epicCare User Guide

Contents

1.0 Introduction to the epicCare Manual

Welcome to the epicCare 2.0 User Manual. This manual aims to prepare you to contribute effectively to the recording of care on epicCare. This is a practical manual and is built around three key questions:

- What do you need to know to record your nursing care on epicCare?
- How do you go about recording your nursing care on epicCare?
- How do you monitor and correlate the nursing care you have recorded?

To answer these questions you will:

1) Examine the context for and factors that impact on recording your care on epicCare
2) Explore the sequential steps of recording care on epicCare
3) Examine the vast areas of clinical care management that can be recorded on epicCare

The answers to these questions will have a very practical application for you.

1.1 Learning Objectives

The aim of this manual is to enable the registered nurse to develop basic skills in the use of epicCare within the context of recording a detailed level of nursing care.

On successful completion of this course, you will be able to:

1. Access and navigate safely to record care within epicCare
2. Manage the Resident Details and Clinical Record
3. Manage the recording of nursing care for residents in Daily Progress Notes
4. Conduct Assessments, create and manage Care Plans for Residents
5. Manage the recording and evaluation of clinical areas such as Wound Care, Catheter Care for Residents
6. Explain the relevance of correlating data to provide accurate up-to-date information for planning, reporting and decision making

2.0 Introduction to epicCare

In this section, we will cover accessing epicCare, logging in, logging out, managing your password and getting help.

Learners should note that if at any stage they have any questions or queries relating to either this training program or epicCare their first point of contact will be their in-house designated epicCare Facilitator.

2.1 Learning outcomes

On successful completion of this section, you will be able to:

1. Access epicCare
2. Understand your User ID, Password and Site Code
3. Login and logout of epicCare
4. Navigate epicCare using the Menu System
5. Source support with epicCare

2.2 Access to epicCare

epicCare can be access by typing the following link into your address bar in your browser:

www.epiccare.ie

There are two primary ways that you can make revisiting epicCare even simpler:

Internet Explorer:

1. Bookmark: Right click on the epicCare login page and choose 'Add To Favourites...'
2. Short Cut: Right click on the epicCare login page and choose 'Create Short Cut' on your desktop

Google Chrome:

1. Click on the options menu
2. Click More Tools
3. Click Create Application Shortcut

2.3 Your User ID

It is vital to understand that the combination of your **User ID** and **Password** are your **signature** in the world of electronic records. Therefore it is extremely important that you at all times:

1. Logout whenever you intend to leave epicCare unattended. By clicking the logout button 
2. Never allow another epicCare user or individual to record or view records under your username and password

Your epicCare Facilitator will provide you with your epicCare User ID. If you forget your User ID contact your epicCare Facilitator.

2.4 Your Site Code

Your Site Code is unique to your organisation and it is required whenever you are logging into epicCare.

Your epicCare Facilitator will provide you with your epicCare Site Code. If you forget your Site Code contact your epicCare Facilitator.

2.5 Logging In and Out of epicCare

Navigate to the epicCare login page and simply enter the combination of your User Id, Site Code and Password.

Note: Your epicCare Facilitator will provide you with a default Password, which you must change immediately. Please see section 'Your epicCare Password'

2.6 Choosing your Site/Wing/Floor

Once you have logged into epicCare, the first page you will see is the epicCare Home Page.

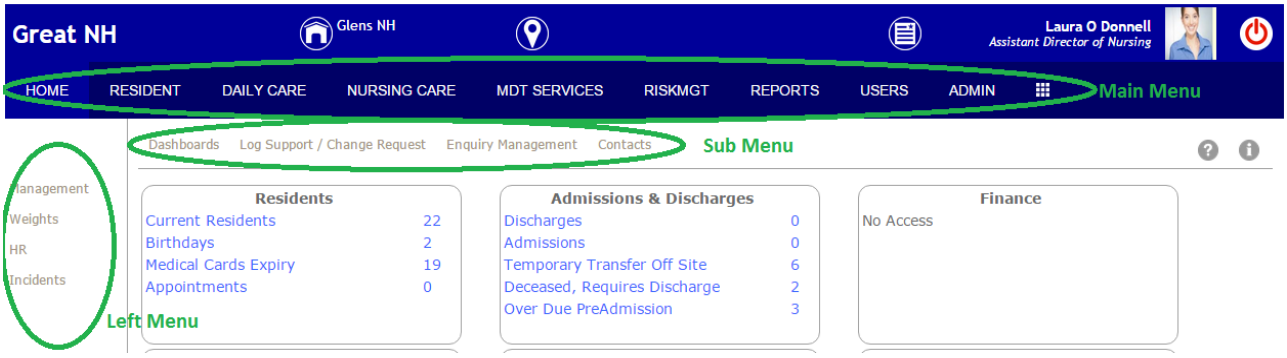
Depending on the configuration of your organisation and or permissions you may be presented with an option to choose to work on a particular site, multiple sites and or wing/floor.

Choose the site and or wing/floor that you intend to work in.

2.7 Navigating epicCare Using the Menus System

Navigating epicCare is very straight forward and the vast majority of navigation is achieved using the three main menus bars:

1. Main Menu Bar
2. Sub Menu Bar
3. Side Menu Bar

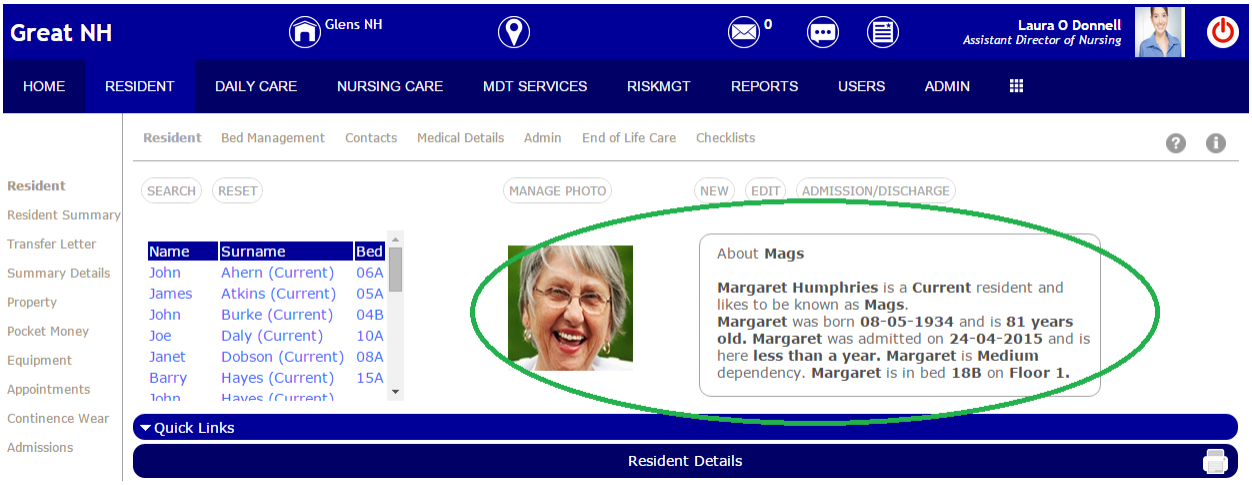


When you choose an option on the Main Menu Bar this option is then highlighted so it is very obvious which option you have chosen.

Each option on the Main Menu Bar will show a new set of relevant and appropriate options on the Sub Menu and Side Menu Bars.

Again which ever option you choose on the Sub Menu or Side Menu Bars will be highlight to make it easy to determine which options you have chosen which makes it very obvious which screen you are currently using.

2.8 Resident Bar

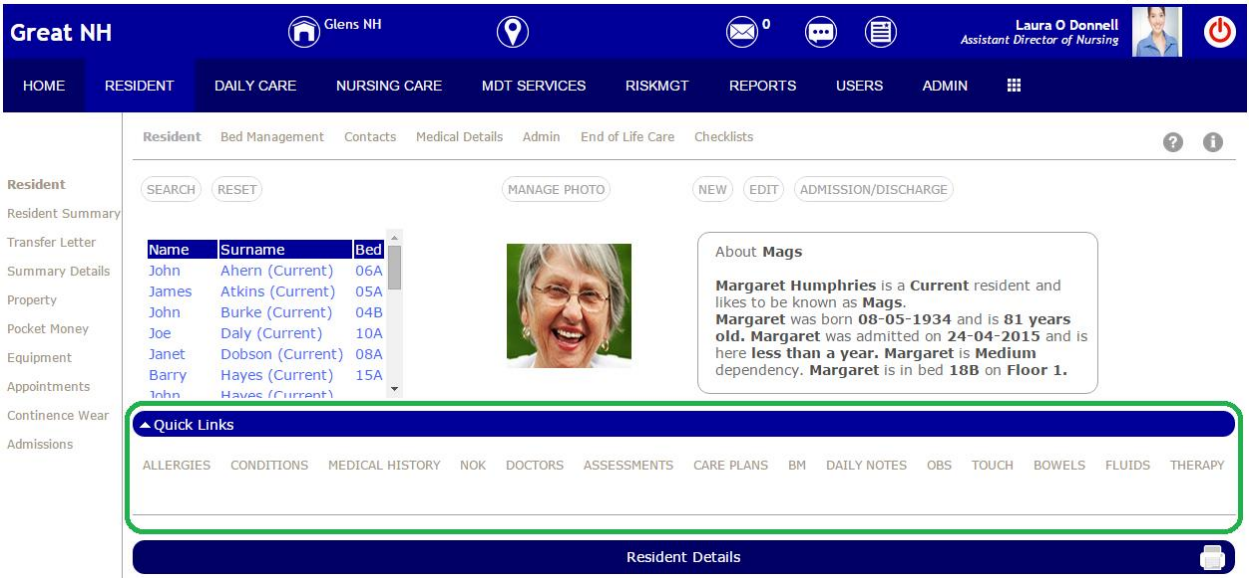


The Resident Bar is a short Biographic of the selected resident. It is designed for two reasons:

1. To clearly show which resident has been selected throughout the system in order to avoid recording notes on the incorrect resident
2. To give a short synopsis of the resident's basic information for quick reference, especially to get to know a new resident's preferred name, age and dependency level.

Throughout the Resident section, the Daily Care section and the Nursing Care section, the resident bar will always be visible. However, the photo and 'About Me' box can be minimized by simply clicking on the resident photo. This can be beneficial for example, when printing Progress Notes or a Resident Care Plan as it clearly shows which resident has been selected but does not take up too much of the page. The Resident Bar can be maximized again in the same way, by clicking on the Resident Photo.

2.9 Quick Links

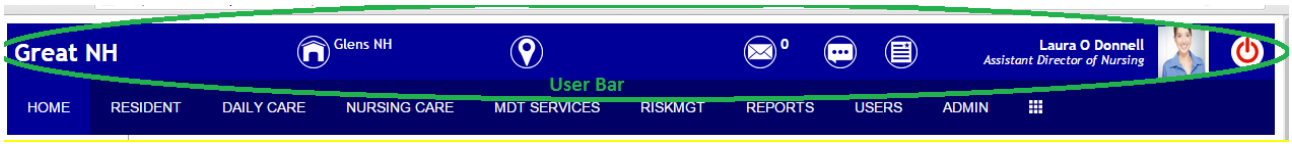


As you begin to work in the various areas of the system, the need will arise to reference particular information while carrying out a specific task or recording certain information. The new Quick Links are available from all relevant screens and are, as the name describes, a quick reference to the most pertinent Resident Information.

To Access quick links for any resident, simply click on ‘Quick Links’ and choose from the list of options displayed. You will notice that some information is blue in colour. These can be clicked to view further detail in a new Tab. Please remember to close any open additional Tabs when you are finished to avoid confusion.

To hide the Quick Links panel, simply click on ‘Quick Links’ again.

2.10 epicCare User Bar



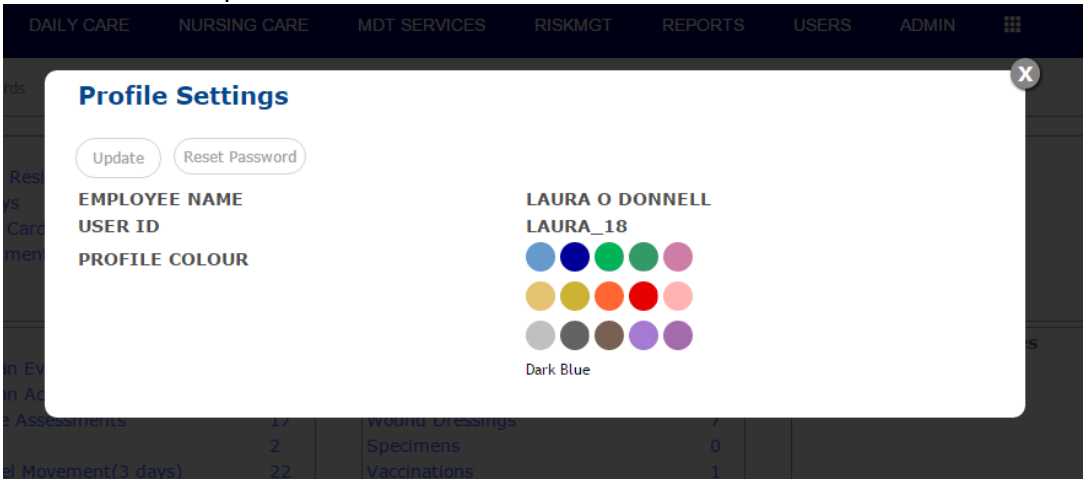
The epicCare User Bar is situated at the top of the screen immediately above the Main Menu Bar. It is designed to:

1. Make it extremely obvious who is currently logged into epicCare by displaying the Name, Job Description and Image (if uploaded) of the current user
2. Show what records you are currently accessing by displaying the Company Name, Site Name and Floor/Wing being accessed
3. Link to Reports you have added to you list of favourite reports
4. Link to your epicCare messages

2.11 epicCare User Profile

Your User Profile is accessed by simply clicking on your image on the User Bar.

