

eCase: How to Guide

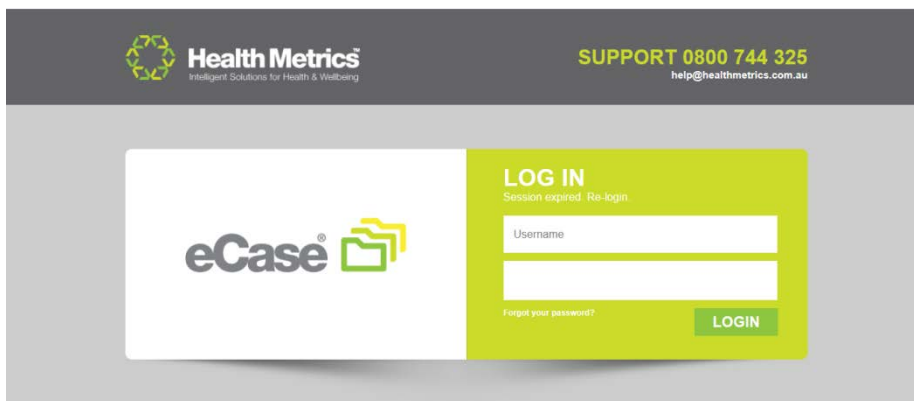
For: Registered & Enrolled Nurse

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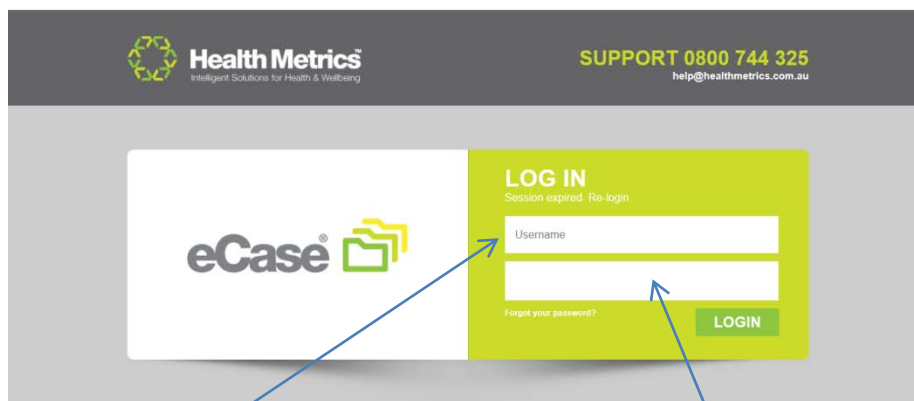
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Accessing eCase:

When you go to the computer/desktop the eCase screen should appear as below.



Logging into eCase:



- 1) Place your issued username into the open field:
- 2) Place your issued password into the open field:
- 3) Then select > LOGIN

The first time you log into eCase you will be given a generic password, you will need to select the Menu> Change Password and change your password to your own personal password. Make sure you select a password you are likely to remember.

For all password resets you will need to contact your Clinical or Facility Manager.

Message Board

When logging into eCase the Message Board (**MB**) link will automatically pop-up on your screen. You can then review if a message has been left for you by your colleagues or managers. To acknowledge the message you must click on the message link and read the message.

When in eCase you are expected to click on the **MB** link periodically throughout your shift to view if messages have been sent to you. To access **MB** you must be on the Main Menu and select the link **MB** next to POC.

To send a message via MB

Select **MB** > select **NEW** > enter all details including Subject, Date, Whom the message is to be sent to (Role/Individual) and complete the body of the message > then select **SEND**. Your MB is now sent.

You can send a MB to yourself for your reference. To review read messages on your MB click on the UNREAD ONLY box on the top right hand corner of your MB link.

The screenshot shows the 'NEW' message form in eCase. It includes fields for 'Subject', 'Future Date:', and 'LastName Fast Filter'. A large text area is provided for the message body. To the right, there are two columns of checkboxes for selecting recipients: 'Roles' (including EN, HCA, RN, Health Metrics Consultants, Activities and Lifestyle, Medical Practitioner, ADMIN, PHYAID, Maintenance, Facility Manager, Dietician, Dentist, Audiologist, and PODIATRIST) and 'Individuals' (including (TAM) Faatamalii, ABDEAN Rozina, ABELGAS Elizer, ABERNETHY Barbara, ABLAS Grelyn, ACE Veronica, ACKROYD Julie, AC_SENATE HCA, ADAMS Olivia, ADAMS Rebekah, AGENCY Matua, and AGENCY Matua). 'Send' and 'Cancel' buttons are located at the bottom.

Admission into eCase:

There is a different process for admitting:

- 1) Add Resident: Long Term Care/Palliative Care
- 2) Add Resident: Respite/Day Stay
- 3) Waitlist

In most facilities the Administrator and or Receptionist will admit a new resident into eCase. After hours or as per your facility process it is the responsibility of the Registered Nurse/Senior Role on Duty to admit a resident into eCase.

New residents can be added to the data base prior to admission as a person of interest. If the resident is interested in being admitted to the facility the status of the resident can be made to waitlist. (Admit to waitlist) The resident can then be admitted to the facility from the waitlist.

Add Resident: Long Term/Palliative Care:

Step 1: MENU > ADD RESIDENT > Complete the fields – the red highlighted fields are mandatory fields > then select ADD

MENU

ADD RESIDENT

Residential Aged Care
 Funded Resident
 Un-Funded Resident
 Independent Living Unit
 Home Care
 Disability Services
 Transitional Care

Resident Care Level
Rest Home

Title: [dropdown] **First Name:** [text] **Last Name:** [text]

Facility name: Select A Facility... [dropdown] **Nationality:** Not Specified [dropdown] **Religion:** [dropdown]

Cultural Background: [dropdown] **Ethnic Group:** [dropdown]

Type of Care: Aged Non Aged **Term of Care:** Long Term Short Term

Gender: Male Female Indeterminate/Intersex/Unspecified

Date of Birth: DD / MM / YYYY

WINZ Number: [text] **NHI Number:** [text]

Add

*Fields in red are required fields

eCase will pick up if a resident with a similar name is currently admitted into your facility. Your screen may display “There is a resident in this facility with similar details, are you sure you would like to add this resident”. This will display to reduce the incidence of a resident being entered into the system twice. To check there is no double up select the NO option, go into the Main Search page (eCase Hot Key) and search for the resident you are wishing to add to the system.

Once you have selected ADD, the process will take you to a created Residents profile page. On the Resident profile page the resident’s eCase Status will appear as **NON-RESIDENT** in blue.

Step 2: In the Residents profile, scroll down to the Resident Functions Tab at the bottom of your screen, then select > ADMISSION/RTN > you need to complete the field’s inclu. Wing/Room/Bed > select NEXT. You can skip the finance fields (as this data is covered by

RIMS currently) select > NEXT > Select the correct Agreement > Aged or Non-Aged > then select NEXT.

eCase will take you to the new residents MMT/LIST displaying the recent movement into the system. Once you have completed this step the clinical workflows will be triggered for clinical staff to manage the admission process for the resident.

When you view the Residents Profile their eCase status will then appear **red** and state **ACTIVE** – with their attached funded level of care.

Add Resident: Respite/Day Stay:

Step 1: MENU > ADD RESIDENT > Complete the fields – the **red highlighted** fields are mandatory fields > then select ADD

MENU

ADD RESIDENT

Residential Aged Care

Funded Resident

Un-Funded Resident

Independent Living Unit

Home Care

Disability Services

Transitional Care

Resident Care Level

Rest Home

Title: **First Name:** **Last Name:**

Facility name: **Nationality:** **Religion:**

Cultural Background: **Ethnic Group:**

Type of Care: Aged Non Aged

Term of Care: Long Term Short Term

Gender: Male Female Indeterminate/Intersex/Unspecified

Date of Birth: DD / MM / YYYY

WINZ Number: **NHI Number:**

Add

*Fields in red are required fields

Once you have selected ADD, the process will take you to a created Residents profile page. On the Resident profile page the resident's eCase Status will appear as **NON-RESIDENT** in blue.

Step 2: MENU > BOOKING > BOOKING

Select a Resident > once you have located your resident from the provided list > complete the outlined fields > When choosing a booking position select the next available position provided in the list.

For Test Test

Resident: Select a Resident

Facility: RADIUS TRAINING

Booking type: Day Care Respite Confirmed Respite Tentative

Booking Notes:

Commencement Date:

Completion Date:

Booking Positions: Choose a Position ▼

Show Calendar
Resident Bookings
Save

Step 3: Go to MENU > BOOKING> BOOKING ADMISSION - Complete the fields including admitting the resident into the allocated Wing/Room/Bed, then select > Next > Respite Agreement > complete/update the fields then select > Complete Admission. The Resident is now admitted into eCase – Clinical Workflows are now triggered for the Resident.

Booking Select a Booking

Booked Date: **26 May 2017 to 31 May 2017**

Admission Date:

Wing/Room/Bed: Yellow ▼ 25 ▼ a ▼

Next

[Resident movements in eCase:](#)

The movements list in eCase will provide information on the current eCase status of your resident’s profile. This list commences from admission of the Resident into eCase and shows movement of your residents status in and out of the facility.

