

# VTE Assessment Documentation

- Document on “\*VTE Risk and Standing Order\*” from Assessments
- Complete all fields on Page 1 to obtain score
- Acknowledge that you need to place the order, then indicate Y/N if SCDs were applied to your patient (Acceptable contraindications are listed in the on-screen display box; SCDs MUST be placed if none of these are present). You will be taken to the ordering screen.

NUR.COCSNM (NMLCSND/NMD.TEST.MIS/118/COCSNM) - Wright,Dana J \*\*\* TEST \*\*\*

Process Patient Assessments

Current Date/Time DJW Status ADM IN Room NM.0322  
Admit 06/10/13 Bed 2  
Patient NM0300000712 RN,FIVESIXSIXNURTEST Age/Sex 33 F Loc NM 380

VTE RISK AND STANDING ORDER

7/2/24/14 1118 DJW NM0300000712 RN,FIVESIXSIXNURTEST

**5 = Spinal Cord Injury w/Paresis**  
When Finished With Assessment  
CLICK On "VTE Risk Score" To calculate Score.  
If Changes Are Made, RECALCULATE By Clicking on "VTE Risk Score"

\*\*\*VTE Risk Factors\*\*\*

Current smoker: >1	CHF, AMI: >0
Minor Surg (Anes < 1hr): >1	Acute Resp Failure/COPD: >0
Varicose veins/Leg swelling: >1	Sepsis: >0
Inflammatory Bowel Disease: >1	Hx VTE/PE: >0
Pregnancy: >1	Hx Increased Clotting: >0
Obesity (BMI > or = 30): >1	Age > 75 years: >0
PO contraceptive/hormone replace: >1	Hip/Pelvis/Leg Fracture < 1month: >0
Age 61-74 years: >0	Stroke < 1month: >0
Malignancy, except skin: >0	Multiple trauma < 1month: >0
Major surgery (Anes > 1hr): >0	Major LE Arthroplasty: >0
Central venous access: >0	Acute spinal cord inj w/paresis: >0
Confined to bed > 72hrs: >0	

VTE Risk Score: >7 \* Risk Level: > HIGH

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Current Date/Time DJW Status ADM IN Room NM.0322  
Admit 06/10/13 Bed 2  
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VTE RISK AND STANDING ORDER

02/26/14 1403 DJW NM0300000712 RN,FIVESIXSIXNURTEST

Standing Order Form for Adult Medical Venous Thromboembolism (VTE) Prophylaxis

SCDs will be applied for DVT/VTE prophylaxis unless there is a documented contraindication or an order for pharmacologic prophylaxis

**\*\*If there is a reason/contraindication preventing the use of SCDs, contact the physician, and obtain an order for pharmacologic prophylaxis or an order not to give pharmacologic prophylaxis due to a specific contraindication \*\***

An order MUST be placed for either contraindication OR SCD application.  
Acceptable contraindications for SCDs: Pt refusal, Acknowledged: >Y\*  
Pt on Enoxaparin (Lovenox) or Heparin SubQ, SCDs Applied >Y\*  
Present DVT/PE, Bilateral above/below knee amputee  
Open leg wounds/leg injury  
Enter the Attending as ordering provider Use Order Source "SO" (Standing Order).

Use the Attending MD as the ordering provider and select **SO (Standing Order)** as the Order Source

**Order Management**

Ordering Provider

Other Provider

Order Source

OK Cancel

Complete the order details appropriately. This documents contraindications and where SCDs were applied (or NA). Once filed the Provider will be able to sign the order from his/her queue

Review Patient's Orders - Mon, Feb 24

RN, FIVESIXSIXNURTEST - 33/F NM.3RD NM.0322/2 Unit No:NM00000933  
 165.1 cm 54.5 kg ADM IN Acct No:NM0300000712  
 011 Leg/leg #00Pe1 Phenylephrine HCL (From IV/ENOL ALLERGY MULTI-SYMPTOM) (More)

