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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.

User ID:	ISTONE	
Full Name:	ISAAC STONE RN	
Job Title:	RN	

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

Login :	don
Last Name :	DON
First Name :	Ima
Initials :	DON
Title :	RN

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.

Clinical: 

- Admission Procedures
- Documentation
- MDS / Care Plans
- Case Mix
- QI / QA / Survey Reports
- Reporting
- Libraries
- File Utilities
- 5 - Day Calendar
- Edit Medical Record
- [View Medical Record](#)

Demographics



Resident ID

Prefix

First Name

Middle Name

Last Name

Suffix

Nickname / Preferred Name

Social Security No.


Canadian SIN


Date of Birth


Phone

Group Id's

Admit Date Time

Source  PRIVATE HOME OR APPT.

City  SKOWHEGAN

County  SOMERSET

Original Admission Date

HIPAA

☒ Consent


☒ Authorization


Gender (M/F)


Marital Status

Race

Level of Care


Primary Payer  MEDICAID


Unit  NF UNIT


Room/Bed  ROOM & BOARD

Discharge Date

Time

Status 

To 



Attach Picture

Demographics

- Contacts
- Insurance
- Physicians / Diagnoses
- Allergies / Adv Dir / Other
- Vitals
- Order / Flowsheet / Kardex
- Clinical Assessments
- Care Plans
- Activities / Events
- Inoculations
- Calendar
- Notes
- Documents
- Stay Tables
- Patient Liability Data
- Balances

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.

☒ 1 Resident by ID numbe

(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.

The screenshot shows a software window titled "W-NRPK Pick Detail Screen". It contains a list of reports with checkboxes for selection. The first report, "Resident by ID numbe", is selected. Below the list is a date field labeled "Date to use on Reports" with the value "06/07/2012". At the bottom, there are four action buttons: "Print", "New Report", "Delete", and "End".

Checkbox	ID	Report Name
<input checked="" type="checkbox"/>	1	Resident by ID numbe
<input type="checkbox"/>	2	Residents-Last Name
<input type="checkbox"/>	3	Residents religions
<input type="checkbox"/>	4	All birthdays
<input type="checkbox"/>	5	December birthdays
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

Date to use on Reports: 06/07/2012

Select Reports from the above list to print **Print**

Build a New Report **New Report**

Select Reports from the above list to Delete or End **Delete** **End**

Select "ONE" Report from the above list to Edit **Edit**

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:

Resident Reporting - Pick Detail Report			
Select Sort Order <input type="radio"/> Resident ID <input checked="" type="radio"/> Last Name <input type="radio"/> Unit / Room Bed <input type="radio"/> Religion <input type="radio"/> Physician <input type="radio"/> Birth Date <input type="radio"/> Primary Payor	Active Residents Only	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Individual	Resident ID: <input type="text"/>
	<input type="checkbox"/> Include Zero Admit Dates		
HIPAA Privacy / Disclosure <input type="checkbox"/> Log Non-Care Purpose / Use (Skip Residents without Authorization)	All Residents	<input checked="" type="radio"/> Yes <input type="radio"/> No	
	Disch. Residents Only	<input type="radio"/> Yes <input checked="" type="radio"/> No	Census Date <input type="text"/>
Page Break on Resident <input type="checkbox"/> Double Space <input type="checkbox"/> Number of Copies <input type="text" value="1"/> Report Date <input type="text" value="11/24/2009"/>	Print Birthday List	<input type="radio"/> Yes <input checked="" type="radio"/> No	Birthday Month <input type="text"/>
	All Units	<input checked="" type="radio"/> Yes <input type="radio"/> No	From <input type="text" value="1"/> Thru <input type="text" value="9999"/>
	All Physicians	<input checked="" type="radio"/> Yes <input type="radio"/> No	From <input type="text" value="1"/> Thru <input type="text" value="9999"/>
	Admit Date Range	<input type="radio"/> Yes <input checked="" type="radio"/> No	From <input type="text"/> Thru <input type="text"/>
	Discharge Date Range	<input type="radio"/> Yes <input type="radio"/> No	From <input type="text"/> Thru <input type="text"/>
	All Groups	<input checked="" type="radio"/> Yes <input type="radio"/> No	From <input type="text" value="1"/> Thru <input type="text" value="999"/>

Select the **Sort Order** that you want. You will usually sort in alphabetic order by Last Name or 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.

Select Sort Order
<input type="radio"/> Resident ID
<input checked="" type="radio"/> Last Name
<input type="radio"/> Unit / Room Bed
<input type="radio"/> Religion
<input type="radio"/> Physician
<input type="radio"/> Birth Date
<input type="radio"/> Primary Payor

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**.

HIPAA Privacy / Disclosure
<input type="checkbox"/> Log Non-Care Purpose / Use (Skip Residents without Authorization)

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.

HIPAA Disclosure Information	
Request Date	<input type="text" value="02/27/2003"/>
Requestor Name	<input type="text"/>
Address	<input type="text"/>
City State Zip	<input type="text"/>
Purpose	<input type="text"/>
What disclosed	<input type="text" value="PICK DETAIL REPORT"/>
Authorization:	<input checked="" type="radio"/> On File <input type="radio"/> Written Request
<input type="button" value="Cancel"/> <input type="button" value="Ok"/>	

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:

Active Residents Only	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Individual	Resident ID:	
<input type="checkbox"/> Include Zero Admit Dates			
All Residents	<input type="radio"/> Yes <input checked="" type="radio"/> No		
Disch. Residents Only	<input type="radio"/> Yes <input checked="" type="radio"/> No	Census Date	

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.

Active Residents Only	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Individual	Resident
<input type="checkbox"/> Include Zero Admit Dates		
All Residents	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Disch. Residents Only	<input type="radio"/> Yes <input checked="" type="radio"/> No	Census Date

Print Birthday List	<input type="radio"/> Yes <input checked="" type="radio"/> No	Birthday Month	
----------------------------	---------------------------------------------------------------	----------------	--

: 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.

All Units	<input type="radio"/> Yes <input checked="" type="radio"/> No	From	1	Thru	9999
All Physicians	<input type="radio"/> Yes <input checked="" type="radio"/> No	From	1	Thru	9999
Admit Date Range	<input type="radio"/> Yes <input checked="" type="radio"/> No	From		Thru	
Discharge Date Range	<input type="radio"/> Yes <input checked="" type="radio"/> No	From		Thru	
All Groups	<input type="radio"/> Yes <input checked="" type="radio"/> No	From	1	Thru	999

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.

Page Break on Resident <input type="checkbox"/>	
Double Space	<input type="checkbox"/>
Number of Copies	1
Report Date	06/07/2012

Page Break on Unit <input type="checkbox"/>	
Break Total on Unit	<input type="checkbox"/>
Double Space	<input type="checkbox"/>
Number of Copies	1
Report Date	06/07/2012

Sorted by	Last Name	Space Left	122																				
Select up to 10 items for Detail Line																							
<input checked="" type="checkbox"/> 01 RESIDENT ID <input type="checkbox"/> 02 LAST NAME <input type="checkbox"/> 03 FIRST NAME <input type="checkbox"/> 04 LEVEL OF CARE <input type="checkbox"/> 05 SOC SEC NO <input type="checkbox"/> 06 GENDER <input type="checkbox"/> 07 MS CODE <input type="checkbox"/> 08 BIRTHDAY <input type="checkbox"/> 09 AGE <input type="checkbox"/> 10 RELIGION <input type="checkbox"/> 11 PARISH <input type="checkbox"/> 12 N/A <input type="checkbox"/> 13 IDEAL WEIGHT <input type="checkbox"/> 14 N/A <input type="checkbox"/> 15 N/A <input type="checkbox"/> 16 N/A <input type="checkbox"/> 17 N/A <input type="checkbox"/> 18 PRIMARY DR & 2ND <input type="checkbox"/> 19 1ST 8 DIAGNOSES <input type="checkbox"/> 20 1ST 2 ALLERGIES <input type="checkbox"/> 21 PREV. ADDRESS 1 <input type="checkbox"/> 22 PREV. ADDRESS 2		<div style="background-color: #007bff; color: white; padding: 5px;"> WARNING: Items will be printed on the report in the order shown below. </div> <div style="background-color: #007bff; color: white; padding: 5px; margin-top: 5px;"> Selection Order: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 5%;">1</td><td>RESIDENT ID</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table> </div>		1	RESIDENT ID																		
1	RESIDENT ID																						
<div style="display: flex; justify-content: space-around; margin-top: 10px;"> Run End Reset Save List Choices </div>																							

