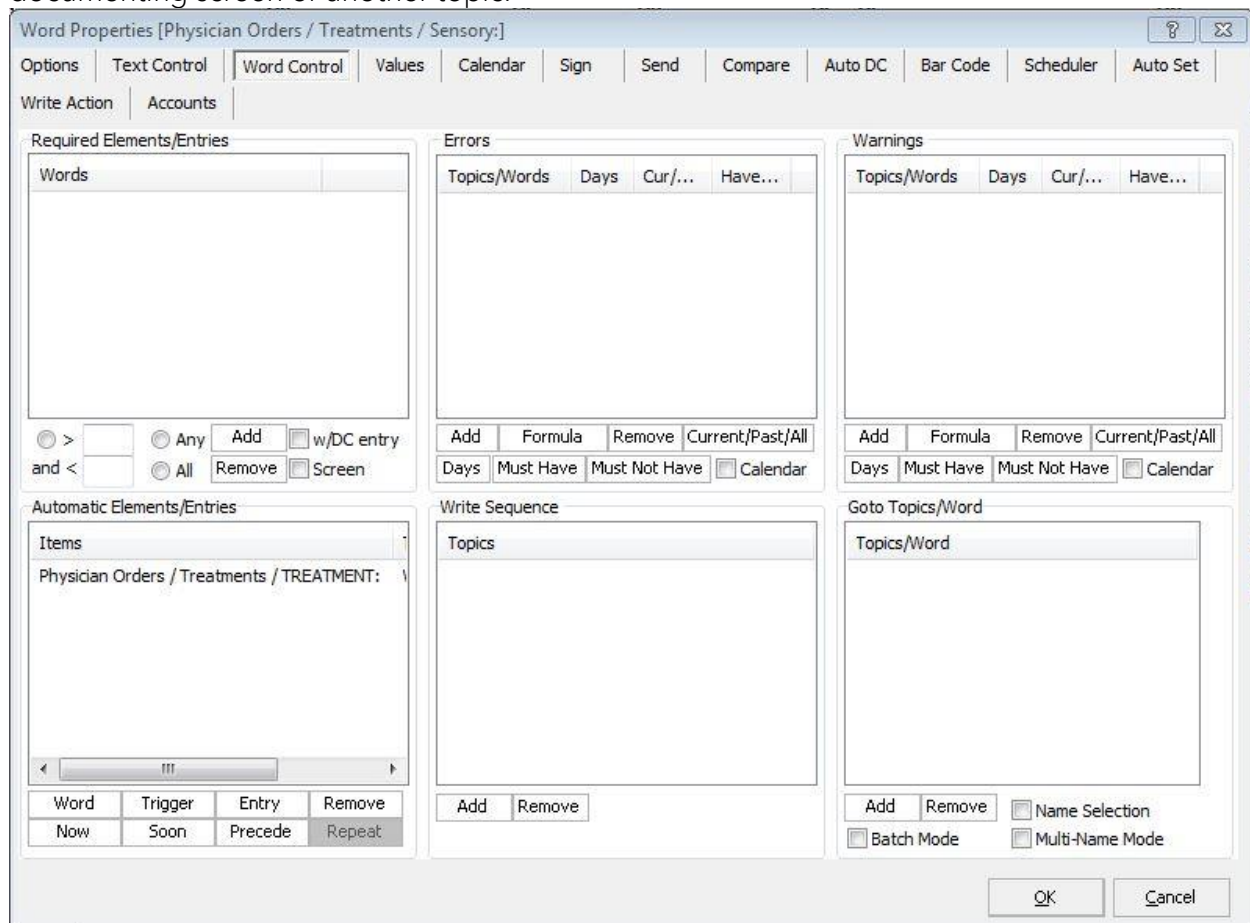# Word Properties – Word Control

Word Properties – Word Control tab

The Word Control tab allows words in the system to control the documentation process. A word can require the use of other word(s) in the same entry. A word in an order can be setup with errors or warnings based on formulas or the use of other word(s). Words can be setup to automatically document items within the same topic or in other topics, to flip users to other topics for documentation upon saving their entry, or to jump users to another area of the documenting screen or another topic.

