NOTICE (DISPLAY ONLY)
This field displays whether or not an Assessment Order Notice prints.

Impact

If you enter **C** to complete the order, the order no longer prints on the Patient Care Profile (PCP) or the Active Order Worksheet. In addition, the completed order no longer displays on the Assessment Order Update screen as an active/pending order. If it is the last order that was completed, it displays on the Assessment Order Update screen as the last completed order.

If you enter **D** to cancel or delete, the order, the order no longer prints on the Patient Care Profile (PCP) or the Active Order Worksheet, and an Assessment Order Notice

does not print. Also, the cancelled order no longer displays on the Assessment Order Update screen as an active/pending order.

Adding an Order

After you enter **A** to Add an order from the Assessment Order Update screen, the system displays an Assessment Order Detail screen, like the following example, for you to enter the necessary information for the assessment order. If an active order already exists, the system displays the message *Already ordered* and displays the following prompt:

Order again? (Y/N)--

Enter **Y** for Yes to enter another order for this assessment. Enter **N** for No when you do not want to enter another order.

The system displays the Assessment Order screen. After you accept the screen, the system assigns an order number to the new order, as shown on the following screen:

```
               General Hospital Patient Assessment Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 71

 1 Assessment                                  2 Print      3 Initials
   0101 REVIEW OF SYSTEMS (GRP)                             EM
 4 Priority            5 Request Date    6 Request Time   7 Request Shift
   Shift 1               02/17/09          07:00am          Daytime
 8 Recurring           9 Stop Date      10 Stop Time     11 Interval
   No                    02/17/09          11:00am
12 Ordering Physician          13 Shifts to Print        14 Print Order Notice
   17 ZELLER, HECTOR C




Order #82 assigned.  Enter additional orders? (Y/N) [N]--
```

Field Explanations

The patient's Account Number, Name, Sex, Birthdate, Room, Attending Physician, Medical Service and Status display across the top of the screen.

1. ASSESSMENT (DISPLAY ONLY)
The Assessment Order code and descriptive name display in this field.

2. PRINT (1-A-R)
You can designate whether or not this order prints on the Patient Care Profile. Enter **Y** for Yes to print the order on the PCP; enter **N** for No when you do not want to print the order on the PCP. The default response for this field is Yes.

3. INITIALS (DISPLAY ONLY)
This field displays the initials of the individual who entered the order.

4. PRIORITY (TABLE LOOKUP)
This field stores the order's priority, relating to when the order needs to be done. Enter a hyphen (-) to display a table lookup for selection. Priority examples include Shift 1, Routine, and Now.

5. REQUEST DATE (DISPLAY ONLY)
This field displays the date you request the order to begin.

6. REQUEST TIME (DISPLAY ONLY)
The time the order has been requested to begin displays in this field.

7. REQUEST SHIFT (DISPLAY ONLY)
The shift on which this order has been requested to begin displays in this field.

8. RECURRING (DISPLAY ONLY)
Whether or not this is a recurring order displays in this field. *Yes* displays if it is a recurring order; *No* displays if it is not a recurring order.

9. STOP DATE (DISPLAY ONLY)
This field displays the stop date for a recurring order.

10. STOP TIME (DISPLAY ONLY)
This field displays the stop time for a recurring order.

11. INTERVAL (DISPLAY ONLY)
This field displays the interval of elapsed time between order jobs for a recurring order.

12. ORDERING PHYSICIAN (TABLE LOOKUP-R)
The physician or care provider who requested this order displays in this field.

To enter a physician or care provider, you have the following choices:

- Enter the code of the ordering physician as listed in the Physician table.
- Enter a hyphen (-) to display a list of the physicians in the Physician table for your selection. You can enter one or more characters of the physician's name and then hyphen (-) to display a list of physician names that start with the letters you enter. This reduces the size of the list that displays.
- Enter a hyphen (-) and the name of the ordering physician or care provider when the care provider is not listed in the Physician table.
- When the ordering physician for a patient was selected on a prior order screen, you have an additional option available in the prompt. In this example, NAME represents the ordering physician's name.

Enter name'-', table code, or '-'name to override
or '=' for NAME--

The equal sign (=) copies the ordering physician from department to department when you order items from multiple departments for the same patient. For multiple orders within the same department, the equal sign copies the ordering physician from screen to screen. When you enter the equal sign for a physician who has not already been identified, the message *Error -Not Defined* displays.

13. SHIFTS TO PRINT (3-N-R)
This field specifies the shifts for which the order prints on the Patient Care Profile. You can enter 1 for Shift 1, 2 for Shift 2 and 3 for Shift 3. You can enter any combination of the numbers 1,2 and 3, such as: *1*, *12*, *13*, *123*. The system defaults to *123*.

14. PRINT ORDER NOTICE (1-A-O)
You can designate whether or not the assessment order generates a printed order notice when the order is placed. The order notice can print at the nursing station's default printer or in the designated department. Enter **Y** for Yes when you want the system to print an Order Notice. Enter **N** for No when you do not want a notice to print.

Impact

Adding an order places an active order in the system that prints on the Patient Care Profile and Active Order Worksheet, if requested. The new order also displays on the Assessment Order Update screen as an active/pending order.

Output

When you add an assessment order and specify that the system print an Assessment Order Notice, the notice prints at the nursing station's default printer (if there is a printer entry in the Order Notice Printer field of the Station Parameters screen). In addition, when the assessment order has a department designated for notification in the Dept Notify field of the Assessment Order function of Standard File Maintenance, the Assessment Order Notice automatically prints at the department's default printer.

Following is an example of an Assessment Order Notice.

ASSESSMENT ORDER NOTICE EXAMPLE

The Assessment Order Notice provides a printed notice to the department that needs to perform the order generated by the assessment. For example, the order notice informs Social Service of home care needs after discharge. The printing of the Order Notice is optional for each assessment. The system provides the option to print the notice when the caregiver adds the order (refer to "Review a Completed Assessment Order" on page 1-36 for more information.)

Figure 1.2 Assessment Order Notice

```
Assessment Notice: 05/15/96 11:34am       Printer: Dietary and Census Messages
                                                Status: Order

Stn: 2N            ADM : 05/12/96
Bed: 1207-1        Phys: ZELLER, JOHN

LANE,EMILY W             89250-00002        Sex: F         BD:08/04/79   10Y
Dx: TONSILLITIS
SGY: 05/13/93

Assessment Order:  NURSING ASSESSMENT              Priority: NOW
   Request Date: 05/17/93
   Request Time: 03:33pm

Order Date : 05/17/93   Order Time: 11:33am   Ordering Int: EMT   CRT: 2 North
Recurring  : No         Stop Date :           Stop Time   :
```

PROBLEM LIST

Menu Access

The Problem List is a list of the patient's current Problems, such as Mobility Impairment, and/or previous or ongoing Problems, such as blindness or diabetes. There are three ways Problems are added to the list:

- You can use the Problem List function to add or revise Problems on the list. You can delete Problems that do not have a priority number assigned.
- The system automatically adds a Problem to the list when the caregiver selects a response for the patient that has a Problem linked to it.
- The system automatically adds Problems from the Master Problem List. These are Problems that were identified during a previous patient visit and were added to the Master Problem List to be stored across patient visits.

The Problem List displays the Problems currently linked to this patient, including the Problem Number, Problem Name, Status, and whether the Problem prints on the Patient Care Profile and the Assessment Report.

There are three ways you can view a patient's Problems:

- Use the Problem List function, as explained below. This lists the Problems for the patient's current visit and includes the Problems added to the list by the three methods outlined above.
- View the Problem List by visit. (Refer to “VIEW PROBLEM LIST BY VISIT” on page 1-58.) The Problems that display are the Problems that were specific to the visit.
- View the Master Problem List, which can only be accessed by MPI Inquiry. (Refer to “MASTER PROBLEM LIST” on page 1-55.) These are ongoing Problems that have been designated by the user to be copied to the patient's Master Problem List and are maintained across visits.

To access the Problem List function, select Plan of Care Process from the Nursing main menu.

```
                General Hospital 2R1 Station ID Processor
                                                Mon May 15, 1996 02:52 pm
2R1 Station ID Input Options

            Option No.  Option
            ---------------------------------------
                1       Orders
                2       Diet Review
                3       Plan of Care Process
                4       Critical Pathways
                5       Vital Signs & Fluid Balances
                6       Revise Patient
                7       Patient History / Misc.
                8       Patient Print
                9       Station Print
               10       Nursing Management
               11       Staffing Functions
               12       Census
               13       Name Inquiry
               14       Send Message
               15       File Maintenance
               16       Hospital Employee File
Enter option number--
```

A prompt displays requesting you to identify the patient for whom you are creating a Problem List:

Enter acct #, '-'bed code, first chars of name'-' [1E Census]--
'C' for Census

You have the following options:

- Enter the patient's account number.
- Enter a hyphen (-) followed by the patient's bed code.
- Enter the beginning letters of the patient's name. The system displays a list of patients whose last names begin with these letters. Select the correct patient. (The more letters you enter, the more specific the selection list is.)
- Press ENTER to select the default nursing station's census of patients. The list of patients on the nursing station displays for your selection. The list includes the patient's first and last names and the room-bed occupied.

  This is the census of the primary nursing station of the CRT you are using.
- When your station has a secondary station, you can enter **C** to select a secondary station's census. The following prompt displays:

  Enter station code [1E]--

You can enter the secondary station or enter a hyphen (-) to display a list of the available secondary stations. The primary nursing station is the default in the prompt. The census displays for the secondary station.

The Plan of Care Menu displays after you identify the patient:

```
                General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN       F  02/14/15 2R15-1  DUNHAM,TOM R ENT 10 I/P 31
            Option No.  Option
            ----------------------------------------
                1       Defining Characteristics
                2       Patient Assessment
                3       Recommended Plan of Care/Outcomes
                4       Plan of Care
                5       Discharge/Exp Outcome
                6       Problem/Exp Outcome
                7       Discharge Plan
                8       Intervention/Treatments
                9       ADL's / Misc.
               10       Problem List
               11       Display Patient Care Profile

 Print         12       Patient Care Profile
               13       Nursing Plan of Care
               14       Assessment Reports

Enter option number--
```

Select the Problem List option. A screen displays with the list of Problems already linked to this patient. The Problems display in order of priority, according to their Problem number (Prob #).

```
                General Hospital Problem List Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 84

     Prob #  Problem                          Status     Print PCP  Print AR
( 1)  02     PROBLEM W/ VISION                ACTIVE       Yes        Yes
( 2)  04     POTENTIAL PROBLEM WITH COMPLIANCE ACTIVE       Yes        Yes
( 3)  06     DERMATOLOGICAL PROBLEMS          ACTIVE       Yes        Yes
( 4)  07     ORAL HYGIENE PROBLEM             ACTIVE       Yes        Yes
( 5)  08     LEGALLY BLIND                    EVALUATING   Yes        Yes
( 6)  09     POTENTIAL PROBLEM HEALING        EVALUATING   Yes        Yes




Enter add(A), delete(D) or option # to revise--
```

The following prompt displays:

Enter add(A), delete(D) or option # to revise--

You have the following choices:

- Enter **A** to add a Problem. Refer to the following procedure for adding a Problem.
- Enter **D** to delete a Problem that does not have an assigned number (##) You can only delete a Problem that has no Problem Number assigned (##).

  NOTE: When you try to delete a Problem that has an assigned number, the following error message displays:

  Error: Invalid selection!

- Enter the selection number of the Problem you want to revise. Refer to "Revising a Problem" on page 1-52 for revising a Problem.

Adding a Problem

When you add a Problem, the following prompt displays:

Enter Problem code or '-' to list--

You can select a Problem in one of three ways:

- Enter the Problem code, up to four digits in length.
- Enter the beginning letters of the Problem name, followed by a hyphen (-), to display a partial table lookup.
- Enter a hyphen (-) to display a full table lookup.

  NOTE: If you try to assign a Problem number that is already in use, the system displays the following error message:

  Duplicate problem number!--

  You must assign a number that currently is not in use by another Problem.

After you specify the Problem to add, the following screen displays.

```
                  General Hospital Problem List Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 84

 1 Problem #    2 Problem Code           3 Problem Description
   1              0019                     DEAF
 4 Status       5 Date/Time Int          6 Print on PCP      7 Shifts to Print
   ACTIVE         02/15/09 02:17pm MWL     Yes                 123
 8 Print on Assess Rpt                   9 Retain in Master Problem List
   Yes                                      Yes









Enter field number or '/' starting field number--
```

The prompt for the first field requests that you do one of the following:

- Enter the Problem number, up to four digits.
- Assign pound signs (##) to the Problem until you assign a number later.
- Press ENTER for the system to automatically assign the number.

Field Explanations

1. PROBLEM # (SPECIAL FORMAT)
This field contains the number of this Problem on the patient's list of Problems.

You can assign the number manually, have the system assign the next number in sequence, or temporarily assign pound signs (##) to this Problem until you can later assign a real number manually.

2. PROBLEM CODE (DISPLAY ONLY)
This field displays the code of the Problem you selected.

3. PROBLEM DESCRIPTION (DISPLAY ONLY)
This field displays the descriptive name of the Problem you specified at the prompt leading into this screen.

4. STATUS (TABLE LOOKUP)
This field displays the current status of the Problem. Examples are Active, Complete, Evaluating, and Resolved.

5. DATE/TIME INT (DISPLAY ONLY)
This field displays the date and time the Problem is added and the initials of the person who added the Problem.

6. PRINT ON PCP (1-A-O)
This field indicates whether or not the Problem prints on the Patient Care Profile (PCP). Enter **Y** for Yes when you want the Problem to print on the PCP. The default is Yes.

NOTE: Regardless of the entry in this field, the Problem does not print on the PCP unless the Problem List On PCP parameter in Station Parameters is also set to Yes. If the parameter is set to No, the Problem List does not print on the PCP.

7. SHIFTS TO PRINT (1-A-O)
This field specifies the shifts when the Problem prints on the Patient Care Profile. Enter 1 for Shift 1, 2 for Shift 2, or 3 for Shift 3, or any combination. The default response is *123*.

8. PRINT ON ASSESS RPT (1-A-O)
This field indicates whether or not the Problem prints on the Assessment Report. The following prompt displays:

Print problem on the Assessment Report? (Y/N) [Y]--

Enter **Y** for Yes to print the Problem on the Assessment Report. The Problem prints on the Problem List and Problem List History regardless of the entry in this field.

NOTE: Regardless of the entry in this field, the Problem does not print on the PCP unless the Problem List on Active Order Worksheet parameter in Station Parameters is also set to Yes. If the parameter is set to No, the Problem List does not print on the Active Order Worksheet.

9. RETAIN IN MASTER PROBLEM LIST (1-A-O)
This field enables you to store the Problem in the Master Problem List. The Master Problem List stores the Problem by patient in the Master Patient Index. A facility parameter allows the system to copy the Problems you designate in this field to the Master Problem List during the patient historization process.

You specify in this field whether you want the system to copy this specific Problem to the Master Problem List. The following prompt displays:

Retain this problem in the Master Information? (Y/N) [Y]--

Enter **Y** for Yes to copy the Problem to the Master Problem List. Entering Yes in this field, with the Facility Parameter set to copy, means that when the patient is readmitted, the Problems stored for them in the Master Problem List automatically display on the patient's Problem List.

NOTE: When you enter **Yes**, but the facility parameter is set to No, the system does not copy the Problem. The facility parameter must be set to Yes to enable the system to copy the Problem. Refer to "Chapter 2 - PATIENT ASSESSMENT MAINTENANCE" for information on this parameter.

If you enter **N** for No in this field, the Problem is retained for this visit only.

After you enter the data in the fields, thesystem prompts you to accept the screen, and redisplays the Problem List with the Problems you just added.

Impact

The Problems assigned to the patient print on the Problem List Report. The Problems also print on the

- Patient Care Profile (PCP), if requested on this screen and in Station Parameter,
- Assessment Report, if requested on this screen, and
- Active Order Worksheet, depending on the parameter setting in Station Parameters.

During patient historization, the system copies the Problem to the Master Problem List if the Retain in Master Problem List field is set to Yes and the Facility parameter is also set to copy Problems.

Revising a Problem

To revise a Problem, enter the selection number. For example, in the following screen, you enter the number 7 to select Problem with mobility.

```
                General Hospital Problem List Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY        F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 84

     Prob #  Problem                          Status     Print PCP  Print AR
( 1)  02     PROBLEM W/ VISION                ACTIVE       Yes        Yes
( 2)  04     POTENTIAL PROBLEM WITH COMPLIANCE ACTIVE       Yes        Yes
( 3)  06     DERMATOLOGICAL PROBLEMS          ACTIVE       Yes        Yes
( 4)  07     ORAL HYGIENE PROBLEM             ACTIVE       Yes        Yes
( 5)  08     LEGALLY BLIND                    EVALUATING   Yes        Yes
( 6)  09     POTENTIAL PROBLEM HEALING        EVALUATING   Yes        Yes
( 7)  ##     PROBLEM W/MOBILITY               EVALUATING   Yes        Yes
( 8)  ##     POTENTIAL PROBLEM W/MEMORY       EVALUATING   Yes        Yes




Enter add(A), delete(D) or option # to revise--
```

The Problem Detail screen displays, as shown in the following example. If the Problem you selected does not have a real number assigned to it, the following prompt displays:

Enter problem number,(##) for unassigned,or (NL) for automatic [NL]--

You have three options:

- Enter the Problem Number you want to assign to the Problem, up to four digits.
- Assign pound signs (##) to the Problem until you assign a number later.
- Press ENTER for the system to automatically assign the number.

If the system already has a number assigned to it (not the pound signs, ##), the system does not allow you to change the Problem # field; however, you can revise any of the following fields: Status, Shifts to Print, Print on PCP, Print on Assess Rpt, and Retain in Master Problem List.

```
                  General Hospital Problem List Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 84

 1 Problem #    2 Problem Code           3 Problem Description
   1              0019                     DEAF
 4 Status       5 Date/Time Int          6 Print on PCP      7 Shifts to Print
   ACTIVE         02/15/09 02:17pm MWL     Yes                 123
 8 Print on Assess Rpt                   9 Retain in Master Problem List
   Yes                                      Yes









Enter field number or '/' starting field number--
```

Impact

The Problem List Report reflects the changes you make on this screen to Status, Shifts to Print, or Print on Assessment Report.

DELETING A PROBLEM

When you enter **D** to delete a Problem, the system prompts you to enter the selection number of the Problem you want to delete:

Enter option # to delete--

You can only delete a Problem that has no Problem Number assigned (##).

NOTE: When you try to delete a Problem that has an assigned number, the following error message displays:

Error: Invalid selection!

Enter the option number of the Problem you want to delete. The system displays the message *Deleted!*

Impact

The system deletes the Problem from the Problem List and the Master Problem List. Problems that do not have a number assigned (##) do not print on any reports.

MASTER PROBLEM LIST

The Master Problem List is a list of Problems stored for each patient in the Master Patient Index (MPI). When a caregiver adds a Problem to the patient's Problem List for the current visit, the caregiver can designate that the Problem also be added to the Master Problem List (during patient historization). On subsequent visits, this Problem automatically displays in the current visit's Problem List and is maintained in the Master Problem List for future visits.

Your facility uses a facility parameter to select whether or not to maintain a Master Problem List. See "Chapter 2 - PATIENT ASSESSMENT MAINTENANCE" for information on this parameter in the Facility Parameters table.

View the Master Problem List

You can view a patient's Master Problem List using any of the following options that are on your menu:

- Revise MPI
- MPI Inquiry
- MPI Visit

These options are available on Admissions, Medical Records, Surgery, and other CRTs. A nursing station does not have the option of viewing the Master Problem List. Nursing stations can view Problem Lists from a patient's previous visits using the View Problem List by Visit function. For more information refer to "VIEW PROBLEM LIST BY VISIT" on page 1-58.

When you access the Master Problem List function from your CRT's menu, the MPI prompt displays for you to select the patient:

Enter Unit No, name, '=' for current--
'-'Social Security No, '#'Corporate No, '%'name for soundex, ''Account No*

Select the patient by entering all or part of the name and hyphen(-) to display a list of patients for your selection. Refer to the *General Information Volume* of the *STAR Patient Care Reference Guide* for information on all the options available for selecting a patient from the MPI prompt. The following prompt displays:

Enter Sex (M/F) or [all]--

You have the following choices:

- Enter **M** for Male to display only male patients.
- Enter **F** for Female to display only female patients.

- Press ENTER to display all patients.

A list of patients displays. Enter the selection number of the patient for whom you want to view the Master Problem List. A menu similar to the following displays with Master file options:

```
                        General Hospital Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORMED 10 I/P 84
            Option No.  Option
            ----------------------------------------
   MASTER       1       Medical Detail
                2       Patient Employer Page
                3       Guarantor Page
                4       Guarantor Employer Page
                5       Relative One Page
                6       Relative One Employer Page
                7       Relative Two Page
                8       Insurance Process
                9       UB Page One
               10       UB Page Two
               11       User Defined Fields
               12       Visit History
               13       Physician Page
               14       Surgery Information
               15       Problem List

Enter option number--
```

Select Problem List. The following screen displays with ongoing Problems that are stored by patient and are not visit specific:

```
                General Hospital Problem List Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 84

     Prob #  Problem                          Status     Print PCP  Print AR
( 1)  02     PROBLEM W/ VISION                ACTIVE       Yes        Yes
( 2)  08     DIABETIC                         ACTIVE       Yes        Yes









Enter # to view--
```

The following prompt displays:

Enter # to view--

Enter the number of the Problem about which you want to view more information. The following screen is displayed:

```
                General Hospital Problem List Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 84

 1 Problem #    2 Problem Code           3 Problem Description
   1              0019                     DEAF
 4 Status       5 Date/Time Int          6 Print on PCP      7 Shifts to Print
   ACTIVE         02/17/09 02:17pm MWL     Yes                 123
 8 Print on Assess Rpt                   9 Retain in Master Problem List
   Yes                                      Yes









Press NL--
```

The screen displays detailed information about the Problem. The fields are the same as those displayed on the Problem List. Notice that the Retain in Master Problem List field is set to Yes, ensuring that this Problem displays on the Master Problem List. The fields are display only.

