Psychiatric Emergency Assessment & Treatment - Assessment and Documentation Guidelines with CST Cerner

Site Applicability

Lions Gate Hospital Emergency Department

Basic: RPN, RN

Requirements

Documentation of assessments, as outlined in this guideline, must be completed in Cerner.

Need to Know

This guideline outlines the expectations for documentation and assessments for patients of various acuities in the psychiatric emergency and assessment zone. This guideline is not for use during downtime (see downtime procedures used during Code Grey).

Quick Links

Guideline

Vital Sign and Focused Assessment Frequency

Vital signs are done based on clinical judgment and according to CTAS reassessment guidelines.

Vital Sign and Focused Assessment Frequency

Role	Frequency	Head-to-toe	Focused Assessment*
Upon Arrival			
Nursing	Upon arrival	Full head-to-toe	N/A
Reassessment			
Nursing	Patient waiting to be seen by physician	Per Canadian Triage & Acuity Scale (CTAS) Reassessment Guidelines: • CTAS 2 q15min; • CTAS 3 q30min; • CTAS 4 q60min; • CTAS 5 q120min	Focused reassessment and vital signs to be completed based on clinical judgement, document in IView
Ongoing			
Nursing	If medically cleared and primary presentation is Mental Health Substance Use (MHSU) then **once per shift,** if not then as per orders.	As indicated	q 1-2h, document in IView

**focused assessment* is a detailed nursing assessment of specific body system(s) related to the chief complaint or presenting problem

Triage

All patients will be seen in Triage prior to coming to the PEAT zone.

PEAT Care

Requirements

Complete the following upon arrival:

- A complete head-to-toe under **ED Adult (or Pediatrics) Systems Assessment - Adult** form
- **Mental Health Emergency Nursing Assessment**
- A Mental Status Exam (MSE) (as part of the **Mental Health Emergency Nursing Assessment**).

- **ED Screening** - Adult (or Pediatrics)
- Columbia Suicide Screen (**CSSRS brief screen**)
- Vital Signs, if it has been over an hour since triage

Complete the following after arrival:

- Ongoing MSE assessments in **Interactive View (iView)** upon shift change and/or more frequently per clinical judgement.

Topic	Where to find in Cerner	Complete
Applicable areas		PEAT

Documentation Frequency	Located under **iView** as separate banners	Documentation should be done for all patients in an acute area **q1-2hrs**, and should include any of the following:
		• Completing the initial assessment
		• Documenting the **ED Adult Assessment** under one of the following areas:
		  ○ ED Initial Assessment
		  ○ Clinical comment
		  ○ Annotations or Flagged annotations
		  ○ *Any* applicable section of **iView** other than Vital Signs
		• Documenting an intervention in ED Adult/Pediatric Interventions or **ED Lines**
		
		Safety and Attendance as per observation level (i.e. q15min to q30min as per clinical presentation and acuity). Q15min when patient on seclusion.
		
		Nursing Narrative Note for:
		• Ongoing summary of patient's care during shift. To be done per shift. Use naming convention *Date* and *Time.* (i.e. June 30 0730-1530)
		• Seclusion min. q2hr and any entry / interventions (see restraints section below)
		
		Documentation is based on observation level and may increase with any significant change in presentation as per clinical judgement.
		
		Vitals signs by itself is not considered ongoing documentation

Adding Annotations	Located in **iView** under *Quick View* or *Systems Assessment*	Used when: • A subjective report on the patient's status is to be documented at regular intervals during the patient's stay ○ Used to clearly highlight the patient's condition *or* to provide additional documentation to the focused assessment • Patient is taken to or transported to another area of the ED, or when transfer of accountability (TOA) occurs Use **Flagged Annotations** when there is a critical event or acute changes to patient's status.

Head-to-Toe Assessment	Under **ED Assessment - Adult** form
	Relevant iView banners
		Document a complete head-to-toe assessment on arrival and as needed.
		
