RESOURCE AND PATIENT MANAGEMENT SYSTEM

Patient Information Management System (PIMS)

Admission/Discharge/Transfer (BDG)

User Manual

Version 5.3 Patch 1009
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Preface

The purpose of this manual is to provide user information about the Admission/Discharge/Transfer (ADT) module that is part of Patient Information and Management System (PIMS) package version 5.3. Included in this manual is the information providing instructional guidance to a broad range of users within IHS medical facilities in daily use of the ADT Module of the PIMS software.
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1.0 Introduction

The PIMS user manual is divided into three modules: ADT, Scheduling, and Sensitive Patient Tracking. The PIMS ADT user manual provides instructional guidance to a broad range of users within IHS medical facilities in daily use of the Admission/Discharge/Transfer (ADT) Module of the PIMS software.

The ADT module of the PIMS package provides a comprehensive range of software dedicated to the support of administrative functions related to patient admission, discharge, transfer, census, incomplete chart tracking, and day surgery.

The information gathered and maintained by the ADT software is available online to a broad range of users within the medical facility to assist in daily operations, providing for greater efficiency, reduction of paperwork, and minimization of error. The ADT software provides for efficient and accurate collection, maintenance, and output of data, thus enhancing your health care facility's ability to provide quality care to its patients.

ADT includes the following submenus:

- Bed Control
- Day Surgery
- Incomplete Chart
- ADT Reports
- ADT Supervisor

Other related materials are the PIMS technical manual, the PIMS installation guide, and the PIMS release notes. The technical manual is provided to assist the site manager in maintenance of the software. The installation guide provides assistance in installation of the package and the release notes describe any modifications and enhancements to the software that are new to the version.
2.0 **Orientation**

2.1 **How To Use This Manual**

The ADT user manual is provided in Adobe Acrobat PDF (portable document format) files. The Acrobat Reader is used to view the documents. If you do not have the Acrobat Reader loaded, it is available from the Adobe home page (www.adobe.com).

Once you open the PDF file, click on the entry name in the table of contents on the left side of the screen to go to that entry in the document. You can print any or all pages of the file. Click on the Print icon and select the pages you need, then click OK.

2.2 **Online Help**

When the format of a response is specific, there usually is a HELP message provided for that prompt. HELP messages provide lists of acceptable responses or format requirements that provide instruction on how to respond. A HELP message can be requested by typing `?` or `??`. The HELP message will be displayed under the prompt, then the prompt will be repeated. For example:

```
Sort by TREATING SPECIALTY: ?
CHOOSE FROM:
  01 SURGERY
  1 CARDIOLOGY
  12 PSYCHIATRY
Sort by TREATING SPECIALTY:
```

Figure 2-1: Example of a help message

For some prompts, the system will list the possible answers from which you can select. Any time choices are displayed with numbers, the system will usually accept the number or the name.

A HELP message may not be available for every prompt. If you type `?` or `??` at a prompt that does not have a HELP message, the system will repeat the prompt.
2.3 Note to Users With “C-WYSE” Terminal Settings

Most options in PIMS are written using list manager. Certain terminal type settings do not work using this browse function. To see if you are set with a “C-WYSE” terminal type and to fix it, follow these Steps: At any menu in RPMS, type TBOX to access the User’s Toolbox menu. From that menu, select Edit User Characteristics. The first question will be your terminal type. If the default answer contains the term “C-WYSE”, change it to “C-VT220.” A ScreenMan data entry screen will now open. Close it by pressing the F1 key once and then the E key.
3.0 Bed Control Menu (BC)

This is the main menu for entering data on inpatient and observation patient stays. In this menu, you can admit, discharge, or transfer a patient. You can also switch a patient to a different bed within the same ward or change the patient’s attending physician.

To select the Bed Control menu, type BC at the “Select ADT Menu Option:” prompt in the ADT Main menu (Figure 3-1).

---

** Figure 3-1: Accessing the BC menu

The Bed Control menu will be displayed (Figure 3-2). Sections 3.1 through 3.10 explain how to use each option.

---

** Figure 3-2: Using the Bed Control menu
3.1 Admit a Patient (ADM)

Use this option to admit a patient to your facility for inpatient or observation status. The treating specialty you select will determine the status. You can also use this option to change admission data typed in error, but only if the patient has not yet been discharged.

1. To admit a patient, type ADM at the prompt at the “Select Bed Control Option:” prompt in the Bed Control menu.

2. Type the patient’s name, IHS chart number, or date of birth at the “Admit Patient:” prompt.

3. The patient’s current statistics (e.g., inpatient status, previous discharge date, admission date, ward, provider, discharge date, room/bed, and specialty) will be displayed (Figure 3-3).

4. To continue the admission process, type C (continue) or M (view more data about the patient before continuing) at the “Continue, More, or Quit” prompt.

```
Bed Control

(UNSPECIFIED HO)
ADM  Admit a Patient
DSC  Discharge a Patient
EBC  Extended Bed Control
EPI  Extended Inpatient Inquiry
PCH  Provider Change
SWB  Switch Bed
TTX  Treating Specialty Transfer
WTX  Ward Transfer

Select Bed Control Option: ADM

Admit PATIENT: PATIENT, ALLISON
  F 02-02-1901 000785650    MH 4298
Status      : ACTIVE INPATIENT-on WARD (SERIOUSLY ILL)
Admitted    : OCT 7,2002@14:59         Transferred    : OCT 8,2002@13:40:14
Ward        : PED                      Room-Bed/Ext   : 211-1 /
Provider    : PROVIDER, ISABEL        Specialty      : UROLOGY
Attending   : PROVIDER, ISABEL        Admitted by    : PROVIDER, JADE
Admission LOS: 22

<C>ontinue, <M>ore, or <Q>uit? C
```

Figure 3-3: Admitting a patient (Steps 1-4)
5. Type the date and time the patient was admitted at the “Select ADMISSION DATE:” prompt. If a patient is currently being admitted, press the Return key or type NOW at the “Select ADMISSION DATE:” prompt and the current date and time will be recorded as the admission date and time. The date and time must be typed with no spaces, as follows: Feb 18, 2002@2:00pm or 02/18/02@1400.

6. Type Y (Yes) at the “Sure You Want to Add (fills in Date-Time) as a New Admissions Date?” prompt to verify the new admission date.

7. At the “DOES THE PATIENT WISH TO BE EXCLUDED FROM THE HOSPITAL DIRECTORY?” question, answer ‘Yes’ to keep the patient’s name off the Operator’s Inpatient List. A ‘Yes’ answer also adds a warning under Patient Inquiry. Otherwise, answer ‘No.’

8. The next three questions pertain to admission codes:

   ADMISSION TYPE-UB92: (optional)
   Choices are: 1 – EMERGENCY
                 2 – URGENT
                 3 – ELECTIVE
                 4 – NEWBORN

   ADMISSION SOURCE-UB92: (optional)
   Choices are: 1 – PHYSICIAN REFERRAL
                2 – CLINIC REFERRAL
                3 – HMO REFERRAL
                4 – TRANSFER FROM HOSPITAL
                5 – TRANSFER FROM SNF
                6 – TRANSFER FROM ANOTHER FACILITY
                7 – EMERGENCY ROOM
                8 – COURT/LAW ENFORCEMENT
                9 – INFORMATION NOT AVAILABLE
                A – TRANSFER FROM RURAL HOSPITAL

   For Newborns: 1 – NORMAL DELIVERY
                  2 – PREMATURE DELIVERY
                  3 – SICK BABY
                  4 – EXTRAMURAL BIRTH

   TYPE OF ADMISSION: These are IHS admission codes (required)
   Choices are: 1 – DIRECT
                2 – TRANS-NON IHS HOSPITAL
                3 – TRANS-IHS HOSPITAL
                4 – REFERRED FROM IHS CLINIC
                5 – OTHER
9. **DIAGNOSIS [SHORT]:** A free text admitting diagnosis; can be up to 30 characters long, no semicolons.

10. The group of questions pertains to where the patient will be placed and under whose care. At any prompt, type ?? for a listing of possible answers.

   - **WARD LOCATION:** Enter ward name. Required.
   - **ROOM-BED:** Enter room and bed name. Optional but recommended.
   - **FACILITY TREATING SPECIALTY:** Required.
     
     This field determines whether the patient is admitted as an inpatient or an observation patient. For observation patients, select one of the choices containing the word “OBSERVATION.”

   - **REFERRING PROVIDER:** Optional free text name of who referred patient for admission, if any.
   - **ADMITTING PROVIDER:** Physician who wrote admission order. Required.
   - **ATTENDING PHYSICIAN:** Physician responsible for care. Required.

11. **ADDITIONAL COMMENTS:** Word processing field for placing any additional information about admission.

12. When all admission information has been entered, Patient Admitted will be displayed on the screen.

13. If the patient was admitted to a ward defined as having seriously ill patients (such as an ICU), the CONDITION question will be asked. If the patient was admitted to a ward not so designated but does need to be listed as seriously ill or DNR, you must use the “ Seriously Ill List Entry” option on the main ADT menu.

   - **Choices are:**
     - **S – SERIOUSLY ILL**
     - **D – DO NOT RESUSCITATE**
     - **B – SI & DNR**
     - **@ - To delete patient off the list**

14. Then the following message should display:

    "Visit Created for date of admission.

For inpatients, a hospitalization visit will be created. For observation patients, an observation visit will be created. If the incorrect treating specialty was entered and subsequently corrected, the visit’s service category will also be fixed.

15. Examples of these questions are displayed in Figure 3-4.
Select ADMISSION DATE:  NOW// [Enter]  (SEP 26,2002@14:41:50)
SURE YOU WANT TO ADD 'SEP 26,2002@14:41:50' AS A NEW ADMISSION DATE? // Y  (Yes)
ADMISSION TYPE-UB92:  ??
Choose from:
1  EMERGENCY
2  URGENT
3  ELECTIVE
4  NEWBORN
ADMISSION TYPE-UB92:  EMERGENCY
ADMISSION SOURCE-UB92:  PHYSICIAN REFERAL
TYPE OF ADMISSION:  ??
Choose from:
1  DIRECT  ADMISSION  ACTIVE  1
2  TRANS-NON IHS HOSPITAL  ADMISSION  ACTIVE  2
3  TRANS-IHS HOSPITAL  ADMISSION  ACTIVE  3
4  REFERRED FROM IHS CLINIC  ADMISSION  ACTIVE  4
5  OTHER  ADMISSION  ACTIVE  5
TYPE OF ADMISSION:  DIRECT
DIAGNOSIS [SHORT]:  Broken Leg
WARD LOCATION:  PEDS
ROOM-BED:  200-1
FACILITY TREATING SPECIALTY:  ORTHOPEDICS
REFERRING PROVIDER:  ADAMS, ADAM
ADMITTING PROVIDER:  DOCTOR, KARYN
ATTENDING PHYSICIAN:  PROVIDER, JADE
ADDITIONAL COMMENTS:  PATIENT IN EXTREME PAIN
Patient Admitted
CONDITION:  ??
Choose from:
S  SERIOUSLY ILL
D  DO NOT RESUSCITATE
B  SI & DNR
CONDITION:  S  SERIOUSLY ILL
Visit created for date of admission

Figure 3-4: Admitting a patient (Steps 5–14)
16. Once admitted, there may be one to four more printing questions based on site parameters.

WRISTBANDS: Do you want to print a Patient Wristband? Default is ‘Yes.’ Parameter should only be turned on if you have the appropriate printer setup to print bar coded wristbands.

A SHEET: If the parameter PRINT A SHEET AT ADMISSION is set to ‘Yes,’ the system will automatically prompt for the printing of the A sheet. If you do not want to print an A sheet in this instance, type ^ to bypass the option. You will then be asked if you want to “Print Bottom Half of A Sheet,” the number of copies to print, and the printer. If the A Sheet is to print directly on the ward, you can define those default printers under ward setup.

```
Printing A Sheet for admission. Type ^ to bypass.
Print Bottom Half of A Sheet? YES// N
Print How Many Copies: (1-10): 1// [Enter]
DEVICE: HOME//
```

Figure 3-5: Admitting a patient (Step 16)

- LOCATOR CARD: Answer ‘Yes’ to print a card to be used by operators or medical records for a manual backup method of looking up who is in which ward.

- REQUEST CHART: If the parameter is set to ‘Yes,’ you will be asked to supply the clinic name for this chart request. The default admitting chart request clinic name can be defined under ADT parameters. To bypass requesting the paper chart, type ^.

17. Following these print questions, one or more messages from other RPMS applications may be displayed.

3.2 Edit Admission Data

Use the following Steps to edit patient admission data:

1. To edit admission data on an active inpatient, type the name (or chart number) of the patient to be admitted at the “Admit Patient:” prompt.

2. The patient’s current statistics (e.g., inpatient status, previous discharge date, admission date, ward, provider, discharge date, room/bed, and specialty) will be displayed.
3. Type the new information at the default prompts and then press the Return key to record the changes (Figure 36).

<table>
<thead>
<tr>
<th>Admit PATIENT: PATIENT, ANDREA B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status : ACTIVE INPATIENT-on WARD (SI &amp; DNR)</td>
</tr>
<tr>
<td>Admitted : SEP 26, 2002@15:33:30</td>
</tr>
<tr>
<td>Ward : GMS Room-Bed/Ext : 219-1 /</td>
</tr>
<tr>
<td>Provider : PROVIDER, JADE Specialty : INTERNAL MEDICINE</td>
</tr>
<tr>
<td>Attending : PROVIDER, JADE Admitted by : PROVIDER, JADE</td>
</tr>
<tr>
<td>Admission LOS: 1</td>
</tr>
<tr>
<td>&lt;C&gt;ontinue, &lt;M&gt;ore, or &lt;Q&gt;uit? CONTINUE// [Enter]</td>
</tr>
</tbody>
</table>

CHOOSE FROM:
1> SEP 26, 2002@15:33:30 DIRECT TO: GMS [219-1]

Select ADMISSION DATE: SEP 26, 2002@15:33:30// 1 [Enter]
ADMISSION DATE: SEP 26, 2002@15:33:30// [Enter]
ADMISSION TYPE-UB92: URGENT// EMERGENCY <<<<<<
ADMISSION SOURCE-UB92: PHYSICIAN REFERRAL// [Enter]
TYPE OF ADMISSION: DIRECT// [Enter]
DIAGNOSIS [SHORT]: BLAH// BROKEN LEG <<<<<<
WARD LOCATION: GMS// [Enter]
ROOM-BED: 219-1// [Enter]
FACILITY TREATING SPECIALTY: INTERNAL MEDICINE// ORTHOPEDICS <<<<<<
REFERRING PROVIDER: JOE BLW// [Enter]
ADMITTING PROVIDER: PROVIDER, JADE// [Enter]
ATTENDING PHYSICIAN: PROVIDER, JADE// [Enter]
ADDITIONAL COMMENTS: [Enter]
No existing text
Edit? NO// [Enter]
CONDITION: SI & DNR// [Enter]

Admit PATIENT:

Figure 3-6: Editing patient admission data

3.3 Discharge a Patient (DSC)

Use this option to enter the date and time a patient is discharged, as well as the type of discharge. Use this option to release an inpatient or an observation patient from your facility. You will be asked for IHS discharge type, UB92 disposition code, and transfer facility, if appropriate. Once a patient is discharged, use the “Edit Past Day Surgeries” option (Section 3.4) to edit the patient’s data. If an observation patient is to be admitted as an inpatient, discharge that patient and then readmit them to an inpatient service.

1. To discharge a patient, type DSC at the “Select Bed Control Option:” prompt in the Bed Control menu.
Bed Control

(UNSPECIFIED HO)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADM</td>
<td>Admit a Patient</td>
</tr>
<tr>
<td>DSC</td>
<td>Discharge a Patient</td>
</tr>
<tr>
<td>EBC</td>
<td>Extended Bed Control</td>
</tr>
<tr>
<td>EPI</td>
<td>Extended Inpatient Inquiry</td>
</tr>
<tr>
<td>PCH</td>
<td>Provider Change</td>
</tr>
<tr>
<td>SWB</td>
<td>Switch Bed</td>
</tr>
<tr>
<td>TTX</td>
<td>Treating Specialty Transfer</td>
</tr>
<tr>
<td>WTX</td>
<td>Ward Transfer</td>
</tr>
</tbody>
</table>

Select Bed Control Option: **DSC**

---

**Figure 3-7: Discharging a patient (Step 1)**

2. Type the name of the patient to be discharged at the “Discharge Patient:” prompt.

   **Note:** If only the last name of the patient is typed and more than one patient is registered by the last name typed, a list will be displayed (Figure 3-8). Type the number of the patient to be viewed at the “Choose 1-5:” prompt (Figure 3-8).

3. Type C (to continue) or M (to view more data about the patient before continuing) at the “Continue, More, or Quit” prompt.

4. Type the date and time the patient was discharged at the “Discharge Date:” prompt. If a patient is currently being discharged, press the Return key or type NOW at the “Discharge Date:” prompt.

   **Note:** The date and time must be typed with no spaces, as follows: Feb 18,1997@2:00pm (FEB 18, 1997@14:00:00).

5. Type the discharge type at the “Type of Discharge:” prompt. To view a list of available options, type ?? at the “Type of Discharge:” prompt (Figure 3-8).

6. If you enter a transfer discharge type, you will then be asked to enter the transfer facility name. Type ?? for the list for your site. This list can be customized under ADT System Definition Menu.

7. Next, you will be asked for the UB92 Discharge code. When the discharge process is complete, Patient Discharged will be displayed.
Discharge PATIENT: PATIENT  
1  PATIENT, ANDREA B.                F 07-05-1901 000775162    MH 7852  
2  PATIENT, ANNE MARIE               F 08-20-1901 000311756    MH 1745  
3  PATIENT, ANNETTE FLORENE          F 08-29-1901 000287093    MH 4294  
4  PATIENT, AVALINE M.               F 07-04-1901 000660902    MH 5640  
5  PATIENT, BEN                      M 10-31-1973 000444448    MH 6133  
ENTER '^' TO STOP, OR  
CHOOSE 1-5: 2  
PATIENT, ANNE MARIE                     F 08-20-1901 000311756    MH 1745  

Status : ACTIVE INPATIENT-on WARD
Admitted : SEP 27, 2002@09:34:05    Transferred :  
Ward : PED  
Room-Bed/Ext : 211-1 /  
Provider : PROVIDER, JADE  
Specialty : FAMILY PRACTICE  
Attending : PROVIDER, JADE  
Admitted by : PROVIDER, JADE  

Admission LOS: 1  

<C>ontinue, <M>ore, or <Q>uit? C  
DISCHARGE DATE: NOW// (SEP 27, 2002@09:58:39) [Enter]  
TYPE OF DISCHARGE: ??
Choose the type of movement this patient had. You will be selecting from active
FACILITY MOVEMENT TYPES for which the TRANSACTION TYPE of this movement matches the
TRANSACTION TYPE of the FACILITY MOVEMENT TYPE. For example, if you are admitting a
patient, you will only be able to select active admission types.

Choose from:  
12 REGULAR DISCHARGE DISCHARGE ACTIVE 1  
13 TRANSFERRED DISCHARGE ACTIVE 2  
15 DEATH W/I 48 HRS W AUTOPSY DISCHARGE ACTIVE 4  
16 DEATH W/I 48 HRS W/O AUTOPSY DISCHARGE ACTIVE 5  
17 DEATH AFTER 48 HRS W AUTOPSY DISCHARGE ACTIVE 6  
18 DEATH AFTER 48 HRS W/O AUTOPSY DISCHARGE ACTIVE 7  
21 IRREGULAR (AMA) DISCHARGE ACTIVE 3  

TYPE OF DISCHARGE: 12 REGULAR DISCHARGE  
DISCHARGE STATUS-UB92: [Enter]  
Patient Discharged  
V Hospitalization Entry Created  
Updating automated team lists...completed.  
Updating appointment status...completed.

Figure 3-8: Discharging a patient (Steps 2-7)

### 3.4 Extended Bed Control (EBC)

Use this option to edit any past admission, ward transfer, or discharge data on a patient. You will not be able to edit any item older than your census lockout parameter setting. To correct older items, please contact your application coordinator.

1. To use the Extended Bed Control option, type EBC at the “Select Bed Control Option:” prompt in the Bed Control menu.
Bed Control

(UNSPECIFIED HO)

ADM  Admit a Patient
DSC  Discharge a Patient
EBC  Extended Bed Control
EPI  Extended Inpatient Inquiry
PCH  Provider Change
SWB  Switch Bed
TTX  Treating Specialty Transfer
WTX  Ward Transfer

Select Bed Control Option: EBC

Figure 3-6: Editing patient information (Step 1)

2. Type the name or chart number of the patient whose data needs to be edited at the “Select Patient Name:” prompt.

3. Type the number of the admission date to be displayed. A summary of patient data and an option to edit that data will be displayed (Figure 3-7). The questions asked will be the same as when you first entered the admission, ward transfer, or discharge.

ADMISSION:
SEP 26,2002@15:33:30  DIRECT TO:  GMS [219-1]

TRANSFERS:

TREATING SPECIALTY CHANGES:
SEP 26,2002@15:33:30 SPECIALTY:  INTERNAL MEDICINE
PROVIDER :  PROVIDER, JADE
ATTENDING:  PROVIDER, JADE
ADMITTING:  PROVIDER, JADE

DISCHARGE:

CHOOSE FROM:
1 - Admit Patient
2 - Transfer Patient
3 - Discharge Patient
Select Option:

Figure 3-7: Editing patient information (Step 3)

3.5 Extended Inpatient Inquiry (EPI)

Use this option to view all information about a specific patient for an individual admission. This is the same option as selecting “Expand Entry under Patient Inquiry” and selecting Section 2.

1. To use the Extended Inpatient Inquiry option, type EPI at the “Select Bed Control Option:” prompt in the Bed Control menu.
Figure 3-8: Viewing inpatient information (Step 1)

2. Type the name of the patient for whom data will be displayed at the “Select Patient Name:” prompt.

3. Type the number of the admission date to be displayed at the “Choose:” prompt.

Figure 3-9: Viewing inpatient information (Steps 2-3)

4. A summary of patient data will be displayed (Figure 3-10).

Figure 3-10: Detailed patient inquiry screen
3.6 Provider Change (PCH)

Use this option to change patient’s attending provider during an inpatient stay. This option can also be used when a treating specialty transfer does not accompany a change of provider.

1. To use the Provider Change option, type PCH at the “Select Bed Control Option:” prompt in the Bed Control menu.

   (UNSPECIFIED HO)

   ADM    Admit a Patient
   DSC    Discharge a Patient
   EBC    Extended Bed Control
   EPI    Extended Inpatient Inquiry
   PCH    Provider Change
   SWB    Switch Bed
   TTX    Treating Specialty Transfer
   WTX    Ward Transfer

   Select Bed Control Option: PCH

2. Type the patient’s name at the “Provider Change for Patient:” prompt.

3. Type C, M, or Q at the “<C>ontinue, <M>ore, or <Q>uit?” prompt.

4. Type the date of the provider change at the “Select Provider Change Date:” prompt. You may also go back and fix previous changes by selecting by number. The #1 entry is always the providers at admission.

5. Type ‘Yes’ at the “SURE YOU WANT TO ADD '(date/time filled in here)' AS A NEW PROVIDER CHANGE DATE?” question.

6. Type the name of the patient’s new provider at the “Attending Physician:” prompt. Type ?? for a list of providers.

7. Type Y at the “Edit?” prompt to enter comments, or type N at the “Edit?” prompt if you do not have any comments to type.

8. Type Y or N at the “Print Locator Card?” prompt.
Provider Change for PATIENT: PATIENT, ANNE MARIE

PATIENT, ANNE MARIE F 08-20-1901 00311756 MH 1745

Status: INACTIVE INPATIENT Discharge Type: REGULAR DISCHARGE

Admitted: SEP 27, 2002@09:34:05 Discharged: SEP 27, 2002@09:58:39
Ward: PED Room-Bed/Ext: 211-1/
Provider: PROVIDER, JADE Specialty: FAMILY PRACTICE
Attending: PROVIDER, JADE Admitted by: PROVIDER, JADE

Admission LOS: 1

<Continue, <More, or <Quit? CONTINUE// C

CHOOSE FROM:
1> SEP 27, 2002@09:34:05 SPECIALTY: FAMILY PRACTICE
   PROVIDER: PROVIDER, JADE
   ATTENDING: PROVIDER, JADE
   Admitting: PROVIDER, JADE

Select PROVIDER CHANGE DATE: NOW
SURE YOU WANT TO ADD 'SEP 28, 2002@15:46:17' AS A NEW PROVIDER CHANGE DATE? Yes// [Enter]
ATTENDING PHYSICIAN: PROVIDER, JADE// PROVIDER, LEONA
ADDITIONAL COMMENTS:
No existing text
Edit? NO//
Print Locator Card? YES// N

Updating automated team lists...completed.

Figure 3-12: Changing providers (Steps 2-8)

3.7 Print Patient Wristband (PPW)

Use this option to print a patient wristband.

1. To use the Print Patient Wristband option, type PPW at the “Select Bed Control Option:” prompt in the Bed Control menu.

Figure 3-13: Printing Patient Wristband (Step 1)

2. Type the patient’s name at the “PATIENT NAME:” prompt.
3. Type in the device at the PRINT WRISTBAND ON DEVICE prompt.

### 3.8 Switch Bed (SWB)

Use this option to record a change in a patient's bed assignment within the same ward.

1. To use the Switch Bed option, type **SWB** at the “Select Bed Control Option:” prompt in the Bed Control menu.

<table>
<thead>
<tr>
<th>ADM</th>
<th>Admit a Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSC</td>
<td>Discharge a Patient</td>
</tr>
<tr>
<td>EBC</td>
<td>Extended Bed Control</td>
</tr>
<tr>
<td>EPI</td>
<td>Extended Inpatient Inquiry</td>
</tr>
<tr>
<td>PCH</td>
<td>Provider Change</td>
</tr>
<tr>
<td>SWB</td>
<td>Switch Bed</td>
</tr>
<tr>
<td>TTX</td>
<td>Treating Specialty Transfer</td>
</tr>
<tr>
<td>WTX</td>
<td>Ward Transfer</td>
</tr>
</tbody>
</table>

Select Bed Control Option: **SWB**

![Figure 3-14: Switching beds (Step 1)]

2. Type the patient’s name at the “Switch Bed for Patient:” prompt.

3. Type the bed number of the bed you are moving the patient to at the “Room-Bed:” prompt. Type ? for a list of available beds.

4. If your parameters are turned *on*, you will be asked to print an updated A Sheet and a Locator Card.
SWITCH BED FOR PATIENT: **PATIENT, ALLISON**  

<table>
<thead>
<tr>
<th>Status</th>
<th>ACTIVE INPATIENT-on WARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted</td>
<td>OCT 7, 2002@14:59</td>
</tr>
<tr>
<td>Ward</td>
<td>GMS</td>
</tr>
<tr>
<td>Provider</td>
<td>PROVIDER, JADE</td>
</tr>
<tr>
<td>Attending</td>
<td>PROVIDER, JADE</td>
</tr>
<tr>
<td>Admission LOS:</td>
<td>1</td>
</tr>
<tr>
<td>ROOM-BED:</td>
<td>219-1// ??</td>
</tr>
<tr>
<td>CHOOSE FROM</td>
<td>219-1, (NO DESCRIPTION).</td>
</tr>
<tr>
<td>Select from the above listing the bed you wish to assign this patient.</td>
<td></td>
</tr>
<tr>
<td>ROOM-BED:</td>
<td>219-1// 219-2</td>
</tr>
</tbody>
</table>

Printing A Sheet for admission. Type ^ to bypass.  
Print Bottom Half of A Sheet? YES// N  
Print How Many Copies: (1-10): 1// 2  
DEVICE: HOME//  
Print Locator Card? YES// N  
Updating automated team lists...completed.  
Updating appointment status...completed.

**Figure 3-15: Switching beds (Steps 2-7)**

### 3.9 Treating Specialty Transfer (TTX)

Use this option to enter a specialty change (e.g., General Medicine, Newborn, Obstetrics, Pediatrics, or Surgery) for an inpatient. Select the option that best describes the care an inpatient is receiving. For example, a patient’s treating specialty can change from Newborn to Pediatrics if that patient is a newborn with special needs.

1. To use the Treating Specialty Transfer option, type TTX at the “Select Bed Control Option:” prompt in the Bed Control menu.

---

**Figure 3-16: Transferring a treating specialty (Step 1)**
2. Type the name of the inpatient for whom a specialty change will be entered at the “Specialty Change for Patient:” prompt. The inpatient’s current status (date admitted, ward, provider, etc.) will be displayed.

3. To continue the specialty change process, type C (to continue) or M (to view more data about the patient before continuing) at the “<C>ontinue, <M>ore, or <Q>uit?” prompt.

```
Specialty Change for PATIENT: PATIENT,ALLISON
M 02-02-1901 000785650 MH 4298
Status : ACTIVE INPATIENT-on WARD
Admission LOS: 1
<C>ontinue, <M>ore, or <Q>uit? C
```

Figure 3-17: Transferring a treating specialty (Steps 2-3)

4. Type the date the specialty change occurred at to the “Select Specialty Transfer Date:” prompt or select by number if you need to fix an earlier transfer.

5. Type Y (Yes) at the “Sure You Want to Add (Date-Time) as a New Specialty Transfer Date?” prompt to verify the new specialty transfer date.

6. Type the new treating specialty assigned to the inpatient that best describes the care the inpatient is receiving at the “Facility Treating Specialty:” prompt. Type ?? to display a list of available options.

```
CHOOSE FROM:
1> OCT 7,2002@14:59 SPECIALTY: INTERNAL MEDICINE
PROVIDER : PROVIDER,JADE
ATTENDING: PROVIDER,JADE
ADMITTING: PROVIDER,JADE

Select SPECIALTY TRANSFER DATE: NOW
SURE YOU WANT TO ADD 'OCT 8,2002@13:11:52' AS A NEW SPECIALTY TRANSFER DATE? Yes// Y
FACILITY TREATING SPECIALTY: PEDIATRICS
```

Figure 3-18: Transferring a treating specialty (Steps 4-6)

7. Type the healthcare provider that has primary responsibility for direct care of the inpatient at the “Admitting Physician:” prompt.

8. Type comments at the “Additional Comments:” prompt, or press the Return key at the “Additional Comments:” prompt if there are no comments.
9. When the required specialty transfer changes are entered, Updating automated team lists...completed will be displayed on the screen.

Figure 3-19: Transferring a treating specialty (Steps 7-9)

3.10 Ward Transfer (WTX)

Use this option to transfer a patient between wards. You will also be prompted with the "Treating Specialty Transfer Date:" prompt, where you can transfer the patient’s treating specialty and/or provider if either are changed at the time of transfer.

1. To use the Ward Transfer option, type WTX at the “Select Bed Control Option:” prompt in the Bed Control menu.

Figure 3-20: Transferring wards (Step 1)

2. Type the name of the patient to be transferred at the “Transfer Patient:” prompt. The patient’s current status will be displayed.

3. To continue the transfer process, type C (to continue) or M (to view more data about the patient before continuing) at the “<C>ontinue, <M>ore, or <Q>uit?” prompt.
Transfer PATIENT: PATIENT, ALLISON

Status : ACTIVE INPATIENT-on WARD

Admitted : OCT 7,2002@14:59 Transferred : 
Ward : GMS Room-Bed/Ext : 219-1 /
Provider : PROVIDER, JADE Specialty : PEDIATRICS
Attending : PROVIDER, JADE Admitted by : PROVIDER, JADE

Admission LOS: 1

Figure 3-21: Transferring wards (Steps 2–3)

4. Type the date and time the patient was transferred at the “Select Transfer Date:” prompt.

5. Type Y (Yes) at the “Sure You Want To Add ‘(Date/Time)’ as a New Transfer Date?” prompt.

6. Type the information requested at the prompts that follow. To view a list of available options at any prompt, type ?? at the prompt to display a list of the available options.

7. When the transfer process is complete, Patient Transferred will be displayed.

Select TRANSFER DATE:  NOW// [Enter]

SURE YOU WANT TO ADD 'OCT 8,2002@13:40:14' AS A NEW TRANSFER DATE? Yes// (Yes)
WARD LOCATION: PED
ROOM-BED: 211-1

Do you wish to associate a 'facility treating specialty' transfer? Y

FACILITY TREATING SPECIALTY: CARDIOLOGY

ATTENDING PHYSICIAN: PHYSICIAN, ISABEL
ADDITIONAL COMMENTS:
No existing text
Edit? NO

Patient Transferred.

Updating automated team lists...completed.

Figure 3-22: Transferring wards (Steps 4–7)
4.0 Day Surgery Menu (DS)

Use this menu to track patients in an Ambulatory Surgery program at a facility. This module has not been updated since MAS v5.0 but is slated for a complete overhaul in an upcoming PIMS patch.

To use the Day Surgery menu, type DS at the “Select ADT Menu Option:” prompt in the ADT main menu.

![Figure 4-1: Accessing the Day Surgery menu](image)

4.1 Day Surgery Audit Report (DSAU)

Use this option to print the total number of all patients who have had day surgery between specified dates. At the end of the report, the total number of patients in each category (e.g., total sent to observation, total unescorted, total admitted, etc.) is listed separately.

