BC Nephrology Days

PROMIS

Acuity Assessment and Comorbidities

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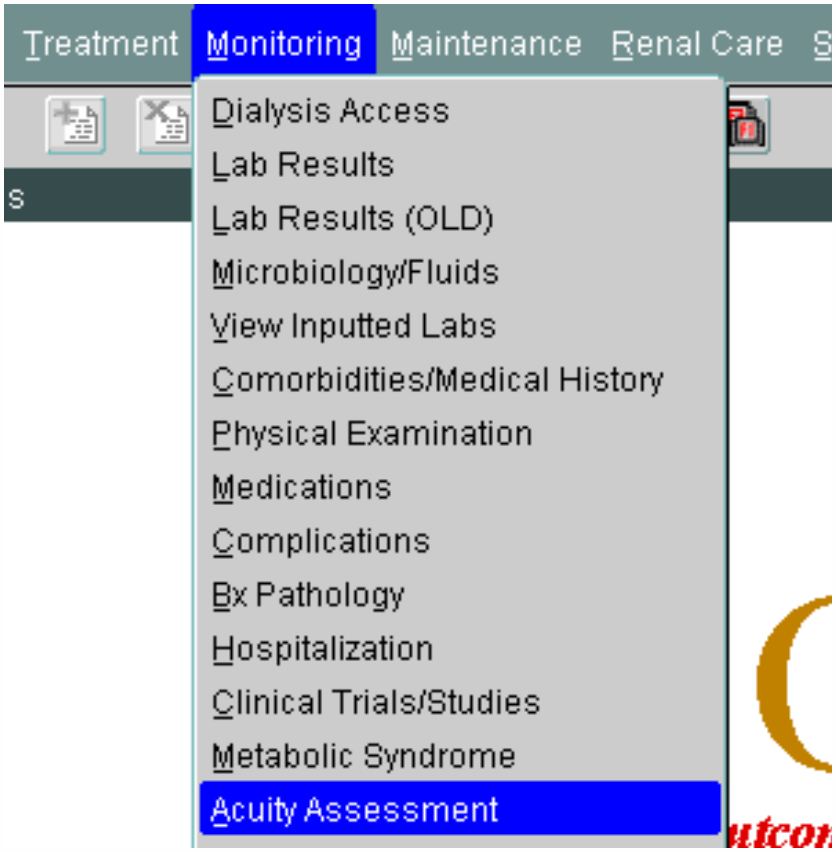
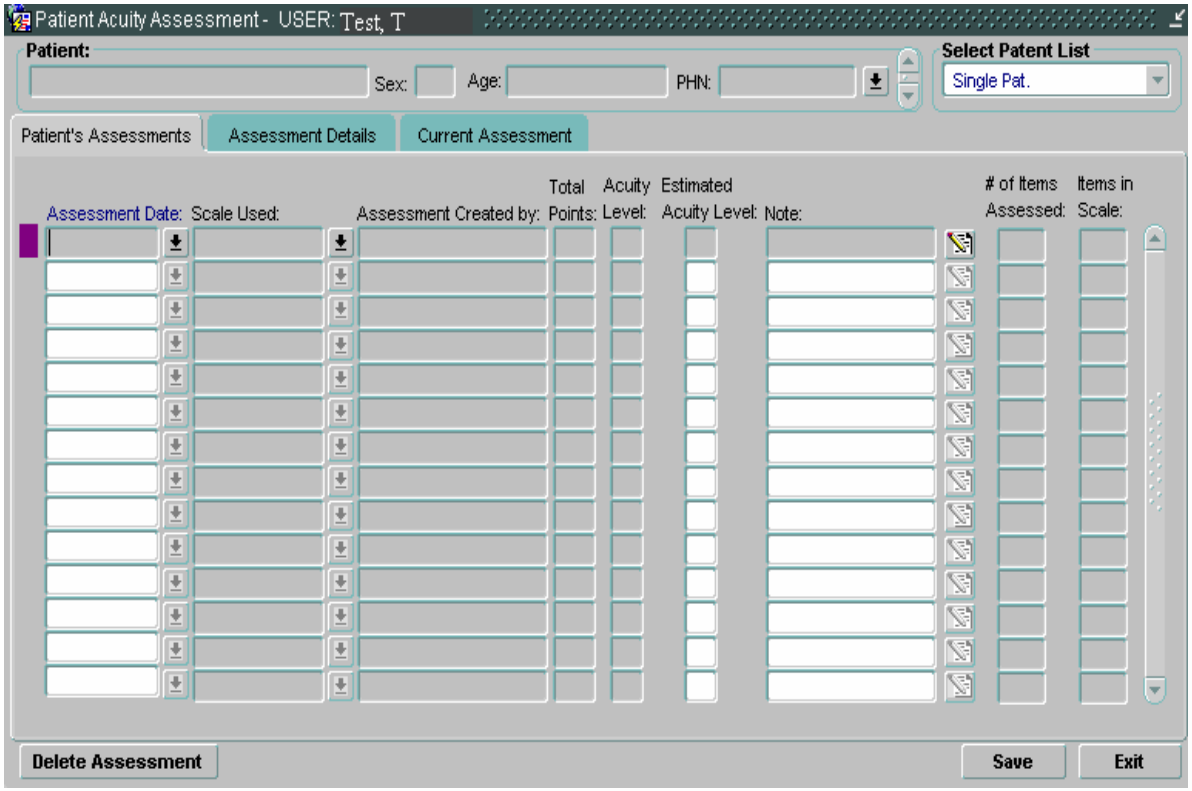
Amy E. Majeski

BC Renal Agency
An agency of the Provincial Health Services Authority

Acuity Assessment
Where to Find It
Main Menu: Monitoring
Sub-Menu: Acuity Assessment
Purpose
PROMIS users can record the results of the patient's acuity assessment here. Past and present assessment levels and specific details are recorded here, but can only be edited or updated by the original user who entered them.

