Acute Medicine Assessment and Documentation Guidelines- Adult (CST Cerner)

Quick Links

Site Applicability

All VCH Acute Adult Medicine Units, and off-service Medicine patients – Live on CST Cerner

Practice Level

Basic: RN, RPN, LPN within respective scope

Requirements

Assessments, as outlined in this guideline must be documented in Cerner.

Exception: Systems downtime, where charting reverts to paper based processes, and paper based forms such as care plans and consent forms.

Refer to criteria for frequency of vital signs and physical assessment

Need to Know

During assessments, nursing staff will introduce themselves to the patient, explain the procedure, receive patient consent follow principles of asepsis and safety, and finally ensure patient's privacy and dignity.

Professional Standards require nurses to document timely and appropriate reports of their assessments, decisions about patient status, plans, interventions and outcomes. VCH does not endorse a charting by exception model. It is the nurse's responsibility to notify the most responsible provider of any abnormal finding, concerns or issues (BCCNM, 2022).

This document is a guideline to support, not replace, a nurse's clinical judgement in assessment and documentation of an Adult Acute Medicine patient using the CST Cerner system. This is a basic physical assessment that serves a general survey. See Appendix B for guidance as to when to complete assessments outlined in this document.

Use iView to document vital signs, NEWS2 score, physical assessment, intake and output, shift handoff, and lines and devices. Comments and annotations may be used to supplement an individual item with clinically relevant information in iView. Comments may be flagged to highlight clinically significant events that a nurse wishes to highlight, which will be populated on the Patient Summary page.

Document on medication administration using the Medication Administration Wizard and Medication Administration Record (MAR).

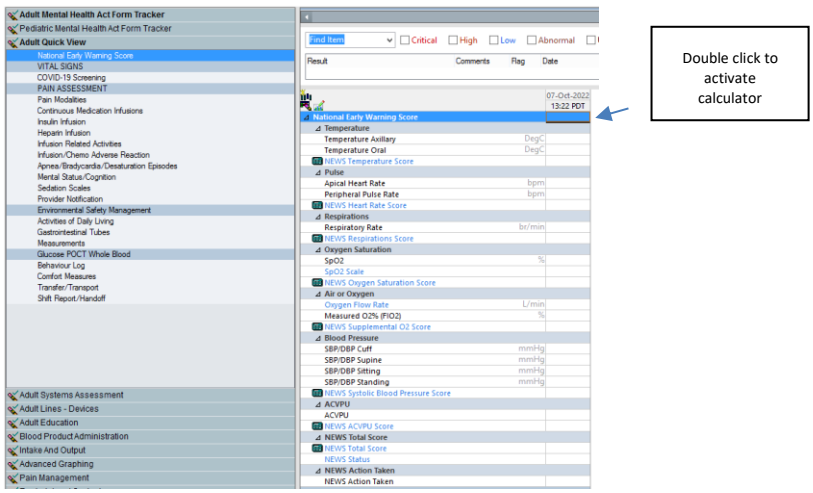
Use a nursing narrative note to expand upon pertinent events, deviations from patient baseline status, patient/family concerns. Document narrative note upon patient admissions and transfers to include any information not captured within Cerner Documentation flowsheets, ensuring nursing narrative note uses structured format such as DAR (data-action-response) or SOAP (subjective-objective-assessment-plan) and is titled to the focus of that note.

Guideline

Patient Assessment & Documentation

Document assessments within Interactive View and I&O section within PowerChart. See Quick Reference Guide in Appendix A for where to locate fields in iView.

(Assessment categories are in the order they appear in the Cerner Electronic Health Record)

A. Adult Quick View	
Category	**Assessment & Documentation**
Vital Signs & NEWS2	Vital Signs: • Temperature • Heart Rate • Blood Pressure • Respiratory Rate • SpO_2 (Scale 1 – default (normal, most pts) Scale 2- Provider Order req – chronic "hypercapnic resp failure") • Supplementary Oxygen • CNS Response (ACVPU – Alert, Confusion, Voice, Pain & Unresponsive) A **National Early Warning Score (NEWS2)** score is to be completed with EACH set of vital signs. Refer to SHOP for National Early Warning Score Protocol.  *Note: Activate cells from the dark blue shaded field to activate NEWS2 score calculation