1. To print a Day Surgery Audit report, type DSAU at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

2. Type the date to begin printing the Day Surgery Audit Report at the “Select Beginning Date:” prompt.

3. Type the date to stop printing the Day Surgery Audit Report at the “Select Ending Date:” prompt.

4. Type a print device at the “Device:” prompt.
Day Surgery menu
(UNSPECIFIED HO)

DSAU   Day Surgery Audit Report
DSE   Day Surgery Enter/Edit
DSL   Patient List by Day Surgery Date
DSNR   List of Patients Not Released
DSP   Edit Past Day Surgeries
DSPC   PCC Day Surgery Visits Listing
DSPQ   Provider QA Report
DSQ   Inquiry Day Surgery Entry
DSTX   Statistics by Treating Specialty
DSW   Print DS Worksheet

Select Day Surgery Menu Option: DSAU   Day Surgery Audit Report

DAY SURGERY AUDIT REPORT

Select beginning date: Oct 1, 2001 (OCT 01, 2001)
Select ending date: Oct 1, 2001 (OCT 1, 2001)

Report uses 132 columns; use wide printer or condensed print!

DEVICE: HOME// [Enter]

Figure 4-2: Printing the Day Surgery Audit report (Steps 1-4)

5. A Day Surgery Audit report will print (Figure 4-3).

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>LOS</th>
<th>OBSV</th>
<th>FROM W/IN</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>POST-OP DATE</td>
<td>PATIENT HRCN AGE SRV PROCEDURE</td>
<td>HRS</td>
<td>LOS</td>
<td>UNESC DS</td>
</tr>
<tr>
<td>COMMENTS</td>
<td>---------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>---------</td>
</tr>
</tbody>
</table>

*****Confidential Patient Data Covered by Privacy Act*****
UNSPECIFIED Indian Hospital          Page 1
9:43 am                  DAY SURGERY AUDIT REPORT
Oct 31, 2002         from OCT 01, 2001 to OCT 1, 2002

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>LOS</th>
<th>OBSV</th>
<th>FROM W/IN</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>POST-OP DATE</td>
<td>PATIENT HRCN AGE SRV PROCEDURE</td>
<td>HRS</td>
<td>LOS</td>
<td>UNESC DS</td>
</tr>
<tr>
<td>COMMENTS</td>
<td>---------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>---------</td>
</tr>
</tbody>
</table>

TOTAL PATIENTS: 3
TOTAL SENT TO OBS 1
TOTAL UNESCORTED 1
TOTAL ADMITTED FROM DS 0
TOTAL ADMITTED W/IN WEEK 1
TOTAL CANCELLED 0
TOTAL NO-SHOWS 0

End of Report; Press RETURN to continue:

Figure 4-3: Day Surgery Audit report
4.2 Day Surgery Enter/Edit (DSE)

Use this option to record basic data on a day surgery visit. Once the patient has been released, use the “Edit Past Day Surgeries” option (Section 4.5) to edit a previous day surgery visit.

**Important Note:** You must have a valid HOSPITAL LOCATION entered in to the DAY SURGERY HOSP LOCATION field, found in the 'Edit ADT Parameters' menu or you will see the following error:

Each Division must have a valid Clinic entered in the DAY SURGERY HOSP LOCATION field, found in the ADT parameters set up

(See install manual for details).

To add or edit a day surgery patient, type DSE at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

**Figure 4-4:** Entering/editing day surgery

<table>
<thead>
<tr>
<th>Day Surgery Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>(UNSPECIFIED HO)</td>
</tr>
<tr>
<td>DSAU   Day Surgery Audit Report</td>
</tr>
<tr>
<td>DSE    Day Surgery Enter/Edit</td>
</tr>
<tr>
<td>DSL    Patient List by Day Surgery Date</td>
</tr>
<tr>
<td>DSNR   List of Patients Not Released</td>
</tr>
<tr>
<td>DSP    Edit Past Day Surgeries</td>
</tr>
<tr>
<td>DSPC   PCC Day Surgery Visits Listing</td>
</tr>
<tr>
<td>DSPQ   Provider QA Report</td>
</tr>
<tr>
<td>DSQ    Inquiry Day Surgery Entry</td>
</tr>
<tr>
<td>DSTX   Statistics by Treating Specialty</td>
</tr>
<tr>
<td>DSW    Print DS Worksheet</td>
</tr>
</tbody>
</table>

**Select Day Surgery Menu Option:** **DSE** Day Surgery Enter/Edit

**4.2.1 Add a New Day Surgery Patient**

Use this option to add a new day surgery patient into your system.

1. Type the name of the patient being added to the day surgery list at the “Select Day Surgery Patient:” prompt.

2. Type Y (Yes) at the “Are you adding ‘(patient name)’ as a new Day Surgery?” prompt to confirm your entry.

3. The patient’s data will be displayed. Press the Enter key at the “Enter Return to continue or ‘^’ to exit:” prompt to begin adding a patient to day surgery.
Select Day Surgery Patient: PATIENT, ALLISON

Are you adding 'PATIENT, ALLISON' as a new DAY SURGERY? No// Y (Yes)

***Confidential Patient Data Covered by Privacy Act***

<table>
<thead>
<tr>
<th>PATIENT, ALLISON</th>
<th>HRCN: 00-42-98</th>
<th>DOB: FEB 2,1901</th>
</tr>
</thead>
<tbody>
<tr>
<td>(505) 555-8031</td>
<td>PHONE: 464-4775</td>
<td>PROV: PROVIDER, JADE</td>
</tr>
<tr>
<td>UNSPECIFIED NM 88340</td>
<td>ELIG: CHS &amp; DIRECT</td>
<td>SSN: 000785650</td>
</tr>
</tbody>
</table>

Inpatient Status: INACTIVE INPATIENT-on WARD Admission LOS: 1 day

<table>
<thead>
<tr>
<th>Admitted</th>
<th>OCT 7, 2002@14:59</th>
<th>Discharged</th>
<th>OCT 8, 2002@13:40:14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>PED</td>
<td>Room-Bed</td>
<td>211-1</td>
</tr>
<tr>
<td>Provider</td>
<td>PROVIDER, ISABEL</td>
<td>Specialty</td>
<td>UROLOGY</td>
</tr>
</tbody>
</table>

Future Appointments: Date Time Clinic

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/30/02</td>
<td>9:00</td>
<td>CARDIOLOGY</td>
</tr>
<tr>
<td>10/31/02</td>
<td>14:00</td>
<td>CARDIOLOGY</td>
</tr>
<tr>
<td>10/31/02</td>
<td>15:00</td>
<td>CARDIOLOGY</td>
</tr>
<tr>
<td>11/07/02</td>
<td>14:00</td>
<td>CARDIOLOGY</td>
</tr>
<tr>
<td>11/07/02</td>
<td>15:00</td>
<td>CARDIOLOGY</td>
</tr>
<tr>
<td>12/02/02</td>
<td>9:00</td>
<td>CARDIOLOGY</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: [Enter]

**Figure 4-5: Adding a day surgery patient (Steps 1—3)**

4. Type the date and time the day surgery will take place at the “Select Day Surgery Date/Time:” prompt.

   **Note:** A time is not required for entry of the day surgery date/time field, but the prompt for releasing the patient will not be displayed until a time is included. The time is needed to calculate the length of stay in hours.

5. To verify the new entry, type Y (Yes) at the “Are you adding ‘(Date of Surgery)’ as a new Day Surgery Date/Time (the 1st for this Day Surgery)?” prompt.

6. Press the Enter key again to confirm the day surgery date and time at the “Day Surgery Date/Time:” prompt. You can add the time at this prompt if you have not already done so.

7. Type the procedure the patient is having at the “Procedure:” prompt. This field is free text.

8. Type the diagnosis of the patient at the “Diagnosis:” prompt. This field is free text.
9. If the patient is to be kept on a ward for observation after recovery, type the date and time the patient was moved to that ward at the “Date/Time To Observation:” prompt. The observation date and time must be after surgery has occurred. Then enter the Ward and Room-Bed where the patient is staying. You will still have to enter that patient under “Admit a Patient” option in Bed Control for the observation stay to be recorded.

10. Next, enter the Surgical Specialty under which this patient is receiving care as a day surgery patient. This is a required field. Next enter the surgeon’s name and any comments you need recorded.

```
Select DAY SURGERY DATE/TIME: OCT 25, 2002@900
Are you adding 'OCT 25, 2002@9' as
a new DAY SURGERY DATE/TIME (the 1ST for this DAY SURGERY)? No// Y

Remember to include the time before discharging the patient

DAY SURGERY DATE/TIME: OCT 25,2002@9// [Enter] (OCT 25, 2002@09:00)
PROCEDURE: ACL REPAIR
DIAGNOSIS: RUPTURED ACL
DATE/TIME TO OBSERVATION: 10/25/02@1500 (OCT 25, 2002@15:00)
WARD LOCATION: PED
ROOM-BED: 200
SPECIALTY: SURGERY
PROVIDER: DOCTOR,KATHRYN MRQ MEDICAL OFFICER
INTERVIEW COMMENTS:
No existing text
Edit? NO// [Enter]
```

Figure 4-6: Adding a day surgery patient (Steps 5–10)

11. When the patient is released from day surgery, type the release information at the “Release Date/Time:” prompt. Remember, this prompt will not be displayed until there is a time on the Day Surgery Date/Time field.

12. If the patient did not show up for surgery, type Y (Yes) at the “No-Show?” prompt. If Y is typed, no release date will be entered. The same is true for the Surgery Cancelled question. If the patient who is receiving general anesthesia did not bring an escort, enter Y at that prompt.

13. If the patient was admitted directly from day surgery, enter Y at the Patient Admitted question. You will still have to admit the patient under the Bed Control menu to record the admission.

14. At the end, you will be asked if you want to print out a day surgery worksheet. It has a format similar to the IHS Clinical Record Brief used for admissions.
4.2.2 Edit a Day Surgery Patient

Use this option to update the information on a day surgery patient who has not yet been released.

1. Type the name of the day surgery patient to be edited at the “Select Day Surgery Patient:” prompt.

2. The patient’s data will be summarized and displayed onscreen.

3. To edit entries for a Day Surgery patient, type the changes at the default prompt and press the Enter key to record the changes.

Select DAY SURGERY DATE/TIME: 102502@9//102602@9
DAY SURGERY DATE/TIME: Oct 26, 2002@900// [Enter]
PROCEDURE: Knee Surgery// FOOT SURGERY
DIAGNOSIS: Torn Ligament// BROKEN TOE
DATE/TIME TO OBSERVATION: OCT 26, 2002@17:00// [Enter]

Figure 4-8: Editing a day surgery inpatient

4.3 Patient List by Day Surgery Date (DSL)

Use this option to print a list of patients who have had day surgery between the dates specified. Sections 4.3.1 and 4.3.2 detail how to use this option.

To use the Patient List by Day Surgery Date, type DSL at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.
Day Surgery Menu
(UNSPECIFIED HO)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSAU</td>
<td>Day Surgery Audit Report</td>
</tr>
<tr>
<td>DSE</td>
<td>Day Surgery Enter/Edit</td>
</tr>
<tr>
<td>DSL</td>
<td>Patient List by Day Surgery Date</td>
</tr>
<tr>
<td>DSLR</td>
<td>List of Patients Not Released</td>
</tr>
<tr>
<td>DSP</td>
<td>Edit Past Day Surgeries</td>
</tr>
<tr>
<td>DSPC</td>
<td>PCC Day Surgery Visits Listing</td>
</tr>
<tr>
<td>DSPQ</td>
<td>Provider QA Report</td>
</tr>
<tr>
<td>DSQ</td>
<td>Inquiry Day Surgery Entry</td>
</tr>
<tr>
<td>DSTX</td>
<td>Statistics by Treating Specialty</td>
</tr>
<tr>
<td>DSW</td>
<td>Print DS Worksheet</td>
</tr>
</tbody>
</table>

Select Day Surgery Menu Option: **DSL**  Patient List by Day Surgery Date

---

**4.3.1 Print List of All Day Surgery Patients**

Use DSL to print a list of all patients who have had day surgery at a facility.

1. To print a list of all patients who have had day surgery at your facility, press the Return key at the “Start With Day Surgery Date/Time: First//” prompt.

2. Type a print device at the “Device:” prompt.

3. All recorded day surgeries at a facility (up to the present date) will print.

---

**4.3.2 Print List of Day Surgery Patients between Specified Dates**

Use DSL to print a list of all day surgery patients between specified dates.

1. To print a list of day surgery patients between dates, type the date to begin printing the list at the “Start With Day Surgery Date/Time: First//” prompt.

2. Type the date to stop printing the list at the “Go to Day Surgery Date/Time: Last//” prompt.

3. Type a print device at the “Device:” prompt.
4.4 List of Patients Not Released (DSNR)

Use this option to print a list of patients not yet released from day surgery.

1. To print a list of patients in day surgery, type DSNR at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

2. Type the date to start printing the list of day surgery patients at the “Beginning date:” prompt.

3. Type the date to stop printing the list of day surgery patients at the “Ending date:” prompt.

4. Type a print device at the “Device:” prompt.

Figure 4-11: Printing a list of day surgery patients between dates

4.5 Edit Past Day Surgeries (DSP)

Use this option to edit a day surgery visit after the patient has been released from day surgery.
1. To edit a past day surgery visit, type DSP at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

2. Type the name of the patient whose past day surgery visit needs to be edited at the “Select Day Surgery Patient:” prompt.

3. The patient’s data will be displayed.

4. Press the Enter key at the “Press Return to continue or ‘^’ to exit:” prompt.

5. Type the date and time of the day surgery visit to be edited at the “Select Day Surgery Date/Time:” prompt.
6. To edit entries for a Day Surgery patient, type the changes at the default prompts and press the Enter key to record the changes.

```plaintext
Select DAY SURGERY DATE/TIME: ??
  1    OCT 25, 2002@09:00

Select DAY SURGERY DATE/TIME: 1    10-25-2002@09:00:00

DAY SURGERY DATE/TIME: OCT 25, 2002@09:00// 102602@10  (OCT 26, 2002@10:00)
PROCEDURE: Leg Surgery// Knee Surgery
DIAGNOSIS: Knee pain// Torn Ligament
DATE/TIME TO OBSERVATION: OCT 25, 2002@15:00// [Enter]
WARD LOCATION: PED// [Enter]
ROOM-BED: 200// [Enter]
SPECIALTY: SURGERY// [Enter]
PROVIDER: DOCTOR,KATHRYN// [Enter]
INTERVIEW COMMENTS:
  No existing text
  Edit? NO// [Enter]
RELEASE DATE/TIME: OCT 25, 2002@15:00// [Enter]
NO-SHOW?: [Enter]
SURGERY CANCELLED?: [Enter]
UNESCORTED?: [Enter]
PATIENT ADMITTED?: YES// [Enter]
POST-OP COMMENTS: [Enter]
Print Clinical Record Brief? NO// [Enter]
```

Figure 4-14: Editing past day surgeries (Steps 5–6)

4.6 PCC Day Surgery Visits Listing (DSPC)

Use this option to print all day surgery visits and their diagnosis and procedures as coded in the PCC. If you have a link with PCC, a day surgery visit will automatically be created when a patient is discharged from the facility. All PCC coding is done through the PCC Data Entry menu.

1. To print day surgery visits linked with the PCC, type DSPC at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

2. Type the date to begin printing day surgery visits at the “Select beginning date:” prompt.

3. Type the date to stop printing day surgery visits at the “Select ending date:” prompt.

4. Type a print device at the “Device:” prompt.
Day Surgery Menu
(UNSPECIFIED HO)

DSAU   Day Surgery Audit Report
DSE   Day Surgery Enter/Edit
DSL   Patient List by Day Surgery Date
DSNR   List of Patients Not Released
DSP   Edit Past Day Surgeries
DSPC   PCC Day Surgery Visits Listing
DSPQ   Provider QA Report
DSQ   Inquiry Day Surgery Entry
DSTX   Statistics by Treating Specialty
DSW   Print DS Worksheet

Select Day Surgery Menu Option: dspc  PCC Day Surgery Visits Listing

DAY SURGERY VISITS WITH ICD CODES

Select beginning date: T-365  (OCT 25, 2001)
Select ending date: T  (OCT 25, 2002)
DEVICE: HOME//

Figure 4-15: Printing a PCC Day Surgery Visits listing (Steps 1–4)

5. A PCC Day Surgery Visits Listing screen will print as seen in Figure 4-16.

*****Confidential Patient Data Covered by Privacy Act*****

JAC                              UNSPECIFIED HO                        Page 1
1:54 pm               CLINIC VISITS FOR DAY SURGERY (44)
OCT 25,2002                 for 10/25/01 to 10/25/02
NAME            HRCN  AGE  VISIT DATE    PRV  ICD    PROV NARRATIVE
PATIENT,ALLISO    4298  41 10/25/02 0900

TOTAL PATIENTS FOR CLINIC:  1
TOTAL VISITS FOR CLINIC:  1

Enter RETURN to continue or '^' to exit:

RUN TIME (H.M.S): 0.0.1
End of report. HIT RETURN:

Figure 4-16: Printing a PCC Day Surgery Visits listing (Step 5)

4.7 Provider QA report (DSPQ)

Use this option to print a Quality Assurance (QA) Report on a selected provider or all providers at a facility. The QA Report lists those day surgeries where the patient was held over for observation, admitted directly, or admitted within a week. It is printed for a range of dates listing each patient with chart number, age, service, and procedure.
To use Provider QA reports, type DSPQ at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

<table>
<thead>
<tr>
<th>Day Surgery Menu</th>
<th>(UNSPECIFIED HO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSAU</td>
<td>Day Surgery Audit Report</td>
</tr>
<tr>
<td>DSE</td>
<td>Day Surgery Enter/Edit</td>
</tr>
<tr>
<td>DSL</td>
<td>Patient List by Day Surgery Date</td>
</tr>
<tr>
<td>DSNR</td>
<td>List of Patients Not Released</td>
</tr>
<tr>
<td>DSP</td>
<td>Edit Past Day Surgeries</td>
</tr>
<tr>
<td>DSPC</td>
<td>PCC Day Surgery Visits Listing</td>
</tr>
<tr>
<td>DSPQ</td>
<td>Provider QA Report</td>
</tr>
<tr>
<td>DSQ</td>
<td>Inquiry Day Surgery Entry</td>
</tr>
<tr>
<td>DSTX</td>
<td>Statistics by Treating Specialty</td>
</tr>
<tr>
<td>DSW</td>
<td>Print DS Worksheet</td>
</tr>
</tbody>
</table>

Select Day Surgery Menu Option: DSPQ  Provider QA Report

Figure 4-17: Using provider QA report

4.7.1 Print QA Report for All Providers

Use this option to print a QA report for all providers:

1. To print a QA report for all providers, type DSPQ at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

2. Type the date to begin printing the QA Provider report at the “Select beginning date:” prompt.

3. Type the date to stop printing the QA Provider report at the “Select ending date:” prompt.

4. Type Y (Yes) at the “Print Report for All Providers:” prompt.

5. Type a print device at the “Device:” prompt.

6. A QA Report for all providers (similar to the QA Report for Individual Provider, see Figure 4-20) will print.
4.7.2 Print QA Report for Individual Provider

Use this option to print a QA Report for individual providers:

1. To print a QA Report for an individual provider, type DSPQ at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

2. Type the date to begin printing the QA Provider Report at the “Select beginning date:” prompt.

3. Type the date to stop printing the QA Provider Report at the “Select ending date:” prompt.

4. Press the Return key at the “Print Report for All Providers:” prompt.

5. Type the provider’s name at the “Select Provider:” prompt.

6. Type a print device at the “Device:” prompt.

---

Figure 4-18: Printing a QA report for all providers

Select Day Surgery Menu Option: DSPQ  Provider QA Report

DAY SURGERY PROVIDER QA REPORT

Select beginning date: T-365  (OCT 25, 2001)
Select ending date: T  (OCT 25, 2002)
Print Report for ALL Providers? NO// Y

Report requires wide printer or condensed print.

DEVICE: HOME//
Day Surgery Menu
(UNSPECIFIED HO)

DSAU  Day Surgery Audit Report
DSE   Day Surgery Enter/Edit
DSL   Patient List by Day Surgery Date
DSNR  List of Patients Not Released
DSP   Edit Past Day Surgeries
DSPC  PCC Day Surgery Visits Listing
DSPQ  Provider QA Report
DSQ   Inquiry Day Surgery Entry
DSTX  Statistics by Treating Specialty
DSW   Print DS Worksheet

Select Day Surgery Menu Option: DSPQ  Provider QA Report

DAY SURGERY PROVIDER QA REPORT

Select beginning date: T-365  (OCT 25, 2001)
Select ending date: T  (OCT 25, 2002)
Print Report for ALL Providers? NO// [Enter]
Select PROVIDER: DOCTOR,KATHRYN  FAMILY PRACTICE  OTHER
IHS   980IHS

Report requires wide printer or condensed print.

DEVICE:

Figure 4-19: Printing a QA report for one provider (Steps 1–6)

7. A QA report for an individual provider will print, as displayed in Figure 4-20.

<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT</th>
<th>HRCN</th>
<th>SRV</th>
<th>PROVIDER</th>
<th>PROCEDURE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/25/02</td>
<td>DEMO,ALICE</td>
<td>12344</td>
<td>ORT</td>
<td>SURGEON,KATE</td>
<td>LAP KNEE FIX</td>
<td>OBS 8</td>
</tr>
<tr>
<td>19/25/02</td>
<td>DEMO,FRED</td>
<td>22334</td>
<td>SUR</td>
<td>SURGEON,KATE</td>
<td>APPENDECTOMY</td>
<td>ADM W/IN</td>
</tr>
</tbody>
</table>

Figure 4-20: QA report for individual provider

4.8 Inquiry Day Surgery Entry (DSQ)

Use this option to print data on a selected day surgery patient:
1. To print day surgery history on a selected patient, type **DSQ** at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

2. Type the name of the day surgery patient whose data will be printed at the “Select Day Surgery Patient Name:” prompt.

3. Type a print device at the “Device:” prompt.

4. A list of the selected patient’s day surgeries will print (Figure 4-22).

4.9 **Statistics by Treating Specialty (DSTX)**

Use this option to print the total number of day surgery patients in each of the treating specialty categories (e.g., general medicine, pediatrics, surgery, etc.).

1. To print the total number of day surgery patients by treating specialty, type **DSTX** at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.
2. Type the date to begin printing the Day Surgery Statistics by Service (Treating Specialty) at the “Select beginning date:” prompt.

3. Type the date to stop printing the Day Surgery Statistics by Service (treating specialty) at the “Select ending date:” prompt.

4. Type a print device at the “Device:” prompt.

5. A Day Surgery Statistics by Service report will print (Figure 4-24).

---

**Figure 4-23: Printing statistic by treating specialty (Step 1–4)**

**Figure 4-24: Statistics by treating specialty screen (Step 5)**
4.10 Print DS Worksheet (DSW)

Use this option to print a day surgery patient’s cover sheet similar to an IHS Clinical Record Brief used for admissions:

1. To print a day surgery worksheet for a patient, type DSW at the “Select Day Surgery Menu Option:” prompt in the Day Surgery menu.

2. Type the name of the patient whose worksheet will be printed at the “Select Patient Name:” prompt.

3. Type the day surgery date and time at the “Select Day Surgery Date/Time:” prompt.

   **Note:** To view a list of the selected patient’s previous day surgery visits, type ?? at the “Select Day Surgery Date/Time:” prompt.

   ```
   Day Surgery Menu
   (UNSPECIFIED HO)
   DSAU   Day Surgery Audit Report
   DSE   Day Surgery Enter/Edit
   DSL   Patient List by Day Surgery Date
   DSNR   List of Patients Not Released
   DSP   Edit Past Day Surgeries
   DSPC   PCC Day Surgery Visits Listing
   DSPQ   Provider QA Report
   DSQ   Inquiry Day Surgery Entry
   DSTX   Statistics by Treating Specialty
   DSW   Print DS Worksheet
   Select Day Surgery Menu Option: DSW  Print DS Worksheet
   Select PATIENT NAME: PATIENT, ALLISON  F 02-02-1901 000785650    MH 4298
   Select DAY SURGERY DATE/TIME: OCT 26, 2002@10:00//@ Enter] OCT 26, 2002@10:00
   Print bottom half of form? NO//@ Enter]
   Print How Many Copies: (1-10): 1//@ Enter]
   DEVICE: HOME//@ Enter]
   ```

   Figure 4-25: Printing a DS worksheet (Steps 1–3)

4. The day surgery worksheet for the surgery date selected will print (Figure 4-26).
<table>
<thead>
<tr>
<th>IHS Unit No.</th>
<th>Soc Sec No</th>
<th>Classif.</th>
<th>Facility</th>
<th>Facility Code</th>
<th>UNSPECIFIED HO</th>
</tr>
</thead>
<tbody>
<tr>
<td>00-42-98</td>
<td>559-78-5650</td>
<td>IND-01</td>
<td>UNSPECIFIED HO</td>
<td>20-23-01</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name, First, Middle</th>
<th>Age</th>
<th>Religion</th>
<th>Hr Arrvd</th>
<th>Visit Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, ALLISON</td>
<td>41</td>
<td>CATHOLIC</td>
<td>1000</td>
<td>DAY SURGERY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthdate</th>
<th>Sex</th>
<th>Tribe</th>
<th>Service &amp; Code</th>
<th>Surgery Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEB 2, 1901</td>
<td>F</td>
<td>APA008</td>
<td>SUR 04</td>
<td>OCT 26, 2002</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community, County, State Code</th>
<th>Ward</th>
<th>Provider</th>
<th>Release Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>167-19-35</td>
<td>PED</td>
<td>DOCTOR, KATHRYN</td>
<td>OCT 25, 2002</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present Address</th>
<th>Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNSPECIFIED, NM 88340</td>
<td>-19.0 hrs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Next of Kin</th>
<th>Telephone</th>
<th>Address</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>KIN, NANCY</td>
<td></td>
<td></td>
<td>AUNT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person to Notify</th>
<th>Telephone</th>
<th>Address</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>KIN, CAROLYN</td>
<td>671-9114</td>
<td>P.O. BOX 4092</td>
<td>FRIEND</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DX, Procedure &amp; Comments</th>
<th>Medicaid #</th>
<th>Medicare #</th>
<th>Railroad #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torn Ligament</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Figure 4-26: Day surgery worksheet
5.0 Incomplete Chart Menu (IC)

Use this menu to track the completion of charting requirements for inpatient stays, observations, and day surgeries. You can code the inpatient stays here as well. Various worksheets and reports are also available.

To select the Incomplete Chart menu, type IC at the prompt in the ADT Main menu.

Figure 5-1: Accessing the incomplete chart menu

5.1 Inpatient Chart Coding (CODE)

This option is used to code inpatient visits. The actual coding is done in PCC, as this option will drop you into PCC as needed. Any data in common between ADT and PCC, if edited here, will be updated in both databases.

1. To use Inpatient Chart Coding, type CODE at the “Select Incomplete Chart Menu Option:” prompt.

2. Type the patient’s name whose chart needs coding at the “Select Patient:” prompt.

3. Type the visit number that you need to code at the “Select Hospitalization:” prompt. All hospitalizations for the past 2 years will be displayed. They will be marked as to whether or not they have previously been exported. This is important, as changes to an exported hospitalization will not be re-exported unless you flag it so under PCC.
Select Incomplete Chart Menu Option: **CODE** Inpatient Chart Coding

Select Patient: **PATIENT, ALLISON**

Select from these recent admissions:
1. Admitted on SEP 07, 2005@13:37 Current Inpatient
2. Admitted on JUN 02, 2005@13:45
3. Admitted on AUG 25, 2004@08:00 Exported on Sep 15, 2004

Select Hospitalization: (1-3): 1// 2

---

**Figure 5-2: Accessing the Code Inpatient Visit screen (Steps 1–3)**

4. The Code Inpatient Visit screen will be displayed (Figure 5-3). Sections 5.1.1 through 5.1.8 will explain how to use the options listed at the bottom of the screen.

---

**Figure 5-3: Code Inpatient Visit screen (excerpt)**
5.1.1 Admission Data

Use this option to edit data common to both ADT and PCC. You can enter number of consults, coded admitting diagnosis, and DRG.

1. Type 1 or adm at the “Select Action:” prompt.

2. First you will be asked three PCC data items that are stored in the V Hospitalization file: Number of Consults (optional), Admitting Diagnosis (required & ICD code), and DRG (optional).

3. Next you are dropped into the “Extended Bed Control” option. Here you can change data in ADT and any corresponding data in PCC will be automatically updated. At the “Select Option:” prompt, type 1 to edit admission, type 2 to edit a transfer, type 3 to edit the discharge, or press the Enter key to return to the review screen.

4. Follow each of the prompts as they are displayed on your screen. Type new or edited information at the prompts, or press the Return key to go to the next prompt.

5. Type a new patient name at the “Select Patient Name:” prompt, or press the Return key to return to the Code Inpatient Visit screen.

Figure 5-4: Using admission data
5.1.2 Add/Modify PCC Data

Use this option to perform the actual coding in PCC:

1. Type 2 at the “Select Action:” prompt.

2. Major coding categories are now displayed. Type a number from the list of options at the “Select One: (1-6)” prompt. Number six is used to access any mnemonic in PCC.

3. Type A to add information or M to modify existing information at the “Select Mode:” prompt.

4. You will then be dropped into the corresponding PCC mnemonic and its associated questions.

5.1.3 Problem List Update

Use this option to update the patient’s problem list. This drops you into the “PCC Problem List Update” option as if you selected it off of your PCC menu.

1. Type 3 at the “Select Action:” prompt.

2. Type the location where the problem happened at the “Location where Problem List Update Occurred:” prompt. It will default to your current facility. It will then ask for a date.

3. Select Action:Next Screen// 3   Problem List Update
   Location where Problem List update occurred: UNSPECIFIED HO   569
   ALB
   Date Problem List Updated: Today
4. Figure 5-6: Updating the problem list (Steps 1–2)

5. The Problem List Update screen will be displayed (Figure 5-7). Use the options at the bottom of the screen to execute any of the listed options (e.g. add a problem, add a note, edit a problem).

6. Follow the prompts as they are displayed on your screen. For details on using this option, see your PCC manuals. Type Q at the “Select Action:” prompt to return to the Code Inpatient Visit screen.

```
Problem List Update          Oct 30, 2002 08:59:22          Page: 1 of 0
---------------------------------------------------------------------------
Patient Name: PATIENT,ALLISON   DOB: FEB 02, 1901   Sex: F   HRN: 4298
---------------------------------------------------------------------------

1) Problem ID: THCl  DX: 250.00  Status: ACTIVE   Onset: 
Provider Narrative: DM
Notes: 
THC Note#1              PER TESTING TODAY

Enter ?? for more actions

AP   Add Problem          IP   Inactivate Problem   RN   Remove Note
EP   Edit Problem         DD   Detail Display       HS   Health Summary
DE   Delete Problem       NO   Add Note             FA   Face Sheet
AC   Activate Problem     MN   Edit Note            Q    Quit

Figure 5-7: Updating the problem list (Steps 3-4)
```

5.1.4 List I Visits

Use this option to review all PCC visits within the date range of this inpatient stay. This was designed to quickly change any ancillary visits (labs, pharmacy, radiology, etc.) that were created as Ambulatory visits but should be In-hospital visits tied to this inpatient stay.

1. Type 4 at the “Select Action:” prompt.

2. The List I Visits screen will be displayed (Figure 5-8). Use the options at the bottom of the screen to make changes or view more information on the list I visits. You can edit a service category, edit visit, or view visit.

3. When you have completed all changes, type Q at the “Select Action:” prompt to return to the Code Inpatient Visit screen.

```
```
## 5.1.5 Display All Data

Use this option to display all data on a given patient’s inpatient visit. This simply drops you into the “Display Data for a Specific Patient Visit” option found in PCC.

1. Type 5 at the “Select Action:” prompt.

2. The PCC Visit Display screen will be displayed (Figure 5-9).

```markdown
|--------------------|-----------------------|--------------|

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>PATIENT, ALLISON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart #:</td>
<td>4298</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>FEB 02, 1901</td>
</tr>
<tr>
<td>Sex:</td>
<td>F</td>
</tr>
<tr>
<td>VISIT/ADMIT DATE&amp;TIME:</td>
<td>OCT 07, 2002@14:59</td>
</tr>
<tr>
<td>DATE VISIT CREATED:</td>
<td>OCT 07, 2002</td>
</tr>
<tr>
<td>TYPE:</td>
<td>IHS</td>
</tr>
<tr>
<td>THIRD PARTY BILLED:</td>
<td>NO 'V' FILES POINTING TO THIS VISIT</td>
</tr>
<tr>
<td>PATIENT NAME:</td>
<td>PATIENT, ALLISON</td>
</tr>
<tr>
<td>LOC. OF ENCOUNTER:</td>
<td>UNSPECIFIED HO</td>
</tr>
<tr>
<td>SERVICE CATEGORY:</td>
<td>HOSPITALIZATION</td>
</tr>
<tr>
<td>DEPENDENT ENTRY COUNT:</td>
<td>2</td>
</tr>
<tr>
<td>DATE LAST MODIFIED:</td>
<td>OCT 30, 2002</td>
</tr>
<tr>
<td>CREATED BY USER:</td>
<td>PROVIDER, JADE</td>
</tr>
<tr>
<td>USER LAST UPDATE:</td>
<td>PROVIDER, JADE</td>
</tr>
<tr>
<td>DRG:</td>
<td>DRG8</td>
</tr>
</tbody>
</table>

Enter ?? for more actions
+ Next Screen - Previous Screen Q Quit
Select Action: +//
```

Figure 5-9: Displaying all data
5.1.6 Final A Sheet

Use this option to print a final A sheet. You have the ability to include a CPT list or print a Medicare/Medicaid A sheet.