		The minimum requirements for head-to-toe are:
		• Primary Airway Assessment
		  ○ Airway patency
		• Respiratory
		  ○ Respiratory assessment
		  ○ Respiratory sounds
		• Cardiovascular
		  ○ Cardiac assessment
		  ○ Heart sounds
		  ○ Edema
		• Neurological
		  ○ Glasgow Coma Scale (GCS)
		  ○ +/- Level of Consciousness (LOC)
		  ○ Pupils
		  ○ Hand grips
		  ○ Leg strength
		• Gastrointestinal
		  ○ Abdominal sounds
		  ○ Abdominal assessment
		  ○ Last bowel movement
		• Genitourinary
		  ○ Urinary assessment
		  ○ Last urinary assessment
		  ○ Last menstrual period (for females of child-bearing age)

Allergies	Under **Allergies**	Verify allergies (even if it was checked at triage), update allergy band as needed

Medical History	Under **Diagnoses and Problems**	Review medical history recorded in triage.
Screening	**Screening tool** list Under *AdHoc* tab	On arrival, complete the **ED Screening - Adult (or Pediatrics)**, including: • Falls risk screen • Violence risk screen • Infectious Control Screen
Vital Signs	Under **IView** or **ED Adult Systems Assessment**	See "Vital sign and focused assessment frequency" Complete a Temperature on arrival. If sepsis is suspected, complete Temperature q1h, otherwise repeat temperature checks should be done q4h.

Mental Health Emergency Assessment	**Mental Health Emergency Nursing Assessment** sections
	
	Or Under *AdHoc* tab
		Complete the following sections <u>on arrival</u>:
		• General Information
		• History of Presenting Concern
		  ○ Complete **Nursing Narrative Note**, which should also include:
		  ▪ Problem history
		  ▪ Family history
		  ▪ Social history
		  ▪ Medication history
		• Appearance and Behaviour
		• Speech, Affect, and Mood
		• Thought Process and Content
		• Cognition, Insight and Judgment
		• Suicidal Ideation
		  ○ Complete **CSSRS ED Brief Screen** *(follow prompts to determine if full CSSRS Screen is required)*
		• Homicidal Ideation (Located under **IView***)*
		• Violence and Aggression Screen
		• Substance Use Assessment (if known)
		• Housing, Employment and Education
		• Legal Status and History
		• Recommended Disposition

Interventions	In appropriate **IView** sections *(Commonly documented sections are*): - **ED Adult/Pediatric**	Documentation in CST Cerner is preferred. Document interventions in a timely manner. In the case where close observation levels require increased documentation frequency (i.e. for seclusion, restraints, or safety plans), clinician may document in corresponding flowsheets in formfast (see below) and place in patients chartlet.

	systems assessment - **ED Mental Health** - **ED lines** - **ED Adult/Pediatric Interventions**.	Refer to SHOP for documentation guidelines for specific interventions, otherwise guidelines per *Elsevier Clinical Skills* prevail. Document: • Safety checks and Seclusion room as per level of observation in **Safety and Attendance** *(This will populate in iView under the ED Mental Health Band, Behavior Log section)* • Safety Plans (*found in Formfast* **Form ID. 6402***)* • Seclusion room - may also use Seclusion Flow Sheet (*found in Formfast* **Form ID. 1581***)* • Restraints – see restraints section below and may also use Seclusion Flow Sheet (*found in Formfast* **Form ID. 1581)** • Medication Administration
Line Interventions	**ED Lines** band	Document lines (IV, NG. Chest Tubes, Foley, Central Lines, etc.). Do not use *clinical comments* for line interventions. Refer to SHOP for specific documentation guidelines. To document under ED Lines include the following: • Size and type of line • Location, measurements • Number of attempts • Securement • Condition of line (e.g. patent, infusing, draining, etc.) • Patient's response (e.g. tolerated)
Task clean-up	**ED LaunchPoint** then hover over Nurse Activities	It is the responsibility of the nurse who reviews a task to ensure that it is documented against or moved from the task list. If there are any tasks that are no longer required they should be removed prior to shift change. Any tasks that are/were accidentally removed should be re-added.
End-of-shift	Orders Tab Handover Tool	On handover, patient orders are to be reviewed with oncoming staff including: • Any nursing tasks that are outstanding • Any medications that are pending • Any communication orders Complete a handover note with a succinct summary of shift; note any ongoing patient concerns. Used for admitted PEAT patients transitioning to Inpatient psychiatry or continued stay

		in PEAT (if stay > 24hrs) for the purpose of communicating patient status between shifts and/or clinician handover.

