ABC

Activity BarCoding

Activity Barcoding User Training Supplemental Materials

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Revision History (Major Revisions)

Revision	Issue Date	Comment
1.0	2008-02-01	First version of document detailing the ABC functionalities for users.
2.0	2012-04-11	Second major revision
3.0	2014-02-04	Third major revision – update of screenshot to reflect the new ABC look and feel.

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Your Super Users:

Your local super users are:

Department Manager

Super Users can:

Help you with business rules

Teach you how to scan complex situations

Show you how to customise your scan sheet

Replace your scanner

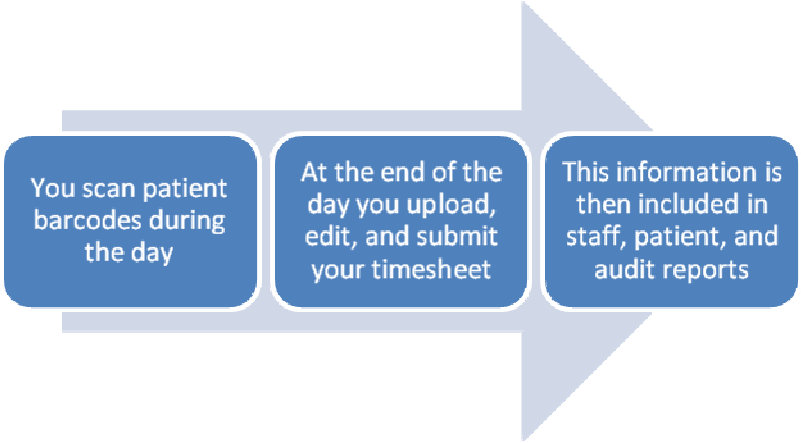
Help

Don't forget you can use the help feature on ABC's website, assistance at your fingertips.

http://help.activitybarcoding.com/default.asp?W1

1. Overview

ABC – Activity BarCoding system is designed to release time to care- to allow you more time to spend with your patients and to help your managers make better decisions by improving the accuracy of the information.



The process is very simple. You use a barcode scanner to record patient session details during the day. At the end of the day, you connect your barcode scanner to your computer and upload your scans. You then see a diary-style representation of what you did during the day. You are free to make modifications, enter missing information, delete mistaken sessions scans, and add new sessions. Once done, you submit your timesheet and it is then included in staff, patient, and audit reports.

The barcode scanner is a tool to make recording your statistics more efficient, more accurate and to save you time. You don't have to use the scanner. You can add all of your statistics onto the system manually if you prefer. If you forget to scan a patient, don't worry. You can add them in manually later when you upload.

2. The Bar Code Scanner

The scanner is very small and can be attached to your lanyard. It has two buttons, scan and delete. No complex user interfaces. The scanner knows the date and time each barcode was scanned, meaning you don't have to type this information in. The scanner date and time is based on the computer date and time where you initialised your scanner on.

Cleaning

Please use a soft, clean cloth. Do not use any solvent, such as alcohol, or any abrasive substances.

Low-battery

The scanner will indicate low batteries by blinking the light red while trying to scan a barcode.

Please make sure that you recharge your scanner once a week by plugging it into the computer (make sure it is switched on) for 2.5 - 3 hours.

Opticon scanners: Have a rechargeable battery so doesn't need replacement battery. The scanner's battery is charged when the scanner is plugged into the computer's USB port. While the battery is being charged, the light will glow red. When the scanner is connected and the battery is fully charged, the light will glow green.

Scanner memory

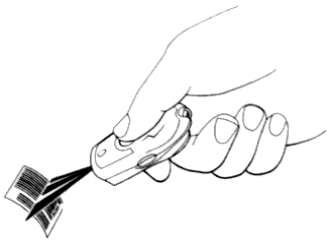
To answer a few common questions:

YES the barcode scanner's memory lasts overnight. If you can't upload at the end of a day you can upload at the beginning of the next day.

The barcode scanner has a clock, so it knows the date & time you scan patients, meaning you don't have to enter this data yourself!

Once you have uploaded from the scanner those scans are automatically deleted from the scanners memory.

3. Scanning Technique



Scanning is simple. The big button triggers the laser. Position the laser so that it covers the entire barcode at about 45 degree angle, plus some "slack" either end, and a small beep and a green flash should indicate a successful read.

Tips:

Not scanning at all? Make sure the red line covers the entire barcode and some extra either end. You do not need to scan the barcode precisely. Make sure the barcode is flat.

Taking a while to scan? Try holding the scanner at 45° about 3 – 4 inches (8cm) from the barcode for best reading

Not getting a beep? Your sound is probably turned off. Try pressing the big button for ten seconds until you hear a beep. This turns the scanner's sound on. Similarly you can turn the scanner's sound off again by holding down the big button for another 10 seconds

See below video on several scanning techniques (See "How to use a scanner")

http://activitybarcoding.com/ABCVideos/tabid/943/language/en-US/Default.aspx#VideoUser

Deleting a scan

You can delete scans as well. To do this, press the small "-" button behind the big button, which will trigger the laser. Position the laser so that it covers the entire barcode you want to delete, and a beep will indicate a successful deletion. By having you scan the barcode again, this prevents accidental deletions.

However, the system is smart enough to correct many simple mistakes, such as a scanning stop twice, scanning the same patient in a group session, etc.

If you try and delete a barcode that you haven't scanned, the scanner will beep (even if the sound has been turned off) and the indicator light will flash red.

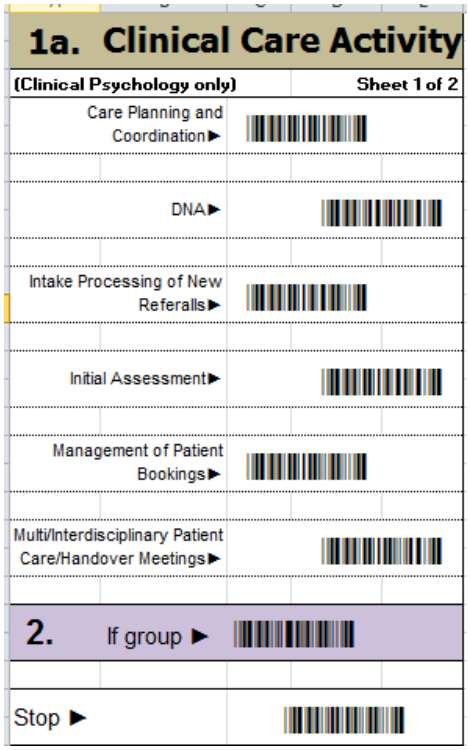
Tips:

To delete the entire scanner's memory (say your kid got ahold of it and scanned the contents of the fridge!) hold down the delete button (small button) for 15 seconds.