1. Type 6 at the “Select Action:” prompt.

2. Type the number of the type of A sheet you want to print at the “Select Report to Print:” prompt.

3. Type the number of copies of this report you want at the “Print How Many Copies:” prompt.

4. Type a print device name at the “Device:” prompt.

<table>
<thead>
<tr>
<th>Select Action: Next Screen// 6 Final A Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select one of the following:</td>
</tr>
<tr>
<td>1 A Sheet Only</td>
</tr>
<tr>
<td>2 A Sheet with CPT List</td>
</tr>
<tr>
<td>3 Medicare/Medicaid A Sheet</td>
</tr>
</tbody>
</table>

Select Report to Print: 2// 2 A Sheet with CPT List

Printing A Sheet for admission. Type ^ to bypass.
Print How Many Copies: (1-10): 1// [Enter]
DEVICE: HOME// [Enter]

Figure 5-10: Printing a final A sheet

5.1.7 Run Edit Check

Use this option to run an edit check on a patient’s file. This option will determine if there are still actions that need to be taken on a patient’s file.

1. Type 7 at the “Select Action:” prompt.

2. A list of the actions still needing to be taken on the patient’s file will be displayed (Figure 5-11).

3. Press the Return key at the “Press Enter to Continue:” prompt to return to the Code Inpatient Visit screen.
Select Action: Next Screen// 7 Run Edit Check

Coding Complete? NO
WARNING: No provider of service entered for this VISIT!

WARNING: No PRIMARY POV entered for this Hospitalization!
WARNING: No primary provider entered for this visit!
Press ENTER to continue: [Enter]

Figure 5-11: Running an edit check

5.1.8 Rebuild Display

Use this option to refresh the Code Inpatient Visit screen.

Type 8 at the “Select Action:” prompt and the screen will automatically display any updates to the screen.

5.2 Edit Chart Deficiency List (ECD)

Use this option to add or edit the list of available chart deficiencies for use in the Incomplete Chart process. A basic set of deficiencies is added the first time ADT is installed on your system. After that, you may add any you need and inactivate those you do not.

To edit or add a chart deficiency, type ECD at the “Select Incomplete Chart Menu Option:” prompt in the Incomplete Chart menu.

Incomplete Chart Menu
(UNSPECIFIED HO)

<table>
<thead>
<tr>
<th>CODE</th>
<th>Inpatient Chart Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECD</td>
<td>Edit Chart Deficiency List</td>
</tr>
<tr>
<td>FVH</td>
<td>Fix Missing V Hospitalization Entries</td>
</tr>
<tr>
<td>ICE</td>
<td>Incomplete Charts Edit</td>
</tr>
<tr>
<td>ICF</td>
<td>Incomplete Chart Forms</td>
</tr>
<tr>
<td>ICR</td>
<td>Incomplete Chart Reports</td>
</tr>
<tr>
<td>ICS</td>
<td>Incomplete Chart Statistics</td>
</tr>
<tr>
<td>ICV</td>
<td>Fix Visit in ICE</td>
</tr>
<tr>
<td>NICE</td>
<td>NEW Incomplete Charts Edit</td>
</tr>
<tr>
<td>SET</td>
<td>Set Up IC Parameters</td>
</tr>
</tbody>
</table>

Select Incomplete Chart Menu Option: ECD Edit Chart Deficiency List

Figure 5-12: Accessing the Chart Deficiency List
5.2.1 Add or Edit a Chart Deficiency

Use this option to add a new chart deficiency or update one already in your system:

1. Type the name of the deficiency at the “Select Chart Deficiency Name:” prompt.

2. If you are adding a new entry, type Y (Yes) at the “Are you adding ‘(Chart Deficiency Name)’ as a new Chart Deficiency?” prompt to confirm.

3. SYNONYM: Type an abbreviation for the new chart deficiency.

4. ACTIVE/INACTIVE: Type 1 to activate or 0 to inactivate the entry.

5. GROUPING: For those deficiencies that fit under special groupings used in the Provider lists, enter that grouping here. Choose from:
   - ASH if deficiency relates to A Sheet requirements
   - OPR if deficiency relates to completing operative report
   - SIG if deficiency means a signature is missing
   - SUM if deficiency relates to completing discharge summary
   - ADM if deficiency should not appear on provider reports

6. TIU DOCUMENT LINK: For those sites using TIU and updating deficiencies from within TIU, enter TIU document class associated with this deficiency, if any. These would be any deficiency associated with dictations.

---

Select CHART DEFICIENCY NAME: NEW CHART DEFICIENCY
Are you adding 'new chart deficiency' as a new CHART DEFICIENCY (the 44TH)? No// Y (Yes)
NAME: NEW CHART DEFICIENCY Replace [Enter]
SYNONYM: NEW
ACTIVE/INACTIVE: ??
Choose from:
0 INACTIVE
1 ACTIVE
ACTIVE/INACTIVE: 1 ACTIVE
GROUPING: ??
Choose from:
ASH A SHEET
OPR OP REPORT
SIG SIGNATURE
SUM DSCH SUMMARY
ADM ADMIN ONLY
GROUPING: ASH A SHEET

Figure 5-13: Adding a chart deficiency
5.3 Fix Missing V Hospitalization Entries (FVH)

Use this option when the link with PCC did not create a visit or V hospitalization entry for an admission. This option will print a list of patients for the selected discharge dates who need PCC updated for their inpatient stays.

1. To fix missing V Hospitalization entries, type FVH at the “Select Incomplete Chart Menu Option:” prompt in the Incomplete Chart menu.

2. Type the date to begin processing the missing V Hospitalization entries at the “Beginning Discharge Date:” prompt.

3. Type the date to stop processing the missing V Hospitalization entries at the “Ending Discharge Date:” prompt.

4. Type a print device at the “Device:” prompt.

5. The “Fix Missing V Hospitalization Entries” screen will print (Figure 5-15).

---

**Figure 5-15: Fixing missing V hospitalization entries (Step 5)**

---

---

---
5.4 Incomplete Charts Edit (ICE) – [To be removed soon]

With PIMS patch 1004, this option becomes obsolete. It has been left on the menu to ease the transition to the New Incomplete Chart Edit (NICE) option.

Use this option to track and edit all inpatient, observation, and day surgery charts for discharged inpatients. Upon discharge, the patient’s name, discharge date, admission date, ward, and service are automatically recorded into the patient’s file. The rest of the fields in this file are used to determine what still needs to be done to the chart. The following Section details these fields.

You can track deficiencies by provider and completion dates for different phases of the incomplete chart process. Entries can no longer be deleted upon completion, just marked as completed.

1. To use the Incomplete Chart Entry/Edit option, type ICE at the prompt in the Incomplete Chart menu.

2. Type the name of the patient at the “Select Patient:” prompt. If the patient has more than one visit, you will be prompted to select the visit that you need.

<table>
<thead>
<tr>
<th>CODE</th>
<th>Inpatient Chart Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECD</td>
<td>Edit Chart Deficiency List</td>
</tr>
<tr>
<td>FVH</td>
<td>Fix Missing V Hospitalization Entries</td>
</tr>
<tr>
<td>ICE</td>
<td>Incomplete Charts Edit</td>
</tr>
<tr>
<td>ICF</td>
<td>Incomplete Chart Forms</td>
</tr>
<tr>
<td>ICR</td>
<td>Incomplete Chart Reports</td>
</tr>
<tr>
<td>ICS</td>
<td>Incomplete Chart Statistics</td>
</tr>
<tr>
<td>ICV</td>
<td>Fix Visit in ICE</td>
</tr>
<tr>
<td>NICE</td>
<td>NEW Incomplete Charts Edit</td>
</tr>
<tr>
<td>SET</td>
<td>Set Up IC Parameters</td>
</tr>
</tbody>
</table>

Select Incomplete Chart Menu Option: ICE Incomplete Charts Edit
Select Patient: PATIENT, ALLISON

Incomplete Chart Menu
(UNSPECIFIED HO)

Incomplete Chart Entries for PATIENT, ALLISON:
1    DAY SURGERY
2    OCT 29, 2002@15:27    HOSPITALIZATION
6    ADD NEW ENTRY
Select Discharge Date: (1-3): 2

Figure 5-16: Using the incomplete chart menu option (Steps 1–2)

3. The Incomplete Chart Edit screen will be displayed (Figure 5-17). This screen uses ScreenMan. When using ScreenMan for entering data, use the tab or arrow keys for moving between fields. If you make a change or new entry on the form, press the Return key to record the change. If necessary, a pop-up window may be displayed for further entry of information. You can type ?? at any prompt to display your options at the bottom of the screen.
4. When you are done filling in the prompts, use the options at the bottom of the screen to exit, save, or go to the next page.

| COMMAND: | Press <PF1>H for help Insert |

<table>
<thead>
<tr>
<th>Options</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Chart Coding</td>
<td>CODE</td>
</tr>
<tr>
<td>Edit Chart Deficiency List</td>
<td>ECD</td>
</tr>
<tr>
<td>Fix Missing V Hospitalization Entries</td>
<td>FVH</td>
</tr>
<tr>
<td>Incomplete Charts Edit</td>
<td>ICE</td>
</tr>
<tr>
<td>Incomplete Chart Forms</td>
<td>ICF</td>
</tr>
<tr>
<td>Incomplete Chart Reports</td>
<td>ICR</td>
</tr>
<tr>
<td>Incomplete Chart Statistics</td>
<td>ICS</td>
</tr>
<tr>
<td>Fix Visit in ICE</td>
<td>ICV</td>
</tr>
<tr>
<td>NEW Incomplete Charts Edit</td>
<td>NICE</td>
</tr>
<tr>
<td>Set Up IC Parameters</td>
<td>SET</td>
</tr>
</tbody>
</table>

Select Incomplete Chart Menu Option: ICF Incomplete Chart Forms

Figure 5-17: Using the incomplete chart menu option (Steps 3–4)

5.5 Incomplete Chart Forms (ICF)

This option gives you a choice of forms to print such as discharge Outguides, worksheets, and final A sheet.

To access Incomplete Chart Forms menu, type ICF at the “Select Incomplete Chart Menu Option:” prompt.

Figure 5-18: Accessing the incomplete chart forms menu
The Incomplete Chart Forms menu will be displayed (Figure 5-19). Sections 5.5.1 through 5.5.5 detail how to use each form.

| 1. Discharge Outguides                      |
| 2. Deficiency Worksheets                    |
| 3. Incomplete Chart Summary                 |
| 4. Final A Sheet/Bill Prep Worksheet        |
| 5. Online Help (Report Descriptions)        |

Choose Form To Print:  (1-5):

Figure 5-19: The incomplete chart forms menu

5.5.1 Discharge Outguides

Use this option to print a one page charge-out slip to be used by the incomplete chart staff when pulling charts. For a given date range, one Outguide will print for every discharge.

1. Type 1 at the “Choose Form To Print: (1-5):” prompt in the Incomplete Chart Forms submenu.

2. Type the beginning date and time at the “Start with Date/Time:” prompt. Be very careful because if you press the Enter key, it will print discharge Outguides from the very first discharge date on your system to the last.

3. Type the ending date and time at the “Go to Date/Time:” prompt.

4. Type a print device at the “Device:” prompt.
Choose Setup Option:  (1-5): 1
* Previous selection: DATE/TIME not null
START WITH DATE/TIME: FIRST// 10/25/02  (OCT 25, 2002)
GO TO DATE/TIME: LAST// [Enter]
DEVICE:

Example:
Chart Number:             81215
Patient Name:             TEST,EILEEN TIU
Discharge Date:           JUN  2,2005  11:00
Discharge Ward:           4 WEST
Discharge Service:        SURGERY

_X__Incomplete Chart, Paper chart in the Incomplete Chart Room.

_____Patient has expired. Paper chart in the Incomplete Chart Room.

Figure 5-20: Printing discharge outguides

5.5.2 Deficiency Worksheets

Use this option to print deficiency worksheets, which serve as checklists for providers when reviewing incomplete charts. After the incomplete chart clerk reviews the chart, determines the deficiencies and records them in the software, a one page worksheet can be printed which lists all the deficiencies and the provider assigned to correct each.

1. Type 2 at the “Choose Form To Print: (1-5)” prompt in the Incomplete Chart Forms submenu.

2. Type 1 (inpatients), 2 (day surgeries), or 3 (both) at the “Select Records to Print:” prompt.

3. Type the name of the patient at the “Select Patient Record:” prompt.

4. If the patient has more than one incomplete chart, the system will prompt you to select which one of the patient’s charts you want to use.

5. When you are done selecting patient charts, press the Enter key at a blank “Select Another Patient Record:” prompt.

6. Type the name of a print device at the “Device:” prompt.
Choose Form To Print: (1-5): 2

Select one of the following:
1. Inpatients
2. Day Surgeries
3. Both

Select Records to Print: 1 Inpatients
Select PATIENT Record: PATIENT, ALLISON

DEVICE: HOME// [Enter]

Example:
DEFICIENCY WORKSHEET

Chart #: 08-12-15   Discharged on AUG 26, 2004   Date Printed: Sep 29, 2005
MARES, F G          DICT OP REPORT
MARES, F G          AWAITING TRANS OR
RINEHART, H K       ORDERS

Figure 5-21: Printing deficiency worksheets

5.5.3 Incomplete Chart Summary

Use this option to display all the data stored on an incomplete chart entry. From this option, all active and completed entries can be viewed. This option will also list all deficiencies with their date resolved and how long it took to have them completed.

1. Type 3 at the “Choose Form To Print: (1-5)” prompt in the Incomplete Chart Forms submenu.

2. Type the name of the patient at the “Select Patient:” prompt.

3. The system will display a list of all the data stored on the patient’s incomplete chart entry.
Choose Form To Print: (1-5): 3
Select Patient: TEST,EILEEN

Incomplete Chart Summary
Sep 29, 2005 13:35:17
Page: 1 of 2

Confidential Patient Data Covered by Privacy Act
TEST,EILEEN #81215 Coverage: PVT

INCOMPLETE HOSPITALIZATION CHART
VISIT: AUG 25, 2004@08:00
DISCHARGE DATE: AUG 26, 2004@10:27
SERVICE: SURGERY
DISCHARGE DATE: AUG 26, 2004@10:27
Chart Received On: AUG 26, 2004

Deficiencies:
MARES,F G SIGN NARR SUMMARY Resolved
Resolved on AUG 26, 2004 in 0 days
MARES,F G DICT OP REPORT Pending
Comment: TEST COMMENTS
MARES,F G AWAITING TRANS OR Pending
+
   Enter ?? for more actions

Select Action: Next Screen//

Figure 5-22: Printing incomplete chart summary

5.5.4 Final A Sheet/Bill Prep Worksheet

Use this option to print a final A sheet (or Clinical Record Brief). This is printed after the inpatient stay has been coded.

1. Type 4 at the “Choose Form To Print: (1-5)” prompt in the Incomplete Chart Forms submenu.

2. Type the name of the patient at the “Select Patient:” prompt.

3. If the patient has more than one admission, then you will be prompted to select the one that you need.

4. Type 1 (A sheet only), 2 (A sheet with CPT list), or 3 (Medicare/Medicaid A sheet) at the “Select Report to Print:” prompt.

5. Type the number of copies that you want to print at the “Print How Many Copies:” prompt.

6. Type a print device at the “Device:” prompt.
Choose Form To Print: (1-5): 4
Select Patient: PATIENT, ALLISON

Admission(s)
1. OCT 07, 2002@14:59 Hospitalization

Select one of the following:
1. A Sheet Only
2. A Sheet with CPT List
3. Medicare/Medicaid A Sheet

Select Report to Print: 2/  A Sheet with CPT List

Printing A Sheet for admission. Type ^ to bypass.
Print How Many Copies: (1-10): 1/ [Enter]

DEVICE:

Figure 5-23: Printing a final A sheet

5.5.5 Online Help (Report Descriptions)
Use this option to display a detailed description of each of the reports in the incomplete chart forms submenu. All the descriptions will be onscreen.

1. Type 5 at the “Choose Form To Print: (1-5)” prompt in the Incomplete Chart Forms submenu.

2. Type the number of the report at the “Select Help System Action or <Return>:” prompt.
Choose Form To Print:  (1-5): 5

INCOMPLETE CHART FORMS

Use this option to print various forms used in the Incomplete Chart process. Select a form from the list for details.

1  Discharge Outguides
2  Deficiency Worksheets
3  Incomplete Chart Summary
4  Final A Sheet/Bill Prep Worksheet

Select HELP SYSTEM action or <return>: 4

FINAL A SHEET/BILL PREP WORKSHEET

A "Final" A Sheet (or Clinical Record Brief) is printed AFTER the inpatient stay has been coded. Those items not filled in at admission will be included. The format for the A Sheet is determined by a site parameter. There are 2 formats sent with this version - IHS and ANMC. Any site can create their own through FileMan but it is not a simple process. See the PIMS Technical Manual for details.

To assist in the billing process, a "bill prep" worksheet can be printed after the A Sheet. This worksheet lists all CPT codes and other possible billable items on I (In-hospital) visits attached to a hospitalization. Also included are any other visits 72 hours before admission and 24 hours after discharge. There are 2 versions of this CPT listing - full list or an abbreviated list for Medicare/Medicaid patients. The abbreviated listing only includes CPT codes and radiology exams. The full listing also prints all inpatient medications, supplies, lab tests, transaction codes and immunizations.

Select HELP SYSTEM action or <return>:

Figure 5-24: Using online help

5.6 Incomplete Chart Reports (ICR)

Use this option to run various reports based on the incomplete chart file. Use this option to access the various ways of listing incomplete and delinquent charts. See the online help for details on each report.

To access the Incomplete Chart reports submenu, type ICR at the “Select Incomplete Chart Menu Option:” prompt.
Figure 5-25: Accessing the incomplete chart report menu

The Incomplete Chart Report menu will be displayed (Figure 5-26). Sections 5.6.1 through 5.6.7 detail how to use each report.

1. Discharges by Date
2. Day Surgeries by Date
3. Incomplete Charts by Patient
4. Incomplete Charts by Provider
5. Daily/Weekly Completed Charts
6. Listing of Coded A Sheets
7. Online Help (Report Descriptions)

Choose Report To Print: (1-7):

Figure 5-26: Accessing the incomplete chart report menu

5.6.1 Discharges by Date

Use this report to produce a simple list of all discharges for a specific date range. The list is drawn from entries in the Incomplete Chart file for hospitalizations and observations.

1. Type 1 at the “Choose Report To Print: (1-7)” prompt in the Incomplete Chart Reports submenu.
2. Type the beginning date of the report at the “Start with Discharge Date:” prompt.
3. Type the ending date of the report at the “Go to Discharge Date:” prompt.
4. Type a print device at the “Device:” prompt.
5.6.2 Day Surgeries by Date

1. Use this report to produce a simple list of all day surgeries for a specific date range. The list is drawn from entries in the Incomplete Chart file. Type 2 at the “Choose Report To Print Setup Option: (1-7)” prompt in the Incomplete Chart Reports submenu.

2. Type the beginning date of the report at the “Start with Surgery Date:” prompt.

3. Type the ending date of the report at the “Go to Surgery Date:” prompt.

4. Type a print device at the “Device:” prompt.

Choose Report To Print:  (1-7): 2

* Previous selection: SURGERY DATE from Feb 1,2002 to Feb 28,2002
START WITH SURGERY DATE: FIRST// 0801  (AUG 01, 2005)
GO TO SURGERY DATE: LAST// t  (SEP 29, 2005)
DEVICE:  Virtual

Example:

DAY SURGERIES BY DATE SEP 29,2005 13:51 PAGE 1
PATIENT HRCN SURGERY DATE INSURANCE
-----------------------------------------------
DEMO,FRED 5107 AUG 26,2005 IHS
DEMO,BRIAN 35033 SEP 14,2005 IHS
-----------------------------------------------
COUNT 2

Figure 5-28: Printing a day surgeries by date report
5.6.3 Incomplete Charts by Patient

Use this report to list all incomplete charts (inpatient, day surgery, or both) either alphabetically by patient name or by chart number terminal digit order. You will have the option to sort the report by chart number terminal digit, and can include only those waiting to be coded.

1. Type 3 at the “Choose Report To Print: (1-7)” prompt in the Incomplete Chart Reports submenu.

2. Type 1 (inpatient only), 2 (day surgeries only), or 3 (both) at the “Select Visit Types to Include:” prompt.

3. Type the beginning date of the report at the “Start with Discharge/Surgery Date:” prompt.

4. Type the ending date of the report at the “Go to Discharge/Surgery Date:” prompt.

5. Type a number that corresponds to the type of charts you need printed at the “Select Charts to Print: (1-7):” prompt. You can choose all incomplete charts or only those at a particular stage.

6. Type 1 to sort alphabetically or 2 to sort by terminal digit.

7. Select a method of displaying/printing the report at the “Print Mode:” prompt. If you select browse, the report will be displayed on screen. If you select print, you will be prompted to select a printer and a number of copies needed.
Choose Report To Print: (1-7): 3

Select one of the following:

1. Inpatients Only
2. Day Surgeries Only
3. Both

Select Visit Types to Include: 3 Both
Select Beginning Discharge/Surgery Date: T-365 (OCT 28, 2001)
Select Ending Discharge/Surgery Date: T (OCT 28, 2002)

1. All Incomplete Charts
2. Charts Not Yet Received
3. Charts Not Yet Tagged
4. Insurance Not Identified
5. Not Coded (Tagged or Not)
6. Coded, Not Completed
7. Completed, In Bill Prep

Select Charts to Print: (1-7): 1/

Select one of the following:

1. Sort Alphabetically by Name
2. Sort by Terminal Digit

Select Patient Sort: 1 Sort Alphabetically by Name

Select one of the following:

B. BROWSE ON SCREEN
P. PRINT ON PAPER

PRINT MODE: BROWSE// [Enter]

Example:

Incomplete Chart by Patient   Sep 29, 2005 13:58:51          Page:  1 of  1
Confidential Patient Data Covered by Privacy Act
Inpatients (All Incomplete Charts)
from 08/01/2005 to 09/29/2005

Patient             Chart #  Visit Dates       Ward/Srv     Ready-Coded___
DEMO,ASHLEY          35909    08/31/05          OBS
                    09/09/05          MEDO
PATIENT,IRENE        12421    08/12/05          4 WEST
                    08/25/05          SUR

TOTAL INCOMPLETE CHARTS: 2

Enter ?? for more actions >>>

Select Action:Quit//

Figure 5-29: Printing incomplete charts by patient
5.6.4 Incomplete Charts by Provider

Use this report to list incomplete charts by provider. This report can be run for all providers, for those within select hospital services, within select provider classes, or by name.

1. Type 4 at the “Choose Report To Print: (1-7)” prompt in the Incomplete Chart Reports submenu.

2. Type the number of the visit type you want to include in your report at the “Select Visit Types to Include:” prompt.

3. Type Y or N at the “Print Report for All Providers:” prompt.

4. Type the number that corresponds to the selection criteria you want to include on your report at the “Choose Selection Criteria:” prompt.

5. If you typed 1 (service), type a hospital service at the “Select Hospital Service Name:” prompt. If you typed 2 (class), type provider’s class at the “Select a Provider Class:” prompt. If you typed 3 (providers by name), type the provider’s name at the “Select Provider Name:” prompt. When you are done making entries, press the Return key at the “Select Another Provider/Class/Service:” prompt.

6. Type the number of the report you want to print at the “Select Report to Print:” prompt.

7. Select a method of displaying/printing the report at the “Print Mode:” prompt. If you select browse, the report will be displayed onscreen. If you select print, you will be prompted to select a printer and a number of copies needed.
Select Provider Name: **DOCTOR, KATHRYN**  MRQ  MEDICAL OFFICER
Select Another Provider Name:  [Enter]

Select one of the following:
1. Individual Provider Listings Only
2. Summary Page Only
3. Both

Select Report to Print:  3  Both

Select one of the following:
B  BROWSE ON SCREEN
P  PRINT ON PAPER

PRINT MODE: BROWSE//  [Enter]

Example:

Providers' Incomplete Charts  Sep 29, 2005 14:20:58  Page: 1 of 2

+Patient  Chart #  Date     Type  Deficiencies  #Days
Incomplete Charts for **DOCTOR, KATHRYN**
TEST, EILEEN TIU 81215  04/06/04  INF  *HISTORY & PHYSICAL  541
               *ORDERS     541

Total Delinquent Charts: 1
Total Incomplete Charts: 1
Incomplete/Delinquent for Signature  1

SUMMARY PAGE

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>INCOMP</th>
<th>DELINQ</th>
<th>DEFICIENCY CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOCTOR, K</strong></td>
<td>1</td>
<td>1</td>
<td>0 0 0 0 0 1</td>
</tr>
</tbody>
</table>

+  Enter ?? for more actions

Select Action: Next Screen//

---

**Figure 5-31: Printing incomplete charts by provider (Steps 5–7)**
5.6.5 Daily/Weekly Completed Charts

Use this report to produce a list of charts that have been coded, completed, or have been through bill prep for a date range you specify. You can use the report for daily lists of charts that need to be passed on to the staff that processes the chart in its next stage.

1. Type 5 at the “Choose Report To Print: (1-7)” prompt in the Incomplete Chart Reports submenu.

2. Type the number of the completion stage at the “Select Completion Stage:” prompt.

3. Type the beginning date of the report at the “Beginning Date Coded:” prompt.

4. Type the ending date of the report at the “Ending Date Coded:” prompt.

5. Type 1 to sort alphabetically or 2 to sort by date at the “Select Sorting Choice:” prompt.

6. Type 1 to include only inpatient records on the list, 2 for day surgery only, or 3 for both, at the “Select Visit Types To Include:” prompt.

7. Select a method of displaying/printing the report at the “Print Mode:” prompt. If you select browse, the report will be displayed onscreen. If you select print, you will be prompted to select a printer and a number of copies needed.
Choose Report To Print: (1-7): 5

Select one of the following:
1. Coded
2. Completed
3. Bill Prep Done

Select Completion Stage: 1 Coded
Enter Beginning Date Coded: T-365 (OCT 28, 2001)
Enter Ending Date Coded: T (OCT 28, 2002)

Select one of the following:
1. Alphabetical
2. By Date Coded

Select Sorting Choice: 1 Alphabetical

Select one of the following:
1. Inpatients Only
2. Day Surgeries Only
3. Both

Select Visit Types To Include: 1 Inpatients Only

Select one of the following:
B. BROWSE ON SCREEN
P. PRINT ON PAPER

PRINT MODE: BROWSE/

Example:

CHARTS COMPLETED BY DATE Sep 29, 2005 15:33:35 Page: 1 of 2
Confidential Patient Data Covered by Privacy Act
Inpatients Only - Coded Charts
Sep 28, 2005 to Sep 28, 2005

<table>
<thead>
<tr>
<th>Coded</th>
<th>HRCN</th>
<th>Patient Name</th>
<th>Typ</th>
<th>Dsch/Sur</th>
<th>WHO</th>
<th>Compl</th>
<th>BPrep</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/28/05</td>
<td>55555</td>
<td>PATIENT, JERRY</td>
<td>IP</td>
<td>09/27/05</td>
<td>ABC</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>09/28/05</td>
<td>141414</td>
<td>DEMO, ARTHUR</td>
<td>IP</td>
<td>09/22/05</td>
<td>XYZ</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

+ Enter ?? for more actions

Select Action: Next Screen/

Figure 5-32: Running daily/weekly completed charts (Steps 1–4)
5.6.6 Listing of Coded A Sheets

Use this report to list all coded inpatient records for a range of discharge dates. It can be run listing the date coded or the date the visit was exported.

1. Type 6 at the “Choose Report To Print: (1-7)” prompt in the Incomplete Chart Reports submenu.

2. Type the number of the sorting option for your report at the “Select Coded A Sheet Report:” prompt.

3. Type the beginning date of the report at the “Select Beginning Discharge Date:” prompt.

4. Type the ending date of the report at the “Select Ending Discharge Date:” prompt.

5. Type a print device at the “Device:” prompt. Press the Return key to display the report onscreen.
Choose Report To Print: (1-7): 6

CODED A SHEET REPORTS

Select one of the following:
1 WITH DATE CODED
2 WITH DATE EXPORTED

Select CODED A SHEET REPORT: 1 WITH DATE CODED
Select BEGINNING Discharge Date: T-365 (OCT 28, 2001)
Select ENDING Discharge Date: T (OCT 28, 2002)
DEVICE: HOME [Enter]

Example:

Confidential Patient Data Covered by Privacy Act

<table>
<thead>
<tr>
<th>Patient</th>
<th>Chart #</th>
<th>Discharged Coded</th>
<th>Days</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE: FAMILY PRACTICE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEMO,SHORTY</td>
<td>38355</td>
<td>09/01/05 09/02/05</td>
<td>1</td>
<td>DOCTOR,KATHERI</td>
</tr>
<tr>
<td>DEMO,LEO</td>
<td>40920</td>
<td>09/01/05 09/02/05</td>
<td>1</td>
<td>DOCTOR,SHEILA</td>
</tr>
<tr>
<td># Coded</td>
<td>Low</td>
<td>High</td>
<td>Average</td>
<td></td>
</tr>
<tr>
<td>Totals for Service:</td>
<td>2</td>
<td>1</td>
<td>1.00</td>
<td></td>
</tr>
</tbody>
</table>

SERVICE: GENERAL MEDICINE

<table>
<thead>
<tr>
<th>Patient</th>
<th>Chart #</th>
<th>Discharged Coded</th>
<th>Days</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT MARIE</td>
<td>16895</td>
<td>09/01/05 09/02/05</td>
<td>1</td>
<td>DOCTOR,JIM</td>
</tr>
<tr>
<td>PATIENT,PHINA</td>
<td>71678</td>
<td>09/01/05 09/06/05</td>
<td>5</td>
<td>DOCTOR,THOMAS</td>
</tr>
<tr>
<td># Coded</td>
<td>Low</td>
<td>High</td>
<td>Average</td>
<td></td>
</tr>
<tr>
<td>Totals for Service:</td>
<td>2</td>
<td>1</td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>

+ Enter ?? for more actions

Select Action:Next Screen

Figure 5-33: Running a listing of coded A sheets

5.6.7 Online Help (Report Descriptions)

Use this option to display detailed report descriptions of all reports in the incomplete report submenu. All reports descriptions will be displayed on your screen.

1. Type 7 at the “Choose Report To Print: (1-7)” prompt in the Incomplete Chart Reports submenu.

2. Type the number of the report for which you need a description at the “Select Help System Action or <Return>:” prompt.
Choose Report To Print:  (1-7): 7

INCOMPLETE CHART REPORTS

These reports show incomplete chart data from many different angles. Select a report by number for details on it.

1    Discharges by Date
2    Day Surgeries by Date
3    Incomplete Charts by Patient
4    Incomplete Charts by Provider
5    Daily/Weekly Completed Charts
6    Listing of Coded A Sheets

Select HELP SYSTEM action or <return>:

Figure 5-34: Using online help

5.7 Incomplete Chart Statistics (ICS)

Use this option to access reports giving statistics on current and past incomplete/delinquent charts.

To access the Incomplete Chart Statistics submenu, type ICS at the “Select Incomplete Chart Menu Option:” prompt in the Incomplete Chart menu.

Incomplete Chart Menu

(UNSPECIFIED HO)

CODE   Inpatient Chart Coding
ECD    Edit Chart Deficiency List
FVH    Fix Missing V Hospitalization Entries
ICE    Incomplete Charts Edit
ICF    Incomplete Chart Forms
ICR    Incomplete Chart Reports
ICS    Incomplete Chart Statistics
ICV    Fix Visit in ICE
NICE   NEW Incomplete Charts Edit
SET    Set Up IC Parameters

Select Incomplete Chart Menu Option: ICS  Incomplete Chart Statistics

Figure 5-35: Accessing the incomplete chart statistics menu

The Incomplete Chart Statistics menu will be displayed (Figure 5-36). Sections 5.7.1 through 5.7.4 detail how to use each report.
1. Inpatient Coding Status Report
2. Day Surgery Coding Status Report
3. Workload Report (Completion Times)
4. Online Help (Report Descriptions)
Choose Report To Print: (1-4):

5.7.1 Inpatient Coding Status Report
Use this report as a replacement of the ASR - Coding Status of A Sheets report from MAS. For the months selected, this report will count the number of discharges, number coded, number not coded, number exported, and number of errors. Errors are any inpatient record where there is something not correct with the ADT or PCC entry.

1. Type 1 at the “Choose Report To Print:” prompt in the Incomplete Chart Statistics submenu.

2. Type the month and year that you want your report to start at the “Select Beginning Month:” prompt.

3. Type the month and year that you want your report to end at the “Select Ending Month:” prompt.

4. Type a print device at the “Device:” prompt.

Choose Report To Print: (1-4): 1
Select Beginning Month: AUG 2005
Select Ending Month: AUG 2005
DEVICE: HOME// [Enter]

Example:

Inpatient Coding Status       Sep 29, 2005 15:15:37          Page:  1 of  1
Confidential Patient Data Covered by Privacy Act
TAOS-PICURIS HEALTH CENTER
Aug 2005 to Aug 2005

<table>
<thead>
<tr>
<th>Month/Year</th>
<th># Disch</th>
<th># Coded</th>
<th># Not-Coded</th>
<th># Exported</th>
<th># Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 2005</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Enter ?? for more actions
Select Action: Quit//

Figure 5-37: Printing inpatient coding report
5.7.2 Day Surgery Coding Status Report

Use this report like the Inpatient Coding Status report but this report counts day surgery visits. For the months selected, it will count the number of day surgeries, number coded, number not coded, number exported, and number of errors. Errors are any inpatient record where there is something not correct with entry.

