



QIDP Training Manual

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PURPOSE

This document provides an overview of the Individual Support Plan process using PowerChart, including ISP Prep, ISP Meetings, and ISP Addenda. Users can also review several forms which inform the ISP process.

Note: You will only see the drop-down menus, functionality, buttons, or windows that are relevant to your role. You will see these items based on your system security access. The following information provides common functionality available across multiple system roles.

OBJECTIVES

- Navigate to IRIS for the completion of Individual Support Plan tasks and document monthly reviews
- Use IRIS functionality to coordinate care for residents based on individual preferences, strengths, and goals
- Complete programmatic assessments which would inform the ISP process

SECURITY



Please keep your laptop with you at all times. If it is necessary to step away from the computer, make sure it is password protected and/or secured with a laptop lock. Password protect your laptop by using **⌘+L on the keyboard. A password is required to log back in.**

LOGGING IN

Training Login

1. Double click the training application icon to open the login window.
2. Type the training username in the **Username** field.
3. Type the training password in the **Password** field.
4. Click **OK**.

Daily Login

1. Log into Cerner.
2. Click the icon for PowerChart.

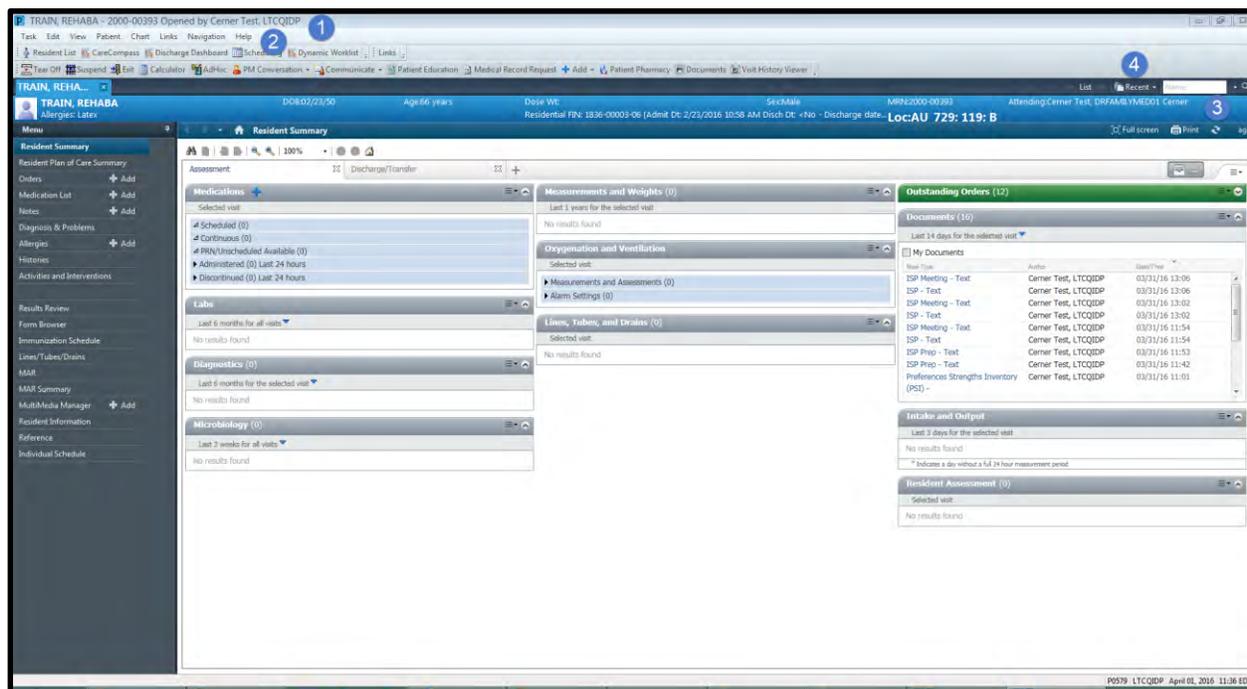
Logging Out (Exit)

- From any window within the application, click the Red X () at the top right corner of the window to log out.

POWERCHART OVERVIEW

PowerChart Overview will provide an overview of the main sections of the IRIS windows, how to view a resident's chart, and use common functions.

Note: Rehab Therapy Techs and Active Treatment Coordinators may have a slightly different view.



Resident Summary: Window Overview

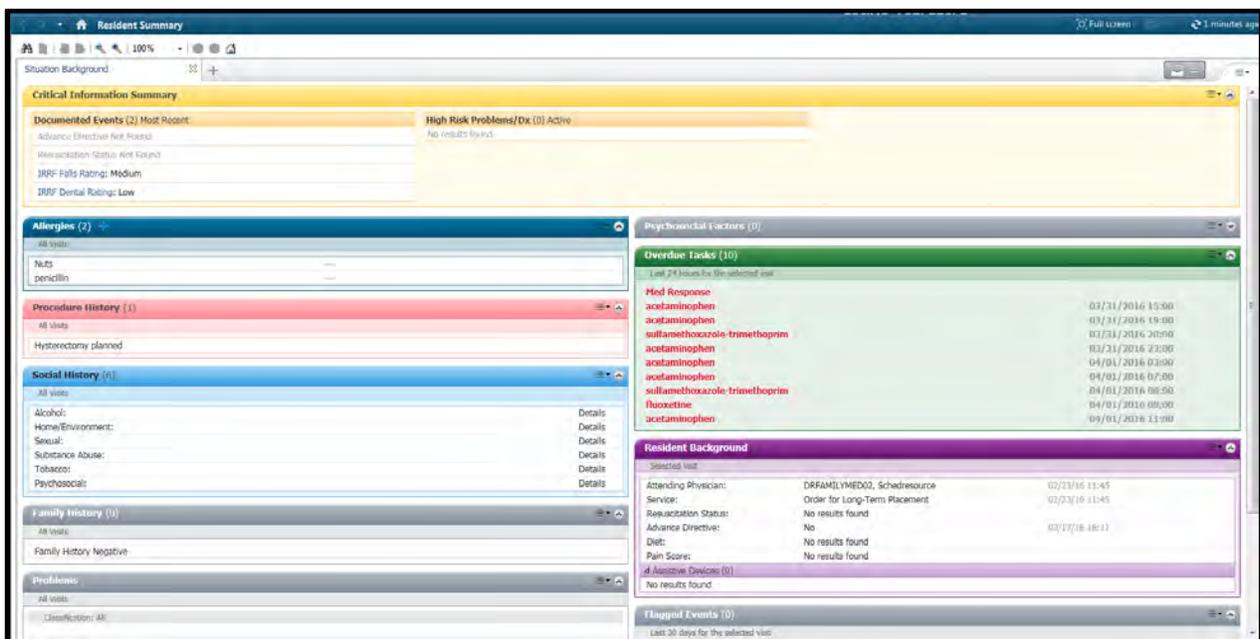
Title	Description										
1. Title Bar	Displays the application that is currently open, and the name of the individual logged in. On the right, there are buttons to minimize, maximize, or close the application.										
2. Menu Bar	Includes the following menus:										
	<table border="1"> <thead> <tr> <th>Menu</th> <th>Description/Functionality</th> </tr> </thead> <tbody> <tr> <td>Task</td> <td>Change a password, suspend the application, view report, print, refresh the window, or exit the application.</td> </tr> <tr> <td>View</td> <td>QIDPs will be able to view the Resident List, CareCompass, Discharge Dashboard, Scheduling, and Dynamic Worklist. Rehab Therapist Technicians will be able to view Resident List, CareCompass, Census Task List, and CareTracker.</td> </tr> <tr> <td>Patient</td> <td>Perform a resident search, view a recent resident, add a patient to a patient list, input new orders/ medication list/allergies or notes, review images, or view the MultiMedia Manager.</td> </tr> <tr> <td>Chart</td> <td>This menu contains all of the items that are also located on the Chart menu, which displays on the left side of the window when a chart is open. The following functions are also available: <ul style="list-style-type: none"> Clinical Calculator, AdHoc Charting, Patient Education, Patient Pharmacy, Tear Off This View, review who has accessed the current chart, and close the current chart </td> </tr> </tbody> </table>	Menu	Description/Functionality	Task	Change a password, suspend the application, view report, print, refresh the window, or exit the application.	View	QIDPs will be able to view the Resident List, CareCompass, Discharge Dashboard, Scheduling, and Dynamic Worklist. Rehab Therapist Technicians will be able to view Resident List, CareCompass, Census Task List, and CareTracker.	Patient	Perform a resident search, view a recent resident, add a patient to a patient list, input new orders/ medication list/allergies or notes, review images, or view the MultiMedia Manager.	Chart	This menu contains all of the items that are also located on the Chart menu, which displays on the left side of the window when a chart is open. The following functions are also available: <ul style="list-style-type: none"> Clinical Calculator, AdHoc Charting, Patient Education, Patient Pharmacy, Tear Off This View, review who has accessed the current chart, and close the current chart
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Chart	This menu contains all of the items that are also located on the Chart menu, which displays on the left side of the window when a chart is open. The following functions are also available: <ul style="list-style-type: none"> Clinical Calculator, AdHoc Charting, Patient Education, Patient Pharmacy, Tear Off This View, review who has accessed the current chart, and close the current chart 										

	Navigation	Navigate through the application with the following functionality: Zoom in or out, perform a search within the window, or go to the Home window. (Note: This menu will only appear when viewing the Resident Summary or Resident Plan of Care Summary)
	Help	Links for Resident Summary, Navigation, HNA Help topics, Support Center and About Power Chart.
3. Refresh		Keeps track of how many minutes have lapsed since the window was last refreshed. Click this after editing a chart to reflect changes immediately, or at any time to refresh the window and return the minute counter to zero.
4. Recent drop-down menu		Displays the most recent nine residents viewed.

MPAGES

The MPage is the first view that displays when a resident’s chart is opened in PowerChart, and displays differently based on roles. It consists of multiple sections, each containing information about the resident. MPage views can be customized by the individual end-user.

Note: Click the refresh icon  in the top right of the Resident Summary page to view recent updates made to AdHoc forms.



The screenshot displays the Resident Summary MPage interface. The top navigation bar includes a home icon, the title 'Resident Summary', a search icon, a refresh icon, and a 'Full screen' button. The main content area is divided into several sections:

- Critical Information Summary:** A yellow header section containing 'Documented Events (2) Most Recent' (Advance Elderstar Risk Factors, Resuscitation Status Alert Found), 'JRRF Falls Rating: Medium', 'JRRF Dental Rating: Low', and 'High Risk Problems/Dx (0) Active' (No results found).
- Allergies (2):** A blue header section listing 'Nuts' and 'penicillin'.
- Procedure History (1):** A pink header section listing 'Hysterectomy planned'.
- Social History (0):** A blue header section with sub-sections for Alcohol, Home/Environment, Sexual, Substance Abuse, Tobacco, and Psychosocial, each with a 'Details' link.
- Family History (0):** A grey header section listing 'Family History Negative'.
- Profoundness:** A grey header section with a 'Classification: All' dropdown.
- Resident Background:** A purple header section listing 'Selected Visit' and 'Attending Physician: DRFAMILYMED02, Schedresource' (02/23/16 11:45), 'Service: Order for Long-Term Placement' (02/23/16 11:45), 'Resuscitation Status: No results found', 'Advance Directive: No', 'Diet: No results found' (03/27/16 16:11), 'Pain Score: No results found', and 'd.Assistive Devices (0) No results found'.
- Med Response:** A green header section listing 'Last 143 hours for the selected visit' and a table of medications with dates and times: acetaminophen (02/21/2016 15:30), acetaminophen (02/21/2016 19:30), sulfamethoxazole-trimethoprim (02/21/2016 20:00), acetaminophen (02/21/2016 23:00), acetaminophen (04/01/2016 03:00), acetaminophen (04/01/2016 07:00), sulfamethoxazole-trimethoprim (04/01/2016 08:50), fluoxetine (04/01/2016 08:00), and acetaminophen (04/01/2016 11:00).
- Flagged Events (0):** A grey header section listing 'Last 30 days for the selected visit'.

MPages Overview: Sample View

Tabs

Based on roles, different tabs display along the top of the window.

1. To view the contents of a tab, click the tab.
2. To close a tab, click the **X** on the right side of the tab.
3. To reopen a tab, click the **+** that displays to the right of the tabs that are currently open, then click the name of the tab to reopen.
4. Rearrange the order of the open tabs by dragging and dropping a tab to the new desired location.

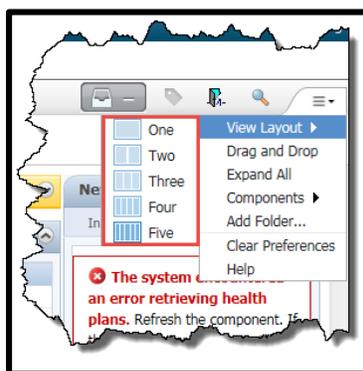


MPages Tabs

Layout

The location of sections within MPages can be customized using the drop-down menu (☰) at the top right of the window.

- Create Columns
 1. From the drop-down menu, select **View Layout**.
 2. Select the amount of columns to display. The window automatically refreshes to incorporate this change.
- Drag and Drop
 1. From the drop-down menu select **Drag and Drop**.
 2. When marked with a check mark, drag and drop sections to different areas of the window to further customize the view. When unchecked, the drag and drop functionality is not available.



View Layout

Sections

The look of each individual section can be customized, to help manage work.

- Color
 1. From the top of the section, click the drop-down menu (☰).
 2. Select **Color Theme**.
 3. Select the desired color for the section. The section automatically refreshes to incorporate this change.

- Expand/Collapse
 1. From the drop-down menu at the top of the window, select **Expand All** or **Collapse All** to expand or collapse all sections at the same time.
 2. From the top of a section, click the collapse icon () to expand or collapse only the selected section.

RESIDENT SEARCH

Resident Search

1. From the **Resident Toolbar**, click the down arrow to the right of the Search box.
2. Select to search by MRN, Name or FIN.
3. In the Search box, type the search criteria.
4. Press Enter.
5. From the **Resident Search** pop-up window, double click the resident or encounter to open and view.

Note: If the Resident Toolbar is hidden, the Search bar is not available.



Resident Toolbar

Quick Search

1. From the **Resident Toolbar**, click the search icon ().
2. From the **Resident Search** pop-up window, type in the Phone Number, Encounter Identifier, Person Identifier, Last Name, First Name and/or DOB to conduct the search.
3. Click **Search**, or press Enter to display the search results.
4. Double click the resident or encounter to open and view.

Open Multiple Residents at a Time

1. Perform a *Resident Search* or *Quick Search*, as indicated above.
2. Each new resident opens in a new tab on the Resident Toolbar, and also in a new window.
3. Click the name of the desired resident to move between charts.
4. Click the **X** next to the resident's name to close a chart.

Note: The maximum number of resident charts that you can open at any time is two. If you attempt to open a third chart, a pop-up displays with a request to close one chart.



Multiple Resident Tabs

RESIDENT DEMOGRAPHIC BANNER BAR

Resident Demographic Banner

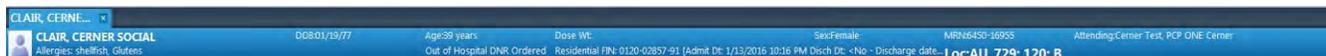
Located at the top of the window above the **Resident Summary** and **Chart** menu, the Resident Demographic Banner displays when a chart is open. Displayed in blue, it provides pertinent information about the resident's demographics.

Note: When two resident charts are opened at one time, the second resident's banner displays in yellow.

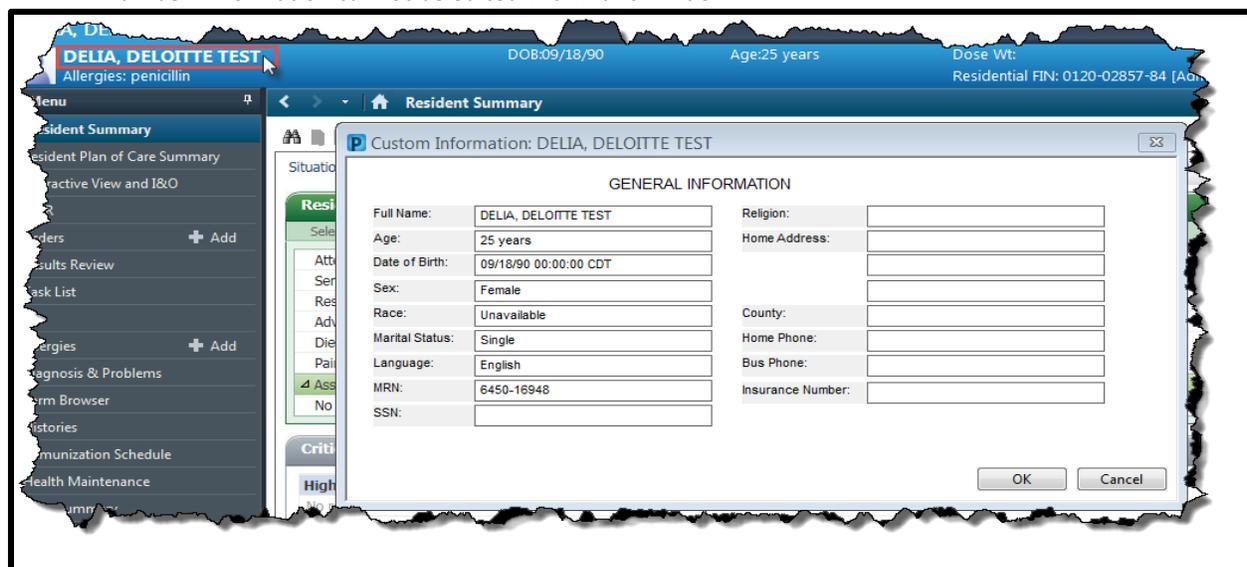
- Resident Name
- Date of Birth
- Age
- Dose Weight
- Sex
- Medical Record Number
- Attending Physician
- Allergies
- DADS Pre-Admit status
- Residential FIN
- Admit/Discharge Dates
- Location

Several items within the Resident Demographic Banner are clickable links, as shown in the screen images below:

Resident Demographic Banner

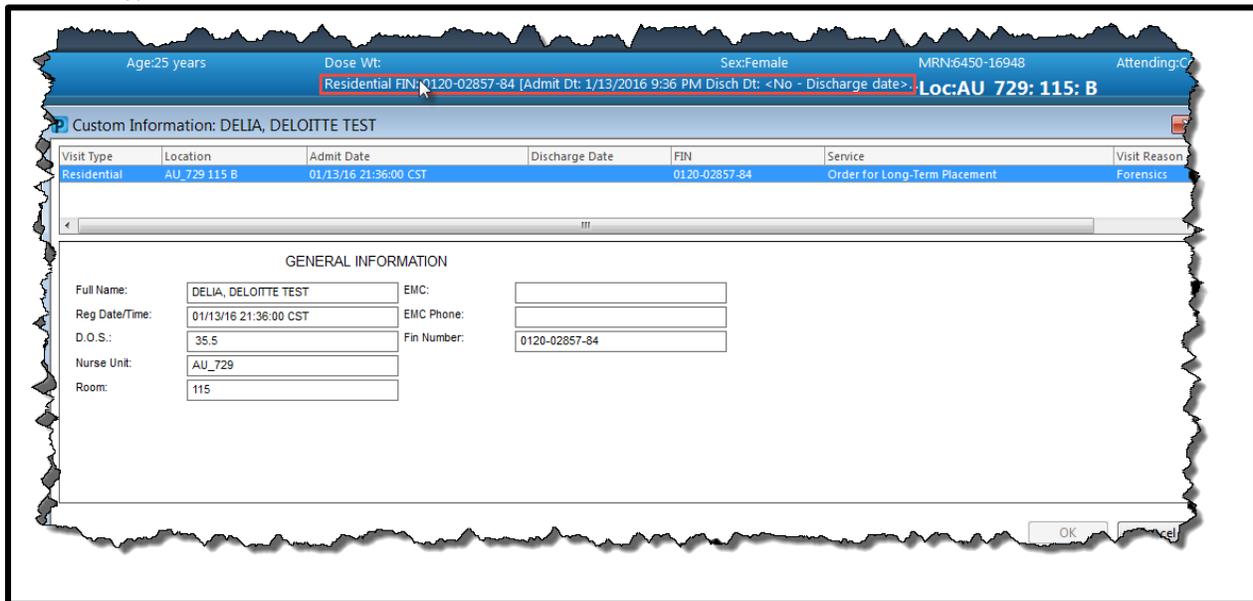


- Click the resident's name to display a pop-up window with general resident information including: Age, DOB, Sex, Race, Marital Status, Language, MRN, SSN, Religion, Address, Phone Numbers, and Insurance Number. Information cannot be edited within this window.



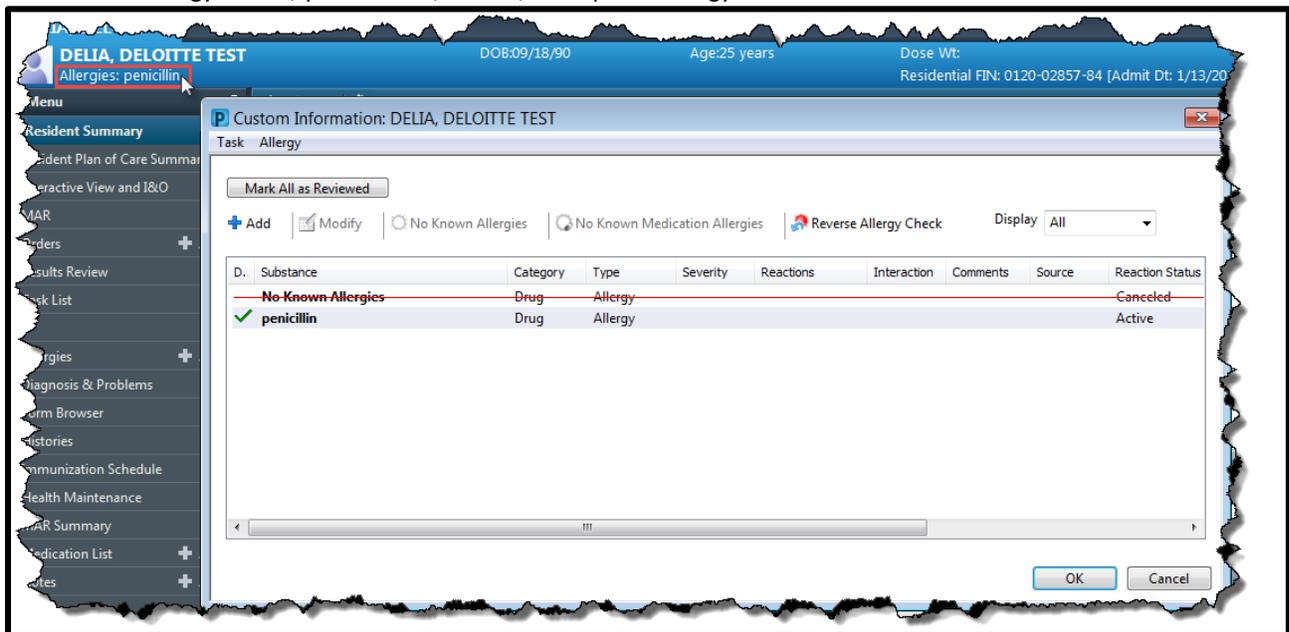
Resident Demographic Banner: Click the resident's name

- Click **Residential FIN** to display a pop-up window with the following information: Name, Registration Date/Time, Discharge Date if applicable, DOS, Nurse Unit, Room, EMC, EMC Phone, FIN Number, Service type, and Visit Reason. Information cannot be edited within this window.



Resident Demographic Banner: Click Residential FIN

- Click **Allergies** to display a pop-up window, which displays a list of allergy information including: Substance, Category, Type, Severity, Reactions, Interaction, Comments, Source and Reaction Status. From the Allergy Profile, you can add, review, and update allergy information.



Resident Demographic Banner: Click Allergies

TOOLBARS

Resident List

Click **Resident List** under the Menu Bar to display the **Resident List** window. Click the tabs across the top of the window to view all residents within each list. From this window, the functions to add or modify lists are available.

- Add a New List

1. From the **Resident List** window, click the list maintenance icon ().

Note: The window will display a master list of all lists created by the individual end-user.

2. From the **Modify Resident Lists** pop-up window, click **New**.
3. From the **Resident List Type** pop-up window, select the type of resident list to build and click **Next**.
4. From the **Care Team Resident List** pop-up window, select all list preferences.

Note: Click the properties icon () to modify list preferences.

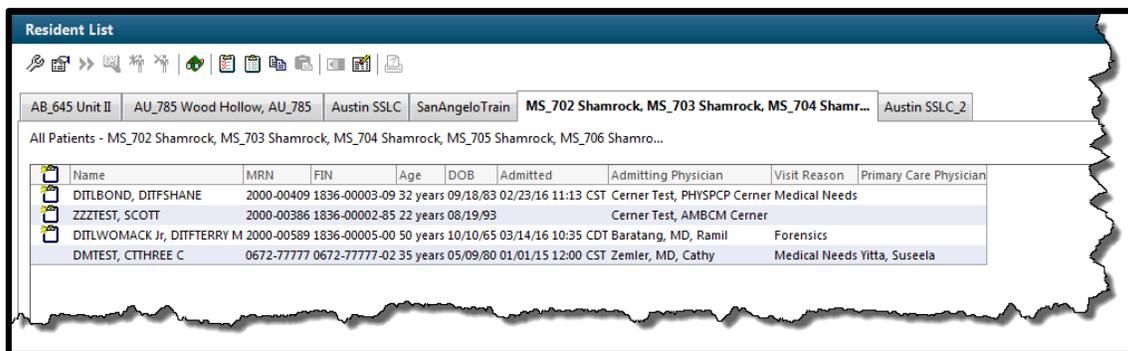
5. At the bottom of the window, type a name to add to the list, then click **Finish**.
6. Find the newly created list in the left column of the window under **Available Lists**, and select it.
7. Click the right arrow to move the new list to the **Active Lists** column.
8. Click **OK**. The new list displays as a new tab on the **Resident List** window.

- Add a Resident From Another List

1. From the **Resident List** window, right click on the resident's name.
2. Click **Add to a Resident List**.
3. Click the list to add the resident to.
4. Click the tab for a list to view the updated list.
5. Click **Refresh**. The resident now displays in the list.

- Add a Resident From the Resident's Chart

1. From the **Resident List** window, click **Resident** on the Menu Bar.
2. Click **Add Resident to a Resident List**.
3. Click the list to add the resident to.

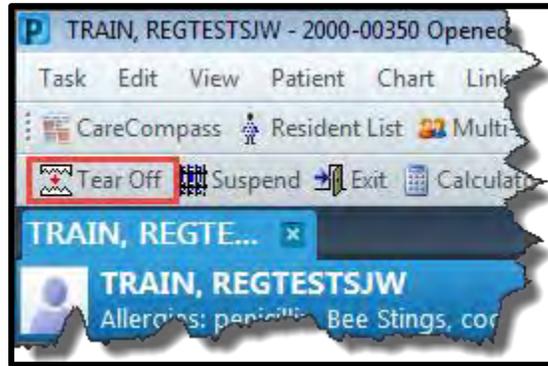


Name	MRN	FIN	Age	DOB	Admitted	Admitting Physician	Visit Reason	Primary Care Physician
DITLBOND, DITFSHANE	2000-00409	1836-00003-09	32 years	09/18/83	02/23/16 11:13 CST	Cerner Test, PHYSPCP	Cerner Medical Needs	
ZZZTEST, SCOTT	2000-00386	1836-00002-85	22 years	08/19/93		Cerner Test, AMBCM	Cerner	
DITLWOMACK Jr, DITFERRY M	2000-00589	1836-00005-00	50 years	10/10/65	03/14/16 10:35 CDT	Baratang, MD, Ramil	Forensics	
DMTEST, CTHREE C	0672-77777	0672-77777-02	35 years	05/09/80	01/01/15 12:00 CST	Zemler, MD, Cathy	Medical Needs	Yitta, Suseela

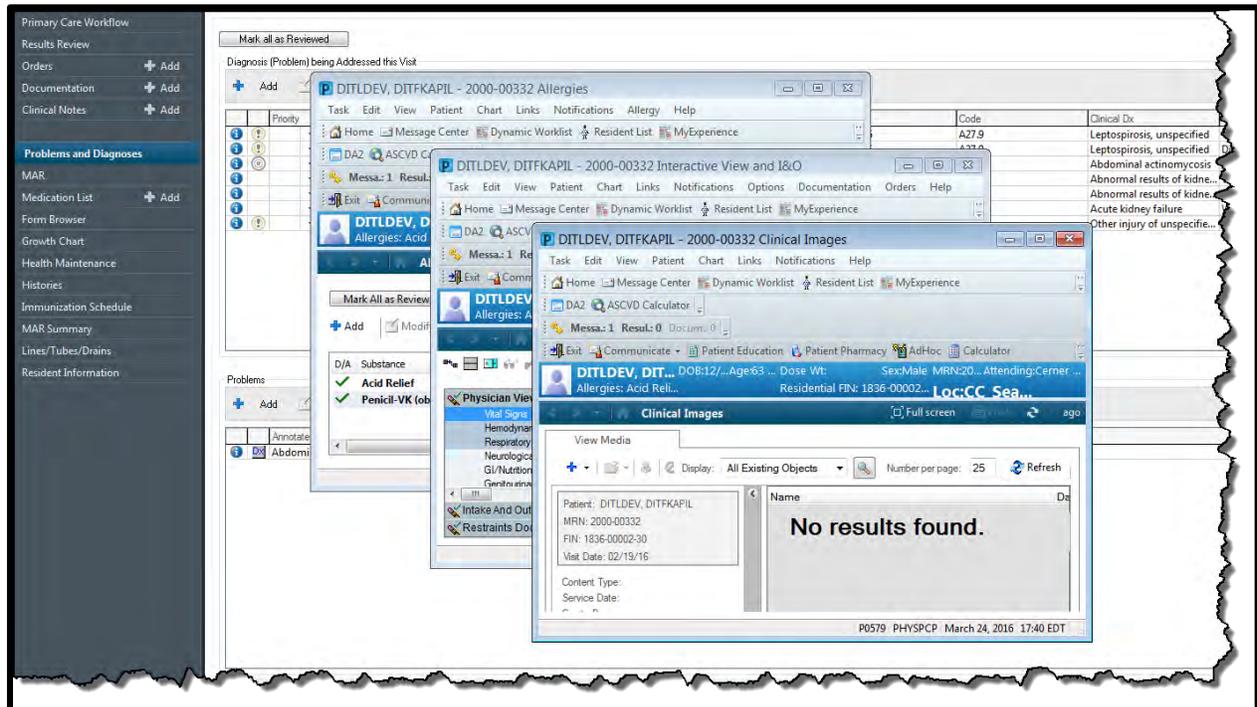
Resident Lists

Tear Off

When a resident's chart is open, from the **Action Toolbar** click **Tear Off** to separate the **Resident Summary** from the main window and display it as a pop-up window.



