POC Essentials
Version 4
Additional Training Opportunities

Enhance the skill you learn in your MED e-Care training and learn new skills by taking advantage of additional training options.

Online Training

We offer interactive classes delivered only by a MED e-Care Education Specialist. These classes cover a range of supplemental material including optional module and task-specific functionality.

Onsite Training

If your organization has a larger group of employees to train, you may find that onsite training best meets your needs. When you schedule onsite training, a MED e-Care Education Specialist conducts training at your organization. Onsite training can consist of the MED e-Care curriculum, or you can create your own class outline to meet your specific training needs.

To learn more about these training opportunities, ask your account manager or contact MED e-Care directly.
# Table of Contents

ADDITIONAL TRAINING OPPORTUNITIES ........................................................................ III

OVERVIEW .......................................................................................................................... 5

GETTING STARTED ............................................................................................................. 6

Logging On to Regular PC Devices .................................................................................. 7

Logging On to Touch Screen Devices .............................................................................. 8

Using On-line Help ............................................................................................................ 10

General Conventions ....................................................................................................... 11

Using POC .......................................................................................................................... 12

Navigating to POC ............................................................................................................. 13

Selecting an Assignment .................................................................................................... 13

The Selected Residents List .............................................................................................. 14

Capturing ADL Data .......................................................................................................... 15

Navigating to Subsequent ADL Items ............................................................................... 15

Viewing Recent Entries .................................................................................................... 16

Wound Tracker .................................................................................................................. 31

Creating and Managing POC Assignments ....................................................................... 38

POC Related Reports ........................................................................................................ 42
Overview

Introduction to POC

The MED e-Care POC (Point Of Care) module provides an electronic means of capturing resident ADL, Flowsheet, Dietary, and Nursing Rehab information. It is intended for use by clients that have deployed the latest touch screen technology throughout their facilities, but it can also be utilized by facilities using regular PC based devices.

The touch screen design of the system allows Personal Support Workers (PSWs) and/or Health Care Aides (HCAs) to record information about residents quickly and easily.

Objectives

Upon completion of training, you will be able to:

- Navigate the POC software module.
- Select an Assignment (shift/unit).
- Select a recording Date/Time/Shift.
- Record resident ADL, Flowsheet, Dietary and Nursing Rehab information.
- View the Kardex.
- Review Recent Entries.
- Modify or Delete Entries.
- Generate POC reports.
- Use Wound Tracker
- Create and Manage Assignments
Getting Started

MED e-Care’s suite of software applications gives you a complete Healthcare solution for your organization. With MED e-Care, it is a seamless process from completing the MDS and working with RAPs, to preparing a care plan. This dynamic application has a user friendly interface and is as intuitive as many of today’s applications.

Objectives

Upon completion of this lesson, you will be able to:

➢ Log in and change your password.
➢ Understand the system’s General Conventions.
➢ Access and use our online Help options.
Logging In

In order to access the c-Notes module you will need to Logon to the MED e-Care software. This option allows you to access any of the modules that have been installed in your organization.

Double click the on the MED e-Care icon (example above).

Logging On to Regular PC Devices

On regular PC devices, single click the left mouse button in the Short Name or Alias field and enter your first name. If this is your first time logging on to a specific computer you will also be required to click the User Name field and enter the username assigned by your System Administrator. Then single click in the Password field and enter the Password assigned by your System Administrator.
Logging On to Touch Screen Devices

Touch screen devices are designed to be used without the keyboard or mouse so the process for logging on is a little different and makes use of MED e-Care’s built-in virtual keyboard (shown below).

Simply touch or tap the virtual keyboard button immediately to the right of the User Name field to open the virtual keyboard. Use the virtual keyboard to enter the username assigned by your System Administrator. Then close the keyboard by tapping the Close button.

Repeat this process for the Password field and enter the Password assigned by your System Administrator. Then tap the Sign-In button.
After you have logged on to the **MED e-Care** system, you will see the Home Screen as illustrated below:

The options you see here may not reflect the modules you have installed in your live system, only the options your organization has installed will show on your Green Bar”.

In this training guide we will be accessing the **POC** module.
Using On-Line Help

Find answers to your MED e-Care questions with a simple click of the mouse button. To access the Help features in the software you can use the following methods:

In the top right-hand corner of the Home Screen click the | Help | link to access the MED e-Care on-line help system.

Simple select the option from the contents window to access help for a particular module.
General Conventions

The system has the following general conventions:

- The left mouse button is used to access an application. **Double** click on the icon for the appropriate application you would like to access.