Press ENTER when you finish viewing the Problem. The Master Problem List redisplays for you to select another Problem for viewing. When you finish viewing Problems, press ENTER to exit the Master Problem List. The Master Files menu is redisplayed.

VIEW PROBLEM LIST BY VISIT

Nursing stations can view a patient's Problems for the current visit using the Problem List function. For more information refer to “PROBLEM LIST” on page 1-46. In addition, the caregiver can view Problems identified on previous visits using the View Problem List by Visit function.

From the Nursing main menu, select the Revise Patient option. The following prompt displays:

Enter acct #, '-'bed code, first chars of name'-' [1E Census]--
'C' for Census

You have the following options:

- Enter the patient's account number, and press ENTER.
- Enter a hyphen (-) followed by the patient's bed code, and press ENTER.
- Enter the beginning letters of the patient's name followed by a hyphen (-) and press ENTER. The system displays a list of patients whose last names begin with these letters. Select the correct patient and press ENTER. (The more letters you enter, the more specific the selection list is.)
- Press ENTER to select the default nursing station's census of patients. The list of patients on the nursing station displays for your selection. The list includes the patient's first and last names and the room-bed occupied. This is the census of the primary nursing station of the CRT you are using.
- When your station has a secondary station, you can enter **C** to select a secondary station's census. The following prompt displays:

  Enter station code [1E]--

  You can enter the secondary station or enter hyphen (-) to display a list of the available secondary stations. The primary nursing station is the default in the prompt. The census displays for the secondary station. The following menu displays:

```
                  General Hospital Revise Patient Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN       F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51
            Option No.  Option
            ----------------------------------------
                1       Demographic Page
                2       Medical Page
                3       Physician Page
                4       Relative Information
                5       User Defined Fields
                6       View Problem List by Visit









Enter option number--
```

Select View Problem List by Visit. The following screen displays with the patient's previous visits:

```
              General Hospital View Problem List by Visit Processor
                                                    Mon May 15, 1996 05:07 pm


No Pt Acct Nmbr   Adm Date Dsch Date Typ Attending Dr.  Service FC Dsch Status
 1 89155-00012   04/04/93 04/10/93  I/P ADAMS,HAROLD R  MED     S  HOM
 2 89200-00052   02/09/93 02/13/93  I/P ADAMS,HAROLD R  MED     C  HOM
 3 89243-00007   06/03/92 09/04/92  I/P ZELLER,HECTOR   PED     K  DIS
```

Select visit--

Select the visit for which you want to see the Problem List. The following screen displays:

```
            General Hospital View Problem List by Visit Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 84

     Prob #  Problem                          Status     Print PCP  Print AR
( 1)  02     PROBLEM W/ VISION                ACTIVE       Yes        Yes
( 2)  08     DIABETIC                         ACTIVE       Yes        Yes









Enter # to view--
```

Enter the number of the Problem about which you want to view more information. The following screen displays with detailed information about the Problem:

```
            General Hospital View Problem List by Visit Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
89243-00007   LANE,EMILY         F  08/04/79 1202-2  ZELLER,HECTORPED 10 I/P 84

 1 Problem #    2 Problem Code           3 Problem Description
   1              0019                     PROBLEM W/ VISION
 4 Status       5 Date/Time Int          6 Print on PCP      7 Shifts to Print
   ACTIVE         02/17/09 02:17pm MWL     Yes                 123
 8 Print on Assess Rpt                   9 Retain in Master Problem List
   Yes                                      Yes









Press NL--
```

Press ENTER when you finish viewing the Problem. The visit's Problem List redisplays for you to select another Problem for viewing. When you finish viewing Problems, press ENTER to exit the View Problem List by Visit function. The Revise Patient menu redisplays.

Chapter 2 - PATIENT ASSESSMENT MAINTENANCE

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MCKESSON TABLES

The McKesson tables used in the Patient Assessment process are the Facility Assessment File Types and Department/Order Control tables. McKesson maintains these tables. Your McKesson representative sets up Assessment Orders as a non-SIM Department with a code of S in the Department/Order Control table. In addition, the McKesson representative defines the Assessment file types.

Assessment File Types

The file types for the Assessment Standard Files used in the Patient Assessment Process are defined in the STAR Patient Care McKesson Tables. Your McKesson representative set them up for you.The three Standard Files are as follows:

Descriptive Name	File Code	File Type
Assessments	AA	Description
Assessment Groups	AG	Description
Assessment Questions	AQ	Description/Text

The system uses these codes to define the type of standard assessment file. Assessment Responses are linked to the Assessment Questions in Standard File Maintenance. Refer to “Adding or Editing a Question/Prompt and Response” on page 2-19 for more information.

USER-DEFINED TABLES

Nursing Facility Parameters

The Nursing Facility Parameters function defines parts of the Patient Assessment process, such as

- whether automatic assessment maintenance is Daily or Weekly,
- how many days the system retains versions of standard Assessment files, and
- whether or not to copy assessment data to a Master Problem List retained across patient visits.

You can access the Nursing Facility Parameters by selecting the following menu options from the Nursing main menu:

1. File Maintenance
2. Standard File Maintenance
3. Report Build Options
4. Nursing Facility Parameters

You can also access the Nursing Facility Parameters by selecting the following menu options from the Data Processing main menu:

1. Tables
2. Nursing Facility Parameters

The Nursing Facility Parameters screens contain fields which define facility-specific parameters. There are two screens of nursing parameters. The second Nursing Facility Parameters, shown in the following example, contains three Assessment parameters.

```
              General Hospital Nursing Facility Parameters Processor
Model Hospital A                                    Wed Feb 15, 1996 04:01 pm
 PATIENT ACUITY
 1 Admission Bed Override                2 Transfer Bed Override

 3 Acuity Retention   4 Historical Acuity Retention       5 Historical Key
   7                    999                                  DRG
 ASSESSMENT / PLAN OF CARE
 6 Assessment Maint   7 Assessment History Retention      8 Master Problem List
   Weekly               30                                   Yes
 9 Pending Authorization Status   10 Log Text  11 Report Name
   Yes                               Yes          1E  1 East Census and Mess
 CRITICAL PATHWAYS
12 Retention Days                13 Print Frequency
   999                           ->
 MATERNITY RETENTION DAYS
14 Care Plans        15 Assessment       16 Labor & Delivery     17 Vital Signs
   9125                 9125                9125                    9125

Enter field number or '/' starting field number--
                      next(/) or previous screen(/P) [/]
```

The following field explanations are for the Assessment-related fields. For complete information about the fields on this screen, refer to Chapter 2: High Level Tables in the *Tables Volume* and Appendix A: Nursing Tables in the C*are Planning and Documentation Module*, both of the *STAR Patient Care Reference Guide*.

Field Explanations

6. ASSESSMENT MAINT (1-A-O)
The Assessment Maint field enables you to define how often the system runs automatic maintenance of the Assessment files. The maintenance function removes stray codes left from deletions of file components that are attached to responses (PCR codes, Problems, Plan of Care elements) or to an Assessment (Assessment Orders). Enter **D** for a Daily Run Cycle for Assessment File Maintenance. Enter **W** for a Weekly Run Cycle. The system defaults to Weekly. For information on how to manually run assessment maintenance refer to "BACKGROUND FILE DESCRIPTION UPDATE" on page 2-64.

7. ASSESSMENT HISTORY RETENTION (3-N-O)
This field enables you to retain versions of assessment standard files. When you make changes to the assessment standard file, the system retains the previous version of the file for patients that currently have that assessment. When you perform an initial assessment after that, the system uses the new version. You can enter up to 999 days to retain a version of an assessment.

8. MASTER PROBLEM LIST (1-A-O)
This parameter enables the facility to retain patient Problem information across visits. The Problems are ongoing patient Problems that are valid from visit to visit, such as blindness or deafness. When the caregiver adds a Problem to the patient's Problem

List, the caregiver designates whether that Problem is to be copied to the Master Problem List during patient historization.

The following prompt displays for this field:

Retain Master Problem List? (Y/N) [N]--

- When you enter **Y** for Yes, the system copies designated patient Problems during patient historization. When the patient is readmitted, the system automatically lists the Problems on the patient's Problem List.
- When you enter **N** for No, the system does not copy the Problems to the Master Problem List.

Station Parameters

The Station Parameters function contains several fields which require data entry before you can begin using the Patient Assessment Module. You must enter this information for each nursing station in the hospital that uses assessments.

NOTE: You need to build your Assessment Menus before you can complete the Assessment Menu field. Refer to "Assessment Menus" on page 2-42 for information on the procedure.

You can access Station Parameters through the File Maintenance or Staffing File Maintenance options on the Nursing main menu. From the Nursing main menu, select the following menu options:

1. File Maintenance
2. Standard File Maintenance or Staffing File Maintenance
3. Station Parameters

After you select the Station Parameters option, the following prompt displays:

Enter outpatient (O), maternity (M), station code or '-' to list--

Enter **O** for Outpatient to access Station Parameters for outpatients. The screen displays Outpatient Parameters in the upper left corner, but field functionality is the same.

NOTE: The Acuity Parameters fields are accessible from the Outpatient Parameters screen, but entries in these fields have no effect within STAR Patient Care functions, as Acuity is not calculated for outpatients.

Enter **M** for Maternity to access Station Parameters for maternity patients. The screen displays Maternity Parameters in the upper left corner, but field functionality is the same.

If you know the nursing station code, enter it directly. Enter a hyphen (-) to access a listing of all established stations within your facility. When you select a station from the list, the Station Parameters screen displays with the selected station name in the upper left corner.

The Station Parameters function contains two screens. After you specify the station, the system displays the following Station Parameters Screen 1.

SCREEN 1

The first screen, as shown in the following example, does not contain the Assessment parameters. Bypass this first screen by pressing ENTER twice.

```
              General Hospital Station Parameters Processor
NURSERY Station Parameters                        Thu Apr 03, 1997 02:03 pm


 1 Live on Nursing  2 Def Characteristics Menu    3 ADL Menu
   Yes                FACILITY A MENU             NURSERY
 4 Plan of Care at DIS  5 Standard Text for Pt. History      6 Default Edit Txt
   No                     NURSERY                           ->
 Acuity Parameters
 7 Live on Acuity   8 Patient Attrib. Menu        9 Second Pt. Attr. Menu
   Yes                CHECK-LIST                  CHECK-LIST
                   10 Station Attrib. Menu       11 Bed Override Menu
                                                    B/O TEST MENU
 PCP Parameters
12 User Formatted PCP      13 Laser Printer      14 PCP Default Format Name


15 PCP Plan of Care Name   16 PCP Treatment Date 17 PCP Freq/Sched Days Code
   No                         No


Default prompt for editing Treatment order text (Y/N) [N]--  |
```

The name of the station for which you are displaying the station parameters displays in reverse video in the upper left portion of the screen.

SCREEN 2

The Station Parameters Screen 2, shown in the following example, contains the Assessment parameters that require data entry for the patient assessment process to function on the station.

```
                General Hospital Station Parameters Processor
1 NORTH Station Parameters                        Fri Dec 29, 1995 04:16 pm
 1 ADL Worksheet Categories
   All
 2 Active Order Worksheet
   All
 3 Treatments   4 Consultations     5 Patient History    6 Precautions
   Yes            Yes                 Yes                  Yes
Assessment Parameters
 7 Assessment Menu          8 Order Notice Printer
   MED/SURG                   1E
 9 Asmt Change Tone        10 Group Change Tone
   Yes                        Yes
11 Problem List on PCP     12 Problem List on Active Order Worksheet
   Yes                        No



Enter field number or '/' starting field number--
```

Field Explanations

The following field explanations are for the Assessment-related fields. For complete information about the fields on this screen, refer to Chapter 2: High Level Tables in the *Tables Volume* of the *STAR Patient Care Reference Guide*.

7. ASSESSMENT MENU (TABLE LOOKUP-O)
This field specifies which Assessment Menu displays on this station. The table of Assessment Menus built in Standard File Maintenance displays for selection. Examples of user-defined Assessment Menus are Admission Assessment, Critical Care Assessment, Dietary Assessment, Medical/Surgical Assessment and Psychiatric Assessment.

8. ORDER NOTICE PRINTER (TABLE LOOKUP-R)
This required field identifies the printer on which the Assessment Order Notice prints for the nursing station. The system prompts you to enter the spooler report name of the nursing station's printer. You can enter the printer code or perform a table lookup and make your selection.

9. ASMT CHANGE TONE (1-A-O)
As the caregiver enters responses to Assessment questions, the system moves from one Question Detail screen to the next. If the caregiver is answering questions from several Assessments, he/she may not notice when the system has moved into a different Assessment. (The system displays the description of the Assessment at the top of the Question Detail screen.) This field determines whether or not the system

alerts the caregiver with a beep when the system moves to a new Assessment. Enter **Y** for Yes to activate the system beep; enter **N** for No if you do not want to activate the beep. The default is No.

10. GROUP CHANGE TONE (1-A-O)
As the caregiver enters responses to Assessment questions, the system moves from one Question Detail screen to the next. If the caregiver is answering questions from several Groups, he/she may not notice when the system has moved into a different Assessment Group. (The system displays the description of the Group at the top of the Question Detail screen.) This field determines whether or not the system alerts the caregiver with a beep when the system moves to a new Group. Enter **Y** to activate the system beep; enter **N** if you do not want to activate the beep. The default is No.

11. PROBLEM LIST ON PCP (1-A-O)
This field determines whether or not the patient's Problem List prints on the Patient Care Profile (PCP). Enter **Y** for Yes if you want the Problem List to print on the PCP; enter **N** for No if you do not want the Problem List to print on the PCP. The default is No.

12. PROBLEM LIST ON ACTIVE ORDER WORKSHEET (1-A-O)
This field determines whether or not the patient's Problem List prints on the Active Order Worksheet. Enter **Y** if you want the Problem List to print on the Active Order Worksheet; enter **N** if you do not want the Problem List to print on the Worksheet. The default is No.

Problem Statuses Table

The Problem Statuses table lists the possible statuses for an assessment Problem. Possible statuses can include Active, Resolved, Evaluating, and Complete. You need to build this table prior to building Standard Files for Patient Assessment. You use the information you enter in this table to complete the Problem Status field in the Problem List Standard File.

To access the Problem Statuses table, select the following:

1. Tables from the STAR Patient Care Data Processing Menu
2. Nursing Table Maintenance
3. Problem Statuses

The following prompt displays:

Enter problem status code--

Enter a number from 1 to 10 for the code. You can perform a table lookup to display a list of existing codes when you want to revise a Problem status. When you enter a code that does not already exist, the following prompt displays:

Add this code '8'? (Y/N) [Y]--

Enter **Y** for Yes to add this code. Enter **N** for No when you do not want to add this code. After you enter a code, the following screen displays:

```
              General Hospital Nursing Table Maintenance Processor
                                                  Mon May 15, 1996 09:29 am
Problem Statuses
( 1)Code         : 8
( 2)Description  : RESOLVED
( 3)Edit by      : Damer,Mary
( 4)Edit date    : 4/15/93









Enter field number or '/' starting field number--
```

Field Explanations

1. CODE (DISPLAY ONLY)
The system displays the numeric code you entered to display this screen.

2. DESCRIPTION (33-C-R)
You can enter up to 33 characters to describe the Problem status. The description you enter in this field displays during table lookup for the Problem Status field in the Problem List Standard File.

3. EDIT BY (DISPLAY ONLY)
This field displays the name of the user (as signed on) who last edited this Problem status.

4. EDIT DATE (DISPLAY ONLY)
This field displays the date and time of the last edit.

Impact

The entries you make in this table display during table lookup in the Problem Status field of the Problem List Standard File.

STANDARD FILES

The Standard File elements you must build for the Patient Assessment Process include:

- Assessment (AA)
- Assessment Group (AG)
- Assessment Questions/Responses (AQ)
- rPblems

In addition, you link assessment orders to the assessment, and create Assessment Menus to allow access to specific assessments at different locations.

You need to build the items you want to link to the files first (Problems, PCRs, assessment orders, and Plan of Care elements), and then build the assessment files to which you want to link them (questions, groups, assessments, etc.).

Similar to file building for the Plan of Care Process, this process works best when you build from the item detail level. For example, start by building the Problem List so that you can link the Problems to questions/responses when you build them. Questions/ Responses are linked to Groups and Groups are linked to an Assessment. If your hospital does not define Assessment Groups, you do not have to build a Group file.

You should build the Assessment files in the following order:

1. Assessment Questions
2. Assessment Groups
3. Assessments
4. Assessment Menus

Flowchart

Refer to *Figure 2.1* on page 2-13 to view the flowchart that illustrates the order in which to build standard Assessments. Following is an explanation of the various terms.

- Assessment is the title of the Patient Assessment or Questionnaire.
- Order is the element that makes the assessment an active order. The order remains active until the caregiver completes the order. The assessment can be built so the Assessment Order prints on the Active Order Worksheet and Patient Care Profile (PCP).

- Group is the element in which similar questions are gathered under one heading, the group name.

- Question is the assessment question or prompt to which the caregiver enters a response and comment.

- Response is the patient's answer to the Assessment Question. You can link multiple responses to a question.

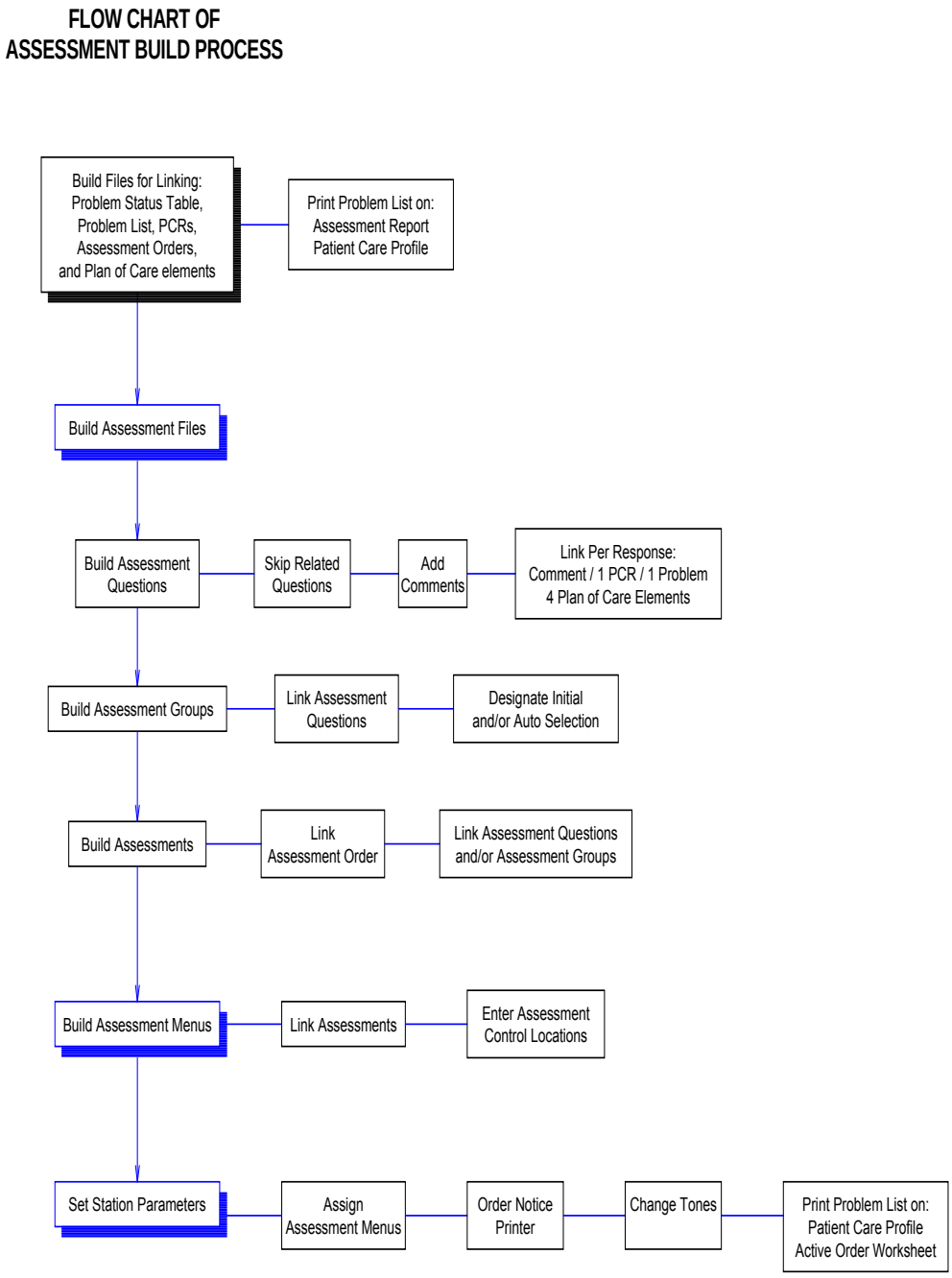
- PCR code is the Patient Care Requirement code assigned to a response. The PCR code enables you to associate an acuity value with the response that helps measure the patient's required care.

- Problem code is the code for a Problem indicated by a response. You assign a Problem code to a response that indicates the patient has the Problem. For example when the patient answers the question *Are you short of breath?* with a *Yes* response, the response indicates that the patient has an acute problem of respiratory difficulty.

- PC, DO, PO, and DP are the Plan of Care elements that can be linked to a response (Plan of Care, Discharge/Expected Outcome, Problem/Expected Outcome, and Discharge Plan). You can link up to four Plan of Care elements to a response.

- The Master Problem List stores patient Problems across visits when the Facility Parameter is set to copy Problems (that the caregiver designates) to the Master Problem List. The system automatically copies the stored Problems to the patient's Problem List on the next visit.

