

Cerner Streamlining Changes

At the request of numerous Nursing Associates, Streamlining to Cerner Documentation has been developed. The streamlining changes are the result of verbal comments, help desk tickets, and suggestions placed on the Clinical Systems Policies site, located on Molli. Various associates from all of the facilities were involved in the final revisions. Some of the changes were also the result of requirements by regulatory organizations, such as JCAHO. These changes will make the Cerner documentation more focused and more time efficient.

- Admission History
- Adult Assessment and Pediatric Assessment.
- Admission Skin Assessment
- Multidisciplinary Discharge Planning
- Immunization Screening
- Home Meds
- Clinical Problems Plan
- Safety ADL
- Nutrition
- Fall Risk Assessment
- Patient Education

Effective April 26, 2006, all of the above documents will now be included in the Admission Careset.

These changes will affect both the adult and pediatric patient population.

Please forward all questions to the Clinical Systems Policies page on MOLLI:
<http://molli.methodisthealth.org/Departments/clinicalst/bridgepage.htm>

Look in the “View Current Implementations and FAQs” section

Cerner Streamlining Changes

The following will highlight the primary changes to each item:

1. Admission History

The **Reason for Admission** has been moved to the History form (from the Admission Assessment).

The pediatric documentation has been removed and placed on the Pediatric History Form

2. Adult and Pediatric Assessment

There will no longer be an Admission Assessment or an Ongoing Assessment form. There will be an Adult and Pediatric Assessment form.

The height and weight documentation has been added to this form.

The vital signs have been added to this form.

The **Pain Assessment** has been removed from the grid and placed on a page with documentation for two sites. If more than 2 sites are needed, there is an area on the page to retrieve additional sites. A task will fire for reassessment, once interventions have been documented.

The format for the physical assessment has been changed. The nurse must assess whether the patient meets guidelines for a normal assessment for each system. If the patient **meets guidelines**, the basic and detailed assessments do not open for documentation.

If the patient **does not meet** the guidelines for a normal assessment, once a response of **assessment details** is selected, the basic assessment will open.

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At the end of each basic assessment, there is an area to select the detailed assessment if needed. When the basic/detailed assessments are completed, the save and return icon should be selected when completing the form.

The neurological and psychosocial pages have been combined.

The Intravenous site documentation has been removed from the grid. If more than five sites are needed, use the IV form in Ad Hoc charting.

Trach Care/Assessment has been added to the assessment and will automatically open when Trach/ETT care is selected on the detailed Respiratory assessment.

3. Skin Assessment Documentation

The Admission Skin Assessment Form will continue to be included in the Admit Careset and populate to the task list for completion. The Skin AM Daily Assessment Form will populate to the task list every am. The differences in the two forms are the “wound/ulcer present on admission” area located on the Admission Skin Assessment Form and “new wound/wound progress” has been added to the Skin AM Daily Assessment Form. SNF and MECH will continue to receive the forms they are currently using. The skin tab should be reviewed daily before documenting the Skin AM Daily Assessment Form.

Patient skin assessment with no skin problems

Open the document, Admission Skin Assessment Form.

- Complete the Braden Scale Risk Assessment. In the skin integrity section, choose no skin discoloration for both pressure/non-pressure related alterations areas. Click no to the ulcer/wound present upon admission box. An area has been added to document skin conditions such as birthmarks, healed burns, moles, etc. Select the appropriate response of yes/no to this area and free text the skin area that does not require treatment.

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- Click on skin problems and choose no skin problem. If the patient has a normal Braden and no ulcer related alterations, choose no skin problem. If the patient's Braden score is 16 or less, (when documenting Skin Clinical Problems) and no ulcer related alterations, select **altered skin integrity/wound or potential for** so that the prevention measures may be documented.
- Click nutritional problems and choose the appropriate responses for the patient's nutritional status. The reference text in **Nutrition Problems** should be reviewed to make sure the patient does not have any of the symptoms/diagnoses listed. If the patient's symptoms/diagnoses are listed, the patient will be considered having a nutritional problem.
- If patient education has been provided, document under the patient education section
- Sign the form.

Patient skin assessment with pressure related skin problem(s).

Open the document, Admission Skin Assessment Form.

- Complete the Braden Scale Risk Assessment. Under skin integrity, choose the pressure-related wound. A new window with pressure sites 1-10 will open. Click on pressure related and chart detail buttons. The pressure ulcer assessment site window will open for documenting the pressure wound site specifics. Note that when the dressing status selection is chosen, the appropriate conditional fields for this documentation will open. If the dressing requires changing at the time of the assessment, this change can be documented on the form. However, if a dressing change is needed after the assessment, select Dressing Change/Care: Pressure Sites Form found in Ad-Hoc. (If the patient has more than 10 sites, continue to document using the Admission Skin Assessment Add'l Pressure Sites Form found in Ad-Hoc.) Sign and return the two opened forms. Remember to also choose no skin discoloration or breakdown in the non-pressure related alteration box. Make a selection in the ulcer/wound present upon admission box. Select the appropriate response of yes/no to the non-pressure areas and free text the skin area that does not require treatment, which includes skin conditions such as birthmarks, healed burns, moles, etc. in the space provided.

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- Next, click on skin problems and choose the altered skin integrity/wound or potential and active buttons. Both selections in the prevention/pressure/non-pressure area will be checked when the problem status of active is selected. Select appropriate interventions for the patient. Additional documentation for skin tears, Stage II, III, IV or unstageable areas are also available on this page. Stage III, IV, and unstageables will generate a task to the Clinical Nurse to notify the Physician.
- Click nutritional problems and choose the appropriate responses for the patient's nutritional status.
- If patient education has been provided, document under the patient education section.
- Sign the form.

Patient skin assessment with wound/incision site(s)

Open the document, Admission Skin Assessment Form.

- Complete the Braden Scale Risk Assessment. Under skin integrity, choose the appropriate response under the pressure related alteration. Also, under skin integrity choose non-pressure related wound in the non-pressure related alteration area. A new window for non-pressure related wounds will appear. Click on non-pressure site and chart detail buttons. The non-pressure wound/incision assessment area will open for documenting the wound/incision site specifics. Note that when the dressing status selection is chosen, the appropriate conditional fields for documentation will open. If the dressing requires changing at the time of the assessment, this change can be documented on the form. However, if a dressing change is needed after the assessment, select dressing change/care: pressure sites forms from Ad-Hoc for documentation. (If the patient has more than 10 sites, continue to document using the Admission Skin Assessment Add'l Non-pressure Areas Form found in Ad-Hoc.) Sign and return both of the opened forms. Make a selection in the ulcer/wound present upon admission area. Select the appropriate response of yes/no to the non-pressure areas and free text the skin area that does not require treatment, which includes skin conditions such as birthmarks, healed burns, moles, etc. in the space provided.