Locate your Resident > scroll down the screen to the Resident Function tab > select Mmt/List

When to check the Mmt List in eCase:

MENU MOUSE > MOVEMENT LIST

TYPE	ID	MOVEMENT DATE	DISCHARGE DATE	USER	DESCRIPTION	ATTACHMENT		SELECT
NR	1	02 Mar 2017		radius27	Add Resident			<input type="radio"/>
EC	2	02 Mar 2017		radius27	eContract			<input type="radio"/>
AR	3	02 Mar 2017		radius27	Booking Admission			<input type="radio"/>
RC	4	23 Mar 2017		radius28	Room Change: From Purple-10-3 To Red-6-1			<input type="radio"/>

Update Discharge Date
Reactivate Resident
Undo Reactivate Resident
Cancel



- a) To check your Resident is correctly admitted into the Facility
- b) To check the current status of your Resident
- c) To monitor the movement in and out of the facility (i.e. transfer home or to hospital)
- d) To track the date of Resident movement

Move a Resident out of eCase:

In most facilities the Administrator/ Receptionist will move a Resident out and or discharge a Resident. After hours or as per your facility process it is the responsibility of the Registered Nurse/Senior role on duty to manage the movement process.

Select the Resident > Scroll down the screen to the Functions Tab > select MMT/OUT >

- Social/Home/Hospital Leave/Other - Select the Temporary option > Type of Leave > SAVE

- Respite/Day Stay – The correct data is reflected just select > SAVE.

- Discharge/Death – Select Permanent > Type > SAVE (**MANAGERS ONLY**)

When selecting the fields the system will ask a series of questions in particular to discharging a Resident out of eCase permanently, once you have selected SAVE the profile of your resident will no longer be accessible for a clinical documentation. It is important to note moving a Resident out of eCase is the final process to closing the workflow for your Resident.

To finalise clinical workflows a permanent discharge may be delayed, all clinical workflows will need to be inactive to stop triggers appearing on the work log – this is a (**MANAGERS ONLY DECISION**)

MENU ☰

SCOTT SMITH > MOVEMENT OUT

Movement Date: 19 Apr 2017

Type: Temporary Permanent

Reason:

- Death (Natural)
- Death (Suicide)
- Hospital
- Social
- Home
- AWOL
- To another residential aged care service (initiated by resident)
- To another residential aged care service (initiated by provider)

Save Cancel



Return a Resident from leave back to Facility:

Day	Activity	Person/s responsible	Start Date

Select the Resident > at the bottom of the screen in the Resident Functions tab, select ADMISSION/RTN > Complete the field's including Wing/Room/Bed > select SAVE. The Resident is now successfully admitted back into the Facility.

Locate Active/Inactive/Waitlist/Non-Resident Files:

To locate a Resident profile which may hold a status of Active/Inactive/Waitlist/Non-Resident or Discharged permanently > Go to the Main Search Page (eCase Hot Key)

To filter to the correct status of the Residents profile complete the required fields > In the Status Filter, ensure to select the correct status or select the All option, this will search the eCase database and display your Resident.

Search for:
 Resident Contact Staff

Resident code: First Name: Last Name: Gender:
 Male Female
 Indeterminate/Intersex/Unspecified

Facility name: Wing: Room: Bed:
All Accessible Facilities All Accessible Wings All Accessible Rooms All Accessible Beds

WINZ Number: NHI Number: Is Booking:
 Yes No

Status Filter:
 Active
 Inactive
 Wait List
 Non-Resident
 ALL

Resident Care Level:
 Rest Home
 Dementia Care
 Hospital
 Psychogeriatric Care
 Mental Health Care
 Daycare Care
 Rehab High Level Care
 Rehab Low Level Care
 Rehab Medium Level Care
 Rest Home LTO
 D
 H
 Secure Rest Home
 All

Sort order:
 Alphabetical
 Room Number

Admission Care Workflow Long Term:

The following table sets out admission workflows once the Resident is admitted into eCase. Activities will automatically appear on work logs, with each task assigned to a responsible role/s.

1	Notify Medical Practitioner of Admission	RN, EN	In 8 hours
	Notify Pharmacy of Admission	RN, EN	Immediately
	Add Resident Photo	Activities & Lifestyle, Admin, RN, EN	Immediately
	Complete admission information on Resident tab include Diagnosis/Allergies/Alerts	RN, EN	Immediately
	Complete TRP and BP Monitoring	RN, EN	Immediately
	Admission Task - Weight Resident	RN, EN, HCA	Immediately
	Schedule - Add Activity – Weigh Resident	RN, EN, HCA	Immediately
	Schedule – Blood Pressure Management Chart	RN,EN	Immediately
	Schedule – Daily Personal Care Chart	RN,EN	Immediately
	Comprehensive Multidisciplinary Assessment & Medical Review for GP	Medical Practitioner, Clinical Manager, RN,EN	Immediately
	Schedule - Pressure Care Chart (if applicable)	RN,EN	Immediately
	Ensure all clinical tasks are scheduled	RN,EN	Immediately
	RN Complete Pain Charting 2hrly for the 24hrs (1200, 1400, 1600,1800,2000,2200,2400, 0200, 0400, 0600, 0800, 1000)	RN,EN	Immediately
	Complete Progress Note – Orientation Checklist	RN,EN	Immediately
	Initial Case Conference	RN,EN	Immediately
	Print Kitchen form from Dietary Care plan - Provide to Kitchen	RN,EN	Immediately
	Complete Admission Progress Note	RN,EN	Immediately
	Complete Continence Monitoring Chart (for 3 days)	RN,EN,HCA	Immediately
	Complete Behaviour Identification Chart each shift for 7 days	RN,EN,HCA	Immediately
	Chart Review: Complete Bowel Chart		
2			
	Complete Belongings List: Take photos/list of residents glasses, hearing aids, valuables and load in gallery/ complete progress note	Activities and lifestyle, administration, RN, EN	In 48 hours
	Medical Practitioner Admission to be Completed (Community)	Medical Practitioner, RN,EN	In 48 hours
	RN Complete Pain Charting 2hrly for the 24hrs (1200, 1400, 1600,1800,2000,2200,2400, 0200, 0400, 0600, 0800, 1000)	RN,EN	Immediately
	Complete Continence Monitoring Chart each shift for 3 days (Pre-Set – Appears each shift automatically)	RN,EN,HCA	Immediately
	Complete Behaviour Identification Chart each shift for 7 days	RN,EN,HCA	Immediately
3	Reminder Request InterRAI File	Clinical Manager, Administration, RN	In 72 hours
	Medical Practitioner Admission to be completed (Public Hospital)	RN,EN	In 72 hours
	Complete Continence Monitoring Chart (for 3 days, 1000,1900,0500hrs)	RN,EN,HCA	Immediately

	Complete Behaviour Identification Chart each shift for 7 days	RN,EN,HCA	Immediately
	Complete Contenance Order	RN,EN	Immediately
4	Complete Behaviour Identification Chart each shift for 7 days	RN,EN,HCA	Immediately
5	Sleep Chart Complete hourly for 3 days (between 2000 -0800 hrs)	RN,EN,HCA	In 5 days
	Complete Behaviour Identification Chart each shift for 7 days	RN,EN,HCA	Immediately
6	Sleep Chart Complete hourly for 3 days (between 2000 -0800 hrs)	RN,EN,HCA	In 5 days
	Complete Behaviour Identification Chart each shift for 7 days	RN,EN,HCA	Immediately
7	Sleep Chart Complete hourly for 3 days (between 2000 -0800 hrs)	RN,EN,HCA	In 5 days
	Complete Behaviour Identification Chart each shift for 7 days	RN,EN,HCA	Immediately

Admission Care Workflow Long Term – Assessment & Care Planning:

The below table sets out admission workflows for Assessment & Care Planning from day one of admission . Activities will automatically appear on work logs, with each task assigned to a responsible role/s.

