

Transitioning to an Electronic Health Record: Optimizing Documentation in Mental Health with Flowsheet Methodology

eHealth 2015
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Presentation Goals

- Provide an overview of the eCare Project at St. Joseph's Health Centre
- Provide an overview of the Clinical Information System software and associated functionality
- Demonstrate how the use of flowsheet functionality can support comprehensive documentation in a Mental Health Setting
- Share the benefits gained from the electronic documentation tools in the Mental Health program

St. Joseph's Health Centre, Toronto

Catholic community teaching hospital in Central Toronto serving a multi-cultural neighbourhood with broad socio-economic status

- 400 beds;
 - 98,000 ED visits annually;
 - 3250 births annually
- Wide range of services: Medicine, Surgery, Obstetrics, Pediatrics, Mental Health; Regional Dialysis Program

- Mental Health Services

- ED -Mental Health Emergency Services Unit (MHESU)- 12 beds
- 35 bed Inpatient beds including 6 bed PICU
- 6 bed Adult Short Stay Unit
- 7 bed Child and Adolescent Unit
- Out-patient clinics
- 5 ACT teams
- Addictions Services
- Interprofessional team RNs, MDs, SWs, Crisis Workers, Addiction Service Workers etc.



eCare Project

- “eCare will deliver a comprehensive electronic health record at St. Joseph's Health Centre by 2014. The eCare program will support improved patient outcomes by leveraging the Sunrise Clinical Manager platform to promote timely and efficient clinical management via real time electronic order entry and electronic documentation. This paperless record will provide a single accessible and integrated electronic chart for every patient treated at St. Joseph’s.” (Source: eCare Project Charter, 2013)
- Major deliverables (to date):
 - Clinical Order Management
 - Orders and Order Sets
 - Medication Management and eMAR
 - Medication Reconciliation
 - Clinical Documentation-Nursing and Interprofessional
 - Emergency Room –in progress
- Live on 15 Inpatient Units and Mental Health Emergency Services Unit (MHESU) with final planning for ED



Clinical Design Principles

- Screen design and system functionality will:
 - Be based on current practice and current tools as appropriate
 - Enhance practice with revised tools as required
 - Support patient safety and the delivery of best possible care
 - Comply with hospital and College standards/regulations
 - Support interprofessional documentation
 - Support discipline-specific needs
 - Support best practices for clinical practice and documentation practice
 - Standardize form and tools as much as possible
 - Improve documentation through use of guided descriptors which improves care
 - Support interprofessional communication and teamwork



Sunrise Clinical Manager (SCM™)

- Clinical Documentation
- Computerized Provider Order Entry
- Electronic Medication Records
- Medication Reconciliation
- Patient Care Plans
- Flowsheets and structured notes
- Functionality to auto-transfer data between flowsheets and other tools

Patient List

Allscripts Gateway | My Applications | Sunrise Clinical Manager

My Applications ► Sunrise Clinical Manager ► Patient List

File Registration View GoTo Actions Preferences Tools

Previous Next Refresh Find Find Signature Enter Allergies Order Outpatient Enter Flowsheet Worklist Print Change More Header Preferences Add Care Calculator
 Patient Patient Screen Patient Visit Manager Order Summary Reconciliation Medication Review Document Manager Manager Reports Location Info Provider

PAUL TEEN 099900125 / 00999001/85 16y (01-Jan-1998) Male
 2L14-1
 Allergy: No Known Allergies
 WT: 58 kg 26-Sep-2014 HT: 172.7 cm

CPR Status:

Patient List Orders Results EasyAccess-PACS Pharmacy Documents Flowsheets Patient Info Data Viewer Clinical Summary ED Full Scanned Chart ED Scanned Notes TCLHIN eReferral PROVIEWER PYRAMIS

Patient List

New Visit Modify Delete Delete Flag Select Save Selected Remove Selected Select Visit Define Save Sort Reset Sort
 List Visit List Current List Visit List New On New Off All Visits Visits Visits List Column Sort Order Order Order

Current List: 2L Medicine - Phase II Go-Live Unit Select All Patients 19 Visit(s) Save Selected Patients...

Patient Name	Patient ID / Visit Number	Birthdate	Current Location	Tempor... Location	Admit Date	Admit Time	Visit Reason	Current Diet Order	Flag New	New Ord...	New Results	New Docu...	New Alerts	Orders Pendi...	To Sign	To Verify	Unack Alerts	Incom... Docu...	Order Rec	Use and Disclosur
PAUL TEEN	099900125/00999001/85	01-Jan-19...	2L14-1		13-Aug-2014	16:50									!	!			!	
PHARMACY, KAM	099900100/00999001/60	05-Jun-19...	2L14-1		11-Aug-2014	09:19									!				!	
Ben, Test	099900225/00999002/85	10-Oct-19...	2L15-1		05-Sep-2014	13:05													!	
KOZAK, TEST MH	099900112/00999001/72		2L15-1		12-Aug-2014	10:11													!	
MARK, LIQUID-THURSDAYS	099900204/00999002/64		2L16-1		28-Aug-2014	08:25													!	
WAHLBURGER, MARKY-MARK	099900141/00999002/01		2L16-1		20-Aug-2014	10:25													!	
FLOWMED, DEMO	099900253/00999003/17	12-May-1...	2L16-2		08-Oct-2014	11:22													!	
MARK, CREAM-FRIDAYS	099900215/00999002/75		2L16-2		29-Aug-2014	11:26													!	
PARKS, TRIAGE TEST	099900213/00999003/03	19-Sep-19...	2L16-2		18-Sep-2014	08:15													!	
Tip, Sheets	099900223/00999002/83	09-Sep-19...	2L16-2		05-Sep-2014	09:30													!	
MARK, INJECTABLES-THURSDAY	099900212/00999002/72		2L17-1		28-Aug-2014	12:52													!	
shylah,	099900250/00999003/14		2L17-1		06-Oct-2014	13:45													!	
MARK, FORM-CODE	099900176/00999002/36		2L17-2		25-Aug-2014	15:03													!	
MEENAFS,TESTONE	099900109/00999001/69	12-Feb-19...	2L17-2		12-Aug-2014	08:44													!	
Discharge, Reconciliation	099900224/00999002/84	09-Sep-19...	2L18-1		05-Sep-2014	11:38													!	
Laura, Test	J00006854/AC000367/14	10-Oct-19...	2L18-1		11-Aug-2014	09:02	IM SICK												!	
MARY ELLEN, FB3 2	099900124/00999002/90	19-Jul-1966	2L18-1		12-Sep-2014	10:54													!	