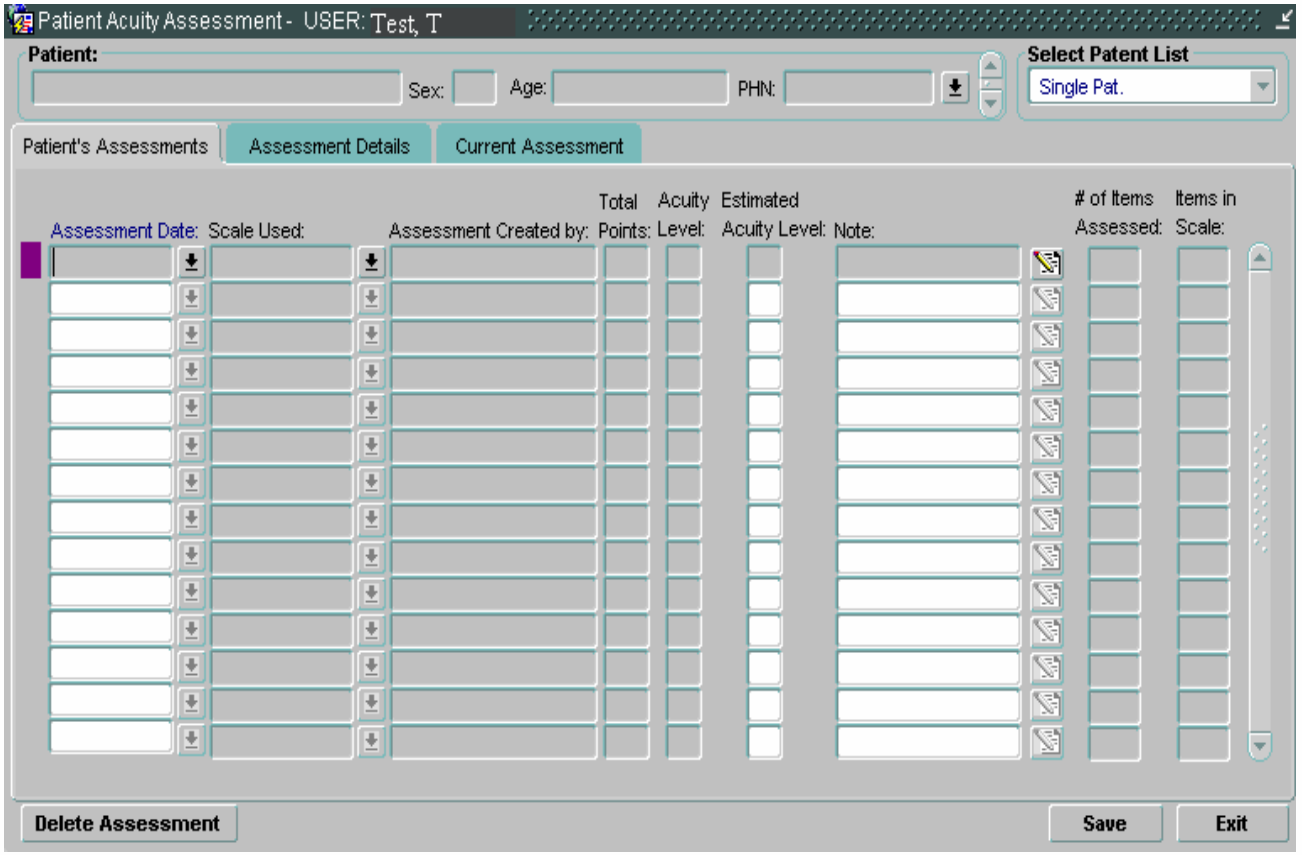




- To begin, go to Monitoring→Acuity Assessment and the form called Patient Acuity Assessment will open.

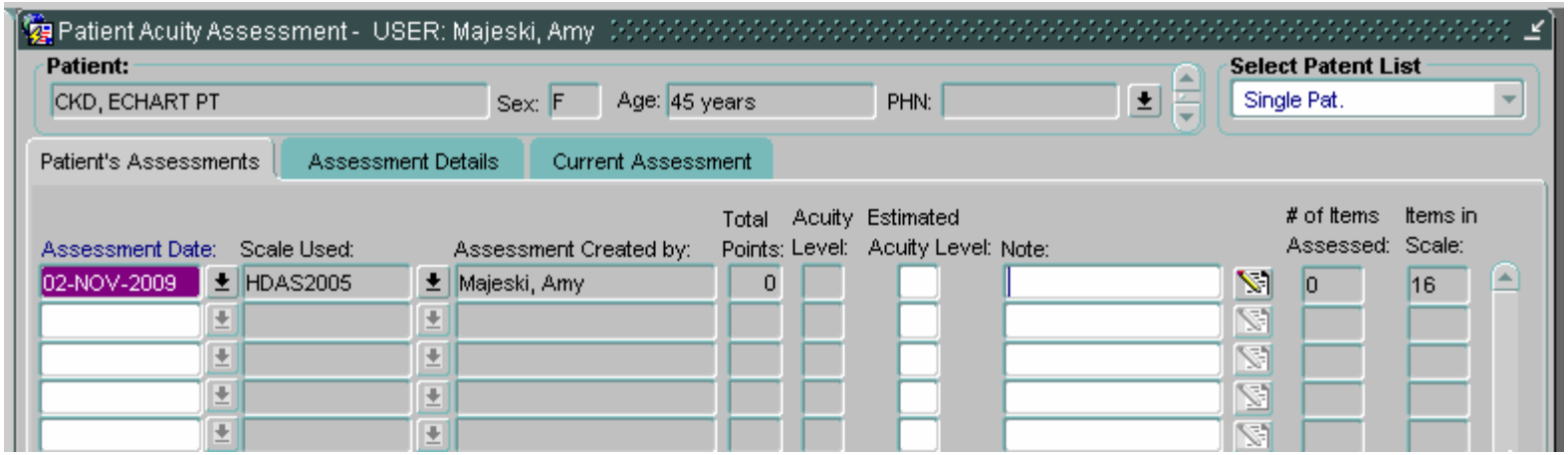
The Acuity Assessment form consists of 3 tabs:

- Patient's Assessments lists the history of acuity assessment, including dates, levels, and relevant notes.
- Assessment Details provides multiple screens, one for each parameter, with tick-boxes and descriptions for easy reference.
- Current Assessment summarizes results of a previously entered assessment.

