DON/ADON/Nurse Supervisor

Daily Tasks

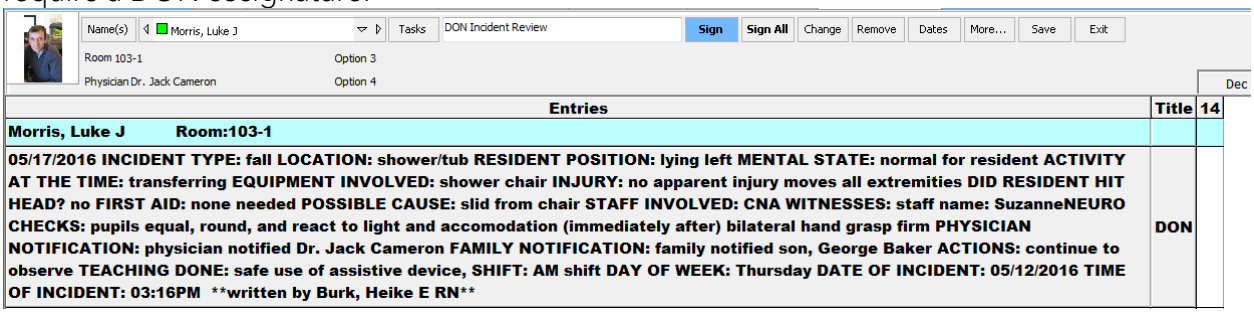
24 Hour Report

Displays all changes within the past day. After clicking the button, select the desired name(s) and click OK. The 24-hour report is setup to populate the following data:

- New/discontinued physician orders
- Stop and Watch items reported by the CNA/Care Assistant
- Entries detailing medications that were held, refused, or signed out
- PRN medications administered
- Medication errors
- Nurses notes
- Fall notes
- Incident notes
- Neuro check notes

DON Incident Review

Opens an electronic Cosign screen displaying all the incidents on the selected resident(s) that require a DON cosignature.



Click within the box under the date to enter the user's initials and cosign the entry. Incidents may be reviewed and cosigned all at once by using the Sign All button at the top of the screen. When finished, click Save and then Exit to return to the prior Access screen.

New Order Review

Opens a View screen to display changes in physician orders for the selected name(s). Only orders that have been changed within the past day will be displayed. The screen may be printed by clicking the Print button under More… at the top of the screen. Click the Exit button to return to the prior Access screen.

Current Infections

Opens a View screen displaying any unresolved infections that have been documented for the selected name(s). To resolve an infection so it no longer appears on the View screen, the user must use the *OUTCOME* word appended onto an existing infection entry.

Risk Review

Opens a View screen to display all charting related to Falls, Wounds, Weight Loss, and Physician Orders for the selected resident(s). The user will first be prompted to select a date range, if desired. The screen may be printed by clicking the **Print** button under **More…** at the top of the screen. Click the **Exit** button to return to the prior Access screen.

Chart Audit

Provides the user with several task reporting options. These include Admission, IDT Assessments, Nursing Assessments, Quality Checks, and Therapy. To run a select group of the reports, use the **CTRL** key on the computer keyboard to highlight the desired reports, and then click **Load**.

Quality Audits

(X = Incomplete items found within the residents chart)

Date: 12/14/2017

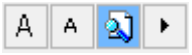
Name	TB Skin Test Due (365 Days)	Pneumo. Immun. Due (365 Days)	Flu Immun. Due (365 Days)	PRN Med No Follow Up (30 Days)	Fall No Follow Up (30 Days)	ABT No Inf. Charting (30 Days)	Weekly Skin Check Missing	Psych. Med Red. Due (180 Days)	Vital Signs Missing (30 Days)	CNA - No BM 3 Days	CNA - No Bath 7 Days
Edwards, Jack C		X	X					X			X
Einstein, Albert	X	X	X					X			X
Hershey, Darlene	X		X					X			X
Jefferson, Thomas	X	X	X					X			X
4	3	3	4					4			4

Chart Review

View Chart

Allows the user to review specific charting information. Select the desired resident name(s) and click **OK**. Once inside the View Screen, click **Topic** or **Tasks**, and select the specific Section/Topic or load the desired Task, and then click **Go**. To narrow down the dates for review, click **Date From** and/or **Date To** and click **Go**. The View screen may be printed by clicking the **Print** button located under the **More…** option. Click **Exit** to return to the Access screen.

