Features, Facts, and Fireworks of ECS10

Diagnosis Coding

Client records may now be searched for invalid ICD10 codes. This is most useful when a facility is sending financial forms (UB04s, 1500s) out of ECS as a user will receive a claim rejection if they include invalid ICD10 codes. This occurs when a code was at one point in time valid, but since updates made to the diagnosis database, the code has now become invalid.

It is recommended that once this view task is setup that someone in the billing department run it prior to running any financial forms to ensure there is nothing listed. If the view task comes up with "Nothing Found," then there are no invalid codes that will need to be updated.

Before completing any setups, check to see if this task already exists in your facility's database. Click onto the **Toolbar** > green **View** icon > **Tasks** > look for a task titled "Diagnosis (Invalid ICD10 Codes)." If you see this task or something similar, then your facility already has the task in place and now it is ready to be linked to an easy button.

Setup the view task:

1. Click onto the **Toolbar** > green **View** icon > make sure no resident names are selected > Click **OK**.
2. Click onto **Tasks.**
3. Click onto **Save**.
4. Name the task "Diagnosis (Invalid ICD10 Codes)" and click **OK**.
5. Specify which Sites/Services and User Groups should have access to load this task. Click **OK** through both selections.
6. Find your task in the list and highlight it. Select **Edit.**
7. Navigate to the **Formula** tab.
8. Click IF > Add Other > ICD10(Inactive).
9. Click **OK** to save changes.

Link the task to an easy button:

1. Navigate to the access screen which you would like to add an easy button onto.
2. Click onto the **Toolbar** and click onto the **Setup** icon.
3. This will load the access screen you are on via Setup mode allowing you to make changes as needed.
4. Right click onto an existing easy button and select **Copy**.
5. Right click into a blank space and select **Paste.**
6. Double click onto the newly created button to access the **Properties**.

7. Rename the button in the **Short Name**. Remove any items located on the Word Control tab in the **Goto Topics/Words** box. Also remove anything located on the Options tab in the **Actions** area.
8. Lastly, on the Options tab, in the Actions area, click **Add** > **Pick Task(s)** > place the dot in **View** > find your newly created task and highlight it > click **OK** > place a checkmark in **Name Selection** > click **OK** > click **OK.**

Reports

Set Reports to Inactive

Reports may now be set to inactive, rather than deleting them completely out of ECS. Sometimes deletion sounds too permanent, and a system supervisor may not know if/when that report is being used for something that they are potentially unaware of. Reports may be set to Inactive so that they will no longer show up in the report setup, or for any users. This assists in cleaning up the list so that users are not seeing too many reports and therefore unaware of which one they should use.

The "Last Run" column will assist a system supervisor in knowing which reports have been utilized frequently. Keep in mind however that the "Last Run" date will only begin to populate after your facility has converted to ECS10. If your facility has recently converted, you may want to wait several months prior to inactivating reports that you are unsure of.

Inactivate a Report via Report Maker

1. Click onto American Data – ECS > Setup > Report > Report Maker.
2. In here, click onto the file folder icon to open the list of available reports.
3. Notice the first column has the report name, second has the last run date, and the third states whether the report is active or not. By default, only active reports will display. Place a checkmark in **Show Inactive Reports** to also display ones that have already been inactivated.
4. Once you locate a report that needs to be inactivated, click onto it, and select the **Inactivate** button. You may only inactivate one report at a time within the **Open Report** screen. If wanting to inactivate more reports at one time, follow steps below.

Inactivate a Report via Tasks/Reports Security

1. Click onto American Data – ECS > Setup > Security > Tasks/Reports.
2. Notice at the top of the screen, there are three boxes (Types, Sites/Services, Groups). In the **Types** box, locate the option for **General Reports**. Once highlighted, click **Display** on the left.
3. In the middle portion of the screen, notice that all general reports are now displaying. Highlight one (or multiple by holding down the Ctrl or Shift keys on your keyboard) and click onto **Inactive** to move the report(s) to the inactive status. Notice that in this view, all active and inactive reports will display by default.

4. To move a report back to an active status, highlight it and click onto Active on the left-hand side of the screen.

Common Reports to Check for Potential Inactivation

- Face Sheet – some facilities have several default face sheet options still available or legacy ones that they are no longer utilizing. Make sure only the Face Sheet report that staff should be utilizing is kept as active.
- CNA – the CNA module has assignment sheets and incompletion reports for each 8-hour shift, as well as 12-hour shifts. If your facility is only using the 8-hour shifts or 12-hour shifts currently, then the other set can be inactivated.
- RA – the AL RA module has assignment sheets and incompletion reports for each 8-hour shift, as well as 12-hour shifts. If your facility is only using the 8-hour shifts or 12-hour shifts currently, then the other set can be inactivated.
- Any reports that start with "z" – this was a popular mechanism used to "hide" reports in ECS prior to the Inactive feature being introduced. Any reports with a "z" or some other Legacy wording within them can be inactivated.
- HR – if your facility is not currently utilizing the Human Resources module.
- Marketing – if your facility is not currently utilizing the Marketing module.
- F. Services – if your facility is not currently utilizing the Facility Services (housekeeping/maintenance) modules.
- INTERACT – if your facility is not currently utilizing the INTERACT (Re-hospitalization) module.
- Physician Orders – we tend to see that facilities have several different PO reports. This may be intuitive to staff (such as one for current month, one for last month, etc.) or there may be too many options available, and staff are unsure which one is correct. Think about downsizing the PO reports, if able, and determining the correct ones that should remain active.
- Care Plans – we tend to see that facilities have several different care plan reports. This may be intuitive to staff (such as one includes the evaluation and one does not, etc.) or there may be too many options available, and staff are unsure which one is correct. Think about downsizing the care plan reports, if able, and determining the correct ones that should remain active.
- Admission Agreement – if you notice admission agreement reports and your facility is not currently utilizing these in ECS, then these reports can be inactivated until a time comes that you would want to begin using that within ECS.