Preview/Edit

Add More Add to Favorites  
 Clear Unchecked Save as Set

Orders	Pri	Start/Service	Series	Directions	Qty	Details
<input checked="" type="checkbox"/> SCD standing order (NURORD)		02/24 1129	D			Req

Done Cancel

Enter/Edit Responses : SCD standing order

Procedure Ordered

Contraindication/Reason for no mechanical VTE prophylaxis

Patient on Enoxaparin (Lovenox) SubQ  N\* Patient on HEPARIN SubQ  N\*

Patient refusal  N\* Bilateral above or below knee amputee  N\*

Present DVT/PE  N\* Open leg wounds/leg injury  N\*

SCDs applied  \*  Bilateral  Right leg  Left leg

Ok Cancel Help Prev Next

**\*\*IF PHARMACOLOGIC PROPHYLAXIS IS NEEDED YOU MUST PLACE AN ORDER FOR THE SPECIFIC MEDICATION USING THE USUAL ORDERING METHOD, IN ADDITION TO THE ABOVE\*\***

# ***ACKNOWLEDGING ORDERS FROM STATUS BOARD***

- **Why is it important?**
- All orders must be acknowledged from the Status Board so that all the appropriate flags appear.
- Acknowledging orders from the Status Board is the **ONLY** way nurses will see new orders that have been entered electronically by the provider
- Flags appear under the **NEW ORDERS** column and will show in order of urgency
  - **STAT** – Stat orders or medications have been ordered.
  - **ACKnowledge** – immediate notification and ability to acknowledge new orders or medications entered by staff or provider.
  - **NEW** – provides opportunity to review orders or medications entered and acknowledged by previous RN.
  - **UNCollected** – uncollected specimens are ordered and need to be collected.

# “ACK” Definitions:

- **Status Board ACK for non medication orders:**  
I, as clinician, am aware of this order.
- **Status Board ACK for medication:**  
I, as clinician, am aware of this order and I have reviewed the order for appropriateness for my patient as well as reviewed dose, route, frequency, start/stop dates and all comments/instructions on the order. I agree that the order appears to be appropriate based on my clinical knowledge.

# What is the process?

- To acknowledge orders click on the flag in the NEW ORDERS column on the Status Board.
- Place a check mark on ANY order with a box next to it and click the Ack/Ver button at the bottom left of the screen

Patients on Location NM.6TH								
LOCAT	NAME		RES	MEDTIME	FLU DATE	WANTS	NEW ORDERS	
ROOM	AGE	DOB	SEX	Call	patient	PNEU DATE	WANTS	
NM.6TH	RN,	THIRTY				REFUSED	N	Ack
NM.0601-1	81	03/30/30	F			REFUSED	N	

		All Orders	meds	Non-meds		
Order		Category	Pri	Event	Status	Event Dt/Tm
<input checked="" type="checkbox"/>	Diet Order	FNS		New	Active	02/23 1746
<input checked="" type="checkbox"/>	BLOOD GASES ARTERIAL (RT)	LAB	R	New	Active	02/23 1746
<input checked="" type="checkbox"/>	CBC WITH AUTOMATED DIFF	LAB	R	New	Active	02/23 1746
<input checked="" type="checkbox"/>	RAD CHEST ONE VIEW	RAD	R	New	Active	02/23 1746
<input checked="" type="checkbox"/>	RESPIRATORY THERAPY	RFS		New	Active	02/23 1746

# Review the screen to make sure the order entered matched the physician written order.

**Order Record**

Patient: RN, THIRTY    Acct No.: NM0000003785    Unit No.: NM000000289  
Ordered By: PCI TEST PHYSICIAN    Entered By: NMDTRN1    02/23/12 1746  
Other Prov: \_\_\_\_\_