Required Elements/Entries

This box will display the words you have selected to be required when a specific word is charted. You can add or remove words from the required words list by clicking the buttons underneath. Required information may be dependent upon what has been documented. For example, when writing a medication order for Tylenol to be taken twice a day, the user is required to select two times from the list because the word "bid" has two times required in its setup. When writing an order for Tums to be taken four times per day, the user is required to select four times from the list because the word "qid" has four times required in its setup. Use the **Add** and **Remove** buttons to add/remove words to/from the list.

- Use ">" and "<" to define how many of the listed words are required (e.g. >1 and <3 would establish that two of the listed words are required).   <u>OR</u>

- Choose "**Any**" or "**All**" to establish *any* of the listed words be used OR *all* the listed words be used, as required. For example, when documenting an infection, on the site word for "eye" it is requiring that the origin, date of infection, and treatment ALL also be documented in the same entry.
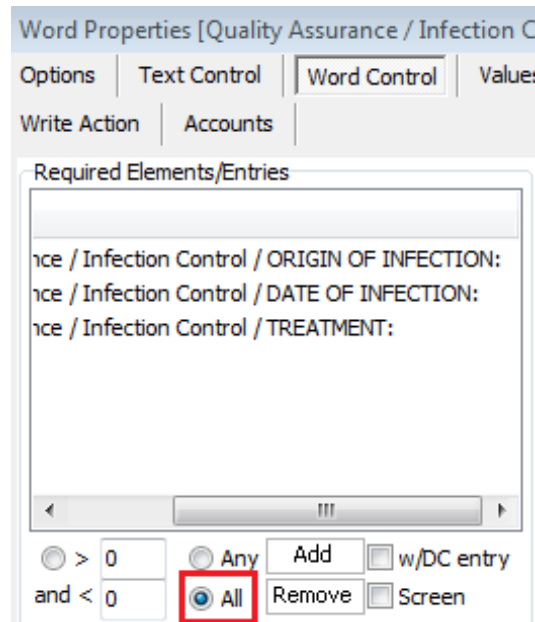
- Select the **w/DC entry** checkbox to require a word be documented upon discontinuing an entry, such as a reason for discontinuing a physician order.

- Select the **Screen** checkbox to allow adding words above that are either "entry break" words or would presumably be written in a separate entry as the selected word when documenting on the screen. It means that one word can require the use of other words even if those words will be in a different entry. Example: The word "Admitted from" and "Discharged to" can be set to require that "Occupancy Status" also be documented, even though the occupancy will be saved as a separate entry.

Errors

Contraindication errors are designed to prevent words from being documented that would directly contradict another word previously documented. They can also serve the purpose of not allowing certain documentation to be saved unless other documentation has occurred first or not at all.
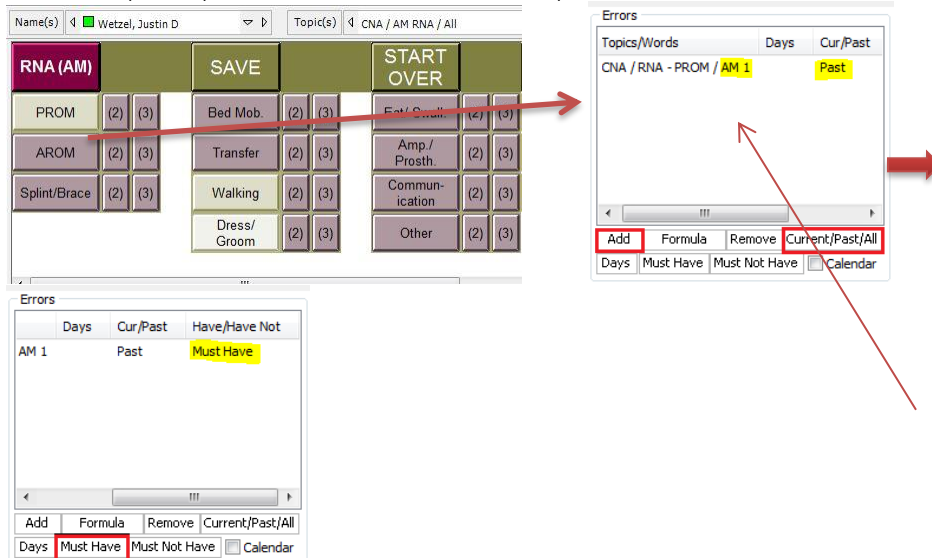Some examples of these include: not allowing a medication order with a route of "by mouth" to be saved on a resident that has "NPO" documented as their diet; not allowing CNAs to document restorative minutes on residents who do not have a restorative plan; allowing a medication order to save only after all requirements have been met for facilities using a Script interface.