The User Profile is where you will change your epicCare Password (See Section 'Your epicCare Password'). It also enables you to make simple changes to your preferences such as changing your epicCare themes. The theme you choose will be only visible to you and will not affect other epicCare users.



2.12 Your epicCare Password

As mentioned above, your password is a vital part of protecting your electronic signature.

1. Protect your password and never share it with anyone
2. Change your password immediately if you suspect that someone may know it

Your epicCare Facilitator will provide you with your default epicCare Password. You should immediately login to epicCare and change your password to something only you should know.

To reset your password click on your image on the User Bar. Choose the Password option and enter your old Password followed by your new Password and enter your new Password again in the verification area, before clicking the Save button.

If you forget your Password contact your epicCare Facilitator and they will reset it for you. If your Password has to be reset you will then have to again login to epicCare and change your Password to something only you know.

When choosing a Password it is important to ensure that it is secure and as difficult to guess as possible. Here are some guidelines to consider when choosing your password:

- Use a minimum password length of 8 characters
- Include lowercase and uppercase alphabetic characters, numbers and symbols
- Generate passwords randomly where feasible
- Avoid using the same password twice (e.g., across multiple user accounts and/or software systems)
- Avoid character repetition, keyboard patterns, dictionary words, letter or number sequences, usernames, relative or pet names, romantic links (current or past) and biographical information (e.g., ID numbers, ancestors' names or dates)
- Avoid using information that is or might become publicly associated with you or your account
- Avoid using information that your colleagues and/or acquaintances might know to be associated with you
- Do not use passwords which consist wholly of any simple combination of the aforementioned weak components

2.13 Message Board

The new Message Board is located at the top of the screen in the User Bar.

Here you will have quick access to your message inbox, sent box and to create a new message.

2.14 Contact Customer Support

Learners should note that if at any stage they have any questions or queries relating to either this training program or epicCare their first point of contact will be their in-house designated epicCare Facilitator.

If your epicCare Facilitator is unable to help they will contact epicCare support on your behalf and revert to you with a solution.

If your query is urgent and your epicCare Facilitator is unavailable you can contact epicCare support directly by:

Email: **support@epicCare.ie**

Phone: (021) 453 33 33

3.0 Home Screen

The home page on epicCare displays the most useful information relating to the various main menu items.

Within each menu box you can click on the blue text to view the textual details that the count relates to e.g. Click 'Current Residents' to view the list of current residents on the day you have logged in to epicCare.

3.1 Dashboards

Management Dashboard

1. Choose ‘Home’ from the Main Menu
2. Choose ‘Dashboards’ from the Sub Menu
3. ‘Management’ is automatically selected from the Left Menu

Types of Management Dashboards

Residents:	% Occupancy Report
	Age Profile (% Residents over 90)
Wounds:	% Residents with Wounds
	% Pressure Ulcer Prevalence
Clinical:	Dependency Level (% High or Maximum)
	Detailed Infections Report

Click on the name of the dashboard item you wish to view e.g. On the management dashboard, click '% Occupancy Report' and you will be presented with a graphical overview and/ or the textual details of this.

3.2 Weights Dashboard

1. Choose ‘Home’ from the Main Menu
2. Choose ‘Dashboards’ from the Sub Menu
3. Choose ‘Weights’ from the Left Menu
4. Select the required Time Period from the options provided (Optional)

Types of Weights Dashboards

Weights:	Detailed Weight Recording Report
Weight Changes:	Weight Change Report Detailed Weight Time Elapsed Report
BMI:	BMI Change Report

Click on the name of the dashboard item you wish to view e.g. On the weights dashboard, click 'BMI Change Report' and you will be presented with a graphical overview and/ or the textual details of this.

3.3 HR Dashboard

1. Choose ‘Home’ from the Main Menu
2. Choose ‘Dashboards’ from the Sub Menu
3. Choose ‘HR’ from the Left Menu

Types of HR Dashboards

Training:	Training Due in coming Month Annual Training Budget Amount Consumed
Attendance:	Sick in last 6 Months Late in last 6 Months
Qualifications:	Less than FETAC Level 5 Without Garda Clearance
Probation:	Appraisals Due in coming Month Ending in coming Month Disciplined in last 6 Months
Personal:	Pin No. Over Due/Due in coming Month
Review:	Less than 3 References

3.4 Incidents Dashboard

1. Choose ‘Home’ from the Main Menu
2. Choose ‘Dashboards’ from the Sub Menu
3. Choose ‘Incidents’ from the Left Menu
4. Select the required Date Range, Event and Site (Optional)

Types of Incident Dashboards

Who is involved:	Break Down of what Incidents Relate To
	Incidents specifically involving Residents
	Incidents specifically involving Employees
	Incidents specifically involving Other People
Incident Categories:	Type of Events
	Incident Locations
	Status of Incidents
	Overall View of Incidents
Incident Dates:	Age Profile of those involved in Incidents
	Incidents by Month
	Time of Day Incidents Happen

4.0 Resident

In this section, we will cover all aspects of the Resident Profile from Admission to Discharge and including management of information such as Contacts, Bed Management, Property, Appointments and other information relevant to the Resident.

Learners should note that if at any stage they have any questions or queries relating to either this training program or epicCare their first point of contact will be their in-house designated epicCare Facilitator.

4.1 Learning outcomes

On successful completion of this module, you will be able to Manage Residents':

1. Admissions & Discharges
2. Resident Profile Photo
3. Searching Resident Records
4. Resident Summary Sheet
5. Resident Transfer Letter
6. Property, Pocket Money and Equipment
7. Appointments
8. Bed Management
9. Temporary Transfer
10. Evacuations
11. Off Site Stay
12. Previous Visits
13. Contacts
14. Contract Details
15. Resident Folder and Scanning
16. End of Life Care
17. Resident Checklists

4.2 Admissions and Discharges

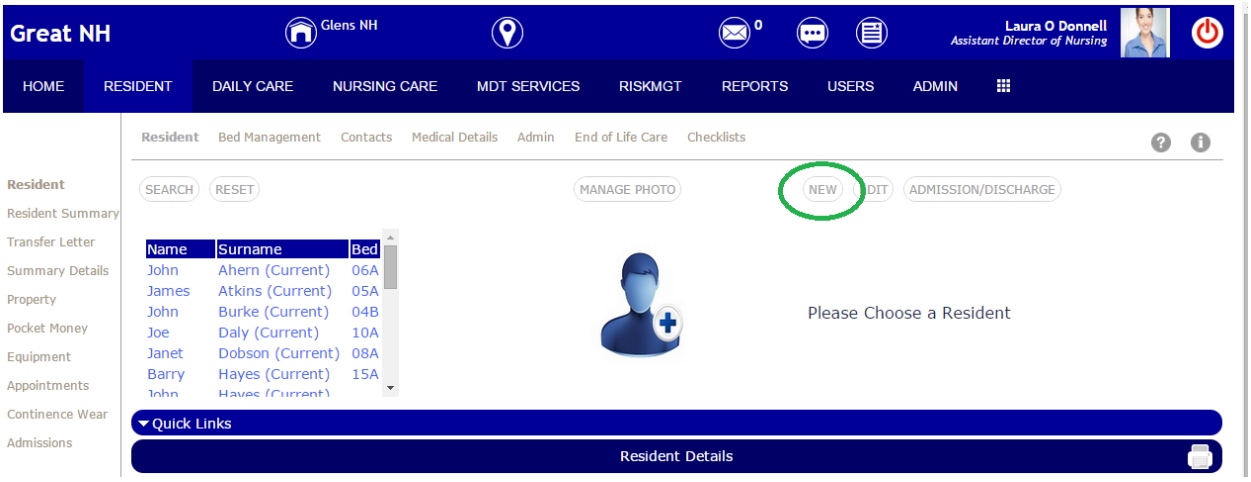
Mandatory Resident Information

Before you begin an Admission it is important to note that the following information is mandatory in order to construct a useful Resident record and should be at hand before adding a new Resident to the system:

1. First Name
2. Last Name
3. Date of Birth
4. Admission Date
5. Accommodation Status
6. Resident Term
7. Site
8. Admitted From

The process of Admitting a Resident will involve entering information for that Resident under many headings. However a basic Admission is simply recording the Mandatory Resident Information. Once you have learned to enter this basic Admission, you will be familiar with adding more information as it works in precisely the same way.

Adding a New Resident

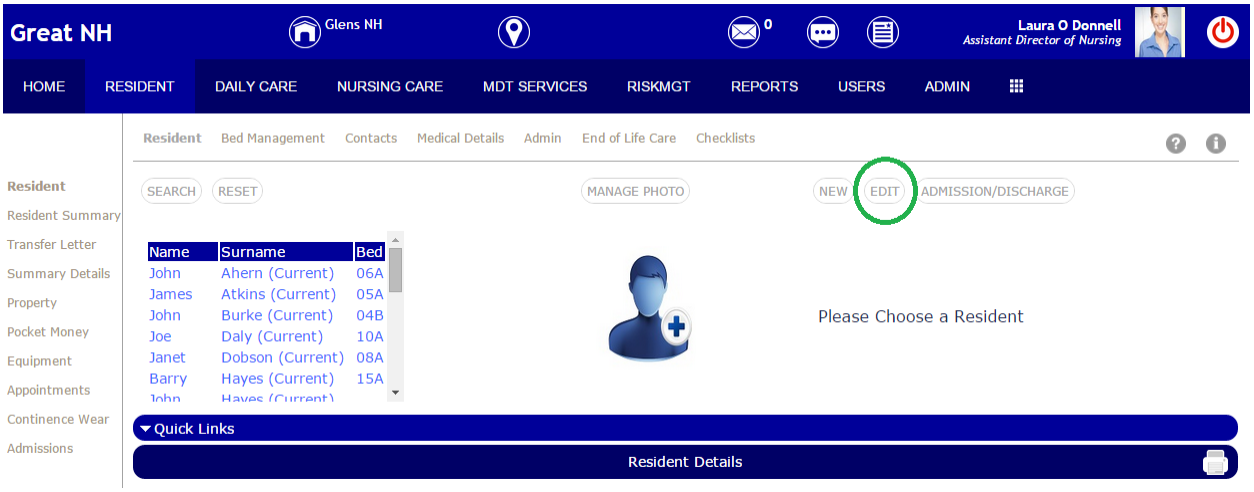


Navigate to Resident on the Main Menu. You will automatically be presented with the Residents Biographic page. To enter a New Resident follow these simple steps:

1. Choose 'Resident' from the Main Menu
2. Click the 'New' button. A pop up window will appear and you will be presented with a popup window that gives you two options.
    a. **Current:** This option should be used where the Resident is already in the facility or for new epicCare clients that are entering the details of their Current Residents for the first time.
    b. **Preadmission:** These are Residents that are due in the future or Residents that require Preadmission Assessment.

3. Click the required option and you will be presented with the Mandatory required Resident Information
4. Fill out the Mandatory fields
5. Fill out more advanced information if required
6. Click the 'Create' button

Edit Resident Records



You may require to either change information you have entered or add new information relating to the resident. To do this follow these simple steps:

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Click the 'Edit' button. A pop up window will appear and you will presented with the most commonly changed Resident Information
4. Enter or change the information required
5. To enter further information click on the 'Advanced' Tab
6. Click the 'Save' button

Admit a Preadmission Resident

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Click the 'Admission/Discharge' button and a popup window will appear
4. Click the 'Admit' button
5. Enter the required information
6. Click the 'Save' button

Cancel a Resident

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Click the 'Admission/Discharge' button and a popup window will appear
4. Click the 'Cancel' button
5. Enter the required information
6. Click the 'Save' button

Discharge a Resident

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Click the ‘Admission/Discharge’ button and a popup window will appear
4. Click the ‘Discharge’ button
5. Enter the required information
6. Click the ‘Save’ button

Note: If a Resident has passed away, consult ‘4.17 End of Life Care’

4.3 Resident Profile Photo

It is a good idea to save a Photo of the Resident to the Resident Record in order to reduce errors and ensure you are always working with the correct Resident. You may want to consult your policy on Resident Photos as consent may be required.

