CubHub Clinical

Nursing Initial Assessments

Initial Assessments

A patient's initial Assessment is going to trigger the Live Patient Record.

The Live Patient Record is a live record of patient's clinical data.

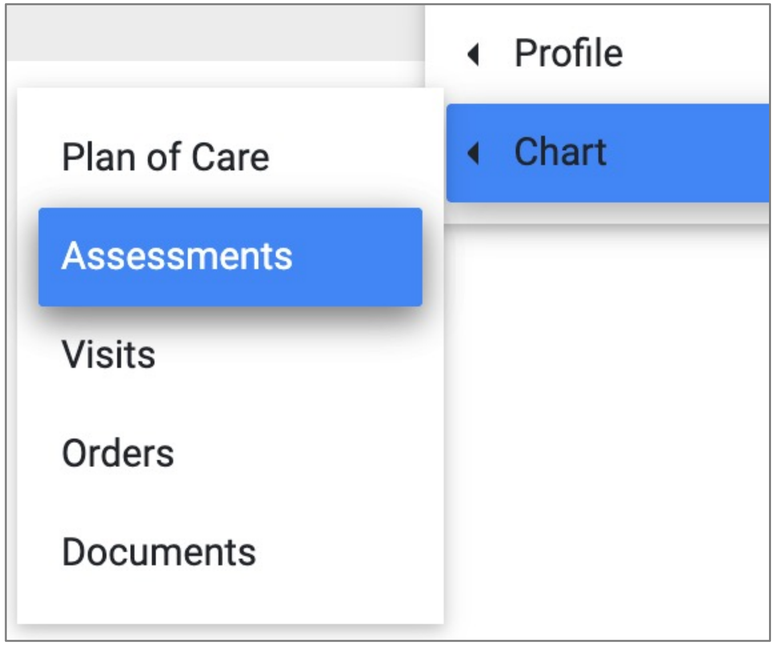
Once created, the live patient record allows clinical updates to the patient chart between recertifications and allows up to date patient care through immediate communication with the mobile app.

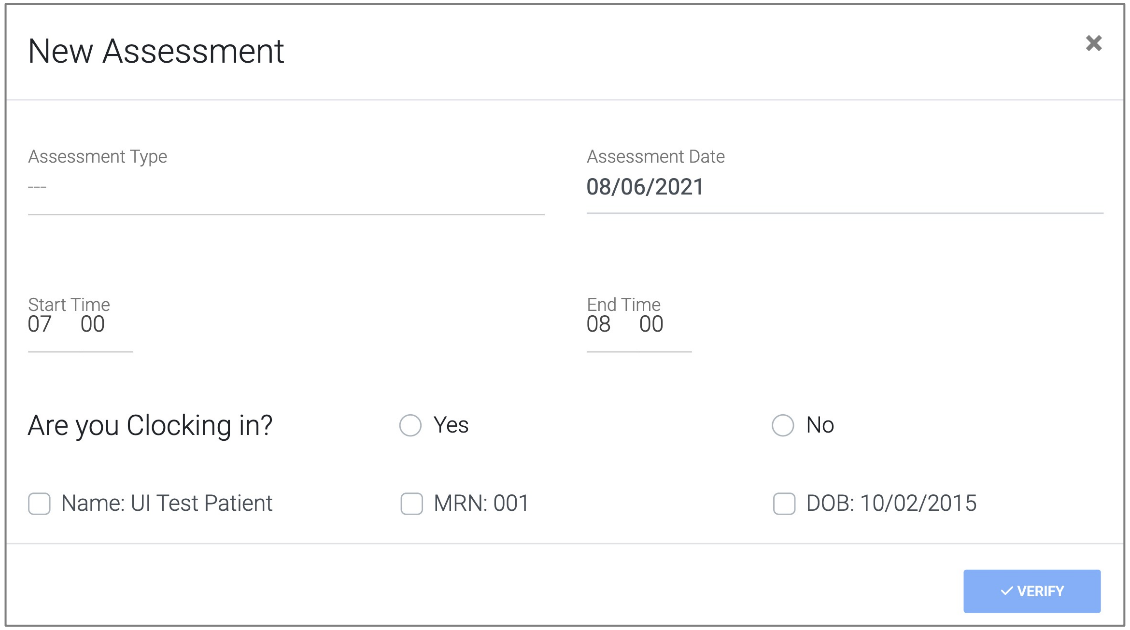
Only once a patient in CubHub has a Live Patient Record can the Plan of Care be created.