- The left mouse button is used to access any field. **Single** click in the field you would like to access.

- To move from field to field within a given screen, use the **Tab** key on your keyboard or **Single** click in the appropriate field.

- There are three types of responses within the Assessment. A value is required to respond to the question.

- For entering numeric data, the numbers at the top of the keyboard can be used or if you are using an extended keyboard the number pad on the right can also be used provided the **NUM LOCK** key is on.
Using POC

The Point Of Care or POC module is used for capturing the details of care delivered to residents on a day to day basis. Just like the paper forms and flow sheets that have been in use for many years, they are critical part of every facility’s record keeping responsibility.

In this chapter we will explore the navigation and main features of the POC module.

Objectives

Upon completion of this lesson, you will be able to:

- Navigate the POC module.
- Select an Assignment.
- Select a resident.
- Record ADL, Flowsheet, Dietary, and Nursing Rehab data.
- View the Kardex.
- View Recent Entries.
- Edit and Delete Entries.
Navigating to POC

From the Home screen tap the POC tab on the green bar as shown below.

This will open the POC screen on the ADL sub-tab. It displays a Select Assignment control, lists the residents associated with each assignment and provides navigation to other sub-tabs (Flow Sheet, Dietary, and Nursing Rehab) and the controls for recording the details of care provided.

Selecting an Assignment

After logging on and navigating to the POC screen an assignment must selected. Assignments are unique to each facility and are setup by the RAI Coordinator or designate in each home. Should you have any questions regarding which assignment to select, please refer to your RAI or facility administrator.

To select an assignment, tap the selection box at the right-hand edge to open the selection menu. Then tap your assignment. At this stage you should recognize the names of the residents you are looking after on the current shift.
The example below shows the Oakwood 7AM to 12PM assignment and the associated list of residents. The first resident in the list, Bart Simpson, is selected by default. This can be verified by checking the Resident’s Picture, Name, Chart and Room Numbers located in the top left hand corner of the entry panel. A notepad/pencil icon on the resident’s name in the Selected Residents List also indicates that Bart Simpson is the resident currently available for data entry.

The Select Date, Select Time, and Select Shift fields will always display the current system date and time. These fields can be modified to allow backdated entries but this will be covered in a subsequent section.

To shift the selection to subsequent residents simply tap the resident’s name on the Selected Residents list.

**The Selected Residents List**

When an assignment first opens all of the residents appearing in the Selected Residents list will be displayed with a reddish background.

Once entries have been saved under the current assignment for the resident the background colour will change to orange indicating that at least one (1) entry exists for today’s activities.
Capturing ADL data

After selecting an assignment and resident you are ready to begin capturing ADL data. In the example below we will record the Bed Mobility values for resident Bart Simpson.

In this instance the resident required Limited Assistance / One Person Physical Assistance has been entered with a single tap or touch on each selection. Please note that there are also tick boxes for Refused and LOA (Leave of Absence) across the bottom of the panel.

To complete the item capture process, simply tap the Save button.

The system will indicate that these ADL items have been saved with the following message.

Navigating to Subsequent ADL Items

Once the details of an ADL item have been saved proceed to record subsequent ADL items by tapping the category (Transferring, Walk in Room, Walk in Corridor, etc.)
**Viewing Recent Entries**

To review recent entries tap the Recent Entries button.

In the example above, the Incomplete ADL Items and Completed ADL Items are listed for the resident.

Another way to confirm if an entry has been made for a specific ADL is to review the list of ADL items as shown below. ADLs that have been completed will have a green checkmark.
Navigating to Subsequent Residents

Once the recording of ADL information have been completed for the resident and it is time to begin capturing information on the next resident navigate to the next resident by tapping their name on the Selected Residents List. In the example below resident Beatrice King has been selected.
Capturing Resident Flowsheet Data

POC also has screens for capturing Flowsheet data. Navigate to the Flowsheet screen tap the Flowsheet sub-tab.