Scan Sheets

Scan sheets take you through the process of scanning, and allow you to scan extra information your department might be collecting, such as interventions. Other information, such as an patient's location, patient's cost centre/receiving unit are derived from your hospitals' patient administration system.

NOTE :
The 'If Group' barcode is a bundled barcode meaning that when it is scanned it will automatically include 'Group' intervention.



4. Scanning Scenarios

1. Inpatient and Outpatient scenario

- Scan a clinical care activity
- Scan a patient THCI barcode
- Scan an intervention(s)
- Scan stop

Inpatient and Outpatient information such as location(ward), clinical unit , admission date, patient status (inpatient or outpatient) will be retrieved from PAS therefore no scanning is required.

However, the same does not apply for community type patient therefore user will need to add the location to the session.

2. Community patient scenario

- Scan a clinical care activity
- Scan a patient THCI barcode
- Scan 'If patient is community type patient"
- Scan an intervention(s)
- Scan a location
- Scan stop

Group session = Every patient would be assigned equals total amount of session time.

Multiple patients session = Patient's session time is divided equally amongs all patients.

3. Group activity

- Scan a clinical care activity
- Scan 'if group'
- Scan an intervention(s)
- Scan patient THCI barcode(S)
- Scan stop

To assigned interventions to all patients in a group session, scan these information first before any patient THCI barcode is scanned.

4. Multiple patients activity

Similar steps to group activity but without scanning "if group"

5. Patient's Barcode Unavailable

- Scan a clinical care activity
- Scan a temporary patient barcode
- Scan an intervention(s)
- Scan stop

Replace the 'Unknown' patient with a valid patient THCI manually in the session editor.

For inpatient and outpatient, scanning location and clinical unit are not required as both will be retrieved from PAS.

6. Non clinical care activity

- Scan an activity on the 'Non CC Activity' scan card
- Scan stop

Tips:

Save scanning for inpatient and outpatient. Location and clinical unit do not need to be scanned for inpatient and outpatient as this information is retrieved from PAS.

Scan the patient's session late? You can correct the start time in ABC after uploading your scans.
In fact, scan all necessary information of the session (i.e. activity, interventions, etc) , even though the start time is not accurate, this will act as a reminder of what sessions you have done. Once uploaded, the only thing you have to do is to change the date and time.

Can't remember if you scanned stop? A second stop barcode is ignored – so scan stop again to be safe!

Anything scanned after stop is ignored. Scan all session information i.e. activity, patient THCI barcode, interventions etc before scanning stop.

Patient has been discharged from the discipline. If you are attending the last session with a patient before he/she is discharged , scan the 'Close Referral' barcode which finalise the referral. This way the next time the same patient is referred for a different treatment, he/she will be classified as a new patient instead of existing patient.

Performing the same intervention for every patient in a group or a co-treatment session? Scan the interventions after scanning the clinical care activity but before your first patient. This tells the system you are performing the same intervention for all patients. You don't need to scan the intervention again.

Scan an activity to start the session and all other scans can be done when the session has finished !! Don't worry about scanning everything at the start of a session, once you scan an activity barcode, the session has started and all other scans can be done once the session has finished before scanning stop to avoid interuption when attending to the patient.

Interruptions while treating a patient?

If you are treating a patient and get interrupted to perform some other task, stop the existing session and scan the start the new session. When you return, re-scan the activity type and patient's THCI barcode to start a new session with the patient. Any supplies or interventions already scanned will be associated with the earlier session and don't need to be re-scanned.

For inpatients and outpatients, the clinical unit and location, as usual, are pulled through from your hospital's patient administration system. For community type patient, the clinical unit is maintained from the previous session. The location will need to be rescanned for community type patient, as will the clinical unit if it has changed.

If you used any extra supplies and interventions not already recorded, these will also need to be scanned.

Of course, be sensible. If the interruption is for less than 5 minutes, you may decide it is unnecessary to record the interruption.

Remember: The more you scan in as you go the less you need to enter manually!

IPA and NIPA

IPA (Individual Patient Attributable)

NIPA (Non-Individual Patient Attributable)

IPA and NIPA are terms developed by the NAHCC in an attempt to record as much patient time in your day directly to patient care.

IPA is time you spend treating identifiable patients.

NIPA is where you are unable or it is impractical to assign clinical care time to identifiable patient eg, large ward rounds, handover, allocation meetings .

Please refer to your Departmental rules when determining whether time is IPA or NIPA.

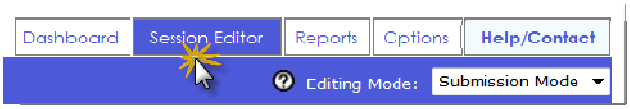
In ABC, if you scan or enter a patient, the time is IPA. If you do not, it is NIPA.

5. Uploading

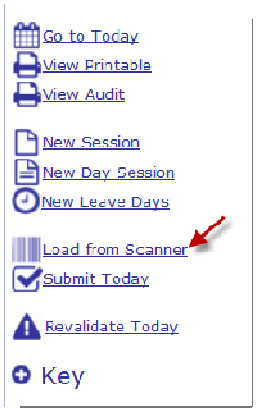
1. Connect your Opticon barcode scanner to your computer via the USB connecting cable
2. Open to the ABC web site (shortcut provided by IT at the hospital) and log in

   You should have been issued with a username and password.

