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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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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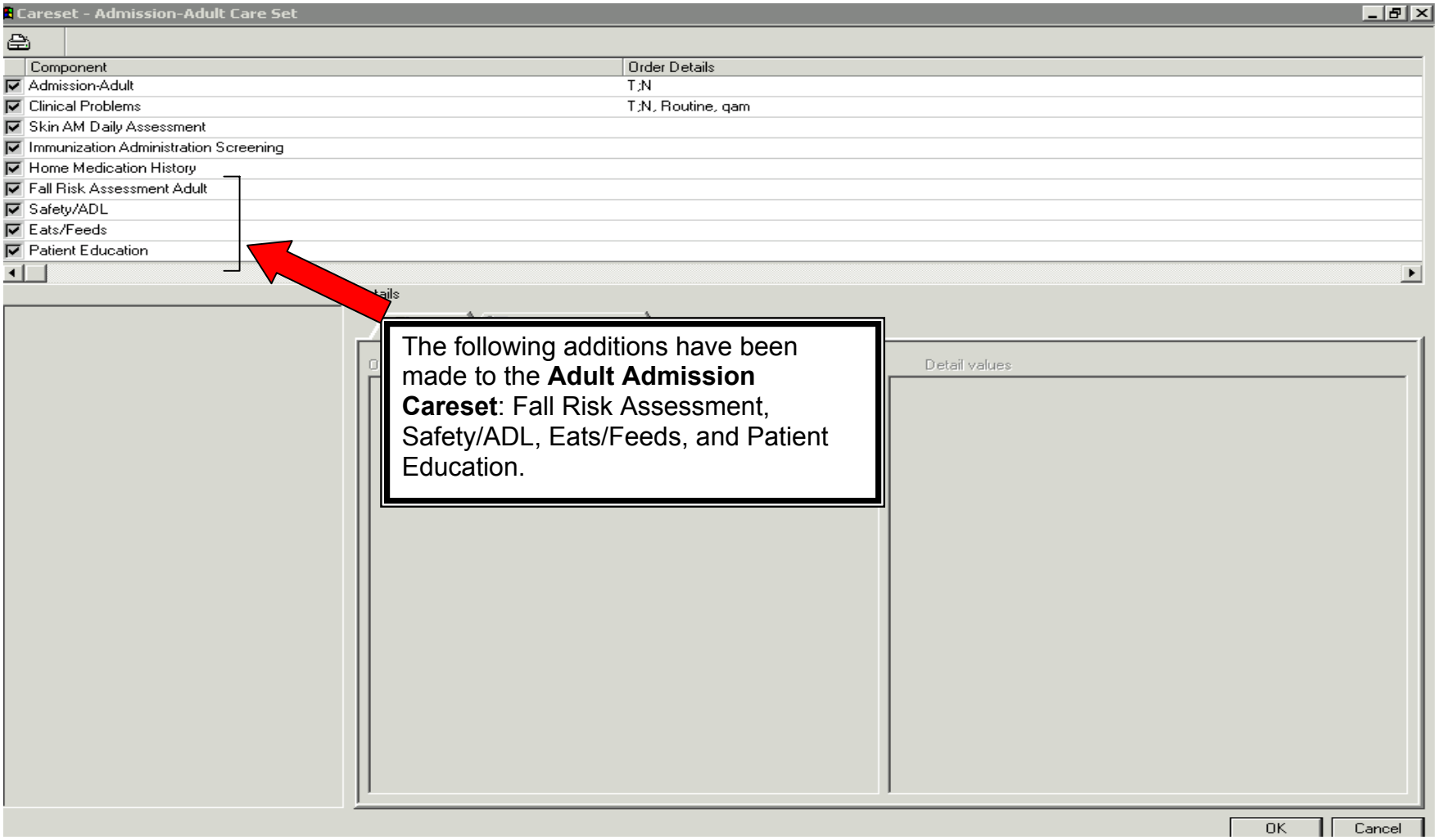

The following additions have been made to the **Adult Admission Careset**: Fall Risk Assessment, Safety/ADL, Eats/Feeds, and Patient Education.

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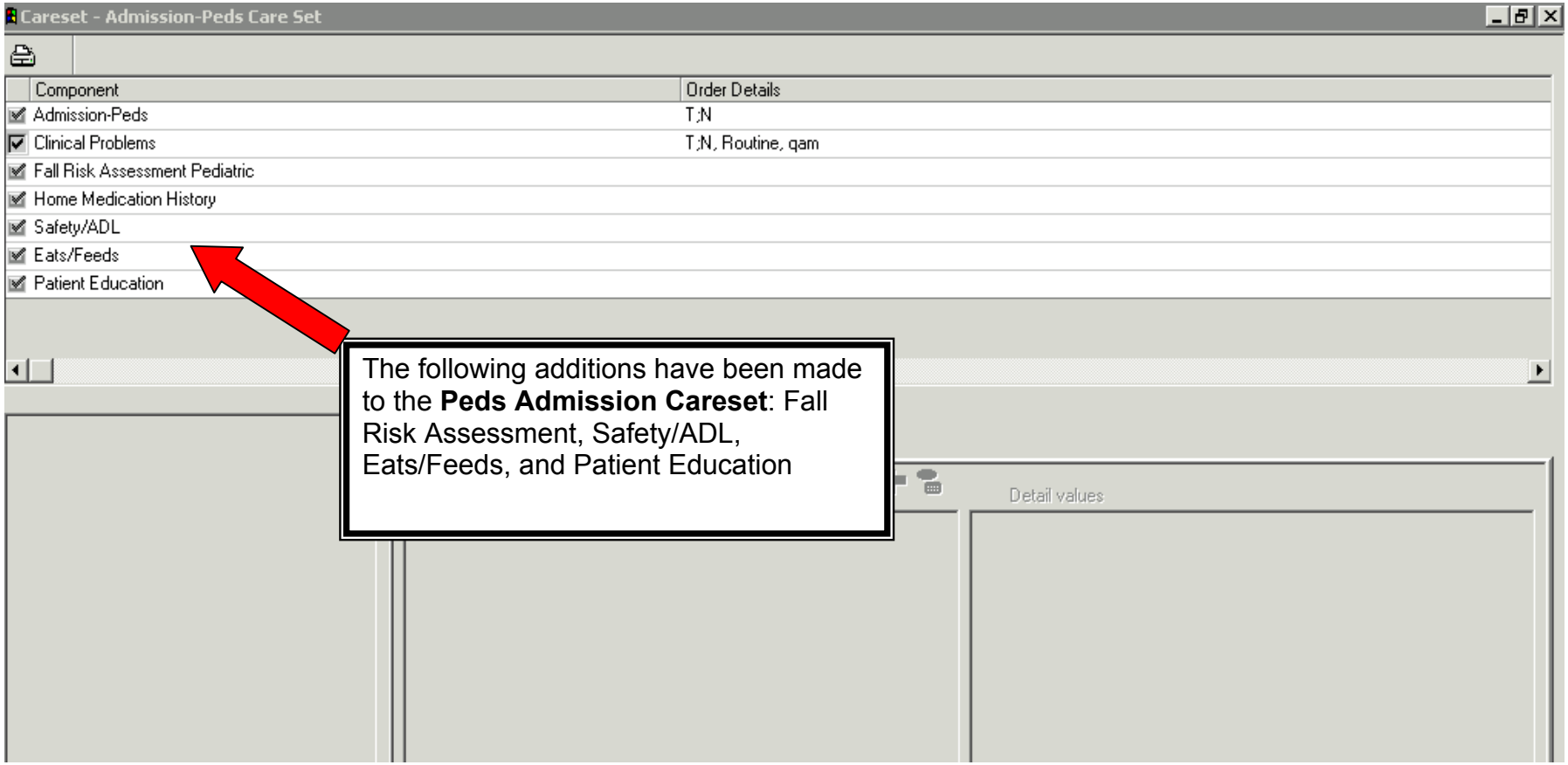