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:

<input type="checkbox"/>	1	Resident by ID numbe
<input type="checkbox"/>	2	Residents-Last Name
<input type="checkbox"/>	3	Residents religions
<input type="checkbox"/>	4	All birthdays
<input type="checkbox"/>	5	December birthdays
<input type="checkbox"/>	20	PAYMENT NUMBERS

Code	20
20 Character Description	PAYMENT NUMBERS
Save	End

	Report Saved - Do you want to print it now?
Yes	No

Other Face Sheet Reports

Reporting > Face Sheet Reporting

Admission Procedures	⇒ Face Sheet Reporting	Resident Labels
Documentation	Custom Reporting	Census Statistics
MDS / Care Plans	Orders	Medicaid Eligibility List
Case Mix	MDS	Medicare Length of Stay
QI / QA / Survey Reports	Care Plans	Transfer Form
⇒ Reporting	Calendar	Medical Eligibility Form
Libraries		Face Sheet Changes
File Utilities		Resident Diagnosis List
5 - Day Calendar		Allergy/Phys List/Adv Dir

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.

Print Resident Transfer Form		
Report Date 12/20/2012		
Residents to Print <input type="radio"/> All <input checked="" type="radio"/> Individual <input type="radio"/> Blank Form		
Resident ID <input type="text"/>		RESIDENTS SELECTED:
How many copies? <input type="text"/>		
Select Modules to Print: <input checked="" type="checkbox"/> Background Information		
<input checked="" type="checkbox"/> Transfer Forms		

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).

Print Resident Diagnosis List

Residents to Print
☒ All
☐ Individual

Resident ID

All

Types to Include
☐ Current
☐ Resolved
☒ Both

Resolved Dates
☒ All
☐ Range
From:
Thru:

☐ Include Discharged Residents

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 >**

Physicians / Diagnoses

Allergies / Adv Dir / Other

Print Resident Allergies / Physicians /Advance Directives List

Residents to Print
☒ All
☐ Individual

Resident ID

All



Types to Print
☐ Allergies
☐ Doctors
☐ Advance Directives
☒ All

☐ Include Discharged Residents

Reporting Options: Print, Display, Create File

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

1564	DILLINGHAM	LORRAINE J
1238	DRAPER	DELILAH J
1537	GENTRY	ARIANNA G
1556	GILESPIE	LILLIAN F
1376	GUNDERSON	JEREMIAH M
1492	JAMES	HANNAH P
1404	KETCHUM	VERNETTA G
1561	LANCASTER	YVETTE
1263	LANDRY	CONSTANCE L

  ☐ Condense Print

Beginning of Report Exit End of Report PageUp

Jump to Page 0001 of 0003 Top Margin: PageDn



Left Margin:

Print Report Print Page
☐ Create File

Print the Report

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

0860	OLDHAM	ALBERTA F
0870	RUNYAN	RITA M

  ☐ Condense Print

Beginning of Report Exit End of Report PageUp

Jump to Page 0001 of 0003 Top Margin: PageDn

Left Margin:

Print Report Print Page
☐ Create File

File Path/Name

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.

11314	ALLEN	IRENE E	2	511 68 8972 F	W	03/30/1912	91	820.9	OPEN FRACTURE UNSPECIFI
									Q57.1 OTHER PHYSICAL THERAPY
									Q57.2 OCCUPATIONAL THERAPY&00
									518.4 UNSPECIFIED ACUTE EDEMA
									486 PNEUMONIA, ORGANISM UNS

Uncheck ☐ **Condense Print** to expand the text.

0469	DANIELSON	MARTHA	2	025448975	F	W	09/08/1918	84	380	C BAPTISTA
									00	
1564	DILLINGHAM	LORRAINE J	1	652125895	F	W	10/21/1926	76	70	E ERSTWHILE



☐ Condense Print

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.

RESIDENT	LAST NAME	FIRST NAME	LE	SOC	SEC NO	GEN	MS	BIRTHDAY	AGE	
1132	ADAMS	HANNAH J	2	105378545	F	M	06/10/1934	61		207 474 8544

To move this edge to see more text, adjust  **Panel Freeze Point** using the up  and down  arrows. On the sample below, we increased the Panel Freeze Point to display the age:

RESIDENT	LAST NAME	FIRST NAME	LE	SOC	SEC NO	GEN	MS	BIRTHDAY	AGE	
1132	ADAMS	HANNAH J	2	105378545	F	M	06/10/1934	69		207 474 8544

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

RESIDENT	LAST NAME	FIRST NAME	LE	SOC	SEC NO	CE	BOTH PHYSICIANS			
1132	ADAMS	HANNAH J	2	105378545	F		1125 R KNOX			207 474 8544

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

Admission Procedures	Clinical Assessments	Edit Resident Activities
⇒ Documentation	Vitals	Edit by Activity
MDS / Care Plans	⇒ Activities	Print Activity Report
Case Mix	Notes	Inactivate Resident Activities

Admission Procedures	Clinical Assessments	Edit Resident Events
⇒ Documentation	Vitals	Print Event Report
MDS / Care Plans	Activities	Inactivate Resident Events
Case Mix	Notes	
QI / QA / Survey Reports	Therapy	
Reporting	Inoculations	
Libraries	⇒ Events	

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.

☒ Edit Activities
☐ Edit Events

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**.

Edit User Medical Record Access							
User ID: CRB CLAIRE BOURQUE							
Demographics	<input checked="" type="radio"/> Access	<input type="radio"/> Inquiry Only	Inoculations	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only	
Contacts	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only	Calendar	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only
Insurance	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only	Notes	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only
Physicians/Diagnosis	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only	Documents	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	
Allergies/Adv Dir/Other	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only	Stay Tables	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only
Height & Weights	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only	Patient Liability Data	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only
Order/Flowsheet/Kardex	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only	Balances	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only
Clinical Assessments	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only	Events	<input type="radio"/> Access	<input checked="" type="radio"/> No Access	<input type="radio"/> Inquiry Only
Care Plans	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only				
Activities	<input checked="" type="radio"/> Access	<input type="radio"/> No Access	<input type="radio"/> Inquiry Only				

Delete Cancel Ok End

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 >

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
Inoculation Library
Event Library
Notes Library
Activity Comments Library
Event Comments Library


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.

Edit Activity Library

☐ Inactive

Activity ID 

Description

Alpha Code

Length

Instructor

Satisfies RCA Section N-4

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.

1800. Any Falls Since Admission or Prior Assessment (OBRA or Scheduled PPS)	0 No
Pull J1800 response from Events Detail	

Events	
03/07/2012	Fall
03/07/2012	Fall
12/16/2010	Fall

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**.

7. Accidents: a. <input type="checkbox"/> Fell in past 30 days b. <input type="checkbox"/> Fell in past 31-180 days	Pull J-7 a/b responses from Events Detail
----------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------

Libraries > Documentation >

Activity Comments Library


MD89

Events Comments Library

MDE5

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

Edit Activity Comment Library


Comment Code 

Description

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.

Edit Event Comment Library

Comment Code 

Description

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

Admission Procedures	Clinical Assessments	Edit Resident Activities
⇒ Documentation	Vitals	Edit by Activity
MDS / Care Plans	⇒ Activities	Print Activity Report
Case Mix	Notes	Inactivate Resident 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 to view or edit the record.

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

Edit Activity Detail by Resident

Resident ID ADAMS

Date

Time

Activity ID Bingo

Length

Instructor

☒ Participated

Comments

Add Note

HANNAH

Won first game. Asked to attend again.

