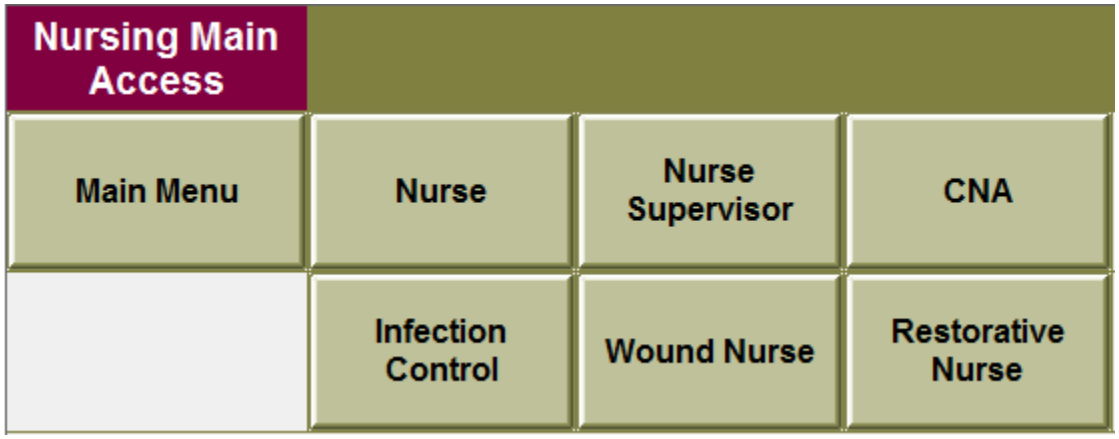
Nurses Notes

Nurse Main Access Screen



Part 1: Nurse Access

Clicking the **Nurse** button opens the main Nurse Access screen. Buttons in the first column take the user to areas within ECS for more information.

Nurse	Daily Tasks	Charting				Chart Review	Other		Internal Memo
Main Menu	To Do List	ADLs	DC Arrangements / Summary	Lab/ X-ray	PPD / Vaccine	View Chart	Physician Orders	Schedules	Write Internal Memo
	eMAR / eTAR	Admit/ Return	Discharge/ Transfer/Rm Change	Med Error	SBAR	CNA Review	Nursing Reports	Edit CNA Flow Sheet	
	BM List	Appt/LOA	Family/ Physician Contact	Med Use	Systems	Shift Report	Care Plans	Supplies	
	Lab Calendar	Assessment	Hospice	Medicare	Vital Signs / Weights	Status Summary	Cleaning	Maintenance	
	RN Cosign	Behavior	Incident	Mood					

Daily Tasks Buttons

To Do List

Click the **To Do List** button to open additional choices.

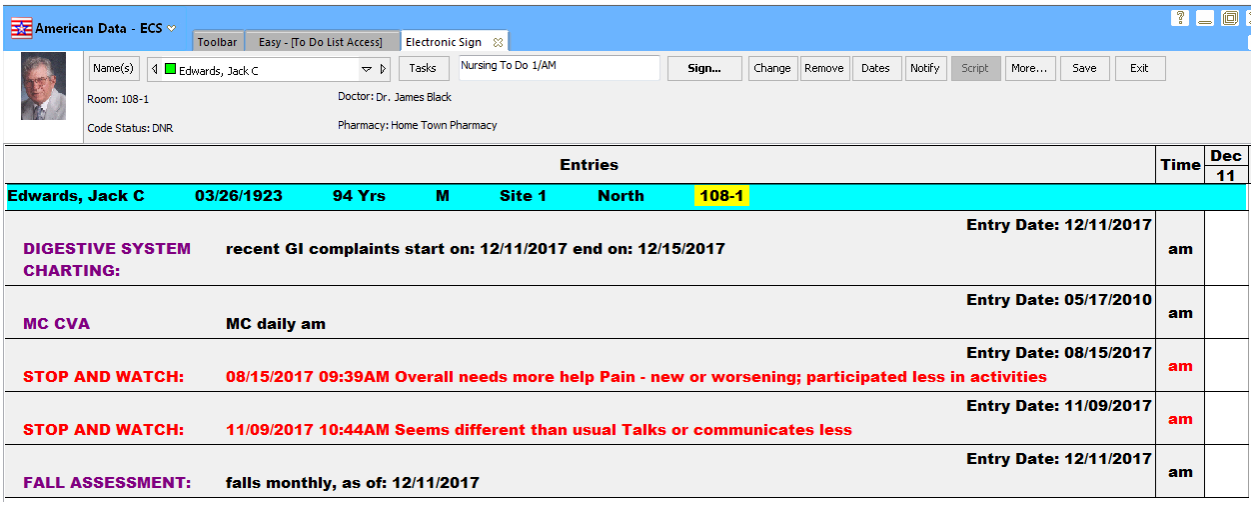
Initiate or Edit To Do List

1. To initiate or edit the Nursing To Do List, select the desired name(s) and click the **Edit To Do List** button.
2. A Write screen will appear. Entries appearing at the bottom of the screen show what is already in the To Do List for this resident.
3. Working from left to right, select items to add to the nursing to do list. Select a start date, and an end date if desired. To edit the items in the To Do list, refer to Editing Nurses Notes below.

View / Sign To Do List

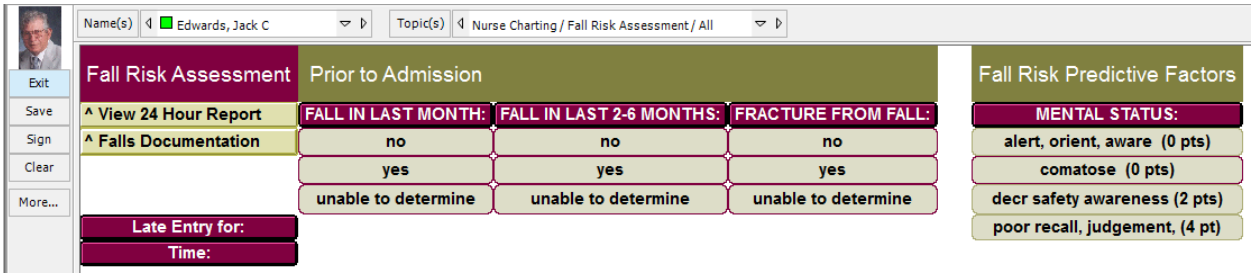
Clicking any of the buttons under the To Do menu opens the Nursing To Do List under the Electronic Sign screen:

Nursing To Do List



To document on a particular item, click in the cell on the right under today's date. A Write screen will load.

Write screen



Document a note by clicking on red question words and canned phrases.

- When finished documenting on this screen, click the arrow pointing to the right after the Topic window. This will save the entry and load the next Write screen.

- When no more new topics load, click **Sign** to save to save the entry and return to the prior screen.

Items on the To Do list may be marked Held or Refused by clicking on the appropriate button at the top of the list, and clicking on the cell under today's date.