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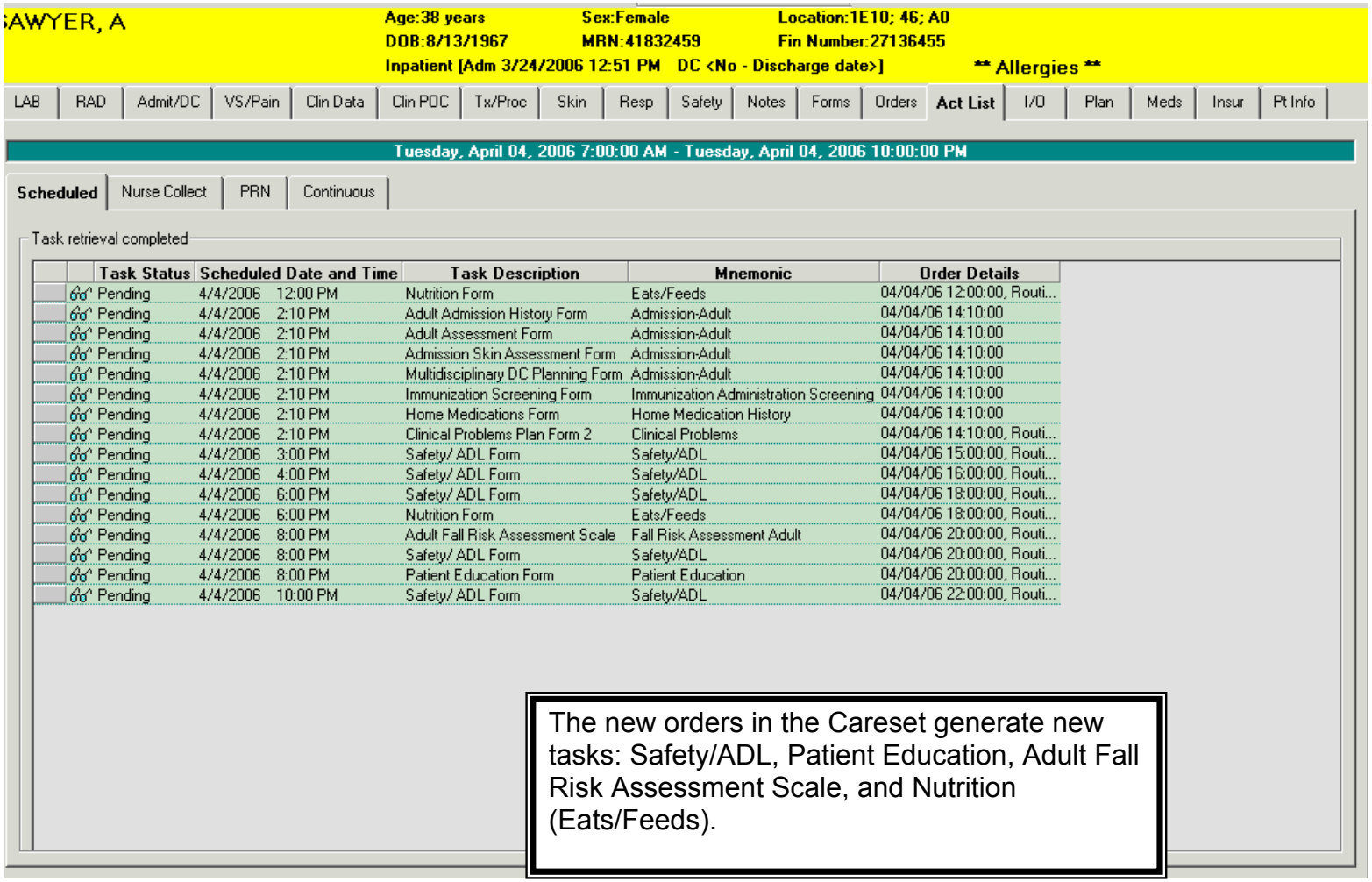
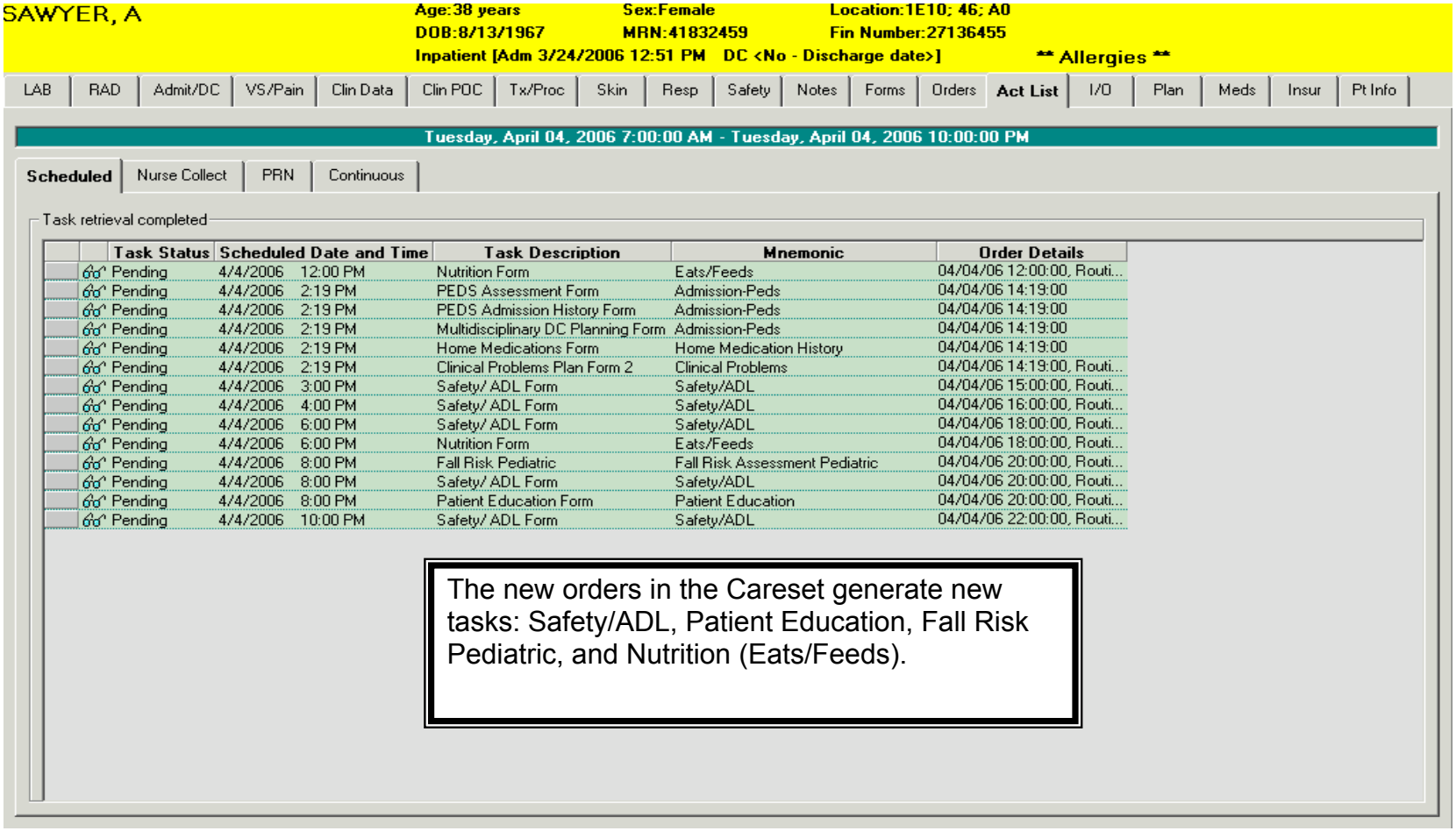


The new orders in the Careset generate new tasks: Safety/ADL, Patient Education, Adult Fall Risk Assessment Scale, and Nutrition (Eats/Feeds).