					Previous Detail as of:
					03/06/2012
	Date	ID	Time	Description	
<input type="checkbox"/>	09/22/2011	0011	13:34	Individual Activity	
<input type="checkbox"/>	09/22/2011	0003	10:00	Morning Stretch	
<input type="checkbox"/>	09/20/2011	0003	10:00	Morning Stretch	
<input type="checkbox"/>	09/20/2011	0011		Individual Activity	
<input type="checkbox"/>	12/16/2010	0003	09:00	Morning Stretch	
<input type="checkbox"/>	09/15/2010	0003	09:00	Morning Stretch	
<input type="checkbox"/>	07/01/2010	0003	08:15	Morning Stretch	

Documentation > Activities

Edit by Activity

MD85

Resident	Last Name	First Name
<input checked="" type="checkbox"/> 1132	ADAMS	HANNAH
<input checked="" type="checkbox"/> 1476	AKERS	HENRY
<input checked="" type="checkbox"/> 1314	ALLEN	IRENE
<input type="checkbox"/> VT1500	AMIDON	LEATRICE
<input checked="" type="checkbox"/> 1273	ANISTON	THERESA
<input checked="" type="checkbox"/> 1517	APPLEBEE	CLARA
<input checked="" type="checkbox"/> 2187	APPLETON	THERESA
<input type="checkbox"/> 1200	ARCHER	BENJAMIN
<input type="checkbox"/> 0068	AXELROD	LORNA
<input type="checkbox"/> 1523	BALLARD	RALPH
<input type="checkbox"/> 1566	BARNETT	LILLIAN
<input type="checkbox"/> 07192011	BENTLY	JUDITH
<input checked="" type="checkbox"/> 1514	BOHR	DORIS
<input checked="" type="checkbox"/> 1201	BOULDER	BRENT
<input type="checkbox"/> 1301	BRYANT	MARGARET
<input checked="" type="checkbox"/> 1490	BURKE	MILLCENT

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.

HANNAH ADAMS

Comments

Cancel Ok Add Note

Documentation > Activities

Print Activity Report

MD86

Print Resident Activity Report

Report Date

Resident
☐ All
☒ Individual

Dates
☒ All
☐ Range
From: Thru:

Activity
☐ All
☒ Individual

Units
☒ All
☐ Individual

☐ Page Break by Resident
☐ Sort by Activity Id
☐ Include Discharged Residents

Residents Selected

1132

Activities Selected

Bingo
Birthday Party
Community Event

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	LNTH	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.

Inactivate Activity Detail

Resident ID ADAMS

HANNAH

Date

Activity ID

Previous Detail as of:

	Date	ID	Time	Description
<input checked="" type="checkbox"/>	03/06/2012	0004	15:02	Movie & Popcorn
<input type="checkbox"/>	03/06/2012	0001	14:56	Bingo
<input type="checkbox"/>	09/22/2011	0011	13:34	Individual Activity
<input type="checkbox"/>	09/22/2011	0003	10:00	Morning Stretch
<input type="checkbox"/>	09/20/2011	0003	10:00	Morning Stretch
<input type="checkbox"/>	09/20/2011	0011		Individual Activity
<input type="checkbox"/>	12/16/2010	0003	09:00	Morning Stretch
<input type="checkbox"/>	09/15/2010	0003	09:00	Morning Stretch
<input type="checkbox"/>	07/01/2010	0003	08:15	Morning Stretch
<input type="checkbox"/>	10/22/2009	0025	15:00	Community Event
<input type="checkbox"/>	02/25/2009	0007	13:00	Monthly Lunch Outing
<input type="checkbox"/>	02/01/2009	0004	18:00	Movie & Popcorn
<input type="checkbox"/>	01/21/2009	0003	10:00	Morning Stretch
<input type="checkbox"/>	01/05/2009	0009	17:00	Holiday Party

Date
Time
Activity
Instructor
Reason for Inactivation

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.

Activity ID

Movie & Popcorn

Previous Detail as of:

	Date	ID	Time	Description
<input type="checkbox"/>	03/06/2012	0004	15:02	Movie & Popcorn
<input type="checkbox"/>	02/01/2009	0004	18:00	Movie & Popcorn

Date
Time
Activity
Instructor
Reason for Inactivation


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

Print Inactivated Activity Report

Print Resident Inactivated Activity Report

Report Date **03/07/2012**

Resident ☒ All ☐ Individual



Dates ☒ All ☐ Range

From:

Thru:

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

Admission Procedures	Clinical Assessments	Edit Resident Events
Documentation	Vitals	Print Event Report
MDS / Care Plans	Activities	Inactivate Resident Events
Case Mix	Notes	
QI / QA / Survey Reports	Therapy	
Reporting	Inoculations	
Libraries	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.

Edit Event Detail by Resident

Resident ID  ADAMS

Date 

Time

Event ID  Fall

Reported By

Add Note

Comments

☒ while getting out of bed
☐ Fall without injury

Previous Detail as of:

	Date	ID	Time	Description
<input type="checkbox"/>	12/16/2010	0200	07:45	Fall
<input type="checkbox"/>	02/20/2009	0100	15:00	ER Visit
<input type="checkbox"/>				
<input type="checkbox"/>				

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

Documentation > Events

Print Event Report

MDE46

Print Resident Event Report

Report Date
03/07/2012

Resident
☒ All
☐ Individual

Dates
☒ All
☐ Range
From: Thru:

Events
☒ All
☐ Individual

Units
☒ All
☐ Individual
0000

☐ Page Break by Resident
☐ Sort by Event Id
☐ Include Discharged Residents

Residents Selected

Events Selected

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, complained 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.

Inactivate Event Detail

Resident ID  ADAMS HANNAH

Date 

Event ID 

Previous Detail as of:

	Date	ID	Time	Description
<input type="checkbox"/>	12/16/2010	0200	07:45	Fall
<input type="checkbox"/>	02/20/2009	0100	15:00	ER Visit
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Date

Time

Event

Reason for Inactivation

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
<input checked="" type="checkbox"/>	03/07/2012	0300	10:08	Infection
<input type="checkbox"/>	03/07/2012	0200	10:00	Fall
<input type="checkbox"/>	03/07/2012	0200	10:00	Fall
<input type="checkbox"/>	12/16/2010	0200	07:45	Fall
<input type="checkbox"/>	02/20/2009	0100	15:00	ER Visit

Date

Time

Event

Reason for Inactivation

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

Print Resident Inactivated Event Report

Report Date **03/07/2012**

Resident

☒ All ☐ Individual



Dates

☒ All ☐ Range

From:

Thru:

☐ Page Break by Resident

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.

Clinical: Nursing Care		Date: 03/1
Admission Procedures	Clinical Assessments	Enter Vitals
⇒ Documentation	⇒ Vitals	Print Vitals
MDS / Care Plans	Activities	Print Weight Trend
Case Mix	Notes	Print Weights QA
QI / QA / Survey Reports	Therapy	Inactivate Vitals

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

Clinical: Nursing Care	
⇒ Admission Procedures	⇒ Edit Medical Record

Demographics	
Resident ID <input type="text" value="1132"/>	
Prefix <input type="text"/>	
First Name <input type="text" value="Hannah"/>	<div>HIPAA <input checked="" type="checkbox"/> Consent <input checked="" type="checkbox"/> Authorization</div>
Middle Name <input type="text" value="J"/>	
Last Name <input type="text" value="Adams"/>	Gender (M/F) <input type="text" value="Female"/>
Suffix <input type="text"/>	Marital Status <input type="text" value="Married"/>
Nickname / <small>Preferred Name</small> <input type="text" value="MRS A"/>	Race <input type="text" value="5 - White, not of Hispanic origin"/>
<div>Attach Picture</div>	

Demographics
Contacts
Insurance
Physicians / Diagnoses
Allergies / Adv Dir / Other
Vitals
Order / Flowsheet / Kardex

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.

