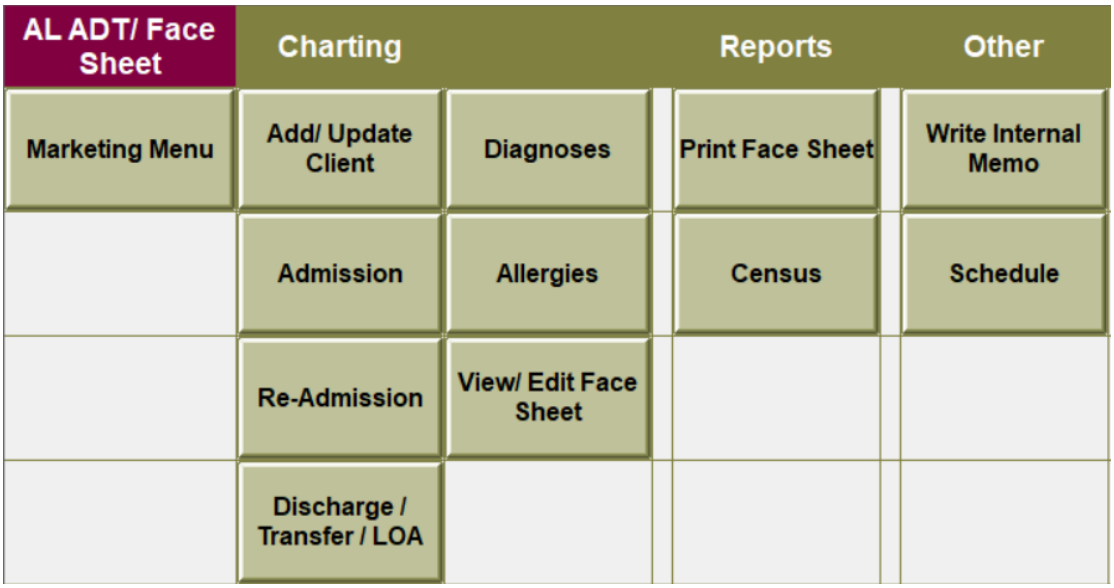
Demographics & Face Sheets

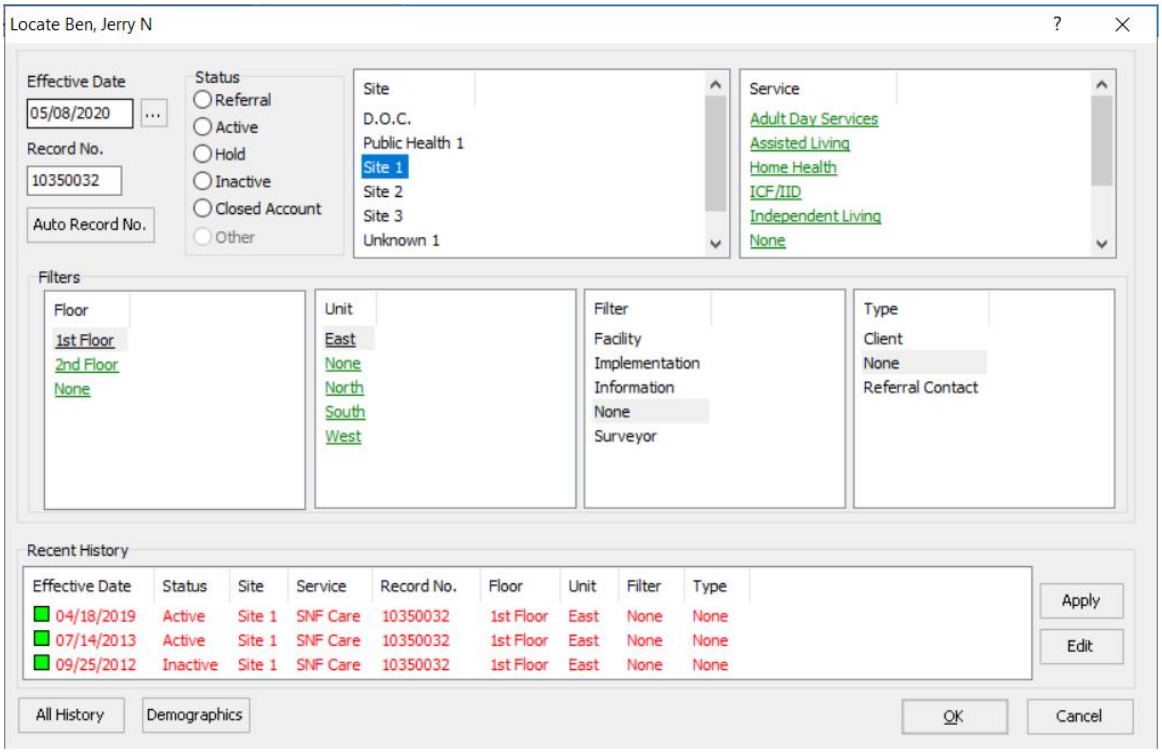


Demographics/Locate

Enter a New Client

1. From the ADT/Face Sheet Access screen, click **Add/Update Client**.
2. Select **New**.
3. The Name Type window will appear with selections for Client, Vendor, and Provider. Select **Client** and click **OK**.
4. Enter in the client's demographic information.
    a. **First Name**, **Last Name**, and **Birthday** are all required fields to create a new client record. If you are entering in a client as a referral and are unsure of any of this data, enter in any data as it can be updated later once it is known.
    b. Note that the **Client Number** is only used as a secondary tracking tool (to Record Number) if a facility so chooses. The **Record Number** will be added in this next step.
    c. If the resident already has an existing record in the database, enter the **Social Security Number** and click **Check SSN**. The matching record will be found and may be selected. A client should only exist within the database one time, which means Check SSN should be utilized to ensure the client does not already exist, potentially within a different status, site, or service.
    d. Select the **Do Not Disclose** checkbox if the resident prefers his/her admission to not be disclosed to others.
5. Click **OK** to save. The Locate screen appears next.

6. Complete this screen to indicate the client's status and location within the facility. This status area only affects the client list, not the occupancy status (entered within the Face Sheet).
