In PointClickCare, how do I...

Health PEI Long Term Care Division

Version 1.3 (June 9, 2025)

In PointClickCare, how do I…

General

ADT

Maintaining the Resident's Admin Profile

Maintaining the Resident's Clinical Profile/Chart

Care Planning and POC Task Management

Assessments

Internal Referrals

Orders

Common Clinical Actions

RCW-specific Work Processes

LPN-specific Work Processes

RN-specific Work Processes

Recreation-specific Work Processes

PT/OT/Rehab Activities

IPAC Activities

Trust Account Management

…change my PIN?

1 In the top right corner, click your name and select 'Edit Profile'.

My Profile Settings

Long Username: Jennifer Jelley   Change Alternate Password/PIN **2**

Login Name: peltctrain. jjelley@ih

Password Change

Changing password for user jjelley@ihis.org:

Old Alternate Password/PIN:	●●●●●●●●●●●●
New Alternate Password/PIN:	
Confirm Alternate Password/PIN:	0/26

3 Create a new PIN and click 'Save'.

Do **not** check ☐ Terminate all sessions for this user after password/PIN update

Save   Cancel

…access SmartZone training?

1. From the PointClickCare LIVE software, click Home > External Links > SmartZone with SSO (automatically signs into your SmartZone account).
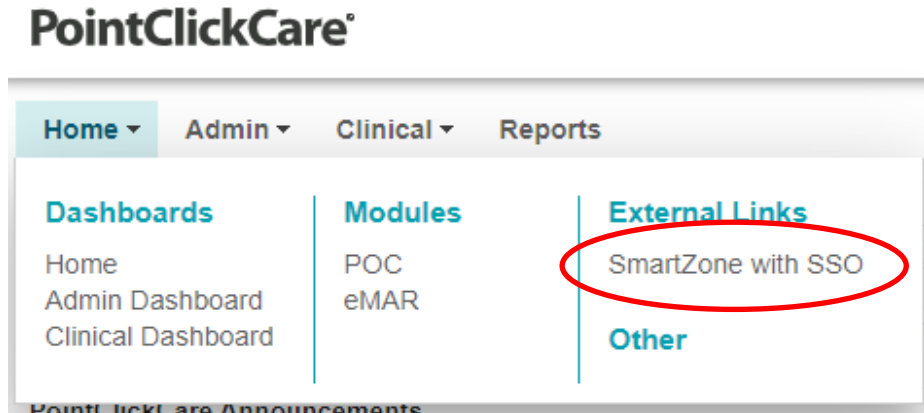
- OR -

2. From the PointClickCare LIVE software, click on the question mark that appears on the top right side of the screen and pick 'Train Me'.
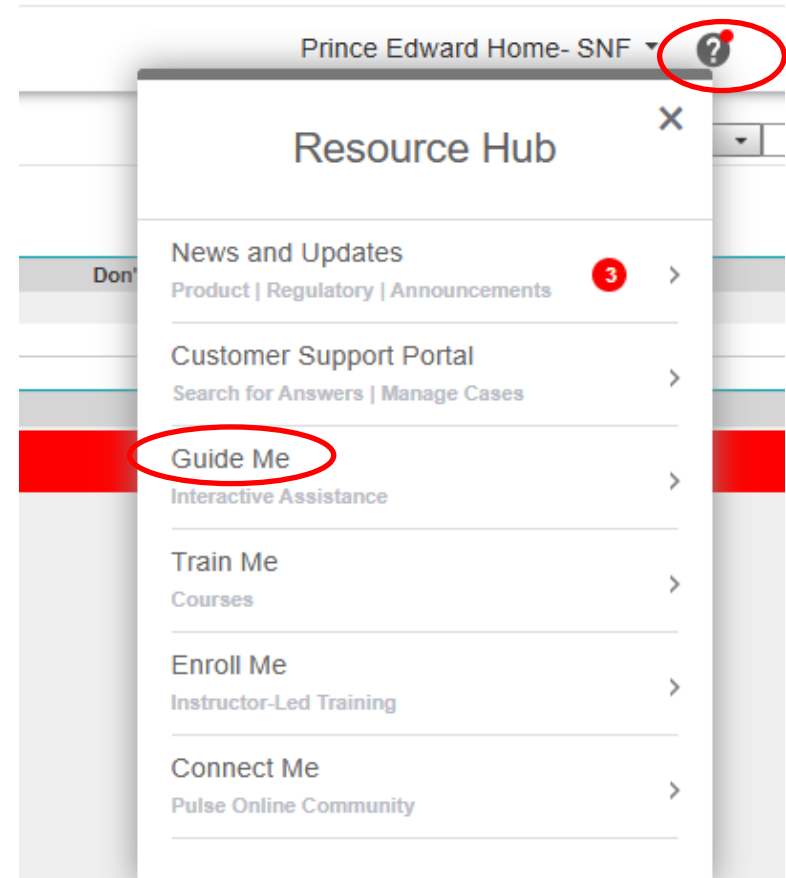
…have additional picklist items added to the system?

Please email a completed Change Request Form to: LTCSolutionoffice@ihis.org

Note: Forms will be added to the Staff Resource Centre.

…edit the layout of the Resident Dashboard?
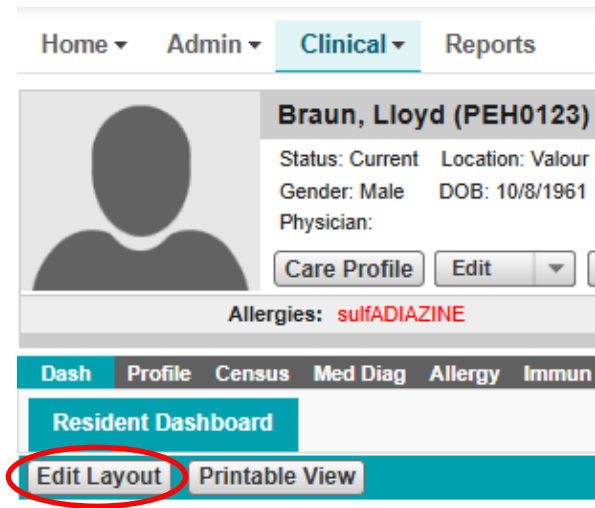
Edit the layout of your dashboard by clicking/unclicking from the list of options.

You can also drag and drop the positions of the boxes on the right-hand side.
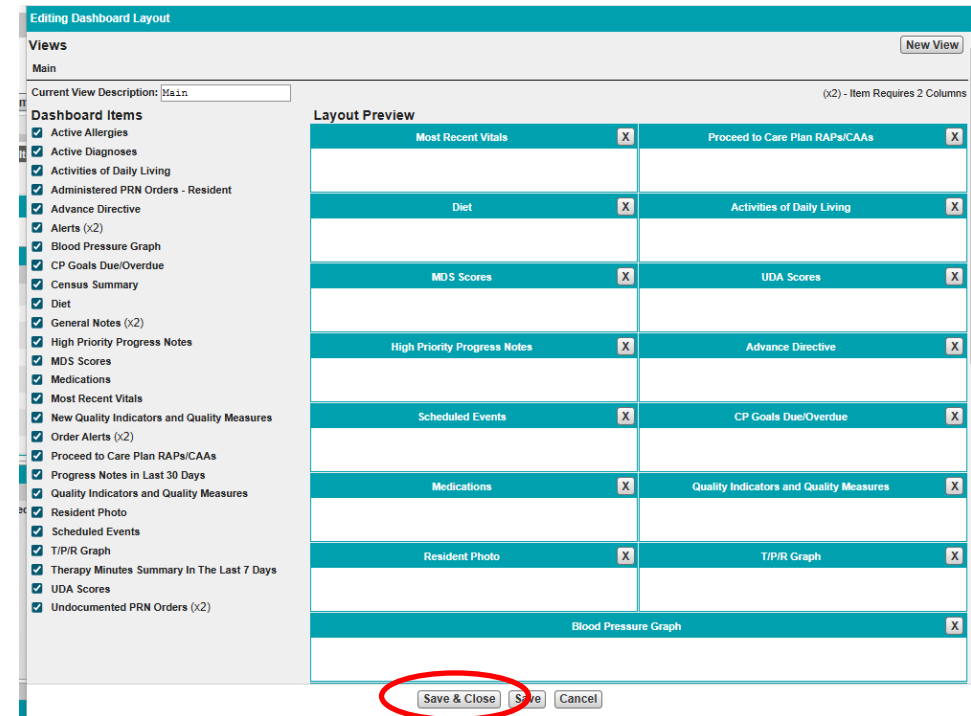
…run a report?
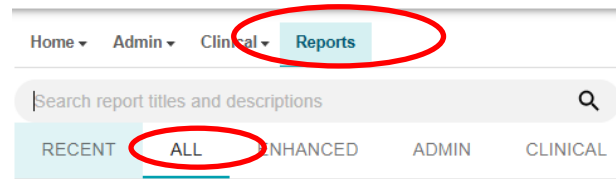
Under the Reports tab, type in a key word to search 'ALL' reports available

- Recent: Reports you run in the last 60 days
- Enhanced: Features save settings for future use

- To narrow down a search, click on a Sub Module

Reports (Finance)

Topic	Report
List of cheques written Review all Trust Account Transactions	• Bank Activity Report - *must copy and paste into excel and remove the cell merging to manipulate until csv export is ready*
Month-end reconciliation	• Audit Report
Account Balance	• Current Account Balance Report • Min/Max Balances (to ensure thresholds are not exceeded)
Resident summary statement	• Trust Statement • Trust Transaction History
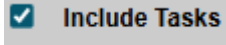
Reports (Clinical)

Topic	Report
Shift Summary	• Shift Report (can also be accessed via clinical dashboard) • 24-Hr Summary
Audits	• Alert Audit Report • Alert Listing Report
Data Integrity	• Missing Entries Report • Task List Report (*check last box – include only tasks that require documentation*)
Vaccinations	• Enterprise Immunization Rates • Immunization Report • Missing Entries Report – *select 'report on immunizations'*
Care Planning	• Care Plan Report • Care Plan Review Due • Care Plan Focus Summary • Care Plan Item/Task Listing • Care Records
Restraint Use	• Look Back Report (select Monitoring Restraints)

Reports (Clinical)

Topic	Report
Orders	• Order Listing Report • Order Summary Report • Order Recap Report
Allergies	• Allergy Report
Alerts	• Alert Audit Report (view multiple homes) • Alert Listing Report – shows cleared alerts for a household (uncheck complex)
Weights	• Monthly Weight Report • Weight Calculations Range Report • Weights and Vitals Summary
Assessment Status	• Assessment Scheduling Report • Assessment Warnings Report • Assessment Schedule Audit Report
Late Documentation	• Audit Report (Clinical – Point of Care) > select documentation type 'late' in the filters

Reports (Clinical)

Topic	Report
Progress Notes	• Progres Notes NEW Report (Select type of note to display under filter options)
Infection Control	• Progress Notes NEW Report – select Infection Prevention & Control Note Type from the list • Alert Listing Report • Task List Report
Assigned Tasks	• Kardex Report – select Position to view all assigned tasks assigned to that group within a defined period ☑ **Include Tasks**
Planning and scheduling resources	• Intervention/Task Schedule Report
Basic Resident Summary	• Kardex Report
Transfer out to Hospital	• Transfer/Discharge Report • From the resident's chart > Print > Generate/View Clinical Chart (option to include photo)

Reports (Diet/Nutrition)

Topic	Report
Orders	• Order Listing Report • Order Summary Report • Order Recap Report
Diet/Nutrition	• Diet Type Report - More than one Diet Type cannot be selected in a Diet Order As a Work around to show a secondary Diet Type, navigate to: •Clinical > Residents > Orders •New > Order Category: Diet > Diet Type: Choose the Type In the Additional Directions enter the secondary diet or create an additional Order for the secondary diet type OR Request the creation of a new diet type that contains more than one type through the LTCSolutionOffice@ihis.org: Clinical > Orders > Picklists > Diet Type New > Add new name > Save • Nutrition Report - The Nutrition Report uses the documented responses from the existing "system" Follow Up Question "What percentage of the meal was eaten?" High risk (decreased meal intake of 2 meals @ =<50% at least one time during report week AND weight loss for report week) Medium risk (decreased meal intake OR weight loss)
Allergies	• Allergy Report
Alerts	• Alert Audit Report (view multiple homes)
Weights	• Monthly Weight Report • Weight Calculations Range Report • Weights and Vitals Summary

Reports (Clinical)

Q: How can I get a list of residents who have no bowel movement documented in 3 days?
A: You can run the Complex Alert Documentation Report

Reports (Recreation)

Topic	Report
Birthdays	• Birthday List
Spiritual Preference	• Religion List
Food/Diet	• Diet Type Report
Program Participation	• Event Calendar Report • Event Calendar Comparison Report • Look Back Report
Language Preference	• Language List
Allergies	• Allergy Report
Contact Emails	• Resident Contacts Report

Reports (Events)

Event Calendar - Report Setup

Report Options

Resident Number:	[ ] 🔍 Leave blank for all residents
Resident:	[ ] 🔍 clear
Unit	All ▾
Floor	All ▾
Status:	Current ▾
Sort By:	Event Type ▾

Filter Options

Scheduled Month:	February ▾ 2025 ▾
Include Calendar Events From:	All ▾
Event Type:	🔍

Choose Home Events or Resident Events

Reports (Admin)

Topic	Report
Number of Residents and Resident Days	• Census • Detailed Census • Midnight Census
Resident Demographics & Length of Stay	• Resident List Report (New) – *leave most filters blank and select fields to display* • Age Summary Report
Bed Occupancy	• Occupancy Report • Empty Beds list • 24 Hour Summary Report
Deaths & Transfers	• Action Summary Report
Resident Complexity	• Order Listing Report
User roles and security profile	• User List Report
Information audits and data integrity	• Missing Entries Report
Assessment Results	• Assessment Scoring Report • Resident Response Comparison • Resident Response List
Contact List	• Resident Contacts Report

Reports (Clerical Staff)

Topic	Report
Resident List	• Resident List Report (New)
Scheduling Care Plan meetings	• Care Plan Reviews Due
Print a resident's Care Plan	• Care Plan Report
Contact list	• Resident Contacts Report
Face Sheet (resident summary)	• Admission Record Report
Check chart completion	• Missing Entries Report

…register a new Resident?

3

New Resident Entry - Google Chrome

www60.pointclickcare.com/admin/client/mpisearch.jsp

New Resident Entry

○ **No residents were found matching the search criteria**
First: bet Last: wh
If you wish to perform another search, please click the 'Back' button.
If you wish to create a new resident, click the 'Continue' button.

Back   Continue   Cancel

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Do not enter 'Last Physician Visit. **Clear** 'Next Physician Visit'.

PointClickCare

Home ▾ | Admin ▾ | Clinical ▾ | Reports

Resident Detail - New Resident

Save | Save & New | Cancel

Last Admission: Sturgeon, Gerry (112)   On: 12/2/2024

Resident Number:
Prefix / First Name: ▾   *
Surname / Suffix: ▾
*
Preferred Name:
Medicare Beneficiary ID:
RN Supervisor and Contact Number:

Middle Name:
Maiden Name:
Provincial Health Number:
Social Insurance Number:
Resident Barcode #:   H

Birth Date: (M/D/YYYY)
Estimated Discharge Date:
Most Recent Admission (Re-entry):
Birth Place:
Sex: ▾
Sexual Orientation: ▾
Gender Identity: ▾
Ethnicity: ▾
Secondary Language: ▾
Occupations:
Education: ▾
Allergies: To Be Determined   *

Initial Admission Date:
Discharge Date:
Deceased Date:

Citizenship: ▾
Marital Status: ▾
Religion: ▾
Race: +
Primary Language: ▾
Interpreter Needed: ▾
Default Pharmacy: PEI Provincial Pharmacy (Pharmacare) ▾
No Known Allergies: ☐

High Risk: ☐
Waiting List: ☐

Last Physician Visit: 📅
Last Order Review: 📅
Previous address:

Next Physician Visit:
Next Order Review:

Grant Consent to Share and Receive Records, for the Purpose of Coordinating Care. H

Consent Date: 📅
Provider of Consent: ○ Client
○ Substitute Decision Maker
Name of Person Providing Consent:
Relation to Client: ▾
Allow staff involved in my care to get access to my medical records from my prior caregivers, and to share my current medical record with other providers who can assist in my current or future care.: ○ Yes   Reset Consent
○ No

Ensure General Consent paper form is completed and filed. Dates must align

City:
Country: Canada
Prov/State:
Postal/Zip Code:

Home Phone:
Mobile Phone:
Email Address:

Resident's phone and email.

Save | Save & New | Cancel

Do not use either of these

Required fields to complete:
First Name, Surname, Health Card Number, Birthdate, Sex, Consent, Marital Status, Religion, Mobile Phone, Email

Recommended: Preferred name, middle name, primary language

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…admit a new Resident?

Go to the Resident list > select 'New' > click on 'adt' beside resident's name
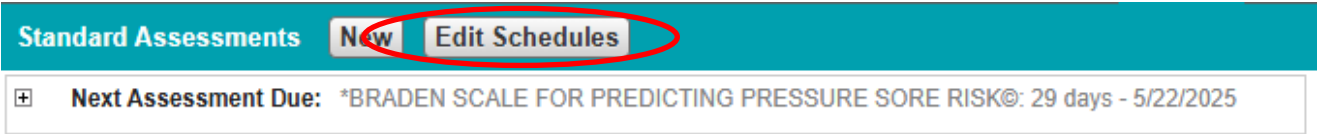
Quick ADT Method (After Hours)

- Use Quick ADT when there is limited information available to start the resident's chart.
  - Search for the resident to ensure they have not already been setup in the system.

- Effective Date should be accurate – clinical tasks and schedules may be triggered using this date.

- This creates an incomplete census entry which appears yellow until updated.
  - Staff need to update the Incomplete Census Dashboard to review and complete the required information.

Click on the name or 'update'

Edit and Save
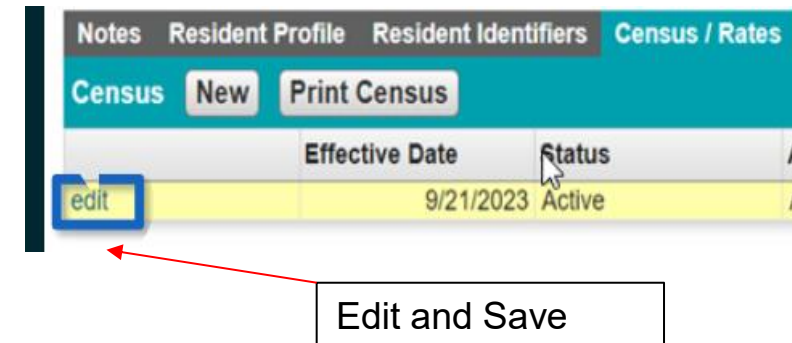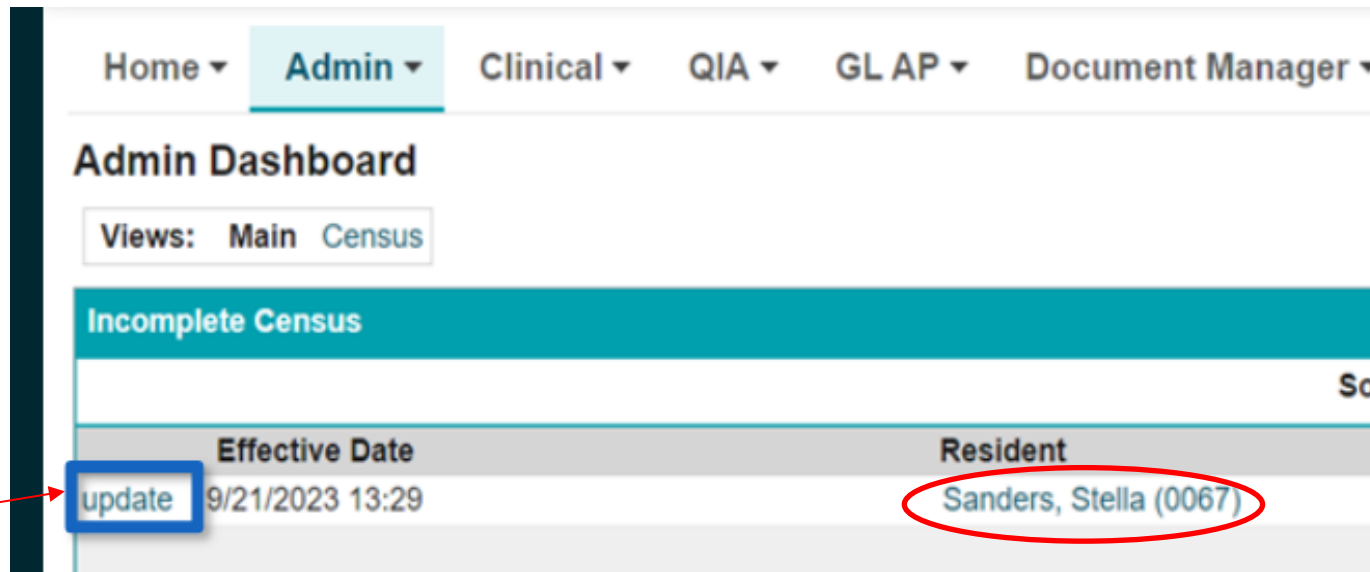
Respite Admission Assessments

Not all admission assessments are necessary for respite stays. Therefore, when admitting for a respite stay, follow these directions to prevent overdue assessments.

1. To clear the assessment schedules, select 'Edit Schedules' in the Assessment tab of the resident's chart.

Standard Assessments   New   Edit Schedules

⊞   **Next Assessment Due:**   *BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK©: 29 days - 5/22/2025

2. A new window will open. Select 'Clear All'.

Assessment Scheduling - Work - Microsoft Edge
https://www60.pointclickcare.com/care/chart/assess/activateschedule.jsp?ESOLminiToken=pY3...

Schedule Activation   **Assessment:** *Time of My Life
Default Schedule
De-activate   Admission   Admission

Clear All   Close

Clear All Schedule - Work - Microsoft Edge
https://www60.pointclickcare.com/care/chart/assess/clearallschedule.jsp?ESOLclientId=8285

Clear All Schedules

Reason for Clearing: Not necessary to complete for   **As of Date:** 4/23/2025   Refresh List

	Schedule Description	Assessment Description	As of Date
☑	Admission	*Time of My Life	4/17/2025
☑	ACTIVITY INITIAL - ADMIT	*Recreation - Admission Assessment	4/19/2025
☑	Podiatric - Admission	*Foot Assessment	4/19/2025
☑	TB Screen - Admission	*TB Screening for LTC Residents	4/17/2025
☑	Tena Assessment - Admission	*Continence Assessment	4/19/2025
☑	Nursing Admission	*Admission Database - Multi-disciplinary	4/18/2025
☑	Initial assessment	*Violence Assessment Tool	4/19/2025

Check All   Uncheck All   Clear All   Cancel

3. Another window will open. Select only the assessments you do not wish to complete for the respite admission. Select 'Clear All' once more to clear the assessment schedules.

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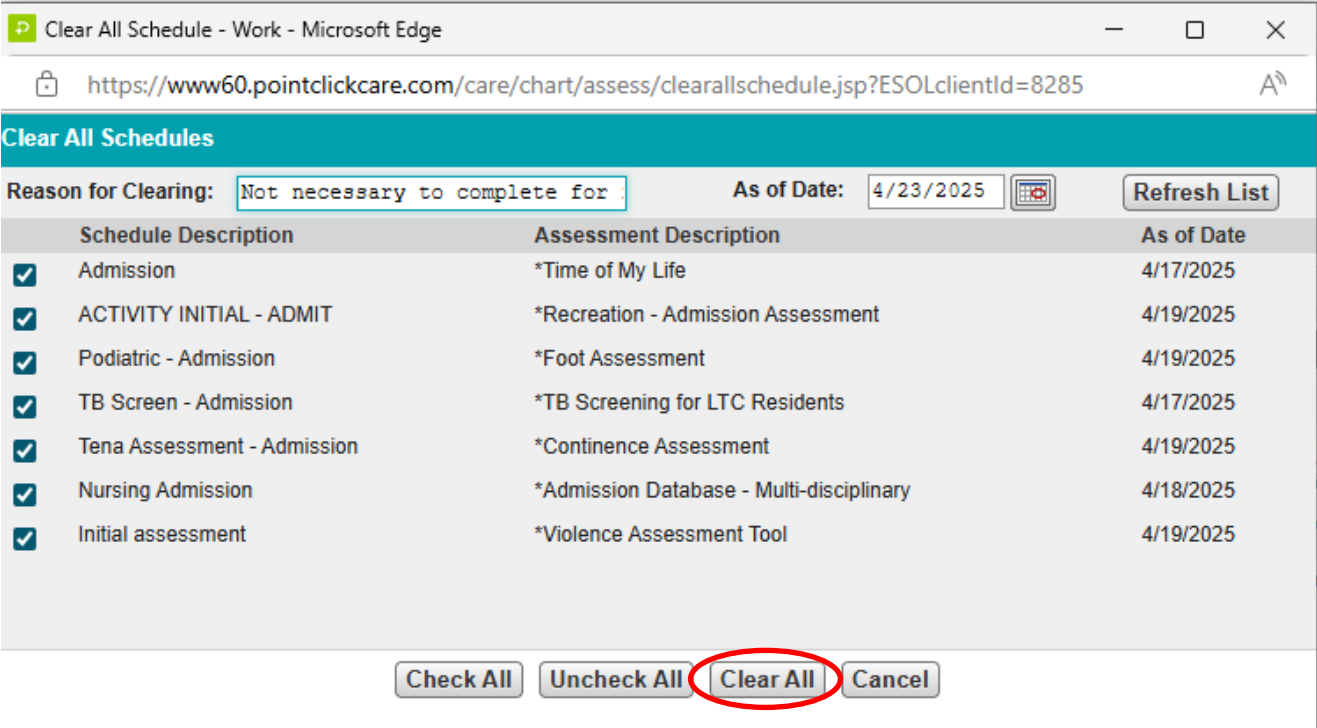
Admission Assessments

Upon admission, there are several assessments that will be generated in the resident's Assessment tab.
Various roles are responsible for these assessments, shown on the next slide.

Significant Change Notice:

The previously known 'Nursing Database' has been turned into two separate documents: One prior to admission and one on day of admission.

1. Pre-Admission Review
    a. As it suggests, this can be done prior to the resident's actual admission.
    b. The Pre-Admission Review captures all the resident's historical data, the extent to which they can assist in caring for themselves, i.e., ADL assistance, emergency contact information, etc.
    c. Upon locking this assessment, the initial care plan will be generated. Once locked, you're responsible for going to the care plan to customize all required information. See Care Plan slides.

2. Head-to-Toe Assessment – Captures the initial assessment of the resident on the day they move into the home.

For instructions on how to complete an assessment, please refer to the Assessments section of the 'How do I...' slides.

Admission Assessments
(Note role responsible)

Assessment Name	Notes on Changes	Frequency							Role Most Responsible										
		Upon Admission	Monthly	Annually	After Event	At Discharge / Death	Upon Change in Resident Status	As Needed	RN	LPN	PT	OT	Rehab Assistants	RD	FSS	SW	RCW	Recreation	TLR Trained Assessors
Braden Scale		✓	✓														✓		
Columbia Suicide Severity Scale	Only when triggered	✓		✓				✓	✓										
Continence Assessment	(Formerly "Tena" Assessment)	✓						✓									✓		
Footcare Assessment		✓*							✓										
Head to Toe Assessment		✓							✓										
Pain Assessment in Advanced Dementia (PAINAD)	Only when triggered	✓†							✓	✓									
Pre-Admission Review	Captures resident history and generates the initial care plan. Can be done before admission.	✓							✓										
Recreation – Admission Assessment		✓																✓	
Scott Fall Risk Screening Tool		✓			✓				✓	✓									
TB Screening		✓							✓										
Time of my Life		✓																✓	
TLR Assessment		✓		✓			✓												✓
Violence Assessment Tool (VAT)		✓			✓				✓	✓									

Pre-Admission Review – Building the initial Care Plan

Sample page of Pre-Admission Review

Embedded within this assessment is the ability to build the initial Care Plan.

