EMR Features of the Clinical Records System

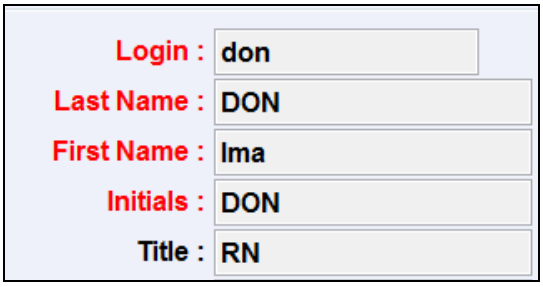
Electronic Signatures

As you move towards more electronic documentation and signature in Hi-Tech, be sure that each staff person's User ID record also includes credentials that should be included with the electronic signature.

Your System Administrator can access to these records through **Utilities > System Structure > Maintenance > User/Security**.

In the Full Name field, add the credentials after the last name, as shown on the right.

In the IMAR System, enter the credentials in the Title field, as shown below:

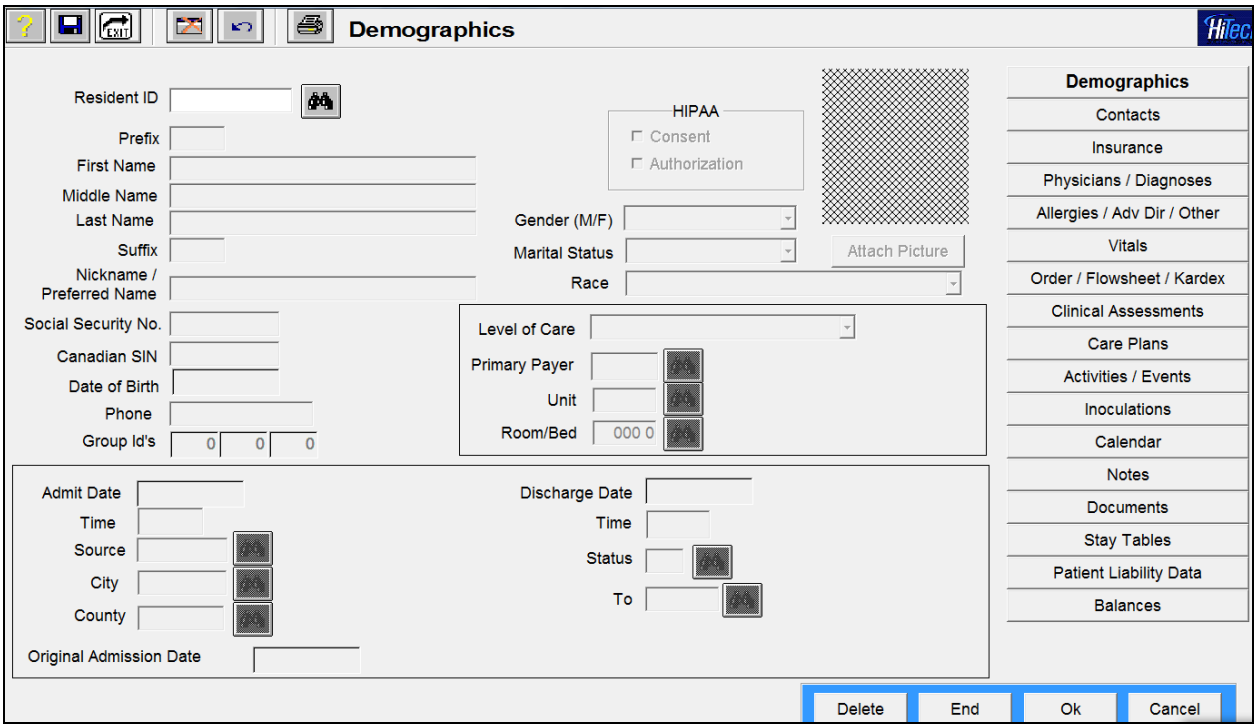


Admission Procedures >

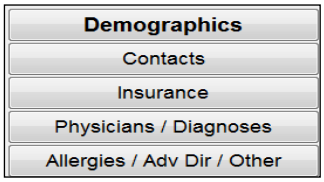
Edit Medical Record

NR03

Edit Medical Record accesses "traditional" face sheet information and parts of a resident's clinical record that can be maintained outside of the **Edit Medical Record** program.

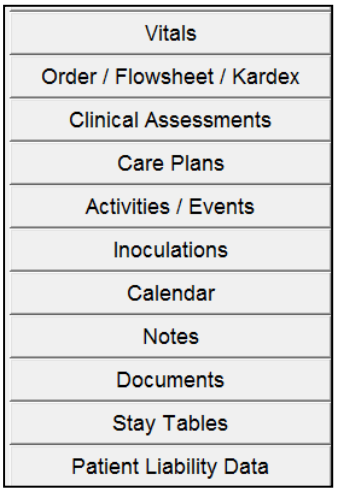


Click the binoculars to select a resident. You can then edit several parts of a resident's clinical record from the **button panel** on the right side of the screen.



The top five buttons access parts of the "traditional" Face Sheet**.**

Other buttons access information that you can also maintain *outside* of **Edit Medical Record** by selecting an edit option on a menu, for example, **Documentation > Vitals.**



If you select the button from the **Edit Medical Record**, when you complete processing in that record, the program will return you to the resident's **Demographics** screen.

Your System Administrator can limit which users can access certain information. Call HTS for assistance.

For Surveyors or users who can only view Medical Records, see the next page.

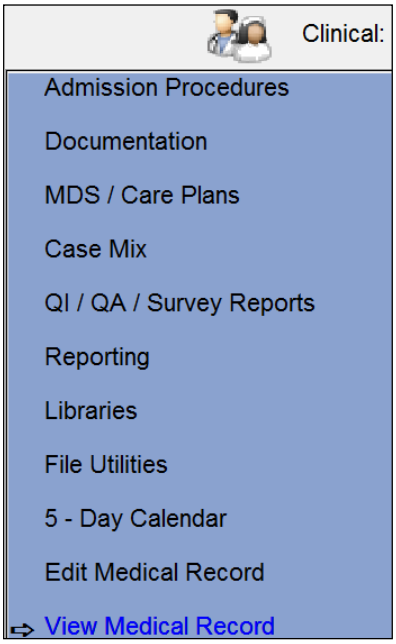
View Medical Record

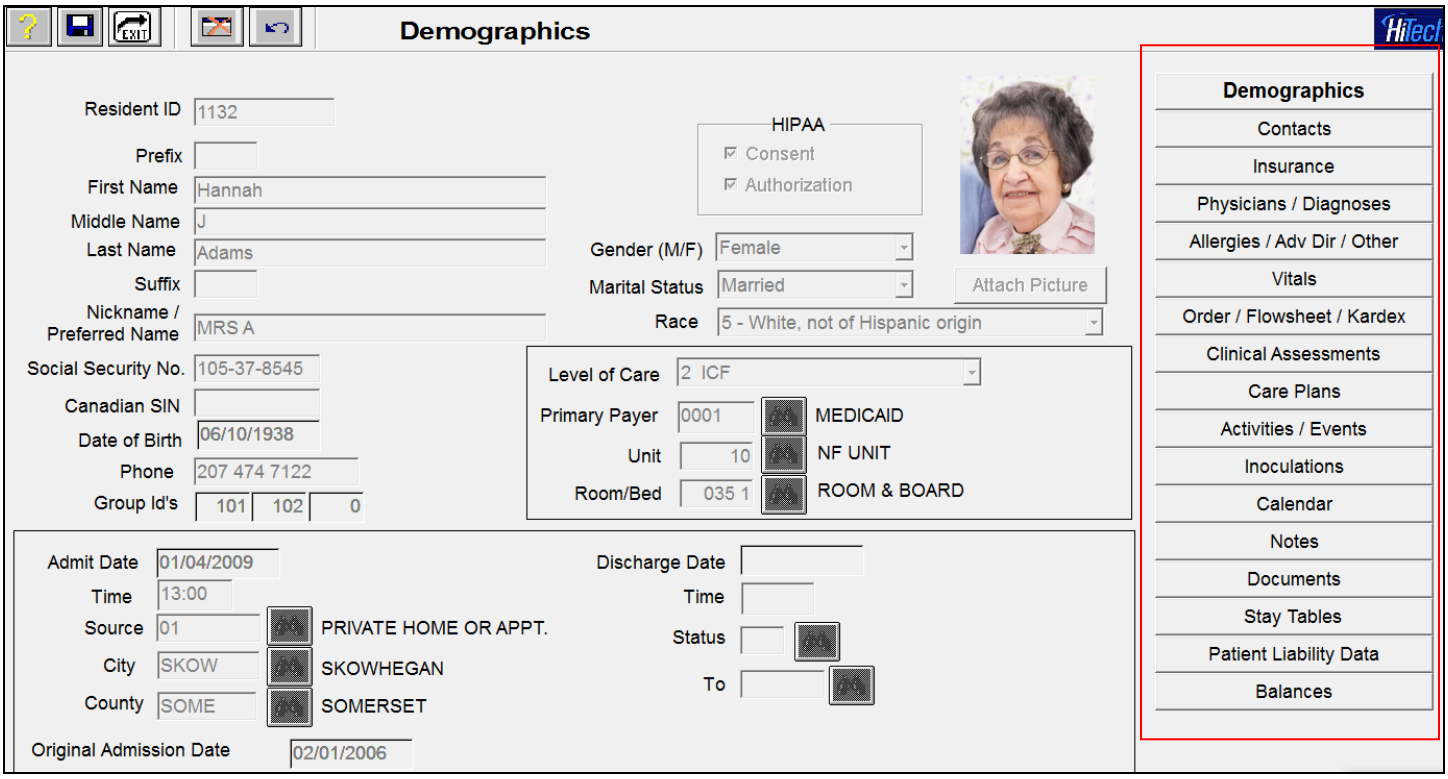
Use this method to provide view-only access to Surveyors and users who can view, and not change, the Medical Record.

From the Clinical Menu, select **View Medical Record**.
This will display **Edit Medical Record > Demographics**.

Select the resident and then select the type of information in the button panel on the right side of the screen.

You will be able to view but not change the information on that screen.





Reporting > Custom Reporting > Resident - Clinical

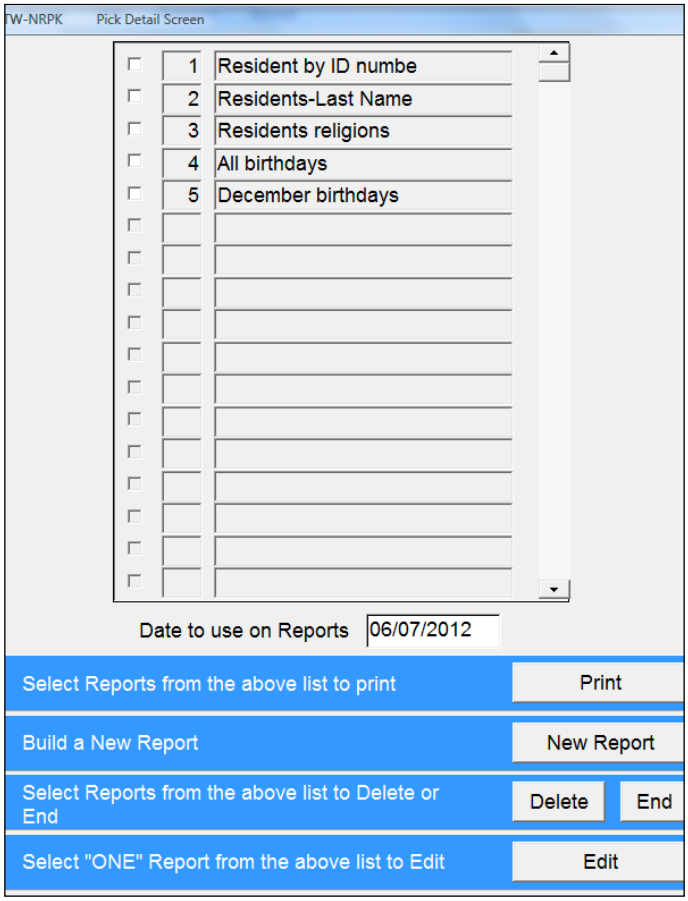
Custom Reporting

NRPK

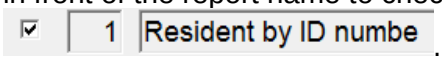
You can design listings of information that you have entered into residents' face sheets; for example:

- Resident names and room numbers
- Birth dates and age
- Religions
- Medicare and Medicaid numbers
- Admit and discharge dates.

If you have already created and saved report designs, the program will first display a list of these reports (on right).



To *print* a report listed on this screen, click the checkbox in front of the report name to check mark it.



(You can select more than one.)
Click Print at bottom of the screen.

To *design* and print a *new* report,
click New Report. See the next page.

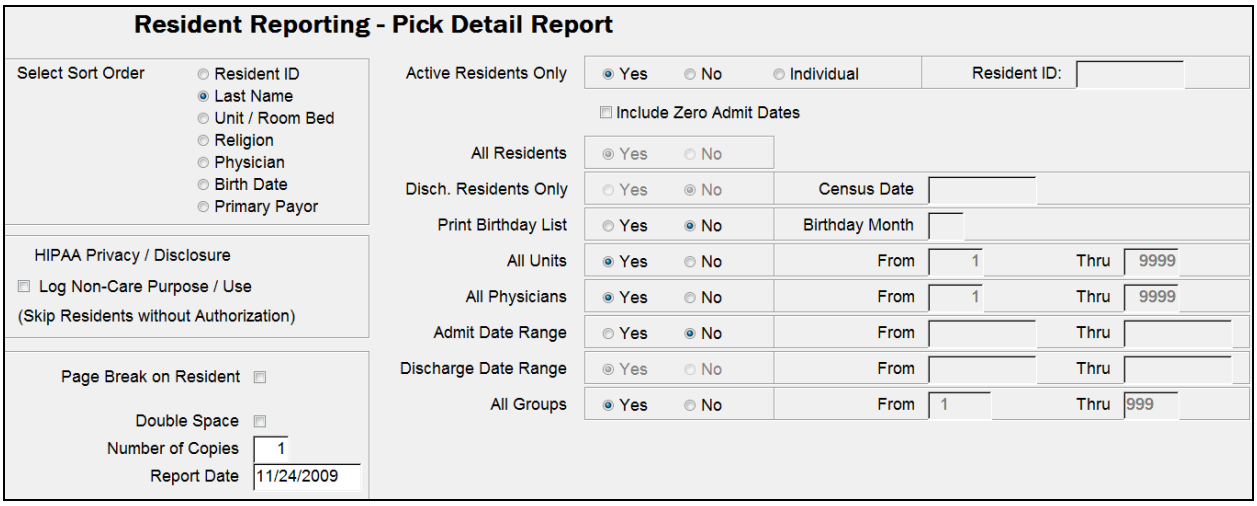
To *delete* an existing report design, select report title and click Delete.

To *change* an existing report design, select that report and click Edit. The report will display the existing report design screens for you to change and record. See the next page.

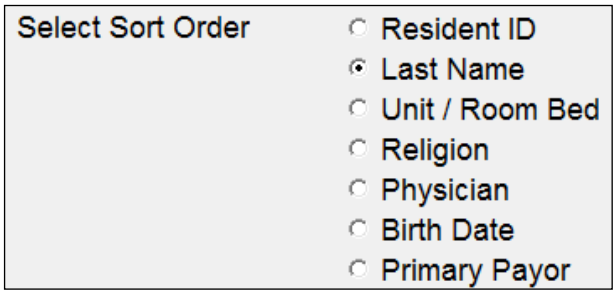
Click End to end the program without printing.

Design a New Report or Edit an Existing Report Design

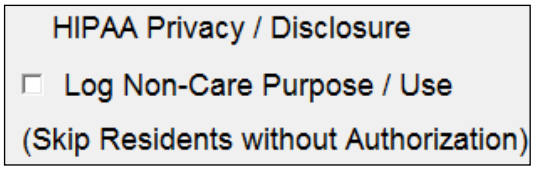
You must complete *two* screens when designing a report. Screen 1 (below) allows you to select which residents will be included on the report, and in what order:



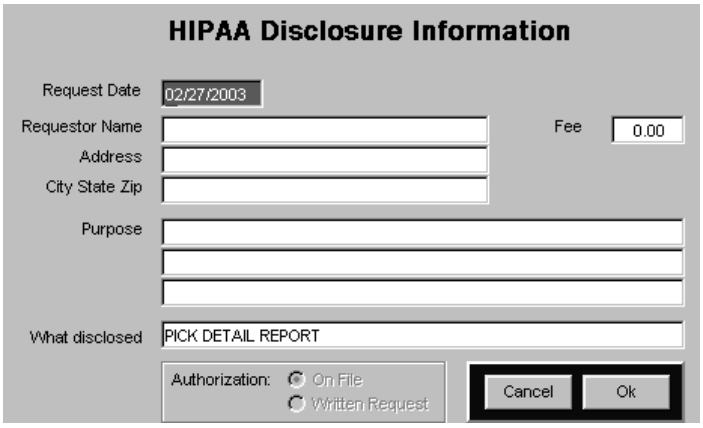
Select the Sort Order that you want. You will usually sort in alphabetic order by Last Name of in numeric order by resident ID. Choose the other options depending on the type of information you are printing. Please note that selecting Birth Date sorts by the year born, so oldest residents are listed first.



If this is a list that will include protected health information (PHI), and it will be disclosed to persons outside the facility for reasons other than treatment, payment, or other health care operations (TPO) click ☑ Log Non-Care Purpose/Use and complete the **HIPAA Disclosure Information.**



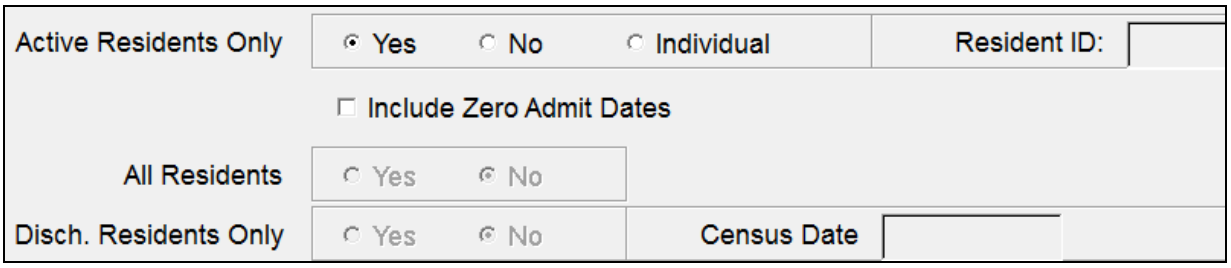
This record will be added to the HIPAA Disclosure Log which can be printed by selecting from the Master Menu: **Utilities > HIPAA Processing > Print Disclosure Log** (on right).



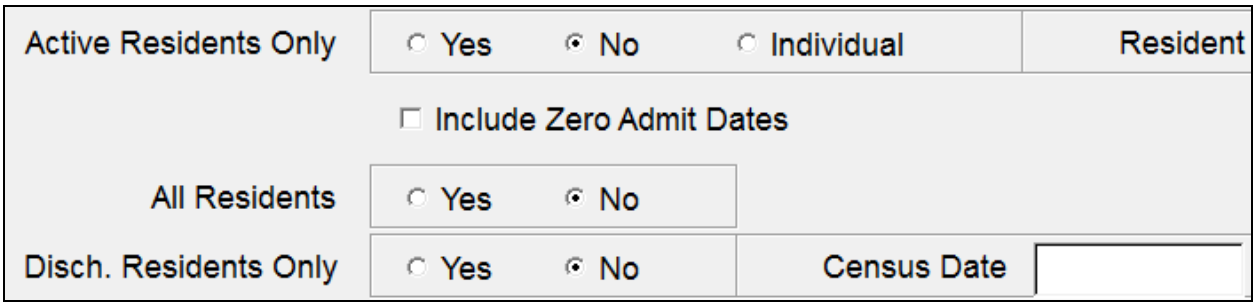
Click User Manual icon on the Utilities Menu for more information on HIPAA.

Decide which residents to list. Active, All or Individual.

If Active Resident Only ⊙Yes, you can select to☑ Include Zero Admit Dates (without Admit Dates in the face sheet because not yet entered into the census:



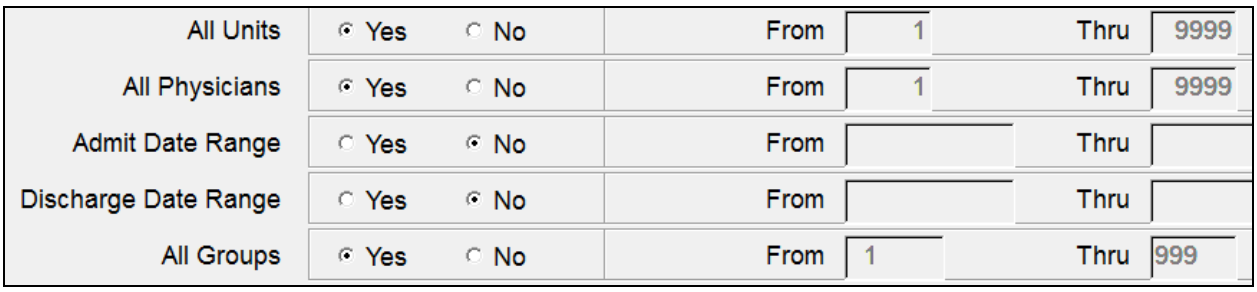
If you respond ⊙No, you can list Active and/or Discharged residents, and enter a Census Date to list thos in the facility on that date.



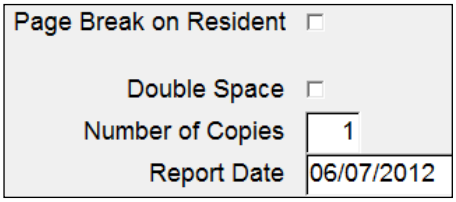
: This will select only those residents with birthdays in a specific month. Enter the birthday month (i.e. 1 for January, 12 for December)

The next part of the screen allows you to be more specific about which residents should be included on the report.

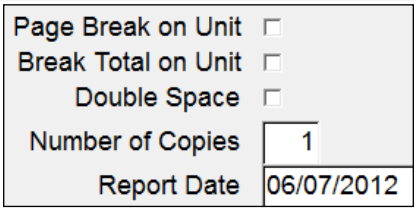
- If you do not want to exclude any residents, leave the existing selections.
- If you do want to be more selective, click the opposite radio box ⊙ and enter a selection range at From and Thru.



Access to these items might depend on previous selections. For example, if you have selected Active residents only, it makes no sense to ask for a discharge date range, because Active residents should have no discharge date in their face sheet.

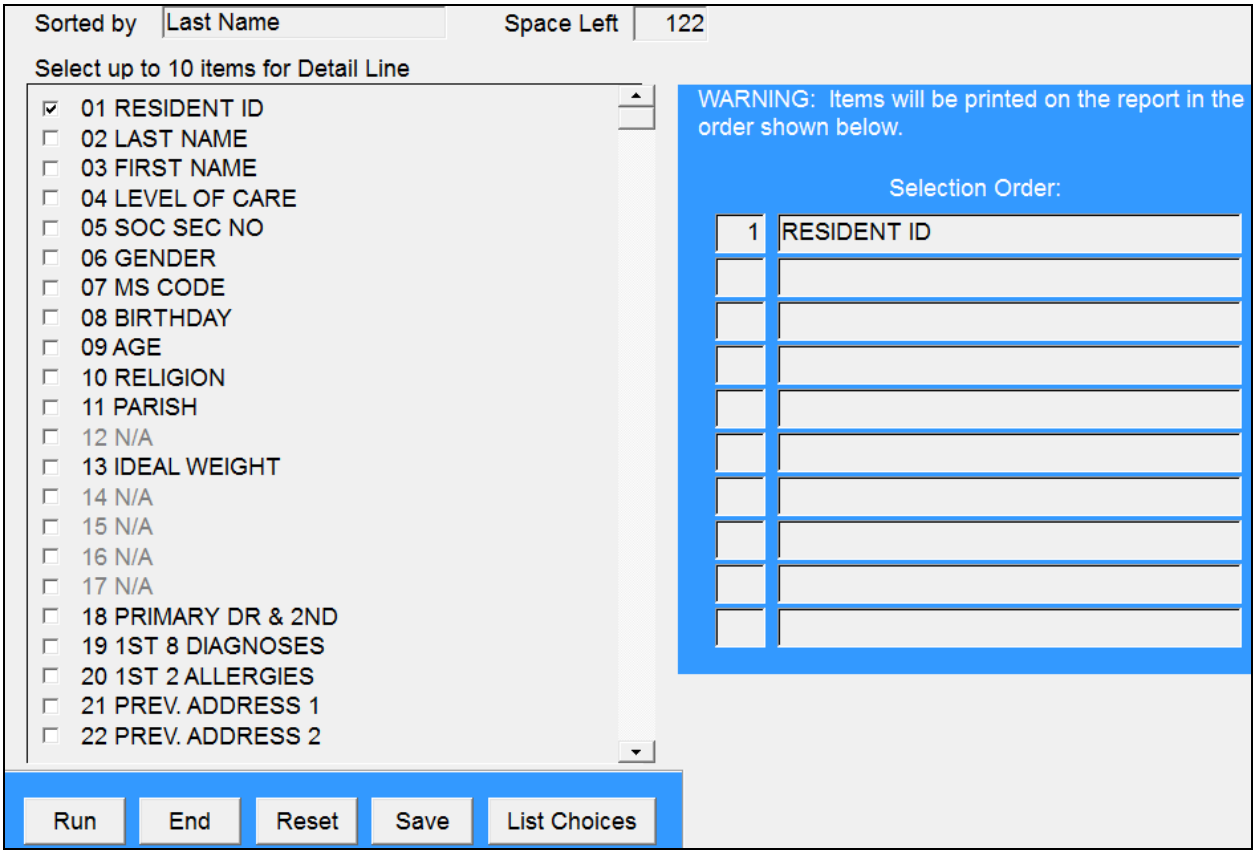


Page Break on…: This part of the screen depends on previous selections. For example, the text at the right will be displayed if you are sorting by Resident ID or Last Name. If you select Page Break it will print a *separate page for each resident,* which is **not** a good idea..



If you selected another sort order, for example ⦿Unit /Room Bed, the screen will display the options to the right. Clicking Page Break and Break Total on Unit *is a good idea* because it will print each Unit on its own page, making the report easier to read.

Click Ok to display Screen 2. On Screen 2, select the columns of information that will be listed on the report.



Sorted by lists sort order selected on Screen 1.

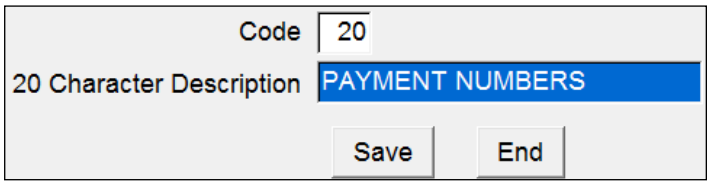
Space Left indicates how much space is left on the page (from left to right margin) for information to be printed each time you select an item.

Click an item to check mark it: ☑ 01 Resident ID. Selected items will be listed under **Selection Order** in the sequence selected. Column headings will be printed in this same order. To change the order you can uncheck an item, and then check it again to add it to the end of the order.

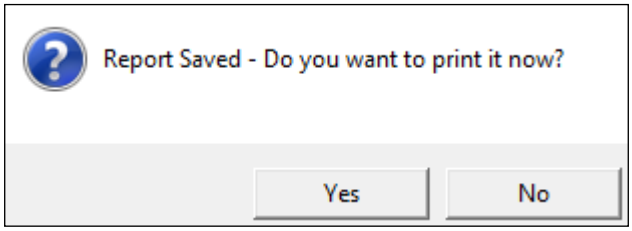
Run To print or display the selected records. Does not save the design.
End To end the program without printing.
Reset To remove selections from Screen 2 so you can choose again.
List Choices To print a listing of the items on the screen.

Save To save this report design.