Day	Activity	Person/s Responsible	Start Date
1	Complete Interim Care Plan	RN,EN	In 8 hours
	Complete FRAT Chart	RN,EN	In 8 hours
	Complete Consent Assessment	RN,EN	In 8 hours
	Complete Medication Assessment & Care Plan	RN,EN	In 8 hours
	Complete Dietary Assessment & Care Plan	RN,EN	In 8 hours
	Complete Pain Assessment & Care Plan	RN,EN	In 8 hours
	Complete Pressure Risk Assessment & Care Plan	RN,EN	In 8 hours
	Complete Risk Assessment & Care Plan	RN,EN	In 8 hours
	Complete Advanced Care Directive Assessment & Care Plan	GP, Clinical Manager, RN	In 8 hours
	Complete Restraint Assessment & Care Plan (if applicable)	Clinical Manager, RN	In 8 hours
2	Complete Mini Nutritional Assessment and Care Plan	RN,EN	In 48 hours
3	Complete Toileting Assessment and Care Plan	RN,EN	In 72 hours
	Complete Mobility and Transfers Assessment & Care Plan	RN,EN	In 72 hours
	Complete About Me Assessment	Activities & Lifestyle, RN,EN	In 72 hours

4	Complete Skin Assessment & Care Plan	RN,EN	In 4 days
	Complete Personal Hygiene Assessment & Care Plan	RN,EN	In 4 days
	Complete Continence Assessment & Care Plan	RN,EN	In 4 days
5	Complete Communication & Comprehension Assessment & Care Plan	RN,EN	In 5 days
	Complete Swallowing Difficulties Assessment & Care Plan	RN,EN	In 5 days
	Complete Bed Stick/ Lever Risk Assessment & Care Plan (if applicable)	RN,EN	In 5 days
6	Complete Smoking Assessment & Care Plan (if required)	RN,EN	In 6 days
7	Complete Sensory Assessment & Care Plan	RN,EN	In 7 days
8	Complete Sleep Assessment and Care Plan	RN,EN	In 8 days
9			
10	Complete Maori Health Care Assessment & Care Plan (if applicable)	RN,EN	In 10 days
	Complete Life History Assessment	Activities & Lifestyle, RN,EN	In 10 days
11	Complete Leisure Assessment & Care Plan	Activities & Lifestyle, RN,EN	In 11 days
12	Complete Physiotherapy Assessment & Care Plan	Physiotherapist, RN, EN	In 12 days
	Complete Podiatry Assessment & Care Plan	Podiatrist, RN, EN	In 12 days
13			
14			
15	Complete PAS Assessment & Care Plan	RN,EN	In 15 days
16			
17	Complete Cornell Depression Scale Assessment & Care Plan	RN,EN	In 17 days
18	Review all Assessments/Care Plans and ensure all are published	RN,EN	In 18 days
	Schedule: Care Plan Review: Care Plan Evaluations 6 Monthly	RN,EN	In 18 days
19			
20			

21			
22	Archive Interim Care Plan	RN,EN	At 22 days
	Contact NOK/Family to discuss Care Plan – Document a Progress Note	Clinical Manager, RN, EN	At 22 days

Admission Care Workflow Short Term:

The below table sets out admission workflows for Assessment & Care Planning from day one of admission . Activities will automatically appear on work logs, with each task assigned to a responsible role/s.

Load the Resident Tab:

Day	Activity	Person/s responsible	Start Date
1	Add Resident Photo	Activities & Lifestyle, Administration, RN, EN	Immediately
	Complete Admission Progress Note	RN, EN, HCA	Immediately
	Complete Belongings List: Take photos/list of residents glasses, hearing aids, valuables and load in gallery/ complete progress note	Activities & Lifestyle, Administration, RN, EN	Immediately
	Complete Orientation Checklist – Progress Notes	RN, EN, HCA	Immediately
	Complete TRP and BP Monitoring	RN,EN	Immediately
	Weigh Resident	EN, HCA	Immediately
	Complete admission information on Resident tab include Diagnosis/Allergies/Alerts	RN, EN	Immediately
	Schedule – Daily Personal Care Chart	RN,EN	Immediately
	RN to schedule all required Charts	RN,EN	Immediately
	Print Kitchen form, from Dietary Assessment - Provide to Kitchen	RN,EN	Immediately
	Complete Bowel Chart (<i>Pre-Set – Appears each shift automatically</i>)	RN,EN, HCA	Immediately
	Pain Chart (<i>Pre-Set – Appears each shift automatically for 24hrs</i>)	RN,EN	Immediately for 24hrs
	Complete Medication Assessment & Care Plan	RN,EN	Immediately
	Complete Consent Assessment	RN,EN	Immediately
	Complete Skin Assessment & Care Plan	RN,EN	Immediately
	Complete Interim Care Plan	RN,EN	Immediately
	Complete FRAT Chart	RN,EN	Immediately
	Complete Dietary Assessment & Care Plan	RN,EN	Immediately
18	Review Assessment & Care Plans and ensure required are published	Clinical Manager, RN, EN	Immediately

On admission a workflow will appear “Complete admission information on Resident Tab include Diagnosis/Allergies/Alerts” > To complete this Activity:

Select the Resident > On the top Resident profile banner the following sub-headings will appear RESIDENT - CLINICAL- ABOUT ME- LIFE HISTORY- FINANCIAL- CONTACTS -GRAPHS - NOTES - GALLERY - OTHER



Step 1: - Select the > Resident tab in the green banner - Enter the information as requested in the fields (refer to below diagram – Usually completed by Administration/Reception).

Step 2: - Select the Clinical Tab > Enter the information as requested in the fields, ensure to complete the Medical History, Diagnosis, Allergies and Sensory details then select> UPDATE DETAILS

Step 3: - The Administrator and or Receptionist may have already added this information for you. Select the Contacts Tab > to enter a contact select the > CONTACT TYPE and then select >ADD. The option >ADD NEW CONTACT will appear, complete the fields and select > SAVE.

How to Clone a Contact:

Select the Resident > Once the Resident is selected > select the CONTACTS tab > In the Contacts Type > select the contact you wish to clone by clicking on the contact name, their contacts will display on the right side of your screen. Scroll down your screen and select the Clone option > In the Clone box select the Contact Type you wish to Clone to > select CLONE.

Step 4: - Select the Notes Tab > This is where you enter Allergies and Notes (*of importance*) to the Resident. When you enter information in the Allergies box this will trigger an ALERT for the Resident each time the Resident is selected.

You can enter and delete Allergies and Notes as you require.

How to upload/access information in the Resident Gallery:

Load into the Resident Gallery:

Select the Resident > Go to the Resident Tab > Select Gallery > Select ADD > select the correct CATEGORY > then document the SUBJECT > Select the DATE > then select FILE BROWSE > this will take you to the devices drive to access the correct file for loading, then select > UPLOAD

You can upload more than one document at a time by selecting the plus option. You can also add a note to your upload.

We recommend when selecting SUBJECT you add the date of the file being uploaded so this appears for easy reference in the Gallery.

At any time you can change the CATEGORY scanned documents are residing in by selecting the document with a tick > then select CHANGE CATEGORY > CHANGE

GALLERY [SEARCH](#) > [JOHN SMITH](#) > GALLERY

Supported file: xls,xlsx, doc, docx, pdf, mpg, mpeg, avi, wmv, jpeg, jpg, jpg

Category:

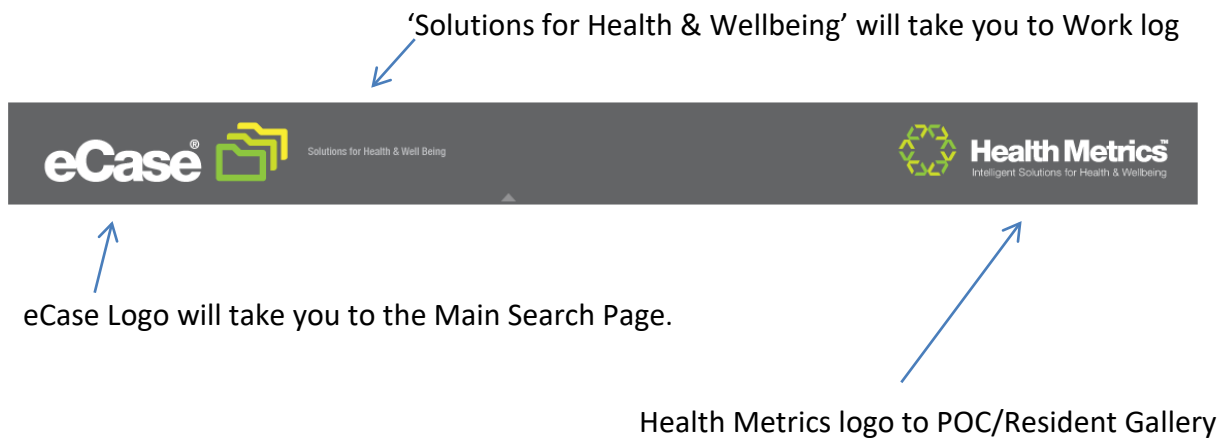
SUBJECT	NOTES	DATE	FILE	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="Browse..."/>	X
				+

Access information scanned in the Resident Gallery:

Select the Resident > Go to the Resident Tab > Select Gallery > Scroll down the CATEGORYS to the scanned document you wish to view > then select the blue arrow > the document will load to view via PDF Format. Once you have completed viewing the document select the X button on the top right corner of the page. Galleries will always open in PDF format.

Hot Keys:

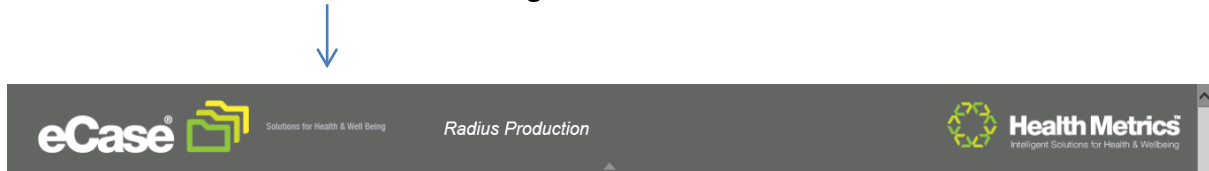
No matter where you are in eCase, the Hot Keys are a quick way to return to the Main Search Page/ Work log/ or List/Gallery of Residents.