When finished charting on the To Do List, click **Exit** to return to the Nurse Access screen. When the To Do List closes, an Exception Report will display showing items on the To Do List that were either left blank, or marked Held or Refused. The nurse may choose **Return** to open the To Do List again, or **Exit** to go back to the Nurse Access screen.

BM List

The **BM List** button will take the user to a view screen which displays a list of residents for whom nurse aides have charted a small BM or no BM for the past 3 days. Nurses will typically use this list to determine which residents may need PRN laxatives. The list can be reviewed, or printed if desired using the Print button underneath More options at the top of the screen. Click the **Exit** button to return to the prior Nurse Access screen.

Lab Calendar

The **Lab Calendar** button creates a report showing residents who have labs scheduled for the current month. Select a different date range by clicking onto **Control**. The report may be printed by clicking on the print button at the top of the screen. Click the **Exit** button at the top of the screen to return to the Nurse Access screen.

RN Cosign

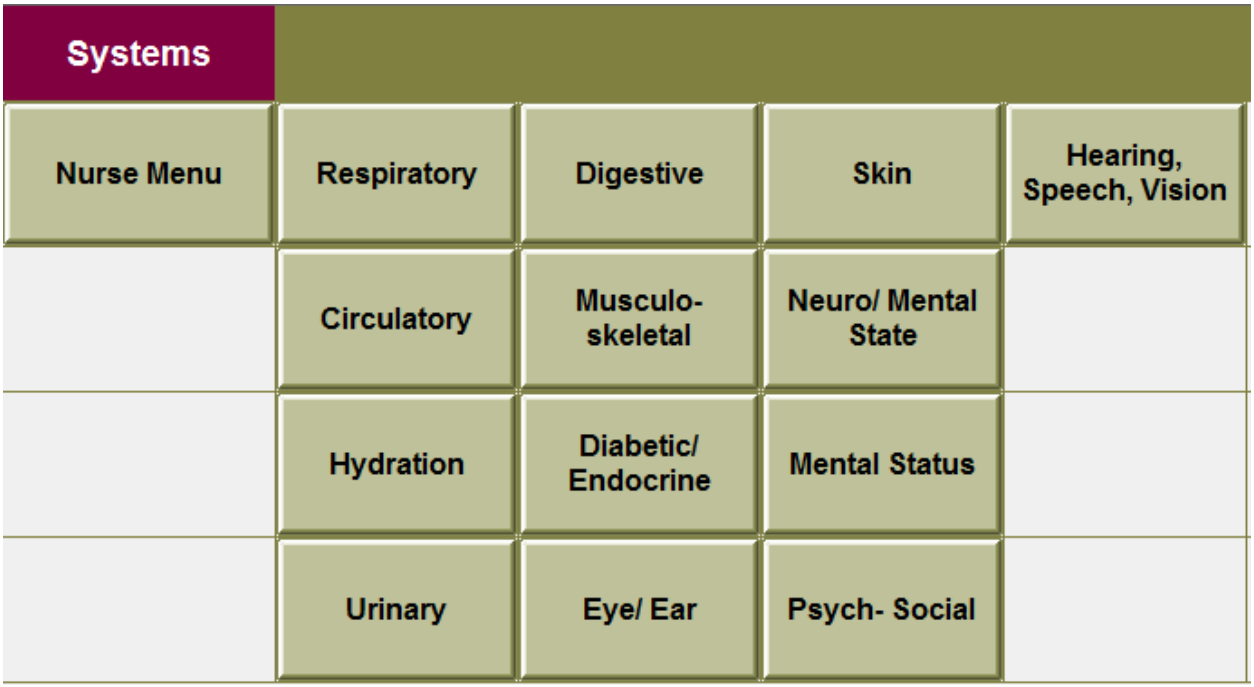
The **RN Cosign** button will open an Electronic Cosign screen displaying all of the physician orders on the selected residents which require a nurse's co signature. This functionality is used if the facility requires an RN to sign off on Physician Orders that are transcribed by LPNs/HUCs.

Click in the box under the date to enter the user's initials and cosign the entry. Orders may be reviewed and cosigned all at once using the **Sign All** button at the top of the screen. When finished, click the **Exit** button to return to the prior Access screen.

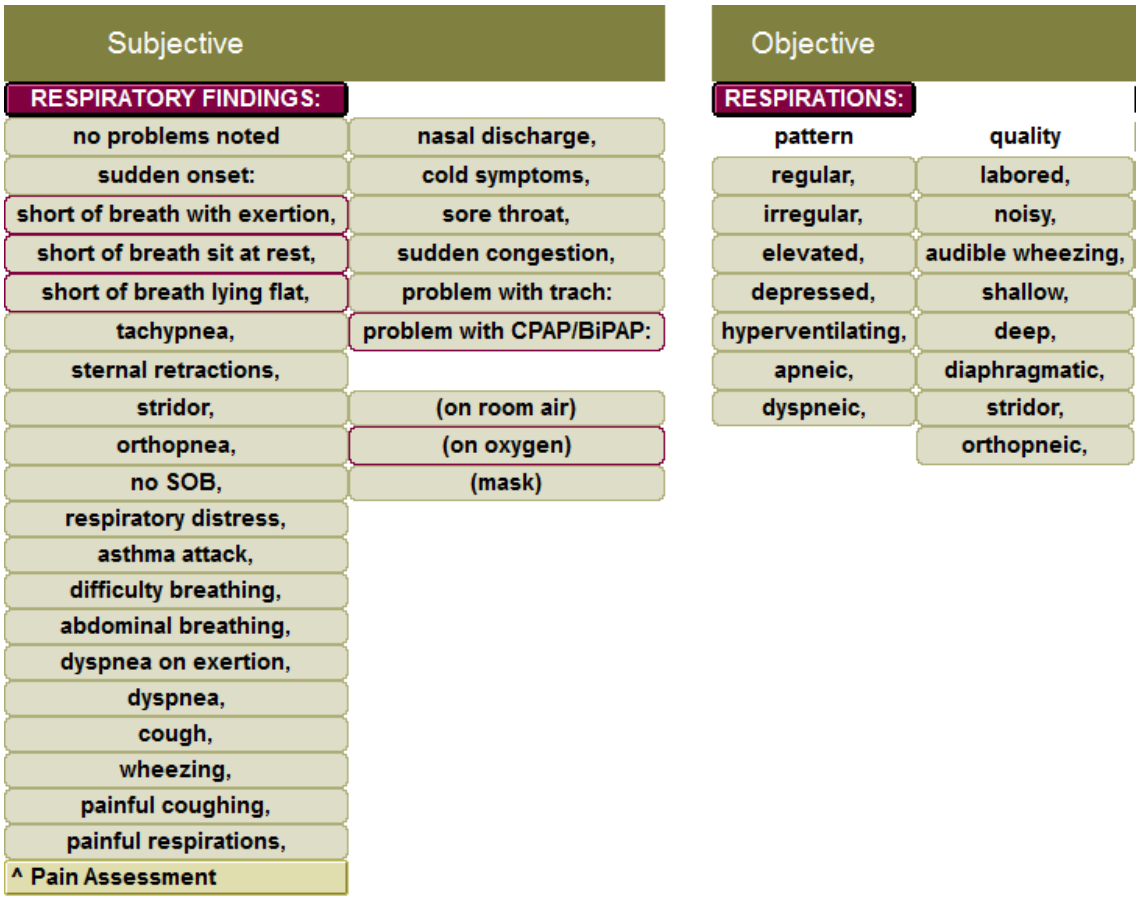
Nurse Charting Buttons

The middle section of the Nurse Access screen consists of buttons which take the user to various Write screens. Select a name [more than one may be selected by holding the Ctrl button on the keyboard and clicking on multiple names]. Click the desired button, and a Write screen will appear.

