

ALBERTA HEALTH SERVICES

South Zone-NP Manual

Step by Step Guide to Care Manager

Meditech Test Environment:

Care Manager Support:

Email: seniorshealth.southzoneeducation@albertahealthservices.ca for questions, corrections and access requests.

Test Client Name:

PHN/ULI #:

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Chapter 1: Introduction to Meditech Basics

What is Meditech?

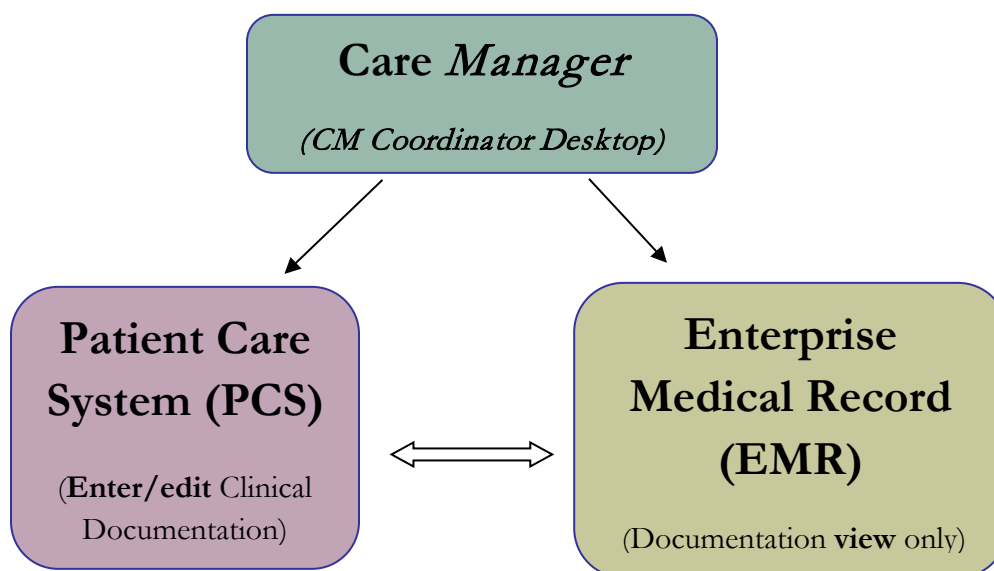
- Meditech is a software information management system used by Healthcare Organizations around the world for electronic clinical documentation.
- Meditech was developed in Boston so some fields and functions are not used. It is used by most zones in Alberta Health Services, but the extent of its use varies within each zone.
- Meditech integrates with other systems (e.g. NetCARE, Provincial Alberta Continuing Care Information System).

What are the benefits to Meditech?

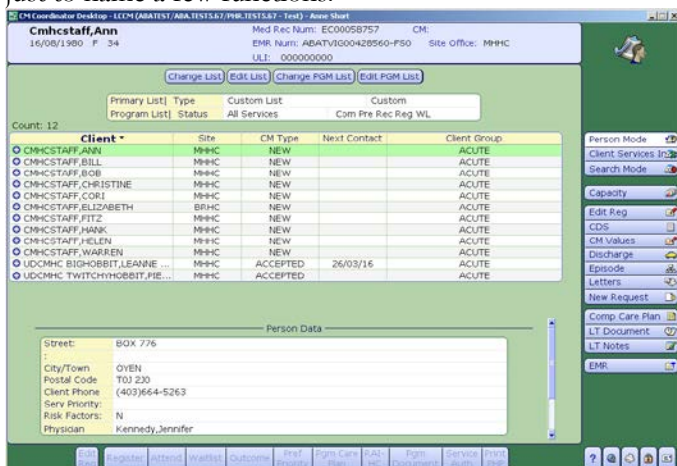
- share information electronically within Continuing Care
- access to timely, reliable and up-to-date client information
- electronic entry of client demographics and clinical assessments for data reporting
- information is entered in a consistent format

Care Manager vs. Patient Care System (PCS) vs. Enterprise Medical Record (EMR)

Meditech operates between Care Manager, Patient Care System and the Enterprise Medical Record. Which system you access will depend on the task you are performing.

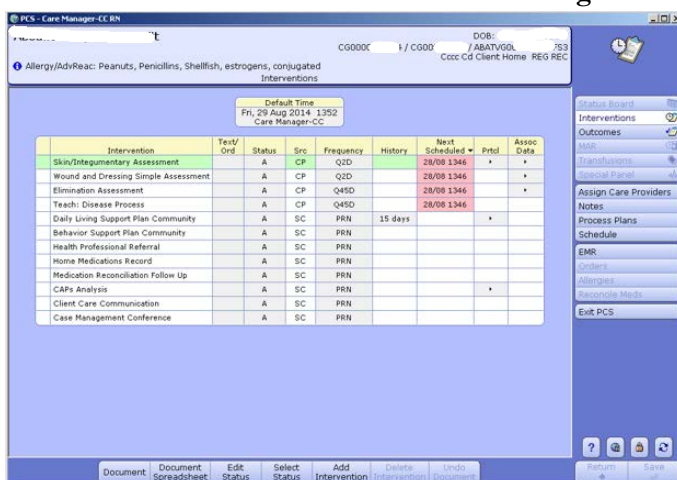


CM Coordinator Desktop in Person Mode is where all Home Care clients will be registered and demographic details recorded. Clinicians can also register Programs, complete a RAI-HC assessment, and authorize services, just to name a few functions.



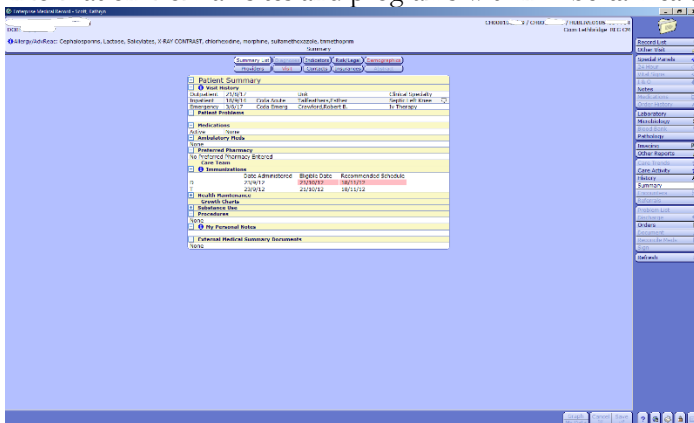
The screenshot shows the 'CM Coordinator Desktop' interface. At the top, it displays 'Cmhcstaff, Ann' with a date of '16/05/1990' and a gender of 'F'. Below this, there are tabs for 'Change List', 'Edit List', 'Change PGM List', and 'Edit PGM List'. A table lists clients with columns for 'Client', 'Site', 'CM Type', 'Next Contact', and 'Client Group'. The table shows several clients, including 'Cmhcstaff, Ann', 'Cmhcstaff, Bill', 'Cmhcstaff, Bob', 'Cmhcstaff, Christine', 'Cmhcstaff, Cori', 'Cmhcstaff, Eliza Beth', 'Cmhcstaff, Fitz', 'Cmhcstaff, Hank', 'Cmhcstaff, Helen', 'Cmhcstaff, Warren', 'UDCMHC, Bighobbit, Leanne', and 'UDCMHC, Twitcheobbit, Pie'. Below the table, there is a 'Person Data' section with fields for 'Street', 'City/Town', 'Postal Code', 'Client Phone', 'Serv Priority', 'Risk Factors', and 'Physician'. The bottom of the screen has a navigation bar with buttons for 'Register', 'Attend', 'Waitlist', 'Outcomes', 'Print', 'Print Care Plan', 'RAI-HC', 'Print Assessment', 'Service', 'Print', and 'Help'.

Patient Care System (PCS) is where clinical information is **documented** on a client's Lifetime or Program Account. **Documentation should be done using standard upper and lower case rules.**



The screenshot shows the 'PCS - Care Manager - CC RN' interface. It displays a table of interventions with columns for 'Intervention', 'Text/Ord', 'Status', 'Src', 'Frequency', 'History', 'Next Scheduled', and 'Prtd'. The table lists various interventions such as 'Skin/Integumentary Assessment', 'Wound and Dressing Simple Assessment', 'Elimination Assessment', 'Teach: Disease Process', 'Daily Living Support Plan Community', 'Behavior Support Plan Community', 'Health Professional Referral', 'Home Medications Record', 'Medication Reconciliation Follow Up', 'CAPs Analysis', 'Client Care Communication', and 'Case Management Conference'. The bottom of the screen has a navigation bar with buttons for 'Document', 'Document Spreadsheet', 'Edit Status', 'Select Status', 'Add Intervention', 'Delete Intervention', and 'Links'.

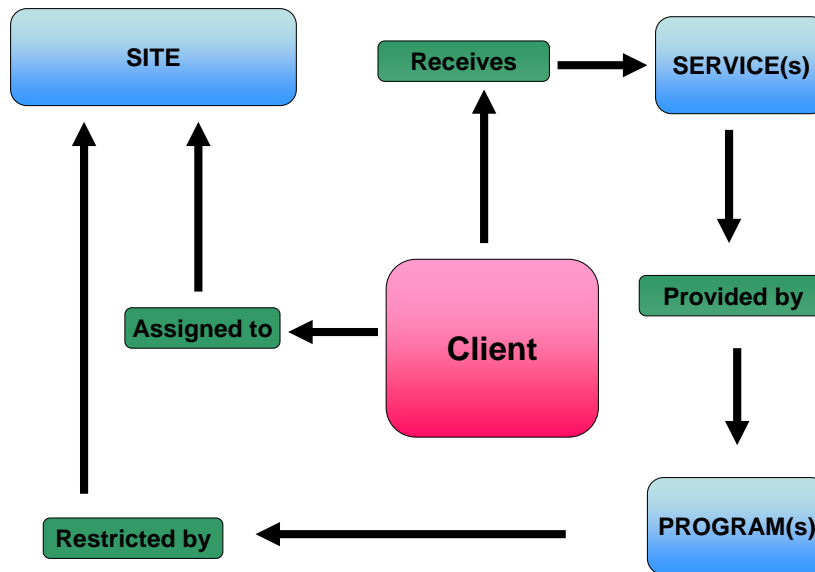
The Enterprise Medical Record (EMR) is where clinicians view current or historical documentation that was entered in PCS or has been scanned into the client's electronic record. Clinicians will have access to **view** client information from all sites and programs within Alberta Health Services.



The screenshot shows the 'Enterprise Medical Record' interface. It displays a patient's medical history with a table of interventions. The table has columns for 'Intervention', 'Text/Ord', 'Status', 'Src', 'Frequency', 'History', 'Next Scheduled', and 'Prtd'. The table lists various interventions such as 'Skin/Integumentary Assessment', 'Wound and Dressing Simple Assessment', 'Elimination Assessment', 'Teach: Disease Process', 'Daily Living Support Plan Community', 'Behavior Support Plan Community', 'Health Professional Referral', 'Home Medications Record', 'Medication Reconciliation Follow Up', 'CAPs Analysis', 'Client Care Communication', and 'Case Management Conference'. The bottom of the screen has a navigation bar with buttons for 'Document', 'Document Spreadsheet', 'Edit Status', 'Select Status', 'Add Intervention', 'Delete Intervention', and 'Links'.

Understanding the Language of Meditech: Site/Services/Programs

The Client is assigned to a **Site** and receives **Services** that are provided by a **Program**.



Site (should reflect the care setting where the primary services are currently provided)

- client can only have one site at a time
- restricts the Programs available to meet a client's needs
- must be changed when client moves to a new site

Service(s) (a high level description of the type of care a client requires in order to meet their needs)

- can have multiple service types occurring at once
- the choice of service determines the default list of Programs available for the registered site

Program(s) (lower level name of the setting or group providing the service)

- can have multiple Programs at the same time
- documentation and care plan occurs on the main Program account where care is being provided

Electronic Documentation & Security

Both Regulated and Non-Regulated Health Care Professionals are responsible for ensuring they follow appropriate guidelines when using electronic documentation.

General Charting Principles in PCS

- Use upper and lowercase, and proper sentence structures,
- There is an **Intent** section at the top of most assessments for information purposes, **DO NOT** document anything in this section,
- Circle selections mean you can select only one option,
- Square selections mean you can select more than one option,
- Comment boxes are for free text,
- Some assessments are on multiple pages which are identified in the upper right corner of the screen.

Documentation

- Can include Client Assessment data, clinical findings, care plans, Interventions, Client goals, critical pathways, medication administration, risk Assessments, and discharge planning. “Staff will document immediately after care has been provided, or within the same scheduled shift that care has been provided” (*Home Care Policy and Procedure #3.2.20*).
- Must be comprehensive, accurate, timely, and clearly identify who provided the care/service. It must be objective, factual and reflect appropriate use of abbreviations. (*CARNA, September, 2006*).
- Health Care Professionals must sign off any entries; signatures are considered valid if used to demonstrate accountability specifically by that person. (*CNO, 2004*)
- Incorrect entries must be corrected indicating the person making the correction and when it was made. Previously entered data that is part of the record should not be deleted.
- Late entries must clearly be identified noting the date and time late entry was made.

Downtime Procedure

Chinook Zone: Downtime files can be found in the Shared Drive.

Palliser Zone: Downtime files can be found in the Shared Drive. Check with Site Manager and Super users.

Electronic Records and Security

- Entries made and stored in an electronic health record are considered a permanent and legal part of Client records.
- Access to Client information should occur only when that professional is involved with the Client and his/her plan of care. Authorized individuals; people providing services or acting on behalf of AHS granted access to Personal and Health Information on a “need to know basis”.

Users are responsible for updating their passwords. Passwords should not be easily deciphered.

NEVER reveal or allow anyone else access to your personal identification number (PIN) or password as it acts as a personal signature and identify YOU as the person accessing and documenting Client information. Users are responsible for all actions performed under their user ID login.

- Use only systems that have secured access.
- Do not use automatic login procedures (automatic password saving).

- Protect Client information displayed on monitors by locking workstation. Keep devices in users possession at all times.
- Transport information securely by logging off when not using the system or when walking away from or leaving the terminal.

Employer Expectations Regarding E-documentation (Alberta Health Services)

All AHS employees and others acting on behalf of AHS shall:

- Take reasonable precautions to ensure AHS IT resources are placed to prevent potential risks from unauthorized access, security threats, and environmental hazards.
- Report breaches of privacy/security to your immediate supervisor. Cooperate with investigations into breaches of confidentiality, requests for access to information and other activities in order to be in compliance with FOIPP and HIA.

Personal information and Health Information shall only be collected; accessed and/or used when the requirements of the FOIPP, the HIA, and other applicable legislation have been met.

Protection and Privacy of Health & Personal Information

Policy Statement: all Personal and Health Information under the control or custody of AHS, in any format, is confidential and shall only be available to Authorized Persons. Authorized persons collecting, accessing, using, or disclosing personal and Health Information shall comply with all applicable legislation and AHS policies.

Authorized Persons shall use the Information responsibly and appropriately, and maintain the confidentiality, security, integrity, and accuracy of the Information. Breaches of confidentiality shall be considered grounds for disciplinary action up to and including dismissal.

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-privacy-protect-ia.pdf#search=approved%20protection%20of%20privacy.pdf>

Access to Information (Physical, Electronic, Remote)

Policy Statement: AHS shall employ physical administrative and technical access controls at all facilities for areas continuing information processing and storage, IT Resources, Information, and Information systems Such controls include but are not limited to surveillance video, alarms, card and key controlled entry doors, access codes, staff identification badges, unique user IDs and passwords, Access levels and privileges' shall be restricted to the minimum required to fulfill and individuals' role and responsibility with AHS.

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-access-information.pdf#search=approved%20access%20to%20information.pdf>

Contractor Requirements for Security of Information and IT resources

Policy Statement: Contractors granted access to AHS information or IT resources shall implement and maintain controls for the security of information and IT resources and comply with applicable AHS policies and information Security Program Standards.

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-contractor-requirements.pdf#search=contractor%20requirements%20for%20security.pdf>

Information Technology (IT) Acceptable Use

Policy Statement: The IT resources of AHS, including the internet and electronic forms of communication (“email”) are intended for AHS business purposes. Users using AHS IT resources shall comply with applicable AHS policies and procedures including, but not limited to those related to user ID’s, password, emails, information security, privacy and confidentiality. Users, as representatives of AHS shall use proper judgment when using the internet, email or other IT Resources.

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-it-acceptable-use.pdf#search=approved%20acceptable%20use.pdf>

Delegation of Authority and Responsibilities for Compliance with FOIPP and HIA

Policy Statement: Authorized persons responsible for collection, access, use, disclosure retention of Personal and Health Information shall comply with the requirements of *Freedom of Information and Protection of Privacy Act (Alberta)* (FOIPP), the Health Information Act (Alberta) (“HIA”) and with applicable AHS policies.

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-doa-foipp-hia.pdf#search=approved%20delegation%20of%20authority%20foipp%20hia.pdf>

Documentation & Security References

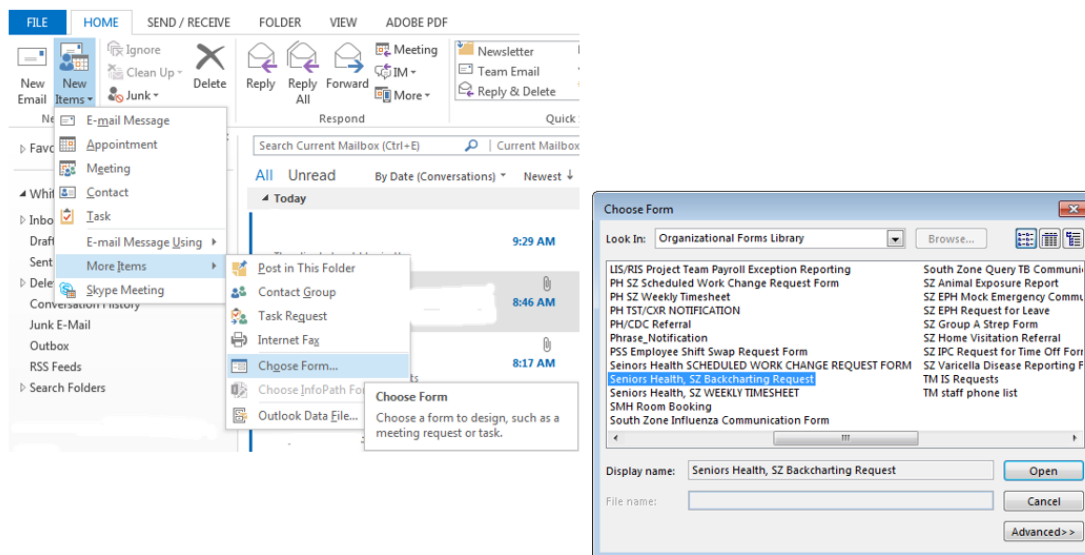
College and Association of Registered Nurses of Alberta. (2006). Documentation Guidelines for Registered Nurses. Edmonton, AB: Author
Kirkley, D. & Rennick, D. (2003). Evaluating clinical information systems. Journal of Nursing Administration, 33 (12), 647.

Back Charting

Note: late entries greater than 72 hours will require special changes to your charting access. To change your access you will need to email: SeniorsHealth.SouthZoneEducation@ahs.ca, cc your manager and complete the back charting form (see below).

Accessing the Back Charting Form on Outlook

- Open Outlook
- In top left of Mail page, Click 'New Items' → 'More Items' → 'Choose Form...' → and open 'Seniors Health, SZ BACK CHARTING FORM'



- The back charting form will display like this. Follow all instructions and E-mail completed from to seniroshealth.southzoneeducation@ahs.ca

Send	To...	<input type="text" value="Seniors Health South Zone Education"/>
	Cc...	<input type="text"/>
	Subject	Seniors Health, SZ Backcharting Request



Seniors Health South Zone BACKCHARTING REQUESTS

Instructions:

- Please complete ALL sections below. We cannot process incomplete requests.
- Email completed forms to: seniorshealth.southzoneeducation@ahs.ca and cc: your manager.
- When your request is Approved a member of the Seniors Health Education team will respond with inserting an "A" in the last column (displays in red).
- Back charting access will only be granted on a daily basis and will be removed at the beginning of the next business day.
EXCEPTION: On Fridays access will be removed at 1600, please notify if you do require access over the weekend and we can make the appropriate arrangements.
- Please provide a brief explanation as to why you are requesting back charting access. If required, your manager may follow up with more questions to inquire about the situation.

* Indicates this field MUST be completed for every request

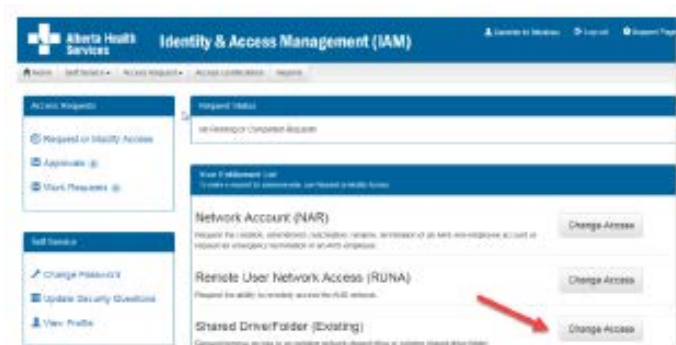
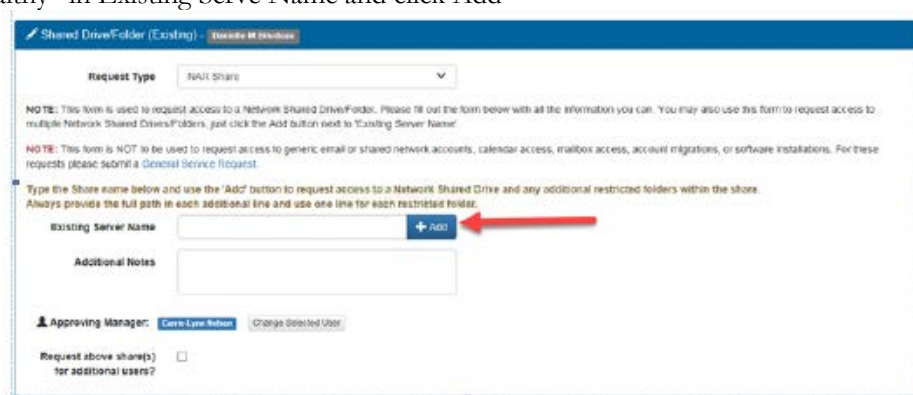
* Name	* Designation	* 6 Digit Meditech Number	* Location/Site	*Manager Name	*Brief Description to WHY You're Requiring Back Charting	*Educator Use Only* Status: A pproved

Accessing the Back Charting Form on the Shared Drive

Adding Shared Drive to your computer

Adding Shared Drive to your computer

- Type in Identity and Access Management in “Everything” Search field on Insite.
- Click on “Identity & Access Management (AHS IAM) Insite”
- Scroll down and click on “IAM Login”
- Enter your AHS network Username and Password (the Username and Password you use to login to a computer).
- Click “Change Access” beside Shared Drive/Folder (Existing).
- Enter “healthy” in Existing Server Name and click Add

Shared Drive/Folder (Existing) - Available in Insite

Request Type:

NOTE: This form is used to request access to a Network Shared Drive/Folder. Please fill out the form below with all the information you can. You may also use this form to request access to multiple Network Shared Drives/Folders, just click the Add button next to Existing Server Name.

