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How to Reset the Initial password:

1. Log into AHT through the GREEN SCREEN using your username and password. This has to be done on your computer or on a computer that can log into AHT through the GREEN SCREEN. Username is given to the administrator when he/she turns in the user request form to the help-desk. Do not use spaces or caps. Ex. John Doe = jdoe. Enter password, for first time user it will always be “pruitt’ then click on log in. System will prompt you to change your password, make sure you remember your password. Before training staff you should make sure that the “ELECTRONIC SIGNATURE ATTESTATION FORM” is signed.

** Note: Username and password is your signature and cannot be shared it is illegal to do so**.

When it is time for your password to be reset, after entering your user ID and password you will get another log in screen asking for a new password and to confirm new password. Pay close attention as the screens look very similar.
CNA View: Smart Chart Login Window
CNA View: Smart Chart Login Window

This is the view that the C.N.A will have during log in into Smart Chart. This will also be how the C.N.A will view the C.N.A Care Interventions that are within Scheduled Care. First each CNA will need to log onto the kiosk or Computer on Wheels (COW) utilizing their log in ID and passwords. The screen looks as follows:

Smart Chart –Login Window

![Login Window](image)

American HEALTHTECH\textsuperscript{\textregistered} LTC
Post-Acute Care Clinical and Financial Software

User ID
Password

Copyright 2009 American Health Tech, Inc. All Rights Reserved
Point of Care Documentation
Unscheduled / Scheduled Care
Accessing Unscheduled Care/ Scheduled Care

1. Once you have logged into the Smart Chart screen the following screen will appear. For the C.N.A only their role of NA should show and for your nurses in the facility they should have access to the N.A and Nurse roles. The consultant should have both roles and should have access to all their facilities. To view different roles you will need to use the drop down menu and pull in the appropriate role.

2. Once you have chosen the role the screen will populate with the patient data.
3. Next click on the “Selection Criteria” button this will allow you to select your patients by Unit, Location or Room Group.

4. Once you have selected the criteria, room group, unit or location, click OK
Next highlight your patient or bring the black arrow next to the patient's name as shown above and record the events that have taken place on your shift.

The “Scheduled Care” button will show a list of tasks that need to be completed for the patients. Included in this task list is a list of care plan interventions you will need to carry out for each patient based on the patient’s needs.

Documentation should occur as care is provided. This concept is known as Point of Care documentation and allows for a more accurate picture of the care that is provided throughout the shift.

Review your patients’ needs in the Scheduled Care button but document the care you deliver under the Unscheduled Care button. As you document care delivered using Unscheduled Care those items that are listed under Scheduled Care will be removed.
Scheduled Care

When you click on Scheduled Care you will see the tasks that are to be documented on. Example: ADL’s, bowel/bladder, meals etc. Make sure documentation is done at the time the car is delivered. This is “Point of Care” documentation.
Unscheduled Care

Below is the view that you will have when you click on UNSCHEDULED CARE. You will see a series of buttons on the right-hand side that let you chart many different areas of care.

With the new update the DONE BUTTON will be replaced with the SAVE BUTTON
ADL Constants
ADL Constants

What are ADL Constants and how do I view them?

ADL Constants are TASKS that can be added to a patients’ display in addition to the 11 ADL’s. The most common of these are the Bowel/Bladder, Meals. ADL Constants can be set to display/fire automatically when the patient is ADMITTED or READMITTED. (THIS PROCESS WILL BE DONE DURING SET UP FOR THE FACILITY)

VIEWING ADL CONSTANTS in AHT:

1. In AHT Click on the Nurse Folder (you can find this folder once you follow the below screen.)
2. Click on the ADMISSION OR DAILY TASK FOLDER
3. Click on Care Guide ADL’s/Interventions

