



# Practical Health

S Y S T E M S

*InfoServ DD<sub>SM</sub>*  
**Quick Start Guide**  
For  
**Direct Support Professionals**  
A how-to guide using  
*InfoServ DD<sub>SM</sub>*

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## ***Direct Support Professionals:***

Direct Support Professionals are those individuals who work hand in hand with the service recipients who reside in a community based setting. To begin, you must log into the application using your username and password, which has been given to you by the Agency or Provider with whom you are employed. To log in follow these steps:

- Double click on the Internet Explore icon on your desktop.
- Type in the following web address if InfoServDD does not come up immediately
  - [www.infoservdd.com](http://www.infoservdd.com)

### **To Log in to the application**

- Click in the User Name box
- Type in your User Name
- Click in the Password box
- Type in your password
- Click on the Submit button

Once logged into *InfoServ DD*, direct support professionals only have access to two of the four main focus areas: **Personal Info** and **Maintenance**. Your job description allows you to have more direct access to the information and responsibilities that you will have to complete for service recipient you serve by limiting access throughout the system with previously set permissions. This certainly can allow you for quicker more efficient access without the need to search through the system capabilities to find the information you may need.

### **InfoServ DD's Home Page:**

If you have already logged in using your User Name and Password and by clicking 'Submit,' the Home Page screen will load giving you numerous links to choose from. The main links on the home page designed for you are in two separate locations: News and Regulations and the drop down 'Content' list.

### ***News and Regulations:***

The links under this heading will guide you though the use of Practical Health Systems' *InfoServ DD*. The main links you should familiarize yourself with are:

#### **Help Manuals**

Help Manuals are designed to answer any questions you may have concerning how to operate the system. These are to help familiarize yourself with how you will accomplish the tasks set forth for your job description.

- Click on the Help Manuals link
  - This is where you can find this manual)
  - Click on the Help manual link that you want to review
    - Example: Quick Start Guide for Direct Support Professionals

#### **Training Schedule for Current Month**

The 'Training Schedule for Current Month' shows you whether or not you are expected to be in a training course during the month. This will list the time, place, and other employees who are expected to complete a training course during a current month.

- Click on the Training Schedule for Current Month
  - Look for your name in the training schedule list

## **Content:**

The links under the 'Content' heading will help you with any other questions concerning *InfoServ DD*. All links can certainly be viewed and used. The main links you want to familiarize yourself with are:

### **My Messages**

My Messages allow you to send and receive a message from any employee who has a username and password in *InfoServ DD*.

- Click on My Messages on the left side of your screen
  - This link is also located on the right side of your screen in the blue bar and can be accessed from any other location in the application.
  - Click on the Add Message link to add a message
    - Select the Employee(s)
      - If you want to send a message to multiple people, simply hold down the *Ctrl* key and click on any of the names you want your message to be sent.
    - Click in the box to the right of Message
    - Type in the Message you want to send
    - Click on the Submit button
  - To view your messages, click on view link to the right of the message you want to view
  - To delete a message, click on the delete link to the right of the message
  - To print a message, click on the Print link to the right of the message

### **Help Desk**

The Help Desk has been designed to answer any questions or comments you may have according to the system; whether or not you need help in completing a task; or you are working in the system and get an error.

- Click on 'Help Desk'
  - Enter the Problem Encountered in the box.
    - The more information you can supply in this box, the quicker we can fix the problem.
    - The information you might consider supplying:
      - The service recipient you are working with,
      - The task you are performing,
      - The error or problem you encountered, and
      - A phone or cell phone number where we can reach you.
    - We strive to answer any and all of your questions within a timely manner.

### **Change Password**

The 'Change Password' link allows you to change your existing password to a new password. You may consider changing your password every 30 – 60 days to limit any one else discovering your password. Passwords are very sensitive in *InfoServ DD* and are used to identify who is writing and operating different parts of the application.

- To change your password, click on the 'Change Password' link
  - Fill out your current password
  - Fill in your new password
  - Click the 'Submit' button

Now that you are familiar with the basic features of *InfoServ DD*, it is time to get started with the work responsibilities as a Direct Care Professional.

