MED e-care

Your Care, Our Mission

RELEASE NOTES

e-Care IV Version 407.7

July 10, 2014

Notice

Proprietary & Confidential Information Enclosed
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Published July 2014

Table of Contents

SECTION 1 - OVERVIEW

1.1 - Document Purpose

This document provides the latest information on changes made to the 407.7 release of the e-Care IV application. The intended audience is all end users of the product.

1.2 - Background

MED e-Care provides a full platform with an integrated Electronic Health Record (EHR) system, in French and English, for complete management of the Resident Care Lifecycle. From single-home independents to large chains, our healthcare software links an organization's clinical, medication, financial and business processes to manage and use information for progressive improvements. Increased operational effectiveness, funding opportunities, staff productivity, quality of resident care, and reduced risk to business are accomplished with MED e-care's software.

1.3 – Documentation

Product documentation is available in the Med e-Care *e-Care IV User manuals*. To view MED e-Care product documentation in PDF format, log into the application and navigate to the *Help* section. Manuals are printable from that location.

SECTION 2 – What's New in this Release

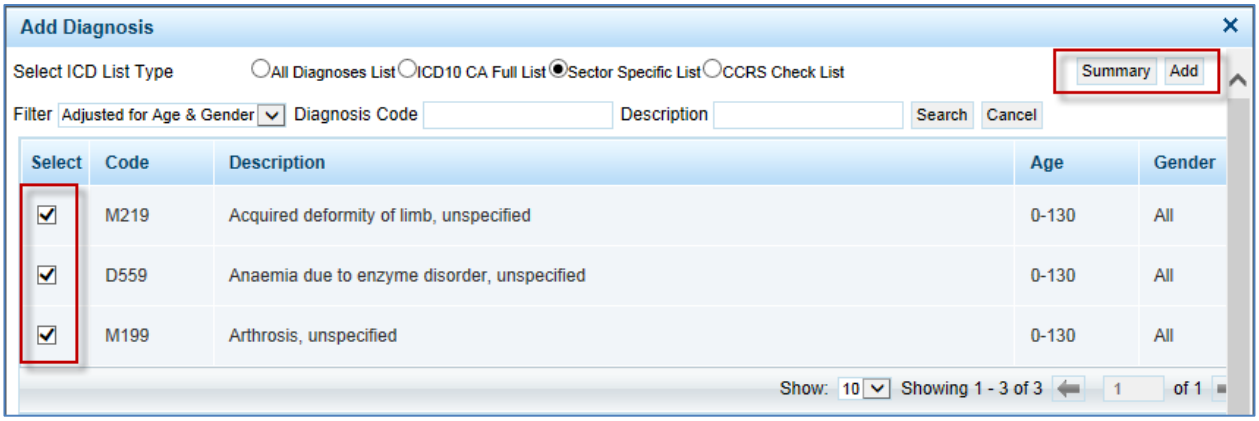
2.1 e-ADT

2.1.1 FEATURE: Selectable Diagnoses from Search

LOCATION: e-ADT > Admission Document > Client Health Status Tab> Diagnoses

ENHANCEMENT: Adding diagnoses through ADT or Care Plan is now faster and easier. When searching for diagnoses, the user is now able to select multiple options by checking the relevant check boxes.

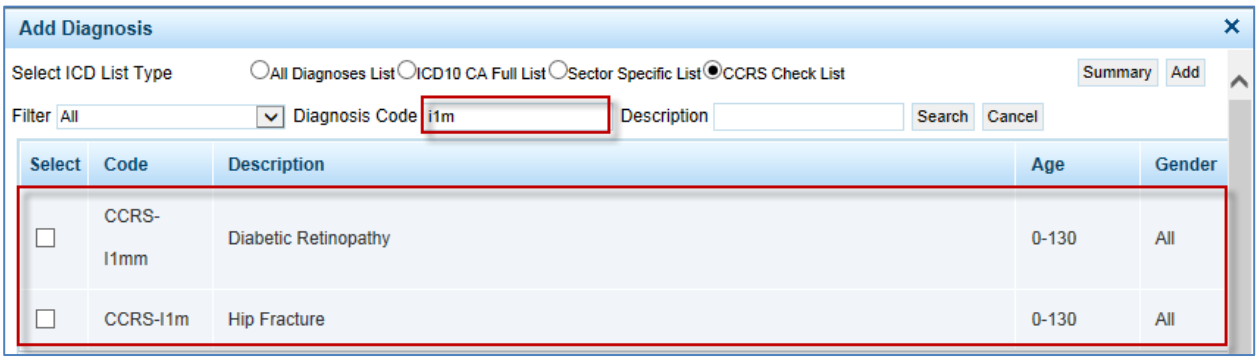
Select the required diagnoses and then click on the Summary option to view all selected items at once. Click Add to save the items to the record.



2.1.2 FEATURE: Enhanced Diagnoses Search

LOCATION: e-ADT > Admission Document > Client Health Status Tab> Diagnoses

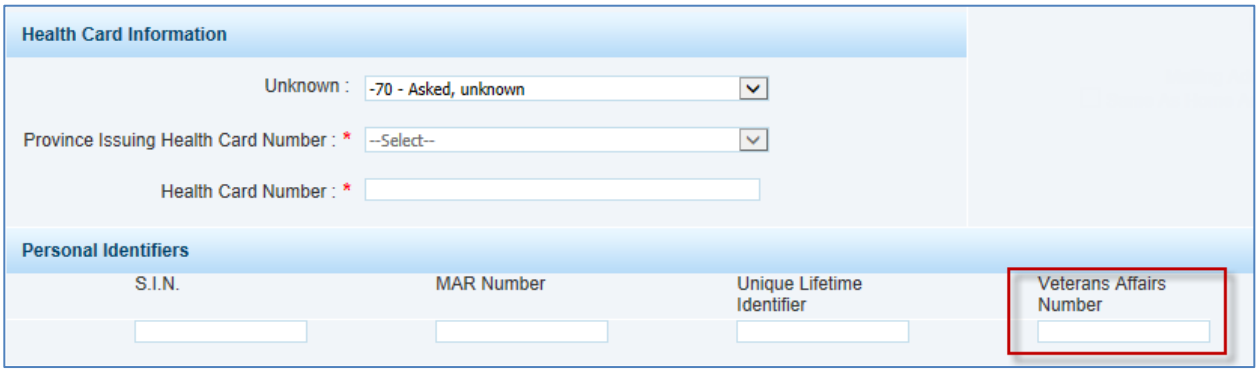
ENHANCEMENT: Searching for a diagnosis by code or description will now return search results by typing in at least a portion of the diagnosis.



2.1.3 FEATURE: Veterans Affairs Number option

LOCATION: e-ADT > Admission Document > Client Identification Tab > Personal Identifiers

NEW: A new option to enter the resident's Veterans Affairs Number has been added to the Admission Document. The option is available in the *Personal Identifiers* section.

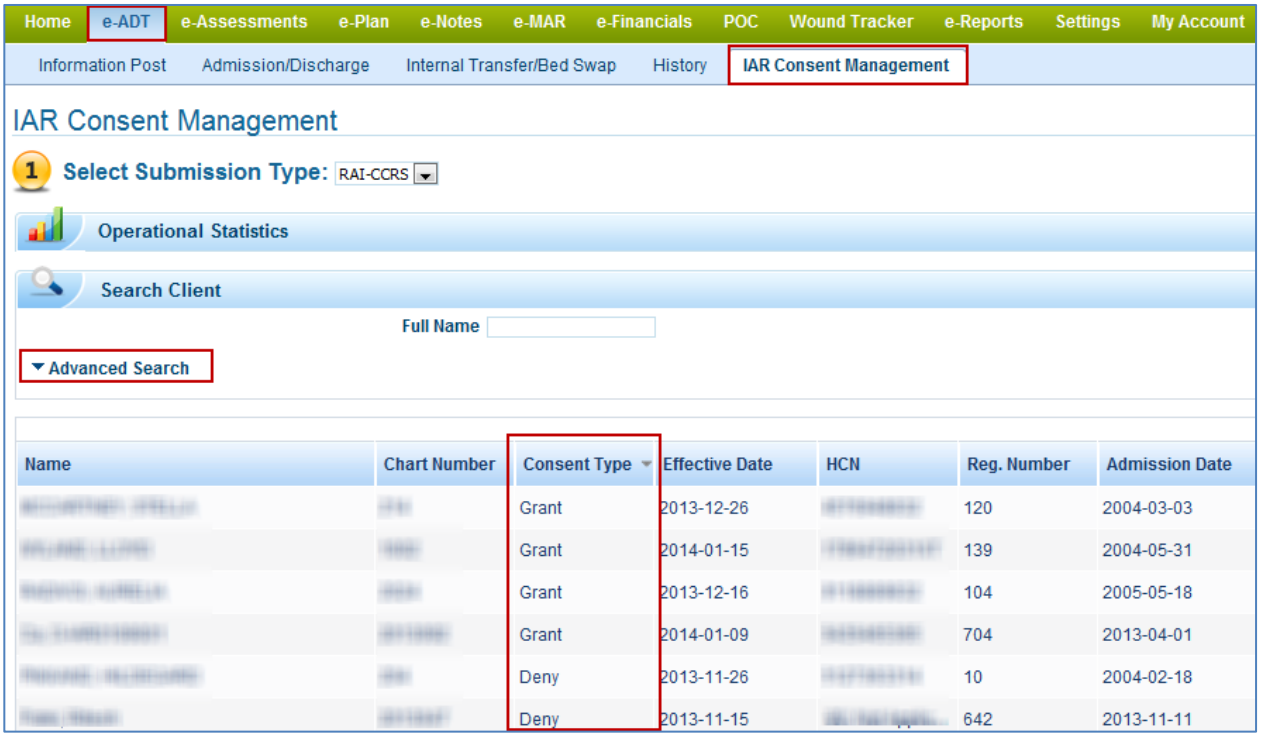


2.1.4 FEATURE: New IAR Consent Type Column Display

LOCATION: e-ADT > IAR Consent Management

NEW: A new column has been added to show Consent Type. This column can be sorted by clicking on the header of the column to see all residents that have consent granted, denied or have not had consent data entered.

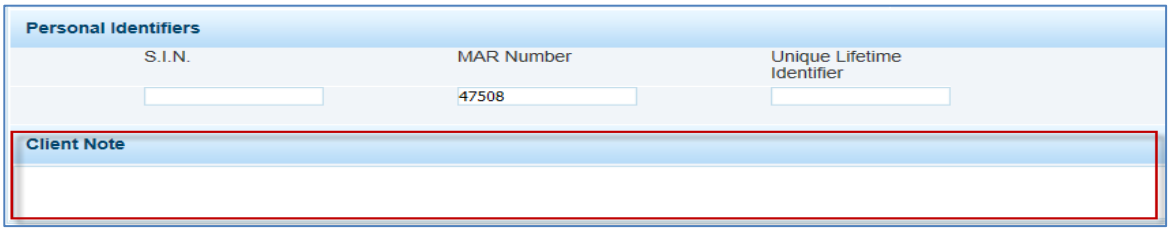
Use the Advanced Search option to further filter any search requirements.



2.1.5 FEATURE: Client Note Free Text

LOCATION: e-ADT > Admission Document > Client Information tab

NEW: The Client Note text area has been added to provide the user with a customizable option that allows for the addition of optional demographic information.

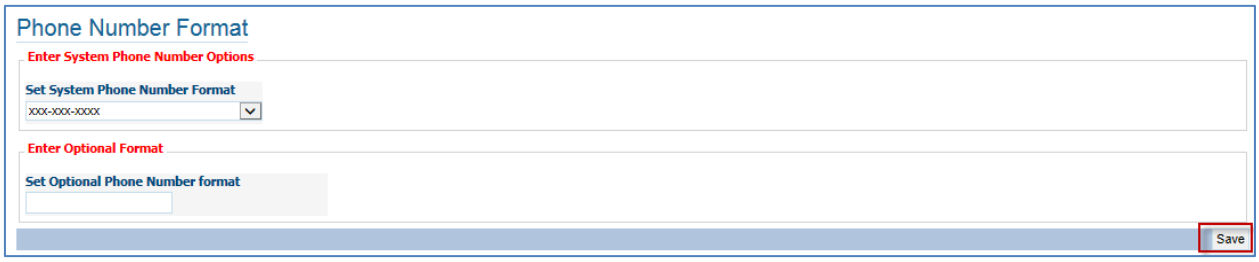


2.1.6 FEATURE: Phone Number Format Mask

LOCATION: Settings > Facility > Options > Phone Number Format

NEW: A phone number format mask has been implemented that is used for validating phone number fields. The phone number mask is used for validating phone numbers in e-ADT client information and contact information, Employee setup and Facility contact information.

Navigate to the settings to select from the options.



The default format is xxx-xxx-xxxx (416-987-3454) but the user can select other options from the drop down list. If no predefined format meets facility needs, the user can select *User-defined Format* from the dropdown list and then type in preferred format in the *Set Optional Phone Number format* textbox.
The *No Mask* option is also available for users who do not need a mask.

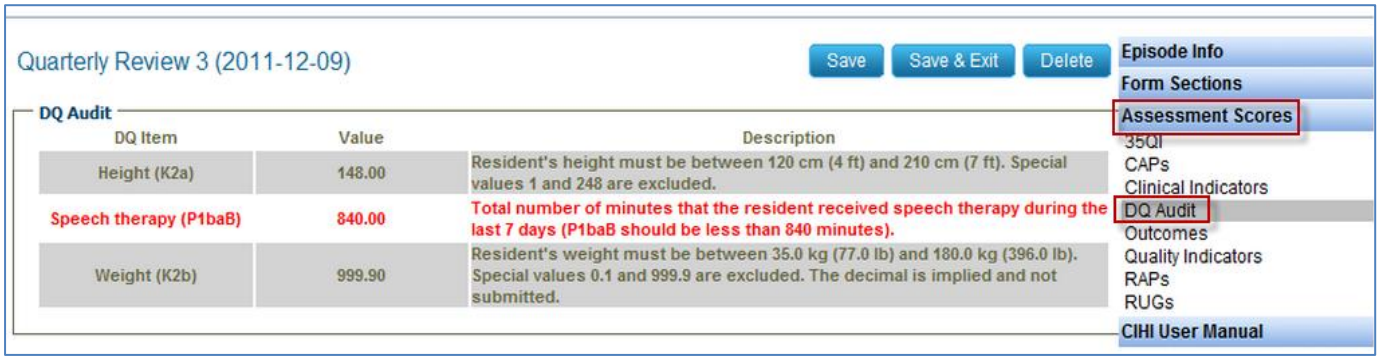
2.2 e-Assessments

2.2.1 FEATURE: CCRS Data Quality Tool

LOCATION: e-Assessments > Assessment Tools > CCRS Assessment > Assessment Scores > DQ Audit

NEW: This functionality has been added to the CCRS Assessment screen to show Data Quality issues found in the current assessment according to the CIHI data quality audit specifications. Any DQ items that would have been rejected by CIHI will be displayed in **red** so that coding can be modified prior to submission.

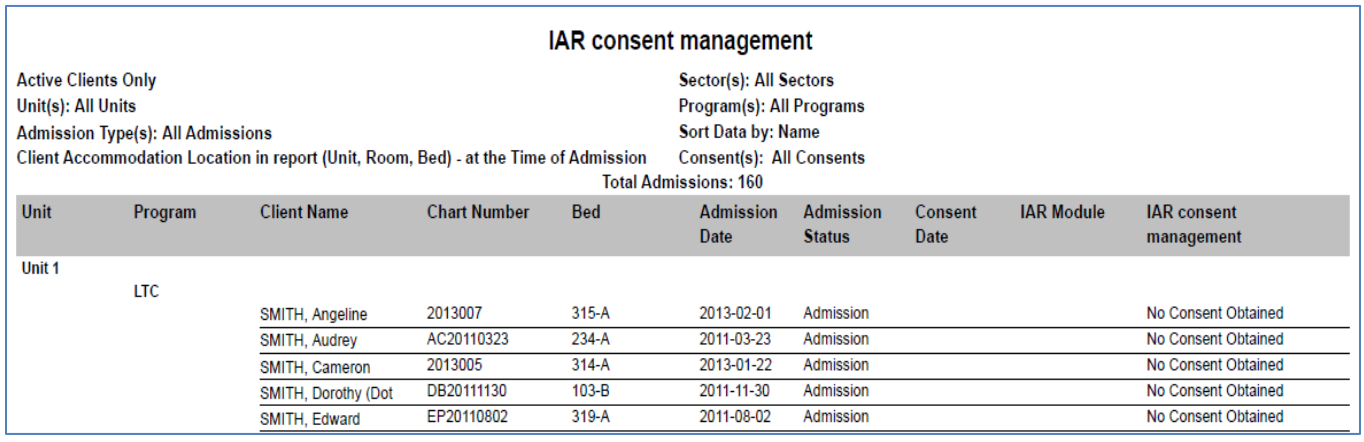
When in any CCRS Assessment, navigate to this section on the right hand side and click on 'DQ Audit' which is found directly underneath the Assessment Scores section.



2.2.2 FEATURE: IAR Consent Management Report

LOCATION: e-Reports > ADT > Group > IAR Consent Management

NEW: This report was created to provide a way for the facility to see a breakdown of consent results. The report will show in list format, all applicable results: Given Consent, Declined Consent and No Consent Obtained.



IAR consent management

Active Clients Only
Unit(s): All Units
Admission Type(s): All Admissions
Client Accommodation Location in report (Unit, Room, Bed) - at the Time of Admission
Sector(s): All Sectors
Program(s): All Programs
Sort Data by: Name
Consent(s): All Consents
Total Admissions: 160

Unit	Program	Client Name	Chart Number	Bed	Admission Date	Admission Status	Consent Date	IAR Module	IAR consent management
Unit 1									
	LTC								
		SMITH, Angeline	2013007	315-A	2013-02-01	Admission			No Consent Obtained
		SMITH, Audrey	AC20110323	234-A	2011-03-23	Admission			No Consent Obtained
		SMITH, Cameron	2013005	314-A	2013-01-22	Admission			No Consent Obtained
		SMITH, Dorothy (Dot	DB20111130	103-B	2011-11-30	Admission			No Consent Obtained
		SMITH, Edward	EP20110802	319-A	2011-08-02	Admission			No Consent Obtained

2.2.3 FEATURE: Ability to Select Assessment options for viewing

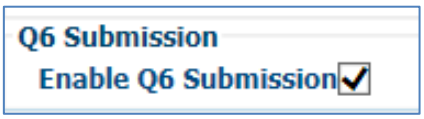
LOCATION: Settings > e-Assessments > Options

NEW: This new setting provides Facility Administrators with the ability to hide unwanted assessment tools for the e-Assessments module. This way, when viewing the e-Assessment module, only relevant options will be displayed.

2.2.4 FEATURE: Q6 Submission Functionality

LOCATION: Settings > e-Assessments > Options

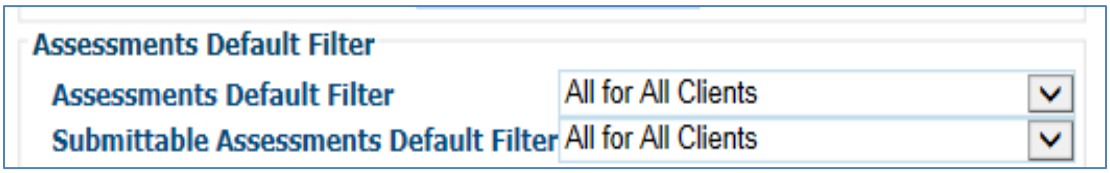
NEW: An option now exists that provides a Facility Administrators with the ability to enable a Q6 submission.



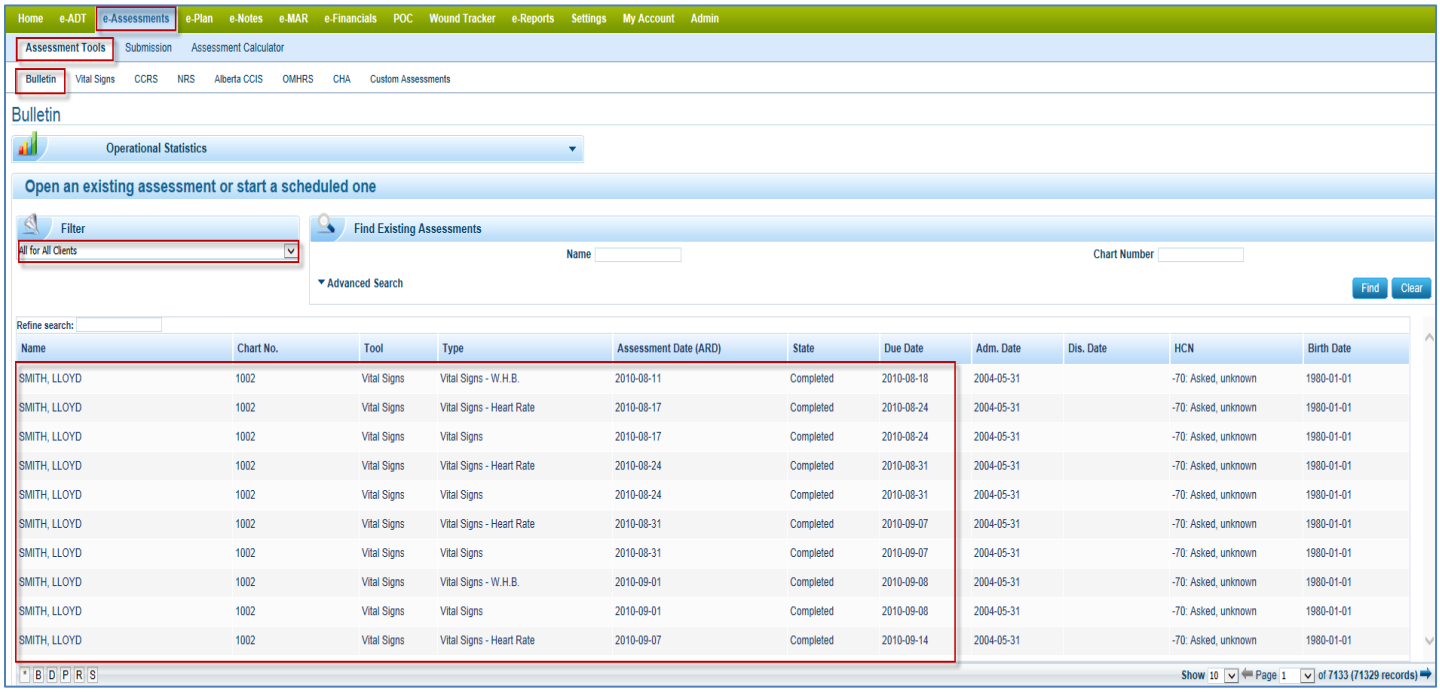
2.2.5 FEATURE: New Assessment Filter options

LOCATION: Settings > e-Assessments > Options

NEW: The default filter option for Assessments has been implemented.
Use the *Assessment Default Filter* option for Bulletin, Vital Signs and Custom Assessments.
Use the *Submittable Assessments Default Filter* option for CCRS, NRS, Alberta CCIS, OMHRS and CHA. If you leave these fields blank the default will continue to be *Overdue*.



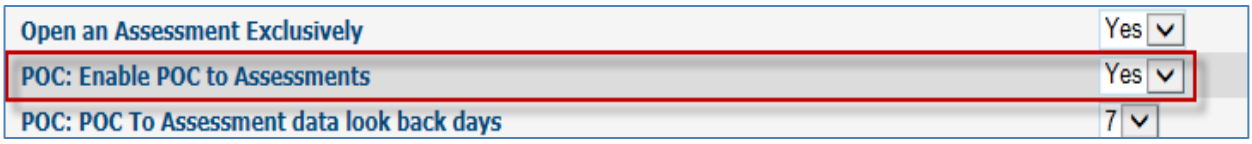
For example, the *Assessment Default Filter* selects the default view for the Assessment Tools - Bulletin view. Select an option from the filter drop down list to modify viewing.



2.2.6 FEATURE: Information Collected in POC populates to CCRS

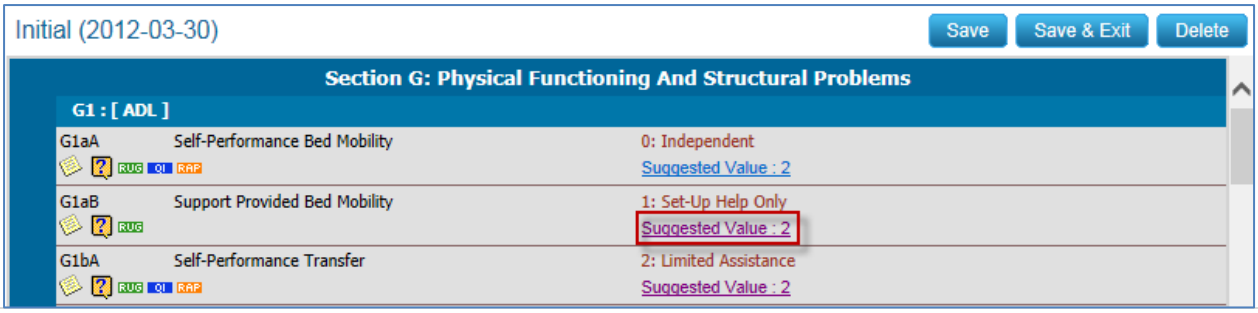
LOCATION: Settings > e-Assessments > Assessment Tool Options > CCRS > POC: Enable POC to Assessments

NEW: Navigate to this setting and select Yes to enable and also select the number of look back days required.