To view the ADL CONSTANTS you can go into the NURSE FOLDER and choose either ADMISSION FOLDER or DAILY TASK to view the CARE GUIDE ADLs/INTERVENTIONS BUTTON.
4. When the below screen appears use the drop down to choose patient and then CLICK on Interventions to view the ADL Constants for that patient.
5. If NO ADL Constants display on the screen after choosing the patient and clicking on Interventions, then CLICK on MODIFY to turn YELLOW and CLICK on LOAD ADL CONSTANTS.
6. If there is a need for an additional ADL constant click modify. Once the ADL constant has been added, click apply.
7. Once you have determined that the ADL Constants are correct then you would CLICK on APPLY to make them start displaying/firing. NOTE: REMEMBER AS WITH EVERYTHING THAT IS DONE A PATIENT THAT IS ADMITTED OR READMITTED AFTER TASKS HAVE ALREADY FIRED THESE ITEMS WILL NOT DISPLAY/FIRE IN SCHEDULED CARE UNTIL THE NEXT SCHEDULED SHIFT, SO UNSCHEDULED CARE MUST BE UTILIZED TO DOCUMENT TASKS THAT HAVE OCCURRED.
CNA Care Interventions
C.N.A Care Interventions

The CNA Care Interventions will be available to the CNA’s through the Scheduled Care section of Smart Charting. In Scheduled Care they will have items to be charted every shift as well as informational items describing the care each patient needs. The interventions must be created for each patient in order to insure complete and accurate charting. The instructions for creating the CNA Care Interventions follow:

1. Open the Nurse folder
2. Open the ADMISSION OR DAILY TASK FOLDER.
3. Double-click on the Care Plan section.
4. **Select a patient.**
5. **Click the Add button.** The Add button is found near the bottom left-hand corner of the Care Plan window.
6. The “Add a New Problem” window will open. In the “Select Problem From” be sure that “Fixed Care Plan Library is selected.

7. In the Category section, use the drop-down menu to find the category labeled “ADL’s”, which is category number 5. It is near the bottom of the list. Do not select the category labeled “ADL Functional/Rehabilitation Potential.”
8. In the “Fixed Care Plans” sections use the drop-down menu to find and select the CNA Care Interventions.

9. Click OK.
10. After CLICKING OK you will see the below window. At this point you should locate the APPROACH portion of the SCREEN TOWARDS THE BOTTOM OF THE SCREEN.

When you get to this screen you will start adding your APPROACHES (WHICH ARE YOUR C.N.A Care Interventions). To start this you will CLICK on the GRAY BOX beside the DELETE BOX under APPROACHES.
11. When you CLICK on the GRAY BOX you will see the APPROACHES WINDOW. In the Approaches window you must choose from the already created list of approaches. Use the drop-down menu on the “Approaches” line to find the needed items. NOTE: Some of the approaches contain blanks that must be filled in. When you select an approach with a blank type the needed information in the box just below the selected approach. When finished click OK.
Approaches with blanks require you to type in information.

DO NOT CHANGE ANYTHING BELOW THE START DATE!!
THIS INFORMATION IS SET UP TO PULL CORRECTLY INTO SMAR CHART

When finished click OK.
12. If you cannot locate the APPROACH that you want (this might be when a patient/resident/family has a special request) then you can create your own by following the below screenshots.

When you pull up the approaches window and select an approach you will noticed that the approach is in the very top header and also below the top header (besides where it says PHYSICIAN’s ORDER). THE INFORMATION IN BLUE (BESIDE PHYSICIAN’s ORDERS) can be MODIFIED/DELETED and customized information about the patient can be put in.
This is what your screen might look like after you CLICK on the DELETE KEY. NOTICE THAT THE INFORMATION REMAINS THE SAME IN THE HEADER, BUT IS GONE BESIDES PHYSICIAN’S ORDERS.

I have went in and typed in a special request from the family about this patient/resident.

When I am done I will CLICK on OK.
13. Continue clicking the small GRAY box underneath the newly created approaches and adding approaches until the care plan is individualized.

14. Click Apply or OK to save your work. Clicking Apply will leave the Care Plan window open. Clicking OK will close the Care Plan window.
15. To add approaches to UPDATE/MODIFY the C.N.A Care Interventions CLICK on MODIFY and highlight in yellow (THIS IS ONCE YOU HAVE LOCATED THE C.N.A Care Interventions care plan), find the blank line under the last entered approach. On that line click on the small box that is located to the right of the Delete column. This will open the “Approaches” menu.
<table>
<thead>
<tr>
<th>Delete</th>
<th>Approaches</th>
<th>Role</th>
<th>Order</th>
<th>Interval</th>
<th>Time Code</th>
<th>Question</th>
<th>Form</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Elimination</td>
<td>NA</td>
<td>CD</td>
<td>OSHIFT</td>
<td>Bowel</td>
<td>Sched 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ELIMINATION</td>
<td>NA</td>
<td>CD</td>
<td>OSHIFT</td>
<td>Did the</td>
<td>Sched 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NUTRITION</td>
<td>NA</td>
<td>CD</td>
<td>OSHIFT</td>
<td>Select</td>
<td>Sched 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DNA CARE RECORD - Signature</td>
<td>NA</td>
<td>CD</td>
<td>OSHIFT</td>
<td>Identify</td>
<td>Sched 0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Click the box to add more approaches.*
C.N.A Care Interventions view in Smart Chart:

In this screen you will see the CNA Care Interventions that were created and added to the resident within the Care Plan module. These will not turn RED, or YELLOW, they are only informative like the current ADL Care record. The CNA’s will be required to electronically sign via the CNA acknowledgement of care provided each shift in SCHEDULED CARE.

**CNA Care Record Signature: Is Required by each CNA on every shift**.
Resident Availability
Resident Availability

An important part of Smart Chart management is accounting for resident’s who leave the facility but are not discharged by the business office. Tasks are assigned in “Scheduled Care” as long as the resident’s status is active within LTC. Utilizing “Resident Availability” will enable you to account for those tasks assigned while the residents are not in-house. It will also “lock” the resident’s record while they are not in-house.

** If a resident’ is changed to “OUT” then they must be changed back to “IN” as soon as they return. If the resident is not changed to “IN” then the CNA’s will not be able to chart on any tasks assigned to the resident. **

1. Click on the NURSE FOLDER
2. Locate and CLICK on the ADMISSION FOLDER OR DAILY TASK FOLDER.
3. CLICK on RESIDENT AVAILABILITY.

To access the RESIDENT AVAILABILITY BUTTON you will CLICK on the NURSE FOLDER and choose either the ADMISSION FOLDER OR THE DAILY TASK FOLDER and LOCATE THE RESIDENT AVAILABILITY BUTTON.
4. A list of residents will then be displayed. Find the resident you wish to work with and double-click on the name, or click the folder in the upper left-hand corner of the window.

5. The Resident Availability screen will open.
6. Enter a departure date and time
7. Select a reason from the drop down menu.
8. Click Save in the upper left-hand corner.
9. When the resident returns, he or she must be marked as “In”. To do this, return to the Smart Chart folder, Main folder, and again select Resident Availability. Double-click the resident you wish to work with. Residents marked as “Out” will be listed alphabetically at the top of the resident list.

10. The Resident Availability window will open. This time, your only option will be to mark the resident as “In”.

11. Enter a date and time, then click save.
Scheduled Care Monitor
Scheduled Care Monitor

The Scheduled Care Monitor is a listing of all charting tasks that were assigned to the resident and will appear in the “Scheduled Care” section of Smart Charting. Each task, past due (red), due (yellow) and not due (white) will appear. You will be required to check the monitor periodically to ensure that charting is being done as care is provided to the resident. You will also be required to check the monitor at the end of every shift to ensure that all charting by shift has been completed. Below is an example of the Scheduled Care Monitor:

1. Click on NURSE FOLDER
2. Click on DAILY TASK FOLDER.
3. Locate and CLICK on SCHEDULED CARE MONITOR

To locate SCHEDULED CARE MONITOR CLICK on NURSE FOLDER then CLICK on DAILY TASK and locate and CLICK on SCHEDULED CARE MONITOR.
All items in the Scheduled Care Monitor will have a date scheduled, the patient’s name and room number, the task itself, which role at the center the task was assigned to, and a color. All patients in the center are assigned the following charting tasks each shift or at meal times:

1. Percentage of meal intake for breakfast, lunch, and dinner assigned at meal times.
2. Eleven ADL scores (all ADL’s from Section G of MDS 3.0) for each shift.
3. Bowel movement information for each shift.
4. Bladder information for each shift.

The color will indicate the status of each item. Items that are red are past due. Items that are yellow are due currently and are awaiting completion. Items that are white are not due until the next shift. Meals that are due will be yellow at meal times and turn red after two hours. All other items are assigned at the beginning of the shift and turn red at shift-end.