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- Next, click on skin problems and choose altered skin integrity/wound or potential and active buttons. Both selections in the prevention/pressure/non-pressure area will be selected when the problem status of active is checked. Select the appropriate interventions. Additional documentation for skin tears, Stage II, III, IV or unstageable areas is also available on this page.
- Click nutritional problems and choose the appropriate response for the patient's nutritional status.
- If patient education has been provided, document under the patient education section
- Sign the form.

4. Multidisciplinary Discharge Planning/Patient Education Immunization Screening/Clinical Problems Plan/Home Meds

There have been no additional changes to the Multidisciplinary DC Planning form, nor are there any changes to the Immunization Screening form. The Patient Education form will populate Q12H to the RN/LPN task list at 0800 and 2000.

5. Safety ADL and Nutrition

The nutritional information that was originally on the Safety ADL form has been removed and placed on a separate form called the Nutrition form. The **Nutrition** form will populate to the RN/LPN/MA/MCA task list at 0800/1200/1800. The Nutrition form is generated from the Eats/Feeds order in the Careset. Documentation has been added to note tube feedings and a diet status of NPO.

The Safety ADL form includes documentation of Safety and Hygiene information. The Safety ADL form will populate to the RN/LPN/MA/MCA task list Q2H. A section for Pressure Wound Prevention has been added to the Hygiene page.

6. Clinical Problems Plan Form

Fall Risk has been added to the clinical plan.

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7. Fall Risk Assessment Scale

This scale is based on the Morse Fall Scale. It has been trialed in multiple nursing areas within the Methodist system. The task to complete the scale will fire with the Admission Careset and Q24H at 2000.

Depending upon how the scale is answered, the patient will be assigned a low risk, moderate risk, or high risk assessment status. The scoring is as follows:

- 0-44 = Low Risk
- 45-70 = Moderate Risk
- >70 = High Risk

The Risk Assessment status will determine how often the Falls Precautions form will populate to the task list.

- Low Risk = Q8H
- Moderate Risk = Q4H
- High Risk = Q2H

This will automatically create an order depending on the fall risk assessed. If the fall risk changes, the previous order will discontinue and a new order will be created. This will also occur with the tasks.

If “immediate” is chosen on the Adult Fall Risk Assessment scale, an order is automatically generated for a Clinical Pharmacist consult to review the patient’s medications.

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Cerner Streamlining Changes

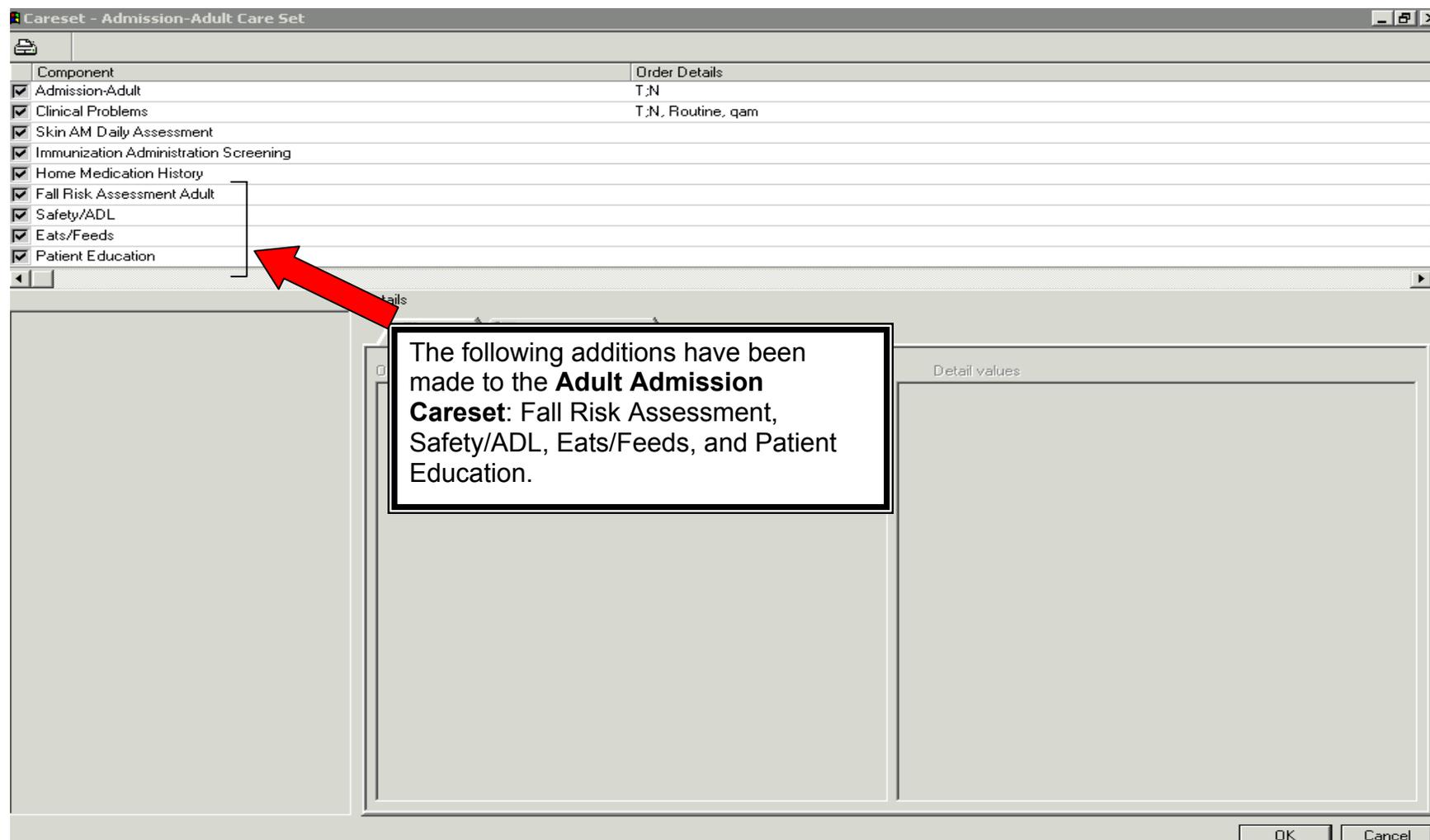
8. Fall Risk Pediatric

The Pediatric Fall Risk Assessment includes low and high risk factors. If any of the high risk factors are selected, a Q2H task for the Fall Risk Safety Guidelines form will be generated.