Residents Selected for Editing	
1132	ADAMS, HANNAH
1476	AKERS, HENRY

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:

User		Enter Vitals												Date	
Edit	Res ID	Name	Date	Time	BP Syst	BP Dias	Pulse	Temp	Resp Rate	O2 Sat	Pain Scale	Non Verbal	Glucose	Add Comment	View History
<input type="checkbox"/>	1132	ADAMS, HANNAH	05/10/2011	11:53											
<input type="checkbox"/>	1476	AKERS, HENRY	05/10/2011	11:53											
<input type="checkbox"/>	1314	ALLEN, IRENE	05/10/2011	11:53											
<input type="checkbox"/>	VT1500	AMIDON, LEATRICE	05/10/2011	11:53											
<input type="checkbox"/>	1273	ANISTON, THERESA	05/10/2011	11:53											
<input type="checkbox"/>	1517	APPLEBEE, CLARA	05/10/2011	11:53											
<input type="checkbox"/>	2187	APPLETON, THERESA	05/10/2011	11:53											
<input type="checkbox"/>	1200	ARCHER, BENNY	05/10/2011	11:53											
<input type="checkbox"/>	0068	AXELROD, LORNA	05/10/2011	11:53											

Screen 2 Vitals:
Height, Weight, Edema Scale, Intake, Output

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

User		Enter Vitals										Date 05/10/2011	
Edit	Res ID	Name	Date	Time	Height	Weight	Edema Scale	Intake	Output	Add Comment	View History		
<input type="checkbox"/>	1132	ADAMS, HANNAH	05/10/2011	11:53									
<input type="checkbox"/>	1476	AKERS, HENRY	05/10/2011	11:53									
<input type="checkbox"/>	1314	ALLEN, IRENE	05/10/2011	11:53									
<input type="checkbox"/>	VT1500	AMIDON, LEATRICE	05/10/2011	11:53									
<input type="checkbox"/>	1273	ANISTON, THERESA	05/10/2011	11:53									
<input type="checkbox"/>	1517	APPLEBEE, CLARA	05/10/2011	11:53									
<input type="checkbox"/>	2187	APPLETON, THERESA	05/10/2011	11:53									
<input type="checkbox"/>	1200	ARCHER, BENNY	05/10/2011	11:53									
<input type="checkbox"/>	0068	AXELROD, LORNA	05/10/2011	11:53									

Screen 1 Vitals:
BP, Pulse, Temp, Resp Rate, O2 Sat, Pain Scale, Glucose

Click **Back** (lower right) to return to Screen 1

Documentation > Vitals > Enter Vitals

To enter vitals, check mark the resident:

User		Enter Vitals										Date			
Edit	Res ID	Name	Date	Time	BP Syst	BP Dias	Pulse	Temp	Resp Rate	O2 Sat	Pain Scale	Non Verbal	Glucose	Add Comment	View History
<input checked="" type="checkbox"/>	1132	ADAMS, HANNAH	05/10/2011	13:04								<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

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

Edit	Res ID	Name	Date	Time	BP Syst	BP Dias	Pulse	Temp	Resp Rate	O2 Sat	Pain Scale	Non Verbal	Glucose	Add Comment	View History
<input checked="" type="checkbox"/>	1132	ADAMS, HANNAH	05/10/2011	13:04	135	89	90	98.6	20	98	01	<input type="checkbox"/>	100	<input type="checkbox"/>	<input type="checkbox"/>

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.

Enter Vitals Comments	
ADAMS, HANNAH	
BP	<input type="text"/>
Pulse	<input type="text"/>
Temp	<input type="text"/>
Resp Rate	<input type="text"/>
O2 Sat	<input type="text"/>
Pain Scale	<input type="text"/>
Glucose	reduce sugar intake
Height	<input type="text"/>
Weight	<input type="text"/>
Edema Scale	<input type="text"/>
Intake	<input type="text"/>
Output	<input type="text"/>
<input type="button" value="Ok"/> <input type="button" value="Cancel"/>	

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

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

Edit	Res ID	Name	Date	Time	Height	Weight	Edema Scale	Intake	Output	Add Comment	View History
<input checked="" type="checkbox"/>	1132	ADAMS, HANNAH	05/10/2011	13:04	54	128.0	+1			<input checked="" type="checkbox"/>	<input type="checkbox"/>

☒ **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.

Height	<input type="text"/>
Weight	<input type="text"/>
Edema Scale	low salt diet
Intake	<input type="text"/>
Output	<input type="text"/>

Documentation > Vitals > Enter Vitals

View
History



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	<input type="checkbox"/>	
05/10/2011	13:04	HTS*	Temperature	98.6	<input type="checkbox"/>	
05/10/2011	13:04	HTS*	Resp Rate	20	<input type="checkbox"/>	
05/10/2011	13:04	HTS*	Pulse	90	<input type="checkbox"/>	
05/10/2011	13:04	HTS*	Pain Scale	1	<input type="checkbox"/>	
05/10/2011	13:04	HTS*	O2 Sat	98	<input type="checkbox"/>	
05/10/2011	13:04	HTS*	Height	54	<input type="checkbox"/>	
05/10/2011	13:04	HTS*	Glucose	100	<input type="checkbox"/>	reduce sugar intake
05/10/2011	13:04	HTS*	Edema Scale	+1	<input type="checkbox"/>	low salt diet
05/10/2011	13:04	HTS*	Blood Pressure	135/ 89	<input type="checkbox"/>	
					<input type="checkbox"/>	

Print

Notes

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.

Save & Exit

Cancel

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:



WARNING: This will clear all vitals entered in this session. Are you sure?

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.

Print Resident Vitals

Resident to Print
☐ All
☒ Individual

Print by Unit
☐ All
☐ Individual

Enter Unit ID

Print by Physician
☐ All
☐ Individual

Enter Physician ID

Dates to Print
☐ All
☐ Most Recent
☐ Range

From: 00/00/0000 Thru: 99/99/9999

Vitals to Print

☒ All Vitals

☒ Blood Pressure
☒ Pulse
☒ Temperature
☒ Respiratory Rate
☒ O2 Sat
☒ Pain Scale

☐ By Date
☒ By Vital

☒ Glucose
☒ Height
☒ Weight
☒ Edema Scale
☒ Intake
☒ Output

Sort By
☒ Last Name
☐ Unit

☐ Page Break by Resident
☐ Include Discharged Residents
☐ Inactivated Vitals Only

Print End

Residents Selected for Printing

1132 HANNAH ADAMS

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.

☒ **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:

Inactivate Vitals			
Resident ID	1132	ADAMS	HANNAH
<div> <div>Dates</div> <div> <input checked="" type="radio"/> All <input type="radio"/> Range </div> <div> From: 00/00/0000 Thru: 99/99/9999 </div> </div>			
<div> <div> <div>Vitals</div> <div> <input type="checkbox"/> All Vitals </div> </div> <div> <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Pulse <input type="checkbox"/> Temperature <input type="checkbox"/> Respiratory Rate <input type="checkbox"/> O2 Sat <input checked="" type="checkbox"/> Pain Scale </div> <div> <input type="checkbox"/> Glucose <input type="checkbox"/> Height <input type="checkbox"/> Weight <input type="checkbox"/> Edema Scale <input type="checkbox"/> Intake <input type="checkbox"/> Output </div> </div>			

Inactivate Vitals							
User	HTS*						
Resident	1132	ADAMS	HANNAH				
Pick	Date	Time	User	Type	Reading	Reason for Inactivating	
<input type="checkbox"/>	05/10/2011	13:04	HTS*	Pain Scale	1		

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

Pick	Date	Time	User	Type	Reading	Reason for Inactivating
<input checked="" type="checkbox"/>	05/10/2011	13:04	HTS*	Pain Scale	1	No pain.

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

Documentation > Inoculations

Inoculations

Admission Procedures	Clinical Assessments	Edit Detail by Resident
⇒ Documentation	Vitals	Edit Detail by Inoculation
MDS / Care Plans	Activities	Print Inoculation Report
Case Mix	Notes	
QI / QA / Survey Reports	Therapy	
Reporting	⇒ Inoculations	

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

Demographics

HIPAA

☒ Consent

☒ Authorization

Gender (M/F)

Female

Marital Status

Married

Race


5 - White, not of Hispanic origin

Level of Care

2 ICF


Primary Payer


0001

 MEDICAID

Unit

10

 NF UNIT



Attach Picture

Demographics

Contacts

Insurance

Physicians / Diagnoses

Allergies / Adv Dir / Other

Vitals

Order / Flowsheet / Kardex

Clinical Assessments

Care Plans

Activities / Events

Inoculations

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**.

