QIDP

Open the QIDP Access screen

1. Log into ECS as a user with access to the QIDP Access screen.
2. Once your Access screen begins to load, you will be presented with a Name Selection screen.
   a. Utilize the Filter button if wanting to narrow down the name(s) by specific floors, units, or wings.
   b. Click the **Multi** button.
   c. Choose the name(s) you would like to chart on.
   d. Click **OK**.
   e. Your access screen will load with the names of the residents that you have chosen listed on the left side of the screen.

Main QIDP Access screen

This screen is divided up into four sections: Programs, Charting, Reports, and Other.

QIDP	Programs	Charting	Reports	Other
Main Menu	Habilitation Plans	Comp. Functional Assmt	Comp. Functional Assessment	View Chart
	Goal Target Dates (Calendar)	Money Management Assess.	Face Sheet	Schedules
	IPP Review	Water Temp Regulating Assess.	Other Reports	Write Internal Memo
	View Full Program	Additional Assessments		
		Seizure Record		
		Edit Hab Aide/CNA Assignments		

Part 1: Programs

Habilitation Plans

Reference the secondary handout for instructions regarding the habilitation plans.

Goal Target Dates (Calendar)

When you click onto this button, it will load a calendar for the current month. Calendar reports display the name and "event", in this case the target date word, on the left-hand side of the report. On the right-hand side is every day of the current month. Weekends are shown in a shaded green color. A "1" on a day indicates that is when that program goal is coming due and therefore should be reviewed on or before that date. If nothing displays when this is opened, that may mean that there are no programs written or none that are coming due this month. To adjust the dates shown, click onto **Control**, change the dates, and click **OK** to reload it. Calendar reports may be easily printed or exported by utilizing the buttons on the upper left-hand side of the screen.

IPP Review

This topic allows for the QIDP to document all the reviews that occur and who attends these meetings (annual, quarterly, monthly, special circumstances, etc.). A user can also scan in a sign-in form, program report, or safety device worksheet.

View Full Program

This will display the full habilitation program. Some facilities may call this the problem list, goals, or the program. The verbiage of your facility will be adjusted within the database so that it matches what you are used to seeing. Once the report loads, the facility can print or save by utilizing the necessary icons.

Part 2: Charting

Click onto a button within the charting column to load the Write screen. Select name(s) needing to document on. Work from left to right in the screen clicking onto the relevant answers. Once completed, click onto **Sign** to save documentation, and be brought back to the Access screen.

Click onto Clear if wanting to start over completely. Click **More…** to access additional charting features, such as spell checker (*Spelling* button) or on-screen keyboard (*Keyboard* button).

If wanting to document on another resident within the list, utilize the arrow to the left/right of the resident name or click the downward arrow to access the dropdown list and select a new name.

Potential Charting Topics

The topics available may vary based on your facility's policies and procedures, as well as required assessments. However, each charting topic will work in the same manner as described above.

Comp. Functional Assmt: ECS has two comprehensive functional assessment options built in by default. However, if a facility wants their functional assessment built into ECS instead, that is an option as well. Work from left to right within the assessment and click onto the ^ Preview Assessment button at the end of the screen if wanting to view the report.
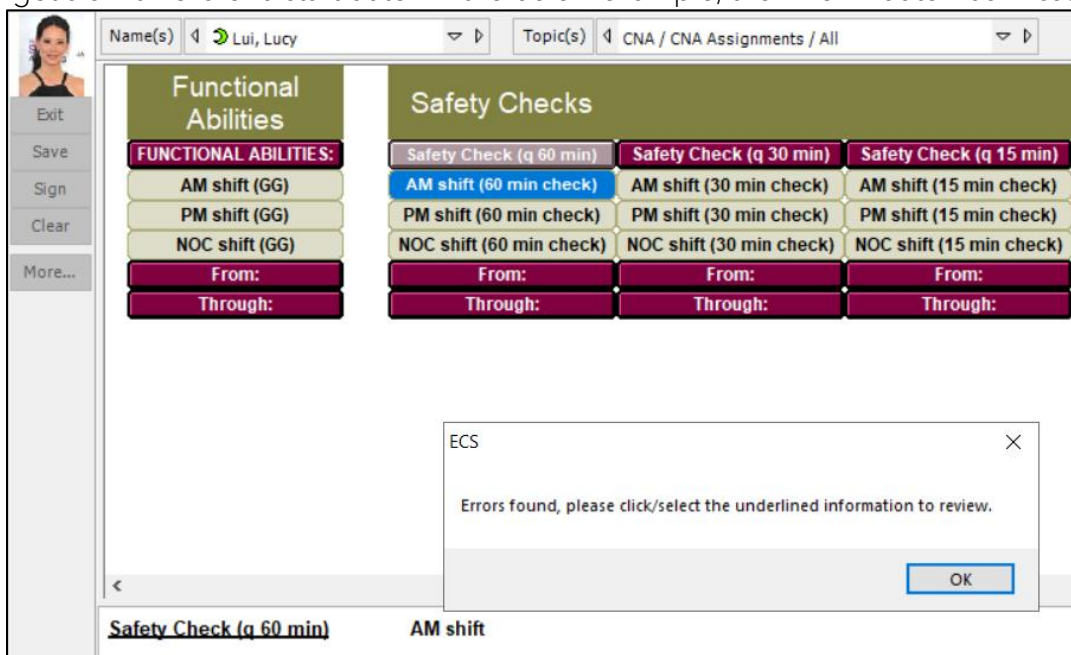
Money Management Assess.: This topic assesses whether a resident can handle their own money or not. In addition, it acts as a tool to determine what pieces of money handling a resident can complete on their own.

