EXTENDED CARE CLINICAL
DON MEETING
JULY 27, 2017

AGENDA

INTRODUCTIONS

MATRIX 2017 R3

- Census Sub Categories
- PT/INR Values in Vitals
- Pending Orders
- CCD-Blood Sugars & PT/INRs added
- Chart Access Report
- Resident Quickview
- DC Multiple Lab & Radiology orders

LAB UPDATE – LIFESCAN AND NICL

NP/PHYSICIAN ORDER ENTRY

REQUIREMENTS OF PARTICIPATION – FACILITY ASSESSMENT

COMPLIANCE

RELIAS UPDATE

RESIDENT DISCHARGE

MPAC

Darria Warnock

From:	dwarnock@extendedcarellc.com
Sent:	Wednesday, July 19, 2017 6:18 PM
To:	'Facility DONs'
Cc:	'FACILITY ADMINISTRATORS'; 'Darria's Consultant Group'; Patty Hupke
Subject:	New Release of Matrix

Hi everyone, There was a new` release for Matrix over the weekend. We will be reviewing some of the changes at the next DON meeting.
Here is an overview and when these things will be changed:

1. New Census Subtypes – there will be a way to setup subtypes in Matrix. An example, instead of saying info change – it can say Information Change – Room Change, or Information Change – Payor Change. Financial will be implementing this in the near future.
2. PT/INR values can be entered into vitals. Once there, a report can be run. The result, who drew the lab and if doctor notified is all included in the entry. Also this will now show up under vitals in quick view and will show up on the CCD when used. This is currently live in Matrix. We are not using it at this time. We will be implementing after training at the DON Meeting.
3. Pending Orders. We will be able to add orders for residents who do not have a census entry. If they are added, they will stay in a pending area until the resident admits and the nurse actually clicks that the orders are valid. I know lots of folks have wanted this. We will be implementing this as of August 1st, after training at the DON Meeting.
4. The CCD will now include Blood Sugars and PT/INRS in the results areas with the TB Results that are already there. This went live on Sunday.
5. The Chart Summary Report is being replaced with the Chart Access Report. It will contain more items, one being the administration record for the emar buildings. This went live on Sunday.
6. Resident Quickview will be updated to include the PT/INR in vitals and emar administration record. This went live on Sunday
7. dc multiple lab or radiology orders. Works just like prescriptions. This went live on Sunday.
8. There will be new groupings available. So we will be able to mark certain meds with a code that says they are in our emergency box and some that are housestock. Those will group up so the nurse can select the correct medication. This will be put into place at a later date.

If anyone has any questions, please let me know.

Thanks!
Darria

Darria Warnock
Matrix Director
Extended Care Clinical
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CENSUS SUB CATEGORIES

Information changes:
Room Change
Payer Change
Level of care change

Admit:
From a SNf
From the Hospital
From Other

Discharged:
to Home
To a SNF
To a Hospital

DRAFT

COUMADIN AND PT/INR LABS

All residents on Coumadin should have their next PT/INR Lab Draw order in Matrix

The lab will draw all orders based on the Lab Due Report – This can be printed by the phlebotomist or by the nurse

The lab due report should be used every day by the afternoon shift to identify any labs that should have results and contact the lab if they are not received.

Once lab results are received. The PT/INR Results should be entered into MatrixCare under vitals.

The actual lab result should be stamped or label affixed and completely filled out by the nurse.

Any changes to medications should also have family notification documented in the chart.

Recording PT/INR Results in Matrix

To add PT/INR Results to Matrix

1. From your **Residents** menu, select **Vitals.** The **Vitals** page appears. A list of the most recent vitals taken shows on this page.
2. Click **Add Vitals**. The **Select Vitals** page appears.
3. Select the check box(es) for **PT** and **INR.**
4. Click **Next** to enter the vitals selected.
5. The **Enter Vitals** page appears and displays all vitals selected. The **Vital Taken** field defaults to **Yes.**

    Note: Bolded fields indicate information that is required for each vital.

6. Enter the Vital value. If a vital has two digits after the decimal point you will need to do simple rounding up or down to enter the vital.

    Simple rounding rules

    Rules for **Rounding**. Here's the general **rule** for **rounding**: If the number you are **rounding** is followed by 5, 6, 7, 8, or 9, **round** the number up. Example: 38 **rounded** to the nearest ten is 40. If the number you are **rounding** is followed by 0, 1, 2, 3, or 4, **round** the number down. Example: 33 **rounded** to the nearest ten is 30.

    If the vital is out of range, a message will appear stating this.

7. Enter additional information such as **Physician Notified,** and **Type of Draw Lab Source.**
8. Enter the **Date/Time Taken**. (This defaults to the current date/time.)
9. Enter **Taken By**:This defaults to the current user.
10. Click **Save** to save the vital entered and return to the **Vitals** page.
11. The **Vitals** page displays the following message:

    <*x*> vitals have been added.

    where <*x*> indicates the number of vitals.

Running the Lab or Radiology Due Report

The Lab or Radiology Due report provides a listing of residents that have lab or radiology tests due.

To run the Lab Due Report

1. From the **Facility** menu, select **Reports**.

   The **Facility Report** page appears.

2. Select the **Lab Due Report** radio button and click **Next**.

   The **Report Parameters** page appears.

3. Select the **Type** of report from the drop-down list **Labs**.
4. Enter Today for the **Due Date Start** and **End** date.

   You can use the Calendar feature to select a date.

5. Select the **Units** and **Residents** to include on the report.

   To select more than one item in each area, press the **Ctrl** key while you are making your selection.

   You can click **Select All** in either of the areas if you want to report on all units or all residents.

6. Check **Include Phlebotomist Signature column** to include space on the report for the phlebotomist to sign for each order. This option is not checked by default.
7. From the **Sort by** drop-down list, select whether you want the report to sort by **Unit/Room/Bed**.
8. In the **Report output type** drop-down list, select either **PDF**.
9. Click **Report**.

A printable PDF or EXCEL worksheet of the report appears in a new window. You can print the report or save it as a new copy.

Note: Click **Back** if you want to select a different report to run.

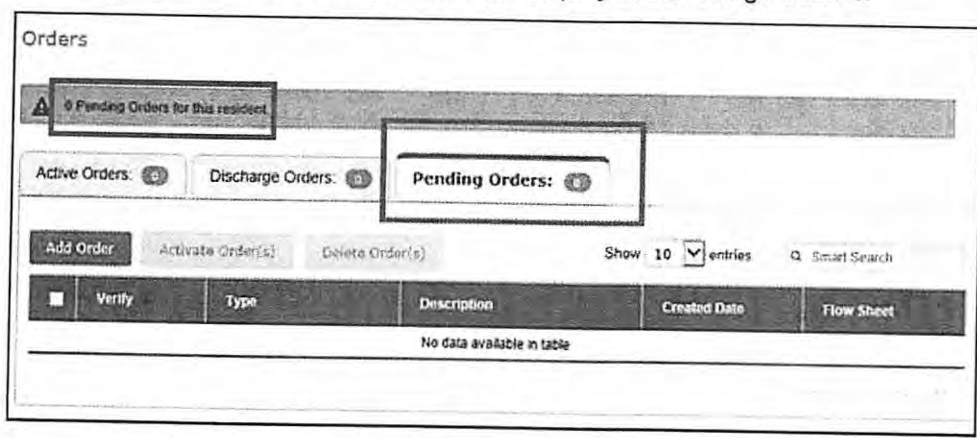
Pending Orders

Pending Orders are those orders added prior to the initial admission of a resident – you will no longer need an admission census event to add orders. You will only need a face sheet for a **future** resident (with the attending physician added), then you can add ***pending*** orders for the resident.