NOTE: This form is NOT to be used to request access to generic email or shared network accounts, calendar access, mailbox access, account migrations, or software installations. For these requests please submit a [General Service Request](#).

Type the Share name below and use the 'Add' button to request access to a Network Shared Drive and any additional restricted folders within the share. Always provide the full path in each additional line and use one line for each restricted folder.

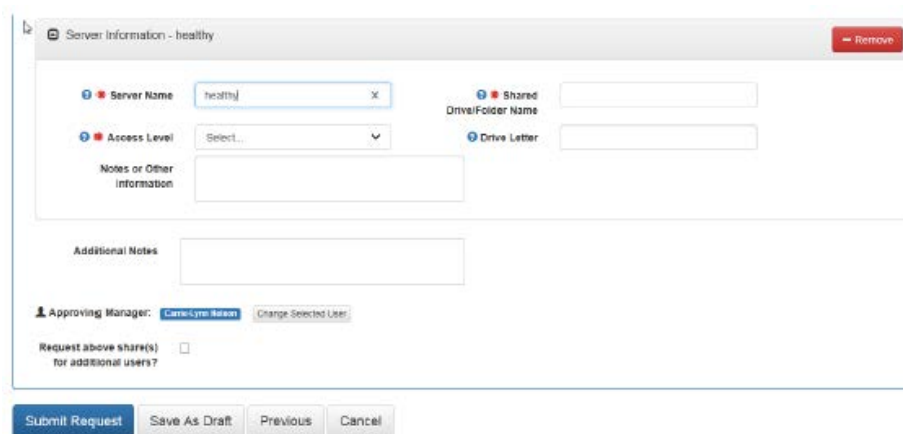
Existing Server Name: **Add**

Additional Notes:

Approving Manager: [Care-Lyn Nelson](#) [Change Selected User](#)

Request above share(s) for additional users? ☐

- Enter the following information:
Shared Drive/Folder Name: Seniors Health Education
Access Level: Read Only
Drive Letter: K
Click “Submit Request”



Server Information - healthy [Remove](#)

Server Name: X

Access Level:

Shared Drive/Folder Name:

Drive Letter:

Notes or Other Information:

Additional Notes:

Approving Manager: [Care-Lyn Nelson](#) [Change Selected User](#)

Request above share(s) for additional users? ☐

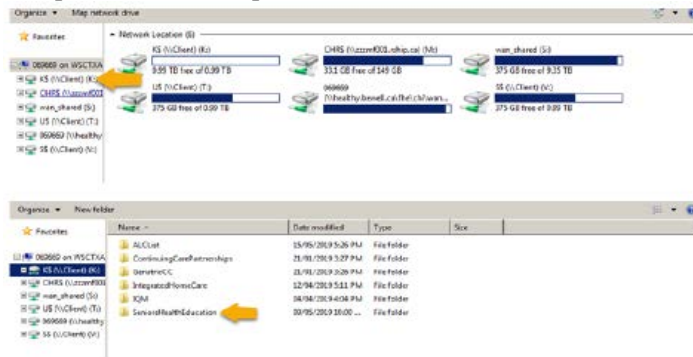
[Submit Request](#) [Save As Draft](#) [Previous](#) [Cancel](#)

Using Shared Drive for Electronic Documentation Resources



a. Open

b. Open Windows Explorer, Select the “K” drive, and the choose SeniorsHealthEducation



c. Access the E-doc Education Folder

1 Clinical Care Topic Links	6/6/2019 8:51 AM	File folder
Accreditation	2/26/2019 9:59 AM	File folder
Case Management	2/26/2019 9:59 AM	File folder
CCHSS	1/28/2019 8:07 AM	File folder
Clinical Education	5/27/2019 2:53 PM	File folder
E-Doc	2/26/2019 10:11 AM	File folder
General SH Education Info	3/18/2019 9:50 AM	File folder
InfoCare	5/9/2019 10:46 AM	File folder
LTC	3/27/2019 9:23 AM	File folder
Public Health, IPC	2/26/2019 10:12 AM	File folder
SATT	6/7/2019 3:43 PM	File folder
SMC Case Managers Program Manual	2/26/2019 10:12 AM	File folder
Specialty Referral	2/26/2019 10:13 AM	File folder
Pressure Ulcer	3/25/2019 3:46 PM	Microsoft Word D

d. In the E-doc folder you will find the Care manager Manual folder as well as the Back charting folder as well as other E-doc related updates and education packages

Back Charting	26/02/2019 10:07	File folder
Care Manager Manual	04/06/2019 3:35 PM	File folder
Care Manager Updates	30/05/2019 11:51	File folder
Checklists	20/03/2019 11:03	File folder
Downtime Packages	26/02/2019 10:10	File folder
E-Doc Newsletter	04/03/2019 10:44	File folder
Medication Risk Management	26/02/2019 10:10	File folder
RAI	30/05/2019 10:41	File folder
Refresher CM Education 2016	26/02/2019 10:11	File folder
Super User Meetings	26/02/2019 10:12	File folder

e. The Outlook back charting form will display like this. Follow all instructions and E-mail completed from to seniorshealth.southzoneeducation@ahs.ca

Alberta Health Services		Seniors Health South Zone BACKCHARTING REQUESTS				
Instructions: <ul style="list-style-type: none"> Please complete ALL sections below. We cannot process incomplete requests. Email completed forms to: seniorshealth.southzoneeducation@ahs.ca and cc: your manager. When your request is Approved a member of the Seniors Health Education team will respond with inserting an "A" in the last column (displays in red). Back charting access will only be granted on a daily basis and will be removed at the beginning of the next business day. 						
EXCEPTION: On Fridays access will be removed at 1600, please notify if you do require access over the weekend and we can make the appropriate arrangements.						
<ul style="list-style-type: none"> Please provide a brief explanation as to why you are requesting back charting access. If required, your manager may follow up with more questions to inquire about the situation. 						
* Indicates this field MUST be completed for every request						
* Name	* Designation	* 6 Digit Meditech Number	* Location/Site	* Manager Name	* Brief Description to WHY You're Requiring Back Charting	* Educator Use Only* Status: Approved

Chapter 2: Care Manager

Logging into Meditech

1. Click the **MyApps** icon.



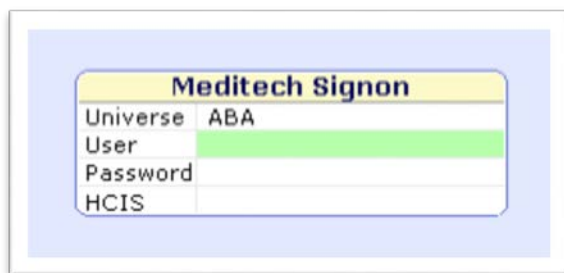
2. Click the **Meditech** folder.



3. Click the **Meditech LIVE** folder.



4. Enter your **6 Digit Meditech User Number** and press the Tab key.
5. Enter your personal, case sensitive **Meditech password** and press the Tab key.
6. The HCIS will default to the zone you work in. Chinook= CHR.LIVE, Palliser= PHR.LIVE



Meditech Signon	
Universe	ABA
User	
Password	
HCIS	

Common Errors to Logging into Meditech

- Caps Lock is on (or off) when it shouldn't be, that is the Login Name and Password is case sensitive.
- Interchanging the letter "O" with the number "0".

Note: The system allows 3 attempts to log on. After the 3rd unsuccessful attempt, you will receive a warning, "Keyboard locked for 60 seconds".

Meditech Screens

Once in Care Manager the desktop is where different modules are accessed. Your Meditech desktop may have different selections, depending upon your role and user access.

Meditech Screen Title Bars

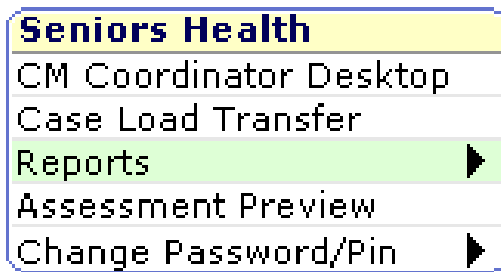
Every Screen in Meditech will display two title bars. The top title bar provides the Meditech Logo, Palliser Health Region (PHR) or Chinook Health Region (CHR), the Environment (Live or Test), site, and the full name of the person logged in.

The 2nd bar notes Meditech Care Manager Module is in view.

Palliser Health Ring (PHR)  CM *Palliser TEST 5.67* - LCCM (ABATEST/ABA.TEST5.67/PHR.TEST5.67 - Test)

Chinook Health Ring (CHR)  CM *Chinook Regional TEST 5.67* - CCCM (ABATEST/ABA.TEST5.67/CHR.TEST5.67 - Test)

Seniors Health Menu



Print Reports (Client Profile/Discharge Summary/Labels)

Reports are accessible from the **Seniors Health** menu which are located on the main menu following login.

1. To print a **Reports** and **Labels**, return to the Main Menu screen. In the Seniors Health Menu select **Reports**.
2. From the **Reports** menu:
 - a. Select **Report** you would like print.
 - b. Enter the client's name, or if you use spacebar and the enter key it will bring up the last client you worked with (it will bring up the client name to confirm. Select "Yes". It will bring up a different number, ignore that).
 - c. Click **OK** in the bottom right or do an **F12**.
 - d. On the **Print Destination** screen **Preview** will default first to preview report before printing to ensure information is correct. Click **OK** in the bottom right or do an **F12**. Zoom in using magnifying glass icon at the top left of the page.
 - e. This will bring up the **Report**. You can now print from this screen by selecting the **Printer Icon** at the top of the screen. Select the correct printer in the printer field. Place check mark in the **Print All** box and click **OK**.
 - f. Once the **Report** has been printed, use the **ESC** key or x out in the top right to exit.

Assessment Preview

Allows you to preview non-grouped Interventions prior to adding them to your care plan Problems.

1. Go to the **Applications** screen and in the Seniors Health Menu scroll down and click on **Preview Assessments**,
2. Search for an Intervention by typing in "?" and the 1st few letter of the Intervention you would like to preview (e.g. ?MOBILITY),
3. Highlight the Intervention and **ENTER**,
4. From the **Footer Menu** click on **PCS Preview**
5. This will open up the Intervention in a **VIEW ONLY**,
6. To add the **Intervention** to the **Care Plan** you will have to have to go to **Additional Care Plan**, and ensure the intervention is linked to the problem.

Forgotten Password

Contact AHS Information Management and Technology help Desk:

Phone: (403) 388-6235; (403) 529-8952

Email Service Desk CHI: ServiceDesk.CHI@albertahealthservices.ca

Initially the I.T. Service Desk will assign you a password. It is important to change this password to a personal password the first time you log into the system.

Your password should have:

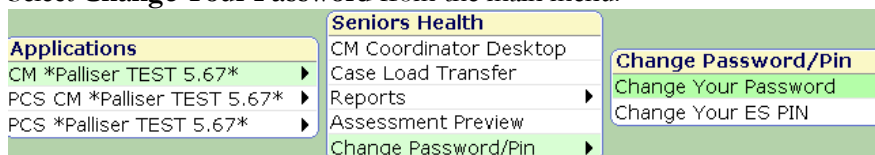
- At least 8 characters in length
- A combination of letters and numbers
- Special characters such as % or & to add an additional level of security
- Memorized and not written in a place where others may see it.

Your password should not contain:

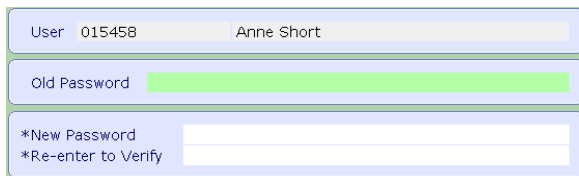
- Easily identifiable numbers (i.e. 'Birthdate' or address).
- Nickname or initials, Names of pets or children.
- Words that would easily be associated with you (i.e. favorite sport or team).

Changing Your Password

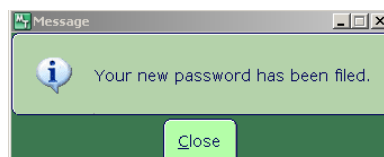
1. Select **Change Your Password** from the main menu.



2. Enter your **Old Password**.
3. Enter your **New Password**.
4. **Re-enter** your new password to confirm the accuracy. Press *Enter*.

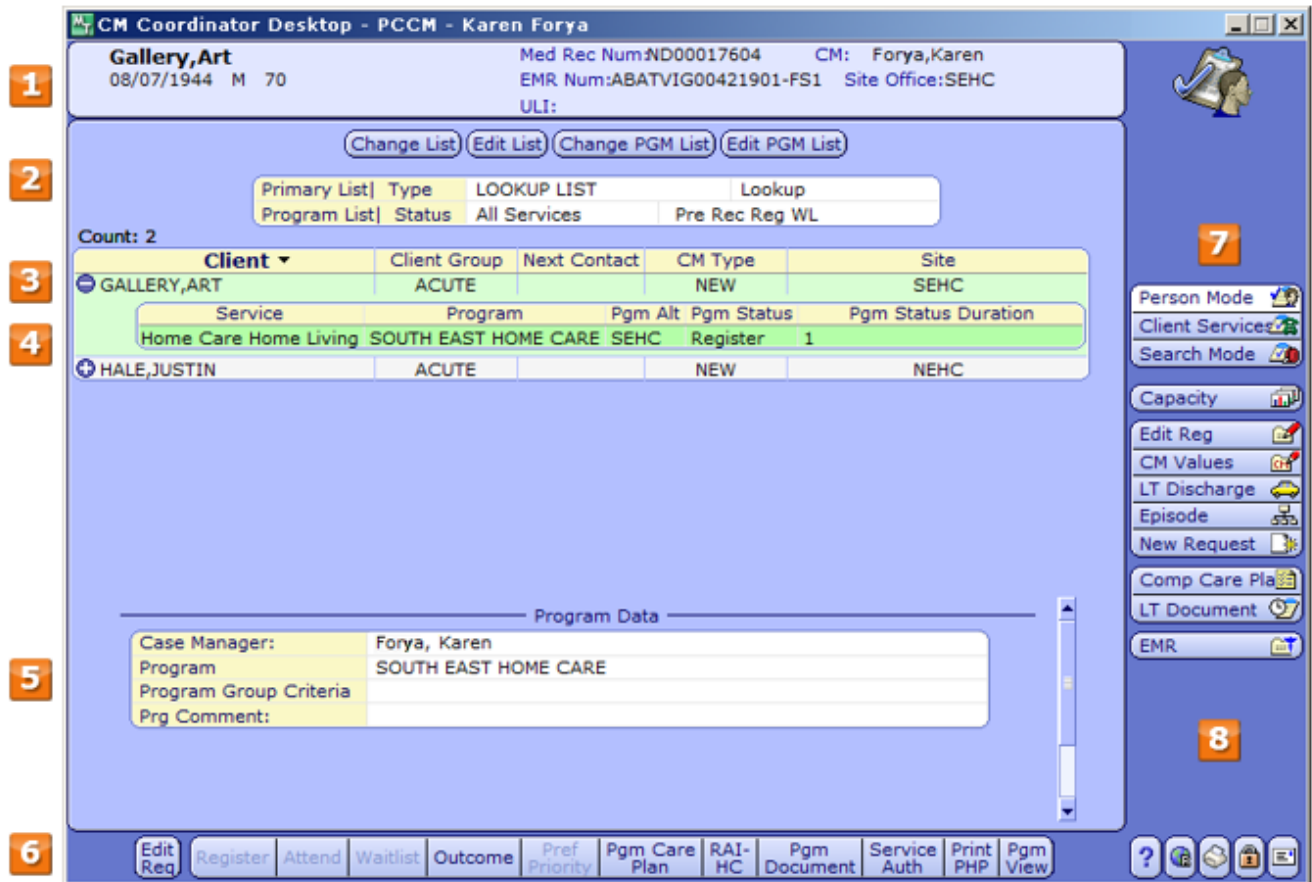


5. A message displays stating your password has been changed (and filed or saved).
6. Select **CLOSE**.



7. The **CM Coordinator Desktop** will display once you select your CM site 5.67, then **CM Coordinator Desktop**.

CM Coordinator Desktop Layout



The screenshot shows the 'CM Coordinator Desktop - PCCM - Karen Forya' window. The interface includes a header for the selected client, a list of programs, and a sidebar with various action buttons. Numbered callouts 1 through 8 point to specific elements: 1. Client header information (Name, birthdate, sex, age, Case Manager). 2. Primary List Type dropdown and management buttons. 3. Client list table with columns for Client, Client Group, Next Contact, CM Type, and Site. 4. Program list table with columns for Service, Program, Pgm Alt, Pgm Status, and Pgm Status Duration. 5. Program Data section with fields for Case Manager, Program, Program Group Criteria, and Prg Comment. 6. Bottom toolbar with buttons like Edit Req, Register, Attend, Waitlist, Outcome, Pref Priority, Pgm Care Plan, RAI-HC, Pgm Document, Service Auth, Print PHP, and Pgm View. 7. Right sidebar with buttons like Person Mode, Client Services, Search Mode, Capacity, Edit Reg, CM Values, LT Discharge, Episode, New Request, Comp Care Pla, LT Document, and EMR. 8. A small icon in the bottom right corner of the main window.

Client	Client Group	Next Contact	CM Type	Site
GALLERY,ART	ACUTE		NEW	SEHC

Service	Program	Pgm Alt	Pgm Status	Pgm Status Duration
Home Care Home Living	SOUTH EAST HOME CARE	SEHC	Register	1

Client	Client Group	Next Contact	CM Type	Site
HALE,JUSTIN	ACUTE		NEW	NEHC

Program Data

Case Manager: Forya, Karen
 Program: SOUTH EAST HOME CARE
 Program Group Criteria:
 Prg Comment:

1. The **CM** header displays the information of the selected (Green Highlighted) client, including name, birthdate, sex, age, and even Case Manager.
2. The **Primary List Type** displays the type of list you are viewing. The buttons above this field are used to manage the different lists. This is useful when searching for clients and managing your program lists.
3. Each client only has one **Lifetime Account**. **Lifetime Account** documentation includes general client information accessible to all programs and applicable for all care providers (e.g., physician and pharmacy contacts, medical history, safety risks, goals of care, legal and financial information, advanced care planning discussions, reason for needing home care services). After screening and registration, the Lifetime Account is opened or reopened if the client is eligible for Continuing Care Services. It remains open until such time that no care is provided to the client from any program in Continuing Care Services.
4. Each client may have multiple **Program Accounts** active at the same time, depending on their care needs. For example, a client may receive services from a Home Care Program and a Day Program.

The **Program Account** contains clinical documentation specific to that program. For example, it may include clinical assessments, consults to other disciplines and functional assessments. A **Program Account** remains open as long as that program is providing service(s) to the client.

5. This area will display **Person Data** such as demographics if the **Lifetime Account** is chosen or **Program Data** if the **Program Account** is chosen.

6. Footer buttons become active when working with a selected **Program Account** for the client. Ensure both the correct client and program is highlighted.
 - **Edit Req, Register, Attend, Waitlist, Outcome** and **Pref Priority** either add information to a program or change the status of the program.
 - **Pgm Care Plan** enables the creation of a care plan with a client specific problems and interventions.
 - **RAI-HC** enables the documentation of the RAI-HC assessment and viewing of the outputs.
 - **Pgm Document** opens another application – Patient Care System where clinical documentation is entered.
 - **Service Auth** enables creation of documents detailing the personal care to be provided by providers
 - **Print PHP** enables printing of the Personal Health Profile generated by the RAI-HC. (we do not use this in South Zone).
7. Based on your role and access level, **Person Mode** is where you will access your client lists, perform caseload management activities, care plans, make referrals and create service authorizations.
8. The right menu contains buttons to access functions that apply to items on the main display or launch specific routines. For example, if a client is highlighted (green) clicking **CM Values** will apply to that client. Any buttons that are low-lit are not active and are not accessible.

Comp Care Plan-Accesses a printable comprehensive care plan for the client selected on the main display. When you open the routine, you can select specific parameters for the report.

Lifetime Document- Allows you to document on a Lifetime Account. Select a client in the main display to select that client's Lifetime Account.

Look-up Clients in Care Manager

1. Click on highlighted **CM 5.67** line in the **Applications** Menu, and then click the highlighted **CM Coordinator Desktop** line in the **Seniors Health** Menu to get to the **CM Coordinator Desktop**.
2. **CM Coordinator Desktop** will display in **Person Mode** where the Case Management activities take place.
3. Click on header button **Change List** at the top of the **CM Coordinator Desktop** screen to display the **Process List Lookup** screen with the following list options:
 - a. **Lookup List** - Searches for specific clients registered in Care Manager.
 - i. Cursor defaults to Person field. Enter one of the following:
 - Client's LAST NAME, FIRST NAME (no spaces).
 - ULI number.- preceded by # sign with no space
 - Chart number (if known) CH (Chinook) EC (Palliser).
 - ii. Use **Enter** key, **F9**, or drop down arrow to search for the client.
 - iii. Sex and Birthdate confirmation box appears; can bypass by selecting **green check mark** OK in bottom right.
 - iv. The system will search and show the closest matches at top of screen and display related information at bottom of screen
 - v. Single click client name to select.
 - vi. If you need to look up numerous clients you can repeat this process by using a new line for each new client.
 - vii. Once you have located all the clients you need, press **enter** or **F12**.
 - viii. File by clicking on the **green check mark** in the bottom right to “**save**”.
 - b. **Need CM Assign** - Displays clients who have not yet been assigned a Case Manager

Note: Clients should be assigned to a Case Manager by the Team Lead or Manager. If it has been missed, then the client's name will appear here and on no other lists.

