

Abylss Systems

Email: support@ablyss.co.uk

Website: www.ablyss.co.uk

CMS Release 7.2

Abylss Care Management System Release Notes
January 2020



- Release Overview..... 3**

- Body Maps 4**
 - Body Map Overview 5
 - Creams 7
 - Condition Follow-Ups 8
 - Body Maps and CMS Touch 9
 - Admission Snapshots 9
 - Body Map Links..... 10
 - Body Maps on CMS Tablet..... 10

- Complaints and Suggestions.....11**
 - Details 12
 - Investigation 13
 - Actions 14
 - Security Settings 15
 - Reporting 15

- Tasks16**

- Task Performance18**
 - Useful Information..... 19
 - Audit Trail 19

- Standardised Attachment Folders20**
 - Attachments Audit trail 20
 - Attachments Renaming File Type 21
 - Attachment Folders Naming Conventions..... 21

- MCA Improvements22**
 - Ability to perform different MCA assessments. 22
 - Flow of the MCA screen & Final Decisions 23

- CMS Desktop Changes.....24**
 - BMI for Amputees..... 24
 - Accidents and Incidents - Updating Care Records 25
 - Care Plan Text Formatting 26
 - Care Plan Importance Level 26
 - Care Plan Read Request Changes 27
 - Daily Care Emotions..... 27
 - Filter Positions 27

- Employee Training 28
- Quality of Life Updates.....29**
 - Adding Next of Kin 29
 - Employee Notes – Text Length 29
 - Employee Assessments..... 29
 - Accidents & Incidents 29
 - Residents Contact Details 30
 - Date Performed 30
- Reports31**
 - Admissions & Departures 31
 - About Me – Full and Summary reports..... 31
 - Changes to Templates setup..... 32
 - Assessments Report – Risk level 32
- Bug Fixes:33**
 - Cost of Room Visible 33
 - Multiple Home Environments..... 33
 - MCA Assessment Review Dates 34
 - Daily Observation Contact Notes..... 34
 - Deletion of a Task’s Daily Care Assessment..... 34
 - Re-admission date 34
 - Accidents & Incidents Filters..... 34
- CMS Tablet App Changes.....35**
 - Body Map Overview 35
 - New Body Map Conditions 36
 - Body Map Treatment Notes 37
 - Add Resident Profile Photos 38
 - Pre-Admission Residents on Tablet 38
 - Tablet Auditing 39
 - Synch Reports 39
 - Ease of Use..... 40

Release Overview

The body maps have been completely rewritten to allow for the recording of creams as well as the introduction of body maps on the tablets. This will allow staff to add conditions / treatment notes at the point of care including the option to take a photo with the handheld devices to upload directly to CMS.

A complaints and suggestions area can be found under the Home module alongside the Accidents & Incidents. This will allow you to keep track of received complaints and resolve them before the need of a 3rd party.

The release comprises of the following: -

- Body Map Redesign
- Complaints & Suggestions
- Further MCA Improvements
- Task
- Resident / Employee Attachments
- Tablet Pre-admissions
- Tablet Body Map
- Employee Training Archiving
- Care Plan Font Improvements
- Minor Enhancements
 - Reports
 - Desktop
 - Touch
 - Tablet

Body Maps

The Body Maps module has been redeveloped to provide you with greater flexibility. We had also received requests to implement the body maps on the tablet devices.

We took this opportunity to redesign the body maps to improve the way that you record conditions and to introduce a cream chart. Finally, a 'Body Map Admissions' will allow you to take snapshots of the current body map allowing for documentation of before/after hospital admissions.

One of the most requested changes was to add more diagrams to the body map, to include Head, Hands, Feet and Oral, in addition to this we have separated the front and back and introduced a side profile.



Key Points

- **Body Maps now allow for a Cream chart**
- **Body Map admissions to create a snapshot of all Body Map Conditions**
- **Additional Diagrams to record conditions on**
- **Link a Custom Assessment to a body map condition**
- **Predefined locations linked to diagrams**

Body Map Overview

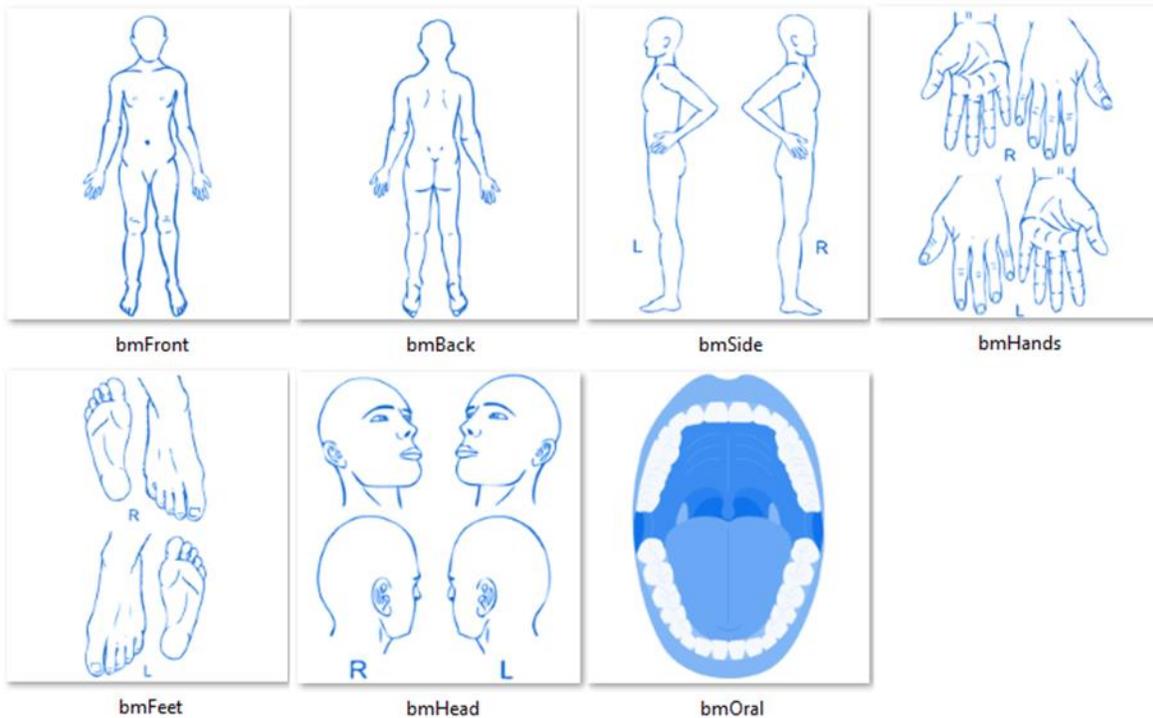
The screenshot displays the 'Body Map Overview' for resident June Armstrong. The interface is divided into several sections:

- Header:** Resident name 'June Armstrong' and status indicators for DNAR, Diabetic, and DOL. The page is titled 'Assessment' and includes navigation for 'Custom Assessments', 'Likes & Dislikes', 'Vitals', and 'Body Map'.
- Wound Chart List (2):** A list of conditions:
 - 1 - Bruise Front Shoulder
 - 2 - Cut Front Foot
- Body Map:** A human silhouette with a purple circle (1) on the right shoulder and a green circle (2) on the right foot.
- Condition Details - #1:**
 - Wound Details:** Condition: Bruise, Location: Shoulder, Onset Date: 25/11/2019, Review Date: (empty).
 - Measurement (mm):** Length: 1, Width: 0, Depth: 1, Pain: 0.
 - Comments:** Bruised shoulder raised from a fall in the living room.
 - Treatment Plan:** Monitor healing process applying Arnica when required.
 - Task Frequency:** This task should happen every 6 hours from 08:00 to 22:00. It was last performed on 06/01/2020 at 15:52.
- Treatment Notes (1):**

Date	Time	Logged By	Subject	Details
06/01/2020	15:51	Daniella Thornley	Treatment Note - Wound	Treatment note for Bruise located on Front, Shoulder. Arnica applied, healing well!

The body map now allows for wounds (previously a condition), creams and admissions. Although we haven't made any changes to the conditions, a new feature that has been introduced is the ability to link a Custom Assessment to a body map condition. A different assessment can be set against each specific condition allowing for full customisation. For example, you could have an assessment to be performed after a new pressure sore has been located and an assessment upon recording a burn. This can be viewed on the "Further details" tab.

Each diagram has a list of predefined locations for example, when adding a condition to the persons Front, you will be able to choose from one of the following: Bicep, Chest, Foot, Forearm, Hand, Head, Knee, Pelvis, Shin, Stomach or Thigh. You can alter and add to these lists by going to 'Admin > Locations' in the toolbar. This secondary location will be used to identify individual conditions when reviewing or writing treatment notes from the shift handover.



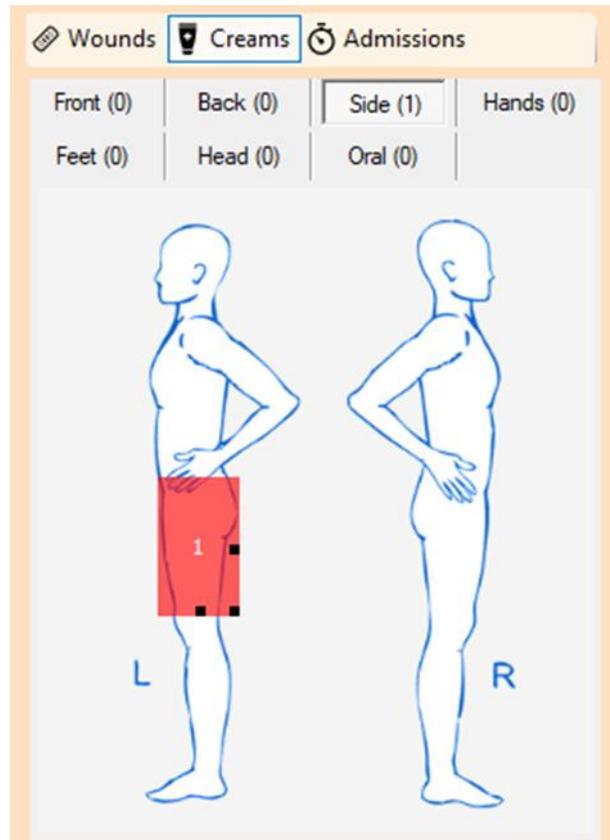
Against each diagram will be a number indicating how many conditions are displayed on each tab, as highlighted above.

Creams

When adding a Cream, after clicking 'New' a red highlighted box will appear to allow you to indicate where the cream is to be applied. You can drag and drop this box to move it to the affected area and resize it by using the sizing handles, any time you are creating or editing a cream, it will be highlighted by this red background.

Once saved the cream area will turn green indicating it has been saved. When you are viewing a cream, the colour will be purple to indicate the current highlighted cream.

You can alter the creams frequency list by going to 'Admin > Cream Frequencies' in the toolbar



Condition Follow-Ups

We have integrated the tasks feature into the body maps, whilst you are looking at a specific condition you are able to set up a task that will alert users to perform a treatment note, this will be available for conditions for activities such as redressing a wound or to set a cream frequency that will alert staff when a cream is to be applied.

Task Frequency: This task should happen every 6 hours from 08:00 to 22:00
It was last performed on 06/01/2020 at 14:53



When adding a treatment note from a task you will use a new form (shown below), at the point of writing a treatment note you are able to attach a/multiple photo's, this expands on the previous body map which only allowed one photo per review. The details about the cream/ condition will be disabled as these should only be updated in a Review. Any time a task has been completed, the treatment notes will be displayed in the daily care and against the body map entry they have been written for.

Body map task for June Armstrong

Name: E 45 Start Date: 06/01/2020
Location: Palm Recorded By: Daniella Thomley
Frequency: Once a day

How to be applied: Apply a moderate amount to the right palm

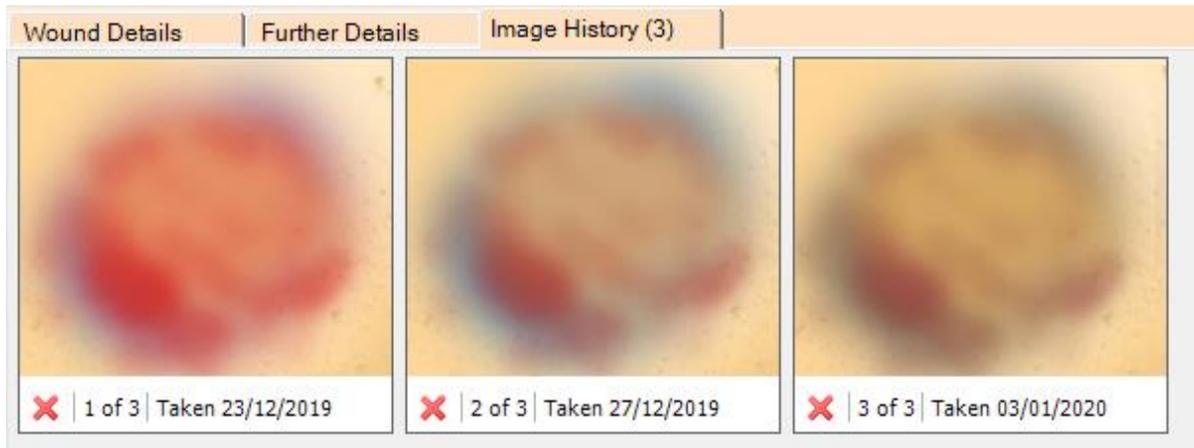
Treatment Note

Photos - (1) Attach Photo

Importance Level: ● Low Emotion: 😊

Details: Treatment note for E 45 located on Hands, Palm. E45 applied to June's palm, dry skin regaining moisture.