The selected focus, goal, and intervention(s) will be populated in the care plan upon locking this assessment.

After locking, you will proceed to the care plan tab to add the customization that's required, i.e., stating what the resident is able to do for themselves and how staff will assist. Doing so also begins to create the resident's Kardex, which gives RCWs instructions as to how to care for the resident.

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Initial Care Plan and Kardex – Baseline for all residents

ADLs
- Bathing
- Eating
- Dressing
- Personal Hygiene
- Toileting / Elimination

Ambulation
- Bed Mobility
- Transferring
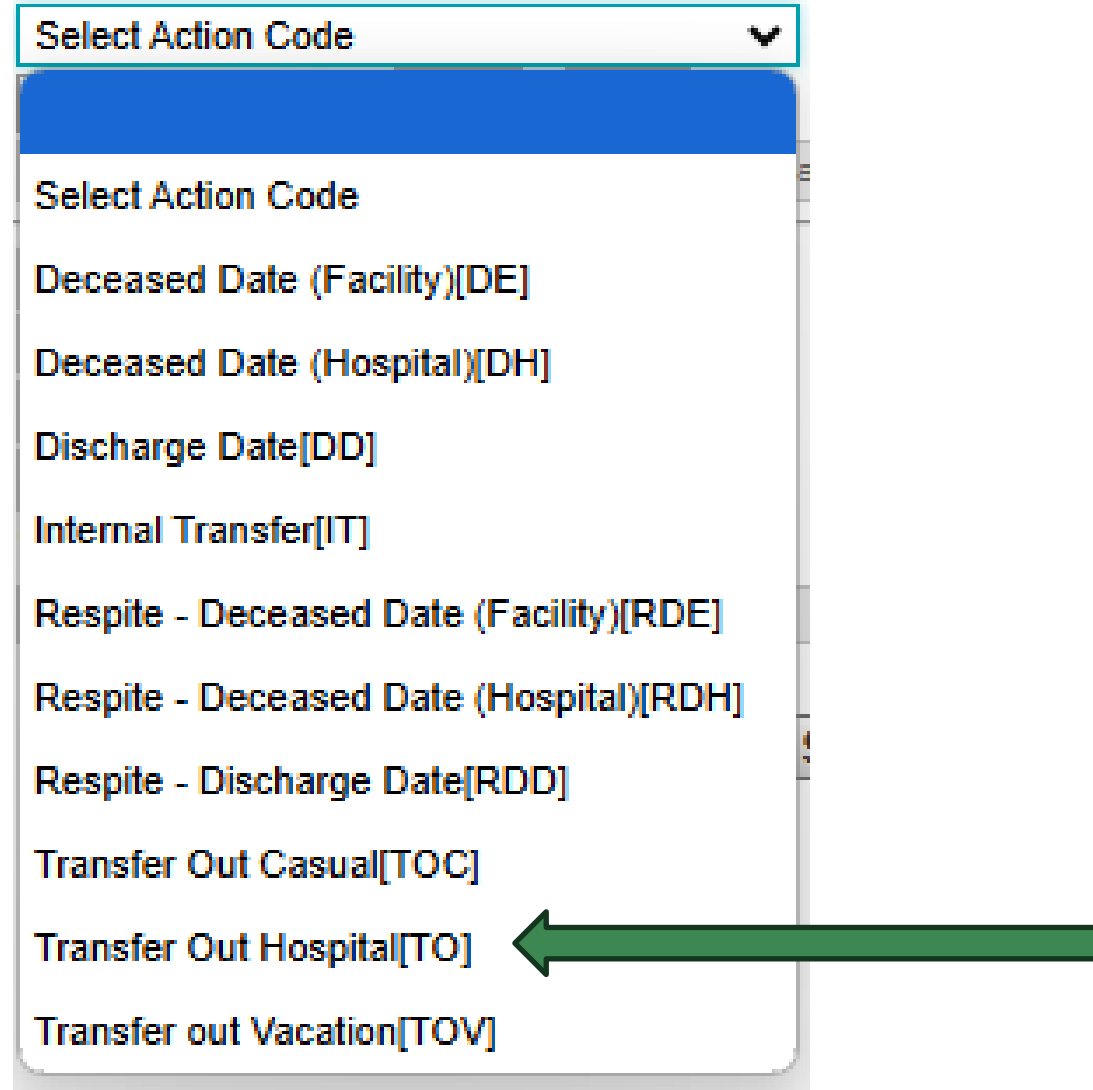
Behaviours / Aggression

Communication Concerns

Health Concerns that require active intervention, including Mental Health

…transfer a Resident to hospital?

- Use Quick ADT for these actions:

Select Action Code ⌄

Select Action Code

Deceased Date (Facility)[DE]

Deceased Date (Hospital)[DH]

Discharge Date[DD]

Internal Transfer[IT]

Respite - Deceased Date (Facility)[RDE]

Respite - Deceased Date (Hospital)[RDH]

Respite - Discharge Date[RDD]

Transfer Out Casual[TOC]

Transfer Out Hospital[TO]

Transfer out Vacation[TOV]

Print >> Generate/View Clinical Chart >> Transfer to Hospital

Include Photo on Cover Page

Top Right Corner

Home ▾   Admin ▾   **Clinical** ▾   Reports

Jones, Betty (PEH0160)

Status: Current   Location: Sunrise Place 515-A
Gender: Female   DOB: 10/8/1961   Age: 63
Physician:

[Care Profile] [Edit | ▾] [Print | ▾] [Provincial Import] [▦]

Allergies: To Be Determined

| Dash | Profile | Census | Med Diag | Allergy | Immun | Orders | Wts/Vitals | Results | RAI | Assmnts | Prog Note | Care Plan | Tasks | **Misc** |

[New Document]

⊞ Display Filters

	Effective Date	Document Name
del	4/3/2025	Transfer to Hospital 3/27/25 to 4/2/25.pdf

⟵ Misc Tab

Resident Chart >> Misc Tab >> Click on Document hyperlink

⟵ Print

viewfile.xhtml   1 / 12   — 60% +   ⬇ 🖨 ⋮

COVER PAGE
Medical Record Request
Transfer to Hospital

Total # Pages of EMR: 12 (including cover page)

Home Name and Address:		Resident:	Jones, Betty
TRAINING - Prince Edward Home		D.O.B.:	10/8/1961
Ap #188-5107 Omara Road		Gender:	Female
Charlottetown, PE C1E 1V6, CA		Resident/MR#:	1125688
Data Range : 3/27/2025 to 4/2/2025		Run on : 4/3/2025 15:41

MEDICAL RECORD SECTIONS

1. Profile (5 pages)	Admission Record (2 pages)	Pg. 2-3	Page# 2-6
	Transfer / Discharge Report (3 pages)	Pg. 4-6	
2. Med Diag (1 page)	Diagnosis Report *NEW*	Pg. 7	Page# 7
3. Allergy (1 page)	Allergy Report	Pg. 8	Page# 8
4. Orders (1 page)	Order Listing Report *NEW*	Pg. 9	Page# 9
5. Weights and Vitals (1 page)	Weights and Vitals Summary	Pg. 10	Page# 10
6. Care Plan (2 pages)	Care Plan (2 pages)	Pg. 11-12	Page# 11-12

Note: A copy of the paper MAR must also accompany the Resident.

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…transfer a Resident within the home?

From within a Resident chart, select 'Quick ADT' from the Clinical menu

Select 'Internal Transfer' as the Action Code

…complete Discharge activities?

Complete the 'Discharge from LTC' assessment for a living Resident and a 'Post-mortem Care' assessment for a deceased Resident.

Select the 'Discharge from LTC' or 'Post-mortem Care' assessment.

Change type to 'Discharge'.

Discuss the resident's care requirements with the Substitute Decision Maker or Partner in Care.

2. Based on the resident's care requirements, does the SDM/PIC feel capable of managing the care needs? H ○ a. Yes ○ b. No clear

3. Is the family home safe and can the care be safely provided until there is an opportunity for re-admission? H ○ a. Yes ○ b. No clear

II.

1. Can someone be home 24 hours a day to check for safety and well-being? ○ a. Yes ○ b. No clear H

2. Can the daily help that is needed with personal support be given? For example: transferring, toileting, intake, hygiene, dressing. ○ a. Yes ○ b. No clear H

3. Can medications be given at the right dose and time each day? ○ a. Yes ○ b. No clear H

4. Do you have a medical provider willing to assume care of the resident? ○ a. Yes ○ b. No clear H

5. Does your family have access to private caregivers or additional supports to fill in scheduling gaps or provide respite care when needed? ○ a. Yes ○ b. No clear H

6. What safety features/equipment do you currently have in the home? Select all that apply.

☐ a. Video Monitor
☐ b. Grab bar - Toilet
☐ c. Grab bar - Bath
☐ d. Grab bar - Shower
☐ e. Raised Toilet Seat
☐ f. Secured Safe Area
☐ g. Comfortable seating
☐ h. Modified dishware
☐ i. Ramps
☐ j. Wandering-alert Mechanisms
☐ k. Toilet seat arms
☐ l. Commode
☐ m. Wheelchair accessible
☐ n. Mechanical bed
☐ o. Safety barriers

7. List any other safety features or equipment not previously identified: H

SECTION Cust. *Discharge from LTC

[Save & Sign] [Save] [Save & Exit] [Save & Sign & Lock & Exit] [Cancel] [Clear All]

1) Complete the assessment
2) Save & Sign & Lock & Exit

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Discharge Workflow Instructions

Clinical ▾   Reports

People
Residents

Actions
Quick ADT
New Resident
New Staff
New Medical Professional
Manage Users

Care Management
Dashboard
Calendar
Hospital Tracking
Orders
Lab/Rx Results
Risk Management
Weights and Vitals
UDA
Clinical Chart Dashboard

Quick Entry
Therapy Minutes
Physician Visits
Order Review Dates
Blood Pressure
Temperature
Pulse
Respiration
Blood Sugar
O2 Saturation
Pain Level

Modules
POC
eMAR

Other
Reports
Setup

Select 'Quick ADT'

Quick ADT - Work - Microsoft Edge

https://www60.pointclickcare.com/admin/client/quick_adt.jsp?ESOLclientid=8314&ESOLsearchflag=N&ESOLqui...

Quick ADT - Jones, Betty (PEH0160)

Action Code: Select Action Code ▾ *

Effective Date:

Surname:
Middle Name:
Resident Number:
Health Card #:

Allergies:

Last Action Type: Room Change - 4/8/2025 16:06

Title/First Name: ▾ / Betty

Social Insurance Number:
(NNN NNN NNN)

No Known Allergies: ☐

Save & New   Back   Cancel

Action Code dropdown:
- Select Action Code
- Deceased Date (Facility)[DE]
- Deceased Date (Hospital)[DH]
- Discharge Date[DD]
- Internal Transfer[IT]
- Respite - Deceased Date (Facility)[RDE]
- Respite - Deceased Date (Hospital)[RDH]
- Respite - Discharge Date[RDD]
- Transfer Out Casual[TOC]
- Transfer Out Hospital[TO]
- Transfer out Vacation[TOV]

Discharge Options for LTC Resident

Select one of the three LTC discharge types

Discharge Options for Respite Resident

Select one of the three Respite discharge types

Quick ADT - Work - Microsoft Edge

https://www60.pointclickcare.com/admin/client/quick_adt.jsp

Quick ADT - Jones, Betty (PEH0160)

Action Code: Deceased Date (Facility)[DE] *
Last Action Type: Room Change - 4/8/2025 16:06
Effective Date: 4/8/2025 16 ∨ 30 ∨ *
To/From Type: Nursing home ∨ ℹ
To/From Location: ∨

Click on the down arrow to open the dropdown list

Surname:
Middle Name: Andrews of Park West
Resident Number: Andrews of Stratford
Health Card #:   Andrews of Summerside

Atlantic Baptist Home

Beach Grove Home

Allergies: Clinton View Lodge

Colville Manor

Dr. John Gillis Memorial Lodge

Garden Home

Maplewood Manor

Margaret Stewart Ellis Home

Prince Edward Home

Title/First Name: ∨ / Betty
Suffix: ∨ Sex : Female ∨
Date of Birth: 10/8/1961
Social Insurance Number:
(NNN NNN NNN)

* No Known Allergies: ☐

Save & New   Back   Cancel

Select the correct home as the 'From Location'

Discontinue all orders upon discharge

Set the discontinue date and time

Choose the communication method

Who authorized the orders being discontinued

Select all orders

Resident: Acosta, Caleb (GE8DDE11BE)

Discontinue Date: 4/28/2025   [📅]   09 ▾   20 ▾   *   ⇄

ⓢ Linked Order Set. You will have the ability to discontinue all the orders that are part of a linked set.

Communication Method: ○ Phone   ○ Verbal   ○ Prescriber Written   ○ Prescriber Entered clear   *   ⇄

Ordered By: [_____]   🔍   *   ⇄   (Current Primary Physician: Henderson, GerriLynn)

Reason for Discontinue: [_____]

⊞ Batch Filter Options

☑	Order Summary	Category	Order Status	Revision Date	Last Ordered
☑	⊞ Hidden Description	Other	On Hold	11/25/2024	
☑	⊞ Regular diet, Regular texture, Regular/Thin consistency	Diet	On Hold	11/25/2024	
☑	⊞ Diabetic diet, Mechanical soft - Ground texture, Regular/Thin consistency	Diet	Active	2/3/2025	
☑	⊞ CBC	Laboratory	On Hold	3/11/2025	
☑	⊞ Goals of Care C - Care and Interventions focused on comfort, excluding Resuscitation.	Other	On Hold	3/11/2025	
☑	⊞ Creatine	Laboratory	On Hold	3/17/2025	
☑	⊞ Regular diet, Ground Meat texture, Regular/Thin consistency	Diet	On Hold	3/25/2025	
☑	⊞ Diabetic diet, Finely Cut Up Meat texture, Regular/Thin consistency	Diet	On Hold	3/25/2025	
☑	⊞ Boost/Ensure	Supplement	Active	3/28/2025	
☑	⊞ Regular diet, Cut-Up Meat texture, Nectar/Mildly Thick consistency	Diet	Active	3/28/2025	
☑	⊞ Enteral Feed	Enteral Feed	Active	3/28/2025	
☑	⊞ Fruit Boost	Supplement	Active	3/28/2025	
☑	⊞ cleanse with nss and covered with mepore.	Other	Active	3/28/2025	
☑	⊞ intersite gel to right lower arm	Other	Active	4/4/2025	
☑	⊞ Apply to open areas on BID daily and PRN.	Other	Active	4/4/2025	
☑	⊞ fucidin to right lower leg lesion once a d	Other	Active	4/4/2025	

[**Discontinue Order**] [Cancel]

…add or update a Resident photo?

Click Edit to import photo
- Select file and insert date

Photo file sizes can be up to 512Kb.
Photo files must be .jpg, .gif, or .jpeg

Instructions for reducing photo file size:
➢ open the photo in 'Photos' and click on
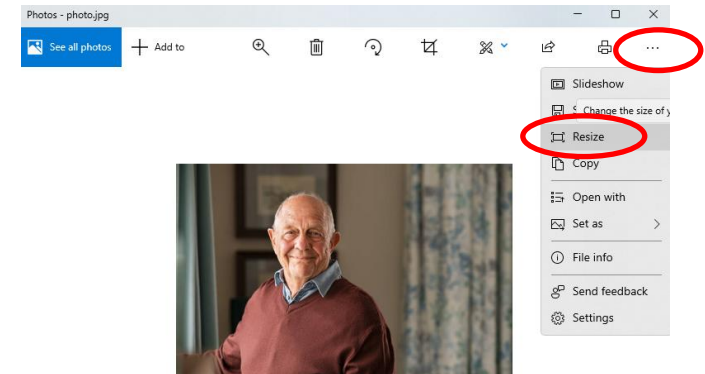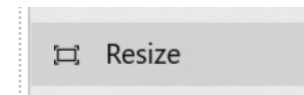
…edit the Resident's Care Profile (risk for violence and infection control measures)?

Information typed in the 'Special Instructions' box will appear in the chart header.

VAT Score should be added here as follows:
** LOW/MODERATE/HIGH/VERY HIGH RISK FOR VIOLENCE **

Any infection control measures currently in place should also be added here, for example:
** DROPLET/CONTACT PRECAUTIONS **
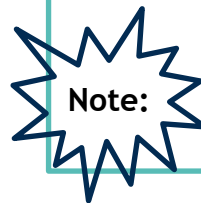
Note: Infection Control measures are to only be added, edited, or removed by IPAC.

Care Profile - Skinner, Ayla (NV31CD607C) | Reports ▼

Special Instructions

```
** MED RISK FOR VIOLENCE **

** DROPLET/CONTACT PRECAUTIONS **
```
(500 max.)

Auxiliary Devices and Services

- ☐ Amplified Device
- ☐ Hearing Aid (☐ Left ☐ Right)
- ☐ TTY/TTD/Relay Equipment
- ☐ Contact Lenses
- ☐ Glasses
- ☐ Reading Only
- ☐ Magnify Glass
- ☐ Dental Appliance (☐ Upper Partial ☐ Upper Full)
- ☐ Dental Appliance (☐ Lower Partial ☐ Lower Full)

- ☐ Braille
- ☐ Interpreter Needed - Foreign Language
- ☐ Interpreter Needed - Sign Language
- ☐ Cane/Crutch
- ☐ Electric Wheelchair
- ☐ Manual Wheelchair
- ☐ Walker
- ☐ Prosthetic Eye
- ☐ Limb Prosthesis

- ☐ Jewelry
- ☐ Other: _____

Devices and Treatments

- ☐ Bladder (Foley) Catheter (☐ Chronic ☐ New)
- ☐ Condom Catheter
- ☐ Urostomy
- ☐ External Catheter
- ☐ Suprapubic Catheter
- ☐ Urinary Toileting Program
- ☐ Ostomy
- ☐ Ileostomy
- ☐ Colostomy
- ☐ Bowel Toileting Program
- ☐ Hemodialysis
- ☐ Peritoneal dialysis
- ☐ Dialysis Shunt

- ☐ Nebulizer Therapy (☐ Chronic ☐ New)
- ☐ O2 at ____ L/min by Nasal Canula/Mask (☐ Chronic ☐ New)
- ☐ BiPAP
- ☐ CPAP
- ☐ Ventilator
- ☐ Suction
- ☐ Tracheostomy
- ☐ Internal Defibrillator
- ☐ Lifevest
- ☐ Pacemaker

- ☐ PiCC Line
- ☐ IV (☐ IV Medication ☐ Parenteral/IV Feeding)
- ☐ Chest Tube
- ☐ Drains
- ☐ TPN
- ☐ Enteral Feeding
- ☐ No Active Medications
- ☐ No Known Diagnoses
- ☐ Cancer Treatments
- ☐ Other: _____

Isolation/Precautions

- ☐ Airborne Precautions
- ☐ Chemo Precautions
- ☐ Contact Isolation Precautions
- ☐ Droplet Precautions
- ☐ Isolation - Active Infectious Disease
- ☐ Reverse Isolation

Special Care

- ☐ Goal to return home (alone)
- ☐ Goal to return home with assist
- ☐ Hospice
- ☐ LTC, AL/IL
- ☐ Palliative Care
- ☐ Respite Care
- ☐ Unknown
- ☐ Other: _____

Therapies

- ☐ Physical Therapy (PT)
- ☐ Occupational Therapy (OT)
- ☐ Speech Therapy (ST)

Save Close

Other areas of the Care Profile can also be edited or updated.
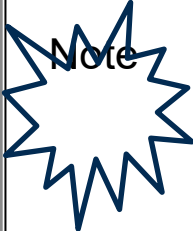
Note

These fields are not automatically updated from other areas of PCC. If you are using this section of the Resident Chart, please ensure you keep it aligned to the Care Plan.

These items do get included in the Admission Record that is part of the package sent with a transfer to acute care.

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…create a Resident contact?
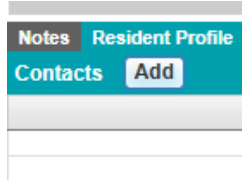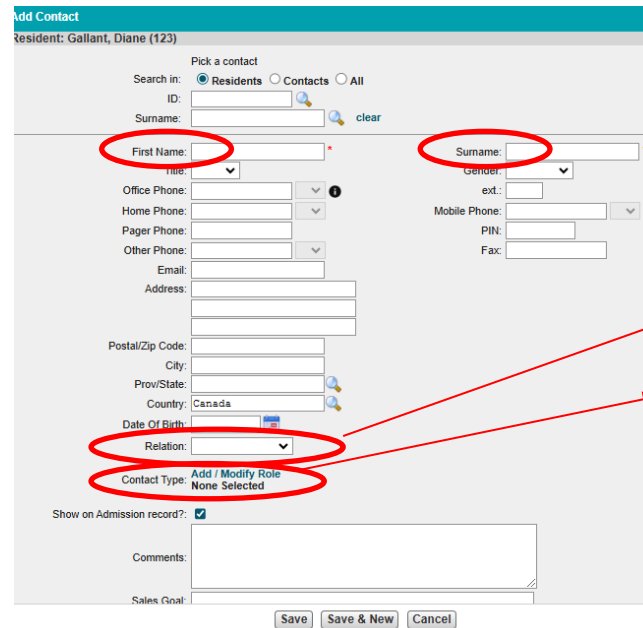
Under the Admin tab
- Click Resident Profile tab
- Add new contact details
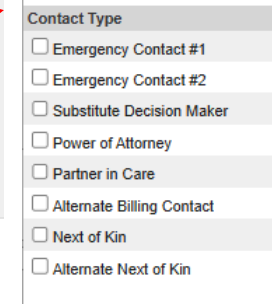
Search for existing contacts to ensure no duplication
- updates on one record will update to other resident records who share that same contact person

- First and last names are required
  - insert 'TBD' if unknown

- Select one relation

- Multiple 'contact types' may be checked
- **Emergency Contact #1 is seen on the transfer/discharge record**

…properly represent Substitute Decision Makers?

1) Navigate to 'Residents' in the Clinical menu, then search for and select the desired Resident.

2) Under the 'Profile' tab, you'll find the 'Contacts' section.

3) To 'Add' a new contact.

4) Click on "Add/Modify Role" to add a new Substitute Decision Maker.

5) Select the checkbox corresponding to the appropriate Substitute Decision Maker level.

Click 'Save'.

…manage a Resident's associated medical professionals?
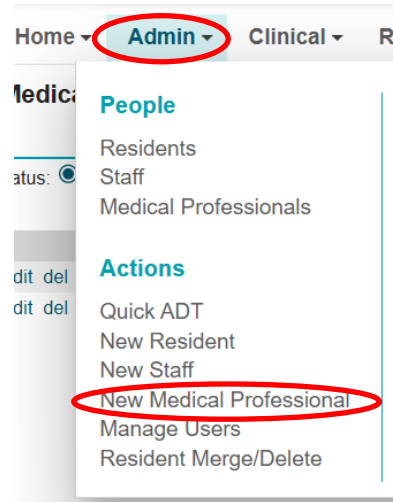
- Add as many medical professionals as needed.

- Only **one primary** medical professional can be checked.
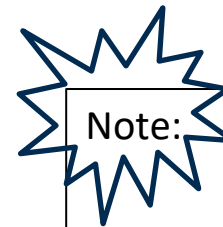
Note: At minimum, all residents should have:

1. A primary practitioner – usually the on-site NP/MD, unless they have chosen to retain their own family physician.

2. The on-site Dietitian

3. Nursing Order

…add or update a Resident's additional (custom) information?

Note: This is the only place where this information is stored in the resident chart. It is not automatically updated, so please keep this up-to-date if any of these items change.

Use "Edit All" to edit multiple at once

Note: Only IPAC will be editing the Infection Control Precautions in this section.

…manage a Resident's external facilities?

Search for and select the Resident's Clinical chart.

Select the 'Profile' tab.

See 'External Facilities' at the bottom.

2) Use the search option or scroll down to see if the facility name is on the list.

Note: If you do not see it, make sure 'All Facilities' are selected.

If you are unable to locate it, please send an email to: 'LTCSolutionoffice@ihis.org' to have it added to the list.

1) Click the 'Select' button, which then brings up the list of External Facilities.

1) Select the checkbox to the corresponding external facility and hit 'Save'.

2) You will see the name appear under the External Facility heading.

…upload documents to a Resident's chart?

Types of documents that should be scanned and uploaded:

- Signed consents
- History and physicals
- External consult reports

3 Scan the document(s) from the printer to your email and then save the file(s) from your e-mail to your OneDrive folder.

Upload New Document

After uploading, it is recommended to open the document to confirm it was uploaded successfully.

Effective Date: 12/9/2024

Name:

Category: Immunization Consent Form

File: * Upload   Choose File   No file chosen

Upload   Cancel

Name the file you are uploading. Use a descriptive name that will be easy to identify.

Make sure you pick the correct category.

Select the file to be uploaded from your OneDrive folder.

Click 'Upload'.
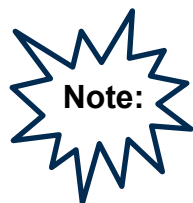
Note: After the files are uploaded, please delete the email and the documents from your OneDrive folder.

…add or update an allergy?

Use admission date or date you became aware
(not when they developed it)

Select severity level

Type reaction manifestation and select from the dropdown

…add or update a diagnosis?

Search by description if you do not know the ICD10-CA code

Primary is visible in the chart header and Point of Care

If nothing appears, ensure to view 'All Diagnosis' (not the 'Hot List')

…set a Resident's baselines and customize thresholds?

Change thresholds if needed

* Use admission weight and vitals as baseline.

…enter or update the Resident's Goals of Care?
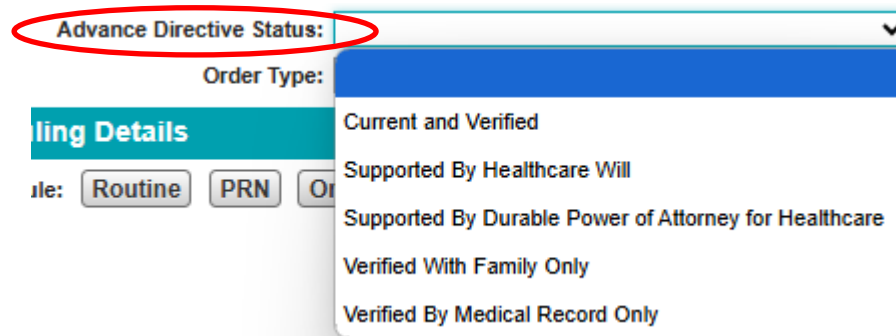
- Choose 'Advance Directive Status'
- Goals of Care: Select the appropriate option from the menu

Appears in chart header under 'Code Status'

- *Description* - include additional specific interventions.

- *Advance Directive Status* - indicate supporting documentation and upload same.

- *Order Type* - must go under Goals of Care.

- *Order Summary* - check summary before saving.

…request Nursing to perform a Care Plan review (through a Progress Note)?

Always select 'Care Plan Review Request'.

Document what changes need to be made to the Care Plan.

You will be prompted to enter your PIN to sign the Progress Note.

…receive and action Care Plan review requests?

1. Locate the 'High Priority Progress Notes' pane on the Clinical Dashboard.

2. View the Progress Note details.

3. Proceed to the Resident's chart to review any necessary information about the Resident's care or status. Speak with the necessary staff involved in care. Update the care plan accordingly.

Part of your review will be of the Progress Notes to ensure the review was not already completed by another RN.

If not yet reviewed, there won't be record of it in the Progress Note tab....you can proceed with your review.