Lastly, if your facility has reports that start with ADC, ADS, HH, PH, or DOC, then these can either be inactivated or deleted. ADC/ADS are for Adult Day Programs, HH is for Home Health, PH is for Public Health, and DOC is for Department of Corrections. If your facility adds any of these services onto your existing database, we will merge in brand new sections/topics/reports/tasks/etc., so there is truly no need to keep them in your existing system if you do not have these services currently.

Final Note Regarding Inactivating

If you do decide to go through your facility's report list and clean things up, keep that in mind for future searches of reports. For example, if you hide the 12-hour CNA reports, but in a year decide to introduce 12-hour shifts into your building, make sure that before building new reports that you look in your existing report list with the "Show Inactive Reports" checked. This will show you all reports that you may have inactivated in the past and help you to determine if a new report needs to be created or if one already exists.

Variable Height

A new field property called Variable Height exists which can be applied to View and/or Column field. This property causes the field to be drawn as tall as necessary based on the content that pulls into the field. Some possible applications for this would include Physician Order reports, Therapy Evals, and Behavior Goal Tracking. This feature can reduce blank space and the number of pages printed per person, as well as be more appealing visually.

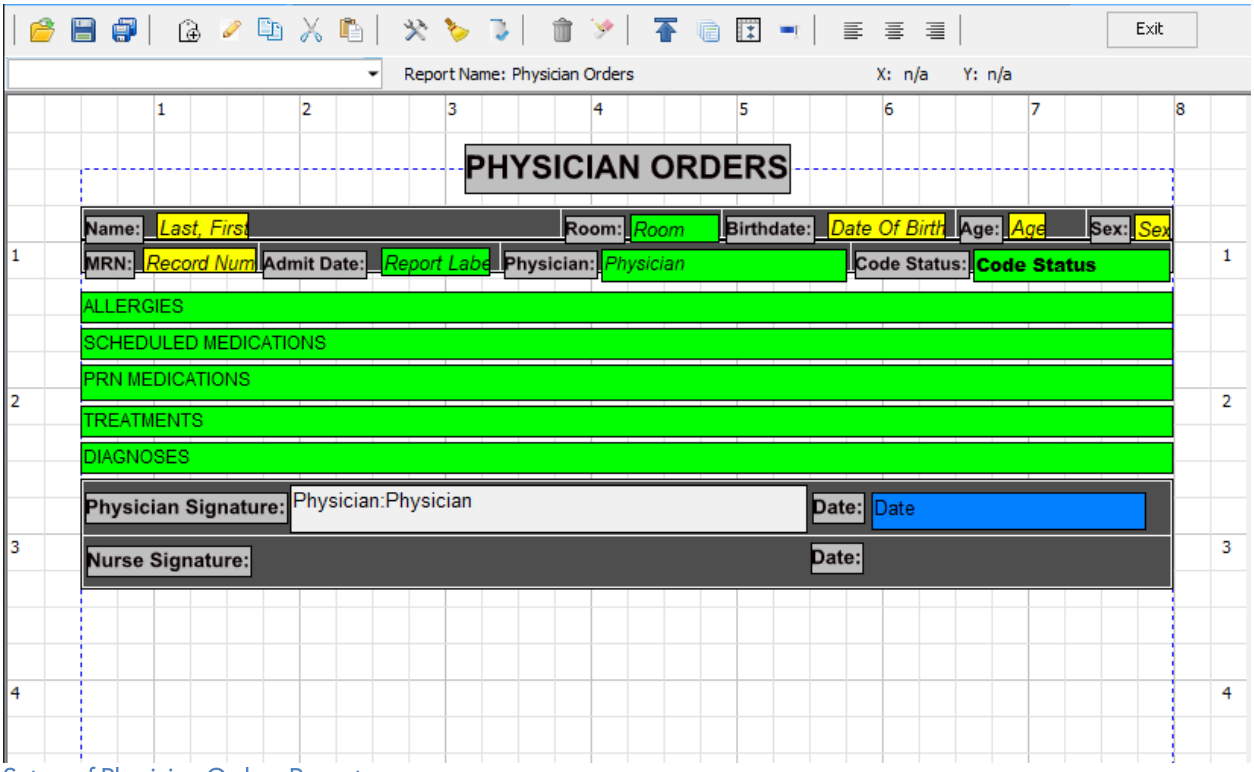
The most popular report to switch to this format type is the Physician Orders – 3 column report as there is often lots of blank space and multiple pages. This is because one resident may have many scheduled medications, but not many treatments. Redesigning the report to print in blocks instead of columns would let field sizes adjust as needed per resident and eliminate large amounts of blank space.