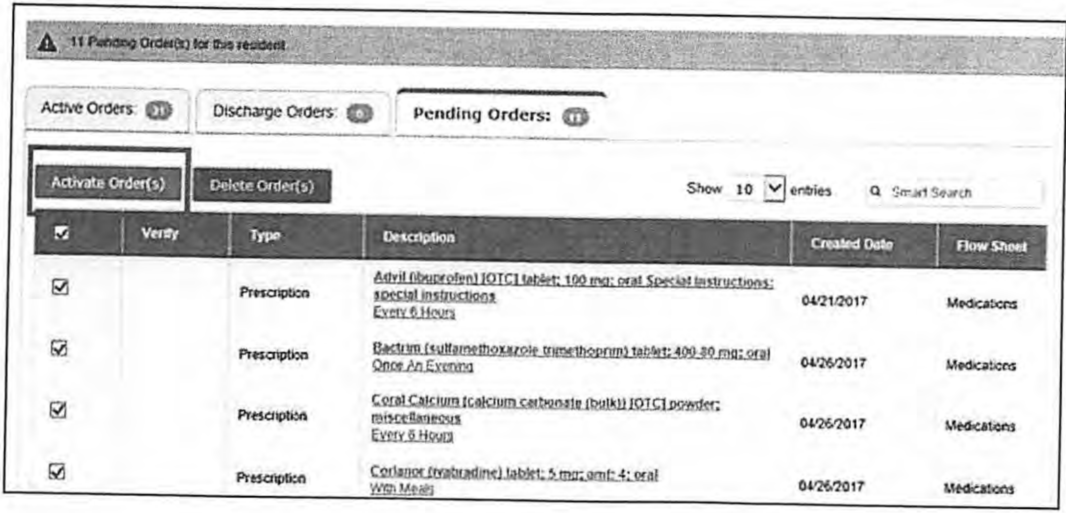
1. Add your resident as usual, creating a Face Sheet.
2. Add the **Attending Physician** to the Face Sheet.
3. **DO NOT** create a census.
4. Go to the **Orders** page and on the **Pending Orders** tab, create any order(s) you want, just as you would create an **Active Order**.
5. When your resident is admitted, select the check box(s) of the order(s) you want transferred to **Active** and click the **Activate Order(s)** button to transfer the selected orders over to **Active Orders**.

Create a Pending Order

1. Create your orders as you usually do, however, create them on the Pending Orders tab.
    - The number of **Pending Orders** will display in the orange banner.

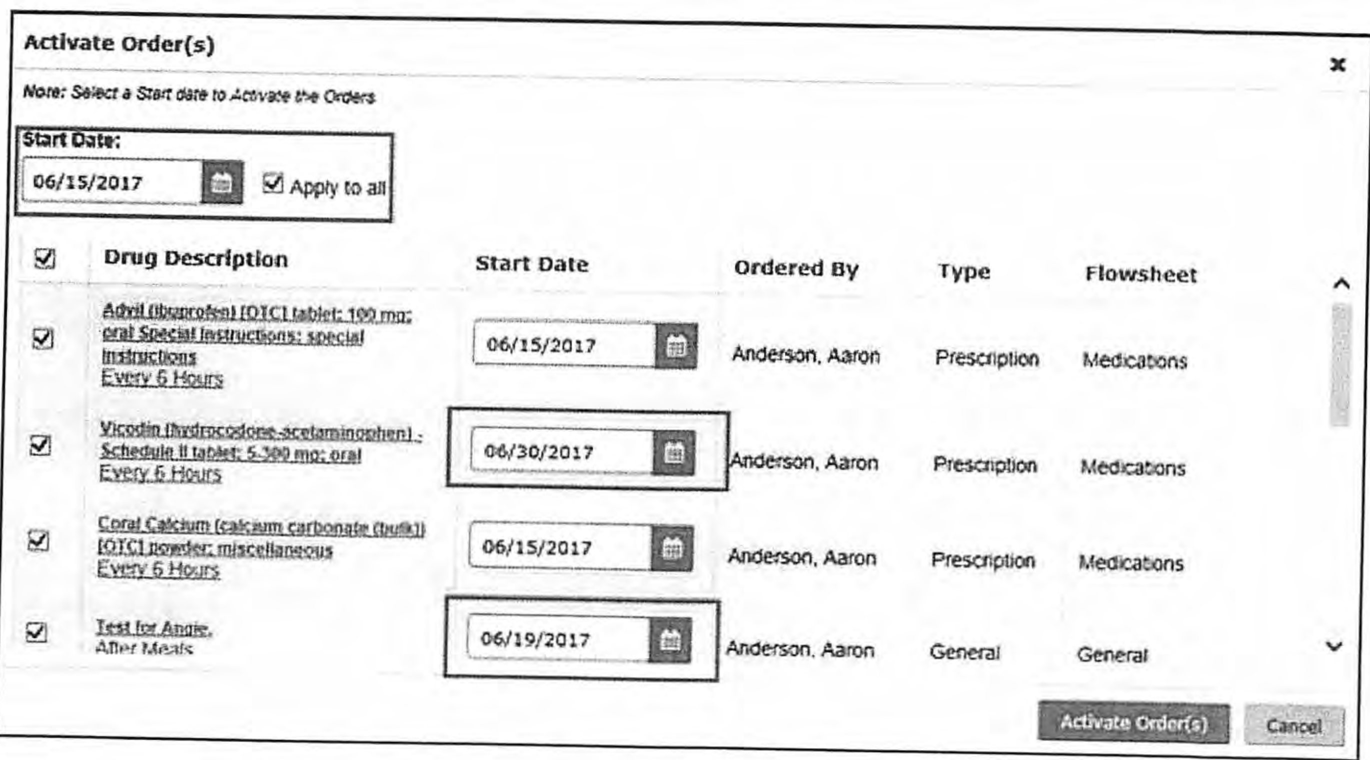


2. When your resident is admitted, select the check box(s) of the order(s) you want transferred to **Active** and click the **Activate Order(s)** button to transfer the selected orders over to **Active Orders**.

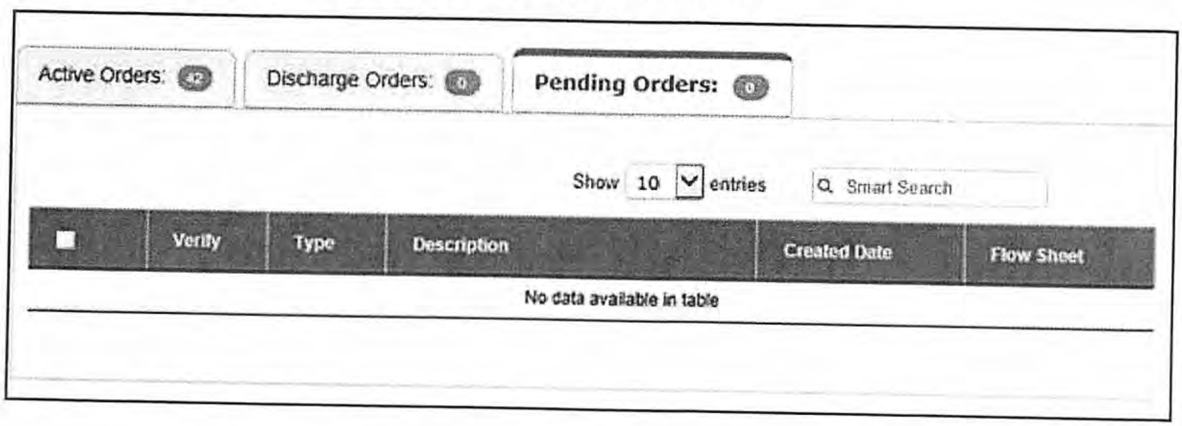


3. An **Activate Order(s)** page opens and requests setting a start date for the pending orders to become active.

4. Select your orders and set a date(s) for activation.
    - You can select a date and select the Apply to all checkbox, applying this date to all orders.
    - You can separately select dates for orders to be activated on those dates.



5. All selected orders will be moved to **Active Orders**.



Running the Pending Orders Report

1. The **Pending Orders** report includes all pending orders for residents selected as of a certain date.
2. From the **Facility** menu, select **Reports**. The **Facility Reports** page appears.
3. From the **Orders** section, select the **Pending Reports** radio button and click **Next**. The **Report Parameters** page appears.
4. Enter a **As Of** date. You can use the Calendar feature to select a date.
5. Select the **Ordered By:** parameter of the report.
6. Select one or more **Order Types**. You can select one or more types by holding the **Ctrl** key while making your selections. Click **Select All** to select all types.
7. Select one or more **Residents**. You can select one or more residents by holding the **Ctrl** key while making your selections. Click **Select All** to select all residents.
8. If you want to include residents **With no Unit, Admitted Only,** or **All residents with Pending Orders**, select the corresponding radio button.
9. If you want to include allergies, select the **Include Allergies** check box.
10. If you want to include diagnosis, select the **Include Diagnosis** check box.
11. In the **Report output type** drop-down list, select either **PDF** or **EXCEL**.
12. Click **Report**.