Example: Select a name on the left, and click the **Systems** button. Another screen appears to select a specific symptom or body system to chart on.

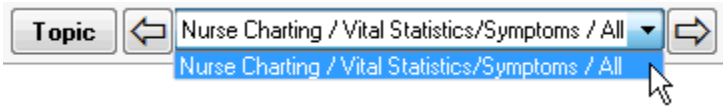


Select a charting button (e.g., Respiratory). A Write screen appears in the Nurse Charting topic Respiratory Condition.



When finished in this Topic, click the Save button at the end of the screen. This will advance the user to the next topic (if there is one) or save the entry and exit the user back to the previous screen.

The user can see if more than one screen is linked to a documenting button by clicking the drop-down arrow in the Topic window.

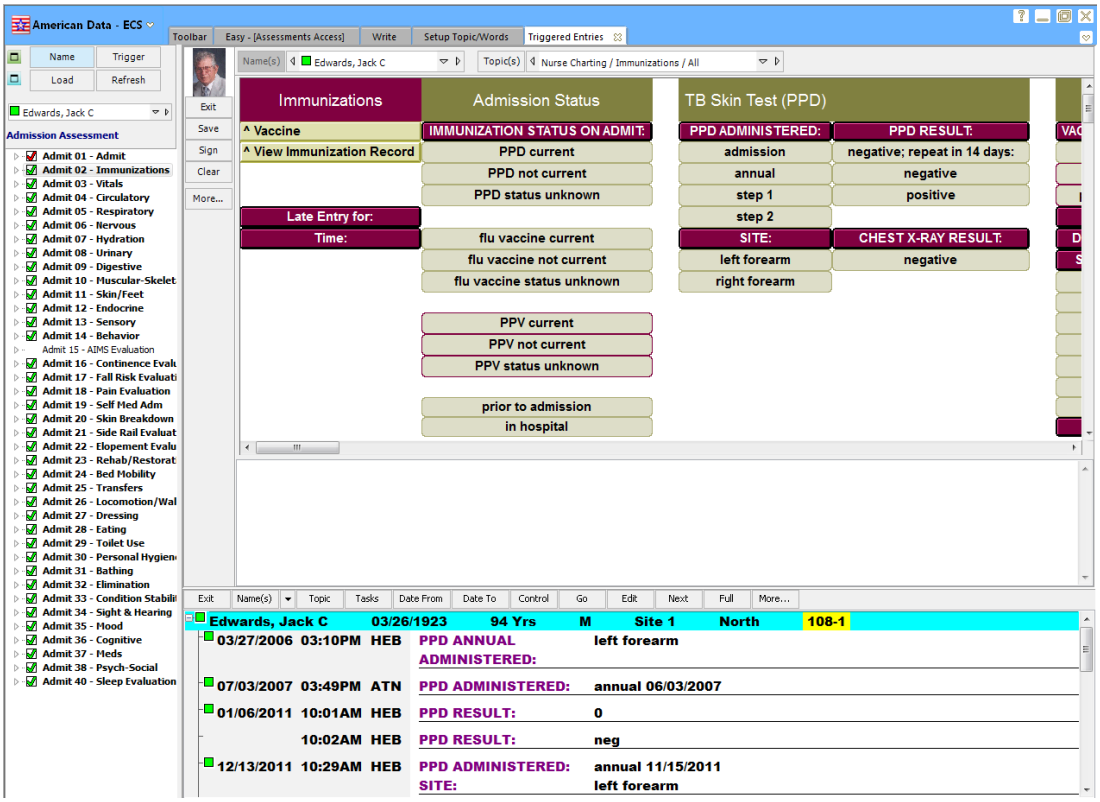


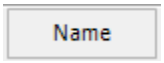
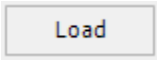
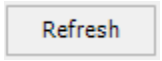
Some screens, such as Medicare Charting screen, consist of words specific to the condition selected and pull from various topics. When the user is in a Medicare Charting documentation screen, the Topic window will be blank.

Admission Assessment

The **Admission Assessment** button loads a trigger Write screen that displays specific documentation requirements based on the selected resident's condition. This is also called Trigger charting.

Select the desired resident(s) and click the **Assessment** button and **Admission Assessment** to load the Trigger Screen. A 3-way split screen will appear. The top right half of the screen is a Write screen, the bottom right half is a view screen, and the left half of the screen is a trigger list. The view screen will display previous charting and care plans.



Icons in the Trigger Screens	
 (Green)	Maximizes the View screen.
 (Blue)	Maximizes the Write screen.
	Opens the Name Selection screen.
	Brings up the information into the Write/View screen t work the trigger.
	Reloads the trigger list.
	Refreshes the screen.

1. The first step is to review the information in the view screen. To enlarge the View portion of the screen, click the small green maximize view icon  . Scan through the information, then click the maximize view icon again to make the view screen smaller.
2. The second step involves documenting the nurse's note. If desired, enlarge the Write screen by clicking on the small blue maximize write icon  .
3. Document the notes by working from left to right.
4. When finished documenting on that triggered area, click the next trigger that has a green checkmark. The checkmark next to the trigger previously worked will now turn Red, indicating that it has been completed.
    - To load the new trigger, click the **Load** icon above the trigger list. Document following the steps outlined above.
5. Click onto **Name** to switch to a different resident.
6. Click the **Exit** button to return to the Nurse Access screen.

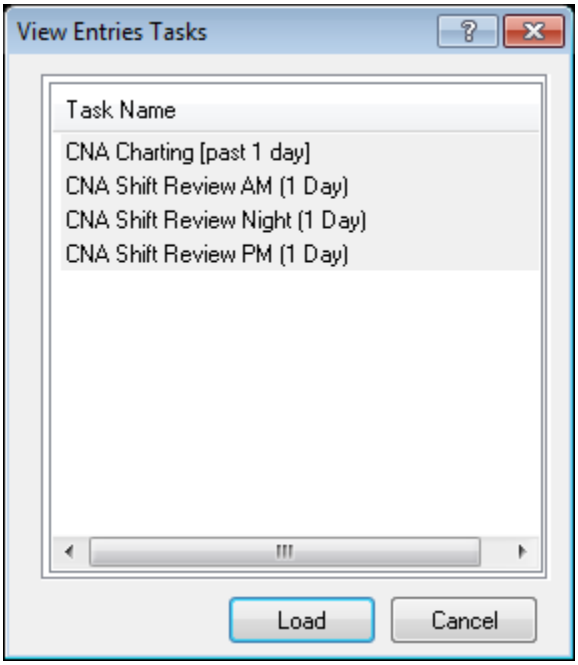
Chart Review Buttons

View Chart

The View Chart button allows the user to review selected information. Select the desired resident(s), 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 the **Control** button at the top of the View screen, enter Start and End dates, and click **OK** and **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.