- Adjust the font size by clicking **More…** and clicking the big or little "A."
- Search for words within the View screen by clicking **More…** and then clicking the magnifying glass symbol. Type in the text to be searched and click **OK**. This feature searches both words that were clicked within a topic as well as free text.

- Click the arrow to the right of the search feature to have it bring you to the next found word. 

Topic

Clicking the **Topic** button allows navigation through the Sections and Topics available within the system that the user has rights to. The user may select a specific word within a topic to narrow down their search. For example, to view any Observed Falls, click **Topic** > **Nursing** > double-click **Fall Note** > click the **Observed Fall** word > **OK** > **Go**.

Task

Clicking the **Task** button loads a pre-determined task item. Once a task is highlighted, click **Load**, and then **Go**. Examples of Tasks include: Blood Pressures, Diagnoses, Fall List Past 31 Days, Infections – Unresolved, Medication Review (Psychotropics), Pain Review, and Vital Signs.

Control Button

Clicking the **Control** button within the View screen gives the user more options for how to view the information. Some popular options are listed below:

- **Filter** tab
  - D/C'd Entries – Displays all discontinued entries.
  - Users – Use this to narrow down the charting being viewed based on the user(s) who entered it in. This is a great tool for auditing specific user(s) charting.
  - Free Text – Allows the user to search within the charting on the view screen for a specific free typed word. If wanting to search through all of the fall notes for a specific caregiver's name, simply enter the name in the Free Text box, click OK and Go.
- **Look** tab
  - Separator – For ease of viewing, the user may choose to add lines/spaces between entries or topics.
  - Order – Allows the user to determine the order in which the entries display on the screen.
  - Show Name of Initials – Displays the full name and title of the person who entered/discontinued each entry.
  - Free Text Highlighter – Used frequently in troubleshooting as it will turn all free text on the view screen blue.
  - Show Topic Name – Displays the topic that the entry was documented in.

Resident Daily Summary

Displays the following summary information for specific residents: most recent set of vitals, new physician orders from the past 7 days, nurses notes from the past 7 days, and meal and fluid intake from the past 7 days. Click the **Exit** button at the top of the screen to return to the Access screen.