7. Select the picklist box to the right of **Effective Date** to select the appropriate date (if not today). This is typically the admission date.



8. In Status, select **Active** (or **Referral** if entering the client as a potential).
    a. **Referral** – used for a potential client.
    b. **Active** – used for a client who is currently located within your facility.
    c. **Hold** – used for a client who is on a hospital bed hold or leave of absence.
    d. **Inactive** – used once a client has discharged from the facility.
    e. **Closed Account** – used by billing staff once an inactive client has a $0 balance on their account.
9. If multiple sites are listed, select the applicable **Site**.
10. If multiple services are listed, select the applicable **Service**.
11. Select appropriate **Filters** (Floor, Unit, Wing, Filter, Type, etc.)
    a. Filters listed in green are required to create the record. Filters in black are optional.
12. Enter the **Record Number** (required) or click **Auto Record No**.
13. Click **OK** to save the new client into the system.
14. Click **Close** to return to the ADT/Face Sheet Access screen.

Update an Existing Client's Demographic Information

1. From the ADT/Face Sheet Access screen, click **Add/Update Client**.
2. Right-click the client's name and select **Demographics**.
3. Enter the updated demographic information. All information can be edited except the Client field (this is an auto populated number which increments based on each new client added into ECS; it is only utilized by AD support staff).
4. Click **OK** to save and **Close** to return to the ADT/Face Sheet Access screen.