Pediatrics

Topic	Activities
Applicable Areas	PEAT
Admission Process	Pediatric patients will be admitted to PEAT on a case-by-case basis. In order to ensure the safety of the patient demographic, please consider: • Initial assessment in ED • Unit acuity/milieu • Assess need for security presence • Consultation should always be done with EDD PCC, PEAT CRN, ERP and POC to ensure the safety of the child/youth
Observation	Maintain close observation, q15min to q30 min (as per clinical presentation and acuity). Q15min when patient on seclusion. • auto populations into behavior log

Mental Health Act

Topic	Activities
Applicable area	All areas of the ED
Mental Health Act(MHA) Documents	**MHA Form 4** and **6** are electronically available All other MHA forms are on paper including **Form 5, 13, 15,** and **16** and can be found in **Form Fast**. • **Form 4** and **5** to be completed by a physician.
Close Observation	All patients certified under the Mental Health Act in the ED are automatically on q 15min close observation. Including circulation, sensation, movement (CSM) checks when chemical/physical restraints are in use. Document under **Restraints and Seclusion band** • Patient location • Patient activity

Restraints: Mechanical, Chemical, Environmental

Requirements

All patients who are in restraints must have a Provider's Order in Cerner

Topic	Activities
Applicable areas	In Acute Care/Resuscitation
Orders for Restraint	A Prescriber's Order is obtained for all patients who are in restraints. A nurse may take a verbal order for a restraint. A nurse may also place patients in restraints without an order in an *Emergency Code White* situation and then obtain an order within an hour of the event taking place.

Restraint Documentation	Please refer to restraint guideline on specifics related to the different types of restraints: Mechanical, Chemical, Environmental
	VCH Guideline: Restraints
	
	Document all assessments (i.e. relevant components of MSE) prior to initiation of restraints.
	Document in the relevant sections in iView under **ED Mental Health** band, **Restraints** section.
	
	On initiation of restraints complete:
	• Restraint prevention
	• Restraint initiation
	• Restraint information
	
	Ongoing complete:
	• Restraint monitoring
	• Restraint evaluation
	• **Nursing Narrative Note** with frequency:
	  ○ **q 1hr** for patients in physical restraints
	  ○ **q 2hr** for patients in quiet room
	  ○ Titling convention *Date, Shift, and "Restraints"*
	
	q15min assessment for the duration of physical and environmental restraints.
	Document in **Restraints Monitoring** and **Restraints Evaluation** Sections.
	
	q15min x2; q 30min x2; then q 1h assessment for chemical restraints ONLY.
	Document in **Restraints Monitoring** and **Restraints Evaluation** Section.
	
	On Discontinuation complete:
	• Restraint Information
	• Restraint Education

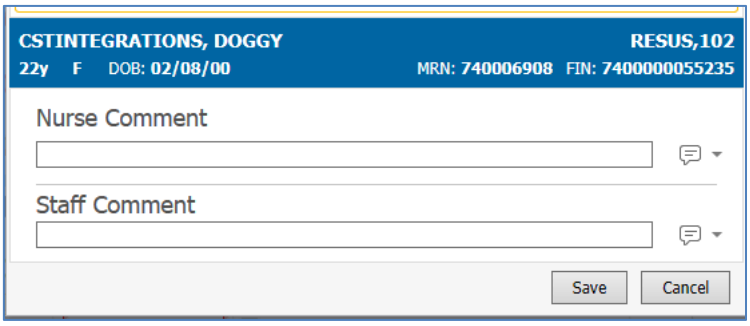
	• Restraint Debriefing *See also Close Observation under Mental Health Act section above.*

