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New Nursing Module

The purpose for designing this new charting module is to make everyday use of ECS easier and more streamlined for nursing staff. American Data has taken feedback received from clients over the years and completed research to determine what change would be most beneficial to our end users. In addition, for those facilities who offer several different service levels in their communities, this new module allows for some sharing of topics to assure that charting is consistent across the entire campus.

If your facility is interested in moving forward with the entire nursing module, this would replace your current nurse charting workflow. A facility may also determine that there are only specific topics or reports they are interested in, rather than implementing the entire module. That is always an option as well and for specific estimates for only the topic(s) you would like, speak to a clinical department staff member.

Key Differences

	Existing Nursing Module	New Nursing Module
Nurse Note	Multiple Topics (body systems)	One Topic
Medicare Note	Hybrid Task/Write Task	One Topic
Vital Signs	One Topic	Multiple Topics
View Reports/View Chart	Multiple Access Buttons	One Button (user then defines specific task they want)
Name Selection Panel	Yes	No
AANAC Baseline Care Plan	Unavailable	Admission Note

Current Module: All the current topics used to write a nurse's note.

Diagnosis | Nurse Ch | Plans | Therapy | Face Sheet | Clinical Calculations | Sche

Systems/Symptoms
- Vital Statistics/Symptoms
- Hydration Status/IV
- Respiratory Condition
- Nervous System Condition
- Circulatory Condition
- Urinary/Repro Condition
- Digestive Condition
- Muscular-Skeletal Condition
- Skin/Feet Condition
- Endocrine Condition
- Sensory Condition
- Hearing, Speech & Vision

Appts/Contact
- Appointment Schedule
- Physician/Family Contact

Incidents
- Falls and Incidents
- Follow Up Falls/Incidents
- Neuro Checks

Psych-Social
- Mood
- Behavior
- Cognitive
- Psych-Social

Special Treatments
- Immunizations
- Lab/Xray
- Special Treatments/Programs
- Near End of Life

Assessments
- MMS Assessment
- Continence Assessment
- Dehydration Risk Assessment
- Dyskinesia Identification
- Elopement Risk Assessment
- Fall Risk Assessment
- McGeer Criteria
- Pain Assessment
- Restorative Nursing Assessment
- Self Med Adm. Assessment
- Side Rail Assessment
- Skin Breakdown Risk Assess.
- Sleep Assessment
- Smoking Assessment
- Supportive Devices
- Wound Charting
- Func. Abilities & Goals (GG)
- On-Time Wound Assessment
- Sleep Assessment

ADLs
- Bed Mobility
- Transfers
- Locomotion/Walking
- Dressing
- Eating
- Toilet Use
- Personal Hygiene
- Bathing
- Elimination
- Restorative

To Do List
- To Do List
- MC Charting flip backs

New Module: One topic to write a nurse's note.

Schedule | Qual | Orders | Human Resources | Supplie
Memo | Physic | Nursing | Assessments | MAR/TAR

Nursing Home Specific
- NH Nurse Note
- NH Admission Note
- NH Medicare Note
- NH Summary Note

Assisted Living Specific
- AL Nurse Note
- AL Level of Care Assessment
- AL Charges

ICF/IDD Specific
- ICF/IDD Nurse Note
- ICF/IDD Admission Note

- Fall Note
- Incident Note
- Neuro Checks
- Hospice/End of Life
- Lab/X-Ray Results
- Immunizations
- LOA/Rm Change/DC/Transfer
- Physician Contact/Visit
- Pressure Injury Assessment
- Non-Pressure Wounds
- Restorative Nursing
- To Do List
- Seizure Record

What's Included

The following sections and topics are included in the new module.

Nursing Section

- NH Nurse Note, AL Nurse Note, ICF/IDD Nurse Note
- NH Admission Note, AL Level of Care Assessment, ICF/IDD Admission Note
- NH Medicare Note
- NH Summary Note
- AL Charges
- AL Summary Note (MDS RCA)
- Fall Note
- Incident Note
- Neuro Checks
- Hospice/End of Life
- Lab/X-Ray Results
- Immunizations
- LOA/Rm Change/DC/Transfer
- Physician Contact/Visit
- Pressure Injury Assessment
- Non-Pressure Wounds
- Restorative Nursing
- To Do List
- Seizure Record

Assessments Section

- AIMS
- BIMS
- Bladder & Bowel Continence
- Cornell Scale for Depression
- Dehydration
- Dyskinesia Identification
- Elopement and Wandering
- Evacuation
- Fall Risk
- Functional Abilities & Goals
- Geriatric Depression Scale
- McGeer Criteria
- Mini-Mental Exam
- Nestle MNA
- Oral Health (OHAT)
- Pain