Cerner Streamlining Changes



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

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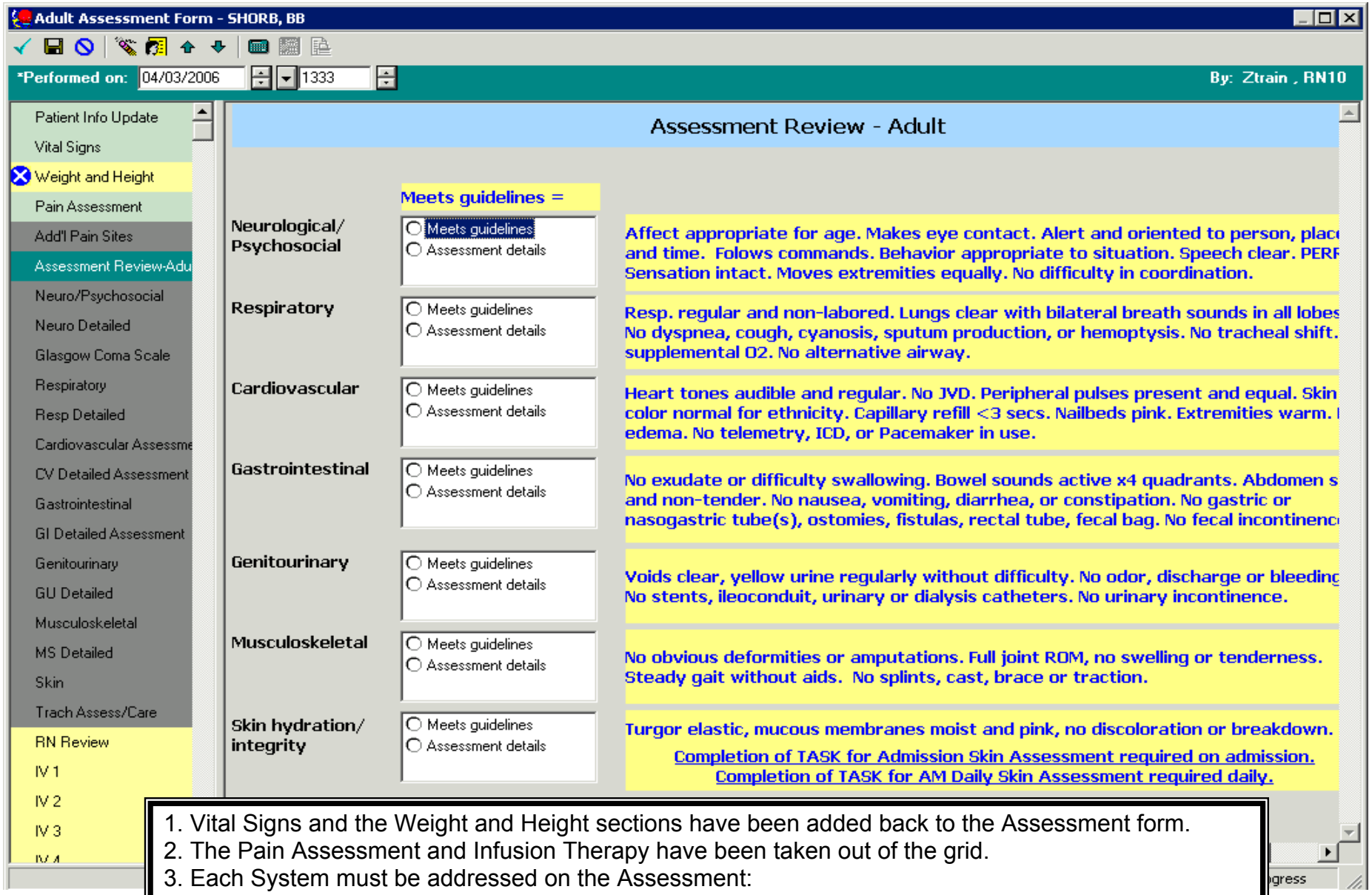
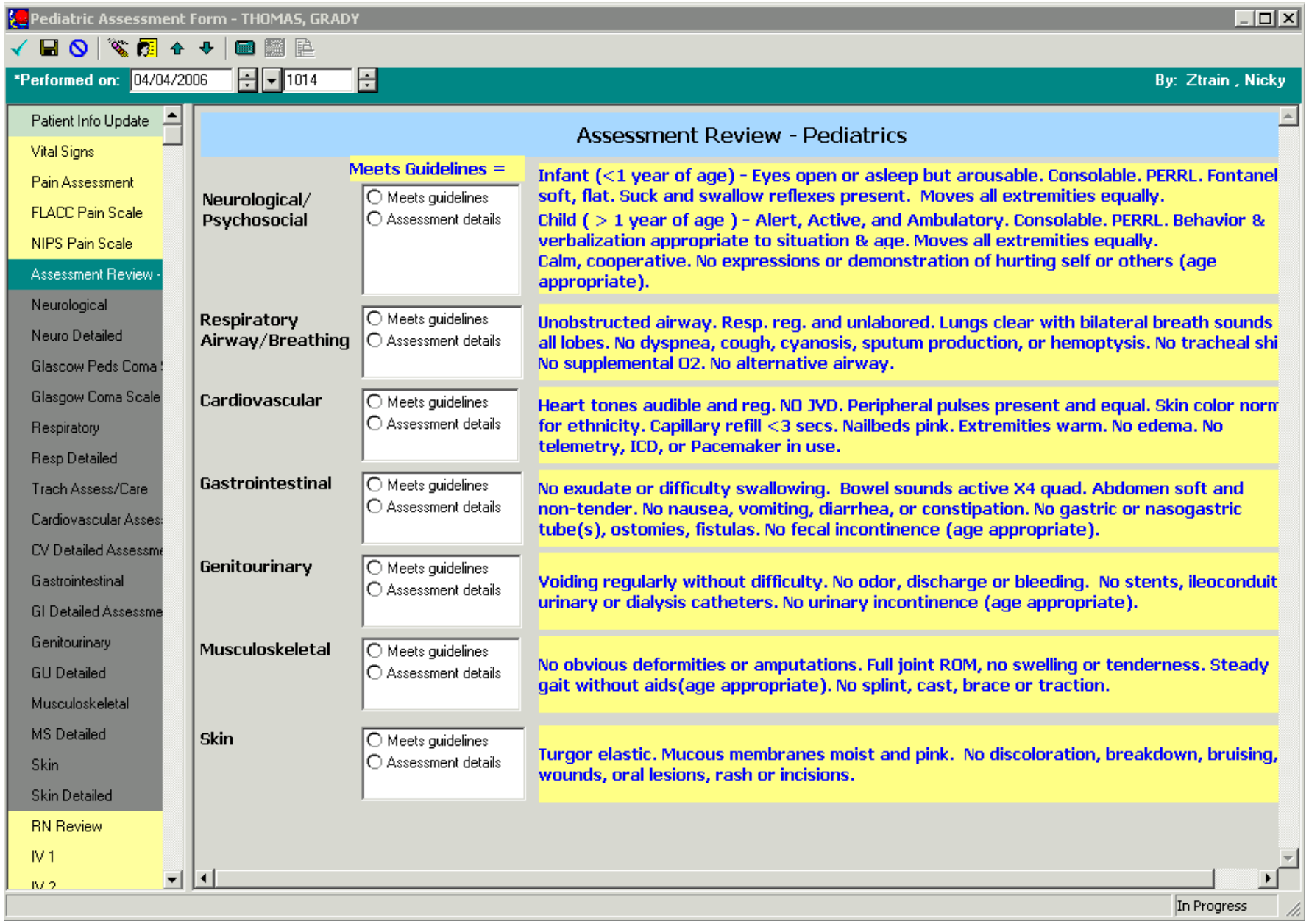
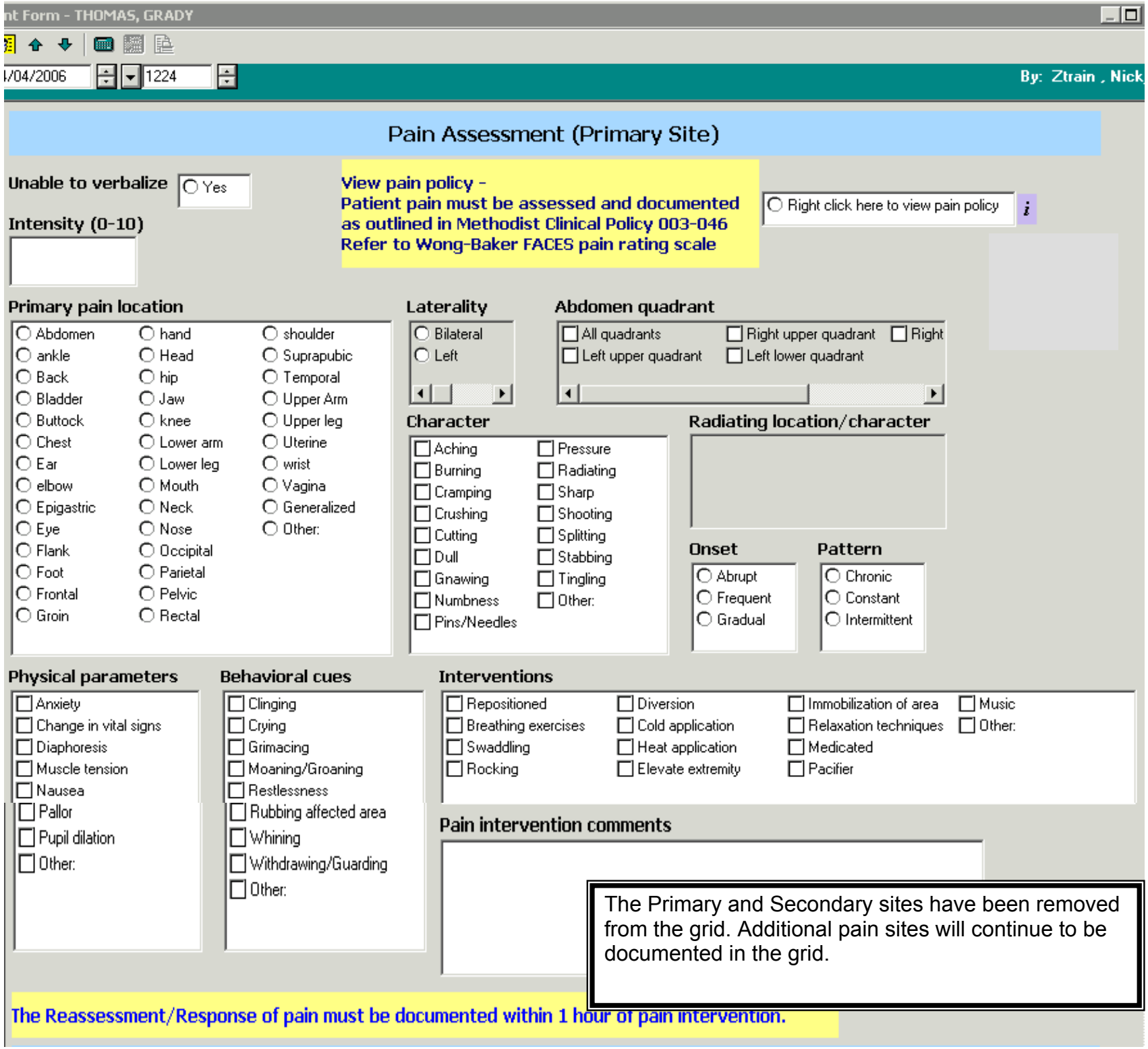