Running the Chart Access Report

You can use this report to report on key clinical areas of the resident medical record.

To run the Chart Summary Report

1. From the **Resident** menu, select **Reports**. The **Resident Report** page appears.
2. Go to **Resident Info** > **Chart Summary Report.**
3. Click **Next**. The **Chart Access Report** page appears.
4. Select what you want to include on the report using the following check boxes, or click **Check All** or **Clear All** to select or deselect all options.
    - Facility Address
    - Face Sheet
    - Care Plan
    - Certifications
    - Census Daily Detail
    - Orders
    - Resident Administration History
    - Observation Summary List
    - Observation Detail List
    - Event Summary List
    - Event Detail List
    - Resident Vitals Report
    - Progress Notes
5. Enter a **Start Date** and **End Date.**

   You can use the Calendar feature to select a date.

6. Click **Generate Report(s).**

A printable PDF of the report appears in a new window. You can print the report PDF or save it as a new copy.

This report can only be run for a year at a time.

Note: Click **Back** if you want to select a different report to run.

Chart Access Report

Description

This report pulls several individual reports together in to one report. The **Chart** section selection includes face sheet, orders, care plan, observation summary, observation detail, event summary, event detail, vitals and progress notes. These individual reports are shown throughout this report book.

Parameters

You can run the report:

- To include one or more of the following
  - Facility Address
  - Face Sheet
  - Orders
  - Care Plan
  - Certifications
  - Census Daily Detail
  - Resident Administration History
  - Assessment Detail List
  - Observation Summary List
  - Observation Detail List
  - Event Summary List
  - Event Detail List
  - Resident Vitals Report
  - Progress Notes
- For a specified date range.
- To include optional **Diagnosis Notes**.
- Including the resident's **SSN**, if desired.
- Including the resident's **Medicare Number**, if desired.
- Including the resident's **Medicaid Number**, if desired.

MatrixCare Center

Resident Face Sheet: Harold DT23 Aaron (DNR/DNI)

Unit:	NorthWest	**Preferred Name:**	Hardy
Room/Bed:	WN 101/D	**Attending:**	Harvey Benson - (952) 995-0767
Status:	Hospital Leave		

Admit Date:	02/24/2017 03:59 PM (current)	**Last Qualifying Hospital Stay:**	01/18/2004 - 01/20/2004
Admitted From:		**Referral Source:**	
Discharged:		**Discharged To:**	
Primary Discharge Diagnosis:		**Discharge Reason:**	
		Condition on Discharge:	

Primary Payer:	Private AL	**Birth Date:**	01/01/1930
SSN:	008638999	**Age:**	87
Medicare A #:	238638999A	**Sex:**	M
Medicare B #:		**Marital Status:**	Married
Medicaid #:	238638999A	**Mother's Maiden Name:**	Johnson
MR#:	04312-01	**Religion:**	Catholic
Pharmacy:	QS1		
Race:	White, not of Hispanic origin	**Prev Occupation:**	Teacher
Language:	English		
Is Responsible for Self:	No	**Address:**	10 Main Street Rockford, IL 60010
		County:	Winnebago
		Military Svc:	No
Service Connected Disability & %:	Yes 24.72%	**Veteran Elig (10-5588):**	No
VA Claims Number:		**Last Branch of Service:**	Army/Air Force
Service Number:		**Last Branch of Service Dates:**	07/01/2015 - 07/06/2015

Insurance Information:

Insurance	Group Name	Group #	Insured's ID #	Payer Address	Payer Phone
Co-Insurance			414798		

Health Information Exchange Consent

Continuity of Care Document Exchange:
Opt In (allows CCD to be exchanged)

Purpose

You can use this report as it provides you with one place to obtain multiple reports/sections of a resident's medical record for a selected date range. It is useful for medical chart review, audits, survey, Medicare reporting, and interdisciplinary care conferences, discharge information, etc.

MatrixCare Center

Physician Order Report: 05/22/2017 - 06/22/2017

Attending: Benson, Harvey (952) 995-9767

Aaron, Harold DT23 (DNR/DNI)

MR#: 04312-01
Room/Bed: WN 101/D Unit: NorthWest
Alerts:
DOB: 01/01/1930 Age: 87 Sex: M
Admit Date: 02/24/2017 03:59PM
Allergies: Aspirin (ASA), Dander, Shrimp, Wheat
Diagnoses: E44.1 Mild protein-calorie malnutrition(Primary, Admission), I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure, J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation, L02.13 Carbuncle of neck(History of), M00.051 Staphylococcal arthritis, right hip(History of), I10 Essential (primary) hypertension

Dietary flow sheet

Order Type	Start Date End Date	Description	Ordered By
Dietary	05/25/2017 - Open Ended	Finger Foods, Chopped, Nectar Thickened	Harvey Benson

Labs flow sheet

Order Type	Start Date End Date	Description	Ordered By
Lab	06/06/2017 - 06/19/2017 (DC Date)	CBC c Man Diff 85027 Once A Day on 1st Mon of Every 3rd Month; 06:00 AM - 03:30 PM	Harvey Benson
Lab	06/06/2017 - 06/19/2017 (DC Date)	Hemoglobin A1c Once A Day on 1st Mon of the Month; 06:00 AM - 03:30 PM	Harvey Benson

Medications flow sheet

Order Type	Start Date End Date	Description	Ordered By
General	05/25/2017 - Open Ended	Test general Once A Day; 07:00 AM	Harvey Benson
General	05/25/2017 - 06/06/2017 (DC Date)	Test general Once A Day; 07:00 AM	Harvey Benson
General	05/25/2017 - Open Ended	Test general Once A Day; 07:00 AM	Harvey Benson
General	05/25/2017 - 06/19/2017 (DC Date)	Test general Once A Day; 07:00 AM	Harvey Benson
Prescription	05/25/2017 - 06/06/2017 (DC Date)	Advil (ibuprofen) [OTC] tablet; 100 mg; oral Once A Day; 07:00 AM	Edward King
Prescription	05/25/2017 - 06/06/2017 (DC Date)	Advil (ibuprofen) [OTC] tablet; 100 mg; oral Once A Day; 07:00 AM	Edward King
Prescription	06/22/2017 - Open Ended	Novolog Flexpen (insulin aspart) insulin pen; 100 unit/mL; amt: Per Sliding Scale; If Blood Sugar is less than 100, call MD. If Blood Sugar is 100 to 125, give 2 Units. If Blood Sugar is 126 to 150, give 4 Units. If Blood Sugar is 151 to 200, give 6 Units. If Blood Sugar is greater than 200, call MD. subcutaneous Before Meals; 07:00 AM, 12:00 PM, 08:00 PM	Harvey Benson

MatrixCare Center

Medications Administration History: 05/22/2017 - 06/22/2017

Aaron, Harold DT23(DNR/DNI) U/R/B: NW/WN 101/D MR#: 04312

Physician: Benson, Harvey ph: (952) 995-9767

Resident Status = Administration Notes:

Order	Frequency	Special Instructions	Diagnosis	Start/End Date
Test general	Once A Day			05/25/2017 - Open Ended

Time	Mon 22	Tue 23	Wed 24	Thu 25	Fri 26	Sat 27	Sun 28	Mon 29	Tue 30	Wed 31	Thu 1	Fri 2	Sat 3	Sun 4	Mon 5	Tue 6
7:00 AM	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Time	Wed 7	Thu 8	Fri 9	Sat 10	Sun 11	Mon 12	Tue 13	Wed 14	Thu 15	Fri 16	Sat 17	Sun 18	Mon 19	Tue 20	Wed 21
7:00 AM	x	x	x	x	x	x	x	x	x	H	H	H	H	H	H

Order	Frequency	Special Instructions	Diagnosis	Start/End Date
Test general	Once A Day			05/25/2017 - 06/19/2017 (DC Date)

Time	Mon 22	Tue 23	Wed 24	Thu 25	Fri 26	Sat 27	Sun 28	Mon 29	Tue 30	Wed 31	Thu 1	Fri 2	Sat 3	Sun 4	Mon 5	Tue 6
7:00 AM	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Time	Wed 7	Thu 8	Fri 9	Sat 10	Sun 11	Mon 12	Tue 13	Wed 14	Thu 15	Fri 16	Sat 17	Sun 18	Mon 19	Tue 20	Wed 21
7:00 AM	x	x	x	x	x	x	x	x	x	H	H	H	H	x	x

