



WinRecs User Guide



Version 2026.03

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MED2020 Health Care Software Inc.

MED2020 Health Care Software Inc. (MED2020) is a leading provider of modular health information management solutions for the health care industry.

MED2020 provides solutions to assist capturing, reporting and analyzing health data to:

- Enable enhanced information sharing
- Encourage informed decision making, and
- Streamline facility operations.

MED2020's flagship product, WinRecs™, is the foundation for a complementary suite of modules designed to assist health information management departments with their operational needs.

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Document Convention

Convention	Description
screen	Courier font shows an example of information or code displayed on the screen or specific names.
boldface	Boldface text indicates commands; keywords or menu selections you use to do a task. Example: click the menu File
<i>italics</i>	Indicates information that should be entered in a field.
→	Indicates navigation from an icon or menu to another. Example: click the menu File → Open
	Toolbar Icon – When a specific toolbar item is referenced
[Ctrl + ?] or [F00]	This convention is used to describe a specific key combination or key that must be pressed to trigger an action.
<u>Underlined</u>	Underlined text refers to a hyperlink or cross reference

Table 1 - Document convention

This is the note format.



This is the tips format.

Printing This Document

For the best print quality when printing this document, select the Print as Image option in the Adobe® Acrobat® Reader™ print window or the Advance→Print as Image option in the Adobe® Acrobat® print window.

About WinRecs

First introduced to the Canadian market in 1996, MED2020's flagship product, WinRecs™, has evolved to become one of the most comprehensive Health Information Management software solutions on the Canadian market. WinRecs is a customizable abstracting and reporting system that is currently being used by hospitals to support decision-making at corporate, regional and provincial levels. The WinRecs Suite of Products provides solutions for Inpatient, Clinical and Ambulatory Care Services, including modules for DAD, NACRS, CJRR, Cancer Care, OHMRS, NRS and CCRS. Furthermore, WinRecs offers an Edit Engine to allow the creation of user-defined edits, in addition to the complementary modules, Concurrent Review and Chart Maintenance.

WinRecs Features

- Docking windows allow users to expand, collapse, tab or pin information windows in the application, such as Visit History, Message List, Grouper and Module Menu.
- Individuals can customize their view of the abstracting window for font size, row height and column width.
- More options are available to navigate the abstract including the mouse, function or arrow keys or the Enter key to tab through the abstract.
- Text can be directly entered into data entry fields, eliminating the data entry dialog box and reducing key strokes. Users may also copy and paste directly into text fields.
- Contextual look up tables can be accessed by double-clicking in the entry field.
- Multiple abstracts can be open at the same time, allowing users to toggle between as many open abstracts as they like. The active window is highlighted so users are certain which abstract is being worked on.
- Multi-forms are presented in a new horizontal format which allow users to see multiple lines of occurrences at a single glance.
- Multi-form columns can be re-arranged for quick revisions to data.
- An Edit Engine module provides users with an intuitive interface that enables health records professionals to define and create their own data quality edits.

1. Opening the WinRecs Application

To open the application, double-click on the shortcut displayed below:

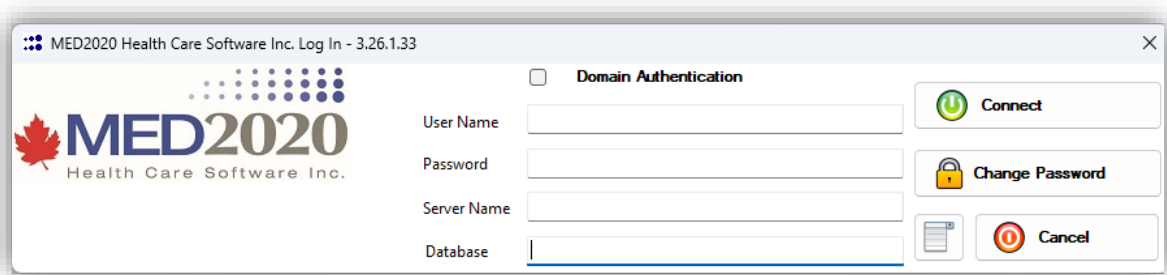
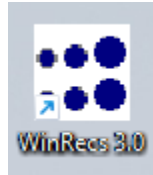


Figure 1 - Log In Screen

If the WinRecs application cannot be found on the workstation contact the site IT department.

- **Domain Authentication:** A checkmark will allow the user to sign in with Domain Authentication. This will need to be set up in the User Profile/Domain Authentication.
- **User Name:** This is assigned by the System Administrator
- **Password:** This is assigned by the System Administrator. Change the password at any time by clicking on the 'Change Password' button on the right hand side of the Log in Window. The password area is masked for security reasons.
- **Server Name:** Depending on whether the dropdown or text options is selected. Press the down arrow and choose the Server Name where WinRecs resides or Type in the Server Name. The information will retain for subsequent sign in.
- **Database Name:** Depending on whether the dropdown or text options is selected. press the down arrow and these are databases available for the Server or type in the Server Name. This will retain for subsequent sign in.

The buttons displayed in the WinRecs Log On dialog are:

 Connect	Click this button to log in to WinRecs once all fields have been populated.
 Change Password	Click to initiate a password change.
 Cancel	Click to close the log in screen
	Click this button to toggle between the drop down and text field options for Server Name & Database.

Table 2 – WinRecs Log On

Changing your Password:

To change an existing password, type in the current password but **do not** hit '**Enter**' or '**OK**' (*this will actually log into the WinRecs application*).

Click on the **Change Password** button.

Type a new password, and confirm in the boxes provided. Click **Change Password** and the new password will be saved.

Clicking **Cancel** will return to the initial sign on.

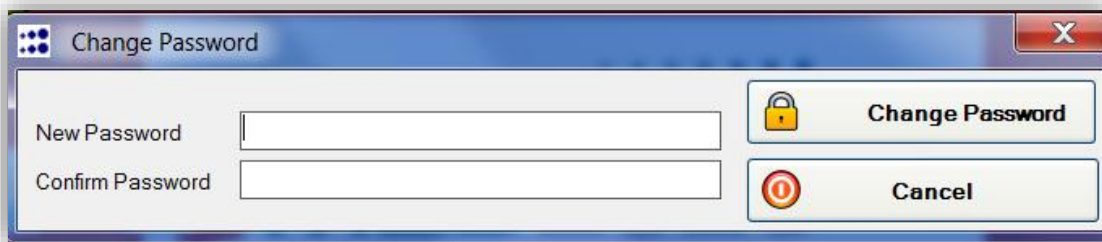


Figure 2 – Change Password

For security reasons, the password is masked. WinRecs tracks all user activity. For new installation, it is recommended to change a password as soon as possible. Do not share this password and passwords are case sensitive.

Once **Connect** is clicked or press **Enter**, the CIHI Licensing requirement is displayed press **OK** button or **ESC** key on the keyboard to bypass this screen.

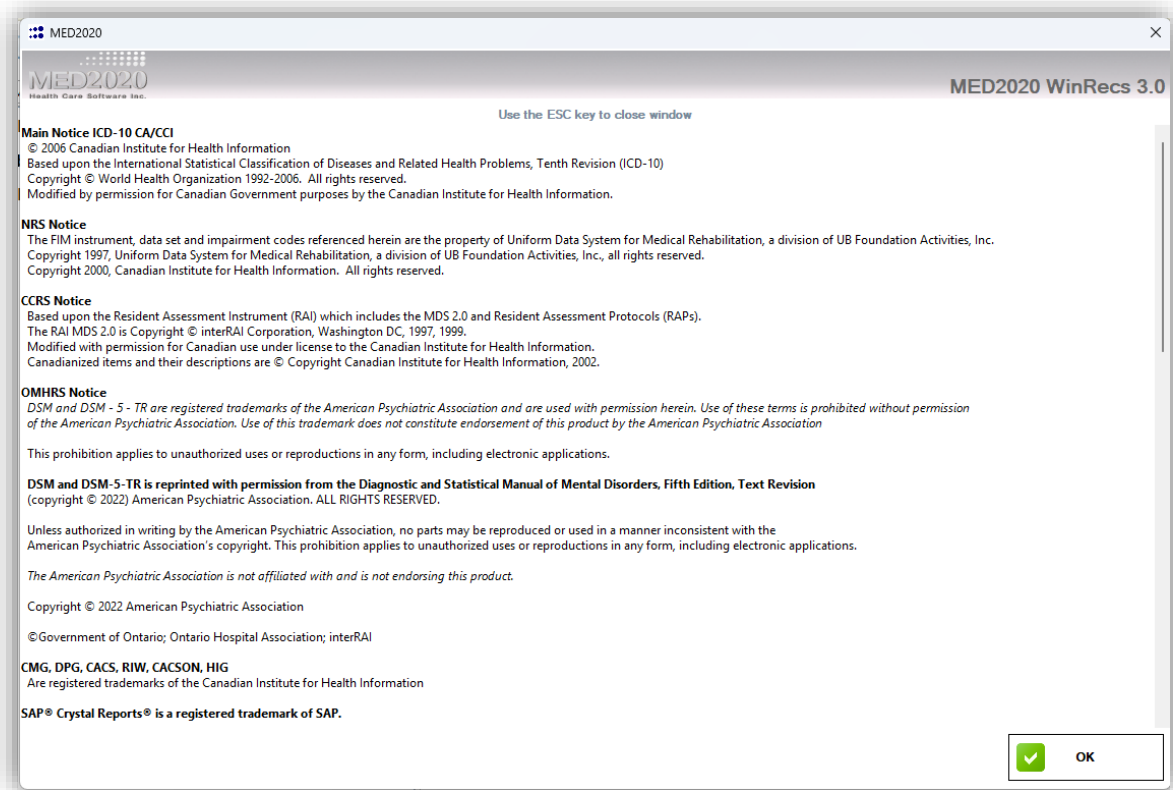


Figure 3 – License Agreement Window

1.1 Custom Privacy Message

The Privacy Message can be set at the Regional or Hospital Level from the Options tab. By default, this feature is disabled and only available if there is text entered into the Privacy Message field for either the Regional Profile or Hospital Profile. If no text is entered at either level, then the Privacy Message will not show.

If there is text entered, then The Privacy Message will be displayed after the user closes the License screen. The Privacy Message will display the message provided in the Regional or Hospital Profile with the option to Accept or Decline. If the user accepts the agreement, then they will have access to WinRecs. However, if the user declines the agreement, they are immediately logged off the application.

If there is a message in both the Regional and Hospital settings, then the Hospital Privacy Message will override the Regional Privacy Message.

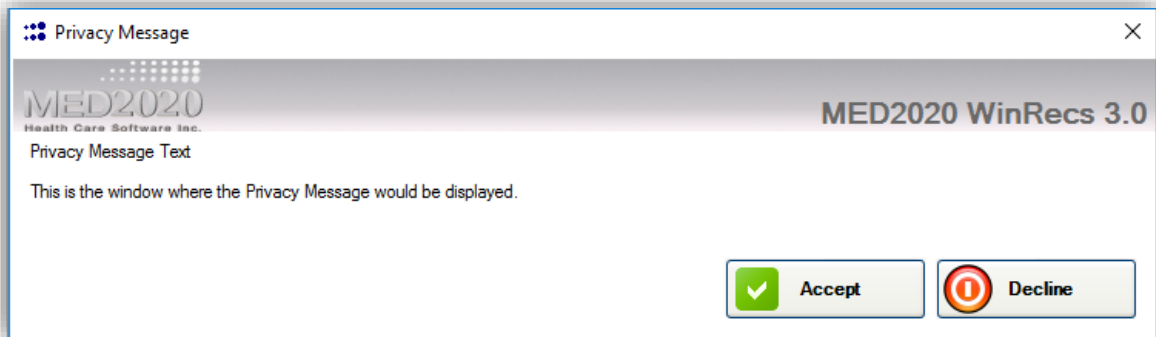


Figure 4 - Privacy Message

To configure

- At the Regional Level: Enter text in the “Privacy Message” field in Regional Profile settings. The privacy message will be the same for all the Hospitals in that Region.
- At the Hospital Level: Enter text in the “Privacy Message” field in Hospital Profile settings. The privacy message will only display for all the institution assigned to that specific hospital.

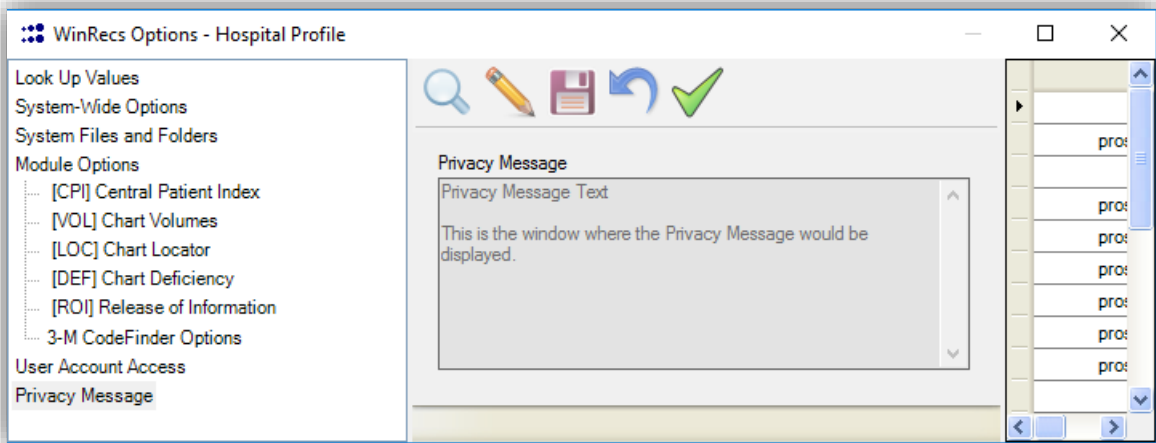


Figure 5 - Configure Privacy Message

1.2 WinRecs User Interface

WinRecs uses the newest technology available to deliver a state-of-the-art user interface, which allows users to tailor the display of individual tasks and user preferences. To provide this new feature, the concept of Dockable windows is used. Dockable windows and their management will be described in this section. The following section will describe the parts of the user interface; the menu items and toolbar actions.

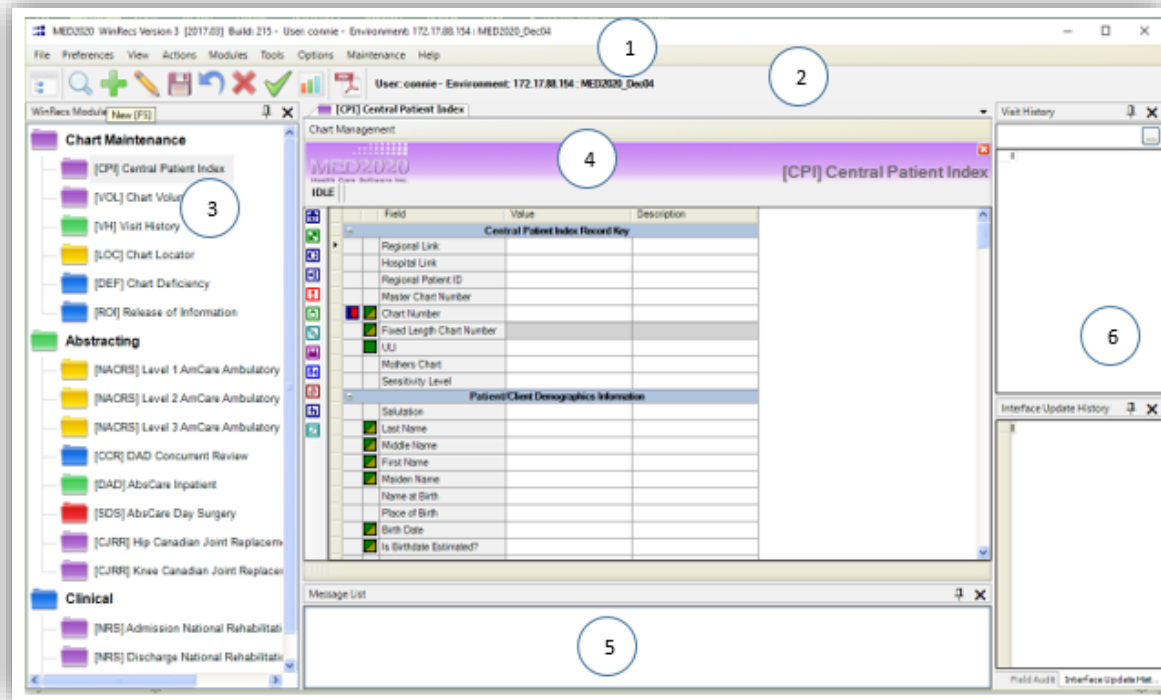


Figure 6 - Main Screen

1. The Menu Bar – The menu bar displays the menu items which include **File, Preferences, View, Actions, Modules, Tool, Options, Maintenance** and **Help**.
2. The Toolbar – The toolbar provides single-click shortcuts to commonly used activities.
3. WinRecs Module Menu – This Dockable Window provides access to the WinRecs modules. Only the module(s) licenced by the site's institution will be listed.
4. Main Window – This is the main part of WinRecs. It displays all currently opened abstracts.
5. Message List – This Dockable window displays information messages from the system, hard errors and warnings for Canadian Institute for Health Information (CIHI) edits and user defined edits created using the Edit Engine module.
6. Dockable Windows – This allows a user to customize what they would like to display from the options from the View menu bar.

1.3 The Menu Bar

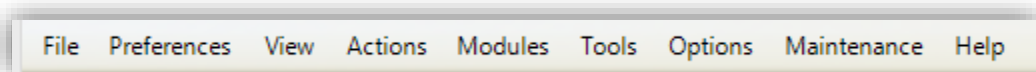


Figure 7- Menu Bar

The menu bar provides access to all of the functions of WinRecs. Only the functions and modules licenced by the user's institution will be available.

The File Menu

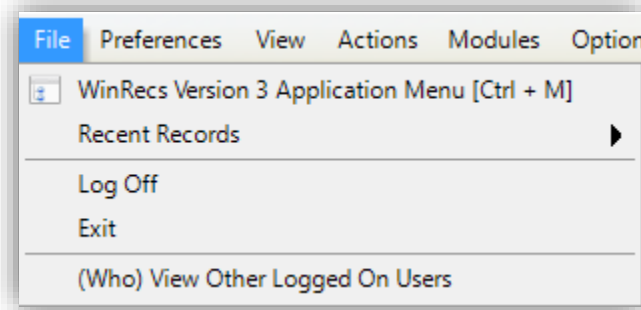


Figure 8 - The File Menu

The **File** Menu provides access to core functions of WinRecs. The features included are:

- WinRecs Version 3 Application Menu [CTRL + M] – Displays the WinRecs Module Menu.
- Recent Records – Hovering will open a list of the 10 last records accessed.
- Log Off – Logs the user off and returns to the Log In screen.
- Exit – Exits the application. When finished using WinRecs it is best practice to use Exit from the File Menu.
- (Who) View Other Logged On Users – Opens the Other Logged In Users (Who) page, with the options to:
 -  'Clear My Dead Log In' – Clears any log in that is not being used by the user
 -  'Log Off User' – Allows the user to log off any other one user
 -  'Log Off All Users' – Allows the user to log off all users

The Preferences Menu

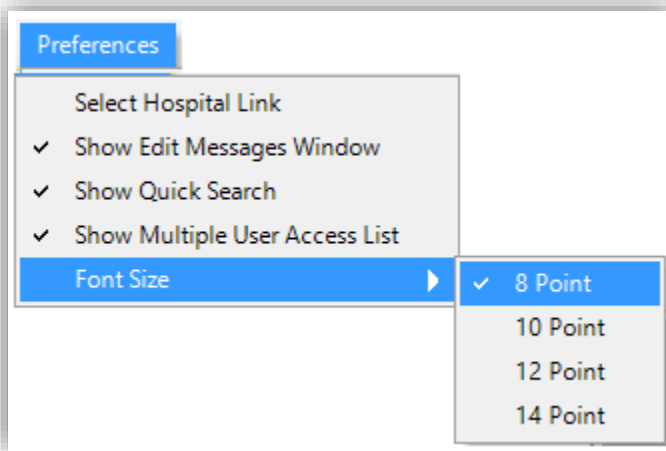


Figure 9 - The Preference Menu

The Preferences Menu provides access to certain user preference settings in WinRecs. The features included are:

- Select Hospital Link – A pop up display which allows users with regional access to select the preferred hospital link.
- Show Edit Messages Window – Displays the Edit Messages Window, can press 'Esc' button to remove the message.
- Show Quick Search – Displays the Quick Search Window.
- Show Multiple User Access List – Displays the Multiple User Access List Window.
- Font – Allows you to change the font size used to display the information in the modules, Grouper Window and Record Information window.

The View Menu

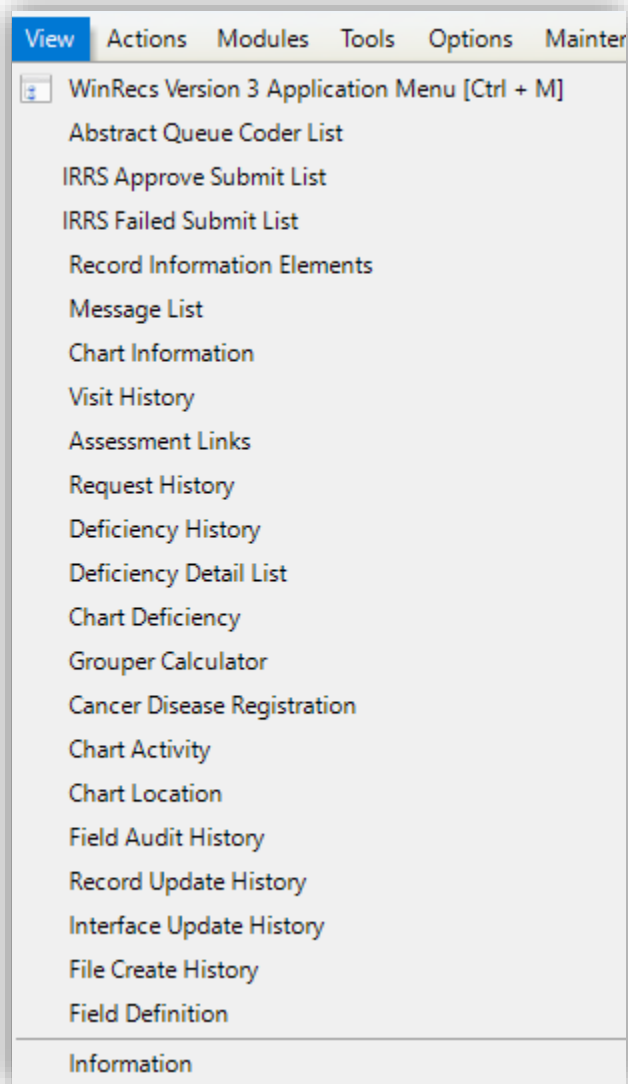


Figure 10 - The View Menu

The View Menu provides access to the view functions in WinRecs. It allows the user to view the windows that are not displayed. Selecting one of the View Menu items will open the selected window in the last location it was previously opened.

- WinRecs Version 3 Application Menu [CTRL + M] – Displays the WinRecs Module Menu.
- Abstract Queue Coder List – Displays the Abstract Queue Coder List.
- IRRS Approve Submit List – Displays IRRS Assessments that are ready to be submitted to CIHI.
- IRRS Failed Submit List – Displays IRRS Assessments that were rejected by CIHI. Once the assessment passes it is removed from this list.

- Record Information Elements – Displays the Record Information Element window.
- Message List – Displays the Message List window.
- Chart Information – Displays the Chart Information window.
- Visit History – Displays the Visit History window.
- Assessment Links – Displays the Clinical Modules assessment links
- Chart Volume List – Displays the Chart Volume window.
- Request History – Displays the Request History window.
- Deficiency History – Displays the Deficiency History window.
- Deficiency Detail List – Displays the Deficiency Detail List window.
- Chart Deficiency – Displays the Chart Deficiency window.
- Grouper Calculator – Displays all grouper calculations pertaining to the accessed module.
- Cancer Disease Registration – Displays the Cancer Disease Registration information
- Chart Activity – Displays the Chart Activity
- Field Audit History – Displays the Field Audit History window.
- Record Update History – Displays the Record Update History window.
- Interface Update History – Displays the Interface Update History window.
- File Create History – Displays the File Create History window.
- Field Definition – Displays the fields definitions in the clinical modules.
- Information – Opens up File Explorer to look for documents.

The Actions Menu

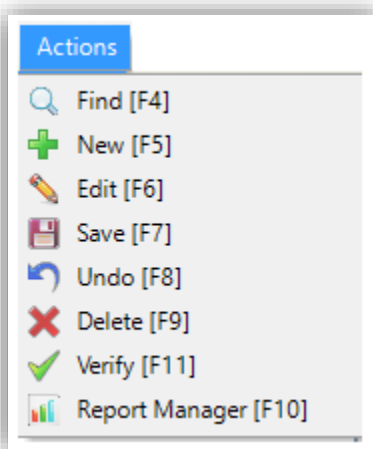
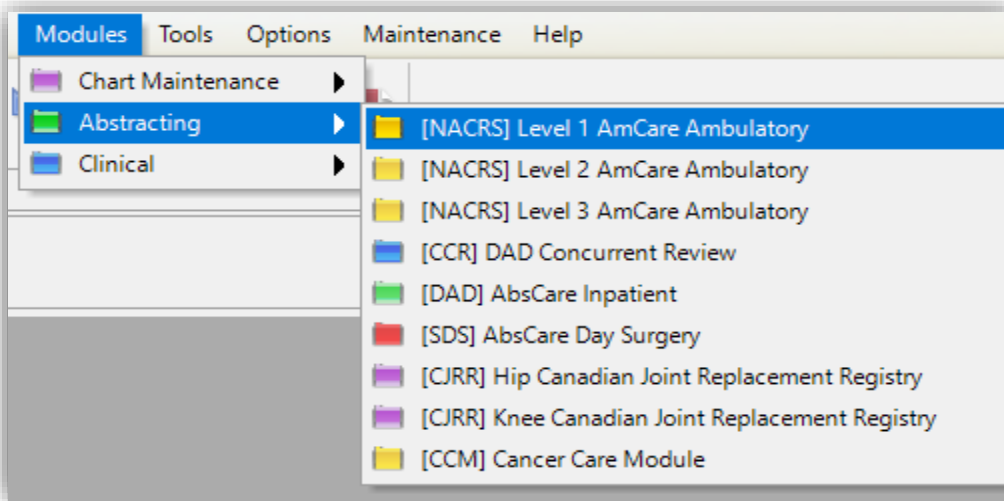
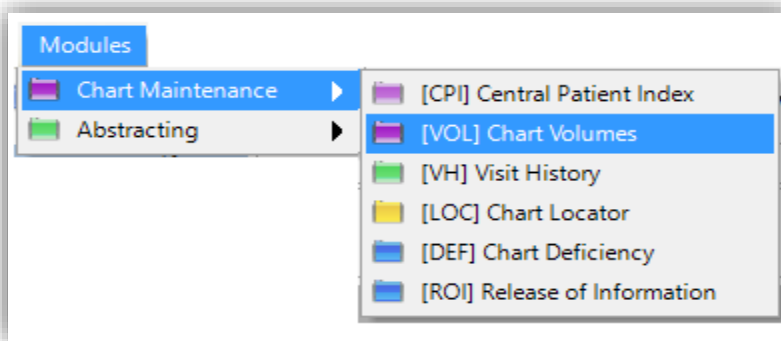


Figure 11 - The Actions Menu

The Actions Menu provides access to all of the actions available in WinRecs. All of the action items are available on the Toolbar and via shortcut keys. The Toolbar and shortcut keys are described below.

- Find [F4] – Opens the Record Search window. This window is context sensitive and will automatically select the appropriate module based on the currently selected module in WinRecs.
- New [F5] – Creates a new record in the currently selected module.
- Edit [F6] – Enables editing of the currently selected record.
- Save [F7] – Saves the current record if there are unsaved changes.
- Undo [F8] – Undoes any unsaved changes to the current record and returns it to the previously saved state.
- Delete [F9] – Deletes the current record.
- Verify [F11] – Verifies the current record for any errors or warnings.
- Report Manager [F10] – Opens the Report Manager window.

The Modules Menu



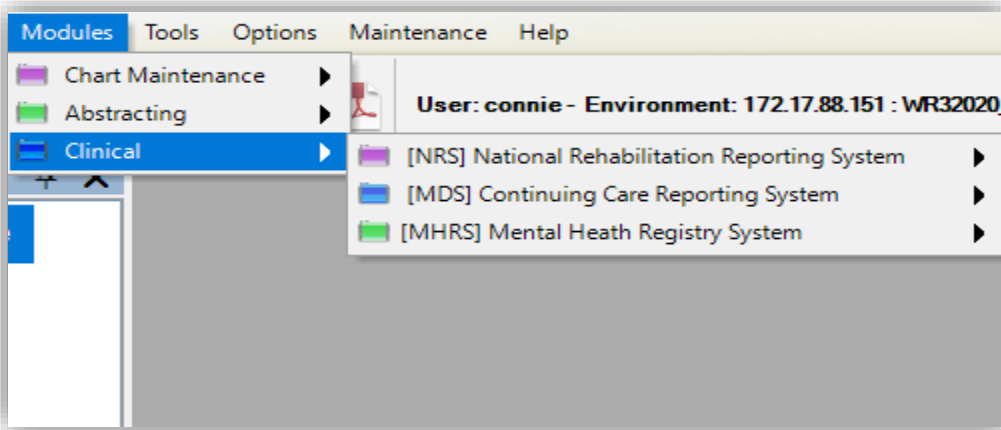


Figure 12 - The Modules Menu

The Modules Menu provides access to all the modules of WinRecs. Selecting an item from this menu will add a new tab in the Main window. It allows you to toggle between tabs in the Main window.

The Tools Menu

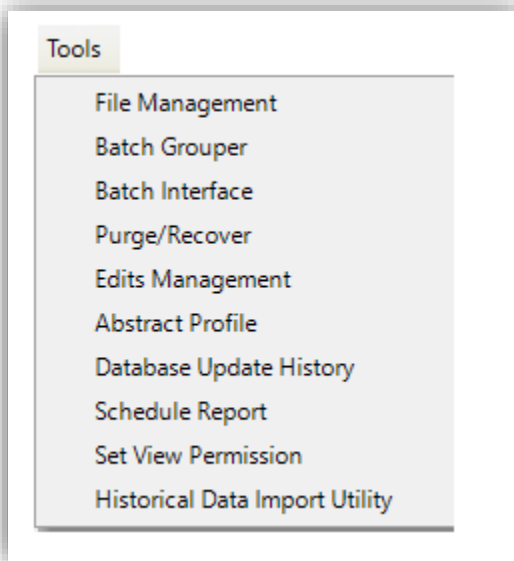


Figure 13 - The Tools Menu

The Tools Menu provides access to the following functions:

- File Management – Creates the CIHI submission, correction, deletion, institution and no separation files.

- Batch Grouper – Running the Batch Grouper ensures that Grouper values are assigned to all records in a batch.
- Batch Interface – Allows users to locate and run an existing batch interface.
- Purge/Recover – Used to completely remove or restore deleted data.
- Edits Management – Allows users to create their own user-defined data quality edits that are run at the time of validation with other CIHI-defined edits.
- Abstract Profile – Creates the Abstract Profile for DAD/SDS/NACRS.
- Database Update History – The area to run .wru patches
- Schedule Report – The ability to attach reports to modules and set up report schedules.
- Set View Permission – The ability to allow users access to the views or have Read-Only access.
- Historical Data Import Utility – The ability to allow users access to Historical Data Import Utility (HDIU).

The Options Menu

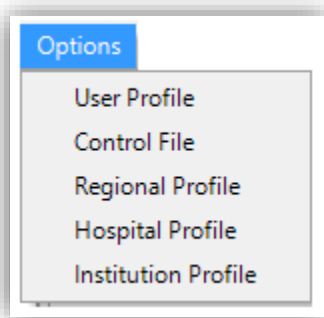


Figure 14 - The Options Menu

The Options Menu provides access to the following functions:

- User Profile – Maintains the users of the system and their privileges.
- Control File – Used to specify default values for fields, change field names, restore fields to the main grid, make fields visible/invisible or enable/disable fields for each module.
- Regional Profile – Maintains the regional profile of the system.
- Hospital Profile – Maintains the hospital profile.
- Institution Profile – Maintains the institution profile.

The Maintenance Menu

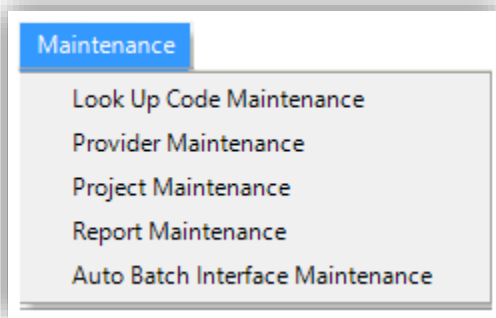


Figure 15 - The Maintenance Menu

The Maintenance Menu provides access to the following functions:

- Look Up Code Maintenance – Opens the Look Up Code Maintenance window.
- Provider Maintenance – Opens the Provider Maintenance window to edit information for a facility's physicians and other health providers.
- Project Maintenance – Open the Project Maintenance window to add new projects or edit existing projects.
- Report Maintenance – Opens the Report Maintenance window to run and schedule Crystal Reports within WinRecs.
- Auto Batch Interface Maintenance – Opens the Auto Batch Interface to run the batch in/out Interface.

The Help Menu

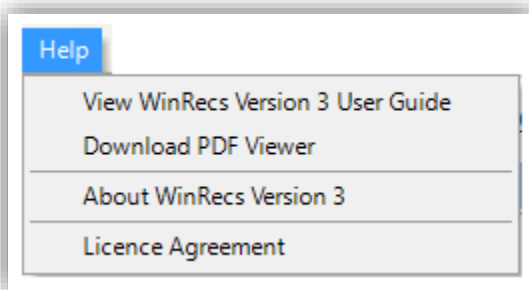


Figure 16 - The Help Menu

The Help Menu provides access to the following functions:

- View WinRecs Version 3 User Guide – Open the WinRecs User Guide (this document) in PDF format.
- Download PDF Viewer – Downloads and installs the Adobe® Acrobat® Reader™.

- About WinRecs Version 3 – Opens the About dialog box and displays the WinRecs application information and MED2020 contact information.
- Licence Agreement – Opens the licence agreement window.

1.4 The Toolbar



The toolbar provides quick access to all of the actions that can be performed in WinRecs.

<i>Icon</i>	<i>Menu Item</i>	<i>Function</i>	<i>Keyboard</i>
	Module Menu	Opens the WinRecs Module Menu	[Ctrl+M]
	Find	Search for a record	[F4]
	New	Creates a new record	[F5]
	Edit	Makes changes to a record.	[F6]
	Save	Saves changes to the current record.	[F7]
	Cancel	Cancels changes made to record since the previous save. Warning prompt will display.	[F8]
	Delete	Deletes a record and puts in the purge file	[F9]
	Verify	Verifies (edit checks) the current record, without saving the record. This is applicable for abstracting modules.	[F11]
	Print	If applicable , this button displays a list of available reports to view on screen (or view/print).	[F10]
	PDF viewer	Opens the Windows Explorer folder allowing you to view PDF files stored on the PC or Server. The path to the scanned patient records will be provided to you by your instructor.	N/A
	Chart Maintenance Menu	Allows quick access to Chart Maintenance Menu	N/A

	Abstracting Menu	Allows quick access to Abstracting menu	N/A
	WinRecs Environment Colour	Allows the user to assign specific colour to a WinRecs Session. This is beneficial if user accesses more than one WinRecs environment.	N/A
	Abstract Queue	Allows the user to access the Abstract Queue	N/A
	IRRS Submit Viewer	Allows the user to view the assessments submitted to CIHI and if passed or failed.	N/A

Table 3 - The Toolbar Icon

WinRecs Shortcuts Cheat Sheet

Shortcut	Action
[F2]	Opens the Lookup table for the selected field.
[F3]	Fields grid quick search; only available in modules.
[F4]	Opens the Find dialog box for the selected module or field.
[F5]	Creates a new record in the current module.
[F6]	Set the current record in edit mode.
[F7]	Saves the current record.
[F8]	Undoes any unsaved changes to the current record and returns it to the previously saved state.
[F9]	Deletes the current record.
[F10]	Report Manager
[F11]	Verifies the current record for any errors.
[CTRL + M]	Displays the WinRecs Module Menu.
[ALT + F3]	Opens the Notes Window
[ESC]	Closes popup messages
[CTRL + C]	Copies Fields that are enabled
[CTRL + V]	Pastes fields that have been copied

Table 4 - WinRecs Shortcuts

Figure 17 shows enabled fields have white background and disabled fields have grey backgrounds.

	** Coder Number	34	jennifer
	** Chart Number	JA111222	.
	Volume Number		
	Register Number		
	Second Chart/Register		

Figure 17 - Fields

In order to copy text from a disabled field, user can right click the field and selecting copy.

	** Coder Number	34	jennifer
	** Chart Number	JA111222	.
	Volume Number		
	Register Number		
	Second Chart/Register		

Figure 18 - Copy Option

1.5 Dockable Windows

WinRecs now allows moving, hiding, custom sizing, docking or undocking of certain windows.

A Dockable window is a window that can exist in a floating state or be attached to the main application window. This feature allows the user to tailor the user interface to suit their particular needs. By being able to hide, dock or float some windows, the user can display only the information necessary to perform specific tasks. This section will explain how to manage the Dockable windows.

The highlighted windows below - WinRecs Module Menu, Message List, Chart Information and Field Audit - are dockable. The dimmed portion, in the center of the figure, is the main abstracting area. This is where the module-specific windows will be added.

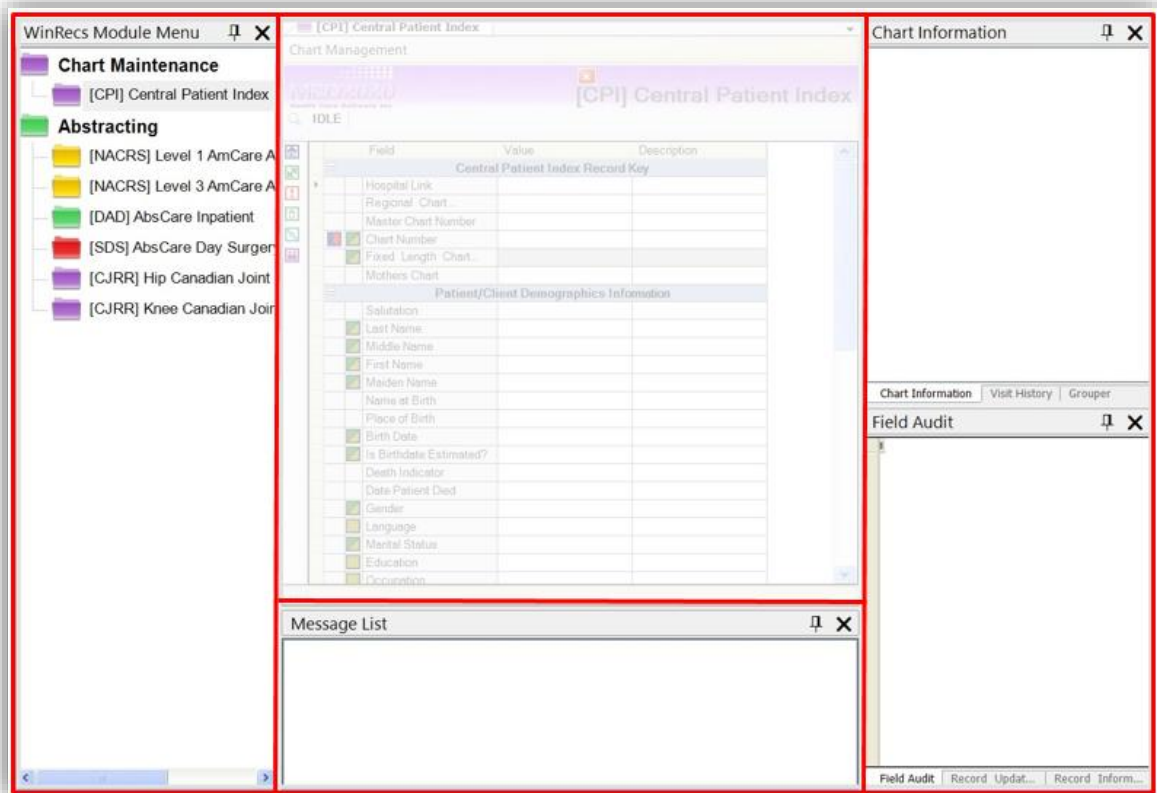


Figure 19 - Dockable Windows

Dockable Window Parts

A Dockable window has a title bar, control buttons and a display area.

- **Title Bar** – Displays the name of the window. Can be used to drag the window or to make the window float or dock. How to interact with the title bar is described in detail in this section.
- **Control Buttons**

 	This button will switch the AutoHide feature. The Pin pointing down is displayed when AutoHide is disabled and the window is showing. The Pin pointing to the left indicates that AutoHide is enabled; the window automatically hides when the focus is on a different window. Interacting with the pin button is described in detail in this section.
	Clicking this button will close the window. Closed windows can be reopened via the View menu. Example: after closing the Visit History window it can be reopened by selecting View→Visit History.

Table 5 – Control Buttons

- **Display** – This area displays the content of the window. Users can interact with it at all times; floating or docked.

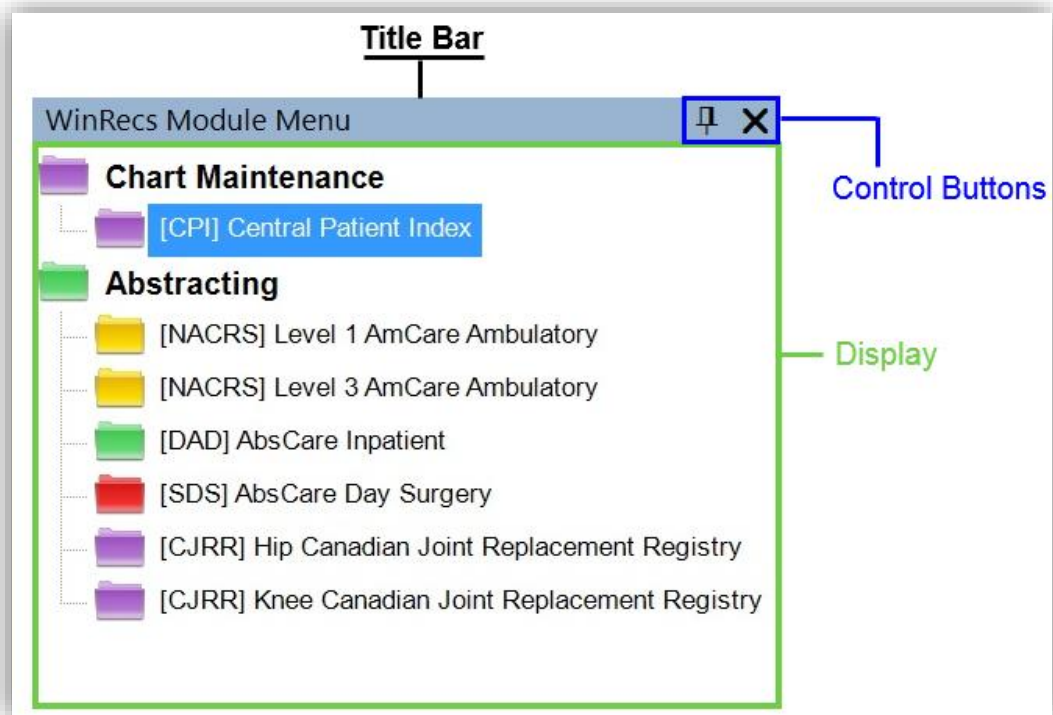


Figure 20 - Dockable Window Parts

Pin / AutoHide

The following windows support Pin/AutoHide: WinRecs Module Menu, Record Information Elements, Message List, Chart Information, Visit History, Request History, Grouper Calculator, Field Audit History, Record Update History, Interchange Update History and File Create History. This feature allows a user to hide a window while being able to quickly consult the information displayed in it. This feature is only to show or hide the window; to change the location of the window see [To turn off AutoHide](#)

- Click the window to keep visible and to give it focus.
- Click the Pin icon on the title bar.

AutoHide Disable 

When AutoHide is disabled the window will be visible, docked left, right, up or down.

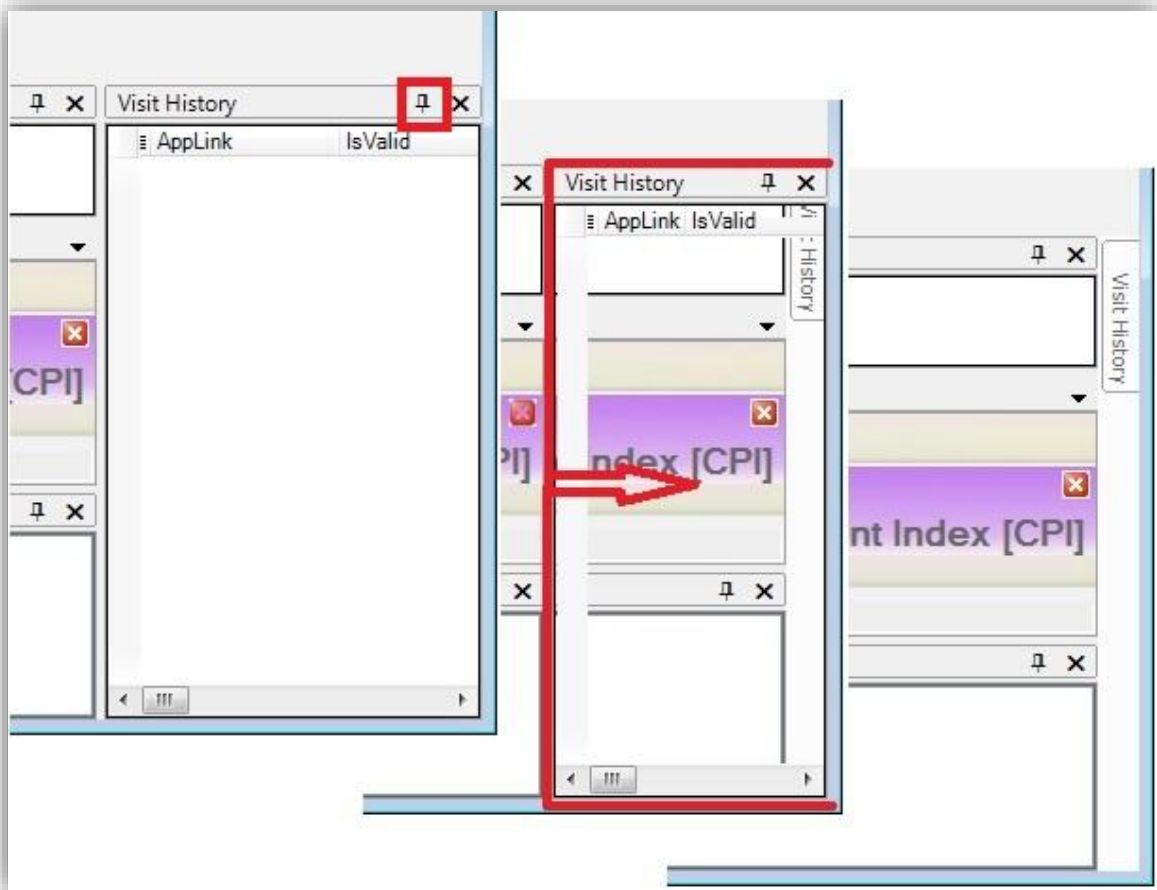


Figure 25 - Example of AutoHide

To dock a window,

To turn on AutoHide

- Click on the window needed to keep visible and to give it focus.
- Right click the title bar to display the context menu, then click **AutoHide**.

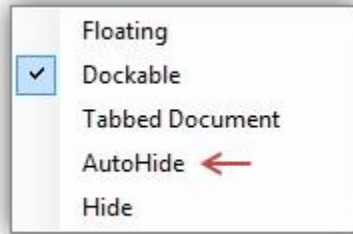


Figure 21 - Dock Context Menu (AutoHide)

— or —

- Click the Pin on the title bar of the window.

AutoHide Enabled 

When an “AutoHidden” window loses focus it will automatically slide back to its edge, creating a tab with the name of the window.

Close/Hide

The following windows support Close / Hide: WinRecs Module Menu, Record Information Elements, Message List, Chart Information, Visit History, Request History, Grouper Calculator, Field Audit History, Record Update History, Interchange Update History and File Create History. This feature allows the user to hide a window that is not regularly needed.

To close/hide a window

- Click the window needed to keep visible and to give it focus.
- Right click the title bar to display the context menu, then click **Hide**.

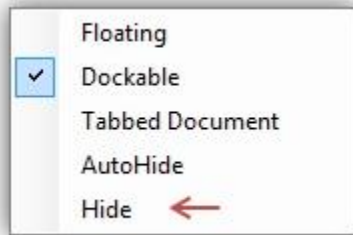


Figure 22 - Dock Context Menu (Hide)

— or —

- Click the  on the title bar of the window.

To show a closed window

- Open the **View** menu, then select the window to display.
 - If the window you select is already displayed no action will be performed
 - The window will be displayed at its last location.

— or —

- To show the WinRecs Module Menu press **[CTRL + M]**

— or —

- To show the WinRecs Module Menu press  on the Toolbar

Floating/Docking

A floating window appears detached from the main screen and can be displayed outside of the boundary of WinRecs or on a different screen (when using a dual monitor workstation).

To float a window

- Click the window needed to keep visible and to give it focus.
- Right click the title bar to display the context menu, then click **Floating**.

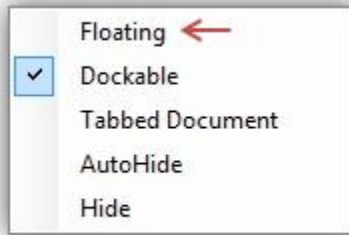


Figure 23 - Dock Context Menu (Floating)

— or —

- Double click the title bar of the window to automatically make the window float.

— or —

- Click and drag the title bar to make the window float. Release the drag action when the window is in the desired position.

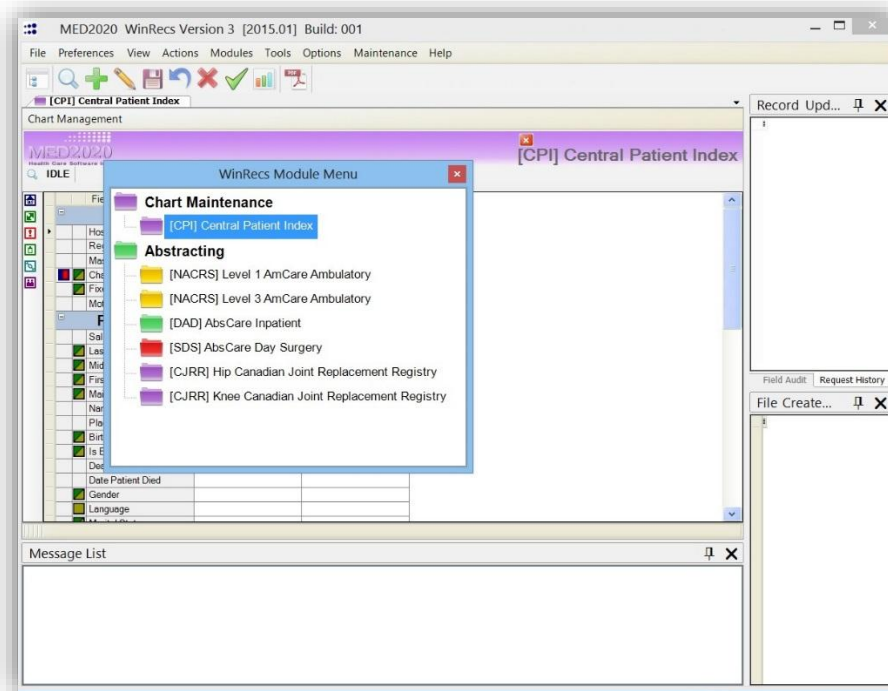


Figure 24 - Example of a Floating Window

To turn off AutoHide

- Click the window to keep visible and to give it focus.
- Click the Pin icon on the title bar.

AutoHide Disable 

When AutoHide is disabled the window will be visible, docked left, right, up or down.

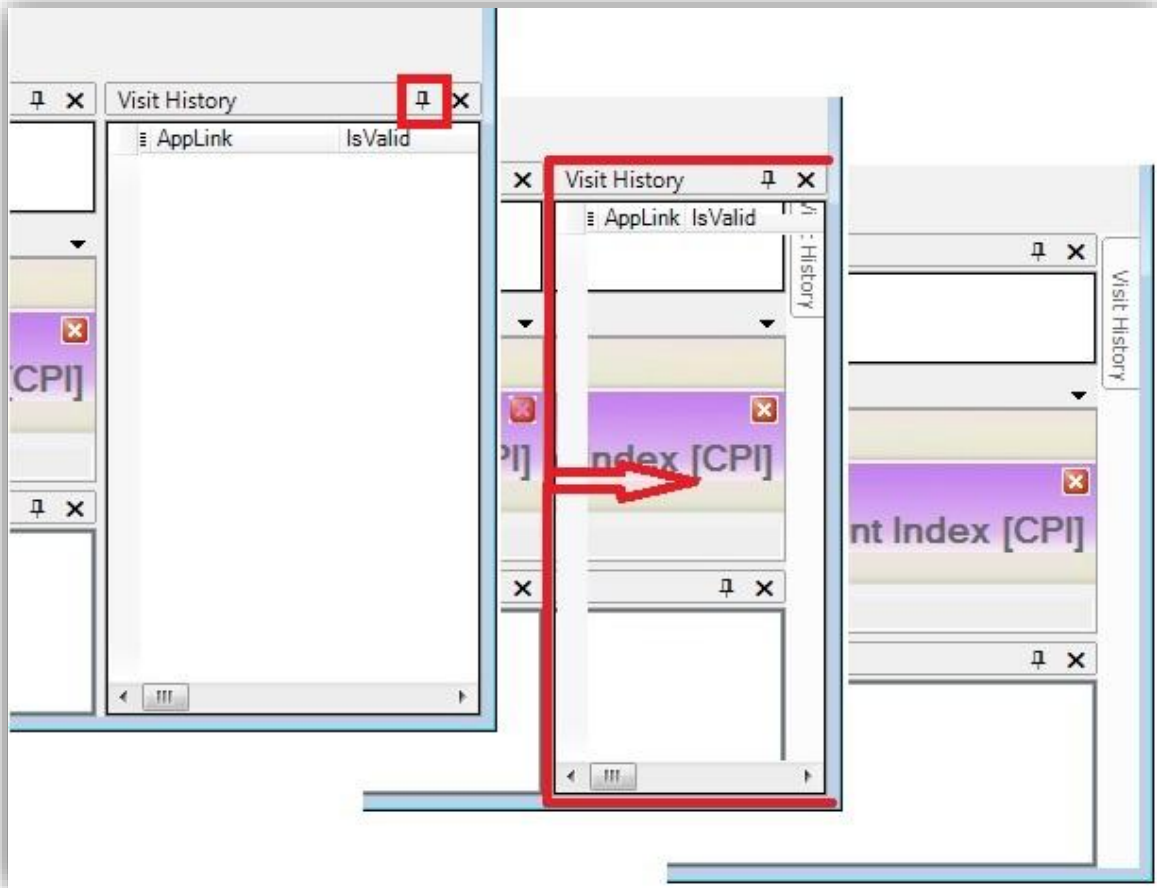


Figure 25 - Example of AutoHide

To dock a window

- Click the window needed to keep visible and to give it focus.
- Right click the title bar to display the context menu, then click **Dockable**.



Figure 26 - Dock Context Menu (Dockable)

— or —

- Double click the title bar of the window to automatically dock the window to its last docked position.

— or —

- Click and drag the title bar to make the dock controller appear. Drag the cursor over the dock controller to dock the window to the desired position.

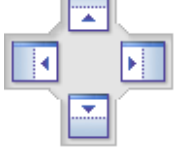
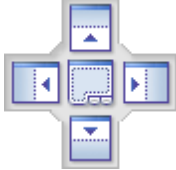
	Docks to the top of the application.
	Docks to the right of the application.
	Docks to the bottom of the application.
	Docks to the left of the application.
	This control is displayed in the center of the application and allows you to dock the floating window to any location based on the selected control you drop the window on.
	This control is displayed in a docked window. It allows you to create a group of window tabs, explained in <u>Docked window group</u> .

Table 6 - Docking Controls

Example of docking controls

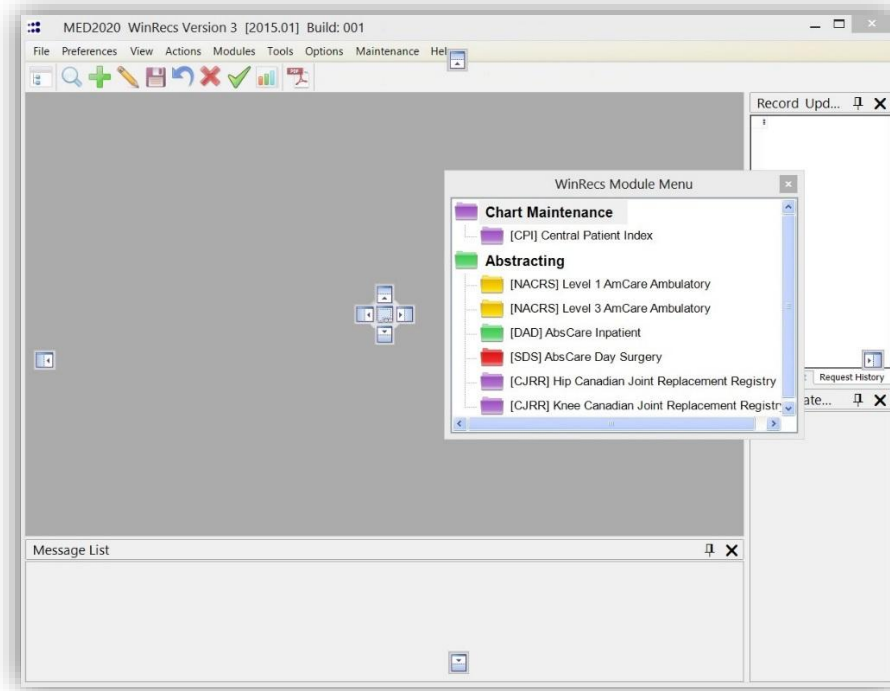


Figure 27 - Example of the dock controls

Example of docking control for tabbed windows

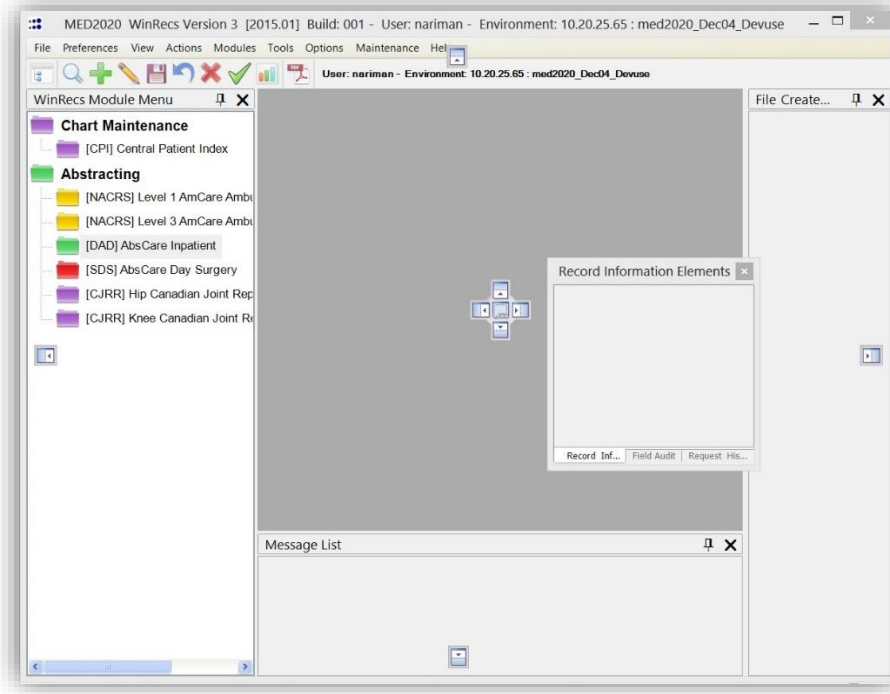
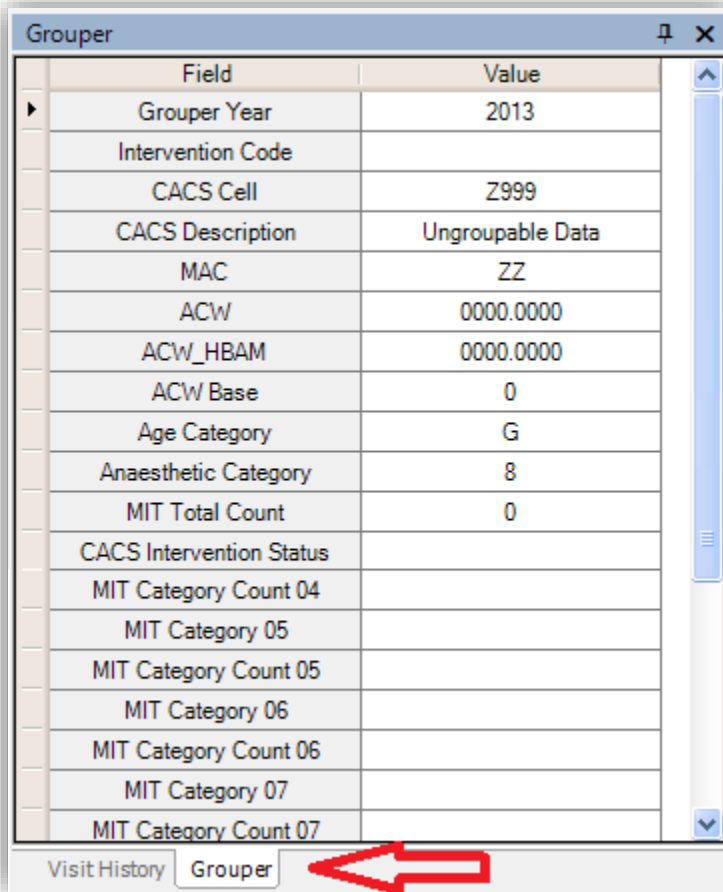


Figure 28 - Example of docking control for tabbed windows

Docked window group

Grouping docked windows in tabs allows the user to minimize the space used by the windows while giving the ability to quickly toggle between the windows.

As seen in the figure below the `Group` and `Visit History` windows are grouped.



Field	Value
Grouper Year	2013
Intervention Code	
CACS Cell	Z999
CACS Description	Ungroupable Data
MAC	ZZ
ACW	0000.0000
ACW_HBAM	0000.0000
ACW Base	0
Age Category	G
Anaesthetic Category	8
MIT Total Count	0
CACS Intervention Status	
MIT Category Count 04	
MIT Category 05	
MIT Category Count 05	
MIT Category 06	
MIT Category Count 06	
MIT Category 07	
MIT Category Count 07	

Visit History Grouper

Figure 29 - Example of grouped docked windows

To toggle between grouped docked windows

- Click on the tab of the window the user wants to view.

To group Dockable windows

- Follow the instruction [To turn off AutoHide](#)
- Click the window to keep visible and to give it focus.
- Click the Pin icon on the title bar.

AutoHide Disable 

When AutoHide is disabled the window will be visible, docked left, right, up or down.

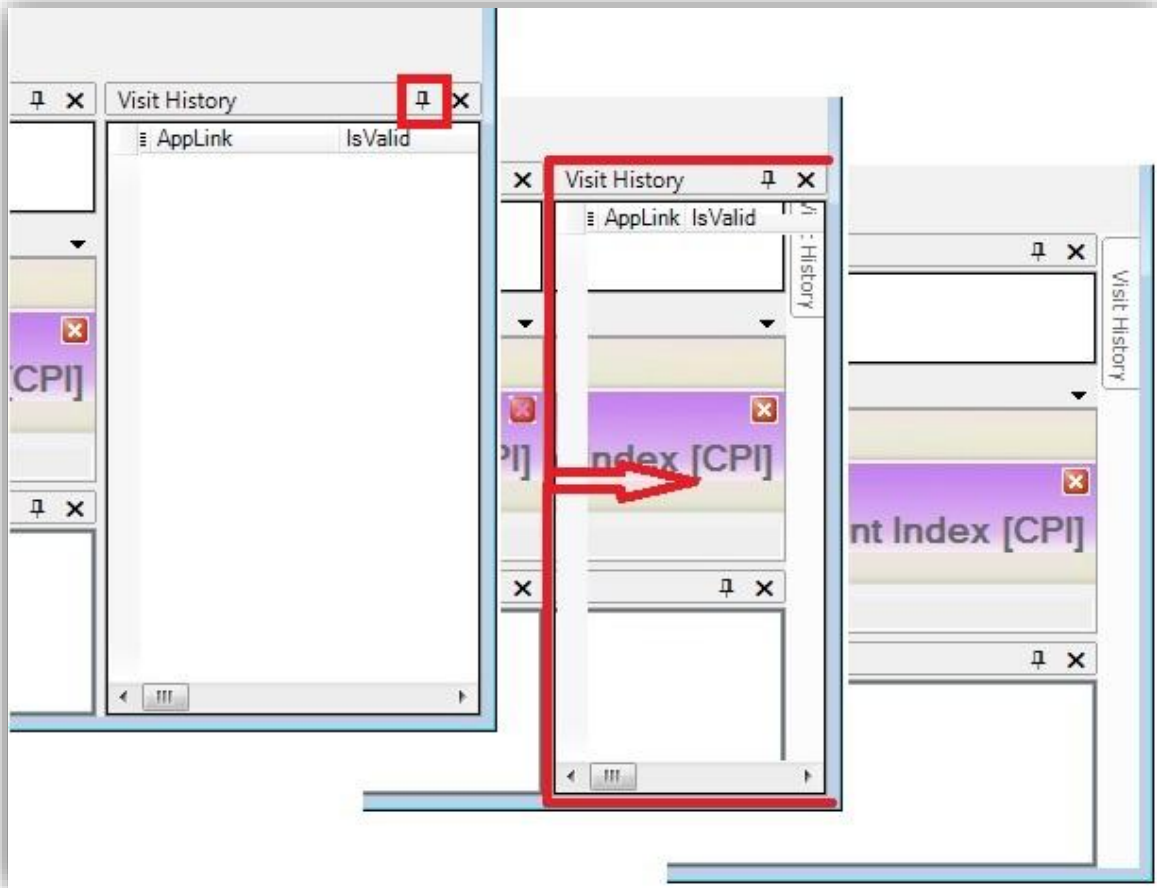


Figure 25 - Example of AutoHide

To dock a window and drop the window on the docking tab control 

Resizing a window

Windows can be resized, which allows the user to view more of the data needed to see to perform the tasks. Docked and floating windows can be resized.

To resize a floating window with the mouse

- Move your cursor to the edge of the window; the mouse pointer will switch to an adjustment icon.

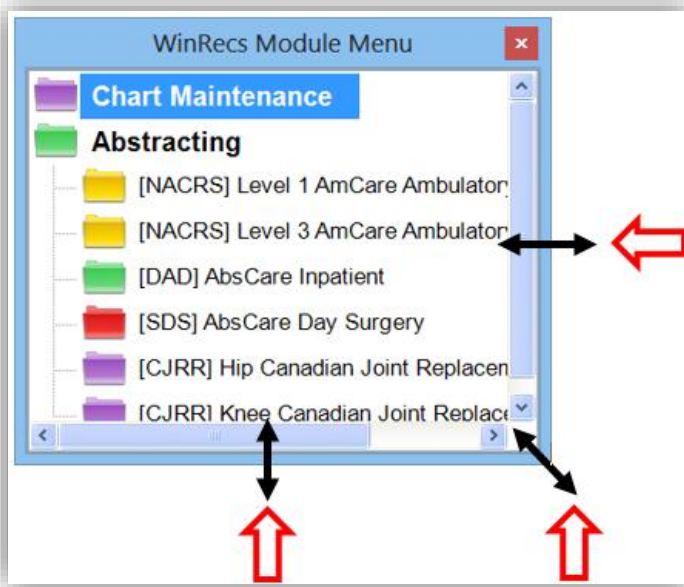


Figure 30 - Window resizing with the mouse pointer

- When the mouse pointer icon is displayed as an adjustment icon, click and drag the edge of the window.
- Release the drag motion when the window is the desired size.

To resize a floating window with the keyboard

- Press **[ALT + SPACEBAR]** to display the window context menu.

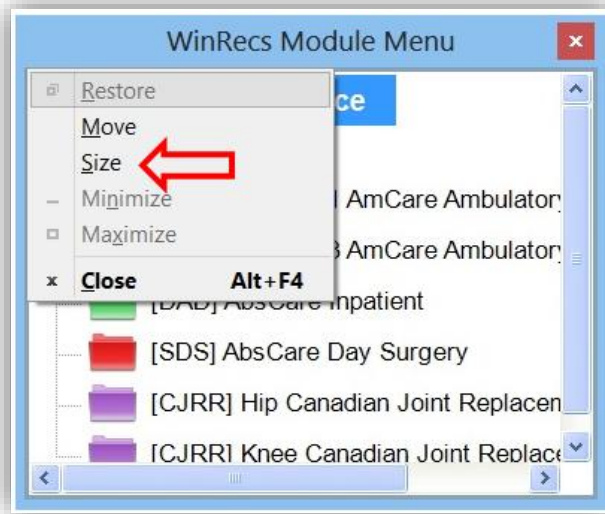


Figure 31 - Floating window context menu Click Size.

— or —

- Press **[ALT + S]**.
- or —
- Move the focus to **Size** using the keyboard arrows.

Next:

- Use the keyboard arrows to resize the window to the desired size.
- When the window is the desired size, press **[ENTER]**.

To resize a docked window with the mouse

Docked windows can only be resized with the mouse.

- Move the cursor to the edge of the window; the mouse pointer will switch to an adjustment icon.

	For side docked windows
	For top and bottom docked windows

Table 7 - Docked Window Cursors

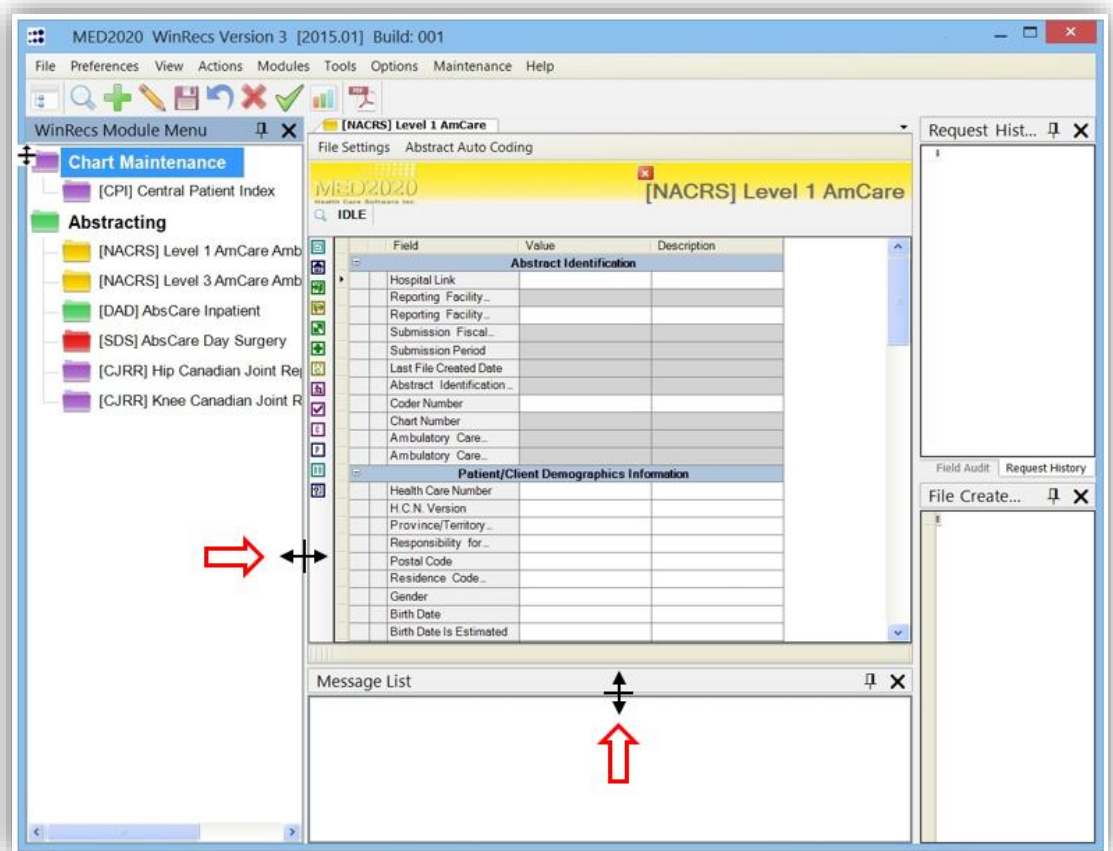


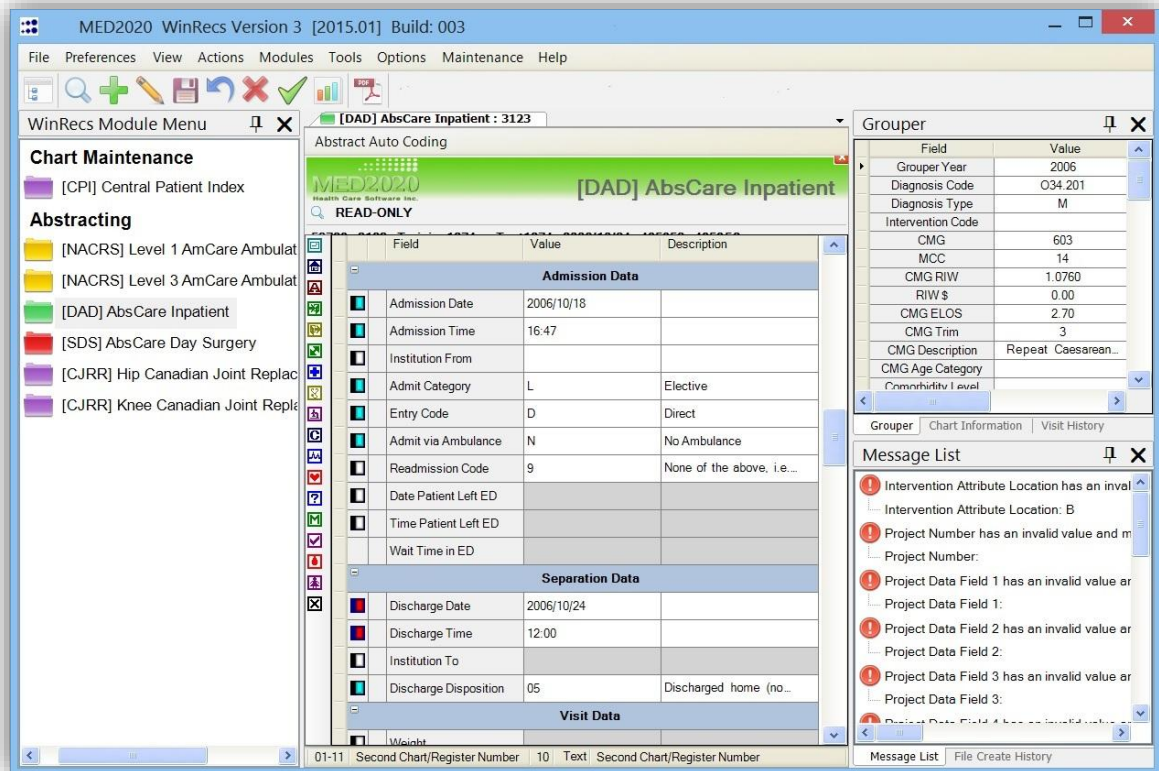
Figure 32 - Docked window cursors

- When the mouse pointer icon is displayed as an adjustment icon, click and drag the edge of the window.
- Release the mouse button when the window is the desired size.

Example of configuration

This configuration allows for a maximum number of fields to be displayed while still providing access to the messages and Record Information Elements. The WinRecs Module Menu can be viewed by clicking the side tab or pressing **[CTRL + M]** or **View → WinRecs Application Menu**.

The Visit History can also be consulted by clicking the side tab Visit History or by clicking **View → Visit History**.



MED2020 WinRecs Version 3 [2015.01] Build: 003

File Preferences View Actions Modules Tools Options Maintenance Help

WinRecs Module Menu

Abstract Auto Coding

[DAD] AbsCare Inpatient : 3123

Abstract Auto Coding

READ-ONLY

Field	Value	Description
Admission Data		
Admission Date	2006/10/18	
Admission Time	16:47	
Institution From		
Admit Category	L	Elective
Entry Code	D	Direct
Admit via Ambulance	N	No Ambulance
Readmission Code	9	None of the above, i.e...
Date Patient Left ED		
Time Patient Left ED		
Wait Time in ED		
Separation Data		
Discharge Date	2006/10/24	
Discharge Time	12:00	
Institution To		
Discharge Disposition	05	Discharged home (no...
Visit Data		
Weight		

01-11 Second Chart/Register Number 10 Text: Second Chart/Register Number

Grouper

Field	Value
Grouper Year	2006
Diagnosis Code	O34.201
Diagnosis Type	M
Intervention Code	
CMG	603
MCC	14
CMG RIW	1.0760
RIW \$	0.00
CMG ELOS	2.70
CMG Trim	3
CMG Description	Repeat Caesarean...
CMG Age Category	
CMG Risk Level	

Message List

- Intervention Attribute Location has an invalid value
- Intervention Attribute Location: B
- Project Number has an invalid value and message
- Project Number:
- Project Data Field 1 has an invalid value and message
- Project Data Field 1:
- Project Data Field 2 has an invalid value and message
- Project Data Field 2:
- Project Data Field 3 has an invalid value and message
- Project Data Field 3:
- Project Data Field 4 has an invalid value and message
- Project Data Field 4:

Figure 33 - Docking windows example

1.6 Grid Manipulation

Grids are used in a lot of different areas of the application. For example, the result of the search feature is displayed in a grid and Look Up values are also displayed in a grid. Grids can be manipulated in a variety of ways; columns can be sorted, moved or their width can be modified.

The main abstracting area can NOT be manipulated like grids; it can, however, be tailored via the Control File.

Sorting

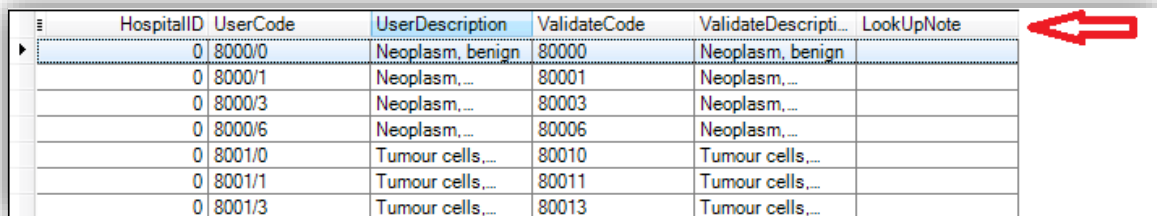
Most columns in grids can be sorted. When a column header is clicked the grid will be sorted based on the column clicked. A sorted column will display an icon indicating that it's sorted and the direction of the sort.

	This icon is displayed on the header of a column when it's sorted in ascending order.
	This icon is displayed on the header of a column when it's sorted in descending order.

Table 8 - Grid Manipulation Sorting Icons

To sort a grid

- Click on the column header



HospitalID	UserCode	UserDescription	ValidateCode	ValidateDescripti...	LookUpNote
0	8000/0	Neoplasm, benign	80000	Neoplasm, benign	
0	8000/1	Neoplasm,...	80001	Neoplasm,...	
0	8000/3	Neoplasm,...	80003	Neoplasm,...	
0	8000/6	Neoplasm,...	80006	Neoplasm,...	
0	8001/0	Tumour cells,...	80010	Tumour cells,...	
0	8001/1	Tumour cells,...	80011	Tumour cells,...	
0	8001/3	Tumour cells,...	80013	Tumour cells,...	

Figure 34 - Sorting a grid

- Clicking the *UserDescription* column header will initially sort the grid in ascending order by user description.

HospitalID	UserCode	UserDescription	ValidateCode	ValidateDescripti...	LookUpNote
0	Q99.1	46.XX true...	Q991	46.XX true...	
0	Y45.5	4-Aminophenol...	Y455	4-Aminophenol...	
0	A42.1	Abdominal...	A421	Abdominal...	
0	I71.3	Abdominal aortic...	I713	Abdominal aortic...	
0	I71.4	Abdominal aortic...	I714	Abdominal aortic...	
0	8822.1	Abdominal...	88221	Abdominal...	
0	O00.0	Abdominal...	O000	Abdominal...	
0	R19.3	Abdominal rigidity	R193	Abdominal rigidity	
0	O28.103	Abnormal...	O28103	Abnormal...	
0	O28.102	Abnormal...	O28102	Abnormal...	
0	O28.101	Abnormal...	O28101	Abnormal...	
0	O28.109	Abnormal...	O28109	Abnormal...	
0	R19.1	Abnormal bowel...	R191	Abnormal bowel...	
0	R94.31	Abnormal...	R9431	Abnormal...	
0	O28.503	Abnormal...	O28503	Abnormal...	
0	O28.502	Abnormal...	O28502	Abnormal...	
0	O28.501	Abnormal...	O28501	Abnormal...	

Figure 35 - Grid sorted in ascending order

- Clicking the *UserDescription* column again will sort the grid in descending order by user description.

HospitalID	UserCode	UserDescription	ValidateCode	ValidateDescripti...	LookUpNote
0	B46.9	Zygomycosis...	B469	Zygomycosis...	
0	B02.9	Zoster without...	B029	Zoster without...	
0	B02.2	Zoster with other...	B022	Zoster with other...	
0	B02.8	Zoster with other...	B028	Zoster with other...	
0	B02.3	Zoster ocular...	B023	Zoster ocular...	
0	B02.1	Zoster meningitis	B021	Zoster meningitis	
0	B02.0	Zoster...	B020	Zoster...	
0	A28.9	Zoonotic...	A289	Zoonotic...	
0	U99.055	Yoga and Tai Chi	U99055	Yoga and Tai Chi	
0	L60.5	Yellow nail...	L605	Yellow nail...	
0	A95.9	Yellow fever...	A959	Yellow fever...	
0	A66.9	Yaws, unspecified	A669	Yaws, unspecified	
0	Y57.5	Xray contrast...	Y575	Xray contrast...	
0	Q80.1	X-linked...	Q801	X-linked...	
0	L85.3	Xerosis cutis	L853	Xerosis cutis	
0	Q82.1	Xeroderma...	Q821	Xeroderma...	
0	H02.6	Xanthelasma of...	H026	Xanthelasma of...	

Figure 36 - Grid sorted in descending order

- Clicking the *UserDescription* column again will return the grid to its original sort order.

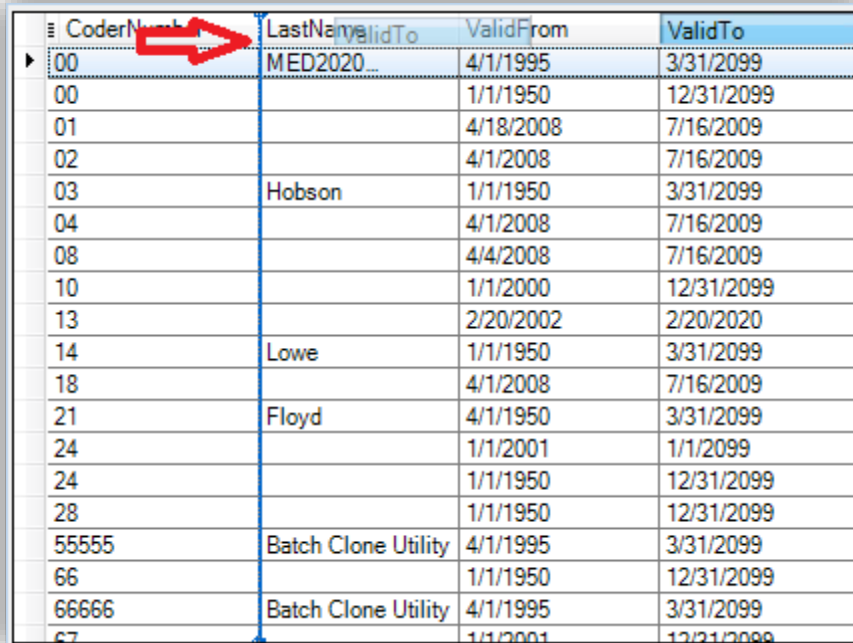
The sequence of sort is ascending, descending and original.