Tear Off



Tear-off View

Note: When the Tear-off function is used, the items are removed from the Chart menu and can be worked with in a separate pop-up menu.

Tip ▶ This feature may be beneficial when there is a need to update multiple windows in a resident chart simultaneously, or see multiple windows at the same time.

Suspend

From the **Action Toolbar**, click **Suspend** to close and lock the application. A password is required to reopen the application.

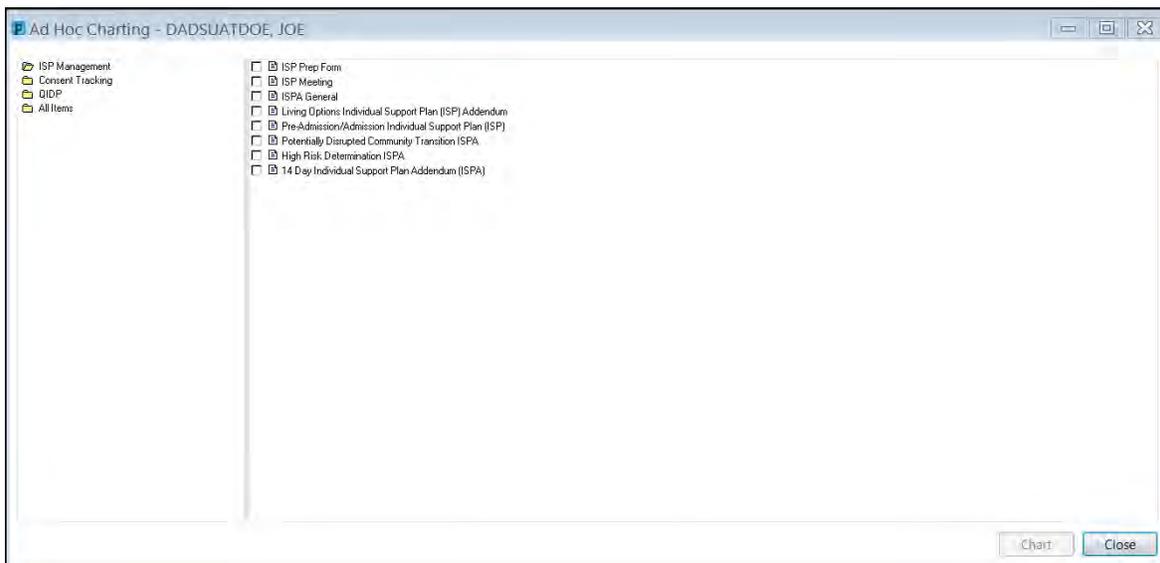


Suspend the application if it is necessary to step away from the computer, to prevent unauthorized individuals from viewing private resident information.

AdHoc

AdHoc Forms allow a user to document required and important information in pre-defined templates and easily add the form to a resident's chart.

1. Open a resident's chart.
2. From the **Action Toolbar**, click **AdHoc** to open the AdHoc Charting pop-up window to chart unordered results and documents.
3. Double click a folder in the left column of the window to select the charting category.
4. In the center of the window, select the task that needs to be charted.



AdHoc Charting

5. Click **Chart**.
6. Another pop-up window displays fields that are specific to the task being charted. Fill out all pertinent information.

Note: The date that the screening/procedure/etc. is performed is a required field on these windows. The date/time defaults to the current date/time. The time is displayed in military time, CST. To change to the date or time, click in the field and type in the correct numbers, or use the up and down arrows to adjust the date/time as needed.

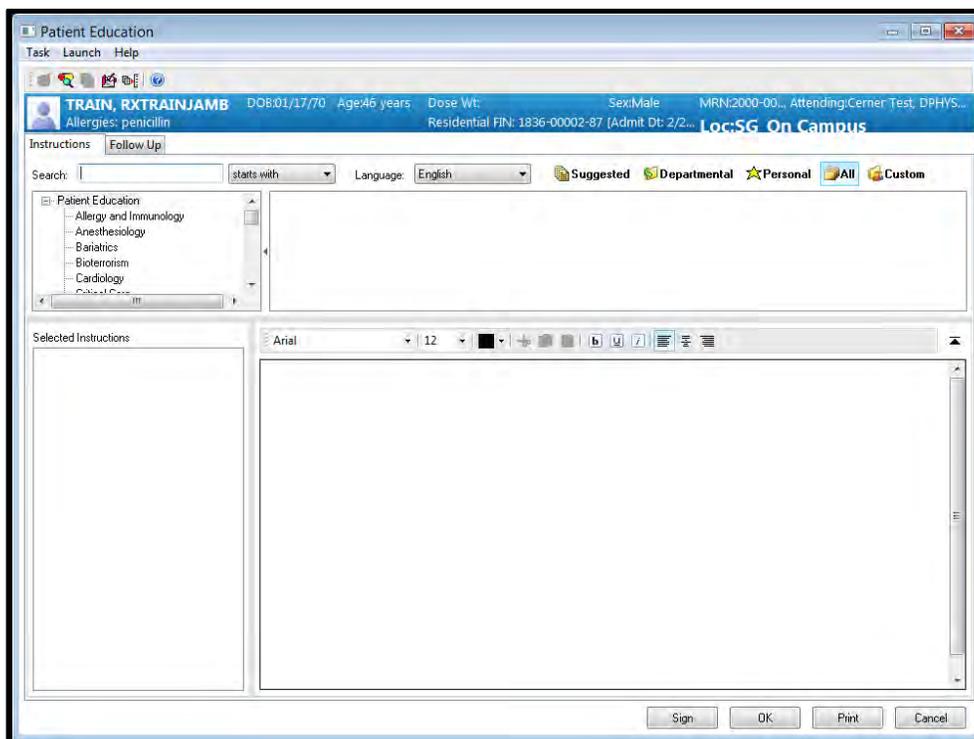
7. After the form is complete, click the sign form icon (✓).

Patient/LAR Education

1. Open a resident's chart.
2. From the **Action Toolbar**, click **Patient Education** to add new education details.
3. From the **Patient Education** pop-up window, use the search field to search for a specific type of Patient Education.

Tip ▶ Leave the search field blank and double click the type of Patient Education in the left column under **Patient Education**.

4. From the search results window to the right, double click the **Click here for instructions** link.
5. Double click the topic, to display the selected educational information on the bottom of the window.
6. Click **Sign** to sign the Patient Education before saving to the chart; click **OK** to close the pop-up window and save all information to the chart; click **Print** to print; click **Cancel** to close the pop-up window without saving.

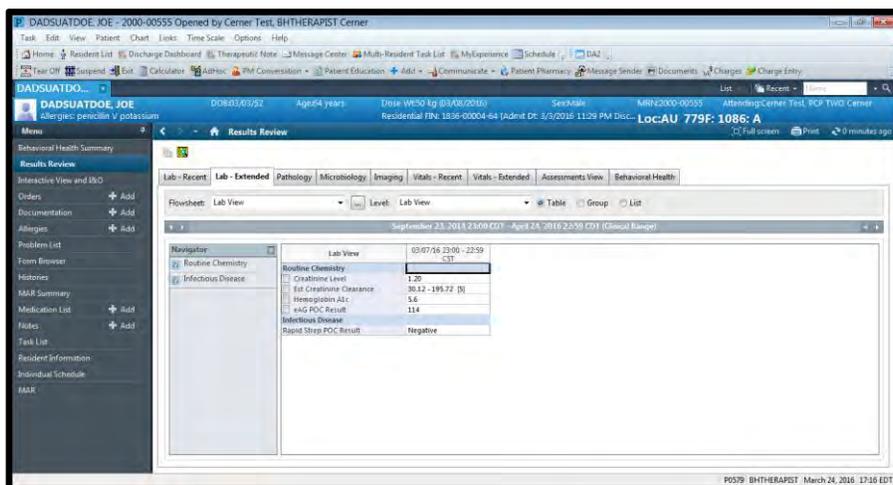


Patient Education Pop-up Window

Note: Add as many Patient Educational materials as needed to a chart. To delete one, click the Red X () next to the topic to delete.

RESULTS REVIEW

Open a resident's chart. From the **Chart** menu, click **Results Review** to view all recent results including: Ambulatory, Lab, Pathology, Microbiology, Imaging, Vitals, Assessments and Cardiology. Click on each tab to review the results within that category.

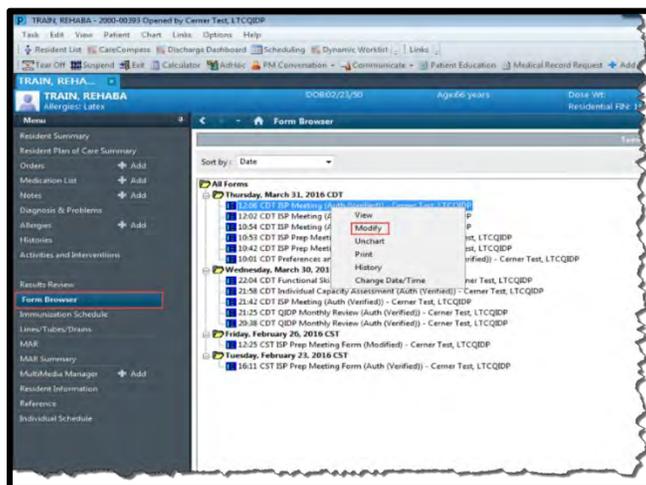


Results Review Window

FORM BROWSER

Form Brower allows you to modify forms or complete documents that have been added to a resident's chart, and placed into the resident chart by **Date**. From the **Chart** menu, click **Form Browser** to view all forms in a chart. All forms are displayed on the **Form Browser** window.

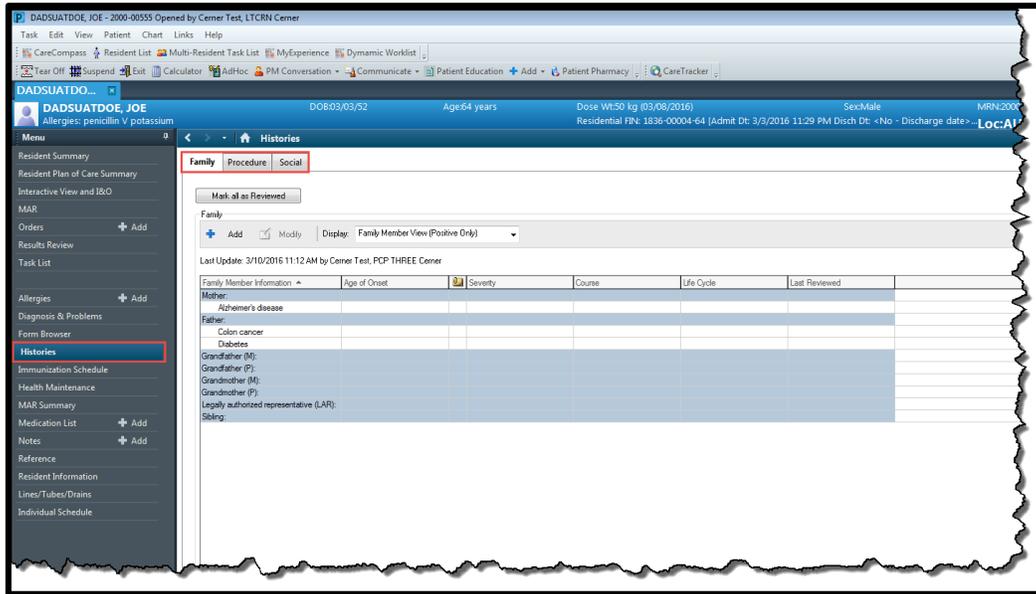
1. Click the **Sort By** drop-down menu to view forms by date, form, status, encounter-date or encounter-form.
2. Double click a form to view its details.
3. To modify a form, right-click on its title and select **Modify** from the drop-down menu.
4. When complete, click  to sign the form.



Form Browser Window

HISTORIES

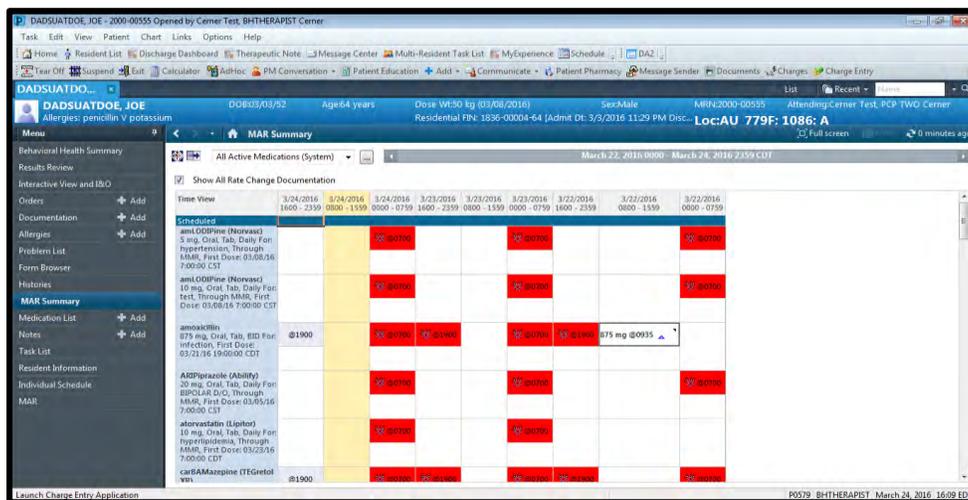
From the **Chart** menu click **Histories** to view family, procedure and social historical information for the resident. From any of the tabs at the top of the window, a new history can be added. Click the add icon (**+** Add). Add all information, then click **OK** to save the record.



Histories Window

MAR SUMMARY

From the **Chart** menu, click **MAR Summary** (Medication Administration Record) to view the medication summary. This window displays the dates and times that medications were administered, or are due. Hover the mouse over each medication to view medication details.



MAR Summary Window

- In the **Communication Type** field, select **Phone, Verbal, Signature Required or Written (Paper)/Fax**, then click **OK**.

Note: If a physician is adding the order, steps 11 and 12 are omitted.

- Type all details, comments and diagnoses for the order, including the **Medication Indication**.
- Click **Sign**. The medication now populates in the Medication List and has a Processing status until it is filled by the pharmacy.

Note: For a Physician, when an order needs to be signed Orders For Signature at the bottom of the window are enabled.

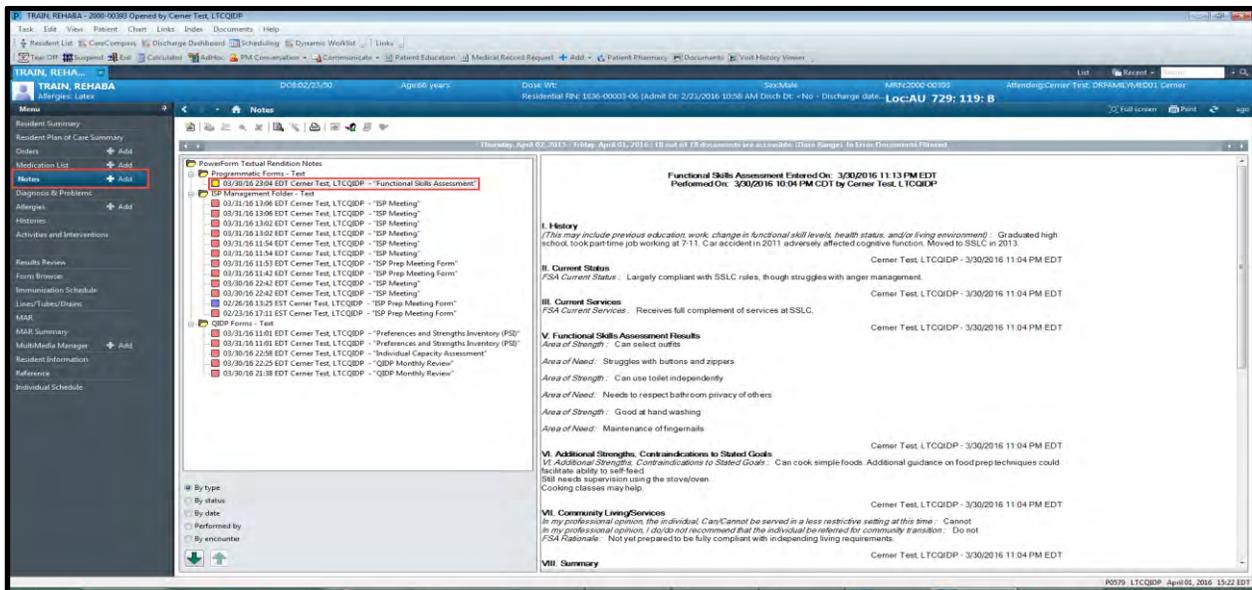
Note: For anyone other than a Physician, the Orders for Co-Signature button is enabled.

Note: For a Nurse, when an order needs to be reviewed, Orders For Nurse Review at the bottom of the window are enabled.

NOTES

From the **Chart** menu click the **Notes** band to access the Notes functionality. From this window, review or add notes. Users can review completed forms which have been completed by members of the IDT.

- View Notes
 - From the **Notes** window, view any **Notes** that have been added to a chart within the dates specified on the information bar along the top of the window.
 - On the left side of the window, select the folder that contains the note that needs to be viewed. The note displays in the center of the window.



The screenshot shows the IRIS Notes window for patient TRAIN, REHADA. The left sidebar contains a 'Notes' section with a list of notes. The main window displays the content of a selected note titled 'Functional Skills Assessment'. The note content includes the following sections:

- I. History:** /This may include previous education, work, changes in functional skill levels, health status, and/or living environment/ Graduated high school, took part time job working at 711. Car accident in 2011 adversely affected cognitive function. Moved to SSLC in 2013.
- II. Current Status:** FSA Current Status: Largely compliant with SSLC rules, though struggles with anger management.
- III. Current Services:** FSA Current Services: Receives full complement of services at SSLC.
- IV. Functional Skills Assessment Results:**
 - Area of Strength:** Can select outfits
 - Area of Need:** Struggles with buttons and zippers
 - Area of Strength:** Can use toilet independently
 - Area of Need:** Needs to respect bathroom privacy of others
 - Area of Strength:** Good at hand washing
 - Area of Need:** Maintenance of fingernails
- VI. Additional Strengths, Contradictions to Stated Goals:**
 - VI. Additional Strengths, Contradictions to Stated Goals:** Can cook simple foods. Additional guidance on food prep techniques could facilitate ability to self-feed
 - VI. Additional Strengths, Contradictions to Stated Goals:** Still needs supervision using the stove/oven. Cooking classes may help.
- VII. Community Living Services:**
 - VII. Community Living Services:** In my professional opinion, the individual *Can* be served in a less restrictive setting at this time... Cannot in my professional opinion, I do not recommend that the individual be referred for community transition... Do not FSA Rationale: Not yet prepared to be fully compliant with independent living requirements.
- VIII. Summary:**

View Notes Window

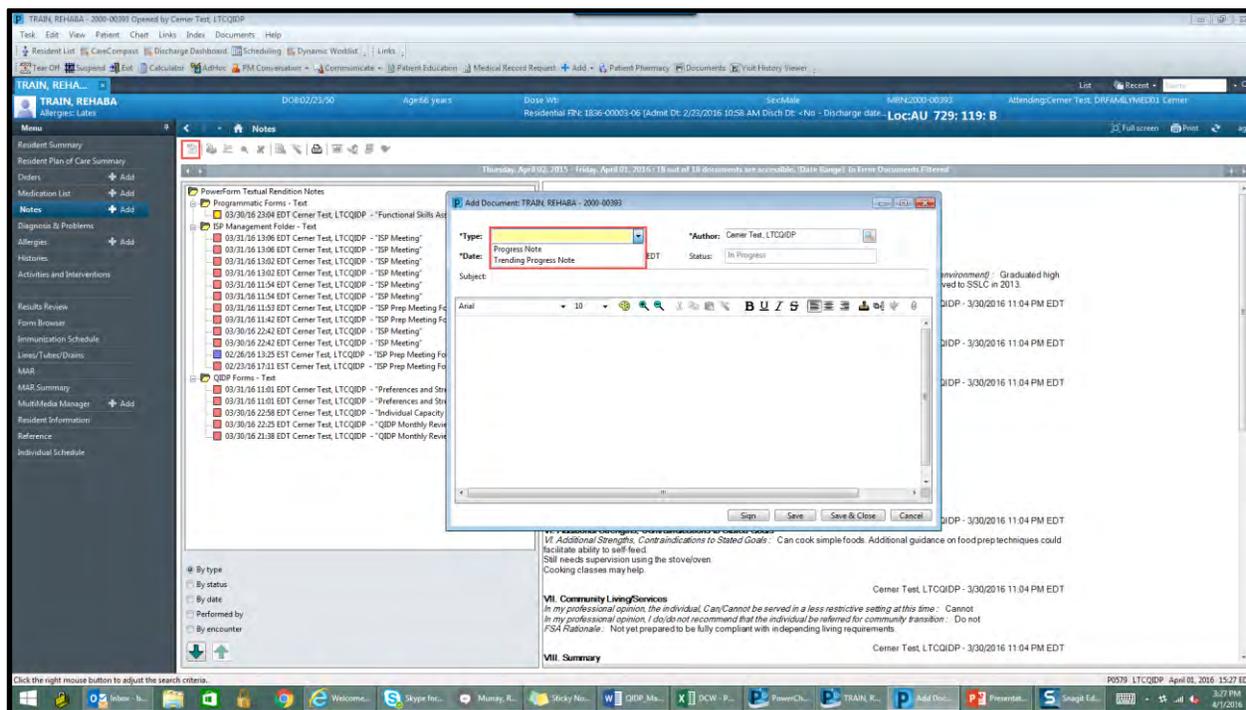
- Sort the notes view by selecting a radio button: By type, By status, By date, Performed by or By encounter.
- Use the up and down arrow buttons to scroll up and down through the available notes.

Note: If the note does not display, the date range may need to be changed. Right click the information bar at the top of the Notes window where the date is displayed, and select Change Search Criteria. In the pop-up window, change the From and To dates, then click OK.

- **Modify a Note**
 1. From the **Notes** window, double click the note that needs to be modified. The note displays in the center of the window.
 2. Click the modify icon ().
 3. After required changes have been made, click **Sign**.
 4. A pop-up window displays and asks: A change has been made to the note details of the document. Would you like to save this change?
 5. Click **Yes**.

Note: After a note is modified, “Document Contains Addenda” will display at the top in red.

- **Add a Progress Note**
 1. From the **Notes** window, click the add icon () to add a new progress note.



Add A Progress Note Pop-Up Window

2. From the **Add Document** pop-up window, click the drop-down menu next to *Type to select the type of progress note to add.
3. Complete all fields on the window and type the note.
4. Complete the note by:
 - Clicking **Sign** – Completes the documentation, and publishes the note to the resident’s chart

- Clicking **Save** – Saves the note without signing it, but leaves the note window open; this provides the ability to make revisions at a later time. The status of the note will remain as *In Progress* until it's closed

Tip ▶

Even when temporarily walking away from the computer, it is important to always save a note to prevent data loss in the event of a power outage or network failure.

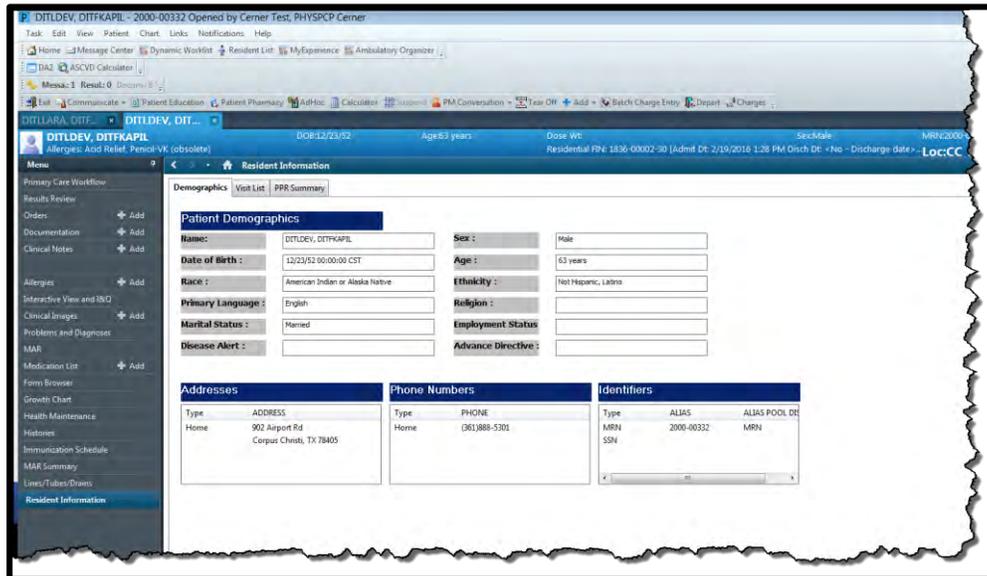
- Clicking **Save & Close** – Saves and closes the note without signing it
- Clicking **Cancel** - Closes the pop-up window without saving changes

All notes are marked with a colored square to indicate the status. When a note is opened, a yellow dot displays in the center of the colored square. Note statuses are as indicated in the chart below:

	In Progress – The note is in progress, and has not yet been signed
	Transcribed – The note has been typed, but not yet signed
	Unauthenticated – The note has been signed, but by someone who is not authorized to provide final approval
	Authenticated – The note is finalized and signed
	Modified/Corrected – The note or document has been modified, and there is an addendum
	Anticipated – A record is anticipated, but has not yet been typed
	Error – The note was typed in error
	Unknown Status

RESIDENT INFORMATION

From the **Chart** menu, click **Resident Information** to view resident demographics, the visit list, and the PPR summary. This is a view-only window, and information contained herein was typed during scheduling and registration.

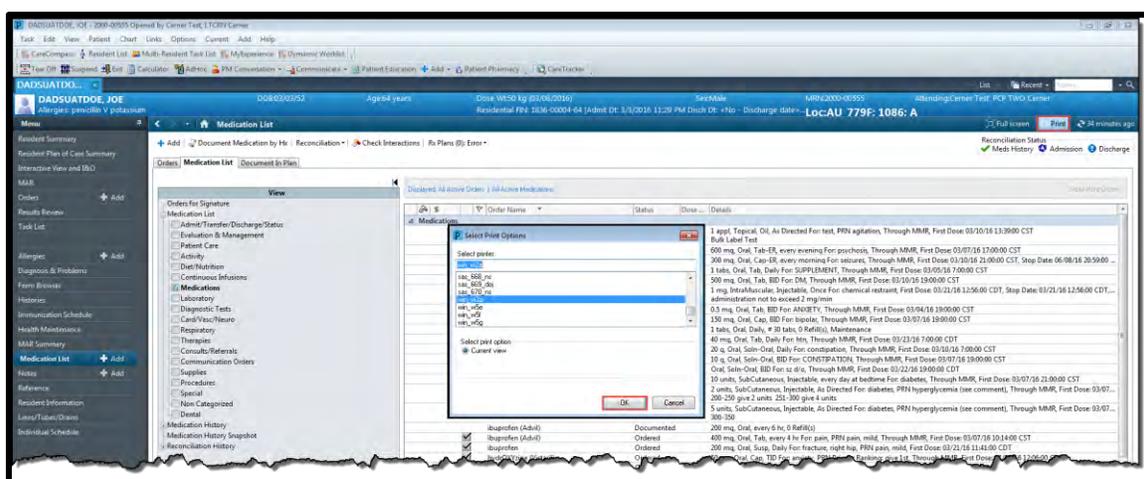


Resident Information Window

PRINTING

Open a resident's chart, then click the print icon () at the top right of any window to print its contents. The print functionality does not display on every window.