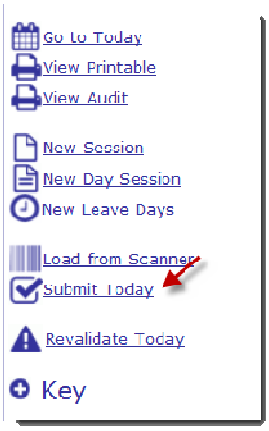
   Note that your username and password should be the same as those used to access the system at Tasmania Health.
3. Navigate to the "Session Editor" tab. For normal users, you will be re-directed to this page upon login.



4. Click the "Load From Scanner" link on the left



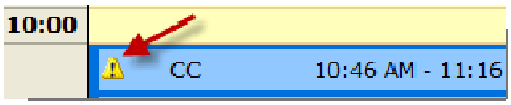
5. Make any alterations or additions to your day
6. Click the "Submit Today" link on the left.



> Once approved, no further modification to the session is allowed however you can always request your manager to update the session for you.

This will submit your timesheet and lock all your sessions from editing. Depending on the approval mode set on your profile, you may or may not be able to edit the sessions once you submit them. For auto-approval staff member, you **will not** be able to edit your sessions as they have been approved. For non auto-approval staff member, you **can** still edit your sessions as they are on pending approval mode.

Please note that a session with a warning message must be submitted individually i.e. cannot be submitted in a bulk through 'Submit Today'.



6. Editing your timesheet

You can make any change in the session editor that you could make with the scanner. By itself, the session editor would be a replacement for your existing time & activity recording application, but the scanner makes it much faster and more accurate.

About approval

There are three approval statuses in the system:

1. Pending Submission – which are waiting to be submitted to a manager for approval
2. Pending Approval – which are waiting for a manager to review and approve the sessions
3. Approved – which are being reported on

As a regular user, you can edit your sessions that are pending submission or pending approval. Only managers can edit approved sessions as these have been included in reports. Your hospital and/or manager may "auto approve" your sessions, in which case when you submit your timesheet, it automatically becomes approved and you can no longer edit these sessions.

NB : Only approved session data will be included in the report unless otherwise stated in the report description.

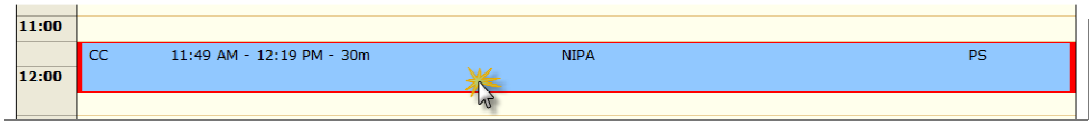
Tasks you can accomplish while editing your timesheet

Some tasks you can accomplish are:

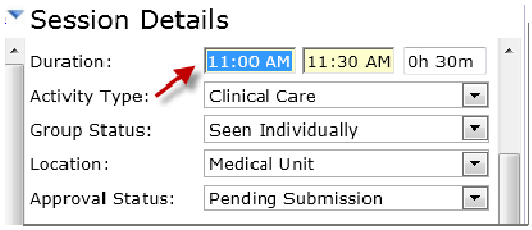
1. Changing the time of an existing session
2. Adding a patient
3. Adding a staff
4. Adding an intervention
5. Setting patient attendances status
6. Changing clinical unit (receiving unit)
7. Changing patient status (inpatient, outpatient and community)
8. Submitting a session
9. Creating a new session and new day session
10. Deleting a session
11. Reviewing previous sessions
12. Fix session with error message

Changing the time of an existing session

1. Click on the session you want to edit. Its details should appear on the right hand side of the screen.



2. You can change the start time, the end time, or the duration.
3. Click "Save" button to save the session you are editing.

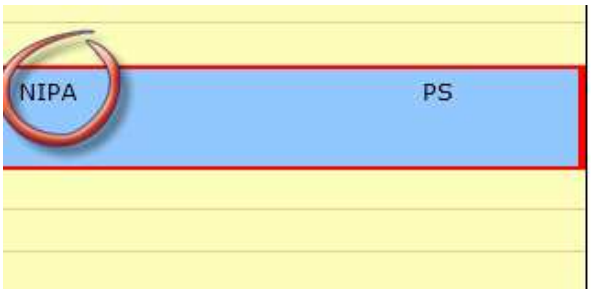


Tips : when you type in “11 A” in the start time or end time box the system will automatically convert this to 11:00 AM. You can also type in a 24 hours time such as 13 and the sytem will automatically convert this to 1:00 PM.

> Clicking another session saves the session you are editing. Just about everything saves the session you are editing, except closing the window!

Adding a patient

1. Click on the session you want to edit. Its details should appear on the right hand side of the screen.
2. Type in the patient THCI under “Patient” and click “Add”. The patient has now been added!
   a. The system does not verify if the patient added exists in your health service. However, it may be able to identify if the THCI doesn’t have, for example, the correct number of digits.
   b. If the patient has no referral in the system, a new referral will automatically be created. See “Create A Referral”.
3. Click “Save” button to save the session you are editing.



Tips:

Not able to add a patient? You can only add patients to a clinical care session

Want to make a NIPA session an IPA session? Add a patient – the change happens automatically

Want to remove a patient? Click the “Del” button beside a patient’s THCI

Want to make the patient a new patient? Close the existing referral if it is an old referral that was not closed when the patient was discharged from the hospital and create a new referral for the patient. See “Create A Referral” section on how to do this.

Adding staff, changing session type, etc

You can perform many other tasks using the session details screen. Play around with it. Create a new session and put in some dummy data. Just be sure to delete it at the end!

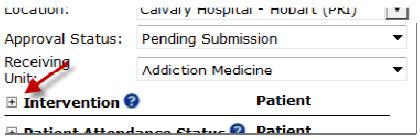
You can also click the “Undo” button on a session to undo any changes on the session since you started editing the session. Remember that if you select another session then return to the same session it will have automatically saved and you will be unable to cancel those changes.

Adding an intervention

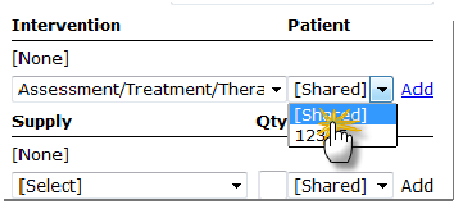
You can add a shared intervention (automatically assigned to all patients in the session) or an individual intervention (only assigned to one patient).

