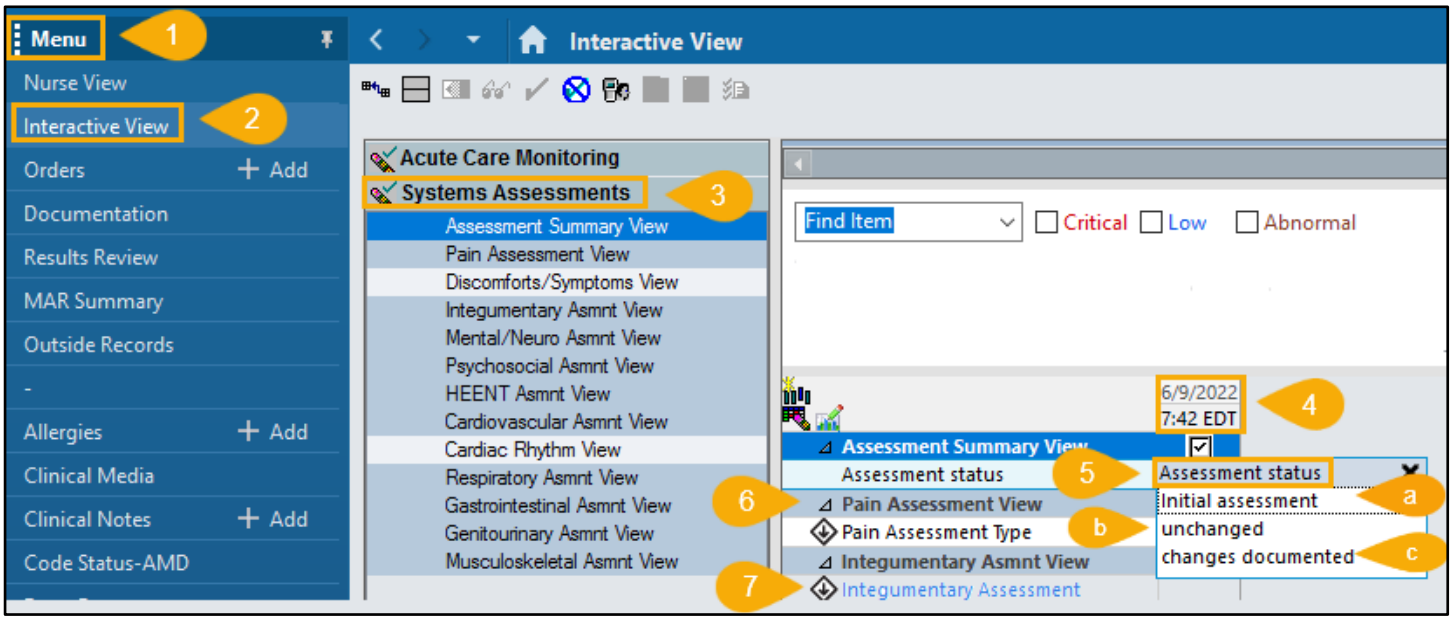
Interactive View: Systems Assessments Band for Nurses

Systems Assessments Band

The **Systems Assessments Band** is used for documentation and viewing the patient's systems assessment.

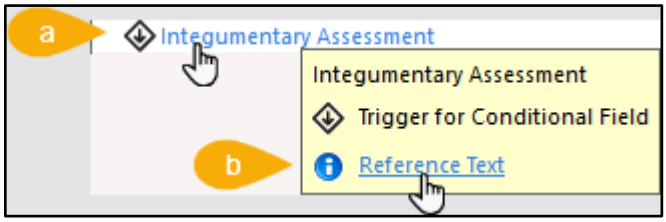
1. Go to the dark blue Menu.
2. Select Interactive View.
3. Select the Systems Assessments Band.
4. The Date and Time should reflect the actual time of the assessment. Double click on time to activate all cells.
5. Assessment Summary – Select one of the following:
    a. **Initial assessment**- first assessment of the shift.
    b. **Unchanged**- Patient assessment is identical to your prior assessment, **excluding** pain assessment.
    c. **Changes documented**- record only what has changed from **your** previous assessment.
6. **Pain Assessment** and documentation is required within one hour of the initial assessment. Subsequent pain assessments are required every 8 hours, after pain medication is given, or more often per unit protocol.