Information Key:

PRN Reasons: BI*=Behavior Issue, CP=Chest Pain, Cg=Congestion, Cn = Constipation, Ch=Cough, D=Diarrhea, DE=Dry Eyes, F=Fever, I=Itching, NV=Nausea/Vomit, P*=Pain, S=Sleep, US=Upset Stomach, O*=Other

PRN Results: E=Effective, NE=Not Effective, SE=Somewhat Effective, O*=Other

* = Comment in Reasons/Comments, *Initial parenthesized* = Not Administered or Not Charted, see Reasons/Comments

H = Hospital Leave, T = Therapeutic Leave

Resident:	Aaron, Harold DT23	**MR#:**	04312				
Admit Date:	2/24/2017 3:59:00PM	**DOB:**	01/01/1930	**Unit:**	NW	**Room/Bed:**	WN 101/D
Physician:	Benson, Harvey ph: (952) 995-9767			**Age:**	87	**Sex:**	M
Allergies:	Aspirin (ASA), Dander, Shrimp, Wheat	**Diagnosis:**	E44.1 Mild protein-calorie malnutrition(Primary, Admission), I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure, J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation, L02.13 Carbuncle of neck(History of), M00.051 Staphylococcal arthritis, right hip(History of), I10 Essential (primary) hypertension				

LIFESCAN LAB – UPDATE FROM LAST DON MEETING

1. **STANDING ORDERS IN THEIR SYSTEM:** Lifescan is removing all of the standing orders from their system. Their phlebotomists will be using the Labe Due Report from MatrixCare, starting the second week in August. We will be giving the phlobotomists access to pull this report, but ***every nurse in the building should also know they can pull it and give it to the phlebotomist***.
2. **INFECTION CONTROL PROTOCOL:** Emails will be sent to the DONs and ADONs mothly. Lab personal will receive monthly PPE Training from Lifescan
3. **ISSUES WITH STATS:** Lifescan has reviewed there protocols for STAT orders. The order that took 48 hours should not, they have hired more phlebotomists and we should not see this happen again. All STATs need to be called in to the lab for accurate dispatching. STAT orders MUST be entered into Matrix.
4. **MICRO SPECIMENS:**

   When calling the lab to request a specimen pick-up, the following information is needed:

   Name of the Facility
   Type of specimen to be picked up
   Name of patient
   Test(s) needed to be ddone
   Location of specimen
   Copy of order from Matrix must be placed in the biohazard bag.

   *Please make sure the specimens have been collected prior to scheduling picku

5. **EPI REPORTS** - Will be emailed on a mothly basis by Ralph Scorpio

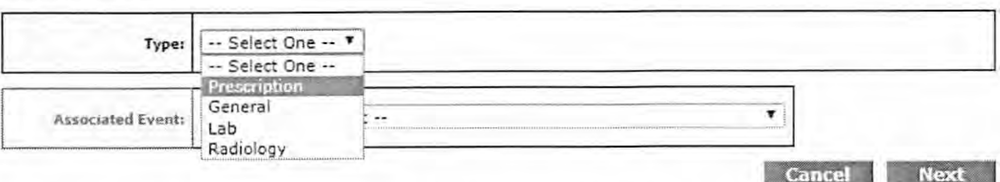
   First week of the month: Preliminary Reports
   Third week of the month: Final Epi Report

Physician / NP Order Entry

Entering an Order into MatrixCare

1. Login to MatrixCare
2. Go to the **Resident Tab** and choose **Orders.**
3. Search for the resident you would like to add orders for.
4. The next page will list any active orders the resident currently has. Click the blue **Add Order** button.

5. The **New Order** page appears. Select the type of order you would like to add.



- Any Drug, including OTC, supplements, etc, should be put in as a **Prescription.**
- Any labs to be drawn will need to put in as a **Lab.** Anything tested outside by the Lab. This does not include BGM.
- Any orders for x-rays, etc should go under **Radiology**
- **General** orders are for everything else, such as orders to monitor BGM, G-Tube feeding, or to refer the resident to a specialist. *Never* put an order into Matrix as a general order if it relates to one of the other types. Do *not* write a general order that says to D/C or hold another prescription. Instead the *original* order needs to be D/C'd and/or reactivated.

Entering a Prescription Order

1. If you choose **Prescription**, the following screen appears. When you start to put in the order, you should only put the ***name of the drug*** in; don't worry about the route, dosage, etc. yet. Click **Search.**

Drug Search

Enter brand or generic drug name ex. Tylenol or tyl

furosemide **Search**

furosemide oral
furosemide injection
furosemide (bulk)
furosemide in 0.9 % sod.chloride intravenous
furosemide in dextrose 5 % intravenous

2. Anything in the drug database will appear. Choose the correct drug.

Your search for "furosemide" returned 5 results:

furosemide oral (Generic)
furosemide injection (Generic)
furosemide (bulk) (Generic)
furosemide in 0.9 % sod.chloride intravenous (Generic)
furosemide in dextrose 5 % intravenous (Generic)

3. On the next screen, choose the dosage and form of the medication.

furosemide oral tablet

furosemide oral tablet 20 mg
Rx , Generic
Safety Alerts

4. The order entry page appears. You can leave **Received Date** and **Received By** blank.
Start Date should be changed to when the order will first be carried out. For example, if you are ordering a medication QAM but it's already the afternoon, change the start date to the next day.
End Date should be used only if the resident will stop the medication at a future date, such as an antibioitic, etc. Otherwise, leave it **Open Ended.**

Received Date:		Received By:	-- None --
Start Date:	07/24/2017	End Date:	☑ Open Ended

5. Next is the section for the medication itself.

Customize:	☐		
Drug Name:	furosemide OTC		
Drug Class:	Cardiovascular Drugs | Hypotensive Agents | Diuretics (Hypotensive Agents)		
Schedule:	Not Scheduled	NDC Code:	00054429725
Form:	tablet ☐ Crushed		
Strength:	20 mg	Route:	oral
Amount to Administer:	1 tablet		

Customize should never be used, unless it's a compounded medication that is not a normal dosage made by the drug companies. Do *not* use **Customize** unless absolutely necessary. If the dosage or form is incorrect, it usually means that the wrong drug was chosen at the beginning.
If the medication must be crushed, check the **Crushed** checkbox. If the route is different than usual for the medication (such as via G-Tube), change the **Route**. For **Amount to Administer**, enter how much to give, such as "1 tablet" or "15ml".

6. The next section is for **Frequency**; how often the order is being carried out.

Frequency:	Daily ▼
	Description
	Once A Day
	Choose times / shifts: ◉ Time ○ Shift ○ PRN ○ Custom
	Time: 1: 05 ▼ 00 ▼ PM ▼ — Add Rows: 0 ▼
	Repeats On: ◉ Daily ○ Cyclical ○ Weekly ○ Monthly
	Repeat: Every Day

The first box says **Frequency**. Get as close as you can to what you want to order. If this medication is Daily, you can choose that. If it's specifically QAM, that's also an option. If the exact frequency does not appear in the list, get as close as you can get. You can then manipulate the parameters below to get exactly what you want. For example, if the above order was Daily – PRN, you can click on the **PRN option.** If the time that it gives you (5pm in this example) that can also be changed. If you want to order this medication every other day, weekly, monthly, those are also options.

7. The next section is **Special Instructions.** The diagnosis needs to be typed in this field. This should *always* be provided, even if the diagnosis seems obvious. You should also type anything additional that the nurse carrying the order out needs to know. For example "Hold if pulse is less than 60", or "Give with a glass of juice". Do ***not*** retype the order here.

Special Instructions:	[text field] ABC 1200 remaining

8. The next section is **Task(s) to record.** Click any box that the nurse passing the medication needs to record, such as pulse for digoxin or blood sugar for insulin.

Task(s) to record:

Vital Sign(s)

☐ Temperature ▼	☐ Respirations ▼	☐ O2 Saturation ▼
☐ Pulse ▼	☐ Blood Pressure ▼	☐ Blood Sugar ▼

Med Note(s)

☐ Physician Notified ▼	☐ Site ▼
☐ Result ▼	☐ Units ▼

9. For **Category** you can simply choose "Medications". For flowsheet, you should choose "Medications", "PRN Medications", or "Diabetic/Insulin", depending on the type of drug. This determines where the nurse will find the order on the printed MAR.