Figure 2.1 Flowchart of Assessment Build Process



Menu Access

To build assessment elements, select the following menu options:

1. File Maintenance
2. Standard File Maintenance

The following menu displays:

```
          General Hospital Standard File Maintenance Processor
                                                  Mon May 15, 1996 09:29 am
Standard File Maintenance Input Options
            Option No.  Option
            ----------------------------------------
                1       Standard Plan of Care
                2       Critical Pathways
                3       Standard Assessments
                4       ADL's/Misc.
                5       Treatment Orders
                6       Vital Signs & Fluid Balances
                7       Defining Characteristics
                8       Routine Orders
                9       Preps and Special Instructions
               10       Custom Documents
               11       Standard Text - Patient History
               12       Station Parameters
               13       Report Build Options
               14       Print Standard Files
               15       Custom Worksheet


Enter option number--
```

Select Standard Assessments. The following menu displays:

```
              General Hospital Standard Assessments Processor
                                                  Mon May 15, 1996 09:29 am
Standard Assessments Input Options
            Option No.  Option
            ----------------------------------------
                1       Build Assessment Files
                2       Build Assessment Menu
                3       Assessment Order
                4       Build Problem List
                5       Print Assessment Files
                6       Background File Description Update









Enter option number--
```

Problem List

The Problem List is a table of standard Problems from which the caregiver can select the Problems that apply to the patient. You can link up to four Plan of Care Types to each standard Problem you build. In addition, you can link a Problem to a response for an Assessment Question.

The system automatically generates a Problem List for a patient when the caregiver selects a response that has a Problem linked to it, or when there are existing Problems stored in the Master Problem List. For more information, refer to "Flowchart" on page 2-11.

NOTE: You need to build the Problem Statuses table, before you can complete the Problem Status field on this screen. See "Problem Statuses Table" on page 2-9.

To access the Build Problem List function, select the following menu options:

1. File Maintenance
2. Standard File Maintenance
3. Standard Assessments
4. Build Problem List

If necessary, select the facility. The following prompt displays:

Enter first letter(s) '-' or problem list code--

You have the following options:

- Enter all or part of the Problem description, followed by a hyphen (-). The system displays the list of Problems that begin with these letters.
- Enter a hyphen (-) to display all the Problems in the system.
- Enter the Problem List code, up to four digits in length.

The following screen displays:

```
              General Hospital Build Problem List Processor
GENERAL HOSPITAL A                              Mon May 15, 1996 10:29 am
 1 Code               2 Problem Description                  3 Edit Description
   0010              -> URINARY ELIMINATION                    No
 4 Problem Status     5 Auto Print PCP    6 Auto Print AR    7 Auto Assign Number
   06 Active            Yes                 Yes                No
 8 Plan Type          9 Plan Code        10 Plan Description
   PC                   3001               URINARY ELIM, ALT IN
11 Plan Type         12 Plan Code        13 Plan Description
14 Plan Type         15 Plan Code        16 Plan Description
17 Plan Type         18 Plan Code        19 Plan Description









Enter description--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the Problem List code you entered to display this screen. The code can be a maximum of four digits.

2. PROBLEM DESCRIPTION (3-C-R)
You enter the descriptive name of the Problem, up to 33 characters in length.

3. EDIT DESCRIPTION (1-A-O)
This field determines whether or not the caregiver can edit the Problem description for the patient. Enter **Y** for Yes to allow editing. Enter **N** for No to prevent editing. The default is No.

4. PROBLEM STATUS (TABLE LOOKUP)
The system displays the status you enter in this field as the default Problem status on the Problem List for Problems that are automatically generated by the system. The system automatically adds Problems to the Problem List when a Problem code is linked to a response.

Perform a table lookup of the Problem Statuses table to make your selection. Examples of Problem statuses are Active, Complete, Evaluating, and Resolved. The caregiver can change the status when editing the Problem List for the patient.

5. AUTO PRINT PCP (1-A-O)
This field specifies whether or not the Problem prints on the PCP. The entry in this field overrides the entry in the Problem List on PCP field on the Station Parameters screen.

6. AUTO PRINT AR (1-A-O)
This field specifies whether or not the Problem prints on the Assessment Report. Enter **Y** for Yes to print the Problem on the Assessment Report. Enter **N** for No when you do not want to print the Problem on the Assessment Report. The default is No.

7. AUTO ASSIGN NUMBER (1-A-O)
This field determines whether or not the system automatically assigns the Problem number when the caregiver selects the Problem for the patient. Enter **Y** for Yes to allow automatic assignment. Enter **N** for No to prevent automatic assignment - the system enables the caregiver to enter the number or assign the characters ## (two pound signs) until he or she can manually assign a number to the patient's Problem. The default is No.

8, 11, 14, 17 PLAN TYPE (2-A-O)
You use this field to link a Plan Type to this Problem. Examples of types of plan elements include the following:

- Plan of Care (PC)
- Discharge/Expected Outcome (DO)
- Discharge Plan (DP)
- Problem/Expected Outcome (PO)

When the caregiver assigns this Problem to a patient, the system lists these plan types as Recommended Plan of Care components to facilitate the caregiver's Plan of Care Process.

9, 12, 15, 18 PLAN CODE (TABLE LOOKUP)
This field contains the code for the Plan Type. You can perform a table lookup to make your selection.

10, 13, 16, 19 PLAN DESCRIPTION (DISPLAY ONLY)
This field displays the descriptive name of the Plan Type. When you enter the Plan Code, the system automatically displays the corresponding plan description in the field.

Assessment Questions/Prompts and Responses

You build each of the questions you want to ask the patient in order to assess the patient's current state of health. You can designate the question to be for female, male, or all patients. You also can define whether or not the question can have multiple responses. Once you define the question, another screen displays for you to enter the response and the plans of care appropriate for the response.

To build the Assessment Questions/Responses, select the following:

1. File Maintenance
2. Standard File Maintenance
3. Standard Assessments
4. Build Assessment Files

If necessary, select the facility. A screen displays with the following File types for your selection.

```
              General Hospital Build Assessment Files Processor
GENERAL HOSPITAL A                                  Mon May 15, 1996 10:29 am
Page:01                            File Types
( 1) ASSESSMENT
( 2) ASSESSMENT GROUP
( 3) ASSESSMENT QUESTION/PROMPT









Enter choice--
```

Select Assessment Question/Prompt. The following prompt displays:

Enter first letter(s)`-` or assessment question/prompt code--

Enter 'C' to Copy all assessment question/prompts and elements

You have the following options:

- Enter the first letters of the question's descriptive name, followed by a hyphen (-). The system displays the list of questions that begin with these letters.
- Enter a hyphen (-) to display all the questions in the system.
- Enter the question code, up to four digits in length.
- Enter **C** to copy a question/prompt and its elements. For Assessment questions which are similar and require much of the same information, this function saves you data entry time. Refer to "Copy an Assessment Question/ Prompt and Its Elements" on page 2-29 for the procedure to copy an assessment question/prompt and its elements.

ADDING OR EDITING A QUESTION/PROMPT AND RESPONSE

When you want to add or edit aquestion in the Standard Files, enter the questioncode. The following screen displays:

```
                  General Hospital Build Assessment Files Processor
Model Hospital A                                    Thu Mar 21, 1996 12:22 pm

 1 File Type    2 File Code    3 File Description
   AQ             0020           FIRST PREGNANCY?
 4 Question/Prompt Text
   |Is this your 1st pregnancy?                                              |
   |                                                                         |
 5 Female/Male/All             6 Multiple Responses  7 External/Internal
   Females only                  No                    External









Enter field number or '/' starting field number--
```

Field Explanations

1. FILE TYPE (DISPLAY ONLY)
This field displays the type of file you are building. In this case, AQ displays for Assessment Questions.

2. FILE CODE (DISPLAY ONLY)
This field displays the file code you entered to display this screen.

3. DESCRIPTION (33-C-R)
This field contains the descriptive name of the Assessment Question. You can enter up to 33 characters in this field to describe the question. The description you enter here automatically displays in the Question/Prompt Text field.

4. QUESTION/PROMPT TEXT (FREEFORM)
This field provides two lines for you to enter the question or prompt. The text you entered in the Description field automatically displays in this field. The following prompt displays to enable you to edit the text:

Edit Question (Y/N) [Y]--

Enter **Y** for Yes when you want to change the text that displays in the field. Enter **N** for No when you do not want to change the text. The default is Yes. The system prints this text as the Assessment Question/Prompt on assessment reports.

When you enter **Y**, the following function keys display at the bottom of the screen.

Key	Function
F1 (Del Line)	Deletes the line where the cursor is positioned.
F2 (Ins Line)	Inserts a line above the line where the cursor is positioned.
F3 (Done)	Exits the text-entry screen.
F4 (Del Char)	Deletes the character where the cursor is positioned.
F5 (Ins Char)	Inserts a space in front of the character where your cursor is positioned. You can then enter the character you want to insert.

5. FEMALE/MALE/ALL (1-A-R)
This field specifies whether this question applies to males, females, or all patients.

You have the following choices:

- Enter **M** for Males when the question applies to only males.
- Enter **F** for Females when it applies to only females.
- Press ENTER to select the default ALL when the question applies to all patients.

6. MULTIPLE RESPONSES (1-A-O)
This field enables you to designate whether there can be multiple responses to this question. The following prompt displays:

Are Multiple Responses allowed?--

Enter **Y** for Yes when you want the caregiver to be able to enter more than one response to the question. Enter **N** for No when there can be only one response. The default is No.

This field controls the type of prompt that displays in the Response field for the caregiver to answer an Assessment Question. When thequestion is a single-response question, you are prompted to enter your choice. When you designate that there can be multiple responses, the following prompt displays:

Enter choices (e.g. 1,3,7-9) or '-'choices to remove--
end selection(NL)

7. EXTERNAL/INTERNAL (1-A-R)
This field indicates whether the question is considered an external or internal question type for printing assessment reports. When you access this field, the following prompt displays:

Is question print classification external (E) or internal (I) [E]--

Enter **E** to specify external print classification for the question. Enter **I** to specify internal print classification for the question. The default for this field is External, since most assessment questions are not of a sensitive nature.

NOTE: When printing assessment reports that include detail question information, you can choose whether or not to include Internal Questions. The sensitive nature of some of the assessment questions (such as previous pregnancies and/or abortions) present times when you should not include these questions on the printout. Printouts that do not include internal questions are marked with asterisks by the title of report which include additional internal assessment questions and responses associated with the record. Refer to Chapter 3 - "PATIENT ASSESSMENT OUTPUT" for more information.

This additional flag is added to the Assessment Question/Prompt version of the Assessment File printouts as well.

After you accept the screen, new fields display with any responses already linked to this question, as shown in the following example. The system prompts you to add, move, or update a response.

```
                  General Hospital Build Assessment Files Processor
Model Hospital A                                      Thu Mar 21, 1996 12:22 pm

 1 File Type    2 File Code    3 File Description
   AQ             0020           FIRST PREGNANCY?
 4 Question/Prompt Text
   |Is this your 1st pregnancy?                                              |
   |                                                                         |
 5 Female/Male/All             6 Multiple Responses  7 External/Internal
   Females only                  No                    External




No Response               SkipQ Com  PCR   Prob  Plans/Outcomes
1  Yes                          O
2  No                           O


Enter add(A), move(M) or #NL to select [A]--
```

Field Explanations

NO (DISPLAY ONLY)
This field displays the selection number of the response. You can move a response to change its order on the list.

RESPONSE (DISPLAY ONLY)
This field displays the descriptive name of the response.

SkipQ (DISPLAY ONLY)
This field displays whether or not this response causes the system to skip related questions in the assessment.

COM (DISPLAY ONLY)
This field displays whether the Comment field associated with this response is Required (R), Optional (O), or Skipped (S).

PCR (DISPLAY ONLY)
The system displays the PCR code if a Patient Care Requirement is linked to this response.

PROB (DISPLAY ONLY)
The system displays the Problem Code if a Problem is linked to this response.

PLANS/OUTCOMES (DISPLAY ONLY)
The system displays the Plan of Care/Outcomes that are linked to this response. The following prompt displays on the screen:

Enter add(A), move(M) or #NL to select [A]--

You have the following options:

- Enter **A**, or press ENTER, to add a response to this question. The system prompts you to enter a response code.

  NOTE: For ease of use, you may want to build the most frequently chosen response first. The first time the caregiver answers this question, the first response in the list displays as the default in the prompt. The caregiver can press ENTER to select the response.

- Enter **M** to move an existing response to another place on the list. The responses display for the caregiver in the order you place them in this maintenance file.

  The system instructs you to enter the number where you want the question to be located. You enter **E** to move it to the end of the list. After you press ENTER, the system displays the list in its new order.

- Enter the option number of the response you want to edit.

When you add or edit a response to aquestion, the following screen displays. You can link a Patient Care Requirement (PCR), Problem, and up to four Plan of Care Types to this response. In addition, you can instruct the system to skip related questions when the patient gives this response.

```
              General Hospital Build Assessment Files Processor
GENERAL HOSPITAL A                                  Mon May 15, 1996 10:29 am
 1 Response                    2 Skip Related Questions       3 Comment Action
 4 Comment Text




   PCR               5 Code              6 Description
   PROBLEM           7 Code              8 Description
   PLAN              9 File Type        10 Code   11 Description
                    12 File Type        13 Code   14 Description
                    15 File Type        16 Code   17 Description
                    18 File Type        19 Code   20 Description

Enter response description--
```

Field Explanations

1. RESPONSE (20-C-R)
You enter one of the possible responses to the Assessment Question in this field. The response can be freeform text of up to 20 characters.

2. SKIP RELATED QUESTIONS (1-A-R)
You can use this field to skip related questions when the response does not require additional information. For example, when a patient responds to the question, *Do you smoke?* with *No*, you do not need to ask additional questions, such as: *How long have you smoked?*, *Do you experience shortness of breath?*, and so on. The following prompt displays:

Are there related questions to be skipped? (Y/N) [N]--

Enter **N** for No, or press ENTER, when you do not want to skip any questions. Enter **Y** for Yes when you want to list the questions to skip. One of two prompts displays, depending on whether there are questions already defined to be skipped.

- When there are no existing questions to skip, the following prompt displays when you enter Yes:

  Enter first letter(s)'-' or code--

  You can enter either the code(s) of the question(s) you want to skip one at a time, or perform a table lookup of the available questions. The following prompt displays:

  Enter '-'choices (e.g. 1,7,5-9) to add (max. 30)--
  end selection(NL) next page(/)

You can select a maximum of 30 questions to skip. The system stores these questions, and when the caregiver selects this response during assessment, the system skips displaying the questions you list in this field. The system displays the next assessment question the caregiver selected.

NOTE: It is important to note that the system skips the related questions in the current assessment and in any other assessment with this question/response. The question/response always causes the system to skip the listed questions.In addition, you need to build the assessment so that the questions are in the correct order for skipping related questions. For example, you want to ask the question, *Do you smoke?*, before you ask the question *How long have you been smoking?*, since the answer to *Do you smoke?* skips the question about how long you have been smoking.

- When there are existing questions toskip, a list of the existing questions to skip displays on the screen, as shown on the following screen:

```
              General Hospital Build Assessment Files Processor
GENERAL HOSPITAL A                                  Mon May 15, 1996 10:29 am
 1 Response                      2 Skip Related Questions       3 Comment Action
Page:01                          Selected Questions to Skip        ##=Current Choices
( 1) 0129-ABDOMEN DISTENDED?
( 2) 0130-ABDOMINAL TENDERNESS?









Enter add(A) or '-'choices to remove--
                                  end selection(NL)
```

The following prompt displays:

Enter add(A) or '-'choices to remove--
end selection(NL)

You have the following choices:

- Enter **A** to add an additional related question you want to skip. The system removes the question from the list. The following prompt displays:

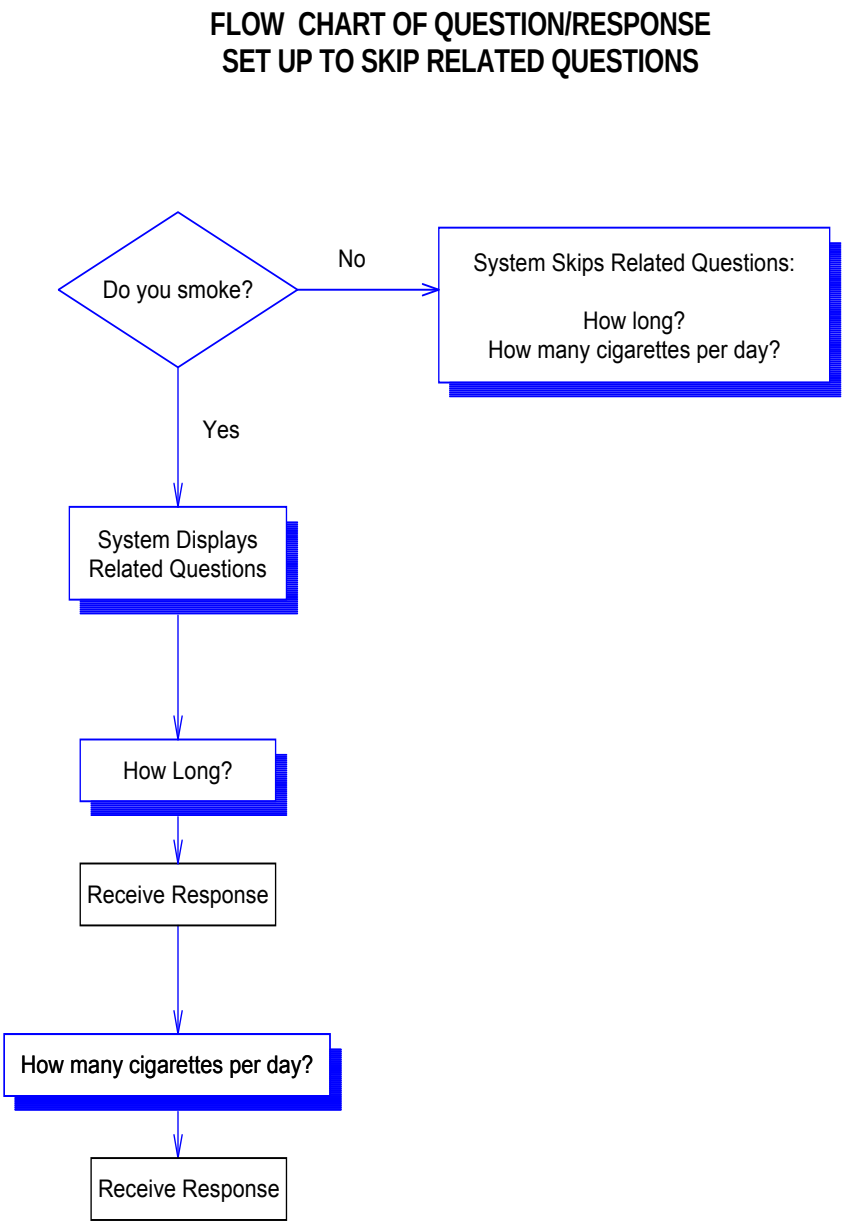
Enter first letter(s)'-' or code--

You follow the same procedure as when there are no existing questions to skip, as outlined above for this field.

- Enter hyphen (-) and the selection number(s) of the question(s) you no longer want to skip.

Press ENTER when you finish listing the questions you want to skip for this response. The flowchart below shows how this field works. *Yes* displays in the Skip Related Questions field.

Figure 2.2 Flowchart of How System Skips Related Questions



3. COMMENT ACTION (TABLE LOOKUP)
This field indicates whether the response's Comment Text field is Required, Optional, or Skipped during the patient assessment process. The following prompt displays:

Is the Comment required(R), optional(O) or skipped(S) [S]--

- Enter **R** for Required to require a comment when the caregiver selects this response during the assessment process. During the Assessment process, the system positions the cursor in the Comment field for entry.

- Enter **O** for Optional, or press ENTER, to have the system display a prompt for the Comment Text field, but not require a comment entry to accept the screen.

- Enter **S** for Skipped to enable the caregiver to skip the Comment field and display the next or previous Assessment Question.

NOTE: When you enter **Y** in the Multiple Responses field, the system automatically enters Skipped in this field.

4. COMMENT TEXT (FREEFORM)
This field provides three lines and function keys for entering comment text about the response. The following prompt displays:

Edit Comment (Y/N) [N]--

Enter **N** for No, or press ENTER, when you do not want to enter or edit the comment. Enter **Y** for Yes to enter comment text about the response. The comment you enter here displays when the caregiver selects the associated response during an assessment. If you want the caregiver to enter the comment text during the assessment process, bypass this field by pressing ENTER.

NOTE: When you enter Yes in the Multiple Responses field, you cannot enter a default comment. The following error message displays:

No default comment for multiple response questions!

The following function keys display at the bottom of the screen.

Key	Function
F1 (Del Line)	Deletes the line where the cursor is positioned.
F2 (Ins Line)	Inserts a line above the line where the cursor is positioned.
F3 (Done)	Exits the text-entry screen.
F4 (Del Char)	Deletes the character where the cursor is positioned.
F5 (Ins Char)	Inserts a space in front of the character where your cursor is positioned. You can then enter the character you want to insert.

5. PCR CODE (TABLE LOOKUP-O)
This optional field contains the Patient Care Requirement code you are linking to this response. Enter the code or perform a table lookup to make your selection.

6. PCR DESCRIPTION (DISPLAY ONLY)
The system displays the PCR descriptive name that corresponds to the PCR code you selected in the PCR Code field.

7. PROBLEM CODE (TABLE LOOKUP-O)
You can link a Problem Code to this response. Enter the Problem's code or perform a table lookup to make your selection. The Problem automatically prints on the Problem List when the caregiver selects this response.

8. PROBLEM DESCRIPTION (DISPLAY ONLY)
The system displays the Problem's descriptive name that corresponds to the Problem you selected in the Problem Code field.

9,12,15,18 PLAN FILE TYPE (2-A-O)
You can link a Plan of Care element to a question's response. The four Plan File Type fields enable you to link up to four Plan of Care elements to the response. To specify the file type, enter PC for Plan of Care, DO for Discharge/Expected Outcome, PO for Problem/Expected Outcome, and DP for Discharge Plan. The Plan of Care Type automatically displays on the list of Recommended Plans of Care/Outcomes that displays after the caregiver completes an assessment.

10,13,16,19 PLAN CODE (TABLE LOOKUP)
You can enter the Plan Code of the file type you are linking to this question/response. To specify the Plan Code, you can enter the code or perform a table lookup to list the available Plan file types.

11,14,17,20 PLAN DESCRIPTION (DISPLAY ONLY)
This field displays the plan's descriptive name that corresponds to the Plan Code you selected in the Plan Code field.

After you accept the screen, the list of responses linked to the question and the following prompt redisplays:

Enter add(A), move(M) or #NL to select [A]--

Enter a period (.) and press ENTER when you are finished adding, moving, or editing responses.

COPY AN ASSESSMENT QUESTION/PROMPT AND ITS ELEMENTS

The prompt that displays when you select the option to build assessment question/prompts enables you to copy one assessment question/prompt and its elements to another:

Enter first letter(s) '-' or assessment question/prompt code--
Enter 'C' to Copy all assessment question/prompt and elements

Enter **C** to copy an assessment question and its elements. The following prompt displays:

Enter first letter(s)'-' or code to copy from--

You have the following choices:

- Enter the code of the assessment question that you want to copy.
- Perform a table lookup to display a list of available assessment questions. Select the assessment question that you want to copy.

The following prompt displays:

Enter the assessment question/prompt new code--

Enter a unique numeric code, up to four digits for the new code of the assessment question you are adding. A screen displays with the new code you entered. The cursor is in the File Description field for you to enter a description for the new assessment question. The remaining fields contain the copied elements. You can enter up to 33 characters for the description.

For information on how to edit this question, including how to edit/add responses or skip related questions refer to"Adding or Editing a Question/Prompt and Response" on page 2-19.

Assessment Groups

You can build Assessment Groups by selecting the following menu options:

1. File Maintenance
2. Standard File Maintenance
3. Standard Assessments
4. Build Assessment Files

If necessary, select the facility. The following screen displays with the File types for you to select the one you want to build.