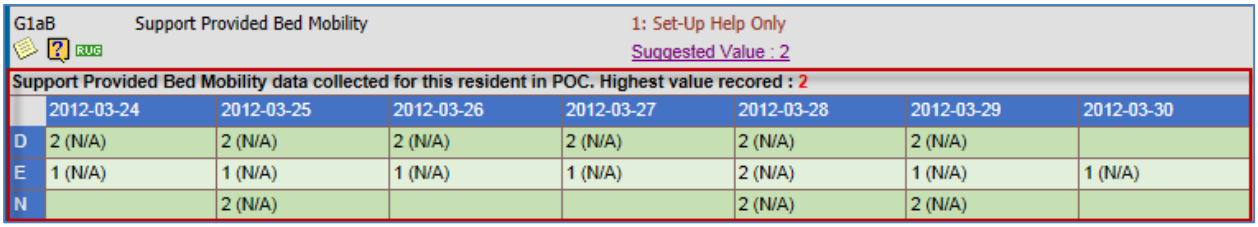


If this new setting is turned on, it will push data entered in the POC module to the CCRS Assessment. This applies to sections G1(a-j)A, G2A, G1(a-j)B, P3a-P3k of the CCRS Assessment.

From the resident's assessment, select the *Suggested Value* link that is displayed.



This will show the details from POC.



G1aB Support Provided Bed Mobility 1: Set-Up Help Only

RUG Suggested Value : 2

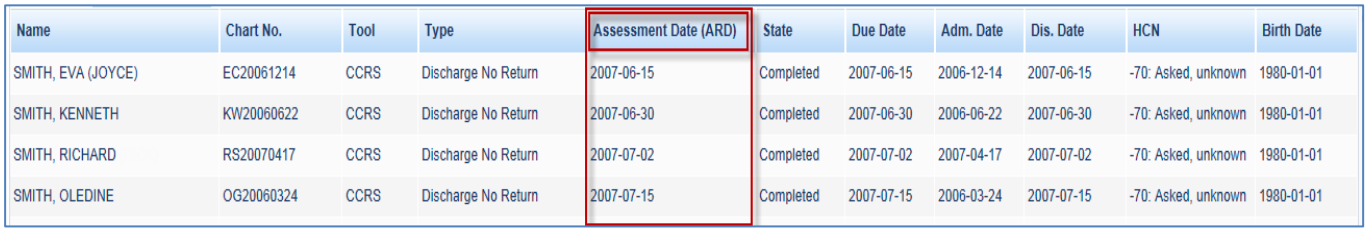
Support Provided Bed Mobility data collected for this resident in POC. Highest value recored : 2

	2012-03-24	2012-03-25	2012-03-26	2012-03-27	2012-03-28	2012-03-29	2012-03-30
D	2 (N/A)	2 (N/A)	2 (N/A)	2 (N/A)	2 (N/A)	2 (N/A)	
E	1 (N/A)	1 (N/A)	1 (N/A)	1 (N/A)	2 (N/A)	1 (N/A)	1 (N/A)
N		2 (N/A)			2 (N/A)	2 (N/A)	

2.2.7 FEATURE: ARD Column title change

LOCATION: e-Assessments > Assessment Tools

NEW: The ARD column on the assessment search table has been renamed *Assessment Date (ARD).* This change promotes clarity as what date that column represents.

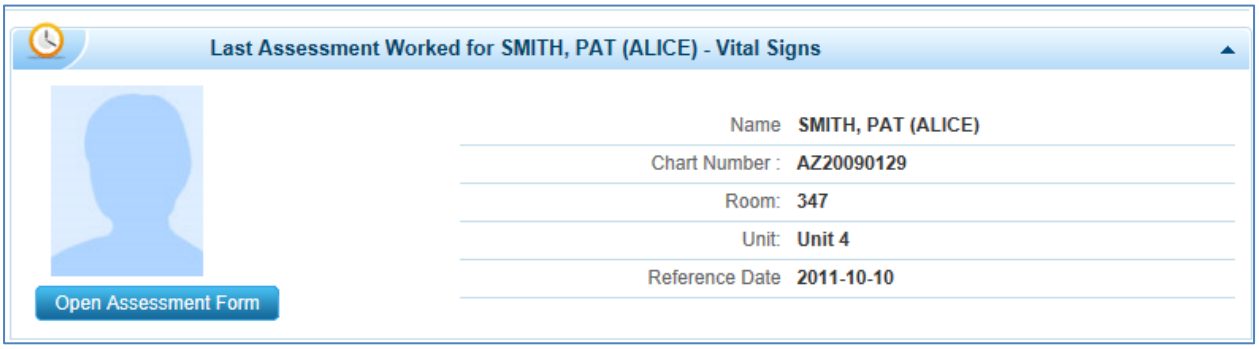


Name	Chart No.	Tool	Type	Assessment Date (ARD)	State	Due Date	Adm. Date	Dis. Date	HCN	Birth Date
SMITH, EVA (JOYCE)	EC20061214	CCRS	Discharge No Return	2007-06-15	Completed	2007-06-15	2006-12-14	2007-06-15	-70: Asked, unknown	1980-01-01
SMITH, KENNETH	KW20060622	CCRS	Discharge No Return	2007-06-30	Completed	2007-06-30	2006-06-22	2007-06-30	-70: Asked, unknown	1980-01-01
SMITH, RICHARD	RS20070417	CCRS	Discharge No Return	2007-07-02	Completed	2007-07-02	2007-04-17	2007-07-02	-70: Asked, unknown	1980-01-01
SMITH, OLEDINE	OG20060324	CCRS	Discharge No Return	2007-07-15	Completed	2007-07-15	2006-03-24	2007-07-15	-70: Asked, unknown	1980-01-01

2.2.8 FEATURE: Link to Last edited Assessment

LOCATION: e-Assessments > Assessment Tools

NEW: If the user was working on an assessment but had to navigate away from the screen, upon returning to the Assessments module, the *Last Assessment Worked* section will be displayed. This allows re-access to that assessment without having to search for the resident again. Click on the *Open Assessment Form* option to open the assessment.

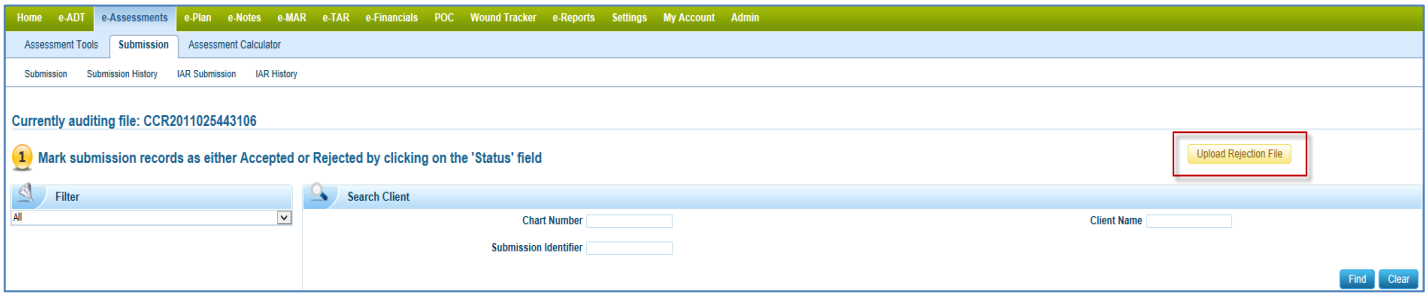


2.2.9 FEATURE: Rejection File Parser Integration

LOCATION: e-Assessments > Submission > Submission History > Manage (per file)

NEW: A Rejection File Parser has been integrated into the application to automatically flag files as per status: Accepted/Rejected.

The new **Upload Rejection File** button allows the user to browse for a save the rejection file after having downloaded it from CIHI.



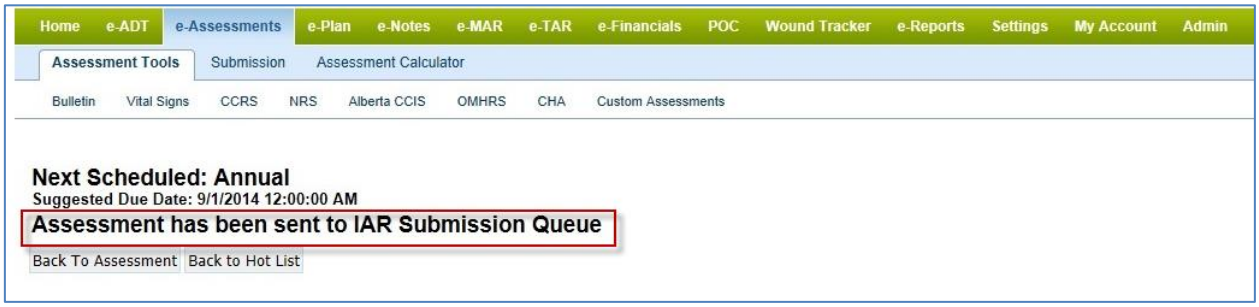
Once the file is saved successfully, files will be automatically marked according to their received status: Accepted/Rejected.

Chart Number	Client Name	Asmt Type	Reference Date	Operation Type	Identifier	Status
MA20081017	SMITH, MURRAY Donald	Quarterly	2011-07-08		54431200810170000292	Accepted
MK20091105	SMITH, MARIJA	Quarterly	2011-08-10		54431200911040000362	Accepted
ML20102211	SMITH, Maria	Quarterly	2011-08-25		54431201011220000477	Accepted
MS20081126	SMITH, MARION	Quarterly	2011-08-10		54431200811250000300	Rejected
MS20100128	SMITH, MARIA	Quarterly	2011-09-17		54431201001280000381	Accepted
FH20101015	SMITH, FRANCIS FRANK	Quarterly	2011-07-17		54431201010150000468	Accepted
GK20091124	SMITH, GERTRUDE	Quarterly	2011-08-14		54431200911240000366	Rejected
HW20091130	SMITH, HELEN	Quarterly	2011-08-25		54431200911300000368	Accepted

2.2.10 FEATURE: IAR Submission Queue Notification

LOCATION: e-Assessments > Assessment Tools > CCRS Assessment

NEW: Once an assessment is signed, the system will now display a message notifying the user that the file has been added to the queue for submission. The message will read “Assessment has been sent to the IAR Submission Queue”.

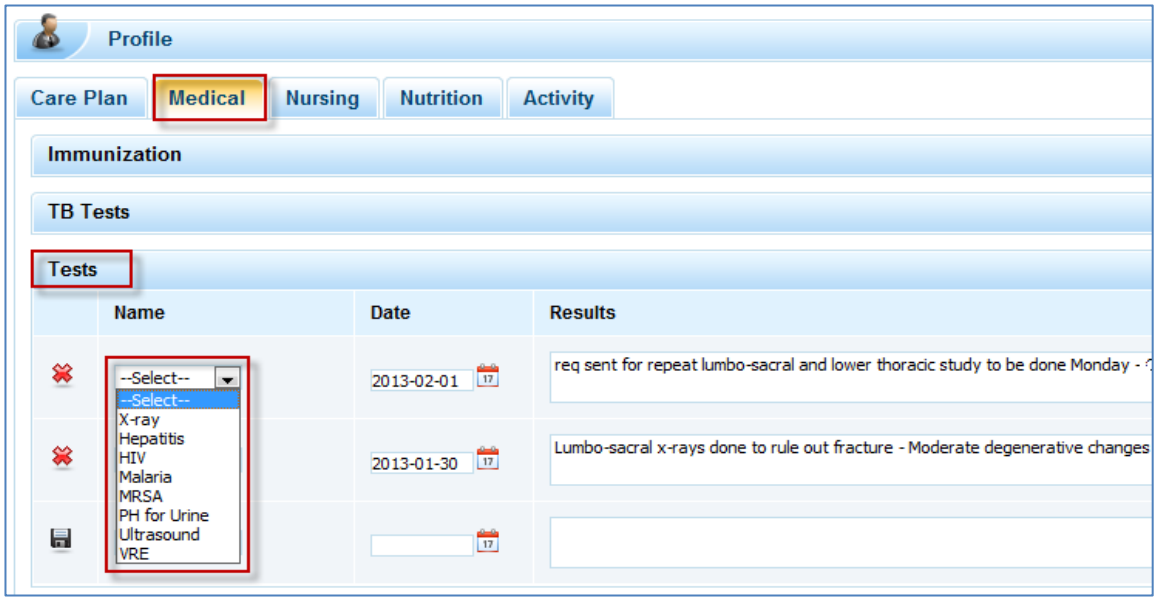


2.3 e-Plan

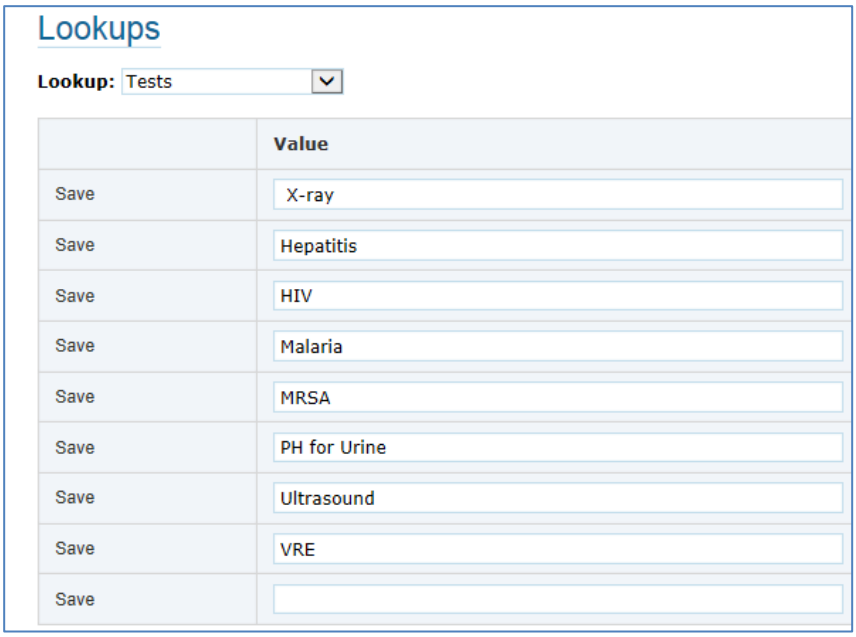
2.3.1 FEATURE: Tests Enhancement

LOCATION: e-Plan > Care Plan Resident Profile > Medical Tab > Tests

ENHANCEMENT: The *X-Ray* section of the medical tab has been renamed to *Tests*. This section includes a drop down menu for the selection of the test type (X-ray, Hepatitis, HIV, Malaria, MRSA, PH for Urine, Ultrasound and VRE), a calendar option to note the date of the test, and a free text box to clarify the given results.



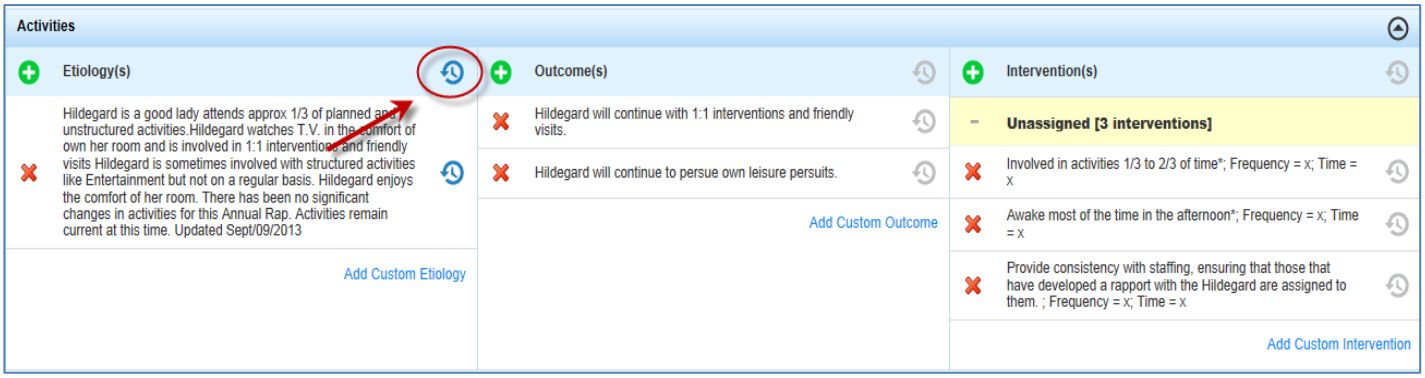
The user can customize the items for this list from the Lookup Settings. This is located in Settings > e-Plan > Lookups > Tests



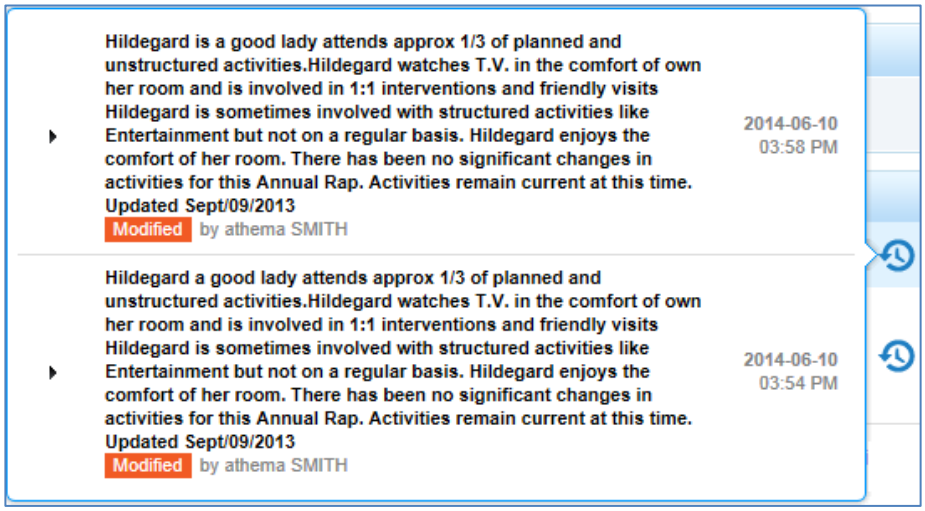
2.3.2. FEATURE: Etiology, Outcome and Intervention History display

LOCATION: e-Plan > Care Plan > Resident Profile > History for Etiology, Outcome and Intervention

NEW: Care Plan history records any action preformed on Etiology, Outcome, Intervention (EIO). It records actions such as add, edit, delete and also by user and time. This is to be accessed via the history icon as highlighted below. The gray history icon indicates that the history is empty and blue icon indicates that history records exist.



Click on the blue history icon in order to view all modifications relating to that care plan item.



2.3.3 FEATURE: Enhanced Immunization Table

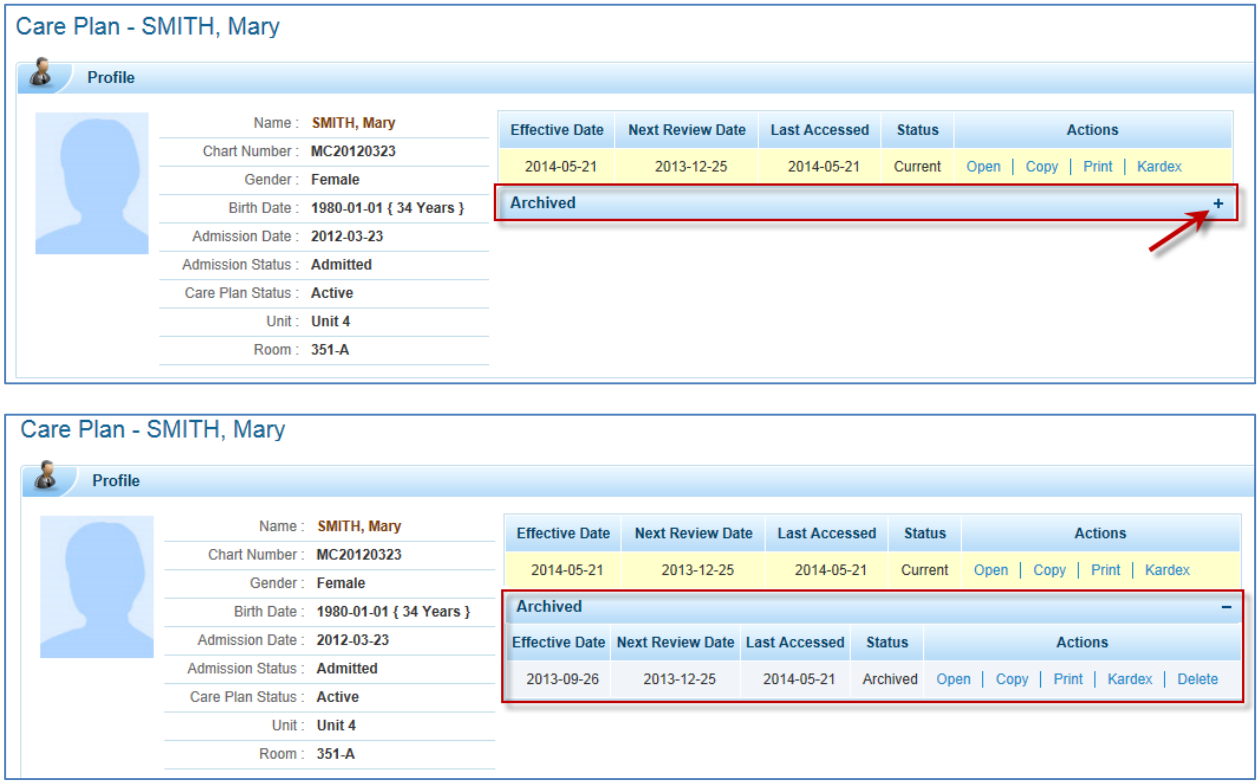
LOCATION: e-Plan > Care Plan > Medical tab > Immunization

ENHANCEMENT: The Immunization section of the Medical tab has been enhanced and is now more user-friendly. The Consent options are *Consent Obtained* and *Refused to Give Consent*.

2.3.4 FEATURE: Collapsible Control for Archived Care Plans

LOCATION: e-Plan > Care Plan > Resident Care Plan

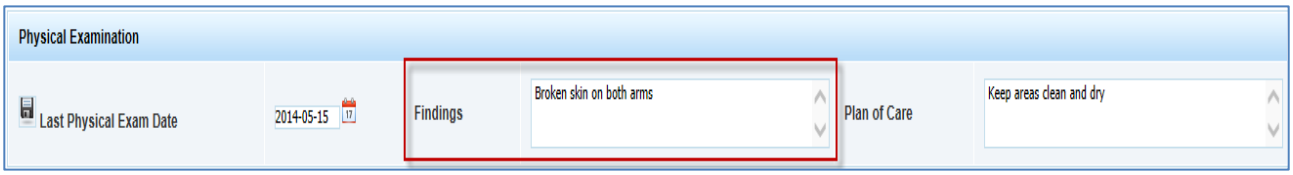
ENHANCEMENT: Archived Care Plans now reside in a collapsible menu thus allowing the user to choose when to view them.



2.3.5 FEATURE: Enhanced Physical Examination Field

LOCATION: e-Plan > Care Plan > Medical tab > Physical Examination

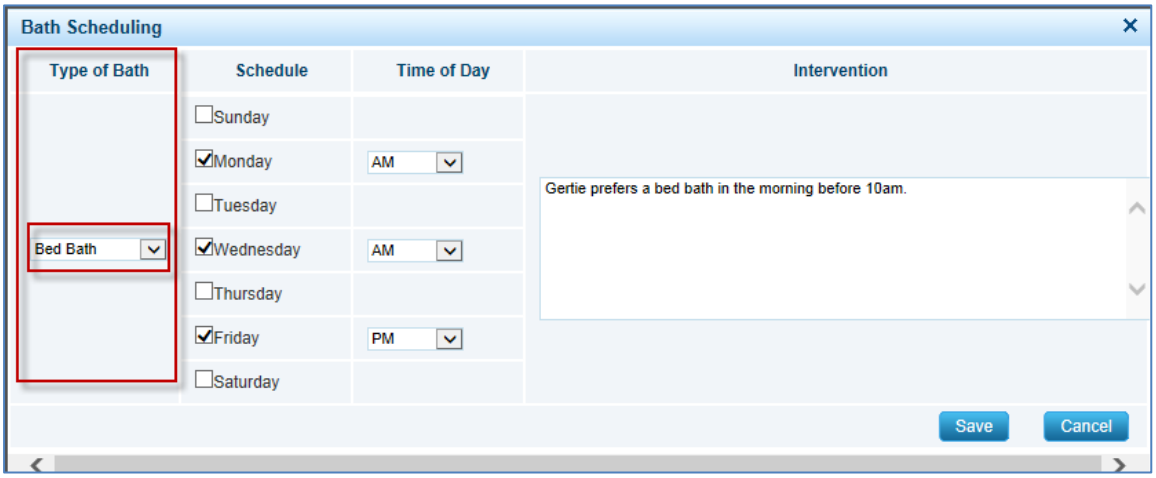
ENHANCEMENT: The *Findings* field in the Physical Examination section is now non-mandatory. The user now has the flexibility to enter the exam date and opt out of a Findings note if findings were not previously provided.



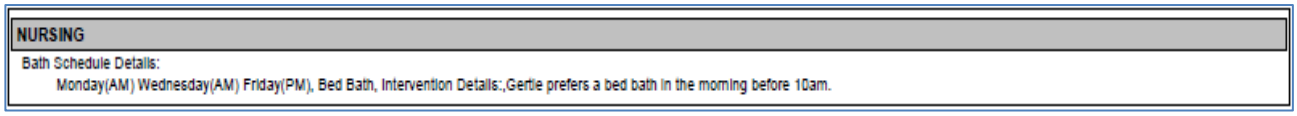
2.3.6 FEATURE: New Bath Type List for Bath Scheduling

LOCATION: e-Plan > Care Plan > Nursing tab > Type of Bath

NEW: Bath types are now selectable options for a resident's bath schedule.



Once saved, these details are also available on the Nursing section of the Care Plan report.