10. You can ignore the rest of entry page, with one exception. If you wish this order to be "Dispense As Written" instead of "Substitution Permited, you can say so under **Dispense Directives.**

Pharmacy Directives:	Dispense Directives
	Dispense As Written (DAW) ▼

11. We do not use Two Order Sets.
12. When you're done entering the order, click the blue Next button. You will now be on the Confirm Prescription Order page. **Your order is not saved yet.** This page allows you to review your order to make sure you didn't make any typos are other mistakes. If you made a mistake, you can click on the blue **Modify** on the bottom of the page. If you are happy with the order, you can click on the blue **Sign** button. This will save and electronically sign your order.
13. A nurse will need to verify your order before it is active.

Entering a Lab or Radiology order

1. Any labs to be drawn will need to put in as a **Lab.** Anything tested outside by the Lab. This does not include BGM.
2. Any orders for x-rays, etc. should go under **Radiology.**
3. For the most part, entering a Lab or Radiology order works exactly the same way as putting in a Prescription order with a few exceptions.
4. When clicking the blue **Add Order** button, you will choose **Lab** or **Radiology.**
5. For Lab orders, unless the lab is to be ordered stat, it is very important to set the start date to be the ***next day*** the lab company will be in the building. This will usually be the next day, however if you order the lab on a Friday, the start date will need to be on the following Monday. Please consult with facility staff if you are not sure when the lab will be in to draw. Setting an incorrect start date means that there is a very good chance the lab will not be drawn.

   Start Date: 07/25/2017

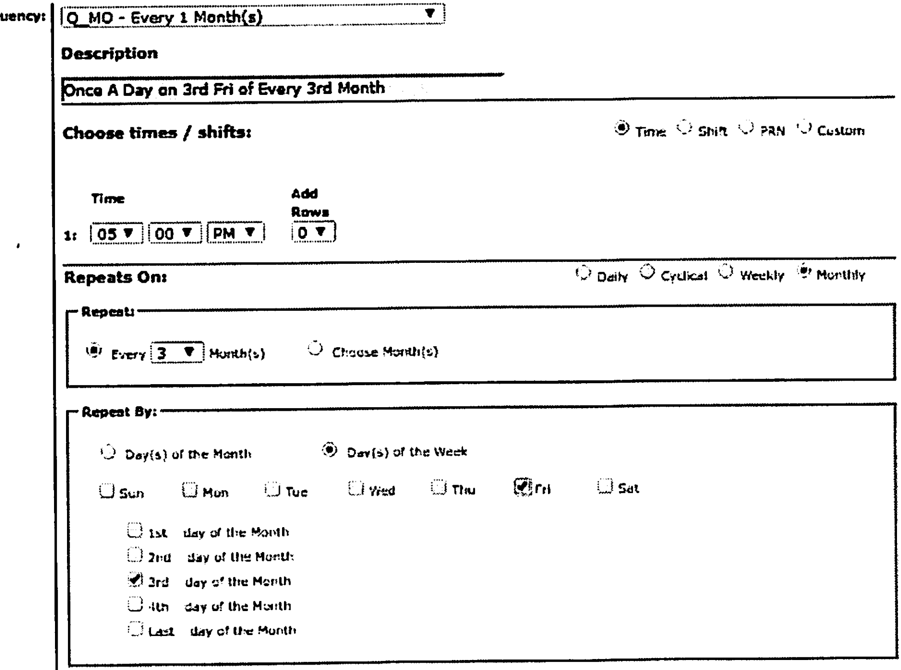
6. For either Lab or Radiology orders, you will need to select the tests you want to order.

Lab(s) to Order:

☐ AFP	☐ Electrolytes	☐ PTT
☐ Amylase	☐ Folate	☐ Sed Rate/ ANA Screen
☐ Basic Metabolic Panel	☐ Glucose	☐ SGOT (AST)
☐ BUN	☐ Glycohemoglobin	☐ SGPT (AST)
☑ CBC	☐ H&H	☐ T4
☐ CBC w/ Differential	☐ Hemogram	☐ T4, Free
☑ Comprehensive Metabolic Panel	☐ Hepatic Panel	☐ Tegretol
☐ CPK	☐ Iron	☐ Theophylline
☐ Culture, GC	☐ Lipid Profile	☐ Triglycerides
☐ Culture, Urine	☐ Protime & INR	☐ TSH
☐ Digoxin	☐ PSA	☐ Urinalysis
☐ Dilantin	☐ PSA/Screen	

Other Tests:

7. If a test is not on the list, it can be typed in the **Other Tests** box. This should *always* be provided, even if the diagnosis seems obvious.
8. If the lab will be drawn periodically, such as every 3 months, you will want to use the **Q_MO** frequency. It is ***very*** important that a specific date for the tests is ***not*** used. Labs must always be scheduled for a specific day of the week, not a day of the month. Go to the **Repeat By** section. By default, it will be set to "Day(s) of the Month". Change it to **"Day(s) of the week"**. If the first draw is on the third Friday of the month, then click the checkbox for Friday and the checkbox for "3rd _ day of the month" Below is an example. Notice that **Description** says "Once a day on the 3rd Fri of


Frequency: Q_MO - Every 1 Month(s)
Description
Once A Day on 3rd Fri of Every 3rd Month
Choose times / shifts: ◉ Time ○ Shift ○ PRN ○ Custom
Time Add Rows
1: 05 00 PM 0
Repeats On: ○ Daily ○ Cyclical ○ Weekly ◉ Monthly
Repeat:
◉ Every 3 Month(s) ○ Choose Month(s)
Repeat By:
○ Day(s) of the Month ◉ Day(s) of the Week
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☑ Fri ☐ Sat
☐ 1st day of the Month
☐ 2nd day of the Month
☑ 3rd day of the Month
☐ 4th day of the Month
☐ Last day of the Month

Every 3rd Month.

9. **Special Instructions** needs to include the diagnosis, why is the lab being ordered?
10. **Category** and **Flowsheet** should both be set to a Lab or Radiology depending on the type of order.
11. When you're done entering the order, click the blue Next button. You will now be on the Confirm Lab (or Radiology) Order page. **Your order is not saved yet.** This page allows you to review your order to make sure you didn't make any typos are other mistakes. If you made a mistake, you can click on the blue **Modify** on the bottom of the page. If you are happy with the order, you can click on the blue **Sign** button. This will save and electronically sign your order.
12. A nurse will need to verify your order before it is active.

Entering a General Order

1. **General** orders are for orders that are ***not*** prescription, radiology, or lab orders, such as orders to monitor BGM, G-Tube feeding, or to refer the resident to a specialist. *Never* put an order into Matrix as a general order if it relates to one of the other types. Do ***not*** write a general order that says to D/C or hold another prescription. Instead the ***original*** order needs to be D/C'd and reactivated if necessary.
2. Make sure your start date is correct.
3. The only difference between a General order and other kinds of orders is that you just have to type what the order is. For example,

   Order Description: `Send to Munster Community Hospital.`

4. Do ***not*** type an order in that should be a prescription, lab, or radiology order instead. If you do, the order could be missed, not sent to the pharmacy, not drawn, etc. Also Matrix will not screen for allergies, interactions, etc. if a medication is put in as a general order.
5. **Category** should be chosen based on the type of order it is. An order to give O2 should be put on the "Oxygen" category, and an order for G-Tubes should be put in the "G-Tube" category. If there is no appropriate category, "Standard Orders" can be used.
6. **Flowsheet** should be set depending on the kind of order. Think about where the nurses will end up seeing the order. Will it be in their MAR? Use the medication flowsheet. Will it be in their Treatment book? Use the treatment flowsheet. More generic orders, such as the example above, can be placed on the "Order Sets" flowsheet. If you are unsure where to put this, please ask facility staff. They will also check this when they verify the order.
7. When you're done entering the order, click the blue Next button. You will now be on the Confirm General Order page. **Your order is not saved yet.** This page allows you to review your order to make sure you didn't make any typos are other mistakes. If you made a mistake, you can click on the blue **Modify** on the bottom of the page. If you are happy with the order, you can click on the blue **Sign** button. This will save and electronically sign your order.
8. A nurse will need to verify your order before it is active.