Progress Notes	New	View All			☑ Display eMAR Progress Notes			
	Effective Date	Type	Note		Care Plan Item or Task	Dept.	Shift Report	24 Hour Report
view print	4/24/2025 17:59	Care Plan Review Request	Care plan items related to physiotherapy. Please s...				Y	Y

If it has been reviewed, the entries will look something like this:

Progress Notes	New	View All			☑ Display eMAR Progress Notes			
	Effective Date	Type	Note		Care Plan Item or Task	Dept.	Shift Report	24 Hour Report
view print	4/24/2025 18:21	Nursing Progress Note	Care Plan reviewed as requested. [linked]				Y	Y
view print	4/24/2025 17:59	Care Plan Review Request	Care plan items related to physiotherapy. Please s...				Y	Y

This Progress Note indicates that the Care Plan has been updated. This is indicated by the [linked] symbol next to the Nursing Progress Note, which is linked to the Care Plan Review Request.

After you've updated the Care Plan, return to the High Priority Progress Note in the Clinical Dashboard and select 'view'.

Select 'Follow Up' on the next screen.

…edit and customize Care Plans?

Care Plan Navigation

'View Triggered Items Now' - will identify any new Care Plan items that have been triggered by recently completed Assessments

Filter by department here

Page navigation

Focuses

Goals

Interventions

Filtering options:

- Search: Use key words to narrow down focuses
- Sort by: Search by order or by date initiated/reviewed
- Show only: Allows you to focus in on items that are yet to be personalized.
- Show Resolved/Cancelled: Allows you to see items that are no longer on the active care plan
- Show Tasks: Ignore this – tasks have not been added to the care plans
- Show Symbol Legend: If you forget what some symbols mean, refer to this area

Alert staff to changes made to the Care Plan and/or Kardex

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Reviewing Triggered Care Plan Items

Care Plan Detail

Resident: Skinner, Ayla (NV31CD607C)
Triggered Care Plan Items: View Triggered Items Now

Select 'View Triggered Items Now' to review all focuses that were triggered during assessments.

You will be taken to the screen below:

Select the Goal(s) and Intervention(s) that you wish to add to the resident's Care Plan. Select 'Save'. You'll then be taken back to the care plan to add more details and specify to the resident's care needs.

Once finished specifying, return to the triggered items link and select the items that weren't added to the Care Plan. Select 'Remove all'.

Hovering over the 'UDA' link tells you from which assessment the item was triggered.

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Manually Adding Goals, Focuses, and Interventions

Department:

| All | Food Services | Nursing/Care Services | Recreation | Therapy |

[New Focus] [New Custom Focus] [Printable View] [Back] [Care Plan PN] [New Alert]

[1] [2] [3] [4] [5] [6] [7] [8] [Next »]

Focus	Goals	Interventions/Tasks
	New Goal New Custom Goal	New Intervention New Custom Intervention
edit pn Acute Pain r/t Chest pain + H	edit pn Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain. + H edit pn Will voice/display a level of comfort acceptable to the resident through the review date. + H edit pn Will maintain pain at or below the level of _____5_ (Specify) as per resident. + H	edit pn Anticipate need for pain relief. [LPN,RN,REHA] + H edit pn Determine the appropriate pain management methods: Analgesia(Opioid/non-Opioid), Imagery/Distraction techniques, Relaxation exercises , Biofeedback, breathing exercises, music therapy, Massage, TENS, Hot/moist compresses, Cold compresses. + H New Task **NO ASSIGNED TASKS**
edit pn Coronary Heart Disease r/t lifestyle choices + H	New Goal New Custom Goal	New Intervention New Custom Intervention New Task **NO ASSIGNED TASKS**
edit pn Scott Fall Risk Score: (11 = high risk) + H	New Goal New Custom Goal edit pn Risk of injury from fall will be minimized + H	New Intervention New Custom Intervention edit pn Universal precautions - Bed in low position. Call bell in place. Well-fitted footwear. Toileting schedule / Incontinence Routine. Environment uncluttered, well lit, non-slip floors, accessible grab bars. Ensure walker is within reach. [RCW,RECPR] + H edit pn Score 11: In addition to universal fall prevention plan, discuss use of hip protectors with family. [RCW,RECPR] + H New Task **NO ASSIGNED TASKS**
edit pn TLR Logo + H	New Goal New Custom Goal edit pn Resident goal - maintain mobility + H	New Intervention New Custom Intervention edit pn Total lift. (Two staff to assist. Medium sling used.) [RCW,LPN,RECPR,PT,RN] + H K New Task **NO ASSIGNED TASKS**
edit pn Bed Mobility + H	New Goal New Custom Goal edit pn Resident Goal - specify △ H	New Intervention New Custom Intervention edit pn Independent [RCW,LPN] + H K New Task **NO ASSIGNED TASKS**

[1] [2] [3] [4] [5] [6] [7] [8] [Next »]

[New Focus] [New Custom Focus] [Printable View] [Back] [Care Plan PN] [New Alert]

To create a new Focus, click 'New Focus'.

Focus

Resident: Skinner, Ayla (NV31CD607C)

Instructions: 1. Select Focus Category from the drop down.
2. Click add to add the Standard Focus from the resulting list **or** click go to/unresolve to navigate to the listed item in the care plan.

Select Library: Standard LTCF Care Plan Library

Focus Category: Communication

Focus List Cancel

	Description
add	Communication - altered ability to be understood due to
add	Communication - altered ability to understand due to
	go to Communication - altered ability to understand due to
add	Hearing care needs related to
	go to Hearing care needs
add	Vision care needs related to
	go to Vision care needs

<u>Always</u> select the 'Standard LTCF Care Plan Library'.

Select the appropriate category.

Customize the Focus to be specific to the Resident.

Click 'Add' to include the new Focus(es) in the Care Plan.

Identify which Department is primarily responsible for the Focus.

Click 'Next'.

https://www60.pointclickcare.com/care/chart/cp/neededit_rev.jsp?ESOLrevie...

Edit Focus

Resident: Skinner, Ayla (NV31CD607C)

Standard Focus: **Communication - altered ability to be understood due to**

Instructions: 1. Make any changes required.
2. Click Next.

Date Initiated: 4/8/2025

Status: Active   Resolved   Cancelled

Communication - altered ability to be understood due to

Description:

Care Plan Type:
Review Department One: Nursing/Care Services
Review Department Two:
Review Department Three:
Review Department Four:
Review Department Five:

Food Services

Nursing/Care Services

Recreation

Social Services

Therapy

Cancel

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Select the goals to be added for the new focus by checking the corresponding checkbox(es).

Click 'Next'.

Choose the interventions to be added for the new focus by checking the corresponding checkbox(es).

Click 'Save'.

Care Plan Customization

The newly added Focus(es) with draft sets of Goals and Interventions is added to the Care Plan. They must now be customized to fully represent the Resident's situation.

Home ▾   Admin ▾   **Clinical** ▾   Reports   Search

Care Plan Detail

Resident: Villanueva, Ayla (HQ90D3CEE6)
Triggered Care Plan Items: None

Care Plan Type:
All

Department:
All   Nursing/Care Services

New Focus   New Custom Focus

Focus   **Goals**   Interven
                             New Goal New Custom Goal   New Int
edit pn Other - specify behaviour + H   edit pn Resident will do no harm to self or others + H   edit pn
                             edit pn Triggers to behaviour will be recognized early with intervention to minimize risk of escalation + H   edit pn
                                                                                           edit pn
                                                                                           edit pn
                                                                                           edit pn
                                                                                           edit pn
                                                                                           edit pn
                                                                                           edit pn
                                                                                           edit pn
                                                                                           New Tas

1. Customize the Focus – Indicate the problem. Relate to a symptom/diagnosis when possible.

2. Ensure the appropriate department is chosen. The department selected should be the department responsible for reviewing this section during the care plan review.

Edit Focus Statement - Work - Microsoft Edge

https://www60.pointclickcare.com/care/chart/cp/needededit_rev.jsp?ESOLreviewi...

Edit Focus

Resident: Villanueva, Ayla (HQ90D3CEE6)

Standard Focus: **Other - specify behaviour**
Created By: Jennifer Pitre
Created Date: 4/24/2025

Date Initiated: 4/24/2025

Status: ● Active   ○ Resolved   ○ Cancelled

Description:
Safety Plan

Care Plan Type: 🔍
Review Department One: Nursing/Care Services ▾
Review Department Two: ▾
Review Department Three: ▾
Review Department Four: ▾
Review Department Five: ▾

Etiologies Library

Save   Delete   Cancel

Customize the Resident's Goals

When the goal is no longer relevant for the resident or a new goal is needed, change the status to 'Resolved' or 'Cancelled'. This will also be the case for interventions on the next slide.

Ensure the goal is specific to the resident and is attainable.

Customize the Interventions

Interventions/Tasks

New Intervention   New Custom Intervention

edit pn	Effective de-escalation actions include (specify going for walk indoors/outdoors
edit pn	Expressions display as (describe behaviour) + H
edit pn	Keep care routine as consistent as possible + H
edit pn	Known triggers to responsive behaviour are (specify) + H
edit pn	Other - specify + H
edit pn	See MAR for prn medication orders when non-pharmacologic interventions are
edit pn	Time of day when responsive behaviours(specify) are more prevalent are (spec
edit pn	Two staff will be present when care is being provided (buddy system). [RCW,LPN,RN] + H 🅚
edit pn	Where lack of response to de-escalation strategies are effective, staff are to (s

Most Interventions will require customization to fit the resident's needs.

Edit the description to best describe the resident's Intervention.

Edit Intervention - Work - Microsoft Edge

🔒 https://www60.pointclickcare.com/care/chart/cp/interedit_rev.jsp?ESOLgenneedid=1501&ESOLpnintid=10108&ESO...

Edit Intervention

Resident: Villanueva, Ayla (HQ90D3CEE6)

Focus: **Other - specify behaviour**
Created By: Jennifer Pitre
Created Date: 4/24/2025
Status: ● Active   ○ Resolved   ○ Cancelled
Date Initiated: 4/24/2025 📅
Standard Intervention: Effective de-escalation actions include (specify going for w...(more)

ⓘ Only the first **100** characters will display without having to expand further in POC.

Description: Effective de-escalation actions include distraction with a family book of pictures or take for a walk, if agreeable. Also enjoys music.

135 characters

ⓘ Only the first **200** characters will display without having to expand further in POC.

Instruction:

0 characters

Kardex Category: [▾]
Flowsheet Type: **None**
Position One: [▾]
Position Two: [▾]
Position Three: [▾]
Position Four: [▾]
Position Five: [▾]
Frequency: 🔍

☐ Intervention will appear on the documentation record.

Where is documentation used? 🔍

Care Plan Schedule [New]

[Save] [Delete] [Cancel]

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Assign a Kardex Category and Position(s) when applicable:

If the intervention is something that care staff should be aware of or monitor, i.e. safety, assistance level, etc., select the most appropriate Kardex Category.

Kardex Category dropdown options:
- TLR
- Safety Plan Interventions
- Monitoring / Safety
- Daily Routine
- Cognition / Communication
- Hearing / Vision
- Dressing / Splint Care
- Eating / Nutrition
- Bladder / Bowel
- Bathing
- Toileting
- Hygiene / Oral Care
- Bed Mobility
- Behaviour / Mood
- OT / PT Programming
- Recreation / Social Activities

Position dropdown options:
- Chef/Cook
- Development Worker
- Dietitian
- Director of Nursing
- Food Services Manager
- Infection Control Nurse
- Licensed Practical Nurse
- MSIP Consultant
- Nurse Manager
- Nursing Clerk
- Occupational Therapist
- Physiotherapist
- Quality & Risk Consultant
- Recreation Manager
- Recreation Program Staff
- Registered Nurse
- Rehab Assistant
- Resident Care Worker
- Social Worker

Edit Intervention window:

Edit Intervention - Work - Microsoft Edge

https://www60.pointclickcare.com/care/chart/cp/interedit_rev.jsp?ESOLgenneedid=1501&ESOLpnintid=10108&ESO...

Edit Intervention

Resident: Villanueva, Ayla (HQ90D3CEE6)
Focus: Other - specify behaviour
Created By: Jennifer Pitre
Created Date: 4/24/2025
Status: ● Active ○ Resolved ○ Cancelled
Date Initiated: 4/24/2025
Standard Intervention: Effective de-escalation actions include (specify going for w...(more)

ⓘ Only the first 100 characters will display without having to expand further in POC.

Description: Effective de-escalation actions include distraction with a family book of pictures or take for a walk, if agreeable. Also enjoys music.

135 characters

ⓘ Only the first 200 characters will display without having to expand further in POC.

Instruction:

0 characters

Kardex Category:
Flowsheet Type: None
Position One:
Position Two:
Position Three:
Position Four:
Position Five:
Frequency: 🔍
☐ Intervention will appear on the documentation record.
Where is documentation used? 🔍

Care Plan Schedule [New]

[Save] [Delete] [Cancel]

You may assign a position(s) responsible for the intervention. Chose the role most responsible.

Only interventions identified by OH&S for resident safety plans will go under Safety Plan Interventions.

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…schedule and manage annual Care Plan Reviews?

Who schedules the Care Plan Reviews? →

The role responsible for scheduling the annual care plan meetings will be responsible for maintaining the schedule of each resident's Care Plan Review Date.

The review date will be set for 7 days prior to the scheduled care plan meeting (the care plan meeting date will be the Target Completion Date, in the Review History section).

To schedule the review, select the hyperlinked date below 'Next Review Date'.
The window to the right will open. Schedule the review start date here.

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Notification – How to monitor for upcoming care plan reviews

In the Clinical Dashboard, there are two areas that monitor Care Plans.
Find the area '**Care Plan Reviews Overdue/Due in Next <u>(1-7)</u> Days.**
Your home will also continue using the notification process in place prior to implementing PointClickCare.

Starting the Review → Any role responsible for reviewing an area of the care plan can begin the review process.

1. To go to the resident's chart, select the resident's name from the Clinical Dashboard pane > 'Care Plan Reviews Overdue/Due'. You will be directly taken to the review page.

or

Navigate to the resident's chart using the search bar and proceed to the resident's Care Plan tab.
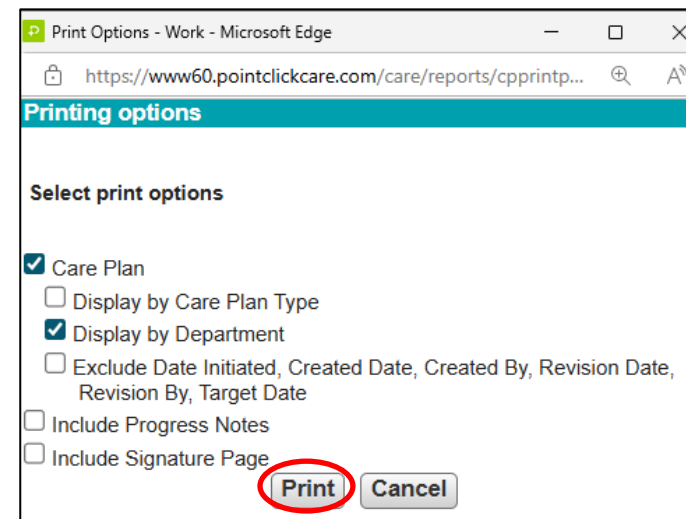
Step 2. In the Care Plan tab of the resident's chart, under 'Review History' select 'print' to open a view of the care plan in another internet tab. Leave this tab open, you'll come back to it in a moment. (You may use either of the 'print' buttons shown above.)

Select the following print options.

Selecting to 'Display by Department' will group by Nursing/Care Services, Recreation, Therapy.

Select 'Print'.

This will generate a view of the care plan in another browser window, allowing you to leave it to come back to in a moment.

Step 3. Multidisciplinary Care Plan Review Assessment
>> After you've generated the printable view of the care plan and set that aside, go back to the PointClickCare browser and navigate to the Assessments tab of the resident's chart.

Step 4. Open the 'Multidisciplinary Care Plan Review'
>> First, determine if the assessment is already one in progress.

| Dash | Profile | Census | Med Diag | Allergy | Immun | Orders | Wts/Vitals | Results | RAI | **Assmnts** | Prog Note | Care Plan | Tasks | Misc |

Standard Assessments [New] [Edit Schedules]

⊞ **Next Assessment Due:** *BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK©: 8 days - 5/29/2025

| ☐ View All | Date | Description | Status |
| edit del close print | 5/13/2025 | *Multidisciplinary Care Plan Review - V 1 | In Progress |

 If it's already been started by someone else, select 'edit' to enter the assessment.

| Dash | Profile | Census | Med Diag | Allergy | Immun | Orders | Wts/Vitals | Results | RAI | **Assmnts** | Prog Note | Care Plan | Tasks | Misc |

Standard Assessments [New] [Edit Schedules]

⊞ **Next Assessment Due:** *BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK©: 6 days

| ☐ View All | Date | Description | Status |
| edit del close print | 5/22/2025 | *Rehab Assistant Assignment - V 3 | In Progress |

Clinical - Work - Microsoft Edge — ☐ ✕
🔒 https://www60.pointclickcare.com/care/chart/assess/newasses... Aᴺ

Reasons for Assessment

Assessment Date:
4/29/2025   Time: 15 ✔ 20 ✔

Assessment:
*Multidisciplinary Care Conference ✔

Type of Assessment:
Annual ✔

[Save] [Cancel]

If you don't see the assessment already in progress, you may select 'New' to open the assessment.

Select 'Multidisciplinary Care Plan Review' from the dropdown list.

Select 'Save'.

Step 5. Providing input.

>>Once within the Multidisciplinary Care Plan Review, proceed to your respective area by selecting 'edit'.

While filling out the information within your section of the Multidisciplinary Care Plan Review, there are two goals:

1 – Provide an accurate reflection of the resident's status

2 – ensure the current care plan is accurate and up-to-date

Remember a few slides back when we set aside a printed view of the care plan?

>>This is when you'll want to refer to it. You'll review items that are assigned within your department and fall within your scope and document any changes within the Multidisciplinary Care Plan Review.

Working with dual monitors is ideal when performing a care plan review. It will allow you to view both items at the same and more easily.

*Multidisciplinary Care Plan Review - V 1

Resident:	Bennett, Ivy (NE35147811)
Description:	Admission
Date:	5/13/2025 11:28
Section Status:	Unedited ○
Lock Date:	

SECTION B. Nursing Summary

1. Nursing Summary

1a. Indicate all areas of concern: H

- a. Hearing / Vision
- b. Skin Concerns
- c. Pain Control
- d. Cognition / Behaviors
- e. ADLs
- f. Mobility / TLR
- g. Safety Concerns
- h. Medications
- i. Other

1b. Provide details for all items selected above: H

SECTION B. Nursing Summary

Care Plan Report

Special Instructions

Department: Nursing/Care Services

Focus	Goal	Interventions	Position	Freq/Resolved
• Bladder continence care needs related to (specify) Date Initiated: 03/28/2025 Revision on: 04/14/2025	• Resident goal - specify Date Initiated: 04/14/2025 Revision on: 04/14/2025 Target Date: 11/25/2025	• Resident has a (specify type of catheter) Catheter size (specify); frequency of change is (specify). See TAR for next change date. Date Initiated: 03/28/2025 Revision on: 04/14/2025 Revision by: Peter Lawlor • Resident uses a night drainage bag - at night only /all the time Date Initiated: 03/28/2025 Revision on: 04/14/2025 Revision by: Peter Lawlor		
• Bleeding risk due to anti-coagulation therapy Date Initiated: 03/14/2025	• Risk of bleeding from anticoagulant use will be minimized by care team Date Initiated: 03/14/2025 Target Date: 11/25/2025	• Should resident have a fall implement head injury routine Date Initiated: 03/14/2025 Revision on: 04/14/2025 Revision by: Peter Lawlor		
• Cardiac Care needs related to specify diagnosis Date Initiated: 04/14/2025 Revision on: 04/14/2025	• Interdisciplinary care and support to maintain stable cardiac status Date Initiated: 04/14/2025 Target Date: 11/25/2025	• Administer medication as per MAR Date Initiated: 04/14/2025 • Blood pressure and pulse to be taken every (specify frequency) Date Initiated: 04/14/2025 • Observe for any new edema; report to Registered Staff Date Initiated: 04/14/2025 • Observe for signs of hypo/hypertension (dizziness, lightheadedness, headache, difficulty/changes with vision, tight feeling in chest) Date Initiated: 04/14/2025		
• Chronic Pain (specify location) Date Initiated: 03/14/2025 Revision on: 04/14/2025	• Residents pain will be effectively managed minimizing impact on daily living Date Initiated: 03/14/2025 Target Date: 11/25/2025	• Non-pharmacologic methods of pain relief used include - specify (heat, massage, TENS, positioning, cold, acupuncture, etc.) Date Initiated: 03/14/2025 Revision on: 04/14/2025 Revision by: Jennifer Pitre • Non-verbal cues of pain include - specify (facial grimacing, tight fists, crying,		

Allergies	clonazePAM, Codeine, Penicillin, Sertraline, Ativan, Ma...See last page for a complete listing of the Resident's allergies	D.O.B.	03/08/1937	Physician	GerriLynn Henderson	
Diagnosis	Unspecified dementia(F03), Asthma, unspecified, with stated status asthmaticus(J45.91), Arthritis, unspecified, unspecified site(M13.99), Anxiety disorder, unspecified (F41.9), Benign hypertension...See last page for a complete listing of the Resident's diagnoses					
Home	(train) Training - Prince Edward Home					
Resident	Bennett, Ivy Charlotte (NE35147811)	Admission Date	04/12/2024	Location	Lady Slipper Path 401 A	No Image Found

Bennett, Ivy Charlotte (NE35147811)   Page 1 of 8

Every department responsible for contributing to the care plan reviews will go through this same process.

Items of concern will be noted within the Multidisciplinary Care Plan Review assessment, as well as anything within the care plan that requires change and/or review.

Once you have completed your review and documentation, Select 'Save & Sign & Next'.

Save & Sign & Next | Save & Next | Save | Save & Exit | Cancel | Clear All

NOTE: 'next' means you'll be taken into the next section of the review assessment. This is okay and expected. Select 'Cancel' to leave the review section.

After exiting the review, your section of the assessment should now be green.

If you see that it's yellow, as shown below, this is your reminder that your section remains unsigned; if it's yellow, just attempt to sign it again.

Once green, you're now done of the review required before the Care Plan Meeting with the resident and/or family.

| view reopen | D | Recreation Summary |
| edit sign | E | Therapy Summary |

Prior to the care plan meeting, the RN will do the following:

Go to the resident's Assessment tab and 'edit' to open the Multidisciplinary Care Plan Review.

		Date	Description	Status	Type
☐ View All					
edit del close print		5/21/2025	*Multidisciplinary Care Plan Review - V 2	In Progress	Annual

Sections B through E should all be signed and in green, as shown below. You will first generate a printed view by selecting 'Print'. You may refer to this electronically or print and distribute to the other participants in the meeting.

*Multidisciplinary Care Plan Review - V 2

Resident:	Buck, Kieran (QC5D3631BC)
Description:	Annual
Date:	5/21/2025 16:56
Lock Date:	

Click Here to View Quick Entry - Keyboard Navigation Tips

Back	Sign All	Regenerate Triggers	Lock	Print

	Section	Description
edit	A	Annual Information Review - Complete Section A at Care Plan Meeting
view reopen	B	Nursing Summary
view reopen	C	Dietary Summary
view reopen	D	Recreation Summary
view reopen	E	Therapy Summary

The RN will then select 'edit'. This is the area where key discussion topics and outcomes of the care plan meeting will be documented.

Following the Care Plan Meeting, the RN will 'Save & Sign & Exit' section A.

All sections will now be highlighted in green and the whole assessment can be locked.

It's time to navigate to the Care Plan tab.

When arriving at the resident's Care Plan tab – the first thing to ensure is that the Care Plan Review has been started:

| Dash | Profile | Census | Med Diag | Allergy | Immun | Orders | Wts/Vitals | Results | RAI | Assmnts | Prog Note | Care Plan | Tasks | Misc |

Care Plan

	Date Initiated	Next Review Date
edit del print close	2/5/2025	2/5/2026

Review History	New Review

☐ View All	Start Date	Target Completion Date	Completed Date
		No records found.	

If there are no options to select in this area, the review has not yet been started.

When this is the case, select 'New Review'.

When the review has begun select 'edit'.

| Dash | Profile | Census | Med Diag | Allergy | Immun | Orders | Wts/Vitals | Results | RAI | Assmnts | Prog Note | Care Plan | Tasks | Misc |

Care Plan

		Date Initiated		Next Review Date
edit print close		4/2/2025		5/21/2026

Review History

	Start Date	Target Completion Date
☐ View All		
del edit reassign print	5/21/2025	4/2/2026

You'll be taken to the screen below. Enter the care plan using any of the 'edit' buttons shown.

Care Plan Reviews

Client: Butler, Zackary (KHCBFF4EEB)
Review Start Date: 5/23/2025
Target Completion Date: 5/30/2025
Completed Date:

Once in the care plan, the filter will default to 'Nursing/Care Services'. Select ALL.

Back	Complete Review
	Department
edit sign	Nursing/Care Services
edit sign	Recreation
edit sign	Therapy

Department:
| All | Nursing/Care Services | Recreation | Therapy |

Make all necessary adjustments to the care plan based on the outcomes of the care plan meeting. Refer to the Multidisciplinary Care Plan Review document.

When all edits are made to the care plan and all other necessary actions complete, i.e., new alert, progress note, etc. Select 'Back' to leave the care plan and return to the review area.

New Focus | New Custom Focus | Printable View | Back | Care Plan PN | New Alert

Care Plan Reviews

Client:	Butler, Zackary (KHCBFF4EEB)
Review Start Date:	5/23/2025
Target Completion Date:	5/30/2025
Completed Date:	

		Department
Back	Complete Review	
edit sign		Nursing/Care Services
edit sign		Recreation
edit sign		Therapy

The RN must now sign all sections of the care plan review. When all areas are highlighted green, select 'Complete Review'.

The annual Care Plan Review is now complete.

	Department	Assigned To
Back	Complete Review	
view reopen	Nursing/Care Services	Karen Ball
view reopen	Recreation	Brittany Ellands
view reopen	Therapy	Elizabeth Clark

…manage Point of Care tasks?

Point of Care tasks assigned to this Resident. Includes task assignments (to a role) and their administration schedule.

Adding a Task

Always select the 'PEI TASK LIBRARY'.

Check Task(s) you would like to add to the Resident's POC care assignments.

Click 'Save'.

Editing and Customizing a Task

The day you want the Task to start.

Describe the Task to be completed.

If you want the Task to be visible on the Kardex, select the most appropriate category.

Which role(s) will be responsible for completing the Task?

Define the administration schedule.

Choose the icon to be used in the POC module.

Edit Task

Resident: Salinas, Reese (OU6A15F525)

Created By: System Generated POC Go Live - Auto Assign Copy
Created Date: 12/18/2024
Status: ● Active   ○ Resolved   ○ Cancelled
Date Initiated: 12/18/2024
Standard Task: Toileting Routine
Focus: 🔍 clear

ⓘ Only the first **100** characters will display without having to expand further in POC.

Description: Toileting Routine

17 characters

ⓘ Only the first **200** characters will display without having to expand further in POC.

Instruction:

0 characters

Kardex Category: Bladder / Bowel
Flowsheet Type: **None**
Position One: Resident Care Worker
Position Two:
Position Three:
Position Four:
Position Five:
Frequency: Every 2 Hours 🔍 clear
☑ Task will appear on the documentation record.
Where is documentation used? 🔍
Follow Up Questions: view questions
Quick Entry Group: None

Icon:

Task Schedule [New]

edit del   Every 2 Hours starting at 00:00

[Save] [Delete] [Cancel]

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…document Resident behaviour that requires a Safety Plan?

Trigger:

1. A Resident has been displaying violent or inappropriate behaviours towards staff or other Residents.
2. The Violence Assessment Tool (VAT) has been used to assess the Resident.
3. The VAT score designates the Resident as a "High" or "Very High" risk.
4. It's been determined by OH&S that a Safety Plan is required.

Update Special Instructions

Home ▾   Admin ▾   Clinical ▾   Reports

Gallant, Diane (123)
Status: Current   Location: Blue
Gender: DOB:
Physician:
Care Profile   Edit   ▾
Allergies: To Be Determined

Special Instructions

Information typed in the 'Special Instructions' box will appear in the chart header.