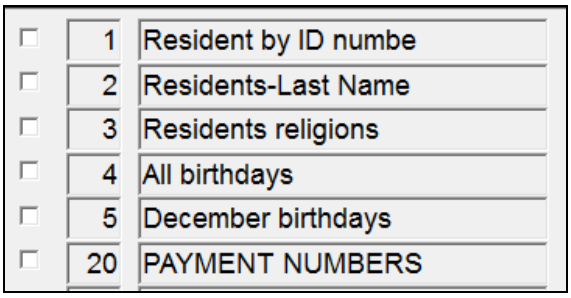
When *saving a report design*, the program first lists the existing report designs. Enter a Code not yet in use and the description of the report, for example:



Click Save. The program will ask if you want to print the report now.

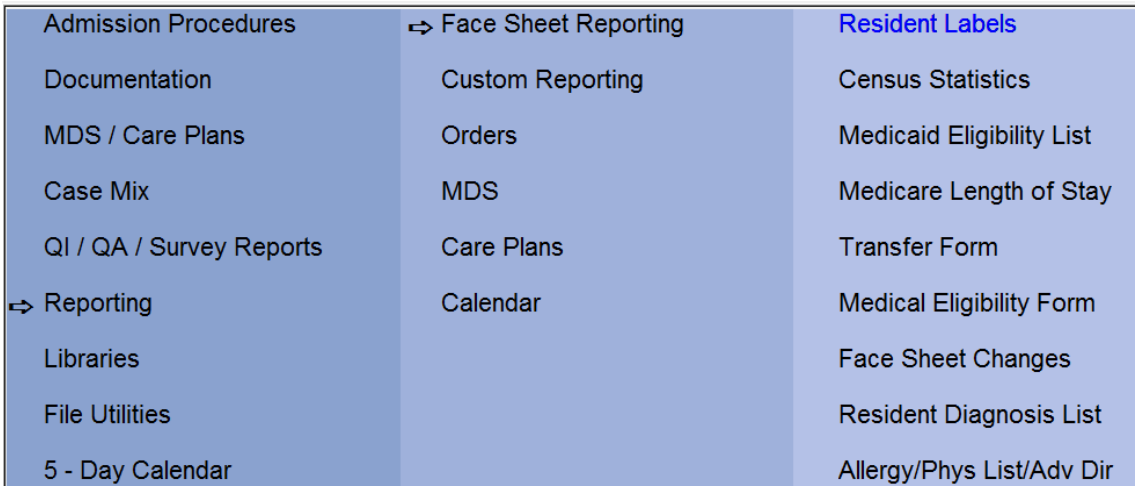


The next time you run this program, the saved report will be available for selection:



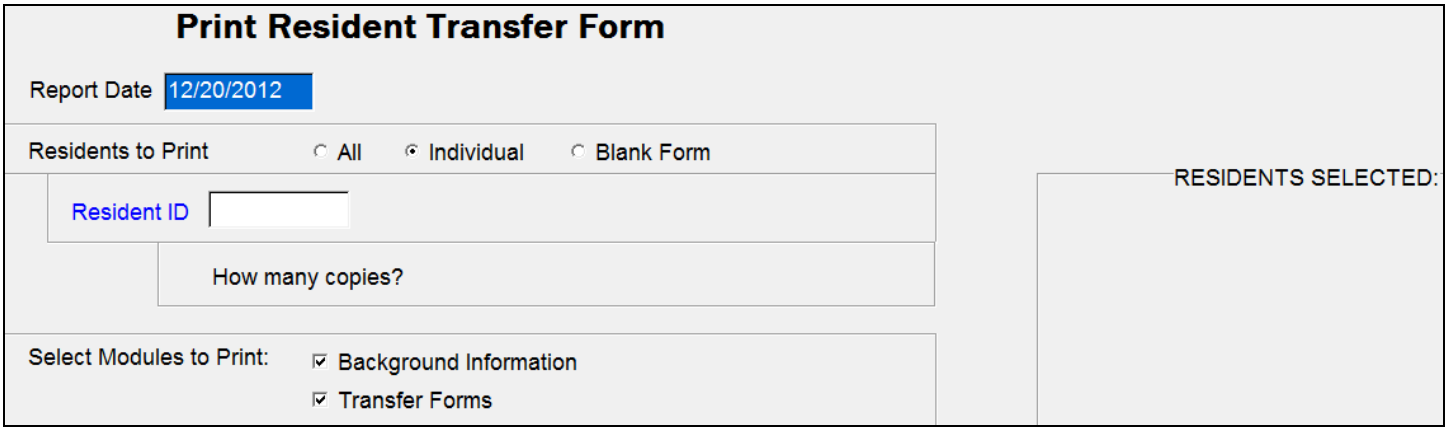
Other Face Sheet Reports

Reporting > Face Sheet Reporting



Transfer Form

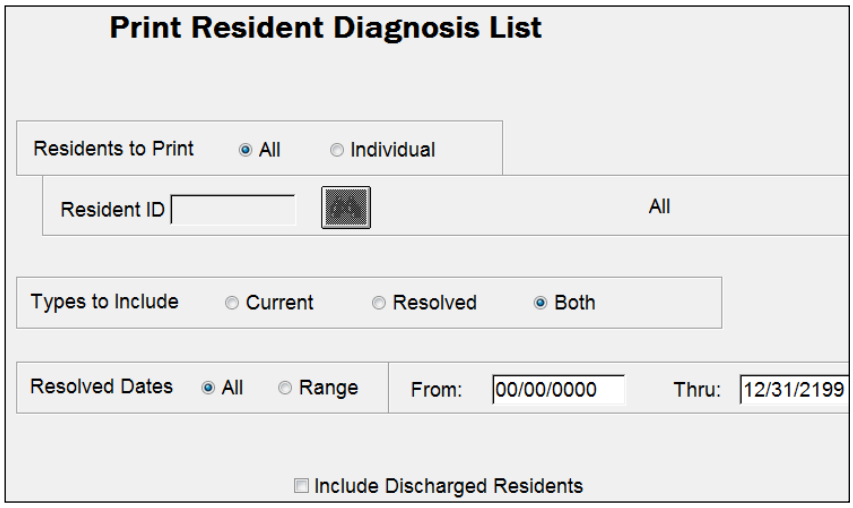
Print this 2-page form and send it with a resident's other records when they transfer to the hospital or other facility. The form combines information recorded on MDS and RCA records, face sheets, physicians' orders, and care plans. Several items must be completed manually.



Resident Diagnosis List

NR06

Types to Include ⊙Resolved: Through **Edit Medical Record > Physician/Diagnoses** you can checkmark a diagnosis in the Move to History column and enter a Resolved date. This moves the diagnosis from current to history, and you can now print a list of these resolved diagnoses (sample below).



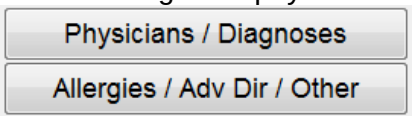
HTS-NR06 Resident Resolved Diagnosis List PAGE 1

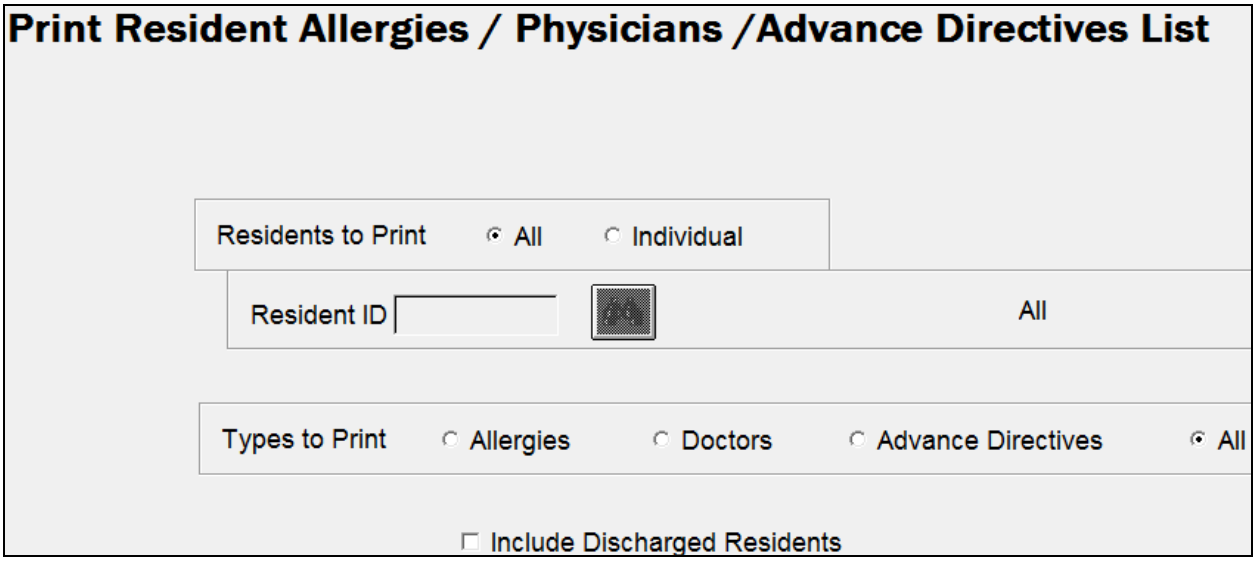
Res Id	Name		Diag Code	Resolve Date	Description
1132	ADAMS	HANNAH	401.9	06/11/2009	ESSENTIAL HYPERTENSION/UNSPECIFIED ESSENTIAL HYPERTENSION

Allergy/Phys List/Adv Dir

NR07

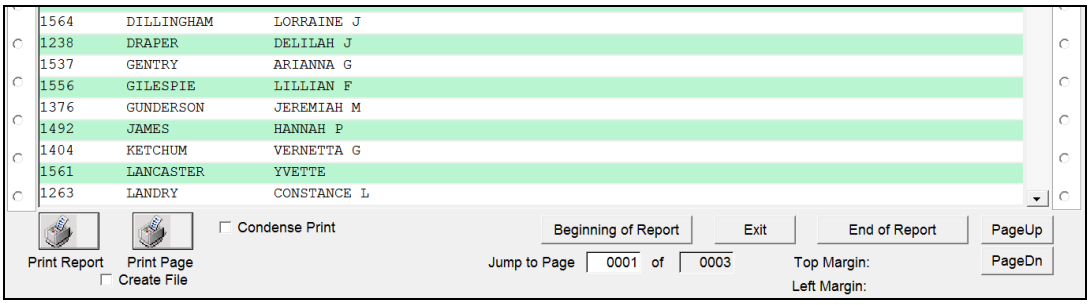
List the allergies or physicians recorded for a resident through **Edit Medical Record >**





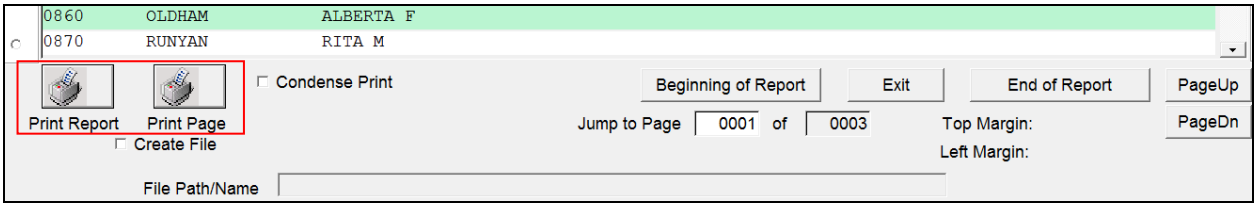
Reporting Options: Print, Display, Create File

Most Reporting programs will display in the following format and provide options to print a paper copy.



Print the Report

Make your selections on the program screen. Click Ok or Print.
The report will be displayed. For example:



Click the Print Report or Print Page buttons (on left) to print to paper all or portions of the displayed report. The report will remain on the screen.

To view other parts of the report:

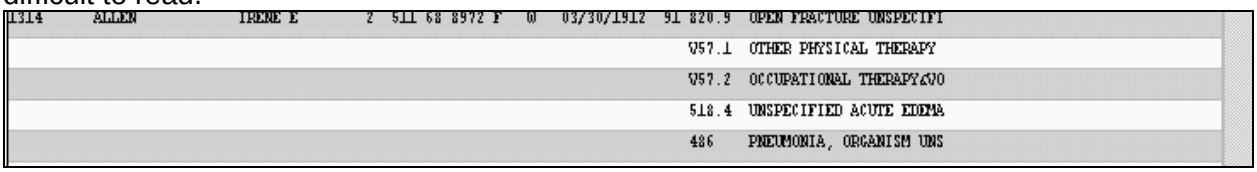
Click Beginning of Report or End of Report to move directly to the top or bottom of the report.

Click PageUp PageDn to move up or down one page at a time.

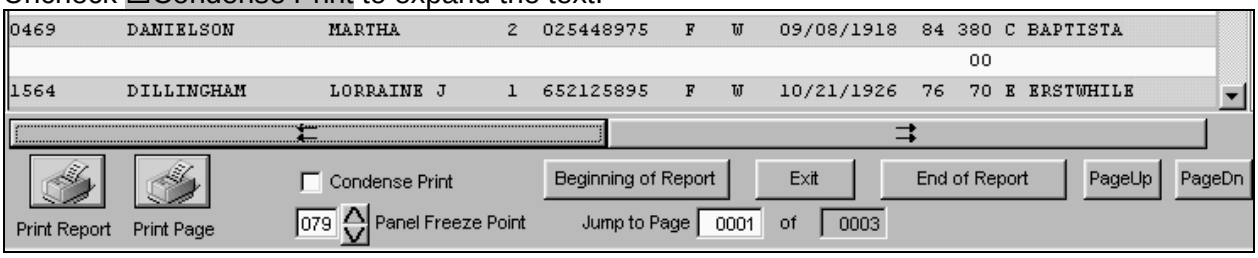
Use Jump to Page of 002 to move to a specific page of the report.
Use the vertical scroll bars on the right side of the screen to scroll up and down through the report.
Click the up or down arrow to move one line at a time, or click and hold on the movable button to scroll quickly.

Condense Print

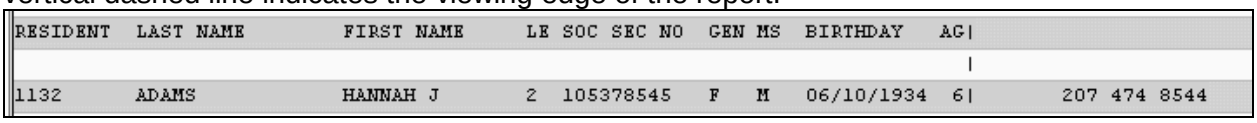
☑Condense Print: A wide report with several columns will be condensed to fit on one screen, and it might be difficult to read.



Uncheck ☐Condense Print to expand the text.

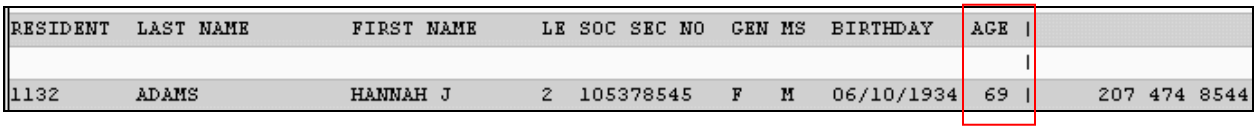


You won't see the entire report, so click ⇉ at the bottom of the report to display the right side of the report. A vertical dashed line indicates the viewing edge of the report.

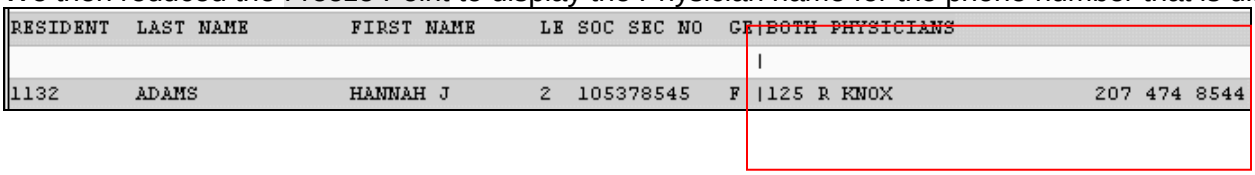


To move this edge to see more text, adjust 

using the up ⩓ and down ⩔ arrows. On the sample below, we increased the Panel Freeze Point to display the age:



We then reduced the Freeze Point to display the Physician name for the phone number that is displayed.



Activities and Events

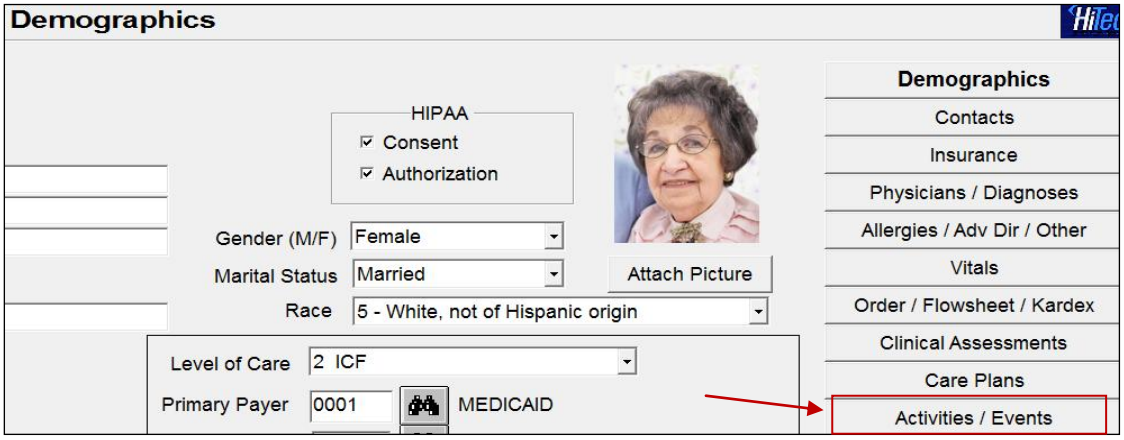
Suggested Uses for Activities and Events

- Use **Activities** to record items such as bingo, birthday party, music hour, etc.
- Use **Events** to record health-related items such as ER visits, falls, infection, flu, etc.

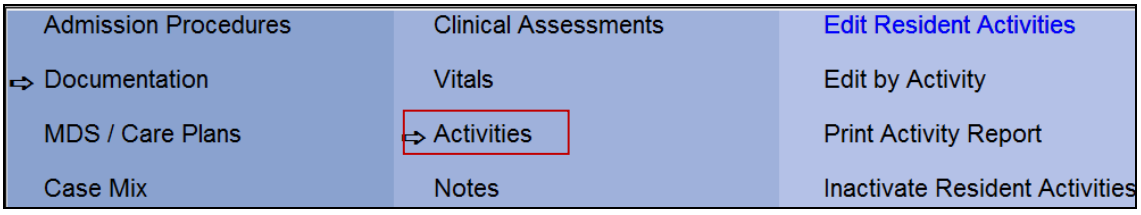
You can assign security to limit access to the more confidential, health-related **Events** records. For example, allow only Nursing and Administration to access Events, while all clinical staff can access Activities. See the Security instructions that follow.

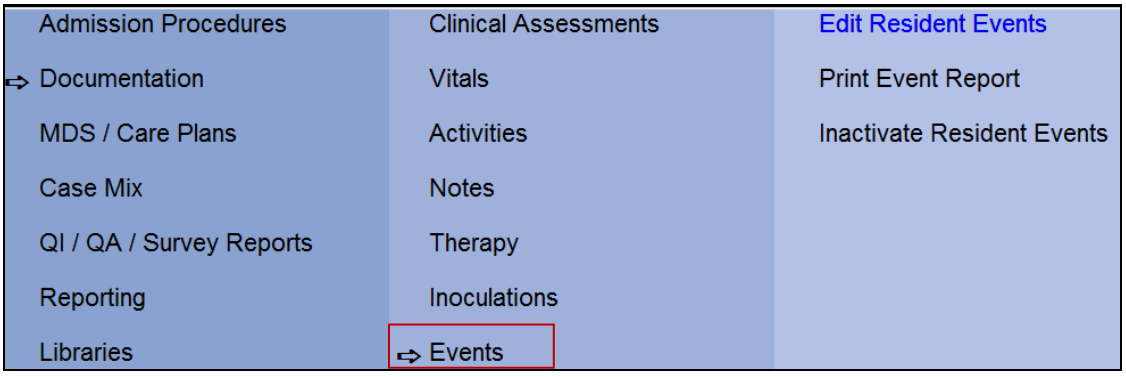
Select Activities and Events from Edit Medical Record

Click the Activities/Events button on the right side of the screen.



Select Activities and Events from the Documentation Menu

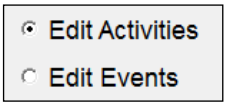




EMR Security for Activities and Events

The Release 12.03 conversion process applied previous security settings for **Activities/Events** to the new **Activities** and **Events** options.

From Edit Medical Record:

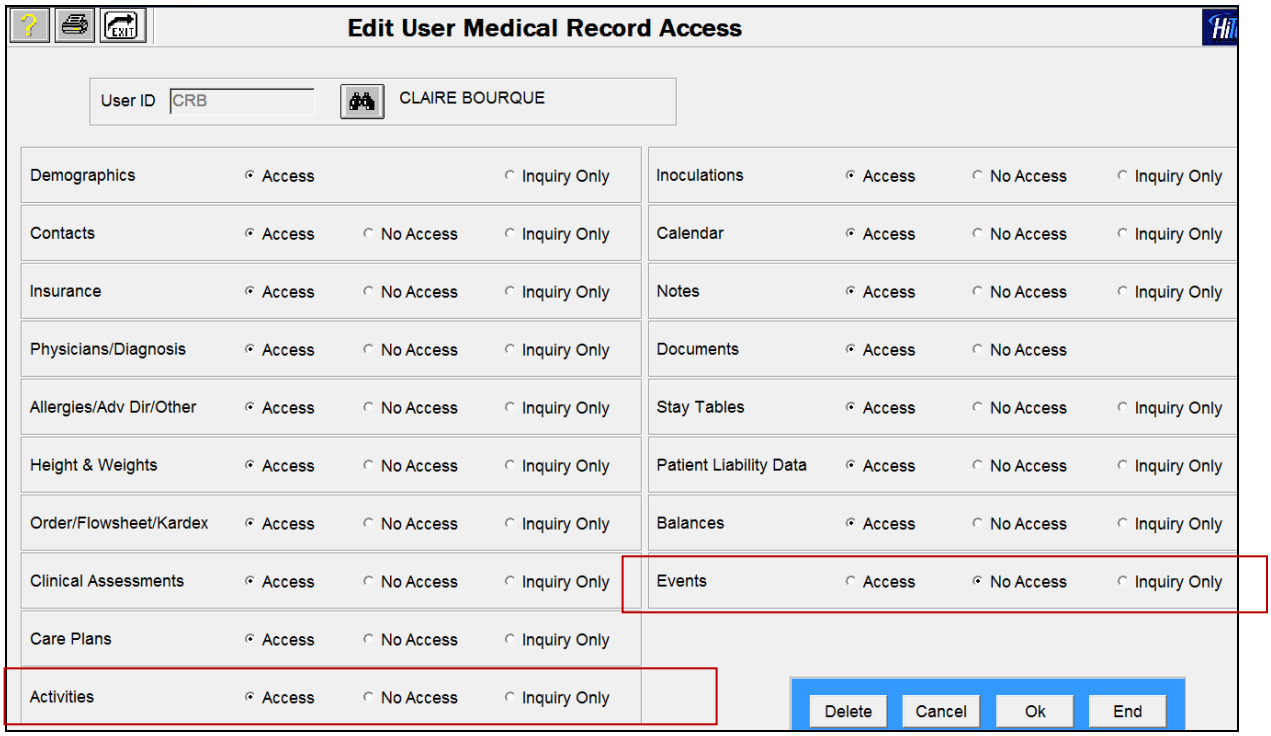


- If you had access to **Activities/Events**, when you click the Activities/Events button, you will have access to both **Edit Activities** and **Edit Events**.
  Select the program you want to edit.
- If you did *not* have access to **Activities/Events**, you will not have access to the Edit Activities or Edit Events from the EMR record. Activities/Events button will be grayed out.
- If you change the security to allow access to only *one* of these modules, when you click Activities/Events the program will display the edit screen for the module you can access.

See your System Administrator if you do not have access to these security programs.

Utilities > System Structure > Maintenance > Medical Record Security

Select the areas of the EMR this user can access through **Edit Medical Record**.



This user, Claire Bourque, has access to Activities (⊙Access), but not Events. (⊙No Access).

If Claire clicks the Activities/Event button in **Edit Medical Record**, the **Edit Activity Detail** screen will display. She will *not* be able to **Edit Events**.

NOTE: A third option, ⊙Inquiry Only, allows a user to view but not add or change records.

Libraries > Documentation >

- Activities Library
- Inoculation Library
- Event Library
- Notes Library
- Activity Comments Library
- Event Comments Library

How to Use the Activities and Events Programs

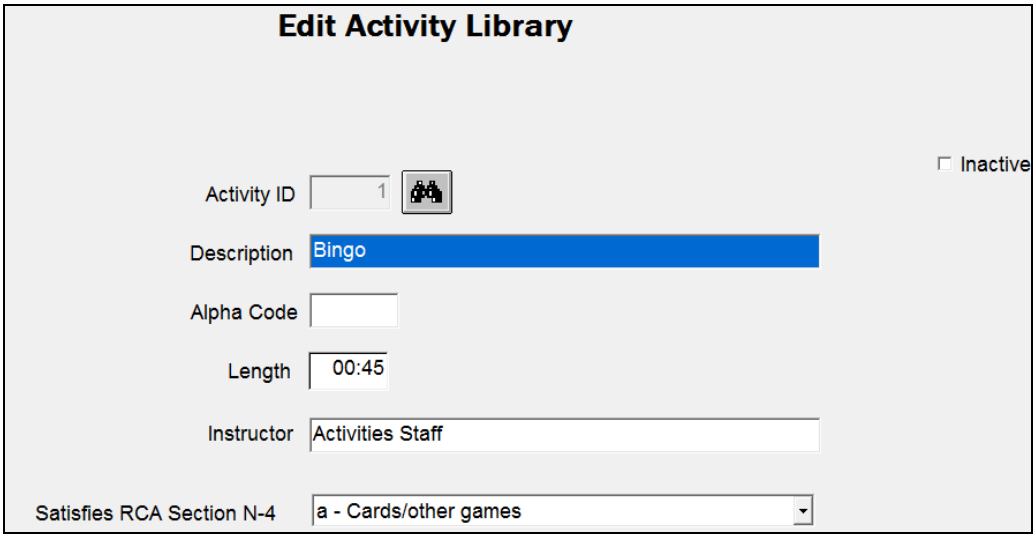
IMPORTANT: When you installed Release 12.03, all previous Activities/Events records became **Activities**. To transfer Event-type records out of Activities into Events, please contact Hi-Tech Support. We will help you transfer both library items and actual detail records into the Events category.

CAUTION: Do *not* Inactivate Event records in the Activities Library and then recreate them in Events. Contact Hi-Tech for assistance in *transferring* these records.

Activities Library

MD84

Build a library of the Activities that you want to track for your residents. When you record an actual activity, select the item from the library. This helps to keep your activity records organized and standardized for reporting and analytical purposes.



Activity ID: Assign ID numbers. Enter the Description.

Alpha Code: a "short hand" for an activity. Example, BP for Birthday Party. In **Documentation > Activities**, enter the Alpha Code and the program will look up and display the event.

Provide the Length (HH:MM) of time for a typical session of this activity. Specify the Instructor.