A. Adult Quick View	
Category	**Assessment & Documentation**
Pain Assessment	Assess presence or absence of pain. Consider both reported and suspected pain. Document assessment findings. If Yes, **Pain Present**, further assess pain and document: • Onset • Location • Laterality • Quality • Provoking • Palliating • Radiation Characteristics • Pain Tool Used Document Pain Modalities utilized, as applicable. Assess sedation using the Pasero Opioid-Induced Sedation Scale, if receiving opioids (See Adult Quick View > Sedation Scales). Refer to Appendix C for reference.
Mental Status/Cognition	• Level of consciousness • Depth of consciousness • Orientation Assessment Confusion Assessment Method (CAM), as applicable refer to Delirium: Screening, Assessment and Management for guidance.
Environmental Safety Management	**Environmental Safety Implemented**: A response of, 'Yes,' acknowledges for all of below: • Bedside safety checks performed (call bell within reach, side rails appropriate, bed in lowest position) • Patient received orientation to their role in maintaining safety (i.e. calling staff for help with ambulation if mobility concerns exist) • Equipment checks performed (safety equipment at bedside, oxygen and suction outlet working and tubing/supplies stocked) • Patient ID Band & Allergy Band in situ (if applicable). • Ensure Process alerts are up to date in Cerner as applicable: (Hazardous Drugs precaution signage and equipment, Violence risk alert and care plan, Falls, Infection Control precautions signage and equipment) • Universal Falls Precautions (SAFE step) in place for all patients

<table>
<tr><th colspan="2">A. Adult Quick View</th></tr>
<tr><th>Category</th><th>Assessment & Documentation</th></tr>
<tr><td>Activities of Daily Living</td><td>Document as applicable to patient for the following areas:
<table>
<tr><th>Functional Assessment</th><th>Activity</th><th>Nutrition – ADLs</th><th>Hygiene - ADLs</th></tr>
<tr><td>• Bathing
• Personal hygiene
• Walking
• Toilet use
• Bed Mobility
• Dressing
• Eating
• Bladder Continence
• Sleeping behaviour</td><td>• Use of assistive device
• Weight bearing performance
• Lifting equipment
• Activity status ADL
• Bed Angle, Anti-embolism device/SCD</td><td>• Diet type
• For calorie count, use the tool printable from FormFast</td><td>• Personal care provided
• Routine oral care provided</td></tr>
</table></td></tr>
<tr><td>Glucose POCT Whole Blood</td><td>• Point of care (POC) glucose testing, as required
• Complete scheduled POCT glucose tasks from Care Compass</td></tr>
<tr><td>Measurements</td><td>On admission, enter admission weight as dosing weight in kilograms
• Measure and record weight at frequency ordered
• Indicate type of scale used</td></tr>
</table>

B. Adult Systems Assessment	
Category	**Assessment & Documentation**
Neurological	**Neurological Symptoms Reported** For patients with neurological diagnoses, with stroke, or if neurological symptoms are reported, complete neurological assessment including: • Nystagmus • Diplopia • Characteristics of communication • Characteristics of speech • Characteristics of expression • Characteristics of comprehension • Ability to follow command

<table>
<tr><th colspan="2">B. Adult Systems Assessment</th></tr>
<tr><th>Category</th><th>Assessment & Documentation</th></tr>
<tr><td></td><td>

Aspiration risk - complete field for patients with dysphagia
Facial symmetry
Brainstem reflexes, as applicable

Patients who have had a stroke assess Post Stroke NIHSS (Certified nurses only).
For suspected acute stroke, complete FAST stroke screen (face, arm, speech, time) if any parameters are positive, follow site specific practises to activate hot stroke protocol. Refer to Stroke: Hyper Acute & Acute Stroke Care.
MORSE Fall Scale

Complete within 24 hours of admission or transfer, with a significant change in status, or following a fall.
All patients who are identified as being at high risk for falls will have a care plan to prevent falls and fall- related injuries.
Should a fall occur, ensure interventions and monitoring is documented in the Post Fall Evaluation section of iView.

Refer to Fall Injury Prevention Guideline.
Assess Level of Consciousness (LOC), using Glasgow Coma Scale (GCS) when:

The ACVPU (Alert, Confusion, Voice, Pain, Unresponsive) is anything but ‘Alert’
Completing neuro vital signs (including following post-fall guideline)
Monitoring for neurologic change

Glasgow Coma Scale
<table>
<tr><th>Best Eye Response</th><th>Best Verbal Response</th><th>Best Motor Response</th></tr>
<tr><td>4 Spontaneous
3 To sound
2 To pressure
1 None
NT – Not testable</td><td>5 Orientated
4 Confused
3 Words
2 Sounds
1 None
NT – Not testable</td><td>6 Obeys Commands
5 Localising
4 Normal flexion
3 Abnormal flexion
2 Extension
1 None
NT – Not testable</td></tr>
</table>
Neuromuscular/Extremities Assessment for all patients:

Inspect for any obvious signs of musculoskeletal abnormalities (e.g. posture, gait, etc.)