VAT Score and presence of a Safety Plan should be added here as follows:
** HIGH/VERY HIGH RISK FOR VIOLENCE - Safety Plan in Place **

Edit Custom Information

Change to 'Yes – See Care Plan' and click 'Save'.

Add Safety Plan Interventions to Care Plan

Department:

| All | Food Services | Nursing/Care Services | Recreation | Therapy |

[New Focus] [New Custom Focus] [Printable View] [Back] [Ca...

1 2 3 4 5 6 7 8 Next »

Focus	Goals	Interventions/Tasks
	New Goal New Custom Goal	New Intervention New Custom In...
edit pn Acute Pain r/t Chest pain + H	edit pn Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain. + H edit pn Will voice/display a level of comfort acceptable to the resident through the review date. + H edit pn Will maintain pain at or below the level of ____5_ (Specify) as per resident. + H	edit pn Anticipate need for pain re... [LPN,RN,REHA] + H edit pn Determine the appropriate Imagery/Distraction techn... exercises, music therapy, compresses. + H New Task **NO ASSIGNED TASKS**
edit pn Coronary Heart Disease r/t lifestyle choices + H	New Goal New Custom Goal	New Intervention New Custom In... New Task **NO ASSIGNED TASKS**
edit pn Scott Fall Risk Score: (11 = high risk) + H	New Goal New Custom Goal edit pn Risk of injury from fall will be minimized + H	New Intervention New Custom In... edit pn Universal precautions - Be Toileting schedule / Incont floors, accessible grab ba [RCW,RECPR] + H edit pn Score 11: In addition to universal fal [RCW,RECPR] + H New Task **NO ASSIGNED TASKS**
edit pn TLR Logo + H	New Goal New Custom Goal edit pn Resident goal - maintain mobility + H	New Intervention New Custom In... edit pn Total lift. (Two staff to assist. Medium sling used.) [RCW,LPN,RECPR,PT,RN] + H K New Task **NO ASSIGNED TASKS**
edit pn Bed Mobility + H	New Goal New Custom Goal edit pn Resident Goal - specify ⚠ H	New Intervention New Custom Intervention edit pn Independent [RCW,LPN] + H K New Task **NO ASSIGNED TASKS**

1 2 3 4 5 6 7 8 Next »

[New Focus] [New Custom Focus] [Printable View] [Back] [Care Plan PN] [New Alert]

Care Plan Wizard - Google Chrome

www60.pointclickcare.com/care/chart/cp/needwizard_rev.jsp

Focus

Resident: Acosta, Caleb (GE8DDE11BE)

Instructions: 1. Select Focus Category from the drop down.
2. Click add to add the Standard Focus from the resulting list or click go to/unresolve to navigate to the listed item in the care plan.

Select Library: [Standard LTCF Care Plan Library]

Focus Category: [ ]

Focus List [Cancel]

Description
All standard fo...

Dropdown list:
- ADL
- Behaviours/expressions including elopement wandering
- Cognitive
- Communication
- Continence
- Palliative/End of Life
- Falls
- Health Conditions
- Infections
- Mental Health
- Mood
- Nutrition & Hydration
- Other Risk (Heat, Alcohol, Smoking, Substance Use)
- Pain
- Recreation
- Restraints
- Restorative Care
- Skin

...d to the resident.

Select the LTCF Library.

Always select 'Behaviours/expressions including elopement wandering'.

99

Always select
'Other – specify behaviour'.

Customize the description to "Safety Plan".

Assign to "Nursing/Care Services", which is the default.

Select all Goals that apply and click 'Next'.

Select all Interventions that apply and click 'Save'.

The new Focus with your selected set of Goals and Interventions is added to the Care Plan. They must now be customized to fully represent the Resident's situation.

Care Plan Detail

Home ▼ Admin ▼ **Clinical** ▼ Reports

Search: _____ Search

Resident: Acosta, Caleb (GE8DDE11BE)
Triggered Care Plan Items: View Triggered Items Now

Search: _____
Sort By: Library Order ▼
Show only Δ: ☐
Show Resolved/Cancelled: ☐
Show Tasks: ☑
Show Symbol Legend

Care Plan Type:
All

Department:
All Nursing/Care Services Recreation Therapy

[New Focus] [New Custom Focus] [Printable View]
« Prev 1 2 3 N

Focus	Goals	Interventions
	New Goal New Custom Goal	New Intervention New Custom Int
edit pn Safety Plan + H	edit pn Resident will exhibit no outward behaviours. + H	edit pn Use a team approach to ... aggressive behaviour. Be
	edit pn Triggers to behaviour will be recognized early with intervention to minimize risk of escalation + H	edit pn Use a calm voice to comi... appropriate. + H K
		edit pn Triggers include: Δ H K
		edit pn Provide the resident time
		edit pn Keep a safe proximity and
		edit pn Ensure two staff for care
		edit pn Document / report each i
		edit pn All staff must use the san
		edit pn Use white board in room
		edit pn **Recognize compassion**

Focus: Safety Plan

Δ Personalization of this Intervention is Required

Status: ◉ Active ○ Resolved ○ Cancelled
Date Initiated: 4/17/2025 📅
Standard Intervention: Use a team approach to care, i.e. identify one staff member ...(more)

ⓘ Only the first **100** characters will display without having to expand further in POC.

Description: Use a team approach to care, i.e. identify one staff member as communicator, one staff to do cares, one staff go observe and/or block aggressive behaviour. Be mindful not to overwhelm resident with too many staff members if this is a trigger for that resident.

260 characters

ⓘ Only the first **200** characters will display without having to expand further in POC.

Instruction: _____

0 characters

Kardex Category: Safety Plan Interventions ▼
Flowsheet Type: **None**
Position One: ▼
Position Two: ▼
Position Three: ▼
Position Four: ▼
Position Five: ▼
Frequency: 🔍
☐ Intervention will appear on the documentation record.
Where is documentation used? 🔍

[Save] [Delete] [Cancel]

All Interventions must be customized. Edit the description to best describe the resident's Intervention.

<u>Always</u> set the Kardex category to 'Safety Plan Interventions'. Only OH&S-led safety plan interventions will reside in this category.

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Caleb Acosta (GE8DDE11BE)

Admission Date: 11/11/2023   **Location:** LV & LSP 403-A
D.O.B: 9/14/1973   **Age:** 51   As of 4/9/2025
Allergies: Morphine, Penicillin
Special Instructions: ** MED RISK FOR VIOLENCE ** ** DROPLET/CONTACT PRECAUTIONS **

TLR	Safety Plan Interventions
⋆ Independent Mobility / Dementiability. Uses a 4ww. May need reminders at times.	⋆ Effective de-escalation actions include going for walk indoors/outdoors, distraction, re-direction, music, conversation, looking at pictures of family. ⋆ Keep care routine as consistent as possible. ⋆ Known triggers to responsive behaviour are: 1) entering the room quickly and unexpected; 2) not delivering care on the normal schedule.

Monitoring / Safety	Daily Routine
⋆ 2 staff for cares ⋆ Educate resident and family on infection control measures in place due current COVID-19 status. ⋆ Educate resident in hand washing and hand hygiene	⋆ Turn & Reposition ⋆ weight every day for 30 days

Safety Plan Interventions now appear on the Kardex as well as in the Care Plan.

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…add and clear an Assessment schedule?

Assessments that need to be done on a routine basis can easily be scheduled to remind staff to complete these when they become due.

The Braden Scale and TLR Assessments are automatically triggered on a resident's admission to the home. Upon completion of the first and each subsequent assessment, the next assessment will be automatically scheduled. No further action is required.

If the resident has a change in status and needs to be assessed before the next assessment is due, the schedule will automatically reset once the ad hoc assessment is locked.

Some assessments will require manual activation for them to be scheduled for the resident. These are shown on the following slides:

- Foot Assessment
- Neurological Checklist
- Weekly Wound Observation

To edit an assessment schedule, in the 'Assessments' tab of the resident's chart, select 'Edit Schedules'.
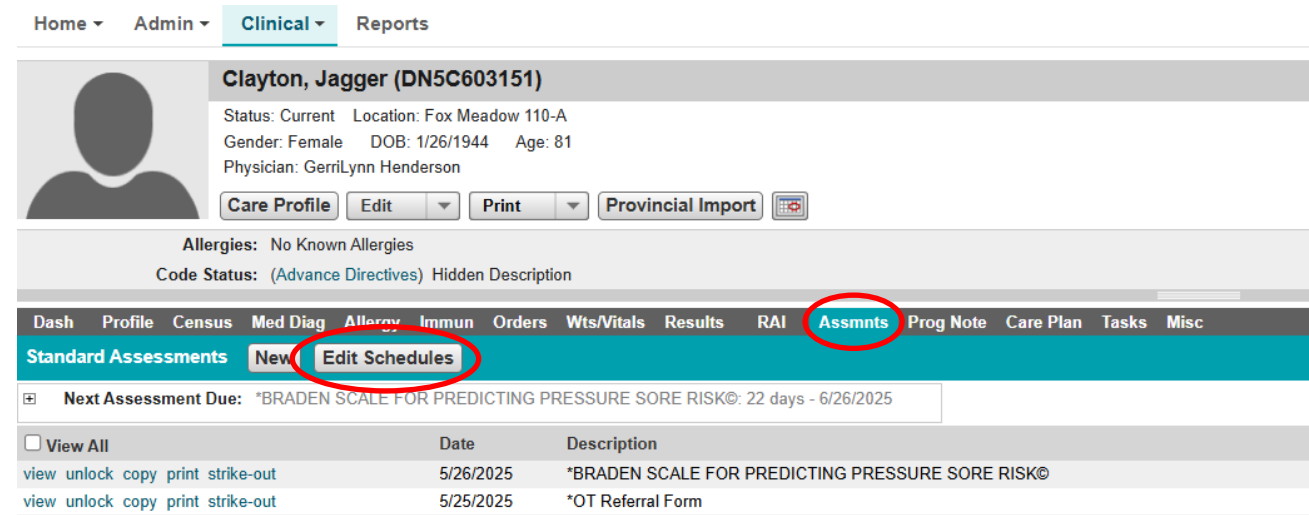
In the drop-down menu, select the assessment you wish to schedule.
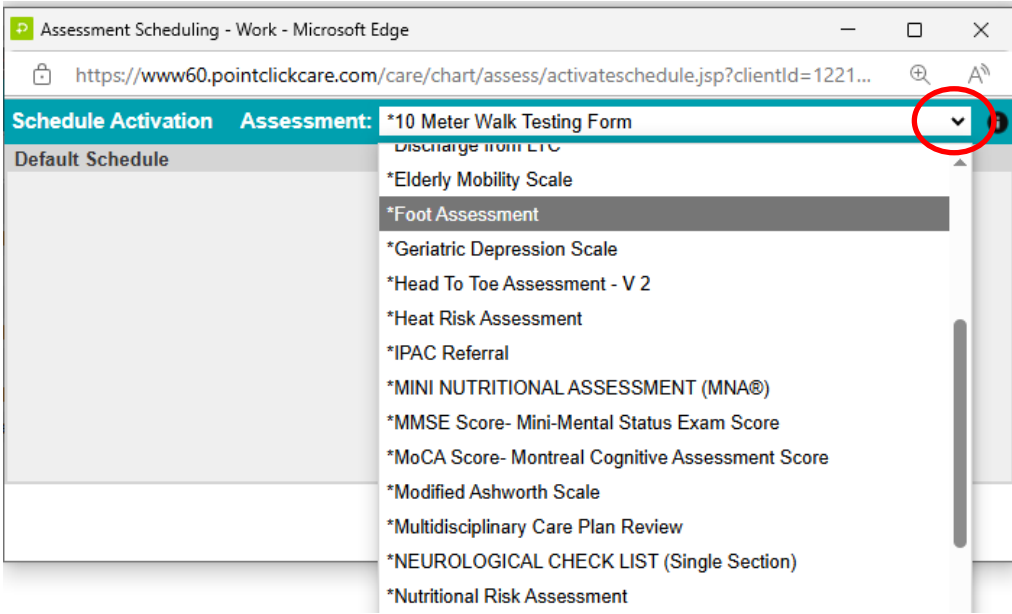
Foot Assessment:

- This assessment is automatically scheduled on admission for one time only.
- If the RN determines that the resident needs to be seen by the advanced foot care nurse on a 6-week schedule, this schedule must be manually activated.

Select 'Foot Assessment' from the drop-down list. The '+' will provide more details about the schedule of the assessment being chosen. Select 'Activate'. A new window will open allowing you to select the start date.

Choose the date and time for the initial assessment in the schedule. Select 'Save' and 'OK'.

Neurological Checklist:

- Following an unwitnessed fall, this schedule will require manual activation. Doing so will put the assessment on a schedule as per the Health PEI Fall Intervention and Management Policy.

Upon activation of this schedule, you will do the initial set of Neurovitals due after an unwitnessed fall or expected head injury.

Following the initial set of neurovitals, the schedule will continue as shown, until the final set of neurovitals is collected.

Complete the same steps in the previous slides to activate the schedule.

Weekly Wound Observation:

- If the resident has a wound that is being monitored on a weekly basis, this assessment can be manually activated.

Complete the same steps in the previous slides to activate the schedule.

Clearing an Assessment Schedule

Select 'De-activate'. You will be prompted to enter a reason for the cancellation. Once entered, select 'Save'.

…complete scheduled Assessments (UDAs)?
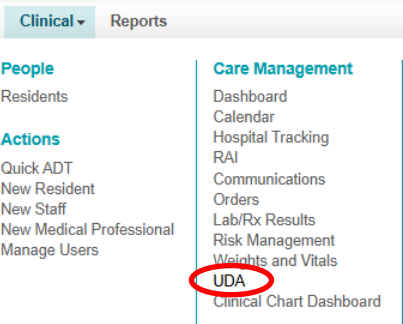
Select UDA under the Clinical Tab > Care Management

The UDA Portal is where you can see all assessments that are "Scheduled, "In Progress", and "Completed" across the entire home. Filters also allow you to narrow the list in each assessment category.

Select a category

Takes you to Resident's UDA schedule

Filter by Household

Filter by assessment type

Filter by date range

The 'Assmnts' tab in the Resident's chart is where you will find all Scheduled, In Progress, and Completed assessments

PointClickCare®

TRAINING - Prince Edward Home ▾   Peter Lawlor ▾

Home ▾   Admin ▾   Clinical ▾   Reports

🏠 ▾ Search resident, room #, ID #...   [Search] ℹ

Avelino, Pau (PEH0166)   3 of 116 [Prev] [Next]

Status: Current   Location: Lupin Valley 419-A
Gender: Male   DOB: 2/14/1985   Age: 40
Physician: GerriLynn Henderson

[Care Profile] [Edit ▾] [Print ▾] [Provincial Import] 🖼

Current Vitals   ℹ

BP: 125/82 mmHg	Temp:36.7 °C	Pulse:78 bpm	Weight:61 Kg
4/1/2025 10:10	4/1/2025 10:10	4/1/2025 10:10	4/1/2025 10:10
Resp:18 Breaths/min	BS:6.5 mmol/L	O2:99 %	Pain:0
4/1/2025 10:10	4/1/2025 10:10	4/1/2025 10:10	4/1/2025 10:10

Allergies: Ice cream
Code Status: (Advance Directives) Goals of Care R - Medical Care and Interventions, including Resuscitation

Dash   Profile   Census   Med Diag   Allergy   Immun   Orders   Wts/Vitals   Results   RAI   **Assmnts**   Prog Note   Care Plan   Tasks   Misc

Standard Assessments [New] [Edit Schedules]   Type: [All ▾] 🖼

⊟ ← Next Assessment Due: *Time of My Life: 8 days overdue - 4/1/2025

Assessment Name	Due Date	Trigger By / Schedule Frequency
*Time of My Life	4/1/2025	Admission / One Time Only
*TB Screening for LTC Residents	4/1/2025	Admission / One Time Only
*Scott Fall Risk	4/1/2025	Admission / One Time Only
*Recreation - Admission Assessment - - V 1	4/3/2025	Admission / One Time Only
*Violence Assessment Tool	4/3/2025	Admission / One Time Only
*Continence Assessment	4/3/2025	Admission / One Time Only
*Footcare Assessment	4/3/2025	Admission / One Time Only
*BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK©	4/8/2025	Schedule Completion of Braden Admission / Weekly
*TLR & Bed Mobility Assessment	4/1/2026	Schedule Completion of TLR Assessment Admission / Annually

☐ View All

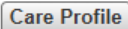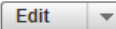|	Date	Description	Status	Type	Category	Score	Created By	Revised By
edit del close sign print	4/1/2025	*Time of My Life	In Progress	Admission			mevangelista@ihis.org	mevangelista@ihis.org
edit del close lock print	4/1/2025	*Admission Database - Multi-disciplinary - V 2 - V 1	In Progress	Admission			mevangelista@ihis.org	mevangelista@ihis.org
view unlock copy print strike-out	4/1/2025	*BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK©	Complete	Admission	No Risk	20.0	mevangelista@ihis.org	mevangelista@ihis.org
view unlock copy print strike-out	4/1/2025	*TLR & Bed Mobility Assessment	Complete	Admission			mevangelista@ihis.org	mevangelista@ihis.org

Click the '+' sign to see the list pre-scheduled assessments and their due dates.

Click on the assessment you would like to complete.

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After completing the assessment, select "Save & Sign & Lock & Exit".

Home ▾   Admin ▾   Clinical ▾   Reports

*BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK©

Resident: Braun, Lloyd (PEH0123)
Description: Admission   Score: To Be Determined
Date: 4/9/2025 16:23
Section Status: Unedited ○
Lock Date:

[Save & Sign] [Save] [Save & Exit] [Save & Sign & Lock & Exit] [Cancel] [Clear All]

SECTION Cust. *BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK©		
Ins.	INSTRUCTIONS	Complete on admission for 4 weeks and then quarterly thereafter. H
1.	SENSORY PERCEPTION	Ability to respond meaningfully to pressure-related discomfort H ◉ 1. **Completely Limited**: Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. **OR** limited ability to feel pain over most of body surface. ○ 2. **Very Limited**: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body. ○ 3. **Slightly Limited**: Responds to verbal commands, but cannot always communicate discomfort or need to be turned. **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. ○ 4. **No Impairment**: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. clear
2.	MOISTURE	Degree to which skin is exposed to moisture H ○ 1. **Constantly Moist**: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. ◉ 2. **Very Moist** : Skin is often, but not always, moist. Linen must be changed at least once a shift. ○ 3. **Occasionally Moist** : Skin is occasionally moist, requiring an extra linen change approximately once a day. ○ 4. **Rarely Moist**: Skin is usually dry. Linen only requires changing at routine intervals. clear
3.	ACTIVITY	Degree of physical activity H ○ 1. **Bedfast**: Confined to bed. ◉ 2. **Chairfast**: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. ○ 3. **Walks Occasionally**: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. ○ 4. **Walks Frequently**: Walks outside room at least twice a day and inside room at least once every two hours during waking hours. clear
4.	MOBILITY	Ability to change and control body position H ○ 1. **Completely Immobile**: Does not make even slight changes in body or extremity position without assistance. ○ 2. **Very Limited**: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. ○ 3. **Slightly Limited**: Makes frequent though slight changes in body or extremity position independently. ○ 4. **No Limitation**: Makes major and frequent changes in position without assistance. clear
5.	NUTRITION	Usual food intake pattern H ○ 1. **Very Poor**: Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. **OR** is NPO and/or maintained on clear liquids or IV's for more than 5 days. ○ 2. **Probably Inadequate**: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. **OR** receives less than optimum amount of liquid diet or tube feeding. ○ 3. **Adequate**: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement when offered. **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs. ○ 4. **Excellent**: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. clear
6.	FRICTION & SHEAR	H ○ 1. **Problem**: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction. ○ 2. **Potential Problem**: Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down. ○ 3. **No Apparent Problem**: Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times. clear **NB**. Copyright. Barbara Braden and Nancy Bergstrom, 1988. Reprinted with permission. All Rights Reserved. H

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You will be asked to sign the assessment. Enter your PIN and click 'Sign'.

…complete unscheduled Assessments (UDAs)?

Select the assessment you would like to initiate.

Choose the type of assessment from the dropdown.

After completing the assessment, select "Save & Sign & Lock & Exit".

*BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK©

Resident: Braun, Lloyd (PEH0123)	
Description: Admission	**Score:** To Be Determined
Date: 4/9/2025 16:23	
Section Status: Unedited ○	
Lock Date:	

[Save & Sign] [Save] [Save & Exit] [Save & Sign & Lock & Exit] [Cancel] [Clear All]

SECTION Cust. *BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK©

Ins.	INSTRUCTIONS	Complete on admission for 4 weeks and then quarterly thereafter. H
1.	SENSORY PERCEPTION	Ability to respond meaningfully to pressure-related discomfort H
		● 1. **Completely Limited**: Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. **OR** limited ability to feel pain over most of body surface.
		○ 2. **Very Limited**: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.
		○ 3. **Slightly Limited**: Responds to verbal commands, but cannot always communicate discomfort or need to be turned. **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.
		○ 4. **No Impairment**: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. clear
2.	MOISTURE	Degree to which skin is exposed to moisture H
		○ 1. **Constantly Moist**: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.
		● 2. **Very Moist** : Skin is often, but not always, moist. Linen must be changed at least once a shift.
		○ 3. **Occasionally Moist** : Skin is occasionally moist, requiring an extra linen change approximately once a day.
		○ 4. **Rarely Moist**: Skin is usually dry. Linen only requires changing at routine intervals. clear
3.	ACTIVITY	Degree of physical activity H
		○ 1. **Bedfast**: Confined to bed.
		● 2. **Chairfast**: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.
		○ 3. **Walks Occasionally**: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.
		○ 4. **Walks Frequently**: Walks outside room at least twice a day and inside room at least once every two hours during waking hours. clear
4.	MOBILITY	Ability to change and control body position H
		○ 1. **Completely Immobile**: Does not make even slight changes in body or extremity position without assistance.
		○ 2. **Very Limited**: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.
		○ 3. **Slightly Limited**: Makes frequent though slight changes in body or extremity position independently.
		○ 4. **No Limitation**: Makes major and frequent changes in position without assistance. clear
5.	NUTRITION	Usual food intake pattern H
		○ 1. **Very Poor**: Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. **OR** is NPO and/or maintained on clear liquids or IV's for more than 5 days.
		○ 2. **Probably Inadequate**: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. **OR** receives less than optimum amount of liquid diet or tube feeding.
		○ 3. **Adequate**: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement when offered. **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs.
		○ 4. **Excellent**: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. clear
6.	FRICTION & SHEAR	H
		○ 1. **Problem**: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.
		○ 2. **Potential Problem**: Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.
		○ 3. **No Apparent Problem**: Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times. clear
		NB. Copyright. Barbara Braden and Nancy Bergstrom, 1988. Reprinted with permission. All Rights Reserved. H

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You will be asked to sign the assessment. Enter your PIN and click 'Sign'.

…request an internal Referral (Dietitian, OT, PT, and Social Work)?

Enter date and time of Referral. The system defaults to current.

Select the referral you'd like to complete from the dropdown list.

Select the type/reason for referral.

Click 'Save' to create the referral.

All referrals are two-part assessments. The requestor completes ("edits") Section A, saves and signs. The receiver (a Dietitian in the example) acknowledges receipt of the referral by completing Section B.

3. Unintended Weight Gain (check one if applicable)   H
   ○   a.   Weight gain of 5% or more in the last month
   ○   b.   Weight gain of 7.5% or more in the last 3 months
   ○   c.   Weight gain of 10% or more in the last 6 months
   ○   d.   Weight gain not categorized
   ⦿   e.   Not applicable   clear

4. Details/comments (Add detail regarding the selections above)   H

   Poor intake leading to weight loss.

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C.	VITALS	
		1. Most Recent Weight new view all clear H
		Weight: 65.0 (Kg) Date: 4/4/2025 11:53
		Scale: Bath
		2. Most Recent Height new view all clear H
		Height: 169.0 (Cm) Date: 4/1/2025 10:50
		Method: Standing
		3. BMI Score H

SECTION A. Referral

Save & Sign & Next   Save & Next   Save   **Save & Exit**   Cancel   Clear All

After completing the referral questionnaire, click 'Save & Exit'.

Electronic Signature - Custom Assessments

Attestation Statement: By electronically signing this record, I attest that the information recorded was entered by me and that I am authorized by the facility to record and sign this record.

User: Peter Lawlor
Password: •••••

Sign   Cancel

Enter your PIN to sign and click 'Sign'.

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*Dietitian Referral Form

Resident:	Skinner, Ayla (NV31CD607C)
Description:	Other
Date:	4/7/2025 17:52
Lock Date:	

Click Here to View Quick Entry - Keyboard Navigation Tips

Back | Sign All | Regenerate Triggers | Lock | Print

	Section	Description	Signed By ⓘ	Signed Date
view reopen	A	Referral	Peter Lawlor	4/7/2025
edit	B	Dietitian Acknowledgement		

You will be returned to this screen, which shows that Section A is now complete. Section B awaits the receiver of the referral.
Click 'Back'.

The referral is 'In Progress'.

Home ▾ Admin ▾ Clinical ▾ Reports

Skinner, Ayla G. (NV31CD607C)   6 of 13 Prev Next

Status: Current   Location: Red Rock Inn 510-A
Gender: Male   DOB: 1/8/1943   Age: 82
Physician: GerriLynn Henderson

Care Profile | Edit ▾ | Print ▾ | Provincial Import |

Current Vitals   ⓘ
⚠ BP: 188/98 mmHg   ⚠ Temp:46 °C   ⚠ Pulse:222 bpm   ⚠ Weight:65 Kg
  4/4/2025 11:53   4/4/2025 11:53   4/4/2025 11:53   4/4/2025 11:53
Resp:21 Breaths/min BS:6 mmol/L   ⚠ O2:6 %   Pain:3
  4/4/2025 11:53   4/4/2025 11:53   4/4/2025 11:53   4/1/2025 15:06

Allergies: Condensed milk
Code Status: (Advance Directives) Goals of Care C - Care and Interventions focused on comfort, excluding Resuscitation
Special Instructions: ** MED RISK FOR VIOLENCE ** ** DROPLET/CONTACT PRECAUTIONS **

Dash Profile Census Med Diag Allergy Immun Orders Wts/Vitals Results RAI Assmnts Prog Note Care Plan Tasks Misc

Standard Assessments New Edit Schedules   Type: All

⊞ Next Assessment Due: *Rehab Assistant Assignment (PT) - V 1: 5 days overdue - 4/2/2025

☐ View All	Date	Description	Status	Type	Category	Score	Created By	Revised By
edit del close print	4/7/2025	*Dietitian Referral Form	In Progress	Other			pwlawlor@gov.pe.ca	pwlawlor@gov.pe.ca

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…receive and action internal Referrals (Dietition, OT, PT, and Social Work)?

Make sure 'In Progress' is selected.

Filter by the referral type(s) you are interested in.

This example shows all 'In Progress' Dietitian Referral Forms, sorted oldest to newest.

Click 'edit' to action a referral request.