```
              General Hospital Build Assessment Files Processor
GENERAL HOSPITAL A                                  Mon May 15, 1996 10:29 am
Page:01                            File Types
( 1) Assessment
( 2) Assessment Group
( 3) Assessment Question/Prompt









Enter choice--
```

Select Assessment Group. The following prompt displays:

Enter first letter(s) '-' or assessment group code--

Enter 'C' to Copy all assessment group and elements

You have the following options:

- Enter the first letters of the group descriptive name, followed by a hyphen (-). The system displays the list of groups that begin with these letters.
- Enter a hyphen (-) to display all the groups in the system.
- Enter the group code, up to four digits in length.
- Enter **C** to copy an existing group and its elements. For groups which are similar and require much of the same information, this function saves you data entry time. For information on how to copy a group refer to "Copy an Assessment Group and Its Elements" on page 2-35.

ADDING OR EDITING AN ASSESSMENT GROUP

When you add or edit Assessment Groups, the following screen displays:

```
                    General Hospital Build Assessment Files Processor
Model Hospital A                                      Thu Mar 21, 1996 02:44 pm
 1 File Type  2 File Code   3 File Description                   4 OB History
   AG           0020          MATERNITY GROUP                      Yes









Enter field number or '/' starting field number--
```

Field Explanations

1. FILE TYPE (DISPLAY ONLY)
This field identifies the type of file you are building. In this case, *AG* displays for Assessment Groups.

2. FILE CODE (DISPLAY ONLY)
This field contains the file code you entered to display this screen.

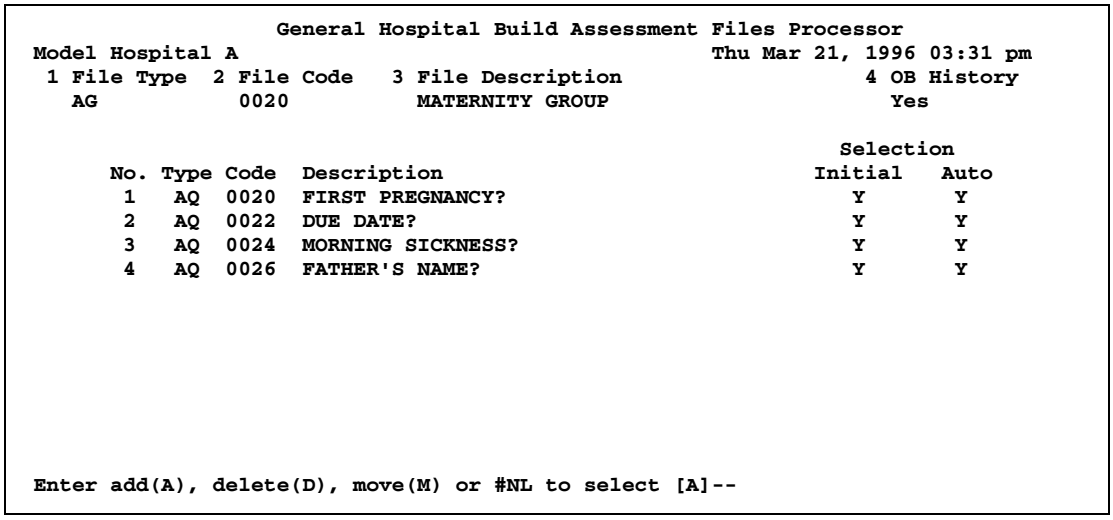
3. FILE DESCRIPTION (33-C-R)
This field contains the descriptive name of the Assessment Group. You can enter up to 33 characters for the description.

4. OBST HIST (1-A-R)
This field indicates whether or not the group you are building or editing relates to an obstetric history assessment. When you access this field, the following prompt displays:

Is this group related to obstetrical history? (Y/N) [N]--

Enter **Y** for Yes, or **N** for No. This flag enables you to build one set of Obstetric History questions. The system then brings up the assessment questions the appropriate number of times, based on the number of previous Registerable Births associated with the patient. The default for this field is **N**.

After you enter the Assessment Group Description and accept the screen, the system displays new fields. When there are Assessment Questions linked to the group, the system lists them in these fields.



The following prompt displays:

Enter add(A), delete(D), move(M) or #NL to select [A]-- |

You have four options:

- Enter **A** for Add, or press ENTER, to add an Assessment Question. Refer to "Adding an Assessment Question" on page 2-32 for the procedure for adding an Assessment Question.
- Enter **D** to delete an Assessment Question. Enter the number of the question you want to delete. The message *Deleted!* displays. The system redisplays the list without the question you deleted.
- Enter **M** to move a question. Enter the number of the question you want to move. The system instructs you to enter the number where you want the question to be located. Enter **E** to move it to the end of the list. After you press ENTER, the system displays the list in its new order.
- Enter the option number of the Assessment Question that has settings you want to change. Refer to "Adding an Assessment Question" on page 2-32 to view the procedure.

Adding an Assessment Question

When you add or edit an Assessment Question in this Group, the system prompts you to enter an Assessment Code:

Enter first letter(s)`-` or assessment question/prompt code--

You have three options:

- Enter the first letters of the question's descriptive name, followed by a hyphen (-). The system displays the list of questions that begin with these letters.
- Enter a hyphen (-) to display all the questions in the system.
- Enter the question code, up to four digits in length.

After selecting the Assessment Question, the system displays the following prompt:

Will this Assessment Question/Prompt be Initially Selected? (Y/N) [Y]--

Enter **Y** for Yes if you want this question to be an automatic selection the first time the caregiver performs this Assessment for a patient. Enter **N** if you do not want it to be an automatic selection. The default is Yes.

The following prompt displays:

Will this Assessment Question/Prompt be Auto Selected? (Y/N) [Y]--

Enter **Y** for Yes if you want this question to be an automatic selection every time (after the initial assessment) the caregiver performs this Assessment for a patient. Enter **N** for No if you do not want it to be an automatic selection each time. The default is Yes.

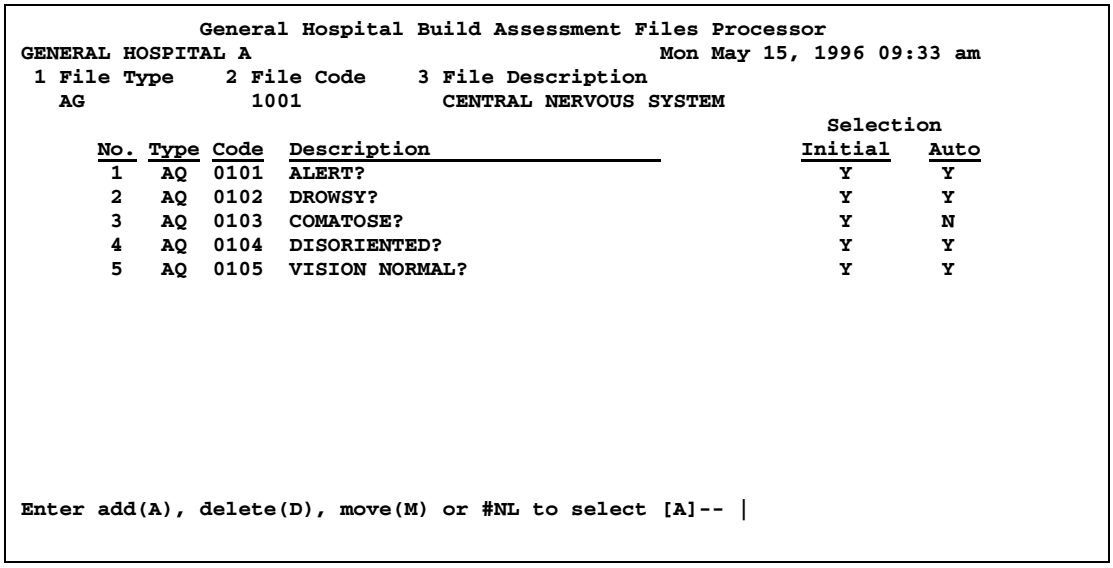
When you answer *Yes* to both of the above prompts, the question is automatically selected every time the caregiver performs the Assessment, both initial and subsequent assessments.

The system displays the information you entered in the fields on the screen, as in the following screen example. The following prompt displays:

Enter add(A), delete(D), move(M) or #NL to select [A]--

When you have no more questions to add, edit, delete, or move, enter a period (.) and press ENTER to exit from this screen.

As you add Assessment Questions to this Group, the system displays them on the screen. The following screen example shows a list of questions added to the Assessment Group.



Field Explanations

NO. (DISPLAY ONLY)
This field displays the selection number of the question. You use this number when you want to delete or move a question on the list.

TYPE (DISPLAY ONLY)
This field displays the file type, such as Assessment Question (AQ).

CODE (DISPLAY ONLY)
This field displays the code assigned to the question.

DESCRIPTION (DISPLAY ONLY)
This field displays the descriptive name of the question.

INITIAL SELECTION (DISPLAY ONLY)
The caregiver can have the system automatically select the questions. This field displays whether or not the system selects this question for the initial selection of an assessment. The field displays *Yes* when the question is set for initial selection and *No* when it is not set for initial selection.

AUTO SELECTION (DISPLAY ONLY)
The caregiver can have the system automatically select the questions. This field displays whether or not the system selects this question for automatic selection in subsequent assessments after the initial assessment (which is controlled by the Initial Selection field).

For example, when the Initial Selection field is set to No and this field is set to Yes, the question is *not* selected the first time the caregiver assesses the patient, but *is* selected every time after that.

The field displays *Yes* when the question is set for automatic selection and *No* when the question is not set for automatic selection.

Copy an Assessment Group and Its Elements

The prompt that displays when you select the option to build assessment groups enables you to copy one assessment group and its elements to another:

Enter first letter(s) '-' or assessment group code--

Enter 'C' to Copy all assessment group and elements

Enter **C** to copy an assessment group and its elements. The following prompt displays:

Enter first letter(s)'-' or code to copy from--

You have the following choices:

- Enter the code of the assessment group that you want to copy.
- Perform a table lookup to display a list of available assessment groups. Select the assessment group that you want to copy.

The following prompt displays:

Enter the assessment group new code--

Enter a unique numeric code, up to four digits for the new code of the assessment group you are adding. A screen displays with the new code you entered. The cursor is in the File Description field for you to enter a description for the new assessment group. You can enter up to 33 characters for the description.

For information on how to edit this group refer to "Adding or Editing an Assessment Group" on page 2-31.

Assessments

To build Assessments, select the following menu options:

1. File Maintenance
2. Standard File Maintenance
3. Standard Assessments

4. Build Assessment Files

If necessary, select the facility. A screen displays for you to select the File Type you want to build:

```
              General Hospital Build Assessment Files Processor
GENERAL HOSPITAL A                                Mon May 15, 1996 10:29 am
Page:01                            File Types
( 1) Assessment
( 2) Assessment Group
( 3) Assessment Question/Prompt









Enter choice--
```

Select Assessments. The following prompt displays:

Enter first letter(s) '-' or assessment code--
Enter 'C' to Copy all assessment and elements

You have four options:

- Enter the first letters of the assessment descriptive name, followed by a hyphen (-). The system displays the list of assessments that begin with these letters.
- Enter a hyphen (-) to display all the assessments in the system.
- Enter the Assessment Code, up to four digits in length.
- Enter **C** to copy an assessment and its elements. For assessments which are similar and require much of the same information, this function saves you data entry time. For more information on how to copy an assessment refer to "Copy an Assessment and Its Elements" on page 2-41.

ADDING OR EDITING AN ASSESSMENT

When you are adding or editing an assessment, enter the Assessment Code. The following screen displays:

```
              General Hospital Build Assessment Files Processor
GENERAL HOSPITAL A                                  Mon May 15, 1996 09:35 am
 1 File Type    2 File Code    3 File Description
   AA             0100        ->
 4 Order Dept   5 Order Code   6 Order Description









Enter description--
```

Field Explanations

1. FILE TYPE (DISPLAY ONLY)
This field displays the type of file you are building. In this case, *AA* displays for Assessments.

2. FILE CODE (DISPLAY ONLY)
This field displays the file code you entered to display this screen.

3. DESCRIPTION (33-C-R)
This field contains the descriptive name of the Assessment. You can enter up to 33 characters in this field.

4. ORDER DEPARTMENT (DISPLAY ONLY)
When you build a newassessment, this field displays AS for the order department until you accept the screen. After you accept the screen, the field displays S, which is the SIM Department code for the Assessment Order Department. The department code displays in this field when you select an assessment order in the Order Code field on this screen.

5. ORDER CODE (TABLE LOOKUP-R)
Enter the code in this field for the assessment order you want to link to this assessment. You can enter the code or perform a table lookup and make your selection.

6. ORDER DESCRIPTION (DISPLAY ONLY)
The system displays the descriptive name of the assessment order you are linking to the assessment. The descriptive name displays when you select an assessment order in the Order Code field.

After you accept the screen, the system displays fields that list any existing Assessment Groups or Questions linked to this assessment:

```
              General Hospital Build Assessment Files Processor
GENERAL HOSPITAL                                  Mon May 15, 1996 10:26 am
 1 File Type    2 File Code    3 File Description
   AA             0100           DIETARY ASSESSMENT
 4 Order Dept   5 Order Code   6 Order Description
   S              0008           DIET REVIEW
                                                                 Selection
     No. Type Code  Description                              Initial   Auto









Will elements selected be Group or Questions? (G/Q) [Q]--  |
```

The following prompt displays:

Will elements selected be Group or Questions? (G/Q) [Q]--

This enables you to link Assessment Groups or Questions to this Assessment. If your facility has built Assessment Groups, you can link Groups. If your facility does not use Assessment Groups, and does not build them, you link Questions. You have the following choices:

- Enter **G** to link groups to this Assessment
- Enter **Q** to link questions to this Assessment

When you select either of these options, the following prompt displays:

Enter add(A), delete(D), move(M) or #NL to select [A]--

You have the following options:

- Enter **A**, or press ENTER, to add an Assessment Group or Question.

- Enter **D** to delete an Assessment Group or Question. Enter the number of the Question or Group you want to delete. The system removes that Question or Group from the list.

- Enter **M** to move a Group or Question. Enter the number of the Question or Group you want to move. The system instructs you to enter the number where you want the Group or Question to be located. Enter **E** to move it to the end of the list. After you press ENTER, the system displays the list in the new order.

- Enter the selection number of the Group or Question you want to edit.

When you choose to add or edit an Assessment Group or Question, the system prompts you to specify the Group or Question:

When you are adding a group, the following prompt displays:

Enter first letter(s)'-' or assessment group code--

When you are adding a question, the following prompt displays:

Enter first letter(s)'-' or assessment question/prompt code--

You have the following options:

- Enter the first letters of the group or question descriptive name, followed by a hyphen (-). The system displays the list of questions or groups that begin with these letters.

- Enter a hyphen (-) to display all the groups or questions in the system.

- Enter the group or question code, up to four digits in length.

After you select the assessment group or question, the system displays either of the following prompts:

Will this ASSESSMENT QUESTION/PROMPT be Initially Selected? (Y/N) [Y]--
Will this ASSESSMENT GROUP be Initially Selected? (Y/N) [Y]--

Enter **Y** for Yes if you want this Group or Question to be an automatic selection the first time the caregiver does this Assessment for a patient. Enter **N** for No if you do not want it to be an automatic selection. The system defaults to Yes.

After you make an entry, one of the following prompts displays:

Will this ASSESSMENT QUESTION/PROMPT be Auto Selected? (Y/N) [Y]--
Will this ASSESSMENT GROUP be Auto Selected? (Y/N) [Y]--

Enter **Y** for Yes if you want this Group or Question to be an automatic selection every time (after the initial assessment) the caregiver does this assessment for a patient. Enter **N** for No if you do not want it to be an automatic selection each time. The system is Yes.

When you answer *Yes* to both of the above prompts, the question is automatically selected every time the caregiver performs the assessment, both initial and subsequent assessments.

After you add the appropriate Group or Question, the system displays the list of group(s) or question(s) that have been linked to the assessment. The following screen example shows a question that has been added to the assessment.

When you have no more questions to add, edit, delete or move, enter a period (.) and press ENTER to exit from this screen.

```
              General Hospital Build Assessment Files Processor
PROVIDENCE MEDICAL CENTER                          Mon May 15, 1996 10:26 am
 1 File Type     2 File Code     3 File Description
   AA              0100            MOBILITY ASSESSMENT
 4 Order Dept    5 Order Code    6 Order Description
   S               0008            DIET REVIEW
                                                              Selection
      No. Type Code  Description                            Initial   Auto
       1   AQ  0217  ACTIVITY LIMITATIONS?                      Y       Y









Enter add(A), delete(D), move(M) or #NL to select [A]--    |
```

Field Explanations

NO. (DISPLAY ONLY)
This field displays the selection number of the group or question. You enter this number to designate the group or question you want to delete, move, or edit.

TYPE (DISPLAY ONLY)
This field displays the element type, Assessment Group (AG) or Assessment Question (AQ).

CODE (DISPLAY ONLY)
This field displays the code assigned to the group or question.

DESCRIPTION (DISPLAY ONLY)
This field displays the descriptive name of the group or question.

INITIAL SELECTION (DISPLAY ONLY)
This field determines whether or not the group or question is automatically selected the first time the caregiver assesses a new patient. Enter **Y** for Yes for automatic selection for the initial assessment. Enter **N** for No when you do not want the group or question to be automatically selected for the initial assessment.

AUTO SELECTION (DISPLAY ONLY)
This field determines whether or not the group or question is selected in subsequent assessments after the initial assessment. Enter **Y** for Yes for automatic selection after the initial assessment. Enter **N** for No when you do not want the group or question to be automatically selected. The Initial Selection field determines whether or not the question is selected for the initial assessment.

For example, when the Initial Selection field is set to No and this field is set to Yes, the group or question is *not* selected the first time the caregiver assesses the patient, but *is* selected every time after that. When you want to select the question or group for each assessment, enter **Y** for Yes in both fields.

COPY AN ASSESSMENT AND ITS ELEMENTS

The prompt that displays when you select the option to build assessment question/ prompts enables you to copy one assessment and its elements to another:

Enter first letter(s) '-' or assessment code--
Enter 'C' to Copy all assessment and elements

Enter **C** to copy an assessment and its elements. The following prompt displays:

Enter first letter(s)'-' or code to copy from--

You have the following choices:

- Enter the code of the assessment that you want to copy.
- Perform a table lookup to display a list of available assessments. Select the assessment that you want to copy.

The following prompt displays:

Enter the assessment new code--

Enter a unique numeric code, up to four digits for the new code of the assessment you are adding. A screen displays with the new code you entered. The cursor is in the File Description field for you to enter a description for the new assessment. You can enter up to 33 characters for the description.

For information on how to edit this assessment, refer to “Adding or Editing an Assessment” on page 2-37.

Assessment Menus

You build Assessment Menus for standard assessments used frequently by specific areas and/or nursing stations. For example, you can build a Medical/Surgical Assessment Menu. To build AssessmentMenus, you add assessments to a menu that you name. You can link an assessment to multiple Assessment Menus.

For each assessment added to the menu name, you can define locations which can use the assessment, and you can specify whether the staff at the location can revise or only view the assessment.

To access the Assessment Menu function, select the following menu options:

1. File Maintenance
2. Standard File Maintenance
3. Standard Assessments
4. Build Assessment Menu

If necessary, select the facility. The following screen displays. From this screen, you can add, copy, or revise an Assessment Menu.