Range of motion (ROM) – any abnormalities noted during normal care
</td></tr>
</table>

B. Adult Systems Assessment	
Category	**Assessment & Documentation**

Cardiovascular	**Cardiovascular Symptoms Reported**
	• Assess for presence of cardiovascular symptoms including chest pain, dizziness and palpitations.
	• Assess and document heart rhythm & sounds.
	• **Upper & Lower Extremity Assessment** – skin temperature, capillary refill
	• **Edema Assessment:** If edema present, assess:
	  ○ Location, laterality
	  ○ degree of edema
	• **Pulses** – Peripheral pulses should be assessed for presence and strength, note anatomical location.
	• Note if Doppler utilized (absent, present or diminished).

Respiratory	**Respiratory Symptoms Reported** • Assess for presence of respiratory symptoms including rate, depth, dyspnea, cough, hemoptysis, or presence of sputum (add description if present). Document abnormalities under Respiratory section, • If no symptoms are reported, document respirations as regular. Document **oxygen activity** and **therapy** (if applicable) • Device, flow rate, percentage of oxygen **Breath Sounds Assessment** • Auscultate anterior and posterior lung fields for quality and location of any adventitious sounds As applicable, presence and strength of cough, sputum amount.
Gastrointestinal	**Gastrointestinal Symptoms Reported** • Assess for presence of gastrointestinal symptoms including nausea, vomiting, abdominal tenderness/pain **Abdomen Description** - for distension, presence of ascites **Bowel Sounds** – auscultate and describe presence, location and quality. Do not palpate before auscultation is performed **Abdominal Palpation** – assess for firmness and tenderness **Bowel Movement** • At a minimum, document stool count per shift. Include amount, color, and description if stool observed. • Document ‘0’ if no bowel movements observed or reported on the current shift. • Bowel elimination: Continence/Incontinence

B. Adult Systems Assessment	
Category	**Assessment & Documentation**
	G.I. Tubes/Appliances • If ostomy present add Wound Ostomy navigator band to iView and assess/document skin integrity, output, consistency. • Enteral feeding tubes if present – document in Dynamic Groups > Gastrointestinal Tubes.
Genitourinary	**Urinary symptoms reported** • Assess for presence of dysuria. **Urinary Elimination** • Assess for changes in elimination pattern (i.e. urinary retention), continence • Colour, volume and quality of urine output • If indwelling urinary catheter present, assess need for catheter and remove promptly, see: Guideline to prevent catheter associated urinary tract infections (CAUTI). If assessing for urinary retention or post-void residual add Bladder Scan/Post Void Residual section to documentation. Document intermittent urinary catheterization, if applicable create dynamic group and document Urostomy.
Integumentary	**Skin colour general** – if unusual for ethnicity or concern exists, inspect: • Skin temperature • Skin turgor • Skin moisture Complete **Head-to-Toe Pressure Injury Skin Check**, "all sites intact" indicates there are no areas of breakdown or concern.
	Braden Assessment • **Initial screening** complete **within 24 hours of admission.** • **Score greater than 19** – Complete **daily.** • **Score less than 18** – Complete **every shift,** and ensure a Pressure Injury Prevention Care Plan is in place. • See Braden Risk and Skin Assessment (Adult) for guidance.
	Incision/Wound/Skin/Pin Site For each individual Dynamic Group document: • Activity • Type/Etiology • Dressing Activity • Interventions/Wound Assessment (refer to wound care plan if applicable) • If dressing present but no change required, document "dressing intact"

B. Adult Systems Assessment	
Category	**Assessment & Documentation**
	Refer to Wound Management for Adults and Children for direction If ostomy present assess for skin integrity, leakage, and amount of output. Document under wound and ostomy. Refer to Ostomy, Assessment and Management of for guidance. If Negative Pressure Wound Therapy is in situ, monitor at a minimum of every 2 hours. Refer to Vacuum Assisted Closure (VAC) Therapy for further directions.
Musculoskeletal	Create a Dynamic Group for specific location (e.g. for fractured limb, spine injury) and document assessment appropriate to that anatomy.
Psychosocial	• Affect • Behaviour during interaction • Aggression (If present, follow process for Violence & Aggression Alert Acute Care Standard & Workplace Violence Prevention Standard) • Psychosocial Symptoms Reported ○ Assess for any mental health concerns, if suicidal ideation reported complete the Columbia Suicide Severity Rating Scale Quick Screen and notify MRP • Family/social support
Other (as required)	Measurements (i.e. height)

