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Data Entry Instructions for Entering an Individual's Demographics

1. First, check to see if the individual is in the system:

- Go to "Individuals"
- Either check the pull-down list or use the search to enter by last name and click on "Search / Select".

2. If the individual's record is not in the system, add the record via the following steps:

- Go to "Individuals" (if you're not there already)
- Click on "Add Individual" under the "Personal Info" menu heading on the left-hand side.

3. If the individual's record is already in the system, edit their demographics via the following steps:

- Go to "Individuals" (if you're not there already)
- Click on "[Edit Demographics](#)" under the "[Personal Info](#)" menu heading on the left-hand side.

4. Required Fields

The following fields are required.

First Name

Last Name

Social Security Number

Gender *(Note that you may choose "N/A" if not known at the time of entry)*

Race *(Note that you may choose "N/A" if not known at the time of entry)*

Birth Date is marked as required, but I believe it is not required anymore -- please check and update this document and report to Joe to take off "*" if not required.

Site *(Note, if the sites appearing in the sites list are not from your organization and you're an ISC Agency, the sites are from the individual's residential services provider.)*

Eligibility *(Note, if unknown, select "Mental Retardation")*

Marital Status

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Eye Color	<i>(Note that you may choose "N/A" if not known at the time of entry)</i>
Hair Color	<i>(Note that you may choose "N/A" if not known at the time of entry)</i>
Legal Status	<i>(If not known, choose "Adult adjudicated incompetent")</i>
Class Member	<i>(If not known, choose "Non Class Member")</i>

Click on "[Save](#)" at the bottom of the screen to save the information, or "[Reset](#)" to reset it to the way it was prior to adding or editing.

Entering an Individual's Certification Date

- Go to "Individuals"
- Go to "[Encounters / Events](#)"
- Click on "[View Encounters](#)" if you need to see if the information is already in the system (not necessary on a newly added individual).
- Click on "[Add Encounter](#)"
- The required fields have an asterisk beside them.
- If the individual does not have a physician listed, then move down the page to find and click on the "[Adding a Physician for an Individual](#)" link and then come back to this section and start over.
- Choose "[Certification Date](#)" as the encounter type.
- Fill in the certification date in the date area.
- The time is not important and may be left as-is.
- No other information is necessary to enter for a certification date.
- Click on "[Submit](#)"

Entering an Individual's Physical Date

- Enter just as you would a Certification Date, except changing the encounter type to Physical Date

Entering an Individual's Visit Date (PAE Date)

- Enter just as you would a Certification Date, except changing the encounter type to PAE Date (a.k.a. "Pre-Admission Evaluation Date")

Entering an Individual's Admit Date (Waiver Admit Date)

- Enter just as you would a Certification Date, except changing the encounter type to Admit Date (a.k.a. "Waiver Admit Date")

Entering an Individual's Doctor or Dental Appointment

Enter just as you would a Certification Date, except changing the encounter type to the appropriate topic. A regular doctor visit is named "Doctor Visit". There are other choices such as "Annual Physical" that may apply or "Dental Visit". Check the list for the type that best describes your needs. If the visit is in the future, then choose "Scheduled" instead of "Completed". Be sure to come back in to the record after the visit has been completed and change the status to "Completed" as well as being sure to enter any follow-up notes or recommendations. You may also need to schedule a follow-up visit by adding a new encounter/event with a new date and type.

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Entering an Individual's County

An individual's County is not entered directly -- it is ascertained from the individual's residential site.

Entering an Individual's MR Level

- Go to "Individuals"
- Select the correct individual.
- Go to "[Health](#)"
- Go to "[Diagnoses](#)"
- Click on "[Add...](#)"
- Select "MR Level" as the type
- Select the correct MR Level
- Save the record.

Entering an Individual's AB Level

- Follow the instructions for entering an individual's MR Level, except choosing the "AB Level" category.

Entering an Individual's Disability

- Follow the instructions for entering an individual's MR Level, except choosing the "Dual-Diagnosis" category.