- PHQ-9
- Psychotropic Medication Eval
- Self-Med Administration
- Side Rail
- Skin Breakdown Risk
- Sleep
- SLUMS Exam
- Smoking Safety Evaluation
- Supportive Devices
- Trauma Informed Care Tools

MAR/TAR Section

- Side Effects – Psychotropics
- Targeted Behavior Plan/Monitoring
- Med Exceptions
- PRN Meds
- Med Use/Pharmacology
- Gradual Dose Reduction
- Med Occurrence
- Nursing Orders (TAR)
- Vital Sign Write Backs
- Intake/Output Write Backs
- Blood Glucose Write Backs
- Nebulizer Assessments

Next Steps

Merging in a new nursing module into your existing database to replace a previously used nursing charting and/or assisted living charting tabs can have up to four phases to take into consideration. These include: Merge, Linking, Training, and Go live.

A merge request would need to be completed to incorporate the nursing module. This merge is scheduled with our technical department on a first come, first serve basis. This type of merge generally takes about 60 minutes (billable at $130/hour).

Once the items are merged in, there are several setups/linking that may include various tasks depending on the various areas of the system that you would like to be updated. In addition, there may be some existing reports and view tasks that these newly merged in topics should be linked to (Ex. Nurses Notes, 24-hour report, etc.).

Training is optional, dependent on the facility's comfort level. Training would be billed as incurred. The facility may also choose to complete most of their own training with the handouts provided by the clinical department.

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Prior to go live, a facility will need to document the following items in the new module (if they are currently being utilized in the old): Side Effect Monitoring orders, Targeted Behavior Plans, and To Do List assignments for nurses. If Side Effect Monitoring and Targeted Behavior Plans are currently entered at your facility in the MAR/TAR tab, then these will not need to be re-documented prior to go live.

The final step with this module is the day of go live. On this go live date, the nurses must be completely out of ECS for **one hour** as they cannot be charting or on the eMAR/eTAR during this transition. We are only able to perform the go live setups during business hours (7am-5pm CST).

Estimate of Charges

Charges		Estimated Cost
Merge	1 hr. @ $130/hour	130.00 (required)
Access button, view task, and report linking (integration into existing database)	12 hr. @ $90/hour	1080.00 (required)
User Group Setups (dependent upon number of user groups)	2 hr. @ $90/hour	180.00 (required)
Training (remote)	6 hr. @ $90/hour	540.00 (optional)
Go live Setups	4 hr. @ $90/hour	360.00 (required)

**Please note that this is a general estimate of costs only. Costs may vary depending on the facility's existing setups and needs. The final bill will reflect the actual costs incurred. Do not hesitate to contact the clinical department at 1-800-464-9942 or clinical@american-data.com with any further questions regarding this process.

Screen Shot Examples

NH Nurse Note Topic excerpt

NH Nurse Note

PURPOSE FOR NOTE:	VITAL SIGNS	ACUTE NOTE (MISC.):	SKIN STATUS:	
new or sudden onset/change	BP:	Lab results:	no skin issues	Location:
ongoing change in condition	Pulse:	Fever:	NEW Skin Impairment:	Treatment:
follow-up	Respirations:	Mood:	Surgical Wound:	Dressing:
progress note	Temp:	Behavior:	Abrasion/Bruise:	
	Weight:	^ Additional behavior	Rash:	^ Non-Pressure Wound Charting
	Pulse Oximetry:	Infection/ABT:	Blister:	^ Pressure Injury Assessment
	Blood Glucose:	Isolation:	Wound:	
	Pain (0-10):	Medication:	Pressure Area:	
	Pain (descriptor):	COVID-19:	Other skin issue:	
	Fluid Intake (mL):			
	Fluid Output (mL):			

RESPIRATORY:	CARDIOVASCULAR STATUS:	GI/DIGESTIVE:	GU/URINE STATUS:	MUSCULOSKELETAL STATUS:	NEUROLOGICAL STATUS:	HYDRATION STATUS:
Respiratory Complaint:	Circulatory Complaint:	GI/Digestive Complaint:	Urinary Complaint:	Musculoskeletal complaint:	Neurological complaint	IV fluids/meds:
Respiration Characteristics:	Pulse Characteristics:	Abdomen:	Urinary/Renal pain:	Musculoskeletal Pain:	Mental Status:	I & O:
Nasal discharge:	Chest Pain:	Bowel Sounds:	Urine Clarity:	Movement/limitation:	Motor Function:	Symptoms of decreased fluids:
Cough:	Edema:	Vomitus:	Voiding Concerns:	Swelling:	LOC:	Fluids:
Lung Sounds:	Circulation:	Stool Output:	Peritoneal Concerns:	Precautions:	Seizure activity:	Site care:
Mucus:	Cardiac Implant/Device:	Oral/dental:	Catheter:	Positioning:	Speech:	
Oxygen:	Peripheral Pulse:	Swallowing:	Urine sample:	Exercise/ROM:	Hallucination/delirium:	
Nebulizer:	Anti-anginal:	Colostomy:		Assistive Device:	Neuro check:	
Trach:	Diuretic/BP Med:	Feeding Tube:				
Suctioning:	Positioning:					