To create a shared intervention choose “Shared” in the patient drop down on the intervention section and click “Add”.

1. Expand the intervention section by clicking the plus sign



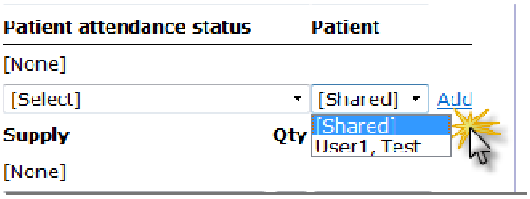
2. Choose [Shared] or the patient’s THCI number



When no intervention is added to the session, the intervention section is minimised.

Setting patient attendances status

You can manually set the patient attendance status to ‘*Patient is not present*’ for a session where the patient is not present however you still want to capture the details of the patient that you are working on.

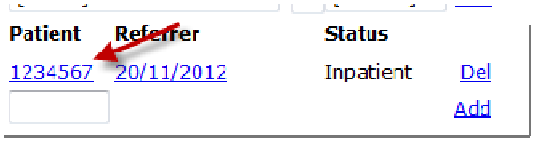


This can be a shared one (for all patient attendances in that session) or an indivudual one (for a specific selected patient)

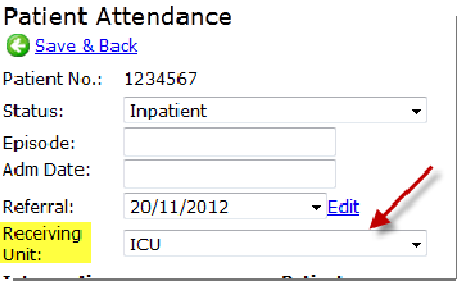
Changing clinical unit (receiving unit)

A large number of ABC reports can be filtered to a specific receiving unit and also show data based on different type of receiving unit. Most of the time, the value of the receiving unit is retrieved from your hospital’s patient administration system however you can easily change this value through the patient attendance editor.

1. Click on the patient number or name



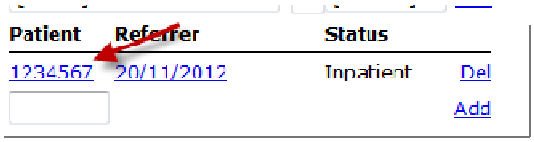
2. Change the receiving unit



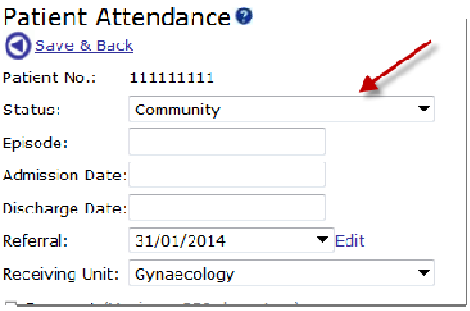
Changing patient status (inpatient, outpatient and community)

The patient status is tied to the patient attendance and therefore changing the patient status is done in a similar fashion as changing the receiving unit.

1. Click on the patient number or name



2. Change the patient status



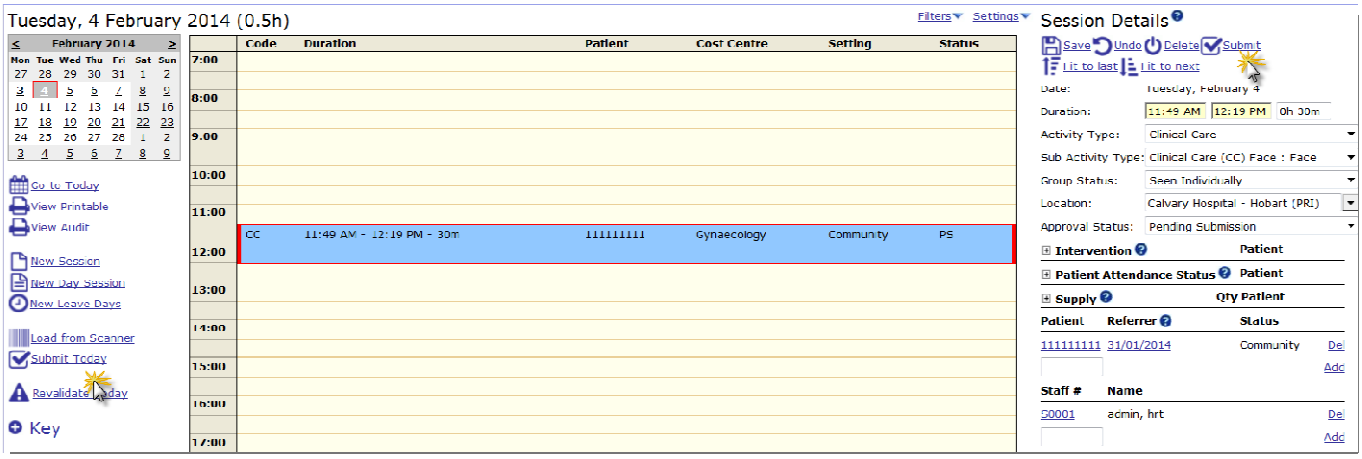
Submitting a session

You can approve a session in one of the two ways:

1. Click the "Submit Today" button on the left hand side of the screen to submit all sessions (those without a warning) for a day

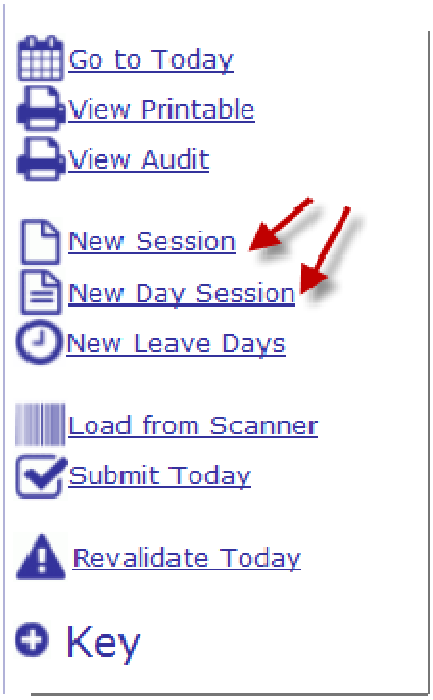
   or

1. Click the session you want to submit
2. Click the "Submit" link
3. Click anywhere



Creating a new session

1. Click the "New Session" button on the left hand side of the screen
    a. If you are currently editing a session, it will be saved
    b. A new session will be created, and its details will be shown on the right hand side of the screen
    c. It will be for the same day as you are currently viewing
    d. It will start at the current time of day (as in, the time of day in real life!)
    e. It will be for 30 minutes
2. You can make any changes you like in this session
3. Click "Save" to save the session.