Linking (Adding) a Physician to an Individual's Record

- Go to "Individuals"
- Select the correct individual
- Go to "[Contacts](#)"
- Go to "[Professionals](#)"
- Go to "[View Prof](#)" to check to see if the physician is already linked
- If not, click on "[Link Prof](#)" and type in the physician's last name in the last name box and click on "OK"
- If the physician appears, click on his/her record to link to the selected individual.
- If no physician appears in the results, then the physician must be added into the system from Maintenance.
- To add the physician from Maintenance, click on the "Maintenance" menu choice.
- Go to "[Professionals Mgmt](#)"
- Go to "[Add Prof](#)" and add the physician's information and save it.

Deleting a Physician from an Individual's Record

- Go to "Individuals"
- Select the correct individual
- Go to "[Contacts](#)"
- Go to "[Professionals](#)"
- Go to "[View Prof](#)" to find the physician you wish to delete.
- Click on the "[Delete Link](#)" option to the right of the physician you wish to delete.

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Linking (Adding) a Contact (Family member, friend, etc.) to an Individual's Record

- Go to "Individuals"
- Select the correct individual
- Go to "[Contacts](#)"
- Go to "[Contacts](#)"
- Go to "[View Contacts](#)" to check to see if the physician is already linked
- If not, click on "[Link Contact](#)" and type in the person's last name in the last name box and click on "OK"
- If the contact's name appears, click on his/her record to link to the selected individual.
- If the contact's name does not appear in the results, then the contact must be added into the system from Maintenance.
- To add the physician from Maintenance, click on the "Maintenance" menu choice.
- Go to "[Contact Mgmt](#)"
- Go to "[Add Contact](#)" and add the contact's information and save it.

Deleting a Contact from an Individual's Record

- Go to "Individuals"
- Select the correct individual
- Go to "[Contacts](#)"
- Go to "[Contacts](#)"
- Go to "[View Contacts](#)" to find the contact person you wish to delete.
- Click on the "[Delete Link](#)" option to the right of the contact you wish to delete.

Other Information

- Discharge Date -- should be entered from "Movements / Transfers"
- Discharge Reason -- should be entered from "Movements / Transfers" on the comments section of the above "Discharge" date record.
- Diagnosis -- could be entered from "DSMIV" type if it exists under the Diagnosis menu under "Health" (like MR Level, AB Level).
- Region -- is already known from individual's agency
- Medicaid Number -- under Personal Demographics

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Med. Admin. (Medication Administration)

Overview

Any medication, whether it is a psychotropic or other drug or an over-the-counter medication, along with any physician's order may be entered and tracked in the system. Medications are first entered per consumer through the "Add Med" link. When adding a medication, the system also presents you with the first prescription information to enter. Once that information has been entered, you may optionally schedule the dates and times for the medication to be given. A direct caregiver would then click on the "Give Medication" link in order to record whether a medication that was scheduled was given or not. If a medication is discontinued, then the medication is marked as "Yes" for the question "Is this an end date?" that appears on the "Give Medication" screen. The "List Open MARs" link gives you another option for recording medication administration in case you opt not to use the scheduling calendar function.

Some organizations may opt to simply track in InfoServ DD the medications used per consumer at first and plan for full implementation later as users involved become more familiar with the system

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A. MAR (Medication Administration Record)

If no medications have been entered for the consumer, skip to "B. Med / Prescript".

1. Give Medication

This link allows you to record the administration of the medication. The first time that a medication is given, InfoServ DD will automatically "Create a MAR" start date (which may be ended when the medication is discontinued). The screen contents are the same, other than the fact that a newly created MAR won't ask if this is the end date (since it is the first record and therefore it is the start date).

[Create New MAR](#)

(* means required field)

* Date: *	1/2/2002	-	<c>	+
* Time: *	2	36	am	pm
Medication: *	Enalapril - Vasotec			
Quantity of Measure:	1			
Measurement:	tbl			
Quantity of Container:	1			
Medicine Container:	tablet			
* Diagnosis: *	Hypertension			
Method of Administration:	Oral			
Comments:				
Allergies:	There are no allergies on record			
Diet Instructions:	There are no diet instructions on record			

Click on the "Medication Not Given" button if the medication was not given so that the reason may be recorded. Click on the "Next" button to save this record and have the option of entering in any vital signs taken at the time of the administration. Click on "Cancel" if you do not wish to save the record at all.

