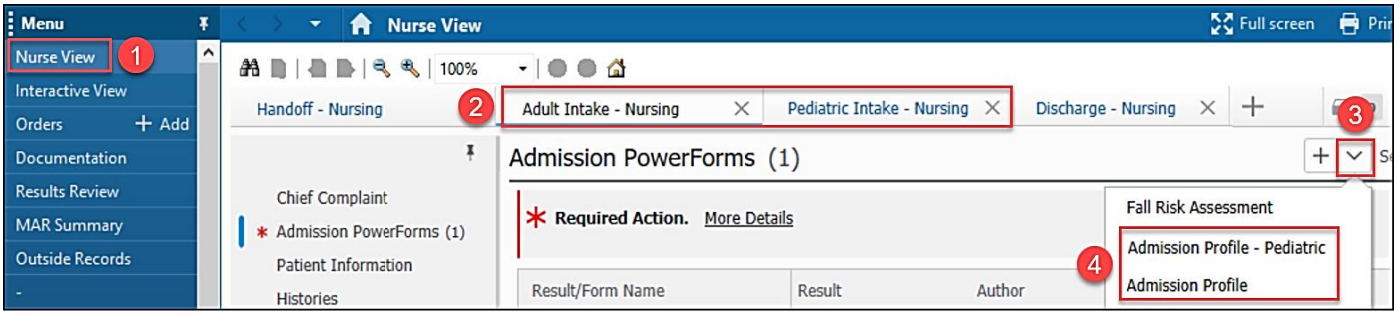
Social History Documentation for Nurses

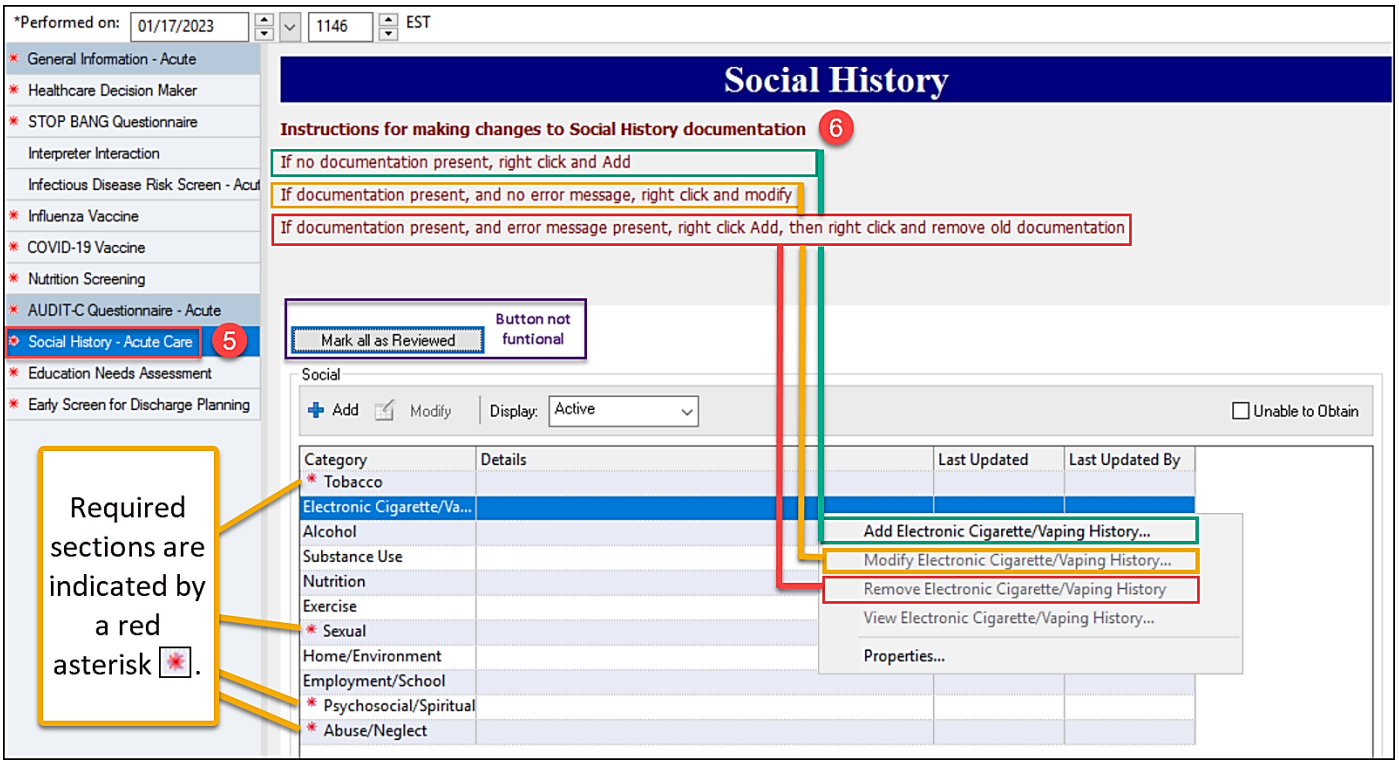
Accessing Social History Documentation

Social History is documented as part of the Admission Profile. To access this form:

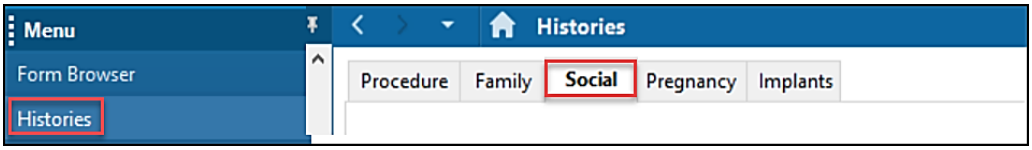
1. Select Nurse View in the dark blue menu.
2. Select the appropriate Intake tab.
3. Click the drop-down arrow in the Admission PowerForms header.
4. Select the appropriate Admission Profile.



5. Select the Social History-Acute Care section.
6. Add, Modify or Remove results by following the instructions on the page. **Existing results must be modified to update** Last Updated and Last Updated by fields.



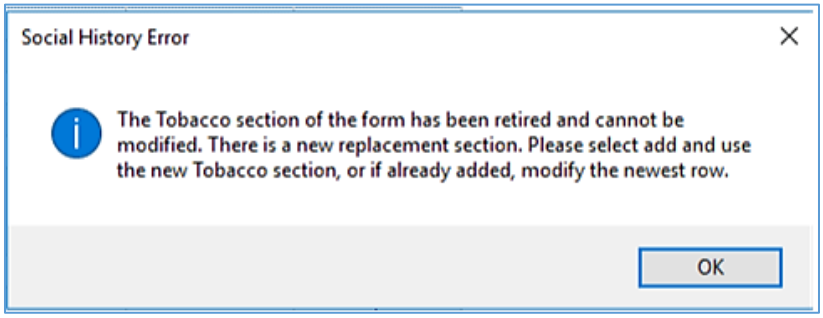