1. Type 2 at the “Choose Report To Print:” prompt in the Incomplete Chart Statistics submenu.

2. Type the month and year that you want your report to start at the “Select Beginning Month:” prompt.

3. Type the month and year that you want your report to end at the “Select Ending Month:” prompt.

4. Type a print device at the “Device:” prompt.

```plaintext
Choose Report To Print: (1-4): 2
Select Beginning Month: T-7 (OCT 21, 2002)
Select Ending Month: T (OCT 28, 2002)
DEVICE: HOME// [Enter]

Example:

Day Surgery Coding Status     Sep 29, 2005 15:19:52          Page:  1 of  1
Confidential Patient Data Covered by Privacy Act
TAOS-PICURIS HEALTH CENTER
Aug 2005 to Sep 31, 2005

<table>
<thead>
<tr>
<th>Month/Year</th>
<th># Surgeries</th>
<th># Coded</th>
<th># Not-Coded</th>
<th># Exported</th>
<th># Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 2005</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sep 2005</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>---------</td>
<td>-------------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Surgery Date  Patient Name      Chart #  Srv  Insurance
08/25/2005    TEST,EILEEN TIU  81215  PVT
08/25/2005    TEST,EILEEN TIU  81215  PVT
08/26/2005    DEMO,FRED        5107   IHS
09/14/2005    DEMO,BRIAN       35033  IHS
09/28/2005    DEMO,BRIAN       35033  IHS

Enter ?? for more actions
Select Action:Quit//
```

Figure 5-38: Printing the day surgery coding status report
5.7.3 Workload Report (Completion Times)

Use this report to show how long each stage in the completion process takes. You select to report on either inpatients or day surgery patients and sort the list alphabetically or by chart number terminal digit.

1. Type 3 at the “Choose Report To Print:” prompt in the Incomplete Chart Statistics submenu.

2. Type the number of the visit type you need at the “Select Visit Type to Include:” prompt.

3. Type the beginning date of your report at the “Select Beginning Discharge Date:” prompt.

4. Type the ending date of your report at the “Select Ending Discharge Date:” prompt.

5. Select how you want the report sorted at the “Select Patient Sort:” prompt.

6. Type the name of a print device at the “Device:” prompt.
Choose Report To Print:  (1-4): 3

Select one of the following:

1 Inpatients
2 Day Surgeries

Select Visit Type to Include: 1 Inpatients
Select Beginning Discharge Date:  T-7  (OCT 21, 2002)
Select Ending Discharge Date:  T  (OCT 28, 2002)

Select one of the following:

1 Sort Alphabetically by Name
2 Sort by Terminal Digit

Select Patient Sort: 1 Sort Alphabetically by Name

If printing to paper, please use wide paper or condensed print DEVICE: HOME// [Enter]

Example:

Incomplete Chart Workload     Sep 29, 2005 15:22:53          Page:  1 of  1
Inpatients
Jan 01, 2005 to Sep 29, 2005

Patient Name      Chart#  Disch/Surg    Rcvd   Taggd   Insur   Ready   Coded
TEST,JADA         65040  MAY 13, 2005    2      ---     ---     ---       4
DEMO,FRED          5107  APR 16, 2005   ---     ---     ---     ---     ---
DEMO, ASHLEY      35989  SEP 09, 2005   ---     ---     ---     ---     ---
TEST,EILEEN TIU   81215  JUN 02, 2005   ---     ---     ---     ---     ---
TEST,RUBY JANE    18703  JUL 14, 2005    4      ---     ---     ---      10
TEST,RUBY JANE    18703  JUL 20, 2005   ---     ---     ---     ---     ---
TOHTSONI,IRENE S. 12431  AUG 25, 2005   ---     ---     ---     ---     ---

=============================================================================
Averages:          3                                7

New Incomplete Charts              7
TOTAL INCOMPLETE CHARTS:           7
TOTAL COMPLETED CHARTS:            0

Enter ?? for more actions                                       >>>

Select Action:Quit//

Figure 5-39: Printing a workload report

5.7.4 Online Help (Report Descriptions)

Use this report to display detailed report descriptions of the incomplete chart statistic reports. All descriptions will be displayed onscreen.

1. Type 4 at the “Choose Report To Print:” prompt in the Incomplete Chart Statistics submenu.

2. Type the number of the report for which you would like a description at the “Select Help System action or <return>:” prompt.
Choose Report To Print:  (1-4): 4

INCOMPLETE STATISTICAL REPORTS

Welcome to the online help for the Incomplete Chart Statistical Reports. These reports give various views of the status of incomplete charts. For incomplete chart listings use the ICR option. Please select from the list below for details on the selected report.

1. Inpatient Coding Status Report
2. Day Surgery Coding Status Report
3. Workload Report (Completion Times)

Select HELP SYSTEM action or <return>:

Figure 5-40: Using online help

5.8 Fix Visit in ICE (ICV)

Use this option to edit the visit pointer in Incomplete Chart entries. You will want to use this option when the links with PCC did not work properly or when an entry was added manually and the wrong visit was chosen.

1. Type ICV at the “Select Incomplete Chart Menu Option:” prompt.
2. Type the name of the patient at the “Select Incomplete Chart Patient:” prompt.
3. Type the date & time of the visit at the “Visit:” prompt. If there is more than one visit in PCC for that date/time combination, please choose the one for the correct patient and service category.
Incomplete Chart Menu
(UNSPECIFIED HO)

<table>
<thead>
<tr>
<th>CODE</th>
<th>Inpatient Chart Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECD</td>
<td>Edit Chart Deficiency List</td>
</tr>
<tr>
<td>FVH</td>
<td>Fix Missing V Hospitalization Entries</td>
</tr>
<tr>
<td>ICE</td>
<td>Incomplete Charts Edit</td>
</tr>
<tr>
<td>ICF</td>
<td>Incomplete Chart Forms</td>
</tr>
<tr>
<td>ICR</td>
<td>Incomplete Chart Reports</td>
</tr>
<tr>
<td>ICS</td>
<td>Incomplete Chart Statistics</td>
</tr>
<tr>
<td>ICV</td>
<td>Fix Visit in ICE</td>
</tr>
<tr>
<td>NICE</td>
<td>NEW Incomplete Charts Edit</td>
</tr>
<tr>
<td>SET</td>
<td>Set Up IC Parameters</td>
</tr>
</tbody>
</table>

Select Incomplete Chart Menu Option: **ICV**  Fix Visit in ICE

Select INCOMPLETE CHART PATIENT: **PATIENT, ALLISON**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PATIENT, ALLISON</td>
<td>02-02-1901 000785650</td>
</tr>
<tr>
<td>2</td>
<td>PATIENT, ALLISON</td>
<td>10-25-2002</td>
</tr>
</tbody>
</table>

CHOOSE 1-2: 1 PATIENT, ALLISON 10-25-2002

VISIT: OCT 25, 2002@09:00/

---

**Figure 5-41: Fixing a visit in ICE**

**5.9 New Incomplete Chart Edit (NICE)**

Use this new and enhanced method of entering data on incomplete charts, instead of ICE. By using list manager to display data, we have incorporated more flexibility in how data is entered and updated.

1. Type **NICE** at the “Select Incomplete Chart Menu Option:” prompt.

2. Type the name of the patient at the “Select Patient:” prompt. If the patient has more than one visit, you will be prompted to select the visit that you need. Deleted entries can only be accessed by holders of the DGZICE key.

3. A list manager screen will be displayed showing all data your facility is tracking as well as pending deficiencies. Your supervisor can customize which completion dates to track by using the new “Set Up IC Parameters” option detailed in Section 5.10.
Incomplete Chart Menu
(UNSPECIFIED HO)

CODE   Inpatient Chart Coding
ECD    Edit Chart Deficiency List
FVH    Fix Missing V Hospitalization Entries
ICE    Incomplete Charts Edit
ICF    Incomplete Chart Forms
ICR    Incomplete Chart Reports
ICS    Incomplete Chart Statistics
ICV    Fix Visit in ICE
NICE   NEW Incomplete Charts Edit
SET    Set Up IC Parameters

Select Incomplete Chart Menu Option: NICE  NEW Incomplete Charts Edit
Select PATIENT: TEST,EILEEN  <CAD>  F 01-25-1969 555244444  THC 81215

Incomplete Chart Entries for TEST,EILEEN:
1 DEC 16, 2003            DAY SURGERY
2 APR 09, 2004@08:50      HOSPITALIZATION  **COMPLETED**
3 APR 06, 2004@00:30      HOSPITALIZATION
4 OCT 14, 2004@10:30      OBSERVATION  **DELETED**
5 ADD NEW ENTRY

Select Discharge/Day Surgery Date: (1-5): 3

Figure 5-42: New Incomplete Chart Edit (Steps 1–2)

Incomplete Chart Edit         Sep 30, 2005 09:06:48          Page: 1 of 2
TEST,EILEEN                 #81215         Insurance: PVT
Category: HOSPITALIZATION   Service: GENERAL MEDICINE

Admit Date/Time:              APR 05, 2004@04:35
Discharge Date:               APR 06, 2004@00:30

Chart Received On:
Chart Tagged On:
Insurance Identified On:
Chart Ready To Code On:
Chart Coded On:                  By
Chart Completed On:

COMMENTS:

Provider                  Deficiencies                       Status
===========================================================================
DOCTOR,A                 HISTORY & PHYSICAL                 Pending    DOCTOR,A
ORDERS                   Pending

Comments: marked orders for 7/2 & 7/4 on chart
+ Enter ?? for more actions
1  Edit Tracking Dates   4  Add/Edit Deficiencies  7  Mark As Completed
2  Fix Visit Date       5  (View Pending Defic.)  8  Change Provider for
Deficiency              9  Delete Chart
3  Comments Edit        6  View All Deficiencies

Select Action: Next Screen//

Figure 5-43: New Incomplete Chart Edit (Step 3)
4. Type 1 or EDIT to access the “Edit Tracking Dates” action. These are the dates your facility has decided to track in the chart completion process. Simply type in the dates as appropriate. The “Date Chart Completed” will not be asked here unless the chart has already been completed. Use action number seven, “Mark As Completed,” to enter that date.

5. Type 2 or FIX to access the “Fix Visit Date” action. This action is only available to holders of the DGZICE key. It performs the same function as the ICV menu option detailed in Section 5.8. It was duplicated here for convenience.

6. Type 3 or COM to access the “Comments Edit” action. This is simply used to add comments on this chart.

7. Type 4 or ADD to access the “Add/Edit Deficiencies” action. You will be asked for a provider name. Then for that provider, you can add, edit, or close out deficiencies. The first time the provider is selected for this chart, you will be automatically dropped into Add mode. You may close several deficiencies for one provider by entering deficiency numbers separated by commas (i.e. 1, 3, 5). “Select PROVIDER” is asked until you press the Enter key to return to the display screen.
8. As you can see in Figure 5-45, the orders deficiency for Doctor, A no longer displays because it was closed (resolved). The newly added orders deficiency for Doctor, Z does display. To view all deficiencies, even resolved and deleted ones, type 6 to access the “View All Deficiencies” action.
Incomplete Chart Edit   Sep 30, 2005 09:06:48   Page: 1 of 2
TEST, EILEEN   #81215   Insurance: PVT
Category: HOSPITALIZATION   Service: GENERAL MEDICINE

Admit Date/Time: APR 05, 2004@04:35
Discharge Date: APR 06, 2004@00:30

Chart Received On:  
Chart Tagged On:  
Insurance Identified On:  
Chart Ready To Code On:  
Chart Coded On:  By
Chart Completed On:  

COMMENTS:

Provider               Deficiencies                       Status
================================================================================
DOCTOR, A               HISTORY & PHYSICAL                 Pending
DOCTOR, A               ORDERS                             Resolved
                          Comments: marked orders for 7/2 & 7/4 on chart
DOCTOR, Z               ORDERS                             Pending
                          Comments: lab orders on 6/2
                           + Enter ?? for more actions
1  Edit Tracking Dates   4  Add/Edit Deficiencies  7  Mark As Completed
2  Fix Visit Date        5  View Pending Defic.     8  Delete Chart
3  Comments Edit         6  (View All Deficiencies)  9  Quit
Select Action: Next Screen//

Figure 5-46: New Incomplete Chart Edit (results after Step 8)

9. Notice in figure 5-46 that action 5, “View Pending Deficiencies,” is now available and action 6, “View All Deficiencies,” is not (bracketed by parentheses). These two actions toggle back and forth depending on which one was last accessed.

10. Type 7 or MARK to access the “Mark As Completed” action. This action simply asks for DATE CHART COMPLETED. If the chart has at least one pending deficiency, you cannot mark the chart as completed. If you try, you will receive this message “SORRY, you cannot complete this chart; there are pending deficiencies.”

11. Type 8 or Change to access the Change Provider for Deficiency action.
Figure 5-47: New Incomplete Chart Edit (results after Step 7)

12. Type 9 or DEL to access the “Delete Chart” action. This action is only available to holders of the DGZICE key. Enter a delete date only for duplicate entries or records added by mistake.

5.10 Set Up IC Parameters (SET)

Use this new option to modify general Incomplete Chart Tracking (IC) parameters and to customize which tracking dates your facility will use. Only those dates you turn on will be asked under the new NICE option.

1. Type SET at the “Select Incomplete Chart Menu Option:” prompt.
2. A list manager screen will be displayed containing your current settings for all IC parameters. See Figure 5-47 for an example.

![Set Up ICE Questions](image)

<table>
<thead>
<tr>
<th>IC Parameter</th>
<th>Current Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>CREATE INCOMPLETE CHART AT DISCHARGE:</td>
<td>YES</td>
</tr>
<tr>
<td>DAYS TO DELINQUENCY:</td>
<td>20</td>
</tr>
<tr>
<td>DO YOU HAVE DAY SURGERY INCOMPLETE CHARTS?:</td>
<td>YES</td>
</tr>
<tr>
<td>FINAL A SHEET DEFAULT:</td>
<td>A SHEET ONLY</td>
</tr>
<tr>
<td>BILL PREP TRACKED?:</td>
<td>NO</td>
</tr>
<tr>
<td>DATE CHART RECEIVED USED IN ICE?:</td>
<td>YES</td>
</tr>
<tr>
<td>DATE CHART TAGGED USED IN ICE?:</td>
<td>YES</td>
</tr>
<tr>
<td>DATE INSURANCE IDENTIFIED USED IN ICE?:</td>
<td>YES</td>
</tr>
<tr>
<td>READY TO CODE DATE USED IN ICE?:</td>
<td>YES</td>
</tr>
<tr>
<td>DATE CHART CODED USED IN ICE?:</td>
<td>YES</td>
</tr>
<tr>
<td>DATE CHART COMPLETED USED IN ICE:</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>DATE BILL PREP COMPLETED USED IN ICE?:</td>
<td>NO</td>
</tr>
<tr>
<td>DATE BILLED USED IN ICE?:</td>
<td>NO</td>
</tr>
</tbody>
</table>

Enter ?? for more actions
Edit ICE Parameters Quit
Select Action: Quit//

Figure 5-48: Set up IC parameters

3. Type EDIT to access the “Edit ICE Parameters” action. This action simply asks each parameter in turn. At any question type ?? for help in answering.
6.0 Patient Inquiry (PI)

Use this option to view basic demographic, admission, day surgery, appointment, and incomplete chart information. You can expand each Section for more detail.

1. Type PI at the “Select ADT Menu Option:” prompt.

2. Type the name or chart number of the patient at the “Select Patient:” prompt.

3. The Patient Inquiry screen will be displayed (Figure 6-2). Use the options at the bottom of the screen to navigate through the report.

4. To expand an entry, type X at the “Select Action:” prompt, then type the number of the Section that needs expansion. When done with the Section, type Q to return to Patient Inquiry main screen.

5. If you are running the TIU (Text Integration Utility) application and have document titles defined under the special CWAD categories, then type CWAD at the “Select Action:” prompt to access any specialized notes on the current patient. If a patient has such a note, one or more of the CWAD letters will be displayed between these brackets <>. CWAD stands for Crisis Notes, Clinical Warnings, Allergies, and Advance Directives.
Patient Inquiry
Oct 28, 2002 15:30
Page: 1 of 2

*** Confidential Patient Data Covered by Privacy Act ***

(1) Demographics -
PATIENT, ALLISON <AD> HRCN: 4298 DOB: 02/02/1901
(505) 555-8031 PHONE: 464-4775 SEX: FEMALE
UNSPECIFIED, NM 88340 ELIG: CHS & DIRECT SSN: 559-78-5650
(UNSPECIFIED Service Unit)
PCP/TEAM: PROVIDER, JADE / CARDIOLOGY

(2) Current Inpatient Status - Patient currently an Inpatient on PED
Admitted: OCT 7, 2002@14:59 Transferred: OCT 8, 2002@13:40:14
Ward: PED Room-Bed/Ext: 211-1/
Admitted by: PROVIDER, JADE Specialty: UROLOGY
Attending: DOCTOR, ISABEL

(3) Last Day Surgery -
Service: Surgeon:

+ Enter ?? for more actions
X Expand Entry C CWAD Display Q Quit
Select Action: Next Screen//

Figure 6-2: Patient Inquiry screen (excerpt)

6. Expanded Entry for Section 1 – Demographics shows insurance information, emergency contact, and next of kin.

7. Expanded Entry for Section 2 – Admission data will display all inpatient data stored in ADT for any of this patient’s admissions. This is the equivalent of Expanded Patient Inquiry on the Bed Control Menu.

8. Expanded Entry for Section 3 – Day Surgery shows all information entered into the day surgery module for the patient’s last day surgery entry.

9. Expanded Entry for Section 4 – Appointments drops you into the “Display Patient’s Appointments” option in scheduling where you can view details on the appointment and even the PCC visit, if one is linked.

10. Expanded Entry for Section 5 – Incomplete Chart Status drops you into the Incomplete Chart Summary report under “ICF – Incomplete Chart Forms” option.
7.0 Provider Inquiry (PV)

Use this option to display the current patient information on a given provider. This includes information about current inpatients, surgeries, and appointments. An expanded view of each patient encounter is also available.

For inpatients, it will first list all current inpatients for whom this provider is the attending, then all who were admitted by this provider but who have a different attending, and lastly, all inpatients who have this provider as their designated primary care provider in the ambulatory setting. Next, all of today’s day surgery patients with this provider listed as surgeon are displayed. Lastly, all outpatient appointments for this provider are listed. These are based on the provider being designated as the default provider for one or more clinics.

1. Type PV at the “Select ADT Menu Option:” prompt.

2. Type the name of the physician at the “Select Provider Name:” prompt.

3. To sort your report by service, type SERVICE at the “Inpatients Sorted by Ward or Service:” prompt, or press the Enter key to sort by ward.

4. Type B (browse onscreen) or P (print on paper) at the “Print Mode:” prompt. If you type P, you will be prompted to select a printer.

Figure 7-1: Running a provider inquiry (Steps 1-4)
5. The Provider Inquiry screen will be displayed. Use the options at the bottom of the screen to navigate through the report.

6. To EXPAND an entry, type X at the “Select Action:” prompt, then type the number of the Section that needs expansion. When done with the Section type Q to return to Patient Inquiry Main screen.

7. If you are running the TIU (Text Integration Utility) application and have document titles defined under the special CWAD categories, then type CWAD at the “Select Action:” prompt to access any specialized notes on the current patient. If a patient has such a note, one or more of the CWAD letters will be displayed between these brackets <>. CWAD stands for Crisis Notes, Clinical Warnings, Allergies, and Advance Directives.

```
Provider Inquiry Oct 28, 2002 15:51:17 Page: 1 of 1
** Confidential Patient Data Covered by Privacy Act **
PROVIDER,JADE
Patient Name Chart # Wrd/Srv Room-Bed Admit Date Admitting Dx
Attending Provider:
For GMS Ward
1) PATIENT,A.PAUL 7897 GM OCT 07, 2002 54544
   PROVIDER,JADE/PROVIDER,JADE/
Admitting Provider:
For GMS Ward
2) PATIENT,NICOLE 7744 SURG 216-4 SEP 26, 2002 HEART ATTACK
   DOCTOR,MD/PROVIDER,JADE/
For PED Ward
3) PATIENT,ALLISON 4298 UROL 211-1 OCT 07, 2002 BLAH
   DOCTOR,ISABEL/PROVIDER,JADE/PROVIDER,JADE
Attending/Admitting/Primary Care
X Expand Entry C CWAD Display Q Quit
Select Action:Quit//
```

Figure 7-2: Provider Inquiry screen (excerpt)
8.0 **ADT Reports Menu (RM)**

Use this option to print various reports to obtain information on admissions and discharges, A sheets, bed availability, and incomplete charts.

To access the ADT Reports menu, type **RM** at the “Select ADT Menu Option:” prompt from the ADT main menu.

---

**Figure 8-1: Accessing the ADT Reports menu**

The ADT Reports menu will be displayed (Figure 8-2). The options in the ADT Reports menu are explained in the Sections 8.1 through 8.11.

---

**Figure 8-2: ADT Reports menu**

---

8.1 **Admission Forms (AFM)**

Use this option to print the various admission forms available.
To print admission forms, type **AFM** at the “Select ADT Reports Menu Option:” prompt.

<table>
<thead>
<tr>
<th>ADT Reports Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>(UNSPECIFIED HO)</td>
</tr>
</tbody>
</table>

AFM  Admission Forms  
ASR  ADT Statistical Reports  
BED  Bed Availability  
CIC  Current Inpatient Census  
CIL  Current Inpatient Listings  
ILD  Inpatient Listings by Date  
IWA  Inpatients with Appointments  
OIL  Operators' Inpatient List  
PMR  Patient Movement Reports  
SVL  Scheduled Visits Listing  
VAH  View Admission History

Select ADT Reports Menu Option: **AFM**  Admission Forms

Figure 8-3: Accessing admission forms

The admission form menu will be displayed. How to use these options is explained in Sections 8.1.1 through 8.1.4.

Select one of the following:

1. Locator Card  
2. A Sheet  
3. A Sheets by Admit Date  
4. Final A Sheet

Select Admission Form to Print:

Figure 8-4: Accessing admission forms

### 8.1.1 Locator Card (1)

Use this option to print a locator card for an individual patient.

1. To print a Locator Card, type 1 at the “Select Admission Form to Print:” prompt.

2. Type the name of the patient at the “Select Patient:” prompt.

3. If the patient has more than one admission, you will be prompted to select a particular visit.

4. Type a printer device at the “Device:” prompt or type **HOME** to display the information on the screen.

5. A locator card similar to what is seen in Figure 8-6 will print.
Select Admission Form to Print: 1 Locator Card
Select Patient: PATIENT, ALLISON  F 02-02-1901 000785650  MH 4298

Admission(s)
1. OCT 07, 2002@14:59
DEVICE: HOME

Figure 8-5: Printing a locator card

**Confidential Patient Data**
PATIENT, ALLISON  Chart #: 4298
Age: 41 YRS  Date of Birth: 02/02/1901
Sex: F  Religion: CATHOLIC

Patient’s Address:
(505)555-8031  UNSPECIFIED, NM  88340

Next of Kin:
KIN, NANCY

Admission Date: Oct 07, 2002 2:59 pm
Attending Provider:

Figure 8-6: Sample locator card

8.1.2 A Sheet (2)

Use this option to print an A sheet for an individual patient.

1. To print an A sheet, type 2 at the “Select Admission Form to Print:” prompt.

2. Type the name of the patient at the “Select Patient:” prompt.

3. If the patient has more than one admission, you will be prompted to select a particular admission date.

4. Type Y or N at the “Print Bottom Half of A Sheet?” prompt.

5. Type the number of copies you need at the “Print How Many Copies:” prompt.

6. Type a print device at the “Device:” prompt or type HOME to display the information on the screen.

7. An A sheet similar to the one seen in Figure 8-7 will print.
CLINICAL RECORD BRIEF **Confidential Patient Data Covered by Privacy Act**

---

1. IHS Unit No. 2 Soc Sec No 10 Classif. 11 Facility 12 Facility Code 00-42-98 559-78-5650 INDIAN/ALAS UNSPECIFIED HO 202301
---

3. Last Name, First, Middle 13 Age 14 Religion 15 Hr Admit 16 Admit Code
   PATIENT, ALLISON 41 2:59 PM 1 DIRECT
---

4. Birthdate 5 Sex 6 Tribe 17&18 Admit Srvc & Code 19 Admit Date
   02/02/1901 F APA008 INTM 06 OCT 07, 2002
---

8. Community, County, State Code Ward Provider 20 Discharge Date 351-91-67 GMS PROVIDER, JADE
---

9. Present Address 22 Length of Stay (505) 555-8031 UNSPECIFIED, NM 88340 22 days
---

23. Next of Kin Telephone Address Relationship
    KIN, NANCY ,
---

24. Person to Notify 25 Admitting Diagnosis Insurance Coverage
    FRIEND, CAROLYN 555-9114 P.O. BOX 4092 ,
---

Figure 8-7: Printing an A Sheet

8.1.3 A Sheets by Admission Dates (3)

Use this option to print an A sheet by an admission date.

1. To print an A sheet by admission dates, type 3 at the “Select Admission Form to Print:” prompt.

2. Type the admission date at the “Select Admission Date:” prompt.

3. Type Y or N at the “Print Bottom Half of A Sheet:” prompt.

4. Type the number of copies you would like to print at the “Print How Many Copies:” prompt.

5. Type a print device name at the “Device:” prompt.
8.1.4 Final A Sheet

Use this option to print a final A sheet. You have the ability to include a CPT list or print a Medicare/Medicaid A sheet.

1. To print a final A sheet, type 4 at the “Select Admission Form to Print:” prompt.

2. Type the name of the patient at the “Select Patient:” prompt.

3. If the patient has more than one admission date, you will be prompted to select which date interests you.

4. Type the number of the type of A sheet you want to print at the “Select Report to Print:” prompt.

5. Type the number of copies of this report you want at the “Print How Many Copies:” prompt.

6. Type a print device name at the “Device:” prompt.
Select Admission Form to Print: 4 Final A Sheet  
Select Patient: **PATIENT, ALLISON**  

<table>
<thead>
<tr>
<th>Admission(s)</th>
<th>Date</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. OCT 07, 2002@14:59</td>
<td>Hospitalization</td>
<td></td>
</tr>
</tbody>
</table>

Select one of the following:

1. A Sheet Only
2. A Sheet with CPT List
3. Medicare/Medicaid A Sheet

Select Report to Print: 2// A Sheet with CPT List

Printing A Sheet for admission. Type ^ to bypass.

Print How Many Copies: (1-10): 1//

DEVICE: HOME

**CLINICAL RECORD BRIEF **Confidential Patient Data Covered by Privacy Act**

<table>
<thead>
<tr>
<th>1 IHS Unit No.</th>
<th>2 Soc Sec No</th>
<th>10 Classif.</th>
<th>12 Facility Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-23-45</td>
<td>555-66-7777</td>
<td>INDIAN/ALAS</td>
<td>UNK HOS</td>
</tr>
<tr>
<td>999901</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 Last Name, First, Middle</th>
<th>13 Age</th>
<th>14 Religion</th>
<th>15 Hr Admit</th>
<th>16 Admit Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, JOHN A</td>
<td>66</td>
<td>MORMON</td>
<td>0700</td>
<td>1 DIRECT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 Birthdate</th>
<th>5 Sex</th>
<th>6 Tribe</th>
<th>17&amp;18 Admit Srvc &amp; Code</th>
<th>19 Admit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/27/1938</td>
<td>M</td>
<td>NAV084</td>
<td>SURG. 04</td>
<td>JAN 24, 2005</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8 Community Code</th>
<th>Admtg Ward</th>
<th>Admtg Provider</th>
<th>20 Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>631-24-35</td>
<td>MED/SURG</td>
<td>DOCTOR, STEVEN J MD</td>
<td>FEB 11, 2005</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9 Present Address</th>
<th>22 Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOX 9999 SHIPROCK, NM</td>
<td>87290</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>23 Next of Kin</th>
<th>Telephone</th>
<th>Address</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, MARY</td>
<td>444-5555</td>
<td>BOX 9998 FARMINGTON, NM</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24 Person to Notify</th>
<th>Telephone</th>
<th>Address</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, JULIA</td>
<td>444-6666</td>
<td>BOX 8889 SHIPROCK, NM</td>
<td>DAUGHTER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25 Admitting Diagnosis</th>
<th>Insurance Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>GASTROINTEST HEMORR NOS (578.9)</td>
<td></td>
</tr>
<tr>
<td>012405LJ: AM ADMIT</td>
<td>Medicare #525409111A exp</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>26 ICD</th>
<th>27 POA</th>
<th>28 Established DX</th>
</tr>
</thead>
<tbody>
<tr>
<td>562.12</td>
<td>DIVERTICULOSIS</td>
<td></td>
</tr>
<tr>
<td>998.59</td>
<td>INTRAABDOMINAL SEPSIS</td>
<td></td>
</tr>
<tr>
<td>567.2</td>
<td>PERITONITIS</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>29 ICD</th>
<th>30 DX</th>
<th>31 Op &amp; Selec Procedures</th>
<th>32 Infect Date</th>
<th>Phys Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>45.79</td>
<td>562.12</td>
<td>EXTENDED LAPAROSCOPIC SIGMOID</td>
<td>0124</td>
<td>177SJM</td>
</tr>
<tr>
<td>45.79</td>
<td>998.59</td>
<td>EXPLORATORY LAPAROTOMY WITH RESECTION OF THE ISCHEMIC COLON</td>
<td>0201</td>
<td>177SJM</td>
</tr>
<tr>
<td>46.10</td>
<td>998.59</td>
<td>COLOSTOMY</td>
<td>0201</td>
<td>177SJM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>34 Discharge Type</th>
<th>35 Facility Transferred To</th>
</tr>
</thead>
<tbody>
<tr>
<td>REGULAR DISCHARGE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>37 &amp; 38Discharge Service and Code</th>
<th>39 # Consults</th>
<th>40 Injury Date</th>
<th>41 Alleged Injury Cause</th>
<th>42&amp;43 E-Codes &amp; Place of Occurrence</th>
</tr>
</thead>
</table>
8.2 **ADT Statistical Reports (ASR)**

Use this option to review ADT census and other statistics by ward or by service. Each report gives a different view of the ADT activity at your facility.

To access the ADT Statistical Reports menu, type `ASR` at the “Select ADT Reports Menu Option:” prompt in the ADT Reports menu.
ADT Reports Menu

(UNSPECIFIED HO)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFM</td>
<td>Admission Forms</td>
</tr>
<tr>
<td>ASR</td>
<td>ADT Statistical Reports</td>
</tr>
<tr>
<td>BED</td>
<td>Bed Availability</td>
</tr>
<tr>
<td>CIC</td>
<td>Current Inpatient Census</td>
</tr>
<tr>
<td>CIL</td>
<td>Current Inpatient Listings</td>
</tr>
<tr>
<td>ILD</td>
<td>Inpatient Listings by Date</td>
</tr>
<tr>
<td>IWA</td>
<td>Inpatients with Appointments</td>
</tr>
<tr>
<td>OIL</td>
<td>Operators' Inpatient List</td>
</tr>
<tr>
<td>PMR</td>
<td>Patient Movement Reports</td>
</tr>
<tr>
<td>SVL</td>
<td>Scheduled Visits Listing</td>
</tr>
<tr>
<td>VAH</td>
<td>View Admission History</td>
</tr>
</tbody>
</table>

Select ADT Reports Menu Option: **ASR** ADT Statistical Reports

**Figure 8-10:** Accessing statistical reports

The ADT Statistical Report options menu will be displayed (Figure 8-11). Sections 8.2.1 through 8.2.4 explain how to use each option.

<table>
<thead>
<tr>
<th>Number</th>
<th>Report Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Average Daily Patient Load (ADPL)</td>
</tr>
<tr>
<td>2</td>
<td>Inpatient Statistics by Ward</td>
</tr>
<tr>
<td>3</td>
<td>Inpatient Statistics by Service</td>
</tr>
<tr>
<td>4</td>
<td>Online Help (Report Descriptions)</td>
</tr>
</tbody>
</table>

Choose Report from List: (1-4):

**Figure 8-11:** Using the statistical reports menu

### 8.2.1 Average Daily Patient Load (ADPL)

Use this option to run a report showing the average daily patient load sorted by ward or service. This report lists the total patient days and average number of patients per day for wards or services. You have the choice of including inactive wards or services. This would be used when reporting statistics for a date range when a ward or service was once active, but is now inactivated.

1. To use the Average Daily Patient Load option, type **1** at the “Choose Report from List:” prompt.

2. Type **1** (by ward) or **2** (by service) at the “Select Format:” prompt to select the way you would like your report sorted.

3. Type **Y** or **N** at the “Include Inactive Services/Wards:” prompt.

4. Type the date that you would like your report to start at the “Select Beginning Date:” prompt.
5. Type the date that you would like your report to end at the “Select Ending Date:” prompt.

6. Type the name of a print device at the “Device:” prompt or type HOME to display the report on your screen.

Choose Report from List:  (1-4): 1
Select one of the following:
1  By Ward
2  By Service

Select Format: 1  By Ward
Include INACTIVE Wards? NO//Y YES
Select Beginning Date: T-365 (OCT 29, 2001)
Select Ending Date:  T (OCT 29, 2002)
DEVICE: HOME//[Enter]

Figure 8-12: Printing average daily patient load (Steps 1—6)

7. A report similar to Figure 8-13 will print. If you select to display your report onscreen, use the options at the bottom of the screen to navigate through the report.