Roberts, Janet (RN-eCare) 10/15/2014 12:33 FutureBuild3

12:33 PM 10/15/2014

Acute Care Flowsheet

Allscripts Gateway | My Applications | Sunrise EDIS

My Applications ► Sunrise EDIS ► Flowsheets

File Registration View GoTo Actions Preferences Tools

SUNSHINE, PATTY TWO
4G02-2 J00006862 / AC000378/14 89y (10-Oct-1925) Female
Allergy: penicillin G sodium Visit Reason: UTI
Name Alert! WT: 45 kg 14-Aug-2014 HT: cm
Isolation: Contact CPR Status: Limited

Patient List Orders Results EasyAccess-PACS DIR Pharmacy Documents Flowsheets Patient Info Data Viewer Clinical Summary ED Full Scanned Chart ED Scanned Notes

Options Panel

Flowsheet Criteria

Chart Selection
 This chart All available charts

Date Range
 From: 13-Aug-2014
Start of This Chart
 To: 13-Mar-2015
Today

Filter
 Default to summary
 Show abnormal only
 Suppress blank rows and cols
 Show ml/Kg
 Show cancelled columns
 Retain selections for next patient

Flowsheet Selection
 4G
 Flowsheet
 Acute Care, Medicine
 Intake & Output
 Interprofessional
 Interprofessional, Child & Adole...
 MH Interprofessional, Adult
 MH Plan of Care, Adult
 Plan of Care

Save Options
 Graph Options

Acute Care, Medicine, From 13-Aug-2014 to 13-Mar-2015

Save Cancel

	30-Sep-2014 22:01	06-Oct-2014 11:18	06-Oct-2014 11:46	06-Oct-2014 11:49
IDENTIFICATION				
Identification			Deland,S(SUPERUS	Deland,S(SUPERUS
	Clinician(s)			
	Discipline (Nursing)		N/A	
TRANSFER OF ACCOUNTABILITY				
END OF LIFE CARE				
FOCUS NOTE (DARP)				
ROUTINE CARE - SHIFT SUMMARY				
SAFETY & MONITORING				
RESPIRATORY				
CARDIOVASCULAR				
NEUROLOGICAL				
GASTROINTESTINAL				
GENITOURINARY				
MUSCULOSKELETAL				
SKIN				
INCISION/WOUND/DRAIN				
ACCESS DEVICES				
PSYCHOSOCIAL ASSESSMENT				
PATIENT PERSPECTIVE				

Sidebar
 Parks, Janine (RN) 3/13/2015 11:14 FutureBuild3

Start Novell GroupWise - Mailbox Sunrise Clinical Manager ... Allscripts Gateway | ... untitled - Paint Print Screens - Mar 13 2... 11:14 AM

Acute Care Flowsheet

Allscripts Gateway | My Applications | Sunrise EDIS

My Applications ► Sunrise EDIS ► Flowsheets

File Registration View GoTo Actions Preferences Tools

SUNSHINE, PATTY TWO
 4G02-2 J00006862 / AC000378/14 89y (10-Oct-1925) Female
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Chart Selection
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Flowsheet Selection

4G
 Flowsheet
 Acute Care, Medicine
 Intake & Output
 Interprofessional
 Interprofessional, Child & Adole...
 MH Interprofessional, Adult
 MH Plan of Care, Adult
 Plan of Care

Save Options
 Graph Options

Acute Care, Medicine, From 13-Aug-2014 to 13-Mar-2015

Save Cancel

	30-Sep-2014 22:01	06-Oct-2014 11:18	06-Oct-2014 11:46
IDENTIFICATION			
Identification			
Clinician(s)			Deland,S(SUPERUS ▶)
Discipline (Nursing)			N/A
TRANSFER OF ACCOUNTABILITY			
END OF LIFE CARE			
FOCUS NOTE (DARP)			
ROUTINE CARE - SHIFT SUMMARY			
Routine Care			
Routine Care			
Activities of Daily Living			
Skin Incontinence Protection			
Eye Care			
Activity			
Ambulation Total Time (hr.min)			
Care Delegated to Health Care Aide			
Up in Chair Total Time (hr.min)			
Dangle/Side of Bed Total Time (hr.min)			
Patient Activity			
Position			
Head of Bed			
Elevate Extremities			
SAFETY & MONITORING			
RESPIRATORY			
CARDIOVASCULAR			
NEUROLOGICAL			

Routine Care

Filter To:

Patient observed every 1-2 hrs
 Safe environment maintained
 Comfort measures provided
 Program standards of care followed

OK Cancel

Sidebar

Parks, Janine (RN) 3/13/2015 11:15 FutureBuild3

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Allscripts Gateway | My Applications | Sunrise EDIS

My Applications ► Sunrise EDIS ► Flowsheets

File Registration View GoTo Actions Preferences Tools

SUNSHINE, PATTY TWO 4G02-2 J00006862 / AC000378/14 89y (10-Oct-1925) Female
 Allergy: penicillin G sodium Visit Reason: UTI
 Name Alert! WT: 45 kg 14-Aug-2014 HT: cm Alerts:
 Isolation: Contact CPR Status: Limited

Patient List Orders Results EasyAccess-PACS DIR Pharmacy Documents Flowsheets Patient Info Data Viewer Clinical Summary ED Full Scanned Chart ED Scanned Notes

Options Panel

Flowsheet Criteria

Chart Selection

This chart All available charts

Date Range

From: 13-Aug-2014 Start of This Chart

To: 13-Mar-2015 Today

Filter

Default to summary
 Show abnormal only
 Suppress blank rows and cols
 Show ml/Kg
 Show cancelled columns

Retain selections for next patient

Flowsheet Selection

4G

- Flowsheet
 - Acute Care, Medicine
 - Intake & Output
 - Interprofessional
 - Interprofessional, Child & Adole...
 - MH Interprofessional, Adult
 - MH Plan of Care, Adult
 - Plan of Care

Save Options

Graph Options

Acute Care, Medicine, From 13-Aug-2014 to 13-Mar-2015 Save Cancel

	30-Sep-2014 22:01	06-Oct-2014 11:18	06-Oct-2014 11:46
END OF LIFE CARE			
FOCUS NOTE (DARP)			
ROUTINE CARE - SHIFT SUMMARY			
SAFETY & MONITORING			
RESPIRATORY			
CARDIOVASCULAR (Contains Unsaved Data)			
Cardiovascular	Radial and dorsal pedal pulses palpable bilaterally, regular. HR 60-100 bpm. Mu		WDL (within defined l Tachycardia greater i headache, face flushed
	Pulse		
	Blood Pressure		
	Skin Colour		
	Skin Quality		
	Capillary Refill		
Dorsalis Pedal Pulses			
	Left		
	Right		
Radial Pulses			
	Left		
	Right		
Edema			
	Fingers		
	Hands		
	Arms		
	Feet		
	Ankle		

Left

Filter To:

- 0 - absent, not palpable
- 1 - diminished, barely palpable
- 2 - expected/normal
- 3 - full pulse, increased
- 4 - bounding pulse
- Doppler
- unable to assess

OK Cancel

Sidebar

Parks, Janine (RN) 3/13/2015 11:16 FutureBuild3

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Vital Signs

Allscripts Gateway | My Applications | Sunrise EDIS

My Applications ► Sunrise EDIS ► Flowsheets

File Registration View GoTo Actions Preferences Tools

SUNSHINE, PATTY TWO J00006862 / AC000378/14 89y (10-Oct-1925) Female
 4G02-2 Kapur, Ajay
 Allergy: penicillin G sodium Visit Reason: UTI
 Name Alert! WT: 45 kg 14-Aug-2014 HT: cm Alerts: Isolation: Contact CPR Status: Limited

Patient List Orders Results EasyAccess-PACS DIR Pharmacy Documents Flowsheets Patient Info Data Viewer Clinical Summary ED Full Scanned Chart ED Scanned Notes

Options Panel

Flowsheet Criteria

Chart Selection

This chart All available charts

Date Range

From: 13-Aug-2014
 Start of This Chart

To: 13-Mar-2015
 Today

Filter

Default to summary
 Show abnormal only
 Suppress blank rows and cols
 Show ml/Kg
 Show cancelled columns

Retain selections for next patient

Flowsheet Selection

Interprofessional, Child & Adole...
 MH Interprofessional, Adult
 MH Plan of Care, Adult
 Plan of Care
 Respiratory Therapy
 Respiratory Therapy, ICU
Vital Signs/Screening, Medicine
 zzJP_Enhancements_Preliminary...