All of the condition's photos can then be viewed on the Image History tab when looking at the body map, again a number will display the total number of photo's attached to this condition. When viewed you can see the progress of the condition with the dates of when the images were taken.

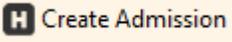


Body Maps and CMS Touch

Although the ability to add body maps has not been introduced to the touch system, because you can now set up tasks within CMS, you have the ability to record treatment notes on CMS Touch using the Body map form shown above.

Admission Snapshots

Snapshots allow you to keep an archive of a "current body map" state, allowing you to see the conditions present when a resident is admitted to hospital, so that when they return, you can identify which conditions may have happened whilst outside of your care. When viewing a snapshot, you will only see the review current at the time of the snapshot.

To create a new admission, click the:  button, after a prompt CMS will confirm that a snapshot has been taken, please note, you may only take one snapshot per day.

Body Map Links

When you add a condition e.g. a pressure sore, you may want to attach relevant documentation to the issue. Links allow you to associate a combination of Custom assessments, Risk Assessments, Care plans or other body map conditions to the current body map record. For example, you can link a resident's pressure sore to a cream chart and a 'maintaining skin integrity' care plan.

When viewing a document that has linked records you have the option to access or even review that document.

Body Maps on CMS Tablet

Body maps have been added to the tablets!

One of the primary benefits this brings is the ability to write body map entries at the point of care. As the carers identify new conditions, they are able to add a record to the body map, complete with photo's if necessary straight from the tablet's camera or gallery. Read more in the Tablet release notes below.

Complaints and Suggestions

One of the new modules that we have created is designed to help you log, investigate and respond to any complaints / Suggestions / concerns made. Complaints can be logged against individual residents, employees or against the home in general.

To begin using this new module please go to: **Home > A&I > Complaints / Suggestions**

The screenshot shows a web-based form for logging complaints and suggestions. The form is organized into three main areas:

- Details (Left Panel):** Contains fields for 'New Record', 'Category', 'In relation to a:', 'Reason for:', 'Made By:', 'Contact details:', 'Date Logged:', 'Reported To:', 'Review date:', and 'Date Closed:'.
- Investigation Details (Right Panel):** Contains sections for 'Evidence provided for the service user's consent to complain on their behalf? 1', 'Investigation Overview: 2', 'Investigation Plan:3', 'Investigation Findings: 4', and 'Proposed Response: 5'.
- Action Log (Bottom Panel):** A table with columns for 'Subject', 'Date', 'Logged By', and 'Action'.

- ❖ The screen has 3 main areas, firstly, on the left we have the details of the feedback itself:
- ❖ The right side contains the investigation details of the feedback
- ❖ The bottom keeps a record of all actions made against the current feedback.

Details

Details

New Record

Category:

In relation to a:

Reason for:

Made By:

Contact details:

Date Logged:

Reported To:

Review date:

Date Closed:

Category: You are able to distinguish between complaints, suggestions or concerns.

Relation: State whether the complaint is against a Resident, Employee or the home. You can also state, if applicable, who the complaint is against.

Reason for: The basis of the complaint

Made By / Contact details: Details of who complained and how the home can contact and respond to them.

Date & Reported To: When the complaint was added to CMS and also who uploaded the data

Date Closed: Setting a date here will archive the complaint. Archived complaints are no longer displayed in the default list.

Investigation

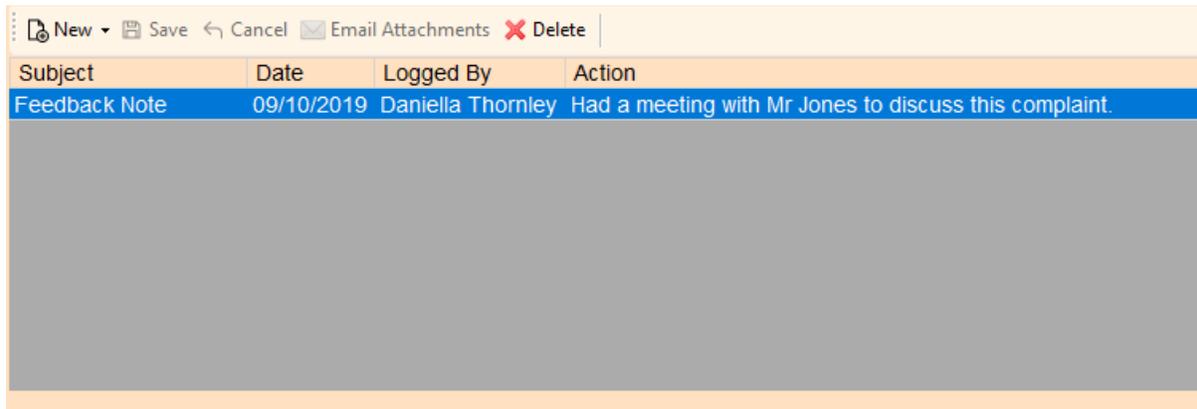
Evidence provided for the service user's consent to complain on their behalf?	
Investigation Overview:	
Investigation Plan:	
Investigation Findings:	
Proposed Response:	

These labels can be changed by going to **Admin > Change Label Descriptions**.

These textboxes are to include information on the complaint. How you will investigate issues raised, what issues were found and how you will resolve them.

Actions

You will also be able to attach your own complaint template documents by going to **Admin > Setup Complaint Templates**. Once set up in here they can be accessed when adding a new complaint note at the bottom of the screen.



The notes area will allow you to write quick notes as the investigation into the complaint progresses. When you send a template letter, a note will be saved into the actions grid with a link to the attachment. Once you have added and made any changes to the document you can highlight which letter you wish to send and click 'Email attachments', If you have CMS set that you can send emails, you will be able to send an email straight from this record.

When feedback is due to be reviewed it will be displayed on both the shift handover and the home dairy. Anyone with access to view Complaints will be able to see these reminders and clicking one will open the complaints form to the record so the user is able to review.



Security Settings

To manage the access rights of who can view this feature, we have added a new security setting in the Home module so that you may control who can access to the Complaints / Feedback area. After first updating CMS users will be able to view the complaints module if they are able to view the Home A&I. This will mean if you wish to start using this area you will need to go to: **Admin > Security > User Profiles** so that you can assign who has the access to view and add new records.

Reporting

Individual Complaint

This report will print all details about the report the user is currently viewing. You will also have the option to print this same report but for all unresolved complaints.