Rules to Using VH Fields

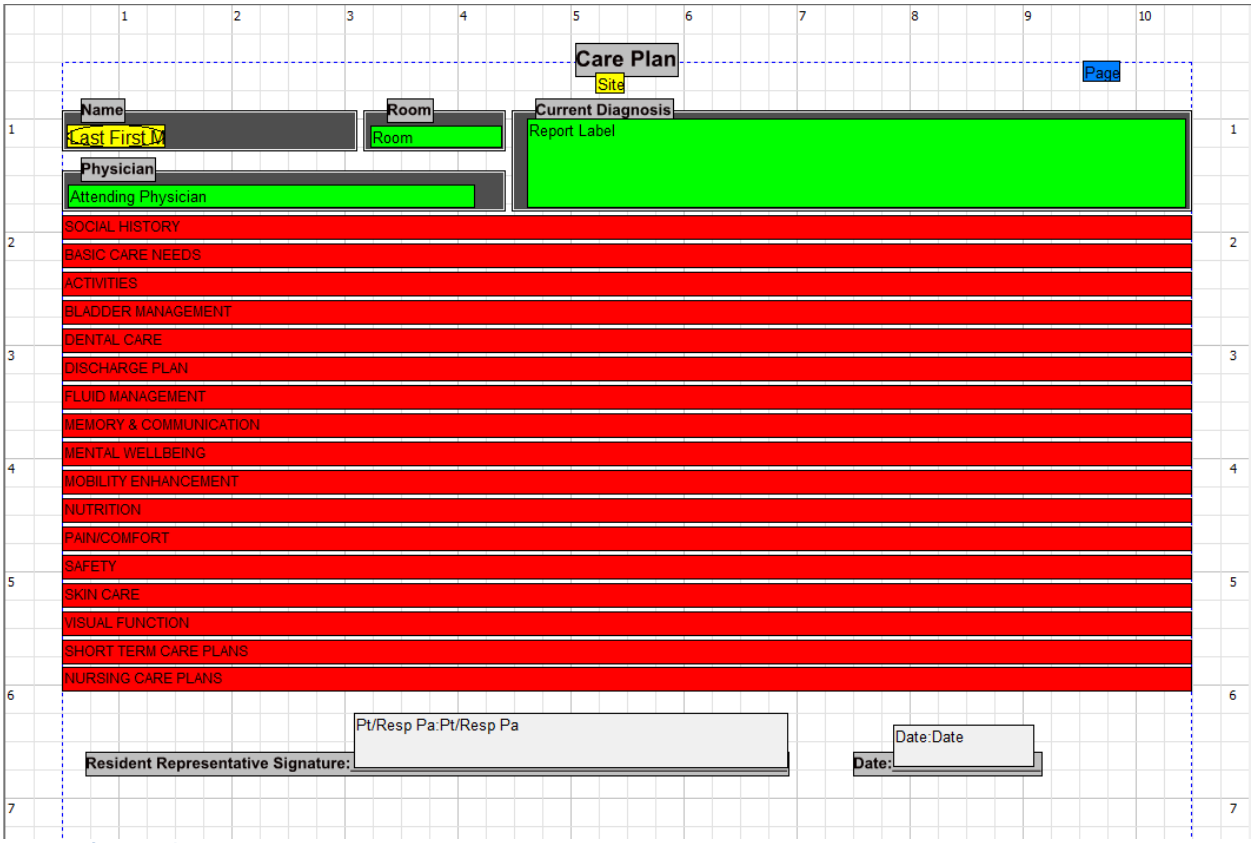
1. You may not set variable height fields up next to each other or overlapping as this will cause printing issues. If you do so, you will receive a warning when you save the report.
2. You may have as many other fields on the report as you like, above, below, or between variable height fields. However, once you have created a variable height field, all view and/or column fields below the fist one must also be setup to variable height. If you do not do this, you will receive a warning when you save the report and affected fields will automatically be adjusted.
3. Variable height fields may be any height or width on the report setup screen, but on the print preview, the field height will be based upon the amount of content. The default height of a newly created works fine.
4. No fields under/after a variable height field will repeat. For example, if there is a signature field at the bottom of the variable height field, then there will only be one signature line, rather than one on each page.

Tips & Tricks with VH Fields

1. With a view field, enter a heading into the Report Label, this will appear as a heading for that field, therefore not needing to create a separate text field as a heading.
2. With a view field, check the Frame option on the Look tab if you would like a box to highlight around the data displayed within this field.



