Editing

General Information about editing entries

- You must be viewing the entry in order to edit it. This may be via a "View Entries" screen or via the "Defined Review" screen that appears at the bottom of most Write screens.
- All changes to entries are tracked by date, time, and user.
- Entries are never completely removed from the record.
- The User Group a person is in affects which editing features are available for him or her and can also control from which topics the user may view/edit entries.

Function/Purpose of Editing Features

Editing Feature	Function	Example
Append	A new note is permanently attached to the tagged note. Each retains its own identifiers.	Appending the results/effectiveness of a PRN medication to the original entry.
Append All	A new note is permanently attached to multiple tagged entries at once.	
New	Allows you to write a new entry in the same topic area as the tagged entry.	
Copy	Creates an exact copy of the tagged entry that is displayed on the Write screen. The copied entry may be edited before it is saved.	To bring up a copy of a previous note (e.g., physician or consult note, or a CAA) and modify and save it to create a new note.
Add Extension	Not functional.	N/A
Copy One to other Client	Allows user to copy an active or discontinued entry from one record to another or back into the same record.	You charted information into the wrong record and want to copy it to the correct record. Or, you want to copy inactive entries back into the record as active entries – such as on re-admission.
Copy All to other Client	Allows user to copy more than one active or discontinued entry from one record to another, or back into the same record.	Same as above.

DC & Append	Discontinues the entry but adds an addendum to it, typically an explanation for the discontinuation.	You wish to remove an entry from Nurses Notes but need to explain why you are removing it.
DC All & Append All	Discontinues more than one entry simultaneously but adds an addendum to them, typically an explanation for the discontinuation.	Same as above, often used when you have charted in the wrong record and wish to remove the incorrect entries.
DC & New	Entry is discontinued; a new entry is made in its place.	
DC & Copy	Entry is discontinued; copy of entry is displayed allowing user to make changes to the original entry.	
DC	Entry is discontinued.	Entry is no longer needed, for example, a temporary care plan or a short term physician order.
DC All	More than one entry may be discontinued simultaneously for one client.	
DC Multiple Client Entries	Entries may be discontinued simultaneously across client records.	Typically used in a chart auditing situation, where periodic record review reveals entries that are no longer needed, e.g., old lab orders.
Archive Selected	Used to remove an incorrect entry.	Used to maintain the Calendar feature and billing processes – mostly used in Face Sheets, Therapy billing, and Activity attendance.
Skip	When a user is sequentially editing multiple tagged entries, this allows the user to skip an entry.	

Guide to Use of Editing Features in ECS Modules

Editing Feature	Face Sheet Status, Room, VA, Insurance	Face Sheet other topics	Diagnosis	CAAs	Care Plans	IDT Notes & Assessments	Physician Orders	CNA Charting
Append	N	O	N	N	N	O	O	O
Append All	N	O	N	N	N	O	N	O
New	Y	Y	Y	O	Y	O	O	O
Copy	N	N	N	Y	N	O	N	N
Add Extension	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Copy One to other Client	O	O	O	O	O	O	O	O
Copy All to other Client	O	O	O	O	O	O	O	O
DC & Append	N	N	Y	O	O	Y	O	Y
DC All & Append All	N	O	O	N	O	Y	O	O
DC & New	N	Y	N	O	Y	O	Y	Y
DC & Copy	N	Y	N	Y	Y	O	Y	N
DC	N	Y	N	O	Y	N	Y	N
DC All	N	O	N	O	Y	N	Y	N
DC Multiple Client Entries	N	O	O	N	O	O	O	O
Archive Selected	Y	N	Y	N	N	N*	N	N
Skip	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Y – Used Commonly
N – Not Recommended
O – Optional

*Archive is used in certain situations:
Correcting Therapy Treatment entries &
Activity Attendance

Editing Face Sheet Entries

Example 1: Archiving Status, Room, VA, or Insurance information

(e.g., Archiving an entry with an incorrect effective date or other incorrect information)

