



# **Clinical Charting System Overview**

## **Anzer IT Solutions**

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### Table of Content

<a href="#">Clinical Charting System Application Overview.....</a>	<a href="#">3</a>
<a href="#">Multi-Functions Program Area, supported by the CCS .....</a>	<a href="#">4</a>
<a href="#">Task Tree Menu and Alerts.....</a>	<a href="#">4</a>
<a href="#">Service Plan / Recovery Plan.....</a>	<a href="#">5</a>
<a href="#">Risk Management Plan.....</a>	<a href="#">7</a>
<a href="#">Recovery Plan.....</a>	<a href="#">9</a>
<a href="#">Referrals .....</a>	<a href="#">10</a>
<a href="#">Referral Feedback .....</a>	<a href="#">11</a>
<a href="#">Pre-Admit .....</a>	<a href="#">12</a>
<a href="#">Admission.....</a>	<a href="#">14</a>
<a href="#">Discharge.....</a>	<a href="#">14</a>
<a href="#">Transfer.....</a>	<a href="#">15</a>
<a href="#">The Schedule .....</a>	<a href="#">16</a>
<a href="#">Completing Scheduled Tasks.....</a>	<a href="#">17</a>
<a href="#">The Progress Note .....</a>	<a href="#">19</a>
<a href="#">Contact tab.....</a>	<a href="#">21</a>
<a href="#">The Assessment Tools.....</a>	<a href="#">29</a>
<a href="#">Camberwell.....</a>	<a href="#">32</a>
<a href="#">CANSAS.....</a>	<a href="#">32</a>
<a href="#">CAN-C.....</a>	<a href="#">33</a>
<a href="#">Clinical Outcome Measures.....</a>	<a href="#">34</a>
<a href="#">Clinical Documentation Manager.....</a>	<a href="#">37</a>
<a href="#">Report Generator.....</a>	<a href="#">38</a>
<a href="#">Clinical Statistics and Sample Reports.....</a>	<a href="#">39</a>
<a href="#">MIS Client Contact Information and Workload.....</a>	<a href="#">41</a>
<a href="#">Discipline Specific Reports.....</a>	<a href="#">42</a>
<a href="#">CDS Demographic Reports.....</a>	<a href="#">44</a>
<a href="#">CDS Diagnosis and Illness information Reports.....</a>	<a href="#">45</a>
<a href="#">CDS Hospitalization Reports Calculated by year of Admission.....</a>	<a href="#">46</a>
<a href="#">Features that will make your charting easier.....</a>	<a href="#">47</a>



## **Clinical Charting System Application Overview**

The following is a brief application overview with a few examples of functionality and features. It is very hard to capture the scope and capabilities of the Clinical Charting System in a short Document

The CCS software application designed for a variety of Mental Health programs, both inpatient and outpatient.

There are currently ACTT, Case Management, Child and Adolescent, Psycho geriatric and 27 other Mental Health programs using the application at many different hospitals ranging from Court Diversion, to Social Recreation. The application is designed to be highly intuitive and user friendly. All familiar paper based charts have been converted to an electronic chart format. There are over 150 different forms, tables and reports available. The system requires a minimum amount of training and your staff will be up and running in no time.

**\*\*\*\*\*For a greater understanding of the Scope and Capabilities of this Product a Demonstration is recommended.**

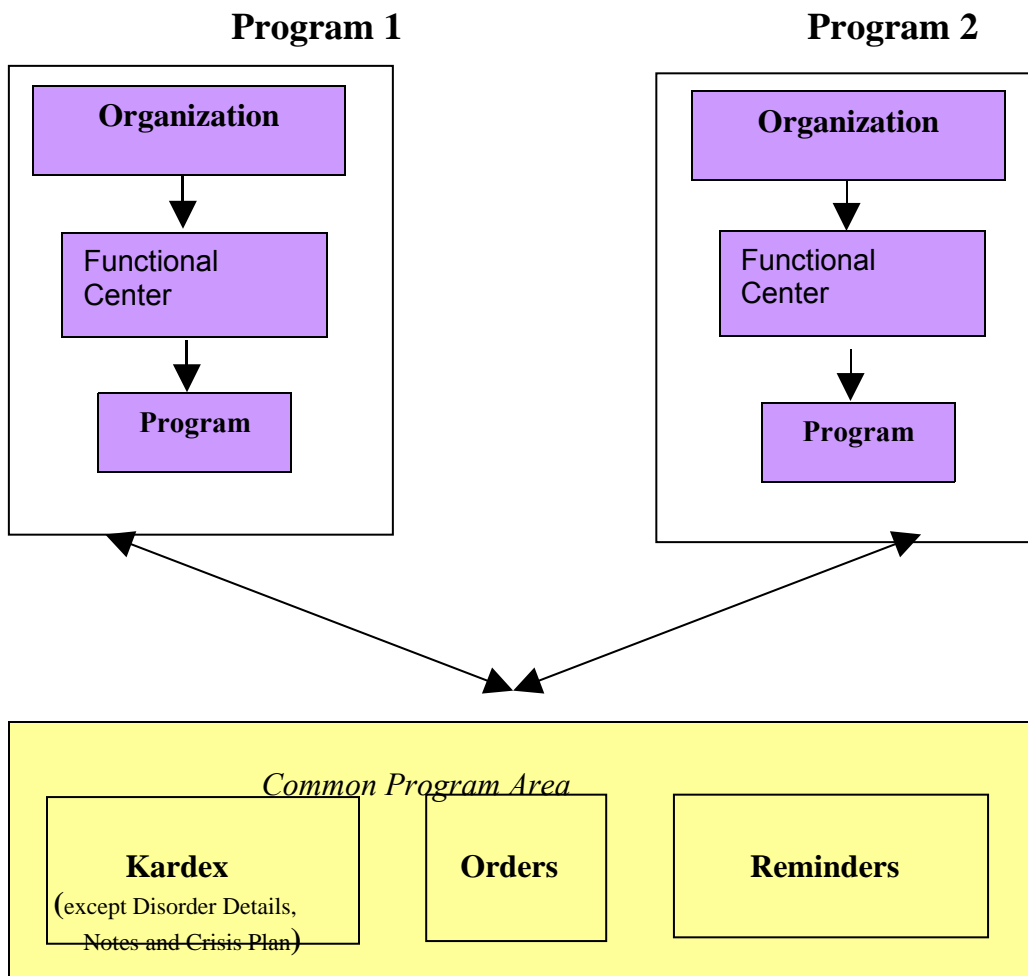


The system supports multi-functions program area, which allows user to access different data sets in the mental health sector.

## Multi-Functions Program Area, supported by the CCS

The system supports multi-functions program area, which allows user to access different data sets in the mental health sector.

Below you can see the **Multi-Functions Program Area diagram**:



The user can be authorized to operate with the specific data set. The user's right to access the appropriate **Program** (for example Program 1, Program 2, etc.) is given by a system administrator with a help of Administrating option, User Programs sub option of the CCS. For example, you can be given a right to enter and retrieve client's data in the options, which can be called as Restricted Area, such as Patient Referrals; Kardex (i.e. Disorder Details, Notes and Crisis Plan forms); Progress Note, Recovery Plan, Service Plans, Assessment Tools, etc. for the specific program, which you are

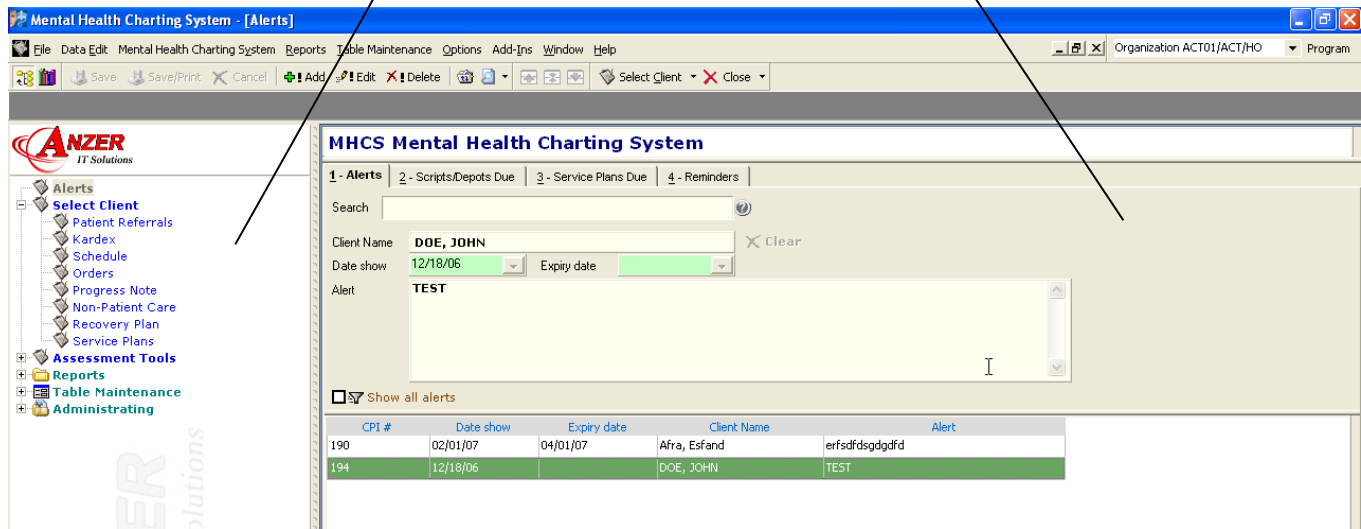
## Task Tree Menu and Alerts



The Task Tree Menu is an overview of the whole system. You have access to all options of the MHCS using the Task Tree Menu as well as Selecting Clients, managing Referrals and Discharges, generating Reports and performing other Administrative Actions. Mission critical alerts such as due dates of depot injections, scripts, service plans are provided in a dashboard type of view.

Task Tree

Alerts screen



You will see the Alerts screen with Client Alerts, Scripts/Depots Due, Service Plans Due and Reminders tabs on your screen first when you open the system. Alerts, notifications about depots and scripts due, pending service plan reassessments and reminders are permanent parts of the Alerts option. They are intended for clinicians to communicate and provide each other with a quick and easy method of accessing important and current data pertaining to clients.

## Service Plan / Recovery Plan



These documents are used by teams and their clients to map out a plan of service. There are two options to choose from when creating a plan of care for your client's.

### **Service Plan**

There are six life domains in the service plan: Medical Therapeutic, Substance Use/Abuse, Living, Learning, Working, and Social. To make easy comparisons with the previous service plan, the previous service plan's entries are carried forward into the current plan. Changes can be more easily noted, and repetitive re-entry of common information is avoided. Service plan re-assessment dates can be set independently for each life domain (medical therapeutic, substance abuse, learning, living, work, and social). This provides the flexibility to monitor a client's status in the different life domains at different intervals.

### **Recovery Plan**

The Recovery Plan option is for entering and viewing a recovery plan, which includes areas for desired change in client treatment, resources to use, steps to take as well as strengths and additional information. It relates to eight different life domains such as mental health, physical health, substance use, living, work, education and spirituality and helps to monitor a client's status.

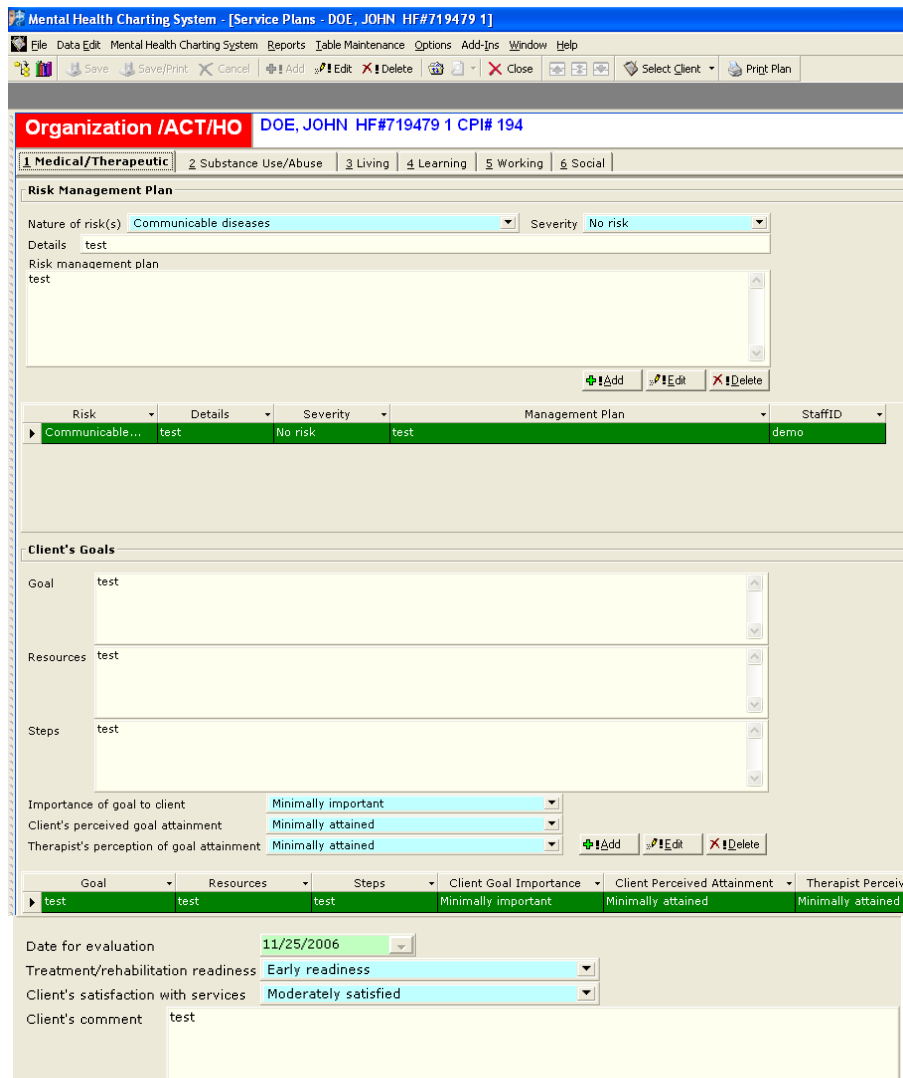
The Recovery Plan is entirely client rehabilitation focused. It includes eight different life domains and is used to map out a plan of recovery based on the client's desired changes. This plan is designed to involve and engage the client in the recovery process. The client is encouraged through the Recovery Plan to take ownership of and drive the direction of their care.

### **Service Plan**



The Service Plan has two sections: Risk Management and Rehabilitation. The risk management is an arbitrary length list of risks, which teams will need to customize. The risks are also specific to the life domain: medical risks are different than substance abuse risks, which are different from living risks, etc. The severity ratings are important in prioritizing the risks, and may need to be modified by the teams.