Changing a Client's Status or Filter

(e.g., Active to Inactive, East Wing to West Wing, or Change Record Number)

1. From the ADT/Face Sheet Access screen, click **Add/Update Client**.
2. Right-click the client's name and select **Locate**.
3. Select the picklist box next to **Effective Date** and select the date of the change (if different from today).
4. The client's current locate settings will be highlighted. Only select the date, status, and the item(s) that have changed (if any).
5. If you need to record an additional Status/Filter change, click **Apply** to save the first one, and then continue with the next change.
6. Click **OK** to save and **Close** to return to the ADT/Face Sheet Access screen.

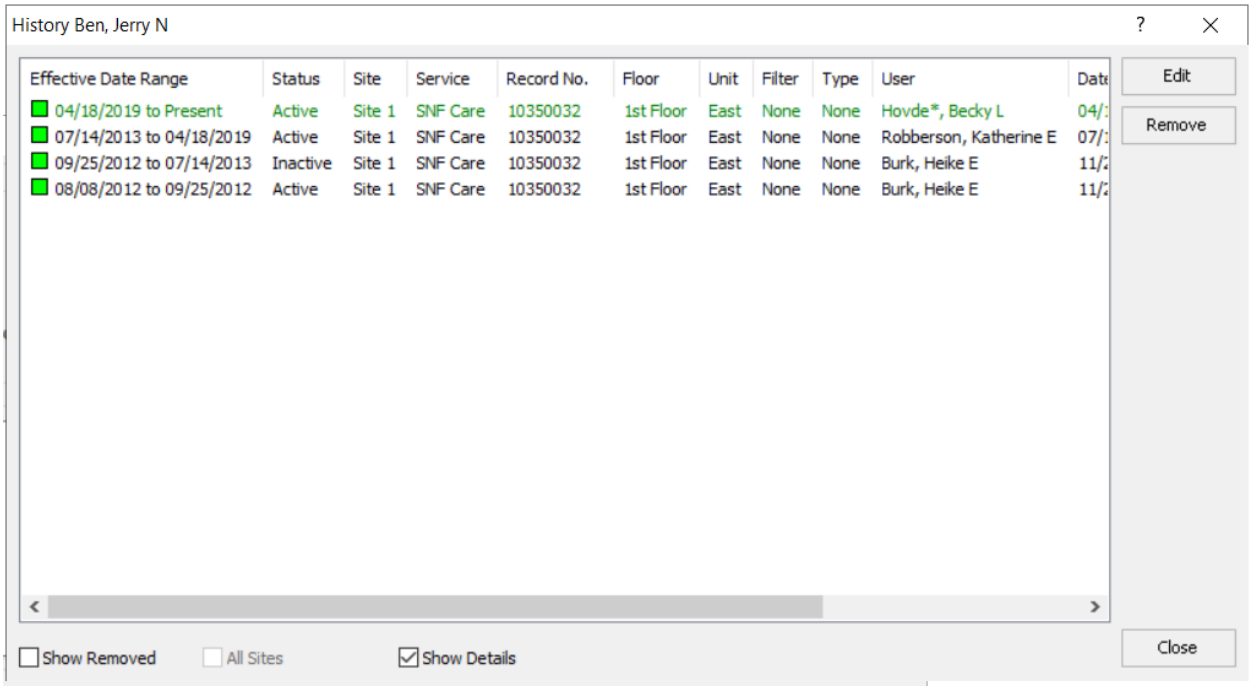
Moving a Client from One Service to Another

1. From the ADT/Face Sheet Access screen, click **Add/Update Client**.
2. Right-click the client's name and select **Locate**.
3. Select the picklist box next to **Effective Date** and select the date of the change (if different from today).
4. Select the status of **Inactive**, **Hold**, or **Closed Account**.
    a. When services do not "co-exist", the client must be marked as Inactive, Hold, or Closed Account in one service before they can be marked as Active in the new service. A client can only be active in one service at a time. For example, if a client is temporarily living in the nursing home, but they have an assisted living apartment; they will be listed as Inactive in assisted living and Active in the nursing home. Billing will still occur for client's listed in the Inactive statuses.
    b. When services do not "co-exist", and you wish to pre-admit a client into a new service before they are discharged from the old one, you may put the client in the new service under a Referral or Hold status (without altering the Active status of the original service.
5. Click **Apply** to save the status change.
6. Enter the information for the new service. Select the **Effective Date**, a status of **Active**, the appropriate **Site/Service**, and any other required **Filters**.
7. Click **OK** to save and **Close** to return to the ADT/Face Sheet Access screen.