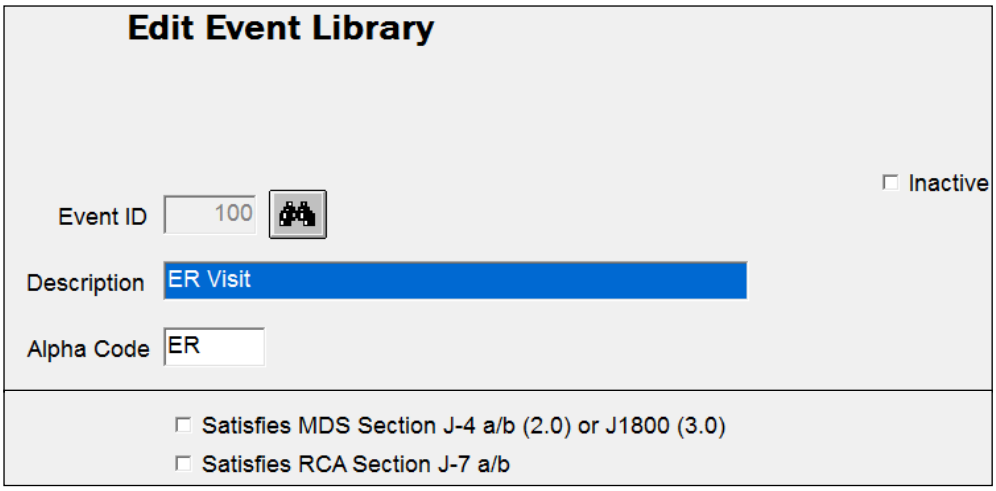
Satisfies RCA Section N-4 (Maine only): Select the RCA item matched by this Activity.
In **Edit RCA**, at **N4. General Activity Preferences** when you select Import General Activities, this item under N4 will be checked if the resident participated. Note that you should also consider the resident's preferences when answering N.4.

☑Inactive: You can no longer delete Activity records from the library. You can inactivate them. This will retain the residents' detail associated with this item.

Libraries > Documentation >

Events Library

MDE1



IMPORTANT: if you had established Event records in the previous Activities/Events library, and you want to transfer these records into the Events library, call Hi-Tech Support for assistance.

Enter the Event ID and Description. This helps to keep your records organized and standardized for reporting and analytical purposes.

Alpha Code: a "short hand" for an activity or event record. Example, ER for ER Visit.
When you record an event through **Edit Resident Events**, rather than look up the event ID, enter the Alpha Code. The program will look up and display the event

Does this Event satisfy the MDS and RCA questions indicated? See ***Tracking and Reporting Falls*** below.

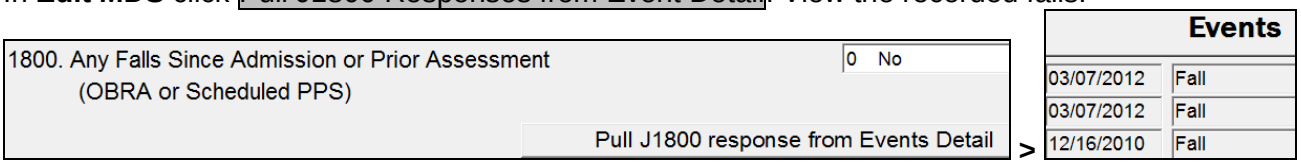
MDS 3.0: J1800. Any Falls Since Admission or Prior Assessment

RCA: J7 Accidents a. Fell in past 30 days and b. Fell in past 31-180 days.

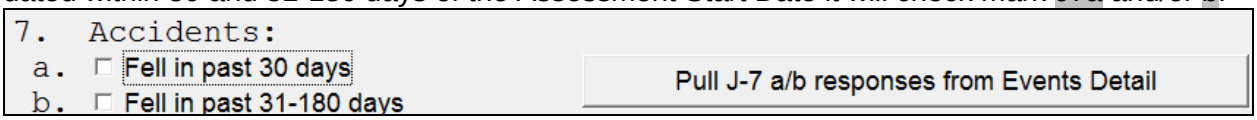
Tracking and Reporting Falls in the MDS and RCA

Define a Falls event through **Libraries > Documentation > Activities / Events Library.**
Check ☑Satisfies MDS J1800 (3.0)or ☑Satisfies RCA Section J-7 a/b.

1. Record Falls on dates that they occur (**Documentation > Events > Edit Resident Events)**.
2. Complete resident's MDS 3.0 (**Edit MDS**) or MDS-RCA (**Edit RCA**).
3. In **Edit MDS** click Pull J1800 Responses from Event Detail. View the recorded falls.



4. In **Edit RCA**, click Pull J-7 a/b responses from Event Detail button. If the program finds Falls records dated within 30 and 31-180 days of the Assessment Start Date it will check mark J7a and/or b.



Libraries > Documentation >

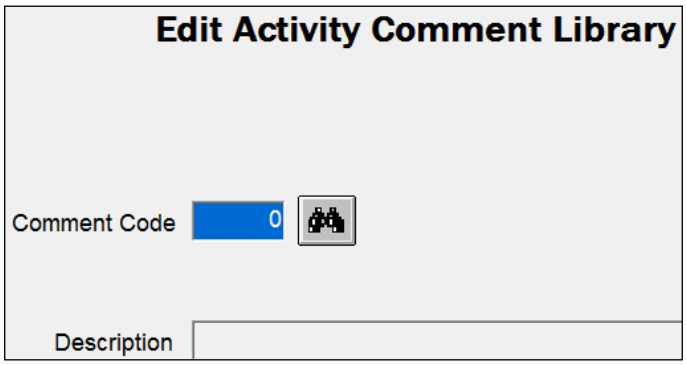
Activity Comments Library

MD89

Events Comments Library

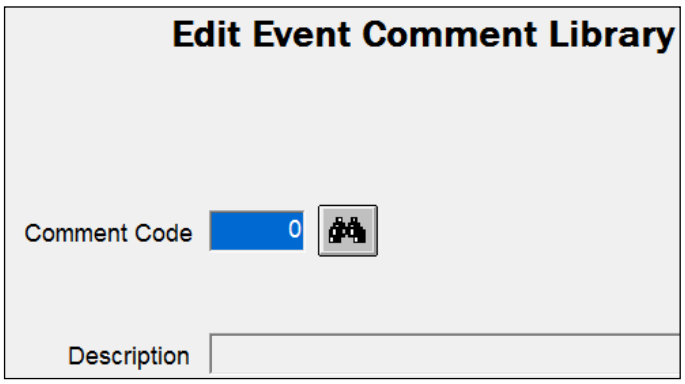
MDE5

Create standardized Comments that you can add to Activity and Events records.



Example: Activity Comments:.

Code	Description
0002	Attended and participated
0005	Attended and participated as cheerleader
0003	Attended with encouragement
0004	Attended, but left early
0001	Attended, did not participate
0020	No transport required, family notified.



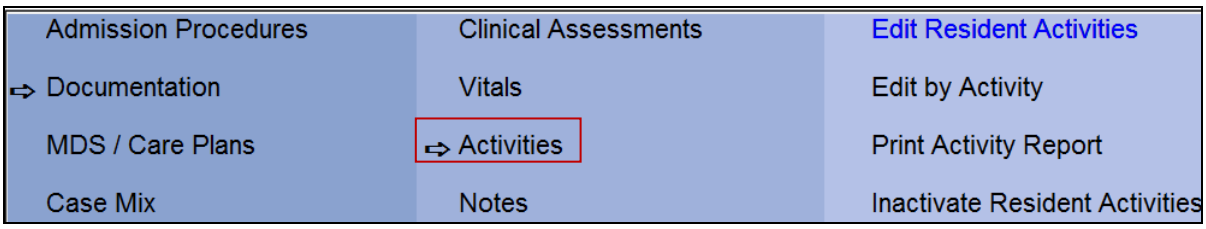
Example: Event Comments

0003	ER visit, admitted for observation
0004	ER visit, returned to facility
0002	Fall with injury
0001	Fall without injury

.

Documentation > Activities

Document Activities



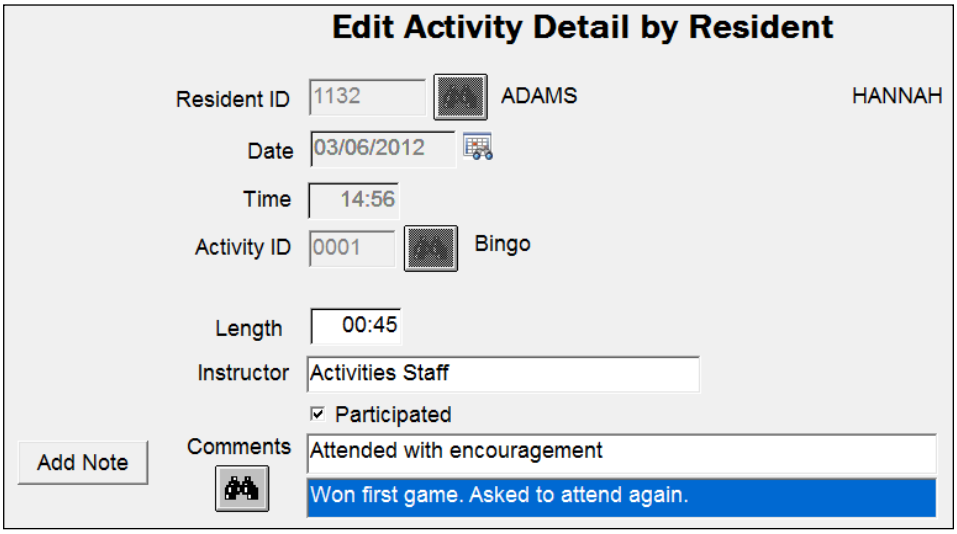
Hi-Tech suggests that you use **Activities** to record items such as bingo, birthday party, music hour, etc.

After you define an activity in the library, record the residents who were offered and participated in the activity.

- To record individual resident's activities, use **Edit Detail by Resident**.
- To record the activity for several or all residents, use **Edit Detail by Activity**.

Edit Detail by Resident

MD84



Enter or select a Resident ID.

Enter Date and Time of activity.

Activity ID: Enter or lookup the Activity ID. (assigned through **Activities Library)** or enter the *Alpha Code* created for this event. For example, BP for Birthday Party.

Length: amount of time the activity took if it differs from that recorded in the library.

Instructor: Input from the Activity Library record or manually entered.

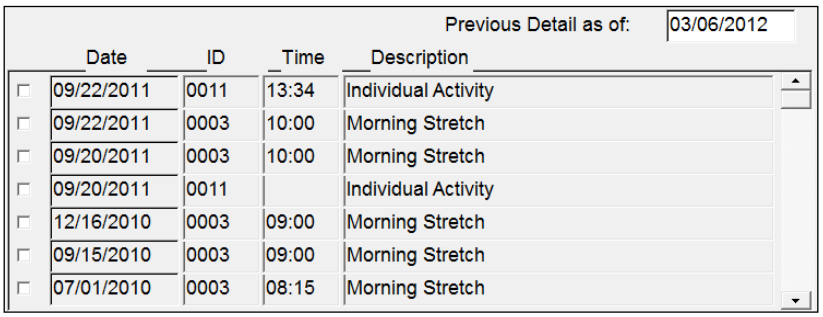
☑Participated Leave checked if resident participated. Uncheck if the resident was offered the activity but declined to participate. This helps track staff intervention with residents whose care plan goal is increased participation in activities.

Comments: Enter additional comments or select from the Activity Comments Library.

Add Note to add a Progress Note related to the activity.

Review activity records at the bottom of the screen (on right). Select an activity too view or edit the record.

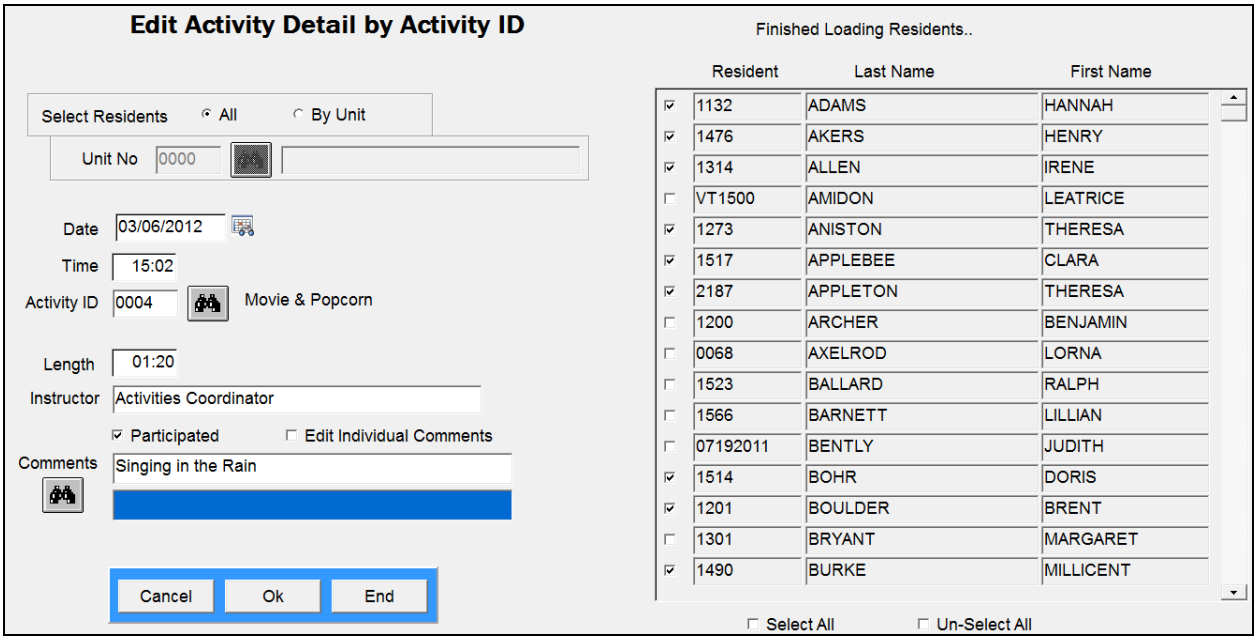
You cannot delete Activity records. You can *inactivate* records through **Inactivate Resident Activities**. See Page 22.



Documentation > Activities

Edit by Activity

MD85



Provide the Date and Time of the Activity. Select the Activity ID number or enter the Alpha Code that identifies the activity (i.e. BP for Birthday Party) The program will translate it.

Enter the Length of time for the activity.

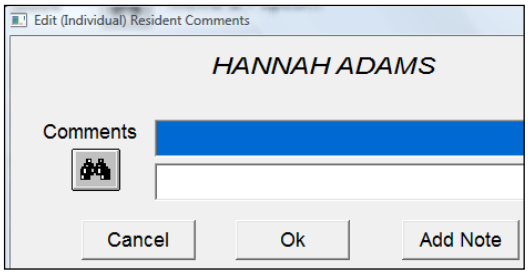
☑Participated: Leave checked if the residents you are about to select *participated in* (attended) the activity. Uncheck to build a separate batch of records for residents who were offered the activity and did not participate.

Select Residents: Select ⊙All or ⊙By Unit. If you select By Unit, enter or look up the Unit No.

Residents' names will then be listed on the right side of the screen.

Use ☑ Select All and ☑ Un-Select All to select/deselect all the residents listed for the entire facility or the unit. You can also ☑ Select All and then deselect individual residents.

Comments Enter a general comment for the activity.
To record different Comments for each resident check☑ Edit Individual Comments.
This will display a Comment entry window for each resident (see window for ***HANNAH ADAMS*** on the right). Enter comment text or click the binoculars to select from the Comments library.

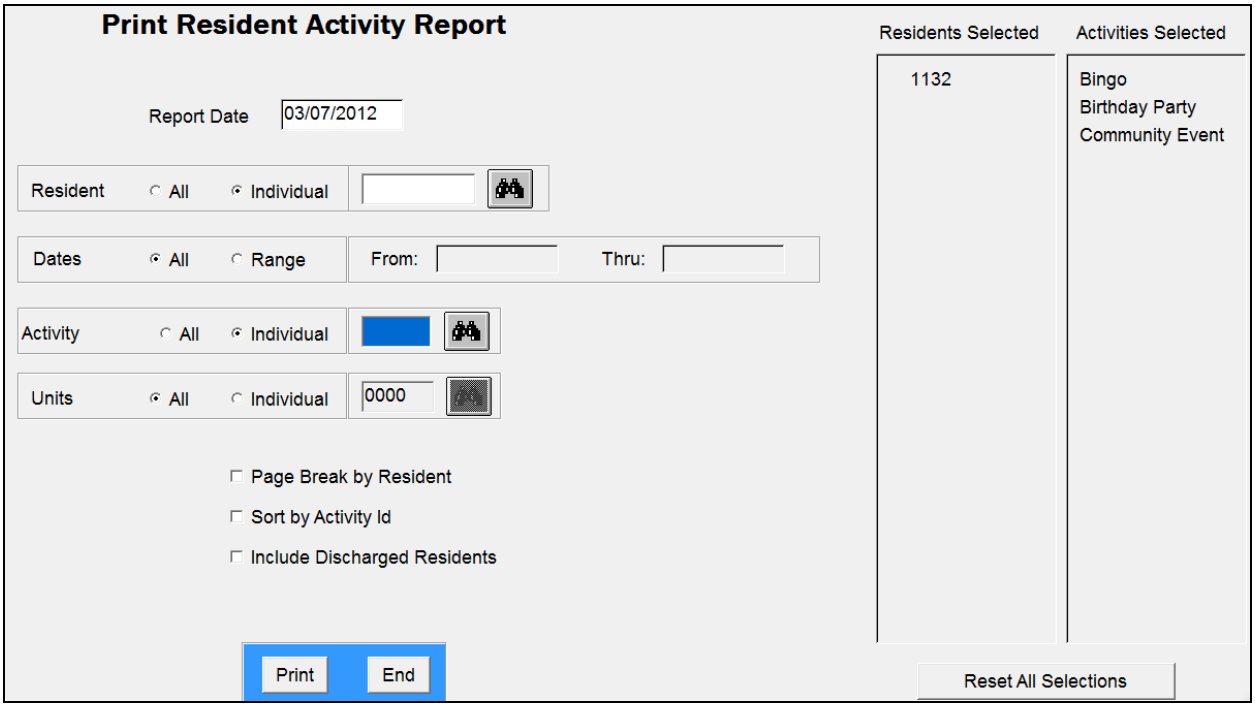


Click Add Note to add a Note related to the activity to the resident's Progress.

Documentation > Activities

Print Activity Report

MD86



Resident: Select ⊙All or ⊙Individual and provide the ID.
Selections will be listed under Residents Selected:

Dates: Select ⊙All or a ⊙Range of records by date.

Activity: Select ⊙All or ⊙Individual activities. Click the binoculars to select multiple items. Selections will be listed under Activities Selected.

Units: If you select ⊙Individual, select the Unit.

Sample: All residents, Dates and Activities:

DATE: 03/07/2012 RESIDENT ACTIVITIES REPORT HTS-MD86 PAGE: 1

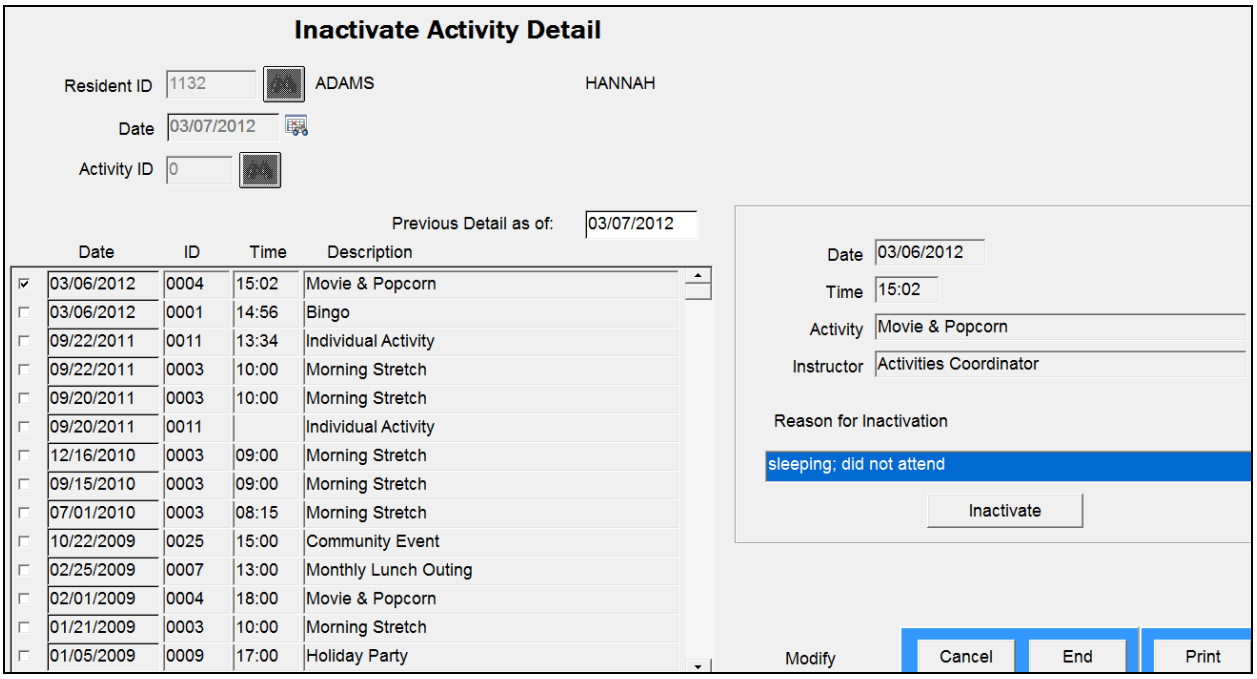
ID	NAME		DATE	TIME	LNGTH	ACTIVITY	INSTRUCTOR	P
0068	AXELROD	LORNA	09/22/2011	15:32	00:30	0008 Friday Night Social	MBM	Y
0575	GREENE	JULIANNE	09/22/2011	10:00	00:00	0003 Morning Stretch	Activities Staff	Y
	Sit and Get Fit							
05965	SAMPSON	SAMANTHA	09/22/2011	10:00	00:00	0003 Morning Stretch	Activities Staff	Y
	Sit and Get Fit							
1132	ADAMS	HANNAH	09/20/2011	00:00	00:00	0011 Individual Activity		Y
	Puzzle							
1132	ADAMS	HANNAH	09/20/2011	10:00	00:30	0003 Morning Stretch	Activities Staff	Y
	Attended and participated							
1132	ADAMS	HANNAH	09/22/2011	10:00	00:00	0003 Morning Stretch	Activities Staff	Y

Documentation > Activities

Inactivate Resident Activities

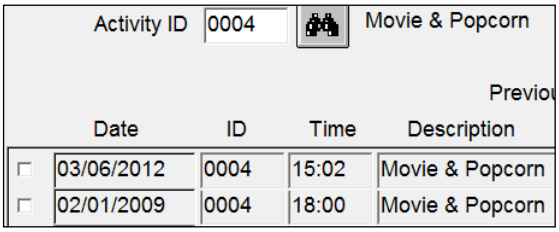
MD96

You cannot delete activities that have been recorded; however, you can inactivate them.



Select the Resident ID to display all the recorded activities for that resident.

You can also select a specific Activity ID to display just those activities, as shown on the right.



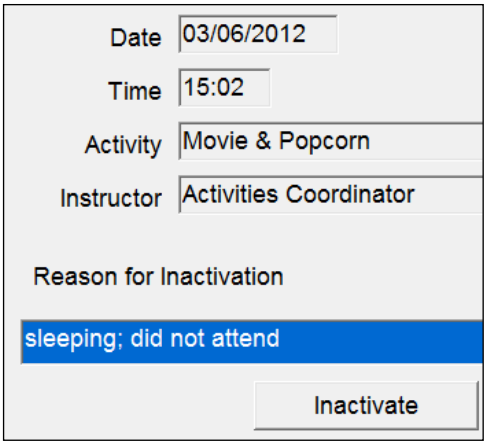
Select the specific occurrence to be inactivated and complete the information on the right side of the screen (see below).

You must enter a Reason for Inactivation.

Click the Inactivate button.

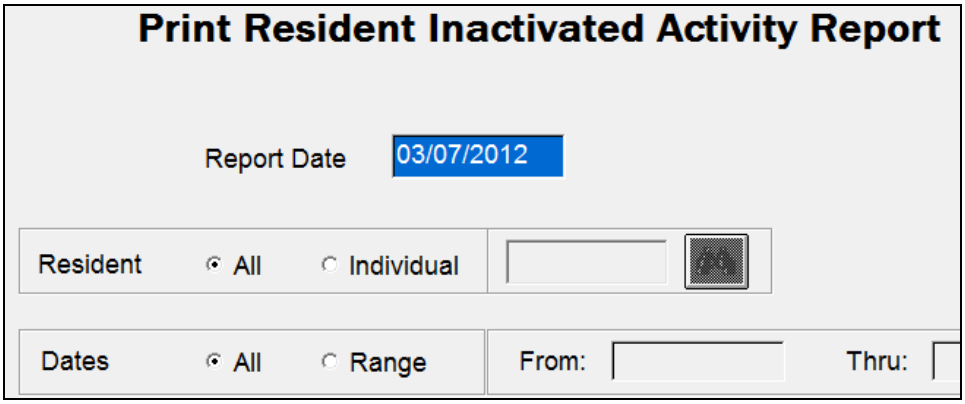
This activity will no longer be displayed in the resident's activity record.

To view inactivated activities, click Print. See next page.



Select through **Documentation > Activities > Inactivate Resident Activities**

Print Inactivated Activity Report



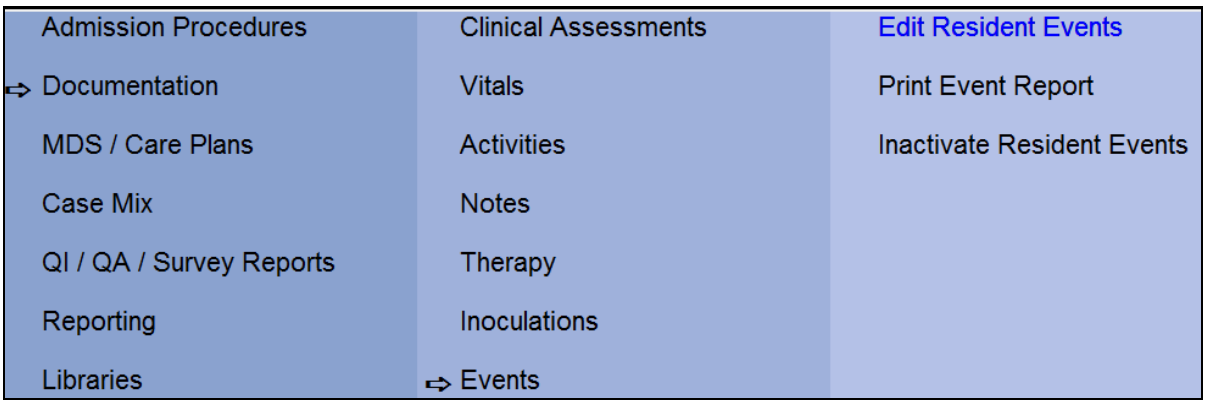
Select the items you want to review and click Print.

DATE: 03/07/2012 INACTIVATED RESIDENT ACTIVITIES HTS-MD97 PAGE: 1

ID	NAME	DATE	TIME	ACTIVITY	INACTIVATED BY-DATE-REASON	
1132	H ADAMS	09/22/2011	15:29	0004 Movie & Popcorn	CRB	03/01/2012 ill; did not attend
1132	H ADAMS	02/29/2012	09:36	0001 Bingo	CRB	03/01/2012 out of facility; did not atten
1132	H ADAMS	03/06/2012	15:02	0004 Movie & Popcorn	HTS*	03/07/2012 sleeping; did not attend

Documentation > Events >

Document Residents' Events



Hi-Tech suggests that you use **Events** to record health-related items such as ER visits, falls, infection, flu, etc.

You can assign user security to limit access to confidential, health-related **Events** records. For example, allow only Nursing and Administration to access Events, while all clinical staff can access Activities.

Edit Resident Events

MDE3

Enter or select a Resident ID. Enter the Date and Time of event.