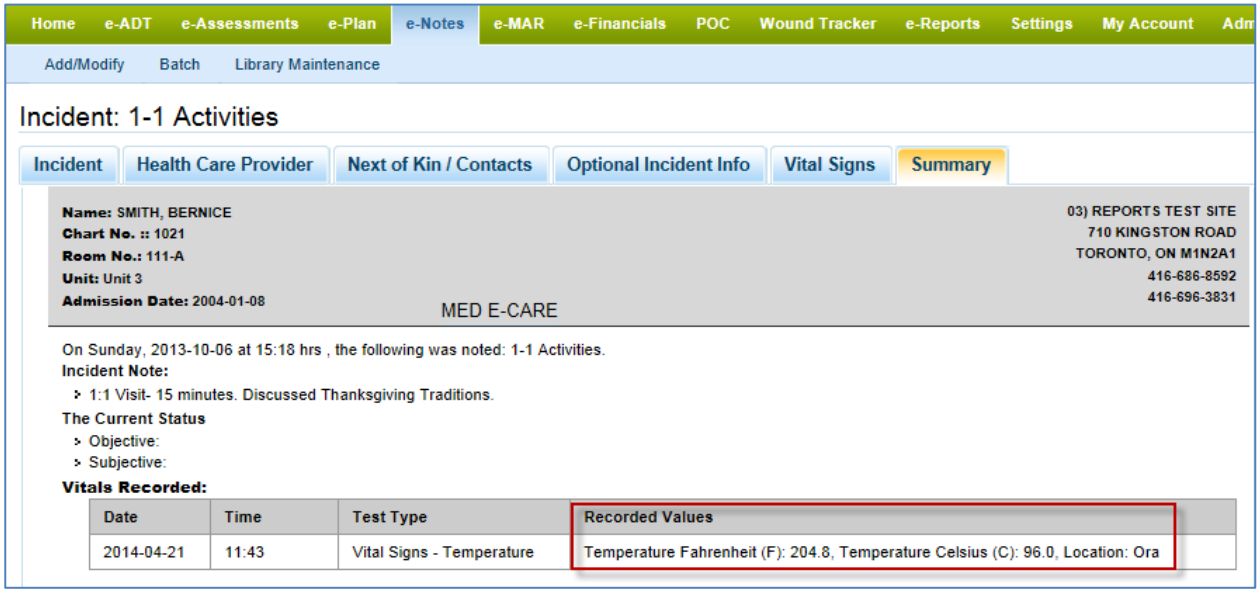


2.4 e-Notes

2.4.1 FEATURE: Vital Signs Value displayed on the Incident Note Summary

LOCATION: e-Notes > Incident Notes > Summary

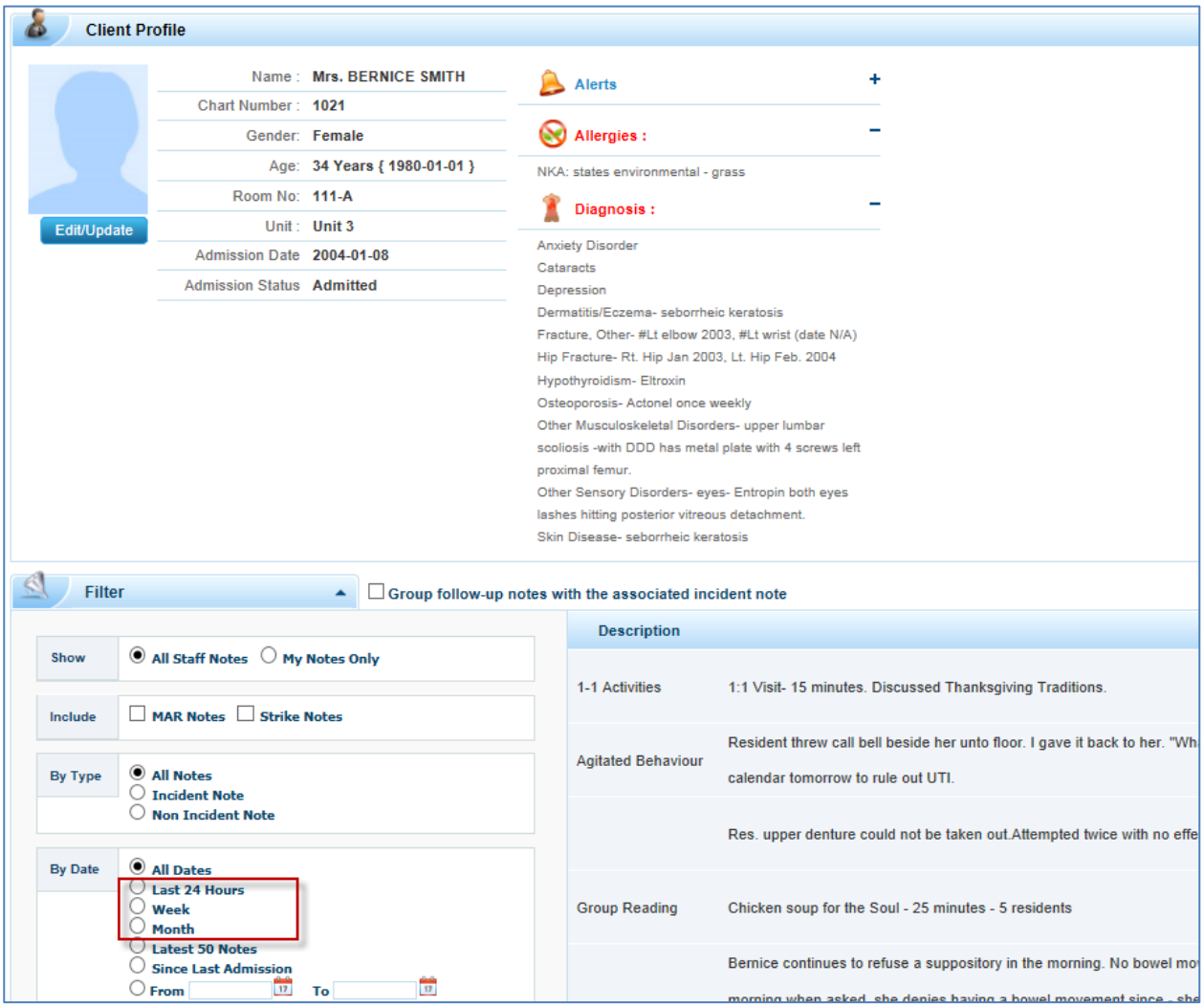
ENHANCEMENT: If vital signs measurements have been documented in the incident note, the values of measured vital signs will be viewed in the incident note summary screen.



2.4.2 FEATURE: Enhanced Notes Filter

LOCATION: e-Notes > Client Notes > Filter

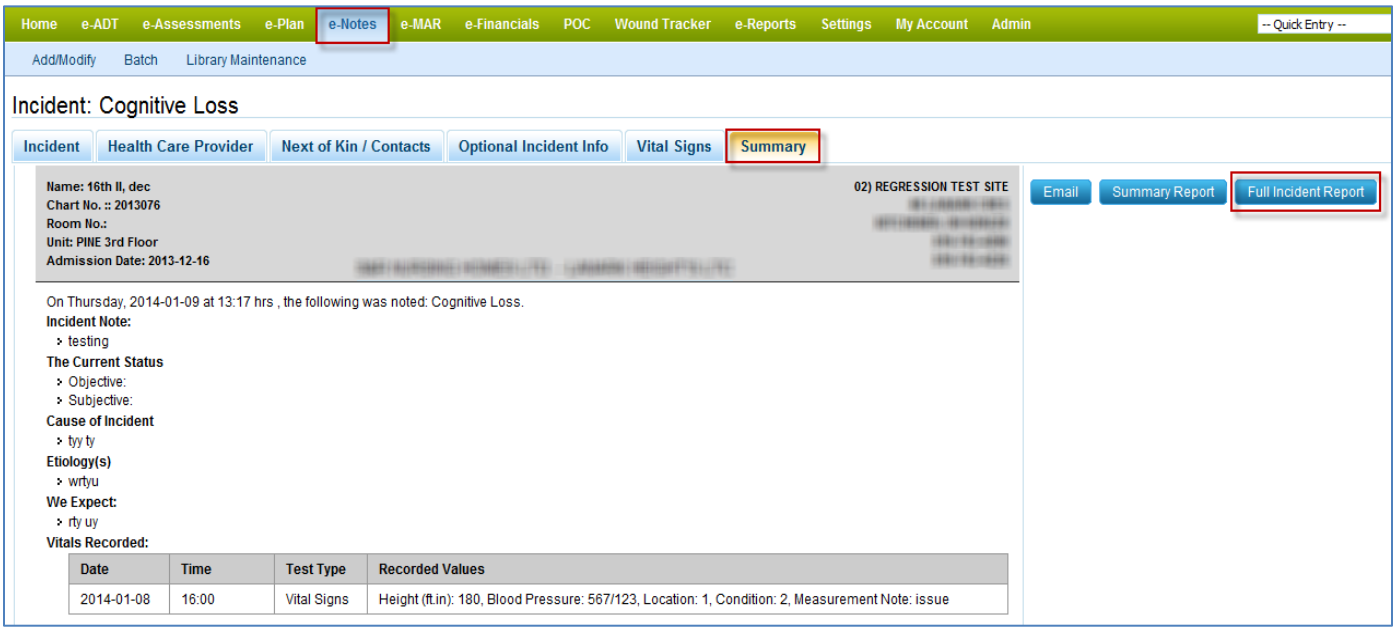
ENHANCEMENT: Three new filters options were added to Client/Resident Notes filter thereby making it easier to track progress. These include: Last 24 Hours, Week and Month.



2.4.3 FEATURE: Quick Link to Full Incident Report

LOCATION: e-Notes > Incident Note > Summary Tab

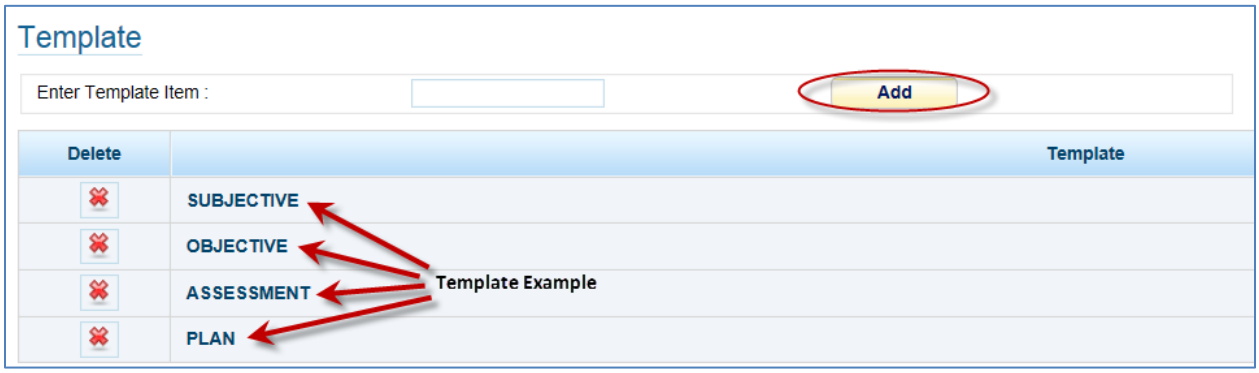
ENHANCEMENT: A quick link to the Full Incident Note Report has been added to the Incident Note Summary tab. This link complements the existing location of the report from the e-Reports module. Previously only a link to the Summary Report was available. The user can now view the report directly from the summary screen without navigating away from e-Notes.



2.4.4 FEATURE: Progress Note Templates

LOCATION: Settings > e-Notes > Template

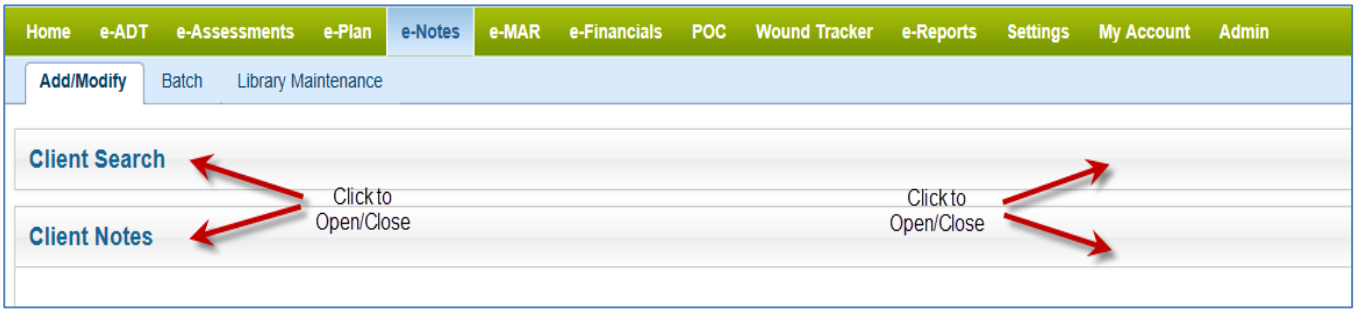
NEW: Users are now able to create note templates in settings. Common templates can include SOAP or DARP templates among others. Once a template is added to the settings, creating a resident note will be displayed in the format of the template.



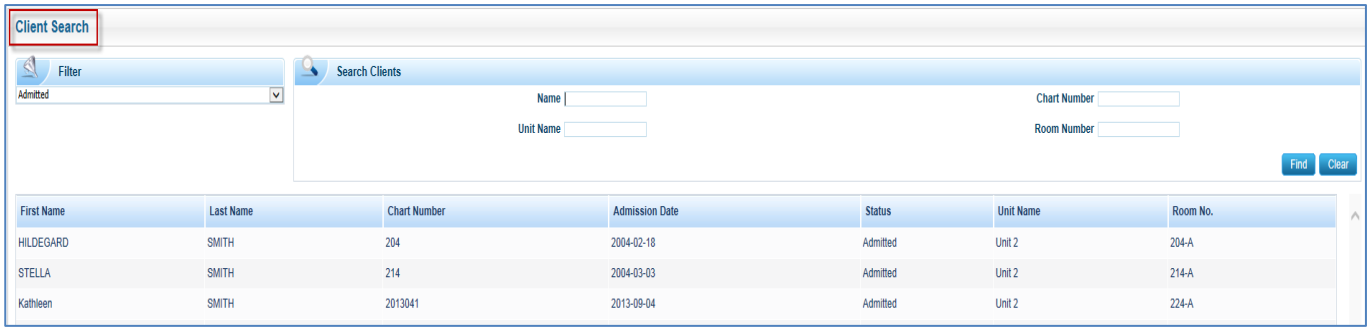
2.4.5 FEATURE: Enhanced Search for e-Notes

LOCATION: e-Notes > Add/Modify

ENHANCEMENT: The search client screen has been modified and will now allow the user to easily switch between the *Client Search* and *Client Notes* accordions. Only one section can be viewed at a time. However, click on the accordion to open and/or close it.



Below is an example of what Client Search looks like when opened.

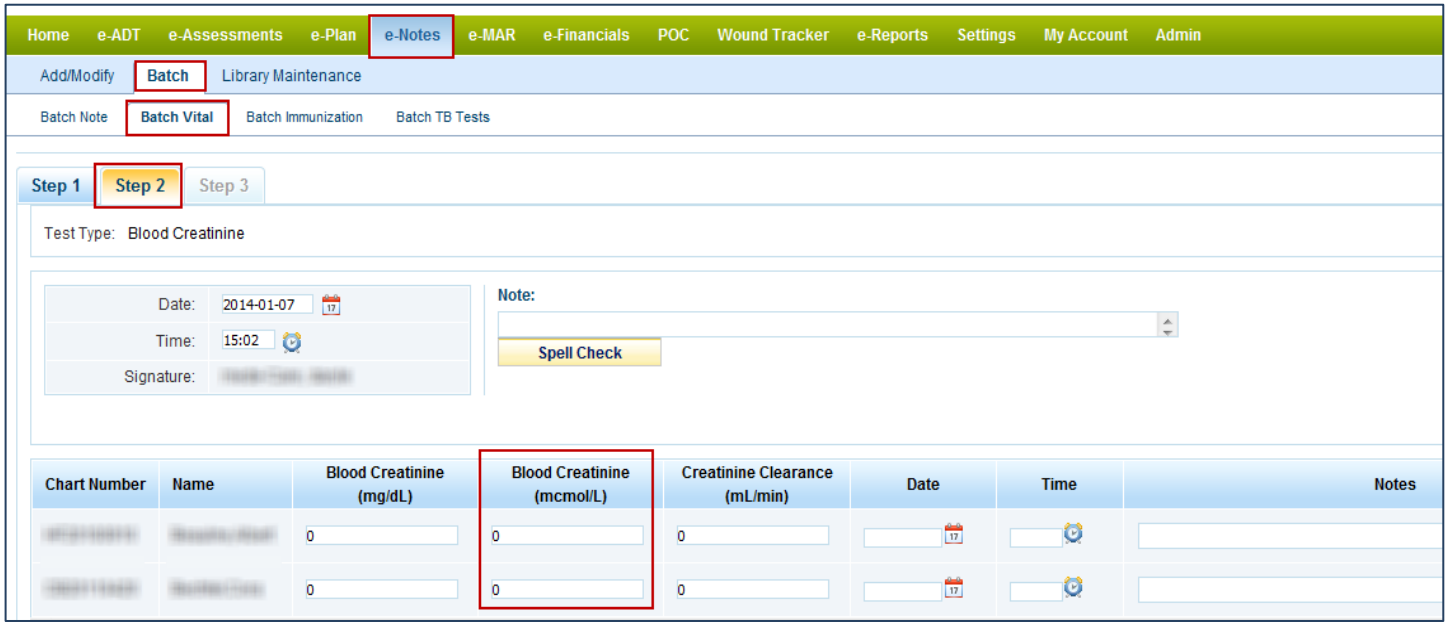


Below is an example of what Client Notes looks like when opened.

2.4.6 FEATURE: New Blood Creatinine Column

LOCATION: e-Notes > Batch > Batch Vital > Step 2

NEW: In Step 2 of performing a Batch Vital entry, a new field labelled Blood Creatinine (mcmol/L) has been added.



2.5 e-MAR

2.5.1 FEATURE: Medication Profile View for Discharged residents

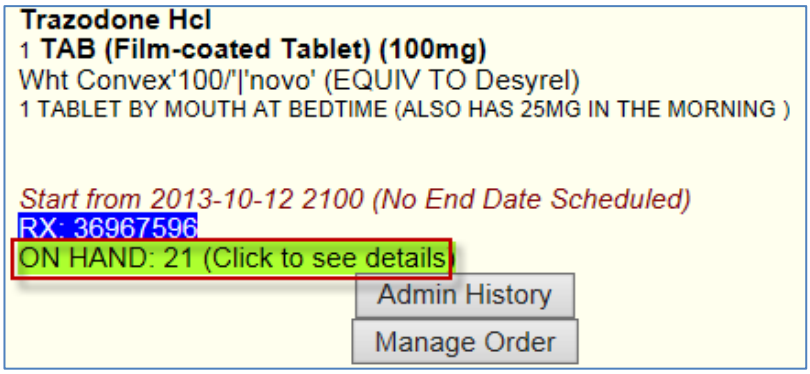
LOCATION: e-MAR > MAR/TAR > Orders > Medication Profile

NEW: Users are now able to search for and view the Medication Profile for discharged residents.

2.5.2 FEATURE: On Hand Medication Quantity Display

LOCATION: e-MAR > MAR/TAR > MED Pass Status > MAR Administration screen

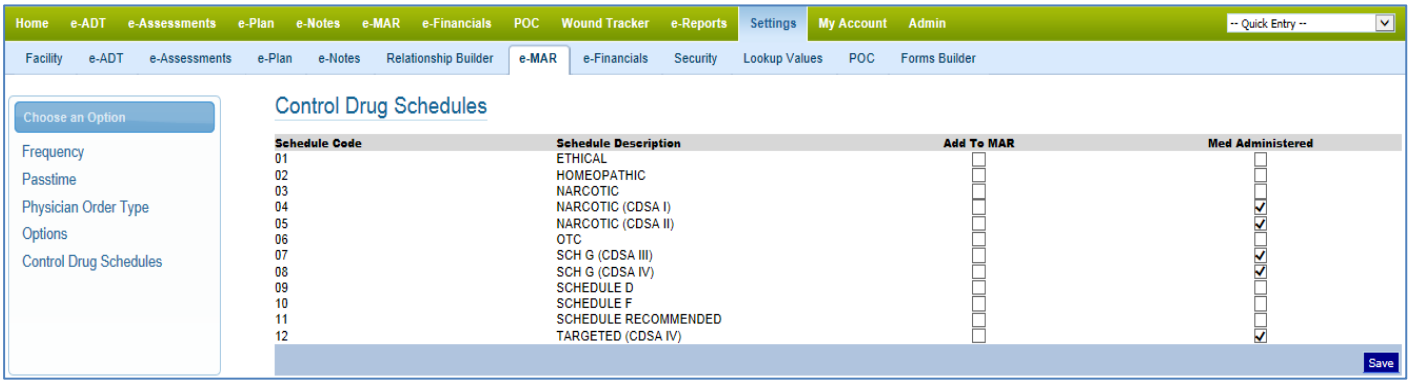
NEW: An *On Hand* quantity will now be displayed on the MAR Administration screen. This amount is derived from summing up the individual on hand quantities for all orders in the medication chain. Clicking on the display will open up a summary of the order chain in table format.



2.5.3 FEATURE: Controlled Drugs Setting for Double Signatures

LOCATION: Settings > e-MAR > Controlled Drug Schedules

NEW: A Controlled Drugs table in Settings has been provided thereby allowing the facility to identify which groups of controlled medications will require a double signature. The settings will allow for options in Add to Mar and administration.



2.5.4 FEATURE: Settings for Double Signature Options

LOCATION: Settings > e-MAR > Options

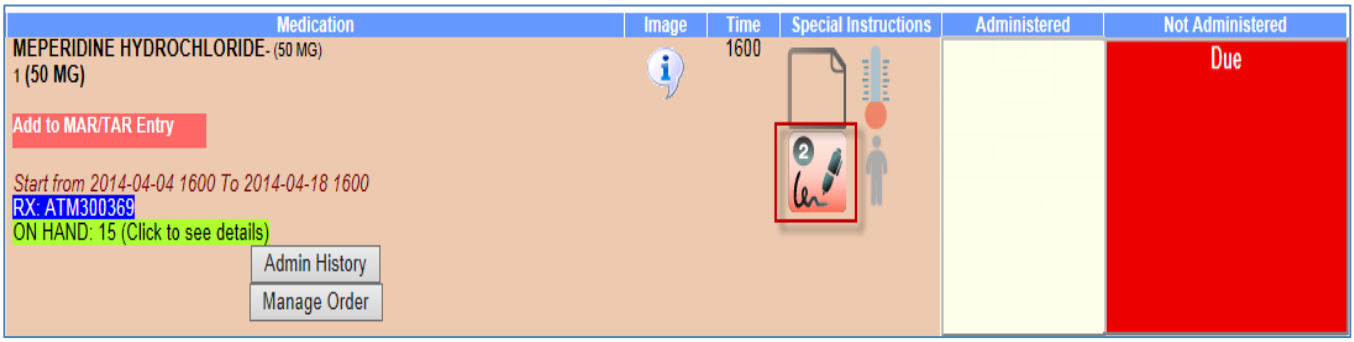
NEW: Three new options have been added to the e-MAR options settings that will enable the double signature feature in the application.

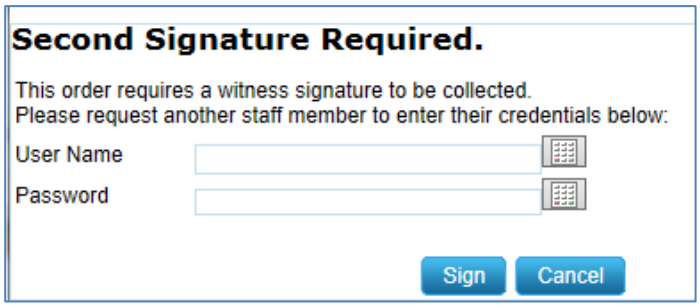
1. Enable Double Signature Administration of Controlled Medications
2. Enable Batch Double Signature Administration of Controlled Medications
3. Enable Double Signature Add to MAR

2.5.5 FEATURE: Double Signature for Controlled Drugs on MAR Administration

LOCATION: e-MAR > MAR Administration Screen

NEW: A new feature has been implemented for those sites that require a second signature to administer controlled medications. With this setting turned on, any controlled drug being administered will prompt a pop-up for the second user login and password. If the user is an active user and their role permissions are set to allow for a second signature, the medication will be administered or not administered according to what is being asked to be recorded.

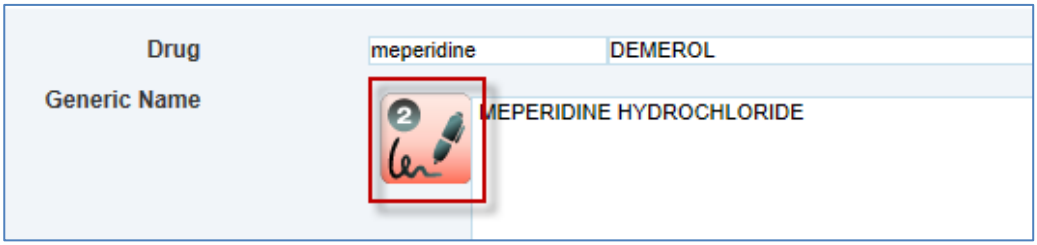




2.5.6 FEATURE: Double Signature for Controlled Drugs on Add to MAR

LOCATION: e-MAR > MAR/TAR > Orders > Add to MAR/TAR

NEW: The *Add To MAR* function will now require two signatures regarding Controlled drugs if the "Enable Double Signature Add To MAR" is turned on in e-MAR settings. With this setting turned on, any controlled drug being administered will prompt a pop-up for the second user login and password. The second signature will need to be given by any user whose permissions are set to allow for a signature.



2.5.7 FEATURE: Double Signature for Controlled Drugs Order Edit

LOCATION: e-MAR > MAR/TAR > MED Pass Status > MAR Administration screen > Manage Order > Edit Order

NEW: The *Edit Order* function for Controlled drugs will now require two signatures if the "Enable Double Signature Add To MAR" and “Enable Double Signature Administration of Controlled Medications” is turned on in e-MAR settings. With this setting turned on, any controlled drug being administered will prompt a pop-up for the second user login and password. The second signature will need to be given by any user whose permissions are set to allow for a signature.