The “Scheduled Care Monitor “contains several columns, each can be sorted For example, click on the top of “Resident Name” column, once you click, all tasks will be sorted alphabetically by the resident’s name.
In this example, Jane A. Doe has one item past due (red), seven items due on the current shift (yellow), and nine items not due (white).
When a task is charted it is complete it will then be removed from the task list. At the end of the shift only white tasks should be listed. As shown below (the tasks that will be due in a later shift).
INCOMPLETE DOCUMENTATION:
CLEARING REDS
Incomplete Documentation
When documentation has not been completed for the shift corrective action should be taken with the CNA who failed to document care provided. One on one training may be required to ensure the CNA is aware of the requirement of Point of Care Documentation. Following corrective action with the CNA the documentation that was not completed needs to be removed from the Scheduled Care list so that the next shift may document care rendered.

Clearing the REDS:

When clearing the REDS you will need to go to SCHEDULED CARE MONITOR as shown above.

1. You will need to review the REDS and determine how to SKIP them.

![Scheduled Care Monitor](image)

2. The Black arrow will let you know where you are at.
3. Choose the GREEN CHECK MARK to select 1 task to be SKIPPED

4. Check the RED CHECK MARK to select ALL REDS to be SKIPPED
5. Once you have determined what is to be SKIPPED then you will CLICK on SKIP TASKS
6. When you CLICK on SKIP TASKS you will be asked to CHOOSE the REASON FOR SKIPPING. CLICK OK to SKIP (or CLEAR THE REDS).

NOTE: The Nurse’s electronic signature will be applied to this skip reason.

7. To CLEAR the OUT TASKS you would CLICK on the SELECT OUT TASKS, this will pull up any patients that has been MARKED as OUT. Once you choose this feature you can CLICK on SKIP TASKS and these tasks will be SKIPPED. You would not have to place a reason because the reason should have been selected in the RESIDENT AVAILABILITY when patient was taken OUT.
You may further customize the sort by using the Selection Criteria button to limit the number of scheduled items you are viewing.
Completed Care
**Completed Care**

Completed Care allows you to view all information that has been entered into Smart Charting. You will also have the ability to make corrections on data entered into LTC incorrectly.

1. Click on NURSE FOLDER.
2. Click on DAILY TASK FOLDER
3. Locate and CLICK on COMPLETED CARE BUTTON.
Before the Completed Care window displays any information, you will be prompted with the “Selection Criteria” window. Choosing from the selection criteria is a critical step that should not be overlooked. Smart Chart holds a large volume of data, leaving any criteria blank, will prompt the system to pull all data “everything”. This will slow down your search criteria and will take a longer time for the system to return any data to you, and is not recommended.

There are four ways to retrieve your selections: by date, by a block of rooms, by shift, and by resident. You can use multiple criteria if you wish. For example, in order to view just the charted information for only one resident over the span of two days, you would enter your date range, select your resident then Click on OK.
The information requested was all completed tasks for Susan B. Anthony for the days of September 12 through September 14. By default, the completed tasks are sorted from oldest to newest. If you wanted to reverse the order, click at the top of the Completed column to change the order to newest to oldest.
Making Corrections to tasks

Any completed tasks that were entered into LTC incorrectly can be corrected within this Completed Care window. If a CNA informs his/her supervisor they entered a task incorrectly into LTC on a specific resident it can be corrected. Example: For the Bowel Toileting Action Plan they entered Prompted instead of Maintenance, first find the task in the list of questions and answers. To do this you would sort by task.

1. Sort by Task.

2. Double-click the line you want to change.

Click the column head for Task to group the questions alphabetically then scroll for the Bowel Toileting Action Plan. Once you find the incorrect answer, double-click on that line.

The Completed Care Task Detail window will open. Click the white piece of paper to the left of the answer.

The Completed Care Task Detail window will populate giving you the ability to make the necessary corrections for that particular task. All the descriptions for that task are located in
the” Answer Box” within the pop up window. A reason as to why the correction has been made is also required. To select a reason utilize the selections within the reason drop down menu. Once you have corrected the answer for the task and chosen a reason for the correction “click OK’.
Once the correction has been made click save to save the correction.