- Use the **Add** button to add topics and/or words to the list. Use the **Remove** button to remove topics, words, or formulas from the list.

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- Use the **Formula** to create/link a formula to require certain conditions.

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- Use **Days** to designate the number of days to search for data.

- Use **Current/Past/All** to define whether the error should look at the current entry, a past entry, or the entire record.

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- Use **Must Have** and **Must Not Have** to define whether another word should or should not appear in the record.

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- Use the **Calendar** checkbox if the word being used needs to also be on the Calendar, for example, an "in-house" occupancy status.

Example: CNA Restorative buttons

For CNAs to document and save restorative minutes, a plan for the specific restorative area must be written for the corresponding shift. Focusing on the PROM word (first AM option) in the AM RNA topic, the Errors box is setup to require that the "AM 1" word from the CNA/RNA-PROM topic is present (Must Have) in the past documentation (Current/Past).
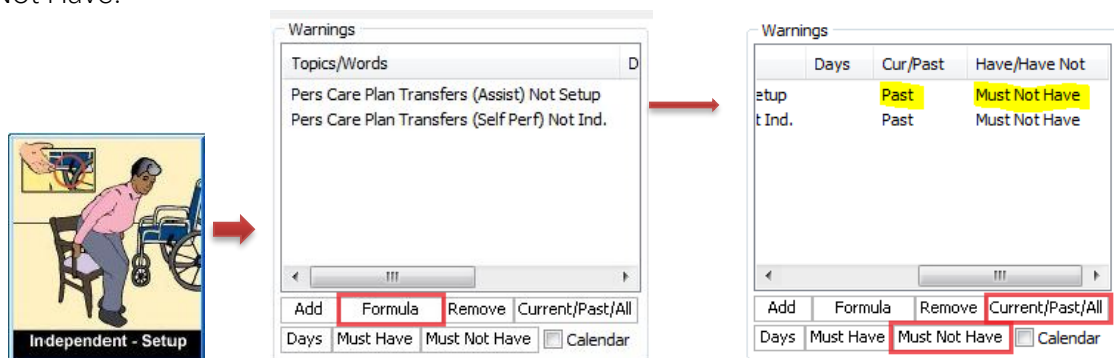
Warnings

Contraindication warnings are very similar to errors in that they are designed to prevent words from being documented that would directly contradict another word previously documented, however a warning provides just that – a warning, and the user can override the contraindication, where with an error they cannot. (See Errors for setup information)

Example: CNA ADL charting

When CNAs document assistance levels for daily ADL charting, if a resident is care planned to need assistance at a different level than what is being charted, a contraindication warning will pop up and the entry can still be saved if desired. The example below is set-up like the error example above, only using a formula looking at items from the care plan and being set to "Must Not Have."

Automatic Elements/Entries

Words, triggers, and/or entry tasks can be linked to this area to automatically document or run when users document the word in an entry. For example, a fall could trigger for a temporary care plan to be automatically written on a resident and automatically write an order for follow-up charting on the To Do List.

- Click on **Word** to add a word, **Trigger** to add a trigger, **Entry** to add in an entry task, and **Remove** to remove a highlighted item from the setup.

- Use **Now/Soon** to determine whether the automatic documentation is to occur immediately (now) or upon saving the entry (soon). Words from other topics and triggers may only be set to "Soon." Only words from the same topic may be set to either "Now" or "Soon."