2.5.8 FEATURE: Pharmacy Dispensing System Identifier (PDS)

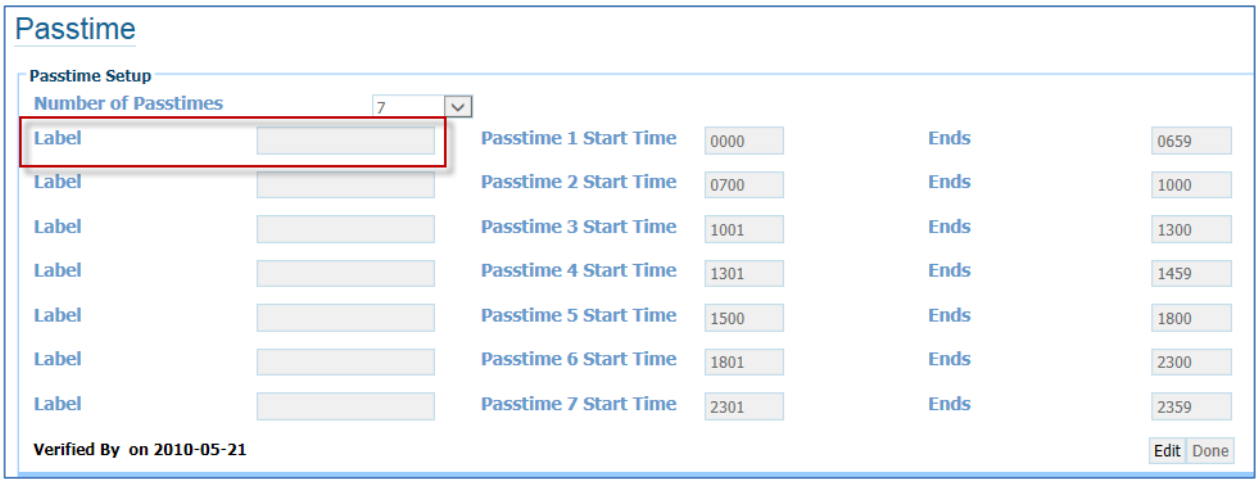
LOCATION: Settings > e-MAR > Options

NEW: This setting will be visible to the user in order to verify that the correct PDS has been selected. However, this is not be editable by the user. It will be set by MED e-Care during the facility setup phase and can only be changed by MED e-Care in the event that changes need to be made.

2.5.9 FEATURE: Passtime Labels

LOCATION: Settings > e-MAR > Passtime

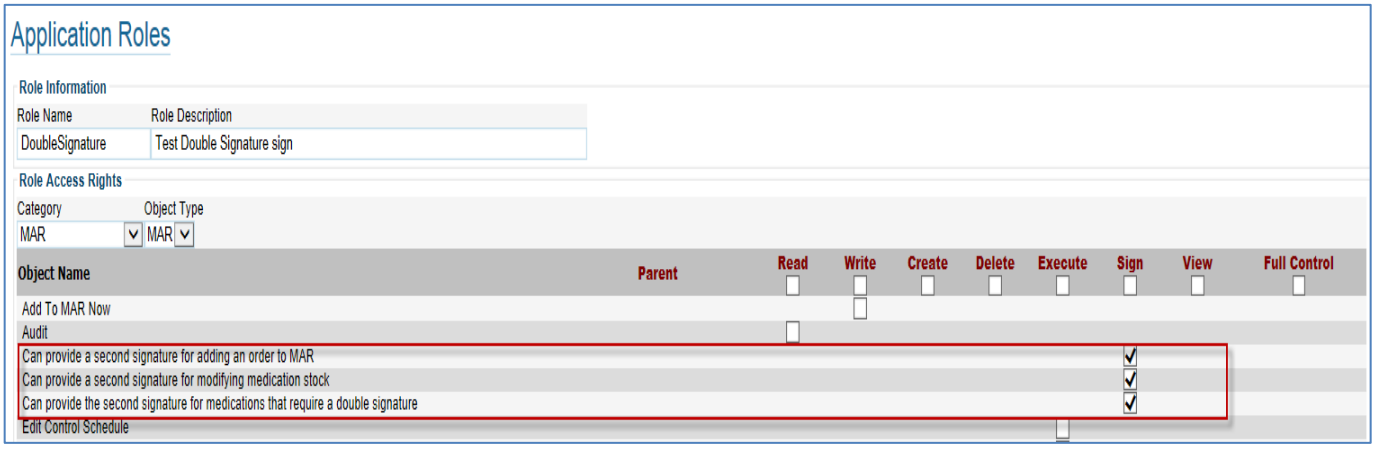
NEW: Users are now able to manage the names of MED Passes. Descriptive labels can be added to set medication administration or pass times. Some examples of this would be: breakfast pass, lunch pass, or dinner pass.



2.5.10 FEATURE: User Permission to Provide Second Signature

LOCATION: Settings > Security > Application Roles

NEW: This new role permission for the MAR will allow a user to provide the second signature for medications that require a double signature. It is not mandatory that this individual be an active application user. This provides more flexibility and allows the Facility to choose freely.



2.5.11 FEATURE: Medication Expired/Expiring MAR display

LOCATION: Settings > e-MAR > Options

NEW: There are now two new settings that allow users to set an alert when an order is approaching, has reached, or has passed the end date (the last date on which the order would normally be present on the MAR sheet).

Below are the alerts:

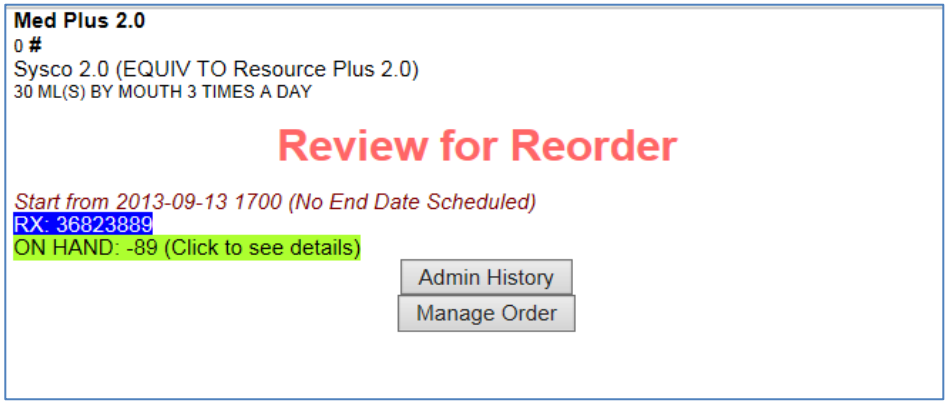
1. Alert the user that a medication is about to expire [___] days prior to the end date. Enter "0" to prevent the alert from being displayed.

2. Retain expired medications on the MAR administration screen [___] days after the end date. The user will not be able to administer an expired medication. Enter "0" to prevent expired medications from being displayed.

2.5.12 FEATURE: Medication Review for Reorder display

LOCATION: Settings > e-MAR > Options

NEW: This option in settings will display the *Review for Reorder* message on the resident's MAR Administration screen. This message, as per the days selected in settings, is dependent on the medication quantity that remains.



2.5.13 FEATURE: Administration Location Body Map Setting

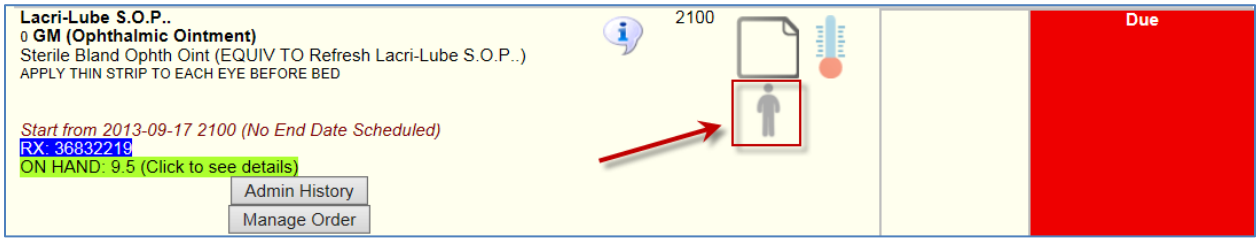
LOCATION: Settings > e-MAR > Options

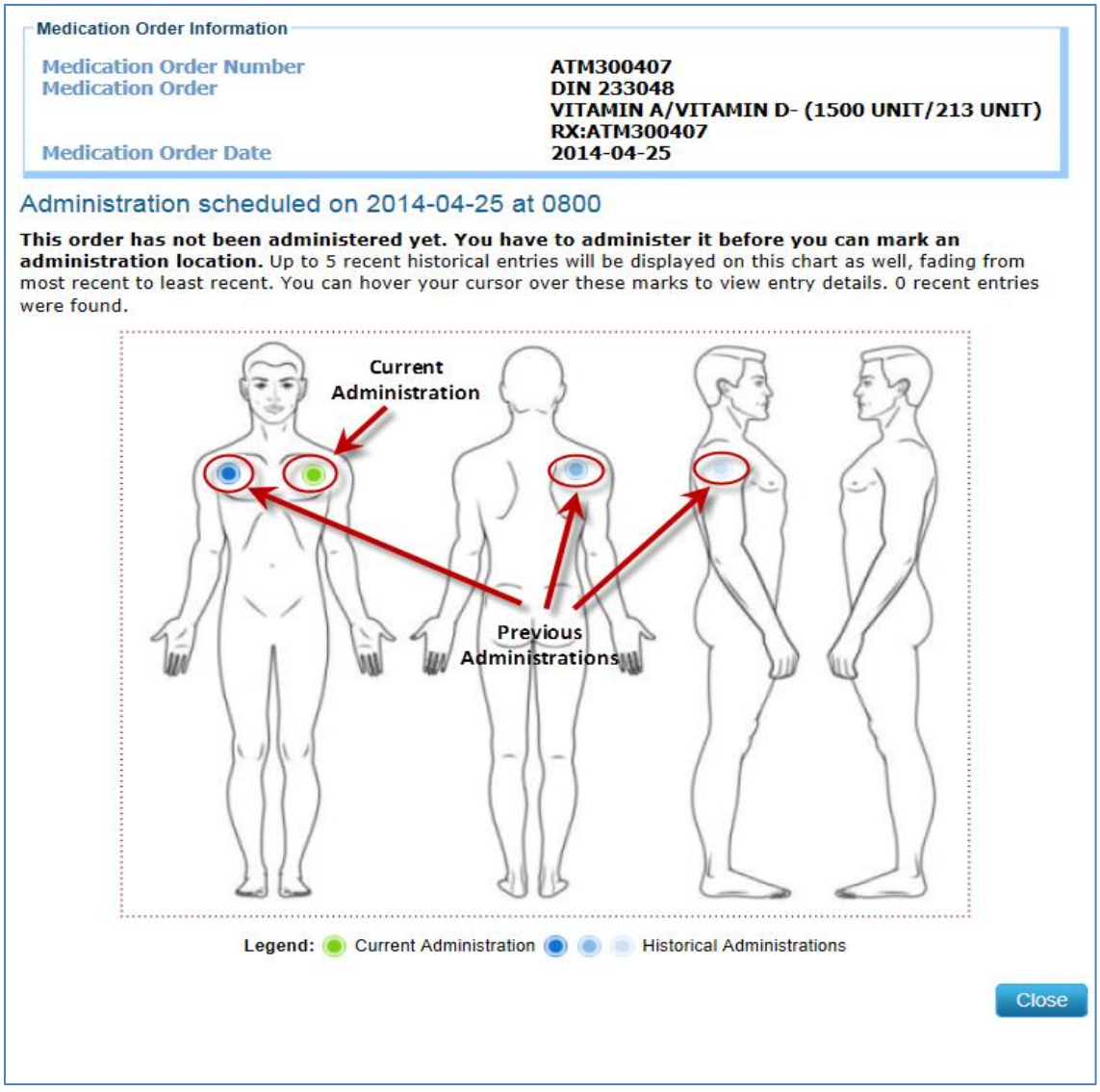
NEW: A new 'Use Body Map to record administration locations' option in settings has been implemented. This will turn on or off the body map that displays on a resident's medication administration screen. The 'Number of historical entries to be displayed on MAR Body Map' option also allows the user to choose the number of historical administrations to show on the map.

2.5.14 FEATURE: Body Map for Medication Administration Location

LOCATION: e-MAR > MAR/TAR > MED Pass Status > Unit > Scheduled > Medication Administration Screen

NEW: This body map will allow the user to document on the map exactly where the medication was administered. These can be in the form of patches, injections, where to apply ointments and so on. The feature will also provide a historical view of administration by displaying a progressively lighter blue color coding.

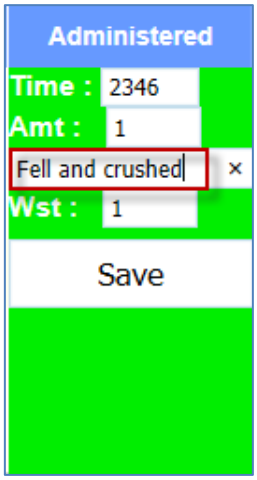




2.5.15 FEATURE: Wasted Dosage Progress Note

LOCATION: e-MAR > MAR/TAR > MED Pass Status > Unit > Scheduled > Medication Administration Screen

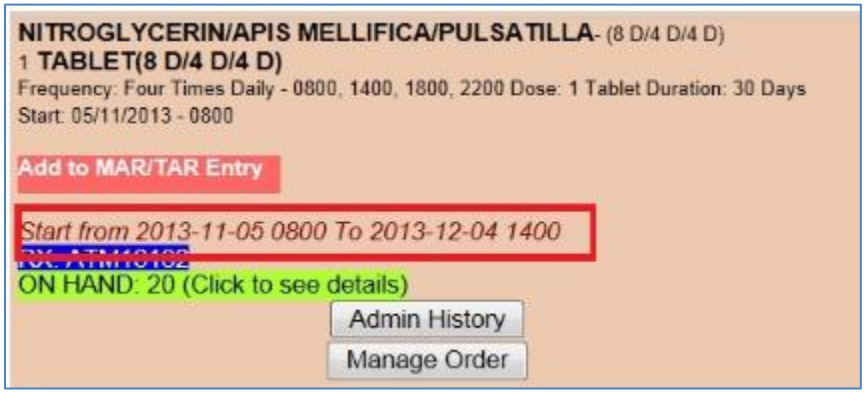
NEW: When a dose or part thereof is wasted, the user can document notes in the note field provided. These notes will directly be duplicated in the e-Notes module for the resident as a Progress Note.



2.5.16 FEATURE: Start and End Date display on MAR Administration Screen

LOCATION: e-MAR > MAR/TAR > MED Pass Status > Unit > Scheduled > Medication Administration Screen

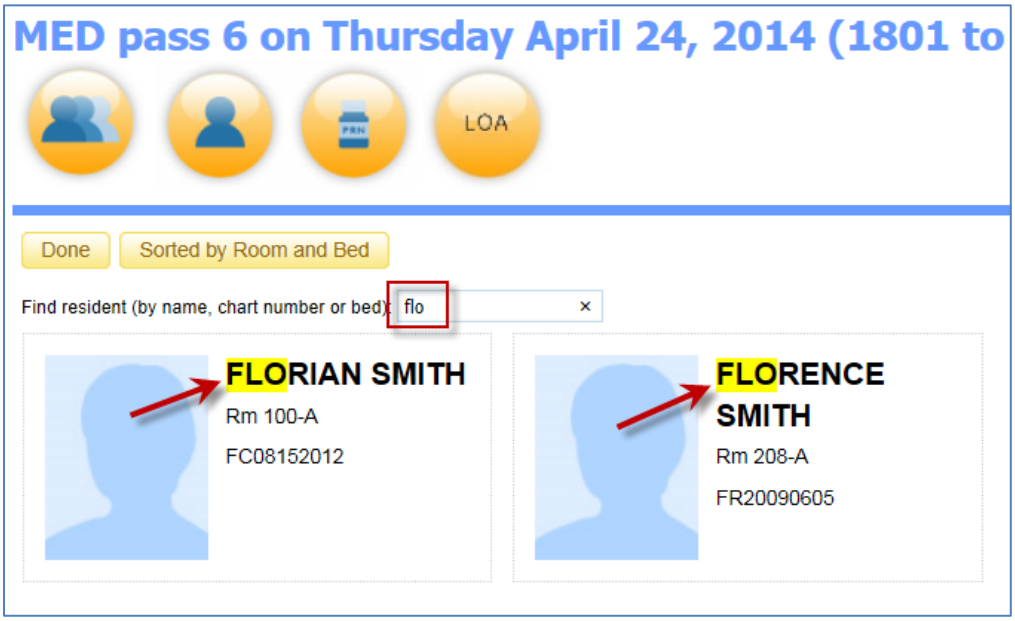
NEW: The medication Start and End date are now clearly displayed on the administration screen.



2.5.17 FEATURE: Optimized Resident Search in MED Pass

LOCATION: e-MAR > MAR/TAR > MED Pass Status > Unit > Scheduled

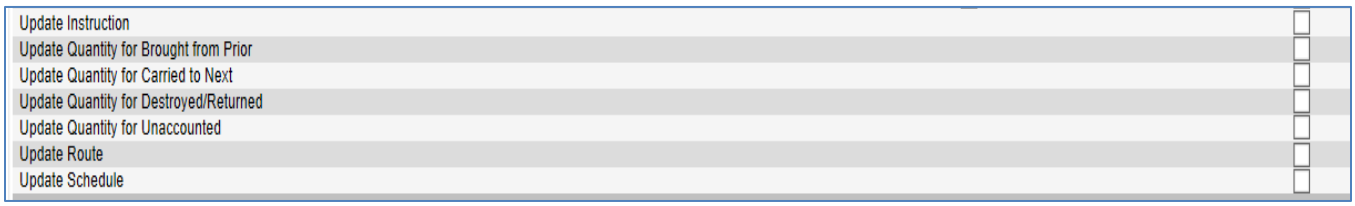
NEW: The resident search field for the MED Pass has been optimized to allow for a quicker and easier search function. When the user begins to type in the search field, the results will be shortlisted as such.



2.5.18 FEATURE: Security Setting on each Edit Order field

LOCATION: Settings > Security > Application Roles

NEW: Each field in *Edit Order* option now has separate security, so that any combination of the fields can be accessible by the user based on their role.

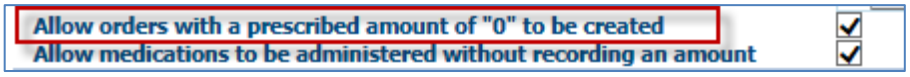


2.5.19 FEATURE: Variable Dose and Zero Dose Administration

LOCATION: Settings > e-MAR > Options

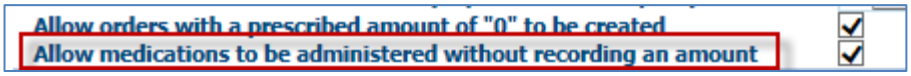
NEW: To facilitate the administration of variable-dose medications, we have created new settings options to compliment the e-MAR.

1. We have added the **Allow orders with a prescribed amount of "0" to be created** setting.

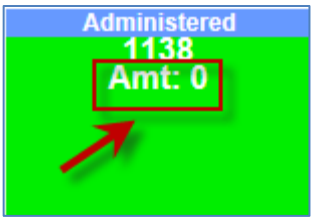


   If the setting is selected, the user will be able to add a resident's medication order on the Add to MAR screen with a dosage amount of '0'. With this zero dosage order added, the user can now key in the correct amount administered on the MED Pass based on the medication strength.

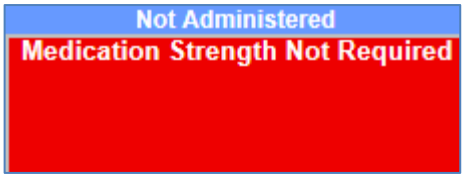
2. Also added, is the **Allow medications to be administered without recording an amount** setting.



   If this setting is selected, the user will be able to enter an amount of '0' for administration if that particular drug strength was not needed for complete administration.



3. The **Medication Strength Not Required** option has also been added the list of reasons for not administering a medication. *This will apply to United Kingdom sites only.*

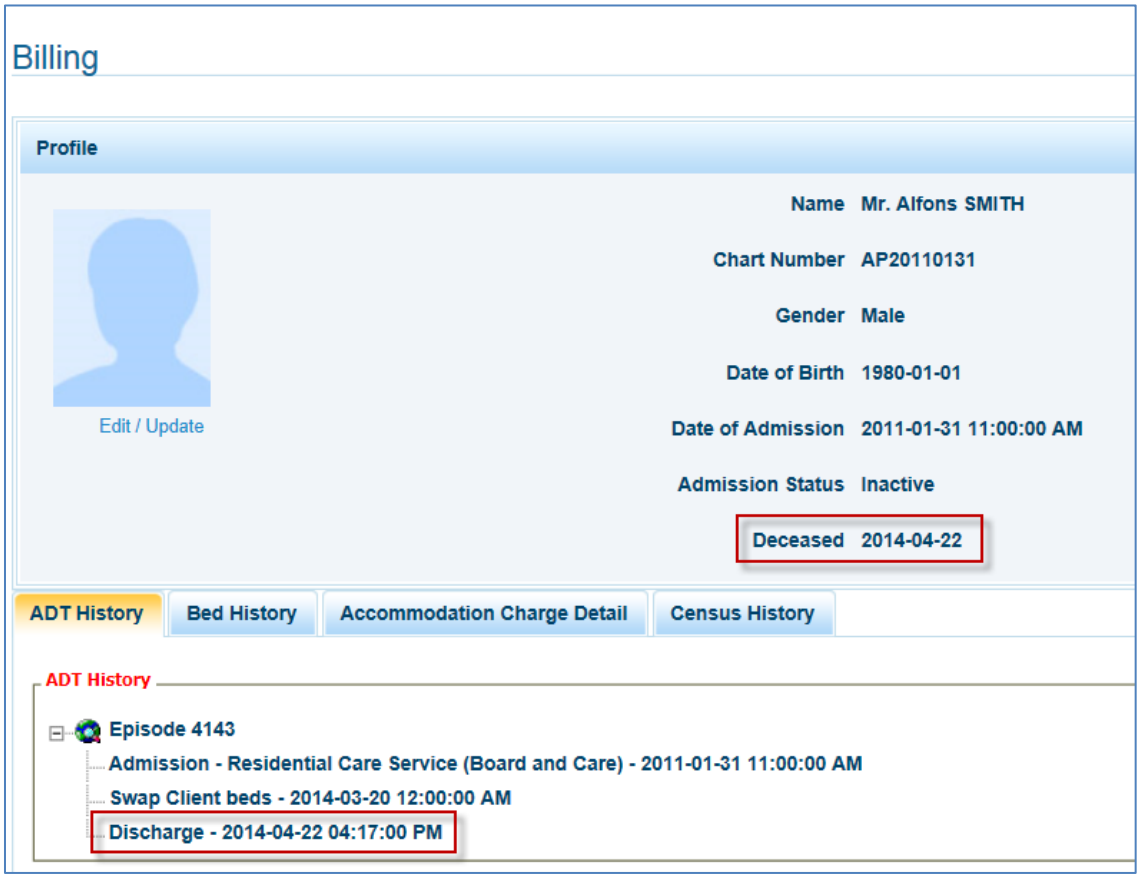


2.6 e-Financials

2.6.1 FEATURE: Deceased Date Display on in Resident Process Section

LOCATION: e-Financials > Resident Process > All tabs

ENHANCEMENT: A resident's deceased date is now displayed on all tabs in the Resident Process section.



2.6.2 FEATURE: Trust Batch Balance Display Option

LOCATION: Settings > e-Financials > Trust Setting

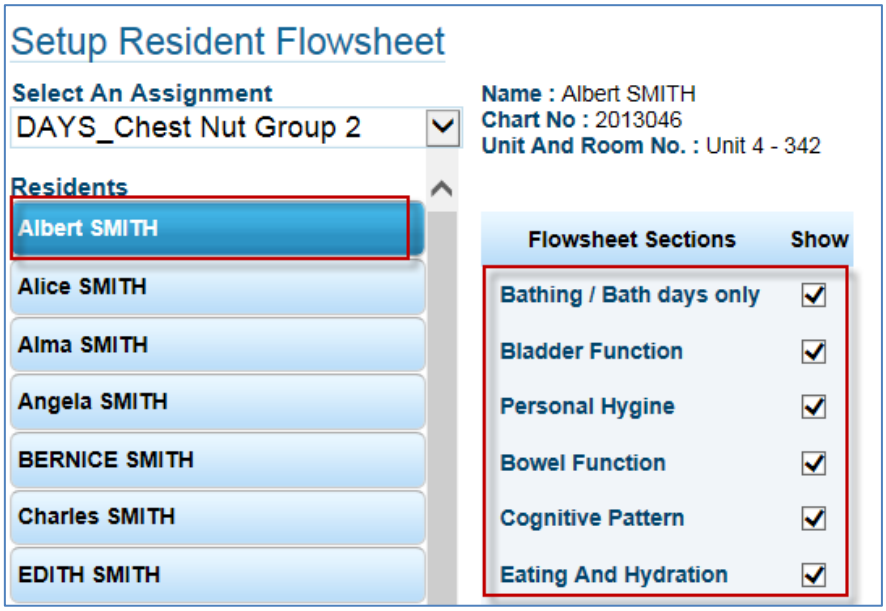
ENHANCEMENT: This setting option was created to provide the user with an option to print a Trust Batch excluding or including a resident's outstanding balance.

2.7 POC

2.7.1 FEATURE: Enable/Disable Flow Sheet Items by Resident

LOCATION: Settings > POC > Flow Sheet > Customization

NEW: This function will allow the user to customize flow sheet options display per resident. When the user is in the POC module for the resident, only the select items will be displayed for documentation.