```
              General Hospital Build Assessment Menu Processor
GENERAL HOSPITAL A                                 Mon May 15, 1996 02:49 pm









Add(A), Copy(C), or Revise(R) menu--
```

ADD AN ASSESSMENT MENU

After you enter **A** to add an Assessment Menu, the system prompts you to enter the name of the menu, up to 18 characters:

Enter new name--

The next prompt enables you to add all assessments to this menu name or add individual assessments.

Add all(ALL) or add one(A)--

You can add all existing assessments or one assessment at a time, as explained following in Add All Assessments and Add One Assessment.

Add All Assessments

Enter **ALL** to add all the assessments to the menu. All the assessments display, as shown on the following screen:

```
               General Hospital Build Assessment Menu Processor
SYSTEM REVIEW                                      Mon May 15, 1996 02:09 pm

                                  Assessment Menu
( 1) CHEST PAIN ASSESSMENT
( 2) CVA ASSESSMENT
( 3) DECUBITUS ASSESSMENT
( 4) DIET REVIEW
( 5) HIGH RISK FALL ASSESSMENT
( 6) NURSING HISTORY
( 8) PATIENT ADMISSION DATABASE
( 9) PULMONARY ASSESSMENT
(10) SYSTEM REVIEW
(11) VASCULAR ASSESSMENT
(12) WELLNESS ASSESSMENT




Enter #, move(M) or add(A)--
```

If you want to make any changes to these assessments, you can do the following:

- Enter the selection number of the assessment when you want to revise the assessment name or edit the locations to which this assessment is assigned.
- Enter **M** to move an assessment on the displayed list. Enter the number of the assessment you want to move. The system instructs you to enter the number where you want the question to be located. You enter **E** to move it to the end of the list. After you press ENTER, the system displays the list in its new order.
- Enter **A** to add a new assessment to the list.

When you finish defining the assessments for this menu, press ENTER. The system prompts you to accept the assessments currently displaying. When you accept the screen, the system informs you that it is building the screen and beeps to let you know when it has filed the screen. The system redisplays the prompt that enables you to add, copy or revise a menu.

Add One Assessment

The following prompt displays:

Add all(ALL) or add one(A)--

Enter **A** to add assessments one at a time. The following screen displays:

```
               General Hospital Build Assessment Menu Processor
SYSTEM REVIEW                                      Mon May 15, 1996 02:09 pm
                                Assessment Menu









Enter # to insert before, or at end(E)--
```

Enter **E** to add the first assessment.

NOTE: If assessments were previously added to this menu name, they would display on this screen, and you could insert this assessment before another assessment by entering the number before which you want to insert the assessment.

The following Assessment screen displays for you to specify the Assessment you are adding to this menu name:

```
              General Hospital Build Assessment Menu Processor
ER MENU                                          Mon May 15, 1996 02:50 pm

                                  Assessment Menu

( 1)Assessment      :
( 2)Screen display  :

                              Assessment Control
                                   Locations









Enter first letter(s)`-` or code--
```

You have the following options:

- Enter the first letters of the assessment descriptive name, followed by a hyphen (-). The system displays a partial list of assessments that begin with these letters.
- Enter a hyphen (-) to display all the assessments in the system.
- Enter the assessment code, up to four digits in length.

After you select the assessment, the system prompts you to specify how you want the name to display on the Assessment Menu:

Enter screen display [DIET REVIEW]--

The default is the assessment's descriptive name. You can enter a different name. The name you enter displays on the caregiver's Assessment Menu.

After you accept the screen, the following prompt displays for you to add, revise, or delete locations for this assessment:

Enter add(A), revise(R) or delete(D) for Assessment Control locations--
/ for next page /P for previous page

You have the following options:

- Enter **A** to add a new location. The following prompt displays for you to add a new location (using the code or selecting from a table) or ALL to add all locations:

  Enter location, all(ALL) or `-` for location table--

- Enter **R** to revise an existing location. The following prompt displays for you to enter the location or ALL to revise all locations:

  Enter location, all(ALL)--

- Enter **D** to delete an existing location. The following prompt displays for you to enter the location or ALL to delete all locations:

  Enter location, all(ALL)--

  NOTE: You cannot use the ALL option when there are individual locations already displaying. In addition, you cannot select an individual location when the ALL option was used to select all nurse stations and/or departments. When you try to mix options (ALL and individual), the following error message displays:

  Error: Not allowed!

  NOTE: To change from individual locations to ALL locations, you first need to delete the existing individual locations. To change from all locations to individual locations, you first need to delete ALL locations.

  You have the following options:

  - Enter the location code.

  - Enter **ALL** to specify whether you want to assign this assessment to all nurse stations, all departments, or all stations and departments. The following prompt displays:

    Enter 'A' for all nurse stations, 'B' for all departments or 'C' for both--

    Enter **A** to assign the menu to all nurse stations, **B** to all departments, or **C** to all departments and nurse stations.

- When you are adding a location, enter a hyphen (-) and press ENTER to display a table of locations for your selection.

Once you specify the location(s), the system displays the flashing code on the screen.

- When you are deleting the location(s), the system displays the following prompt:

  Delete? (Y/N) [N]--

  Enter **Y** for Yes to delete the location(s). Enter **N** for No, or press ENTER, when you do not want to delete the location(s).

- When you are adding or revising the location(s), the system prompts you to indicate whether the staff at the location(s) can revise or only view the assessment data:

  Should this location revise(R) or view(V) assessments?--

  You have the following options:

  - Enter **R** for Revise to enable the staff to change the data in addition to viewing it.

  - Enter **V** for View to allow the staff only to view the data, and not be able to change it.

The system redisplays the prompt for you to add, revise, or delete locations:

Enter add(A), revise(R) or delete(D) for Assessment Control locations--
/ for next page /P for previous page

When you finish working with locations, you can press ENTER to display the prompt to accept the screen:

Accept? (Y/N) [Y]--

Press ENTER to accept the screen. The system displays the screen containing the assessment(s) added to the menu name, as shown on the following screen:

```
              General Hospital Build Assessment Menu Processor
SYSTEM REVIEW                                        Mon May 15, 1996 02:50 pm

                                  Assessment Menu
( 1) CHEST PAIN ASSESSMENT
( 2) DIET REVIEW









Enter #, move(M) or add(A)--
```

You can edit, move, or add another assessment, or you can press ENTER twice to accept this screen. The system files the assessments with the menu name. The system then redisplays the initial prompt, enabling you to add, copy, or revise a new menu:

Add(A), Copy(C), or Revise(R) menu--

Press ENTER to redisplay the Standard Assessments Menu.

COPY AN ASSESSMENT MENU

To copy an Assessment Menu, select the following menu options:

1. File Maintenance
2. Standard File Maintenance
3. Standard Assessments
4. Build Assessment Menu

If necessary, select the facility. The following prompt displays:

Add(A), Copy(C), or Revise(R) menu--

Enter **C** to copy an Assessment Menu. The screen containing the list of available Assessment Menu Names displays for you to select the menu you want to copy:

```
              General Hospital Build Assessment Menu Processor
GENERAL HOSPITAL A                                Mon May 15, 1996 02:53 pm
Page:01                         Assessment Menus
( 1) CRITICAL CARE
( 2) DIETARY ASSESSMENT
( 3) MED/SURG ASSESSMENT
( 4) SURGICAL ASSESSMENT
( 5) ADMISSION ASSESSMENT









Enter choice--
```

Enter the selection number of the menu you want to copy. The system prompts you to enter the new menu name:

Enter new name--

You can enter up to 18 characters. The system displays the assessments that are assigned to the menu you copied. You can change any of the assessment screen descriptions or locations. You can move any of the assessments to a different location on the menu. You can add assessments to the menu. For information on adding assessments refer to "Add One Assessment" on page 2-44.

```
              General Hospital Build Assessment Menu Processor
GENERAL HOSPITAL A                                 Mon May 15, 1996 02:53 pm
Page:01                        Assessment Menus
( 1) NURSING HISTORY
( 2) REVIEW OF SYSTEMS
( 3) WELLNESS ASSESSMENT
( 4) DIET REVIEW









Enter #, move(M) or add(A)--
```

When you finish editing, adding, or moving assessments, press ENTER twice and accept the screen. The system builds the new menu as displayed on the screen.

REVISE AN ASSESSMENT MENU

To revise an Assessment Menu, select the following menu options:

1. File Maintenance
2. Standard File Maintenance
3. Standard Assessments
4. Build Assessment Menu

If necessary, select the facility. The following prompt displays:

Add(A), Copy(C), or Revise(R) menu--

Enter **R** to revise an Assessment Menu. The screen containing the list of Assessment Menu names displays for you to select the menu you want to revise:

```
               General Hospital Build Assessment Menu Processor
GENERAL HOSPITAL A                                  Mon May 15, 1996 02:53 pm
Page:01                          Assessment Menus
( 1) CRITICAL CARE
( 2) DIETARY ASSESSMENT
( 3) MED/SURG ASSESSMENT
( 4) PATIENT ASSESSMENT









Enter choice--
```

Enter the option number of the menu you want to revise. The system enables you to change the menu name, as shown on the following screen:

```
               General Hospital Build Assessment Menu Processor
GENERAL HOSPITAL A                                  Mon May 15, 1996 02:53pm









                                CRITICAL CARE

Enter new name [no change]--
```

You can enter up to 18 characters for the new menu name. Press ENTER when you do not want to change the menu name. The system displays the assessments already linked to the menu, as shown on the following screen:

```
               General Hospital Build Assessment Menu Processor
CRITICAL CARE                                        Mon May 15, 1996 02:54 pm

                                  Assessment Menu
( 1) PATIENT ADMISSION DATABASE
( 2) NURSING HISTORY
( 3) WELLNESS ASSESSMENT
( 4) CHEST PAIN ASSESSMENT
( 5) PULMONARY ASSESSMENT
( 6) VASCULAR ASSESSMENT
( 7) CVA ASSESSMENT
( 8) HIGH RISK FALL ASSESSMENT
( 9) DECUBITUS ASSESSMENT




Enter #, move(M) or add(A)--
```

You have the following options:

- Enter the number of the assessment you want to revise. For more information, refer to the procedure following.
- Enter **M** to move an assessment on the displayed list. Enter the number of the assessment you want to move. The system instructs you to enter the number where you want the assessment to be located. You enter **E** to move it to the end of the list. After you press ENTER, the system displays the list in the new order.
- Enter **A** to add a new assessment to the list. Refer to "Add One Assessment" on page 2-44 and follow the procedure.

To revise an assessment, enter the number of the assessment you need to revise. The following screen displays:

```
               General Hospital Build Assessment Menu Processor
SYSTEM REVIEW                                        Mon May 15, 1996 02:50 pm

                                  Assessment Menu

( 1)Assessment      : 0010 PULMONARY ASSESSMENT
( 2)Screen display  : PULMONARY ASSESSMENT

                             Assessment Control
                                  Locations
  1E - Revise               2N - Revise









Enter field number or /starting field number--
```

You can change the Assessment and Screen Display fields. If you do not want to change either field, press ENTER. The system gives you the option to delete this assessment:

Delete? (N)--

When you want to delete the assessment, enter **Y**. When you do not want to delete the assessment, press ENTER. The system displays the following prompt:

Enter add(A), revise(R) or delete(D) for Assessment Control locations--
/ for next page /P for previous page

This prompt enables you to add, revise, or delete assessment control locations. Refer to "Add One Assessment" on page 2-44 for more details.

Build Assessment Orders

An assessment order designates the assessment as an active order. The assessment is active until the caregiver completes the order. The assessment can be built so the assessment order prints on the Active Order Worksheet and Patient Care Profile (PCP). To build assessment orders, select the following options:

1. File Maintenance
2. Standard File Maintenance
3. Standard Assessments
4. Assessment Order

If necessary, select the facility. The following prompt displays:

Enter first letter(s)`-` or assessment order code--

You have three options:

- Enter the first letters of the order name, followed by a hyphen (-). The system displays a list of assessment orders that begin with these letters.
- Enter a hyphen (-) to display all the assessment orders and make your selection.
- Enter the Assessment Order code, up to four digits.

To add an assessment order for the first time, enter the Assessment Order code you want to add. The following Assessment Order Detail screen displays:

```
                General Hospital Assessment Order Processor
GENERAL HOSPITAL A                              Mon May 15, 1996 09:38 am
 1 Department   2 Code          3 File Description
   S              0008           ->
 4 PCR Code     5 PCR Description
 6 Dept Notify









Enter assessment order file description--
```

Field Explanations

1. DEPARTMENT (DISPLAY ONLY)
The Department type S automatically displays in this field. The department type for all Assessment Orders is S.

2. CODE (DISPLAY ONLY)
This field displays the Assessment Order code you entered to display this screen.

3. FILE DESCRIPTION (33-C-R)
This field stores the descriptive name for the assessment order. You can enter up to 33 characters.

4. PCR CODE (TABLE LOOKUP-O)
This field stores the Patient Care Requirement (PCR) code associated with this assessment order. You can enter the code, or perform a table lookup and make your selection. This field information is used only by the Patient Acuity and Nurse Staffing Module. Press ENTER to bypass this optional field if you do not use this module.

5. PCR DESCRIPTION (DISPLAY ONLY)
The system displays the PCR descriptive name in this field when you specify a code in the PCR Code field.

6. DEPT NOTIFY (TABLE LOOKUP)
This field stores the charge/order department for this assessment order. Perform a table lookup and select the department. The Assessment Order Notice prints at the default printer of the department you specify here.

When you finish entering data, accept the screen. The system redisplays the initial prompt:

Enter first letter(s)`-` or assessment order code--

You can add another assessment order, or perform a table lookup of the existing orders and make your selection. If you select an existing order, a screen like the previous example displays. You can update every field except the Department field.

FILE MAINTENANCE OUTPUT

STAR Patient Care Patient Assessment Module provides a menu of options that enable you to print a hard copy of the Standard Files you create.

To print these files, select the following menu options:

1. File Maintenance
2. Standard File Maintenance
3. Standard Assessments
4. Print Assessment Files

The following menu displays.

```
             General Hospital Print Assessment Files Processor
                                                  Mon May 15, 1996 10:29 am
Print Assessment Files Input Options
            Option No.  Option
            ----------------------------------------
 Print           1       Assessment Menus
                 2       Assessments
                 3       Assessment Groups
                 4       Assessment Question/Prompts
                 5       Assessment Orders
                 6       Problem List









Enter option number--
```

When you select one of the options, and the facility if necessary, a prompt displays enabling you to print three reports: an alphabetic report, a numeric report, or a detailed report of the assessment element. The following pages display screens with the prompts for each option in addition to a report example.

Assessment Menus

When you select the Assessment Menus option, and the facility if necessary, the following prompt displays:

Enter station code--

Enter the code of the station for which you want to print the Assessment Menu information or perform a table lookup and make your selection. The following screen displays:

```
              General Hospital Build Assessment Menu Processor
                                                  Mon May 15, 1996 02:09 pm
( 1)Assessment Area to print:
                                Assessment Menu
( 1) CHEST PAIN ASSESSMENT
( 2) CVA ASSESSMENT
( 3) DECUBITUS ASSESSMENT
( 4) DIET REVIEW
( 5) HIGH RISK FALL ASSESSMENT
( 6) NURSING HISTORY
( 8) PATIENT ADMISSION DATABASE
( 9) PULMONARY ASSESSMENT
(10) SYSTEM REVIEW
(11) VASCULAR ASSESSMENT
(12) WELLNESS ASSESSMENT



Enter choice to print [ALL]--
```

The following prompt displays:

Enter choice to print [ALL]--

You have the following choices:

- Enter ALL when you want to print information for all Assessments on the menu.
- Enter the selection number of the individual Assessment for which you want to print information.

Once you make your selection, the Assessment name or ALL displays in the field Assessment Area to Print field. The prompt displays for your to accept the screen. Once you accept the screen, the system displays the message *Printing!* and redisplays the Print Assessment Files menu for you to print another report.

The report prints the following information:

- The Assessment Menu description
- The Assessment Menu description used for display
- The Assessment Control Locations with their capability (Revise or View)

An example of the Standard File Assessment Menu Report is shown below.

Figure 2.3 Standard File Assessment Menu Report

```
                                GENERAL HOSPITAL A                          PAGE 1
05/17/93 11:55am       STANDARD FILE ASSESSMENT MENU REPORT
-------------------------------------------------------------------------------
                                   MENU NAME
 ASSESSMENT                                        SCREEN DISPLAY
 CONTROL LOCATIONS
-------------------------------------------------------------------------------
                                PATIENT ASSESSMENT
( 1) NURSING HISTORY                               NURSING HISTORY
     1E R,2N R,DTY V
( 2) SYSTEM REVIEW                                 SYSTEM REVIEW
     2N R,1E R
( 3) WELLNESS ASSESSMENT                           WELLNESS ASSESSMENT
     1E R,2N R
( 4) DIET REVIEW                                   DIET REVIEW
     DTY R,2N V,1E V
( 5) CHEST PAIN ASSESSMENT                         CHEST PAIN ASSESSMENT
     DTY R,2N V,1E V
                                End of Report
```

Assessments

When you select the Assessments option, and the facility if necessary, the following screen displays:

```
                  General Hospital Assessments Processor
                                                  Mon May 15, 1996 02:09 pm
( 2)Type of Report          :
( 1)Assessment to Print     :









Print alphabetic(A) or numeric(N) report, or an individual(I) assessment--
```

The following prompt displays:

Print alphabetic(A) or numeric(N) report, or an individual(I) assessment--

You have the following choices:

- Enter **A** to print the Assessment descriptions in alphabetic order.

- Enter **N** to print the Assessment descriptions in numeric order by Assessment Code.

- Enter **I** to print information for an individual Assessment.

  When you select this option, the system displays a table of Assessments for your selection. Select the individual Assessment for which you want to print all information.

The system displays the message *Printing!* and redisplays the Print Assessment Files menu for you to print another report.

The alpha and numeric reports print the following information:

- The Assessment code and description

- The Order code and description of the assessment order linked to the assessment

The individual assessment report prints the following information:

- Assessment code and description

- Initial and Auto Selection settings

- Whether there can be multiple responses

- Assessment Groups

- Question/Prompt Text

- Comment Text and whether required, skipped, or optional

- Each of the possible responses

- Elements linked to the response, such as PCR codes, Problems, and Plan of Care Elements

An example of the Standard File Assessment Report in alphabetical order is seen below.

Figure 2.4 Standard File Assessment Report in Alphabetical Order

```
                              GENERAL HOSPITAL A                          PAGE 1
05/17/93 11:55am       STANDARD FILE ALPHA ASSESSMENT REPORT
-------------------------------------------------------------------------------
 CODE DESCRIPTION                 ORDER CODE AND DESCRIPTION
-------------------------------------------------------------------------------


0200 CHEST PAIN ASSESSMENT           201 CHEST PAIN
0700 CVA ASSESSMENT                  701 CVA
0300 DECUBITIS ASSESSMENT            301 DECUBITIS
0100 DIET REVIEW                     101 DIET REVIEW
0500 HIGH RISK FALL ASSESSMENT       501 HIGH RISK FALL
0600 NURSING HISTORY                 601 NURSING HISTORY
0400 PATIENT ADMISSION DATABASE      401 PATIENT ADMISSION
0900 PULMONARY ASSESSMENT            901 PULMONARY
1100 SYSTEM REVIEW                  1101 SYSTEM REVIEW
1000 VASCULAR ASSESSMENT            1001 VASCULAR
1500 WELLNESS ASSESSMENT            1501 WELLNESS

                                 End of Report
```

Assessment Groups

When you select the Assessment Groups option, and the facility if necessary, the following prompt displays:

Print alphabetic(A) or numeric(N) report, or Group/Question(G) report--

You have the following choices:

- Enter **A** to print the Assessment Group descriptions in alphabetic order.
- Enter **N** to print the Assessment Group descriptions in numeric order by code.
- Enter **G** to print information for an individual Assessment Group.

The system displays the message *Printing!* and redisplays the Print Assessment Files Menu for you to print another report.

The alpha and numeric reports print the Assessment Group Code and Description.

The individual Assessment Group report prints the following information:

- The Assessment Group Code and Description
- The Question/Prompt Text
- Comment Text and whether required, skipped, or optional
- Each of the possible responses

- Elements linked to the response, such as PCR codes, Problems, and Plan of Care Elements.

Following is an example of the Standard File Assessment Group Report in numeric order.

Figure 2.5 Standard File Assessment Group Report in Numeric Order

```
                                GENERAL HOSPITAL A                          PAGE 1
05/17/93 11:55am          STANDARD FILE NUMERIC GROUP REPORT
-------------------------------------------------------------------------------
 CODE DESCRIPTION
-------------------------------------------------------------------------------
0001 HEALTH PERCEPTION MANAGEMENT
0003 ELIMINATION
0004 ACTIVITY/EXERCISE
0006 COGNITIVE/PERCEPTUAL
0010 COPING/STRESS TOLERANCE
0101 CENTRAL NERVOUS SYSTEM
0103 CARDIOVASCULAR
0104 GASTROINTESTINAL
0105 GENITOURINARY
0107 INTEGUMENTARY
0045 GENERAL INFORMATION
0046 HABITS
0052 MEDICATIONS
0100 MUSCLE/SKELETAL
0400 PRELIMINARY DISCHARGE PLANNING
0500 NUTRITIONAL/METABOLIC
0600 ORIENTATION
0900 PSYCHOSOCIAL
1000 SEXUAL/REPRODUCTIVE
1100 ROLE/RELATIONSHIP
1200 RESPIRATORY
1600 SELF PERCEPTION/SELF CONCEPT
1800 SLEEP/REST
2000 VALUE/BELIEF

                                End of Report
```

Assessment Questions

When you select the Assessment Question/Prompts option, and the facility if necessary, the following prompt displays:

Print alphabetic(A) or numeric(N) question/prompt, or Question/Prompt(Q) report--

You have the following choices:

- Enter **A** to print the Assessment Question/Prompt descriptions in alphabetic order.
- Enter **N** to print the Assessmert Question/Prompt descriptions in numeric order by code.
- Enter **Q** to print information for an individual Assessment Question.

The system displays the message *Printing!* and redisplays the Print Assessment Files Menu for you to print another report.

The reports print the following information:

- Assessment Question/Prompt code and description
- The Question/Prompt Text
- Comment Text and whether required, skipped, or optional
- Each of the possible responses
- Elements linked to the response, such as PCR codes, Problems, and Plan of Care Elements

Following is an example of the Standard File Assessment Question Report in alphabetical order.

Figure 2.6 Standard File Assessment Question Report in Alphabetical Order

```
                                  GENERAL HOSPITAL            PAGE  1
05/17/93 16:30       STANDARD FILE ALPHA QUESTION/PROMPT REPORT
--------------------------------------------------------------------------------
CODE QUESTION/PROMPT DESCRIPTION       MULTIPLE
      TEXT
RESPONSE                  C/A PCR   PROB  PLAN OF CARE ELEMENTS
      COMMENT
--------------------------------------------------------------------------------
2129 ABDOMEN DISTENDED #2 (COPIED)       No
      :Is the patient's abdomen distended?
0130 ABDOMINAL TENDERNESS?               No
      :Does the patient have abdominal tenderness?
NO                          S        #12999
YES                         R        #12999

8888 ACCIDENT PRONE?                     No
      :Have you had any accidents?
NO                          S        #27794
YES                         R        #27794

5600 ACCOMPANIED BY AND INFO OBTAINED?   No
      :Who accompanied the patient to the unit and who was the admitting
      :information obtained from?