There are two methods of adding a Resident Image:

1. Use a portable device such as a Tablet that has a build in camera
2. Use a photo that you have taken and stored on the computer or device you are using

Using a Portable Device

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Click the ‘Manage Photo’ button
4. You will be presented with the ‘Resident Photo’ Screen
5. In the top ‘Camera Frame’ you will see the image from your camera
6. Line up your photo and click the ‘Capture’ button
7. A preview of your photo will appear in the ‘Preview Frame’
8. To use this photo click the ‘Save’ button
9. To retake the photo click the ‘Clear’ button and repeat these steps

Using a Stored Photo

To add a Resident Profile Image follow these simple steps:

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Click the ‘Manage Photo’ button
4. Click the ‘Choose File’ option and navigate to where you have your photo stored
5. To use this photo click the ‘Upload Photo’ button
6. To upload another photo click the ‘Choose File’ button and repeat these steps

4.4 Searching Resident Records

A list of all Residents in the Company, Site, Wing/Floor you have selected, and as appears in your User Bar, will automatically be displayed in the 'Resident List Frame'. To carry out a more specific search use the following steps:

1. Choose 'Resident' from the Main Menu
2. Click the 'Search' button. A pop up window will appear and you will presented with the most commonly searched Resident Information
3. Enter the information required for the search
4. To search less commonly searched information click on the 'Advanced' Tab
5. Enter the information required for the search
6. Click the 'Search' button
7. All Residents matching your search criteria will appear in the 'Resident List Frame'

4.5 Resident Summary Sheet

To view the Resident Summary

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Resident Summary' from the Left Menu
4. The Resident Summary for the chosen resident will be displayed

To add details to the Resident Summary

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Summary Details' from the Left Menu
4. Tick the section(s) you wish to include in the Resident Summary
5. Enter relevant information in the textboxes provided
6. Click the 'Update' button
7. These details will then show in the Resident Summary

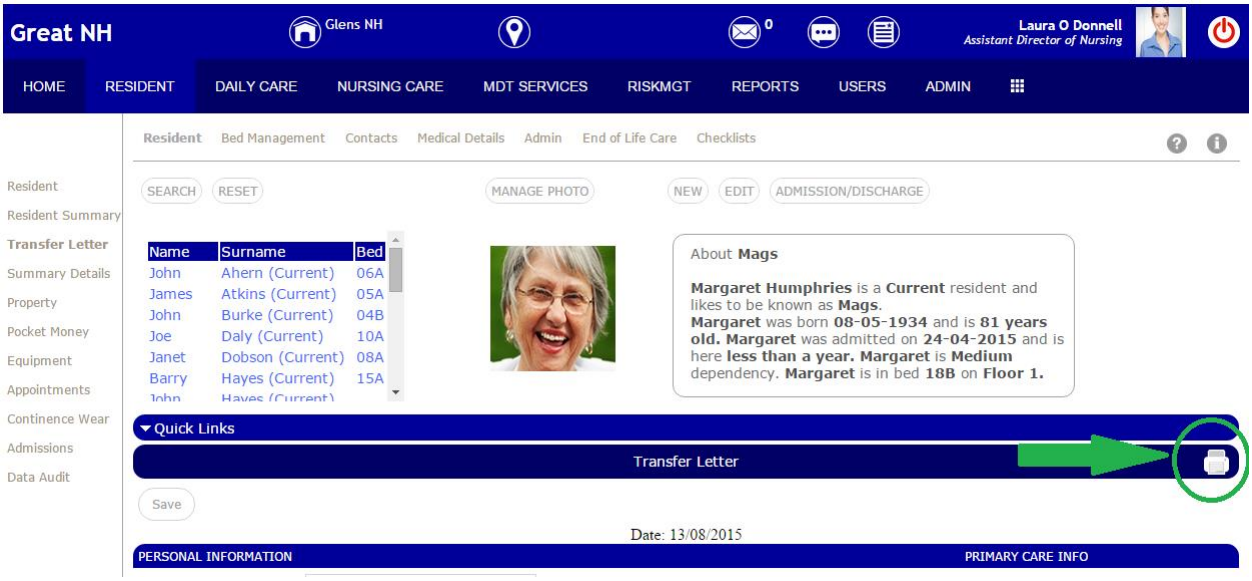
4.6 Resident Transfer Letter

To view the Resident Transfer Letter

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Transfer Letter' from the Left Menu
4. The Resident Transfer Letter for the chosen resident will be displayed

To add details to the Resident Transfer Letter and Print

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Transfer Letter' from the Left Menu
4. Enter relevant information in the textboxes provided
5. Click the 'Save' button
6. Before navigating to any other screen, click the Print icon to print the saved Transfer Letter



To access previous Resident Transfer Letter details

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Bed Management' from the Sub Menu
4. Choose 'View Transfer Letter Details' from the Left Menu
5. All previous Transfer Letter Details for the chosen resident will be displayed

4.7 Pocket Money, Property and Equipment

Pocket Money

The Pocket Money area is used to track Residents Money through a simple Deposit and Withdrawal system. The current Balance is displayed and is recalculated based on the Deposit and Withdrawal transactions carried out.

Deposit

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose the 'Pocket Money' from the Left Menu
4. Click the 'Deposit' button
5. In the pop up window enter the 'Date', 'Amount' and 'Description'
6. Click the 'Make Deposit' button

Withdrawal

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Pocket Money' from the Left Menu
4. Click the 'Withdrawal' button
5. In the pop up window enter the 'Date', 'Amount' and 'Description'
6. Click the 'Make Withdrawal' button

Delete Transaction

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Pocket Money’ from the Left Menu
4. Click the Date of the Transaction to be Deleted
5. Click the ‘Delete’ button

Property

The Property area is used to track Residents Property through a simple Property List.

Recording Property

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Property’ from the Left Menu
4. Click the ‘Add’ button
5. In the pop up window enter the:
    - Category (Explain)
    - Where the Property is being kept
    - Date Received
    - Received By
    - Note
    - Quantity
    - Reason in Safe (Explain)
6. Click the ‘Save’ button

Remove Property

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Property’ from the Left Menu
4. Click the Name of the Item to be Removed
5. In the pop up window enter the Reason
6. Click the ‘Remove’ button

Equipment

The Equipment area is used to track Equipment used by Residents through a simple Equipment List.

Add Equipment

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Equipment’ from the Left Menu
4. Click the ‘New Equipment’ button
5. In the pop up window enter the details of the Equipment
6. Click the ‘Save’ button

Remove Equipment

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Equipment’ from the Left Menu
4. Click the Name of the Item to be Removed
5. In the pop up window enter the Reason
6. Click the ‘Remove’ button

4.8 Appointments

The Appointments area is used to keep track of any appointments a resident may have.

To add a new Appointment

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Appointments’ from the Left Menu
4. Click the ‘New Appointment’ button
5. Enter the details of the Appointment
6. Click the ‘Save’ button

To update or delete an Appointment

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Appointments’ from the Left Menu
4. Click the Date of the Appointment to be Updated
5. In the pop up window enter the necessary updates
6. Click the ‘Update’ button or the ‘Delete’ button

4.9 Bed Management

The Bed Management section has been divided into two areas:

1. Basic Assign Beds
2. Advanced Assign Beds

Basic Assign Beds

This is used to check current bed availability, to assign a resident to a bed immediately and to remove a resident from a bed immediately

Check current bed availability

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Bed Management’ from the Sub Menu
4. Choose ‘Basic Assign Beds’ from the Left Menu
5. The Current Bed Availability will automatically appear

Assign a resident to a bed

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Bed Management’ from the Sub Menu
4. Choose ‘Basic Assign Beds’ from the Left Menu
5. From the list of available beds, choose the bed you wish to assign to the resident
6. In the popup window that appears, ensure you have selected the correct bed and click the ‘Assign’ button

Remove a resident from a bed

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Bed Management’ from the Sub Menu
4. Choose ‘Basic Assign Beds’ from the Left Menu
5. Click the ‘Current Bed’ button and a popup window will appear
6. Click the ‘Remove’ button to remove the resident from the bed

Advanced Assign Beds

This is used to check bed availability for a specific date range, to assign to a resident to a bed for a specific time period and to remove a resident from a bed on a date in the future

Check bed availability

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Bed Management’ from the Sub Menu
4. Choose ‘Advanced Assign Beds’ from the Left Menu
5. Click the ‘Check Bed Availability’ button
6. Enter the date range for which you would like to check

Assign a resident to a bed

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Bed Management’ from the Sub Menu
4. Choose ‘Advanced Assign Beds’ from the Left Menu
5. Follow steps 5 and 6 above to check bed availability for a specific date range
6. From the list of available beds, choose the bed you wish to assign to the resident
7. In the popup window that appears, ensure you have selected the correct bed and click the ‘Assign’ button

Remove a resident from a bed on a date in the future

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Bed Management’ from the Sub Menu
4. Choose ‘Advanced Assign Beds’ from the Left Menu
5. Click the ‘Remove From Bed’ button to and a popup window will appear
6. Enter the exit date and click the ‘Remove’ button

4.10 Temporary Transfer

This option applies when a resident is leaving the home overnight or for a number of nights but is expected to return to the home i.e. admitted to hospital, going on a holiday etc.

1. Choose 'Resident' from the Main Menu
2. Choose 'Bed Management' from the Sub Menu
3. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
4. Choose 'Temporary Transfer Location' from the Left Menu
5. Click the 'New Temporary Transfer Location' button
6. Fill out the details in the pop up window
7. Click the 'Save' button

Note: When the resident returns to the home, repeat these steps and choose 'Currently in nursing home (No transfer)' in the 'Transferred To:' list.

4.11 Evacuations

Add New Evacuation Details

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Bed Management' from the Sub Menu
4. Choose 'Evacuation' from the Left Menu
5. Click the 'New Evacuation' button
6. In the pop up window enter the details of the Evacuation Requirements
7. Click the 'Save' button

Delete an Evacuation Requirement

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Bed Management' from the Sub Menu
4. Choose 'Evacuation' from the Left Menu
5. Click the Name of the Evacuation Requirement to be deleted
6. In the pop up window enter the reason for deleting the Evacuation Requirement
7. Click the 'Delete' button

4.12 Off Site Stay

This option applies when a resident is leaving the home for a period during the day but will be returning on the same day i.e. visiting family/friends, attending an event etc.

1. Choose 'Resident' from the Main Menu
2. Choose 'Bed Management' from the Sub Menu
3. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
4. Choose 'Off Site Stay' from the Left Menu
5. Click the 'New Off Site Stay' button
6. Fill out the details in the pop up window
7. Click the 'Save' button

4.13 Previous Visits

Residents will at times leave the home for the purpose of spending time in hospital, attending social or family events, visiting healthcare professionals or visiting family or friends.

What differentiates these Visits from Appointments is the need to record more comprehensive, formal and contemporaneous information. This would include information such as how long they were away, who was looking after them, their medication needs and possibly if a staff member needed to accompany them.

Visits are therefore Categorised into the following:

1. Appointments
2. Off Site Stay
3. Temporary Transfer

4.14 Contacts

Navigate to 'Resident' on the Main Menu and then to 'Contacts' on the Sub Menu. You will automatically be presented with the Residents Next of Kin Contacts.

Add New Contact

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Contacts' from the Sub Menu
4. Choose the type of contact from the Left Menu (Next of Kin, Doctor etc.)
5. Click the 'New' button for the type of Contact you have selected, i.e. 'New NOK'
6. Fill out the details in the pop up window
7. Click the 'Save' or 'Assign' button

Add an Existing Contact

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Contacts' from the Sub Menu
4. Choose the type of contact from the Left Menu (Next of Kin, Doctor etc.)
5. Click the 'Add' button for the type of Contact you have selected, i.e. 'Add Doctor'
6. Choose the Contact in the pop up window
7. Click the 'Save' or 'Assign' button

Update Existing Contact

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Contacts' from the Sub Menu
4. Choose the type of contact from the Left Menu (Next of Kin, Doctor etc.)
5. Click the Name of the Contact, from the list of Contacts, to be Updated
6. Change the details in the pop up window
7. Click the 'Save' button

Remove a Contact from the Residents Record

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Contacts’ from the Sub Menu
4. Choose the type of contact from the Left Menu (Next of Kin, Doctor etc.)
5. Click the Name of the Contact, from the list of Contacts, to be Removed
6. Click the ‘Remove’ button in the pop up window

4.15 Contract Details

The Contract Details area is used to keep track of details of each Residents’ Contract of Care

Add New Contract Details

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Admin’ from the Sub Menu
4. Choose ‘Contract Details’ from the Left Menu
5. Click the ‘New Contract Details’ button
6. In the pop up window enter the details of the Contract
7. Click the ‘Save’ button

Update or De-assign a Contract

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Admin’ from the Sub Menu
4. Choose ‘Contract Details’ from the Left Menu
5. Click the Name of the Contract to be Updated or De-assigned
6. In the pop up window enter the necessary updates
7. Click the ‘Update’ button or the ‘De-Assign’ button

4.16 Resident Summary Sheet

To view the Resident Summary

5. Choose ‘Resident’ from the Main Menu
6. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
7. Choose ‘Resident Summary’ from the Left Menu
8. The Resident Summary for the chosen resident will be displayed

To add details to the Resident Summary

8. Choose ‘Resident’ from the Main Menu
9. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
10. Choose ‘Summary Details’ from the Left Menu
11. Tick the section(s) you wish to include in the Resident Summary
12. Enter relevant information in the textboxes provided
13. Click the ‘Update’ button
14. These details will then show in the Resident Summary

4.16 Resident Folder and Scanning

Add Upload a File to a Resident Folder

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Admin’ from the Sub Menu
4. Choose ‘Scanned Files’ from the Left Menu
5. Click the ‘Upload File’ button
6. In the pop up window, choose the folder to which you want to upload a file
7. Enter a file name
8. Click the ‘Choose File’ button
9. Select the file you want to upload
10. Click the ‘Open’ button to choose that file
11. Click the ‘Upload’ button

4.17 End of Life Care

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘End of Life Care’ from the Sub Menu
4. Click the ‘Enter RIP Details’ button
5. Enter any relevant information
6. Click the ‘Save’ button

Note: Entering a Resident’s RIP Details does not automatically Discharge the Resident and therefore, does not remove the resident from a bed. It has been designed in this way to facilitate for Residents who may have passed away but have not yet been removed from the Home and are therefore still occupying that particular bed. There is a distinct difference between discharging a Resident and entering RIP details in that ‘Discharge’ is an Administrative function whereas ‘End of Life Care’ is a Clinical function.

