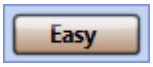
AL Social Services Access Screen

Social Services Access	Charting		Chart Review	Reports	MDS/CAAs/ Care Plans	Schedule	Internal Memo
Main Menu	ADT/ Face Sheet	Care Conference Notes	Social Service Notes	Social Service Notes	MDS Manager	Resident	Write Internal Memo
	Progress Notes	GDS	Risk Review	Advance Directives	Print CAAs	Care Conference	
	Admission Assessment	BIMS/ Cognitive Patterns	View Chart	HIPAA Consent Form	Care Plans		
	Quarterly Assessment	PHQ / Mood		More Reports			
	DC Arrangements / Summary	SLUMS					
		Trauma Informed Care Tools					

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

to re-load the screen.

ADT/Face Sheet

This button will take the user to the ADT/Face Sheet Access menu in case they are involved in the admission process. This allows the user to add/update clients, enter in face sheet data, and run admission agreement reports. Please reference the *Demographics & Face Sheet* handout for more information regarding how to use this specific screen.

Document Admission/Quarterly Assessment

1. From the Social Services Access menu, click Admission Assessment or Quarterly Assessment, select name(s) (hold down the CTRL key on the computer keyboard if needing to select more than one name).
2. A two-way split screen will appear. The top half of the screen is a Write screen and the bottom half is a View screen. The view screen will display previous notes and other pertinent information.
3. Document the assessment by working from left to right.
4. When finished documenting on this screen, click the Sign button.
5. The next topic will load. Once completed with the assessment, the user will be brought back to the Social Services Access menu.

Social Services Admission Assessment includes: Social History, Social Service Notes, Cognitive Patterns (C), Mood (D), Discharge Planning (Q), and the Mental Wellbeing Care Plan.

Social Services Quarterly Assessment includes: Social Service Notes, Cognitive Patterns (C), Mood (D), Discharge Planning (Q), and the Mental Wellbeing Care Plan.

Document Progress Notes/DC Arrangements/Care Conference Notes/GDS/BIMS (Cognitive Pattern)/PHQ (Mood)/SLUMS

1. From the Social Services Access menu, click onto the button to chart into, select name(s) (hold down the **CTRL** key on the computer keyboard if needing to select more than one name).
2. A two-way split screen will appear. The top half of the screen is a Write screen and the bottom half is a View screen. The view screen will display previous notes and other pertinent information.
3. Document the assessment by working from left to right.
4. When finished documenting on this screen, click the **Sign** button.

Care Conference Notes can be used to document all items which were discussed during the care conference.

DC Arrangements/Summary can be used to document a resident's discharge summary and/or any of their discharge arrangements to be aware of. There are a couple of reports including: Discharge – Plan of Care and Discharge Summary which can be viewed from this screen as well.

View Social Service Documentation

1. From the Social Service Access menu, click onto a button underneath the Chart Review column.
2. Select name(s) and click **OK**.
3. Select more than one resident by holding the **CTRL** key on the computer keyboard.
    a. If a Control screen appears, put in a start and end date and click **OK**.
        i. Click **Go** at the top of the view screen to retrieve the notes in the specified date range.
4. When finished viewing, click **Exit**, which will take the user back to the Social Service Access menu.

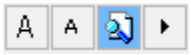
Social Service Notes allows the user to select a date range and view all social service notes completed in the specified date range. The date/time/initials of who completed the entry will all display to the left of each entry. To view discontinued entries, click Control and place a check mark in D/C'd Entries, click OK and Go.

Risk Review allows the user to select a date range and view all social service "risk" notes completed in the specified date range.
This task will include residents with

- Orders of any of the following types of medications: antianxiety, antidepressants, anypsychotics, and hypnotics
- No directives documented in the chart
- Mood/behavior documented by the CNA or nurses

View Chart allows a user to select any documentation within the record that they have rights to view. Click onto Topic or Task to choose the area of the chart to be viewed. Click Control to choose start and end date(s). Click onto the Look tab to select other options (such as show names of initials, show topic name, show cosign, or free text highlighter). Once all options have been chosen, click OK and Go to retrieve the requested information.

- 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.
- Control button > 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 the fall notes for a specific caregiver's name, simply enter the name in the Free Text box, click OK and Go.
- Control button > 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.

Edit Assessments/Notes

1. Click onto the Social Services Notes button underneath the Chart Review column.
2. Select name(s) and click OK.
3. Select a date range and click OK.
4. Click Go.

5. Click the entry that needs to be edited. The entry will turn red. This is called 'tagging' the entry.
6. Click **Edit**.
7. Click the desired editing feature.
8. When using Append, DC and Explain, or DC and Copy, make the desired change and then click **Next**.
9. Click **Go** to see your changes.

Editing features which are bolded are utilized most often in Social Services Documentation.

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 Client[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 client	Not typically used when editing department notes
Discontinue Multiple Client Entries	All highlighted entries are discontinued for multiple clients	Not typically used when editing department notes
Skip	Allows user to skip a highlighted entry	Highlighted an entry that does not need editing

View/Print Reports

1. From the Social Services Access menu, click the desired report button under the Reports heading.
2. Select name(s) and click **OK**. Select more than one name by holding the **CTRL** key on the computer keyboard.
3. Choose the appropriate date range if prompted to do so.
4. The report preview appears.
5. Click the printer icon in the upper left corner to print.
6. Click **Close** to return to the Social Services Access menu.

Advance Directives will display the Code Status order and Advance Directives on all selected resident(s). This information is populating from Physician Orders>Code Status and Face Sheet>Personal Information.

HIPAA Consent Form will run the HIPAA Privacy Authorization Form. This can be electronically signed by clicking onto the Signature button in the report preview. In addition, it can be attached into the record by clicking on Attach after it has been signed.

Write an Internal Memo

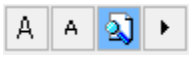
1. From the Social Services Access menu, click on the **Write Internal Memo** button.
2. Once in the Internal Memo topic, the user will be presented with a pop up that states, "This task has clients associated with it. Do you want to override your currently selected clients?" Always click **Yes**. (Messages 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. Make sure to select to whom the message will be sent. The user can choose a user group(s), or click **pick user on Save** for a user list to pop up once the entry is saved; the user can then select the individual(s) to whom the message will be sent.

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

Follow steps above for viewing information.

1. Click the entry that needs to be edited. The entry will turn red. This is called 'tagging' the entry.
2. Click the **Edit** button.

3. Click the desired editing feature. Refer to the table below for editing features.
4. When using Append, DC and Explain or DC and Copy, make the desired change and then click the **Next** button.
5. 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