How to D/C or Hold an Order

1. Go to the **Resident Tab** and choose **Orders.**
2. Search for the resident you would like to DC or hold an order for.
3. The list of active orders will appear. Find the order you wish to DC or hold.
4. To hold an order you must D/C it first.
5. Click the red **DC** button to the left of the order.
6. Change the **Discontinue Date** and **Discontinue Time** if the order is not being discontinued or held immediately.
7. Set **Discontinue Reason** to **Order Changed**

Discontinue Date:	07/27/2017	**Discontinue Time:**	10 : 48 AM
Discontinue Ordered By:	Dr. Harvey Benson MD		
Discontinue Reason:	Order changed		

8. Click the Blue **DC** button
9. If you are just DC'ing the order, you're done. A nurse will have to verify the DC order.
10. If this is a hold, you will need to input the order again, with the Start date changed to when order is held until. If you do not yet know when the order will resume, or if you are not sure if the order will remain the same when it resumes, then just DC the order and put it in again later.
11. **Never create a general order that says to DC or Hold a medication. If you do, it could be missed, the pharmacy will not know about it, and reports that list prescription orders will not show that it is held or DC'd.**

How to add General Orders with Order Sets

Order Sets are general orders that have are already created in Matrix. You can use these to save time, to ensure order accuracy, and to keep things consistent across residents. Order sets should always be used when possible.

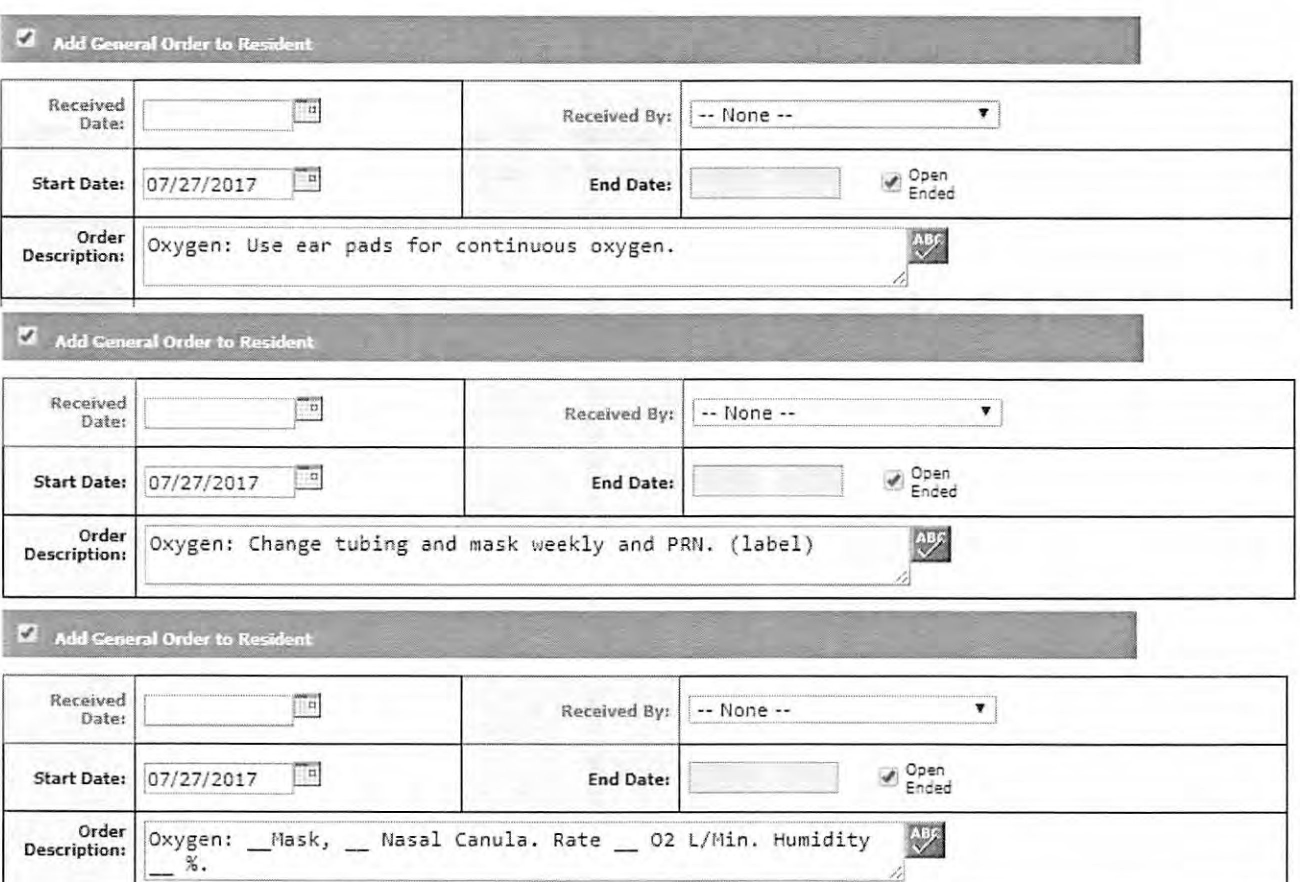
1. After clicking the blue Add Order button choose the appropriate category for the type of order you are putting in. Order sets start at Standing Orders – Admission and continue down the list. For example, if you are putting in an order for Oxygen, you would choose Respiratory. If you are entering an order for a Foley, you would choose Foley Catheter.

   -- Select One --
   Prescription
   General
   Lab
   Radiology
   Standing Orders - Admission
   Tube Feeding / Parenteral Nutrition
   Dietary
   Vaccination Status
   Foley Catheter
   Intravenous Therapy
   Intake/Output
   Vitals
   Blood Glucose
   Rehabilitative Services
   Isolation
   Restorative Nursing Services
   Skin Care Protocols
   Respiratory
   Ostomy Care
   Dialysis
   Psychiatry Protocol
   Side Effects List
   Target Behaviors
   PT Clarification Orders
   Community Access

2. In this example, we will enter in an order for Oxygen: **2L O2 continuous**. You would choose **Respiratory** on the list.
3. The next page loads. This will be a list of *possible* orders. If you want to add an order, you will need to click the checkbox in the corner of the order you would like to add. Multiple orders can be added in all at one time by clicking more than one checkbox.

   ☑ Add General Order to Resident

4. Go down the list and click on the checkbox for each order that is appropriate. You will need to read the order and make sure everything is correct, and customize it as needed. For our O2 example, you would choose the following orders:

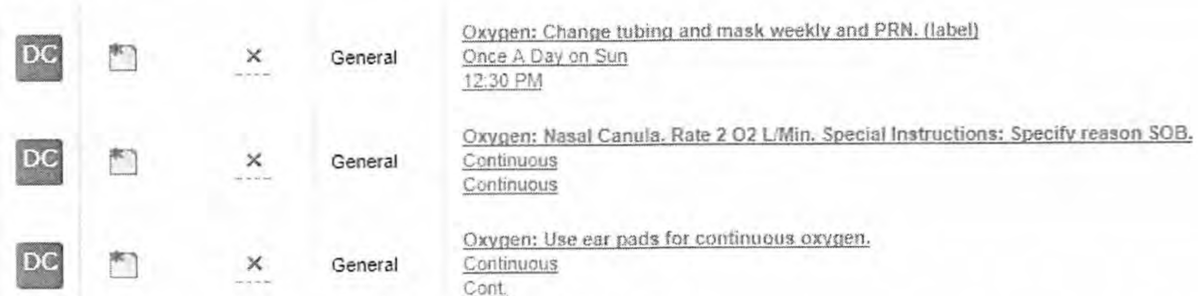


5. As you can see, if you were to just type this order in as a General order, you would likely miss the first two required orders (tubing changes and earpads). You also could miss some of the information required in the order for O2 itself.
6. The first two orders selected are fine, but as you can tell, the third order is not complete. It is important to review these orders before saving them so that you can edit them as appropriate.
7. In this case, look at the entire order and make changes. You will need to edit the **Order Description**. You will also want to look at **Special Instructions** to see if there is any additional information that needs to be added. The next page shows an example of what the order should look like when you are finished.