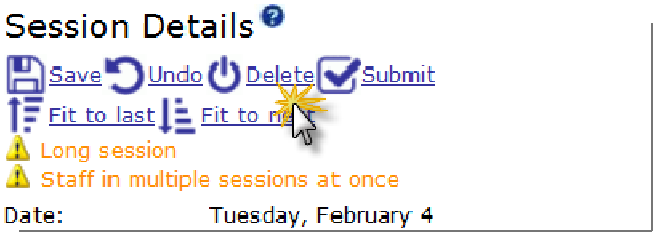


Creating a new day session

1. Click the "New Day Session" button on the left hand side of the screen
    1. If you are currently editing a session, it will be saved
    2. A new session will be created, and its details will be shown on the right hand side of the screen
    3. It will be for the same day as you are currently viewing
    4. It will start at 9 am and run until 5 pm
    5. It will be a clinical care session
2. You can make any changes you like in this session
3. Click "Save" to save the session.

Deleting a session

1. Click the "Delete" button on top of the session
2. If you did this by mistake, you have one last opportunity to click "Restore" to cancel the deletion
3. When you click away, your change will be saved



Reviewing previous sessions

You can review past sessions. Simply click on a day on the calendar up the top left hand side of the screen to change days, and click on the session to view its details.

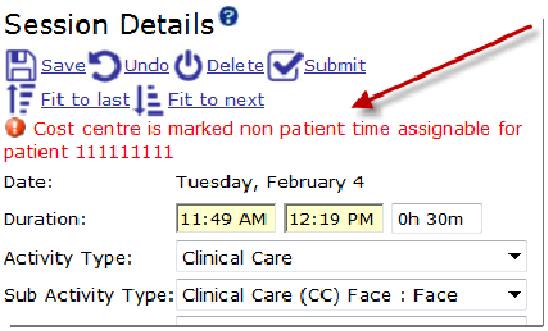
You are able to edit "pending submission" sessions, which are waiting for you to submit them.

You are able to "unlock" "pending approval" sessions, which are waiting for a manager/super user to review and approve your timesheet. You will need to resubmit any sessions you unlock.

You can view but not edit "approved" sessions, as these have been reported on (only managers/super users can edit approved session)

Fix session with error message

The below error message will be displayed if you accidentally assign a staff payroll unit to the patient receiving unit drop down above. Error message : Cost centre is marked non patient time assignable for patient x.



It occurs when the "allow patient time assigned" attribute of a cost centre has not been selected.

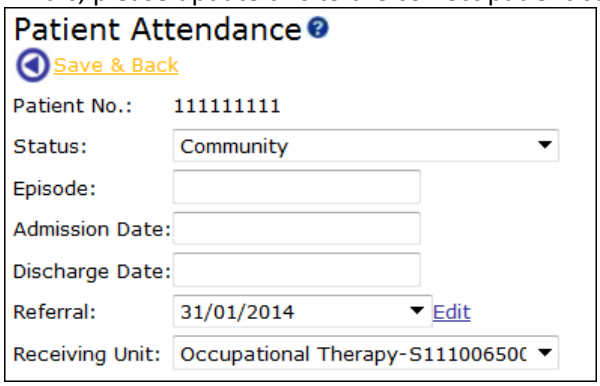
This is normally the case of staff payroll cost centre which should not be assigned to a patient, for example :

a. Physiotherapy
b. Dietetic
etc

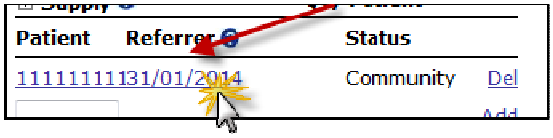
Please do the below to have this rectified:

1. Click on 'Patient' link

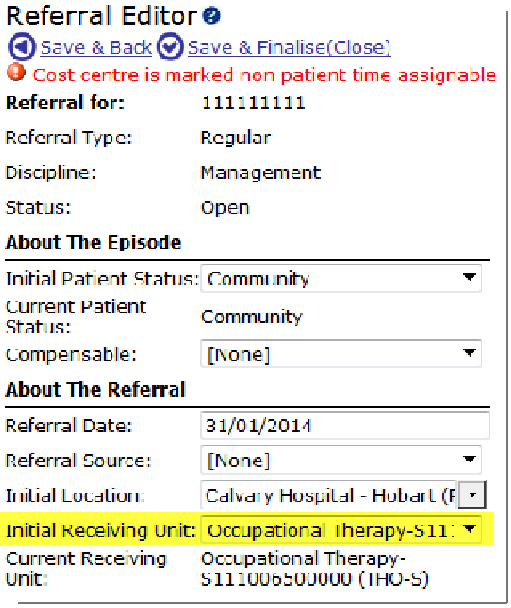
2. Make sure the receiving unit is not one of the staff payroll cost centres or cost centre with the "allow patient time assigned" attribute not selected.
   If it is, please update this to the correct patient cost centre/receiving unit.