C. Intake and Output	
Category	**Assessment & Documentation**

Intake & Output	If intake and output measurement is indicated:
	• Assess and document per MRP order and PRN
	• Tubes, lines or drains in situ are to be emptied, measured and recorded Q6hrs (0600h/12000h/1800h/2400h)
	  ○ **Total fluid balance** is **calculated every 12 hours** or **at the end of the shift (0600h & 1800h).**
	  ○ The **24 hour cumulative total** is completed at the **end of the night shift (0600h)**.
	Document accurate Intake and Output volumes for all:
	• IV therapy
	• Enteral Feeding
	• Parenteral Nutrition
	• Indwelling urinary catheter output
	• NG tube attached to suction

	• Output from all tubes and drains • Other intake and output as ordered or clinically indicated

D. Adult Lines - Devices	
Category	**Assessment & Documentation**
• Inactivate Dynamic Groups when they are no longer in situ. • Ensure when starting a new Dynamic Group that the insertion is documented (under Activity). • Activate a new Dynamic Group for lines/devices on admission, include the date of insertion if known.	
Dynamic Groups	**Peripheral IV & Central Lines**: • Note type and location of line (e.g. PIV, CVC/PICC). Note external length as required. • IV line saline locked or TKVO. • Note line's dressing, assess patency, and any swelling, redness, or drainage around the site. • Note expiry date of IV tubing. • Confirm correct medication infusing: drug, concentration, dose and rate.
	Urinary Catheter: • Type and size of catheter • Activity (i.e. insertion, removal) • Management • Site condition See Indwelling urinary catheter: Guideline to prevent catheter associated urinary tract infections (CAUTI) for guidance.
	Chest Tube(s): • Assess for activity, drainage device, air leak, dressing, amount and type of drainage. See Chest Tubes: Patient Assessment and Interventions for guidance.

	GI Tubes (G-Tubes, J-tubes and NG-tube)
	• Assess for position, signs of migration:
	  • Tube care
	  • Site condition
	  • Suction settings if applicable
	Document type and rate of feed if applicable and flush volumes.

	Subcutaneous Catheter • Catheter Site and Laterality • Subcutaneous Catheter Medication and Concentration

D. Adult Lines - Devices	
Category	**Assessment & Documentation**
	• Size of catheter • Activity, Line Care • Site condition • Dressing
	Ostomy Create a dynamic group under **Adult Systems Assessment** **Gastrointestinal** **GI Ostomy**: Ileostomy or Colostomy **Genitourinary** **Urinary Diversion**: Ileal Conduit/Urostomy (**Note:** You may need to select "Customize View" to add these fields to your navigator bands in iView – this only needs to be set up once.)

E. Restraint and Seclusion	
Category	**Assessment & Documentation**
Restraints	**Mandatory for all patients who have physical or environmental restraints in situ** • Create a dynamic group for each restraint device (including Seclusion). • Document the initiation and removal of any restraint device, ongoing care and assessment of the patient, and the need for the device. Vital signs, neurovascular checks, extremities assessment (color, warmth, sensation and movement), integumentary and pain assessments should also be conducted and documented in the electronic record. • Document restraint monitoring and behaviour log. • Document patient/family debriefing when appropriate. • Document the situation that led to application of restraints as a nursing narrative note with the title "restraint." Refer to Restraints: Care of the Patient at Risk for or Requiring Restraint for guidance.