In the Flowsheet portion of POC you will be capturing information a variety of information that should closely mirror the paper flowsheet used by your facility.
**Mood & Behavior**
- Self-deprecation (I'm no good)
- Unrealistic fears (being alone/crowd)
- State something bad will happen
- Complains repetitively about health
- Repetitive non-health related complaints
- Unpleasant mood in the morning
- Does not sleep at night
- Change in usual sleep pattern
- Sad/pained/worried facial expression
- Crying/tearful
- Repetitive movements (pacing, tapping, rocking)
- Withdrawal from activities of interest
- Reduced social interaction
- Wandering behavior
- Verbally abusive (swears/threatens/yells)
- Physically abusive (hits/kicks/scratches)
- Socially inappropriate (spits/hears)
- Resist care

**Restraints**
- Enter checked time
- 
  - S = Seat belt
  - T = Table Top
  - B = Bedrails
  - P = Re-Poison
  - R = Removed

**Behavioural**
- Enter checked time
- 
  - 1 = Repetitive
  - 2 = Making Noise
  - C = Constant groaning
  - 4 = Swearing
  - 1 = Pacing
  - 2 = Striking out
  - 7 = Restlessness
  - 8 = Resist Care

**Restraint and Personal Safety Device Monitoring Record**
- Enter checked time
- 
  - A = Application
  - O = Restraint removed/off
  - R = Restraint release & reposition
  - C = Calm/Awake
  - R = Restless
  - S = Sleeping

**Individual Routine Log**
- Enter checked time
- 
  - Sleeping in bed
  - Sleeping in chair
  - awake
  - Watching TV
  - Reading
  - Looking outside
  - Attending activities
  - Visiting with family/friends
Down the right-hand side of some of the information panels there are Current Day Entry and History Entry display icons.

Tapping the Current Day Entry icon will open the following window showing the current day entries as shown below.

Tapping the History Entry icons will display historical entries (including Current Day).
**Recording Numeric Values**

Some of the POC panels will contain fields where numeric values are to be recorded. To work with these fields simply tap the field area directly on the touch screen device to cause the numeric entry pad to be displayed as shown below.

Tap in the numeric value, then tap Close.

Always remember to Save entries.
Capturing Dietary Data

Navigate to the Dietary section by tapping the Dietary sub-tab. The system will retain the previously selected assignment and will open with the first resident in the Selected Resident ready to receive entries. The process for navigating the subsequent residents is identical the ADL and Flow Sheet navigation.

The Dietary section is broken down into the daily feeding events: Breakfast, AM Snack, Lunch, PM Snack, Dinner, HS Snack, and Additional Fluids. Each feeding event is broken down further into Solid(s) and Fluid(s) as shown below.
At the top of each feeding event there is a checkbox that be selected is LOA.

In the example below you will see that our sample resident Bart Simpson only ate half of his breakfast. This was recorded by the tapping the half-eaten plate icon. A value of 50 appears in the Food entry area.

<table>
<thead>
<tr>
<th>Breakfast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident LOA</td>
</tr>
<tr>
<td>Solid(s)</td>
</tr>
<tr>
<td>Food</td>
</tr>
</tbody>
</table>

The Fluid(s) section works a little differently in that the values are cumulative, meaning the count will increase with each tap of the respective serving icon. In the example below, two taps of the full glass icon record that Bart drank two full servings of Coffee at Breakfast.

<table>
<thead>
<tr>
<th>Fluid(s) - Enter Fluid amount in number of cups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coffee / Tea</td>
</tr>
<tr>
<td>Water</td>
</tr>
<tr>
<td>Juice</td>
</tr>
<tr>
<td>Milk</td>
</tr>
</tbody>
</table>

Likewise, a single tap the half –full juice glass and full milk glass icons record his consumption of other fluids at Breakfast. Once the consumption details are recorded and Saved (always remember to tap the Save button) the Total Fluid Intake value at the top of the Dietary will be updated.

![Dietary Report Save]

Total Fluid Intake: 557.5 ml / 4.5 Servings
Correcting Dietary Information

To perform a correction, tap the field where the incorrect entry appears. This will activate the Clear Field menu. Then redo the entry with the correct value. In the example below a value of 4 and ½ has been entered for Coffee/Tea.

The resident actually consumed only 2 and ½ cups. To correct this entry, tap filed itself, select Clear. Then redo the entry with the correct value.

Always remember to Save the corrected entry.
The Dietary Report

Tapping the Dietary Report button will produce a report that lists the current month’s intake record for the selected resident.
Capturing Nursing Rehab Data

The Nursing Rehab sub-tab is the POC section for recording the details of rehabilitation care delivered to residents. Navigate there by tapping the Nursing Rehab sub-tab.

Nursing Rehab provides places to record the time spent delivering care. In initiate entry, tap the Minutes field, this will display the numeric pad used for entries, as shown below.

Alternatively, you can tap the blue + and – sign buttons located just to the right of the field to add or subtract in 5 minute increments.
The data elements in the Nursing Rehab section are:

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Minutes</th>
<th>Refused</th>
<th>LOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of motion (passive)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range of motion (active)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splint or Brace Assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Mobility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing or Grooming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating or Swallowing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amputation or Prosthesis care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Just like every other type of POC entry it is important to remember to tap the Save button.

