Nursing Documentation Re-Design/ Meditech Changes

Several changes will occur in December/January to Nursing Documentation. A collaborative effort has occurred over the past year between **Nursing Re-Design Team** (clinical nurses), **Informatics Team/Department**, and Phelps Laboratory/Blood Bank.



Goals of the Re-Design Team are to:

- *Eliminate* double documentation
- Reduce redundant documentation
- Alian Phelps documentation and Northwell Policies/Guidelines/Procedures/Protocols, and
- Standardize documentation between clinical areas.

New/Updated documentation includes:

A. Blood Product Administration

1. CHANGE from Paper to Electronic

- Physician's Order Form/Blood Product Order Set
- Transfusion Administration Record

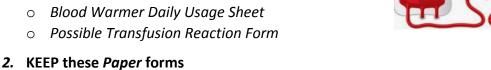
- Consent to Blood Transfusion
- Blood and Blood Product Release (used to pick up blood)
- Blood Bank Record (blood tag)
- Blood Verification SCRIPT Cards
- Code Fusion/Massive Blood Transfusion forms

Education includes an iLearn, unit posters, and Clinical Educators support with 1:1 assistance & rounding on clinical areas. Watch for scheduled TEAMs online Help Sessions.

Education planned for December 2021 and Implementation/Go-Live January 2022.

B. ADMISSION Documentation for the Medical Surgical Patient (SOC)

- 1. Update/Change from Paper to Electronic
 - HxDB: ADMISSION Interview [update]
 - HxDB: PMH/PSH [update]
 - REMOVED → HxDB: Med/Surg Physical Assessment
 - UPDATE → Med/Surg Shift Assessment "One-Stop-Shop"
 - For ADMISSION, Shift Assessment, Transfer (when a patient is received from another unit/ED/ICU), or **Ongoing Assessment** (update assessment due to change in patient condition).





C. Pain Management [see also next page]

Education & Implementation in December, 2021

- 1. Update or Change from Paper to Electronic
 - Pain Assessment [update]
 - PCA Assessment [new]
 - Handoff—Controlled Substance/PCA/Transdermal Patch [new]
 - eMAR Pain Assessment/Reassessment [update]

2. Changes in Practice to align with Northwell System PAIN Management Policy

- **RASS Sedation Scale** (Richmond Agitation Sedation Scale) → No longer using the POSS scale. *Laminated guides will be placed on WOWs for reference*.
- Critical Care Pain Observation Tool Scale (CPOT) → Adult critically ill who are unable to self-report pain (intubated or extubated patients).
- **FLACC** may be used for **Pediatric** AND **Adult patients** who are <u>unable to verbalize</u> pain or <u>express pain</u> with numeric values or Faces scale.



New Northwell Policies-Implementation January 2022

PCS.1610 Wristbands, Color-Coded, High Alert Conditions

Color-coded wristbands are placed on the patient with the specified **HIGH ALERT CONDITIONS**, including Inpatient and Emergency Department patients.

Corresponding Standardized Processes Related to High Alert Conditions***

Wristband Color	High Alert Condition	Related Standardized Processes
RED	ALLERGY	Patient and allergy specific
YELLOW	FALL RISK	#PCS.1619: Fall Prevention
PURPLE	DO NOT RESUSCITATE	#100.24: Withholding and Withdrawing Life Sustaining Treatment Including Do Not Resuscitate (DNR) Orders #100.049: MOLST (Medical Orders for Life – Sustaining Treatment)
PINK	DO NOT USE EXTREMITY	#PCS.1631: Vital Signs for Adult and Pediatric Patients #PCS.1612: IV Insertion (Short Peripheral Catheters); #PCS.1625: Midline Catheter, Insertion, Maintenance, and Removal; #PCS.1602: Central Venous Access Devices CVAD
GREY	ASPIRATION PRECAUTIONS	#PCS.1664: Dysphagia Screening for Adults
BLUE	CRITICAL AIRWAY	#C100.2: Critical Airway Patients (Pediatrics); Site Policy may address Adult Critical Airway

^{***}For all wristbands: other standardized processes not listed here, and patient specific interventions may apply.



PAIN Northwell System Policies – *Implementation December 2021*

Pain Management PCS.1603

PCA: IV Patient Controlled Analgesia PCS.1644



<u>Transdermal Medication</u> PCS.1615 [Fentanyl Patch → Handoff and Skin & Patch Integrity/Disposal]

- 1. **Reassessment timeframes** are now:
 - **PO** analgesia = within 60 minutes
 - > **SC/IM** analgesia = within 30 minutes
 - > IV/IVP analgesia = within 15-30 minutes
 - Non-Pharmacologic Interventions (reposition/ice/heat) = within 60 minutes
- To support the *change in practice* on Sedation Assessment for Opioid-Induced Respiratory
 Depression (OIRD), the *Richmond Agitation-Sedation Scale* (RASS) will be used to assess sedation--replacing the POSS scale.

The following laminated cards will be readily placed on computers, to reference.

Richmond Agitation-Sedation Scale (RASS)				
Sco	Score RASS Description		RASS Description	
4 Combative		Combative	Violent, immediate danger to self or staff	
3		Very Agitated	Pulls at or removes tubes, aggressive	
2		Agitated	Frequent non-purposeful movements, fights ventilator	
1		Restless	Anxious, apprehensive but movements not aggressive or vigorous	
TAI Ra	0	Alert & Calm		
TARGET Range	- 1	Drowsy	Not fully alert, sustained awakening to voice (Keeps eye open & maintains eye contact > 10 seconds)	
-	2	Light Sedation	Briefly awakens to voice (eye opening & contact <10 secs)	
-3		Moderate Sedation	Movement or eye-opening to voice (no eye contact)	
-4		Deep Sedation	No response to voice, but movement or eye opening to physical stimulation	
-5		Unarousable	No response to voice or physical stimulation	
	Consider RRT with Score -2 or less (RED)			

Meditech Screen for RASS Assessment

RASS	
Richmond Agitation & Sedation Scale (RASS)	○ 0/Alert & Calm ○ -1/Drowsy ○ +1/Restless ○ -2/Light sedation** ○ +2/Agitated ○ -3/Moderate sedation** ○ +3/Very Agitated ○ -4/Deep sedation** ○ +4/Combative ○ -5/Unarousable**
	*Scores of 0 to -1 are normal. **NOTIFY MD if sedation is less than -1; Consider RRT.