The rehabilitation focus is handled by the "Client Goals" section. Basically, the client stipulates what they want to achieve in a given life domain, and the staff member fills in information on the resources needed and the steps required to achieve progress towards that goal. There are also a variety of ratings regarding readiness, achievement, etc.



**Mental Health Charting System - [Service Plans - DOE, JOHN HF#719479 1]**

File Data Edit Mental Health Charting System Reports Table Maintenance Options Add-Ins Window Help

Save Save/Print Cancel Add Edit Delete Close Select Client Print Plan

**Organization /ACT/HO** DOE, JOHN HF#719479 1 CPI# 194

1 Medical/Therapeutic 2 Substance Use/Abuse 3 Living 4 Learning 5 Working 6 Social

**Risk Management Plan**

Nature of risk(s) Communicable diseases Severity No risk

Details test

Risk management plan test

Add Edit Delete

Risk	Details	Severity	Management Plan	StaffID
Communicable...	test	No risk	test	demo

**Client's Goals**

Goal test

Resources test

Steps test

Importance of goal to client Minimally important

Client's perceived goal attainment Minimally attained

Therapist's perception of goal attainment Minimally attained

Add Edit Delete

Goal	Resources	Steps	Client Goal Importance	Client Perceived Attainment	Therapist Perceiv
test	test	test	Minimally important	Minimally attained	Minimally attained

Date for evaluation 11/25/2006

Treatment/rehabilitation readiness Early readiness

Client's satisfaction with services Moderately satisfied

Client's comment test

## Risk Management Plan

You can specify nature of risk(s), severity; provide details, and a risk management plan description.



There are two combo boxes with drop-down list, namely: **Nature of risk** and **Severity** in this section.

Nature of risk(s)	Severity
Medication non-compliance	Mild risk
Treatment non-compliance (physical)	Moderate risk
Exacerbation of symptoms (psych)	Moderate-severe risk
Decrease in self-care due to physical deterioration	Severe risk
Exacerbation of symptoms (physical)	
Medication/medical regimen misuse	
Self-harm	
Aggression	

### Client's Goals

The rehabilitation focus is handled by the Client Goals section. Basically, the client stipulates what they want to achieve in a given life domain, and the staff member fills in information on the resources needed and the steps required to achieve progress towards that goal. There are also a variety of ratings regarding readiness, achievement, etc.

This contains the following entry fields: **Goal**, **Resources** and **Steps** in which the needed information should be entered.

There are three combo boxes with drop-down list, namely: **Importance of goal to client**, **Client's perceived goal attainment**, **Therapist's perception of goal** in this section.

#### Importance of goal to client

Not applicable
Minimally important
Somewhat important
Moderately important
Very important
Extremely important

#### Client's perceived goal attainment / Therapist's perception of goal

Not applicable
Not attained
Minimally attained
Partially attained
Mostly attained
Completely attained

### Date of Evaluation

Service plan reassessment dates can be set independently for each life domain (medical therapeutic, substance use/abuse, living, learning, working, and social). This provides the flexibility to monitor a client's status in the different life domains at different intervals. One week before the scheduled reassessment date, the client's name and reassessment date will appear in the Service Plan Due reminder list on the Alerts screen.



This contains -three drop-down lists, i.e. **Date of Evaluation, Treatment/rehabilitation readiness, Client satisfaction with services**

- Click the arrow on the right-hand side of the combo boxes to access the following drop-down lists.

**Date of Evaluation**

October 2006						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
24	25	26	27	28	29	30
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4

Today: 10/27/2006

**Treatment/rehabilitation readiness**

Not applicable
Pre-engagement
Engagement
Early readiness
Readiness
Early active treatment/rehabilitation
Late active treatment/rehabilitation
Goal attainment

**Client’s satisfaction with services**

Not applicable
Not satisfied
Minimally satisfied
Moderately satisfied
Very satisfied
Extremely satisfied

**Service plans** are linked to the individual clinician charting or can be set to allow additions from multiple clinicians. .

When you open the Service Plans option you are creating a new plan – if you have created a previous service plan for a client the last service plan for each environment will be carried forward to the new plan. This is designed to ease re-typing requirements.

**Recovery Plan**

The Recovery Plans option is for entering and viewing recovery plan data, which includes desired change, resources to use, steps to take as well as strengths and additional information. This recovery plan relates to eight different life domains such as mental health, physical health, substance use, living, work, education and spirituality.



Recovery plans can be set independently for any life domain such as mental health, physical health, substance use, living, work/volunteering, education, social and spirituality. Accessing appropriate tab of this option enables you to enter the data for each life domain.

Mental Health Charting System - [Recovery Plan - DOE, JOHN HF#719479 1]

File Data Edit Mental Health Charting System Reports Table Maintenance Options Add-Ins Window Help

Save Save/Print Cancel Add Edit Delete Close Select Client Print Recovery

**Organization /ACT/HO** DOE, JOHN HF#719479 1 CPI# 194

1 Mental Health 2 Physical Health 3 Substance Use 4 Living 5 Work/Volunteering 6 Education 7 Social 8 Spirituality

Save Cancel Delete Updated 01/30/2007 Next Review 02/15/2007

Desired Change test

Resources test

Steps test

Strengths test

Additional Information test

Staff	Updated	Next Review	Desired Change	Resources	Steps	Strengths	Additional Information
demo	1/30/2007..		test	test	test	test	test

These are free text areas for writing

- Goals to achieve in the given life domain - in the **‘Desired Change’**;
- Information on the resources needed - in the **‘Resources’**;
- Steps required to achieve goals - in the **‘Steps’**;
- What strengths the client possesses that may help with desired change – in the **Strengths**;
- Additional information if required – in the **‘Additional Information’**.

## Referrals

Upon accessing the Patient referrals option, the **Referrals tab screen** will be displayed first as follows:



**Mental Health Charting System - [Patient referrals - DOE, JOHN HF#719479 1]**

File Data Edit Mental Health Charting System Reports Table Maintenance Options Add-Ins Window Help

Save Cancel Add Edit Delete Close Select Client

**Organization /ACT/HO** DOE, JOHN HF#719479 1 CPI# 194

1 Referrals 2 Referral feedback 3 Pre-Admit 4 Admit 5 Discharge summary

Referral number: M\*06-1 Referral Date: 12/20/2006

Referring Agency: Family Practioner

Source Type: General Hospital

Address: 541 Eglinton Ave. E.

Telephone: (416) 487-2442 Fax: (416) 487-2508

Referred by: Phone:

**Presenting Issues :**

Threat to others/attempted suicide  Educational  Problem with Relationships

Specific symptom of Serious Mental Illness  Housing  Problem with substance abuse/additions

Physical/Sexual Abuse  Financial  Activities of daily living

Occupational/Employment/Vocational  Legal  Other

**Details :**

test

Referral discussed with client  Referral discussed with physician

Referral discussed with family  Release completed

Comments:

Referral Number	Referral Date	Referring Agency	Address	Phone	Fax	Referred by	Telephone
M*06-1	12/20/2006...	Family Practioner	541 Eglinton...		(416) 487-2508		(416) 487-2442
2	12/11/2006	Rehab Express			(416) 226-2469		(416) 226-6141

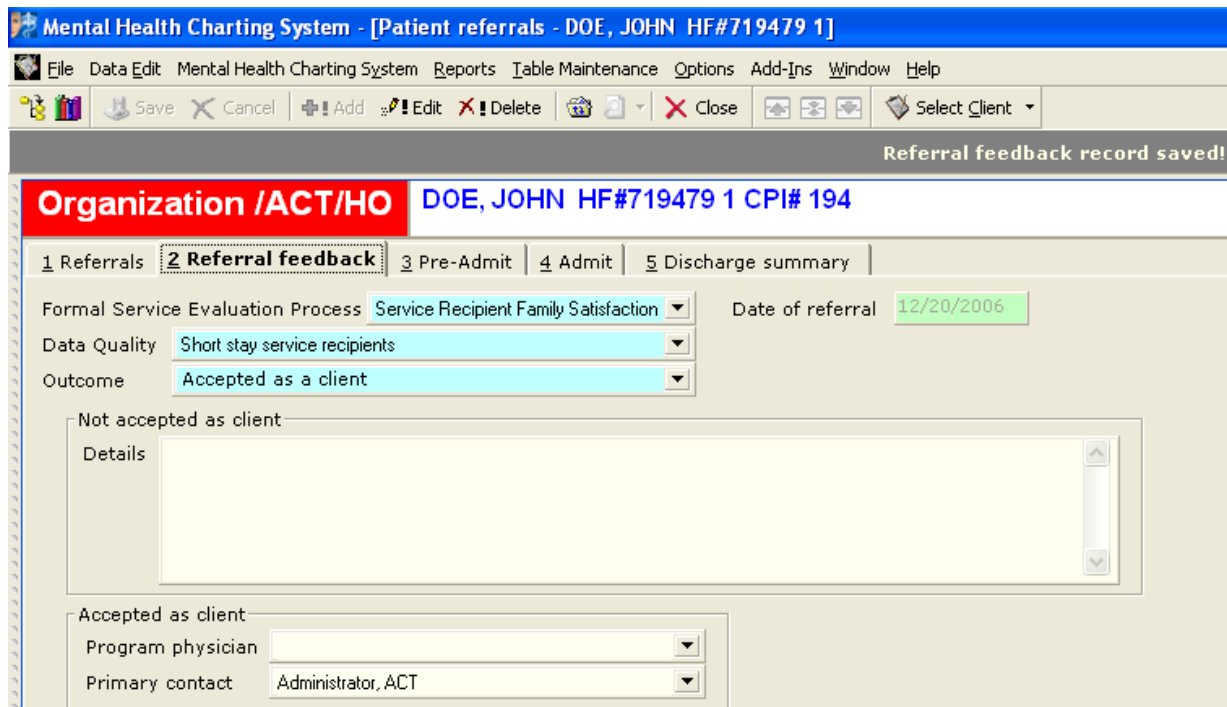
**Note:** The client may have several referrals and one Referral Feedback, Pre-Admit, Admit as well as Discharge Summary per one Referral record.  
 A referral number can be automatically given by the system and displays in the **Referral Number** field, or this function can be disabled to allow manual referrals.

## Referral Feedback

Referral feedback is provided to facilitate communication and the recording of outcome of the referral



Upon accessing the ‘Referral Feedback’ tab, the following screen will be displayed:



The screenshot shows the 'Mental Health Charting System' window for patient 'DOE, JOHN HF#719479 1'. The 'Referral feedback' tab is active, displaying a 'Referral feedback record saved!' message. The interface includes a menu bar (File, Data, Edit, Reports, Table Maintenance, Options, Add-Ins, Window, Help) and a toolbar with icons for Save, Cancel, Add, Edit, Delete, Close, and Select Client. The main area shows the patient's name and ID, and a series of tabs: 1 Referrals, 2 Referral feedback (selected), 3 Pre-Admit, 4 Admit, and 5 Discharge summary. The 'Referral feedback' tab contains several dropdown menus: 'Formal Service Evaluation Process' (Service Recipient Family Satisfaction), 'Data Quality' (Short stay service recipients), and 'Outcome' (Accepted as a client). A 'Date of referral' field is set to 12/20/2006. Below these are sections for 'Not accepted as client' (with a 'Details' text area) and 'Accepted as client' (with dropdowns for 'Program physician' and 'Primary contact' set to 'Administrator, ACT').

The Referral Feedback tab is linked to the current referral. So the **Date of Referral** is automatically displayed on this tab and the entry field in this combo box is disabled.

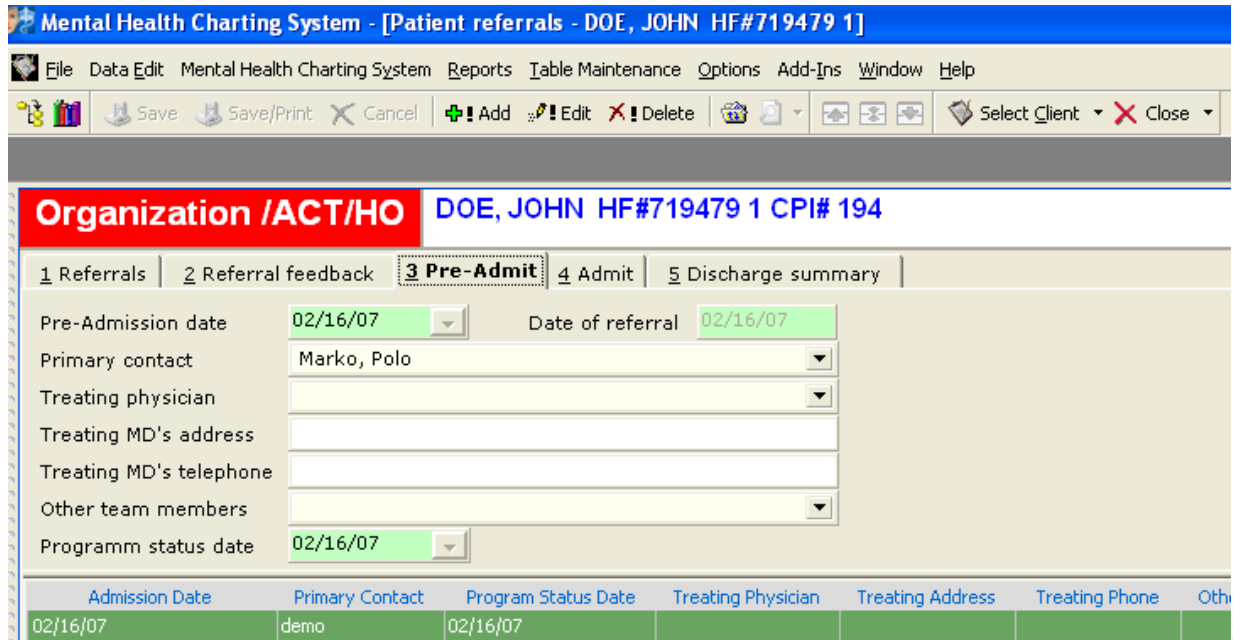
## Pre-Admit

This option enables you to chart the pre-admitting information including a name of a treating physician, who examined the client before admission, pre-admission date. Other team members



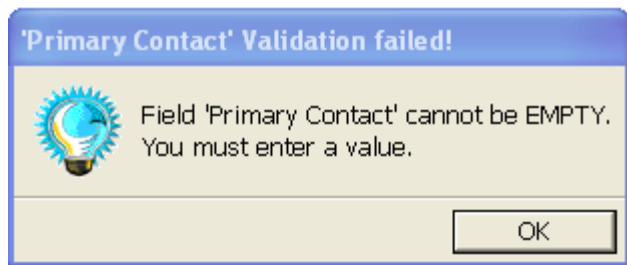
can be specified as well. Assign a primary clinician in the **Primary Contact** combo box, any other team members can be assigned at this time as well.

This information will automatically port over to the Admit Record when it is created



The **Pre-Admit** tab is linked to the current referral being displayed on the Referrals tab. So the **Date of Referral** is automatically displayed on this tab and the field in this combo box is disabled.