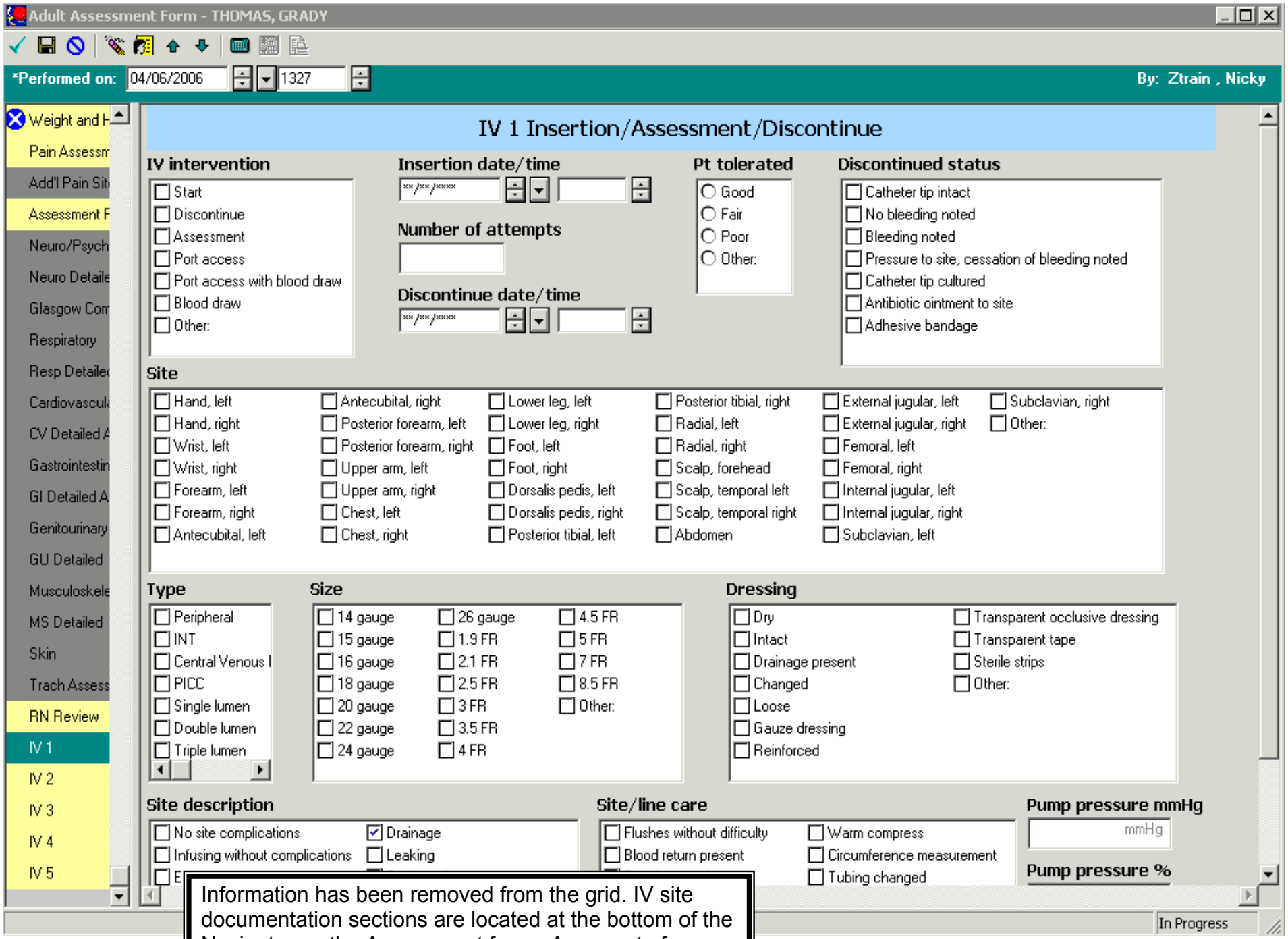
1. Vital Signs and the Weight and Height sections have been added back to the Assessment form.
2. The Pain Assessment and Infusion Therapy have been taken out of the grid.
3. Each System must be addressed on the Assessment:
   Meets guidelines—no additional documentation required
   Does not meet guidelines—assessment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

Cerner Streamlining Changes





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



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.

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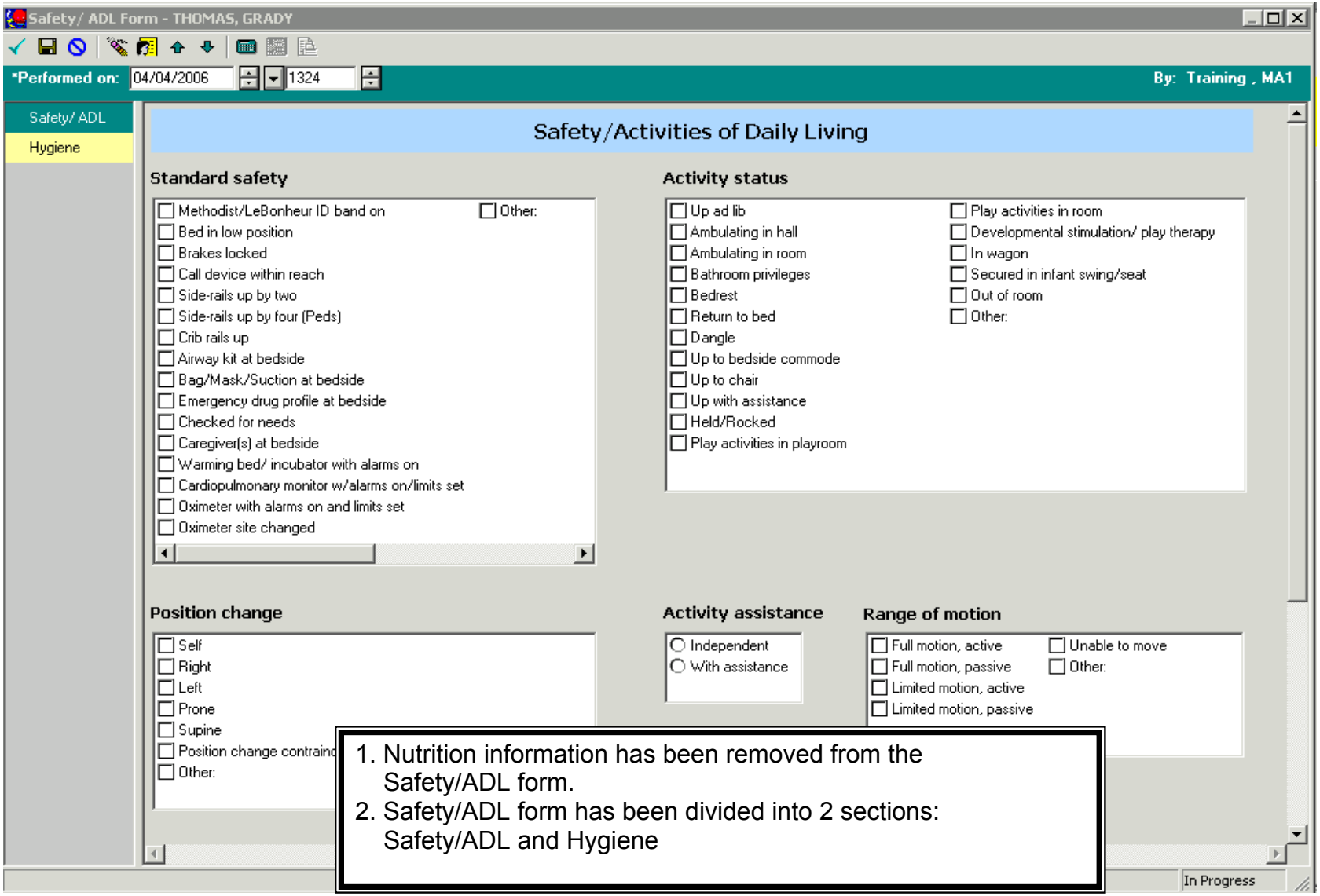

1. Nutrition information has been removed from the Safety/ADL form.
2. Safety/ADL form has been divided into 2 sections: Safety/ADL and Hygiene