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The screenshot shows the 'Careset - Admission-Peds Care Set' window. It features a table with two columns: 'Component' and 'Order Details'. The components listed are: Admission-Peds, Clinical Problems, Fall Risk Assessment Pediatric, Home Medication History, Safety/ADL, Eats/Feeds, and Patient Education. A red arrow points to the 'Eats/Feeds' component. A text box with a black border contains the following text: 'The following additions have been made to the Peds Admission Careset: Fall Risk Assessment, Safety/ADL, Eats/Feeds, and Patient Education'. Below the table, there is a 'Detail values' section which is currently empty.

Component	Order Details
<input checked="" type="checkbox"/> Admission-Peds	T,N
<input checked="" type="checkbox"/> Clinical Problems	T,N, Routine, qam
<input checked="" type="checkbox"/> Fall Risk Assessment Pediatric	
<input checked="" type="checkbox"/> Home Medication History	
<input checked="" type="checkbox"/> Safety/ADL	
<input checked="" type="checkbox"/> Eats/Feeds	
<input checked="" type="checkbox"/> Patient Education	

The following additions have been made to the Peds Admission Careset: Fall Risk Assessment, Safety/ADL, Eats/Feeds, and Patient Education

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Cerner Streamlining Changes

LAWYER, A **Age: 38 years** **Sex: Female** **Location: 1E10; 46; A0**
DOB: 8/13/1967 **MRN: 41832459** **Fin Number: 27136455**
Inpatient [Adm 3/24/2006 12:51 PM DC <No - Discharge date>] **** Allergies ****

LAB RAD Admit/DC VS/Pain Clin Data Clin POC Tx/Proc Skin Resp Safety Notes Forms Orders **Act List** I/O Plan Meds Insur Pt Info

Tuesday, April 04, 2006 7:00:00 AM - Tuesday, April 04, 2006 10:00:00 PM

Scheduled Nurse Collect PRN Continuous

Task retrieval completed

	Task Status	Scheduled Date and Time	Task Description	Mnemonic	Order Details
	⌚ Pending	4/4/2006 12:00 PM	Nutrition Form	Eats/Feeds	04/04/06 12:00:00, Routi...
	⌚ Pending	4/4/2006 2:10 PM	Adult Admission History Form	Admission-Adult	04/04/06 14:10:00
	⌚ Pending	4/4/2006 2:10 PM	Adult Assessment Form	Admission-Adult	04/04/06 14:10:00
	⌚ Pending	4/4/2006 2:10 PM	Admission Skin Assessment Form	Admission-Adult	04/04/06 14:10:00
	⌚ Pending	4/4/2006 2:10 PM	Multidisciplinary DC Planning Form	Admission-Adult	04/04/06 14:10:00
	⌚ Pending	4/4/2006 2:10 PM	Immunization Screening Form	Immunization Administration Screening	04/04/06 14:10:00
	⌚ Pending	4/4/2006 2:10 PM	Home Medications Form	Home Medication History	04/04/06 14:10:00
	⌚ Pending	4/4/2006 2:10 PM	Clinical Problems Plan Form 2	Clinical Problems	04/04/06 14:10:00, Routi...
	⌚ Pending	4/4/2006 3:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 15:00:00, Routi...
	⌚ Pending	4/4/2006 4:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 16:00:00, Routi...
	⌚ Pending	4/4/2006 6:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 18:00:00, Routi...
	⌚ Pending	4/4/2006 6:00 PM	Nutrition Form	Eats/Feeds	04/04/06 18:00:00, Routi...
	⌚ Pending	4/4/2006 8:00 PM	Adult Fall Risk Assessment Scale	Fall Risk Assessment Adult	04/04/06 20:00:00, Routi...
	⌚ Pending	4/4/2006 8:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 20:00:00, Routi...
	⌚ Pending	4/4/2006 8:00 PM	Patient Education Form	Patient Education	04/04/06 20:00:00, Routi...
	⌚ Pending	4/4/2006 10:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 22:00:00, Routi...

The new orders in the Careset generate new tasks: Safety/ADL, Patient Education, Adult Fall Risk Assessment Scale, and Nutrition (Eats/Feeds).

Cerner Streamlining Changes

SAWYER, A Age: 38 years Sex: Female Location: 1E10: 46: A0
 DOB: 8/13/1967 MRN: 41832459 Fin Number: 27136455
 Inpatient [Adm 3/24/2006 12:51 PM DC <No - Discharge date>] **** Allergies ****

LAB RAD Admit/DC VS/Pain Clin Data Clin PDC Tx/Proc Skin Resp Safety Notes Forms Orders **Act List** I/O Plan Meds Insur Pt Info

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	Pending	4/4/2006 12:00 PM	Nutrition Form	Eats/Feeds	04/04/06 12:00:00, Routi...
	Pending	4/4/2006 2:19 PM	PEDS Assessment Form	Admission-Peds	04/04/06 14:19:00
	Pending	4/4/2006 2:19 PM	PEDS Admission History Form	Admission-Peds	04/04/06 14:19:00
	Pending	4/4/2006 2:19 PM	Multidisciplinary DC Planning Form	Admission-Peds	04/04/06 14:19:00
	Pending	4/4/2006 2:19 PM	Home Medications Form	Home Medication History	04/04/06 14:19:00
	Pending	4/4/2006 2:19 PM	Clinical Problems Plan Form 2	Clinical Problems	04/04/06 14:19:00, Routi...
	Pending	4/4/2006 3:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 15:00:00, Routi...
	Pending	4/4/2006 4:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 16:00:00, Routi...
	Pending	4/4/2006 6:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 18:00:00, Routi...
	Pending	4/4/2006 6:00 PM	Nutrition Form	Eats/Feeds	04/04/06 18:00:00, Routi...
	Pending	4/4/2006 8:00 PM	Fall Risk Pediatric	Fall Risk Assessment Pediatric	04/04/06 20:00:00, Routi...
	Pending	4/4/2006 8:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 20:00:00, Routi...
	Pending	4/4/2006 8:00 PM	Patient Education Form	Patient Education	04/04/06 20:00:00, Routi...
	Pending	4/4/2006 10:00 PM	Safety/ ADL Form	Safety/ADL	04/04/06 22:00:00, Routi...

The new orders in the Careset generate new tasks: Safety/ADL, Patient Education, Fall Risk Pediatric, and Nutrition (Eats/Feeds).