- c. **My Caseload** - Displays the Case Manager's client list, including new and transferred clients.
- d. **New Client List** - Displays any new clients assigned to a Case Manager that they have not yet been accepted.
- e. **CM Transfer List** - Displays clients transferred to a Case Manager's Caseload that they have not yet accepted. These clients will also show up on your **New Client List**.
- f. **Custom List** - List of clients which can be built by the user.
- g. **Edit List** – use to add or remove clients from the Lists.
- h. **Custom List 1** - List of clients which can be built by the user.
- i. **Search List** - Allows the user to search for a list of clients as defined by specific criteria. This list is used most often by non-case managers to find clients specific to their own Program. Select the header button **Edit List** to access the **Enter Request Search Criteria** screen.
 - i. Cursor defaults to **Search** field. Do an **F9** to find a list of Programs for example, NP, or Paramedic (CH).
 - ii. Highlight and save the desired Program, **F12 or enter**. Meditech System will default in the following fields:
 - **Status=** Recommend,
 - **Programs=** program you selected in Search field,
 - **Service=** service attached to the
 - **Program** in the Search field
 - iii. You can change what appears in the Status field by **Deleting** unwanted Status by highlighting it and using the Delete on your keyboard or you can **Add** any Status by placing the cursor on a blank line and doing an **F9**. For example, you may want to add "Register", to see all clients Registered in the Program.
 - iv. Once you are satisfied with the Statuses to be displayed, do an **F12 or enter**, and the computer will generate the requested list.
 - v. You can arrange the list by Site by clicking on the Up and Down arrows below the word "Site". This will arrange the list alphabetically by site in either ascending or descending order.
- j. **Other Lists** - These lists are used most often by non-case managers to find clients specific to their own Program. You will need to select the header button **Change List** to access the **Process List Lookup** screen.
 - i. Select the specialty **recommend list** (pulled from recommend to specialty Program) or the **RG Palliative list**, (pulled from registration into Palliative Program) or the **Transition List** (pulled from registration into Hospital Program) to display clients related to those disciplines.
- k. **Primary List Type** displays what list you are in. To access a different list use the header button **Change List**. To add or delete clients from the current list, use the header button **Edit List**. Note: all the client lists will also have columns to display Client, Site, Care Manager Type, Next Contact Date, and Client Group.

Programs and Referrals

Recommend or Register a Client to Service(s) & Program(s)

The client is assigned to a **Site** and receives **Services** that are provided by a **Program**. The **Site** is the Home Care office that will manage the client. Under each site there are specific **Services and Programs** that are available. **Service** is the high level description of the type of care a client requires in order to meet their needs. Under each Service there are several Programs to choose from. Each client must be Registered into one or more Services to be eligible for a Program. A client can be Registered in more than one Service and Program.

The capacity for Allied Health to chart electronically is growing. Recreation therapy/Aids, Occupational Therapy/Aids, Physical Therapy/Aids, Respiratory Therapy, Speech Language Pathology, Nurse Continence Advisor, Nurse Practitioner, Enterostomal Therapy Nurse, and Social Work will all require the Health Professional Referral intervention to be documented as well as a Recommended New Request to that Allied Health discipline. If you are unsure if the allied health discipline is able to actively chart on Meditech, contact the education team to inquire at seniorshealth.southzoneeducation@albertahealthservices.ca

Note: If you have more than 1 discipline to recommend you need to do each New Request separately. You only document Health Professional Referral for the initial referral request. You also cannot have 2 of the same Allied Health referrals for one client.

Registered- means the clinical specialty is involved.

Recommend: New referral


Waitlist: The discipline is aware of the referral but the client is not being seen.

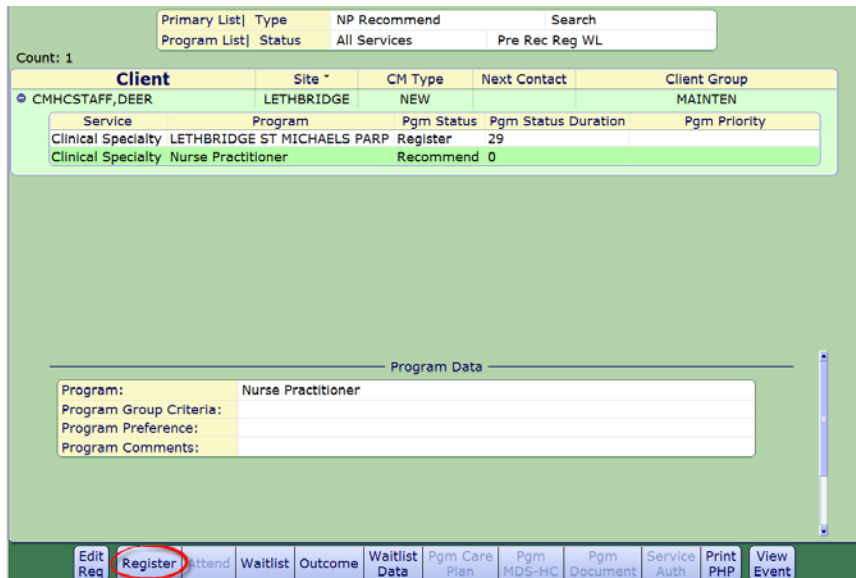
Complete: The clinical specialty has ended; these programs then are hidden but can be found by selecting “Edit PGM List” and select Complete.

Find New Referrals Recommended to NP Program

1. Click on highlighted **CM 5.67** line in the **Applications** Menu, and then click the highlighted **CM Coordinator Desktop** line in the **Seniors Health** Menu to get to the **CM Coordinator Desktop**.
2. Click on **Change List** button and select **NP Recommend** from **Process Lookup List** menu. This will display your new referrals.
3. Proceed with Registering the client and ensure the appropriate Start date for when the client is seen (you are able to back date). Follow steps below on how to register clients.

Registering a Referred Client into Your Program

1. Before accepting a client referral ensure that you are previewing the Health Professional Referral documentation in the EMR to preview details about the referral specific to the client’s NP needs (It is the Case Managers responsibility to complete the Health Professional Referral documentation).
2. In the CM Coordinator Desktop screen, select header button **Change List**, then select **NP_ REC NP Recommend** in the pop up box.
3. To accept a client:
 - a. Highlight the clients name
 - b. To access the clients programs, click the  sign to the left of the clients name
 - c. Click on the **Nurse Practitioner** Recommend program
 - d. On the footer select **Register**



Count: 1

Client	Site *	CM Type	Next Contact	Client Group
CMHCSTAFF, DEER	LETHBRIDGE	NEW		MAINTEN

Service	Program	Pgm Status	Pgm Status Duration	Pgm Priority
Clinical Specialty LETHBRIDGE ST MICHAELS PARP	Register	29		
Clinical Specialty Nurse Practitioner	Recommend	0		

Program Data

Program: Nurse Practitioner

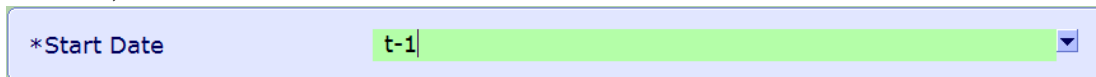
Program Group Criteria:

Program Preference:

Program Comments:

Buttons: Edit Reg, **Register**, Attend, Waitlist, Outcome, Waitlist Data, Pgm Care Plan, Pgm MDS-HC, Pgm Document, Service Auth, Print PHP, View Event

- e. In the pop up only fill in the ***Start Date** of when you began involvement in the clients care (you are able to back date).



*Start Date t-1

- f. Select footer button **Save** with **Green Check** in bottom right corner.

Note: The client will no longer display on the NP Recommend List. You will now need to add the client to one of your Custom Lists so you can continue to follow and document on the client.

Once you return to the CM Coordinator Desktop the recommended program will now be registered.

Registering a Client into Your Program

1. In the CM Coordinator Desktop search/add the client in one of your custom lists by their name or ULI
2. Highlight the name of the client
3. On the right hand side of the CM Coordinator Desktop screen; select **New Request**



Edit Reg

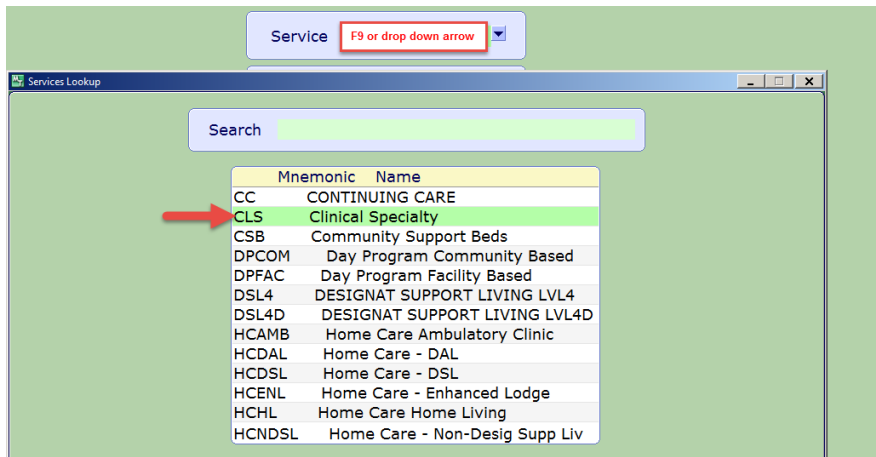
CDS

CM Values

Episode

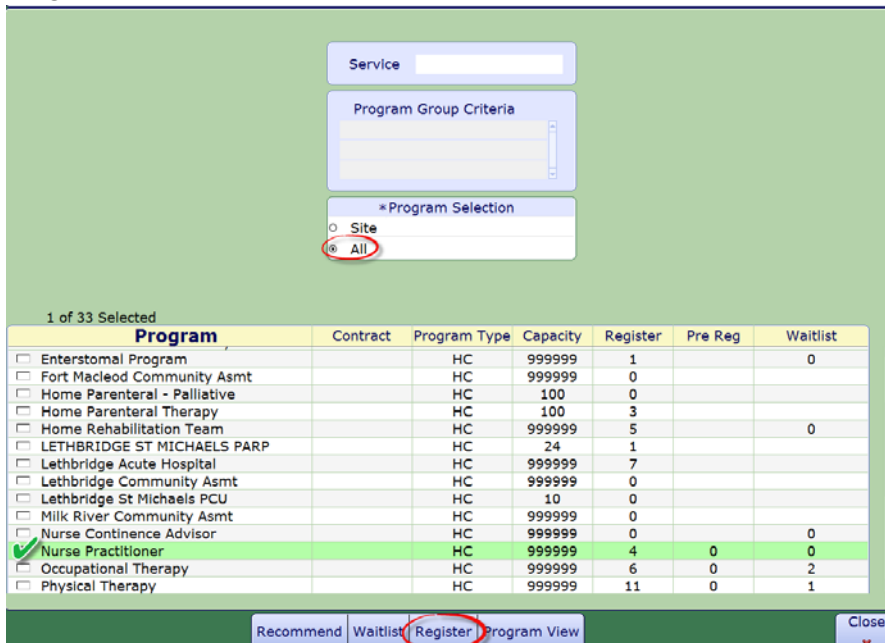
New Request

4. In the Service box select drop down, or F9.
5. In The pop up Service box select **Clinical Specialty**



Mnemonic	Name
CC	CONTINUING CARE
CLS	Clinical Specialty
CSB	Community Support Beds
DPCOM	Day Program Community Based
DPFAC	Day Program Facility Based
DSL4	DESIGNAT SUPPORT LIVING LVL4
DSL4D	DESIGNAT SUPPORT LIVING LVL4D
HCAMB	Home Care Ambulatory Clinic
HCDAL	Home Care - DAL
HCDSL	Home Care - DSL
HCENL	Home Care - Enhanced Lodge
HCHL	Home Care Home Living
HCNDSL	Home Care - Non-Desig Supp Liv

- Choose **All** in the Program Selection field
- Scroll and select your Nurse Practitioner Program by placing a check mark in box beside
- You are the 'owner' of the NP Program so you are able to directly **Register** to the Nurse Practitioner Program

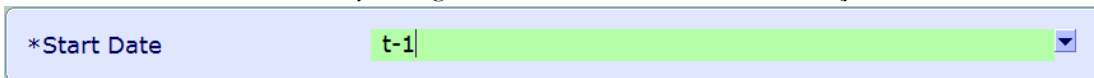


1 of 33 Selected

Program	Contract	Program Type	Capacity	Register	Pre Reg	Waitlist
<input type="checkbox"/> Enterstomal Program		HC	999999	1		0
<input type="checkbox"/> Fort Macleod Community Asmt		HC	999999	0		
<input type="checkbox"/> Home Parenteral - Palliative		HC	100	0		
<input type="checkbox"/> Home Parenteral Therapy		HC	100	3		
<input type="checkbox"/> Home Rehabilitation Team		HC	999999	5		0
<input type="checkbox"/> LETHBRIDGE ST MICHAELS PARP		HC	24	1		
<input type="checkbox"/> Lethbridge Acute Hospital		HC	999999	7		
<input type="checkbox"/> Lethbridge Community Asmt		HC	999999	0		
<input type="checkbox"/> Lethbridge St Michaels PCU		HC	10	0		
<input type="checkbox"/> Milk River Community Asmt		HC	999999	0		
<input type="checkbox"/> Nurse Continence Advisor		HC	999999	0		0
<input checked="" type="checkbox"/> Nurse Practitioner		HC	999999	4	0	0
<input type="checkbox"/> Occupational Therapy		HC	999999	6	0	2
<input type="checkbox"/> Physical Therapy		HC	999999	11	0	1

Recommend Waitlist **Register** Program View Close

- Fill in the *Start Date of when you began involvement in the clients care (you are able to back date).



*Start Date t-1

- Select footer button **Save** with **Green Check** in bottom right corner.
- Once saved you will return to the CM Coordinator Desktop and the NP program with now be registered.

Note: The case manager will still have to complete the Health Professional Referral intervention so ensure that they are informed the NP Program has been added and they need to still complete the Health Professional Referral documentation.

Documentation in Programs

- All documentation must be completed in the program where the client is being seen.

2. The Clinical Specialty programs (ie. Nurse Practitioner) are inactive accounts and documentation is not completed in these programs.
3. Document in the home care or supportive living program where you saw the client.
4. If the program the client was in has been ended or closed, follow steps below to open it to complete documentation.

Outcome Program(s)


This is done to complete your involvement in the client's care. You are **not discharging** them from Home Care (ending their **Episode** of care). **Prior to Outcoming** your Program be sure to do the following:

- **Finish all clinical documentation – do final documentation on any relevant PCS Interventions.**

Process to Outcome Program(s)

1. In **Person Mode** screen - highlight the **Service and Program** you want to **Outcome** (for example, Clinical Specialty: NP).
2. Click on footer button **Outcome** at bottom of screen.
3. Cursor defaults to the Outcome Box. Do an **F9**. (See [Appendix H](#) for Program Outcome Reason definitions).
4. Click on the appropriate reason for completing the Program (for example, "No Longer Requires Service"). See [Appendix H](#) for other Program Outcome Definitions.
5. Cursor defaults to the Date - enter **T** for today (do not backdate when **Outcoming** a program). Do an **F12**.
6. Click **green check mark** in bottom right corner to **Save** and file **Program Outcome**.
7. In **Chinook** the completed programs are not displayed, unless you click on the **Edit PGM List** header button on the top. If you check next to "Completed", you will see Completed and Active Programs (see instructions below).
8. For **Palliser** all programs will display and sometimes we want to hide the completed programs. You will click on the header button "**Edit PGM List**" then uncheck next to "Completed", which will then temporarily remove Completed programs from view until you log in again or refresh the **Person Mode** button (full instructions below).

How to Access Completed Programs in Care Manager (to chart)

1. From the *CM Coordinator Desktop* screen look up your client
2. Click the  beside the Client's Name to display the Client's Programs. If you do not see the old program. Locate the old Program by selecting the **Edit PGM List** from the View buttons at the top of the screen



3. Place a checkmark beside **Complete**. This will open all **Programs** including the Programs that are in a Completed status.

✓	Service
<input type="checkbox"/>	Cancel
<input checked="" type="checkbox"/>	Complete
<input checked="" type="checkbox"/>	Pre Reg
<input checked="" type="checkbox"/>	Recommend
<input checked="" type="checkbox"/>	Register
<input checked="" type="checkbox"/>	Waitlist

4. Highlight the Program you want to add/edit/undo your documentation. For further information on how to edit/undo documentation see “[How to Edit/Undo Documentation in Program Account](#)”

Clinical Review

A Clinical Review must be conducted upon initial assessments, reassessments and with any significant change to client status. The Clinical Review steps are as follows and are expanded on as the chapter continues.

1. Review EMR
2. Review/Update Lifetime account
3. Review/Update Edit Reg
4. Review/Update CM Values
5. Review/Update Episode

Access EMR

All information **entered electronically** on your client is viewable in EMR (Enterprise Medical Record). For example, previous admissions & discharges to Home Care or hospital, ER visits, Outpatient visits, Lab or DI reports, etc. will all be viewable in EMR, provided they were recorded electronically. All **Lifetime Account** information and active **Program Account** Assessments will also be viewable.

Find a Client in EMR

1. Access EMR by selecting the **EMR button** from the right menu buttons or using **F11**.
2. The first screen will be the client **Summary List** in the **Lifetime Account**.
3. To access information in both the **Lifetime Account** and **Program account**, select **Other Visits** from the toolbar on the right.
4. Then select **“ALL”** under View to.
5. You will return to the **Summary List** view, this time with information from both the **Lifetime account** and **Program Account**.
6. Always read the top left corner of the screens to identify what screen you are viewing and that you have selected the right Client.
7. Exit the **EMR** by clicking **Red X** top right corner.

View Client Information in EMR

This can be done from the **Lifetime Account** or **Program Account** by selecting your client and then clicking on the **EMR** button on right toolbar or using **F11**.


Once in EMR:

1. Select **Other Visits**
2. Select from mid screen **View “All”**.
3. Select **Care Activity**.
4. The last 3 interventions/assessments that were charted on appear in a spreadsheet.


Note: Only **3 assessments** can be viewed at a time. To view other assessment, **right click** on the name of assessment you want and select **“Display”** at the bottom of the page (you may have to scroll down to view the names of all the assessments).

Note: You can change the view by using the buttons on the top left of the page.

- i. **Spreadsheet view** - view by spreadsheet of all documentation over a period of time
- ii. **Date view** - sorts documentation in a chronological order
- iii. **Name view** - views documentation on a specific assessment/intervention
- iv. **Recorded by** - view documentation done by a specific person

To view additional information, if any, **click on the**  **icon to view.**

Print in EMR

1. Select appropriate client
2. Select **Other Visits**
3. Select from mid screen **View “All”**.
4. Select **Care Activity**.
5. Click on **Notes** button on right hand side
6. Find desired assessment and click on the . This will display the assessment as it will be printed.
7. Select the printer icon at the top left of the page. Make sure the correct printer is selected.
8. Click on **Return** on the bottom toolbar to exit the Notes view.

How to Exit EMR

Click on the **X** in the top right corner of the screen to return to CM Coordinator Desktop.

Edit/Update Edit Reg

Edit Reg provides more information on client demographics. Review and update as required. Note: Data collected by **ACCIS** is preceded by an asterisk to the left of the required information.

Registration Data Discrepancies

When verifying/editing client information currently within the **CM REG – Census** and/or **Reg Summary** tab info in Meditech, it may occur that the data provided verbally by the patient does not exactly match the data that is currently in Chinook’s Master Patient Index. This could be a discrepancy in client’s name or date of birth. **There are restrictions on editing the Episode and Registration Information. It is important to follow both ACCIS and Canada Post Guidelines when updating the Registration Information.**

1. Please e-mail Rural.HIM.DataIntegrityStaff@albertahealthservices.ca – regarding anything that is of concern such as a duplicate or inconsistencies. Examples include: incorrect date of birth or incorrect spelling of names. Please verify the correct information using **birth certificate, marriage certificate** or **Alberta Health Care Card**.
2. The **subject line** of the email to **Data Integrity** must include the **client’s former health region**. Example: Chinook or Palliser Region.

Ensure correct client is highlighted in the **Person Mode Screen** and verify client name in **CM Header** then select **Edit Reg**:

There are **8 Buttons** in **Edit Reg**:

1. **Client**

- a. **Address Line One** (physical address for client).
- b. **Address Line Two** (mailing address - complete if different than physical address, for example, Box number, RR#1, etc.). Do not include PO in the Box number.
 - i. **Ensure** the mandatory fields indicated by the asterisks are filled.
 - ii. If client in any **apartment, lodge or Facility** & **mail is received at the apt, lodge or Facility**, enter Room Number and apt, lodge or Facility name in 1st Street field, and apt, lodge or Facility's Street address into 2nd Street field.
- c. Click in city field and type in the postal code (with space). Hit Tab and this will auto populate city, province, and Residence Code and move the postal code into the postal code field. Hit Tab to auto-populate country.
- d. Language code. Can use **F9** or type 1st letter of the language, highlight the desired language and enter.
- e. Home phone number is required (Primary phone number to reach client).
- f. Other phone number is optional.
- g. Email address is optional.
- h. **ULI** – required field, check EMR or NetCARE if client does not know.

Note: If the ULI is missing, contact: SeniorsHealth.SouthZoneEducation@ahs.ca, we will have to determine what to do.