ER
 Flowsheet

Save Options
 Graph Options

Vital Signs/Screening, Medicine, From 13-Aug-2014 to 13-Mar-2015

Save Cancel

	18-Aug-2014 9:53	06-Oct-2014 11:18	22-Oct-2014 10:42	26-Jan-2015 9:50
IDENTIFICATION				
Identification				
Discipline (Nursing)		N/A		
Clinician(s)			Cardiff,B(RN-eCare)	Generic2,R(OT)
BODY MEASUREMENTS				
TEMPERATURE				
HEART RATE				
BLOOD PRESSURE				
RESPIRATORY				
PAIN				
PAIN MODALITIES				
NEUROVITALS / SEDATION SCORE				
BEHAVIOURAL VITAL SIGNS				
LEAST RESTRAINT				
IV CONTINUOUS INFUSION				
TRANSFUSION MEDICINE				

Sidebar

Parks, Janine (RN) 3/13/2015 11:17 FutureBuild3

Start Novell GroupWise - Mailbox Sunrise Clinical Manager ... Allscripts Gateway | ... untitled - Paint Print Screens - Mar 13 2... 11:17 AM

Allscripts Gateway | My Applications | Sunrise EDIS

My Applications ► Sunrise EDIS ► Flowsheets

File Registration View GoTo Actions Preferences Tools

SUNSHINE, PATTY TWO J00006862 / AC000378/14 89y (10-Oct-1925) Female
 4G02-2 Kapur, Ajay
 Allergy: penicillin G sodium Visit Reason: UTI
 Name Alert! WT: 45 kg 14-Aug-2014 HT: cm Alerts: Isolation: Contact CPR Status: Limited

Patient List Orders Results EasyAccess-PACS DIR Pharmacy Documents Flowsheets Patient Info Data Viewer Clinical Summary ED Full Scanned Chart ED Scanned Notes

Options Panel

Flowsheet Criteria

Chart Selection

This chart All available charts

Date Range

From: 13-Aug-2014
Start of This Chart

To: 13-Mar-2015
Today

Filter

Default to summary
 Show abnormal only
 Suppress blank rows and cols
 Show ml/Kg
 Show cancelled columns

Retain selections for next patient

Flowsheet Selection

Interprofessional, Child & Adole...
 MH Interprofessional, Adult
 MH Plan of Care, Adult
 Plan of Care
 Respiratory Therapy
 Respiratory Therapy, ICU
Vital Signs/Screening, Medicine
 zzJP_Enhancements_Preliminary...
 ER
 Flowsheet

Save Options
 Graph Options

Vital Signs/Screening, Medicine, From 13-Aug-2014 to 13-Mar-2015

Save Cancel

		18-Aug-2014 9:53	06-Oct-2014 11:18	22-Oct-2014 10:42
Identification	Discipline (Nursing)		N/A	
	Clinician(s)	Parks,J.(RN)	Parks,J.(RN)	Cardiff,B.(RN-eCare)
BODY MEASUREMENTS				
TEMPERATURE				
HEART RATE				
BLOOD PRESSURE (Contains Unsaved Data)				
<input checked="" type="checkbox"/> Blood Pressure	Systolic (mmHg)/Diastolic (mmHg) MAP (mmHg) Position Source	120 / 80 Sitting, Right Manual	122 / 78	/
RESPIRATORY				
<input checked="" type="checkbox"/> Respiratory/Pulse Oximetry	Respiratory Rate (/min) SpO2 (%) O2 Delivery Additional O2 Delivered Oxygen (%) Flow Rate (L/min) Humidity Used Humidification Set Up Changed Humidification Changed Date			

Position

Filter To:

Sitting, Right
 Standing, Right
 Supine, Right
 Sitting, Left
 Standing, Left
 Supine, Left

OK Cancel

Sidebar Parks, Janine (RN) 3/13/2015 11:18 FutureBuild3

Clinical Summary

2L32-2 Drzymala, Lukasz
Allergy: Gall bladder dye Visit Reason: CELLULITIS AND ASTHMA
WT: 156.9 kg 08-Mar-2015 HT: cm CPR Status: Full CPR

Patient List Orders Results EasyAccess-PACS DIR Pharmacy Documents Flowsheets Patient Info Data Viewer **Clinical Summary** ED Full Scanned Chart ED Scanned Notes

view: Interprofessional Exchange Start of chart Start of Chart To 13-Mar-2015 11:21

Relevant Medical History		POC - Access Devices/Tubes/Drains			
Item Info	Value	Item	Item Info	Value	Last Date
General	schizophrenia; visually impaired		Foley Catheter...	14 Fr; 2-way	12-Mar-2015 21:37
Infectious Disease	hepatitis A	Peripheral IV #1	Site	left antecubital	12-Mar-2015 21:37
Cardiovascular	hypertension				
Oncology	breast cancer				
Respiratory	asthma; Sleep apnea				
Endocrine	Type 2 Diabetes				
Past Surgical History	unremarkable				
Head / Neck / Chest Surgery	mastectomy				

Patient Safety			Plan of Care - Functional Level		
Item Info	Value	Last Date	Item Info	Value	Last Date
FRAT Risk Level	High Risk	07-Mar-2015 08:15	Transferring	assist of 2	12-Mar-2015 14:05
Braden Risk Level	At Risk	11-Mar-2015 08:16			
Nutrition Risk Score	0 - Not at risk of malnutrition	11-Mar-2015 08:16			
Level of Consciousness	oriented to person oriented to...	12-Mar-2015 21:37			

Vitals (Most Recent)			Current Medications			Non-Med Orders (Orders TAB for Details)			Consults (Active Orders)		
Item Info	Value	Last Date	Medication	Status	Last Give	Order	Order Date	Status	Order	Requested Date	Schedule
Weight (kg)	156.9	08-Mar-2015...	spironolactone 50 mg PO...	Active	13-Mar-	Wound Care...	13-Mar-2015...	Active	Social...	06-Mar-2015	Routine
Temp (degrees...)	36.7	13-Mar-2015...	digoxin 0.125 mg PO daily	Active	13-Mar-	Transfer MRP	12-Mar-2015...	Active	Diabetes...	06-Mar-2015	Routine
Heart Rate...	72	13-Mar-2015...	bisoprolol 5 mg PO bid	Active	13-Mar-	Telemetry	12-Mar-2015	Active	Occupational...	06-Mar-2015	Routine
Signs and...	hemodynami...	13-Mar-2015...	furosemide INJ 40 mg IV...	Active	13-Mar-	Communicatio...	11-Mar-2015...	Active	Follow-up to...	10-Mar-2015	Routine
Systolic (mmHg)	134	13-Mar-2015...	cephalexin 500 mg PO q6h	Active	13-Mar-	DI Contrast...	10-Mar-2015...	Active	Cardiology -...	10-Mar-2015	Non Urgent...
Diastolic...	83	13-Mar-2015...	RisperiDONE 6 mg PO qhs	Active	12-Mar-	Oxygen...	07-Mar-2015	Active			
Respiratory...	20	13-Mar-2015...	salmeterol-fluticasone 25...	Active	13-Mar-	Diabetic /Calori...	06-Mar-2015	Active			
SpO2 (%)	95	13-Mar-2015...	Insulin Detemir...	Active	11-Mar-	Activity	06-Mar-2015	Active			
O2 Delivery...	Nasal Bronco...	13-Mar-2015...				Vital Signs	06-Mar-2015	Active			