Note: Use the print function when you want to print a medication list, or document from the resident chart.



Select Print Options Pop-up Window

Note: The Print option also allows you to send a portion of the resident chart to someone.

Medical Record Request - DADSUATDOE, JOE - 2000-00555 - cardiology consult

Template: Document Report

Purpose: Patient/Personal

Proper authorization received?

Destination: _____

Requester: _____

Comment: _____

Device: _____ Copies: 1

Device selected Device cross referenced

Preview Send

Name	Relationship	Device
<input checked="" type="checkbox"/> Cerner Test, LTCRN Cerner	Long Term Care Nurse	

Medical Record Request Pop-up Window

Medical Record Request

The report for DADSUATDOE, JOE - 2000-00555 - cardiology consult is ready.
Preview it now?

Yes No Cancel

Medical Record Request Confirmation Pop-up Window

QIDP INDIVIDUAL SUPPORT PLAN PREP MEETING

Purpose

This lesson guides QIDPs through the ISP Prep meeting process.

Objectives

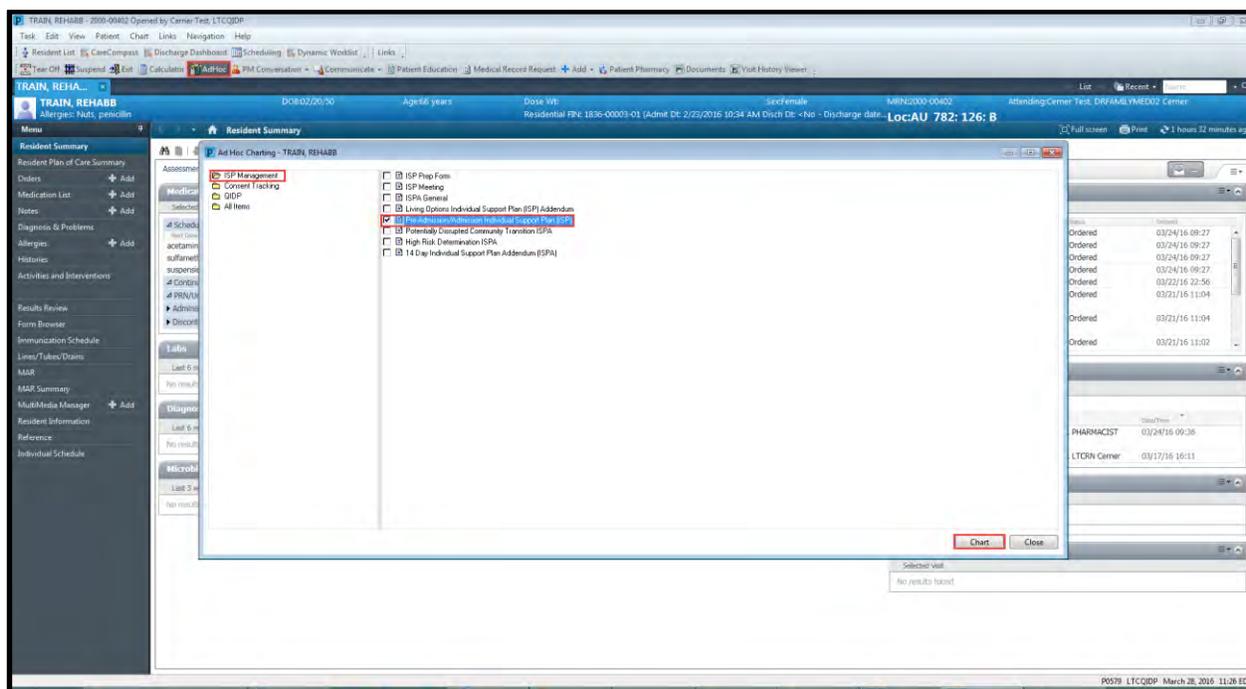
- Complete Pre-Admission/Admission ISP
- Complete Preferences and Strengths Inventory
- Document Required Fields in ISP Prep Form

Scheduling ISP Prep Meeting

1. From **Schappptbook**, select the resident.
2. Schedule ISP Meeting according to policy and procedure, using **On Campus ISP/ISPA** appointment in **Schappptbook**.

Pre-Admission/Admission ISP

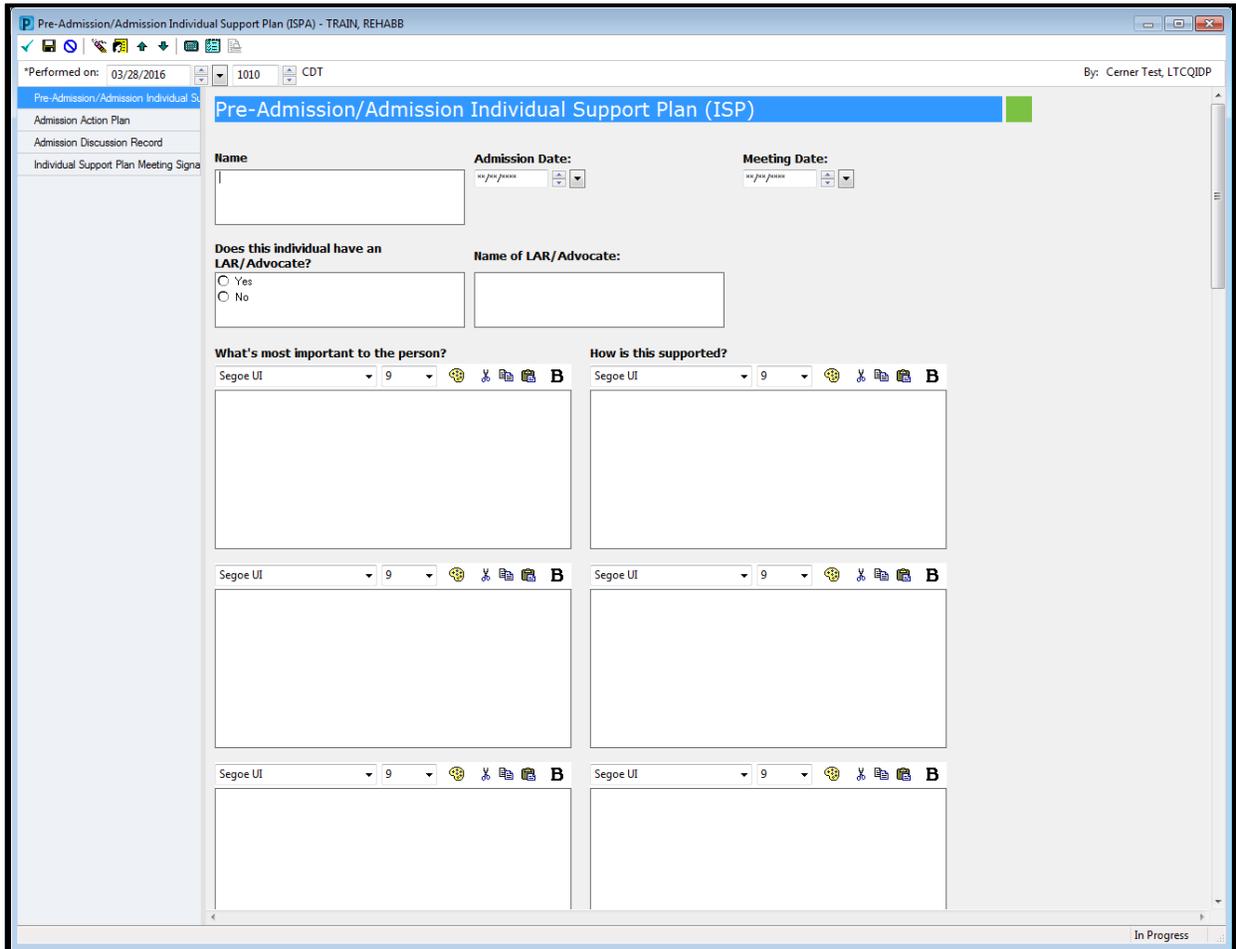
1. From the **Action Toolbar**, click **AdHoc**.
 The **AdHoc Charting** pop-up window displays.



AdHoc Charting Pop-up Window

2. Click the **ISP Management** folder.
3. Mark the **Pre-Admission/Admission Individual Support Plan** check box.
4. Click **Chart**.

The Pre-Admission/Admission Individual Support Plan pop-up window displays.



ISP Management: Pre-Admission/Admission Individual Support Plan

- Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
Pre-Admission/Admission Individual Support Plan	Document what is most important to the resident, and how it is supported.
Admission Action Plan	Document admission action plan including responsibilities of IDT.
Admission Discussion Record	Record discussion of admission conversation, including resident's medical issues, appointments, current medications, risks, and status.
Individual Support Plan Meeting Signatures	Document names of attendees.

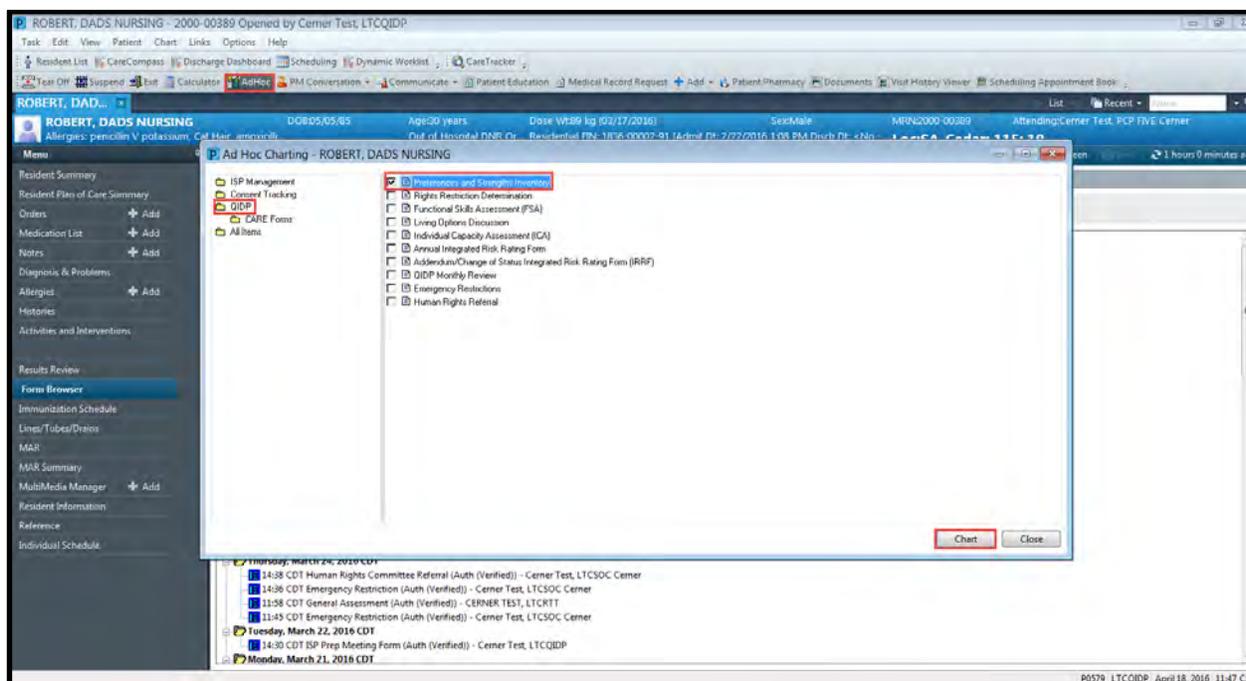
Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident’s legal medical record. Use the **Save Form** (💾) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

6. After the form is complete, click the sign form icon (✓).

Preferences and Strengths Inventory

1. From the **Action Toolbar**, click **AdHoc**.

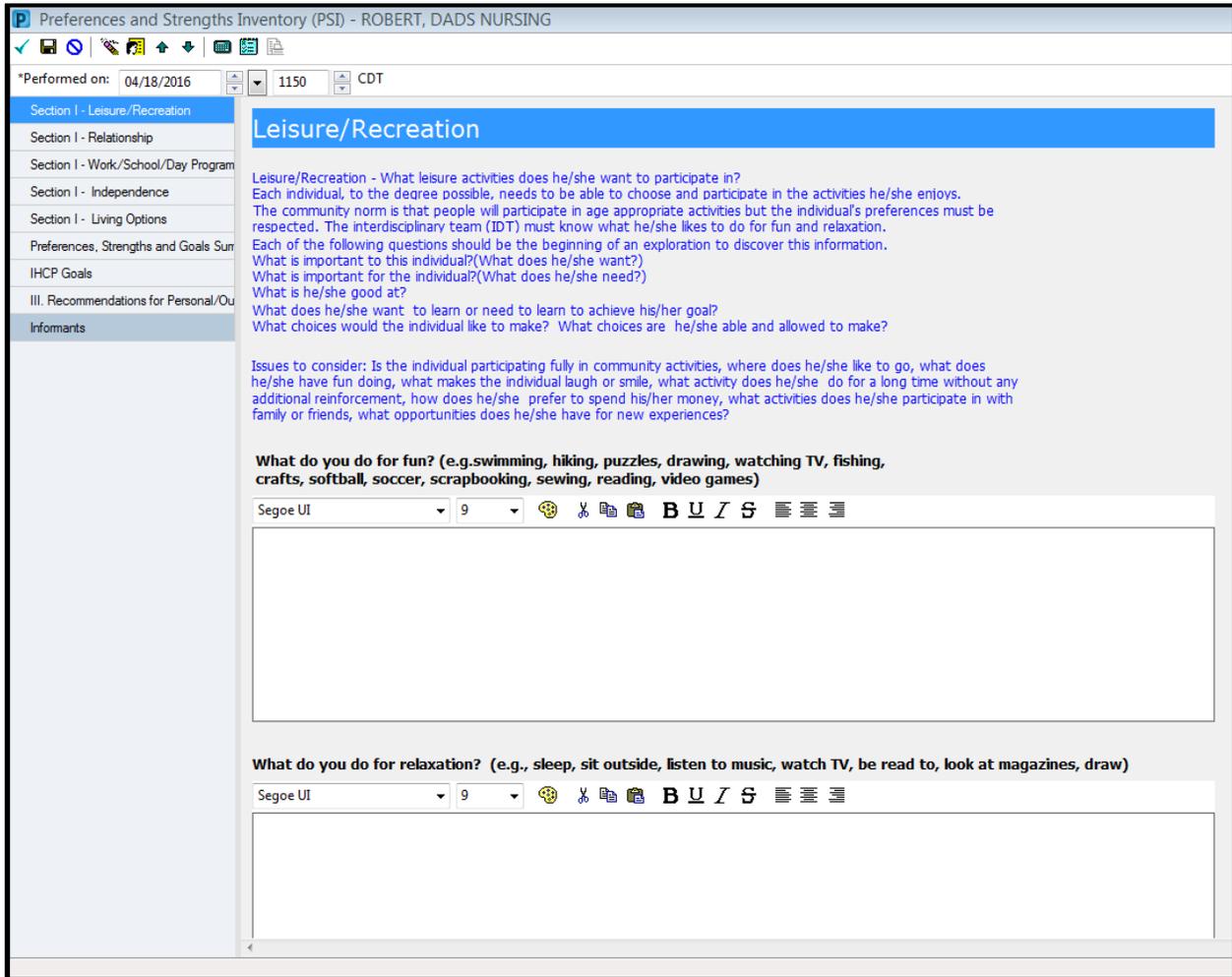
 The **AdHoc Charting** pop-up window displays.



AdHoc Charting Window

2. Click the **QIDP** folder.
3. Mark the **Preferences and Strengths Inventory (PSI)** check box.
4. Click **Chart**.

The Preferences and Strengths Inventory (PSI) pop-up window displays.



Preferences and Strengths Inventory (PSI) - ROBERT, DADS NURSING

*Performed on: 04/18/2016 11:50 CDT

Section I - Leisure/Recreation

Leisure/Recreation - What leisure activities does he/she want to participate in?
 Each individual, to the degree possible, needs to be able to choose and participate in the activities he/she enjoys.
 The community norm is that people will participate in age appropriate activities but the individual's preferences must be respected. The interdisciplinary team (IDT) must know what he/she likes to do for fun and relaxation.
 Each of the following questions should be the beginning of an exploration to discover this information.
 What is important to this individual?(What does he/she want?)
 What is important for the individual?(What does he/she need?)
 What is he/she good at?
 What does he/she want to learn or need to learn to achieve his/her goal?
 What choices would the individual like to make? What choices are he/she able and allowed to make?

Issues to consider: Is the individual participating fully in community activities, where does he/she like to go, what does he/she have fun doing, what makes the individual laugh or smile, what activity does he/she do for a long time without any additional reinforcement, how does he/she prefer to spend his/her money, what activities does he/she participate in with family or friends, what opportunities does he/she have for new experiences?

What do you do for fun? (e.g. swimming, hiking, puzzles, drawing, watching TV, fishing, crafts, softball, soccer, scrapbooking, sewing, reading, video games)

Segoe UI 9

What do you do for relaxation? (e.g., sleep, sit outside, listen to music, watch TV, be read to, look at magazines, draw)

Segoe UI 9

AdHoc: Preferences and Strengths Inventory Form

5. Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
Section I - Leisure/Recreation	Document the resident's preferred leisure activities.
Section I - Relationship	Document the resident's growth and goals in relationships with family and friends.
Section I - Work/School/Day Program	Document the resident's preferred work, school, or meaningful activity.
Section I - Independence	Document the resident's self-help skills and goals.
Section I - Living Options	Document the resident's preferred living arrangements.
Preferences, Strengths and Goals Summary	Summarize the resident's preferences and strengths as compiled through the Preferences and Strengths Inventory (PSI).
IHCP Goals	Review the resident's integrated health care plan goals.

III. Recommendations for Personal/Outcomes/Goals	Document the tentative goals from the previous tabs, including supporting preferences and strengths, and needs/barriers.
Informants	Document names of contributors to the PSI.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident’s legal medical record. Use the **Save Form** (💾) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

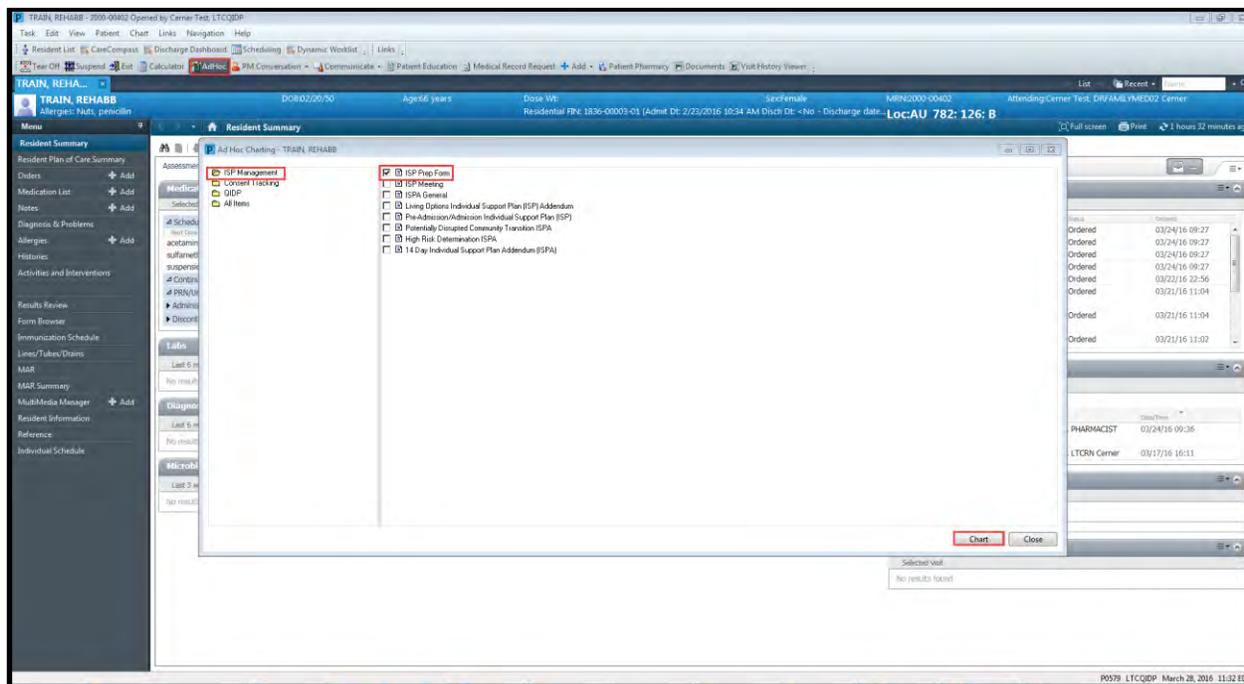
- After the form is complete, click the sign form icon (✓).

ISP Prep Form

Complete the ISP Prep Form to prepare for the ISP Meeting.

- From the **Action Toolbar**, click **AdHoc**.

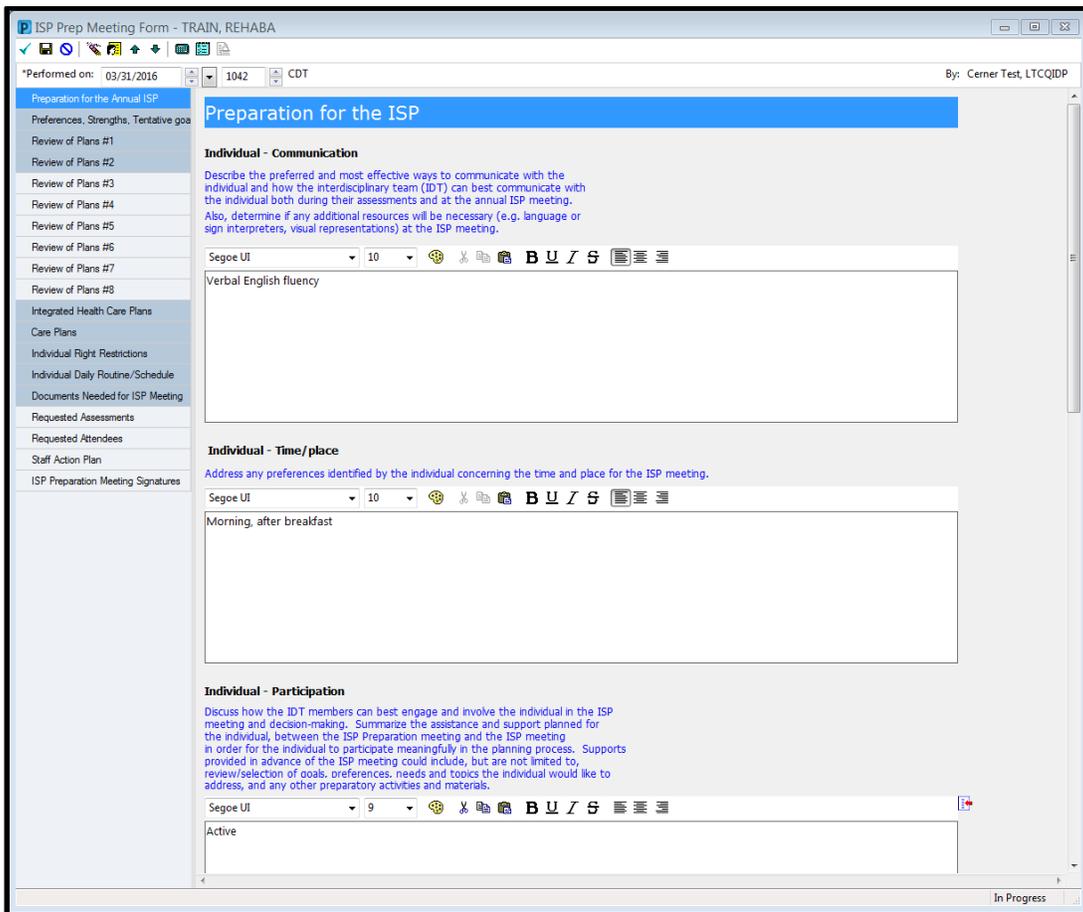
 The **AdHoc Charting** pop-up window displays.



AdHoc Charting Window

- Click the **ISP Management** folder.
- Mark the **ISP Prep Form** check box.
- Click **Chart**.

The ISP Prep Meeting Form pop-up window displays.



AdHoc: ISP Prep Meeting Form

- Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
Preparation for the Annual ISP	Document the resident's preferred communication style, time and place for the meeting; how the IDT can engage the resident during the meeting; what accommodations the staff should make for the meeting; and how to engage the resident's family or legally-authorized representative and direct support professional in the meeting.
Preferences, Strengths, Tentative Goals	Review, evaluate, and revise the Preferences, Strengths, Recommendations for Personal Outcomes/Goals, and Vision Statement identified in the updated Preferences and Strengths Inventory (PSI). <i>Note: This information is pulled directly from the Preferences and Strengths Inventory.</i>

Review of Plans (#1-8)	Document/review goals and action plans for each goal type: Leisure/recreation, relationships, work, independence, and living. This information will flow forward to the ISP Meeting Guide.
Integrated Health Care Plans	Summarizes resident's health care goals as outlined in Review of Plans 1-8. Update with previous and current data, and recommendations. This information will flow forward to the ISP Meeting Guide.
Individual Right Restrictions	Document restriction, rationale, and action plan for any rights restriction, including right to private communication, personal possessions, privacy, freedom of movement, right to make choices, right to manage money, or any restrictive medical/dental or restraint procedures. Data pulls from the Rights Restriction Determination.
Individual's Daily Routine/Schedule	Describe the current status of and make recommendations about the resident's daily routine, including time, community engagement, scheduling, and activities.
Documents Needed for ISP Meeting	Request forms, including Individualized Education Plan (IEP), Behavior Intervention Plan (BIP), Draft NPMP, Draft IHCP, Draft PBSP, etc. Also document who should prepare the document prior to the meeting.
Requested Assessments	Request assessments from IDT members and document specific questions for each member of the IDT regarding assessments, including the FSA, ICA, pharmacy, nutrition, vocational, and others.
Requested Attendees	Select which members of the IDT should attend the ISP Meeting.
Staff Action Plan	Document efforts to prepare resident and LAR/Family member for ISP Meeting and other actions needed to prepare for the annual ISP Meeting.
Individual Support Plan Meeting Signatures	Document names of attendees.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

6. After the form is complete, click the sign form icon (✓).

EXERCISE

1. Navigate to the ISP Prep Form and review the tabs within it.

Notify IDT of ISP Prep Meeting

Outside of PowerChart, notify the resident's IDT of the ISP Prep Meeting.

Hold ISP Prep Meeting

Per policy and procedure, hold the ISP Prep Meeting.

INDIVIDUAL SUPPORT PLAN MEETING

Purpose

This lesson guides QIDPs through the ISP Meeting process.