4.18 Resident Check Lists

The Resident Checklist area is designed to ensure every relevant step has been completed before a Resident attends an appointment or leaves the Nursing Home for any reason.

Assign New Resident Checklist

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Checklists’ from the Sub Menu
4. Click the ‘Assign Checklist’ button
5. In the pop up window choose the relevant checklist
6. Click the ‘Assign’ button

If the required checklist does not appear in this list, you can simply add a new checklist

Add a New Checklist Framework

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Checklists’ from the Sub Menu
4. Choose ‘Checklist Frameworks’ from the Left Menu
5. Click the ‘New Checklist’ button
6. In the pop up window enter the Checklist name and the basic steps involved in this kind of Checklist
7. Click the ‘Save’ button

Complete a Resident’s Checklist

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Checklists’ from the Sub Menu
4. Click on the name of the Checklist you wish to complete
5. Click on the number of the step which you wish to complete
6. In the pop up window, click the ‘Complete Step’ button

4.0 Resident Medical Record

In this section, we will cover all aspects of the Resident Medical Record including Medical History, Conditions, Allergies and Oxygen.

Learners should note that if at any stage they have any questions or queries relating to either this training program or epicCare their first point of contact will be their in-house designated epicCare Facilitator.

4.1 Learning outcomes

On successful completion of this section, you will be able to Manage Residents':

1. Medical History
2. Conditions
3. Allergies
4. Oxygen

4.2 Medical History

Residents Medical History is where all aspects of the Resident Medical History are recorded.

Add Medical History

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Medical Details’ from the Sub Menu
4. ‘Medical History’ is automatically selected from the Left Menu
5. Click the ‘New Medical History’ button.
6. In the pop up window enter a ‘Description’ and choose a ‘Diagnosis’
7. Click the ‘Save’ button

Update Medical History

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Medical Details’ from the Sub Menu
4. Click the Description of the Medical History to be Updated
5. Enter any updates you wish to include
6. In the pop up window click the ‘Update’ button

Void Medical History

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Medical Details’ from the Sub Menu
4. Click the Description of the Medical History to be Voided
5. In the pop up window click the ‘Void’ button

4.3 Conditions

Resident Conditions are where all conditions such as Dementia, Asthma, and Vertigo are recorded.

Add Condition

1. Choose ‘Resident’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Medical Details’ from the Sub Menu
4. Choose ‘Conditions’ from the Left Menu
5. Click the ‘New Condition’ button.
6. In the pop up window enter a Condition and enter a Comment if required
7. Click the ‘Save’ button

Void Condition

1. Choose ‘Resident’ from the Main Menu
2. Choose ‘Medical’ from the Sub Menu
3. Choose ‘Conditions’ from the Left Menu
4. Click the Condition to be Removed
5. In the pop up window click the ‘Remove’ button

4.4 Allergies

Allergies are where all the Resident's allergies are recorded

Add Allergy

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Medical Details' from the Sub Menu
4. Choose 'Allergies' from the Left Menu
5. Click the 'Add' button
6. In the pop up window selection an 'Allergy' and enter a Note
7. Click the 'Save' button

Void Allergy

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Medical Details' from the Sub Menu
4. Choose 'Allergies' from the Left Menu
5. Click the Allergy from the displayed list of Allergies to be Removed
6. In the pop up window click the 'Void' button

4.5 Oxygen

Oxygen is where the Resident's preference for oxygen is recorded.

Add Oxygen

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Medical Details' from the Sub Menu
4. Choose 'Oxygen' from the Left Menu
5. Click the 'New Oxygen' button
6. In the pop up window selection an 'Oxygen' preference and enter a Note
7. Click the 'Save' button

Void Oxygen

1. Choose 'Resident' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Medical Details' from the Sub Menu
4. Choose 'Oxygen' from the Left Menu
5. Click the 'Oxygen' preference from the displayed list of preferences to be Removed
6. In the popup window, click the 'Void' button

5.0 Daily Care

Recording nursing care is an integral component of nursing practice. The maintenance of good clinical records is essential to document nursing care (ABA, 2002). In this module, we will cover the recording of daily nursing care in the 'Daily Care' section on epicCare.

5.1 Learning outcomes

On successful completion of this module, you will be able to Manage Resident's:

1. Progress Notes
2. Team Notes
3. OBS/Results
4. Personal Notes

5.2 Progress Notes

View a Resident's Progress Notes

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. That Resident's Progress Notes will be displayed

Add a new Progress Note

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Click the 'Add Entry' button
4. Enter your Progress Note details
5. Select a type (i.e. Priority, Daytime, Nightime)
6. Click the 'Save' button

Void a Daily Note

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Void Daily Reports' from the Left Menu
4. Enter the search criteria and click the 'Search' button
5. Click on the ID of the Daily Note you wish to void
6. In the popup window, enter the reason for voiding the Daily Note
7. Click the 'Void' button

5.3 Team Notes

Team Notes enable the resident's care team to record notes relevant to their discipline. Team Notes available include Therapy and Medical

View a Resident's Team Notes

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Team Notes' from the Sub Menu
4. 'Therapy' is the default page displayed
5. The resident's Therapy Team Notes will be displayed
6. To view other Team Notes such as Medical, simply choose that option in the Left Menu

Add a Resident's Team Notes

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Team Notes' from the Sub Menu
4. Choose either 'Therapy' or 'Medical' from the Left Menu
5. Click the 'Add Entry' button
6. Enter the details of the Therapy or Medical Notes
7. Select a type (i.e. Priority, Daytime, Night time, DON & CNM Entry)
8. Click the 'Save' button

Void a Resident's Team Notes

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Void Daily Reports' from the Left Menu
4. Enter the search criteria and click the 'Search' button
5. Click on the ID of the Daily Note you wish to void
6. In the popup window, enter the reason for voiding the Daily Note
7. Click the 'Void' button

5.4 OBS/Results

There are two variations to the OBS section. Standard OBS and Neurological OBS. The Neurological OBS are added in column fashion, with the earliest to latest, being displayed by date, from left to right. This facilitates easy comparison of Neurological OBS.

A new feature of epicCare 2.0 is the automatic calculation of the Resident's BMI. A Resident's height is not likely to vary by much so therefore only needs to be recorded once. After this, each time that the Resident's weight is entered, the BMI will automatically be calculated and will be displayed in the Full OBS section.

View a Resident's OBS

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'OBS' from the Sub Menu
4. A list of that Resident's Full OBS are automatically displayed

To Enter a Full or Partial Set of OBS

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'OBS' from the Sub Menu
4. Choose 'Full OBS' from the Left Menu
5. Complete the details in the relevant sections
6. Click the 'Save' Button

To Enter a Specific Observation

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'OBS' from the Sub Menu
4. Choose the Specific Observation from the Left Menu
5. Enter the details of that Observation
6. Click the 'Save' Button

To Enter Neurological OBS

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'OBS' from the Sub Menu
4. Choose 'View Neurological Observations' from the Left Menu
5. Click the 'Add Entry' button
6. Enter the details of the Neurological Observation
7. Click the 'Save' Button

5.5 Resident's Personal Notes

'Personal Notes' facilitate the recording of resident information such as 'Behaviour', 'Bowels' and 'Mood'.

View a Resident's Personal Notes

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Personal Notes' from the Sub Menu
4. Choose the relevant option from the Left Menu
5. That Resident's Personal Notes are automatically displayed

Add Resident's Personal Notes

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Personal Notes' from the Sub Menu
4. Choose the relevant option from the Left Menu
5. Click the 'Add Entry' button
6. Enter the details of the Notes
7. Click the 'Save' Button

5.6 Handover Reports

There are three variations to the Handover Reports:

1. HO Not Done
2. HO Priority
3. HO Daily Notes

HO Not Done

This report is designed to highlight items which have not been done prior to end of shift. It displays key actions not done, such as fluid intake, progress report and personal hygiene.

View the HO Not Done Report

1. Choose 'Daily Care' from the Main Menu
2. Choose 'HO Not Done' from the Left Menu

HO Priority

To facilitate for a smooth handover, a Specific Handover Priority Report is available. This returns priority entries for each resident that were recorded in that time period. It also includes any care plan evaluations, wound priority notes or incidents which occurred for each resident.

View the HO Priority Report

1. Choose 'Daily Care' from the Main Menu
2. Choose 'HO Priority' from the Left Menu
3. Select the time period from which you want a Hand Over (e.g. The last 8 or 12 hours)
4. Optional: You may narrow the search further by selecting a single resident or named nurse
5. Click the 'Search' button

HO Daily Notes

This report shows all daily progress notes recorded within a specific time range.

View the HO Daily Notes Report

1. Choose 'Daily Care' from the Main Menu
2. Choose 'HO Priority' from the Left Menu
3. Select the time period from which you want a Hand Over (e.g. The last 8 or 12 hours)
4. Optional: You may narrow the search further by selecting a single resident or named nurse
5. Click the 'Search' button

5.7 Notes Search

This functionality is designed to allow a user to search for notes within a specific date range. It returns notes from many areas including Behaviour, Falls/Incidents, Medical, Observations, Progress Notes, Touch and many more

Search for Notes

1. Choose 'Daily Care' from the Main Menu
2. Choose 'Notes Search' from the Left Menu
3. Enter the relevant Date Range and Type
4. Click the 'Search' button

6.0 Assessments

In this section, we will cover the recording of an Assessment for a Resident using Assessment tools on epicCare. The purpose of assessment tools is to enable you to carry out an effective assessment. Assessment tools can be categorised by what they do:

- health screening and diagnosis – identifying the problem and its severity.
- descriptive – describing the problem but not necessarily directing action, for example the Abbey pain-rating scale (Chapman, 2010).
- predictive – identifying the potential for problems to develop, for example the Multi-dimensional Falls assessment (Lyons et al., 2005).

Assessment tools offer a way to map the problem or consider potential problems, in terms that can be easily communicated to other professionals (Barrett et al., 2009).
epicCare enables you to choose your preferred Assessments tools. The Care Administration Section has an option that allows you to choose the Assessments you already use on paper. If a residential care setting chooses to create their own Assessment in epicCare, their request will be relayed to the epicCare Development Team for review.

6.1 Learning outcomes

On successful completion of this module, you will be able to:

1. Choose and complete the preferred Assessment for your resident
2. Plan Next Assessment date
3. View Resident History of Assessment

6.2 Choose your preferred Assessment for your resident

When using an assessment tool it is important to explain as fully as possible to the resident of what the tool is and why it is being used, to ensure patient consent. This is why you need to understand how the tool works and what you hope to achieve in using it, in order to give an accurate description.

Being clear about why you are using a particular tool and what you hope to achieve provides justification for the nurses' actions, what the nurse is doing with the resident and communicate this to other professionals who may be involved in the resident's care.

The next step is to choose your preferred Assessment for your resident in epicCare:

Carry out an Assessment

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Assessments' from the Sub Menu
4. Click the 'Add Assessment' button
5. Choose the relevant Assessment from the dropdown list
6. Click the 'Assign' button
7. Complete the Assessment and set the Next Reminder Date
8. Click the 'Insert New Details' button

Add an Assessment Reminder

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Assessments' from the Sub Menu
4. Choose 'Assessment Reminders' from the Left Menu
5. Click the 'Add Assessment Reminder' button
6. Enter the relevant details for the Assessment Reminder
7. Click the 'Assign' button

Delete an Assessment Reminder

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Assessments' from the Sub Menu
4. Choose 'Assessment Reminders' from the Left Menu
5. Click the name of the Resident next to the Assessment Reminder you wish to remove
6. Enter a reason for deleting the reminder
7. Click the 'Delete' button

Void an Assessment

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Assessments' from the Sub Menu
4. Choose 'Assessment Void' from the Left Menu

5. Select the Assessment you wish to void
6. Enter a reason for deleting the reminder
7. Click the 'Void' button

NOTE:
When reviewing the Comprehensive Assessment at the required time, instead of starting from the beginning with a new document you can click '**Create as New**' and a copy of the previous Comprehensive Assessment is there for you to edit, complete and save.
Remember to set the '**Next Assessment date**'.
This is currently the only Assessment that has this facility.

NOTE:

If you need to print any of the Assessments click on the print icon

NOTE:

It is recommended that a general risk assessment is carried out and recorded upon admission to the residential care setting and as indicated by the resident's changing needs or circumstances and no less frequently than four monthly intervals (HIQA, 2014).

A comprehensive assessment of resident's health, personal and social care needs is completed within 72 hours of his/her admission or sooner if the risk assessment indicates (HIQA, 2014)

7.0 Care Plans

Care plans are a list of nursing Interventions that guide the nurses/care assistants through dealing with a resident's care. Care planning is necessary because resident's needs are greater than just their medical needs and therefore will involve different professionals.