- The option **Precede** allows linked words to document BEFORE the designated word (the word that the setup is in). For example, the canned phrase "fall" could be set up with the header word "INCIDENT TYPE" set to Precede when documented. This decreases the instances where users forget to document the header or "question" word and allows for faster documentation.
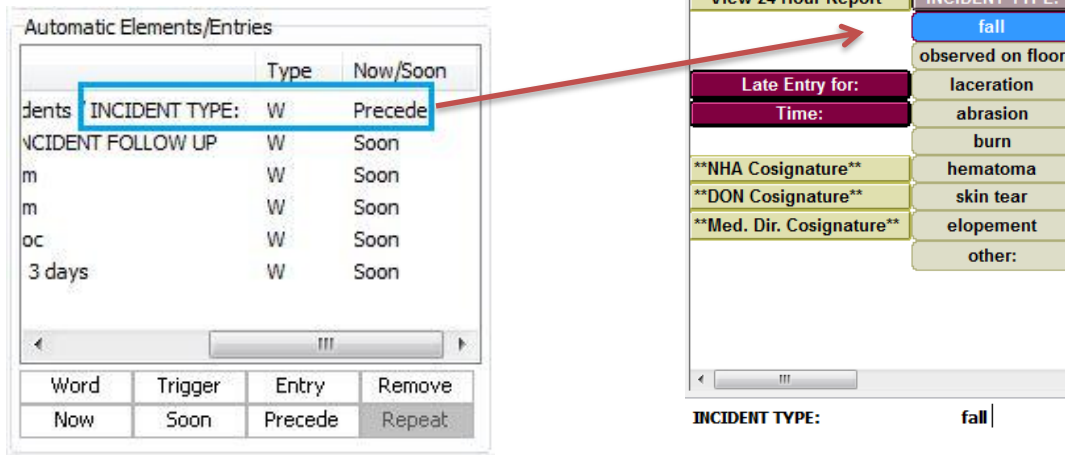
- Click **Repeat** so that any time the word is clicked on, the Precede word will document. This can be useful when documenting certain assessments or entering in certain orders where each item needs to be listed separately. For example, when an OT treatment plan is documented, if more than one treatment is needed, they will just list consecutively, however if Precede/Repeat is used, each treatment will be separate.

Write Sequence

Topics can be linked/sequenced to flip on Sign from one topic to the next. For example, PRN Analgesics could have Pain Assessment in the Write Sequence. This would present the Pain Assessment topic to the user every time he or she documented in the PRN Analgesics topic.

- Click on **Add** to add a topic, navigate into the **Tab** and select the **Topic.** Repeat the process if you want to have a second or third topic.
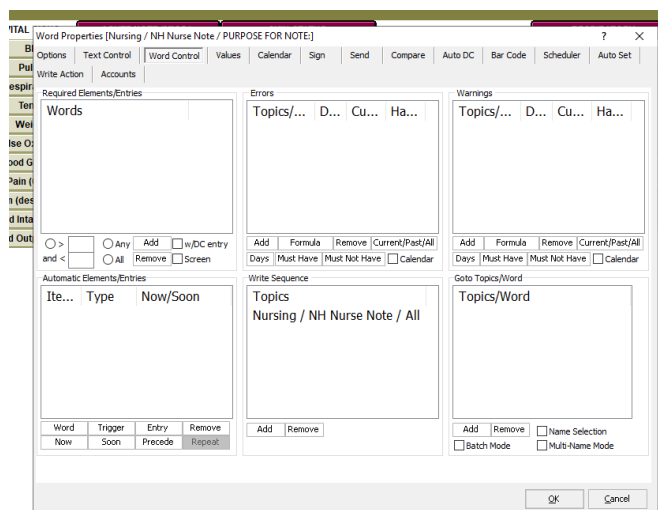
Go To Topics/Word

Words with this Goto property are used as quick buttons for navigating the user through the Write Screens. The use of GoTo topics/words decrease the amount of in-screen scrolling. Goto topics/words take the user to the designated coordinates in the word grid. Whichever GoTo item you select will display in this box. You can Add or Remove an item from the list by using the buttons below. For example, in the PHQ-9 Assessment and your resident can not answer the questions there is a button that says staff assessment. If you click on the staff assessment button it jumps to the staff assessment instead of having to scroll.

- Click on Add, navigate to the Tab, select the topic you want to GoTo and OK.
- Click on Add, navigate to the Tab, select the topic and double-click into the topic to link a word you want to goto.