1. From the ADT/Face Sheet Access menu, select the resident(s) name, and click **View/Edit Face Sheet Info**.
2. The face sheet entries will appear. Click the incorrect entry to turn it red. This is called 'tagging' the entry. You may tag multiple entries if all are incorrect.
3. Click the **Edit** button and select **Archive Selected**. A box will pop and ask: *Are you sure you want to archive all selected entries?* Click **Yes**.
4. The entry or entries will appear gray to show the edit is complete.
5. Re-tag the edited entry.
6. Click the **Edit** button again and select **New**.
7. A documentation screen will appear. Re-chart the updated information.
8. Click **Next** to save your changes and return to the View screen.
9. Click **Go** to refresh the screen and see your changes.
10. Click **Exit** to return to the ADT/Face Sheet Access menu.

Example 2: New: Updating Status, Room, VA, or Insurance information

(e.g., The Room, payer source, or other information has changed)

1. From the ADT/Face Sheet Access menu, select the resident(s) name and click **View/Edit Face Sheet Info**.
2. The face sheet entries will appear. Click the outdated information (e.g., the previous room number)
3. Click the **Edit** button and select **New**.
4. A documentation screen will appear. Chart the updated information.
5. Click **Next** to save your changes and return to the View screen.
6. Click **Go** to refresh the screen and see your changes.
7. Click **Exit** to return to the ADT/Face Sheet Access menu.

Example 3: Discontinue and Copy (for Face Sheet entries WITHOUT an effective date)

(e.g., to change PART of an entry, such as a primary contact phone number)

1. From the ADT/Face Sheet Access menu, select the resident(s) name and click **View/Edit Face Sheet Info**.
2. The face sheet entries will appear. Click the incorrect entry to turn it red. This is called 'tagging' the entry. You may tag multiple entries if all are incorrect.

3. Click the **Edit** button and select **Discontinue and Copy**. A box will pop up and ask: *Are you sure you want to DC selected Entry?* Click **Yes**.
4. A documentation screen will appear with a copy of the entry. Make the appropriate changes to the copied entry.
5. Click **Next** to save your changes and return to the View screen. The original entry will appear gray to show the edit is complete.
6. Click **Go** to refresh the screen and see your changes.
7. Click **Exit** to return to the ADT/Face Sheet Access menu.

Example 4: Discontinue/Discontinue All (for Face Sheet entries WITHOUT an effective date)

(e.g., to remove one or more entries, for example if an attending physician was inadvertently charted twice)

1. From the ADT/Face Sheet Access menu, select the resident(s) name and click **View/Edit Face Sheet Info**.
2. The face sheet entries will appear. Click the incorrect entry to turn it red. This is called 'tagging' the entry. You may tag multiple entries.
3. Select **Discontinue** to remove a single entry or **Discontinue All** to remove multiple entries at the same time.
4. A box will appear and ask: *Are you sure you want to DC selected entry?* or *Discontinue all tagged entries?* Click **Yes**.
5. The entry or entries will appear gray to show the edit is complete.
6. Click **Go** to refresh the screen and see your changes.
7. Click **Exit** to return to the ADT/Face Sheet Access menu.

Editing Diagnosis Entries

Example 1: Archiving

(e.g., Archiving an entry with an incorrect effective date, code, or description)

1. From the ADT/Face Sheet Access menu, select a resident(s) name and click **View/Edit Current Diagnoses**.
2. The diagnoses (with professional medical condition name in parentheses), ICD-9 code, and effective date will appear.
3. Click the incorrect entry to turn it red. This is called tagging the entry. You may tag multiple entries if all are incorrect.
4. Click the **Edit** button. A menu will appear.
5. Select **Archive**. A box will pop and ask: *Are you sure you want to archive all selected entries?* Click **Yes**.
6. The entry or entries will appear gray to show the edit is complete.
7. Click **Go** to refresh the screen and see your changes.