Tasks

We have redesigned some of the underlying functionality of the tasks, to help improve performance and to offer the following new features:

1. Addition of weekly events to the Task Frequency

Task Frequency
Complete Task every Month(s) Week(s) Day(s) Hour(s) between and
Weekly Options: Monday Tuesday Wednesday Thursday Friday Saturday Sunday
Effective from at On-Going
Importance Low Medium High

2. Addition of specific days on the month for the Task Frequency. Select between

- a. The same day for each month
- b. A specific event each month, such as the first day or the second Monday
- c. A month after the last task was performed (default value prior to version 7.2)

Task Frequency
Complete Task every Month(s) Week(s) Day(s) Hour(s) between and
Monthly Options: on Day The day After last task was completed
Effective from at On-Going
Importance Low Medium High

3. Ability to assign multiple residents to one task. Traditionally you either needed to create a separate task for each resident or create a task based on a filter such as ground floor.

- Ensure that Specific Resident is selected from the Resident Group
- Click Add / Remove Residents to select your residents

Daily Care Tasks

New Edit Delete Save Cancel Exit

Task To Monitor: Daily Care Assessment | 12 CMS Pressure Area Care (position change)

Resident Group: Specific Resident

Task Frequency: Complete Task every 3 Hour(s) between 08:00 and 20:00

Tasks will only be visible during these hours

Effective from: 14/05/2019 at 08:00 On-Going

Importance: High

Residents Selected for task

Resident Name	Room
June Armstrong	01
Mary Duddy	08
Dorothy Goodie	09

+ Add / Remove Residents

4. Assigning Tasks to Body Map wounds and Creams. You must be within the Body Map module to create a new task however when in the Task Admin screen, you will be able to view all tasks assigned to an individual resident

Task Performance



A new feature, Task Performance, has been added. This feature is accessible from the Task Screen in the main CMS Desktop

The purpose of this feature is to help inform you how regularly tasks are being missed. Enter a date range (this will default to the last day) and click calculate. By default, any missed tasks within this date range will be shown, however you can change your focus by increasing the number of missed tasks to be displayed. In this example only tasks which have been missed twice or more consecutively are displayed.

TASK PERFORMANCE

Tasks performance between the period: 08/12/2019 and 09/12/2019 Show Missed Tasks > Calculate

Sort By: Date

Resident Name	Room No	Performed	Next Performed	Missed Episodes
Continance				
May Camberley	35	08/12/2019 19:44	09/12/2019 06:03	3
Catherter Care & Stoma Care				
John Mycroft	18	08/12/2019 17:45	09/12/2019 00:53	2
Night staff cleanning record				
Abyss Home		06/12/2019 06:34	No Record	3
Fluid Intake				
Julie Lynnwood	02	08/12/2019 17:04	09/12/2019 10:02	2
Brenda Newbridge	19	08/12/2019 17:21	09/12/2019 10:04	2
Annette Saxon	06	08/12/2019 17:21	09/12/2019 10:08	2
Joan Warburton	04	08/12/2019 17:44	09/12/2019 10:25	2
Doris Nickleby	10	08/12/2019 17:47	09/12/2019 10:05	2
Susanna Wilkins	14	08/12/2019 18:24	09/12/2019 10:26	2
Terry Webber	27	08/12/2019 19:27	09/12/2019 10:17	2
Amelia Smith	37	08/12/2019 19:44	09/12/2019 10:20	2
Ronnie Evans	24	08/12/2019 19:45	09/12/2019 10:18	2
Christina Oppenheimer	15	08/12/2019 19:46	09/12/2019 10:08	2
Gwen Ogilvey	15	08/12/2019 19:47	09/12/2019 10:08	2
Eric Munday	22	08/12/2019 21:11	09/12/2019 10:03	2

All Tasks vs Missed Tasks %

Category	Percentage
On time	77%
Missed Episodes = 1	20%
Missed Episodes >= 2	3%

Number Missed tasks by category (Missed tasks > 2)

Category	Count
Continance	1
Catheter Care & Stoma...	1
Night staff cleaning record	1
Fluid Intake	12

Useful Information



Hover your mouse over the icon to display details about the task. For example, this task should happen every day between 08:00 and 20:00.

Hourly Tasks

If a task is set to perform say every 4 hours, a task will be classified as missed if it is more than 20% of the time frame overdue. So, if a task is due every 4 hours, it would be flagged as missed if it has not performed in the first 48 minutes of its due date.

Next Performed

- Date – If a date is displayed this is the date the task was next actioned after the Performed Date
- No Record – No record could be found of this task being performed within the date range specified
- Outstanding – The task is still outstanding and due now.

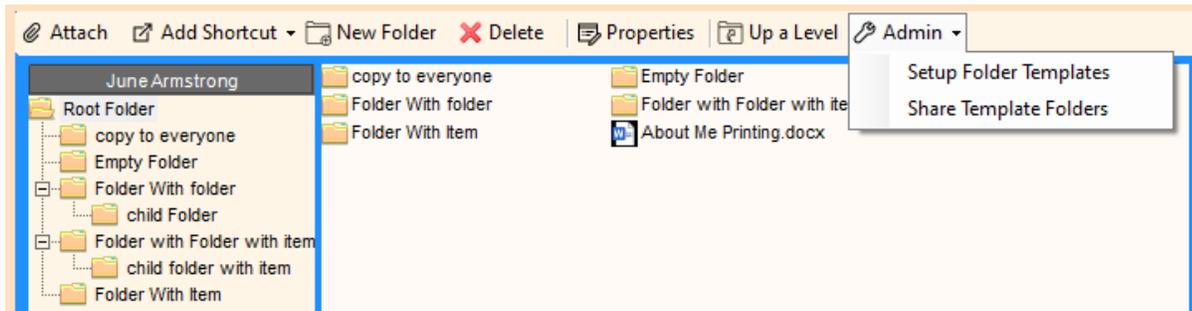
Audit Trail

An audit trail has now been added for the creation, amendment and deletion of tasks.

Standardised Attachment Folders

It has been requested that users can add a specific set of folders into each residents / employees Attachments folder. We have added a 'Folder Templates' structure to allow you to do this.

To access this feature, when looking at a Residents or Employees attachment, click on “**Admin > Setup folder templates**”.



When activating setup mode to create your templates, the screen will be highlighted by a blue border. When you exit the setup mode, this will return to normal.

To expedite this process, if you have an existing resident set up with the folders and files that you wish to be created for all your new residents, you can click '**Admin > Share Template Folders**'. CMS will then copy all the content from the active resident to the default template folder. An existing folders or files in the template folder will **not** be replaced.

This will also allow you to copy Files as well as folders.

Attachments Audit trail

We have added in the capability for CMS to track changes within the Docstore when it is altered through CMS.

CMS will now track:

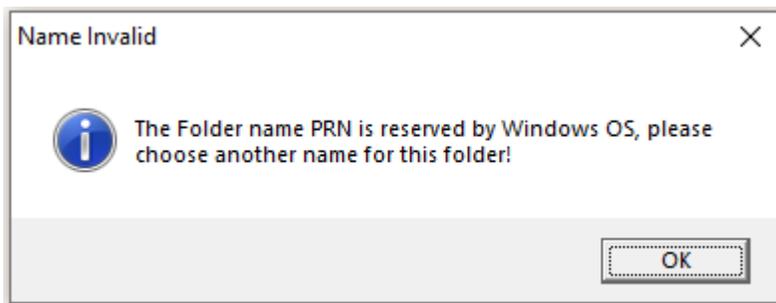
- When a file has been Added / Deleted.
- When a File/Folder has been renamed
- When a file/folder has been copied to the clipboard

Attachments Renaming File Type

We have also changed the renaming of files in CMS so that users are no longer able to change the extension of a file. For example you are no longer able to rename a “.Docx” document to “.txt” however you can still change the name of the document.