Inpatient Stats by Ward     Oct 29, 2002 11:53:36     Page:  1 of  1
For Oct 29, 2001 through Oct 29, 2002

<table>
<thead>
<tr>
<th>Ward</th>
<th>Patient Days</th>
<th>ADPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMS</td>
<td>138</td>
<td>0.38</td>
</tr>
<tr>
<td>PED</td>
<td>7</td>
<td>0.02</td>
</tr>
<tr>
<td>TOTALS</td>
<td>145</td>
<td>0.40</td>
</tr>
</tbody>
</table>

Enter ?? for more actions
Select Action: Quit//

Figure 8-13: Sample average daily patient load output

8.2.2 Inpatient Statistics by Ward

Use this option to print an inpatient statistics report by ward report.

1. To print inpatient statistics by ward, type 2 at the “Choose Report from List:” prompt.
2. Type the date that you would like your report to start at the “Select Beginning Date:” prompt.

3. Type the date that you would like your report to end at the “Select Ending Date:” prompt.

4. Type Y or N at the “Include Inactive Wards:” prompt.

5. Type a patient type at the “Select Patient Type:” prompt.

6. Type the name of a print device at the “Device:” prompt or type HOME to display the report on your screen.

Choose Report from List: (1-4): 2
Select Beginning Date: T-365 (OCT 29, 2001)
Select Ending Date: T (OCT 29, 2002)
Include INACTIVE Wards? NO// Y (YES)

Select one of the following:

1. Inpatients Only
2. Observation Patients Only
3. Both

Select Patient Type: BOTH// 3 Both
DEVICE: HOME

Figure 8-14: Printing inpatient statistics by ward (Steps 1–6)

7. A report similar to Figure 8-15 will print. If you select to display your report onscreen, use the options at the bottom of the screen to navigate through the report.
ADT Statistics by Ward Oct 29, 2002 12:05:59 Page: 1 of 1
For Oct 29, 2001 through Oct 29, 2002
Includes Inpatients AND Observations

<table>
<thead>
<tr>
<th>Ward</th>
<th>ADM</th>
<th>TXI</th>
<th>TXO</th>
<th>DSC</th>
<th>DTH</th>
<th>1DAY</th>
<th>DAYS</th>
<th>ADPL</th>
<th>LOSD</th>
<th>LOSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMS</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>17</td>
<td>1</td>
<td>1</td>
<td>138</td>
<td>0.38</td>
<td>61 / 1</td>
<td>7</td>
</tr>
<tr>
<td>PED</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0.02</td>
<td>7 / 0</td>
<td>1</td>
</tr>
</tbody>
</table>

TOTAL: 25 0 0 23 1 1 145 0.40 68 / 1 8

ADM = admissions, TXI = ward transfers in
TXO = ward transfer out, DSC = discharges
DTH = deaths, 1DAY = admitted & discharged same day
DAYS = total patient days, ADPL = ave daily patient load
LOSD = length of stay for patients discharged: total / average
(discharged = TXO + DSC + DTH)
LOSA = length of stay by admissions (inpt days/#ADM+TXI)

Enter ?? for more actions
Select Action: Quit

Figure 8-15: Sample inpatient statistics by ward output

8.2.3 Inpatient Statistics by Service

Use this option to print an inpatient statistic by service report.

1. To print an inpatient statistic by service, type 3 at the “Choose Report from List:” prompt.

2. Type the date that you would like your report to start at the “Select Beginning Date:” prompt.

3. Type the date that you would like your report to end at the “Select Ending Date:” prompt.

4. Type Y or N at the “Include Inactive Services:” prompt.

5. Type a patient type at the “Select Patient Type:” prompt.

6. Type the name of a print device at the “Device:” prompt or type HOME to display the report on your screen.
Choose Report from List:  (1-4): 3
Select Beginning Date:  T-365  (OCT 29, 2001)
Select Ending Date:  (T  (OCT 29, 2002)
Include INACTIVE Services? NO// Y

Select one of the following:
1  Inpatient Services Only
2  Observation Services Only
3  Both
Select Patient Type: BOTH// 3  Both
DEVICE:  HOME

Figure 8-16: Printing inpatient statistics by service (Steps 1–6)

7. A report similar to Figure 8-17 will print.

<table>
<thead>
<tr>
<th>Serv</th>
<th>ADM</th>
<th>TXI</th>
<th>TXO</th>
<th>DSC</th>
<th>DTH</th>
<th>1DAY</th>
<th>DAYS</th>
<th>ADPL</th>
<th>LOSD</th>
<th>LOSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GMED</td>
<td>102</td>
<td>2</td>
<td>0</td>
<td>92</td>
<td>3</td>
<td>9</td>
<td>317</td>
<td>10.57</td>
<td>269</td>
<td>2</td>
</tr>
<tr>
<td>GYN</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0.10</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>NEW</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OB</td>
<td>53</td>
<td>0</td>
<td>1</td>
<td>54</td>
<td>0</td>
<td>1</td>
<td>96</td>
<td>3.20</td>
<td>98</td>
<td>1</td>
</tr>
<tr>
<td>PEDS</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0.07</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>SURG</td>
<td>38</td>
<td>0</td>
<td>1</td>
<td>39</td>
<td>0</td>
<td>0</td>
<td>134</td>
<td>4.47</td>
<td>148</td>
<td>3</td>
</tr>
<tr>
<td>SUBTOTAL:  195</td>
<td>2</td>
<td>2</td>
<td>188</td>
<td>3</td>
<td>10</td>
<td>552</td>
<td>18.40</td>
<td>523</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Pediatric Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GMED</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GYN</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NEW</td>
<td>47</td>
<td>0</td>
<td>0</td>
<td>49</td>
<td>0</td>
<td>2</td>
<td>78</td>
<td>2.60</td>
<td>80</td>
<td>1</td>
</tr>
<tr>
<td>OB</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PEDS</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>1.33</td>
<td>44</td>
<td>2</td>
</tr>
<tr>
<td>SURG</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>22</td>
<td>0.73</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>SUBTOTAL:  73</td>
<td>0</td>
<td>0</td>
<td>79</td>
<td>0</td>
<td>2</td>
<td>140</td>
<td>4.67</td>
<td>146</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL:     268</td>
<td>2</td>
<td>2</td>
<td>267</td>
<td>3</td>
<td>12</td>
<td>692</td>
<td>23.07</td>
<td>669</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

ADM = admissions, TXI = ward transfers in
TXO = ward transfer out, DSC = discharges
DTH = deaths, 1DAY = admitted & discharged same day
TPD = total patient days, ADPL = ave daily patient load
LOSD = length of stay for patients discharged: total / average
LOSA = length of stay by admissions (inpt days/# ADM+TXI)
Enter ?? for more actions

Select Action: Quit//

Figure 8-17: Sample inpatient statistics by service output
8.2.4 Online Help (Report Descriptions)

Use this option to view a detailed description of each of the reports in the ADT statistical report menu. All descriptions will be displayed on your screen.

1. To use the Online Help option, type 4 at the “Choose Report from List:” prompt.

2. Type the abbreviation of the report that you would like a description of at the “Select Help System Action or <Return>:” prompt.

<table>
<thead>
<tr>
<th>ADT STATISTICAL REPORTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to the online help for the ADT Statistical Reports. These reports display data stored in the ADT Census files. For listings of patient admissions or discharges, use the Inpatient Listings by Date option. Please select from the list below for details on the selected report.</td>
</tr>
</tbody>
</table>

ADPL | Average Daily Patient Load |
WARD | ADT Statistics by Ward |
SERV | ADT Statistics by Service |

Select HELP SYSTEM action or <return>:

Figure 8-18: Using online help

<table>
<thead>
<tr>
<th>ADT Statistics by Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use this option to report patient movement and workload statistics by ward. The following statistics are reported:</td>
</tr>
<tr>
<td>ADM: # of admissions for date range</td>
</tr>
<tr>
<td>TXI: # of transfers into ward from other wards</td>
</tr>
<tr>
<td>TXO: # of transfers to other wards</td>
</tr>
<tr>
<td>DSC: # of discharges for date range (excluding deaths)</td>
</tr>
<tr>
<td>DTH: # of deaths</td>
</tr>
<tr>
<td>1DAY: # of one day patients (admitted and discharged on same day)</td>
</tr>
<tr>
<td>DAYS: # of patients remaining at midnight plus one day patients</td>
</tr>
<tr>
<td>ADPL: Average # of patients per day (total patient days/# of days)</td>
</tr>
<tr>
<td>TLOS: Length of stay of all patients discharged during date range</td>
</tr>
<tr>
<td>ALOS: Average length of stay of all discharged patients</td>
</tr>
</tbody>
</table>

You have a choice to include only inpatients, only observation patients or both. Newborn numbers are always separated out and listed at the end of the report. You have the choice to include inactive wards.

Select HELP SYSTEM action or <return>:

Figure 8-19: Sample online report help for the ASR option
8.3 Bed Availability (BED)

Use this option to produce a listing of available beds. You can select to see the bed availability for a single ward (abbreviated listing) or multiple wards or services (expanded listing). You can select to have the room-bed description displayed on either listing.

The expanded report can be sorted by ward or service. One, many, or all wards/services can be selected. The user can also select to have the report show future scheduled admissions and/or lodgers. If there are no beds available on a selected ward/service, a message stating this will be displayed.

To use the Bed Availability report, type **BED** at the “Select ADT Reports Menu Option:” prompt. Sections 8.3.1 through 8.3.2 will detail how to run an abbreviated and expanded listing.

![ADT Reports Menu](UNSPECIFIED HO)

<table>
<thead>
<tr>
<th>AFM</th>
<th>Admission Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASR</td>
<td>ADT Statistical Reports</td>
</tr>
<tr>
<td>BED</td>
<td>Bed Availability</td>
</tr>
<tr>
<td>CIC</td>
<td>Current Inpatient Census</td>
</tr>
<tr>
<td>CIL</td>
<td>Current Inpatient Listings</td>
</tr>
<tr>
<td>ILD</td>
<td>Inpatient Listings by Date</td>
</tr>
<tr>
<td>IWA</td>
<td>Inpatients with Appointments</td>
</tr>
<tr>
<td>OIL</td>
<td>Operators' Inpatient List</td>
</tr>
<tr>
<td>PMR</td>
<td>Patient Movement Reports</td>
</tr>
<tr>
<td>SVL</td>
<td>Scheduled Visits Listing</td>
</tr>
<tr>
<td>VAH</td>
<td>View Admission History</td>
</tr>
</tbody>
</table>

Select ADT Reports Menu Option: **BED** Bed Availability

(A)bbreviated or (E)xpanded Bed Availability Listing?

Figure 8-20: Accessing bed availability report

8.3.1 Abbreviated Listing

Use this option to view bed availability for a single ward on your screen.

1. To run an abbreviated listing, type **A** at the “(A)bbreviated or (E)xpanded Bed Availability Listing?” prompt.

2. Type the name of the ward at the “Select Ward Location Name:” prompt. Type **??** for a listing of wards.

3. Type **Y** or **N** at the “Do you want to display room-bed descriptions?” prompt.

4. The bed availability for the ward you selected will be displayed (Figure 8-22).
(A)bbreviated or (E)xpanded Bed Availability Listing?  A ABBREVIATED

Select WARD LOCATION NAME: PED
Do you want to display room-bed descriptions? No// N (No)

Figure 8-21: Displaying an abbreviated listing

PED:
211-2  213-1  213-2  216-1
216-2  216-3  216-4  219-1
219-2  279-1  279-2

Select WARD LOCATION NAME:

Figure 8-22: Sample abbreviated listing

8.3.2 Expanded Listing

Use this option to print or display bed availability for multiple wards or services.

1. To run an expanded listing, type E at the “(A)bbreviated or (E)xpanded Bed Availability Listing?” prompt.

2. Type the name of one/many/all divisions at the “Select Division:” prompt. When you are done typing division names, press the Return key at the “Select Another Division:” prompt.

3. Type the name of one/many/all wards at the “Select Ward:” prompt. When you are done typing ward names, press the Return key at the “Select Another Ward:” prompt.

4. Type Y or N at the “Do you want to display scheduled admissions?” prompt.

5. Type Y or N at the “Do you want to display lodgers?” prompt.

6. Type Y or N at the “Do you want to display room-bed descriptions?” prompt.

7. Type the name of a print device at the “Device:” prompt or type HOME to display the report on your screen.
(A)bbreviated or (E)xpanded Bed Availability Listing?   A//E EXPANDED
Select division: ALL// UNSPECIFIED INDIAN HOSPITAL  1569
Select another division: [Enter]
Select ward: ALL// PED
Select another ward: GMS
Select another ward: [Enter]
Do you want to display scheduled admissions? Yes// Y  (Yes)
Do you want to display lodgers? Yes// Y  (Yes)
Do you want to display room-bed descriptions? No// Y  (Yes)

DEVICE: HOME

Figure 8-23: Printing extend bed availability (Steps 1-7)

8. A report similar to Figure 8-24 will print. If you select to display your report onscreen, use the options at the bottom of the screen to navigate through the report.

Figure 8-24: Sample extended bed availability output

8.4 Current Inpatient Census (CIC)

Use this option to print or view the total number of inpatients and observation patients currently admitted to your facility. You can sort this report by ward and by service.

1. To run a Current Inpatient Census report, type CIC at the “Select ADT Reports Menu Option:” prompt.

2. Type P (print on paper) or B (browse onscreen) at the “Print Mode:” prompt. If you select P, you will be prompted to select a printer name.
ADT Reports Menu  
(UNSPECIFIED HO)

AFM    Admission Forms  
ASR    ADT Statistical Reports  
BED    Bed Availability  
CIC    Current Inpatient Census  
CIL    Current Inpatient Listings  
ILD    Inpatient Listings by Date  
IWA    Inpatients with Appointments  
OIL    Operators' Inpatient List  
PMR    Patient Movement Reports  
SVL    Scheduled Visits Listing  
VAH    View Admission History

Select ADT Reports Menu Option:  

CIC    Current Inpatient Census

Select one of the following:

B    BROWSE ON SCREEN  
P    PRINT ON PAPER

PRINT MODE: B

3. A report similar to Figure 8-26 will print. If you select to display your report onscreen, use the options at the bottom of the screen to navigate through the report.

8.5 Current Inpatient Listings (CIL)

Use this option to print nine different types of reports on current inpatients (e.g. alphabetical listing, list by ward and patient, list by ward and room, list by service and patient, list by service and provider, chaplain's list, insurance coverage list, LOS >n days listing, and seriously ill/DNR list).
To access the Current Inpatient Listing menu, type CIL at the “Select ADT Reports Menu Option in the ADT Reports menu.

![ADT Reports Menu](image)

Select ADT Reports Menu Option: CIL  Current Inpatient Listings

Figure 8-27: Accessing the current inpatient listing menu

The Current Inpatient Listing menu will be displayed (Figure 8-28). Sections 8.5.1 through 8.5.10 will explain how to use each report.

1. Alphabetical Listing
2. List by Ward and Patient
3. List by Ward and Room
4. List by Service and Patient
5. List by Service and Provider
6. Chaplain's List
7. Insurance Coverage List
8. LOS >n Days Listing
9. Seriously Ill/DNR List
10. Online Help (Report Descriptions)

Choose Report from List:  (1-10):

Figure 8-28: Current Inpatient Listing menu

### 8.5.1 Alphabetical Listing

Use this report to print a list of inpatient demographic information, including inpatient visit information. This report is a combination of the alphabetical listing under MAS Patient List by Ward option and MAS Listing of Current Inpatients option.

1. To print an Alphabetical Listing report, type 1 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.

2. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
1. Alphabetical Listing
2. List by Ward and Patient
3. List by Ward and Room
4. List by Service and Patient
5. List by Service and Provider
6. Chaplain’s List
7. Insurance Coverage List
8. LOS >n Days Listing
9. Seriously Ill/DNR List
10. Online Help (Report Descriptions)

Choose Report from List:  (1-10): 1

Select one of the following:

B         BROWSE ON SCREEN
P         PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-29: Printing the alphabetical inpatient list (Steps 1–2)

3. The Alphabetical Inpatient list will print (Figure 8-30). If you typed B (browse onscreen), use the options at the bottom of the screen to navigate through the report. You can also select any patient on the list for more details on the patient's demographics, view ADT record, and view PCC visit.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Chart #</th>
<th>Age</th>
<th>Community</th>
<th>Insurance</th>
<th>Admission Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, BERNARD</td>
<td>00-72-50</td>
<td>24 YR</td>
<td>UNKNOWN</td>
<td>IHS</td>
<td>Admitted to PED (207-1) GM DOCTOR, KAREN L on 04/19/02 (194 days)</td>
</tr>
<tr>
<td>PATIENT, NICOLE</td>
<td>00-77-44</td>
<td>4 YR</td>
<td>UNKNOWN</td>
<td>MCD</td>
<td>Admitted to GMS (216-4) SURG BOB, MD on 09/26/02 (34 days)</td>
</tr>
<tr>
<td>PATIENT, CHIP</td>
<td>11-01-10</td>
<td>30 YR</td>
<td>UNKNOWN</td>
<td>MCD</td>
<td>Admitted to GMS (213-1) INTM PROVIDER, MINDY A. on 02/13/02 (259 days)</td>
</tr>
<tr>
<td>PATIENT, PAUL</td>
<td>00-78-97</td>
<td>6 YR</td>
<td>UNKNOWN</td>
<td>IHS</td>
<td>Admitted to GMS (213-3) INTM PROVIDER, JADE on 10/07/02 (23 days)</td>
</tr>
<tr>
<td>PATIENT, BRIAN</td>
<td>00-88-96</td>
<td>8 YR</td>
<td>UNKNOWN</td>
<td>MCD</td>
<td>Admitted to PED (211-2) UROL PROVIDER, JADE on 10/29/02 (1 days)</td>
</tr>
</tbody>
</table>

+ Enter ?? for more actions
1 View Demographics 2 View ADT Record 3 View PCC Record

Select Action: Next Screen/

Figure 8-30: Printing the alphabetical inpatient list (Step 3)

8.5.2 List by Ward and Patient

Use this option to print an alphabetical listing of current inpatients at a facility. The inpatients will be printed by ward, then alphabetical by patient name. This report lists patient name, chart number, age, admission date, length of stay, room-bed, and current provider. You have the option to print the list for all wards or just one. This report is a revision of the MAS Inpatient Roster report.
1. To print a List by Ward and Patient report, type 2 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.

2. Type Y or N at the “Print for All Wards:” prompt. If you select N, you will be prompted to enter the individual ward name.

3. Type Y or N at the “Would you like the Report Double Spaced?” prompt.

4. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

5. The Inpatient List by Ward/Name report will print (Figure 8-32). If you typed B (browse onscreen), use the options at the bottom of the screen to navigate through the report. You can also select any patient on the list for more details on the patient's demographics, view ADT record, and view PCC visit.

---

**Figure 8-31: Printing list by ward and patient (Steps 1–4)**

**Figure 8-32: Printing list by ward and patient (Step 5)**
8.5.3 List by Ward and Room

Use this option to print an inpatient list sorted by ward. You have the option to print the list for all wards or just a single ward. Within each ward, the list will be sorted by room-bed. Any patients not assigned to a room-bed will be listed at the end of each ward. You will also be able to customize the report by deciding what to have displayed in the last column. This report displays room-bed, patient name, chart number, age, length of stay, and primary and attending providers. This report is a revision of the MAS Patient List by Ward report.

1. To run a List by Ward and Room report, type 3 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.

2. Type Y or N at the “Print for All Wards:” prompt. If you select N, you will be prompted to type the individual ward name.

3. Type the number of the data option you would like to include in the last column of your report at the “Select Last Column Data:” prompt.

4. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

5. The Inpatient List by Ward/Room report will print (Figure 8-34). If you typed B (browse onscreen), use the options at the bottom of the screen to navigate through the report. You can also select any patient on the list for more details on the patient's demographics, view ADT record, and view PCC visit.
8.5.4 List by Service and Patient

Use this option to print an inpatient listing sorted by service and patient (e.g., General Medicine, Pediatrics, Surgery, etc.). Within each service, the list will be sorted by patient name. Any patient that was admitted to a service and then transferred to another will be listed at the end of the admission service's Section. This report displays patient name, chart number, ward, room-bed, and providers (primary/attending). This report is a revision of the MAS Patient List by Service report.

1. To run a List by Service and Patient report, type 4 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.

2. Type Y or N at the “Print for All Treating Specialties:” prompt. If you type N, you will be prompted to type the name of the individual treating specialty. If you type Y, you will be prompted to select the type of service you would like included (e.g. inpatient, observation, or both).

3. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
Choose Report from List: (1-10): 4
Print for ALL Treating Specialties? NO// N
Select Treating Specialty: **UROLOGY**

    Select one of the following:
        B  BROWSE ON SCREEN
        P  PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-35: Printing list by service and patient (Steps 1–3)

4. The Current Inpatients by Service report will print (Figure 8-36). If you typed B (browse onscreen), use the options at the bottom of the screen to navigate through the report. You can also select any patient on the list for more details on the patient's demographics, view ADT record, and view PCC visit.

Current Inpatients by Service Oct 30, 2002 15:34:29          Page:    1 of  1
** Confidential Patient Data Covered by Privacy Act **
UROLOGY

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Chart #</th>
<th>Ward</th>
<th>Room-Bed</th>
<th>Attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) PROVIDER,BRIAN CLAY</td>
<td>8896</td>
<td>PED</td>
<td>211-2</td>
<td>PROVIDER,JADE</td>
</tr>
<tr>
<td>2) PROVIDER,ALEX LEIGH</td>
<td>1234</td>
<td>GMS</td>
<td>216-1</td>
<td>AAAAA,MD DAVID T.</td>
</tr>
</tbody>
</table>

Enter ?? for more actions
1   View Demographics     2   View ADT Record       3   View PCC Record
Select Action:Quit//

Figure 8-36: Printing list by service and patient (Step 4)

8.5.5 List by Service and Provider

Use this option to print an inpatient listing sorted by service and then sorted by provider. You have the option to print the list for all services and providers or just a single provider. If a patient was transferred from an admitting service, they will be listed at the end of that service's Section. This report displays patient name, chart number, age, sex, community, admitting diagnosis, ward, room-bed, admit date, and length of stay.

1. To run a List by Service and Provider report, type 5 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.
2. Type Y or N at the “Print for All Treating Specialties?” prompt. If you type N, you will be prompted to type the individual treating specialty. If you type Y, you will be prompted to select the type of service you would like included (e.g. inpatient, observation, or both).

3. Type the number of the service type you would like to include in your report at the “Select Service Type:” prompt.

4. Type the name of the treating specialty you would like to include in your report at the “Select Treating Specialty:” prompt.

5. Type Y or N at the “Print for All Attending Providers?” prompt. If you type N, you will be prompted to type the individual provider’s name.

6. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

---

**Choose Report from List:**  (1-10): 5

**Print for ALL Treating Specialties?** NO// Y YES

Select one of the following:

1 Inpatient Services Only
2 Observation Services Only
3 Both

**Select Service Type: Both// 3 Both**

**Select Treating Specialty:** PEDIATRICS

**Print for ALL Attending Providers?** NO// N

**Select Provider:** DOCTOR, KATHRYN MRQ MEDICAL OFFICER

Select one of the following:

B BROWSE ON SCREEN
P PRINT ON PAPER

**PRINT MODE:** BROWSE//

---

**Figure 8-37:** Printing list by service and provider (Steps 1–6)

7. The Current Inpatients by Service/Provider report will print (Figure 8-38). If you typed B (browse onscreen), use the options at the bottom of the screen to navigate through the report. You can also select any patient on the list for more details on the patient's demographics, view ADT record, and view PCC visit.
** Chaplain's List **

Use this report to print a list of inpatients sorted by religion. This report is a new report to be used by the hospital chaplains to visit patients. You have the option to print the list for all religions or just one. Within each religion, the list will be sorted by ward then room. This report includes patient ward, room, patient name, age, community, and admission date.

1. To print the Chaplain’s list, type 6 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.
2. Type Y or N at the “Print All Religions?” prompt. If you type N, you will be prompted to type the name of the individual religion.
3. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

```
Choose Report from List:  (1-10): 6
Print ALL Religions? NO// N
Select RELIGION: CATHOLIC

Select one of the following:
  B  BROWSE ON SCREEN
  P  PRINT ON PAPER

PRINT MODE: BROWSE
```

Figure 8-39: Printing Chaplin list (Steps 1–3)
4. The Chaplin list will print (Figure 8-40). If you typed B (browse onscreen), use the options at the bottom of the screen to navigate through the report. You can also select any patient on the list for more details on the patient's demographics, view ADT record, and view PCC visit.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Room</th>
<th>Patient Name</th>
<th>Age</th>
<th>Community</th>
<th>Admit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMS</td>
<td>216-1</td>
<td>DEMO, ALEX LEIGH</td>
<td>11</td>
<td>RUIDOSO</td>
<td>02/25/02</td>
</tr>
<tr>
<td>GMS</td>
<td>216-2</td>
<td>DEMO, ELENA LOUIS</td>
<td>37</td>
<td>VIRGINIA UNK</td>
<td>05/08/02</td>
</tr>
<tr>
<td>GMS</td>
<td>216-3</td>
<td>DEMO, ALICIA</td>
<td>59</td>
<td>UNSPECIFIED RES</td>
<td>05/29/02</td>
</tr>
<tr>
<td>GMS</td>
<td>216-4</td>
<td>DEMO, NICOLE RACHE</td>
<td>4</td>
<td>TULAROSA</td>
<td>09/26/02</td>
</tr>
<tr>
<td>GMS</td>
<td>UNK</td>
<td>DEMO, A. PAUL</td>
<td>6</td>
<td>RUIDOSO</td>
<td>10/07/02</td>
</tr>
</tbody>
</table>

Enter ?? for more actions

Select Action: Quit//

Figure 8-40: Printing Chaplin list (Step 4)

8.5.7 Insurance Coverage List

Use this option to print a list of patients who are covered by insurance and listed by the patient’s discharge date. This report is sorted by patient and displays patient name, chart number, room, service, provider, admit date, admitting diagnosis, Medicare/Medicaid numbers (if any), patients with current private insurance coverage (one line will print for each policy displaying insurer), and policy number. This is a revision of the MAS Inpatient Medicare/Medicaid Listing report.

1. To print the Insurance Coverage list, type 7 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.

2. Type Y or N at the “Print for All Ward?” prompt. If you type N, you will be prompted to type the name of the individual ward.

3. Type in W or C to sort by either Ward or Coverage Type.

4. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
Choose Report from List: (1-10): 7
Print for ALL Wards? NO// N
Select Ward Name: GMS

Select one of the following:
W Ward
C Coverage Type

Sort By: Ward//

Select one of the following:
B BROWSE ON SCREEN
P PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-41: Printing the insurance coverage list (Steps 1—4)

5. The Inpatient Insurance Coverage report will print (Figure 8-42). If you typed B (browse onscreen), use the options at the bottom of the screen to navigate through the report. You can select any patient on the list for more details on the patient's demographics, view ADT record, and view PCC visit.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Chart #</th>
<th>Room</th>
<th>Srv</th>
<th>Provider</th>
<th>Admit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEMO, ALICE</td>
<td>00-77-44</td>
<td>216-4</td>
<td>SURG</td>
<td>BOB, MD</td>
<td>09/26/02</td>
</tr>
<tr>
<td>Adx Dx: HEART ATTACK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Additional Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEMO, CHIP</td>
<td>11-01-10</td>
<td>213-1</td>
<td>INTM</td>
<td>PROVIDER, MINDY</td>
<td>02/13/02</td>
</tr>
<tr>
<td>Adx Dx: PUNCTURED LUNG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid #575201972</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEMO, A. PAUL</td>
<td>00-78-97</td>
<td>GM</td>
<td>PROVIDER, JADE</td>
<td>10/07/02</td>
<td></td>
</tr>
<tr>
<td>Adx Dx: 54544</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Additional Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEMO, ALICIA</td>
<td>00-01-29</td>
<td>216-3</td>
<td>GM</td>
<td>AAAAA, BOB</td>
<td>05/29/02</td>
</tr>
<tr>
<td>Adx Dx: NECK PAIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Additional Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEMO, ALEX LEIGH</td>
<td>00-12-34</td>
<td>216-1</td>
<td>UROL</td>
<td>AAAAA, MD DAVID</td>
<td>02/25/02</td>
</tr>
<tr>
<td>Adx Dx: BLADDER PROBLEM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Additional Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEMO, ELENA LOUIS</td>
<td>00-07-74</td>
<td>216-2</td>
<td>GM</td>
<td>AAAAA, MD DAVID</td>
<td>05/08/02</td>
</tr>
</tbody>
</table>

Enter ?? for more actions

1 View Demographics 2 View ADT Record 3 View PCC Record

Select Action: Next Screen//

Figure 8-42: Printing the insurance coverage list (Step 4)
8.5.8 LOS >n Days Listing

Use this option to print a list of patients who have been inpatients for a specified number of days or more. The list printed will include patients who have been inpatients for the number of days entered or more. Within each ward, the list will be sorted by patient name. You will be asked to specify a minimum length of stay for the report. This report displays patient name, chart number, age, length of stay, room-bed, service, and community. This report is a revision of the MAS Los > n Days Inpatient List report.

1. To print the LOS>n Days list, type 8 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.

2. Type Y or N at the “Print for All Ward?” prompt. If you type N, you will be prompted to type the name of the individual ward.

3. Type the minimum length of stay that you want for your report in days at the “What is the Minimum Length of Stay for this Report:” prompt.

4. The Inpatient by length of stay report will print (Figure 8-44). If you typed B (browse onscreen), use the options at the bottom of the screen to navigate through the report. You can select any patient on the list for more details on the patient's demographics, view ADT record, and view PCC visit.
8.5.9 Seriously Ill/DNR List

Use this option to print a list of patients currently on the Seriously Ill List. To add or delete from the list, use the Seriously Ill Enter/Edit option in the ADT menu. Within each ward, the list will be sorted by patient name. You will be asked if you want to also include DNR (Do Not Resuscitate) patients in addition to the Seriously Ill patients. If you include DNR patients, then the first sort will be by SI vs. DNR followed by ward. This report displays patient name, chart number, age, room-bed, service, provider, and the date the patient was added to the list. This report is a revision of the MAS Seriously Ill List report.

1. To print the Seriously Ill/DNR list, type 9 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.

2. Type Y or N at the “Print for All Ward?” prompt. If you type N, you will be prompted to type the name of the individual ward.

3. Type Y or N at the “Include DNR Patients on List?” prompt.

4. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

### Inpatients by Length of Stay

<table>
<thead>
<tr>
<th>WARD: GMS</th>
<th>Patient Name</th>
<th>Chart #</th>
<th>Age</th>
<th>Admit</th>
<th>LOS</th>
<th>Srv</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> DEMO, ALICE</td>
<td>7744</td>
<td>4 YR</td>
<td>SEP 26</td>
<td>35</td>
<td>SURG</td>
<td>TULAROSA</td>
<td></td>
</tr>
<tr>
<td><strong>2)</strong> DEMO, CHIP</td>
<td>110110</td>
<td>30 YR</td>
<td>FEB 13</td>
<td>260</td>
<td>INTM</td>
<td>ANCHOR POINT</td>
<td></td>
</tr>
<tr>
<td><strong>3)</strong> DEMO, A.PAUL</td>
<td>7897</td>
<td>6 YR</td>
<td>OCT 07</td>
<td>24</td>
<td>GM</td>
<td>RUIDOSO</td>
<td></td>
</tr>
<tr>
<td><strong>4)</strong> DEMO, ALICIA</td>
<td>129</td>
<td>6 YR</td>
<td>OCT 07</td>
<td>24</td>
<td>GM</td>
<td>RUIDOSO</td>
<td></td>
</tr>
<tr>
<td><strong>5)</strong> DEMO, ALEX LEIGH</td>
<td>1234</td>
<td>11 YR</td>
<td>FEB 25</td>
<td>248</td>
<td>UROL</td>
<td>RUIDOSO</td>
<td></td>
</tr>
<tr>
<td><strong>6)</strong> DEMO, ELENA LOUIS</td>
<td>774</td>
<td>37 YR</td>
<td>MAY 08</td>
<td>176</td>
<td>GM</td>
<td>VIRGINIA UNK</td>
<td></td>
</tr>
<tr>
<td><strong>7)</strong> DEMO, KATHRYN MAR</td>
<td>8779</td>
<td>22 YR</td>
<td>JUN 03</td>
<td>150</td>
<td>GM</td>
<td>RUIDOSO</td>
<td></td>
</tr>
<tr>
<td><strong>8)</strong> DEMO, SANTEE NATA</td>
<td>5053</td>
<td>68 YR</td>
<td>DEC 17</td>
<td>318</td>
<td>GM</td>
<td>UNSPECIF RES</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WARD: PED</th>
<th>Patient Name</th>
<th>Chart #</th>
<th>Age</th>
<th>Admit</th>
<th>LOS</th>
<th>Srv</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9)</strong> DEMO, BERNARD</td>
<td>7250</td>
<td>24 YR</td>
<td>APR 19</td>
<td>195</td>
<td>GM</td>
<td>ALAMOGORDO</td>
<td></td>
</tr>
<tr>
<td><strong>10)</strong> DEMO, BRIAN CLAY</td>
<td>8896</td>
<td>8 YR</td>
<td>OCT 29</td>
<td>2</td>
<td>UROL</td>
<td>LINCOLN CO O</td>
<td></td>
</tr>
</tbody>
</table>

Enter ?? for more actions

<table>
<thead>
<tr>
<th>1 View Demographics</th>
<th>2 View ADT Record</th>
<th>3 View PCC Record</th>
</tr>
</thead>
</table>

Select Action: Quit//
Choose Report from List:  (1-10): 9
Print for ALL Wards? NO// N
Select Ward Name: PED
Include DNR Patients on List? YES// N

Select one of the following:

B   BROWSE ON SCREEN
P   PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-45: Printing the seriously ill/DNR list (Step 1–4)

5. The Seriously Ill List will print (Figure 8-46). If you typed B (browse onscreen), use the options at the bottom of the screen to navigate through the report. You can select any patient on the list for more details on the patient's demographics, view ADT record, and view PCC visit.