Option 1

Begin an Initial Assessment from the Patient Chart

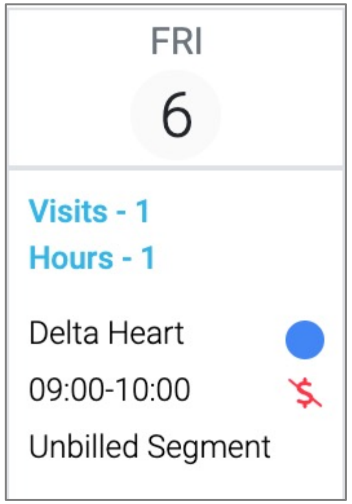
Clients> List> Action ellipsis> Chart> Assessments> +> Make Selections> Verify



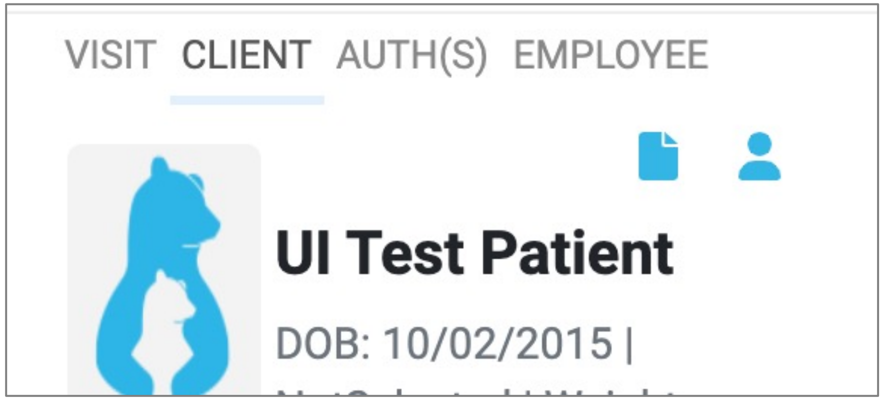


Option 2
Schedule the Initial Assessment in the calendar & navigate to patient chart to begin assessment

Calendar> Filter by patient> Select blank space in calendar> Fill in event scheduling box by selecting date, Initial Assessment, assigning employee> Save



Client> Profile icon> Action ellipsis> Chart> Assessments> Select assessment> Verify details of shift to begin assessment



Selection Options

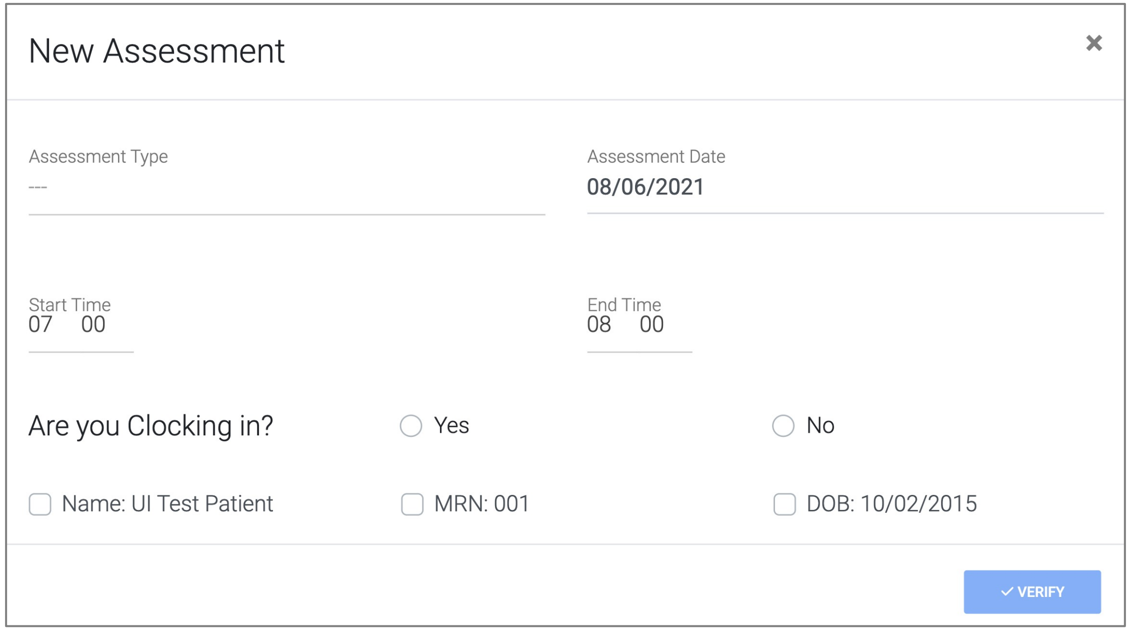
Assessment Type: When starting patient's care inside CubHub, an Initial Assessment should be selected for completion.