If you do choose "Next" and wish to record vital signs (optional), then you will receive a screen that gives you a list of vital sign types to choose from such as "Temperature", "Blood Pressure", etc. Choose one and type in the reading or entry in the "Entry" field. To record another vital sign, simply select another vital sign type and fill in an additional reading/entry. Click on "Done" when finished.

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2. List Open MARs

What is an “Open MAR”? An open MAR is a medication administration record or group of records that has already been created for a specific medication for a specific individual. You must first have added the medication and prescription for the medication prior to adding a MAR. An “Open MAR” is one that has not yet been closed out. You can close out a MAR by clicking on the “Is this an end date” check box. A MAR would be closed out if the medication is no longer needed to be given (even though the prescription is still valid).

3. Add MAR

If a medication exists and there is not yet an open MAR for it, you may create an open MAR.

4. Edit MAR

You may edit a MAR from this option whether or not it is open or closed (ended).

4. Delete MAR

You may delete a MAR from this option as long as you have the rights to do so.

5. MAR Report

The MAR report lists all the medication administration record information associated with the currently selected individual. The Tennessee MAR lists it in the Tennessee format.

Note: The MAR has a scheduling mechanism per person, per day, per dose. You are able to schedule the administration of the medication for multiple times per day with varying dosages and times per day of week.

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B. Med / Prescrip (Medications and Prescriptions)

1. Add Med

- Select the individual (Click on “Individuals” and select them from the pull-down menu and click on “Search (above)”).
- Click on the plus sign to the left of the menu option “MED ADMIN”.
- Click on the plus sign to the left of the menu option “Med/Prescrip”.
- First, make sure the medication is not already there by clicking on the “Prescriptions” link.
- Click on the “Medication Name” pull-down to view all meds that exist for this individual.

Add Medication

Individual Name: Sally Doe

Medication Info:

Medication Name: * Enalapril

Brand: * Vasotec

Generic: * Enalapril

Medication Type: * Medication

Approval Info:

Guardian / Individual: 1/2/2002 - <c> +

Human Rights: 1/2/2002 - <c> +

Interactions:

Prescription Info:

Start Date: 1/2/2002 - <c> +

End Date: 1/1/2003 - <c> +

Has the Guardian or Individual approved the medication? If so, what was the date of approval?

When you add a medication, it also asks for the prescription information.

- If the medication is not there, click on the “Add Med” link on the left-hand menu.

Quantity of Measure: 1

Measurement: * tbl

Quantity of Container: 1

Medicine Container: * tablet

Refill - Reorder Date: 2/2/2002 - <c> +

Administration Instructions: Take one in the morning

Reason For Med: * Hypertension

Side Effects: * Dry mouth, cough

Professional: new, professional

[Associate a professional with this client](#)

Qty of Measure is the amount being taken. Most of the time, it equals 1 and the measurement equals "pill".

What is the next refill

BACKGROUND: In order to be able to add a medication administration record, the medication and a prescription for it must first exist. The medication and prescription areas are split out into separate areas in

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case you wish to have supervisors set up medications for individuals, while having direct care workers actually doing the medication administration record entry. When you first enter a medication, it also asks for start and stop dates for the medication's prescription. You enter this information one time, and then all subsequent prescription renewals can be created with the information carried forward.

2. Edit Med.

To change information associated with a medication, simply click on "Edit Med." from the "Med./Prescrip" menu. The change in the medication information is immediately reflected in all reports listing that medication.

3. Delete Med

To delete a medication, simply click on "Delete Med" from the "Med/Prescrip" menu. Note that the medication may not be deleted if a medication administration record has been created for it. (If you must delete the medication anyway, then delete the medication administration record first, and then delete the medication.) The change in the medication information is immediately reflected in all reports listing that medication.

4. Prescriptions

To edit a prescription that already exists, click on the "Prescriptions" option from the "Med/Prescrip" menu. You must fill in the start and end dates for the entire prescription period. Once a prescription runs out, you may click on "Renew Prescription" to renew it.