Objectives

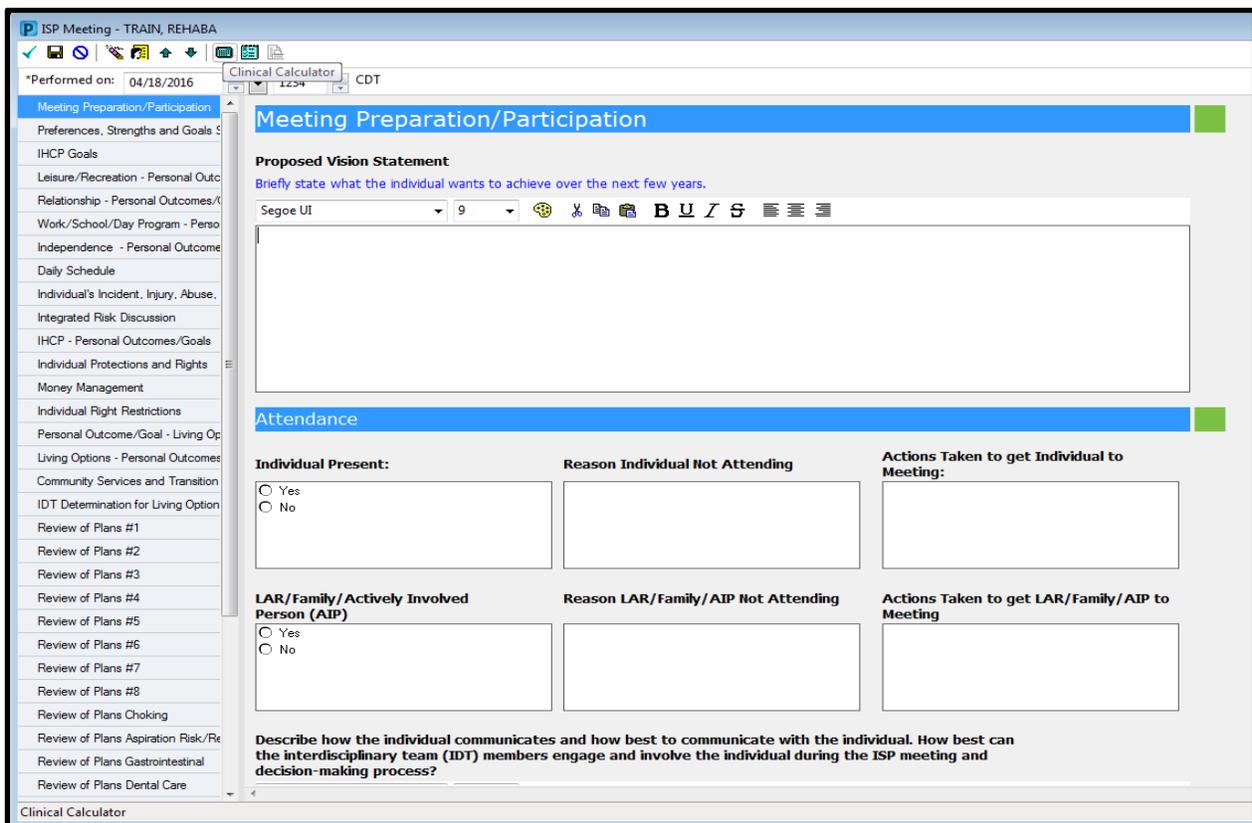
- Complete ISP Meeting Guide
- Create and review Annual Integrated Risk Rating Form

ISP Meeting Guide

Most of the data for the ISP Meeting Guide flows in from comprehensive assessments completed by other members of the Interdisciplinary Team. The QIDP reviews and updates the ISP Meeting Guide five days before the ISP Meeting.

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Mark the **ISP Meeting** check box.
3. Click **Chart**.

 The **ISP Meeting** pop-up window displays.



ISP Meeting - TRAIN, REHABA

*Performed on: 04/18/2016

Meeting Preparation/Participation

Proposed Vision Statement
Briefly state what the individual wants to achieve over the next few years.

Segoe UI 9

Attendance

Individual Present:	Reason Individual Not Attending	Actions Taken to get Individual to Meeting:
<input type="radio"/> Yes <input type="radio"/> No		
LAR/Family/Actively Involved Person (AIP)	Reason LAR/Family/AIP Not Attending	Actions Taken to get LAR/Family/AIP to Meeting
<input type="radio"/> Yes <input type="radio"/> No		

Describe how the individual communicates and how best to communicate with the individual. How best can the interdisciplinary team (IDT) members engage and involve the individual during the ISP meeting and decision-making process?

AdHoc: ISP Meeting Guide

4. Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
Meeting Preparation/Participation	Document the resident's proposed vision statement and attendance details.
Preferences, Strengths, and Goals Summary	Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate.
IHCP Goals	Resident's integrated health care plan goals
Leisure/Recreation – Personal Outcomes/Goals	Document the resident's goals, preferences, strengths, and barriers, and IDT recommendations for accomplishing those goals as discussed in the ISP Meeting.
Relationship - Personal Outcomes/Goals	Document the resident's goals, preferences, strengths, and barriers, and IDT recommendations for accomplishing those goals as discussed in the ISP Meeting.
Work/School/Day Program - Personal Outcomes/Goals	Document the resident's goals, preferences, strengths, and barriers, and IDT recommendations for accomplishing those goals as discussed in the ISP Meeting.
Independence - Personal Outcomes/Goals	Document the resident's goals, preferences, strengths, and barriers, and IDT recommendations for accomplishing those goals as discussed in the ISP Meeting.
Daily Schedule	Populates from ISP Prep Form
Individuals Incident, Injury, Abuse, Neglect and Exploitation Data/Trends	Document data, trends, and action plans pertaining to any incidents, injuries, allegations of abuse/neglect, or other concerns.
Integrated Risk Discussion	Document the IDT's approval of the IRRF and plans addressed in the ISP/Risk Discussion
IHCP - Personal Outcomes/Goals	Document the resident's goals, preferences, strengths, and barriers, and IDT recommendations for accomplishing those goals as discussed in the ISP Meeting.
Individual Protections and Rights	Document the IDT's determination of the resident's ability to provide consent, the need for an LAR/AIP/Advocate, and plans to support the resident's right to vote.
Capacity Assessment Summary	Summarizes the IDT's determination regarding the resident's capacity to provide informed consent. Data pulls from Individual Capacity Assessment.
Money Management	Document the resident's money management plan using information from the Functional Skills Assessment, as discussed in the ISP Meeting
Individual Right Restrictions	Document rationales for all right restrictions, as identified in the Rights Restriction Determination, including action plans to reinstate or reduce the rights restriction (if possible).
Personal Outcome/Goals - Living Options	Document "permanency planning" for residents 22 and younger
Living Options - Personal Outcomes/Goals	Document the resident's goals, preferences, strengths, and barriers, and IDT recommendations for accomplishing those goals as discussed in the ISP Meeting.
Community Services and Transition	Document assessment determinations and rationales from the IDT for Community Services and Transition, including any additional assessment recommendations regarding living in the community, as discussed in the ISP Meeting.

IDT Determination for Living Options	Document the IDT's determination for living options as discussed in the ISP Meeting.
Review of Plans (#1-8)	Document/review goals and action plans for each goal type: Leisure/recreation, relationships, work, independence, and living.
Review of Plans Choking	Develop and review plans for the risk area.
Review of Plans Aspiration Risk/Respiratory Compromise	Develop and review plans for the risk area.
Review of Plans Gastrointestinal	Develop and review plans for the risk area.
Review of Plans Dental Care	Develop and review plans for the risk area.
Review of Plans Cardiac Disease	Develop and review plans for the risk area.
Review of Plans Weight	Develop and review plans for the risk area.
Review of Plans Diabetes	Develop and review plans for the risk area.
Review of Plans Osteoporosis	Develop and review plans for the risk area.
Review of Plans Infection Skin Integrity	Develop and review plans for the risk area.
Review of Plans Neurological	Develop and review plans for the risk area.
Review of Plans Medication	Develop and review plans for the risk area.
Review of Plans Behavioral Health	Develop and review plans for the risk area.
Review of Plans Other	Develop and review plans for the risk area.
Individual Support Plan Meeting Signatures	Document names of attendees.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

5. After the form is complete, click the sign form icon (✓).

EXERCISE

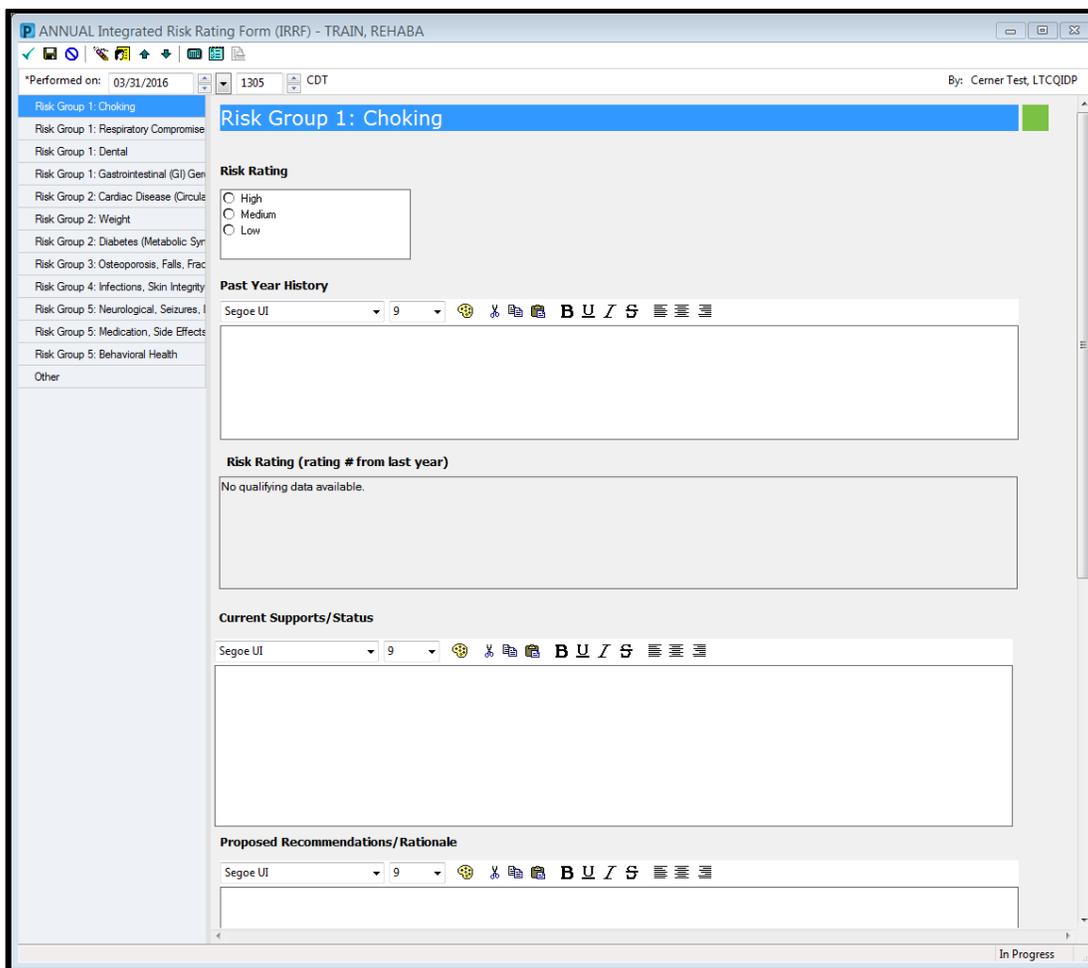
1. Navigate to ISP Meeting Guide and update or complete the form.

Integrated Risk Rating Form (IRRF)

Complete the Integrated Risk Rating Form within five days of the ISP Meeting.

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Click the **QIDP** folder.
3. Mark the **Annual Integrated Risk Rating Form** check box.
4. Click **Chart**.

 The **Annual Integrated Risk Rating Form** pop-up window displays.



Annual Risk Rating Form



5. Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
Risk Group 1: Choking	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 1: Respiratory Compromise/Aspiration	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 1: Dental	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 1: Gastrointestinal (GI) Gerd Constipation	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 2: Cardiac Disease (Circulatory Issues, Edema)	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 2: Weight	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 2: Diabetes (Metabolic Syndrome)	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 3: Osteoporosis, Falls, Fractures	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 4: Infections, Skin Integrity	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 5: Neurological, Seizures, Dementia	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Risk Group 5: Medication, Side Effects/Interactions	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.

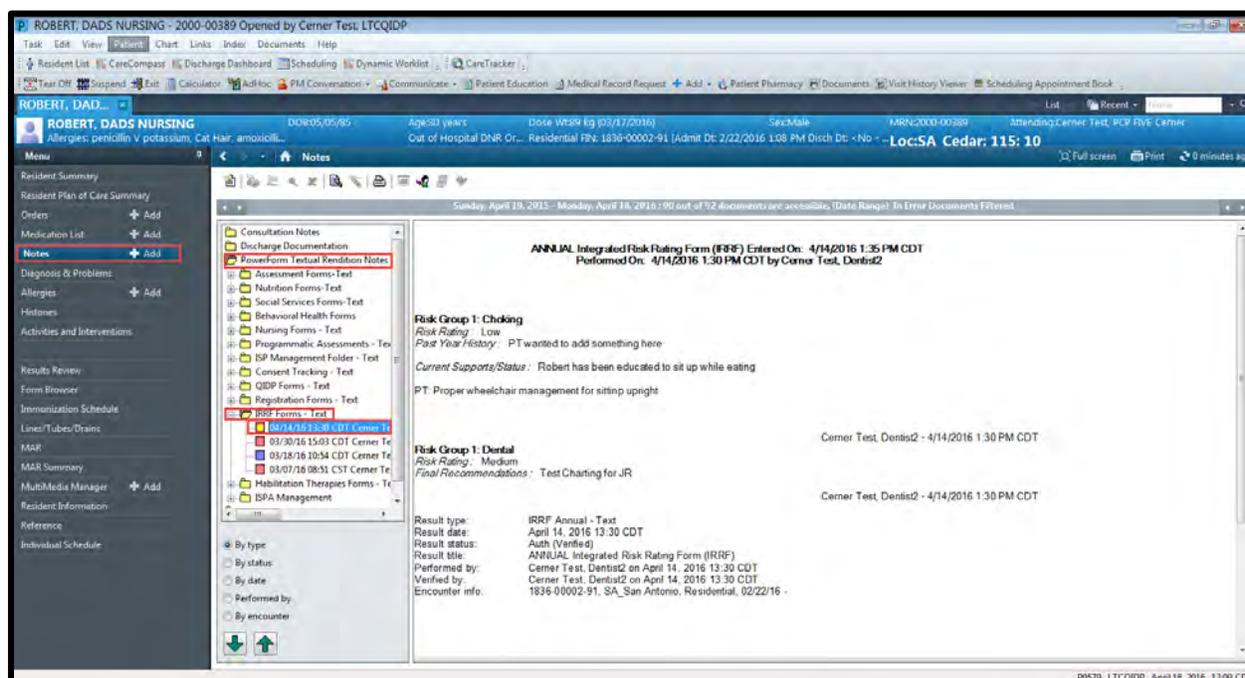
Risk Group 5: Behavioral Health	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.
Other	Document resident's risk rating, past year history, current supports/status, recommendations with rationale, team deliberations, and final recommendations.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form.

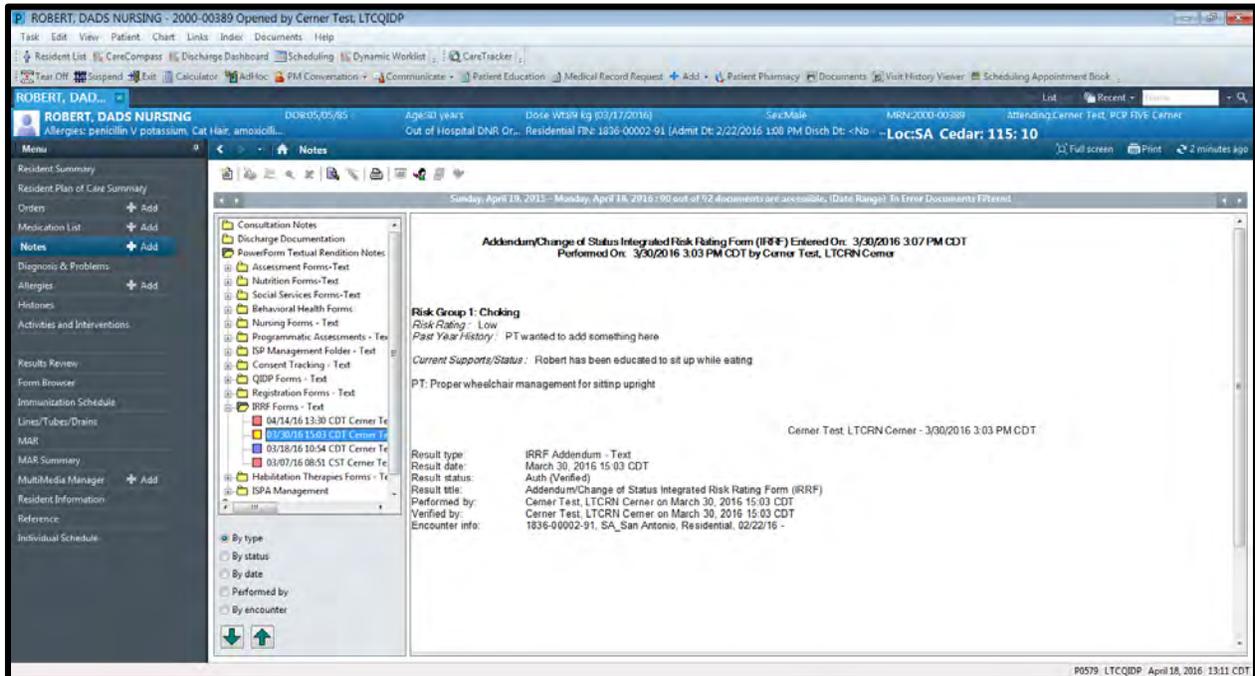
- After the form is complete, click the sign form icon (✓).

Reviewing the Integrated Risk Rating Form

- From the **Menu**, click the **Notes** band.
- The **Notes** window opens.
- Click the **PowerForm Textual Rendition Notes** folder.
- Click to expand the **IRRF Forms – Text** folder.
- Select the appropriate form to review the recommendations from the resident's IDT.



Integrated Risk Rating Form



Addendum/Change of Status – Integrated Risk Rating Form

Scheduling ISP Meeting

1. From **Schaptbook**, select the resident.
2. Schedule ISP Meeting according to policy and procedure, using On Campus ISP/ISPA appointment in **Schaptbook**.

Notify IDT of ISP Meeting

Outside of PowerChart, notify the IDT of the ISP Meeting.

Hold ISP Meeting

Per policy and procedure, hold the ISP Meeting.

ISP Meeting Guide

Finalize the ISP Meeting Guide within 30 days of the ISP meeting.

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Mark the **ISP Meeting** check box.
3. Click **Chart**.
4. Review all the bands within the form and update as necessary.
5. After the form is complete, click the sign form icon (✓).

Tip ▶ To edit an ISP Meeting form in progress but not yet signed, right click on the form using the directions above and click Modify from the menu that appears. Similarly, to remove a chart, right click on the form and click Unchart.

INDIVIDUAL SUPPORT PLAN ADDENDUM MEETING

Purpose

This lesson guides QIDPs through the ISPA Meeting process.

Objectives

- Complete an ISPA General form
- Complete a 14 Day ISPA
- Complete a Living Options ISPA
- Complete a Potentially Disrupted Community Transition form
- Complete a High Risk Determination ISPA

Scheduling ISPA Meeting

1. From **Schaptbook**, select the resident.
2. Schedule ISP Meeting with the IDT according to policy and procedure, using On Campus ISP/ISPA appointment in **Schaptbook**.

Notify IDT of ISPA Meeting

Outside of PowerChart, notify the IDT of ISPA Meeting.

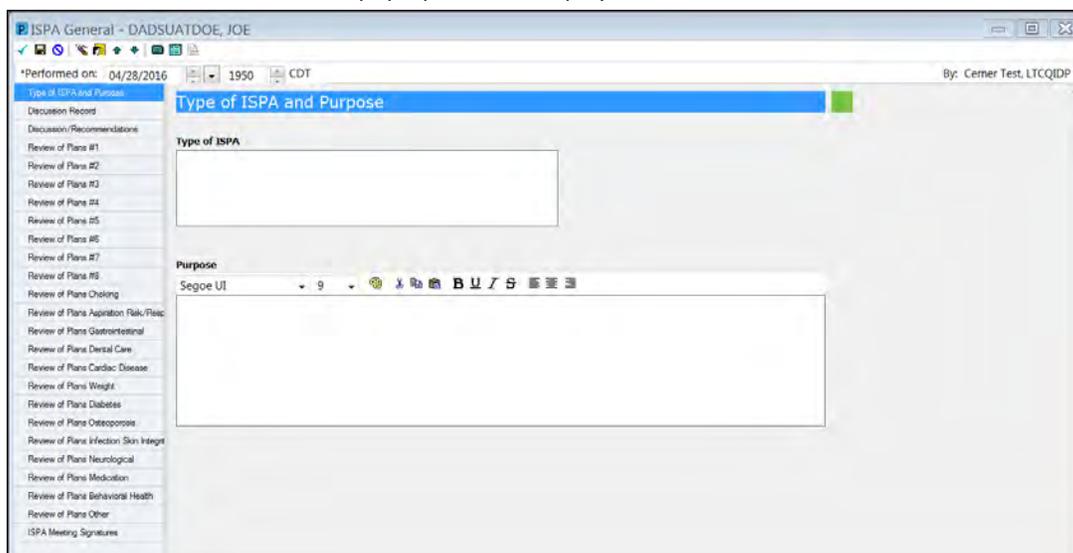
Hold ISPA Meeting

Per policy and procedure, hold the ISPA meeting.

ISPA General Form

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Click the **ISP Management** folder.
3. Mark the **ISPA General** check box.
4. Click **Chart**.

 The **ISPA General** pop-up window displays.



AdHoc: ISPA General Form

5. Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
Type of ISPA and Purpose	Document type and purpose of ISPA meeting.
Discussion Record	Document the issues that required the ISPA meeting and the IDT's discussion of those issues.
Discussion/Recommendations	Document the IDT's recommendations pertaining to the issues that required the ISPA meeting.
Review of Plans (#1-8)	Document/review goals and action plans for each goal type: Leisure/recreation, relationships, work, independence, and living.
Review of Plans Aspiration Risk/Responsibility	Document goals and action plans for the risk area.
Review of Plans Behavioral Health	Document goals and action plans for the risk area.
Review of Plans Cardiac Disease	Document goals and action plans for the risk area.
Review of Plans Choking	Document goals and action plans for the risk area.
Review of Plans Dental Care	Document goals and action plans for the risk area.
Review of Plans Diabetes	Document goals and action plans for the risk area.
Review of Plans Gastrointestinal	Document goals and action plans for the risk area.
Review of Plans Infection Skin Integrity	Document goals and action plans for the risk area.
Review of Plans Medication	Document goals and action plans for the risk area.
Review of Plans Neurological	Document goals and action plans for the risk area.
Review of Plans Osteoporosis	Document goals and action plans for the risk area.
Review of Plans Weight	Document goals and action plans for the risk area.
Review of Plans Other	Document goals and action plans for the risk area.

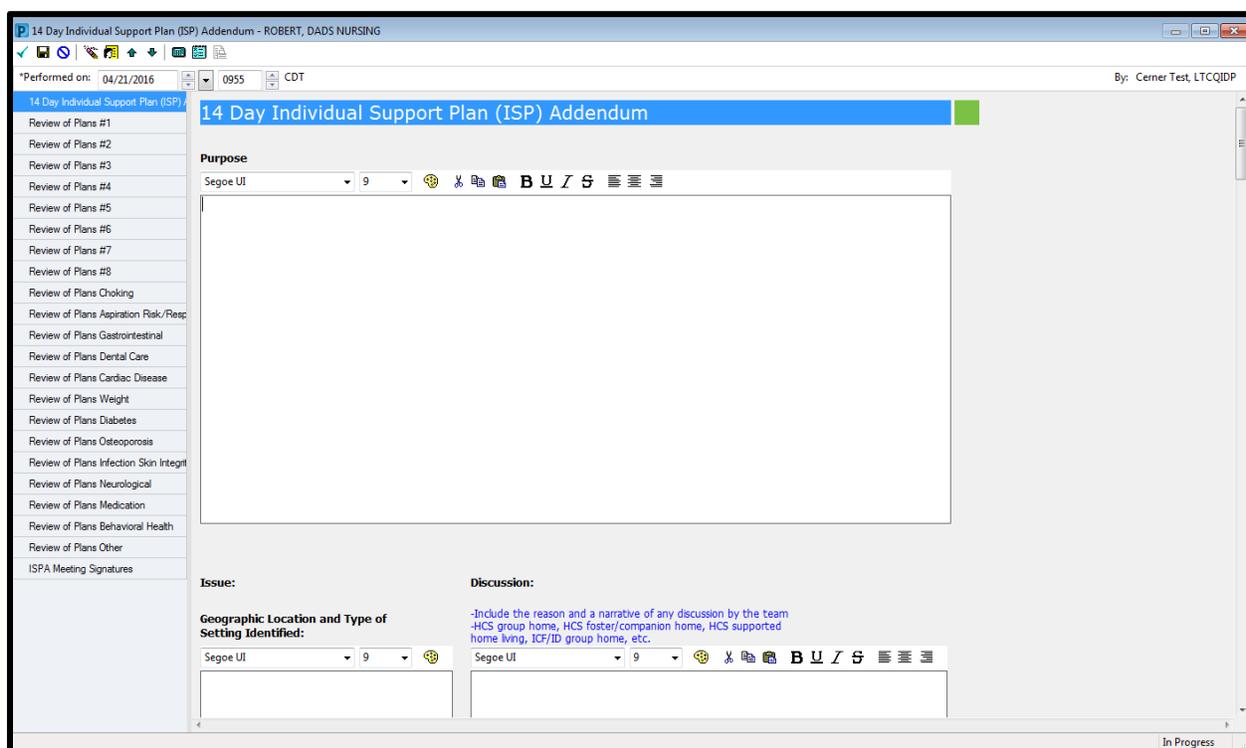
Tip ► Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form.

6. After the form is complete, click the sign form icon (✓).

14 Day Individual Support Plan Addendum

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Click the **ISP Management** folder.
3. Mark the **14 Day Individual Support Plan Addendum (ISPA)** check box.
4. Click **Chart**.

 The 14 Day Individual Support Plan Addendum pop-up window displays.



14 Day Individual Support Plan Addendum

5. Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
14 Day Individual Support Plan Addendum	Document reason for ISPA meeting.
Review of Plans (#1-8)	Document/review goals and action plans for each goal type: Leisure/recreation, relationships, work, independence, and living.
Review of Plans Choking	Document goals and action plans related to the risk area.
Review of Plans Aspiration Risk/Responsibility	Document goals and action plans related to the risk area.
Review of Plans Gastrointestinal	Document goals and action plans related to the risk area.
Review of Plans Dental Care	Document goals and action plans related to the risk area.

Review of Plans Cardiac Disease	Document goals and action plans related to the risk area.
Review of Plans Weight	Document goals and action plans related to the risk area.
Review of Plans Diabetes	Document goals and action plans related to the risk area.
Review of Plans Osteoporosis	Document goals and action plans related to the risk area.
Review of Plans Infection Skin Integrity	Document goals and action plans related to the risk area.
Review of Plan Neurological	Document goals and action plans related to the risk area.
Review of Plans Neurological	Document goals and action plans related to the risk area.
Review of Plans Medication	Document goals and action plans related to the risk area.
Review of Plans Behavioral Health	Document goals and action plans related to the risk area.
Review of Plans Other	Document goals and action plans related to the risk area.
ISPA Meeting Signatures	Collect signatures.

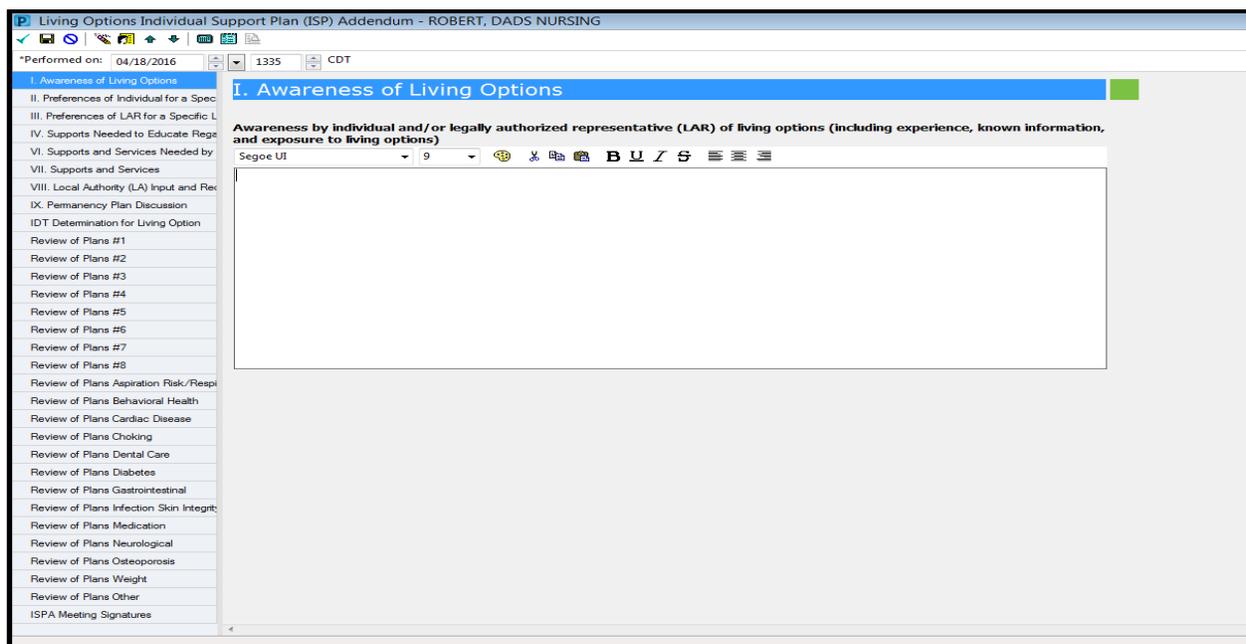
Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident’s legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

6. After the form is complete, click the sign form icon (✓).

Living Options Individual Support Plan (ISP) Addendum

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Click the **ISP Management** folder.
3. Mark the **Living Options Individual Support Plan (ISP) Addendum** check box.
4. Click **Chart**.