Category: LAB    Procedure: CBC - CBC WITH AUTOMATED DIFF    Status: TRN  
Order No.: 0223-0001    Pri: ROUTINE    Qty:     Date: 02/23/12    Time: 1745    Order Source: W - W

Signed by  
1: \_\_\_\_\_  
2: \_\_\_\_\_

**Audit Trail**

2	02/23/12	1746	NMDTRN1	Ordering Doctor: PCI TEST PHYSICIAN
3	02/23/12	1746	NMDTRN1	Order Source: Written

COLLECTED BY NURSING OR RT?  N    Collected By: (USER ID) \_\_\_\_\_  
Comment: \_\_\_\_\_  
MN Check     ED ADD-ON ORDER?

•If there is not a written order found, check the Order Source field. **If the order was submitted electronically by the provider the order source will be POM or EPOM and there will be NO paper copy.**



Audit Trail				
3	09/06/12	1359	NMDTPHY	Order Source: EPOM
4	09/06/12	1359	NMDTPHY	Signed by PCI TEST PHYSICIAN

•If order is correct, **F12** to file. You will be prompted to proceed to the next order: Repeat step 1-4 for all orders (if an order is incorrect, continue acknowledging orders. When you have finished, the incorrect order must be cancelled and reordered correctly)

# Viewing Orders by Date/Time - Allows RN to view **ALL** procedural and Medications orders entered

Access **ORDERS** from Status Board.

All orders will appear under collapsed cells. Open cells by clicking the **+** icon near **CATEGORY**.

LOCATION	NAME	NEXT MED	new results	Last Pain Med
ROOM	AGE DOB SEX	Call Patient	RESTRAIN DATE	ALLERGIES
NM.3RD	RN.FIVE			06/15/09 0919
NM.0308-1	59 05/05/50 M			*Ranitidine
NM.3RD	RN.SIX			06/15/09 1520
NM.0309-1	49 06/06/60 M	ELVIS		*CLAMS
NM.3RD	RN.SEVEN			
NM.0309-2	39 07/07/70 F			*No Known Dr*
NM.3RD	RN.EIGHT			
NM.0310-1	28 08/08/80 F	CAT		*Iodine
NM.3RD	RN.TEN			06/12/09 1420
NM.0311-1	98 10/10/10 F			*Latex

- Allergies
- Admin Data
- Assessment
- Process Int
- Plan of Care
- Pt Notes
- PI Loc/List
- Orders
- Review

+	Category	Orders	Pri	Date/Time	Status	Stop	My
- Laboratory (4)							
	CBC WITH AUTOMATED DIFF (LAB)	Timed		09/26 0600	Comp		
	UA W/MICROSCOP REFLEX CULTURE (L	Timed		09/25 0600	Comp		
	COMP METABOLIC PANEL (LAB)	Timed		09/25 0600	Comp		
	CBC WITH AUTOMATED DIFF (LAB)			09/24 1545	Comp		
- Blood Bank (1)							
	TYPE AND SCREEN (BB)			09/24 1545	Comp		
- Medications (4)							
	Prenatal Vits W-Ca,Fe,Fa Tab (Pren...			09/25 0959	Active	10/25 1000	
	PO 1 COMBO D						
	Acyclovir Cap (Zovirax Cap)			09/25 0958	Active	10/25 0959	
	PO 400 MG BID						

•Click on **DATE/TIME TWICE** to list orders from newest to oldest

# To view details of a specific order:

Highlight order by clicking order to view;  
Click View/Change button

- Radiology (3)		* Allergies
US ABD LIMITED (US)		View/Change
SHOULDER 2 VIEW RIGHT (RAD)	Stat	Renew/Repeat
CT BRAIN W/O CONTRAST (CT)	Stat	Hold Resume
+ Special Services (1)		DC
+ Medications (4)		Undo

Screen will default to DETAILS which shows information entered when procedure or medication was ordered.