8. Click **Exit** to return to the ADT / Face Sheet Access menu.

Example 2: Discontinue and Append/Discontinue All and Append All

(e.g., urinary tract infection or skin ulcer is healed)

1. From the ADT/Face Sheet Access menu, select a resident(s) name and click **View/Edit Current Diagnoses**.
2. The diagnoses (with professional medical condition name in parentheses), ICD-9 code, and effective date will appear.
3. Click the entry to turn it red. This is called tagging the entry. You may tag multiple entries if all are incorrect.
4. Click the **Edit** button. A menu will appear.
5. Select **Discontinue and Append** to resolve a single diagnosis or **Discontinue All and Append All** to resolve multiple diagnoses at the same time.
6. A box will pop up and ask: *Are you sure you want to DC selected entry?* or *Discontinue all tagged entries?* Click **Yes**.
7. A Write screen will appear with (discontinued) in the text box. Click **DISCONTINUE DATE** and select the date the diagnosis is considered no longer current.
8. Click **Next** to save the DC Date and return to the View screen.
9. The entry or entries will appear gray to show the edit is complete.
10. Click **Go** to refresh the screen and see your changes.
11. Click **Exit** to return to the ADT / Face Sheet Access menu.

Example 3: New and Discontinue and Append

(e.g., a current primary diagnosis becomes a secondary diagnosis or a current diagnosis becomes historical)

1. From the ADT/Face Sheet Access menu, select the resident(s) name and click **View/Edit Current Diagnoses**.
2. The diagnoses (with professional medical condition name in parentheses), ICD-9 code, and effective date will appear.
3. Click the entry to turn it red. This is called tagging the entry.
4. Click the **Edit** button. A menu will appear.
5. Select **New**.
6. A documentation screen will appear to re-enter the diagnosis with the new heading.
7. Click the appropriate heading. A Diagnosis menu will appear. Begin typing the diagnosis name or ICD-9 code in the Search field. A list of matches will appear.
8. Select a diagnosis from the list and click **OK**. **Red codes are invalid codes.**
9. ECS automatically charts headings ICD-9 CODE and the EFFECTIVE DATE after you select the diagnosis. Enter the effective date that this diagnosis will have changed headings (e.g., date the diagnosis became historical) or today's date if the effective date is unknown and click **OK**.

10. The charting screen will display the diagnosis and date that was selected – the ICD-9 code will appear to be blank (the diagnosis ICD-9 code will be inserted at the time the entry is saved).
11. Click **Next** to save the updated entry and return to the View screen.
12. Click the outdated entry to turn it red.
13. Click the **Edit** button.
14. Select **Discontinue and Append**
15. A box will pop up and ask: *Are you sure you want to DC selected entry?* Choose **Yes**.
16. A Write screen will appear with "(discontinued)" in the text box. Click **DISCONTINUE DATE** and select the date the diagnosis is considered no longer current.
17. Click **Next** to save the DC Date and return to the View screen.
18. The entry will appear gray to show the edit is complete.
19. Click **Go** to refresh the screen and see your changes.
20. Click Exit to return to the ADT / Face Sheet Access menu.

Editing Physician Orders

Example 1: Discontinue and Append

(e.g., Discontinuing an order and saving an explanation or reason why)

1. From the *Physician Orders* Access menu, select a resident's name and click **View/Edit Current Orders**.
2. A View screen with the resident's current physician orders will appear.
3. Click on the entry to turn it red. This is called 'tagging' the entry.
4. Click **Edit**. A menu will appear.
5. Select **Discontinue and Append**. A box will pop up and ask: *Are you sure you want to DC selected entry?* Click **Yes**.
    - A Write screen will load with the phrase "(discontinued)" in the text box.
6. Click **^D/C** (in the first column).
7. A list of reasons for discontinuing the order will appear. Select the desired reason.
8. If none of the reasons apply, click "other:." A box will appear. Type in the desired reason for discontinuing the order and click **OK**.
9. Click **Next** to save the explanation and return to the View screen.
10. The entry will appear gray to show the edit is complete.
11. Click **Go** to refresh the screen. The entry will no longer appear.
12. Click **Exit** when finished to return to the *Physician Orders* Access menu.