The Living Options Individual Support Plan (ISP) Addendum pop-up window displays.



Living Options Individual Support Plan (ISP) Addendum

5. Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
I. Awareness of Living Options	Document resident and/or LAR's awareness and/or LAR of living options
II. Preferences of Individual for a Specific Living Option	Document resident's preferences for a Specific Living Option
III. Preferences of a LAR for a Specific Living Arrangement	Document resident's preferences for a Specific Living Option
IV. Supports Needed to Educate Regarding Living Options	Document supports Needed to Educate Individual and/or LAR Regarding Living Options
VI. Supports and Services Needed by the Individual	Document resident's supports and Services Needed (guardianship, safety, mobility, etc.)
VII. Supports and Services	Document pre- and post-move essential and non-essential supports and services
VIII. Local Authority (LA) Input and Recommendations	Document Local Authority (LA) Input and Recommendations
IX. Permanency Plan Discussion	Document the permanency plan discussion
IDT Determination for Living Option	Document the IDT's determination for the resident's living option
Review of Plans (#1-8)	Document captures recommendations.
Review of Plans Aspiration Risk/Responsibility	Document goals and action plans related to the risk area.

Review of Plans Behavioral Health	Document goals and action plans related to the risk area.
Review of Plans Cardiac Disease	Document goals and action plans related to the risk area.
Review of Plans Choking	Document goals and action plans related to the risk area.
Review of Plans Dental Care	Document goals and action plans related to the risk area.
Review of Plans Diabetes	Document goals and action plans related to the risk area.
Review of Plans Gastrointestinal	Document goals and action plans related to the risk area.
Review of Plans Infection Skin Integrity	Document goals and action plans related to the risk area.
Review of Plans Medication	Document goals and action plans related to the risk area.
Review of Plans Neurological	Document goals and action plans related to the risk area.
Review of Plans Osteoporosis	Document goals and action plans related to the risk area.
Review of Plans Weight	Document goals and action plans related to the risk area.
Review of Plans Other	Document goals and action plans related to the risk area.

Tip ► Click the sign form icon (✓) finalizes the form and makes it part of the resident’s legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

6. After the form is complete, click the sign form icon (✓).

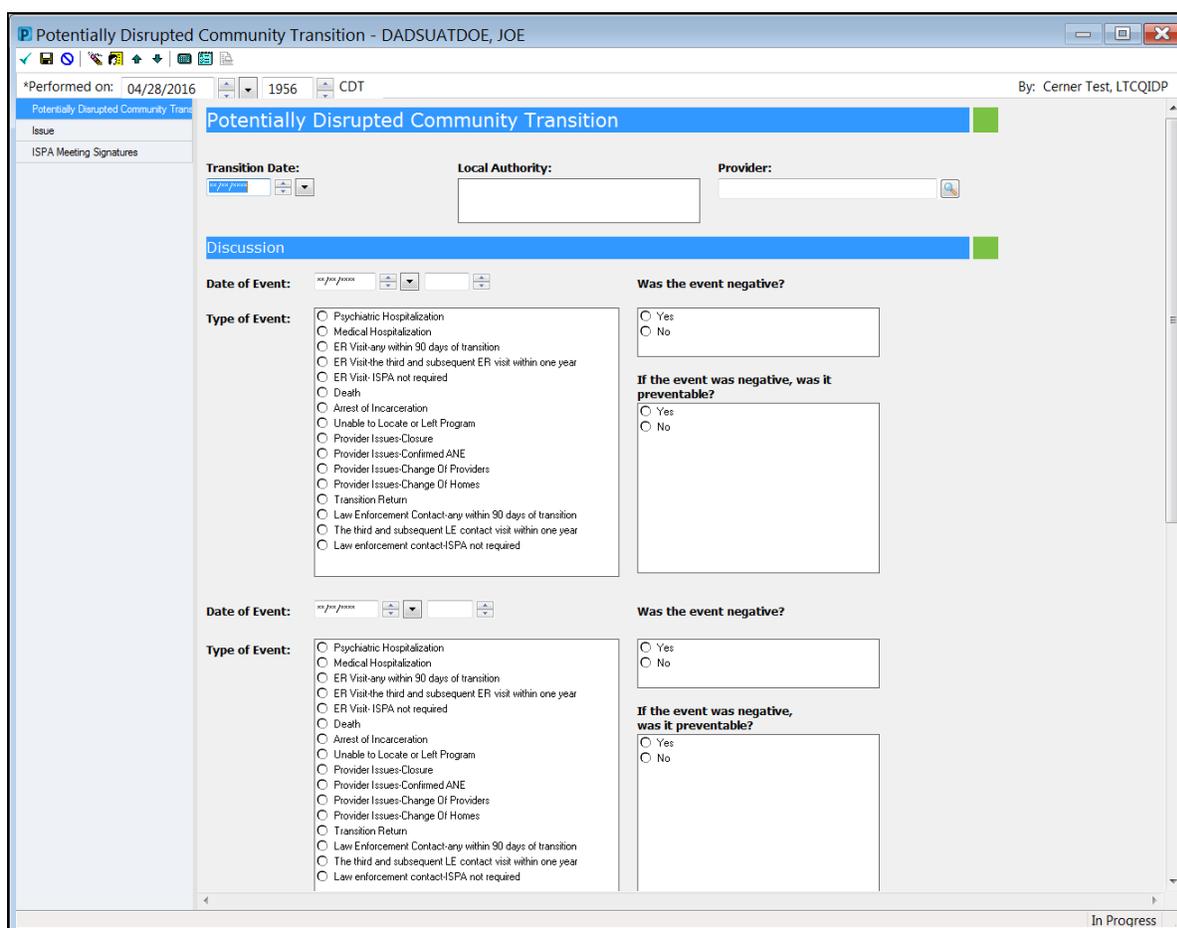
EXERCISE

Navigate to the ISPA General Form and complete the required fields.

Create a New Potentially Disrupted Community Transition Form

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Mark the **Potentially Disrupted Community Transition (PDCT) ISPA** check box.
3. Click **Chart**.

The Potentially Disrupted Community Transition window displays.



AdHoc: Potentially Disrupted Community Transition Form

- Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
Potentially Disrupted Community Transition	Document event and discussion that required the PDCT meeting.
Issue	Document the issues that required the ISPA meeting and the IDT's discussion of those issues.

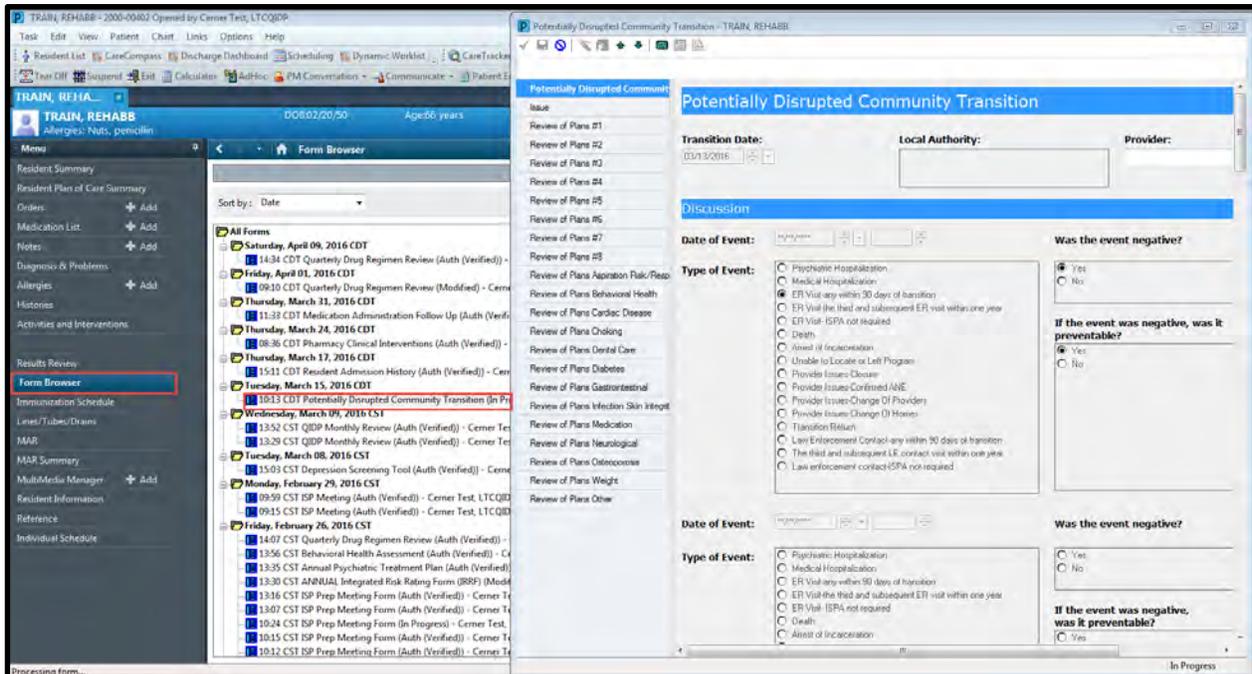
Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

- After the form is complete, click the sign form icon (✓).

Review a Potentially Disrupted Community Form

1. From the **Menu**, click the **Form Browser** band.
2. The **Form Browser** window displays.
3. Double-click to expand the **All Forms** folder.
4. Double-click the appropriate **Potentially Disrupted Community Transition** form.

 The **Potentially Disrupted Community Transition** pop-up window displays.



Form Browser: Potentially Disrupted Community Transition Form

5. Review all the bands within the form.
6. Click the Red X () at the top right corner of the window to log out.

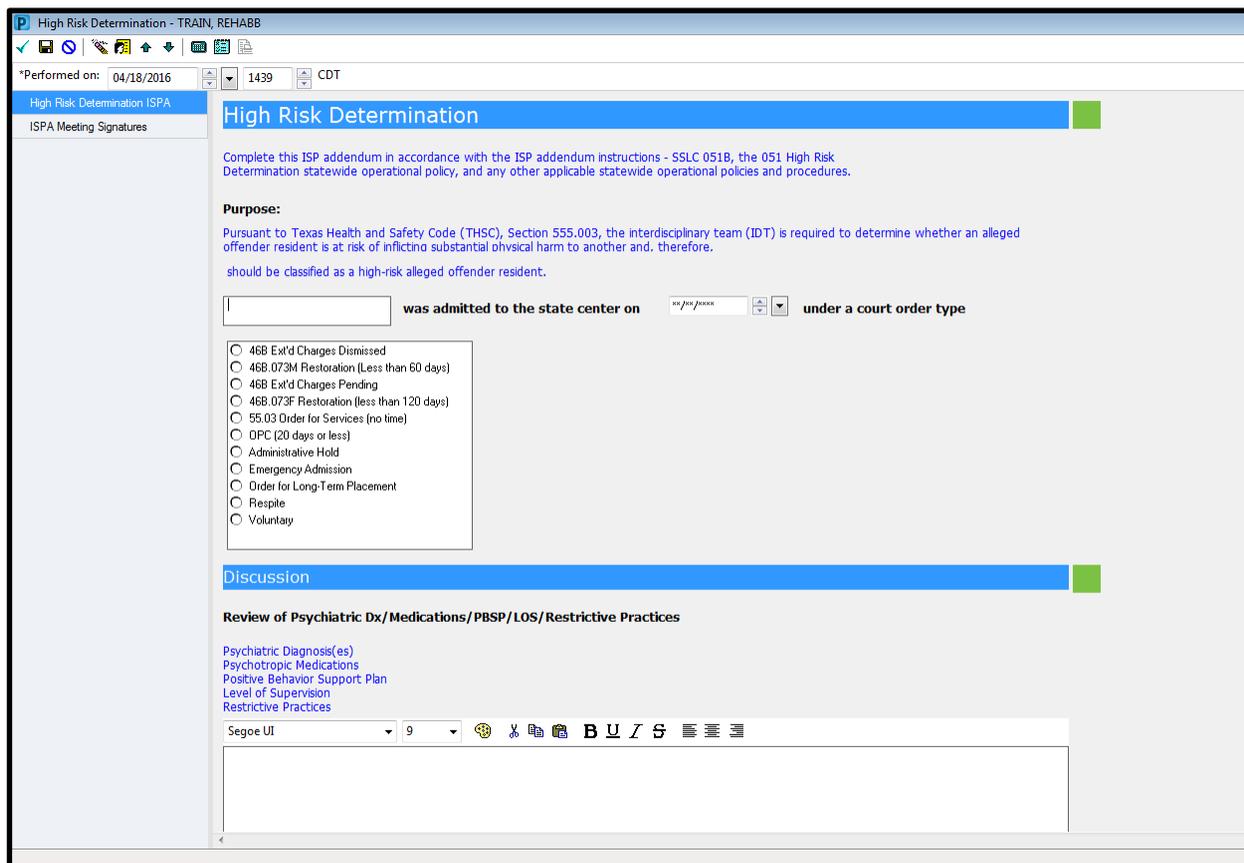
EXERCISE

Navigate to the Potentially Disrupted Community Transition Form and complete the required fields.

High Risk Determination ISPA

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Click the **ISP Management** folder.
3. Mark the **High Risk Determination ISPA** check box.
4. Click **Chart**.

The High Risk Determination ISPA pop-up window displays.



ISP Management: High Risk ISPA

5. Review and document recommendations from the IDT to update the form as appropriate.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident’s legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

6. After the form is complete, click the sign form icon (✓).



FORMS

Purpose

This lesson guides QIDPs through reviewing additional forms which impact the resident's ISP or ISPA.

Note: Additional forms are important for you to complete. They are not covered in this manual. However, those forms are titled: Living Option Discussion (QIDP folder) and Care ID Needs and Care Physical Characteristics (CARE Forms folder).

Objective

- Write and Review Monthly Reviews
- Place an ISP Orderset
- Review Individual Capacity Assessment (FSA)
- Review Functional Skills Assessment (FSA)
- Locate and review supplemental forms.

Review Forms

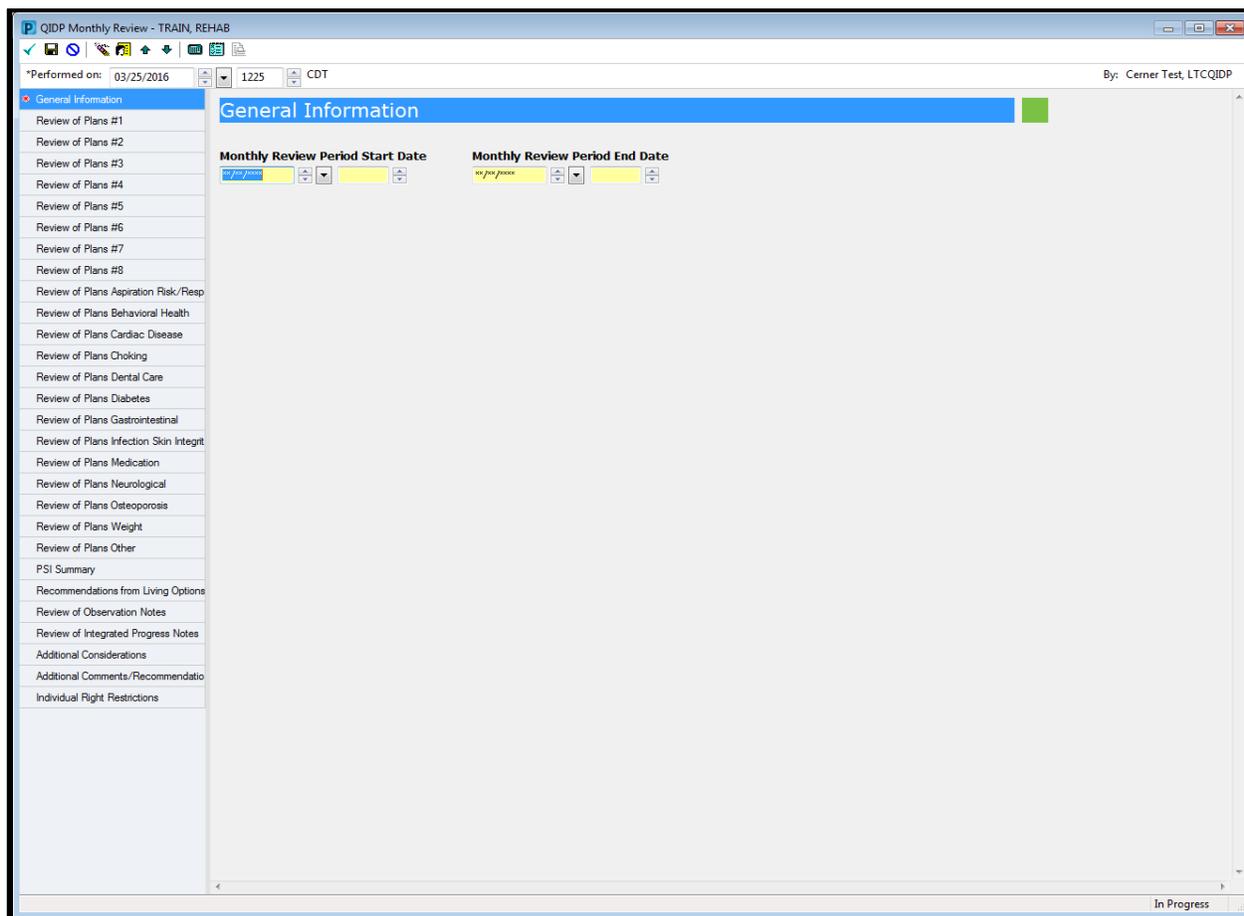
Forms can be located using the AdHoc button on the Action toolbar.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Write QIDP Monthly Review

1. From the **Action Toolbar**, click **AdHoc**.
2. Click the **QIDP** folder.
3. Mark the **QIDP Monthly Review** check box.
4. Click **Chart**.

The QIDP Monthly Review pop-up window displays.



AdHoc: QIDP Monthly Review

- Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
General Information	Document the monthly review period start and end date.
Review of Plans (#1-8)	Document/review status of goals and action plans for each goal type: Leisure/recreation, relationships, work, independence, and living.
Review of Plans Aspiration Risk/Responsibility	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Behavioral Health	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Cardiac Disease	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Choking	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Dental Care	Review and document the status of implementation and whether progress is being made on the action plans.

Review of Plans Diabetes	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Gastrointestinal	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Infection Skin Integrity	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Medication	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Neurological	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Osteoporosis	Review and document the status of implementation and whether progress is being made on the action plans.
Review of Plans Weight	Document from the ISP Meeting: Make recommendations to modify, continue, or discontinue these plans in the coming year.
Review of Plans Other	Review and document the status of implementation and whether progress is being made on the action plans.
PSI Summary	Summarize the resident's preferences and strengths (populates from the Preferences and Strengths Inventory form).
Recommendations from Living Options	Document any recommendations on the resident's living options.
Review of Observation Notes	Document any significant events and activities, as well as any associated action plans.
Review of Integrated Progress Notes	Document any significant events and activities, as well as any associated action plans.
Additional Considerations	Document any significant events and activities, as well as any associated action plans relating to ISPA's, Assessments/Evaluations, Incidents/ANE allegations, illnesses/hospitalizations, medication changes, incidents of peer-to-peer aggression, restraint or injury trending, HRC Referrals/Emergency Restrictions, or other issues.
Additional Comments/Recommendations	Document any recommendations for IDT reviews or ISPA's for plans that are regressing, or have not met criteria and would benefit from additional goals.
Individual Right Restrictions	Document restriction, rationale, and action plan for any rights restriction, including right to private communication, personal possessions, privacy, freedom of movement, right to make choices, right to manage money, or any restrictive medical/dental or restraint procedures.

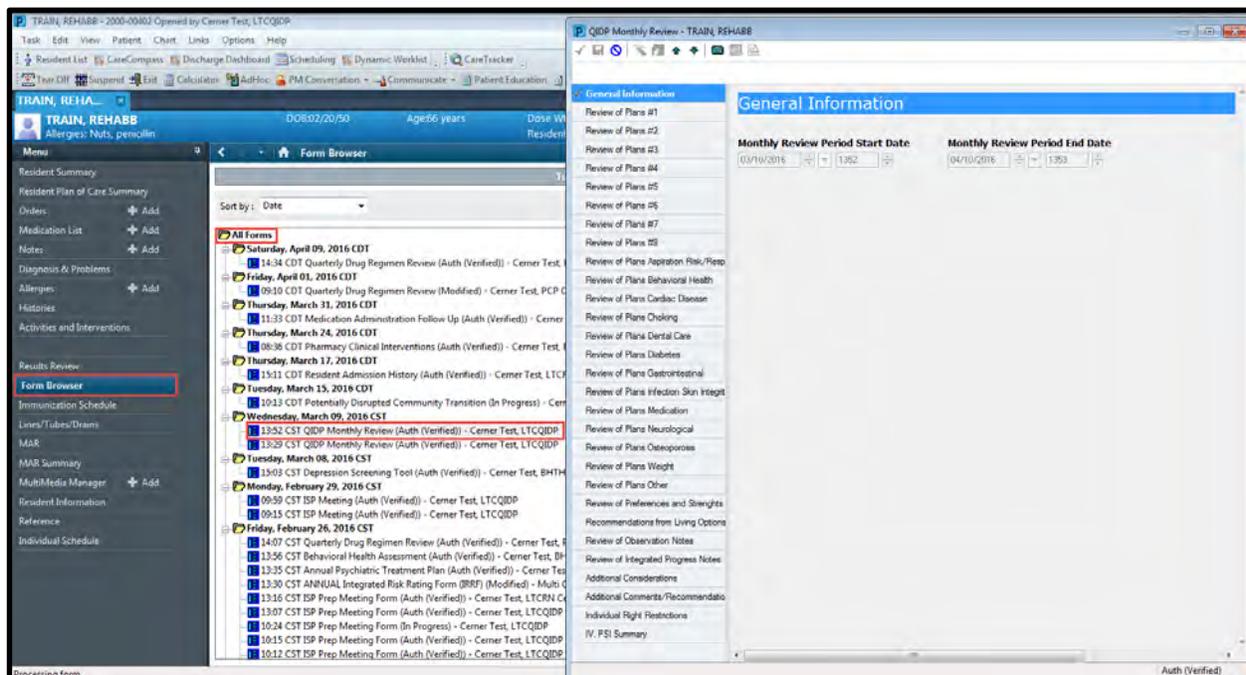
Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** (📁) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

- After the form is complete, click the sign form icon (✓).

Review Existing QIDP Monthly Reviews

1. From the **Menu** in the resident's record, click the **Form Browser** band.
2. In the **Form Browser** window, double-click **All Forms**.
3. The **All Forms** folder expands.
4. Double-click on the dated folders to find the desired **Monthly Review**.
5. The folder expands.
6. Double-click on the desired **QIDP Monthly Review (Auth (Verified))**.

 The **QIDP Monthly Review** pop-up window displays.



Form Browser: Monthly Review Form

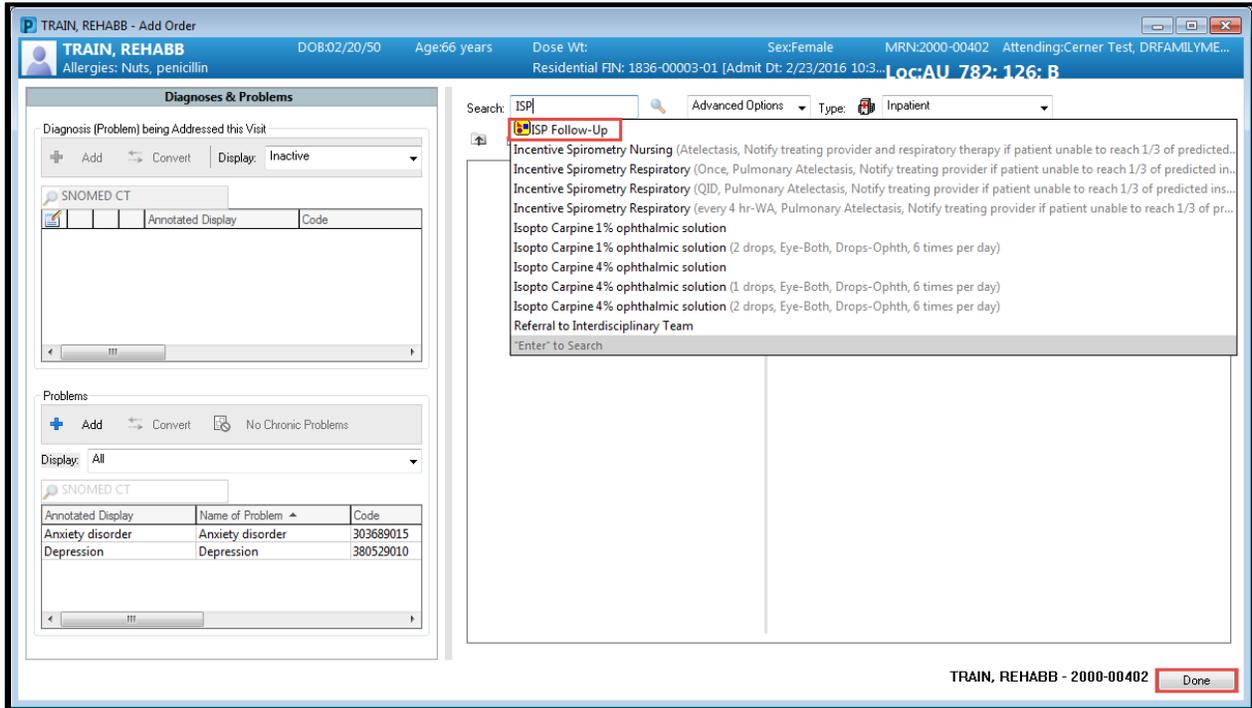
7. Click the bands to review plans from other members of the IDT.
8. Click the Red X () at the top right corner of the window to log out.

ISP Orderset

Use the ISP Orderset to notify and remind the care team to complete tasks following the ISP or ISPA meeting.

1. From the **Menu**, click the **Orders** band and click **+ Add**

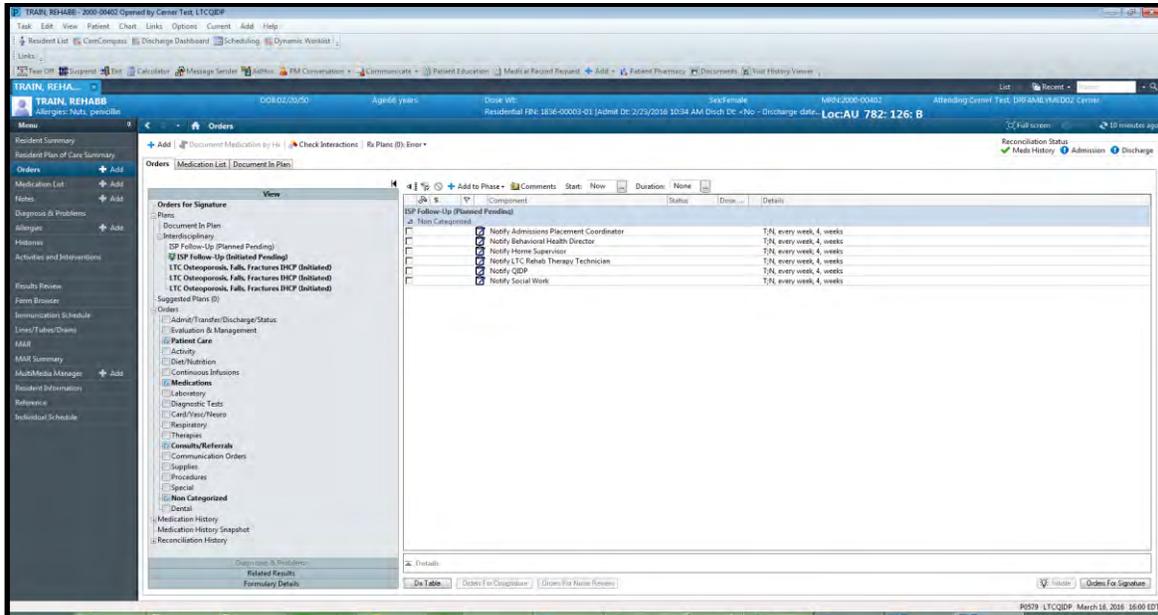
 The **Add Order** pop-up window displays.



