

Benefits

Enhance Record Accuracy
 Improve Communication
 Shared Database
 Ensure Chart Uniformity

Features

Anatomical Diagrams
 Assessment Templates
 Auto-Create Care Plans
 Auto-Create Initial Care Plan
 Auto-Score Assessments
 Condition / Pain Monitoring
 Import / Export Features
 Multi-Disciplinary Approach
 Patient Scheduling
 Point-of-Care Data Entry
 Visual Body Charting
 Multi-Disciplinary Approach
 Point-of-Care Data Entry
 Visual Condition Tracking

Integrated With

ADT / Census Control
 CNA Charting
 Dietary
 EMR / HER
 MDS / Care Planning
 HIPAA Security
 Progress Notes
 Recreation / Activities
 Resident Scheduler

Report Writers

ADL Reportwriter
 Crystal Reports
 Fast Reports
 SQL Reporting Services

The screenshot displays a software interface for patient assessments. At the top, it shows patient information: Name (ADDRESS, TEST), MRN (300124), ID (123862), and Admitted date (09-30-2013). Below this is a navigation bar with tabs for Index, ADL, Condition, Skin Risk, Fall Risk, Braden, Norton + Ulcer, Bladder, and Bowel. The main area is divided into several assessment categories, each with a list of sub-items:

- Nursing**: ADL, Condition, Skin Risk, Fall Risk, Braden Scale, Norton Plus, Bladder, Bowel, Dehydration, Neuro Checks, Glasgow Coma Scale, Respiratory Eval, Cardiovascular, Cornell Depression Scale, Geriatric Depression Scale.
- Social Work**: Social History, Abuse, Elopement, Spiritual/Coping, Survey Satisfaction.
- Activity**: Activity.
- Pain**: Pain.
- Outcome Tracking**: Outcome Tracking.
- Smoking**: Smoking.
- Rehab**: Physical Therapy, Occupational Therapy, Speech Therapy.
- Dietary**: Nutrition.
- SF-36 Health Survey**: SF-36 Health Survey.
- Rehab Form 700**: Form CMS-700.
- Rehab Form 701**: Form CMS-701.
- Physician**: Physician Assessment.
- VA Form 10-10SH**: Form 10-10SH.
- CT DPH Report Event**: DPH Reportable Event Form.
- AI Report Form**: Accident/Incident Report.

Admission Assessments

Capture a resident's conditions at the time of admissions and use this initial assessment to automatically create a Care Plan.

Periodic Assessments

Periodically or episodically record a resident's condition on either a desktop or tablet PCs and use these assessments to automatically populate an MDS.

Comprehensive Discipline Sections

Easily navigate and enter data for every aspect of the resident's condition then view and print all charting documentation.

Includes:

- 1. Nursing:** ADL Functional/ Restorative, Bladder, Bowel, Current Resident Status, Dehydration, Elopement, Fall Risk, Skin Risk
- 2. Rehab:** Physical, Occupational, Speech, Rehabilitation Therapy
- 3. Nutrition:** Nutrition Risk Screening
- 4. Social Services:** History Assessment and Abuse
- 5. Activities:** Resident Activity Assessment
- 6. Pain: Comprehensive Pain Assessment** - Standardized "happy/sad" face pictures and questionnaire check boxes
- 7. Education: Interdisciplinary Teaching** - Each discipline can address knowledge deficits and detail topics to be covered
- 8. Additional Assessments** include Dental, Discharge, Physician, Podiatry, Psychiatric, Religious, and more.