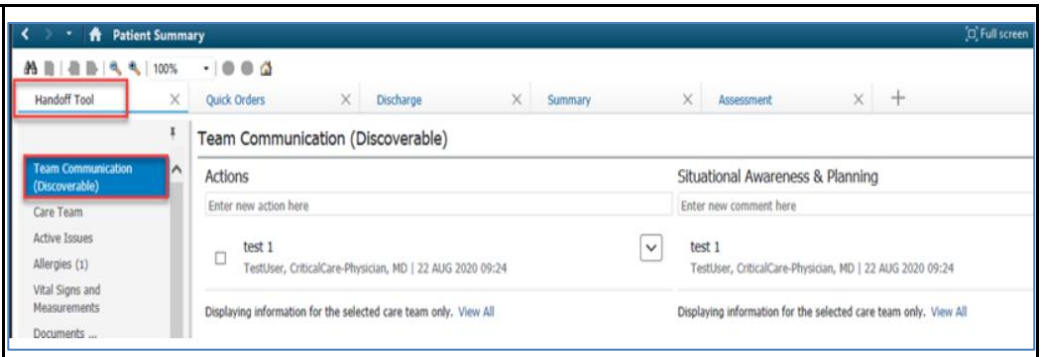
Discharge and Admission

Requirements

Topic	Activities
Applicable areas	All areas of the ED
Review prior to discharge and admission	Prior to any discharge or admission transfer, nurses are expected to review any outstanding tasks or medications that need to be completed and ensure the relevant individuals (UCs, receiving nurse) are aware of the task.
Discharge Documentation	Ensure under **ED Lines** - any IVs or Foleys, etc. that were inserted and removed and not required upon discharge are documented as such. Ensure discharge instructions have been provided to patient. Document in Nursing Narrative Note or annotations as appropriate. Ensure Safety Plan (*found in Formfast* **Form ID. 6402 LGH***)* is completed. A copy to go with patient and a copy to go into patient's chartlette. If initial vital signs are out of range for the patient's baseline, prior to discharge by an RN and/or RPN reassessment of vital signs and a focused assessment should be completed and documented. Under **Disposition Documentation** for ***Discharge***, all relevant fields should be completed before the patient is removed from Launchpoint • Document a *free text* note in **Discharge Comments** if the patient is discharged by the physician prior to RN and/or RPN discharge instructions or reassessment vital signs and/or focused assessment
Admission Documentation	Complete the **Valuables/Belongings** Powerform Complete a **Transport Ticket**. Under **Disposition Documentation** for ***Admit,*** all relevant fields should be completed.

Communication

Topic	Activities
Applicable areas	All areas of the ED
ED Launchpoint comments	Use the "Nursing comment" field for any important comments that are relevant to nursing only that may assist in patient flow and organization. Use the "Staff comment" field for comments relevant to all staff members; typically any consults, reminders, timing of diagnostic tests, non-urgent requests for physicians.  **Patient Summary Page** can be used to view detailed patient information including all flagged annotations and clinical comments. **This is not an area for legal documentation**
Situational Awareness and Team Communication	Used for admitted PEAT patients transitioning to Inpatient psychiatry or continued stay in PEAT (if stay > 24hrs) for the purpose of communicating patient status between shifts and/or clinician handover. This is not used in the ED, but consulting services may enter information in this section when a patient is admitted so it should be reviewed regularly. This is found under "**Patient Summary - ED Handoff Tool**" **This is not an area for legal documentation** and is removed after the chart has been discharged.



QUICK REFERENCE: LABELS

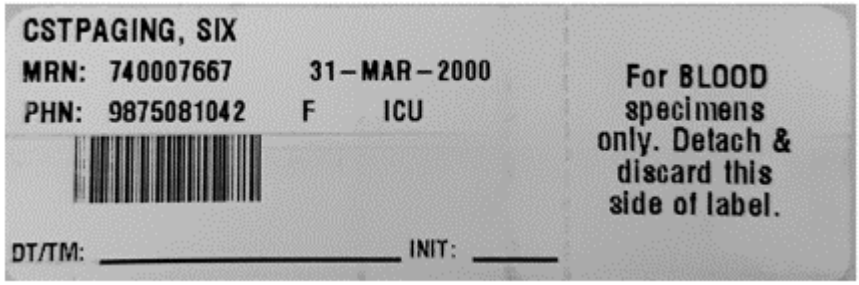
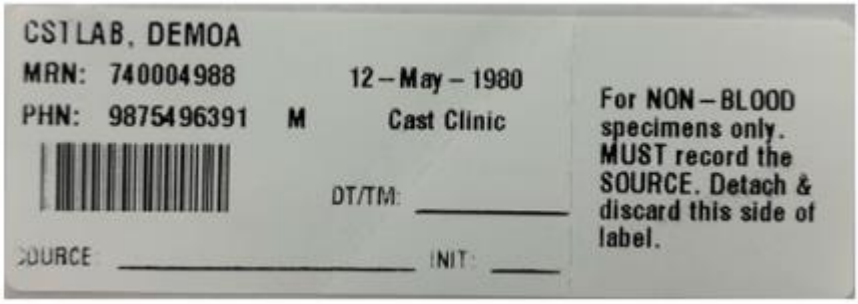
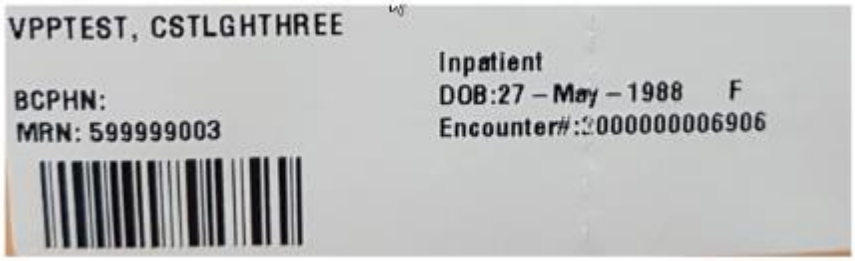
Description	Label
Armband Label	
Blood Specimen	
Non-Blood Specimen	