Moving columns

Most columns in the grid can be moved. This feature is particularly useful when you need to compare values from different columns and you need to view two columns side by side.

To move a column

- Click on a header and hold the mouse button down (to initiate the drag).
- Move your mouse pointer to the left or right.
- A blue marker line will appear between two (2) adjacent columns and this will be the new location of the column.
- Release the mouse button when the marker line is located at the desired position.



CoderNumber	LastName	ValidTo	ValidFrom	ValidTo
00	MED2020...		4/1/1995	3/31/2099
00			1/1/1950	12/31/2099
01			4/18/2008	7/16/2009
02			4/1/2008	7/16/2009
03	Hobson		1/1/1950	3/31/2099
04			4/1/2008	7/16/2009
08			4/4/2008	7/16/2009
10			1/1/2000	12/31/2099
13			2/20/2002	2/20/2020
14	Lowe		1/1/1950	3/31/2099
18			4/1/2008	7/16/2009
21	Floyd		4/1/1950	3/31/2099
24			1/1/2001	1/1/2099
24			1/1/1950	12/31/2099
28			1/1/1950	12/31/2099
55555	Batch Clone Utility		4/1/1995	3/31/2099
66			1/1/1950	12/31/2099
66666	Batch Clone Utility		4/1/1995	3/31/2099
67			1/1/2001	12/31/2099

Figure 37 - Grid column moved

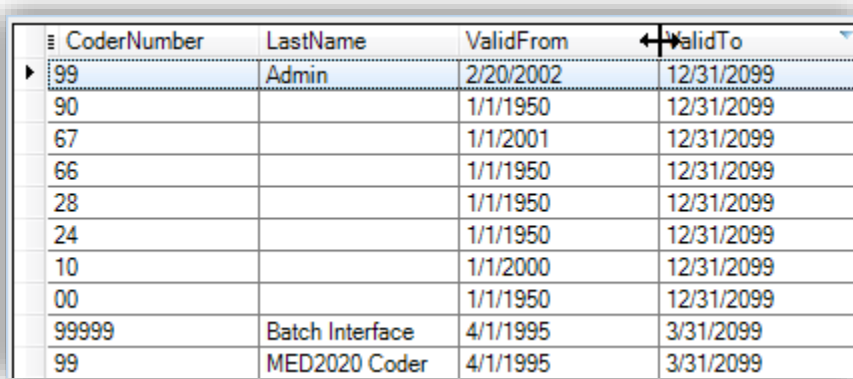
In this example, the column *ValidTo* will be moved to the right of the *CoderNumber* column.

Increasing / Decreasing Column Width

On some occasions, the text displayed in a column is wider than the width of the column, preventing the user from viewing the complete data. In this case, the user can increase or decrease the width of the column.

To increase or decrease the width of a column

- Move the mouse pointer, slowly from over the grid header, until the mouse pointer changes to the column width adjustment cursor .
- Click and hold the mouse button.
- Move left or right; increasing the width of one column decreases the width of the neighbouring column.
- Release the button when satisfied with the new widths.



	CoderNumber	LastName	ValidFrom	ValidTo
▶	99	Admin	2/20/2002	12/31/2099
	90		1/1/1950	12/31/2099
	67		1/1/2001	12/31/2099
	66		1/1/1950	12/31/2099
	28		1/1/1950	12/31/2099
	24		1/1/1950	12/31/2099
	10		1/1/2000	12/31/2099
	00		1/1/1950	12/31/2099
	99999	Batch Interface	4/1/1995	3/31/2099
	99	MED2020 Coder	4/1/1995	3/31/2099

Figure 38 - Grid column adjustment

1.7 Grid Orientation

Grids can be displayed vertically or horizontally; this feature is useful when changing the orientation of the window via the docking feature.

The Grids in the following windows can be toggled: Grouper, Record Information Elements and Visit History.

For example, in the figure below, the Grouper window is displayed while the grid is displayed horizontally, preventing the user from easily viewing all of the grouper information. This scenario will be used to describe the grid orientation feature.

Grid orientation example

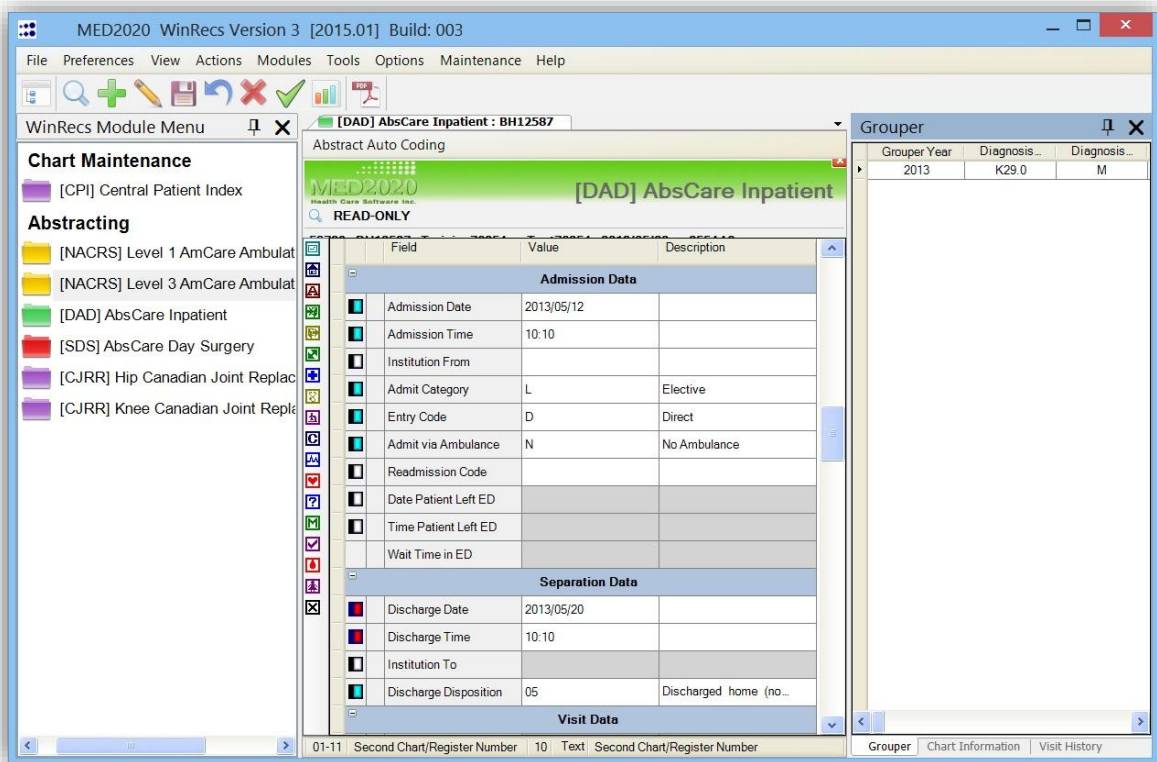


Figure 39 - Grid orientation example

To toggle the grid orientation

- Right click on any data on the grid- NOT the header - to display the context menu.

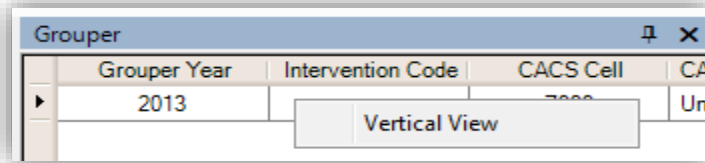


Figure 40 - Grid orientation context menu

- Click on the menu item.

A grid displayed horizontally will provide the Vertical View menu.
A grid displayed vertically will provide the Horizontal View menu.

Grid orientation after toggling the view to vertical

Using the vertical view for the Grouper window allows the user to view more information at once and to quickly scroll through the information.

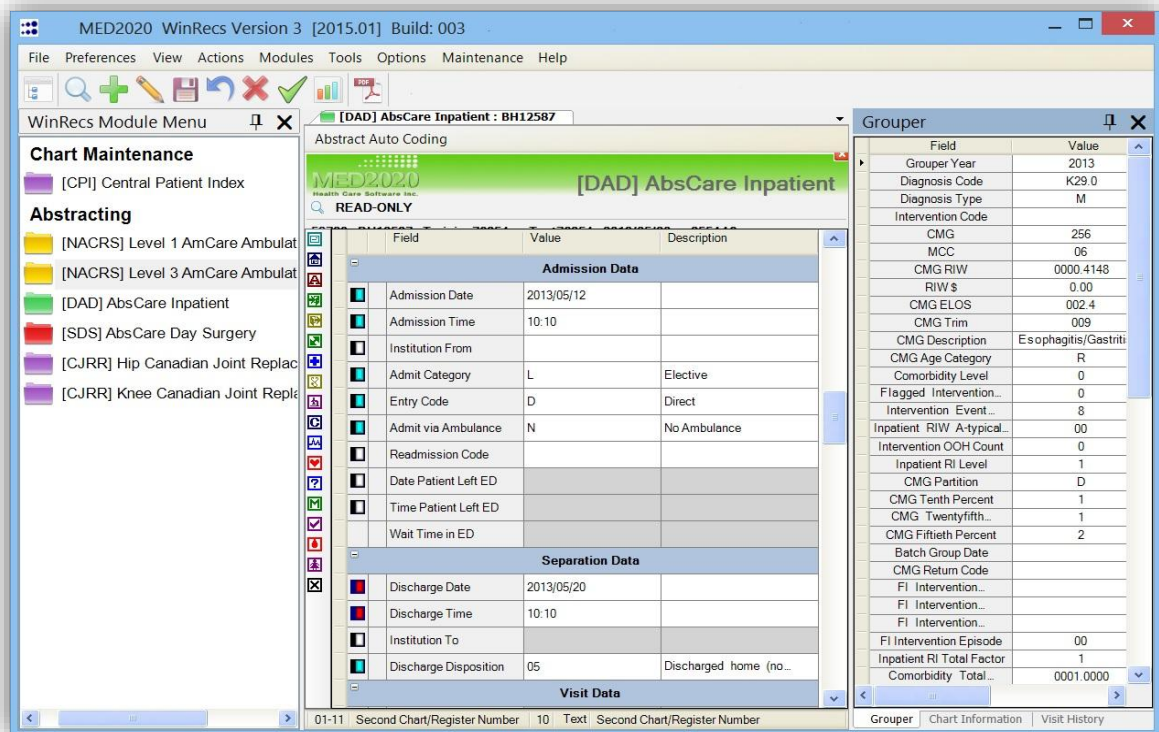


Figure 41 - Grid orientation after toggling the view to vertical

2. WinRecs Options Menu

The WinRecs Menu consists of the 5 features in the **Options Menu**: **Regional Profile**, **Hospital Profile**, **Institution Profile**, **User Profile**, and **Control File**.

2.1 Options Menu Use

The following will be the options that are the same for Regional Profile, Hospital Profile, Institution Profile & User Profile.

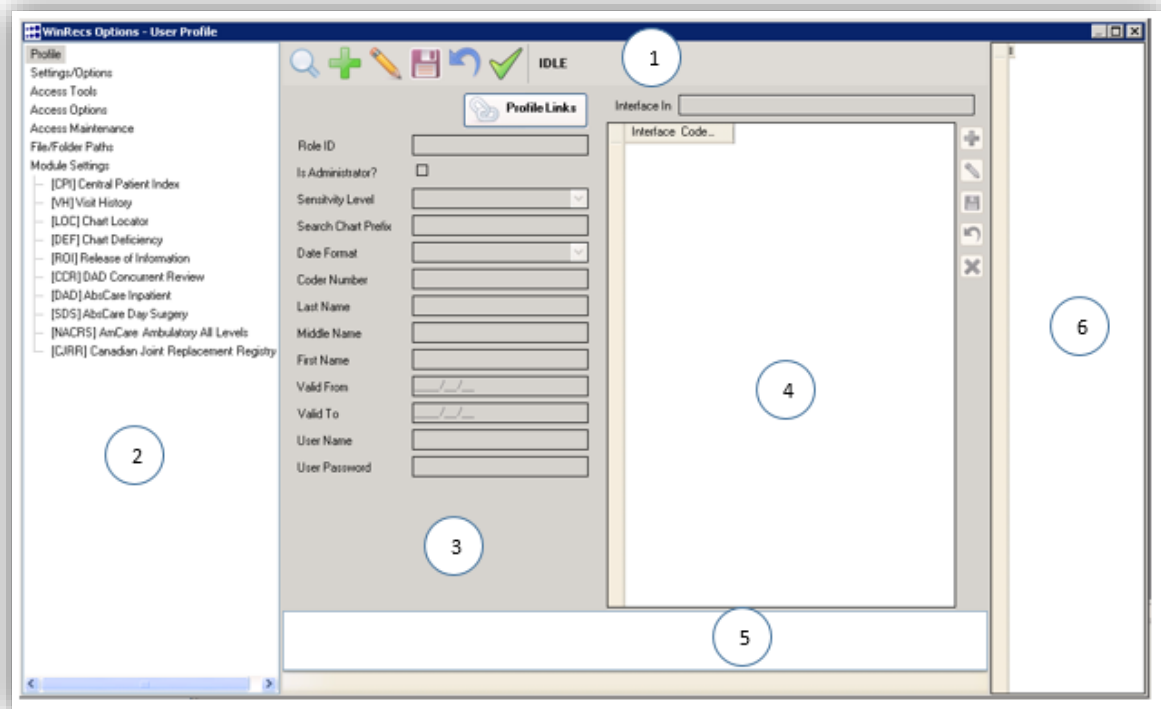


Figure 42 – Options Menu Layout

1. Tool bar

Icon	Description	Shortcut Keys
	Search for existing Institutions	[F4]
	Create a New Institution	[F5]
	Enables editing of the currently selected record.	[F6]
	Saves the current record if there are unsaved changes.	[F7]
	Undoes any changes and returns the record to the previous state since the last save.	[F8]
	Verifies the current record for any errors or warnings.	[F11]

Table 9 - User Profile Maintenance Toolbar

2. **Profile Options** - Clicking on any of these options gives the administrator the option to choose or not choose it.
3. **Field Panel** - Displays the field that can be modified for each of the options chosen.
4. **Interface Panel**- Provides the option to add the *Interface In* value for the **HL7** and **Batch Interface** fields.
5. **Mandatory Items** – The items that are mandatory will display
6. **Update History** – Displays the coder(s) who made changes in that field.

To edit the current record

- Click the  on the toolbar.
— or —
- Press [F6].

This will set the current record in edit mode, allowing the user to modify the values.

To save the current record

- Click the  on the toolbar.
— or —
- Press [F7].

This action will save the record and set it back to read only.

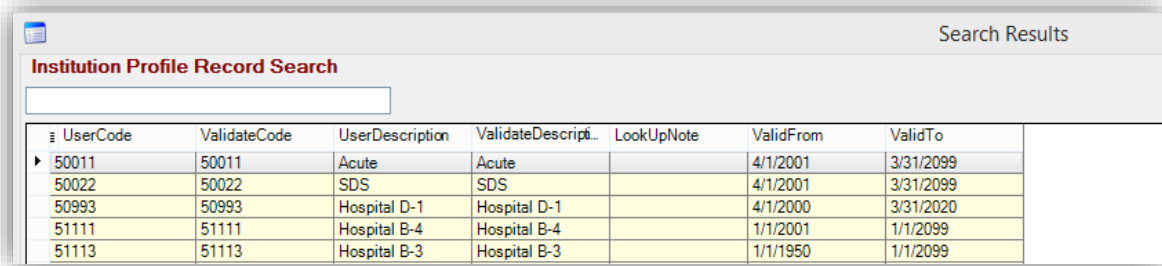
To undo the changes of the current record

- Click the  on the toolbar.
— or —
- Press **[F8]**.

This action returns all modified values to their last saved state.

To access an existing entry

- Click the  icon.
— or —
- Press **[F4]**
- Double click on the Entry the user would like to view



Institution Profile Record Search							Search Results
UserCode	ValidateCode	UserDescription	ValidateDescripti...	LookUpNote	ValidFrom	ValidTo	
50011	50011	Acute	Acute		4/1/2001	3/31/2099	
50022	50022	SDS	SDS		4/1/2001	3/31/2099	
50993	50993	Hospital D-1	Hospital D-1		4/1/2000	3/31/2020	
51111	51111	Hospital B-4	Hospital B-4		1/1/2001	1/1/2099	
51113	51113	Hospital B-3	Hospital B-3		1/1/1950	1/1/2099	

Figure 43 – Accessing an existing entry

To create a New Entry

- Click the  icon.
— or —
- Press **[F5]**

2.2 Regional Profile and Hospital Profile

Regional Profile

The **Regional Profile** is used to specify default values to be inherited by the individual **Hospital Profiles**.

If a field is configured in the **Regional Profile**, it will be inherited by the **Hospital Profile** if the corresponding fields in the **Hospital Profile** are blank. If the **Hospital Profile** field is populated it will override the **Regional Profile** settings. Administrators can use this feature to manage multiple hospitals that use the same WinRecs database.

If a Regional solution is not being used, then the **Hospital Profile** will be used.

Hospital Profile

The **Hospital Profile** is used to specify default values for hospitals. The Hospital Profile contains the same fields as the Regional Profile.

To access the Regional Profile

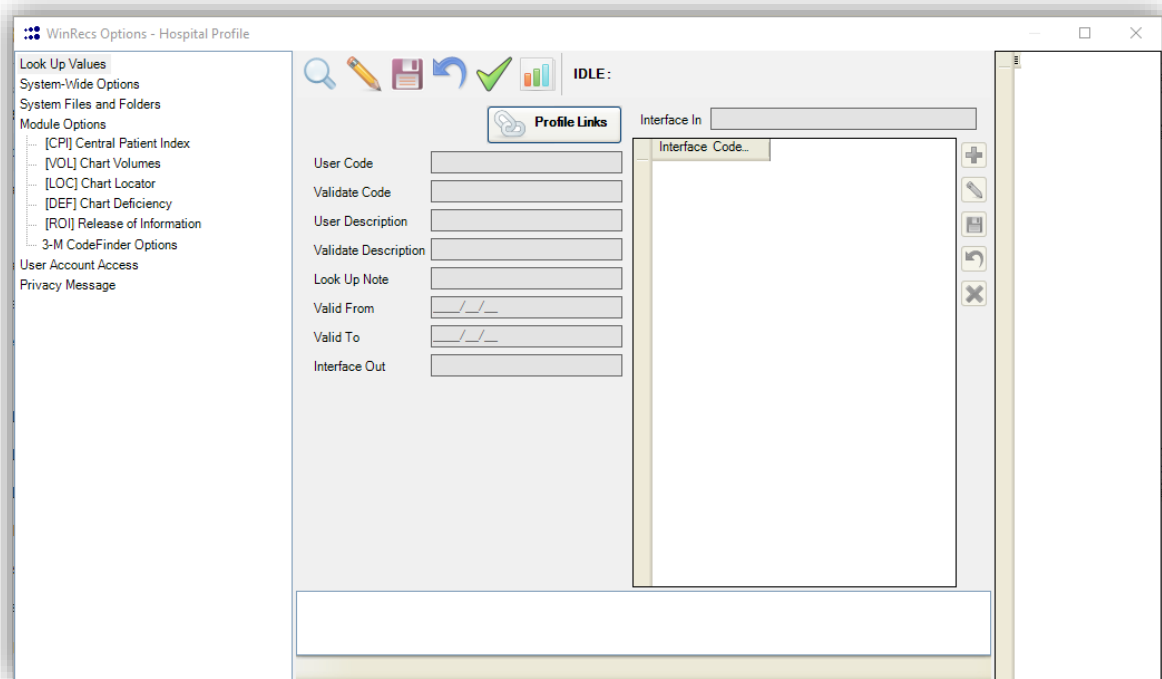
- Select **Options** → **Regional Profile**.

To access the Hospital Profile

- Select **Options** → **Hospital Profile**.

WinRecs Options Regional Profile & Hospital Profile

Look Up Values



The screenshot shows the 'WinRecs Options - Hospital Profile' window. On the left is a sidebar with a tree view containing 'Look Up Values', 'System-Wide Options', 'System Files and Folders', 'Module Options' (with sub-items like [CPI] Central Patient Index, [VOL] Chart Volumes, [LOC] Chart Locator, [DEF] Chart Deficiency, [ROI] Release of Information), '3-M CodeFinder Options', 'User Account Access', and 'Privacy Message'. The main area has a toolbar with icons for search, edit, save, undo, redo, and a status bar showing 'IDLE:'. Below the toolbar is a 'Profile Links' button. The main form contains several input fields: 'User Code', 'Validate Code', 'User Description', 'Validate Description', 'Look Up Note', 'Valid From' (with a date picker), 'Valid To' (with a date picker), and 'Interface Out'. To the right of these fields is a large text area labeled 'Interface Code...'. At the bottom of the main area is a large empty text box.

Figure 44 – Regional Profile/ Hospital Profile – Look Up Values Screen

- Profile Links (Hospital Profile only) – Gives the user the ability to link the hospital to a region if there is more than one region in the database.
- User Code – The code or number assigned to the Region or Hospital.
- Validate Code – This code will populate with the User Code (Once the record is saved this field cannot be changed)
- User Description – The description of the Region/Hospital (Once the record is saved this field cannot be changed)
- Validate Description – This will populate with the default description
- Look Up Note – Defines note text viewed when performing Look ups
- Valid From - The date the region/hospital is valid from
- Valid To – The date the region/hospital is valid to
- Interface Out – Value used as region/hospital in interface populating out of WinRecs, populates with User Code.
- Interface In – Value used as the region/hospital in Batch and HL7 Interfaces



- To add a value press

- Add the *Interface In* value

Interface In

- Press  to save the entry
-  to cancel the entry before saving
-  to delete the entry after it is saved
-  used to edit an existing value

System-Wide Options

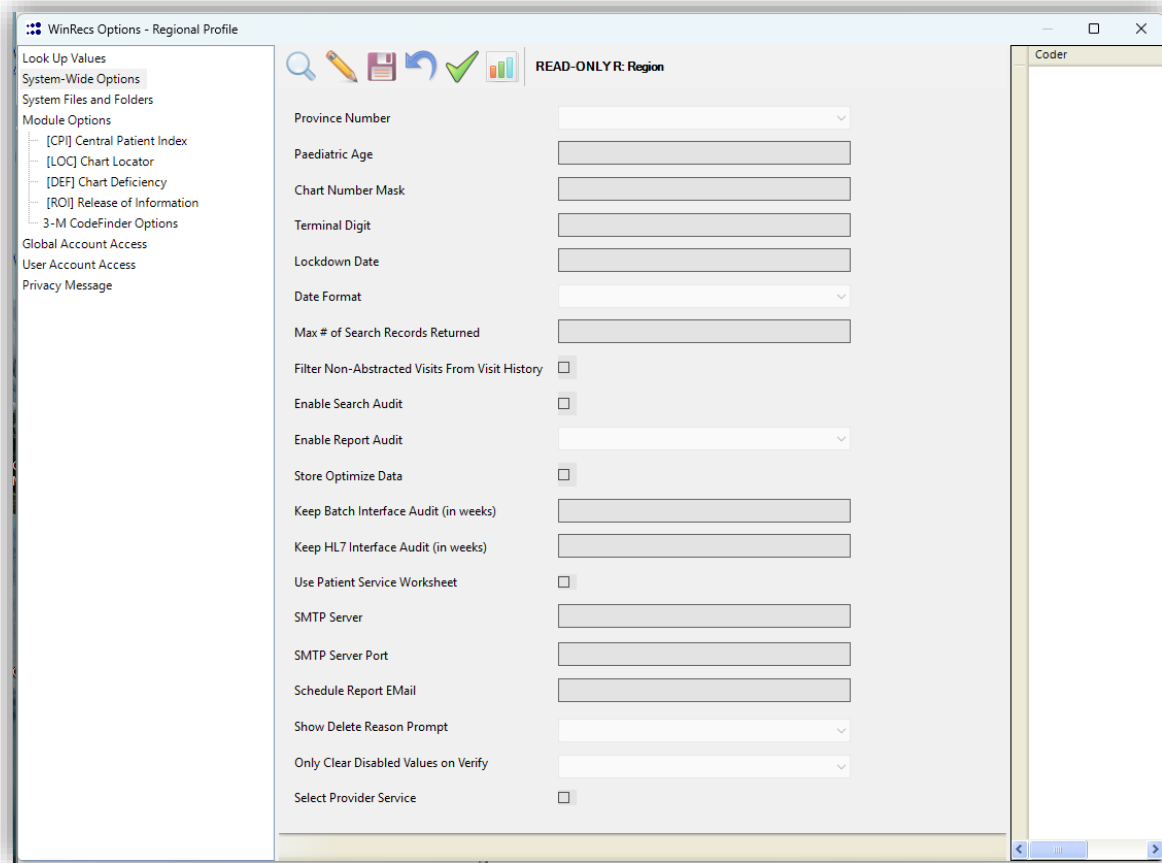
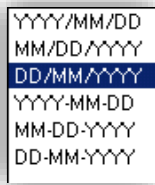


Figure 45 – Regional Profile/ Hospital Profile – System-Wide Option Screen

- Province Number – This is a drop-down list of the provinces, choose the province the region or hospital belongs to
- Paediatric Age - Defines the Paediatric Age for Pediatric Services. The value may be defined by the specific institution or specified province and must be manually entered. For example: '14' defines Paediatric Age as patients 14 years old and under.
- Chart Number Mask - Defines how to view chart numbers on the system - without the leading zeros, or with characters between the characters. Examples: ##### (10 X #) will view a chart number without any leading zeros unless '0' is part of the number. E.g. 309. #####00000, will view the chart number 00309. #####00-000 will view the chart number 00-309. #####000-00 will view the chart number 003-09.
- Terminal Digit – Used to re-arrange the chart number in order to produce report sorted in a way that leads to randomized distribution. If this field is configured, the value must be 10 digits long using all digits between 0 and 9. Each number represents the new position of the corresponding chart number. For example:

Chart Number	Terminal Digit Mask	Terminal Digit Value
0000123456	9012345678	5600001234

- Lockdown Date - Defines the date records will be locked down and accessible in a 'View' mode only. For example, once all corrections are made for fiscal 2015 a lock down date of 2016/04/01 the users will have read-only access to all data prior to this date (system mandatory).
- Date Format – The date format the hospital or region would like displayed in WinRecs. The following options are:



- Max # of Search Records to Return – Defines the maximum number of records to return in a search
- Filter Non-Abstracted Visits from Visit History – Checking this will filter all non-abstracted visits from the Visit History, unchecking will keep all visits
- Enable Search Audit – When checked a record of all searches plus all abstracts appearing in searches is stored in the database.
- Enable Report Audit – This is for the audit trail and has 3 levels:
 - N...None – Turn off Audit Report
 - B...who, what, when, where info of main and sub-reports – When a report is generated, the Audit Trail records the user running the report from WinRecs, records when the user logged on, when the report was run and the report path.
 - B.... Binary – (Basic plus binary image of main report)
- Store Optimize Data – When checked the optimized data will be stored on the database.
- Keep Batch Interface Audit (in weeks)– The date in weeks that Batch data will be kept anything after that date will be purged.
- Keep HL7 Interface Audit (in weeks)– The date in weeks that HL7 data will be kept anything after that date will be purged.
- Use Patient Service Worksheet – Enables the Transfer Worksheet in the [DAD] AbsCare Inpatient module
- SMTP Server – Enter the mail server address here
- SMTP Server Port – Enter the port if it is not a standard port
- Schedule Report EMail– The email that indicates where the email is coming from

- Show Delete Reason Prompt – The different options of displaying the prompt when deleting. The options are:

N: No, Delete Reason is not required
O: Yes, Delete Reason is optional
Y: Yes, Delete Reason is required

- Only Clear Disabled Values on Verify – The different options of when to clear disabled Values. The options are:

Always Clear Disabled Values
Only Clear Disabled Values on Full Verify (F11)
Only Clear Disabled Values on Save (F7)

- Select Provider Service – Checking this option will show all provider services if there are multiple provider services for a provider.
- Only Full Verify EMT Edits (Hospital Profile) – Checking this option will have EMT edits execute on Full Verify.

System Files and Folders

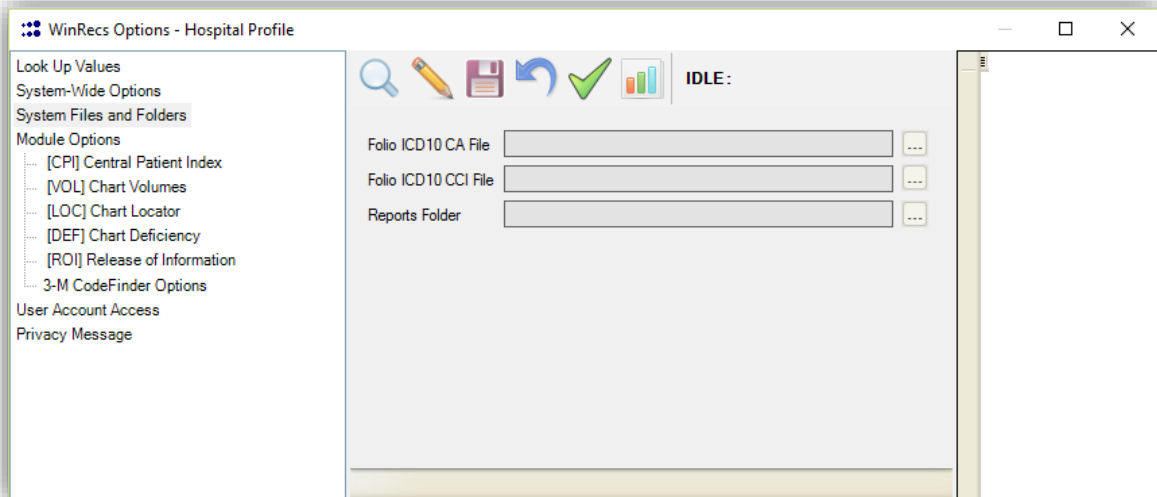


Figure 46– Regional Profile/ Hospital Profile – System Files and Folders

- Folio ICD 10 CA File – Pressing the  will bring up the browser folder to find the ICD-10-CA Folio file
- Folio ICD 10 CCI File – Pressing the  will bring up the browser folder to find the ICD-10-CCI Folio file

- Reports Folder – Pressing the  will bring up the browser folder to find the Folder Reports are kept.

Module Options

[CPI] Central Patient Index

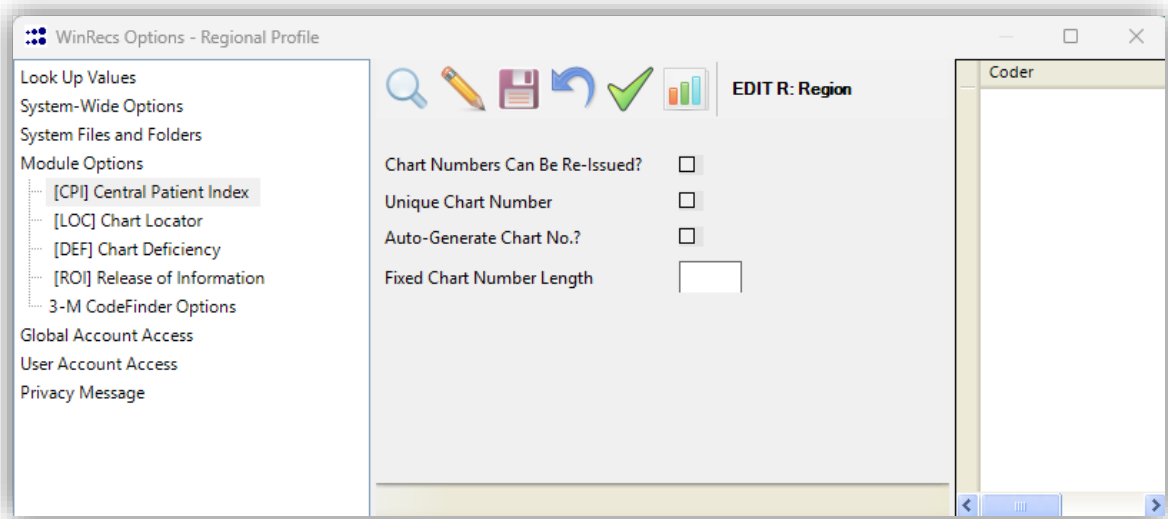


Figure 47 – Regional Profile/ Hospital Profile – Module Options/[CPI]Central Patient Index

- Chart Numbers Can Be Re-Issued? – Checking this will allow the Region or Hospital to re-issue chart numbers to be used again. Must be unchecked for the Un-Merge function to work.
- Unique Chart Number – Used for regional set up to display the unique number shared among the different hospitals.
- Auto-Generate Chart No.? – If checked WinRecs uses the Start with Chart Number field to assign new chart numbers.
- Fixed Chart Length – This field saves a zero filled version of the chart number to the database where the chart number is always the same length. The value is pulled from the CPI and is saved with the chart not the visit. Can be left blank.
- Start with Chart Number (Hospital Profile) – This defines the starting point for chart number assignment. The Start with Chart Number field will automatically increment as the number are used. For example, the value 123 is entered, the next patient chart created that does not have a record will be assigned chart number 124. If attempting to create a new chart number using a number other than the number outlined in the Start with Chart Number field, the program will try to assign the Start with Chart Number value. Going back to the Chart Number field in the **CPI** before proceeding will ensure the chart number value is the appropriate one.

[VOL] Chart Volumes (Hospital Profile)

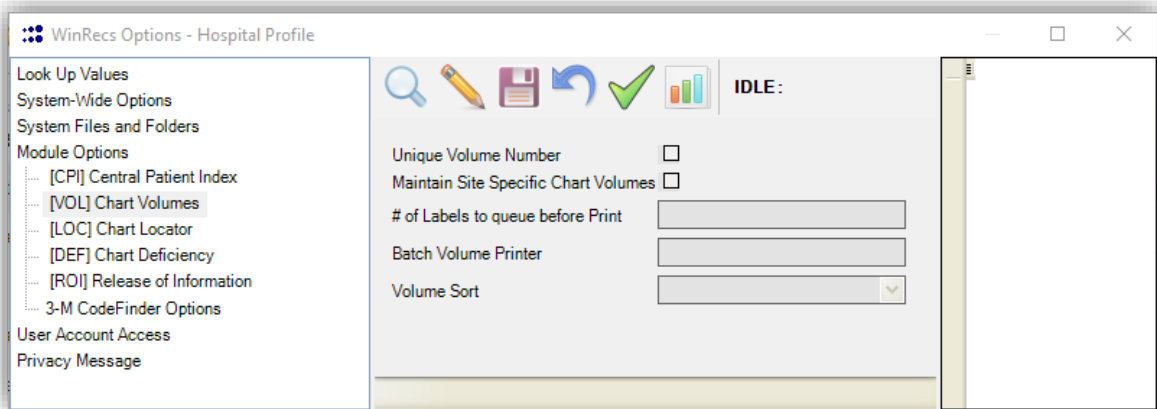
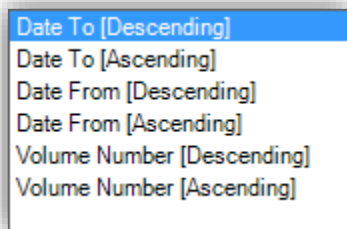
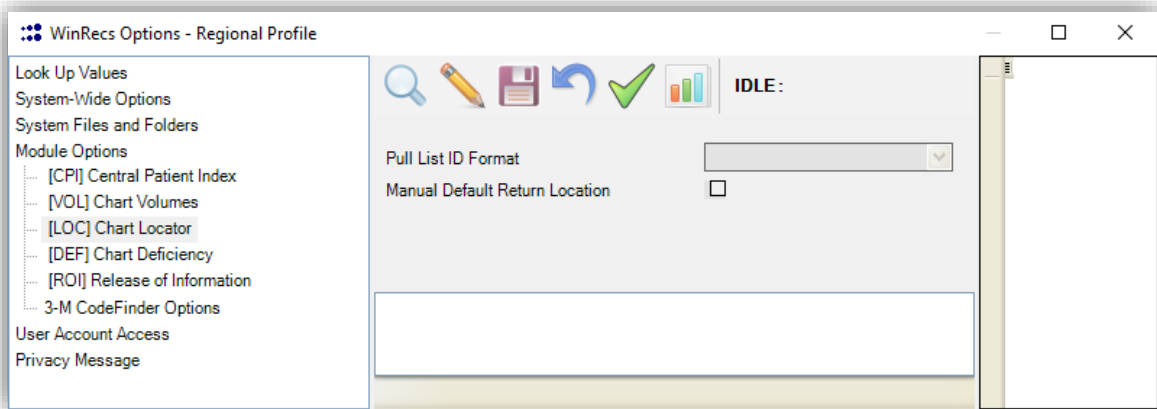


Figure 48 – Hospital Profile – Module Options/[VOL]Chart Volumes

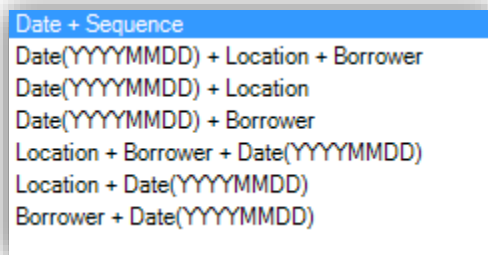
- Unique Volume Number – A check mark indicates that all volume numbers must be unique.
- Maintain Site Specific Chart Volumes – A check mark indicates that all chart volumes will be site specific.
- # of Labels to queue before Print – Users who interface chart volumes can define the number of labels to print.
- Batch Volume Printer – The path the labels are to print. For example:
\\medcorp2\SHARP_Copier
- Volume Sort – The ability to sort how the volumes appear in the Chart Volumes module:



[LOC] Chart Locator



- Pull List ID Format - Gives the site ability to sort the Pull List by:



- Manual Default Return Location - When the box is checked and the Transaction Type is 'R', users are prompted to select the Return Location and more than one chart can be returned to that location. When the box is unchecked, when the Transaction Type is 'R', it must be entered for each chart being returned.

[DEF] Chart Deficiency

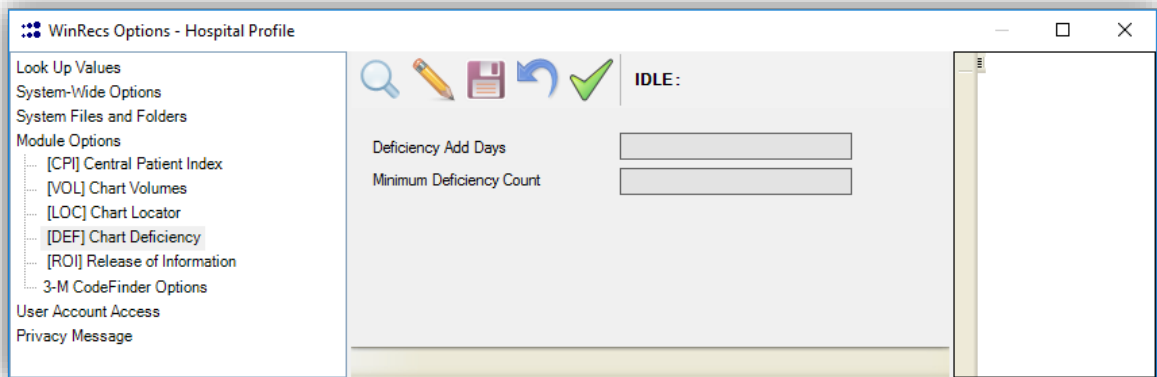
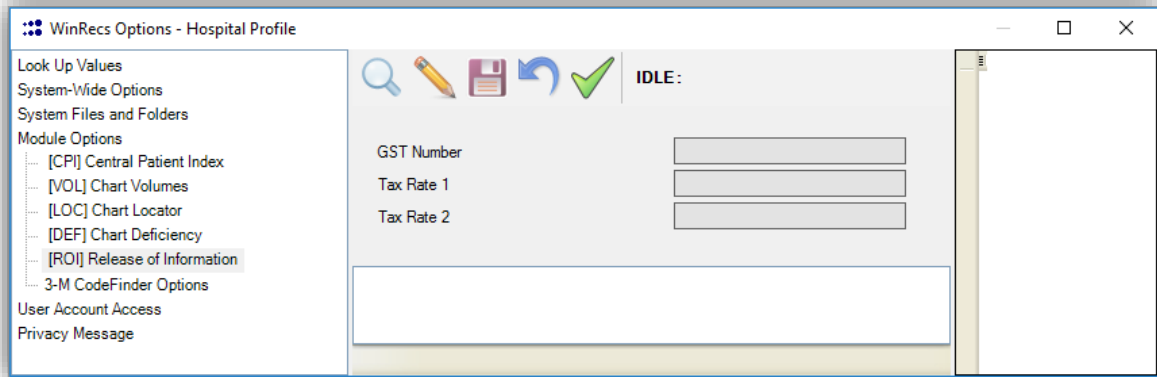


Figure 49 – Regional Profile/ Hospital Profile – Module Options/ [DEF]Chart Deficiency

- Deficiency Add Days – This indicates when to start counting the day that the chart is deficient. If the user does not want to count the day the deficiency is put in the Provider's chart completion area, enter "1" in this field and the count will begin one day after the deficiency is entered.
- Minimum Deficiency Count – The minimum number of deficiencies for a letter to be generated.

[ROI] Release of Information (See ROI documentation)



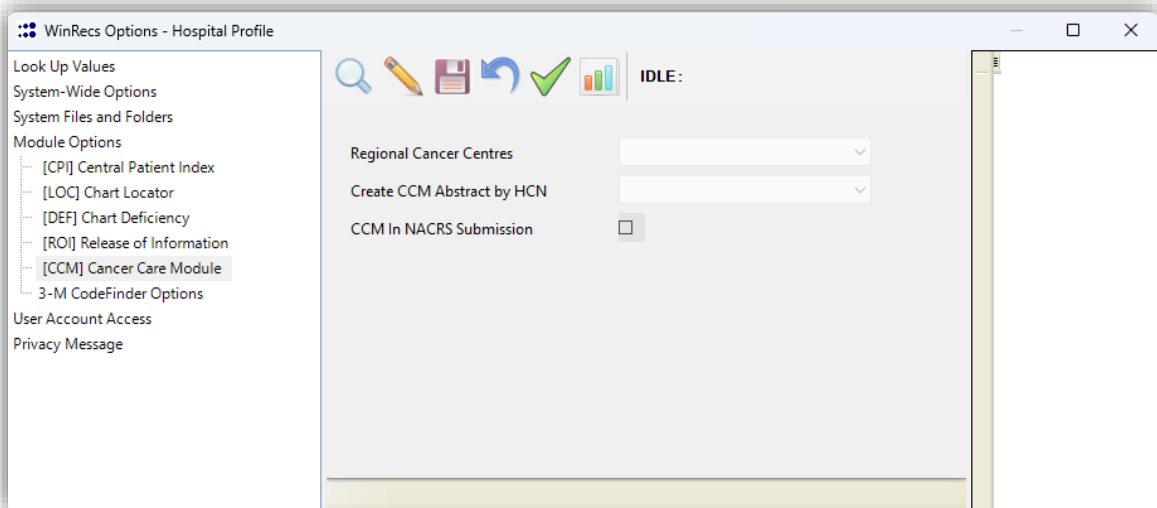
The screenshot shows the 'WinRecs Options - Hospital Profile' window. The left sidebar lists various options, with '[ROI] Release of Information' selected. The main area contains the following fields:

- Look Up Values:** Search, Edit, Save, Undo, and Confirm icons.
- System-Wide Options:** None listed.
- System Files and Folders:** None listed.
- Module Options:**
 - [CPI] Central Patient Index
 - [VOL] Chart Volumes
 - [LOC] Chart Locator
 - [DEF] Chart Deficiency
 - [ROI] Release of Information**
 - 3-M CodeFinder Options
 - User Account Access
 - Privacy Message
- Fields:**
 - GST Number: [Text Box]
 - Tax Rate 1: [Text Box]
 - Tax Rate 2: [Text Box]
 - [Empty Text Box]
- IDLE:** [Empty Text Box]

Figure 50 – Regional Profile/ Hospital Profile – Module Options/ [ROI] Release of Information

- GST Number – This number is used for billing purposes in the ROI module.
- Tax Rate 1 – Used to enter the GST or PST for the ROI module
- Tax Rate 2 – Used to enter the GST or PST for the ROI module

[CCM] Cancer Care Modules (Hospital Profile)



The screenshot shows the 'WinRecs Options - Hospital Profile' window. The left sidebar lists various options, with '[CCM] Cancer Care Module' selected. The main area contains the following fields:

- Look Up Values:** Search, Edit, Save, Undo, Confirm, and Bar Chart icons.
- System-Wide Options:** None listed.
- System Files and Folders:** None listed.
- Module Options:**
 - [CPI] Central Patient Index
 - [LOC] Chart Locator
 - [DEF] Chart Deficiency
 - [ROI] Release of Information
 - [CCM] Cancer Care Module**
 - 3-M CodeFinder Options
 - User Account Access
 - Privacy Message
- Fields:**
 - Regional Cancer Centres: [Dropdown Menu]
 - Create CCM Abstract by HCN: [Dropdown Menu]
 - CCM In NACRS Submission: ☐
- IDLE:** [Empty Text Box]

Figure 51 – Hospital Profile – Module Options/ [CCM] Cancer Care Module

- Regional Cancer Centres – Select 'Y' or 'N' if facility is a Regional Cancer Center.
- Create CCM Abstract by HCN – Select 'Y' or 'N' if hospital wants to create CCM abstract by HCN.

- CCM in NACRS Submission – A checkmark will activate CCM mandatory status for 'CCM HP Number' and "CCM Program Code" in NACRS. No checkmark, these two fields will not be mandatory.

3-M CodeFinder Options – used to configure 3M Bridge – Contact MED2020 for further instructions.

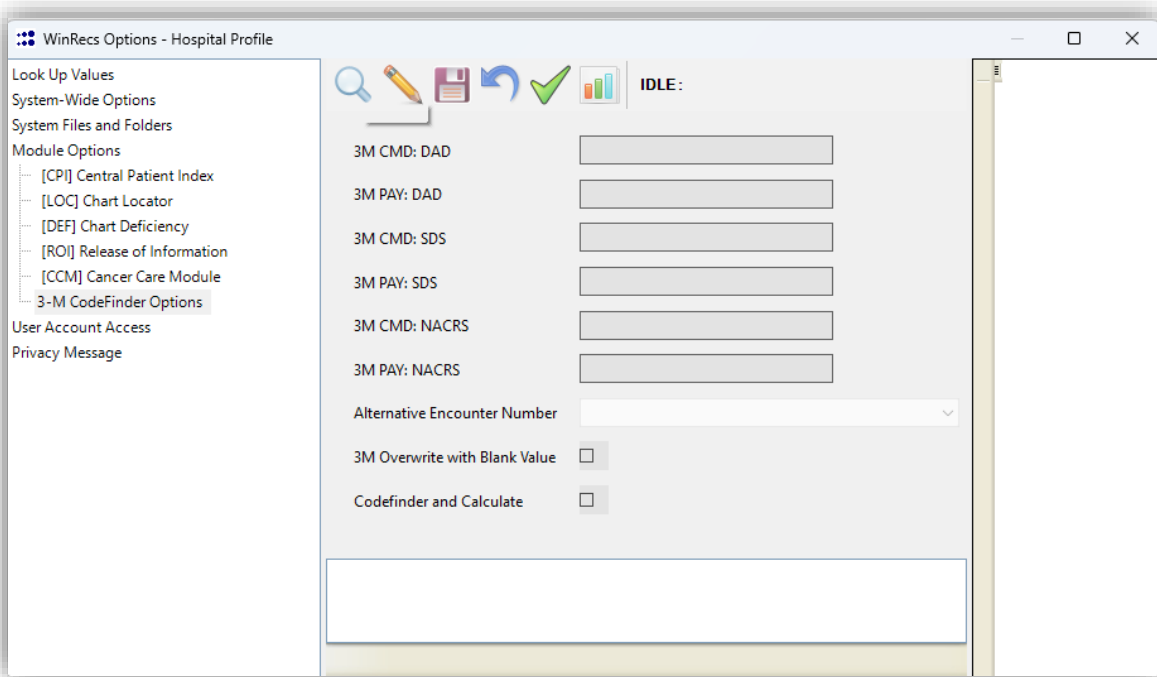
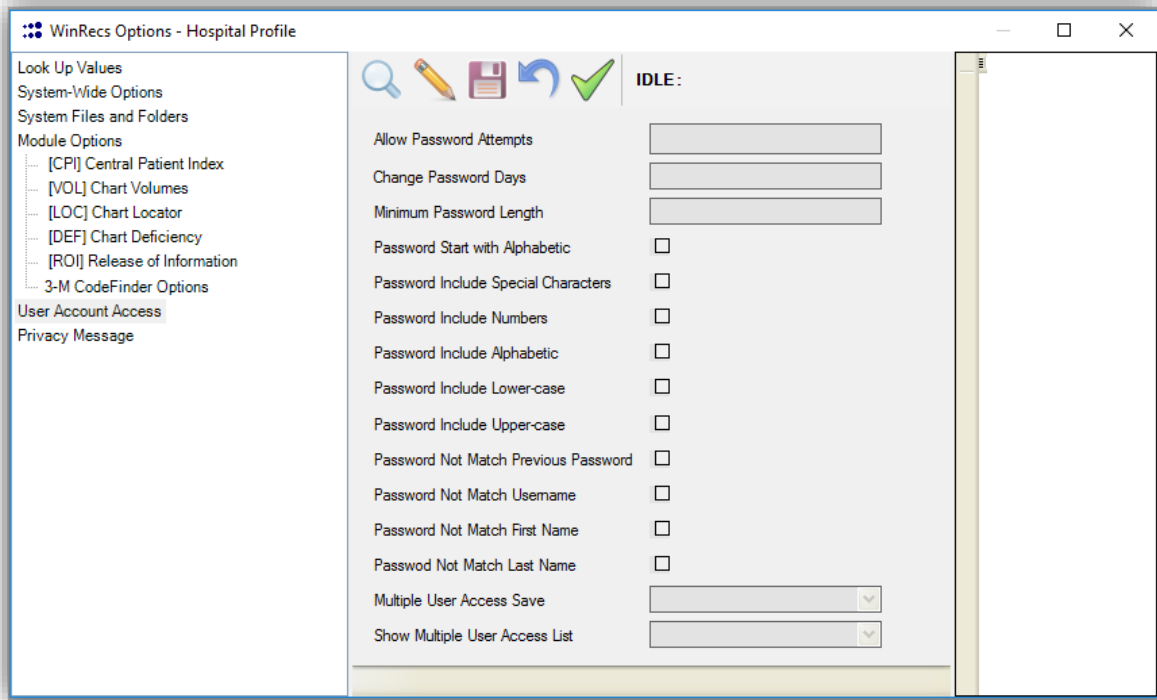


Figure 52 – Regional Profile/ Hospital Profile – Module Options/ 3-M CodeFinder Options

- 3M CMD: DAD – Used to configure 3M Bridge – Contact MED2020 regarding this field
- 3M PAY: DAD – Used to configure 3M Bridge – Contact MED2020 regarding this field
- 3M CMD: SDS – Used to configure 3M Bridge – Contact MED2020 regarding this field
- 3M PAY: SDS – Used to configure 3M Bridge – Contact MED2020 regarding this field
- 3M CMD: NACRS – Used to configure 3M Bridge – Contact MED2020 regarding this field
- 3M PAY: NACRS – Used to configure 3M Bridge – Contact MED2020 regarding this field
- Alternative Encounter Number – The ability to use alternative values in place of the encounter number when passing values via 3M. – Contact MED2020 regarding this field
- 3M Overwrite with Blank Value – If checked 3M will overwrite fields where the values is blank in 3M with a blank value. – Contact MED2020 regarding this field
- Codefinder and Calculate – If checked the WinRecs 3M bridge will add tag 'SYS:1'. Not checked with tag with 'SYS:0' – Contact MED2020 regarding this field

Global Account Access (Regional Profile)



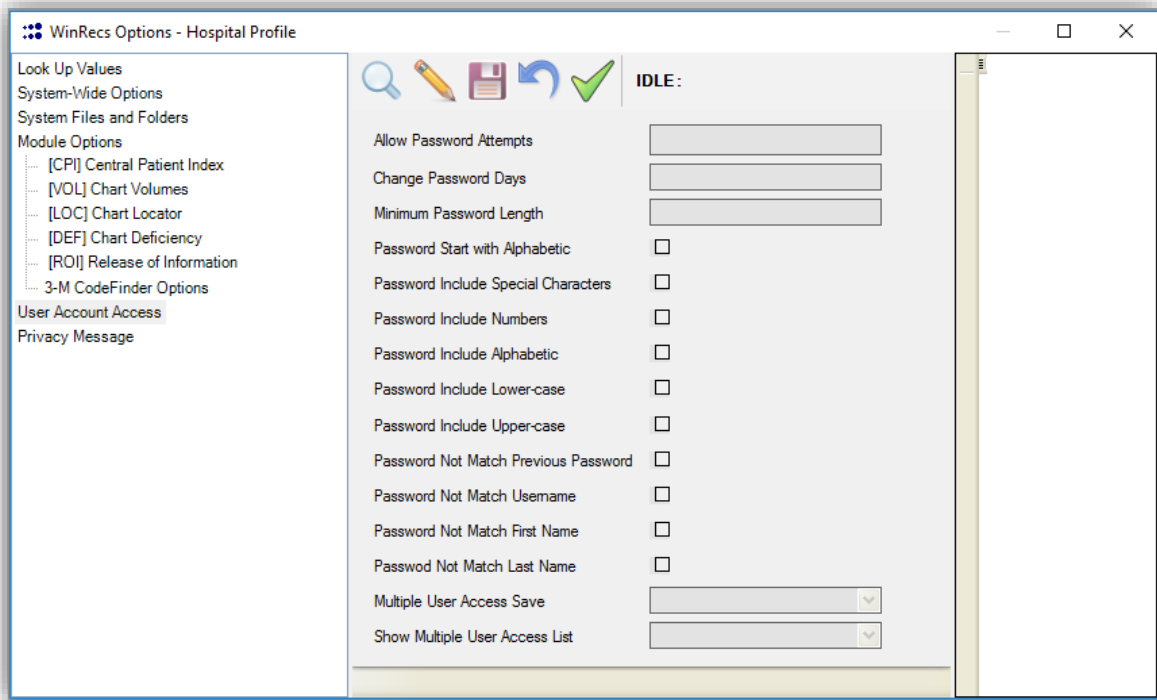
The screenshot shows the 'WinRecs Options - Hospital Profile' window. The left sidebar contains a tree view with the following items: Look Up Values, System-Wide Options, System Files and Folders, Module Options, [CPI] Central Patient Index, [VOL] Chart Volumes, [LOC] Chart Locator, [DEF] Chart Deficiency, [ROI] Release of Information, 3-M CodeFinder Options, User Account Access (selected), and Privacy Message. The main area displays the 'User Account Access' settings. It includes a toolbar with icons for search, edit, save, undo, and redo. Below the toolbar, there are several settings: 'Allow Password Attempts' (text box), 'Change Password Days' (text box), 'Minimum Password Length' (text box), 'Password Start with Alphabetic' (checkbox), 'Password Include Special Characters' (checkbox), 'Password Include Numbers' (checkbox), 'Password Include Alphabetic' (checkbox), 'Password Include Lower-case' (checkbox), 'Password Include Upper-case' (checkbox), 'Password Not Match Previous Password' (checkbox), 'Password Not Match Username' (checkbox), 'Password Not Match First Name' (checkbox), 'Password Not Match Last Name' (checkbox), 'Multiple User Access Save' (dropdown menu), and 'Show Multiple User Access List' (dropdown menu). An 'IDLE:' label is visible on the right side of the main area.

Figure 53 – Regional Profile – Module Options/ Global Account Access

- Allow Password Attempts – Enter the number of times a user can attempt to log in to WinRecs
- Change Password Days – Enter the number of days till a user must change a password
- Minimum Password Length – Enter a number for the minimum length the password must be.
- Password Start with Alphabetic – If checked the password must start with a letter
- Password Include Special Characters – If checked the password must include special characters
- Password Include Numbers – If checked the password must include numbers
- Password Include Alphabetic – If checked the password must include letters
- Password Include Lower-case – If checked the password must include lower case letters
- Password Include Upper-case – If checked the password must include upper case letters
- Password Not Match Previous Password – If checked the password must not match the previous password

- Password Not Match Username – If checked the password must not match the WinRecs *Username* field
- Password Not Match First Name - If checked the password must not match the *First Name* field
- Password Not Match Last Name – If checked the password must not match the *Last Name* field
- Multiple User Access Save – **Yes** - will allow a user to save a record already accessed by another user. **No** – able to open the record access by another user but unable to save, the chart will be Read-Only.
- Show Multiple User Access List – **Yes** - will allow a user to see the list of users accessing the record, **No** – user will not see the list of users accessing the record.

User Account Access



The screenshot shows the 'WinRecs Options - Hospital Profile' window. The left sidebar contains a tree view with the following items: Look Up Values, System-Wide Options, System Files and Folders, Module Options, [CPI] Central Patient Index, [VOL] Chart Volumes, [LOC] Chart Locator, [DEF] Chart Deficiency, [ROI] Release of Information, 3-M CodeFinder Options, User Account Access (selected), and Privacy Message. The main area is titled 'IDLE:' and contains the following settings:

- Allow Password Attempts: [Text Box]
- Change Password Days: [Text Box]
- Minimum Password Length: [Text Box]
- Password Start with Alphabetic: ☐
- Password Include Special Characters: ☐
- Password Include Numbers: ☐
- Password Include Alphabetic: ☐
- Password Include Lower-case: ☐
- Password Include Upper-case: ☐
- Password Not Match Previous Password: ☐
- Password Not Match Username: ☐
- Password Not Match First Name: ☐
- Password Not Match Last Name: ☐
- Multiple User Access Save: [Dropdown Menu]
- Show Multiple User Access List: [Dropdown Menu]

Figure 54 – Regional Profile/ Hospital Profile – Module Options/ User Account Access

- Allow Password Attempts – Enter the number of times a user can attempt to log in to WinRecs
- Change Password Days – Enter the number of days till a user must change a password
- Minimum Password Length – Enter a number for the minimum length the password must be.
- Password Start with Alphabetic – If checked the password must start with a letter
- Password Include Special Characters – If checked the password must include special characters
- Password Include Numbers – If checked the password must include numbers
- Password Include Alphabetic – If checked the password must include letters
- Password Include Lower-case – If checked the password must include lower case letters
- Password Include Upper-case – If checked the password must include upper case letters
- Password Not Match Previous Password – If checked the password must not match the previous password

- Password Not Match Username – If checked the password must not match the WinRecs *Username* field
- Password Not Match First Name - If checked the password must not match the *First Name* field
- Password Not Match Last Name – If checked the password must not match the *Last Name* field
- Multiple User Access Save – **Yes** - will allow a user to save a record already accessed by another user. **No** – able to open the record access by another user but unable to save, the chart will be Read-Only.
- Show Multiple User Access List – **Yes** - will allow a user to see the list of users accessing the record, **No** – user will not see the list of users accessing the record.

Privacy Message

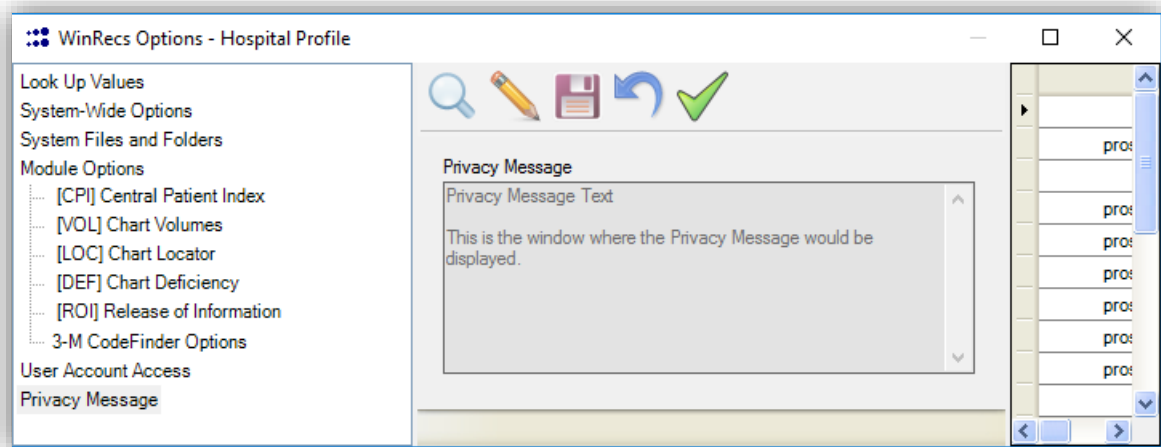


Figure 55 – Regional Profile/ Hospital Profile – Privacy Message

- Privacy Message - Enter text to be displayed or leave blank so no message is displayed

- Press the Edit  or **[F6]** and type in message

- Press the Save  or **[F7]** to save

- Press the Undo  or **[F8]** to undo any changes made since last saved.

2.3 Institution Profile

The Institution Profile is where institution specific information is entered. More than one institution profile can be defined per hospital profile.

To access the Institution Profile

- Select **Options** → **Institution Profile**.

WinRecs Options - Institution Profile

Look Up

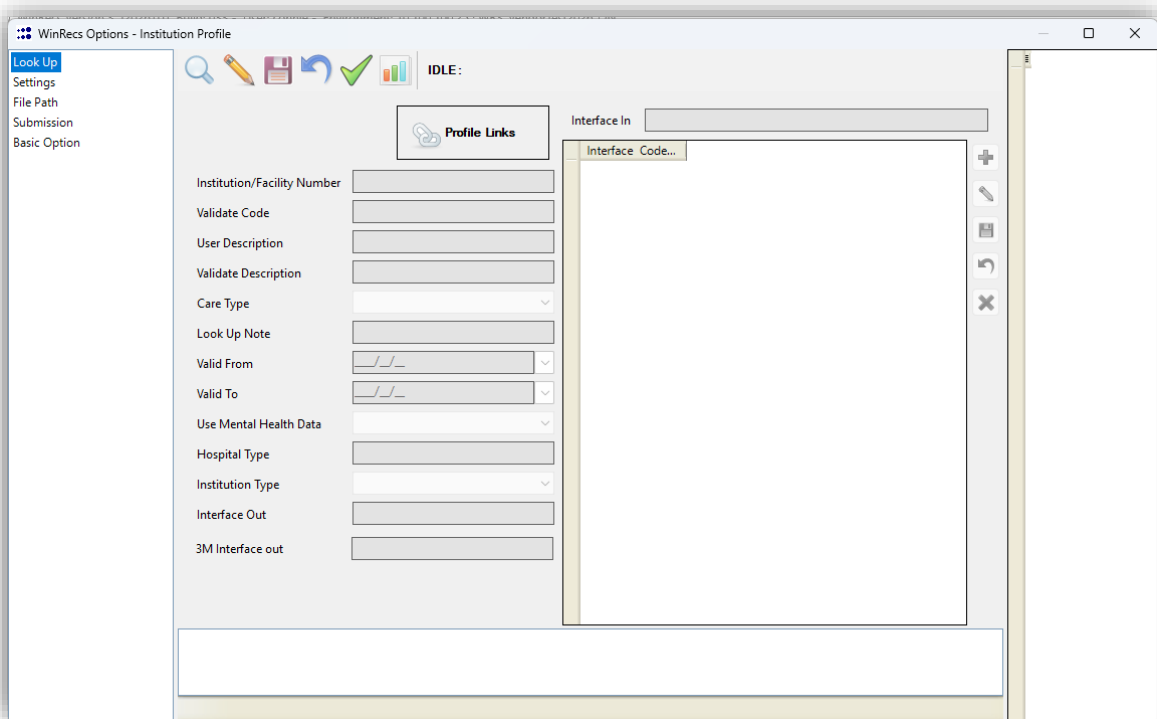
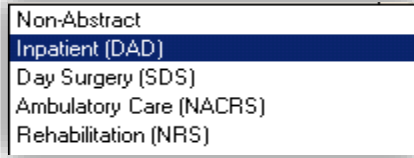
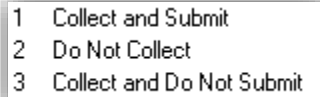


Figure 56 – Institution Profile– Look Up Screen

- **Profile Links**– The ability to link an institution to a region if there is more than one region in the database or to a specific hospital if there is more than one hospital
- **Institution/Facility Number** – The Institution number
- **Validate Code** – This number populates from the Institution/Facility Number (cannot change after saved)
- **User Description** –The description of the Institution
- **Validate Description** – Populates from the *User Description* (cannot change after saved)
- **Care Type** – Describes the type of Institution the facility is:



- Look Up Note – Defines note used in **[F2]** lookup
- Valid From – The date the Institution is valid from
- Valid To - The date the Institution is valid to
- Uses Mental Health Data – Determines at what level the Institution is collecting Mental Health Data:



- Hospital Type – The type of Hospital
- Institution Type – The type of Institution
- Interface Out – Value used as region/hospital in interface populating out of WinRecs, populates with User Code.

3M Interface Out – When populated this value will be sent to the bridge in the export file instead of the validate code.

- *Interface In* – Value used as the region/hospital in Batch and HL7 Interfaces



- To add a value press

- Add the *Interface In* value

Interface In



- Press to save the entry



- to cancel the entry before saving

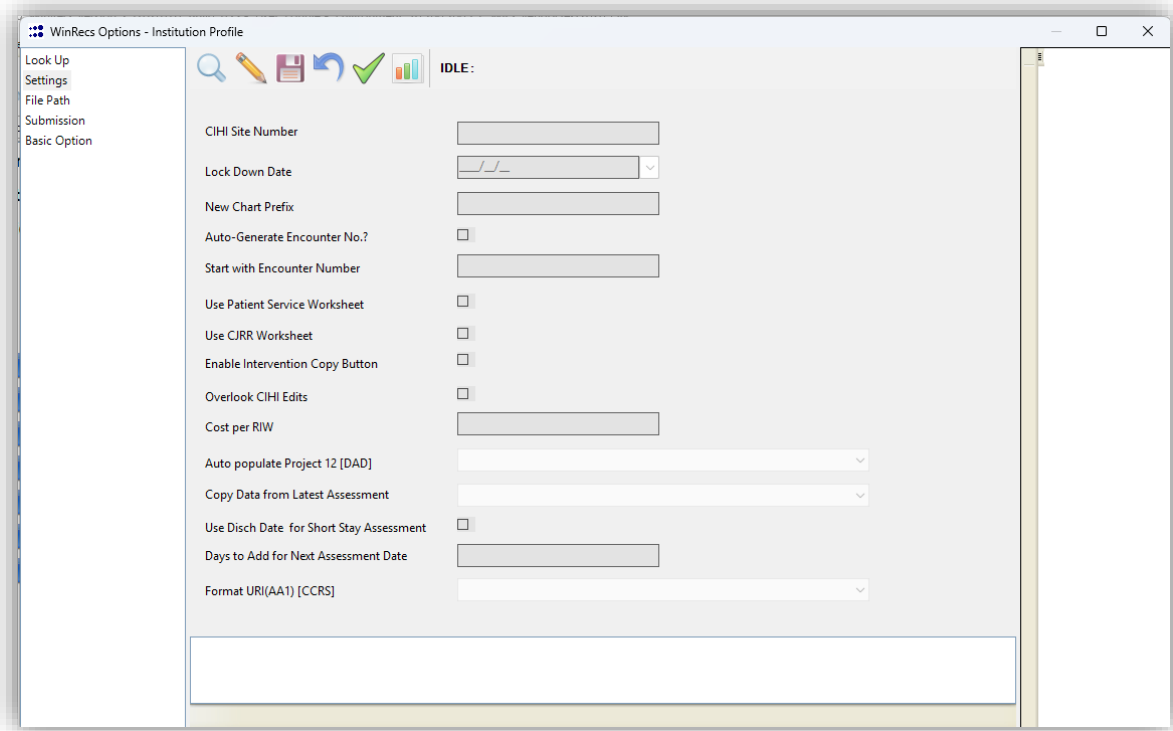


- to delete the entry after it is saved



- used to edit an existing value

Settings



The screenshot shows the 'WinRecs Options - Institution Profile' window. On the left is a sidebar with a tree view containing 'Look Up', 'Settings', 'File Path', 'Submission', and 'Basic Option'. The 'Settings' option is selected. The main area displays various configuration fields for an institution profile. At the top right of the main area is a status bar that says 'IDLE:'. The fields include:

- CIHI Site Number: A text input field.
- Lock Down Date: A date picker showing '11/11'.
- New Chart Prefix: A text input field.
- Auto-Generate Encounter No?: A checkbox, currently unchecked.
- Start with Encounter Number: A text input field.
- Use Patient Service Worksheet: A checkbox, currently unchecked.
- Use CJRR Worksheet: A checkbox, currently unchecked.
- Enable Intervention Copy Button: A checkbox, currently unchecked.
- Overlook CIHI Edits: A checkbox, currently unchecked.
- Cost per RIW: A text input field.
- Auto populate Project 12 [DAD]: A dropdown menu.
- Copy Data from Latest Assessment: A dropdown menu.
- Use Disch Date for Short Stay Assessment: A checkbox, currently unchecked.
- Days to Add for Next Assessment Date: A text input field.
- Format URI(AA1) [CCRS]: A dropdown menu.

At the bottom of the main area is a large, empty rectangular box.

Figure 57 – Institution Profile– Settings Screen

- CIHI Site Number – distinguishes multiple sites of the same care type within a facility
- Lock Down Date – Defines the date records will be locked down and accessible in a 'View' mode only. For example, once all corrections are made for fiscal 2015 a lock down date of 2015/04/01 to have read-only access to all data prior to this date (system mandatory as shown on bottom of page). **Please note: If you enter the date in Institution Profile it will override the Lock Down Date in the Hospital and/or Regional Profile.**
- New Chart Prefix – Defines the alpha prefix used when creating a new chart. It can be used to limit user access as defined in User Profile.
- Auto-Generate Encounter No? – Checking this box will have WinRecs automatically generate encounter numbers.
- Start with Encounter Number – The starting number for the 'Auto-Generate Encounter No?' field and WinRecs will automatically increment as the numbers are used. **If you try to create a new Encounter Number other than what is outlined in the 'Start with Encounter Number' field, WinRecs will still try to assign the value.**
- Use Patient Service Worksheet – Enables the Transfer Worksheet in the [DAD] AbsCare Inpatient module.

- Use CJRR Worksheet – Enables the CJRR worksheet in order to capture CJRR records in the Institution chosen (DAD or NACRS)
- Enable Intervention Copy Button – Enables the Intervention Copy button found in the Intervention multiform in AbsCare Inpatient and NACRS modules.
- Overlook CIHI Edits – Checking this box will allow the Institution to overlook the CIHI edits when abstracting. Please contact CIHI if using this option.
- Costs per RIW – The institution's cost per resources intensity weight.
- Auto populate Project 12[DAD] – Three different options to populate encounter number in Project 12 for DAD. The options are:

N: No
 U: Auto populate Project 012 and update from Encounter Number
 Y: Auto populate Project 012 Once from Encounter Number

- Copy Data from Latest Assessment – Three different options to populate data from the previous assessment for clinical modules. The options are:

No
 Yes, for assessments created by a User or Interface
 Yes, only for assessments created by a User

- Use Disch Date for Short Stay Assessment – Checking this box will populate the Discharge Date for OMHRS Short Stay Assessments instead of the Assessment Reference Date.
- Days to Add for Next Assessment Date – Enter the number of days the next assessment is to be completed for IRRS.
- Format URI (AA1) [CCRS] –.

File Path

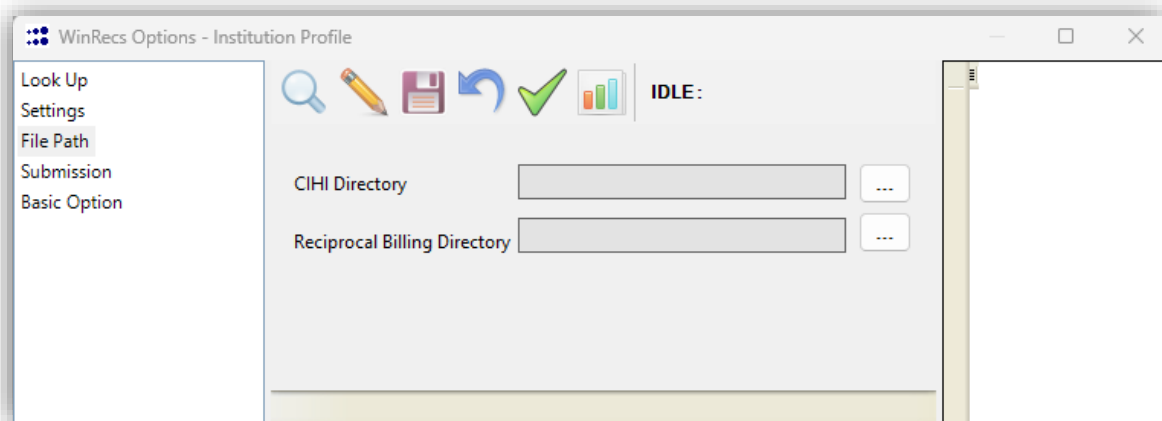
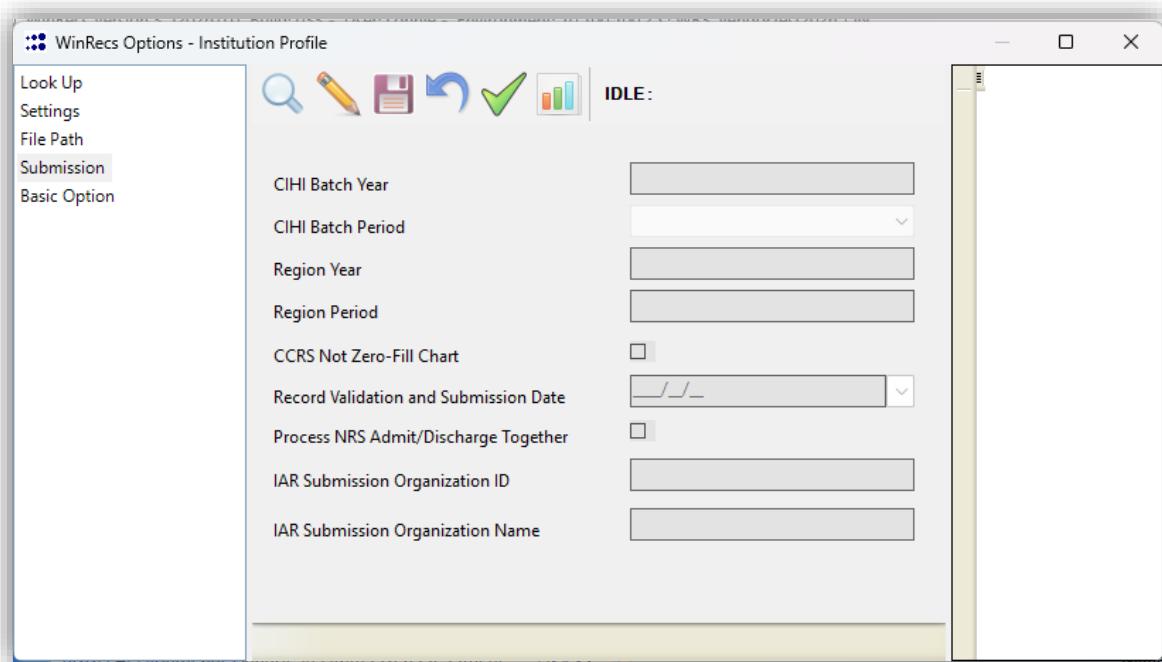


Figure 58 - Institution Profile – File Path

- CIHI Directory – Defines the path for the CIHI Submission and CIHI Correction files.
Press the  and then select the path where the submission files are stored. Select the folder and click OK. If this is left blank, the files and folders will default to the C:WR3 on the PC the user is on when running the files.
- Reciprocal Billing Directory – Defines the path for the Reciprocal Billing Submission files. Press the  and then select the path where the submission files are stored. Select the folder and click OK. If this is left blank, the files and folders will default to the C:WR3 on the PC the user is on when running the files.

Submission



The screenshot shows the 'WinRecs Options - Institution Profile' window with the 'Submission' tab selected. The left sidebar contains a list of options: Look Up, Settings, File Path, Submission (highlighted), and Basic Option. The main area displays various submission settings:

- CIHI Batch Year: Text input field
- CIHI Batch Period: Dropdown menu
- Region Year: Text input field
- Region Period: Text input field
- CCRS Not Zero-Fill Chart: Checkmark box (unchecked)
- Record Validation and Submission Date: Date picker (MM/YY)
- Process NRS Admit/Discharge Together: Checkmark box (unchecked)
- IAR Submission Organization ID: Text input field
- IAR Submission Organization Name: Text input field

At the top right of the main area, there is a status indicator 'IDLE:' and a set of icons including a magnifying glass, a pencil, a floppy disk, a circular arrow, a checkmark, and a bar chart.

Figure 59 – Institution Profile – Submission Screen

- CIHI Batch Year – Can enter the current Batch Year for the institution
- CIHI Batch Period – Can enter the current Batch Period for the institution
- Region Year – Can enter the current Batch Year for the Region (if using)
- Region Period – Can enter the current Batch Period for the Region (if using)
- CCRS Not Zero-Filled Chart –
- Record Validation and Submission Date – Date for that OMHRS and NRS assessments will be validated and submitted.

- Process NRS Admit/Discharge Together – A checkmark will send NRS Admit and Discharge Assessments together.
- IAR Submission Organization ID – The Organization ID that will be used in submission file for IAR.
- IAR Submission Organization Name – The Organization Name that will be used in submission file for IAR.

Basic Options

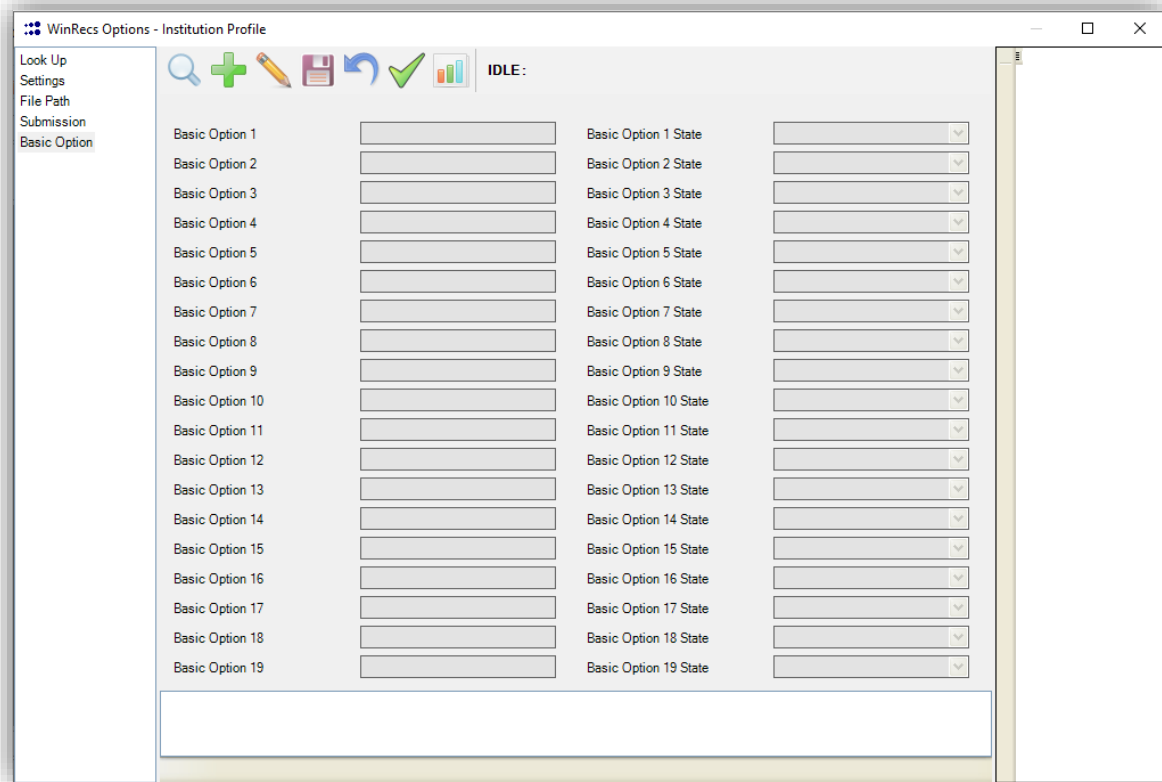


Figure 60 – Institution Profile – Submission Screen

Entering a Basic Option:

1. Press the  or **[F4]** and select the institution from the Institution look up
 2. Press the  or **[F6]** to edit the Institution
 3. Press the Basic Option tab on the left-hand side
- Basic Option 1 – 19 – Enter the name of the Basic Option in the desired Basic Option
 - Basic Option (1-19) State – Click on Drop Down Menu to choose the State

C	CIHI Mandatory
D	Disabled
E	Enabled
HE	Hospital Error
HR	Hospital Required
HW	Hospital Warning

- CIHI Mandatory – Choose this if the Basic Option is mandated by CIHI and needs to be submitted
- Disabled – **Choose this option to no longer collect the Basic Option**
- Enabled – Choose this option to collect the Basic Option with no errors or warnings
- Hospital Error – Choose this option to display an error if it is left blank
- Hospital Required – Choose this option to not be able to save a record if it is left blank
- Hospital Warning – Choose this option to display a warning if it is left blank

Basic Option Look Up Values

1. To add look up values for Basic Options go to **Maintenance/ Look Up Code Maintenance**
2. On the left hand side go to Abstracting and choose the module the Basic Option is in
3. Click on the Basic Option Box (1-19) – choose the corresponding number you entered in Institution Profile.



- Press  or **[F5]** to create a new entry.
- Institution Number – will link to the Inst number the Basic option is located
- User Display Code – the display code to be displayed in the abstract
- Validation Code – will automatically populate the User Display Code, cannot change after saved
- User Description – the description of the display code
- Default Description – will default the user description, cannot change after saved
- Look Up Note – enter any notes (optional)
- Valid From – this will correspond with the discharge date or registration visit date and the value will start displaying at this time
- Valid To – the date the value to stop being used
- Interface Out – an optional field if the user would like the value to be used in a Batch Out

- Interface In – enter the interface in value if bringing in a value from the interface.
- Press  or **[F7]** to save the record.

2.4 User Profile

Any user wanting to access WinRecs must have a unique **User Profile** created. The User Profile controls the access level to modules and assigning user ID and passwords.

The profile is used to log entries and to track modifications to WinRecs patients and system records.

To access the user profile

- Select **Options** → **User Profile**.

To create a new user

- Press the 
— or —
- Press **[F5]**.
- A Search Results window will pop up with existing users

- Choose the user or Role ID you would like to base the User Profile by highlighting and double click or press 'Select Record'

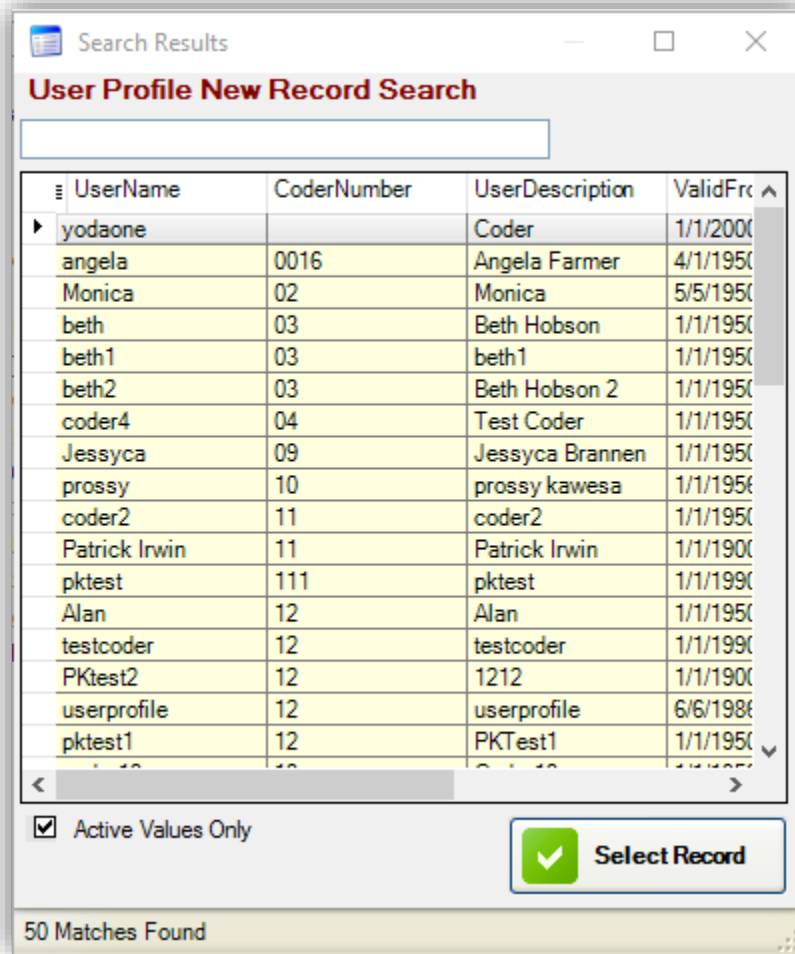


Figure 61 – Institution Profile – Submission Screen

- Enter the required fields

To search the user profile

- Press **[F4]** or click on the  icon.