Example 2: Discontinue All and Append All

(e.g., discontinuing multiple orders and saving an explanation or reason why)

1. From the *Physician Orders* Access menu, select a resident's name and click **View/Edit Current Orders**.
2. A View screen with the resident's current physician orders will appear.
3. Click the entries to turn them red. This is called 'tagging' the entries.
4. Click **Edit**. A menu will appear.
5. Select **Discontinue All and Append All**. A box will pop up and ask: *Discontinue All tagged entries?* Click Yes.
6. **If all tagged entries are from the same topic (e.g., Medications):**
   Skip to step 10 if entries are from more than one topic
7. A Write screen will load with the phrase "(discontinued)" in the text box.
8. Click **^D/C** (in the first column).
9. A list of reasons for discontinuing the order will appear. Select the desired reason.
10. If none of the reasons apply, click "other:." A box will appear. Type in the desired reason for discontinuing the order and click **OK**.
11. Click **Next** to save the explanation and return to the View screen.
12. If all tagged entries are not saved in the same topic (e.g., Medications and treatments), a text box will appear with the phrase "(discontinued)" written in it. Place your cursor at the end of the phrase, type in the desired reason, and click **OK**.
    - The entries will appear gray to show the edit is complete.
13. Click **Go** to refresh the screen. The entry will no longer appear.
14. Click **Exit** when finished to return to the *Physician Orders* Access menu.

Example 3: Discontinue and Copy

(e.g., Changing a frequency/time from an existing physician order)

1. From the *Physician Orders* Access menu, select a resident's name and click **View/Edit Current Orders**.
2. A View screen with the resident's current physician orders will appear.
3. Click on the entry to turn it red. This is called 'tagging' the entry.
4. Click **Edit**. A menu will appear.
5. Select **Discontinue and Copy**. A box will pop up and ask: *Are you sure you want to DC selected entry?* Click Yes.
6. A Write screen will load with a copy of the entry. Make the appropriate changes to the copied entry.
7. Click **Next** to save your entry and return to the View screen.
8. The entry will appear gray to show the edit is complete.
9. Click Go to refresh the screen and see the changes.
10. Click **Exit** when finished to return to the *Physician Orders* Access menu.

Example 4: Discontinue and New

(e.g., When discontinuing an order and documenting a new one from scratch)

1. From the *Physician Orders* Access menu, select a resident's name and click **View/Edit Current Orders**.
2. A View screen with the resident's current physician orders will appear.
3. Click on the entry to turn it red. This is called 'tagging' the entry.
4. Click **Edit**. A menu will appear.
5. Select "Discontinue and New." A box will pop up and ask: *Are you sure you want to DC selected entry?* Click **Yes**.
6. A Write screen will load. Document the new order.
7. Click **Next** to save the entry and return to the View screen.
    - The entry will appear gray to show the edit is complete.
8. Click **Go** to refresh the screen and see the changes.
9. Click **Exit** when finished to return to the *Physician Orders* Access menu.

Example 5: Discontinue

(e.g., when an order is no longer current)

1. From the *Physician Orders* Access menu, select a resident's name and click **View/Edit Current Orders**.
2. A View screen with the resident's current physician orders will appear.
3. Click on the entry to turn it red. This is called 'tagging' the entry.
4. Click **Edit**. A menu will appear.
5. Select **Discontinue**. A box will pop up and ask: *Are you sure you want to DC selected entry?* Click **Yes**.
    - The entry will turn gray to show the edit is complete.
6. Click **Go** to refresh the screen. The edited entry will no longer show.
7. Click **Exit** when finished to return to the *Physician Orders* Access menu.

Example 6: Discontinue All

(e.g., when multiple orders are no longer current)

1. From the *Physician Orders* Access menu, select a resident's name and click **View/Edit Current Orders**.
2. A View screen with the resident's current physician orders will appear.
3. Click on the entries to turn them red. This is called 'tagging' the entries.
4. Click **Edit**. A menu will appear.
5. Select **Discontinue All**. A box will pop up and ask: *Discontinue all tagged entries?* Click **Yes**.
    - The entries will turn gray show the edit is complete.
6. Click **Go** to refresh the screen. These entries will no longer show.
7. Click **Exit** to return to the *Physician Orders* Access menu.