How to access/filter/complete - Work log:

Access:

Select > Solutions for Health & Wellbeing



Filter:

Select > EXPAND > select the correct fields by filtering by DATE FORM> DATE TO > FACILITY > WING > ROLE > SHIFT > then select REFRESH – your Work log will appear to your filtered fields.

When filtering you can select previous and future dates, you can filter by resident to only view an individual residents profile and filter by status for task management.

When filtering to view a Work log it is important to ensure the filter status is ticked for NOT DOING/NOT STARTED/ IN PROGRESS - You can select COMPLETED to view work logs which are already marked complete.

Date From: 19 Apr 2017
 Date To: 19 Apr 2017
 Facility: RADIUS TRAINING
 Wing: All Wings
 Bed Group: All Bed Groups












Role: All Roles
 Activity: All Activities
 Wait List Residents?: No Yes
 Status: Not Doing Not Started In Progress Completed
 Shifts: 1

Resident First Name: _____
 Resident Last Name: _____

Correctly Mark Complete:

When accessing the Work log to document task completion > filter to the correct fields > then select REFRESH > Resident Work logs will appear to your filter divided by date and shift timeline.

19 Apr 2017 07:00 - 15:00

RESIDENT	ACTIVITY	STATUS	NOTES	TIME	ROLES	FORM	CONTACTS	CHART	REGISTER	ASSESS.	CARE PLAN	GENERIC ATTACH.	ATTACH.
	• Complex health procedures : Food and Fluid record	Not Started		14:00	EN, HCA, RN								
	• Complex health procedures : BGL management	Not Started		07:00	EN, RN								
	• Care activity : Apply Hearing aid	Not Started		07:00	HCA								

In the Resident profile on the Work log, select the ACTIVITY you wish to document by clicking on the associated CHART > a CHART link will appear opening the CHART. To document on the CHART complete the fields then select > SAVE.

eCase automatically is programmed under the log in to sign the CHART by Author & Role.

You can document on more than one chart by selecting the plus sign. **When logging a time > document the time you completed the procedure for the Resident.**

[Expand All](#) [Collapse All](#)

DATE	TIME	HYGIENE	COMMENTS	AUTHOR	ROLE	
	HH:MM	 Hygiene	<div style="border: 1px solid #ccc; height: 40px;"></div>	1r	RN	X
						+

[Expand All](#) [Collapse All](#)

Once selecting SAVE > the screen will link to a checklist > ACTIVITIES WHICH MAY NEED TO BE CLOSED > Select the CHECK ALL then select > SAVE - **this will automatically mark the activity as Complete and remove from the Work log.**

Chart(s) has been successfully Saved.

ACTIVITIES WHICH MAY NEED TO BE CLOSED					
ACTIVITY	FORM	REGISTER	DATE	START TIME	COMPLETE CURRENT
Personal Hygiene - Shower resident			19 Apr 2017	08:00	CHECK ALL <input checked="" type="checkbox"/>

Save

Back to Chart

Alternatively you can go back to the Work log > input a task completion time > select status MARK COMPLETE then select > SAVE. This will then refresh and the activity will no longer display on the Work log.

NOT STARTED will automatically default in the status on the Work log you can move the status to IN PROGRESS/ COMPLETED or NOT DOING at any time– when selecting NOT DOING a notes link will appear requesting a reasoning for the status request then select > SAVE .

You will work off your Work log for your entire rostered shift, by shift completion activities will be moved in status so no outstanding tasks remain for completion. It is important tasks are moved in status to their charted time frames as reflected on the Work log.

Work Log Management – Night Shift/ Shift 3:

When logging eCase Work logs on Night Shift /Shift 3, you will filter the Work log by the current date you are rostered on shift – you will continue to work off this Work log across the shift till the shift end.

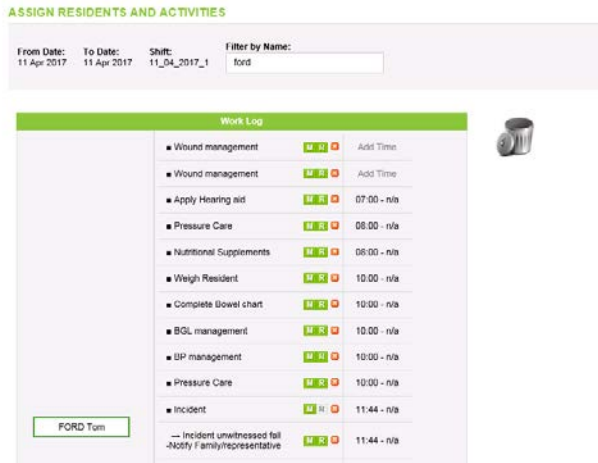
As the time on shift 3 moves into a new day 00:00hrs staff will continue to filter and work from the Work log on the day they commenced the shift, however will log in chart the new date and time they complete procedures for the Resident.

[How to edit/inactivate Work logs](#)

Work logs can be edited two ways via inactivating scheduled Charts in CHARTING (first step) and by accessing

Menu > Care > Logs > Work Log Editor

Work Log Editor can be used to inactive and edit Charts **scheduled directly off the Work log**. Once accessing Work Log Editor > complete the required fields then select > Load Calendar. Work assigned for the associated shifts will appear > select the correct time frame > then filter by name to locate your resident > select the task you wish to edit.



You can edit by using the keys M/R/X

Selecting M > refers to movement date > select update

Selecting R > refers to recursion

Selecting X > **to delete the Work log completely** (this selection will discontinue all future Work logs)

Charting:

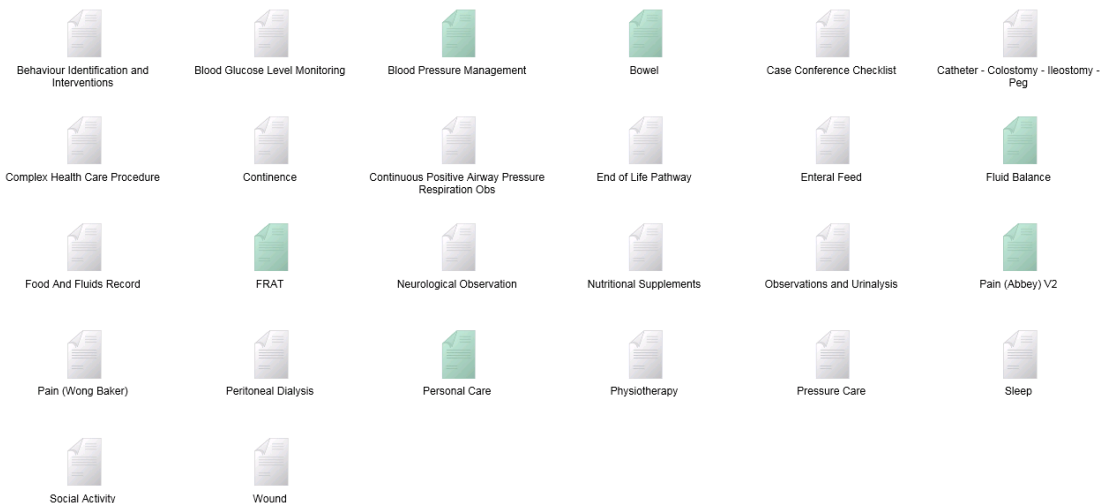
Most clinical scheduling will be completed via Charting through the relevant chart. For example Pressure Care should be scheduled via a Pressure Care Chart or Blood Pressure Collection via a Blood Pressure Management Chart.

Charting is the first point of call for creating an Activity to appear via Work log. The reason for this is charting provides a nursing directive for the Activity charted. Some activities however can only be scheduled via the Work log and do not hold a nurses directive.

We advise you review Charting for your activity prior to scheduling via the Work log.

To Activate a Chart:

Select the Resident > Scroll down to the Resident Functions Tab > select CHARTING > various charts will appear (refer to the screenshot provided).



Select the corresponding Chart you wish to activate > then select New > check the name of the procedure is correct > Input a Directive of Procedure – a Directive Date and Designation will automatically populate reflective of the user, then select > ADD ACTIVITY.

Once selecting ADD ACTIVITY > a link will appear to implement the required time directives for the Chart to trigger on a Work log. Fields need to be completed to the required monitoring needs of the Resident > then select SAVE.

Your Chart is now scheduled to trigger on the Work log for completion to your specified directives.

Active charts will be displayed in a green colour to notify you these are currently scheduled.

Select activity type: Resident Facility

Resident: Activity: Start Date: Start Shift Number: OR Start Time:

Would you like this activity to:

Occur once:

Occur every:

- Day
 - Monday
 - Tuesday
 - Wednesday
 - Thursday
 - Friday
 - Saturday
 - Sunday
- Minutes
- Hours
- Days
- Weeks
- Months

Occur:

for one day

every day for days

every day until

Indefinitely (until further notice)

Exceptions to the rule:

- Any clinical scheduling that doesn't have a specific chart can usually be located in the Complex Health Procedure Chart
- Charts that carers (HCA) can start (e.g. Behaviour Monitoring) can be scheduled from the Work log
- Any non-clinical items or those that do not have a corresponding chart and that do not require actual charting can be scheduled from Work log (e.g. Change Bed Linen)
- Most commonly used charts which are scheduled via Work log are: Weight Resident, Care Plan Review: Care Plan Evaluations 6mnlthly, Short Term Care Plan Evaluation, and Restraint/Enabler Review).