Edit Resident Inoculation Detail

Resident ID	1301		BRYANT	MARG
Date	05/09/2008			
Reference No	1		FLU SHOT	
Administered By	MAGGIE MCGEE RN			
Comments	<div></div>			
Previous Inoculation Detail as of:	05/09/2008			
Date	Inoculation	Administered By		
<div></div>	<div></div>	<div></div>		

Edit Resident Inoculation Info by Library Code

Date: 03/14/2012 


Library Code: 0 

Description:

Administered By:

Comments:

☐ Select Residents by Unit

Unit No: 0 

Resident	Last Name	First Name	
<input type="checkbox"/>	1132	ADAMS	HANNAH
<input type="checkbox"/>	1476	AKERS	HENRY
<input type="checkbox"/>	1314	ALLEN	IRENE
<input type="checkbox"/>	VT1500	AMIDON	LEATRICE
<input type="checkbox"/>	1273	ANISTON	THERESA
<input type="checkbox"/>	1517	APPLEBEE	CLARA
<input type="checkbox"/>	2187	APPLETON	THERESA
<input type="checkbox"/>	1200	ARCHER	BENJAMIN
<input type="checkbox"/>	0068	AXELROD	LORNA
<input type="checkbox"/>	1523	BALLARD	RALPH
<input type="checkbox"/>	1566	BARNETT	LILLIAN
<input type="checkbox"/>	07192011	BENTLY	JUDITH
<input type="checkbox"/>	1514	BOHR	DORIS
<input type="checkbox"/>	1201	BOULDER	BRENT
<input type="checkbox"/>	1301	BRYANT	MARGARET
<input type="checkbox"/>	1490	BURKE	MILLCENT
<input type="checkbox"/>	1202	CHASE	ALLEN
<input type="checkbox"/>	2010	CONWAY	LILLIAN

☐ Select All
 ☐ Un-Select All

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.

Edit Inoculation Library

Inoculation Code: 0 

Description:

Frequency:
 ☒ One Time Only
 ☐ Every

00

 Months
 ☐ Every


00


 Years

Requirement:
 ☒ Optional
 ☐ Recommended
 ☐ Required

☐ Satisfies RCA Section T-1 e (Influenza)
 ☐ Satisfies RCA Section T-1 f (Pneumococcal)

Care Plans

 Clinical: Nursing Care		Date: 03/16/2012
Admission Procedures	Scheduling / Pre-Asmnt	Edit Care Plan
Documentation	MDS	Print Care Plan
⇒ MDS / Care Plans	⇒ Care Plans	Print Evaluations

 Clinical: Res Care / Asstd Lvg		Date: 03/16/2012
Admission Procedures	RCA	Print Service Plan-Part 1
Documentation	⇒ Service Plans	⇒ Edit Service Plan
⇒ RCA / Service Plans	RCA Submission	Print Service Plan

Sample Care Plan

First Page: Diagnoses, Allergies, problem list

RESIDENT CARE PLAN HI-TECH NURSING & REHAB
<p>DIAGNOSIS:</p> <p>SCHIZOPHRENIC DISORDERS/OTHER SPECIFIED TYPES OF SCHIZOPHRENIA, UNSPECIF</p> <p>DISORDERS OF CONJUNCTIVA/CONJUNCTIVITIS, UNSPECIFIED</p> <p>EPISODIC MOOD DISORDERS/BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURR</p> <p>MULTIPLE SCLEROSIS</p> <p>SYMPTOMS INVOLVING HEAD AND NECK/OTHER SPEECH DISTURBANCE</p> <p>DEFICIENCY OF B-COMPLEX COMPONENTS/OTHER B-COMPLEX DEFICIENCIES</p> <p>TRIGEMINAL NERVE DISORDERS/TRIGEMINAL NEURALGIA</p> <p>ALLERGIES:</p> <p>TEGRETOL</p> <p>DISCHARGE PLAN:</p> <p>COMFORT CARE</p> <p>Problem List:</p> <p>0014 Lillian requires assist in performing ADLs due to decreased strength associated with exten</p> <p>0016 Lillian is incontinent of bladder and is at risk for rash, skin breakdown, social isolatio</p>

RESIDENT NAME	RESIDENT NO.	ROOM NO.	ADMIT DATE	BIRTH DATE	AGE	PHYSICIAN	DATE	PAGE
BARNETT, LILLIAN V	1566	046/2	05/04/2008	08/08/1919	92	BARKLEY, WILLIAM	11/01/2011	01

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

Problem with two goals and approaches attached to each goal.

RESIDENT CARE PLAN							
HI-TECH NURSING & REHAB							
Review Date/ Signature	Problem / Goal / Approach					Notes	
<p>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.</p> <p>Goal: 0001 Date: 08/15/2010 Lillian will receive assistance with ADLs and present a neat, clean, odor-free appearance daily. Thru next review.</p> <p>Approach: 0003 Disciplines: N NA Provide assistance with ADLs as needed.</p> <p>Approach: 0004 Disciplines: N NA Encourage to participate in ADLs as much as possible.</p> <p>Approach: 0006 Disciplines: N NA Dress in clothes that are clean and in good repair daily.</p> <p>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.</p> <p>Approach: 0011 Disciplines: N NA Keep call bell within reach.</p> <p>Approach: 0012 Disciplines: N NA Encourage resident to request assistance when needed.</p>							
<p>Goal: 0002 Date: 08/15/2010 Target: 11/07/2010 Resident will be able to turn self while in bed, and call for assistance when needed.</p> <p>Approach: 0010 Disciplines: N NA Resident utilizes 1/2 side rails on bed to help position self while in bed.</p> <p>Approach: 0011 Disciplines: N NA Keep call bell within reach.</p> <p>Approach: 0012 Disciplines: N NA Encourage resident to request assistance when needed.</p>							
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	02

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

HI-TECH NURSING & REHAB																					
Review Date/ Signature	Problem / Goal / Approach					Notes															
<p>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.</p> <p>Goal: 0001 Date: 08/15/2010 Target: 11/07/2010 The resident will have no skin breakdowns or odors. Thru next review.</p> <p>Goal: 0003 Date: 08/15/2010 Target: 11/07/2010 Resident will remain free of infection. Thru next review.</p> <p>Approach: 0001 Disciplines: N NA Assess for causes of Urinary incontinence.</p> <p>Approach: 0002 Disciplines: N NA Encourage resident to ask for assistance or use call bell.</p> <p>Approach: 0003 Disciplines: N NA Maintain adequate hydration, monitor and document fluid intake.</p> <p>Approach: 0004 Disciplines: N NA Follow toileting schedule.</p> <p>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.</p> <p>Approach: 0007 Disciplines: N NA Give positive reinforcement.</p>																					
<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">RESIDENT NAME</th> <th style="width: 10%;">RESIDENT NO.</th> <th style="width: 10%;">ROOM NO.</th> <th style="width: 10%;">ADMIT DATE</th> <th style="width: 10%;">BIRTH DATE</th> <th style="width: 5%;">AGE</th> <th style="width: 30%;">PHYSICIAN</th> </tr> <tr> <td>BARNETT, LILLIAN V</td> <td>1566</td> <td>046/2</td> <td>05/04/2008</td> <td>08/08/1919</td> <td>92</td> <td>BARKLEY, WILLIAM</td> </tr> </table>								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
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	03														