Chart Label	

ORDER STATUS

Status	Description
Cancelled	Order was terminated before it started
Completed	Order has reached its stop date/time or the associated task was completed
Discontinued	Order was terminated after it has been completed at least once
Future	Order is scheduled for a future visit
Incomplete	Order is entered but has required fields that do not have information
In Process	Order has a preliminary result and is awaiting a final result

PROCESS ALERTS DESCRIPTION (See CERNER Help for additional Process Alerts)

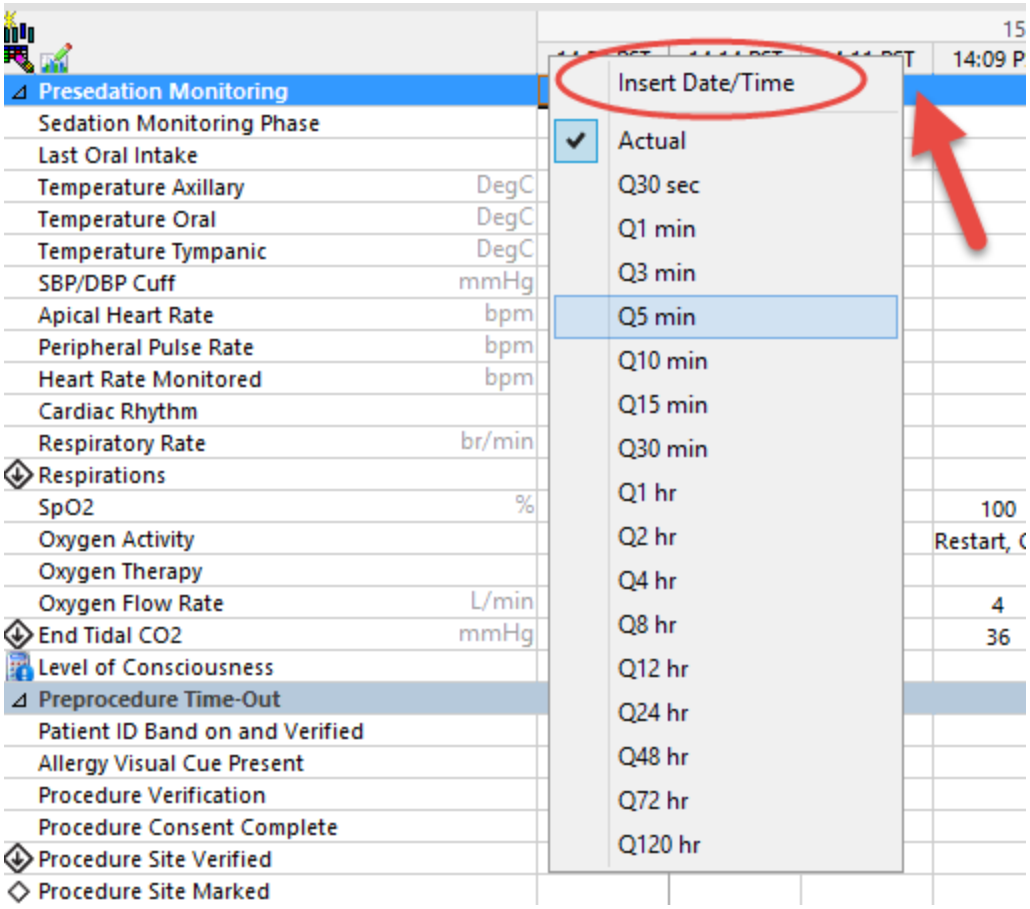
Status	Description	When to Add	When to Remove
Falls Risk	Patient has been assessed for falls risk and has been found to have an increased risk of falls	When the assessment has been completed and the patient is found to be at risk of falling	When the assessment has been completed and the patient is found to NOT be at risk of falling
Isolation Precaution	Patient has been assessed for infectious disease and has been identified to need isolation precautions initiated	Anytime the patient self identifies as having an infectious disease (ie. MRSA, TB, Influenza-like illness, etc.) or when the staff recognize potential infectious symptoms on assessment	When the assessment has been completed and the patient is found NOT to be an infectious disease risk—after consultation with physician and/or infection control practitioner