3. Click on 'Referrer' link



4. Update the initial receiving unit to the correct receiving unit (as assigned to the patient in Step 2)

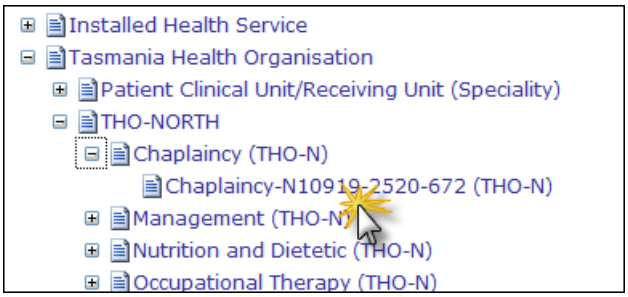


When this patient is seen the next time, it will use the receiving unit/patient cost centre that was assigned to the previous session i.e. the receiving unit information is carried forward, therefore you would only need to do the above once.

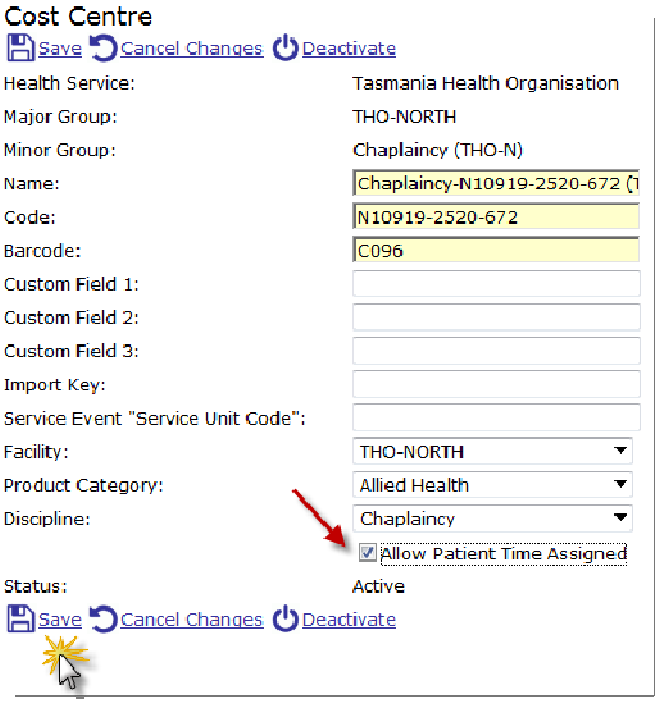
If you would like the cost centre to be assignable to a patient, please do the below:
NB: Only super user/manager has access to the "Health Service Structure" page

1. Go to "Options" tab -> "Health Service Structure"

2. Select the desired cost centre



3. In the cost centre editor on the right hand side of the page, tick the 'Allow Patient Time Assigned' tick box and hit 'Save'



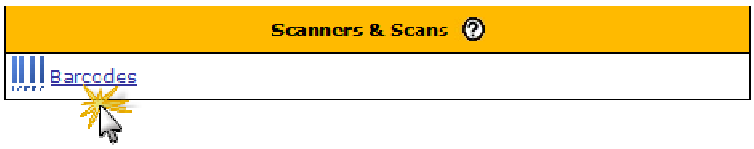
This way, you will be able to assign this cost centre/receiving unit to a patient.

7. Create a scan item in a scan card

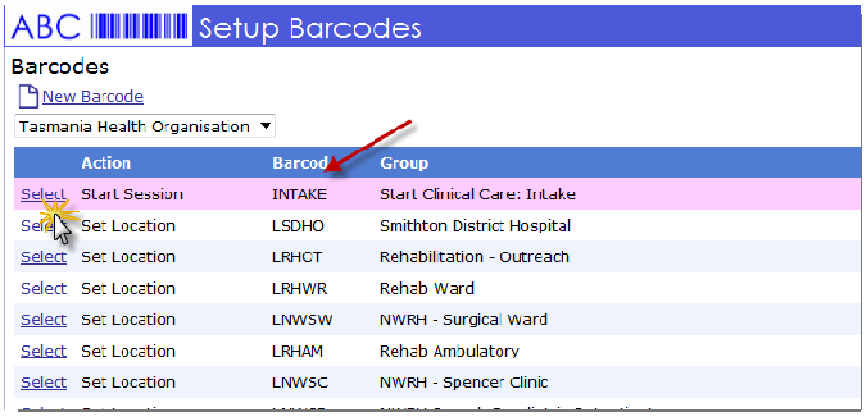
Below is a sample scenario of creating a new scan item – a sub-activity called 'Intake'.

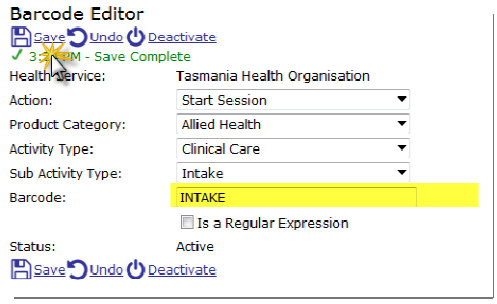
a. Open MS Excel file.

b. Type the new barcode text in a cell – the barcode text is retrieved from the ABC system -> *Options* tab -> *Barcodes* page.



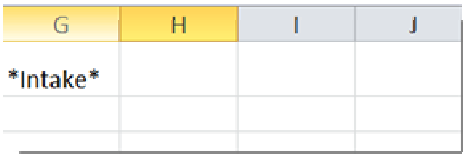
NB : If you have just created a new item in ABC such as intervention, activity etc, a barcode will be automatically created in the "Barcodes" page. Check the first item in the table and click "Select" to update the barcode to any desired pattern.





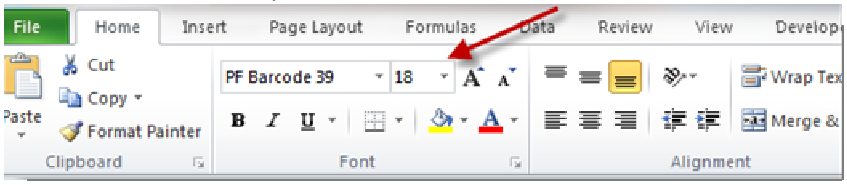
Barcodes can only be detected by the scanner if the underlying text starts and ends with an asterisk (*) in Excel.