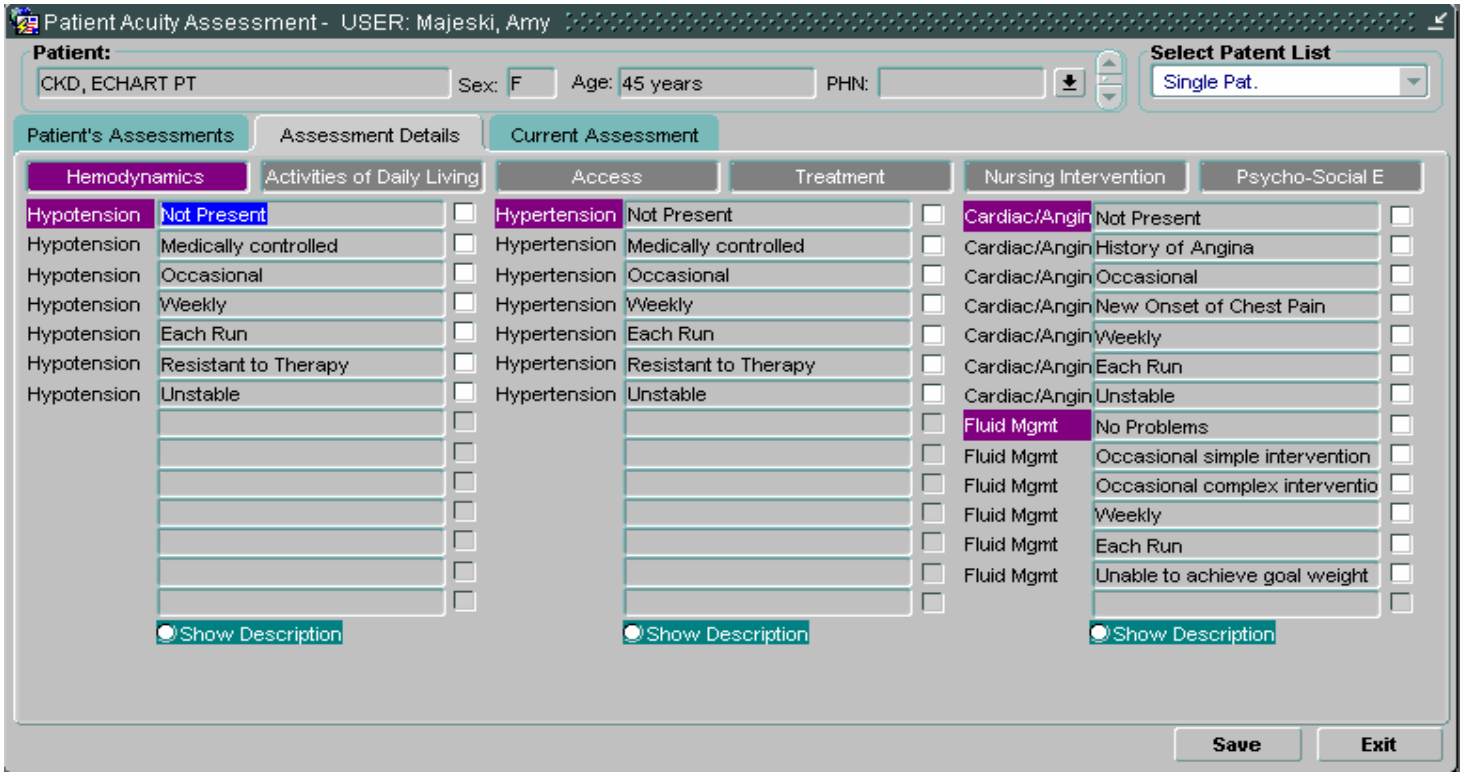


Select a patient by clicking on the (black and underlined) drop-down arrow located at the end of the gray PHN field. If the patient selected has been previously assessed, his/her acuity information will appear onscreen. Otherwise, the screen will be blank to allow data entry.

Patient's Assessments Tab



- Enter applicable information in the following fields:
- Assessment Date Enter the appropriate assessment date or click on the drop-down arrow to view the pop-up calendar.
- Scale Used Use the arrow keys on your keyboard or click on the drop-down arrow to select HDAS2005. Scale selection may be increased as the need arises.
- Assessed by This will automatically populate with your name (the person signed into PROMIS)
- Total Points Display field only. Value is extracted from the Assessment Details form.
- Acuity Level Display field only. Value is extracted from the Assessment Details form.
- Estimated Acuity Level Enter the appropriate value.
- Note Enter any comments relevant to the patient's acuity assessment.
- # of Items Assessed Display field only. Value is extracted from the Assessment Details form.
- Items In Scale Display field only. Value is extracted from the Assessment Details form.



Assessment Details Tab

There are various parameters used to determine a patient's acuity level. In PROMIS, these are divided into six (6) parameter columns with the following headings:

Hemodynamics

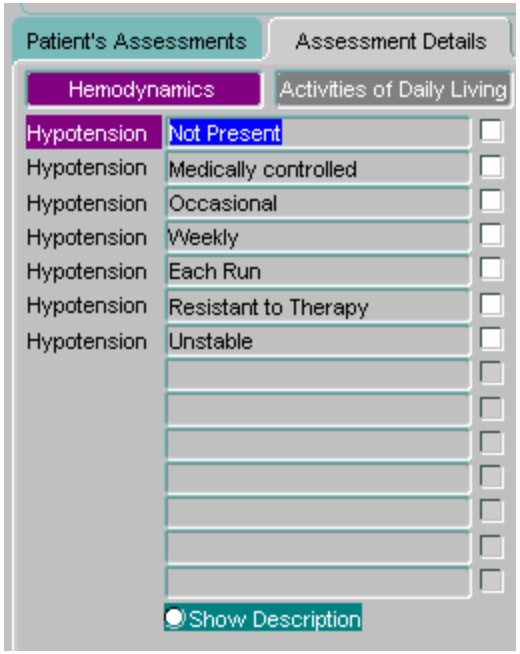
ADL

Access

Treatment

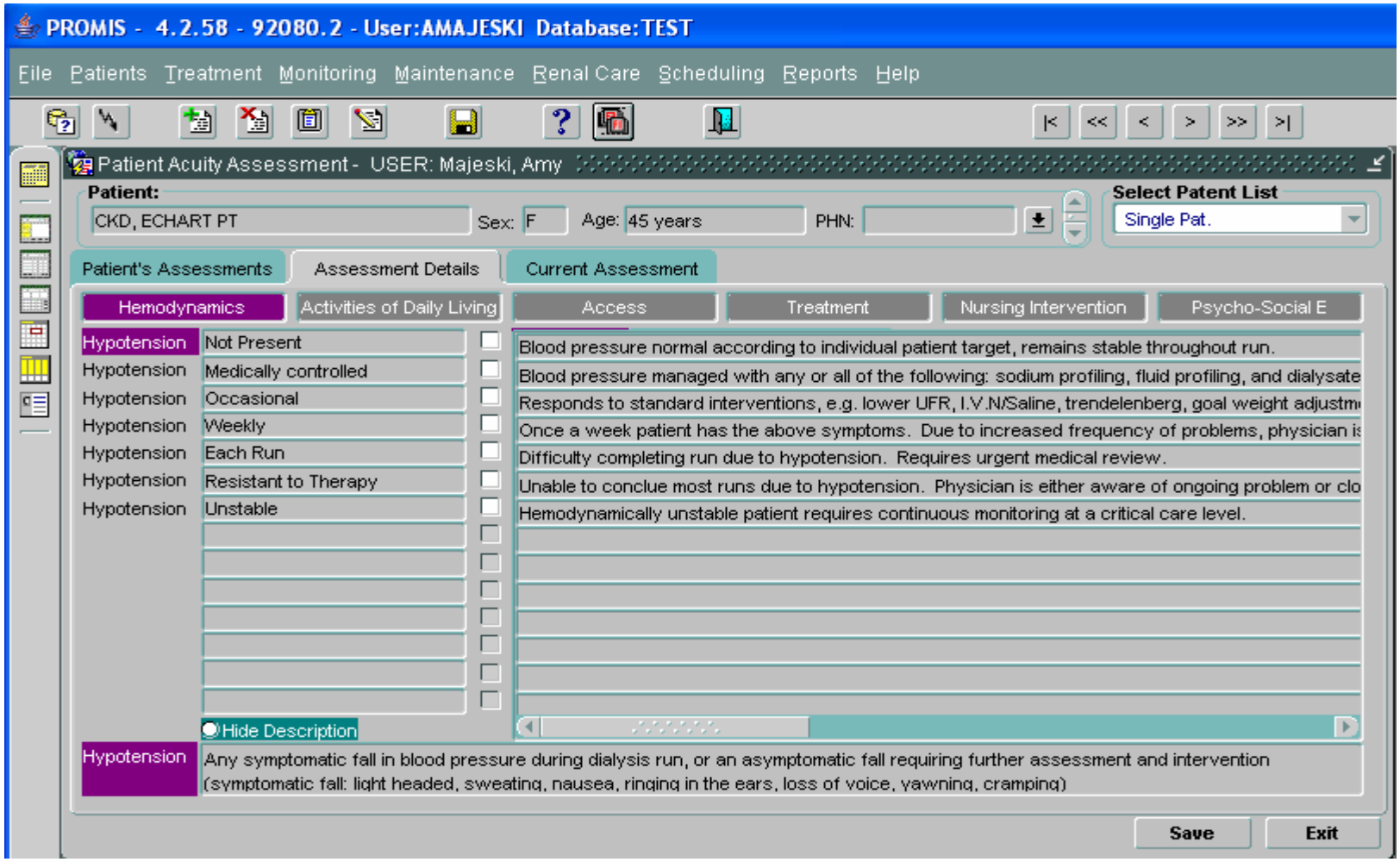
Nursing Interventions

Psycho-Social E



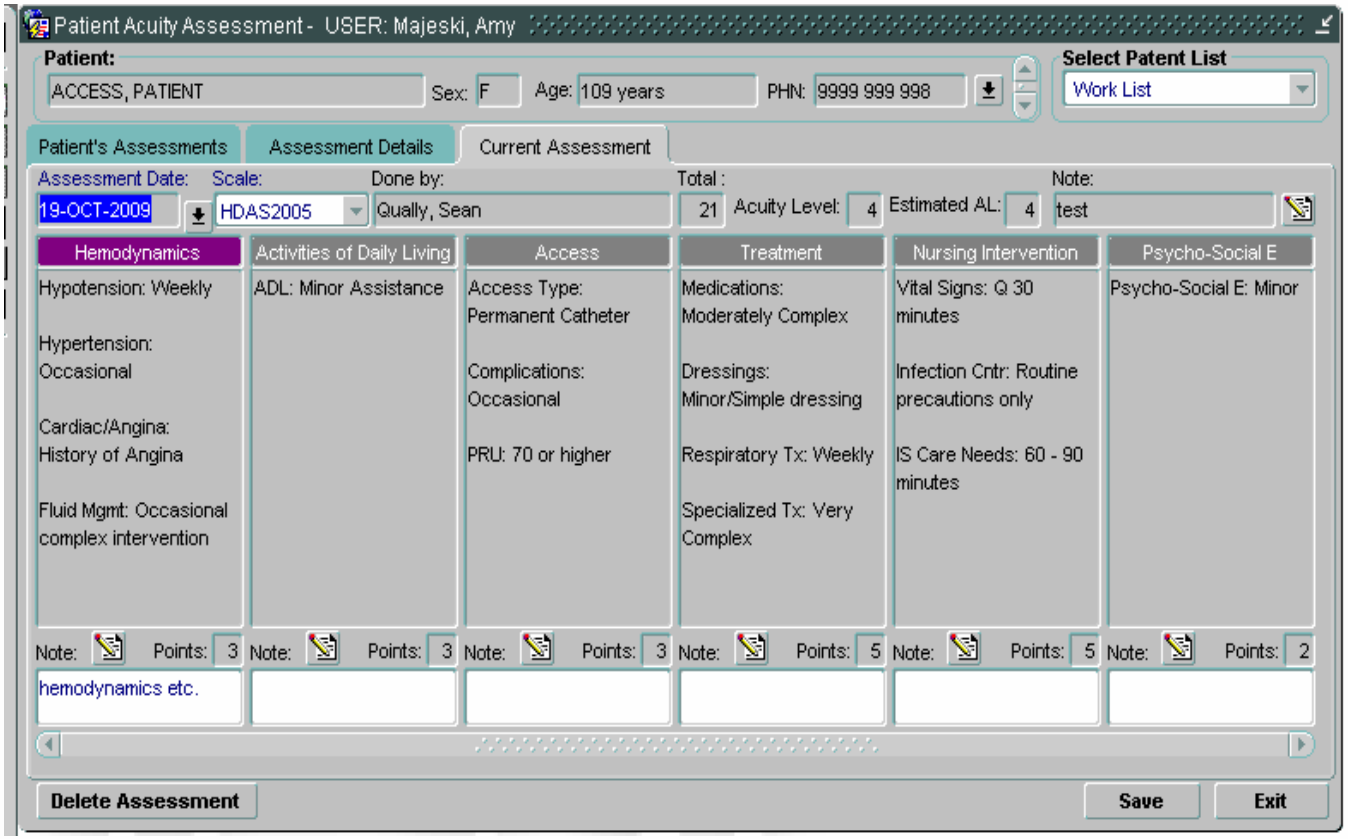
Click on each parameter heading to view its comprehensive list of values. [For example: the *Hypotension* parameter contains the following values – *Not Present*, *Medically Controlled*, *Occasional*, *Weekly*, *Each Run*, *Resistant To Therapy*, and *Unstable*.]

Note that each parameter value has a corresponding tick-box. Click on all the parameter values that apply to the renal patient being assessed.



If uncertain whether the parameter or the values apply to the patient, click on the Show Description radio button. The description (or definition) of both the parameter and its values will appear onscreen for easy reference. (Note: If space constraints prevent you from seeing the entire description, click on the Edit Item toolbar icon. To return to the previous screen format (no parameter or value descriptions), click on the Hide Description radio button.

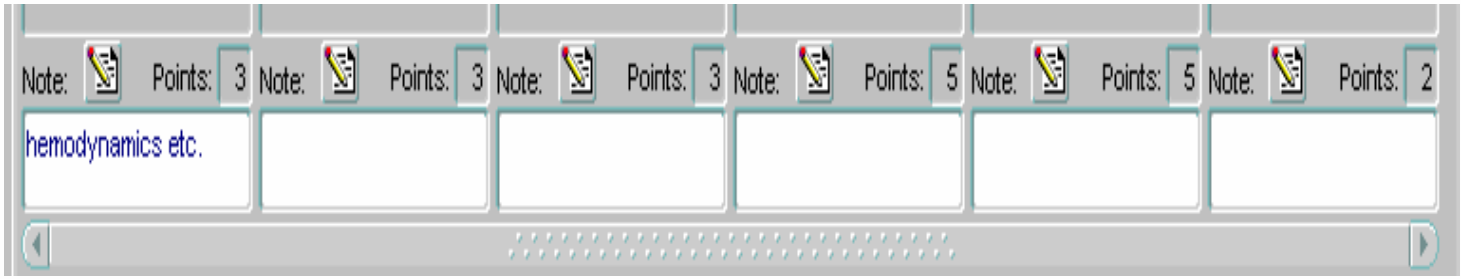
Current Assessment Tab



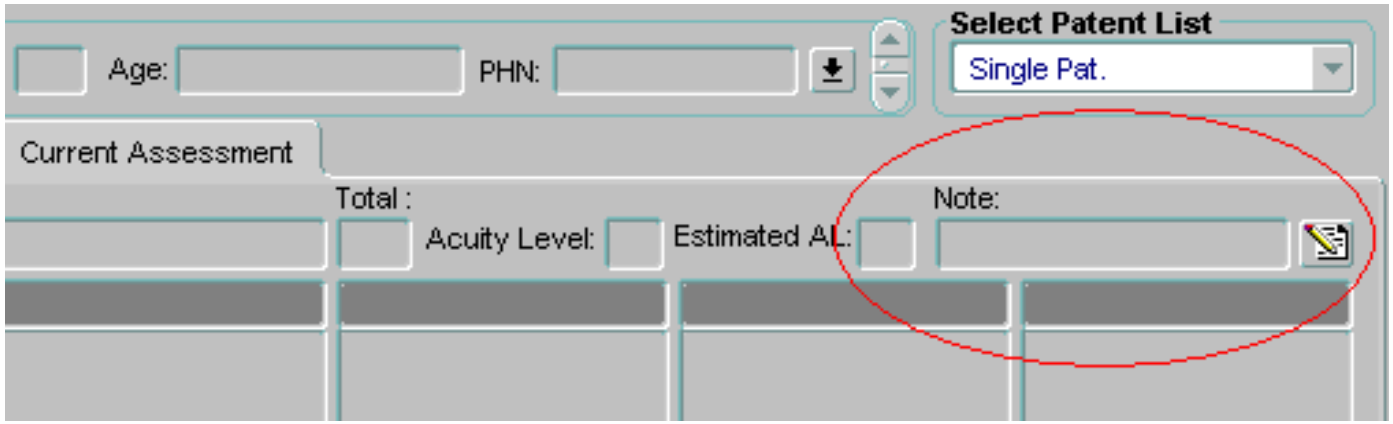
This form is automatically populated with the information you entered in the two other tabs, *Patient's Assessment* and *Assessment Details*.