The search screen opens to allow for a search of a user.

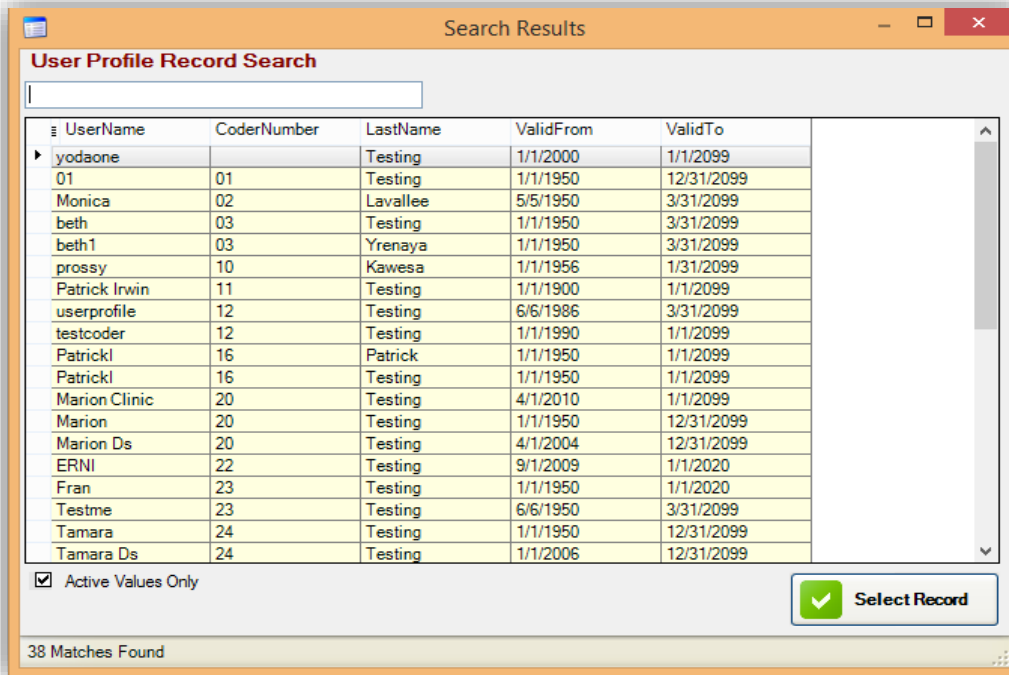


Figure 62 – User Profile Search Screen

- Enter a user name or coder number in the **User Profile Record Search** box. If there is only one match, the record will open in the **User Profile** window for editing. If there is more than one match, the matching records will be presented in the **Search Results** window.
- In the example below, the user has entered the search “me”. WinRecs has returned two matching user profiles. A User profile is selected by double-clicking on it, which opens it in the User Profile window for editing.

Search Results

User Profile Record Search

UserName	CoderNumber	LastName	ValidFrom	ValidTo
▶ MED2020	76		4/1/2000	3/31/2099
Testme	23	Testing	6/6/1950	3/31/2099

☒ Active Values Only

✓

Select Record

2 Matches Found

Figure 63 – User Profile Record Search

Role ID

Links users to a common profile/template. When a user is linked to a **Role ID**, all User Profile and Control File settings will be identical to those of the **Role ID User Profile** it is linked to. This feature is used to maintain groups of users. If a change is made in the Role ID user profile, all users linked to the Role ID will have the same change.

To use the Role ID:

- Use the [F4] function key or  to call up the search window, choose the user you would like to assign the Role ID
- In the Role ID field, press [F2] to select the user to be used as the Role ID

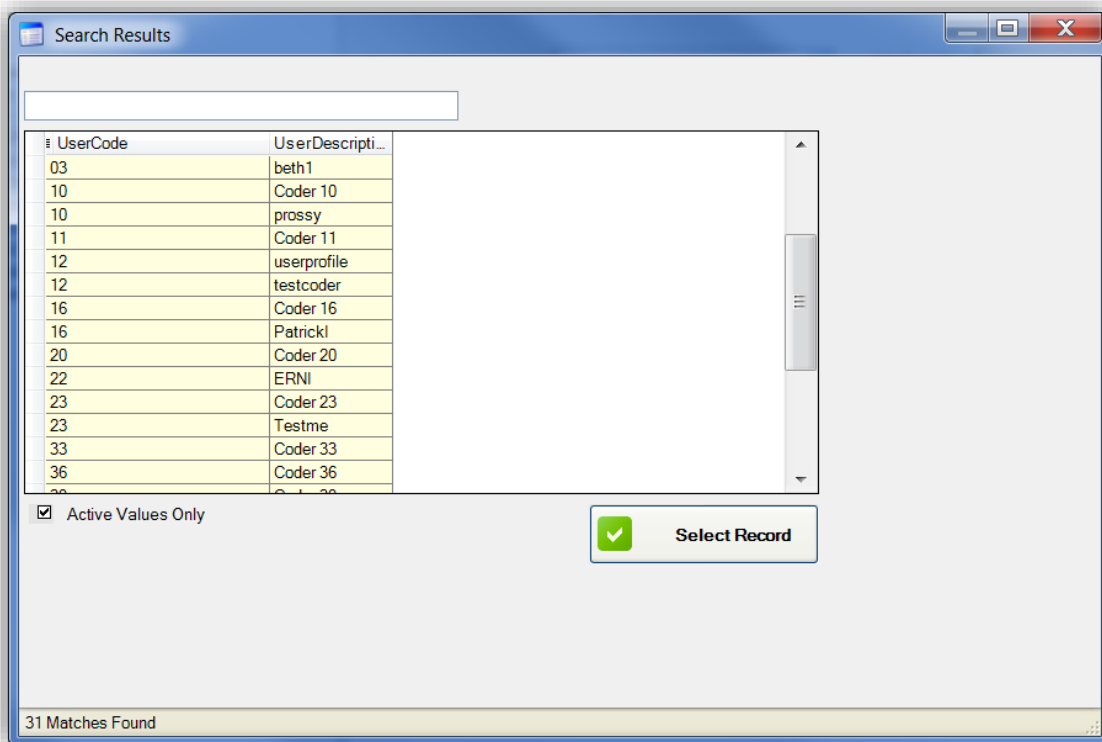


Figure 64 – User Profile Role ID Search

- Save the user profile.

Once a user is linked to another user's setting (using the Role ID), individual profile settings cannot be modified until the Role ID is removed.

- All user permission fields for the User are now disabled. Additionally, this user will not be available in the Control File user list.

- All user permissions and Control File settings will be identical to the *Role ID* this profile is linked to.

Any time changes are made to the source Role ID (in the Users Profile or Control File), all users linked to the source profile will be affected.



If a user wants to have most of the same settings as another user, but would like different settings such as a different sort of fields, link the user to the Role ID and save the record, then remove the Role ID and save again. Now all of the settings will be identical, and now changes can be made to the profile.

WinRecs Options - User profile

Profile

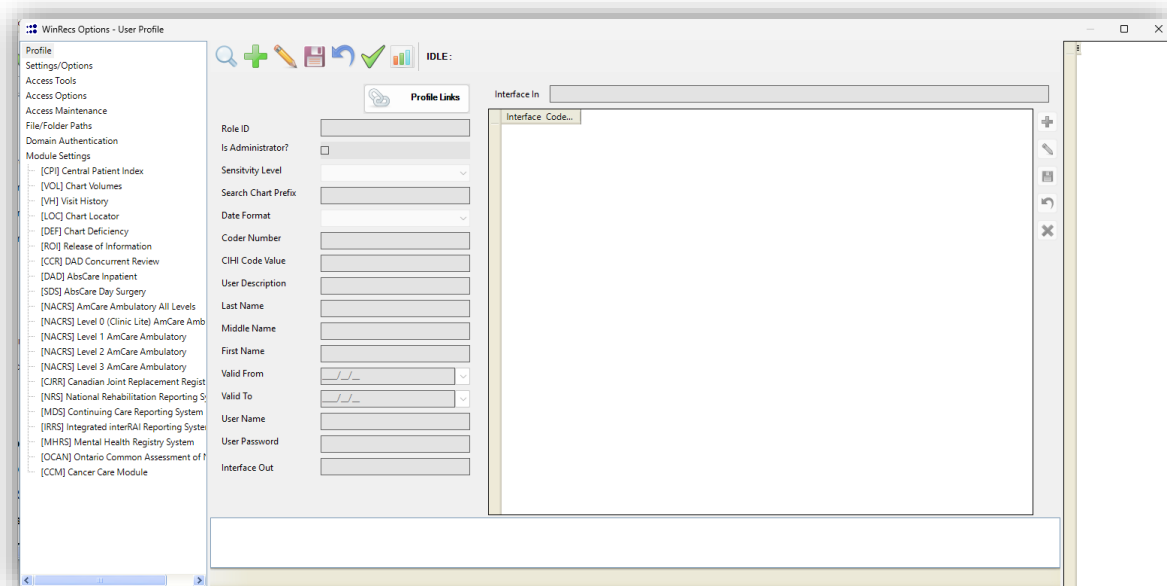
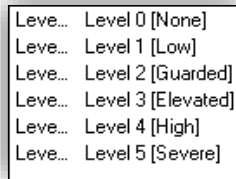


Figure 65 – User Profile – Profile Screen

- **Profile Links**– The ability to link an institution to a region if there is more than one region in the database or to a specific hospital if there is more than one hospital
- **Role ID**– Identifies the user account the user is linked to, please see [Role ID](#)
- **Is Administrator?**– Check the box if the user has administrative privileges, allowing the user to view all other users in the profile and make changes. If the box is not checked, the user can only view their own profile.

- *Sensitivity Level* – There are 5 sensitivity levels in the drop down box to choose from:



- *Search Chart Prefix* – The alphabetic prefix of the chart numbers the user can access. If blank, the user can access all records in the database. For example, if a site uses 'M' as their chart number prefix, and 'M' is typed in the **Search Chart Prefix** field, then the user will only see charts with a prefix of 'M'. This is useful for regions that are using a shared database.
- *Date Format* – Click on the drop down menu to specify the date format used to display on abstracts:

YYYY/MM/DD
MM/DD/YYYY
DD/MM/YYYY
YYYY-MM-DD
MM-DD-YYYY
DD-MM-YYYY

- *Coder Number* – The unique number assigned to each WinRecs user
- *CIHI Code Value* – This is the value submitted to CIHI where applicable. This defaults to the coder number.
- *User Description* – The custom description of the user.
- *Last Name* – The Last Name of the user
- *Middle Name* – The Middle Name of the user
- *First Name* - The First Name of the user
- *Valid From* – The date defining the start date of when the user is valid. The user account cannot be used before this date. (Mandatory)
- *Valid To* – The date defining the end date of when the user is valid. The user account can't be used after this date. (Mandatory)
- *User Name* – The name used to log in to WinRecs.
- *User Password* – The password used to log in to WinRecs, the value entered in the field is masked, [see Password Setup](#)
- *Interface Out* – Value used as region/hospital in interface populating out of WinRecs, populates with User Code.
- *Interface In* – Value used as the region/hospital in Batch and HL7 Interfaces



- To add a value press

- Add the *Interface In* value

Interface In

- Press  to save the entry
-  to cancel the entry before saving
-  to delete the entry after it is saved
-  used to edit an existing value

Settings/Options

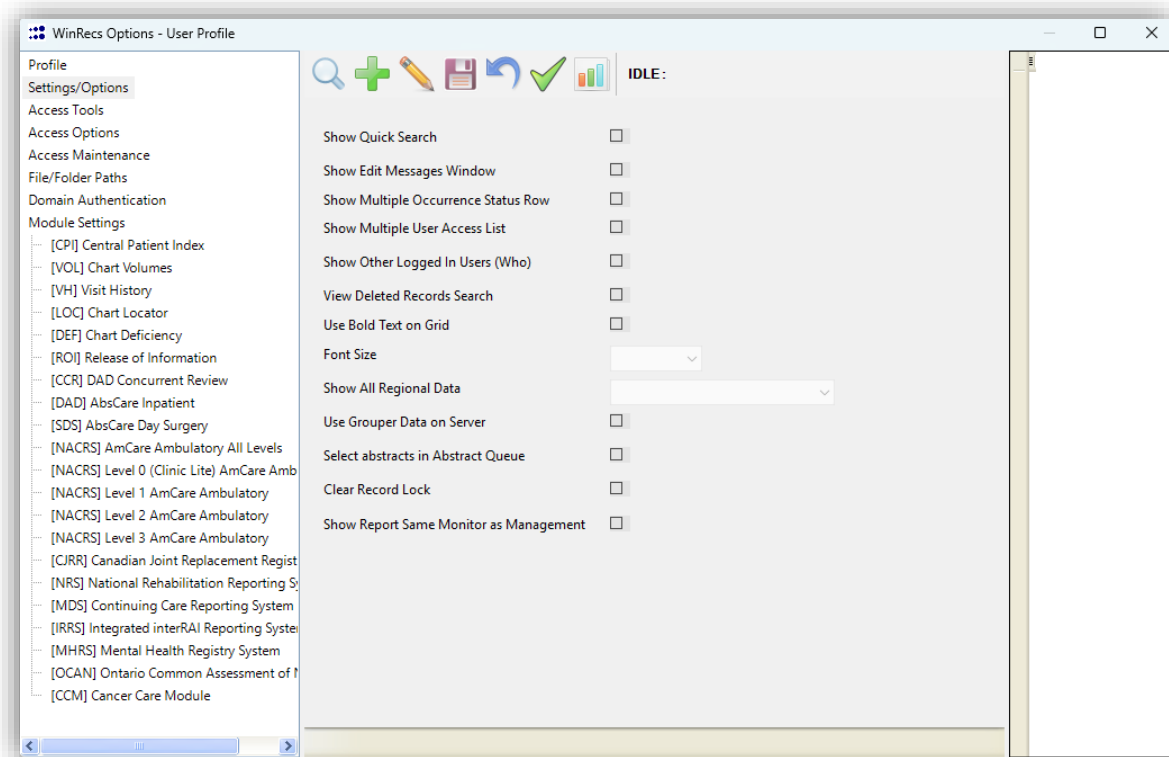


Figure 66 – User Profile – Settings/Options Screen

- Show Quick Search – Checking this enables the *Quick Search* feature. The *Quick Search* feature is available in Abstracting Modules. After an abstract is saved, a Visit Date and Chart number search window will display. The Window will display the previous visit date search. You can modify the date if required or you can modify the chart number. This can be set in the [Preferences Menu](#)

- Show Edit Messages Window – Checking this creates a pop up message of all the error messages when the abstract is opened, validated or saved.
- Show Multiple User Access List – Check this enables the *Show Multiple User Message* feature. When a user accesses a record when another user is in it, a message displays. “*At least one other User is currently accessing this record*”. This can be set in the [Preferences Menu](#).
- Show Other Logged In Users (Who) - Allows access to a list of other users logged into WinRecs
- View Deleted Records Search – This field gives rights to the user to be able to see visits that have been deleted. In the search window there is a check box to 'View Deleted' records”
- Font Size – Can set the font size for the user. This can be set in the [Preferences Menu](#).
- Show All Regional Data – Users in a regional solution can be configured to have no access, read only or full access.
- Use Grouper Data on Server – Allows the user to determine if the grouper runs local on the workstation or if the calculation is performed on the server. For users with less powerful workstations, setting the grouper to run on the server will decrease the amount of local resources required for WinRecs and may increase WinRecs speed. Users with more powerful workstations are recommended to set the grouper to calculate on the workstation.
- Select abstracts in Abstract Queue – When selected the user has the ability to select abstracts in the Abstract Queue.
- Clear Record Lock – When selected the user has the option to clear the record lock.
- Show Report Same Monitor as Management – When checked when the user runs a report it will open on the same monitor as Report Manager is located. This applies to users who have more than one monitor.

Access Tools – Access to all modules in the Tools menu

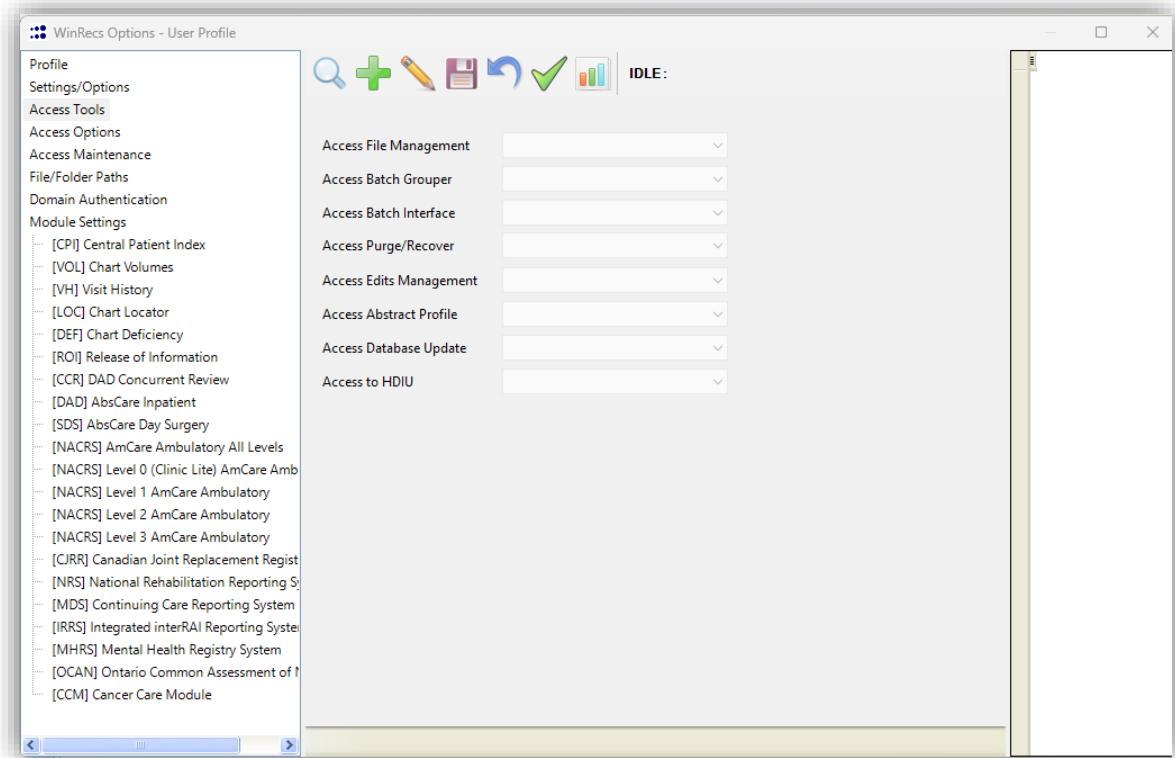


Figure 67 – User Profile – Access Tools Screen

- Access File Management – The drop down displays an ‘Y’ or ‘N’ option, click ‘Y’ will give the user access to File Management under the **Tools** Menu.
- Access Batch Grouper – The drop down displays an ‘Y’ or ‘N’ option, click ‘Y’ will give the user access to Batch Grouper under the **Tools** Menu.
- Access Batch Interface – The drop down displays an ‘Y’ or ‘N’ option, click ‘Y’ will give the user access to Batch Interface under the **Tools** Menu.
- Access Purge/Recover - The drop down displays an ‘Y’ or ‘N’ option, click ‘Y’ will give the user access to Purge Recover under the **Tools** Menu.
- Access Edits Management - The drop down displays an ‘Y’ or ‘N’ option, click ‘Y’ will give the user access to Edits Management under the **Tools** Menu
- Access Abstract Profile – This drop down displays an “Y” or ‘N’ options, click ‘Y’ will give the user access to the Abstract Profile in the **Tools** Menu.
- Access Database Update - This drop down displays an “Y” or ‘N’ options, click ‘Y’ will give the user access to the Access Database Update History which is the tool used to run updates.

- Access HDIU - This drop down displays an “Y” or ‘N’ options, click ‘Y’ will give the user access to the Historical Data Import in the **Tools** Menu.

Access Options – all modules found under the Options menu

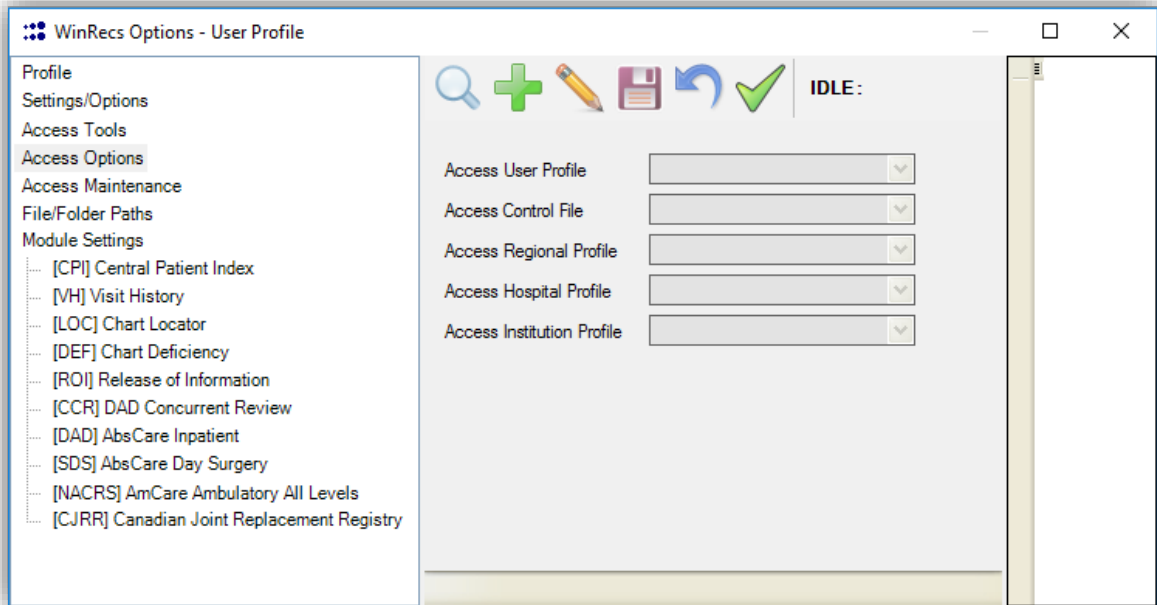


Figure 68 - User Profile – Access Options Screen

- Access User Profile - The drop down displays ‘**No Access**’ the user has no access to User Profile, ‘**Read Only**’ access where the user can only view the User Profile and ‘**Full**’ the user can view and make changes to the User Profile. The **User Profile** is under the **Options** menu.
- Access Control File - The drop down displays ‘**No Access**’ the user has no access to Control File, ‘**Read Only**’ access where the user can only view the Control File and ‘**Full**’ the user can view and make changes to the Control File. The **Control File** is under the **Options** menu.
- Access Regional Profile - The drop down displays ‘**No Access**’ the user has no access to Regional Profile, ‘**Read Only**’ access where the user can only view the Regional Profile and ‘**Full**’ the user can view and make changes to the Regional Profile. The **Regional Profile** is under the **Options** menu.
- Access Hospital Profile - The drop down displays ‘**No Access**’ the user has no access to Hospital Profile, ‘**Read Only**’ access where the user can only view the Hospital Profile and ‘**Full**’ the user can view and make changes to the Hospital Profile. The **Hospital Profile** is under the **Options** menu.
- Access Institution Profile - The drop down displays ‘**No Access**’ the user has no access to Institution Profile, ‘**Read Only**’ access where the user can only view the Institution Profile and ‘**Full**’ the user can view and make changes to the Institution Profile. The **Institution Profile** is under the **Options** menu.

Access Maintenance

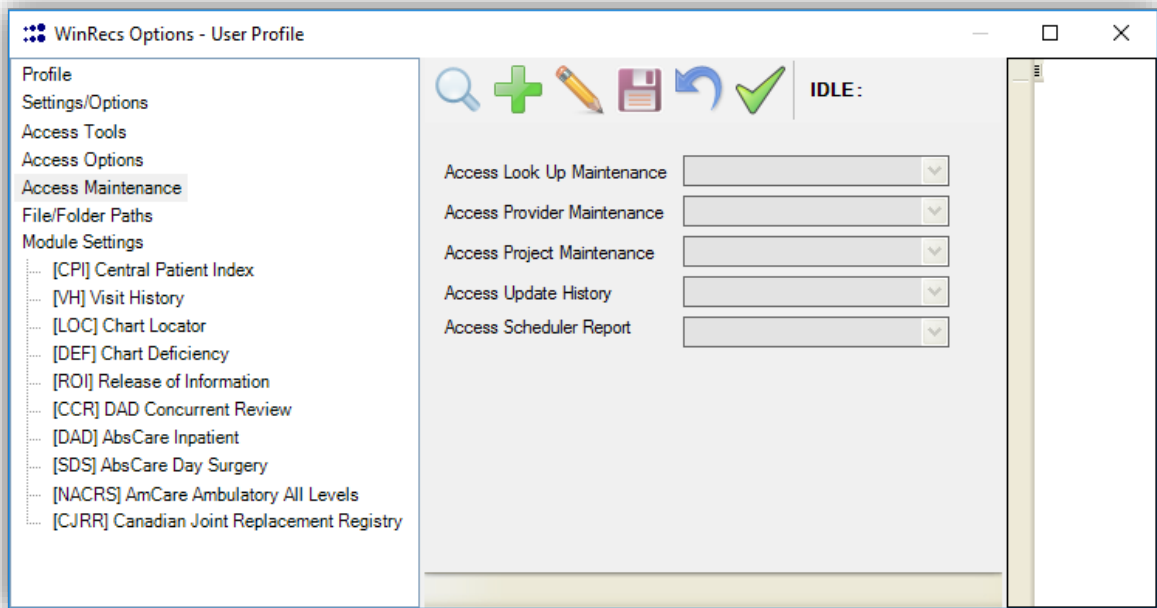


Figure 69 – User Profile – Access Maintenance Screen

- Access Look Up Maintenance - The drop down displays '**No Access**' the user has no access to Look Up Maintenance, '**Read Only**' access where the user can only view the Look Up Maintenance and '**Full**' the user can view and make changes to the Look Up Maintenance. The **Look Up Maintenance** is under the **Maintenance** menu.
- Access Provider Maintenance- The drop down displays '**No Access**' the user has no access to Provider Maintenance, '**Read Only**' access where the user can only view the Provider Maintenance and '**Full**' the user can view and make changes to the Provider Maintenance. The **Provider Maintenance** is under the **Maintenance** menu.
- Access Project Maintenance - The drop down displays '**No Access**' the user has no access to Project Maintenance, '**Read Only**' access where the user can only view the Project Maintenance and '**Full**' the user can view and make changes to the Project Maintenance. The **Project Maintenance** is under the **Maintenance** menu.
- Access Update History- The drop down displays a 'Y' or 'N' option, click 'Y' will give the user access to Access Update History. Access Update History is the Window Pane that displays Coder, Date and Time record was saved.
- Access Scheduler Report – The drop down displays a 'Y' or 'N' option, clicking 'Y' will give user access to scheduled reports.

File/Folder Paths

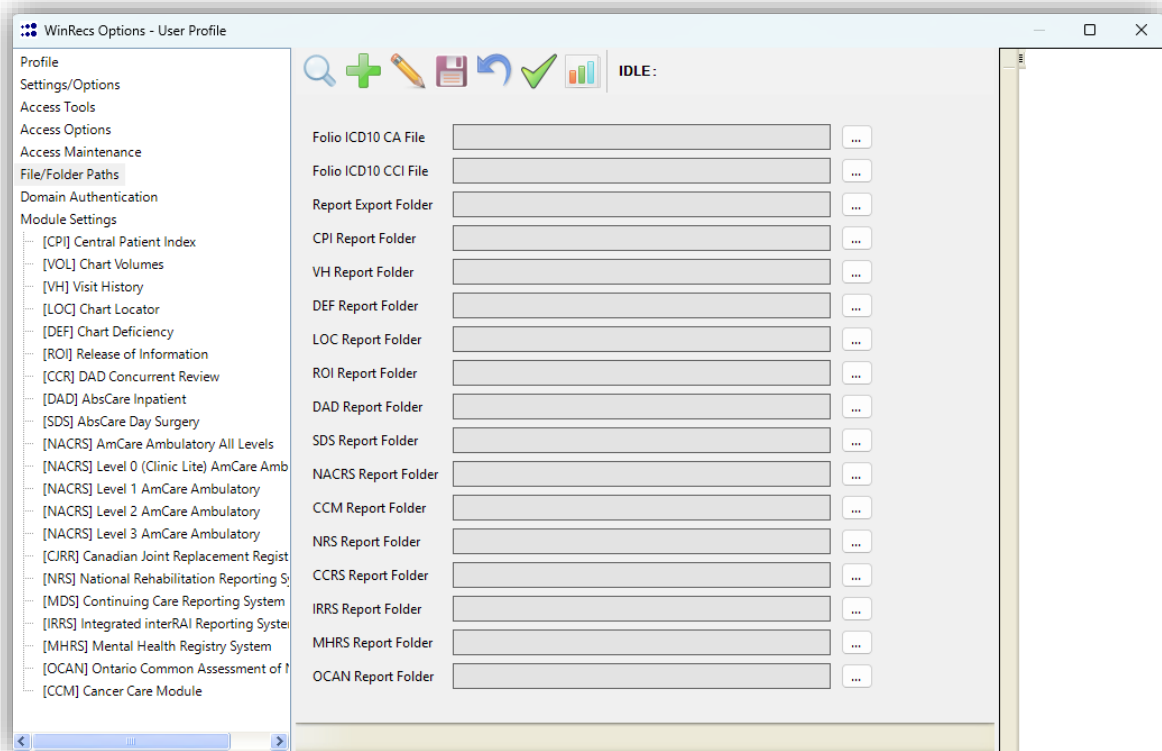


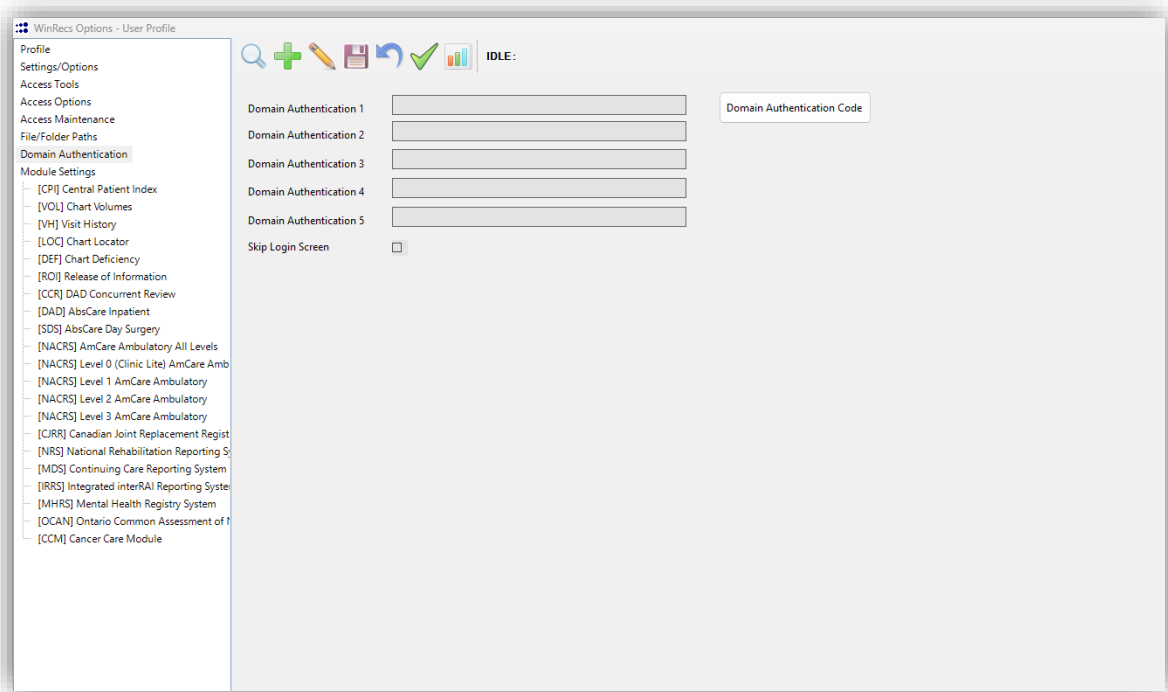
Figure 70 – User Profile – Folio/Folder Paths Screen

- *Folio ICD10 CA File* – Allows user to launch FOLIO when on the Diagnosis Code field when in the **Diagnosis Multiform**. Press on the  to open the File Directory to find the ICD10-CA File.
- *Folio ICD10 CCI File* – Allows user to launch FOLIO when the on the Intervention Code field when in the **Intervention Multiform**. Press on the  to open the File Directory to find the ICD10 CCI file.
- *Report Export Folder* – By inputting a file path, when the user exports a report, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- *CPI Report Folder* – By inputting a file path, when the user exports a report from the CPI module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- *VH Report Folder* – By inputting a file path, when the user exports a report from the Visit History module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- *DEF Report Folder* – By inputting a file path, when the user exports a report from the Deficiency Module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.

- LOC Report Folder – By inputting a file path, when the user exports a report from Chart Locator, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- ROI Report Folder – By inputting a file path, when the user exports a report from Release of Information module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- DAD Report Folder – By inputting a file path, when the user exports a report from the DAD module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- SDS Report Folder – By inputting a file path, when the user exports a report from Surgical Daycare Module module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- NACRS Report Folder – By inputting a file path, when the user exports a report from NACRS module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- CCM Report Folder – By inputting a file path, when the user exports a report from CCM module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- NRS Report Folder – By inputting a file path, when the user exports a report from NRS module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- CCRS Report Folder – By inputting a file path, when the user exports a report from CCRS module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- IRRS Report Folder – By inputting a file path, when the user exports a report from IRRS module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- MHRS Report Folder – By inputting a file path, when the user exports a report from MHRS module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.
- OCAN Report Folder – By inputting a file path, when the user exports a report from OCAN module, it will go to this file path. If left blank the exported report will go to folder where the user last saved.

See Section 5.15 Interfacing with Folio Views Code Basket

Domain Authentication



The screenshot shows the 'WinRecs Options - User Profile' window. On the left is a tree view with categories: Profile, Settings/Options, Access Tools, Access Options, Access Maintenance, File/Folder Paths, Domain Authentication, and Module Settings. The 'Domain Authentication' category is selected. The main area contains five text input fields labeled 'Domain Authentication 1' through 'Domain Authentication 5'. To the right of these fields is a button labeled 'Domain Authentication Code'. Below the input fields is a checkbox labeled 'Skip Login Screen'.

Figure 71 – User Profile – Domain Authentication

- Domain Authentication 1 – Entering the full path of the network and user in this field. When this is populated, the password used for network login for this user will be used for WinRecs.
- Domain Authentication 2 -5 – Same as Domain Authentication 1 and if user has multiple domains.
- Domain Authentication Code – Clicking on this button, will populate the current domain login and populate it in Domain Authentication 1.
- Skip Login Screen – IF there is a checkmark in this field, when the user signs into the WinRecs icon, they are logged into WinRecs and don't have to enter a username or password. Leave it unchecked, the user will have to enter username and password.

Module Settings

[CPI] Central Patient Index

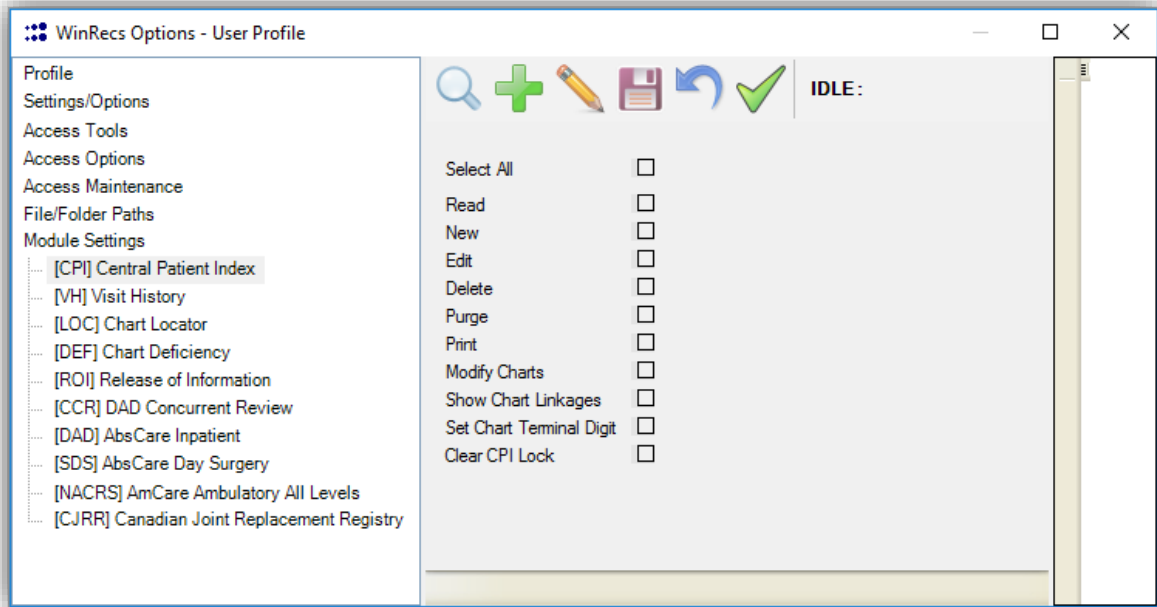


Figure 72 – User Profile – Module Settings/[CPI] Central Patient Index screen

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **CPI** module
- New – When checked allows the user to create new abstracts in the **CPI** module
- Edit – When checked allows the user to edit abstracts in the **CPI** module
- Delete – When checked allows the user to delete abstracts in the **CPI** module
- Purge – When checked allows the user to purge abstracts from the **CPI** module
- Print – When checked allows the user to print in the **CPI** module
- Modify Charts – Allows the user to the Modify Charts module in the **CPI Chart Management** feature
- Show Chart Linkages – When checked it will display if a chart number is linked to another chart number. The information pane will display *Potential Duplicates* or *Chart Ancestry*. When not checked the *Patient Visit History* will display.
- Set Chart Terminal Digit – When checked allows the user to use the **Set Chart Terminal Digit Utility**.
- Clear CPI MODULE Lock – When checked allows the user to clear any CPI MODULE locks by going to CPI MODULE/Actions/Clear CPI MODULE Lock and this will allow an unmerge of records.

[VOL] Chart Volumes

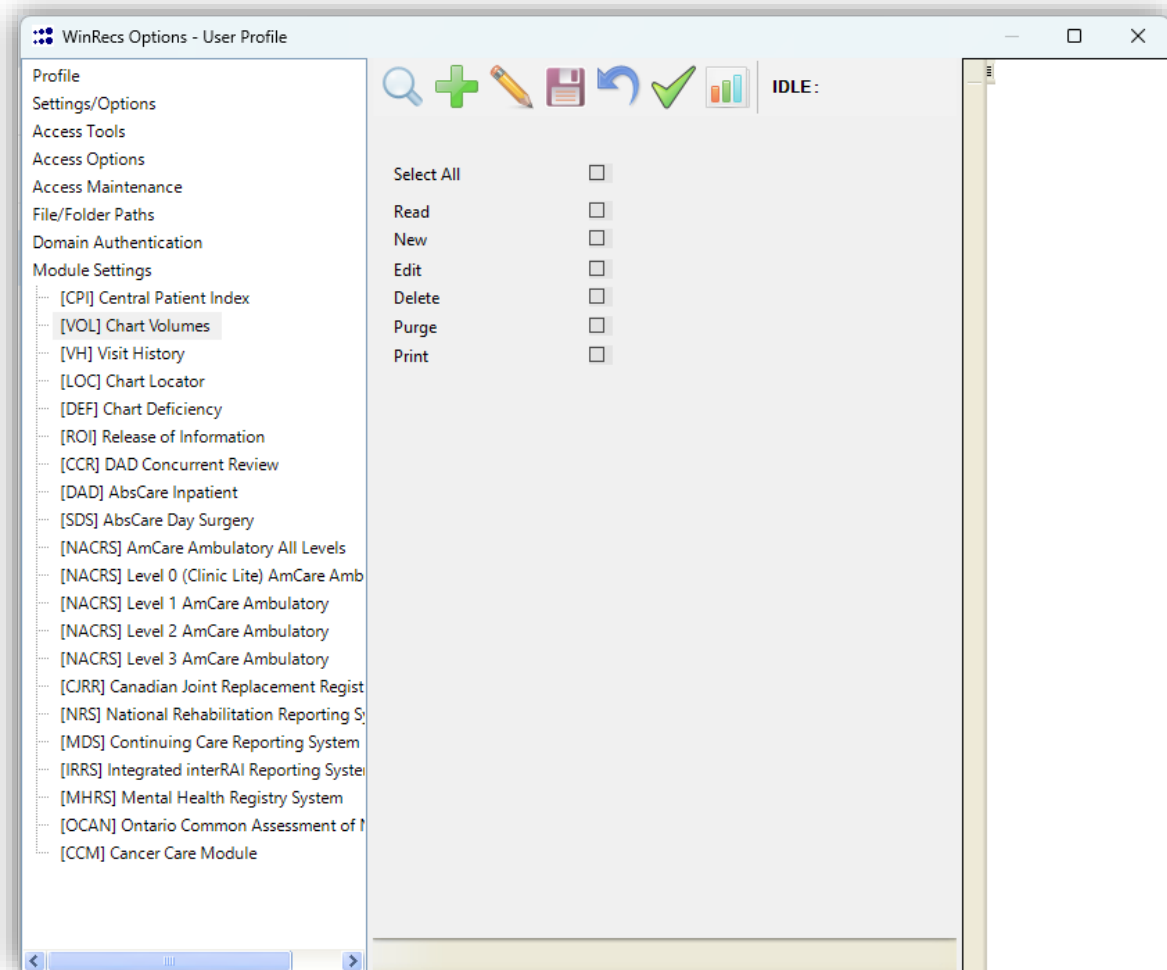


Figure 73 – User Profile – Module Settings/Chart Volumes screen

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **Chart Volumes** module
- New – When checked allows the user to create new abstracts in the **Chart Volumes** module
- Edit – When checked allows the user to edit abstracts in the **Chart Volumes** module
- Delete – When checked allows the user to delete abstracts in the **Chart Volumes** module
- Purge – When checked allows the user to purge abstracts from the **Chart Volumes** module
- Print – When checked allows the user to print in the **Chart Volumes** module

VH] Visit History

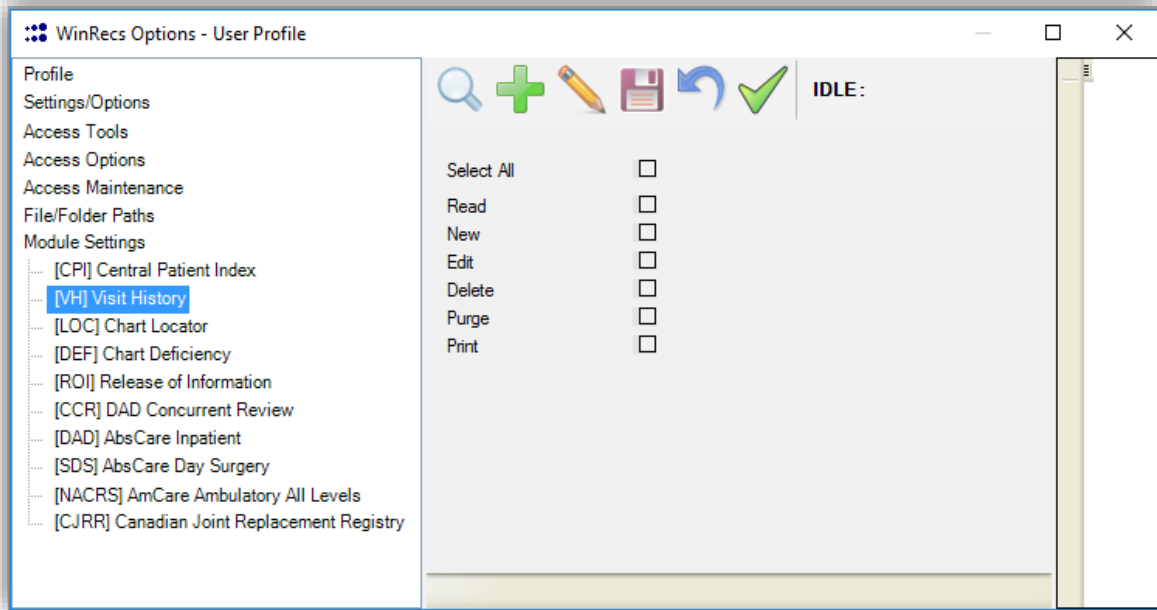


Figure 74 – User Profile – Module Settings/[VH] Visit History screen

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **Visit History** module
- New – When checked allows the user to create new abstracts in the **Visit History** module
- Edit – When checked allows the user to edit abstracts in the **Visit History** module
- Delete – When checked allows the user to delete abstracts in the **Visit History** module
- Purge – When checked allows the user to purge abstracts from the **Visit History** module
- Print – When checked allows the user to print in the **Visit History** module.

[LOC] Chart Locator

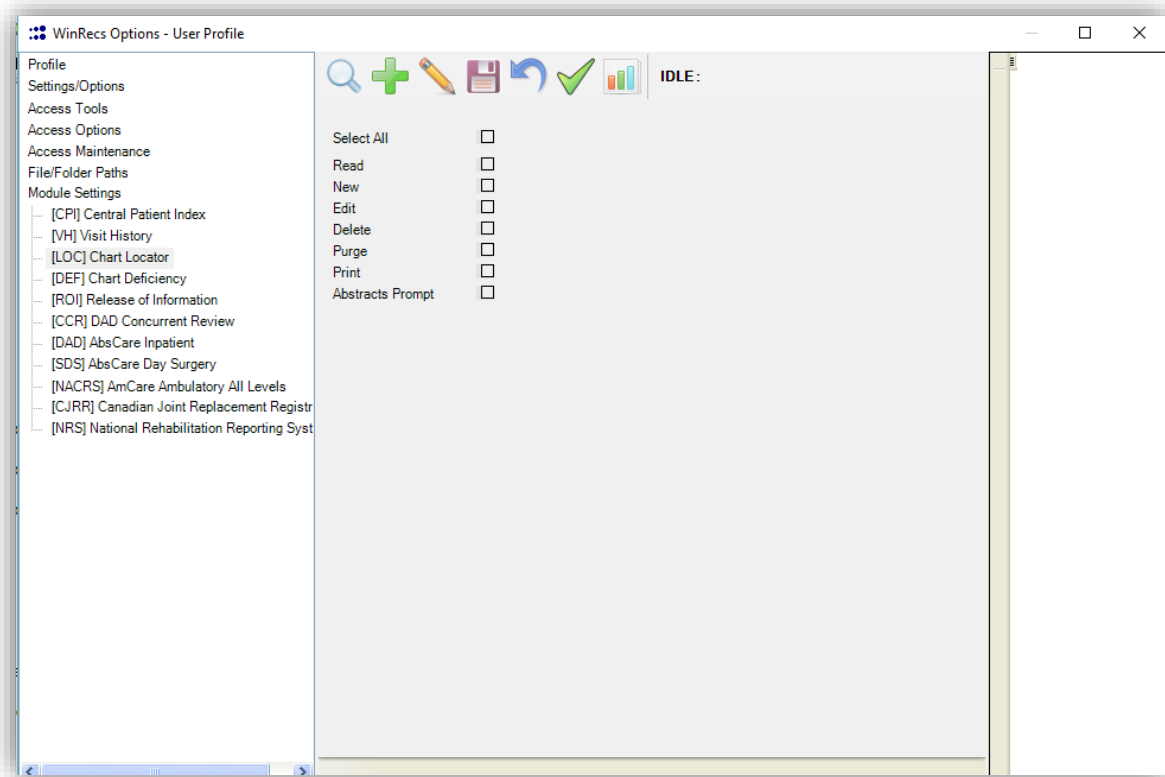


Figure 75 – User Profile – Module Settings/[LOC] Chart Locator screen

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **Chart Locator** module
- New – When checked allows the user to create new abstracts in the **Chart Locator** module
- Edit – When checked allows the user to edit abstracts in the **Chart Locator** module
- Delete – When checked allows the user to delete abstracts in the **Chart Locator** module
- Purge – When checked allows the user to purge abstracts from the **Chart Locator** module
- Print – When checked allows the user to print in the **Chart Locator** module
- Abstracts Prompt – When checked when an abstract is saved, a prompt will display asking you to go to Chart Locator, selecting Yes will take you to the **Chart Locator** module.

[DEF] Chart Deficiency

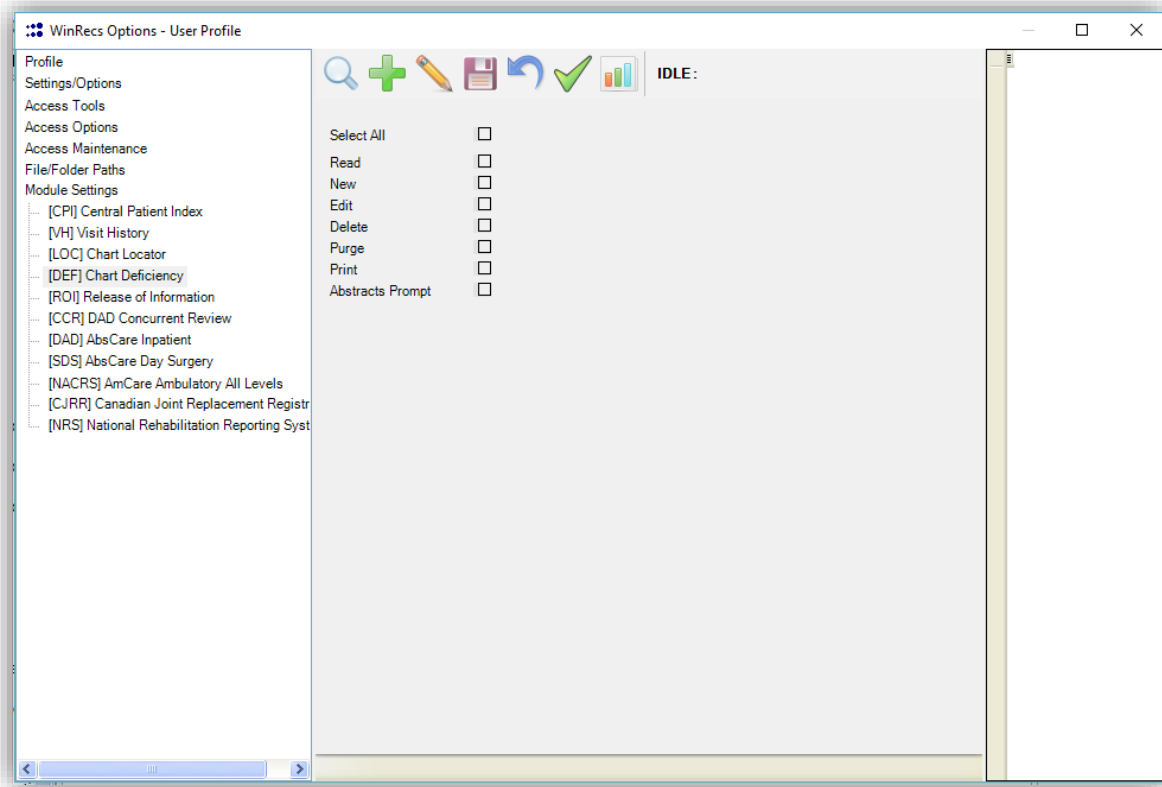


Figure 76 – User Profile – Module Settings/[DEF] Chart Deficiency screen

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **Chart Deficiency** module
- New – When checked allows the user to create new abstracts in the **Chart Deficiency** module
- Edit – When checked allows the user to edit abstracts in the **Chart Deficiency** module
- Delete – When checked allows the user to delete abstracts in the **Chart Deficiency** module
- Purge – When checked allows the user to purge abstracts from the **Chart Deficiency** module
- Print – When checked allows the user to print in the **Chart Deficiency** module
- Abstracts Prompt – When checked when an abstract is saved, a prompt will display asking you to go to Chart Deficiency, selecting Yes will take you to the **Chart Deficiency** module.

[ROI] Release of Information

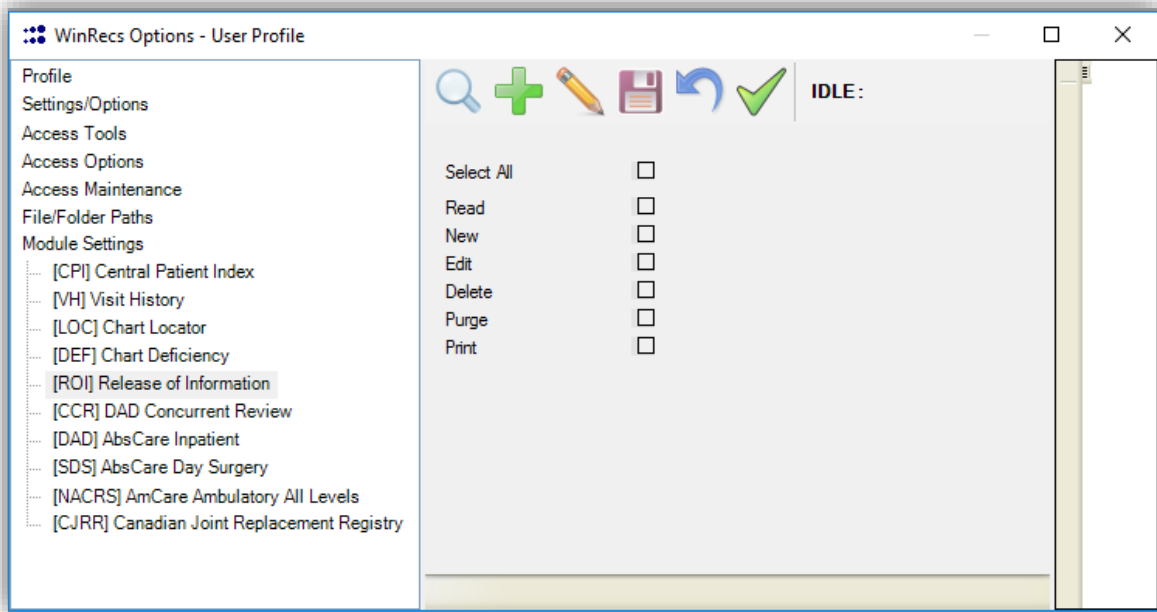


Figure 77 – User Profile – Module Settings/[ROI] Release of Information screen

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **Release of Information** module
- New – When checked allows the user to create new abstracts in the **Release of Information** module
- Edit – When checked allows the user to edit abstracts in the **Release of Information** module
- Delete – When checked allows the user to delete abstracts in the **Release of Information** module
- Purge – When checked allows the user to purge abstracts from the **Release of Information** module
- Print – When checked allows the user to print in the **Release of Information** module

[CCR] DAD Concurrent Review

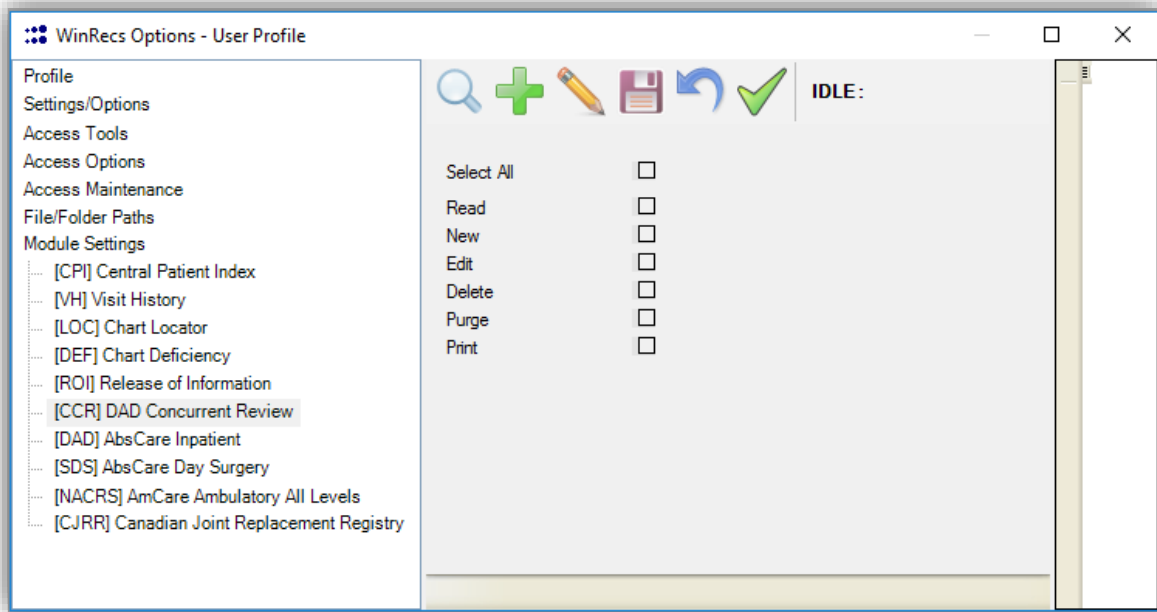


Figure 78 – User Profile – Module Settings/ [CCR] DAD Concurrent Review screen

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **DAD Concurrent Review** module
- New – When checked allows the user to create new abstracts in the **DAD Concurrent Review** module
- Edit – When checked allows the user to edit abstracts in the **DAD Concurrent Review** module
- Delete – When checked allows the user to delete abstracts in the **DAD Concurrent Review** module
- Purge – When checked allows the user to purge abstracts from the **DAD Concurrent Review** module
- Print – When checked allows the user to print in the **DAD Concurrent Review** module

[DAD] AbsCare Inpatient

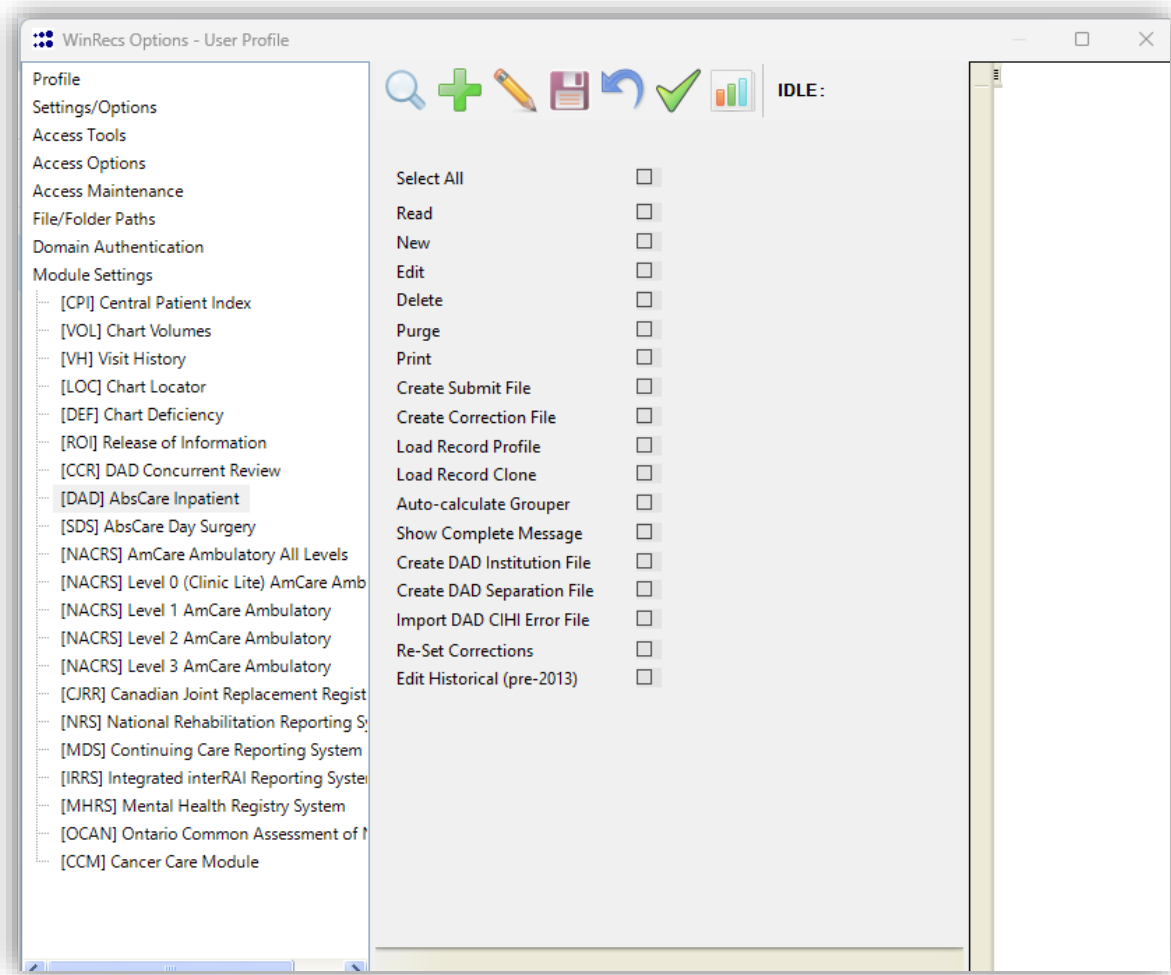


Figure 79 – User Profile – Module Settings/ [DAD] AbsCare Inpatient screen

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **AbsCare Inpatient** module
- New – When checked allows the user to create new abstracts in the **AbsCare Inpatient** module
- Edit – When checked allows the user to edit abstracts in the **AbsCare Inpatient** module
- Delete – When checked allows the user to delete abstracts in the **AbsCare Inpatient** module
- Purge – When checked allows the user to purge abstracts from the **AbsCare Inpatient** module
- Print – When checked allows the user to print in the **AbsCare Inpatient** module.
- Create Submit File – When checked allows the user to create a **CIHI Submission File**

- Create Correction File- When checked allows the user to create a **CIHI Correction File**
- Load Record Profile – Allows the user access to the Copy Abstract Profile in **AbsCare Inpatient** module.
- Load Record Clone – Allows the user access to the Clone Abstract routine in **AbsCare Inpatient** module.
- Auto-calculate Grouper – When checked allows the grouper to automatically calculate values when relevant grouper data is provided for that user.
- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Create DAD Institution File – When checked allows the user to create a **DAD Institution File**
- Create DAD Separation File – When checked allows the user to create a **DAD Separation File**.
- Import DAD CIHI Error File – When checked allows the user to use **the Import CIHI Error File**
- Re-Set Corrections – When checked, if a submitted record is flagged for correction, the user has the option to remove the correction flag, and it won't be submitted to CIHI. This can be found under **File Settings→Re-Set File Correct Status**.
- Edit Historical (pre-2013) – When checked, when a record before 2013 is opened and there are edits on the record, they will not be displayed.

[SDS] AbsCare Day Surgery

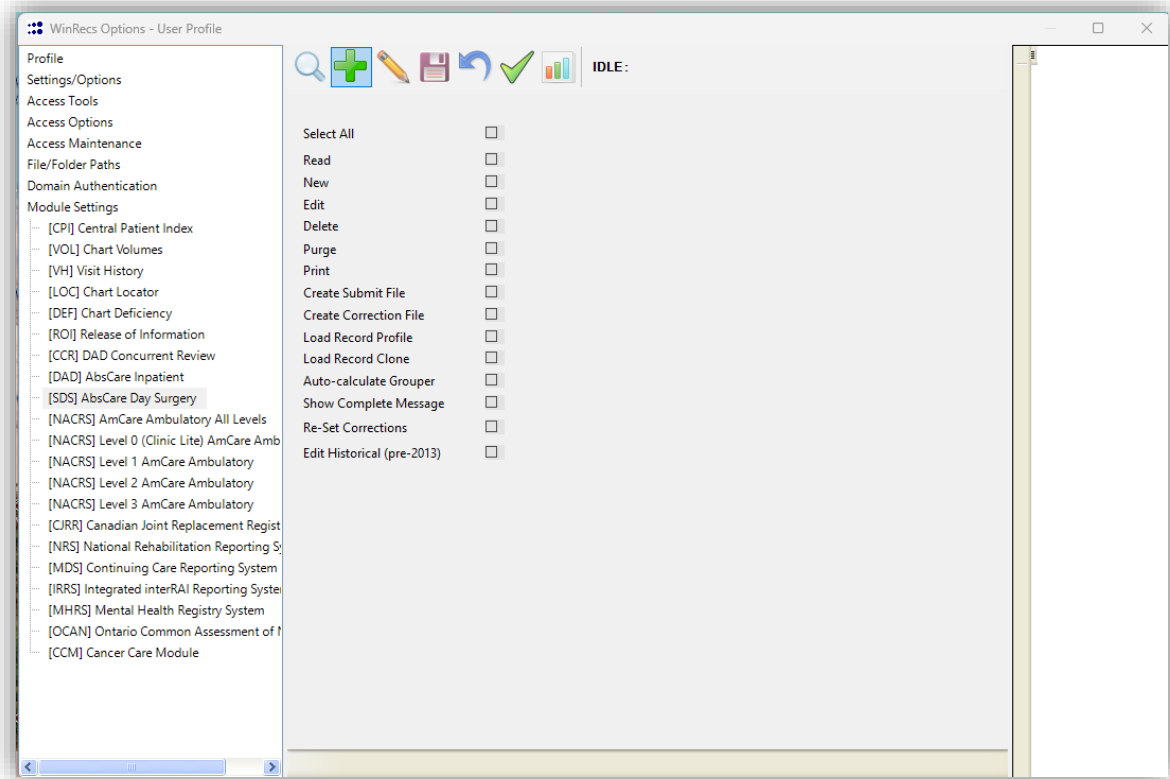


Figure 80 – User Profile – Module Settings/ [SDS] AbsCare Day Surgery screen

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **AbsCare Day Surgery** module
- New – When checked allows the user to create new abstracts in the **AbsCare Day Surgery** module
- Edit – When checked allows the user to edit abstracts in the **AbsCare Day Surgery** module
- Delete – When checked allows the user to delete abstracts in **the AbsCare Day Surgery** module
- Purge – When checked allows the user to purge abstracts from the **AbsCare Day Surgery** module
- Print – When checked allows the user to print in **AbsCare Day Surgery** module
- Create Submit File – When checked allows the user to create a **CIHI Submission File**
- Create Correction File- When checked allows the user to create a **CIHI Correction File**

- Load Record Profile – Allow the user access to the Copy Abstract Profile in **AbsCare Day Surgery** module.
- Load Record Clone – Allows the user access to the Clone Abstract routine in **AbsCare Day Surgery** module.
- Auto-calculate Grouper – When checked allows the grouper to automatically calculate values when relevant grouper data is provided for that user.
- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Re-Set Corrections – When checked if a submitted record is flagged for correction, the user has the option to remove the correction flag, and it won't be submitted to CIHI. This can be found under **File Settings→Re-Set File Correct Status**.
- Edit Historical (pre-2013) – When checked, when a record before 2013 is opened and there are edits on the record, they will not be displayed.

[NACRS] AmCare Ambulatory All Levels

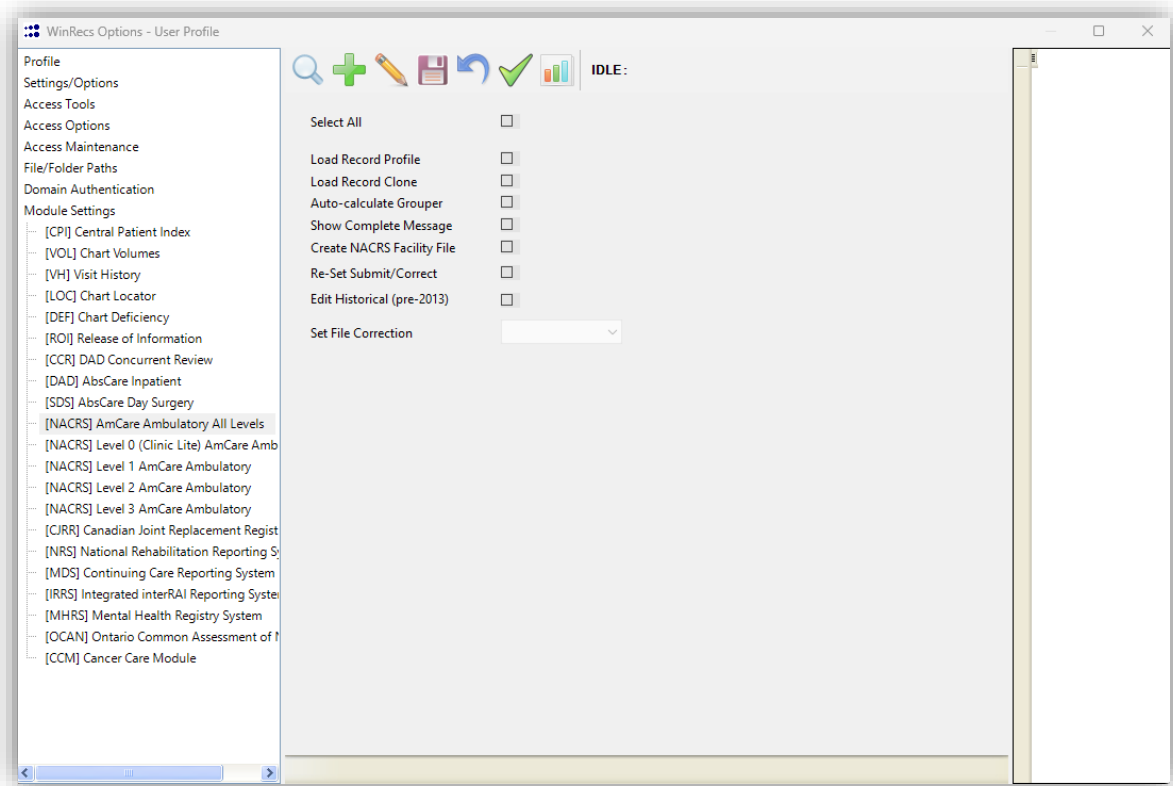


Figure 81 – User Profile – Module Settings/ [NACRS] AmCare Ambulatory All Levels

- Select All – Checking this button will check all the buttons below.
- Load Record Profile – Allow the user access to the Copy Abstract Profile in **Amcare Ambulatory** module
- Load Record Clone – Allows the user access to the Clone Abstract routine in **Amcare Ambulatory** module
- Auto-calculate Grouper – When checked allows the grouper to automatically calculate values when relevant grouper data is provided for that user.
- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Create NACRS Facility File – When checked allows the user to create a **NACRS Facility File**
- Re-Set Submit/Correct – When checked allows the user to Re-Set Submissions in the NACRS Abstract under **File Settings→Re-Set File Create Status**. If a submitted record is flagged for correction, the user has the option to remove the correction flag, and it won't be submitted to CIHI. This can be found under **File Settings→Re-Set File Correct Status**.
- Edit Historical (pre-2013) – When checked, when a record before 2013 is opened and there are edits on the record, they will not be displayed.
- Set File Correction – Gives the user different options on how to set NACRS Level 1 corrections.
 - A – Automatic – Automatically set the correction status as needed
 - M – Manual – Correction status will not be set; you will need to set it manually in the actions menu
 - P – Prompt – A prompt will appear asking to set the correction status.

[NACRS] Level 0 (Clinic Lite) AmCare Ambulatory

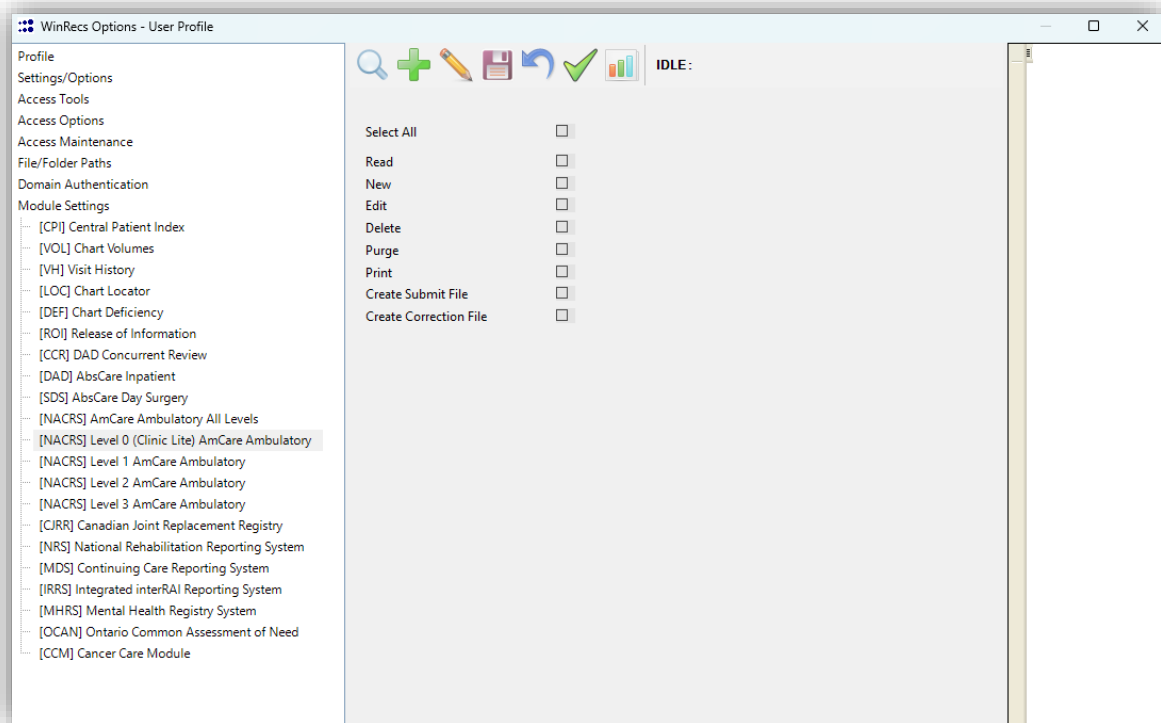


Figure 82 – User Profile – Module Settings/ [NACRS] Level 0

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **NACRS Level 0** module
- New – When checked allows the user to create new abstracts in the **NACRS Level 0** module
- Edit – When checked allows the user to edit abstracts in the **NACRS Level 0** module
- Delete – When checked allows the user to delete abstracts in the **NACRS Level 0** module
- Purge – When checked allows the user to purge abstracts from the **NACRS Level 0** module
- Print – When checked allows the user to print from the **NACRS Level 0** module
- Create Submit File – When checked allows the user to create a **CIHI Submission File** for **NACRS Level 0**.
- Create Correction File- When checked allows the user to create a **CIHI Correction File** for **NACRS Level 0**.

[NACRS] Level 1 AmCare Ambulatory

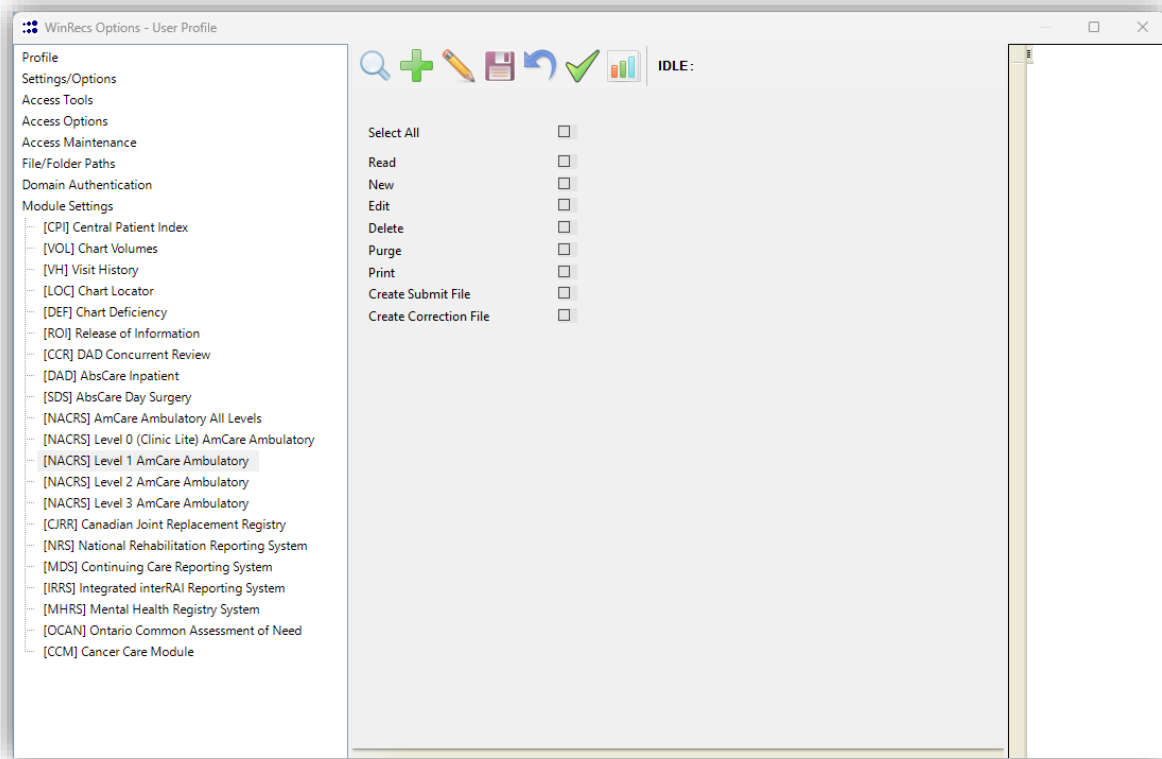


Figure 83 – User Profile – Module Settings/ [NACRS] Level 1

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **NACRS Level 1** module
- New – When checked allows the user to create new abstracts in the **NACRS Level 1** module
- Edit – When checked allows the user to edit abstracts in the **NACRS Level 1** module
- Delete – When checked allows the user to delete abstracts in the **NACRS Level 1** module
- Purge – When checked allows the user to purge abstracts from the **NACRS Level 1** module
- Print – When checked allows the user to print from the **NACRS Level 1** module
- Create Submit File – When checked allows the user to create a **CIHI Submission File** for **NACRS Level 1**.
- Create Correction File- When checked allows the user to create a **CIHI Correction File** for **NACRS Level 1**.

[NACRS] Level 2 AmCare Ambulatory

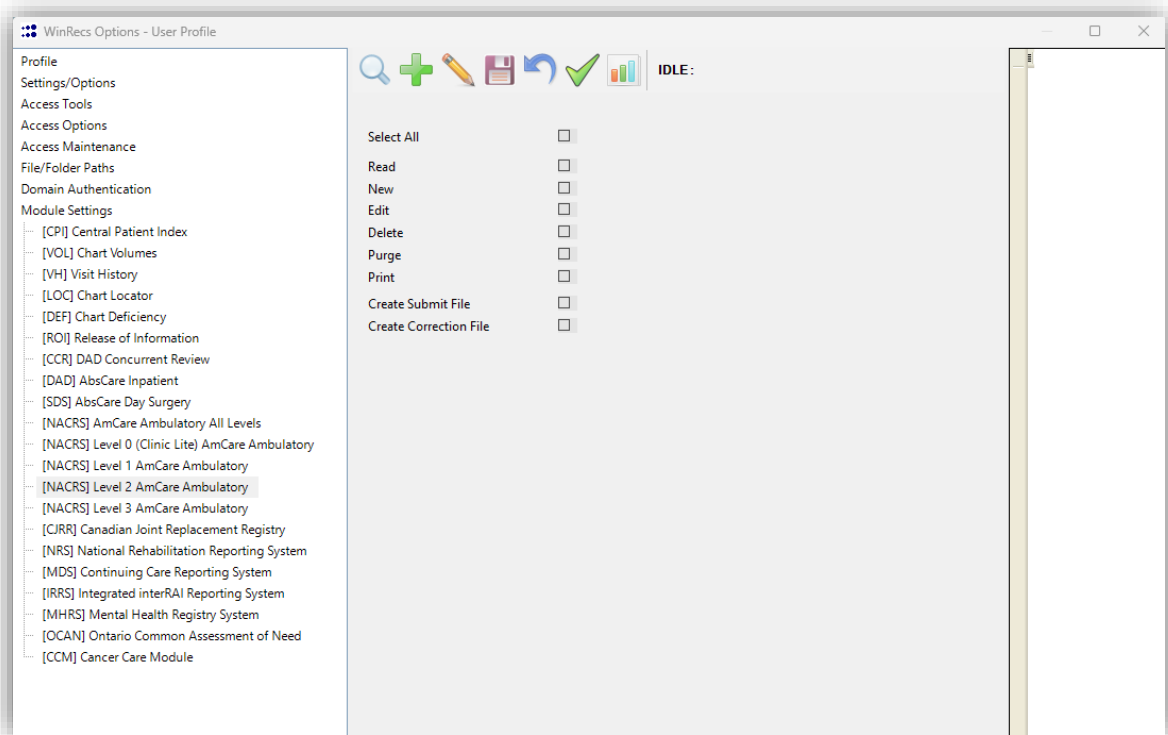


Figure 84 – User Profile – Module Settings/ [NACRS] Level 2

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **NACRS Level 2** module
- New – When checked allows the user to create new abstracts in the **NACRS Level 2** module
- Edit – When checked allows the user to edit abstracts in the **NACRS Level 2** module
- Delete – When checked allows the user to delete abstracts in the **NACRS Level 2** module
- Purge – When checked allows the user to purge abstracts from the **NACRS Level 2** module
- Print – When checked allows the user to print from the **NACRS Level 2** module
- Create Submit File – When checked allows the user to create a **CIHI Submission File** for **NACRS Level 2**.
- Create Correction File- When checked allows the user to create a **CIHI Correction File** for **NACRS Level 2**.

[NACRS] Level 3 AmCare Ambulatory

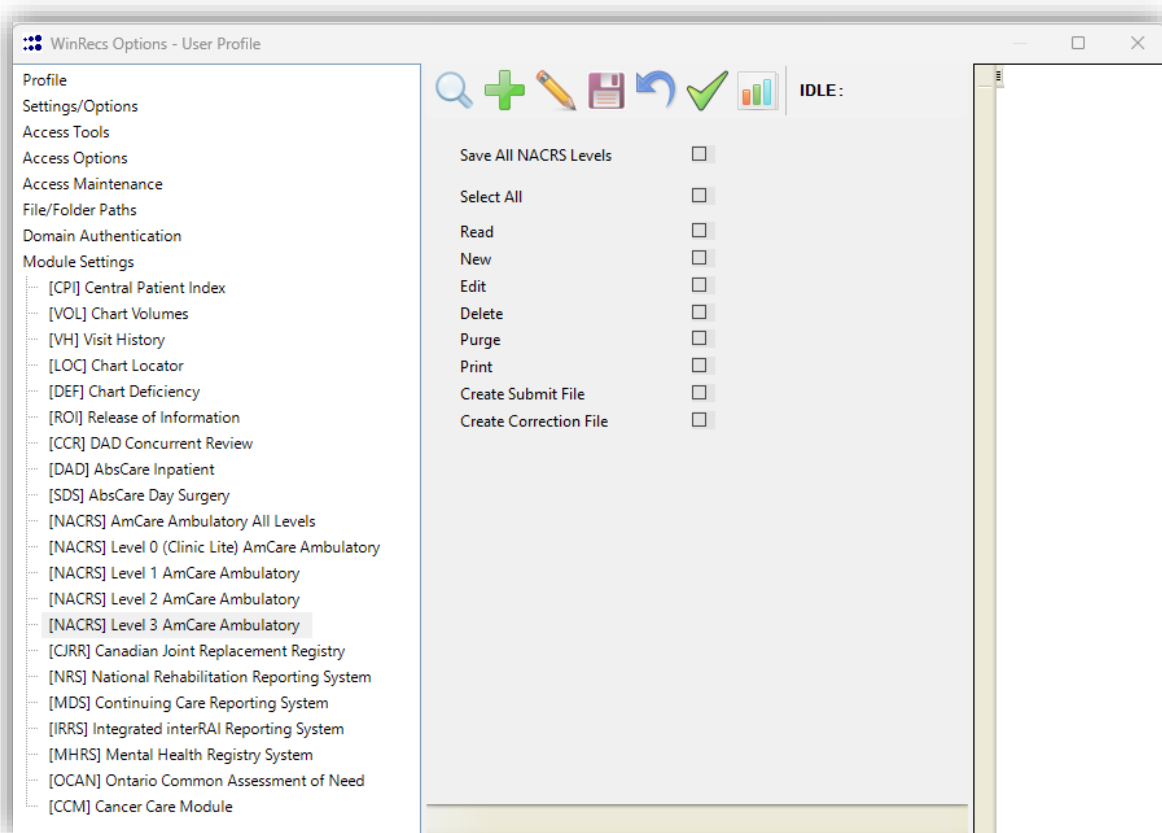


Figure 85 – User Profile – Module Settings/ [NACRS] Level 3

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **NACRS Level 3** module
- New – When checked allows the user to create new abstracts in the **NACRS Level 3** module
- Edit – When checked allows the user to edit abstracts in the **NACRS Level 3** module
- Delete – When checked allows the user to delete abstracts in the **NACRS Level 3** module
- Purge – When checked allows the user to purge abstracts from the **NACRS Level 3** module
- Print – When checked allows the user to print from the **NACRS Level 3** module
- Create Submit File – When checked allows the user to create a **CIHI Submission File** for **NACRS Level 3**.
- Create Correction File- When checked allows the user to create a **CIHI Correction File** for **NACRS Level 3**.