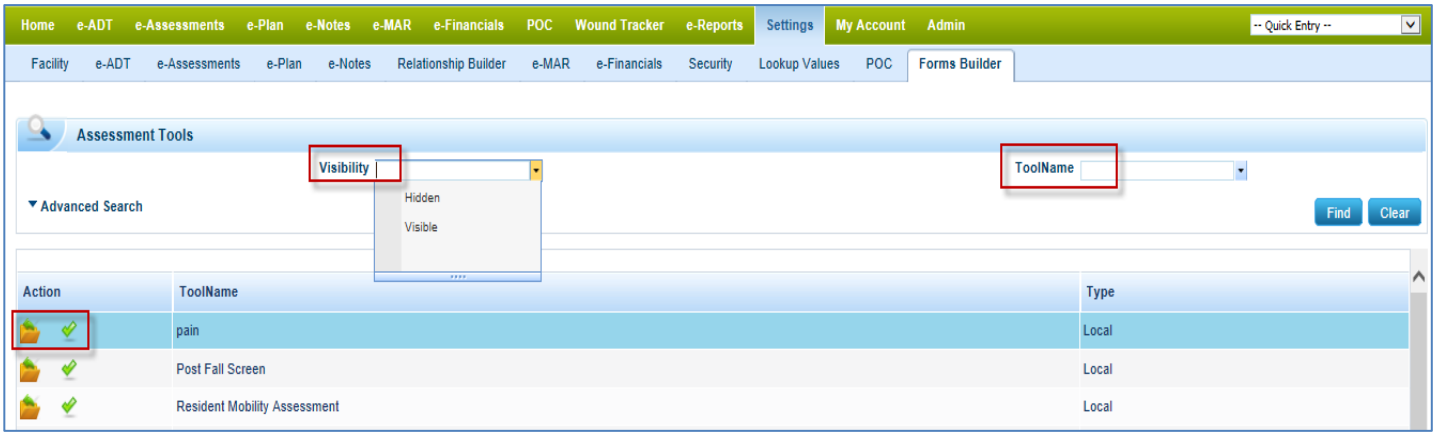


2.8 Forms Builder

2.8.1 FEATURE: Ability to select the visibility of Custom Assessments

LOCATION: Settings > Forms Builder

NEW: The Facility now has the ability to select the visibility of globally defined custom assessments at the facility level. The user can now filter based on Visibility and Tool Name. Actions that exist are to view the tool and Show/Hide the tool.



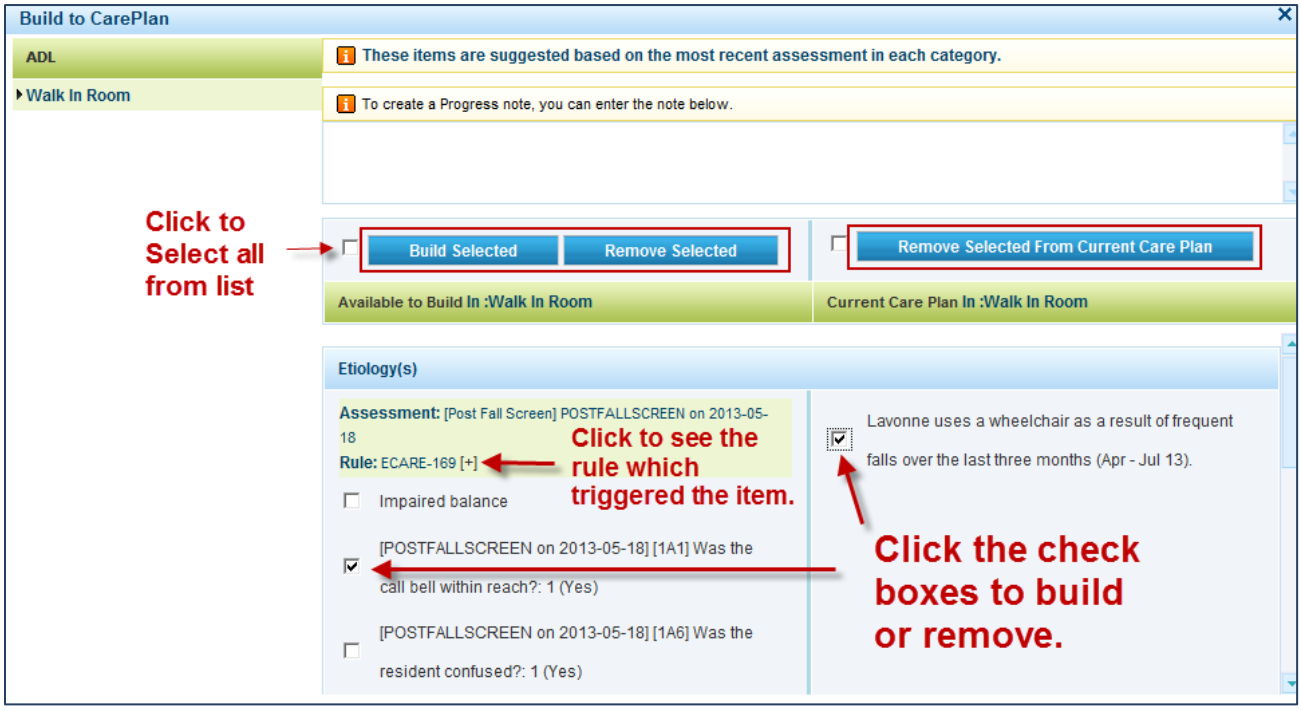
2.9 Relationship Builder

2.9.1 FEATURE: Build to Care Plan from Assessment

LOCATION: e-Plan > Build To Care Plan Window

ENHANCEMENT: Building or Removing Care Plan items through the Build to Care Plan Window is now faster and easier. This has been improved by providing the ability to check multiple items for adding. Removing multiple items from the current Care Plan can be done in the same manor.

Any items removed from the list will be removed permanently. The next time the Build to Care Plan window is accessed those items will not be visible.

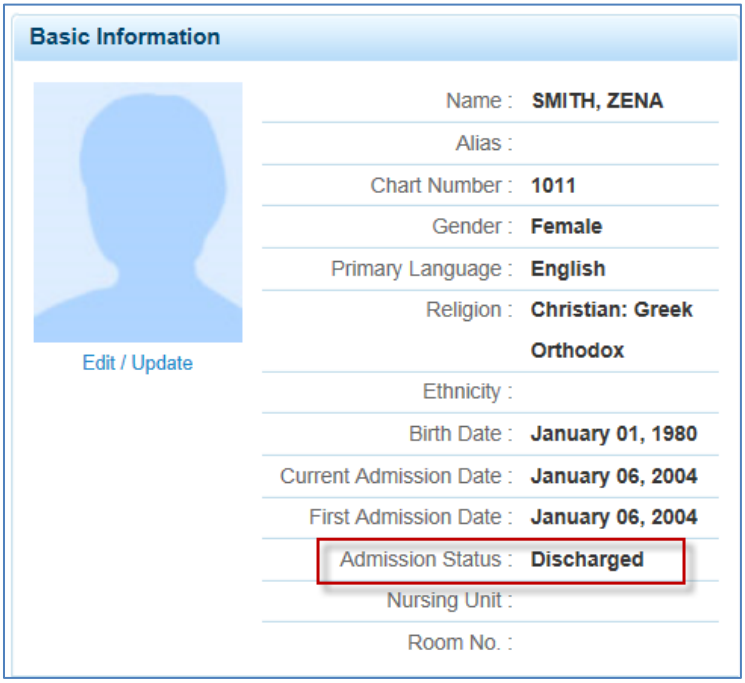


2.10 Patient Profile

2.10.1 FEATURE: Discharged or LOA Status display on Patient Profile

LOCATION: Quick Entry/Resident Name > Patient Profile > Basic Information

ENHANCEMENT: The Patient Profile has now been enhanced to display the Discharged or LOA Status for a resident.



2.10.2 FEATURE: Physician Fax Number display on Patient Profile

LOCATION: Quick Entry/Resident Name > Patient Profile > Physician Information

ENHANCEMENT: The Patient Profile has now been enhanced to display the Physician's fax number.

2.10.3 FEATURE: Order Contacts by Rank

LOCATION: Quick Entry > Patient Profile > Contacts Information

NEW: The *Call First* message will be displayed for the contact that needs to be contacted first in the event that they need to be reached. Then Call First option is available when creating or editing contacts. Only one contact may be saved with this designation.

To add this designation when adding or modifying a contact, select the Call First check box before saving.


Relationship Other
Save
Delete
Close
Call First
Associations
Next of Kin
Billing Contact (Primary)
Care Contact
Emergency Contact (Primary)
Emergency Contact (Secondary)
POA - Personal Care (Primary)
POA - Personal Care (Secondary)

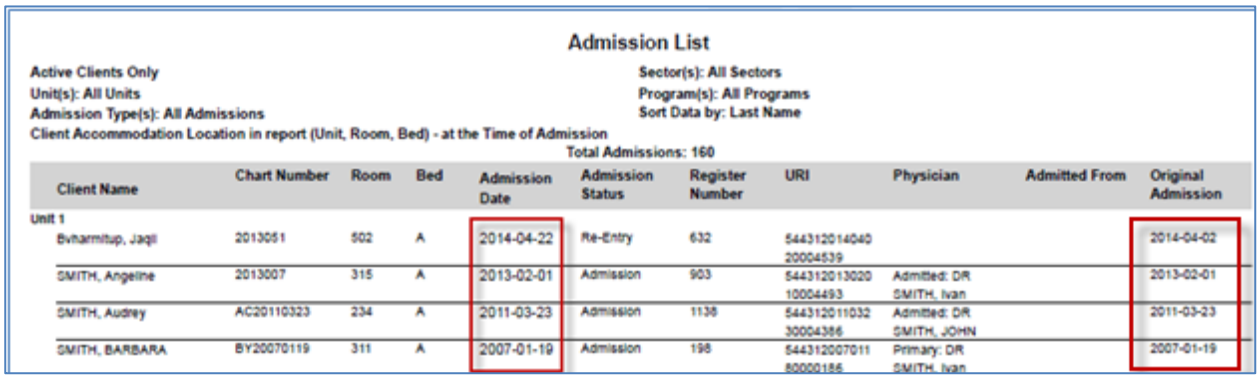
2.11 e-Reports

a) Reports – ADT

a.1 FEATURE: View of Latest Admission Date for Resident

LOCATION: e-Reports > ADT > Group > Admission

ENHANCEMENT: This report has been enhanced to display the latest admission dates for residents. The Original Admission date will still be displayed as shown below.



Admission List

Active Clients Only
Unit(s): All Units
Admission Type(s): All Admissions
Client Accommodation Location in report (Unit, Room, Bed) - at the Time of Admission
Sector(s): All Sectors
Program(s): All Programs
Sort Data by: Last Name
Total Admissions: 160

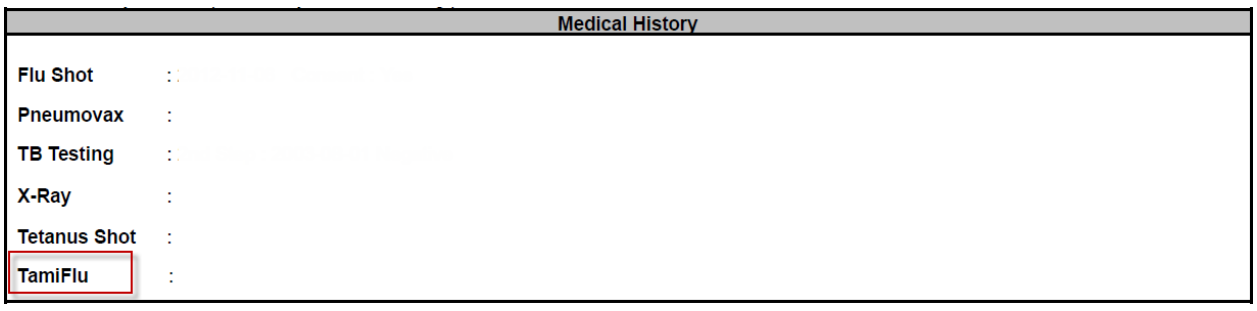
Client Name	Chart Number	Room	Bed	Admission Date	Admission Status	Register Number	URI	Physician	Admitted From	Original Admission
Unit 1										
Bvharmitup, Jagi	2013051	502	A	2014-04-22	Re-Entry	632	544312014040 20004539			2014-04-02
SMITH, Angeline	2013007	315	A	2013-02-01	Admission	903	544312013020 10004493	Admitted: DR SMITH, Ivan		2013-02-01
SMITH, Audrey	AC20110323	234	A	2011-03-23	Admission	1138	544312011032 30004386	Admitted: DR SMITH, JOHN		2011-03-23
SMITH, BARBARA	BY20070119	311	A	2007-01-19	Admission	198	544312007011 80000186	Primary: DR SMITH, Ivan		2007-01-19

b) Reports – Care Plan

b.1 FEATURE: Tamiflu drug added to Face Sheet/Profile Report

LOCATION: e-Reports > Care Plan > Individual/Group > Face Sheet/Profile

ENHANCEMENT: This report has been modified to add Tamiflu to the Medical History list displayed.



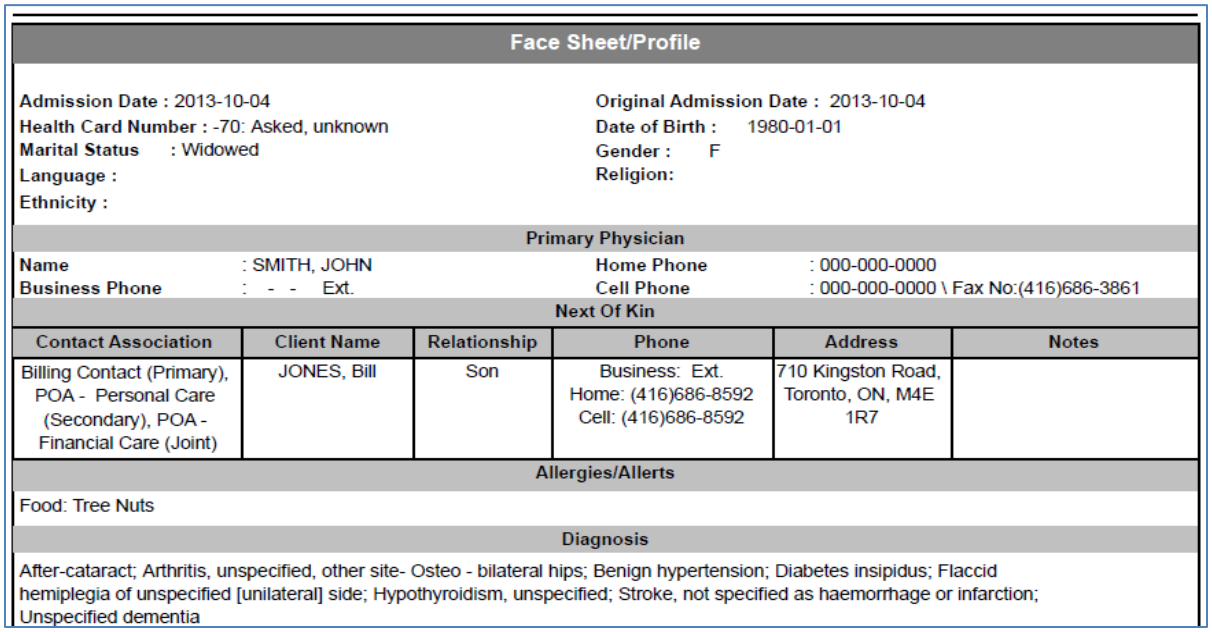
Medical History

Flu Shot	:
Pneumovax	:
TB Testing	:
X-Ray	:
Tetanus Shot	:
TamiFlu	:

b.2 FEATURE: Group Face Sheet/Profile Report

LOCATION: e-Reports > Care Plan > Group > Face Sheet/Profile

NEW: This new report can be run for all residents based on the parameters Status, Unit/Program and Facility. It includes the resident's demographic and medical information. For those situations where the most current Resident/Patient Data is needed, this is a useful report to generate.



Face Sheet/Profile

Admission Date : 2013-10-04
Health Card Number : -70: Asked, unknown
Marital Status : Widowed
Language :
Ethnicity :

Original Admission Date : 2013-10-04
Date of Birth : 1980-01-01
Gender : F
Religion:

Primary Physician

Name : SMITH, JOHN
Business Phone : - - Ext.
Home Phone : 000-000-0000
Cell Phone : 000-000-0000 \ Fax No:(416)686-3861

Next Of Kin

Contact Association	Client Name	Relationship	Phone	Address	Notes
Billing Contact (Primary), POA - Personal Care (Secondary), POA - Financial Care (Joint)	JONES, Bill	Son	Business: Ext. Home: (416)686-8592 Cell: (416)686-8592	710 Kingston Road, Toronto, ON, M4E 1R7	

Allergies/Allerts

Food: Tree Nuts

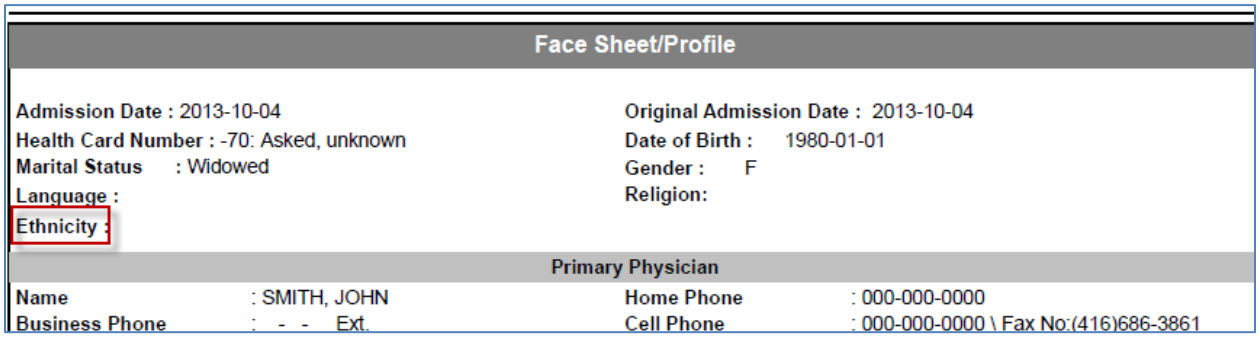
Diagnosis

After-cataract; Arthritis, unspecified, other site- Osteo - bilateral hips; Benign hypertension; Diabetes insipidus; Flaccid hemiplegia of unspecified [unilateral] side; Hypothyroidism, unspecified; Stroke, not specified as haemorrhage or infarction; Unspecified dementia

b.3 FEATURE: Ethnicity Display on Reports

LOCATION: e-Reports > Care Plan

NEW: A resident's ethnicity is now displayed on the following three reports: Face sheet/Profile and Care Plan.



Face Sheet/Profile

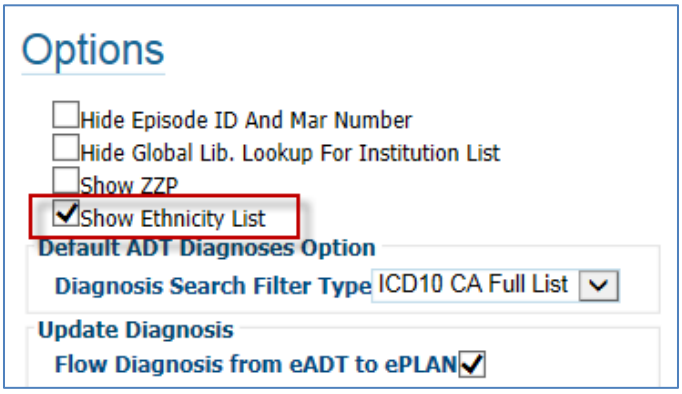
Admission Date : 2013-10-04
Health Card Number : -70: Asked, unknown
Marital Status : Widowed
Language :
Ethnicity :

Original Admission Date : 2013-10-04
Date of Birth : 1980-01-01
Gender : F
Religion:

Primary Physician

Name : SMITH, JOHN
Business Phone : - - Ext.
Home Phone : 000-000-0000
Cell Phone : 000-000-0000 \ Fax No:(416)686-3861

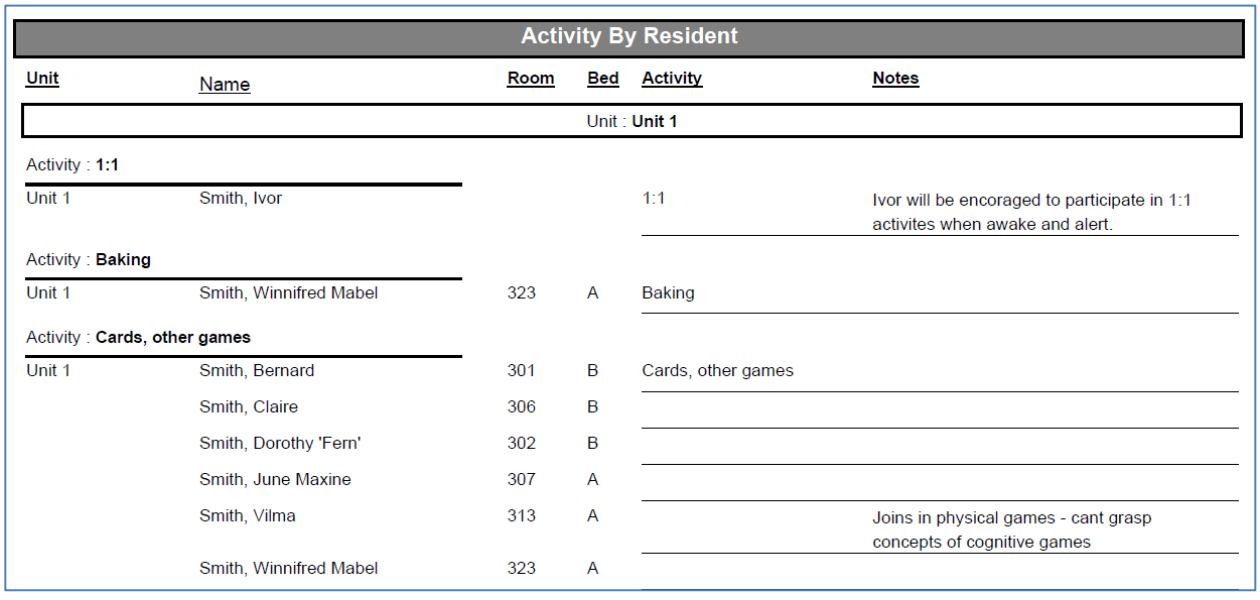
This displayed feature is an option. Navigate to settings to enable/disable function: Settings > e-ADT > Options.



b.4 FEATURE: Residents and Activities Report

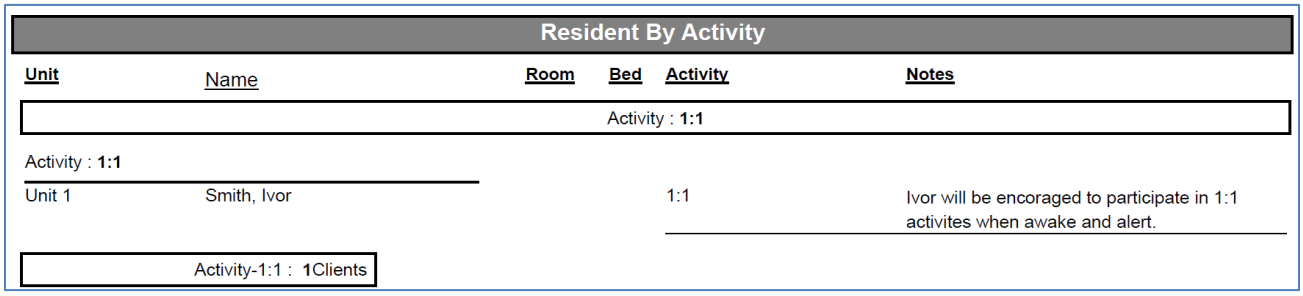
LOCATION: e-Reports > Care Plan > Group > Residents And Activities

NEW: This new Resident and Activities report shows the activities residents have joined as shown in the Activity tab of the Care Plan. This will allow the user to see which activities the resident has attended within the time specified in the report parameters. Residents And Activities Reports Note: If Unit is selected as Group 1 in Group By (irrespective of what is selected in Group 2), the report title is "Activity By Resident"; if Activity is selected as Group 1 in Group By, the report title is "Resident By Activity". If Group 1 is None, the title is "Residents and Activities"



Activity By Resident

Unit	Name	Room	Bed	Activity	Notes
			Unit : **Unit 1**		
Activity : **1:1**					
Unit 1	Smith, Ivor			1:1	Ivor will be encoraged to participate in 1:1 activites when awake and alert.
Activity : **Baking**					
Unit 1	Smith, Winnifred Mabel	323	A	Baking	
Activity : **Cards, other games**					
Unit 1	Smith, Bernard	301	B	Cards, other games	
	Smith, Claire	306	B		
	Smith, Dorothy 'Fern'	302	B		
	Smith, June Maxine	307	A		
	Smith, Vilma	313	A		Joins in physical games - cant grasp concepts of cognitive games
	Smith, Winnifred Mabel	323	A		



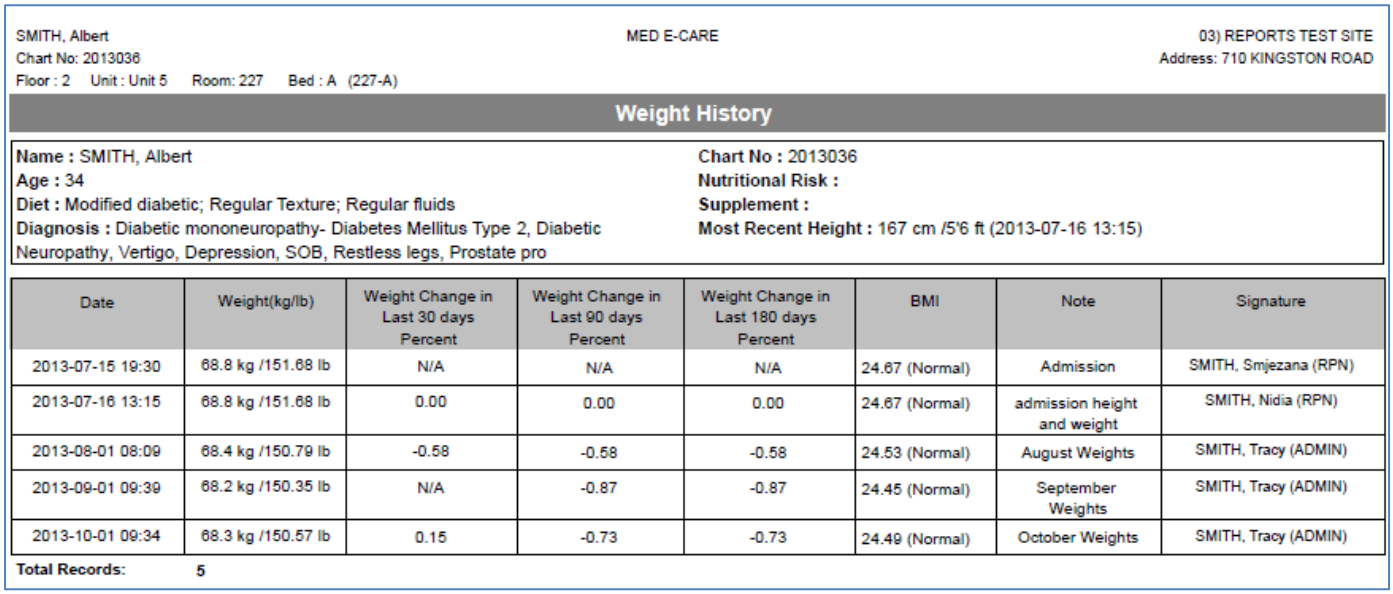
Resident By Activity

Unit	Name	Room	Bed	Activity	Notes
				Activity : **1:1**	
Activity : **1:1**					
Unit 1	Smith, Ivor			1:1	Ivor will be encoraged to participate in 1:1 activites when awake and alert.
				Activity-1:1 : **1**Clients	

b.5 FEATURE: New Weight/Height History Report

LOCATION: e-Reports > Care Plan > Group > Weight/Height History

NEW: There is now a weight/height history report that will include the ability to show a graph, include a BMI legend and also exclude empty data. If the latter is included, then the report will display a list of all the residents without weight/height. The report will also display the Most Recent Weight/Height. It can be generated for an individual, a unit or the whole facility.