Lab Orders - To be done Diagnostics Imaging Orders - To be done

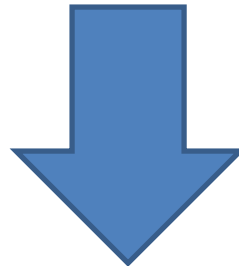


MENTAL HEALTH

Documentation Transition

- Long narrative notes and lack of summary or overview of specific patient issues
 - Difficult to follow the patient story: *Patient said.....Clinician said>>>>Patient then.....Clinician.....* “need to read a book to understand the patient”
- Limited ability for data extraction

- *“It will be impossible to move from narrative notes to flowsheet documentation and meet our documentation requirements”*
- *“Mental health is different than the rest of the hospital. Our patients, our care and our documentation requirements are different”*



“examine how this approach to documentation can support our transition to an enhanced patient care model”



Designing the Mental Health Tools

- Identified the critical elements required for quality, safety, support of the patient's goals and a team approach to care

Full Mental Status Exam	Restraints
Physical Assessment	Physical functions/self care
Nutrition	Level of Autonomy (Passes)
Sleep Patterns	Risk
Significant Events	Communication
Behavior	NASGAR
DASA-IV	

- Use the advanced functionality of the system to provide prompts and reminders
 - Restraints
 - Forms



MENTAL HEALTH DOCUMENTATION TOOLS

MH Initial Nursing Assessment

Applications | Sunrise EDIS

Structured Notes Entry - SUNSHINE, PATTY TWO - Nursing Initial Assessment, MHESU

Create Preview

Sections

- Document Info
 - **NURSING INITIAL ASSESSMENT, MHESU
 - PRESENTING COMPLAINT & HISTORY
 - Presentation
 - PRE-HOSPITAL CARE
 - **HEALTH HISTORY
 - ALLERGIES
 - PAST MEDICAL HISTORY
 - CURRENT MEDICATIONS
 - PHYSICAL ASSESSMENT
 - Vital Signs/Other Measurements
 - Pupil Scale and Reactivity
 - Skin Colour/Quality
 - Respiratory
 - Cardiovascular
 - Neurological
 - Gastrointestinal
 - Genitourinary
 - Reproductive
 - Musculoskeletal
 - Skin
 - Injuries / Skin Breakdown Documents
 - PSYCHOSOCIAL ASSESSMENT
 - Psychosocial Focus Assessment
 - **VIOLENCE ASSESSMENT
 - DASA-IV: Dynamic Appraisal of Situation
 - Safety Plan for Violence
 - FALLS RISK ASSESSMENT (FRAT)
 - FALLS RISK ASSESSMENT

Copy Forward Refer to Note Preview Modify Template

PRESENTING COMPLAINT & HISTORY

Presentation

Clinician(s)
MHESU Nurse

CTAS Chief Complaint

Information Source
 patient
 family
 friend
 hospital employee
 language line
 translation program

Accompanying
 Yes
 No

EDP
 Yes
 No

Restrained
 Yes
 No

Complaint Details:

PRE-HOSPITAL CARE

Interventions Prior to Arrival

Interventions
 Not Applicable IV Lock
 One-Touch Glucose

Medications given:

EMS Vital Signs

Temperature (C)	Heart Rate	Respiratory Rate (/min)	SpO2 (%)	Systolic

ALLERGIES

Show all available Show selected only 2/2

Allergen/Product	Reaction

Retrieve Last Charted Values

Insert Default Values

Clear Unsaved Data

Need Help? Mark Note As: Results pending Priority Incomplete Calculate after save Save Cancel

MH Initial Nursing Assessment – Structured Note

MRN: J0900682
 Visit: ER001703/11
 Age: 65y (10-Oct-1925)

SUNSHINE, PATTY TWO
 Gender: Female
 Location: Emergency

St Joseph's Health Centre

Nursing Initial Assessment - MHESU - 124-94
 ER001703/11, Complete, Entered, Signed in Full, Gen

PRESENTING COMPLAINT & HISTORY:

- Clinician(s): MHESU N
- CTAS Chief Complaint: Substance
- Complaint Details: Patient as
- Information Source: diaphoretic
- Accompanied by Police: patient, to

HEALTH HISTORY:

ALLERGIES:

- Allergen/Product
 penicillin G sodium
 Cats

PAST MEDICAL HISTORY:

- PMH Reviewed: Positive history for the follow
- Schizophrenia: Onset at 18 yrs
- Substance abuse: ETOH, Cocaine
- Surgery: Appendectomy

CURRENT MEDICATIONS:

* Incomplete Medication History as of 23-Mar-2015

Med	Type	Water
Hx	salbutamol 100 inhalation aerc	
Hx	acetaminophen tablet	
Hx	medFORMIN 56	
Hx	citalopram 40	
Hx	rampiril 10 mg	

PHYSICAL ASSESSMENT:

Vital Signs/Other Measurements:

- Temp (degrees C): 36.5
- Temp Site: oral
- Heart Rate (bpm): 100 bpm
- Rhythm: regular
- Respiratory Rate (1/min): 22
- SpO2 (%): 98
- NIBP Systolic (mmHg): 85
- NIBP Diastolic (mmHg): 55
- Position: Sitting, R
- Pain Score (1-10): 7
- Blood Glucose POC Testing: 2.3 mmol

- Right Pupil Size (mm): 2 mm
- Pupil Reaction: Reacts
- Left Pupil Size (mm): 2 mm
- Pupil Reaction: Reacts

- Skin Colour/Quality:**
- Skin Colour: ashen
 - Skin Quality: cool, clammy

- Respiratory:**
- Assessment: Significant findings
 - Rate: rate above 20
 - Rhythm: regular, shallow
 - Effort: shortness of breath
 - Air Entry: clear throughout

- Cardiovascular:**
- Assessment: Significant findings
 - Pulse: regular
 - Blood Pressure: hypotension (systolic below 90 mmHg)
 - Skin Colour: ashen
 - Skin Quality: cold, clammy
 - Capillary Refill: less than 2 seconds
 - Where is your pain?: abdomen
 - Description of pain: pressure, squeezing

- Neurological:**
- Assessment: Significant findings
 - Level of Consciousness: oriented to person, oriented words
 - Facial Droop: none
 - Altered Speech: mumbles
 - Upper Extremity Sensation: intact
 - Lower Extremity Sensation: intact

- Gastrointestinal:**
- Assessment: Significant findings
 - Abdominal Assessment, Abnormal: guarding
 - Bowel Sounds: bowel sounds active
 - Abnormal BMs/Enteric Infections: constipation
 - GI Discomfort: abdominal cramps
 - Nausea/Vomiting: nausea