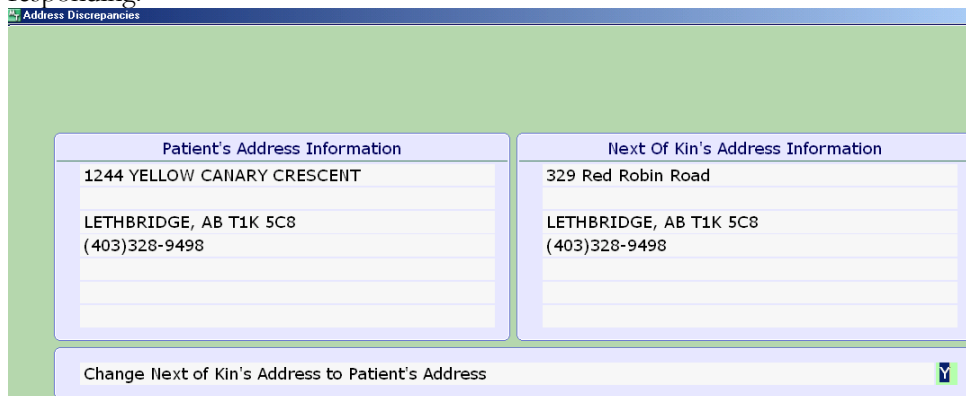
2. **Contact**

- a. **Person to Notify** – Should be contact #1
- b. **Next of Kin** - Should be contact #2-enter in client's Next of Kin name:

Note: Refer to “[Appendix A](#) Meditech Shortcuts” to help you quickly fill in address, (E.G. Same as Next of Kin/Person to Notify can use SNOK). **Relationship to client** - **F9** and select appropriate one and double click. Ensure Next of Kin (NOK) is current.

Note: Staff will put in two different contacts in these fields, if there is no Next of Kin (AKA Secondary Contact), then leave blank.

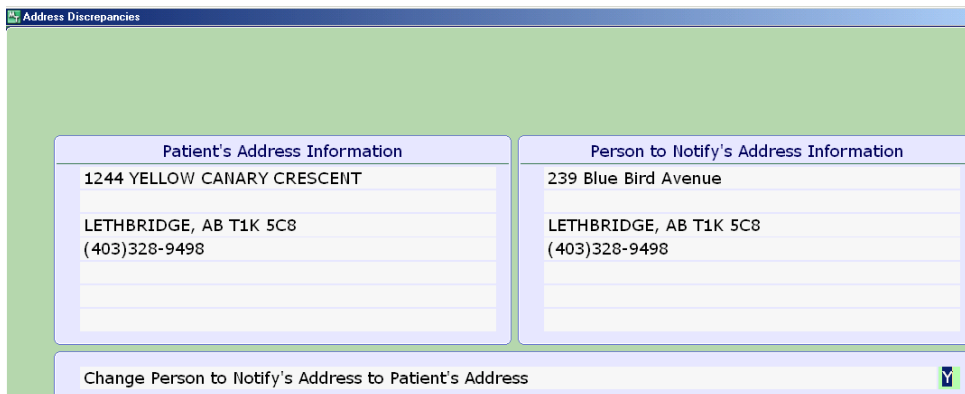
Confirmations: You must answer Confirmation questions if information has been changed. Read carefully before responding.



The screenshot shows a window titled "Address Discrepancies" with a green header. It contains two side-by-side panels for address information.

Patient's Address Information	Next Of Kin's Address Information
1244 YELLOW CANARY CRESCENT	329 Red Robin Road
LETHBRIDGE, AB T1K 5C8	LETHBRIDGE, AB T1K 5C8
(403)328-9498	(403)328-9498

At the bottom, there is a button labeled "Change Next of Kin's Address to Patient's Address" with a confirmation icon.




Address Discrepancies

Patient's Address Information	Person to Notify's Address Information
1244 YELLOW CANARY CRESCENT	239 Blue Bird Avenue
LETHBRIDGE, AB T1K 5C8	LETHBRIDGE, AB T1K 5C8
(403)328-9498	(403)328-9498

Change Person to Notify's Address to Patient's Address

The following Confirmation may be asked re the Guarantor's address: answer "Yes" if the client is the Guarantor and pays the bills, answer No if client is not his own Guarantor:



Address Discrepancies

Patient's Address Information	Guarantor's Address Information
1244 YELLOW CANARY CRESCENT	1233 Baby Owl BLVD
LETHBRIDGE, AB T1K 5C8	LETHBRIDGE, AB T1K 5C8
(403)328-9498	(403)328-9498

Change Guarantor's Address to Patient's Address

3. Additional Census

Do not use if you need to enter additional contacts. Add all additional contacts to **Client Contact** intervention in **Lifetime Account**.

4. Guarantor

a. **Guarantor** - this is the person responsible for payment. If it is the same as the client can type in SP and enter. **Do not fill out Guarantor's Employer.**

i. Update Guarantor Demo Recall defaults to **Y** - **leave it.**

b. **Insurance Button** - do an **F9** and select the appropriate one (should be Alberta Health) and a window will appear to show the information for the insurance you selected. Do an **F12** to save. (This should be filled out by Intake Coordinator)

5. Risk Scr

Single click in the **Risk Factors Present** field and enter **Y** or **N**. Details are collected in the **Safety Risk Assessment** in the **Lifetime Account** and information pulls into **Client Profile**.

Note: Do not leave the area blank; it requires a 'Y' or an 'N'

6. Prov/Site

a. Tab **DO NOT** fill out **Primary Care** line.

b. Family Physician is completed by typing in the first four letters of the last name and do an **F9**. **Highlight** the one you want and **Enter**.

- c. **DO NOT** fill out **Other** line.
- d. **Reason for Visit** defaults to “**Receiving Continuing Care Services**” **Do not change.**
- e. **Service Date/Time:** is the Community Care office where Case Manager works
- f. **Service Date/Service Time:** **This will default to the date and time of first registration, and should not be changed.**

7. Service Loc

This is the physical address where the client will receive services.

Note: Changes to the client’s address on the census tab will **not** automatically be updated on the **Service Address** tab. You will need to update this tab if there are changes.

- a. **Homeless** – indicate Y/N.
- b. **Street Address** - enter in correct information or SP if same as the client information you already entered.
- c. From date - enter **T** for today. Do not back date.
- d. **Thru date- Do not fill out.**
- e. **Level of Care** (*for more detailed information see **Designated Living Option Guidelines***) (CH case managers **do not** do this step)
 - i. Do an **F9** select appropriate choice and **enter**.
- f. **Congregate Sites:** is associated with the Home Care office providing services (identified in the Prov/Site Tab) will appear. Highlight and select the appropriate option. **Service Location Address** will then automatically auto-populate. This will not change the address in the Client screen.

Note: Intake Coordinator updates the congregate Site field

Note: If no supportive site is selected DLS 3, 4, or 4D the system will skip over Congregate Site box.


- g. Can use **Directions Box** to record any required directions (e.g. rural directions).
 - i. **Home living** - private home, condominium, and apartment; included is care provided in retirement communities or independent housing for the elderly/disabled & in a hotel/motel if this is the client’s primary residence.
 - ii. **Non-Designated/Private Supportive Living** –Regular lodges, also Adaptacare, Rosewood Villa and Bethesda
 - iii. **SL3** –Enhanced Lodges (*Chosen only by Access Centre*)
 - iv. **SL4 (D)**– Supportive Living 4 (*Chosen only by Access Centre*)
 - v. **Long-Term Care** - (*Chosen only by Access Centre*)
 - vi. **Other** – (rarely used) shelter/public place, night shelters, hostels for the homeless, streets, parks, correctional facilities & other public places, also care provided in a hotel/motel (when this is temporary accommodation) schools, workplace settings, hospice, sub-acute, transition, community support beds, or a hospital. If you have a client that receives service at school or the workplace setting, they should be coded as Home Living as they live at home and do not live at school or the workplace.

8. Allergies

VIEW only. Allergies can be entered in PCS, EMR or Lifetime Account.

Update Allergies

Allergies can be updated in the **Lifetime Account**, **Program Account** or **EMR**. The process is the same regardless of which screen you are accessing them from.

Click on  **Allergy/ADR** at top left of screen. If there are allergies present, they will be listed.

1. To **Add Allergies**:

- a. Select footer button “**Enter New**” to enter in a new allergy.
- b. Start typing the allergen you are looking for in the green bar of Allergen/Adverse Reaction field. As you start typing, a drop down list will appear and will narrow the search as you type in more letters.
- c. Once the allergen is identified, click on it. Another field will open with the identified allergen listed.
- d. Complete the remaining fields. Anything with an * is required
 - i. Type - defaults to Allergy. **Leave it**.
 - ii. Severity - select one.
 - iii. Verified - select **Yes** or **No**. Yes means a licensed health professional has discussed and recorded the allergy with the client. (Only Palliser).
 - iv. Reaction is free text and/or **F9** for a drop down menu. You can only select one reaction through the **F9** function. If there is more than one, use free text instead of **F9**.
 - v. Comment - to be used for additional information.
- e. Once all data has been entered, select **Save** in the toolbar at the bottom of the screen.
- f. If there are more allergies to be entered, follow the same process.
- g. Once all allergies have been entered, select **Save**, then **Done**.

Note: If there are **no known allergies**, type NKA in Allergen/Adverse Reaction field. Then only the **verified field needs to be completed**. Remember to delete NKA if on subsequent reviews of allergies, the client reports an allergy.

2. To **Confirm Allergies** already listed (must be done with each new Episode). Review all allergies and then you can confirm one at a time or all at once. Select **Process**.

a. To **Confirm all at once**:

- i. Click on “**Select All**” at the bottom of the screen
- ii. All allergens will highlight
- iii. Select “**Confirm**” button on the toolbar
- iv. The date should change to the current date for all coded allergies.
- v. Select “**Save**”.
- vi. Select “**Done**”.

To “**Confirm**” **one at a time**:

- vii. Highlight the allergen.
- viii. Select “**Confirm**” at the bottom of the screen.
- ix. Do this for each allergen.
- x. Once the data for each allergen have been confirmed, select “**Save**”.
- xi. Select “**Done**”.

b. You will be returned to the main screen.

3. To **Delete Allergies** (already listed or NKA) click on “**Process**”:

- a. Click on “**Process**”
- b. Highlight the allergy you want to delete by clicking on it
- c. Select “**Delete**” from the toolbar at the bottom of the screen

- d. You will get the prompt “Are you sure you want to Delete?” Choose “**Delete**”
- e. Select “**Save**”

Edit/Update CM Values

All Home Care clients are assigned a **Client Group**. This must be completed on admission to identify the **Client Group** and to determine the priority level. If it is assessed that the **Client Group** has changed, this screen must also change.

In the **Person Mode Screen** select **CM Values**:

- a. The cursor will default to **Client Group** field, if there is something in the field delete it, then do an **F9** or **click drop down arrow** to bring up a list of client groups. Click on appropriate Client Group. For definitions of **Client Group** options see [Appendix O](#).
- a.
- b. **Effective Date** - enter **T** for today (if adding or changing Client Group).
- c. Do a Lookup at Case Manager Type. There are 3 **types**:
 - i. **New Client on Caseload**
 - ii. **Accepted New Client**
 - iii. **Transfer Client to Diff Coordinator**
 - iv. **Update**: used to notify the Case Manager that the client has new documentation

Note: All Clinical Specialty staff **MUST** use the **Update** function to notify the Case Manager of any care changes, documentation or notes. This is to trigger the Case Manager that an update has been made to the clients care and they should preview the EMR notes and follow up as needed.

If there is urgent communication or special detail changes this should not replace other methods of contact.

- d. New Client on Caseload is assigned by the Access Centre for all new referrals
- e. The client’s name will then display on the **Case Manager’s New Client List**
- f. The **Case Manager** must **remove the value** of New Client on Caseload and **replace it with Accepted New Client**
- g. The **Case Manager** will use **Transfer Client to Diff Coordinator** when transferring a client to another Case Manager. The client then appears on the new Case Manager’s **New Client List**. The Case Manager Type must then be changed to Accepted New Client
- h. To change Case Manager Type values, insert cursor at Case Manager Type, delete current value. Do a Lookup
 - i. Highlight appropriate Case Manager Type. File.
- j. **Next Contact Date** - is to be used to enter the client’s next RAI-HC reassessment due date.
- k. Save by doing **F12**. Confirm when prompted.

Edit/Update an Episode

When a client is admitted to Home Care, this begins an **Episode of Care**. The **Episode** captures the entire duration of care within the Continuing Care portion of the client’s Services, even though they may receive Service in several Programs during the Episode. The **Episode** continues until all Programs are Complete and the client is discharged from Home Care Services. If the client is discharged and later readmitted, a new **Episode** of Care is started.

During the client’s **Episode of Care**, if there are changes to the client’s **Service Plan Type, Method of Funding, or Episode Summary**, this can be adjusted for the Episode. To do this:

1. Select Right Menu button **Episode Button**.
2. Defaults to and highlights the **Active Episode**.
3. Select footer button **Edit Episode** at bottom of screen.
4. Make changes. For example: going home now instead of SL3. Please note:
 - b. **Start Date:** defaults in - **DO NOT CHANGE**.
 - c. **Summary field:** **DO NOT CHANGE**
 - d. **Date Case Opened:** **DO NOT CHANGE** this is the date the inquiry was Registered into Care Manager (may be different than the start date if the CSI was done on a previous date).
 - e. **Service Plan Decision Date:** (enter **T** for today). This **does** get changed if the **Service Plan Type** changes. (**Completed by Case Managers**).
 - f. If new **Service Plan Type:** do an **F9**. Definitions will appear at the bottom of the screen as you highlight each option. This **does** get adjusted as the client's status changes. (**Completed by Case Managers**).
 - g. If new **Method of Funding:** Services - do an **F9**. For definitions of **Method of Funding** option see [Appendix J](#).

Note: Block Funded is only used for funded beds (SL3, SL4, SL4-D). This **does** get adjusted as the client's status changes. (**Completed by Case Managers**).

5. Select **Ref Source** button - information entered into the CSI will be brought forward.
6. **Enrollments** button gives a summary of the **Services and Programs** the client is or has been enrolled in during this **Episode**. If this is a new **Episode**, this will be blank.
7. To file use **F12** or **green check mark** in bottom right corner. **Red X** in bottom right to **"Close"**

Chapter 3: Lifetime & Program Accounts

Lifetime Account

Each client will only ever have **one** Lifetime Account in each reporting ring (Chinook and Palliser). The **Lifetime Account** will contain general client information that is applicable to all care providers, and is accessible to all Programs. When a client is discharged from Home Care due to death, moving out of the health region or no longer requires service, the Lifetime Account becomes **Inactive**. If the client becomes readmitted through CSI, the Lifetime Account becomes active again and all assessments will be viewable in EMR.

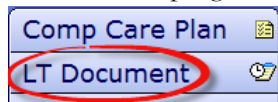
Within the **Lifetime Account** assessments are grouped together as **Standards of Care (SOC)**.

At the time of Intake to Home Care, the **SOC: Lifetime Account** is added (by Intake coordinator). This **Standard of Care** contains core assessments and documentation sets, some of which are **mandatory** and others which are **"Specified"** to be documented according to client need at the discretion of the Case Manager.

Nurse Practitioners may document on some of the specified intervention in the Lifetime account. These assessments include the following: Goals of Care Designation and Advanced Care Planning.

How to Access the Lifetime Account

To access the **Lifetime Account** select the **Lt Document** button from the right button menu. Ensure that you do not have a program selected. Highlight the clients name and enter the Lt Document.



Note **REG CM** in the CM Header can be used to verify the **Lifetime Account (PCS)**.

DOB	CH0001839/06 / CH00072990 / HUBLIVE00783615-FSS
Allergy/AdvReac:	Com Lethbridge REG CM M1 30/07/2017
Interventions	

How to Add the SOC: Lifetime Account

If some of the assessments are not displaying and you are needing to document on them (ie. Advanced Care Planning) follow these steps to add the intervention.

1. **“Mandatory” Assessments:**
 - a. **Intake Assessment Community Care** (Completed by **Intake/Coordinated Access**)
 - b. **Safety Risk Assessment.** Updated upon initial assessment, when significant change(s) occur, upon reassessment periods of Client Group (annually, 90 days).
 - c. **Teach: Client/Family Information Package.** Updated upon initial assessment, when significant change(s) occur, upon reassessment periods of Client Group (annually, 90days).
 - d. **Medical Conditions Community.** Updated upon initial assessment, when significant change(s) occur, upon reassessment periods of Client Group (annually, 90 days).
2. **“Specified” Assessments:**
 - a. **Advanced Care Planning.** Document any advanced care planning discussions (PD/GCD)

Note: As per Continuing Care Health Service Standards we should be discussing Advanced Care Planning regularly.

- b. **Medical History: Past**
- c. **Communication Ability Assessment**
- d. **Client Care Communication.** Only used by **Intake/Coordinated Access**.
- e. **Legal Information** (e.g. Personal Directive, Decision Making, Guardianship, Trusteeship, EPOA)
- f. **Goals of Care Designation (GCD)**

Note: GDC that have been documented after March 14 2017 will display in the header sections of the CM Coordinator Desktop, Process Plans of Care, PCS-Patient Care System, and EMR (Enterprise Medical Record).

- g. **Client Contacts** (use for contacts not identified as the **Person to Notify** and **Next of Kin**)
- h. **Equipment/Supplies Inventory**

Information documented in the Lifetime Account is viewable in EMR. Access the **Lifetime Account** to update this information as needed. All other charting will be completed on the appropriate client **Program Level Account**.

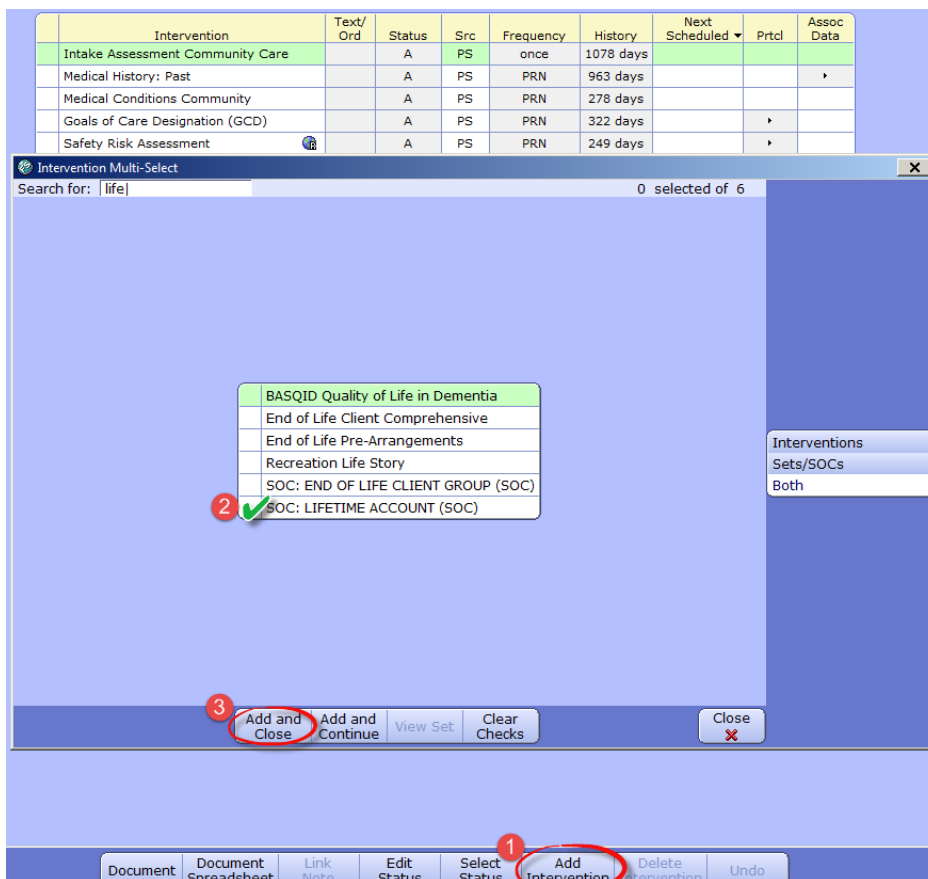
How to Add SOC Intervention in the Lifetime Account

This will be required if the **SOC: Lifetime Account** is not already present in **LT Account** or some assessments from the SOC set are missing (you may see this on clients that have been on Home Care prior to Meditech Update 2014)

If the client already has assessments in the **Lifetime Account** they will be listed on the screen when you enter the PCS environment (**Worklist**). If you need to add the SOC: Lifetime Account, click on footer button **“Add Interventions”** to open the **“Search for”** field.

Note: If the client is new and there are no previous assessments listed, the “**Search for**” field will automatically open.

- a. In the “**Search for**” field, enter the word “**Life**”.
- b. Place check mark beside “**SOC: Lifetime Account**”
- c. Click “**Add & Close**”
- d. Interventions you have added should be magenta on the screen. You can then document as needed on these Interventions.



Intervention	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Data
Intake Assessment Community Care		A	PS	once	1078 days			
Medical History: Past		A	PS	PRN	963 days			
Medical Conditions Community		A	PS	PRN	278 days			
Goals of Care Designation (GCD)		A	PS	PRN	322 days			
Safety Risk Assessment		A	PS	PRN	249 days			

Intervention Multi-Select
Search for: |life| 0 selected of 6

- BASQID Quality of Life in Dementia
- End of Life Client Comprehensive
- End of Life Pre-Arrangements
- Recreation Life Story
- SOC: END OF LIFE CLIENT GROUP (SOC)
- ☒ SOC: LIFETIME ACCOUNT (SOC)

Interventions
Sets/SOCs
Both

Add and Close Add and Continue View Set Clear Checks Close

Document Document Spreadsheet Link Note Edit Status Select Status **Add Intervention** Delete Intervention Undo

Note: If any of these assessment were added previously (they already existed on the **Worklist**) you will see **DUP** in magenta under the **Src Column**. These assessments must be deleted as each assessment should only appear once on the **Worklist**.

How to Delete Duplicate Interventions in Lifetime Account

If Duplicate Assessments are added this will be indicated by **DUP** in magenta under the **Src Column**:

- a. Highlight the single **Duplicate Assessment** or place **checkmarks** to the left of all the Duplicate Assessments that you wish to Delete (**Prior** to any documentation being completed on the Duplicate Intervention)
- b. Select **Delete** Intervention from the bottom tool bar. This will remove the Interventions from your Worklist.