How to Inactive Charts scheduled from Charting:

Charts can be activated and inactivated as required to reflect the needs of the Resident at any time.

Select the Resident > Scroll down to the Resident Functions Tab > Select Charting > Locate the Chart you wish to Inactive by clicking on the Chart link > In the Status field select Inactive > your chart is now Inactive *(If you have scheduled additional triggers for the same task via Work log, you will need to go to Work log Editor to inactive these triggers)*

Expand				
ID	DATE OF CREATION	AUTHOR	CHARTS	STATUS
1035	30 Mar 2017	lpapettas	View Chart	<input checked="" type="radio"/> Active <input type="radio"/> Inactive

New Cancel



The history and documentation of an inactivated Chart will remain visible when the Chart is selected.

Inactivated Charts can be hidden by selecting EXPAND > Tick HIDE INACTIVE CHARTS so they are not viewed as new Charts are triggered.

How to Document/Manage a Progress Note:

A Progress Note is the first point of call for all documentation, as Progress Note types can trigger clinical work flow which will appear on the Work log.

Document a Progress Note:

Select the Resident > Scroll down the screen to the Function Tab select > Prog. Notes > select ADD > in the filter PROGRESS NOTE TYPES > select the type of Progress Note you wish to document > this will appear in the Subject Field > document your Progress Note > then select SHOW ACTIVITIES, this will trigger follow-up tasks on the Work log (*If indicated*) > then select SAVE.

Author: radius16
19 Apr 2017 11:30 PM

Filter Progress Notes Type
falls

Subject
Fall

Notes

Expand All Collapse All
Select Progress Notes Type

- Incident
- Fall
- Fall-unwitnessed
- Post fall review
- RN Review
- Post Fall review

Show activities

Activity	Days till start	Time	Shift 1	Shift 2	Shift 3	Create?
Incident fall- complete incident log	0	23:30	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Incident Fall -review FRAT	0	23:30	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Incident fall - review pain	0	23:30	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Incident fall - notify Dr	0	23:30	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Incident fall - notify family/representative	0	23:30	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Incident fall - Physiotherapy review	0	23:30	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
RN to review resident post incident	0	23:30	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3 day Post fall review	3	0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Save Cancel

NB: You must have a subject heading for the Progress Note to SAVE correctly; you can also select more than one subject heading at a time.

View Progress Note:

To view an individual Progress Note > Select the Progress Note > then select VIEW.

You can view ALL documented Progress Notes by selecting > Print All > a pop-up link will appear on your screen > select OPEN > this will open a printable PDF of documented Progress Notes – You do not need to print.

Remove Progress Note:

You can remove a Progress Note documented in error. Select the Progress Note you wish to remove > select REMOVE > Give a reason for removing then select > SUBMIT.

You can only remove Progress Notes which you have created under your user profile.

Send Message Progress Note via MB:

Progress Notes can be linked as a message (MB) to any user. To send a Progress Note Message > select the Progress Note > select SEND MESSAGE > Message Board (MB) will appear with a link pre-set in the message field > complete the fields > future date and the role/individual the message is to be sent to then select > SEND.

ID	DATE	SUBJECT	REASON FOR REMOVAL	AUTHOR	ROLE	ATTACHMENT	SELECT
1026	11 Apr 2017 11:44 AM	Fall-unwitnessed	wrong entry	radius11	RN		<input type="radio"/>
1010	10 Apr 2017 02:59 PM	Verbal-aggression (non-dementia)	wrong resident	radius6	HCA		<input type="radio"/>
1007	10 Apr 2017 02:57 PM	Nutrition, Personal Hygiene, Toilet		radius6	HCA		<input type="radio"/>
967	31 Mar 2017 11:14 AM	Verbal-aggression (non-dementia)	wrong resident	radius10	HCA		<input type="radio"/>
958	31 Mar 2017 11:07 AM	Nutrition, Personal Hygiene, Toilet		radius10	HCA		<input type="radio"/>
905	30 Mar 2017 11:12 AM	Nutrition, Mobility/transfers, Personal Hygiene, Toilet, Continence,		radius9	HCA		<input type="radio"/>
725	21 Mar 2017 03:31 PM	Verbal-aggression (non-dementia)	wrong resident	radius1	HCA		<input type="radio"/>
718	21 Mar 2017 03:20 PM	Fall-unwitnessed		radius1	HCA		<input type="radio"/>

Filter your Progress Notes to locate by Subject/User:

You can filter documented Progress Notes to locate specific documentation; this is helpful to isolate only Dr Prog. Notes/ Clinical Manager Prog. Notes

Select the Resident > Scroll down to the Functions Tab > Select Prog.Notes > Select EXPAND > Complete the filter fields > usually the Subject or User option is the best fields to complete (i.e. in the Subject field select Dr/Consultation for Dr Prog.Notes) > then select REFRESH.

MENU PROGRESS NOTES

From Date: To Date:
 Staff: Status:
 Activity (Subject):

ID	DATE	SUBJECT	REASON FOR REMOVAL	AUTHOR	ROLE	ATTACHMENT	SELECT
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Care Workflow – Reporting of Accident & Incidences:

eCase resident incident management is initiated from a logged Progress Note. The table below outlines Progress Note and incident type workflows which will automatically appear on the Work log with each task assigned to a responsible role/s.

<i>Incident Type</i>	<i>Workflow</i>	<i>Person/s Responsible</i>	<i>Start Date</i>	
<i>Fall</i>	RN to review resident post incident	RN,EN	Immediately	
	Notify Senior Role on Duty	RN,EN	Immediately	
	Notify Family/Representative	RN,EN	Immediately	
	Notify Dr	RN,EN	Immediately	
	Complete Incident Register	RN,EN	Immediately	
	Consider observation chart for 24hrs	RN,EN	Immediately	
	Consider neurological observation chart hourly for first 4 hours	RN,EN	Immediately	
	Consider neurological observation chart 4 hourly for next 48hrs	RN,EN	In 4 hours	
	Review FRAT Chart	RN,EN	Immediately	
	Review Pain Assessment	RN,EN	Immediately	
	Physiotherapy Review	RN,EN	Immediately	
	Review Mobility & Transfers Assessment & Care Plan	RN,EN	Immediately	
	3 Day post fall review	RN,EN	At 3 days	
<i>Fall – unwitnessed</i>	As above for Fall	RN,EN	Immediately	
<i>Fall – Head Injury</i>	As above for Fall	RN,EN	Immediately	
<i>Incident – Death of a Resident</i>	Notify Facility Manager	RN,EN	Immediately	
	Notify Family/Representative	RN,EN	Immediately	
	Notify GP	RN,EN	Immediately	
	Notify Funeral Director	RN,EN	Immediately	
	Notify Pharmacy	RN,EN	Immediately	
	Complete Medical Death Certificate	GP	Immediately	
	Complete Registered Nurse Verification of Death (If Applicable)	Clinical Manager, RN	Immediately	
	Complete Cremation Regulations: Certificate Medical Practitioner (If Required)	GP	Immediately	
	Notify MOH, WINZ and NASC	Administrator	Immediately	
	Complete ADF96 Form (If the resident is hospital level of care)	Clinical Manager, RN,EN	Immediately	

<i>Absconding</i>	RN review resident post incident	RN,EN	Immediately
	Notify Facility Manager	RN,EN	Immediately
	Notify Family/Representative	RN,EN	Immediately
	Notify GP (If Applicable)	RN,EN	Immediately
	No Police Involvement - Complete Register	RN,EN	Immediately
	Complete Incident Register	RN,EN	Immediately
	Police Involvement - Complete Mandatory Reporting	FM, Clinical Manager	Immediately
	Complete Mandatory Reporting Register	FM, Clinical Manager	Immediately
	Commence Behaviour Chart	RN,EN	
<i>Wandering</i>	Notify Senior Role on Duty	RN,EN	Immediately
	Notify Family/Representative	RN,EN	Immediately
	Complete Incident Register	RN,EN	Immediately
	Commence Behaviour Chart	RN,EN	Immediately
<i>Injury - Known origin/cause</i>	RN review resident post incident	RN,EN	Immediately
	Notify Senior Role on Duty	RN,EN	Immediately
	Notify Family/Representative	RN,EN	Immediately
	Notify Dr (If Applicable)	RN,EN	Immediately
	Commence Pain Chart (If Indicated)	RN,EN	Immediately
	Complete Incident Register	RN,EN	Immediately
	Commence Wound Chart (If indicated)	RN,EN	Immediately
	Complete Neurological Observations (if indicated)	RN,EN	Immediately
<i>Injury - Unknown origin/cause</i>	As per Injury – Known Origin/Cause	RN,EN	Immediately
<i>Injury - Pressure Area</i>	Notify Senior Role on Duty		
	Notify Family/Representative	RN,EN	Immediately
	Notify GP	RN,EN	Immediately
	Complete Wounds Tracking Register & Implement Wound Chart	RN,EN	Immediately
	Update Pressure Injury Assessment & Care Plan	RN,EN	Immediately
	Update Skin Assessment & Care Plan	RN,EN	Immediately
	Complete Section 31 Notification (If required)	Clinical Manager, RN	Immediately