Setup of Physician Orders Report



Setup of Care Plan Report

PHYSICIAN ORDERS

Name: *Adams, Suzanne C*	Room: *118-2*	Birthdate: *03/26/1923*	Age: *98 Yrs*	Sex: *F*
MRN: *1254*	Admit Date: *09/21/2020*	Physician: *Dr. Susan Thomas*	Code Status: **DNR**	

ALLERGIES

Codeine Phosphate, Chocolate Flavor, Coumadin, Contrast Media Ready-Box

SCHEDULED MEDICATIONS

10/19/2011 Allopurinol 100MG Tablet Dose: (1 tablet / 100mg) by mouth twice per day AM PM For: Nephrolithiasis (Kidney Stones)

11/22/2011 busPIRone HCl 5MG Tablet by mouth Dose: (1 tablet / 5mg) daily 1600 For: Anxiety Symptoms

05/07/2012 Magic Mouthwash Dose: (0.25 bottle) by mouth daily AM For: halitosis Administration Instructions: instruct resident to swish and spit, do not swallow

05/07/2015 Aspirin 81MG Tablet Chewable Dose: (1 tablet / 81mg) by mouth daily AM For: Prevention of CVD (Prevention of Cardiovascular Disease)

05/28/2019 [Ativan]LORazepam 1MG Tablet Dose: (1 tablet / 1mg) by mouth daily 0900 For: Anxiety

10/15/2020 Cyanocobalamin 1000MCG/ML Solution Dose: (1 ml / 1000mcg) intramuscular pattern: (9001020B) Administer 1 days, hold 20 days. AM For: Cyanocobalamin Deficiency (Cobalamin Deficiency)

10/19/2020 [Fluzone High-Dose]Influenza Vac Split High-Dose Suspension Dose: (1 vial) intramuscular annually AM For: Influenza Prophylaxis Administration Instructions: Check for egg allergy before administration of flu vaccine.

04/21/2021 Mandrake Root Dose: (1 unit) by mouth twice per day 0800 2000 x 7 days For: Coma (petrification)

PRN MEDICATIONS

10/19/2011 [Phillips Milk of Magnesia]Magnesium Hydroxide 7.75% Suspension Dose: (30 ml / 232.5mg) by mouth daily prn For: Constipation

03/31/2016 [Tylenol]APAP 325MG Tablet Dose: (2 tablet / 650mg) by mouth four times a day as needed For: Pain Administration Instructions: not to exceed 3000mg/24hr

05/16/2018 Albuterol Sulfate (2.5 MG/3ML)0.083% Nebulization Solution Dose: (2.5mg) inhalation daily prn For: Acute Bronchospasm

TREATMENTS

10/19/2020 Nutritional Services Consult COMMENTS: Resident to consult nutrition services concerning decline in weight and SLP for increased difficulty with swallowing.

10/15/2015 Lab: ANTISTREPTOLYSIN O every 4 months 1st Wed January April July October NOC Shift first draw date: 10/15/2015 Reason/Diagnosis: C01 Malignant neoplasm of base of tongue

03/30/2016 Lab: ALBUMIN 1 x/week Tuesdays first draw date: 04/05/2016 Reason/Diagnosis: C64.1 Malignant neoplasm of right kidney, except renal pelvis Ordered by: Dr. James Black

Physician Orders report via VH instead of 3 columns side by side

Full Name Options

A new option exists which allows a report to display the resident's name via First Name, Last Name rather than Last Name, First Name (which has always been the only option). There are two options when populating resident demographics: Last First M or First Last. Both options will display middle initial or middle name if it is entered into the resident's demographics.

Identifiers Only

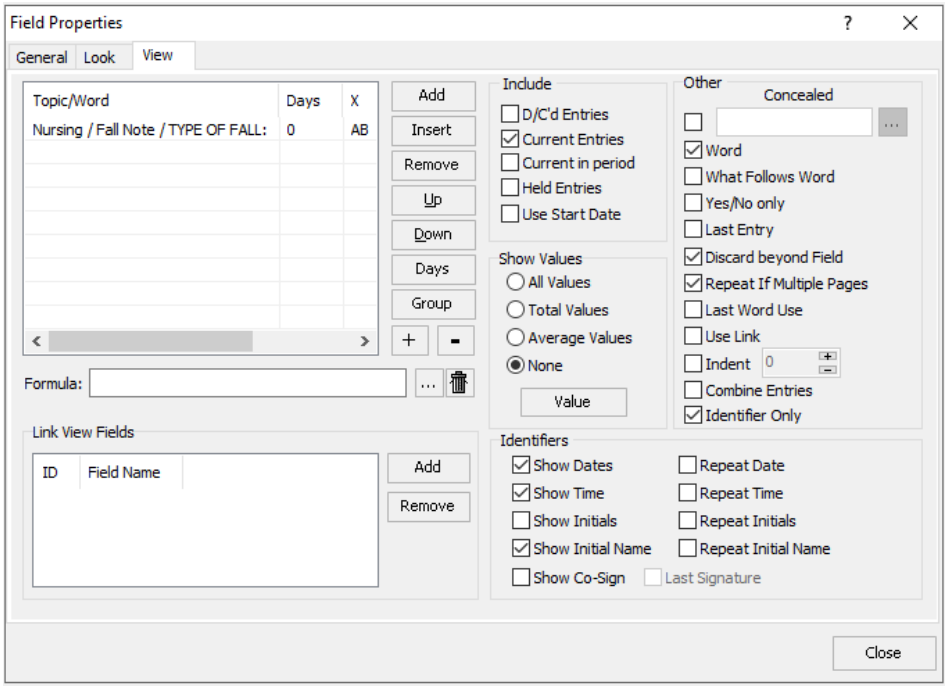
Users can display only the Identifiers of an entry (Initials, Initial Name, Date, Time) within a Column or View field. Prior to this change, users would have needed to add a value of some sort underneath a word that populated into the report (such as an * or _). This new feature (Identifier Only) allows only the identifier to display without extra setups needed to any of the words within the screen.