Assessment Date: Users can back date the assessment to a date on which the assessment was actually completed or keep default of today's date.

Start/End Time: Users can adjust times to reflect the times the assessment was actually completed or keep defaulted times

Clocking In: Optional if assessment started in patient chart, required if assessment first scheduled in calendar

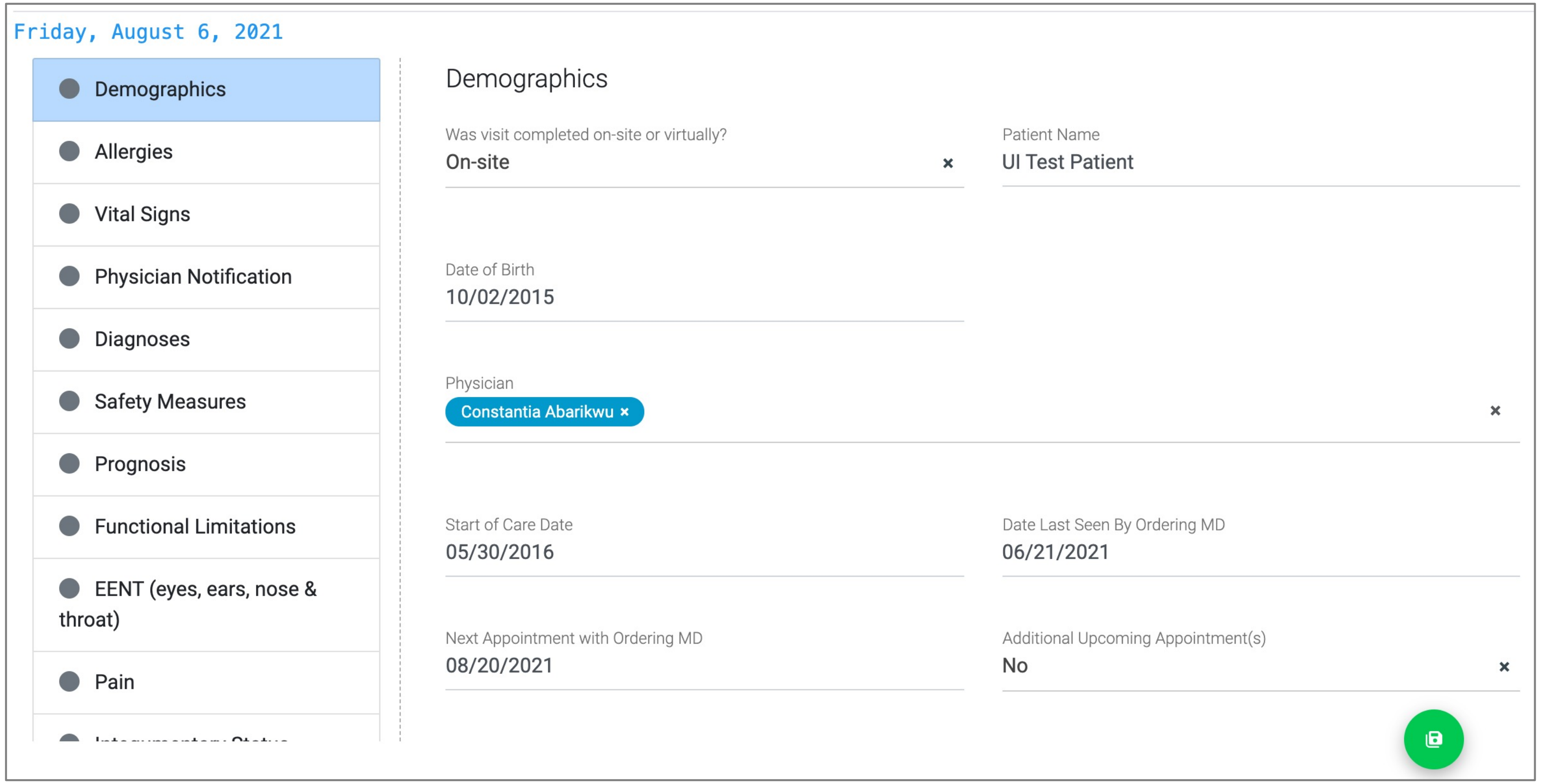
Verify: Select at least two identifying characteristics of the patient to Verify selections