SMITH, Albert
Chart No: 2013036
Floor : 2 Unit : Unit 5 Room: 227 Bed : A (227-A)

MED E-CARE

03) REPORTS TEST SITE
Address: 710 KINGSTON ROAD

Weight History

Name : SMITH, Albert
Age : 34
Diet : Modified diabetic; Regular Texture; Regular fluids
Diagnosis : Diabetic mononeuropathy- Diabetes Mellitus Type 2, Diabetic Neuropathy, Vertigo, Depression, SOB, Restless legs, Prostate pro

Chart No : 2013036
Nutritional Risk :
Supplement :
Most Recent Height : 167 cm /5'6 ft (2013-07-16 13:15)

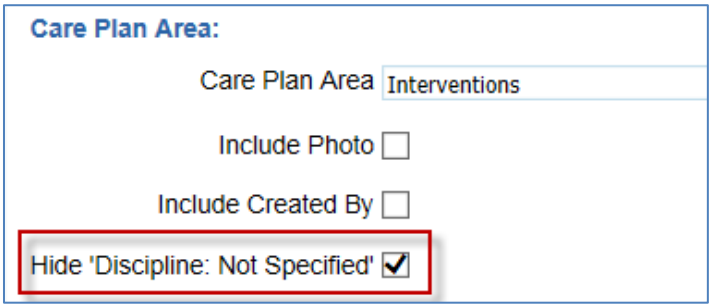
Date	Weight(kg/lb)	Weight Change in Last 30 days Percent	Weight Change in Last 90 days Percent	Weight Change in Last 180 days Percent	BMI	Note	Signature
2013-07-15 19:30	68.8 kg /151.68 lb	N/A	N/A	N/A	24.67 (Normal)	Admission	SMITH, Smjezana (RPN)
2013-07-16 13:15	68.8 kg /151.68 lb	0.00	0.00	0.00	24.67 (Normal)	admission height and weight	SMITH, Nidia (RPN)
2013-08-01 08:09	68.4 kg /150.79 lb	-0.58	-0.58	-0.58	24.53 (Normal)	August Weights	SMITH, Tracy (ADMIN)
2013-09-01 09:39	68.2 kg /150.35 lb	N/A	-0.87	-0.87	24.45 (Normal)	September Weights	SMITH, Tracy (ADMIN)
2013-10-01 09:34	68.3 kg /150.57 lb	0.15	-0.73	-0.73	24.49 (Normal)	October Weights	SMITH, Tracy (ADMIN)

Total Records: 5

b.6 FEATURE: New Discipline Display option for Kardex

LOCATION: e-Reports > Care Plan > Individual > Kardex

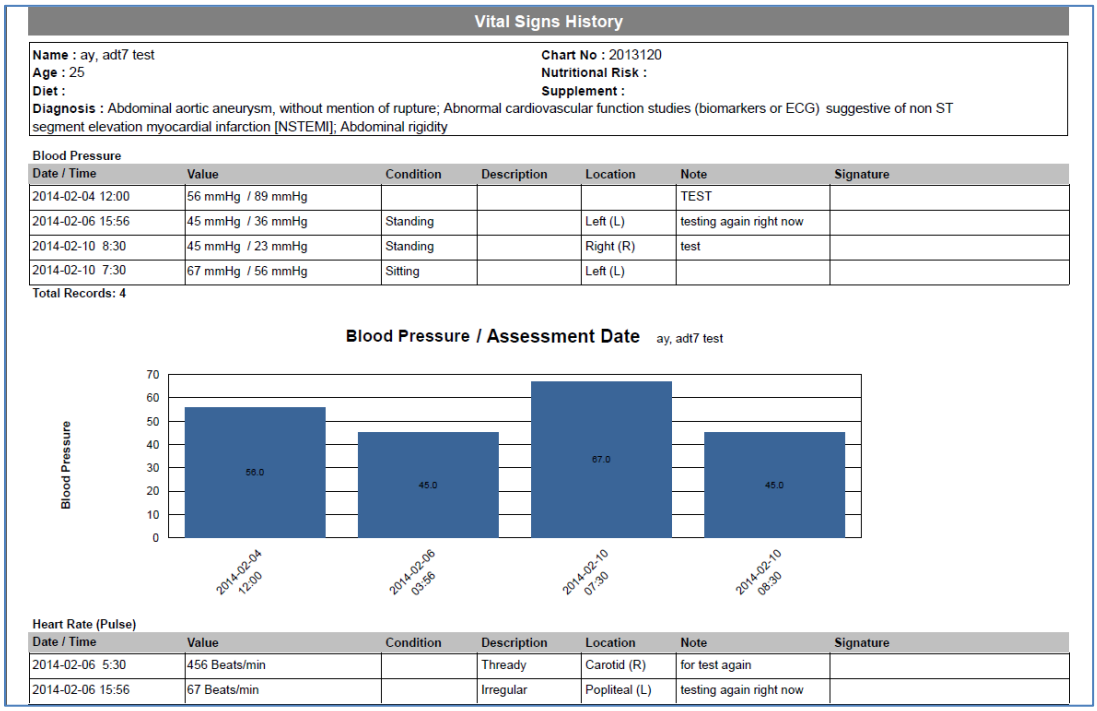
ENHANCEMENT: For Interventions that do not have a discipline assigned to them are labeled *Discipline: Not Specified*. This added parameter provides the option to hide or show this information on the Kardex report.



b.7 FEATURE: New Vital Signs History Report

LOCATION: e-Reports > Care Plan > Group > Vital Signs History

NEW: The new vital signs history report has replaced the Vital Signs, Vitals History (Individual and Group), and Weight History Graph reports. The purpose of this report is to show clients' vitals history based on a selected period. The report can be generated for one individual client or for a group of clients by unit, program or for the entire facility. The report offers an option to include the graph presentation on the vital signs history. To minimize the size of the report, there is also an option to exclude empty data which means any client that does not have any value for weight or height for the period selected will not be included.



Vital Signs History

Name : ay, adt7 test
Age : 25
Diet :
Chart No : 2013120
Nutritional Risk :
Supplement :
Diagnosis : Abdominal aortic aneurysm, without mention of rupture; Abnormal cardiovascular function studies (biomarkers or ECG) suggestive of non ST segment elevation myocardial infarction [NSTEMI]; Abdominal rigidity

Blood Pressure

Date / Time	Value	Condition	Description	Location	Note	Signature
2014-02-04 12:00	56 mmHg / 89 mmHg				TEST	
2014-02-06 15:56	45 mmHg / 36 mmHg	Standing		Left (L)	testing again right now	
2014-02-10 8:30	45 mmHg / 23 mmHg	Standing		Right (R)	test	
2014-02-10 7:30	67 mmHg / 56 mmHg	Sitting		Left (L)		

Total Records: 4

Blood Pressure / Assessment Date ay, adt7 test

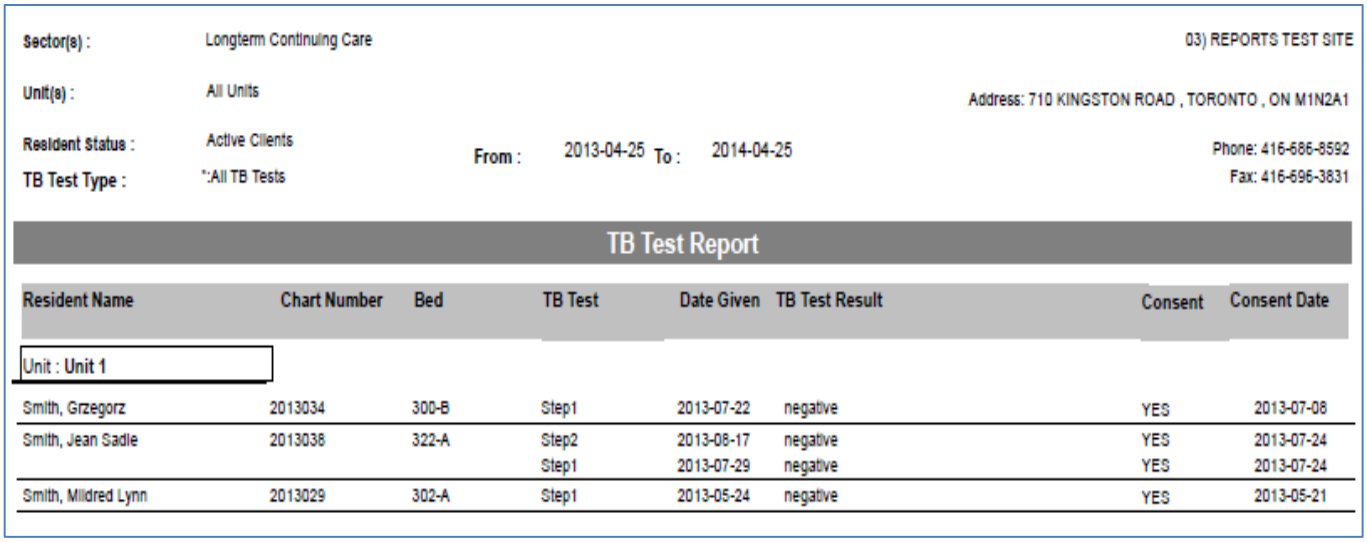
Heart Rate (Pulse)

Date / Time	Value	Condition	Description	Location	Note	Signature
2014-02-06 5:30	456 Beats/min		Thready	Carotid (R)	for test again	
2014-02-06 15:56	67 Beats/min		Irregular	Popliteal (L)	testing again right now	

b.8 FEATURE: New TB Test Report

LOCATION: e-Reports > Care Plan > Group > TB Test

NEW: There is now a group report for TB tests. This report will allow you to see all residents who have had a TB test within the specified time period. There is also a parameter that will allow you to see all the residents who have not had a TB test completed for them within the specified time period of the report.



Sector(s) : Longterm Continuing Care
Unit(s) : All Units
Resident Status : Active Clients
TB Test Type : *:All TB Tests
From : 2013-04-25 **To :** 2014-04-25

03) REPORTS TEST SITE
Address: 710 KINGSTON ROAD , TORONTO , ON M1N2A1
Phone: 416-686-8592
Fax: 416-696-3831

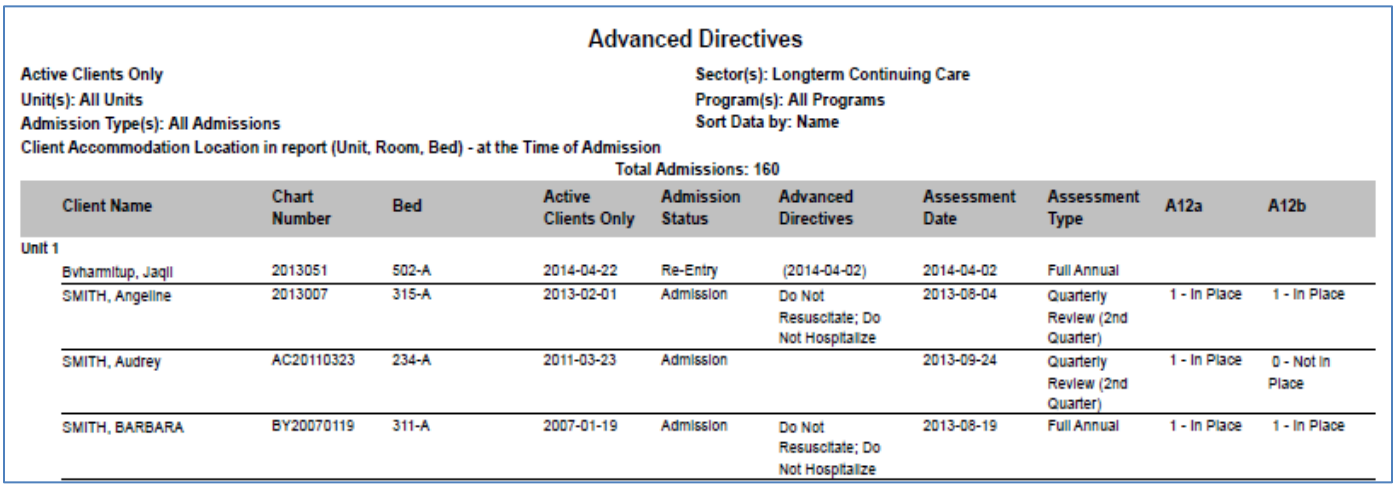
TB Test Report

Resident Name	Chart Number	Bed	TB Test	Date Given	TB Test Result	Consent	Consent Date
Unit : Unit 1							
Smith, Grzegorz	2013034	300-B	Step1	2013-07-22	negative	YES	2013-07-08
Smith, Jean Sadie	2013038	322-A	Step2	2013-08-17	negative	YES	2013-07-24
			Step1	2013-07-29	negative	YES	2013-07-24
Smith, Mildred Lynn	2013029	302-A	Step1	2013-05-24	negative	YES	2013-05-21

b.9 FEATURE: New Advanced Directives Report

LOCATION: e-Reports > Care Plan > Group > Advanced Directives

NEW: This new report will show all Advanced Directives that have been recorded in the CCRS initial assessment and within the Advanced Directives portion of the ADT module.



Advanced Directives

Active Clients Only
Unit(s): All Units
Admission Type(s): All Admissions
Client Accommodation Location in report (Unit, Room, Bed) - at the Time of Admission
Sector(s): Longterm Continuing Care
Program(s): All Programs
Sort Data by: Name

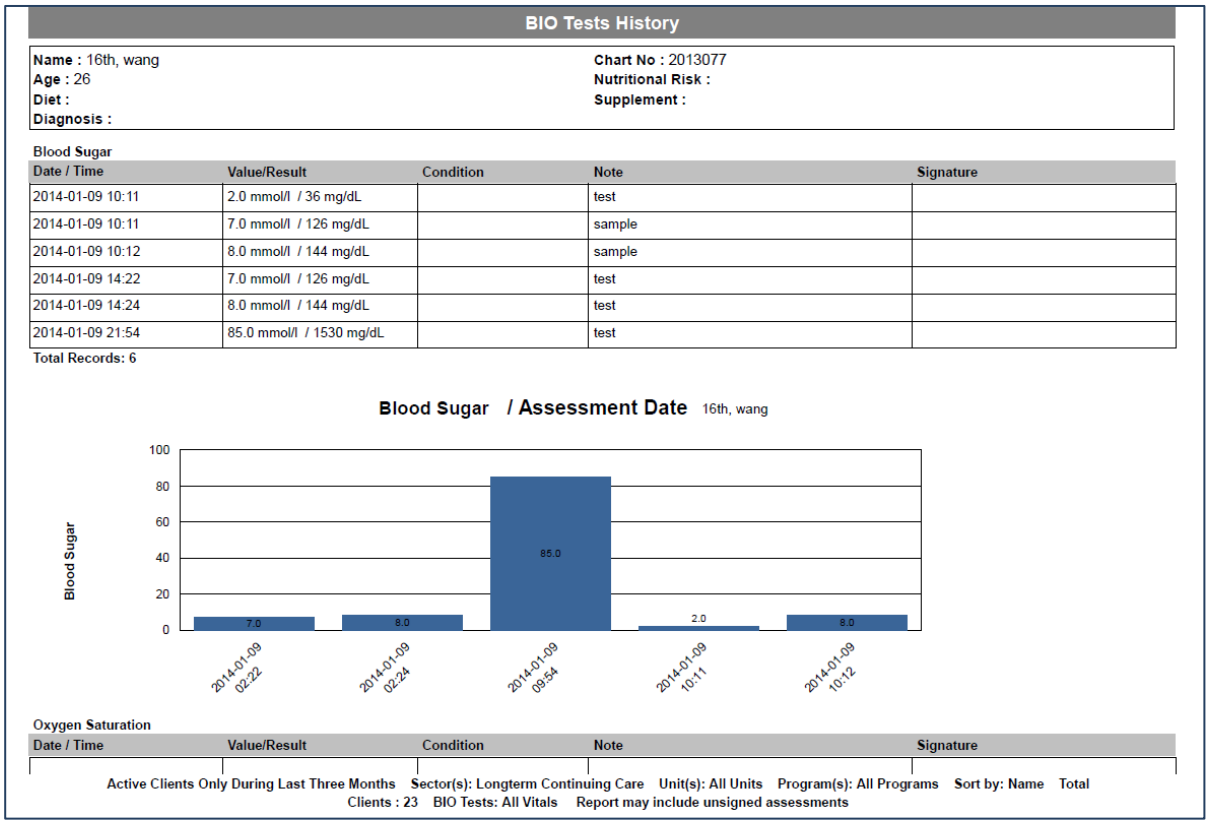
Total Admissions: 160

Client Name	Chart Number	Bed	Active Clients Only	Admission Status	Advanced Directives	Assessment Date	Assessment Type	A12a	A12b
Unit 1									
Bvhamitup, Jaqll	2013051	502-A	2014-04-22	Re-Entry	(2014-04-02)	2014-04-02	Full Annual		
SMITH, Angeline	2013007	315-A	2013-02-01	Admission	Do Not Resuscitate; Do Not Hospitalize	2013-08-04	Quarterly Review (2nd Quarter)	1 - In Place	1 - In Place
SMITH, Audrey	AC20110323	234-A	2011-03-23	Admission		2013-09-24	Quarterly Review (2nd Quarter)	1 - In Place	0 - Not In Place
SMITH, BARBARA	BY20070119	311-A	2007-01-19	Admission	Do Not Resuscitate; Do Not Hospitalize	2013-08-19	Full Annual	1 - In Place	1 - In Place

b.10 FEATURE: New BIO Tests History Report

LOCATION: e-Reports > Care Plan > Group > Bio Tests History

NEW: The new BIO test report will generate a report that will specifically focus on: INR, weights, Oxygen saturation, and blood creatinine. This data can be displayed for: an individual, unit, or whole facility.



BIO Tests History

Name : 16th, wang
Age : 26
Diet :
Diagnosis :

Chart No : 2013077
Nutritional Risk :
Supplement :

Blood Sugar

Date / Time	Value/Result	Condition	Note	Signature
2014-01-09 10:11	2.0 mmol/l / 36 mg/dL		test	
2014-01-09 10:11	7.0 mmol/l / 126 mg/dL		sample	
2014-01-09 10:12	8.0 mmol/l / 144 mg/dL		sample	
2014-01-09 14:22	7.0 mmol/l / 126 mg/dL		test	
2014-01-09 14:24	8.0 mmol/l / 144 mg/dL		test	
2014-01-09 21:54	85.0 mmol/l / 1530 mg/dL		test	

Total Records: 6

Oxygen Saturation

Date / Time	Value/Result	Condition	Note	Signature

Active Clients Only During Last Three Months Sector(s): Longterm Continuing Care Unit(s): All Units Program(s): All Programs Sort by: Name Total Clients : 23 BIO Tests: All Vitals Report may include unsigned assessments

b.11 FEATURE: New Medical Tests Report

LOCATION: e-Reports > Care Plan > Group > Medical Tests

NEW: There is a new report to display the data for all of the medical tests that have been entered in the system. These all the test results that have been entered for: X-rays, Hepatitis, HIV, Malaria, MRSA, PH for Urine, Ultrasound, and VRE. This information can be displayed for; an individual, unit, or the whole facility.

Medical Tests

Name : ePlan, John
Age :
Diet : Modified fat restricted diet - Test Diet Notes 02 update; Regular NAS Diet update - Test Diet Notes 03

Chart No : 2013135
Nutritional Risk : High - Test Consumption Details (2013-12-27)
Supplement : tst add supplement - Test Supplement Notes 02; Resource 2.0 modify - Test Supplement Notes 023 modify

Diagnosis : Abdominal aortic aneurysm, without mention of rupture- Test mention of rupture; Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances (prescription) (overdoses). Includes medicinal substances used to treat illness. These medicinal substances can be those prescribed by a physician, but taken incorrectly by the patient, or medicinal substances that are not prescription and are taken incorrectly by the patient- Test but taken incorrectly by the patient, or medicinal substances that are not prescription and are; Mental and behavioural disorders due to use of alcohol, dependence syndrome- Test dependence syndrome; Deletion of short arm of chromosome 4- Test chromosome 4; Pulmonary actinomycosis- Test actinomycosis

X-ray

Date	Value/Result	Created By	Updated By
2014-01-13	Test X-ray	John, One (2014-02-10)	John, One (2014-02-10)

Total Records: 1

Hepatitis

Date	Value/Result	Created By	Updated By
2014-01-14	Test Hepaitis	John, One (2014-02-10)	John, One (2014-02-10)

Total Records: 1

HIV

Date	Value/Result	Created By	Updated By
2014-01-15	Test HIV	John, One (2014-02-10)	John, One (2014-02-10)

Total Records: 1

Malaria

Date	Value/Result	Created By	Updated By
2013-12-11	Test MAlaria	John, One (2014-02-10)	John, One (2014-02-10)

Total Records: 1

MRSA

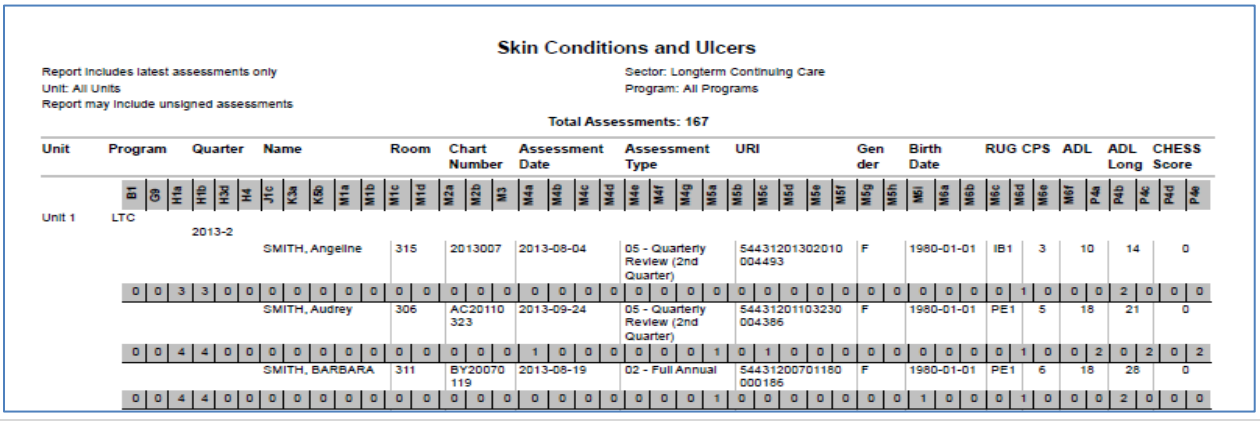
Date	Value/Result	Created By	Updated By

c) Reports – Complex and LTC

c.1 FEATURE: New Skin Conditions and Ulcers Report

LOCATION: e-Reports > Complex and LTC > Group Reports > Custom

NEW: The Skin Conditions and Ulcers Custom Report is a List of all Assessments with data related to Skin Conditions and Ulcers.