CNA Review

The CNA Review button loads a selection window showing the CNA charting tasks. Select the desired name(s) and OK, and then the desired task(s) and click OK. This will display all charting completed on that shift or in the past one day. Click the Exit button at the top of the screen to return to the Nurse Access screen.



Shift Report

The Shift Report button will bring up another screen for the user to select particular blocks of charting to review. Select the button for the shift or time range you wish to review charting for. Select the residents whose charting you wish to review, and click **OK**. Click the **Exit** button at the top of the screen to return to the Nurse Access screen.

Incompletion Reports

Click one of the **CNA Incompletion Reports** button and select the report you would like to run. Select the resident(s) you would like to run the report on. Click **OK**. The Incompletion report will load. The incompletion report will load. Click the arrows to move forward and backward pages of the report if it is multiple pages. Click the printer icon if you would like to print the report.

CNA AM SHIFT: "DAILY" INCOMPLETION REPORT Page 1

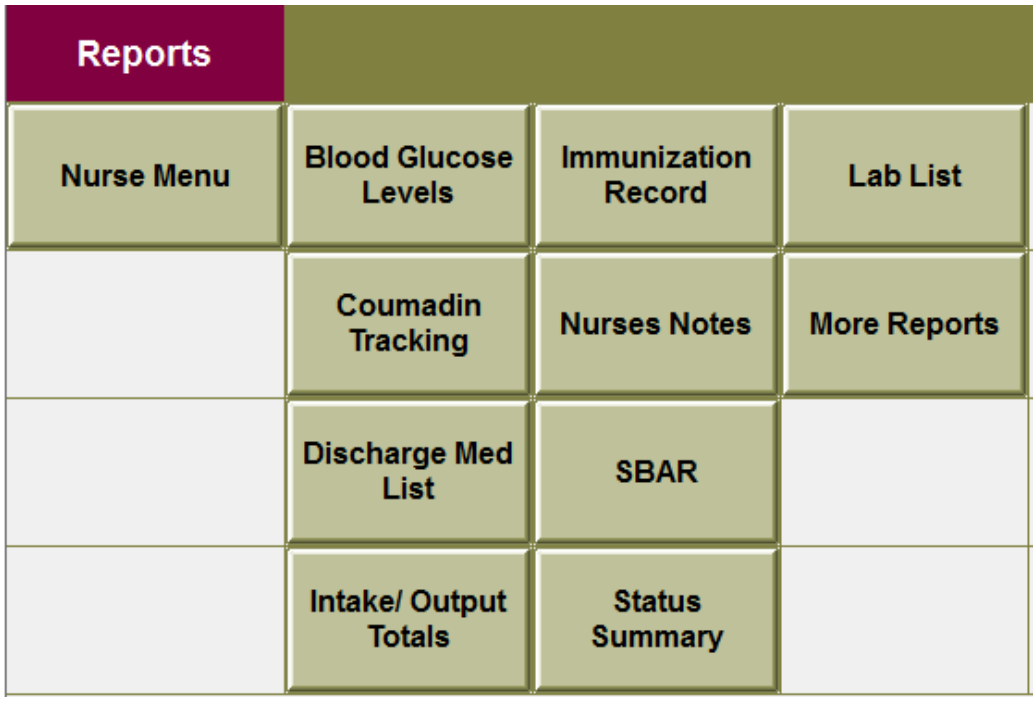
Name	Room	Bed Mob	Transfers	Eating	Toileting	Hygiene	Walk/Rm	Walk/Hall	Move/On Unit	Move/Off Unit	Dressing	Voiding	Stool Output	Brkfst	Lunch	Snack
Morris, Luke J	103-1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Other Buttons

Other buttons in the Nurse Access Screen will allow the user to view, document, and edit in other areas of the chart. For specific information regarding using the buttons titled Physician Orders, Edit CNA Flow Sheets, and Care Plans please refer to handouts specifically regarding these areas.

Nursing Reports

Clicking the **Nursing Reports** button brings the user to a Reports Access screen:



Blood Glucose Levels

Clicking the Blood Glucose Levels button runs a report on selected residents showing blood glucose levels for the chosen time period. The user may print using the Print icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

Coumadin Tracking

Clicking the Coumadin Tracking button runs a report on selected residents showing the Coumadin order and associated lab results for the chosen time period. The user may print using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

Discharge Med List

Clicking the Discharge Med List button runs a report on selected residents showing the discharge medication orders for the resident. This report may be used for medication teaching or at the time of discharge from the facility. The report may be printed using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

Intake/Output Totals

Clicking the Intake/Output Totals button runs a report on selected residents showing the intake and output charted by Nurses and/or Nursing Assistants for the past week. The user

may print using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

Immunization Record

Clicking the Immunization Record button runs a report on selected residents showing the immunizations documented under Nurse Charting. The report may be printed using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

Nurses Notes

Clicking the **Nurses Notes** button runs a report that shows the documentation of nurse's notes. You will first be prompted to select a time period or date range for which to run the report. The report may be printed using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

SBAR

Clicking the **SBAR** button generates a listing of all SBAR forms that have been filled out on the selected resident(s). The user must first select a form that they'd like to view. It can be printed by clicking American Data-ECS>Print. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

Status Summary

Clicking the **Status Summary** button runs a report that shows the resident's code status, most recent set of vital signs, allergies, diagnoses, new physician orders (past 7 days), weight/vital changes (past 7 days), nurses notes (past 7 days), meal intake (past 7 days), and fluid intake (past 7 days). The report may be printed using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

Lab List

Clicking the **Lab List** button runs a report that shows all labs that are due today. This is based on the physician order entries completed for lab orders. The report may be printed using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