<i>Incident – Medication</i>	RN review resident post incident	RN,EN	Immediately
	Notify Senior Role on Duty	RN,EN	Immediately
	Notify Clinical Manager	RN,EN	Immediately
	Notify GP	RN,EN	Immediately
	Notify Family/Representative	RN,EN	Immediately
	Complete Observations and Urinalysis Chart (minimum of 4hrs)	RN,EN	Immediately
	Complete Med Incident Register	RN,EN	Immediately
<i>Incident – Choking</i>	Notify Senior Role on Duty	RN,EN	Immediately
	Notify Family/Representative	RN,EN	Immediately
	Notify GP (If Applicable)	RN,EN	Immediately
	Complete Incident Register	RN,EN	Immediately
	Update Swallowing Assessment & Care Plan	RN,EN	Immediately
<i>Incident – Sexual Assault</i>	RN review resident post incident	RN,EN	Immediately
	Notify Facility Manager	RN,EN	Immediately
	Notify Family/Representative	RN,EN	Immediately
	Notify GP	RN,EN	Immediately
	Complete Mandatory Reporting Register	FM, Clinical Manager, RN	Immediately
	Commence Behaviour Monitoring Chart	RN,EN	Immediately
<i>Incident – Verbal Aggression</i>	As above Incident – Sexual Assault	RN,EN	Immediately
<i>Incident – Physical Assault</i>	As above Incident – Sexual Assault	RN,EN	Immediately
<i>Incident – Physical Aggression</i>	As above Incident – Sexual Assault	RN,EN	Immediately
<i>Incident – Physical Aggression</i>	As above Incident – Sexual Assault	RN,EN	Immediately
<i>Incident – Security Breach</i>	Notify Senior Role on Duty and complete follow-up tasks as directed	RN,EN	Immediately
	Notify Facility Manager and complete	RN,EN	Immediately

	follow-up tasks as directed		
	Notify Family/Representative	RN,EN	Immediately
	Complete Incident Register	RN,EN	Immediately

How to document a Resident Incident Via Register:

In eCase a Resident incident is logged via Register. A Progress Note is the first point of call for all documentation regarding Resident incidences. When a Progress Note incidence is logged this will trigger a Register workflow to be completed on the Work log when Show Activities is ticked (*Requirement*)

From Work log select the Register link – this will automatically take you to the Resident Incident Register, if your incident is Weight/Wound/Mandatory/Infection or Med related, in the Resident Functions tab you can select > REGISTERS > then select the correct REGISTER > then select ADD

Alternatively an incident Register can be opened at anytime to report Resident incidences –

Go to the Resident Function Tab > select REGISTERS > Select the correct REGISTER which reflects the subject you wish to document.



Open the REGISTER > Complete the required fields (*ensure Contributing Factors/Actions/Injury Information areas are complete*) > select SAVE. Once you have documented on the Register an automatic alert will be sent to your Manager to complete a Managers follow- up review.

Assessment & Care Planning Process:

As indicated above Assessment and Care Plan workflows will be triggered on admission. It is expected you will work off your work log and MARK COMPLETE Assessments & Care Plan reviews as they appear. As part of the admission process complete Assessment & Care

Plans will appear on the Work log, these are pre-set to appear on alternate days from Day 1 of admission – If you complete each Assessment and the associated Care Plan and Publish the Care Plan as per the Work log admission process, all mandatory Assessment & Care Plans will be finalised at Day 22 of admission.

Complete an Assessment/Care Plan:

Select the Resident > Scroll down to the Resident Functions tab > Select Assessments > Select New > all available assessments will appear in the link provided.

These are:

END OF LIFE



ADL



SENSORY/COMMUNICATION



BEHAVIOURS



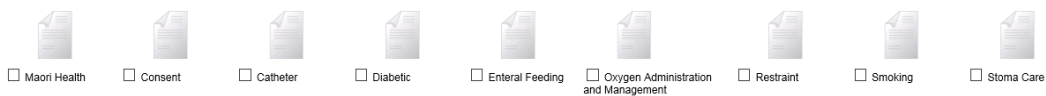
COMPLEX HEALTH MANDATORY



COMPLEX HEALTH CARE - ADDITIONAL



OTHER



LIFE HISTORY AND LEISURE



ALLIED HEALTH



Select the Assessment you wish to complete > then select NEXT > complete the Assessment fields > then select COMPLETE WIZARD > this will take you back to the Assessment screen which will show you completed Assessment.

MENU

radius24 > ASSESSMENT

Expand

[Expand All](#) [Collapse All](#)

ID	DATE	ORIGINATOR	ASSESSMENT	CARE PLAN	
413	29 Mar 2017	radius13	ADL	ADL	<input type="radio"/>
448	11 Apr 2017	radius21	ADL	ADL	<input type="radio"/>
457	11 Apr 2017	radius21	ADL	ADL	<input type="radio"/>
458	11 Apr 2017	radius21	ADL	ADL	<input type="radio"/>
459	11 Apr 2017	radius21	Complex Health Care	Complex Health Care	<input type="radio"/>
461	12 Apr 2017	radius24	End of life	End of life	<input type="radio"/>
462	12 Apr 2017	radius24	End of life	End of life	<input type="radio"/>

[Expand All](#) [Collapse All](#)

You then need to complete the associated Care Plan to the Assessment you have just completed (*as demonstrated in the above screen*) > select the Care Plan option across from the Assessment you have just completed > this will open the associated Care Plan.

The Care Plan is broken into 3 sections:

1. Assessment
2. Care Plan Goals/Aims
3. Care Plan Strategies.

Complete the Goals/Aim and the Care Plan Strategy fields by selecting the EDIT buttons then select > BACK TO ASSESSMENT.

You have now completed the Assessment & associated Care Plan to the Assessment

ASSESSMENT/CAREPLAN INDIVIDUAL NEEDS AND CHOICES	ASSESSMENT/CAREPLAN GOALS/AIMS	ASSESSMENT/CAREPLAN STRATEGIES
<p>Physical Deficits</p> <p>Unsteady hands or fingers</p> <p>Safety risk (falls)</p> <p>Cognitive Deficits</p> <p>Refused to attend to personal hygiene</p> <p>Further Information</p> <p>Resistive to cares. Especially when scheduled to have a shower.</p> <p>The above identified factors affect me in the following ways:- (Eg. I cannot be left alone in the bathroom as I may fall)</p> <p>Needs to be assisted. High risk for falls.</p>	<p>To provide best practice care outcomes appropriate for my care needs and preferences.</p> <p>Showering/Bathing/Washing <small>last edited by 2r on 11 Apr 2017 02:10 PM</small></p> <p>The resident will achieve hygiene and be dressed and groomed in accordance with their needs / preferences</p>	<p>I require the following support and assistance for Personal Hygiene</p> <p>Staff <small>last edited by 1r on 29 Mar 2017 09:13 AM</small></p> <p>No of staff required: 2</p> <p>Comments: High risk for falls and is resistive with his cares.</p> <p>Hygiene Preference <small>last edited by 1r on 29 Mar 2017 09:14 AM</small></p> <p>Shower</p> <p>How do I transfer in and out of shower? Needs to be assisted by 2 staff members, high risk for falls.</p> <p>Frequency of Hygiene <small>last edited by 1r on 29 Mar 2017 09:15 AM</small></p> <p>2nd daily</p> <p>Preferred time: 09:00</p> <p>Comments: Wants to be showered in the morning, preferably at 0900.</p>

Once you have selected > BACK TO ASSESSMENT you need to Publish your Care Plan.

Publish the Care Plan:

In the Assessment field > Select the Care Plan you wish to Publish by the selecting the Care Plan with a tick > the Publish Care Plan option will appear Green > now select Publish Care Plan

[Expand](#)

ID	DATE	ORIGINATOR	ASSESSMENT	CARE PLAN
843	31 Oct 2017	truss	<input type="checkbox"/> ADL Swallowing Difficulties	<input checked="" type="checkbox"/> ADL Swallowing Difficulties Care Plan

[Expand All](#) [Collapse All](#)

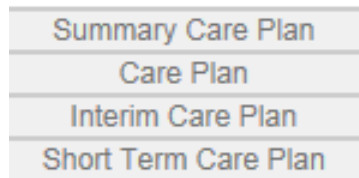
[New](#) [Publish Care Plan](#) [Delete Manager](#) [Cancel](#)

Key Notes:

- Assessments will appear green in colouration if they are published.
- All assessments other than 'About Me' and 'Life History' have an associated Care Plan
- When completing assessments it is recommended the associated Care Plan is completed at the same time and published to finalise the process, alternatively you can go back and finalise at a later date.
- Enrolled Nurses can document Assessments and Care Plans and have a Registered Nurse publish to support countersigning of their Assessment and Care Plan process.
- Once you have selected the Assessment via the New field this Assessment will be reflected in the Assessment field even if you do not complete the Care Plan associated.
- Assessments can be deleted via your Managers access only.