[CJRR] Canadian Joint Replacement Registry

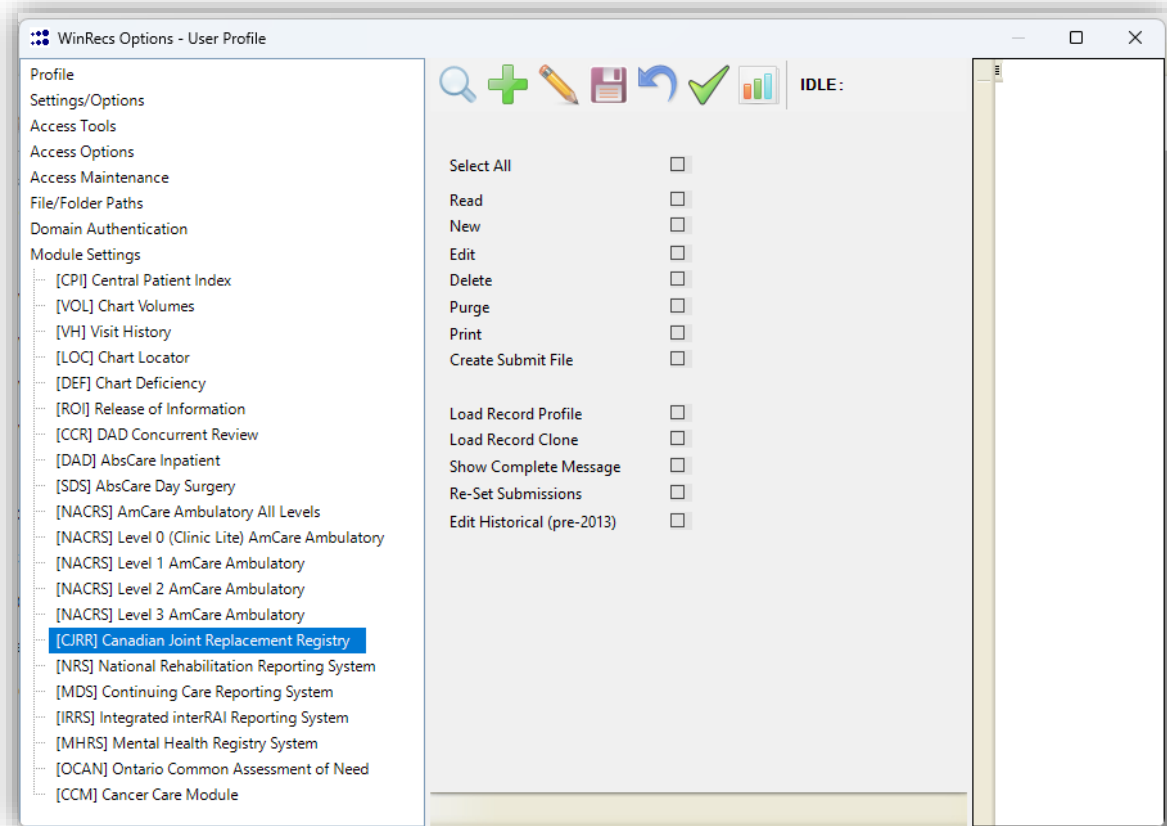


Figure 86 – User Profile – Module Settings/ [CJRR] Canadian Joint Replacement Registry

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **CJRR** module
- New – When checked allows the user to create new abstracts in the **CJRR** module
- Edit – When checked allows the user to edit abstracts in the **CJRR** module
- Delete – When checked allows the user to delete abstracts in the **CJRR** module
- Purge – When checked allows the user to purge abstracts from the **CJRR** module
- Print - When checked allows the user to use the print feature in the **CJRR** module
- Create Submit File – When checked allows the user to create a CJRR CIHI Submission File
- Load Record Profile – Allow the user access to the Copy Abstract Profile in the **CJRR** module
- Load Record Clone – Allows the user access to the Clone Abstract routine in **CJRR** module

- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Re-Set Submissions – When checked allows the user to Re-Set Submissions in the **CJRR Abstract → File Settings → Re-set File Create Status**
- Edit Historical (pre-2013) – When checked, when a record before 2013 is opened and there are edits on the record, they will not be displayed.

[NRS] National Rehabilitation Reporting System

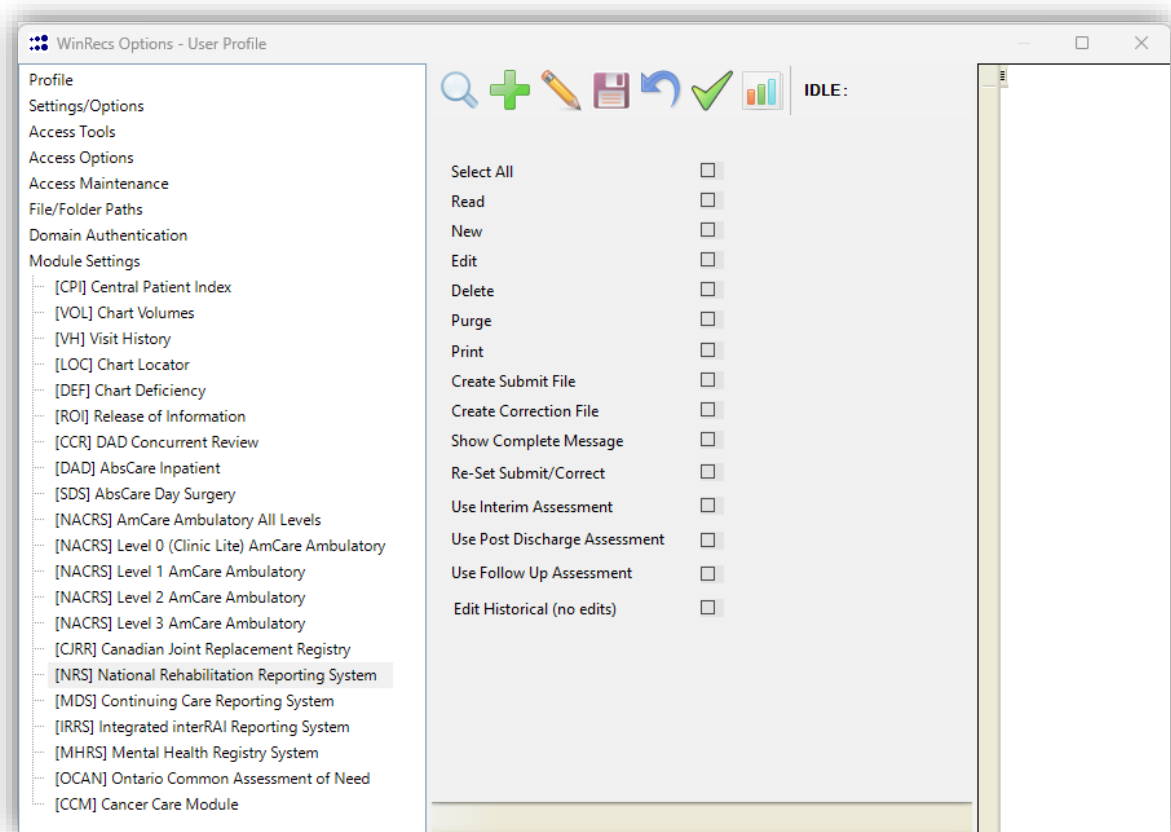


Figure 87 – User Profile – Module Settings/ NRS

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **NRS** module
- New – When checked allows the user to create new abstracts in the **NRS** module
- Edit – When checked allows the user to edit abstracts in the **NRS** module
- Delete – When checked allows the user to delete abstracts in the **NRS** module

- Purge – When checked allows the user to purge abstracts from the **NRS** module
- Print - When checked allows the user to use the print feature in the **NRS** module
- Create Submit File – When checked allows the user to create a **NRS** CIHI Submission File
- Create Correction File – When checked allows the user to create a **NRS** CIHI Correction File
- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Re-Set Submissions – When checked allows the user to Re-Set Submissions in the **NRS Abstract** → **File Settings** → **Re-set File Create Status**
- Use Interim Assessment – When checked allows the user to access the Interim Assessments
- Use Post Discharge Assessment – When checked allows the user to access the Post Discharge Assessments.
- Use Follow Up Assessment – When checked allows the user to access Follow Up Assessments.
- Edit Historical – When checked when a record has an assessment date of pre-2019 then the edits will not display.

[MDS] Continuing Care Reporting System

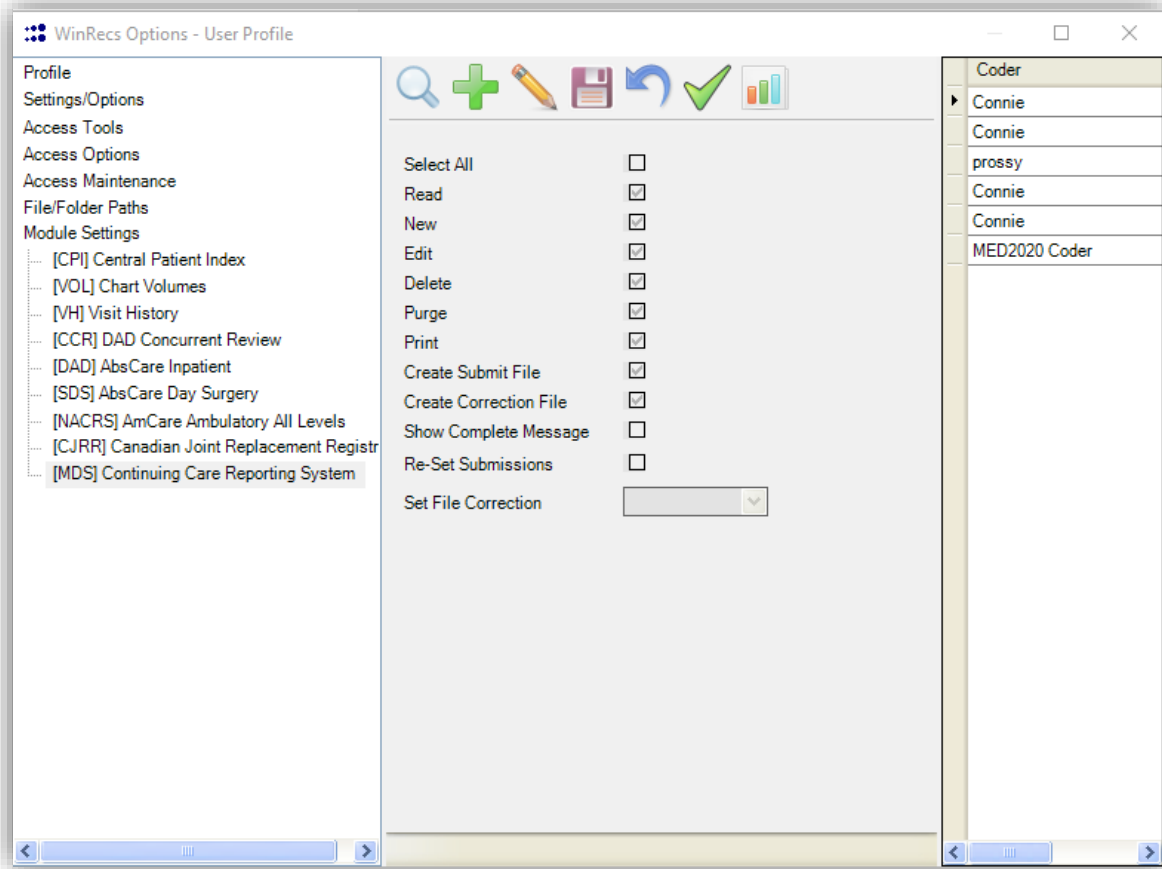


Figure 88 – User Profile – Module Settings/ [MDS] Continuing Care Reporting System

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **MDS** module
- New – When checked allows the user to create new abstracts in the **MDS** module
- Edit – When checked allows the user to edit abstracts in the **MDS** module
- Delete – When checked allows the user to delete abstracts in the **MDS** module
- Purge – When checked allows the user to purge abstracts from the **MDS** module
- Print - When checked allows the user to use the print feature in the **MDS** module
- Create Submit File – When checked allows the user to create a **MDS** CIHI Submission File
- Create Correction File – When checked allows the user to create a **MDS** CIHI Correction File

- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Re-Set Submissions – When checked allows the user to Re-Set Submissions in the **MDS Abstract** → **File Settings** → **Re-set File Create Status**

[IRRS] Integrated interRAI Reporting System

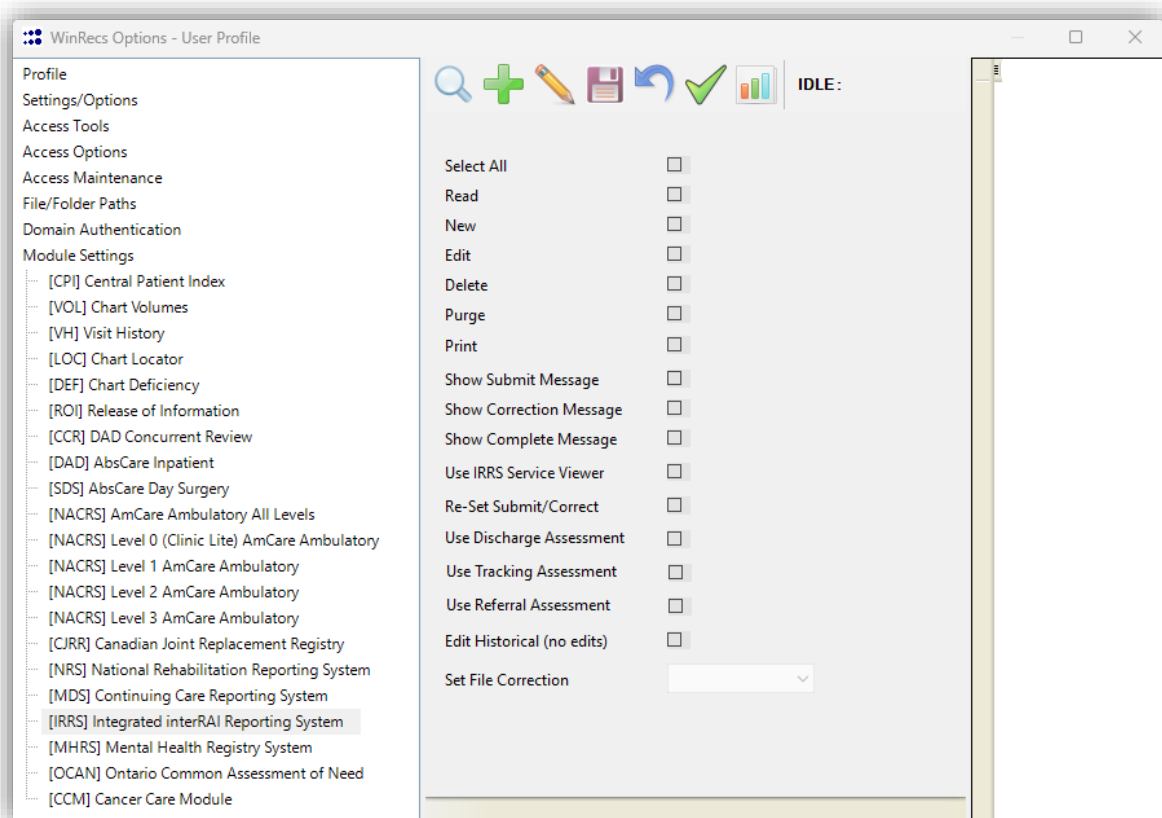


Figure 89 – User Profile – Module Settings/ NRS

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **IRRS** module
- New – When checked allows the user to create new abstracts in the **IRRS** module
- Edit – When checked allows the user to edit abstracts in the **IRRS** module
- Delete – When checked allows the user to delete abstracts in the **IRRS** module
- Purge – When checked allows the user to purge abstracts from the **IRRS** module
- Print - When checked allows the user to use the print feature in the **IRRS** module

- Show Submit Message – When checked displays the message 'Is this record ready to send for submission?' giving the user a 'Yes' or 'No' option. Not checking the message will not display the assessment will not submit.
- Show Correction Message – When checked displays the message for Corrections or for Correction/Updates depending on the fields being corrected or updated.
- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Use IRRS Service Viewer – When checked, will give the user access to the 'IRRS Submit Viewer' which displays all the PASS and FAIL transactions that have been submitted to CIHI.
- Re-Set Submit/Correct – Not applicable for IRRS
- Use Discharge Assessment – When checked, gives the user access to Discharge Assessments
- Use Tracking Assessment – When checked, gives the user access to the Discharge Tracking Assessments
- Use Referral Assessment – When checked, gives the user access to the Referral Assessment
- Edit Historical (no edits) – When checked when a record has an assessment date of pre-2019 then the edits will not display.
- Set File Correction – not applicable

[MHRS] Mental Health Reporting System (Ontario only)

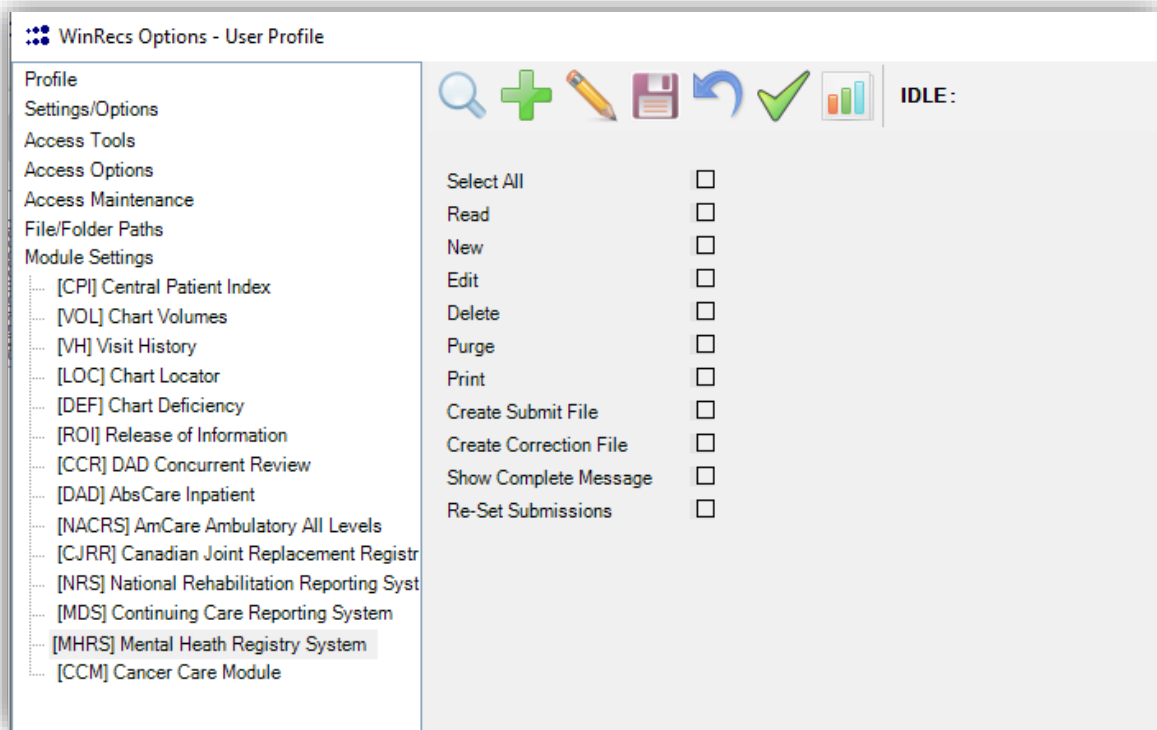


Figure 90 – User Profile – Module Settings/ OMHRS

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **MHRS** module
- New – When checked allows the user to create new abstracts in the **MHRS** module
- Edit – When checked allows the user to edit abstracts in the **MHRS** module
- Delete – When checked allows the user to delete abstracts in the **MHRS** module
- Purge – When checked allows the user to purge abstracts from the **MHRS** module
- Print - When checked allows the user to use the print feature in the **MHRS** module
- Create Submit File – When checked allows the user to create an **MHRS** CIHI Submission File
- Create Correction File – When checked allows the user to create an **MHRS** CIHI Correction File
- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Re-Set Submissions– When checked allows the user to Re-Set Submissions in the **OMHRS Abstract** → **File Settings** → **Re-set File Create Status**

- Edit Historical (no edits) – When checked when a record has an assessment date of pre-2019 then the edits will not display

[OCAN] Ontario Common Assessment of Need

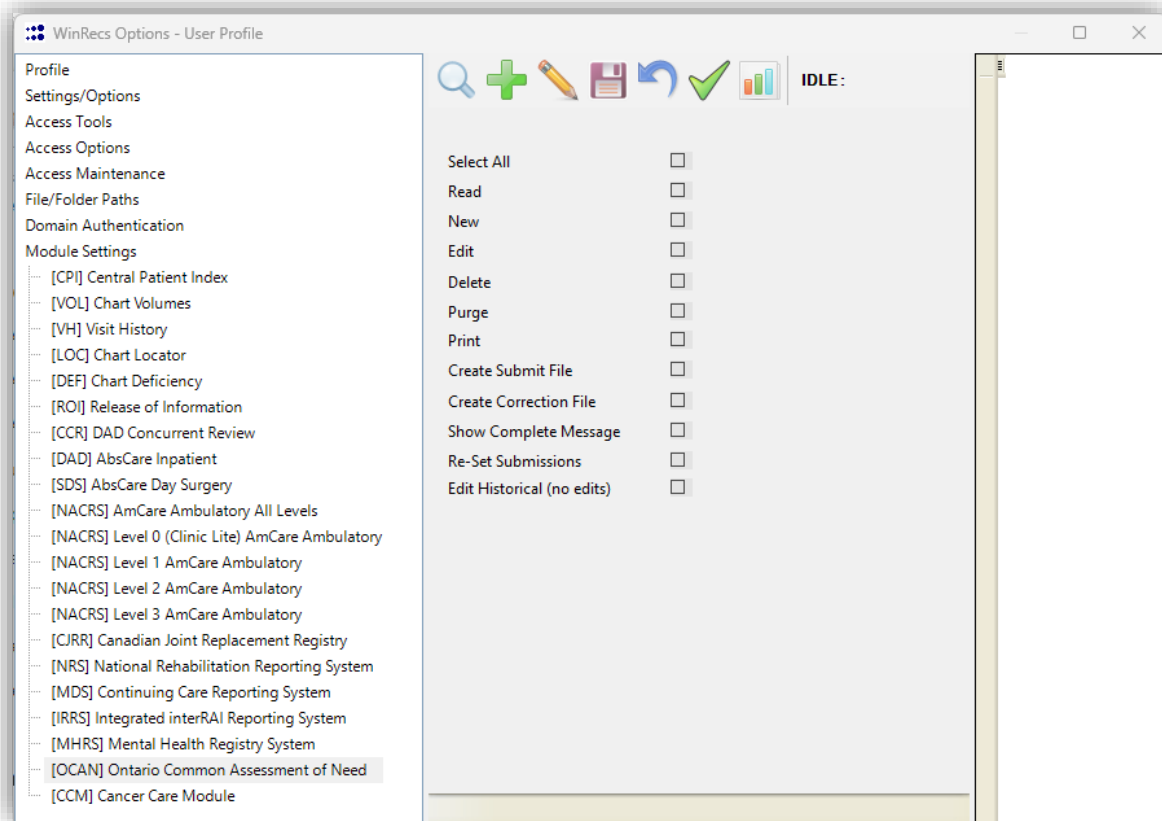


Figure 91 – User Profile – Module Settings/ OCAN

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **OCAN** module
- New – When checked allows the user to create new abstracts in the **OCAN** module
- Edit – When checked allows the user to edit abstracts in the **OCAN** module
- Delete – When checked allows the user to delete abstracts in the **OCAN** module
- Purge – When checked allows the user to purge abstracts from the **OCAN** module
- Print - When checked allows the user to use the print feature in the **OCAN** module
- Create Submit File – Allows the user to create a submission file via File Management.
- Create Correction File – Allows the user to create a correction file via File Management.

- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Re-Set Submissions – Gives the user ability to the submission status to 'N' (Not Submitted) for the assessment.
- Edit Historical (no edits) – When checked when a record has an assessment date of pre-2020 then the edits will not display.

[CCM] Cancer Care Module

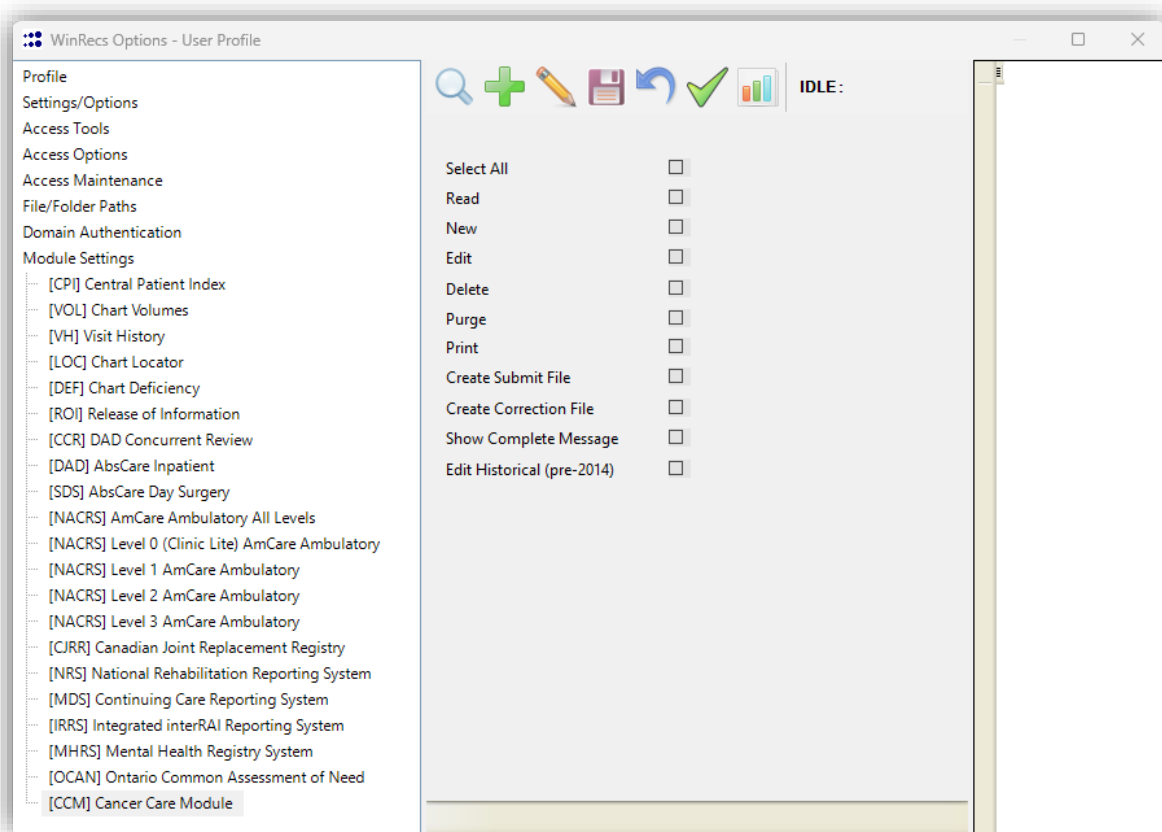


Figure 92 – User Profile – Module Settings CCM

- Select All – Checking this button will check all the buttons below.
- Read – When checked allows the user read only access to the **CCM** module
- New – When checked allows the user to create new abstracts in the **CCM** module
- Edit – When checked allows the user to edit abstracts in the **CCM** module
- Delete – When checked allows the user to delete abstracts in the **CCM** module
- Purge – When checked allows the user to purge abstracts from the **CCM** module

- Print - When checked allows the user to use the print feature in the **CCM** module
- Create Submit File – Allows the user to create a submission file via File Management.
- Create Correction File – Allows the user to create a correction file via File Management.
- Show Complete Message – When checked, if there are no hard (red) errors, a message displays after each abstract prompting if the abstract is complete. 'Y' or 'N' is used to respond to the prompt.
- Edit Historical (pre-2014) – When checked when a record has an assessment date of pre-2014 then the edits will not display.

2.5 Control File

The Control File is used to specify default values for fields, change field name, restore fields on the main grid, make fields visible/invisible or enable/disable for each module.

If a user does not have administrative rights, the user can only modify their own settings. If a user is linked to a Role ID in the User Profile, the user will not be able to change the Control File settings.

To access the Control File

Select **Options** → **Control File**

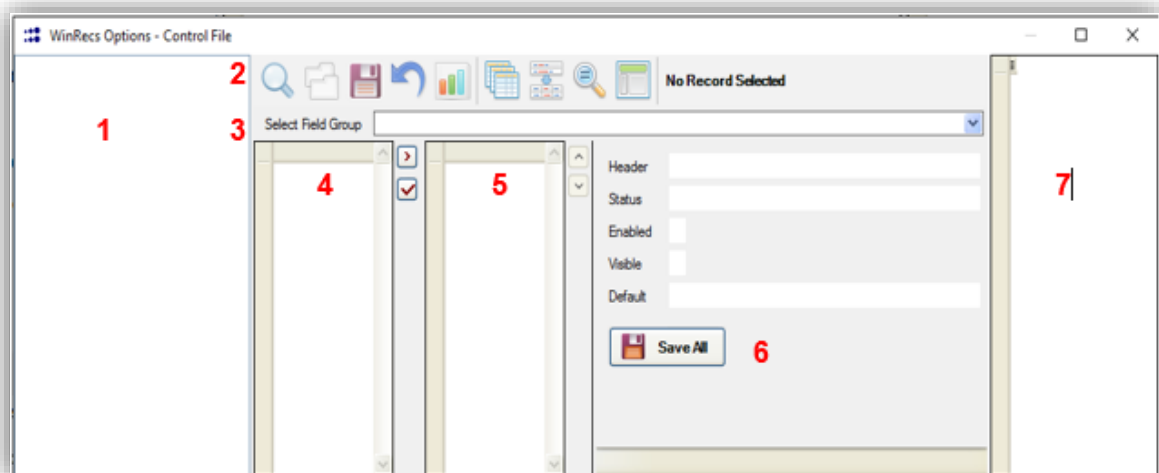


Figure 93 – Control File Screen Options

1. **Control File Options** – Displays the list of modules

2. Toolbar



Toolbar items with functionality and short cut keys listed.

<i>Icon</i>	<i>Menu Item</i>	<i>Function</i>	<i>Keyboard</i>
	Find	Search for an existing profile	[F4]
	Copy	Copy a profile	[F5]
	Save	Saves changes to the current profile	[F7]
	Cancel	Cancels changes made	[F8]
	Reports	If applicable this button displays a list of available reports to view	[F10]
	Multiple Occurrence Fields	Apply settings, change sort order to each of the fields in the multiform	N/A
	Group Headers	Apply settings for each Field Group	N/A
	Search Fields List	Apply the fields to display in the Search Results for each module.	N/A
	Record Information Fields List	Apply the fields that display in the Record Information Elements window.	N/A
	Visit History List	Apply the fields that display in the Visit History List window	N/A

Table 10 - Control File Toolbar

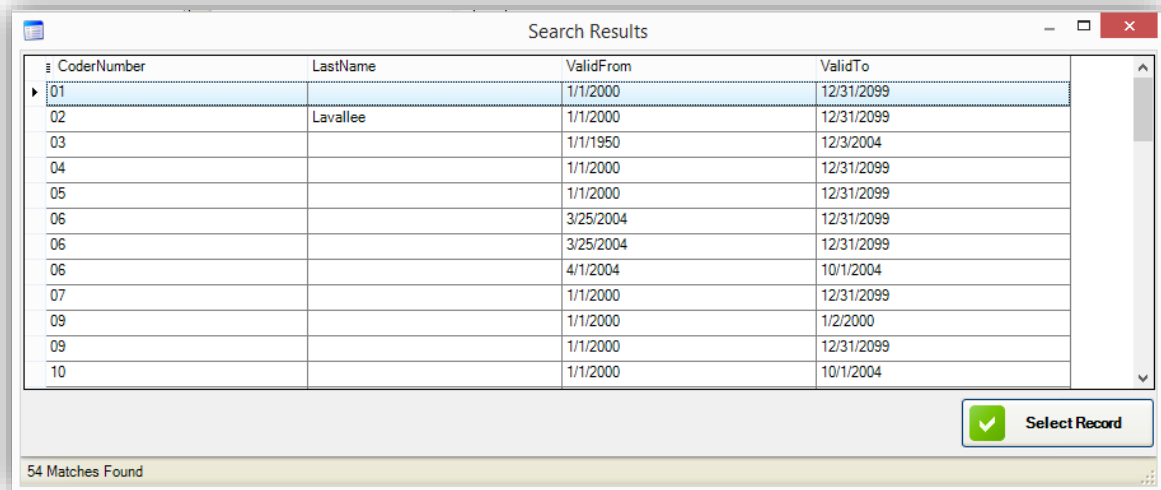
3. **Select Field Group** – The fields in the main grid within WinRecs are grouped together. The drop down menu provides the Group Header.
4. **Fields** – The list of the fields that are within the selected module.
5. **Field Group** - The fields that are within the group chosen in the **Select Field Group**
6. **Settings Options** – The settings option for each group/field:

- **Header** – the name of the field, the name of a field can be changed to reflect terminology a site may use.
 - **Status** – the drop down allows the assignment of the following options:
 - **Not Set** – there is no status assigned to the field
 - **Hospital Required** – the abstract will not save if the field is blank
 - **Hospital Error** – the field will generate an error if left blank
 - **Hospital Warning** – the field will generate a warning if left blank
 - **Enabled** - when checked the field is accessible in the abstract, not checked the field will be greyed out and not accessible.
 - **Visible** – when checked the field can be viewed in the abstract, not checked the field will be not show in the abstract
 - **Default** – can enter a default value for the field. If there are set values can select the value from a drop down list or press **[F2]** and a searching window for the field will popup.
 - **Save All** – this function allows the field to be saved on all users and profiles.
7. **Update History**– Display the details of whom made changes to the item selected from the control file options section. The coder name and the date and time the changes were made will be listed

Find

The first step to accessing fields the Control File is to select a User or Role ID. When editing the Role ID all users linked to the Role ID will have the same Control File settings.

- Press **[F4]** or click on the  icon.
- Double click the User



CoderNumber	LastName	ValidFrom	ValidTo
01		1/1/2000	12/31/2099
02	Lavallee	1/1/2000	12/31/2099
03		1/1/1950	12/3/2004
04		1/1/2000	12/31/2099
05		1/1/2000	12/31/2099
06		3/25/2004	12/31/2099
06		3/25/2004	12/31/2099
06		4/1/2004	10/1/2004
07		1/1/2000	12/31/2099
09		1/1/2000	1/2/2000
09		1/1/2000	12/31/2099
10		1/1/2000	10/1/2004

54 Matches Found

Figure 94 – Control File Search Screen

Copy

Copy is a function that allows another users module settings to be copied to another users account.

When working on a user account select the module that needs to be copied.

Press the Copy Button  and the following message will display:

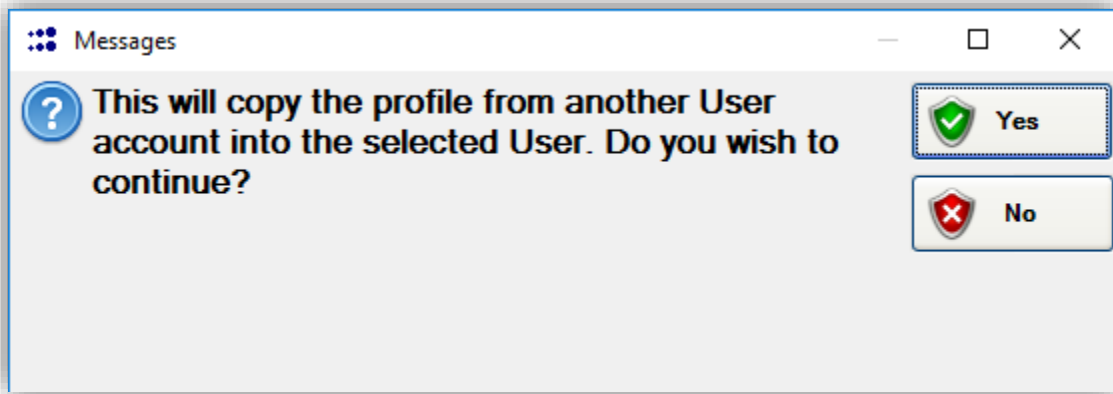


Figure 95 - Control File Message for Copying a User Account

- Selecting 'Yes' will bring up the Search Results window with the list of users and Role ID's that can be copied.
- Select the user account that needs to be copied. Once complete the user will be back to the main Control File screen with all the changes applied.

Choosing Modules

Once the user has been selected, the modules that the user has access to will be displayed on the left-hand side. Click on the module that needs to be modified. Once the module has been selected the fields will be displayed and the Select Field Group drop down will now have options available to select from.

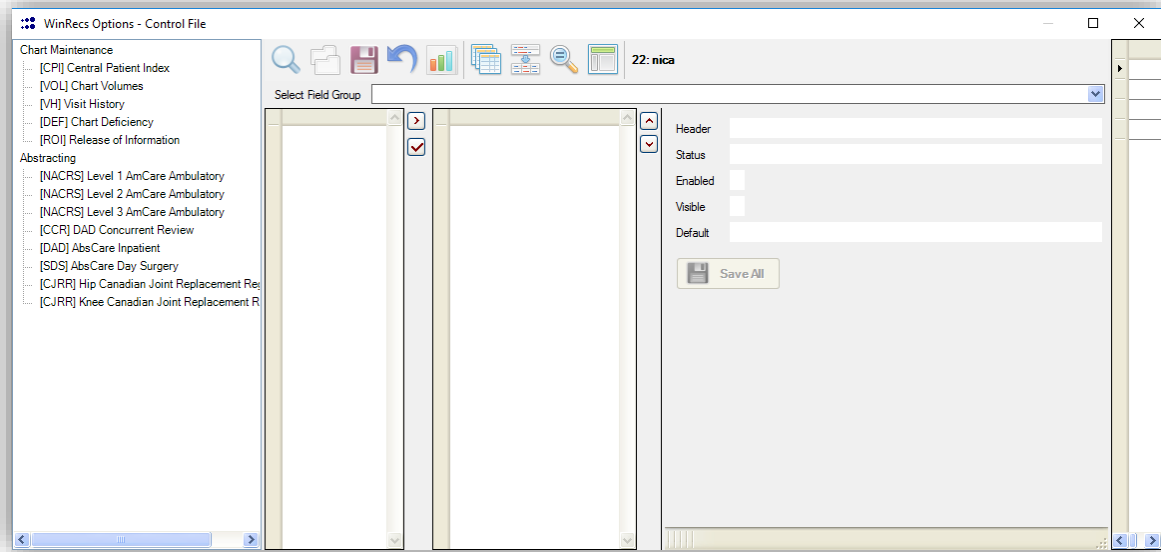


Figure 96 - Control File Options

Field List

This gives the user the ability to adjust the fields within the main grid of the abstract.

- Click on the module that contains the field that needs to be adjusted.
- The list of fields available for that module will appear on the Fields List panel.

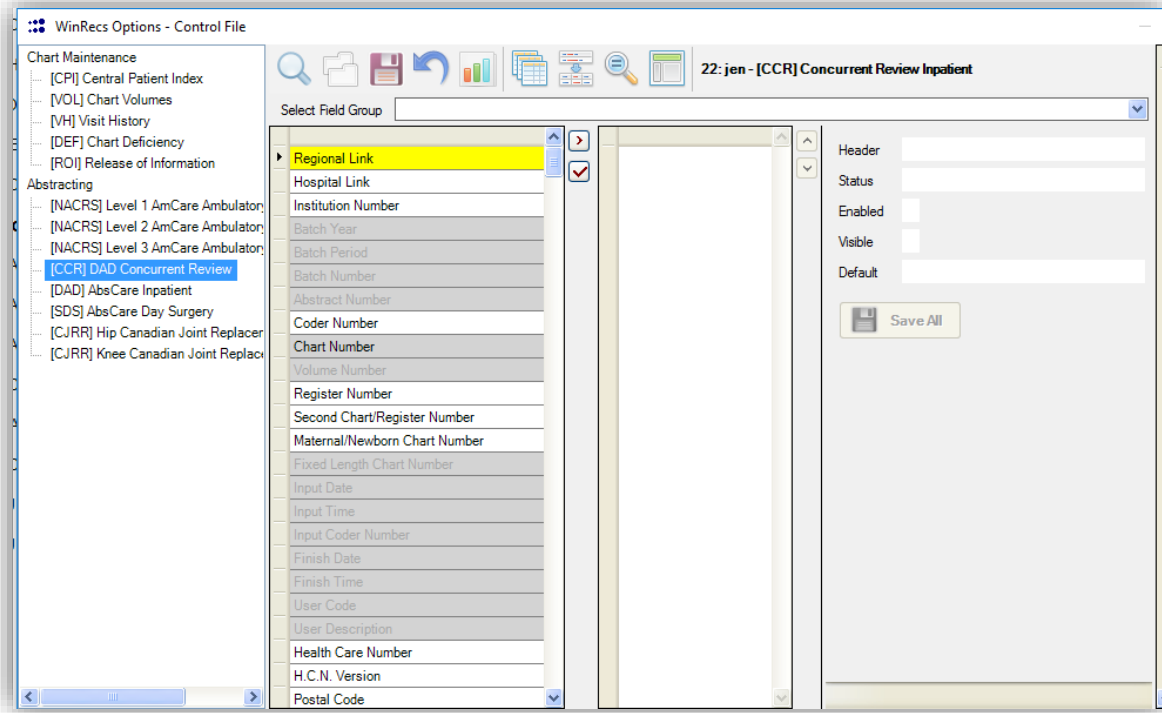


Figure 97 - Field List

- Any fields that are highlighted grey are **Visible** but not **Enabled**.

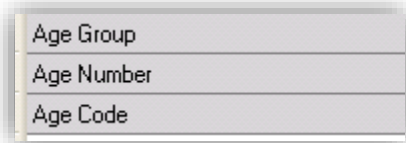


Figure 98 – Visible but Not Enabled

- Any fields highlighted grey and the font is grey are not **Visible** and may or may not be **Enabled**.

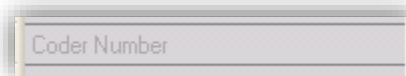


Figure 99 – Not Visible, May or May not be Enabled.

- Some fields maybe highlighted grey and are only made visible. If a field cannot be enabled, it could be the field is a calculated field or a field cannot be changed.

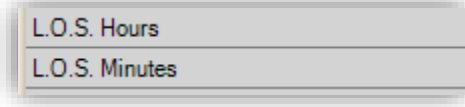


Figure 100 – Calculated Fields

- To modify a field, select the field and click the check mark  button.
- The **Select Field Group** dropdown will fill in and populate the **Field Group** with all the fields contained within the Group.
- The **Settings Options** area will also display the options for the field selected. [See Setting Options](#)

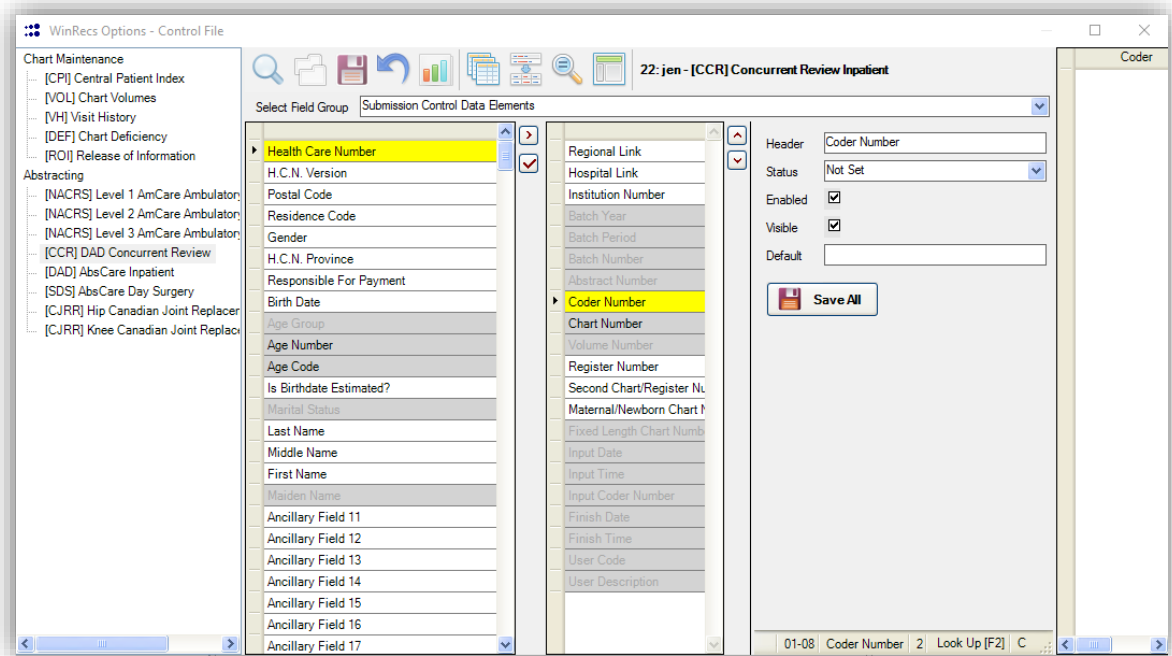


Figure 101 - Field List Selection

- To make changes to a different field in a different field group, there are 2 options:
 - Navigate to the field listed under the Fields list and use the check mark button to populate the Settings Options.
 - Use the Select Field Group drop down to select the group header that the field belongs and click the field title.

Moving Fields

The **Control File** has the ability to move fields into different **Field Groups**.

- Click on the field in the **Field** list.

- In **Select Field Group** select the field group to move the field to.
- Click on the arrow button  between the **Field List** and **Field Group** or double click on the field and it will move the **Field Group**
 - **For example:** Moving the field 'Maternal/Newborn Chart Number' from the 'Submission Control Data Elements' field group to 'Patient/Client Demographics Information'
 - In the **Select Field Group** click on the drop down menu and click on 'Patient/Client Demographics Information'
- In the Field List Click on 'Maternal/Newborn Chart Number' so it is highlighted yellow and press the  or double click the field and it will move to the 'Patient/Client Demographics Information' group

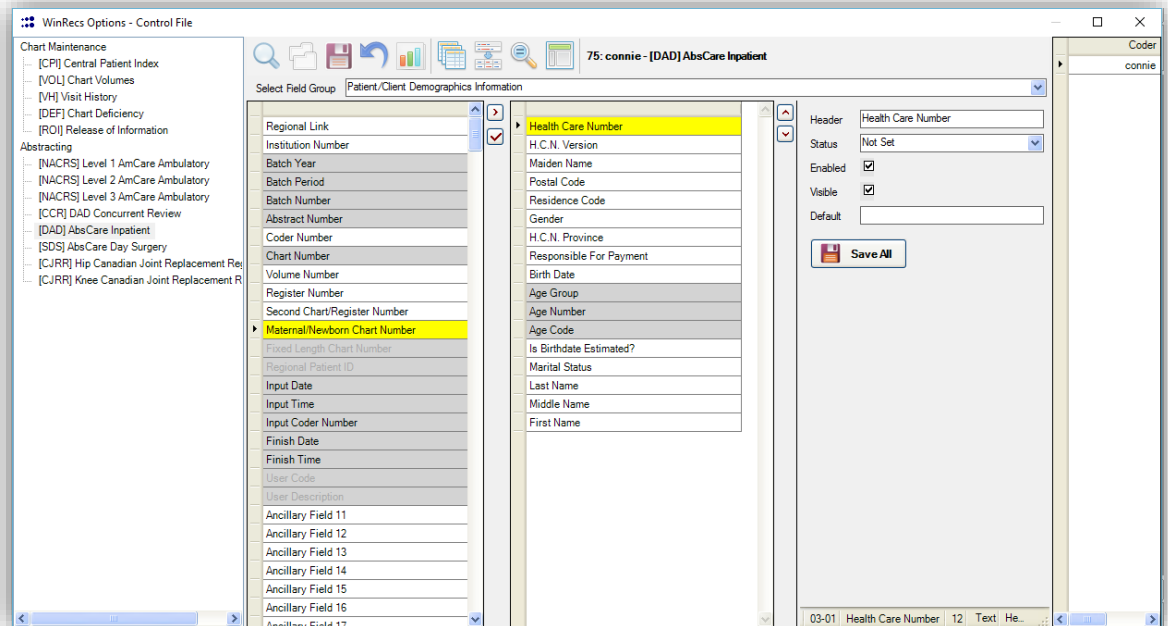


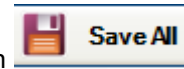
Figure 102 – Moving Fields to New Field Group

- To move a field back to it's original **Field Group**
 - Click on the field in the **Field List**
 - In **Select Field Group** choose the group the field was in
 - Press the arrow button to move
- To move the field up or down, click on the field in the **Field Group** list
 - Click on the up and down arrows  to move the field up or down.

Save

To save the changes for a user select the save button  or press F7.

To save the changes for all users in the system select the Save all button



Cancel

To cancel any changes made press the  or press F8.

Multiple Occurrence Fields

This options allows the ability to adjust the fields within the multi-forms of the abstract.



- Click on the Multiple Occurrence Fields button. A pop up screen will display:

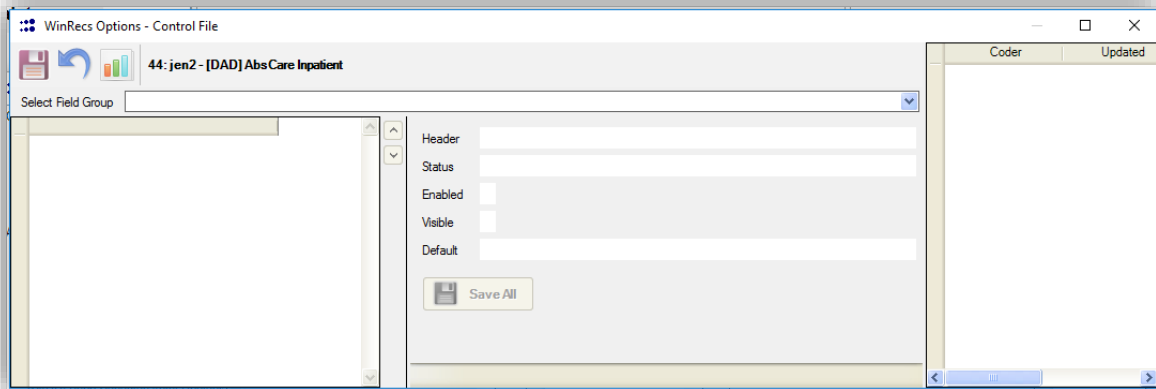


Figure 103 – Control File Multiple Field Entry List

- Click down on the '**Select Field Group**' and choose the multiform that needs adjusting, the list of fields for the selected multiform will populate on the left panel. The first field will be highlighted by default.
- To move the field up or down, click on the field to be moved
 - Click on the up and down arrows  to move the field up or down.
- The settings options can also be set for the fields . [See Setting Options](#)

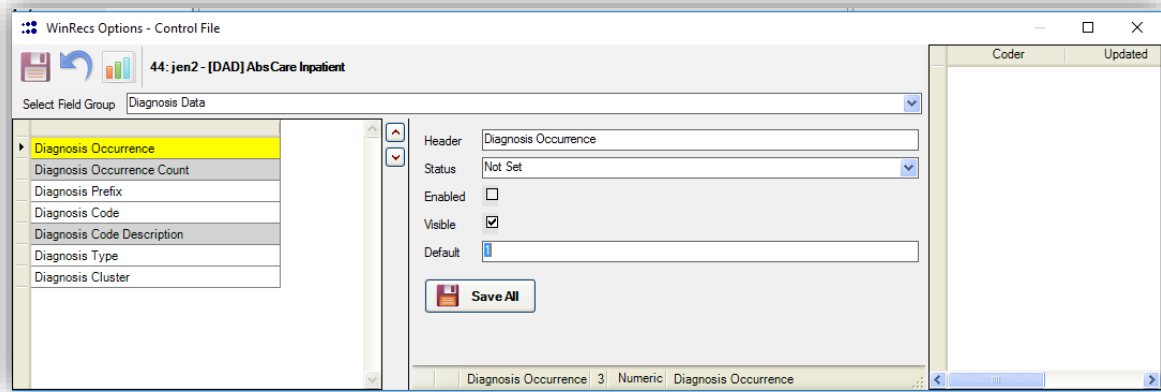


Figure 104 - Control File Multiple Field Entry List Specific

Group Headers

The Control File has the ability to adjust the setting for a whole section within the Abstract.

To adjust the setting of a section:



- Click on the Group Header icon . A pop up screen will display
- The list of Field Group Headers for that module and the Setting Options will display. Please note that the Status is not accessible. In the example below, the [DAD] AbsCare Inpatient module has been selected therefore the list of headers show in the popup window apply to that module.
- On this window the Header can be edited.

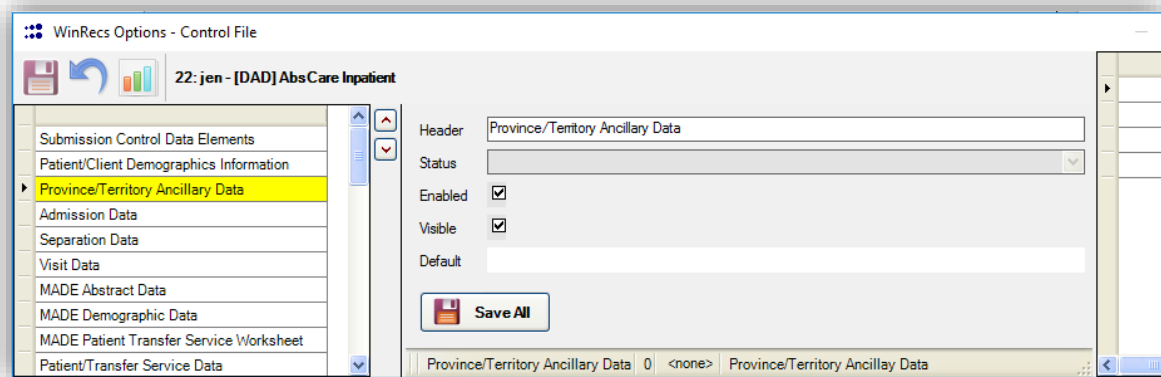


Figure 105 – Control File Group Header Screen

- If the **Enabled** and **Visible** were unchecked, this whole section would not appear in the abstract and the group would be highlighted grey and the font would be grey



Figure 106 – Enabled and Visible Unchecked

- If the **Enabled** was unchecked and the **Visible** was checked, the whole section would appear in the abstract but the user would not be able to enter into the fields in that section

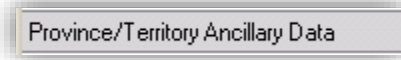


Figure 107 – Enabled Unchecked and Visible Checked

- To move the field up or down, click on the group to be moved
 - Click on the up and down arrows  to move the field up or down

Search Fields List

The Search Fields List is where the settings and configuration of the Search Results window are configured for each module. The fields and order in which the fields are to be displayed on the Search Results window can be configured here for each user.

- After selecting a user and the module that needs to be modified click the Search Field List

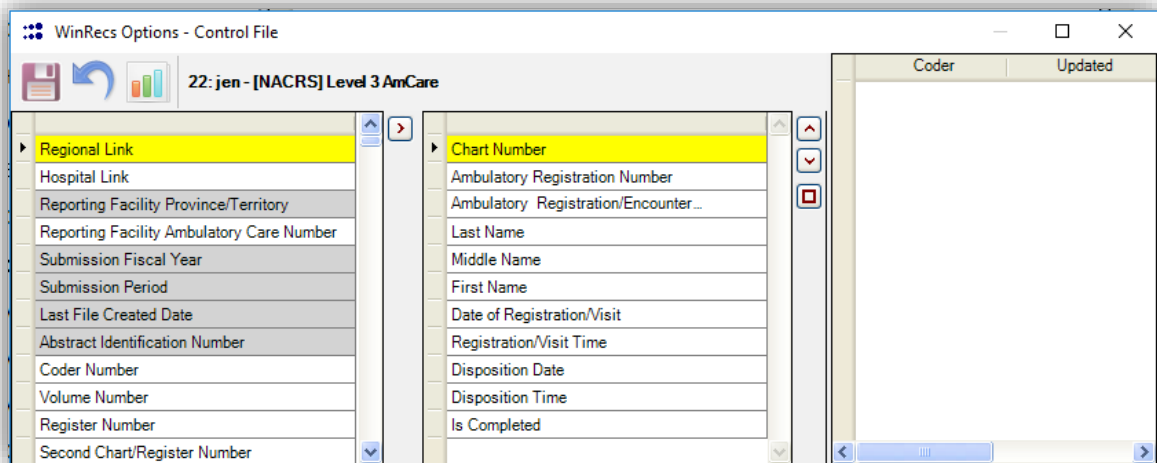


Figure 108 - Control File Search Fields List

- The first column list of fields for the selected module in the first column (all fields including multiform)
- The second column lists all the fields already selected to show in the Search Results window and the order they will be displayed.
- The third column lists who and the date the Search Fields list had been modified
- To add a field to the Search Results window, click on the field that needs to be added and click the add button 
- To remove a field from the Search Results window, click on the field that needs to be removed and click the remove button 
- To rearrange the order of the fields, select a field to be moved and click the appropriate arrow to move the field up  or down 

Record Information Fields List

This allows the user to select the fields to be displayed in the Record Information Elements screen.

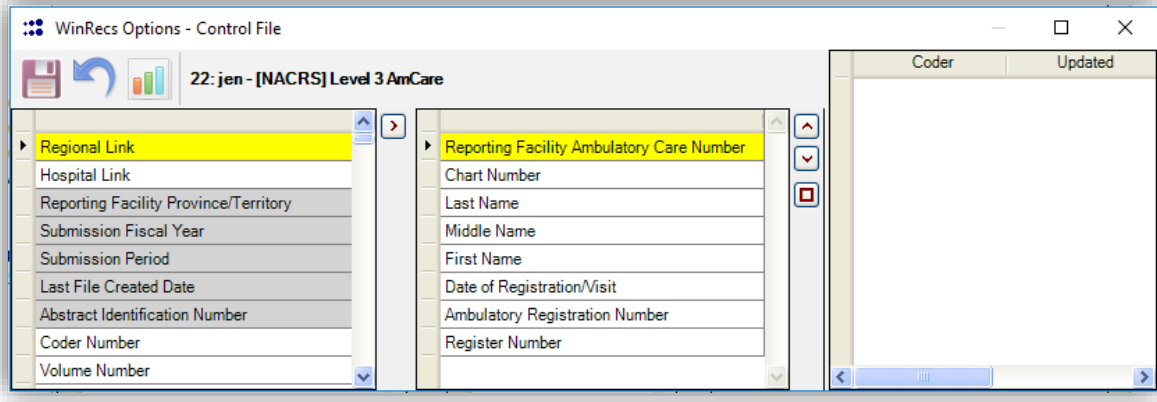


Figure 109 - Control File Record Information Fields List

- The first column contains all the fields from the main grid and multi-forms,
- The second column contains the fields shown in the Record Information Elements.
- The third column lists who and the date the Record Information Fields list had been modified
- To add a field to the Record Information Elements window, click on the field that needs to be added and click the add button 
- To remove a field from the Record Information Elements window, click on the field that needs to be removed and click the remove button 
- To rearrange the order of the fields, select a field to be moved and click the appropriate arrow to move the field up  or down 

User Defined Fields

WinRecs provides 6 User Defined Fields (UD) and 25 of each. These fields are found in all modules as follows:

- User Date Fields (1-25)
- User Time Fields (1-25)
- User Note Fields (1-25)
- User Look Up Fields (1-25)
- User Text Fields (1-25)
- User Numeric Fields (1-25)

These fields are set up in the Control File and can be found at the end of the of all fields in the main grid or can be found by selecting the Select Field Group drop down menu. User Defined Fields can be moved to other areas on the main grid, but cannot be included in multi-forms.

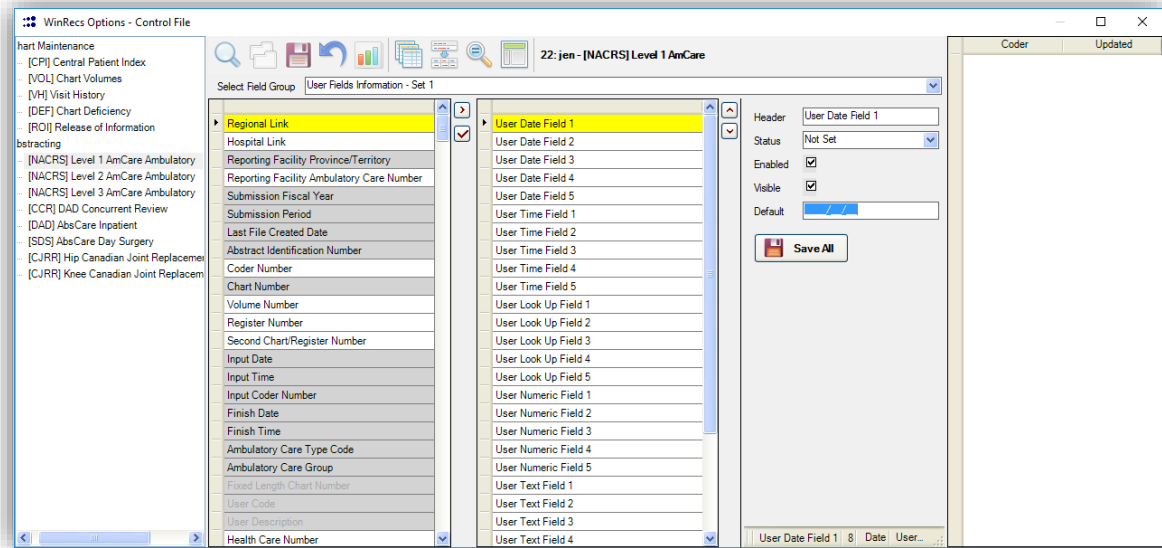


Figure 110 – User Defined Fields

- On the right hand side fill in the following:
 - Header – This is the name of the user field
 - Status – the drop down allows the user to assign the following options:
 - Not Set – there is not status assigned to the field
 - Hospital Required – the abstract will not be able to be saved if the field is blank
 - Hospital Error – the field will generate an error if left blank
 - Hospital Warning – the field will generate a warning if left blank
 - Enabled - when checked the user will be able to access the field in the abstract, not checked the user will not be able to access the field
 - Visible – when checked the user will be able to view the field in the abstract, not checked the user will not be able to view the field
 - Default Value – allows the user to default values into a field
- User Look Up fields will require the user to create the Look Up Values in [Look Up Code Maintenance](#).

3. WinRecs Maintenance Menu

The WinRecs **Maintenance** Menu consist of five modules : Look Up Code Maintenance, Provider Maintenance, Project Maintenance. Report Maintenance, and Auto Batch Interface Maintenance

3.1 Look Up Code Maintenance

This feature is used to maintain the lookup tables. These tables contain values defined by CIHI, other provincial authorities or specific values used by the facility. In any WinRecs module, **[F2]** will access the look ups for any field that has an associated look up table.

To access the Look Up Code Maintenance screen

- Select **Maintenance** → **Look Up Code Maintenance**

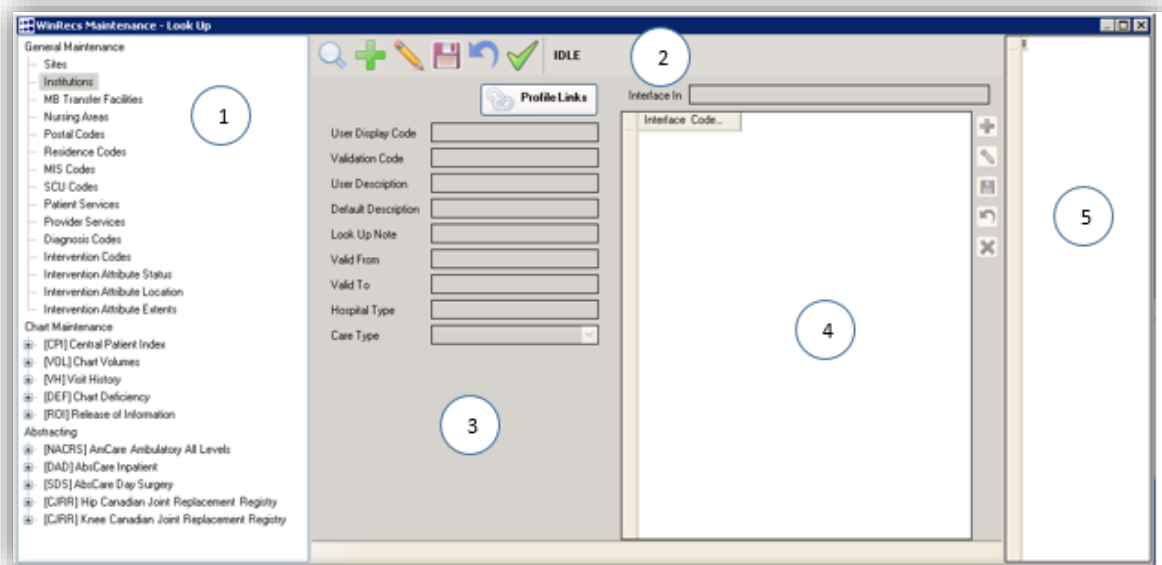


Figure 111 – Look Up Code Maintenance Screen

1. **Look Up Code Maintenance Modules** - Click on the Look up Table that needs adjusting. There are 3 main sections of the Look Up Code Maintenance
 - **General Maintenance** – These are the look up tables that are similar in all **WinRecs** Modules
 - **Chart Maintenance** – These are specific look up tables that are found in the specific **Chart Maintenance** Modules
 - **Abstracting** – There are specific look up tables that are found in the specific **Abstracting** modules.
2. **Toolbar** – [see Toolbar](#)
3. **Code Values**

- **Profile Links**– The ability to link a look up code to a region if there is more than one region in the database or link to a hospital if there is more than hospital. (Optional)
Leaving it blank will show for all hospitals.
- **User Display Code** – The displayed value for the look up field
- **Validation Code** – The displayed value for the look up field
- **User Description** – The description of the code
- **Default Description** – The default description of the code (same as user description)
- **Look Up Note** – Additional description of the value if needed
- **Valid From** – The date the code is valid from
- **Valid To** – The date the code is valid to
 - **Interface Out** – Value used as region/hospital in interface populating out of WinRecs, populates with User Code.
 - **Interface Out** – Value used as region/hospital in interfaces populating out of WinRecs, populate with the User Code.
- 4. **Interface In** – add the interface in values from your Batch and HL7 interfaces.
- 5. **Update History** – Displays the user(s) that made changes to the look up value.

To add a new code

1. Select, by clicking the desired code group in the Code List panel on the left hand side.
2. Click the  on the toolbar.
— or —
3. Press **[F5]**.
4. Enter all of the required fields in the code editing panel on the right hand side.
5. Click the  on the toolbar to save the new record.
— or —
6. Press **[F7]**.

To edit an existing code

1. Select, by clicking the desired code group in the Code List panel (1).
2. Click the  on the toolbar to display the search code screen.
— or —
3. Press **[F4]** to display the search code screen.

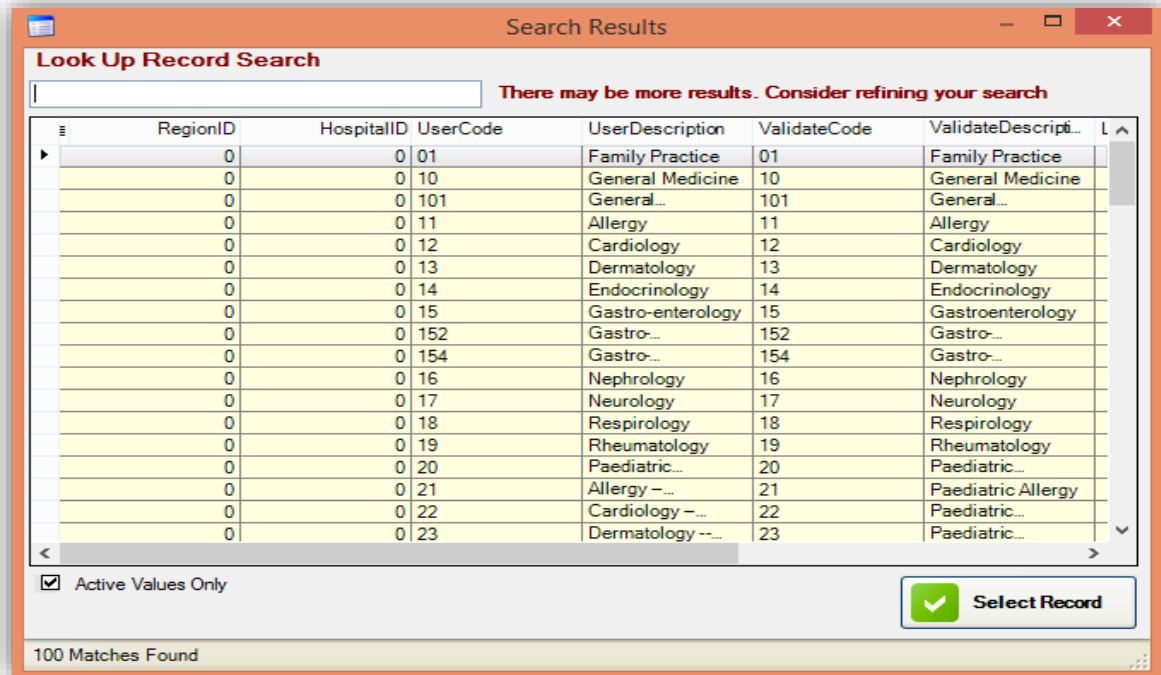


Figure 112 - Look Up Code Search

4. In the list, select the code that you need to modify.
5. Double click the desired code.
— or —
6. Select the desired code, then press **[ENTER]**.
— or —
7. Select the desired code, then click .

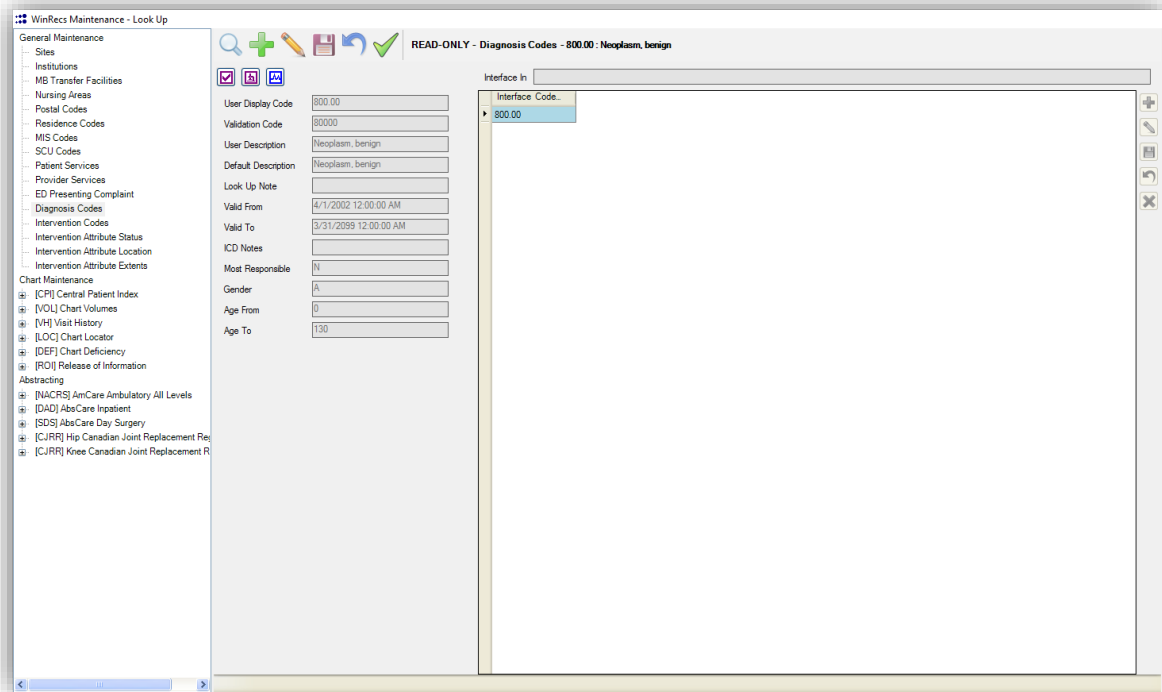
Greyed out values cannot be changed. These fields are found throughout the Look Up Code Maintenance tables and are either WinRecs default fields/descriptions or fields that have been submitted to CIHI.

Once a Look Up Code has been saved, the Validation Code and Default Description cannot be changed. To change these fields, the current Look Up Code must be deactivated by resetting the Valid To Date and creating a new entry with the new values.

ICD-10 Diagnostic and Intervention Codes

There are limited fields that can be updated in the ICD-10 and CCI tables. The CIHI values are visible but not enabled and these fields cannot be changed. The user can only change the fields that are visible and enabled.

Edits for Diagnosis and Intervention codes can be viewed in the Look Up. For example, gender and age from and to.



The screenshot shows the 'WinRecs Maintenance - Look Up' window. The left sidebar contains a tree view with categories like 'General Maintenance', 'Chart Maintenance', and 'Abstracing'. The central form is titled 'READ-ONLY - Diagnosis Codes - 800.00: Neoplasm, benign'. It contains fields for 'User Display Code' (800.00), 'Validation Code' (80000), 'User Description' (Neoplasm, benign), 'Default Description' (Neoplasm, benign), 'Look Up Note', 'Valid From' (4/1/2002 12:00:00 AM), 'Valid To' (3/31/2099 12:00:00 AM), 'ICD Notes', 'Most Responsible' (N), 'Gender' (A), 'Age From' (0), and 'Age To' (130). The right pane is titled 'Interface Code.' and shows a list of interface codes, with '800.00' selected.

Figure 113 - Diagnostic and intervention Codes

The Diagnostic and Intervention windows in the Lookup Maintenance have 3 additional buttons that allow Diagnosis, Intervention and Projects to be linked. Linking of more than one Diagnosis, Intervention or Project can be done.

	Project Link -when selected a popup window with the list of Projects that can be linked to the Diagnosis or Intervention code that is being edited
	Diagnosis Codes - when selected a popup window with the list of Diagnosis Codes that can be linked to the Diagnosis or Intervention code that is being edited
	Intervention Codes - when selected a popup window with the list of Intervention Codes that can be linked to the Diagnosis or Intervention code that is being edited

Table 11 – Project, Diagnostic and Intervention Buttons

- The following example will display how to link a diagnosis code to a project
 - WinRecs Maintenance – Look Up/General Maintenance/Diagnosis Codes
 - Search for 'I64, Stroke, not specified as haemorrhage'



- Press Edit



- Press the Project icon



Figure 114 - Diagnostic and intervention Codes

- Press the new button 
- Click in the Project Number Box and Press **[F2]** or type in the Project number

Project Number

- From the list of projects double click or highlight and press Select Record

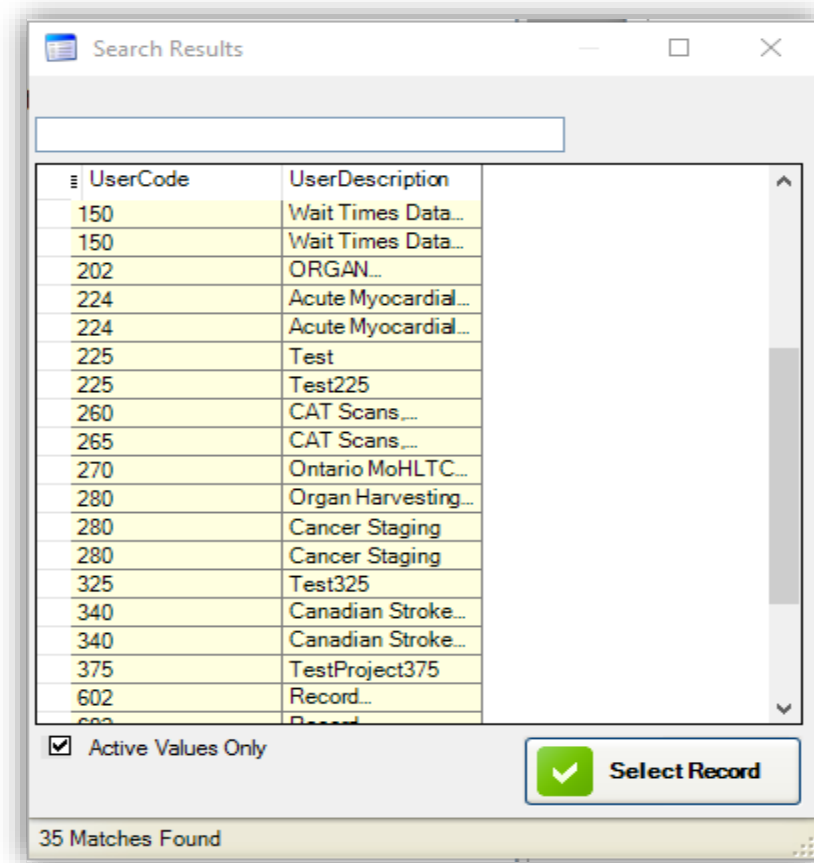


Figure 115 – Linking Project to Diagnosis Code

*Please note the button for Active Value Only, if checked it will only display active projects, uncheck will display all active and inactive projects.

- Press the  Save button
- To edit the project press the 
- To cancel any changes press the 
- To delete a project press the 

3.2 Provider Maintenance

The provider maintenance module is used to add or revise information for a facility's physicians and other providers. Providers may be added, modified and deactivated as required.

To access the Provider Maintenance screen

Select **Maintenance** → **Provider Maintenance**.

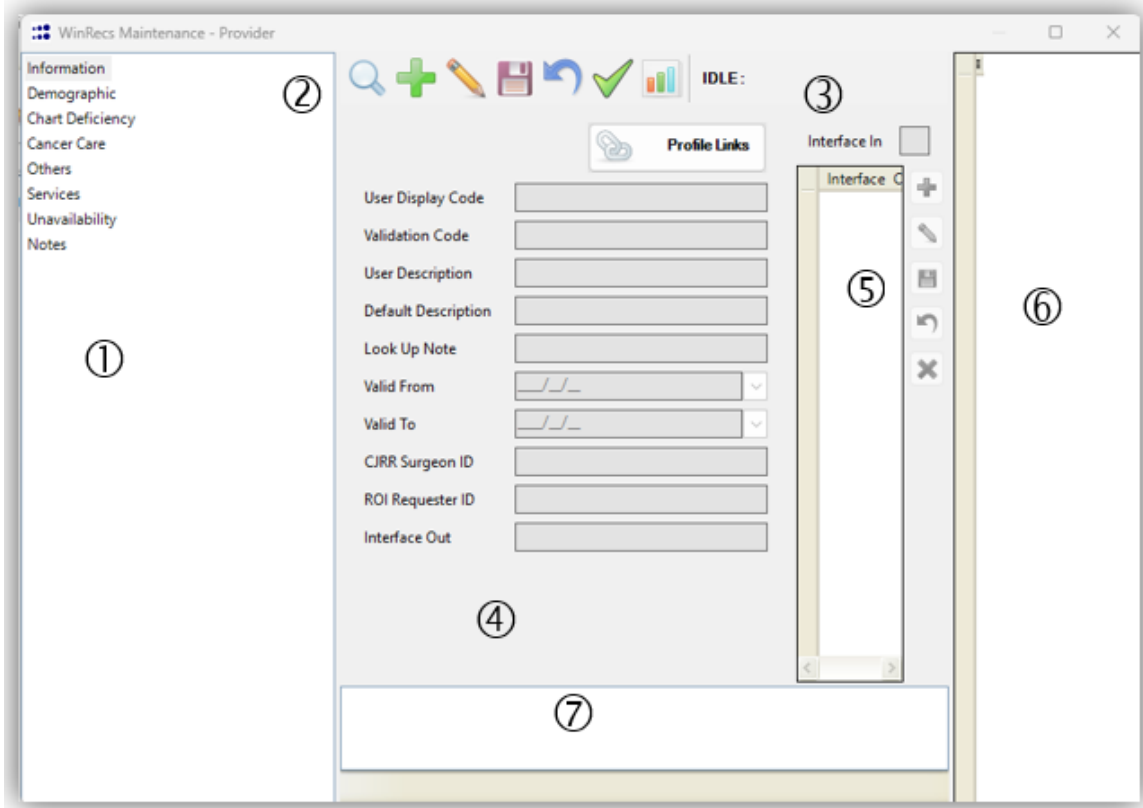


Figure 116 - Provider Maintenance screen

1. Provider List panel

- **Information** – is the display information for the provider
- **Demographic** – the demographic information for the provider
- **Chart Deficiency** – the information pertaining to Chart Deficiency for the provider
- **Cancer Care** – the information pertaining to Cancer Care for the provider
- **Others** – Other information for the provider
- **Services** – Lists the provider service/speciality for the provider, may enter more than one.
- **Unavailability** – Dates the provider is away used for Chart Deficiency
- **Notes** – Ability to leave notes regarding the physician.

2. Toolbar – [see Toolbar](#)
3. Provider identifier – Displays the provider being modified or entered. If new, will display 'NEW', if no provider chosen will display 'EDIT'
4. Editing panel – Displays the fields that can be modified for the selected provider.
5. Interface Value – Allows linking an interface value with a provider.
6. Update History – Displays the user(s) and date/time who have created or updated the provider.
7. Messages – displays a message of any fields that need to be entered, the fields will disappear as they are filled in

To add a new provider

1. Click the  on the toolbar or Press **[F5]**.
2. Select the Information Panel
3. Enter all of the required fields in the Editing panel (4).

Provider Maintenance - Information

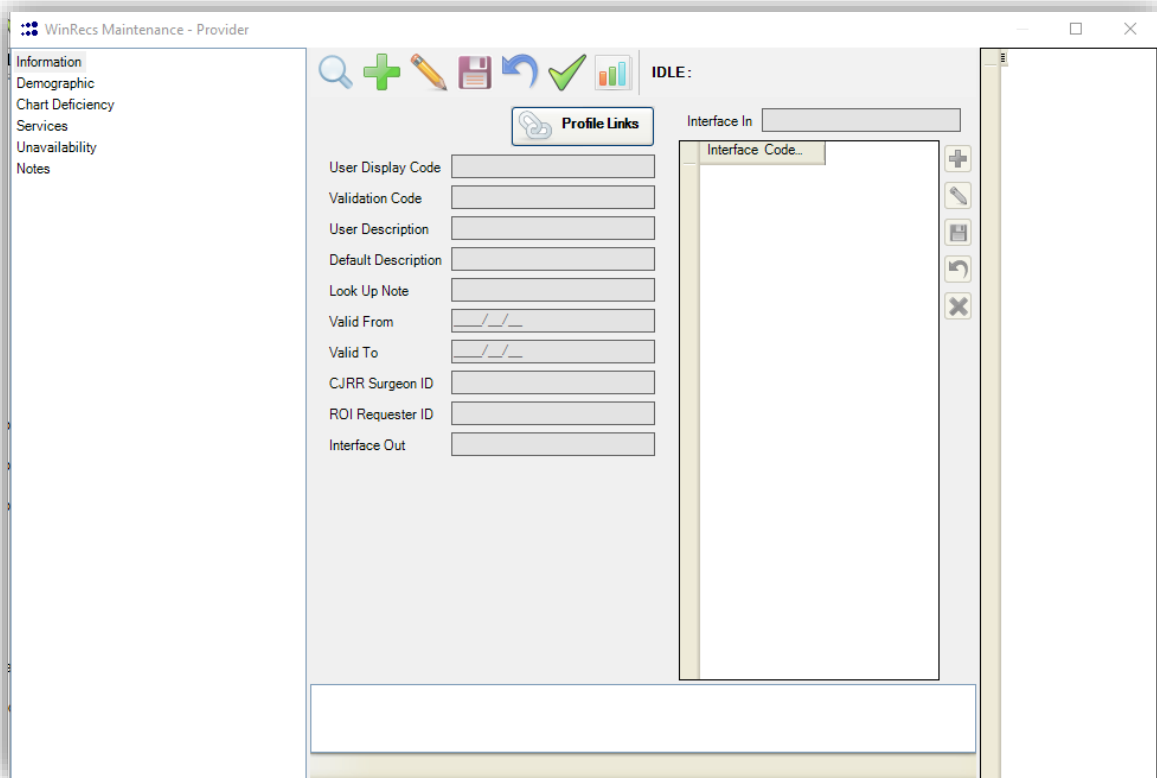


Figure 117 - Provider Maintenance - Information

- Profile Links – the ability to assign a provider to a region from the dropdown list or from the available hospital(s). (Optional) Leaving it blank will show for all regions and hospitals.
- User Display Code – The provider number
- Validation Code – Same as User Display Code
- User Description – The provider name
- Default Description – The same as User Description
- Look Up Note – Additional Description of the value or rules for use
- Valid From – Date when the provider became active.
- Valid To – Date when the provider became invalid.
- CJRR Surgeon ID – The surgeon ID as assigned by CIHI for CJRR.
- Interface Out – Value used as region/hospital in interface populating out of WinRecs, populates with User Code.