PointClickCare

TRAINING - Prince Edward Home ▾   ❓   🔔   👤 Peter Lawlor ▾

Home ▾   Admin ▾   Clinical ▾   Reports

🏠 ▾ | Search resident, room #, ID #... | **Search** ❶

UDA List

Set as My Default View

| Scheduled | **In Progress** | Completed |

| In Progress List | Batch Update ▾ |

		⇕ Name	⇕ Status	▲ Created Date ▼	⇕ Unit	⇕ Floor	⇕ Assessment Type	⇕ Assessment Status	⇕ Score	⇕ Category	⇕ Created By	⇕ Revised By
		Search	Set Filter ▾	Edit	Set Filter ▾	Set Filter ▾	*Dietitian Referra... ▾	Search	Searc	Search	Search	Search
					Search							
☐	edit del close copy	Bean, Donovan (BZ996FD8C5)	Current	02/12/2025	Red Rock Inn	RRI & SRP	*Dietitian Referral Form	In Progress			jrpitre@ihis.org	pwlawlor@gov.pe.ca
☐	edit del close copy	Bean, Donovan (BZ996FD8C5)	Current	02/12/2025	Red Rock Inn	RRI & SRP	*Dietitian Referral Form	Errors			jrpitre@ihis.org	laura.macaulay@davispier.ca
☐	edit del close copy	Acosta, Caleb (GE8DDE11BE)	Current	03/25/2025	Lady Slipper Path	LV & LSP	*Dietitian Referral Form	Errors			drmartin@ihis.org	drmartin@ihis.org
☐	edit del close copy	Acosta, Caleb (GE8DDE11BE)	Current	03/25/2025	Lady Slipper Path	LV & LSP	*Dietitian Referral Form	In Progress			lisaking@ihis.org	lisaking@ihis.org
☐	edit del close copy	Forbes, Izabelle (CKD1701219)	Current	03/25/2025	Fox Meadow	LHC & FM	*Dietitian Referral Form	In Progress			cmclantoria@ihis.org	cmclantoria@ihis.org
☐	edit del close copy	Mckenzie, Lena (KX68387E3E)	Current	03/25/2025	Fox Meadow	LHC & FM	*Dietitian Referral Form	In Progress			wlholland@ihis.org	wlholland@ihis.org
☐	edit del close copy	Acosta, Caleb (GE8DDE11BE)	Current	03/26/2025	Lady Slipper Path	LV & LSP	*Dietitian Referral Form	In Progress			smjones@ihis.org	smjones@ihis.org
☐	edit del close copy	Acosta, Caleb (GE8DDE11BE)	Current	03/26/2025	Lady Slipper Path	LV & LSP	*Dietitian Referral Form	In Progress			drmartin@ihis.org	drmartin@ihis.org
☐	edit del close copy	Mckenzie, Lena (KX68387E3E)	Current	03/26/2025	Fox Meadow	LHC & FM	*Dietitian Referral Form	In Progress			rquizon@ihis.org	rquizon@ihis.org
☐	edit del close copy	Forbes, Izabelle (CKD1701219)	Current	03/26/2025	Fox Meadow	LHC & FM	*Dietitian Referral Form	Errors			brittanyyoung@ihis.org	brittanyyoung@ihis.org
☐	edit del close copy	Acosta, Caleb (GE8DDE11BE)	Current	03/26/2025	Lady Slipper Path	LV & LSP	*Dietitian Referral Form	In Progress			brittanyyoung@ihis.org	brittanyyoung@ihis.org
☐	edit del close copy	Coleman, Dante (QY20081A75)	Current	03/26/2025	Fox Meadow	LHC & FM	*Dietitian Referral Form	In Progress			cemacdonnell@ihis.org	cemacdonnell@ihis.org
☐	edit del close copy	Cox, Lydia (CR9CE71336)	Current	03/26/2025	Fox Meadow	LHC & FM	*Dietitian Referral Form	In Progress			seadams@ihis.org	seadams@ihis.org
☐	edit del close copy	Jackson, Micheal (PEH0153)	Current	03/26/2025	Lupin Valley	LV & LSP	*Dietitian Referral Form	Errors			lyoronglim@ihis.org	lyoronglim@ihis.org
☐	edit del close copy	Jackson, Michael (PEH0151)	Current	03/26/2025	Lupin Valley	LV & LSP	*Dietitian Referral Form	In Progress			almadura@ihis.org	almadura@ihis.org
☐	edit del close copy	Jackson, Michael (PEH0151)	Current	03/26/2025	Lupin Valley	LV & LSP	*Dietitian Referral Form	In Progress			smjones@ihis.org	smjones@ihis.org
☐	edit del close copy	Jackson, Michael (PEH0151)	Current	03/26/2025	Lupin Valley	LV & LSP	*Dietitian Referral Form	In Progress			rquizon@ihis.org	rquizon@ihis.org
☐	edit del close copy	Garfield, Ronald (PEH0116)	Current	03/26/2025	Fox Meadow	LHC & FM	*Dietitian Referral Form	In Progress			aumurerwa@ihis.org	aumurerwa@ihis.org
☐	edit del close copy	Bennett, Lexi (BX249A12B6)	Current	03/27/2025	Red Oak Heights	BJW & ROH	*Dietitian Referral Form	Errors			jkarandini@ihis.org	jkarandini@ihis.org

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1 Click 'view' to see the referral request details provided by the requester.

2 Click 'edit' to open and acknowledge the referral request.

PointClickCare®

TRAINING - Prince Edward Home ▾   Peter Lawlor ▾

Home ▾   Admin ▾   Clinical ▾   Reports

Search resident, room #, ID #...   Search

*Dietitian Referral Form

Resident: Acosta, Caleb (GE8DDE11BE)
Description: Significant Change
Date: 3/25/2025 13:29
Lock Date:

Click Here to View Quick Entry - Keyboard Navigation Tips

Back   Sign All   Regenerate Triggers   Lock   Print

	Section	Description	Signed By
view reopen	A	Referral	Peter Lawlor
edit	B	Dietitian Acknowledgement	

PointClickCare®

TRAINING - Prince Edward

Home ▾   Admin ▾   Clinical ▾   Reports

*Dietitian Referral Form

Resident: Acosta, Caleb (GE8DDE11BE)
Description: Significant Change
Date: 3/25/2025 13:29
Section Status: Unedited ○
Lock Date:

Save & Sign & Exit   Save   Save & Exit   Cancel   Clear All

SECTION B. Dietitian Acknowledgement

B. ACKNOWLEDGEMENT   1. ☐ Dietitian Reviewed Referral   H
1a. Additional Comments: H

3 Complete the referral acknowledgement. Then 'Save & Sign & Exit'

SECTION B. Dietitian Acknowledgement

Save & Sign & Exit   Save   Save & Exit   Cancel   Clear All

Click Here to View Quick Entry - Keyboard Navigation Tips

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Lock the referral request to mark it 'Complete'.

…enter lab orders?

Enter the date and time the order was written.

If a written order was provided by the NP/physician, select this option. Phone and Verbal orders will prompt you to print a copy of the order that can be signed by the NP/physician and placed in the paper chart.

Search for and select the ordering NP/physician.

Provide a description.

This directs the Order to the 'LAB' tab in the eMAR module.

Pick a schedule type. This example is 'Routine'.

Use the combination of these fields to define the frequency – one the first day of each month in this example.

In this example, the lab draw will be done starting Apr 7/25, once a month for 6 months, then reassessed.

…enter diet orders?

If a written order was provided, select this option. Phone and Verbal orders will prompt you to print a copy of the order that can be signed and placed in the paper chart.

Search for and select the ordering clinician – usually the Dietitian.

Complete the required fields.

Leave as the default value.

Complete optional fields if applicable.

Murphy, Abigail (56397)

Status: Current   Location: Lighthouse Cove 122-A
Gender: DOB:
Physician:

| Care Profile | Edit ▼ | Print ▼ | Provincial Import | 🔳 |

Allergies: To Be Determined
Code Status: (Advance Directives)
Special Instructions:
Diet: Heart Healthy diet, Mechanical Soft texture, Nectar/Mildly Thick consistency

The summary of the Diet Order appears in the resident header throughout the system.

…enter supplement orders?

Order Entry – Google Chrome

www60.pointclickcare.com/clinical/pho/popup/enhancedOrderEntry/newOrder.xhtml?ESOLclientid=525&ESOLminiToken=MPjPqpgVv25&ESOLCategoryI...

Resident: Skinner, Ayla (NV31CD607C)

Order Details

Order Date: 4/7/2025 18 ▾ 54 ▾ *

Order Category: Supplement ▾ *

Communication Method: ○ Phone ○ Verbal ⦿ Prescriber written ○ Prescriber entered *

Ordered By: Barbie Matheson   **Last prescribed by:** Barbie Matheson
(Current Primary Physician: GerriLynn Henderson)

Order Template Search: [   ] clear

Diet Supplement: Boost/Ensure ▾ *

Order Type: Diet Orders - Supplements - [] ▾ *

Order Summary:

Boost/Ensure

in the morning Prefers to drink it while reading the paper

Scheduling Details

Add Schedule: [Routine] [PRN] [One Time Only] [STAT]

Routine 1 ⊗

Frequency: in the morning ▾ *

Schedule Type: Everyday ▾ *

Facility Time Code: 0900 ▾ *

Related Diagnoses: [   ] 🔍 clear

For (Indications for Use): [   ] 🔍 clear

Additional Directions: Prefers to drink it while reading the paper

Start Date: 04/08/2025   End Date: Indefinite ▾
0900 ▾ *

Specific Time(s): 0900   Admin Notes: [   ]   Supplementary Documentation: Add

[Save] [Queue & New] [Cancel]

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If a written order was provided, select this option. Phone and Verbal orders will prompt you to print a copy of the order that can be signed and placed in the paper chart.

Search for and select the ordering clinician – usually the Dietitian.

Select the type of supplement from the drop-down list.

Leave as the default value.

Pick a schedule type. This example is 'Routine'.

Use the combination of these fields to define the frequency – every day in the morning around 9am in this example.

In this example, the supplement will be given daily around 9am starting on Apr 8/25 indefinitely.

…enter enteral feed orders?

Order Entry - Google Chrome

www60.pointclickcare.com/clinical/pho/popup/enhancedOrderEntry/newOrder.xhtml?ESOLclientid=525&ESOLminiToken=MPjPqpgVv25&ESOLCategoryId=...

Resident: Skinner, Ayla (NV31CD607C)

Order Details

Order Date: 4/7/2025 19 ∨ 06 ∨ *

Order Category: Enteral Feed ∨ *

Communication Method: ○ Phone ○ Verbal ● Prescriber written ○ Prescriber entered *

Ordered By: GerriLynn Henderson   * Last prescribed by: GerriLynn Henderson
(Current Primary Physician: GerriLynn Henderson)

Order Template Search: _____ clear

Order Summary:

in the morning every Mon, Wed, Fri Specific directions to be entered here.

Scheduling Details

Add Schedule: [Routine] [PRN] [One Time Only] [STAT]

Routine 1 ⊗

Order Type: Enteral Orders - TAR - [TAR] ∨ *

Frequency: in the morning ∨ *

Schedule Type: Specific Day(s) of Week ∨ * Every 1 ∨ Week(s)
☑ Mon ☐ Tue ☑ Wed ☐ Thu ☑
Fri ☐ Sat ☐ Sun

Facility Time Code: 0900 ∨ *

Directions: Specific directions to be entered here.

Specific Time(s) | **Admin Notes** | **Supplementary Documentation**
0900 | | Add

Related Diagnoses: 🔍 clear

For (Indications for Use): _____ 🔍 clear

Start Date: 04/09/2025   End Date: Indefinite ∨
0900 ∨ *

All enteral feed schedules in this order use the same start date and end date. If a schedule requires a different start date or end date, create a separate order.

[Save] [Queue & New] [Cancel]

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If a written order was provided, select this option. Phone and Verbal orders will prompt you to print a copy of the order that can be signed and placed in the paper chart.

Search for and select the ordering clinician.

Pick a schedule type. This example is 'Routine'.

Select 'Enteral Orders – TAR – [TAR]' to direct these orders to the LPN's TAR tab in the eMAR module.

Use the combination of these fields to define the frequency – every Mon, Wed, and Fri around 9am in this example.

In this example, the Enteral Feed will be performed M-W-F around 9am starting on Apr 9/25 indefinitely.

…enter treatment orders?

To enter a resident's treatment order, navigate to the 'Orders' tab in the resident chart. Select 'New' and 'Other' from the drop-down list.

Fill out all order details.

Description: Identify the product and/or treatment to be applied.

Order Type: This is determined by the scope of the staff member assigned to apply the treatment, i.e. RN, LPN, RCW.

Adding scheduling details to the treatment order

There are 4 types of schedules: Routine, PRN, One Time Only, STAT.
Once you've made your initial selection, a window will open as shown below.

Frequency: Allows you to choose once daily, twice daily, before or after meals, etc.

Schedule Type: Where you select whether the treatment is to be done every day, every xx days, etc.

Facility Time Code: Where you select the times of day when the treatment will be provided. If you don't see your desired times, they can be better tailored to the resident's routine down the page a bit further.

➤ When selected, the person responsible for doing the treatment will also be responsible for documenting the removal of the previous treatment applied.

Scheduling Details

Add Schedule: [Routine] [PRN] [One Time Only] [STAT]

Routine 1 ⊗

Frequency: [two times a day ▾] *
Schedule Type: [Everyday ▾] *
Facility Time Code: [0800-1700 ▾] * ☐ Document Removal
Related Diagnoses: [_____] 🔍 clear
For (Indications for Use): [_____] 🔍 clear
Additional Directions: [_____]
Start Date: [6/2/2025] 📅   End Date: [Indefinite ▾]
[1700 ▾] *

Specific Time(s)	Admin Notes	Supplementary Documentation
0800	[_____]	Add
1700	[_____]	Add

[Save] [Queue & New] [Cancel]

Related Diagnoses: Allows you to link a treatment to a resident's diagnosis.
For (Indications for Use): Allows you to apply parameters for when the product should be used.

Additional Directions: You may provide additional directions or instructions here.

Start Date: The date and time that the treatment is to start.
End Date: If the treatment has an end date, it can be defined here. Also, if reassessment is needed, it can also be indicated here when an end date is selected.

You can request additional information be gathered, such as vital signs, by adding them here.

Specific Times: This is the area where you can specify a more exact time for the resident's treatment to be applied.
Admin Notes: This is another area where instructions can be noted. You would use this section if administration directions differ between admin times.

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Multiple Schedules for a Single Order

More than one schedule can be added to a single order, such as routine and PRN.

For a PRN order, you will choose one of these two options:
- If you choose 'PRN', you will be required to enter a time frequency in the 'Additional Directions'.
- Alternatively, you may choose 'PRN Every xx' where you can indicate the frequency.

One Time Only Orders

A 'One Time Only' schedule allows you to indicate a timeframe for the treatment to be administered.

STAT Orders

A 'STAT' schedule will appear as follows, generating the current time as the start date. It does not enable you to enter an end date due to the nature of the order (i.e., to be carried out immediately).

Confirming an Order

After you select 'Save', you'll be asked to confirm your order.

Select 'Acknowledge' when reviewed.

View of a Completed Order

Your order will appear as depicted below.
Documentation will take place in the eMAR Module.

…update an existing order?

Order Actions

Discontinue an Order

Hold an Order

Strike Out an Order

Making a Progress Note on an Order

…create a Progress Note?

Gavin, Barry (PEH0162)
Status: Current   Location: Lupin Valley 416-A
Gender: Male   DOB: 3/19/1947   Age: 78
Physician: GerriLynn Henderson

Care Profile | Edit ▾ | Print ▾ | Provincial Import 🔲

Allergies: No Known Allergies
Code Status: (Advance Directives) Goals of Care C - Care and Interventions focused on comfort, excluding Resuscitation. Comfort only. Do no
Special Instructions: ** HIGH RISK FOR VIOLENCE **

Dash | Profile | Census | Med Diag | Allergy | Immun | Orders | Wts/Vitals | Results | RAI | Assmnts | **Prog Note** | Care Plan | Tasks | Misc

Progress Notes New **View All**

Effective Date   Type   Note   Care Plan Item or Task

Views: [All Notes] - Custom - Last 8 hrs - Last 24 hrs - Last 72 hrs - Last 7 days - Last 30 days

Progress Notes **New** View All

➢ In the resident's chart, choose the 'Prog Note' tab

'View All' and choose the timeframe
(Last 8 hours up to Last 30 days)

Select 'New' to create a new Progress Note

Type: **SELECT APPROPRIATE TYPE** ▾
up to: **SELECT APPROPRIATE TYPE**
Task: Admission Summary
Date: Care Plan Review Request
         COMMUNICATION
         Critical Event Summary
         Dietitian Progress Note
         Discharge Summary
         Infection Prevention & Control
osition: Medication / PRN Follow Up
ed By: NP / MD Progress Note
Date: Nursing Progress Note
         OT Progress Note
         PT Progress Note
         Recreation Progress Note
         Rehab Assistant Progress Note
         Social Work Note
         Specimen Collection
         Transfer / Mobility (TLR) Note
         Transfer to Hospital Summary

Select the type from the picklist

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Using the DARP method…

Data:	Ensure all notes begin with a standard word/focus, i.e. Behaviour - … , Pain - … Write what you observe/experience.
Action:	Describe your own or other people's actions and interventions.
Response:	Describe the resident's response, including any behaviours or changes in condition.
Plan:	Describe next steps … Ongoing monitoring, further interventions, referrals, etc.

☑ Show on Shift Report
☑ Show on 24 Hour Report

Sign

DARP is an acronym to describe the format for nursing and recreation Progress Notes.

Click 'Show on Shift Report' and 'Show on 24 Hour Report'

Sign and enter your PIN

Linking Progress Notes

Under the Prog Note Tab
➤ Select the Progress Note Type from the dropdown list
➤ Search for and link it to a past Progress Note

-- OR --

➤ Search for and link it to a Care Plan item

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…enter weights and vitals?

Metric system

$lb \times 0.4536 = kg$

$in \times 2.54 = cm$

Murphy, Abigail (56397)

Status: Current   Location: Lighthouse Cove 122-A
Gender: DOB:
Physician:

[Care Profile] [Edit ▾] [Print ▾] [Provincial Import]

Allergies: To Be Determined
Code Status: (Advance Directives)
Special Instructions:
Diet: Heart Healthy diet, Mechanical Soft texture, Nectar/Mildly Thick consistency
Diagnosis:
Admission (Re-entry): 11/8/2024   Provincial Health Number:
Initial Admission Date (MDS): 11/8/2024   Enterprise ID: 121
Discharge Date:

Dash   Profile   Census   Med Diag   Allergy   Immun   Orders   **Wts/Vitals**   Results   RAI   Assmnts

Weights & Vitals   [Nov ▾] [2024 ▾]   [New]   [Add Baselines]

	Vital Sign	Recent Monthly Value	Date	Time	Baseline / Admission Value (Go
view all	Weight:	90.0 Kg	11/19/2024	11:36	
view all	Blood Pressure:				/
view all	Temperature:				
view all	Pulse:				
view all	Respirations:				
view all	Blood Sugar:				
view all	O2 Saturation:				
view all	Height:				
view all	Pain Level:				

Weights & Vitals - Google Chrome

www60.pointclickcare.com/care/chart/wandv/editclientvitals.jsp?ESOLclie

Weights & Vitals

Vital Sign	New Value	Date	Time
Date & time shown will apply to vital(s) entered:		11/19/2024	15 ▾ 28 ▾

Weight: [   ] Kg
Scale: [Sitting ▾]   Last Scale: Sitting
Blood Pressure: [   ] [   ] mmHg
Position: [▾]
Temperature: [   ] °C
Route: [▾]
Pulse: [   ] bpm
Pulse Type: [▾]
Respirations: [   ] Breaths/min

Blood Sugar: [   ] mmol/L

O2 sats: [   ] %
Method: [▾]
Flow Rate: [   ] L/min
Inhaled Concentration: [   ] %
Height: [   ] Cm
Method: [▾]
Pain Level: [   ] clear
Pain Scale: [   ]

Blood glucose readings will continue to be documented on the paper MAR.

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Quick Entry

Clinical ▾ Reports

People
Residents

Actions
Quick ADT
New Resident
New Staff
New Medical Professional
Manage Users

Care Management
Dashboard
Calendar
Hospital Tracking
RAI
Communications
Orders
Lab/Rx Results
Risk Management
Weights and Vitals
UDA
Clinical Chart Dashboard

Quick Entry
Therapy Minutes
Physician Visits
Order Review Dates
Immunization
Weight
Blood Pressure
Temperature
Pulse
Respiration
Blood Sugar
O2 Saturation
Pain Level

Quick Entry allows care providers to do batch data entry instead of going into each resident's chart.

Quick Entry - Weights

Quick Entry – Blood Pressure

Quick Entry – Therapy Minutes

…administer an immunization to a single Resident?

1

Immunizations

2

3

Add Immunization

Immunization *
Source: All Immunizations

Consent

* Indicates a required field for completion

Consent Confirmed By *

Consent Confirmed Date *

☐ Education provided to Resident/Family

Education Comments

0 / 150

Add immunization details as per CPHO requirements:
- ➢ Type
- ➢ Consent
- ➢ Leave 'Education' unchecked
- ➢ Administration date, route, dose, unit
- ➢ Location given
- ➢ Use comments box if vaccine was given at pharmacy/hospital/doctor's office

…administer an immunization to a group of Residents?

Select Immunization from the 'Quick Entry' list

Filter by vaccine type, consent status, and household

Complete details

Leave education unchecked

Select residents

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…add a Resident event/appointment?
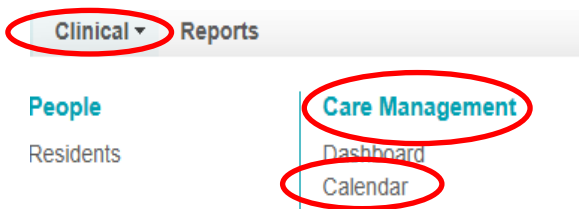
➢ Under the Clinical Heading, go to the Care Management tab and select 'Calendar'.
➢ This will bring you to the overall facility calendar.
➢ You can view by day, week, or month.

➢ Search for and find a Resident's chart under the Clinical tab.
➢ Click on the calendar icon.
➢ Add appointments or recreation activities specifically for this Resident.

➢ Repeated events can be scheduled using the 'Enable' Button..

…start my shift as an RCW?

1) Select 'Communications' from the Clinical menu.

2) The screen will display the Shift Reports, Summary Reports, and Communications/Message Board.

Shift Reports and Summary Reports

Resident Summary

RRI & SRP 521 - A	Arias, Nasir (MVD2C954D5)

No Weights and Vitals for the date range specified
No Immunizations for the date range specified
Progress notes
6/3/2025 11:24 - Nursing Progress Note
Data: Hidden name
Action: Hidden name
Response: Hidden name
Plan: Hidden name

No UDA completed for the date range specified.

BJW & ROH 309 - A	Barnett, Chris (QP663A2365)

No Weights and Vitals for the date range specified
No Immunizations for the date range specified
Progress notes
6/3/2025 10:49 - Rehab Assistant Progress Note
Subjective: Hidden name
Objective: Hidden nameHidden name
Assessment: Hidden name
Plan: Hidden name

No UDA completed for the date range specified.

LHC & FM 101 - A	Barnett, Orion (MB925542C6)

No Weights and Vitals for the date range specified
No Immunizations for the date range specified
Progress notes
6/3/2025 10:59 - EMAR - Administration Note
Note Text: Hidden name

6/3/2025 11:01 - EMAR - Administration Note
Note Text: Hidden name

6/3/2025 11:05 - EMAR - Administration Note
Note Text: Hidden name

6/3/2025 11:31 - Nursing Progress Note
Data: Hidden name
Action: Hidden name
Response: Hidden name
Plan: Hidden name

No UDA completed for the date range specified.

LHC & FM 123 - A	Berg, William (HY605D144C)

No Weights and Vitals for the date range specified
No Immunizations for the date range specified
Progress notes
6/3/2025 11:26 - OT Progress Note
Subjective: Hidden name
Objective: Hidden name
Assessment: Hidden nameHidden name
Plan: Hidden name

3) After selecting the desired report, a new tab will open displaying the building's report.

Close the browser tab when you are finished reviewing.

Home ▾   Admin ▾   Clinical ▾   **Reports**

alert listing Report   ✕

| RECENT | **ALL** | ENHANCED | CLINICAL |

Sub Modules

☐ ADT / Profiles
☐ Assessments
☐ eMAR
☐ General Clinical Reports
☐ Point of Care
☐ Weights and Vitals

Alert Listing Report

1) Click on 'Reports' and select 'Alert Listing Report'.

Home ▾   Admin ▾   **Clinical** ▾   Reports

Alert Listing Report
Report Options

Resident Number:	🔍 Leave blank for all residents
Resident:	🔍 clear
Unit	All ▾
Floor	All ▾
Status	Current ▾
Report On	☑ Simple Alerts ☑ Complex Alerts
☐ **Include Cleared Alerts**	
Effective Date	5/30/2025 📅 to 6/6/2025 📅
Sort By	Resident Name ▾
Filter by	All ▾

2) Filter by Unit.

3) Check the 'Include Cleared Alerts' box to view previously cleared alerts.

Date: Jun 9, 2025
Time: 11:05:18 AT
User:
TEST_Resident_Care_Worker

(train) Training - Prince Edward Home
Clinical and Order Alerts Listing Report
4/15/2025 - 5/2/2025

Facility # 25

Page # 1

Status: Current   Unit: Blue Heron   Floor: All   Alert Type: All

Resident Names	Effective Date	Alert Description	Cleared By	Cleared Date
Elliott, Taniyah (VO45899DFC) BH & VH 214 - A				
	5/2/2025 18:51	Hidden description	tlguitard@ihis.org	5/4/2025 21:51
	4/30/2025 17:57	Hidden description	mmahumot@ihis.org	4/30/2025 20:50
	4/20/2025 02:45	Hidden description	bmmaclean@ihis.org	4/23/2025 11:44
	4/19/2025 19:17	Hidden description	skemp@ihis.org	4/20/2025 00:10
	4/17/2025 20:16	Hidden description	slablackett@ihis.org	4/18/2025 19:10
Horn, Jade (LH5108025F) BH & VH 224 - A				
	4/25/2025 20:57	Hidden description	tlguitard@ihis.org	4/26/2025 09:55
	4/19/2025 09:10	Hidden description	bmmaclean@ihis.org	4/23/2025 11:44
	4/19/2025 07:56	Hidden description	bmmaclean@ihis.org	4/23/2025 11:44
Morales, Bria (BW7A061A34) BH & VH 225 - A				
	4/30/2025 04:40	Hidden description	rquizon@ihis.org	4/30/2025 04:59
	4/27/2025 05:44	Hidden description	tlguitard@ihis.org	4/27/2025 09:42
	4/26/2025 21:10	Hidden description	tlguitard@ihis.org	4/27/2025 09:42
	4/26/2025 21:08	Hidden description	tlguitard@ihis.org	4/27/2025 09:42
Moreno, Jade (NW28B9862C) BH & VH 217 - A				
	5/1/2025 04:35	Hidden description	mihunter@ihis.org	5/1/2025 13:15
	4/28/2025 04:55	Hidden description	jquizon@ihis.org	4/29/2025 13:49
	4/28/2025 04:55	Hidden description	jquizon@ihis.org	4/29/2025 13:30
	4/27/2025 21:38	Hidden description	jquizon@ihis.org	4/29/2025 13:52
	4/27/2025 08:59	Hidden description	tlguitard@ihis.org	4/27/2025 09:42
	4/27/2025 05:28	Hidden description	tlguitard@ihis.org	4/27/2025 09:42
	4/22/2025 18:44	Hidden description	kbaby@ihis.org	4/22/2025 21:20
Moyer, Colten (LPBEF134BB) BH & VH 221 - A				
	4/25/2025 20:58	Hidden description	tlguitard@ihis.org	4/26/2025 09:55
	4/23/2025 10:16	Hidden description	bmmaclean@ihis.org	4/23/2025 11:43
	4/20/2025 09:26	Hidden description	bmmaclean@ihis.org	4/23/2025 11:43

4) The report will display in a new browser tab. Close the browser tab when you are finished reviewing.

1) In the Reports menu, search for 'Behavior Report'.

Behavior Report
The Behavior Report is an advanced report that summarizes resident behavior trends. This report helps nursing and social services staff members identify changes in resident behaviors, understand patterns across shifts, and summarize information for MDS reporting.

2) Filter by Unit and run report

Date: 6/9/2025
Time: 11:17:40
User:
TEST_Resident_Care_Worker

(train) Training - Prince Edward Home
Behaviour Summary Report
Report for the Week Ending 6/9/2025

Unit: Blue Heron

Facility #: Eu Elit Corporat
Page #: 1

UNIT: Blue Heron

Shift	Frequent Crying	Repeats Verbalization	Repeats Movement	Yelling Screaming	Kicking Hitting	Pinching Scratching Spitting	Biting	Wandering	Abusive Language	Threatening Behaviour	Sexually Inappropriate	Resistant to Care
D	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
E	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
N	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
ALL	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

4) The report will display in a new browser tab. Close the browser tab when you are finished reviewing.