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Adult Assessment Form - SHORB, BB

*Performed on: 04/03/2006 1333 By: Ztrain, RN10

Patient Info Update
 Vital Signs
 Weight and Height
 Pain Assessment
 Add'l Pain Sites
 Assessment Review-Adult
 Neuro/Psychosocial
 Neuro Detailed
 Glasgow Coma Scale
 Respiratory
 Resp Detailed
 Cardiovascular Assessment
 CV Detailed Assessment
 Gastrointestinal
 GI Detailed Assessment
 Genitourinary
 GU Detailed
 Musculoskeletal
 MS Detailed
 Skin
 Trach Assess/Care
 RN Review
 IV 1
 IV 2
 IV 3
 IV 4

Assessment Review - Adult

Neurological/ Psychosocial

Meets guidelines =

Meets guidelines
 Assessment details

Affect appropriate for age. Makes eye contact. Alert and oriented to person, place and time. Follows commands. Behavior appropriate to situation. Speech clear. PERF Sensation intact. Moves extremities equally. No difficulty in coordination.

Respiratory

Meets guidelines
 Assessment details

Resp. regular and non-labored. Lungs clear with bilateral breath sounds in all lobes. No dyspnea, cough, cyanosis, sputum production, or hemoptysis. No tracheal shift. supplemental O2. No alternative airway.

Cardiovascular

Meets guidelines
 Assessment details

Heart tones audible and regular. No JVD. Peripheral pulses present and equal. Skin color normal for ethnicity. Capillary refill <3 secs. Nailbeds pink. Extremities warm. No edema. No telemetry, ICD, or Pacemaker in use.

Gastrointestinal

Meets guidelines
 Assessment details

No exudate or difficulty swallowing. Bowel sounds active x4 quadrants. Abdomen soft and non-tender. No nausea, vomiting, diarrhea, or constipation. No gastric or nasogastric tube(s), ostomies, fistulas, rectal tube, fecal bag. No fecal incontinence.

Genitourinary

Meets guidelines
 Assessment details

voids clear, yellow urine regularly without difficulty. No odor, discharge or bleeding. No stents, ileoconduit, urinary or dialysis catheters. No urinary incontinence.

Musculoskeletal

Meets guidelines
 Assessment details

No obvious deformities or amputations. Full joint ROM, no swelling or tenderness. Steady gait without aids. No splints, cast, brace or traction.

Skin hydration/ integrity

Meets guidelines
 Assessment details

Turgor elastic, mucous membranes moist and pink, no discoloration or breakdown.

Completion of TASK for Admission Skin Assessment required on admission.
Completion of TASK for AM Daily Skin Assessment required daily.

1. Vital Signs and the Weight and Height sections have been added back to the Assessment form.
2. The Pain Assessment and Infusion Therapy have been taken out of the grid.
3. Each System must be addressed on the Assessment:
 - Meets guidelines—no additional documentation required
 - Does not meet guidelines—assessment details must be documented

Cerner Streamlining Changes

Pediatric Assessment Form - THOMAS, GRADY

*Performed on: 04/04/2006 1014 By: Ztrain, Nicky

Assessment Review - Pediatrics

Meets Guidelines =

Neurological/ Psychosocial	<input type="radio"/> Meets guidelines <input type="radio"/> Assessment details	<p>Infant (<1 year of age) - Eyes open or asleep but arousable. Consolable. PERRL. Fontanel soft, flat. Suck and swallow reflexes present. Moves all extremities equally.</p> <p>Child (> 1 year of age) - Alert, Active, and Ambulatory. Consolable. PERRL. Behavior & verbalization appropriate to situation & age. Moves all extremities equally. Calm, cooperative. No expressions or demonstration of hurting self or others (age appropriate).</p>
Respiratory Airway/Breathing	<input type="radio"/> Meets guidelines <input type="radio"/> Assessment details	<p>Unobstructed airway. Resp. reg. and unlabored. Lungs clear with bilateral breath sounds all lobes. No dyspnea, cough, cyanosis, sputum production, or hemoptysis. No tracheal shift. No supplemental O2. No alternative airway.</p>
Cardiovascular	<input type="radio"/> Meets guidelines <input type="radio"/> Assessment details	<p>Heart tones audible and reg. NO JVD. Peripheral pulses present and equal. Skin color normal for ethnicity. Capillary refill <3 secs. Nailbeds pink. Extremities warm. No edema. No telemetry, ICD, or Pacemaker in use.</p>
Gastrointestinal	<input type="radio"/> Meets guidelines <input type="radio"/> Assessment details	<p>No exudate or difficulty swallowing. Bowel sounds active X4 quad. Abdomen soft and non-tender. No nausea, vomiting, diarrhea, or constipation. No gastric or nasogastric tube(s), ostomies, fistulas. No fecal incontinence (age appropriate).</p>
Genitourinary	<input type="radio"/> Meets guidelines <input type="radio"/> Assessment details	<p>Voiding regularly without difficulty. No odor, discharge or bleeding. No stents, ileoconduit urinary or dialysis catheters. No urinary incontinence (age appropriate).</p>
Musculoskeletal	<input type="radio"/> Meets guidelines <input type="radio"/> Assessment details	<p>No obvious deformities or amputations. Full joint ROM, no swelling or tenderness. Steady gait without aids (age appropriate). No splint, cast, brace or traction.</p>
Skin	<input type="radio"/> Meets guidelines <input type="radio"/> Assessment details	<p>Turgor elastic. Mucous membranes moist and pink. No discoloration, breakdown, bruising, wounds, oral lesions, rash or incisions.</p>

Patient Info Update
 Vital Signs
 Pain Assessment
 FLACC Pain Scale
 NIPS Pain Scale
 Assessment Review -
 Neurological
 Neuro Detailed
 Glasgow Peds Coma
 Glasgow Coma Scale
 Respiratory
 Resp Detailed
 Trach Assess/Care
 Cardiovascular Assess
 CV Detailed Assessment
 Gastrointestinal
 GI Detailed Assessment
 Genitourinary
 GU Detailed
 Musculoskeletal
 MS Detailed
 Skin
 Skin Detailed
 RN Review
 IV 1
 IV 2

In Progress

Pain Assessment (Primary Site)

Unable to verbalize Yes

View pain policy - Patient pain must be assessed and documented as outlined in Methodist Clinical Policy 003-046 Refer to Wong-Baker FACES pain rating scale

Right click here to view pain policy

Intensity (0-10)