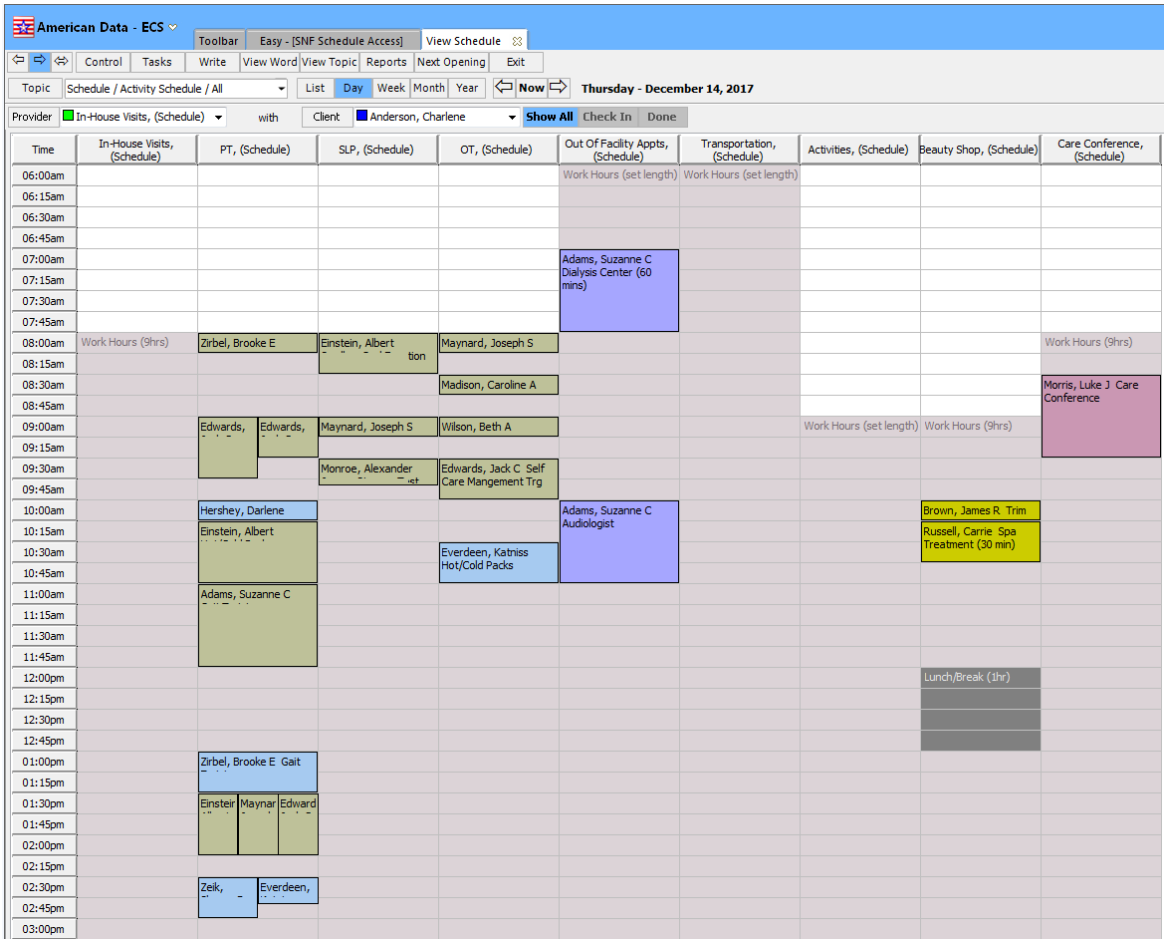
More Reports

Clicking the **More Reports** button will display a list of all the reports available to the user. Highlight the desired Report(s), select Start/End dates if desired, and click **OK**. The report may be printed using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Reports Access screen.

Schedules

The **Schedules** button will take the user to the schedule access screen. Click into any of the View options to see that specific schedule. Scroll down and scroll over to view the entire day. Double-click the box with the appointment to view details of that appointment. Change the

dates viewed by clicking on the **Day/Week/Month/Year** buttons at the top of the screen, or by clicking the forward and back arrows by the **Now** button. Click the **Exit** button at the top of the screen to return to the Nurse Access screen.



Cleaning, Supplies, and Maintenance Buttons

The **Cleaning**, **Supplies**, and **Maintenance** buttons may be used to document information regarding supplies used for a resident, or to request housekeeping or maintenance services. Information documented under these screens is not considered part of the resident's medical record, and can be set up to send the entry to the required staff.

Internal Memo

Write Internal Memo

1. 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.

Part 2: Wound Nurse Access

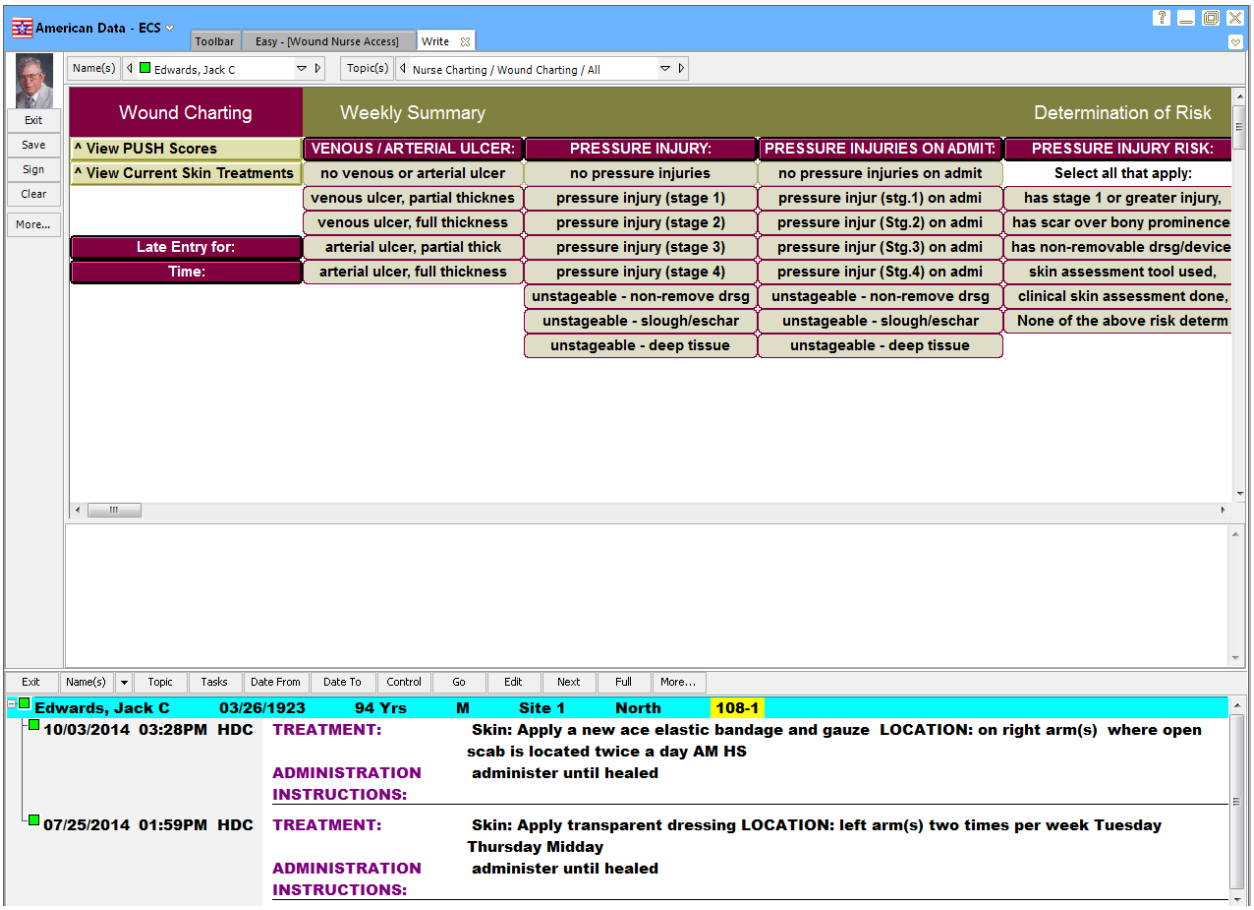
Clicking the **Wound Nurse** button opens the main Wound Nurse Access screen.