Then you should specify a name of a staff member for primary contact in the **Primary Contact** combo box selecting it from the drop-down list of the respective combo box. This combo box is mandatory. Otherwise the following information window shows up after saving the entries:



You need to specify a name of **Treating Physician** by selecting needed doctor from the drop-down doctor's list, which has been entered in the Doctor's List Table. The **Address** of selected treating physician and his **Telephone** are automatically displayed in the appropriate fields.

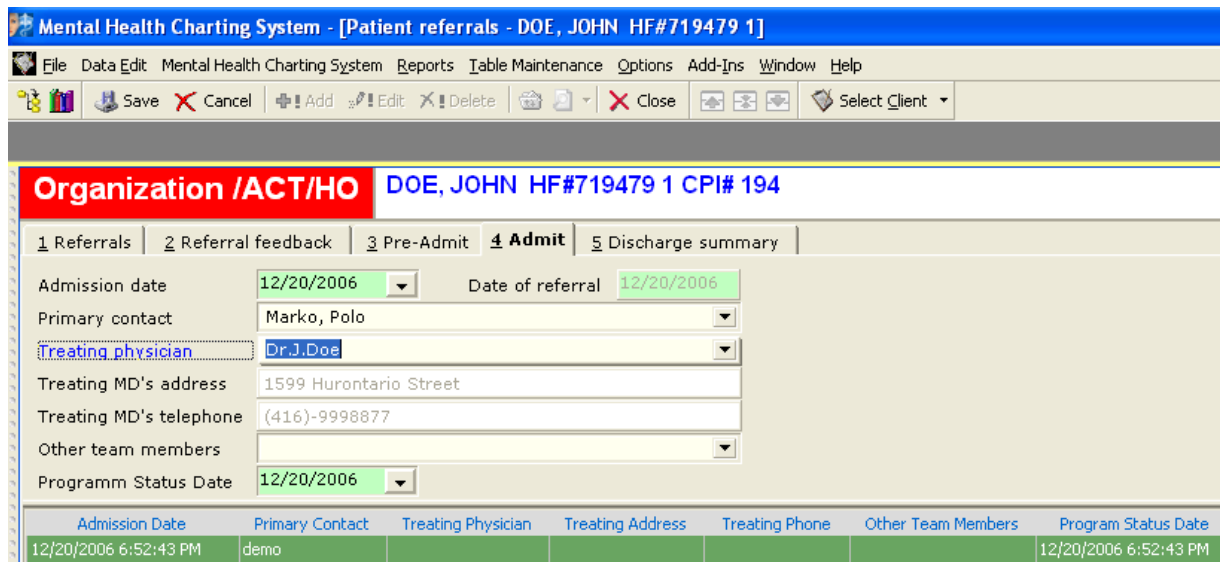
The user can enter names of other team members in the **Other Team Members** text entry field when the client needs their examination.



Clinicians can examine the client more than once before final decision concerning the admission has taken. You should specify the dates of the next pre-admission by selecting a date from date selector calendar, which automatically opens with today's marked date by clicking downward arrow at the right hand end of the **Program Status Date** combo box.

## Admission

This option enables you to chart the client's admission information including treating physician, who examined the client while admitting; the date of his admission, and contact information for treating MD. Other team members can be specified if they examined the client as well.



The screenshot shows the 'Mental Health Charting System' interface for a patient named 'DOE, JOHN HF#719479 1'. The 'Admit' tab is selected, showing the following fields:

- Admission date: 12/20/2006
- Date of referral: 12/20/2006
- Primary contact: Marko, Polo
- Treating physician: Dr. J. Doe
- Treating MD's address: 1599 Hurontario Street
- Treating MD's telephone: (416)-9998877
- Other team members: (empty)
- Program Status Date: 12/20/2006

At the bottom, a table displays the current record's data:

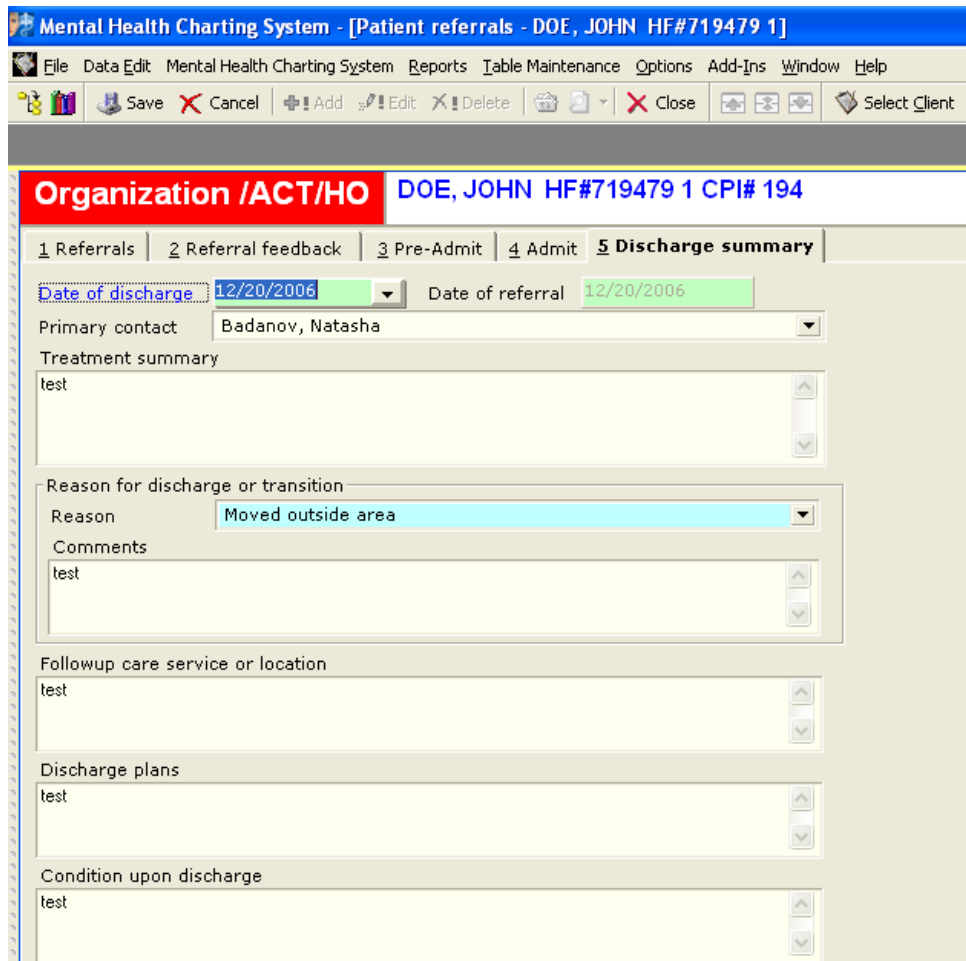
Admission Date	Primary Contact	Treating Physician	Treating Address	Treating Phone	Other Team Members	Program Status Date
12/20/2006 6:52:43 PM	demo					12/20/2006 6:52:43 PM

The **Admit** tab is linked to the current referral being displayed on the Referrals tab. So the **Date of Referral** is automatically displayed on the Admit tab and the entry field in this combo box is disabled.

Then you should enter the admission date, which defaults as current one in the **Admission Date** combo box. This date cannot backdate the Referral and Pre-Admission Dates or postdate the Discharge Date. The current date defaults there. Otherwise the following information window shows up after saving the record:

## Discharge

A brief discharge summary can be completed for each referral. As with the referral feedback, pre-admit and admit, the discharge summary is linked to the current referral being displayed on the referral tab.

The **Discharge** tab is linked to the current referral being displayed on the Referrals tab. So the **Date of Referral** is automatically displayed on this tab and the entry field in this combo boxes is disabled.

Then you should enter the discharge date, which defaults as current one in the **Discharge Date** combo box. This date cannot backdate the Referral or postdate the current one, which defaults in this combo box. Otherwise the following information window shows up after saving the record:

Then you should specify a name of a staff member for primary contact in the **Primary Contact** combo box selecting it from the drop-down list of the respective combo box. This combo box is mandatory. Otherwise the following information window shows up after saving the entries:

You can enter the description of treatment in the **Treatment Summary** text entry field and specify a reason for discharge in the **Reason for Discharge or Transition** group of fields where you should select a reason from the drop-down list of the respective combo box. Comments can be added in the **Comments** text entry field if required.

## Transfer

We have an advanced transfer system that allows clients to be transfer to both internal and external programs and agencies. This file can be sent via mail, fax, email, or XML.



CCS - Clinical Charting System - MetaFrame Presentation Server Client

CCS Clinical Charting System - [Patient referrals - LOU, CINDY CPI#236]

File Data Edit CCS Clinical Charting System Reports Table Maintenance Options Add-Ins Window Help

Save Save/Print Cancel Add Edit Delete Select Client

**Bloorview Kid/Seati/Physi** LOU, CINDY CPI#236

1 Referrals 2 Referral feedback 3 Pre-Admit 4 Admit 5 Discharge summary **6 Transfer**

Type: Internal Date of transfer: 09/21/07

Program:

Send by: Mail

- Mail
- Fax
- Email
- XML

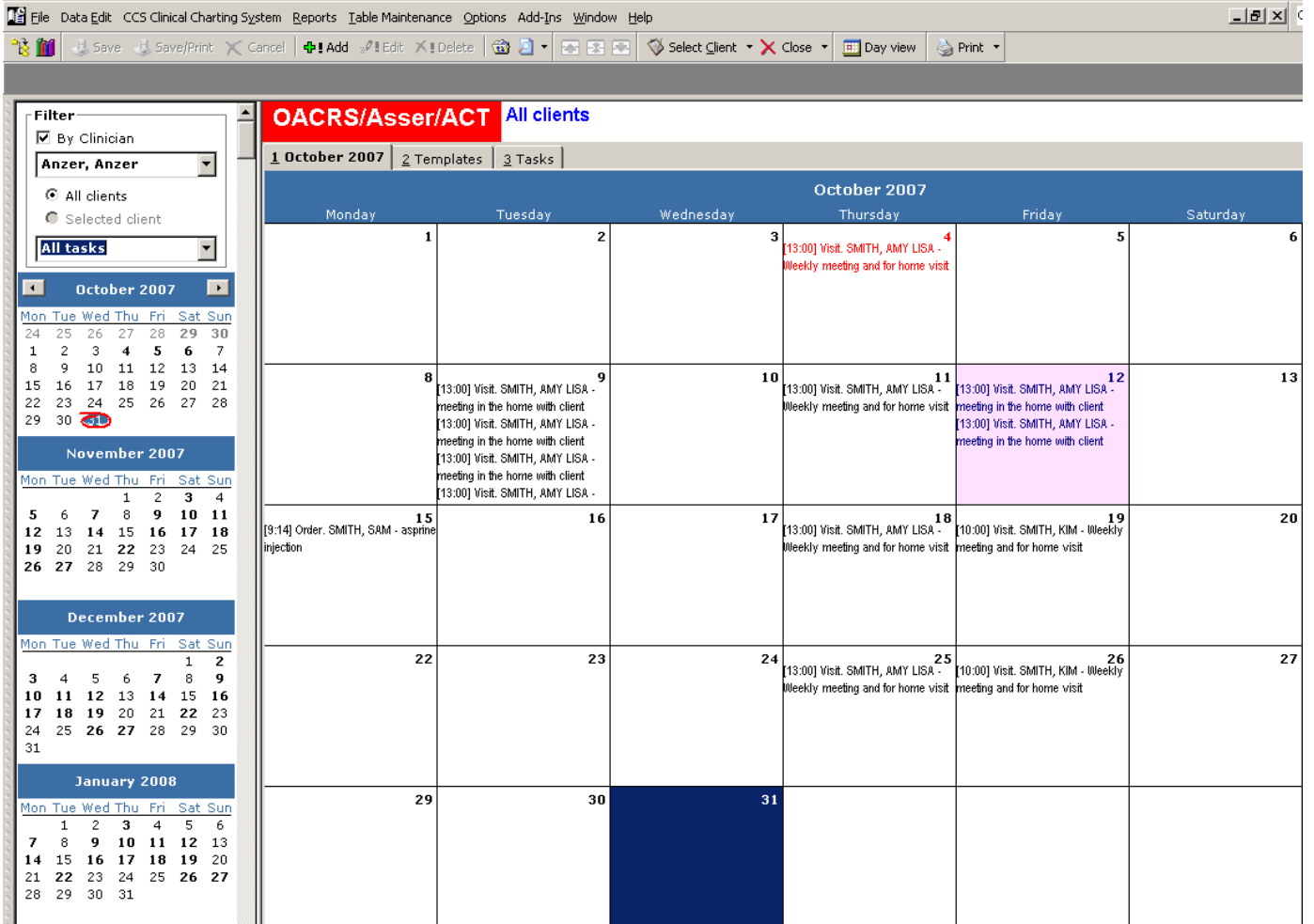
## The Schedule

This module is an excellent planning guide for scheduling service days for clients. It's designed for Clinicians to populate with scheduled visits, med drops, injections, and other service the client is going to receive. It is integrated with the Progress Notes for easy charting.



\*\*\*\*This is a modified schedule used for Outpatient Clinical programs such as ACT and Case Management.

The schedule also offers a visual guide by colour coding tasks that are outstanding, complete or partially complete.



The screenshot shows a software window titled "OACRS/Asser/ACT All clients". The interface includes a menu bar (File, Data Edit, CCS Clinical Charting System, Reports, Table Maintenance, Options, Add-Ins, Window, Help) and a toolbar with options like Save, Save/Print, Cancel, Add, Edit, Delete, Select Client, Close, Day view, and Print. On the left, there is a "Filter" panel with options for "By Clinician" (Anzer, Anzer), "All clients", and "Selected client", along with a "All tasks" filter. Below the filter is a calendar navigation section for October 2007, November 2007, and December 2007. The main area is a calendar grid for October 2007, with columns for Monday through Saturday. Tasks are scheduled as follows:

- Monday 1: No tasks.
- Tuesday 2: No tasks.
- Wednesday 3: No tasks.
- Thursday 4: [13:00] Visit. SMITH, AMY LISA - Weekly meeting and for home visit.
- Friday 5: No tasks.
- Saturday 6: No tasks.
- Sunday 7: No tasks.
- Monday 8: [13:00] Visit. SMITH, AMY LISA - meeting in the home with client.
- Tuesday 9: [13:00] Visit. SMITH, AMY LISA - meeting in the home with client.
- Wednesday 10: [13:00] Visit. SMITH, AMY LISA - Weekly meeting and for home visit.
- Thursday 11: [13:00] Visit. SMITH, AMY LISA - meeting in the home with client.
- Friday 12: [13:00] Visit. SMITH, AMY LISA - meeting in the home with client.
- Saturday 13: No tasks.
- Sunday 14: No tasks.
- Monday 15: [9:14] Order. SMITH, SAM - aspirine injection.
- Tuesday 16: No tasks.
- Wednesday 17: No tasks.
- Thursday 18: [13:00] Visit. SMITH, AMY LISA - Weekly meeting and for home visit.
- Friday 19: [10:00] Visit. SMITH, KIM - Weekly meeting and for home visit.
- Saturday 20: No tasks.
- Sunday 21: No tasks.
- Monday 22: No tasks.
- Tuesday 23: No tasks.
- Wednesday 24: No tasks.
- Thursday 25: [13:00] Visit. SMITH, AMY LISA - Weekly meeting and for home visit.
- Friday 26: [10:00] Visit. SMITH, KIM - Weekly meeting and for home visit.
- Saturday 27: No tasks.
- Sunday 28: No tasks.
- Monday 29: No tasks.
- Tuesday 30: No tasks.
- Wednesday 31: No tasks.

