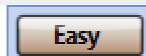
AL Manager Charting

AL Nurse Manager Access Screen

AL Director	Face Sheet		Chart Review	Other	Depts.
	New / Inactivate Client	Allergies	View Chart	New / Inactivate User	Marketing
	Face Sheet	Service Plan	Reports	Schedules	Nursing
	Re-Admit	RA Assignments	RA Review	Quality Assurance	Care Assist
	DC/ Transfer/ LOA	Room Change	Co-Sign Incidents	Send Internal Memo	Activities
	View/ Edit Face Sheet	Contacts		View Messages	Social Services
	Diagnosis				Dietary
					Beauty Shop
					Survey

If you happen to close the Access screen, click the Easy icon 

to re-load the screen.

Access Screen Options

Face Sheet

New / Inactivate User – This button will take you to the User screen, so you can create new Users or Inactivate users in the system. When creating the new user, you must have his or her full first name, middle initial, and last name. Assign the user to the appropriate user group and make sure to set the temporary password to the first letter of first name and last name (ex., brown). Then check the box for User Must Change Password at Next Login. This will prompt

the user to change the password to something unique when logging in with the temporary password. When finished, click the Close button to return to the Access screen.

New / Inactivate Client – This button will call up the Client Demographics area to enter the client into the system or to update any data (ex., DOB, SSN). When finished, click OK to save any changes, and then click the Close button to return to the Access screen.

Face Sheet – This button will pull up a screen to document basic resident information, such as a photograph, admission information, or payment source.

Re-Admit - This button will take the user through some re-admission charting areas to allow the user to update/change any documentation for the client. When finished, click the Sign button to save any changes and return to the Access screen.

Discharge/Transfer/LOA – This button will load up the AL – Discharge/Transfer documenting task. The first screen that loads is the Client Demographics. This allows you to go in and change a Status from Active to Hold or Inactive. Click the Close button when finished making changes. The next part of the task will allow you to document the Discharge, Transfer, or LOA information. Enter what is known. When finished, click the Sign button to save and return to the Access screen.

View/Edit Face Sheet Info – This button will present a viewing screen and allow the user to change/update any face sheet data for the client. You may refer to the Editing Documentation section below in the handout for detailed information on editing data. When finished, click the Exit button to close the viewing screen and return to the Access screen.

Diagnosis – This button will take you to the Diagnosis area to enter the client's ICD-9 diagnosis data. Click on the appropriate button word (Primary, Admission, Secondary, Other, or Historical). This will present a screen. Type in the name of the diagnosis or the code. The system will present matches for you. Select the desired match from the list and click OK. Enter the effective date of the diagnosis also. Click the Sign button to save the entry and return to the main Access screen.

Allergies – This button will take you to the Allergies area to enter in the client's allergies. When you are in the screen, click the button word Allergies. Start typing in the allergy. Locate the match for the allergy from the menu. Click the Add button to add it to the list. If you type something in and it does not find a match, click the Add button in the top right of the box where you typed the information in to add the verbiage you typed into the listing. Click the Sign button to save the entry and return to the Access screen.

Service Plan – This button will present the Service Plan. There are tan colored "GoTo" words that will take you to that area of the Service Plan to enter data. There is more detailed information on Service Planning below. Please see that area for more information. When finished, click the Sign button to save the data and return to the access screen.

Assignments – This button will take you to the RA Assignments area where you can document duties the RAs need to complete for each resident that day.

Room Change – This button will present the Room/Apartment area for the user to document a room/apartment. Click on the button word, and then select the appropriate room in which the client is residing. You must state the correct effective date (this is the date the client moved into the room). When finished, click the Sign button to save the data and return to the Access screen.

Contacts – This will take you to the Emergency Contacts area to update/edit contact information. When finished, click the Sign button to return to the Access screen.

AMERICAN DATA

Charting

Assessments – This button will present a screen and let you select the assessment you need to complete. Your options include: Pre-/Admit Assess, AIMS, Skin, Cognitive, Elopement, Evacuation, Fall Risk, GDS, Mini Mental, Pain, Psychotropic Med, PUSH, and Self-Admin Med. Select an assessment from the list to be taken to that area. When finished with the assessment, click the Sign button to save the data and return to the Access screen.
Incident – This will take you to the Incidents area where you can document an incident. Enter the data that is known. At the end, you can print the report if needed. Click the Sign button to save the entry and return to the Access screen when finished.
Incident Investigation – This will take you to the investigation area, where you can enter data about the fall/incident that occurred. When finished, click the Sign button to save and return to the Access screen.
Physician Orders – This button will take you to the Physician Orders area where you can enter orders, co-sign, run reports, etc. This will be covered in more depth later.
MAR/TAR – This button will take you to the MAR/TAR area where all administration records, treatment records, co-signature options, and reports will be displayed. This will be covered in more depth later.
Misc. – This will present the AL Charting area where you can pick the topic in which you need to chart. When finished, click the Sign button to save the data and return to the Access screen.