Information available on this Form includes, among other things: the assessment summary, points per column and its sum total, and estimated acuity level. The score, associated with the highest selected value for each parameter, is displayed under the column representing the parameter.

At this point, you may add your clinical observations to complement the pre-defined values you selected. Click on the Note button to open the text box.



Any other comments related to the acuity assessment or overall patient status may be entered in the Note box located at the top right-hand corner of the window. See image below:



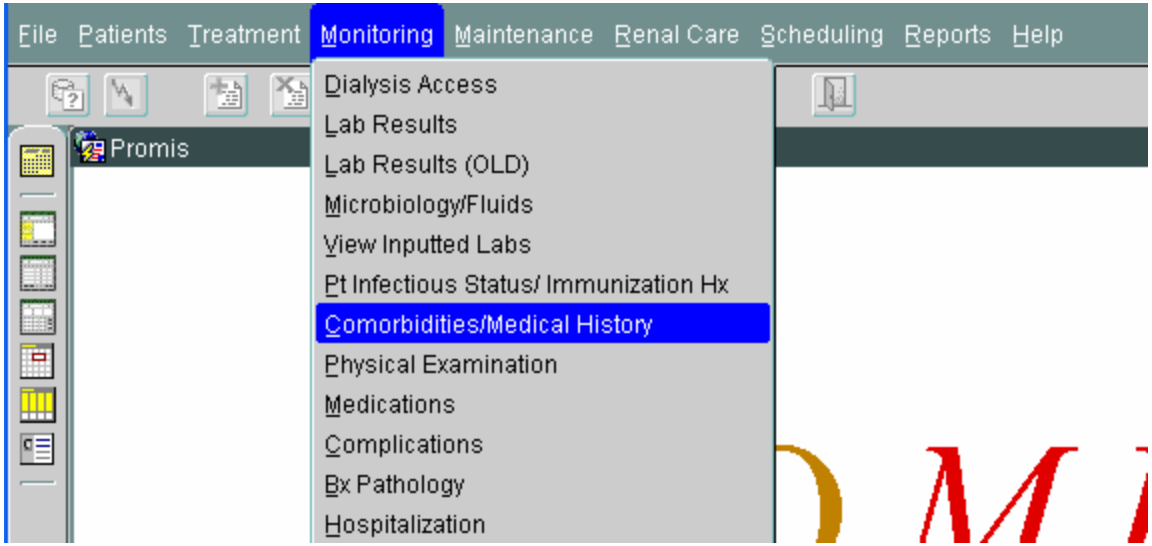
Questions ????????????

Comorbidities

Purpose / Where to Find It

The Patient Comorbidities/Medical History form is used for assessing patient comorbidities and related events.

To open the form, select Monitoring in the main PROMIS menu and Comorbidities/Medical History in the submenu.