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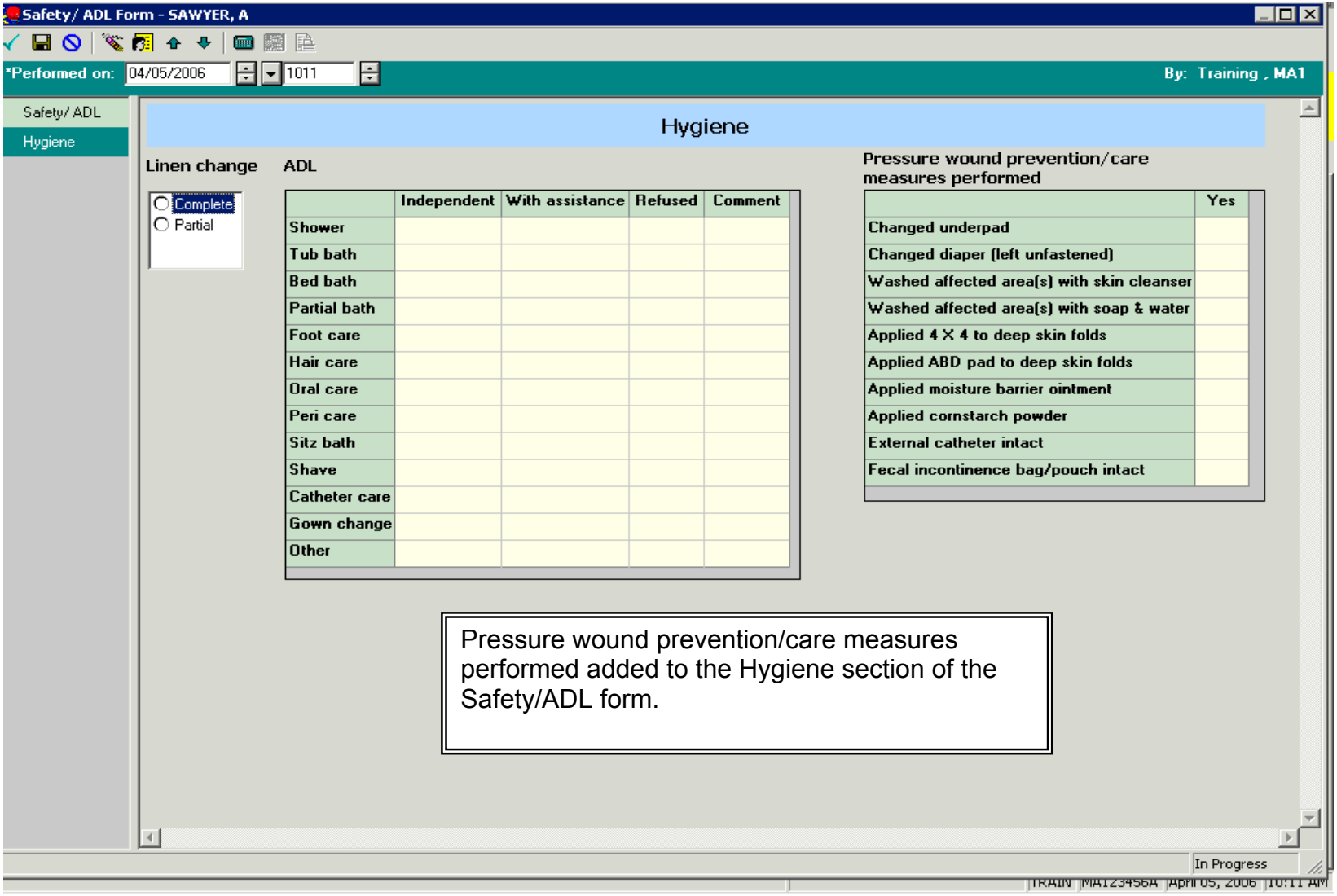

Pressure wound prevention/care measures performed added to the Hygiene section of the Safety/ADL form.

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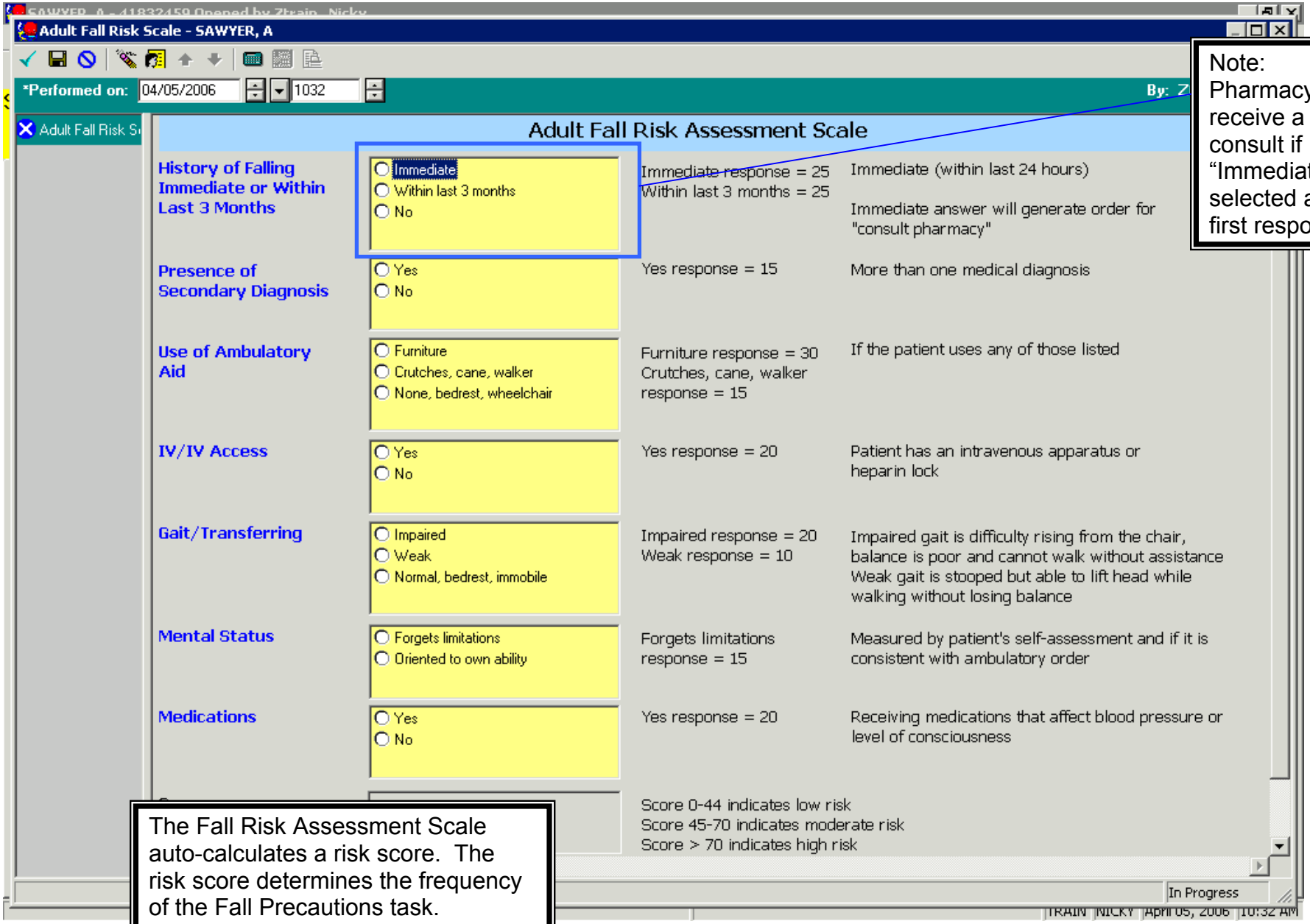

Note: Pharmacy will receive a consult if "Immediate" is selected as the first response.

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

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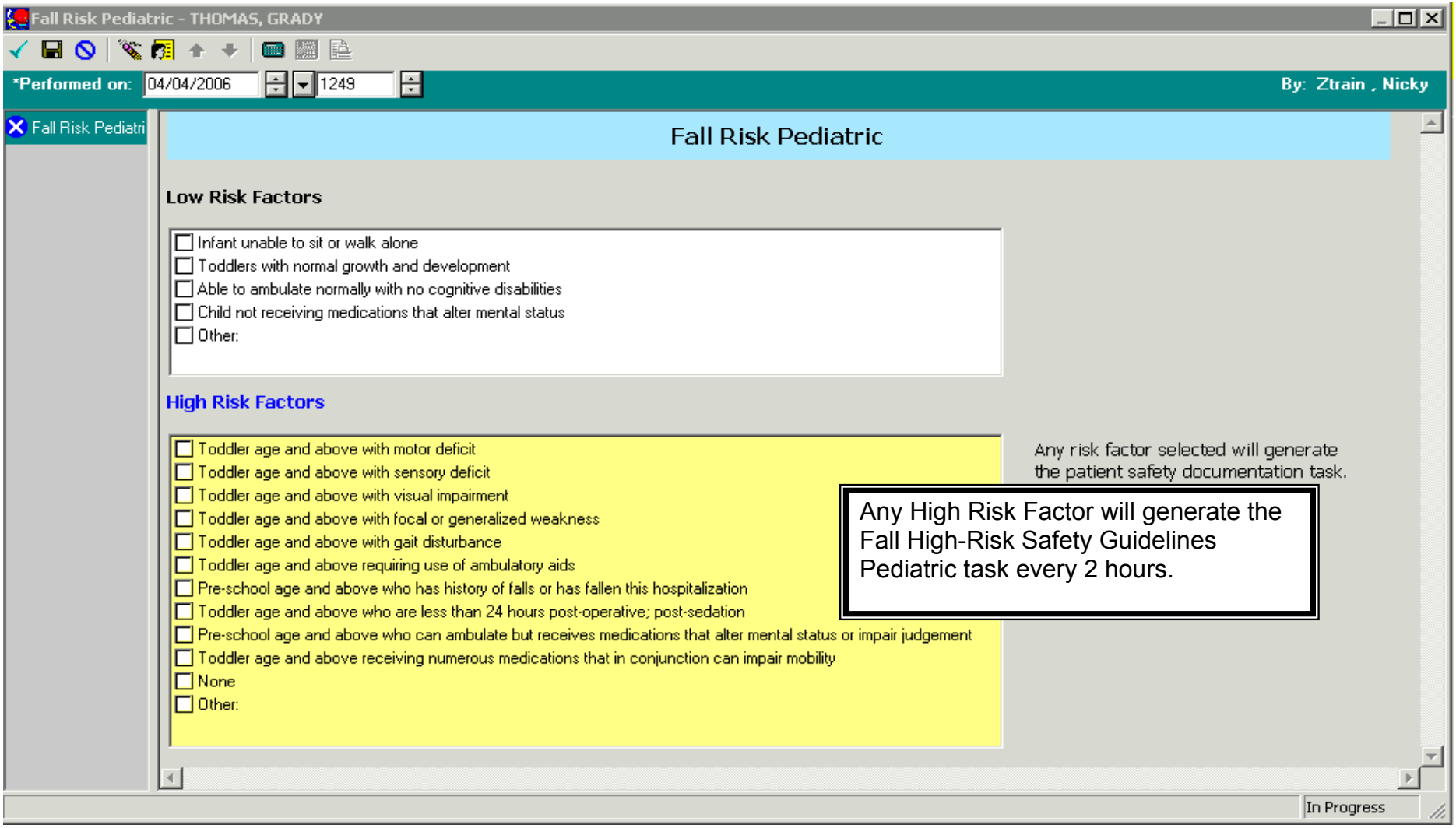