0217 ACTIVITY LIMITATIONS?               No
      :Do you have any activity limitations?
YES                         R        #30913
NO                          R        #30913
```

Assessment Orders

When you select the Assessment Orders option, and the facility if necessary, the following prompt displays:

Print alphabetic(A) or numeric(N) order report--

You have the following choices:

- Enter **A** to print the Assessment Orders descriptions in alphabetic order.
- Enter **N** to print the Assessment Orders descriptions in numeric order by code.
- Enter **Q** to print information for an individual Assessment Group.

The system displays the message *Printing!* and redisplays the Print Assessment Files Menu for you to print another report.

The report prints the following information:

- Assessment Order code and description
- The Department
- PCR Code and Description

An example of the Standard File Assessment Orders Report in alphabetical order is shown below.

Figure 2.7 Standard File Assessment Orders Report in Alphabetical Order

```
                                GENERAL HOSPITAL A                          PAGE 1
05/17/93 11:55am          STANDARD FILE ALPHA ORDER REPORT
-------------------------------------------------------------------------------
 CODE DESCRIPTION                    PCR CODE     PCR DESCRIPTION
-------------------------------------------------------------------------------
0008 DIET REVIEW                     0704 INTAKE/OUTPUT GEN- STRICT
0700 HISTORY ORDER
 0300 INTAKE & OUTPUT ORDER          0704 INTAKE/OUTPUT GEN- STRICT
0100 NURSING HISTORY
0500 PATIENT ADMISSION ASSESSMENT
0600 REVIEW OF SYSTEMS
0400 REVIEW OF SYSTEMS II
0900 REVIEW OF SYSTEMS III           1101 NEURO ASSESSMENT Q 4 HOURS
1100 NEURO ASSESSMENT


                                End of Report
```

Problem List

When you select the Problem List option, and the facility if necessary, the following prompt displays:

Print alphabetic(A) or numeric(N) problem report--

You have the following choices:

- Enter **A** to print the Problem List descriptions in alphabetic order.
- Enter **N** to print the Problem List descriptions in numeric order by code.

The system displays the message Printing! and redisplays the Print Assessment Files Menu for you to print another report.

The report prints the following information:

- Problem code and description
- Problem Status
- Whether the caregiver can edit the Description
- Whether there is auto assignment of Problem number
- Whether the Problem List prints on Assessment Report

Following is an example of the Standard File Problem Report in alphabetical.

Figure 2.8 Standard File Problem Report in Alphabetical Order

```
                              GENERAL HOSPITAL A                          PAGE 1
05/17/93 11:55am          STANDARD FILE ALPHA PROBLEM REPORT
-------------------------------------------------------------------------------
 CODE DESCRIPTION                          EDIT      STATUS         AUTO#  PCP  AR
-------------------------------------------------------------------------------
0019 DEAF                                  NO     02 ACTIVE          YES   YES  YES
0004 DERMATOLOGICAL PROBLEMS               NO     03 EVALUATING      YES   YES  YES
0018 DIFFICULTY HEARING/ AID               NO     02 ACTIVE          YES   NO   YES
0026 DISCHARGE PLANNING                    NO     02 ACTIVE          YES   NO   NO
8217 EVALUATE NIGHT SWEATS                 NO     03 EVALUATING      YES   YES  NO
9852 HICCUPS                               NO     02 ACTIVE          YES   YES  NO
8956 LEGALLY BLIND                         NO     03 EVALUATING      NO    NO   NO
9032 NUTRITION, LESS THAN REQUIRED         NO     02 ACTIVE          NO    YES  YES
9321 ORAL HYGIENE PROBLEM                  NO     03 EVALUATING      YES   YES  YES
8157 POTENTIAL DERMATOLOGICAL PROBLEMS     NO     03 EVALUATING      YES   YES  YES
8101 POTENTIAL HYGIENE PROBLEMS            NO     02 ACTIVE          YES   YES  NO
9321 POTENTIAL ORAL HYGIENE PROBLEM        NO     03 EVALUATING      NO    YES  YES
8098 POTENTIAL PROBLEM HEALING             NO     03 EVALUATING      YES   NO   NO
8147 POTENTIAL PROBLEM W/MEMORY            NO     03 EVALUATING      NO    YES  YES
8047 POTENTIAL PROBLEM W/COMPLIANCE        NO     02 ACTIVE          NO    YES  NO
9113 POTENTIAL PROBLEM W/NUTRITION         NO     03 EVALUATING      YES   NO   YES
9126 POTENTIAL PROBLEM W/VISION            NO     03 EVALUATING      NO    YES  NO
9017 BATH, REQUIRES ASSISTANCE             NO     02 ACTIVE          YES   YES  NO
9030 PROBLEM W/MOBILITY                    NO     02 ACTIVE          NO    YES  YES
8216 TOILETING, NEEDS ASSISTANCE           NO     02 ACTIVE          YES   NO   YES
9345 PROBLEM W/VISION                      NO     02 ACTIVE          NO    YES  NO
8659 GROOMING, NEEDS ASSISTANCE            NO     02 ACTIVE          NO    NO   YES
8234 PROBLEM W/BOWEL ELIMINATION           NO     03 EVALUATING      YES   YES  NO
8023 MEALS, REQUIRES ASSISTANCE            NO     02 ACTIVE          NO    YES  YES
9137 PROBLEMS W/SLEEP                      NO     03 EVALUATING      YES   NO   NO
                              End of Report
```

BACKGROUND FILE DESCRIPTION UPDATE

The Background File Description Update function is a maintenance function you can run to clean up stray codes left after an Assessment file component has been deleted.

The file components linked to responses are:

- PCR codes
- Problems
- Plan of Care elements

The file component linked to an assessment is Assessment Orders.

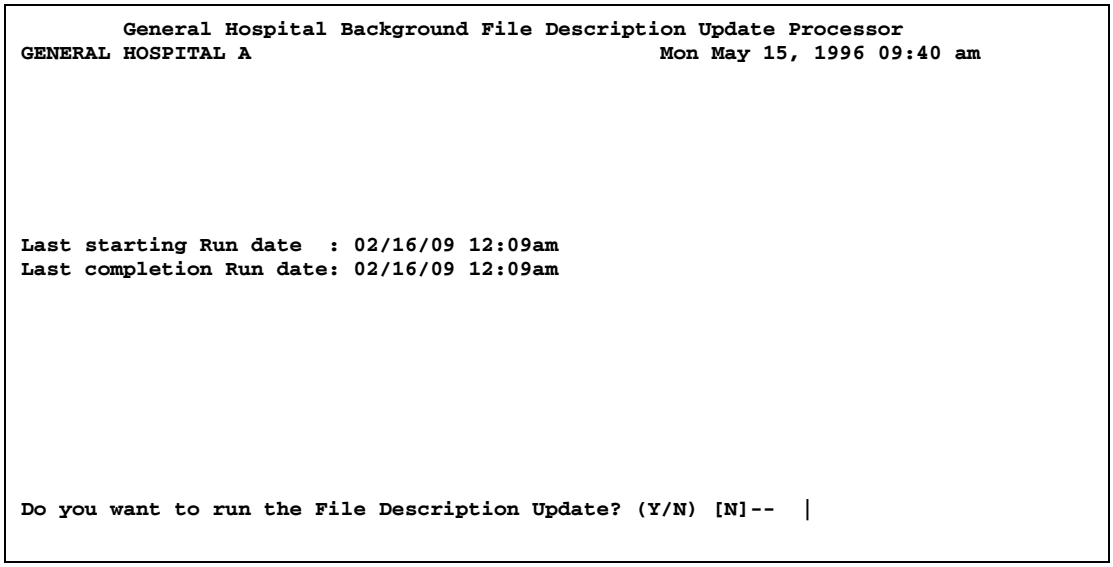
When you delete one of these components from their standard file (such as a Problem from the Build Problem List), the system deletes the file description in the Assessment files, but not the code. The system automatically runs maintenance on these codes either Daily or Weekly during midnight processing, depending on the Assessment Maintenance facility parameter. For more information refer to "USER-DEFINED TABLES" on page 2-4.

You can manually run the maintenance function using the Background File Description Update function. This enables you to clean up the codes between automatic maintenance runs. The program runs in the background and does not affect system operation.

To access this function from the Nursing Menu, select the following menu options:

1. Standard File Maintenance
2. Standard Assessments
3. Background File Description Update

A screen displays the dates and times of the last assessment maintenance update, including the starting and completion run dates and times:



The following prompt displays:

Do you want to run the File Description Update (Y/N) [N]--

Enter **Y** for Yes when you want to immediately update the codes/file descriptions throughout the system. The system beeps, tells you it is processing and redisplays the Standard Assessments menu. Enter **N** for No, or press ENTER, when you do not want to run the update. The system redisplays the Standard Assessment menu.

Impact

When you use the function to update the codes/file descriptions, the system deletes stray codes that do not have file descriptions.

Chapter 3 - PATIENT ASSESSMENT OUTPUT

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OVERVIEW

The Patient Assessment Module provides six reports to aid and track the assessment process:

- Assessment
- Assessment History
- Assessment History Summary
- Assessment Worksheet
- Problem List
- Problem List History

ASSESSMENT REPORT

The Assessment Report provides documentation of the patient's completed assessment for inclusion in the patient's chart. You can print assessments at any time during the patient's stay. You can print the most current assessment or you can print any previously entered assessment. The report can include an entire assessment or specific assessment groups.

ASSESSMENT HISTORY REPORT

The Assessment History Report provides a history of the patient's responses from one assessment to the next. The report lists all the questions and each response, including any changes or late entries. You can print the report for entire assessments or for specific assessment groups. The report begins with the date and time you enter and prints assessments performed through the current date/time.

ASSESSMENT HISTORY SUMMARY REPORT

The Assessment History Summary Report provides a list of only the changes that have been made to the patient's responses from one assessment to the next. This includes changes in questions, comments, and responses, including any late entries. The system includes the user's initials and the date/time of the change. You can print the changes for entire assessments or for specific assessment groups. The report begins with the date and time you enter and prints assessments performed through the current date/time.

PROBLEM LIST REPORT

The Problem List Report is a list of the patient's Problems and the current status of each Problem. The system automatically generates the Problem List from the

Problems that are linked to the patient's responses in the Assessment Standard Files. You can use the Problem List function on the Plan of Care Menu to manually add Problems to the list.

PROBLEM LIST HISTORY REPORT

The Problem List History Report lists the patient's Problems that have had a change in status. The system prints the date, time, and initials of the user who updated the status.

ASSESSMENT WORKSHEET

The Assessment Worksheet is a printed copy of an assessment that the caregiver can use when there is no PC at the bedside. The caregiver can use the assessment to gather information on the patient's status in a specific area. This report is also useful for teaching purposes. You can print one or more assessments and can include the comments as well.

Menu Access

You can access all Assessment report functions in two ways: from the Patient Print Menu and the Plan of Care Process Menu. In addition, you can print the Assessment Worksheet from the Station Print Menu. The following sections show you how to access the report functions from each menu.

MENU ACCESS FROM THE PATIENT PRINT MENU

You can print any of the reports using the Patient Print function. To access these report functions, select Patient Print from the Nursing main menu. The Patient Print menu displays, as in the following example:

```
                    General Hospital Patient Print Processor
                                                 Thu Mar 21, 1996 10:02 am
Patient Print Input Options

            Option No.  Option
            ---------------------------------------
                1       Patient Care Profile
                2       Nursing Plan of Care
                3       Care Reference Sheet
                4       Discharge Plan
                5       Discharge Summary
                6       PCP Nursing Notes
                7       Order History
                8       Custom Document Display/Print
                9       Print Patient Label
               10       Maternity Information Print
               11       Assessment
               12       Assessment History
               13       Assessment Worksheet
               14       Problem List
               15       Problem List History

Enter option number--
```

You can select any of the Assessment Report functions from this menu.

The following prompt displays when your station has secondary stations:

Enter station code--

Enter the code of the patient's nursing station. You canperform a table lookup to select from a list of the available stations.

The following prompt displays for you to select the patient:

Enter Station(S), '-' to list bed groups, or [list patients]--

You have three options:

- Enter **S** to print a report for every patient on the station.
- Enter a hyphen (-) to display a list of bed groups and print a report for each patient in a bed group.
- Press ENTER to display a list of the patients on the station. You can print a report for one or more patientsby entering the selection numbers at the prompt.

The screen displays for the report you select. The screen does not display patient header information at the top of the screen. Refer to the following pages for the report you want to print:

- “ASSESSMENT REPORT” on page 3-10

- “ASSESSMENT HISTORY REPORTS” on page 3-18
- “ASSESSMENT WORKSHEET” on page 3-29
- “PROBLEM LIST” on page 3-25
- “PROBLEM LIST HISTORY” on page 3-27

MENU ACCESS FROM THE STATION PRINT MENU

You can also access the Assessment Worksheet by selecting Station Print from the Nursing main menu. The Station Print menu displays, as shown on the following screen:

```
                General Hospital Station Print Processor
                                                Wed Jul 07, 2004 05:16 pm
Station Print Input Options

            Option No.  Option
            ----------------------------------------
                1       User Defined Worksheets
                2       General Worksheet
                3       Active Orders Worksheet
                4       ADL / Misc. Worksheet
                5       Assessment Worksheet
                6       Diet Worksheet
                7       Diet List
                8       Custom Document Display/Print
                9       Standard Plan of Care
               10       Update Bed Groups
               11       Print Bed Groups
               12       Uncollected Specimen List
               13       Incomplete Items
               14       Custom Worksheet
               15       Order Revision Audit
               16       Unknown Opt Out Preference Report
Enter option number--
```

Select the Assessment Worksheet option to print this report. The following prompt displays when your station has secondary stations:

Enter station code--

Enter the code of the patient's nursing station. You canperform a table lookup to select from a list of the available stations. The following prompt displays for you to select the patient:

Enter Station(S), '-' to list bed groups, or [list patients]--

You have three options:

- Enter **S** to print a report for every patient on the station.

- Enter a hyphen (-) to display a list of bed groups and print a report for each patient in a bed group.

- Press ENTER to display a list of the patients on the station. You can print a report for one or more patients by entering the selection numbers at the prompt.

The screen displays for the Assessment Worksheet. Refer to "ASSESSMENT WORKSHEET" on page 3-29 for specific information on the Assessment Worksheet.

MENU ACCESS FROM THE PLAN OF CARE PROCESS MENU

You can also access the Patient Assessment print options from the Plan of Care Process menu. To access these report functions, select Plan of Care Process from the Nursing main menu. The following screen prompts you to identify the patient for whom you want to print the report.

```
                  General Hospital Plan of Care Processor
                                                Fri Feb 27, 2009 04:22 pm

No   Pat No       Stn  Rm-Bed   Patient Name            Srvc      PC  Cnd
 1 A 89275-00005  ICU  ICU-04   Dennard,Eve T.          Med           S
 2 A 89307-00002  1E   2111-1  !Jones,John James        Car       BRD I
 3 A 89276-00008  ICU  ICU-01   Walton,Lamar            Lab           C
 4 A 89286-00003  IE   2110-2   Johnson,Molly           Med       VIP OPS
 5 A 89286-00002  ICU  ICU-02  *Smith,Sydni             Car           C









Select #--
```

The following prompt displays:

Enter acct #, '-'bed code, first chars of name'-' [2N Census]--
'C' for Census

You have the following options:

- Enter the patient's Account Number.

- Enter a hyphen (-) followed by the patient's bed code to perform a table lookup.

- Enter the beginning letters of the patient's name followed by a hyphen (-). The system displays a list of patients whose last names begin with these letters. Select the patient.

- Press ENTER to select the default nursing station's census of patients. The list of patients on the nursing station displays for your selection. The list includes the patient's first and last names and the room-bed occupied.

  This is the census of the primary nursing station of the CRT you are using.

- When your station has a secondary station, you can enter **C** to select a secondary station's census. You receive the following prompt:

  Enter station code [1E]--

  You can enter the secondary station or enter hyphen (-) to display a list of the available secondary stations. The primary nursing station is the default in the prompt. The census displays for the secondary station.

The following menu displays after you identify the patient.

```
                  General Hospital Plan of Care Processor
                                                    Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90247-00004   LINSKI,ELLEN      F  02/14/15 2R15-1  REINER,MICHAEENT 10 I/P 51
            Option No.  Option
            ---------------------------------------
                1       Defining Characteristics
                2       Patient Assessment
                3       Recommended Plan of Care/Outcomes
                4       Plan of Care
                5       Discharge/Exp Outcome
                6       Problem/Exp Outcome
                7       Discharge Plan
                8       Intervention/Treatments
                9       ADL's / Misc.
               10       Problem List
               11       Display Patient Care Profile

 Print         12       Patient Care Profile
               13       Nursing Plan of Care
               14       Assessment Reports

Enter option number--
```

Select Assessment Reports from the Print portion of the menu. The following prompt displays:

Select Assessment(A), Worksheet(W), Problem List(P) [A]--

Assessment History(H), Problem List History(L)

You have the following choices:

Type...	To print...
A	an Assessment Report.
W	an Assessment Worksheet.

Type...	To print...
P	a Problem List.
H	an Assessment History or Assessment History Summary.
L	a Problem List History.

The default is A for Assessment Report. The screen displays for the report you select. The screen displays patient header information at the top of the screen. Refer to the following pages for the report you want to print:

- “ASSESSMENT REPORT” on page 3-10
- “ASSESSMENT HISTORY REPORTS” on page 3-18
- “ASSESSMENT WORKSHEET” on page 3-29
- “PROBLEM LIST” on page 3-25
- “PROBLEM LIST HISTORY” on page 3-27

ASSESSMENT REPORT

The Assessment Report provides documentation of the patient's completed assessment for inclusion in the patient's chart. You can print the most current assessment, or you can print any previously entered assessments. The report can include the entire assessment or specific assessment groups.

The Assessment Report function enables you to print a report that includes all or some of the following assessment information:

- Problem List
- Assessment Orders (Active, Pending, and/or Completed)
- Precautions
- Assessment(s)
- Assessment Group(s)

You can print the Assessment Report using either of the following methods of menu access:

- Patient Print Menu
- Plan of Care Process Menu

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide*.

The Patient Print menu provides several Assessment report functions. Refer to "Menu Access from the Patient Print Menu" on page 3-4 for access procedures. The Plan of Care method of access displays patient header information at the top of the screen. Refer to "Menu Access from the Plan of Care Process Menu" on page 3-7 for the procedures.

After you access the appropriate Assessment function (Assessment from Patient Print menu, Assessment Report from Plan of Care menu) and enter the station, the following prompt is displayed:

Enter station (S), '-' to list bed groups or [2N Census]--

NOTE: This prompt also displays the following option, specific to the currently selected patient when you access Assessment from the Plan of Care menu:

'=' for NAME, PATIENT

When you identify a station or patient, the following screen displays, enabling you to select the information you want to print on the Assessment Report:

```
                        General Hospital Assessment Processor
Station: 1 EAST                                    Fri Dec 18, 2009 11:09 am



( 1)Problem List       :
( 2)Assessment Order   :
( 3)Active Orders      :
( 4)Pending Orders     :
( 5)Completed Orders   :
( 6)Precautions        :
( 7)External/Internal  :
( 8)Assessment         :
( 9)Assessment Group   :
(10)Print Question Desc:
(11)Number of Copies   :




Do you want to print the Problem List? (Y/N) [Y]--  |
```

Field Explanations

1. PROBLEM LIST (1-A-R)
This field enables you to designate whether or not you want the patient's Problem List to print on the Assessment Report. The following prompt displays:

Do you want to print the Problem List? (Y/N) [Y]--

Enter **Y** for Yes to print the Problem List on the report. Enter **N** for No when you do not want to include the Problem List.

2. ASSESSMENT ORDER (1-A-R)
This field enables you to designate whether or not you want to print Assessment Orders on the Assessment Report. The following prompt displays:

Do you want Assessment Orders to print? (Y/N) [Y]--

Enter **Y** for Yes to print assessment orders. The following fields enable you to designate whether or not you want to include active, pending, and/or completed assessment orders on the report. Enter **N** for No when you do not want to print the assessment orders. The system then skips the fields that enable you to select the types of assessment orders you want to print.

3. ACTIVE ORDERS (1-A-R)
This field enables you to designate whether or not you want to include assessment orders with an Active status. The following prompt displays:

Include Active Orders? (Y/N) [Y]--

Enter **Y** for Yes to print active orders. Enter **N** for No when you do not want to print the active orders.

4. PENDING ORDERS (1-A-R)
This field enables you to designate whether or not you want to include assessment orders with a Pending status. The following prompt displays:

Include Pending Orders? (Y/N) [Y]--

Enter **Y** for Yes to print pending orders. Enter **N** for No when you do not want to print the pending orders.

5. COMPLETED ORDERS (1-A-R)
This field enables you to designate whether or not you want to include assessment orders with a Completed status. The following prompt displays:

Include Completed Orders? (Y/N) [Y]--

Enter **Y** for Yes to print completed orders. Enter **N** for No when you do not want to print the completed orders.

6. PRECAUTIONS (1-A-R)
This field enables you to designate whether or not you want a list of the precautions to print on the Assessment Report. The following prompt displays:

Do you want precautions to print on the report? (Y/N) [Y]--

Enter **Y** for Yes to print the precautions. Enter **N** for No when you do not want to include precautions on the report.

7. EXTERNAL/INTERNAL (1-A-R)
This field enables you to specify that only External Assessment questions print. When you access the field, the following prompt displays:

Print internal (I) or external (E) assessment questions? [I]--

Enter **E** for External when you are going to give the patient a copy of printed assessment to exclude all assessment questions marked as Internal. If you want all questions to print, enter **I** for Internal. The default response is Internal. This field is required.

NOTE: Asterisks (*) print by the title of a report to indicate the presence of additional internal assessment questions and responses associated with the record.

Asterisks do not print if there are no internal assessment items linked to the patient's record.

8. ASSESSMENT (TABLE LOOKUP)

This field enables you to select one or all assessments to print on the report. When you access the Assessment field, the system displays an Assessment Menu like the following example:

```
                    General Hospital Assessment Processor
Station: 2 NORTH                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
92113-00001   ANDERSON,LANE     F  05/28/62 1203-2  CONROY,MARY MMED 10 IP1 282

                                Assessment Menu

 ( 1)NURSING HISTORY
 ( 2)SYSTEM REVIEW
 ( 3)WELLNESS ASSESSMENT
 ( 4)DIET REVIEW
 ( 5)CHEST PAIN ASSESSMENT









Enter Assessment to print or (NL) for all active [ALL]--
```

The following prompt displays:

Enter Assessment to print or (NL) for all active [ALL]--

You have two options:

- Press ENTER to print all active Assessments for the patient. If you print all assessments, the system displays ALL ACTIVE in the Assessment field. The system skips the Assessment Group and highlights the Print Question Desc field.

- Select a specific assessment from the list. If you select an assessment that is not active for the patient, the following error message displays:

  Error: Assessment Not Active on Patient!

  If you select an assessment to which you do not have access, the system displays the following error message:

  Error: Not allowed to select!

When you enter the specific assessment to print, the system enables you to choose the date of the assessment you want to print. The system displays assessment dates at the bottom of the Assessment Menu, as shown on the following screen:

```
                    General Hospital Assessment Processor
Station: 2 NORTH                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92113-00001   ANDERSON,LANE      F  05/28/62 1203-2  CONROY,MARY MMED 10 IP1 282

                                 Assessment Menu

 ( 1)NURSING HISTORY
 ( 2)SYSTEM REVIEW
 ( 3)WELLNESS ASSESSMENT
 ( 4)DIET REVIEW
 ( 5)CHEST PAIN ASSESSMENT



Page:01                           Assessment Dates
( 1) 2/23/93 1707
( 2) 2/23/93 0805
( 3) 2/22/93 2310

Select Assessment to print [current]--
```

Enter the selection number of the assessment date you want to print. The default Current is the most recent assessment. When you select an assessment other than the current assessment, the system prints the word Reprinted at the top of the Assessment Report to indicate it is a reprinted copy.

Once you select the assessment date, the system redisplays the Assessment Processor screen with the selected assessment and its corresponding date in the Assessment field.

9. ASSESSMENT GROUP (TABLE LOOKUP)

The Assessment Group function is only available if you have selected an individual assessment. All existing Assessment Groups for the selected patient assessment display in a lookup table along the bottom of the screen. The following prompt displays at the bottom of the table:

Enter choices (e.g. 1,3,7-9) or (NL) for all groups [ALL]--
and selection (NL)

You can select one or more of the groups listed in the table. The default is ALL. The following screen displays:

```
                  General Hospital Assessment Processor Station
                                                        Mon Jun 24, 1996 08:06 am


( 1)Problem List       : Yes
( 2)Assessment Order   : Yes
( 3)Active Orders      : Yes
( 4)Pending Orders     : Yes
( 5)Completed Orders   : Yes
( 6)Precautions        : Yes
( 7)External/Internal  : Internal
( 8)Assessment         : ADMISSION DATA BASE
( 9)Assessment Group   :
(10)Print Question Desc:

Page:01                          Assessment Groups             ##=Current Choices
( 1) SEXUAL/REPRODUCTIVE                    ( 5) ROLE-RELATIONSHIP PATTERN
( 2) COPING/STRESS TOLERANCE
( 3) VALUE/BELIEF
( 4) SEXUALITY/REPRODUCTIVE PATTERN

Enter choices (e.g. 1,3,7-9) or (NL) for all groups [ALL]--
                                 end selection(NL)
```

The Assessment Groups for this assessment display at the bottom of the screen.

NOTE: If there are no groups set up for this assessment, the prompt displays for you to accept the screen. You cannot select the Assessment Groups field since there are no groups set up for the assessment.

You have the following options when there are groups set up for the assessment:

- Select one or more Groups from the list. The system highlights the Groups you select. When you finish your selection(s), press ENTER.
- Press ENTER to print all Assessment Groups linked to the Assessment.
- Enter a slash (/) to view the next page of available Groups.

10. PRINT QUESTION DESC (1-A-R)
This field enables you to print only the descriptions for all included assessment questions. When you access this field, the following prompt displays:

Print file description only? (Y/N) [N]--

Enter **Y** for Yes, **N** for No. The default for this field is N.

11. NUMBER OF COPIES (1-N-O)
This field determines the number of copies to print. Each one prints as a separate report on the spooler or printer.

When you access this field, the system displays the following prompt:

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

After you complete you entries in the table, the system prompts you to press ENTER to accept the screen. The system beeps and displays the following message:

Processing!

The menu from which you accessed the Assessment Report function redisplays.

NOTE: When you print an assessment report for a maternity patient that includes Obstetric History Assessments in the print criteria, the assessments print in chronological order for each pregnancy/baby. The report indicates clearly which assessment is associated with which baby.

Impact

The report prints on the default printer for the CRT. Following is an example of an Assessment Report.

Figure 3.1 Assessment Report

```
                                  GENERAL HOSPITAL                          PAGE 1
04/02/96                          Assessment Report
--------------------------------------------------------------------------------
                                   Problem List
                           2  POTENTIAL PROBLEM WITH NUTRITION
                           5  POTENTIAL PROBLEM WITH COMPLIANCE
--------------------------------------------------------------------------------

                                 Assessment Orders
Active
    WELLNESS ASSESSMENT                              03/29/96 12:26pm
Pending
Completed
--------------------------------------------------------------------------------
                                WELLNESS ASSESSMENT
Dt/Tm Assessed: 02/16/09 06:50pm Damer,Mary T
 HEALTH PERCEPTION MANAGEMENT
  01 :How has your general health been?
      GOOD
  02 :In the past year have you had any health problems?
      YES :EXPLAIN Frequent sore throat with elevated temp.
  03 :What things do you do to stay healthy?
      EXERCISE & TAKE VITAMINS
  04 :Do you smoke?
      NO
  05 :Do you drink?
      NO
  06 :Do you take any medication (prescription or over-the-counter)?
      NO
  07 :Do you take drugs?
      NO
  09 :Have you had any accidents?
      NONE
  10 :In the past has it been easy to follow things doctors or nurses suggest?
      YES :EXPLAIN They provide written instructions to take home.









 ------------------------------------------
 Dx: TONSILLITIS                          |
 Alg: SULFA DRUGS                         |  Precautions:
 Iso:                        Smk: NO      |
 Sgy: 02/28/93              Type:  I/P    |
                                          |
 1207-1  0010-4533-5     89250-00002      |
 Adm : 02/27/93    Dob:  08/04/79   10Y   |
 Phys: ZELLER, JOHN T       Level: 1      |
 LANE, EMILY W                SEX: F      |
```

ASSESSMENT HISTORY REPORTS

You can use this function to print either the Assessment History Report or the Assessment History Summary Report:

- The Assessment History Report provides a history of the patient's responses. The report lists all the questions and each response, including changes. The report includes the user's initials and the date/time of each response.

- The Assessment History Summary Report provides a list of only the changes made to the patient's Assessment. This includes changes to questions, comments, and responses, as well as late entries. The report includes the user's initials and the date/time of the change.

For both reports, you can include the entire assessment or specific assessment groups. You can specify one or all assessments, as well as a period of days or hours for which to print the report. This is useful for documenting changes in the patient's condition.

You can print the Assessment History Reports using either of the following methods of menu access:

- Patient Print Menu

- Plan of Care Process Menu

The Patient Print menu provides several Assessment report functions. Refer to "Menu Access" on page 3-4 from the Patient Print Menu for access procedures. The Plan of Care method of access displays patient header information at the top of the screen. Refer to "Menu Access from the Plan of Care Process Menu" on page 3-7 for the procedures.

When you identify a station or patient, the following screen displays, enabling you to select either the History or History Summary Report:

```
                  General Hospital Assessment Reports Processor
Station: 1 EAST                                    Fri Dec 18, 2009 11:22 am



( 1)Changes since      :
( 2)Questions Include  :
( 3)External/Internal  :
( 4)Assessment         :
( 5)Assessment Group   :
( 6)Print Question Desc:
( 7)Number of Copies   :









Include changes since date [ALL]--
```

Field Explanations

1. CHANGES SINCE (DATE-R)
This field enables you to specify the date(s) for which you want to print the changes made to the patient's assessment. The following prompt displays:

Include changes since date [ALL]--

You have the following options:

- Enter the date with which you want the report to start. When you do not enter a time, the system enters a time of zero (0:00) and prints the changes from midnight on the date.
- Enter the date and the time. By entering the time, you can limit the report to include only the hours from the date/time you enter.
- Press ENTER to select the default, All. This selection prints the changes to the assessment for all dates since admission.

2. QUESTIONS INCLUDE (1-A-R)
You can specify the types of questions you want to include. The following prompt displays:

Include All(A) or Changed(C) questions [C]--

This field selects the report you want to print.

Enter **A** to print the Assessment History Report. This report includes all questions, responses, and comments, along with any changes or late entries.

Enter **C** to print the Assessment History Summary Report. This report includes only the questions, responses, or comments that changed from the date you entered in the Changes Since field through the current date. The report also includes late entries.

3. EXTERNAL/INTERNAL (1-A-R)
This field enables you to specify that only External Assessment questions print. When you access the field, the following prompt displays:

Print internal (I) or external (E) assessment questions? [I]--

Enter **E** for External when you are going to give the patient a copy of printed assessment to exclude all assessment questions marked as Internal. If you want all questions to print, enter **I** for Internal. The default response is Internal.

NOTE: Asterisks (*) print by the title of a report to indicate the presence of additional internal assessment questions and responses associated with the record. Asterisks do not print if there are no internal assessment items linked to the patient's record.

4. ASSESSMENT (1-N-R)
This field enables you to select one or all assessments to print on the report. When you access the Assessment field, the system displays an Assessment Menu:

```
                General Hospital Assessment Reports Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
9607300001    SMITH,MARTHA      F  01/01/70 4302-02 SMITH,JOANNA OBS 10 OB  9

                                 Assessment Menu

 ( 1) MATERNITY ASSESSMENT
 ( 2) NURSING HISTORY
 ( 3) WELLNESS ASSESSMENT
 ( 4) DIET REVIEW









Enter Assessment to print or (NL) for all active [ALL]--
```

You have two options:

- Press ENTER to print all active assessments. If you print all Assessments, the system displays ALL ACTIVE in the Assessment field and prompts you to accept the screen. When you Press ENTER, the system beeps and displays the message *Processing!*.

- Select a specific assessment from the list. When you select an Assessment to which you do not have access, the system displays the following error message:

  Error: Not allowed to select!

Once you select the assessment, the system redisplays the Assessment Reports screen for you to select the Assessment groups you want to print.

5. ASSESSMENT GROUP (2-N-R)
The Assessment Groups for this assessment display at the bottom of the screen, as shown on the following screen:

```
                General Hospital Assessment Reports Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9607300001    SMITH,MARTHA       F  01/01/70 4302-02 SMITH,JOANNA OBS 10 OB  9
 ( 1)Changes since      : ALL
 ( 2)Questions Include  : Changed
 ( 3)External/Internal  : Internal
 ( 4)Assessment         : MATERNITY ASSESSMENT
 ( 5)Assessment Group   :
 ( 6)Print Question Desc:



 Page:01                          Assessment Groups             ##=Current Choices
 ( 1) MATERNITY GROUP


 Enter choices (e.g. 1,3,7-9) or (NL) for all groups [ALL]--
                                      end selection(NL)
```

NOTE: If there are no groups set up for this assessment, the prompt displays for you to accept the screen. You cannot select the Assessment Groups field since there are no groups set up for the assessment.

You have the following options:

- Select one or more Groups from the list. The system highlights the Groups you select and displays the selections in the middle of the screen. When you finish your selection, press ENTER.

- Press ENTER to print all Assessment Groups linked to the Assessment. The word ALL displays in the Assessment Group field.

- Enter a slash (/) to view the next page of available Groups.

6. PRINT QUESTION DESC (1-A-R)
This field enables you to print only the descriptions for all included assessment questions. When you access this field, the following prompt displays:

Print file description only? (Y/N) [N]--

Enter **Y** for Yes, **N** for No. The default for this field is N.

7. NUMBER OF COPIES (1-N-O)
This field determines the number of copies to print. Each one prints as a separate report on the spooler or printer.

When you access this field, the system displays the following prompt:

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

After you complete you entries in the table, the system prompts you to press ENTER to accept the screen. The system beeps and displays the following message:

Processing!

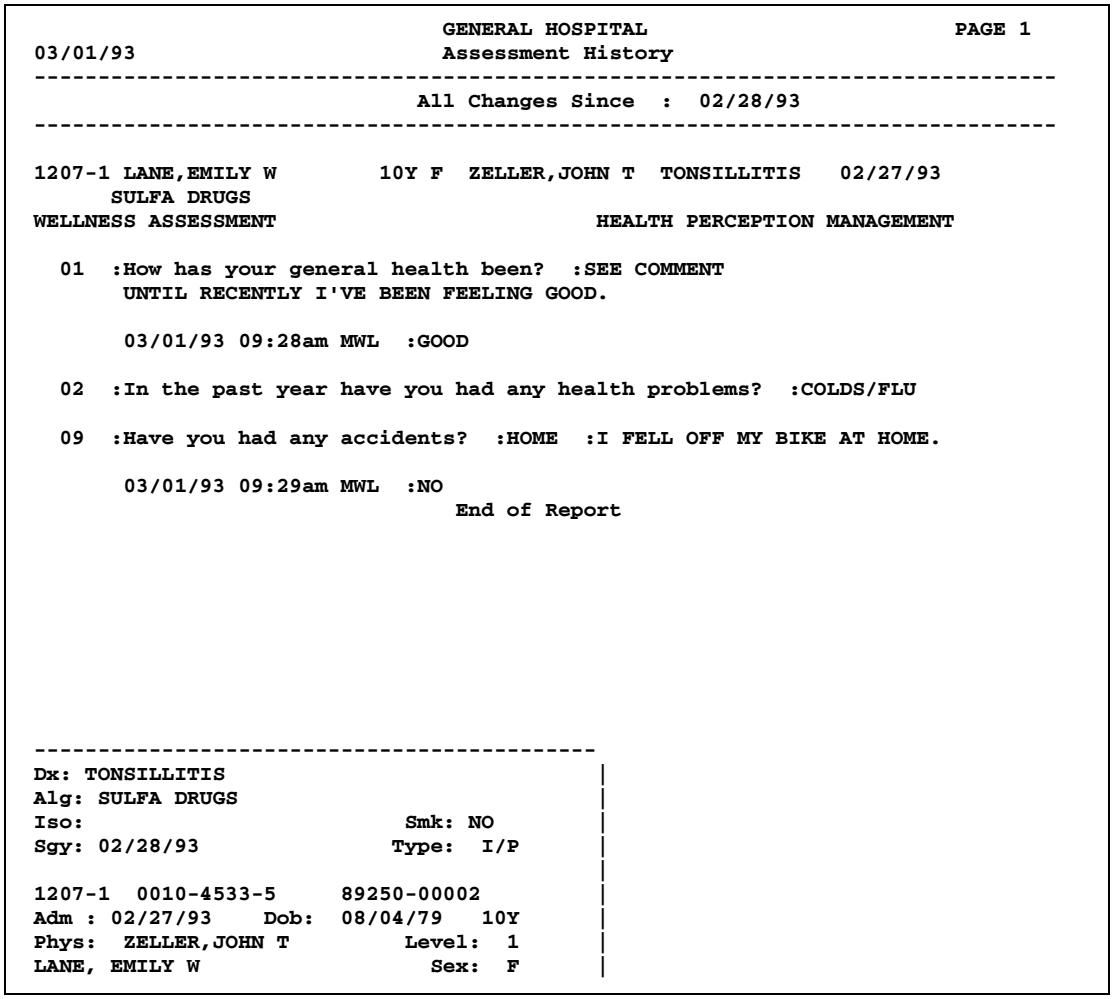
The menu from which you accessed the Assessment History function redisplays.

Impact

The report prints on the default printer for the CRT. The most recent response displays below the question with the date and time whether or not the user is different. The user initials display for the response only when the user is different from the user who last completed the assessment.

Following are examples of an Assessment History Report and an Assessment History Summary Report.

Figure 3.2 Assessment History Report



```
                              GENERAL HOSPITAL                          PAGE 1
03/01/93                      Assessment History
-------------------------------------------------------------------------------
                           All Changes Since  :  02/28/93
-------------------------------------------------------------------------------

1207-1 LANE,EMILY W        10Y F  ZELLER,JOHN T  TONSILLITIS   02/27/93
      SULFA DRUGS
WELLNESS ASSESSMENT                          HEALTH PERCEPTION MANAGEMENT

  01  :How has your general health been?  :SEE COMMENT
       UNTIL RECENTLY I'VE BEEN FEELING GOOD.

       03/01/93 09:28am MWL  :GOOD

  02  :In the past year have you had any health problems?  :COLDS/FLU

  09  :Have you had any accidents?  :HOME  :I FELL OFF MY BIKE AT HOME.

       03/01/93 09:29am MWL  :NO
                                 End of Report









-------------------------------------------
Dx: TONSILLITIS                            |
Alg: SULFA DRUGS                           |
Iso:                          Smk: NO      |
Sgy: 02/28/93                Type:  I/P    |
                                           |
1207-1  0010-4533-5     89250-00002        |
Adm : 02/27/93    Dob:  08/04/79   10Y     |
Phys:  ZELLER,JOHN T         Level:  1     |
LANE, EMILY W                  Sex:  F     |
```

Figure 3.3 Assessment History Summary

```
                                  GENERAL HOSPITAL                          PAGE 1
 05/17/93                      Assessment History Summary
 ------------------------------------------------------------------------------

                               ADMISSION HISTORY DATA
Dt/Tm Assessed: 02/16/09 8:32 Miller,John H
SECTION 1
  04 :Where was the patient admitted from?
      OTHER :PATIENT LIVES IN A HIGH RISE FOR SENIOR CITIZENS.
      05/15/93 16:20 #33220 : Lives at home with daughter.
                                  End of Report




 ---------------------------------------------
 Dx: TONSILLITIS                             |
 Alg: SULFA DRUGS                            |
 Iso:                          Smk: NO       |
 Sgy: 02/28/93                Type:  I/P     |
                                             |
 1207-1  0010-4533-5     89250-00002         |
 Adm : 02/27/93    Dob:  08/04/79   10Y      |
 Phys:  ZELLER,JOHN T          Level:  1     |
 LANE, EMILY W                   Sex:  F     |
```

PROBLEM LIST

The Problem List is a list of the patient's Problems and the current status of each Problem. The hospital defines the valid statuses, which can include statuses such as Active, Resolved, and Evaluating.

The system automatically generates the Problem List from the Problems that are linked to the patient's responses in the Assessment Standard Files. You can use the Problem List function on the Plan of Care Menu to manually add Problems to the list. See "Chapter 1 - PATIENT ASSESSMENT PROCESS" for information on how to add a Problem to the Problem List.

You can print the Problem List using either of the following methods of menu access:

- Patient Print Menu
- Plan of Care Process Menu

Refer to "Menu Access" on page 3-4 for the procedures.

After you enter the station and identify the patient, the following prompt is displayed:

Enter number of copies to print (1/5) [1]-- |

Enter the number of copies you want. The system displays the following prompt:

Print Problem list? (Y/N) [Y]--

Enter **Y** for Yes or press ENTER to print the report for the patient.

The message *Processing!* displays. Enter **N** for No when you do not want to print the list.

Impact

The report prints on the default printer for the CRT. Following is an example of a Problem List Report.

Figure 3.4 Problem List Report

```
                                GENERAL HOSPITAL                          PAGE 1
03/01/93                      Patient Problem List
-------------------------------------------------------------------------------
        Problem #                Problem Description                Status
-------------------------------------------------------------------------------

          01                     DEAF                               Active
          03                     LEGALLY BLIND                      Active
          04                     PROBLEM WITH MOBILITY              Evaluating