**Reviewing Recent Nursing Rehab Entries**

Tap the Recent Entries button.

The resulting display.

<table>
<thead>
<tr>
<th>Nursing Rehab</th>
<th>Minutes</th>
<th>LOA / Refused</th>
<th>Date</th>
<th>Support User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of motion (passive)</td>
<td>5</td>
<td>LOA</td>
<td>Jan 10 2012 1:27PM</td>
<td>bob@mede-Care</td>
</tr>
<tr>
<td>Range of motion (passive)</td>
<td>5</td>
<td></td>
<td>Jan 10 2012 12:27PM</td>
<td>bob@mede-Care</td>
</tr>
<tr>
<td>Bed Mobility</td>
<td>3</td>
<td></td>
<td>Jan 10 2012 12:27PM</td>
<td>bob@mede-Care</td>
</tr>
<tr>
<td>Range of motion (active)</td>
<td>10</td>
<td></td>
<td>Jan 10 2012 12:27PM</td>
<td>bob@mede-Care</td>
</tr>
</tbody>
</table>
Editing/Deleting Recent Nursing Rehab Entries

The ability to edit or delete Recent Entries is also available by selecting the Recent Entry sub-tab.

From the Recent Entry screen you can select Modify to edit an entry. Make the necessary corrections and tap the Update button to save the changes.
On your own exercise #1

1. Using what you have learned so far, navigate to the POC section and begin recording details for the resident assigned by the instructor. Make sure you include:
   a. Several ADL entries
   b. Several Flow Sheet entries
   c. Dietary entries for at least one feeding event
   d. Several Nursing Rehab entries

2. Modify at least one ADL entry, Flow Sheet Entry, Dietary Entry, and Rehab Entry.

3. Delete an entry.

4. View the Dietary Report for your assigned resident.
Wound Tracker

Med e-Care’s version 4 software includes an on-module within POC called Wound Tracker. It is intended to be used by nurses and replaces the paper-based wound assessment tools that have been in place for many years.

Objectives

Upon completion of this lesson, you will be able to:

- Navigate within Wound Tracker
- Use the Wound Location panel
- Record the details of a wound
- Add a follow-up assessment
- Record the details of additional wounds
Wound Tracker

The Wound Tracker section is designed for use by clinical staff as they record the nature and status of skin integrity issues of residents. Navigate to the section by selecting the Wound Tracker sub-tab.

The Wound Tracker section is not linked to PSW Assignments and requires that a specific resident be selected. Enter the Surname of the resident in the Last name field of the Search Client box. Select the Search Residents button.

Selecting the name of the resident from the resulting list will open the Wound Location screen shown below.
Use the mouse pointer to pinpoint the location of the wound with a single click of the mouse button. In the example shown below we are documenting a wound on Bart Simpson’s left shoulder blade.

![Image of a person with a marked wound on the shoulder]

This will cause a large red dot to appear on the wound location. Next to the red dot please note that there is now a circled number 1. This indicates the most recent wound to be recorded for this resident. Below the diagram there are two buttons: Open Assessment and Delete Assessment.

**Recording the Details of the Wound**

Select the Open Assessment button to open the screen shown below.

![Screen showing wound location with tabs for recording details]

From here you can proceed to record specific details of the wound across the series of six tabs shown below.
### Wound Image

**Assessment PUSH Score**

**Assessment Score**

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Ex.</th>
<th>Depth</th>
<th>Ex.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Stage</th>
<th>Ex.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ex.</td>
</tr>
<tr>
<td>2</td>
<td>Ex.</td>
</tr>
<tr>
<td>3</td>
<td>Ex.</td>
</tr>
<tr>
<td>4</td>
<td>Ex.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
</tr>
<tr>
<td>Gray</td>
</tr>
<tr>
<td>Necrotic</td>
</tr>
<tr>
<td>Aseptic</td>
</tr>
</tbody>
</table>

### Type of exudate

- Bloody
- Purulent
- Serous
- Serosanguinous
- Other

### Amount of exudate

- 0: None
- 1: Light
- 2: Moderate
- 3: Heavy

### Pain

- No Pain
- Mild Pain
- Moderate Pain
- Severe Pain

### Tissue Type

- 0: Closed (the wound is completely covered with epithelium - new skin)
- 1: Epithelial Tissue (for superficial ulcers, new skin or shiny tissue that grows in from the edges or as islands on the ulcer surface)
- 2: Granulation Tissue (Pink or bloody red tissue with either, moist, granular appearance)
- 3: Slough (Yellow or white tissue that adheres to the ulcer bed in strips of thick clumps, or is mucoid)
- 4: Necrotic Tissue/Escar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges and may be either firmer or softer than surrounding skin)