Skin Conditions and Ulcers

Report includes latest assessments only
Unit: All Units
Report may include unsigned assessments

Sector: Longterm Continuing Care
Program: All Programs

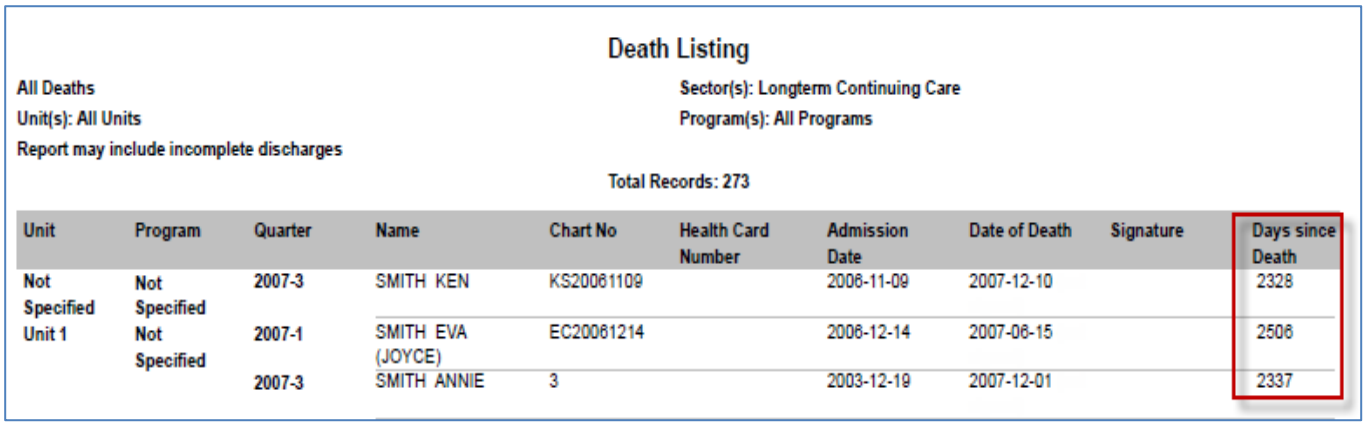
Total Assessments: 167

Unit	Program	Quarter	Name	Room	Chart Number	Assessment Date	Assessment Type	URI	Gender	Birth Date	RUG CPS	ADL	ADL Long	CHESS Score
Unit 1	LTC	2013-2	SMITH, Angeline	315	2013007	2013-08-04	05 - Quarterly Review (2nd Quarter)	544312013020100 04493	F	1980-01-01	IB1	3	10	14	0
			SMITH, Audrey	306	AC20110 323	2013-09-24	05 - Quarterly Review (2nd Quarter)	544312011032300 04386	F	1980-01-01	PE1	5	18	21	0
			SMITH, BARBARA	311	BY20070 119	2013-08-19	02 - Full Annual	544312007011800 00186	F	1980-01-01	PE1	6	18	28	0

c.2 FEATURE: Updated Death Listing Report

LOCATION: e-Reports > Complex and LTC > Group Reports > MDS Administrative

ENHANCEMENT: A new column entitled 'Days since Death' has been added to the report to facilitate the process of reviewing, destroying or returning medications once a certain period has elapsed since a resident's death.



Death Listing

All Deaths
Unit(s): All Units
Report may include incomplete discharges

Sector(s): Longterm Continuing Care
Program(s): All Programs

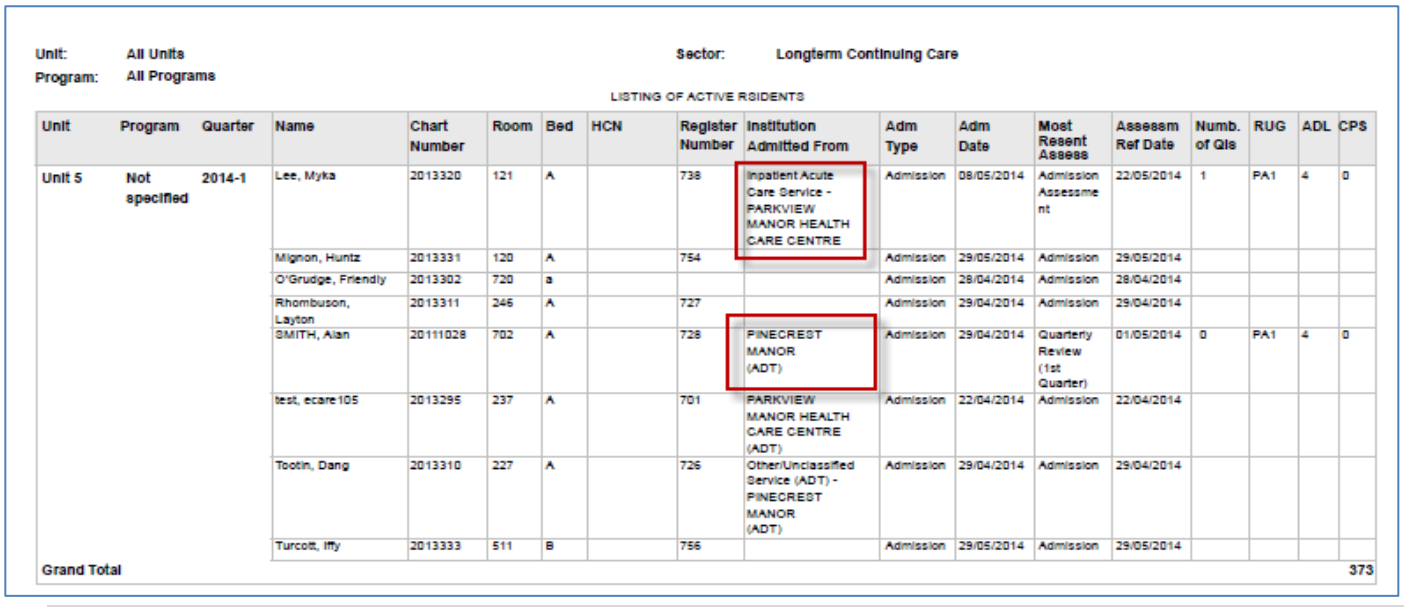
Total Records: 273

Unit	Program	Quarter	Name	Chart No	Health Card Number	Admission Date	Date of Death	Signature	Days since Death
Not Specified	Not Specified	2007-3	SMITH KEN	KS20061109		2006-11-09	2007-12-10		2328
Unit 1	Not Specified	2007-1	SMITH EVA (JOYCE)	EC20061214		2006-12-14	2007-06-15		2506
		2007-3	SMITH ANNIE	3		2003-12-19	2007-12-01		2337

c.3 FEATURE: Updated Active Residents Report

LOCATION: e-Reports > Complex and LTC > Group Reports > MDS Administrative

ENHANCEMENT: This report has been enhanced to display Level of Care and Facility name in the Institution Admitted From column. This information will be populated from the CCRS Assessment. If no CCRS Assessment exists for the resident, then the report will with indicate that the information came from ADT.



Unit: All Units
Program: All Programs

Sector: Longterm Continuing Care

LISTING OF ACTIVE RSIDENTS

Unit	Program	Quarter	Name	Chart Number	Room	Bed	HCN	Register Number	Institution Admitted From	Adm Type	Adm Date	Most Resent Assess	Assessm Ref Date	Numb. of QIs	RUG	ADL	CPS
Unit 5	Not specified	2014-1	Lee, Myka	2013320	121	A		738	Inpatient Acute Care Service - PARKVIEW MANOR HEALTH CARE CENTRE	Admission	08/05/2014	Admission Assessment	22/05/2014	1	PA1	4	0
			Mignon, Huntz	2013331	120	A		754		Admission	29/05/2014	Admission	29/05/2014				
			O'Grudge, Friendly	2013302	720	a				Admission	28/04/2014	Admission	28/04/2014				
			Rhombuson, Layton	2013311	246	A		727		Admission	29/04/2014	Admission	29/04/2014				
			SMITH, Alan	20111028	702	A		728	PINECREST MANOR (ADT)	Admission	29/04/2014	Quarterly Review (1st Quarter)	01/05/2014	0	PA1	4	0
			test, ecare105	2013295	237	A		701	PARKVIEW MANOR HEALTH CARE CENTRE (ADT)	Admission	22/04/2014	Admission	22/04/2014				
			Tootin, Dang	2013310	227	A		726	Other/Unclassified Service (ADT) - PINECREST MANOR (ADT)	Admission	29/04/2014	Admission	29/04/2014				
			Turcott, Ifty	2013333	511	B		756		Admission	29/05/2014	Admission	29/05/2014				
Grand Total																	373

d) Reports – Financial

d.1 FEATURE: Financial Report Descriptions

LOCATION: e-Reports > Financial

NEW: Eight of the remaining financial reports now have detailed descriptions. Among them are AR Detail, Billing Activity, PAP Log, PAP Result, Payment Agent Invoice, Pre-Authorized Payment, Resident Payments, Trust Statement.

Title:

AR Detail

Purpose:

The AR Detail report gathers all posted Accommodation, Recurring, Ancillary charges and all deposited Payments to provide an up to date debit or credit balance of each client for the selected billing period. The report can be run for All clients or for an individual of a given period.

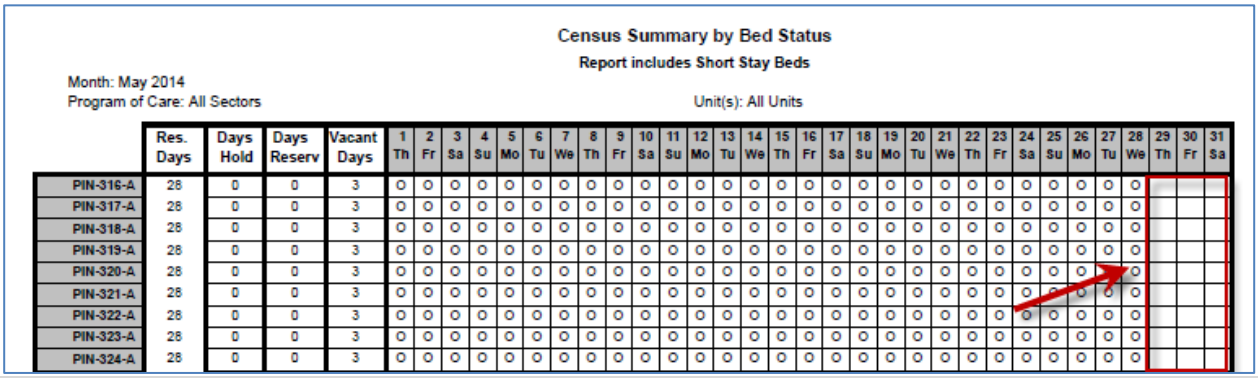
Parameters:

1. Billing Period: user may choose a complex date range from the 'From – To' calendar. Normally, date selection is full billing period, i.e. 2012-08-01 to 2012-08-31.
2. Client search: this option is used to run the AR detail report for a single client, leave it blank to run the report for group.

d.2 FEATURE: Enhanced Census Summary by Bed Status report

LOCATION: e-Reports > Financial > Census > Census Summary by Bed Status

ENHANCEMENT: The report has been enhanced to have vacant bed slots show as a blank space. We have removed the 'V' for Vacant and left it blank for more clarity.



Census Summary by Bed Status

Report includes Short Stay Beds

Month: May 2014
Program of Care: All Sectors

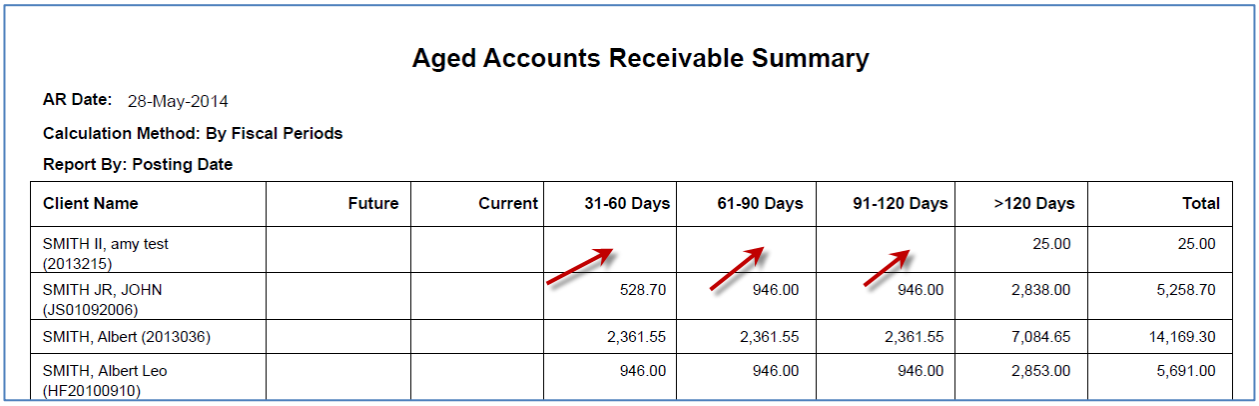
Unit(s): All Units

	Res. Days	Days Hold	Days Reserv	Vacant Days	1 Th	2 Fr	3 Sa	4 Su	5 Mo	6 Tu	7 We	8 Th	9 Fr	10 Sa	11 Su	12 Mo	13 Tu	14 We	15 Th	16 Fr	17 Sa	18 Su	19 Mo	20 Tu	21 We	22 Th	23 Fr	24 Sa	25 Su	26 Mo	27 Tu	28 We	29 Th	30 Fr	31 Sa
PIN-316-A	28	0	0	3	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O			
PIN-317-A	28	0	0	3	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O			
PIN-318-A	28	0	0	3	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O			
PIN-319-A	28	0	0	3	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O			
PIN-320-A	28	0	0	3	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O			
PIN-321-A	28	0	0	3	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O			
PIN-322-A	28	0	0	3	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O			
PIN-323-A	28	0	0	3	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O			
PIN-324-A	28	0	0	3	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O			

d.3 FEATURE: Enhanced Aged AR Summary Report

LOCATION: e-Reports > Financial > Billing > AR Aged Summary

ENHANCEMENT: The report has been enhanced to display a blank space instead of '$0.00' where no values are applicable.



Aged Accounts Receivable Summary

AR Date: 28-May-2014

Calculation Method: By Fiscal Periods

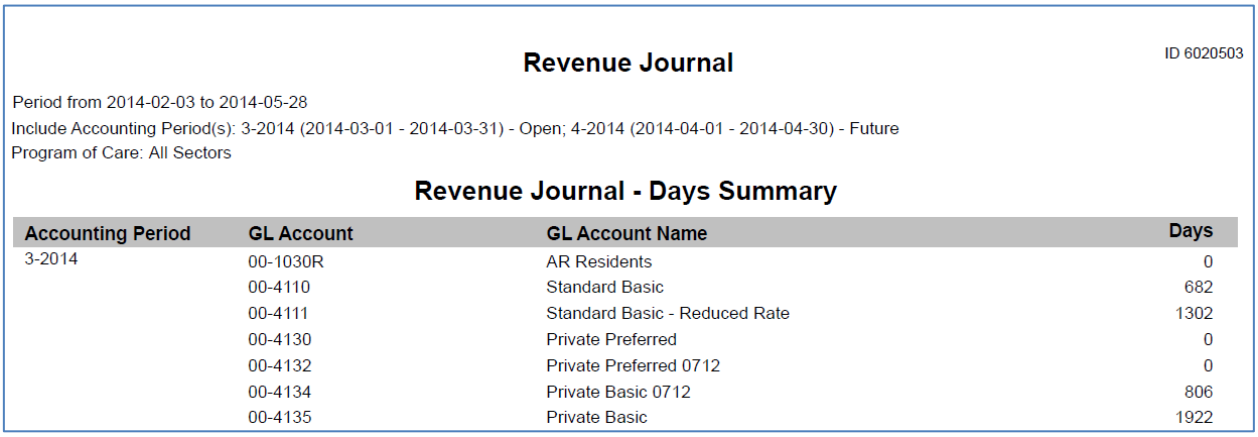
Report By: Posting Date

Client Name	Future	Current	31-60 Days	61-90 Days	91-120 Days	>120 Days	Total
SMITH II, amy test (2013215)						25.00	25.00
SMITH JR, JOHN (JS01092006)			528.70	946.00	946.00	2,838.00	5,258.70
SMITH, Albert (2013036)			2,361.55	2,361.55	2,361.55	7,084.65	14,169.30
SMITH, Albert Leo (HF20100910)			946.00	946.00	946.00	2,853.00	5,691.00

d.4 FEATURE: Enhanced Revenue Journal Report

LOCATION: e-Reports > Financial > Transaction Journals > Revenue Journal

ENHANCEMENT: This report has been modified to limit the summary of current revenue amounts by GL and number of corresponding days to the selected time period. The Days Summary section has also been modified to exclude ancillary, preferred and subsidy type charges.



Revenue Journal ID 6020503

Period from 2014-02-03 to 2014-05-28

Include Accounting Period(s): 3-2014 (2014-03-01 - 2014-03-31) - Open; 4-2014 (2014-04-01 - 2014-04-30) - Future

Program of Care: All Sectors

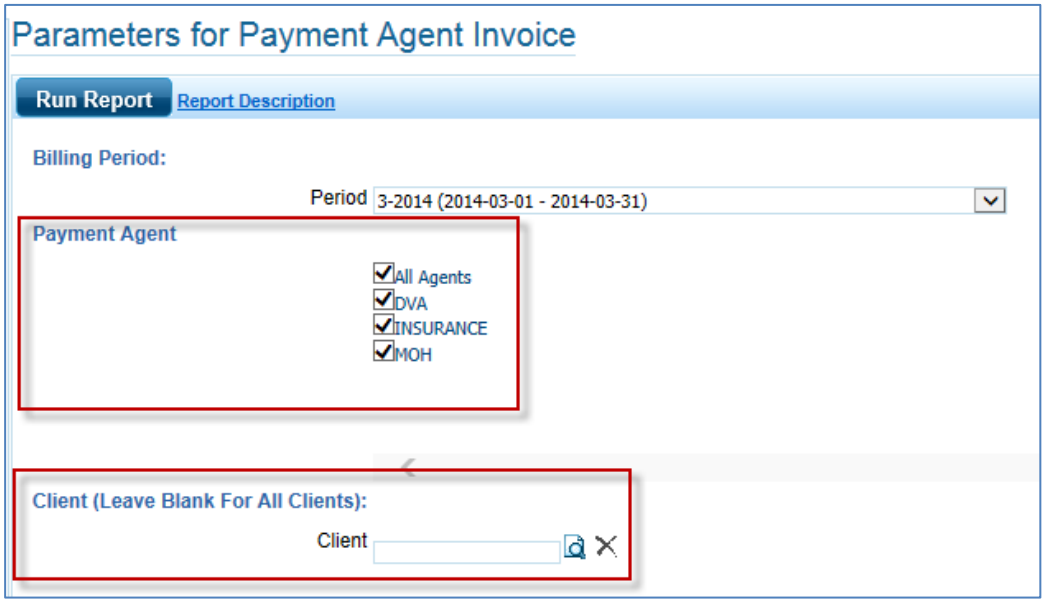
Revenue Journal - Days Summary

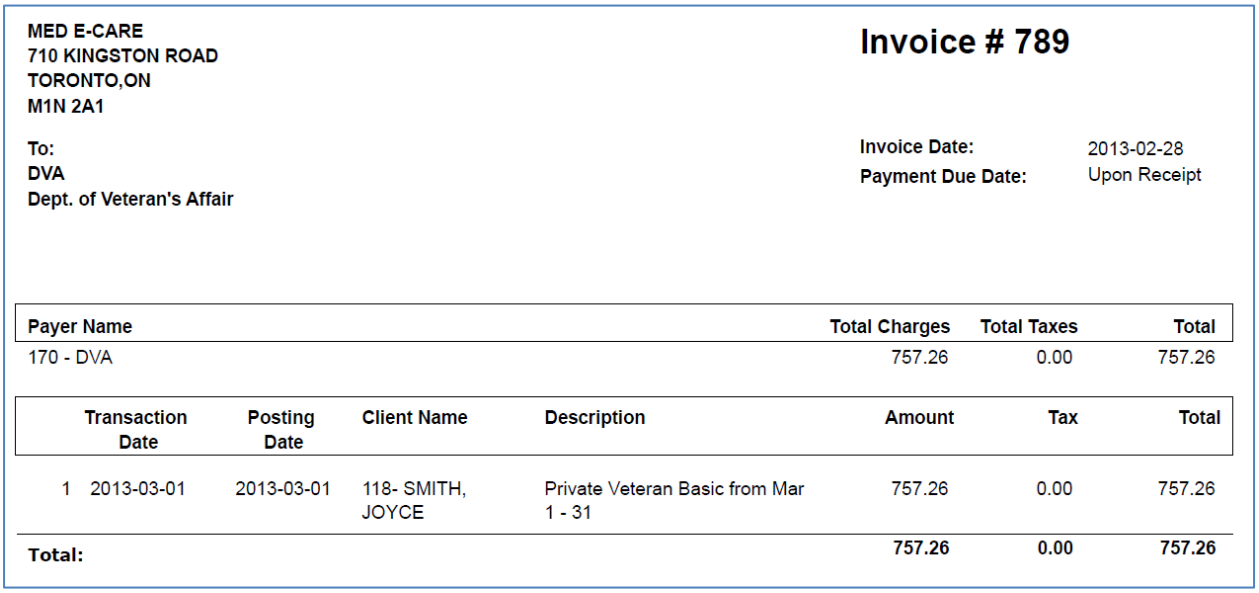
Accounting Period	GL Account	GL Account Name	Days
3-2014	00-1030R	AR Residents	0
	00-4110	Standard Basic	682
	00-4111	Standard Basic - Reduced Rate	1302
	00-4130	Private Preferred	0
	00-4132	Private Preferred 0712	0
	00-4134	Private Basic 0712	806
	00-4135	Private Basic	1922

d.5 FEATURE: Payment Agent Invoice

LOCATION: e-Reports > Financial > Billing

ENHANCEMENT: New search/filter parameters have been added to the Payment Agent Invoice report. The selectable Payment Agents added will be the same as those listed in the Facility's financial setup. A client search field has also been added.





MED E-CARE
710 KINGSTON ROAD
TORONTO,ON
M1N 2A1

Invoice # 789

To:
DVA
Dept. of Veteran's Affair

Invoice Date: 2013-02-28
Payment Due Date: Upon Receipt

Payer Name	Total Charges	Total Taxes	Total
170 - DVA	757.26	0.00	757.26

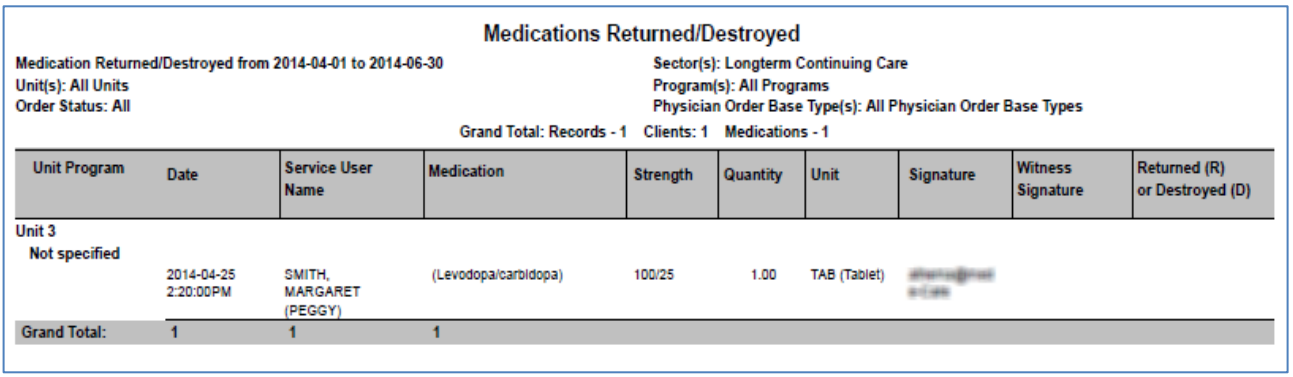
	Transaction Date	Posting Date	Client Name	Description	Amount	Tax	Total
1	2013-03-01	2013-03-01	118- SMITH, JOYCE	Private Veteran Basic from Mar 1 - 31	757.26	0.00	757.26
Total:					**757.26**	**0.00**	**757.26**

e) Reports – MAR

e.1 FEATURE: New Medication Returned/Destroyed Report

LOCATION: e-Reports > Medication

NEW: This report shows a list of medications that have been marked as returned/destroyed using the Edit Order function. This report serves as a record for all medications that have returned to pharmacy or disposed of. The report provides a section for witness signature. The report can then be signed by the Pharmacy or Waste Collector as part of the facility's record keeping.



Medications Returned/Destroyed

Medication Returned/Destroyed from 2014-04-01 to 2014-06-30
Unit(s): All Units
Order Status: All

Sector(s): Longterm Continuing Care
Program(s): All Programs
Physician Order Base Type(s): All Physician Order Base Types

Grand Total: Records - 1 Clients: 1 Medications - 1

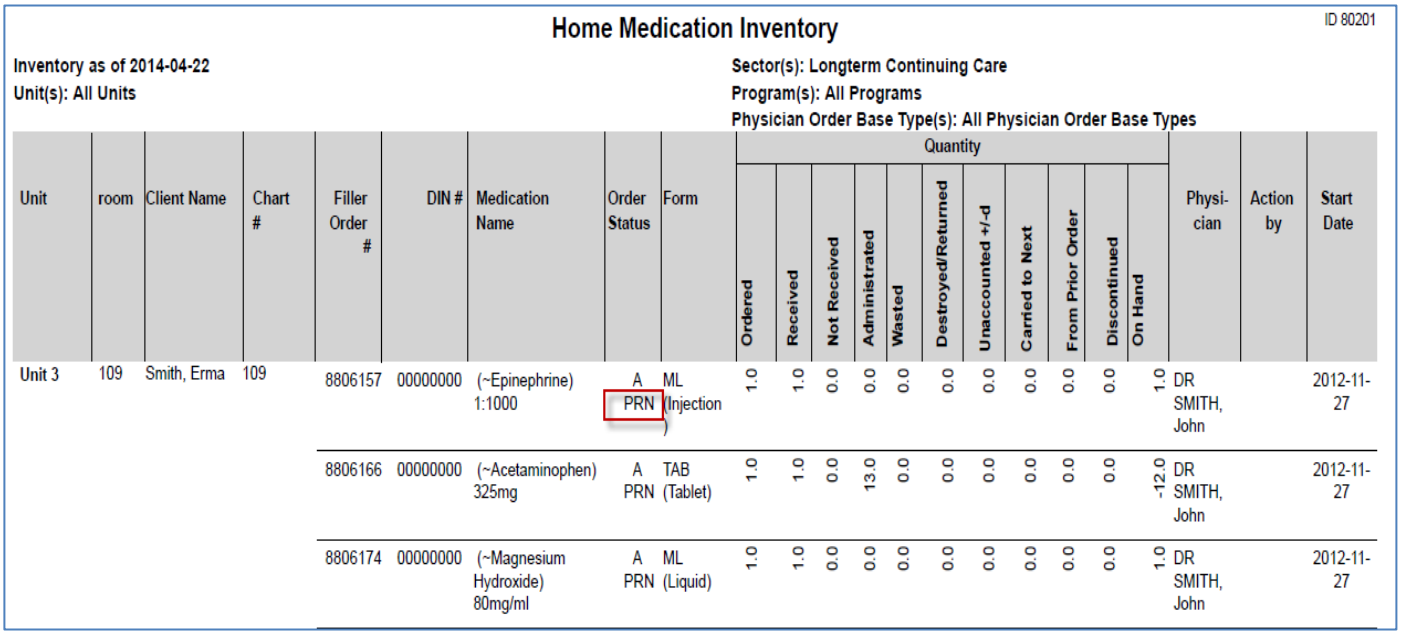
Unit Program	Date	Service User Name	Medication	Strength	Quantity	Unit	Signature	Witness Signature	Returned (R) or Destroyed (D)
Unit 3									
Not specified									
	2014-04-25 2:20:00PM	SMITH, MARGARET (PEGGY)	(Levodopa/carbidopa)	100/25	1.00	TAB (Tablet)	[redacted]		
Grand Total:	1	1	1						

e.2 FEATURE: Enhanced Home Medication Inventory report

LOCATION: e-Reports > Medication > Home Medication Inventory

ENHANCEMENT: The report has been modified to:

- Provide an indication of PRN orders.