Add Order Search Window

2. Type **ISP** into the search box, and select **ISP Follow-up**.
3. Click **Done**.

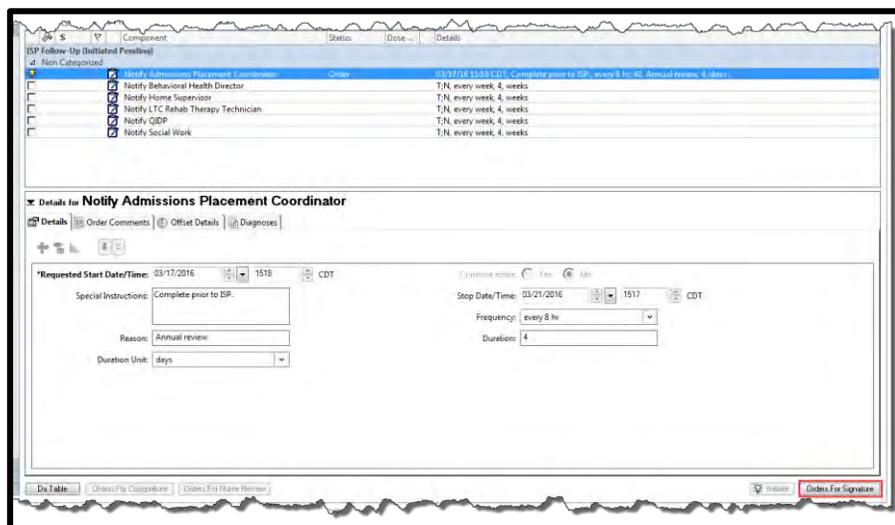
The **Orders** window displays. From the **View** window, under **Orders for Signature**, the **ISP Follow-Up (Planned Pending)** order displays in the Interdisciplinary folder. The **Notify** orders display in the **Orders** window.



Orders window

4. Mark the check box next to the appropriate role(s) to notify.
5. Click **Initiate**.
6. In the **Orders** window, click on role that is to be notified.

The **Details** window expands.



ISP Orderset: Details for Notify Admissions Placement Coordinator

7. Fill out the **Details, Order Comments, Offset, and Diagnoses** as needed for each role to be notified.

Tip ▶ Use the Order Comments text box to request specific feedback from the user (e.g., “Please complete the Therapeutic Riding Assessment.”)

8. From the **Orders** window, click **Orders for Signature**.
9. From the **Orders** window, click **Sign**.
10. Click **Refresh**.

Tip ▶ Signed orders display in the user’s task list, and the status will change to Complete once the task has been completed.

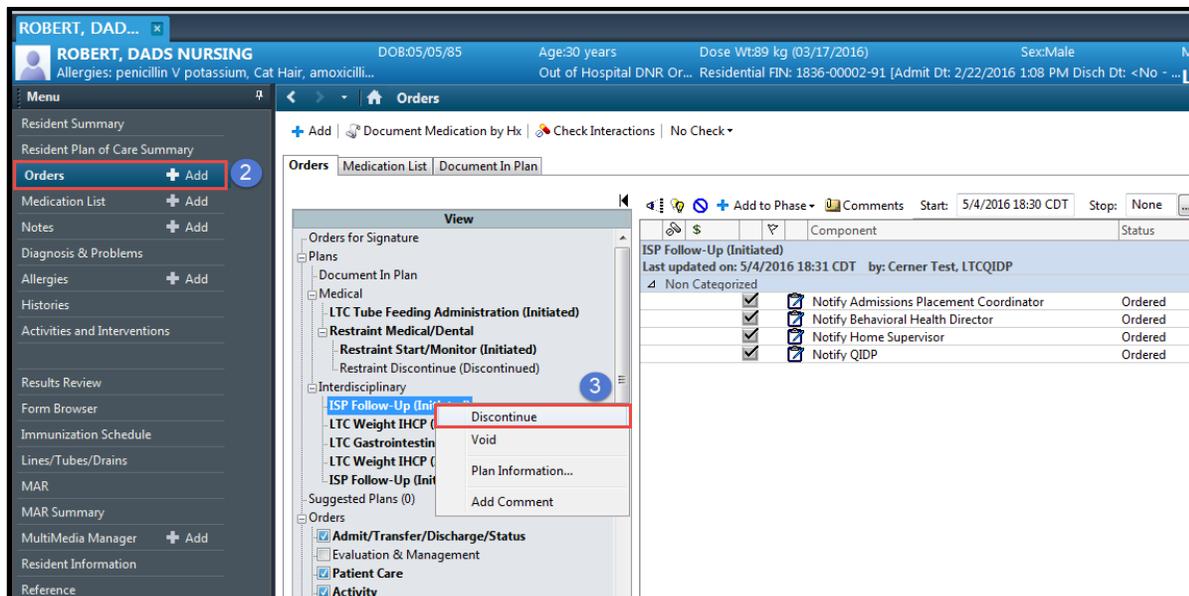
Note: Tasks are automatically sent immediately after clicking sign/refresh. In the task list, the time frame criteria may need to be adjusted for the task to display.

Note: If a weekly frequency is selected for a task, the task will display immediately on the task list (after clicking Refresh), assuming that you did not select a future date for the task. The task will automatically display every seven days until the order is discontinued or the duration of the order is complete.

Discontinue an Order

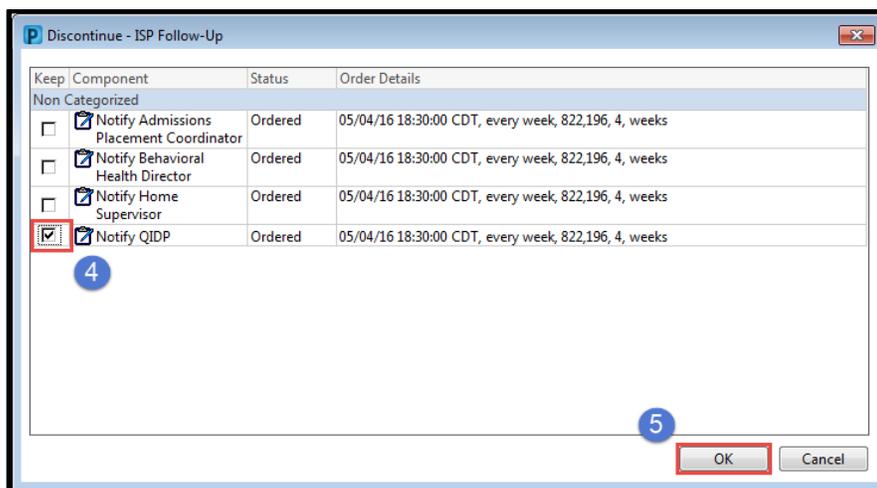
To discontinue an order:

1. Perform a resident search and select the resident for which the order should be discontinued.



2. From the Chart **Menu**, click the **Orders** band.
3. In the **View** window, right-click **ISP Follow-Up (Initiated)**. Select **Discontinue**.

 The **Discontinue – ISP Follow-up** window displays.



The Discontinue – ISP Follow-up Window

4. Mark the check-box next to orders that should **NOT** be discontinued.

Note: If you want to discontinue an entire orderset, do **NOT** select any of the checkboxes.

5. Click **OK**.

6. Click **Orders for Signature**.
7. Click **Sign**.

EXERCISE

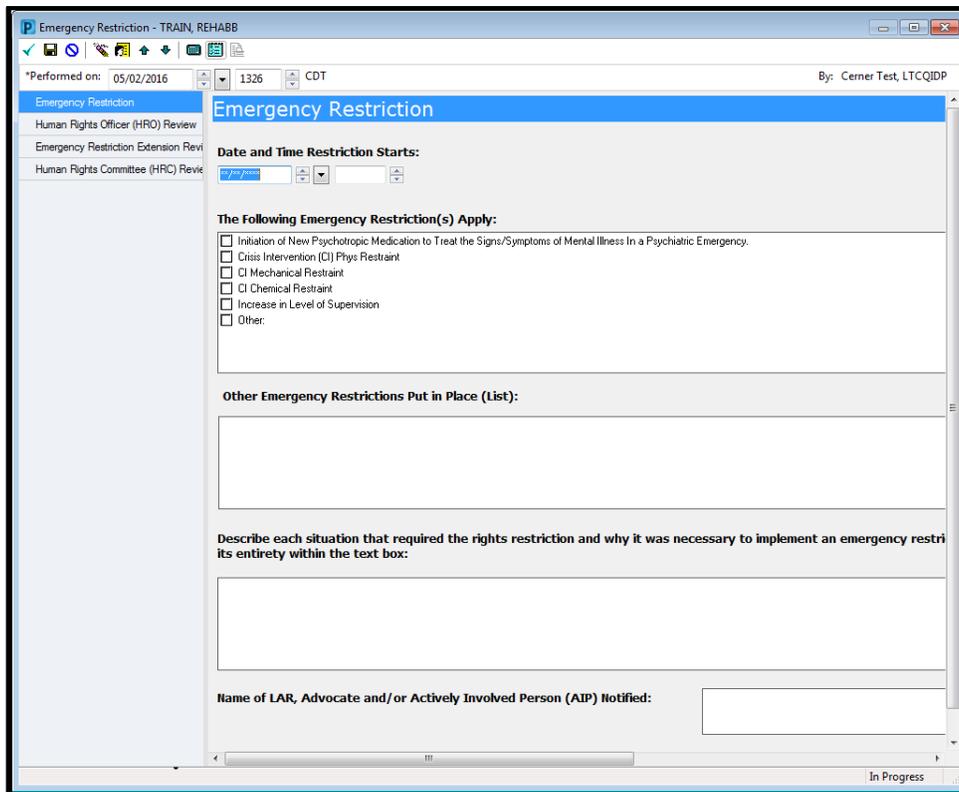
1. Complete an ISP Orderset.
2. Discontinue an order.

Emergency Restriction Form

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Click on the **QIDP** folder.
3. Mark the **Emergency Restrictions** check box.
4. Click **Chart**.

 The **Emergency Restriction** pop-up window displays.



Emergency Restriction Form

- Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
Emergency Restriction	Document the type of emergency restriction(s) and reasons they were implemented.
Human Rights Officer (HRO) Review	Document Human Rights Officer's notification of the emergency restriction.
Emergency Restriction Extension Review	If the team determines the emergency restriction is needed past the approved 3 days, this tab must be filled out to document IDT's rationale and provide oversight for the extension. Select N/A if the team meets and decides to discontinue all restrictions. <u>Note:</u> This still applies if the team meets and reduces the emergency restriction (i.e. a restriction is still needed but it has not yet been approved in the Human Rights Committee).
Human Rights Committee (HRC) Review	Members of the Human Rights Committee document the receipt and provide comment. Only the HRO can document within this tab.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

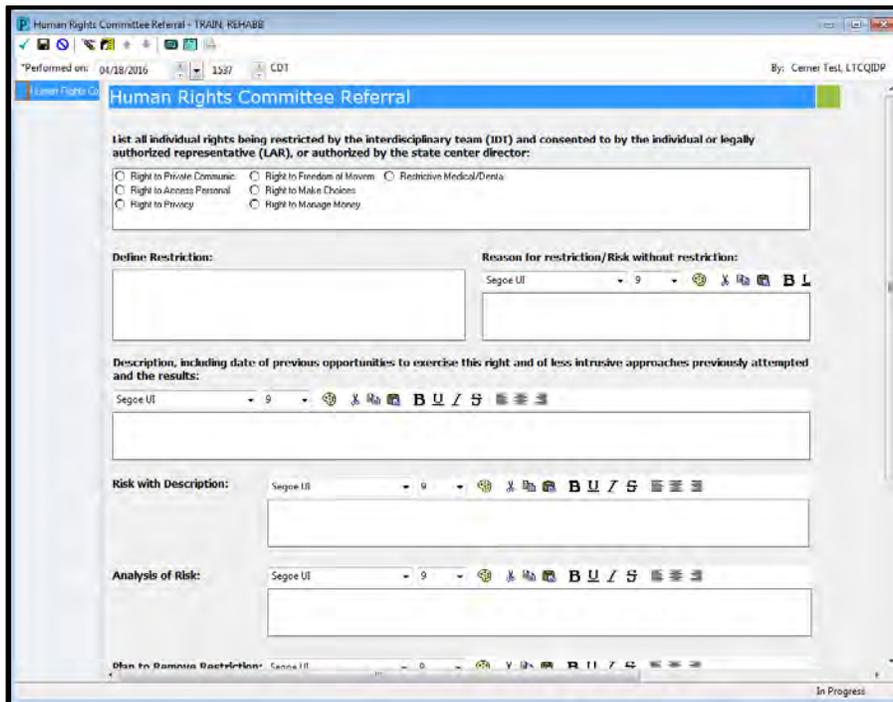
- After the form is complete, click the sign form icon (✓).
- Follow center procedures to notify Human Rights Officer of your submission.

Human Rights Committee Referral

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

- From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
- Click on the **QIDP** folder.
- Mark the **Human Rights Referral** check box.
- Click **Chart**.

 The Human Rights Committee Referral pop-up window displays.



Human Rights Committee Referral

5. Document any rights being restricted, risks associated with the restriction, and plans to remove the restriction.

Tip  Click the sign form icon () finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** () button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon () right click the form, and click **Modify**.

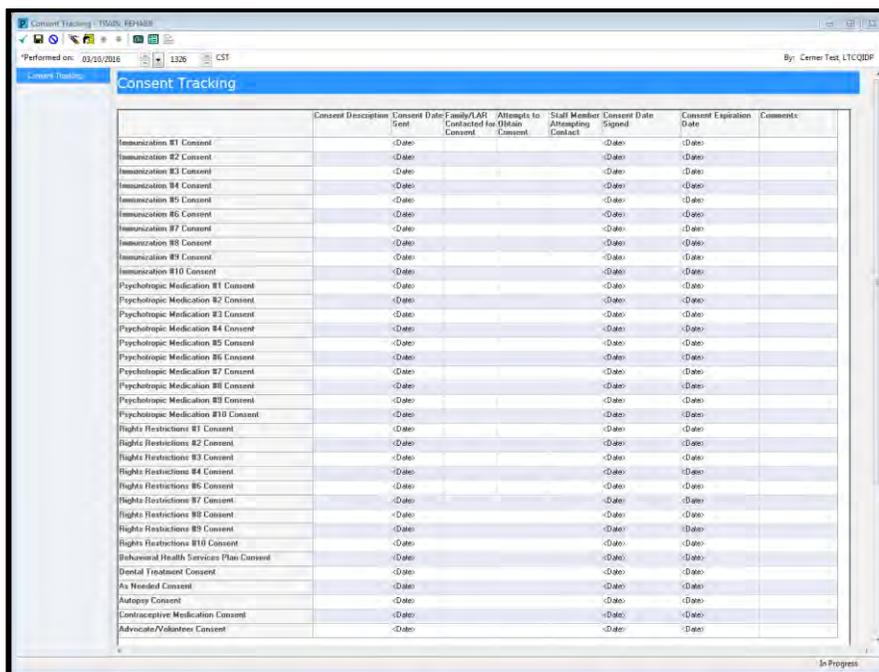
6. After the form is complete, click the sign form icon ()
7. **Follow center procedures to notify Human Rights Officer of your submission.**

Consent Tracking Form

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

1. From the **Action Toolbar**, click **AdHoc** to open the **AdHoc Charting** pop-up window.
2. Click on the **Consent Tracking** folder.
3. Mark the **Consent Tracking** check box.
4. Click **Chart**.

 The **Consent Tracking** pop-up window displays.



Consent Description	Consent Date/ Sent	Family/LAR Contacted for Consent	Attempts to Obtain Consent	Staff Member Attempting Contact	Consent Date Signed	Consent Expiration Date	Comments
Immunization #1 Consent	-Date-				-Date-	-Date-	
Immunization #2 Consent	-Date-				-Date-	-Date-	
Immunization #3 Consent	-Date-				-Date-	-Date-	
Immunization #4 Consent	-Date-				-Date-	-Date-	
Immunization #5 Consent	-Date-				-Date-	-Date-	
Immunization #6 Consent	-Date-				-Date-	-Date-	
Immunization #7 Consent	-Date-				-Date-	-Date-	
Immunization #8 Consent	-Date-				-Date-	-Date-	
Immunization #9 Consent	-Date-				-Date-	-Date-	
Immunization #10 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #1 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #2 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #3 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #4 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #5 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #6 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #7 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #8 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #9 Consent	-Date-				-Date-	-Date-	
Psychotropic Medication #10 Consent	-Date-				-Date-	-Date-	
Rights Restrictions #1 Consent	-Date-				-Date-	-Date-	
Rights Restrictions #2 Consent	-Date-				-Date-	-Date-	
Rights Restrictions #3 Consent	-Date-				-Date-	-Date-	
Rights Restrictions #4 Consent	-Date-				-Date-	-Date-	
Rights Restrictions #5 Consent	-Date-				-Date-	-Date-	
Rights Restrictions #7 Consent	-Date-				-Date-	-Date-	
Rights Restrictions #8 Consent	-Date-				-Date-	-Date-	
Rights Restrictions #9 Consent	-Date-				-Date-	-Date-	
Rights Restrictions #10 Consent	-Date-				-Date-	-Date-	
Behavioral Health Services Plan Consent	-Date-				-Date-	-Date-	
Dental Treatment Consent	-Date-				-Date-	-Date-	
As Needed Consent	-Date-				-Date-	-Date-	
Autopsy Consent	-Date-				-Date-	-Date-	
Contraceptive Medication Consent	-Date-				-Date-	-Date-	
Advocate/Volunteer Consent	-Date-				-Date-	-Date-	

Consent Tracking Form

- Document the consent tracking as appropriate to your role. Refrain from revising or deleting information regarding consents you are not directly managing.

Tip ▶ Click the sign form icon () finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** () button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon () right click the form, and click **Modify**.

- After the form is complete, click the sign form icon ()

Individual Capacity Assessment (ICA)

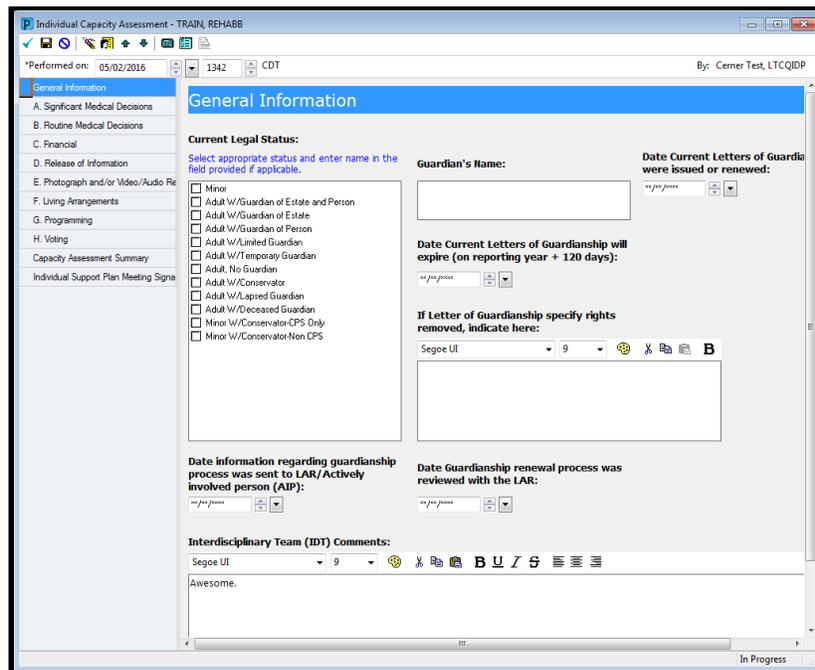
Note: This function is typically completed by the QIDP.

Complete the Individual Capacity Assessment via a team meeting (inclusive of the individual and LAR) following the ISP Prep Meeting.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

- Mark the **Individual Capacity Assessment (ICA)** check box.
- Click **Chart**.

The Individual Capacity Assessment pop-up window opens.



Individual Capacity Assessment

3. Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
General Information	Document general information about the resident, including legal status
A. Significant Medical Decisions	Document resident's ability to identify his or her acute health care issues, including treatments and side effects.
B. Routine Medical Decisions	Document resident's ability to identify his or her routine health care issues, including treatments and side effects.
C. Financial	Document resident's understanding of money and its value.
D. Release of Information	Document resident's understanding of his/her personal information and its usage.
E. Photograph and/or Video/Audio Recording Release	Document resident's understanding of his/her personal information and its audio/video usage.
F. Living Arrangements	Document resident's understanding of his/her input into his/her living arrangements.
G. Programming	Document resident's understanding of his/her input into his/her current programming (diet, exercise, activities, etc.).
H. Voting	Document the support needed to enable the resident to vote.
Capacity Assessment Summary	Document the resident's capacity to provide informed consent about simple and routine medical decisions, financial decisions, release of information decisions, living arrangements, and programming.
Individual Support Plan Meeting Signatures	Document names of attendees.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident’s legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

4. After the form is complete, click the sign form icon (✓).

Rights Restriction Determination

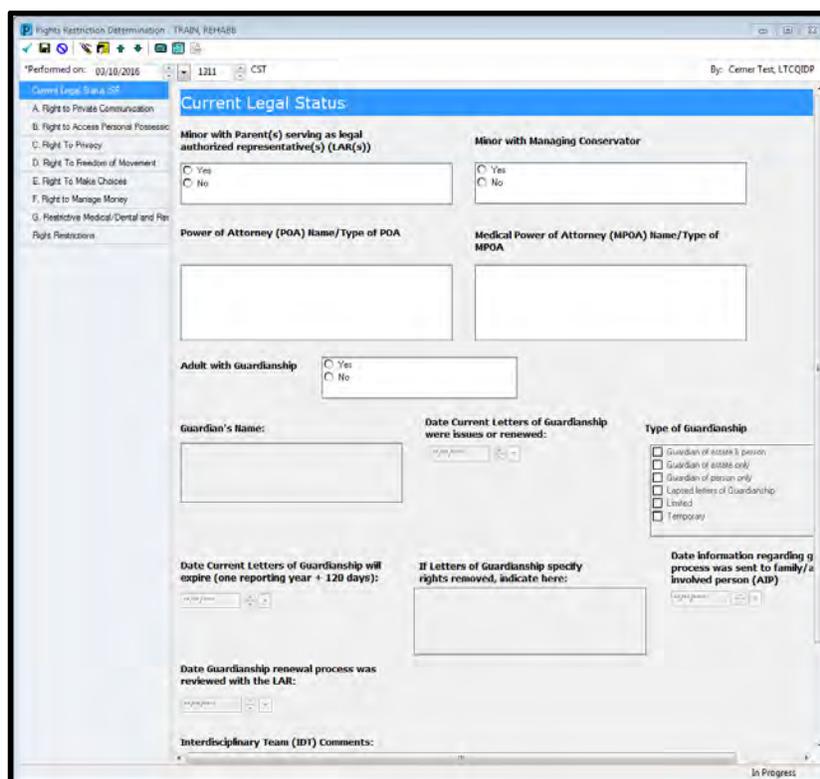
Note: This function is typically completed by the QIDP.

Determine any proposed changes to the Rights Restriction and update the Rights Restriction Determination form.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

1. Mark the **Rights Restriction Determination** check box.
2. Click **Chart**.

📄 The **Rights Restriction Determination** pop-up window displays.



Rights Restriction Determination

3. Click each band to review recommendations from the IDT and to update the form as appropriate.

Band	Purpose
Current Legal Status ISP	Document resident's current legal status
A. Right to Private Communication	Document any need the resident might have to restrict the right to private communication
B. Right to Access Personal Possessions	Document any need the resident might have to restrict the right to access personal possessions.
C. Right to Privacy	Document any need the resident might have to restrict the right to privacy during treatment and personal care, private meetings, or when communicating to people of the resident's choice.
D. Right to Freedom of Movement	Document any need the resident might have to restrict the right to freedom of movement within the home, or during on-campus or community events.
E. Right to Make Choices	Document any need the resident might have to restrict the right to make choices regarding food/drink/tobacco.
F. Right to Manage Money	Document any need the resident might have to restrict the right to manage his/her own money.
G. Restrictive Medical/Dental and Restraint Procedures and Practices	Document the resident's right to be free from medications or restraints.
Right Restrictions	Document that the resident or LAR has been informed of any rights restrictions.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal medical record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

4. After the form is complete, click the sign form icon (✓).
5. **Follow center procedures to notify Human Rights Officer of your submission.**

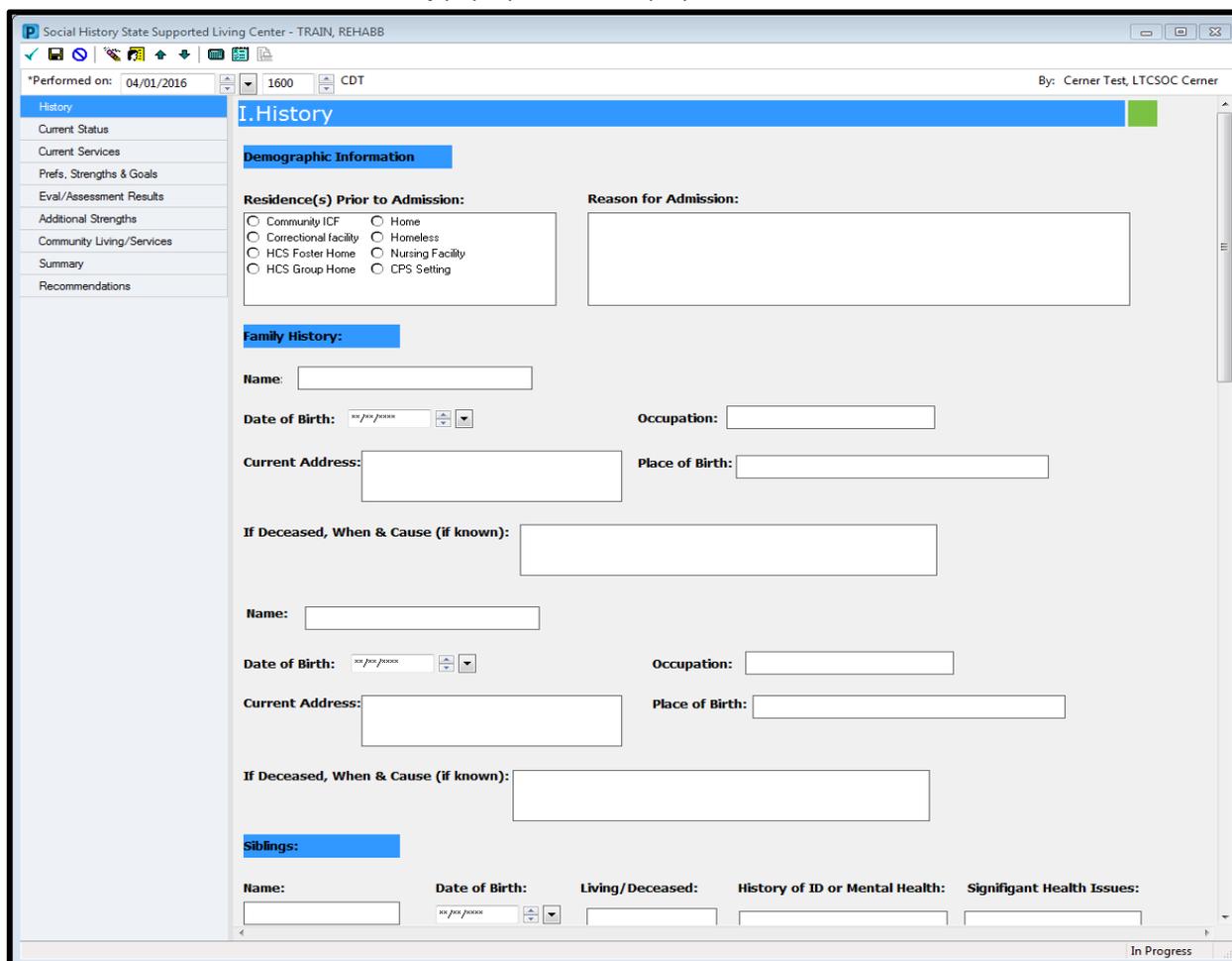
Social History

Note: Social Workers typically complete this process.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident's file.

1. Click **AdHoc** from the Action Toolbar.
2. Click the **Social Services** folder.
3. Mark the **Social History** check box.
4. Click **Chart**.

The **Social History** pop-up window displays.



Social History

- Click each band on the left hand column to complete the social history. Remember to scroll down on the right hand side to ensure all fields within the band have been addressed before moving onto the next one.

Band	Purpose
History	Discuss the rationale for the admission and gather all available history on the individual's family.
Current Status	Document resident's legal status, including guardianship, court stipulations, medical information, trauma history, social behavior, spiritual and cultural needs, and educational/vocational history.
Current Services	Document any services resident current receives at the center or received in the community (if being completed at admission).
Prefs, Strengths & Goals	Document resident's strengths, areas of growth, and preferences supported by himself/herself and his/her family.

Eval/Assessment Results	Document results of any assessment completed. This could include assessments performed by a Social Worker, or assessment information from other disciplines that you deem relevant to the completion of the social history.
Additional Strengths	Document additional strengths/contraindications to stated goals.
Community Living/Services	Document resident's ability to be served in a less restricted setting, and recommendations for the resident's transition to a community setting.
Summary	Provide a narrative synopsis of the individual's case based on the history collected, assessments conducted, clinical perspective and input from the individual and other significant persons in their life.
Recommendations	Document recommendations for the IDT's consideration. These recommendations should be action orientated (as opposed to the narrative format).