Primary pain location

- Abdomen
- ankle
- Back
- Bladder
- Buttock
- Chest
- Ear
- elbow
- Epigastric
- Eye
- Flank
- Foot
- Frontal
- Groin
- hand
- Head
- hip
- Jaw
- knee
- Lower arm
- Lower leg
- Mouth
- Neck
- Nose
- Occipital
- Parietal
- Pelvic
- Rectal
- shoulder
- Suprapubic
- Temporal
- Upper Arm
- Upper leg
- Uterine
- wrist
- Vagina
- Generalized
- Other:

Laterality

- Bilateral
- Left

Abdomen quadrant

- All quadrants
- Left upper quadrant
- Left lower quadrant
- Right upper quadrant
- Right

Character

- Aching
- Burning
- Cramping
- Crushing
- Cutting
- Dull
- Gnawing
- Numbness
- Pins/Needles
- Pressure
- Radiating
- Sharp
- Shooting
- Splitting
- Stabbing
- Tingling
- Other:

Radiating location/character

Onset

- Abrupt
- Frequent
- Gradual

Pattern

- Chronic
- Constant
- Intermittent

Physical parameters

- Anxiety
- Change in vital signs
- Diaphoresis
- Muscle tension
- Nausea
- Pallor
- Pupil dilation
- Other:

Behavioral cues

- Clinging
- Crying
- Grimacing
- Moaning/Groaning
- Restlessness
- Rubbing affected area
- Whining
- Withdrawing/Guarding
- Other:

Interventions

- Repositioned
- Breathing exercises
- Swaddling
- Rocking
- Diversion
- Cold application
- Heat application
- Elevate extremity
- Immobilization of area
- Relaxation techniques
- Medicated
- Pacifier
- Music
- Other:

Pain intervention comments

The Primary and Secondary sites have been removed from the grid. Additional pain sites will continue to be documented in the grid.

The Reassessment/Response of pain must be documented within 1 hour of pain intervention.

Adult Assessment Form - THOMAS, GRADY

*Performed on: 04/06/2006 1327 By: Ztrain, Nicky

IV 1 Insertion/Assessment/Discontinue

IV intervention

 Start
 Discontinue
 Assessment
 Port access
 Port access with blood draw
 Blood draw
 Other:

Insertion date/time

Pt tolerated

 Good
 Fair
 Poor
 Other:

Discontinued status

 Catheter tip intact
 No bleeding noted
 Bleeding noted
 Pressure to site, cessation of bleeding noted
 Catheter tip cultured
 Antibiotic ointment to site
 Adhesive bandage

Site

<input type="checkbox"/> Hand, left	<input type="checkbox"/> Antecubital, right	<input type="checkbox"/> Lower leg, left	<input type="checkbox"/> Posterior tibial, right	<input type="checkbox"/> External jugular, left	<input type="checkbox"/> Subclavian, right
<input type="checkbox"/> Hand, right	<input type="checkbox"/> Posterior forearm, left	<input type="checkbox"/> Lower leg, right	<input type="checkbox"/> Radial, left	<input type="checkbox"/> External jugular, right	<input type="checkbox"/> Other:
<input type="checkbox"/> Wrist, left	<input type="checkbox"/> Posterior forearm, right	<input type="checkbox"/> Foot, left	<input type="checkbox"/> Radial, right	<input type="checkbox"/> Femoral, left	
<input type="checkbox"/> Wrist, right	<input type="checkbox"/> Upper arm, left	<input type="checkbox"/> Foot, right	<input type="checkbox"/> Scalp, forehead	<input type="checkbox"/> Femoral, right	
<input type="checkbox"/> Forearm, left	<input type="checkbox"/> Upper arm, right	<input type="checkbox"/> Dorsalis pedis, left	<input type="checkbox"/> Scalp, temporal left	<input type="checkbox"/> Internal jugular, left	
<input type="checkbox"/> Forearm, right	<input type="checkbox"/> Chest, left	<input type="checkbox"/> Dorsalis pedis, right	<input type="checkbox"/> Scalp, temporal right	<input type="checkbox"/> Internal jugular, right	
<input type="checkbox"/> Antecubital, left	<input type="checkbox"/> Chest, right	<input type="checkbox"/> Posterior tibial, left	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Subclavian, left	

<p>Type</p> <input type="checkbox"/> Peripheral <input type="checkbox"/> INT <input type="checkbox"/> Central Venous I <input type="checkbox"/> PICC <input type="checkbox"/> Single lumen <input type="checkbox"/> Double lumen <input type="checkbox"/> Triple lumen	<p>Size</p> <table border="0"> <tr> <td><input type="checkbox"/> 14 gauge</td> <td><input type="checkbox"/> 26 gauge</td> <td><input type="checkbox"/> 4.5 FR</td> </tr> <tr> <td><input type="checkbox"/> 15 gauge</td> <td><input type="checkbox"/> 1.9 FR</td> <td><input type="checkbox"/> 5 FR</td> </tr> <tr> <td><input type="checkbox"/> 16 gauge</td> <td><input type="checkbox"/> 2.1 FR</td> <td><input type="checkbox"/> 7 FR</td> </tr> <tr> <td><input type="checkbox"/> 18 gauge</td> <td><input type="checkbox"/> 2.5 FR</td> <td><input type="checkbox"/> 8.5 FR</td> </tr> <tr> <td><input type="checkbox"/> 20 gauge</td> <td><input type="checkbox"/> 3 FR</td> <td><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> 22 gauge</td> <td><input type="checkbox"/> 3.5 FR</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 24 gauge</td> <td><input type="checkbox"/> 4 FR</td> <td></td> </tr> </table>	<input type="checkbox"/> 14 gauge	<input type="checkbox"/> 26 gauge	<input type="checkbox"/> 4.5 FR	<input type="checkbox"/> 15 gauge	<input type="checkbox"/> 1.9 FR	<input type="checkbox"/> 5 FR	<input type="checkbox"/> 16 gauge	<input type="checkbox"/> 2.1 FR	<input type="checkbox"/> 7 FR	<input type="checkbox"/> 18 gauge	<input type="checkbox"/> 2.5 FR	<input type="checkbox"/> 8.5 FR	<input type="checkbox"/> 20 gauge	<input type="checkbox"/> 3 FR	<input type="checkbox"/> Other:	<input type="checkbox"/> 22 gauge	<input type="checkbox"/> 3.5 FR		<input type="checkbox"/> 24 gauge	<input type="checkbox"/> 4 FR		<p>Dressing</p> <input type="checkbox"/> Dry <input type="checkbox"/> Intact <input type="checkbox"/> Drainage present <input type="checkbox"/> Changed <input type="checkbox"/> Loose <input type="checkbox"/> Gauze dressing <input type="checkbox"/> Reinforced <input type="checkbox"/> Transparent occlusive dressing <input type="checkbox"/> Transparent tape <input type="checkbox"/> Sterile strips <input type="checkbox"/> Other:
<input type="checkbox"/> 14 gauge	<input type="checkbox"/> 26 gauge	<input type="checkbox"/> 4.5 FR																					
<input type="checkbox"/> 15 gauge	<input type="checkbox"/> 1.9 FR	<input type="checkbox"/> 5 FR																					
<input type="checkbox"/> 16 gauge	<input type="checkbox"/> 2.1 FR	<input type="checkbox"/> 7 FR																					
<input type="checkbox"/> 18 gauge	<input type="checkbox"/> 2.5 FR	<input type="checkbox"/> 8.5 FR																					
<input type="checkbox"/> 20 gauge	<input type="checkbox"/> 3 FR	<input type="checkbox"/> Other:																					
<input type="checkbox"/> 22 gauge	<input type="checkbox"/> 3.5 FR																						
<input type="checkbox"/> 24 gauge	<input type="checkbox"/> 4 FR																						