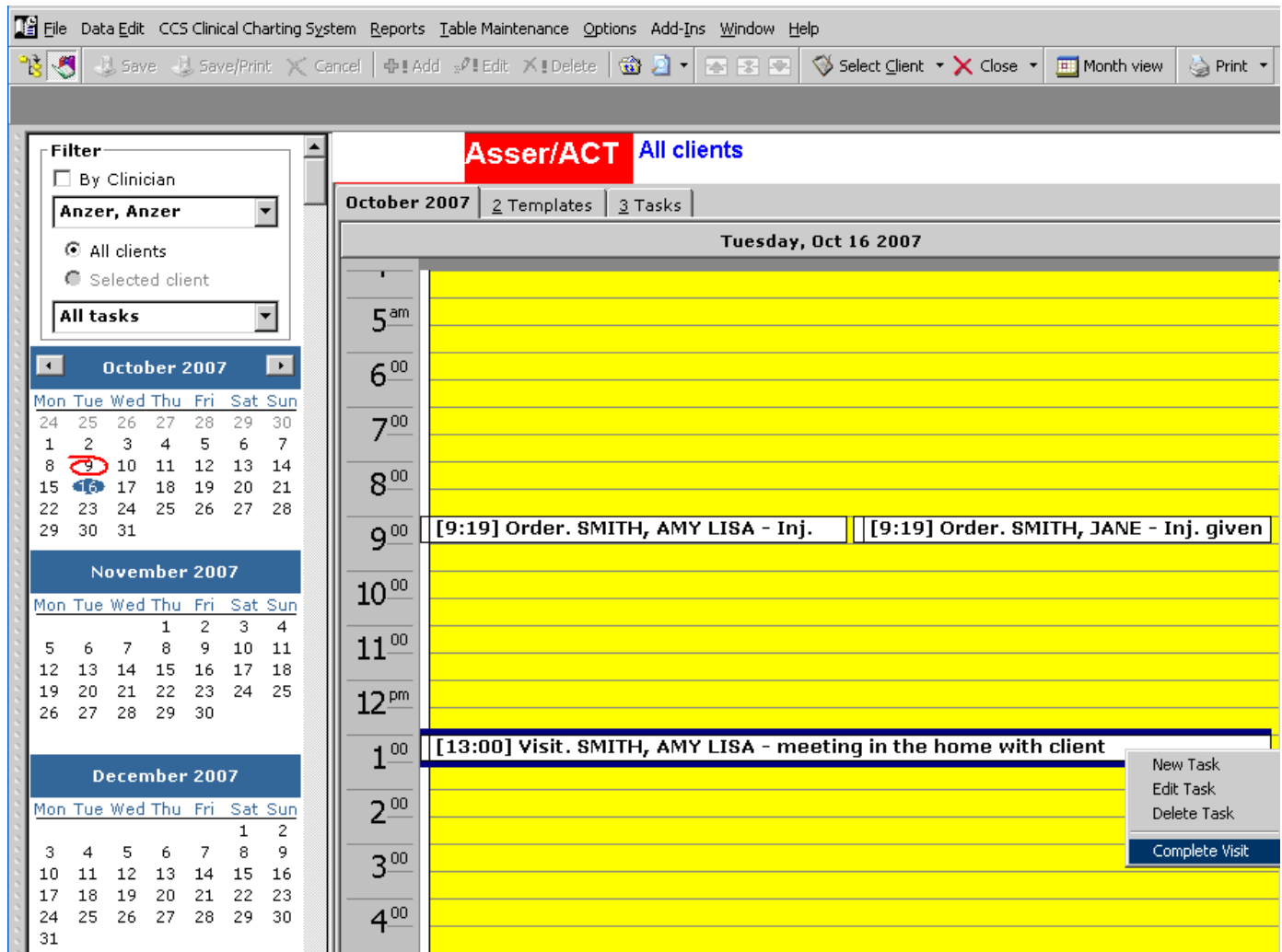
## Completing Scheduled Tasks



Completing Progress Notes, Order Actions and Renewing/Refilling Scripts from the schedule are streamlined and simple.

The schedule will automatically notify you when any injections or script refills are due. You can schedule and complete your visits, orders, and scripts on the schedule screen by “right clicking” on the completed task and selecting “Complete Visit”.

When “complete visit” is selected the program goes directly to the client's file and opens up a progress note with all of the information ported over from the schedule.



The screenshot displays the ANZER Clinical Charting System interface. At the top, there is a menu bar with options like File, Data Edit, Reports, Table Maintenance, Options, Add-Ins, Window, and Help. Below the menu bar is a toolbar with various icons for actions like Save, Save/Print, Cancel, Add, Edit, Delete, and Select Client. The main interface is divided into several sections:

- Filter Panel (Left):** Contains a 'Filter' section with a dropdown for 'By Clinician' (set to 'Anzer, Anzer'), radio buttons for 'All clients' (selected) and 'Selected client', and a dropdown for 'All tasks'.
- Calendar (Left):** Shows a monthly calendar for October 2007, with the 16th highlighted in blue.
- Schedule Grid (Main):** Displays a grid for Tuesday, Oct 16, 2007. The grid is mostly yellow, indicating no tasks. There are two task entries:
  - At 9:00: "[9:19] Order. SMITH, AMY LISA - Inj." and "[9:19] Order. SMITH, JANE - Inj. given"
  - At 1:00: "[13:00] Visit. SMITH, AMY LISA - meeting in the home with client"
- Context Menu (Right):** A menu is open over the 1:00 task, showing options: 'New Task', 'Edit Task', 'Delete Task', and 'Complete Visit'.

### Advanced Filtering and Printing Options on the Schedule

The Filtering Options on the schedule allows a user to see and print a schedule by Clinician, by a specific Client, and you can drill down to see All tasks, Operating Tasks completed tasks and unassigned tasks.



**Filter**

By Clinician

Anzer, Anzer

All clients

Selected client

All tasks

All tasks

Operating tasks

Completed tasks

Unassigned tasks

The printing options for the schedule include option by clinician, by client, and All Scheduled Activities

Print

Schedule by Clinician

Schedule by Client

All Scheduled Activities

### All Scheduled Activities

Status: All tasks

Start Date: 10/09/2007

End Date: 10/31/2007

Date	Time	Type	ClientName	Description	Clinicians	Completed
10/09/2007	13:00	Visit	SMITH, AMY LISA	meeting in the home with client	Anzer, Anzer	No

### The Progress Note



This is the heart of the system. Each progress note has a contact, which is an interaction of a staff member with someone (typically the Client) to affect some sort of treatment, assessment or consultation. The application captures the workload measures as part of the charting process. For a given contact, you will have one or more interventions, which can be assessment, therapeutic, or consultation interventions. These categories are stipulated by the Government. Progress Notes are used to enter and retrieve information about your day-to-day clinical work with a given client. There is a Clinical Contact pane for entering contact information (when, where, how, etc.), and a Service provided pane for entering assessment, consultation, and therapeutic information. Also, “general patient care” is available for charting general patient care activities and “note additions” for additional information for past progress notes. A progress note text entry field is available that allows the entry of narrative clinical information.

The Mental Health Charting System supports different service time reporting options (service time reporting at the level of the individual intervention, and service time reporting at the level of the Contact (when, where, how, etc.). Documentation is provided for both service time reporting options, please, refer to the documentation that reflects your clinic’s service time reporting policy.

\*Note There are three different Progress Note options and formats to choose from to best suit your charting needs.

Progress Notes are used to enter and retrieve information about user’s day-to-day clinical work with a given client.

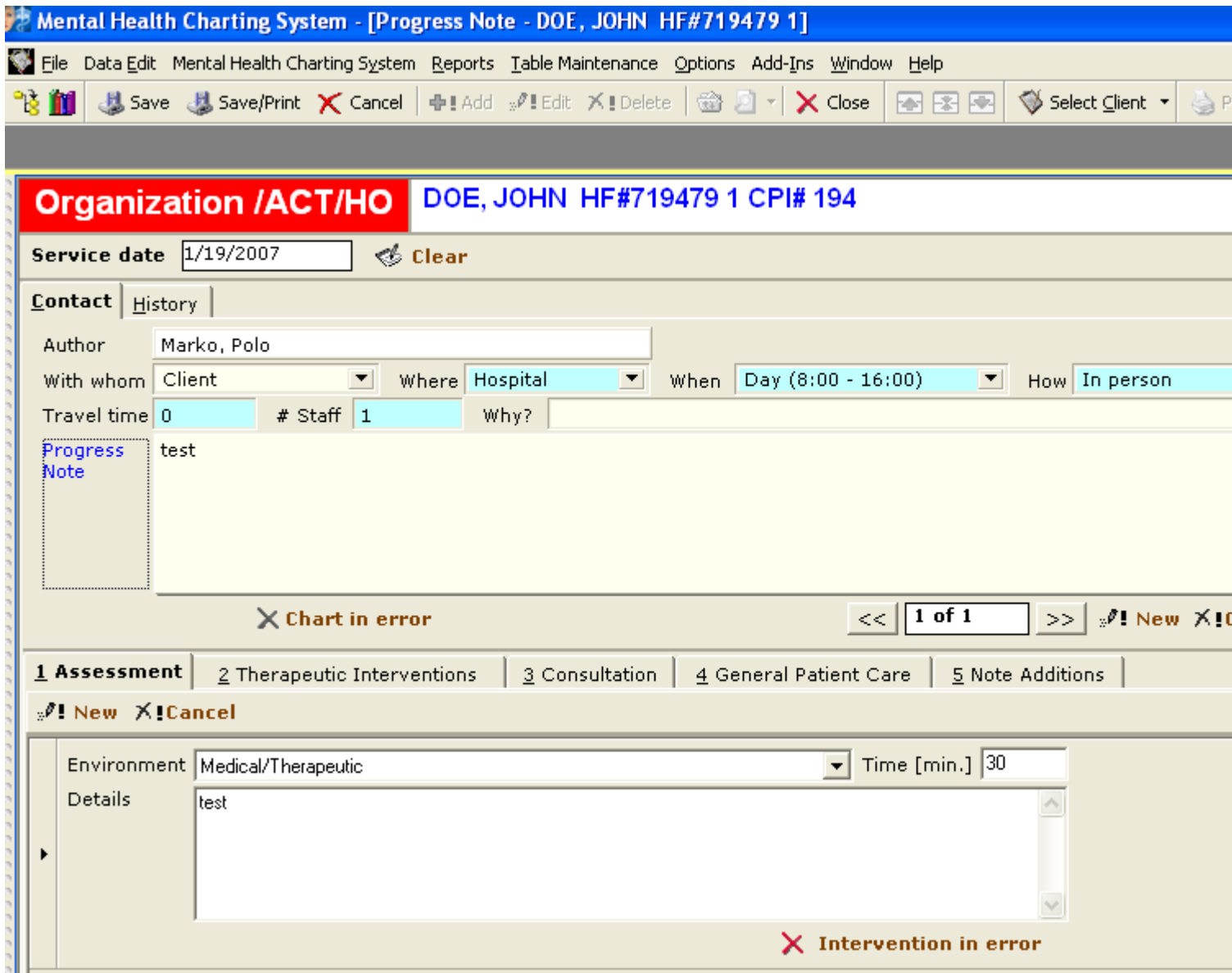
**This option contains two tabs: ‘Contact’ and ‘History’.**



## Contact tab

Each progress note has a contact, which is an interaction of a staff member with someone (typically the Client) to affect some sort of treatment, assessment or consultation. The application captures the workload measures as a part of the charting process. For a given contact, you will have one or more interventions, which can be assessment, medical/therapeutic, or consultation interventions. You can enter information regarding general patient care activities.

Upon accessing the Progress Note', the **Contact tab** screen will display first as follows:



**Mental Health Charting System - [Progress Note - DOE, JOHN HF#719479 1]**

File Data Edit Mental Health Charting System Reports Table Maintenance Options Add-Ins Window Help

Save Save/Print Cancel Add Edit Delete Close Select Client

**Organization /ACT/HO** DOE, JOHN HF#719479 1 CPI# 194

Service date 1/19/2007 Clear

**Contact** History

Author Marko, Polo

With whom Client Where Hospital When Day (8:00 - 16:00) How In person

Travel time 0 # Staff 1 Why?

Progress Note test

Chart in error 1 of 1 New Cancel

1 Assessment 2 Therapeutic Interventions 3 Consultation 4 General Patient Care 5 Note Additions

New Cancel

Environment Medical/Therapeutic Time [min.] 30

Details test

Intervention in error



## Clinical Contact pane

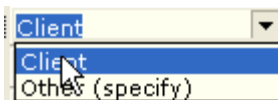
The Mental Health Charting System supports different levels of service time, namely service time at the level of the Contact (when, where, how, etc.) and service time at the level of the individual intervention (why). The service time is entered in minutes for each individual intervention chart.

The user should enter the required information into the fields:

There are **combo boxes** with drop-down lists that can be customized to reflect each programs clinical activities. Here the user can enter the context of the clinical encounter. They are as follows: **With whom, Where, When, How.**

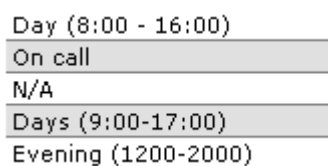
- Click the arrow on the right-hand side of the combo boxes to access the following drop-down lists.

### **With whom**




*Note: You can type in the name of the specific "Other" person involved in the contact*

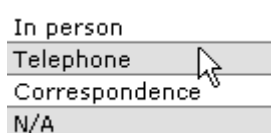
### **When**



### **Where**



### **How**



**Progress Note.** This is where you enter your narrative process note for this client. The upper limit to the size of your process note is approximately 4 typed pages. The process notes entered are linked to each contact charted.

**Note:** *You can chart an unlimited number of contacts.*

## Service Provided



This pane contains the following **subtabs: Assessment, Therapeutic Interventions, Consultation, General Patient Care** and **Note Additions**.

For each date of service the lower part of the Progress Note is where you enter the details of the service provided during each contact charted. The details of the service provided are linked to the context of the clinical encounter, as such; the details cannot be entered until you have entered the full Contact information (With Whom, Where, When, How, and, if time is being reported at the contact level, the Service time).