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the individual's legal record. Use the **Save Form** (💾) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**.

6. After the form is complete, click the sign form icon (✓).

EXERCISE

1. Navigate to three of the above forms and review the documents.

Functional Skills Assessment (FSA)

Complete the Functional Skills Assessment following the ISP Prep Meeting.

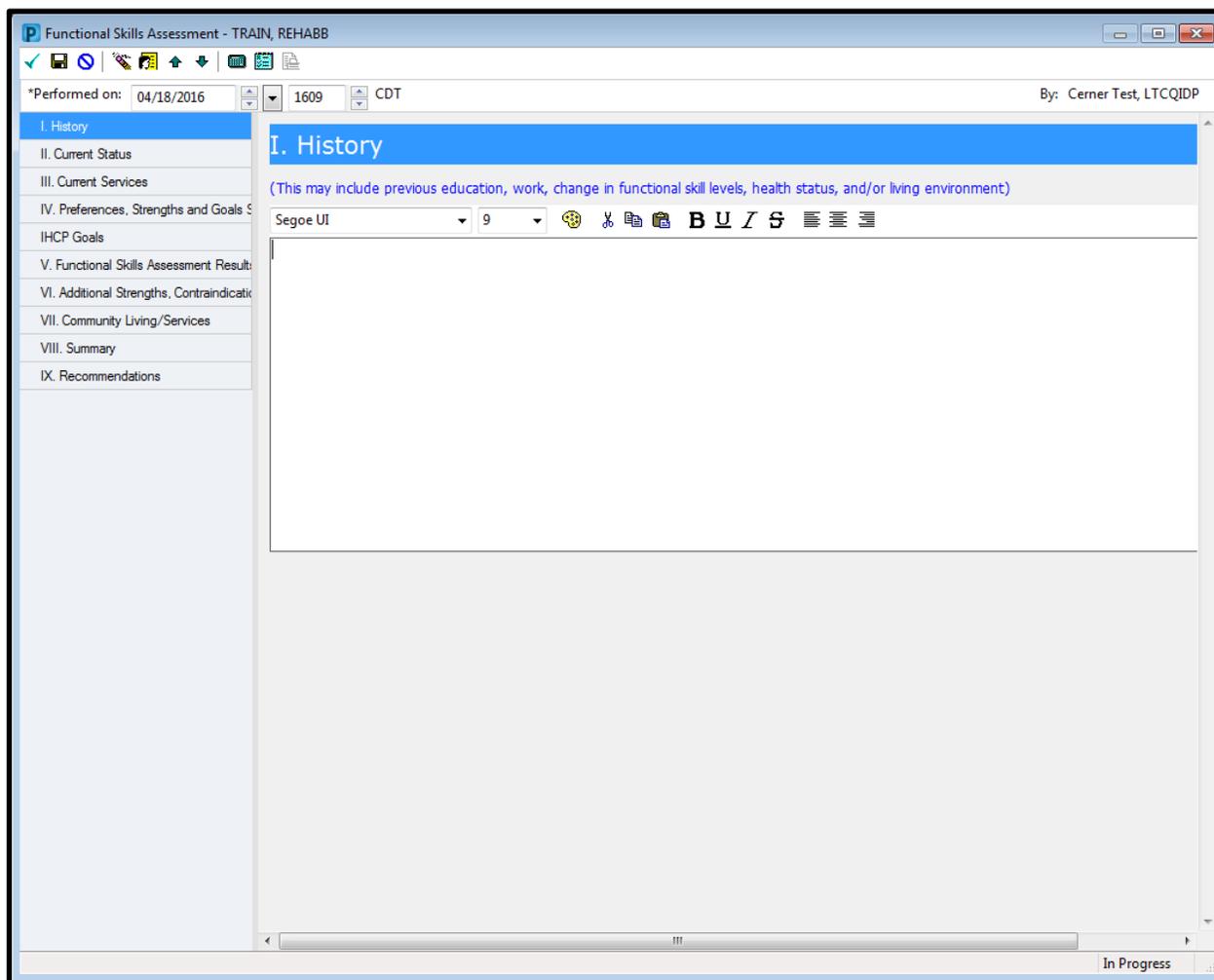
Note: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident's file.

1. Mark the **Functional Skills Assessment (FSA)** check box.
2. Click **Chart**.

The **Functional Skills Assessment** pop-up window displays.



Functional Skills Assessment

- Click each band and complete fields as appropriate (Note: Section IV is reviewed prior to completing assessment and filling out the remaining bands I, II, III, V, VI, VII, VIII, IX).

Band	Purpose
I. History	Document general information about the resident, including input from the PSI
II. Current Status	Document strengths/needs on a variety of skills, including dressing, restroom, hygiene/grooming, communication, social skills, domestic skills, dining skills, academic skills, leisure, campus/community awareness, telephone skills, adaptive equipment, and community living.
III. Current Services	Document the resident's current services.
IV. Preferences, Strengths, and Goals Summary	Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate.

V. Functional Skills Assessment Results	Document results of the resident's FSA.
VI. Additional Strengths, Contraindications to Stated Goals	A. Identify additional strengths that may assist in achieving increased independent living skills. B. Identify any contraindications/barriers to achieving goals and objectives. C. Indicate what supports and services are needed to overcome these barriers.
VII. Community Living/Services	Document professional opinion recommendation if resident can/cannot be served in a less restrictive setting at this time. Rational must be entered if "Do Not" selected.
VIII. Summary	Document overall analysis and major conclusions.
IX. Recommendations	Document recommendations for SAPs/service objectives regarding skills acquisition, service objectives, leisure/recreation recommendations, relationship recommendations, work/school/day recommendations, independence recommendations, and living option recommendations.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal and electronic life/health records. Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate. Use the **Save Form** (📁) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

Vocational Assessment

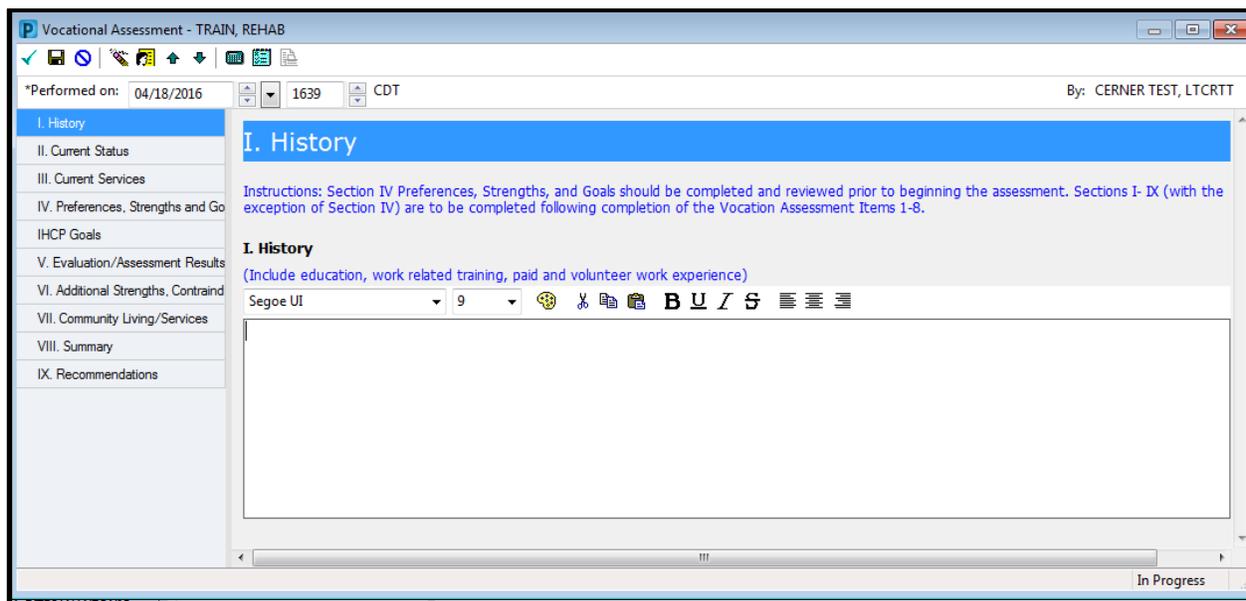
NOTE: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident's file.

1. Mark the **Vocational Assessment** check box.
2. Click **Chart**.

The Vocational Assessment pop-up window displays.



Vocational Assessment

- Click each band and complete fields as appropriate (Note: Section IV is reviewed prior to completing assessment and filling out the remaining bands I, II, III, V, VI, VII, VIII, IX).

Band	Purpose
I. History	Document resident's vocational history.
II. Current Status	Document the resident's current vocational status.
III. Current Services	Document the resident's current vocational services.
IV. Preferences, Strengths, and Goals Summary	Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate.
IHCP Goals	Review integrated health care plan goals.
V. Evaluation/Assessment Results	Summarize the vocational assessment, touching on Communication, Physical Characteristics, Assessment of Strengths and Barriers, Vocational Characteristics, Safety, Assessment of Work Preferences/History, and Vocational Exploration.
VI. Additional Strengths, Contraindications to Stated Goals	Document and review the resident's greatest strengths, barriers, and supports needed related to his or her vocational/employment vision.
VII. Community Living/Services	Document professional opinion recommendation if resident can/cannot be served in a less restrictive setting at this time. Rational must be entered if "Do Not" selected.
VIII. Summary	Summarize the resident's vocational assessment.
IX. Recommendations	Document recommendations for meaningful SAPs/service objectives.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident’s legal and electronic life/health record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

Day Programming Assessment

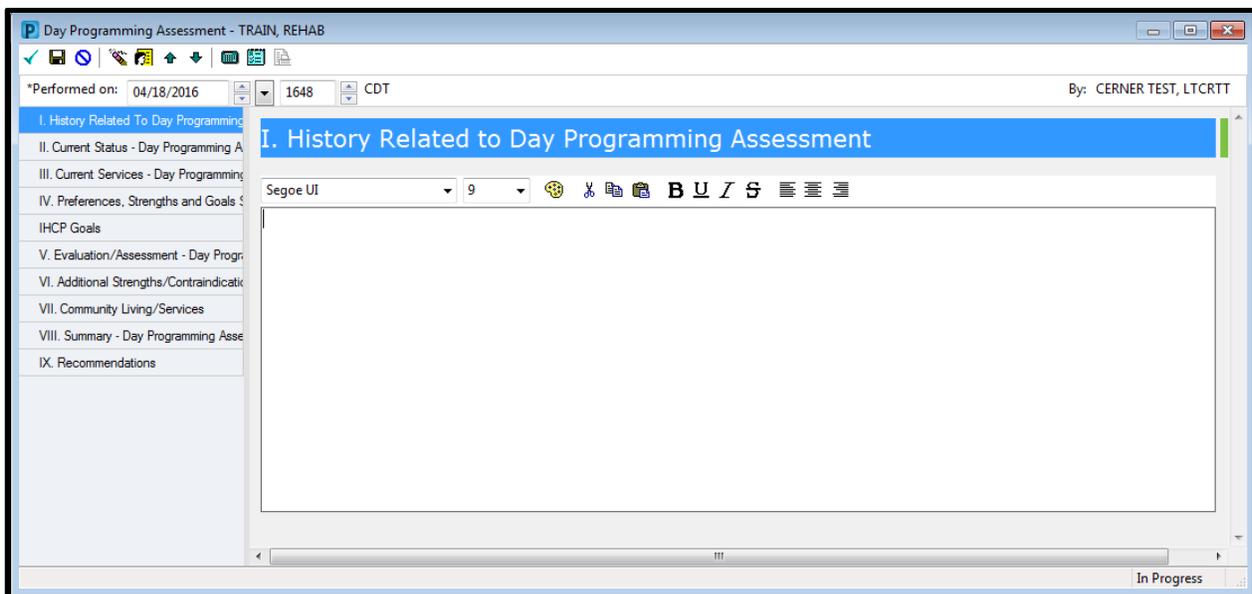
Note: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident’s file.

1. Mark the **Day Programming Assessment** check box.
2. Click **Chart**.

🖥️ The **Day Programming Assessment** pop-up window displays.



Day Programming Assessment

3. Click each band and complete fields as appropriate (Note: Section IV is reviewed prior to completing assessment and filling out the remaining bands I, II, III, V, VI, VII, VIII, IX).

Band	Purpose
I. History Related to Day Programming	Document resident's history.
II. Current Status – Day Programming	Document the resident's current status.
III. Current Services – Day Programming	Document the resident's current services.
IV. Preferences, Strengths and Goals Summary	Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate.
IHCP Goals	Review integrated health care plan goals.
V. Evaluation/Assessment – Day Programming	Document resident's evaluation and assessment.
VI. Additional Strengths, Contraindications to Stated Goals	Document the resident's additional strengths/contraindications to stated goals.
VII. Community Living/Services	Document professional opinion recommendation if resident can/cannot be served in a less restrictive setting at this time. Rational must be entered if "Do Not" selected.
VIII. Summary	Document overall analysis and major conclusions.
IX. Recommendations	Document recommendations for SAPs/service objectives regarding skills acquisition, service objectives, leisure/recreation recommendations, relationship recommendations, work/school/day recommendations, independence recommendations, and living option recommendations.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal and electronic life/health record. Use the **Save Form** (📁) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

Water Safety Assessment

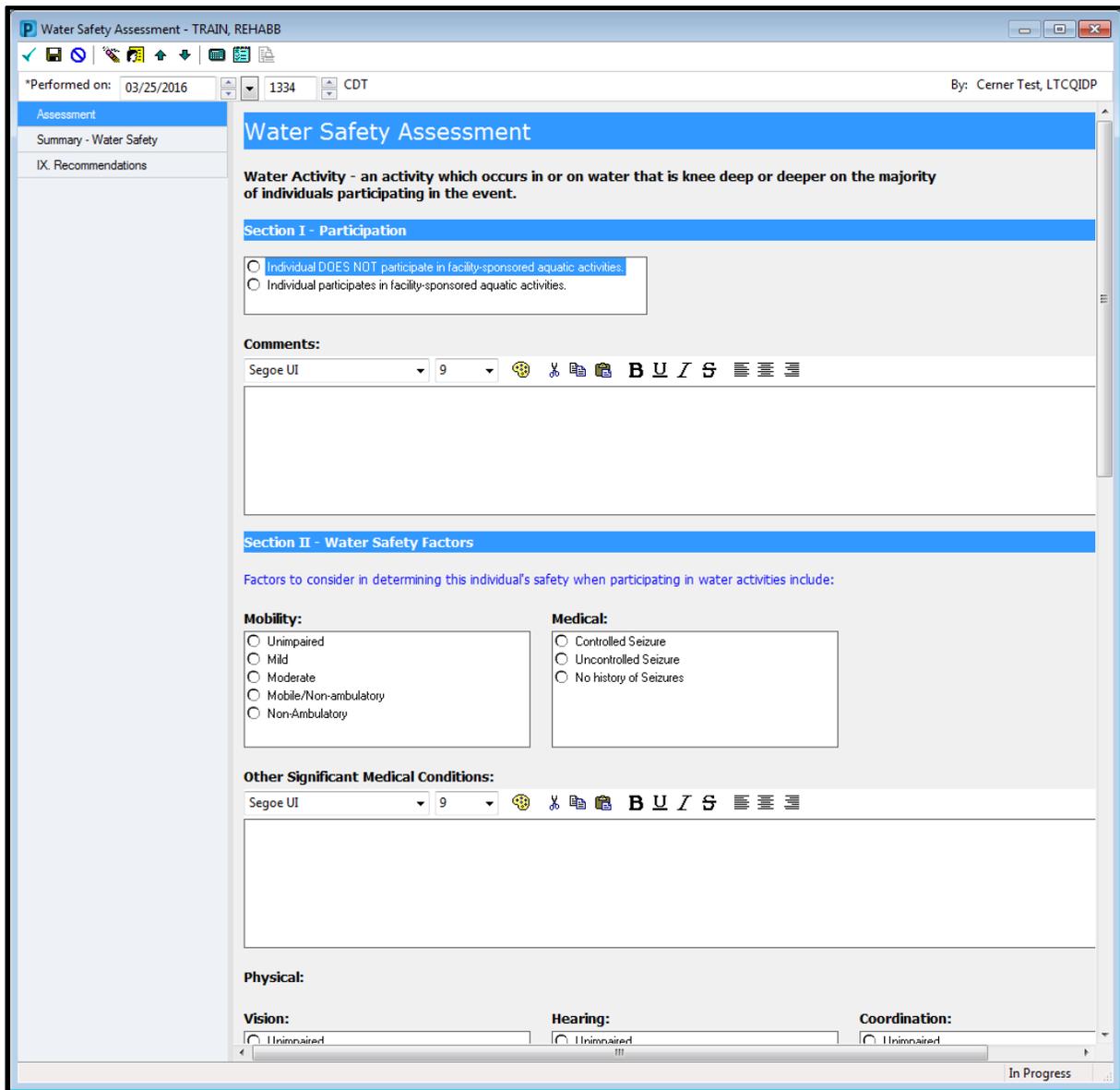
NOTE: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident's file.

1. Mark the **Water Safety Assessment** check box.
2. Click **Chart**.

The **Water Safety Assessment** pop-up window displays.



Water Safety Assessment

3. Click each band and complete the form as appropriate.

Band	Purpose
Assessments	Document the resident's water safety factors, such as mobility, medical conditions, and skills.
Summary - Water Safety	Document summary information.
IX. Recommendations	Document recommendations.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal and electronic life/health records. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (↻), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

Recreational Assessment

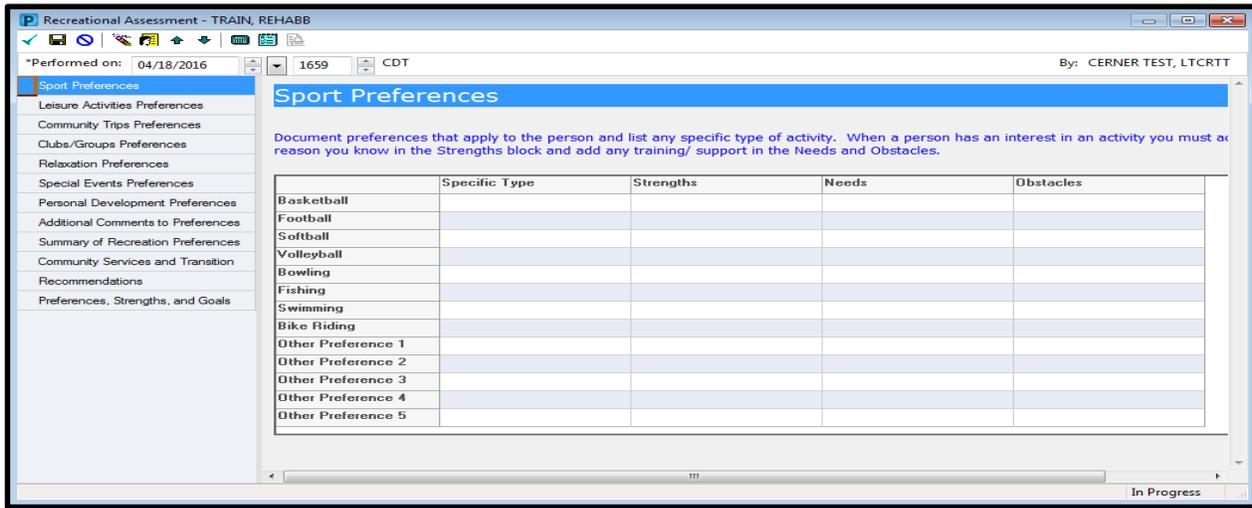
Note: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident's file.

1. Mark the **Recreational Assessment** check box.
2. Click **Chart**.

The Recreational Assessment pop-up window displays.



Recreational Assessment

- Click each band and complete fields as appropriate (Note: Preferences Strengths and Goals Summary is reviewed prior to completing assessment and filling out the remaining bands).

Band	Purpose
Sport Preferences	Document resident's preferences, including strengths, needs (training), and obstacles (support needed).
Leisure Activities Preferences	Document resident's preferences, including strengths, needs (training), and obstacles (support needed).
Community Trips Preferences	Document resident's preferences, including strengths, needs (training), and obstacles (support needed).
Clubs/Groups Preferences	Document resident's preferences, including strengths, needs (training), and obstacles (support needed).
Relaxation Preferences	Document resident's preferences, including strengths, needs (training), and obstacles (support needed).
Special Events Preferences	Document resident's preferences, including strengths, needs (training), and obstacles (support needed).
Personal Development Preferences	Document resident's preferences, including strengths, needs (training), and obstacles (support needed).
Additional Comments to Preferences	Document additional comments to preferences.
Summary of Recreation Preferences	Summarize recreation preferences.
Community Services and Transition	Document resident's ability to meet recreational preferences in a less restricted setting, and recommendations for the resident's transition to a community setting.
Recommendations	Document recommendations regarding the resident's recreational preferences.
Preferences, Strengths, and Goals	Summarize the individual's preferences, strengths, and goals.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal I record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (↻), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

Retirement Assessment

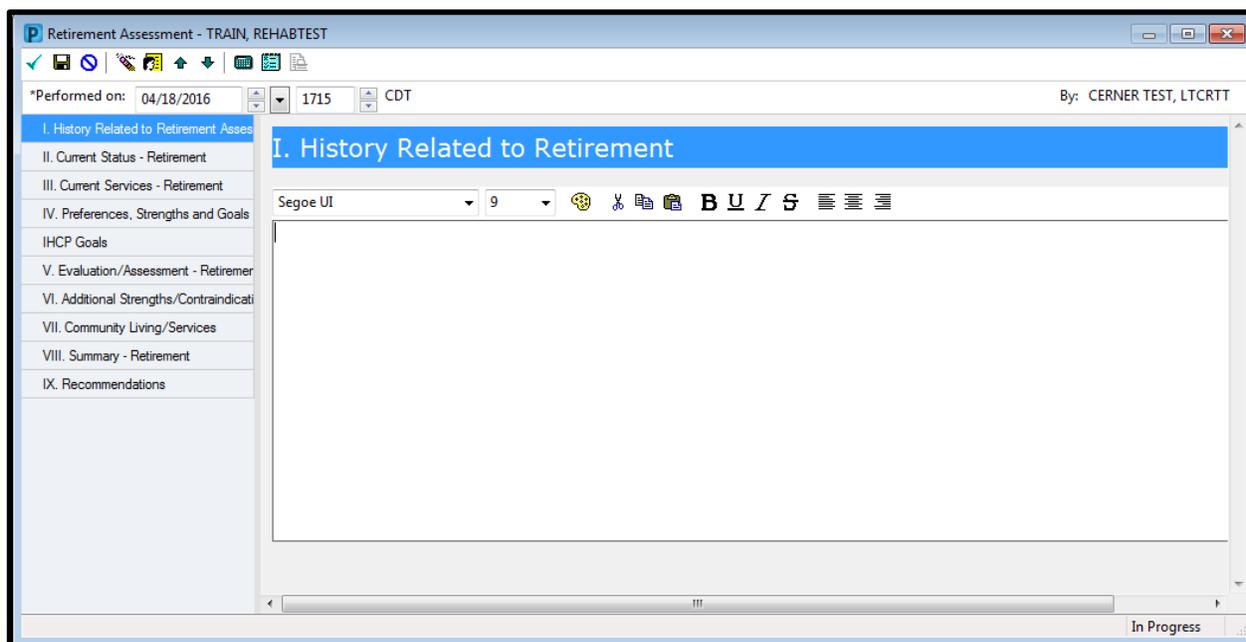
Note: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident's file.

1. Mark the **Retirement Assessment** check box.
2. Click **Chart**.

📄 The **Retirement Assessment** pop-up window displays.



Retirement Assessment

3. Click each band and complete fields as appropriate (Note: Section IV is reviewed prior to completing assessment and filling out the remaining bands I, II, III, V, VI, VII, VIII, IX).

Band	Purpose
I. History Related to Retirement Assessment	Document the resident's history with retirement preparations.
II. Current Status - Retirement	Document the resident's current status with retirement preparations.
III. Current Services - Retirement	Document the resident's current services with retirement preparations.
IV. Preferences, Strengths and Goals	Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate.
IHCP Goals	Review integrated health care plan goals.
V. Evaluation/Assessment - Retirement	Document the resident's evaluation or assessment with retirement preparations.
VI. Additional Strengths/Contraindications to Goals	Document the resident's additional strengths/contraindications to stated goals
VII. Community Living/Services	Document professional opinion recommendation if resident can/cannot be served in a less restrictive setting at this time. Rational must be entered if "Do Not" selected.
VIII. Summary - Retirement	Document summary information.
IX. Recommendations ISP	Document recommendations for the IDT's consideration (this populates the ISP Meeting Form).

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal and electronic life/health records. Use the **Save Form** (📁) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (↻), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

General Assessment

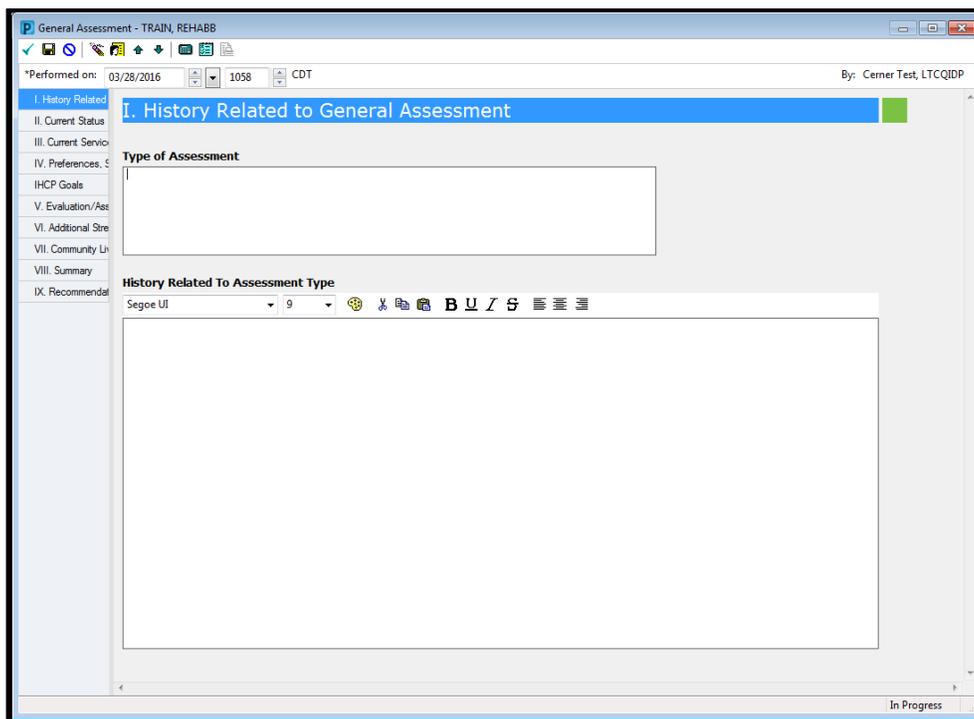
Note: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident's file.

1. Mark the **General Assessment** check box.
2. Click **Chart**.

The **General Assessment** pop-up window displays.



General Assessment

- Click each band and complete fields as appropriate (Note: Section IV is reviewed prior to completing assessment and filling out the remaining bands I, II, III, V, VI, VII, VIII, IX).

Band	Purpose
I. History Related to General Assessment	Document the resident's general assessment history.
II. Current Status	Document the resident's general assessment current status.
III. Current Services	Document the resident's general assessment current services.
IV. Preferences, Strengths and Goals	Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate.
IHCP Goals	Review integrated health care plan goals.
V. Evaluation/Assessment	Document the resident's general assessment evaluation or assessment.
VI. Additional Strengths/Contraindications to Goals	Document the resident's general assessment additional strengths/contraindications to stated goals.
VII. Community Living/Services	Document resident's ability to be served in a less restricted setting, and recommendations for the resident's transition to a community setting.
VIII. Summary	Document recommendations for the IDT's consideration (this populates the ISP Meeting Form).
IX. Recommendations	Document resident's general assessment needs, skills, and conditions.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident’s legal and electronic life/health records. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (↻), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

Social Development Assessment

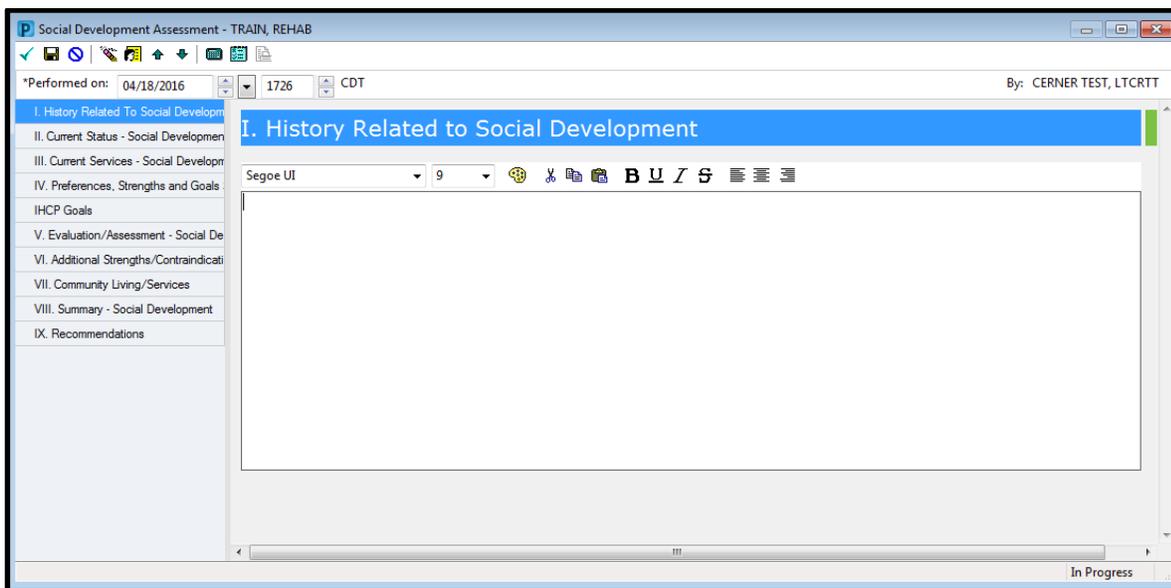
Note: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident’s file.