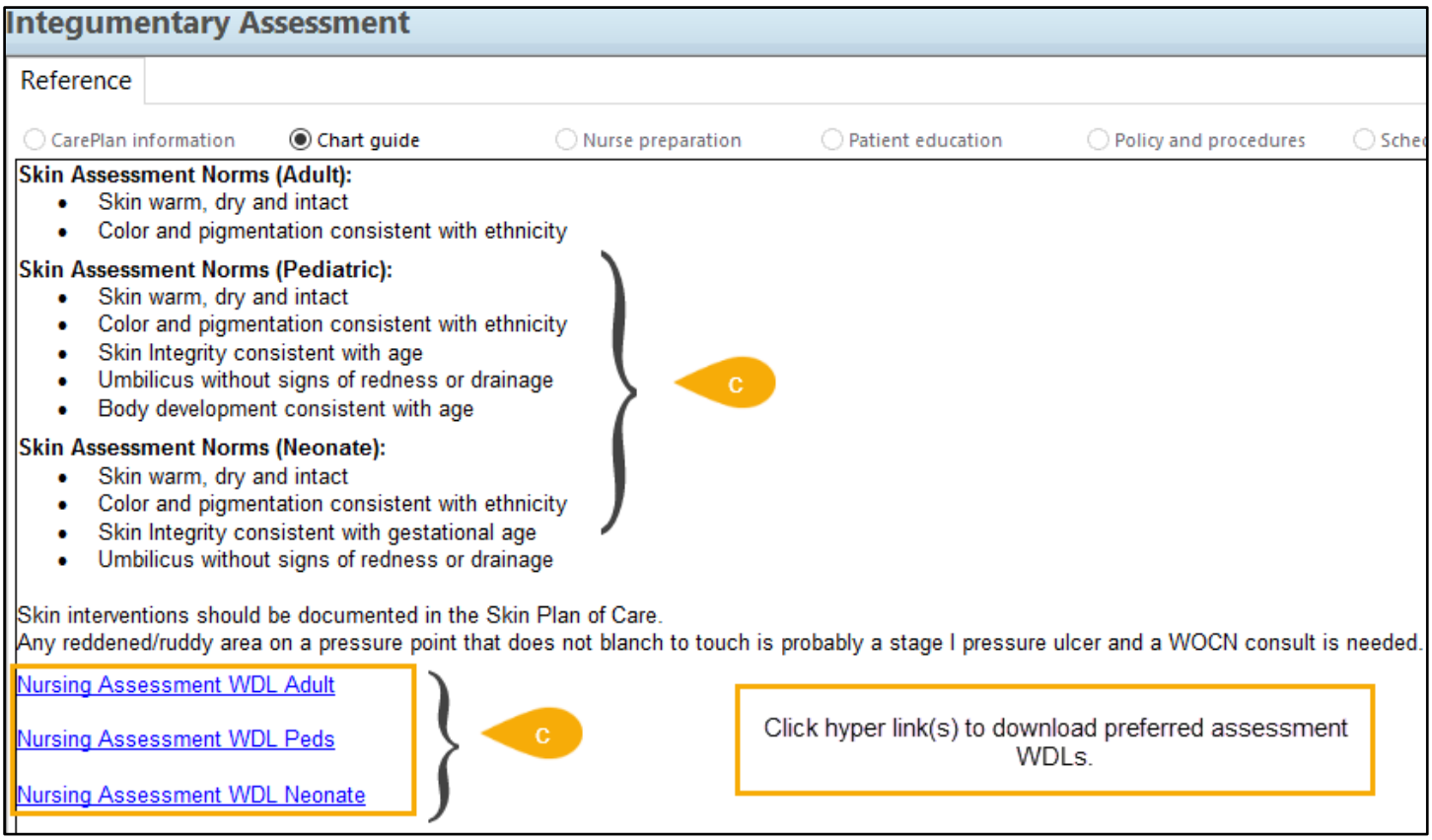
7. **Charting by Exception**: Nurses are required to chart only departures from expected patient norms. All systems have an established **Within Defined Limits** (WDL) standard. The blue text indicates a hyperlink which provides an explanation of MHC defined normal for each system.

8. To review MHC defined norms for each system:
    a. Hover over selected blue text in systems assessment, cursor will change from an arrow to a hand.

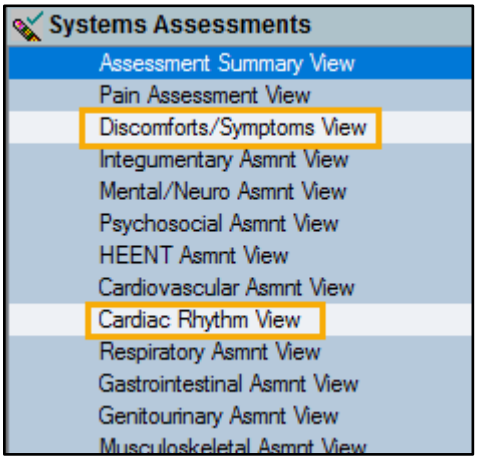
    b. Select Reference Text.



c. Adult, Pediatric and Neonate Norms are displayed. The option to select and print WDL system norms documents can be printed for each age group.