Signature page

RESIDENT CARE PLAN						
HI-TECH NURSING & REHAB						
<p>INITIAL CARE PLAN:</p> <p>Advanced directives status reviewed: Date __/__/__ Init __.</p> <p>Current Advanced Directives Status: Durable POA for health care (Date) __/__/__ Living Will (Date) __/__/__</p> <p>Do not resuscitate (Date) __/__/__ Do not Hospitalize (Date) __/__/__</p> <p>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</p> <p>_____ _____</p> <p>_____ _____</p>						
<p>UPDATE:</p> <p>Advanced directives status reviewed: Date __/__/__ Init __.</p> <p>Discharge plan has been discussed as follows: __ Indefinite stay indicated __ Discharge to another setting is under consideration. See social service notes for details.</p> <p>Problems, goals, approaches, and discharge plan reviewed (Date) __/__/__ and continue to be appropriate.</p> <p>The following problems have been added to the current plan of care _____.</p> <p>Review all problems in __ months.</p> <p>_____ _____</p> <p>_____ _____</p>						

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 04

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 habits, 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

 Clinical: Nursing Care		Date: 08/10/2011
Admission Procedures	⇒ Clinical Assessments	Edit Assessment
⇒ Documentation	Vitals	Print Assessment
MDS / Care Plans	Activities / Events	Inactivate Assessments
Case Mix	Notes	Print Assessment Exceptions

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

Admission Procedures	Face Sheet	Clinical Asmnt Library
Documentation	Orders/Flow Sheet/Kardex	Activities / Events Library
MDS / Care Plans	MDS / Care Plans	Inoculation Library
Case Mix	⇒ Documentation	Activity/Event Comments
QI / QA / Survey Reports	Facility	Notes Library
Reporting	Calendar	
⇒ Libraries		

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
- Risk for Dehydration
- BIMS Brief Interview Mental Status
- Bowel & Bladder Training
- Nutritional Risk
- PHQ-9 Mood Interview
- Contracture Risk
- Skin Risk
- 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** to view a list of current assessments:

	Assessment	Date	User	Status
<input type="checkbox"/>	015 Norton Plus Pressure Ulcer Sca	01/23/2012	SALLY	
<input type="checkbox"/>	050 Pressure Ulcer Risk Assessment	01/13/2012	SALLY	
<input type="checkbox"/>	100 Assessment of Urinary Incontin	08/25/2011	HTS*	
<input type="checkbox"/>	100 Assessment of Urinary Incontin	08/25/2011	SALLY	
<input type="checkbox"/>	001 Risk for Falls	01/05/2010	CRB	
<input type="checkbox"/>	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**:

Sort By: ☐ Reference Number
☒ **Alpha by Title**

☐ Display Favorites Only

Ref No	Title	Status
<input type="checkbox"/> 031	BIMS Brief Interview Mental Status	F
<input type="checkbox"/> 002	Bowel and Bladder Training	
<input type="checkbox"/> 003	Contracture Risk	
<input type="checkbox"/> 005	Nutritional Risk	
<input type="checkbox"/> 033	PHQ-9 Mood Interview	F
<input type="checkbox"/> 004	Risk for Dehydration	
<input type="checkbox"/> 001	Risk for Falls	
<input type="checkbox"/> 006	Skin Risk Assessment	

Sort By: ☐ Reference Number
☒ **Alpha by Title**

☒ **Display Favorites Only**

Ref No	Title	Status
<input type="checkbox"/> 031	BIMS Brief Interview Mental Status	F
<input type="checkbox"/> 033	PHQ-9 Mood Interview	F

Edit Resident Clinical Assessments

Resident ID: 1132 ADAMS, HANNAH DOB: 06/10/1938

View Assessments on File

Assessment: 001 Risk for Falls

Date: [Blue Box]

User: HTS* ID not on File

Questions/Answers

Score

Acuity range defined for this assessment in the assessment library. Compare to Total Score on a Complete Assessment.

000 -006 Resident is low risk

Questions defined for this assessment in the library.

(Q) Cognitive Status.

(Q) General Health

(Q) Mobility

(Q) Transfer Ability

(Q) Weight Bearing Status

(Q) Appliance in use at this time

Total Score: 00

☐ Score Override

Override Score: 00

Reason:

☐ Assessment Complete (Locked)

Cancel Ok End Print Notes

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
<input type="checkbox"/>	08/10/2011	HTS*	
<input type="checkbox"/>	08/04/2011	HTS*	
<input type="checkbox"/>	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.

Questions/Answers
☐ (Q) Cognitive Status
☐ (Q) General Health
☒ (Q) Mobility

Select Answer(s) to Question
03 Mobility
Select One Answer
☒ Independent
☐ With Assist
☐ Immobile

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

Select Answer(s) to Question

01 Cognitive Status.

Assessment Question

Select One Answer

☐ Intact
☒ Mild / Moderate Impairment
☐ Severe Impairment

Score
01
02

Answers defined for this Question and the acuity score for each answer

Comment
Wanders into other residents' rooms and becomes agitated

Cancel

Ok

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

Cancel	Help	Ok
--------	------	----

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

Questions/Answers	Score
<input type="checkbox"/> (Q) Cognitive Status	
(A) Mild / Moderate Impairment	01
(C) Wanders into other residents' rooms and becomes agitated.	

(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).

<input type="checkbox"/> (Q) Cognitive Status	
(A) Severe Impairment	02

<input checked="" type="checkbox"/> (Q) General Health	02

<input type="checkbox"/> (Q) Mobility	

<input type="checkbox"/> (Q) Transfer	

Select Answer(s) to Question

General Health

Answers

<input type="checkbox"/> Stable	
<input type="checkbox"/> Declining	01
<input type="checkbox"/> Terminal / Failure to Thrive	02

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.

(Q)uestion / (A)nswer / (C)omment
Add

(Q)uestion / (A)nswer / (C)omment
Modify

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.

The screenshot shows the 'Scoring' interface. At the top, under the heading 'Ranges', there are two lines of text: '0000-0006 Resident is low risk' and '0007-0018 Resident is high risk-Follow falls protocol, document in CP'. A red box labeled 'Acuity range' points to the second line. Below this is a table with a header 'Score' and three rows of values: '00', '01', and '00'. A red box labeled 'Score for each Answer' points to the first row. To the right of the table, there is a section labeled 'Total Score: 10'. A red box labeled 'Score for entire assessment' points to this section. Below the total score, there is a checkbox labeled 'Score Override'. If checked, there is a text input field for 'Override Score' (containing '00') and a text area for 'Reason:'.

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.

☐ **Assessment Complete (Locked & Signed)**

Not all questions have been answered - Continue?

Yes No

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.

Completing this Assessment will Lock It - OK?

Yes No

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

Buttons at Bottom of Screen

Cancel Ok End Print Notes

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

Print Resident Clinical Assessments			
Report Date		<input type="text" value="08/10/2011"/>	
Resident	<input type="radio"/> All <input checked="" type="radio"/> Individual	<input type="text" value="1132"/>	
Unit	<input type="radio"/> All <input type="radio"/> Individual	<input type="text" value="0"/>	
Assessment	<input type="radio"/> All <input type="radio"/> Individual	<input type="text"/>	
<input checked="" type="checkbox"/> Most recent Date			
Assessment Date	<input type="radio"/> All <input checked="" type="radio"/> Range	<input type="text" value="07/11/2011"/>	thru <input type="text" value="08/10/2011"/>
User	<input type="radio"/> All <input type="radio"/> Individual	<input type="text"/>	
Print Options		<input checked="" type="checkbox"/> Print Comments	
<input type="radio"/> Detail			
<input type="radio"/> Summary			

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** *unchecked* 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	Risk for Falls			
Asmnt Date	08/04/2011	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 and 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

<input checked="" type="checkbox"/> Most recent Date			
Assessment Date	<input type="radio"/> All <input checked="" type="radio"/> Range	07/11/2011	thru 08/10/2011
User <input checked="" type="radio"/> All <input type="radio"/> Individual			
Print Options	<input type="radio"/> Detail <input checked="" type="radio"/> Summary	<div style="border: 1px solid red; padding: 2px;">See the next page.</div> <input type="checkbox"/> Include Assessment Key	

Report Date	08/10/2011	Risk for Falls			
Asmnt Date	08/04/2011	HI-TECH NURSING & REHAB			
000-006 Resident is low risk 007-018 Resident is high risk-Follow falls protocol, document in CF					
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

<input type="radio"/> Summary	<input checked="" type="checkbox"/> 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-NRE0	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.