Editing an Existing Client's Locate Information

(e.g., a locate status was entered in error or with the incorrect effective date)

1. From the ADT/Face Sheet Access screen, click **Add/Update Client**.
2. Right-click the client's name and select **Locate**.
3. To see the client's full history, click the **All History** button.



4. If you select the option for Edit, start by selecting the appropriate Effective Date of when the change should occur.
5. Select all required fields: Effective Date, Status, Site, Service, and any required Filters.
    a. The client's current Locate settings will be highlighted. You only need to select the item(s) which have changed.
    b. If you make an invalid selection, you will be alerted via a pop-up message when clicking OK.
6. Click **OK** to save and **Close** to exit out of the All History screen.
7. Click **Cancel** to return to the **ID/Demographics** screen (as your change has already been saved, you do not click OK or you will receive a warning message).

ID/Demographics Screen Features

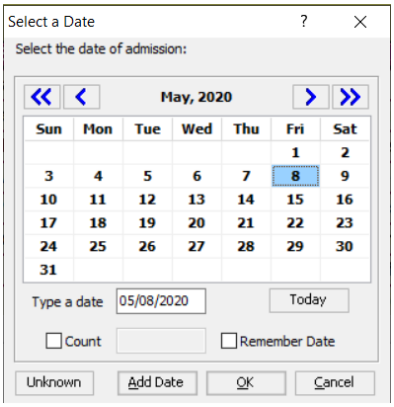
Feature	Description
Select All	Selects all clients.
Filter	Filters the client list (e.g., Discharged clients, North Unit). Additional options for "Other Demographics" are also available on this screen (ability to filter clients based on age, birth month, search by record number, etc.)
Sort	Sorts the client list (e.g., by room number).

Common	Narrows down the client list based on something all client's have in common with one another (e.g., CNA Assignment, all clients with an attending physician of Dr. Jane).
Refresh	Refreshes the client list to its default list.
Legend	Describes all the color-coded symbols (most useful in multi facility databases).
Date	Defaults to the current date. Change this date prior to filtering to filter clients for a specific date.

Face Sheets

Document a New Admission (Full Face Sheet)

1. From the ADT/Face Sheet Access screen, click **Admission**.
2. Select client's name and click **OK**.
3. A write screen will load. Chart the appropriate information by working from left to right. Notice the screen is split into three sections, the top portion gives button words to select from, the middle portion is where your charting is developed, and the lower portion is a defined review that will show any prior documentation in each topic.
    a. Skip any questions that are unknown or do not apply.
    b. Several questions may ask for an **Effective Date** (e.g., Occupancy Status, Payer Source, Admission Date). Select the appropriate date and click **OK**. To save the effective date used throughout all screens in the Face Sheet, place a checkmark in **Remember Date**.



4. Click **Sign** to advance to the next topic answering all appropriate questions as you go. When you are on the last topic and click Sign, you will be exited back out to the ADT/Face Sheet Access screen.

Document a Re-Admission

1. From the ADT/Face Sheet Access screen, click **Re-Admission**.
2. Select client's name and click **OK**.
3. A Write screen will load. Chart the appropriate information by working from left to right. Start by clicking onto where the client was **Readmitted From**. Then chart the appropriate **Occupancy Status**. Click **Sign** to advance to the next topic. The Re-Admission button will prompt for updated **Status** charting, **new room number** (chart new room with effective date, do nothing with the prior room number), as well as potentially **updated insurance information**.
    a. Several questions may ask for an **Effective Date** (e.g., Occupancy Status, Payer Source, Admission Date). Select the appropriate date and click **OK**. To save

the effective date used throughout all screens in the Face Sheet, place a checkmark in **Remember Date**.