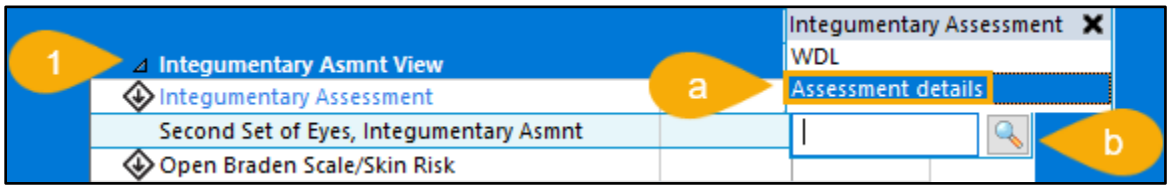


d. In the navigator, all darker colored bands show face up. To view and document on the lighter colored bands, select the appropriate band. The bands will remain face up once the documentation is completed.

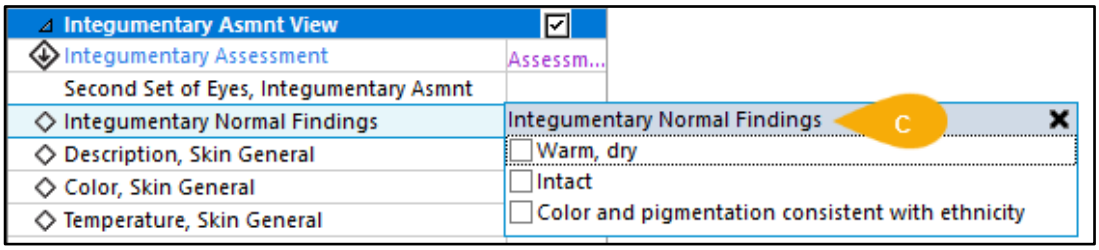


Integumentary Assessment Key Points

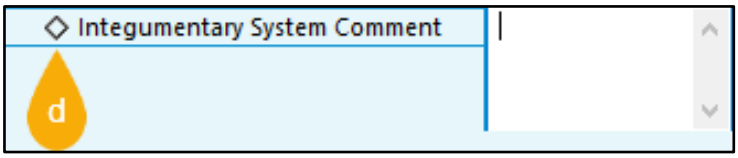
1. **Integumentary Assessment:** The Nursing assessment is to be completed and documented at a minimum every 8 hours. Additional Integumentary Assessments occur with new admits and transfers to the unit. For example, patients from the ED, OR, and/or Direct Admits.
   a. For any assessment, if the patient **does not meet WDL criteria**, select **Assessment Details**.
   b. **Second Set of Eyes** (SSOE) requires two staff members, RN, LPN, NT, SN or NA to inspect and assess each patient's skin status. The second nursing staff member's name is to be entered as part of the SSOE documentation.



   c. Each system has a Normal Findings field.

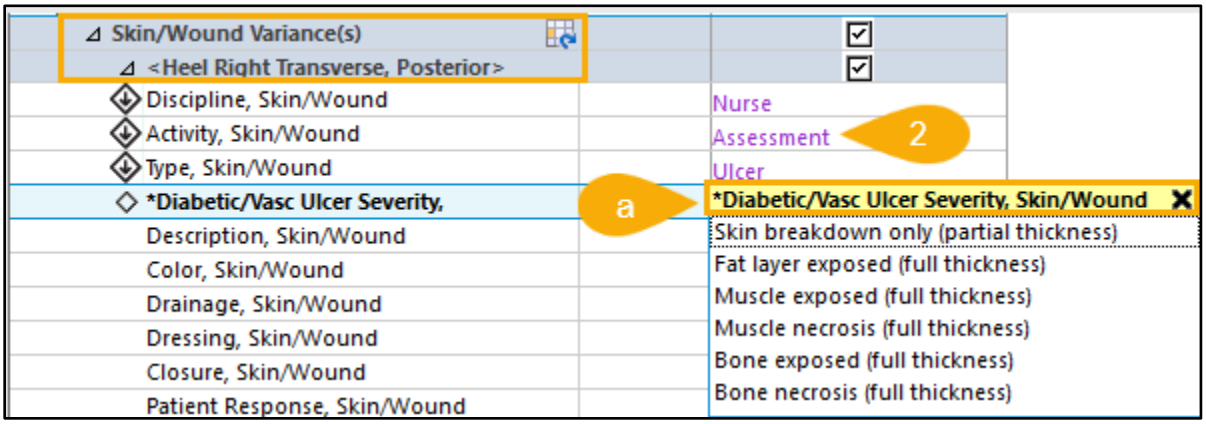


   d. Each system has a free text comment field of 255 characters.



Integumentary Assessment Key Points

2. Skin/Wound Variance(s) Dynamic Group: When **Type, Skin/Wound**, **ulcer** is selected, the **Diabetic/Vascular Ulcer Severity, Skin/Wound Ulcer Severity** field is required.
    a. Documenting in this field is not considered staging. Staging of pressure injuries can only be done by a Wound Ostomy Continence Nurse. The assessing nurse should describe what they see when documenting the ulcer.



Note: All other systems assessments follow the same documentation requirements as the Integumentary Assessment**.**

Additional References

Refer to the **EHR Education website,** Hospital Nursing page, for further information regarding Interactive View and Dynamic Groups.

Search path: Clinical EHR Education > Nursing Staff > Documentation