<p>Site description</p> <input type="checkbox"/> No site complications <input type="checkbox"/> Infusing without complications <input type="checkbox"/> E	<p>Site/line care</p> <input type="checkbox"/> Flushes without difficulty <input type="checkbox"/> Blood return present <input checked="" type="checkbox"/> Drainage <input type="checkbox"/> Leaking	<p>Pump pressure mmHg</p> <input type="text" value="mmHg"/> <p>Pump pressure %</p>
--	---	---

Information has been removed from the grid. IV site documentation sections are located at the bottom of the Navigator on the Assessment form. A separate form must be used for each site.

Cerner Streamlining Changes

Safety/ ADL Form - THOMAS, GRADY

*Performed on: 04/04/2006 1324 By: Training , MA1

Safety/ ADL

Hygiene

Safety/Activities of Daily Living

Standard safety

- Methodist/LeBonheur ID band on Other:
- Bed in low position
- Brakes locked
- Call device within reach
- Side-rails up by two
- Side-rails up by four (Peds)
- Crib rails up
- Airway kit at bedside
- Bag/Mask/Suction at bedside
- Emergency drug profile at bedside
- Checked for needs
- Caregiver(s) at bedside
- Warming bed/ incubator with alarms on
- Cardiopulmonary monitor w/alarms on/limits set
- Oximeter with alarms on and limits set
- Oximeter site changed

Activity status

- Up ad lib
- Ambulating in hall
- Ambulating in room
- Bathroom privileges
- Bedrest
- Return to bed
- Dangle
- Up to bedside commode
- Up to chair
- Up with assistance
- Held/Rocked
- Play activities in playroom
- Play activities in room
- Developmental stimulation/ play therapy
- In wagon
- Secured in infant swing/seat
- Out of room
- Other:

Position change

- Self
- Right
- Left
- Prone
- Supine
- Position change contraindicated
- Other:

Activity assistance

- Independent
- With assistance

Range of motion

- Full motion, active Unable to move
- Full motion, passive Other:
- Limited motion, active
- Limited motion, passive

1. Nutrition information has been removed from the Safety/ADL form.
2. Safety/ADL form has been divided into 2 sections: Safety/ADL and Hygiene

In Progress

Cerner Streamlining Changes

Safety/ ADL Form - SAWYER, A

*Performed on: 04/05/2006 1011 By: Training , MA1

Safety/ ADL
Hygiene

Hygiene

Linen change **ADL**

Complete
 Partial

	Independent	With assistance	Refused	Comment
Shower				
Tub bath				
Bed bath				
Partial bath				
Foot care				
Hair care				
Oral care				
Peri care				
Sitz bath				
Shave				
Catheter care				
Gown change				
Other				

Pressure wound prevention/care measures performed

	Yes
Changed underpad	
Changed diaper (left unfastened)	
Washed affected area(s) with skin cleanser	
Washed affected area(s) with soap & water	
Applied 4 X 4 to deep skin folds	
Applied ABD pad to deep skin folds	
Applied moisture barrier ointment	
Applied cornstarch powder	
External catheter intact	
Fecal incontinence bag/pouch intact	

Pressure wound prevention/care measures performed added to the Hygiene section of the Safety/ADL form.

In Progress

TRAINING | MA123456A | APR 05, 2006 | 10:11 AM

Cerner Streamlining Changes

SAWYER, A - 41932450 Opened by Ztrain, Nicky
 Adult Fall Risk Scale - SAWYER, A

*Performed on: 04/05/2006 1032 By: Z

Adult Fall Risk Assessment Scale

History of Falling Immediate or Within Last 3 Months	<input checked="" type="radio"/> Immediate <input type="radio"/> Within last 3 months <input type="radio"/> No	Immediate response = 25 Within last 3 months = 25	Immediate (within last 24 hours) Immediate answer will generate order for "consult pharmacy"
Presence of Secondary Diagnosis	<input type="radio"/> Yes <input type="radio"/> No	Yes response = 15	More than one medical diagnosis
Use of Ambulatory Aid	<input type="radio"/> Furniture <input type="radio"/> Crutches, cane, walker <input type="radio"/> None, bedrest, wheelchair	Furniture response = 30 Crutches, cane, walker response = 15	If the patient uses any of those listed
IV/IV Access	<input type="radio"/> Yes <input type="radio"/> No	Yes response = 20	Patient has an intravenous apparatus or heparin lock
Gait/Transferring	<input type="radio"/> Impaired <input type="radio"/> Weak <input type="radio"/> Normal, bedrest, immobile	Impaired response = 20 Weak response = 10	Impaired gait is difficulty rising from the chair, balance is poor and cannot walk without assistance Weak gait is stooped but able to lift head while walking without losing balance
Mental Status	<input type="radio"/> Forgets limitations <input type="radio"/> Oriented to own ability	Forgets limitations response = 15	Measured by patient's self-assessment and if it is consistent with ambulatory order
Medications	<input type="radio"/> Yes <input type="radio"/> No	Yes response = 20	Receiving medications that affect blood pressure or level of consciousness

Score 0-44 indicates low risk
 Score 45-70 indicates moderate risk
 Score > 70 indicates high risk

In Progress
 TRAIN, NICKY | APR 05, 2006 | 10:32 AM

Note: Pharmacy will receive a consult if "Immediate" is selected as the first response.

The Fall Risk Assessment Scale auto-calculates a risk score. The risk score determines the frequency of the Fall Precautions task.