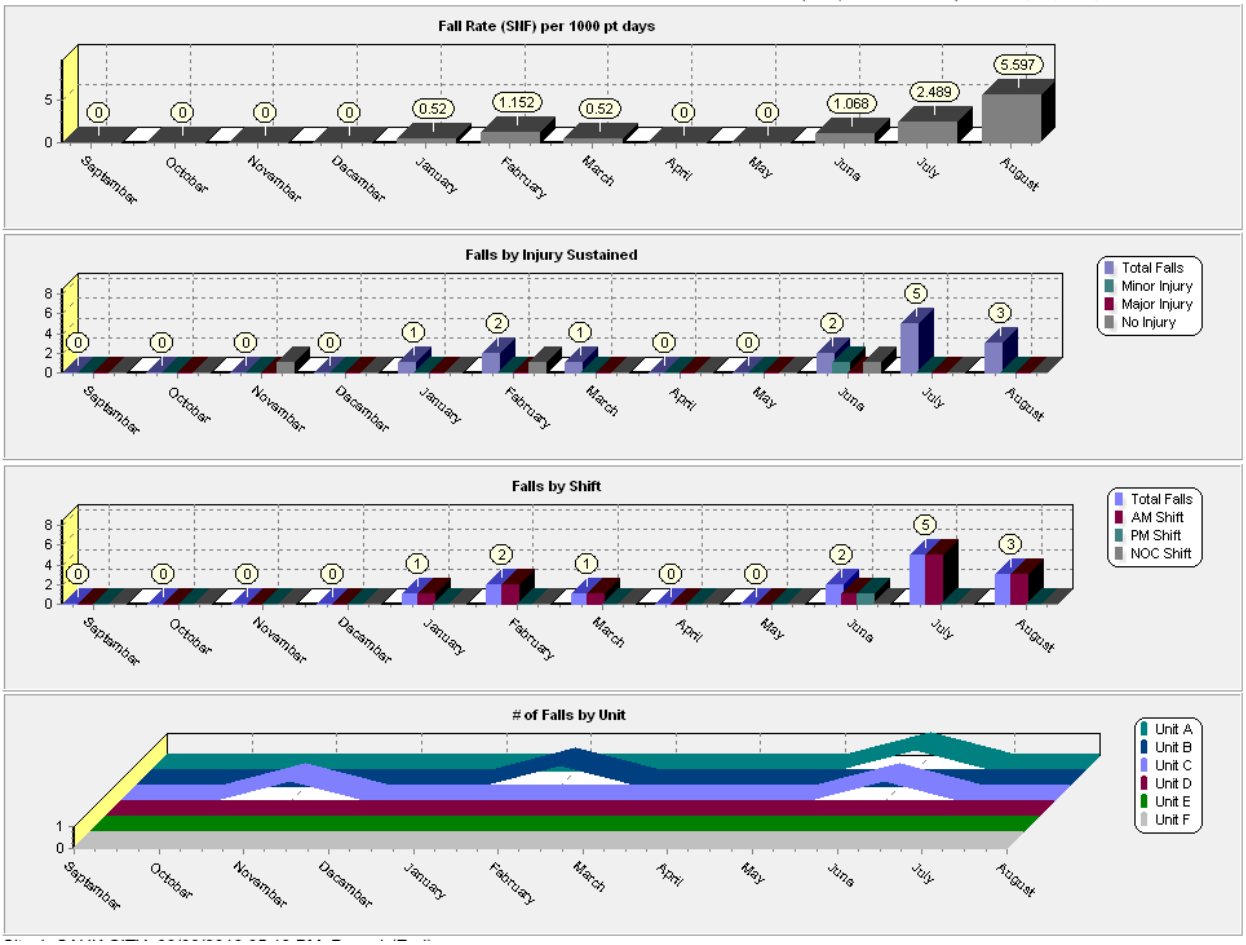
Quality Measure Reports

Loads two QM reports for both the short and long stay residents. This information is populated based on the MDSs and only displays from MDSs that have already been submitted into ECS. Click the Exit button at the top of the screen to return to the Access screen.

QA Reports

Brings the user to a new Access screen displaying all Quality Assurance Graphs and Reports built into ECS. The user may click any of the report buttons , select the desired name(s), and then click OK to load. Click Exit when completed with viewing the report. To navigate back to the Nurse Supervisor Access screen, click Main Menu > Nursing > DON/ADON/Nurse Supervisor.

*The user may complete other work in ECS while the report(s)/graph(s) load.



Other Reports

Clicking the Other Reports button displays a list of all reports available to the user. First, select the desired name(s) and then highlight the specific report(s) to run. Then, select start and end dates and click OK. The report may be printed using the printer icon at the top of the screen. Click the Exit button at the top of the screen to return to the Access screen.