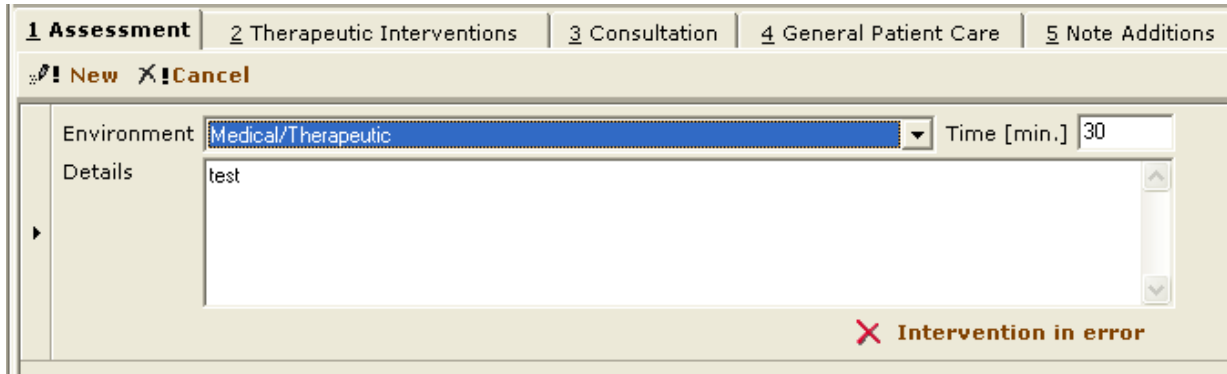
Charting of the details of the service provided is done by **type of activity (e.g. Assessment, Therapeutic Interventions, Consultation, General Patient Care)**.

For Assessment, Therapeutic Interventions, and Consultation activities charting details are also linked to the service environment (e.g. Medical/Therapeutic, Substance use/abuse, Learning, Living, Working, and Social). General Patient Care activities are those clinical activities that cross service environment – for example, a comprehensive Intake assessment completed with a client would involve all service environments and be charted on the General Patient Care subtab.

If service time is reported at the Contact level: you would also chart your service time for each contact on this pane.

### **Assessment Subtab**

Upon accessing the **Assessment tab**, the following **screen** is displayed:

The user can do the following to display the required record in **the Environment combo box**:

Medical/Therapeutic
Substance use/abuse
Learning
Living
Working
Social

- Click the arrow on the right-hand side of the combo boxes to access the above said drop-down list.
- Click the required record in the drop down lists to display it in the combo box.

When the combo box has been completed the user can enter needed information into the entry fields of this pane such as: **Time and Details**.

*Note:* The content of the Environment field on this pane is linked to the Time Field.

### **Therapeutic Interventions Subtab**

Upon selecting the **Therapeutic Interventions tab**, the following **screen** is displayed:



1 Assessment | **2 Therapeutic Interventions** | 3 Consultation | 4 General Patient Care | 5 Note Additions

! New X! Cancel

Environment: Living Time [min.]: 40

Risk or Rehab: Risk reduction Intervention: Daily living skill related intervention

Details: test

X Intervention in error

For Therapeutic Interventions, the service provided is linked to the following **combo boxes**:

- **Environment**
- **Risk or Rehab**
- **Intervention.**

**Environment**

- Medical/Therapeutic
- Substance use/abuse
- Learning
- Living
- Working
- Social

**Risk or Rehab**

- Risk reduction
- Rehabilitation
- Support

**Intervention**

- Crisis intervention
- Daily living skill related intervention
- Finance related intervention
- Housing related intervention
- Legal related intervention
- Other
- Supportive counselling

The user should do the following to display the required record in the combo box:

- Click the arrow on the right-hand side of the combo box to access the above said drop-down lists.
- Click the required record in the drop down lists to display it in the combo box.

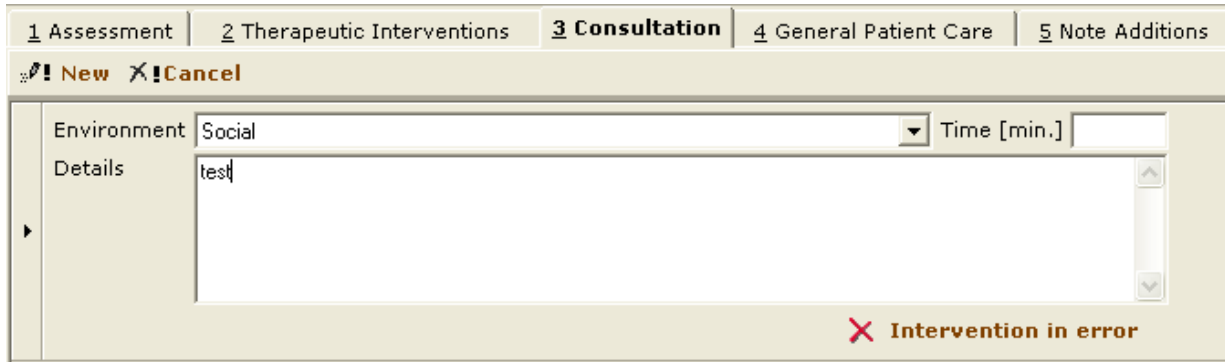
When the combo boxes have been completed, the user can enter needed information into the entry fields of this pane such as: **Time and Details**. The content of the fields in this on this pane are linked between each other. If any field is empty on this subtab, information windows will show up as follows:

**Consultation Subtab**



You can chart the consultation activity information here, specifying the type of environment, the time for activity provided and the details.

Upon accessing the **Consultation tab** the following **screen** is displayed:



The user should do the following to display the required record in the **Environment combo box**:

- |                     |
|---------------------|
| Medical/Therapeutic |
| Substance use/abuse |
| Learning            |
| Living              |
| Working             |
| Social              |

- Click the arrow on the right-hand side of the combo boxes to access the above said drop-down list.
- Click the required record in the drop down lists to display it in the combo box.

When the combo box has been completed the user should enter needed information into the entry fields of this such as: **Time and Details**.

*Note: The content of the Environment field on this subtab is linked to the Time field.*

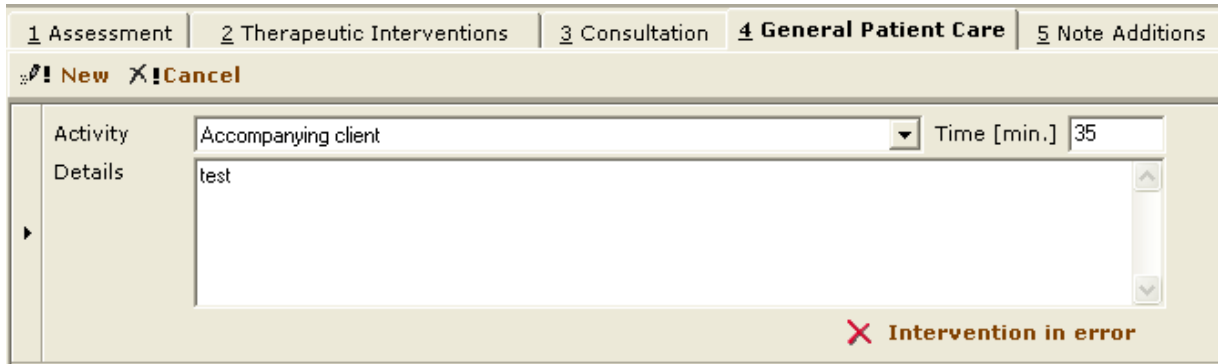
The Environment and Time entry fields are mandatory. You should fill them in before switching to another tab.

**General Patient Care Subtab**

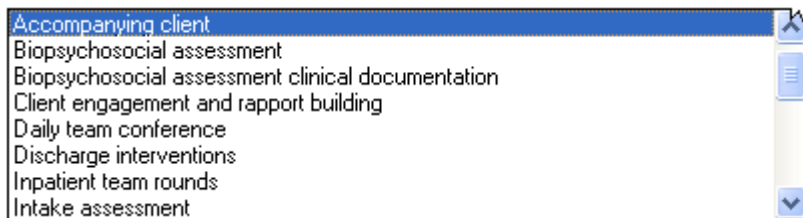


General Patient Care activities are those clinical activities that cross service environment – for example, a comprehensive Intake assessment completed with a client would involve all service environments and be charted on the General Patient Care tab.

Upon selecting the **General Patient Care subtab**, the following screen is displayed:



The user should do the following to display the required record in the **Activity combo box**:



- Click the arrow on the right-hand side of the combo boxes to access the above said drop-down list.
- Click the required record in the drop down lists to display it in the combo box.

When the combo box has been completed the user should enter needed information into the entry fields of this such as: **Time and Details**.

*Note: The content of the Activity field on this subtab is linked to the Time field.*

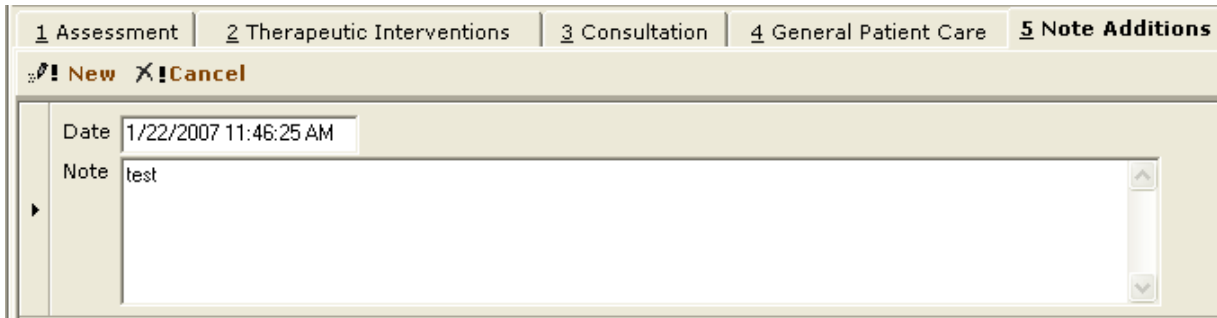
The information window will show up if the Activity field is empty on this subtab.

### **Note Additions Sub tab**



You can enter additional information there for either current or past records. Once a Progress Note has been saved, you cannot alter or delete previous entries. Moreover, the system only enables you to edit records, if you created them personally and your user name is displayed in the Author field on the Clinical Contact pane.

Upon selecting the **Note Additions sub tab**, the following **screen** is displayed:



The screenshot shows a software interface with a tabbed menu at the top containing five options: 1 Assessment, 2 Therapeutic Interventions, 3 Consultation, 4 General Patient Care, and 5 Note Additions. The '5 Note Additions' tab is selected. Below the tabs is a header bar with a 'New' button (indicated by a plus sign) and a 'Cancel' button (indicated by an X). The main area contains two input fields: 'Date' with the value '1/22/2007 11:46:25 AM' and 'Note' with the value 'test'. A vertical scrollbar is visible on the right side of the text entry field.

The current date defaults in the **Date** entry field. This is the date you enter additional information regarding service provided (Assessment, Therapeutic Intervention, Consultation and General Patient Care. Postdating is prevented.

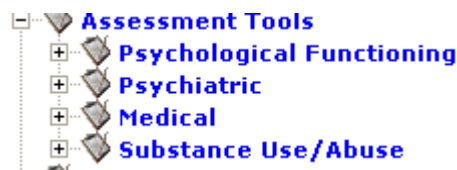
You can enter needed records into the **Note** text entry field.




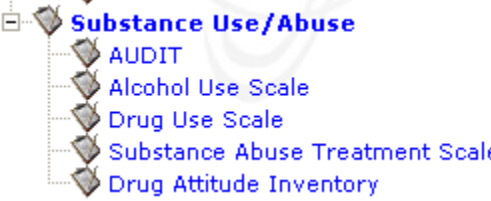


## The Assessment Tools

The Mental Health Charting System provides a wide variety of clinical assessment tools. These tools provide clinical outcome measures integrated into the client's chart. A client's progress during treatment can be tracked using these assessment tools and a variety of summary reports are included to monitor a client's progress

This section holds a variety of standardized tools as well as some ad hoc and team specific tools. This section is perhaps the most relevant to the choice of implementation technology, because every team has their own assessment and assessment protocols. The application has over 20 Assessment Tools currently built in. Most tools create a set of numerical scores indicating the relative ability within analytic areas. The application automatically scores the assessment, and can graph outcomes over time.



 <ul style="list-style-type: none"> <li>Psychosocial Functioning           <ul style="list-style-type: none"> <li>Biopsychosocial History</li> <li>Burden Assessment Scale</li> <li>CAN-C</li> <li>CANSAS</li> <li>Empowerment Scale</li> <li>Health Care Utilization</li> <li>Multnomah</li> <li>Sickness Impact Profile</li> </ul> </li> </ul>	 <ul style="list-style-type: none"> <li>Psychiatric           <ul style="list-style-type: none"> <li>Psychiatric Assessment</li> <li>BPRS Expanded</li> <li>Clinical Diagnosis</li> <li>PANSS</li> </ul> </li> </ul>
 <ul style="list-style-type: none"> <li>Medical           <ul style="list-style-type: none"> <li>Medication Use</li> <li>Medical Hx</li> <li>Lab Results</li> <li>Parkinsonism Scale</li> <li>AIMS</li> <li>Hillside</li> </ul> </li> </ul>	 <ul style="list-style-type: none"> <li>Substance Use/Abuse           <ul style="list-style-type: none"> <li>AUDIT</li> <li>Alcohol Use Scale</li> <li>Drug Use Scale</li> <li>Substance Abuse Treatment Scale</li> <li>Drug Attitude Inventory</li> </ul> </li> </ul>

**\*\*\*Any assessment tool in uses that is not currently available in the CCS will be added to the system before implementation.**



Filling out an onscreen questionnaire (see the sample questionnaire form below) can be done on-line as a part of a structured interview with a client or the client can enter a paper-based version of the questionnaire and the information can be entered into the chart after the fact. Entering questionnaire information on-line is simplified – there are no data codes to remember, or scoring to be done manually and there is data entry validation (meaning you can't enter data that is not a part of a given scale).