Assessment: Data Points

Assessment information is captured for each of the patient's body systems.

Users should save the information input to data points by clicking the green save button.



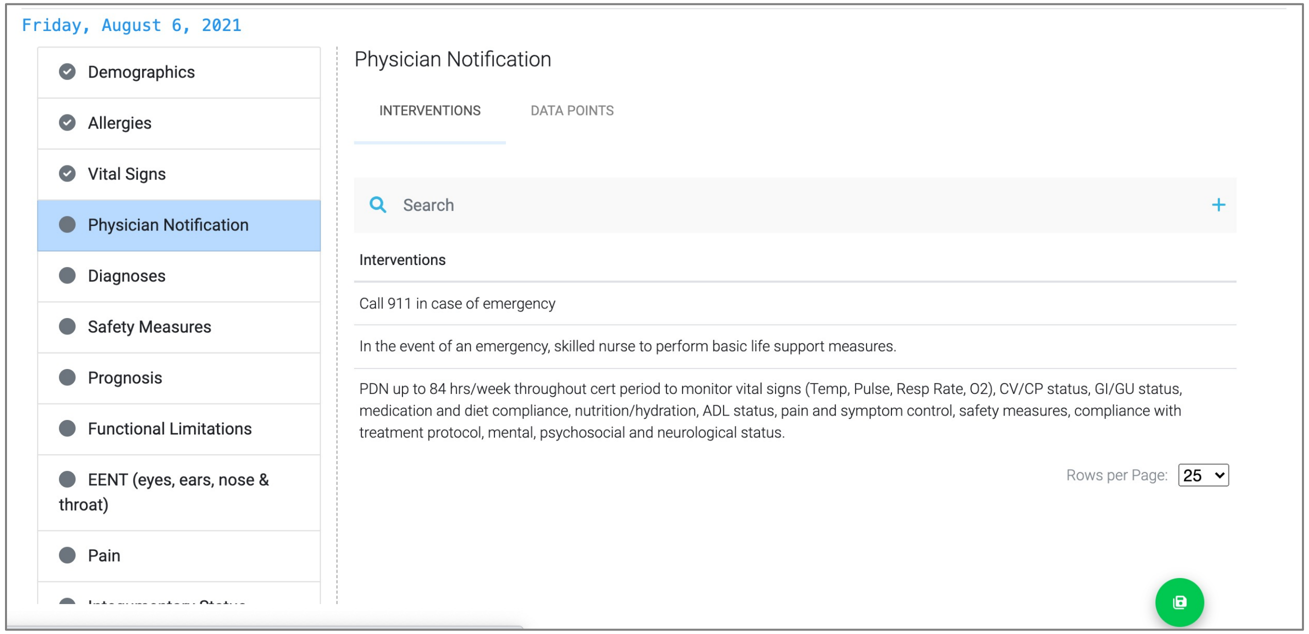
Only the data points that are addressed and input to the system will pull to the PDF of the assessment.