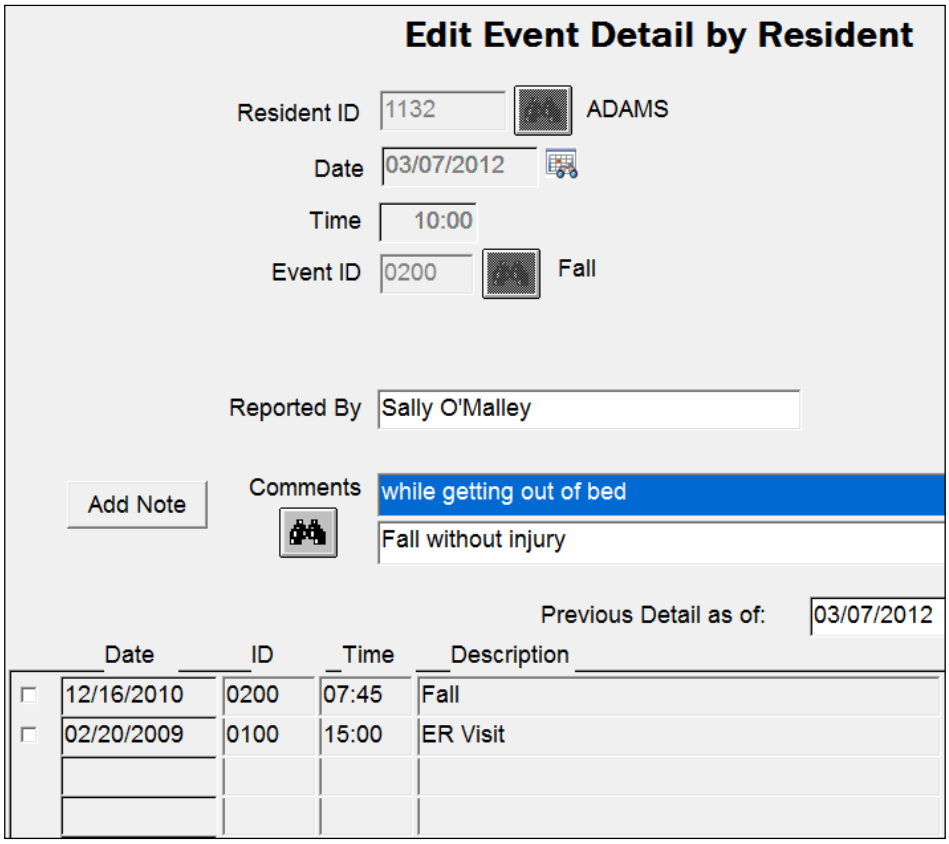
Event ID: Enter or lookup the Event ID. (assigned through **Events Library)** or enter the *Alpha Code* created for this event. For example, ER for Emergency Room Visit.

Reported By: Name of person who reported or recorded this event.

Comments: Enter additional comments and/or select from the Event Comments Library.

Click Add Note to add a Note related to the event to the resident's Progress Notes.

Review event records at the bottom of the screen. To view or edit the comment for a specific record, check it to display it on the screen for editing.

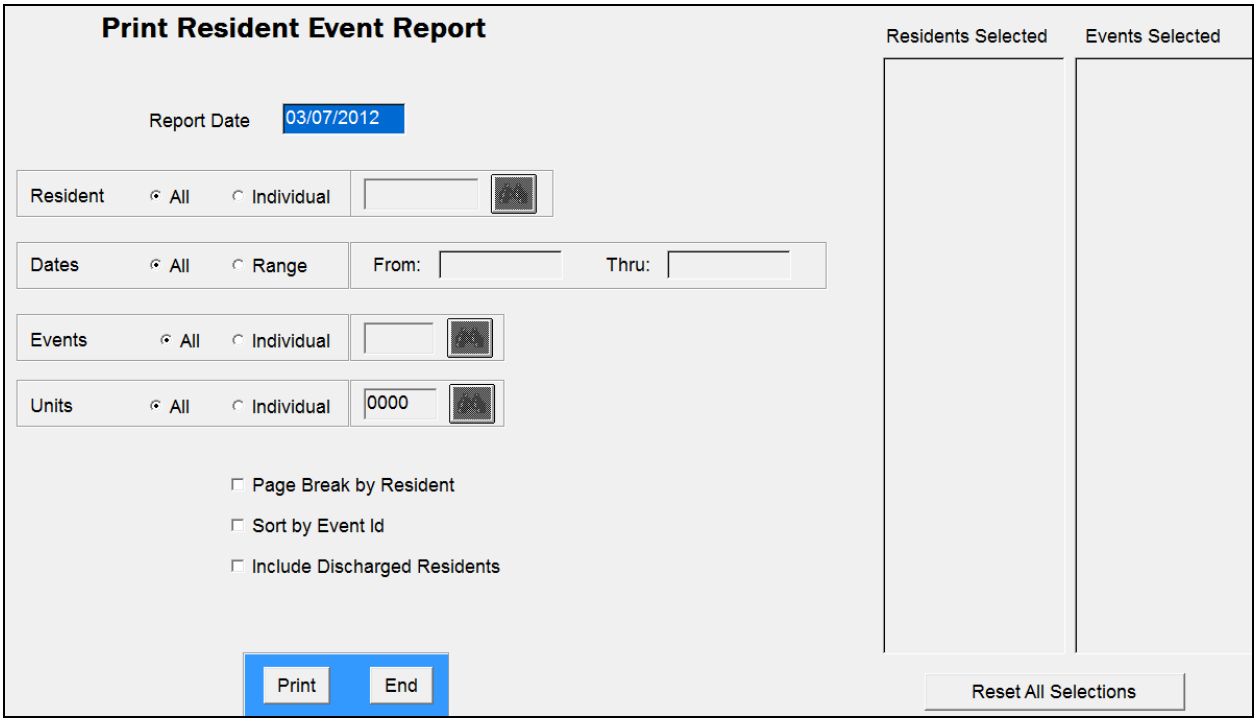


You cannot delete Event records. You can inactivate records. See **Inactivate Resident Events** on Page 26.

Documentation > Events

Print Event Report

MDE46



Resident: Select ⊙All or ⊙Individual and provide the ID.
Selections will be listed under Residents Selected:

Dates: Select ⊙All or a ⊙Range of records by date.

Event: Select ⊙All or ⊙Individual events. Click the binoculars to select multiple records.

Selections will be listed under Events Selected.

Units: If you select ⊙Individual, select the Unit.

Sample: All residents, Dates and Events:

DATE: 03/07/2012 RESIDENT EVENTS REPORT HTS-MDE4 PAGE: 1

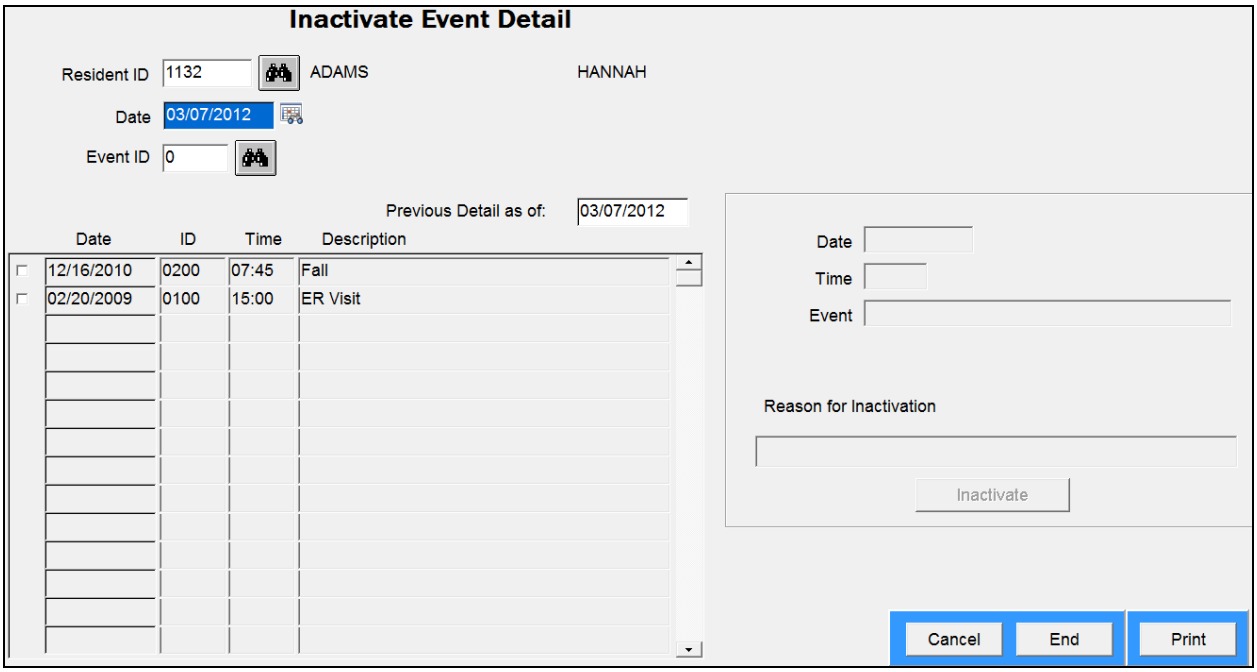
ID	NAME		DATE	TIME	EVENT	REPORTED BY
1132	ADAMS	HANNAH	02/20/2009	15:00	0100 ER Visit	
	Bumped her elbow on the door jamb, compl				ained of severe pain-Xray recommended	
1132	ADAMS	HANNAH	12/16/2010	07:45	0200 Fall	
	Fell in bathroom during morning care.				Monitored, no transport required.	
1132	ADAMS	HANNAH	03/07/2012	10:00	0200 Fall	Sally O'Malley
	while getting out of bed				Fall without injury	
1476	AKERS	HENRY	01/15/2009	10:35	0200 Fall	
	Fell while walking in hallway.				No transport required.	

Documentation > Events

Inactivate Resident Events

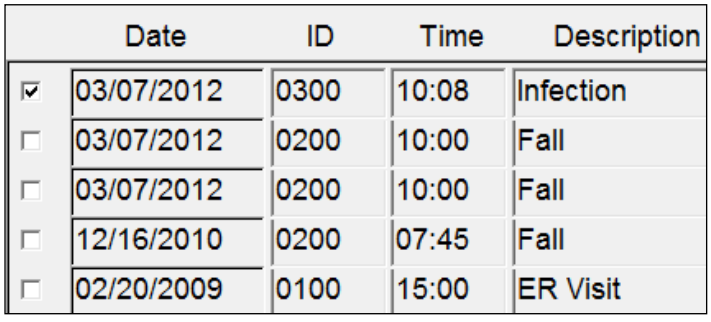
MDE8

You cannot delete events that have been recorded; however, you can inactivate them.

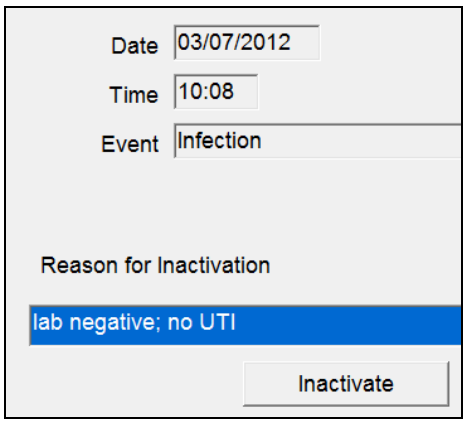


Select the Resident ID to display all the recorded events for that resident.
You can also select a specific Event ID to display just those events.

Select the specific occurrence to be inactivated and complete the information on the right side of the screen (see below). You must enter a Reason for Inactivation. Click the Inactivate button.



	Date	ID	Time	Description
☑	03/07/2012	0300	10:08	Infection
☐	03/07/2012	0200	10:00	Fall
☐	03/07/2012	0200	10:00	Fall
☐	12/16/2010	0200	07:45	Fall
☐	02/20/2009	0100	15:00	ER Visit

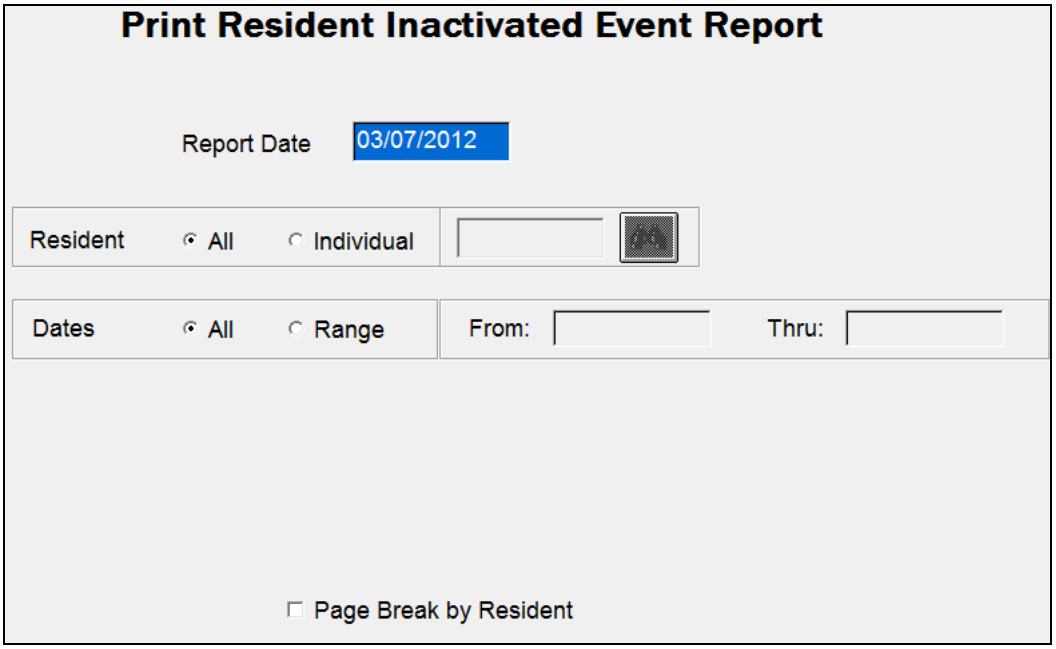


This event will no longer be displayed in the resident's event record.

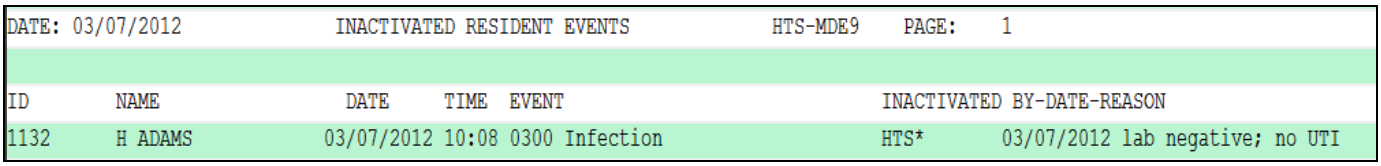
To view inactivated events, click Print. See next page.

Documentation > Events

Print the Inactivated Event Report



Select the items you want to review and click Print.



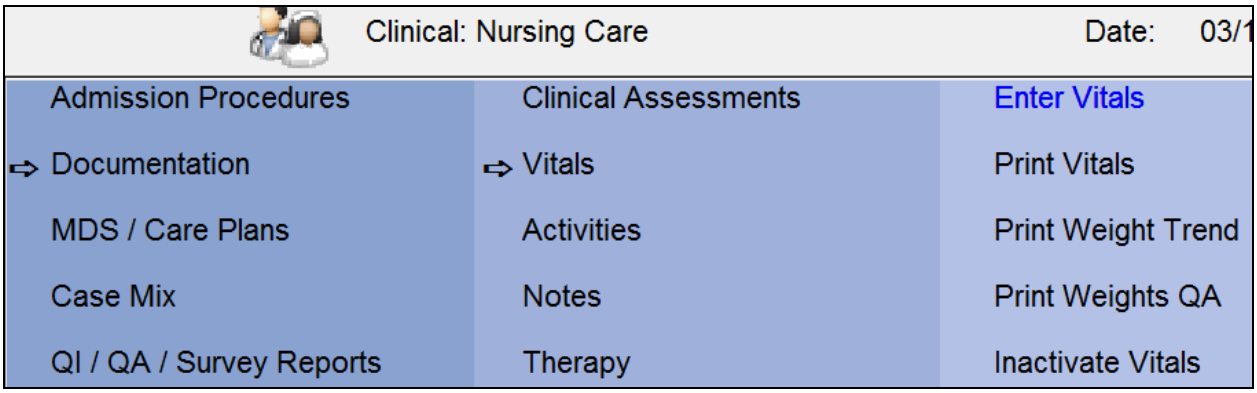
DATE: 03/07/2012	INACTIVATED RESIDENT EVENTS	HTS-MDE9	PAGE: 1

ID	NAME	DATE	TIME	EVENT	INACTIVATED BY-DATE-REASON
1132	H ADAMS	03/07/2012	10:08	0300 Infection	HTS* 03/07/2012 lab negative; no UTI

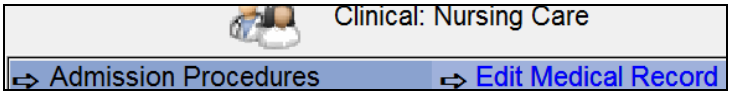
Documentation > Vitals

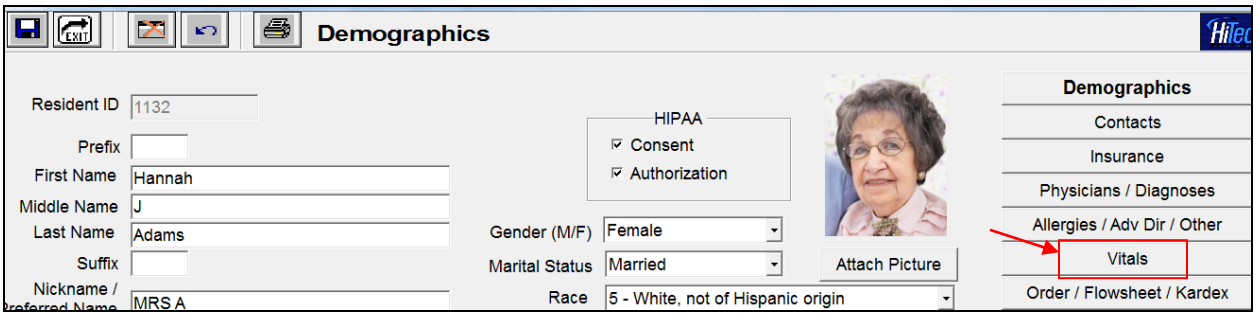
Residents' Vitals

You can record residents' **Vitals** through the Documentation menu shown below.



You can also access Vitals through **Edit Medical Record** shown below:





Click the Vitals button to launch the **Enter Vitals** program. See the next page.

View Vitals from Edit MDS and Edit RCA

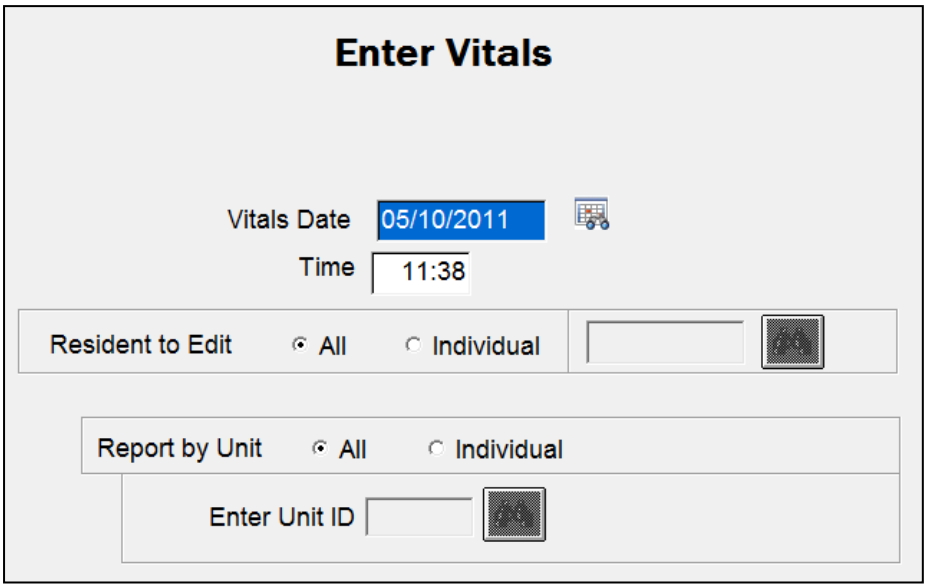
Hi-Tech has added View Vitals buttons to the following programs:

- **Edit MDS** > Section I, J and K
- **Edit RCA** (Maine & Vermont) > Section I, J and K, and import Height and Weight

Documentation > Vitals

Enter Vitals

NRH3

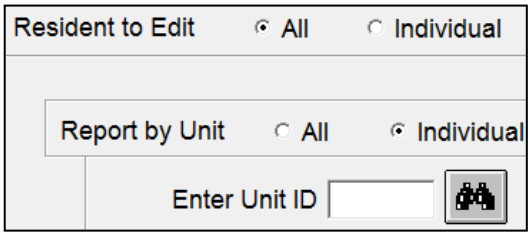


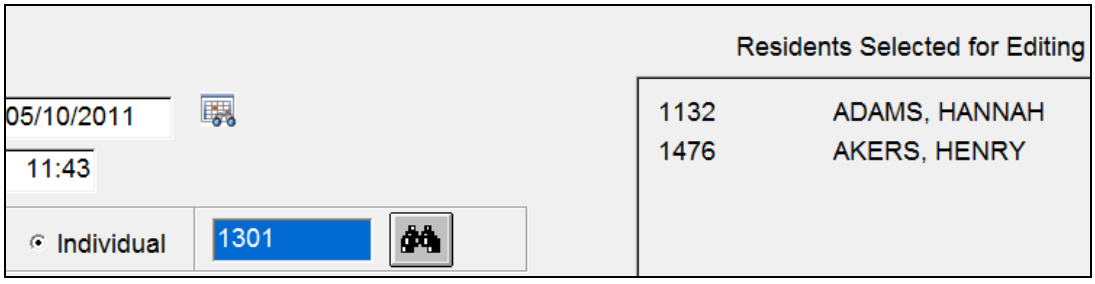
The Vitals Date and Time will default to the current date and be recorded with the vitals that you enter.

You can change the date and time here or on the vitals entry screen for individual residents.

Resident to Edit: select ⊙All to list all residents on the **Enter Vital** screen. If you select ⊙All, you can then select an ⊙Individual Unit and enter vitals for residents on that unit. (The residents must already be assigned to that unit through the Census program or on the Demographics screen of **Edit Medical Record**.)

Select ⊙Individual [Residents] to select the residents for whom you will enter vitals. These residents will be listed on the right side of the screen. When you click the Edit button, only these residents will be listed on the **Enter Vitals** screen.





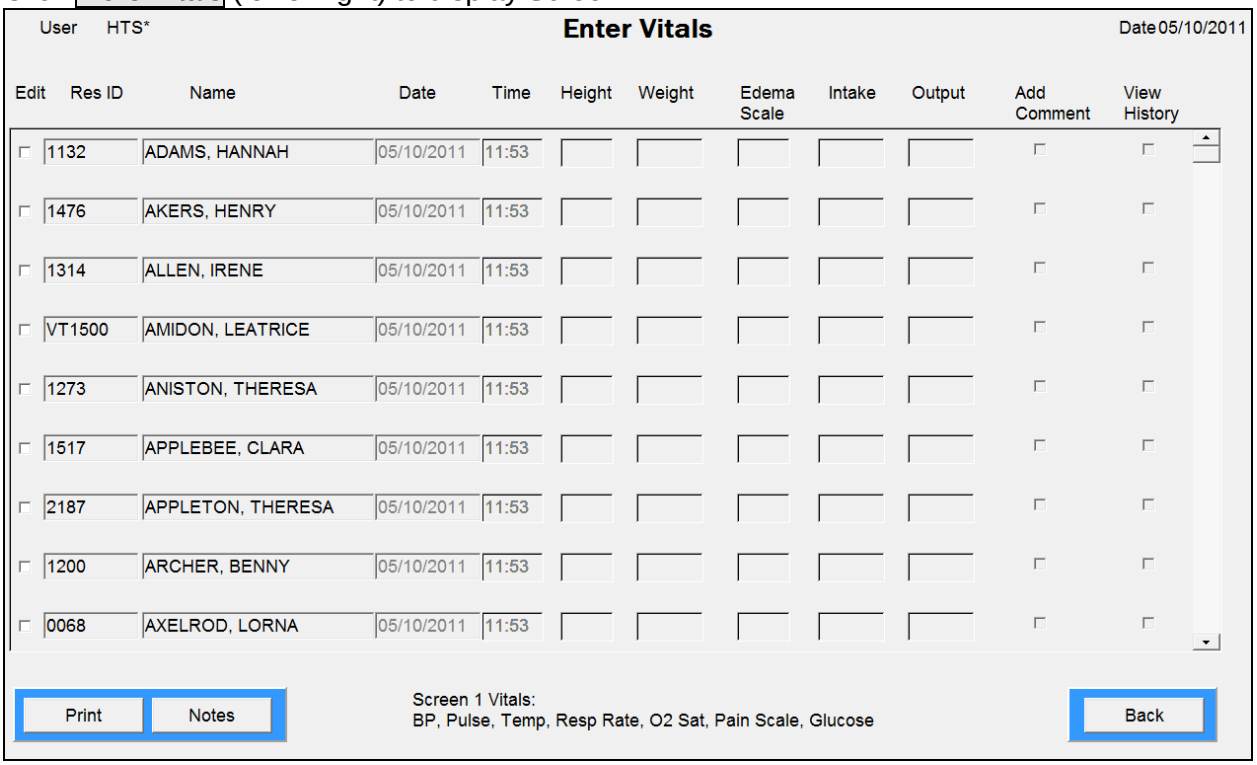
When you have made your choices, click the Edit button.

Documentation > Vitals > Enter Vitals

There are two Vitals entry screens that will list selected residents. Use the scroll bar to see more residents.

Screen 1:

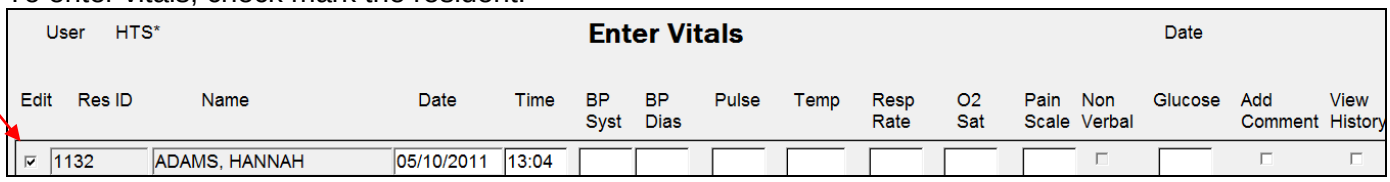
Click More Vitals (lower right) to display *Screen 2*:



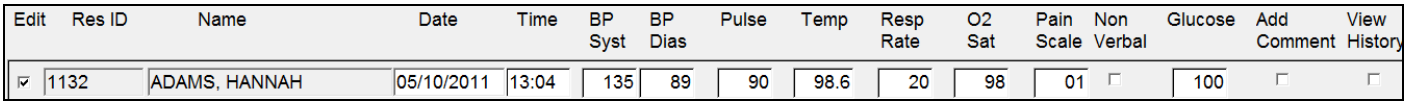
Click Back (lower right) to return to Screen 1

Documentation > Vitals > Enter Vitals

To enter vitals, check mark the resident:

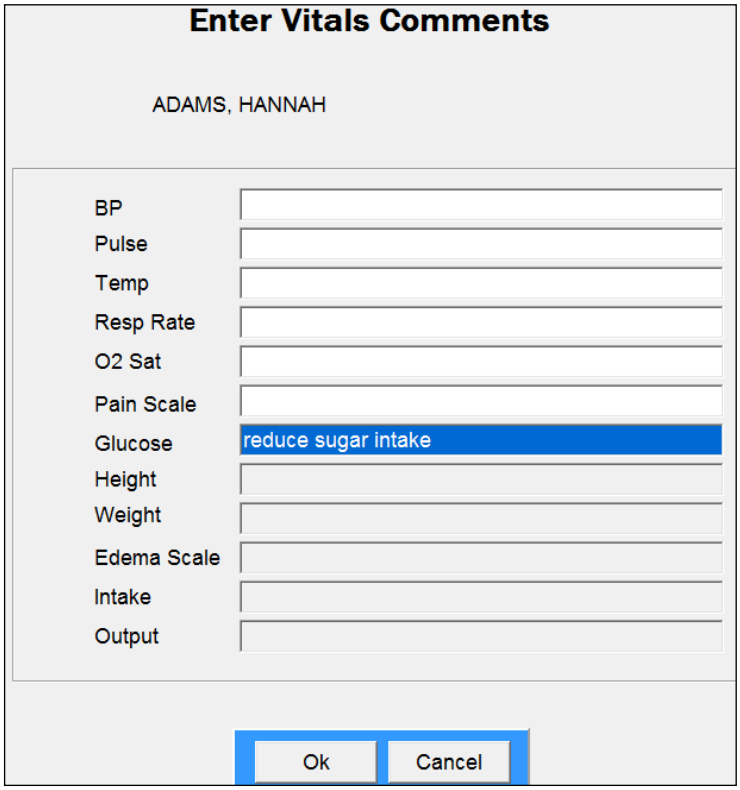


If necessary, change the Date and Time. Enter the vitals information.