The corrected information will be updated into the resident’s medical record.
Completed Care as a Monitoring Tool:

There are a couple of different ways you can use Completed Care as a monitoring tool. First you can sort the information using the “By” column, the “By” column will denote which CNA charted or completed specific tasks on a specific shift. Scroll to the right and click on “By”.

This will sort the lines by who entered the information. If a partner completed and saved any tasks within Smart Charting their name will appear in the list. If they did not save information their name will not appear.

Second, the Asterisk next to the name can be used to find charting discrepancies. The asterisk means that the answer entered does not match the last answer entered for that question. If you click on the line with the asterisk the system will display the last four answers in the box below the main portion of the window.
This is one way to find discrepancies within the information being entered. For example, using the selection criteria to look at one patient’s information over a chosen date range you can look for problems with ADL coding. Tap the Selection Criteria button and fill out the information below.
When the requested information appears sort by Task. That way all of the ADL’s will be grouped together.

You can now interview the partner that entered the information and see if the differences are legitimate or if you need to provide further ADL training and or make the necessary corrections.
Completed Care: Nurse Notified

HOW TO FILTER OUT ANSWERS USING COMPLETED CARE TO CREATE A NURSE NOTIFIED REPORT:

Completed Care can also be utilized as a filter to locate only certain answers that you might be seeking. This is very useful and can be utilized as a report to filter out the Nurse Notified added to the Smart Chart Buttons. To utilize this feature you would go to the Completed Care module within the Smart Chart Folder and Main Folder of Smart Chart.

When the Completed Care screen appears filter the answers for the Date Range, Room numbers or patient that you would like to review.
Once this is complete and all the information you pulled based on your filter is pulled up then you can use the A/Z filter to filter out even more detailed information.

<table>
<thead>
<tr>
<th>Completed</th>
<th>Unit</th>
<th>Room</th>
<th>Resident Name</th>
<th>Task</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/15/12 12:29 PM</td>
<td>U1</td>
<td>69</td>
<td>Wonderland, Alice</td>
<td>Did the patient urinate on this</td>
<td>Catheter</td>
</tr>
<tr>
<td>01/15/12 12:29 PM</td>
<td>U1</td>
<td>69</td>
<td>Wonderland, Alice</td>
<td>Did the patient urinate on this</td>
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<td>01/15/12 12:29 PM</td>
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<td>U1</td>
<td>69</td>
<td>Wonderland, Alice</td>
<td>Did the patient urinate on this</td>
<td>Catheter</td>
</tr>
</tbody>
</table>

To filter out answers click on the A/Z filter ICON.
The next screen shows how to filter even further.

- Use Drop down box to select appropriate Column.
- Filter information can be saved.
- You can add a value such as Nurse Notified to generate a report during the look-back period you selected.
- Click OK to view results.
When you have filtered all the information and Click OK you will see the answers that contain “Nurse Notified”. This can be reviewed by the Nurse, Nurse Supervisor or DHS/ADHS to follow up on what the C.N.A has charted as “Nurse Notified”.

Nurse Notified items are useful to assist the charge nurse in the following areas:

- Assist the charge nurse with daily documentation for areas related to patient care such as pain, behaviors, refusals of care, poor meal intake, etc.
- Assist with CNA monitoring for completing Point of Care Documentation.
- Assist with CNA management to ensure verbal communication is occurring with items documented as nurse notified.
Smart Charting Reports
**Smart Charting Reports**

To utilize the reports, open the Smart Chart folder then click on the Report folder. In the Reports folder you will be able to access several reports. The two you will probably use most often is the Data Collection History and the Daily Care Roster reports. These two modules allow you to pull information based on Reports that have been set up to pull based on information from Smart Chart charting.
HOW TO USE DATA COLLECTION HISTORY REPORT:

The Data Collection History Report is used to show MDS questions and user-defined questions that have had data collected on them from the Smart Chart (Scheduled/Unscheduled Care) or a User Defined Assessment (UDA).

1. Click on Data Collection History

2. Utilize the screen that comes up to choose your report and filter out things based on your needs for that particular report.