- Genitourinary:**
- Assessment: Within Defined Limits * - Urine colour, y frequency, urgency, discomfort/burning, or foul odour

- Reproductive:**
- Assessment: Within Defined Limits * - No abnormal pain to perineum

Musculoskeletal:

- Assessment: Within Defined Limits * - Able to change position independently. Equal strength and range of motion in all limbs. No noted joint/limb weakness, swelling, tenderness, pain, atrophy or deformity. No involuntary movement

Skin:

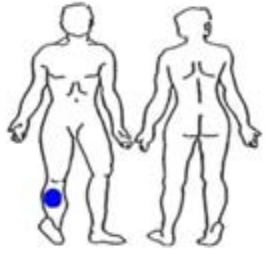
- Assessment: Significant findings
- - wounds: Notable abrasion to right shin. Patient states they fell

Injuries / Skin Breakdown Documentation:

Full Body:

MMMS:

- Fracture
- Open fracture
- Contusion
- Crush
- Abrasion
- Laceration
- Penetrating wound
- Amputation



PSYCHOSOCIAL ASSESSMENT:

Psychosocial Focus Assessment:

- Level of Consciousness: Drowsy
- Appearance - Clothing: Under-dressed
- Appearance - Hygiene: Dishvelled
- Appearance - Physical Movements: Normal
- Eye Contact: Intense
- Orientation: Time (disoriented to)
- Cooperative: Yes
- Speech - Amount: Poverty of speech
- Speech - Rate: Slow
- Speech - Rhythm: Rhythm is normal
- Speech - Spontaneity: Spontaneous
- Speech - Volume: Quiet
- Thought Process: Circumstantial
- Suicidal Ideation: No
- Homicidal Ideation: No
- Indicators of Psychosis: None

- Affect: Inappropriate
- Perceptual Abnormalities: None
- Other Mental Disturbances: None
- Judgement (understands outcomes of behaviour): Full
- Insight (Awareness/understanding of illness): Full insight
- Intelligence (estimate): Average
- Substance Abuse: yes
- - substance(s) used: alcohol cocaine
- - intentional overdose: no
- Life Situation: lives alone
- - situational concerns: Financial, Housing
- Safety: Belongings search completed

VIOLENCE ASSESSMENT:

DASA-IV: Dynamic Appraisal of Situational Aggression

- Irritability: Yes (1)
- Impulsivity: Yes (1)
- Unwillingness to follow directions: No (0)
- Sensitivity to perceived provocation: No (0)
- Easily angered when requests are denied: Yes (1)
- Negative attitudes: No (0)
- Verbal threats: No (0)
- TOTAL SCORE: 4/3

Safety Plan for Violence:

- Completion Requirements: Safety Plan for Violence to be completed if DASA-IV Score > 4

FALLS RISK ASSESSMENT:

- Reason for Screening: On Admission
- Falls Risk Categories: impaired mental state-agitated/confused/substance withdrawal, impaired mobility, balance and/or gait
- FRAT Total Score: 2
- FRAT Risk Level: Not at Risk

MH Interprofessional Flowsheet

The screenshot displays the Allscripts Gateway interface for a patient named SUNSHINE, PATTY TWO. The patient's information includes ID J00006862 / AC000378/14, age 89y (10-Oct-1925), and gender Female. The visit reason is UTI, and the patient is currently in Contact Isolation with Limited CPR Status. The interface shows a navigation menu with options like Patient List, Orders, Results, EasyAccess-PACS, DIR, Pharmacy, Documents, Flowsheets, Patient Info, Data Viewer, Clinical Summary, ED Full Scanned Chart, and ED Scanned Notes. The main window displays the 'MH Interprofessional, Adult, From 13-Aug-2014 to 13-Mar-2015' flowsheet. The left sidebar contains an 'Options Panel' with 'Flowsheet Criteria' (This chart selected), 'Date Range' (From: 13-Aug-2014, To: 13-Mar-2015), and 'Flowsheet Selection' (4G selected, MH Interprofessional, Adult selected). The main content area shows a list of flowsheet categories: IDENTIFICATION, COMMUNICATION/COMMENTS, SIGNIFICANT EVENTS, FOCUS NOTES, PHYSICAL ASSESSMENT/ADLS, SCREENING TOOLS, (NGASR) NURSES GLOBAL ASSESSMENT OF SUICIDAL RISK, (NGASR) IMMEDIATE SUICIDE PROTECTIVE FACTORS, (DASA-IV) APPRAISAL OF SITUATIONAL AGGRESSION, CLIENT ACTIVITY & GROUP PARTICIPATION, AUTONOMY & PASSES, MENTAL STATUS EXAM, BEHAVIOUR & MONITORING, INTERVENTIONS, INTERPROFESSIONAL, VITAL SIGNS, RESPIRATORY, CARDIOVASCULAR, NEUROLOGICAL, GASTROINTESTINAL, GENITOURINARY, MUSCULOSKELETAL, and SKIN. The Windows taskbar at the bottom shows the Start button and several open applications including Novell GroupWise - Mailbox, Sunrise Clinical Manager, Parks, Janine (RN) - My..., Print Screens - Mar 13 2..., and Allscripts Gateway | ...

Allscripts Gateway | My Applications | Sunrise EDIS

My Applications ► Sunrise EDIS ► Flowsheets

File Registration View GoTo Actions Preferences Tools

SUNSHINE, PATTY TWO
 4G02-2 J00006862 / AC000378/14 89y (10-Oct-1925) Female
 Allergy: penicillin G sodium Visit Reason: UTI
 Name Alert! WT: 45 kg 14-Aug-2014 HT: cm Alerts:
 Isolation: Contact CPR Status: Limited

Patient List Orders Results EasyAccess-PACS DIR Pharmacy Documents Flowsheets Patient Info Data Viewer Clinical Summary ED Full Scanned Chart ED Scanned Notes

Options Panel

Flowsheet Criteria

Chart Selection
 This chart All available charts

Date Range
 From: 13-Aug-2014
 Start of This Chart
 To: 13-Mar-2015
 Today

Filter
 Default to summary
 Show abnormal only
 Suppress blank rows and cols
 Show ml/Kg
 Show cancelled columns
 Retain selections for next patient

Flowsheet Selection
 4G
 Flowsheet
 Acute Care, Medicine
 Intake & Output
 Interprofessional
 Interprofessional, Child & Adole...
MH Interprofessional, Adult
 MH Plan of Care, Adult
 Plan of Care

Save Options
 Graph Options

MH Interprofessional, Adult, From 13-Aug-2014 to 13-Mar-2015

26-Jan-2015
9:50

PHYSICAL ASSESSMENT/ADLS

Physical Assessment

Physical Assessment
 Skin
 Bowel movements (patient's normal)
 Number of BMs in shift
 Stool Record for Abnormal BMs/Enteric Infections
 Urinary Function
 Physical Assessment Focus Note

Nutrition
 Meal Intake (oral)

Activities of Daily Living
 Hygiene
 Level of Activity

Sleep
 Slept between 07:30 - 1530 (#hrs)
 Slept between 15:30 - 2330 (#hrs)
 Slept between 23:30 - 0730 (#hrs)