An example of this may be if a facility has a vital sign report which utilizes a column field to display the last 30 days of vital signs. They would like to display the username of who charted the entry, as well as the date and time it was charted. However, this report is also exported and if that information is displayed to the left of each entry, this causes problems once it is exported. Rather than including these identifiers with each entry, they can be included in their column.

Another example may be on a fall or incident report where the username of who entered in the report needs to display on the bottom of the report in a "Writer's Signature" field. Identifier Only can be utilized to populate only the username rather than a symbol with the username.

Setup Instructions

1. Open report maker via American Data – ECS > Setup > Report > Report Maker.
2. Open a report that has a column or view field(s) that you would like to add identifiers onto.
3. Double click onto the field to be adjusted to access the Field Properties.
4. Place a checkmark in Identifier Only (located under Options).
5. Place a checkmark in any Identifier(s) you would like to display in this field (Date, Time, Initial, Initial Name).
    a. Note: to use the option for Identifier Only, you must also setup this field in full. This means that something will need to be in Topic/Word or Review Words, something checked underneath Show, as well as something checked underneath Include. Although only the identifier will display in this field, you still must tell the system which entry it is populating identifiers from. It is typically easiest to copy an existing view field or column within the report.
6. Click the Save icon to update the report with all changes made.



Setup of the Fall Report – Nurse Signature field

Electronic Sign

Signature Details Report

This report type displays all details that correlate with each set of initials in a cell. The date, time, and user initials for each cell that was signed in will display in this report. This may assist a user in more easily troubleshooting if/when medications were signed out late. Although cells can be audited on the MAR/TAR one by one, this report was created to allow users to see more than one cell at a time.

To Run this Report from Scratch

1. Load a MAR/TAR task as you usually would (whether from an access screen or Toolbar>Sign). Load the resident name(s) you want to view the report for.
2. Click onto the chevron arrows to the right of Script.
3. Click onto **Reports**.
4. Place a dot in **Signature Details**.
5. Select a date range.
6. Click **Print**.

Drug Count Report

This report type counts the number of doses of each order that was signed out vs. held/declined. This report may be most useful in situations where a billing department needs to know how many times the staff signed out Oxygen orders or Catheter orders as it will automatically count the total doses administered in each time frame. Another example is if

trying to determine whether a PRN medication can be discontinued off a resident's chart, this will display the total doses of each PRN order the resident has received.