Print Notes Library

Report Date 06/22/2009

Discipline ☒ All ☐ Individual 

☐ Page Break by Discipline

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**.


Edit Note Library

Discipline 

Library # 

Text

Discipline  FACE SHEET

Library # 

EMERGENCY ROOM VISITS
TO WHICH HOSPITAL:
DATE:
TIME:
RETURNED DATE:
RETURNED TIME:

EMERGENCY ROOM VISITS
TO WHICH HOSPITAL:
DATE:
TIME:
RETURNED DATE:
RETURNED TIME:

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**.

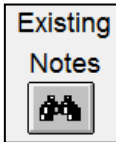
The screenshot shows the 'Edit Resident Notes' window. At the top, there's a title bar with 'Edit Resident Notes' and a 'HiTech' logo. Below the title bar, there are fields for 'Resident' (1301), 'MARGARET BRYANT', and 'User' (HTS*). There's a 'Type' section with radio buttons for 'Progress', 'Face Sheet', 'CAA', and 'MDS'. A red box labeled 'Choose Note Type' points to the 'Type' section. To the right of the 'Type' section, there's a checkbox for 'Note Complete (Locked)'. Below the 'Type' section, there are fields for 'Date' (02/02/2011), 'Time' (09:54), 'Page' (1), and 'Discipline'. A red box labeled 'Select standardized text from library' points to the 'From Library' button on the right. Below these fields, there's a large text area for 'Add Note'. A red box labeled 'Add new notes here' points to this area. To the right of the 'Add Note' area, there's a 'Next Page' button. Below the 'Add Note' area, there's a section for 'Existing Notes'. It includes a 'View' checkbox, a 'Discipline Only' checkbox, and a list of note types: 'All', 'Progress', 'Face Sheet', 'CAA', and 'MDS'. A red box labeled 'Click binoculars to display Note Inquiry. See next page.' points to the binoculars icon. Another red box labeled 'View All or select a Type of Note. Use scroll bar on right to scan through Notes.' points to the 'All' radio button and the scroll bar on the right. At the bottom, there's a 'Source: Edit Notes' label. A red box labeled 'View All or select a Type of Note. Use scroll bar on right to scan through Notes.' points to the 'All' radio button and the scroll bar on the right. A 'Print' button is located at the bottom right.

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**.)

Hi-Tech Software Solutions

EMR Features of the Clinical Records System



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 and it will be displayed at Modify Note on the Edit Resident Notes screen (below).

NOTE: You cannot edit RAP or CAA notes.

Note Inquiry

Start Date: 02/02/2011

Type: ☐ All ☒ Progress ☐ Face Sheet ☐ CAA ☐ MDS

Date	Time	User	Type	ARD	Subset	Pg	Complt	Text
06/30/2006			Progress			1	<input type="checkbox"/>	Margaret became confused during lunch because

Selected Note displays in text box below.
To edit the note, click to display note at Modify Note (next screen).

Margaret became confused during lunch because she thought it was breakfast, and she wanted orange juice. Aide explained that it was lunch and that she had orange juice at breakfast, but Margaret grew agitated. Aide gave her juice to calm her. After lunch she was assisted to her room, but she was confused about its location. She asked where her TV was and that she wanted to watch TV. She would not go to the activity room to watch TV. She was so agitated that we called daughter Mary Joe who came

Modify Note

Date: 05/19/2009 Time: 11:40 Page: 1 Discipline:

Margaret became confused during lunch because she thought it was breakfast, and she wanted orange juice. Aide explained that it was lunch and that she had orange juice at breakfast, but Margaret grew agitated. Aide gave her juice to calm her. After lunch she was assisted to her room, but she was confused about its location. She asked where her TV was and that she wanted to watch TV. She would not go to the activity room to watch TV. She was so agitated that we called daughter Mary Joe who came to visit Margaret. After visiting with daughter and napping, Margaret was calmer.

- 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 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 button to copy the text of that note to the Add Note area as a new note that you can edit and save.

Note Inquiry

Start Date: 03/26/2010

Type: ☐ All ☒ Progress ☐ Face Sheet ☐ RAP

Date	Time	User	Type	Pg	Complt	Text
<input type="checkbox"/> 03/26/2010	14:04	HTS*	Progress	1	<input checked="" type="checkbox"/>	ADL Issues:
<input type="checkbox"/> 03/26/2010	14:04	HTS*	Progress			ADL Progress:
<input type="checkbox"/> 03/26/2010	14:04	HTS*	Progress			ADL Outcomes:

Document Storage

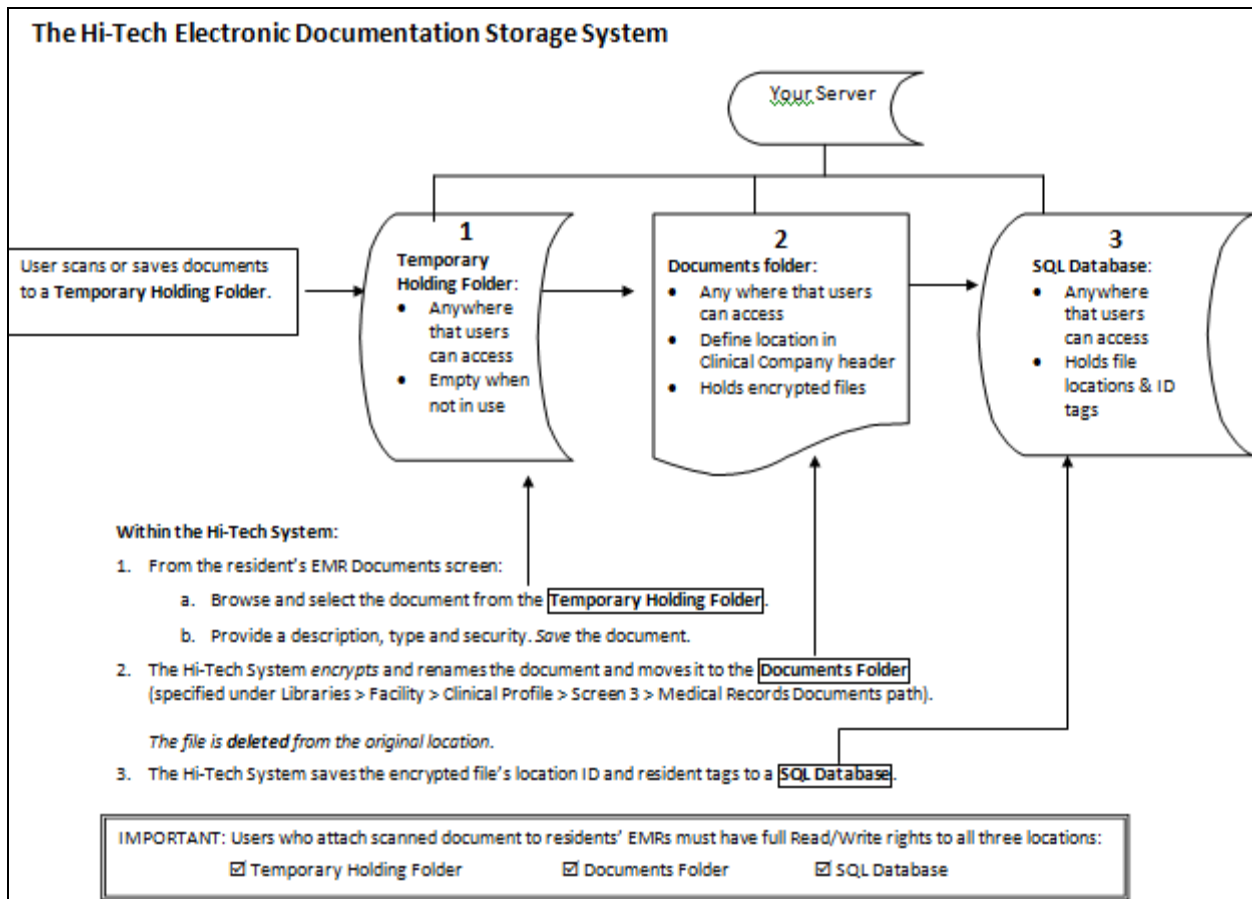
Electronic Document Storage System

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.