<table>
<thead>
<tr>
<th>Seriously Ill List</th>
<th>Oct 05, 2005 15:57:28</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>** Confidential Patient Data Covered by Privacy Act **</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Name</td>
<td>Chart #</td>
<td>Age</td>
</tr>
<tr>
<td>DEMO, BRIAN</td>
<td>35033</td>
<td>27 YR</td>
</tr>
</tbody>
</table>

Do Not Resuscitate List

<table>
<thead>
<tr>
<th>WARD: 4 WEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) TEST, EILEEN TIU</td>
</tr>
</tbody>
</table>

Enter ?? for more actions

1   View Demographics     2   View ADT Record       3   View PCC Record
Select Action: Quit//

Figure 8-46: Printing the seriously ill/DNR list (Step 5)

8.5.10 Online Help (Report Descriptions)

Use this option to get a detailed description of each of the reports in the Current Inpatient Listing menu. All report descriptions will be displayed on your screen.

1. To use the Online Help option, type 10 at the “Choose Report from List: (1-10):” prompt in the Current Inpatient Listing menu.

2. Type the number of the report that you need a description of at the “Select Help System Action or <Return>:” prompt.
**CURRENT INPATIENT LISTINGS**

Welcome to the online help for the Current Inpatient Listings. Please choose a report from the list for detailed information about that report.

1. Alphabetical Listing
2. List by Ward and Patient
3. List by Ward and Room
4. List by Service and Patient
5. List by Service and Provider
6. Chaplain's List
7. Insurance Coverage List
8. LOS > n Days
9. Seriously Ill/DNR List

Select HELP SYSTEM action or <return>:

---

**8.6 Inpatient Listings by Date (ILD)**

Use this report to access reports that provide various inpatient information listed by date. The reports available include admissions, readmissions, non-beneficiary admissions, ICU transfers, discharges, inter-facility transfers, inpatient deaths, and LOS by discharge month and ward. You will be given several sorting options for each report, and you will be able to either print the report on paper or display it on the screen.

To display the Inpatient Listings by Date menu, type ILD at the “Select ADT Reports Menu Option:” prompt in the ADT Reports menu.
The Inpatient Listings by Date menu will be displayed (Figure 8-49). Sections 8.6.1 through 8.6.9 will explain how to use each report.

1. Admissions
2. Readmissions
3. Non-Beneficiary Admissions
4. ICU Transfers
5. Discharges
6. Inter-Facility Transfers
7. Inpatient Deaths
8. LOS by Discharge Month & Ward
9. Online Help (Report Descriptions)

Choose Report from List: (1-9):

Figure 8-49: Inpatient listings by date menu

8.6.1 Admissions

Use this report to list patient admissions (inpatient and observations) for a given date range. You can sort this report by date, ward, service, admitting provider, admitting provider's, hospital service, or alphabetically by patient name.

1. To run the Admissions report, type 1 at the “Choose Report from List: (1-9):” prompt in the Inpatient Listing by Date menu.

2. Type the starting date at the “Select Beginning Date:” prompt.

3. Type the ending date at the “Select Ending Date:” prompt.

4. Type the number of the type of admissions report you would like to run at the “Select Admission Report to Run:” prompt. Each report will prompt you for different information.

5. Follow the prompts for the report selection you selected as they are displayed on your screen.

6. Type Y or N at the “Include Insurance Coverage on Report?” prompt.

7. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
Choose Report from List:  (1-9): 1
Select Beginning Date:  T-365  (OCT 31, 2001)
Select Ending Date:    T  (OCT 31, 2002)

Select one of the following:
1       By DATE Only
2       By WARD
3       By SERVICE
4       By ADMITTING Provider
5       By Provider's SERVICE
6       By Community
7       By Service Unit
8       By Patient Name

Select Admission Report to Run: 1  By DATE Only
Include Insurance Coverage on Report? NO//  Y  YES

Select one of the following:
B       BROWSE ON SCREEN
P       PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-50: Printing admissions listing (Steps 1–7)

8. The Admissions by Date report will print (Figure 8-51). If you selected to browse
the report onscreen, use the options at the bottom of the screen to navigate
through the report.

*** Confidential Patient Data Covered by Privacy Act ***
Sorted by Ward
For Oct 31, 2001 through Oct 31, 2002

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Chart #</th>
<th>Admission Dates</th>
<th>LOS</th>
<th>Serv</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT,LARRY ALBE</td>
<td>5791</td>
<td>10/31/2001 - 11/01/2001</td>
<td>1</td>
<td>GM</td>
<td>GMS</td>
</tr>
<tr>
<td>(Admitted by</td>
<td></td>
<td>Dx: CRUSH INJURY LEFT LEG)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No Additional Coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATIENT,MARGARET MA</td>
<td>5617</td>
<td>11/01/2001 - 11/02/2001</td>
<td>1</td>
<td>GM</td>
<td>GMS</td>
</tr>
<tr>
<td>(Admitted by</td>
<td></td>
<td>Dx: LLE CELLULITIS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No Additional Coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATIENT,LARRY ALBE</td>
<td>5791</td>
<td>11/04/2001 - 11/09/2001</td>
<td>5</td>
<td>GM</td>
<td>GMS</td>
</tr>
<tr>
<td>(Admitted by</td>
<td></td>
<td>Dx: CRUSH INJURY/LLE, DM II)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No Additional Coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
+ Enter ?? for more actions

Select Action:Next Screen//

Figure 8-51: Printing admissions listing (Step 8)
8.6.2 Readmissions

Use this report to list patient readmissions within a certain number of days since the patient’s last discharge. This report also includes admissions after release from day surgery as long as they fall within the selected time limit. You select the time limit and date range.

1. To run the Readmissions report, type 2 at the “Choose Report from List: (1-9):” prompt in the Inpatient Listing by Date menu.

2. Type the starting date of the date range you would like your report to cover at the “Select Beginning Date:” prompt.

3. Type the ending date of the date range you would like your report to cover at the “Select Ending Date:” prompt.

4. Type the number of the type of readmission report you would like to run at the “Select Readmission Report to Run:” prompt. Each report will prompt you for different information.

5. Follow the prompts for the report selection you selected as they are displayed on your screen.

6. Type the maximum number of days you would like to include in your report at the “Maximum # of Days between Admissions:” prompt.

7. Type Y or N at the “Include Insurance Coverage on Report?” prompt.

8. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
Choose Report from List:  (1-9): 2

This includes admissions after release from Day Surgery.

Select Beginning Date:  T-365  (OCT 31, 2001)
Select Ending Date:  T  (OCT 31, 2002)

Select one of the following:

1         By DATE Only
2         By WARD
3         By SERVICE
4         By ADMITTING Provider
5         By Provider's SERVICE
6         BY Community
7         By Service Unit
8         By Patient Name

Select Readmission Report to Run: 2  By WARD
Print for ALL Wards? NO//[Enter]
Select Ward Name: PED
Select Another Ward Name: GMS
Select Another Ward Name: [Enter]
MAXIMUM # of Days between admissions:  (1-365): 365
Include Insurance Coverage on Report? NO// Y YES

Select one of the following:

B         BROWSE ON SCREEN
P         PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-52: Printing a readmissions list (Steps 1–8)

9. The Readmissions by Date report will print (Figure 8-53). If you selected to browse the report onscreen, use the options at the bottom of the screen to navigate through the report.
### 8.6.3 Non-Beneficiary Admissions

Use this report to list patient admissions (inpatient and observations) for a given date range for patients with an eligibility listing of ineligible. This report can be sorted by date, ward, service, admitting provider, admitting provider's hospital service, or alphabetically by patient name.

1. To list Non-Beneficiary admissions, type 3 at the “Choose Report from List: (1-9):” prompt in the Inpatient Listing by Date menu.

2. Type the starting date of the date range you would like your report to cover at the “Select Beginning Date:” prompt.

3. Type the ending date of the date range you would like your report to cover at the “Select Ending Date:” prompt.

4. Type the number of the type of non-beneficiary report you would like to run at the “Select Non-beneficiary Report to Run:” prompt. Each report will prompt you for different information.

5. Follow the prompts for the report selection you selected as they are displayed on your screen.

6. Type the number of the service type you would like to include in your report at the “Select Service Type:” prompt.

7. Type Y or N at the “Include Insurance Coverage on Report?” prompt.

---

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Chart #</th>
<th>Admit Date</th>
<th>Last Dsch</th>
<th>Diff</th>
<th>Serv</th>
<th>Ward</th>
<th>New Dx</th>
<th>Last Dx</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, MARGARET</td>
<td>5617</td>
<td>11/01/2001</td>
<td>08/15/2001</td>
<td>78</td>
<td>GM</td>
<td>GMS</td>
<td>LLE CELLULITIS</td>
<td>LLE CELLULITIS</td>
</tr>
<tr>
<td>PATIENT, LARRY</td>
<td>5791</td>
<td>11/04/2001</td>
<td>11/01/2001</td>
<td>3</td>
<td>GM</td>
<td>GMS</td>
<td>CRUSH INJURY/LLE, DM II</td>
<td>CRUSH INJURY LEFT LEG</td>
</tr>
<tr>
<td>PATIENT, NIKI</td>
<td>4670</td>
<td>11/04/2001</td>
<td>02/21/2001</td>
<td>256</td>
<td>GM</td>
<td>GMS</td>
<td>HYPOXIA, PNEUMONIA, ETOH</td>
<td>HYPOXIA, PNEUMONIA, ETOH ABU</td>
</tr>
</tbody>
</table>

Select Action: Next Screen //
8. Type **B** (to browse the report onscreen) or **P** (to print the report on paper) at the “Print Mode:” prompt. If you select **P**, you must then select the printer where you would like your report to print.

Choose Report from List:  (1-9): 3
Select Beginning Date:  T-365  (OCT 31, 2001)
Select Ending Date:  T  (OCT 31, 2002)

Select one of the following:
1. By DATE Only
2. By WARD
3. By SERVICE
4. By ADMITTING Provider
5. By Provider's SERVICE
6. By Community
7. By Service Unit
8. By Patient Name

Select Non-beneficiary Admission Report to Run: 3  By SERVICE
Print for ALL Treating Specialties? NO// YES

Select one of the following:
1. Inpatient Services Only
2. Observations Only
3. Both

Select Service Type: Both// [Enter]
Include Insurance Coverage on Report? YES//[Enter]

Select one of the following:
B  BROWSE ON SCREEN
P  PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-54: Printing the non-beneficiary admissions list (Steps 1–8)

9. The Non-Beneficiary Admits report will print (Figure 8-55). If you selected to browse the report onscreen, use the options at the bottom of the screen to navigate through the report.
**NON-BENEFICIARY ADMITS**
Oct 06, 2005 09:36:37  Page: 1 of 2
*** Confidential Patient Data Covered by Privacy Act ***
Sorted by Admitting Provider
For Aug 01, 2005 through Aug 15, 2005

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Chart #</th>
<th>Admission Dates</th>
<th>LOS</th>
<th>Serv</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** DOCTOR,JOY P ***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATIENT,JAMES</td>
<td>261234</td>
<td>08/08/2005 - 08/16/2005</td>
<td>8</td>
<td>RES</td>
<td>5EA</td>
</tr>
<tr>
<td>(Admitted by DOCTOR,JOY P</td>
<td>Dx: RESEARCH VOLUNTEER)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATIENT,RUBEN</td>
<td>264321</td>
<td>08/09/2005 - 08/19/2005</td>
<td>10</td>
<td>RES</td>
<td>5EA</td>
</tr>
<tr>
<td>(Admitted by DOCTOR,JOY P</td>
<td>Dx: RESEARCH VOLUNTEER)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*** DOCTOR,DIANE J ***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATIENT,JENNIFER</td>
<td>266666</td>
<td>08/09/2005 - 08/12/2005</td>
<td>3</td>
<td>OB</td>
<td>4WE</td>
</tr>
<tr>
<td>(Admitted by DOCTOR,LIAM</td>
<td>Dx: INTRAUTERINE PREGNANCY@TERM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+ Enter ?? for more actions

Select Action:Next Screen// /

---

### 8.6.4 ICU Transfers

Use this report to list ICU transfers or to list returns to ICU for a given date range.

1. To list ICU transfers, type 4 at the “Choose Report from List: (1-9):” prompt in the Inpatient Listing by Date menu.

2. Type the starting date of the date range you would like your report to cover at the “Select Beginning Date:” prompt.

3. Type the ending date of the date range you would like your report to cover at the “Select Ending Date:” prompt.

4. Type the number of the ICU report you would like to print at the “Select ICU Report to Run:” prompt.

5. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
Choose Report from List: (1-9): 4
Select Beginning Date: OCT 31, 2001
Select Ending Date: NOV 3, 2002

Select one of the following:
1         TRANSFERS to ICU
2         RETURNS to ICU

Select ICU Report to Run: 1 TRANSFERS to ICU

Select one of the following:
B         BROWSE ON SCREEN
P         PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-56: Printing the ICU transfer list (Steps 1–5)

6. The ICU Transfers report will print (Figure 8-57). If you selected to browse the report onscreen, use the options at the bottom of the screen to navigate through the report.

ICU TRANSFERS               Oct 31, 2002 10:54:39          Page:    1 of    1
*** Confidential Patient Data Covered by Privacy Act ***
     Transfers to ICU
For Oct 31, 2001 through Nov 3, 2001

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Chart #</th>
<th>Transferred</th>
<th>Serv</th>
<th>Admitting Dx</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, LEONARD</td>
<td>112233</td>
<td>10/31/2001@1621</td>
<td>MED</td>
<td>ASCITIES HYPERTENSION</td>
</tr>
<tr>
<td>PATIENT, LINDA</td>
<td>24680</td>
<td>11/02/2001@1522</td>
<td>SUR</td>
<td>RIGHT LABIAL ABSCCESS</td>
</tr>
</tbody>
</table>

Enter ?? for more actions

Select Action: Quit/

Figure 8-57: Printing the ICU transfer list (Step 6)

8.6.5 Discharges

Use this report to list patient discharges (inpatient and observations) for a given date range. You can then sort the report by date, ward, service, attending provider, attending provider's hospital service, or alphabetically by patient name.

1. To run a list of patient discharges, type 5 at the “Choose Report from List: (1-9):” prompt in the Inpatient Listing by Date menu.

2. Type the starting date you would like your report to cover at the “Select Beginning Date:” prompt.
3. Type the ending date you would like your report to cover at the “Select Ending Date:” prompt.

4. Type the number of the type of discharge report you would like to run at the “Select Discharges Report to Run:” prompt. Each report will prompt you for different information.

5. Follow the prompts for your report selection as they are displayed on your screen.

6. Type Y or N at the “Include Insurance Coverage on Report?,” prompt.

7. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

Choose Report from List: (1-9): 5
Select Beginning Date: T-365 (OCT 31, 2001)
Select Ending Date: T (OCT 31, 2002)

Select one of the following:

1. By DATE Only
2. By WARD
3. By SERVICE
4. By ATTENDING Provider
5. By Provider's SERVICE
6. By Community
7. By Service Unit
8. By Patient Name

Select Discharges Report to Run: 4 By ATTENDING Provider
Print for ALL Providers? NO/ [Enter]
Select Provider Name: DOCTOR, KATHRYN MRQ MEDICAL OFFICER
Select Another Provider Name: PROVIDER, JADE JAC
Select Another Provider Name: [Enter]
Include Insurance Coverage on Report? NO/ YES

Print Mode: BROWSE/

Figure 8-58: Printing discharges by date (Step 1–7)

8. The Discharges by Date report will print (Figure 8-59). If you selected to browse the report onscreen, use the options at the bottom of the screen to navigate through the report.
### Inter-Facility Transfers

Use this report to list all admissions and all discharges that were direct transfers from or to other inpatient facilities. You can print just the list of patients, just the statistics counting the number to and from each facility, or both. The patient listings are sorted by date, then service, and then transfer facility.

1. To list inter-facility transfers, type 6 at the “Choose Report from List: (1-9):” prompt in the Inpatient Listing by Date menu.

2. Type the starting date you would like your report to cover at the “Select Beginning Date:” prompt.

3. Type the ending date you would like your report to cover at the “Select Ending Date:” prompt.

4. Type the number of the report you would like to run at the “Select Report to Run:” prompt.

5. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

---

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Chart #</th>
<th>Admission Dates</th>
<th>LOS</th>
<th>Serv</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, MARTHA</td>
<td>87878</td>
<td>10/21/2001 - 10/29/2001</td>
<td>8</td>
<td>MED</td>
<td>3EA</td>
</tr>
<tr>
<td>(Attending: BUSH, GERALD R)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Dx: PNEUMONIA, END STAGE LIVER)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Chart #</th>
<th>Admission Dates</th>
<th>LOS</th>
<th>Serv</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, BEVERLY</td>
<td>200999</td>
<td>12/04/2001 - 12/05/2001</td>
<td>1</td>
<td>SUR</td>
<td>2EA</td>
</tr>
<tr>
<td>(Attending: CARMAN, DONNA R)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Dx: RIGHT BREAST CANCER)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Choose Report from List: (1-9): 6
Select Beginning Date: T-36 (SEP 25, 2002)
Select Ending Date: T (OCT 31, 2002)

Select one of the following:
1 LISTING Only
2 STATISTICS Only
3 BOTH Listing and Stats

Select Report to Run: 1 LISTING Only

Select one of the following:
B BROWSE ON SCREEN
P PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-60: Printing inter-facility transfers list (Steps 1–5)

6. The Inter-Facility Transfers report will print (Figure 8-61). If you selected to browse the report onscreen, use the options at the bottom of the screen to navigate through the report.

Confidential Patient Data Covered by Privacy Act
Transfers to/from UNSPECIFIED HOS
Admt/Dsch Date Patient Name HRCN Serv Facility
10/07/2002@1503 PATIENT,A.PAUL 7897 GM ALBUQUERQUE HOSPIT

Enter ?? for more actions

Select Action: Quit//

Figure 8-61: Printing inter-facility transfers list (Step 6)

8.6.7 Inpatient Deaths

Use this report to list patient deaths (inpatient and observations) for the date range you specify. You can sort the report by date, ward, service, attending provider, attending provider's hospital service, or alphabetically by patient name.

1. To list inpatient deaths, type 7 at the “Choose Report from List: (1-9):” prompt in the Inpatient Listing by Date menu.

2. Type the starting date of the date range you would like your report to cover at the “Select Beginning Date:” prompt.
3. Type the ending date of the date range you would like your report to cover at the “Select Ending Date:” prompt.

4. Type the number of the type of discharge report you would like to run at the “Select Discharges Report to Run:” prompt. Each report will prompt you for different information.

5. Follow the prompts for your report selection as they are displayed on your screen.

6. Type Y or N at the “Include Insurance Coverage on Report?” prompt.

7. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

Choose Report from List:  (1-9): 7
Select Beginning Date:  T-365  (OCT 31, 2001)
Select Ending Date:  T  (OCT 31, 2002)

Select one of the following:

1 By DATE Only
2 By WARD
3 By SERVICE
4 By ATTENDING Provider
5 By Provider's SERVICE
6 By Community
7 By Service Unit
8 By Patient Name

Select Discharges Report to Run: 6 By Community
Print for ALL Communities? NO//[Enter]
Select Community Name:  UNSPECIFIED RES     OTERO     NEW MEXICO     167     3519167
Select Another Community Name:  MILE CORN     PINAL     ARIZONA     207     0411207
Select Another Community Name:  [Enter]
Include Insurance Coverage on Report? YES// [Enter]

Select one of the following:

B BROWSE ON SCREEN
P PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-62: Printing inpatient death list (Steps 1–7)

8. The Inpatient Deaths report will print (Figure 8-63). If you selected to browse the report onscreen, use the options at the bottom of the screen to navigate through the report.
**LOS by Discharge Month and Ward**

Use this report to list patients in order by month discharged and within month by the discharge ward. This report is designed to review length of stay trends by ward. The report lists month discharged, ward, patient name, chart number, admission date, and length of stay.

1. To list LOS by discharge month and ward, type 8 at the “Choose Report from List: (1-9):” prompt in the Inpatient Listing by Date menu.

2. Type the starting date of the date range you would like your report to cover at the “Select Beginning Date:” prompt.

3. Type the ending date of the date range you would like your report to cover at the “Select Ending Date:” prompt.

4. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
Choose Report from List:  (1-9): 8
LENGTH OF STAY BY DISCHARGE MONTH AND WARD

Select Beginning Date:  T-365  (OCT 31, 2001)
Select Ending Date:  T  (OCT 31, 2002)

Select one of the following:

B           BROWSE ON SCREEN
P           PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-64: Printing LOS by discharge month and ward (Steps 1–4)

5. The LOS by Discharge Month and Ward report will print (Figure 8-65). If you selected to browse the report onscreen, use the options at the bottom of the screen to navigate through the report.

<table>
<thead>
<tr>
<th>Month</th>
<th>Ward</th>
<th>Patient</th>
<th>Chart #</th>
<th>Admit Date</th>
<th>LOS (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2001</td>
<td>GMS</td>
<td>PATIENT,CHRISTINE</td>
<td>3793</td>
<td>OCT 30, 2001</td>
<td>2</td>
</tr>
<tr>
<td>Oct 2001</td>
<td>GMS</td>
<td>PATIENT,LARRY</td>
<td>5791</td>
<td>OCT 31, 2001</td>
<td>1</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>GMS</td>
<td>PATIENT,MARGARET</td>
<td>5617</td>
<td>NOV 01, 2001</td>
<td>1</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>GMS</td>
<td>PATIENT,LOUISE</td>
<td>6412</td>
<td>NOV 19, 2001</td>
<td>1</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>GMS</td>
<td>PATIENT,STEVE J</td>
<td>6198</td>
<td>NOV 21, 2001</td>
<td>1</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>GMS</td>
<td>PATIENT,SHARON</td>
<td>5545</td>
<td>NOV 05, 2001</td>
<td>9</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>GMS</td>
<td>PATIENT,REGINA</td>
<td>3205</td>
<td>NOV 27, 2001</td>
<td>1</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>GMS</td>
<td>PATIENT,NIKI</td>
<td>4670</td>
<td>NOV 04, 2001</td>
<td>2</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>GMS</td>
<td>PATIENT,ANGELA</td>
<td>6596</td>
<td>NOV 07, 2001</td>
<td>6</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>GMS</td>
<td>PATIENT,ANNA</td>
<td>5832</td>
<td>NOV 13, 2001</td>
<td>3</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>GMS</td>
<td>PATIENT,RAY</td>
<td>5088</td>
<td>NOV 30, 2001</td>
<td>1</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>PED</td>
<td>PATIENT,KYLE</td>
<td>8836</td>
<td>NOV 07, 2001</td>
<td>1</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>PED</td>
<td>PATIENT,LOU</td>
<td>9164</td>
<td>NOV 27, 2001</td>
<td>1</td>
</tr>
</tbody>
</table>

+ Enter ?? for more actions

Select Action:Next Screen//

Figure 8-65: Printing LOS by discharge month and ward (Step 5)

8.6.9 Online Help (Report Descriptions)

Use this option to view detailed descriptions of each of the reports in the Inpatient Listings by Date menu. All report descriptions will be displayed onscreen.

1. To use the Online Help option, type 9 at the “Choose Report from List: (1-9):” prompt in the Inpatient Listing by Date menu.

2. Type the abbreviation of the report that you would like a description at the “Select Help System Action or <Return>:” prompt.
Choose Report from List: (1-9): 9

Inpatient Listings by Date

These are a series of reports by date range listing patient data on a variety of ADT events. Please choose report by number for details:

1  Admissions
2  Readmissions
3  Non-Beneficiary Admissions
4  ICU Transfers
5  Discharges
6  Inter-Facility Transfers
7  Inpatient Deaths
8  LOS by Discharge Month & Ward

Select HELP SYSTEM action or <return>:

Figure 8-66: Using the online help option

8.7 Inpatients with Appointments (IWA)

Use this option to produce reports concerning appointments for current inpatients.

To display the Inpatients with Appointments options, type IWA at the “Select ADT Reports Menu Option:” prompt in the ADT report menu.

ADT Reports Menu
(UNSPECIFIED HO)

AFM  Admission Forms
ASR  ADT Statistical Reports
BED  Bed Availability
CIC  Current Inpatient Census
CIL  Current Inpatient Listings
ILD  Inpatient Listings by Date
IWA  Inpatients with Appointments
OIL  Operators' Inpatient List
PMR  Patient Movement Reports
SVL  Scheduled Visits Listing
VAH  View Admission History

Select ADT Reports Menu Option: IWA  Inpatients with Appointments

Figure 8-67: Accessing inpatients with appointments

The Inpatient with Appointments menu will be displayed (Figure 8-68). Sections 8.7.1 and 8.7.2 will explain how to use each report.
Select one of the following:

1. Future Appts for New Admissions
2. Appts for Current Inpatients

Select Report to Run: 1  Future Appts for New Admissions

LIST PATIENTS WITH PENDING APPOINTMENTS ADMITTED ON DATE: 10/25/02 (OCT 25, 2002)

DEVICE: HOME//

Figure 8-69: Printing the future appointments for new admissions report (Steps 1–3)

4. The Future Appointments for New Admits report will print (Figure 8-70). If you chose to display the report onscreen, use the options at the bottom of the screen to navigate through the report.
8.7.2 Appointments for Current Inpatients

Use this report to print a list of appointments for current inpatients. This list assists inpatient staff in tracking appointments for their current patients and to make sure follow-up appointments for patients being discharged are made.

1. To print a list of appointments for current inpatients, type 2 at the “Select Report to Run:” prompt in the Inpatient with Appointments menu.

2. Type the name of one, many, or all divisions at the “Select Division:” prompt. When you are done typing division names, press the Return key at a blank “Select Another Division:” prompt.

3. Type the name of one, many, or all wards at the “Select Ward:” prompt. When you are done typing ward names, press the Return key at a blank “Select Another Ward:” prompt.

4. Type the name of one, many, or all clinics at the “Select Clinic:” prompt. When you are done typing clinic names, press the Return key at a blank “Select Another Clinic:” prompt.

5. Type the starting date of the date range you would like your report to cover at the “Select Beginning Date:” prompt.

6. Type the ending date of the date range you would like your report to cover at the “Select Ending Date:” prompt.

7. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
Select one of the following:

1  Future Appts for New Admissions
2  Appts for Current Inpatients

Select Report to Run: 2  Appts for Current Inpatients
Select division: ALL// UNSPECIFIED INDIAN HOSPITAL 1569
Select another division: [Enter]
Select ward: ALL// FED
Select another ward: GMS
Select another ward: [Enter]
Select clinic: ALL// CARDIOLOGY
Select another clinic: PEDIATRIC
Select another clinic: [Enter]
Select Beginning Date: T-365 (OCT 31, 2001)
Select Ending Date: T (OCT 31, 2002)

Select one of the following:
B  BROWSE ON SCREEN
P  PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-71: Printing appointments for current inpatients (Steps 1–7)

8. The Appointments for Current Inpatients report will print (Figure 8-72). If you chose to display the report onscreen, use the options at the bottom of the screen to navigate through the report.

Appts for Current Inpatients  Oct 31, 2002 13:25  Page: 1 of 1
*** Confidential Patient Data Covered by Privacy Act ***
For Oct 31, 2001 through Oct 31, 2002
Appt D/T  Patient Name  Chart #  Clinic______________________
          *** GMS Ward ***
Oct 25, 2002
10:00 AM  PATIENT,ALICIA  129  CARDIOLOGY
          Appt Made 10/25/02@09:26:20

Enter ?? for more actions
Select Action:Quit//

Figure 8-72: Printing appointments for current inpatients (Step 8)

8.8 Operator's Inpatient List (OIL)

Use this option for an alphabetical list of current inpatients with no clinical information displayed. Patients who have declared that they wish to be excluded from the hospital directory will appear on this list with “*******” instead of their names.

1. To print the Operator’s Inpatient list, type OIL at the “Select ADT Reports Menu Option:” prompt.
2. Type **B** (to browse the report onscreen) or **P** (to print the report on paper) at the “Print Mode:” prompt. If you select **P**, you must then select the printer where you would like your report to print.

![ADT Reports Menu](image)

**ADT Reports Menu**
(UNSPECIFIED HO)

- AFM Admission Forms
- ASR ADT Statistical Reports
- BED Bed Availability
- CIC Current Inpatient Census
- CIL Current Inpatient Listings
- ILD Inpatient Listings by Date
- IWA Inpatients with Appointments
- OIL Operators' Inpatient List
- PMR Patient Movement Reports
- SVL Scheduled Visits Listing
- VAH View Admission History

Select ADT Reports Menu Option: OIL Operators' Inpatient List

Select one of the following:

- **B** BROWSE ON SCREEN
- **P** PRINT ON PAPER

PRINT MODE: BROWSE//

![Figure 8-73: Printing operator's inpatient list (Steps 1 and 2)](image)

3. The Operator’s Inpatients list report will print (Figure 8-74). If you chose to display the report onscreen, use the options at the bottom of the screen to navigate through the report.

![Operators' Inpatient List](image)

**Operators' Inpatient List**
Oct 31, 2002 14:08:17
Page: 1 of 1
**Confidential Patient Data Covered by Privacy Act**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Phone</th>
<th>Room</th>
<th>Ward</th>
<th>Sex</th>
<th>Age</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEMO, BERNARD</td>
<td>x247-207</td>
<td>207-1</td>
<td>PED</td>
<td>M</td>
<td>24 YRS</td>
<td>ALAMOGORDO</td>
</tr>
<tr>
<td>DEMO, RACHEL</td>
<td>216-4</td>
<td>GMS</td>
<td>F</td>
<td>4 YRS</td>
<td>TULAROSA</td>
<td></td>
</tr>
<tr>
<td>DEMO, CHIP</td>
<td>213-1</td>
<td>GMS</td>
<td>M</td>
<td>30 YRS</td>
<td>ANCHOR POINT</td>
<td></td>
</tr>
<tr>
<td>DEMO, PAUL</td>
<td></td>
<td>GMS</td>
<td>M</td>
<td>6 YRS</td>
<td>RUIDOSO</td>
<td></td>
</tr>
<tr>
<td>***************</td>
<td>211-2</td>
<td>PED</td>
<td>M</td>
<td>8 YRS</td>
<td>LINCOLN CO O</td>
<td></td>
</tr>
<tr>
<td>DEMO, ALICIA</td>
<td>216-3</td>
<td>GMS</td>
<td>F</td>
<td>59 YRS</td>
<td>UNSPECIFIED</td>
<td></td>
</tr>
<tr>
<td>DEMO, LEIGH</td>
<td>216-1</td>
<td>GMS</td>
<td>F</td>
<td>11 YRS</td>
<td>RUIDOSO</td>
<td></td>
</tr>
<tr>
<td>DEMO, LOUIZA</td>
<td>216-2</td>
<td>GMS</td>
<td>F</td>
<td>37 YRS</td>
<td>VIRGINIA UNK</td>
<td></td>
</tr>
<tr>
<td>DEMO, KATHRYN</td>
<td>x247-207</td>
<td>207-1</td>
<td>GMS</td>
<td>F</td>
<td>22 YRS</td>
<td>RUIDOSO</td>
</tr>
<tr>
<td>***************</td>
<td>213-2</td>
<td>GMS</td>
<td>F</td>
<td>68 YRS</td>
<td>UNSPECIFIED</td>
<td></td>
</tr>
</tbody>
</table>

Enter ?? for more actions
Select Action: Quit//

![Figure 8-74: Printing operator's inpatient list (Step 3)](image)
8.9 Patient Movement Reports (PMR)

Use this option to display various reports dealing with census changes.

To display the Patient Movement Report menu, type PMR at the “Select ADT Reports Menu Option:” prompt in the ADT report menu.

<table>
<thead>
<tr>
<th>ADT Reports Menu</th>
<th>(UNSPECIFIED HO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFM</td>
<td>Admission Forms</td>
</tr>
<tr>
<td>ASR</td>
<td>ADT Statistical Reports</td>
</tr>
<tr>
<td>BED</td>
<td>Bed Availability</td>
</tr>
<tr>
<td>CIC</td>
<td>Current Inpatient Census</td>
</tr>
<tr>
<td>CIL</td>
<td>Current Inpatient Listings</td>
</tr>
<tr>
<td>ILD</td>
<td>Inpatient Listings by Date</td>
</tr>
<tr>
<td>IWA</td>
<td>Inpatients with Appointments</td>
</tr>
<tr>
<td>OIL</td>
<td>Operators' Inpatient List</td>
</tr>
<tr>
<td>PMR</td>
<td>Patient Movement Reports</td>
</tr>
<tr>
<td>SVL</td>
<td>Scheduled Visits Listing</td>
</tr>
<tr>
<td>VAH</td>
<td>View Admission History</td>
</tr>
</tbody>
</table>

Select ADT Reports Menu Option: PMR  Patient Movement Reports

Figure 8-75: Accessing the PMR option

The PMR menu will be displayed (Figure 8-76). Sections 8.9.1 through 8.9.5 will explain how to use each of these options.

1. Reprint Admissions & Discharges Sheet
2. Selected Patient Movements
3. Census Movement Worksheet
4. Track Census by Ward
5. Online Help (Report Descriptions)

Choose Report from List: (1-5):

Figure 8-76: PMR menu

8.9.1 Reprint Admissions & Discharges Sheet

Use this option to list a daily report that lists census changes for a facility. The Admission and Discharges (A&D) sheet lists admissions, discharges, and transfers. This report also displays the changes in the census files for reporting purposes. The original A&D sheet must be run daily to update the census numbers and is found on the Supervisor Menu (Section 10.4). This report gives you the ability to reprint this report after the original one has been printed, checked, and balanced against manual nursing counts.