Facility Calendar

1) Select 'Calendar' from Clinical menu to view events happening in the building, with options to filter by day, week, or month

Resident Calendar

Home ▾ Admin ▾ **Clinical** ▾ Reports   1) Go to the resident's chart to see their individual calendar.

Salinas, Reese (OU6A15F525)

Status: Current Location: Red Oak Heights 319-A
Gender: Female DOB: 4/22/1973 Age: 51
Physician: GerriLynn Henderson

2) Click the calendar icon to see scheduled events and appointments for that Resident

Care Profile Edit ▾ Print ▾ ▣

Current Vitals

BP: 128/80 mmHg
4/4/2025 11:53

⚠ Temp:36 °C
4/4/2025 11:53

Resp:18 Breaths/min
4/4/2025 11:53

BS:

Allergies: sulfADIAZINE, Penicillins, Adhesive Tape
Code Status: (Advance Directives) Hidden Description

Dash **Profile** Census Med Diag Allergy Immun Orders Wts/Vitals RAI Assmnts Prog Note Care Plan Tasks Misc

☐ Show Cancelled Events

| Day | Week | Month | Agenda | New | | 6 Apr 2025 – 12 Apr 2025 | | ▦ | CSV | 📄 |

	Sun, April 6	Mon, April 7	Tue, April 8	Wed, April 9	Thu, April 10	Fri, April 11
01:00pm						
02:00pm						
03:00pm						
04:00pm						
05:00pm		05:10pm - 06:10pm Sun Tanning (ROH Outdoor Patio)	05:10pm - 06:10pm Sun Tanning (ROH Outdoor Patio)	05:10pm - 06:10pm Sun Tanning (ROH Outdoor Patio)	05:10pm - 06:10pm Sun Tanning (ROH Outdoor Patio)	05:10pm - 06:10pm Sun Tanning (ROH Outdoor Patio)
06:00pm						
07:00pm						

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Point of Care (POC) Module – selecting your assignment

Point of Care (POC) Module – the 'Shift Dashboard'

Lock screen

Use the door to logoff

Alerts to be aware of

Summary of all tasks

Tasks not completed from previous shift

New admissions, transfers, discharges

PointClickCare

| Home | POC Shift Dashboard | POC |

Shift: Even(15-23)
Assignment: All
Shift Start Date: Current Date
Position: Resident Care Worker

Change Password | Change Home | Edit Assignment | Change Date

Alerts Triggered in the last 24 hours: Sort By: Date | Name

Date	Name	Description
4/8/2025 09:00	Dean, Kiley	No BM documented for 2 days
4/8/2025 09:00	Dean, Kiley	No Voiding reported in last 24 hours
4/8/2025 08:39	Nguyen, Leia	No BM documented for 2 days
4/8/2025 08:34	Bender, Lily	Very high risk for violence.
4/8/2025 08:34	Copeland, Thomas	No Voiding reported in last 24 hours
4/8/2025 08:32	Ballard, Eleanor	No BM documented for 2 days
4/8/2025 08:32	Blake, Jillian	No BM documented for 2 days
4/8/2025 08:32	Escobar, Ethen	No Voiding reported in last 24 hours

Shift Summary   Task List | Kardex

# of Residents: **116**

# of Scheduled Tasks: **129**

| 1515 (1) | 1530 (3) | 1700 (116) | 1900 (3) | 2000 (1) | 2100 (4) |
| 2245 (1) |

# of Repeating Tasks: **768**

# of QShift Tasks: **1694**

# of Monthly Duration Tasks: **1**

Overdue Tasks from Previous Shift (Night(23-07))

Date	Name	Description
4/8/2025 00:00	Acosta, Caleb	Turn & Reposition
4/8/2025 00:00	Acosta, Caleb	Toileting Routine
4/8/2025 00:00	Andersen, Stanley	Turn & Reposition
4/8/2025 00:00	Andersen, Stanley	Toileting Routine
4/8/2025 02:00	Acosta, Caleb	Turn & Reposition
4/8/2025 02:00	Acosta, Caleb	Toileting Routine

ADTs in the last 72 hours

Date	Name	Action	Location
4/7/2025	Jones, Betty	Internal Transfer	Sunrise Place - 518 (A)
4/7/2025	Pan, Shelly	Actual Admit/ReAdmit Date	Sunrise Place - 522 (A)
4/7/2025	Newman, Sally	Actual Admit/ReAdmit Date	Sunrise Place - 521 (A)
4/7/2025	Jane, Melissa	Actual Admit/ReAdmit Date	Lupin Valley - 420

Point of Care (POC) Module – Home tab (red means information to view)

Clinical Communications relate to a particular resident
(all staff can view, so it should not include sensitive details)

Home Bulletin Board displays general information
(Do not post personal health information)

Software downtime, PCC updates appear here

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Point of Care (POC) Module – Resident Tasks (Cares)

Click on Resident tile that you would like to view

…document Point of Care tasks?

Click on Resident tile that you would like to view

Point of Care (POC) – Documenting by Resident

Within the Resident chart, select the task tile you would like to document. A pop-up screen will display the documentation required for that task.

Important: Ensure you adjust the 'Effective Date' to be as close to reflect when the task was completed.
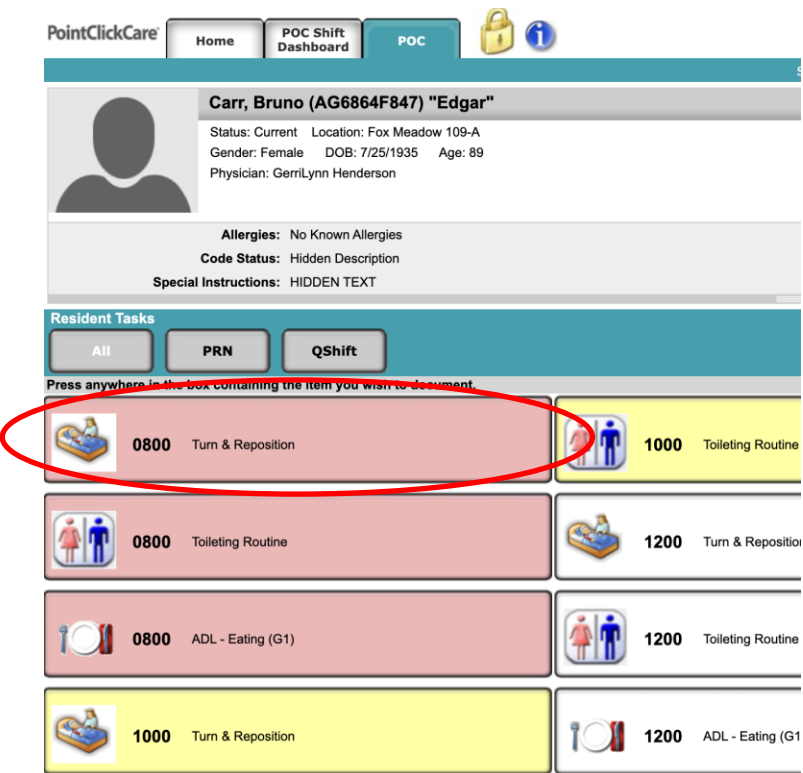
Point of Care (POC) – Documenting using Quick Entry

Quick Entry allows you to document multiples of the same type of task at once across all Residents in a Household.
For example, if you supported multiple residents with eating within a short period of time.

1) Click on 'Quick Entry' button.

4) Use fields on the right to document this task for each Resident.

2) Ensure you are documenting on the right shift.

3) Select which Resident you want to document. Blue indicates you are documenting on that Resident.

PointClickCare Home POC Shift Dashboard POC

Quick Entry: Adverse Behaviour

All Residents in your Assignment/Unit

PointClickCare Home POC Shift Dashboard POC   SmartZone with Back

Shift: 0700 - 1500 [Day(07-15)] Shift Start Date: Current Assignment: Fox Meadow Position: Resident Care Worker

Eating *0800 (12) 1200 (12) PRN (12)   Sort by: Name Location

* Carr, Bruno
Fox Meadow - 109 (A)

Ochoa, Paisley
Fox Meadow - 111 (A)

Coleman, Dante
Fox Meadow - 103 (A)

Pruitt, Janelle
Fox Meadow - 110 (A)

Cox, Lydia
Fox Meadow - 108 (A)

Vargas, Londyn
Fox Meadow - 112 (A)

Forbes, Izabelle
Fox Meadow - 102 (A)

Ward, Karsyn
Fox Meadow - 107 (A)

Garfield, Ronald
Fox Meadow - 104 (A)

Warren, Gina
Fox Meadow - 101 (A)

Mckenzie, Lena
Fox Meadow - 106 (A)

Young, Selah
Fox Meadow - 105 (A)

Carr, BrunoFox Meadow - 109 (A)

Resident Not Available Resident Refused Not Applicable

1. Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) (G1 1j)

Independent - no physical assistance	Independent - set up help only	Supervision, oversight, cueing
Limited assistance	Extensive assistance - weight bearing support by 1 staff	Maximal assistance - weightbearing support by 2+
Total dependence - full performance by others	Activity did not occur	Resident Not Available
Resident Refused	Not Applicable N/A	

Save & Next Save & Exit Save Cancel & Next View Details

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Viewing the Kardex in POC

1) Ensure you are in the POC tab

2) Click on a Resident chart

3) Select the 'Kardex' button to the right in the Resident chart

…document Treatments in the eMAR module?

Select eMAR from Clinical

Change the household and shift time.

Ensure you're on the correct administration tab

If a treatment is completed, click 'Y' and then 'Save'

Summary Tab:
View Order details
and instructions here.

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The heart symbol indicates that follow-up documentation is required for this treatment

➢ Upon completion of treatment, ensure administration details, supplementary documentation, and progress notes are completed as needed.

Cream to leg for dry skin

| Summary | Administration Details | Supplementary Documentation | Progress Notes | | Effective Date: 04/29/2025 | 18 ▾ : 37 ▾ |

Chart Code:

0 - Administered	8 - Nauseated/Vomiting
3 - Absent from home	9 - Other / See Nurse Notes
5 - Hold/See Nurse Notes	11 - Start IV/Feed
6 - Hospitalized	12 - Stop IV/Feed
7 - Sleeping	

Next Administration: 4/29/2025 12:00

Administration History

	Scheduled For	Effective Date	Code	Amount Administered	Administration By	Documented
PN	2100	4/10/2025 17:59	0		rmwagner@ihis.org	4/10/2025 18:00
	1700	4/10/2025 17:34	0		baolanipekun@ihis.org	4/10/2025 17:38
	1200	4/10/2025 13:06	3		pchambers@ihis.org	4/10/2025 13:06
PN	0900	4/10/2025 13:02	0		tjstride@ihis.org	4/10/2025 13:03
PN	1200	4/9/2025 09:11	6		jgillis@ihis.org	4/9/2025 09:12
	0900	4/9/2025 09:11	6		jgillis@ihis.org	4/9/2025 09:12

| Record | Record and Next | Close |

If treatment is not completed, provide the reason and include any necessary documents in the supplementary documentation and progress notes, if applicable.

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…start my shift as an LPN?

➢ Review Facility Communications
  • Review Home Bulletin Board and Clinical Communications tab and review messages added since your last shift.
➢ Resident Calendar
  • Review the Resident Event Listing in the Calendar. Filter for your household/neighbourhood to know who has reminders, appointments, or outings that day.
➢ Review Dashboard
  • Shift Report – View shift report from the Clinical Dashboard (filter for your neighbourhood). Coordinate with the team to ensure all items/tasks are assigned and there's a plan for the day.
  • **Alerts - Come back to these areas repeatedly throughout your shift.
  • Due and overdue assessments – This area will inform you about assessments that are in progress, scheduled within the next 2 weeks, or currently overdue. Pay special attention to any that are in progress or overdue and ensure these are completed.
  • POC Assignment Status & Med Passes in Last 24 Hours – As team leads, monitor this area to ensure tasks and treatments are being completed and documented in a timely manner.
➢ Go to eMAR for treatments and lab draws – Review the treatment and lab tabs to identify any scheduled items
➢ Go to POC – Review tasks that are scheduled and get an outline of what the shift will look like.
➢ Book Resident Appointments in the calendar as needed
➢ Task Customization – This is where the residents' daily routines are structured. Add tasks, specify to the resident's likes/needs, and add a Task Schedule. This allows the task to show in POC for RCWs to action at the time it's due.
➢ End of Shift – Review Dashboard to ensure all tasks, treatments, and assessments have been completed. Follow up with staff regarding any outstanding alerts or other items.

Facility Communications

When logging into PCC, you will arrive on Home page where you can access all communication areas:
- Clinical Communications – use the hyperlink to take you to the Clinical Communications area of PCC. Shift reports can be accessed here (see next slide).
- Home Bulletin Board
- PointClickCare Announcements

Review each of these areas when logging into PCC.

Clinical Communications Board

Resident-specific information can be shared in this space.

➤ Important: These communication boards are to be used for communicating information only.

➤ Should NOT be used for making requests. Those should be passed on verbally and/or using alerts.

Access Shift & Summary Reports for the whole home

Resident Events

Clinical ▾ Reports

People
Residents

Actions
Quick ADT
New Resident
New Staff
New Medical Professional
Manage Users

Care Management
Dashboard
Calendar
Hospital Tracking
RAI
Communications
Orders
Lab/Rx Results
Risk Management
Weights and Vitals
UDA
Clinical Chart Dashboard

To access the Calendar, hover over Clinical to access the drop-down menu.

Calendar
Calendar **Resident Event Listing**
➕ Display Filters

Select 'Resident Event Listing'.

Day Week Month

20 Apr 2025 – 26 Apr 2025
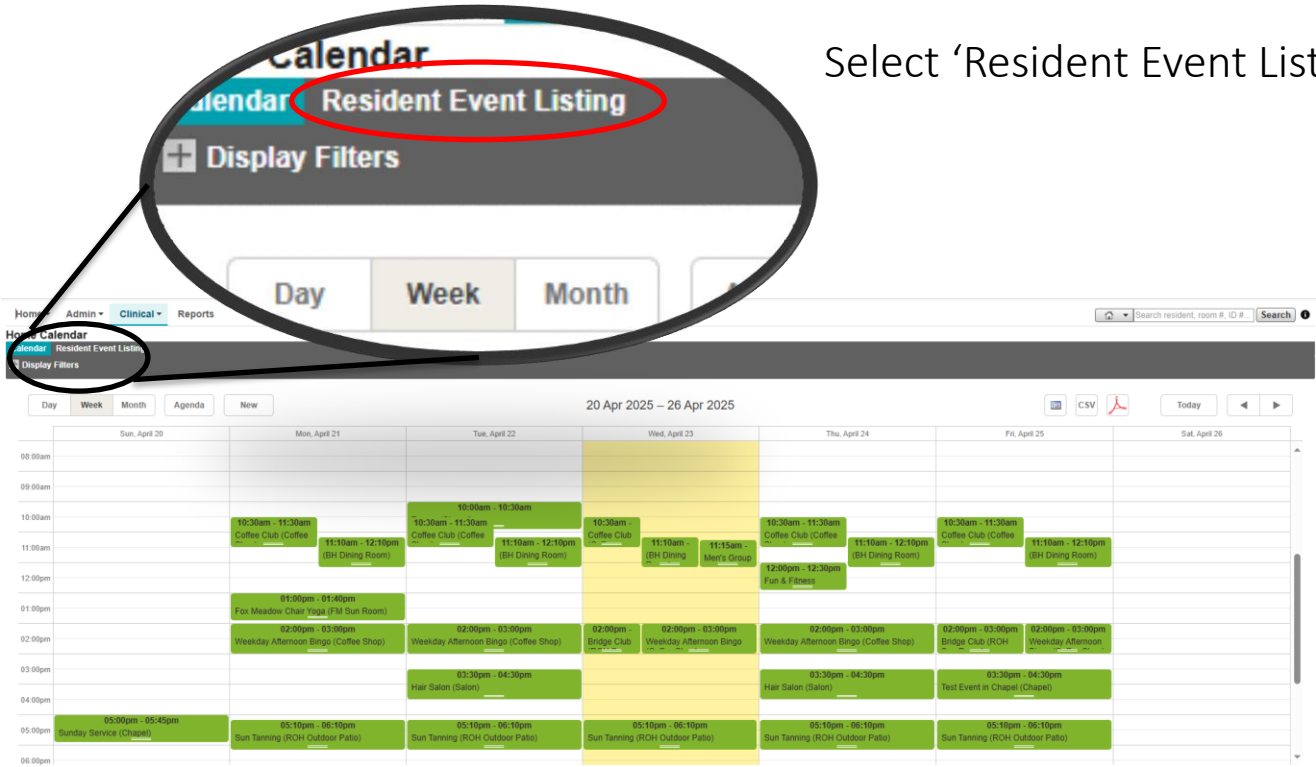
'Resident Event Listing' will allow you to easily filter and sort different event types, dates ranges, and by resident or unit.

Home Calendar

Calendar | **Resident Event Listing**

Display Filters | Export to CSV

Event Types: Choose an option...

Responsible: Choose an option...

Event Date Range: 04/23/2025 to 04/23/2025

Personnel:

Resident:

Unit: All | Floor: All

Show Cancelled Events: ☐

Search | Reset

Home Calendar

Calendar | **Resident Event Listing**

Display Filters

Event Types: Care Plan Meeting ✕ | Reminder ✕ | Resident Appointment ✕

Event Date Range: 05/01/2025 to 05/31/2025

Resident:

Unit: Blue Heron | Floor: All

Show Cancelled Events: ☐

This search is looking for residents on Blue Heron who have a care plan meeting, reminders, or appointments in May 2025.

Reviewing Key Areas of the Clinical Dashboard

- Shift Report
- Due and overdue assessments
- POC Assignment Status
- Med Passes in Last 24 Hours

Shift Report

To run a shift report narrowed down to one household or neighbourhood,
Select your desired area in the drop-down filters 'Unit' or 'Floor'.
Click 'Reports' and select your shift report.

View Clinical Alerts in your Clinical Dashboard

Select 'view' to review the alert details, if any. Assess the resident and/or determine necessary actions to address the alert.

Following your assessment, document your actions.
- Your documentation will vary based on the actions you were required to take. Regardless of the action(s), you will always add a progress note (pn) to address the issue or concern and your follow up actions.

❖ Remember to clear the alert when complete.
   Select the check box and click 'Clear Alerts'.

Due and Overdue Assessments

There are two ways to view: 1. Through the UDA Portal OR 2. Daily Summary on the Clinical Dashboard

1. UDA Portal - under Care Management, select 'UDA'.

You will automatically be shown 'Scheduled' UDAs.
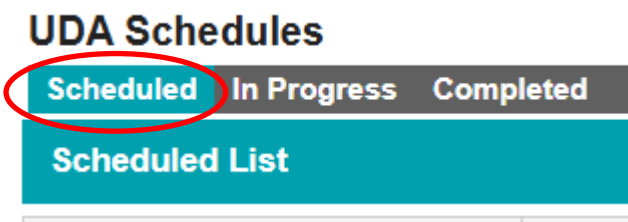
Click 'Due Date' to reorganize the UDA list by due date. This will show all those overdue at the top of the page and allow you to prioritize and delegate as needed.

2. Clinical Dashboard: Daily Summary

Use dashboard filters to show only assessments that are due or overdue on your household.

POC Assignment Status

Monitor this area to ensure tasks are done and documented on time. Follow up with staff, as necessary.

You can narrow your assignment to a single household

RCWs are primarily responsible for documenting in POC, however, LPNs will document in POC when they supervise a household overnight.

Monitoring eMAR Assignments

Status provides a visual to indicate if there are treatments due or overdue.

eMAR assignments can be viewed here and are broken down by:

eMAR tab   Shift   Household filter

Med Passes in the Last 24 hours for assignment:	All ⌄			
Record	**Shift**	**Assignment (Group)**	**Status**	**Tasks**
LPN	Even(15-23) (Tue)	Blue Heron (EMAR)	●	(0 of 1)
LAB	Even(15-23) (Tue)	Blue Heron (EMAR)	○	(0 of 0)
RN	Even(15-23) (Tue)	Blue Heron (EMAR)	○	(0 of 0)
RCW	Even(15-23) (Tue)	Blue Heron (EMAR)	●	(4 of 9)
LPN	Night(23-07) (Tue)	Blue Heron (EMAR)	○	(0 of 0)
RN	Night(23-07) (Tue)	Blue Heron (EMAR)	○	(0 of 0)

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10] [11] [12] [13] [14] [15] [16] [17] [18] [19] [20] [Next]

Tasks tells you how many treatments have been done out of the total treatments that are due on that shift.

Use these hyperlinks to drill down and see which resident(s) have treatments due.

Select the plus sign next to the
resident name to display
all treatments that are due.

Navigate to the eMAR to view the
order and administer at the time due.

Due and Overdue Assessments

Clinical Dashboard: Daily Summary

Daily Summary	
Assessments In Progress	4
Due for Reassessment in the next 14 Days	69
Assessments Past Due *(includes in progress assessments)*	21
Care Plan Reviews Overdue/Due for Active Residents	0

➢ Use dashboard filters to show only assessments that are due or overdue on your household.

➢ Once determined, follow up with the household teams to ensure the assessments are getting completed.

POC Dashboard Navigation - Home

View the same communications that are available in the Home tab of PointClickCare.

Exit

Home: TRAINING - Prince Edward Home

Welcome: Jennifer Pitre. Today is April 28, 2025 11:01:00

PointClickCare   Home   POC Shift Dashboard   POC

Change Password   Change Home

Home Bulletin Board

Date Posted	Message
3/18/2025 12:55	You can only access the SmartZone training courses via the LIVE environment.
3/18/2025 08:47	Welcome to the TRAINING environment. Please DO NOT put real resident information here. This space is for learning/testing using **FAKE residents only**. Thank you!

Communications

Date Posted	Message
3/28/2025 08:49	Garfield, Ronald (PEH0116) - Appointment at QEH for TURP on April 4 10am
3/18/2025 09:18	Skinner, Ayla (NV31CD607C) - 'Ayla Skinner' - to see a complete care plan example.

PointClickCare Version 4.4.41.2 www60-pcc-web-reporting-75b98f74-mbj7z   Copyright 2000-2025 PointClickCare Technologies Inc. All rights reserved.

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POC Dashboard Navigation – POC Shift Dashboard

Confirm that you're on the correct assignment

To change your assignment, select 'Edit Assignment'

Home: TRAINING - Prince Edward Home

Welcome: Jennifer Pitre.   **Today is April 28, 2025**   **10:55:06**

PointClickCare | Home | POC Shift Dashboard | POC |

Shift: Day(07-15)
Assignment: Blue Heron

Shift Start Date: Current Date
Position: Resident Care Worker

| Change Password | Change Home | Edit Assignment | Change Date |

Alerts Triggered in the last 24 hours: Sort By: | Date | Name |

Shift Summary | Task List | Kardex |

Date	Name	Description
No alerts found		

# of Residents: **12**

# of Scheduled Tasks: **24**
    0800 (12) 1200 (12)

# of Repeating Tasks: **112**

# of QShift Tasks: **169**

# of Monthly Duration Tasks: **0**

Refer here for a quick look at the number of tasks due at specific times of day.

Select the 'Task List' for a chronological list of tasks that will become due throughout your shift.

Overdue Tasks from Previous Shift (Night(23-07))

ADTs in the last 72 hours

Date	Name	Description
4/27/2025 23:30	Bender, Lily	MONITOR - Restraints (pen release)
4/28/2025 00:00	Bender, Lily	Turn & Reposition
4/28/2025 00:00	Bender, Lily	Toileting Routine
4/28/2025 00:00	Bender, Lily	Custom Task # 2
4/28/2025 00:00	Cherry, Bert	Turn & Reposition
4/28/2025 00:00	Cherry, Bert	Toileting Routine
4/28/2025 00:30	Bender, Lily	MONITOR - Restraints (pen release)
4/28/2025 01:30	Bender, Lily	MONITOR - Restraints (pen release)
4/28/2025 02:00	Bender, Lily	Turn & Reposition
4/28/2025 02:00	Bender, Lily	Toileting Routine

Date	Name	Action	Location
No ADTs found			

Overdue tasks from the previous shift that will require action during your shift.

200

Welcome: Jennifer Pitre. Today is April 28, 2025 11:21:18

Change Password | Change Home | Edit Assignment

Task List

Shift/Assignment Selection

Current Shift / Assignment Selection

Shift: 0700 - 1500 [Day(07-15)]

My Position: Resident Care Worker

Assignment: ● Blue Heron

Unit: ○ All

Show Tasks for: Resident Care Worker

OK | Cancel

0700 - 1500 [Day(07-15)]

0700 - 1500 [Day(07-15)]
1500 - 2300 [Even(15-23)]
2300 - 0700 [Night(23-07)]

Select your desired shift.

Select your desired household

…review and action Alerts?

A red dot will appear beside the Bell icon when a new Alert is triggered

Filter >>

Filter to view the alerts on your household (unit) or neighbourhood (floor).

Alerts are generated by POC staff (manually) or triggered automatically by POC documentation (e.g., no bath in 7 days, no voiding in 24hrs, ate 25% or less, low oxygen level).

Alerts will only appear in the Bell Alert section for 7 days. They can be actioned directly from this area of the chart by Nursing staff.

Select from suggestions

After assessing the resident, use the appropriate action buttons to document your findings and follow up.

202

…document Treatments in the eMAR module?

PointClickCare

Welcome: Jennifer Pitre.   Today is April 25, 2025 14:48:32

| Portal | LPN | LAB | RCW | RN |

Shift: 4/26/2025, 0700 - 1500 [Day(07-15)]
Assignment: Lady Slipper

(train) Training - Prince Edward Home

Filter By: | Overdue (0) | Now (0) | Shift (2) | PRN (0) | Reminders (0) | Advanced |

Sort By: | Name | Location |

Acosta, Caleb (GE8DDE11BE)
Lady Slipper Path 403 - A

Bennett, Carlo (QNA92AFEDE)
Lady Slipper Path 408 - A

PointClickCare

| Portal | TAR | LAB | RCW | RN |

TRAINING - Prince Edward Home

Acosta, Caleb (GE8DDE11BE)

Status: Current   Location: Lady Slipper Path 403-A

Gender: Male   DOB: 9/14/1973   Age: 51

Physician: GerriLynn Henderson

Allergies: Morphine, Penicillin

Code Status: Goals of Care C - Care and Interventions focused on comfort, excluding Resuscitation. , Hidden Description

Special Instructions: ** MED RISK FOR VIOLENCE ** ** DROPLET/CONTACT PRECAUTIONS **

Filter By: | Overdue (0) | Now (0) | Shift (1) | PRN (0) | Reminders (0) | Advanced (0) |

0900   **Nephrostomy catheter change**
one time a day every Sat Product used ... | Y | N |

If you want to look at a date in the future, you may do that here.

If treatment is completed, click 'Yes' and save.
If not completed, click 'No,' enter details, and add progress notes as needed.

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Summary Tab:
View Order details and instructions here.

Hidden Description

| Summary | Administration Details | Progress Notes |

Effective Date: 04/30/2025 15 : 35

Order Date: 04/11/2025
Ordered By: Henderson,GerriLynn
Contact #: N/A
Directions: one time a day
Administrative Notes:
Order Status: Active

Administrative Orders

Date	Type	Ordered By	Notes
		No Administrative information to display	

Supply

Last Re/Order Date	Date Dispensed	Date Received	Status	Supply Medication/Directions	RX #	Source
			No Supply information to display.			

Record   Close

Administration Details Tab:
Indicate whether the treatment was administered or, if not, the most applicable reason to indicate the treatment was not done.

You can also view the administration history.

Depending on the selection you choose, you may be asked if you'd like to set up a reminder to go back to the resident and offer again.

You can send your progress note to the shift report.