Note: Social History is also accessed by selecting Histories from the dark blue menu and selecting the Social tab.



Social History Error Messages

If an error message appears after right clicking and selecting Modify, the data is outdated and cannot be modified.

For example, the error message shown will display when an attempt to modify information entered prior to a system update (documented before 9/14/21).



Abuse/Neglect Screening Details

The Abuse/Neglect Screening must be documented for all patients in all settings. The screening contains 5 mandatory fields for patients 18 and older (1 field for pediatric patients).

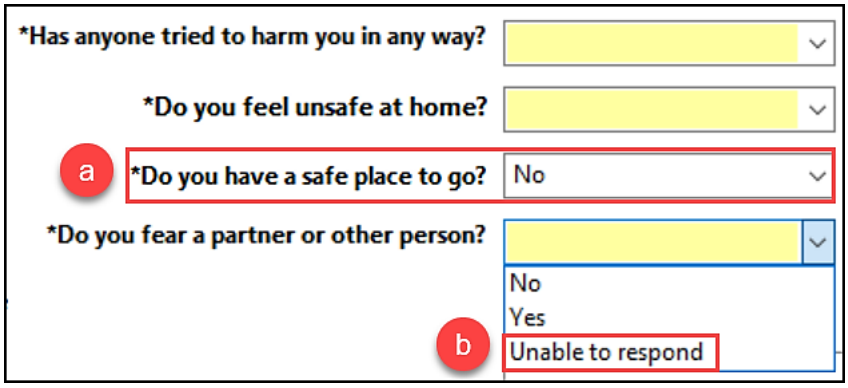
1. Screen the patient and document the patient's response to each question.