Attachment Folders Naming Conventions

Windows reserves various folder names for its own use. One that people have been having issues with is ‘PRN’. We have added a check so that if you are trying to rename a folder and you choose one of these reserved folders you will now get a message telling you so and will be able to rename it before it will cause an error.



The full list of reserved folders. is as follows: CON, PRN, AUX, NUL, COM1, COM2, COM3, COM4, COM5, COM6, COM7, COM8, COM9, LPT1, LPT2, LPT3, LPT4, LPT5, LPT6, LPT7, LPT8, and LPT9

Please note that a folder called ‘Resident PRN’ will cause no issues with the windows naming system.

MCA Improvements

In 7.1 we introduced the new MCA area. We have received feedback on how we can improve this further, these are the changes we have made.

Ability to perform different MCA assessments.

The MCA was designed to have one Assessment to be used for all records. We had received requests for the ability to have a number of different assessments depending on the category of the MCA. For example, the assessment for financial capacity can differ to the assessment for personal hygiene.

Now, if you select Yes to Stage 1, you will be able to select from a list of available assessments.

Assessment of Mental Capacity for June Armstrong

[Health or Social Care issue that needs a specific decision:](#)

Stage One Mental Capacity Assessment
Is there an impairment or disturbance in the functioning of the person's mind or brain? E.g. dementia / short term memory problems / mental health issue or thinking problems / learning difficulties?

Yes No

Please select which MCA assessment you would like to perform!

[Reason why the MCA has been completed:](#)

[Decisions Made by:](#)

- General MCA Assessment
- General MCA Assessment
- MCA - Financial Capacity
- MCA - Getting Dressed, Personal Hygiene
- MCA - Decisions affecting Will or Medication

To add more assessments, click the **'Admin'** button in the MCA toolbar. The Assessment wizard is the same as used when creating Residents or Touch assessments. You can also reposition the assessments and set a 'Default' Assessment by moving it to the top of the MCA assessments list.

Flow of the MCA screen & Final Decisions

We have adapted the MCA's so that they take the user through as more of a step by step process. When they first open a new MCA they are displayed with Stage one.

Assessment of Mental Capacity for June Armstrong

[Health or Social Care issue that needs a specific decision:](#)

Stage One Mental Capacity Assessment
Is there an impairment or disturbance in the functioning of the person's mind or brain? E.g. dementia / short term memory problems / mental health issue or thinking problems / learning difficulties?

Yes No

Assessed By: Date Assessed: Review Date:

Once making a selection CMS will provide the 'Comments' and 'Decision Makers' fields and if you have selected yes, the MCA assessment combo box will also be displayed.

If you answer Yes, to Stage 1, you will need to complete a mental capacity assessment as before. Once the assessment has been completed, you will be brought back to the summary screen to make any final changes. We have also added a 'Summary of Final Decision' Textbox. So that when you come to review the MCA you can easily see the outcome of the initial/previous assessments.

Summary of Final Decision:

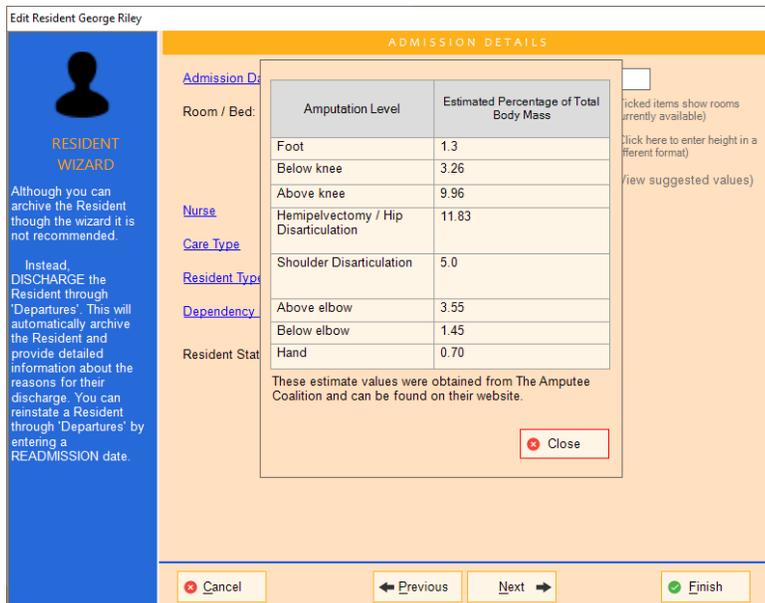
CMS Desktop Changes

We have made the following changes, which originated from your suggestions on improving the CMS system. Your requests enable us to continually evolving the CMS system, thereby ensuring that your needs are always met.

BMI for Amputees

When recording a resident's height, a new entry has been added - 'Missing Body Mass'. This is to be used where the resident is an amputee and aids the calculation of the BMI.

Click on the  icon from the resident wizard, to display the recommended values to use for different types of amputation as estimated by the Amputee Coalition. Please note that these are only estimated values and you can adjust according to the severity of the amputation.



The screenshot shows the 'Edit Resident George Riley' interface. On the left is a blue sidebar with a 'RESIDENT WIZARD' section. The main area is titled 'ADMISSION DETAILS' and contains a table of amputation levels and their estimated percentages of total body mass. A 'Close' button is visible at the bottom of the table. Below the table are 'Cancel', 'Previous', 'Next', and 'Finish' buttons.

Amputation Level	Estimated Percentage of Total Body Mass
Foot	1.3
Below knee	3.26
Above knee	9.96
Hemipelvectomy / Hip Disarticulation	11.83
Shoulder Disarticulation	5.0
Above elbow	3.55
Below elbow	1.45
Hand	0.70

These estimate values were obtained from The Amputee Coalition and can be found on their website.

To calculate the BMI simply add a weight and CMS will consider any missing body mass the resident has and calculate their correct BMI.

Accidents and Incidents - Updating Care Records

We have added the ability upon completing an Accident / Incident report to update an existing care plan or if no relevant documents exist, you can create a new one. On the final page of an A&I report you will see a list of the resident's Care plans & Risk assessments. Simply choose any that you wish to review/update in relation to this Incident & click finish.