Below you can see the sample of the **Clinical Diagnosis** form in the Psychiatric Sub option of the **Assessment Tools** Option

**Mental Health Charting System - [Clinical Diagnosis - DOE, JOHN HF#719479 1]**

File Data Edit Mental Health Charting System Reports Table Maintenance Options Add-Ins Window Help

Save Cancel Add Edit Delete Close Select Client

**Organization /ACT/HO** DOE, JOHN HF#719479 1 CPI# 194

### Clinical Diagnosis

Assessed Date : 11/14/2006  
 Assessed by : Marko, Polo  
 Age at onset of Mental Illness: 18 Age at first psychiatric hospitalization: 21  
 Primary Diagnostic Problem Area: Schizophrenia or other psychotic disorder

Concurrent Disorders Present: Psychiatric and Substance Use diagnoses  
 Dual Disorders Present: Psychiatric and Developmental Handicap diagnoses  
 Other chronic illnesses and/or physical disabilities

**Main Axis I:** 0 - Unknown  
 Focus 2:  
 Focus 3:

**Main Axis II:** 301.2 - Schizoid Personality Disorder  
 Focus 2:  
 Focus 3:

**Main Axis III:**  
 1st Other Axis III:  
 2st Other Axis III:  
 3st Other Axis III:  
 4th Other Axis III:  
 5th Other Axis III:

**Axis IV Problems :**

primary support group     social environment     educational  
 occupational     housing     economic  
 health care access     legal system/crime     other psychological /environmental

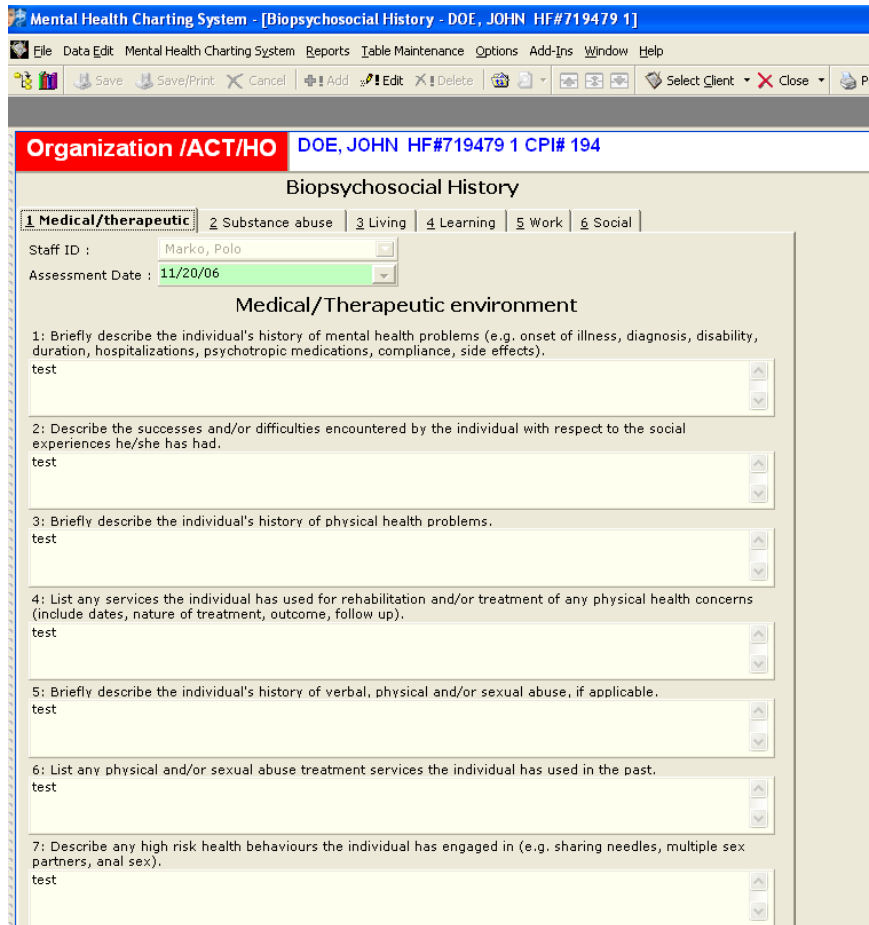
**Axis V: GAF Score**  
**Diagnosis Comments:**

Assessed By	Assessment Date	Age Onset Mental Illness	Age First Psych Admission	Primary Psychiatric Category
Marko, Polo	11/14/2006	18	21	5 - Schizophrenia or other...



With the exception of the Biopsychosocial History questionnaire, when you click the button above any of the assessment tools you will open an empty questionnaire. You can enter the information for a new administration of that questionnaire.

Below you can see a sample of the **Biopsychosocial History form** in the in the Psychosocial Functioning Sub option of the **Assessment Tools** Option.



The screenshot shows a web application window titled "Mental Health Charting System - [Biopsychosocial History - DOE, JOHN HF#719479 1]". The interface includes a menu bar with options like File, Data Edit, Reports, Table Maintenance, Options, Add-Ins, Window, and Help. Below the menu is a toolbar with icons for Save, Save/Print, Cancel, Add, Edit, Delete, and other functions. The main content area displays the "Biopsychosocial History" form for "Organization /ACT/HO DOE, JOHN HF#719479 1 CPI# 194".

The form has several tabs: "1 Medical/therapeutic", "2 Substance abuse", "3 Living", "4 Learning", "5 Work", and "6 Social". The "1 Medical/therapeutic" tab is selected. The form includes fields for "Staff ID" (Marko, Polo) and "Assessment Date" (11/20/06). Below these are seven numbered sections for text entry:

- 1: Briefly describe the individual's history of mental health problems (e.g. onset of illness, diagnosis, disability, duration, hospitalizations, psychotropic medications, compliance, side effects).
- 2: Describe the successes and/or difficulties encountered by the individual with respect to the social experiences he/she has had.
- 3: Briefly describe the individual's history of physical health problems.
- 4: List any services the individual has used for rehabilitation and/or treatment of any physical health concerns (include dates, nature of treatment, outcome, follow up).
- 5: Briefly describe the individual's history of verbal, physical and/or sexual abuse, if applicable.
- 6: List any physical and/or sexual abuse treatment services the individual has used in the past.
- 7: Describe any high risk health behaviours the individual has engaged in (e.g. sharing needles, multiple sex partners, anal sex).

Each section contains a "test" label and a scrollable text area.

In accordance with clinical practice, a clinician can complete the Biopsychosocial history over multiple sessions. It functions in the same fashion as the Service Plans with the most recent information carried forward each time an addition is made to the history.



## Camberwell

There are two versions of the Camberwell that come built into the system, the CANSAS and the CAN-C

### CANSAS

CCS Clinical Charting System - [CANSAS - LOU, CINDY CPI#236]

File Data Edit CCS Clinical Charting System Reports Table Maintenance Options Add-Ins Window Help

Save Save/Print Cancel Add Edit Delete Select Client Close

New record added into CAH

**LOU, CINDY CPI#236**

**CANSAS**  
Camberwell Assessment of Need Short Appraisal Schedule

Client Name : LOU, CINDY Date of Admission : 09/21/07

C.B.# Date of Assessment :

Team Name BKR / S&M

Domain	Rating	Comment
1. Accommodation		
2. Food		
3. Looking after home		
4. Self-care		
5. Daytime activities		
6. Physical health		
7. Psychotic symptoms		
8. Information		
9. Psychological distress		
10. Safety to self		
11. Safety to others		
12. Alcohol		
13. Drugs		
14. Company		
15. Intimate relationships		
16. Sexual expression		
17. Child care		
18. Education		
19. Telephone		
20. Transport		
21. Money		
22. Benefits		

Number of met needs

Number of unmet needs

Total number of needs

\* Adapted for Community Central Intake Committee



## CAN-C

The Camberwell Assessment of Needs Clinical Appraisal is an example of many of the Assessment Tools available in the system

CCS Clinical Charting System - [CAN-C - LOU, CINDY CPI#236]

File Data Edit CCS Clinical Charting System Reports Table Maintenance Options Add-Ins Window Help

Save Save/Print Cancel Add Edit Delete Select Client Close

**Bloorview Kid/Seati/Physi** LOU, CINDY CPI#236

CAN-C  
Complete assessment summary sheet

Staff Name : mhcadmin - mhcadmin, mhc Date Of Client Assessment : 09/21/07  
Date Of Staff Assessment : Review Date :

1 Client 2 Staff

	Rating	Need	Informal Help Given	Formal Help Given	Formal Help Needed
1. Accommodation					
2. Food					
3. Looking after home					
4. Self-care					
5. Daytime activities					
6. Physical health					
7. Psychotic symptoms					
8. Information					
9. Psychological distress					
10. Safety to self					
11. Safety to others					
12. Alcohol					
13. Drugs					
14. Company					
15. Intimate relationships					
16. Sexual expression					
17. Child care					
18. Education					
19. Telephone					
20. Transport					
21. Money					
22. Benefits					
<b>Number of met needs</b>					
<b>Number of unmet needs</b>					



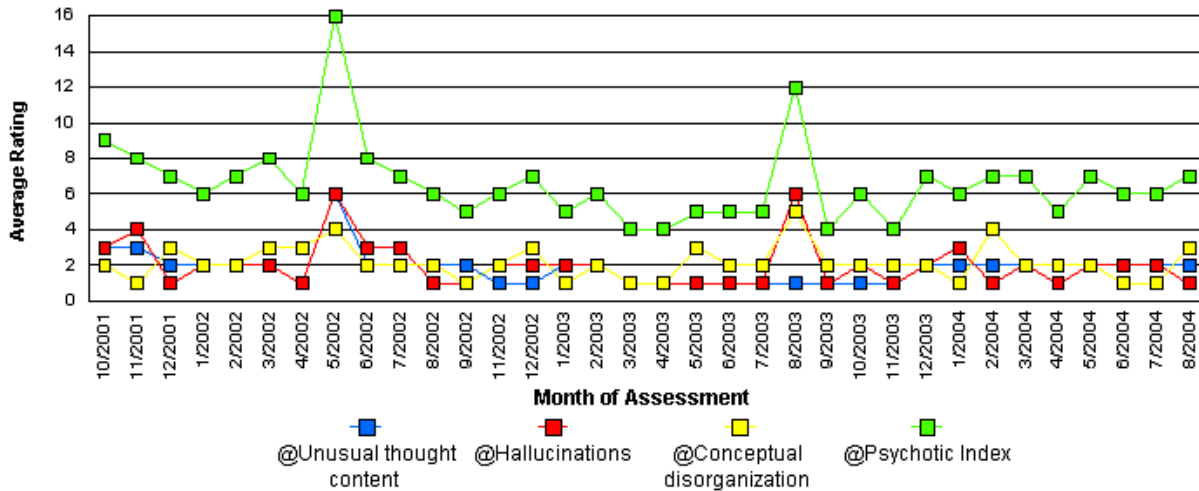
## Clinical Outcome Measures

Clinical Outcome Measures provide users with graphs that map out a client's progress over time. The graphs are produced based on the Assessment given to the client.

\*\*\*\*\*Sample Graph based on the BPRS Expanded Assessment

ACT

### Psychotic Index Overview



Average BPRS Psychotic Index Ratings for all BPRS assessments summarized by month assessed

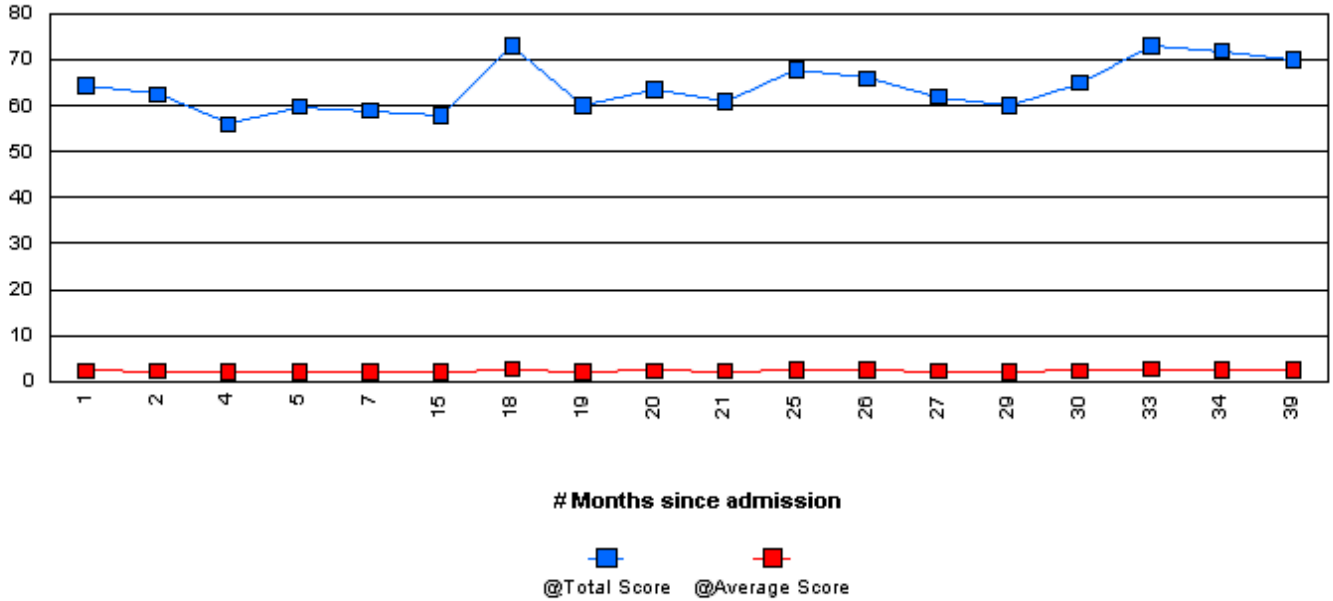
Month/Year Assessed	Unusual thought content	Hallucinations	Conceptual disorganization	Psychotic Index	# Assessments
10/2001	3.00	3.00	2.00	9.00	7
11/2001	3.00	4.00	1.00	8.00	1
12/2001	2.00	1.00	3.00	7.00	9
01/2002	2.00	2.00	2.00	6.00	1
02/2002	2.00	2.00	2.00	7.00	8
03/2002	2.00	2.00	3.00	8.00	8
04/2002	1.00	1.00	3.00	6.00	7
05/2002	6.00	6.00	4.00	16.00	1
06/2002	2.00	3.00	2.00	8.00	9
07/2002	2.00	3.00	2.00	7.00	2
08/2002	2.00	1.00	2.00	6.00	6
09/2002	2.00	1.00	1.00	5.00	10
11/2002	1.00	2.00	2.00	6.00	7
12/2002	1.00	2.00	3.00	7.00	7
01/2003	2.00	2.00	1.00	5.00	2
02/2003	2.00	2.00	2.00	6.00	14
03/2003	1.00	1.00	1.00	4.00	17
04/2003	1.00	1.00	1.00	4.00	2



\*\*\*Sample Graph based on the **Empowerment Scale Assessment**

ACT

## Empowerment Outcome



Average of Empowerment Scores (total, average) for all assessments summarized by # months since admission

# Months since admission	# assessments	Total Score	Average Score
1	5	64.40	2.30
2	2	62.50	2.24
4	3	56.00	2.00
5	5	59.80	2.14
7	1	59.00	2.11
15	1	58.00	2.07
18	1	73.00	2.61
19	1	60.00	2.14
20	2	63.50	2.27
21	1	61.00	2.18
25	2	68.00	2.43