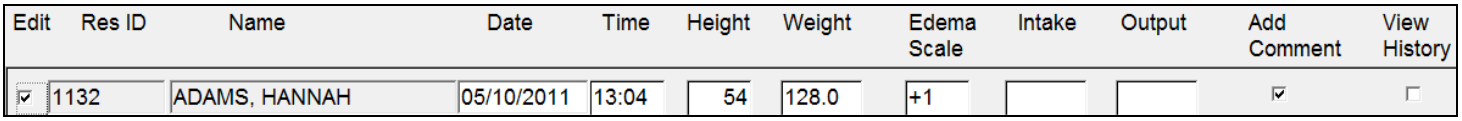
Pain Scale: check mark Non Verbal if that is how level of pain was determined.

☑Add Comment to display the **Enter Vitals Comments** screen (on right). Enter comments for any Vitals recorded on screen 1.
Click Ok to record the comments.

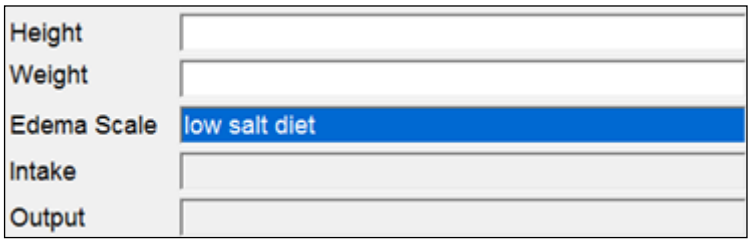


Click More Vitals (lower right) to display screen 2.

On Screen 2, checkmark the resident and enter the vitals information.

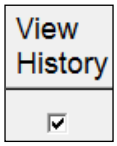


☑Add Comment to display the **Enter Vitals Comments** screen. Enter comments for any Vitals you have recorded on screen 2.
Click Ok to record the comments.



Documentation > Vitals > Enter Vitals

View Vitals History



Check mark View History to display *saved* vitals.

Note: Vitals being entered will not yet be included.
You must return to Screen 1 and click Save & Exit.
Reselect the resident and checkmark View History.

Vitals 30 Day History

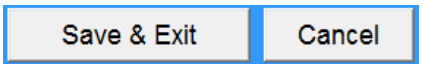
1132 ADAMS, HANNAH

Date	Time	User	Type	Reading	Non Verb	Comment
05/10/2011	13:04	HTS*	Weight	128.0		
05/10/2011	13:04	HTS*	Temperature	98.6		
05/10/2011	13:04	HTS*	Resp Rate	20		
05/10/2011	13:04	HTS*	Pulse	90		
05/10/2011	13:04	HTS*	Pain Scale	1		
05/10/2011	13:04	HTS*	O2 Sat	98		
05/10/2011	13:04	HTS*	Height	54		
05/10/2011	13:04	HTS*	Glucose	100		reduce sugar intake
05/10/2011	13:04	HTS*	Edema Scale	+1		low salt diet
05/10/2011	13:04	HTS*	Blood Pressure	135/ 89		

lower left.

Click Notes to add a Note regarding these Vitals using the existing Hi-Tech Notes program

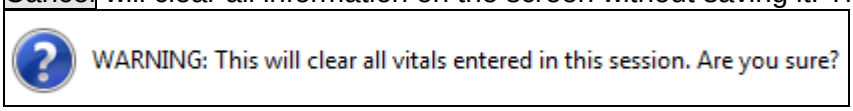
Click Print to launch the **Print Vitals** program. See Page 33.



lower right.

Save & Exit will record the information displayed on both screens and then return to the Enter Vitals select residents screen.

Cancel will clear all information on the screen without saving it. This choice will ask you:



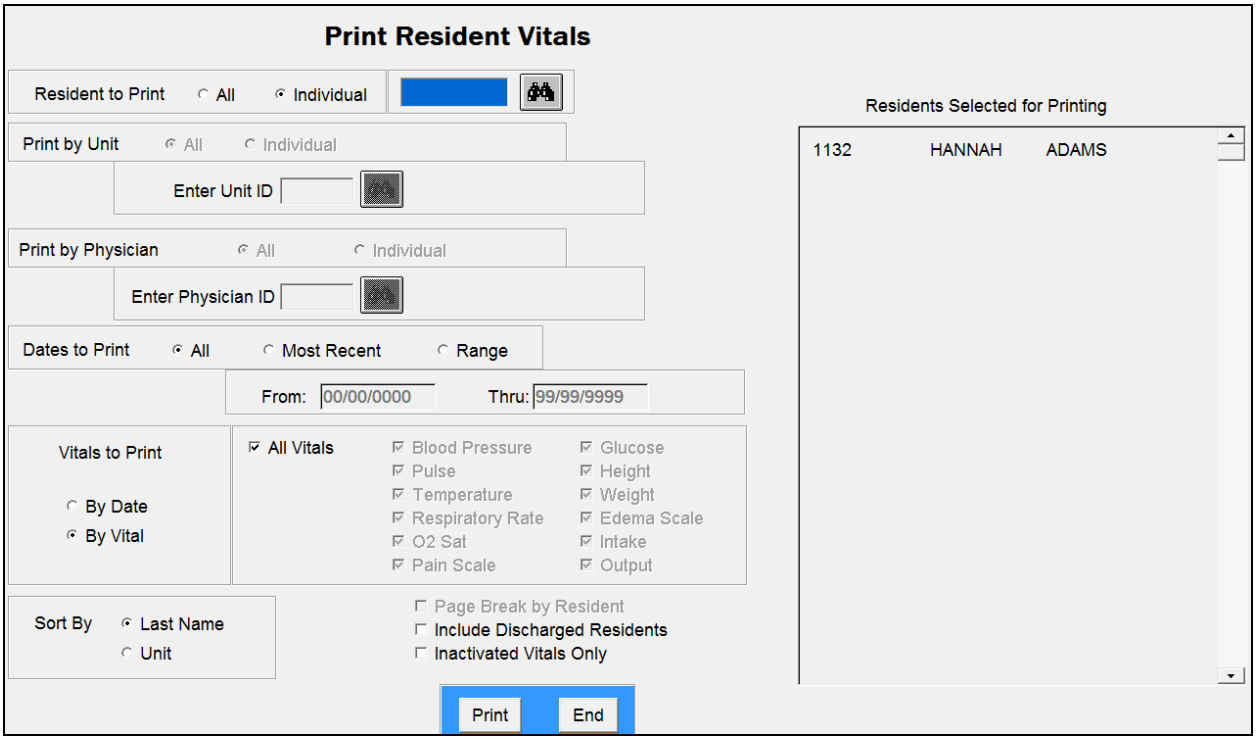
Click Yes to discard all the information without saving it.
Then click Save & Exit to close the program.

Documentation > Vitals

Print Vitals

NRH5

Select **Print Vitals** from the menu, or by clicking the Print button on the **Enter Vitals** screen.



Select the resident(s).If you select individual residents, each will be listed on the right side of the screen under Residents Selected for Printing.

Note that you can only select by Unit and Physician if you choose All residents.

Dates to Print: ⊙All, the ⊙Most Recent (as of today's date), or ⊙Range and enter a date range.

Vitals to Print in sequence By Date or By Vital.

Select ☑All Vitals, or uncheck All Vitals and select specific vitals.

Sort By: if printing for multiple residents, select ⊙Last Name or ⊙Unit.

☑Include Discharged Residents to include residents with a discharge date on EMR Demographics screen.

☑I Inactivated Vitals Only. See Page 34 for more information on inactivated vitals.

ID	NAME		DATE	TIME	TYPE	READING	COMMENTS
1132	HANNAH	ADAMS	05/10/2011	13:04	Weight	128.0	
			05/10/2011	13:04	Temp	98	
			05/10/2011	13:04	Resp Rate	20	
			05/10/2011	13:04	Pulse	90	
			05/10/2011	13:04	Pain Scale	01	
			05/10/2011	13:04	O2 Sat	98	
			05/10/2011	13:04	Height	54	
			05/10/2011	13:04	Glucose	100	reduce sugar intake
			05/10/2011	13:04	Edema Scale	+1	low salt diet
			05/10/2011	13:04	BP	135/ 89	

Documentation > Vitals >

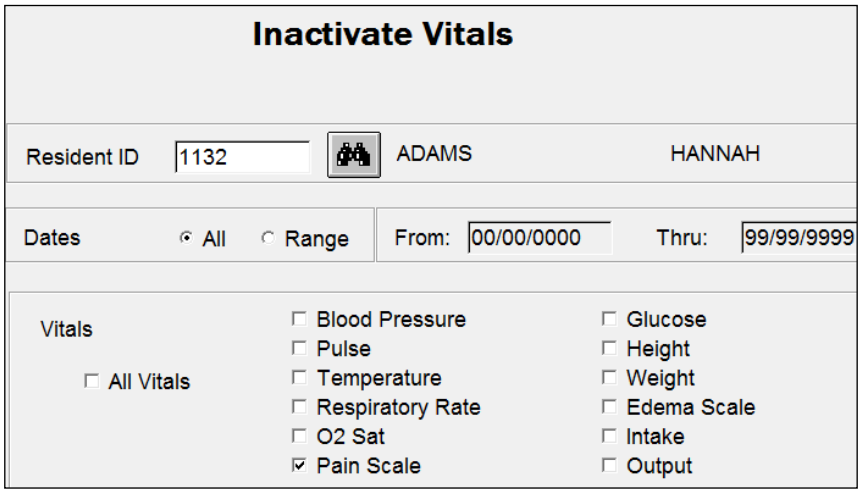
Inactivate Vitals

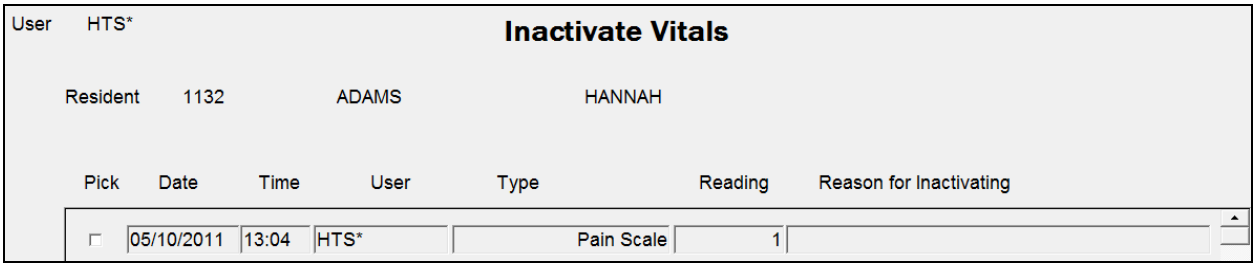
NRH4

If you enter inaccurate vitals information, you cannot change it. You must inactivate the information.

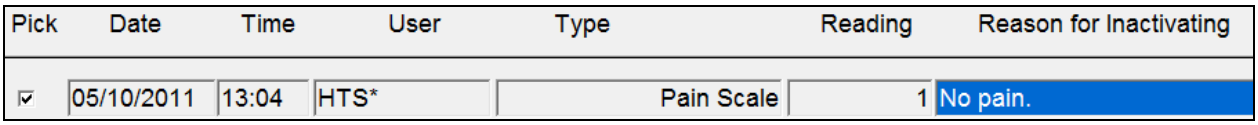
Select the Resident.
Dates: select All or Range and enter a date range.

Select the type of Vitals you need to inactivate. The selected items will be displayed:





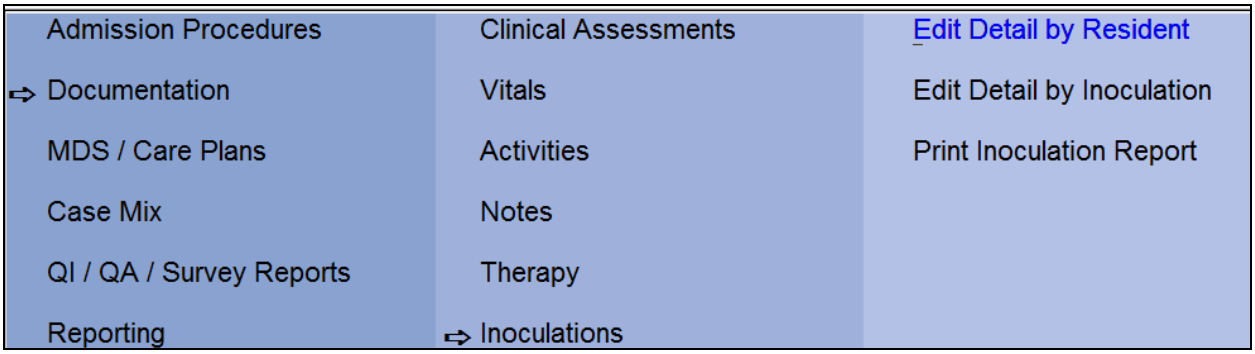
Checkmark the vitals to be inactivated and enter a Reason for Inactivating (required):



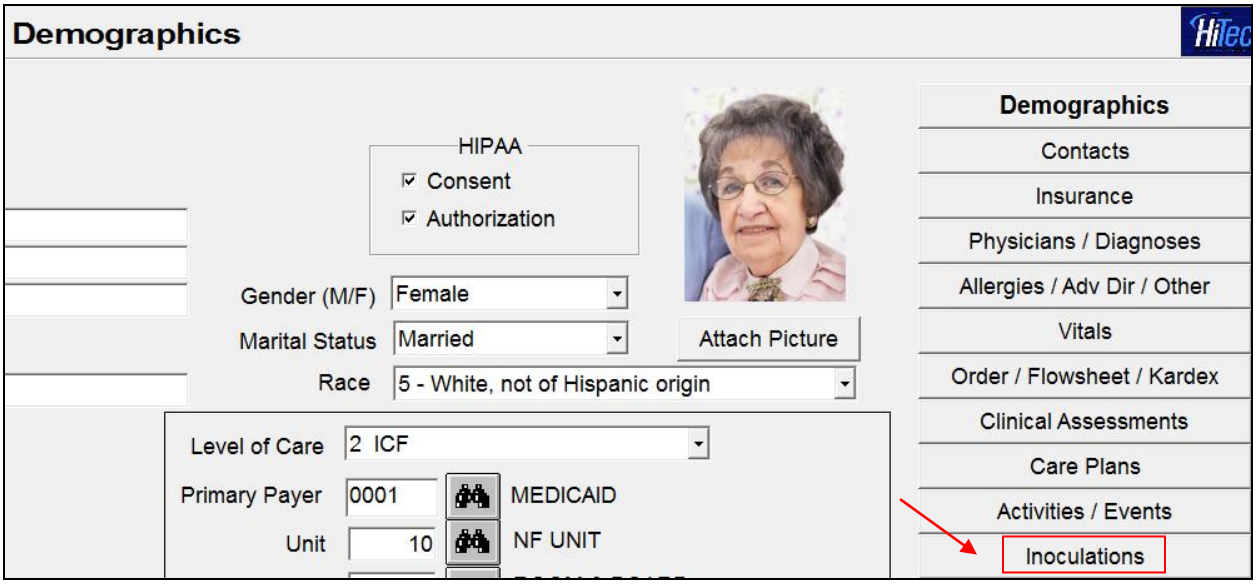
You can re-enter correct information through **Enter Vitals** to replace the information that you inactivate.

Documentation > Inoculations

Inoculations



You can also access Inoculations through **Edit Medical Record > Demographics**:



MDS 3.0 and RCA Records: View Inoculations

Edit MDS, Section O, click View Inoculations to display the resident's inoculation record so you can respond to O250 Influenza Vaccine and O300 Pneumococcal Vaccine.

Edit RCA:

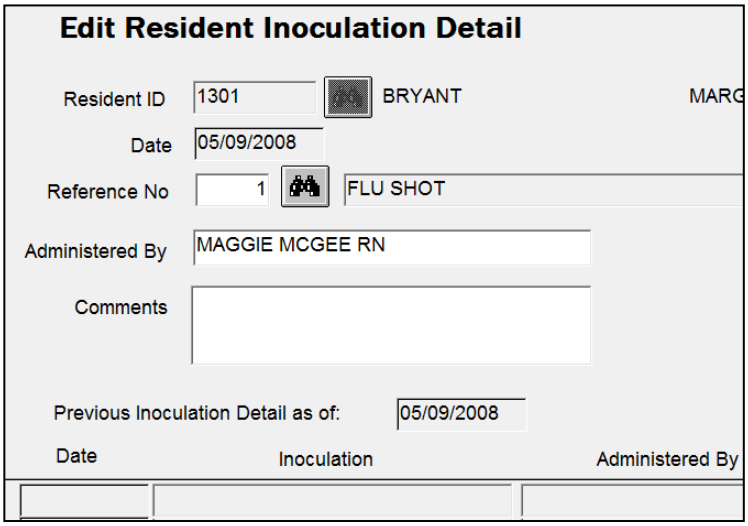
1. When you set up an inoculation code in the library, indicate that the inoculation satisfies the RCA Section T-1-e (Influenza) or RCA Section T-1-f (Pneumococcal).
2. Record those inoculations when given.
3. In RCA Section T, click Pull T-1-e/f responses from Inoculations Detail to update T-1-e and T-1-f automatically from these inoculation records.

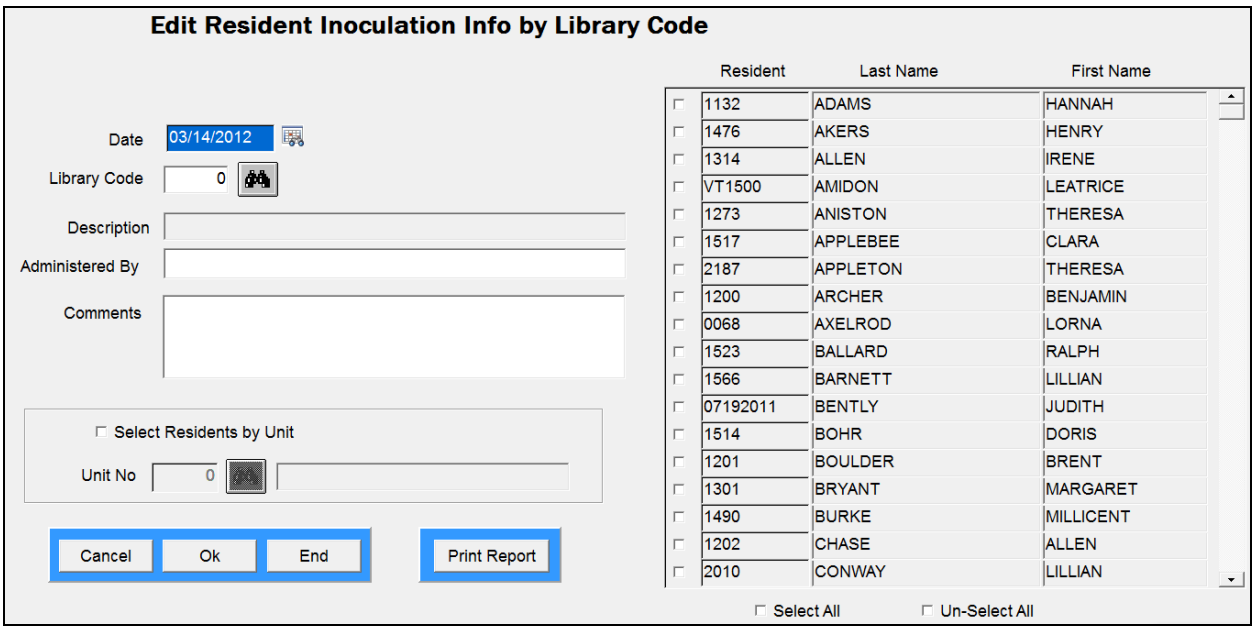
Documentation > Inoculations

Edit Detail by Resident

Edit Detail by Inoculation

(below) Use if several residents receive the same inoculation on the same day.
Print or view the inoculation report by clicking Print Report from either Edit program or through **Print Inoculation Report**.





Libraries > Documentation > Inoculations

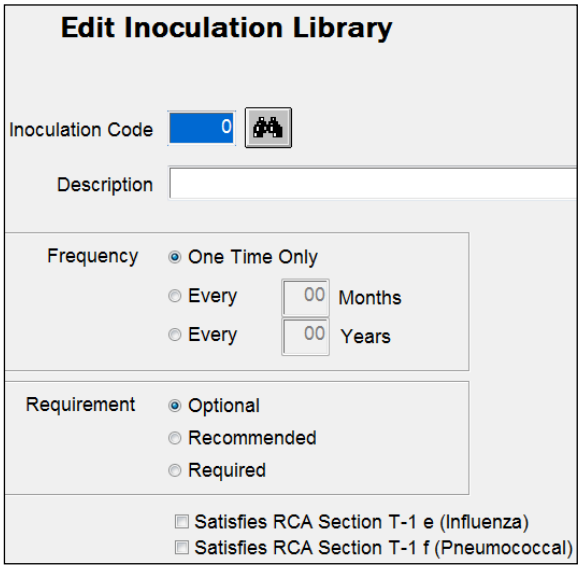
Inoculations Library

Create inoculations codes for all inoculations that will be administered to your residents.

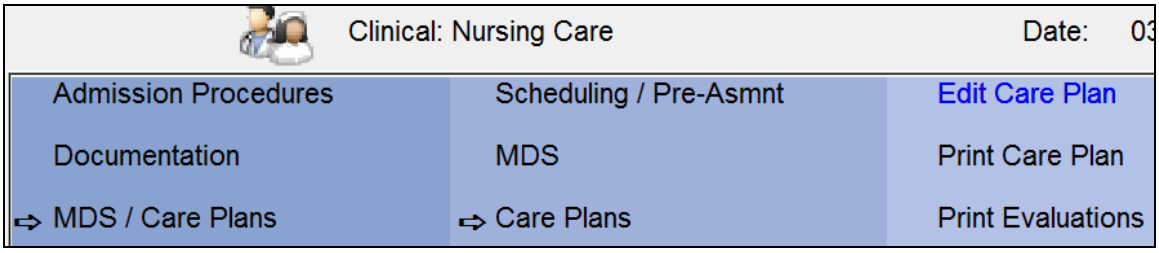
Select if an inoculation Satisfies RCA Section T-1-e (Influenza) or RCA Section T-1-f (Pneumococcal).

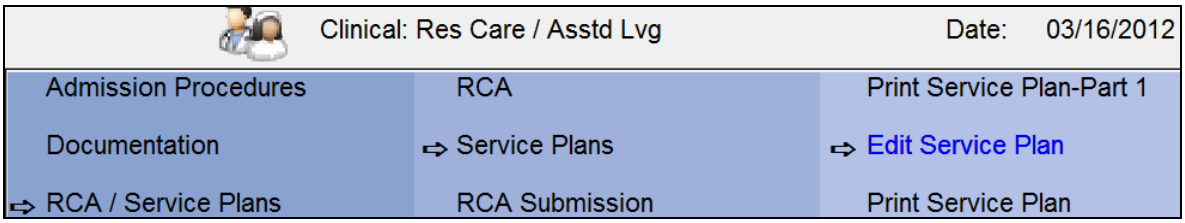
Record those inoculations when given.

When you complete the residents' RCA Section T, click Pull T-1-e/f responses from Inoculations Detail to automatically from the inoculation records linked to the Section T.



Care Plans





Sample Care Plan

First Page: Diagnoses, Allergies, problem list

RESIDENT CARE PLAN

HI-TECH NURSING & REHAB

DIAGNOSIS:
SCHIZOPHRENIC DISORDERS/OTHER SPECIFIED TYPES OF SCHIZOPHRENIA, UNSPECIF
DISORDERS OF CONJUNCTIVA/CONJUNCTIVITIS, UNSPECIFIED
EPISODIC MOOD DISORDERS/BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURR
MULTIPLE SCLEROSIS
SYMPTOMS INVOLVING HEAD AND NECK/OTHER SPEECH DISTURBANCE
DEFICIENCY OF B-COMPLEX COMPONENTS/OTHER B-COMPLEX DEFICIENCIES
TRIGEMINAL NERVE DISORDERS/TRIGEMINAL NEURALGIA

ALLERGIES:
TEGRETOL

DISCHARGE PLAN:
COMFORT CARE

Problem List:
0014 Lillian requires assist in performing ADLs due to decreased strength associated with exten
0016 Lillian is incontinent of bladder and is at risk for rash, skin breakdown, social isolatio

RESIDENT NAME	RESIDENT NO.	ROOM NO.	ADMIT DATE	BIRTH DATE	AGE	PHYSICIAN	
BARNETT, LILLIAN V	1566	046/2	05/04/2008	08/08/1919	92	BARKLEY, WILLIAM	
						DATE	PAGE
ALL ENTRIES MUST BE IN INK - THIS IS A PERMANENT PART OF THE HEALTH RECORD						11/01/2011	01

Problem with two goals and approaches attached to each goal.

RESIDENT CARE PLAN

HI-TECH NURSING & REHAB

Review Date/ Signature	Problem / Goal / Approach	Notes

Problem: 0014 Date: 08/15/2010 Type: Active
Lillian requires assist in performing ADLs due to decreased strength associated with extended illness and hospitalization for pneumonia.

Goal: 0001 Date: 08/15/2010
Lillian will receive assistance with ADLs and present a neat, clean, odor-free appearance daily.
Thru next review.

Approach: 0003 Disciplines: N NA
Provide assistance with ADLs as needed.

Approach: 0004 Disciplines: N NA
Encourage to participate in ADLs as much as possible.

Approach: 0006 Disciplines: N NA
Dress in clothes that are clean and in good repair daily.

Approach: 0008 Disciplines: N NA
Monitor for changes in ADL participation and notify charge nurse of changes for further evaluation and possible physician and responsible party notification.

Approach: 0011 Disciplines: N NA
Keep call bell within reach.

Approach: 0012 Disciplines: N NA
Encourage resident to request assistance when needed.

Goal: 0002 Date: 08/15/2010 Target: 11/07/2010
Resident will be able to trun self while in bed, and call for assistance when needed.

Approach: 0010 Disciplines: N NA
Resident utilizes 1/2 side rails on bed to help position self while in bed.

Approach: 0011 Disciplines: N NA
Keep call bell within reach.

Approach: 0012 Disciplines: N NA
Encourage resident to request assistance when needed.

RESIDENT NAME	RESIDENT NO.	ROOM NO.	ADMIT DATE	BIRTH DATE	AGE	PHYSICIAN
BARNETT, LILLIAN V	1566	046/2	05/04/2008	08/08/1919	92	BARKLEY, WILLIAM

ALL ENTRIES MUST BE IN INK - THIS IS A PERMANENT PART OF THE HEALTH RECORD

DATE	PAGE
11/01/2011	02

Problem with two goals and approaches attached to both of the goals

HI-TECH NURSING & REHAB

Review Date/ Signature	Problem / Goal / Approach	Notes

Problem: 0016 Date: 08/15/2010 Type: Active
Lillian is incontinent of bladder and is at risk for rash, skin breakdown, social isolation, infection, etc.

Goal: 0001 Date: 08/15/2010 Target: 11/07/2010
The resident will have no skin breakdowns or odors.
Thru next review.

Goal: 0003 Date: 08/15/2010 Target: 11/07/2010
Resident will remain free of infection. Thru next review.

Approach: 0001 Disciplines: N NA
Assess for causes of Urinary incontinence.

Approach: 0002 Disciplines: N NA
Encourage resident to ask for assistance or use call bell.

Approach: 0003 Disciplines: N NA
Maintain adequate hydration, monitor and document fluid intake.

Approach: 0004 Disciplines: N NA
Follow toileting schedule.

Approach: 0005 Disciplines: N NA
Use prompting to encourage resident to go to bathroom. Do not rush. Provide stimulation i.e., run water in the sink. Provide privacy.

Approach: 0007 Disciplines: N NA
Give positive reinforcement.

