RDW – Subject Area Guide (Last Updated: July, 2013)

Nursing Subject Area

General:

1. Available Date Range (Overall): Jan 1, 2000 – June 30, 2013
2. Unit Go-Live Dates:
    a. BICU/BACU: January 2000 – Present
    b. 5D: December 2007 – Present
    c. 4B/4C: November 2009 – Present
    d. 4DNI: May 2010 – Present
    e. 6D/8DNS/7DN: June 2010 – Present
    f. 10W/11W: October 2010 – Present
    g. 10E/12E/12W: November 2010 – Present
    h. 7E1/8W: December 2010 – Present
    i. 6AP/8A1/9C: February 2011 – Present
    j. 4A/4AS/6B/6C/7A1: March 2011 – Present
    k. 5A/5B/7B/7C: April 2011 – Present
    l. 5C/6A/8B1/8C/AMOU: May 2011 – Present
    m. 1OBS: June 2011 – Present
    n. 7W1: December 2011 – Present
    o. 8A2: May 2012 – Present
3. Type Specific Go-Live Dates:
    a. ECMO/SWAT/VAST/RT: June 2011 – Present

Getting Around:

Views containing nursing documentation will have names beginning with "**Nursing**".

Currently the Nursing content contains 2 types of documentation: **Flowsheets** and **Forms**. The flowsheets contain the daily (24 hour chunks) assessment data for the patient. All the flowsheets start at midnight. Their document date would be the date of the assessment at midnight. Forms are individual sets of Point-In-Time documents. They are created with their document date based on the date / times the document was observed, and are assessments of the patient at that specific point in time. Some examples would be the shift assessments, progress notes, FHPA, etc.

Every "Nursing" view should contain the following GUIDS: PatientID and EncounterID. These are unique identifiers for the Patient record and the Encounter record. You can join the views together by these GUIDS. Most of the views also contain a DocumentDate, in which you can pass specific date ranges for documentation.

Nursing Views:

- **NursingDailyCardiovascularInfusions** - A flat daily summarized view of the most common MIN / MAX cardiovascular infusions. The common infusions are: Norepinephrine, Phenlyephrine, Vasopressin, Milrinone, Dobutamine, Dopamine, Diltiazem, Nicaripine, Amiodarone, Esmolol, Labetalol, Nitroprusside, Nitroglycerin, and Fenoldopam.
- **NursingDailyFluidInputTotals** - A flat daily summarized view of the Total Fluid Inputs grouped together in the following specific categories: TotalFluidsIntake, Crystalloid, Colloid, POTubeFeeding, PRBCs, FFP, Platelet, Cryprecipitate, and Cell Saver.
- **NursingDailyFluidOutputTotals** - A flat daily summarized view of the Total Fluid Outputs grouped together in the following specific categories: TotalFluidsOutput, Urine, NGDrainage, and OtherOutput.
- **NursingDailyIntubatedYesNo** - A flat daily summarized view of whether or not the patient was intubated. (1=YES, 0=NO, -1=UNKNOWN)
- **NursingDailyStandardVitalSigns** - A flat daily summarized view of the most common MIN / MAX vital signs. Some examples are: Arterial and Cuff BP Systollic / Diastolic, Respiratory Rate, SPO2, Heart Rate, etc.
- **NursingDailyUncommonVitalSigns** - A flat daily summarized view (MIN / MAX) of uncommon vital signs. Some examples of Uncommon vital signs are: Respiratory Rate Set / Actual, Tidal Volume Set / Actual, FiO2 Set, Ventilator Mode, etc.
- **NursingForms** - A view containing all the nursing forms in Centricity created on a patient since 2000-01-01. You can join to the NursingFlowsheets with the PatientID and EncounterID. Some examples of the forms (documents) are: Adult / PEDS Shift Assessments, SOAP Notes, FHPA, Progress Notes, etc.
- **NursingFormsDetailed** - A "Tall / Skinny" detailed view of all the nursing forms in Centricity created on a patient since 2000-01-01. This view contains the field that was documented, the date at which it was documented, and the value that was documented. You can join this view back to the NursingForms view with PatientID, EncounterID, and ObservationContextID.
- **NursingFlowsheets** - A view containing all the nursing flowsheets created on a patient since 2000-01-01. Some examples of the types of flowsheets are: Nursing Flowsheets, and Adult / PEDS RT Flowsheets.
- **NursingFlowsheetsDetailed** - A "Tall / Skinny" detailed view of all the Nursing Flowsheets created on a patient since 2000-01-01. This view contains the field that was documented, the date at which it was documented, and the value that was documented. You can join this view back to the NursingFlowsheets view with PatientID, EncounterID, and ObservationContextID.
- **NursingFluidsDetailed** - A "tall / skinny" detailed view of the fluids documented on the flowsheet. (This view contains both Input and Output fluids).
- **NursingHourlyAssessments** - A view that contains the most common assessments, broken up in 24 hour chunks. Each "ObservationHour" will contain the most current vitals as of that hour up until 179 minutes in the past. Some examples of typical assessments are: GCS Score Total, GCS Eye Opening, GCS Verbal, Pain Score, etc.

- **NursingHourlyStandardVitalSigns** - A view that contains the most common vital signs, broken up in 24 hour chunks. Each "ObservationHour" will contain the most current vitals as of that hour up until 179 minutes in the past. Ex: Arterial and Cuff BP Systollic / Diastolic, Respiratory Rate, SPO2, Heart Rate, etc.
- **NursingHourlyUncommonVitalSigns** - A view that contains Uncommon vital signs, split in 24 hour chunks. Each "ObservationHour" will contain the most current vitals as of that hour up until 179 minutes in the past. Some examples of Uncommon vital signs are: Respiratory Rate Set / Actual, Tidal Volume Set / Actual, FiO2 Set, Ventilator Mode, etc.
- **NursingMedicationInfusionsDetailed** - A "tall / skinny" detailed view of the documented medication infusions.