POST A&I REVIEW

If you would like to update or review any of Juney (June Armstrong)'s care plans or risk assessments to reflect the outcome of this A&I , please select one or more items from the list

Category	Next Review
<input type="checkbox"/> New Care Plan	11/07/2019
<input type="checkbox"/> Body. Temperature	21/06/2019
<input type="checkbox"/> Personal Care and Physical Well-being	23/05/2019
<input checked="" type="checkbox"/> Eyesight	06/04/2019
<input type="checkbox"/> Pain Management	15/06/2019
<input type="checkbox"/> 7. Behaviour or. mood	30/05/2019
<input type="checkbox"/> Foot Care	10/02/2019
<input type="checkbox"/> Medical Health	20/12/2015
<input type="checkbox"/> Oral Health	20/12/2015
<input type="checkbox"/> Mobility and Dexterity	20/12/2015
<input type="checkbox"/> 6. Infection	20/10/2018
<input type="checkbox"/> 7. Communication - Eyesight	19/10/2018
<input type="checkbox"/> 7. Communication - General	19/10/2018
<input type="checkbox"/> Cognition (Memory)	20/12/2015
<input type="checkbox"/> 123. Body. Temperature	19/10/2018
<input type="checkbox"/> 4. Cognition (Memory)	18/10/2018
<input type="checkbox"/> Communication - Hearing	20/12/2015

Care Plan Text Formatting

Many people have requested that we add the ability to use text features such as the ability to colour, bold, underline & highlight text within the care plans & risk assessments. When editing / reviewing a care plan you will see a font toolbar at the top of the screen.



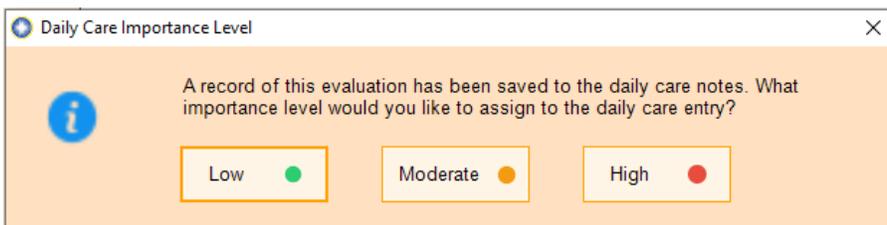
- 1
- 2
- 3
- 4
- 5
- 6

- 1. Bold
- 2. Italic
- 3. Underline
- 4. Text Colour
- 5. Highlight Text
- 6. Add bullet points
- 7. Hyperlinks

Condition:	Objective:	Action:
June suffers from Osteoporosis . Sometimes she does not make us aware of her pain and symptoms at this time include Physical and social withdrawal, Changes in sleep pattern, Limited range of motion, Limited ability to transfer and ambulate.	Establish a pain goal of tolerable limits on a standardized pain scale Alert staff of the need for PRN pain medication to maintain comfort Check with June when she exhibits untoward symptoms about her degree of pain	Notify GP if pain medication less than effective Teach and perform non-medication interventions and evaluate effect • Positioning • Massage • Cold/Heat • Relaxation • Diversion • Exercise • Deep Breathing • Music

Care Plan Importance Level

When adding a new evaluation after clicking save, CMS will ask for a daily care importance value, you are now able to close this using the 'X' and continue to update the care plan.



Care Plan Read Request Changes

In CMS anyone can make a request for a user to read a care plan or risk assessment. This caused problems when someone who doesn't have permission to view the 'Request Reading' report needed to check on who had read their care plan changes.

Traditionally a user can only access the 'Request Reading' report if they have Admin privileges for the Care Plan module

Our resolution to this, is to allow those users who have made a read request to be able to access the 'Request Reading' report for any requests that they have initiated.

Daily Care Emotions

Last release we introduced an emotion status in the daily care. We have added 2 more status, these are:

 Confused

 Sleepy

Filter Positions

We have added the ability to order the resident / employee filters. When you click the filter button to edit filters you will see an Up/Down arrow. Highlight the filter you want to move and using the up/down arrows position it within the list. Finally close this screen and the position will be remembered. This will order the list for all staff. Please note any 'Private' filters will always be placed below the 'Public' filters.

Employee Training

Archiving

As users have added training records over the years, a lot of the older records have become irrelevant, this is why we have introduced this feature that will allow you to archive training records. To archive a record select the Archive record checkbox when editing training.

Archive Training Record?

To view archived training simply click the  Show Archived button in the toolbar.

Archived training will be displayed in the list and will be displayed with the archived icon used elsewhere in CMS:

Fire Training					
	Fire Training	28/06/2018	28/06/2018	Pending	17/10/2018
	Fire Training	30/12/2014	30/12/2014	Passed	30/12/2015
	Fire Training	06/02/2013	06/02/2013	In Progres	06/02/2014
	Fire Training	07/02/2012	07/02/2012	Passed	06/02/2013
	Fire Training	06/02/2010	06/02/2010	In Progres	07/02/2011

If you archive all training records for a category category, that category will no longer be displayed.

Show Archived:

RoleOfInspection					
	RoleOfInspection	18/04/2018	18/04/2018	Passed	07/11/2018
Testing Printout					
	Testing Printout	17/04/2018	17/04/2018	Passed	07/12/2018

Hide Archived: The whole 'Testing Printout' record is hidden

RoleOfInspection					
	RoleOfInspection	18/04/2018	18/04/2018	Passed	07/11/2018

Reports

The training matrix has been adapted so that it will only print archived data if the user has selected 'show archived'. This will allow you to hide any training records that are no longer relevant.

Quality of Life Updates

Adding Next of Kin

When adding a new contact, if the contact type is either 'NOK' or 'Next of Kin' CMS will automatically default them to a Private Contact. This will ensure that the contact can only be seen from the Resident / Employee record they were created against/Linked to.

This will not affect any existing Next of Kin contact records.

Employee Notes – Text Length

Employee notes character limit removed, previously capped at 500 characters.

Employee Assessments

When completing an employee assessment, you were prevented from accessing any other part of the system until the assessment had been completed. This restriction has now been removed.

Accidents & Incidents

Daily Care Entry

When recording an accident or incident record, an option exists 'Write to daily care'. This is selected by default and when selected a summary of the incident is recorded in the resident's daily care notes. This feature is optional, and a user can deselect it. This has caused problems for some customers, so we have now created a system option to prevent a user from deselecting this option.

This setting can be found here:

Tools > Settings > Module Settings > Accidents & Incidents

Write Accidents & Incidents to daily care?



Incident Times

When entering a time on accidents and incidents, the user can now also use a drop-down box prepopulated with times in 15 min increments.

Residents Contact Details

The resident's contact details have been expanded to allow you to record the same information as any other contact.

The Residents mobile number has been added to the basic screen to be displayed with the contact details.