Reports

Census – This will present a calendar and give you information about who is In-House, Bedhold, Therapeutic Leave, payer source, and apartment. When finished, click the Close button to close the calendar screen.
Room Roster – This will present a report display all occupied and unoccupied apartments (as of the current date).
Service Levels – This will generate a report and display each resident's Service Level and with what each resident need assistance. If you would like to print this data, click the printer icon in the upper left corner of the print preview screen. When finished, click the Close button to close the report preview.
Service Plan – This button will generate a print preview of the individualized service plan for the selected client(s). You can print if needed by clicking the printer icon in the upper corner of the screen. When finished, click the Exit button to close the print preview screen.
To Do List – This button will present the To Do List grid (it's a flow sheet format). It will present any assessments, incidents, labs, etc. that are due or need to be followed upon. The user can initial once the item has been completed. The item will resolve itself from the list, once signed off. When finished, click the Exit button to return to the access screen.
Average Length of Stay – This button will allow you to select a date range and resident to check on the total and average in-house days for your specified parameters. Click Exit when you're done viewing.
Face Sheet – This button will generate a print preview of the Face Sheets for the selected clients. First, select the desired face sheet from the General Reports window that appears, and click Load. When finished, click the Exit button to close the print preview screen.
Physician Orders – This will generate a Physician's Orders report for you. To print, click the printer icon in the upper left corner of the print preview screen. When finished, click the Close button to close the print preview screen and return to the Access screen.

View Chart – This button will open a View screen. From here, you can select a section and topic to view information for specified residents. When finished, click Exit to return to the main Access screen.
More Reports – This button will present the report Selection screen for you to manually select a report to run. Click Exit when finished to return to the main Access screen.

Other

Appointments – This button will pull up another access screen with possible schedules based on department or category. You can then check the appointment schedule to see what has been documented. When finished, click Close to return to the prior screen.
Report Maker – This button will take you directly to the Report Maker area of ECS where you can create or modify reports. For more information, please speak with the ECS Trainer about Report Maker.
Send Internal Memo – This button will take you to an area where you can document a message to send to the staff (users) in the system. When documenting messages, you will always use the client Internal Message/Memo. After you have documented the message, click the Sign button. This will present a user selection screen. Select the user(s) to whom you would like to send the message. The screen will close and return you to the Access screen.
View Messages – This button will open the View Messages (internal communications) screen to view any messages you may have.
Quality Assurance – This button will take you to the QA area for documentation. Please see below in the handout for more information.
Co-Sign – This button presents a list of entries that can be co-signed by the designated staff member(s). When finished, click Exit to return to the main Access screen.

Departments

This column of buttons will take you to the various Access screens for the other departments listed.

Quality Assurance

This area will allow the manager to document certain information in the Quality Assurance area. This area is private, and access is not permitted to all staff. Please see the areas below for more information. See QA Nurse Handout for specifics.

QA Reports	Fall / Safety	Infections	Pain	Bx/Mood	Skin	Weights	Re-hosp.	Other
Main Menu	Fall Graph (past month)	Infection Graph (past month)	Pain Graph (past month)	Bx/Mood Graph (past month)	PI Graph (past month)	Weights Graph (past month)	INTERACT	Quality Measure Reports
	Fall Graph (past year)	Infection Graph (past year)	Pain Graph (past year)	Bx/Mood Graph (past year)	PI Graph (past year)	Weights Graph (past year)		Facility Assessment Reports
	Fall Calendar	Antibiotic Use (past year)	PRN Analgesics Calendar	Antipsychotic Med List	Skin / Wound Assessment	Weekly Weight Graph		MDS Analytics
	Supportive Device (past month)	Infection Detail	Pain Review (Charting)	PRN Psychotropic Calendar	Skin Review (Charting)	Food Intake <75%		View Family/ Resident Concerns
	Incident Calendar	Infection Types		Psychotropic Med Graph		Monthly Weight Tracking		Write Internal Memo
	Incident Types (Graph)	Employee/ Resident Illness		Psychotropic Med Report		Monthly Weight Graph		View Reports
	Fall/Incident Summary Report			Psychotropic Meds (MAR)				View Graphs
				Behavior Review (Charting)				

RA Assignments

RA Assignments are entered into the system as a tool and guide for the RAs, so they know what they need to do for each resident and what is due on each day. Follow the steps below for entering in assignments, running reports, and editing the assignment data.