4. Click **Sign** to advance to the next topic answering all appropriate questions as you go. When you are on the last topic and click Sign, you will be exited back out to the ADT/Face Sheet Access screen.

Document a Discharge/Transfer/LOA

1. From the ADT/Face Sheet Access screen, click **Discharge/Transfer/LOA**.
2. Select client's name and click **OK**.
3. A Write screen will load. Chart the appropriate information by working from left to right. Start by clicking onto the location as to where the client **Discharged To** or **Transferred To**. Then document the appropriate **Occupancy Status**.
4. Click **Sign** when completed, you will be exited back out to the ADT/Face Sheet Access screen.

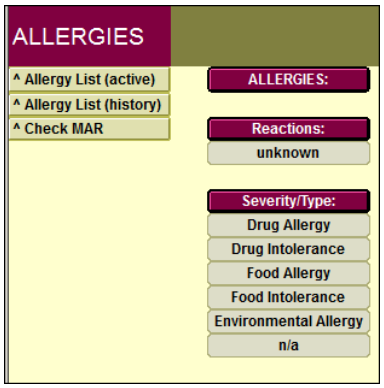
Document Diagnoses

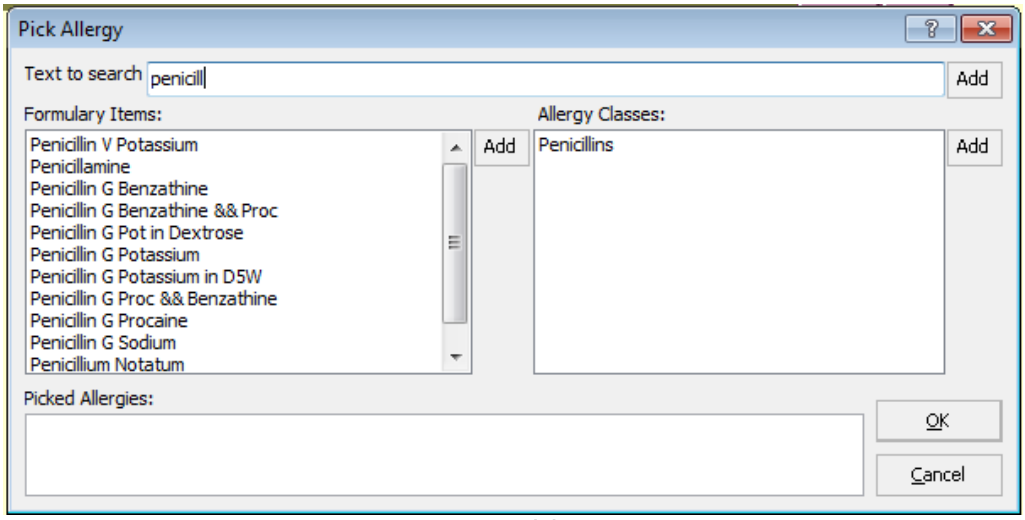
1. From the ADT/Face Sheet Access menu, click onto **Diagnosis**, select a name, and click **OK**.
2. A Write screen will load. Document the desired diagnosis by first selecting one of the Diagnosis Type words (ADMISSION, PRIMARY, SECONDARY, OTHER, or HISTORICAL).
    a. Only one admission and one primary diagnosis can be entered with the same effective date. The system will not allow more than one and will present the user with an error if they attempt to add an additional one with the same effective date.
    b. The admission and the primary diagnosis can be the same code.
    c. If the facility does not differentiate between the admission and primary diagnosis code, one can be moved and only one needs to be utilized.
    d. The UB04 can only electronically transmit up to 12 secondary diagnosis, so it is recommended to not enter more than 12 secondary codes. This ensures that all codes entered are transmitted.
    e. Use Other or Historical for remaining diagnosis codes.
3. Once you have selected a heading, a Diagnosis menu will appear. Begin typing the diagnosis name or ICD-10 code in the **Search** field (do not click Enter, the system searches automatically, but it may take a moment to begin the search). A list of matches will appear.
4. Select a diagnosis from the list and click **OK**. Do not select a red code (these are invalid codes).
5. Select the onset date of the condition (or the admission date if the onset date is unknown) and click **OK**.
6. The charting screen will display the diagnosis and date that was selected. The ICD-10 code will appear to be blank and will not appear until after save (do not type this in manually).