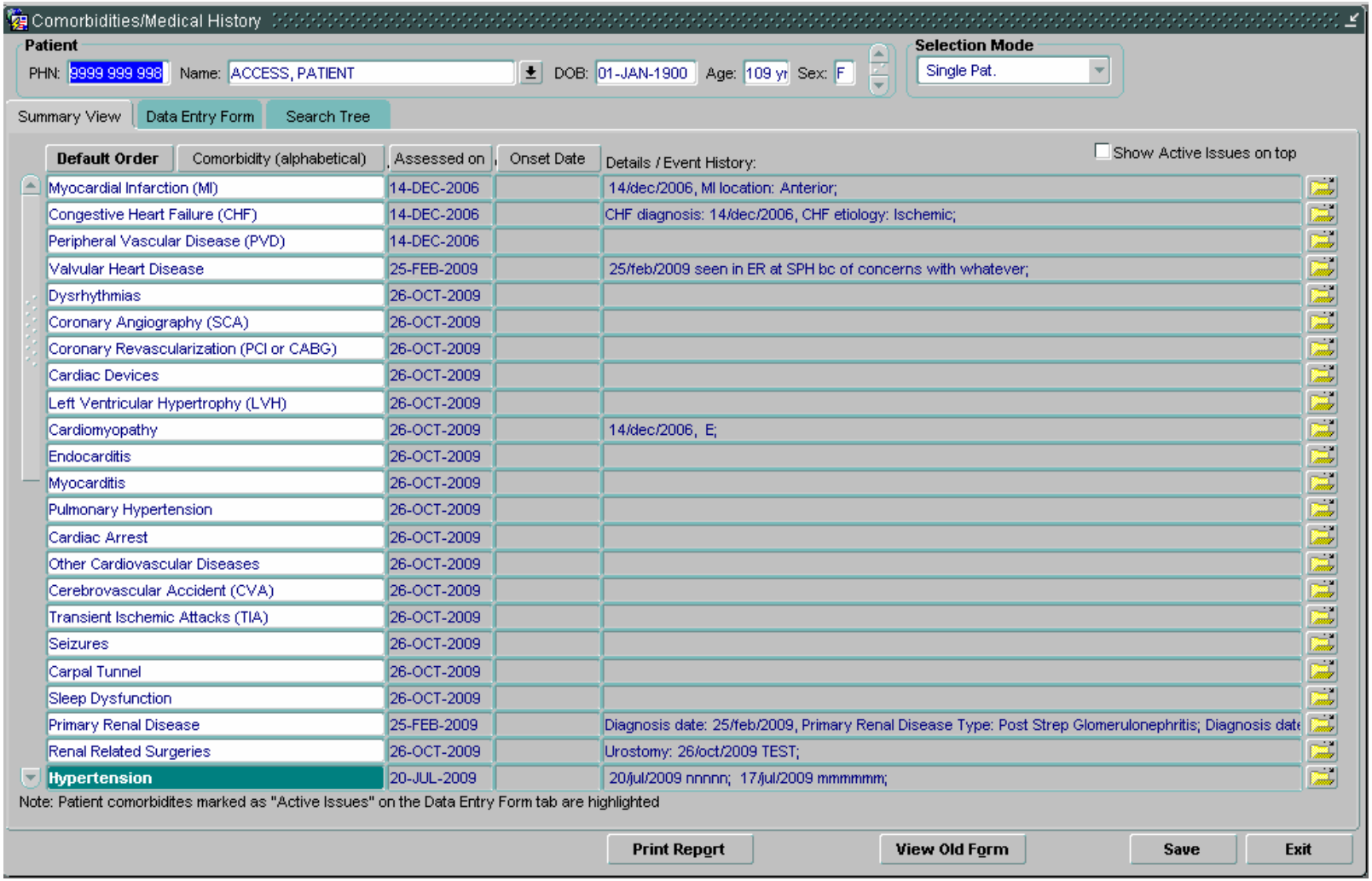
Form Overview

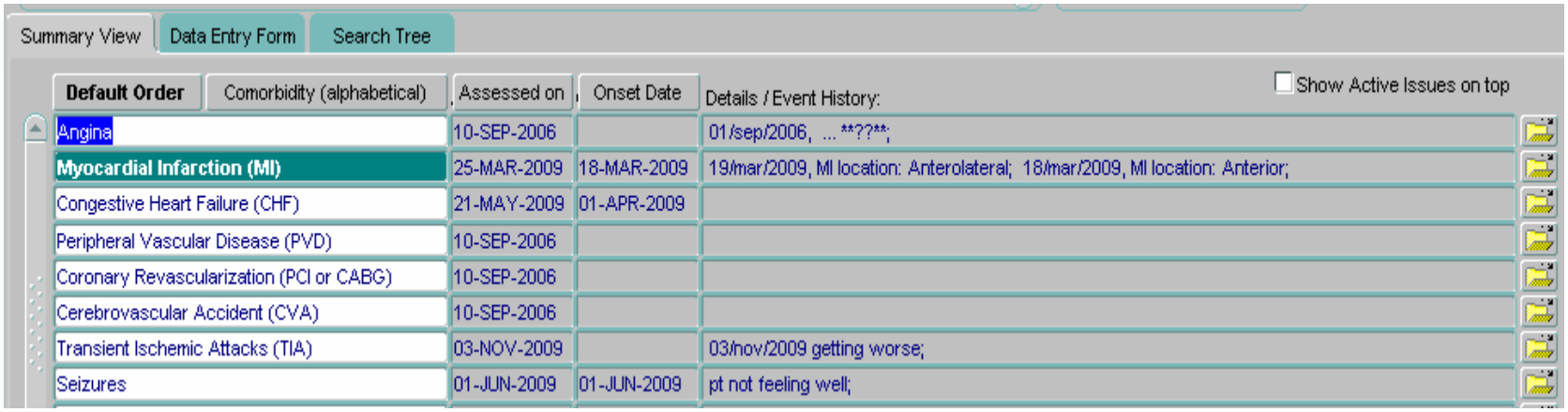
The **Patient Comorbidities** form consists of three separate tabs (pages) which you view by clicking the following menu tabs that appear along the top of the form:

The tab that is displayed in gray is the one that you are currently viewing.

Summary View tab

When you access the Comorbidities form, the Summary View tab appears first.





- This Summary View tab displays the most current comorbidity status of the selected patient.
- The comorbidities that are highlighted in green are the ones that have been marked as "Active Issues“ on the Data Entry Form tab.
- By ticking the box in the upper right hand corner

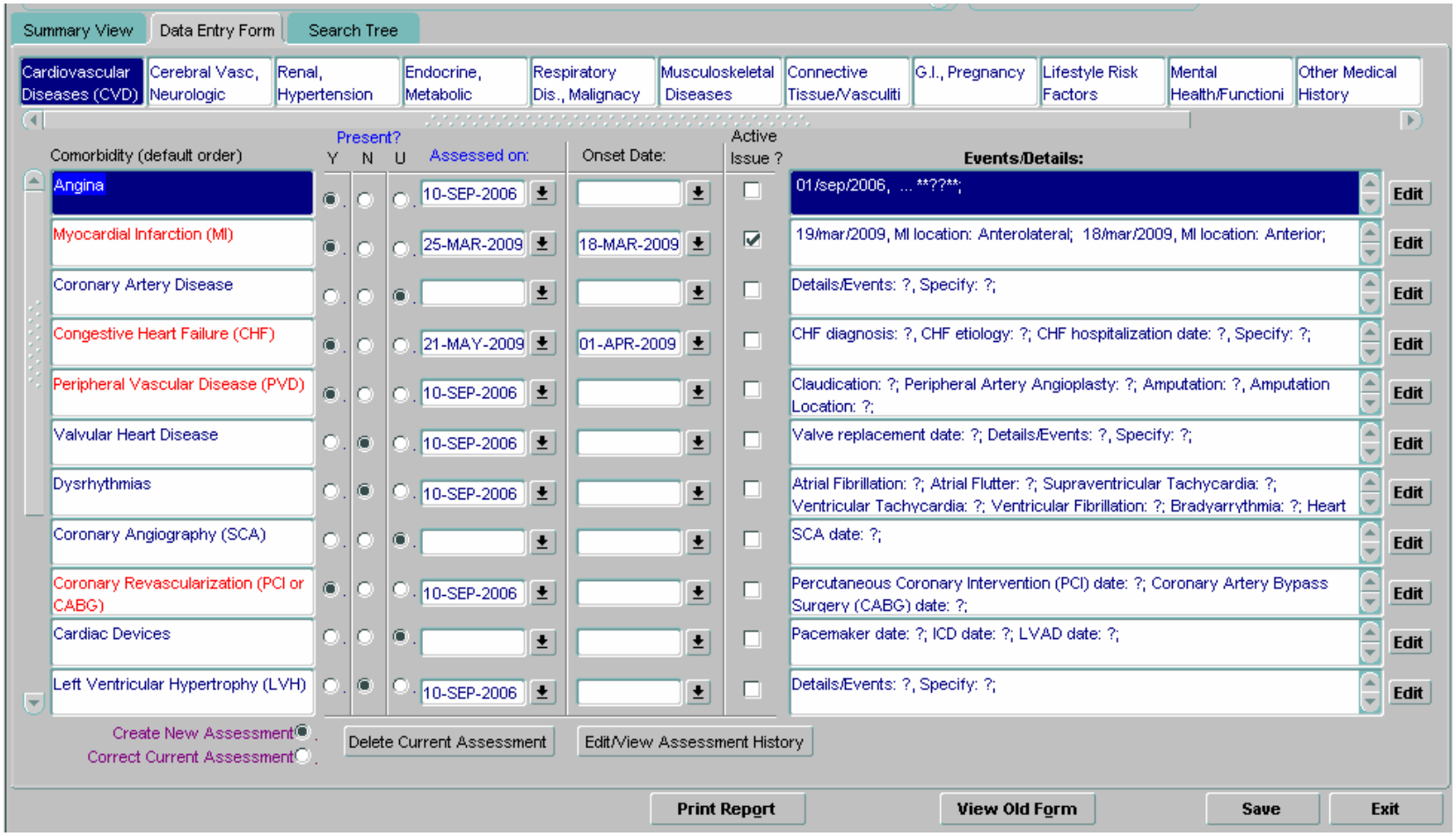
you can view the Summary View tab with the "Active Issues" at the top of the list.

- The summary list of comorbidities can be viewed in one of four orders: (1) default order, (2) alphabetical order, (3) according to the date the patient was assessed, or (4) according to the date of onset of the comorbidity. You can switch between these four views by clicking on one of the following buttons:

- The button displayed in bold is the view that you are currently seeing.
- The **Default Order** button lists the patient's comorbidities as you would see them listed on the **Data Entry Form** tab.
- The **Comorbidity (alphabetical)** button lists the comorbidities alphabetically.
- The **Assessed on** button lists them according to the date that the patient was assessed, with the most current assessment at the top.
- The **Onset Date** button lists the comorbidities according to their date of onset, with the most current date at the top.