Wound Nurse	Charting	Chart Review	Reports	PUSH Graphs	
Main Menu	Wound Assessment	Care Plans	Weekly Wound Report (Mult Res)	PUSH Scores Area 1	PUSH Scores Area 6
	Weekly Wound Note Due	View Chart	New Wounds by Unit	PUSH Scores Area 2	PUSH Scores Area 7
	Skin/Feet Condition		Wound Graph by Unit	PUSH Scores Area 3	PUSH Scores Area 8
	Braden Assessment		Braden Scale Report	PUSH Scores Area 4	PUSH Scores Area 9
	Skin Care Plan		More Reports	PUSH Scores Area 5	PUSH Scores Area 10

Wound Assessment

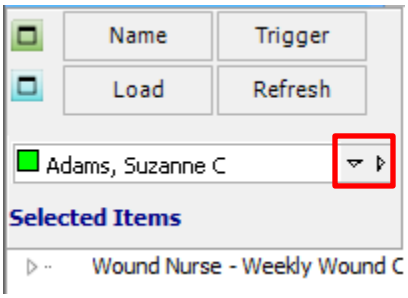
Clicking the **Wound Assessment** button opens a Write screen in the Nurse Charting topic *Wound Charting*. Enter information, working from left to right in the documentation screen. Specify between a pressure injury, wound, or a daily progress note. If completing charting for pressure injury or a wound, use a separate **Area** question word for each problem. Make sure to document from start to finish through the screen for each **Area** documented. Clicking the **Save** button at the end of the screen will save the entry and return to the Wound Nurse Access screen.

Wound Charting Write screen



Weekly Wound Note Due

The **Weekly Wound Note Due** should be run on all residents each week. It will display any resident's that have a pressure injury or wound that has not yet had charting completed on the healing progress in the past six days. To see which residents trigger for this charting, click the arrow to the right of the resident's name. It will flip through all names and only stop on those who do require this charting. Complete charting and then click the arrow to the right again to go to the next resident.



Weekly Wound Report (Mult Res)

The **Weekly Wound Report** button runs a report on selected residents showing the documentation related to wound development and healing. The report may be printed using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Nurse Access screen.

PUSH Graphs

The **PUSH Graph** buttons will display the Graph reports list. Select the desired PUSH graph for the resident's wound areas. The report may be printed using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Nurse Access screen. These graphs will only work if you use the PUSH scoring tool when documenting pressure injuries.

Part 3: Restorative Nurse Access

Clicking the **Restorative Nurse** button opens the main Restorative Nurse Access screen.

Restorative Nursing					Reports
Main Menu	Restorative Assessment	Write PROM Plan	Write Walking Plan		Weekly Minute Totals
	View Restorative Nursing Plan	Write AROM Plan	Write Dressing Plan		Minutes (Calender)
		Write Splint/ Brace Plan	Write Eating Plan		
		Write Bed Mobility Plan	Write Prosthesis Plan		
		Write Transferring Plan	Write Communication Plan		
			Write Other Plan		

Restorative Assessment

Clicking the **Restorative Assessment** button opens a Write screen in the Nurse Charting topic *Restorative Nursing Assessment*. This screen may be used to document regular notes regarding the restorative nursing program. Follow the instructions above to enter information, working from left to right in the documentation screen. Clicking the **Save** button at the end of the screen will save the entry and return to the Restorative Nurse Access screen.

View Restorative Nursing Plan

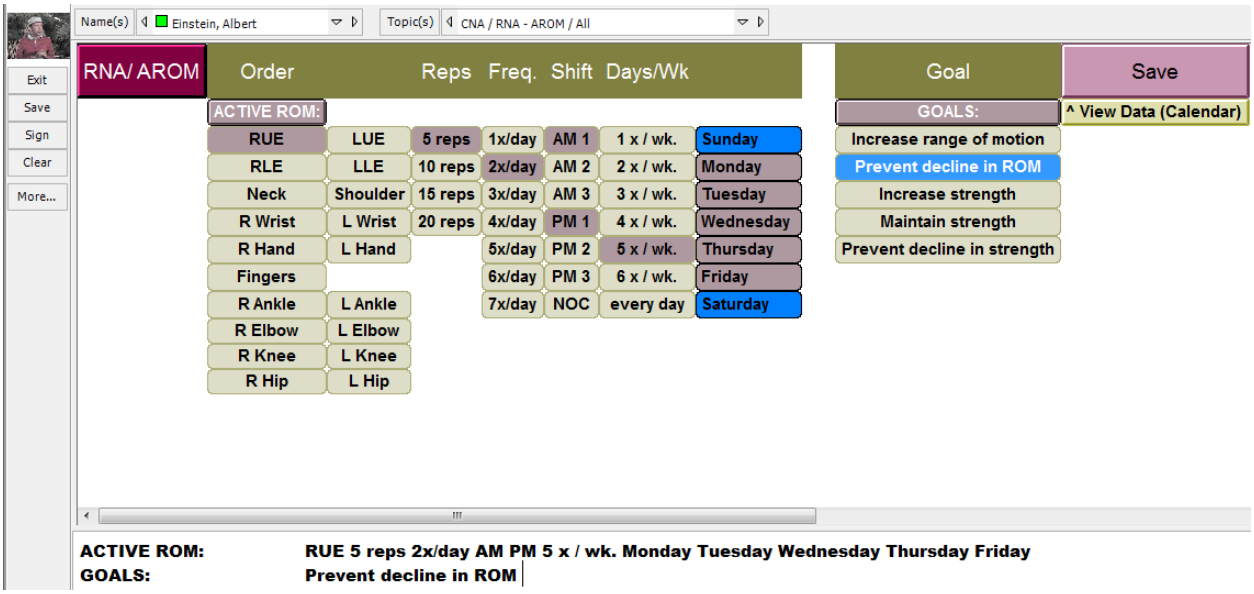
The **View Restorative Nursing Plan** button will open a view screen to display the restorative nursing orders for the selected residents. Orders may be reviewed and edited from this screen (see Editing Nurse Charting below). The screen may be printed if desired using the print button at the top of the screen. Click the **Exit** button to return to the prior Nurse Access screen.