SCREENING TOOLS

(NGASR) NURSES GLOBAL ASSESSMENT OF SUICIDAL RISK

(NGASR) IMMEDIATE SUICIDE PROTECTIVE FACTORS

(DASA-IV) APPRAISAL OF SITUATIONAL AGGRESSION

CLIENT ACTIVITY & GROUP PARTICIPATION

Group Participation
 Groups

Visits
 Type of Visitor
 Description of visit/Pt response

AUTONOMY & PASSES

MENTAL STATUS EXAM

Save Cancel

Start Novell GroupWise - Mailbox Sunrise Clinical Manager ... Parks, Janine (RN) - My ... Print Screens - Mar 13 2... Allscripts Gateway | ... 11:24 AM

Restraints

The screenshot displays a medical software interface for a patient named SUNSHINE, PATTY TWO. The patient's information includes ID J00006862 / AC000378/14, age 89y (10-Oct-1925), gender Female, and visit reason UTI. The chart shows a date range from 13-Aug-2014 to 13-Mar-2015. A dialog box titled 'Patient aggression/staff intervention' is open, containing a text entry field and 'OK' and 'Cancel' buttons. The main chart area lists various assessment categories such as (NGASR) NURSES GLOBAL ASSESSMENT OF SUICIDAL RISK, (NGASR) IMMINENT SUICIDE PROTECTIVE FACTORS, (DASA-IV) APPRAISAL OF SITUATIONAL AGGRESSION, CLIENT ACTIVITY & GROUP PARTICIPATION, AUTONOMY & PASSES, MENTAL STATUS EXAM, and BEHAVIOUR & MONITORING (Contains Unsaved Data). The chart also includes sections for Aggression, Self-harm, and Least Restraints: Application or Removal. The interface includes a menu bar, a toolbar, and a taskbar at the bottom.

Allscripts Gateway | My Applications | Sunrise EDIS

My Applications ► Sunrise EDIS ► Flowsheets

File Registration View GoTo Actions Preferences Tools

SUNSHINE, PATTY TWO J00006862 / AC000378/14 89y (10-Oct-1925) Female
 4G02-2 Kapur, Ajay
 Allergy: penicillin G sodium Visit Reason: UTI
 Name Alert! WT: 45 kg 14-Aug-2014 HT: cm Alerts:
 Isolation: Contact CPR Status: Limited

Patient List Orders Results EasyAccess-PACS DIR Pharmacy Documents Flowsheets Patient Info Data Viewer Clinical Summary ED Full Scanned Chart ED Scanned Notes

Options Panel

Flowsheet Criteria
 Chart Selection
 This chart All available charts

Date Range
 From: 13-Mar-2015
 To: 13-Mar-2015

Filter
 Default to summary
 Show abnormal only
 Suppress blank rows and cols
 Show ml/Kg
 Show cancelled columns
 Retain selections for next patient

Flowsheet Selection
 4G
 Flowsheet
 Acute Care, Medicine
 Intake & Output
 Interprofessional
 Interprofessional, Child & Adole...
MH Interprofessional, Adult
 MH Plan of Care, Adult
 Plan of Care

Save Options
 Graph Options

MH Interprofessional, Adult, From 13-Mar-2015 to 13-Mar-2015

	13-Mar-2015	13-Mar-2015	
	11:28	11:30	
CLIENT ACTIVITY & GROUP PARTICIPATION			
AUTONOMY & PASSES			
MENTAL STATUS EXAM			
BEHAVIOUR & MONITORING (Contains Unsaved Data)			
Aggression	Patient aggression/staff intervention		
Self-harm	Patient self-harm act/staff intervention		
<input type="checkbox"/> Least Restraints: Application or Removal SMP: restraint in correct position with no associated pain or discomfort, no imp Behaviour/Reason for Initiating Restraint Use Alternatives to restraints Consent obtained from Patient/SDM Type of Restraint Environment Check Staff who were present when restraints applied (full name/role) Patient response - Initial Target behaviour for restraint removal Time restraint applied (dd-mmm-yyy hhmm) Time restraint removed (dd-mmm-yyy hhmm) Total time restraints present (min) Restraints removed by (full name/role) Debriefing with patient post removal			
	Standard of care param Restless reorientation, verbal de Yes Roam Alert, Environment appropriat Susie Nurse no physical resistance Patient capable of resp 15-Mar-2015 10:30 15-Mar-2015 11:30 60 Sally Nurse Reason for restraint d	Roam Alert	
INTERVENTIONS			
INTERPROFESSIONAL			
VITAL SIGNS			
RESPIRATORY			

Reason for restraint discussed; Plan for restraint alternatives developed with patient; Therapeutic rapport re-established

Save Cancel

Sidebar Parks, Janine (RN) 3/13/2015 11:31 FutureBuild3

Autonomy and Passes

Allscripts Gateway | My Applications | Sunrise EDIS

My Applications ► Sunrise EDIS ► Flowsheets

File Registration View GoTo Actions Preferences Tools

SUNSHINE, PATTY TWO J0006862 / AC000378/14 89y (10-Oct-1925) Female
 4G02-2 Kapur, Ajay
 Allergy: penicillin G sodium Visit Reason: UTI
 Name Alert! WT: 45 kg 14-Aug-2014 HT: cm
 Isolation: Contact CPR Status: Limited Alerts:

Options Panel

Flowsheet Criteria

Chart Selection

This chart All available charts

Date Range

From: 13-Mar-2015 Today
 To: 13-Mar-2015

Filter

Default to summary
 Show abnormal only
 Suppress blank rows and cols
 Show ml/Kg
 Show cancelled columns

Retain selections for next patient

Flowsheet Selection

4G

- Flowsheet
 - Acute Care, Medicine
 - Intake & Output
 - Interprofessional
 - Interprofessional, Child & Adole...
 - MH Interprofessional, Adult**
 - MH Plan of Care, Adult
 - Plan of Care

Save Options
 Graph Options

MH Interprofessional, Adult, From 13-Mar-2015 to 13-Mar-2015

Save Cancel

	13-Mar-2015 11:28	13-Mar-2015 11:30
IDENTIFICATION		
COMMUNICATION/COMMENTS		
SIGNIFICANT EVENTS		
FOCUS NOTES		
PHYSICAL ASSESSMENT/ADLS		
SCREENING TOOLS		
(NGASR) NURSES GLOBAL ASSESSMENT OF SUICIDAL RISK		
(NGASR) IMMINENT SUICIDE PROTECTIVE FACTORS		
(DASA-IV) APPRAISAL OF SITUATIONAL AGGRESSION		
CLIENT ACTIVITY & GROUP PARTICIPATION		
AUTONOMY & PASSES (Contains Unsaved Data)		
	Level of observation	Close
	Autonomy	Own clothes, Unit
Passes	Passes	
	Pass - patient returned	
	Focus Note	
MENTAL STATUS EXAM		
BEHAVIOUR & MONITORING		
INTERVENTIONS		
INTERPROFESSIONAL		
VITAL SIGNS		

Passes

Filter To:

Day Pass
 Overnight Pass
 Weekend Pass
 Short Time Pass
 None
 Other (specify)

OK Cancel

Sidebar

Parks, Janine (RN) 3/13/2015 11:32 FutureBuild3

Start Novell GroupWise - Mailbox Sunrise Clinical Manager ... Parks, Janine (RN) - My ... Print Screens - Mar 13 2... Allscripts Gateway | ... 11:32 AM