Hidden Description

| Summary | Administration Details | Progress Notes |

Effective Date: 04/30/2025 15 : 35

Show on Shift Report: ☑ Show on 24H Report: ☑ Show on MD/Nursing Communications Report: ☐

Progress Note Text: Characters remaining: 1463

Hidden Description
one time a day

Progress Notes Tab:
This allows you to add additional details to an administration progress note.

When all details for the administration are entered, select record.

Record Close

0900 **Nephrostomy catheter change**
one time a day every Sat Product used ...

Y   N

3   N

Y   N

00 - 1500 [Day(07-15)]
signment: Lady Slipper

1 of 2   Prev   Next

Current Vitals

| BP: 124/64 mmHg 4/4/2025 06:11 | ⚠ Temp:36.2 °C 4/4/2025 06:11 | Pulse:66 bpm 4/4/2025 06:11 | ⚠ Weight:55 Kg 4/12/2025 16:04 |
| Resp:18 Breaths/min 4/4/2025 06:11 | BS:11.2 mmol/L 4/4/2025 06:11 | O2:98 % 4/4/2025 06:11 | Pain:4 4/21/2025 11:29 |

Medication Display: 4   6   8   10

0 Pending
to confirm or review

Other
Actions ▼

Save

One the right side of the screen, select 'Save' to sign for the treatments.

…start my shift as an RN?

Facility Communication & Resident Events

- Home Bulletin Board & Clinical Communications -review messages added since your last shift.
- Access shift report for the entire home in this area. To filter for a specific household or neighborhood, go to the Clinical Dashboard.
- Resident Event Listings in the Calendar. Filter for your household / neighborhood to see who has reminders, appointments, or outings that day.

Clinical Dashboard & eMAR

- View shift report here if you'd like to filter by household / neighborhood.
- Alerts - Come back to this area repeatedly throughout your shift. Ensure there's verbal communication among the household team to ensure items are getting addressed.
- Due and overdue assessments – Monitor this area to ensure assessments are being completed in a timely manner. Follow up with household staff when necessary.
- Treatments – Reassessment & Admin

Care Plans

- Annual Care Plan Reviews
- Incomplete Care Plans
- Care Plan Review Requests

Facility Communications

When logging into PCC, you will arrive on Home page where you can access all communication areas:

- Clinical Communications – use the hyperlink to take you to the Clinical Communications area of PCC.
  - ➢ Shift reports can be accessed here – see next slide.
- Home Bulletin Board
- PointClickCare Announcements

Review each of these areas when logging into PCC.

Clinical Communications Board

Resident-specific information can be shared in this space.

Communications

Messages New

	Date Posted	Created By	Position	Message	Resident	Don't Display After	Revised By	Revised Date
edit del	3/28/2025 08:49	Florante (Jay) Arellano	Registered Nurse	Appointment at QEH for TURP on April 4 10am	Garfield, Ronald (PEH0116)	4/28/2025	fjarellano@ihis.org	3/28/2025 08:49
edit del	3/18/2025 09:18	Jennifer Jelley		'Ayla Skinner' - to see a complete care plan example.	Skinner, Ayla (NV31CD607C)	5/30/2025	jjelley@ihis.org	3/18/2025 09:18

☐ Show expired

Shift Reports
Quick Links
Most Recently Completed Shifts:
- Day(07-15) (0700 to 1500)
- Even(15-23) (1500 to 2300)
- Night(23-07) (2300 to 0700) *
- Current Shift

Summary Reports
Quick Links
Most Recently Completed:
- 24 Hour Report
- 72 Hour Report

Access Shift & Summary Reports for the whole home

Important: These communication boards are to be used for communicating information only.

Should NOT be used for making requests. Those should be passed on verbally and/or using alerts.

Resident Events

To access the Calendar, hover over Clinical to access the drop-down menu.

Select 'Resident Event Listing'.

'Resident Event Listing' will allow you to filter and sort different event types, dates ranges, and by resident or unit.

Home Calendar

Calendar | Resident Event Listing

Display Filters | Export to CSV

Event Types: Choose an option...

Event Date Range: 04/23/2025 to 04/23/2025

Resident:

Unit: All Floor: All

Show Cancelled Events: ☐

Search | Reset

Responsible: Choose an option...

Personnel:

Home Calendar

Calendar | Resident Event Listing

Display Filters

Event Types: Care Plan Meeting ✕ Reminder ✕ Resident Appointment ✕

Event Date Range: 05/01/2025 to 05/31/2025

Resident:

Unit: Blue Heron Floor: All

Show Cancelled Events: ☐

This search is looking for residents on Blue Heron who have a care plan meeting, reminders, or appointments in May 2025.

…monitor the Clinical Dashboard?

Edit the layout of your dashboard

To edit - click/unclick from the list of options on the left-hand side or drag and drop the boxes on the right-hand side.

Your dashboard items can be rearranged.
Priority areas should be near the top.

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Reviewing Key Areas of the Clinical Dashboard

- Shift Report
- Due and overdue assessments
- Treatment Orders requiring reassessment
- Care Plan Reviews

Shift Report

Like the Clinical Communications Board, you can access shift reports here. The benefit to accessing report from here is that you can filter to a specific household or neighbourhood ('Unit' or 'Floor').
Once your area is selected, click 'Reports' and choose your desired shift report.
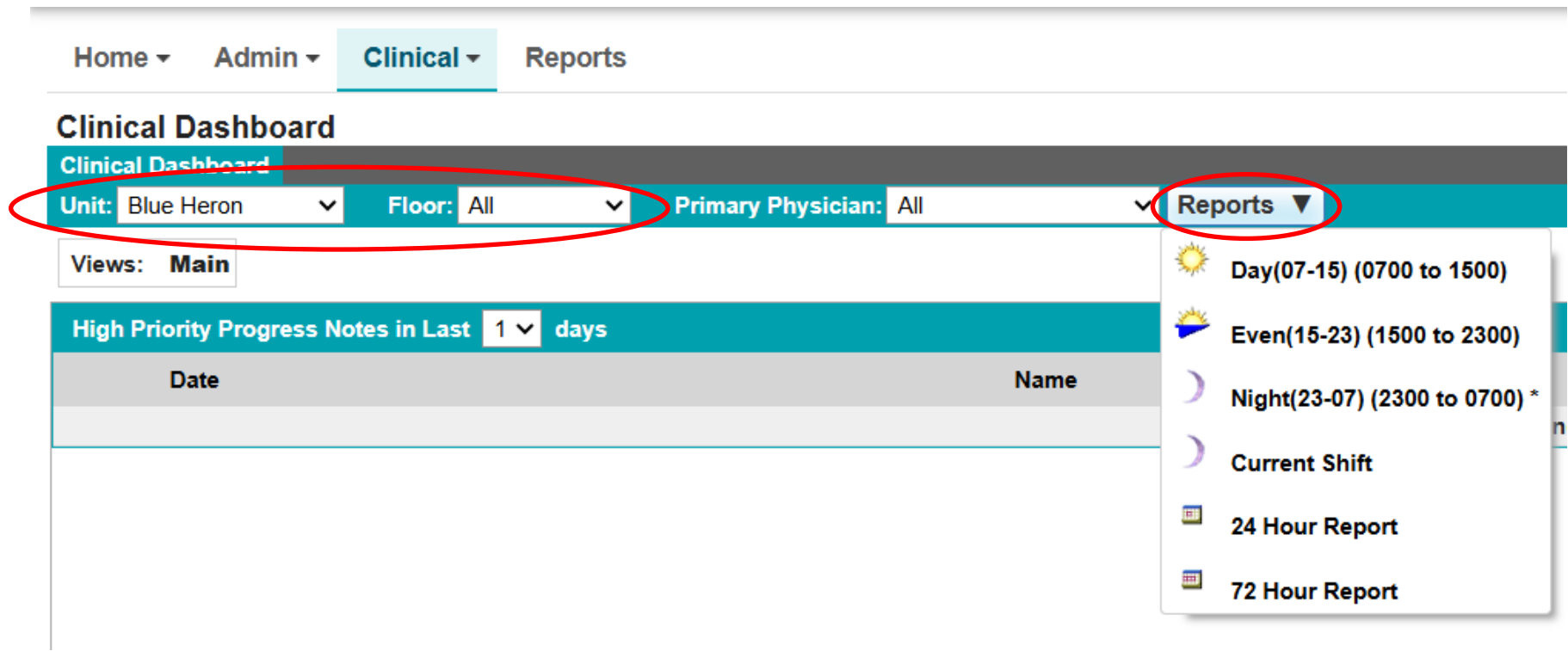
Alerts

Review clinical alerts frequently throughout your shift. To view these, select this 🔔 icon.

Filter to view the alerts on your household (unit) or neighbourhood (floor).

After assessing the resident, use the appropriate action buttons to document your findings and follow up.

View Clinical Alerts in your Clinical Dashboard

Select 'view' to review the alert details, if any. Assess the resident and/or determine necessary actions to address the alert.

Following your assessment, document your actions.

Your documentation will vary based on the actions you were required to take. Regardless of the action(s), you will always add a progress note (pn) to the chart to address the issue or concern and your follow up actions.

Remember to clear the alert when finished.
➤ Select the check box and click 'Clear Alerts' once complete.

Due and Overdue Assessments

Clinical Dashboard: Daily Summary

➢ Use dashboard filters to show only assessments that are due or overdue on your household.

➢ Follow up with the household teams to ensure the assessments are completed.

Treatment Orders Requiring Re-Assessment

Any treatment that has run its course and is selected for reassessment when ordered, will appear in this area of the Clinical Dashboard.

Name	Alert	Order	Order Status	Date
	⚠	Hydrocortisone Nystatin 50/50 cream.	Completed	4/16/2025
	⚠	Hydrocortisone 0.5% cream	Completed	4/16/2025
	⚠	Hydrocortisone/clotrimazole 50/50 topical ointment	Completed	4/16/2025

1. Select ⚠ to open and view the medication and directions.
2. Assess the resident. Use your clinical judgement to determine if the NP needs to be contacted for a new order.

Following your review of the order and assessment of the area:
1. Clear the alert on the Clinical Dashboard.
2. Document your assessment in a progress note.
3. Transcribe the new order, if applicable.

Alert Effective Date: 4/16/2025 23:59
Alert Description: One or more schedules for the following order are expected to complete today and reassessment is required:
Hydrocortisone Nystatin 50/50 cream.
two times a day until 04/16/2025 23:59 apply to perineal area
Medication: Hydrocortisone Nystatin 50/50 cream.
Directions: two times a day until 04/16/2025 23:59 apply to perineal area

Close Clear View

220

Care Plan Reviews

Annual Reviews – Refer to slides ==78-90== for instructions on managing these.

Incomplete

High-Priority Progress Notes – Care Plan Review Request

Incomplete Care Plans

Incomplete Care Plans	
Name	Next Review Date
Acosta, Caleb (GE8DDE11BE)	1/30/2026
Avelino, Pau (PEH0166)	4/1/2026
Baldwin, Colleen (PEH0175)	4/7/2026
Bean, Stanley (BO4476C351)	1/17/2026
Blow, Joe (PEH0119)	4/2/2026
Blue, Sky (PEH0168)	4/2/2026
Boyer, Aliya (TN4DA1FC77)	2/11/2026
Doo, Scooby (PEH0120)	4/2/2026
Forbes, Izabelle (CKD1701219)	3/25/2026
Fowler, Carmen (FKD63755DA)	1/30/2026
Jackson, Micheal (PEH0153)	3/26/2026
Lawson, Krystal (CB3DFA612E)	12/16/2025

- When a care plan is marked incomplete, it's either missing a goal, intervention, or customization.
  - ➢ Put on your detective hat!

- Select the resident's name – you'll be taken directly to the care plan tab where you can look for missing information.

High Priority Progress Notes - Care Plan Review Requests

Select 'view' to open the progress note and review the request.

Proceed to the resident's chart to review any necessary information about the resident's care or status. Speak with the staff involved in care.

Update the care plan accordingly.

Part of your review will be of the progress notes to ensure the request was not already completed (if not passed on in report).

If not yet reviewed, there won't be record of it in the progress tab....you can proceed with your update.

		Effective Date	Type	Note	Care Plan Item or Task	Dept.	Shift Report	24 Hour Report
view	print	4/24/2025 17:59	Care Plan Review Request	Care plan items related to physiotherapy. Please s...			Y	Y

Progress Notes New View All ☑ **Display eMAR Progress Notes**

If it has been reviewed, the entries will look something like this:

Progress Notes New View All ☑ **Display eMAR Progress Notes**

		Effective Date	Type	Note	Care Plan Item or Task	Dept.	Shift Report	24 Hour Report
view	print	4/24/2025 18:21	Nursing Progress Note	Care Plan reviewed as requested. [linked]			Y	Y
view	print	4/24/2025 17:59	Care Plan Review Request	Care plan items related to physiotherapy. Please s...			Y	Y

This progress note indicates that the care plan has been updated. This is shown by the [linked] icon next to the Nursing Progress Note, which is linked to the Care Plan Review Request that was sent earlier in the day.

After you've updated the care plan, return to the High Priority Progress Note in the Clinical Dashboard and select 'view'.

Select 'Follow Up' on the next screen.

225

…monitor the Clinical Communications Board?

After selecting your shift, you can view the communication report for that shift or choose to view a 24-hour or 72-hour report.

To create a new communication:
- click 'New'
- search by resident name using the magnifying glass icon
- select the display end date
- enter the message
- press 'Save'

…document RN Treatment administrations in the eMAR module?

Shift Summary – items overdue or undocumented follow ups for PRNs appear here for quick view and follow up.

Home Summary :
- PRNs not used for 30 days or more
- Discharged residents with active orders
- Orders in the queue

Choose the appropriate administration selection – Y / N
For more than one treatment, select the Y / N for each treatment.

One the right side of the screen, select 'Save' to sign for the treatments.

Monitoring eMAR Assignments

Status provides a visual to indicate if there are treatments due or overdue.

eMAR assignments can be viewed here and are broken down by:

eMAR tab   Shift   Household

Med Passes in the Last 24 hours for assignment:	All		
Record	**Shift**	**Assignment (Group)**	**Status**	**Tasks**
LPN	Even(15-23) (Tue)	Blue Heron (EMAR)	●	(0 of 1)
LAB	Even(15-23) (Tue)	Blue Heron (EMAR)	○	(0 of 0)
RN	Even(15-23) (Tue)	Blue Heron (EMAR)	○	(0 of 0)
RCW	Even(15-23) (Tue)	Blue Heron (EMAR)	●	(4 of 9)
LPN	Night(23-07) (Tue)	Blue Heron (EMAR)	○	(0 of 0)
RN	Night(23-07) (Tue)	Blue Heron (EMAR)	○	(0 of 0)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Next

Tasks tells you how many treatments have been done out of the total treatments that are due on that shift.

Use these hyperlinks to drill down and see which resident(s) have treatments due.

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eMAR Orders

Adding an order to a treatment record (LPN/RCW/RN)

…add a facility event?

Care Management

Dashboard

Calendar

Select 'Calendar'

Home Calendar

Calendar   Resident Event Listing

Display Filters

Day   Week   Month   Agenda   New

Select 'New'

Description (max. 200):

Insert a brief description

Max # of Resident(s):

Residents: 0 Resident(s) selected

Indicate max number allowed (if applicable) or invite select residents

Event Type: Choose an option...

Location: Choose an option...

Resources(s): Choose an option...

Choose an event type and location from the list

Responsible for Event: Choose an option...

Other Personnel:

Notes:

Repeat event   Enable

Select 'Enable' if the event repeats daily/weekly/monthly, etc.

Time period   10:40am 9 April 2025 – 11:40am 9 April 2025

Indicate when it is planned (time and day)

Save   Close

Cancel Event

Please document the reason if cancelled

233

…record Resident attendance at a facility event?

- From the event in the calendar select the Tick mark at the bottom and a new pop up will appear.
- Mark the residents who attended and add it to the progress note if needed.

…complete Rehab Assistant Assignment?

Daily workflows for Rehab Assistants
1. Review facility and resident calendars of the household you're responsible for. This will help you identify any scheduling conflicts that might occur as you deliver care throughout the day.
2. Receive new referrals.
3. Carry out programming for scheduled residents and document accordingly.

1.
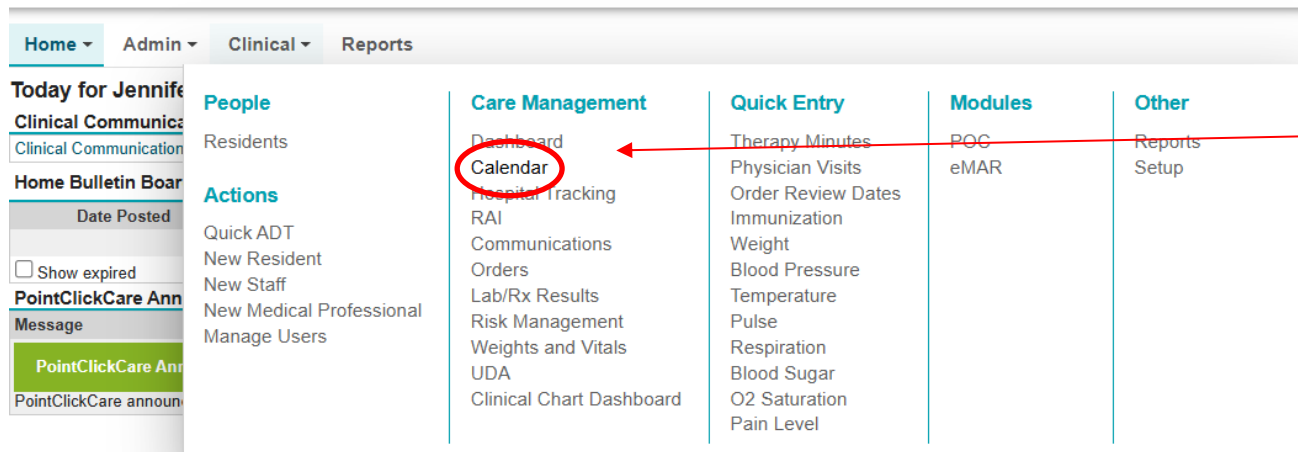
This will take you directly to the facility calendar where you can determine if there are activities happening in the home that might cause scheduling conflicts for you.

There are multiple ways you can review the individual resident calendars:

1) Go directly to each resident's chart and select the calendar in the header.

Campbell, Bennett (ZLD011458F) "Lyla"
Status: Current   Location: Blue Jay Way 308-A
Gender: Male   DOB: 1/6/1964   Age: 61
Physician: GerriLynn Henderson

| Care Profile | Edit | ▼ | Print | ▼ | Provincial Import | 🖥 |

Allergies: Penicillin
Code Status: (Advance Directives) Hidden Description
Special Instructions: HIDDEN TEXT

2) Go to the home calendar, select 'Display Filters'. This will open a window that will allow you to search for a resident's calendar. This will open the facility calendar and the resident's calendar in a side-by-side view.

Home Calendar
Calendar   Resident Event Listing
➕ Display Filters

| Day | Week | Month | Agenda | New |

Home Calendar
Calendar   Resident Event Listing
➖ Display Filters

Event Types: Choose an option...   Responsible: Choose an option... ▼

Locations: Choose an option... ▼   Personnel:

Show Cancelled Events: ☐   Resident: cal

Search Reset

Strong, Callum - PN5D2F5427
Summers, Callum - SPE0286316

In this view, the facility calendar is on the left and the resident calendar on the right. This shows that the resident has been invited to coffee club each morning, as well as Bingo on Tuesday afternoon. You will want to avoid these times for this resident when planning your day.

Home Calendar

Calendar | Resident Event Listing

Display Filters

Event Types: Choose an option...

Locations: Choose an option...

Show Cancelled Events: ☐

Responsible: Choose an option...

Personnel:

Resident: Strong, Callum

Home

Resident

Search | Reset

Day | Week | Month | Agenda | New

1 Jun 2025 – 7 Jun 2025 | Today | ◄ | ►

	Sun, June 1	Mon, June 2	Tue, June 3	Wed, June 4	Thu, June 5	Fri, June 6	Sat, June 7
08:00am							
09:00am	09:30am - Women's group (Chapel)				09:30am Women's group		
10:00am	10:30am - Coffee Club (Coffee Shop)	10:30am - Coffee Club (Coffee Shop)	10:00am - 10:30am - Coffee Club (Coffee Shop)	10:00am Rosary	10:00am - 10:30am - Coffee Club (Coffee Shop)	10:00am - 10:30am - Coffee Club (Coffee Shop)	10:00am - 10:30am - Coffee Club (Coffee Shop)
11:00am				10:30am Coffee Club			
12:00pm							
01:00pm		01:30pm - Bingo (Coffee Shop)					
02:00pm					02:00pm - Church (Chapel)		
03:00pm		03:00pm - Seated Yoga		03:00pm - Seated Yoga			
04:00pm							
05:00pm					05:30pm - Pub Night (Coffee Shop)		
06:00pm							

	Sun, June 1	Mon, June 2	Tue, June 3	Wed, June 4	Thu, June 5	Fri, June 6	Sat, June 7
08:00 AM							
09:00 AM							
10:00 AM	10:30 AM - 11:30 Coffee Club	10:30 AM - 11:30 Coffee Club	10:00 AM - 10:30 10:30 AM - 11:30 Coffee Club	10:30 AM - 11:30 Coffee Club	10:00 AM - 10:30 10:30 AM - 11:30 Coffee Club	10:30 AM - 11:30 Coffee Club	10:00 AM - 10:30 10:30 AM - 11:30 Coffee Club
11:00 AM							
12:00 PM							
01:00 PM			01:30 PM - 03:00 Bingo				
02:00 PM							
03:00 PM							
04:00 PM							
05:00 PM							
06:00 PM							

2. Receive new referrals.

In the Clinical Tab, under Care Management, select UDA. This is where all assessments, (scheduled, in progress, and complete) can be viewed for the entire home.

Make sure 'In Progress' is selected.

Filter by the Assessment Type(s) you are interested in.

UDA List

Scheduled   In Progress   Completed

In Progress List	Batch Update ▼									
		⇕ **Name**	⇕ **Status**	⇕ **Created Date**	⇕ **Unit**	⇕ **Floor**	⇕ **Assessment Type**	⇕ **Assessment Status**	⇕ **Score**	**Category**	⇕ **Created By**	⇕ **Revised By**
		Search	Set Filter ▼	Edit	Set Filter ▼	Set Filter ▼	2 Selected ▼	Search	Searc	Search	Search	Search
☐	edit del print close copy	Mooney, Angel (IM16E9FB6A)	Current	05/11/2025	Red Oak Heights	BJW & ROH					sjholt@ihis.org	sjholt@ihis.org
☐	edit del print close copy	Pham, Beau (RZ761645AD)	Current	05/10/2025	Fox Meadow	LHC & FM					rlake@ihis.org	rlake@ihis.org
☐	edit del print close copy	Montes, Siena (RMF6DD3FBA)	Current	05/09/2025	Fox Meadow	LHC & FM					rlake@ihis.org	rlake@ihis.org
☐	edit del print close copy	Grant, Jayce (UV15DC08BF)	Current	05/09/2025	Fox Meadow	LHC & FM					rlake@ihis.org	djhornby@ihis.org
☐	edit del print close copy	Torres, King (RG11EB6202)	Current	05/07/2025	Red Rock Inn	RRI & SRP					lisaking@ihis.org	lisaking@ihis.org
☐	edit del print close copy	Mooney, Conner (DL3C9D255A)	Current	05/04/2025	Blue Heron	BH & VH					hadeveaurogers@ihis.org	djhornby@ihis.org
☐	edit del print close copy	Pollard, Sara (VO07AF4F47)	Current	05/04/2025	Red Rock Inn	RRI & SRP					wlholland@ihis.org	djhornby@ihis.org
☐	edit del print close copy	Pollard, Terry (NY382D7BE5)	Current	05/02/2025	Sunrise Place	RRI & SRP					wlholland@ihis.org	djhornby@ihis.org
☐	edit del print close copy	Scott, Alanna (SE0B65442E)	Current	04/30/2025	Red Oak Heights	BJW & ROH					sjholt@ihis.org	djhornby@ihis.org
☐	edit del print close copy	Montes, Siena (RMF6DD3FBA)	Current	04/27/2025	Fox Meadow	LHC & FM					eeclow@ihis.org	djhornby@ihis.org
☐	edit del print close copy	Fisher, Angel (MW7752ECA5)	Current	04/22/2025	Red Oak Heights	BJW & ROH					ebclark@ihis.org	djhornby@ihis.org

Dropdown overlay:

Search

Select: All None

- ☐ *Modified Ashworth Scale
- ☐ *Multidisciplinary Care Conference (Retired)
- ☐ *Multidisciplinary Care Plan Review - V 1 (Retired)
- ☐ *Multidisciplinary Care Plan Review - V 2
- ☐ *NEUROLOGICAL CHECK LIST (Single Section)
- ☐ *Nutritional Risk Assessment
- ☐ *OT Assessment
- ☑ *OT Referral Form
- ☐ *PAIN TOOL
- ☐ *PAINAD (PAIN ASSESSMENT IN ADVANCED DEMENTIA)
- ☐ *Post-Fall Huddle
- ☐ *Post-Mortem Care
- ☐ *Power Wheelchair Criteria - Indoor
- ☐ *Power Wheelchair Criteria - Outdoor
- ☐ *Pre-Admission Review
- ☐ *PT Initial Assessment
- ☐ *PT Reassessment
- ☑ *PT Referral Form
- ☐ *Range of Motion Assessment
- ☐ *Recreation - Admission Assessment
- ☐ *Recreation - Annual and Reassessment (Retired)
- ☐ *Rehab Assistant Assignment (PT) - V 1 (Retired)
- ☐ *Rehab Assistant Assignment (PT) - V 2 (Retired)
- ☐ *Rehab Assistant Assignment - V 1 (Retired)
- ☐ *Rehab Assistant Assignment - V 2 (Retired)

11 results   Page [1 ▼] of 1   [20 ▼] Per page
First   Prev   1   Next   Last

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UDA List

Scheduled	In Progress	Completed

In Progress List   Batch Update ▼

	Name	Status	Created Date	Unit	Floor	Assessment Type
	Search	Set Filter ▼	Edit	Set Filter ▼	Set Filter ▼	2 Selected
						Search
☐ edit del print close copy	Mooney, Angel (IM16E9FB6A)	Current	05/11/2025	Red Oak Heights	BJW & ROH	*OT Referral Form

Click 'edit' to enter and review the referral.

*OT Referral Form

Resident:	Mooney, Angel (IM16E9FB6A)
Description:	Other
Date:	5/11/2025 21:30
Lock Date:	

Click Here to View Quick Entry - Keyboard Navigation Tips

Back	Sign All	Regenerate Triggers	Lock	Print

	Section	**Description**
view reopen	A	Referral
view reopen	B	Occupational Therapy Acknowledgement

Lock the referral request to mark it 'Complete'.

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3. Carry out programming for scheduled residents and document accordingly.

TLR	Monitoring / Safety
⋆ Independent Mobility ⋆ Limited Assistance - requests staff to assist with pushing the wheelchair.	⋆ Ensure resident has call bell within reach at all times. Also has a phone. Falls due to his condition.

Daily Routine	Eating / Nutrition
⋆ Call bell to be placed within reach at all times. ⋆ Independent - Resident is independent with all aspects of dressing. May occasionally ask for help with socks if extremely spastic.	⋆ Favourite foods for resident include coffee with milk and sugar and 2 cookies at 1930h daily. ⋆ Food Resident prefers to avoid are sandwiches. ⋆ Limited Assistance - Resident is normally able to feed independently using weighted utensils. Will ask for help during meals if extremely spastic.

Bladder / Bowel	Bathing
⋆ Continent of bowels. Wears large Tena pullup just in case, at his request. ⋆ Continent of urine. Wears large Tena pullup just in case, at his request.	⋆ Independent/Condition Dependent - Resident is normally independent with all aspects of bathing, staff to be present for safety. Resident's preference for bathing shower on Thursday during the day. May require assistance dependent upon Resident's condition.