## **Service Recipients**

The '**Personal Info**' link is located at the top of the screen and will take you to the area in which you can access and work with any relevant information for you concerning a service recipient who is assisted by you.

- To select a service recipient,
  - Select the person from the dropdown
    - Click on the Search button
  - OR type in the Service Recipient's name
    - This can be a partial name or a full name
    - Click on the Search button
      - If you cannot find the service recipient in the drop down box, then try finding him or her by filling in his or her last name.

## **Personal Information**

You arrive at the service recipient's Personal Information page. This page contains all relevant information that you should review often concerning the service recipient's demographics, important dates, scheduled appointments, contacts, and professionals. It also contains nine different links that you as a direct care professional should be very familiar with. These links are located in the middle of the page around a service recipient's 'Personal Info.' They are:

### **View Training Specific to Service Recipient**

The 'View Training Specific to Service Recipient' is an important feature that lists all important information that directly affects the service recipient's needs. If there is not any information, please contact your manager or supervisor to discuss what needs to be entered for each service recipient who lacks information.

- Click on the View Training Specific to Service Recipient
  - This includes all specific training needed for the service recipient

### **View Other**

The 'View Other' link lists other important information concerning a service recipient.

- Click on the View Other link
  - This may include the following
    - Diet patterns,
    - Nutrition needs,
    - Care of personal equipment,
    - Transferring needs, and
    - What an emergency looks like for a specific service recipient.

### **View Last 24 Hours**

The 'View Last 24 Hours' link will tell you everything that has been documented in the last 24 hours. It is recommended to review this information when you begin your shift.

- Click on the View Last 24 Hours
  - You will see a detailed version of the following:
    - All notes entered from the past 24 hours,
    - Any new staff instructions,
    - Medications added,

- Changes to the health charts, and
- Referrals for exam or treatment or doctor visits that were scheduled or completed.

### Add Progress Note

It is important to keep track of what a service recipient does through each day.

- Click on the 'Add Progress Note' link.
  - Fill in the Date of the Note
    - You can change the note's day but be aware that when the note is saved, it is also time stamped to show when the note was actually entered.
    - Select the Start time
    - Select the End time
    - Write your note
      - The more information you provide here, the better the note will be.
  - Click on the 'Save and Add Another' button if you have multiple notes to write;
  - Click on the 'Finish' button
  - Or you can click 'Cancel' if you are unprepared to write your note.
    - **Note:** Direct Care Staff are allowed to only "Add" progress notes. Contact Supervisor or Manager if you have added a note in error; or simply add another progress note detailing that this first note written was an error and include the correct note for the service recipient.

### Give Med

If the Agency or Provider you work for allows direct care professionals to give medications,

- Click on the 'Give Med' link
  - Shows the current day's schedule of meds.
  - Note: If any medication is not listed or scheduled, contact your supervisor or manager to have meds added.
  - Click on the blue and yellow pill to the right of the
  - Fill in the Date
  - Fill in the Time
  - Click 'Next.'
    - Add any vital signs that were taken
    - Click on the 'Finish' button.
  - If a medication is not given, click on the Medication Not Given button
    - Select the Reason the medication was not given
      - R = Refused
      - H = Held at Doctor's Request
      - A = Resident out of Facility
      - O = Resident Out of medication
      - W = Resident at Work
      - DC = Discontinued
  - You can also choose to give a PRN medication, by clicking on the 'Give PRN med' link under the legend.
    - Fill in the Date
    - Fill in the Time

- Fill in the Medication Name
- Fill in the Dosage
- Fill in the Strength
- Fill in the Reason for PRN medication
- Fill in the Route/Method of Administration
- Fill in Comments
- Fill in the result after one hour
- Click on the Next button
  - Add any vital signs that were taken
  - Click on the Finish button.