Additional Documentation

The screenshot displays the Sunrise EDIS software interface. The main window shows a patient chart for **SUNSHINE, PATTY TWO** (4G02-2) with a visit reason of **UTI** and a name alert. The patient's weight is 45 kg and height is cm, recorded on 14-Aug-2014. The chart includes tabs for Patient List, Orders, Results, EasyAccess-PACS, DIR, Pharmacy, and Documents. The left sidebar shows the **Options Panel** with **Flowsheet Criteria** set to **This chart** and a date range from 13-Mar-2015 to 13-Mar-2015. The **Flowsheet Selection** panel shows a tree view with **MH Interprofessional, Adult** selected. The main chart area displays a list of categories with checkboxes, including **IDENTIFICATION**, **COMMUNICATION/COMMENTS**, **SIGNIFICANT EVENTS**, **FOCUS NOTES**, **PHYSICAL ASSESSMENT/ADLS**, **SCREENING TOOLS**, **(NGASR) NURSES GLOBAL ASSESSMENT OF SUICIDAL**, **(NGASR) IMMEDIATE SUICIDE PROTECTIVE FACTORS**, **(DASA-IV) APPRAISAL OF SITUATIONAL AGGRESSION**, **CLIENT ACTIVITY & GROUP PARTICIPATION**, **AUTONOMY & PASSES (Contains Unsaved Data)**, **MENTAL STATUS EXAM**, **BEHAVIOUR & MONITORING**, **INTERVENTIONS**, **INTERPROFESSIONAL**, **Other Interprofessional Consultant**, **VITAL SIGNS**, **RESPIRATORY**, **CARDIOVASCULAR**, **NEUROLOGICAL**, and **GASTROINTESTINAL**.

An **Add Parameter** dialog box is open, showing a search field and a list of **Hidden Parameters** with checkboxes: **END OF LIFE CARE** (Death Documentation, Trillium Gift of Life Network (TGLN)), **PHYSICAL ASSESSMENT/ADLS** (Peripheral IV #1, Wound, Incision), **SCREENING TOOLS** (Pressure Ulcer #2, Pressure Ulcer #3, Nutrition Risk Screening Tool), **BEHAVIOUR & MONITORING** (Least Restraints: Continuous Monitoring, (CIWA) Clinical Institute Withdrawal Assessment), **INTERVENTIONS** (ECT), **INTERPROFESSIONAL** (Dietitian, Respiratory Therapist, Infection Control Practitioner, Spiritual Care, Occupational Therapist), and **VITAL SIGNS** (Neurovitals Adult, Acute Pain Assessment #1, Acute Pain Assessment #2, Acute Pain Assessment #3). The **Added Parameters** list includes (CIWA) Clinical Institute Withdrawal Assessment, Neurovitals Adult, and Peripheral IV #1. The dialog box also shows the current time (11:34) and date (13-Mar-2015).

DASA-IV Appraisal of Situational Aggression

Allscripts Gateway | My Applications | Sunrise EDIS
 My Applications ► Sunrise EDIS ► Flowsheets

File Registration View GoTo Actions Preferences Tools

SUNSHINE_PATTY TWO 4G02-2 J0006862 / AC000378/14 89y (10-Oct-1925) Female
 Allergy: penicillin G sodium Visit Reason: UTI
 Name Alert! WT: 45 kg 14-Aug-2014 HT: cm
 Alerts: Isolation: Contact CPR Status: Limited

Patient List Orders Results EasyAccess-PACS DIR Pharmacy Documents Flowsheets Patient

Options Panel
 Flowsheet Criteria
 Chart Selection
 This chart All available charts
 Date Range
 From: 13-Mar-2015 Today
 To: 13-Mar-2015 Today
 Filter
 Default to summary
 Show abnormal only
 Suppress blank rows and cols
 Show ml/Kg
 Show cancelled columns
 Retain selections for next patient
 Flowsheet Selection
 4G
 Flowsheet
 Acute Care, Medicine
 Intake & Output
 Interprofessional
 Interprofessional, Child & Adole...
MH Interprofessional, Adult
 MH Plan of Care, Adult
 Plan of Care

SCM Notice
Sunrise Clinical Manager
 TOTAL SCORE 5: .
 A DASA Score greater than 4 is a High Risk for Potential Violence in the next 24 hours.
 Please go to "Safety Plan for Violence" and update.

MH Interprofessional, Adult, From 13-Mar-2015 to 13-Mar-2015

<input checked="" type="checkbox"/> (NGASR) NURSES GLOBAL ASSESSMENT OF SUICIDAL RISK <input checked="" type="checkbox"/> (NGASR) IMMEDIATE SUICIDE PROTECTIVE FACTORS <input checked="" type="checkbox"/> (DASA-IV) APPRAISAL OF SITUATIONAL AGGRESSION (Contains Unsaved Data)		
Reason not assessed		
Unable to complete due to		
*Rate based on knowledge and observations of the patient during the PREVIOUS 24 HOUR		
Irritability	Easily annoyed or angered; unable to tolerate the presence of others	Yes (1)
Impulsivity	Displays behavioural and affective instability (dramatic fluctuation in mood/demeanour)	Yes (1)
Unwillingness to follow directions	Tends to become angry or aggressive when asked to adhere to treatment or ward routine	No (0)
Sensitivity to perceived provocation	Tends to see other's actions as deliberate, harmful and reacts disproportionately	Yes (1)
Easily angered when requests are denied	Tends to be intolerant, or is easily angered when a request is denied or when asked to wait	No (0)
Negative attitudes	Displays entrenched antisocial and negative attitudes/beliefs that may relate to aggression	Yes (1)
Verbal threats	Display verbal outburst which is more than a raised voice with intent to intimidate/threaten	Yes (1)
TOTAL SCORE		5
A DASA Score greater than 4 is a High Risk for Potential Violence in the next 24 hour		
<input checked="" type="checkbox"/> CLIENT ACTIVITY & GROUP PARTICIPATION		
<input checked="" type="checkbox"/> AUTONOMY & PASSES (Contains Unsaved Data)		
<input checked="" type="checkbox"/> MENTAL STATUS EXAM		

Sidebar
 Parks, Janine (RN) 3/13/2015 11:35 FutureBuild3

Start Novell GroupWise - Mailbox Sunrise Clinical Manager ... Parks, Janine (RN) - My ... Print Screens - Mar 13 2... Allscripts Gateway | ... 11:35 AM

MH Plan of Care

Blank Rows and Columns Suppressed. VIEW ONLY MH Plan of Care, Adult, From 16-Feb-2015 to 13-Mar-2015

Save Cancel

		03-Mar-2015 14:30	05-Mar-2015 9:51	09-Mar-2015 12:23	12-Mar-2015 9:39
Risk					
Visit History and Psychiatric Problem					
	Visit History		Patient was hospitalized at Etobicoke General H	Patient was hospitalized at Etobicoke General H	
Psychiatric Problem #1	Problem (1) Intervention/coping strategies		Visual hallucinations Assess patient for vis	Visual hallucinations Assess patient for vis	
Psychiatric Problem #2	Problem (2) Intervention/coping strategies	Paranoid ideation. Assess patient for pa	Paranoid ideation. Assess patient for pa	Paranoid ideation. Assess patient for pa	
Medications					
Medical Concerns / Tests / Procedures					
Addictions					
Health Teaching					
	Health Teaching		Regarding the importance of taking medication as ordered.	Regarding the importance of taking medication as ordered.	
Activity / Nutrition / Sleep					
Family / Community Reintegration / Spirituality					
Legal / Housing / Education / Employment					