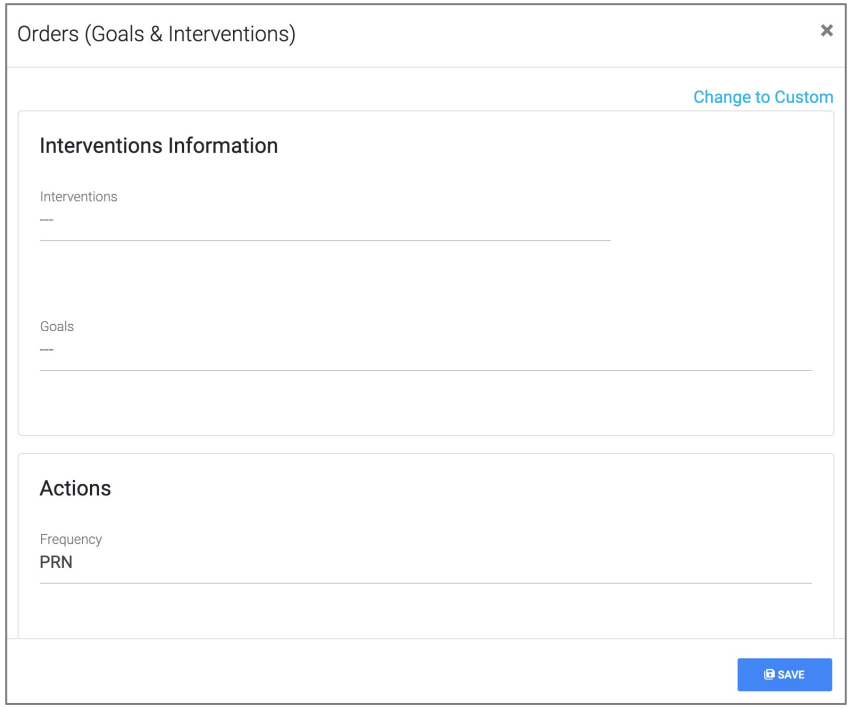
Some data points will auto-populate based on data from the patient's chart.

Assessment: Interventions

Interventions are the patient's orders that will build the patient's plan of care. Intervention frequencies control how tasks pull to the app for charting.

Interventions> +> Select intervention, goal, frequency> Select Actions> Save





See the next slide for general intervention information and the interventions guide for all the details surrounding interventions.

Assessment: Interventions Overview

Order Types: Standard & Custom

Standard: pre-loaded into the system & attached to standard goal

Standard: may include brackets [ ] for patient specific parameters

Standard: may have mobile app functionality built in

Custom: allows user to create all custom text

Custom: allows user to indicate additional mobile app functionality

Goals

Standard Interventions all mapped to a standard goal

Standard goals may be used multiple times in single assessment

When custom intervention created user may create custom goal

Actions

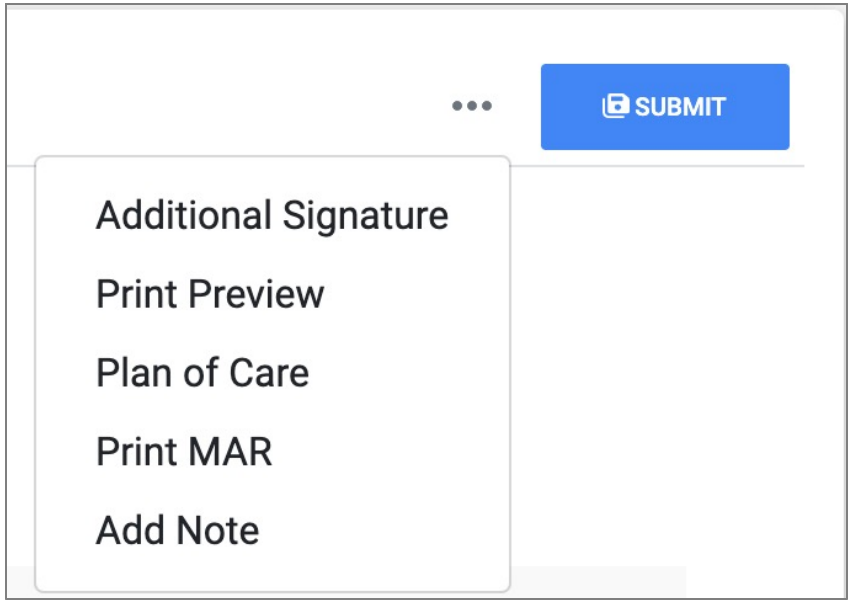
Start Date
Defaults to todays date (SOC date should be used for initial assess)
New/Changes Order dates used after initial End Date
End date
Should NOT be used pre-emptively (i.e. if cert period ends 3/31 do NOT enter end date of 3/31)
Should be left blank until an order is discontinued
If end date accidentally saved user may remove/change as long as intervention has not been charted against from mobile app

Additional Detail Required
Select box to require additional detail each time this task is charted on in a visit
Show in Visit
Select box to allow task to show in visit for charting
Show on 485
Select box to allow task to pull to 485

Working Assessment

When the assessment is in working status, users have the option to preview how data and interventions are pulling to both the PDF of the assessment and the patient's Plan of Care.