## Room Check

Room checks are to be performed at various times throughout the day and night to ensure a service recipient's sleep pattern and/or that the person is okay. From the Personal Info page,

- Click on the 'Room Check' link
  - Select the Site/Home
  - Select the Service recipient
  - Answer if the person OK
  - Answer if the person sleeping
  - Select the Person Responsible
  - Fill in the Date
  - Fill in the Time of Room check
  - Fill in any Comments
    - Required if the Service recipient is not sleeping or the Service recipient is not OK
  - Click 'Submit'

This will determine a service recipient's sleep record. For every hour a person is checked on and determined to be either asleep, awake, or both, a form is automatically filled in with the associated condition. You will be able to find this report under the 'Maintenance' section and under 'General Reports' → Sleep Record.

## Add Incident

If a service recipient has an incident during your shift,

- Click on the 'Add Incident' link.
  - Select the Service Recipient
  - Fill in Today's Date
  - Fill in the Provider Agency
  - Fill in the Incident Location
  - Fill in the Incident Date
  - Select Observed/Discovered
  - Fill in the Incident Time
  - Select the Critical Incident Type(s)
    - If P.R.N. medication for behavioral control is selected:
      - Fill in the PRN medication name
      - Fill in the Time medication was given
      - Fill in the Dose Amount
    - If physical hold is selected:
      - Fill in Amount of time person was in hold
    - If Other is selected:
      - Fill in Other highly restrictive procedure



- Fill in the Non-critical Incident Type(s)
  - If Other significant occurrence involving medication
  - Fill in Other significant occurrence involving medication
- Fill in the Description of Incident
- Click the 'Submit' button

### **Add a Data Collection Note**

These notes are directly related to a Service recipient's Outcome Actions, and therefore, need to be addressed with the required frequency. Over time the scoring will show how well the service recipient is meeting the requirement of the Outcome and action.

- Click on the Add Data Collection Note link
  - If you receive a blank page, contact your supervisor or manager and let them know that a service recipient does not have current Outcomes/Actions, or Staff Instructions have not been selected.
  - Fill in the Data Collection Note
  - Select the Score
    - + : Independent/Meets criteria
    - - : Completed, not meeting criteria
    - R : Refused
    - A : Away
    - / : Training did not occur
  - Fill in the Date
  - Fill in the Start Time
  - Fill in the End Time
  - Click the 'Continue' button

### **Recreation Note**

Recreation Notes are notes that reflect a service recipient's community activities. Multiple staff members may be present during an activity, but only one note should be written concerning that activity.

- Click on the Recreation Note link
  - Select the Note Type
  - Select the Responsible Party
  - Fill in any Other Responsible Party
  - Fill in the Date
  - Select the Start Time
  - Select the End Time
  - Fill in the Number of Trips
  - Fill in How activity was selected
  - Fill in Location
  - Fill in Participation/Effect
  - Fill in Note
  - Fill in Learning Opportunities
  - Fill in Number of Contacts
  - Click on the Submit button

## **BM**

Every shift should document whether or not a service recipient has had a bowel movement during the specified time you are at a service recipient's home.

- Click on the BM link at the top right of the Personal Info Screen
  - Select the Home/Site
  - Select the Shift
  - Select the Consistency
    - If there is not a BM during your shift, select 'N'
  - Select the Size
    - If there is not a BM during your shift, select 'N/A'
  - Fill in the Date
  - Click on the Submit button

## **Referral for Exam or Treatment**

All Scheduled appointments will be listed for a service recipient if that information has been added to the application on the middle of the Personal Info screen under Scheduled Appointments. On the day of the appointment,

- Click on the Referral for Exam/Treatment link
  - Print this form and take it with you to that medical appointment.
  - The doctor will then fill out the following information:
    - Diagnosis/Findings,
    - Treatment/Recommendations,
    - Medications/Dosage/Frequency,
    - Other Concerns, and
    - If there is another visit.
      - More on 'Referral for Exam or Treatment' is listed below.

## ***Personal Info***

You as a direct care professional who works closely with the service recipients should review all of the below information to ensure its validity. If there are errors, discuss with your manager or supervisor on who should fix the mistakes in a service recipient's information.

## **Health Information**

This report contains all pertinent information concerning a service recipient if something should occur while away from home.