Plan of Care

Structured Notes Entry - AGYEI, FOSY - MH Plan of Care, Adult (Patient Copy) v1.0

Create Preview

Risk Identification, Addictions:

- Risk Identification AWOL (1)
- Risk Details Patient ws in 7M elevator cubicle with maintenance staff. Patient was escorted back to unit by nursing staff and patient changed into hospital gowns. Limit setting done and patient was redirected. (1)

Visit History and Psychiatric Problems:

- Visit History Patient was hospitalized at Etobicoke General Hospital from Jan. 31/2015 to Feb. 13/2015. (1)
- Problem (1) Visual hallucinations saying she can see her deceased aunt. (1)
- Intervention/coping strategies Assess patient for visual hallucinations q shift and report abnormality to the Dr. Give medication as per Dr. order and report effect of medication. (1)
- Problem (2) Paranoid ideation. (1)
- Intervention/coping strategies Assess patient for paranoid ideation q shift and report abnormality to the Dr. Give medication as per Dr. order and report effect of medication. (1)

Medical Concerns, Test, Procedures:

- Medical Concerns Scally and dry skin on hands, to continue uremol 22% application on skin. (1)

Patient Education:

- Health Teaching Regarding the importance of taking medication as ordered. (1)

Activity, Nutrition, Sleep:

- Activity Encourage patient to socialize with others and to participate in ward program. (1)
- Nutrition Monitor patients appetite at meal time and report abnormality to the Dr. (1)
- Sleep Monitor patients sleeping pattern and report abnormality to the Dr. (1)

Family, Community Reintegration, Spirituality:

- Spirituality Contact Chaplain at the patient request. Inform the patient that this spiritual service is available if needed. (1)

Legal, Housing, Education, Employment:

- Legal Patient denies. (1)
- Housing Private home/apt./rented room. (1)
- Employment Full-time Employment. Works in custodial service for

Need Help? Mark Note As: Results pending Priority Incomplete Calculate after save Save Cancel

Start | Novell GroupWise - Mai... | Sunrise Clinical Manage... | Print Screens - Mar 13 ... | Allscripts Gateway | M... | Allscripts Gateway | M... | Structured Notes En... | 11:42 AM

MH Clinical Summary

Patient List			Orders			Results			EasyAccess-PACS			DIR			Pharmacy			Documents			Flowsheets			Patient Info			Data Viewer			Clinical Summary			ED Full Scanned Chart			ED Scanned Notes		
View: Mental Health Summary, Adult Start of chart Start of Chart To 13-Mar-2015 11:42																																						
Significant Event															Legal Status - Forms																							
Event		Significant Event Details										Date/Time			Form			Requested Date			Stop Date																	
		Patient expressing suicidal...										03-Mar-2015 13:01			Form 4			03-Mar-2015 10:42			30-Mar-2015 23:59																	
		acting out/violent behaviour										23-Feb-2015 03:12																										
												17-Feb-2015 12:12																										
Visit History and Psychiatric Problems															Autonomy																							
Item Info		Value										Last Date			Privilege			Start Date/Time			Frequency			PRN			PRN Reason											
Visit History		Patient was hospitalized at...										09-Mar-2015 12:23			Level ONE: Accompanied off unit.			05-Mar-2015...																				
Problem (1)		Visual hallucinations saying she...										09-Mar-2015 12:23																										
Problem (2)		Paranoid ideation.										09-Mar-2015 12:23																										
Treatment Goals															Behaviour and Monitoring (Atypical)																							
Item Info		Value										Last Date			Item Info		Value										Last Date											
Goal (1)		Patient does not suffer from...										09-Mar-2015 12:23			Behaviour/Reason for Initiating...		wanting to leave, agitated and...										26-Feb-2015 08:19											
Goal (2)		Patient is not paranoid.										09-Mar-2015 12:23			Patient aggression/staff...		Not aggressive to staff and co...										09-Mar-2015 09:00											
															Patient self-harm act/staff...		No self-harm act.										09-Mar-2015 09:00											
															Time restraint applied (dd-...		26-Feb-2015 10:00:00 AM										26-Feb-2015 10:36											
Risk (Abnormals Only)															Communications (Active Orders)																							
Item		Item Info			Value			Last Date			Order			Category			SignificantDate																					
Risk Identification		Details			Patient ws in 7M...			09-Mar-2015 12:23			Privileges Level ONE: Accompanied off...			Activity			05-Mar-2015 10:38																					
Risk Identification		Risk(s)			AWOL			09-Mar-2015 12:23			Communication Order please arrange...			Communication Orders			04-Mar-2015 16:52																					
											Communication Order Dr Cohen to see...			Communication Orders			25-Feb-2015 12:54																					
											Communication Order Please ask MRP...			Communication Orders			17-Feb-2015 22:21																					
											Electrocardiogram (ECG)			Diagnostics/Procedures			25-Feb-2015 12:54																					
Vitals (Most Recent)										Lab Orders - To be done										Diagnostics Imaging Orders - To be done																		
Item Info		Value			Last Date			Order			Order Date			Status			Order		Order Date			Status																
Temp (degrees C)		3.3			12-Mar-2015 08:53												Electrocardiogram...		25-Feb-2015 12:54...			Active																
Heart Rate (bpm)		116			12-Mar-2015 08:53																																	
Systolic (mmHg)		124			12-Mar-2015 08:53																																	
Diastolic (mmHg)		90			12-Mar-2015 08:53																																	
Respiratory Rate...		18			12-Mar-2015 08:53																																	
SpO2 (%)		97			12-Mar-2015 08:53																																	
O2 Delivery		Room Air			10-Mar-2015 08:55																																	
Mental Status Exam (Abnormals Only)										Physical Assessment ADLS (Atypical)										Current Medications																		



Benefits Realized to date

- Easy to find pertinent patient information
- Automatic reminders related to Form Status ensures all documentation is meeting hospital and provincial standards
- Standardized language to describe patient behavior – less subjective
- Decreased time to document → more time with patients
- Easier review of critical incident information
- Ability to generate reports on various data to assist with resource planning; provide detailed picture of unit
 - # of patients in restraints
 - Length of time in restraints
 - Aggressive behavior score
 - Time of significant events
 - #of patients requiring frequent observation



Recent Optimization

- Initial assessment in MHESU → detailed head to toe assessment to rule out significant medical issues
- Nursing and interprofessional documentation starts in MHESU and follows the patient through admission to unit
- Medication Reconciliation in MHESU → decrease errors with medication
- Electronic completion of belongings list with copy for patient ; descriptor of location of belongings; edit based on belongings returned to patient
- Sharing information with patients –patient access to own record; printed Plan of Care –easily updated daily
- Research → ability to support specific research projects → easy extrapolation of data and interrelationship of observations

“As soon as you open your mind to doing things differently, the doors of opportunity practically fly off their hinges.”

SOURCE:

JAY ABRAHAM, *THE STICKING POINT SOLUTION: 9 WAYS TO MOVE YOUR BUSINESS FROM STAGNATION TO STUNNING GROWTH IN TOUGH ECONOMIC TIMES*



THANK YOU

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