Write (Restorative Nursing Program) Plan

The buttons on the right of the screen will open Write screens for the restorative nurse to write nursing restorative orders.

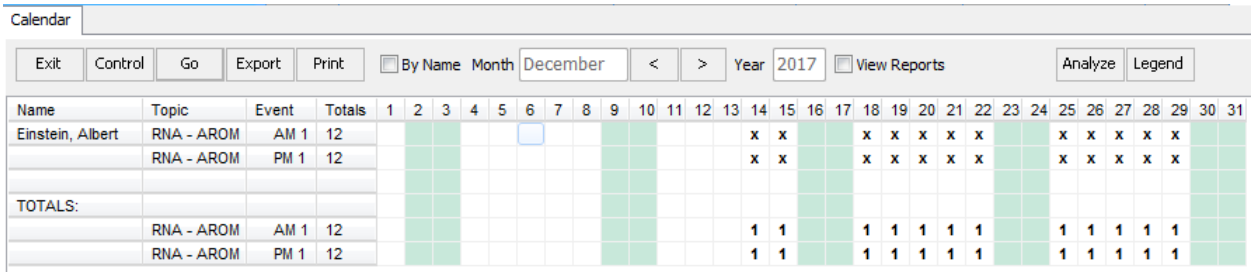
Example: Select a resident, and click the **Write AROM Plan** button. Another screen appears to document the order:

RNA AROM Write screen



Click the **View Data (Calendar)** button to save the order and view a calendar showing the dates the order will appear on the Restorative Aide assignment:

Calendar Screen



Name	Topic	Event	Totals	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Einstein, Albert	RNA - AROM	AM 1	12														x	x			x	x	x	x	x			x	x	x	x	x		
	RNA - AROM	PM 1	12														x	x			x	x	x	x	x			x	x	x	x	x		
TOTALS:																																		
	RNA - AROM	AM 1	12														1	1			1	1	1	1	1			1	1	1	1	1		
	RNA - AROM	PM 1	12														1	1			1	1	1	1	1			1	1	1	1	1		

Click the **Control** button to see a different range of dates on the Calendar. Click the **Exit** button to return to the prior screen. Click the **Exit** button again to return to the prior Nurse Access screen.

Part 4: Nurse Supervisor Access

Clicking the **Nurse Supervisor** button opens the main Nurse Supervisor Access screen.

Nurses Sup. Access	Daily Tasks		Other	QA	Scheduling	Internal Memo	To Do List
Main Menu	24 Hour Report	Current Infections	View Chart	QA Reports	Scheduling	Write Internal Memo	Add/Edit To Do List
	1 Day Chart Review	Risk Review	View Reports	Resident/ Family Concerns			
	DON Incident Review	Chart Audit	O2 Tanks				
	New Order Review	RUG Forecast Tasks	Status Summary				
	RN Phys Order Cosign	Intake Totals	Quality Measure Reports				

Daily Tasks

24 Hour Report

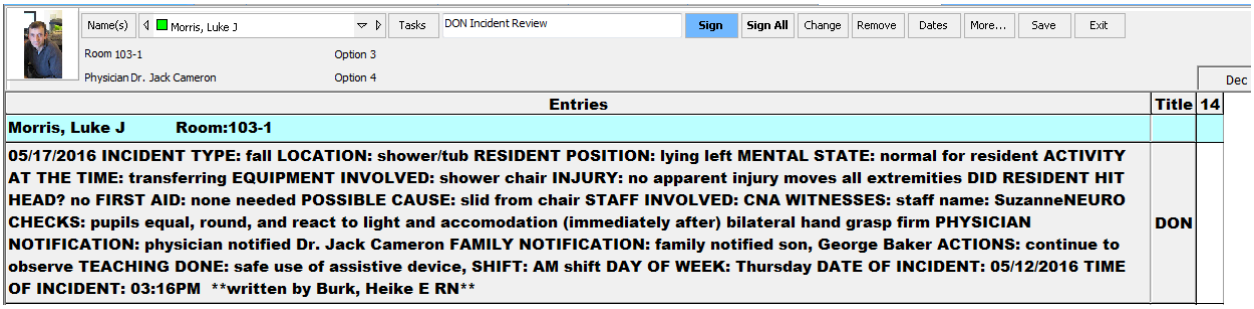
The **24 Hour Report** button will open a view screen to display all nurse charting in the past 24 hours for the selected residents. The screen may be printed if desired using the print button at the top of the screen. Click the Exit button to return to the prior Access screen.

1 Day Chart Review

The **1 Day Chart Review** button will open a view screen to display all charting in the past 1 day for the selected residents. The screen may be printed if desired using the print button at the top of the screen. Click the Exit button to return to the prior Access screen.

DON Incident Review

The **DON Incident Review** button will open an electronic Cosign screen displaying all of the incidents on the selected residents which require a DON cosignature.



Click in the box under the date to enter the user's initials and cosign the entry. Incidents may be reviewed and cosigned all at once using the **Sign All** button at the top of the screen. When finished, click **Save** and then **Exit** button to return to the prior Access screen.

New Order Review

The **New Order Review** button will open a view screen to display changes in physician orders for the selected residents. Only orders that have been changed within the past one day will display on this view screen. The screen may be printed if desired using the print button at the top of the screen. Click the **Exit** button to return to the prior Access screen.

RN Phys Order Cosign

The **RN Phys Order Cosign** button will open an Electronic Cosign screen displaying all of the physician orders on the selected residents which require a nurse's co signature. This functionality is used if the facility requires an RN to sign off on Physician Orders that are transcribed by LPNs/HUCs.

Click in the box under the date to enter the user's initials and cosign the entry. Orders may be reviewed and cosigned all at once using the **Sign All** button at the top of the screen. When finished, click **Save** and then **Exit** button to return to the prior Access screen.

Current Infection

The **Current Infections** button opens a View screen showing any unresolved infections that have been documented on the selected residents. To resolve an infection so it no longer appears on this view screen, the user must use *OUTCOME* word appended onto the existing entry.

Risk Review

The **Risk Review** button will open a view screen to display all charting related to Falls, Wounds, Weight Loss, and Physician Orders for the selected residents. The user will be first prompted to select a date range, if desired. The screen may be printed if desired using the print button at the top of the screen. Click the **Exit** button to return to the prior Access screen.

Chart Audit

The **Chart Audit** button will prompt the user with several different report options. These include Admission, IDT Assessments, Nursing Assessments, Quality Checks, and Therapy. To run just a select group of the reports, use the CTRL key on the keyboard to highlight the reports interested in. If wanting to view them all, leave them all highlighted and click **Load**.