Medicare Note Topic excerpt (Cardiovascular Columns)

Cardiovascular

CARDIOVASCULAR CONDITIONS:	CARDIAC ASSESSMENT:	INTERVENTIONS:	TEACHING/TRAINING:	RESPONSE/PROGRESS:
none	no problems noted	elevated HOB,	signs and symptoms,	improvement in
heart failure,	heart rate/rhythm:	elevated feet/extremities,	fluid restriction,	progressing towards
hypertension,	edema:	prn med given,	use of diuretics,	maintaining
pacemaker,	chest pain:	vital signs obtained,	use of blood thinners,	continues to require
MI,	cardiac meds:		orthostatic hypotension,	return demonstration provided
	weight gain:		pacemaker,	verbalized understanding
	pedal pulses:		**PERSON TRAINED:**	
	extremity color/warmth:		resident,	
	capillary refill (second(s)):		caregiver/ family,	
	numbness/tingling/pain:		nursing assistant,	
	cardiac devices:			

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Medicare Note Topic excerpt (Neuro Columns)

Neuro				
NEUROLOGICAL CONDITIONS:	NEURO ASSESSMENT:	INTERVENTIONS:	TEACHING/TRAINING:	RESPONSE/PROGRESS:
none	no problems noted	lab results reviewed,	disease process,	improvement in
comatose,	level of consciousness:	seizure precautions,	signs and symptoms,	progressing towards
hemiparesis,	pupillary reactions:	splint/ brace application,	dealing with pain,	maintaining
quadriplegia,	muscular weakness:	safety checks conducted,	safety,	return demonstration provided
cerebral palsy,	swallowing issues:		PERSON TRAINED:	verbalized understanding
multiple sclerosis,	seizure activity:		resident,	
CVA,	time of seizure:		caregiver/ family,	
seizures,	symptoms prior:		nursing assistant,	
Parkinson's,	pattern:			
TBI,	time unconscious:			

Fall Note topic excerpt

TYPE OF FALL:	LOCATION:	INJURY:	DID RESIDENT HIT HEAD?	STAFF INVOLVED:	DESCRIBE EVENT:	VITAL SIGN
observed fall	resident's room	no apparent injury	If hit head, Neurological	nurse,		BP:
fall not observed	hallway	moves all extremities	Assessment to be initiated.	CNA / RA,		Pulse:
WHO OBSERVED THE FALL:	bathroom	skin tear, avulsion, hematoma	yes,	housekeeper,		Respiration
N/A	dining room	laceration	no	social worker,		Temp:
staff member	activity room	edema	unwitnessed,	laundry worker,		Pulse Oximet
family member	outside	bruising	initiate neuro assessment	maintenance worker,		
visitor	therapy	scrape		activity aide,		
other:	beauty/barber	no c/o:		other:		
name:	shower/tub	c/o:		none		
	nursing station	c/o pain				
	out of facility	no c/o pain				
	other:					

Immunization topic (all immunizations charted via templates for streamlined charting)

Immunizations	Administered	Not Administered	TB Skin Test - PPD	Other Information	Sign
^ View Immunization Record	Influenza Administered	Influenza Not Administered	PPD Administered	Chart Other Immunization Info	
	PPV Administered	PPV Not Administered	PPD Not Administered	SARS-CoV-2 by 3rd Party(dose1)	
SCANNED DOCUMENT:	Hepatitis B Administered	Hepatitis B Not Administered	PPD Results	Set alarm reminder for dose #2	
Browse for document	SARS-CoV-2 (Pfizer 1st dose)	SARS-CoV-2 Not Administered	PPD Chest X-Ray Results	SARS-CoV-2 by 3rd Party(dose2)	
	SARS-CoV-2 (Pfizer 2nd dose)				
	SARS-CoV-2 (Moderna 1st dose)				
	SARS-CoV-2 (Moderna 2nd dose)				