RESIDENT NAME	RESIDENT NO.	ROOM NO.	ADMIT DATE	BIRTH DATE	AGE	PHYSICIAN
BARNETT, LILLIAN V	1566	046/2	05/04/2008	08/08/1919	92	BARKLEY, WILLIAM

DATE	PAGE
11/01/2011	03

ALL ENTRIES MUST BE IN INK - THIS IS A PERMANENT PART OF THE HEALTH RECORD

Signature page

RESIDENT CARE PLAN

HI-TECH NURSING & REHAB

INITIAL CARE PLAN:

Advanced directives status reviewed: Date __/__/__ Init __.

Current Advanced Directives Status: Durable POA for health care (Date) __/__/__ Living Will (Date) __/__/__

Do not resuscitate (Date) __/__/__ Do not Hospitalize (Date) __/__/__

Discharge plan has been discussed as follows: __ Indefinite stay indicated __ Discharge to another setting is under consideration. See social service notes for details. Review all problems in ___ months

_____ _____ | _____ _____

_____ _____ | _____ _____

UDPATE:

Advanced directives status reviewed: Date __/__/__ Init __.

Discharge plan has been discussed as follows: __ Indefinite stay indicated __ Discharge to another setting is under consideration. See social service notes for details.
Problems, goals, approaches, and discharge plan reviewed (Date) __/__/__ and continue to be appropriate.
The following problems have been added to the current plan of care _____.

Review all problems in ___ months.

_____ _____ | _____ _____

_____ _____ | _____ _____

RESIDENT NAME	RESIDENT NO.	ROOM NO.	ADMIT DATE	BIRTH DATE	AGE	PHYSICIAN
BARNETT, LILLIAN V	1566	046/2	05/04/2008	08/08/1919	92	BARKLEY, WILLIAM

DATE	PAGE
11/01/2011	04

ALL ENTRIES MUST BE IN INK - THIS IS A PERMANENT PART OF THE HEALTH RECORD

Nursing Care Problem List

1. This resident suffers from delusions due to: As evidenced by:
2. Probable delirium as evidenced by confusion and disorientation.
3. The resident has impaired short term memory due to:
4. The resident suffers from the progressive cognitive and communicative deficits associated with Alzheimer's Disease.
5. Resident has memory problem, impaired decision making skills and impaired ability to comprehend.
8. The resident has decreased vision (specify)_____ and is at risk for complications.
10. The resident has difficulty making self understood due to dementia, difficulty being understood.
11. The resident has difficulty making self understood due to:
12. The resident has an alteration in hearing as evidenced by:
14. The resident requires up to ___assist in performing ADLs due to: (list diagnosis & specifics)
15. Decreased independence with ADLs due to:
16. The resident is incontinent of bladder due to:____ and is at risk for rash, skin breakdown, social isolation, infection, etc.
17. The resident requires the use of a Foley catheter due to: and is at risk for infection.
19. The resident is at risk for signs and symptoms of dehydration due to:
21. The resident requires special attention to oral care due to:
23. The resident has multiple risk factors for falls, such as:
24. History of falls.
28. The resident requires to be fed via_____tube due to:__ and is at risk for complications such as: dehydration, aspiration, infection.
29. Use of a feeding tube required related to history of impaired nutrition.
30. The resident is at risk for the development of pressure ulcers due to: (list all risks and diagnoses)

*31. The resident has an open area location:_____

33. Resident unable to perform own dental/oral care.
34. The resident requires the use of an anti-anxiety_____ due to:____ and is at risk for adverse reactions.
35. The resident requires the use of an anti-depressant_____ due to: ___and is at risk for adverse reactions.
36. The resident requires the use of an anti-psychotic_____due to: ____ and is at risk for adverse reactions.
38. The resident requires the use of a sedative-hypnotic____ due to: ___ and is at risk for adverse reactions.

*41. The resident requires the use of:___ due to:(list symptoms and medical condition.).

In an effort to attain or maintain the highest practicable physical, mental and psychosocial well-being of the resident.

*42. The resident is on a trial for restraint reduction: (list devices to be tried)

Reduction is being attempted in an effort to attain or maintain the highest practicable physical, mental and psychological well-being of the resident.

*52. Resident is at risk for decreased ambulation related to: unsteady gait, personal alarm, restraint use, surgical procedure, fracture, decreased strength and endurance.

*53. Resident is at risk for falls and needs assistance to ambulate related to: unsteady gait, inability to independently bear weight. cognitive deficit, general weakness

54. Resident has decreased/lack of motivation to ambulate related to: pain (specify), depression, difficulty ambulating, fear of falling, fatigue

57. Resident is at risk for decreased active range of motion related to: decreased mobility, diagnosis of:____

59. Resident is at risk for decreased active range of motion related to: decreased mobility, diagnosis of:____

62. Resident is unable to independently move self in bed related to: weakness, confusion, obesity, fracture, hemiparesis

65. Resident has difficulty communicating with others related to: cognitive deficit, aphasia, hearing loss, inability to finish thoughts, longer response time, slurred speech

68. Resident is unable to independently feed self related to: confusion, arthritis, contractures, weakness, short attention span, decreased mobility to upper extremities

71. Resident requires assistance with the following tasks: bathing, upper body dressing lower body dressing, hair grooming, brush teeth or denture care, applying lotion, applying deodorant, applying makeup, shaving, other (explain)
Related to: cognitive impairment, diagnosis:___, weakness, tremors, shortness of breath, pain (specify)

74. Resident is at risk for contractures related to: decreased mobility, hemiplegia, diagnosis_____

*75. Resident has decreased mobility and is unable to actively range joints related to: Contractures, hemiplegia, diagnosis_____

78. Resident is at risk for contractures related to: decreased mobility, hemiplegia, diagnosis_____

79. Resident has a contracture of the _____ related to: decreased mobility, hemiplegia, diagnosis:_____

*82. Resident is at risk for aspiration related to swallowing problems, other (explain)

83. Resident has difficulty swallowing related to: Alzheimer's disease or dementia, Cancer of the esophagus, CVA, Multiple Sclerosis, Parkinson's Disease, Throat pain

*84. Resident pockets food related to: Alzheimer's disease or dementia, CVA, Parkinson's Disease, Throat pain, Chewing difficulties

87. Resident (is at risk for urinary incontinence or has incontinent episodes) related to: cognitive deficit, inability to feel urge to void, chronic UTIs, decreased ability to get to and from toilet / commode / bedpan, frequent dribbling

90. Resident is unable to independently transfer self related to: weakness, confusion, restraint use,

fracture, hemiparesis

92. Alteration in comfort related to episodes of breakthrough pain.

95. __End of Life OR __End of Life non-terminal

97. Resident needs cognitive stimulation and socialization.

98. Resident is not comfortable attending or participating in large group activities.

99. Resident often falls asleep (closes eyes and doses off) during activity programs.

101 Resident often suffers discomfort due to pain.

Residential Care and Assisted Living Problem List

Using I Care Plan Language

Assist with ADL/IADL

_____300. My memory is not what it used to be, and I sometimes need your help with personal hygiene.

_____305. I need your help to keep clean, to get dressed, to eat and to meet my bathroom needs because I cannot physically or cognitively do it myself.

_____310. I cannot get around without your help because I have had a stroke.

Social & Emotional Issues & Behavioral Symptoms

_____325. I will need your support as I transition into my new living environment. I am not used to having so many people around or having a roommate, and I miss my own home.

_____330. I prefer self-directed activities such as:_____

_____335. I no longer remember things, so I cannot communicate my needs. When this happens, I become agitated.

Medical Management Issues

_____350. I have a history of having UTI's due to: __Poor hygiene habits; __Poor fluid intake; __My catheter; __Diabetes Mellitus

_____353. I have high blood pressure and need your support to follow my Doctor's recommendations.

_____355. I do not always tell people when I am uncomfortable or in pain.

_____357. I have had some rashes and sore areas in the past.

_____361. I have a high risk for injury because of my __dementia; __seizure disorder; __restlessness.

_____362. My mobility is impaired because I can not understand or follow instructions. Due to _Stroke, _Dementia, _Mental Status.

_____363. I am legally blind and I have been told that my decisions are not always safe. As a result I have fallen a lot and been hurt.

_____375 I often refuse to participate in activities and stay in my room because I am in pain.

Using Traditional Language

Assist with ADL/IADL

_____500. Resident needs assist with bathing, personal hygiene, oral hygiene, dressing, undressing.

_____501. Resident needs assist with toileting, personal hygiene related to toileting, managing incontinent supplies.

_____502. Resident needs assist with eating.

_____503. Resident needs assist with safe transfer.

_____504. Needs supervision or assist with mobility or locomotion to ensure safety in environment by: Improving stability in ambulation, Maintaining current status of mobility, Reduction of hazards of immobility

_____505. Needs assist with ADL functions due to limited mobility of arm/hand.

_____511. Needs assist with telephone use.

_____514. Needs assist with managing finances: Handling cash, making purchases,

Banking, checkbook & writing checks, reconciling checkbook, keeping cash safe

_____516. Needs assist with arranging shopping: making list, obtaining help.

_____518. Needs assist with transportation: making arrangements, keeping appointments.

_____519. Needs assist with safe medication procedure: preparation, administration, documentation, tracking, obtaining, securing.

Social & Emotional Issues & Behavioral Symptoms

_____524. Monitor & evaluate for behavioral symptoms: Frustration, anger

verbal abuse, threats, physical abuse, resistance to care, change in mental functioning

_____525. Support needed to: adjust to new environment, adjust to change in life situation; maintain contact w/family & friends.

_____526. Emotional disturbance which hinders functioning: anxiety; agitation; isolation; depression, crying/calling out, fear.

_____527. Social isolation related to: depression; hearing deficit; withdrawn behavior; cognitive decline; no family involvement.

_____528. Short term memory impairment, resulting in: wandering out of facility; into others' rooms; forgetting essential ADL's; frustration; adverse behavior; impaired social interaction

_____529. Grieving, related to: Loss of significant person, independence, home, control over life situation, functional abilities

_____530. Resident displays ineffective coping skills.

_____531. Sleep pattern disturbance; Poor sleep havits, Change in sleep habits.

_____532. Behavior management -- Resistive to care. Diet/eating; bathing/hygiene; dressing; taking medication; ambulation

_____533. Intimidating behavior. Makes others feel unsafe or at risk; invades others' privacy

_____534. Easily manipulated by others.

_____535. Evaluation of behavior. Monitor for behavioral changes: frustration, anger, verbal abuse, physical abuse, threats, resistance to care, change in mental function

_____536. Behavior Management__VERBAL ABUSE of others: threatens, screams at, swears at, unreasonable demands; PHYSICAL ABUSE of others: hits, shoves/scratches, sexually abuses

_____537. Behavior Management: Socially inappropriate or disruptive behavior: sexual behavior, disrobes in public, smears/throws food or feces, rummages in others' belongings, makes disruptive sounds

Activity Needs & Recreational Issues

_____539. Motivational activities needed to:_____

_____540. Need for participation in activity program, specifically group activity; resuming former hobby or interest; socialize with peers, community involvement, motivational activities, diversional activities.

Communication

_____545. Impaired hearing/vision, resulting in_____

_____546. Impaired communication; difficulty expressing self; understanding others; following directions; making needs known.

Medical Management Issues

_____550. At risk for INFECTIONS (UTI / URI / SKIN); UTI risk due to: HX of UTI, Poor hygiene habits, Poor fluid intake, Catheter, Diabetes Mellitus.

_____551. Impairment of skin integrity. Incontinence, poor circulation, poor hygiene habits

_____552. Ineffective breathing pattern related to COPD.

_____553. Hypertension (med controlled); at risk for orthostatic hypotension.

_____554. Seizure disorder; at risk for injury.

_____555. Tendency toward constipation. Poor fluid intake, lack of activity, chronic constipation, psychological factors, medication

_____556. Pain or discomfort. Chronic, acute or sporadic. Arthritis, headache, joint pains, generalized discomfort, phantom pains, abdominal discomfort

_____557. Special care required due to diabetes mellitus. Special diet, foot care, exercise regimen, complications of insulin therapy

_____558. Recent weight loss. Due to medical problem, depression, ill-fitting dentures, mouth pain

_____559. Dietary limitations related to: diabetes mellitus; gastric problems; medications, food allergies.

_____560. INCONTINENCE, requiring scheduled toileting plan due to:

Urinary incontinence (stress, incontinence stress, functional dementia, urge); Bowel incontinence

_____561. Tendency toward DIARRHEA related to: Medication, Loss of part of intestinal tract, Intolerance to certain foods, Excessive consumption of, Ileostomy

_____562. Anti-Coagulant Therapy: Specific observation and prevention of complications.

_____569. Potential for injury related to TOBACCO abuse and safety related to smoking.

Miscellaneous Issues

_____570. Health maintenance & related issues.

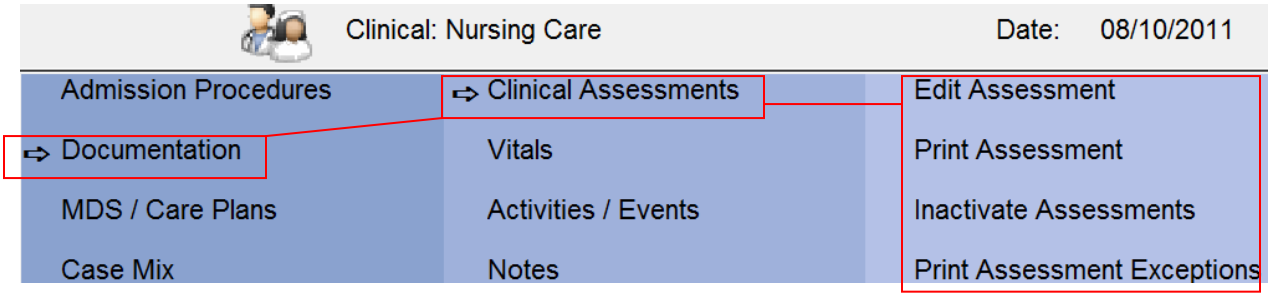
_____571. Discharge planning - assist needed for preparations to live independently.

_____574. Supportive Care: Comfort measures

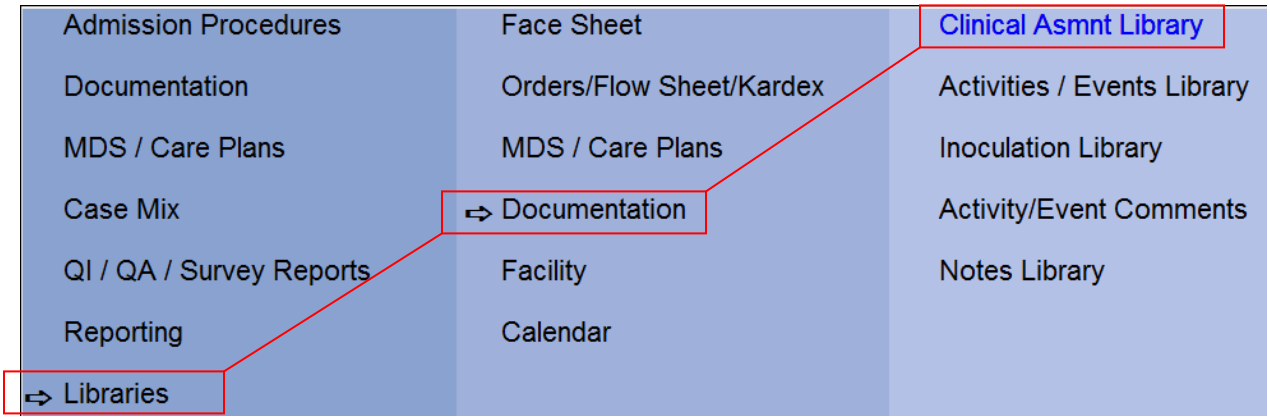
_____575. At high risk for FALLS because of: dizziness, unsafe habits, poor vision, confusion/dementia, balance problem

Clinical Assessments

Clinical: Nursing Care *or* **Clinical: Res Care / Asstd Living**
> Documentation > Clinical Assessments



Edit and create Assessment templates: **Libraries > Documentation > Clinical Asmnt Library**



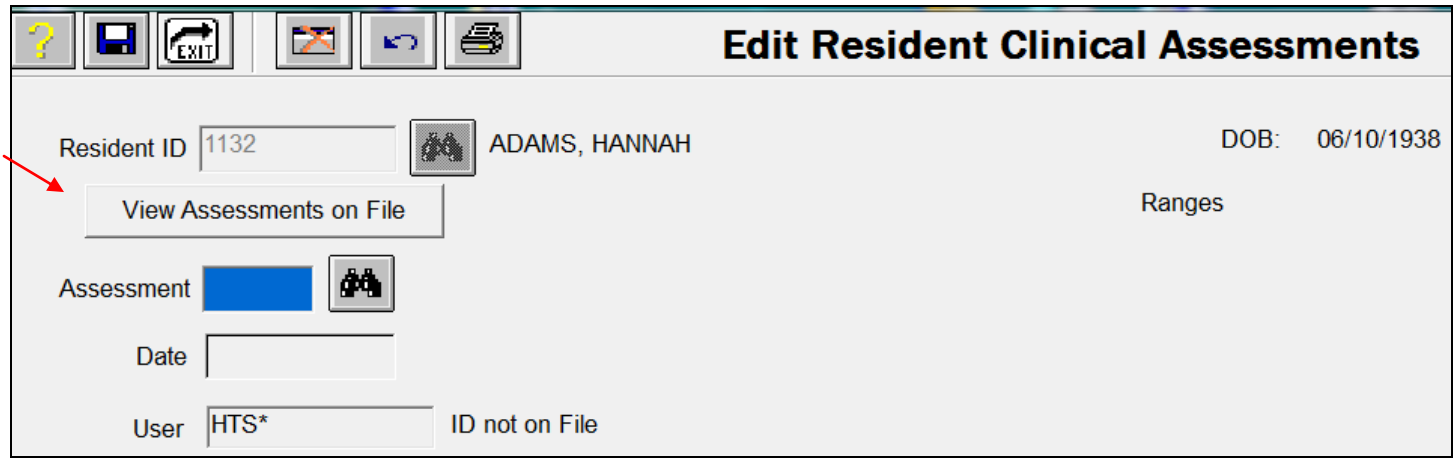
Hi-Tech has defined and provided the following Clinical Assessment areas in the Clinical Assessments Library.

You can edit and add your own assessments through
Libraries > Documentation > Clinical Asmnt Library.

- Risk for Falls
- Bowel & Bladder Training
- Contracture Risk
- Risk for Dehydration
- Nutritional Risk
- Skin Risk
- BIMS Brief Interview Mental Status
- PHQ-9 Mood Interview
- AIMS (Abnormal Involuntary Movement Scale)

Edit Assessment

NRE6



User: **IMPORTANT:**

If this is not your User ID, log out and log back in under your User ID.

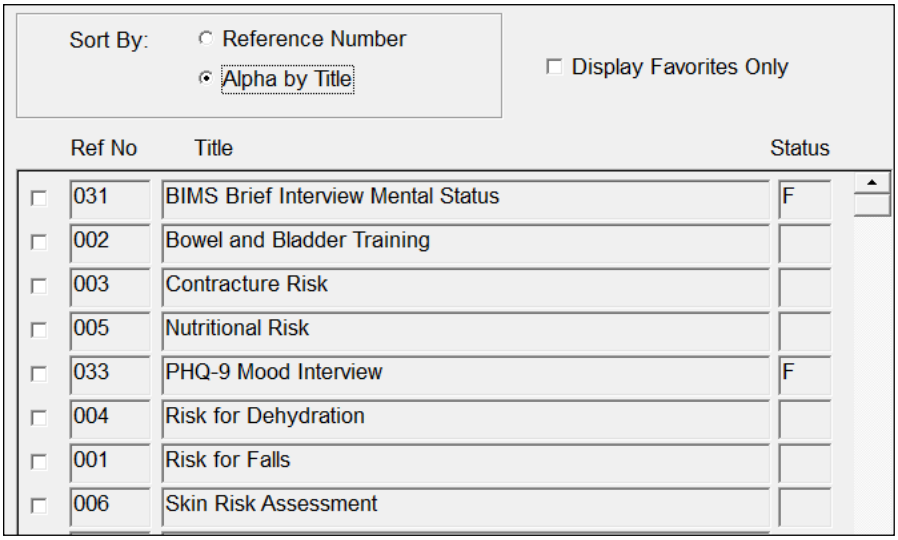
- The User ID is attached to the Assessment record.
- An assessment created by one User cannot be edited by another user.
- You cannot change the User ID from this program.

1. Enter or select the Resident ID.
2. Click View Assessments on File fo view a list of current assessments:

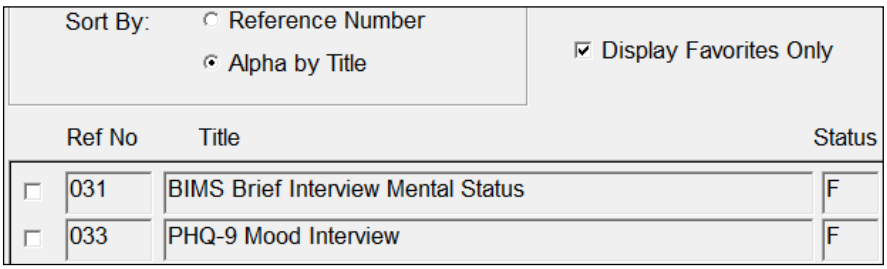
	Assessment		Date	User	Status
☐	015	Norton Plus Pressure Ulcer Sca	01/23/2012	SALLY	
☐	050	Pressure Ulcer Risk Assessment	01/13/2012	SALLY	
☐	100	Assessment of Urinary Incontin	08/25/2011	HTS*	
☐	100	Assessment of Urinary Incontin	08/25/2011	SALLY	
☐	001	Risk for Falls	01/05/2010	CRB	
☐	001	Risk for Falls	01/10/2009	CRB	Locked

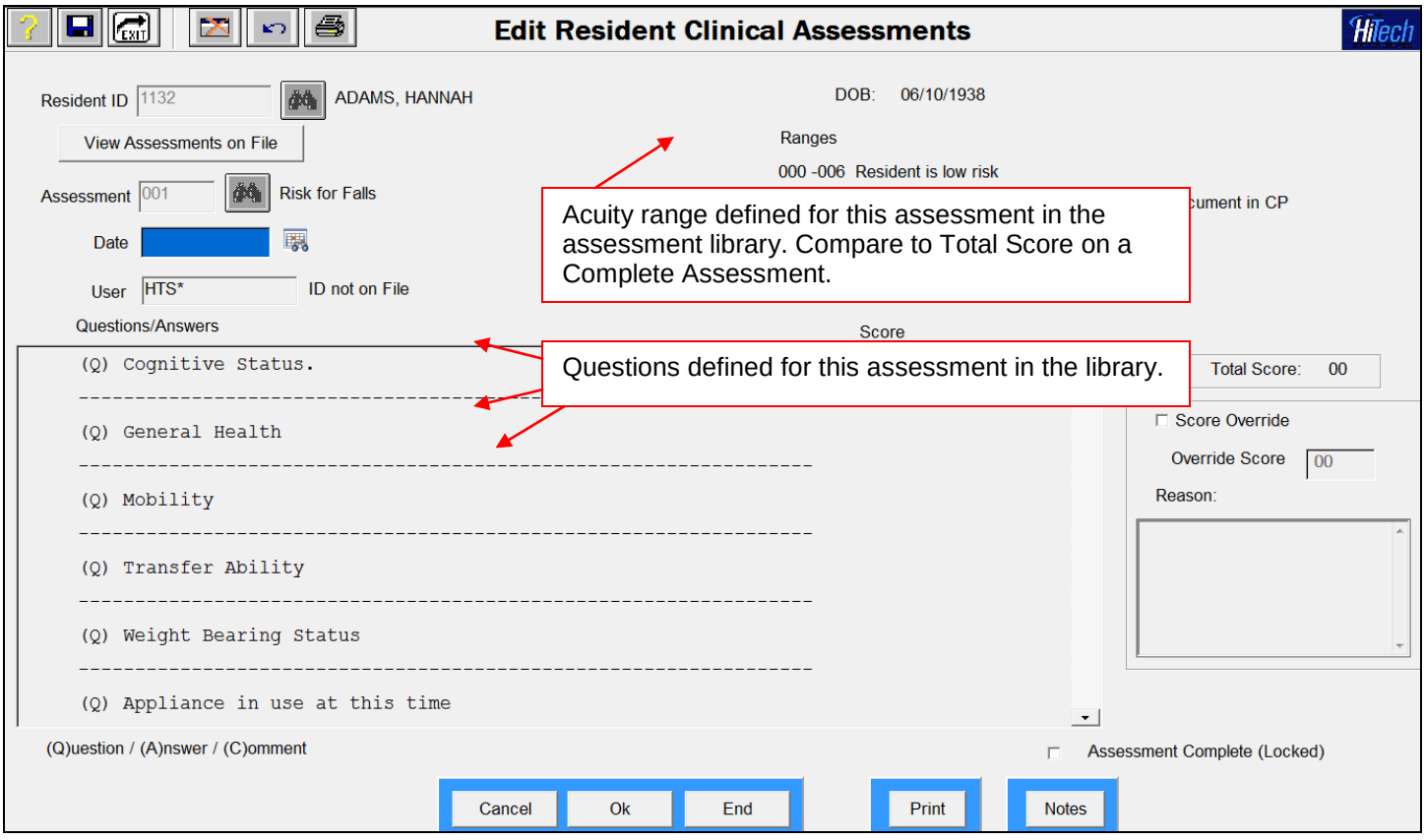
You can select an assessment from this list to view the details of the assessment.

3. Enter the Assessment reference number. Click the binoculars icon to list and select an Assessment (shown on right).
4. Sort By:
   Reference Number or Assessment Title.
5. Status:
   F = Favorites
   I = Inactive



6. Select ☑ Display Favorites Only to display the Assessments flagged as Favorites in the library.
7. The screen below displays Assessment 001: Risk for Falls:



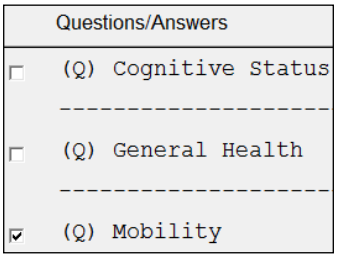


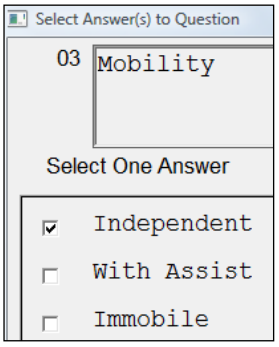
8. Date: Enter or select the date for a new assessment or existing assessment that is not yet Complete.
   Click View History to list and select ***existing*** assessment.
   NOTE: You can create multiple assessments on the same date.

	Date	User	Status
☐	08/10/2011	HTS*	
☐	08/04/2011	HTS*	
☐	07/26/2011	HTS*	Locked

   - You can edit assessments until they have been Locked.
   - You can view but *not* change Locked assessments.
   - View History will display assessments entered by all Users.
     You can view the answers of another User's assessment, but you cannot edit or lock another User's assessment.