Communication Barrier	Factors causing a barrier to clear communication with the patient. This could include sensory deficits such as deafness, being mute, having a language barrier, or cognitive deficit that makes communication a challenge	When clinical assessment has found that there is a challenge to communication between the patient and caregivers that could impact their care	If the challenges in communication are resolved or are no longer present
Seizure Precautions	The patient is at risk of having seizure activity and precautions are in place to ensure their safety in the event of a seizure	When precautions are requested or put in place to ensure patient safety	If or when the precautions for safety during a seizure can be removed
Cytotoxic Precautions	The patient is within the cytotoxic precautions period after having received a cytotoxic medication	When the patient has received a cytotoxic medication as per policy	When the precautionary period that is indicated in policy has elapsed, often 48 hours after the last dose
Palliative Alert	Flagged by the palliative care program to indicate that the patient is receiving palliative care processes. If Palliative Alert not in place when patient arrives in ED, it can be placed manually or on *Launchpoint* by the ED Unit Clerk.	The Palliative Care program will apply this alert when they enroll the patient. This alert may not be applied by others outside of that process. It may take time for this alert to show on CERNER.	The Palliative Care program will manage this alert if it needs to be removed. This alert may not be removed by others outside of that process

Violence Risk	The patient has been assessed and has been found to have an increased risk of violence using the standardized tool for assessment	When a risk has been assessed and a violence alert care plan has been documented	When the patient has been assessed and found to not be at risk
Difficult Airway or Intubation	The patient has physiological components that limit their airway or could pose challenges during intubation	When a risk has been assessed and the information about a difficult intubation or airway needs to be communicated	If or when the airway components are resolved and no longer pose a risk
Special Care Plan	A care plan is in place that spans across care settings (e.g. Familiar Faces)	When the care plan is established and needs to be communicated across encounters or care settings	When the care plan is no longer in place and the alert can be removed
No Ceiling Lift	The patient is not to be lifted using an overhead lifting device. This is to communicate across care settings	When it is determined that patient-specific components restrict the use of an overhead lift	When the restriction on lifting devices can be removed safely
On Research Study	The patient is currently participating in a research study and that information needs to be known across care teams	Research coordinators/nurses will apply this alert when the patient begins participating in a clinical research study	When a patient is no longer participating in a clinical research study, the alert will be removed
Visitor Restrictions	The patient prefers to restrict visitors at this time. This is used in conjunction with registration functions to communicate visitor restrictions	When visitor restrictions are implemented, the documentation and alert will be put in place	When visitor restrictions are no longer needed, the alert may be removed

Adjusting time columns

In some instances, you may be required to *insert* a time column into iView, or to automatically create time intervals to complete your charting. To do this, right-click on the time row in iView and the following will pop-up:



- Selecting Insert Date/Time will add a custom date/time field to iView
- Selecting any of the time intervals will automatically convert the iView time columns to time intervals. For example, selecting Q15 min will cause iView to display time columns of 10:00-10:14, 10:15-10:29, and so forth. To change back to real-time charting, select “Actual”.

References

This document has been adapted from: In draft SPH ED Documentation Guidelines with CST CERNER (2020).

Accreditation Canada. (2019). Standards Emergency Department.