7. Repeat above steps for each diagnosis code.
8. Click **Sign** to save your entry(s) and return to the ADT/Face Sheet Access menu.

Document Allergies

1. From the ADT/Face Sheet Access menu click **Allergies**, select a resident's name, and click **OK**. A write screen will load.
2. Select the **ALLERGIES:** word. The Pick Allergy window appears. Start typing the allergy in the Text to search area. The more you type, the more narrowed down the lists become. Drugs, drug ingredients and products will appear in the Formulary Items fields on the left side of the screen. Drug/Allergy categories will be displayed in the Allergy Classes field on the right side of the screen.





3. Select an item from either list and click **Add** to the right of the corresponding field. The item is displayed at the bottom of the form in the Picked Allergies area. If no match is found in the formulary, you may select Add by the Text to search area.
    - When a medication is selected from field on the left side, its ingredients will be displayed in the field on the right side. You may choose from either list.
    - Selecting an ingredient (e.g., Salicylates) or drug class is preferred over selecting a specific medication (e.g., Aspirin) to narrow the allergy to the specific substance the resident is allergic to.
4. Click **OK** to close the Pick Allergy window.
5. Enter the reaction. If unknown, type 'unknown'.
6. A window appears with a list of **severity/type** options. Select one and click **OK**.
7. Repeat steps 2 – 6 for additional allergies.
8. Click **Sign** to save the entry(s) and return to the ADT/Face Sheet Access screen.

** In the event the resident has no known allergies, enter this into the allergies form. In this instance document the 'Reaction' as N/A and 'Severity/Type' as N/A.

View/Edit Face Sheet Information

1. From the ADT/Face Sheet Access screen, click **View/Edit Face Sheet**.
2. Select client's name and click **OK**.
3. Click **Exit** to return to the ADT/Face Sheet Access screen.

Edit Face Sheet Information

Example 1: When an entry WITH an EFFECTIVE DATE is incorrect (e.g., wrong admission date, charted entry on incorrect client)

1. Follow steps above for View/Edit Face Sheet Information.
2. 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 appear 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. If needing to chart a new one in its place, re-tag the grayed-out entry.
6. Click the **Edit** button again and select **New**.
7. A Write screen will appear. Re-chart the correct information.
8. Click **Next** to save your changes and return to the View screen.
9. Click **Go** to refresh your screen and see the changes.
10. Click **Exit** to return to the ADT/Face Sheet Access screen.

Example 2: To change part of an entry WITHOUT an EFFECTIVE DATE (e.g., change a primary contact's phone number)

1. Follow steps above for View/Edit Face Sheet Information.
2. Click the incorrect entry to turn it red. This is called 'tagging' the entry.
3. Click the **Edit** button and select **Discontinue and Copy**. A box will appear and ask: Are you sure you want to DC selected Entry? Click **Yes**.
4. The old entry will appear grayed out to indicate it has been discontinued. A Write 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.
6. Click **Go** to refresh your screen and see the changes.
7. Click **Exit** to return to the ADT/Face Sheet Access screen.