Water Temp Regulating Assess.: This topic assesses whether a resident can appropriately regulate the temperature of water to ensure they are not burning themselves.

Additional Assessment: When this button is clicked onto, a section will display with all other available assessments in the system. Some examples of assessments available include BIMS, Cornell Scale for Depression, GAD-7 Anxiety Scale, PHQ-9, Sleep, Smoking Safety Evaluation, and Trauma Informed Care Tools. Click onto an assessment folder to load that topic. All scored assessments will total automatically.

Seizure Record: If a user witnesses a seizure, they should document what was witnessed within this topic. Items addressed include the resident's awareness, head movements, speech, vital signs, post ictal, start time, and length of seizure. All information entered within this topic will flow into the Seizure Record report.

Edit Hab Aide/CNA Assignments: Utilize this topic to assign charting requirements to the CNA/Hab Aide. This may include bath/shower days, weights, vital signs, safety checks, ADLs, or resident specific items. Each assignment must include a shift and a "from" date (which can just be the date that the assignments are being entered in). A "through" date is not required but may be added to any task items that have a specific time frame the charting is needed for. If you receive an error message while attempting to save in this topic, it most likely means that you forgot a shift word or a start date. In the below example, the "From" date was missed.

Part 3: Reports

Click onto a button under the Reports column to run that specific report. Once clicked onto, the user will be prompted to select resident name(s) to view the report on. You may also be prompted to select a date/date range. This will then narrow down the results shown within the report to only display documentation within the selected date range.

If a report loads, click onto the printer, or save icon, if needed. Click onto **Export**, if available, if wanting to export the report to Excel. Utilize the **Control** button to change name(s) or date(s).

If a view screen loads, click onto the **More…** button to access additional features, such as a big A (to increase font size), print button, and a search option.

The reports available may vary based on your facility's policies and procedures, as well as required assessments.

Comp. Functional Assessment: This will run the Comprehensive Functional Assessment report. When clicking onto this button, you must first select the date that the comprehensive functional assessment was completed to ensure you see the information just from that assessment. If the assessment was completed over several days, a date range may be selected as well.

Comprehensive Functional Assessment

Name: Depp, Johnny			Room:		Birthdate: 05/08/1956	Age: 65 Yrs	Sex: M
MRN: 2014-134	Admit Date: 08/06/2018		Physician: Dr. Hugh O'Connor		Code Status:		

DATE OF ASSESSMENT: 07/30/2021
PERSON COMPLETING ASSESSMENT: Heather Ceaser

Diagnosis

Localized edema , Opioid use, unsp with unspecified opioid-induced disorder , Type 2 diabetes mellitus without complications , Other specified rheumatoid arthritis, right ankle and foot

Allergies

strawberries, Penicillins

Skills to monitor own health

COMMUNICATES PAIN:	No	
COMMUNICATES ILLNESS:	Yes	Supervision
DRESSES APPROPRIATELY FOR THE WEATHER:	Yes	Partial Assist
ABILITY TO RESPOND TO PERSONAL NEEDS WHEN TOO HOT/TOO COLD - TEMPERATURE REGULATION:	No	
COMPREHENDS DIFFERENT ROUTES OF MEDICATIONS:	Yes	Supervision
MONITORS OWN NUTRITIONAL NEEDS:	Yes	Supervision
ABLE TO SECURE MEDICAL APPOINTMENTS:	Yes	Supervision
ABLE TO ATTEND MEDICAL APPOINTMENTS:	No	
MEDICAL ADVOCACY SKILLS:	Yes	Partial Assist
UNDERSTANDS BENEFITS OF EXERCISE:	Yes	Partial Assist
SAFETY SKILLS REGARDING HEALTH:	No	

Face Sheet: This will display the Face Sheet report. This includes resident information including their demographic information, original admission date, payer sources, emergency contacts, and primary care provider.
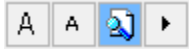
More Reports: Displays all reports available within the system that the user has rights to. Select any report in the list to view it and click **OK.**

Part 4: Other

View Chart

1. From the Access menu, click onto the **View Chart** button in the Other 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 Activities Access menu.