- Click on the '+' to the left of Personal Info
  - Click on the Health Information link

## **Health Care Report**

This link composes a report to help with the understanding of the medical issues for a person with developmental disabilities or mental retardation. It composes a list of the medical diagnoses with the medications a service recipient is taking for each diagnosis; any clinical issues a service recipient faces; and the competency and physical capabilities a service recipient has.

- Click on the '+' to the left of Personal Info
  - Click on the HealthCare Report link

## Personal Information Sheet

This sheet is a general report concerning a service recipient's personal information. It lists a relevant description of the service recipient's characteristics with his or her home information. It also lists all important contacts to this service recipient from the Parents/Guardian to the PCP/Specialists. You can also find the known medical conditions to this service recipient with a list of his or her insurance coverage.

- Click on the '+' to the left of Personal Info
  - Click on the Personal Info Sheet link

## Inventory/Property

This section allows you to track any type of property/inventory a person may have

- Click on the '+' to the left of Personal Info
  - Click on the '+' to the left of Property
    - Click on the Add Property link
      - Fill in the recipient's Name
      - Fill in the Quantity
      - Select the Type
      - Fill in the Property Tag
      - Fill in a Description
      - Fill in any Comments
      - Click on the Submit button
    - Click on the View Property link
      - Displays all property a person may have
    - Click on the Property Report link to display a more detailed report of a person's property
      - Select the Item Type
      - Fill in the Date Entered
        - Leave blank for all
      - Click on the Submit button

## Notes

All notes above can be viewed in a report format.

## Progress Notes

- Click on the '+' to the left of Progress Notes
  - Click on the Add Progress link
    - Fill in a Date
    - Fill in a Start Time
    - Fill in an End Time
    - Write the Note
    - Click on the Save and Add Another
  - Click on the Search link
    - Fill in a Search Date
    - Fill in an End Date
    - Click on the Search
  - Click on the Report link
    - Fill in a Search Date
    - Fill in an End Date

- Click on the Search

## Recreation Notes

- Click on the '+' to the left of Recreation Notes
  - Click on the Add Note
    - Select the Note Type
    - Select the Responsible Party
    - Fill in any Other Responsible Party
    - Fill in the Date
    - Select the Start Time
    - Select the End Time
    - Fill in the Number of Trips
    - Fill in How activity was selected
    - Fill in Location
    - Fill in Participation/Effect
    - Fill in Note
    - Fill in Learning Opportunities
    - Fill in Number of Contacts
    - Click on the Submit button
  - Click on the View Note link
    - Fill in the Note type
      - Leave blank for all types
    - Fill in the Responsible party
      - Leave blank for all members
    - Fill in a From Date
    - Fill in a To Date
    - Click on the Submit button
      - To upload a document acquired during this time frame, click on the upload link to the left of the Note
        - Click on the Browse button
        - Locate the document on your hard drive
        - Click on the Open button
        - Click on the Upload button
  - Click on the Report link to view a full report of the notes
    - Fill in the Note type
      - Leave blank for all types
    - Fill in the Responsible party
      - Leave blank for all members
    - Fill in a From Date
    - Fill in a To Date
    - Click on the Submit button

## Observation Notes

- Click on the '+' to the left of Observation Notes. You will be able to add Nurses Notes to the application once they are sent to you.
  - Click on the Add Note link
    - Fill in the Note Date
    - Select yourself in the Staff Responsible dropdown

- Fill in your Title
- Fill in your observations while the Nurse was present.
- Click on the Submit button
- Click on the View Notes link
  - Click on the Upload link to the right of the note you want to add the actual nurse note to.
  - Click on the browse button
  - Locate and click on the Nurse Note
  - Click Open
  - Click Upload File

## ***Health***

A person's medical history can be documented under this drop down option to document any and all medical conditions a service recipient may have. You can update these charts and familiarize yourself with a service recipient's history by viewing the reports associated with charting and diagnosis.

- Click on the '+' to the left of Health

## **BM**

You can also access the BM chart from this location.