\*\*\* **Sample Graph based on the CANSA**

ACT

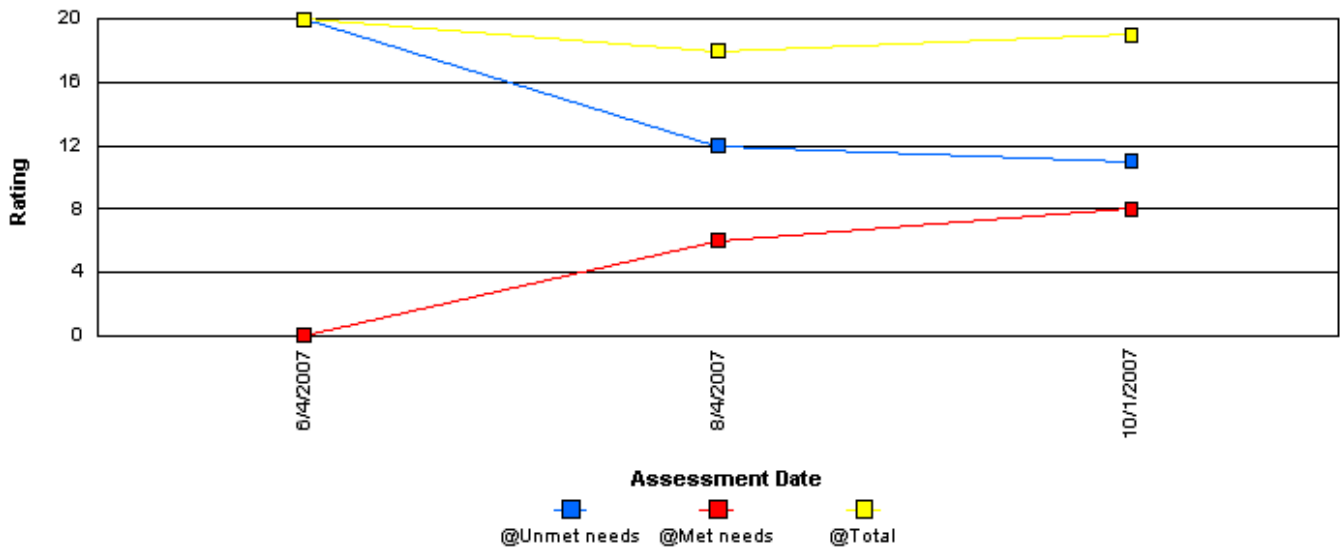
Date Start :   
 Date End :

**CCS Clinical Charting System**

**SMITH, AMY LISA** MD:

Mississauga, Ontario

**CANSAS Overview**



Assessment Date	Unmet needs	Met needs	Total
06/04/2007	20	0	20
08/04/2007	12	6	18
10/01/2007	11	8	19

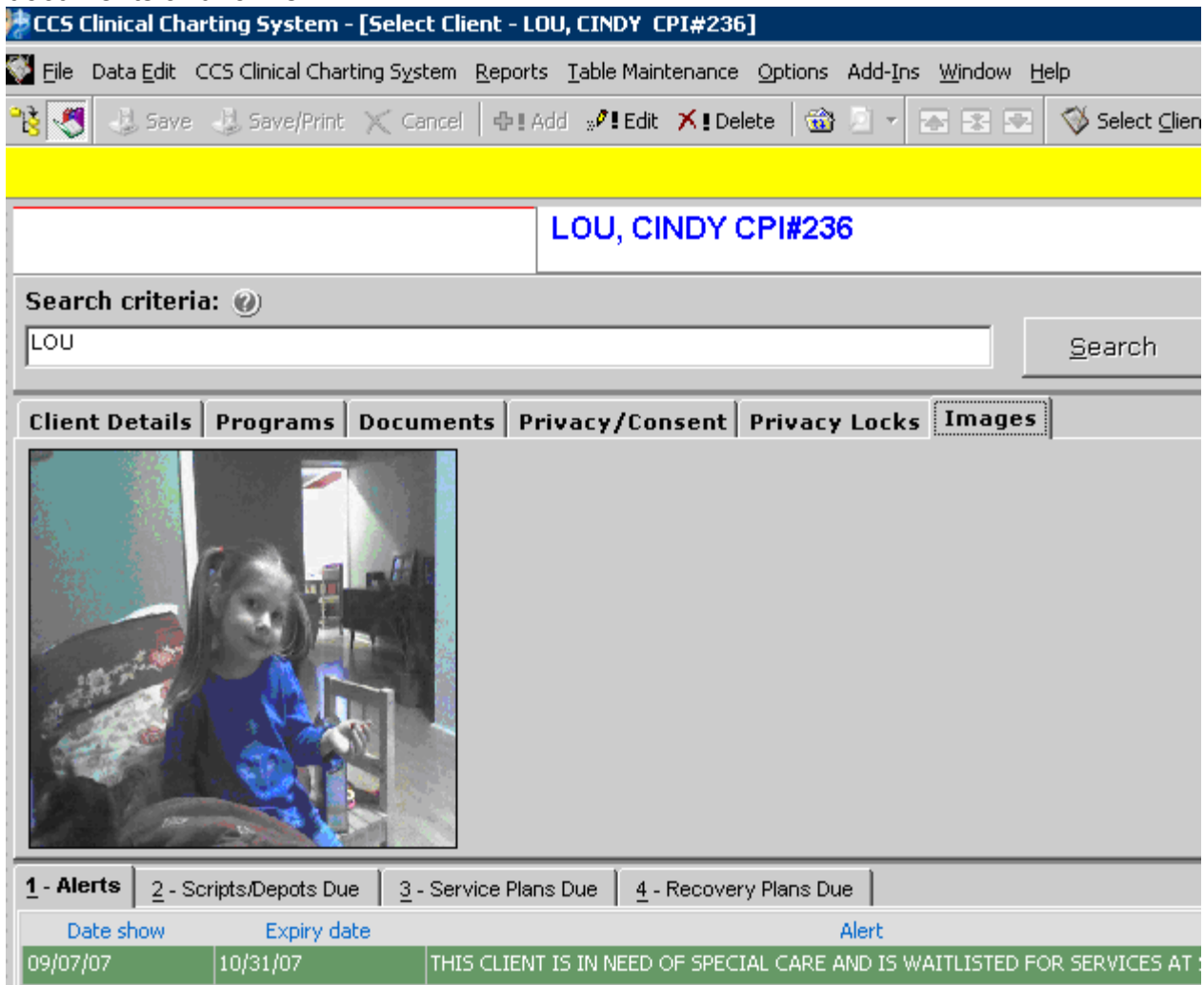


## Clinical Documentation Manager

The Clinical Documentation Manager is a great feature in our system. It allows users to scan and store documents, pictures and video clips attached to client's charts. It is currently utilized by Mental Health teams for scanning in Signed client consent forms, hand written notes or any additional paper based forms, as well as client photo identification.

\*\*\*Store Client Images and Scan Documentation with our Clinical Documentation Manager

\*\*\* We have the ability to scan and load images for photo ID, video clips, common paper documents and forms.



The screenshot displays the CCS Clinical Charting System interface for client LOU, CINDY CPI#236. The interface includes a menu bar (File, Data, Edit, Reports, Table Maintenance, Options, Add-Ins, Window, Help) and a toolbar with icons for Save, Save/Print, Cancel, Add, Edit, Delete, and Select Client. The client name "LOU, CINDY CPI#236" is displayed in a search field. Below the search criteria, there are tabs for Client Details, Programs, Documents, Privacy/Consent, Privacy Locks, and Images. The Images tab is active, showing a photograph of a young girl sitting on a chair. At the bottom, there is an Alerts section with a table showing dates and expiry dates, and a green alert message: "THIS CLIENT IS IN NEED OF SPECIAL CARE AND IS WAITLISTED FOR SERVICES AT".

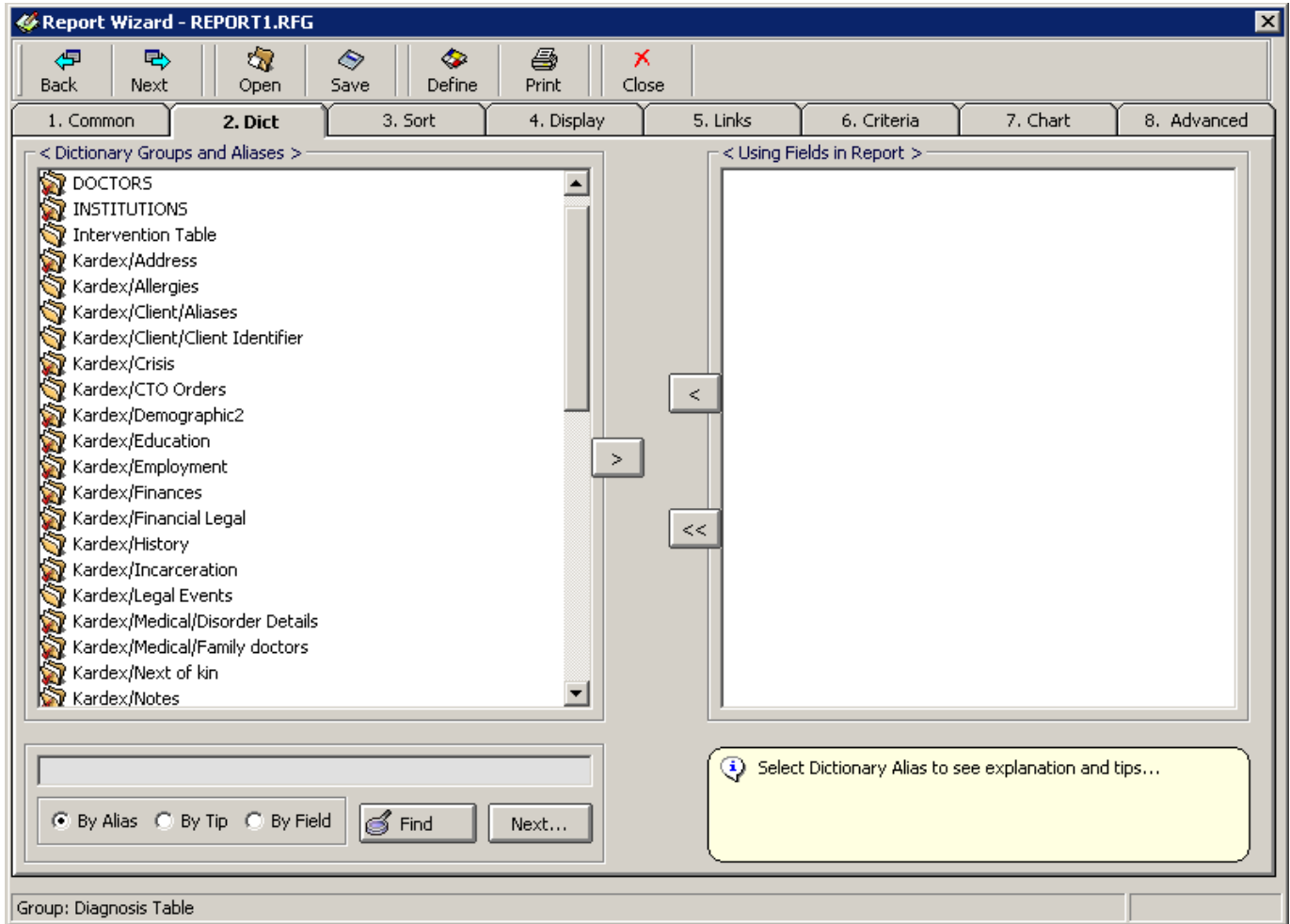
Date show	Expiry date	Alert
09/07/07	10/31/07	THIS CLIENT IS IN NEED OF SPECIAL CARE AND IS WAITLISTED FOR SERVICES AT

Our Outpatient capabilities meet all of the requirements for programs as complex as Assistive Community Treatment Teams or can be modified for smaller programs. The Charting system is available with secure access from a PDA.



## Report Generator

Anzer's Report Generator includes the full data dictionary for the Clinical Charting System. This allows users to easily create custom reports independently using any data field in the system.





## Clinical Statistics and Sample Reports

\*\*\*\*\*We are fully CDS and MIS compliant

There are over 125 different report, graphs, and pie charts to show "Where, When and How" clinical time is spent.

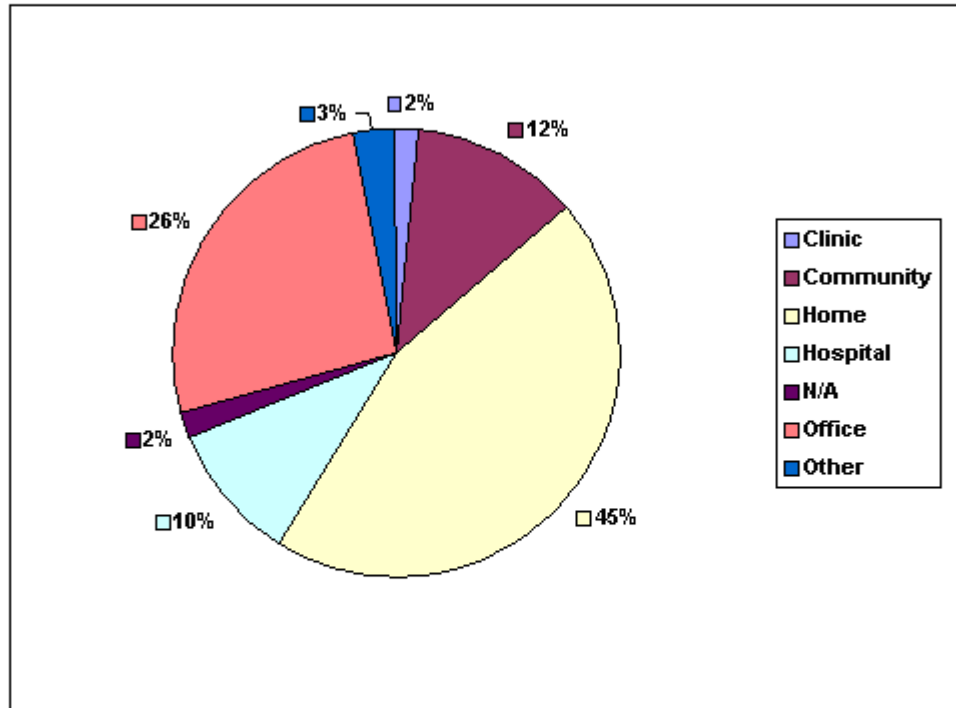
\*\* Below are a few examples of these forms.