Add General Order to Resident

Received Date:		Received By:	-- None --
Start Date:	07/27/2017	End Date:	☑ Open Ended
Order Description:	Oxygen: Nasal Canula. Rate 2 O2 L/Min.		
Discipline(s):	☐ Dietary ☐ Nursing ☐ Physician ☐ Social Services ☐ NP ☐ PA ☐ Rec Services ☐ Student Nursing		
Schedule as Task in POC:	Select POC Charting Category(s) 0 selected		
Display for Care Needs Sign-off in POC:	☐		
Frequency:	Continuous **Description** Continuous Specify rows (1-10) 1 **Choose times / shifts:** ○ Time ○ Shift ○ PRN ◉ Custom Every Day		
Special Instructions:	Specify reason SOB.		
Task(s) to record:	**Vital Sign(s)** ☐ Temperature ☐ Respirations ☐ O2 Saturation ☐ Pulse ☐ Blood Pressure ☐ Blood Sugar **Med Note(s)** ☐ Physician Notified ☐ Site ☐ Result ☐ Units		
Description for Profile:	☐		
Category:	Respiratory Therapy	Flow sheet:	Medications
Ordered By:	Benson, Harvey	Order Class:	Physician Order

8. Once you have selected all the orders you want to add, and have customized them as appropriate, Click on the blue **Save** button on the bottom of the page. You will be taken back to the list of orders and you will see these orders have been added:



9. A nurse will need to verify the orders before they are active.
10. Unlike regular orders, orders from Order Sets cannot be signed on entry and will need to be signed afterwards.

About Verify Orders

Orders require verification if entered into the system by a user who is transcribing orders and does not have the security level to approve the orders, for example, a unit coordinator. Based on a security template, a facility can identify who needs to have orders verified before the orders are faxed and available on flow sheet reports. Only users with a security level to 'verify orders' can do so, such as a licensed nurse.

Note: Orders entered by a user with the security level to verify, do not go through the verification process.

Following is the verification process

1. A message is sent to nursing that verification of an order is required.
2. The nurse can then verify an individual order by selecting the message link, select to verify which will initiate the transmission of the order to the provider.
3. In addition, Orders and DC Orders that require a nurse's verification are held in an unverified orders page. The unverified order page allows the nurse to review all unverified orders, select to verify, and initiate the fax to the provider. This is located under the facility tab/verify orders.
4. The nurse can generate a report to pull up the list of all unverified orders (based on unit permissions).

Important: Verifying an order that is the result of discontinuing a previous order (a significant change) automatically verifies that order and the DC of the previous order. Users cannot verify the unverified DC of the previous order without verifying the new order created from the significant change. Users cannot edit the unverified DC of the previous order until the new order has been verified.

Verify Orders

When verifying and order, you are responsible for "Receiving, Verifying and Carrying out. Orders require verification if entered into the system by a user who is transcribing orders and does not have the security level to approve the orders, for example, a unit coordinator. Based on a security template, a facility can identify who needs to have orders verified before the orders are faxed and available on flow sheet reports. Only users with a security level to 'verify orders' can do so, such as a licensed nurse.

Note: Orders entered by a user with the security level to verify, do not go through the verification process.

Following is the verification process

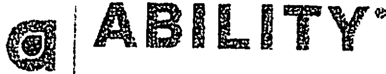
1. A message is sent to nursing that verification of an order is required. This is found in Resident Messages
2. The nurse can then verify an individual order by selecting the message link, select to verify and initiate the fax to the provider.
3. In addition, Orders and DC Orders that require a nurse's verification are held in an unverified orders page. The unverified order page allows the nurse to review all unverified orders, select to verify, and initiate the fax to the provider.
4. The nurse can generate a report to pull up the list of all unverified orders (based on unit permissions).
5. The nurse must complete the notifications to families
6. If the order enter needs to be put on the Medication, Treatment or Diabetic flowsheet, ensure this is completed.

The following additional fields display the participants in the order and verification process:

Action	Participant
Ordered By	Physician/NPPA that gave the order.
Received By	Person receiving the order. This is typically a nurse. A drop-down list of those with security to receive an order appears.
Order Entered By	Person entering the order, This could be nurse or unit coordinator, and so on, depending on the level of security.
Created By	Person verifying order, which would be the nurse. It is probably the same as the Received By person, but could be different. The usual practices in a facility practice would determine this person. A drop-down list of those with the correct security level to receive an order appears.

Note: When orders are successfully faxed, a "Fax Status" message indicates that the fax has been received at the provider's fax.

Important: Verifying an order that is the result of discontinuing a previous order (a significant change) automatically verifies that order and the DC of the previous order. Users cannot verify the unverified DC of the previous order without verifying the new order created from the significant change. Users cannot edit the unverified DC of the previous order until the new order has been verified.



Facility Assessment

Prepared by:
John Sheridan
VP Ability Network

Administration Basis in Law

- Governing Law – Section 1919 [42 U.S.C. 1396r] – **(d) (1)(A)**
  - IN GENERAL.—A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

Administration

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Facility Assessment – Here is the Question!

- Can an operator demonstrate their nursing facility use its resources effectively and efficiently?
- Can an operator show residents attain or maintain the highest practicable physical, mental, and psychosocial well-being each and everyday ?

Person-centered care.

- *For purposes of this subpart, person-centered care means*
  - *focus on the resident as the locus of control*
  - *support the resident in making their own choices*
  - *support the resident as having control over their daily lives.*
  - *§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.*

Lessons form Mega Rule

- 120 of 180 Requirements have changed (2/3 rds.)
- Three phases
  - Starts Person Centered Care
    - Resident Right
    - Assessment changes
    - Care Plan changes
    - Use of Data over time
  - Phase 2
    - Facility Assessment
    - QAPI
  - Phase 3
    - Full implementation Person Centered Care

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§483.70(e) Facility Assessment

- ***The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies.***
- ***The facility must review and update that assessment, as necessary, and at least annually.***
- ***The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.***

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The facility assessment must address or include:

1) The facility's resident population

2) The facility's resources

3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

- What about your Budget?

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The New Era – The Goal and Purpose of Healthcare Reform

- "Triple Aim":
  - Improving the patient experience of care (including quality and satisfaction);
  - Improving the health of populations; and
  - Reducing the per capita cost of health care.

  - http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx

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The facility assessment must address or include:

1) The facility's resident population, including, but not limited to,
   i. Both the number of residents and the facility's resident capacity;
   ii. The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
   iii. The staff competencies that are necessary to provide the level and types of care needed for the resident population;
   iv. The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
   v. Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

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The facility assessment must address or include:

1) The facility's resident population
   i. Both the number of residents and the facility's resident capacity
      i. Age and Gender of Residents
         i. Capacity for Males and Females
         ii. Ability to accommodate preferences
            i. What preferences are in Resident Assessment Instrument (MDS)?
            ii. What pertinent facts are in the MDS?

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The number of residents and the facility's resident capacity;

- How shall we do this?
  - Count daily census versus capacity?
  - Count people served in the period versus capacity to serve people?
  - Distinguish between licensed capacity and actual capacity?
  - How about opportunity for "days of care" and capacity for days?