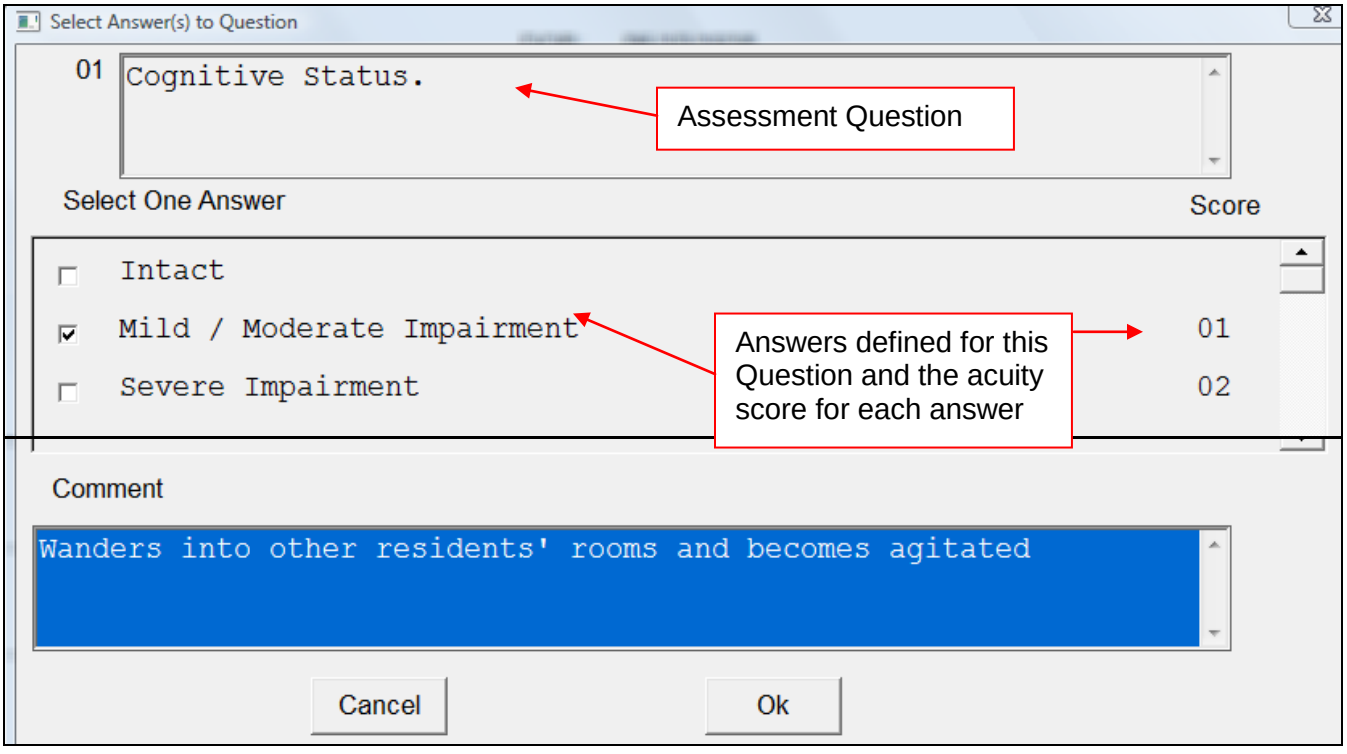
9. After you enter or select a Date, the screen will display each Assessment Question (Q) so you can select the one you want to answer or edit (on the right).





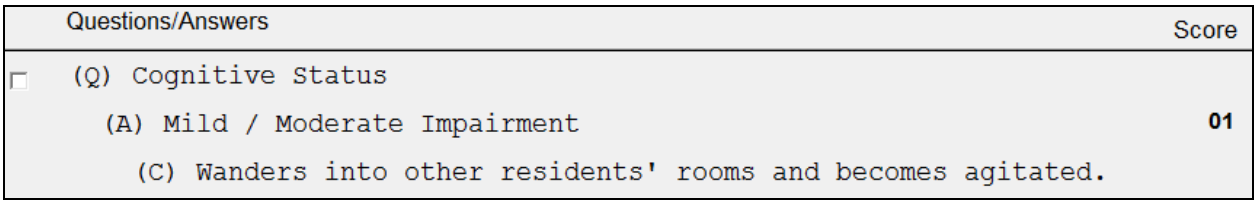
10. Checkmark the Answer to that Question.
    NOTE: In the library you can set up Questions to allow for multiple Answers (shown on the right).
    Enter a comment if necessary.

    The following screens show the selected Question, Answer and Comment.



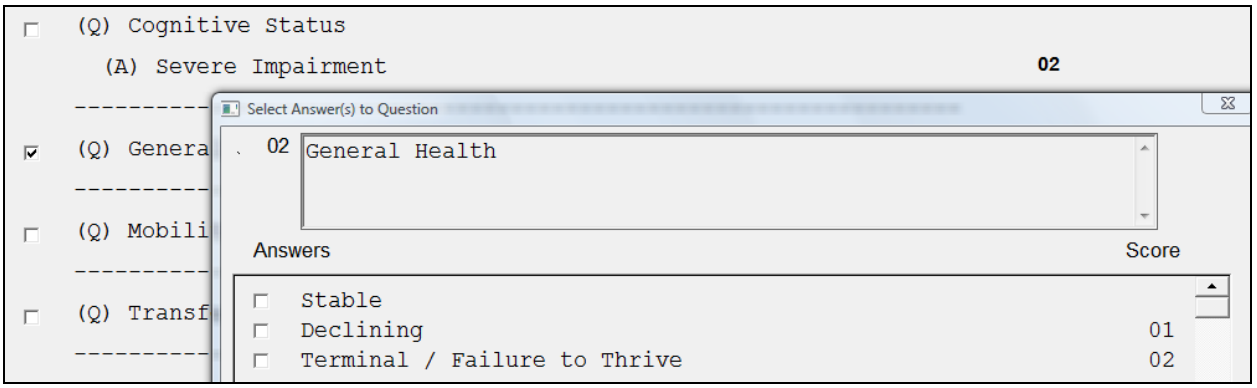
NOTE: If the library template includes **Help** text, you can click the Help button to display that text.

11. Click Ok to save the entries. The Question, Answer, Score and Comment will be displayed:



(Q) = Question (A) = Answer (C) = Comment

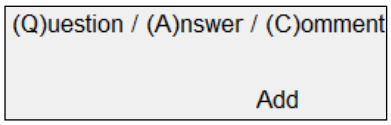
12. New Assessments will be in Add* mode and the program will automatically display the next Question that has been defined for the Assessment. For example, after you click Ok to save the Cognitive Status Question, the screen displays 02 General Health (shown below).

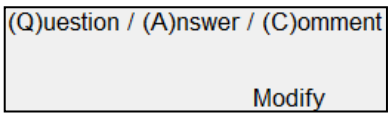


You can continue through the entire assessment this way, selecting Answers to each Question, or you can click the Cancel button to exit the question on display and then manually select the questions you want to add to the assessment.

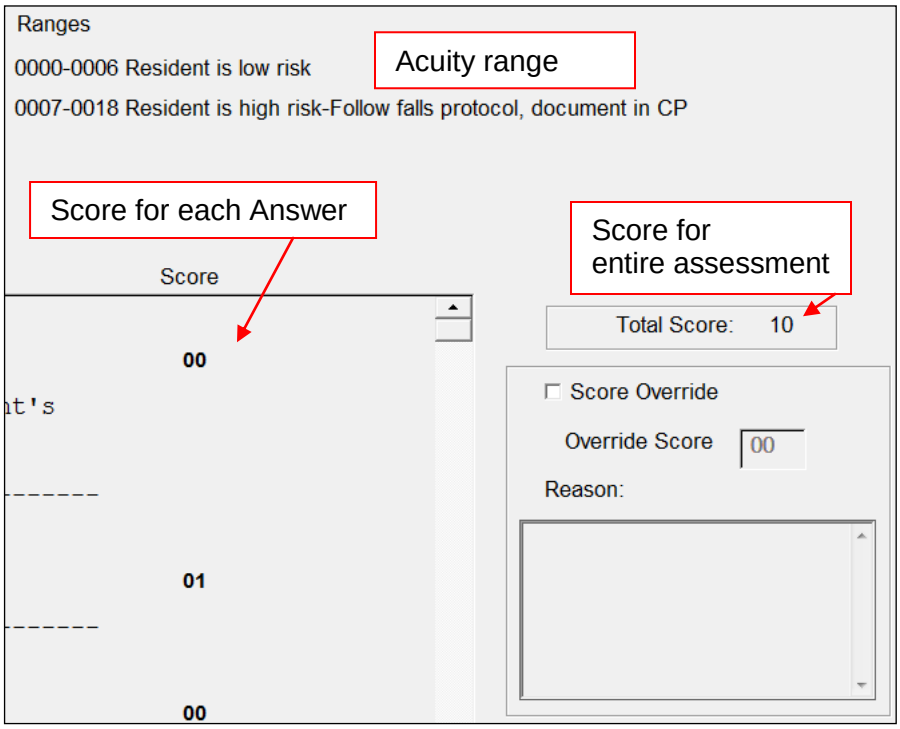
*Add: The program is in Add mode when you start a new assessment.

The word Add displays in lower left corner). If you return to edit an existing assessment Modify will display at the lower left.





Scoring



As you select Answers for Assessment Questions, the program displays the score for each answer in the Score column.

The sum of the answer scores are displayed at Total Score (right side of the screen).

You can compare the Total Score to the Acuity Ranges listed at the top-right corner of the screen. For example: The Total Score of 10 displayed on the right would fall into the 0007-0018 high-risk range.

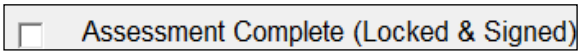
☑ Score Override: Select this item if you want to change the score assigned by the program. Provide a Reason.

For example: When you do a BIMS or PHQ-9 assessment, the resident might give you four or more nonsensical answers. You can enter 99 as the Override Score to reflect the nature of those responses and to reflect the scoring you have also used on the MDS.

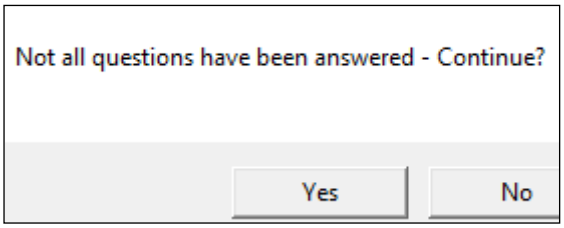
NOTE: Define acuity Ranges in the **Assessment Library > Assessment ID > Scoring Ranges**. In the library, you can also designate non-scored assessments and non-scored questions within a scored assessment.

Complete and Lock an Assessment

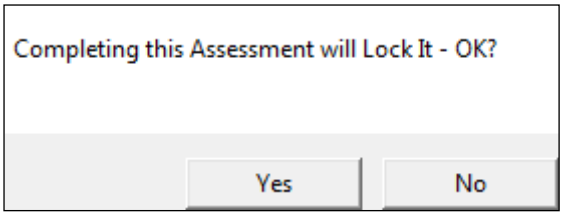
If you have decided an assessment is complete, checkmark ☑Assessment Complete (Locked).
or ☑Assessment Complete – (Locked & Signed) if you allow *electronic signatures* and this resident has permission.



If all Questions are not answered, and you select ☑Assessment Complete (Locked), or Locked & Signed, the screen will display:
Not all questions have been answered – Continue? Click Yes to Continue.



The screen will display the message: Completing this Assessment will Lock It – OK?



- If you click Yes, you will *not* be able to change this assessment.
  You will be able to view and print it.
- If you discover errors in a locked assessment, you can *Inactivate* it. See Page 56.
- If you click Yes, the program will allow you to schedule the next assessment of this type and it will be added to the resident's calendar.

  You should understand how to use the Hi-Tech *Clinical Calendar* if you plan to use this feature..

Buttons at Bottom of Screen

Cancel: Do not save any of the choices or changes. (Add mode only.)

Ok: Save all entries on the screen. Return to Resident ID for next entry.
NOTE: If the assessment does not have any answered questions, it will not be saved.

End: Save all entries on the screen and return to the menu.

Print: Launch **Print Assessment**. The displayed resident and assessment will be selected for printing. See Page 53.

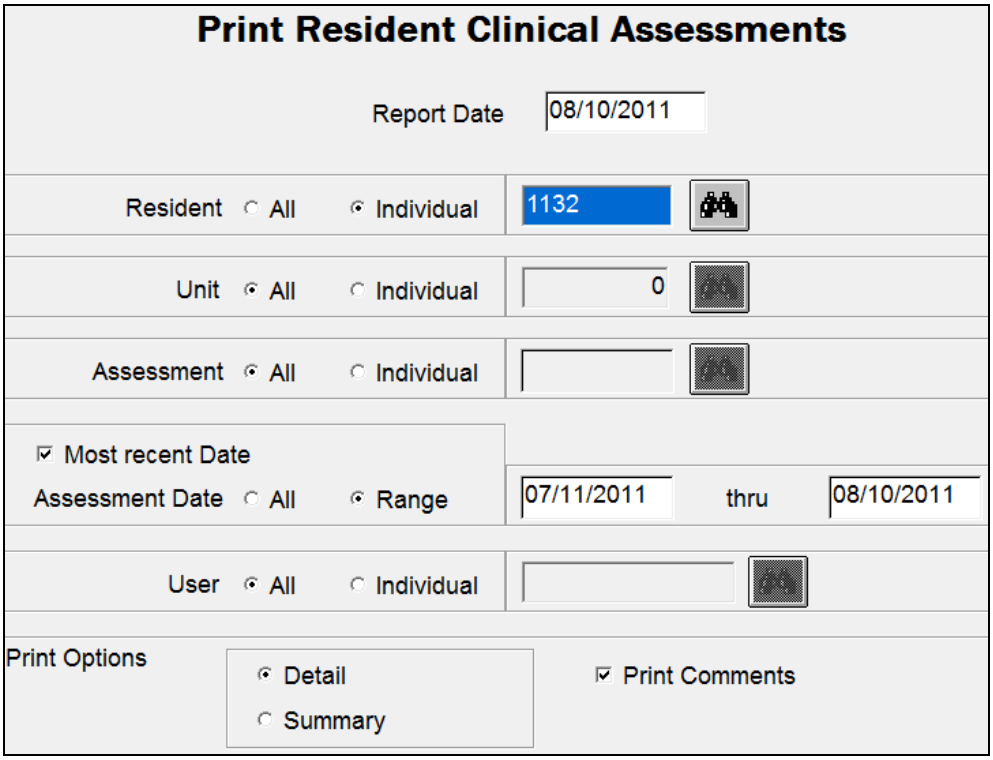
Notes: Launch **Edit Notes** for this resident to enter a *Progress* Note related to this assessment.

TIP: To help you organize Assessment Progress Notes, you can add the notes under specific Discipline codes.
Please see instructions in the *Clinical Records System User Instruction Manual* > Section A > Documentation > Edit Notes.

Documentation > Clinical Assessment >

Print Assessment

NRE9



NOTE: Make selections *carefully* to avoid printing unwanted pages.

Select the Residents by ID number or by Unit.

You can click Print on the **Edit Resident Clinical Assessment** screen to print the selected resident and Assessment displayed on the edit screen.

☑ Most recent Date (Recommended selection).
This will print the most recent assessment date.
Several assessment dates will be included on the same page.

☐ Most recent Date *un*checked will print all selected assessments on separate pages.
This could result in many pages of printed assessments.

Assessment Date ⊙All all assessment dates.
⊙Range (recommended) Enter a range of assessment dates.

See a ⊙Detail Assessment sample on the next page.

See a ⊙Summary sample on Page 55.

Sample: Detail Assessment

Report Date 08/10/2011
Asmnt Date 08/04/2011

Risk for Falls

HI-TECH NURSING & REHAB

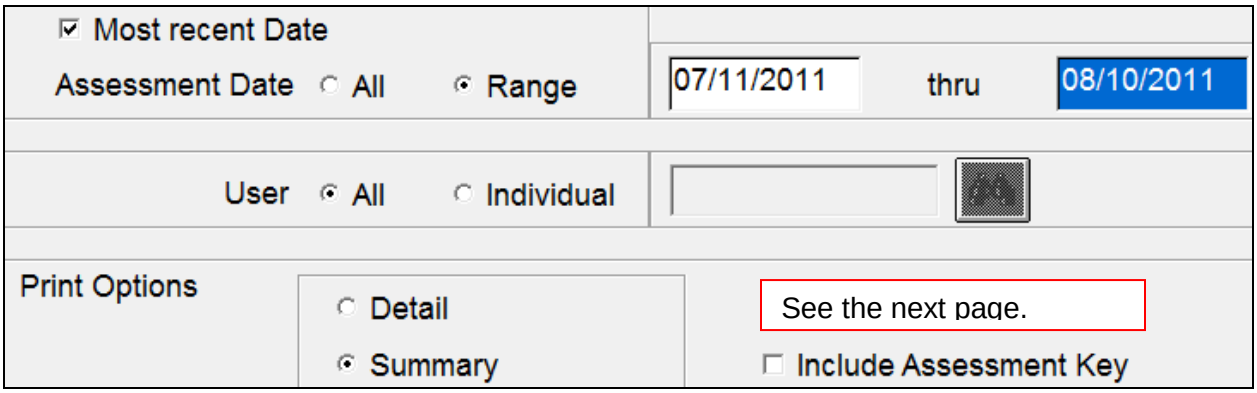
000-006 Resident is low risk
007-018 Resident is high risk-Follow falls protocol, document in CP

Total Score:					010	006
Date:					07/26/2011	08/04/2011
					Locked	

Question	Answer	Score
Cognitive Status	Mild / Moderate Impairment Comment: Wanders into other residents' rooms an becomes agitated	01
General Health	Stable	00
Mobility	Independent	00
Transfer Ability	Minimum Assist	01
Weight Bearing Status	Full Weight Bearing	00
Appliance in use at this time	No equipment needed	00
Vision	Wears glasses / contact lenses	01
Incontinence	Less than daily	01
Medications: Anti-hypertensive Cardiotonic Psychoactive	Receives one	01
History of Falls	1 - 2 falls in the past 3 months	01

Resident: ADAMS, HANNAH Unit: 0010 Primary Physician: KNOX, RANDALL Page: 01
Medical Record No.: 1132 Room / Bed: 035 / 1 User: HTS*

Sample: Summary Assessment



Report Date 08/10/2011
Asmnt Date 08/04/2011

Risk for Falls

HI-TECH NURSING & REHAB

000-006 Resident is low risk
007-018 Resident is high risk-Follow falls protocol, document in CP

Total Score:				010	006
Date:				07/26/2011	08/04/2011
				Locked	

Question				SCORE	SCORE
Cognitive Status				00	01
General Health				01	00
Mobility				00	00
Transfer Ability				01	01
Weight Bearing Status				01	00
Appliance in use at this time				04	00
Vision				01	01
Incontinence				01	01
Medications: Anti-hypertensive Cardiotonic Psychoactive				00	01
History of Falls				01	01

◉ Summary	☑ Include Assessment Key

☑Include Assessment Key to print an additional page that explains the items on an assessment, including the Acuity Range, and Questions and Answers from the Assessment Library.

```
Hi-Tech Manor                                    Run  08/22/11  at  14:08:01
DATE: 08/22/2011            CLINICAL ASSESSMENT LIBRARY            HTS-NRE8    PAGE:    1

ASSESSMENT: 001 Risk for Falls

   RANGE 1: 00-06  Resident is low risk
   RANGE 2: 07-18  Resident is high risk-Follow falls protocol, document in CP

      QUESTION: 01 Cognitive Status                                          SCORE
           ANSWER:   01 Intact                                                 00
           ANSWER:   02 Mild / Moderate Impairment                             01
           ANSWER:   03 Severe Impairment                                      02
      QUESTION: 02 General Health                                            SCORE
           ANSWER:   01 Stable                                                 00
           ANSWER:   02 Declining                                              01
           ANSWER:   03 Terminal / Failure to Thrive                           02
      QUESTION: 03 Mobility                                                  SCORE
           ANSWER:   01 Independent                                            00
           ANSWER:   02 With Assist                                            01
           ANSWER:   03 Immobile                                               02
      QUESTION: 04 Transfer Ability                                          SCORE
           ANSWER:   01 Independent                                            00
           ANSWER:   02 Minimum Assist                                         01
           ANSWER:   03 Maximum Assist                                         02
      QUESTION: 05 Weight Bearing Status                                     SCORE
           ANSWER:   01 Full Weight Bearing                                    00
           ANSWER:   02 Partial Weight Bearing                                 01
           ANSWER:   03 Non-Weight Bearing                                     02
      QUESTION: 06 Appliance in use at this time                             SCORE
           ANSWER:   01 No equipment needed                                    00
           ANSWER:   02 Leg brace                                              02
           ANSWER:   03 walker                                                 02
           ANSWER:   04 wheel chair                                            03
      QUESTION: 07 Vision                                                    SCORE
           ANSWER:   01 Good                                                   00
           ANSWER:   02 Wears glasses / contact lenses                         01
           ANSWER:   03 Poor / Blind                                           02
      QUESTION: 08 Incontinence                                              SCORE
           ANSWER:   01 Never                                                  00
           ANSWER:   02 Less than daily                                        01
           ANSWER:   03 Daily                                                  02
```

Documentation > Clinical Assessment >

Inactivate Assessments

NRE0

Inactivate assessment that should not be an active part of a resident's EMR.
IMPORTANT: A User can only activate assessments entered under his/her User ID.

Print Assessment Exceptions

NRF0

Display and/or print a list of the assessments that:

- have been Inactivated
- are not yet Locked.

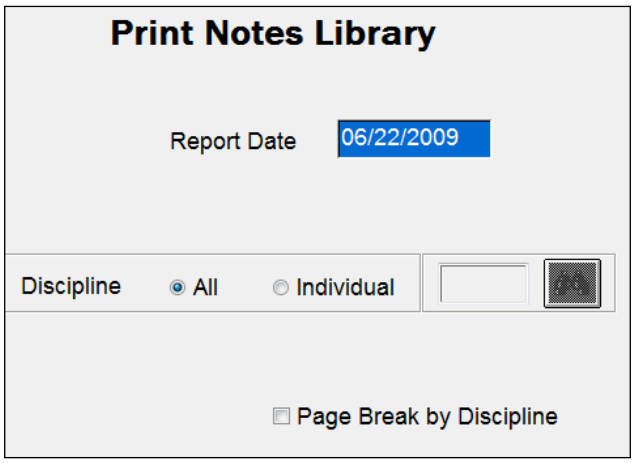
Documentation > Notes

Notes

The Notes programs allow your staff to record Notes to document residents' care, status, behavior, activities, etc.

Print Notes Library

NR34



If you have not used the Notes programs yet, print or display the Notes Library to see what it contains. You can delete records that you won't use.

If you have already built a library, this list could be several pages. You should display the report first to see how long it is.

To display or print the entire library, accept the default response of ⊙All for each item. Click Print.

You can also select specific items by choosing ⊙Individual and then clicking  to select that item from the list that is displayed.

Libraries > Face Sheet >

Edit Notes Library

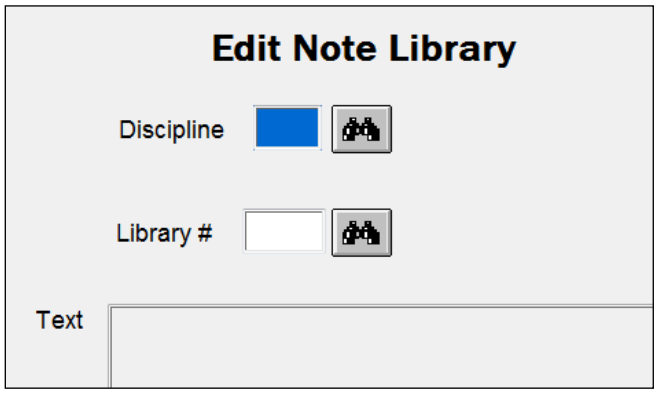
NR49

You can write Face Sheet, Nursing and Progress Notes through **Edit Medical Record** > Notes or through **Documentation > Notes > Edit Notes**.

Build a Notes Library of frequently used Notes text or formats. You can copy these items into individual resident's records and edited to suit that resident.

Spend time deciding what kind of notes you'll record in your notes library. A well-designed library will make it easier to write and manage notes. Here are some suggestions:

1. Begin with the items that will be common to many residents.
   Set these up in the order that you would like to see them on a printed record in the chart.
2. Don't put highly individualized items in the library.
   Enter these in residents' notes as needed.



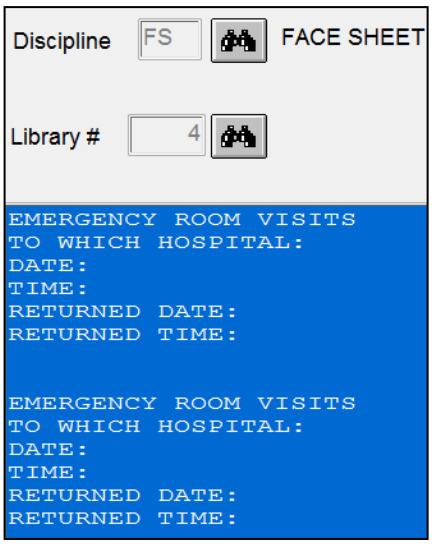
Discipline code is optional. You can assign a code for the staff discipline that will use this kind of note, or you can select FS for Face Sheet if note of this type will be selected as ⊙ Face Sheet in **Edit Notes**.

If the code you want to use does not appear in the Inquiry list of codes, add it to the System through **Libraries > Face Sheet > Disciplines**.

Library #: Enter a number that will identify this note. HTS recommends that you begin with the number 2 or 5 and then number the items by 2s (002, 004, 006, 008) or 5s (005, 010, 015, 020). This will leave space between records so that in the future when you add new records to the library, they can be inserted between existing items, to keep related items together.

The sample on the right is a note "template" record that can be used to document residents' emergency room visits. In Edit Notes, pull this template into a resident's notes records and then completed with the required information.

When you are satisfied with the content of the note record, click Ok.



Documentation > Notes

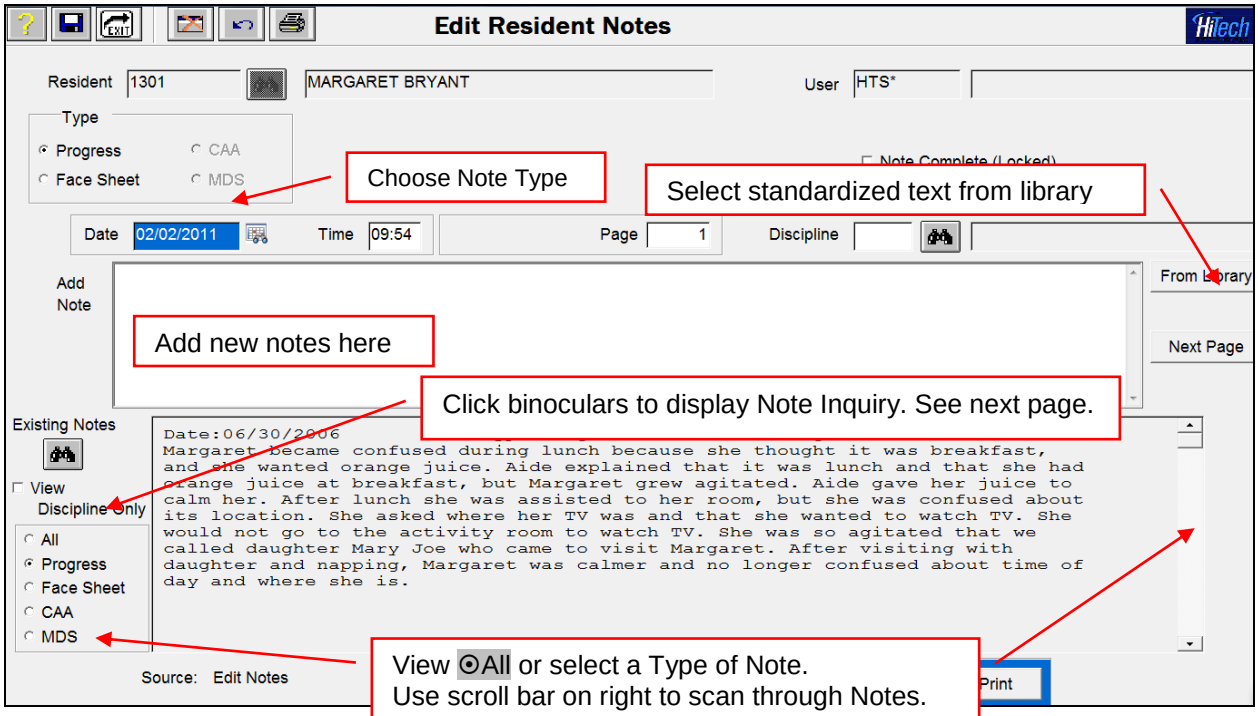
Edit Notes

NR32

IMPORTANT: You cannot delete notes, but you can inactive them through **Inactivate Notes**.

Use this program to enter and edit the following types of notes on residents' conditions, activities, behavior, etc.