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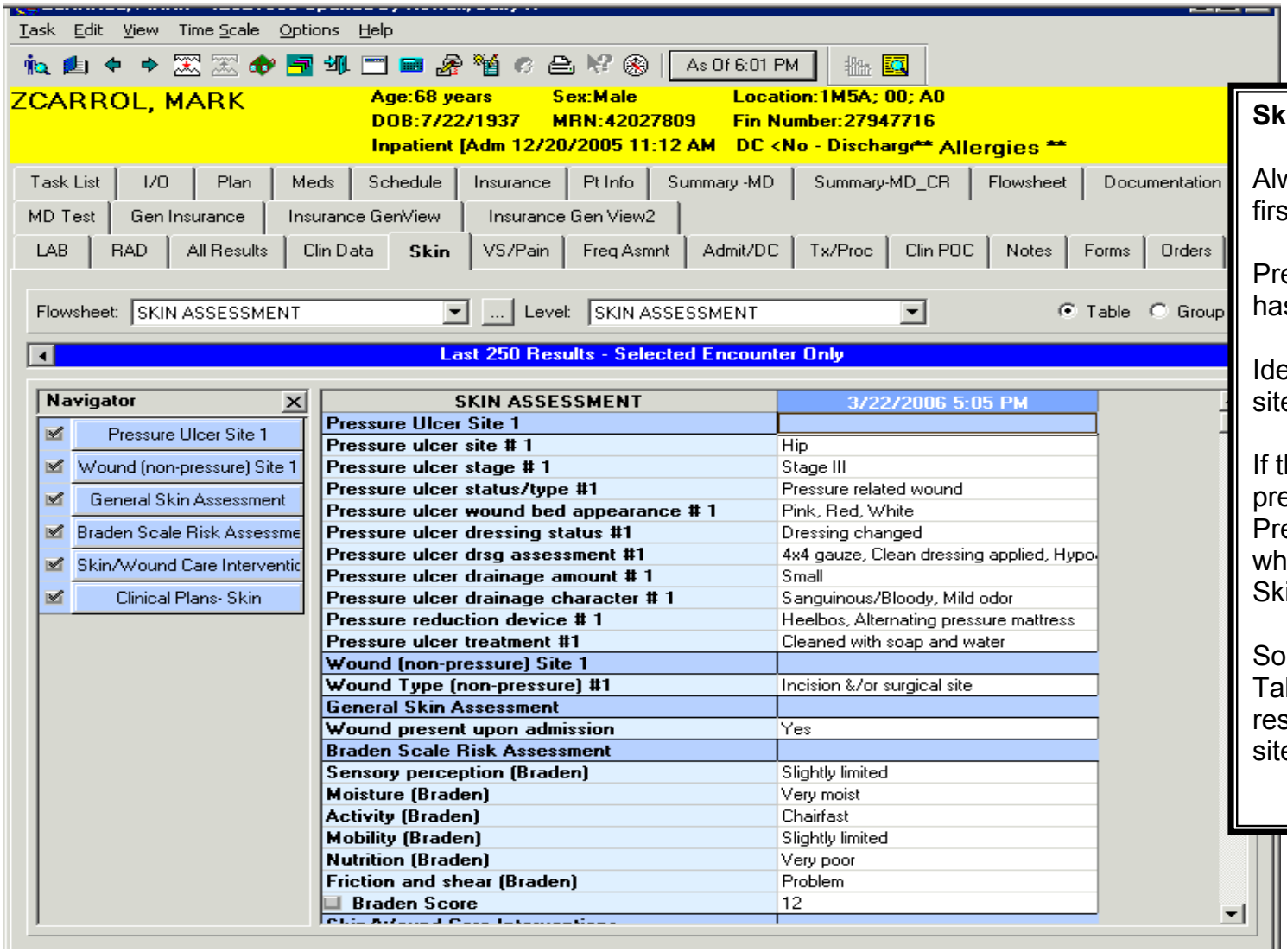

Skin tab improvements

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.

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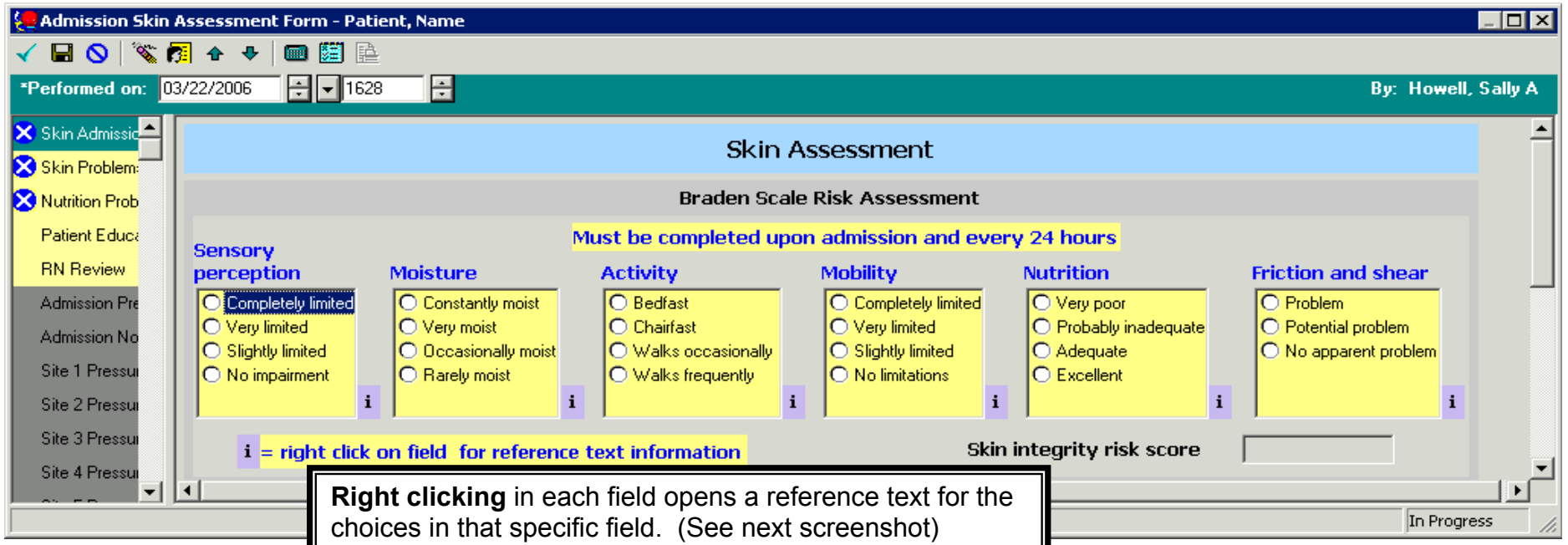

Right clicking in each field opens a reference text for the choices in that specific field. (See next screenshot)

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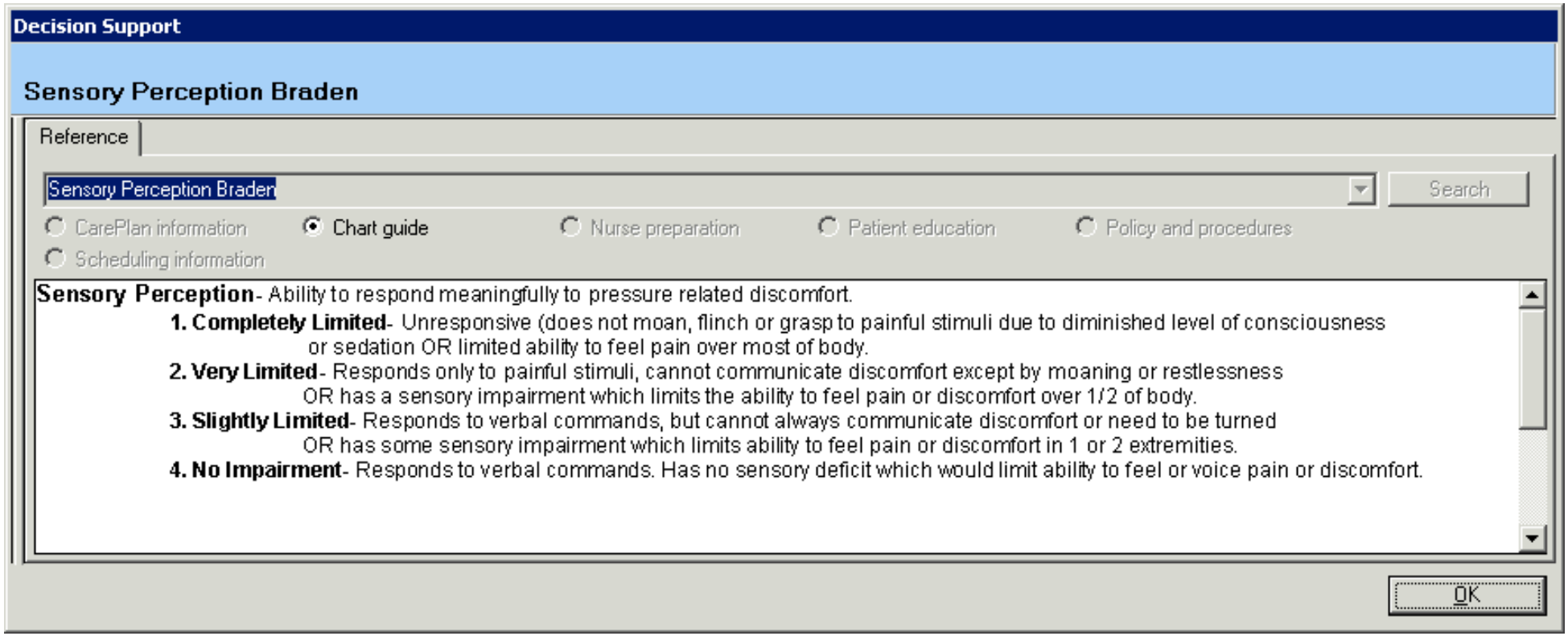