Bullard, M.J., Musgrave, E., Warren, D., et. Al. (2016). Revisions to the Canadian Emergency Department Triage and Acuity Scale (CTAS) Guidelines 2016. Retrieved on January 26, 2021 from: http://ctas-phctas.ca/wp-content/uploads/2018/05/ctas_guidelines_-_2014.pdf

Canadian Association of Emergency Physicians. (1998). Implementation guidelines for the Canadian Emergency Department Triage and Acuity Scale (CTAS). Retrieved on January 26, 2021 from: http://ctas-phctas.ca/wp-content/uploads/2018/05/ctased16_98.pdf

Considine, J., Potter, R., & Jenkins, J. (2006). Can written nursing practice standards improve documentation of initial assessment of ED patients. Retrieved on January 26, 2021 from: https://www.sciencedirect.com/science/article/abs/pii/S1574626706000243

Vafaei, S.M., Mazari, Z.S., & Heydari, A., et. Al. (2018). Nurses' perception of nursing services documentation barriers: a qualitative approach. *Electronic Journal of General Medicine,15(3)*, 1-8.

Related Documents

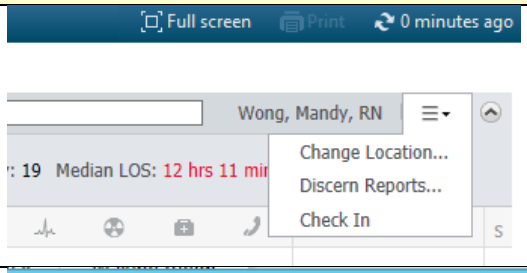
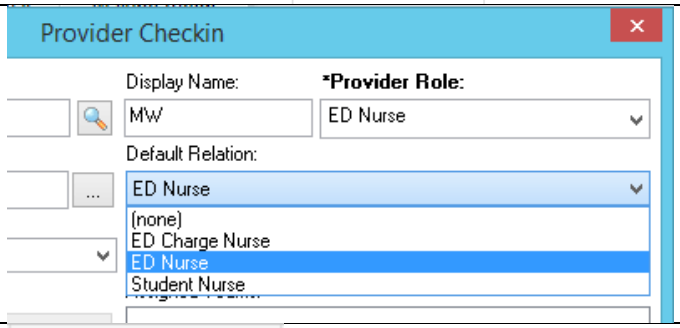
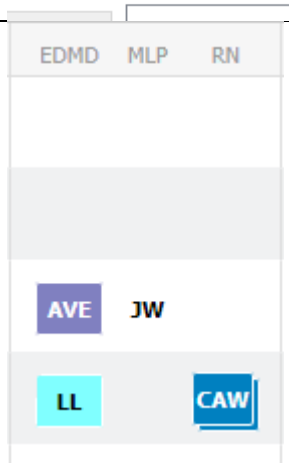
Medication Administration and Bar Code Scanning: http://shop.healthcarebc.ca/CST_Documents/CSTMedicationAdministrationPolicy.pdf

Nurse Initiated Activities: http://shop.healthcarebc.ca/PHCPHSAVCH/BCD-11-11-40001.pdf

Appendices

Appendix A: DAILY SHIFT ROUTINES

Topic	Description
Start of Shift	Ensure in appropriate location (LGH Emergency Department, LGH ED Hold) • Check-in to the system as ED Nurse
When Receiving a Patient*	• Assign self to patients

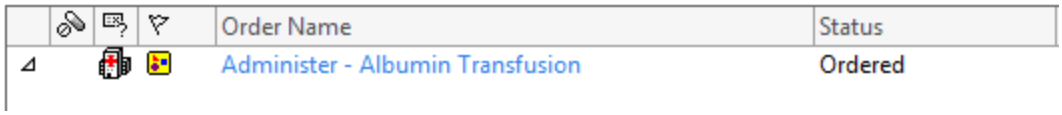
SCREENSHOTS/EXAMPLES	
	
Provider Role and Default Relation should be ED Nurse	
Click on the column next to the patient's name (EDMD MLP RN) to assign self to patient	