Toileting	Personal Hygiene / Oral Care
⋆ Independent - wears large Tena pullup at all times for emergency.	⋆ Independent - Resident is independent with all aspects of personal hygiene including oral care.

Bed Mobility	OT/PT Programming
⋆ Independent - top rails used at all times. Super pole at bedside.	⋆ RA Walking Program Please ambulate 2-3x weekly. Assist x 1 using 4ww and gait belt. Second to follow with w/c. Resident has been festinating with his gait so be mindful and ask him to slow down or stop. Can also come to gym to perform U/E and L/E exercises using wall weights and counter. See sheet in gym. ⋆ Restorative programming - strengthening/balance exercises; wall weight in gym; standing at counter; march on spot and mini squats - 3x10 reps.

The resident's therapy program instructions are found in the resident's Kardex in the OT/PT Programming section.

The Kardex can be found in the 'Task' or 'Care Plan' tab in the resident's chart.
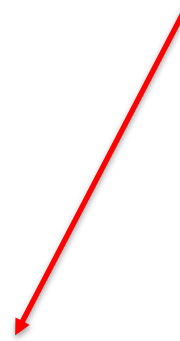
Documentation of the therapy program will take place in two areas:
1) Clinical Tab > Quick Entry > Therapy Minutes
2) Resident Chart > Assessments > Rehab Assistant Assignment

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1) Clinical Tab > Quick Entry > Therapy Minutes

1) Select Occupational Therapy or Physiotherapy
2) You may filter at the top of the page based on your daily assignment / household.
3) Proceed to document the total time spent in the therapy program.
   1) Enter the time in minutes.
   2) Ensure you select the appropriate setting, i.e., group therapy, individual. Only therapists will use the option of 'Evaluation'.
   3) Indicate that the program was planned (vs new – therapist only during evaluation).

2) Resident Chart > Assessments > New > Rehab Assistant Assignment

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*Rehab Assistant Assignment - V 4

Resident: Campbell, Bennett (ZLD011458F)
Description: Other
Date: 6/2/2025 14:48
Section Status: Unedited ○
Lock Date:

[Save & Sign] [Save] [Save & Exit] [Save & Sign & Lock & Exit] [Cancel] [Clear All]

SECTION Cust. *Rehab Assistant Assignment

| RC. | Resident Consent | 1. ☐ Resident provided consent to participate in the RA program. H |
| | | 2. If consent not obtained, indicate reason: [   ] H |

I.	Program Information	1. Select Occupational Therapy Programming or Physiotherapy Programming H
		○ a. Occupational Therapy ○ b. Physiotherapy clear
		2. Name of second staff assist, if applicable: H [ ]

II.	Resident Performance	1. Total RA intervention time: H [ ]
		2. Program carried out as prescribed - see resident's RA Program Task for program details. H
		○ a. Yes ○ b. No clear
		3. Indicate aids / equipment used by the resident during the session: H [ ]
		5. How much assistance / intervention was required? H [ ]
		7. How did the resident tolerate the session? H
		○ a. Good ○ b. Fair ○ c. Poor clear
		7a. Comments or concerns regarding tolerance: H [ ]
		8. Was cueing required for redirection or focus? H
		○ a. Yes ○ b. No clear
		9. Did the resident experience any of the following during the session: TRIG H
		☐ a. Pain
		☐ b. Shortness of breath
		☐ c. Responsive behaviours
		10. Final comments: H [ ]

As you complete the assignment and make your selections, additional fields will be generated for you to complete.

Ensure you 'Save & Sign & Lock & Exit' upon completion.

…record new IPAC measures for a Resident?

If the need for isolation occurs, the RN will do the following:

- Record isolation precautions in the Care Profile of the resident's chart.
- Complete and document necessary focused assessments.
- Complete any necessary tests, as ordered by the medical provider.
- Complete an IPAC Referral.

Insert the precautions.
Please insert <u>after</u> the risk for violence status.

Local facility RNs are to add these Special Instructions as soon as they deem precautions are necessary.

IPAC is consulted upon the admission of a resident who comes with measures in place, i.e., ARO.

Precautions now appear here in the Resident Header.

For illnesses that require the intervention of the **IPAC Nurse**, the facility RN will submit an IPAC Referral.

The primary responsibilities of the IPAC Nurse in PointClickCare:

1. Monitor ARO status in the 'Custom Information' of the Resident Profile (below).
2. Provide support to the home through Isolation Orders and Care Planning for Isolation Precautions and Ambulation Care Plans when necessary.

1. To Edit 'Custom Information'

2. For illnesses that require the intervention of the IPAC Nurse, there are 2 key responsibilities:

   a) Enter an Isolation Order to indicate the conditions the resident needs to meet to have isolation precautions removed.

   b) Edit the Care Plan to reflect the resident's needs.

      i. Isolation Precautions Focus

      ii. Ambulation Care Plan Focus (only when required)

2a. To Enter an Isolation Order

Go to the 'Orders' tab of the resident's chart. In the search bar, begin typing 'isolation orders', as shown below. Select 'Isolation Orders' to generate the ordering window. See next.

Order Date: Displays current date and time – you may change this if needed.

Order Category is pre-determined as 'Other'. Do not change.

Communication Method: Select 'Prescriber written'

Ordered By: 2 ways - Begin typing 'Infection Control Nurse' for an autofill option. or Select the magnifying glass.

Order Entry - Work - Microsoft Edge

https://www60.pointclickcare.com/clinical/pho/popup/enhancedOrderEntry/newOrder.xhtml?ESOLclientid=1172&orderTemplateId=100131&ESOLminiTo...

Resident: Benson, Terry (NP725D4BB7)

Order Details

Order Date: 5/30/2025 15 ˅ 42 ˅ *

Order Category: Other ˅ *

Communication Method: ◯ Phone ◯ Verbal ◉ Prescriber written ◯ Prescriber entered *

Ordered By: Infection Control Nurse, Order 🔍 * Last prescribed by: GerriLynn Henderson
(Current Primary Physician: GerriLynn Henderson)

Order Template Search: Isolation Orders clear

Order Template: Isolation Orders

Description: To discontinue isolation precautions, the resident must meet the following parameters:

-When symptoms resolve
-If lab test results are negative
-If no symptoms develop
-Fever Free for 24 hrs with no fever reducing medication
-48 hours of no symptoms/Normal BM function
* ⚠

Order Type: Isolation Orders - [] ˅ *

Scheduling Details

Add Schedule: Routine PRN One Time Only STAT

Save Queue & New Cancel

Provider Search - Work - Microsoft Edge

https://www60.pointclickcare.com/admin/provider/providerfind.jsp?...

Physicians
Views: Assigned Physician - [All Physicians]

Search: [   ] Search Cancel

All A B C D E F G H I J K L M N O P Q R S
T U V W X Y Z

Name   **Medical Professional Type**
Infection Control Nurse, Order

All A B C D E F G H I J K L M N O P Q R S
T U V W X Y Z

Order Summary:

To discontinue isolation precautions, the resident must meet the following parameters:

-When symptoms resolve
-If lab test results are negative
-If no symptoms develop
-Fever Free for 24 hrs with no fever reducing medication
-48 hours of no symptoms/Normal BM function
-In consultation with Infection Control
-24 hours post initiation of sensitive Antibiotics
-Terminal Clean required

Order Template Search: No need to change.

Description: This is where you will specify the parameters that the resident is required to meet before the facility RN can remove isolation precautions.

Order Type is pre-determined as 'Isolation Orders'. Do not change.

There is no need for a schedule. Disregard this area.

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2b. To Edit the Care Plan

If it's determined that precautions and/or specialized treatments should be represented in the Care Plan, IPAC will make the necessary adjustments to the Care Plan after consulting with the facility RN.

These will include adding an Infection Control Prevention focus and, when necessary, an Ambulation Care Plan focus.

Go to the 'Care Plan' tab of the resident's chart. Select 'edit' to enter the Care Plan.

This is an example of a resident care plan. This is where you will add the focus, goal(s), and intervention(s) for the resident.

Select 'New Focus'.

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Select Library: You must choose the 'Standard LTCF Care Plan Library'.

Focus Category: Select 'Infections' from the drop-down list.

1

2

Customize as necessary. Specify the reason for IPAC measures.

3

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Adding Goals and Interventions to the new Care Plan Focus

Select those that apply.

Customizing the new Goals and Interventions:

Once added, you must customize for the Resident using the 'edit' links next to each Goal and Intervention.

Care Plan Detail

Resident: Acosta, Caleb (GE8DDE11BE)
Triggered Care Plan Items: View Triggered Items Now

Search:
Sort By: Library Order
Show only △:
Show Resolved/Cancelled:
Show Tasks:
Show Symbol Legend

Care Plan Type:
All

Department:
All | Nursing/Care Services | Recreation | Therapy

New Focus | New Custom Focus | Printable View | Back | Care Plan PN | New Alert

« Prev | 1 | 2 | 3 | Next »

Focus	Goals	Interventions
	New Goal New Custom Goal	New Intervention New Custom Intervention
edit pn Physical responses of (describe) related to (specify etiology or known reason) + H	edit pn Resident goal - specify + H	edit pn Effective de-escalation actions include (specify going for walk indoors/outdoors, distraction, re-direction, music, conversation, looking at (specific types) of pictures, etc.) [LPN,NM] + H K
		edit pn Keep care routine as consistent as possible + H
		edit pn Known triggers to responsive behaviour are (specify) + H
	New Goal New Custom Goal	New Intervention New Custom Intervention
edit pn Vision care needs related to + H		
	New Goal New Custom Goal	New Intervention New Custom Intervention
edit pn Head Injury related to (specify how injury was sustained) + H	edit pn Resident goal - specify + H	edit pn Observe for signs of head injury and report to Registered Staff (increased sleepiness, difficulty to arouse, increased or new onset confusion, vomitting, stiff neck, unequal pupil size, complaints of blurred vision or changes to vision, changes in speech, blood coming from ears/nose, complaint of headache, etc.) [RCW,RECPR] + H K
		edit pn Other (specify) + H
edit pn Infection Control Prevention Measures for COVID-19. + H	New Goal New Custom Goal	New Intervention New Custom Intervention
	edit pn Resident goal - specify + H	edit pn Educate resident and family on infection control measures in place due to specify reason + H
	edit pn Resident take steps to minimize risk of spreading infection + H	edit pn Educate resident in hand washing and hand hygiene techniques; remind resident to perform hand hygiene pre/post meals, attendance at exercise/programs and after returning to the home after any outing. + H
	New Intervention New Custom Intervention	
edit pn Urinary Tract Infection + H	edit pn Resident will be monitored during active treatment for infection + H	edit pn Encourage adequate fluid intake. + H
		edit pn Encourage resident to rest (specify routine) + H
		edit pn Medications as per MAR for infection and analgesia as required. Monitor for side effects of medications. + H
		edit pn Observe for changes to urine - change in colour, visble blood, etc. + H

« Prev | 1 | 2 | 3 | Next »

New Focus | New Custom Focus | Printable View | Back | Care Plan PN | New Alert

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Customizing the new Goals and Interventions:

Customize the Description to be specific to the Resident's situation.

If you want the Intervention to appear on the Kardex, select the 'Monitoring / Safety' category. This will be the default selection for all IPAC interventions.

Which role will be responsible for the Intervention?

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Repeat the same process to add an Ambulation Care Plan Focus during periods of isolation.
Your care planning will look as follows:

Edit the Description to reflect as shown below. Be specific so care staff can interpret the care plan.

Select your desired goals and interventions for the resident.

Proceed to 'edit' and customize all areas requiring specification.

Creating a Progress Note to document the Care Plan additions

To be performed by IPAC after they have updated the Care Plan.

Creating a Progress Note to document the Care Plan additions

Document using DARP format.

Include in Shift Report and 24 Hour Report.

…discontinue IPAC measures for a Resident?

When isolation precautions can be removed, the RN is responsible for:

1. Remove Isolation Precautions from the resident's Care Profile.
2. Discontinue the Isolation Order
3. Resolve the IPAC focus(es) in the resident's care plan
4. De-activate any focused assessment schedules, if applicable
5. Document all actions in a progress note

1. Delete the isolation measures from Special Instructions and 'Save'.

2. Discontinue the Isolation Order

Dash	Profile	Census	Med Diag	Allergy	Immu	**Orders**	Wts/Vitals	Results	RAI	Assmnts	Prog Note	Care Plan	Tasks	Misc

New ▼ -or- Type to Create an Order Using an Order Template

Last Order Review: **Next Order Review:** Not specified

▬ Order Listing **Batch Update ▼**

▢ Display Filters

			Order	Directions
⊞	Actions ▾		To discontinue isolation precautions, the resident must meet the following parameters: -When symptoms resolve -If lab test results are negative -If no symptoms develop -Fever Free for 24 hrs with no fever reducing medication -48 hours of no symptoms -In consultation with Infection Control -24 hours post initiation of sensitive Antibiotics -Terminal Clean required	No directions specified for order.
⊞			Hidden Description	as needed apply to affected areas during cares
⊞			Hidden Description	as needed apply daily to dry skin
⊞			Regular diet, Cut Up Meat texture, Regular/Thin consistency	
⊞			Hidden Description	No directions specified for order.

Actions menu:
- View
- Update
- Discontinue
- Hold
- Strike Out
- Files
- Progress Note
- Order Audit Report

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The Communication Method, Ordered By, and Reason for Discontinuation is required. Select 'Discontinue Order'.

Resident: **Carr, Jimena (JU12A3C486)**

Order Summary:

To discontinue isolation precautions, the resident must meet the following parameters: -When symptoms resolve -If lab test results are negative -If no symptoms develop -Fever Free for 24 hrs with no fever reducing medication -48 hours of no symptoms -In consultation with Infection Control -24 hours post initiation of sensitive Antibiotics -Terminal Clean required

Discontinue Date: 5/30/2025   17 ⌄   04 ⌄   * ↩

Communication Method: ○ Phone ○ Verbal ● Prescriber Written ○ Prescriber Entered clear * ↩

Ordered By: Nursing, Order   🔍 * ↩   (Current Primary Physician: Henderson, GerriLynn)

Reason for Discontinue: Isolation Discontinuation parameters met.

Discontinue Order   Cancel

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3. Resolve the IPAC focuses from the Care Plan

Once the parameters for discontinuing isolation precautions have been met, local facility RNs are to remove the applicable portions of the Care Plan, i.e. infection control prevention, ambulation care plan, etc.

Edit the Care Plan and 'Resolve' the previously entering IPAC Focus, Goals, and Interventions.

The Care Plan is versioned, so the history/paper trail is not lost.

Edit Focus

Resident: Carr, Jimena (JU12A3C486)

Standard Focus: Other Infection Specify
Last Revision By: Jennifer Pitre
Last Revision Date: 5/30/2025

Date Initiated: 5/30/2025

Status: ○ Active ● Resolved ○ Cancelled

Description:
Ambulation Care Plan during active infection of
SPECIFY

Care Plan Type:

Review Department One: Nursing/Care Services
Review Department Two:
Review Department Three:
Review Department Four:
Review Department Five:

Etiologies Library

Save Delete Cancel

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IPAC Nurse is solely responsible for removing the ARO flag from a resident's profile when deemed appropriate.

Edit Custom Information

Edit Custom Information

www60.pointclickcare.com/admin/client/clientuserdefinededit.jsp?ESOLfieldtypeid=-1&ESOLclientid=224

Edit All User Defined Field

Resident: Aguilar, Tanya (FT634C5F82)

* Safety Plan	[dropdown]
Infection Control Precautions - MRSA	[dropdown]
Infection Control Precautions - VRE	[dropdown]
Infection Control Precautions - Other	[text field]
Infection Control Precautions - CRE	[dropdown]
Spouse's Name	[text field]
Podiatry Notes	[text field]
Hairdressing Notes	[text field]
Walker information	[text field]
Wheelchair information	[text field]
Resident receives personal mail?	[dropdown]
Laundry - done by?	[dropdown]
Miscellaneous Information:	[text field]
Anniversary Date	[date field]
Prepaid funeral arrangements?	[dropdown]
ASSIGNED STAFFING LEVELS - EVACUATION OF RESIDENTS	[dropdown]

Save **Cancel**

IPAC will be responsible for adding and removing these IPAC flags.

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…request an IPAC assessment?

In addition to the IPAC Referral, ensure all necessary assessments are completed, including the Respiratory Risk Screener or other focused assessment.

Refer to the slides on completing a resident assessment for further details.

Use current date and time.

Select the 'IPAC Referral' assessment from the list.

Select the appropriate type. Should typically be 'Significant Change'.

1 Choose to 'Edit' in Section A of the assessment.

	Section	Description	Sequence
edit del style	A	Referral	1
edit del style	B	IPAC Acknowledgement	2

2 Complete the first section. Then select "Save & Exit".

Insert new question here.
3. Date of Referral   edit   del   rules   Move Up   Move Down   style   lookback   narrative

Insert new question here.
Create New Question Groups
Referral

Save & Sign & Next | Save & Next | Save | Save & Exit | Cancel | Clear All

Click Here to View Quick Entry - Keyboard Navigation Tips

Back | Sign All | Regenerate Triggers | Lock | Print

	Section	Description
edit sign	A	Referral
edit	B	IPAC Referral Acknowledgement

3 Sign the referral, then select 'Back' to exit.

…search for new IPAC assessment requests?

Select 'edit' to open and complete the second section of the assessment.

Choose to show only In Progress 'IPAC Assessment Requests' by checking the box next to that assessment type.

…manage Trust Accounts and associated transactions?

Recurring Charges

Add a recurring charge:

- Select 'New' under Recurring Charges header

- Search for Description, complete all fields and Save

- The withdrawal batch auto-generates when the Trust month is closed

Bring a Negative Balance Forward

➢Make the amount negative when creating the deposit batch (do not use brackets)

Cash Box Balance

To establish the opening balance:
➢ Select Transfer in the Control Accounts window

➢ Enter the amount transferred from the Trust Bank and Save

Cash Box Transactions

Enter details for residents who request cash from their account.

Cash Box Close

➤ Select Print to Reconcile Transactions

✓ Validate closing balance=cash count

Resets to zero – take cheque to bank to restore cash box balance

Resident Income Sources and Special Messages

Identify income sources:

- Select New, complete the fields and Save

Income Sources `New`

Income Source

New Resident Income Source

Resident: Jackson, Brittany (EE37D1FB61)

Source Item:	Accommodation fee Overpayment ⌄	*
Amount:	Accommodation fee Overpayment
Account:	Carbon tax rebate
Comment:	Comfort Allowance Transfer
	Gift
	HST Credit
	Other
	Private pension interest
	RRSP

Client Trust Setup `Edit`

Show Balance on Statement: No

Trust Message: No message has been entered.

Resident Trust Setup

Resident: Jackson, Brittany (EE37D1FB61)

Trust Balance on Bill: ☑

Trust Message:

Enter a message in this box if there are limits to withdrawals per week, etc.

Add Trust message:
- Select Edit under Client Trust Setup
- Enter message in text box and Save
- Message will appear in the cashbox transactions

Create a Deposit Batch

Open Trust Batches

# of Open Deposit Batches: 0
# of Open Interest Batches: 0
# of Open Pay Bills from Trust Batches: 0
# of Open Withdrawal Batches: 0

Select Deposit Batch

New

Click New

New Batch - Google Chrome

www60.pointclickcare.com/admin/trust/batchedit.jsp?ESOLbatc...

New Batch

Batch Type: Deposits

Batch No:	1	*
Batch Description:	Deposit	*
Control Account:	PEH Trust Bank	*
Batch Total:		
Entered Total:	0.00	

Save   Cancel

Save

Add a New Entry to the Deposit Batch

Click New

Save & Cancel to Complete and Post the Batch

Copy Comfort Paid Deposit Batch

Trust - Deposits

Batch Type: [Deposits] - Interest - Pay Bills from Trust - Withdrawals

Batch Status: ALL

edit	post	copy	print
edit	post	copy	print
edit	post	copy	print

← Select Copy

Copy Batch

Instructions
Please enter default effective date for transactions to be copied.

Default Effective Date: 1/10/2025
New Description: Copy of Comfort Paid Feb

[Copy] [Cancel]

← Enter Date and New Description

edit	post	copy	print

← Edit as needed

Create a Withdrawal Batch

Open Trust Batches
# of Open Deposit Batches: 1
# of Open Interest Batches: 0
# of Open Pay Bills from Trust Batches: 0
# of Open Withdrawal Batches: 1

Select Withdrawal Batch

New

New Batch - Google Chrome

www60.pointclickcare.com/admin/trust/batchedit.jsp?ESOLbatc..

New Batch

Batch Type: Withdrawals

Batch No: 2 *
Batch Description: Hairdresser *
Control Account: PEH Trust Bank *
Batch Total:
Cheque No:
Entered Total: 0.00

Save   Cancel

Click New

Insert Description

Save

Add a New Entry to the Withdrawal Batch
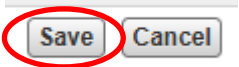

Click Edit to add entries to the batch

Making Financial Corrections

- You cannot reverse actions in the Trust Module
  - You must manually correct entries based on 2 options

Option 1	Option 2
Create an opposite batch (example, when correcting a deposit entry, record a withdrawal)	Create a copy of the batch with the error and edit the amounts in the opposite direction

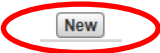**1** edit post copy print
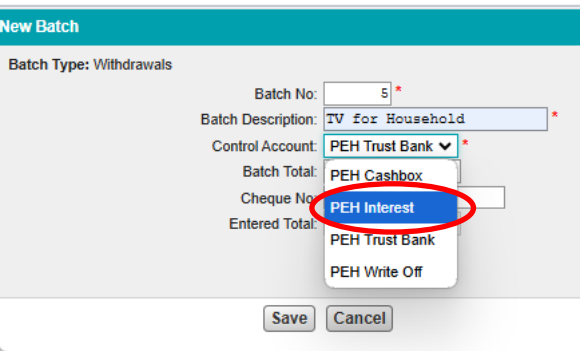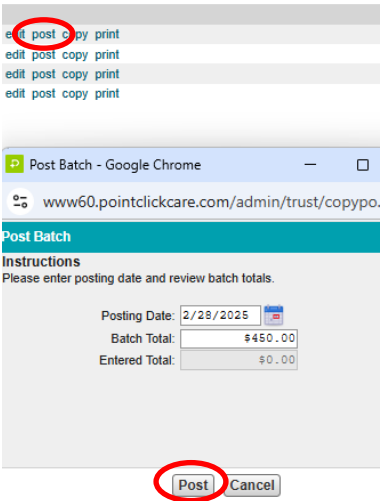
2 Transactions New Edit All Back

3 Save Cancel **4** Transactions New Edit All Back

5 edit post copy print

Using Interest Account to Make Payments

1. Create a new withdrawal batch

2.
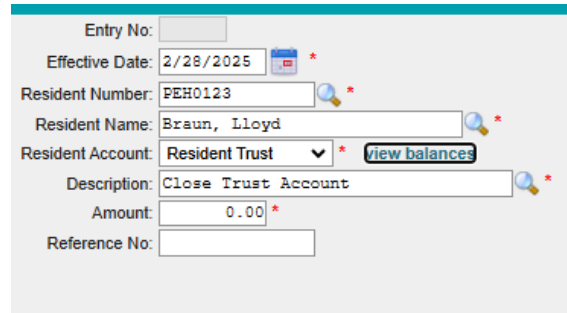
3. Post when complete

Close Resident Account After Discharge

1. Create a withdrawal batch

Field	Value
Entry No:	
Effective Date:	2/28/2025 *
Resident Number:	PEH0123 *
Resident Name:	Braun, Lloyd *
Resident Account:	Resident Trust ▼ * View balances
Description:	Close Trust Account *
Amount:	0.00 *
Reference No:	

Search for resident
View balance in Trust
Insert description – 'Close Trust Account'

2. If there is a negative balance, select 'Resident Bad Debt'
- Use **Min/Max Balances** Report or **Current Account Balances** Report

❖ Once discharged, residents still show on the resident list.
❖ The resident drops off the Current Account Balances report.
❖ Still able to run historical reports ie: Transaction report, Statement or Audit.

Trust Statements

Click 'Include Transactions After Last Statement' to generate in between cycles

Trust Statements Report Setup

Report Options

Print Trust Statements	● By Client ○ By Generation Date

Resident Number:		Leave blank for all residents
Resident:		clear

● Most Recent Statement Since   3/5/2025
○ Statements Between   12/5/2024 and 3/5/2025

☐ Include Transactions After Last Statement

☐ Include default control account

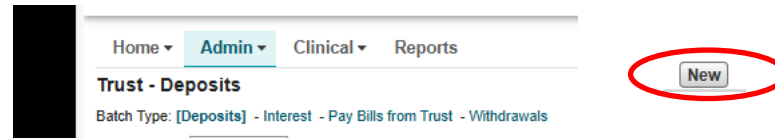| Resident Account	All
Sort By	Statement Date
Reprint from	___ Enter up to 5 letters of Surname
Language Format	English
Statement Message (for all statements)	

Depositing Interest
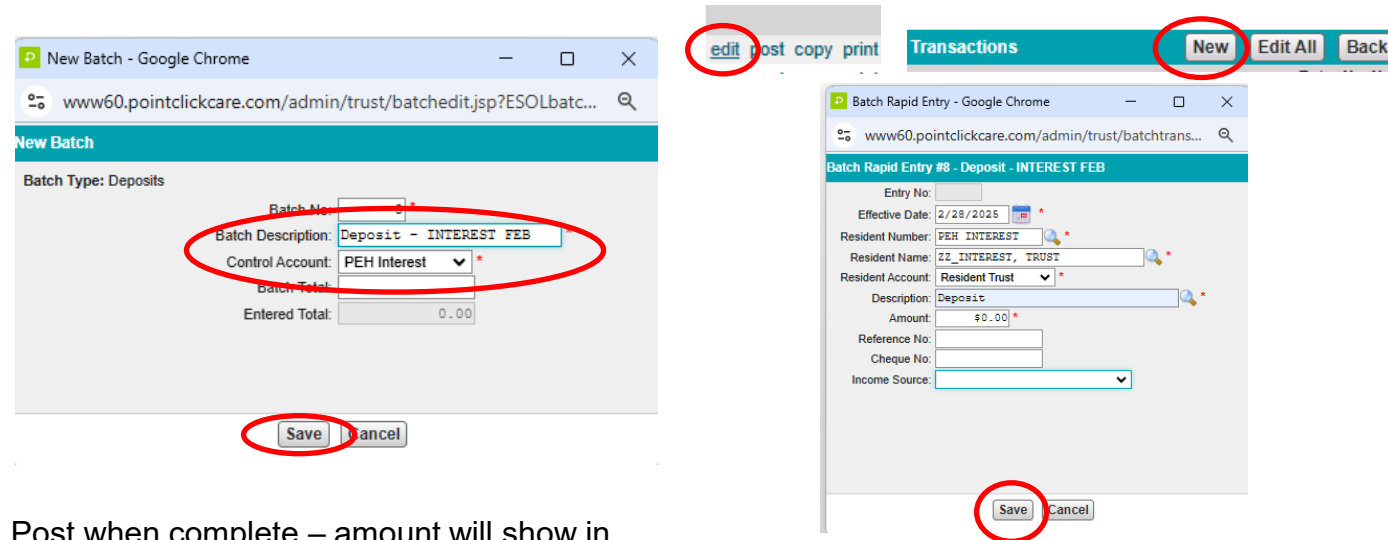
1. Deposit Monthly Interest into Interest Account

2.

3. Post when complete – amount will show in PEH Interest Control Account

Close Current Month

➢ Done after you receive the bank statement for the Posting Month and reconciled balances to the bank balance.

Current Posting Period

Posting Month: 2
Posting Year: 2025

Close Period

Close Trust Period

Posting Month: 2
Posting Year: 2025
Generate Recurring Charges: ☑

Close Period   Cancel

➢ When you select Generate Recurring Charges a Trust Withdrawal Batch is automatically created for residents with recurring charges.

www60.pointclickcare.com says

Are you sure you want to close the current period?

OK   Cancel

Choose OK and Close