Intervention	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Date
Intake Assessment Community Care		A	PS	once	1078 days			
Medical History: Past		A	PS	PRN	963 days			
Medical Conditions Community		A	PS	PRN	278 days			
Goals of Care Designation (GCD)		A	PS	PRN	322 days			
Safety Risk Assessment		A	PS	PRN	249 days			
Communication Ability Assessment		A	PS	PRN				
Client Care Communication		A	PS	PRN				
Teach: Client/Family Information Package		A	PS	PRN	1064 days			
Legal Information		A	PS	PRN				
Client Contacts		A	PS	PRN				
Equipment/Supplies Inventory		A	PS	PRN	249 days			
✓ Intake Assessment Community Care		A	DUP	On Admission				
✓ Medical History: Past		A	DUP	PRN				
✓ Medical Conditions Community		A	DUP	PRN				
✓ Goals of Care Designation (GCD)		A	DUP	PRN				
✓ Safety Risk Assessment		A	DUP	PRN				
✓ Communication Ability Assessment		A	DUP	PRN				
✓ Client Care Communication		A	DUP	PRN				
✓ Teach: Client/Family Information Package		A	DUP	PRN				
✓ Legal Information		A	DUP	PRN				
✓ Advanced Care Planning		A	NEW	PRN				
✓ Client Contacts		A	DUP	PRN				
✓ Equipment/Supplies Inventory		A	DUP	PRN				

Select and delete all
DUP (Duplicate)
interventions

Document Document Spreadsheet Link Note Edit Status Select Status Add Intervention Delete Intervention Undo

How to use “Document” on Interventions in the Lifetime Account

- Click in box beside desired Intervention to place a check mark in it. Once the Intervention is highlighted, click on footer button **Document** at the bottom of the screen. You can also double click on the Intervention.
- Click **OK** when the date stamp appears

Intervention	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Date
Intake Assessment Community Care		A	PS	once	1078 days			
Medical History: Past		A	PS	PRN	963 days			
Medical Conditions Community		A	PS	PRN	278 days			
✓ Goals of Care Designation (GCD)		A	PS	PRN	322 days			
Safety Risk Assessment								
Communication Ability Assessment								
Client Care Communication								
Teach: Client/Family Information Package								
Legal Information								
Client Contacts								
Equipment/Supplies Inventory								

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Document Date & Time

Date: 25/09/2018

Time: 1353

7 8 9
4 5 6
1 2 3
← 0 T/N

☐ Use Real Time

Cancel OK

Note: The date & time of your date stamp should be reflective of when you actually had the conversation with the client/family.

- Document on selected Intervention.
- Click on **Return**.
- Click on **Save**.

Note: If documenting on more Intervention(s), place a check mark beside each of the desired assessments. Then click on **Document** at the bottom of the screen. Double click on the 1st assessment you want to Document on. Once you have documented on the 1st assessment, click on “Go To” button

on the bottom toolbar to access the next assessment. Repeat until you have documented on all the required Assessments and then **Save**.

How to use “Document Spreadsheet” in Lifetime Account

- In the list of Interventions, place a check mark in the box beside the desired Intervention (for example, Safety Risk Assessment). If you are documenting on more than one Intervention, place a check mark beside each of the desired assessments.
- Click on **Document Spreadsheet** at the bottom of the screen.



- Click **OK** on Date stamp screen.
- Your assessment will appear as a spreadsheet. It will show all previous assessments listed according to date and time they were completed. The last column on the right will display the current date and time in magenta and will be blank. This is where you record your current assessment.
- You can choose to drag documentation from any previous column by clicking on the desired information and dragging it over to your current assessment (do not release mouse click until in new section) or you can drag the entire column by clicking on the Heading/Date field and dragging it to the new column. You **MUST** edit as needed in the new column as this is now your assessment and has your electronic signature attached.
- Double click** on any section of the new column to open that section up and document new information or edit information dragged from a previous assessment.
- Click the **“Save”** button in the bottom right hand toolbar to save your documentation. Then choose either **“Save and Return to Worklist”** (will return to list of all Interventions) or **“Save and Refresh Spreadsheet”** (will save and show what you just charted on).

How to Recall Values in Lifetime Account

Recall Values in the document view allows the user to recall the previous assessment. However, this should be used with extreme caution as it will bring forward information from the last time **each field** was documented on (this may not be from the last assessment, but could be a mix from several assessments). You **MUST** edit the assessment to reflect your assessment as it will have your electronic signature attached. **If completely removing narrative notes, place a period “.” In the comment box to ensure previous notes will not pull into the next assessor’s narrative notes.**



Note: In Lifetime Account most Interventions we should **always** use RECALL VALUES: Legal Information, Goals of Care, Client Contacts, Safety Risk Assessment Community, Medication History: Past, Communication Ability Assessment, Teach: Client/Family Information Package, Equipment/Supplies Inventory.

How to Edit Documentation in Lifetime Account

This can be used to correct an error or to add information that was collected at the same time and was meant to be documented as part of the original documentation. If you are the original Documenter and you have made an error, you can edit your Intervention for up to 3 days after the original documentation. To do this:

- Click on the **History** field of the **Intervention** to be edited on the **Worklist**. A list of assessments will open.

Intervention	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Data
Intake Assessment Community Care		A	PS	once	1078 days			
Medical History: Past		A	PS	PRN	963 days			▶
Medical Conditions Community		A	PS	PRN	278 days			
Goals of Care Designation (GCD)		A	PS	PRN	322 days		▶	
Safety Risk Assessment		A	PS	PRN	249 days		▶	
Communication Ability Assessment		A	PS	PRN				▶
Client Care Communication		A	PS	PRN				
Teach: Client/Family Information Package		A	PS	PRN	1064 days			
Legal Information		A	PS	PRN			▶	
Client Contacts		A	PS	PRN				
Equipment/Supplies Inventory		A	PS	PRN	249 days			

- b. Single click on the arrow in the **assessment** column for the **Intervention** to be edited. This will open the **Intervention**.

Date Done	Time Done	Done by	Entered	Entered by	Assessment	Signatures	Type	Note Link
03/05/2016	1346	Edward Zebra	03/05/2016 1352	Edward Zebra	▶		Document	
24/02/2015	1130	EDDIE ZEBRA	24/02/2015 1130	EDDIE ZEBRA			Add	

- c. Make the appropriate edits or corrections. Click **Return** in the bottom right toolbar.
- d. **Edit** will display in magenta in the **Type** column. The original documentation date and time will remain the same. The date and time of the edit will appear in the **Entered** column once the entry has been saved.
- e. Click **Return** again.
- f. Intervention screen opens with the edit detail in magenta. Click **Save** in the bottom right hand toolbar.

Undo Documentation in Lifetime Account

This can be done if you have documented in error, for example, wrong client or incorrect Date/Time. If you are the original Documenter and you have made an error, you can undo the Intervention up to 3 days after the original documentation. To do this:

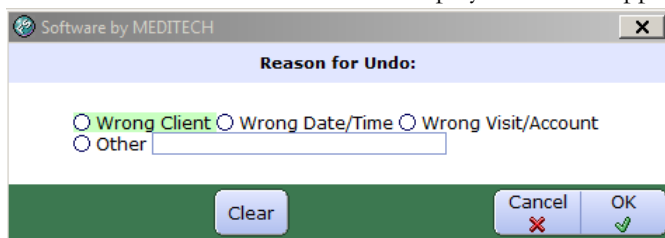
- a. Click on the **“History”** field of the Intervention on the worklist. A list of instances of documentation for the Intervention will open.

Intervention	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Data
Intake Assessment Community Care		A	PS	once	1078 days			
Medical History: Past		A	PS	PRN	963 days			▶
Medical Conditions Community		A	PS	PRN	278 days			
Goals of Care Designation (GCD)		A	PS	PRN	322 days		▶	
Safety Risk Assessment		A	PS	PRN	249 days		▶	
Communication Ability Assessment		A	PS	PRN				▶
Client Care Communication		A	PS	PRN				
Teach: Client/Family Information Package		A	PS	PRN	1064 days			
Legal Information		A	PS	PRN			▶	
Client Contacts		A	PS	PRN				
Equipment/Supplies Inventory		A	PS	PRN	249 days			

- b. **Highlight the Intervention** that contains the documentation to be Undone. If an intervention has been edited, only the edited instance can be undone. You can view the assessment by clicking on it.
- c. Click the **Undo** button at the bottom of the screen.

Date Done	Time Done	Done by	Entered	Entered by	Assessment	Signatures	Type	Note Link
25/09/2018	1401	SHRN Training Acc	25/09/2018 1401	SHRN Training Acc			Document	
03/05/2016	1346	Edward Zebra	03/05/2016 1352	Edward Zebra			Document	
24/02/2015	1130	EDDIE ZEBRA	24/02/2015 1130	EDDIE ZEBRA			Add	

- d. If the Intervention was previously edited, a warning message will display. **This action will undo the assessment documented and all edits, Continue?** Select **Yes**.
- e. The **Reason for Undo** screen will display. Select the appropriate reason for Undoing.



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Reason for Undo:

☐ Wrong Client
 ☐ Wrong Date/Time
 ☐ Wrong Visit/Account
 ☐ Other

- f. Click the **OK** button to file and return to the Intervention History list. The undo will display in magenta in the **Type** column. The original documentation date and time will remain the same. The date and time of the undo will appear in the entered column once the entry has been saved.
- g. Click **Return** in the bottom right hand toolbar.
- h. The date and time of the undo will display in magenta below the Intervention.
- i. Click **Save** in the bottom right hand toolbar.

To exit the Lifetime Account, click on **Exit PCS** to return to Care Manager. If the Exit PCS icon is not on your screen, click **Return** on the bottom right until you see **Exit PCS**. Once Assessments are entered in the Lifetime Account, they can be viewed in EMR.

Program Account

The **Program Account** level contains assessments that are **specific for that Episode of Care**. This is another **Worklist (PCS)** environment. The **Program Account** environment can be verified by referring to **REG REC** written in the upper right hand corner of the PCS screen.

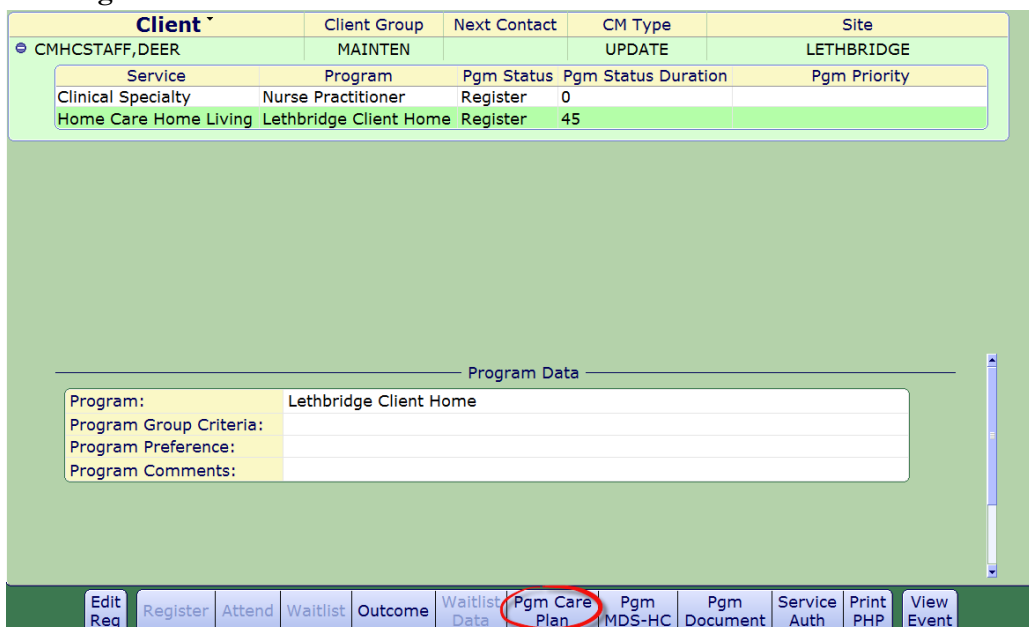


The **Program Account** is where all documentation, by all health professionals pertaining to the client's care during their admission to Home Care will take place. Clients can have multiple Program Accounts. PCS documentation for this account is viewable in EMR. The Electronic **Care Plan** is completed in the appropriate **Program Account** of where the client is being seen.

The **Nurse Practitioner** interventions will need to be added and completed in the appropriate **Program Account** such as Nurse Practitioner Consult Summary & Nurse Practitioner General Assessment

How to Access the Program Account

- In **Person Mode** screen, ensure the correct client is highlighted.
- Select the **(+)** to display programs, ensure the correct program is highlighted.
- Select **Pgm Care Plan** at bottom of screen.



Client	Client Group	Next Contact	CM Type	Site
CMHCSTAFF,DEER	MAINTEN		UPDATE	LETHBRIDGE

Service	Program	Pgm Status	Pgm Status Duration	Pgm Priority
Clinical Specialty	Nurse Practitioner	Register	0	
Home Care Home Living	Lethbridge Client Home	Register	45	

Program Data
 Program: Lethbridge Client Home
 Program Group Criteria:
 Program Preference:
 Program Comments:

Edit Req Register Attend Waitlist Outcome Waitlist Data **Pgm Care Plan** Pgm MDS-HC Pgm Document Service Auth Print PHP View Event

- This will open the **Process Plans** Screen. Here you can access the **Program Account Worklist (PCS)** to document Interventions that were already added.

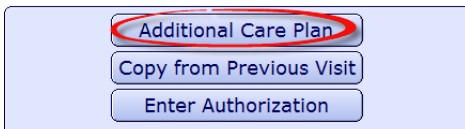
How to Add Program Account Interventions under Omaha Problems

Follow these steps on adding your Nurse Practitioner Consult Summary & Nurse Practitioner General Assessments.

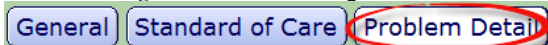
- From the **Process Plans** Screen, click on the **"Enter"** Button from the footer button menu



- Select **Additional Care Plan** from the popup menu



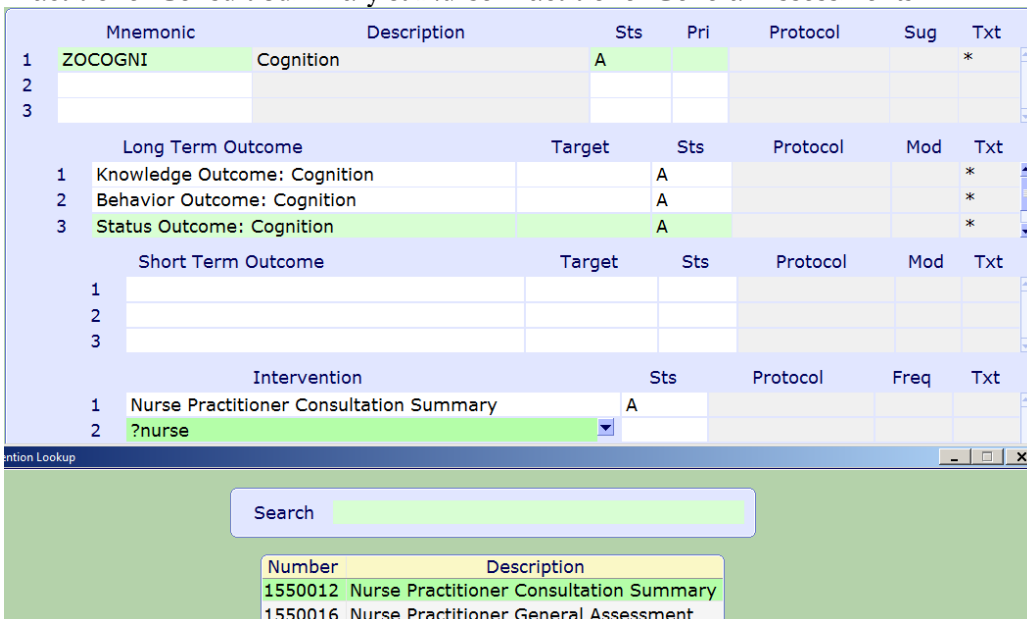
- c. This opens the **Enter/Edit Client's Additional Problems/Interventions** screen
- d. Select the right header button **problem Details** at top of screen



- e. Select the most appropriate Omaha problem that is associated to the reason you are involved in the clients care (ie. orders for behaviors due to Dementia. Link under the Omaha problem of Cognition).

Note: If you feel the client requires a new Omaha problem, you are able to add this problem yourself or connect with the Case Manager to add the Omaha problem and complete the care planning.

- f. Select the appropriate **Omaha Problem**, choose the **Status** Long Term Outcome and add your **Nurse Practitioner Consult Summary & Nurse Practitioner General Assessments**.



	Mnemonic	Description	Sts	Pri	Protocol	Sug	Txt
1	ZOCOONI	Cognition	A				*
2							
3							

	Long Term Outcome	Target	Sts	Protocol	Mod	Txt
1	Knowledge Outcome: Cognition		A			*
2	Behavior Outcome: Cognition		A			*
3	Status Outcome: Cognition		A			*

	Short Term Outcome	Target	Sts	Protocol	Mod	Txt
1						
2						
3						

	Intervention	Sts	Protocol	Freq	Txt
1	Nurse Practitioner Consultation Summary	A			
2	?nurse				

Search

Number	Description
1550012	Nurse Practitioner Consultation Summary
1550016	Nurse Practitioner General Assessment

Tip: When adding your NP interventions insert “?nurse” in the Intervention box to help narrow the search instead of using the drop down arrow as it will list all interventions in Meditech (thousands) for you to scroll through to find.

1. The screen will display three Problems, use the down arrow ↓ on the keyboard to get to a blank line,
2. Use the down arrow to open the **Problem** look up list and choose the appropriate **Problem**,
3. Click on **Problem** to add to the **Care Plan**

Add Frequency

- g. Highlight on each intervention individually and add a **Frequency** for how often you plan or will need to complete your assessments and follow up.

Example. If only a one time referral can use the frequency of ‘ONCE’ and if clients needing ongoing care may be appropriate to use ‘PRN’ if it will not be scheduled visits. If your client will have scheduled follow up can use frequencies like ‘WEEKLY’

Intervention	Sts	Protocol	Freq	Txt
1 >> Nurse Practitioner Consultation Summary	A		*	
2				
3				

Text
Modifier
Frequency

Date	*Time	Frequency
1 "T" for today	0000	drop down arrow or reference Appendix
2		
3		

Date: is always "T" for Today ***Time:** is always '0000' **Frequency:** Reference [Appendix K](#) for options

Note: If you enter a future date, it will not show on the Care Plan until that date. The frequency will automatically change on that date.

- h. Repeat steps e, f and g to add your second intervention and frequency
- i. Select **green check** in bottom right to save.
- j. When "Go to Worklist?" appears, select "**No**"
- k. You will see that the assessments attached to the Omaha Problem will now appear on your **Process Plans** screen as well as your **Worklist (PCS) Program Account**.
1. Proceed to Worklist, PCS or Pgm Document to chart on your Nurse Practitioner interventions.

Edit Frequency

1. Go into the **Pgm Care Plan**, click **Enter** and choose **Additional Care Plan**
2. From the **Problem Detail Tab** find the assessment you choose to change the frequency on,
3. Select the **Frequency** button from the Footer Button menu,
4. Click on the next blank line (**never delete Frequencies**). Enter "**T**" for today, "**0000**" for the Time and "**F9**" or use the arrow to open up list of frequencies,

Mnemonic	Description	Sts	Pri	Protocol	Sug	Txt
1 ZOCONI	Cognition	A				*
2						
3						

Long Term Outcome	Target	Sts	Protocol	Mod	Txt
1 Knowledge Outcome: Cognition		A			*
2 Behavior Outcome: Cognition		A			*
3 Status Outcome: Cognition		A			*

Short Term Outcome	Target	Sts	Protocol	Mod	Txt
1					
2					
3					

Intervention	Sts	Protocol	Freq	Txt
1 >> Nurse Practitioner Consultation Summary	A		*	
2				
3				

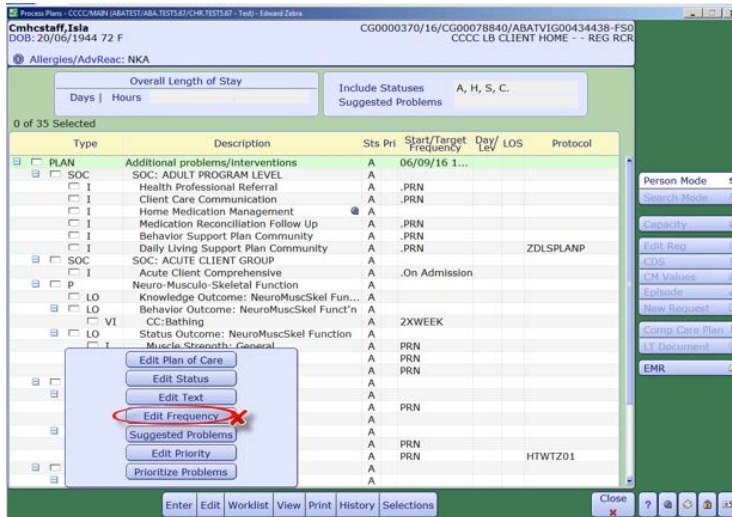
Text
Modifier
Frequency

Date	Time	Frequency
1 25/09/18	0000	ONCE
2 T		
3		

5. Click **SAVE** from **Footer Button** menu or "F12",

Note: If you enter a future date, it will not show on the Care Plan until that date. The frequency will automatically change on that date.