Details	Results	Providers	History
Status			Comp
HOW IS THE PATIENT TRANSPORTED?		BED	
REASON FOR EXAM?		ROUTINE	

**HISTORY** provides audit trail of entire order.

Results	Providers	History
---------	-----------	---------

Order Number		20120803-0004
Date/Time	User	Audit Trail of Events
08/02 1828	DR [ ]	Order ENTER in POM
		Ordering Doctor: E [ ]
		Order Source: POM
		AM was entered as Service Time
		Signed by E [ ]
08/03 0000	interface	order's status changed from TRANS to LOGGED by
08/03 0800	NMRAD [ ]	order viewed from Provider Order Management

# PROCESS INTERVENTIONS

## Process Int

(Click with mouse or type "P")

•Select "**Process Intervention**" from the Status Board. This routine is "multi-functional". You can perform many functions related to patient documentation here. After the patient's Plan of Care is created, it is important to document that the planned care is being carried out. Process intervention is the primary routine for this to be done. From this screen you will be able to:

<input type="checkbox"/>	<u>D</u> ocument	<u>D</u> ocument	<u>P</u> atient	<u>P</u> rocess	<u>E</u> dit	<u>V</u> iew	<u>V</u> iew	<u>&gt;</u> More
	<u>I</u> nterv's	<u>N</u> ow	<u>N</u> otes	<u>M</u> eds	<u>T</u> ext	<u>T</u> ext	<u>H</u> istory	

You may double click on your choice or enter the underlined letters (short keys). The above is called a "Verb Strip".

## THE PROCESS INTERVENTION SCREEN

Interventions are grouped under intervention headers. A dash (-) precedes each intervention. Indented under each intervention is its supplementary text. Listed to the right of each intervention are:

Interventions	Sts	Directions	Lst	Doc	Sc	D	CN	K	Prt
---------------	-----	------------	-----	-----	----	---	----	---	-----

(Sts)	Status of the intervention
(Directions)	Directions (Instructions)
(Doc)	Last date of documentation
(Src)	Source of the intervention
(D)	Duplicate (Is this intervention a duplicate?)
(C/N)	Comment (has a comment been entered?)
(Prt)	Protocol – whether protocol text is associated with this intervention

The first 3 items in the list are of primary importance; the subsequent 4 are listed mostly for informational purposes.

## Moving around the screen:

### Press

↑ or ↓

<PAGE UP>,<PAGE DOWN>

F7

F8

### To Move

from one intervention to the next

from one Intervention Header to another. (The highlight bar moves to the first line of an intervention, not to the Header. Located above arrow keys)

to the TOP of all interventions

to the BOTTOM of all intervention

## ***THE VERB STRIP***

Document  
Now

### Document Now ("DN")

This routine is used to document interventions that are performed at the present time (within 15 minutes). You can click on the Verb Strip icon "**Document Now**" or type in "**DN**" in order to access this routine.

Document  
Interv's

### Document Interventions ("DI")

This is the routine used to document interventions that are performed. You can click on the Verb Strip icon "**Document Intervention**" or type in "**DI**" in order to access this routine. There are 3 ways to "document":

## **Highlight a single intervention**

## **Check off Method**

## **Entering Multiple Dates/Times on Date/Time stamp screen**

More detail of these three methods will be presented on the pages that follow



## Highlight a single intervention

- A screen will appear showing the date, time, and User.
- The number of interventions to be documented along with the number of occurrences is seen at the bottom of the screen. This is called the “date and time stamp”.
- The cursor is in the “OK?” box.
- Type in “Y” if all the information in the box is correct.
- To change the date and/or time, press **F6** (previous field) key. This will take you to the date and time stamp box. Date and time can be changed if needed.
- Hit **<ENTER>** if information is correct. Answer the queries and **F12** to File, when completed.