- Click on the BM chart link
  - This will list all BMs recorded for a person
- Click on the BM report link
  - This generates the actual printable report that shows the entire's month worth of records.

## ***Med Admin***

Medication Administration gives you the opportunity to view all medications associated with a service recipient. You can familiarize yourself with all of the information concerning each prescription with the instruction and interactions a drug may have with other medications. You can also review a service recipient's MAR, record that you have given a medication, and make changes according to nurse directions to a MAR

## **MAR**

The MAR is a service recipients list of current medications with the times the medication should be taken; the diagnosis the med is for; the dosage, strength, and route given. The report also indicates who has given the medication; the vital signs of the service recipient and a reason if the medication was not administered.

- Click on the '+' to the left of MAR
  - Click on Give Medication link
    - Locate the medication that has been given
    - Click on the yellow and blue capsule to the left of the medication name.
      - Fill in the Date
      - Fill in the Time
      - Fill in any comments associated with giving the medication.
      - Click 'Next.'
        - Add any vital signs that were taken
        - Click on the 'Finish' button.

- If a medication is not given, click on the associated button on that screen.

## Med/Prescrip

These reports give detailed information concerning each medication for a service recipient.

- Click on the '+' to the left of Med/Prescrip
  - Click on the Medication Report link
    - Lists all medications ever given to the recipient that has been recorded in the application.
  - Click on the Current Med Report link
    - Lists all current prescriptions and the associated information for each medication.

## Med Variance

Medication Variances determine how severely an event may affect a service recipient's medication schedule.

- Click on the '+' to the left of Med Variance
  - Adding a variance is simple, click on the 'Add' link
    - Fill in Section 2: Time & Location of Variance
      - Fill in Date of Event
      - Select the Time the event occurred
      - Fill in the Location
      - Select if the Physician was notified.
      - Fill in the Date the Physician was notified
      - Fill in the Time the Physician was notified
    - Fill in Section 3: Practitioner/Staff Involved
      - Select a Classification
      - Fill in a description of the Other Classification
        - Fill in only if Other is chosen in selecting the classification.
      - Select a Status
      - Fill in a description of the Other Status
        - Fill in only if 'Other' is chosen in selecting the status
      - Fill in the Duration of Variance (Days)
      - Fill in the Duration of Variance (Hours)
    - Fill in Section 4: Medication and Dose Involved
      - Fill in Drug Ordered
      - Fill in Drug Given
      - Select Route (Drug Ordered)
      - Fill in a description for Other Route (Drug Ordered)
        - Fill in only if 'Other' is chosen in selecting the route (drug ordered)
      - Select Route (Drug Given)
      - Fill in a description for Other Route (Drug Given)
        - Fill in only if 'Other' is chosen in selecting the route (drug given)
    - Fill in Section 5: What happened?
      - Select What happened
        - Multiple choices can be made.

- Hold the 'Ctrl' key down and click on each variance that occurred.
  - If you selected one that did not occur, click on that variance again to deselect it while holding the Ctrl key down
- Fill in a description for Other Variance
  - Fill in only if 'Other' is chosen in selecting the Variance
- Select the form of Variance
- Fill in Section 6: Description of Variance: In your opinion, why did this variance occur?
  - For each of the following, select whether or not each had an effect on the variance and any comments associated with it.
    - Transcribing
    - Prescribing
    - Procurement & Storage
    - Dispensing
    - Administering
    - Monitoring
- Fill in Section 7: Contributing Factors: In your opinion, were there factors that made this variance difficult to prevent or detect?
  - For each of the following, select whether or not each had an effect on the variance and any comments associated with it.
    - Product
    - Medication Use System
    - Communication Dynamics
    - Other
  - Fill in an Explanation of why this occurred
- Fill in Section 8: Severity of the variance (check one), use your best judgment to rate the severity of the variance
  - Select the Severity of the Variance
  - Fill in your Comments
  - Fill in an Outcome/Action to prevent future occurrences
  - Select if this is a Reportable Incident or not
- Click on the Submit button to save
- To view past variances, click on the 'View' link.
  - Click on the 'Report' link to the right of the Variance you want to view.