The Prescriptions area links to a scheduling component so dates, times, and dosage amounts can be maintained. Supervisors, nurses, and/or case managers could fill in the scheduler at the main agency office so that the direct care worker simply clicks on the appropriate medication from the individual's calendar and fills out the time given, etc. InfoServ DD allows for dosage amounts to be variable.

Also note -- We will pull medications, dosages, directions, and side effects from an on-line Physician's Desk Reference database in the near future.

Manage Prescriptions for Enalapril:

Name: Sally Doe

Medication Info:

Medication Name: Enalapril

Brand: Vasotec

Generic: Enalapril

Medication Type: Medication

Approval Date & Other Information:

Guardian / Individual: 01/02/2002

Human Rights: 01/02/2002

Interactions:

Prescriptions:

1. Jan 2, 2002 - Jan 1, 2003 [Edit](#) | [Delete](#)

[Renew Prescription](#)

[Search Again](#)

"Manage Prescriptions" is available immediately after you save after adding a medication or from the "Prescriptions" link under "Med/Prescript".

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You can create a medication schedule for this medication. Please select one of these two options:

- Single part schedule
(Ex: one tablet after awakening)
- Two part schedule
(Ex: one tablet after awakening AND one tablet before bedtime)
- Create A Schedule

You will normally accept the "Single part schedule" and then click on "Create a Schedule" if you want to schedule the dates and times for the medication to be administered. Even though you're accepting the single part schedule, you'll still have the opportunity to schedule the medication to be given multiple times per day.

5. Scheduling

The goal here is to make the recording of medication(s) given very easy by integrating a daily calendar with pre-scheduled medications listed for the individual selected. This makes it much easier and quicker to mark a medication as given, etc. We have linked a schedule of dates and times per each medication an Individual may receive with the default dosage and default method of administration to the Medication/Prescription and to a MAR record. The Direct Care Worker will access the "Give Medication" page and accept all defaults (or change if applicable) and enter the time given or click on the "Medication Not Given" button and fill out a reason why. Reports based on medications not given or medications where the dosage is not the default may be created.

Once you have clicked on "Create Schedule", you will see the following screen:

MAR

Please click the "use" link next to the scenario that best exemplifies your input needs. The basic formula stays the same, but the different variables, of the scenario may change, according to your needs. You will then be shown a screen with the appropriate input choice for you scenario.

- [use](#) dictate the hours per day (8:00 AM, 3:00 PM, 9:00 PM, etc.)
- [use](#) 3 cc every 2 hours
- [use](#) 1 tablet every other day
- [use](#) 2 tablets before bedtime
- [use](#) 5 ml every two hours (max of 10 hours)
- [use](#) 2 pills every Monday, Wednesday, and Friday
- [use](#) Twice Daily
- [use](#) 2 tablets at 8:00 AM
- [use](#) 2 pills, twice daily, every other day
- [use](#) 6 capsules on October 14th
- [use](#) 20 cc on the 1st of each month for the next 3 months
- [use](#) 2 pills between 6:00 AM and 6:00 PM, for the next 4 days
- [use](#) Once daily, for the next 20 days

Use this option for the majority of your scheduling needs.

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Below are the components that best fit your chosen medication scheduling needs. Input the correct information for this schedule. Submit the information to complete the process

Choose a Medication	Enalapril - Vasotec
Quantity of Measure	1
Measurement	tbl
Quantity of Container	1
Medicine Container	tablet

These items will default to what was originally entered.

Please enter the times of the day for this medication. Choose as many as you need and leave the rest blank. Choose them in the order of times to be given (chronological).

Hour of the day	8:00	(24 hour clock)
Hour of the day	20:00	(24 hour clock)
Hour of the day		(24 hour clock)
Hour of the day		(24 hour clock)
Hour of the day		(24 hour clock)
Hour of the day		(24 hour clock)

Currently this is based on a military-like clock. In the near future, times will be represented as AM/PM. If the medication is given at 8:00am and 8:00pm, then put 08:00 in the top box and 20:00 in the second box.