Care Planning:

To access Care Plan options go to the Select the Resident > Scroll down to the Resident Function Tab > select CARE PLAN > the options SUMMARY CARE PLAN/CARE PLAN/INTERIUM CARE PLAN/SHORT TERM CARE PLAN will appear.




Summary Care Plan:


The Summary Care Plan is a summarised version of all published Care Plans, this option can be selected and a pop-up link will appear > select OPEN.



The Summary Care Plan can be printed for client/family representative if required; alternatively the Summary Care Plan provides information to assist staff to manage the needs of the Resident in brief.

Care Plan:

To access/view Published Care Plans > Select the Resident > Scroll down to the Resident Functions Tab > select Care Plan > then select Care Plan > all published Care Plans will appear in the field provided, you can view the Care Plan (*green*) by selecting the Care Plan you wish to open.

MENU  [RESIDENT](#) > [CARE PLAN](#)

 Expand

PUBLISHED ON	CARE PLAN	LAST UPDATED BY	LAST UPDATED ON	STATUS	PUBLISHED BY	LAST REVIEW DATE/TIME	REVIEW HISTORY	NOTES	LAST REVIEWER	
29 Mar 2017 09:19 AM	Personal Hygiene	2r	11 Apr 2017 03:56 PM	Active	1r (RN)	11 Apr 2017 02:16 PM			2r (RN)	<input type="radio"/>
11 Apr 2017 02:05 PM	Dietary	2r	11 Apr 2017 03:56 PM	Under Review	2r (RN)	11 Apr 2017 02:16 PM			2r (RN)	<input type="radio"/>

[Change Status](#) [Fast Edit](#) [CP Evaluation](#) [Cancel](#)



When accessing the Care Plan for editing and review options, eCase has two selection buttons:

1. FAST EDIT
2. CP EVALUATION

Fast Edit:

To Fast Edit a Care Plan select the Care Plan you wish to edit by using the radio button on the right then select > FAST EDIT > select the + option > then select EDIT to make your changes.

Once you have made your changes select > SAVE. You can Fast Edit at any time you wish to ensure your Care Plans remain current to the treatment needs of your Resident.

CP Evaluation:

You can evaluate an Individual Published Care Plan or all Published Care Plans.

Individual: In the Resident Care Plan > select the Care Plan you wish to complete a CP Evaluation for by using the radio button > then select CP Evaluation.

Review all Care Plans: In the Resident Care Plan > select CP Evaluation > all Care Plans will appear for review.

Completing CP Evaluations: Select the radio buttons to the questions provided, you need to open up the Notes field (*left of screen*) to document your review discussions.

Each Note field documented will have a review date in the CP Evaluation evidenced; this is also reflected on the Care Plan screen next to the associated Care Plan.

<p>Dietary</p> <p>Notes</p> <p>25 Sep 2017 11:08 AM</p>	<p>Physical Deficits</p> <p>Unsteady hands or fingers Poor coordination Weak grip of utensils</p> <p>Cognitive Deficits</p> <p>Confused to time and place (does not identify meal times)</p> <p>Allergies</p> <p>Yes Tramadol</p> <p>Special Diet Type / Awareness of Diet</p> <p>Salt-reduced</p> <p>Sensory Dislikes</p> <p>Spicy</p> <p>Preferences</p> <p>Beverages White tea Sugar 2.0 units Milo Breakfast Weetbix/vitabix Toast B Marmalade Fruit Dinner Main Sandwiches</p>	<p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p>	<p>Eating</p> <p>The resident will maintain a healthy weight by continuing to consume food and fluids as provided</p> <p>The resident is being monitored and assisted to gain weight</p> <p>Indicate special needs (palliative)</p> <p>The resident is being monitored for any further weight gains</p> <p>The resident is being monitored for any further weight loss</p> <p>To maintain a stable weight</p> <p>Personal Goals</p> <p>gain weight in 1 month</p>	<p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p>	<p>Staff</p> <p>No of staff required: 1</p> <p>Eating: Physical Assistance</p> <p>During eating, requires 1:1 physical assistance for most or all of the meal</p> <p>Special Textures</p> <p>Special textures required: Yes Texture C - pureed</p> <p>Safety & Equipment</p> <p>Unsafe to manage Food</p> <p>Nutritional Supplements</p> <p>ID: Name of supplement: fortisp Dose: 200 mis at lunch</p> <p>Meal Size</p> <p>Small</p> <p>Dietician</p> <p>Is a dietician required? No</p> <p>Meal Appetite</p> <p>Poor</p> <p>Personal Strategies</p> <p>monitor daily food intake</p>	<p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> No <input type="radio"/></p>	<table border="1"> <tr><td>P</td><td>G</td><td>B</td><td>I</td></tr> <tr><td>WR</td><td>S</td><td>M</td><td>C</td></tr> <tr><td>IR</td><td>IC</td><td>AC</td><td>PC</td></tr> <tr><td>.</td><td>.</td><td>.</td><td>.</td></tr> </table>	P	G	B	I	WR	S	M	C	IR	IC	AC	PC
P	G	B	I																				
WR	S	M	C																				
IR	IC	AC	PC																				
.	.	.	.																				
<p>Mobility and Transfers</p>	<p>Resident's Balance</p> <p>Arm/Leg Stiffness</p>	<p>Yes <input type="radio"/> No <input type="radio"/></p>	<p>Transfers: Supervision</p> <p>Locking wheels on wheel chairs</p>	<p>Yes <input type="radio"/> No <input type="radio"/></p>	<table border="1"> <tr><td>P</td><td>G</td><td>B</td><td>I</td></tr> <tr><td>WR</td><td>S</td><td>M</td><td>C</td></tr> <tr><td>IR</td><td>IC</td><td>AC</td><td>PC</td></tr> <tr><td>.</td><td>.</td><td>.</td><td>.</td></tr> </table>	P	G	B	I	WR	S	M	C	IR	IC	AC	PC		
P	G	B	I																				
WR	S	M	C																				
IR	IC	AC	PC																				
.	.	.	.																				

On the (*right of screen*) you will see a box with letters attached; these reflect the individual Residents Prog.Notes, Registers etc. to assist you in completing your evaluations.

Once you get to the bottom of the CP Evaluation select > SAVE

As CP Evaluations are completed you will be able to see a Review History and Notes History to the associated Care Plan.

All Care Plans need to have a Status of ACTIVE > If any state Under Review a difference in Assessment has been identified in the CP Evaluation where a review of the Assessment needs to occur. When referring back to Assessment data fields will hold previous documentation completed in the Assessment > make the required changes.

MENU BATES > CARE PLAN

Expand

PUBLISHED ON	CARE PLAN	LAST UPDATED BY	LAST UPDATED ON	STATUS	PUBLISHED BY	LAST REVIEW DATE/TIME	REVIEW HISTORY	NOTES	LAST REVIEWER
23 Mar 2017 12:30 PM	Continence			Active	2r (RN)				
23 Mar 2017 12:30 PM	Mini Nutritional Assessment			Active	2r (RN)				
29 Mar 2017 01:50 PM	Dietary	2r	25 Sep 2017 11:08 AM	Under Review	1r (RN)	06 Apr 2017 08:40 AM			2r (RN)
29 Mar 2017 02:11 PM	Mobility and Transfers	2r	05 Sep 2017 02:05 PM	Under Review	1r (RN)	11 Apr 2017 07:20 PM			2r (RN)
06 Apr 2017 08:39 AM	Pain (Abbey)	2r	23 Mar 2017 02:27 PM	Active	2r (RN)	06 Apr 2017 08:40 AM			2r (RN)
26 Apr 2017 01:57 PM	Leisure	2r	26 Apr 2017 03:56 PM	Active	2r (RN)				

Change Status Fast Edit CP Evaluation Cancel

Interim Care Plan:

The Interim Care Plan will appear as a pre-set Admission Task from Day 1 of admission. The Interim Care Plan needs to be MARKED COMPLETE and remain active while Long Term Assessment & Care Plans are being completed and published in the system.

A Work log will appear at Day 22 set from Admission Tasks stating “Archive Interim Care Plan” > you will need to archive the Interim Care Plan and MARK COMPLETE on the Work log. The Long Term Care Plan needs to be fully implemented before inactivating the Interim Care Plan.

Inactivated Interim Care plan can be viewed at any time.

Short Term Care Plan:

Select the Resident > Scroll down the screen to the Resident Function tab > select Care Plan > then select Short Term Care Plan > select ADD NEW > complete the requested fields and document in the evaluation then select > SAVE.

When activating a Short Term Care Plan you need to schedule the Short Term Care Plan to appear on the Work log for Evaluation, to do this go to the Work log > select Add Activity > select > Care Plan Review: Short Term Care Plan Complete Evaluation .

To Evaluate the Short Term Care Plan: Go to the Short Term Care Plan and open up the evaluation field > fill in the contents > select SAVE.