1. Mark the **Social Development Assessment** check box.
2. Click **Chart**.

📄 The **Social Development Assessment** pop-up window displays.



Social Development Assessment

3. Click each band and complete fields as appropriate (Note: Section IV is reviewed prior to completing assessment and filling out the remaining bands I, II, III, V, VI, VII, VIII, IX).

Band	Purpose
I. History Related to Social Development	Document the resident's history.
II. Current Status – Social Development	Document the resident's current status.

III. Current Services – Social Development	Document the resident's current services.
IV. Preferences, Strengths and Goals	Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate.
IHCP Goals	Review integrated health care plan goals.
V. Evaluation/Assessment – Social Development	Document the resident's general assessment evaluation or assessment.
VI. Additional Strengths/Contraindications to Goals	Document the resident's additional strengths/contraindications to stated goals.
VII. Community Living/Services	Document resident's ability to be served in a less restricted setting, and recommendations for the resident's transition to a community setting.
VIII. Summary – Social Development	Document recommendations for the IDT's consideration (this populates the ISP Meeting Form).
IX. Recommendations	Document resident's needs, skills, and conditions.

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's record. Use the **Save Form** (📁) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (↺), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

Animal Activity Assessment

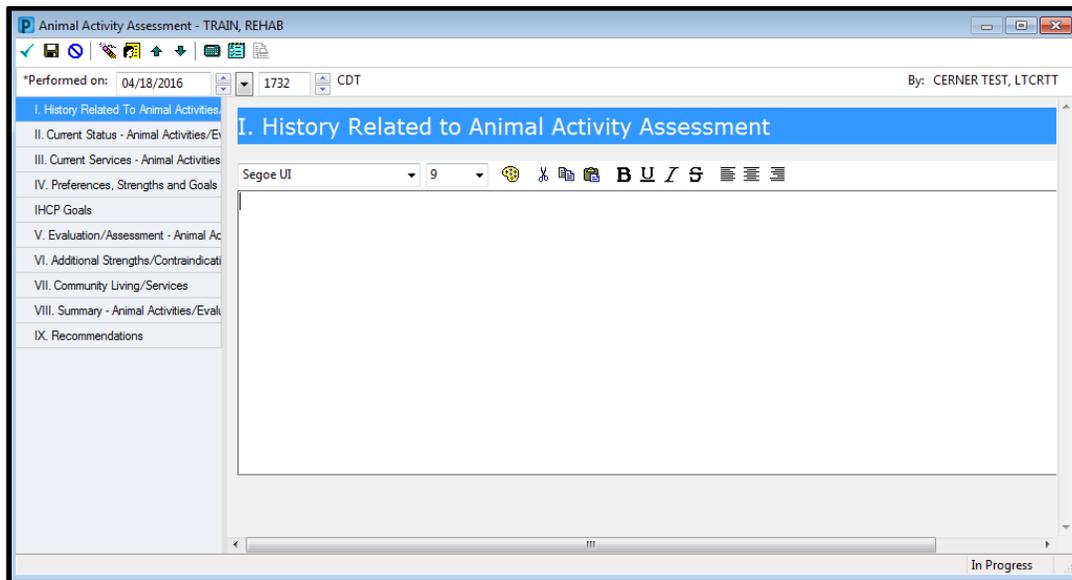
Note: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident's file.

1. Mark the **Animal Activity Assessment** check box.
2. Click **Chart**.

The **Animal Activity Assessment** pop-up window displays.



Animal Activity Assessment

- Click each band and complete fields as appropriate (Note: Section IV is reviewed prior to completing assessment and filling out the remaining bands I, II, III, V, VI, VII, VIII, IX).

Band	Purpose
I. History Related to Animal Activity Assessment	Document the resident's history with animal related activities.
II. Current Status - Animal Activity Assessment	Document the resident's current status with animal related activities.
III. Current Services - Animal Activity Assessment	Document the resident's current services with animal related activities.
IV. Preferences, Strengths and Goals	Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate.
IHCP Goals	Review integrated health care plan goals.
V. Evaluation/Assessment - Animal Activity Assessment	Document the resident's evaluation or assessment with animal related activities.
VI. Additional Strengths/Contraindications to Goals	Document the resident's additional strengths/contraindications to stated goals.
VII. Community Living/Services	Document professional opinion recommendation if resident can/cannot be served in a less restrictive setting at this time. Rational must be entered if "Do Not" selected.
VIII. Summary - Animal Activity Assessment	Document summary information.
IX. Recommendations ISP	Document recommendations for the IDT's consideration (this populates the ISP Meeting Form).

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident’s legal and electronic life/health record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

Therapeutic Riding Assessment

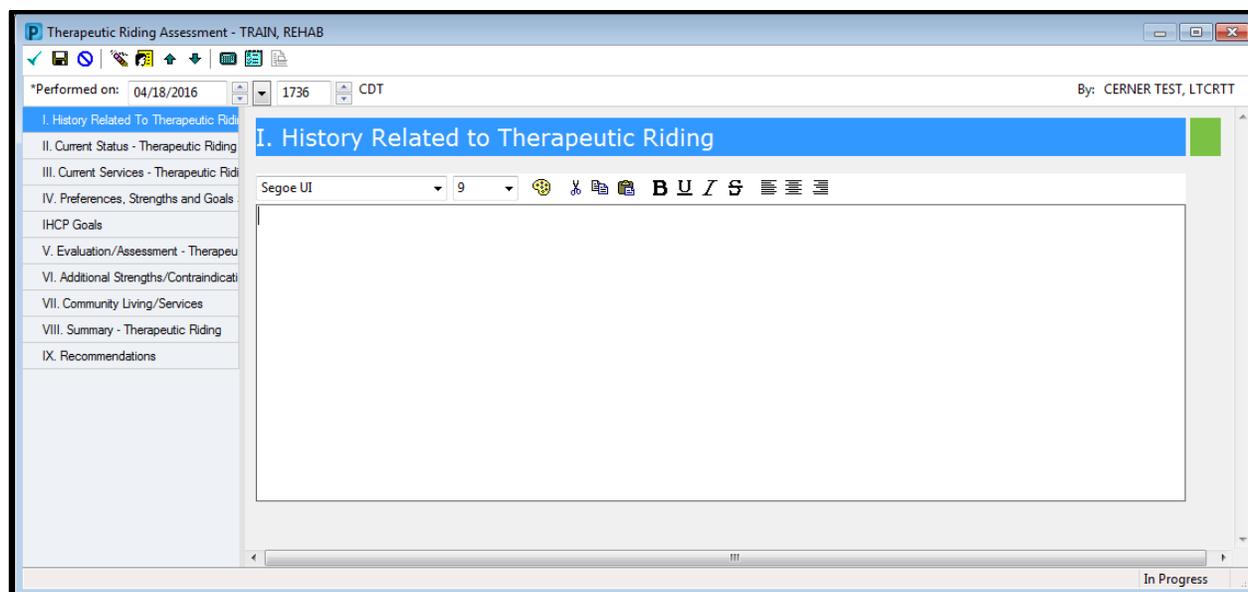
Note: This assessment is typically completed by the LTCRTT.

Note: Many forms may be completed by various members of the Interdisciplinary Team. To access these forms, each user should click AdHoc from the Action Toolbar and click the folder which corresponds to his/her role.

Note: A resident must first be selected in order to complete an AdHoc form. If a resident is not already selected, a pop-up patient search window appears. If a resident chart is already open, check to make sure that you are updating the correct resident’s file.

1. Mark the **Therapeutic Riding Assessment** check box.
2. Click **Chart**.

 The **Therapeutic Riding Assessment** pop-up window displays.



Therapeutic Riding Assessment

3. Click each band and complete fields as appropriate (Note: Section IV is reviewed prior to completing assessment and filling out the remaining bands I, II, III, V, VI, VII, VIII, IX).

Band	Purpose
I. History Related to Therapeutic Riding	Document the resident's history with therapeutic riding.
II. Current Status - Therapeutic Riding	Document the resident's current status with therapeutic riding.
III. Current Services - Therapeutic Riding	Document the resident's current services with therapeutic riding.
IV. Preferences, Strengths and Goals	Review the resident's preferences, strengths, and tentative goals to address them in the assessment and recommendations as appropriate.
IHCP Goals	Review integrated health care plan goals.
V. Evaluation/Assessment - Therapeutic Riding	Document the resident's evaluation or assessment with therapeutic riding.
VI. Additional Strengths/Contraindications to Goals	Document the resident's additional strengths/contraindications to stated goals
VII. Community Living/Services	Document professional opinion recommendation if resident can/cannot be served in a less restrictive setting at this time. Rational must be entered if "Do Not" selected.
VIII. Summary - Therapeutic Riding	Document summary information.
IX. Recommendations ISP	Document recommendations for the IDT's consideration (this populates the ISP Meeting Form).

Tip ▶ Click the sign form icon (✓) finalizes the form and makes it part of the resident's legal record. Use the **Save Form** (📄) button at the top left of the window to save the form if you need to add more information prior to completing the form. To retrieve and modify saved documents, navigate to the **Form Browser**, click the **Refresh** icon (🔄), right click the form, and click **Modify**. To print, right click the form and select **Print**.

4. After the form is complete, click the sign form icon (✓).

KNOWLEDGE REVIEW

1. Which bands can you find in the ISP Prep Meeting form?
 - A. Care Plans
 - B. Individual Right Restrictions
 - C. Requested Attendees
 - D. All of the above

A. Answer: D. All of the above
2. Which of these is NOT included in the PSI?
 - A. Living options
 - B. Automotive options
 - C. Relationships
 - D. Independence

A. Answer: B. Automotive options
3. Where can you find the Individual Capacity Assessment?
 - A. Answer: AdHoc
4. The entire IDT is responsible for updating the ISP Meeting Form.
 - A. TRUE
 - B. FALSE

A. Answer: FALSE
5. Where can you find the Integrated Health Care Plan?
 - A. Answer: Within the ISP Meeting form, from AdHoc.
6. To review the Integrated Risk Rating Form, which band should you click from the menu?
 - A. Form Browser
 - B. Histories
 - C. Notes
 - D. Resident Information

A. Answer: C. Notes
7. Which button would you click to access the Potentially Disrupted Community Transition form?
 - A. Answer: AdHoc
8. An LTCRTT can navigate to the Day Programming Assessment by clicking AdHoc on the Action Toolbar.
 - A. TRUE
 - B. FALSE
9. Using PowerChart, navigate to three of the forms listed above.

APPENDIX A

Cerner Icon Glossary

Icon	Description
	Medication – Indicates medication activities.
	Patient Care – Indicates resident care activities.
	Assessments – Indicates resident assessment activities.
	Other – Indicates other activities.
	Nurse Review – The order requires a nurse review.
	Immediate Priority – Indicates Stat/Now orders for a resident.
	Critical Results – Indicates critical results for a resident.
	Non-Critical New Information – Indicates new non-critical results or orders for a resident. Click this icon to display additional information.
	Critical New Information – Indicates new critical results for Stat/Now orders. Click this icon to display additional information.
	High Risk Alert – Indicates the patient has high risk indicators. Hover over this icon to display additional information about the high risk indicators.
	Isolation – Indicates the patient is in isolation. Hover over this icon to display additional information about the isolation type(s).
	Help – Click this icon to display the CareCompass Help Pages.
	Order Comment – Indicates an order has a comment attached. Hover over this icon to display the comment.
	Establish Relationship – Click this icon to display the Establish Relationship Dialog box.
	List Maintenance – Click this icon to display the List Maintenance dialog box and to edit the list.
	Add – Click either of these icons to open the Add window and to add: a resident, allergies, orders, medication orders, documentation, etc.
	Abnormal Result – Indicates a result is abnormal.
	High Result – Indicates a result is high.
	Low Result – Indicates a result is low.
	Properties – Click this icon to modify the properties in a Resident List.
	Sign Form – Click this icon to sign a form.
	Find – After typing in a text field, click this icon to perform a search.
	New – Click this icon to add a note.
	Modify – Click this icon to modify an element on the window (list, note, etc.).
	Print – Click this icon to print the information displayed on the screen.
	Order Details Not Complete – Click this icon to view fields that must be completed before an Order can be completed.
	Appointment Inquiry – Click this icon to look up appointment information.
	Check In – Click this icon to check in a resident for an appointment.
	Save – Click this icon to save.

	Expand/Collapse – Click the down arrow icon to expand a section of the window. Click the up arrow icon to collapse a section of the window.
	Quick Chart – Click this icon to chart progress for Outcomes and Interventions.
	Settings – Click this icon to open the settings window.
	Search – Click this icon to open the Resident Search pop-up window and perform a resident search.
	Search – Click this icon in the Physician Search pop-up window and perform a physician search.
	Physician Co-signature – The order must be co-signed by the ordering physician.

APPENDIX B

Cerner Terms Glossary

Term	Definition
Account Number	A unique medical record number assigned to each resident or guarantor that remains with the resident regardless of the number of encounters.
Active	An element in the system is active when an action can be performed on it (such as clicking it or pressing ENTER).
Activity Type	A division of a catalog type in the Order Catalog. For example, a catalog type of Laboratory can have activity types of General Laboratory, Blood Bank, Microbiology, and Anatomic Pathology. Activity types also can be subdivided into activity subtypes. For example, Anatomic Pathology may have the activity subtypes of AP Processing and AP Reports. Note - Each activity type is associated with a specific catalog type. Every item in the Order Catalog must have a catalog type and an activity type.
AdHoc Charting	Entering unscheduled results into the resident record. Only individuals with privileges to perform ad hoc charting can access the appropriate menu commands.
AdHoc Pharmacy Order	A pharmacy order added one at a time.
Administration Time	The time at which a medication, or continuous or intermittent order is administered to a resident. A nurse or other health care professional records the administration time on the medication administration record (MAR).
Appointment Availability View	Scheduling Appointment Book offers the option of displaying an availability bar that graphically depicts conflicts or available times during appointment scheduling. Duplicate appointment checking, interaction and sequencing rules, as well as advanced scheduling notification rules are used.
Appointment Notification	Notifications sent to specific routings or printers whenever an action such as confirm, modify, or cancel is performed on an appointment. Advanced appointment notifications can be defined where warnings are sent if an appointment is scheduled with inadequate advance notice according to predefined time limits.
Authenticated	The status of a document or result that has been approved or signed by the person ultimately responsible for it. The result or document is not considered final until it has been authenticated.
Authentication	The process that identifies users through the use of log-on names and passwords.
Availability Conflict	A system-detected difficulty in scheduling one or more requested appointments. This could be the result of person or resource availability checking.
Available Physicians	This window displays all available physicians whose last names agree with the starting value entered in the Physician Name field.



Benefit Order	The insurance plans for a resident.
Billing Code	An alphanumeric identifier assigned to an item to identify it to another system. Some examples are a CDM (Charge Description Master), which identifies items to a hospital billing system, and a CPT (Current Procedure Terminology), which identifies an item to most insurances and Medicare.
Block Scheduling	An enhancement to scheduling slots and is useful for utilization of resources such as operating rooms. With scheduling blocks, you can determine a release time for that slot or block of time to expire into a different slot. Reports can be run that analyze the data to determine the efficiency and utilization of the resources reserved in these blocks. The process of booking appointments to resource calendars composed of slots of a predefined time. Appointment slots have a single usage definition that does not change over time. Attempting to book a slot with an appointment request that does not match the definition of the slot will result in a warning message. Users with proper security may override this warning.
Cancel Status	Indicates that the transmission has been canceled.
Canceled State	A previously scheduled appointment type that has been removed from all resource schedules as well as the person schedule. Canceled appointments no longer occupy time for the originally booked person and resources.
Care Coordination	The Cerner Millennium solution that supports the care planning process and the delivery of the direct resident care that is defined in the plan of care. The solution can use clinical pathways, nursing care plans, and multiple-disciplinary plans of care.
Cerner Millennium	Cerner Millennium is Cerner's comprehensive suite of solutions that promote personal and community health management by connecting consumers, clinicians and healthcare organizations into a streamlined, unified single care process. Cerner Millennium applications work on a cohesive platform that is open, intelligent and scalable, allowing vital health information to be accessed and shared throughout the healthcare system.
Chart Body	The body of a chart that holds the diagnostic information entered for the procedures, administrative information associated with the procedures, or both.
Chart	In PowerChart, a chart is the aggregation of all information recorded about a person's health status. All inpatient and outpatient visits, lab results, procedures, evaluations, orders, reports, X rays, photographs, films, audio recordings, and other multimedia information pertaining to a person's health are considered part of the total chart. Historically, the chart has been paper-based. Recently, many institutions have begun storing resident information in databases accessible by computers, and the chart has become increasingly electronic.
Charted	Comments that can be posted in a chart or report.
Computer-Based Training (CBT)	Standard computer-based training may be purchased for those Cerner Millennium applications for which CBT is available; or a CBT can be custom-designed for a client as an optional service.
Context Menu	A menu that pops up when you right-click some elements.
Comment	A free-form narrative attached to a term in an encounter note using the Comment function.
Continuous Order	One of the three order types used in <i>PharmNet</i> . Continuous orders are intravenous orders marked by uninterrupted infusion over a period of time sufficient to require additional supplies of the product or products at regular intervals. For example, a large volume parenteral is a continuous order. The set of attributes required to correctly distinguish continuous orders from other order types includes interval, rate, and total volume.

Co-Signer	Person who signs off on a document to indicate that the contents of the document are accurate.
Discontinued Order	In <i>PharmNet</i> , a pharmacy order that was stopped by a physician, pharmacist, or clinician, or because its course of therapy has been completed. For example, an order can be discontinued for an antibiotic when the resident has completed the course of therapy. An order can also be discontinued by a clinician when a resident has an adverse drug reaction or does not tolerate the side effects of the medication.
Dosage	In <i>PharmNet</i> , dosage refers to the defined frequency, amount, strength, and quantity of doses of a medication.
Dose	In <i>PharmNet</i> , dose refers to the amount of a drug or drug therapy.
Downtime Sequence	The sequence used by the system when it is assigning numbers during a system downtime. The pool of available numbers for this sequence should be separate from those used for the default sequence.
Downtime	Any period of time during which the system is unavailable to users. The cause is not relevant.
Dispense	In <i>PharmNet</i> , to prepare and distribute medications for a single order, as part of a fill list or batch, and to replenish the medication supplies.
Electronic Medical Record (EMR)	The electronic medical record replaces the resident's paper medical record. The EMR is at the heart of the automated health system. It allows resident records to be viewed and updated by numerous healthcare providers simultaneously. No longer are the residents' records inaccessible while waiting to be refilled.
Electronic Signature	The act of verifying or accepting a transcribed report online instead of signing the physical piece of paper on which the report is printed.
Encounter	A single resident interaction. The following interactions are examples of encounters: resident registered as an inpatient, resident registered as an outpatient. In the homecare setting, the following interactions are examples of encounters: resident admitted to home health, resident admitted to home infusion services.
Encounter Number	An internal number assigned by the system for each resident encounter.
Encounter Type	A classification of resident visit types. Examples include inpatient, outpatient, and emergency room.
Encounter Note	The textual documentation of a clinical encounter, such as inpatient, outpatient, or emergency.
Encounter Access Method	Person name, Person ID, Medical Record Number, and Social Security Number can be used to access encounter information. Person name and Person ID require the selection of an encounter if more than one exists on the person. Medical Record Number and Social Security Number are encounter identifiers, and directly access the appropriate encounter.
Financial Identification Number (FIN)	The Financial Number that is associated with a resident when in a SSLC. The FIN is where all billing is routed.
Floor Stock	Medications stocked at the care location. Also referred to as ward stock. Floor stock items typically are not included on fill lists.
Free Text	User-entered text, which is saved by the system.
Free Text Field	Free-text field types allow you to specify a free-text response.
Future State	A narrative or graphical description of how each type of process in the analyzed work area will work after improvements are completed. This future state may include

	targeted benefits and proposed processes to collect measurement data to monitor improvement.
Go-Live	Conversion or go-live is the process by which Cerner makes the system available to the client for the first production use.
Immediate-Print Label	A specimen label produced by the system as soon as an order is requested. This type of label is typically printed when specimens have already been collected for the orders, or when orders are requested with a <i>stat</i> collection priority.
In-Process Status	This status indicates those requests on which action has been taken but not completed.
Intermittent Order	One of the three order types used in <i>PharmNet</i> . Intermittent orders are intravenous orders defined by short periods of infusion that are interrupted before the next scheduled administration time. An intravenous piggyback is an example of an intermittent order. The set of attributes required to correctly distinguish intermittent orders from other order types includes interval frequency, rate, infuse over value, and total volume.
JCodes	Billing codes associated with pharmacy charges used to identify specific ingredients and dosage in a given injection. It is defined in Charge Services as a bill code.
Label Comment	<p>Label comments are predefined messages created as a database to be shared with other applications. When you enter the corresponding code during order entry, the system displays the appropriate label comment.</p> <p>A textual comment that is to print on container labels or collection lists, depending on the customized label format. Label comments typically are entered when the order is requested, and serve as instructions to persons collecting or handling the specimen. Examples of label comments might be "Draw from right arm" or "Nurse will call when ready."</p>
Location Group	A group of locations by which you can filter a list of tasks to be performed. For example, if you work in the locations 2N and 3N and these are defined together as a group, you could select this group when requesting your list of tasks.
Lot Information	Drug manufacturers and wholesalers routinely supply lot numbers and expiration dates for products. The ability to track lot numbers and expiration dates can be used in a variety of situations, including drug recalls.
Medical Record Number (MRN)	A permanent number used to identify the resident. It typically remains unchanged even if the resident has multiple encounters.
Medication Administration Record (MAR)	A report that serves as a legal record of the drugs and drug-related devices administered to a resident at a facility by a nurse or other healthcare professional. The nurse or healthcare professional signs off on the record at the time that the drug or device is administered. This report also documents that the appropriate therapy is provided to the resident.
Medication Order	One of the three order types used in the <i>PharmNet</i> system. Medication orders are distinguished by administration at a discrete moment in time, whether once or at regular intervals. Examples of medication orders include tablets, capsules, suppositories, and syringes. The presence of frequency, without rate, infuse over value, or total volume distinguishes medication orders from other order types. Medication orders do not require a diagnosis to administer.
Multi-Choice Field Type	Multi-choice field types allow you to specify at least one of several responses.
Multiple Select	To select more than one item, click the first and last items while pressing Shift, if they are listed sequentially. If they are not sequential, press CTRL and click each one individually.

New Orders Display	The area of the Orders view of the resident chart that displays all unsigned orders placed during a particular conversation. Also called the scratch pad.
Order Category Display	Orders are grouped and displayed in a hierarchy according to clinical interest. The site determines the hierarchy and the orders contained within it.
Order Type	Order Types are categories used to classify pharmacy products on the basis of how they are ordered, in particular, on the basis of a set of attributes that varies from one Order Type to the next. The three Order Types available for selection in the <i>PharmNet</i> system are continuous, intermittent, and medication.
Outside Orders	Outside order are those orders place in another order entry application, such as PowerChart, Departmental Order Entry, OSM Requisition Order Entry, or even from an interface with an external system. When the specimens are received in the laboratory, these orders are logged in using Maintain Case.
PharmNet	<i>PharmNet</i> fully integrates with other clinical applications, automating medication use across the entire spectrum of medication management.
Physician Name	The first few letters of the last name of the consulting physician should be entered in this field. Upon doing so, the user can then click Search to reveal a list of physicians from which to choose.
PowerChart	The Cerner Millennium solution that is the enterprise clinician’s desktop solution for viewing, ordering and documenting the electronic medical record.
PowerOrders	A physician order entry solution that gives appropriate access to real-time, relevant clinical information at any point in the care process.
Proxy List	This optional feature allows a user to review, accept, and reject reports on behalf of another radiologist.
Proxy	A person designated to perform a task or review results for another health care provider.
Refresh	To replenish new information from the database and redisplay it within the current screen view.
Resident Chart	In Cerner Health Information Management, a resident chart is an encounter-level collection of resident information. The resident chart includes all documents, notes, and images pertaining to a single visit.
Resident Demographics	Information defined for the person or encounter. Demographic information includes elements such as the current location (nursing station, room, and bed, for example), alias identification values, age, birth date, gender, and maiden name.
Resident Medication Profile	A printed report that lists all of the drugs prescribed for a resident, which may contain active, suspended, or discontinued orders. The resident medication profile can be used to support the health care facility in case of a system failure or power outage to ensure that residents receive the appropriate drug therapy.
Review (Orders)	The process of checking an order for accuracy and appropriateness. Orders subject to nurse review are designated with an icon that resembles a pair of spectacles. The site defines which orders require nurse review.
Review (Results)	To verify a result. Results entered in the flowsheet become part of the resident record. Whether the result records a discrete task assay, document, or laboratory value, the person ultimately responsible for its accuracy must verify or review the result and sign it. When signed by the appropriate person, the result has the status of Authenticated (final).
Reviewer	Additional person who receives a copy of a document for review.
Schedulable	Any item that can be scheduled to a resource or person appointment schedule.
Schedule	The process of creating an appointment request, booking the request to one or more persons or resources, and confirming the booked requests.

Scheduled	A medication order that has fixed dose times. The times can be fixed to always occur at the same time of day or be determined by the system based on an interval. These are usually identified by standard frequency codes, such as bid (twice daily at 0800 and 1600) or q8h (every eight hours starting from 10 a.m.).
Scratch Pad	The new order area of the Orders view of the resident chart. All unsigned orders placed during an order conversation are displayed on the scratch pad until they are signed and submitted.
Selected Physicians	This window displays the names of physicians who have been chosen from the Available Physicians window.
Selection Criteria	Variables that determine which residents are included in a distribution.
Soft-Stop	Soft-stop review policies are implemented to notify the prescriber that a medication order requires review, but the medication actually will not be discontinued if the situation is not addressed by the prescriber.
Sorts	Sorts are used to put data in a particular order.
Subclass	A subclass is a method to categorize or group interesting case files. Subclasses allow radiologists or residents to group certain interesting case files together and assign a name to that group. Subclasses are personal or shared.
Summary Sheet	Used to display a summary of the resident's health history to the healthcare provider.
Tab	A window element resembling a folder tab that is used to group similar information.
Task Type	Task types are used to group similar, individual tasks together. For example, a task type of dietary might contain all dietary tasks such as clear liquid diet, soft diet, and so on.
Toolbar	A window element containing buttons or other window elements to facilitate accomplishing a task.
Tooltip	A description displayed when you move the cursor over a button in the toolbar.
Unauthenticated	The status of a document or result that has not been approved or signed by the person ultimately responsible for it. The result or document is not considered final until it has been authenticated.
Uncommitted Data	Data that has been entered but not saved or signed. Sometimes, uncommitted data is displayed in a special color until it is saved. If the user attempts to close a window or exit an application with uncommitted data, a system prompt warns that this data will be lost.
Untransmitted	The report has not been transmitted.
Unverified Order	In <i>PharmNet</i> , an order entered in the system by a pharmacy technician or other healthcare professional that must be verified by a pharmacist. Unverified orders include all pharmacy order types---continuous, intermittent, and medication.
Verify	To confirm that the result entered for a procedure is correct. The process of verifying updates the status of the result to Complete. Results of procedures are not available for general inquiry, transmission, or charting purposes until verification occurs.
Wildcard	A character that allows a search over a wide range of related data elements.
Worklist	A list of orders that need to be completed.
Worklist ID	The worklist ID is an identifier that is assigned to a specific worklist. The date and time is also stamped with the worklist ID so that if the same worklist ID is used multiple times, the date and time will differentiate each worklist ID.
Worklist Name	The worklist name is the name assigned to a predefined set of selection criteria for the worklist.