### Abnormal smell

- Abscess
- Cellulitis
- Delayed healing not previously anticipated
- Discharge which may be viscous in nature, discoloured and purulent
- Discolouration of tissue both within and at the wound margins
- Edema
- Edible, bleeding granulation tissue despite gentle handling of and the non-adhesive nature of wound management materials used
- Localized Edema
- Localized edema
- Localized pain
- No signs of infection
- Unexpected pain and/or tenderness either at the time of dressing change or complaint of pain even when the wound dressing is in place
- Wound breakdown associated with wound packing/binding at base of wound, i.e. when a wound that was assessed as healing starts to develop strips of granulation tissue in the base as opposed to a uniform spread of granulation tissue across the whole of the wound bed

### Pathogen

- Aspergillus
- Eikenella
cordata (yeast)
- Clostridium
- Enterobacter species
- Enterococcus (e.g. VRE)
- K. intestinalis
c- Other (toxifer)
- Proteus
- Pseudomonas
- Species not sent
- Species sent
- Staphylococcus (e.g. MRSA)
- Streptococcus
Always remember to click the Save button after completing the details.

**Adding a Follow-up Assessment**

Follow-up Assessment can be initiated by clicking the Add Follow-up Assessment button as shown below. The will open a new set of detail tabs where the progress of the wound can be recorded.

**Recording Additional Wounds**

Open the Wound Location panel and repeat the process used to locate and capture the details of the initial wound. The most recently recorded wound will always be labeled #1 and older wounds will automatically be renumbered. For example, if we record a second wound for Bart Simpson on the heel of his left foot this new wound will become wound #1 and the one on his left shoulder will be renumbered wound #2.
On your own exercise #1

1. Using what you have learned so far, record the location of a wound on the right shoulder of the resident assigned by the instructor.

2. Add details regarding the wound in each of the six entry tabs.

3. Add a Follow-up Assessment

4. Upon re-examining the resident you notice that they also have a Stage 1 ulcer on the heel of his/her left foot. Record the location and details of this additional wound.
Wound Tracker is designed for use by nurses for capturing wound assessment information. It replaces the paper based wound assessment tools and provides an electronic means of capturing and reporting wound progress.
Creating and Managing POC Assignments

This chapter reviews the process of creating and managing POC assignments.

Objectives

Upon completion of this lesson, you will be able to:

- Create POC Assignments
- Manage Existing Assignments
Creating POC Assignments

The process for creating assignments is initiated from the Setting Tab on the green bar. These functions can only be accessed on a restricted basis by the facility’s authorized administrative user(s).

1. Select the Settings tab.
2. Select POC sub-tab.
3. Under Choose an Option, select Assignment Setting.

The following screen will open.
In the Setup Assignment panel:

4. Select the Position (usually PSW or HCA).
5. Select the Shift and Nursing Unit.
6. Name the assignment (avoid using special characters such as dashes, but underscore is OK).
7. Select the Beds to be assigned.
8. Click the Save button.

The system will respond with a confirming message.

The assignment will now appear in the Assignment Selection list on the POC screen as shown below.
Managing Existing POC Assignments

In the Setup Assignment panel:

1. Select the Position (usually PSW or HCA).
2. Select the Shift and Nursing Unit.
3. Select the assignment.
4. From the Bed Select add or delete beds to the assignment.
5. Click the Save button.

You can also Delete or Rename Assignments from this screen.
POC Related Reports

Numerous reports are available from within the e-Reports function. As you have seen in other learning modules reports are broken down in major categories and sub-categories.

All of the POC related reports can be found under the e-Reports Tab in the category named POC.

Running POC Reports

Navigate to the e-Reports tab on the green bar and select the POC category as shown below.

The POC reports are broken down into two sub-categories, Individual and Group. Select the appropriate sub-category, then select whichever report is required.
In the example below the Residents Daily Fluid Total report has been selected from the POC – Group sub-category. This report is very popular because it lists the cumulative fluid intake for all residents over the previous 24 hour period.

In the parameters selections area for this report there is the capability to select all units or units on an individual basis. Once the appropriate selections have been made, click the Run button to produce the report.