Example 7: Copy All to Other Client(s)

(e.g., to reactivate orders after a resident is readmitted)

1. From the *Physician Orders* Access menu, select a resident's name and click **View/Edit Current Orders**.
2. A View screen with all of the resident's discontinued physician orders will appear.
3. Click **Control** to narrow down the orders appearing on the screen. The user may choose to specify a date range by selecting a Start Date and End Date.
4. Click on the entries to turn them red. This is called 'tagging' the entries.
5. Click **Edit**. A menu will appear.
6. Select **Copy All to Other Client(s)**.
7. A *Name Selection* menu will appear. Select the resident's name and click **OK**.
    - The entries will automatically copy and will appear when completed.
8. Click **Go** to refresh the screen and see the changes.
9. Click **Exit** to return to the *Physician Orders* Access menu.

Editing IDT Notes and Assessments

Example 1: Copy One to Another Client(s) / Copy All to Another Client(s)

(e.g., copying one or more entries from one record to another, such as if they were documented in the wrong record)

1. From the Access menu, select a resident's name and use the appropriate button to bring up a review screen that displays the entry you wish to edit.
2. Click on the entry to turn it red. This is called 'tagging' the entry.
3. Click **Edit**. A menu will appear.
4. Select **Discontinue and Append** for one entry. A box will pop up and ask: *Are you sure you want to DC selected entry?* Click **Yes.**
5. A Write screen will load with the phrase "(discontinued)" in the text box.
6. Type in the reason for discontinuing the entry.
7. Click **Next** to save the explanation and return to the view screen.
    - The entry will appear grey to show the edit is complete.
8. Click **Go** to refresh the screen. The entry will either no longer appear or will appear grayed out with the discontinued action displayed with it.
9. Click **Exit** when finished to return to the Access menu.

Example 2: Discontinue and Append

(e.g., discontinuing one entry and explaining the reason, such as that it was documented in the wrong record)

1. From the Access menu, select a resident's name and use the appropriate button to bring up a review screen that displays the entry you wish to edit.
2. Click on the entry to turn it red. This is called 'tagging' the entry.
3. Click **Edit**. A menu will appear.
4. Select **Discontinue and Append** for one entry. A box will pop up and ask: *Are you sure you want to DC selected entry?* Click **Yes.**
5. A Write screen will load with the phrase "(discontinued)" in the text box.
6. Type in the reason for discontinuing the entry.
7. Click **Next** to save the explanation and return to the View screen.
    - The entry will appear gray to show the edit is complete.
8. Click **Go** to refresh the screen. The entry will either no longer appear or will appear grayed out with the discontinued action displayed with it.
9. Click **Exit** when finished to return to the Access menu.

Example 3: Discontinue All & Append All

(e.g., discontinuing multiple entries for one client and explaining the reason, such as that they were documented in the wrong record)

1. From the Access menu, select a resident's name and use the appropriate button to bring up a review screen that displays the entries you wish to edit.
2. Click on each entry to turn all affected entries red. This is called 'tagging' the entries.
3. Click **Edit**. A menu will appear.
4. Select **Discontinue All & Append All** for multiple entries.
5. If all of the selected entries were documented in the same topic, a box will pop up and ask: *Are you sure you want to DC selected entries?* Click **Yes**.
6. A Write screen will load with the phrase "(discontinued)" in the text box.
7. Type in the desired reason for discontinuing the entries.
8. Click **Next** to save the explanation and return to the View screen.
    - The entries will appear gray to show the edit is complete.
9. Click **Go** to refresh the screen. The discontinued entries will either no longer appear or will appear grayed out with the discontinued action displayed with them.
10. Click **Exit** when finished to return to the Access menu.