---

### "Where" Contact Information % Service Time (hours) by location of contact

---

Charting Period: May 2007

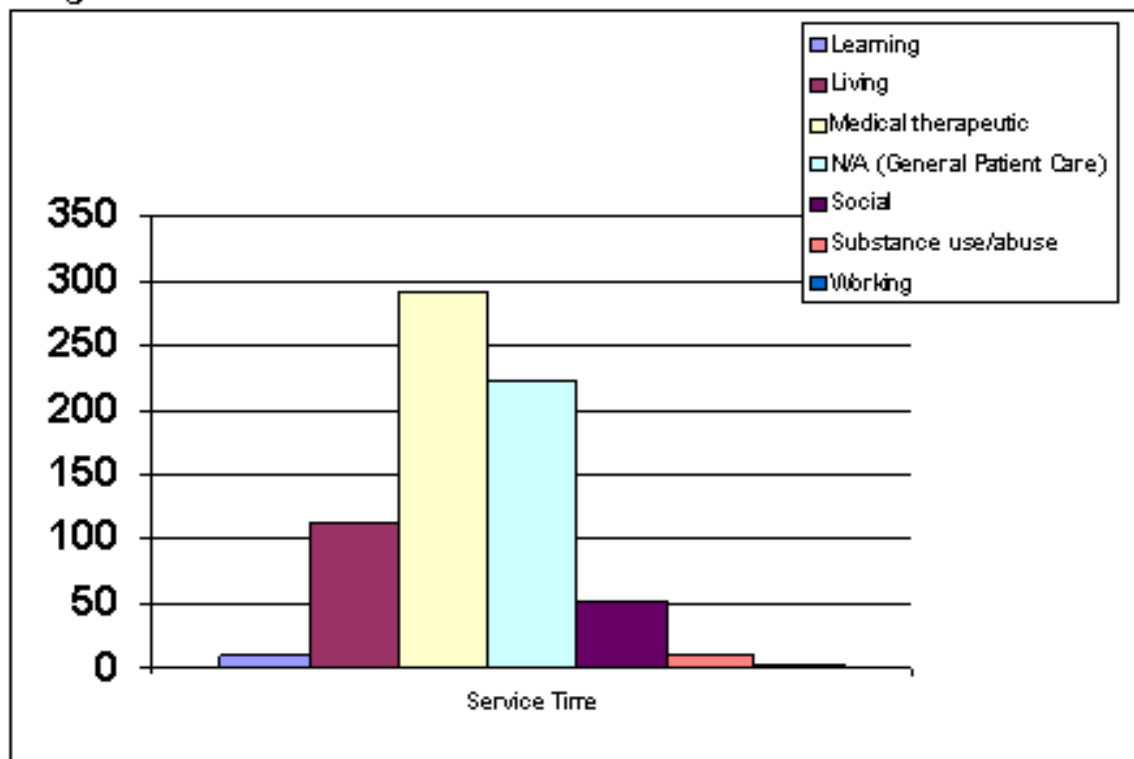


Where	Service Time	# Contacts
Home	337.30	2387
Office	206.45	1438
Hospital	23.75	85
Community	139.28	781
N/A	5.92	42
Clinic	7.58	53
Other	19.83	57



## Service Time (hrs) of Interventions for each Environment by month

Charting Period: March 2007



Environment	Service Time	# Interventions
Substance use/abuse	10.67	29
N/A (General Patient Care)	222.12	1452
Medical therapeutic	292.30	1294
Living	111.50	378
Social	51.33	118
Learning	9.17	9
Working	2.50	9
Sum for month (all environments)	699.58	3289



## MIS Client Contact Information and Workload

### Client Contacts

	<u>Oct</u>	<u>Nov</u>	<u>Dec</u>	<u>Jan</u>	<u>Total</u>
In-Person	503	608	558	641	<b>2310</b>
Telephone	143	170	157	154	<b>624</b>
Correspondence	68	49	39	51	<b>207</b>
N/A	0	0	0	0	<b>0</b>
<b>Monthly Total</b>	<b>714</b>	<b>827</b>	<b>754</b>	<b>846</b>	<b>3141</b>
Number Of Patients Seen			67	61	
New Referrals	2	4	3	10	<b>19</b>
Number Of Patients Discharged	1	2	1	2	<b>6</b>
Active Carryovers	49	51	50	49	
Patient Care Workload [min]	18424	21179	20642	19879	<b>80124</b>
Non-Patient Care Workload [min]	4150	5303	4729	4513	<b>18695</b>

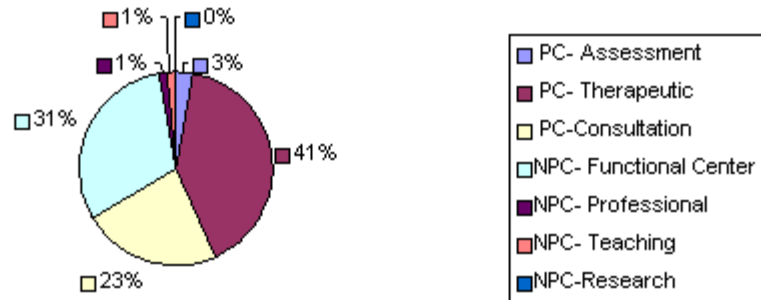


## Discipline Specific Reports

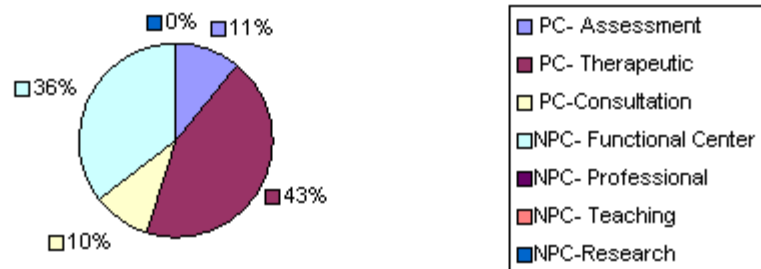
### Fiscal Year to Date Workload Hours for each Staff Discipline

Fiscal Year to November 2006

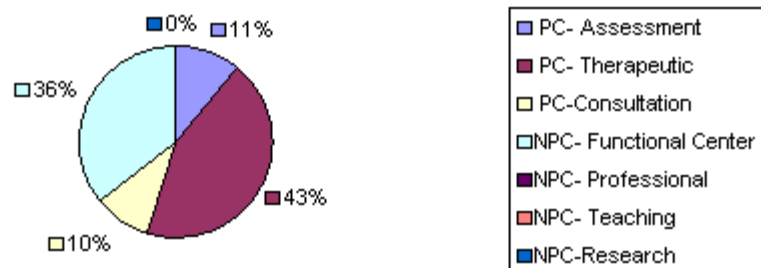
Discipline Addictions Counsellor/Case Manager



Discipline N/A



Discipline Occupational Therapist





## Overview Discipline Direct/Indirect

**Charting period : 10/2006**

**Staff discipline** Nursing

	# Contacts	Assess	The rape utic	Cons ult	Total hrs
Direct	273	7.12	122.87	0.00	129.98
Indirect	160	3.32	49.52	9.60	62.43
<b>Sum for Nursing</b>	<b>433</b>	<b>10.43</b>	<b>172.38</b>	<b>9.60</b>	<b>192.42</b>

**Staff discipline** Occupational Therapist

	# Contacts	Assess	The rape utic	Cons ult	Total hrs
Direct	28	4.25	12.50	0.67	17.42
<b>Sum for Occupational Therapist</b>	<b>28</b>	<b>4.25</b>	<b>12.50</b>	<b>0.67</b>	<b>17.42</b>

**Staff discipline** Social Worker

	# Contacts	Assess	The rape utic	Cons ult	Total hrs
Direct	113	2.58	67.52	1.08	71.35
Indirect	52	5.72	8.55	7.50	21.77
<b>Sum for Social Worker</b>	<b>165</b>	<b>8.30</b>	<b>76.07</b>	<b>8.58</b>	<b>93.12</b>
<b>Sum for 10/2006</b>	<b>626</b>	<b>22.98</b>	<b>260.95</b>	<b>18.85</b>	<b>302.95</b>

**Charting period : 09/2006**

**Staff discipline** Nursing

	# Contacts	Assess	The rape utic	Cons ult	Total hrs
Direct	328	5.95	148.03	0.70	154.68
Indirect	206	5.67	49.18	1.62	56.47
<b>Sum for Nursing</b>	<b>534</b>	<b>11.62</b>	<b>197.22</b>	<b>2.32</b>	<b>211.15</b>

**Staff discipline** Occupational Therapist

	# Contacts	Assess	The rape utic	Cons ult	Total hrs
Direct	100	4.50	54.08	3.50	62.08
<b>Sum for Occupational Therapist</b>	<b>100</b>	<b>4.50</b>	<b>54.08</b>	<b>3.50</b>	<b>62.08</b>



## CDS Demographic Reports

Elm. Name	Ctg. Name	Data	Ch. 0	Ch. 1	Ch. 2	Ch. 3	Ch. 4	Ch. 5
Language of Service Provision	English, French, Other							
Total Service Recipients	Unique individuals - admitted	66	12	22	4	13	6	9
Total Service Recipients	Unique individuals - pre-admission	8	8					
Total Service Recipients	Individuals- not uniquely identified							
Waiting List Information	Individuals Waiting for Initial Assessment	6						
Waiting List Information	Days Waited for Initial Assessment	2175						
Waiting List Information	Individuals Waiting for Service Initiation							
Waiting List Information	Days Waited for Service Initiation	182						
Gender	Male	38						
Gender	Female	36						
Gender	Other							
Gender	Unknown or Service Recipient Declined							
Age	0-15	1						
Age	16-17							
Age	18-24	8						
Age	25-34	9						
Age	35-44	10						
Age	45-54	25						
Age	55-64	16						
Age	65-74	4						
Age	75-84	1						
Age	85 and over							
Age	Unknown or Service Recipient Declined							
Age	Minimum Age (ACT only)	1						
Age	Maximum Age (ACT only)	76						
Age	Average Age (ACT only)	45						



## CDS Diagnosis and Illness information Reports

Diagnostic Categories	Mental Disorders due to General Medical Conditions		
Diagnostic Categories	Mood Disorder	4	
Diagnostic Categories	Personality Disorders		
Diagnostic Categories	Schizophrenia and other Psychotic Disorder	35	
Diagnostic Categories	Sexual and Gender Identity Disorders		
Diagnostic Categories	Sleep Disorders		
Diagnostic Categories	Somatoform Disorders		
Diagnostic Categories	Substance Related Disorders		
Diagnostic Categories	Developmental Handicap		
Diagnostic Categories	Unknown or Service Recipient Declined	35	
Other Illness Information	Concurrent Disorder (Substance Abuse)	14	
Other Illness Information	Dual Diagnosis (Developmental Disability)	5	
Other Illness Information	0		
Other Illness Information	Other Chronic illnesses and/or physical disabilities	1	
Presenting Issues (to be) Addressed	Threat to others/ attempted suicide	36	
Presenting Issues (to be) Addressed	Specific symptom of Serious Mental Illness	71	
Presenting Issues (to be) Addressed	Physical/ Sexual Abuse	15	
Presenting Issues (to be) Addressed	Educational	13	
Presenting Issues (to be) Addressed	Occupational/ Employment/ Vocational	35	
Presenting Issues (to be) Addressed	Housing	52	
Presenting Issues (to be) Addressed	Financial	37	
Presenting Issues (to be) Addressed	Legal	18	
Presenting Issues (to be) Addressed	Problems with Relationships	59	
Presenting Issues (to be) Addressed	Problems with substance abuse/ addictions	24	
Presenting Issues (to be) Addressed	Activities of daily living	53	
Presenting Issues (to be) Addressed	Other	7	



## CDS Hospitalization Reports Calculated by year of Admission

Exit Disposition	Completion without referral						
Exit Disposition	Completion with referral	1					
Exit Disposition	Suicides						
Exit Disposition	Death						
Exit Disposition	Relocation	2					
Exit Disposition	Withdrawal	1					
Baseline Psychiatric Hospitalisations	Not been hospitalised	16	2	3	1	6	1
Baseline Psychiatric Hospitalisations	Total Number of Episodes	102	21	37	4	10	16
Baseline Psychiatric Hospitalisations	Total Number of Hospitalization Days	7,446	403	2564	1499	2119	594
Baseline Psychiatric Hospitalisations	Unknown or Service Recipient Declined	12	5	5	1	1	
Baseline Psychiatric Hospitalisations	Average age at first psychiatric hospitalisation (ACT Only)	23					
Baseline Psychiatric Hospitalisations	Average age at the onset of mental illness (ACT only)	19					
Current Psychiatric Hospitalisations	Not been hospitalised	55	8	19	3	11	6
Current Psychiatric Hospitalisations	Total Number of Episodes	14	5	3	2	3	
Current Psychiatric Hospitalisations	Total Number of Hospitalization Days	1,356	225	479	366	278	
Current Psychiatric Hospitalisations	Unknown or Service Recipient Declined						
Current Psychiatric Hospitalisations	Year 1 Hospital Days (ACT only)	2,138		810	731	439	37
Current Psychiatric Hospitalisations	Year 2 Hospital Days (ACT only)	1,117			730	365	22
Current Psychiatric Hospitalisations	Year 3 Hospital Days (ACT only)	562				559	3
Current Psychiatric Hospitalisations	Year 4 Hospital Days (ACT only)	43					
Current Psychiatric Hospitalisations	Year 5 Hospital Days (ACT only)	48					



## Features that will make your charting easier

1. Limit typing and standardize charting by selecting common entries from drop down lists, check boxes or buttons.

Example of selecting from drop-down lists:

- In most cases, you will know an entry field contains a drop-down list if you see a small downward arrow at the right hand end of the entry field.
- To see the items in the list click on the downward arrow.  
The example below is one of the drop-down lists in the Kardex. Clicking the downward arrow "drops" the list down.

Not applicable
Minimally important
Somewhat important
Moderately important
Very important
Extremely important

Most Drop Down lists are customized tables that reflect each Mental Health's programs clinical practices. This is controlled in Table Maintenance.

2. No "data" codes to remember, whenever entries are coded they are done so "under the hood". Entries are made in terms relevant to your clinical practice rather than reflecting system codes.

3. Automatic (default) entries for assessment dates and times. Date entry formats can be set to reflect the standard date formats used at your clinic.

4. Charting can be done incrementally. For example, if you begin to chart a Progress Note for a client in the morning, and you have to attend a meeting before you have completed the note, you can save what you have done to date. When you return from your meeting, you can continue to chart more on the note, and save your additions. If the next day you remember something else you want to add to the previous day's note, you can open that note and add to it, each addition to a Progress Note will be dated and time stamped on the save.

5. Controls (buttons, check boxes, drop-down lists) throughout the system are designed to support clinical charting activities. That is, in each section of the system the controls available reflect the clinical activity being charted. The actions that result from pressing buttons in the system are clearly labeled. The actions that result when you click each button are the same each time.

6. Entry validation: Post-dating of information is prevented in most sections.



7. Built-in client lists on Alerts page facilitate communication between team members about urgent clinical issues.

8. Hotkeys, tab key and function keys help you to work more productively and efficiently. You can go to needed field, switch from one tab to another, switch between the MHCS menu options and use command options with a help of your keyboard. Hot key combination to button or menu option exists if caption of button or option has underlined letter. To access it, press and hold Alt key and press underlined letter. For example – to access Eile menu press and hold Alt key, press F key.