Start Date *	01/2/2002	- <c> +	(Ex.: 01/01/2001)
End Date	01/1/2003	- <c> +	(Ex.: 01/01/2001)
<input type="button" value="Submit"/> <input type="button" value="Reset"/> <input type="button" value="Back"/>			

The end date would normally be the last day of the prescription period.

Using the first option (above), "dictate the hours per day...", we have the opportunity to fill in a single time or up to six times per day that a medication can be given.

Once you've filled out this screen appropriately, InfoServ DD creates the schedule for you. You'll now be able to go to the "Give Medication" link and record the administration of the medication (or give a reason why it was not given).

The scheduler is then displayed in a monthly view. You will be able to see the detail in the daily view. The weekly view is simply a week cut out of the monthly view.

(See the example below of the monthly view.)

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[Display Month](#)

[Display Week](#)

[Display Day](#)

[Search](#)

December 2001 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	◀ January 2002 ▶	February 2002 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
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SUN	MON	TUE	WED	THU	FRI	SAT
		1	2 🌐 📌 - Rx	3 🌐 📌 - Rx	4 🌐 📌 - Rx	5 🌐 📌 - Rx
6 🌐 📌 - Rx	7 🌐 📌 - Rx	8 🌐 📌 - Rx	9 🌐 📌 - Rx	10 🌐 📌 - Rx	11 🌐 📌 - Rx	12 🌐 📌 - Rx
13 🌐 📌 - Rx	14 🌐 📌 - Rx	15 🌐 📌 - Rx	16 🌐 📌 - Rx	17 🌐 📌 - Rx	18 🌐 📌 - Rx	19 🌐 📌 - Rx
20 🌐 📌 - Rx	21 🌐 📌 - Rx	22 🌐 📌 - Rx	23 🌐 📌 - Rx	24 🌐 📌 - Rx	25 🌐 📌 - Rx	26 🌐 📌 - Rx
27 🌐 📌 - Rx	28 🌐 📌 - Rx	29 🌐 📌 - Rx	30 🌐 📌 - Rx	31 🌐 📌 - Rx		

LEGEND

🌐 - Record Detail

📌 - Give Med

"Record Detail" refers to the process of viewing MAR records -- which spans of time (usually corresponding to the prescription period) for a medication.

"Give Med" lets the computer do the work by having it figure out whether or not a new MAR should be started or not. Direct care workers should normally use the "Give Med" option and should not worry about the "Record Detail" link.

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Nightly Room Checks

Nightly room checks are under the Maintenance heading. Click on the plus sign (+) to the left of “Nightly Room Checks” in order to see the menu options for Nightly Room Checks.

Viewing a List of Nightly Room Check Records

Click on the plus sign (+) to the left of “View Room Checks”. If there are Nightly Room Checks records that have been entered, they will be displayed in order of the most recent on top to the oldest on the bottom. When records are listed, you are given options to “Edit”, “Delete”, “Upload”, or “Scan” the specific record (or row) that you are on.

Adding a Nightly Room Checks Record

In order to add a new Nightly Room Check record, click on “Add Room Check”. You will then see the Room Check form. Fill in the form and scroll down to the bottom of the page and click on “Submit” to save the information. You should then see the record on top of the list.

Editing a Nightly Room Check Record

To edit a Nightly Room Check record you must first click on “View Room Checks”. Then locate the record you wish to edit (or change) and click on the “Edit” link to its right. The Nightly Room Check form will be displayed. Make your changes to the form and scroll down the page and click on the “Submit” button to save the information.

Deleting a Nightly Room Check Record

To delete a Nightly Room Check record you must first click on “View Room Checks”. Then locate the record you wish to delete and click on the “Delete” link to its right. The system will ask you to click on the “Delete” button again to make sure that you wish to delete the record.

Uploading (attaching) a document to a Nightly Room Check Record

You may need to attach a Microsoft Word document or Excel spreadsheet (or any other file type) to a Nightly Room Check record to help further document the visit. If this is the case, first click on “View Room Checks” and locate the record to which you wish to attach the file. Then click on “Upload” to the right of this record. You should then click on the “Browse” button in order to search for the document or spreadsheet to attach. Oftentimes, this document will be found under “My Documents”. If this is the case, you need to double-click on the “My Documents” folder and then locate your document in the folder and double-click it. Then click on the “Upload” button and it will be transferred (and attached) to this record. Now when you “View Room Checks”, you will see “View Upload” as an option.