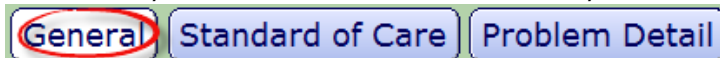
Note: **Do not** change frequencies by using Edit->Edit Frequency as the intervention may not pull forward properly



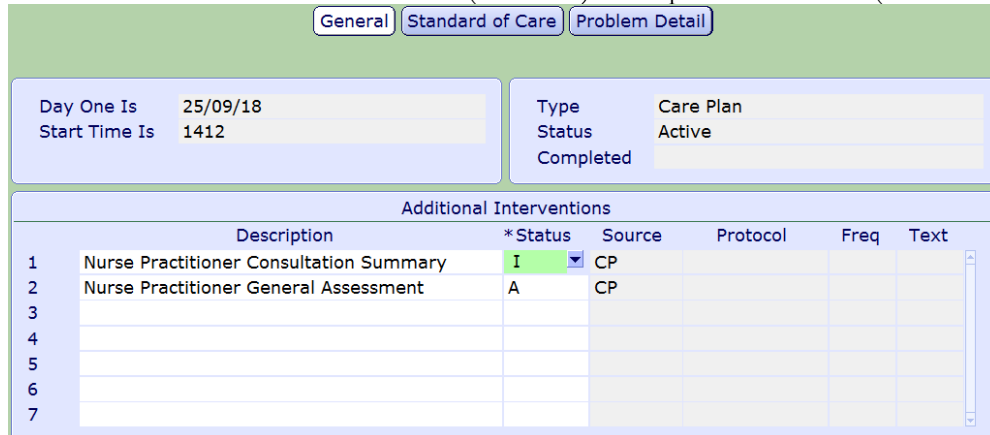
Delete General Tab Interventions

Do not add your Interventions under the General tab. All interventions must be added through an Omaha problem. If your Nurse Practitioner Consult Summary or Nurse Practitioner General Assessment have been added incorrectly or historically under the General tab follow these steps:

- In the **Enter/Edit Client's Additional Problems/Interventions** screen under the **General** tab



- In the *Stats column delete out the "A" (for active) and replace with an "I" (for inactive)



Additional Interventions						
	Description	*Status	Source	Protocol	Freq	Text
1	Nurse Practitioner Consultation Summary	I	CP			
2	Nurse Practitioner General Assessment	A	CP			
3						
4						
5						
6						
7						

- Save the changes.

Note: When going into the PCS to document it will not only display active interventions to chart on.

Ensure that your NP interventions are added properly under an Omaha problem before documenting on them. Follow instructions above on adding interventions under an Omaha problem.

Adding New Problem(s) to the Care Plan

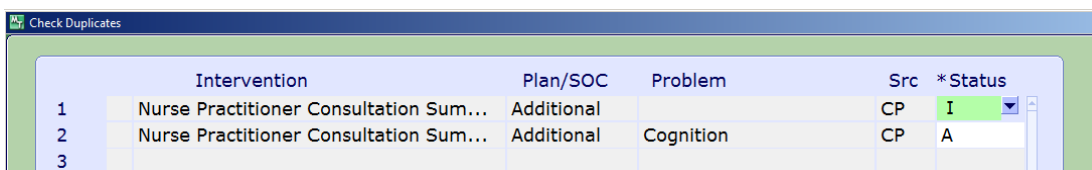
The following steps show **how to add** an **Additional Problem** to the Care Plan that is **NOT** pulled from a Comprehensive Assessment.

4. Ensure you have the correct Client highlighted on the **CM Coordinator desktop**
5. Highlight correct **Program**
6. Click on **Pgm Care Plan** from the **Footer Button** menu,
7. Click on **Enter** button from the **Footer Button** menu,
8. Click on **Additional Care Plan** from the list,
9. This takes you to the **Enter/Edit Additional problems/interventions** screen,
10. Click on the **Problem Detail** section,
11. Use the arrow to open up the **Problem** list and click on **Problem** which will be added to list of Problems,

Duplicate Interventions in the Program Account

If Duplicate Assessments are added this will be indicated by the “Check Duplicate” popup box

- a. Highlight the **status** of the **Duplicate Assessment** to the right of the assessment that you wish to Inactivate (**Prior** to any documentation on the Duplicate Intervention). **Always inactivate Duplicate assessments that are not linked to an Omaha Problem. No interventions should be added under the General tab.**

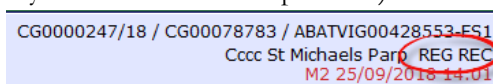


	Intervention	Plan/SOC	Problem	Src	*Status
1	Nurse Practitioner Consultation Sum...	Additional		CP	I
2	Nurse Practitioner Consultation Sum...	Additional	Cognition	CP	A
3					

- b. Select **green check** in bottom right to save.
- c. When “Go to Worklist?” appears, select “No”
- d. The active assessments attached to the Omaha problem will now appear on your **Process Plans of Care** Screen as well as the **Worklist (PCS) Program Account**.

How to Document on Interventions in the Program Account

- a. From the **Process Plans** Screen, select “**Worklist**”
- b. This will take you to the **Program account (PCS)** which is different than the **Lifetime Account** (should say **REG REC** at the top header).



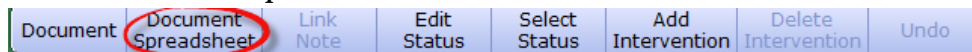
- c. Assessments that have been added to the Program Account (by adding SOCs or by the Care Planning Process) will be listed on the screen when you enter **Program Account** in the PCS environment.
- d. Place a checkmark in the box beside the **desired** Intervention.
- e. With the Intervention highlighted, click on **Document** at the bottom of the screen.
- f. Click **OK** when date stamp appears.
- g. Document on selected Assessment. Click on **Return**.
- h. Once Documentation is completed, click on **Save**.

Note: If you are documenting on more than one Intervention, place a check mark beside each of the desired assessments. Then click on **Document** at the bottom of the screen. Double click on the 1st assessment you want to Document on. Once you have documented on the 1st assessment, click on “**Go To**” button on the bottom toolbar to access the next assessment. Repeat until you have documented on all required Assessments and **Save**.

How to Document Spreadsheet in the Program Account

- a. In the list of Interventions, place a check mark in the box beside the **Intervention**. You can place a check mark beside as many Interventions as you need and they will appear as one long flow sheet for documentation.

- b. Click on **Document Spreadsheet** at the bottom of the screen.



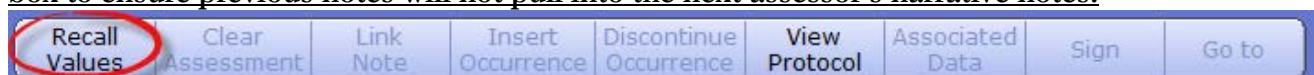
- c. Click **OK** on Date stamp screen.
- d. Your assessment will appear as a spreadsheet. It will show all previous assessments listed according to date and time they were completed. The last column on the right will display the current date and time in magenta and will be blank. This is where you record your current assessment.

	27/09/2018 Thu 11:56 SHRN10	27/09/2018 Thu 11:58 SHRN10
Nurse Practitioner Consultation Summary		Freq: ONCE
NP Consultation Summary Intent		
Type of Report	Interim	
Date of Consultation Visit(s)	October 1, ...	
Acute Consultation Related To	Acute Illness ...	
History of Present Problem		
Client's Perception of Situation		
Most Relevant Medical Diagnoses	CHF ... ▶	
Most Relevant Medications		
Relevant Diagnostic Investigations		
Standardized Assessments Administered		
Relevant Social History and Education		
Interventions Provided		
Prescriptions Ordered	Diuretics	
Other Prescriptions Ordered		
Other Orders	Consults ...	
Recommendations		
Follow Up Plan(s)	labs, DAP ... ▶	
NP Consultation Summary Comment		

- e. You can choose to drag documentation from any previous column by clicking on the desired information and dragging it over to your current assessment (do not release mouse click until in new section) or you can drag the entire column by clicking on the Heading/Date field and dragging it to the new column and then edit as needed in current column. You **MUST** edit as needed in the new column as this is now your assessment and has your electronic signature attached.
- f. **Double click** on any section of the new column to open that section up and document new information or edit information dragged from a previous assessment.
- g. Click the **“Save”** button in the bottom right hand toolbar to save your documentation. Then choose either **“Save and Return to Worklist”** (will return to list of all Interventions) or **“Save and Refresh Spreadsheet”** (will save and show what you just charted on).

How to Recall Values in the Program Account

Recall Values: in the document view, allows the user to recall the previous assessment. However, this should be used with extreme caution as it will bring forward information from the last time **each field** was documented on (this may not be from the last assessment, but could be a mix from several assessments). You **MUST** edit the assessment to reflect your assessment as it will have your electronic signature attached. **If completely removing narrative notes, place a period (.) in the comment box to ensure previous notes will not pull into the next assessor's narrative notes.**



Note: Some Assessments to always use RECALL VALUES: Safety Risk Assessment, Medication History Past, Goals of Care, Communication Ability, Teach: Client/Family Information Package, Legal, Equipment/Supplies Inventory.

How to Edit Documentation in the Program Account


This can be used to correct an error or to add information that was collected at the same time and was meant to be documented as part of the original documentation. If you are the original Documenter and you have made an error, you can edit your Intervention up to 3 days after the original documentation. To do this:

- a. Click on the **History** field of the Intervention to be edited on the work list. A list of instances of documentation for the Intervention will open.

Intervention	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Data
Teach: Disease Process		A	CP	prn				
Nurse Practitioner Consultation Summary		A	CP	ONCE	3 min			
Nurse Practitioner General Assessment		A	CP					

- b. Single click on the **arrow** in the assessment column for the desired Intervention to be edited. This will open the Intervention.

Date Done	Time Done	Done by	Entered	Entered by	Assessment	Signatures	Type	Note Link
27/09/2018	1156	SHRN Training Acc	27/09/2018 1158	SHRN Training Acc			Document	

- c. Make the appropriate edits or corrections. Click  in the bottom right toolbar.
- d. Edit will display in magenta in the **Type** column. The original documentation date and time will remain the same. The date and time of the edit will appear in the Entered column once the entry has been saved.
- e. Click **Return** again.
- f. Intervention screen opens with the edit detail in magenta. Click **Save** in the bottom right hand toolbar.

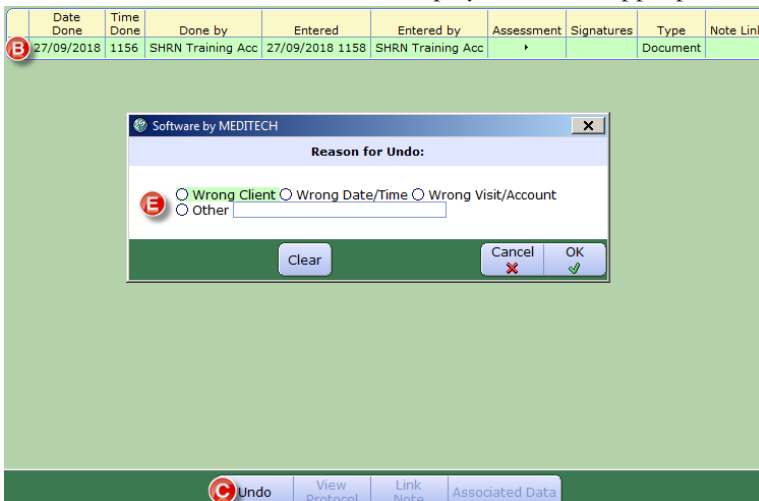
How to Undo Documentation in the Program Account

This can be done if you have documented in error, for example, wrong client or incorrect Date/Time. If you are the original Documenter and you have made an error, you can undo the Intervention up to 3 days after the original documentation. To do this:

- a. Click on the **“History”** field of the Intervention on the work list. A list of instances of documentation for the Intervention will open.

Date Done	Time Done	Done by	Entered	Entered by	Assessment	Signatures	Type	Note Link
27/09/2018	1156	SHRN Training Acc	27/09/2018 1158	SHRN Training Acc			Document	

- b. **Highlight the Intervention** that is to be Undone. If an intervention has been edited, only the edited instance can be undone. You can view the assessment by clicking on it.
- c. Click the **Undo** button at the bottom of the screen.
- d. If the Intervention was previously edited, a warning message will display **“This action will undo the assessment documented and all edits, Continue?”** Select **Yes**.
- e. The **Reason for Undo** screen will display. Select the appropriate reason.



- f. Click the **OK** button to file and return to the Intervention History list. The **Undo** will display in magenta in the **Type** column. The original documentation date and time will remain the same. The date and time of the **Undo** will appear in the **entered column** once the entry has been saved.
- g. Click **Return** in the bottom right hand toolbar.
- h. The date and time of the **Undo** will display in magenta below the Intervention.

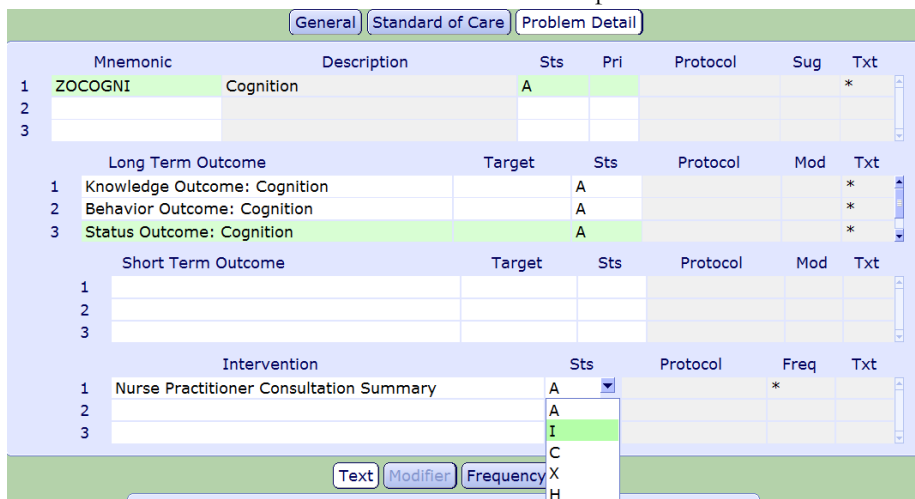
- i. Click **Save** in the bottom right hand toolbar.

To exit the Program Account, click on **Exit PCS** to return to Care Manager. If the Exit PCS icon is not on your screen, click **Return** on the bottom right until you see **Exit PCS**.

How to Inactivate NP Interventions from Care Plan

If you are no longer involved in the clients care you should inactivate the NP interventions as they are no longer active assessments being completed on the client. These steps should be followed before you Outcome the Nurse Practitioner program. To do this:

- a. From the **Process Plans** screen Click on the **Enter** button from the footer menu and select “**Additional Care Plan**” from the drop down menu. This will open the “**Enter/Edit Client’s Additional Problems/Interventions**” screen.
- b. Cursor will default to the **General Tab** section.
- c. Select **Problem Detail** tab
- d. **Highlight the Intervention** you wish to complete and tab to the **status column**.
- e. Do an F9 and select “**I**” for Inactivate from the drop down menu.



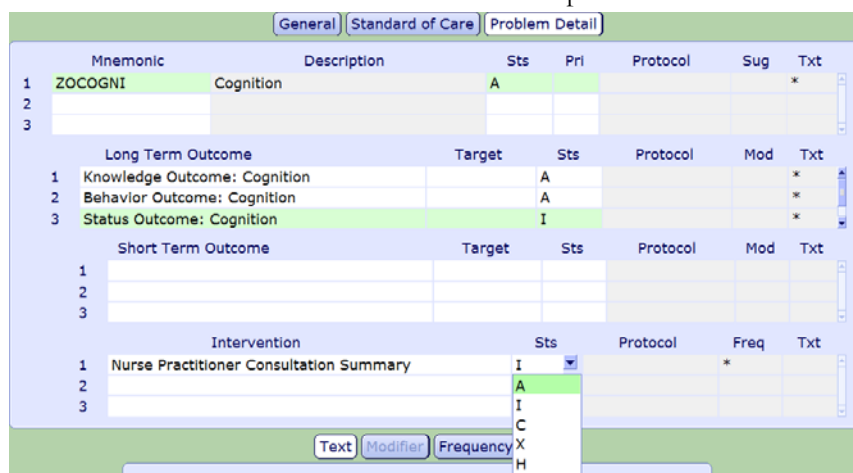
- f. **Save**
- g. The **Intervention** will show as inactive in the **Status column**.
- h. Save and you will get the prompt, “**Go to Worklist**”. Select “No”.
- i. When you refresh your screen the Inactivated Interventions will be hidden in your **Process Plans** screen (CH only) as well as your **Worklist** (CH & PA). You can view any previous charting in EMR. This will **inactivate the intervention and will not display in the PCS to chart on or be printed on the active care plan**.

Note: Charting will never be lost all assessments entered in the Program/Lifetime Accounts in PCS can be viewed in EMR. You can Always re-activate the NP interventions if you are needed to get involved in clients care again, follow steps below for same.

Re-Activate Interventions That are Inactivated

If a client has been referred to you again and they had the Nurse Practitioner interventions added before; follow steps below. First ensure that you are only re-activating the Nurse Practitioner interventions that have been linked to an Omaha problem and are not under the General tab or called 'floating interventions'.

- a. From the **Process Plans** screen Click on the **Enter** button from the footer menu and select **"Additional Care Plan"** from the drop down menu. This will open the **"Enter/Edit Client's Additional Problems/Interventions"** screen.
- b. Curser will default to the **General** tab field.
- c. Select **Problem Detail** tab
- d. Locate and **Highlight the Intervention** you wish to re-activate and tab to the **status** column.
- e. Do an F9 and select **"A"** for Active from the drop down menu.



- f. **Save**
- g. The **Intervention** will show as active in the **Status** column and be viewable to document on in the PCS.

Steps to Complete Intervention(s)

Note: Do not complete the **Intervention** if it is the last **Intervention** listed for a **Problem**. Complete the **Problem** first using **Steps to Complete Problem(s)**. To complete an Intervention:

1. From the Process Plans of Care screen, place a checkmark beside the Intervention that you want to complete,
2. Select the Edit button from the Footer Button menu and select Edit Status from the list menu,
3. The **Edit Status on Selected Items** screen select **Inactive** (Chinook Zone) or **Complete** (Chinook or Palliser Zone),
4. You will notice a **"C"** in the **Status** column beside the **Intervention** you completed.

Note: Interventions with a status of **Inactive** will be hidden (Chinook Zone). To display all Interventions in an **Inactive Status**, select **Selections** from the **Footer Button** menu. This will open the **Select Plan of Care Display** menu. In the **Include Status** section, place a checkmark beside **Display/Inactive**. The **Interventions** will temporarily display on the **Process Plans** screen.

Document Occurrences

This is used when you must document several **Occurrences** for the same assessment, such as assessment on more than one location (e.g. Coccyx ulcer, abdominal incision)

Add an Occurrence

1. From the **Process Plans** screen, click on the **Worklist** button from the Footer Button menu,
2. In the **Worklist (PCS)**, click beside the Intervention and a checkmark will appear,
3. Select **Document** from the Footer Button menu,
4. Document your assessment on “**Location-Occurrence #1**”,
5. To add another **Occurrence**
 - a. Highlight the **Modifier** section
 - b. Click on **Insert Occurrence** on the Footer Button menu
 - c. Another **Occurrence** will be added and labelled “**Occurrence #2**”
 - d. Complete documentation on 2nd Occurrence
6. This process can be repeated as many times as needed for the number of Occurrences required,
7. Complete the remaining sections of the form,
8. Click **SAVE** on the **Footer Button**

Discontinue an Occurrence

1. Once you have added **Occurrences** to an Assessment, these fields will auto populate each time we document on the Assessment.
2. To **Discontinue** an **Occurrence**, select **Document** from the **Footer Button** menu,
3. Click in the **Modifier** section of the **Occurrence** that you would like to remove,
4. Click **Discontinue Occurrence** from the **Footer Button** menu,
5. This will remove that **Occurrence** from your assessment when you,
6. The **Occurrence** will “grey out” when you are viewing the intervention in the **Document Spreadsheet** mode (allows user to view previously active Occurrences and then re-activate them if needed),
7. Complete the remainder of the assessment as required,
8. Ensure you make a note regarding the discontinuance of an Occurrence in the Comment box at the end of the assessment,
9. Click **SAVE** on the **Footer Button**

Update CM Values

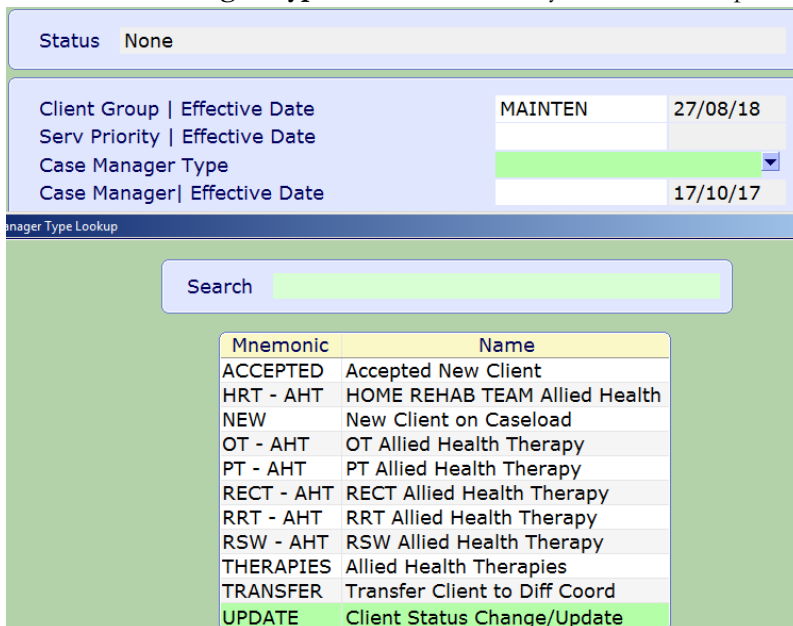
Ensure that you are changing the **CM Values → Case Manger Type** to an **Update** status. This is used to notify the Case Manager that the client has new documentation

Note: All Clinical Specialty staff **MUST** use the **Update** function to notify the Case Manager of any care changes, documentation or notes. This is to trigger the Case Manager that an update has been made to the clients care and they should preview the EMR notes and follow up as needed.