Entering Assignments (from the Access Screen)

1. From the Manager Main Access screen, click on the **RA Assignments** button.
2. Select the client and click **OK**.
3. This will take you to the Assignments area.
4. Begin by determining what needs the client has. At the beginning of the screen, there are tan colored "goto" words which will take you directly to that area to document the assignment.
5. When documenting the assignment information, you must always:
    a. Document the button word (ex., DRESSING) and what it is that the staff needs to do (prompt/cue, physical assist, etc). Please remember you may need to free type in specific information about the resident if you want it to pull to the assignment sheet.
    b. Always document during which shifts the staff needs to perform the task.
    c. Document whether it's daily (needs to be done every day), 1x (will only be done once), weekly (will be done weekly on the specific days selected), or monthly (will be done on specific date(s) in the month). If you use the option for weekly, you must select one or more of the days of the week. If you use the option for monthly, use one of the monthly options.
    d. Always document Start On and the date before moving to the next assignment. End Date is optional, only if you want something to stop on a specific date; this may occur with I&O documentation.

6. When finished entering the assignments, click the **Sign** button. This will take you back to the Access screen.
7. If the system found any problems with the entries, a message will appear and state that it found errors. The errors will be underlined in red.
8. Double-click on the red underlined portion of the entry. A detailed message will appear stating what is missing from the entry.
9. You need to be careful where your cursor is in the documenting area. If you need to add something to an assignment (ex., Start Date), you need to place your cursor at the appropriate location in the assignment entry, and then click the missing word to insert it in the correct area. If this is not done, the entries will not appear right for the RAs and the buttons on their Access screens may not function properly.

Editing Assignments (from the Access Screen)

In the instance that a client discharges (does not include LOAs or Bedholds) from your facility and then returns, please discontinue the previous assignment's information and enter in new updated assignments for the client.
If the client does go out on a LOA or Bedhold, you may just need to add or discontinue data depending on the client's needs when he or she returns. If no changes are needed, you can continue the same assignments as before without making changes.

1. From the Manager Main Access screen, click on the **RA Assignments** button.
2. Select the client and click **OK**.
3. This will take you to the Assignments area.
4. In the viewing area at the bottom, locate the assignment that needs to be changed. Click on it. This will turn the entry red.
5. Click the **Edit** button and select Discontinue and New. This will discontinue the old assignment and allow you to enter in new information. After you have entered the data, click the **Save** button to check for errors. If no errors are found, you can then click the **Sign** button to save data and return to the Access screen, unless you need to edit more assignments.
6. If you need to edit more assignments, repeat steps 4 & 5 until complete.
7. When finished, click the **Sign** button to return to the Manager Main Access screen.

Viewing Documentation

From the Access screen, click **View Chart**. The View Chart button allows the user to review selected information. Select the desired name(s) and click **OK**. Once inside the View Screen, click either **Topic** or **Task**, and select the desired Section/Topic or load the desired Task. Then click **Go**. To narrow the dates for review, click onto **Date From** and/or **Date To** and click **Go**. The View screen may be printed by clicking on the **Print** button located under the **More…** option. Click **Exit** to return to the Nurse Access screen.

- Adjust the font size by clicking **More…** and clicking on the big or little "A."
- Search for words within the view screen by clicking **More…** and onto the magnifying glass symbol. Type in the text to be searched and click OK. This feature will search both words that were clicked on 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 onto **Topic** allows the user to navigate through the Sections and Topics that they have access to. Users may even select a specific word within a topic to narrow their search down further. For example, if a user wants to view any "Observed Falls," they would click Topic > Nursing > Double click into Fall Note > click onto the "observed fall" word and click **OK** and then **Go**.

Task

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

Control Button

The Control button within the View screen gives the user more options as to how they would like to view the information. Some more popular options within here 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.

Editing Documentation

1. Follow steps above for viewing information.
2. Click the entry that needs to be edited. The entry 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 features.
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 see 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