Admission Documentation

F. General Medicine Inpatient – Required Screening & Assessments	
Document from Care Compass	**Assessment & Documentation**
Admission PowerForms & iView Documentation	**Basic Admission Information Adult** • Perform immediately upon admission, and before any medications are administered. • Assess **Allergy Status**: refer to Allergy Documentation Policy for direction. • Record a **Dosing Weight** in kilograms indicate if it was measured (preferred), if not possible estimated or reported by patient. • Perform a Best Possible Medication History (**BPMH**) if this has not been done by the Emergency Department, refer to the Medication Reconciliation Policy for direction. **Admission History – Adult** • Barriers to Communication • Visitor Family information • Violence and Aggression Screening • Advance Care Planning • Delirium Screen • Columbia Suicide Severity Rating Scale – Screen • CAGE-AID Assessment • Tobacco Screening • Psychosocial Assessment (do you feel safe, people that worry you, financial concerns, living situation and cultural spiritual needs) • Nutrition screen **Perform Swallow Screen** • Complete before any food or drink is given. **Braden Assessment** • Complete within 24 hours of admission, refer to Integumentary section in above Systems Assessment section for guidance **Morse Fall Risk Assessment** • Complete within 24 hours of admission, or upon transfer. • Refer to Falls and Injury Prevention Guideline (in Acute Care) for guidance on scoring and associated preventions and care planning. **Infectious Disease Screening** • Includes ARO screening and admission COVID-19 Risk Assessment in Ad Hoc.

	Valuables and Belongings • Document any patient valuables/belongings placed into safekeeping, refer to Safekeeping of Patient Valuables Policy.

Patient and Family Education

- Explain purpose and timing of assessments and interventions required with the patient and or substitute decision maker.
- Provide patient and family with relevant educational materials as appropriate. Ensure patients and families understand information provided to them and have had an opportunity to ask questions.
- Document education provided to patients and families under Adult Education.
- Access educational materials from VCH Patient Health Education Materials.

Related Documents

Related Policies

- Allergy Documentation Policy
- Documentation Policy
- Medication Administration Policy
- Consent to Health Care Policy

References

This document has been adapted with permission from Providence Health Care: Physical Assessment of Patients on an Acute Medicine Ward (2022).

Assessment: Focused. Elsevier Clinical Skills. (2021). Retrieved from https://point-of-care.elsevierperformancemanager.com/skills/357/quick-sheet?skillId=GN_18_1&virtualname=vancouvercoastalhealth

Documentation Practice Standard. (2022). British Columbia College of Nurses and Midwives. https://www.bccnm.ca/RN/PracticeStandards/Pages/documentation.aspx

Pasero, C., & McCaffery, M. (2011). *Pain assessment and pharmacologic management* (p.510). St Louis: Mosby/Elsevier.

Peate, I. (2019). A systematic approach to nursing care. *Learning to Care: The Nurse Associate*, 109.

Definitions

Cerner: The health information technology system that hosts the Electronic Health Record used to document patient care and assessments at some Vancouver Coastal Health sites.

Clinical and Systems Transformation (CST): A multi year project designed to improve the safety, quality and consistency of patient care across Vancouver Coastal Health, the Provincial Health Services Authority and Providence Health Care.

Dynamic Group: Allows the documentation and display of multiple instances of the same grouping of data elements (i.e. Peripheral IV)

Flagged Comments: Allows the writer to flag a clinically significant event in order for it to be viewable from Patient Summary > Assessment Tab for clinicians to review

Interactive View I&O (Iview): An interactive spreadsheet that provides clinicians with a means to view document and monitor a wide variety of patient data in a single area

Medication Administration Wizard (MAW): An application that allows for the barcode scanning of the Patient ID band as well as medications

National Early Warning Score (NEWS2): A score that utilizes physiological parameters to identify patients that are at an increased risk of deterioration with associated escalation aids

Pain Palliation: Refers to the exploration of the precipitating factors behind pain in terms of what factors reduce and increase the patient's level of pain

Patient Summary: A tab in Power Chart which displays summarized patient information

Power Chart: An application within the CST Cerner system used to manage patient care and perform documentation

Appendix A: (Quick Reference Guide) Locating Physical Assessment Fields in Interactive View I&O

Adult Quick View
Vital Signs: Temperature (Oral), Pulse (Peripheral), SBP/DBP, Respiratory Rate, Oxygen Therapy, SpO2, **Oxygen Therapy,** National Early Warning Score (Double click to activate and enter ACVPU)
Pain Assessment: Pain Present, if yes – complete Location/Onset/Provoking/Palliating/Quality/Laterality/Radiation Characteristics/Pain Scale Used
Mental Status/Cognition: LOC/Orientation, CAM (if required)
Environmental Safety Management: Environment/Manage Sensory Impairment/Demos Call Light
Activities of Daily Living: *Functional*: Hygiene/Walking/Toilet Use/Eating/Sleeping Behaviour *Activity*: Assistive Device/Weight Bearing/Activity Status/Bed Angle (if applicable/Anti-Embolism Device (if applicable) *Nutrition*: Diet Type, Enteral Feeding (if applicable) *Hygiene*: Personal Care, Routine Oral Care
Measurements: Weight Measured, Scale Type
Glucose POCT Whole Blood: Complete scheduled task from Care Compass, random/PRN checks from iview