Medical record documents storage path
X:\DOCUMENTS
Medical record documents scanning path
X:\SCANDOCUMENTS

Hi-Tech System Administrator:

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

Enter the Database URL. Example:

Database URL	MARTIPC\SQLEXPRESS
--------------	--------------------

Admission Procedures > Edit Medical Record >

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

Demographics

Resident ID: 1132

Prefix:

First Name: Hannah

Middle Name: J

Last Name: Adams

Suffix:

Nickname / Preferred Name: MRS A

Social Security No.: 105-37-8545

Canadian SIN:

Date of Birth: 06/10/1938

Phone: 207 474 7122

Group Id's: 101 102 0

Gender (M/F): Female

Marital Status: Married

Race: 5 - White, not of Hispanic origin

HIPAA: ☒ Consent ☒ Authorization

Level of Care: 2 ICF

Primary Payer: 0001 MEDICAID

Unit: 10 NF UNIT

Room/Bed: 035 1 ROOM & BOARD

Admit Date: 01/04/2009

Discharge Date:

Time: 13:00

Source: 01 PRIVATE HOME OR APPT.

City: SKOW SKOWHEGAN

County: SOME SOMERSET

Original Admission Date: 02/01/2006

Demographics

- Contacts
- Insurance
- Physicians / Diagnoses
- Allergies / Adv Dir / Other
- Vitals
- Order / Flowsheet / Kardex
- Clinical Assessments
- Care Plans
- Activities / Events
- Inoculations
- Calendar
- Notes
- Documents**
- Stay Tables
- Patient Liability Data
- Balances

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

Document Management

Resident ID: 1132

Resident: HANNAH ADAMS

	File	Description	Type	Added By	Inactivate	Date Added
<input checked="" type="checkbox"/>	View 1132_MR_DOC_2010...	registration	Admission Contract	HTS*	<input type="checkbox"/>	5/2/2011 2:43 PM
<input type="checkbox"/>	View 1132_MR_AdmitOrder...	Admit DR Orders	Doctor Orders	HTS*	<input type="checkbox"/>	5/2/2011 9:14 AM
<input type="checkbox"/>	View 1132_MR_BCBSInsur...	BCBS Insurance	Insurance	HTS*	<input type="checkbox"/>	5/2/2011 9:10 AM

Add Document

Select File:

Description:

Type: Admission Contract

Security:

Add

Filter Documents

Show Inactive: ☐

Type: All

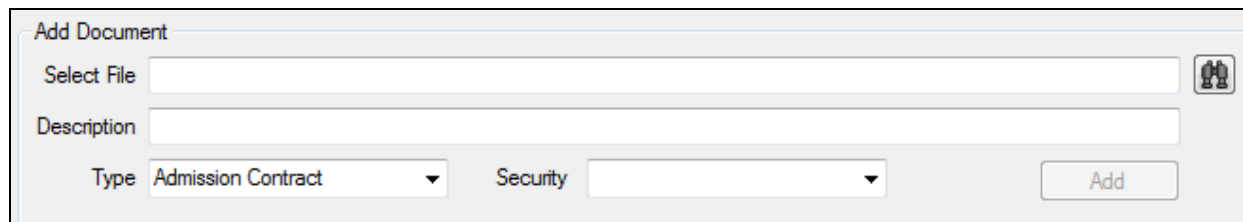
Close

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.

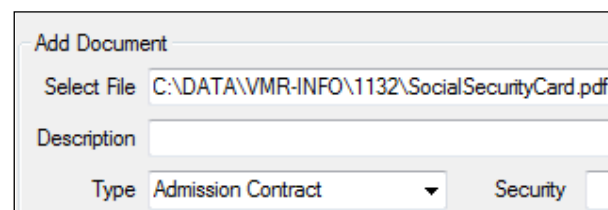
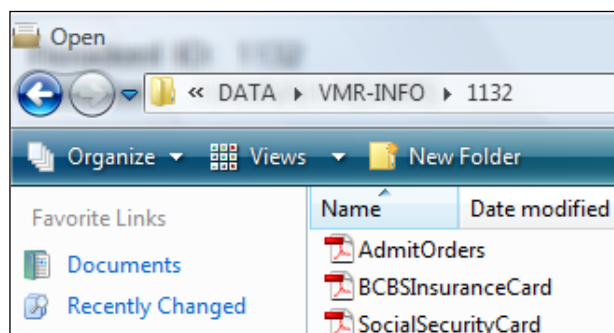


The 'Add Document' dialog box contains the following fields and controls:

- Select File:** A text input field with a binoculars icon on the right for file selection.
- Description:** A text input field.
- Type:** A dropdown menu currently showing 'Admission Contract'.
- Security:** A dropdown menu.
- Add:** A button to confirm adding the document.

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.

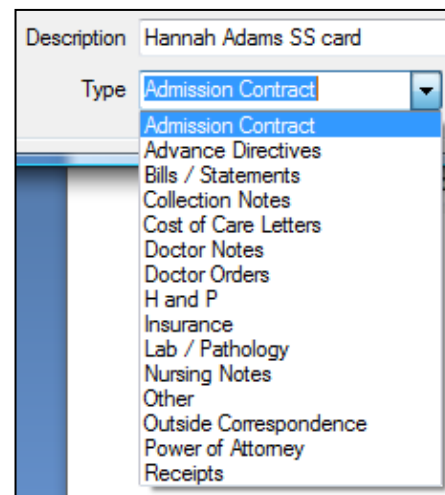
Select the document and click **Open** (or double-click the document file name).
The selected path and document will be displayed.



The 'Add Document' dialog box is updated with the following information:

- Select File:** C:\DATA\VMR-INFO\1132\SocialSecurityCard.pdf
- Description:** (Empty)
- Type:** Admission Contract
- Security:** (Empty)

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



The 'Add Document' dialog box is further updated:

- Description:** Hannah Adams SS card
- Type:** A dropdown menu is open, showing a list of document types. 'Admission Contract' is highlighted.

Type
Admission Contract
Advance Directives
Bills / Statements
Collection Notes
Cost of Care Letters
Doctor Notes
Doctor Orders
H and P
Insurance
Lab / Pathology
Nursing Notes
Other
Outside Correspondence
Power of Attorney
Receipts

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

Security

- Both Clinical and Financial
- Clinical Only
- Financial Only

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

Resident ID: 1132						
Resident: HANNAH ADAMS						
	File	Description	Type	Added By	Inactivate	Date Added
	View	1132_MR_SocialSec...	Hannah Adams SS card	Admission Contract	HTS*	5/11/2011 3:21 PM

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:

Resident ID: 1132						
Resident: HANNAH ADAMS						
	File	Description	Type			
View	1132_MR_SocialSec...	Hannah Adams SS card	Admission Contract			
View	1132_MR_DOC_2010...	registration	Admission Contract			
View	1132_MR_AdmitOrder...	Admit DF				
	View	1132_MR_BCBSInsur...	BCBS Ins			

Are you sure you want to inactivate this record?

Yes No

Add Document

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.

Filter Documents

Show Inactive ☒

Type All

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 Page 64. 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 Page 64. 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.

Schedule	Status	Time	Drug / Order	PRN	Ord #	Start Date	Type	BC
04/19 12:00 PM PP			FUROSEMIDE 80 MG TABLET		106	05/29/2008	MED	*
04/19 12:00 PM PP			RISPERDAL 0.25 MG TABLET [RISPEF		129	05/29/2008	MED	*
04/19 01:00 PM PP			REGLAN 5 MG TABLET [METOCLOPR		107	05/29/2008	MED	*
04/19 02:00 PM PP			DILTIAZEM ER 180 MG CAP SA [DILT		105	05/29/2008	MED	*
			*ACETAMINOPHEN 500 MG TABLET	PRN	147	05/19/2009	MED	*
			DARVOCE-T-N 100 TABLET [PROPOXY	PRN	23	05/29/2008	MED	*
			PROMETHAZINE 25 MG/ML VIAL	PRN	22	05/29/2008	MED	*

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.