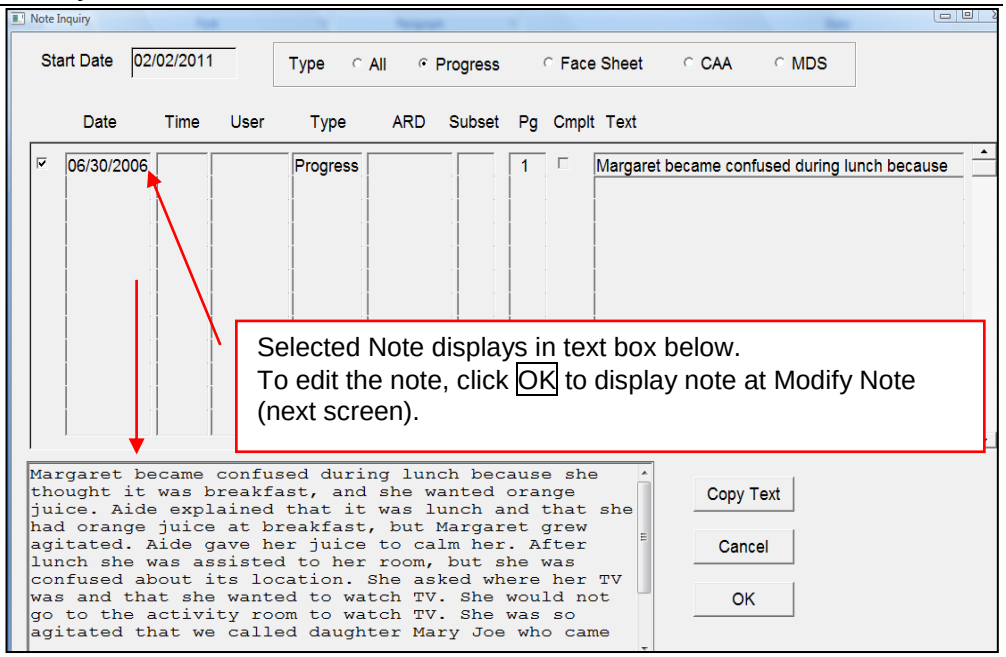
- Face Sheet Notes (previously recorded on **Edit Face Sheet >** Notes screen).
- Nursing and Progress Notes, and other types of notes that you define in the Note Library.
- Secure Notes (i.e. Complete Notes)**.**
- View MDS 3.0 and CAA Notes recorded through **MDS / Care Plans > MDS > Edit MDS.**



When you select a Resident, if the resident has existing notes, the first note of the selected type will display at Existing Notes.

At the bottom of the screen, Source: will identify the program from which you chose to edit notes, i.e. Edit Notes (from menu), Face Sheets, CAA Notes.
(Existing notes converted from previous notes: CV-Notes.)

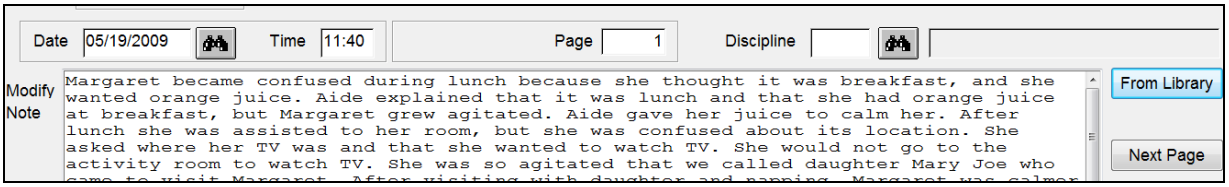
Existing Notes



To select a note, click the binoculars to display the Note Inquiry screen (on right).

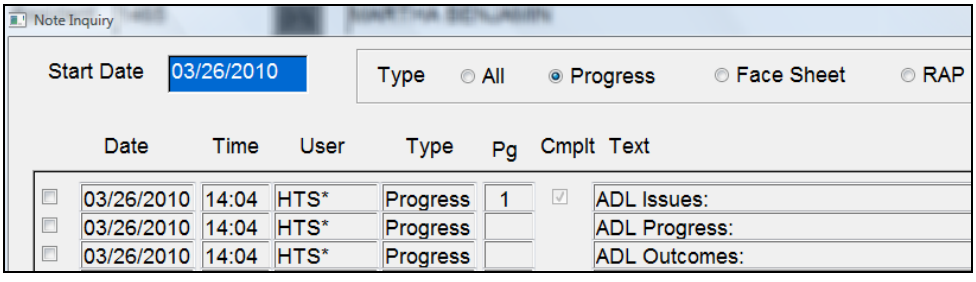
On this screen you select ⊙Progress, ⊙Face Sheet, ⊙CAA or ⊙MDS to list just that type of note.

Select a note to display the full note in the text area at the bottom of the Inquiry screen. If you want to edit this note, click OK and it will be displayed at Modify Note on the Edit Resident Notes screen (below). NOTE: You cannot edit RAP or CAA notes.



- Check ☑ Note Complete (Locked) or ☑ Note Complete (Locked & Signed), if users have permission to e-sign Notes and save the note so you can no longer edit the note.

- The User ID assigned to a note is the only User ID that can edit, lock or inactivate the note.
- Copy Text: On the Note Inquiry screen (top right) select and display the note to be copied. Click the Copy Text button. The text will be copied to Add Note as a new note that you can edit. You can also copy text from each page of a multi-page note. Display the Note Inquiry screen (below). Each page of the note will be listed. Check the box of the note that you want to copy. It will be displayed. Click the Copy button to copy the text of that note to the Add Note area as a new note that you can edit and save.



Document Storage

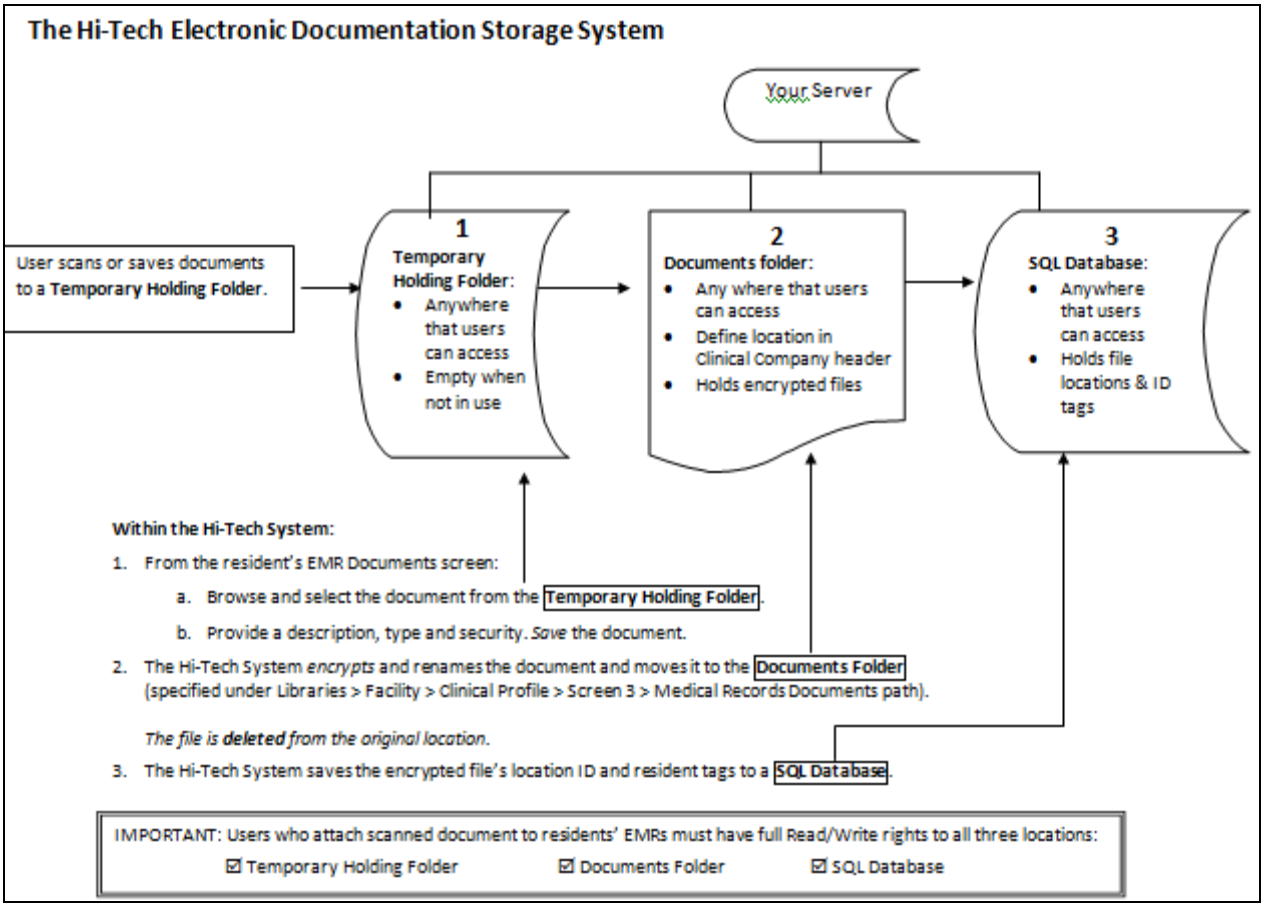
Electronic Document Storage System

Release 11.06: This process provides the following advantages over the existing Documents process.

- Specify where you want to store the documents files.
- Achieve greater HIPAA compliance through our encryption process.
  Access the documents with our application only.
- Apply additional security options for who can view documents—Clinical and/or Resident Accounting.
- Classify documents by type, such as Doctor's Orders, Insurance, POA, Advance Directives, etc.
- Inactivate a document and view inactivated documents.

Read the instructions on the following pages to learn how Electronic Document Storage works.
To activate this feature, set up a phone appointment with Hi-Tech Support at (207) 474-7122
or email support@Hi-TechSoftware.com.

IMPORTANT: This is an optional process, however, it will eventually replace the existing Documents feature that is part of the Electronic Medical Record (described on the previous page). If you are using the existing Document feature, we encourage you to transition to the new Electronic Document Storage process using the SQL database with file encryption.



Set Up Requirements

Hi-Tech must set up Electronic Document Storage on your system for it to work as described on the following pages.

Please work with your IT staff to determine if you meet these requirements.

- A SQL Server or SQL Server Express (free).
- The users' PCs that accesses the database must have:
    1. The ability to run .EXEs.
    2. a .NET framework version 4 or higher.
    3. Permission to access the database.
    4. Permissions to access the folder that holds the documents.
- You can store and view scans, PDFs, MicroSoft Word files, etc.
  The program will allow you to view documents in the native file format in which a document was created; for example: you will need Microsoft Word to open and view Word files and Adobe Acrobat Reader to open and view PDFs. These programs must be installed on the PC used to view these types of documents.

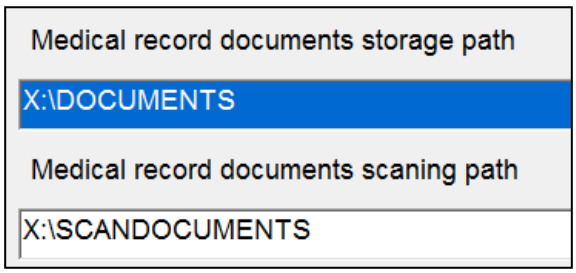
Hi-Tech will assist you in setting up the process and the location where you will save all documents to be attached to your residents.

- You must schedule a phone appointment
- You can use 1 Hi-Q Point

In **Clinical** or **Resident Accounting**, select **Libraries > Facility > Clinical Profile.**
Click OK twice to display the screen with the following fields (shown on the right).

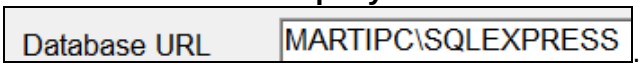
Medical record documents storage path:
Define where documents will be stored for this facility

Medical record documents scanning path:
Define where facility will scan documents *to* and where the program will find the documents to be copied to residents' records.



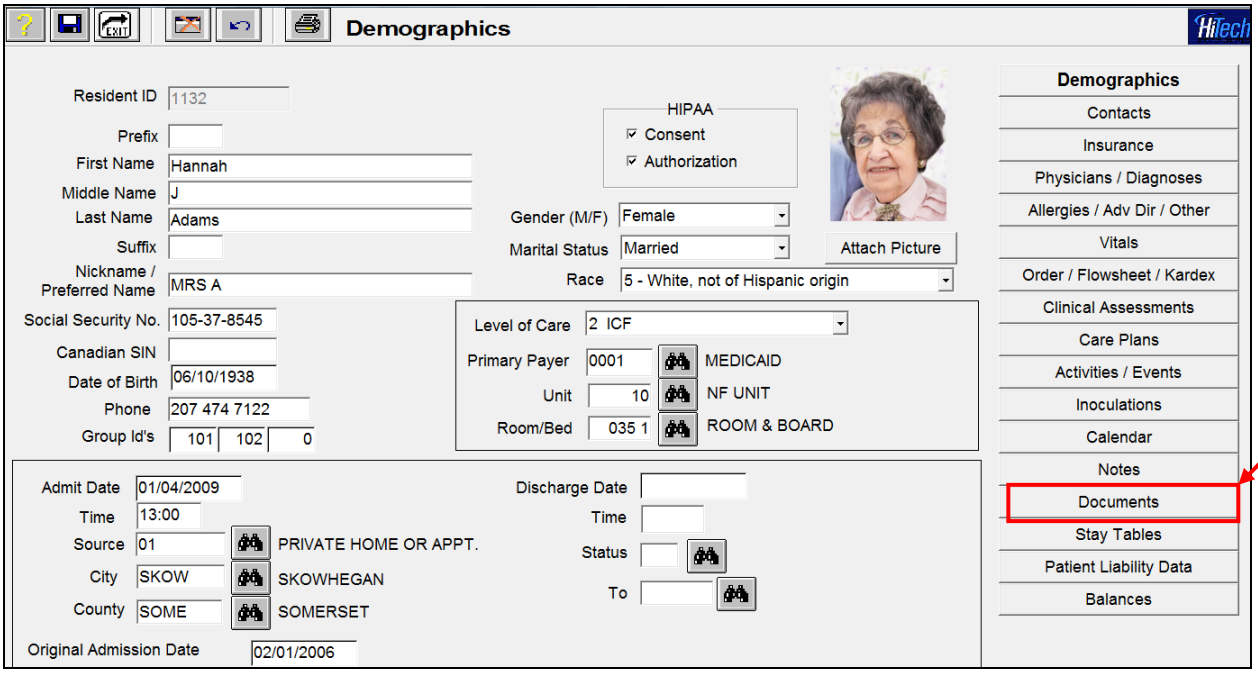
Hi-Tech System Administrator:

Select **Utilities > System structure > Maintenance > Company Profile.**

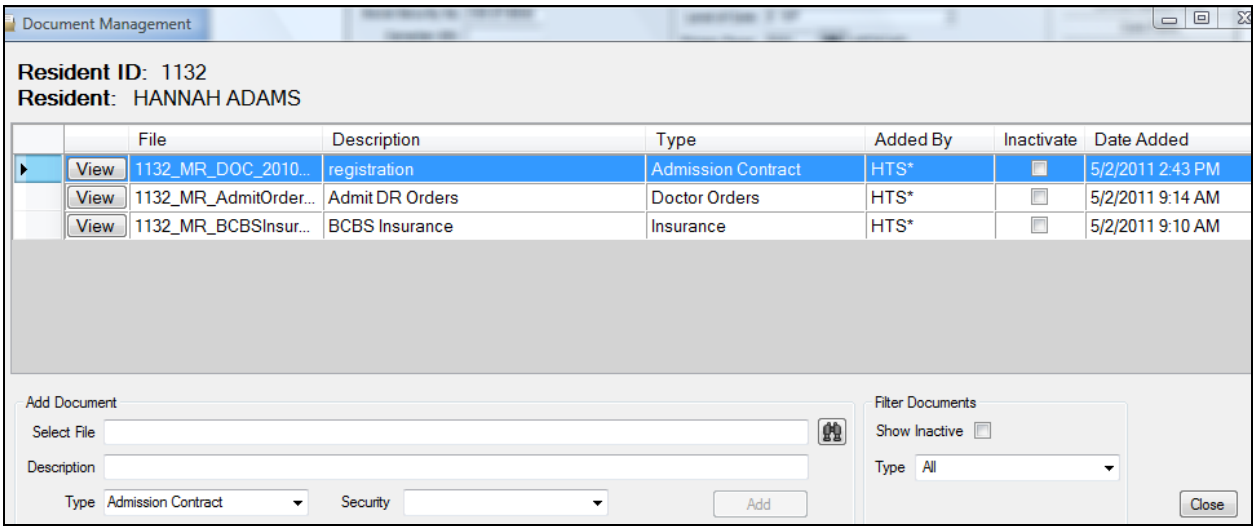
Enter the Database URL. Example: 

Admission Procedures > Edit Medical Record >

Access a resident's document by clicking the Documents button on any EMR screen.



This displays the Electronic Document Storage screen and any documents already saved and selected for this resident. Example:



Click a column heading to sort the documents by that heading criteria, alphabetically or chronologically by date.

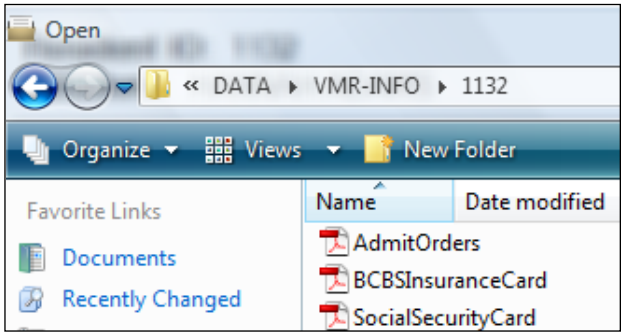
To print a document, click the View button. Use the standard print process for the program that displays the document i.e. Microsoft Word, Adobe Reader, etc.

Add Documents to a Resident's EMR

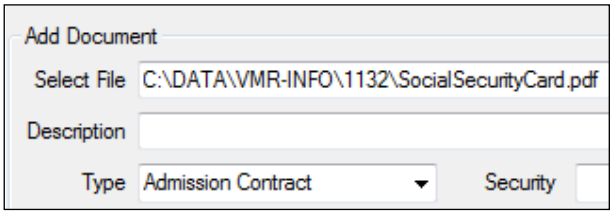
Verify that you have selected the correct resident, then select and add documents to the EMR.

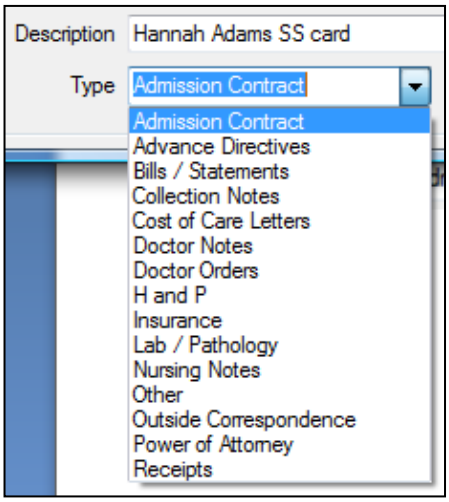
Select File: click the binoculars at the right end of the field and browse to the folder where you save documents to be attached to residents.

Select the document and click Open
(or double-click the document file name).
The selected path and document will be displayed.

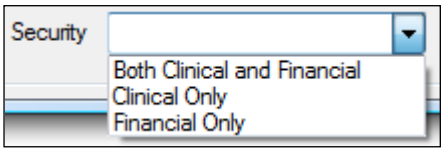


Enter a Description and select a Type from the drop down Type list.

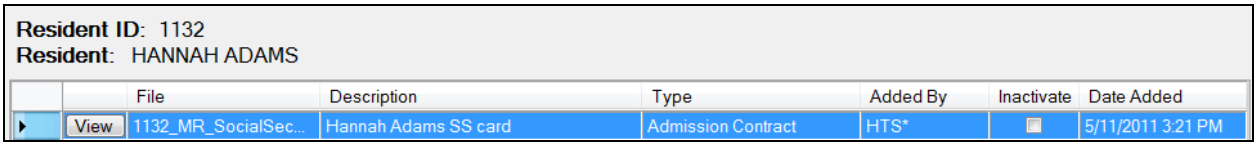




Security: Select the type of users who should be able to view the document.



Click Add. The document will be added to this resident's EMR, renamed using the resident's ID number, and encrypted for security.

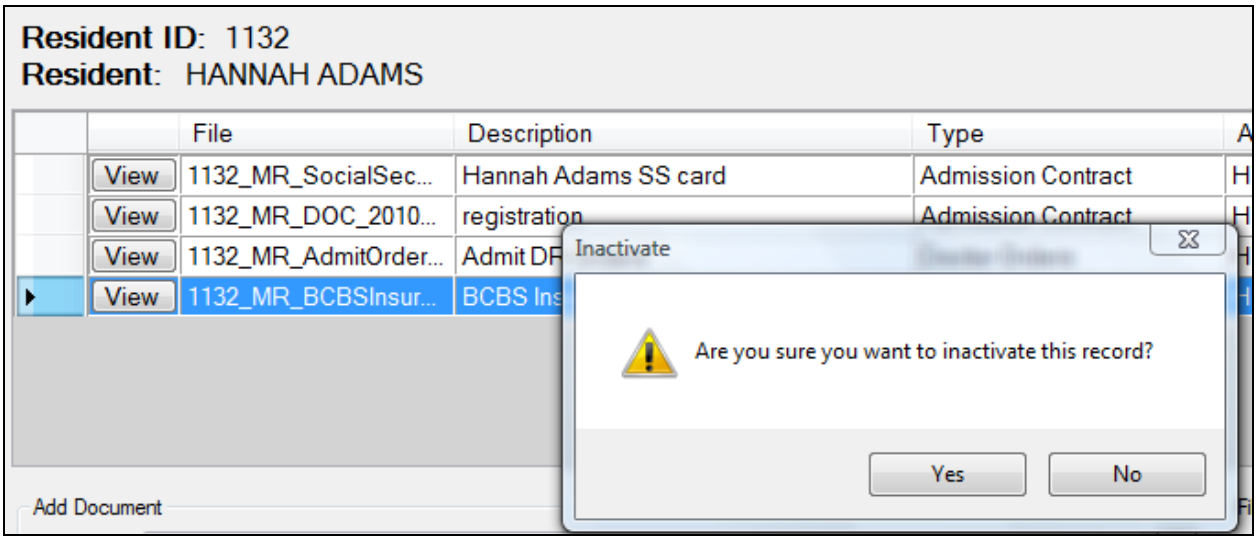


NOTE: The document will be *removed* from its original location.
You can only access it through Hi-Tech Document Management.

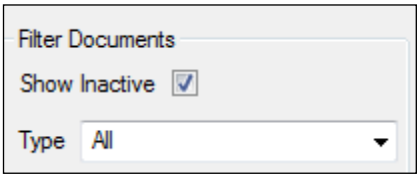
How to Inactivate a Document

You cannot delete documents that were attached to a resident in error or if the information is no longer current. You can *inactivate* them.

Check mark the record in the Inactivate column. The program will ask if you are sure:



Click Yes to continue the inactivation. The inactivated document will no longer be displayed on the resident's document list; unless you select Show Inactive to view inactivated documents.



Click Close to leave the Electronic Document Storage process and return to the resident's EMR record.

How to Reactivate a Document

1. Select Show Inactive ☑.
2. Select the inactivated document and click View button.
3. While the document is displayed, click Save As and Save the document under a name you will recognize in a folder you will remember. Close the document.
   NOTE: Until it is re-added to a resident's EMR, this document is no longer encrypted and can be accessed outside the Hi-Tech System.
4. Deselect Show Inactive☐.
5. Re-add the document using the **Add Documents to a Resident's EMR** instructions on Page64. Select the document from the location used in Step 3.

How to Move a Document added to a Wrong Resident

1. Open Electronic Document Storage in the "wrong" resident's EMR.
2. Select and View the document. Select Save As and Save to a name and location that you will remember.
3. Inactivate the document in the "wrong" resident's record. See **How to Inactivate a Document** on Page 65.
4. Open Electronic Document Storage in the "correct" resident's EMR.
5. Add the document using the **Add Documents to a Resident's EMR** instructions on Page64. Select the document from the location used in Step 2.

Remember: When you add a document to a resident's EMR, the program removes it from the original location.

The IMAR Electronic Medication System

IMAR is a complete medication management application for long term care, including skilled nursing, assisted living, and other healthcare settings. IMAR directs medication management, administration and documentation workflow. IMAR helps ensure the "Five Rights"—Right Resident, Right Medication, Right Dosage, Right Route, and Right Time -- during every med pass.

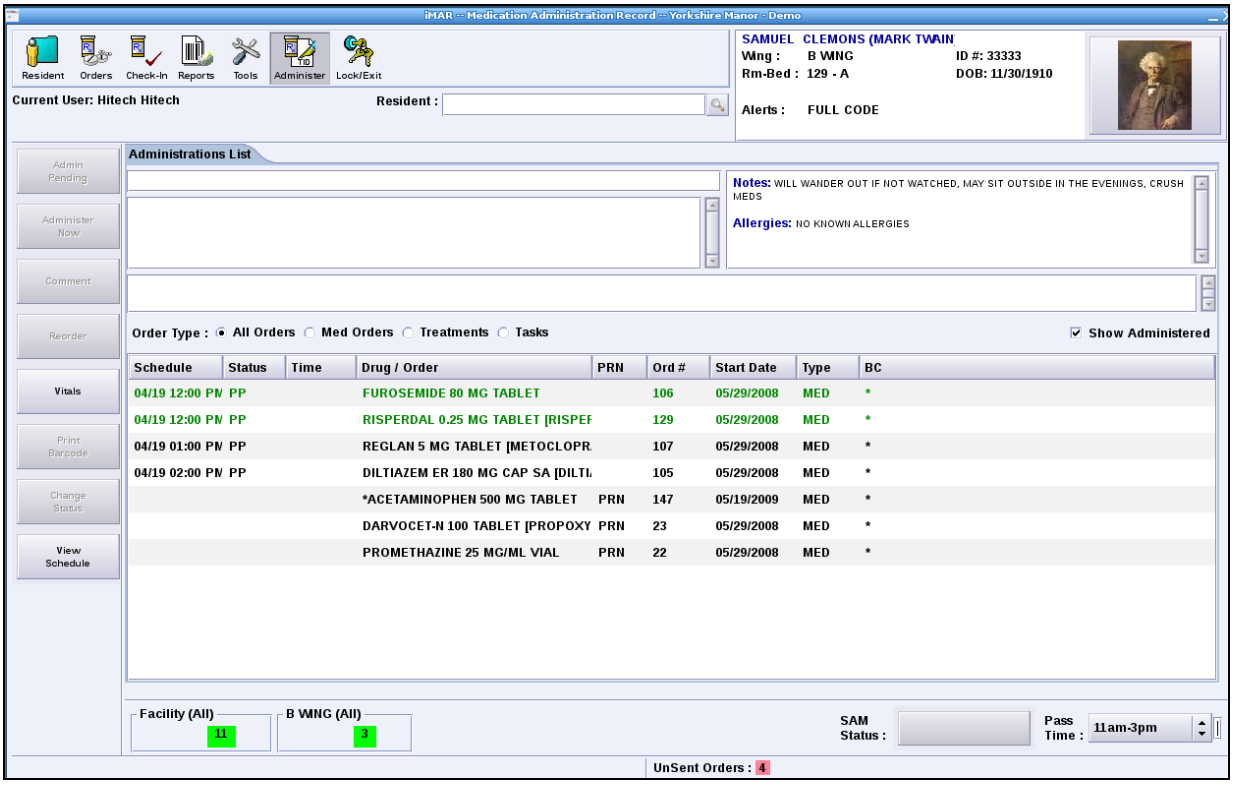
Log in and select the Administer icon in the Application tool bar at the top of the screen. This displays the IMAR Medication Administration Screen from which you will perform the med pass.

IMAR **Medication Administration Record Screen**

The screen will display the resident last displayed before exiting the IMAR system.

You can select and deselect Show Administered (top right of the med list) to display or hide meds that have already been administered.

NOTE: When you log in, the med pass defaults to the current pass time.
The Administration screen displays orders scheduled for that med pass.
If not correct, select *correct* Pass Time from the drop-down list at the bottom right.



Do one of the following:

1. Select orders from the **Work to Do** status bar--  at bottom left..
2. Continue with the displayed resident and administer med.
3. Select another resident.