Options are accessed by clicking the action ellipsis beside the Submit button.

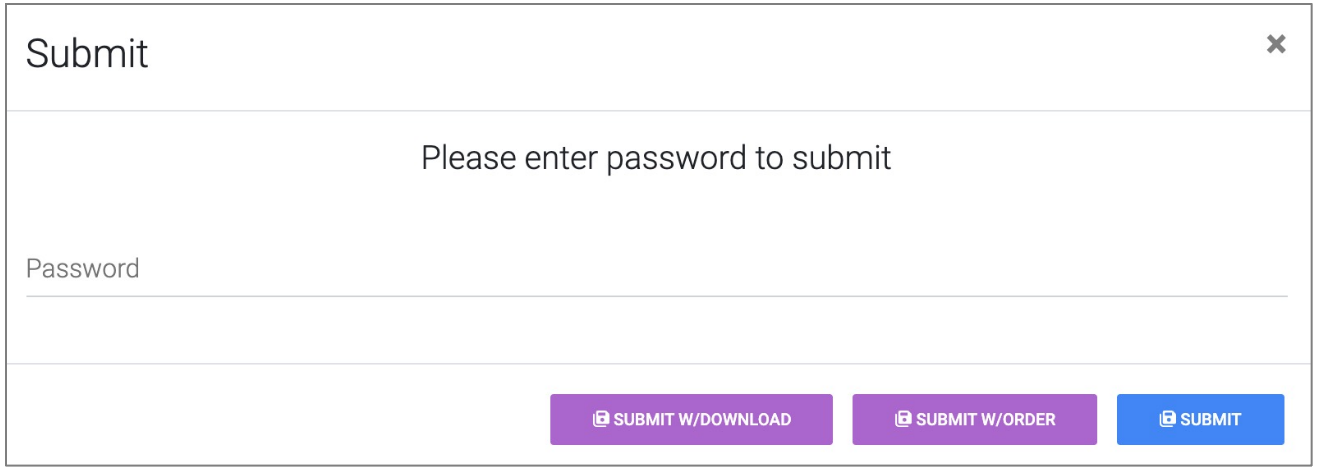


Additional Signature: capture additional user signatures to print on pdf of assessment
Print Preview: preview the PDF of the patient's assessment
Plan of care: preview the patient's 485
Print MAR: download medication administration record
Add Note: add a note to the patient's chart

Sign & Submit

Submit assessment by clicking the blue Submit button, prompting the system to generate the box below.

Users will sign by inputting password & choose from the three submit options.



Submit: moves assessment to Pending QA or Completed status*
Submit w/Order: moves assessment to Pending QA or Completed status* & creates an order in Clinical Orders
Submit w/Download: moves assessment to Pending QA or Completed status* & downloads a PDF of the assessment to user's computer

**status varies based on company preferences/set up*

Initial Assessment FAQs

Q. We are switching to CH from another EMR and the initial evaluation is already completed for my patient. Why can't I just do a re-eval?

A. The initial eval is needed to trigger the LPR and to "tell" the system the start of care details for your patient. If you have a copy of the initial evaluation, you can enter only the required data points into a back-dated initial eval and submit. Then, upload a copy of the completed eval into the patient chart; however, the patient's goals and other data will need to be input to the LPR or a re-eval will need to be completed at that time, as well.

Q. Can I put my evaluation back into working status?

A. Based on a user's permission group, an evaluation can be put back into working status to allow for needed changes. Once the updates are made, the evaluation should be resubmitted.

Q. What status is my evaluation in once it is submitted?

A. Evals will be submitted to QA to be reviewed and e-signed before being sent to the physician. The eval will be in 'Pending QA' status.

Q. Where can I find more information on the process my eval takes next?

A. From QA, and eval will flow to Orders where it is sent to the physician. See our QA, Orders, and Faxing guides for more information.

Permissions

User Groups: only clinical admin users can access and complete evaluations

Access all Assessments: if checked, allows user to access assessments in working status that were started by another clinician

Patient:

Assessment/Evals

Contacts

Details

Live Patient Record

Point of Care

Quality Assurance (View & Edit will allow user to process an assessment into completed status and put it back into working status)