-------------------------------------------------------------------------------









-------------------------------------------
Dx: TONSILLITIS                           |
Alg: SULFA DRUGS                          |
Iso:                          Smk: NO     |
Sgy: 02/28/93                Type:  I/P   |
                                          |
1207-1  0010-4533-5     89250-00002       |
Adm : 02/27/93    Dob:  08/04/79   10Y    |
Phys:  ZELLER,JOHN T         Level:  1    |
LANE, EMILY W                  Sex:  F    |
```

PROBLEM LIST HISTORY

The Problem List History prints a list of the patient's Problems and includes any change in status. The hospital defines the valid statuses, which can include statuses such as Active, Resolved, and Evaluating. The system prints the date, time, and initials of the user who updated the status.

You can print the Problem List History using either of the following methods of menu access:

- Patient Print Menu
- Plan of Care Process Menu

Refer to "Menu Access" on page 3-4 for the procedures.

After you enter the station and identify the patient, the following prompt is displayed:

Enter number of copies to print (1/5) [1]-- |

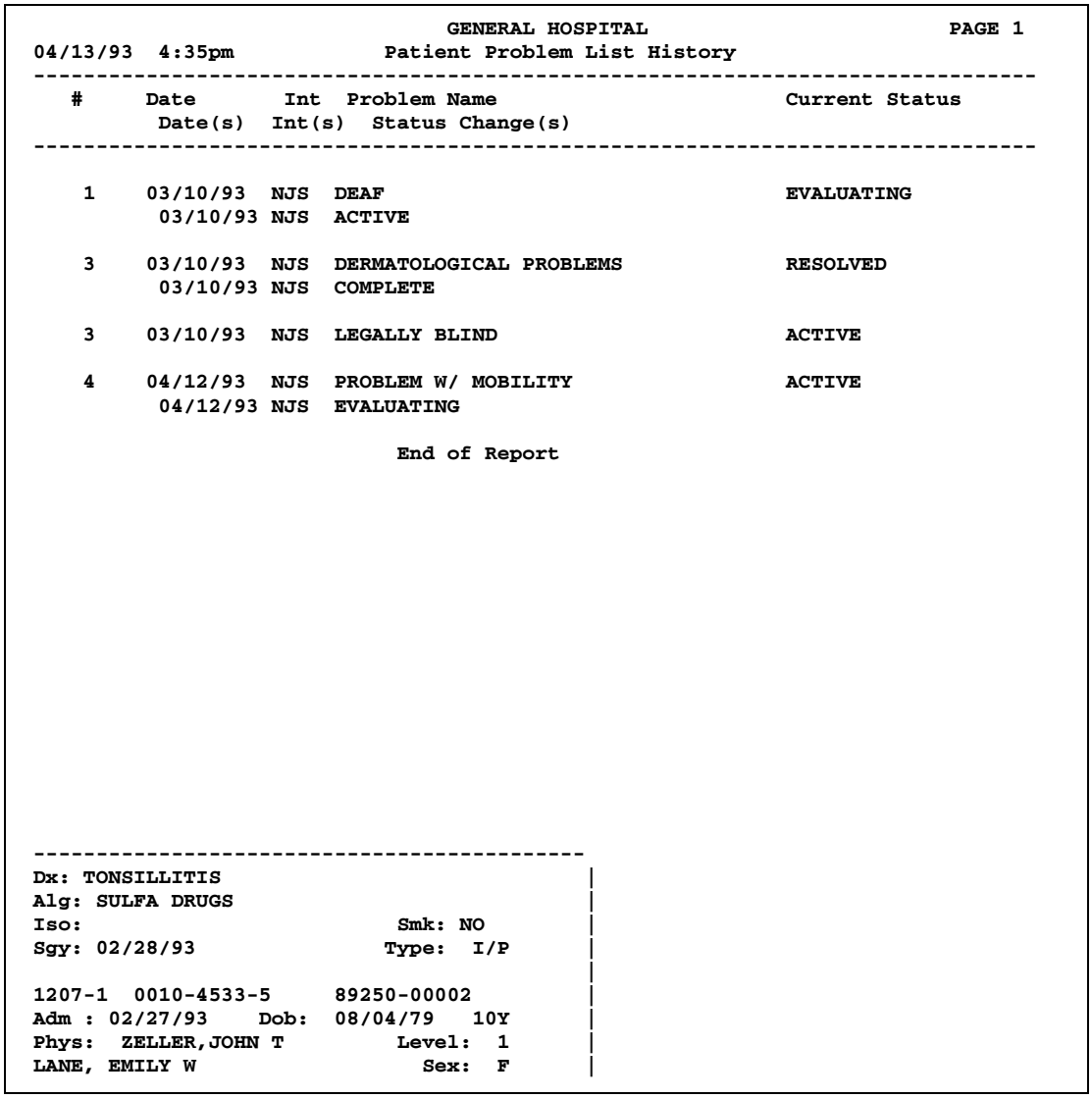
Enter the number of copies you want. The system displays the following prompt:

Print Problem list? (Y/N) [Y]--

Enter **Y** for Yes or press ENTER to print the report for the patient. The message *Processing!* displays. Enter **N** for No when you do not want to print the list.

Following is an example of a Problem List History.

Figure 3.5 Problem List History Report



```
                                GENERAL HOSPITAL                          PAGE 1
04/13/93  4:35pm            Patient Problem List History
-------------------------------------------------------------------------------
   #     Date        Int  Problem Name                          Current Status
          Date(s)  Int(s)  Status Change(s)
-------------------------------------------------------------------------------

    1    03/10/93  NJS  DEAF                                   EVALUATING
          03/10/93 NJS  ACTIVE

    3    03/10/93  NJS  DERMATOLOGICAL PROBLEMS                RESOLVED
          03/10/93 NJS  COMPLETE

    3    03/10/93  NJS  LEGALLY BLIND                          ACTIVE

    4    04/12/93  NJS  PROBLEM W/ MOBILITY                    ACTIVE
          04/12/93 NJS  EVALUATING

                             End of Report

-------------------------------------------
Dx: TONSILLITIS                           |
Alg: SULFA DRUGS                          |
Iso:                          Smk: NO     |
Sgy: 02/28/93                Type:  I/P   |
                                          |
1207-1  0010-4533-5     89250-00002       |
Adm : 02/27/93    Dob:  08/04/79   10Y    |
Phys:  ZELLER,JOHN T         Level:  1    |
LANE, EMILY W                  Sex:  F    |
```

ASSESSMENT WORKSHEET

The Assessment Worksheet is a printed copy of an assessment that the caregiver can use when there is no access to a bedside PC. The caregiver uses the worksheet to gather information on the patient's status in a specific area. The caregiver can enter the information from the worksheet into the PC on the nursing station at a convenient time. You can print one or more assessments and can include the comments as well.

You can print the Assessment Worksheet using any of the following methods of access:

- Patient Print Menu
- Station Print Menu
- Plan of Care Process Menu

The Plan of Care method of access displays patient header information at the top of the screen. Refer to "Menu Access" on page 3-4 for the procedures to access.

After you access the function, the system displays an Assessment Menu:

```
                  General Hospital Assessment Worksheet Processor
Station: 2 NORTH                                        Mon Mar 04, 1996 10:24 am

                                  Assessment Menu

 ( 1)NURSING HISTORY
 ( 2)SYSTEM REVIEW
 ( 3)WELLNESS ASSESSMENT
 ( 4)DIET REVIEW
 ( 5)CHEST PAIN ASSESSMENT









Enter Assessment to print or (NL) for all active [ALL]--
```

You have the following options:

- Press ENTER to print all active assessments. If you print all Assessments, the system displays ALL ACTIVE in both the Assessment and Assessment Group fields and prompts you to accept the screen. When you press ENTER, the system beeps and displays the message *Processing!*.
- Select a specific Assessment from the list.

When you select an assessment to which you do not have access, the system displays the following error message:

Error: Not allowed to select!

If you select a specific assessment, the system displays Assessment Groups, as shown on the following screen:

```
                  General Hospital Assessment Worksheet Processor
Station: 2 NORTH                                        Fri Dec 17, 2009 10:24 am

 ( 1)Assessment       :NURSING HISTORY
 ( 2)Assessment Group :
 ( 3)Print comments   :
 ( 4)Number of Copies :









Page:01                       Assessment Groups                  ##=Current Choices
( 1) HEALTH PERCEPTION MANAGEMENT             ( 6) COGNITIVE/PERCEPTUAL
( 2) NUTRITIONAL/METABOLIC                    ( 7) SELF PERCEPTION/SELF CONCEPT
( 3) ELIMINATION                              ( 8) ROLE/RELATIONSHIP
( 4) ACTIVITY/EXERCISE                        ( 9) COPING/STRESS TOLERANCE
( 5) SLEEP/REST                               (10) VALUE/BELIEF

Select Groups to print or (NL) for all groups [ALL]--
                         end selection(NL)  next page(/)
```

You have the following options:

- Select one or more Groups from the list. The system highlights the Groups you select. When you finish, press ENTER.
- Press ENTER to print all Assessment Groups linked to the assessment.
- Enter a slash (/) to view the next page of available Groups.

After you select Assessments and/or Assessment Groups, or if there are no Groups set up for this assessment, the system displays the following prompt:

Print question comments? (Y/N) [Y]--

Enter **Y** for Yes, press ENTER, to print question comments on the Assessment Worksheet. Enter **N** for No when you do not want to include comments on the Assessment Worksheet. The system displays the following prompt:

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

After you accept the screen, the system beeps and displays the message *Processing!*. The menu you used to access the function redisplays.

Following is an example of an Assessment Worksheet.

Figure 3.6 Assessment Worksheet

```
                                GENERAL HOSPITAL                          PAGE 1
03/01/93                    Patient Assessment Worksheet
-------------------------------------------------------------------------------
                         WELLNESS ASSESSMENT
HEALTH PERCEPTION MANAGEMENT

   01 :How has your general health been?
       GOOD                     FAIR                          POOR
       EXCELLENT                SEE COMMENT
       :
       :
       :

   02 :In the past have you had any health problems?
       NO PROBLEMS              COLDS/FLU                     ABSENCES FROM WORK
       OTHER                                :
       :
       :

   03 :What things do you do to stay healthy?
       EXERCISE                 NOTHING                       FAMILY REMEDIES
       TAKE VITAMINS            SEE COMMENT
       :
       :
       :

   04 :Do you smoke?
       NO                       YES
       :How much?
       :
       :

   05 :Do you drink?
       NO                       YES
       :How much?
       :
       :
```

```
-------------------------------------------
Dx: TONSILLITIS                            |
Alg: SULFA DRUGS                           | Precautions:
Iso:                          Smk: NO      |
Sgy: 02/28/93                Type:  I/P    |
                                           |
1207-1  0010-4533-5     89250-00002        |
Adm : 02/27/93    Dob:  08/04/59   30Y     |
Phys:  ZELLER,JOHN T          Level:  1    |
LANE, EMILY W                   Sex:  F    |
```

ASSESSMENT ORDER NOTICE

The Order Notice provides the nurse with a printed form at the nursing station and serves to remind the nurse that the assessment is due. The printing of the Order Notice is an option specific to each assessment. The system provides the option to print the notice when the nurse adds the order (refer to Reviewing a Completed Order in "Chapter 1 - PATIENT ASSESSMENT PROCESS" for information on the Order Detail Screen).

Impact

The Order Notice prints automatically on the nursing station printer, at the order times specified during order entry. Following is an example of an Order Notice.

Figure 3.7 Assessment Order Notice

```
Assessment Notice: 05/17/93 09:09am       Printer: 2 North Census and Messages
                                                Status: Order

Stn: 2N            ADM : 05/14/93
Bed: 1202-1        Phys: HART, JOHN

TAYLOR,THELMA            91236-00001        Sex: F         BD:02/14/33   58Y
Dx: 239.6-BRAIN NEOPLASM NOS
SGY:

Assessment Order:  REVIEW OF SYSTEMS (GRP)         Priority: TIMED
    Request Date: 05/17/93
    Request Time: 03:00pm

Order Date : 05/17/93   Order Time: 09:08am   Ordering Int: MWL   CRT: 2 North
Recurring  : No         Stop Date :           Stop Time   :
```

Appendix A - INFORMATION WINDOWS

INFORMATION WINDOWS A-3
Patient Information A-4
Physician Information A-5
Pharmacy Profile A-6
Patient Preparation Instructions A-7

INFORMATION WINDOWS

You can display the Patient Information, Physician Information, and Pharmacy Profile Information Windows if you meet the following criteria:

- You must be using McKesson's WEM product on an IBM-compatible personal computer
- Your PC and host ID computer must be set up to enable the use of Information Windows

For more information about using Information Windows, refer to the *WEM User's Guide*.

Information Windows displaying patients' medical information, physicians of record, and pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in these functions. During the download process, the system displays the following message:

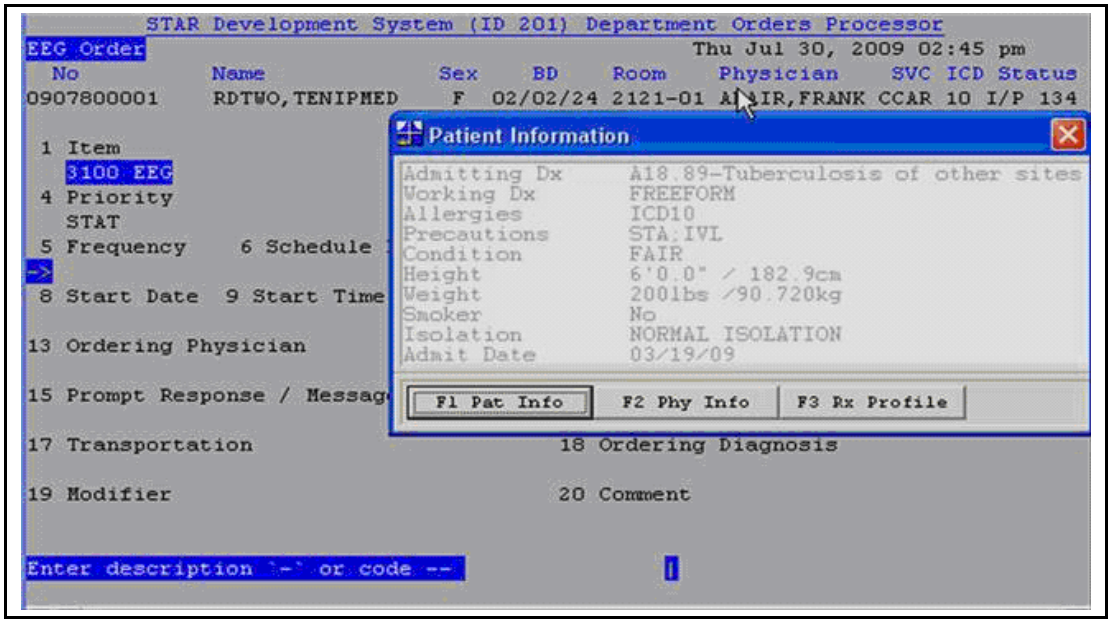
Downloading Information Windows...Please Wait!

NOTE: Pharmacy information is only available when STAR Pharmacy is in the system network.

The information is cleared when you select a different patient in one of the functions where Information Windows are available or when you access a different function from the Nursing menu.

Patient Information

To view the following Patient Information window, select **Tools**, **Information Windows** from the menu bar.



The Patient Information Window is displayed on the right side of the screen. The patient's medical data is displayed, which includes the following:

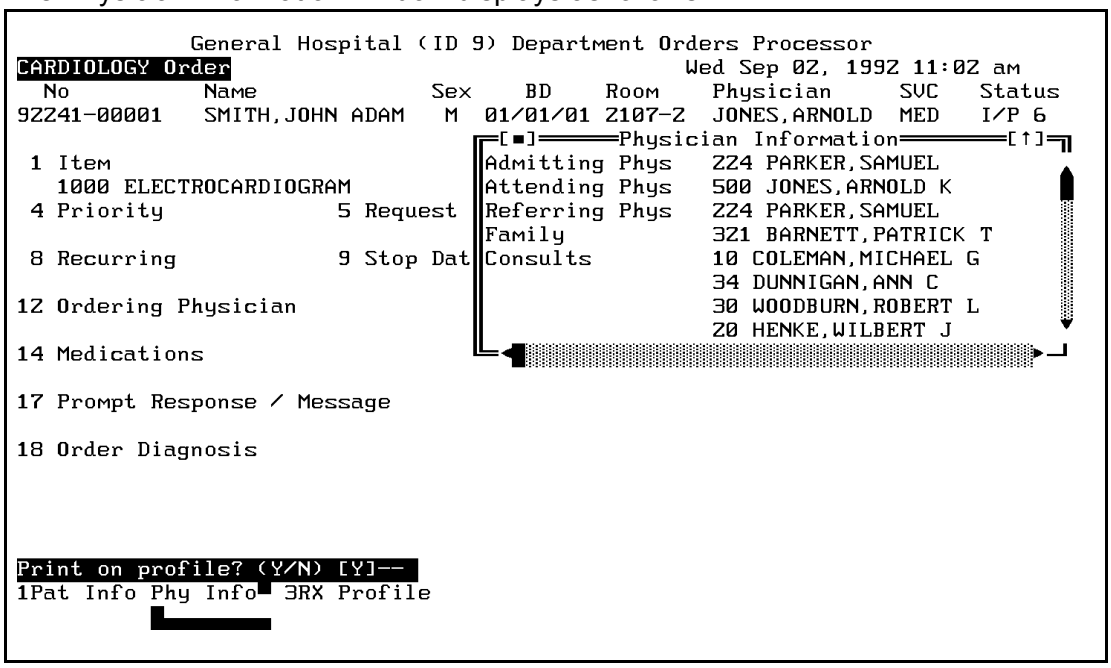
• Admitting diagnosis	• Height
• Working diagnosis	• Weight
• Logged allergies	• Smoking status
• Precautions	• Isolation
• Condition	• Admit date

To scroll through the available information, press the Up Arrow, or Down Arrow key. Press the ESC key to exit Information Windows, F2 to view the Physician Information Window, or F3 to view the Pharmacy Profile Information Window.

For more information about using Information Windows, refer to the *WEM User's Guide*.

Physician Information

The Physician Information window displays as follows:



Notice that the Phys Info option in the lower left corner is highlighted. The Physician Information Window displays on the right side of the screen under the patient demographic information. The following physicians are displayed (if they are logged):

- Admitting Physician
- Attending Physician
- Referring Physician
- Family Physician
- Consulting Physicians

When applicable, you can press the Up Arrow or Down Arrow key to scroll through the physicians of record. Press the ESC key to exit Information Windows, F1 to view the Patient Information Window, or F3 to view the Pharmacy Profile Information Window.

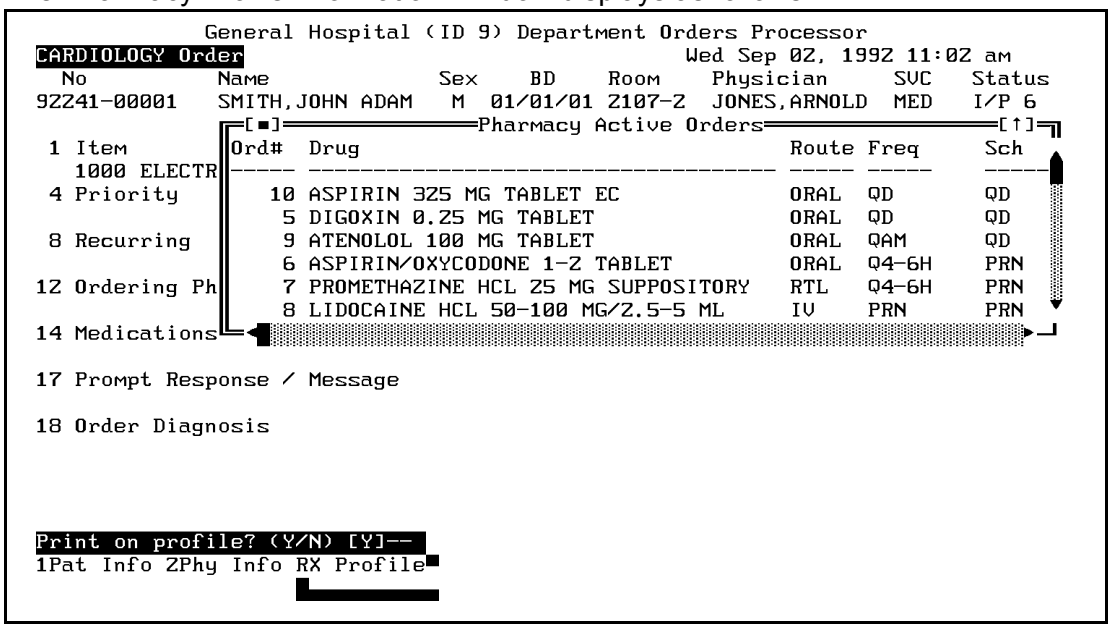
If the patient has more consulting physicians than can display in the Information Window, the system notifies you on the last line with the following message:

More Consultants...see Revise Patient - Physician

For more information about using Information Windows, refer to the *WEM User's Guide*.

Pharmacy Profile

The Pharmacy Profile Information Window displays as follows:



Notice that the Rx Profile option in the lower left corner is highlighted. The Pharmacy Profile Information Window displays on the right side of the screen under the patient demographic information. The Pharmacy Profile Information Window information includes the following:

- Medication order number
- Drug information
- Drug administration route
- Drug administration frequency
- Drug schedule

The drug information includes the formulary name, the strength of the drug, and the dosage form.

NOTE: The Rx Profile Information Window does not display when STAR Pharmacy is not in the system network.

If a patient has more active orders than can display in the Information Window, the system displays the following message:

*** INCOMPLETE LIST ** Use Profile Inquiry for a complete display.*

When you access a patient who does not have any active pharmacy orders, the following message displays:

No active orders for selected account.

When applicable, you can press the Up Arrow or Down Arrow key to scroll through the active medication orders. Press the ESC key to exit Information Windows, F1 to view the Patient Information Window, or F2 to view the Physician Information Window.

For more information about using Information Windows, refer to the *WEM User's Guide*.

Patient Preparation Instructions

The new Preps information window contains patient preparation instructions from up to three sources:

- The STAR Radiology Patient Preparation Instructions function, usually found on the Radiology system's Order Management menu. Information entered here appears in the window under the heading <Dept>-Defined Preps, where <Dept> is actually a STAR Radiology department code, like RAD.
- The STAR Scheduling SIM Item Scheduling Instructions function, usually found on Scheduling's Resource Maintenance menu. Information entered here appears in the window under the heading Scheduling Instructions.
- The STAR Nursing Preps and Special Instructions function, usually found on STAR Nursing's Standard File Maintenance menu. Information entered here appears in the window under the heading Nursing Preps.

Throughout the Scheduling application, the information window indicator appears in one of three situations:

- When a screen displays a SIM item with a defined prep in the Visit Reason field
- When the Visit Reason field is revised to include a SIM item with a defined prep
- When a single SIM item with a defined prep is selected from a table

The Preps information window can be accessed in the following STAR Scheduling processors:

- Appointments
- Walk-in
- Copy Appointment

- Revise Patient Appointment
- Patient Appointment Inquiry/Audit
- Check In/Out
- Resource/Department Schedule (on the Schedule Census menu)

For more information regarding Information Windows, refer to the *WEM User's Guide*.

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■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Patient Assessment Module* of the *STAR Patient Care Reference Guide* for Release 17.0.

Topic	Poor	Fair	Good	Excellent
Organization of information				
Accuracy of information				
Completeness of information				
Clarity of information				
Amount of overview information				
Explanation of processes				

Are there parts of this manual that could be made more helpful to you? Please explain.

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Other Comments:

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5995 Windward Parkway
Alpharetta, GA 30005

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