## Scheduler

The scheduler allows you to view a service recipient's medications and times these meds are to be taken in four different formats: month, week, day, or event list.

- Click on the '+' to the left of Scheduler
  - Click on the Month View link
    - Displays the current month's medication schedule
  - Click on the Week View link
    - Displays the current week's medication schedule
  - Click on the Day View link
    - Displays the current day's medication schedule

- Click on the Event list link
  - Displays the medication name with it's associated start and end dates

## **IPs**

Individual Plans are designed to identify a service recipient's interests and what he or she wants out of his or her life for the next year. You can always reference this by viewing the current IP.

- Click on the '+' to the left of IP
  - Click on 'View IP'
    - Click on 'View Upload.'
      - The most current IP is listed at the top of this section

## **Referral for Exams/Treatments**

Exams/Treatments are different types of appointments that an individual has been scheduled to receive. Reminder: Exam/Treatments have a report that you should take to the doctor/professional/specialist when there is a medical appointment so that he or she can fill out his or her findings, recommendations, medications, and other appointments needed.

- Click on the '+' to the left of Referral for Exams/Treatments
  - Click on the Add link
    - Select the Type
      - Select Scheduled or Completed
        - Scheduled creates an appointment in the application for a future date
        - Completed is after the person has returned from the doctor visit and findings/recommendations are added.
      - Select the Professional
        - If the Professional is not listed, click on the Add Professional link
          - Fill in all relevant information concerning adding a professional.
      - Fill in the Date of the appointment
      - Fill in the Time of the appointment
      - Fill in a Reason for the Exam/Treatment
      - Click on the Submit button
    - To view exam/treatments and make updates after the appointment has been completed, click on the View link
      - A brief listing of Exams/Treatments appear
      - To make updates, click on the Edit link to the right of the specified Exam/Treatment
        - Change Scheduled to Completed
        - Fill in the Doctor's Findings
        - Fill in the Doctor's Recommendations
        - Fill in the Treatments
        - Fill in any Staff Comments concerning the Exam/Treatment
        - Click on the Submit button





## Continuous Medical Record

This spans for a years' time of all instances of new clinical finding and diagnosis that are reported through the Referral for Exam or Treatment, an Incident Report, or another Source. To fill out this information simply fill in the following:

- Click on '+' to the left of Continuous Med Record
  - Click on the Add link
    - Fill in the Date of Event
    - Select the Source of Information
      - DDS 5
      - Incident Report
      - Other
    - Fill in the Clinical Findings/Diagnosis
    - Click on the Submit button.
  - Click on the View link
    - Allows you to view all med records entered into the system
  - Click on the Report link
    - Fill in a From Date
    - Fill in a To Date
    - Click on the Submit button

## Maintenance

Under this heading you can generate and access several different reports from the information you and your co-workers have entered for each service recipient you serve. You can also fill out the Medication Checklist and the Fire & Weather Drill Forms. All of the options under 'Maintenance' are to give you the records needed for a service recipient. These can be generated by looking for different criteria under General Reports. All of the options in Maintenance are listed on the left side of your screen with drop down boxes indicated by a '+' sign. Click on the '+' to pull down the various options for a heading.

### ***Fire & Weather Drills***

Fire & Weather Drills should be preformed periodically throughout each month depending upon a Provider or Agency's monthly procedures

- Click on the '+' to the left of Fire/Weather Drills
- Click on the Add Drill link
  - Select a Site/Facility
  - Person Responsible
  - Type
    - Fire Drill
    - Weather Drill
  - Shift
    - The current shift the drill is preformed on
  - Drill Date
  - Time of Drill/Length of Drill
  - Comments
  - Follow-up
  - Weather
  - Click on the 'Submit' button to save drill record
- The View Drills link allows you to see if a drill has occurred

- Fill in a Start date
- Fill in an End Date
- Select a site/home
- Click Submit
- A more detailed report is provided by clicking on the 'Drill Report' link
  - Fill in a Start date
  - Fill in an End Date
  - Select a site/home
  - Click the Submit button

### **Nightly Room Checks**

Nightly Room Checks can be performed at any time of day. This feature allows you to record whether or not a recipient is sleeping or awake and if that person is okay.