A repository of evidence based Care Plan Frameworks come as standard with the epicCare system. Each care facility has an option to either use epicCare Care Plan Frameworks, customise epicCare Care Plan Frameworks or create your very own repository of Care Plan Frameworks. This enables nurses to choose their care plan framework and then personalise care for the resident. Creating a personalised care plan can offer benefits for Residents, health and social care professionals and the residential care setting. The working together of resident and nurse to develop a personalised Care Plan is vital to facilitate the promotion of health and well-being, minimising risk of harm and promoting safety at all times (Howatson-Jones et al., 2012).

In this module, we will cover these options in more detail enabling evaluation of all choices.

1. Using epicCare Care Plan Frameworks
2. Customising epicCare Care Plan Frameworks
3. Create your own custom Care Plan Frameworks
4. Personalising the Care Plan Framework to your Resident
5. Evaluating and Managing your Care Plans

7.1 Care Plan Frameworks

Each care facility may have differing approaches to Care Planning. Some use Care Plan Frameworks and some don't. Some care facilities use specialised Care Plans for specific problems while others use a more comprehensive single Care Plan that is designed to address the entire needs of the Residents. In some cases care facilities will opt to use a combination of approaches, having a comprehensive Care Plan for the majority of Residents needs while using specialist Care Plans to address specific problems.

Whichever your preference, epicCare can be configured to support any combination of these approaches.

epicCare strongly recommend that only the Director of Nursing and the nominated epicCare Home Facilitator are given permissions to choose, create or modify Care Plan Frameworks. This will ensure control, consistency and a standardised approach to Care Planning is maintained.

Care Plan Frameworks are primarily constructed using:

1. **Aims/goals** - The aims/goals are what the resident will be able to do at the end of a care process, for example, to be able to walk with one stick. Aims/Goals can be formulated in the SMART (Specific, Measurable, Achievable, Relevant, Time-limited) or PRODUCT (Patient-centred, Recordable, Observable and measurable, Directive, Understandable and clear, Credible and Time-related criteria (Barrett et al., 2009)). Which the nurse chooses to use will depend on the best fit with the resident and context of care.
2. **Nursing interventions** - Determining nursing interventions is about giving specific instructions about what you think nurses need to do in order to address the problem identified and reach the specific goal. Nursing interventions should also be evidence-based and use the latest research (Barret et al., 2009).

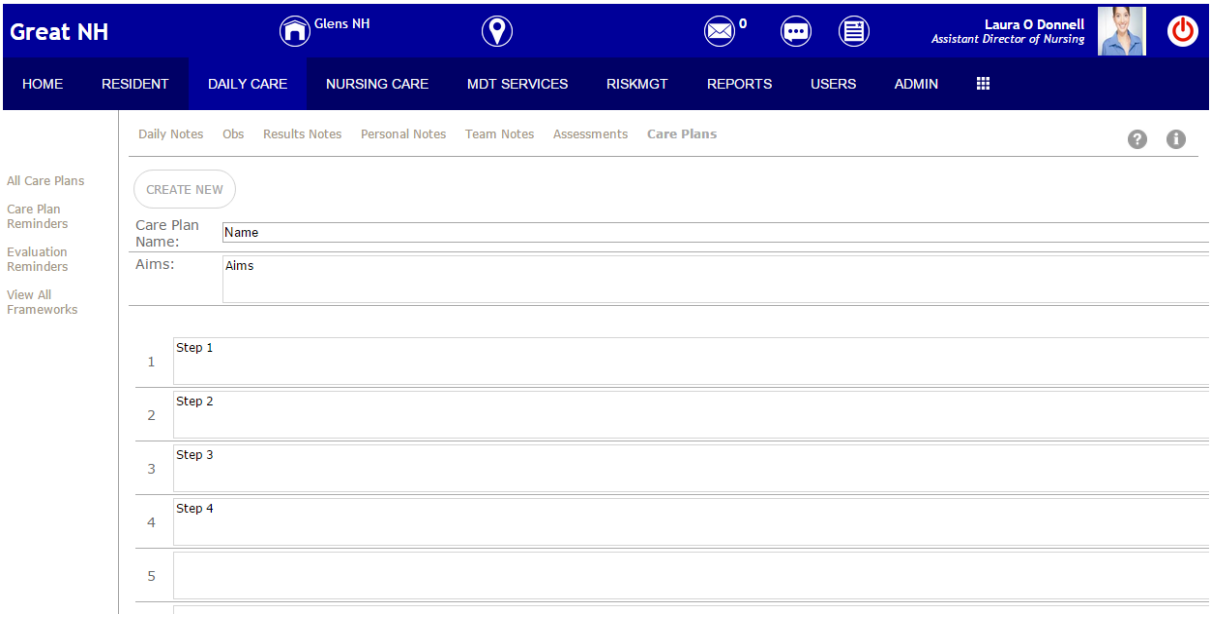
Important Note on use of 'Care Plan Frameworks'

'Care Plan Frameworks' are a standard framework used across all Residents and should be used and/or customised with a cohort of Residents in mind. It is incorrect to create a Care Plan Framework for a specific Resident as this will result in having an unmanageable amount of Care Plan Frameworks on the system. The need may exist, if a resident needs a very specific set of nursing Interventions due to a problem/symptom that they may be suffering from, to create a unique Care Plan for that specific Resident. In this case the Default epicCare 'Blank' Care Plan Framework should be used and assigned to the Resident. This 'Blank' Care Plan Framework can then be personalised to demonstrate inclusion of the patient's priorities and needs and the planning process undertaken with the resident. This specific Resident Care Plan will not be visible in or clutter the repository of 'Care Plan Frameworks'.

Do NOT create 'Care Plan Frameworks' for a specific Resident, use the 'Blank' Care Plan Framework instead!

How to create a Blank Care Plan Framework

1. Follow steps to create a Care Plan Framework (Consult '2.4 Create New Care Plan Frameworks')
2. Enter 'Name' in the Care Plan Name textbox
3. Enter 'Aims' in the Aims textbox
4. Enter 'Step 1', 'Step 2', 'Step 3' and 'Step 4' in the first four Steps textboxes
5. Create the 'Create New' button
6. Assign this Care Plan to a Resident and customise as required (Consult '3.2 Personalising Residents' Care Plans')



epicCare Care Plan Frameworks

epicCare have developed a repository of Care Plan Frameworks that are evidence based and have been evaluated by clinical users of epicCare. It is your sole responsibility to ensure that any Care Plan Frameworks you use are determined by you as fit for purpose, adhere to guidelines, standards and regulations and reflect the needs of your residents and care facility.

A Care Plan Framework does not become an actual Care Plan until it has been assigned and Customised to the specific needs of a Resident.

Activating and Deactivating Care Plan Frameworks

epicCare Care Plan Frameworks are not by default available to use by your nursing staff. A conscious decision has to be made to use a particular Care Plan Framework and it has to be activated by a user with the appropriate permissions to do so.

The following steps explain the process of viewing and activating Care Plan Frameworks:

Activate a Care Plan

1. Choose ‘Admin’ from the Main Menu
2. Choose ‘Daily Care’ from the Sub Menu
3. Choose ‘Care Plans’ from the Left Menu
4. The List of Care Plan Frameworks will be displayed, clearly showing if each one is Active (Yes or No) and for how many sites the Care Plan Framework is active
5. Click on the ‘No’ to activate the Care Plan
6. In the popup window, change the ‘Active’ field to ‘Yes’
7. Click the ‘Update’ button

De-activate a Care Plan

1. Choose ‘Admin’ from the Main Menu
2. Choose ‘Daily Care’ from the Sub Menu
3. Choose ‘Care Plans’ from the Left Menu
4. The List of Care Plan Frameworks will be displayed, clearly showing if each one is Active (Yes or No) and for how many sites the Care Plan Framework is active
5. Click on the ‘Yes’ to de-activate the Care Plan
6. In the popup window, change the ‘Active’ field to ‘No’
7. Click the ‘Update’ button

Choose which sites a Care Plan is active for

1. Choose ‘Admin’ from the Main Menu
2. Choose ‘Daily Care’ from the Sub Menu
3. Choose ‘Care Plans’ from the Left Menu
4. The List of Care Plan Frameworks will be displayed, clearly showing if each one is Active (Yes or No) and for how many sites the Care Plan Framework is active
5. Click on the number of sites for which the Care Plan is already active
6. In the popup window, choose which sites you wish activate the Care Plan for (To select multiple sites, hold down the CTRL key)
7. Click the ‘Update’ button

epicCare automatically includes a default ‘Blank’ Care Plan Framework for use by Care Facilities that prefer to either not use Care Plan Frameworks or have a specific need to write a Custom Care Plan for a specific Resident.

It is possible to use a combination of ‘epicCare Care Plan Frameworks’, ‘Customs Care Plan Frameworks’ and ‘Blank Care Plan Frameworks’ by simply Activating or De-activating your choice of Care Plan Frameworks from the list.

Create New Care Plan Frameworks

If you prefer you can start with a blank sheet and create your own Care Plan Framework or configure epicCare to work with Care Plan Frameworks you have developed. The following steps explain the process of creating new or entering your own Care Plan Frameworks into epicCare:

1. Choose 'Daily Care' from the Main Menu
2. Choose 'Care Plans' from the Sub Menu
3. Choose 'View All Frameworks' from the Left Menu
4. Click the 'Add Frameworks' button
5. Enter the Care Plan Name, Aims and Framework Steps
6. Click the 'Create New' button

7.2 Care Planning for Residents

A Care Plan can be personalised to demonstrate inclusion of the patient's priorities and needs and the planning process undertaken with the resident. It is considered good practice to include people in decisions made about their care (Anthony & Crawford, 2000).

Caring for residents requires a clear vision of what the nurse hopes to achieve, who is to carry out the prescribed nursing interventions and how these are progressing (Barrett et al., 2009).

It is recommended that resident's care plans are commenced within **forty eight hours of admission** (HIQA, 2008).

Add Residents Care Plans

The following steps explain the process of choosing your preferred Care Plan Frameworks for your Resident:

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Care Plans' from the Sub Menu
4. Click the 'Add Care Plan' button
5. Choose a Care Plan from the dropdown menu
6. Click the 'Assign' button
7. You can now personalise the Care Plan for the Resident (Consult 'Personalising Resident Care Plans')

Personalising Residents Care Plans

Personalisation is viewing the resident as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives (Social Care Institute for Excellence (SCIE), 2010). Nurses therefore need to develop a knowledge of the individual person and their life and interest, which can then be used to inform personalised care planning.

Residents' needs and priorities can change and the nursing Interventions need to be personalised to reflect that change.

The following steps explain the process of Personalising Resident's Care Plans:

To edit the Name/Goal of the Care Plan

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Care Plans' from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan name to be personalised
6. Click the 'Edit Name/Goal' button
7. Edit the details as required
8. Click the 'Save Name / Goal' button

To add a new Step to the Care Plan

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Care Plans' from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan name to be personalised
6. Click on the Step where you need to add a New Step Above or Below
7. Click the 'New Step Above' or 'New Step Below' button
8. Enter the details of the Step
9. Click the 'Save Step Above' or 'Save Step Below' button

To edit a Step of a Care Plan

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Care Plans' from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan name to be personalised
6. Click on the Step to be edited
7. Click on the 'Edit Step' button
8. Edit the details as required
9. Click the 'Save Step' button

To remove a Step from a Care Plan

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Care Plans' from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan name to be personalised
6. Click on the Step to be removed
7. Click the 'Remove Step' button

To add or edit a Reminder for a Care Plan Evaluation

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Care Plans' from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan name to be personalised
6. Click on the 'Next Review Date' field and choose a date from the calendar

To add or edit a Reminder Date for a Specific Step Evaluation

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Care Plans' from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan name to be personalised
6. Click on the Review Date field next to the step to be reviewed and choose a date from the calendar

Note: To remove a step reminder date clear the date from the calendar.

Nursing Intervention Rationale

The nursing care plan is a written document that outlines how a patient will be cared for. A typical nursing care plan includes nursing diagnoses, expected outcomes, interventions, rationales and an evaluation. A nursing rationale is a stated purpose for carrying out a nursing intervention. Nursing Interventions are actions that nurses perform to help patients achieve specified health goals. A nursing rationale is written next to each nursing intervention in the nursing care plan.

The following steps explain the process of Adding Notes or Rationale in the individual nursing Intervention:

1. Choose 'Daily Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Care Plans' from the Sub Menu
4. A list of current Care Plans will be displayed

5. Click on the Care Plan name to be personalised
6. Click on the Step to be edited
7. Click on the ‘Edit Rationale’ button
8. Edit the details as required
9. Click the ‘Save Rationale’ button

When a nurse wants to make a change to a nursing Intervention then it is strongly advised that the attached Rationale containing general comments and/or Rationale are also checked for relevancy and updated accordingly.

If a nurse makes a dramatic change to a nursing Intervention then it is strongly advised that the entire nursing Intervention is ‘Removed’, a new nursing Intervention is recorded with relevant general comments and/or Rationale.

Completing or Voiding Residents Care Plans

The following steps explain the process of Discontinuing or Voiding Care Plans associated with a Resident:

1. Choose ‘Daily Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Care Plans’ from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan name to be personalised
6. Click on the ‘Discontinue’ button
7. Edit the details as required
8. Click the ‘Save Discontinue’ button

7.3 Managing Residents Care Plans

Evaluating Residents Care Plans

Effective evaluation is the process of ascertaining whether the personalised care provided has been successful or not. It includes going through all the steps of the nursing process (assessment, diagnosis, planning and implementation) so as to decide whether to continue, modify or terminate the plan. Seeking the resident's and family's views in the Evaluation process will also facilitate decision making.