Example:

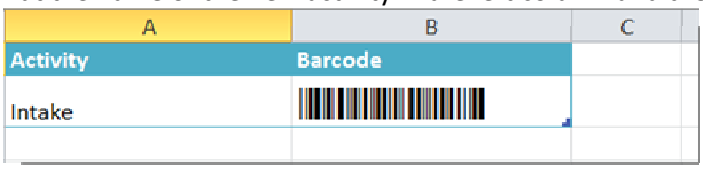


c. You can change the text to a barcode by clicking the cell and changing the font to barcode font ***PF Barcode 39.***

d. Set the font size to 18 pt.



e. Put the name of the new activity in the left column and the barcode in the right column.



Print this out and you now have the new sub-activity barcode to scan.

8. Referrals

Referrals link together the treatments or sessions with a patient for a condition - essentially the "episode of care", 'tracking' the patient's treatment through the hospital. A patient who is seen by multiple therapists of different disciplines will be assigned with a separate referral for each discipline.
NB: Referral is discipline specific.

There are two types of referrals:

- Regular, for a single patient identified by a patient number.
- Blanket, for all patients from a certain unit. It is an easier way to record IPA time, but captures less information about each patient. Blanket referrals are useful in short stay units where you see all patients but only for a short period of time. Blanket referrals can only be created by superusers.

A session with patient attendances must have a referral selected for each patient in the session before the session can be submitted.

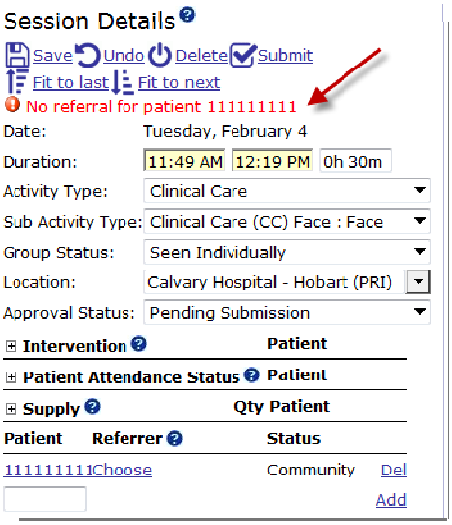
- Patients with an existing regular referral will have that referral selected automatically for new sessions. **In other words if you are seeing a patient regularly you only have to enter the referral information once at the beginning.**
- If there is only one blanket referral in your clinical unit eg. orthopaedics, it will be selected automatically for new patients.
- If there are multiple regular referrals for the patient, or multiple blanket referrals, you can choose between them.
- If there is no referral for a new patient, you will have to create a new referral.

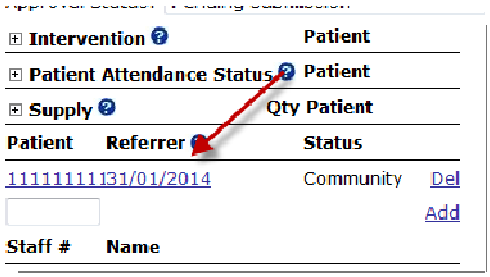
When referrals are no longer needed, they can be closed (finalised) using the 'Maintain Referrals' page. This is so that the next time the patient is seen, he or she will be assigned with a new referral and counted as a new patient in the report (i.e. new patient = new referral)

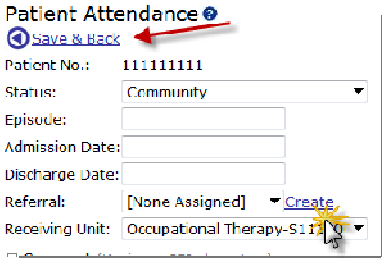
Create a referral

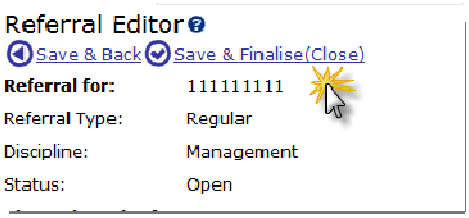
1. Click the session with the patient without a referral.
2. Click the "Create" link next to the referral.
3. Edit the referral's information as required, then click "Save & Back".

Referrals **should be closed** once the patient is discharged. This can be done by clicking the referral -> "Save & Finalise (Close)" instead of "Save & Back"



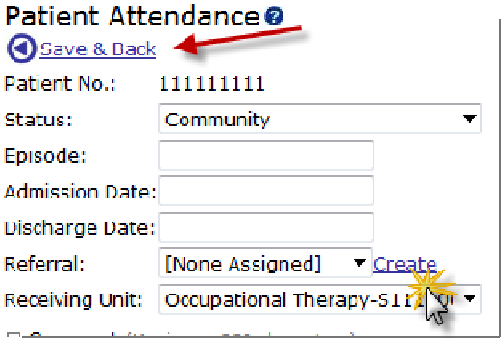






Open a second referral for a patient

This is not something that would happen often. You might need to create a second referral if, for example, there are two referral sources for a patient, and you want to be able to associate sessions with the relevant one.

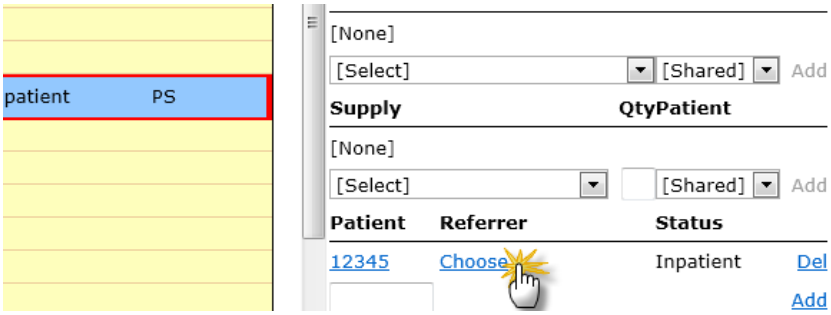


1. Click the session with the patient whose referral you want to change.
2. Click the patient number.
3. In the "Referral" dropdown, select '[None Assigned]'.
4. Click the "Create" link that appears next to the dropdown.
5. Edit the new referral as required, then click "Save &Back".