Example 3: To change an entire entry WITHOUT an EFFECTIVE DATE (e.g., a resident changes his/her attending physician)

1. Follow steps above for View/Edit Face Sheet Information.
2. Click the incorrect entry to turn it red. This is called 'tagging' the entry.
3. Click the **Edit** button and select **Discontinue and New**. A box will appear and ask: Are you sure you want to DC selected Entry? Click **Yes**.
4. The old entry will appear grayed out to indicate it has been discontinued. A Write screen will appear. Document the updated information.
5. Click **Next** to save your changes and return to the View screen.

6. Click **Go** to refresh your screen and see the changes.
7. Click **Exit** to return to the ADT/Face Sheet Access screen.

Example 4: To remove an incorrect entry/entries WITHOUT an EFFECTIVE DATE (e.g., a resident's attending physician was inadvertently charted twice)

1. Follow steps above for View/Edit Face Sheet Information.
2. Click the incorrect entry to turn it red. This is called 'tagging' the entry. You may tag multiple entries if needed.
3. Click the **Edit** button and select **Discontinue** to remove a single entry or **Discontinue All** to remove multiple entries at the same time. A box will appear and ask: Are you sure you want to DC selected Entry? Click **Yes**.
4. The entry or entries will turn gray to show the edit is complete.
5. Click **Go** to refresh your screen and see the changes.
6. Click **Exit** to return to the ADT/Face Sheet Access screen.

Example 5: To remove an allergy that is no longer active

1. From the *ADT/Face Sheet* Access screen click **Allergies**, select a client's name, and click **OK.**
2. A write screen will appear. The bottom portion of the screen (View screen) will display the resident's current allergy entries.
3. Click on the desired entry to turn it red. This is called "tagging" the entry.
4. Click the **Edit** button. A menu will appear.
5. Select **Discontinue**.
6. A box will display *Are you sure you want to DC selected entry?* Click **Yes**.
7. The allergy will now appear in gray font.
8. Click **Exit** to return to the ADT/Face Sheet Access screen.

View/Print the Face Sheet

1. From the ADT/Face Sheet Access screen, click **Print Face Sheet**.
2. Select client's name and click **OK**.
3. Click the **Print** icon to select printing options.
4. Click **Exit** to return to the ADT/Face Sheet Access screen.

Census Calendar

This button will load a calendar defaulted to the Current Month. It will display the following statistics for each client: their occupancy status, payer source, co-pay sources, apartment number, and rental type. A calendar report displays with one column for each day of the month. The bottom gives overall totals (which can be useful if wanting to know total Medicare or In-house days). To adjust the date range, click onto **Control**, select new dates, click **OK** to re-load the calendar based on the updated date.

1. From the ADT/Face Sheet Access screen, click **Census**.

2. Select client(s) name and click **OK**.
3. Click the **Print** icon to select printing options.
4. Click **Exit** to return to the ADT/Face Sheet Access screen.

Other

Write an Internal Memo

1. From the ADT/Face Sheet Access screen, click onto **Write Internal Memo**. A Write screen will load.
    a. A message may appear "This task has clients associated with it. Do you want to override your currently selected clients?" Click **Yes** to this message. This will have you chart your memos on the fake Facility Services or Memo client.
2. Chart the appropriate information utilizing the **Message Regarding** and **Message** buttons.
3. Select an option under **Send To**. If you select "Pick User on Save", you will not be presented with a list of users until after saving the entry by clicking onto Sign.
4. Click **Sign** to save the entry and send it to any user(s) you had selected. This will return you to the ADT/Face Sheet Access menu.

View the Schedules

1. From the ADT/Face Sheet Access screen, click onto **Schedule**.
2. A list of different scheduler tasks will display. Click onto the desired task you would like to view and click **Load.** Schedule options may include: In House Visits/Consults, Out of Facility Appointments, and Transportation.
3. A scheduler screen will appear. If desired, change the view using the **Day/Week/Month/Year** buttons and the forward/backward arrows at the top of the screen.
4. Double click an appointment to view the details. Click "X" to close out of the details.
5. Click **Exit** to return to the ADT/Face Sheet Access menu.