3. Click on Preview to view your report
Data Collection History Custom Reports

1. Activity Log Report:
   a. Replaces the paper copy of the 1 on 1, group and individual activity logs.
   b. Assist to identify or determine patient’s preferences for activities.
   c. Shows proof of patient involvement in activities

2. Bath Report
   a. Replaces the paper copy of the bath log

3. Behaviors Report
   a. Replaces the paper behavior log
   b. Used to screen for behaviors and to individualize interventions based on type of behaviors documented
   c. Identify isolated or pattern of behaviors and triggers, what time are behaviors occurring
   d. Used during behavior management meetings to monitor effectiveness of interventions
   e. May be used to assist with Antipsychotic reduction

4. Bladder Continence Report
   a. Serves as a 3 day bladder screening tool to determine appropriateness toileting program
   b. Identify risk for potential skin breakdown due to frequent incontinence
   c. Used to monitor for dehydration
   d. Used to monitor for success in toileting program (monitor for decreased instances of incontinence)

5. BM Report
   a. Serves as a 7 day bowel screening tool to determine appropriateness of bowel program
   b. Monitor consistency to determine unnecessary meds (lose stools and on laxative) or meds needed (constipation)
   c. Determine the need for a bowel regimen based on disease process and bowel habits
   d. Used to track and identify gastrointestinal infections
   e. Used to monitor for dehydration

6. I &O Report
   a. Used to monitor compliance with fluid restrictions
   b. Monitor for dehydration or fluid overload
   c. Monitor effectiveness of medication regimen (Lasix)
7. Meal Percentages
   a. Used to monitor nutritional intake
   b. Used in weight program to determine if interventions are successful
   c. Used to assess nutritional status related to wound healing

8. Restorative Log
   a. Serves as the Restorative Nursing Program minutes log.
   b. Used to track frequency of participation in programs
   c. Used to identify patients compliance with Restorative programs
   d. Used to identify patients who are receiving Restorative Nursing services
   e. Used to document weekly notes based on programs participated in
   f. Used to discuss Restorative caseload in Weekly Case Mix Meetings and
      Restorative Meetings

9. Snack Report
   a. Serves as a Snack log
   b. Used in weight program to determine if interventions are successful
   c. Used to assess nutritional status related to wound healing

10. Toileting Programs
    a. Serves as documentation to support the patient is receiving a toileting program
    b. Used to track frequency of toileting episodes

11. Vital Signs
    a. Used to monitor for acute changes in condition
    b. Allows for trending of vital signs
    c. Serves as a quick view of history of vitals (print view for MD)

Note: The above description of the reports is not all inclusive and there may be other patient
      specific needs that the above reporting would satisfy.

Data Collection/ Section Detail Reports

1. G0110 (Activities of Daily Living)
   a. Used to monitor for compliance with ADL documentation
   b. Used to monitor for compliance with Care Plan interventions
   c. Used to monitor for decline in ADLs for need to implement skilled therapy or
      restorative nursing interventions
   d. Used to monitor for change in condition to assist with preventing hospital
      readmissions
2. **E0100- E0800 (Behavior Symptoms)**
   a. Used to determine presence and frequency of verbal and physical behaviors
   b. Used to determine a pattern of behaviors and triggers
   c. Used to assist in behavior management program with developing individualized interventions based on specific verbal/physical behaviors

3. **E0900 - E1100 (Wandering)**
   a. Used to determine the presence and frequency of wandering
   b. Used to determine a pattern of wandering behavior
   c. Used to monitor the success of interventions
   d. Used to assist in behavior management program with developing individualized interventions based on specific wandering behaviors

4. **O0500A – O0700 (Restorative Nursing Programs)**
   a. Serves as the Restorative Nursing Program minutes log.
   b. Used to track frequency of participation in programs
   c. Used to identify patients compliance with Restorative programs
   d. Used to identify patients who are receiving Restorative Nursing services
   e. Used to document weekly notes based on programs participated in
   f. Used to discuss Restorative caseload in Weekly Case Mix Meetings and Restorative Meetings
HOW TO USE DAILY CARE ROSTER REPORT:

1. Click on Daily Care Roster

2. Choose Report from dropdown box.
3. Choose a date range:

4. You may also choose other selection criteria such as: specific unit, room group, location, all residents or for a specific resident.