1. From the CM Coordinator screen highlight the client’s name.
2. On the right hand side of the CM Coordinator Desktop screen; select **CM Values**



3. In the **Case Manager Type** field; delete out any text, select drop down or F9, and choose **UPDATE**



Client Group Effective Date	MAINTEN	27/08/18
Serv Priority Effective Date		
Case Manager Type		
Case Manager Effective Date		17/10/17

Mnemonic	Name
ACCEPTED	Accepted New Client
HRT - AHT	HOME REHAB TEAM Allied Health
NEW	New Client on Caseload
OT - AHT	OT Allied Health Therapy
PT - AHT	PT Allied Health Therapy
RECT - AHT	RECT Allied Health Therapy
RRT - AHT	RRT Allied Health Therapy
RSW - AHT	RSW Allied Health Therapy
THERAPIES	Allied Health Therapies
TRANSFER	Transfer Client to Diff Coord
UPDATE	Client Status Change/Update

Note: if the client is already in an Update status you cannot re-update their status. In this case communicate with the Case Manager about following up.

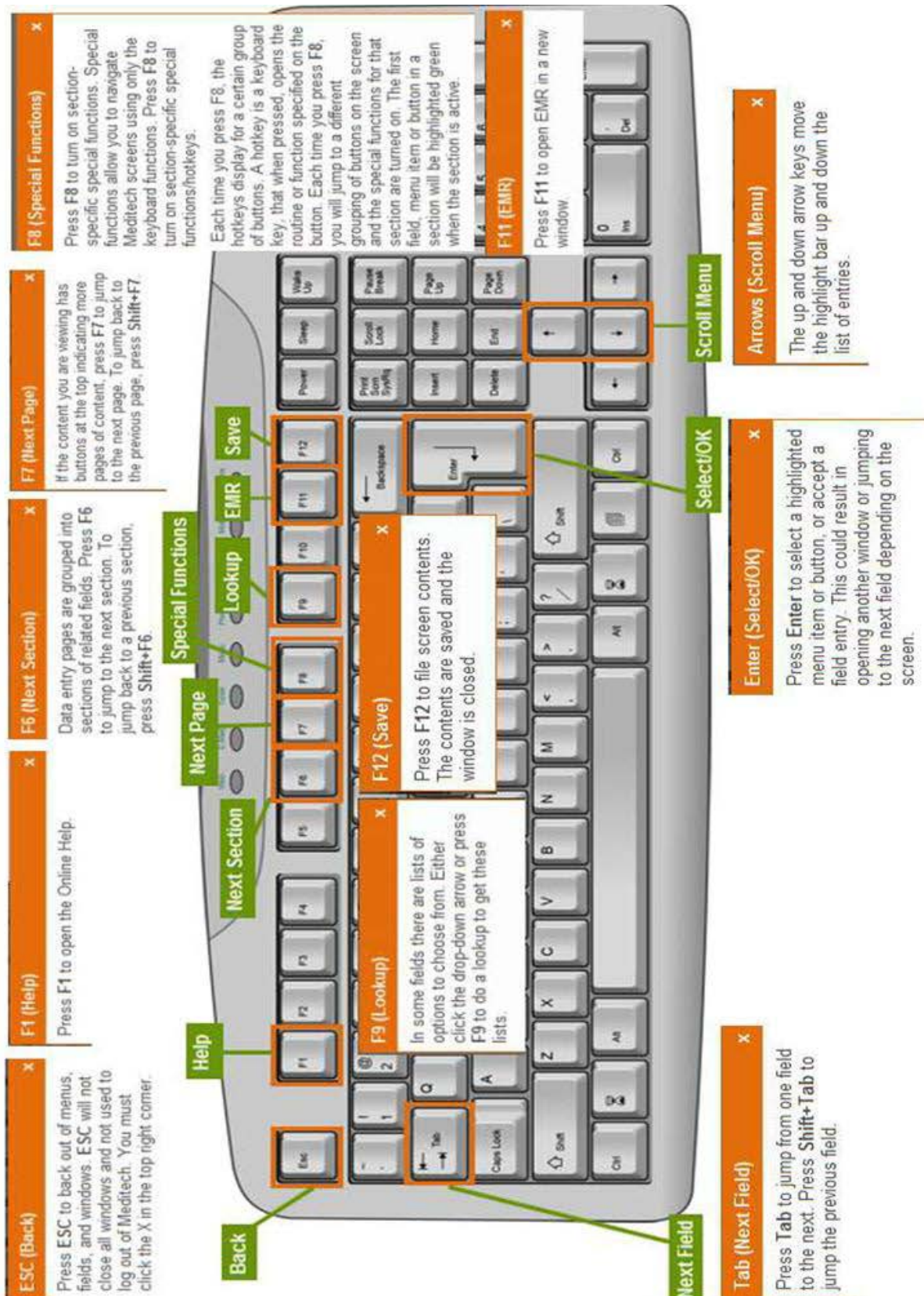
This will notify the Case Manager to look in EMR notes. If there is urgent communication or special detail changes this should not replace other methods of contact, Follow-up with Case Manager via e-mail or telephone. It is the Case Managers responsibility to change clients back into an Accepted status once they preview the EMR

Appendixes & Job Aids

Appendix A: Meditech Short Cuts

T	In Date fields: T = today Date displays as: DDMMYYYY or day, month, year
T+n (T+3)	In date field: T+3=three days in the future. May use other amount of days
T-n (T-2)	T-2=two days in the past. May use other amount of days.
N	In Service Authorization or MDS: N=New
N/LASTNAME	In Name fields: N/plus last name, or portion thereof, will narrow search for Case Manager
SP	Same as Patient / Same Place
SNOK	Same as Next of Kin
SPTN	Same as Person to Notify
SR	Same as Referral
SAC	Same as Caller
Postal Code	In CM Edit Reg, Census Tab, enter Postal Code in City, and the correct information defaults into City, Province, Postal Code, and Residential Code
Shift + Tab	Moves cursor to the next field
Space Bar followed by Enter	When looking a client up, use space bar followed by enter and the last client accessed should default in. Always check to ensure it is the client you want to be accessing.
alt + <u>underlined letter</u>	“Hot key” is used instead of clicking on the button with a mouse
Press Delete + Tab	To Delete a line of information in Care Manager
?___	When looking for interventions typing a “?” followed by the letters in an intervention EG (?Tele) will bring up all interventions with Tele in it.
Ctrl+PrtScn Or Ctrl+Print Screen	Hold Ctrl button down as you press your Print Screen button (should be approximately on the right side of the keyboard along the top buttons) This will make a copy of your full computer screen that you can copy into an email, or copy a word document.
TAB (forward) and SHIFT + TAB (back)	To move curser ACROSS a line

Keyboard Shortcuts



ESC (Back) x
Press ESC to back out of menus, fields, and windows. ESC will not close all windows and not used to log out of Meditech. You must click the X in the top right corner.

F1 (Help) x
Press F1 to open the Online Help.

F5 (Next Section) x
Data entry pages are grouped into sections of related fields. Press F5 to jump to the next section. To jump back to a previous section, press Shift+F5.

F7 (Next Page) x
If the content you are viewing has buttons at the top indicating more pages of content, press F7 to jump to the next page. To jump back to the previous page, press Shift+F7.

F8 (Special Functions) x
Press F8 to turn on section-specific special functions. Special functions allow you to navigate Meditech screens using only the keyboard functions. Press F8 to turn on section-specific special functions/hotkeys.
Each time you press F8, the hotkeys display for a certain group of buttons. A hotkey is a keyboard key, that when pressed, opens the routine or function specified on the button. Each time you press F8, you will jump to a different grouping of buttons on the screen and the special functions for that section are turned on. The first menu item or button in a section will be highlighted green when the section is active.

F9 (Lookup) x
In some fields there are lists of options to choose from. Either click the drop-down arrow or press F9 to do a lookup to get these lists.

F10 (Save) x
Press F12 to file screen contents. The contents are saved and the window is closed.

F11 (EMR) x
Press F11 to open EMR in a new window.

F12 (Save) x
Press F12 to file screen contents. The contents are saved and the window is closed.

Arrows (Scroll Menu) x
The up and down arrow keys move the highlight bar up and down the list of entries.

Enter (Select/OK) x
Press Enter to select a highlighted menu item or button, or accept a field entry. This could result in opening another window or jumping to the next field depending on the screen.

Tab (Next Field) x
Press Tab to jump from one field to the next. Press Shift+Tab to jump the previous field.

Special Functions
Next Page
Next Section
Help
Back
Next Field
Scroll Menu
Select/OK
Enter (Select/OK)
Arrows (Scroll Menu)

Appendix B: Terms Relating to Care Manager Module

Account Number	A consecutive numbering system that gives each person a unique number for the current registration.
CSI Status	Indicates client's status in the Client Service Inquiry. The status is: Open, Assign, Intake & Closed
Program Status	Indicates the status of a Program. The statuses available are: Recommend, Register, Complete, Waitlist and Cancel.
MDS-HC Status	Indicates the status of the MDS-HC Assessment. The Statuses available are: Draft, Complete, Finalized and Xcancelled.
Service Authorization Status	The Service Auth Status help the End-User identify what process the Authorization Form is in. The Statuses available are: Draft, Compiled, Accepted, Finalized and Xcancelled.
Status of an Intervention in Process Plans of Care	The Status of an Intervention in the Process Plans of Care Screen can be one of the following: Active (A), Complete (C), Hold (H), Inactive (I) and XCancel (X.) In the Process Plans of Care screen if the Status of an Intervention is not in the "Active" Status, then the End-User will <u>NOT</u> be able to create a Service Authorization Form needing that specific Intervention.
CM – Care Manager	Community Care Module: Home Care, Continuing Care (Placement Office), Community Rehabilitation Program, Specialty Programs, e.g. DEP, Seniors Resource, Chronic Disease
File	The Meditech word to "save" or record the added information into the client's electronic record. The File function is used to "send" orders to the performing department.
Mnemonic	An abbreviation or code for items on a selection list, e.g. facility, service, program, physician, etc.
Sites	The Care Centre or Community Health Centre where the client's is registered.
Unit Number	The Meditech program's name for the client's Medical Record Number. Patients have the same Unit number for all visits to a facility, allowing the Health Records department to keep old charts together.

Appendix C: Acronyms and Definitions

AADL— Alberta Aids to Daily Living

ACCIS—Alberta Continuing Care Information System. The ACCIS system collects data specific to Home Care patients including demographic data, admission data, RAI, intervention data, transfers and discharges.

ADL Hierarchy—This Outcome Measure from the RAI-HC measures ADL performance. It is a 6-point value with 0 reflecting Independence and 6 reflecting total dependence. It is a valid measurement of ADL function and is also reliable to assess ADL impairment over time

AHS— Alberta Health Services

AIS—Assessment Intelligence System. Web based ELearning Solutions which provide additional computer based learning for Inter-RAI assessments, including the RAI-HC and RAI 2.0.

Assessment— A health care organization-defined questionnaire used to collect client information also called Interventions

CAPs—Client Assessment Protocols. The presence of an accurate RAI-HC assessment lays the ground work for all processes that follow, including identification of problems, causes and associated conditions, and specification of necessary care goals and related approaches to care. CAPs provide guidelines for further assessment and individualized care planning. The RAI-HC can trigger up to 30 different CAPs

CDS—Customer Defined Screen. Screens created that will capture data not captured on standard Meditech screens (example: CSB Type)

CHESS Scale—This outcome scale from the RAI-HC is a 6-point scale designed to be a predictor of health instability and frailty. A score of 0 means the client has no symptoms present while the high-end score of 5 represents a client with very unstable medical conditions and a poor long-term survival rate. A score of 5 at the time of assessment would be predictive of a length of life of less than 30 days

CIHI—Canadian Institute for Health Information. An independent, national, not-for-profit organization working to improve the health of Canadians and the health care system by providing quality health information. CIHI works closely with Inter-RAI to support comprehensive assessment through standardized education. They also work with Healthcare Agencies to support implementation and in turn, receive submission data in relation to Government policy

CPS—Cognitive Performance Scale. Calculated from the **RAI-HC**, it is a hierarchical index used to rate the **cognitive status** of clients. It has been validated against the Mini Mental State Examination and the Test for Severe Impairment. It has a score of 0, Intact, to 6, very severe impairment

CWS—Community Wide Scheduling

Downtime—A description of when the computer system is not available due to system outage, or lack of connectivity with our laptops

DRS—Depression Rating Scale. The DRS can be used as a clinical indicator of depression. Scores above 3 indicate depressive disorders

E-charting—Electronic Charting—Charting done electronically in the computer as opposed to on paper

EMR—Enterprise Medical Record. The EMR represents the patient's online medical record. A tool to view all clinical and administrative data for a patient in one centralized location. Visit data is streamlined, centralized, updated on a real-time basis, and never purges. The **EMR collects, stores, and displays clinical data for patients**

Frequency—The number of times that an Intervention is administered to a client. Also referred to as directions

HCRS—Home Care Reporting System

HCQIs—Home Care Quality Indicators

Intervention—A task or action that a caregiver performs that is directly related to client care also called Assessments

Intervention Status—An Intervention can have any of the following statuses:

Active (A)—are current care delivery responsibilities

Cancelled (X)—entered in error –use only in rare cases

Complete (C)—no longer necessary in the current phase of care, but which appears on the plan of care to show a true picture of the client's progress

Discharged (D)—are no longer being delivered because a client has been released from the current program or from Community Care

Inactive (I)—an inactive item

Hold (H)—has been temporarily stopped

Stopped (S)—a system generated status when an Intervention as reached the stop date. Would not be selected by the end user

MAPLe—Method for Assigning Priority Level. The MAPLe is an algorithm that uses data from the RAI-HC to create a score that is an indicator of stability of the client's current health and living situation. It assists with identifying clients at risk for requiring a change in living/support options

MPI – Master Patient Index

Omaha System — Contains Problems, Modifiers and Outcomes and enables the building of client specific Care plans.

Omaha Modifiers — Refers to two sets of terms (Individual, Family, Community and Health Promotion, Potential, Actual) used in conjunction with problems, which allows practitioners to identify to whom the problem pertains and degree of severity in relation to client strengths, concerns, risk factors , signs and symptoms

Omaha Outcomes —

Knowledge Outcome: Ability of client to remember and interpret information (what the client knows)

Behaviour Outcome: Observable responses, actions, or activities of the client fitting the occasion or purpose (what the client does)

Status Outcome: Condition of the client in relation to objective and subjective defining characteristics (number and severity of client's signs and symptoms or predicament)

Omaha Problems—A potential or actual need that requires Intervention by a caregiver

Outcome Scales—A series of related items from the RAI-HC that are grouped together to help describe the client. The Outcome Scales available from the RAI-HC include the CPS, DRS, ADL Hierarchy, CHESS, Pain Scale, ADL Short Form, ADL Long Form, IADL Difficulty, IADL Summary, IADL Involvement, and MAPLe

Pain Scale—An **Outcome Scale** from the **RAI-HC** that has been shown to be highly predictive of pain when compared to the Pain Thermometer, Numeric Rating Scale, Visual Analog Scale and the Verbal Descriptor Scale. It has a range from 0, no pain to 3, severe daily pain

PCS—Patient Care System. On-line, multidisciplinary clinical documentation, driven by the Patient's (Client's) Plan of care

PHN—Personal Health Number (see ULI)

Plan of Care—A group of **Problems**, **Outcomes**, and **Interventions** assigned to a client

Process Plans—Name of the screen where **Plan of Care** is seen in Meditech

Protocol—A protocol is an instruction or information on how to perform a procedure regarding policy, procedures, or research studies

RAI HC — Resident Assessment Instrument for Home Care

ULI—Unique Lifetime Identifier. Usually the same as the PHN

VI—Seen on the Process Plans of Care screen in front of Interventions which are assigned to a Vendor. The **V** appears once the Service Authorization takes effect

Worklist—Accessed from the Process Plans of Care screen through the **W** button. A list of Interventions scheduled for a client

Appendix D: Terms & Definitions Relating to Meditech

Other Terms & Definitions Relating to Meditech	
ADM	<ul style="list-style-type: none"> Admissions – in the Acute Care Module
EMR – Enterprise Medical Record	<ul style="list-style-type: none"> The EMR represents the patient's online medical record. A tool to view all clinical and administrative data for a patient in one centralized location. Visit data is streamlined, centralized, updated on a real-time basis, and never purges. The EMR collects, stores, and displays clinical data for patients within a community or region.
HCIS	<ul style="list-style-type: none"> Health Care Information System
InterRAI – International Resident Assessment Instrument	<ul style="list-style-type: none"> Comprehensive interdisciplinary standardized instrument for assessing and evaluating needs, strengths and preferences of elderly clients is a collaborative network of researchers in over 20 countries committed to improving health care for persons who are elderly, frail, or disabled.
ITS – Imaging & Therapeutic Services	<ul style="list-style-type: none"> Rehabilitative Services, Cardiology, Respiratory, and Diagnostic Imaging
MDS-HC Minimum Data Set for H.C.	<ul style="list-style-type: none"> Is the screening component that enables a home care provider to assess multiple key domains of function, health, social support, and use of service
MM – Material Management	<ul style="list-style-type: none"> Purchases and Inventory
NFS	<ul style="list-style-type: none"> Nutrition & Food Services in Acute Care Module
OE – Order Entry	<ul style="list-style-type: none"> Orders for clients sent to ITS, Lab, NFS, and Pharmacy from Acute/LTC facilities.
RSHIP –Regional Shared Health Information Project	<ul style="list-style-type: none"> Comprised of the seven non-metro Regional Health Authorities have adopted a collaborative vision to install a common Meditech Health Information System across all non-metro regions.

Appendix H: Program Outcome & Episode End Reason Definitions

Definition of Continuing Care: For the purpose of this document Continuing Care includes all services being provided within the AHS Seniors Health streams of Home Living, Supportive Living, Transition Services, Clinical Specialty Services, and Long Term Care (LTC) Facility Living.

A. Outcome a Program: Choosing a Program Outcome Reason.

When a Program is no longer required for a client, the Program is completed and a *Program Outcome Reason* is selected, based on the reason the client no longer requires the Program. The current Episode remains active if the client is still receiving some services/programs from Continuing

Refer to Table A: Program Outcome and Episode Completion Descriptors including Definitions for Continuing Care.

B. Ending an Episode of Care (Discharge): Choosing an Episode Completion Reason

When a client is no longer receiving any services from Continuing Care, the Episode is completed and an *Episode Completion Reason* is selected based on the reason the client no longer requires further services.

- The Episode will also be completed once a Continuing Care client in the LTC Facility Living stream is in their bed of choice – See Note 3
- Applicable Episode Completion Reasons will have a different mnemonic than the Program Outcome Reasons mnemonic; however both will have the same descriptor and definition/explanation as listed in Table A.

Table A: Program Outcome and Episode Completion Descriptors Including Definitions for Continuing Care

Program Outcome Reason Mnemonic	Episode Completion Reason Mnemonic	Descriptor	Definition/Explanation
CANCEL	N/A	Cancel Program	<ul style="list-style-type: none"> • Program was Recommended or Waitlisted and is no longer required by the client.
CMEX	EXPIRED	Client Expired	<ul style="list-style-type: none"> • Client deceased and services are no longer required
CMINCPR	N/A	Incorrect Program	<ul style="list-style-type: none"> • Program was Recommended or Registered in error or an alternate equivalent Program has been selected.
CMMERGE	MERGED	Client Merged	<ul style="list-style-type: none"> • Do not use - Selection is used <u>only</u> by advanced users in consultation with Health Information Management (HIM) • Program/Episode closed because the client's file will be discharged and merged into a second active file.
CMMVRG	MOVED	Client moved, Episode ended	<ul style="list-style-type: none"> • Episode will be completed because client has moved to a new HCIS/Zone
CMNLE	CLNLELIG	No longer eligible for service	<ul style="list-style-type: none"> • Client does not meet criteria for continued services and Program is ended.
CMNLR	N/A	Service/Program Complete	<ul style="list-style-type: none"> • Client and Health Care Professional in agreement to end services of Program as unmet needs have now been met. <u>Current Episode remains active as client is still receiving some services or Programs from Continuing Care.</u> * See note 1
CMNLRED	CLNLRSV	No service reqd, Episode end	<ul style="list-style-type: none"> • Client is no longer receiving any service or program from Continuing Care, Episode ended *See note 1

CMROHS	CLROTHHSV	Refer other serv, Episode end	<ul style="list-style-type: none"> • Service/Program ended as client to receive services not available from within Continuing Care (e.g. WCB, Veterans Affairs, community rehab). OR client is moving to a bed of choice within the LTC Facility stream. Episode ended. * See note 3 **Change to definition**
CMSTOHS	STOHS	Service term due to OH&S issue	<ul style="list-style-type: none"> • Service or Program terminated related to an OH&S issue(s) • This relates to situations that pose a risk for staff that cannot be managed including physical environment and other situations (e.g. very obese client unwilling to use adequate equipment for transfers)
CMTRPRG	N/A	Client transferred	<ul style="list-style-type: none"> • Episode remains active but client is now registered into a new service or program. *See note 2
CMUNCONT	UCONTC	Unable to contact/reach client	<ul style="list-style-type: none"> • Health Care Professional unable to make contact or reach the client in person or by telephone after multiple attempts
CMWDT	CLWTSV	CI withdrew /terminated service	<ul style="list-style-type: none"> • Client elected to withdraw or terminate services of a program with or without support of Health Care Professional. • Used when further professional or support services could be provided, but the client has refused any additional services.
N/A	REGERR	Incorrect LTA Registration	<ul style="list-style-type: none"> • Do not use - Selection is used only by advanced users in consultation with Health Information Management (HIM) • Lifetime Account was incorrectly registered

* Items in **bold print** highlight definitions and descriptors that have changed significantly

Note: The *Program Outcome or Episode Completion Reason*: “No longer requires Service” has been replaced by “Service/Program Complete” and “No service reqd Episode end”. Please ensure you have a clear understanding of when to correctly use each of these reasons.

Note: It is very important to have a good understanding of a client transfer. Do not end the Episode when the client is still receiving services in Continuing Care Program (unless they are now in a LTC Facility Living stream in their bed of choice).

Use “Client transferred” when the primary responsibility for the client’s needs has changed to a different Continuing Care Program (e.g. Home Care program is being completed and another program is being recommended or is registered, the person responsible for the other program will now become the case manager).