Provider Maintenance - Demographic

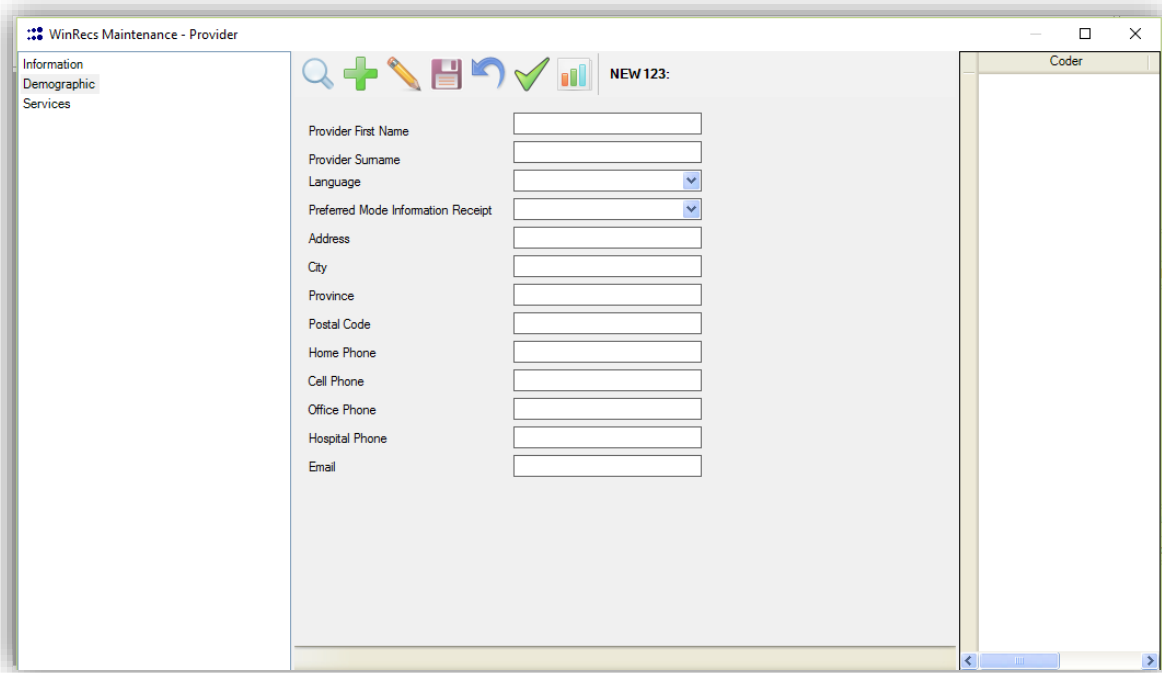


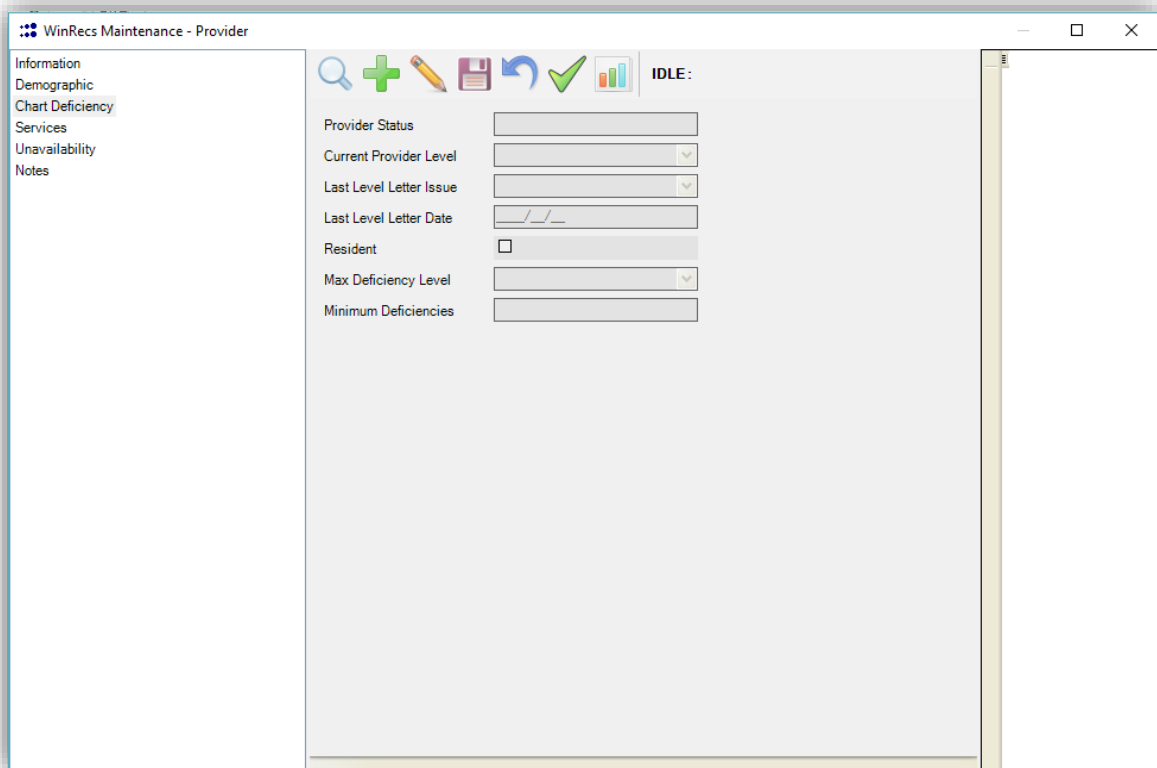
Figure 118 - Provider Maintenance – Demographic

The demographic information is not mandatory and depends on the site and modules using on how much or little is filled in.

- Provider First Name – The provider first name
- Provider Surname – The provider last name
- Language – Drop down of the language preferred

- Preferred Mode Information Receipt – Email/Fax/Postal Mail
- Address – The provider address
- City – The provider city
- Province – The provider province
- Postal Code – The provider postal code
- Home Phone – The provider home phone
- Cell Phone – The provider cell phone
- Office Phone – The provider office phone
- Hospital Phone – The provider hospital phone
- Email – The provider email

Provider Maintenance - Chart Deficiency



The screenshot shows the 'WinRecs Maintenance - Provider' window with the 'Chart Deficiency' tab selected. The form contains the following fields:

- Provider Status: Text input field
- Current Provider Level: Dropdown menu
- Last Level Letter Issue: Dropdown menu
- Last Level Letter Date: Date input field (MM/YY)
- Resident: Checkmark box
- Max Deficiency Level: Dropdown menu
- Minimum Deficiencies: Text input field

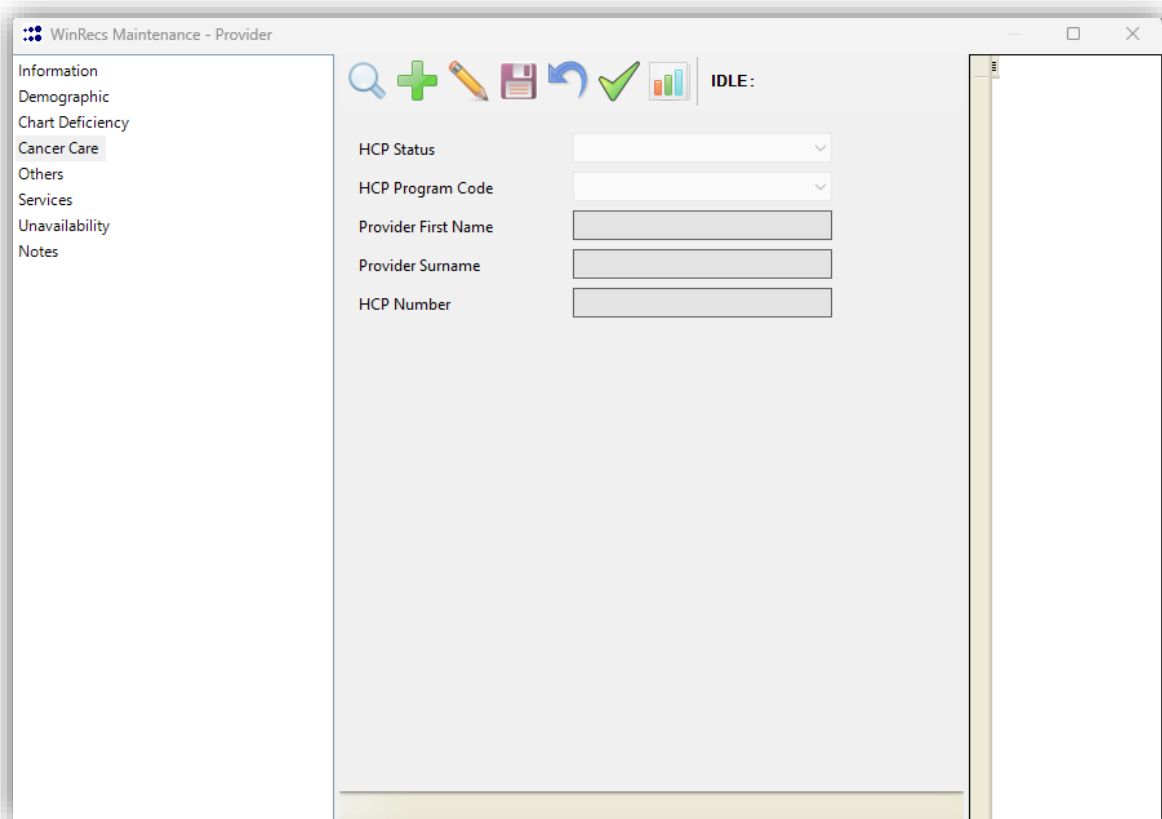
At the top right of the form area, there is an 'IDLE:' label and a series of icons: a magnifying glass, a plus sign, a pencil, a floppy disk, a circular arrow, a checkmark, and a bar chart.

Figure 119 - Provider Maintenance – Chart Deficiency

- Provider Status – Status of Provider – A (Active) or I (Inactive), populated from the Provider Status field in the Chart Deficiency module.
- Current Provider Level – Provider Level is the level of deficiency the provider is at and what letter they will receive next. The level is determined by the site.

- Last Level Letter Issued – The last letter the provider received
- Last Level Letter Date – The date last letter was sent out
- Resident – A check mark indicates if the provider is a resident
- Max Deficiency Level – Indicates the maximum letter level the provider will receive
- Minimum Deficiencies – The minimum level of deficiencies that will generate a letter.

Provider Maintenance - Cancer Care



WinRecs Maintenance - Provider

Information
Demographic
Chart Deficiency
Cancer Care
Others
Services
Unavailability
Notes

HCP Status: A
HCP Program Code: PSO
Provider First Name:
Provider Surname:
HCP Number:

Figure 120 - Provider Maintenance – Cancer Care

- HCP Status – Used for Cancer Care module, two options:
 - A: Active
 - I: Inactive
- HCP Program Code – Used for Cancer Care modules, three options:
 - PSO: Psychosocial Oncology
 - RAD: Radiation
 - SYS: Systemic
- Provider First Name – First Name

- Provider Surname – Surname
- HCP Number – The HCP number of the provider

Provider Maintenance - Others

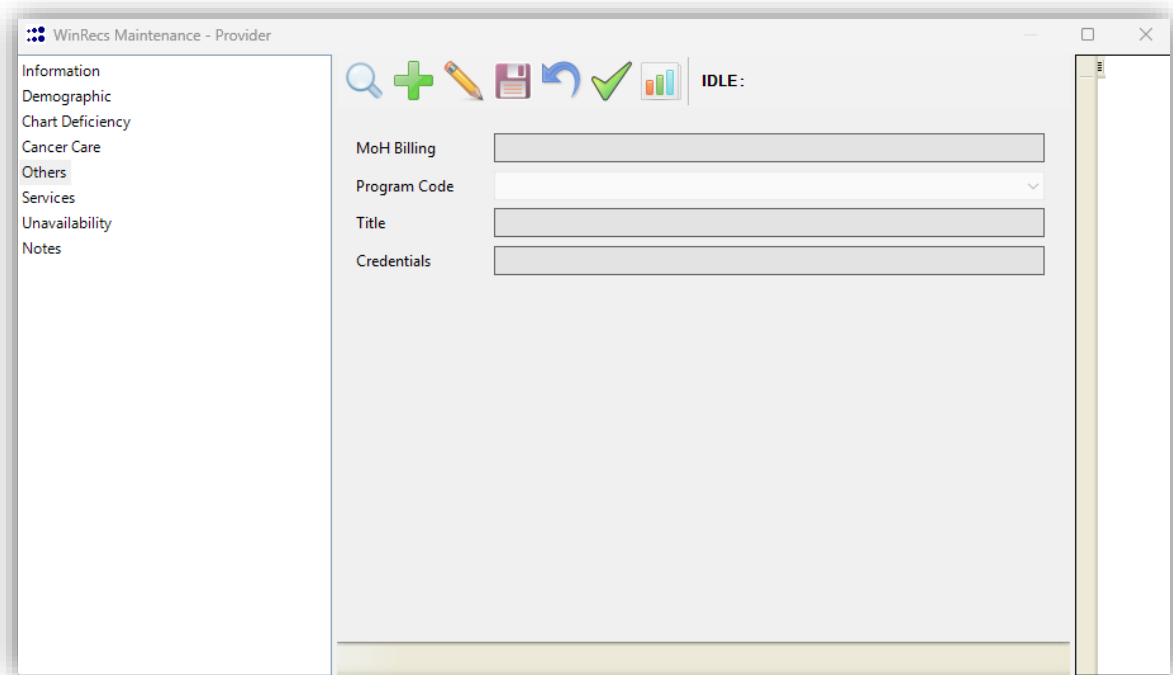


Figure 121 - Provider Maintenance – Others

- MoH Billing–
- Program Code – Used for Cancer Care modules, three options:

PSO: Psychosocial Oncology
 RAD: Radiation
 SYS: Systemic
- Title – Title of Provider
- Credentials – Credentials of Provider

Provider Maintenance - Services

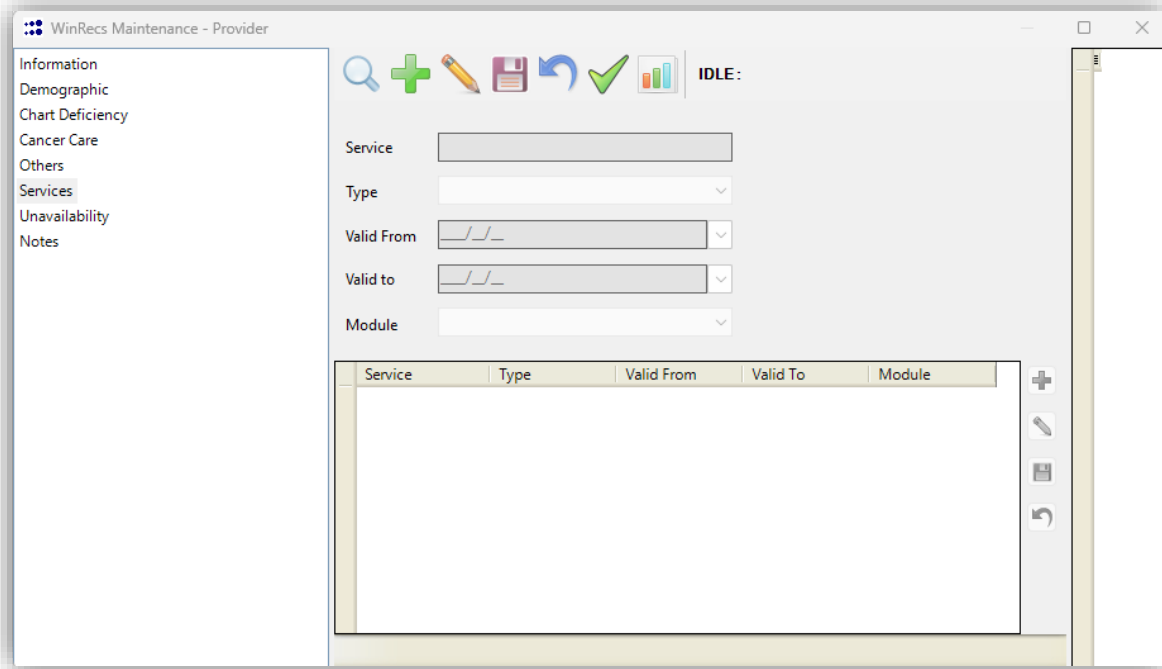


Figure 122 - Provider Maintenance – Services screen

Each provider needs a **Service (Inpatient/SDS)** and/or **Speciality (NACRS)**

- To add, press the  to add the speciality
- The **Service** will open, enter the Service/Speciality number or press **[F2]** to show the list of Service/Speciality numbers
- Enter the Valid From Date – the date the service is valid
- Enter the Valid To Date – the date the service is invalid
- Module – the user can attach the provider service to:

Ambulatory Care
Inpatient (and Clinical) Care

- Once added, press the 
- If you need to delete the service/speciality, press the 
- Click the  on the toolbar to save the new record.
— or —
Press **[F7]**.

Changes to Provider Maintenance will not appear till the user logs out and back into WinRecs

- To edit an existing provider
 - Select, by clicking the desired group in the Provider List panel (1).
 - Click the  on the toolbar to display the search screen.
 - or —
 - Press **[F4]** to display the search screen.

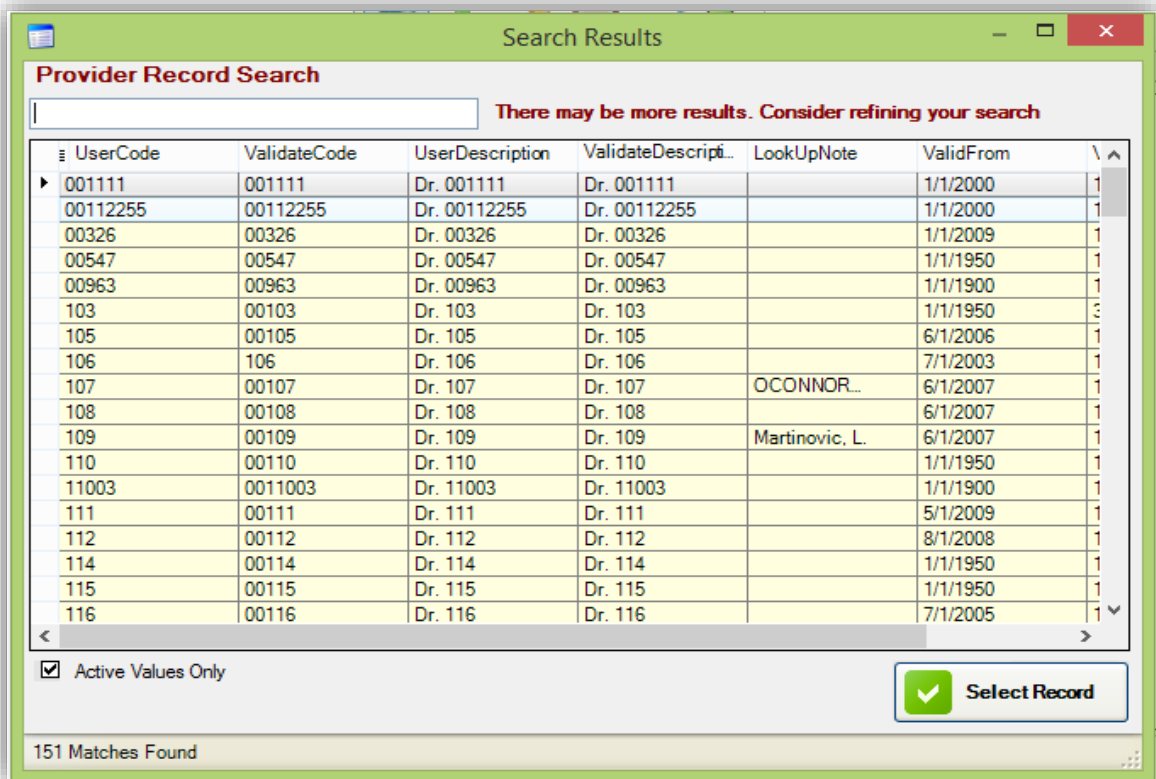


Figure 123 - Provider search

- In the list, select the provider that you need to modify or type in **user code** or **name**
- Double click on the desired provider.
- or —
- Select the desired provider, then press **[ENTER]**.
- Select the desired provider, then click 
- Press  to edit the provider information

- On the Services screen to edit an existing Service or Speciality, press the  , this will open up the Service & Valid To and From Dates to make any changes.

Provider Maintenance - Unavailability

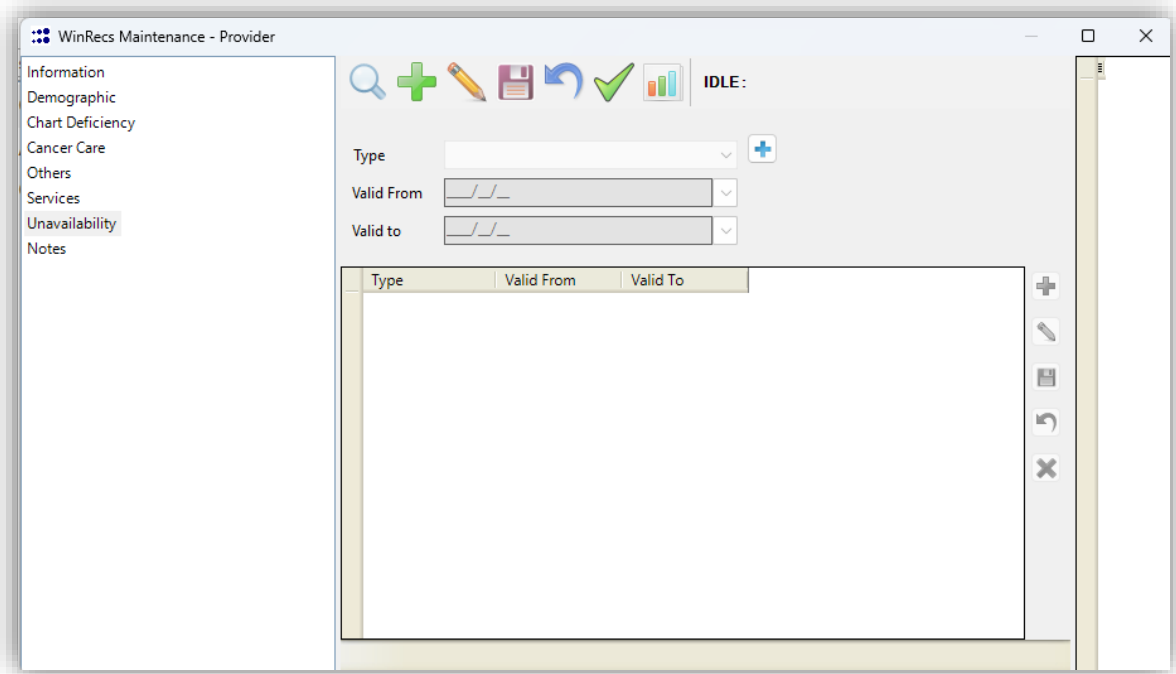
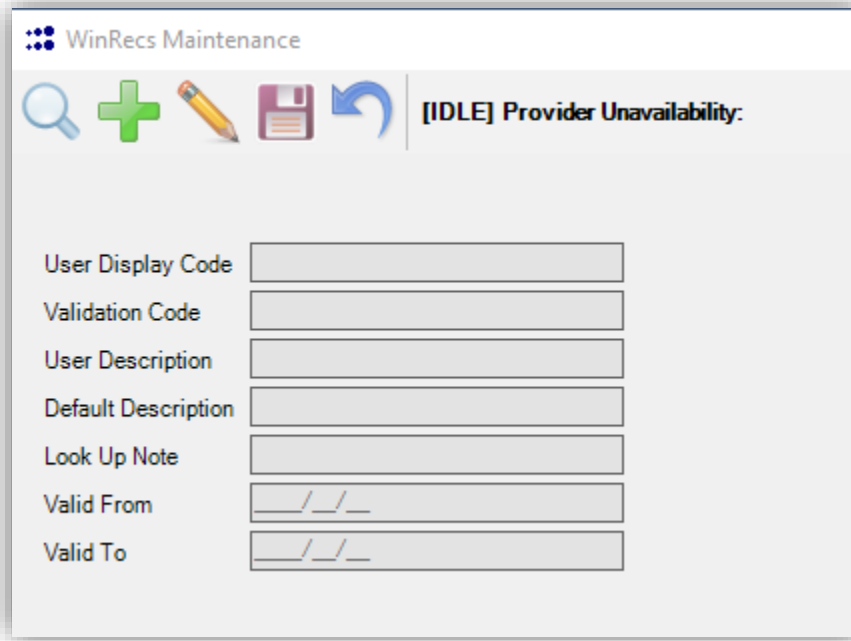


Figure 124 – Provider Maintenance - Unavailability

If a Provider is away for a certain period of time, the Unavailability Screen would be populated. This will also stop the counting of deficient charts.

To enter the Unavailability:

1. Press the  or [F6]
2. Type: Choose the drop down or type the display code of the type
 - To create the type, press the  and the following window will display



WinRecs Maintenance







[IDLE] Provider Unavailability:

User Display Code
 Validation Code
 User Description
 Default Description
 Look Up Note
 Valid From
 Valid To

- To search for an existing Type press the  or [F4]

- To edit an existing Type press the  or [F6]

- To create a new Type press  or [F5] and populate the fields
 - User Display Code – the display code for that type
 - Validation Code – will populate with the User Display code (once saved this field cannot be edited)
 - User Description – the user description of the Type
 - Default Description – will populate with the User Description (once saved this field cannot be edited)
 - Look Up Note – can be populated if a note is preferred
 - Valid From – the date the Type is available
 - Valid To – the date the Type ends

- Press  or [F7] to save.

3. Valid From – enter the start date the provider is not available

4. Valid To – enter the end date the provider is not available.

Provider Maintenance - Notes

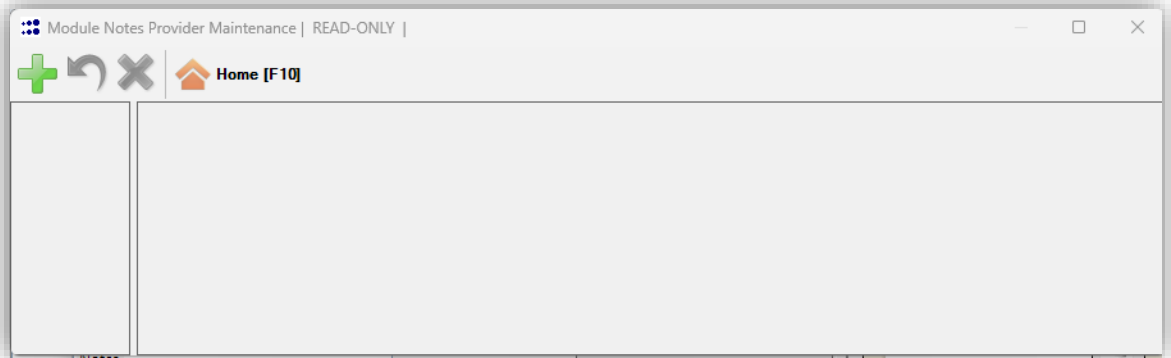


Figure 125 – Provider Maintenance - Notes

If additional information in needs, user can leave a note.

1. To create a note, press the .
2. Date & Time Logged displays in the left hand side.
3. On the right hand side, type in the note.
4. Close the window and it will save the note
5. To Undo what you have typed, click on this icon: . A message will display 'Are you sure you want to undo? Any note(s) entered will be lost. Yes will undo, No will keep the message.'
6. To delete a note, click on the date and press . A message will display "Are you sure you want to delete this Note?" Yes will delete and No will keep the message.
7. Each date and time will record a new note. To click on the note click on the date.

3.3 Project Maintenance

This feature is used to create and maintain Projects.

To access the Project Maintenance

Select **Maintenance** → **Project Maintenance**.

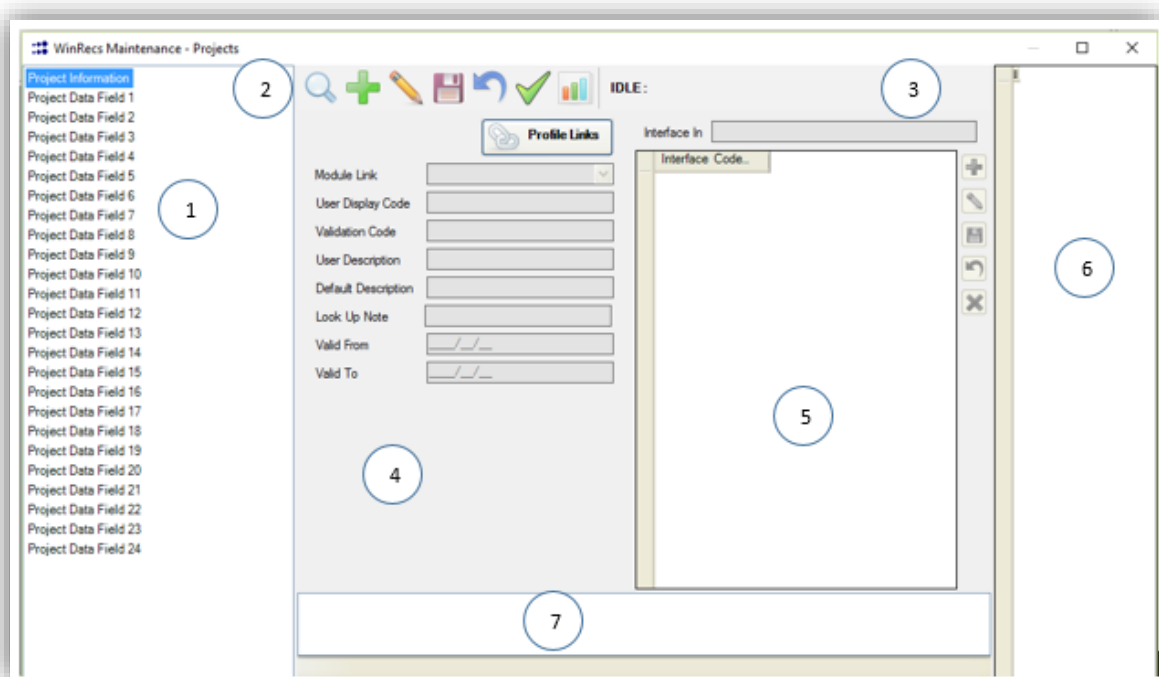


Figure 126 - Project Maintenance Screen

1. Project Information and Project Data Panel – Lists the Project Information and Project Data Fields for each project.
2. Toolbar – [see Toolbar](#)
3. Project identifier – Displays the identifier of the project being viewed, will show IDLE if no project shown and NEW to create a new project.
4. Editing panel – Displays the fields that can be modified for the selected project.
5. Interface Value – Allows linking an interface value with a project.
6. Update History – Displays the user(s) who have made any changes to the Project.
7. Messages – displays a message of any fields that need to be entered, the fields will disappear as they are filled in

To add a new project

- Click the  on the toolbar.
— or —
- Press **[F5]**.
- Click on **Project Information** in the Project Information panel (1). This will create the Project Number, Project Name and Valid From and To Date

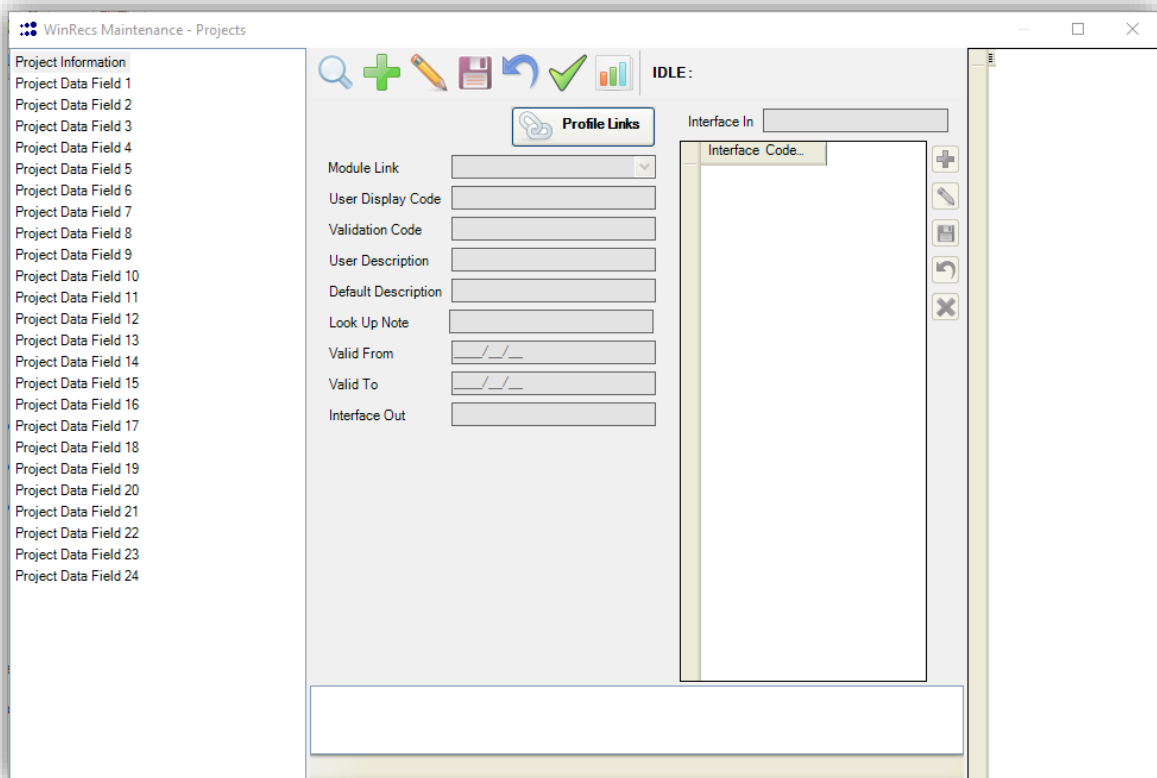


Figure 127 - Project Maintenance Screen

- **Profile Links** – the ability to assign a project to a region or hospital(s). Leaving it blank will show for all regions and hospitals. (Optional)
- **Module Link** – can assign the project to a specific module
- **User Display Code** – The project number
- **Validation Code** – The same number as the User Display Code
- **User Description** – Name of the Project
- **Default Description** – Same as User Description
- **Look Up Note** – Additional description of the value or rules for use

- o Valid From – The date the project is valid
- o Valid To – The date the project is no longer valid
- o Interface Out– Value used as region/hospital in interface populating out of WinRecs, populates with User Display Code.
- o Interface In – This will allow any Interface In values to come across the Batch Interface or HL7 feed.
- o Click on Project Data Field 1 in the Project Information panel.

WinRecs Maintenance - Projects

Project Information

Project Data Field 1

Project Data Field 2

Project Data Field 3

Project Data Field 4

Project Data Field 5

Project Data Field 6

Project Data Field 7

Project Data Field 8

Project Data Field 9

Project Data Field 10

Project Data Field 11

Project Data Field 12

Project Data Field 13

Project Data Field 14

Project Data Field 15

Project Data Field 16

Project Data Field 17

Project Data Field 18

Project Data Field 19

Project Data Field 20

Project Data Field 21

Project Data Field 22

Project Data Field 23

Project Data Field 24

Interface 1

Data Field Title

Data Field State

Data Field Default

User Display Code

Validation Code

User Description

Default Description

Look Up Note

Valid From

Valid To

Interface Out

Record ID	Hospital ID	User Code	Validate Code

Figure 128 - Project Maintenance – Project Data Field

- o Data Field Title – The Project Field Name
- o Data Field Status:
 - X - Closed/Disabled – The project is not being collected
 - O- Open/Submitted – The project is available and is submitted to CIHI
 - W- Warning – A warning will display if the field is not filled out
 - E - Error – An error will display if the field is not filled out
 - C- Critical Error – A critical error will display if the field is not filled out and the abstract will not be saved

- Data Field Default – The ability to add a default, depending on the Project Data Field, it will be a look up (drop down and will appear after the display code are created see below) or free text.
- To add a display code or codes, press the  to enter the following:
 - User Display Code – the code for the value
 - Validation code – Same as the User Display Code
 - User Description – The description of the code
- Default Description – Same as the User Description.
 - Look Up Note - Additional description of the value or rules for use
 - Valid From – The date the code is valid
 - Valid To – The date the code is no longer valid
- Interface Out – The interface out value if interfacing the project out.
- Click the  on the toolbar to save the new record.
 - Or –
- Press **[F7]**
- To delete the display code, press the  or **[F9]**

To edit an existing project

- Click the  on the toolbar to display the search screen.
 - or —
- Press **[F4]** to display the search screen.

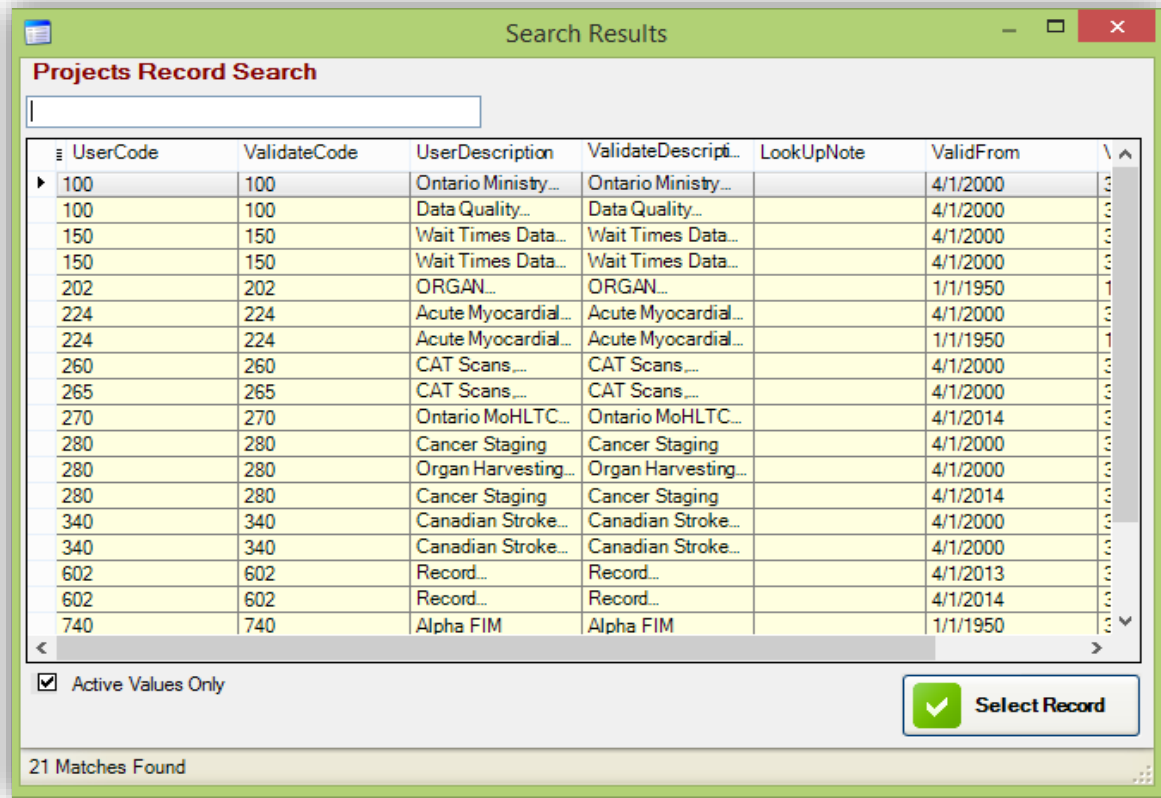


Figure 129 - Project search

- In the list, select the project that you need to modify.
- Double click the desired project.
— or —
- Select the desired project, then press **[ENTER]**.
— or —
- Select the desired project, then click .
- Click on the  on the top tool bar
- In the Project Data Field click on the  on the right-hand side tool bar to edit the display codes.

3.4 Report Maintenance

This feature allows user to setup Reports to be printed in specified modules and/or to Schedule automatic reports.

To access the Report Maintenance screen

Select **Maintenance** → **Report Maintenance**.

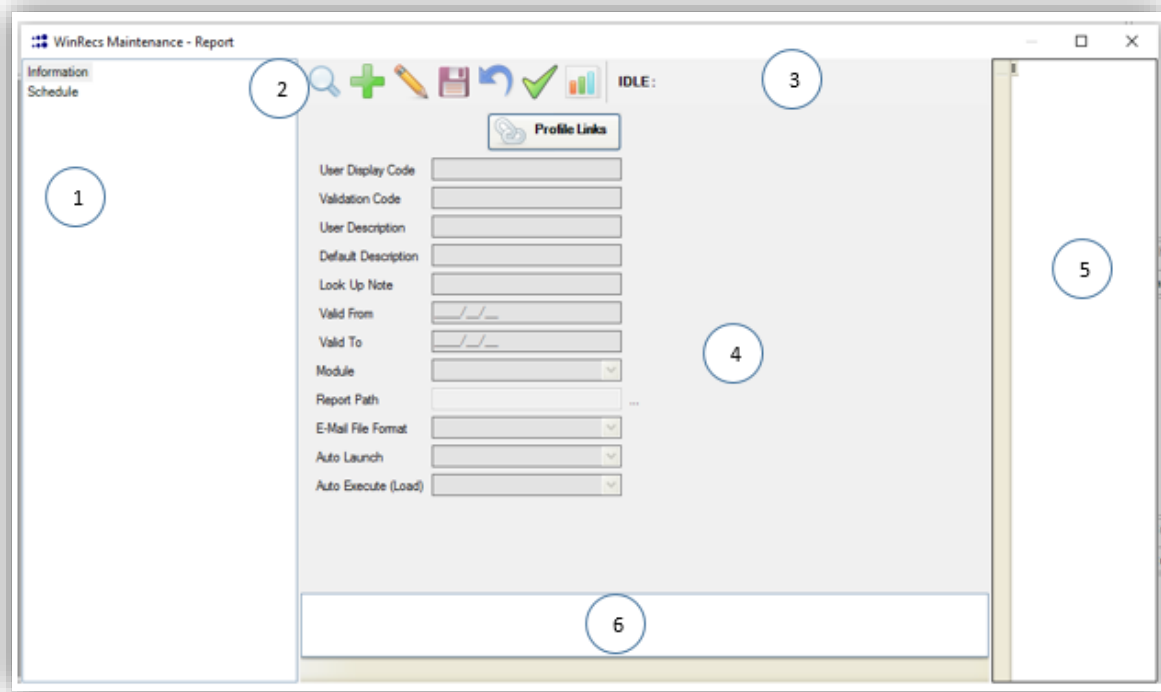
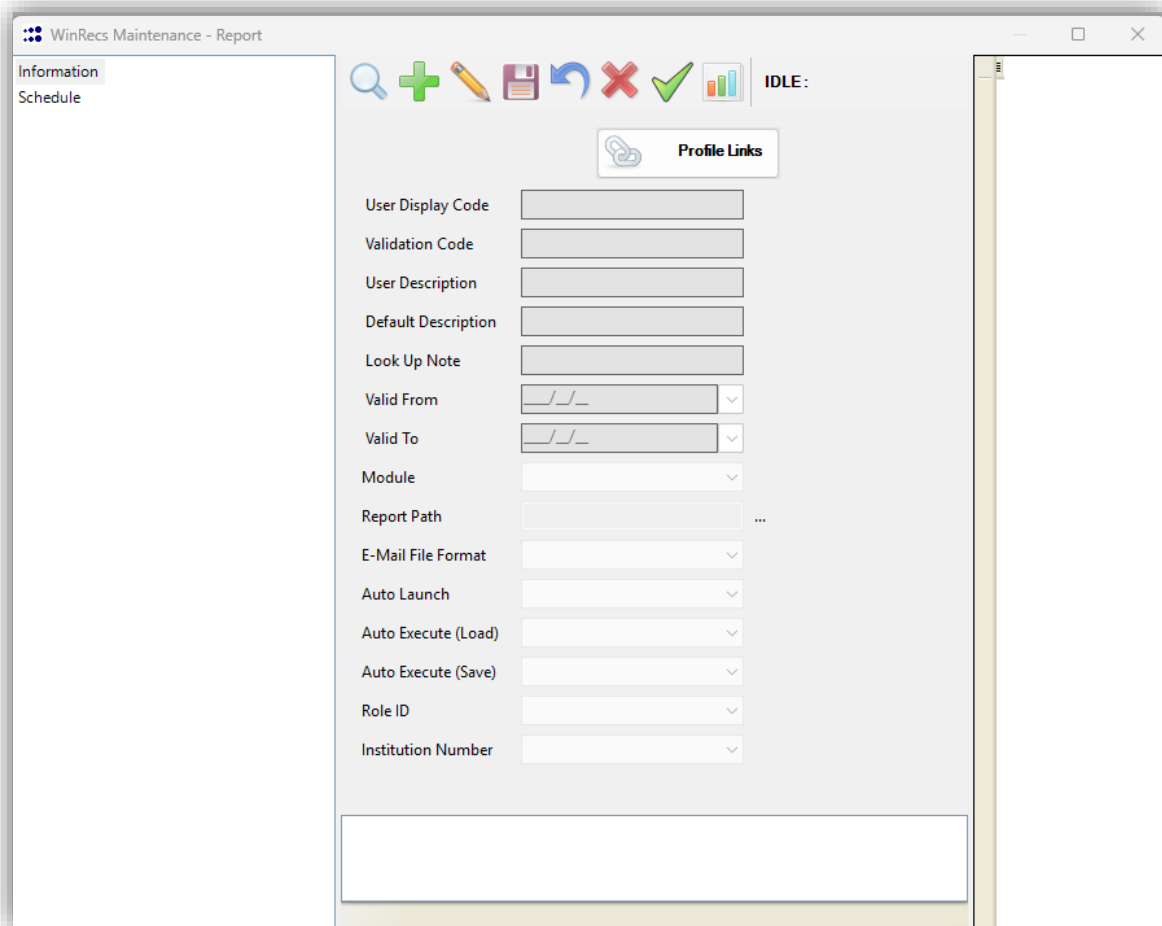


Figure 130 – Report Maintenance Screen

1. Report Information and Schedule Panel – Lists the Report Information and Schedule for each report
2. Toolbar – [see Toolbar](#)
3. Report identifier – Displays the identifier of the project being viewed, will show IDLE if no project shown and NEW to create a new project.
4. Editing panel – Displays the fields that can be modified for the selected scheduled report
5. Interface Value – Allows linking an interface value with a project.
6. Update History – Displays the user(s) who have made any changes to the Project.
7. Messages – displays a message of any fields that need to be entered, the fields will disappear as they are filled in

Information



WinRecs Maintenance - Report

Information
Schedule









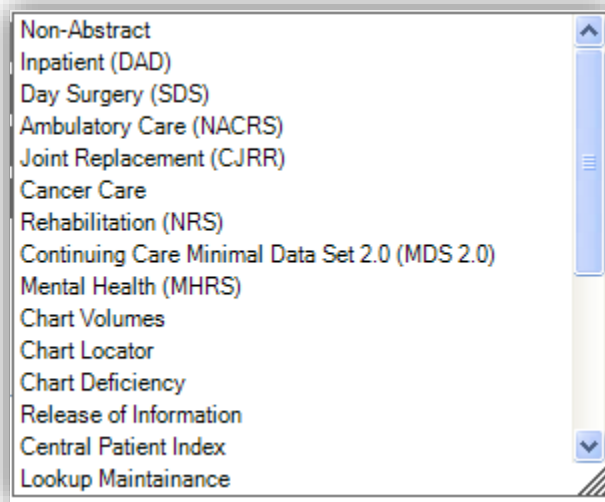

IDLE:

Profile Links

User Display Code
 Validation Code
 User Description
 Default Description
 Look Up Note
 Valid From
 Valid To
 Module
 Report Path ...
 E-Mail File Format
 Auto Launch
 Auto Execute (Load)
 Auto Execute (Save)
 Role ID
 Institution Number

Figure 131 – Report Maintenance – Information Screen

- Profile Links– The ability to link a look up code to a region if there is more than one region in the database or link to a hospital if there is more than hospital. (Optional)
Leaving it blank will show for all hospitals.
- User Display Code – Displayed abbreviated name of the report
- Validation Code – Displayed the name of the report
- User Description – The description of the report
- Default Description – The default description of the report
- Look Up Note – Additional description if needed
- Valid From – The date the report is valid from
- Valid To – The date the report is valid to
- Module – Select the Module from the drop-down list

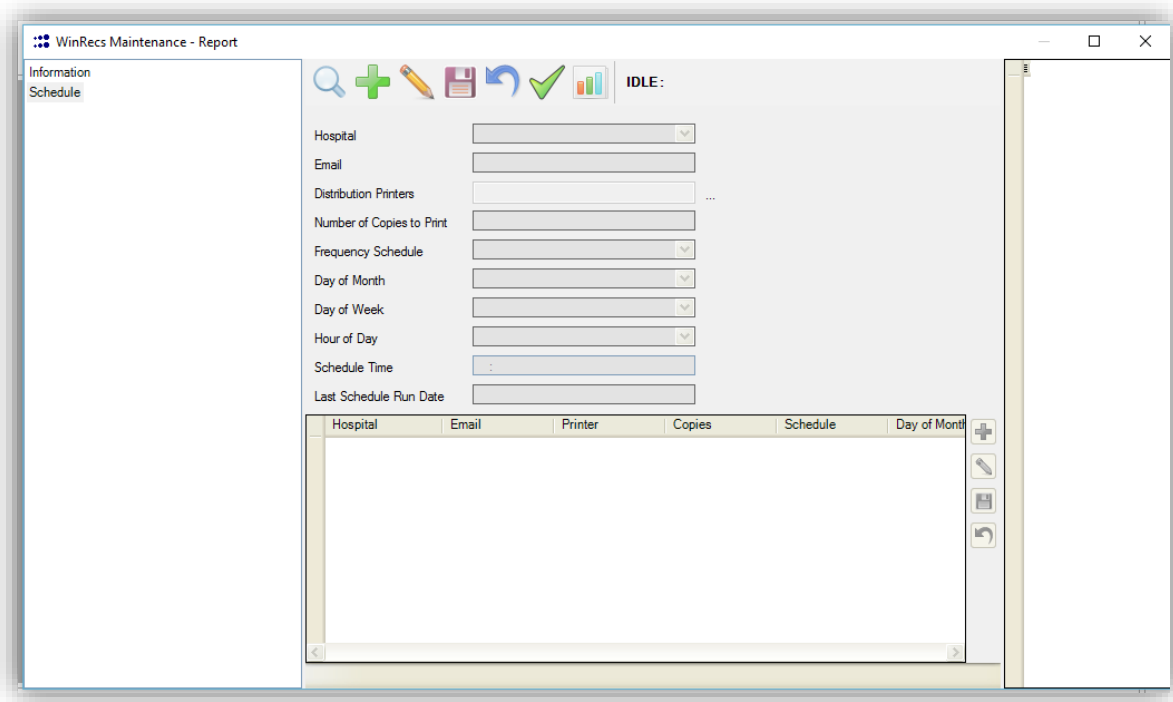


- Report Path – Enter the name of the Report.
- E-Mail File Format – Select the format from the drop-down list
 - Excel File
 - PDF File
 - Crystal Report File
 - Word File
 - HTML File
 - XML File
- Auto Launch – Select Yes and when the user saves a record this will automatically launch the reports
- Auto Execute (Load) – The following options may be selected:
 - No
 - To Printer
 - To Screen
- Auto Execute (Save) – The following options may be selected:

No
To Printer
To Screen

- o Role ID – The drop down will display the WinRecs Users.
- o Institution – The drop down will display the Institutions in the Institution Profile.

Schedule



The screenshot shows the 'WinRecs Maintenance - Report' window. On the left is a sidebar with 'Information' and 'Schedule' options. The main area contains a toolbar with icons for search, add, edit, save, undo, redo, and a bar chart. Below the toolbar are several input fields: 'Hospital' (dropdown), 'Email' (text), 'Distribution Printers' (text), 'Number of Copies to Print' (text), 'Frequency Schedule' (dropdown), 'Day of Month' (dropdown), 'Day of Week' (dropdown), 'Hour of Day' (dropdown), 'Schedule Time' (text), and 'Last Schedule Run Date' (text). At the bottom is a table with columns: Hospital, Email, Printer, Copies, Schedule, and Day of Month. The table is currently empty.

Figure 132 – Report Maintenance –Schedule Screen

- Hospital – Select the Hospital from the drop-down list
- Email – Type the recipient's email address, if required
- Distribution printer – Specify the printer where the report will be sent
- Number of Copies to Print - Type a number from 1-99 for the number of copies to be printed
- Frequency Schedule – Select the frequency type from the drop-down list

Daily
Weekly
BI-Weekly
Monthly
Hourly

- Day of Month – Select the when in the Month it is to be printed from the drop-down list
The First Day of Month
The Last Day of Month
The Middle Day of Month

- Day of Week – Select the day from the drop-down list

Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

- Hour of Day – From the drop-down list select the frequency the report is to be printed
Every one hour
Every two hours
Every four hours
Every six hours
Every eight hours
Every twelve hours
- Schedule Time – Time in which the report will run
- Last Schedule Run Date – Specify the last date for this report to run

Schedule Toolbar

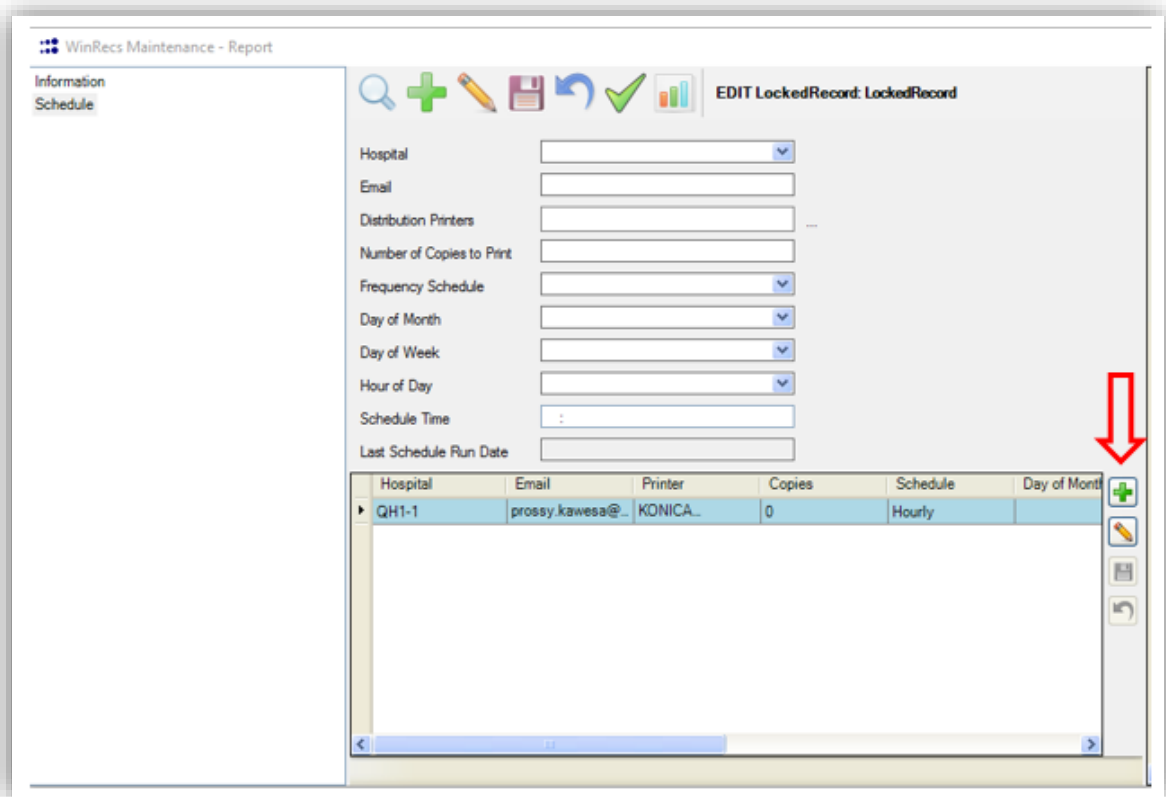
Detailed description of each icons functionality and shortcut key.

	Insert Occurrence	Allows user to insert a new occurrence	[F4]
	Edit Occurrence	Allows user to edit the occurrence	[F5]
	Keep Occurrence	Saves the occurrence	[F6]
	Cancel Occurrence	Cancels changes made to occurrence since the previous save.	

Table 12 - Reports - Schedule Toolbar

To add a new report.

- Click the  on the toolbar or press **[F5]**.
- Click on **Information** in the Report Information panel.
- The following fields must be entered for each report: User Display Code, Validation Code, User Description, Valid From and To Date, Report Path
- To create a report for Report Manager in a specified module the following fields may be populated: Module, Email File Format, Auto Launch and Auto Execute
- To create a report for Scheduler click on **Schedule** in the Report Information Panel
- Click on the  in the Schedule tool bar



- Populate the fields that will pertain to how the report will be scheduled.
- Press the save button  in the Scheduler Tool Bar

Hospital	Email	Printer	Copies	Schedule	Day of Month	
▶ QH1-1	prossy.kawesa@...	KONICA...	0	Hourly		+
						✎
						
						↶

- Press Save or Press  or **[F7]** to save all changed (in upper tool bar)

To edit a report.

- Click the  on the toolbar to display the search screen or press **[F4]** to display the search screen.

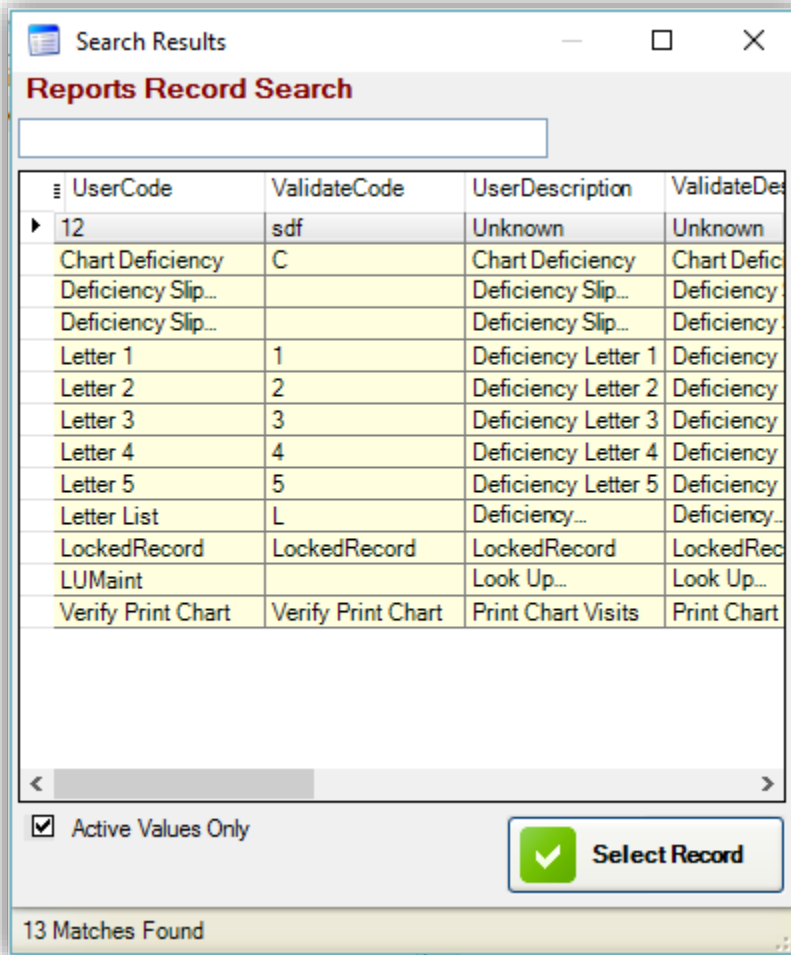
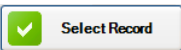


Figure 133 - Provider search

- Under Reports Record Search, enter the report name to pull it up or scroll through the reports
- Double click the desired report.
- or —
- Select the desired report, then press **[ENTER]**.
- or —
- Select the desired provider, then click 
- Press  or **[F6]** to edit the report
- On the Schedule screen to edit an existing scheduled report, click on the schedule to be edited and press the  on the schedule toolbar.

Hospital	Email	Printer	Copies	Schedule	Day of Month	
QH1-1	prossy.kawesa@...	KONICA...	0	Hourly		   

Figure 134 – Editing existing schedules

- The schedule fields will be editable.

3.5 Auto Batch Interface

This feature is used to automate the Batch Interface processes. Please notice that Batch Interfaces are custom built. If you have any questions regarding this process, contact a MED2020 Client Services Representative. Contact information is available above in the section '[Contact MED2020](#)'.

The Auto Batch can be set up from the workstation but the files and the folder that they are to be located in must reside on the network drive and not on the client machine.

To access the Auto Batch Interface Maintenance screen

Select **Maintenance** → **Auto Batch Interface Maintenance**

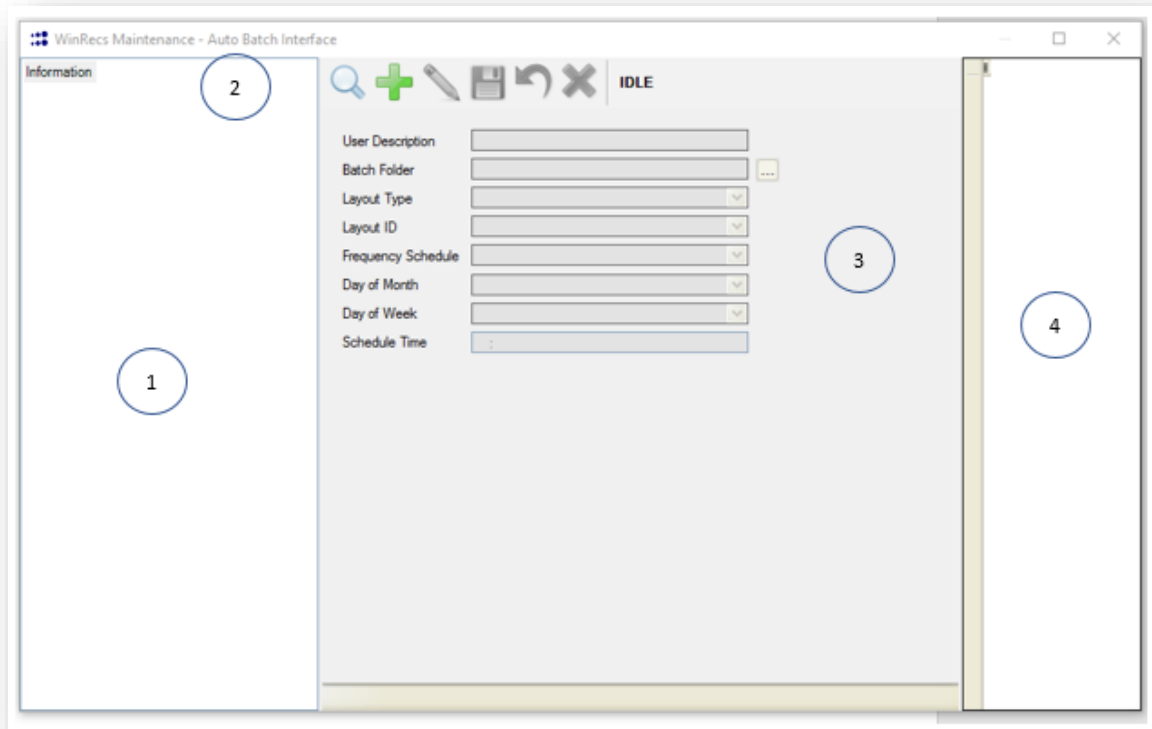


Figure 135 – Auto Batch Interface

1. Information– Lists the Information that needs to be entered for the Auto Batch to work.
2. Toolbar – [see Toolbar](#)
3. Editing panel – Displays the fields that can be modified for the Auto Batch.
4. Update History – Displays the user(s) who have made any changes to the schedule entry.

- User Description – The description of the Batch to run
- Batch Folder – The name of the directory (path) where the Batch Interface file will be located on the Server. Use the button to find the path if you need.
- Layout Type – Indicates which Batch Interface is for. There are mainly 2 types:
 - Standard Batch In (Fixed Length)
 - Custom Batch In
- Layout ID – Indicates which Batch Interface is for. This field only apply for Custom Batch In types.
- Frequency Schedule – Select the frequency type from the drop-down list: Daily, Weekly or Monthly.
 - *Daily* – it will require a time to be entered
 - *Weekly* – it will require a Day of Week and time to be entered
 - *Monthly* – From the Day of the Month drop-down list select between: The First Day, The Last Day or the Middle Day of the month, then enter the time to be run it.
- Day of Month – Select the when in the Month it is to be printed from the drop-down list
 - The First Day of Month
 - The Last Day of Month
 - The Middle Day of Month
- Day of Week – Select the day from the drop-down list
 - Monday
 - Tuesday
 - Wednesday
 - Thursday
 - Friday
 - Saturday
 - Sunday
- Schedule Time – Time in which the report will run

Auto Batch Service will pick up any changes made to the schedule in real-time. There is no need to re-start the service. Notice that there is no limit to the amount of jobs that can be created and maintained.

4. Tools Menu

The Tool Menu consists of the following modules: File Management, Batch Grouper, Batch Interface, Purge/Recover, Edits Management Tool (EMT), Abstract Profile, Database Update History, Schedule Report, Set View Permission, Historical Data Import Utility.

4.1 File Management

The File Management allows the user to submit Submission, Correction and Institution/Facility file information to CIHI. Each of these features are designed to meet current CIHI specifications for data validation and submission file creation. Depending on the type of abstract being completed the applicable file format will be used. The type of abstracts and relevant edits are determined by the Institution Profile (Care Type).

To access File Management

Click the menu **Tools** → **File Management**. The following options will be displayed:

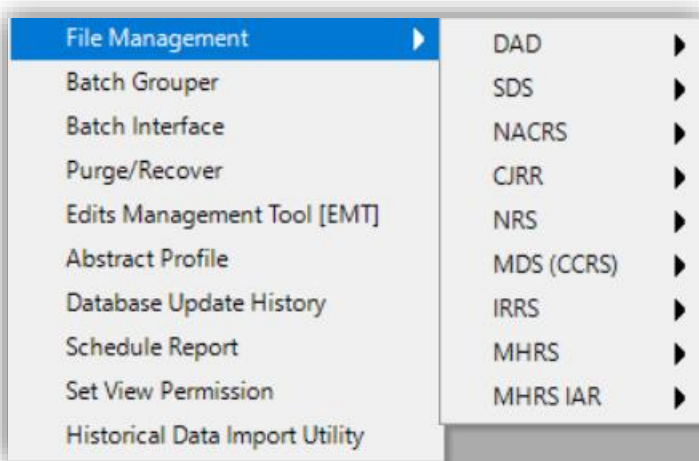


Figure 136 - File Management

4.1.1 CIHI Institution File – DAD and SDS

Institution Files are used to identify the facility to CIHI and provide specific information such as demographics, contact and the vendor. A separation file is set up for each institution number, even if they belong to the same facility.

The Institution File must be sent to CIHI before submitting records and must be updated and resent if there are changes to the information:

- At the start of each fiscal year

- Resend if there is a change in facility information (ie: Primary Contact or Facility merger) after the fiscal year facility file has been sent.
- Resend if there is a change in vendor after the fiscal year facility file has been sent.

At the start of each fiscal year, a new WinRecs update will be issued that allows the creation of the new fiscal year's file format. Users must be on the new version to create the Institution/Facility Information File for the new fiscal year.

CIHI Institution File – DAD/SDS

Entering all the information is required to send in the CIHI Institution File at the beginning of each fiscal year or when there is change in contact information.. This information will retain once saved.

To find the CIHI Institution File go to the following path:

Tools → File Management → DAD → CIHI Institution File

Or

Tools → File Management → SDS → CIHI Institution File

The header will let you know if you are in the correct Institution File:

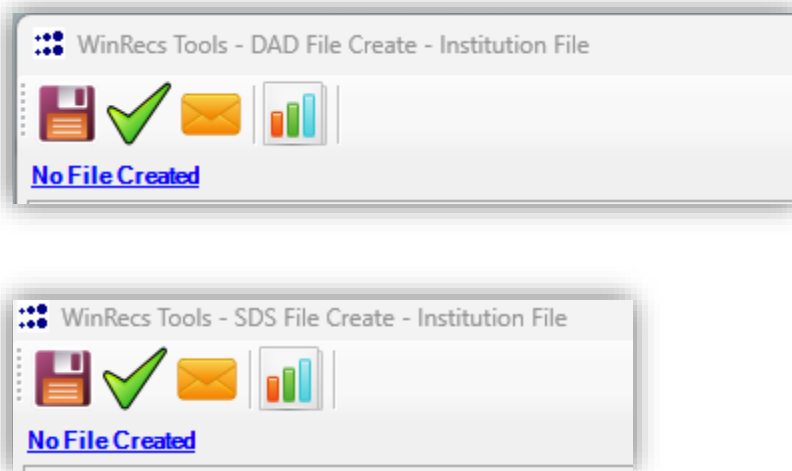
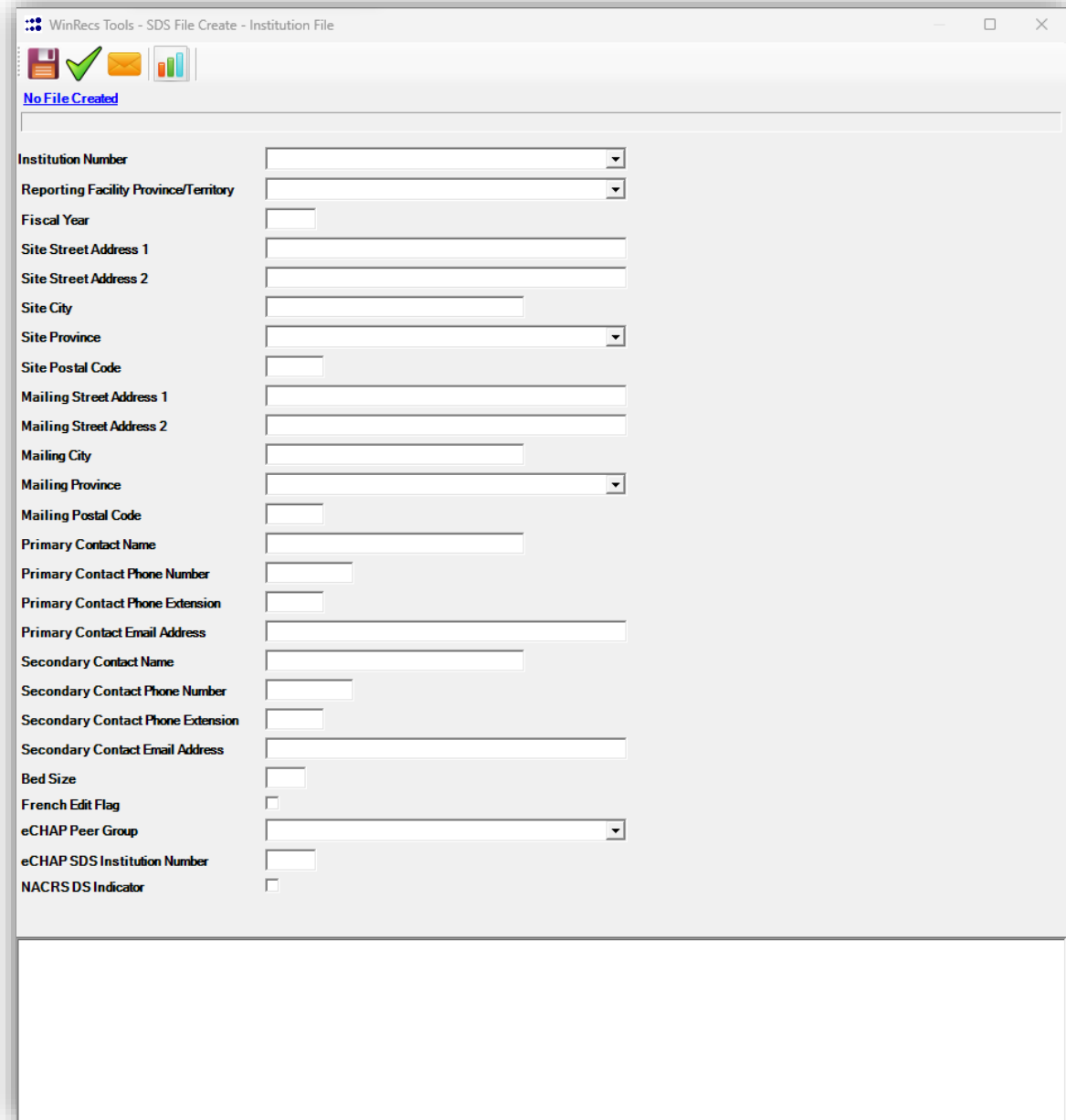


Figure 137 – CIHI Institution File – Identity File Type



WinRecs Tools - SDS File Create - Institution File

[No File Created](#)

Institution Number
 Reporting Facility Province/Territory
 Fiscal Year
 Site Street Address 1
 Site Street Address 2
 Site City
 Site Province
 Site Postal Code
 Mailing Street Address 1
 Mailing Street Address 2
 Mailing City
 Mailing Province
 Mailing Postal Code
 Primary Contact Name
 Primary Contact Phone Number
 Primary Contact Phone Extension
 Primary Contact Email Address
 Secondary Contact Name
 Secondary Contact Phone Number
 Secondary Contact Phone Extension
 Secondary Contact Email Address
 Bed Size
 French Edit Flag ☐
 eCHAP Peer Group
 eCHAP SDS Institution Number
 NACRS DS Indicator ☐

Figure 138 – CIHI Institution File – DAD/SDS

- Institution Number – Select the Institution Number
- Reporting Facility Province/Territory – Select the province
- Fiscal Year – Enter the current fiscal year
- Site Street Address 1 – The address of the site
- Site Street Address 2 – Extra line for the site address

- Site City – The City of the site
- Site Province – Select the province.
- Site Postal Code – Enter the Postal Code
- Mailing Street Address 1 – Enter the mailing address
- Mailing Street Address 2 – Extra line for the mailing address
- Mailing City– Enter City name
- Mailing Province– Select the province
- Mailing Postal Code - The Postal Code of the site
- Primary Contact Name – The primary contact name of site
- Primary Contact Phone Number – The primary contact phone number
- Primary Contact Phone Extension – The primary contact extension
- Primary Contact Email Address – The primary contact email address
- Secondary Contact Name - The secondary contact name
- Secondary Contact Phone Number – The secondary contact phone number
- Secondary Contact Phone Extension - The secondary contact phone extension
- Secondary Contact Email Address - The secondary contact email address
- Bed Size – Number of beds in site, must be numeric
- French Edit Flag – Click if French edits are required
- eCHAP Peer Group – drop down value of peer group beds
- eCHAP SDS Institution Number – enter Day Surgery Institution if applicable
- NACRS DS Indicator – check if Day Surgery is captured using NACRS

Tools:

 Verify **[F11]** – Verifies all the entries for the selected parameters

 Create File **[F12]** – Create the File based on parameters selected

 - Save **[F7]** – Save the file

 - Reports **[F10]** – Displays Select Report

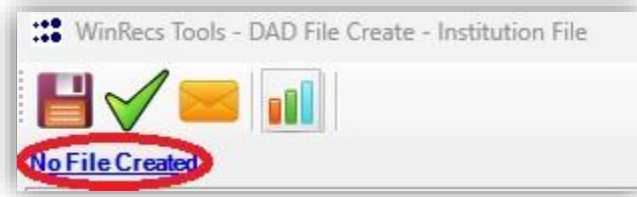
Creating DAD/SDS CIHI Institution File

- Enter all mandatory criteria – users will not be able to create a file with missing mandatory fields. There will be messages listed in the message box of any missing criteria.

- Click  -Verify or F11 - To ensure all mandatory criteria is complete, errors will display in the box below.



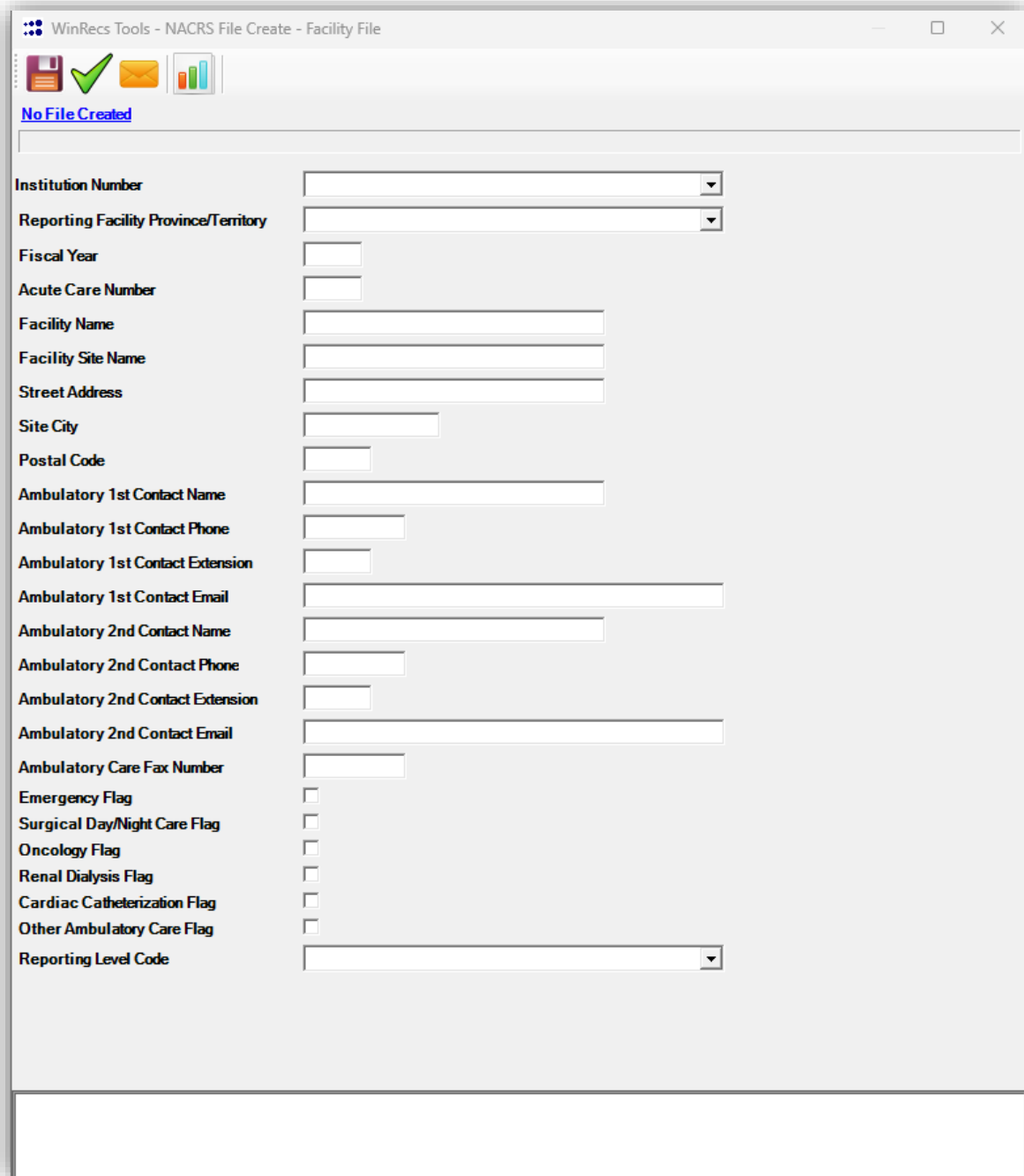
- Click  - Save or F7 to save the file. These criteria will maintain after it is saved once the Institution File is accessed again.
- Click  Create File or F12 to create the Institution File.
- When complete the file path will be displayed here:



4.1.2 CIHI Facility Information File – NACRS

To find the CIHI Facility Information File go to the following path:

Tools → File Management → **NACRS** → **CIHI Facility Information File**



WinRecs Tools - NACRS File Create - Facility File

[No File Created](#)

Institution Number

Reporting Facility Province/Territory

Fiscal Year

Acute Care Number

Facility Name

Facility Site Name

Street Address

Site City

Postal Code

Ambulatory 1st Contact Name

Ambulatory 1st Contact Phone

Ambulatory 1st Contact Extension

Ambulatory 1st Contact Email

Ambulatory 2nd Contact Name

Ambulatory 2nd Contact Phone

Ambulatory 2nd Contact Extension

Ambulatory 2nd Contact Email

Ambulatory Care Fax Number

Emergency Flag ☐

Surgical Day/Night Care Flag ☐

Oncology Flag ☐

Renal Dialysis Flag ☐

Cardiac Catheterization Flag ☐

Other Ambulatory Care Flag ☐

Reporting Level Code

Figure 139 – Facility Information File –NACRS

- Institution Number – Select the Institution Number
- Reporting Facility Province/Territory – Select the province/territory
- Fiscal Year – Enter the current fiscal year
- Acute Care Number – Enter the Acute Institution number
- Facility Name – The name of the facility
- Facility Site Name – The name of the site
- Street – The address of the site
- Site City – The City of the site
- Postal Code – The Postal Code of the site
- Ambulatory 1st Contact Name – The primary contact name of site
- Ambulatory 1st Contact Number – The primary contact phone number
- Ambulatory 1st Contact Extension – The primary contact extension
- Ambulatory 1st Contact Email – The primary contact email
- Ambulatory 2nd Contact Name – The secondary contact name
- Ambulatory 2nd Contact Number – The secondary contact phone number
- Ambulatory 2nd Contact Extension – The secondary contact phone extension
- Ambulatory 2nd Contact Email – The secondary contact email address
- Ambulatory Care Fax Number – Fax number for site
- Emergency Flag – Check this box if submitting ER records
- Surgical Day/Night Care Flag – Check this box if submitting Surgical Day or Night Care records
- Oncology Flag – Check this box if submitting Oncology records
- Renal Dialysis Flag – Check this box if submitting Renal Dialysis records
- Cardiac Catheterization Flag – Check this box if submitting Cardiac Catheterization records
- Reporting Level Code – The NACRS Submitting Level your facility is submitting to CIHI

A	Level 0 or Level 1 only facility
B	Level 0 or Level 3 only facility
C	Level 0 or Level 2 only facility
D	Level 0 or Level 1 plus 3 facility
E	Level 0 or Level 2 plus 3 facility
- Other Ambulatory Care Flag – Check this box if submitting other ambulatory care records not shown above

File creation toolbar.