Date Performed

You will no longer be able to set a future date for when a record was actioned for the following items:

- Daily care notes
- Vitals
- Accidents & Incidents

Reports

Admissions & Departures

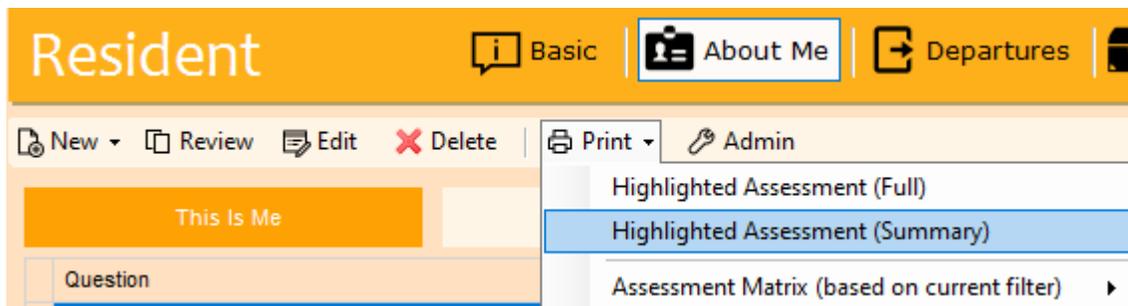
We have changed the admissions and departures report to include a checkbox to show whether a notification has been sent to your regulating body.

We have also fixed a bug where changing the 'Regulation issued' label was not reflected on the departures screen.

The resident reports will now show the status flags in the summary at the top of the first page printed.

About Me – Full and Summary reports

When printing About me records CMS was only able to print the summarised versions of the assessment reports. This has been changed so that when clicking print you will be able to choose a Full Assessment or a Summary.



Changes to Templates setup

In CMS you can create correspondence templates. Currently when adding a new template, CMS will create a blank word document for you before allowing you to build your own document. Now when adding a new template, CMS will allow you to link to an existing document. This will speed up the process when adding new templates.

Assessments Report – Risk level

When printing a scored assessment, the risk level was being cut off after 15 characters. This has been resolved and the text will use all the space available.

Bug Fixes:

Cost of Room Visible

When viewing a list of rooms through the resident’s wizard, the cost of the room was also displayed.

You will now only see this column if you have ‘Administration View’ rights enabled for the admin module.

Room No	Room Type	No. Occupants	Cost	Notes
01	Single	1	£0.00	
017		1	£0.00	
02a	Twin	1	£0.00	
02b	Twin	1	£0.00	
03	Single	1	£0.00	
04	Single	1	£0.00	
05	Single ensuite	1	£0.00	
06	Single Ensuite	1	£0.00	
07	Single Ensuite	1	£0.00	
08	Single Ensuite	1	£0.00	
09	Single	1	£0.00	
10	Single	1	£0.00	
11	Single ensuite	1	£0.00	
12	Single Ensuite	1	£0.00	
13	Single Ensuite	1	£0.00	
14	Single Ensuite	1	£0.00	

Multiple Home Environments

For multiple home installations, labels renamed outside of the admin module were not being set correctly.

When setting templates to show in specific locations there was a bug that stopped CMS from reading which locations, they belong in.

MCA Assessment Review Dates

The MCA assessment was using the system default review dates and not the MCA Assessment specific review dates set when the Custom assessment was created.

Daily Observation Contact Notes

A user that did not have access to the medical notes section could also no view any daily care notes that had been linked to a contact.

Deletion of a Task's Daily Care Assessment

If a daily care assessment was linked to a task and that daily care assessment was then deleted, the task remained active.

Re-admission date

When readmitting someone that had left the home, you were able to enter a readmission date before the date the resident had left.

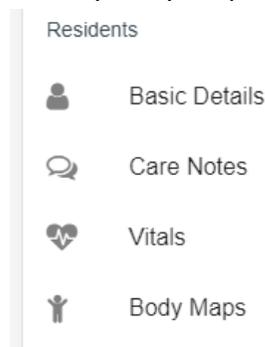
Accidents & Incidents Filters

In the last update, the categories were linked to their associated type. This created problems when trying to create filters.

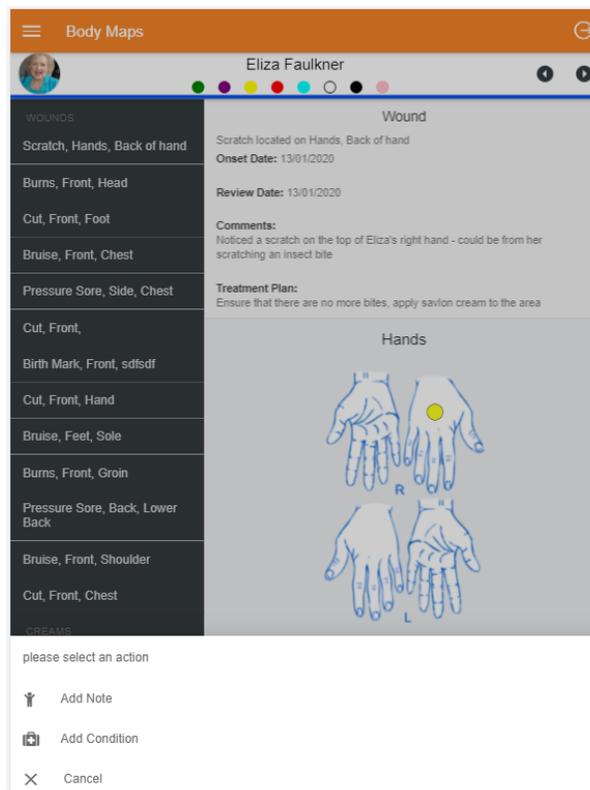
CMS Tablet App Changes

Body Map Overview

Additional menu option for Residents, namely body Maps



This will give you a list of all the current Wounds and Creams and allow you to add either treatment notes to an existing condition or capture a new condition.



New Body Map Conditions

New Condition

Location: Hands

Condition: Bruise

Position: Right Top

R

L

← Cancel Next

To enter a new condition, select the Location, and a Condition.

Once selected, an image of the selected area of the body will be displayed.

Tap the screen to mark the position of the wound.

Finally type a more detailed description of the wound position before clicking next

New Condition

Bruise - Hands, Right Top

Comments:

Hit hand on door knob

Treatment Plan:

Treatment Plan to be confirmed.

Attach Photo: Camera Gallery

← Cancel Save

Enter some comments.

The treatment plan will automatically update with 'Treatment Plan to be confirmed',

Attach the photos and click Save.

A review date will be automatically set for today. This will then prompt carers on the main CMS Desktop to record further details and assign a task for ongoing treatment.

You can create a condition and attach photos offline.