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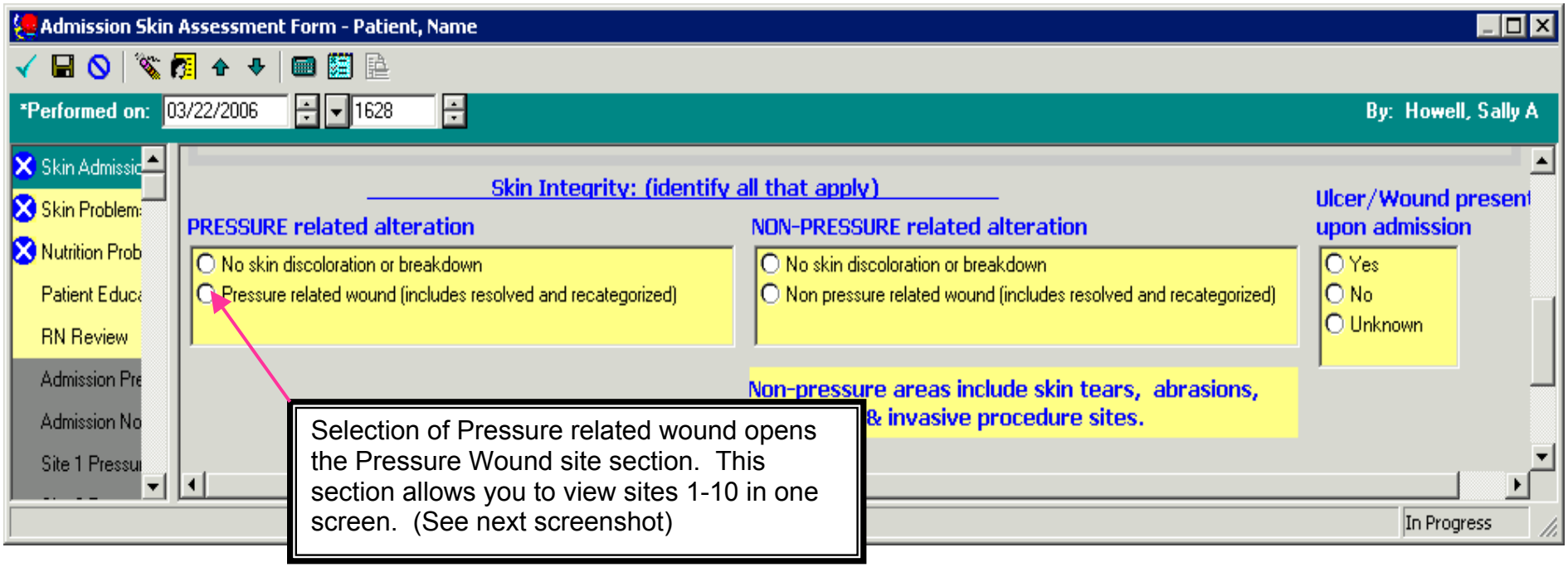

Selection of Pressure related wound opens the Pressure Wound site section. This section allows you to view sites 1-10 in one screen. (See next screenshot)

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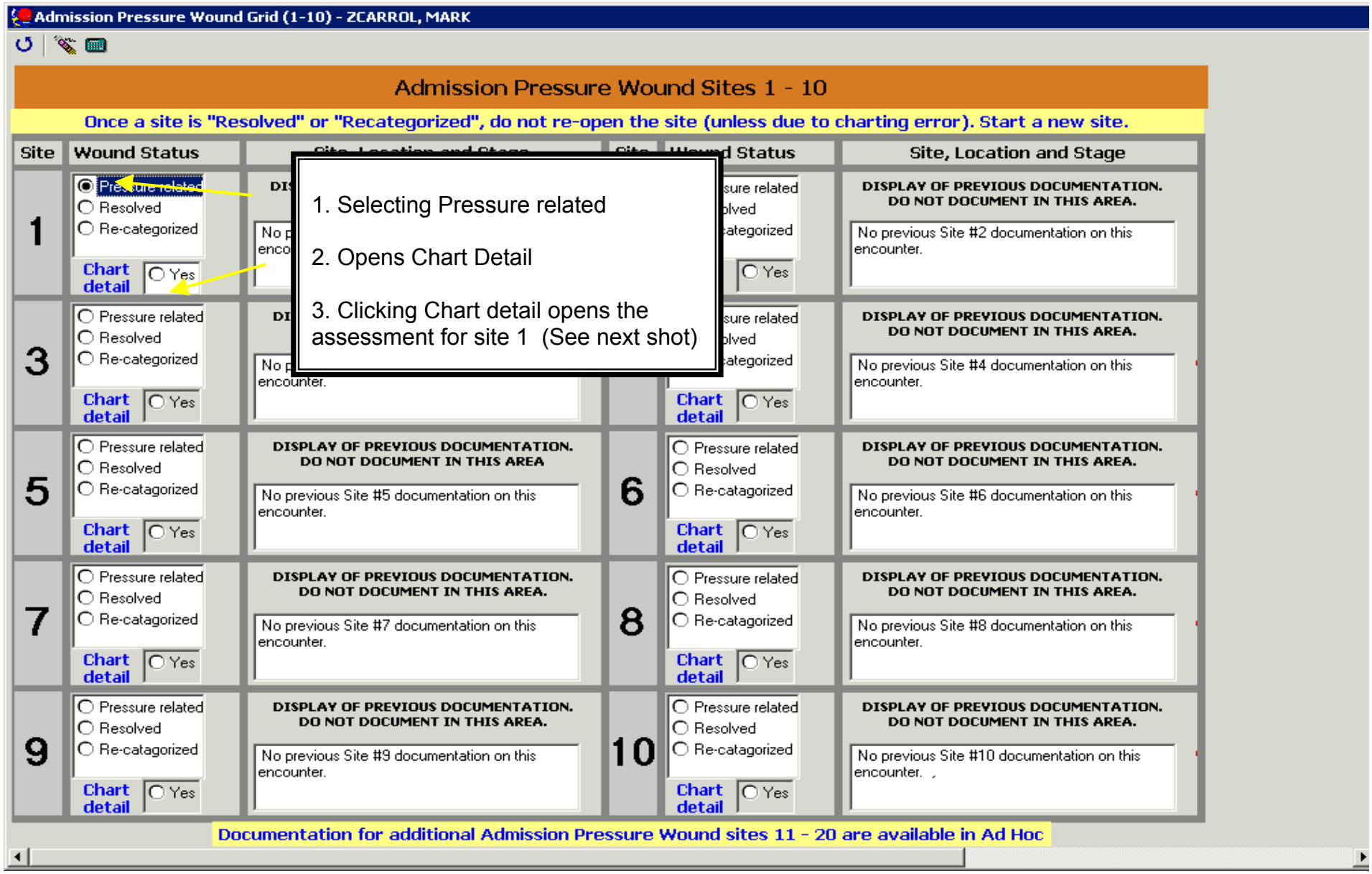