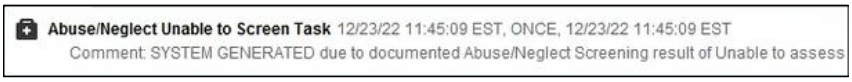
   a. Documenting a response of 'No' in the Safe place to go field will automatically trigger a consult to Case Management/ MSW. The screening is considered complete and will not be retasked.

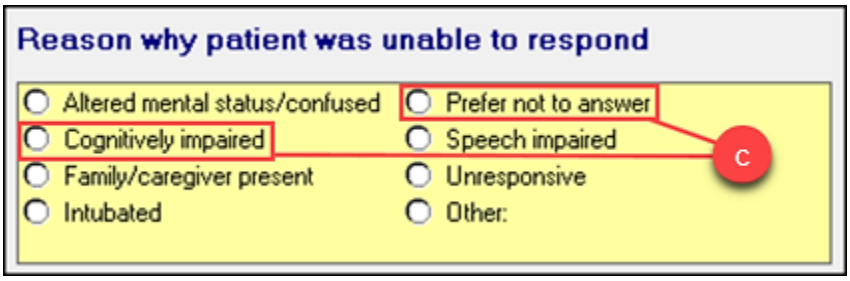
   b. Selecting 'Unable to respond' for any question will prompt staff to provide a reason the patient could not be assessed by triggering the Abuse/Neglect Unable to Screen Task.

   c. If the patient states that they 'Prefer not to respond' or is 'Cognitively impaired' the assessment is considered complete and will not be retasked.

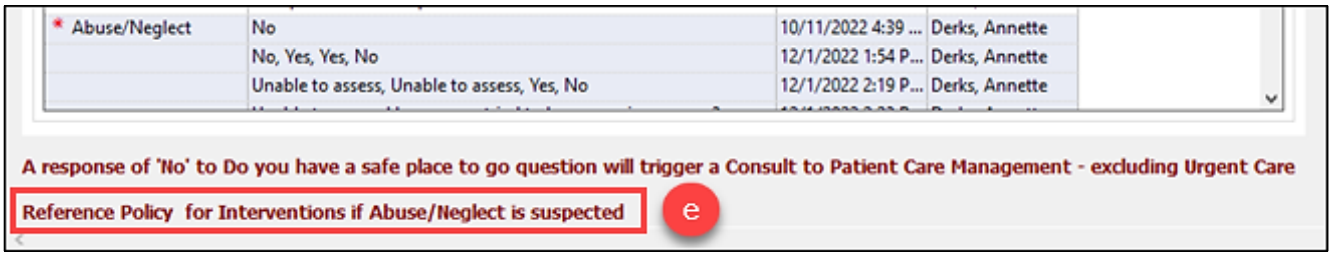
   d. Document whether clinical evidence of Abuse/Neglect Risk is present. **Pediatric screenings will contain this question only.**



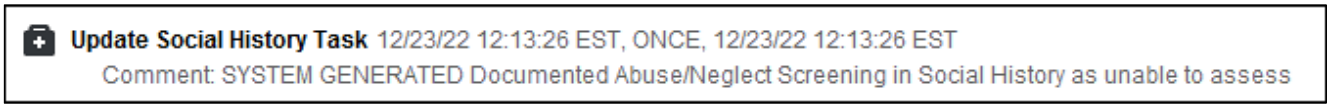




e. If 'Yes' is selected, the screening will direct the user to reference the facility policy for interventions and follow up. The screening is considered complete and will not be retasked.



2. An Update Social History Task will fire **in 12hrs and daily at 0900** until all questions are answered.



Documenting the Sexual Orientation and Gender Identity (SOGI) Information

The following questions are now required fields for each patient 18 years and older. *(Recommendations pending for those under 18.)*

- In the inpatient setting the requirement is that this data be collected once during the admission process.

1. Enter the patient's self-described sexual orientation.

2. Select the patient's self-described gender identity. Please note that this is a multi-select field. If "Addl gender category…" is selected, a comment field will open. Enter the patient's comment using their words.

Note: Sexual History can be edited within the Providers Workflow Histories component.