Residents Served

Residents by Age Group served between
January 1, 2016 and December 31, 2016

120
100
80
60
40
20
0

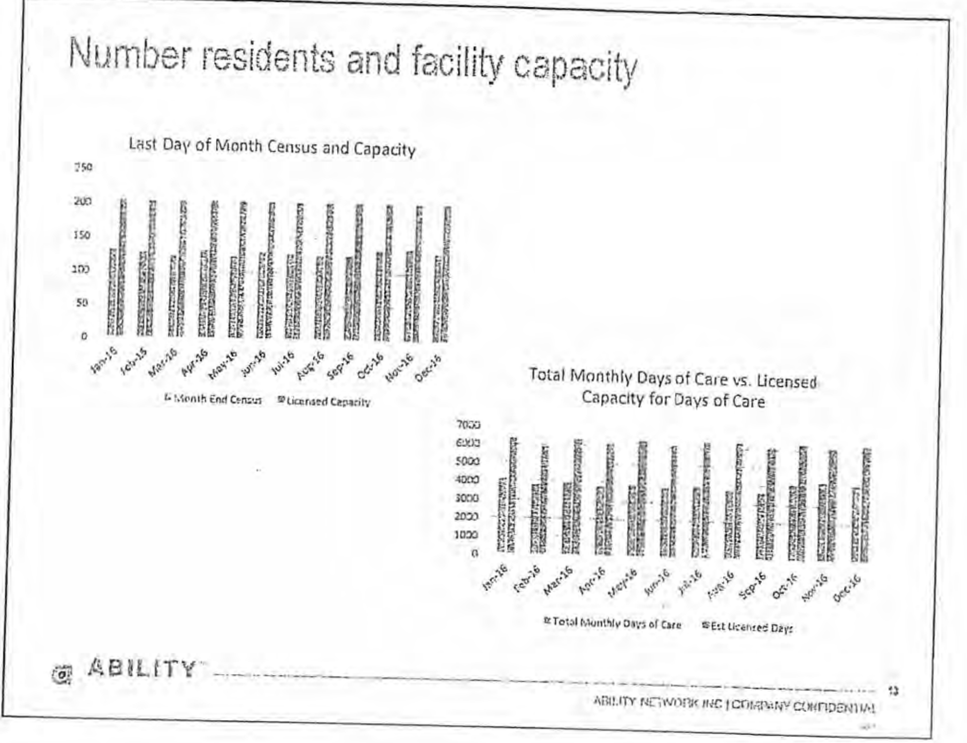
Age group	Males	Females
Less than 65	17	13
65 - 70	22	31
71 - 75	25	22
76 - 80	44	38
81 - 85	42	73
86 - 90	52	97
91 - 95	35	85
96 - 100	7	42
Greater than 100	1	10

Males Females

Total Residents served January 1, 2016 to December 31, 2016

160
140
120
100
80
60
40
20
0

Age group	Total
Less than 65	30
65 - 70	53
71 - 75	47
76 - 80	82
81 - 85	115
86 - 90	149
91 - 95	120
96 - 100	49
Greater than 100	11


Number residents and facility capacity
Last Day of Month Census and Capacity
250
200
150
100
50
0
Month End Census
Licensed Capacity
Total Monthly Days of Care vs. Licensed Capacity for Days of Care
7000
6000
5000
4000
3000
2000
1000
0
Total Monthly Days of Care
Est Licensed Days
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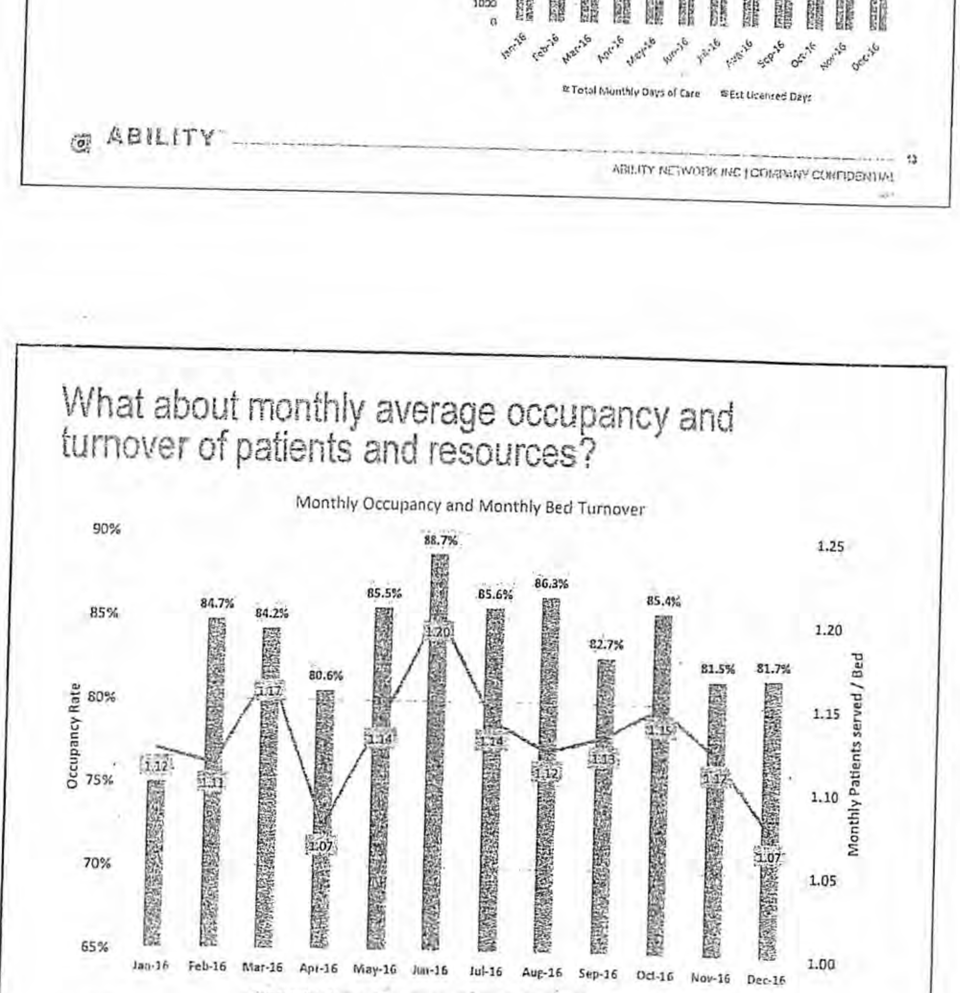
What about monthly average occupancy and turnover of patients and resources?
Monthly Occupancy and Monthly Bed Turnover
90%
85%
80%
75%
70%
65%
Occupancy Rate
84.7%
84.2%
80.6%
85.5%
88.7%
85.6%
86.3%
82.7%
85.4%
81.5%
81.7%
1.12
1.11
1.17
1.07
1.14
1.20
1.14
1.12
1.13
1.15
1.12
1.07
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
1.25
1.20
1.15
1.10
1.05
1.00
Monthly Patients served / Bed
Monthly Licensed Occupancy
Monthly Patients served / Bed
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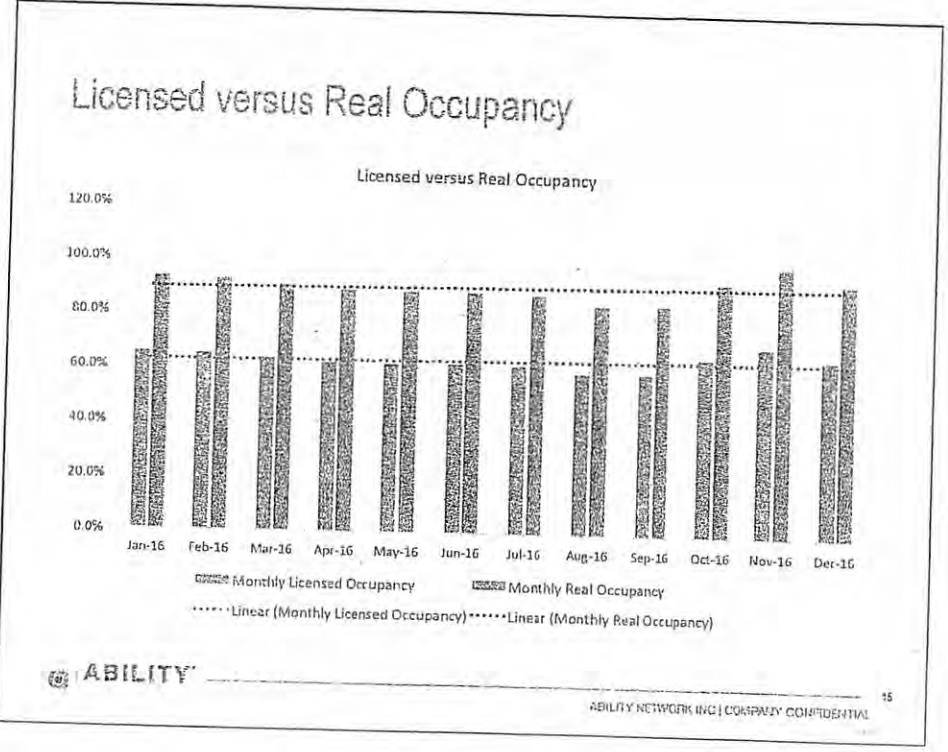

The care required by the resident population;

- ***Considering:***
  - ***Types of diseases***
  - ***Conditions***
  - ***Physical and Cognitive disabilities***
  - ***Overall acuity***
  - ***Other pertinent facts that are present within that population***

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