Appendix B: BLOOD TRANSFUSIONS

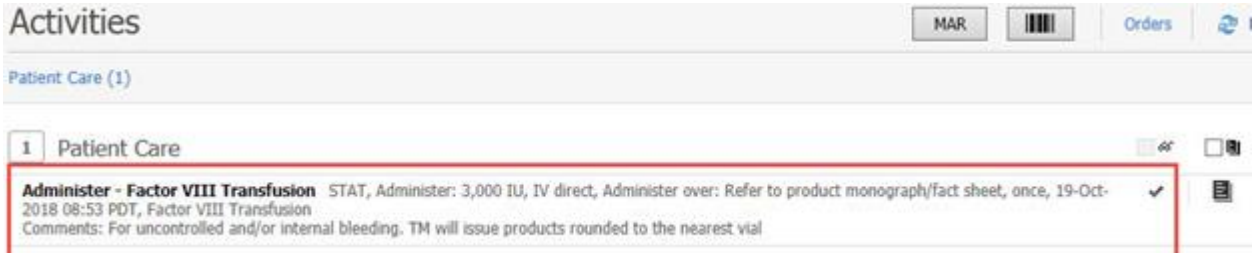
Refer to Blood Components/Products: Administration Procedure

For the purposes of *start time*, *stop time*, *transfusionist*, and *witness*, the blood bank transfusion record is the source of truth. All other documentation will be done in iView.

The order for blood products is Administer - <Blood Product> Transfusion. For example:



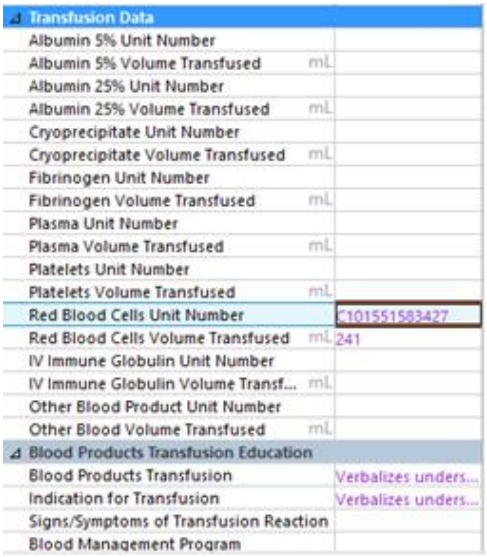
A task should populate in LaunchPoint.



Do NOT complete this task until all units have been transfused.

In the patient's chart, the ED workflow tab in the Patient Summary will have a section for *Transfusion History*:

If there's a current Group and Screen, it will show in the area labelled "A". When the blood product is ready, it will show in the area labelled "B" (including any blood products that have already been issued. If the patient has a history of a transfusion reaction, it will show in "C".

Topic	Activities
Obtaining Blood Products	When the transfusion history indicates blood products are ready, let the UC know and they will print out the requisition to give the porter. If there is no UC, head to the order profile, right click on the blood product order, and reprint requisition.
Initiating Infusions	Chart vital signs in iView: Blood Product Administration > Vital Signs Document the transfusionist, witness, and start time on the Transfusion Record Document the unit number of volume in bag in iView: Blood Product Administration > Transfusion Data Document transfusion education in iView: Blood Product Administration > Indication for Transfusion
Monitoring Infusion	Continue to chart vital signs in IView 15-minutes after starting infusion Every hour
Ending Infusion	Document end time on the Transfusion Record  If infusion was stopped early, modify volume transfused in IView: Blood Product Administration > Transfusion Data Once all units have been transfused, complete the task in LaunchPoint
Transfusion Reaction	Review the Blood/Blood Product: Transfusion Reaction Identification and Management Procedure Order the TM Transfusion Reaction Module (with "No Cosignature Required") on the patient. Note that the transfusion reaction form remains on paper and still needs to be completed and sent to transfusion medicine.

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Approved By: *(committee or position)*	VCH
	Targeted Endorsement: Coastal Professional Practice Director Director, Surgical Services LGH and SGH Director, North Shore and Sea to Sky MHSU Manager MHSU Coastal Manager LGH ED Coastal **Signed off by:** VP Professional Practice and Chief Clinical Information Officer
Owners: *(optional)*	VCH
	Developer Lead(s): • Clinical Resource Nurse, Emergency Department – Psychiatric, Coastal • Clinical Resource Nurse, Emergency Department, Coastal • Patient Care Coordinator, MHSU, Coastal **Development Team members:** • Clinical Informatics Specialist, Coastal • Nursing Practice Initiatives Lead, Coastal • Nursing Practice Initiatives Lead, Professional Practice, Coastal