[How to complete a handover, using eCase?](#)

When completing handover it is recommended you use the following tools:

- 1) Handover Report
- 2) Work log
- 3) Activity Viewer

Handover Report:

To access Handover Report go to > Menu > Reports > Clinical > Handover Sheet > Complete the required fields; you can select to include Resident Notes and Progress Notes in your report.

Handover Report can be used in support of shift handover and can enable you to access and read the latest Notes & Progress Notes for your Residents.

During shift handover and on commencement of your shift, review the previous shift Work log and Activity Viewer to identify any outstanding tasks requiring completion.

[How to use Activity Viewer?](#)

Activity Viewer is an operational tool to support the viewing of activity status through the shift and on shift end. It is the RN/EN and unit manager's responsibility to make sure all tasks and or activities are marked complete at the end of the shift or are handed over for completion to the oncoming role responsible.

It is expected the role responsible should view ACTIVITY VIEWER throughout the shift and approx. 1 hour before shift end thus allowing staff time to complete any outstanding tasks.

At access go to Menu > Care > Logs > Activity Viewer

Activity Viewer will default to all incomplete tasks. The user can change the status to view task management by using the filter at the top of the screen.

Resident First Name: Resident Last Name: Activity: Staff: Facility:

Wing: Bed Group: Status: Not Doing Not Started In Progress Completed

Start Date: End Date:

When viewing Activity Viewer dependant on your status selection the system will show where the task is marked this will be shown as COMPLETE, IN PROGRESS, NOT STARTED or NOT DOING. If staff have marked the task as complete, in progress or not doing their signature sign off will be visible in the viewer field.

Resident First Name: Resident Last Name: Activity: Staff: Facility:

Wing: Bed Group: Status: Not Doing Not Started In Progress Completed

Start Date: End Date:

DATE	SHIFT	START TIME	RESIDENT	ACTIVITY	SOURCE	STAFF	COMPLETE	IN PROGRESS	NOT STARTED	NOT DOING	STATUS SET BY	FORM	CHART	NOTES	CARE PLAN	ATTACHMENTS
12 Apr 2017	1	Not set	Test Admission 002	Bed Linen Change	User: 1r 2017-02-21 08:00:48.000					●	23 radius - RN					
12 Apr 2017	1	Not set	Test Admission 002	Bed Linen Change	User: 1r 2017-03-29 12:51:22.000			●								
12 Apr 2017	1	Not set	Test Admission 002	Bed Linen Change	User: 1r 2017-03-29 12:52:58.000			●								
12 Apr 2017	1	Not set	Test Admission 002	Bed Linen Change	User: 1r 2017-04-11 12:25:30.000			●								
12 Apr 2017	1	Not set	Bincy Anju	Bed Linen Change	User: 1r 2017-03-29 12:51:04.000		●				24 radius - RN					
12 Apr 2017	1	Not set	Anthony bean	Publish Lifestyle plan	Movement: Admission [TranGroupCode:3]			●			23 radius - RN				Fast Edit	

Key points of Activity Viewer:

- When staff select 'Not Doing' on the Work log a note link will appear requesting a justification why this task is not being completed – this note will be available for view in Activity Viewer with a status of 'Not Doing' reflected.
- If tasks remain 'Not Started' you can click on the associated Chart or Register link in Activity Viewer this will take you to the Chart. You can then document and select > SAVE, once SAVE is selected the system will automatically go to the Work log for you to mark the task COMPLETE, then select > SAVE. When refreshing Activity Viewer the task will then appear as 'Complete'.
- You can view any activity associated with Charting or Registers from Activity Viewer.
- Facility task status is able to be viewed in Activity Viewer.
- Attachments can be linked in Activity Viewer.

- Scheduled activities/tasks are to be completed to scheduled time directives
- Managers are to view Activity Viewer throughout the day to monitor the status of activity/task management in the Facility
- Managers will access Activity Viewer minimum 24hourly to review operational status and follow-up as required.

How to check each Resident has a Progress Note:

Go to Menu > Reports > Operational > Resident without Progress Notes > select the date from and to and the facility, then > SELECT.

A report will appear for Residents who are without Progress Notes in the last 24hours.

How to print a Transfer Report:

When transferring a Resident (i.e. to hospital), the first point of call is to document a progress note, then go to Menu > Reports > Operational > Hospital Transfer > complete the filter fields > select > Print and a pop-up link will appear > select OPEN.

Information for the Transfer Report is gathered from the Resident Profile tab inclu. Clinical/Contacts/Notes tab (*ensure these are completed correctly*) along with recent Progress Note documentation. Each region has different processes for transfer reports please check with your Clinical Manager/coordinators.

What reports are available in eCase?

eCase has a reporting suite which is made up of a series of lists and other tabular data sets. All eCase reports output to either PDF or Excel, or both.

Go to Menu > Reports > you will have the following options available;

- Operational
- Analytical (*Managers Tools*)
- Clinical
- Cards

Some areas will be for Managers use only. Your Clinical Manager will be able to provide additional Reports for you including:

Your Managers have open access to generate reports; some pre-set reports will be available to you from your managers, these are:

1. **Social Activity Participation**
2. **Monthly Weight Changes**
3. **Dietary Requirements - Dietician**
4. **Drinks List**
5. **Care Plans Not Published**
6. **Care Plan Reviews**
7. **BNO for more than 3 days**
8. **BGL Out of Range**
9. **Monthly Movements**
10. **Resident Incidents**
11. **Resident Infections**
12. **Wounds Tracking**
13. **Mandatory Reporting**
14. **Allergies**
16. **Register Month end analysis**
17. **Maintenance Report**

Maintenance/House Keeping Log:

To log task for Maintenance or Housekeeping:

Go to MENU > CARE > LOGS > MAINTENANCE LOG then select > NEW > Complete the fields then select SAVE. Your LOG is now in the system.

Maintenance Log

Order Number: 000130	Date: <input type="text"/>	Type: House Keeping Maintenance	Activity: MH-000 - change light globe
Facility: RADIUS TRAINING	Wings: <input type="text"/>	All Accessible Rooms	Bed: All Accessible Beds
Resident: Select Bed	Other: <input type="text"/>	Comments: <input type="text"/>	

Save Cancel

NB: If the activity in the Maintenance Log does not directly cover what is required use the comment field to add more information to your log.

Quality:

Go to MENU > QUALITY > FOR FACILITY > NEW

To report the following:

- Health & Safety Risk/Hazard
- Resident/Relative/Visitor/Staff Comment
- Worker Accident/Incident Form (Staff, Contractors, Visitors)

Then select > FACILITY and the associated form you wish to complete.

QUALITY > FOR FACILITY > NEW

Please select a facility: All Facilities

Health and Safety Risk/Hazard

Quality Improvement Request

Resident/Relative/Visitor/Staff Comment

Worker Accident/Incident Form (Staff, Contractors, Visitors)

Cancel

NB: When completing the Health & Safety Risk/Hazard Form or Worker Accident/incident Form (Staff, Contractors, Visitors) you will get to an area in the form that specifies Facility Manager completes or Managers use only_you can then select > SAVE.

Your manager will review and be in contact with you.

For additional resources refer to your provided Health Metrics – ‘Cheat Sheet’

eCase: RN/EN Frequent Scheduling Cheat Sheet

Mandatory Charts:

Bowel Chart	Schedule off the work log > Chart Review: Complete Bowel Chart
Shower Chart	Charting > Personal Hygiene > Shower Resident (days when resident is showered) add any cream applications in the directive
Cares (Sponge Resident)	Work log > Sponge Resident (schedule for alternate to shower times too appear morning/afternoon) – The Personal Hygiene Chart will appear. Add any cream applications in the directive
Weigh Resident	Schedule off work log > Care Activity: Weight Resident (you require the Height to log your first weight)
Care Plan Review	Schedule off work log > Care Plan Review: Care Plan Evaluations 6 Monthly
BP Management	Charting > Blood Pressure Management

Additional Charts:

Hearing Aids	Charting > Complex Health Care Procedure Chart 1) Apply Hearing Aid 2) Remove Hearing Aid 3) Hearing Aid & Battery Check
Linen Change	Work log > Care Activity: Bed Linen Change
Behavior Charts	Schedule off Work log > Behavior Management: Behavior Chart Review
Comprehensive Multidisciplinary Assessment & Medical Review	Schedule off Work log > Medical: Complete Medical Review & Assessment
Short Term Care Plan Evaluation	Schedule off Work log > Care Plan Review: Short Term Care Plan Complete Evaluation
Restraint Review	Schedule off Work log > Complex Health Care Procedure: Complete 3 Monthly Restraint Review <u>or</u> Complex Health Care Procedures: Restraint Review
Enabler Review	Schedule off Work log > Complex Health Procedure: Enabler Review
Toileting Regime	Charting > Complex Health Care Procedure Chart: Care Activity: Scheduled Toileting
Check Sensor/Landing Mat	Schedule off Work log > Care Activity: Check Sensor/Landing Mat
Test Resident Urine	Schedule off Work log > Complex Health Procedures: Test Resident Urine