Scanning a document and attaching it to a Nightly Room Check Record

You may only have a paper document, instead of an electronic document or spreadsheet to attach. If this is the case, you are still in luck if you have a scanner. If this is the case, first click on “View Room Checks” and locate the record to which you wish to attach the file. Then click on “Scan” to the right of this record. You should then click on the “Scan” icon on the scanning screen that appears in order to start the scan. Find the “Save” button on the screen and click it. Type in a file name that makes sense and save it. When you “View Room Checks” next time, it will have a new choice of “View Scan” for this record.

Creating a Nightly Room Check Report

Click on the “Room Check Report” link. You are able to view the report by Site and by date. You will be able to view it by county in the very near future. Once the report appears on screen, you may optionally click on your browser’s “Print” button to send the report to your printer.

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Medication Checklists

Nightly room checks are under the Maintenance heading. Click on the plus sign (+) to the left of “Med Checklist” in order to see the menu options for Med Checklist.

Viewing a List of Med Checklist Records

Click on the plus sign (+) to the left of “View Med Checklist”. If there are Nightly Room Checks records that have been entered, they will be displayed in order of the most recent on top to the oldest on the bottom. When records are listed, you are given options to “Edit”, “Delete”, “Upload”, or “Scan” the specific record (or row) that you are on.

Adding a Med Checklist Record

In order to add a new View Med Checklist record, click on “Add Med Checklist”. You will then see the Med Checklist form. Fill in the form and scroll down to the bottom of the page and click on “Submit” to save the information. You should then see the record on top of the list.

Editing a Med Checklist Record

To edit a Med Checklist record you must first click on “View Med Checklist”. Then locate the record you wish to edit (or change) and click on the “Edit” link to its right. The Med Checklist form will be displayed. Make your changes to the form and scroll down the page and click on the “Submit” button to save the information.

Deleting a Med Checklist Record

To delete a Med Checklist record you must first click on “View Med Checklist”. Then locate the record you wish to delete and click on the “Delete” link to its right. The system will ask you to click on the “Delete” button again to make sure that you wish to delete the record.

Uploading (attaching) a document to Med Checklist Record

You may need to attach a Microsoft Word document or Excel spreadsheet (or any other file type) to a Med Checklist record to help further document the visit. If this is the case, first click on “View Med Checklist” and locate the record to which you wish to attach the file. Then click on “Upload” to the right of this record. You should then click on the “Browse” button in order to search for the document or spreadsheet to attach. Oftentimes, this document will be found under “My Documents”. If this is the case, you need to double-click on the “My Documents” folder and then locate your document in the folder and double-click it. Then click on the “Upload” button and it will be transferred (and attached) to this record. Now when you “View Med Checklist”, you will see “View Upload” as an option.

Scanning a document and attaching it to Med Checklist Record

You may only have a paper document, instead of an electronic document or spreadsheet to attach. If this is the case, you are still in luck if you have a scanner. If this is the case, first click on “View Med Checklist” and locate the record to which you wish to attach the file. Then click on “Scan” to the right of this record. You should then click on the “Scan” icon on the scanning screen that appears in order to start the scan. Find the “Save” button on the screen and click it. Type in a file name that makes sense and save it. When you “View Med Checklist” next time, it will have a new choice of “View Scan” for this record.

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Creating a Med Checklist Report

Click on the “Med Checklist Report” link. You are able to view the report by Site and by date. You will be able to view it by county in the very near future. Once the report appears on screen, you may optionally click on your browser’s “Print” button to send the report to your printer.

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Health

Direct care workers and others will enter health reports on a frequent periodic basis in order to comply with regulations and in order to provide required documentation of the individual's care. This section includes medical reports, non-regular and regular medical assessments, and various diagnosis records that are associated with an individual.