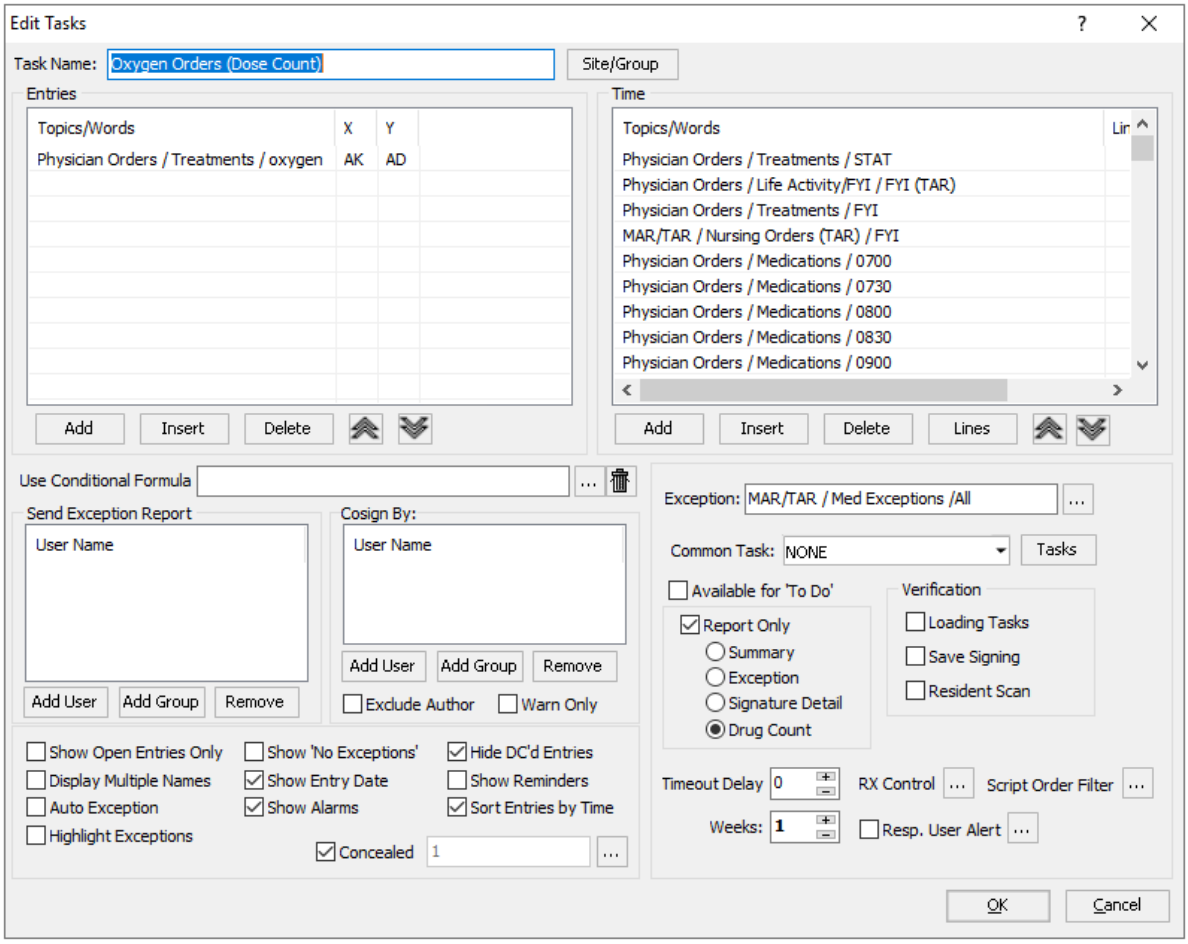
To Run this Report from Scratch

7. Load a MAR/TAR task as you usually would (whether from an access screen or Toolbar>Sign). Load the resident name(s) you want to view the report for.
8. Click onto the chevron arrows to the right of Script.
9. Click onto **Reports**.
10. Place a dot in **Drug Count**.
11. Select a date range.
12. Click **Print**.

To Save a New Task as a Drug Count Report Only

1. Load the MAR/TAR screen as you usually would (whether from an access screen or Toolbar>Sign).
2. Click onto the **Tasks** button. Highlight a task you would like to save as a Drug Count report and select **Save As**.
3. Rename the task in the top portion of the screen to the right of **Task Name.**
4. Place a checkmark in **Report Only** and select the option for **Drug Count.**
5. On the Concealed portion, if there are numbers displayed, remove them all (except for 1) so that not extra data shows on this report that is not needed.
6. Click **OK** to save changes to your new task.
7. Select **Site/Service(s)** who should have access as well as **User Group(s).**
8. This task may now be linked to an easy access button or run by loading the task in the Sign icon.

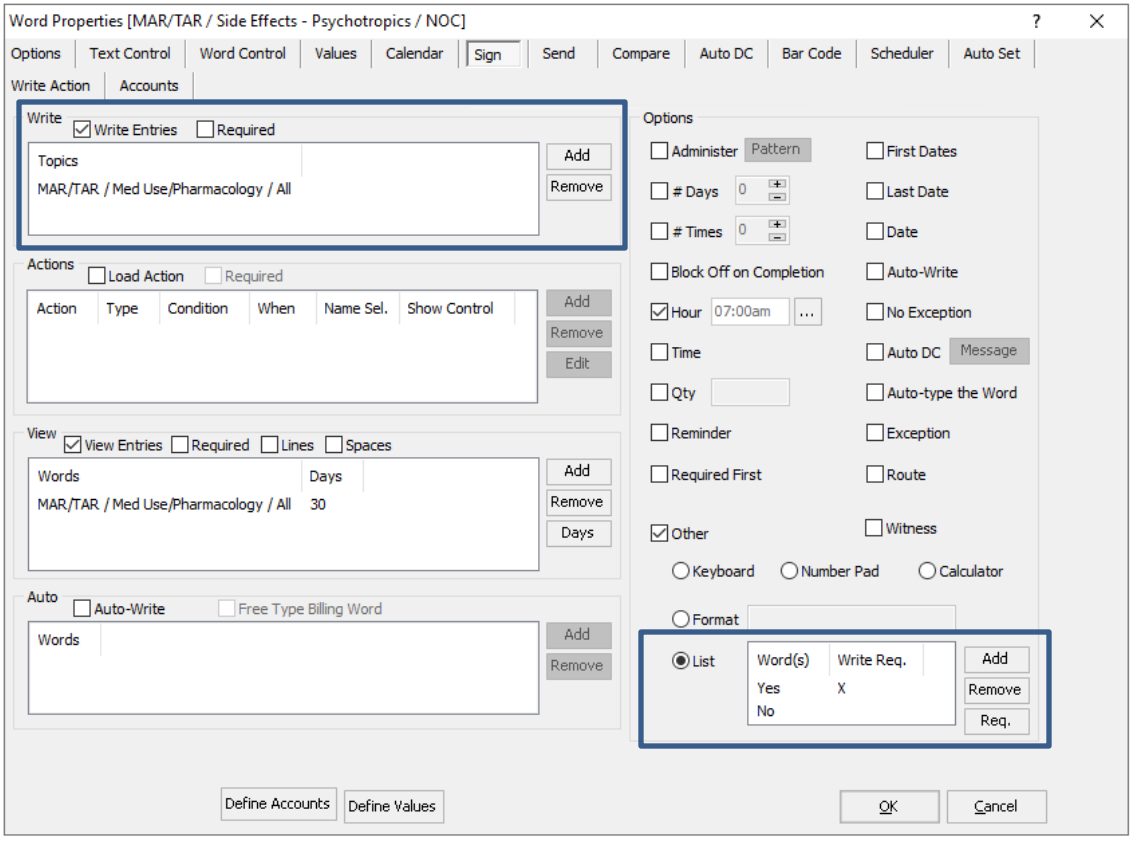
Tips & Tricks: once you complete the Save As on the task, you can alter what information shows up. For example, if you only want to see oxygen treatment orders or only see psychotropic medications, the task can be restricted down to only show such information. Below is an example of O2 orders only. To build this task, do a **Save As** on "Treatments All" and take out the **Conditional Formula**. Then, add in only the word that would be used for an oxygen order from the **Treatments** topic(s). The only entries that will display on this report are those where they click onto the word "oxygen." Keep in mind however that if you utilize this method, you will want to be sure that users are not free typing the words that you are populating into the Entries section so that nothing will be missed.