- Save [F7] – saves the data entered in the Facility Information File



Verify [F11] – all the entries for the selected parameters



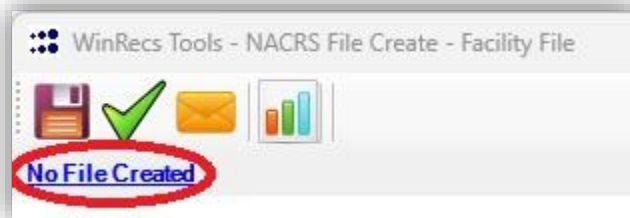
Create File [F12] – Create the File based on parameters selected



Reports [F10] – Displays Select Reports

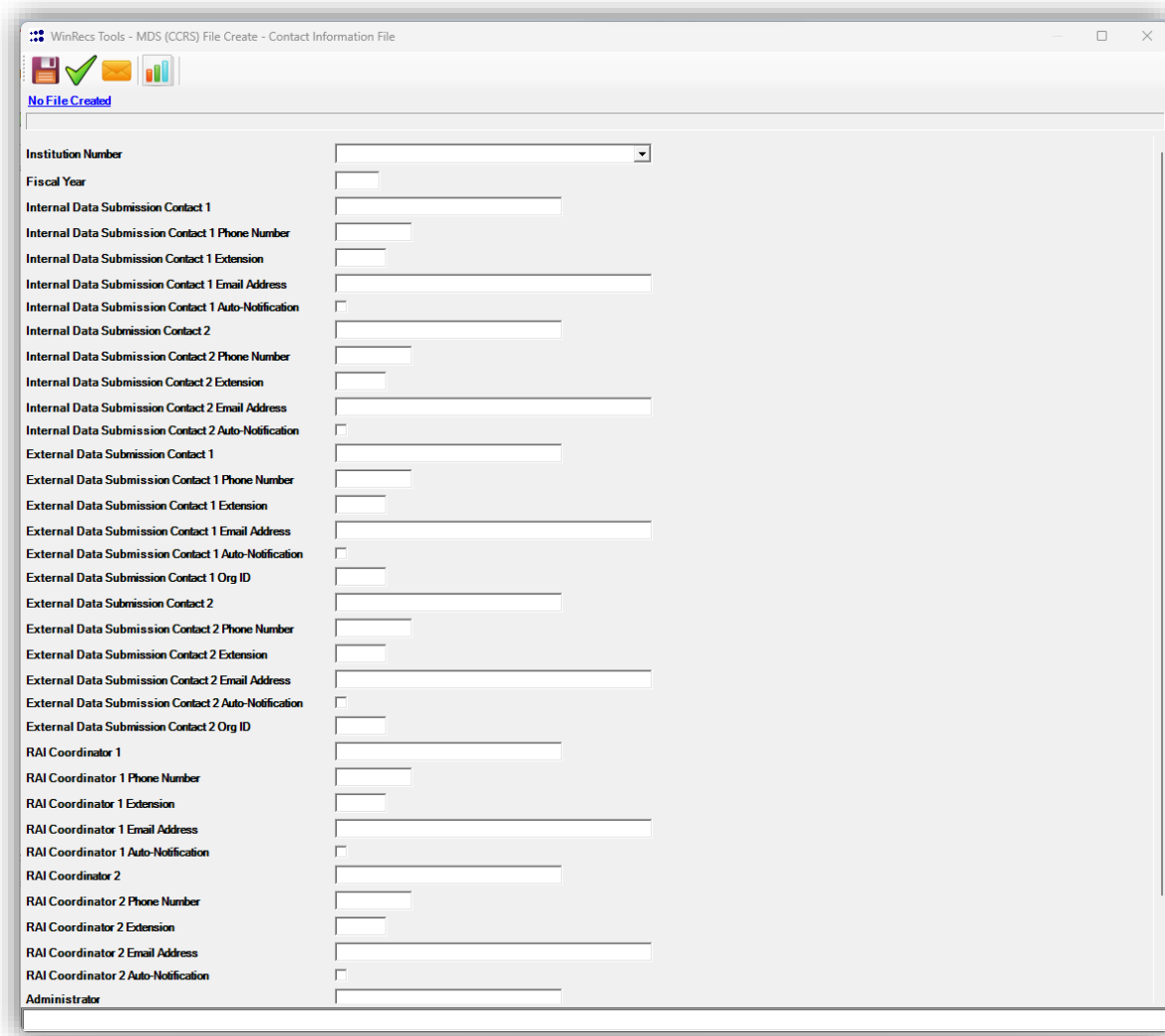
Creating NACRS Facility Information File

- Enter all mandatory criteria – users will not be able to create a file with missing mandatory fields. There will be messages listed in the message box of any missing criteria.
- Click  -Verify or F11 - To ensure all mandatory criteria is complete, errors will display in the box below.
- Click  - Save or F7 to save the file. These criteria will maintain after it is saved once the Institution File is accessed again.
- Click  Create File or F12 to create the Institution File.
- When complete the file path will be displayed here:



4.1.3 MDS(CCRS) CIHI Contact Information File

Tools → File Management → MDS (CCRS) → CIHI Contact Information File



WinRecs Tools - MDS (CCRS) File Create - Contact Information File

No File Created

Institution Number

Fiscal Year

Internal Data Submission Contact 1

Internal Data Submission Contact 1 Phone Number

Internal Data Submission Contact 1 Extension

Internal Data Submission Contact 1 Email Address

Internal Data Submission Contact 1 Auto-Notification ☐

Internal Data Submission Contact 2

Internal Data Submission Contact 2 Phone Number

Internal Data Submission Contact 2 Extension

Internal Data Submission Contact 2 Email Address

Internal Data Submission Contact 2 Auto-Notification ☐

External Data Submission Contact 1

External Data Submission Contact 1 Phone Number

External Data Submission Contact 1 Extension

External Data Submission Contact 1 Email Address

External Data Submission Contact 1 Auto-Notification ☐

External Data Submission Contact 1 Org ID

External Data Submission Contact 2

External Data Submission Contact 2 Phone Number

External Data Submission Contact 2 Extension

External Data Submission Contact 2 Email Address

External Data Submission Contact 2 Auto-Notification ☐

External Data Submission Contact 2 Org ID

RAI Coordinator 1

RAI Coordinator 1 Phone Number

RAI Coordinator 1 Extension

RAI Coordinator 1 Email Address

RAI Coordinator 1 Auto-Notification ☐

RAI Coordinator 2

RAI Coordinator 2 Phone Number

RAI Coordinator 2 Extension

RAI Coordinator 2 Email Address

RAI Coordinator 2 Auto-Notification ☐

Administrator

Figure 140 – MDS(CCRS) CIHI Contact Information File

- o Institution Number – Select the Institution Number
- o Fiscal Year – Enter the current fiscal year
- o Internal Data Submission Contact 1 – Enter the Contact 1 Name
- o Internal Data Submission Contact 1 Telephone – Enter the phone number
- o Internal Data Submission Contact 1 Extension – Enter the extension
- o Internal Data Submission Contact 1 Email Address – Enter the email
- o Internal Data Submission Contact 1 Auto-Notification – Enter a check mark if auto-notification is needed
- o Internal Data Submission Contact 2 – Enter the Contact 2 Name

- Internal Data Submission Contact 2 Telephone – Enter the phone number
- Internal Data Submission Contact 2 Extension – Enter the extension
- Internal Data Submission Contact 2 Email Address – Enter the email
- Internal Data Submission Contact 2 Auto-Notification – Enter a check mark if auto-notification is needed
- External Data Submission Contact 1 – Enter the Contact 1 Name
- External Data Submission Contact 1 Phone Number – Enter the phone number
- External Data Submission Contact 1 Extension – Enter the extension
- External Data Submission Contact 1 Email Address – Enter the email
- External Data Submission Contact 1 Org ID – Enter the Org ID
- External Data Submission Contact 1 Auto-Notification – Enter a check mark if auto-notification is needed
- External Data Submission Contact 2 – Enter the Contact 2 Name
- External Data Submission Contact 2 Phone Number – Enter the phone number
- External Data Submission Contact 2 Extension – Enter the extension
- External Data Submission Contact 2 Email Address – Enter the email
- External Data Submission Contact 2 Auto-Notification – Enter a check mark if auto-notification is needed
- External Data Submission Contact 2 Org ID – Enter the Org ID
- RAI Coordinator 1 – Enter the RAI Coordinator 1 Name
- RAI Coordinator 1 Phone Number – Enter the phone number
- RAI Coordinator 1 Extension – Enter the extension
- RAI Coordinator 1 Email Address – Enter the email
- RAI Coordinator 1 Auto-Notification – Enter a check mark if auto-notification is needed
- RAI Coordinator 2 – Enter the RAI Coordinator 2 Name
- RAI Coordinator 2 Phone Number – Enter the phone number
- RAI Coordinator 2 Extension – Enter the extension
- RAI Coordinator 2 Email Address – Enter the email
- RAI Coordinator 2 Auto-Notification – Enter a check mark if auto-notification is needed
- Administrator – Enter the Administrator Name
- Administrator Phone Number – Enter the phone number
- Administrator Extension – Enter the extension
- Administrator Email Address – Enter the email

- Administrator Auto-Notification – Enter a check mark if auto-notification is needed
- File creation toolbar:



- Save [F7] – saves the data entered in the Facility Information File



Verify [F11] – all the entries for the selected parameters



Create File [F12] – Create the File based on parameters selected



Reports [F10] – Displays Select Reports

Creating MDS (CCRS) CIHI Contact Information File

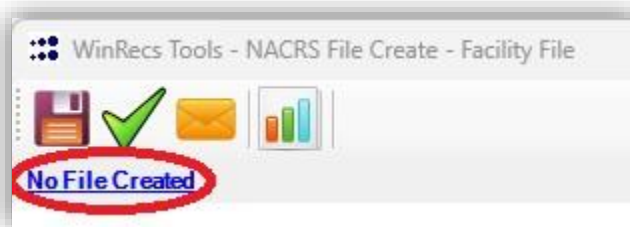
- Enter all mandatory criteria – users will not be able to create a file with missing mandatory fields. There will be messages listed in the message box of any missing criteria.
- Click  -Verify or F11 - To ensure all mandatory criteria is complete, errors will display in the box below.



- Click  - Save or F7 to save the file. These criteria will maintain after it is saved once the Institution File is accessed again.



- Click  Create File or F12 to create the Institution File.
- When complete the file path will be displayed here:



4.1.4 NRS CIHI Contact Information File

Tools → File Management → NRS → CIHI Contact Information File

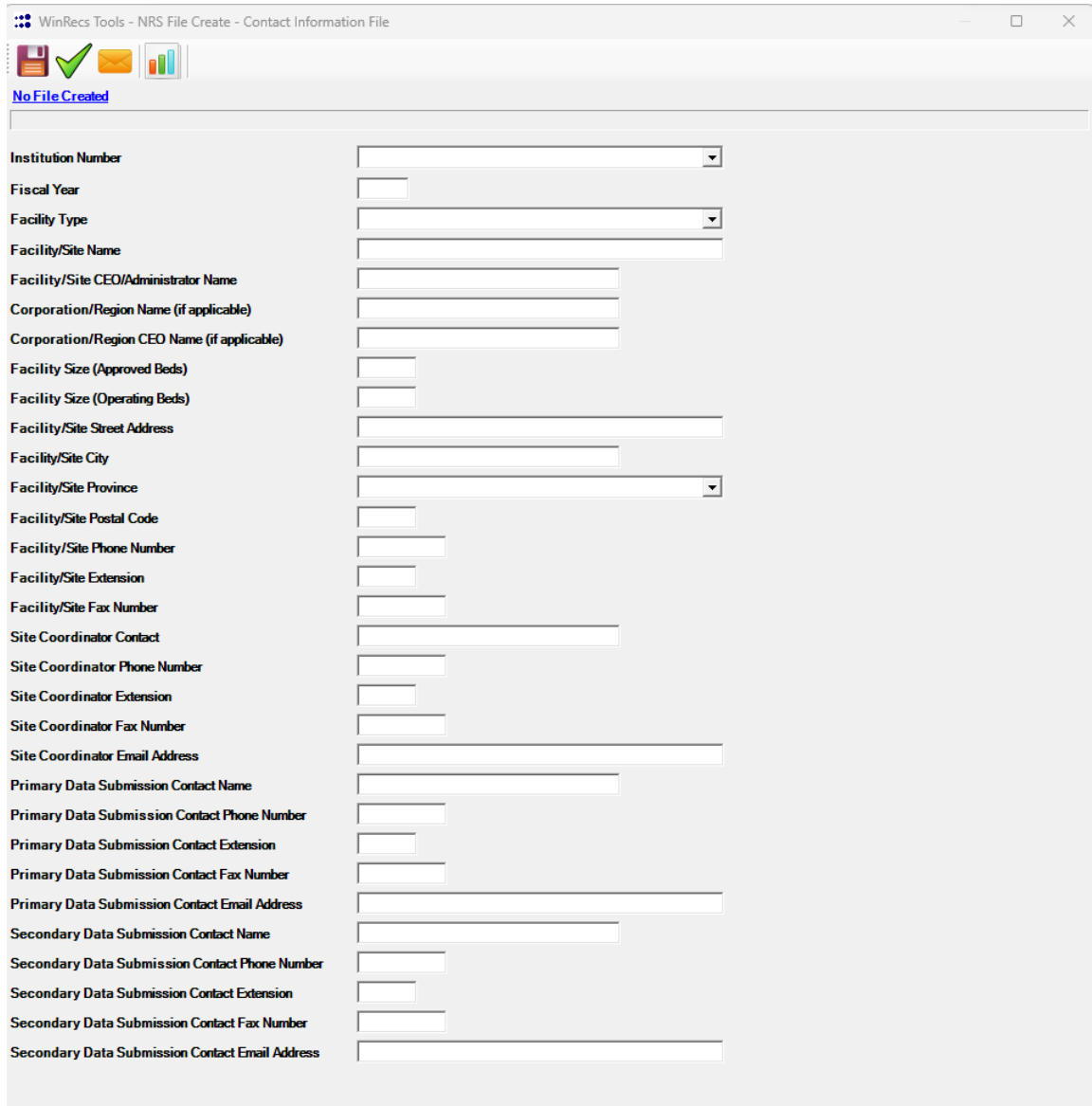


Figure 141 – NRS CIHI Contact Information File

- Institution Number – Select the Institution Number
- Fiscal Year – Enter the current fiscal year
- Type of Facility – Enter the Type of Facility from the drop-down menu
 - 1 Specialty/Free Standing
 - 2 General/Acute
- Facility/Site Name – Enter the Facility/Site name
- Facility/Site CEO/Administrator Name – Enter name

- Corporation/Region Name (if applicable) – Enter name
- Corporation/Region CEO Name (if applicable) – Enter name
- Facility Size (Approved Beds) – Enter bed number
- Facility Size (Operating Beds) – Enter bed number
- Facility/Site Street Address – Enter address
- Facility/Site City – Enter the City
- Facility/Site Province – Enter the province from the drop down menu
- Facility/Site Postal Code – Enter the postal code
- Facility/Site Phone Number – Enter the phone number
- Facility/Site Extension – Enter phone extension
- Facility/Site Fax Number – Enter fax number
- Site Coordinator Contact – Enter Site Coordinator name
- Site Coordinator Phone Number – Enter the phone number
- Site Coordinator Extension – Enter the extension
- Site Coordinator Fax Number – Enter Fax number
- Site Coordinator Email Address – Enter Email Address
- Primary Data Submission Contact Name – Enter name
- Primary Data Submission Contact Phone Number – Enter the phone #
- Primary Data Submission Contact Extension – Enter the extension
- Primary Data Submission Contact Fax Number – Enter the fax number
- Primary Data Submission Contact Email Address – Enter the email
- Secondary Data Submission Contact Name – Enter name
- Secondary Data Submission Contact Phone Number – Enter the phone #
- Secondary Data Submission Contact Extension – Enter the extension
- Secondary Data Submission Contact Fax Number – Enter the fax number
- Secondary Data Submission Contact Email Address – Enter the email
- File creation toolbar:



- Save **[F7]** – saves the data entered in the Facility Information File



Verify **[F11]** – all the entries for the selected parameters



Create File **[F12]** – Create the File based on parameters selected



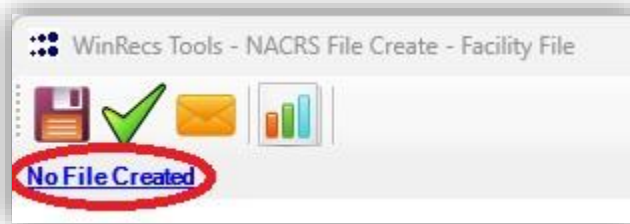
Reports **[F10]** – Displays Select Reports

Creating NRS CIHI Contact Information File

- Enter all mandatory criteria – users will not be able to create a file with missing mandatory fields. There will be messages listed in the message box of any missing criteria.
- Click  -Verify or F11 - To ensure all mandatory criteria is complete, errors will display in the box below.

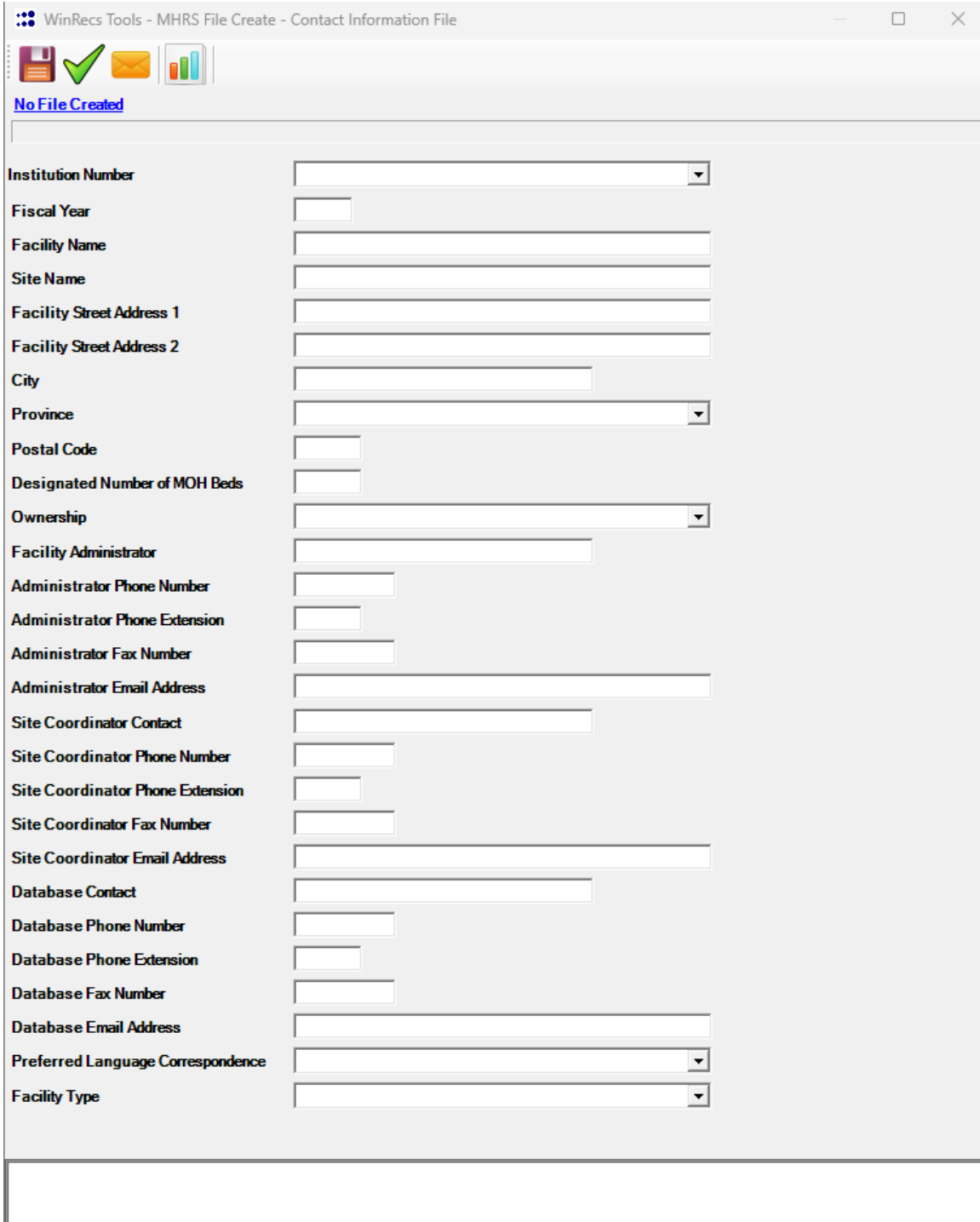


- Click  - Save or F7 to save the file. These criteria will maintain after it is saved once the Institution File is accessed again.
- Click  Create File or F12 to create the Institution File.
- When complete the file path will be displayed here:



4.1.5 OMHRS CIHI Contact Information File

Tools → File Management → OMHRS → CIHI Contact Information File



WinRecs Tools - MHRs File Create - Contact Information File

No File Created

Institution Number	
Fiscal Year	
Facility Name	
Site Name	
Facility Street Address 1	
Facility Street Address 2	
City	
Province	
Postal Code	
Designated Number of MOH Beds	
Ownership	
Facility Administrator	
Administrator Phone Number	
Administrator Phone Extension	
Administrator Fax Number	
Administrator Email Address	
Site Coordinator Contact	
Site Coordinator Phone Number	
Site Coordinator Phone Extension	
Site Coordinator Fax Number	
Site Coordinator Email Address	
Database Contact	
Database Phone Number	
Database Phone Extension	
Database Fax Number	
Database Email Address	
Preferred Language Correspondence	
Facility Type	

Figure 142 – OMHRS CIHI Contact Information File

- Institution Number - Select the Institution Number from drop down
- Reporting Facility Province/Territory - Select Province/Territory from drop down
- Fiscal Year - Enter the current fiscal year
- Facility Name - Enter the Facility Name
- Site Name - Enter the Site name
- Facility Address Line 1 - Enter Facility address
- Facility Address Line 2 - Enter address (if needed)
- City - Enter the City
- Province - Enter the province from the drop down menu
- Postal Code - Enter the postal code
- Designated Number of MOH Beds - Enter number of designated beds
- Ownership - Select from drop down
- Facility Administrator - Enter Facility Administrator name
- Administrator Phone Number - Enter the phone number
- Administrator Phone Extension - Enter the extension
- Administrator Fax Number - Enter Fax number
- Administrator Email Address - Enter Email Address
- Site Coordinator Contact - Enter name
- Site Coordinator Phone Number - Enter the phone #
- Site Coordinator Extension - Enter the extension number
- Site Coordinator Fax Number - Enter the fax number
- Site Coordinator Email - Enter the email
- Database Contact - Enter name
- Database Phone Number - Enter the phone #
- Database Phone Extension - Enter the extension
- Database Fax Number - Enter the fax number
- Database Email Address - Enter the email
- Preferred Language of Correspondence - Enter preferred language from drop down
- Facility Type - Enter facility type from drop down
- File creation toolbar:



- Save **[F7]** – saves the data entered in the Facility Information File



Verify **[F11]** – all the entries for the selected parameters



Create File **[F12]** – Create the File based on parameters selected



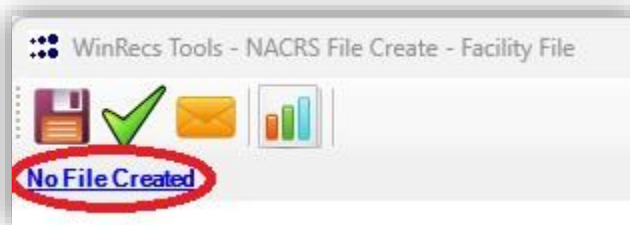
Reports **[F10]** – Displays Select Reports

Creating MHRS CIHI Contact Information File

- Enter all mandatory criteria – users will not be able to create a file with missing mandatory fields. There will be messages listed in the message box of any missing criteria.
- Click  -Verify or F11 - To ensure all mandatory criteria is complete, errors will display in the box below.



- Click  - Save or F7 to save the file. These criteria will maintain after it is saved once the Institution File is accessed again.
- Click  Create File or F12 to create the Institution File.
- When complete the file path will be displayed here:



4.2.1 CIHI Submission File – DAD & NACRS

There are four basic processes involved in the submission of data to CIHI:

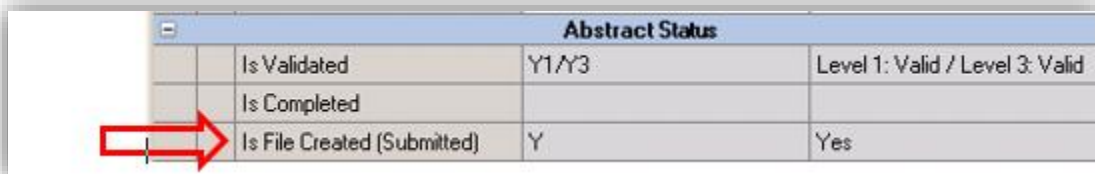
1. Month end balances – ensure the number of abstracts in WinRecs balances with Finance or Registration.
2. Create and send Facility Information File (at the start of the Fiscal Year or if information needs to be updated)
3. Create and submit monthly (or quarterly) data files.
4. Receive and import rejection files for correction and/or resubmission of abstracts.

The submission process will:

1. Verify options
2. Verify all records are complete
3. Verify all records are error free
4. Assign CIHI **Record Types**, **Batch Numbers** and **CIHI Abstract Number** to each record
5. Create the CIHI file so that it conforms to CIHI specifications
6. Save the file to a predetermined location as set in the Institution Profile → File Path → CIHI Directory

If an update to any of the groupers (ie CMG, DPG and CACS) has been applied after the records have been coded, The Batch Grouper ([see Batch Grouper](#)) will need to be run prior to Submission. This ensures that the most up to date calculation will be submitted with the records.

When an abstract has been submitted to CIHI the field `Is File Create (Submitted)` in the Abstract Status section will be filled in with a 'Y' – Yes.



Abstract Status			
Is Validated	Y1/Y3	Level 1: Valid / Level 3: Valid	
Is Completed			
Is File Created (Submitted)	Y	Yes	

Figure 143 – Is File Created(Submitted)

Submission Setup Requirements

Ensure the **Institution Profile/File Path/CIHI Directory** is completed with the path to where the CIHI files will be saved. (Submission & Facility Profile).

If the **CIHI Directory** is left blank, then the file will automatically go to C:\Users

Access File Creation

To access the file creation screen, click the menu **Tools → File Management**. The following will display:

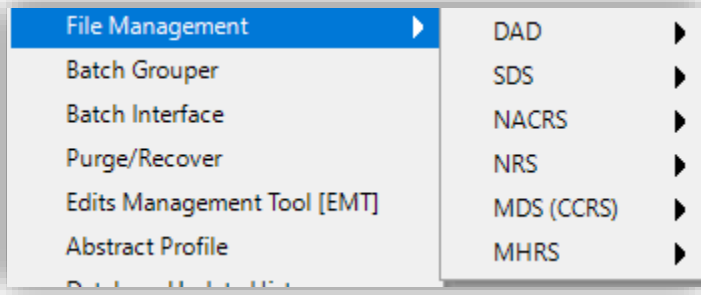


Figure 144 – File Management Screen

DAD/SDS CIHI Submission & CJRR CIHI Insert/Update Data Submission File

- **DAD → CIHI Submission File – or –**
SDS → CIHI Submission File

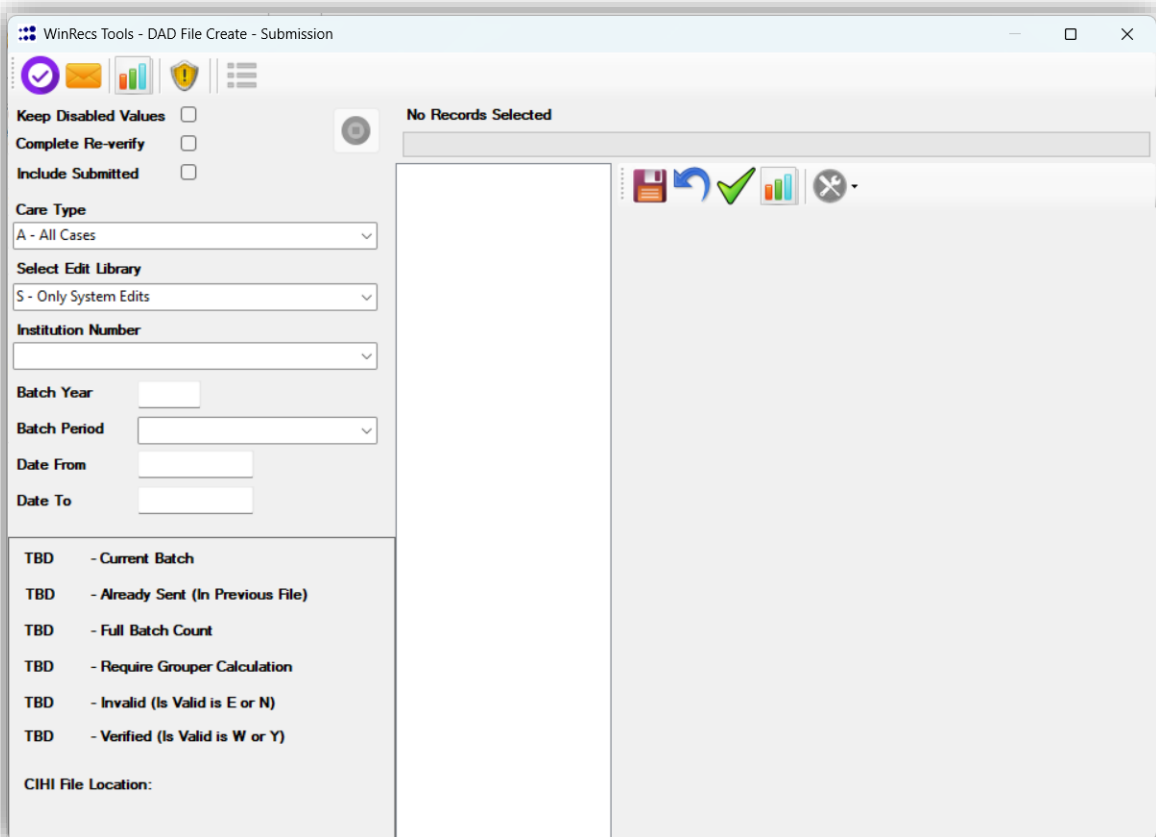
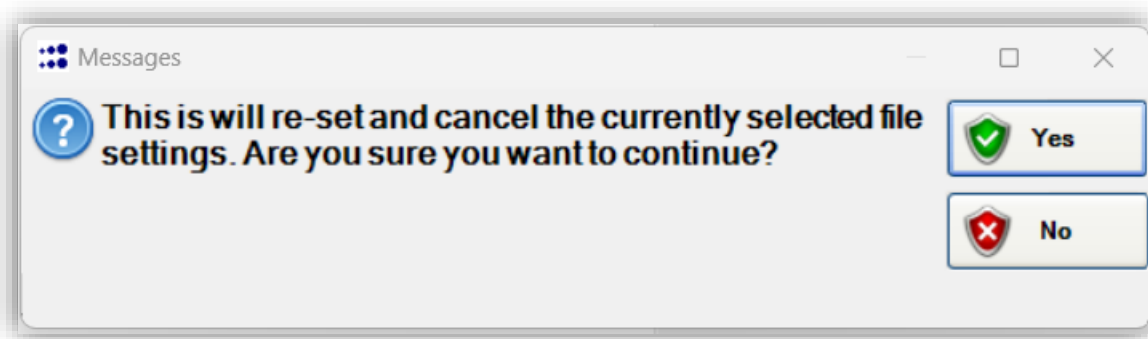


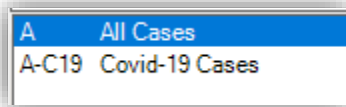
Figure 145 – File Management DAD/SDS Submission File Screen

-  - Batch Verify (**Shift+F11**) – This will reverify all abstracts in the selected Batch
-  - Create File (**F12**) – This will create the file, if the Batch Verify is run just click on Create File and the file will be created.
-  - Batch Reports(**Shift+F10**) – This will display the reports function
-  - Checked Record Locks– checks for locked records
-  - Reset File Settings – This will reset the file setting below. The following message will display when clicked:

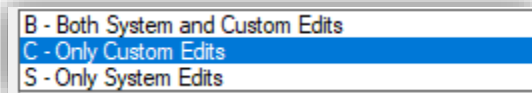


- Yes will clear the below settings, No will retain the current settings.

-  - Work in Standard Environment – this field when enabled will display in blue:
-  when the list of records with errors displays. Clicking on this icon will open the abstract in the standard work environment. When saved a pop will ask if you want to go back to File Management screen.
- Keep Disabled Values – checking this box will keep the disabled values when a batch verify is done, not checking the box the disabled values will be removed during a batch verify.
- Complete Re-verify – checking this box will re-verify every record, not checking the box will not re-verify.
- Include Submitted – Only used to verify submitted EMT edits. Can only be used checking this box will also automatically check the Complete Re-verify and Create File is disabled. Only C- Only Custom Edits can be used in the Select Edit Library.
- Care Type – Drop down menu – A-All Cases defaults



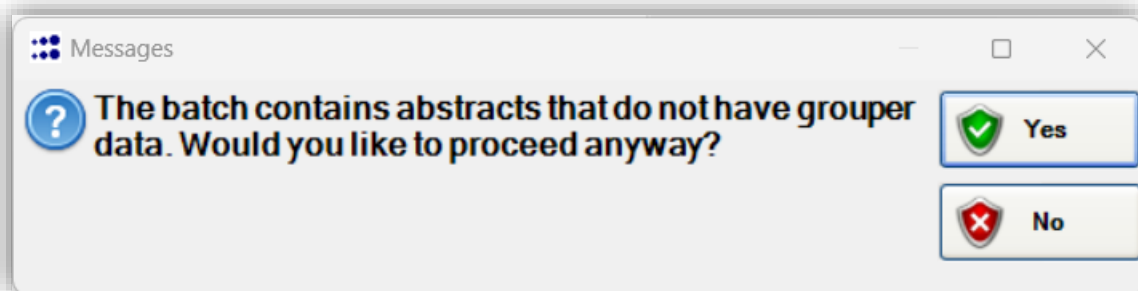
- o Select Edit Library – Allow user to run the submission using:



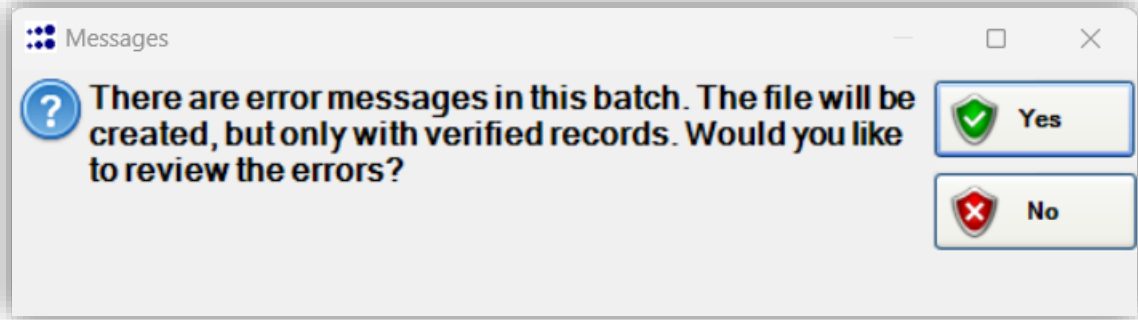
Custom Edits are EMT edits and only used for EMT clients.

System Edits are edits required for submission to CIHI.

- o Institution Number – enter the institution number or click on the down arrow and choose the institution (only the institutions for the module selected will display)
- o Batch Year – this will be blank the first time it is used, entering the fiscal year that is being submitted
- o Batch Period – this will default if previous periods have been submitted/enter the period/or choose from the drop down list
- o Date from – will populate based on the Batch Period, can be modified if required
- o Date to – will populate based on the Batch Period, can be modified if required
- o Current Batch – will populate how many records are in the Current Batch Period
- o Already Sent (In Previous File) – will populate the number of records that have been previously submitted
- o Full Batch Count – Total records in the Batch
- o Require Grouper Calculation – This feature will populate the number of records that do not have grouper information. A message will also populate while running verify that will state the following:



- o Invalid (Is Valid E or N) – This displays the number of abstracts that have “N” or “E” in the is 'Is Valid' field on the abstract. During the File Create process a message will display asking the following:



- “Yes” will display the error messages and give the ability to fix the errors
- “No” will not display the errors and the file will be created without the errors.
- Verified (Is Valid W or Y) – This displays the number of abstracts that have “W” or “Y” in the is ‘Is Valid’ field on the abstract



- - Abstract menu – used when fixing abstracts with Errors and Warnings



- - Save (**F7**) – Saves the record



- - Undo – Undoes any changes to the record



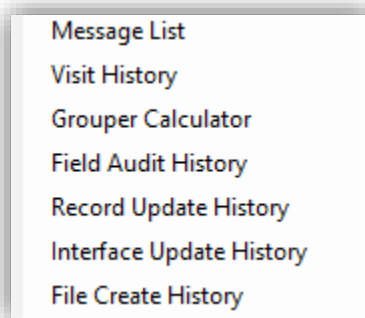
- - Record Verify (**F11**) – Verifies the Record



- - Report Manager(**F10**) – Opens Select Report



- - Tools– Click on the different options to change the view at the bottom of the abstract



NACRS Level 0, 1, 2, 3 Submission

To access NACRS Submissions

Tools → File Management → NACRS →

NACRS Level 0 (Clinic Lite) → CIHI Submission File

NACRS Level 1 → CIHI Submission File

NACRS Level 2 → CIHI Submission File

NACRS Level 3 → CIHI Submission File

The Level that is being submitted is displayed along the top Submission Screen:

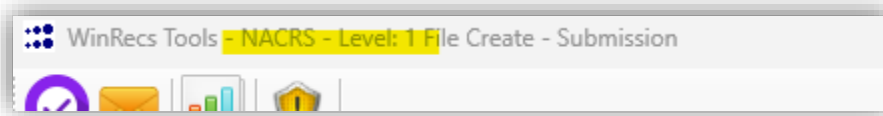
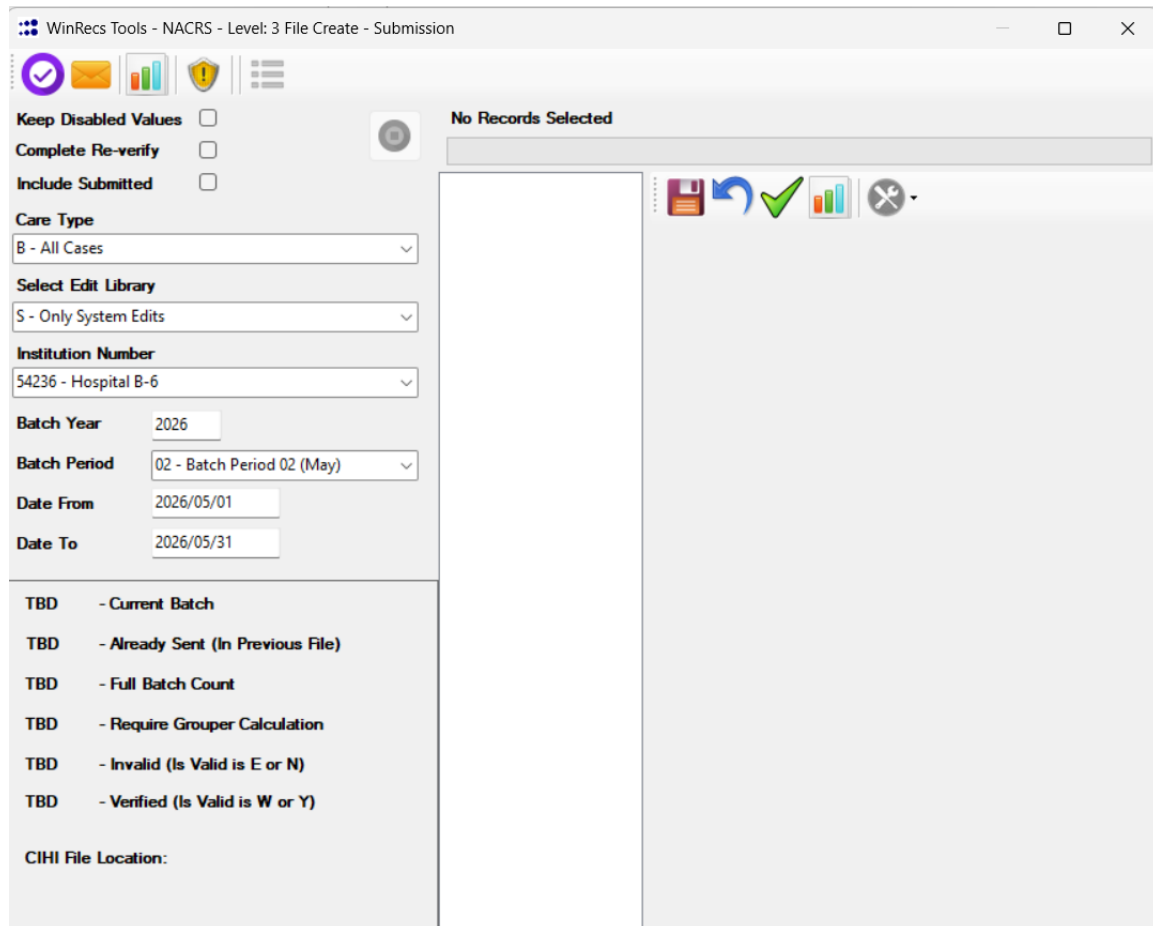


Figure 146 – File Management NACRS CIHI Submission File Identification



WinRecs Tools - NACRS - Level: 3 File Create - Submission

Keep Disabled Values ☐

Complete Re-verify ☐

Include Submitted ☐

Care Type
B - All Cases

Select Edit Library
S - Only System Edits

Institution Number
54236 - Hospital B-6

Batch Year
2026

Batch Period
02 - Batch Period 02 (May)

Date From
2026/05/01

Date To
2026/05/31

TBD - Current Batch

TBD - Already Sent (In Previous File)

TBD - Full Batch Count

TBD - Require Grouper Calculation

TBD - Invalid (Is Valid is E or N)

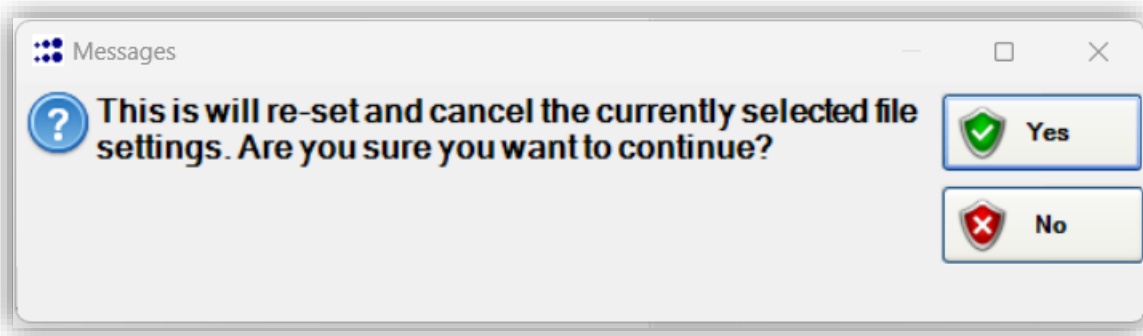
TBD - Verified (Is Valid is W or Y)

CIHI File Location:

No Records Selected

Figure 147 – File Management NACRS CIHI Submission File Screen

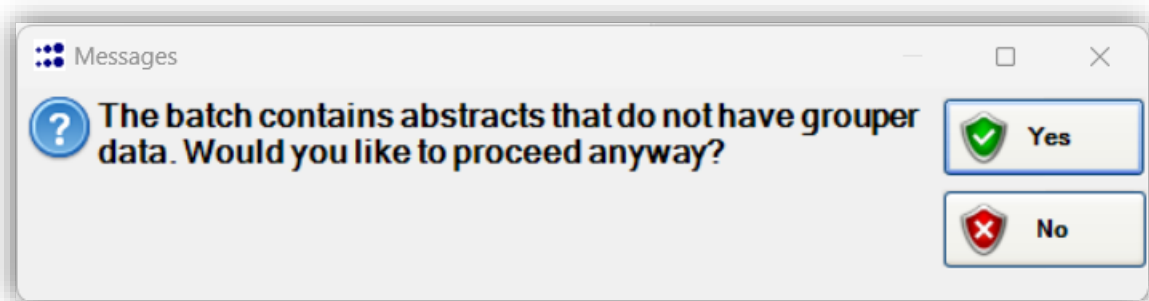
-  - Batch Verify (**Shift+F11**) – This will reverify all abstracts in the selected Batch
-  - Create File (**F12**) – This will create the file, if the Batch Verify is run just click on Create File and the file will be created.
-  - Batch Reports(**Shift+F10**) – This will display the reports function
-  - Checked Record Locks– checks for locked records
-  - Reset File Settings – This will reset the file setting below. The following message will display when clicked:



- Yes will clear the below settings, No will retain the current settings

-  - Work in Standard Environment – this field when enabled will display in blue:
-  when the list of records with errors displays. Clicking on this icon will open the abstract in the standard work environment. When saved a pop will ask if you want to go back to File Management screen.
- Keep Disabled Values – checking this box will keep the disabled values when a batch verify is done, not checking the box the disabled values will be removed during a batch verify.
- Complete Re-verify – checking this box will re-verify every record, not checking the box will not
- Include Submitted – Only used to verify submitted EMT edits. Can only be used checking this box will also automatically check the Complete Re-verify and Create File is disabled. Only C- Only Custom Edits can be used in the Select Edit Library
- Care Type - allows the user the option(not included in Level 0):

- B All Cases – will validate for all Care Types (Level 3 only)
- B-C Clinic – will validate for all MIS codes with a 'Clinic' Care Types (Level 3 only)
- B-D Day Surgery – will validate for all MIS codes with a Day Surgery Care Type (Level 3 only)
- B-E Emergency – will validate for all MIS codes with an Emergency Care Type (Level 1, 2, 3)
- B-E-O ED Opioid Cases – will validate for all Opioid Cases only (Level 1, 2, 3)
- Select Edit Library – Allow user to run the submission using:
 - B-Both System and Custom Edits
 - S- Only System Edits (For NACRS Level 0 this is the only option)
 - C- Only Custom Edits
- Institution Number – enter the institution number that is to be sent or click on the down arrow and choose the institution (only the institutions for the module selected will display)
- Batch Year – this will be blank the first time it is used, entering the fiscal year that is being submitted
- Batch Period – this will default if previous periods have been submitted/enter the period/or choose from the drop down list
- Date from – will populate based on the Batch Period, NACRS submission has the option to submit specified dates in a period
- Date to – will populated based on the Batch Period, NACRS submission has the option to submit specified dates in a period
- Current Batch – will populate how many records are in the Current Batch Period
- Already Sent (In Previous File) – will populate the number of records that have been previously submitted
- Full Batch Count – Total records in the Batch
- Require Grouper Calculation – This feature will populate the number of records that do not have grouper information. A message will also populate while running verify that will state the following:



- Invalid (Is Valid E or N) – This displays the number of abstracts that have “N” or “E” in the is 'Is Valid' field on the abstract.

- “Yes” will display the error messages and give the ability to fix the errors
- “No” will not display the errors and the file will be created without the errors.
- Verified (Is Valid W or Y) – This displays the number of abstracts that have “W” or “Y” in the is ‘Is Valid’ field on the abstract. During the File Create process a message will display asking the following:
- CIHI File Location – Displays the file location, clicking on the link will open the location the file is located.
- Current Batch – number of CJRR records in this Batch Period (Level 3 CJRR only)
- Invalid – CJRR – number of records that are invalid in this Batch Period (Level 3 CJRR only)
- Verified – CJRR – number of records that are verified and included in the file for this Batch Period (Level 3 CJRR only)
- CJRR File Location – Location of the CIHI CJRR file, clicking on link open CIHI CJRR file location. (Level 3 CJRR only)

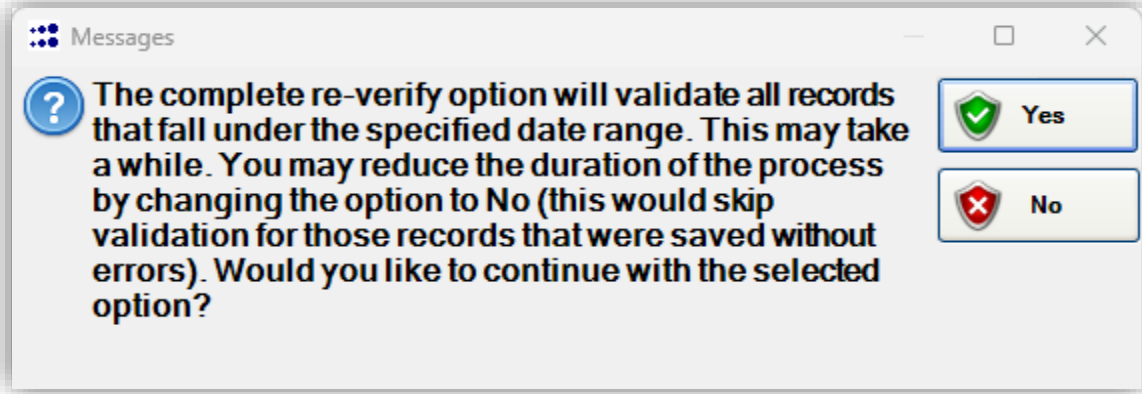
4.2.2 Running the Submission

Verification Only

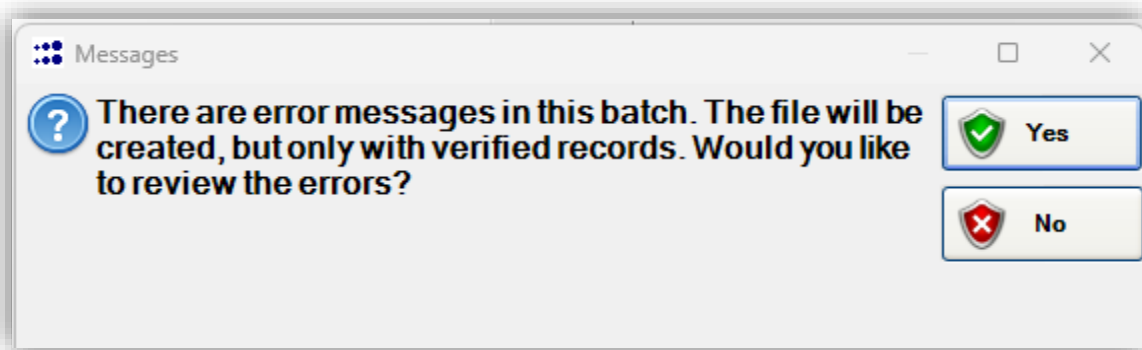
- To run a verification only, enter the following fields:
 - Care Type
 - Select Edit Library
 - Institution Number
 - Batch Year
 - Batch Period
 - Date From – can be adjusted but not necessary.
 - Date to – can be adjusted but not necessary.



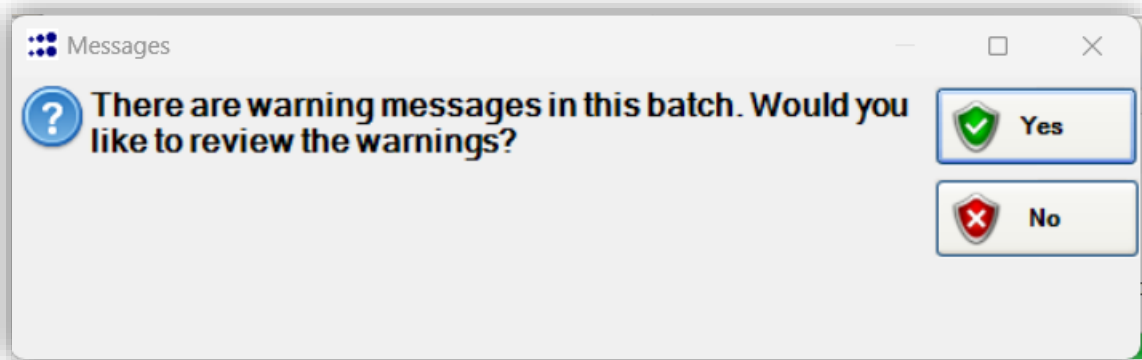
- Press  Batch Verify or **Shift+{F11}**
- The following message will display:



- Click “Yes” to continue verification, “No” to end the process.
- The submission will continue if there are errors or warnings the following message will appear:



- Click “Yes” to review the error messages and “No” to continue the submission without the errors.
- If there are only warnings the following will display:



- Click “Yes” to review the warning messages.
- Click “No” to continue the verification without the errors.

Fixing Errors/Warnings

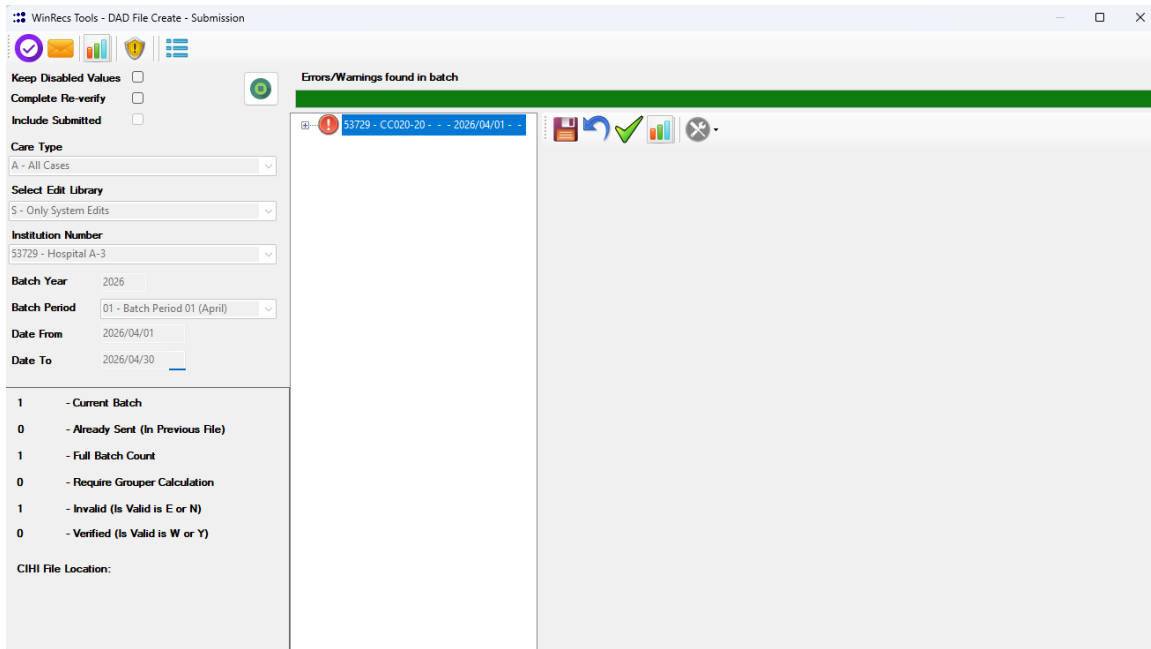
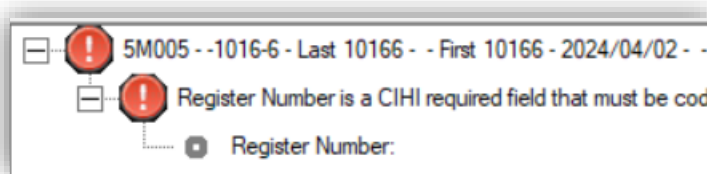
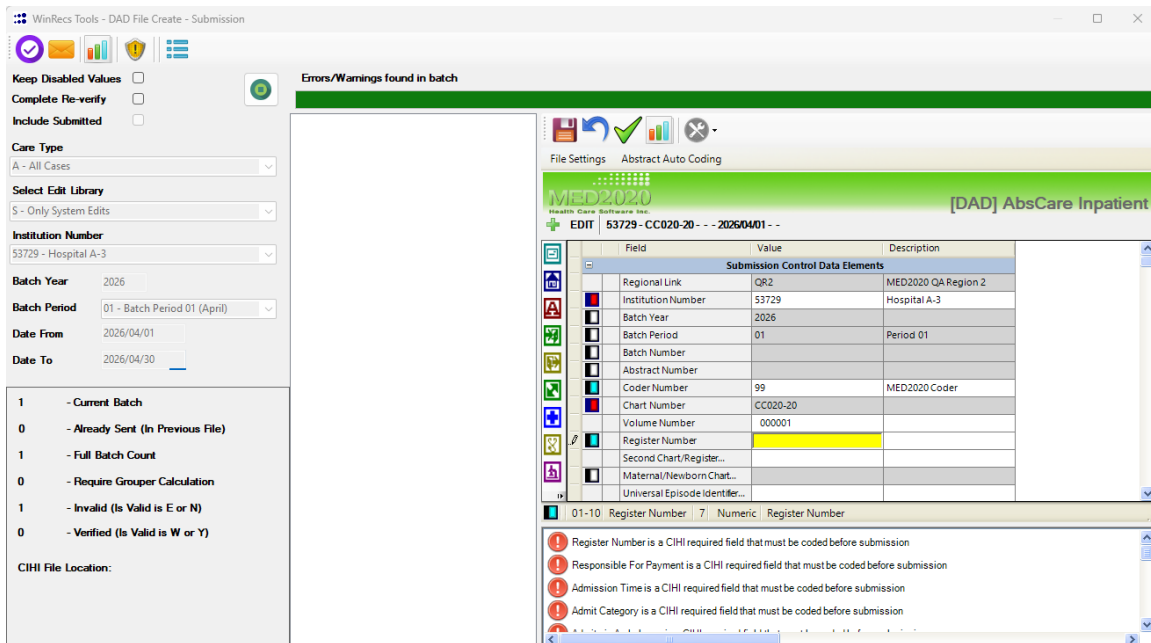


Figure 148 – File Management NACRS CIHI Submission Fixing Errors/Warnings

- Click on the plus sign beside the abstract information
- Click on the plus sign beside the error message
- Double click on the field that is causing the error to open up the abstract on the right-hand side.





WinRecs Tools - DAD File Create - Submission

Keep Disabled Values ☐
Complete Re-verify ☐
Include Submitted ☐

Care Type
A - All Cases

Select Edit Library
S - Only System Edits

Institution Number
53729 - Hospital A-3

Batch Year
2026

Batch Period
01 - Batch Period 01 (April)

Date From
2026/04/01

Date To
2026/04/30

1 - Current Batch
0 - Already Sent (In Previous File)
1 - Full Batch Count
0 - Require Grouper Calculation
1 - Invalid (Is Valid is E or N)
0 - Verified (Is Valid is W or Y)

CIHI File Location:

Errors/Warnings found in batch

File Settings Abstract Auto Coding

MED2020 Health Care Software Inc. [DAD] AbsCare Inpatient

EDIT | 53729 - CC020-20 - - 20260401 - -

Field	Value	Description
Submission Control Data Elements		
Regional Link	QR2	MED2020 QA Region 2
Institution Number	53729	Hospital A-3
Batch Year	2026	
Batch Period	01	Period 01
Batch Number		
Abstract Number		
Coder Number	99	MED2020 Coder
Chart Number	CC020-20	
Volume Number	000001	
Register Number		
Second Chart/Register...		
Maternal/Newborn Chart...		
Universal Episode Identifier...		

01-10 Register Number | 7 | Numeric | Register Number

Register Number is a CIHI required field that must be coded before submission
Responsible For Payment is a CIHI required field that must be coded before submission
Admission Time is a CIHI required field that must be coded before submission
Admit Category is a CIHI required field that must be coded before submission

- Fix the error and it will disappear from the middle.



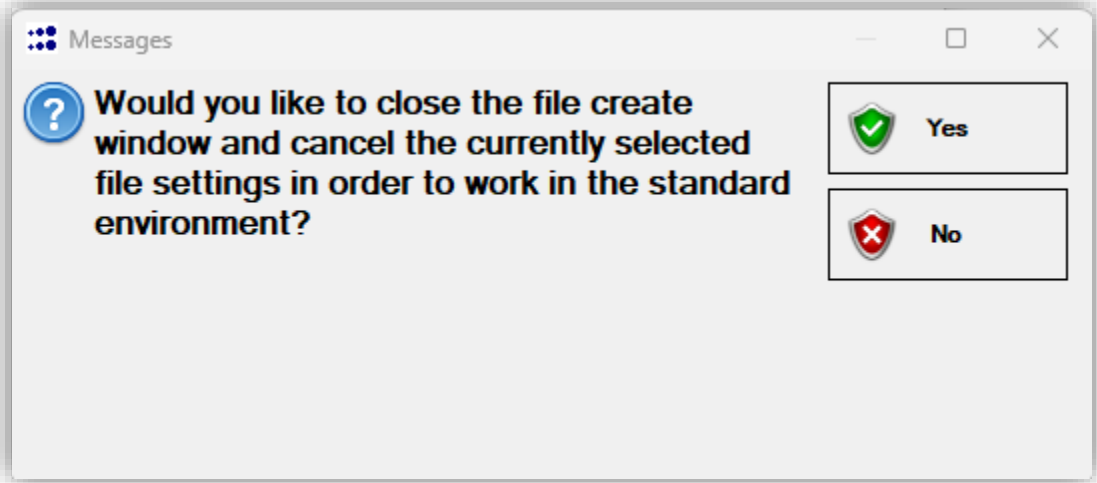
- Press  Save or **[F7]**



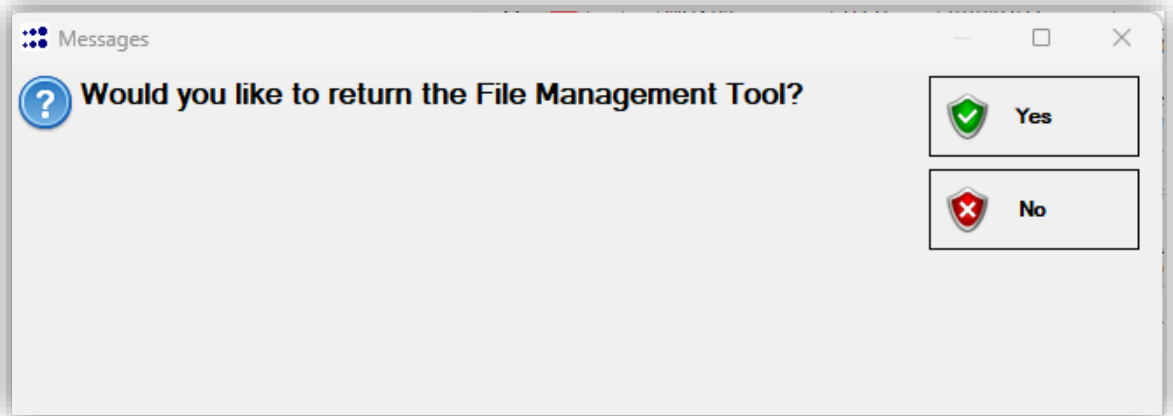
- If you want to create a submission after doing a verification, press  Create File or **[F12]** to create the file.



- Clicking on  - Work in Standard Environment in the toolbar menu will open up the chart in the WinRecs application.
 - A pop up message will display:



- Yes will go to standard environment, No will remain in File Management
- A pop up screen will display the errors, click on the error and it will open in the module.
- Once the record has been corrected and saved, a message will display:

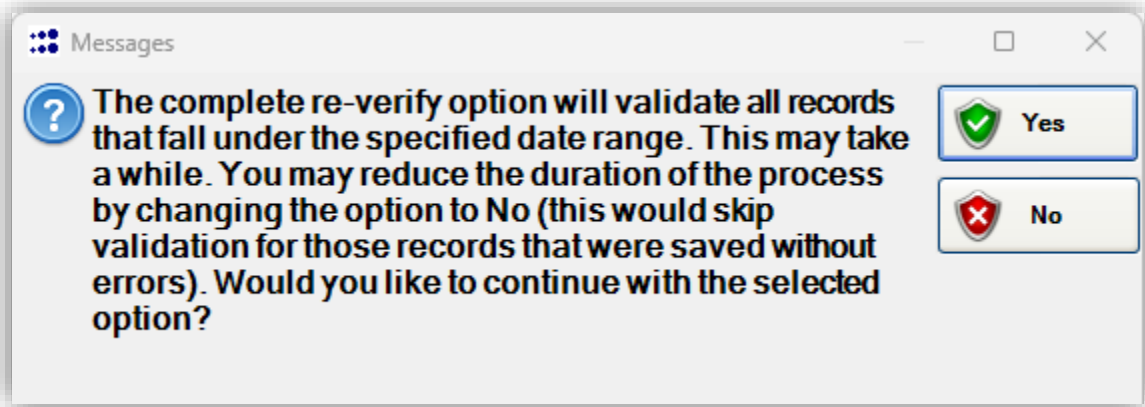


Create Submission

- Select the following fields:
 - Complete Re-Verify – check this if a re-verification is needed.
 - Care Type
 - Select Edit Library
 - Institution Number
 - Batch Year
 - Batch Period
 - Date From – can be adjusted but not necessary.

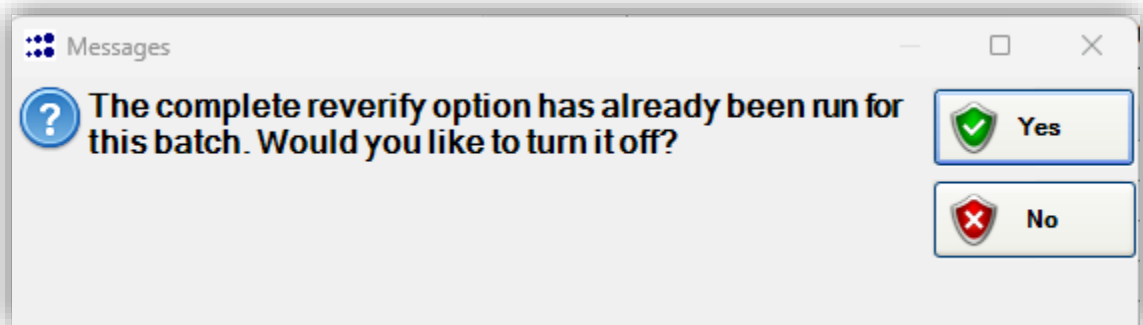
- Date to – can be adjusted but not necessary.
- Press  Create File or [F12]

- The following message will display:



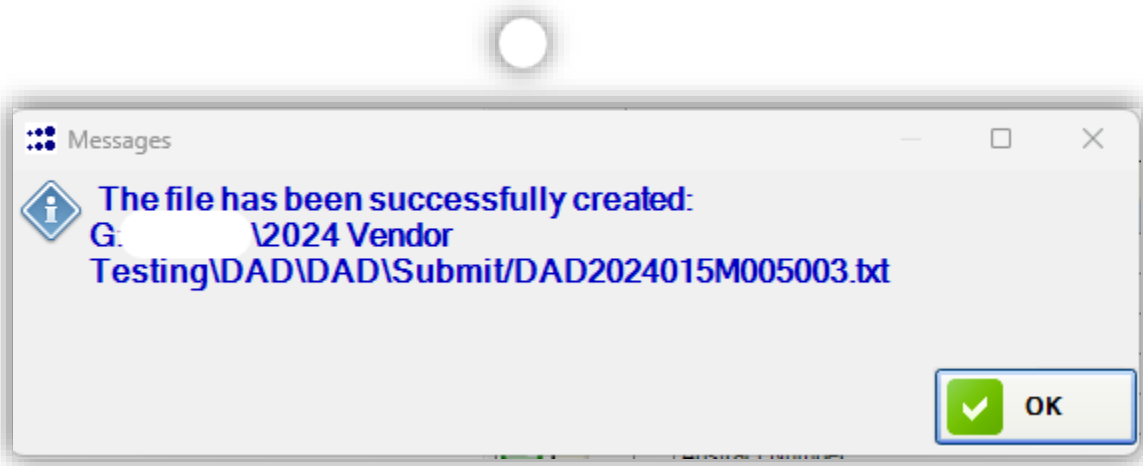
- Click “Yes” to continue verification, “No” to end the process.
- The submission will continue if there are errors and/or warnings the following message will appear see: [Fixing Errors/Warnings](#)

- Once errors are reviewed/fixed, click the  Create File or (F12)
 - The following message will display:



- “Yes” will remove the Complete Re-Verify and the Submission File will be created
- “No, the Re-Verify process will run again and then Submission File will be created.

- Once the submission process is complete, the following message will display and the file path will display on the bottom left hand side. :



4.2.3 CIHI Correction File – DAD & NACRS

The CIHI Correction module tracks, stores, and submits correction for abstracts that have been previously submitted to CIHI. The Correction module is only used with the:

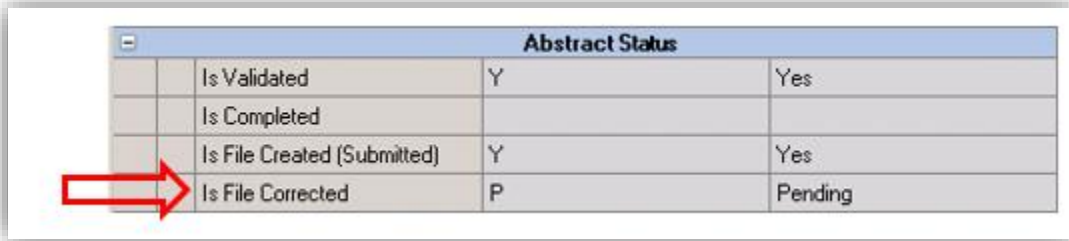
- [DAD] AbsCare Inpatient module
- [SDS] Abscare Day Surgery module
- [NACRS] 1, 2, 3 Amcare Ambulatory module

DAD & SDS are submitted cumulatively over the fiscal year (i.e.: correction files are not period specific but fiscal year specific)

NACRS are submitted period by period and are not cumulative.

All other WinRecs modules submit corrections with their submissions file.

Abstracts that have been sent for correction will have the field 'Is File Corrected' in the Abstract Status section of the abstract.



Abstract Status			
	Is Validated	Y	Yes
	Is Completed		
	Is File Created (Submitted)	Y	Yes
	Is File Corrected	P	Pending

Figure 149 - CIHI Correction Status in the Abstract

The following will display in the **Is File Corrected** field:

- *N* = No there is not correction pending
- *P* = Correction pending in DAD/SDS module
- *P1* = NACRS Level 2 pending
- *P2* = NACRS Level 2 pending
- *P3* = NACRS Level 3 pending

Creating a Correction File

When accessing a submitted record, the following warning message will display:

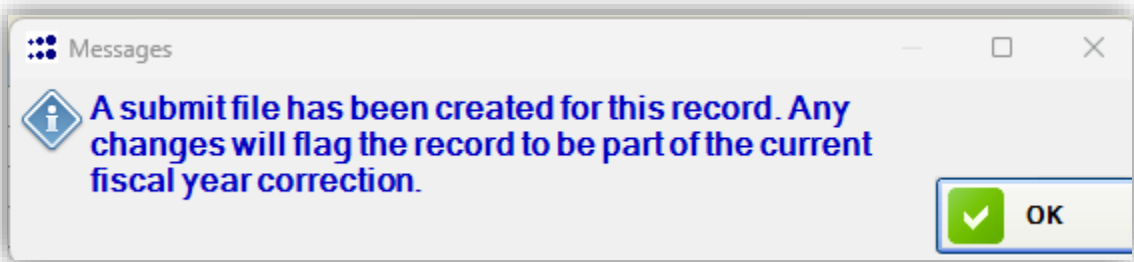


Figure 150 – Message for Accessing a Record Submitted to CIHI

When any changes are made or the abstract is saved, the 'Is File Corrected field' will change to *Pending* as explained above.

Inpatient/SDS Correction

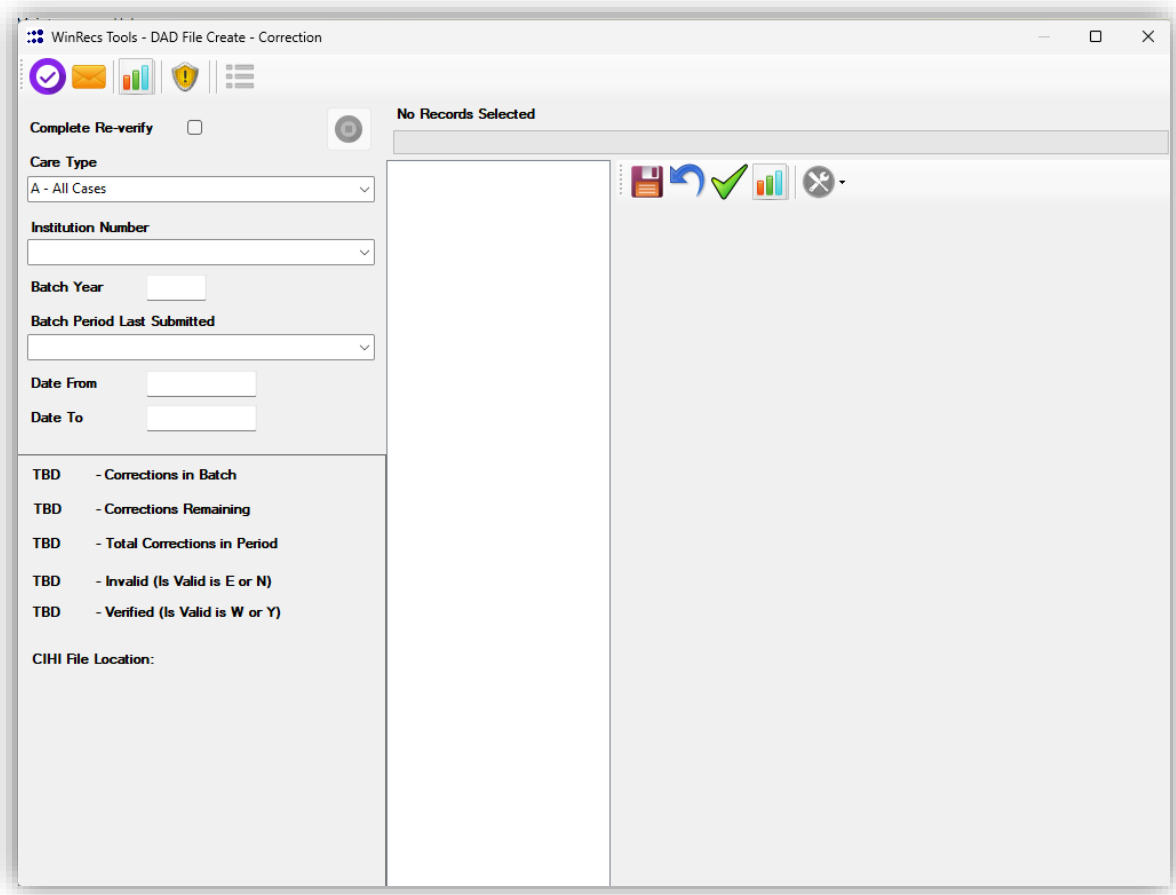
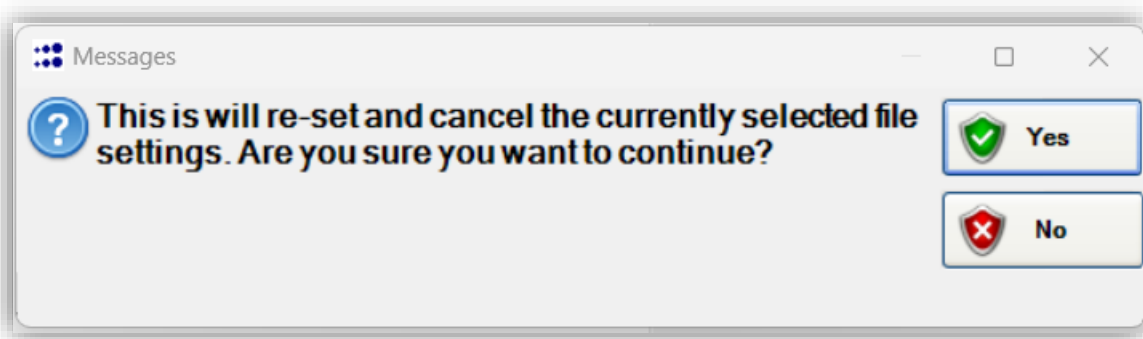


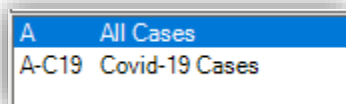
Figure 151 – File Management – DAD/SDS CIHI Correction File Screen

-  - Batch Verify (**Shift+F11**) – This will reverify all abstracts in the selected Batch
-  - Create File (**F12**) – This will create the file, if the Batch Verify is run just click on Create File and the file will be created.
-  - Batch Reports(**Shift+F10**) – This will display the reports function
-  - Checked Record Locks– checks for locked records

-  - Work in Standard Environment – this field when enabled will display in blue:
-  when the list of records with errors displays. Clicking on this icon will open the abstract in the standard work environment. When saved a pop will ask if you want to go back to File Management screen.
-  - Reset File Settings – This will reset the file setting below. The following message will display when clicked:



- Yes will clear the below settings, No will retain the current settings.
- Complete Re-verify – checking this box will re-verify every record
- Care Type – Drop down menu – A-All Cases defaults



- A-C19 – Covid-19 Cases – if you choose this option the date from and date to fields will open and dates can be entered
- Institution Number – enter the institution number that is to be sent or click on the down arrow and choose the institution (only the institutions for the module selected will display)
- Batch Year – this will be blank the first time it is used, entering the fiscal year that is being submitted
- Batch Period Last Submitted – this will default if previous periods have been submitted/enter the period/or choose from the drop down list
- Date from – will populate April 1 for DAD/SDS and will populate with the beginning of the Batch Period (cannot enter into this field)
- Date to – will populated the last date based on the Batch Period (cannot enter into this field)

- Correction in Batch – Total corrections in batch
- Corrections Remaining – Any corrections not included in correction file
- Total Corrections In Period – Total Corrections in Period
- Invalid (Is Valid E or N) – This displays the number of abstracts that have “N” or “E” in the is ‘Is Valid’ field on the abstract.
- Verified (Is Valid W or Y) – This displays the number of abstracts that have “W” or “Y” in the is ‘Is Valid’ field on the abstract
- CIHI File Location – Identifies where the file is located, can click on the link and will take you to the correction/deletion file.



- - Abstract menu – used when fixing abstracts with Errors and Warnings



- - Save (**F7**) – Saves the record



- - Undo – Undoes any changes to the record



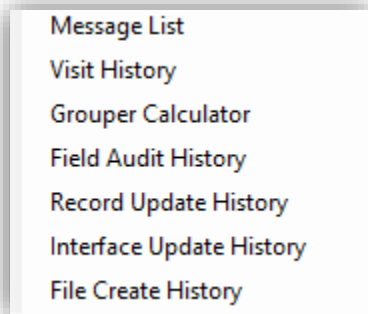
- - Record Verify (**F11**) – Verifies the Record



- - Report Manager(**F10**) – Opens Select Report



- - Tools– Click on the different options to change the view at the bottom of the abstract



- CIHI File Location – Displays the file location, clicking on the link will open the location the file is located.

NACRS Level 0/1/2/3 Correction/Deletion

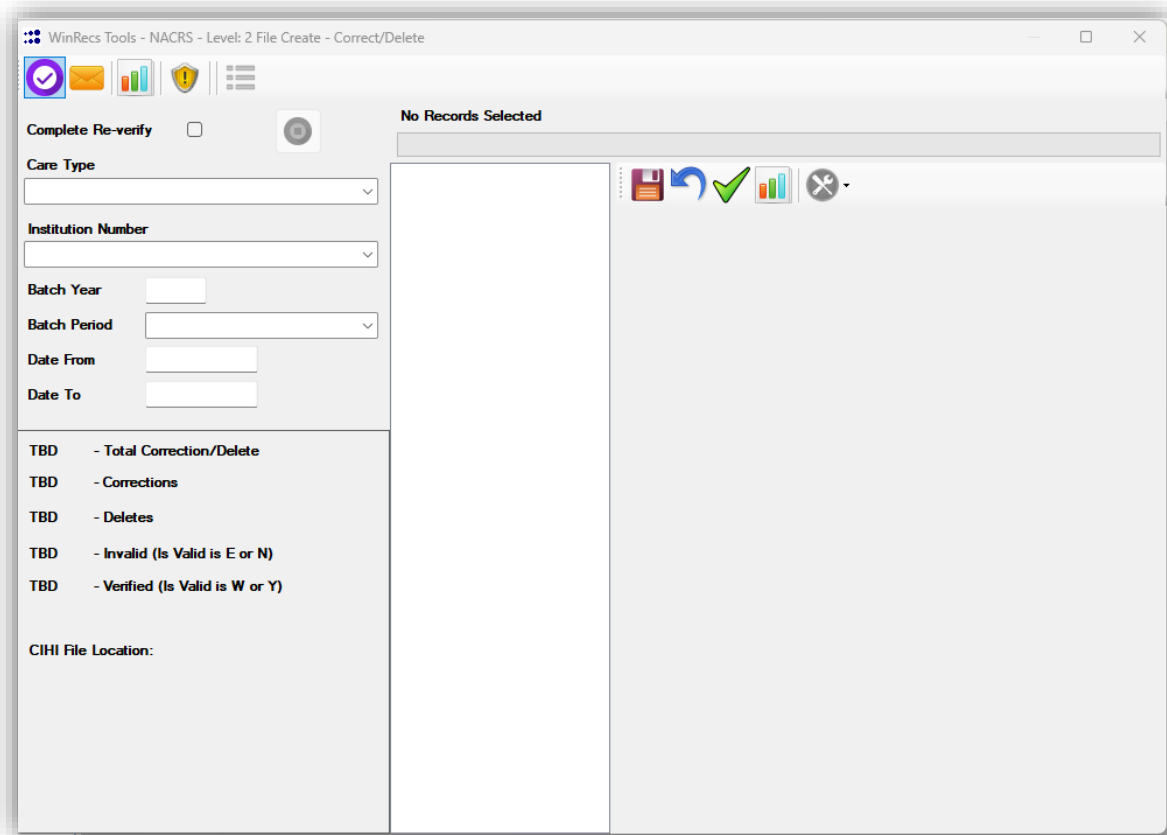
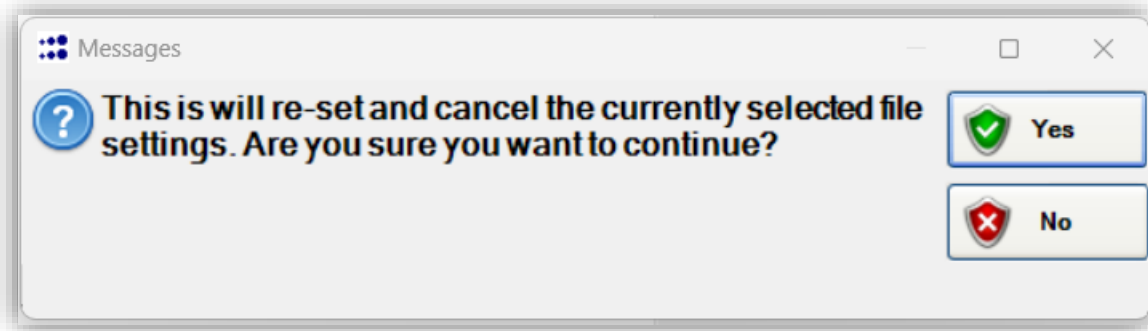


Figure 152 – File Management – NACRS Level 0/1/2/3 CIHI Correction File Screen

-  - Batch Verify (**Shift+F11**) – This will reverify all abstracts in the selected Batch
-  - Create File (**F12**) – This will create the file, if the Batch Verify is run just click on Create File and the file will be created.
-  - Batch Reports(**Shift+F10**) – This will display the reports function
-  - Checked Record Locks– checks for locked records
-  - Work in Standard Environment – this field when enable when the list of records with errors displays. Clicking on this icon will open the abstract in the standard work environment. When saved a pop will ask if you want to go back to File Management screen.

-  - Reset File Settings – This will reset the file setting below. The following message will display when clicked:



- Yes will clear the below settings, No will retain the current settings.
- Complete Re-verify – checking this box will re-verify every record.
- Care Type - allows the user the option(not included in Level 0):
 - B All Cases – will validate for all Care Types (Level 3 only)
 - B-C Clinic – will validate for all MIS codes with a 'Clinic' Care Types (Level 3 only)
 - B-D Day Surgery – will validate for all MIS codes with a Day Surgery Care Type (Level 3 only)
 - B-E Emergency – will validate for all MIS codes with an Emergency Care Type (Level 2, 2, 3)
 - B-E-O ED Opioid Cases – will validate for all Opioid Cases only (Level 2, 2, 3)
- Institution Number – enter the institution number that is to be sent or click on the down arrow and choose the institution (only the institutions for the module selected will display)
- Batch Year – this will be blank the first time it is used, entering the fiscal year that is being submitted
- Batch Period – this will default if previous periods have been submitted/enter the period/or choose from the drop down list
- Date from – this will populate with the beginning of the Batch Period (cannot enter into this field)
- Date to – will populated the last date based on the Batch Period (cannot enter into this field)
- Total Correction/Delete – Total Corrections/Deletions for this Batch Period
- Corrections – Total Corrections in the Batch Period
- Deletes – Total Deletions in the Batch Period
- Invalid (is Valid is E or N) – Total records that have errors or not processed in the Batch Period

- Verified (Is Valid W or Y) – Total records that have warnings or are verified in the Batch Period.
- CIHI File Location – Identifies where the file is located, can click on the link and will take you to the correction/deletion file.



- - Abstract menu – used when fixing abstracts with Errors and Warnings



- - Save (**F7**) – Saves the record



- - Undo – Undoes any changes to the record



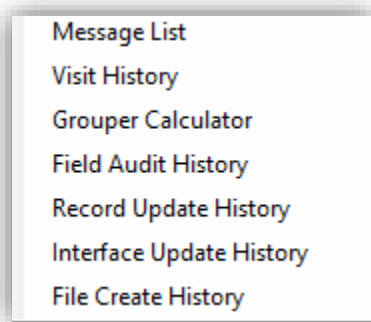
- - Record Verify (**F11**) – Verifies the Record



- - Report Manager(**F10**) – Opens Select Report



- - Tools– Click on the different options to change the view at the bottom of the abstract



Create Correction

To create the correction file is the same as the submission file process but the file naming will be for a correction and will be sent to CIHI as a correction. Click here: [Creating a Correction File](#)

4.2.4 No Separations File – DAD

If an institution has no discharges for a specific period, CIHI requires that a “No Separation File” be submitted to advise that no abstracts to that reporting period.