Do not use “Client transferred” for caseload transfers within a program (e.g. transferring from one nurse to another nurse within the same office).

Use another Program outcome reason when your Program is finished but the Program with primary responsibility for the client’s needs remains unchanged (e.g. Home Care Nurse is the case manager, client has both a Home Care and an OT program registered. OT is now done providing service to the client, the reason for completion of the OT program would be “Service/Program Complete”).

Note: A client who has moved into a LTC Facility and is in their bed of choice, the Episode is ended. The LTC facility program will remain in a register status.

If the client later requires services from another Continuing Care Program, an Episode and new Program registration will be opened for that Program.

“Client moved, episode ended” would not be used for a client moving into a Supportive Living facility within our HCIS/Zone as the client will continue with service on the current active Episode

Appendix J: Method of Funding Definitions

METHOD OF FUNDING SERVICES DEFINITIONS		
Mnemonic	CM Summarized Definition	ACCIS Definition
BF	Block Funded	<ul style="list-style-type: none"> Is a method of funding where an a delivery site receives funds from Alberta Health Services in exchange for providing services to clients who reside in a congregate living setting (e.g. LTC, Supportive Living 3, 4, 4D) ** Not a Lodge **
DS	Direct Service	<ul style="list-style-type: none"> Is a method of funding where clients receive services from staff that are employed / funded directly by Alberta Health Services
FFS	Fee for Service – Contracted	<ul style="list-style-type: none"> Is a method of funding where services are contracted out to a service agency that invoices Alberta Health Services
SM	Self-Managed	<ul style="list-style-type: none"> Is a method of funding where a client receives funds from Alberta Health Services and is empowered to hire their own caregiver(s) to meet their assessed needs. Guardian Managed Care arrangements are considered a form of self-managed care
		<ul style="list-style-type: none">

In the event that a clients is receiving services that are funded by multiple methods, code the funding category that covers the majority of the services for that client.

Appendix K: Frequency Formatting

Frequency F9 (Drop down List) {Combination of both Chinook and Palliser Meditech rings}

Meditech Format (Mnemonic)	Description	Meditech Format (Mnemonic)	Description
2XWEEK	2 Times Weekly	BRKFST	Breakfast
3XWEEK	3 Times Weekly	BRKFST, LUNCH	Breakfast and Lunch
4XWEEK	4 Times Weekly	DAILY	Daily
5X DLY	5 Times a Day	HS	Daily at Bedtime
5XWEEK	5 Times Weekly	LUNCH	Daily at Lunch
6XWEEK	6 times Weekly	LUNCH, SUPPER	At Lunch and Supper
AM, LUNCH, BEDTIME	In Morning, at Lunch at Bedtime	PRN	As Needed
AM, LUNCH, SUPPER, BED	Daily in the Am, Lunch, Supper and Bedtime	ONCE	Once Only
AMHS	Daily in Morning and at Bedtime	Q2DW	Every 2 Days
BEDTIME	Daily at Bedtime	Q4HWA	Every 4 Hours while awake
AS DIRECTED	As Directed	QAM	Daily in the Mornings
AS ORDERED	As Ordered	QID	4 Times a Day
BID	Twice Daily	TID	Three times a Day
BIDM	At Breakfast and Supper	Weekly	1 Time Weekly

Comments

- Only use weekly formats when day of the week is not predetermined. If the day of the week is important use Meditech Format for Days of the week.
- PRN should only be used in Interventions that are not done on a regular basis and the schedule
- Capital letters, commas and spacing are important and must be used correctly

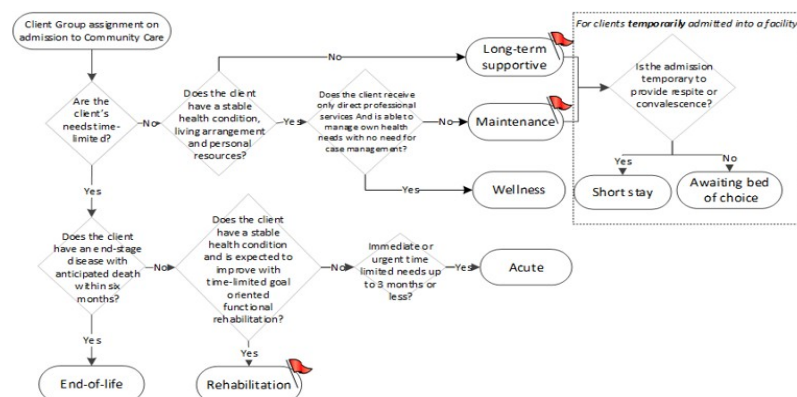
Directions for Format	Example	Meaning
QnnD (every nn days)	Q2D=every 2 days, Q42D = every 6 weeks	Beginning at the specified start date and every 2 days thereafter
QnnH (every nn hours)	Q4H	Beginning at the specified start time and every 4 hours thereafter
Q14D	Q14 Days	Once every other week
Q28D	Q28D	To occur on the same day of the week each month
Multiple time entries separated by a comma	08,10,12,16	0800,1000,1200,1600
A sequence of two letter abbreviation for days of the week; no spacing between	MoWeFr	Monday, Wednesday, and Friday
A combination of specific days and times with the @symbol	MoWeFr@08,17	Every Monday, Wednesday and Friday at 0800 and 1700

Appendix O: Client Group Definitions

All clients will be assigned to a client group based on their health status. The type will be initially assigned by the Access Centre RN or Community Transition Team RN, but will be reviewed by the Case Manager after an initial assessment is done and changed if appropriate. It may also be changed when there is a significant change in the client's status. When assigning client group, refer to the primary need/goal of care.

- **Acute:** a client who needs immediate or urgent time limited (up to 3 months or less) interventions to improve or stabilize a medical or post-surgical condition.
- **End of Life:** a client with an end-stage disease for whom death is anticipated within six months; however, the timeline for death should not be the pivotal criteria for determining end-of-life as a client's group.
- **Rehabilitation:** a client with a stable health condition that is expected to improve with a time-limited focus on goal-orientated, functional rehabilitation. The rehabilitation care plan specifies goals and expected duration of therapy.
- **Long-term Supportive:** a client who is at significant risk of institutionalization due to unstable, chronic health conditions, and/or living condition(s) and/or personal resources.
- **Maintenance:** a client with stable chronic health conditions, stable living conditions and stable personal resources, who requires ongoing support to remain at home.
- **Awaiting Bed of Choice:** a client who has been transferred to a long-term care facility; however, the facility is no their preferred bed of choice. The client remains a community care client, regardless of the need for services, until they are successfully transferred to their preferred bed of choice.
- **Wellness:** receives only professional service for a single unmet need and does not require case management by AHS Continuing Care. The Wellness client has stable health condition(s), living arrangements and personal resources and is otherwise able to identify and manage his/her health needs. A Wellness client is expected to require AHS Continuing Care services for longer than 3 months.
- **Short Stay:** a maintenance or long-term supportive client that is temporarily residing (up to 28 days or less) in a supportive living or long-term care facility (i.e. respite services) Discontinue an Occurrence

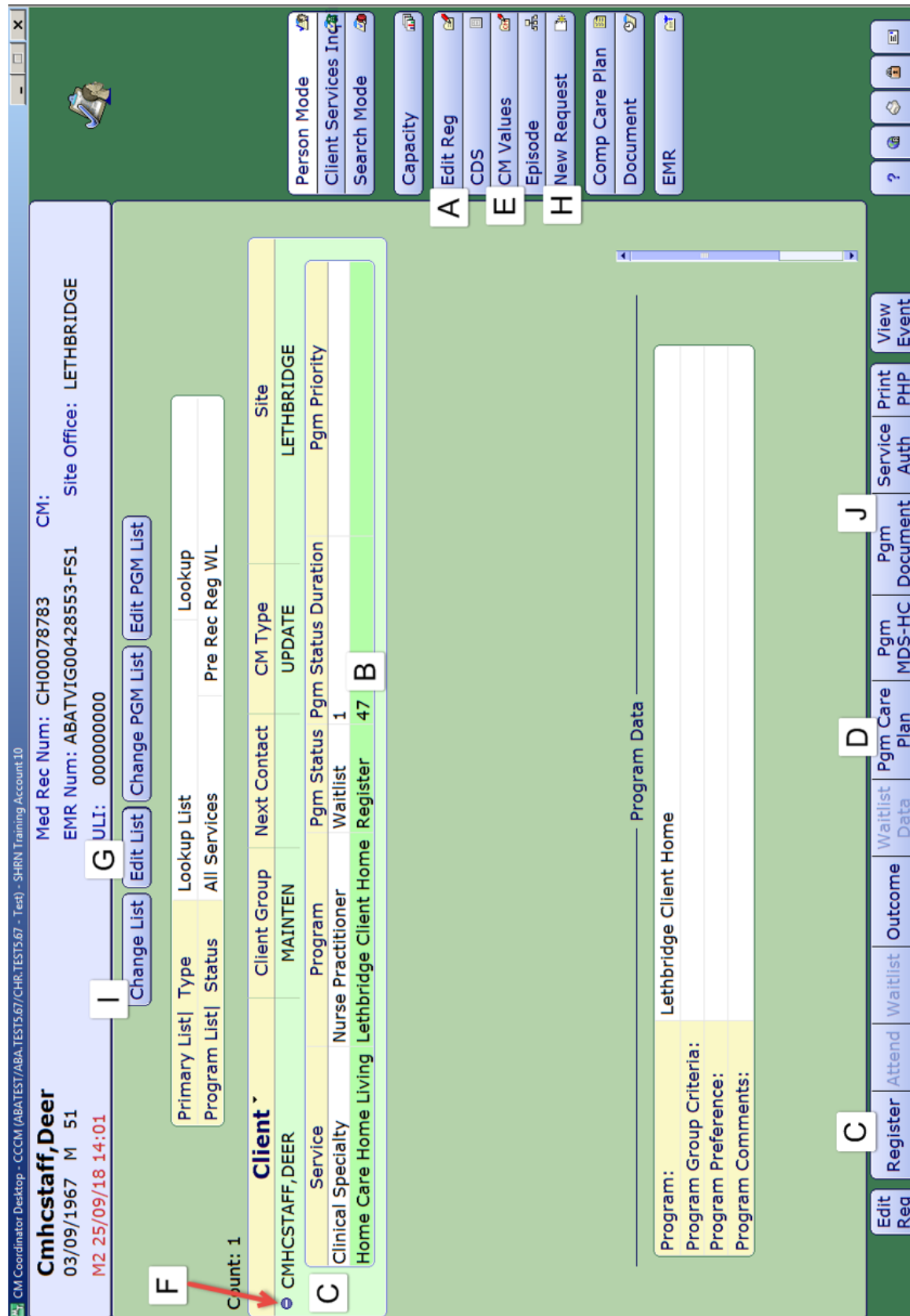
Client Group Decision Tree



Appendix X: Omaha Care Plan Problems & Definitions

Problem Name	Problem Definition
Abuse	Child or adult subjected to non-accidental physical, emotional, or sexual violence or injury.
Bowel Function	Transporting food through the gastrointestinal tract to eliminate wastes.
Caretaking/Parenting	Providing support, nurturance, stimulation, and physical care for dependent child or adult.
Circulation	Pumping blood in adequate amounts and pressure throughout the body.
Cognition	Cognition: Ability to think and use information.
Communicable/Infectious Condition	State in which organisms invade/infest and produce superficial or systemic illness with the potential for spreading or transmission.
Communication with Community Resources	Communication with community resources: Interaction between the individual/family/community and social service
Digestion-Hydration	Process of converting food into forms that can be absorbed and assimilated, and maintaining fluid balance.
Grief	Suffering and distress associated with loss.
Growth and Development	Progressive physical, emotional, and social maturation along the age continuum from birth to death.
Health Care Supervision	Management of the health care treatment plan by health care providers
Hearing	Perception of sound by the ears.
Income	Income = Money from wages, pensions, subsidies, interest, dividends, or other sources available for living and health care
Interpersonal Relationship	Associations or bonds between the individual/family/community and others.
Medication Regimen	Use or application of over-the-counter and prescribed/recommended medications and infusions to meet guidelines for therapeutic action, safety, and
Mental Health	Development and use of mental/emotional abilities to adjust to life situations, interact with others, and engage in activities.
Neglect	Child or adult deprived of minimally accepted standards of food, shelter, clothing, or care.
Neighborhood/Workplace Safety	Freedom from illness, injury or loss in the community or place of employment.
Neuro-Musculo-Skeletal Function	Ability of nerves, muscles, and bones to perform or coordinate specific movement, sensation, or regulation.
Nutrition	Select, consume, and use food and fluids for energy, maintenance, growth, and health.
Oral Health	Condition of the mouth and gums and the number, type, and arrangement of the teeth.
Pain	Unpleasant sensory and emotional experience associated with actual or potential tissue damage.
Personal Care	Management of personal cleanliness and dressing.
Physical Activity	State or quality of body movements during daily living.
Reproductive Function	Condition of the genital organs and breasts and the ability to reproduce.
Residence	Living area
Respiration	Inhaling and exhaling air into the body and exchanging oxygen.
Role Change	Additions to or removal of a set of expected behavioral characteristics.
Sanitation	Environmental cleanliness and precautions against infection and disease.
Sexuality	Attitudes, feelings, and behaviors related to intimacy and sexual activity.
Skin	Natural covering of the body.
Sleep and Rest Patterns	Periods of suspended motor and sensory activity and periods of inactivity, repose, or mental calm.
Social Contact	Interaction between the individual/family/community and others outside the immediate living area.
Speech and Language	Use of articulated vocal sounds, symbols, signs, or gestures for communication.
Spirituality	Beliefs and practices that involve faith, religion, values, the spirit, and/or the soul.
Substance Use	Consumption of medicines, recreational drugs, or other materials likely to cause mood changes and/or psychological/physical dependence, illness, and disease.
Urinary Function	Production and excretion of urine.
Vision	Act or power of sensing with the eyes.

Appendix Y: Teaching Exercise Matching Diagram



CM Coordinator Desktop - CCCM (ABATEST/ABA.TEST/5.67/CHR.TEST/5.67 - Test) - SHRN Training Account 10

Cmhcstaff, Deer
03/09/1967 M 51
M2 25/09/18 14:01

Med Rec Num: CH00078783 CM:
EMR Num: ABATVIG00428553-FS1 Site Office: LETHBRIDGE
G UI: 000000000

I Change List Edit List Change PGM List Edit PGM List

Primary List| Type Lookup List
Program List| Status All Services Pre Rec Reg WL

F Count: 1

Client *		Client Group	Next Contact	CM Type	Site
CMHCSTAFF, DEER		MAINTEN		UPDATE	LETHBRIDGE

C

Service	Program	Pgm Status	Pgm Status Duration	Waitlist	Pgm Priority
Clinical Specialty	Nurse Practitioner			1	
Home Care Home Living	Lethbridge Client Home Register	47			

B

A Edit Reg
E CDS
H CM Values
Episode
New Request
Comp Care Plan
Document
EMR

Program: Lethbridge Client Home
Program Group Criteria:
Program Preference:
Program Comments:

D Waitlist Data Pgm Care Plan Pgm MDS-HC Pgm Document Service Auth Print PHP View Event
J

C Edit Reg Register Attend Waitlist Outcome

Teaching Exercise: Matching Exercise Question

After Training

1. Which button would you click to display list options (i.e. Lookup, Custom List, NP Recommend, etc.)? _____
2. Which button would you click to add or delete clients from your Custom List? _____
3. Where on the screen would you click to display the list of a client's programs? _____
4. Where on the screen would you highlight before you client on LT Document to document in the LT account PCS? _____
5. Where on the screen do you need to highlight to access the footer buttons? (i.e. Pgm Care Plan, Pgm Document, Register, etc.)? _____
6. Which button would you click to change the Service Location address of a client? _____
7. Which button would you click to change the clients Status? _____
8. Which button would you click to refer a client to the Nurse Practitioner Program? _____
9. With the primary program highlighted which button would you click to access the Care Plan? _____
10. What button would you select to Accept (Register) a Recommended client into your program? _____
11. What button would you choose to document on the NP interventions in the PCS? _____

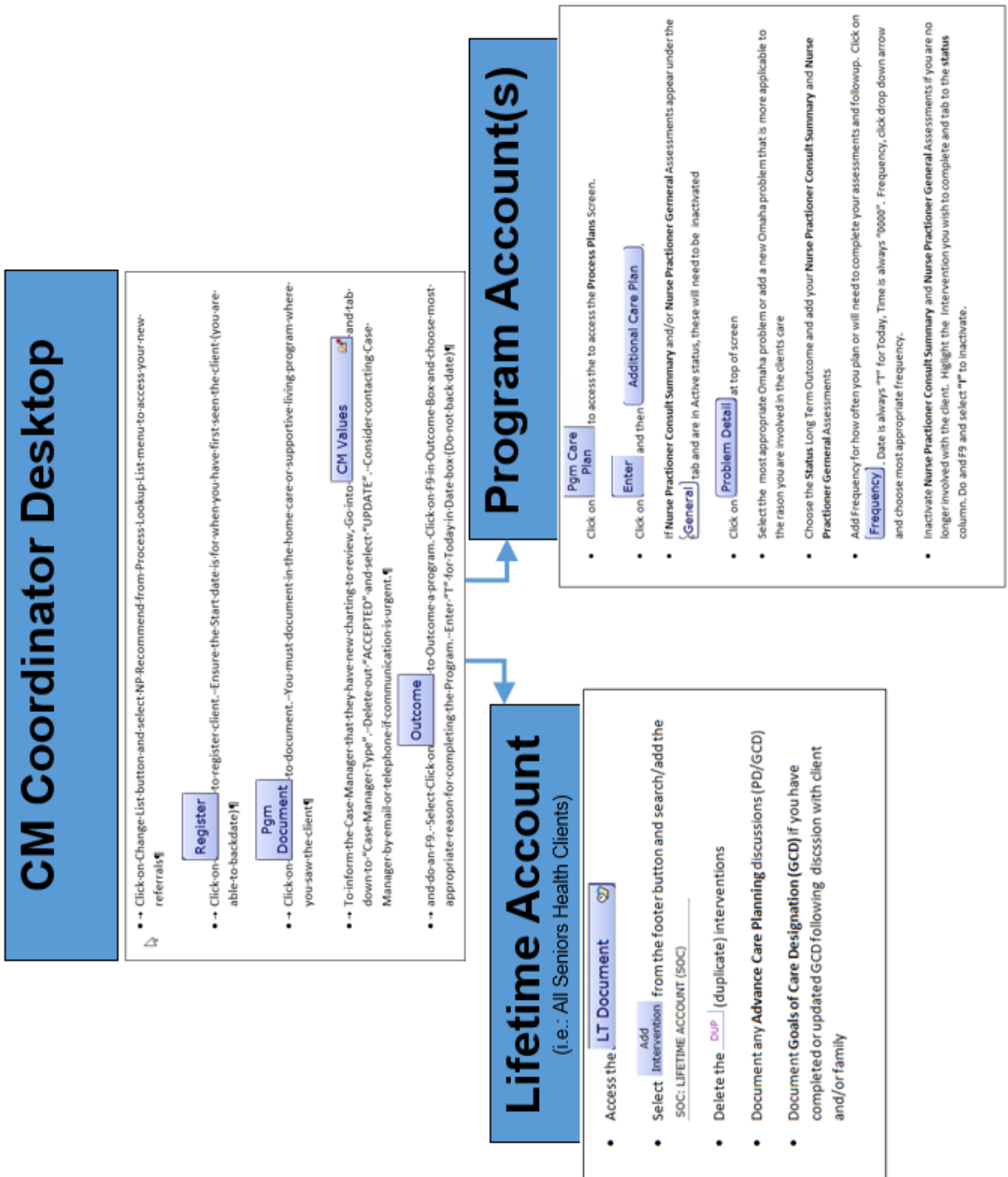
Nurse Practitioner Quick Reference

When a client is admitted to Home Care, this begins an Episode of Care. The Episode captures the entire duration of care within the Continuing Care portion of the client's Services, even though they may receive Services in several Programs during the Episode. The Episode continues until all Programs are Complete and the client is discharged from Continuing Care. If the client is discharged and later readmitted, a new Episode of Care is started.

Within the Episode in ~~Meditech~~, there are two types of accounts. One is the Lifetime Account and the other is the Program Account. This account contains client information that crosses all Continuing Care programs. It includes information that is general enough and important for everyone to know, and so is accessible to all Programs. Each client will only ever have one Lifetime Account in each reporting ring. The Program Account is specific to the Episode of care and what interdisciplinary teams are involved in a client's care. Clients can be registered in multiple programs (i.e. Hospital, home living, etc.). Both the Lifetime Account and Program Accounts can be accessed on the CM Coordinator Desktop.

On the following page is a quick reference that outlines the important steps that need to be completed in both the Program and Lifetime accounts as well varying functions you are able to perform on the CM Coordinator Desktop.

Nurse Practitioner Quick Reference



Care Manager Pre/Post Training Survey: Individual Training Needs Assessment

Name: _____ Date: _____

Professional Title: _____ Site: _____

1. Work and Patient History

A. How long have you worked as a Home Care Provider?

☐ < 1 year ☐ 1 to 2 years ☐ 3 to 5 years ☐ >5 years

2. Self-Assessment of knowledge, skills, and attitudes

Listed below are some knowledge, skills, and attitudes specific to Home Care's role in care planning for Clients. Please read them and then circle the number in the right column that best represents your level of knowledge, skills, and attitude TODAY.

1 = low ←————→ 5 = high

	PRE							POST					
Knowledge of what Meditech Care Manager is	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Navigating CM Coordinator Desktop, Patient Care System (PCS), and Enterprise Medical Record (EMR)	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Skill in performing thorough Clinical Review	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Skill in understanding Lifetime Account vs. Program Account	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Level of comfort in linking Interventions to Problem	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Skill in adding a Frequency to interventions	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Skill in Updating CM Values status	1	2	3	4	5	N/A		1	2	3	4	5	N/A

3. Personal learning

How do you best acquire and retain information? Check all that apply.

☐ WRITTEN ☐ ORAL ☐ VISUAL ☐ HANDS-ON

What do you want to get out of this Course?

Feedback and additional comments