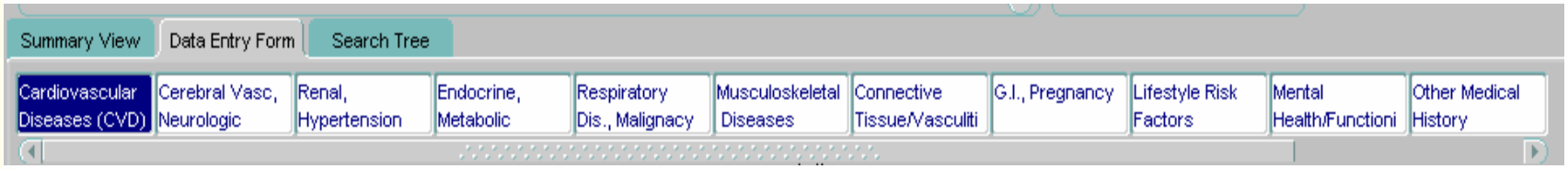
Data Entry Form tab

The Data Entry Form is used to update and make changes to the selected patient's comorbidity status.



Comorbidities and Disease Categories

As shown above, categories of possible diseases are listed across the top of the form. Click on an applicable category and then select the particular disease under the **Comorbidity** heading along the left of the form. Here is a closer look at the disease categories:



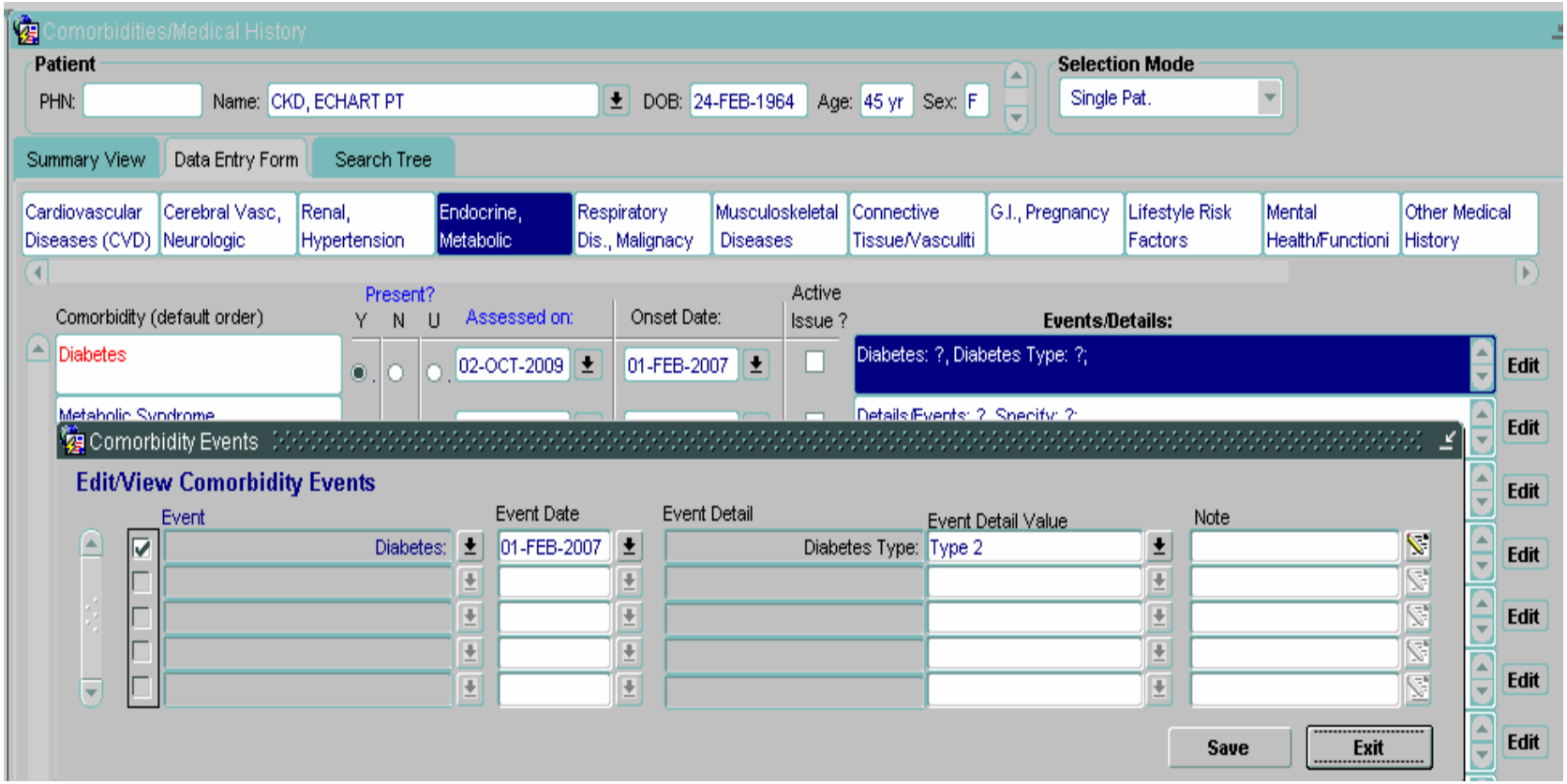
To view all the comorbidities that belong to a certain category, you may have to scroll down using the vertical scroll bar on the left. To switch between different categories, click on each one.

For comorbidities that are not explicitly listed under any of the available categories, select the Other Diseases category located to the far right of the others. (A patient must be selected before this category will appear.)

The data elements of each comorbidity record are the following. Headings in blue font indicate required content.

- a) Under the Present? heading, choose from Y/N/U to indicate whether the patient has the comorbidity or not (Yes, No, Unknown).
- b) Assessed on is where you enter the assessment date.
- c) Onset Date
- d) Active Issue? A checked box indicates that the comorbidity is currently an active issue verses inactive.
- e) Events/Details Here you can only view a summary of events or details. To update either, select the Edit button and the Comorbidity Events pop-up window will appear.

- The Assessed on date is the day when the patient was seen by the health professional and the assessment was done.
- The Onset date is the day the comorbidity first occurred in the patient, therefore it has to be lesser than or equal to the assessment date.
- The Events/Details field allows for additional information. For example, if a patient named CKD, ECHART PT was assessed on 02-OCT-2009 and stated that he had diabetes type 2 since February 2007; the entry would be as follows:



- Viewing Assessment History

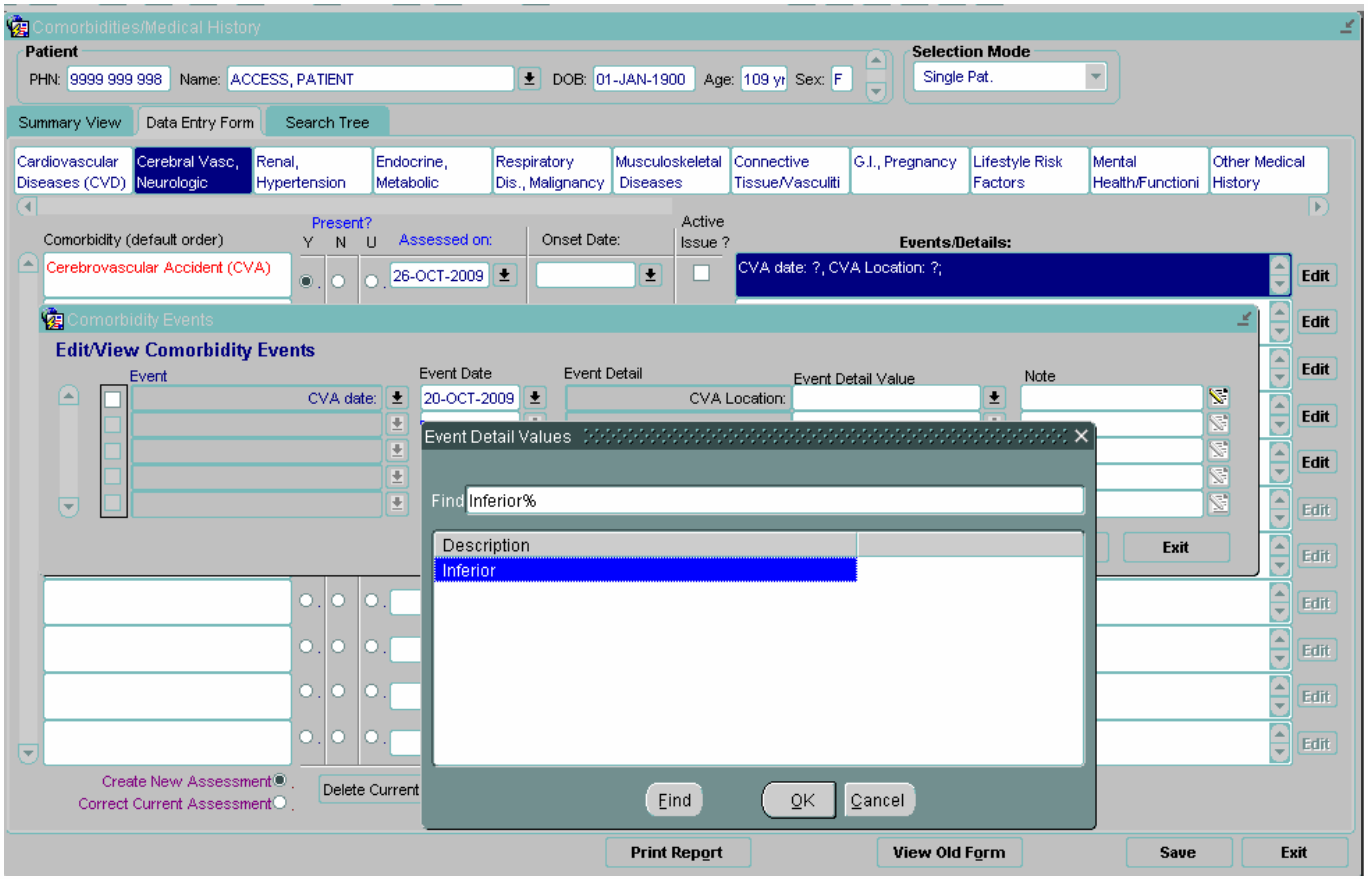
- Creating a New Assessment

- Correcting Existing Assessment

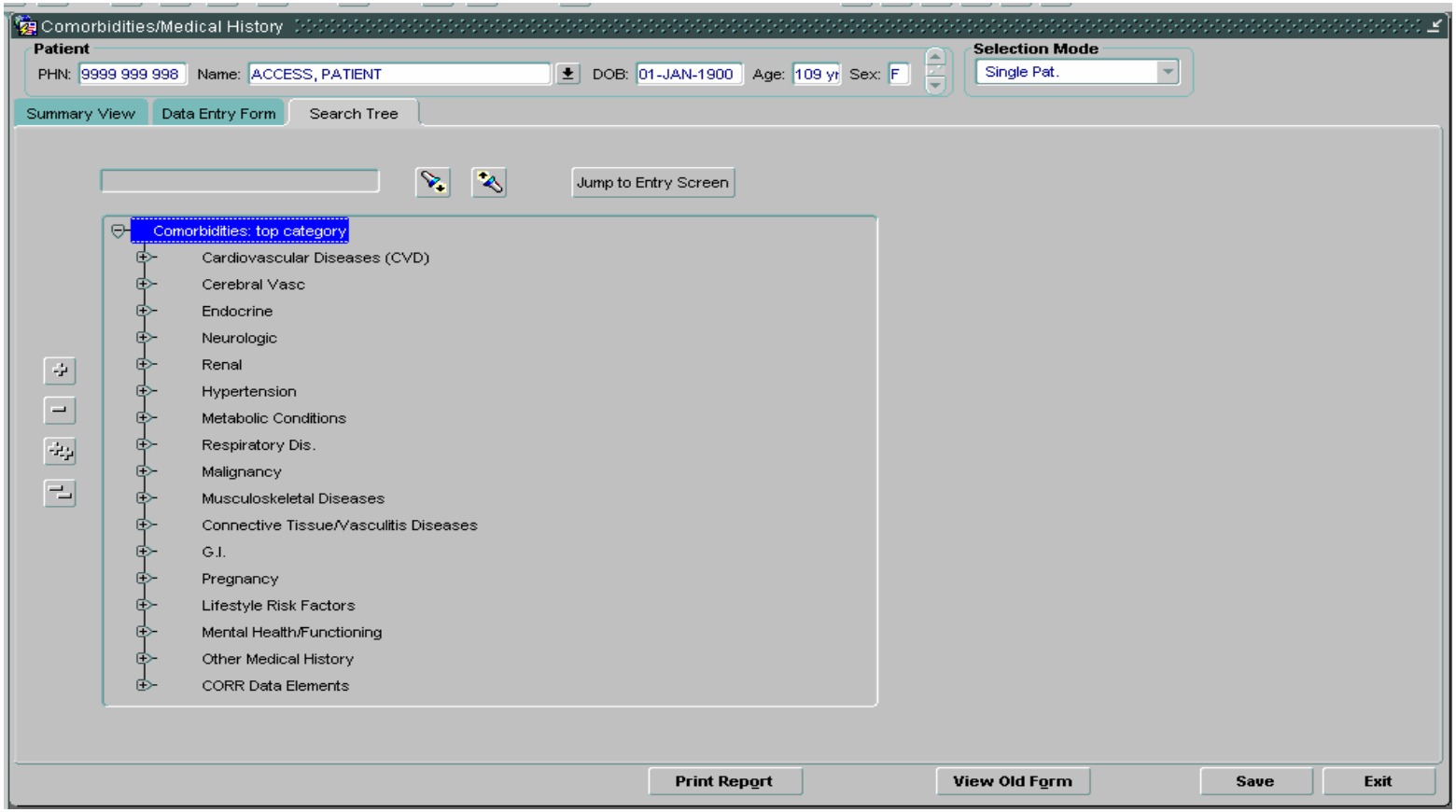
- Deleting Existing Assessment
  - Only current assessment will be deleted

- Changing Assessment History
  - view / correct / delete / insert

- Events / Details Edit



Search Tree


Comorbidities/Medical History
Patient
PHN: 9999 999 998
Name: ACCESS, PATIENT
DOB: 01-JAN-1900
Age: 109 yr
Sex: F
Selection Mode
Single Pat.
Summary View
Data Entry Form
Search Tree
Jump to Entry Screen
Comorbidities: top category
Cardiovascular Diseases (CVD)
Cerebral Vasc
Endocrine
Neurologic
Renal
Hypertension
Metabolic Conditions
Respiratory Dis.
Malignancy
Musculoskeletal Diseases
Connective Tissue/Vasculitis Diseases
G.I.
Pregnancy
Lifestyle Risk Factors
Mental Health/Functioning
Other Medical History
CORR Data Elements
Print Report
View Old Form
Save
Exit

Using Search tree

Thank
you