## Check off Method

- Check off the interventions to be documented.
- Use the **RIGHT <CONTROL>** key. **<SHIFT> RIGHT <CONTROL>** key will check off ALL interventions)
- Type in “DI”. Follow instructions above regarding changing time/date, etc. if needed.
- If more than one intervention is checked off, the screens will be brought up consecutively to document on. ***Note: in the upper right hand corner of the screen, the number of interventions checked off is noted. It is a good idea to always look at this prior to documenting.***
- A box appears at the end of the documenting stating “2 out of 2 done”, “1 out of 2 done”, etc.

## Entering Multiple Dates/Times on Date/Time stamp screen

– Enter multiple times and dates. Example: documentation of frequent vital signs:

- 8/21 @ 0700
- 8/21 @ 0800
- 8/21 @ 1415
- 8/21 @ 1500
- When the screen is **FILED** after documenting a set of vitals for a specific time, a blank screen will appear for the next set time stamp. A new screen will appear for each time stamp entered.
- Be cautious when using this function to document; ensure the correct data is entered for the correct time.

**CHANGE STATUS – (“CS”)**

This routine is used when an intervention has been completed, a duplicate intervention exists, or for some other reason the intervention status needs to be changed. **ARROW** down to highlight the intervention you want to change the status. You can also select more than one intervention using the **RIGHT <CONTROL>** key to check off the interventions you want. This will allow you to change the status for more than one intervention, at the same time. (e.g. to COMPLETE 5 interventions) At the Verb Strip, type in **“CS”** and press **<ENTER>** (or click on the Change Status box). A screen will appear with the cursor flashing in the Status box. Enter the letter **“C”** for complete. Then **F12** to FILE and select **“Y”** to file your change in status. To verify this was completed, look under the “Sts” column in the Process Intervention Screen and it should reflect the change.

Status choices are:

A = Active	In use and waiting to be documented on.
C = Complete	Documentation is completed for the patient’s entire stay.

**You will never use any of the status options listed below!!!!!!!!!!!!**

H = Hold	Active but on hold, e.g. when the patient is off the unit.
I = Inactive	<b>WE DO NOT USE THIS STATUS.</b>
X = Canceled	Reserved for interventions that have been added to the patient’s plan of care in error. Once canceled, cannot be reactivated. Must be added again.
D = Discharged	System generated when the patient is discharged from the system.

## VIEW HISTORY – (“VH”)

This function is an on-line method of looking at the history of a particular Intervention. You can view all changes, edits, and comments made to a particular intervention, here. This function will also allow you to “edit” or “undo” information that you have recorded. At the verb strip type in “VH” (or click on **View History**) A screen appears with a list of verbs at the top of it:

```
□  ->View  Select  Undo  Edit  <-Exit
```

The Intervention number and description shows up along with the status and the source of the Intervention. Under the heading “activity”, it shows when the intervention was created and by whom.

**View:** **RIGHT ARROW (→)** at the intervention to see results of the documentation.

**Undo:** Type “U” and you will be prompted with the question, “Undo this documentation?” Answer “Y” or “N”. If “Y”, it will show up with the date, time, and your monogram. (You will be prompted to enter a comment why Undoing documentation). Use **UNDO** if you document on the wrong patient. **YOU CAN NOT UNDO SOMEONE ELSE’S DOCUMENTATION.**

**Edit:** Type “E” to enter form highlighted. (You will be prompted to enter a comment why editing the documentation). Edits can be made here. **Hit F12 FILE** and you will be prompted to “File changes?” enter “Y” to file? You’ll see the activity “edited results” appear in the activity column directly below the original documentation. You cannot “edit” an Intervention that does not have a screen attached, you can only “undo” the documentation. **YOU CANNOT EDIT SOMEONE ELSE’S DOCUMENTATION.**

**NOTE: You must enter a comment whenever you edit or undo an Intervention.**

**Select:** Type in “S” and you will see a screen appear giving you a choice of looking at all the activity on the Intervention vs. documented activity only. Choose the appropriate one (“all” will show up edits, comments, variances, etc.)