Body Map Treatment Notes

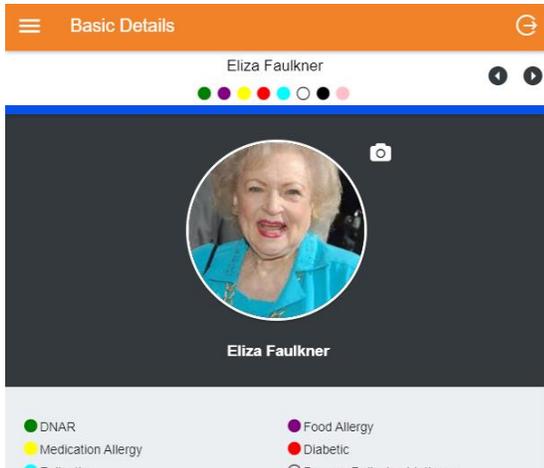
The screenshot shows a mobile application interface for a patient named Eliza Faulkner. At the top, there is a profile picture and a row of colored dots. Below this, the section is titled "Wound Treatment Notes" and specifies "Pressure Sore - Back, Lower Back". There are three buttons for "Importance": "Low" (green), "Med" (orange), and "High" (red). Below that is an "Emotion" section with a "Sad" button (orange) and a dropdown arrow. The "Treatment Notes:" section contains a text input field with the text "Treatment Note for Pressure Sore located on Back, Lower Back." Below this is an "Attach Photo:" section with a camera icon and a large orange bandage graphic with the word "OUCH" written on it. At the bottom, there is an orange bar with "← Cancel" on the left and "Save" on the right.

Treatment notes can be added either through the body map module or from a task.

For each treatment note you can add one or more photos

You can record a treatment note and attach photos offline however the original condition must have been synched with the server before any additional treatment notes can be recorded

Add Resident Profile Photos

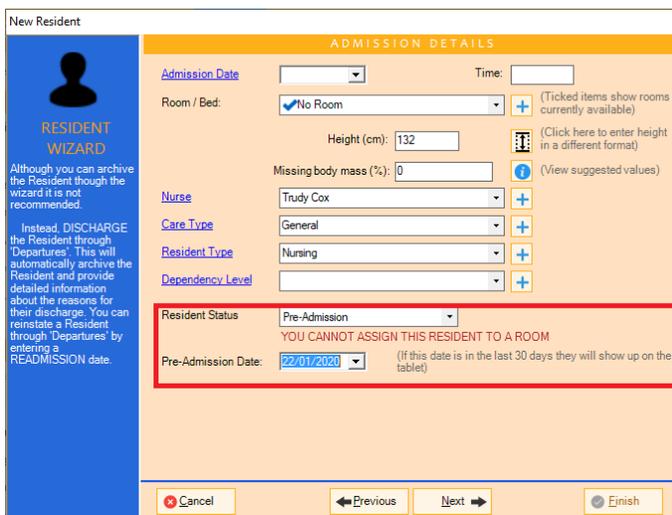


A new feature has now been added allowing you to add and update a resident's photo through the tablet app.

From the resident's basic screen, select the camera icon.

This feature only works if the tablet is working online. If you hit save and you are offline you will get a message telling you to go online to save resident photos. Photos taken using the camera will be saved to the device so if you need to try again later you can use the photo library to retrieve the picture you previously took.

Pre-Admission Residents on Tablet

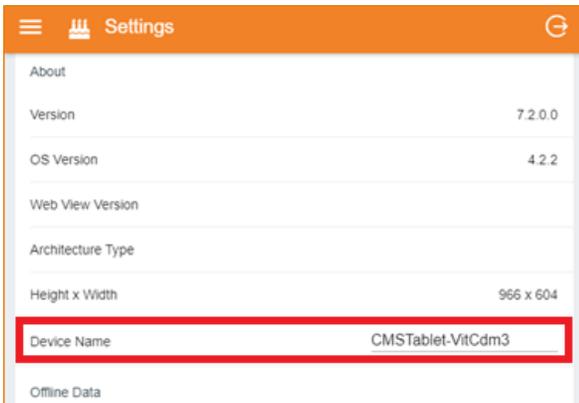


You are now able to view residents that are marked as pre-admission on the tablet.

To avoid an unnecessary amount of data from downloading, only pre-admissions flagged with a pre-admission date within the last 30 days will be downloaded.

This pre-admission date is set within the resident wizard.

Tablet Auditing



Keeping track of where data has come from will now be easier with the introduction of a new setting called Device Name.

The Device Name will be sent with all data created on the tablet and the Device Name will be logged in the audit trail to allow you to know exactly which tablet has been used when uploading data.

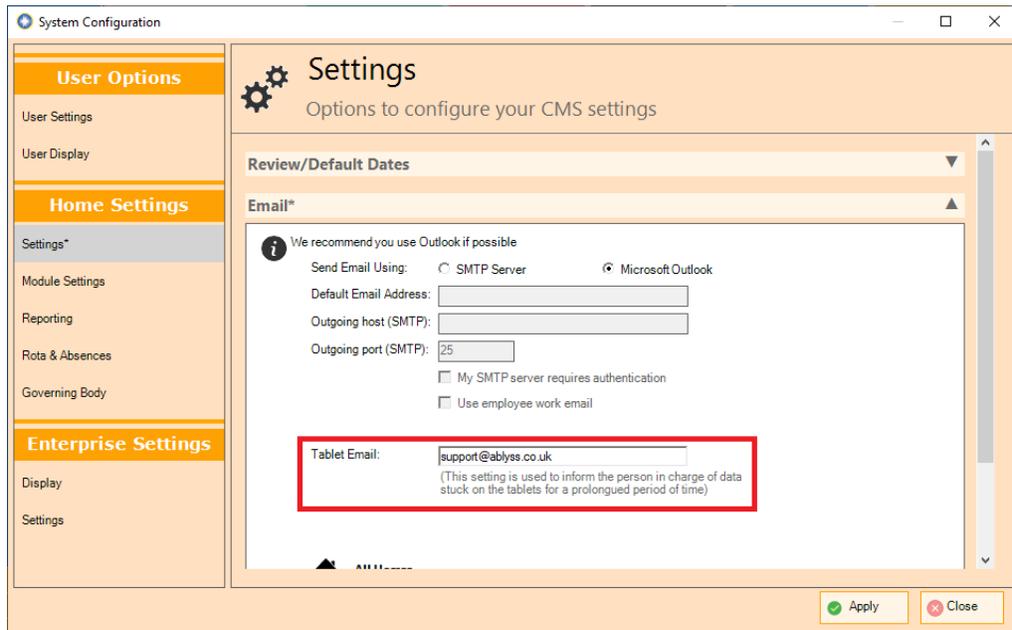
The Device Name will be pre-populated for you with a name beginning with, 'CMSTablet-', followed by seven random letters and numbers. If you wish to, you can overwrite the device name to make it more identifiable.

Synch Reports

We have built in a feature that will automatically send a report to a designated email address if any data remains unsynched on a tablet. The report will tell you which tablet has sent the email and the number of items that need to be synced.

The report will be sent either every 12 hours or, if the app is not active, the next time the app is activated.

The designated email address is set through CMS desktop



Ease of Use

If you select a filter and then log out of the app, the filter will be reset. Now, if you log back in (provided nobody else logs in before you, your filter will be retained.