This button allows a user to select any documentation within the records granted rights to view. Click **Topic** or **Task** to choose the area of the chart to be viewed. Click **Control** to select a start and end date. Click the **Look** tab to select other options to view (*i.e.,* show names of initials, topic name, cosign, or free text highlighter). Once all options have been selected, click **OK** and then **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.
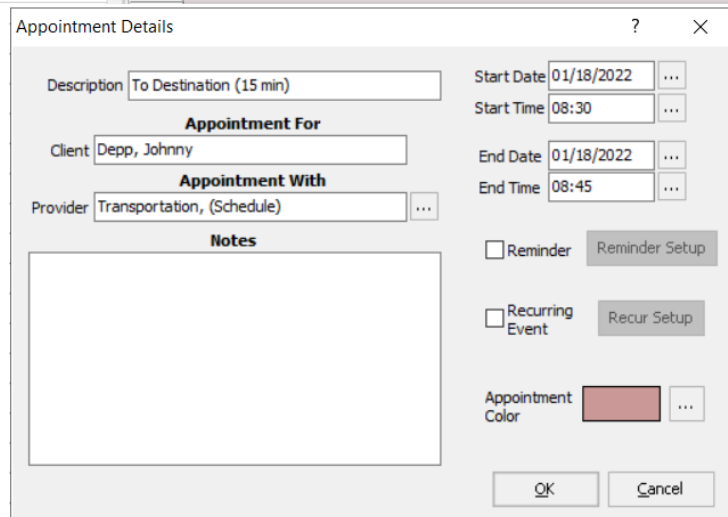
Schedules

Schedules may be utilized within a facility to enter/view in-house visits, out of facility appointments, transportation needs, home visits, or care conferences. If a facility is utilizing this feature, the user will be displayed with a list of different schedule types.

Schedule Appointment

If you select a schedule task that states "schedule" behind it then that is utilized to add new items onto the schedule or edit existing items. Once a task has been selected, a three-way split screen will appear. The top portion of the screen is where a user will have a list of options to select from. The bottom left displays the resident's schedule. The bottom right displays the entire facility's schedule in relation to this schedule type (i.e., transportation, in-house consults, out of facility, etc.).
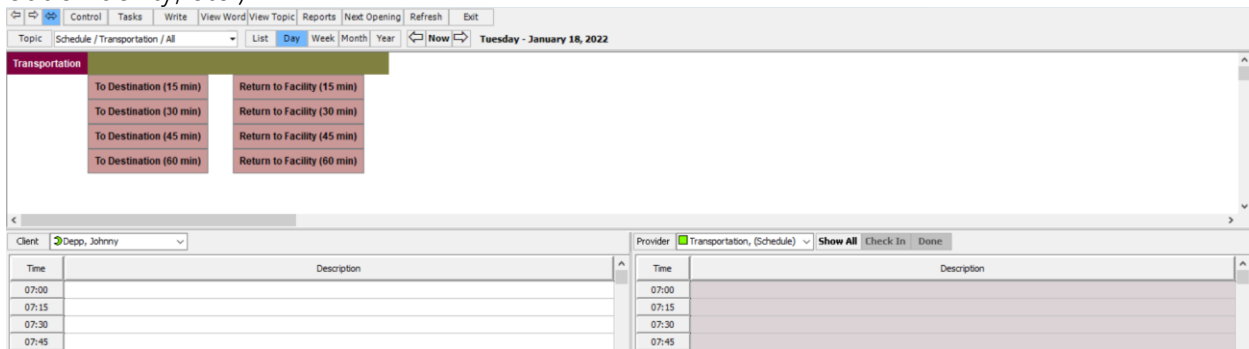
To add to the schedule, click onto an item in the top portion of the screen and click into the lower left-hand side of the screen. Once you click into it, you will be presented with an **Appointment Details** box which allows for additional adjustments (start date/time, end date/time, reminder's to users/user groups, or setups for a recurring event).

View Appointments

If you select a schedule task that states "view", a two-way split screen will appear omitting the option to select a schedule task type. Or a scheduler task may load without a split screen as it is intended to show only a resident's schedule or only the entire facility schedule. Although the view options are primarily for viewing, you may also right click onto an appointment and edit it from within this screen as well.

Write an Internal Memo

1. From the Access menu, click 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. Select a user group(s) to send the message to or click **pick user on Save** to select the person(s) from a user list once the entry is saved.

Part 5: Editing

1. Click the **View Chart** button under the Other 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 QIDP 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	Can be used to add a new discipline approach to a care plan for example
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