When evaluating your care plan, it is necessary to revisit the problem, goal statements, individual nursing Interventions and outcomes in order to identify any changes that have occurred and also any changes that need to be made. Personalised Outcomes centre on the desired results of nursing care. Evaluation of Outcomes provides an opportunity to examine the results to ascertain satisfaction with care (Alfaro-LeFevre, 2002).

Resolution of the problem may not always occur completely and therefore ongoing care may require refining and modifying the problem, goal and planned nursing Interventions.

The following steps explain the process of conducting and Evaluation of a Resident’s Care Plan:

1. Choose ‘Daily Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Care Plans’ from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan name to be Evaluated
6. Choose ‘Evaluation’ from the Left Menu
7. A list of Evaluations are displayed
8. Click the ‘Add Evaluation’ button
9. Enter the details of the Evaluation as required
10. Click the ‘Save’ button

Residents Care Plan History

As the Care Plan evolves over time, from the initial Care Plan Framework, all changes and Personalisation is recorded and can be seen in the Care Plan History. This record of changes and Personalisation is clear Evidence of continued Personalisation of a Residents Care Plan. The following steps explain the process of viewing a Resident’s Care Plan History:

1. Choose ‘Daily Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Care Plans’ from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan you wish to view the history of
6. Choose ‘History’ from the Left Menu
7. That Care Plan’s History is displayed

Resident/Family Input

The following steps explain the process of recording Resident and Family Input on a Resident’s Care Plan:

1. Choose ‘Daily Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Care Plans’ from the Sub Menu
4. A list of current Care Plans will be displayed
5. Click on the Care Plan name to be Evaluated
6. Choose ‘Resident/Family Input’ from the Left Menu
7. A list of Resident/Family Input is displayed
8. Click the ‘Add Input’ button
9. Enter the details of the Resident/Family Input as required
10. Click the ‘Save’ button

Care Plan Reports

To locate Care Plan Reports

1. Choose ‘Reports’ from the Main Menu
2. Choose ‘Daily Care’ from the Sub Menu
3. Choose ‘Care Plans’ from the Left Menu
4. A list of Care Plan Reports is displayed

8.0 Nursing Care

In this module, we will the cover the recording of the most common aspects of daily nursing care.

8.1 Learning Outcomes

On successful completion of this module, you will be able to manage Resident's:

1. Skin Integrity
2. Medical Devices details (Catheter Care, PEG Care, Tracheostomy Care)
3. Infection Control (Infections, Specimens, Vaccinations)
4. Restraints/Enablers
5. Risk Management (Accidents/Incidents, Complaints, Concerns)

8.2 Skin Integrity

Adding a Wound

1. Choose 'Nursing Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. 'Skin Integrity' is automatically displayed
4. The default landing page shows all Current Wounds for the Resident selected (Highlighted in Red on the Body Map)
5. Click on the relevant area of the Body Map to add a wound
6. Enter the wound details
7. Click the 'Save' button

Uploading a Wound Photograph

You can visually document how a wound is progressing by associating photos with the wound

From a Tablet or Smart Phone

1. Choose 'Nursing Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose the relevant Wound Description from the list of Current Wounds displayed
4. Choose 'Photographs' from the Left Menu
5. To save a photo from the device you are currently using, such as a Tablet or Smart Phone, click the 'Capture' button
6. If you are satisfied with the photo, click the 'Save' button
7. If you would like to retake the photo, click the 'Clear' button and repeat step 5

From your Desktop

1. Choose 'Nursing Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose the relevant Wound Description from the list of Current Wounds displayed
4. Choose 'Photographs' from the Left Menu
5. Click the 'Choose File' button
6. Choose the relevant photo from your desktop and click the 'Open' button
7. Click the 'Upload Photo' button

Wound Assessment

Add a Wound Assessment

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose the relevant Wound Description from the list of Current Wounds displayed
4. Choose ‘Assessments’ from the Left Menu
5. The most recent Assessments for this wound will automatically be displayed
6. Click the ‘Add Assessment’ button
7. Fill out the details of the Assessment and click the ‘Save’ button

View Past Assessments

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose the relevant Wound Description from the list of Current Wounds displayed
4. Choose ‘Past Assessments’ from the Left Menu
5. Enter a Date to View the Next 10 Entries from
6. Click the ‘View Entries’ button

PMAP (Prevention and Management Action Plan)

This functionality only applies to Pressure Ulcers so therefore will not be available for other Wound Types

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose the relevant Pressure Ulcer from the list of Current Wounds displayed
4. Choose ‘PMAP’ from the Left Menu
5. Enter a ‘Date Commenced’ for the PMAP Procedure you wish to Commence
6. Click the ‘Commence’ button

Wound Dressing

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose the relevant Wound Description from the list of Current Wounds displayed
4. Choose ‘Dressing’ from the Left Menu
5. Enter the details of the Dressing and the Dressing Reminder Date
6. Click the ‘Save’ button

Healing a Wound

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose the relevant Wound Description from the list of Current Wounds displayed
4. Ensure all relevant updates have been made to the wound
5. Click the ‘Heal Wound’ button

View Healed Wounds

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Healed’ from the Left Menu
4. A list of Healed Wounds will be displayed
5. Choose the relevant Wound Description from the list of Healed Wounds displayed
6. The details of the chosen Wound will be displayed

8.3 Infection Control

In Ireland, the number of older persons in nursing homes is growing and the elderly are more at risk of contracting Health Care Acquired Infections (HCAI). Some residents may have chronic skin ulcers, pressure sores and medical devices such as urinary catheters, feeding tubes which are all risk factors for health care acquired infections. The current prevalence of healthcare acquired infections is unknown in nursing homes in Ireland unlike acute hospitals (RCPI, 2010)

In the residential care setting, residents' can be admitted with an infection or maybe at risk of acquiring an infection at any stage during their stay. Therefore, it is important that nurses are able to record the Resident's infection details and specimens taken in epicCare. The following are steps to enable the nurse to record both:

1. Write in your Resident's infection, specimens, vaccinations details
2. Correlate reports to identify when your Resident's specimens and vaccinations are next due for review

Infections

The following steps explain the process of recording your Resident’s Infection Details:

Record Infection details:

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Infections’ from the Sub Menu
4. The List of the Residents Infection details will be displayed
5. Click the ‘New Infection’ button
6. Enter the details on the popup window, some information is mandatory such as Infection Type
7. Enter Date Infection Update Required
8. Click the ‘Save’ button

Infection Reports

1. Choose ‘Reports’ from the Main Menu
2. Choose ‘Nursing Care’ from the Sub Menu
3. Choose ‘Infections’ from the Left Menu
4. A list of Infection Reports will be displayed

Specimens

The following steps explain the process of recording your Resident's Specimens Details for analysis:

Record Specimens details:

1. Choose 'Nursing Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Infections' from the Sub Menu
4. Choose 'Specimens' from the Left Menu
5. The List of the Residents Specimens details will be displayed
6. Click the 'New Specimens' button
7. Enter the details on the popup window, some information is mandatory such as Specimen Type
8. Enter reminder date for this specimen
9. Click the 'Save' button

Specimens Reports

1. Choose 'Reports' from the Main Menu
2. Choose 'Nursing Care' from the Sub Menu
3. Choose 'Specimens' from the Left Menu
4. A list of Specimen Reports will be displayed

With the number of older persons in nursing homes growing and the elderly more at risk of contracting Health Care Acquired Infections (HCAI), all staff working in residential care settings are at risk of contracting infections. Standard precautions are recommended to prevent the transmission of blood borne viruses and micro-organisms between patients, clients, staff and visitors (RCPI, 2010)

Vaccinations

Vaccination is the most efficient strategy to prevent infectious disease. The increased vulnerability to infection of the elderly makes them a particularly important target population for vaccination (Weinberger & Grubeck-Loebenstein, 2012). The Flu vaccine is recommended for the older person. The following weblinks are a guide for a resident and a healthcare worker regarding the flu vaccine.

HSE Seasonal flu vaccine information for the public
http://www.hse.ie/eng/health/immunisation/pubinfo/fluvaccine/flupublic/Flu.html
HSE Seasonal flu vaccine information for Healthcare workers
http://www.hse.ie/eng/health/immunisation/pubinfo/fluvaccine/infohcw/

Record Vaccination details

1. Choose 'Nursing Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Infections' from the Sub Menu
4. Choose 'Vaccinations' from the Left Menu
5. The List of the Residents Vaccinations details will be displayed
6. Click the 'New Vaccinations' button

7. Enter the details on the popup window, some information is mandatory such as Vaccination Type
8. Enter Expiry Date for the Vaccination
9. Click the 'Save' button

Vaccination Reports

1. Choose 'Reports' from the Main Menu
2. Choose 'Nursing Care' from the Sub Menu
3. Choose 'Vaccinations' from the Left Menu

A list of Vaccination Reports will be displayed

8.4 Medical Devices

This section will cover the care of a resident's medical devices such as a Catheter, PEG and Tracheostomy.

Catheter Care

There are two types of urinary catheters, namely the indwelling urinary catheter and the suprapubic catheter.
Urinary catheterisation is the insertion of a specially designed tube into the bladder using aseptic technique, for the purpose of draining urine, the removal of debris/clots, and the instillation of medication (Dougherty & Lister, 2011). When planning a catheterisation, it is recommended to assess the equipment needed i.e. Catheter type/size/material, balloon size, length of catheter and tip design.
Suprapubic catheterisation is the insertion of a catheter through the anterior abdominal wall into the dome of the bladder. Care of the suprapubic catheter is the same as for a urethral catheter (Doughtery & Lister, 2011).
In the residential care setting, residents' can be admitted with a urinary catheter or require catheterisation at any stage during their stay. Therefore, it is important that nurses are able to record the resident's catheter care details in epicCare. The following are recommended steps to assist nurses to write in their resident's catheter details:

Record Catheter Care

1. Choose 'Nursing Care' from the Main Menu
2. Ensure you are in the correct Resident Record (Consult 'Searching Resident Records')
3. Choose 'Catheter' from the Sub Menu
4. The List of the Residents Catheter Care will be displayed
5. Click the 'New Catheter' button
6. Enter the details on the popup window, some information is mandatory such as Type, Size, Start Date
7. Enter Catheter Review Date
8. Click the 'Save' button

Catheter Reports

1. Choose 'Reports' from the Main Menu
2. Choose 'Nursing Care' from the Sub Menu
3. Choose 'Catheters' from the Left Menu
4. A list of Catheter Reports will be displayed

Percutaneous Endoscopic Gastrostomy (PEG) Care

Percutaneous endoscopic gastrostomy (PEG) is an *endoscopic* medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate for example, because of dysphagia or sedation.

You can view this YouTube clip which describes the procedure of inserting a PEG tube:
http://youtu.be/atQGkK0zW2s

A gastrostomy may be more appropriate than a nasogastric tube where feeding is for medium or long-term feeding. It avoids delays in feeding and discomfort associated with tube displacement (National Collaboration Centre for Acture Care, 2006).

Clinical trials have shown that complications with PEG tubes, such as leakages are rare (Riera et al., 2002). In the residential care setting, residents' can be admitted with a PEG in situ or require a PEG at any stage during their stay. Therefore, it is important that nurses are able to record the resident's PEG care details in epicCare.

Record PEG details

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘PEG’ from the Sub Menu
4. The List of the Residents PEG details will be displayed
5. Click the ‘New PEG’ button
6. Enter the details on the popup window, some information is mandatory such as Tube Type, Pump Type, Size, Insertion Date and Reason for Insertion
7. Enter PEG Review Date
8. Click the ‘Save’ button

PEG Reports

1. Choose ‘Reports’ from the Main Menu
2. Choose ‘Nursing Care’ from the Sub Menu
3. Choose ‘PEG’ from the Left Menu
4. A list of PEG Reports will be displayed

Tracheostomy Care

A tracheostomy (or tracheotomy) is the surgical creation of an opening into the trachea through the neck. Once formed the tracheostomy opening is kept patent with a tube (Serra, 2000) which is curved to accommodate the anatomy of the trachea. A tracheostomy may be carried out:

1. To enable the aspiration of tracheobronchial secretions
2. To bypass any upper respiratory tract obstruction
3. To aid in weaning patients from ventilator support

You can view this YouTube clip to look at undertaking Tracheostomy care:
http://youtu.be/Wimw7bz0fLo
You can view this YouTube clip to look at suctioning a Tracheostomy:
http://youtu.be/UVuPzhOWxRs

In the residential care setting, residents' can be admitted with a Tracheostomy in situ or require a Tracheostomy at any stage during their stay. Therefore, it is important that nurses are able to record the Resident's Tracheostomy care details in epicCare.