Quality Audits Report (one part of the Chart Audit)

Quality Audits

(X = Incomplete items found within the residents chart)

Date: 12/14/2017

Name	TB Skin Test Due (365 Days)	Pneumo. Immun. Due (365 Days)	Flu Immun. Due (365 Days)	PRN Med No Follow Up (30 Days)	Fall No Follow Up (30 Days)	ABT No Inf. Charting (30 Days)	Weekly Skin Check Missing	Psych. Med Red. Due (180 Days)	Vital Signs Missing (30 Days)	CNA - No BM 3 Days	CNA - No Bath 7 Days
Edwards, Jack C		X	X					X			X
Einstein, Albert	X	X	X					X			X
Hershey, Darlene	X		X					X			X
Jefferson, Thomas	X	X	X					X			X
4	3	3	4					4			4

Rug Forecast Tasks

The RUG Forecast is a reporting capability that can display real-time information related to state and federal RUGs/CMIs, Therapy days/minutes, Medicare Days, and ADLs. This is a powerful tool that can assist you with planning assessments, identifying best reference dates, and tracking and monitoring therapy and Medicare days.

When clicking on the **RUG Forecast** button, the user will be presented with the RUG control screen. Select a Task or specific RUG items. Narrow down the date range and select residents. Once finished selecting all items, click **OK** to run the report.

		12/12	12/13	12/14	12/15	12/16	12/17	12/18
Edwards, Jack C	RUG (Calendar Z0100)	CD1	CD1	CD1	CD1	CD1	CD1	CD1
	RUG (Z0100)	PA1	PA1	HD1*	HD1*	HD1*	HD1*	RHC*
	CMI: Z0100	1	1	36	36	36	36	48
	COT Observation Period	4	5	6	7	1	2	3
	Possible Reference days	Tue	Wed	Thu	Fri	Sat	Sun	Mon
	MC Days	0	0	0	0	0	0	0
	MC Days Left	0	0	0	0	0	0	0
	RUG (Calendar Z0200)	SE2	SE2	SE2	SE2	SE2	SE2	SE2
	RUG (Z0200)	PA1	PA1	CC1*	CC1	RMC	RMC*	RMC
	CMI: Z0200	0.749	0.749	1.663	1.663	2.051	2.051	2.051
	ADL	0	0	14	14	14	14	14
	Therapy Days: OT	0	0	1	2	3	4	5
	Therapy Days: PT	0	0	1	2	3	3	4
	Therapy Days: SLP	0	0	0	0	0	0	0
	Therapy Minutes: Concurrent	0	0	0	0	0	0	0
	Therapy Minutes: Group	0	0	46	92	138	138	184
	Therapy Minutes: Individual	0	0	107	214	244	274	381
	Therapy Minutes: OT	0	0	30	60	90	120	150
	Therapy Minutes: PT	0	0	89	177	189	189	277
	Therapy Minutes: SLP	0	0	0	0	0	0	0
	Therapy Minutes: Total	0	0	119	237	279	309	427

Intake Totals

The **Intake Totals** button will display a report of any residents that have had fluid intake of 1500ml or less (within the past three days). If residents have had more than 1500ml, then they will not display at all on this report. The screen may be printed if desired using the print icon at the top of the screen. Click the **Exit** button to return to the prior Access screen.

QA

QA Reports

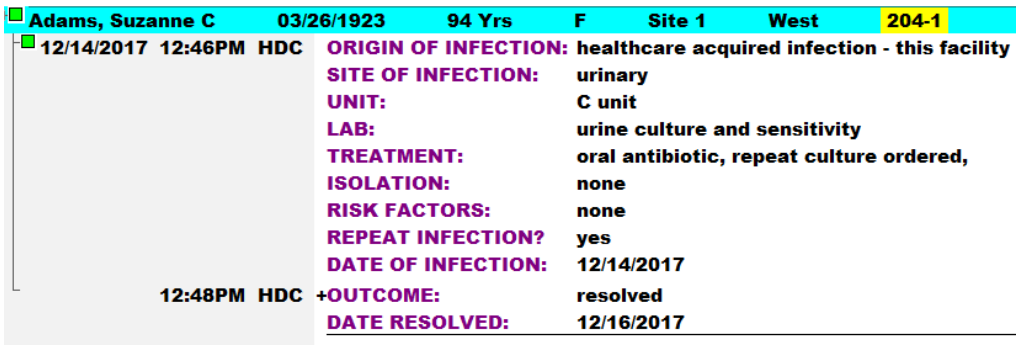
QA Reports	Falls	Infections	Pain	Bx/Mood	Skin	Weights	Re-hosp.	Other	
Main Menu	Fall Graph (past month)	Infection Graph (past month)	Pain Graph (past month)	Bx/Mood Graph (past month)	PU Graph (past month)	Weight Loss Graph (past month)	INTERACT	Quality Measure Reports	Incident Calendar
	Fall Graph (past year)	Infection Graph (past year)	Pain Graph (past year)	Bx/Mood Graph (past year)	PU Graph (past year)	Weight Loss Graph (past year)		QA (Gauges)	Fall/Incident Graphs
	Fall Calendar	Antibiotic Use (past year)	PRN Analgesics Calendar	Antipsychotic Med List	Weekly Wound Charting	Weekly Weight Graph		Average Length of Stay	Incident Types (Graph)
		Infection Detail	Pain Review (Charting)	PRN Psychotropic Calendar	Skin Review (Charting)	Food Intake <75%		View Family/ Resident Concerns	Fall/Incident Summary Report
		Infection Types		Psychotropic Drug Graph		Monthly Weight Tracking		View Reports	Write Internal Memo
				Psychotropic Med Report		Monthly Weight Graph			
				Psychotropic Meds (MAR)					
				Behavior Review (Charting)					

Resident/Family Concerns

When clicking the **Resident/Family Concerns**, the user is presented with a documenting screen which is only found within the Quality Assurance module. This allows the user to document any concerns presented to them by residents or family members. Any progress or notes made on these can also be documented within here. Click **Save** at the end of the screen to save the entry and exit back to the access screen.

Part 5: Infection Control Nurse Charting

Clicking the **Infection Control** button opens the Quality Assurance>Infection Control documenting screen. This is where anything related to infections can be completed. Once an infection is resolved, the user will need to click the original entry in the view portion of the screen and select **Edit>Append**. They will then select **OUTCOME** and document what the outcome is as well as the **Date Resolved**. This will then clear the infection off of the Active Infection view task. Click **^Print Infection Control Log** to view all of the infection control tracking.



Part 6: Viewing, Editing, Printing Nurse Charting

View Nurse Charting

1. Click the **View Chart** button, Select name[s] and click **OK**.
2. Select more than one resident by holding the *CTRL* key on the computer keyboard
3. Click either the Topic or Task button:
    - TOPIC is used to pick and choose folders. Click the Topic button and click the appropriate folder(s). Select more than one folder by holding the *CTRL* key on your keyboard, click OK.
    - TASK is used to load a predetermined set of folders in a customized viewing format. Click the Task button and select the appropriate task, click the Load button.
4. If desired, click the **Control** button to select a start date and end date for documentation to view, then click **OK**.
5. Click the **Go** button.
6. Click the **Exit** button when finished.

Edit Nurse Charting

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