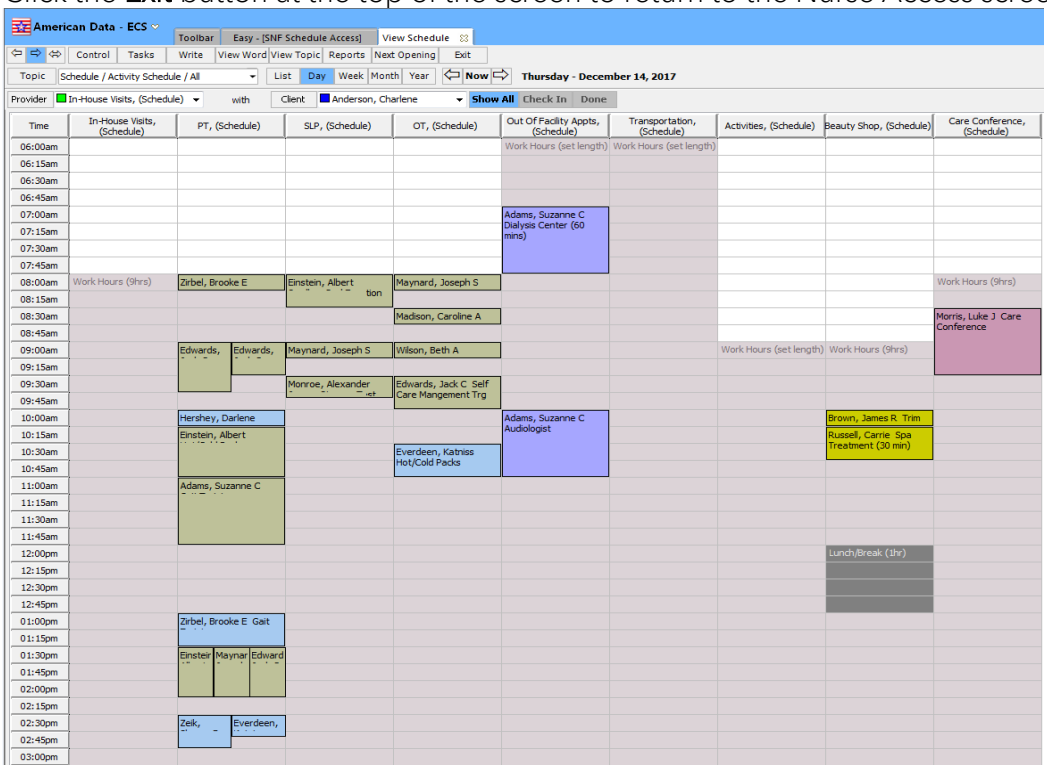
Other/Miscellaneous

Resident/Family Concerns

Presents the user with a documenting screen, which is only found within the Quality Assurance module. This allows the user to document any concerns presented by residents or family members. Any progress or notes made to these concerns should also be documented here. Click **Sign** at the end of the screen to save the entry and go back to the Access screen.

Scheduling

Displays all scheduler tasks available to the user. Click any of the View options to load the specific schedule or select any of the Schedule options to add a new appointment. Scroll down and over to view the entire day. Double-click the box with the appointment to view details of that appointment. Change the dates viewed by clicking the **Day/Week/Month/Year** buttons at the top of the screen, or by clicking the forward and back arrows next to the **Now** button. Click the **Exit** button at the top of the screen to return to the Nurse Access screen.



Add/Edit Nursing To Do List

1. To initiate or edit the Nursing To Do List, click the **Edit To Do List** button, select the desired name(s), and then click **OK**.
2. A Write screen will appear. Entries appearing at the bottom of the screen display information previously entered for the resident(s).
3. Working from left to right, select items to add to the Nursing To Do List. Pick a start date and end date, if desired. To edit the items in the To Do List, refer to *Editing Nurses Notes* below.

Write an Internal Memo

1. Click the **Write Internal Memo** button.
2. Once in the Internal Memo topic, the user will be presented with a pop-up that states, "This task has clients associated with it. Do you want to override your currently selected clients?" Always click **Yes**. (Messages written in this topic most likely will *not* have anything that belongs in their medical record, which is why a fake client is created to attach to this Internal Memo task so that all the messages written are on the fake client's record.)
3. Document the message to be sent.
4. Select a user group(s) to send the message to or click **pick user on Save** to select the person(s) from a user list once the entry is saved.

Edit Nurse Charting

1. Follow the steps above for viewing information.
2. Click the entry that needs to be edited and it will turn red. This is called "tagging" the entry.
3. Click the **Edit** button.
4. Click the desired editing feature. (Refer to the table below for editing feature descriptions and examples).
5. When using Append, DC and Explain or DC and Copy, make the desired change and then click the **Next** button.
6. Click **Go** to view the changes.

Editing Feature	Function	Example
Append / Append All	Information is permanently attached to the entry; further editing will not be able to be done to the entry except to discontinue	Cosigning a student's documentation
New	A new, separate entry made in the same topic area	Not typically used when editing department notes. Can be used to see where an entry was charted
Copy	An exact copy of the entry is made	An entry was accidentally discontinued and needs to be made active again
Copy One (All) to Other Resident[s]	An exact copy of the entry is made and placed in another resident's chart	An entry was accidentally made in the wrong resident's chart. Use ALL if more than one entry was selected
Discontinue and Append	Entry is discontinued and user is taken to a Write screen to document additional notes	An error was made in documenting the entry and the user would like to explain why the entry is being discontinued
Discontinue and New	Entry is discontinued, a new entry is made in its place	Not typically used when editing department notes

Discontinue and Copy	Entry is discontinued, copy of entry is displayed allowing user to make changes to the original entry	User forgot to use a button word when documenting and would like to 'insert' the word into the entry
Discontinue	Entry is discontinued	Not typically used when editing department notes
Discontinue All	All highlighted entries are discontinued for one resident	Not typically used when editing department notes
Discontinue Multiple Resident Entries	All highlighted entries are discontinued for multiple residents	Not typically used when editing department notes
Skip	Allows user to skip a highlighted entry	Highlighted an entry that does not need editing