1. To use the Reprint Admissions and Discharges Sheet option, type 1 at the “Choose Report from List:” prompt in the Patient Movement Reports menu.
2. A list of earliest dates for the report will be displayed (Figure 8-77). Type the date at which you would like your report to start compiling information at the “Print Reports for Which Date:” prompt.

3. Type D (detailed) or S (summary) at the “Select Report Format – Detailed or Summary: (D/S):” prompt.

4. Type the name of a print device at the “Device:” prompt. You can type HOME at the “Device:” prompt to display the report on your screen.

```
Choose Report from List: (1-5): 1
<<< ADMISSIONS & DISCHARGES SHEET >>>
<< Also called GAINS & LOSSES [G&L] >>>

Earliest Date for G&L..........................OCT 1,1995
Earliest Date for Treating Specialty Report............OCT 1,1995
Earliest Date to Recalculate..........................OCT 1,1995

LAST BED STATUS REPORT TOTALS EXIST FOR OCT 31,2002
PRINT REPORTS FOR WHICH DATE: OCT 31,2002 (OCT 31, 2002)
Select Report Format - DETAILED or SUMMARY: (D/S): D Detailed Format

Paper margin must be at least 110.

Printing to HOME puts report into browse mode.

DEVICE: HOME// [Enter]
```

Figure 8-77: Reprinting admission and discharge sheets (Steps 1–4)

5. The Admission and Discharge Sheet report will print (Figure 8-78). If you typed HOME at the “Device:” prompt, the report will be displayed onscreen. Use the options at the bottom of the screen to navigate through the report.
**Figure 8-78: Reprinting admission and discharge sheets (Step 5)**

### 8.9.2 Selected Patient Movements

Use this option to view a report that will enable you to see the patient movements from a given date and time up to the present. You can only go back 14 days. It is intended for viewing recent movements only.

1. To use the Selected Patient Movements option, type 2 at the “Choose Report from List:” prompt in the Patient Movement Reports menu.

2. Type the date you would like your report to start at the “Start with Date@Time:” prompt.

3. Type the letter of the type of movement report you would like to print at the “Choose Movements to Display:” prompt.

4. Type the name of a print device at the “Device:” prompt. You can type HOME at the “Device:” prompt to display your report onscreen.
5. The Patient Movement screen will print (Figure 8-80). If you displayed the report on your screen, press the Return key when you are done with the report.

8.9.3 Census Movement Worksheet

Use this option to print a worksheet used by inpatient nursing units to double check the information in the computer with the manual records. This review will assist the admitting office in balancing the daily census.

1. To print the Census Movement Worksheet, type 3 at the “Choose Report from List:” prompt in the Patient Movement Reports menu.
2. Type Y or N at the “Print for All Ward?” prompt. If you type N, you will prompted to type the name of the individual ward you would like your report to include.

3. Type the beginning date and time of your report at the “Select Beginning Date and Time:” prompt.

4. Type the ending date and time of your report at the “Select Ending Date and Time:” prompt.

5. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

![Figure 8-81: Printing census movement information (Steps 1–5)](image)

6. The Patient Movement worksheet will print (Figure 8-82). If you displayed the report on your screen, use the options at the bottom of the screen to navigate through the report.
8.9.4 Track Census by Ward

Use this option to display the census changes for one ward over time. For a given date range this report will list, in columns, the number of admissions, transfers in, transfers out, discharges, and deaths for a ward. The last 2 columns are the number of patients remaining at the end of each day and a unit score.

1. To use the Track Census by Ward option, type 4 at the “Choose Report from List:” prompt in the Patient Movement Reports menu.

2. Type the name of the ward you would like to track at the “Select Ward:” prompt. You will only be able to type one ward for this report.

3. Type the beginning date of your report at the “Select Beginning Date:” prompt.

4. Type the ending date of your report at the “Select Ending Date:” prompt.

5. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
Choose Report from List: (1-5): 4
Select Ward: PED

   Select one of the following:
   B  BROWSE ON SCREEN
   P  PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 8-83: Tracking census by ward (Steps 1–5)

6. The Track Census by Ward report will print (Figure 8-84). If you displayed the report on your screen, use the options at the bottom of the screen to navigate through the report.

<table>
<thead>
<tr>
<th>Date</th>
<th>Admits</th>
<th>Trans In</th>
<th>Trans Out</th>
<th>Disch</th>
<th>Deaths</th>
<th>Remaining</th>
<th>Unit Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/01/05</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/02/05</td>
<td>2</td>
<td>2</td>
<td></td>
<td>4</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>06/03/05</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/04/05</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/05/05</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/06/05</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/07/05</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/08/05</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/09/05</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/10/05</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average: 10

Enter ?? for more actions

Select Action: Quit//

Figure 8-84: Tracking census by ward (Step 6)

8.9.5 Online Help (Report Descriptions)

Use this option to display detailed report descriptions of the reports in the Patient Movement Reports option. All report descriptions will be displayed onscreen.

1. To use online help, type 5 at the “Choose Report from List:” prompt in the Patient Movement Reports menu.

2. Type the number of the report that you would like a description of at the “Select Help System Action or <Return>:” prompt.
### PATIENT MOVEMENT REPORTS

These are a series of reports on any patient movement that affects census data designed for use by inpatient unit staff. Please select the report by number for details.

<table>
<thead>
<tr>
<th>Number</th>
<th>Report Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reprint Admissions &amp; Discharges Sheet</td>
</tr>
<tr>
<td>2</td>
<td>Selected Patient Movements</td>
</tr>
<tr>
<td>3</td>
<td>Census Movement Worksheet</td>
</tr>
<tr>
<td>4</td>
<td>Track Census by Ward</td>
</tr>
</tbody>
</table>

Select HELP SYSTEM action or <return>:

---

**8.10 Scheduled Visits Listing (SVL)**

Use this option to print out a listing of patients with visits by date range. You can choose to print all types or just admissions, just day surgeries, or just outpatients. Depending on the type of visits chosen, you have customized choices for primary and secondary sorts. Either a brief or detailed report can be chosen.

1. Type `SVL` at the “Select ADT Reports Menu Option:” prompt in the ADT report menu.

2. Type a date at the “Earliest Date Expected” prompt to define the beginning date for your report.

3. Type a date at the “Latest Date Expected” prompt to define the ending date for your report.

4. To include those entries already marked as no-shows and cancellations, type ‘Yes’ at the “Include No-Shows and Cancellations?” prompt.

5. Next select how you want the report sorted and what you would like for a second sort.

6. For a two-line summary of each entry, type `B` for BRIEF at the “Select Report Type” prompt. Type `D` for DETAILED to have most of the information on each entry displayed.

7. Type `B` (to browse the report onscreen) or `P` (to print the report on paper) at the “Print Mode:” prompt. If you select `P`, you must then select the printer where you would like your report to print.
Select Earliest Date Expected:  T  (OCT 06, 2005)
Select Latest Date Expected:  12/1  (DEC 01, 2005)

Select one of the following:
1  Admissions
2  Day Surgeries
3  Outpatient Visits
4  All Types

Select Visit Type for Report: 1  Admissions
Include No-Shows and Cancellations? NO

1. Authorizing Provider
2. Case Manager
3. Community
4. Date Expected
5. Patient Name
6. Service
7. Visit Disposition
8. Ward

Sort Report By:  (1-8): 1

1. Case Manager
2. Community
3. Date Expected
4. Patient Name
5. Service
6. Visit Disposition
7. Ward

Within Authorizing Provider Sort Report By:  (1-7): 1

Select one of the following:
B  Brief
D  Detailed

Select Report Type: B// rief

Select one of the following:
B  BROWSE ON SCREEN
P  PRINT ON PAPER

PRINT MODE: BROWSE/

Figure 8-86: Scheduled Visit Listing

8. The next two figures show examples of the BRIEF and DETAILED displays.
8.11 View Admission History (VAH)

Use this option to view a concise list of all inpatient and observation stays for a patient at your facility. This report will be displayed on your screen. If you need to print this report, use the PL option.

1. To use the View Admission History option, type VAH at the “Select ADT Reports Menu Option:” prompt in the ADT Reports menu.

2. Type the name of the patient whose admission history you would like to view at the “Select Patient:” prompt.
ADT Reports Menu
(UNSPECIFIED HO)

AFM Admission Forms
ASR ADT Statistical Reports
BED Bed Availability
CIC Current Inpatient Census
CIL Current Inpatient Listings
ILD Inpatient Listings by Date
IWA Inpatients with Appointments
OIL Operators' Inpatient List
PMR Patient Movement Reports
SVL Scheduled Visits Listing
VAH View Admission History

Select ADT Reports Menu Option: VAH View Admission History

Select PATIENT: TEST,EILEEN

Figure 8-89: Viewing admission history (Steps 1–2)

3. The View Admission History report will print (Figure 8-90). Use the option at the bottom of the screen to navigate through the report. Type PL at the “Select Action:” prompt to print the report.

Figure 8-90: Viewing admission history (Step 3)
9.0 Seriously Ill List Entry (SI)

Use this option to designate certain patients as seriously ill or DNR (do not resuscitate) or both. I

1. To designate a patient as seriously ill, type SI at the “Select ADT Menu Option:” prompt.

2. Type the name of the patient at the “Select Patient Name:” prompt.

3. Type S (Seriously Ill), D (Do Not Resuscitate), or B (SI and DNR) at the “Condition:” prompt.

4. Type the date you want the patient recorded on the SI list or press the Return key to accept the current date at the “Date Entered on SI List:” prompt.

Figure 9-1: Entering a patient as seriously ill
10.0 ADT Supervisor Menu (SM)

Use this option to access a menu of items to be used only by an admissions supervisor or application coordinator. The menu will enable you to send A&D bulletin, view census information, recalculate A&D totals, set up system parameters, and view any A&D changes made.

To access the Supervisor ADT menu, type SM at the “Select ADT Menu Option:” prompt in the ADT Main menu.

```
Figure 10-1: Accessing the ADT supervisor menu
```

The Supervisor ADT menu will be displayed (Figure 10-2). Each of the options in the Supervisor ADT menu will be explained in Section 10.1 through 10.6.

```
Figure 10-2: ADT supervisor menu options
```
10.1 Admissions & Discharges Sheet (ADS)

Use this option to update and report the daily census for a facility. The Admission and Discharges (A&D) sheet lists admissions, discharges, and transfers. It also records the changes in the census files for statistical purposes. The A&D sheet must be run daily, even if no patient movements occurred at the facility.

1. To use the A&D sheet, type ADS at the “Select Supervisor ADT menu Option:” prompt in the Supervisor ADT menu.

2. Type the date the report will be printed at the “Print Report For Which Date:” prompt.

3. Type Y or N at the “Recalculate totals?” prompt to indicate if existing totals need to be recalculated.

4. Type D (Detailed) or S (Summary) to indicate the type of report to be printed.

5. Type a print device at the “Device:” prompt.

6. Either a detailed or summary report of Admissions and Discharges will print. A detailed report is shown in Figure 10-4.
10.2 Post A&D Sheet Bulletin (BUL)

Use this option to send an Admission and Discharges (A&D) Sheet Bulletin. This bulletin informs selected users throughout the facility that the Admissions & Discharges sheet for a particular day has been checked and verified and can now be reprinted by users. Users to receive the bulletin must be members of the mail group linked to your BDG A&D READY bulletin. The mail group can be linked under the “SAF - Setup ADT Files” option.

1. To print an A&D Sheet Bulletin, type BUL at the “Select Supervisor ADT menu Option:” prompt in the Supervisor ADT menu.

2. Type the date of the A&D sheet that is ready to be reprinted by other users at the “Enter A&D Sheet Date:” prompt. You must enter the date exactly as you would like it to appear – Nov 2, 2004 instead of “T-1” or “11/2.”

3. Type Y or N to indicate if the bulletin should be posted immediately at the “Okay to Post Bulletin Now?” prompt.

4. Type other information as requested at the prompts and press the Enter key after each prompt to record the entry.
Figure 10-5: Posting an A&D sheet bulletin

10.3 Census Reports Menu (CEN)

Use this option to access the Census Report menu. This menu contains reports used by ADT Supervisor staff to balance census files and report on them.

To access the Census Reports menu, type CEN at the “Select ADT Supervisor Menu Option:” prompt in the Supervisor ADT menu.

Figure 10-6: Accessing the census reports menu

The Census Reports menu will be displayed (Figure 10-7). Each option in the Census Reports menu will be explained in Sections 10.3.1 through 10.3.6.
10.3.1 Track Census by Ward (AID1)

Use this option to list an overview of the bed movements for a particular ward for a date range. This report also includes a calculation of ward activity – a benchmark based on number of movements against the number of patients remaining.

1. To list the Track Census by Ward report, type AID1 at the “Select Census Reports Menu Option:” prompt in the Census Reports menu.

2. Type the name of the ward to be printed at the “Select Ward:” prompt.

3. Type the date to begin printing the census at the “Select Beginning Date:” prompt.

4. Type the date to stop printing the census at the “Select Ending Date:” prompt.

5. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

6. The census data for the selected ward will print (Figure 10-9). The census data for each day between the beginning and ending dates typed will print.
Figure 10-9: Tracking census by ward (Step 6)

10.3.2 Track Census by Ward & Service (AID2)

Use this option to view activity for a service within a ward for a date range. You will also be asked to select between adult or pediatric movements for that service.

1. To print a list of patient movements, type AID2 at the “Select Census Reports Menu Option:” prompt in the Census Reports menu.

2. Type the name of the ward that interests you at the “Select Ward:” prompt.

3. Type A (All treating specialties) or O (One treating specialty) at the “Choose Report Format:” prompt. If you typed A, go to Step 5.

4. Type the name of the treating specialty at the “Within Ward, List Which Treating Specialty:” prompt.

5. Type A (Adult) or P (Pediatric) at the “Adult or Pediatric Census:” prompt.

6. Type the date to begin printing a list of patient movements at the “Select Beginning Date:” prompt.

7. Type the date to stop printing a list of patient movements at the “Select Ending Date:” prompt.

8. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.
Select Census Reports Menu Option: **AID2**  Track Census by Ward & Service

Select Ward: **GMS**

Select one of the following:

- **A**  ALL TREATING SPECIALTIES
- **O**  ONE SPECIALTY ONLY

Choose Report Format: **O**  ONE SPECIALTY ONLY

Within Ward, List Which Treating Specialty: **UROLOGY**

Select one of the following:

- **A**  ADULT
- **P**  PEDIATRIC

Adult or Pediatric Census: **A**  ADULT

Select beginning date: **T-365**  (NOV 04, 2001)

Select ending date: **T**  (NOV 04, 2002)

Select one of the following:

- **B**  BROWSE ON SCREEN
- **P**  PRINT ON PAPER

PRINT MODE: BROWSE//

**Figure 10-10: Tracking census by ward and service (Steps 1–8)**

9. The Track Census by Ward & Service report will print (Figure 10-11). If you selected to browse the report onscreen, use the options at the bottom of the screen to navigate through the report.

**Figure 10-11: Tracking census by ward and service (Step 9)**
10.3.3 Track Census by Service (AID3)

Use this option to view service changes in your facility for a date range. You will be given the choice between adult or pediatric movements. This report will also search for errors in the census numbers for inpatient services.

1. To print the Track Census by Service report, type AID3 at the “Select Census Reports Menu Option:” prompt in the Census Reports menu.

2. Type the name of the treating specialty to be printed at the “Select ADT Census-Treating Specialty:” prompt.

3. Type A or P (depending on the type of information needed in the census) at the “Adult or Pediatric Census:” prompt.

4. Type the date to begin printing the census at the “Select Beginning Date:” prompt.

5. Type the date to stop printing the census at the “Select Ending Date:” prompt.

6. Type B (to browse the report onscreen) or P (to print the report on paper) at the “Print Mode:” prompt. If you select P, you must then select the printer where you would like your report to print.

7. The Track Census by Service report will print (Figure 10-13). If you selected to browse the report onscreen, use the options at the bottom of the screen to navigate through the report.
### List Ward Census Movements (AID4)

Use this option to ensure that all patient movements (e.g., admissions, transfers, discharges, and deaths) that occurred between the specified dates are recorded. At the end of the report, if run for the entire facility, a summary sheet is printed to check numbers of patients in each ward. It can also help the admitting supervisor find errors.

1. To print a list of patient movements, type **AID4** at the “Select Census Reports Menu Option:” prompt in the Census Reports menu.

2. To print a list of patient movements on all wards, type **Y** at the “Print All Wards?” prompt, or to print a list of patient movements on a selected ward, type **N** at the “Print All Wards?” prompt.

3. Type the ward name at the “Select Ward:” prompt (if printing for a select ward).

4. Type the date to begin printing a list of patient movements at the “Select Beginning Date and Time:” prompt.

5. Type the date to stop printing a list of patient movements at the “Select Ending Date and Time:” prompt.

6. Type **B** (to browse the report onscreen) or **P** (to print the report on paper) at the “Print Mode:” prompt. If you select **P**, you must then select the printer where you would like your report to print.
Select Census Reports Menu Option: AID4 List Ward Census Movements

Print for ALL Wards? NO// [Enter]
Select Ward: PED

Select beginning date and time: T-365@9 (NOV 04, 2001@09:00)
Select ending date and time: (11/4/2001 - 11/4/2002): T@10 (NOV 04, 2002@10:00)

Select one of the following:

B BROWSE ON SCREEN
P PRINT ON PAPER

PRINT MODE: BROWSE//

Figure 10-14: Listing ward census movements (Steps 1–6)

7. The Patient Movement Worksheet will print (Figure 10-15). If you selected to display the report onscreen, use the options at the bottom of the screen to navigate through the report.

Patient Movement Worksheet Nov 04, 2002 15:00:24 Page: 1 of 3
Confidential Patient Data Covered by Privacy Act
Nov 04, 2001@09:00 to Nov 04, 2002@10:00
For PED

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Patient Name</th>
<th>Chart #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 07, 2001@06:00</td>
<td>PATIENT, TRAVIS CLARK</td>
<td>08836</td>
</tr>
<tr>
<td>Nov 23, 2001@02:30</td>
<td>PATIENT, ALYS</td>
<td>07990</td>
</tr>
<tr>
<td>Nov 27, 2001@11:30</td>
<td>PATIENT, BERDINA LOU</td>
<td>09164</td>
</tr>
<tr>
<td>Nov 29, 2001@18:30</td>
<td>PATIENT, JANICE T.</td>
<td>08736</td>
</tr>
<tr>
<td>Dec 04, 2001@23:05</td>
<td>PATIENT, MELFORD FRANCIS</td>
<td>07564</td>
</tr>
<tr>
<td>Apr 19, 2002@13:46</td>
<td>PATIENT, BERNARD</td>
<td>07250</td>
</tr>
<tr>
<td>Sep 27, 2002@09:34</td>
<td>PATIENT, ANNE MARIE</td>
<td>01745</td>
</tr>
<tr>
<td>Oct 29, 2002@15:17</td>
<td>PATIENT, BRIAN CLAY</td>
<td>08896</td>
</tr>
</tbody>
</table>

SUBTOTAL: 8

WARD TRANSFERS IN
Oct 08, 2002@08:15 PATIENT, ANDREA B. 7852
+ Enter ?? for more actions

Select Action: Next Screen//

Figure 10-15: Listing ward census movements (Step 7)

10.3.5 (HSA-202-1) Monthly Report of Inpatient Services (M202)

Use this option to print the HSA-202-1 form for reporting inpatient services at your facility for a specific month. Unlike most ADT reports, this report is designed to print only on paper, so it is not available in List Manager. This report has inpatient services for a selected month at a facility.
1. To print the Monthly Report of Inpatient Services, type M202 at the “Select Census Reports Menu Option:” prompt in the Census Reports menu.

2. Type the month for which the report will be printed at the “Print report for which month:” prompt.

3. Type a print device at the “Device:” prompt.

4. Type Y or N at the “Do you want your output Queued?” prompt.

5. A Monthly Report of Inpatient Services at the facility will print (Figure 10-17).
## Monthly Report of Inpatient Services IHS Hospitals

<table>
<thead>
<tr>
<th>Medical Services Provided</th>
<th>Bom Census</th>
<th>Adm Discharges</th>
<th>Other</th>
<th>Eom Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL &amp; SURGICAL (Adult)</td>
<td>2</td>
<td>47</td>
<td>0</td>
<td>48</td>
</tr>
<tr>
<td>MEDICAL &amp; SURGICAL (Ped.)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OBSTETRIC</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TUBERCULOSIS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ALCOHOLISM/SUBSTANCE ABUSE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MENTAL HEALTH</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>207</td>
<td>2</td>
<td>203</td>
</tr>
<tr>
<td>NEWBORN</td>
<td>3</td>
<td>40</td>
<td>0</td>
<td>40</td>
</tr>
</tbody>
</table>

### Part II - Special Information

- Peak Census, Excluding Newborn: 28
- Minimum Census, Excluding Newborn: 10

### Part III

<table>
<thead>
<tr>
<th>Beds Available</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAFF UNITS</td>
<td># of Beds</td>
</tr>
<tr>
<td>MEDICAL (Adult)</td>
<td>25</td>
</tr>
<tr>
<td>SURGICAL (Adult)</td>
<td>5</td>
</tr>
<tr>
<td>MEDICAL (Pediatric)</td>
<td>6</td>
</tr>
<tr>
<td>OBSTETRIC</td>
<td>14</td>
</tr>
<tr>
<td>TUBERCULOSIS</td>
<td>0</td>
</tr>
<tr>
<td>ALCOHOLISM/SUBSTANCE ABUSE</td>
<td>0</td>
</tr>
<tr>
<td>MENTAL HEALTH</td>
<td>0</td>
</tr>
<tr>
<td>ICU/SCU</td>
<td>4</td>
</tr>
<tr>
<td>PCU</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>60</td>
</tr>
</tbody>
</table>

**Figure 10-17:** Printing a (HSA-202-1) monthly report of inpatient services (Step 5)

### 10.3.6 (HSA-202-1) Report by Range of Dates (Y202)

Use this report to print a one page report similar to the official M202 but for a range of months. This is to be used internally and is not a submitted report.
1. To print a Range of Months Report of Inpatient Services, type Y202 at the “Select Census Reports Menu Option:” prompt in the Census Reports menu.

2. Type the date to start printing the report at the “Select Starting Month:” prompt.

3. Type the date to stop printing the report at the “Select Ending Month:” prompt.

4. Type a print device at the “Device:” prompt.

5. A Range of Months Report of Inpatient Services report at the facility will print (Figure 10-19).
### RANGE OF MONTHS REPORT FOR INPATIENT SERVICES

<table>
<thead>
<tr>
<th>Name and Location of Hospital</th>
<th>Month and Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>YOUR HOSPITAL TOWN, STATE</td>
<td>Jun 2005 to Aug 2005</td>
</tr>
</tbody>
</table>

#### Part I - Service and Census

<table>
<thead>
<tr>
<th>Medical Services Provided</th>
<th>Bombom</th>
<th>Discharges</th>
<th>Eom</th>
<th>Inpatient</th>
<th>Census</th>
<th>Adm</th>
<th>Death</th>
<th>Other</th>
<th>Census</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL &amp; SURGICAL (Adult)</td>
<td>8</td>
<td>364</td>
<td>9</td>
<td>350</td>
<td>13</td>
<td>1189</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEDICAL &amp; SURGICAL (Ped.)</td>
<td>2</td>
<td>116</td>
<td>0</td>
<td>114</td>
<td>4</td>
<td>218</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OBSTETRIC</td>
<td>2</td>
<td>176</td>
<td>0</td>
<td>175</td>
<td>3</td>
<td>358</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TUBERCULOSIS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALCOHOLISM/SUBSTANCE ABUSE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENTAL HEALTH</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>656</strong></td>
<td><strong>9</strong></td>
<td><strong>639</strong></td>
<td><strong>20</strong></td>
<td><strong>1765</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEWBORN</td>
<td>3</td>
<td>153</td>
<td>0</td>
<td>153</td>
<td>3</td>
<td>268</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Part II - Special Information

- Peak Census, Excluding Newborn: 33
- Minimum Census, Excluding Newborn: 9

#### Part III

<table>
<thead>
<tr>
<th>Beds Available</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAFF UNITS</td>
<td>ALOS: ADULT MED/SUR: 2.90</td>
</tr>
<tr>
<td># of Beds</td>
<td>Peds MED/SUR: 1.91</td>
</tr>
<tr>
<td>% Occup.</td>
<td>MED/SUR: 1.75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
</tr>
<tr>
<td><strong>NEWBORN</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

**NEWBORN**

<table>
<thead>
<tr>
<th>% of Beds</th>
<th>% Occup.</th>
<th>ALOS: ADULT M/S: 2.90</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>
10.4 **Recalculate Census Totals (REC)**

Use this option to run an update to the census fields without printing out any A&D sheets. This option is best used when there are many dates that need to be recalculated.

1. To access the Census Reports menu, type **REC** at the “Select ADT Supervisor Menu Option:” prompt in the Supervisor ADT menu.

2. Type the date from which you want totals recalculated at the “Recalculate Totals from Which Date:” prompt.

   ![Figure 10-20: Recalculating census totals](image)

10.5 **ADT System Definition Menu (SYS)**

Use this option to set up the Administrative/Discharge/Transfer (ADT) System in a way that best suits the facility. This menu contains all parameter setup options.

To access the ADT System Definition menu, type **SYS** at the “Select ADT Supervisor Menu Option:” prompt in the Supervisor ADT menu.

![Figure 10-21: Accessing the ADT system definition menu](image)
The ADT System Definition menu will be displayed (Figure 10-22). Each of the options in the ADT System Definition menu will be explained in Sections 10.5.1 through 10.5.5.

### 10.5.1 Check ADT-PCC Link (CKL)

Use this option to display the status of the link between ADT and PCC. Link must be turned on for data to be passed to PCC.

1. To use the Check ADT-PCC Link option, type CKL at the “Select ADT System Definition Menu Option:” prompt.
2. The ADT-PCC Link Environment screen will be displayed. When you are done looking over the information on the screen, press the ENTER key to return to the ADT System Definition menu.

---

**Figure 10-23: Checking the ADT-PCC link**
10.5.2 Edit ADT Parameters (EAP)

Use this option to set up and maintain facility and system parameters dealing with the ADT functions in PIMS.

To edit ADT parameters, type EAP at the “Select Application Coordinator Menu Option:” prompt located in the Application Coordinator menu.

<table>
<thead>
<tr>
<th>ADT System Definition Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>(UNSPECIFIED HO)</td>
</tr>
<tr>
<td>CKL  Check ADT-PCC Link</td>
</tr>
<tr>
<td>EAP  Edit ADT Parameters</td>
</tr>
<tr>
<td>ICF  Initialize Census Files</td>
</tr>
<tr>
<td>KEY  List ADT Security Keys</td>
</tr>
<tr>
<td>SAF  Setup ADT Files</td>
</tr>
<tr>
<td>Select ADT System Definition Menu Option:</td>
</tr>
<tr>
<td>EAP  Edit ADT Parameters</td>
</tr>
</tbody>
</table>

Figure 10-24: Editing ADT parameters

10.5.2.1 Editing System Wide Parameters

Use this option to edit the Primary Facility Name and whether or not the facility is a Multidivisional Medical Center.

1. Type the name of the Primary Facility at the “Primary Facility Name:” prompt, or press the Return key to keep the current default name.

2. Type Y or N depending if your facility is a multidivisional Medical Center at the “Multidivision Med Center?:” prompt.

```
Editing system-wide parameters:
PRIMARY FACILITY NAME: UNSPECIFIED INDIAN HOSPITAL//[Enter]
MULTIDIVISION MED CENTER?: YES//[Enter]
```

Figure 10-25: Editing system wide parameters

10.5.2.2 Editing facility-wide parameters:

Use this option to edit the parameters within your facility. You will be able to edit several ADT parameters and default entries.

1. Type the division name or number where you will be making changes at the “Select IHS ADT Parameters Division:” prompt.

2. Type Y to confirm your selection at the “OK?” prompt.
3. Type the number or name of the facility where you want to set the file pointer at the “Institution File Pointer:” prompt. Type ?? for more detail on this option.

4. Type the number of your facility at the “Facility Number:” prompt or press the ENTER key to accept the default entry. This number is typically the internal entry number for your facility in the LOCATION file.

```
Editing facility-wide parameters:

Select IHS ADT PARAMETERS NAME: UNSPECIFIED INDIAN HOSPITAL 1569
... OK? Y (Yes)

INSTITUTION FILE POINTER: UNSPECIFIED HO// [Enter]
FACILITY NUMBER: 1569// [Enter]
PRINT WRISTBANDS: Type YES if you have a printer set up to print them.
```

Figure 10-26: Editing facility-wide parameters (Steps 1–4)

5. The system will display the ADT Parameters screen. This screen uses ScreenMan. When using ScreenMan for typing data, use the tab or arrow keys for moving between fields. You can type ?? at any prompt to display your options at the bottom of the screen.

6. Type answers to each of the fields to customize your site (please refer to the PIMS install guide for more information).

7. When you are done typing answers for page one, move the cursor to the command line located at the bottom of the screen and type N or NEXT PAGE.

8. Again, type answer to each of the fields to customize your site.

9. It is important to note that if you do not populate the Day Surgery Hospital field, when users select the Day Surgery (DSE) option they will see the following error (Figure 10-27):

```
Each Division must have a valid Clinic entered in the DAY SURGERY HOSP LOCATION field, found in the ADT parameters set up
Press ENTER to continue:
```

Figure 10-27: Error message

10. When you are done typing answers for page two, move the cursor to the command line and type EXIT.
ADT PARAMETERS for TAOS HEALTH CENTER

REQUEST CHART AT ADMISSION?: YES
ADMISSION REQUEST CLINIC: CHART REQUEST

PRINT A SHEET AT ADMISSION?: YES
USE LOCATOR CARDS?: YES
LOCATOR CARD PRINTER: 
CLINICAL RECORD BRIEF FORMAT: IHS CLINICAL RECORD BRIEF

FINAL A SHEET DEFAULT: A SHEET ONLY
CREATE IC ENTRY AT DISCHARGE: YES
DAYS TO DELINQUENCY: 20
BILL PREP TRACKED?: NO

CENSUS LOCKOUT DAYS: 999
MINIMUM AGE FOR ADULT PATIENTS: 16
DAY SURGERY HOSP LOCATION: DAY SURGERY

COMMAND: Press <PF1>H for help Insert

Figure 10-28: Editing facility-wide parameters, Screen 1

TRANSFER IN BULLETIN? YES
ADMIT AFTER DS BULLETIN? YES
READMISSION BULLETIN? YES
READMIT WITHIN 24HRS BULLETIN? YES
ADMISSION <24 HRS BULLETIN? YES
ADMISSION DELETED BULLETIN? YES

ICU TRANSFER BULLETIN? YES
RETURN TO ICU BULLETIN? YES

TRANSFER OUT BULLETIN? YES
AMA DISCHARGE BULLETIN? YES
INPATIENT DEATH BULLETIN? YES

TIME LENGTH FOR ADMIT DS: 7
TIME LENGTH OF READMISSION: 15
TIME LENGTH FOR RETURN TO ICU: 2

COMMAND: Press <PF1>H for help Insert

Figure 10-29: Editing facility-wide parameters, Screen 2

10.5.3 Initialize Census Files (ICF)

Use this option only when you need to start over with your census files. It will be required to run upon installation of PIMS v5.3.

1. To initialize census files, type ICF at the “Select ADT System Definition Menu Option:” prompt in the ADT System Definition menu.

2. Type the minimum age for adult patients at the “Minimum Age for Adult Patients:” prompt or press the Return key to accept the default age.
3. Type the earliest date for G&L at the “Earliest Date for G&L:” prompt or press the Return key to accept the default date.

4. Type Y at the “Ready to Initialize Census for Oct, 01, 1995?” prompt to initialize files. Type N to escape this option.

<table>
<thead>
<tr>
<th>ADT System Definition Menu</th>
<th>(UNSPECIFIED HO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CKL Check ADT-PCC Link</td>
<td>EAP Edit ADT Parameters</td>
</tr>
<tr>
<td>ICF Initialize Census Files</td>
<td>KEY List ADT Security Keys</td>
</tr>
<tr>
<td>SAF Setup ADT Files</td>
<td></td>
</tr>
</tbody>
</table>

Select ADT System Definition Menu Option: **ICF** Initialize Census Files

MINIMUM AGE FOR ADULT PATIENTS: **15**// [Enter]
EARLIEST DATE FOR G&L: **OCT 1, 1995**// [Enter]

I will now DELETE all data in your census files and start over.

Ready to Initialize Census for Oct 01, 1995? **NO**// Y

---

10.5.4 List ADT Security Keys (KEY)

Use this option to view the active ADT keys. For each key, the criteria for allocating it will also display.

1. To list the ADT security keys, type **KEY** at the “Select ADT System Definition Menu Option:” prompt in the ADT System Definition menu.

2. The ADT Security Keys screen will be displayed (Figure 10-31). To navigate through the screen, use the options at the bottom of the screen.
### ADT Security Keys

**DGZADS** (OBSOLETE - No longer used)
Scheduled for deletion.

**DGZADT** (Unlocks Bed Control options)
Assign this key to staff who will be entering the actual admissions, discharges and transfers.

**DGZAUTH** (Unlocks Scheduled Visit Edit)
Assign to users who will be doing the data entry for the Scheduled Visit module.