Cerner Streamlining Changes

Low Risk Factors

- Infant unable to sit or walk alone
- Toddlers with normal growth and development
- Able to ambulate normally with no cognitive disabilities
- Child not receiving medications that alter mental status
- Other:

High Risk Factors

- Toddler age and above with motor deficit
- Toddler age and above with sensory deficit
- Toddler age and above with visual impairment
- Toddler age and above with focal or generalized weakness
- Toddler age and above with gait disturbance
- Toddler age and above requiring use of ambulatory aids
- Pre-school age and above who has history of falls or has fallen this hospitalization
- Toddler age and above who are less than 24 hours post-operative; post-sedation
- Pre-school age and above who can ambulate but receives medications that alter mental status or impair judgement
- Toddler age and above receiving numerous medications that in conjunction can impair mobility
- None
- Other:

Any risk factor selected will generate the patient safety documentation task.

Any High Risk Factor will generate the Fall High-Risk Safety Guidelines Pediatric task every 2 hours.

In Progress

Cerner Streamlining Changes

Task Edit View Time Scale Options Help

As Of 6:01 PM

ZCARROL, MARK Age: 68 years Sex: Male Location: 1M5A; 00; A0
 DOB: 7/22/1937 MRN: 42027809 Fin Number: 27947716
 Inpatient [Adm 12/20/2005 11:12 AM DC <No - Discharg** Allergies **

Task List I/O Plan Meds Schedule Insurance Pt Info Summary -MD Summary-MD_CR Flowsheet Documentation
 MD Test Gen Insurance Insurance GenView Insurance Gen View2
 LAB RAD All Results Clin Data **Skin** VS/Pain Freq Asmnt Admit/DC Tx/Proc Clin POC Notes Forms Orders

Flowsheet: SKIN ASSESSMENT Level: SKIN ASSESSMENT Table Group

Last 250 Results - Selected Encounter Only

Navigator	SKIN ASSESSMENT	3/22/2006 5:05 PM
<input checked="" type="checkbox"/> Pressure Ulcer Site 1	Pressure Ulcer Site 1	
<input checked="" type="checkbox"/> Wound (non-pressure) Site 1	Pressure ulcer site # 1	Hip
<input checked="" type="checkbox"/> General Skin Assessment	Pressure ulcer stage # 1	Stage III
<input checked="" type="checkbox"/> Braden Scale Risk Assessme	Pressure ulcer status/type #1	Pressure related wound
<input checked="" type="checkbox"/> Skin/Wound Care Interventio	Pressure ulcer wound bed appearance # 1	Pink, Red, White
<input checked="" type="checkbox"/> Clinical Plans- Skin	Pressure ulcer dressing status #1	Dressing changed
	Pressure ulcer drsg assessment #1	4x4 gauze, Clean dressing applied, Hypo
	Pressure ulcer drainage amount # 1	Small
	Pressure ulcer drainage character # 1	Sanguinous/Bloody, Mild odor
	Pressure reduction device # 1	Heelbos, Alternating pressure mattress
	Pressure ulcer treatment #1	Cleaned with soap and water
	Wound (non-pressure) Site 1	
	Wound Type (non-pressure) #1	Incision &/or surgical site
	General Skin Assessment	
	Wound present upon admission	Yes
	Braden Scale Risk Assessment	
	Sensory perception (Braden)	Slightly limited
	Moisture (Braden)	Very moist
	Activity (Braden)	Chairfast
	Mobility (Braden)	Slightly limited
	Nutrition (Braden)	Very poor
	Friction and shear (Braden)	Problem
	Braden Score	12

Skin tab improvements

Always check the Skin tab first.

Pressure wound information has been moved to the top.

Identify all Pressure ulcer sites, resolved and active.

If the pt has a **Resolved** pressure wound still select Pressure related wound when documenting on the Skin Assessment form.

So always check the Skin Tab first to check for resolved pressure wound sites.

Cerner Streamlining Changes

Admission Skin Assessment Form - Patient, Name

*Performed on: 03/22/2006 1628 By: Howell, Sally A

Skin Assessment

Braden Scale Risk Assessment

Must be completed upon admission and every 24 hours

Sensory perception	Moisture	Activity	Mobility	Nutrition	Friction and shear
<input type="radio"/> Completely limited <input type="radio"/> Very limited <input type="radio"/> Slightly limited <input type="radio"/> No impairment	<input type="radio"/> Constantly moist <input type="radio"/> Very moist <input type="radio"/> Occasionally moist <input type="radio"/> Rarely moist	<input type="radio"/> Bedfast <input type="radio"/> Chairfast <input type="radio"/> Walks occasionally <input type="radio"/> Walks frequently	<input type="radio"/> Completely limited <input type="radio"/> Very limited <input type="radio"/> Slightly limited <input type="radio"/> No limitations	<input type="radio"/> Very poor <input type="radio"/> Probably inadequate <input type="radio"/> Adequate <input type="radio"/> Excellent	<input type="radio"/> Problem <input type="radio"/> Potential problem <input type="radio"/> No apparent problem

i = right click on field for reference text information

Skin integrity risk score

In Progress

Right clicking in each field opens a reference text for the choices in that specific field. (See next screenshot)

Please forward all questions to the Clinical Systems Policies page on MOLLI:
<http://molti.methodisthealth.org/Departments/clinicalst/bridgepage.htm>

Look in the “View Current Implementations and FAQs” section

Cerner Streamlining Changes

The screenshot shows a software window titled "Decision Support" with a sub-header "Sensory Perception Braden". Below the header is a "Reference" tab and a search bar containing "Sensory Perception Braden". A row of radio buttons allows navigation between different content types: "CarePlan information", "Chart guide" (which is selected), "Nurse preparation", "Patient education", "Policy and procedures", and "Scheduling information". The main content area displays the definition of "Sensory Perception" and a numbered list of four levels of impairment: 1. Completely Limited, 2. Very Limited, 3. Slightly Limited, and 4. No Impairment. An "OK" button is located at the bottom right of the window.

Decision Support

Sensory Perception Braden

Reference

Sensory Perception Braden

CarePlan information Chart guide Nurse preparation Patient education Policy and procedures Scheduling information

Sensory Perception- Ability to respond meaningfully to pressure related discomfort.

- 1. Completely Limited**- Unresponsive (does not moan, flinch or grasp to painful stimuli due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body.
- 2. Very Limited**- Responds only to painful stimuli, cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.
- 3. Slightly Limited**- Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.
- 4. No Impairment**- Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.