Run the Create Submission the following message will appear:

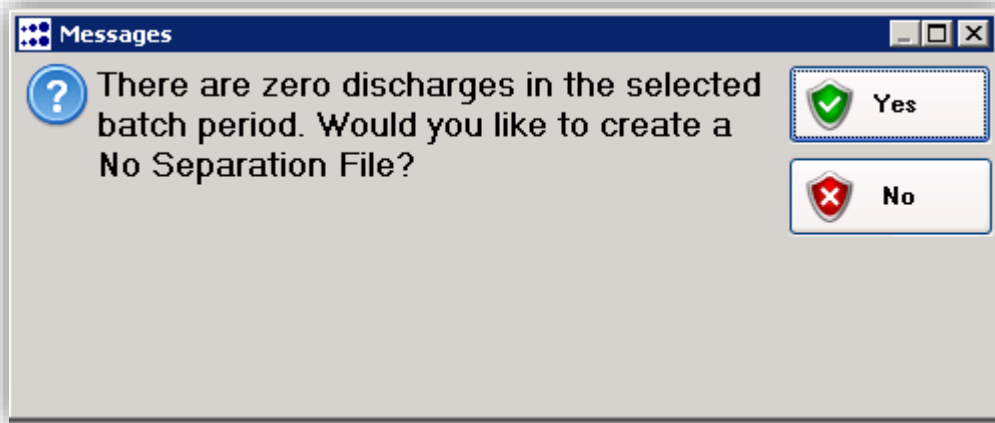


Figure 153 – File Management – Zero discharges in the selected batch period message

Clicking **YES** – will create a No Separation File

Clicking **NO** – will go back to the **File Management** screen

4.2.5 CIHI Deletion File – DAD & NACRS

A deleted record that has previously been submitted to CIHI will remain in the Purge/Recover module until a deletion file or submission/correction file (depending on the module) is run. The file can be deleted via the Abstracting module or via the Modify Chart module.

In the Abstracting module, the following messages will appear when a submitted chart is deleted:

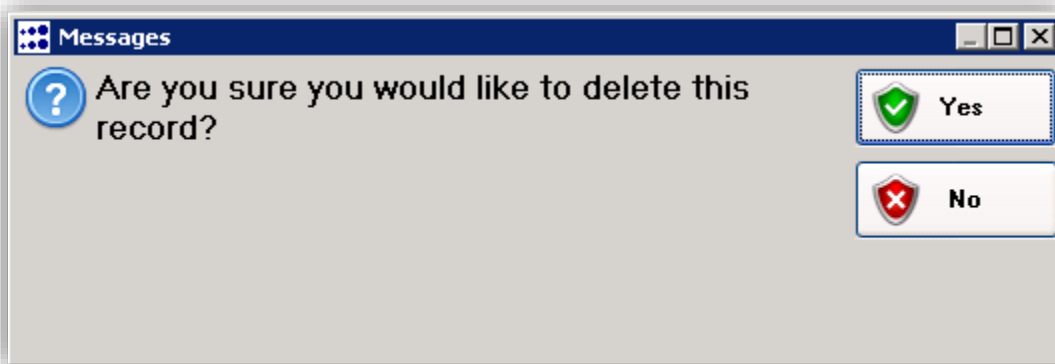


Figure 154 – File Management – Deletion Confirmation Message

Click **YES** will continue with the process

Click **NO** it will go back to the abstract

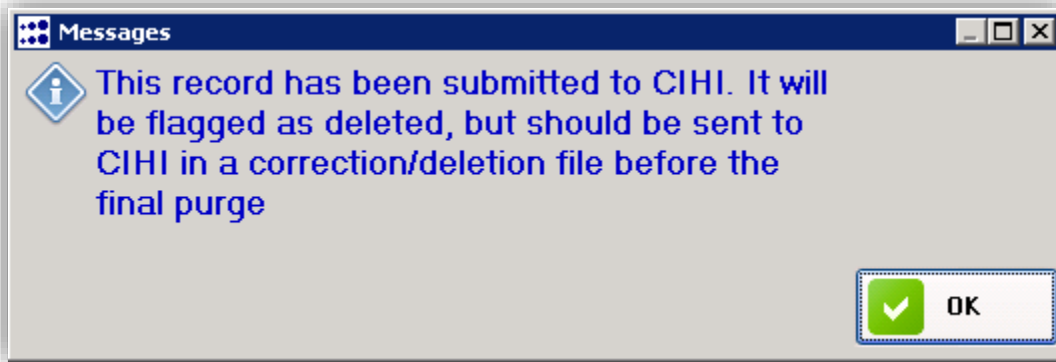


Figure 155 – File Management – Deletion Confirmation Message

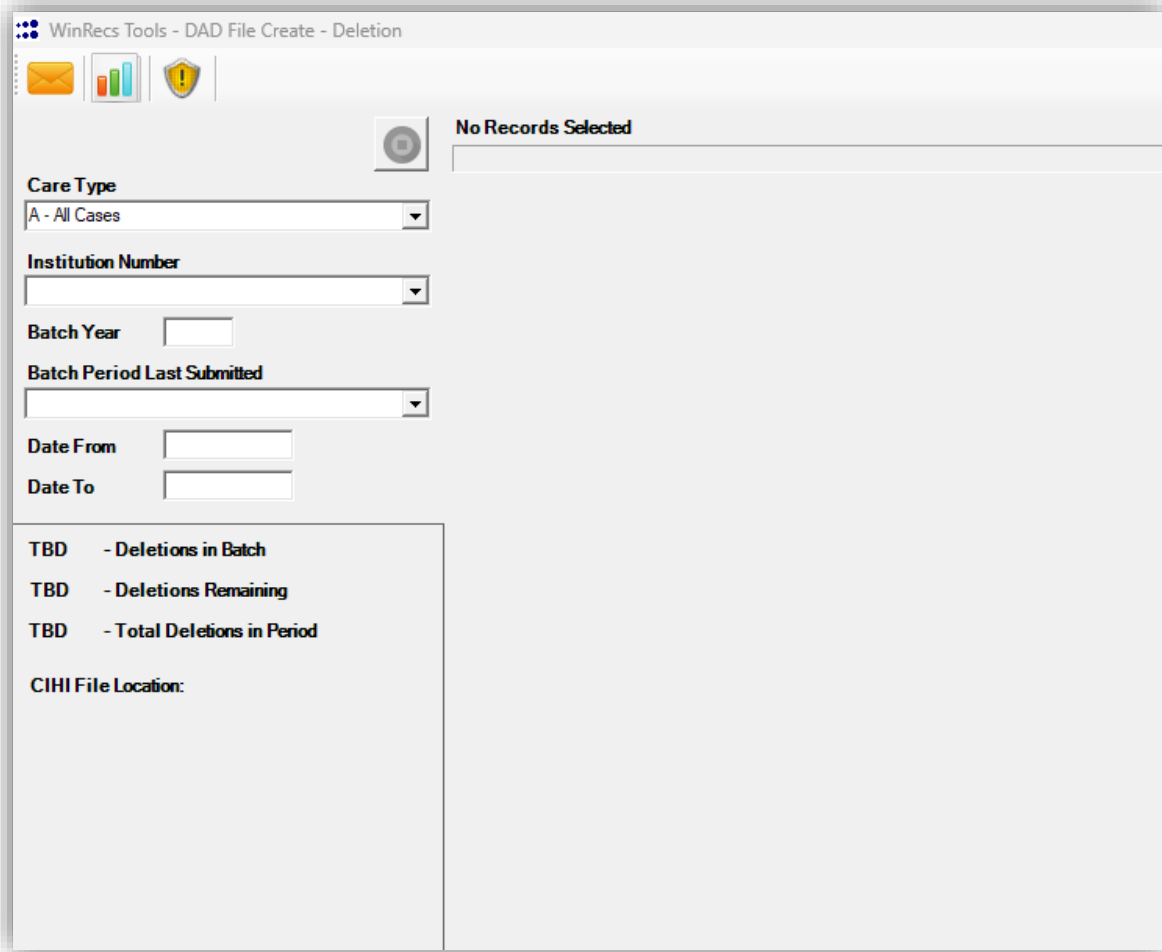
Click **OK** and the abstract will be sent to the purge file.

DAD/SDS Deletion File

The file will be created as a deletion file.

Tools → File Management → DAD → CIHI Deletion File

Tools → File Management → SDS → CIHI Deletion File

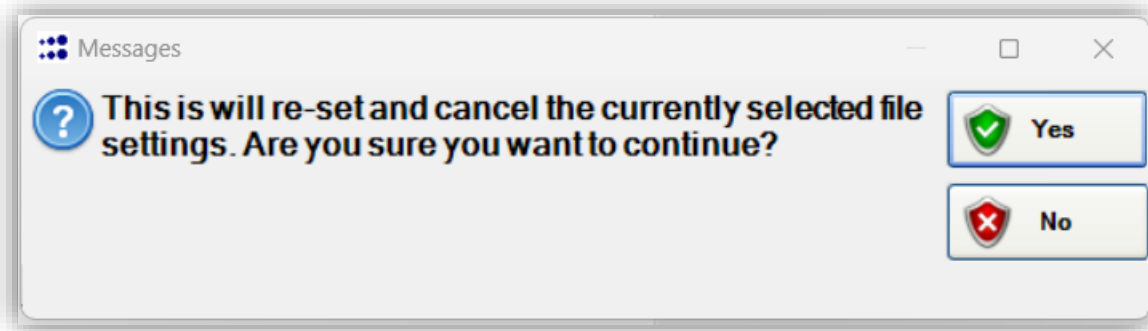


The screenshot shows the 'WinRecs Tools - DAD File Create - Deletion' window. It features a toolbar with three icons: an envelope (Create File), a bar chart (Batch Reports), and a shield with an exclamation mark (Checked Record Locks). Below the toolbar, there are several input fields: 'Care Type' (dropdown menu set to 'A - All Cases'), 'Institution Number' (dropdown menu), 'Batch Year' (text input), 'Batch Period Last Submitted' (dropdown menu), 'Date From' (text input), and 'Date To' (text input). On the right side, there is a large area labeled 'No Records Selected'. At the bottom left, there is a section with three lines of text: 'TBD - Deletions in Batch', 'TBD - Deletions Remaining', and 'TBD - Total Deletions in Period'. Below this, there is a label 'CIHI File Location:' followed by a large empty text area.

Figure 156 – File Management – DAD/SDS Deletion

-  - Create File (**F12**) – This will create the file
-  - Batch Reports(**Shift+F10**) – This will display the reports function
-  - Checked Record Locks– checks for locked records

-  - Reset File Settings – This will reset the file setting below. The following message will display when clicked:

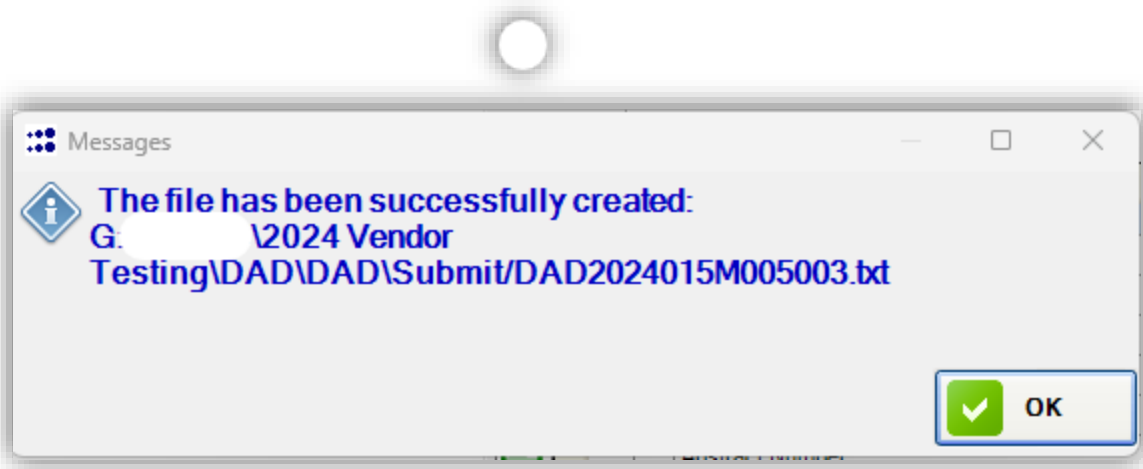


- Yes will clear the below settings, No will retain the current settings.
 - Care Type - allows the user the option:
 - A All Cases – will validate for all Cases
 - A-C19-Covid-19 Cases – will send in COVID 19 deletions.
 - Institution Number – enter the institution number that is to be sent or click on the down arrow and choose the institution (only the institutions for the module selected will display)
 - Batch Year – enter the batch year of the deletions being submitted
 - Batch Period Last Submitted – will enter the last period that has been submitted to CIHI, it will pull all deletions from April 1 to end of that Batch period for the Batch year chosen
 - Date from – this will populate with the beginning of the Batch Year
 - Date to – will populated the last date based on the Batch Period
 - Deletions in Batch – Total deletions in this Batch
 - Deletions Remaining – Total deletions not included in the file for this Batch Period
 - Total Deletions in Period – Total Deletions in the Batch Period
- CIHI File Location – Identifies where the file is located, can click on the link and will take you to the correction/deletion file.

Create DAD/SDS Deletion File

- Select the following fields:
 - Care Type
 - Institution Number
 - Batch Year
 - Batch Period – this will auto populate the last period submitted to CIHI
 - Date From – can be adjusted but not necessary.

- Date to – can be adjusted but not necessary.
- Press  Create File or [F12]
- Once the submission process is complete, the following message will display:



NACRS Level 2/2/3 Deletion File

The file is created and sent as part of the correction file.

Tools → File Management → NACRS Level 2/2/3 → CIHI Correction/Deletion File

Go to: Create Submission on how to create the file.

4.2.6 CIHI Detailed Error File – DAD

The function is used to flag CIHI submitted records as pending corrections. Importing the DAD error file allows user to print the errors for corrections.

1. Save the CIHI Detailed Error File received from CIHI on the computer where it is designated for the facility.
2. Tools → File Management → DAD → CIHI Detailed Error File

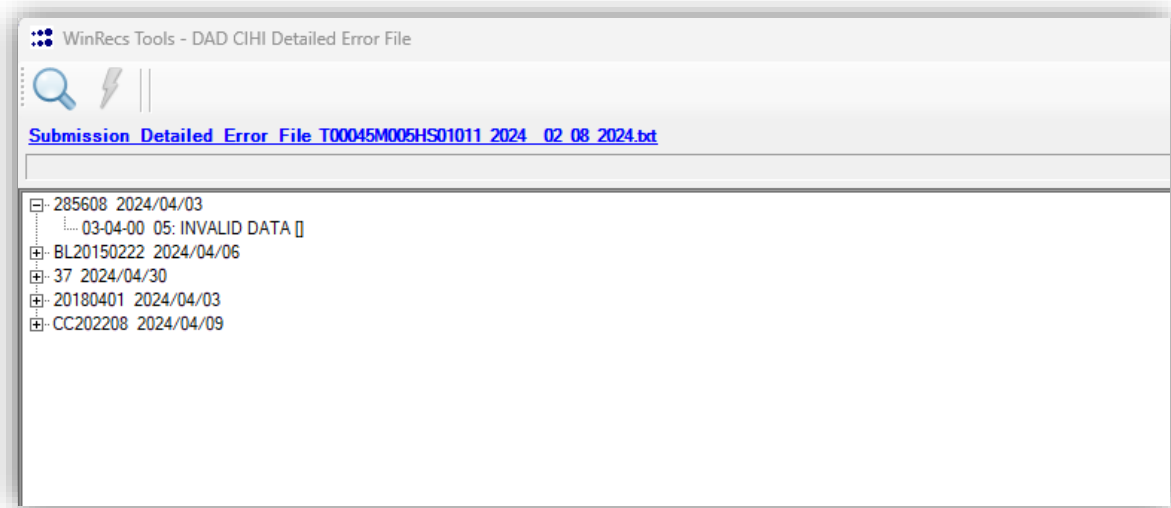
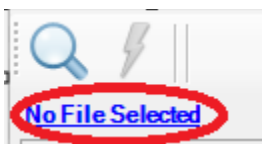
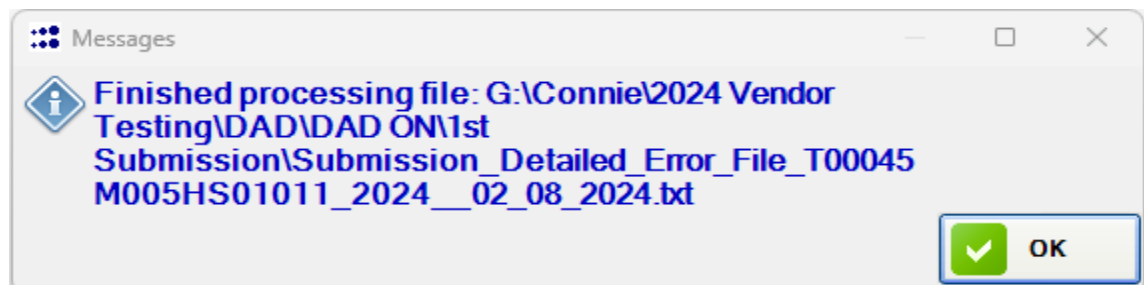


Figure 157 – File Management – CIHI Detailed Error File

3. Press the  to search for the CIHI file and the file directory will display.
4. Once the file has been located press OK and the file name will display in the top. Press the  to process the report and DAD CIHI Errors are imported.

5.  - Displays the file path of the file you are processing.
6. The following message will display:



7. Once the file is finished processing the errors will display.

4.2.7 CIHI Electronic Rejection/Data Quality Warning File - NACRS

This file flags the NACRS files that have been rejected due to errors by CIHI. Once the file is imported it will reset the submission status of rejected records. After the files have been corrected and saved the records will be submitted to CIHI.

1. Save the CIHI Electronic Rejection/Data Quality Warning file from CIHI onto a shared drive (as per hospital decision).
2. **Tools → File Management → NACRS → CIHI Electronic Rejection/Data Quality Warning File**

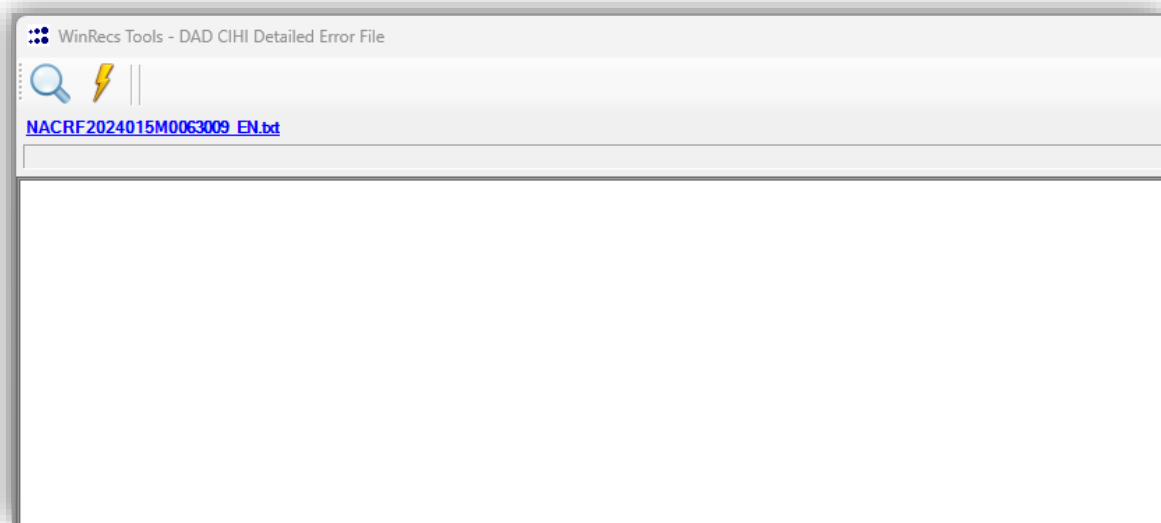
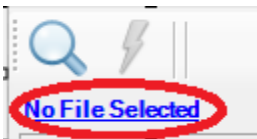


Figure 158 - File Management – CIHI Electronic Rejection Data Quality Warning

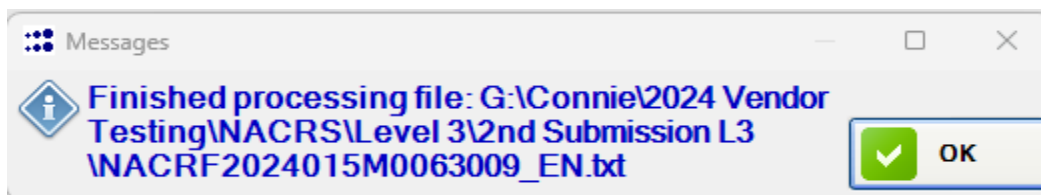
3. Press the  to search for the CIHI file and the file directory will display.
4. Once the file has been located press OK and the file name will display in the top. Press the



to process the report.



5. - Displays the file path of the file you are processing.
6. The following message will display when done and the error messages will display and the visits will have the submission status reset:



4.2.8 Manual Reset of Submission Status - NACRS

When correcting a rejected NACRS record without having imported the NACRS Rejection file from CIHI, the user will have to reset the submission status on each abstract as they are corrected.

To Manually Reset the Submission Status:

- Open the rejected record
- Correct the error(s)
- Select File Settings/Re-Set File Create Status

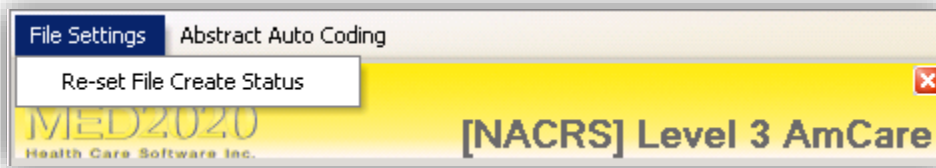


Figure 159 – Re-set File Create Status

- The following message will appear:

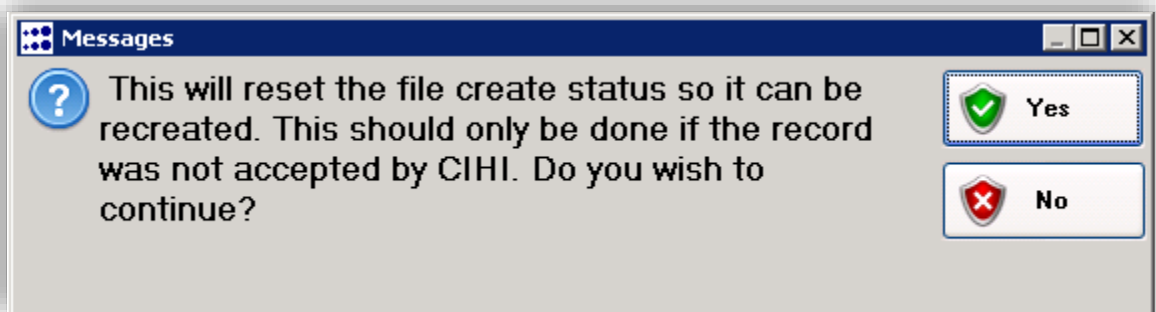


Figure 160 – Re-set File Create Status Message

- Clicking 'Yes' will reset the submission status to a 'N'
- Click 'No' will take you back to the abstract

The 'Is Abstract Submitted' flag will now change to 'N' and the record can be resubmitted via Create Submission

4.2.9 NACRS CJRR Submission/Corrections/Deletions

NACRS CJRR Visit is submitted as a separate Level 3 Submission. The Level 3 submission file must be accepted by CIHI prior to submitting the NACRS CJRR file.

- Run the Level 3 Submission file and the NACRS CJRR file will be created at the same time.
- Click on Create File:
- The following will display the number of NACRS L3 abstracts and the number of NACRS-CJRR L3 abstracts.

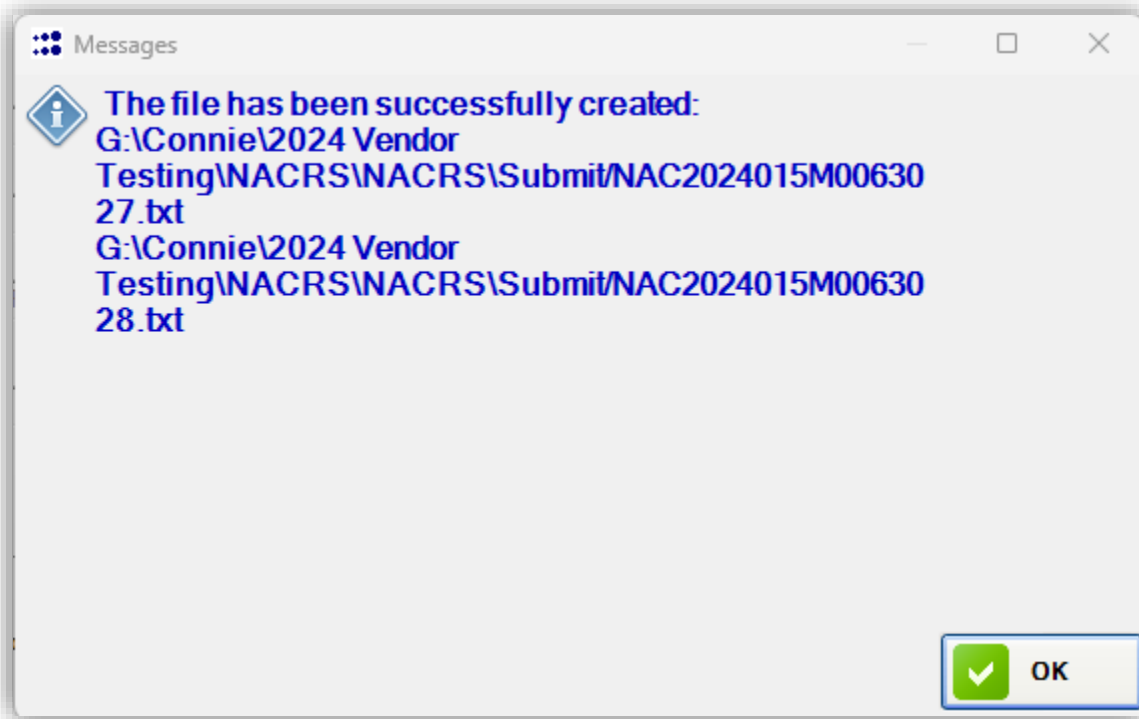


Figure 161 – NACRS CJRR Submission

- When the file is created, 2 files will be created the first will be the Level 3 submission file, the second is the NACRS CJRR submission file.

1	- Current Batch
944	- Already Sent (In Previous File)
946	- Full Batch Count
0	- Require Grouper Calculation
0	- Invalid (Is Valid is E or N)
1	- Verified (Is Valid is W or Y)
CIHI File Location:	
G:\Connie\2024 Vendor Testing\NACRS\NACRS\Submit\NAC2024 015M0063027.txt	
1	- Current Batch - CJRR
0	- Invalid - CJRR
1	- Verified - CJRR
CJRR File Location:	
G:\Connie\2024 Vendor Testing\NACRS\NACRS\Submit\NAC2024 015M0063028.txt	

Figure 162 – NACRS CJRR Submission Files Created

- Current Batch – number of CJRR records in this Batch Period
- Invalid – CJRR – number of records that are invalid in this Batch Period
- Verified – CJRR – number of records that are verified and included in the file for this Batch Period
- CJRR File Location – Location of the CIHI CJRR file, clicking on link open CIHI CJRR file location.

Please Note: The level 3 file with the Amcare Visits (lowest sequence number) must be submitted and accepted by CIHI prior to sending the NACRS CJRR File. The Record Type for the new CJRR visit is 5.

Note: The level 3 file with the Amcare visits (lowest sequence number) must be submitted and accepted by CIHI prior to sending the NACARS CJRR file. The Record Type for new CJRR records is 5.

NACRS CJRR Corrections

- Any changes to the NACRS CJRR submitted cases will also update the Level 3 visit when saved.
- When a NACRS Level 3 correction file (Record Type 4) is created and submitted to CIHI this will in turn delete the associated CJRR file. The NACRS CJRR file will need to send as a Record Type 5 new. When the correction file is run, there will be 2 files created:
 - NACRS Level 3 Correction File
 - NACRS CJRR file – with Record type 5 (new)

These files will need to be submitted as above, the Level 3 correction file first and once accepted by CIHI the NACRS CJRR file.

NACRS CJRR Deletion

- When a NACRS Level 3 abstract and it's associated CJRR file is deleted and is submitted as a Correction file. The deleted visit will be picked up as a Record Type 2. The Record Type 2 will delete both the Level 3 Amcare visit and the associated NACRS CJRR visit.
- If the NACRS CJRR visit is only deleted and the Level 3 Amcare remains. The correction file will create a Record Type 4. This will correct the Level 3 Amcare and delete the NACRS CJRR visit.

4.2.10 File Management – Other Messages

The following messages that may occur at different times of the File Management process.

1. **No File Path for CIHI Files** - If the user tries to save the verification result file to a location that does not exist, WinRecs will prompt the user to create the folder. This means there is no File Path in the CIHI Directory in the Institution Profile

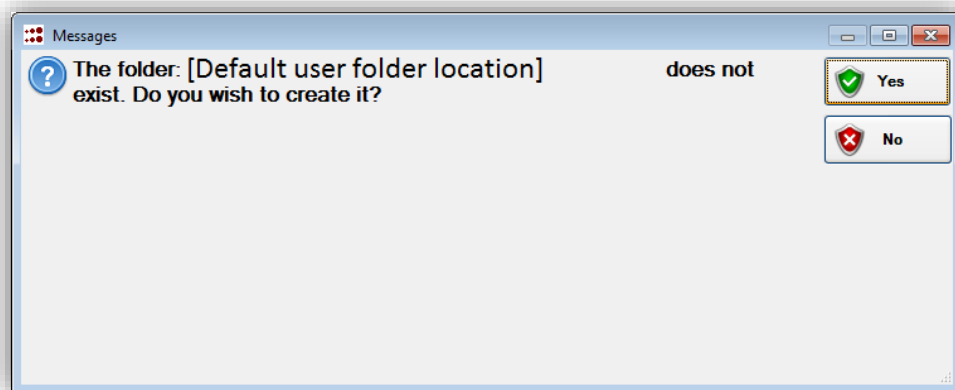


Figure 163 – File Management – Default user Location does not Exist Message

Clicking **YES** – will create a folder for you in the Default user folder location.

Clicking **NO** – will take you back to the File Management screen

2. **Record Being Accessed** – Charts of the submitted period are being accessed, the process cannot be completed till the abstracts are closed.

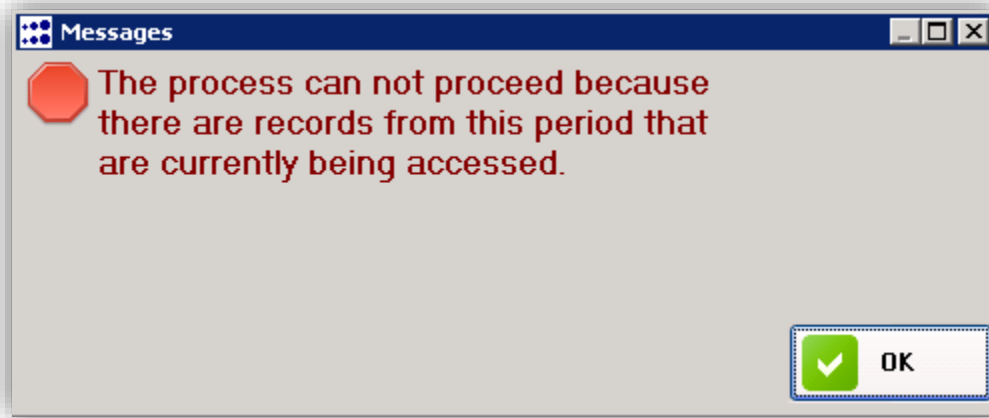


Figure 164 – File Management – Record from this period being accessed

3. **Date Range Includes Future Date** - A message will be displayed to inform you that records outside of the date range will be rejected.

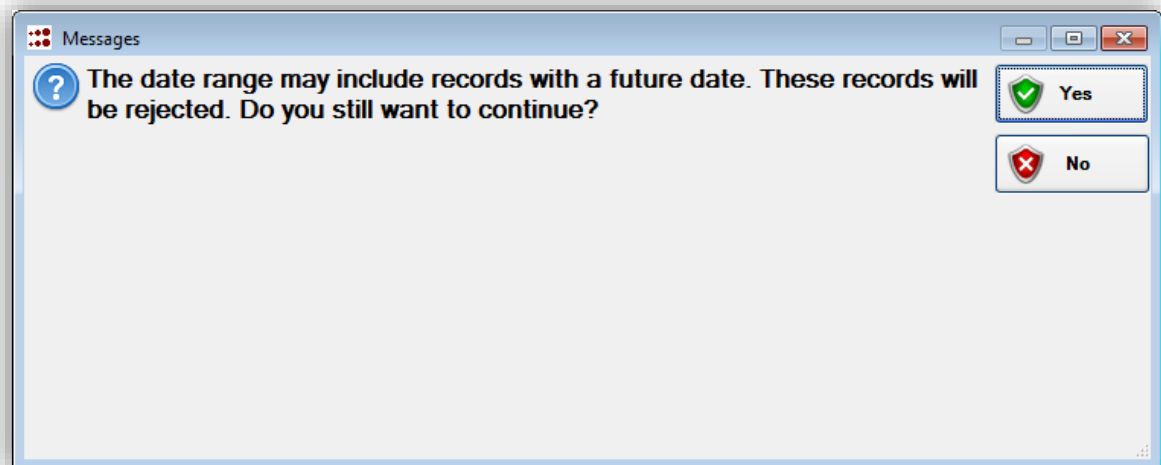


Figure 165 - Confirmation records outside the date range not in submission file

- Click **Yes** to continue submission process
 - Click **No** to go back to the File Management screen.
4. **Required Parameters Missing** - If the user forgets to fill in some of the required parameters, the following error message will be displayed.

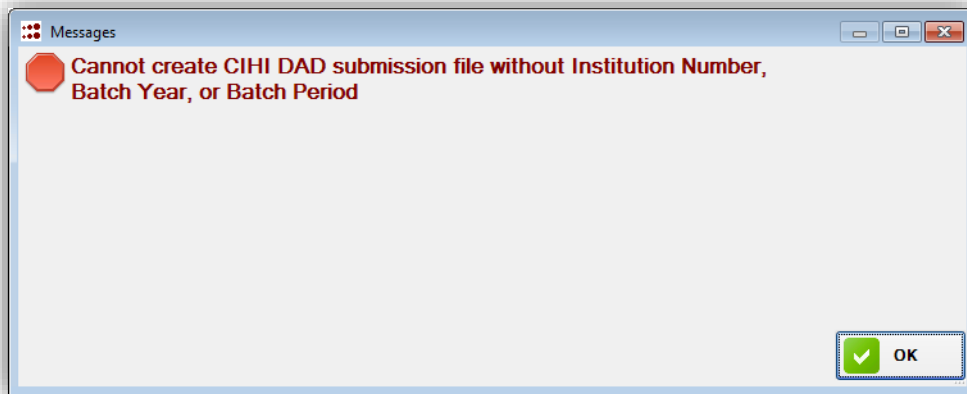


Figure 166 - File creation parameter error

To return to the file creation screen and correct the error

- Click **“Ok”** or Press **[ENTER]**.
- Highlight **No** using the **[TAB]** key, then press **[ENTER]** to cancel the verification.

5. **No Data Found** - If there are no records found for the selected parameters, the following screen will be displayed.

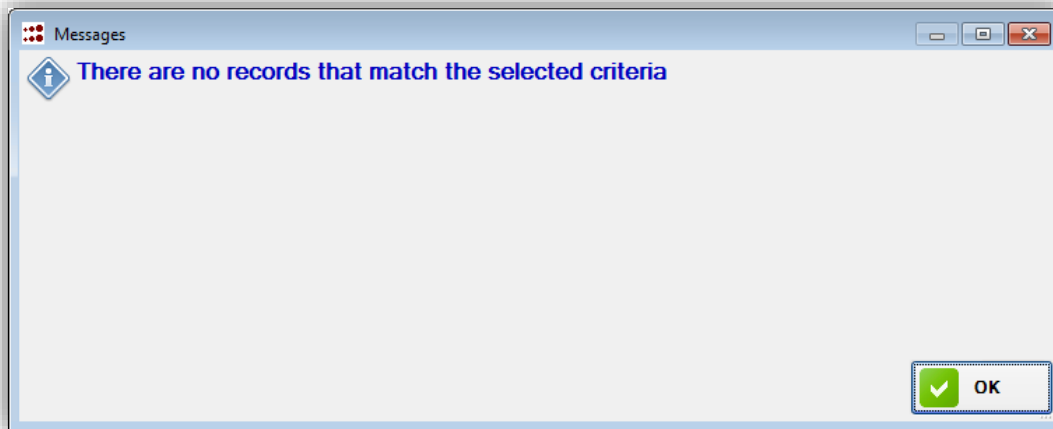


Figure 167 - File creation: No data found

To return to the file creation screen and correct the error:

- Click **“Ok”** or press **[ENTER]**.
6. **No Records Found** - If there are no records found for the selected parameters, the following screen will be displayed.

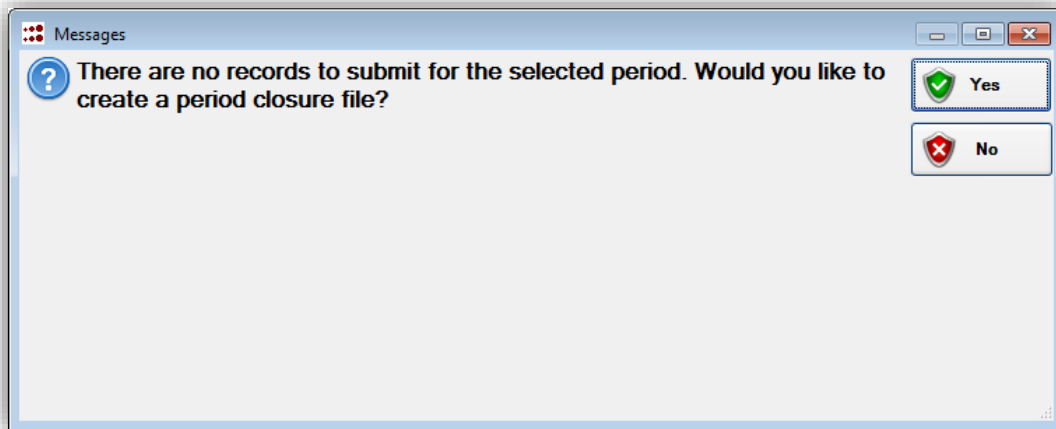


Figure 168 - File creation: No records to submit

- Click **Yes** to create the closure file.
- Click **No** to cancel the process.

4.2.11 CIHI MDS (CCRS) - Submission/Correction/Deletion File

MDS(CCRS) CIHI Insert/Update Data Submission File

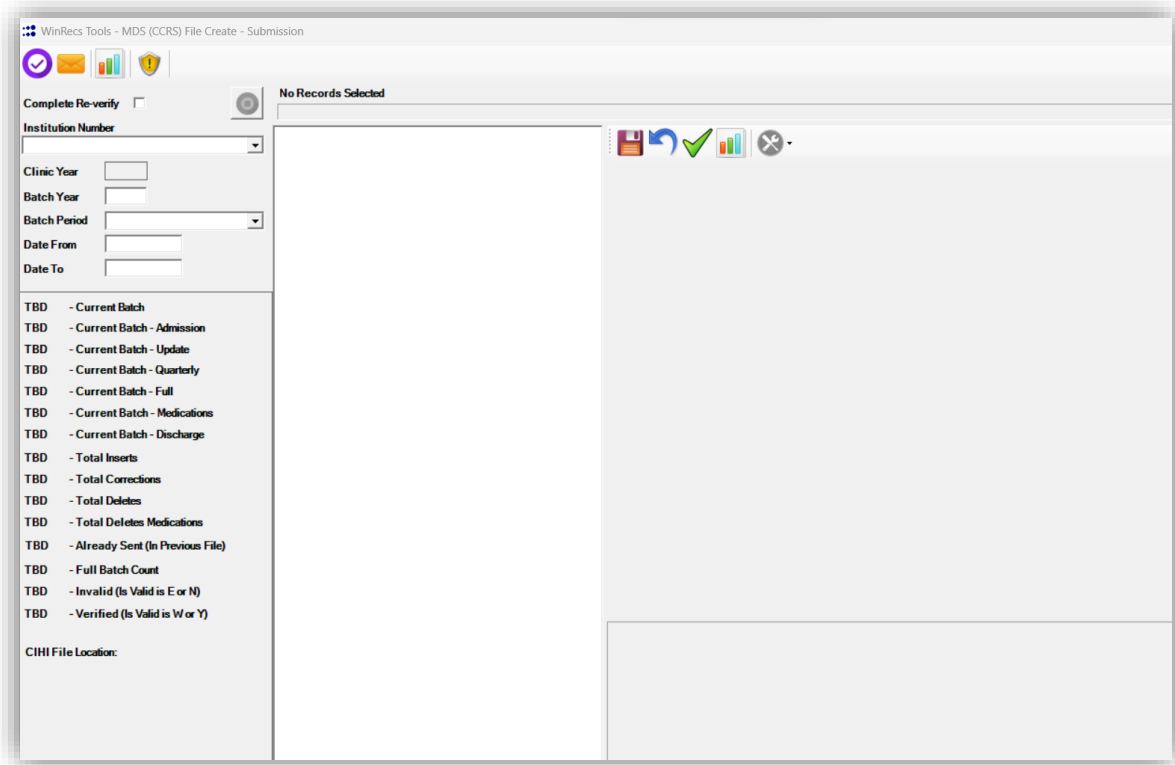
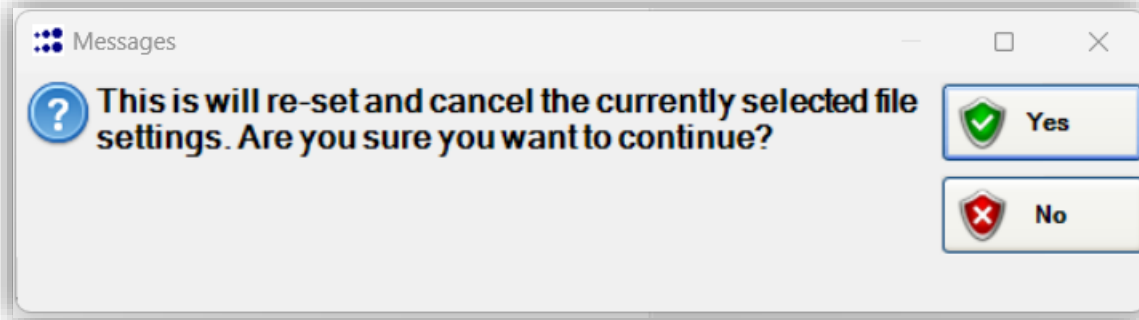


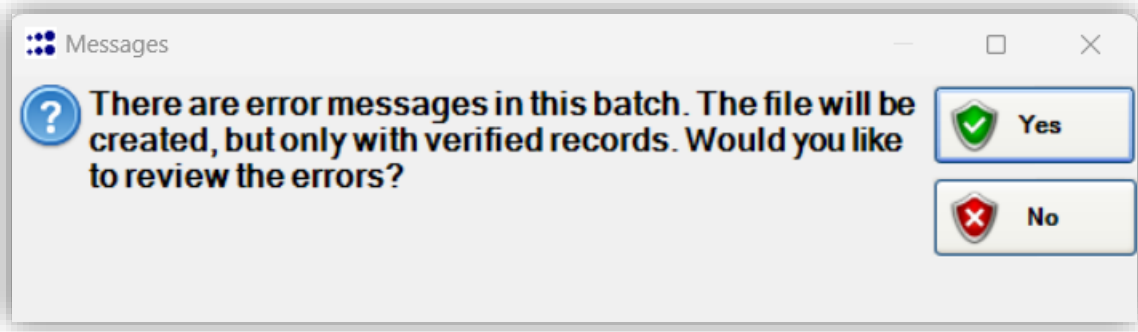
Figure 169 – File Management CIHI Insert/Update Data Submission File

-  - Batch Verify (**Shift+F11**) – This will reverify all abstracts in the selected Batch
-  - Create File (**F12**) – This will create the file, if the Batch Verify is run just click on Create File and the file will be created.
-  - Batch Reports(**Shift+F10**) – This will display the reports function
-  - Checked Record Locks– checks for locked records
-  - Reset File Settings – This will reset the file setting below. The following message will display when clicked:



- Yes will clear the below settings, No will retain the current settings.
- Complete Re-verify – checking this box will re-verify every record.
- Institution Number – enter the institution number that is to be sent or click on the down arrow and choose the institution (only the institutions for the module selected will display)
- Clinic Year – this is the year the edits will be triggered, this field cannot be changed.
- Batch Year – this will be blank the first time it is used, entering the fiscal year that is being submitted
- Batch Period – this will default if previous periods have been submitted/enter the period/or choose from the drop down list
- Date from – this will populate with the beginning of the Batch Period (cannot enter into this field)
- Date to – will populated the last date based on the Batch Period (cannot enter into this field)
- Current Batch – the number of assessments that are contained with in the Batch Period
- Current Batch- Admission – the number of Admission assessments that are contained with in the Batch Period
- Current Batch - Update – the number of Update assessments that are contained with in the Batch Period
- Current Batch - Quarterly – the number of Quarterly assessments that are contained with in the Batch Period
- Current Batch - Full – the number of Full assessments that are contained with in the Batch Period
- Current Batch - Medications – the number of Medication assessments that are contained with in the Batch Period
- Current Batch - Discharge – the number of Discharge assessments that are contained with in the Batch Period
- Total Inserts – number of new assessments included in the file
- Total Corrections – number of assessments that are being sent as corrections
- Total Deletes – number of assessments that are being sent as deletions

- Total Deletes Medications - number of medication assessments that are being sent as deletions
- Already Sent (In Previous File) - number of assessments that have been previously submitted
- Full Batch Count - total # assessments in the CIHI file
- Invalid (Is Valid E or N) - This displays the number of assessments that have “N” or “E” in the is 'Is Valid' field on the abstract. During the File Create process a message will display asking the following:



- “Yes” will display the error messages and give the ability to fix the errors
 - “No” will not display the errors and the file will be created without the errors.
- Verified (Is Valid W or Y) - This displays the number of assessments that have “W” or “Y” in the is 'Is Valid' field
- CIHI File Location: - displays the file location of the CIHI file.



- - Abstract menu – used when fixing assessments with Errors and Warnings



- - Save (**F7**) – Saves the record



- - Undo – Undoes any changes to the record



- - Record Verify (**F11**) – Verifies the Record



- - Report Manager(**F10**) – Opens Select Report



- - Tools– Click on the different options to change the view at the bottom of the abstract

To verify the records to check for errors without creating the file ensure the Complete Re-

verify button is checked and press  or [F11]

To verify the records to check for errors and create the submission file press  or [F12]. If there are errors in the file, the submission file will not create.

Please see [Verifying Records](#) for more information.

MDS(CCRS) Reset Submission Status

When an assessment has been sent to CIHI and has an error, CIHI will send the record back as a rejection. These assessments will need to be corrected and sent in as a new submission. In order, to send it in as a new submission the assessments will need to be reset.

Please note: The CIHI Re-set File Create Status needs to be set the [User Profile/Module Settings/MDS](#)

To Manually Reset the Submission Status:

- Open the rejected assessment
- Correct the error(s)
- Select File Settings/Re-Set File Create Status

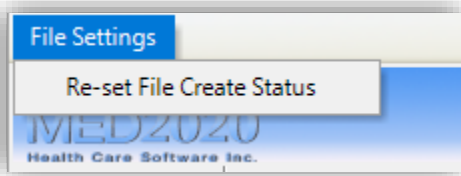


Figure 170 – Re-set File Create Status

- The following message will appear:

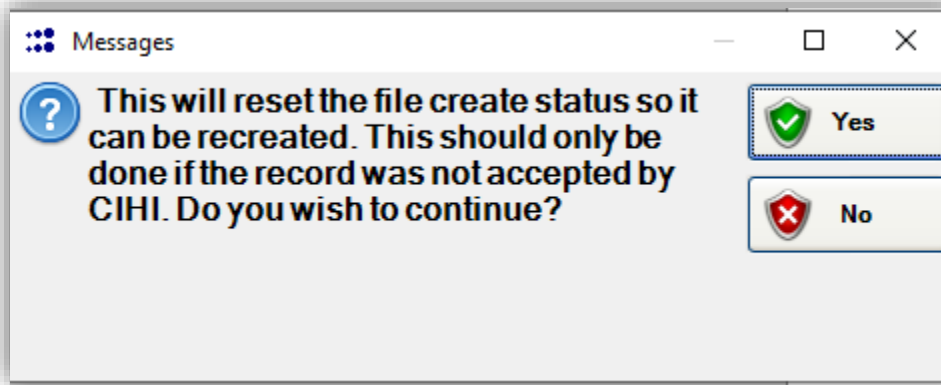


Figure 171 – Re-set File Create Status Message

- Clicking 'Yes' will reset the submission status to a 'N'
- Click 'No' will take you back to the assessment
- Press [F6]/[F7] to save the assessment.
- The 'Is Abstract Submitted' flag will now change to 'N' and the record can be resubmitted via a [CIHI Submission File – MDS \(CCRS\)](#)

MDS(CCRS) Re-set Record Update Status

When an assessment is saved or created/saved, using this feature allows the user to reset the Record Update Status so the interface can still populate the abstract. This option will only be available if the assessment has NOT been submitted to CIHI.

To Manually Reset Record Update Status :

- Open the assessment
- Enter values and save the assessment
- Select Action/Re-Set Record Update Status

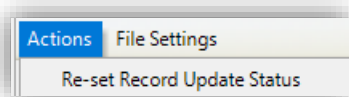
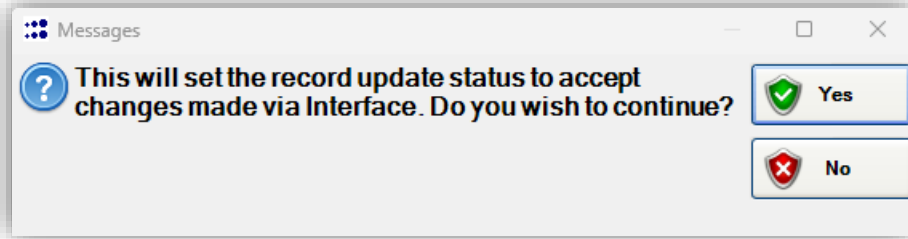
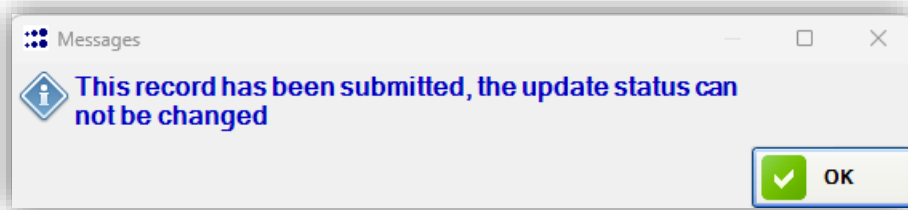


Figure 172 – Re-set Record Update Status

- The following message will appear:



- Clicking 'Yes' will re-set the record update status to a 'N'
- Click 'No' will take you back to the assessment
- Press [F6]/[F7] to save the assessment.
- If an assessment is submitted then the following message will display:



MDS(CCRS) Re-set File Correct Staus

When a submitted assessment is saved the assessment is flagged as a correction. Using this feature allows the user to reset the 'Is File Corrected' flag from a "P" waiting to be set as a correction to a "N" – No correction so the corrected assessment is not sent to CIHI as a correction.

To Manually Re-set File Correct Status :

- Open the submitted assessment
- Make changes to the assessment and save the assessment
- Select Action/Re-Set File Correct Status

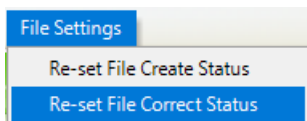
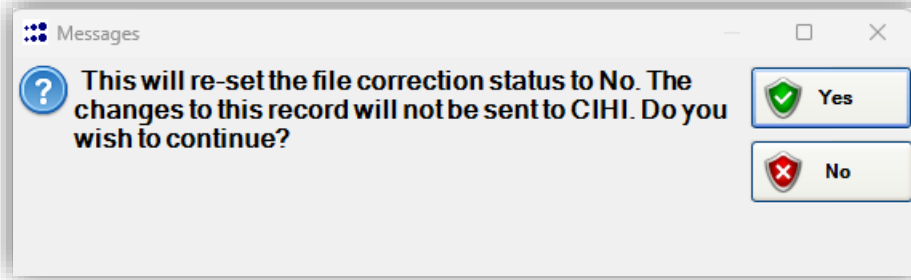


Figure 173 – Re-set File Correct Status

- The following message will appear:



- Clicking 'Yes' will re-set the 'Is File Corrected' = 'N'
- Click 'No' will take you back to the assessment and leave the 'Is File Corrected' = P
- Press [F6]/[F7] to save the assessment.
- If an assessment already has a "Is File Corrected" = 'N' then the following message will display:



MDS(CCRS) CIHI Corrected Submitted Assessment File

An assessment that has been submitted and a change is made will trigger the assessment as a correction. The correction is submitted via a [CIHI Submission File – MDS \(CCRS\)](#) and the record is flagged within the submission file as a correction.

MDS(CCRS) CIHI Deleted Submitted Assessment

An assessment that has been submitted and is deleted, the deletion will be put into the **Purge/Recover** module is submitted via a [CIHI Submission File – MDS \(CCRS\)](#) and the record is flagged within the submission file as a deletion.

To delete a submitted MDS (CCRS) Assessment:

- Open the record that needs deletion and Press  or [F9] and the following message will display:

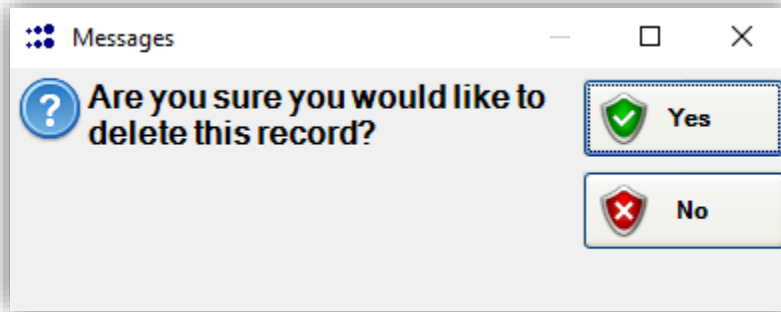


Figure 174 – Deleting an Assessment Message

Yes - will send the record to the **Purge/Recover** module

No - will not delete the record.

- The following message will appear when the record has been submitted:

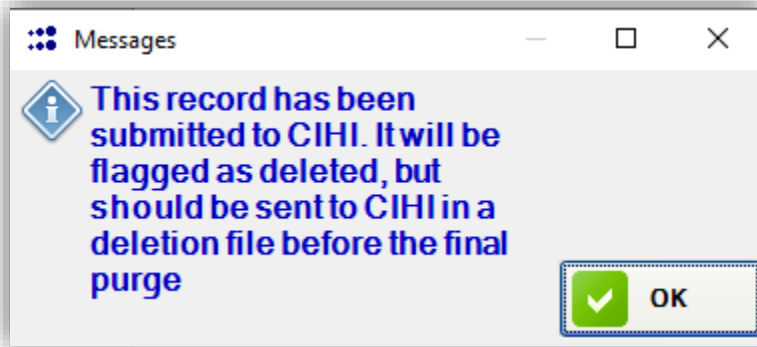


Figure 175 – Deleting an MDS Submitted Assessment Message

- Please note that submitted assessments must be deleted in reverse order of submission (Discharge before Quarterly, Quarterly before Admission etc.) If you try to delete a submitted assessment and the assessment following it has been submitted the following message will display:

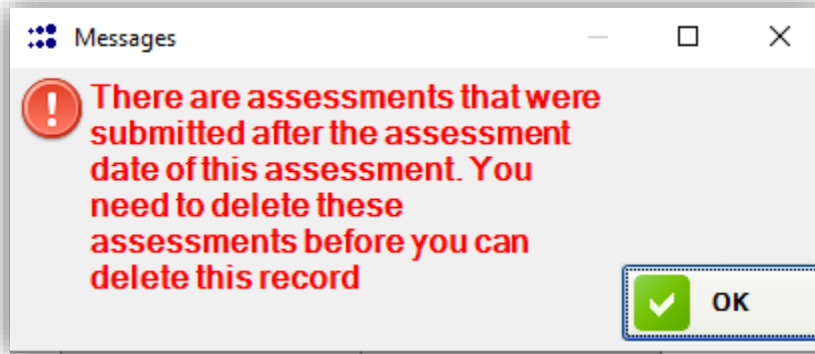


Figure 176 – Deleting an MDS Submitted Assessment Message

Once a Submission File is run, the deleted record will automatically purge from the **Purge/Recover** Module.

4.2.12 CIHI Rehabilitation (NRS) Submissions/Corrections/Deletions

NRS - CIHI Insert/Update Data Submission File

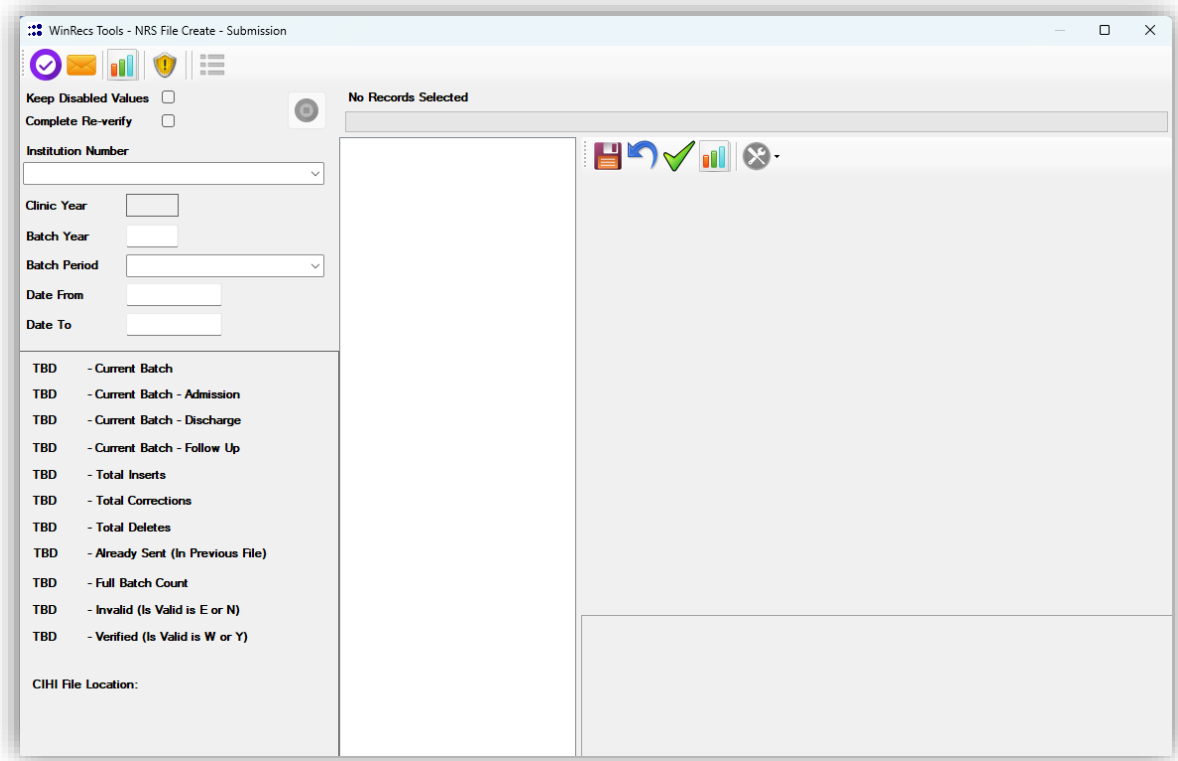
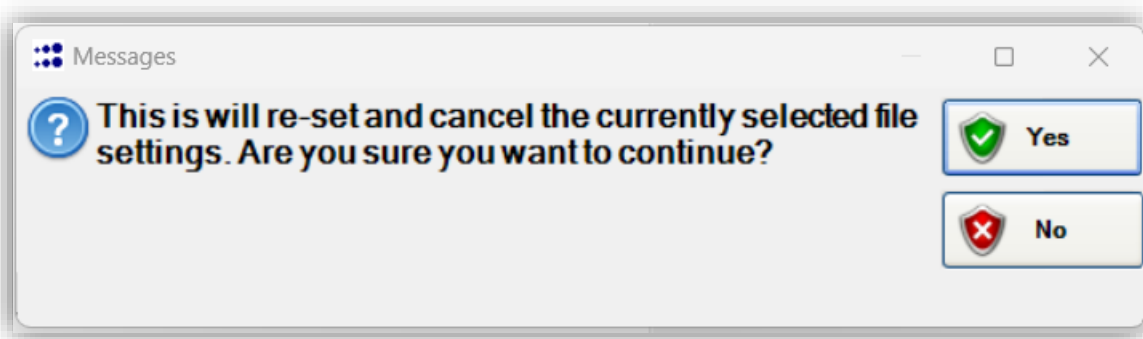


Figure 177 – Rehabilitation (NRS) CIHI Submission Screen

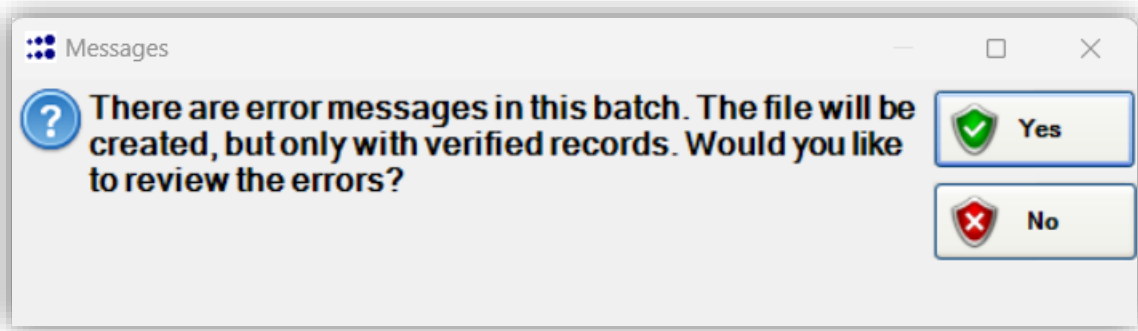
-  - Batch Verify (**Shift+F11**) – This will reverify all abstracts in the selected Batch
-  - Create File (**F12**) – This will create the file, if the Batch Verify is run just click on Create File and the file will be created.
-  - Batch Reports(**Shift+F10**) – This will display the reports function
-  - Checked Record Locks– checks for locked records

-  - Work in Standard Environment – this field when enabled will display in blue:
-  when the list of records with errors displays. Clicking on this icon will open the abstract in the standard work environment. When saved a pop will ask if you want to go back to File Management screen.
-  - Reset File Settings – This will reset the file setting below. The following message will display when clicked:



- Yes will clear the below settings, No will retain the current settings.
- Keep Disabled Values – checking this box will keep the disabled values when a batch verify is done, not checking the box the disabled values will be removed during a batch verify.
- Complete Re-verify – checking this box will re-verify every record, not checking the box will not
- Institution Number – enter the institution number that is to be sent or click on the down arrow and choose the institution (only the institutions for the module selected will display)
- Clinic Year – this is the year the edits will be triggered, this field cannot be changed.
- Batch Year – this will be blank the first time it is used, entering the fiscal year that is being submitted
- Batch Period – this will default if previous quarters have been submitted/enter the quarter/or choose from the drop-down list
- Date From – this will default the dates of the Batch Period and can be changed
- Date To – this will default the dates of the Batch Period and can be changed.
- Current Batch – the number of assessments that are contained with in the Batch Period
- Current Batch- Admission – the number of Admission assessments that are contained with in the Batch Period
- Current Batch – Discharge – the number of Discharge assessments that are contained with in the Batch Period

- Current Batch - Follow Up - the number of Follow-Up assessments that are contained within the Batch Period
- Total Inserts - number of new assessments included in the file
- Total Corrections - number of assessments that are being sent as corrections
- Total Deletes - number of assessments that are being sent as deletions
- Already Sent (In Previous File) - number of assessments that have been previously submitted
- Full Batch Count - total # assessments in the CIHI file
- Invalid (Is Valid E or N) - This displays the number of assessments that have “N” or “E” in the is ‘Is Valid’ field on the abstract. During the File Create process a message will display asking the following:



- “Yes” will display the error messages and give the ability to fix the errors
- “No” will not display the errors and the file will be created without the errors.
- Verified (Is Valid W or Y) - This displays the number of assessments that have “W” or “Y” in the is ‘Is Valid’ field
- CIHI File Location: - displays the file location of the CIHI file.



- - Abstract menu – used when fixing assessments with Errors and Warnings



- - Save (F7) – Saves the record



- - Undo – Undoes any changes to the record

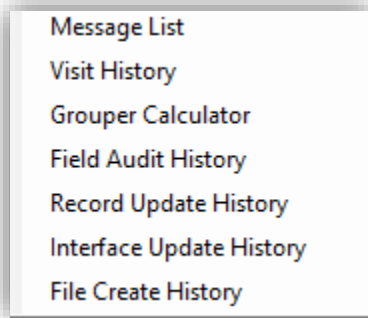


- - Record Verify (F11) – Verifies the Record



- - Report Manager (F10) – Opens Select Report

-  - Tools– Click on the different options to change the view at the bottom of the abstract



NRS – Data Process Rules

- An admission assessment must be submitted before a discharge assessment.
- An admission and discharge assessment must be submitted before a follow-up assessment (optional to record).
- If an encounter requires deletion, the assessments must be deleted in the reverse order (ie: follow-up, discharge, admission).

NRS – Record Validation and Submission Date

- This date will be updated annually by MED2020 via the annual fiscal year update.
- All assessments submitted after the record validation date must follow the new fiscal year edits.
- Any submission file created after the Record Validation and Submission Date, regardless of the fiscal year being processed, will have the current fiscal year file specifications applied.

NRS – Verification and Submission of Assessments

- For Verification go to [Verification Only](#)
- For Submission go to [Create Submission](#)

NRS – Process NRS Admit/Discharge Together

Go to Options/Institution Profile/Submission/Process NRS Admit/Discharge Together

- A checkmark allows the admission assessment and the related discharge assessment to be processed at the same time for submission.

Note: If the value is blank the assessments will be included in the quarterly submission.

Note: If the Process Together option is chosen this may result in more than one submission file. The naming convention will reflect the fiscal year and quarter applicable to that assessment.

Note: After clicking OK on the Information dialog, the first file listed is displayed at the top of the WinRecs CIHI Submission window. It is important to note the files created on the Information dialog, so you are aware of which files have been saved to you REHAB folder.

NRS - Reset Submission Status

CIHI does not provide an electronic file of rejected records for the NRS database. However, if after submission of data you receive a report of assessments that were rejected, they will not have to be corrected and resubmitted.

Once a record has been successfully validated in WinRecs, and included in a submission file, the "Is Abstract Submitted" flag is set to "Y". For a rejected record, the user will need to set this field manually.

Please note: The CIHI Re-set File Create Status needs to be set in the [User Profile/\[OMHRS\] Ontario Mental Health Reporting System](#)

To Manually Reset the Submission Status:

- Open the rejected record
- Correct the error(s)
- Select File Settings/Re-Set File Create Status

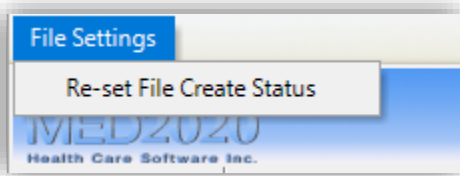


Figure 178 – Re-set File Create Status

- The following message will appear:

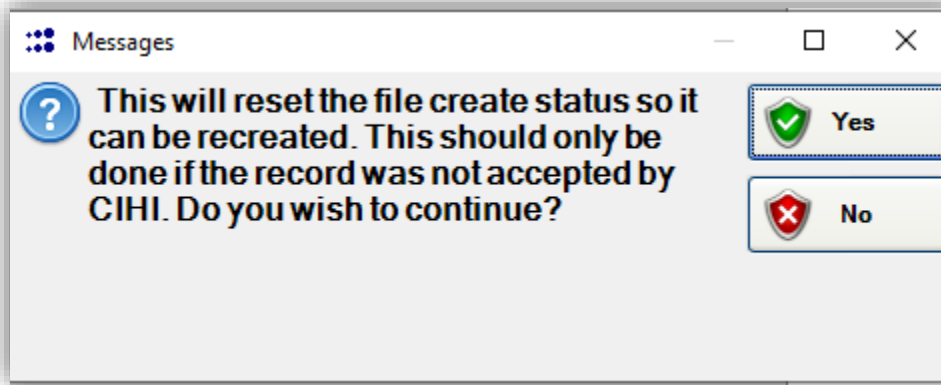


Figure 179 – Re-set File Create Status Message

- Clicking 'Yes' will reset the submission status to a 'N'
- Click 'No' will take you back to the abstract
- Press [F6]/[F7] to save the abstract.
- The 'Is Abstract Submitted' flag will now change to 'N' and the record can be resubmitted via a [CIHI Submission File - Rehabilitation \(NRS\) Submissions](#)

NRS - Re-set Record Update Status

When an assessment is saved or created/saved, using this feature allows the user to reset the Record Update Status so the interface can still populate the abstract. This option will only be available if the assessment has NOT been submitted to CIHI.

To Manually Reset Record Update Status :

- Open the assessment
- Enter values and save the assessment
- Select Action/Re-Set Record Update Status

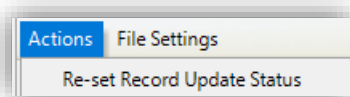
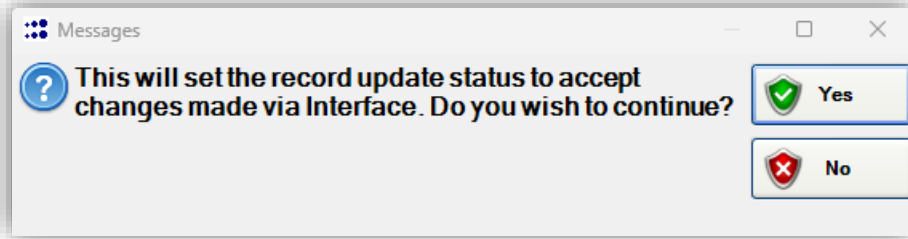
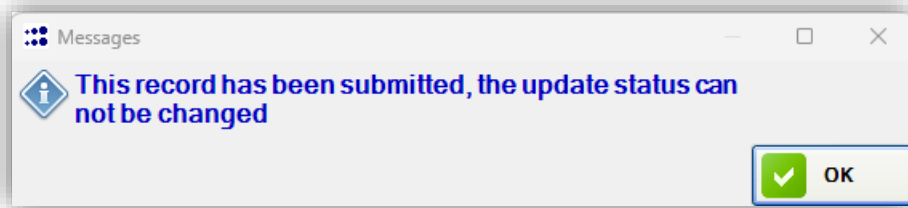


Figure 180 – Re-set Record Update Status

- The following message will appear:



- Clicking 'Yes' will re-set the record update status to a 'N'
- Click 'No' will take you back to the assessment
- Press [F6]/[F7] to save the assessment.
- If an assessment is submitted then the following message will display:



NRS - Re-set File Correct Status

When a submitted assessment is saved the assessment is flagged as a correction. Using this feature allows the user to reset the 'Is File Corrected' flag from a "P" waiting to be set as a correction to a "N" – No correction so the corrected assessment is not sent to CIHI as a correction.

To Manually Re-set File Correct Status :

- Open the submitted assessment
- Make changes to the assessment and save the assessment
- Select Action/Re-Set File Correct Status

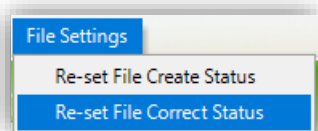
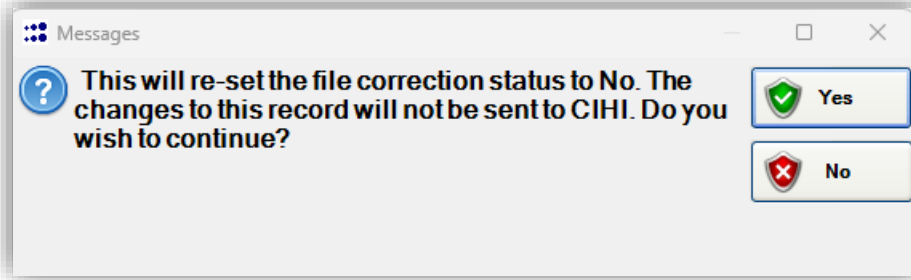


Figure 181 – Re-set File Correct Status

- The following message will appear:



- Clicking 'Yes' will re-set the 'Is File Corrected' = 'N'
- Click 'No' will take you back to the assessment and leave the 'Is File Corrected' = P
- Press [F6]/[F7] to save the assessment.
- If an assessment already has a "Is File Corrected" = 'N' then the following message will display:



NRS - CIHI Corrected Submitted Assessment File

An assessment that has been submitted and a change is made will trigger the assessment as a correction. The correction is submitted via a [CIHI Submission File - Rehabilitation \(NRS\) Submissions](#) and the record is flagged within the submission file as a correction.

NRS - CIHI Deleted Submitted Assessment

An assessment that has been submitted and is deleted, the deletion will be put into the **Purge/Recover** module is submitted via a [CIHI Submission File - Rehabilitation \(NRS\) Submissions](#) and the record is flagged within the submission file as a deletion.

To delete a submitted MDS (CCRS) Assessment:

- Open the record that needs deletion and Press  or [F9] and the following message will display:

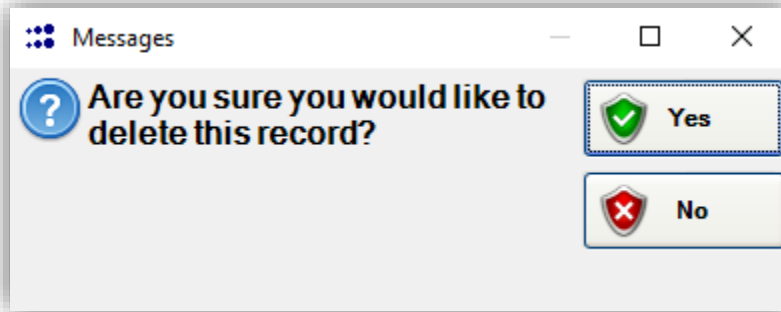


Figure 182 – Deleting an Assessment Message

Yes - will send the record to the **Purge/Recover** module

No - will not delete the record.

- The following message will appear when the record has been submitted:

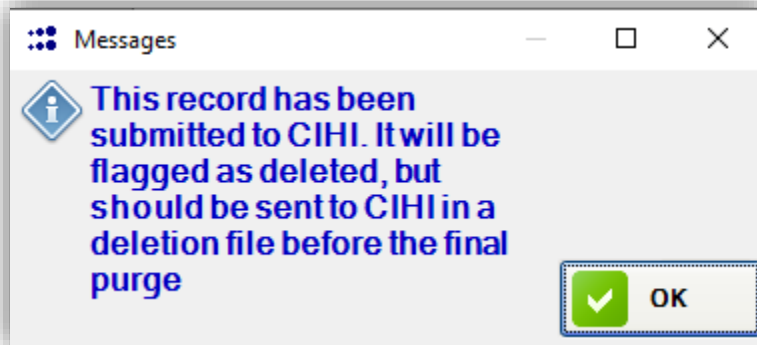


Figure 183 – Deleting an NRS Submitted Assessment Message

- Please note that submitted assessments must be deleted in reverse order of submission (Discharge before Admission) If you try to delete a submitted assessment and the assessment following it has been submitted the following message will display:

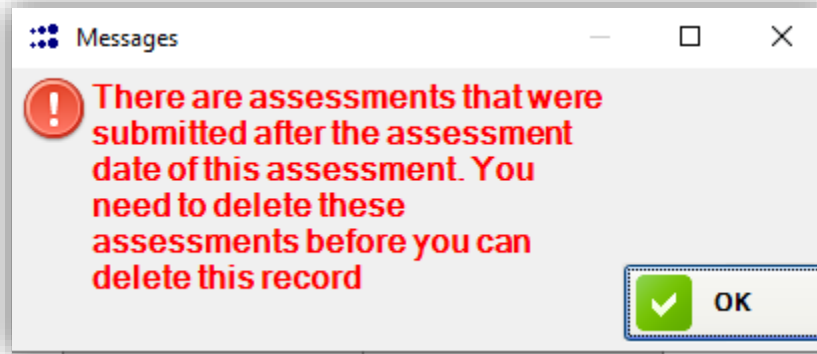
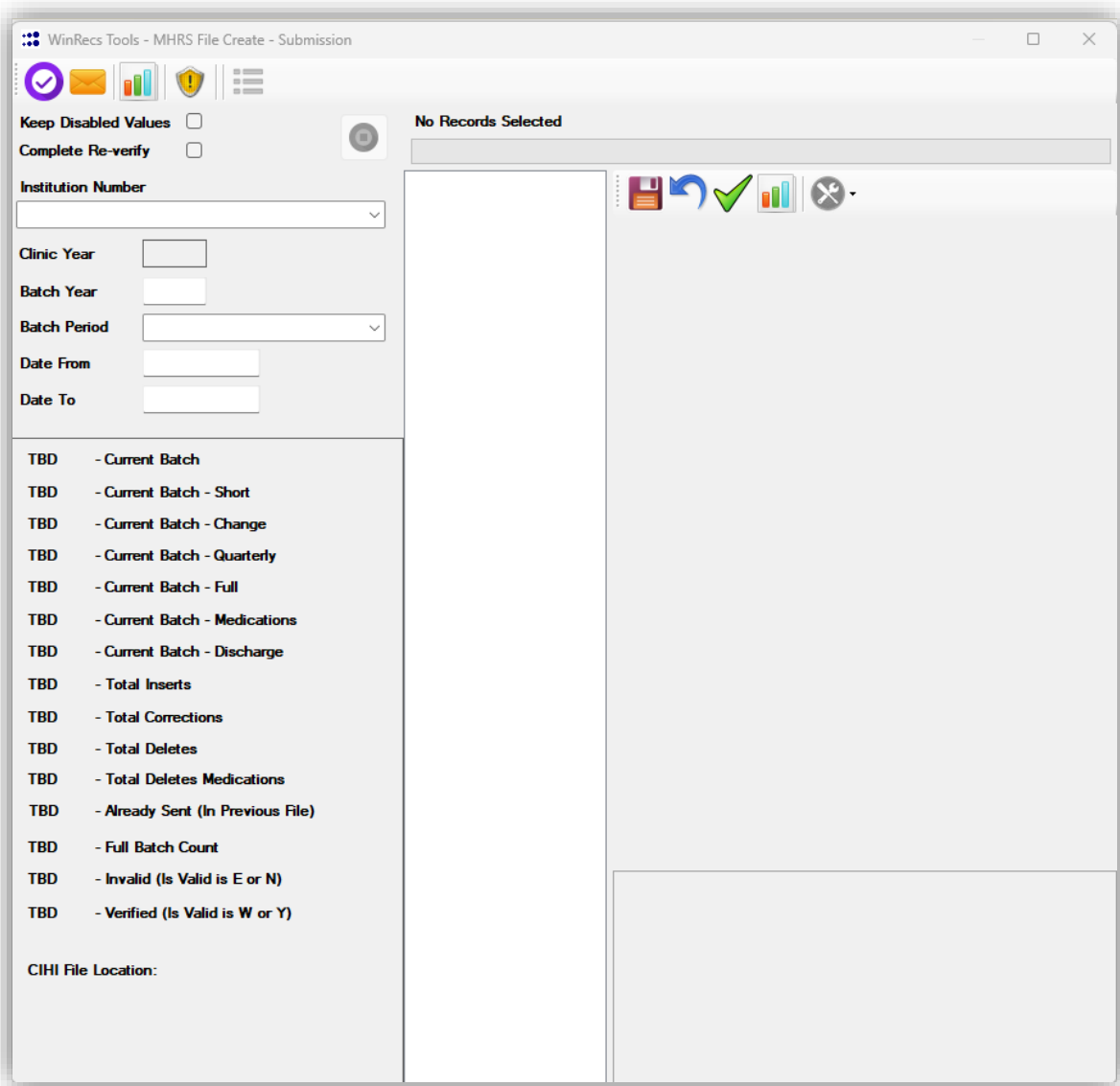


Figure 184 – Deleting an NRS Submitted Assessment Message

Once a Submission File is run, the deleted record will automatically purge from the **Purge/Recover** Module.

4.2.13 CIHI Ontario Mental Health Reporting System (OMHRS) Submissions/ Corrections/ Deletions

- Go to **Tools** → **File Management** → **MHRS** → **CIHI Insert/Update Data Submission File**



The screenshot shows the 'WinRecs Tools - MHRS File Create - Submission' window. It features a sidebar with various options for creating a submission file, including 'Keep Disabled Values', 'Complete Re-verify', and a list of 'TBD' (To Be Determined) options. The main area displays 'No Records Selected' and a toolbar with icons for saving, undo, redo, and other actions.

WinRecs Tools - MHRS File Create - Submission

Keep Disabled Values ☐
Complete Re-verify ☐

Institution Number

Clinic Year
Batch Year
Batch Period
Date From
Date To

TBD - Current Batch
TBD - Current Batch - Short
TBD - Current Batch - Change
TBD - Current Batch - Quarterly
TBD - Current Batch - Full
TBD - Current Batch - Medications
TBD - Current Batch - Discharge
TBD - Total Inserts
TBD - Total Corrections
TBD - Total Deletes
TBD - Total Deletes Medications
TBD - Already Sent (In Previous File)
TBD - Full Batch Count
TBD - Invalid (Is Valid is E or N)
TBD - Verified (Is Valid is W or Y)

CIHI File Location:

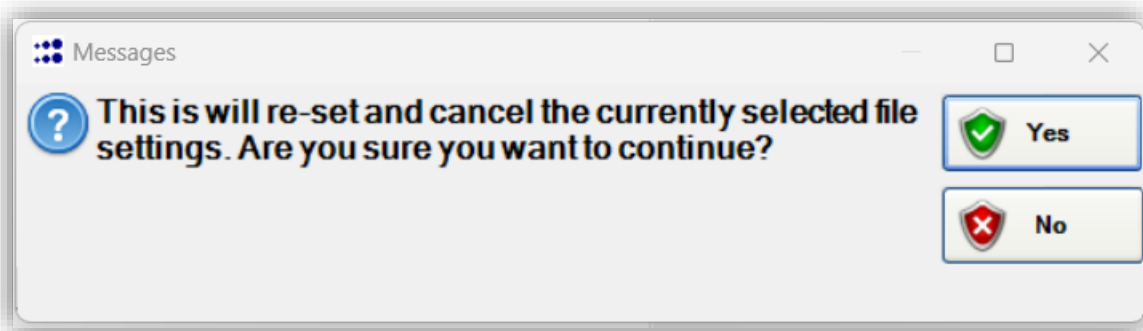
No Records Selected

Save, Undo, Redo, Checkmark, Erase icons

Figure 185 OMHRS Submission Screen

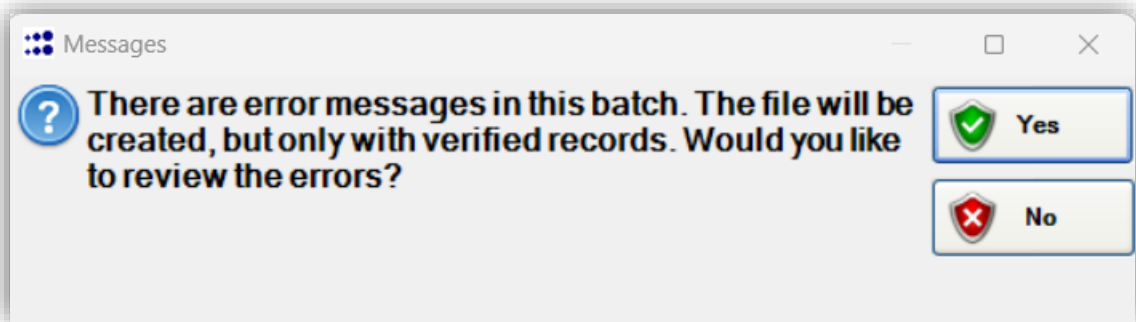
-  - Batch Verify (**Shift+F11**) – This will reverify all abstracts in the selected Batch

-  - Create File (**F12**) – This will create the file, if the Batch Verify is run just click on Create File and the file will be created.
-  - Batch Reports(**Shift+F10**) – This will display the reports function
-  - Checked Record Locks– checks for locked records
-  - Work in Standard Environment – this field when enabled will display in blue:
 when the list of records with errors displays. Clicking on this icon will open the abstract in the standard work environment. When saved a pop will ask if you want to go back to File Management screen.
-  - Reset File Settings – This will reset the file setting below. The following message will display when clicked:



- Yes will clear the below settings, No will retain the current settings.
- Keep Disabled Values – checking this box will keep the disabled values when a batch verify is done, not checking the box the disabled values will be removed during a batch verify.
- Complete Re-verify – checking this box will re-verify every record, not checking the box will not
- Institution Number – enter the institution number that is to be sent or click on the down arrow and choose the institution (only the institutions for the module selected will display)
- Clinic Year – this is the year the edits will be triggered, this field cannot be changed.
- Batch Year – this will be blank the first time it is used, entering the fiscal year that is being submitted
- Batch Period – this will default if previous quarters have been submitted/enter the quarter/or choose from the drop-down list

- Date From – this will default the dates of the Batch Period and can be changed
- Date To – this will default the dates of the Batch Period and can be changed.
- Current Batch – the number of assessments that are contained with in the Batch Period
- Current Batch- Short – the number of Short Stay assessments that are contained with in the Batch Period
- Current Batch – Change – the number of Change Status assessments that are contained with in the Batch Period
- Current Batch – Quarterly – the number of Quarterly assessments that are contained with in the Batch Period
- Current Batch – Full – the number of Full assessments that are contained with in the Batch Period
- Current Batch – Medications – the number of Medication assessments that are contained with in the Batch Period
- Current Batch – Discharge – the number of Discharge assessments that are contained with in the Batch Period
- Total Inserts – number of new assessments included in the file
- Total Corrections – number of assessments that are being sent as corrections
- Total Deletes – number of assessments that are being sent as deletions
- Total Deletes Medications – number of medication assessments that are being sent as deletions
- Already Sent (In Previous File) – number of assessments that have been previously submitted
- Full Batch Count – total # assessments in the CIHI file
- Invalid (Is Valid E or N) – This displays the number of assessments that have “N” or “E” in the is ‘Is Valid’ field on the abstract. During the File Create process a message will display asking the following:



- “Yes” will display the error messages and give the ability to fix the errors
- “No” will not display the errors and the file will be created without the errors.