Record Tracheostomy details

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Tracheostomy’ from the Sub Menu
4. The List of the Residents Tracheostomy details will be displayed
5. Click the ‘New Tracheostomy’ button
6. Enter the details on the popup window, some information is mandatory such as Tube Type, Insertion Date and Reason for Insertion
7. Enter Tracheostomy Review Date
8. Click the ‘Save’ button

Tracheostomy Reports

1. Choose ‘Reports’ from the Main Menu
2. Choose ‘Nursing Care’ from the Sub Menu
3. Choose ‘Tracheostomy’ from the Left Menu
4. A list of Tracheostomy Reports will be displayed

8.5 Restraints/Enablers

Assign Restraint / Enabler to a resident:

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Restraints’ from the Sub Menu
4. The List of the Residents Restraint / Enabler details will be displayed
5. Click the ‘New Restraint/Enabler’ button
6. Enter the details on the popup window, some information is mandatory such as Restraint/Enabler, Type
7. Enter the Decision Review Date
8. Click the ‘Assign’ button

Restraint / Enabler Usage record:

1. Choose ‘Nursing Care’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Restraints’ from the Sub Menu
4. The List of the Residents Restraint / Enabler details will be displayed
5. Click on the type of assigned restraint / enabler
6. On the popup window, click the 'Record / View Usage' button
7. Click the 'Record Usage' button
8. Enter the usage type / time and any details
9. Click the 'Assign' button
10. Click the 'Return to Restraint / Enabler' button

Restraint / Enabler Reports

1. Choose ‘Reports’ from the Main Menu
2. Choose ‘Nursing Care’ from the Sub Menu
3. Choose ‘Restraints/Enablers’ from the Left Menu
4. A list of Restraints/Enablers Reports will be displayed

9.0 Risk Management

9.1 Incidents

Record Incident details:

1. Choose ‘Risk MGT’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Incidents’ from the Sub Menu
4. Whether the incident relates to a Resident, Employee or Other Person, choose the relevant link from the Left Menu
5. Click the ‘Fill Out Form’ button
5. Enter the relevant details , some information is mandatory such as Event, Description, First Person on scene, Health Care Assistant, Injury, Incident Date/Time and Location
6. Click the ‘Save’ button

Update Incident details:

1. Choose ‘Risk MGT’ from the Main Menu
2. Choose ‘Incidents’ from the Sub Menu
3. Choose 'View Incidents' from the left menu
4. Select status (Open / Closed) and click the 'Search' button
5. Click on the ‘Incident Id’ to be Updated
6. Record any additional information / changes
7. Click the ‘Update’ button

Close Incident details:

1. Choose ‘Risk MGT’ from the Main Menu
2. Choose ‘Incidents’ from the Sub Menu
3. Choose 'View Incidents' from the left menu
4. Select status (Open / Closed) and click the 'Search' button
5. Click on the ‘Incident Id’ to be Closed
6. Click the 'Close' button
7. On the close screen, enter Lessons Learnt, Individual happy with Outcome and Closing Statement
8. Click the ‘Close’ button

Incident Report

1. Choose ‘Reports’ from the Main Menu
2. Choose ‘Risk MGT’ from the Sub Menu
3. Choose ‘Incidents’ from the Left Menu
4. Choose ‘Incident Analysis’ from the List of Reports
5. Enter the Search Criteria for the Report
6. Click the ‘Search’ button

9.2 Complaints

Record Complaint details:

1. Choose ‘Risk MGT’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Complaints’ from the Sub Menu
4. Whether the Complaint relates to a Resident, Employee or Other Person, Choose the relevant link from the Left Menu
5. Click the ‘Fill Out Form’ button
6. Enter the relevant details , some information is mandatory such as Description, Complaint Date/Time and Location
7. Click the ‘Save Details’ button

Update Complaint details:

1. Choose ‘Risk MGT’ from the Main Menu
2. Choose ‘Complaints’ from the Sub Menu
3. Whether the Complaint relates to a Resident, Employee or Other Person, Choose the relevant link from the Left Menu
4. Choose 'View Complaints' button from the left menu
5. Select status (Open / Closed) and click the 'Search' button
6. Click on the ‘Complaint Id’ to be Updated
7. Record any ongoing Interventions
8. Click the ‘Update Complaint’ button

Close Complaint details:

1. Choose ‘Risk MGT’ from the Main Menu
2. Choose ‘Complaint’ from the Sub Menu
3. Whether the Complaint relates to a Resident, Employee or Other Person, Choose the relevant link from the Left Menu
4. Choose 'View Complaints' from the left menu
5. Select status (Open / Closed) and click the 'Search' button
6. Click on the ‘Complaint Id’ to be Closed
7. Enter the reason for closure located to the end of the complaint form
8. Click the ‘Close Complaint’ button

Complaint Report

1. Choose ‘Reports’ from the Main Menu
2. Choose ‘Risk MGT’ from the Sub Menu
3. Choose ‘Complaints’ from the Left Menu
4. Choose from the List of Reports
5. Enter the Search Criteria for the Report
6. Click the ‘Search’ button

9.3 Concerns

Record Concern details:

1. Choose ‘Risk MGT’ from the Main Menu
2. Ensure you are in the correct Resident Record (Consult ‘Searching Resident Records’)
3. Choose ‘Concerns’ from the Sub Menu
4. Whether the Concern relates to a Resident, Employee or Other Person, Choose the relevant link from the Left Menu
5. Click the ‘Fill Out Form’ button
6. Enter the relevant details, some information is mandatory such as Concern Type, Title, Category, Location, Details, Expected Outcome, Concern Date, Review
7. Click the ‘Save Details’ button

Update Concern details:

1. Choose ‘Risk MGT’ from the Main Menu
2. Choose ‘Concerns’ from the Sub Menu
3. Whether the Concern relates to a Resident, Employee or Other Person, choose the relevant link from the Left Menu
4. Choose 'View Concerns' from the left menu
5. Select status (Open / Closed) and click the 'Search' button
6. Click on the ‘Concern Title’ to be Updated
7. Record any ongoing Interventions Click the ‘Update Interventions’ button

Close Concern details

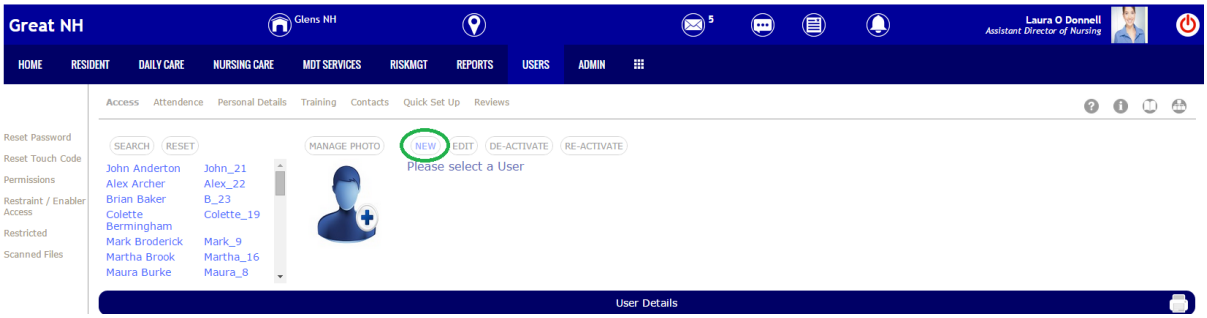
1. Choose ‘Risk MGT’ from the Main Menu
2. Choose ‘Concerns’ from the Sub Menu
3. Whether the Concern relates to a Resident, Employee or Other Person, Choose the relevant link from the Left Menu
4. Choose 'View Concerns' from the left menu
5. Select status (Open / Closed) and click the 'Search' button
6. Click on the ‘Concern’ to be Closed
7. Enter Lessons Learnt and record whether the concerned party was satisfied along with the reason for closure
8. Click the ‘Close Concern’ button

Concern Report

1. Choose ‘Reports’ from the Main Menu
2. Choose ‘Risk MGT’ from the Sub Menu
3. Choose ‘Concerns’ from the Left Menu
4. Choose from the List of Reports
5. Enter the Search Criteria for the Report
6. Click the ‘Search’ button

10.0 Users

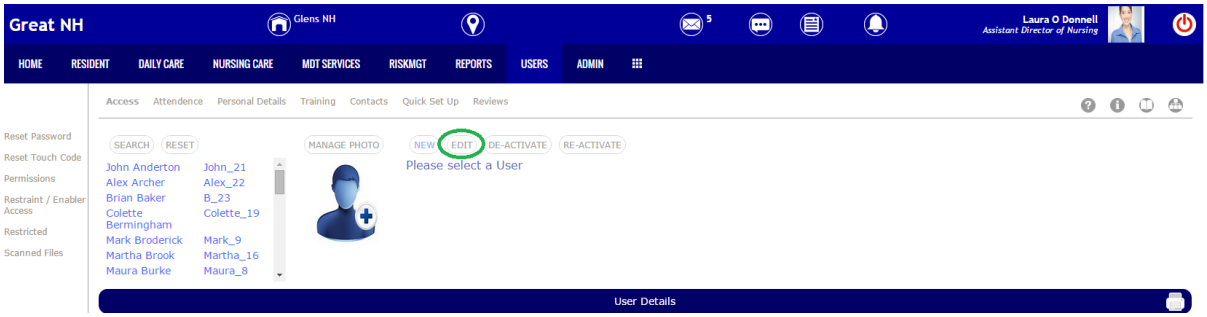
10.1 Adding a New User



Navigate to Users on the Main menu. You will automatically be presented with the Users Biographic page. To enter a New User follow these simple steps:

1. Choose ‘Users’ from the Main Menu
2. Click the ‘New’ button. A pop up window will appear and you will be presented with the Mandatory required Users Information
3. Fill out the Mandatory Fields
4. Click the ‘Create’ button

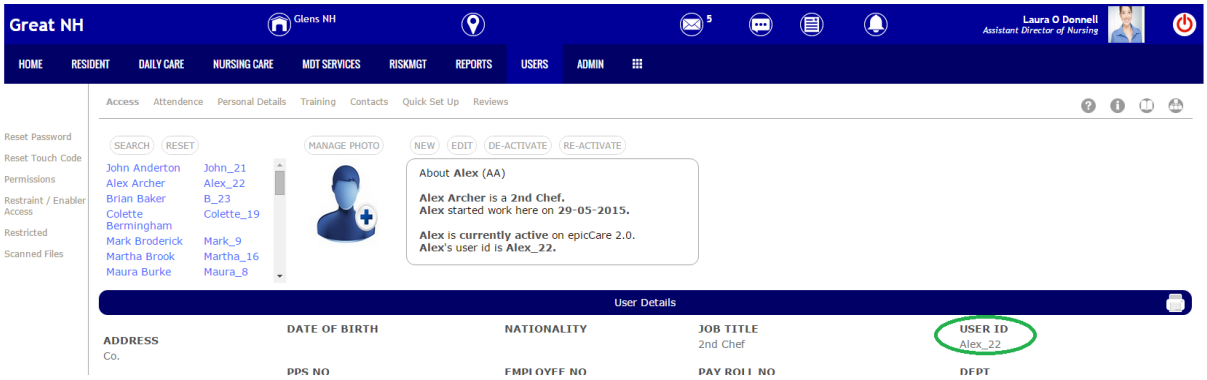
10.2 Edit User Records



You may require to either change information you have entered or add new information relating to the user. To do this follow these simple steps:

1. Choose ‘User’ from the Main Menu
2. Ensure you are in the correct User Record (User selected should appear in the About box)
3. Click the ‘Edit’ button. A pop up window will appear and you will be presented with the most commonly changed User Information
4. Enter or change the information required
5. To enter further information click on the ‘Advanced’ Tab
6. Click the ‘Update’ button

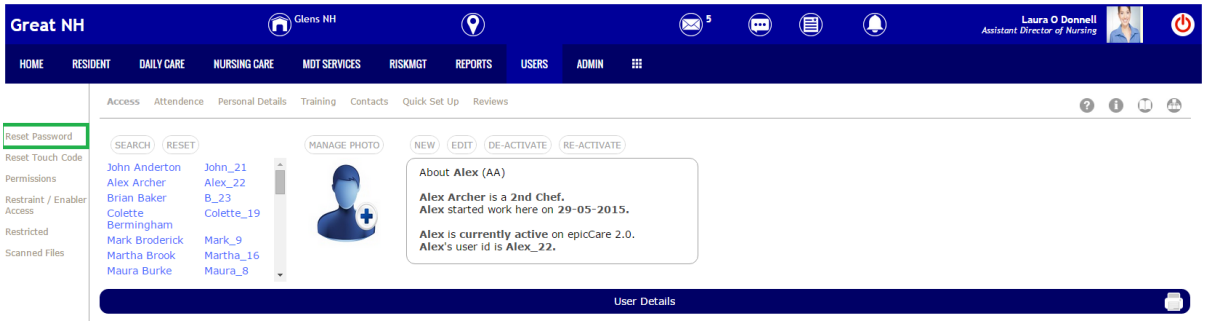
10.3 Check a User Id



When a User is created they are assigned a unique User Id which is required when logging into epicCare 2.0. To view a User's user id, follow these simple steps:

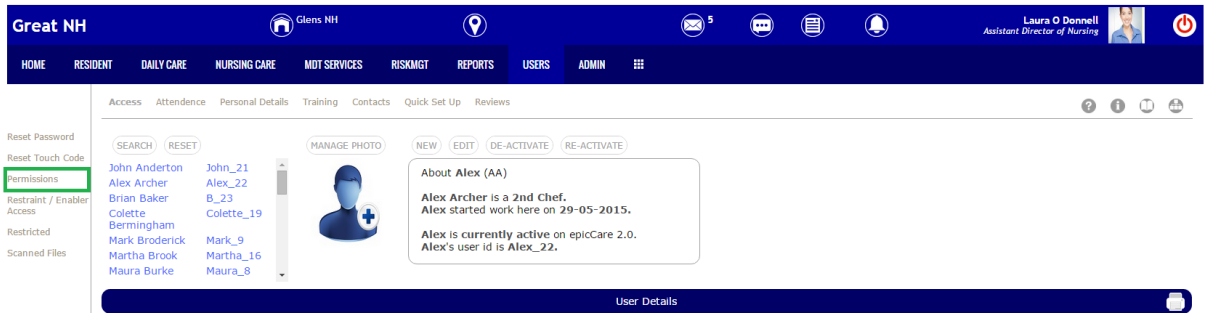
1. Choose 'User' from the Main Menu
2. Click on the name of the user from the scroll list
3. The user id for this user will be displayed on screen for you

10.4 Assign User Permissions



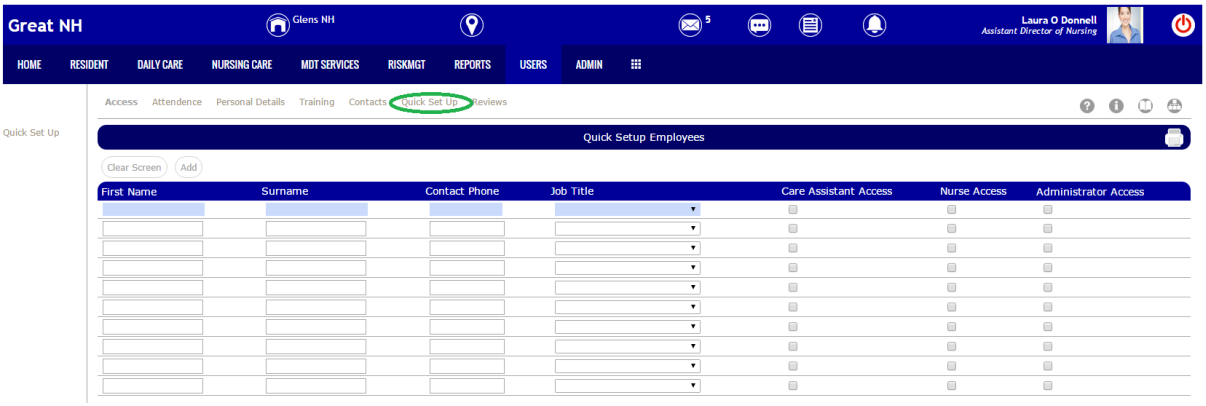
1. Choose 'User' from the Main Menu
2. Click on the name of the user from the scroll list
3. Click 'Permissions' from the left menu
4. Click 'Modify Permissions'
5. Choose the relevant permissions for the user
6. Click 'Update'

10.5 Reset User Password



1. Choose ‘User’ from the Main Menu
2. Click on the name of the user from the scroll list
3. Click ‘Reset Password’ from the left menu
4. Click ‘Password Reset’
5. Enter the Old Password
6. Enter the New Password
7. Enter the New Password to verify it
8. Click ‘Reset’

10.6 Add Multiple Users with Default Permissions



You may wish to add a number of new Users with the same permissions. In this instance you can use our User Quick Set up. To do this, follow these simple steps:

1. Choose ‘User’ from the Main Menu
2. Choose ‘Quick Set Up’ from the sub menu
3. Enter the mandatory information about the new user’s and tick which level of default permissions to assign to each user
4. Click ‘Add’
5. The newly created User’s will appear on the bottom of the screen for you along with their assigned User Id

11.0 CORRELATION OF DATA

epicCare comes with a standard set of integrated reports, audits and dashboards which are a reliable source of consolidated, factual and up-to-date information that can be used for planning and decision making. Inputting data and information into the epicCare system enables significant benefits in terms of reducing the time you need to spend on administrative activities, consolidating information and generating accurate reports for regulatory and operational purposes.

11.1 Learning Outcomes

On successful completion of this module, you will be able to:

1. Explain the importance of inputting various types of data in epicCare
2. Describe the types of Nursing Reports generated by epicCare
3. Describe the types of Resident Reports generated by epicCare

11.2 Overview of the importance of inputting various types of data required to generate Reports

The Code of Professional Conduct states that nurses 'must ensure that the health care record for the patient or client is an accurate account of treatment, care planning and delivery. It should be written with the involvement of the patient or client wherever practicable and completed as soon as possible after an event has occurred. It should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared'. (NMC, 2002a)

In adhering to this, it is important that correct reminder dates / evaluation dates as well as options from drop down menus are chosen as this will have an impact on the data that the reports will display.

11.3 Reporting

Simple Audit Reports

All Resident Reports are located in the Reports section of epicCare

1. Choose 'Reports' from the Main Menu
2. Choose 'Residents' from the Sub Menu
3. Choose the relevant option from the Left Menu depending on the report you are looking for

If you are unable to locate a report, you can use the 'Search Reports':

1. Choose 'Reports' from the Main Menu
2. Choose 'Search' from the Sub Menu
3. Choose 'Search Reports' from the Left Menu
4. Click the 'Find a Report' button
5. Enter:
    - The Report Type, if known
    - Date Search Field Available (Yes or No)
    - Part or all of the name of the report
6. Click the 'Search' button

11.4 Nursing Reports

Types of Nursing Reports:

Resident Allergies Report
Resident Assessment Report
Resident Conditions Report
Resident Reminders Report
Resident Void Report
Resident with MRSA Records
Resident Continence Wear
Assessment & Care Plan Evaluations
Resident Medications Report
Resident Medical History Report
Resident Doctors Report
Resident Falls Report
Resident Restraint Report
Resident Medical Report
Resident Wounds Report
Resident No Bowel Movement Report
Resident Incomplete Admissions Report
Resident Progress Report Entered Report
Resident Latest MRSA Records Report
Resident Contacts Report
Resident Oxygen Report
Resident Handover Report
Resident Priority Entries Report
Resident Body Map Report
Resident Dependency Level Report

11.5 Resident Reports

Types of Resident Reports:

Current Resident Report
Medication Report
Doctor-Patient Report
Resident Nurses Report
Resident Named Nurse
Customised Resident Report
Resident Accommodation Status
Resident Details Report
Resident ADL Report
Touch Care Admin
Resident Facilities Report
Resident Tenancy Report
Resident Directory Report
Resident Registrar Report
Bed Occupancy Report
Residents in Home Report
Resident Transfer Record Report
Pocket Money per Resident Report
Pocket Money Statements
Deceased Residents Report
Resident Admissions & Discharges Report
Older Peoples Services Report
Survey Reports
Resident Therapy Report
Resident Property Report

11.6 Touch Care Reports

1. Choose ‘Reports’ from the Main Menu
2. Choose ‘Cross Reference’ from the Sub Menu
3. Choose ‘Touch Care’ from the Left Menu
4. A list of Touch Care Reports will be displayed

11.7 Overview Reports

The Reports section of epicCare has been designed with Simple, Logical Navigation in mind. The Sub Menu in Reports replicates the epicCare Main Menu and the Left Menu for each Sub Menu option replicates the Sub Menu for that Main Menu option.

For example, if you are looking for an Infections report, the simplest way to find it is to think about where you would record Infections on epicCare:

Main Menu: Nursing Care
Sub Menu: Reports

Therefore, the Infections Reports can be found by repeating this navigation within the Reports Section:

Main Menu: Reports
Sub Menu: Nursing Care
Left Menu: Infections

If you are still unable to find the Report you are looking for, there is a Search Option available:

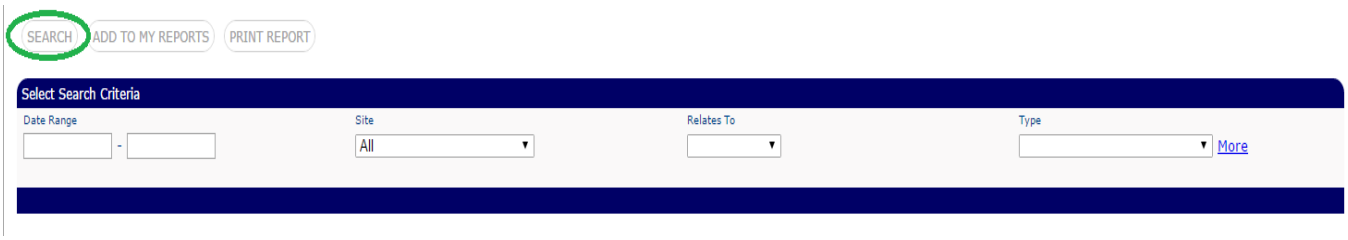
Search for a Report

1. Choose 'Reports' from the Main Menu
2. Choose 'Search' from the Sub Menu
3. Choose 'Search Reports' from the Left Menu
4. Enter any information known
5. Click the 'Search' button

11.8 Navigation / Search Criteria Selection

Within the epicCare reports, if search criteria is available, this will appear in the 'Select Search Criteria' area on the report. Where additional search criteria is available, click the 'More' button to view these options.

Once you have selected your search criteria, click the 'Search' button to view the report results.



11.14 My epicCare Reports

Access to My epicCare Reports

Click the 'My epicCare Reports' icon located in the top menu 

This will take you to the 'My epicCare Reports' screen which will contain all reports you have chosen to 'Add to my report'.

Add Report to My epicCareReports

If you wish to add a report to 'My epicCare Reports', click the 'Add to My Reports' button which is available on each epicCare report.

Example:

To add Dependency Level Report to my Reports

1. Choose 'Reports' from the main menu
2. Choose 'Resident' from the sub menu
3. Choose 'General' from the left menu
4. Click 'Dependency Level' report
5. Click 'Add to My Reports' button

Remove Report from My epicCare Reports

If you wish to remove a report from 'My epicCare Report', click on the report name from the 'My epicCare Report' screen and click the 'Remove From My Reports' button.

Example:
To remove Dependency Level Report from my Reports

1. Click the 'My epicCare Reports' icon from the top menu
2. Click 'Dependency Level' from the list of reports
3. Click the 'Remove From My Reports' button

This report name will then no longer appear in your list of 'My epicCare Reports'.

12.0 epicCare Support Procedure

12.1 epicCare Support Process

Support Requests are categorised into two main areas:

1. General Support - this relates to helping users in the day-to-day operation of the epicCare system where no changes to software are required. This typically involves helping users navigate, perform functions that they may not use regularly, remedy mistakes and assisting with system configuration

2. Change Request – Is typically where users have identified enhancements, changes or modifications to epicCare that they believe would be beneficial to their individual operations or to epicCare as a product.

12.2 General Support

We will endeavour to deal with all General Support requests on the day they are logged. Sometimes this is not always possible, however rest assured we see this as a priority and will work very hard to address any such support at our earliest opportunity.

When dealing with General Support it sometimes becomes apparent that a lack of familiarity with the epicCare system is evident. epicCare only provide support for users that have received formal training on the version and/or specific area of epicCare that they require support for. In such cases we will highlight this to you along with recommending and appropriate training options. In most cases an hour long online training session can achieve a lot and in cases where more specialised training or help is needed, online training with a specialised focus can be scheduled.

12.3 Change Request

We are constantly working very hard to ensure that epicCare software is continually improving and provides the solutions our clients need in terms of usability, flexibility and functionality, while taking account of feedback from our users, Industry Best Practice and Regulations.

While we value all feedback we inevitably have to carefully prioritise and select the feedback that results in the most significant benefits for our clients and work these into our Quarterly Software Release program. Unfortunately we cannot implement all the suggestions and recommendations we receive and some disappointment is unavoidable.

We aim to evaluate all change requests we receive during the week by the end of that week, typically on a Friday. No other updates or changes to epicCare will be considered outside of our normal schedules unless they have been deemed urgent at the sole discretion of the epicCare Customer Services and Software Development teams.

Suggestions and recommendations for new options, features, functionality and enhancements and changes to general look and feel, design, layout, colour, require stringent analysis, development and testing. This takes time, investment and resources so will be carefully planned and scheduled to be released as part of our Quarterly Software Release program. Where our schedules allow, we may implement some changes as part of a Weekly or Monthly Patch.

12.4 – How to determine who is best placed to resolve isses when using epicCare

When an issue occurs, the following categorisation applies:

Issue	Responsibility
Software – epicCare	Epic Solutions
Infrastructure (broadband and network)	Your Infrastructure/boardband Provider
Hardware	Your IT Provider

Determine if issue relates to epicCare software by checking any of the following:

1. Does the epicCare software work in any other part of the building
2. If you have more than one site, does the epicCare software work in any of these sites
3. Call Epic Solutions and ask are there any issues with the epicCare software

If Epic confirms that the epicCare software works then the issue is related to either 'Infrastructure' or 'Hardware' and the effective resolution will be through your IT provider.

12.5 – Typical Infrastructure Issue

Typical Infrastructure Issues include:

1. Network or Internet Connectivity Issues
2. Slow Connections
3. Loose or damaged cables, connection or wires

Typical Hardware Issues include:

12.6 – Hardware Issue

PC will not boot up
Non responsive screens eg Screen 'freezes' or performance is slow

12.7 – Typical Site Support Issues Statistics:

95% of Issues are related to Infrastructure Connectivity
4% of Issues are related to Hardware configuration
1% of issues are related to Software