Choose from a list of open referrals

If there are multiple blanket referrals open, or a patient has had several regular referrals created for them, you will need to select between them for new sessions.

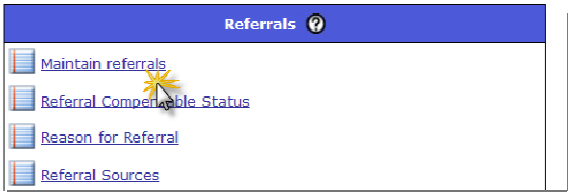
1. Click the session with the patient whose referral you need to select.
2. Click the "Choose" link next to the patient number.
3. In the "Referral" dropdown, pick the referral you want to select.
4. Click "Save & Back".



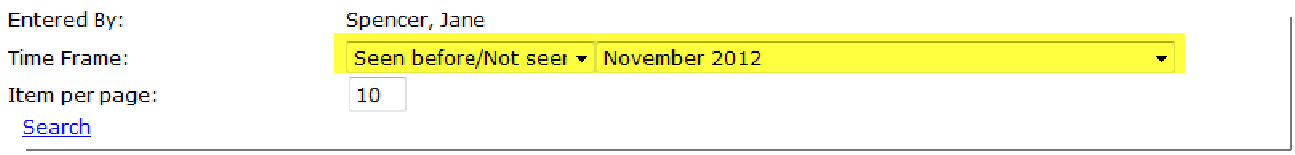
Close multiple open referrals

1. Click the "Options" tab in the top-right of the session editor window.

2. Click on “Maintain Referrals” link



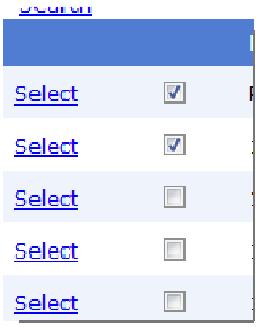
3. Filter to the referral you want to close i.e. set the time frame to a specific time for example if you would like to close all referrals that have not been seen since last month , you can filter time frame to “Seen before/Not seen since” then set the month to last month.



4. Click “Search”
5. Click “Select” next to the referral you want to close.
6. In the referral editor that appears on the right-hand side, click “Save & Finalise (Close)”.

It is also possible to close all or multiple referrals returned by a particular search by clicking

- “Finalise Valid” (to close all referrals in the search that do not have any errors)
- “Finalise All” (to close all referrals in the search, irrespective of errors).
- “Finalise Selected (current page only)” (to close all referrals that have been selected (ticked) from the referral table, irrespective of errors)



It is advised to properly close a referral when it has finished and assign a new referral to a patient especially for outpatient where the clinical unit and patient status are derived from the referral.

This ensure that the latest clinical unit and patient status from the referral (when not scanned) is assigned to the patient

9. Reports

There are two reports that you can generate yourself – click on the "Reports" tab on the top right hand side of your screen

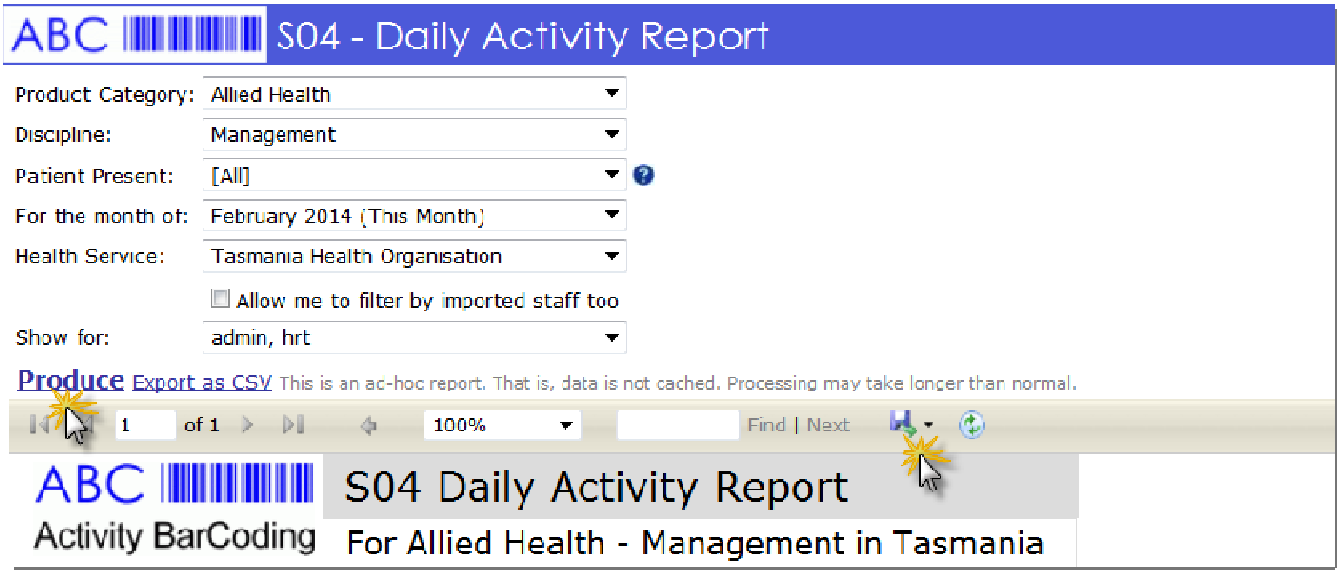
SO4 Daily Activity Report

Shows all time, approved and unapproved, by activity type by day, with clinical care ratio. Report shows trend data.

RO3 Recently Seen Patients Report

Allows you to create a current list of patients that you are working with. The list has printed barcodes for easy scanning. You need to scan the patients barcode once for it to appear on the list.

To print this report, click then choose Excel or PDF or Word. You can open the file for printing now, or save it for future reference.



The 'Patient Present' filter when set to :

1. [All] = will show all sessions data
2. Yes = will only show clinical care sessions data with patient attendances and when the 'Patient is not present' status is not set.
3. No = will only show clinical care sessions data with no patient attendance (NIPA) or with patient attendances but the 'Patient is not present' status is set.
4. Other = all other activity types such as management, research, teaching and training etc.