Yes/No in Cell Determines Flips to Charting

This is an option for when a user fills in a cell that is formatted with certain choices, the user can be flipped to a documentation screen or not, depending on which choice was selected. For example, users document psychotropic side effect monitoring on the MAR. If a user were to click into a cell and answer the question "Were side effects present?" with a Yes, then the user can be setup to flip to document more details. However, if they were to answer with a No, then it may not flip them as nothing further would be required.

This setup needs to be completed on the "Hour" word in the order that populates to the MAR/TAR. If completing this setup for Side Effect Monitoring, there may three-hour words to set this up on. The topic that the user should be flipped to if they answer with a choice that requires documentation is linked on the **Sign** tab in the **Write** box. **Write Entries** should be checked, but **not Required** as you do not want the user flipped to this topic each time they sign in the cell, but only if they answer with a word that requires more charting. In the lower right-hand corner, **Other** should be checked, as well as **List.** Add all choices for the user in the **Word(s)** screen. These will display in a dropdown selection on the MAR/TAR. Highlight a word(s) that should require the user to be flipped and click onto **Req.** to make this word require more documentation.



Witness Co-Signature

Users may have a witness co-sign an order on the MAR/TAR without having to log out of ECS to allow the other user to sign in (or both being logged into two different devices at the same time). This new option is called "Witness." Some injection orders and narcotic medications require that a nurse plus a witness sign out the administration of the order. Users can easily complete this process together logged in as one user with this feature in place.

Setup Instructions

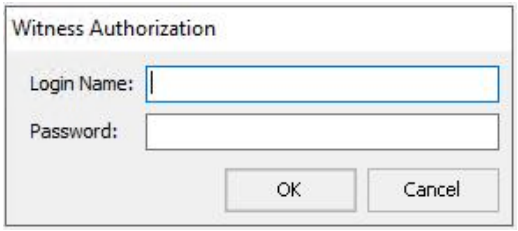
1. Click onto the **Toolbar** > **Setup** icon.
2. Navigate to the topic in which you would like to give users a co-signature witness option. This most likely would be in Physician Orders > Medications but can really be utilized in any of the Physician Order topics that flow onto the MAR/TAR.
3. Once within the topic where the witness feature is needed, locate the word(s) under the Other MAR Info columns that are titled with "Co-Sign."
4. Double click into a Co-Sign word to access the **Properties**.
5. Navigate to the **Sign** tab. Place a checkmark in **Witness**.
6. Click **OK** to save the changes.
7. Repeat the above steps with each Co-Sign word in the topic.

Note: If you do not have or see any Co-Sign words within a topic that you would like this setup in, please contact American Data's clinical support team for assistance in getting these words

added. Dependent on which version of ECS you are in, as well as what topic you need these words in will differentiate the necessary setups.

To Use This

1. Once the MAR/TAR has been loaded, user 1 can sign out in the hour cell as they usually would.
2. User 2 can then click into the Co-Sign cell for the current date.
3. User 2 will be presented with a Witness Authorization box where they will enter in their Login Name and Password.



Rules

1. If a user co-signs a cell out by mistake, they will need to login as themselves to remove the signature.
2. This can only be used to sign out orders on the day that they are given (this will not work in conjunction with the Change feature to back date orders).
3. This only works with login name/password combinations and will not work with fingerprint or magnetic card readers.