Home Medication Inventory

ID 80201

Inventory as of 2014-04-22
Unit(s): All Units

Sector(s): Longterm Continuing Care
Program(s): All Programs
Physician Order Base Type(s): All Physician Order Base Types

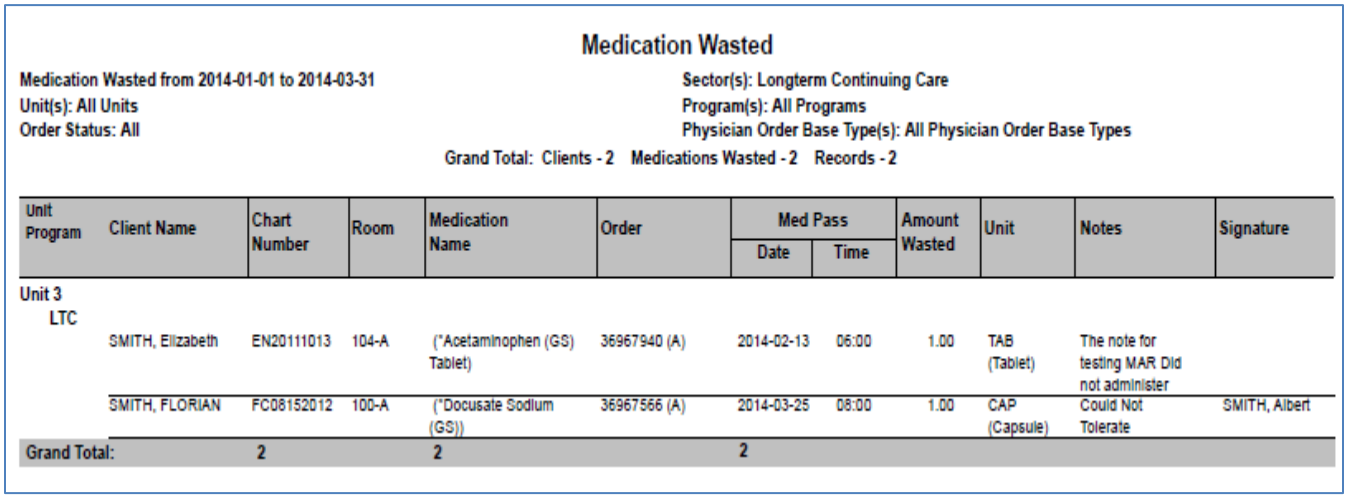
Unit	room	Client Name	Chart #	Filler Order #	DIN #	Medication Name	Order Status	Form	Quantity											Physi-cian	Action by	Start Date
									Ordered	Received	Not Received	Administrated	Wasted	Destroyed/Returned	Unaccounted +/-d	Carried to Next	From Prior Order	Discontinued	On Hand			
Unit 3	109	Smith, Erma	109	8806157	00000000	(~Epinephrine) 1:1000	A PRN	ML (Injection)	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	DR SMITH, John		2012-11-27
				8806166	00000000	(~Acetaminophen) 325mg	A PRN	TAB (Tablet)	1.0	1.0	0.0	13.0	0.0	0.0	0.0	0.0	0.0	0.0	-12.0	DR SMITH, John		2012-11-27
				8806174	00000000	(~Magnesium Hydroxide) 80mg/ml	A PRN	ML (Liquid)	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	DR SMITH, John		2012-11-27

- Exclude (not show) all medications that have a scheduled start date that is later the date the report was generated.

e.3 FEATURE: New MAR Medication Wasted Report

LOCATION: e-Reports > Medication > Medication Wasted

NEW: This new report shows the list of medications that were marked 'Wasted' during administration. This will aid in verifying the medication inventory report and also in reviewing drug utilization. The report can also be useful to identifying areas in medication administration that can be improved.



Medication Wasted

Medication Wasted from 2014-01-01 to 2014-03-31
Unit(s): All Units
Order Status: All

Sector(s): Longterm Continuing Care
Program(s): All Programs
Physician Order Base Type(s): All Physician Order Base Types

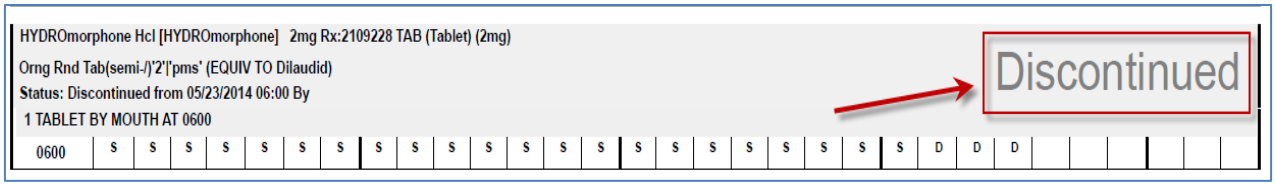
Grand Total: Clients - 2 Medications Wasted - 2 Records - 2

Unit Program	Client Name	Chart Number	Room	Medication Name	Order	Med Pass		Amount Wasted	Unit	Notes	Signature
						Date	Time				
Unit 3 LTC											
	SMITH, Elizabeth	EN20111013	104-A	(*Acetaminophen (GS) Tablet)	36967940 (A)	2014-02-13	06:00	1.00	TAB (Tablet)	The note for testing MAR Did not administer	
	SMITH, FLORIAN	FC08152012	100-A	(*Docusate Sodium (GS))	36967566 (A)	2014-03-25	08:00	1.00	CAP (Capsule)	Could Not Tolerate	SMITH, Albert
Grand Total:		2		2		2					

e.4 FEATURE: Enhanced MAR Sheet

LOCATION: e-Reports > Medication > Medication Administration Record

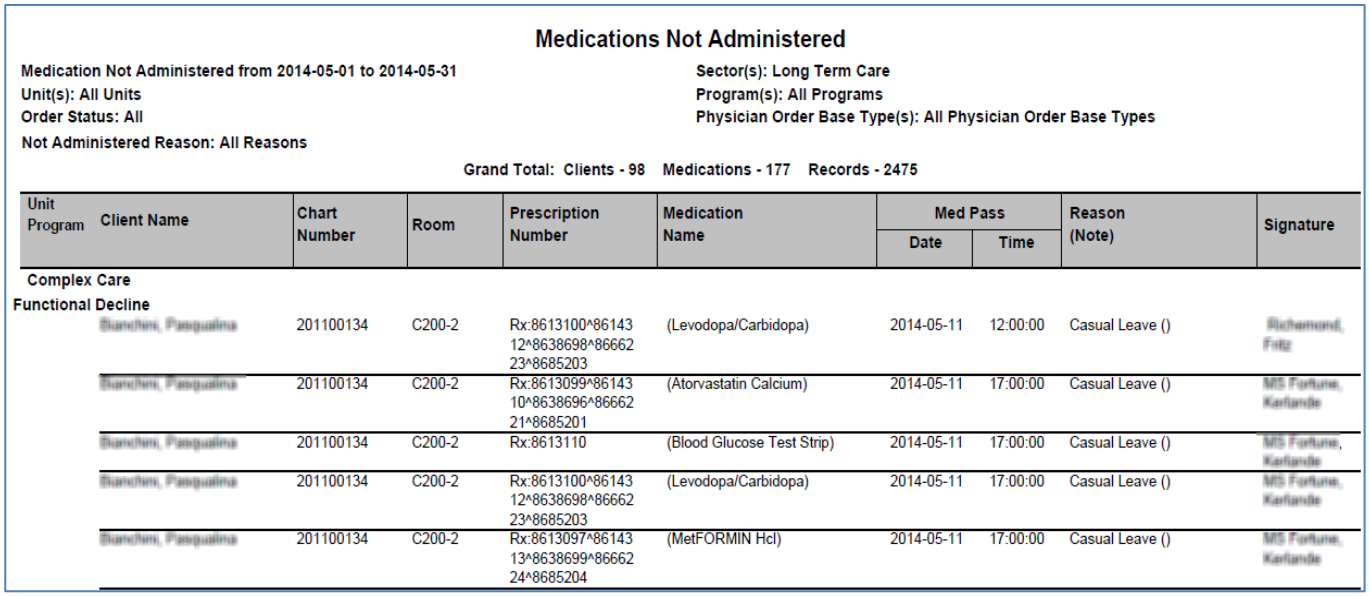
ENHANCEMENT: The MAR record report will now display the complete DISCONTINUED watermark for a discontinued medication.



e.5 FEATURE: New Not Administered Medication Report

LOCATION: e-Reports > Medication > Medications Not Administered

NEW: This new report shows a list of medications that were not administered along with their associated notes as entered on the MED Pass.



Medications Not Administered

Medication Not Administered from 2014-05-01 to 2014-05-31
Unit(s): All Units
Order Status: All
Not Administered Reason: All Reasons
Sector(s): Long Term Care
Program(s): All Programs
Physician Order Base Type(s): All Physician Order Base Types

Grand Total: Clients - 98 Medications - 177 Records - 2475

Unit Program	Client Name	Chart Number	Room	Prescription Number	Medication Name	Med Pass Date	Med Pass Time	Reason (Note)	Signature
Complex Care Functional Decline									
	[redacted]	201100134	C200-2	Rx:8613100^8614312^8638698^8666223^8685203	(Levodopa/Carbidopa)	2014-05-11	12:00:00	Casual Leave ()	[redacted]
	[redacted]	201100134	C200-2	Rx:8613099^8614310^8638696^8666221^8685201	(Atorvastatin Calcium)	2014-05-11	17:00:00	Casual Leave ()	[redacted]
	[redacted]	201100134	C200-2	Rx:8613110	(Blood Glucose Test Strip)	2014-05-11	17:00:00	Casual Leave ()	[redacted]
	[redacted]	201100134	C200-2	Rx:8613100^8614312^8638698^8666223^8685203	(Levodopa/Carbidopa)	2014-05-11	17:00:00	Casual Leave ()	[redacted]
	[redacted]	201100134	C200-2	Rx:8613097^8614313^8638699^8666224^8685204	(MetFORMIN Hcl)	2014-05-11	17:00:00	Casual Leave ()	[redacted]

e.6 FEATURE: Special Instructions display on reports

LOCATION: e-Reports > Medication

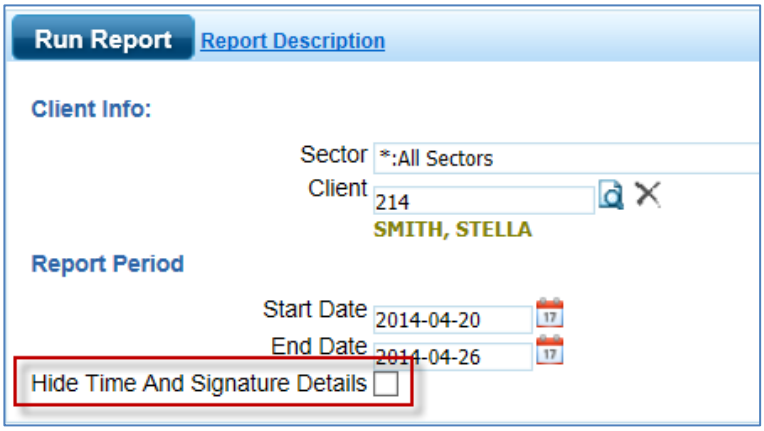
NEW: *Special Instructions* that are transferred to a resident's MED Pass through an interface will be displayed on the following reports: Medication/Treatment Administration Record, Physician Review, Medication Reconciliation and Medication Summary.

f) Reports – POC

f.1 FEATURE: Hide Time and Signature Details option

LOCATION: e-Reports > POC

ENHANCEMENT: The *Hide Time And Signature Details* checkbox has been added to the parameters for the following reports: Documentation Flow Sheet, Flow Sheet, Time Sheet(s), Nursing Rehab and Dietary. This allows the user the option of having time and signature stamps for each entry.



g) Reports – Rehabilitation

g.1 FEATURE: Ensured Discharge Filter on reports

LOCATION: e-Reports > Rehabilitation > Group Reports

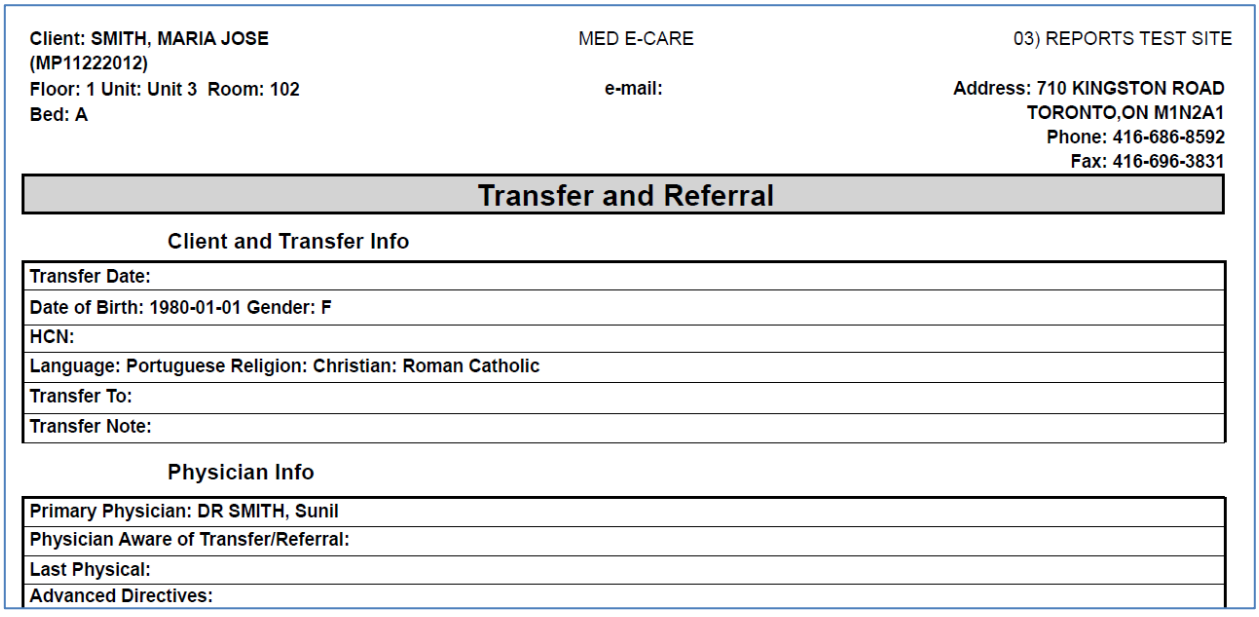
ENHANCEMENT: The following reports have been enhanced to ensure that data that is directly related to the residents' selected ADT discharge date range: Pain Management, Discharge Profile and Functional Status Gain.

h) Reports – Retirement

h.1 FEATURE: New Transfer and Referral Report

LOCATION: e-Reports > Retirement > Individual Reports > Transfer and Referral

NEW: The new Transfer and Referral report has been added. This Report defaults to not show ADL items. The ability to turn ADL items back on through check boxes is available. A check box to not populate the report using latest Vitals has also been included.



Client: SMITH, MARIA JOSE
(MP11222012)
Floor: 1 Unit: Unit 3 Room: 102
Bed: A

MED E-CARE
e-mail:

03) REPORTS TEST SITE
Address: 710 KINGSTON ROAD
TORONTO,ON M1N2A1
Phone: 416-686-8592
Fax: 416-696-3831

Transfer and Referral

Client and Transfer Info

Transfer Date:
Date of Birth: 1980-01-01 Gender: F
HCN:
Language: Portuguese Religion: Christian: Roman Catholic
Transfer To:
Transfer Note:

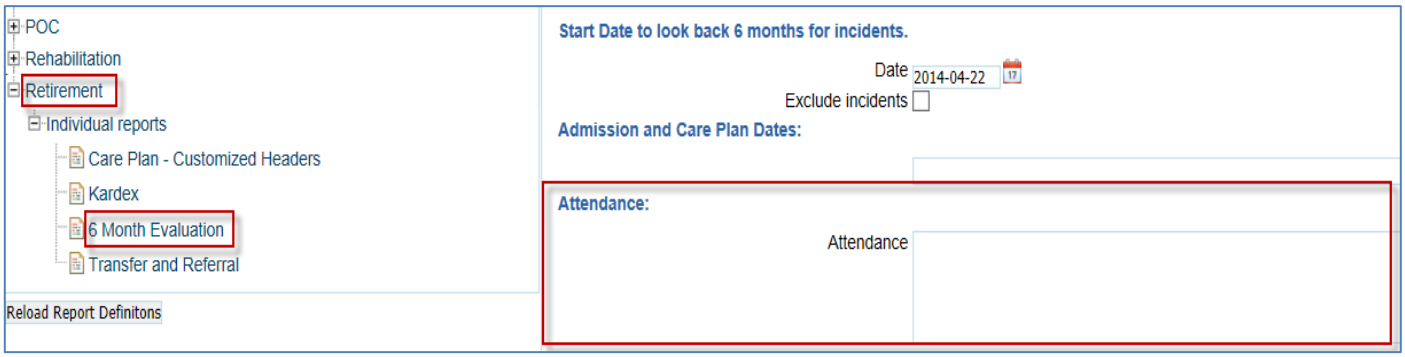
Physician Info

Primary Physician: DR SMITH, Sunil
Physician Aware of Transfer/Referral:
Last Physical:
Advanced Directives:

h.2 FEATURE: Attendance Documentation option

LOCATION: e-Reports > Retirement > Individual Reports > 6 Month Evaluation

ENHANCEMENT: A new free text field has been added to the report parameters. This allows the user to document the list of attendees to the 6 month evaluation.



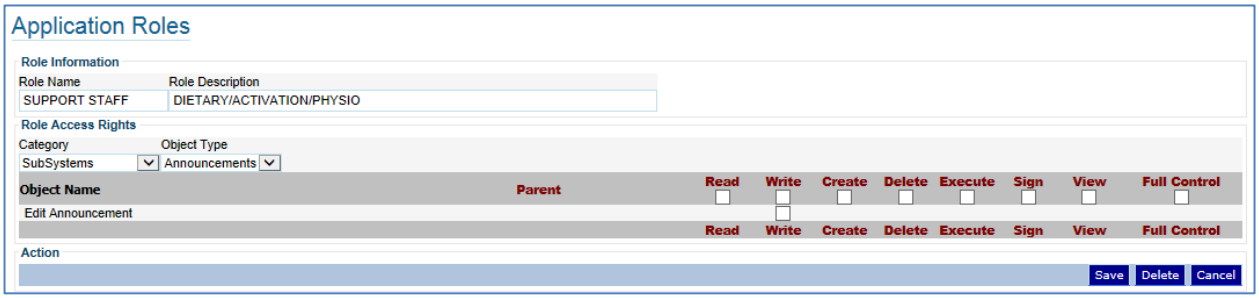
2.12 Miscellaneous

2.12.1 FEATURE: Role Permission to Manage Home Page Announcements

LOCATION: Setting >Security >Application Roles

ENHANCEMENT: We have enhanced the Home Page Announcement function and provided the ability to assign security roles to any user who would manage announcements.

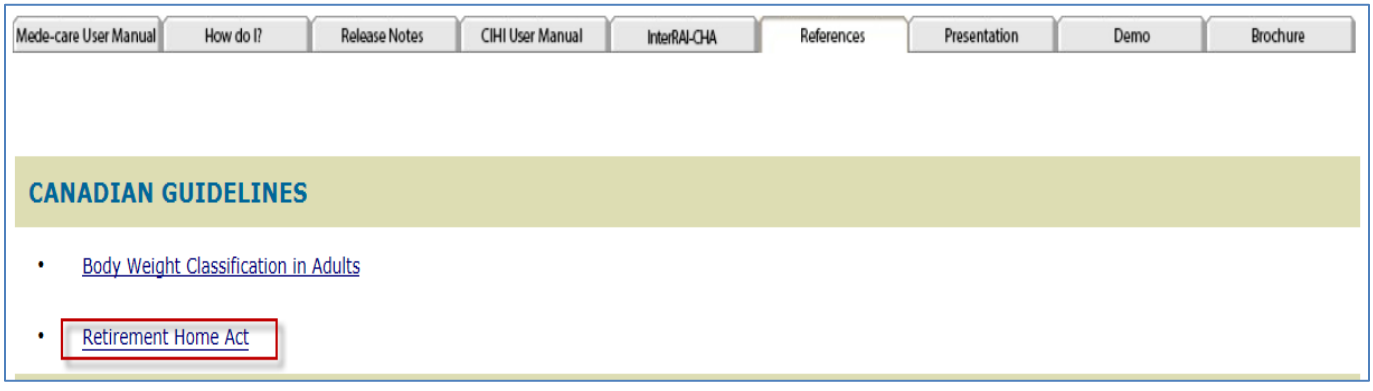
In settings, assign the security for the Announcement role and then enable as needed in the Employee User Setup.



2.12.2 FEATURE: Retirement Home Act

LOCATION: Help > References > Retirement Home Act

ENHANCEMENT: A copy of the Retirement Home Act has been added the application's list of Reference material.



REMINDER

ZENDESK and HELP LINKS

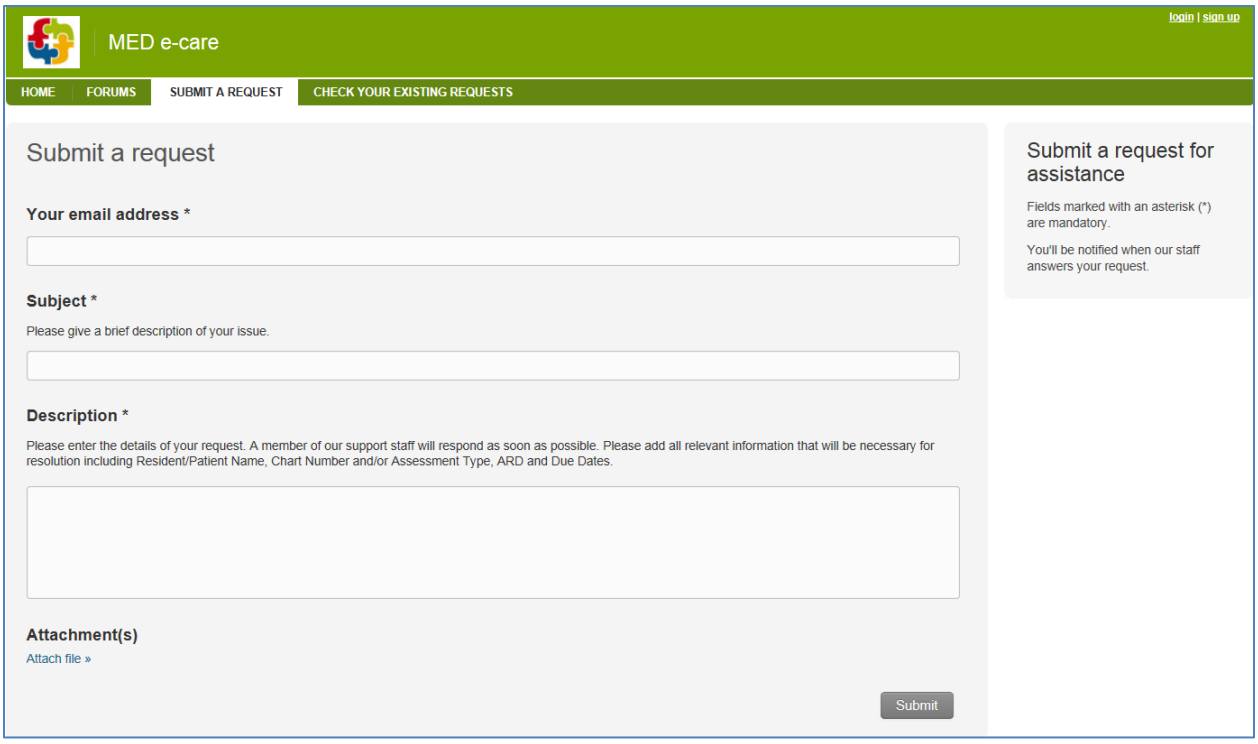
Check out our Forums page on Zendesk!

Zendesk operates primarily as our online ticket tracker, but there are a host of resources built to help you make the best use of your MED e-Care software.

For instance, under our *Community Help* section, the question was asked and another user answered 'How do I print completed RAI assessments'. In FAQ/Tips and Tricks you'll find how-to articles such as, 'How to create a Delete record' and 'How to add a Custom Etiology to Care Plan'.

There is a whole lot more! So go ahead and check it out!

For those new to Zendesk, it's easy to sign up – just click **https://medecare.zendesk.com** or click the 'Support' link in the top right hand corner of the software and follow the simple steps.



Reference materials are just one click away from within the software too! Select the 'Help' link, located at the top, right-hand corner of the MED e-Care screen and a new window will appear with links to **Manuals**, **Release Notes** and **other useful documentation**.