- Click on the '+' to the left of Nightly Room Checks
  - Click on the Add Room check
    - Select the site/home
    - Select the recipient
    - Answer whether or not the person is OK.
      - If the answer is No, you must fill in a comment
    - Answer whether or not the person is sleeping.
      - If the answer is No, you must fill in a comment
    - Select the person responsible
      - This is usually yourself
    - Fill in the room check date
    - Fill in the Room check time
    - Fill in any Comments
    - Click on the Submit button
  - To view whether or not room checks have been performed, click on the View Room Check link.
    - Fill in a Search From Date
    - Fill in a Search To Date
    - Select the County
      - This is optional
    - Select the site/home
    - Select the Sort By category
      - This allows you to see how the information is generated.
    - Click on the Submit button.
  - To see a more detailed report of the room checks, click on the Room Check Report link
    - Fill in a Search From Date
    - Fill in a Search To Date
    - Select the County
      - This is optional
    - Select the site/home
    - Select the Service Recipient
    - Select the Sort By category
      - This allows you to see how the information is generated.
    - Click on the Submit button.

## **Medication Checklist**

It is important to keep track of each service recipient's medications where as not to lose or misplace any pill or capsule since the service recipient relies on these medications.

- Click on the '+' to the left of 'Medication Checklist.'
  - Click the 'Add Med Checklist' link
    - Person Visiting
    - Service recipient
    - Date
    - Answer the following questions:
      - 1. The Name of the medications matches on:
      - 2. The dosage the medication matches on
      - 3. The directions (how to administer) matches on
      - Comments
      - Click 'Submit' to save.
  - To view medication checklists, click on the View Med Checklist link.
    - Select the Recipient
    - Fill in a Search from Date
    - Fill in a Search to Date
    - Select the County
      - This is an optional field.
    - Select the Site/Home
      - By selecting your home, you will see all notes for all recipients for the time frame indicated
    - Click on the Submit button
  - To see the reports of a medication checklist, click on the Med Checklist Report link
    - Select the Recipient
    - Fill in a Search from Date
    - Fill in a Search to Date
    - Select the County
      - This is an optional field.
    - Select the Site/Home
      - By selecting your home, you will see all notes for all recipients for the time frame indicated
    - Click on the Submit button

## **General Reports**

This drop down will generate a number of different reports for you to review concerning the service recipients that you work with and will use a number of different criteria in developing reports concerning each service recipient from the information you and your co-workers have previously entered into *InfoServ DD*.

- Click on one of the report links
  - Fill in a Start Date
  - Fill in an End Date
  - Select the recipient or site/home
  - Click Submit

- The following reports will provide the most information for you as DSPs.
- Charting Report
  - This report will show you all of the medical conditions and medical interest a service recipient has concerning his or her welfare.
- Progress Notes
  - This report shows all progress notes for a service recipient for a specified time frame.
- Recreation Notes
  - This report shows the notes directly related to a service recipient's time in the community.
- Diagnosis Report
  - This report shows all of the medical conditions a service recipient is concerned with.
- Referral for Exam/Treatment Report
  - This report shows all of the exams or treatments that a service recipient is scheduled to have. Once an exam/treatment is marked complete, you can view that the person has been to his or her exam/treatment.
- IPs Due
  - This report will show when a service recipient's IP is coming due. You should be familiar with the dates of an IP and notify your supervisor or manager prior to the IP expiring.
- Outcome Actions
  - This report shows a service recipient's Outcome Actions and whether or not they are being completed.
- Data Collection Notes
  - This report shows the Outcome Actions and the progress notes related to each Outcome Action. This also generates an overall score for how well a service recipient is doing with his or her Outcome Actions.

I testify that I have read and understood the above responsibilities set forth with system requirements in using *Infoserv DD* to complete during the work hours.

Quick Start Manual reviewed: Direct Support Professional

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witness or Supervisor

\_\_\_\_\_  
Date