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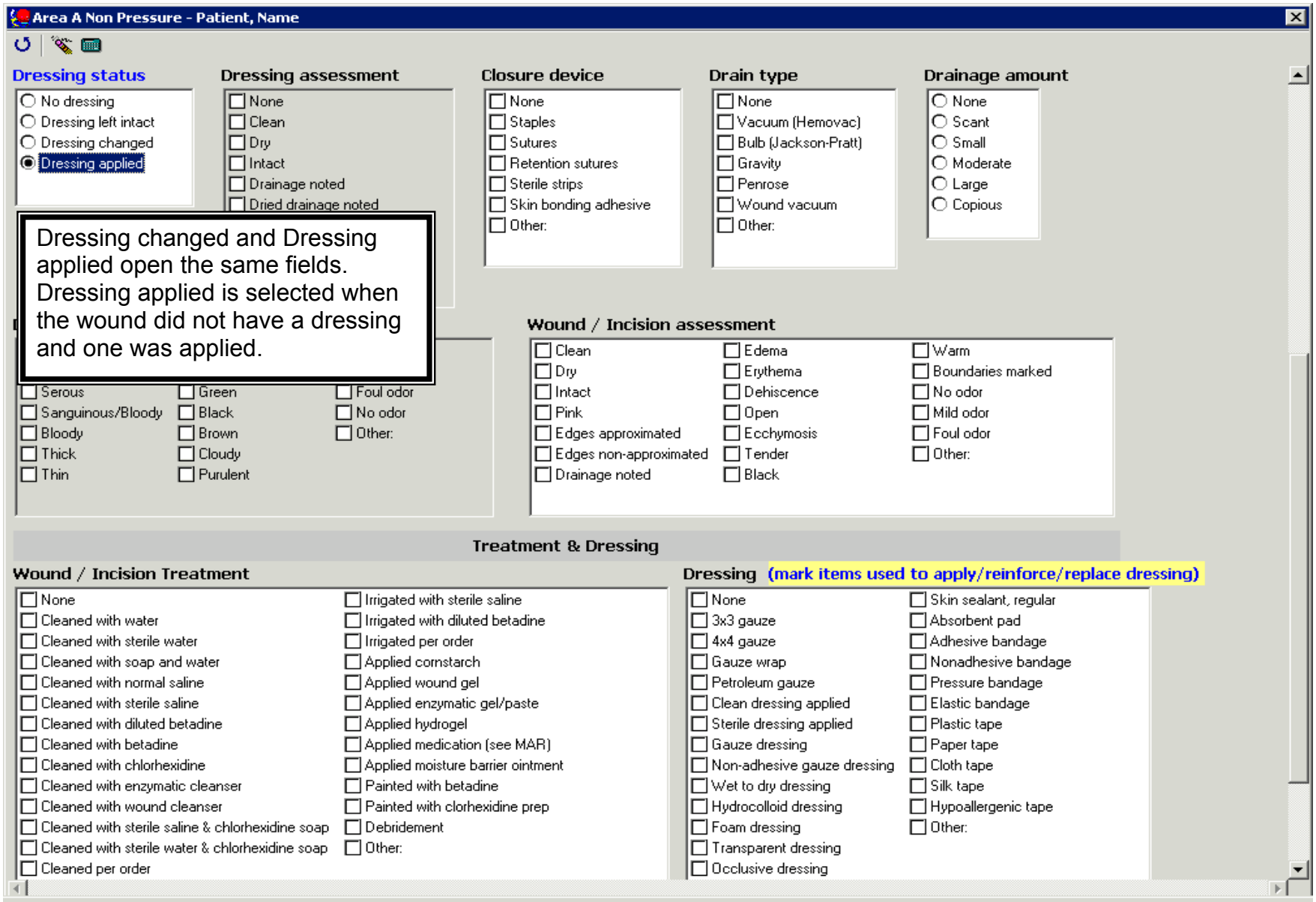

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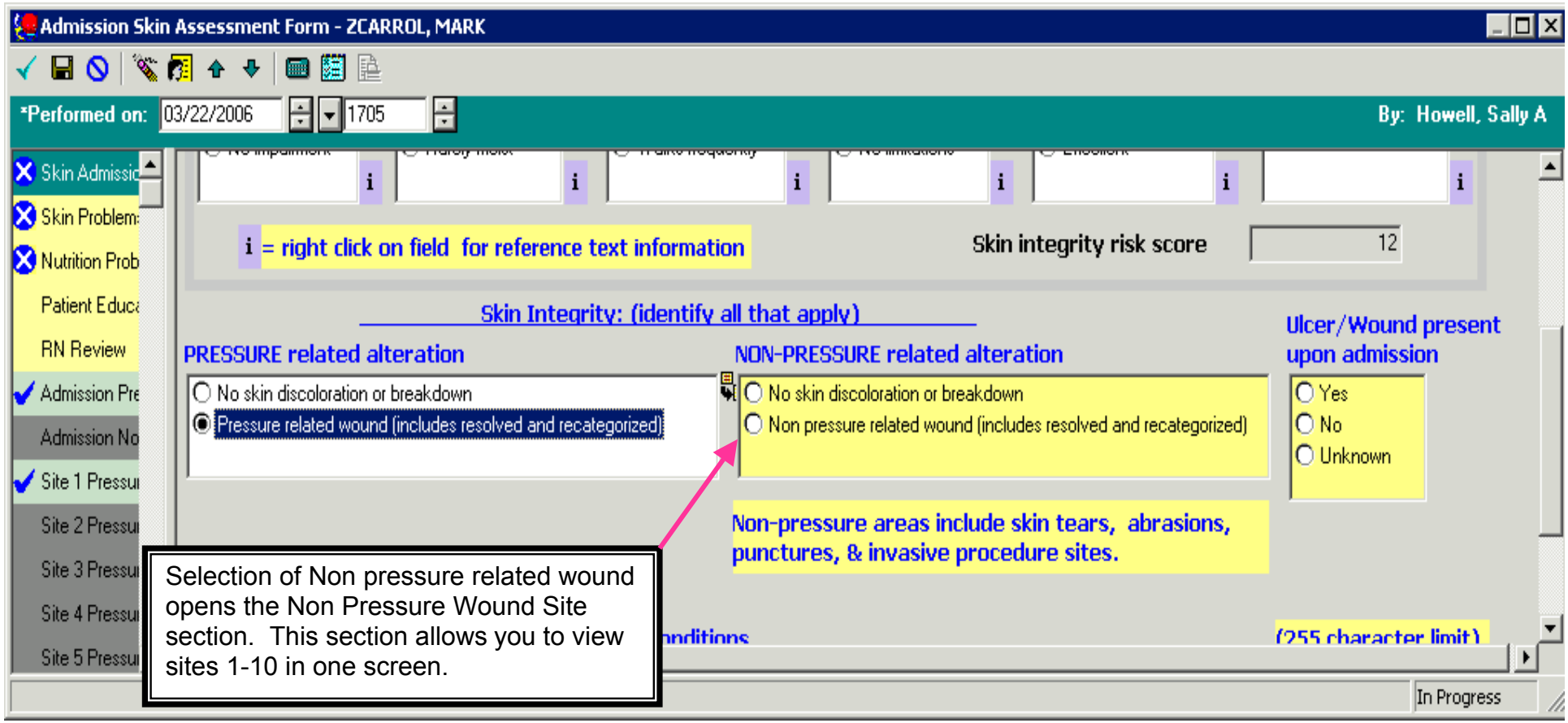

Selection of Non pressure related wound opens the Non Pressure Wound Site section. This section allows you to view sites 1-10 in one screen.

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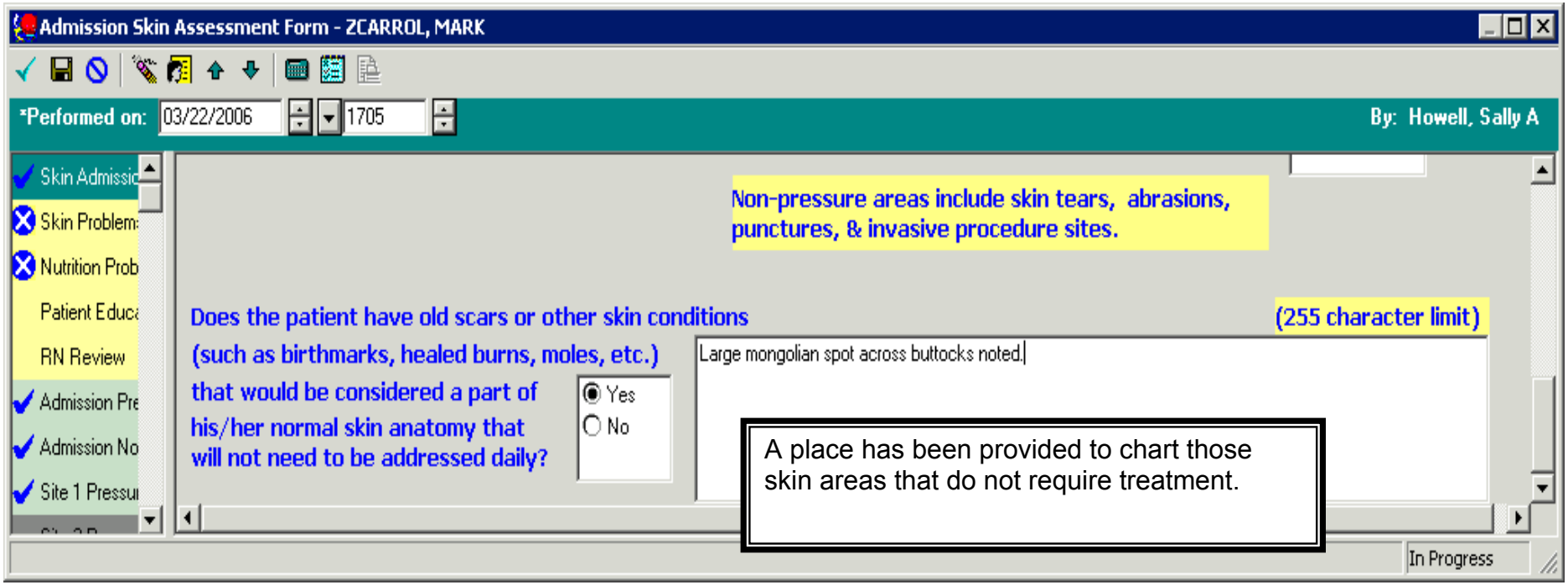

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