**DGZBC** (OBSOLETE - No longer used)
Scheduled for deletion.

**DGZDAY** (Unlocks Day Surgery Menu)
Assign to users who need access to the Day Surgery Menu. DO NOT assign this key if your facility uses the VA Surgery package.

+ Enter ?? for more actions

Select Action:Next Screen/

---

**Figure 10-31: Viewing ADT security keys**

### 10.5.5 Setup ADT Files (SAF)

Use this option to access the Setup ADT Files menu that will enable you to set up and modify local fields in the ADT standard files. You can add local entries to standard ADT files and to edit local fields in those same files.

To access the Setup ADT Files menu, type **SAF** at the “Select ADT System Definition Menu Option:” prompt in the ADT System Definition menu.
ADT System Definition Menu
(UNSPECIFIED HO)

CKL    Check ADT-PCC Link
EAP    Edit ADT Parameters
ICF    Initialize Census Files
KEY    List ADT Security Keys
SAF    Setup ADT Files

Select ADT System Definition Menu Option: SAF  Setup ADT Files

Figure 10-32: Accessing the SAF menu

The SAF menu will be displayed (Figure 10-33). Sections 10.5.5.1 through 10.5.5.8 will explain how to use each option.

1. Hospital Service Setup
2. Treating Specialty Setup
3. Wards Setup
4. Room-Bed Setup
5. Transfer Facilities Setup
6. ADT Event Driver View
7. Add Mail Groups to PIMS Bulletins
8. Online Help (Report Descriptions)

Choose Setup Option:  (1-8):

Figure 10-33: SAF menu

10.5.5.1 Hospital Service Setup

Use this option to add or edit a hospital service in your system. This setup option displays a list of the major services and departments in your facility. These include all patient care and administrative services. The list displays service name, abbreviation, mail code, and type (clinical vs. administrative). If the service has been closed, the closing date will display in the Type column.

1. To use the Hospital Service Setup option, type 1 at the “Choose Setup Option:” prompt in the SAF menu.
2. The Hospital Service Setup screen will be displayed (Figure 10-35). You have the option to add or edit any hospital service. Type the number of the option you would like to use at the “Select Action:” prompt.

<table>
<thead>
<tr>
<th>Service/Section Name</th>
<th>Abbrev</th>
<th>Mail Code</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ADMINISTRATION</td>
<td>ADM</td>
<td>ADMINISTRATIVE</td>
<td></td>
</tr>
<tr>
<td>2. BUSINESS OFFICE</td>
<td>BUS</td>
<td>ADMINISTRATIVE</td>
<td></td>
</tr>
<tr>
<td>3. CLINIC</td>
<td>CLN</td>
<td>PATIENT CARE</td>
<td></td>
</tr>
<tr>
<td>4. FISCAL SERVICE</td>
<td>FSC</td>
<td>ADMINISTRATIVE</td>
<td></td>
</tr>
<tr>
<td>5. INPATIENT</td>
<td>INP</td>
<td>PATIENT CARE</td>
<td></td>
</tr>
<tr>
<td>6. PHARMACY</td>
<td>PHAR</td>
<td>PATIENT CARE</td>
<td></td>
</tr>
</tbody>
</table>

Enter ?? for more actions
1 Add New Entry 2 Edit Entry 3 Print List
Select Action: Quit/

Figure 10-35: Setting up a hospital service (Step 2)

3. The editing/adding will be done using ScreenMan. When using ScreenMan for typing data, use the tab or arrow keys for moving between fields. If you make a change or new entry on the form, press the Enter key to record the change. If necessary, a pop-up window may be displayed for further entry of information.

4. Type in the information requested by the prompts. At any prompt you can type ?? to see a list of available options displayed at the bottom of the screen.

5. When you are done filling in the prompts, use the options at the bottom of the screen to exit, save, or go to the next page.

NAME: NEW SERVICE
ABBREVIATION: NEW
MAIL SYMBOL: NEW
TYPE OF SERVICE: PATIENT CARE
PARENT SERVICE: NEW SERVICE
DESCRIPTION:

DATE CLOSED
DATE REOPENED

COMMAND: Press <PF1>H for help

Figure 10-36: Setting up a hospital service (Step 3)
10.5.5.2 Treating Specialty Setup

Use this option to edit the treating specialties for your facility. This setup option presents all official IHS inpatient services and the corresponding IHS code in alphabetical order. The display also includes abbreviations, hospital service, and whether or not this treating specialty is set up as an active admitting service at your facility. Only those set up correctly can be chosen when admitting a patient.

1. To use the Treating Specialty Setup option, type 2 at the “Choose Setup Option:” prompt in the SAF menu.

2. The Treating Specialty Setup screen will be displayed (Figure 10-38). To edit a treating specialty, type 1 at the “Select Action:” prompt, then type the number of the specialty at the “Select Treating Specialty:” prompt, or to print the treating specialty list, type 2 at the “Select Action:” prompt and then type the name of a print device at the “Device:” prompt.
3. The editing will done using ScreenMan. When using ScreenMan for typing data, use the tab or arrow keys for moving between fields. If you make a change or new entry on the form, press the Return key to record the change. If necessary, a pop-up window may be displayed for further entry of information.

4. Type in the information requested by the prompts. At any prompt you can type ?? to see a list of available options displayed at the bottom of the screen.

5. When you are done filling in the prompts, use the options at the bottom of the screen to exit, save, or go to the next page.

```
NAME: ALCOHOLISM                                IHS CODE: 15

ABBREVIATION: ALCOH                              
HOSPITAL SERVICE: CLINIC                        

ADMITTING SERVICE?: YES  (must be YES if it has EVER been used) 
Effective Date            Active? 
FEB 11,2002               YES 

_____________________________________________________________________________

COMMAND:                                     Press <PF1>H for help    Insert
```

Figure 10-39: Editing a treating specialty (Step 3)

10.5.5.3 Wards Setup

Use this option to add or edit a ward at your facility. The system will list your wards using List Manager and then you can add/edit them using ScreenMan. This setup option presents all active and inactive wards contained in your files.

To use the Wards Setup option, type 3 at the “Choose Setup Option:” prompt in the SAF menu.

```
1. Hospital Service Setup
2. Treating Specialty Setup
3. Wards Setup
4. Room-Bed Setup
5. Transfer Facilities Setup
6. ADT Event Driver View
7. Add Mail Groups to PIMS Bulletins
8. Online Help (Report Descriptions)
Choose Setup Option: (1-8): 3
```

Figure 10-40: Setting up wards

The Inpatient Ward Setup screen will be displayed (Figure 10-41).
Edit an Inpatient Ward

Use this option to edit an existing inpatient ward at your facility.

1. To edit an inpatient ward, type 2 at the “Select Action:” prompt.

2. Type the number of the ward you wish to edit at the “Select Ward:” prompt.

3. The Inpatient Ward Setup screen will be displayed (Figure 10-42). This screen uses ScreenMan which enables you to edit any of the fields on display. When using ScreenMan for typing data, use the tab or arrow keys for moving between fields. If you make a change or new entry on the form, press the Return key to record the change. If necessary, a pop-up window may be displayed for further entry of information.

4. Type in the information requested by the prompts. At any prompt you can type ?? to see a list of available options displayed at the bottom of the screen.

5. When you are done filling in the prompts, use the options at the bottom of the screen to exit, save, or go to the next page.
## INPATIENT WARD SETUP

Name: GMS  
Abbreviation: GMS  
Division: UNSPECIFIED INDIAN HOSPITAL  
Inactive: Active  
ICU/SCU Ward?: No  
Progressive Care Unit?:  
# Adult Medical Beds: 0  
# Pediatric Medical Beds: 0  
# Obstetric Beds: 0  
# Tuberculosis Beds: 0  
# Alcohol/Substance Abuse Beds: 0  
# Mental Health Beds: 0  
A Sheet Printer:  
Seriously Ill Ward?: Include on Seriously Ill List  
Print Order: 1

---

**Add an Inpatient Ward**

Use this option to add a new ward to your facility.

1. To add an inpatient ward, type 1 at the “Select Action:” prompt.
2. Type the name of the new ward at the “Select Ward Location Name:” prompt.
3. Type Y at the “Are you adding (new name) as a new Ward Location?” prompt to confirm your selection.
4. Type the file pointer name at the “Ward Location Hospital Location File Pointer:” prompt.
5. Type the name of the division that this ward belongs to at the “Ward Location Division:” prompt.

---

![Figure 10-42: Editing an inpatient ward](image)

![Figure 10-43: Adding an inpatient ward](image)
6. The Inpatient Ward Setup screen will be displayed (Figure 10-42). This screen uses ScreenMan to enable you to edit any of the fields on display. When using ScreenMan for typing data, use the tab or arrow keys for moving between fields. If you make a change or new entry on the form, press the Return key to record the change. If necessary, a pop-up window may be displayed for further entry of information.

7. Type in the information requested by the prompts. At any prompt you can type ?? to see a list of available options displayed at the bottom of the screen.

8. When you are done filling in the prompts, use the options at the bottom of the screen to exit, save, or go to the next page.

10.5.5.4 Room-Bed Setup

Use this option to add or edit a room or bed at your facility. This setup option presents all defined room-beds in your facility. Those that have been inactivated are listed last. For each, the room-bed designation is displayed along with description, bed phone number, and inactive if inactive.

To use the Room-Bed Setup option, type 4 at the “Choose Setup Option:” prompt in the SAF menu.

Figure 10-44: Selecting room-bed setup

The Room-Bed Setup screen will be displayed (Figure 10-45). Use the options at the bottom of the screen to navigate through the screen. You can add information, edit information, or print the screen.
Figure 10-45: Adding, editing, or printing a room-bed

If you select to add or edit a room-bed, you will do so using ScreenMan. When using ScreenMan for typing data, use the tab or arrow keys for moving between fields. If you make a change or new entry on the form, press the Return key to record the change. If necessary, a pop-up window may be displayed for further entry of information.

Type in the information requested by the prompts. At any prompt you can type ?? to see a list of available options displayed at the bottom of the screen.

When you are done filling in the prompts, use the options at the bottom of the screen to exit, save, or go to the next page.

Figure 10-46: Adding or editing information in the Room-Bed Setup screen
10.5.5.5 Transfer Facilities Setup

Use this option to edit or add transfer facility parameters. This setup option presents a list of all transfer facilities used by your site so far. During the installation of ADT version 5.3, the transfer facility fields in ADT and PCC were converted from variable pointers looking at two files (Institution and Vendor). They now point to one locally maintained table. This option displays the entries in this new table.

To use Transfer Facilities Setup option, type 5 at the “Choose Setup Option:” prompt in the SAF menu.

<table>
<thead>
<tr>
<th></th>
<th>Hospital Service Setup</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Treating Specialty Setup</td>
</tr>
<tr>
<td>3</td>
<td>Wards Setup</td>
</tr>
<tr>
<td>4</td>
<td>Room-Bed Setup</td>
</tr>
<tr>
<td>5</td>
<td>Transfer Facilities Setup</td>
</tr>
<tr>
<td>6</td>
<td>ADT Event Driver View</td>
</tr>
<tr>
<td>7</td>
<td>Add Mail Groups to PIMS Bulletins</td>
</tr>
<tr>
<td>8</td>
<td>Online Help (Report Descriptions)</td>
</tr>
</tbody>
</table>

Choose Setup Option: (1-8): 5

1. Hospital Service Setup
2. Treating Specialty Setup
3. Wards Setup
4. Room-Bed Setup
5. Transfer Facilities Setup
6. ADT Event Driver View
7. Add Mail Groups to PIMS Bulletins
8. Online Help (Report Descriptions)

Choose Setup Option:  (1-8): 5

Figure 10-47: Setting up a transferring facility

The Transfer Facility Setup screen will be displayed (Figure 10-48).

<table>
<thead>
<tr>
<th>TRANSFER FACILITY SETUP</th>
<th>Nov 05, 2002 11:54:17</th>
<th>Page:  1 of   2</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNSPECIFIED INDIAN HOSPITAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer Facility Name</td>
<td>Inactive Date</td>
<td>Link to IHS Facility</td>
</tr>
<tr>
<td>1. ALBUQUERQUE HOSPITAL</td>
<td>ALBUQUERQUE HOSPITAL</td>
<td></td>
</tr>
<tr>
<td>2. ALLIANCE HOSP OF SANTA TERESA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. CASA ARENA BLANCA NURSING CTR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. EASTERN NM MED CTR - NORTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. EASTERN NM MED CTR - SOUTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. EASTERN NM MEDICAL CENTER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. GENERAL MEMORIAL (LAS CRUCES)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. GERALD CHAMPION MEM HOSP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. LA GRONE FUNERAL CHAPEL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. LAS CRUCES RADIOLOGY ASSOC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. LINCOLN COUNTY MED CTR - EMS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. LINCOLN COUNTY MEDICAL CENTER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. MEMORIAL MEDICAL CENTER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. UNSPECIFIED APACHE REHAB</td>
<td>UNSPECIFIED APACHE REHAB</td>
<td></td>
</tr>
<tr>
<td>15. MESILLA VALLEY HOSPITAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. MESILLA VALLEY PSYCH HOSPITAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Enter ?? for more actions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Add Facility</td>
<td>2 Edit Facility</td>
<td>3 Print List</td>
</tr>
</tbody>
</table>

Select Action: Next Screen/|

Figure 10-48: Transfer Facility Setup screen

Add a New Facility

Use this option to add a new transfer facility.

1. To add a new facility, type 1 at the “Select Action:” prompt.
2. Type the name of the new facility at the “Select Transfer Facility Name:” prompt.

3. Type Y at the “Are you adding (new facility name) as a new Transfer Facility:” prompt to confirm your selection.

4. Follow the remaining prompts as they are displayed on your screen.

```
Select Action: Next Screen// 1   Add Facility
Select TRANSFER FACILITY NAME: NEW
Are you adding 'NEW' as a new TRANSFER FACILITY (the 33rd)? No// Y (Yes)
```

Figure 10-49: Adding a new transfer facility

**Edit a Transfer Facility**

Use this option to edit an existing transfer facility.

1. To edit an existing facility, type 2 at the “Select Action:” prompt.

2. Type the number of the facility that you want to edit at the “Select Facility:” prompt.

3. Type the new name of the facility at the “Name:” prompt or press the Return key to keep the default setting.

4. If you are typing this facility as inactive, type the inactive date at the “Inactivation Date:” prompt or press the Return key to bypass this option.

5. Type the name of the facility that this transfer facility is linked with at the “Facility Link:” prompt, or press the Return key to keep the default setting.

```
Select Action: Next Screen// 2   Edit Facility
Select Facility: (1-16): 1
NAME: ABQ HOSPITAL// [Enter]
INACTIVATION DATE: [Enter]
FACILITY LINK: ALBUQUERQUE HOSPITAL// [Enter]
```

Figure 10-50: Editing a transfer facility

**10.5.5.6 ADT Event Driver View**

Use this option to view the ADT event driver. You cannot make any changes to the driver.

1. To use the ADT Event Driver View option, type 6 at the “Choose Setup Option:” prompt in the SAF menu.
2. The ADT Event Driver screen will be displayed (Figure 10-51). Use the options at the bottom of the screen to navigate through the report.

1. Hospital Service Setup
2. Treating Specialty Setup
3. Wards Setup
4. Room-Bed Setup
5. Transfer Facilities Setup
6. ADT Event Driver View
7. Add Mail Groups to PIMS Bulletins
8. Online Help (Report Descriptions)
Choose Setup Option:  (1-8): 6

ADT EVENT DRIVER Nov 05, 2002 12:30:03 Page: 1 of 4
Seq Protocol Description
1 BDGPM VISIT UPDATE UPDATES VISIT POINTER
20 BDGPM A SHEET CLINICAL RECORD BRIEF
25 BDGPM LOCATOR LOCATOR CARD PRINT
27 BDGPM REQUEST CHART Request Chart at Admission
50 BDGPM INCOMPLETE CHART UPDATE UPDATES INCOMPLETE CHART FILE
101 ORU PATIENT MOVMT Review Orders on Patient Movement
105 ORU AUTOLIST Update OE/RR Patient Lists
110 DGOERR NOTE MAS Notifications
115 SD APPT STATUS Appointment Status Update in Event Drive
120 FSJ OR PAT ADT Inpatient Medications Actions on Patient
150 AQL ADT EVENT QI/ADT LINKAGE EVENTS
201 SC PCMM INPATIENT ACTIVITY PCMM Inpatient Activity
205 BDGPM BULLETINS ADT BULLETINS
210 GMRADGPM MARK CHART FIRE MARK CHART BULLETIN ON NEW ADMISSION
+ Enter ?? for more actions
Select Action:Next Screen/

Figure 10-51: Viewing the ADT event driver

10.5.5.7 Add Mail Groups to PIMS Bulletins
Use this option to add mail groups to PIMS bulletins. This setup option is used if you turned on any of the ADT bulletins. The bulletins will not fire if there are no recipients. For those bulletins you have turned on, please type at least one mail group to receive that bulletin. The creation of mail groups must be done under MailMan.

1. To use the Add Mail Groups to PIMS Bulletins option, type 7 at the “Choose Setup Option:” prompt in the SAF menu.
1. Hospital Service Setup
2. Treating Specialty Setup
3. Wards Setup
4. Room-Bed Setup
5. Transfer Facilities Setup
6. ADT Event Driver View
7. Add Mail Groups to PIMS Bulletins
8. Online Help (Report Descriptions)
Choose Setup Option: (1-8): 7

Figure 10-52: Adding a mail group (Step 1)

2. The “Add Mail Groups to Bulletins” screen will be displayed (Figure 10-53).

```
ADD MAIL GROUPS TO BULLETINS  Nov 05, 2002 13:11:27        Page:    1 of   1
UNSPECIFIED INDIAN HOSPITAL

  Bulletin Name               Mail Group(s)_______________________________
  1. BDG A&D READY               PIMS INSTALL GRP
  2. BDG ADMIT AFTER DAY SURG
  3. BDG AMA DISCHARGE
  4. BDG DEATH               PIMS INSTALL GRP
  5. BDG DELETED ADMITS
  6. BDG ICU TRANSFER
  7. BDG ONEDAY ADMIT
  8. BDG READMISSION
  9. BDG RETURN TO ICU
 10. BDG SAME ADMIT
 11. BDG TRANSFER IN ADMIT
 12. BDG TRANSFER OUT DISCH

Enter ?? for more actions
  1  Edit Entry             2  Print List             Q  Quit
Select Action:Quit//
```

Figure 10-53: Adding a mail group (Step 2)

3. Type 1 at the “Select Action:” prompt.

4. Type the number of the bulletin name you wish to edit at the “Select Bulletin:” prompt.

5. Type the name of the mail group at the “Select Mail Group:” prompt. You can add a new mail group at this prompt. Follow the prompts as they are displayed on your screen to add a new group.
Select Action: Quit // 1 Edit Entry
Select Bulletin: (1-12): 1
BULLETIN: BDG A&D READY

Select MAIL GROUP: PIMS INSTALL GRP // NEW GROUP
Are you adding 'new group' as a new MAIL GROUP (the 47TH)? No // Y (Yes)
MAIL GROUP COORDINATOR: PROVIDER, JADE, JAC
Are you adding 'MY GROUP' as a new MAIL GROUP (the 1ST for this BULLETIN)? No // Y (Yes)

Figure 10-54: Adding a mail group (Steps 3–4)

10.5.5.8 Online Help (Report Descriptions)
Use this option to view report descriptions for the reports in the SAF menu. All report
descriptions will be displayed onscreen.

1. To use the Online Help option, type 8 at the “Choose Setup Option:” prompt in the SAF menu.

2. Type the number of the report of which you would like to see a description at the “Select Help System action or <return>:” prompt.

Choose Setup Option: (1-8): 8

Set up ADT Files
Use this option to maintain the various tables used by ADT. Each choice
will display the entries in the file in browse mode and then allow you to edit the entry, print the list and in some cases, add new entries. Choose by number for details on that particular choice.

1 Hospital Service Setup
2 Treating Specialty Setup
3 Wards Setup
4 Room-Bed Setup
5 Transfer Facilities Setup
6 ADT Event Driver View
7 Add Mail Groups to PIMS Bulletins

Select HELP SYSTEM action or <return>: 

Figure 10-55: Using online help
10.6 **View A&D Corrections (VAD)**

Use this option to view any corrections (edits) made under Bed Control that might affect your census numbers. This option is useful to see who is entering movements incorrectly. To select the movement to be viewed, you can type the date of the edit or, if known, the patient for whom the edit was made.

1. To display the View A&D Corrections Screen, type **VAD** at the “Select ADT Supervisor Menu Option:” prompt in the Supervisor ADT menu.

2. Type the date the change to be viewed was made at the “Select G&L Corrections Date of Change:” prompt.

3. The changes made on that date will be displayed (Figure 10-56).

![Figure 10-56: Viewing A&D corrections](image-url)
11.0 Scheduled Visit Entry/Edit (SV)

Use this option to record or track a scheduled admissions, scheduled day surgeries, and scheduled outpatient visits from outside this service unit. Patients can be scheduled to a specific ward or treating specialty. This option also includes travel and housing information. You can also print a scheduled visit summary using this option.

To enter/edit an upcoming patient visit, type **SV** at the “Select ADT Menu Option:” prompt.

The “Select Patient:” prompt will be displayed (Figure 11-1).

<table>
<thead>
<tr>
<th>Select ADT Menu Option: SV Scheduled Visit Entry/Edit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select Patient:</td>
</tr>
</tbody>
</table>

Figure 11-1: Accessing Scheduled Visit Entry/Edit

11.1 Record a New Scheduled Visit

Use this option to schedule an upcoming visit for a patient.

1. To record a new patient visit, type the name of the patient who has an upcoming visit at the “Select Patient:” prompt.

2. Type **Y** at the “Okay to Add New Scheduled Visit?” prompt to verify the entry, or if the patient already has existing scheduled visits, type **A** at the “Select Date by Number or ‘A’ to Add New Entry:” prompt.

3. Type the date of the expected appointment at the “Scheduled Visit Date Expected:” prompt.
4. Type the visit type at the “Scheduled Visit Type:” prompt. Type ?? to see a list of available visit types.

```
Select Patient: PATIENT, ALLISON

F 02-02-1901 000785650 MH 4298

No Scheduled Visits found for patient
OKAY TO ADD NEW SCHEDULED VISIT? NO/ X YES
SCHEDULED VISIT DATE EXPECTED: 10/30/02 (OCT 30, 2002)
SCHEDULED VISIT VISIT TYPE: ??

Choose from:
A      ADMISSION
D      DAY SURGERY
O      OUTPATIENT VISIT

OKAY TO ADD NEW SCHEDULED VISIT? A
```

Figure 11-2: Entering a new patient appointment (Steps 1-4)

5. If you typed A, the Scheduled Admission screen will be displayed. If you typed D, the Scheduled Day Surgery screen will be displayed. If you typed O, the Scheduled Outpatient Visit screen will be displayed. These screens use ScreenMan. When using ScreenMan for typing data, use the tab or arrow keys for moving between fields. If you make a change or new entry on the form, press the Return key to record the change. If necessary, a pop-up window may be displayed for further entry of information.

6. Type in the information requested by the prompts. At any prompt you can type ?? to see a list of available options displayed at the bottom of the screen.

7. When you are done filling in the prompts, use the options at the bottom of the screen to exit, save, or go to the next page.
### SCHEDULED ADMISSION

**PATIENT:** PATIENT, ALLISON  
**CHART #:** 4298  
**COMMUNITY:** UNSPECIFIED RES  
**AGE:** 41

<table>
<thead>
<tr>
<th>DATE EXPECTED: OCT 30, 2002</th>
<th>EXPECTED LENGTH OF STAY: 5</th>
</tr>
</thead>
</table>

**AUTHORIZING PROVIDER:** DOCTOR, KATHRYN  
**CASE MANAGER:** MANAGER, HEATHER E  
**TREATING SPECIALTY:** SURGERY  
**WARD:** GMS  
**DIAGNOSIS:** bad valve  
**REFERRING PROVIDER:** PROVIDER

<table>
<thead>
<tr>
<th>SURGERY DATE: OCT 30, 2002</th>
<th>SAME DAY ADMIT?: YES</th>
</tr>
</thead>
</table>

**PROCEDURE:** heart transplant

**VISIT DISPOSITION:**

---

### SCHEDULED ADMISSION

**PATIENT:** PATIENT, ALLISON  
**CHART #:** 4298  
**COMMUNITY:** UNSPECIFIED RES  
**AGE:** 41

<table>
<thead>
<tr>
<th>TRAVEL AUTHORIZATION: ROUND TRIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOUSING AUTHORIZED: PATIENT'S RESPONSIBILITY</td>
</tr>
<tr>
<td># OF DAYS HOUSING AUTHORIZED:</td>
</tr>
<tr>
<td>TRAVEL/HOUSING DETAILS: by ambulance</td>
</tr>
</tbody>
</table>

**NAME OF ESCORT:** PATIENT, LILY  
**TRAVEL AUTHORIZED FOR ESCORT?: ESCORT ARRANGING**  
**HOUSING FOR ESCORT AUTHORIZED?: ESCORT'S RESPONSIBILITY**  
| # OF DAYS HOUSING FOR ESCORT: |
| ESCORT HOUSING STATUS: |

**ESCORT DETAILS:**

**ADDITIONAL COMMENTS:**

---

**COMMAND:** EXIT

---

Figure 11-3: Entering a new patient visit (Steps 5 – 7)

8. When you exit the ScreenMan screen, type Y or N at the “Want to Print Scheduled Visit Summary?” prompt. If you type Y, you will be prompted to select between printing the report on paper or browsing onscreen.
Want to print Scheduled Visit Summary? NO// Y YES

Select one of the following:
B BROWSE ON SCREEN
P PRINT ON PAPER

PRINT MODE: B

============================================================================= Scheduled Visits Summary Oct 29, 2002 07:17:56 Page: 1 of 1 Confidential Patient Data Covered by Privacy Act
PATIENT, ALLISON #4298 Age: 41 Comm: UNSPECIFIED RES

SCHEDULED ADMISSION

DATE EXPECTED: OCT 30, 2002
AUTHORIZING PROVIDER: DOCTOR, KATHRYN
CASE MANAGER: JONES, HEATHER E
TREATING SPECIALTY: SURGERY
WARD: GMS
DIAGNOSIS: bad valve
REFERRING PROVIDER: PROVIDER
SURGERY DATE: OCT 30, 2002
SAME DAY ADMIT?: YES
PROCEDURE: heart transplant

Enter ?? for more actions

Select Action: Quit// QUIT

Figure 11-4: Entering a new patient visit (Step 8)

11.2 Edit a Scheduled Visit

Use this option to edit a scheduled visit.

1. To edit a patient visit, type the name of the patient whose upcoming visit needs to be edited at the “Select Patient:” prompt.

2. Type the date of the scheduled visit that needs to be edited or select from the list of scheduled visit entries at the “Select Date by Number or ‘A’ to Add New Entry:” prompt.

3. Type changes to be made at the prompts then press the Return key to record the changes.
Select Patient: **PATIENT, ALLISON**

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOV 05, 2002</td>
<td>OUTPATIENT VISIT</td>
<td>Open/Pending</td>
</tr>
<tr>
<td>NOV 01, 2002</td>
<td>DAY SURGERY</td>
<td>Open/Pending</td>
</tr>
<tr>
<td>OCT 30, 2002</td>
<td>ADMISSION</td>
<td>Open/Pending</td>
</tr>
</tbody>
</table>

Select Date by Number or "A" to Add New Entry: 1

It would then drop into the same ScreenMan display as under “Add a New Scheduled Visit”.

*Figure 11-5: Editing a patient visit*
12.0 Glossary

ADPL
Average Daily Patient Load

ALOS
Average Length of Stay

Attending physician
Supervising physician who is responsible for the care of the patient.

DRG
Diagnostic Related Group

G&L
Gains and Losses

Security key
Used in conjunction with locked options or functions.
13.0 Appendix A: RPMS Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is FOR OFFICIAL USE ONLY. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general Rules of Behavior for all users, see the most recent edition of IHS General User Security Handbook (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the IHS Technical and Managerial Handbook (SOP 06-11b).

Both documents are available at this IHS web site,

http://security.ihs.gov/

The Rules of Behavior listed in the following Sections are specific to RPMS.

13.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., PCC, Dental, Pharmacy).

13.1.1 Access

RPMS Users Shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
• Always verify a caller’s identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or non-public agency information.

• Be aware that personal use of information resources is authorized on a limited basis within the provisions Indian Health Manual Part 8, “Information Resources Management,” Chapter 6, “Limited Personal Use of Information Technology Resources.”

**RPMS Users Shall NOT**

• Retrieve information for someone who does not have authority to access the information.

• Access, research, or change any user account, file, directory, table, or record not required to perform your OFFICIAL duties.

• Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.

• Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their job or by divulging information to anyone not authorized to know that information.

13.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

**RPMS Users Shall**

• Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the function they perform such as system administrator or application administrator.

• Acquire a written preauthorization in accordance with IHS polices and procedures prior to interconnection to or transferring data from RPMS.
13.1.3 Accountability

**RPMS Users Shall**
- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Logout of the system whenever they leave the vicinity of their PC.
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Shall abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and IT information processes.

13.1.4 Confidentiality

**RPMS Users Shall**
- Be aware of the sensitivity of electronic and hardcopy information, and protect it accordingly.
- Store hardcopy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media, prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all HIPAA regulations to ensure patient confidentiality.

**RPMS Users Shall NOT**
- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

13.1.5 Integrity

**RPMS Users Shall**
- Protect your system against viruses and similar malicious programs.
- Observe all software license agreements.
• Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.

• Comply with all copyright regulations and license agreements associated with RPMS software.

**RPMS Users Shall NOT**

• Violate Federal copyright laws.

• Install or use unauthorized software within the system libraries or folders.

• Use freeware, shareware, or public domain software on/with the system without your manager’s written permission and without scanning it for viruses first.

13.1.6 System Logon

**RPMS Users Shall**

• Have a unique User Identification/Account name and password.

• Be granted access based on authenticating the account name and password entered.

• Be locked out of an account after 5 successive failed login attempts within a specified time period (e.g., one hour).

13.1.7 Passwords

**RPMS Users Shall**

• Change passwords a minimum of every 90 days.

• Create passwords with a minimum of eight characters.

• If the system allows, use a combination of alpha, numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.

• Change vendor-supplied passwords immediately.

• Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts, or batch files).

• Change password immediately if password has been seen, guessed, or otherwise compromised; and report the compromise or suspected compromise to your ISSO.

• Keep user identifications (ID) and passwords confidential.
RPMS Users Shall NOT

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user’s name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another’s password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per 8 characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

13.1.8 Backups

RPMS Users Shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

13.1.9 Reporting

RPMS Users Shall

- Contact and inform your ISSO that you have identified an IT security incident and you will begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the IHS Incident Handling Guide (SOP 05-03).

RPMS Users Shall NOT

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.
13.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

**RPMS Users Shall**
- Utilize a screen saver with password protection set to suspend operations at no greater than 10-minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on your screen after some period of inactivity.

13.1.11 Hardware

**RPMS Users Shall**
- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

**RPMS Users Shall NOT**
- Eat or drink near system equipment

13.1.12 Awareness

**RPMS Users Shall:**
- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS Manuals for the applications used in their jobs.

13.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that
- Are in writing.
• Provide authentication of the remote user through the use of ID and password or other acceptable technical means.

• Outline the work requirements and the security safeguards and procedures the employee is expected to follow.

• Ensure adequate storage of files, removal, and non-recovery of temporary files created in processing sensitive data, virus protection, intrusion detection, and provides physical security for government equipment and sensitive data.

• Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS Users Shall

• Remotely access RPMS through a virtual private network (VPN) when ever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS Users Shall NOT

• Disable any encryption established for network, internet, and web browser communications.

13.2 RPMS Developers

RPMS Developers Users Shall

• Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.

• Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.

• Only access information or code within the namespaces for which they have been assigned as part of their duties.

• Remember that all RPMS code is the property of the U.S. Government, not the developer.

• Shall not access live production systems without obtaining appropriate written access, shall only retain that access for the shortest period possible to accomplish the task that requires the access.

• Shall observe separation of duties policies and procedures to the fullest extent possible.

• Shall document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer’s initials, date of change and reason for the change.
• Shall use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.

• Shall follow industry best standards for systems they are assigned to develop or maintain; abide by all Department and Agency policies and procedures.

• Shall document and implement security processes whenever available.

**RPMS Developers Shall NOT**

• Write any code that adversely impacts RPMS, such as backdoor access, “Easter eggs,” time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.

• Grant any user or system administrator access to RPMS unless proper documentation is provided.

• Not release any sensitive agency or patient information.

### 13.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators have added responsibilities to ensure the secure operation of RPMS.

**Privileged RPMS Users Shall**

• Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.

• Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.

• Advise the system owner on matters concerning information technology security.

• Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.

• Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.

• Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need to know basis.

• Verify that users have received appropriate security training before allowing access to RPMS.
• Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.

• Document and investigate known or suspected security incidents or violations and report them to the ISSO, CISO, and systems owner.

• Protect the supervisor, superuser, or system administrator passwords.

• Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).

• Watch for unscheduled, unusual, and unauthorized programs.

• Help train system users on the appropriate use and security of the system.

• Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.

• Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.

• Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and back up files.

• Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.

• Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator’s database.

• Shall follow industry best standards for systems they are assigned to; abide by all Department and Agency policies and procedures.

Privileged RPMS Users Shall NOT

• Access any files, records, systems, etc., that are not explicitly needed to perform their duties

• Grant any user or system administrator access to RPMS unless proper documentation is provided.

• Not release any sensitive agency or patient information.
14.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)
Fax: (505) 248-4363
Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm
Email: support@ihs.gov