A. Health Charting

What is "Charting"? Charting includes tracking an individual's medical conditions, medical supplies, medical devices, weight records, seizure records, infections, exposures, and other similar information. New charting categories may be added to the system.

1. Work With Charts

After expanding the "Charting" menu from the Individuals section of the program, click on "Work With Charts" to see the entries that have been added to the system. Charts that exist for the individual will appear and the following options are available:

a. Charting: View Chart: Edit

Once you have clicked on "Work With Charts" and entries appear, you will see that each entry has an "Edit" and possibly a "Delete" option to the right of the entry. By clicking on "Edit", you will be taken to the charting entry form and the information associated with the entry you chose would be loaded. You may then modify the entries.

Click on "Submit" to save the changes you made, or click on "Cancel" to discard the changes you made.

Fields that must have entries (required fields) include:

- Charting Category
- Charting Description
- Entry
- Professional
- Transaction date

b. Charting: Working With Charts: Delete

Once you have clicked on "Working With Charts" and entries appear, you will see that each entry has an "Edit" and possibly a "Delete" option to the right of the entry. By clicking on "Delete", you will be taken to a screen that asks you if you are sure that you would like to delete the transaction. Answer "Yes" to verify the deletion, or "No" to discontinue to delete process (and keep the transaction).

1. Add Chart

Once you have clicked on "Work With Charts", you will see the button "Add Chart" near the bottom of the screen. Click on it to add another charting transaction for the individual. You will be taken to a blank charting entry form. You may then modify the entries.

Click on "Submit" to save the changes you made, or click on "Cancel" to discard the changes you made.

Fields that must have entries (required fields) include:

- Charting Category
- Charting Description

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Entry
Professional
Transaction date

2. Charting Report

Leave all entries blank to see all charting transactions associated with the individual. Otherwise, you may filter the report output by Charting Category and by Date Entered.

Once the report displays, you may click on your browser's "Print" button if you wish to print it to your printer. Click on the "Back" button to go back to the charting menu.

B. Diagnosis

1. View Diagnoses

After expanding the "Health" and then "Diagnosis" menus from the Individuals section of the program, click on "View Diagnoses" to see the entries that have been added to the system.

2. Add Diagnosis

Once you have expanded the "Diagnosis" menu, you will see the menu option "Add Diagnosis". Click on it to add another diagnosis transaction for the Individual. You will be taken to a blank diagnosis entry form. You may then modify the entries.

Click on "Submit" to save the changes you made, or click on "Cancel" to discard the changes you made.

Fields that must have entries (required fields) include:

- Diagnosis Type (or Category)
- Diagnosis Item (or Description)
- Professional
- Transaction date

3. Edit Diagnosis

Once you have clicked on "View Diagnosis" and entries appear, you will see that each entry has an "Edit" and possibly a "Delete" option to the right of the entry. By clicking on "Edit", you will be taken to the diagnosis entry form and the information associated with the entry you chose would be loaded. You may then modify the entries.

Click on "Submit" to save the changes you made, or click on "Cancel" to discard the changes you made.

Fields that must have entries (required fields) include:

- Diagnosis Type (or Category)
- Diagnosis Item (or Description)
- Professional
- Transaction date

An optional process that can be associated with a diagnosis includes scanning original documents by clicking on the "**Scan**" button on the diagnosis screen. The document is automatically compressed and associated with the diagnosis record and can be viewed or printed. Other options are available as well including rotating the image, changing the contrast of the image and more.

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4. Delete Diagnosis

Once you have clicked on “View Diagnosis” and entries appear, you will see that each entry has an “Edit” and possibly a “Delete” option to the right of the entry. By clicking on “Delete”, you will be taken to a screen that asks you if you are sure that you would like to delete the transaction. Answer “Yes” to verify the deletion, or “No” to discontinue to delete process (and keep the transaction).

5. Diagnosis Report

Leave all entries blank to see all diagnosis transactions associated with the individual. Otherwise, you may filter the report output by Diagnosis Type and by Date Entered.

Once the report displays, you may click on your browser’s “Print” button if you wish to print it to your printer. Click on the “Back” button to go back to the diagnosis menu.