Adult Systems Assessment
Neurological System: Neurological Symptoms Reported (if reported, complete Nystagmus, Diplopia, Characteristics of Communication, Speech, Expression, Comprehension, Ability to Follow Command, Facial Symmetry, Aspiration (If Dysphagia present)
Cardiovascular System: Cardiovascular Symptoms Reported, Heart Rhythm, Heart Sounds, Nail Bed Colour, Capillary Refill Peripheral. Pulses, Edema Assessment (If present)
Respiratory System: Respiratory Symptoms Reported, Respirations, All Lobes Breath Sounds
Gastrointestinal System: G.I. Symptoms Reported, Abdo Description, Abdo Palpation, Nausea, Appetite, BM last date (upon admission), Stool Count (per BM or document 0 if none on shift), if BM witnessed include amount, colour, description and bowel elimination
Genitourinary System: Urinary Symptoms Reported, Urinary Elimination, if applicable urine colour and characteristics. Bladder Scan & PVR are found in customizations
Integumentary: Skin Colour General / Temperature / Moisture / Integrity / Turgor, Document Braden Assessment (QShift <18, QDaily >18), Incision/Wound/Pin Site (Dynamic Group – *Wound Care Documentation*)
Psychosocial: Affect

Adult Lines & Devices
Peripheral IV/ Subcutaneous Catheter / Central Line / Chest Tube / Urinary Catheter / Gastrointestinal Tube – Create a Dynamic Group for each instance to assess and document on QShift

*Note: This QRG is not intended as a standalone resource for assessment and documentation, please refer to the Medicine Assessment and Documentation DST for full guidance

Appendix B: General Criteria for frequency of assessments

Exception: Palliative Care/actively dying patients should have VS and assessments completed in line with their goals of care (e.g. pain management). Exceptions to assessment and care should be documented in the appropriate sections in the health record.

Vital Signs	General criteria for monitoring vital signs • On admission or transfer to ward • At the beginning of each shift • Routine vital signs (Q8H) or as ordered by the physician/NP • With any change in the patient's status • When administering medications requiring vital signs monitoring (See PDTM) • As outlined in related Vancouver Coastal Health Care Decision Support Tools (DSTs)
Head to Toe Assessment	Head to Toe assessment is required as follows: • On admission/transfer to the ward • At the beginning of each shift and in alignment with patient's goals of care e.g., in some patient populations, the promotion of sleep hygiene outweighs waking a patient for full head to toe assessment when starting shift at 2300. • With any change in the patient's status

Appendix C: Pasero Opioid-Induced Sedation Scale (POSS)

Level of Sedation	Appropriate Action
S = Sleep, easy to rouse	Acceptable; no action necessary; may increase opioid dose if needed
1 = Awake and alert	Acceptable; no action necessary; may increase opioid dose if needed
2 = Slightly drowsy, easily roused	Acceptable; no action necessary; may increase opioid dose if needed
3 = Frequently drowsy, rousable, drifts off to sleep during conversation	Unacceptable; hold opioid until improved; monitor respiratory status and sedation closely until sedation level is stable at less than 3 and respiratory status is satisfactory. Decrease opioid dose 25% to 50% or notify primary or anesthesia provider for orders; consider administering a non-sedating, opioid-sparing non-opioid, such as acetaminophen or an NSAID, if not contraindicated; ask patient to take deep breaths every 15 to 30 minutes.
4 = Somnolent, minimal or no response to verbal or physical stimulation	Unacceptable; hold opioid and notify prescriber; consider administering naloxone; stay with patient, stimulate and support respiration as indicated by patient status; call Rapid Response Team (Code Blue) if indicated; monitor respiratory status and sedation closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

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Approved By: *(committee or position)*	VCH
	Operations Director, Surgical Services, Executive Offices Professional Practice for Nursing & Allied Health, Professional Practice Regional Director, Professional Practice & Clinical Education, Nursing & Allied Health, Professional Practice Director Professional Practice Nursing and Allied Health, Professional Practice Leaders Professional Practice Director, Nursing and Allied Health, Office of the CNO For Final Approval: Vice President, Professional Practice & Chief Clinical Information Officer, VCH
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