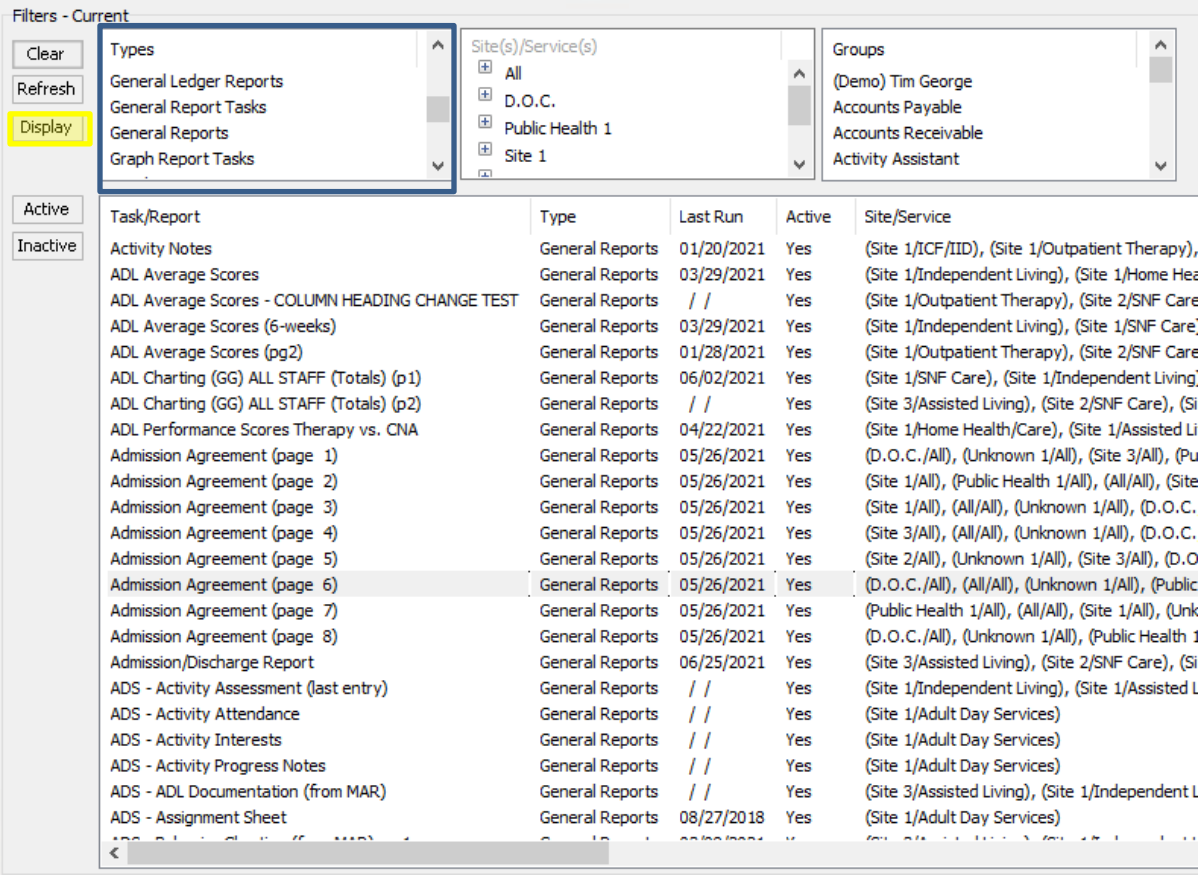
Tasks/Reports Security

When a user navigates to American Data – ECS > Setup > Security > Tasks/Reports and launches any of the task types listed, the Last Run column will populate with the date that task was last run within your facility's database.

- Calendar
- Common Task
- Sign Task
- View Task
- General Reports
- Graph Reports
- Financial Reports – AR
- Financial Reports – AP

This can be utilized when attempting to determine if a report can be moved to inactive or if a task can be deleted.

To utilize the Tasks/Reports screen, start by selecting a task type in the **Types** box. Click onto **Display** to see all Task/Reports in that category. Notice the third column for **Last Run** will populate with the date the task was most recently ran on. This will only begin populating once the ECS10 conversion has been completed, so make sure to give it a few months of before inactivating/deleting tasks.



System Setting – Allow Exit on Hide

Several facilities have requested an option to be able to close out of a locked ECS session without using any additional interventions. This is because users tend to leave their sessions locked and leave for the day, forgetting to log out of ECS. Although there are several ways to close out of a locked session, many end users are unaware of these interventions. Enabling the system setting of **Allow Exit on Hide** will place an Exit button on a "locked" ECS session, so that any other user can log out the person holding up that session. There are things to note about this feature, such as if the user has anything that they were in progress of that they had not saved (e.g., signing out medications on the MAR or writing a nurse's note), that work will be lost. The likelihood of a user leaving unsaved work on a device for a long period of time is slim, however other users must be aware of this and should only use it if they are sure the user locking ECS has left for the day.

To enable this setting, navigate to **American Data – ECS** > **Setup** > **Settings** > **System**. On the General tab there is an option for **Allow Exit on Hide**. Place a checkmark in this and click **OK** to save changes. This is a system wide setting, meaning it will be activated for all users and there is not a way to only enable it for certain sites, services, or user groups.

Delete Obsolete Records

If your facility has been using ECS for 10+ years, you may utilize the Delete Obsolete Records option. This will clean up your database of any clients, providers, or vendors who have not had any documentation completed on them in 10 years or more.

To access this feature, navigate to **American Data – ECS** > **Maintenance** > **Delete Obsolete Record**. Once in this screen, click onto **Name(s),** and select all names that you want ECS to search through for the potential to be deleted out of ECS. We recommend checking all Inactive and Closed Account clients (and vendors/providers if used at your facility). Click **Go** once name(s) have been selected. ECS will now begin searching each record to determine if they have any documentation from within the past 10 years.

A list of name(s) which can be deleted out of ECS will appear. Highlight a name and select **Delete** or hold down the Ctrl or Shift key to highlight multiple. You will be prompted with two messages confirming you want to delete these records as this is permanent and cannot be undone.

ECS10 Notable Mentions

- MDS Manager
- ECS Portal (for family member/resident access to ECS)
- New Nursing Module
- Document Management (coming soon!)
- MDS Analytics (more reports coming this fall)
- E-signatures in Form Maker