OK

Please forward all questions to the Clinical Systems Policies page on MOLLI:
<http://mulli.methodisthealth.org/Departments/clinicalst/bridgepage.htm>

Look in the “View Current Implementations and FAQs” section

Cerner Streamlining Changes

Admission Skin Assessment Form - Patient, Name

*Performed on: 03/22/2006 1628 By: Howell, Sally A

Skin Integrity: (identify all that apply)

PRESSURE related alteration

No skin discoloration or breakdown

Pressure related wound (includes resolved and recategorized)

NON-PRESSURE related alteration

No skin discoloration or breakdown

Non pressure related wound (includes resolved and recategorized)

Ulcer/Wound present upon admission

Yes

No

Unknown

Non-pressure areas include skin tears, abrasions, & invasive procedure sites.

In Progress

Selection of Pressure related wound opens the Pressure Wound site section. This section allows you to view sites 1-10 in one screen. (See next screenshot)

Please forward all questions to the Clinical Systems Policies page on MOLLI:

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Look in the “View Current Implementations and FAQs” section

Cerner Streamlining Changes

Admission Pressure Wound Grid (1-10) - ZCARROL, MARK

Admission Pressure Wound Sites 1 - 10

Once a site is "Resolved" or "Recategorized", do not re-open the site (unless due to charting error). Start a new site.

Site	Wound Status	Site, Location and Stage	Site	Wound Status	Site, Location and Stage
1	<input checked="" type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #2 documentation on this encounter.	1	<input checked="" type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #2 documentation on this encounter.
3	<input type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #4 documentation on this encounter.	3	<input type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #4 documentation on this encounter.
5	<input type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #5 documentation on this encounter.	6	<input type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #6 documentation on this encounter.
7	<input type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #7 documentation on this encounter.	8	<input type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #8 documentation on this encounter.
9	<input type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #9 documentation on this encounter.	10	<input type="radio"/> Pressure related <input type="radio"/> Resolved <input type="radio"/> Re-categorized <input type="button" value="Chart detail"/> <input type="radio"/> Yes	DISPLAY OF PREVIOUS DOCUMENTATION. DO NOT DOCUMENT IN THIS AREA. No previous Site #10 documentation on this encounter.

Documentation for additional Admission Pressure Wound sites 11 - 20 are available in Ad Hoc

Cerner Streamlining Changes

Area A Non Pressure - Patient, Name

Dressing status

No dressing
 Dressing left intact
 Dressing changed
 Dressing applied

Dressing assessment

None
 Clean
 Dry
 Intact
 Drainage noted
 Dried drainage noted

Closure device

None
 Staples
 Sutures
 Retention sutures
 Sterile strips
 Skin bonding adhesive
 Other:

Drain type

None
 Vacuum (Hemovac)
 Bulb (Jackson-Pratt)
 Gravity
 Penrose
 Wound vacuum
 Other:

Drainage amount

None
 Scant
 Small
 Moderate
 Large
 Copious

Dressing changed and Dressing applied open the same fields.
 Dressing applied is selected when the wound did not have a dressing and one was applied.

Wound / Incision assessment

Clean
 Dry
 Intact
 Pink
 Edges approximated
 Edges non-approximated
 Drainage noted

Edema
 Erythema
 Dehiscence
 Open
 Ecchymosis
 Tender
 Black

Warm
 Boundaries marked
 No odor
 Mild odor
 Foul odor
 Other:

Treatment & Dressing

Wound / Incision Treatment

None
 Cleaned with water
 Cleaned with sterile water
 Cleaned with soap and water
 Cleaned with normal saline
 Cleaned with sterile saline
 Cleaned with diluted betadine
 Cleaned with betadine
 Cleaned with chlorhexidine
 Cleaned with enzymatic cleanser
 Cleaned with wound cleanser
 Cleaned with sterile saline & chlorhexidine soap
 Cleaned with sterile water & chlorhexidine soap
 Cleaned per order

Irrigated with sterile saline
 Irrigated with diluted betadine
 Irrigated per order
 Applied cornstarch
 Applied wound gel
 Applied enzymatic gel/paste
 Applied hydrogel
 Applied medication (see MAR)
 Applied moisture barrier ointment
 Painted with betadine
 Painted with chlorhexidine prep
 Debridement
 Other:

Dressing (mark items used to apply/reinforce/replace dressing)

None
 3x3 gauze
 4x4 gauze
 Gauze wrap
 Petroleum gauze
 Clean dressing applied
 Sterile dressing applied
 Gauze dressing
 Non-adhesive gauze dressing
 Wet to dry dressing
 Hydrocolloid dressing
 Foam dressing
 Transparent dressing
 Occlusive dressing

Skin sealant, regular
 Absorbent pad
 Adhesive bandage
 Nonadhesive bandage
 Pressure bandage
 Elastic bandage
 Plastic tape
 Paper tape
 Cloth tape
 Silk tape
 Hypoallergenic tape
 Other:

Cerner Streamlining Changes

Admission Skin Assessment Form - ZCARROL, MARK

*Performed on: 03/22/2006 1705 By: Howell, Sally A

Skin integrity risk score 12

Skin Integrity: (identify all that apply)

PRESSURE related alteration

No skin discoloration or breakdown

Pressure related wound (includes resolved and recategorized)

NON-PRESSURE related alteration

No skin discoloration or breakdown

Non pressure related wound (includes resolved and recategorized)

Non-pressure areas include skin tears, abrasions, punctures, & invasive procedure sites.

Ulcer/Wound present upon admission

Yes

No

Unknown

(255 character limit)

In Progress

i = right click on field for reference text information

Selection of Non pressure related wound opens the Non Pressure Wound Site section. This section allows you to view sites 1-10 in one screen.

Please forward all questions to the Clinical Systems Policies page on MOLLI:

<http://molli.methodisthealth.org/Departments/clinicalst/bridgepage.htm>

Look in the “View Current Implementations and FAQs” section

Cerner Streamlining Changes

Admission Skin Assessment Form - ZCARROL, MARK

Performed on: 03/22/2006 1705 By: Howell, Sally A

✓ Skin Admissi
✗ Skin Problem:
✗ Nutrition Prob
Patient Educ
RN Review
✓ Admission Pre
✓ Admission No
✓ Site 1 Pressu

Non-pressure areas include skin tears, abrasions, punctures, & invasive procedure sites.

Does the patient have old scars or other skin conditions (such as birthmarks, healed burns, moles, etc.) that would be considered a part of his/her normal skin anatomy that will not need to be addressed daily? (255 character limit)

Yes
 No

Large mongolian spot across buttocks noted

A place has been provided to chart those skin areas that do not require treatment.

In Progress

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Look in the “View Current Implementations and FAQs” section