5. When your criteria are selected, click on the Preview button to view your report.
HOW TO USE FLOWSHEET REPORT:

1. Click on Flowsheets.
2. Filter out what information you are needing as in the below screen shot you can filter out by Location or Resident Name (NOTE: If you leave all filtering areas blank you will be pulling report for ALL patients so please be careful because this may take a while to create the report depending on the size of the facility)

3. Click PREVIEW to view report.
4. Screen shots below show what a Flowsheet and what information can be pulled from the report.
ADL Assistance and Support

For the month of: January 2011

Time

3

Bathing (A/D)

1

You will be able to view the Name attached to the initials.

DB: David Smith

ADL Self-Performance (1) | ADL Support Provided (2) | Bathing Self-Performance

1 = Independent - no help or staff | 4 = Total dependence - full staff performance | 0 = No help or physical help from staff | 0 = Independent - no help provided

Legend:

* Task skipped | - Computer not available
HOW TO USE THE NO BM REPORT:

1. Click on the NO BM REPORT.

2. Filter out what is needed for this report and CLICK on PREVIEW.
Note: This report includes only the selection criteria listed below.
Look Back Days: 3
All Active Residents

No BM Report
UniHealth PAC - Rock Hill (36)
As of 1/19/2012

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<tr>
<th>Name</th>
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Patient Search

*Determine if the patient has been previously admitted to the facility.*

**Admission Analysis – Patient search**

A. Search for patient – Ensure patient doesn’t exist prior to creating a referral.
   1. Select Admission Analysis
   2. Select Candidate Information

```
Patient Search

3. Search for patient
   a. Select Facility
   b. Select ALL Candidates
   c. Type patient last name and scroll through list
```

![MyLTC screenshot](image)
4. If patient is not found, proceed to **AA/Candidate Information**

5. If patient is found, Select Re-Activate

6. Select Initial Contact as the Current Stage, then select OK

7. Proceed to **AA/Re-Admission**
Candidate Information

*If the patient has not been previously admitted to the facility and has not been entered as a candidate for admission.*

**Admission Analysis – Candidate Information**

1. Select/Verify correct facility is selected
2. Select **Add** at the bottom of the Candidate Information screen
3. Complete, at a minimum the following required fields.
   a. **Candidate/Referral Source screen**
      - Planned Admission Date
      - First & Last Name
      - Gender
      - DOB
      - Primary Contact
      - Initial Contact Date
      - Initial Contact Source
      - Referral Source Agency
      - Referral Source Contact
      - Assigned To
      - Attending Physician
b. **Financial screen**

- Select checkbox for MCR QL hospital stay & add co-Ins days
- **Primary A/R Type**
- **Type of Room**
- **Ancillary A/R Type**
- Medicare A Co-Ins A/R Type (If Applicable)
- Ancillary Co-Ins A/R Type (If Applicable)
- **SSN (Required by Pruitt)**
- Medicaid ID (If Applicable)
- Medicare A ID (If Applicable)
- Medicare B ID (If Applicable)
- Assign Bed (If Applicable)
c. **Responsible Party Screen**
   - Responsible Party 1-4 (If Applicable)
   - Insurance 1
   - Insurance 2 (If Applicable)

4. Select Apply
   **If there are any required fields that have not been completed you will receive a notification. Please update.**
5. Select OK to save
6. To complete the admission, Proceed to AA/Admission
Admission

Admit the patient that has been entered into the Candidate Information.

AA/Admission

A. Select Admission Analysis, Main, then Admit Candidate

B. Select Admitting Facility
C. Select Candidate
D. Select Admit Date
E. Select Admit Time
F. Select Unit/Room/Bed

G. Select OK
H. If multiple residents are found, select the patient to be admitted, then select Admit as New Resident
I. Verify 0 is present in the Assign a New Resident Number box, Select Ok

![Assign a New Resident Number](image)

J. To complete the admission process
   a. Select Yes
   b. Select No if this is then end of your process

![Candidate has been admitted](image)
Re-Admission

Readmit patient who has had a previous admission into the facility.

AA/Re-Admission

A. Select Admission Analysis, Main, then Admit Candidate

B. Select Admitting Facility
C. Select Candidate
D. Select Admit Date
E. Select Admit Time
F. Select Unit/Room/Bed

G. Select OK
H. If multiple residents are found, select patient to be re-admitted, then Select Readmit Resident.

**Select OK if ADL Constants notification appears**

I. To complete the admission process

a. Select Yes.