- Verified (Is Valid W or Y) – This displays the number of assessments that have “W” or “Y” in the is ‘Is Valid’ field
- CIHI File Location: - displays the file location of the CIHI file.



- - Abstract menu – used when fixing assessments with Errors and Warnings



- - Save (**F7**) – Saves the record



- - Undo – Undoes any changes to the record



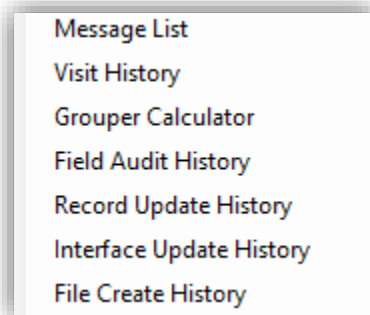
- - Record Verify (**F11**) – Verifies the Record



- - Report Manager(**F10**) – Opens Select Report



- - Tools– Click on the different options to change the view at the bottom of the abstract



OMHRS – Data Processing Rules

- All record types must be submitted chronologically and in order of occurrence for each patient per episode. This avoids possible errors and rejections (ie: an admission assessment must be submitted prior to a quarterly or discharge assessment for the same patient encounter.
- The Case Record Number and Chart Number are key identifiers in linking the various assessment types during an episode of care.
- If assessments must be deleted, they must be done so in the reverse order of submission (ie: a discharge assessment deleted prior to an admission assessment).
- For subsequent admissions for the same patient, the first episode must have the discharge assessment submitted prior to a next admission assessment being submitted (ie: a patient cannot have multiple “open episodes” of care.

OMHRS – Record Validation and Submission Date

- CIHI mandates that as of their annually specified date, any assessments not already submitted that fall in the previous fiscal year, must be submitted under the new fiscal year edits/requirements. This date is communicated by CIHI to both their facility clients and the licensed vendors.
- When an assessment is being completed in WinRecs, if it belongs to the previous fiscal year's data, and the current system date is after the Record Validation and Submission Date, the most current fiscal year edits/requirements will be applied to the assessment.
- Further, any submission file created after the Record Validation and Submission Date, regardless of the fiscal year being processed, will have the current fiscal year file specifications applied.
- This date will be updated annually by MED2020 via the annual fiscal year update, usually released around April 1.

OMHRS – Verification and Submission of Assessments

For Verification go to [Verification Only](#)

For Submission go to [Create Submission](#)

OMHRS - Reset Submission Status

When a record has been sent to CIHI and has an error, CIHI will send the record back as a rejection. These records will need to be corrected and sent in as a new submission. In order, to send it in as a new submission the records will need to be reset.

Please note: The CIHI Re-set File Create Status needs to be set in the [User Profile/\[NRS\] National Rehabilitation Reporting System](#)

To Manually Reset the Submission Status:

- Open the rejected record
- Correct the error(s)
- Select File Settings/Re-Set File Create Status

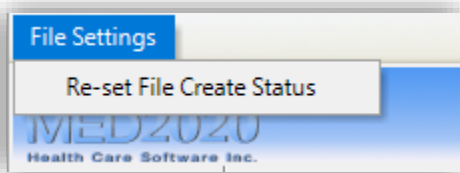


Figure 186 – Re-set File Create Status

- The following message will appear:

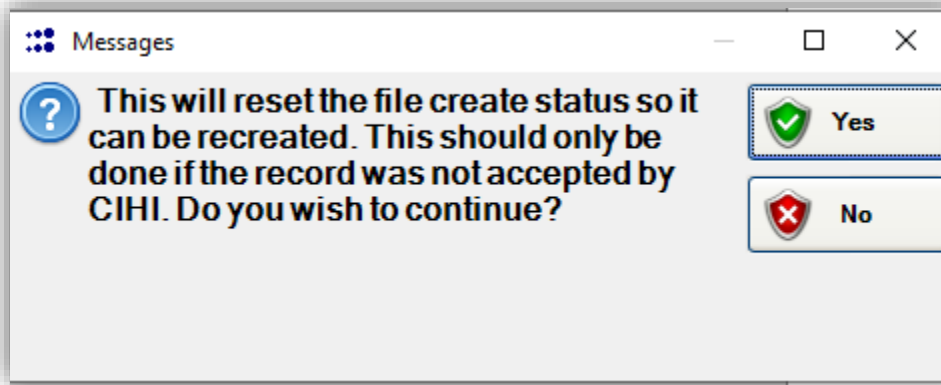


Figure 187 – Re-set File Create Status Message

- Clicking 'Yes' will reset the submission status to a 'N'
- Click 'No' will take you back to the abstract
- Press [F6]/[F7] to save the abstract.
- The 'Is Abstract Submitted' flag will now change to 'N' and the record can be resubmitted via a [CIHI Submission File - OMHRS Submissions](#)

OMHRS - Re-set Record Update Status

When an assessment is saved or created/saved, using this feature allows the user to reset the Record Update Status so the interface can still populate the abstract. This option will only be available if the assessment has NOT been submitted to CIHI.

To Manually Reset Record Update Status :

- Open the assessment
- Enter values and save the assessment
- Select Action/Re-Set Record Update Status

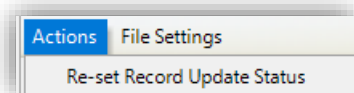
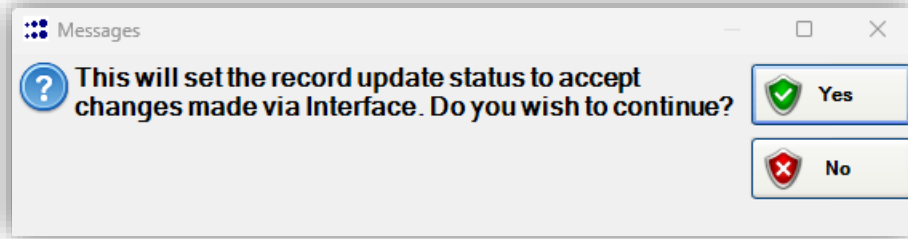
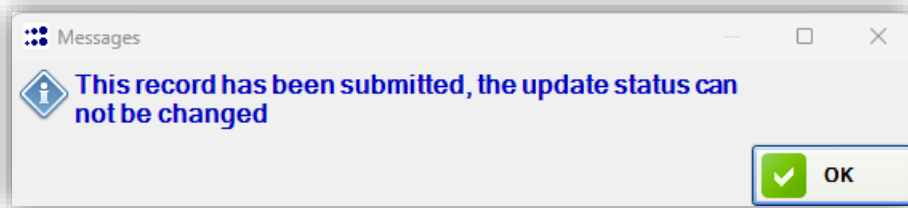


Figure 188 – Re-set Record Update Status

- The following message will appear:



- Clicking 'Yes' will re-set the record update status to a 'N'
- Click 'No' will take you back to the assessment
- Press [F6]/[F7] to save the assessment.
- If an assessment is submitted then the following message will display:



OMHRS - Re-set File Correct Status

When a submitted assessment is saved the assessment is flagged as a correction. Using this feature allows the user to reset the 'Is File Corrected' flag from a "P" waiting to be set as a correction to a "N" – No correction so the corrected assessment is not sent to CIHI as a correction.

To Manually Re-set File Correct Status :

- Open the submitted assessment
- Make changes to the assessment and save the assessment
- Select Action/Re-Set File Correct Status

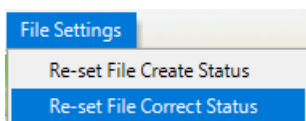
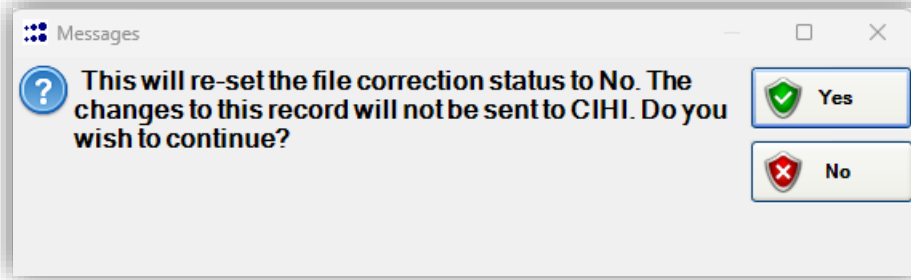


Figure 189 – Re-set File Correct Status

- The following message will appear:



- Clicking 'Yes' will re-set the 'Is File Corrected' = 'N'
- Click 'No' will take you back to the assessment and leave the 'Is File Corrected' = P
- Press [F6]/[F7] to save the assessment.
- If an assessment already has a "Is File Corrected" = 'N' then the following message will display:



OMHRS - CIHI Corrected Submitted Assessment File

An assessment that has been submitted and a change is made will trigger the assessment as a correction. The correction is submitted via a [CIHI Submission File - OMHRS Submissions](#) and the record is flagged within the submission file as a correction.

Note: If any of the elements used to identify a unique record require correction after the record has been accepted into the CIHI database, the record must be deleted and resubmitted. The applicable data elements are:

Z1: Record Type

X1: Record ID

X30: Chart Number

AA3: Case Record Number

A1: Assessment Reference Date

- If a Medication Record needs to be added after the assessment has already been submitted:
 Open the assessment that requires the medication record(s).
 Enter the medication record(s).
 Exit the Medication Records multiform and save the assessment.
- A submission file for the fiscal quarter applicable to the assessment the medication record(s) were recorded in will then need to be created if the medication records are to

be submitted to CIHI. A correction record type will process for “parent” assessment and a new record type specific to the medication information will be included in the file.

OMHRS - CIHI Deleted Submitted Assessment

An assessment that has been submitted and is deleted, the deletion will be put into the **Purge/Recover** module is submitted via a [CIHI Submission File - OMHRS Submissions](#) and the record is flagged within the submission file as a deletion.

To delete a submitted MDS (CCRS) Assessment:

- Open the record that needs deletion and Press  or [F9] and the following message will display:

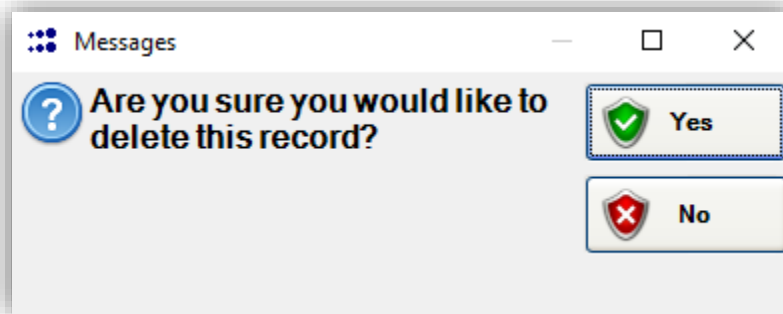


Figure 190 – Deleting an Assessment Message

Yes - will send the record to the **Purge/Recover** module

No - will not delete the record.

- The following message will appear when the record has been submitted:

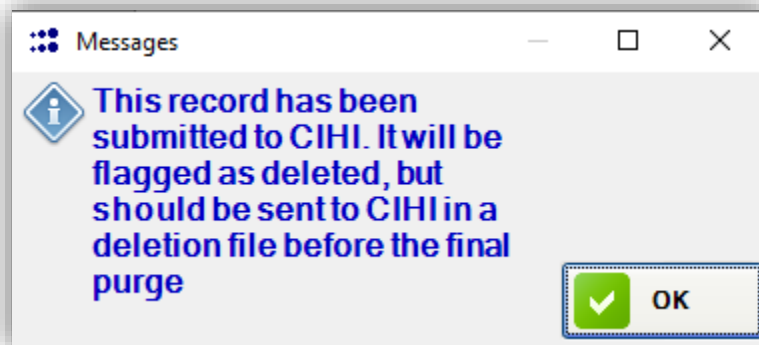


Figure 191 – Deleting an OMHRS Submitted Assessment Message

- Please note that submitted assessments must be deleted in reverse order of submission (Discharge before Quarterly, Quarterly before Admission etc.) If you try to delete a submitted assessment and the assessment following it has been submitted the following message will display:

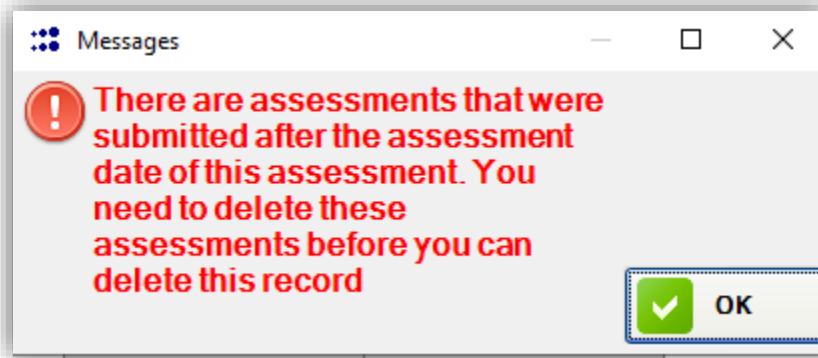


Figure 192 – Deleting an OMHRS Submitted Assessment Message

Once a Submission File is run, the deleted record will automatically purge from the **Purge/Recover** Module.

- Medication Records: Medication records that have been submitted along with the assessment and then the required deletion can be processed as follows:
 Open the assessment that contains the erroneous medication record.
 Select the medication occurrence that requires deletion.
 Click **Delete**.
 - or – Press **F9**.
 Exit the Medication Records multiform and save the assessment.
 Repeat this function until the appropriate assessments have been deleted.
 A submission file for the fiscal quarter applicable to the deleted medication record(s) will then need to be created if the deletions are to be submitted to CIHI. The specific Medication Records deleted will be flagged appropriately in the submission file. See Create a CIHI Submission File for details.

4.2.14 Summary Table of Submission Functions

Function	DAD	NACRS	NRS	OMHRS	MDS 2.0	CJRR
Facility Information File	Create electronically in WinRecs	Create electronically in WinRecs	Create electronically in WinRecs	Create electronically in WinRecs	Create electronically in WinRecs	Uses DAD/ NACRS institution number
New Records	Submit using CIHI Submission module – submit by batch period.	Submit using CIHI Submission module submit by batch period	CIHI Submission module – submit by quarter	Submit using CIHI Submission module submit by quarter <i>IAR- Set "Is this a IAR Submission File to "Y"</i>	Submit using CIHI Submission module submit by quarter	Submit using CIHI Submission module submit by batch period.
Records with errors	Accepted to the CIHI database, DAD error file sent to client	Rejected by CIHI, NACRS Rejection file sent to client	Rejected by CIHI, rejected records report sent to client	Rejected by CIHI, OMHRS Rejection file sent to client <i>IAR- CCIM notifies rejected records</i>	Rejected by CIHI, rejected records report sent to client	Rejected by CIHI, rejected records report sent to client
Error file	Can be imported to WinRecs via Modules/Utilities/Import DAD CIHI Errors option	Can be imported via the Incoming Batch Interface module, select the NACRS Error Import structure file	No electronic error file provided	Can be imported to WinRecs via Modules/Utilities/Import OMHRS CIHI Errors option <i>IAR- N/A</i>	No electronic error file provided	No electronic error file provided
Corrections	Update records with correct information and save – record flags as 'pending' for inclusion in next Corrections file.	-Rejected records are corrected and saved in WinRecs. If NACRS rejection file is not imported, use the "Reset Submission Status" function for each corrected abstract. -Importing the NACRS rejection file re-sets submit status to "not submitted" -Process 'corrected' records initially rejected, as a regular submission (CIHI Submission module) -Submitted and accepted records in NACRS can be	Rejected records are corrected and saved in WinRecs. Use 'Reset Submission Status' function for each rejected abstract. Submitted and accepted records in NRS can be corrected. Open, edit and save the record. Process CIHI Submission file for the applicable quarter.	Rejected records are corrected and saved in WinRecs. If OMHRS rejection file is not imported, use the "Reset Submission Status" function for each corrected abstract. -Importing the OMHRS rejection file re-sets submit status to "not submitted" -Process 'corrected' records initially rejected, as a regular submission (CIHI Submission module) -Submitted and accepted records in OMHRS can be corrected. Open, edit and save record. -Process CIHI Submission file. <i>-IAR Corrections and deletions processed the same way.</i>	Rejected records are corrected and saved in WinRecs. Use 'Reset Submission Status' function for each rejected abstract. Submitted and accepted records in MDS 2.0 are updated using specific Change/Correction assessment types.	Rejected records are corrected and saved in WinRecs and re-sent as an insert. Use the "Reset Submission Status" function for each corrected abstract. Submitted and accepted records can be corrected. Open, edit and save record and it will be sent as an update. Both inserts

		corrected. Open, edit and save record. -Process CIHI Correction file for the applicable period.		<i>Rejected records must be reset manually.</i>		and updates are sent through the submission module.
Deletions	When submitted abstract is deleted, it is flagged in the Purge/Undelete area and will be included in a deletion file next time the CIHI Corrections are processed.	When submitted, accepted, record is deleted, it is flagged in the Purge/Undelete module and will be processed using the CIHI Correction module.	Submitted, accepted, record is deleted, it is flagged in the Purge/Undelete module and will be processed using the CIHI Submission module.	When submitted, accepted, record is deleted, it is flagged in the Purge/Undelete module and will be processed using the CIHI Submission module. Same Process for IAR	Deleted assessments that have been submitted to CIHI are flagged in the Purge/Undelete module and will be picked up as a record type deletion when a submission file for that quarter is created.	Email CIHI Liason and include Record ID, Surgeon ID, Patient's Name, Joint Type, Date of Surgery and Procedure for deletion.

4.3 Batch Grouper

The Batch Grouper ensures that the correct grouper values are assigned to the visit. The Batch Grouper should be run prior to creating Submission Files.

Using the Batch Grouper

Tools → Batch Grouper

Choose the module you would like to regroup:

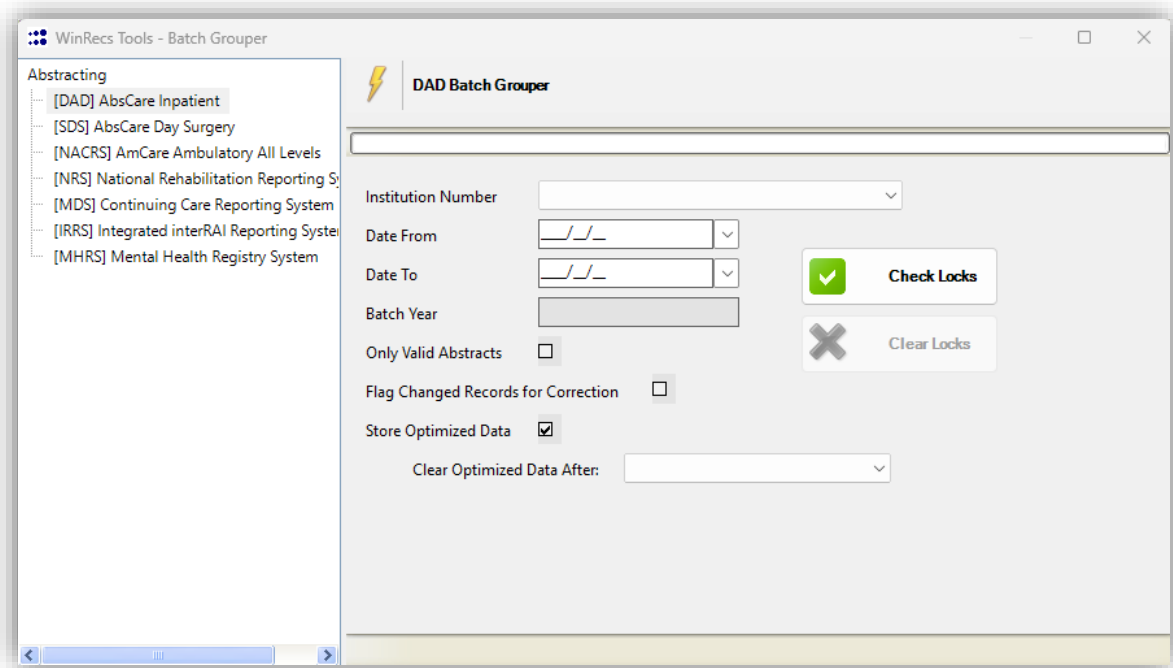


Figure 193 – Batch Grouper

- Institution Number – Enter the number or click on the drop-down arrow
- Date From – The start date of the batch
- Date To – The end date of the batch
- Batch Year – This will default depending on the dates chosen above.
- Only Valid Abstracts – if checked it will only Batch Group valid records where the 'Is Validated' in the abstract is 'Yes', if not checked Batch Group all records.
- Flag Changed Records for Correction - This is an optional function when checked any records that have been submitted will be flagged for Correction (sent as a correction file). Only records found to have changed grouper data would be flagged.
- Store Optimized Data - Defines if the Batch Grouper will store grouper data for other diagnoses. See below section on Store Optimizing Data.

- Clear Optimized Data After - If Store Optimizing Data is selected, optimizing data will automatically be purged after the specified period. Select the dropdown menu to see a list of the available options. See below section on Store Optimizing Data.

1 Month
3 Months
6 Months
1 Year

- Check Locks – checks for locked records
- Clear Locks – clears locked records



- Press the  to start the process
- The green bar will move while processing the records
- Once the process is complete the following will display.

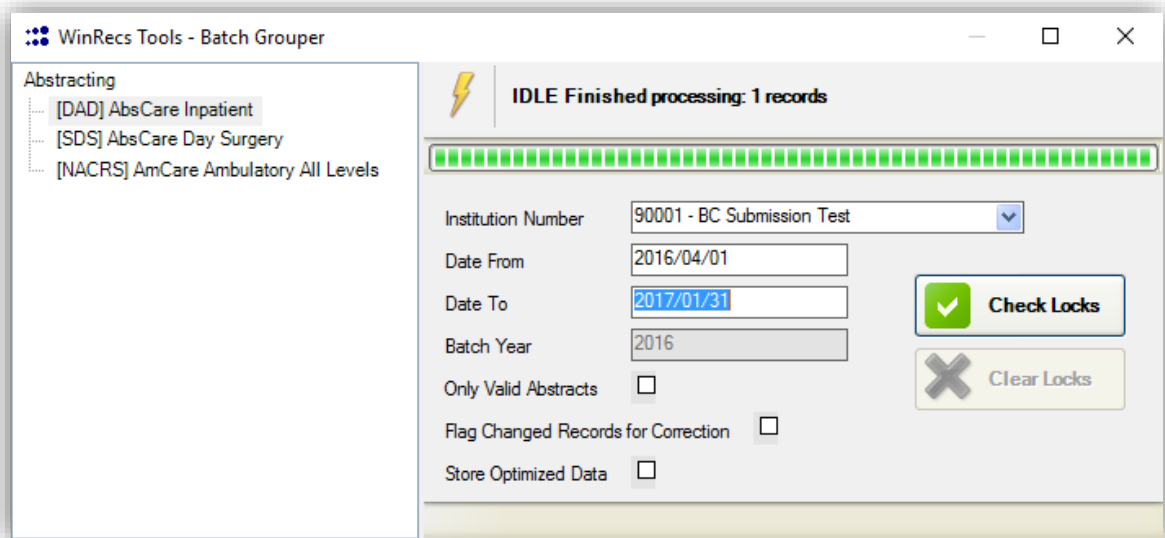


Figure 194 – Batch Grouper – Finished Processing

- The process is now complete.

4.4 Batch Interface

A Batch Interface is used to import text files that contain specifically formatted patient data, into WinRecs. This data is produced by an external patient records system, such as an ADT system. The Interface allows HIMs to bring across patient record data to WinRecs without the need for data re-entry.

Note: Batch Interfaces are custom built. If you have any questions regarding this process, contact a MED2020 Client Services Representative. Contact information is available above in the section '[Contact MED2020](#)'.

Importing with Batch Interface (Batch In)

Note: Installation/ Updates files and instructions must be supplied by MED2020. Instructions are not provided in this guide as they vary from customer to customer. Do not proceed with the following instructions until you have contacted a [Client Services representative](#) for assistance.

The following steps require access to WinRecs and can be performed by a Health Information Management professional in your facility. If a member of IT Services will be performing these steps a login to WinRecs will be required.

The following screen opens when you select **Tools → Batch Interface**

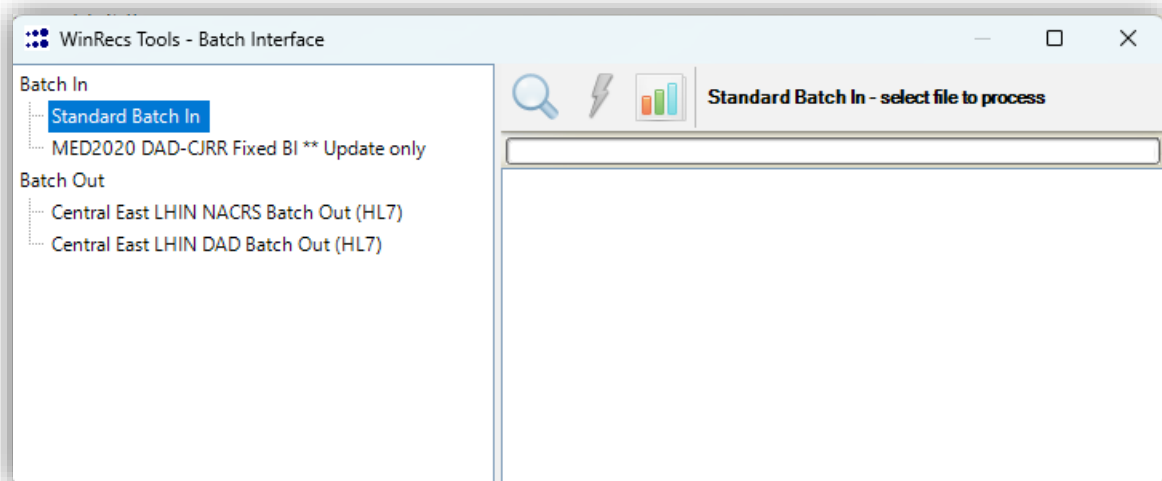


Figure 195 - Batch Interface window

- Click the Search button  in the window.

— or —

- Press **[F4]**.
- Search for the Batch Interface text file on your computer network. Select the filename and click Open.

Note: Contact your WinRecs administrator to learn where the import files are located in your particular environment.

- The name of the file being imported is shown on the Batch Interface window.
- Click the Execute button  in the window.
— or —
- Press **[F11]**.
- A processing bar will show as the records are imported.
- Error messages will be displayed on the same screen if there is any.
- Once the import is finished, close the window by clicking the icon . The records are now in the **CPI MODULE** and appropriate modules.

Exporting with Batch Interface (Batch Out)

- Batch out is site specific.

4.5 Purge/Recover

This module is to completely recover or purge deleted abstracts or CPI MODULE entries.

To access Purge/Recover

Tools →Purge/Recover

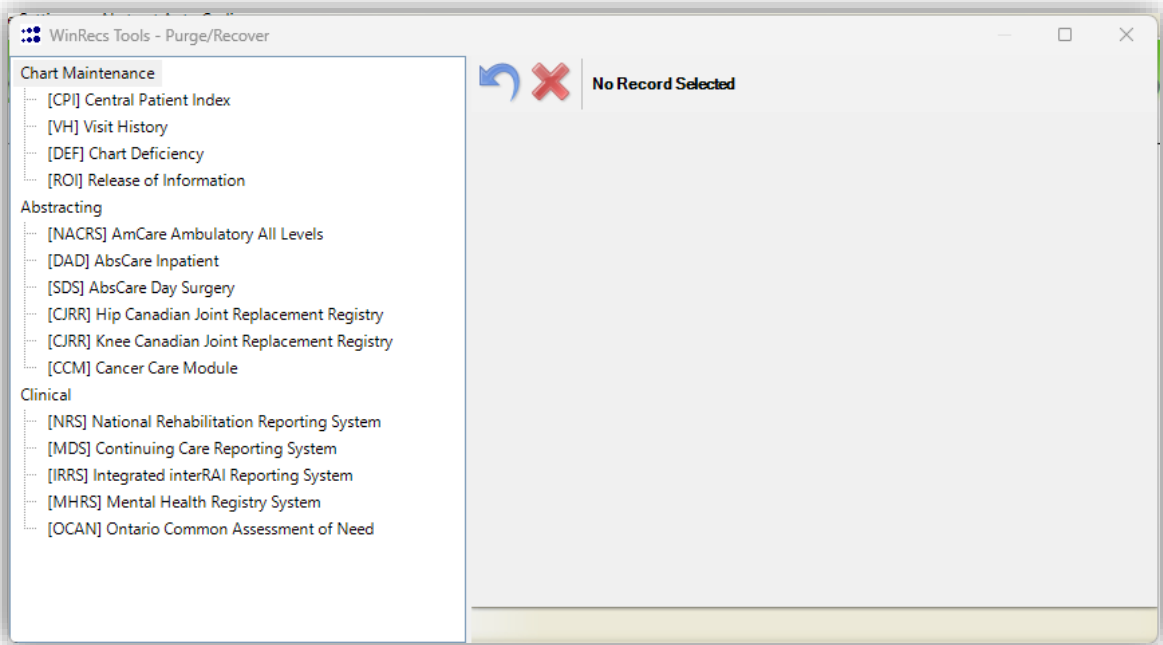


Figure 196 – Purge/Recover Screen

If a deleted record has been sent to CIHI, a Deletion File must be created first. See [CIHI Deletion File](#). Once the file has been created the deleted abstract will purge from Purge/Recover file. Abstracts should also be purged for a period before running CIHI Submissions, CIHI Corrections or reports.

To Purge an Abstract

- Click on the module the abstract was deleted from.
- A list of all the deleted records will display
- Put a checkmark beside the record that needs to be purged
- Click on any column header to sort by that column.

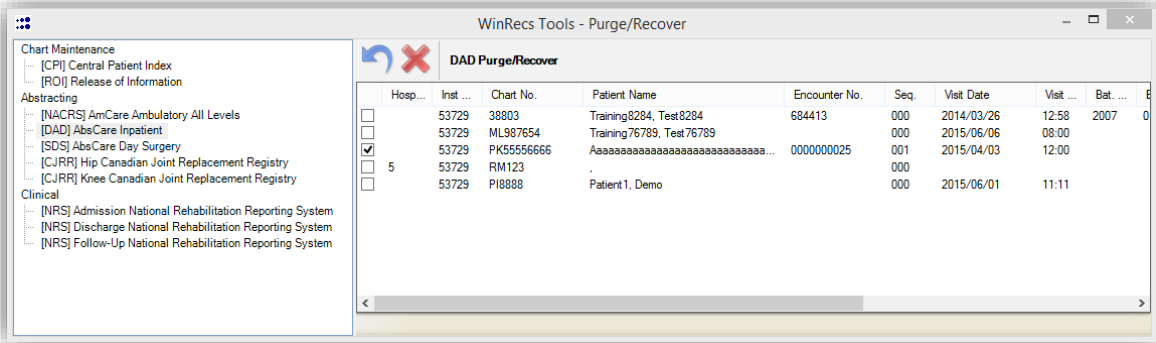


Figure 197 – Purging a Record

- Click on the  or **[F9]** to purge the abstract. This will remove it from all reports and the database.
- The following message will display:

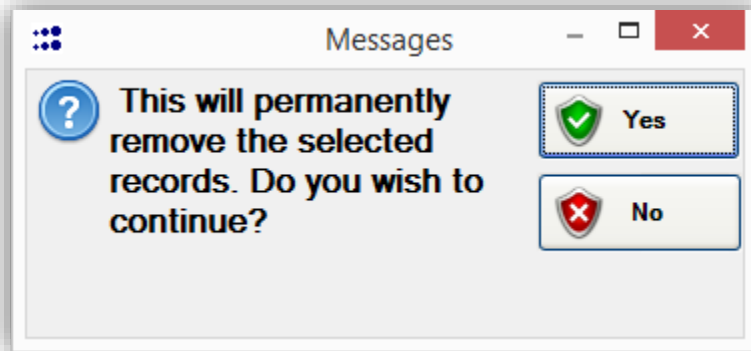


Figure 198 – Purge Message Prompt

Clicking **'YES'** will purge the record

Clicking **'NO'** will go back to the Purge/Recover Screen.

- If a record that is being purged has been submitted to CIHI, the following message will appear:

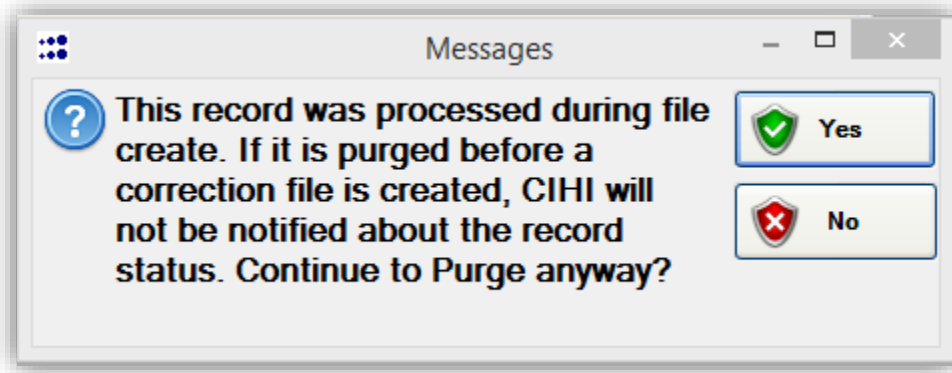
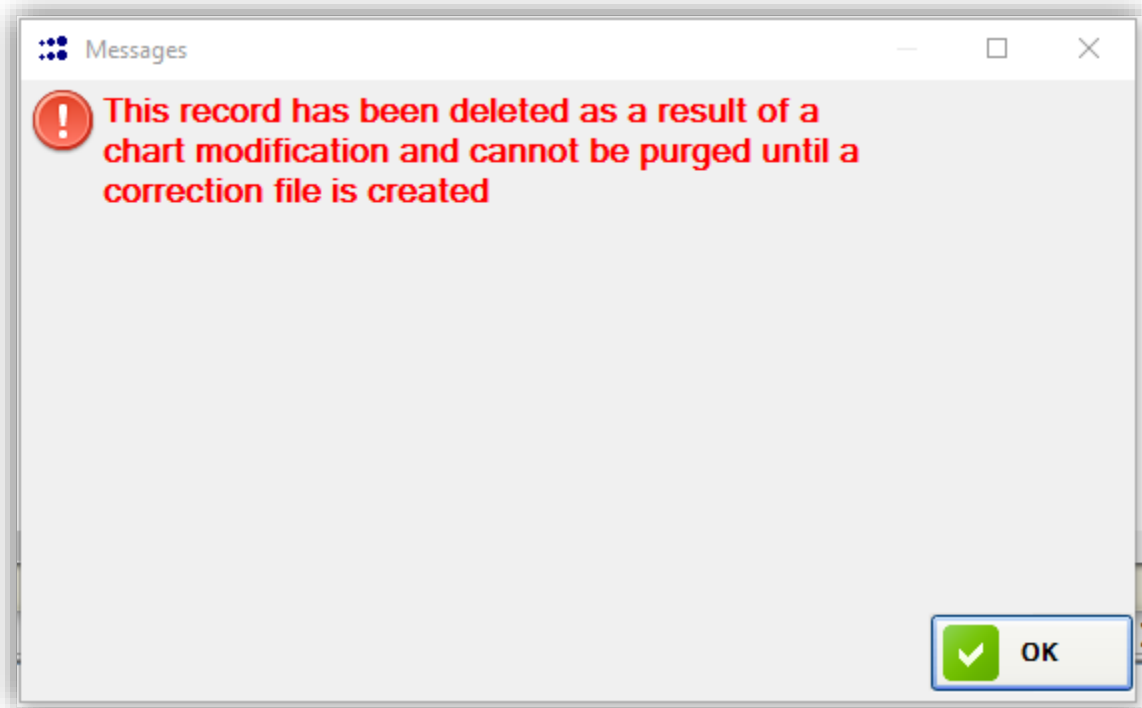


Figure 199 – Purging Abstract Already Submitted to CIHI

- Clicking 'YES' will purge the record and the record will not be sent to CIHI as a deletion.
- Clicking 'NO' will go back to the Purge/Recover Screen and send the record to CIHI via, the [CIHI Deletion File](#).
- If a record has been merged and has been flagged as a sending the record as a deletion to CIHI, the following message will appear



To Recover an Abstract

- Click on the module the abstract was deleted from.
- A list of all the deleted records will display
- Put a checkmark beside the record that needs to be recovered:

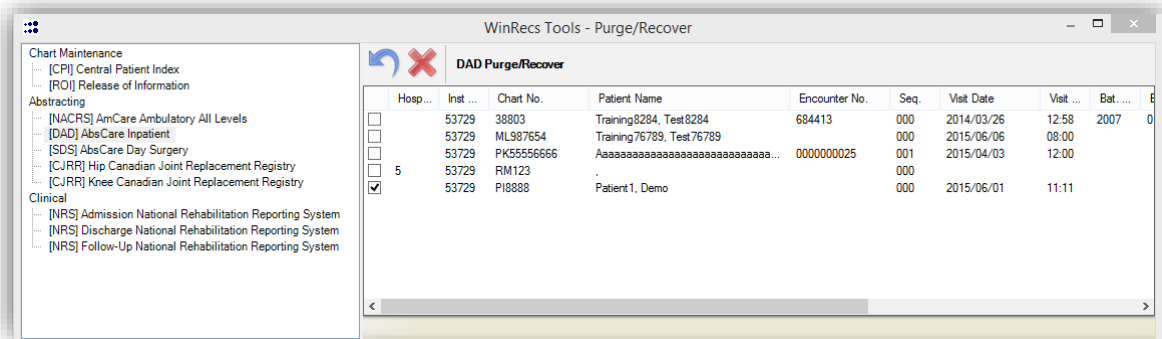


Figure 200 – Recovering an Abstract after Deletion

- Click on the  or **[F8] – Recover** to recover the record.
- The following message will display:

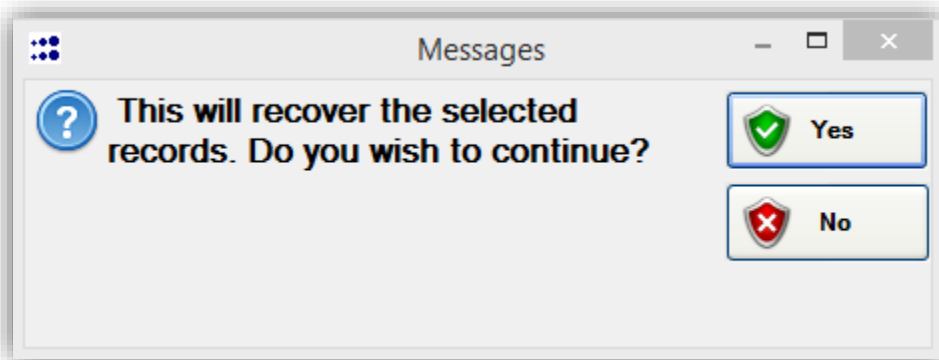


Figure 201 – Recover Abstract Prompt

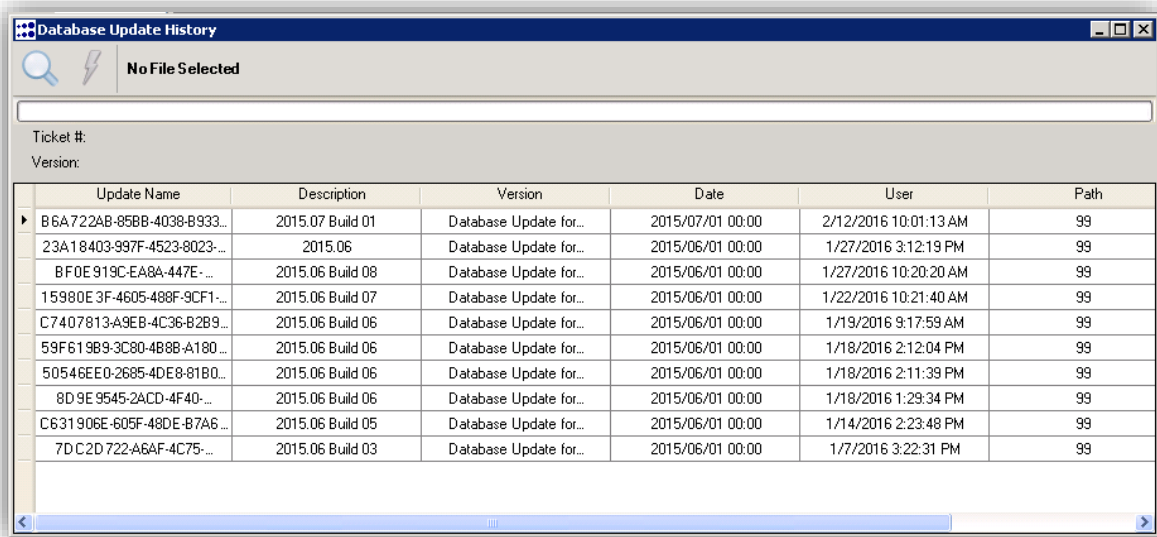
- Clicking **'YES'** will recover the record
- Clicking **'NO'** will go back to the Purge/Recover Screen.

4.6 Database Update History

This gives the user to run patches in WinRecs.

- Download the patch to a directory (as per site policy)
- If the file has .zip, unzip it in the directory you have downloaded to
- Log in WinRecs

○ **Tools → Database Update History**



Update Name	Description	Version	Date	User	Path
B6A722AB-85BB-4038-B933...	2015.07 Build 01	Database Update for...	2015/07/01 00:00	2/12/2016 10:01:13 AM	99
23A18403-997F-4523-8023-...	2015.06	Database Update for...	2015/06/01 00:00	1/27/2016 3:12:19 PM	99
BF0E919C-EA8A-447E-...	2015.06 Build 08	Database Update for...	2015/06/01 00:00	1/27/2016 10:20:20 AM	99
15980E3F-4605-488F-9CF1-...	2015.06 Build 07	Database Update for...	2015/06/01 00:00	1/22/2016 10:21:40 AM	99
C7407813-A9EB-4C36-B2B9...	2015.06 Build 06	Database Update for...	2015/06/01 00:00	1/19/2016 9:17:59 AM	99
59F619B9-3C80-4B8B-A180...	2015.06 Build 06	Database Update for...	2015/06/01 00:00	1/18/2016 2:12:04 PM	99
50546EE0-2685-4DE8-81B0...	2015.06 Build 06	Database Update for...	2015/06/01 00:00	1/18/2016 2:11:39 PM	99
8D9E9545-2ACD-4F40-...	2015.06 Build 06	Database Update for...	2015/06/01 00:00	1/18/2016 1:29:34 PM	99
C631906E-605F-48DE-B7A6...	2015.06 Build 05	Database Update for...	2015/06/01 00:00	1/14/2016 2:23:48 PM	99
7DC2D722-A6AF-4C75-...	2015.06 Build 03	Database Update for...	2015/06/01 00:00	1/7/2016 3:22:31 PM	99

Figure 202 – Database Update History

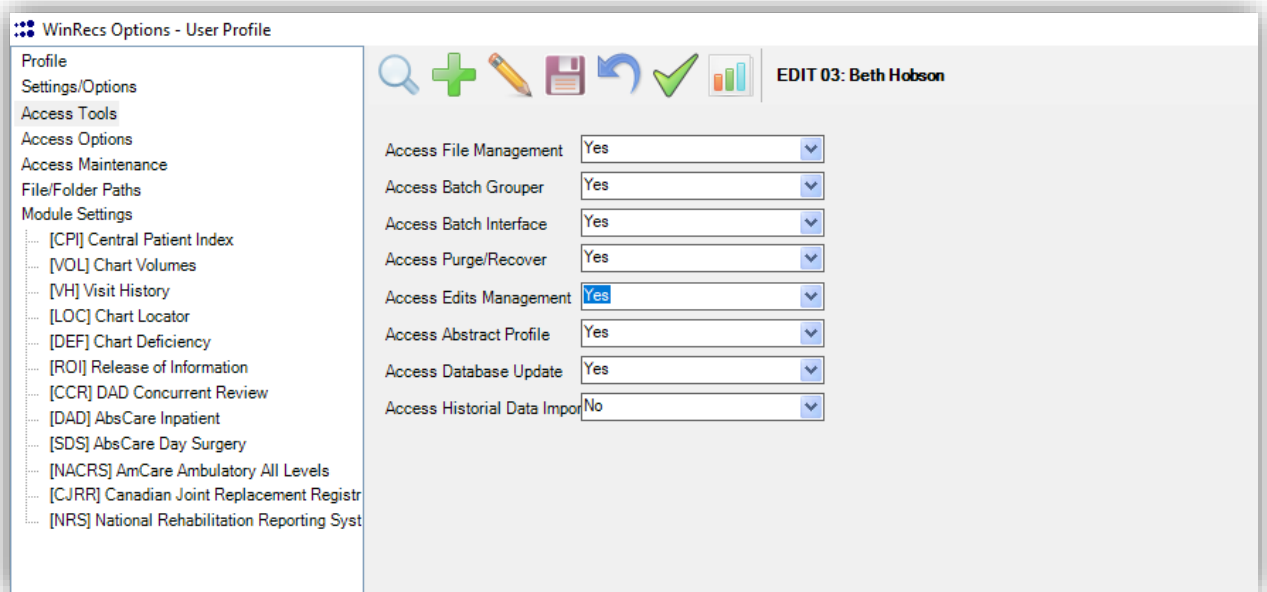
- Press the  and look for the patch in the file directory it was saved in.
- Press the  to process the file.
- The green bar will run and tell you when completed
- For the patch changes to be seen, users must log out and back in.

4.7 Edits Management Tool (EMT)

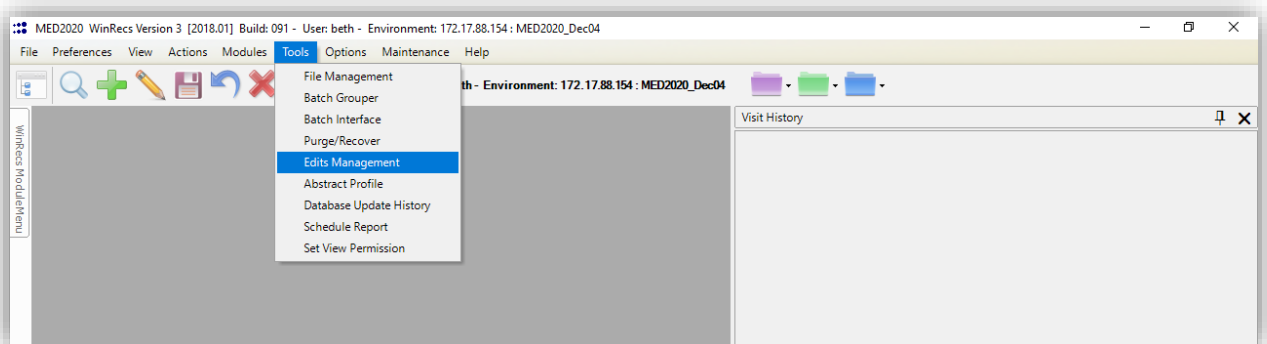
User Profile

There is a field in User Profile that needs to be modified.

Access Edits Management-Yes



Tools>Edit Management



EMT Editor window will display

What is an Operator?

An operator are special symbols or words that describe an operator or an action to take place between two or more values.

Operators

Any Value/Blank (no value)

Equal To/Not Equal

Like/Not Like

Start With/Not Starts With

Less/Less or Equal

Greater /Greater or Equal

And/Or

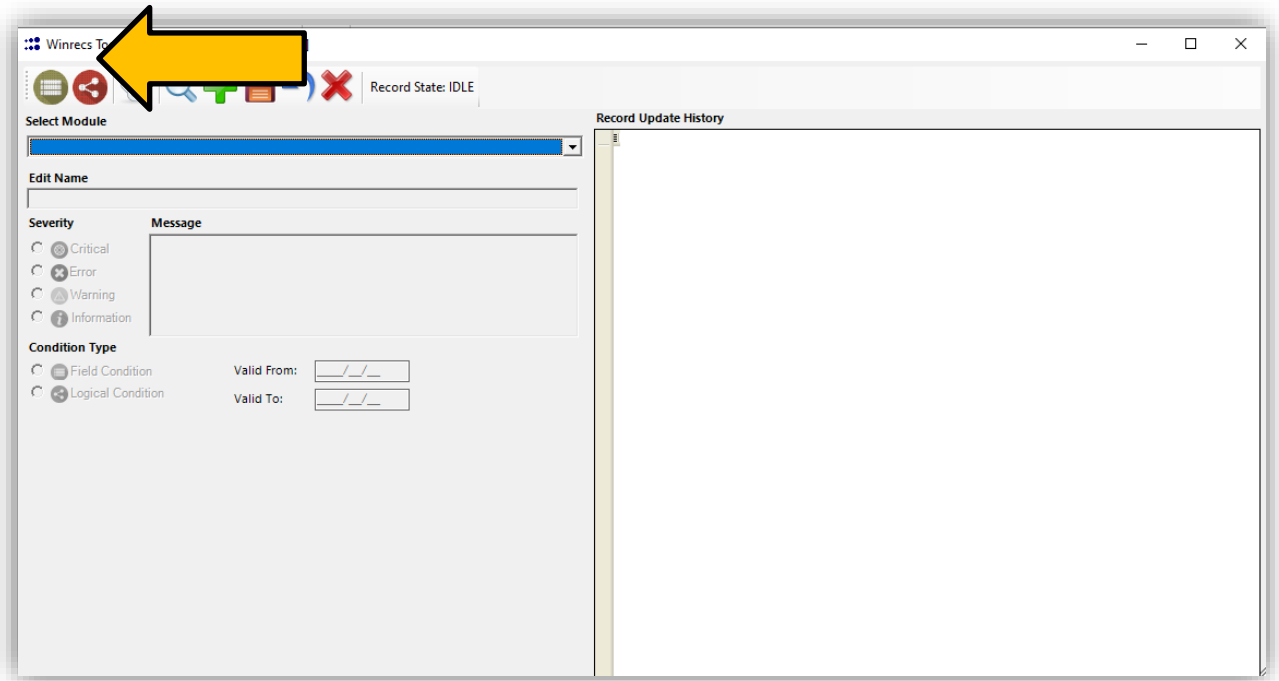
What is a Condition?

Sometimes referred to as a conditional expression and conditional processing, a conditional statement is a set of rules performed if a certain condition is met.

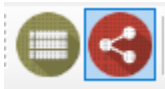
Field Condition- A Field Condition is a when a field refers to value(s) or a field that refers to another field.

Logical Condition- Logical Condition is a combination of field conditions or field conditions and other Logical Conditions. A statement that combines the results of two component conditions to produce a single result.

Condition Editors



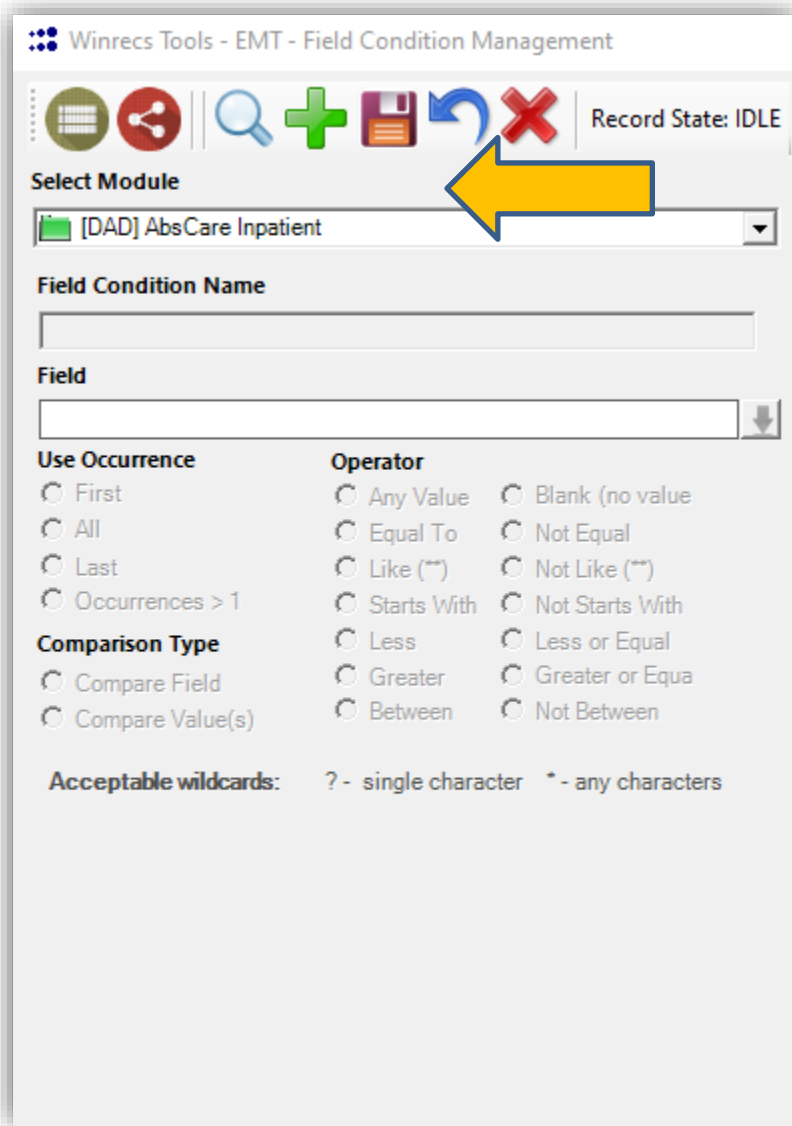
Two icons in tool bar



Field Condition Editor



Select Module in drop down



The screenshot shows the 'Winrecs Tools - EMT - Field Condition Management' window. At the top, there is a toolbar with icons for grid, share, search, add, save, undo, and delete. To the right of the toolbar, it says 'Record State: IDLE'. Below the toolbar is a 'Select Module' section with a dropdown menu currently showing '[DAD] AbsCare Inpatient'. A large yellow arrow points to this dropdown. Below this is a 'Field Condition Name' text box. Underneath is a 'Field' section with a dropdown menu. The main area contains two columns of radio button options: 'Use Occurrence' (First, All, Last, Occurrences > 1) and 'Operator' (Any Value, Equal To, Like (**), Starts With, Less, Greater, Between, Blank (no value), Not Equal, Not Like (**), Not Starts With, Less or Equal, Greater or Equal, Not Between). Below these is a 'Comparison Type' section with radio buttons for 'Compare Field' and 'Compare Value(s)'. At the bottom, it states 'Acceptable wildcards: ? - single character * - any characters'.

New Condition



Field Condition Name

Name the Field Condition you are creating.

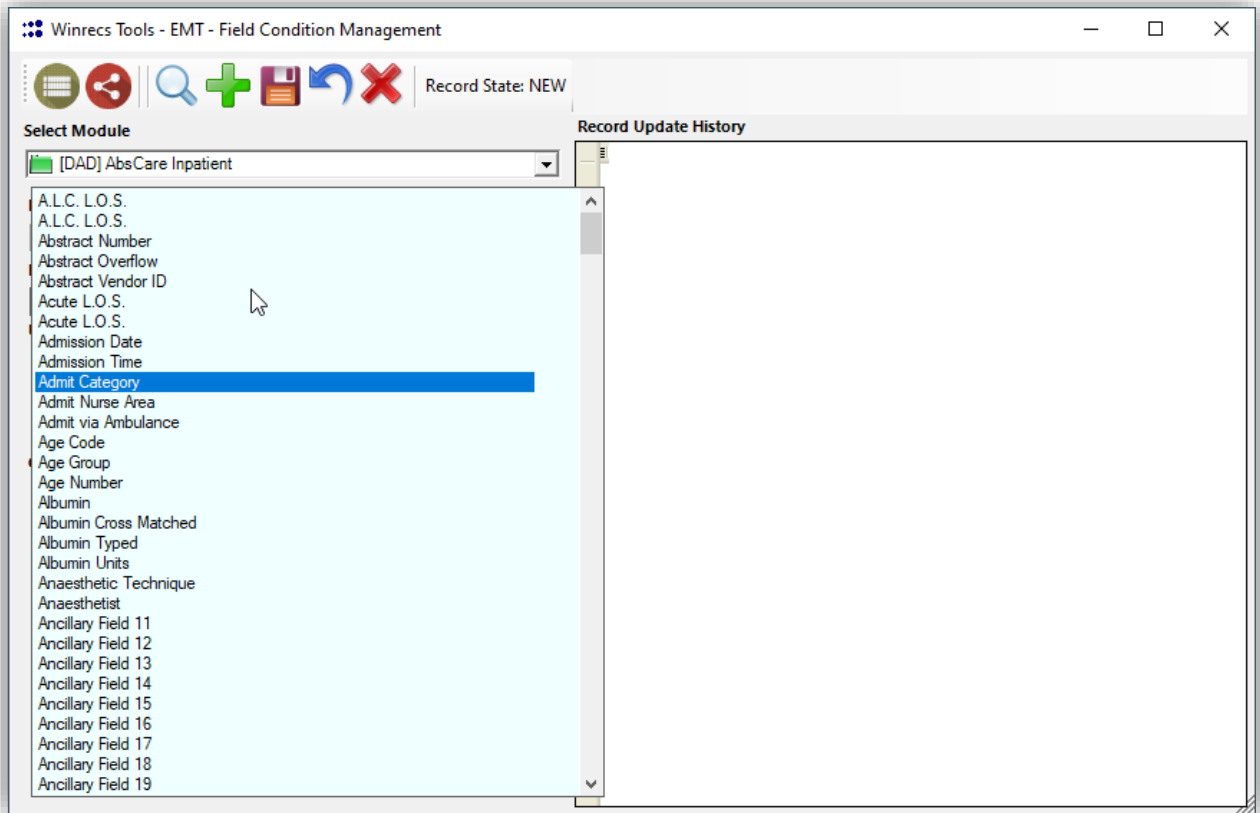
Suggestion: For your Field Conditions, establish a naming convention . If the field condition is referring to Diagnosis, name the Field Condition Diag, Dx, Intervention, Intv I The list of conditions will sort in alphabetical order based on the name.

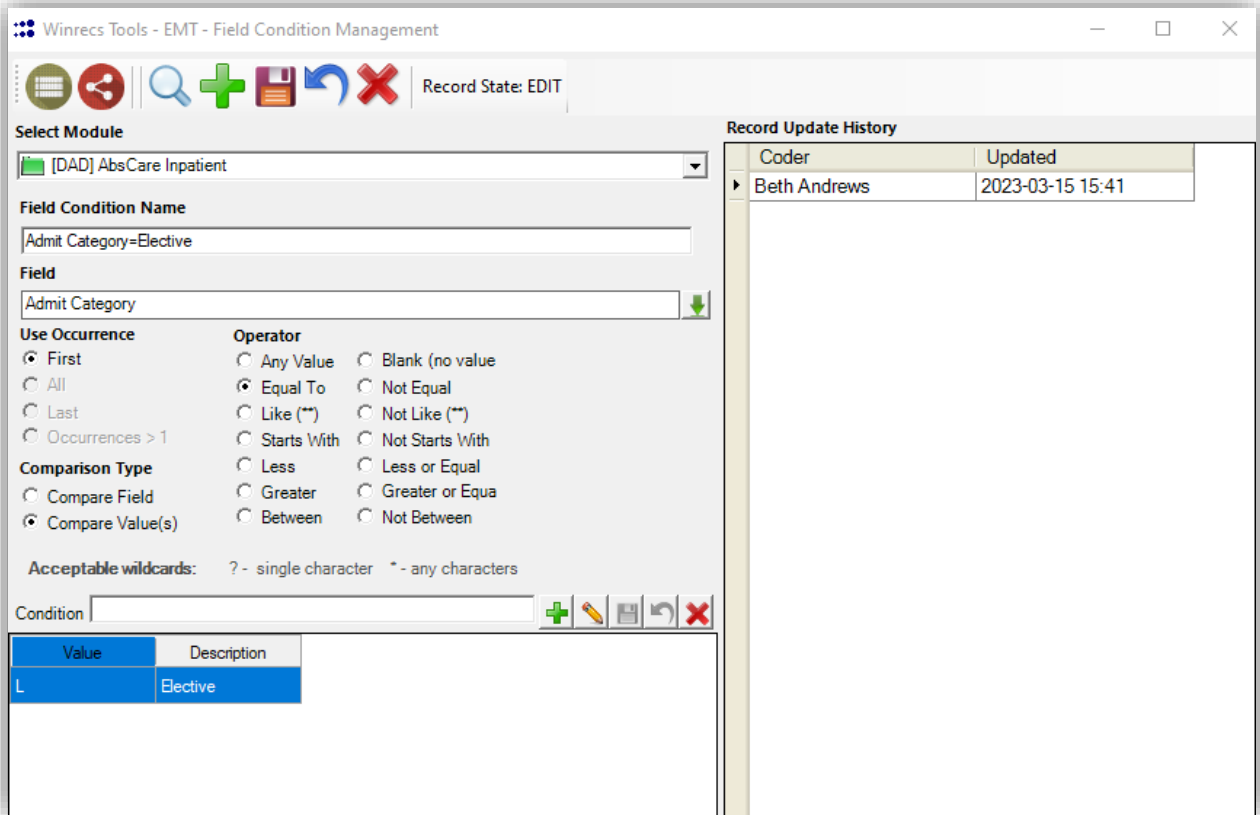
Fields



Use the green arrow to display the module fields available.

Type field name to select from list





The screenshot shows the 'Winrecs Tools - EMT - Field Condition Management' window. The 'Record State' is 'EDIT'. The 'Select Module' dropdown is set to '[DAD] AbsCare Inpatient'. The 'Field Condition Name' is 'Admit Category=Elective'. The 'Field' dropdown is 'Admit Category'. The 'Use Occurrence' section has 'First' selected. The 'Operator' section has 'Equal To' selected. The 'Comparison Type' section has 'Compare Value(s)' selected. The 'Acceptable wildcards' section shows '? - single character' and '* - any characters'. The 'Condition' field is empty. The 'Record Update History' table shows one record: Beth Andrews, updated on 2023-03-15 15:41.

Value	Description
L	Elective

Coder	Updated
Beth Andrews	2023-03-15 15:41

Use occurrence

First

- For fields in main grid, first occurrence will always be selected
- In a multiform this first occurrence refers to the MAIN occurrence

All

- In a multiform this refers to all occurrences from first occurrence and greater

Last

- In a multiform this refers to the last/maximum occurrence number

Occurrences (>1)

- In a multiform this refers to other occurrences in a multi form EXCEPT first occurrence

Field condition operators

- *Any Value/Blank (no value)*- When selecting a field, this operator refers to a value or no value.

- *Equal To/Not Equal*- When selecting a field, this operator refers to an EXACT value or NOT EXACT value. The value in condition can be more than one value.
Example:
Admit Category = L
Admit Category = L, E, N
- *Like/Not Like*- When selecting a field, this operator refers to a field that contains the value or not like the value.
- *Start With/Not Starts With*- When selecting a field, this operator refers to a field that begins not not begins with this value.
Example:
Diagnosis Code starts with K29
- *Less/Less or Equal*- When selecting a field, this operator refers to a NUMBER data type field.
Example:
LOS Days <20, LOS <=20
- *Greater /Greater or Equal*- When selecting a field, this operator refers to a NUMBER data type field
Example:
LOS Days >20, LOS>=20
- *Between/Not Between* - When selecting a field, this operator refers to a NUMBER data type or a STRING data type field
Example:
LOS Days is Between 10 to 25
Diagnosis Code is Between I60 to I68.9

Comparison type

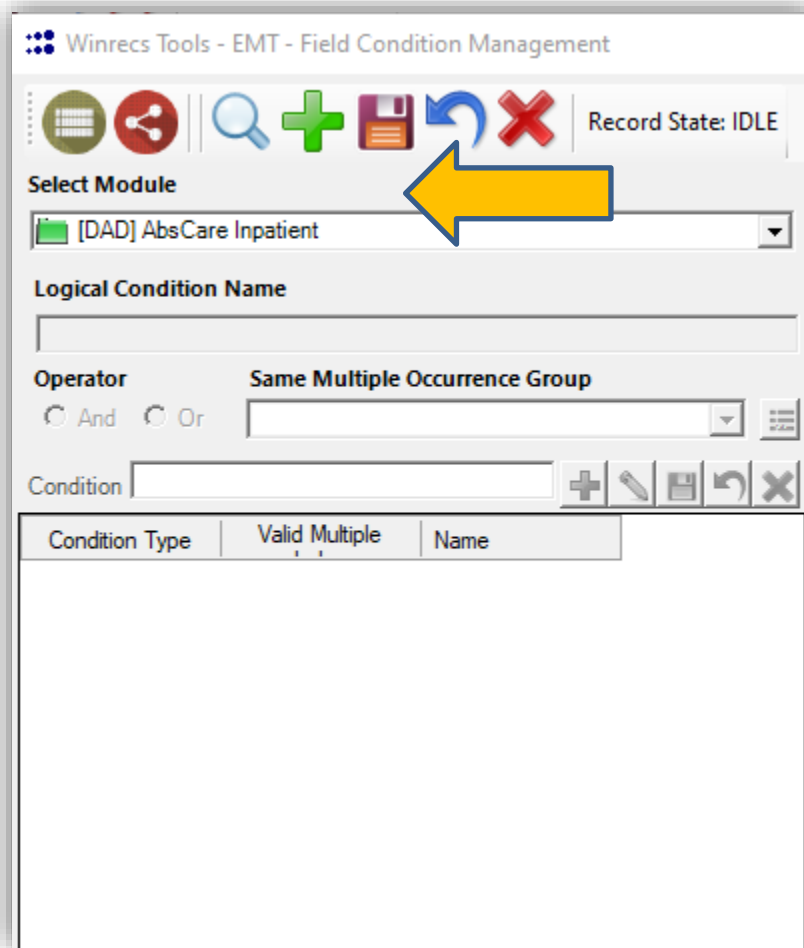
- *Compare Field*- A specific field and it's value compared to another specific field and it's value. Example:
Admission Date = Discharge Date
Triage Date > Registration Date
- *Compare Values(s)*- A specific field that refers to values
Example:
Admit Category = L

Diagnosis Code like K29
Patient Service =10

Logical Condition Editor



Select the module



Winrecs Tools - EMT - Field Condition Management

Record State: IDLE

Select Module

[DAD] AbsCare Inpatient

Logical Condition Name

Operator: ☐ And ☐ Or

Same Multiple Occurrence Group

Condition

Condition Type	Valid Multiple	Name
----------------	----------------	------

New Condition



Logical Condition Name

- Name the Logical Condition you are creating.

Logical condition operators

FIELD condition **AND** FIELD condition

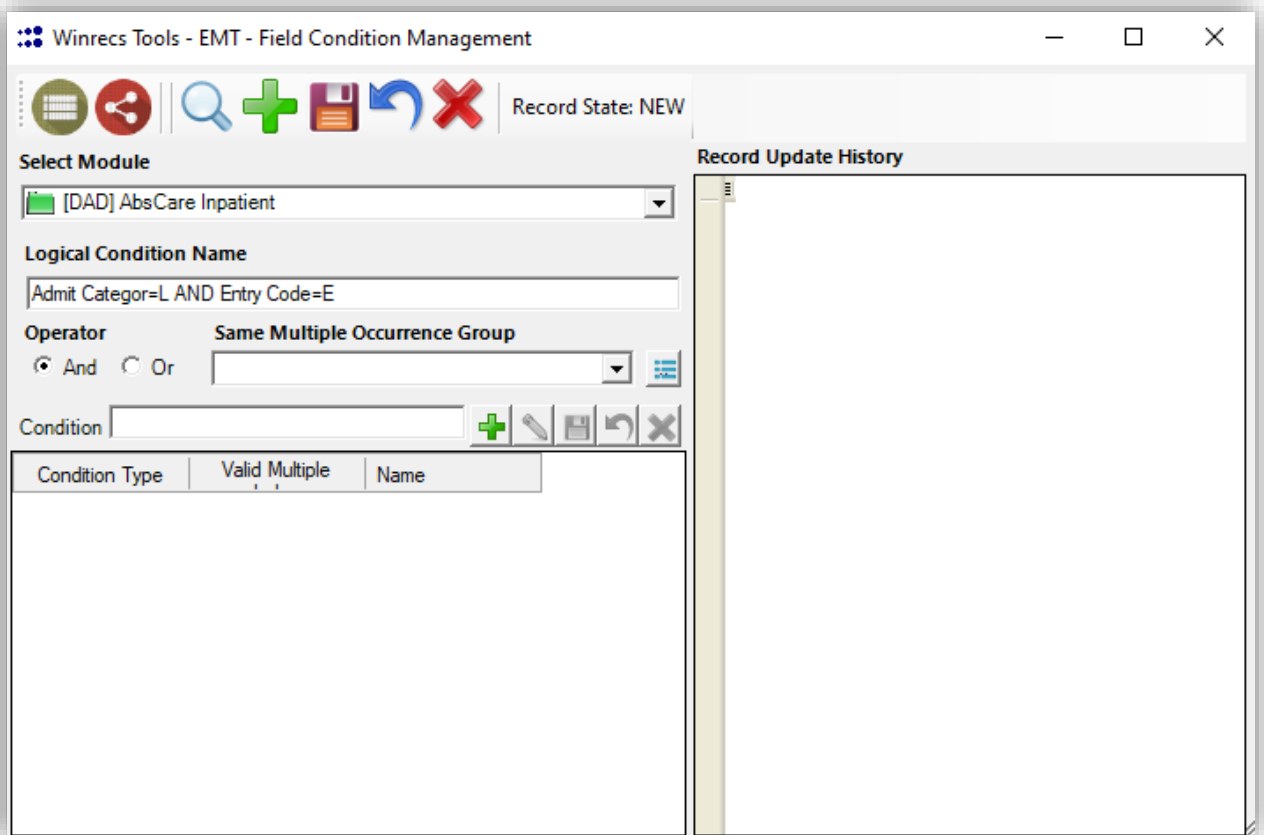
LOGICAL condition **AND** FIELD condition

LOGICAL condition **And** FIELD condition **OR** FIELD condition

LOGICAL condition **AND** LOGICAL condition

LOGICAL condition **OR** LOGICAL condition

- *And/Or-* used to connect field conditions or to connect field conditions with Logical Conditions.



- Click the  to select the Conditions
- Click F2 to see a list of Conditions

Search Results

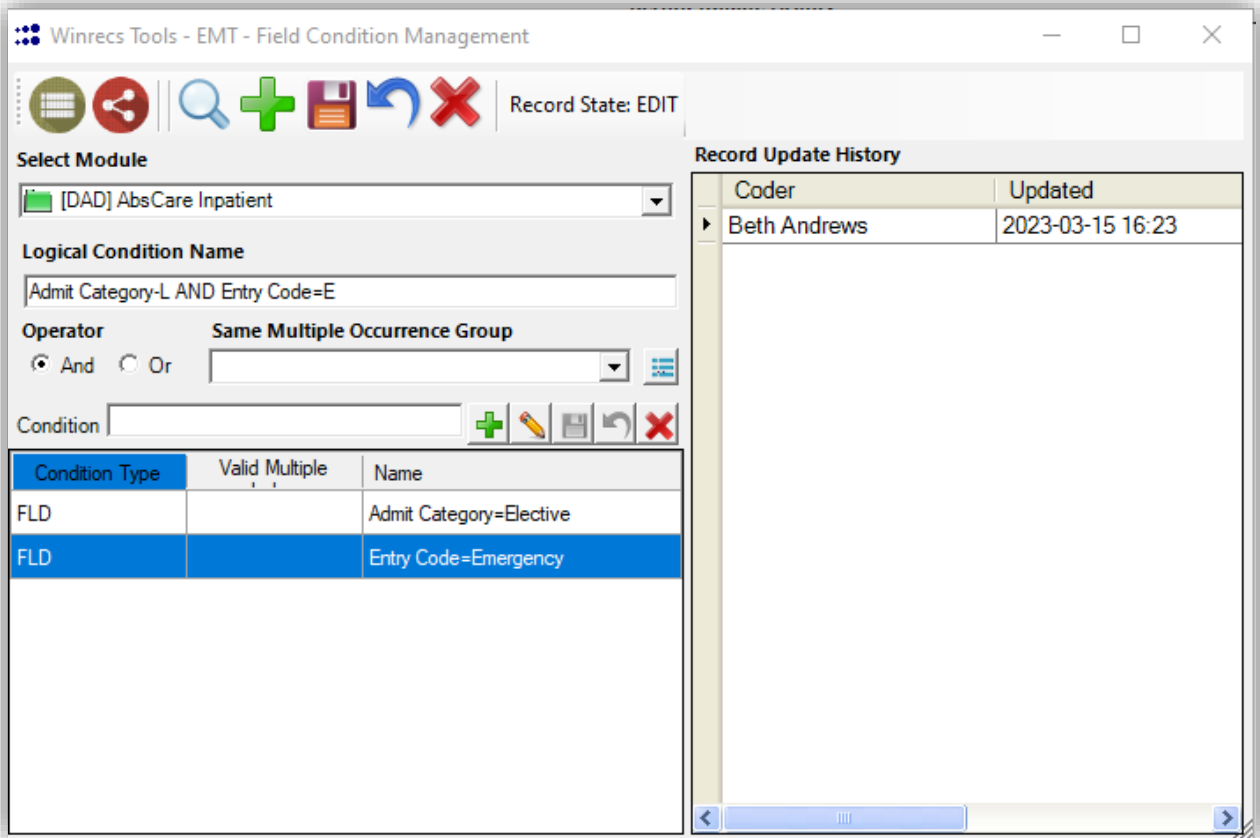
Edits Management: Condition Search

Condition Type	Name
FLD	Exp1 AdmitCatL
FLD	Exp1 EntryCodeE
FLD	Exp2 Dx MitralStenosis
FLD	TEST Exp3 SCU 50
FLD	TEST Exp3 AgeCodeM
FLD	TEST Exp3 AgeNumber >= 12
FLD	Exp4 EntryCodeD
FLD	Exp4 DispCode07
FLD	Exp6 DxCode not J44
FLD	Exp3 Postal Code K2 or K4
FLD	Exp5 Postal Code K2 and K4
FLD	Exp5 Residence Code not 02521
FLD	Exp6 DxCodeJ18
FLD	Age Great than 100
FLD	Exp7 PatService51
FLD	Exp9 DxCodes3-7
FLD	Exp7 IntervProvNum
FLD	Exp20 Dx Code J44
FLD	Exp20 Dx Code not J18
FLD	Exp8 IntervProvService
FLD	Exp8 PatService51
FLD	Exp9 DxCodes8
FLD	TEST Exp3 AgeCode Y
FLD	Admit Category=Elective

☒ Active Values Only
 ☐ Return Top 100 Results

 Select Record

97 Matches Found



Winrecs Tools - EMT - Field Condition Management

Record State: EDIT

Select Module: [DAD] AbsCare Inpatient

Logical Condition Name: Admit Category=L AND Entry Code=E

Operator: ☒ And ☐ Or

Same Multiple Occurrence Group: [Dropdown]

Condition: [Text Box]

Condition Type	Valid Multiple	Name
FLD		Admit Category=Elective
FLD		Entry Code=Emergency

Record Update History

Coder	Updated
Beth Andrews	2023-03-15 16:23

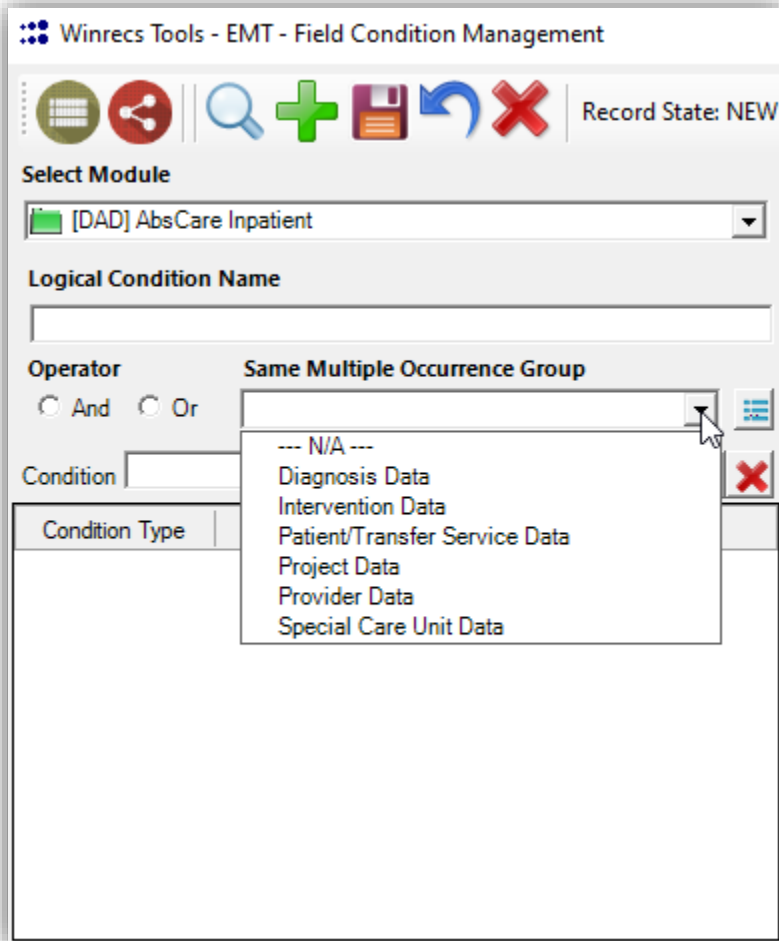
Save F7



Same Occurrence (Multiforms)

When combining two or more conditions (Field and/or Logical Condition) together, it is possible to create a Logical Condition that refers to fields in a multiform. The edit may refer to fields from the SAME Occurrence.

When click on Same Multiple Occurrence Group, a drop down list will display all the multiform sections.



Winrecs Tools - EMT - Field Condition Management

Record State: NEW

Select Module

[DAD] AbsCare Inpatient

Logical Condition Name

Operator

☐ And ☐ Or

Same Multiple Occurrence Group

Condition

Condition Type

--- N/A ---

Diagnosis Data

Intervention Data

Patient/Transfer Service Data

Project Data

Provider Data

Special Care Unit Data

To select a conditions click the  to enable the Condition field.

Click F2 to display the list of Conditions to select from.

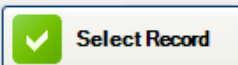
Search Results

Edits Management: Condition Search

There may be more results. Consider refining your search criteria

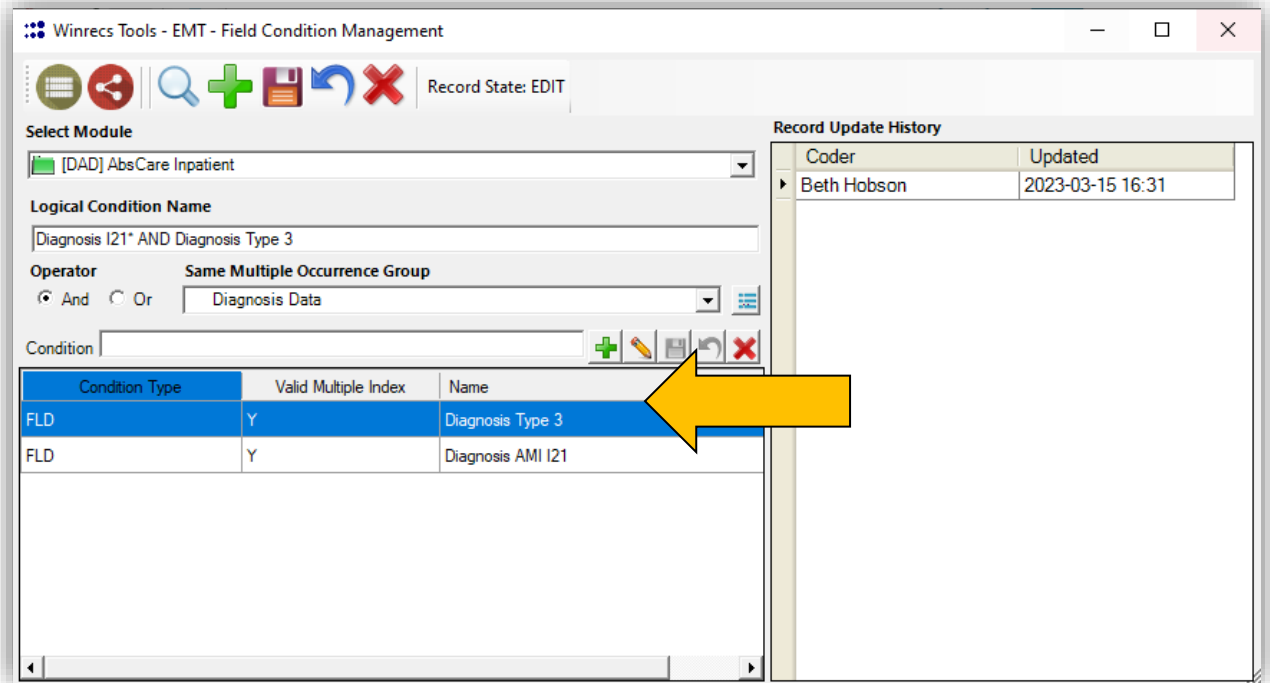
Condition Type	Name
FLD	Exp1 AdmitCatL
FLD	Exp1 EntryCodeE
FLD	Exp2 Dx MitralStenosis
FLD	TEST Exp3 SCU 50
FLD	TEST Exp3 AgeCodeM
FLD	TEST Exp3 AgeNumber >= 12
FLD	Exp4 EntryCodeD
FLD	Exp4 DispCode07
FLD	Exp6 DxCode not J44
FLD	Exp3 Postal Code K2 or K4
FLD	Exp5 Postal Code K2 and K4
FLD	Exp5 Residence Code not 02521
FLD	Exp6 DxCodeJ18
FLD	Age Great than 100
FLD	Exp7 PatService51
FLD	Exp9 DxCodes3-7
FLD	Exp7 IntervProvNum
FLD	Exp20 Dx Code J44
FLD	Exp20 Dx Code not J18
FLD	Exp8 IntervProvService
FLD	Exp8 PatService51
FLD	Exp9 DxCodes8
FLD	TEST Exp3 AgeCode Y
FLD	Admit Category=Elective
FLD	do not use
FLD	PI - Dx Code O08
FLD	PI - Dx Code O03-O07

☒ Active Values Only
 ☐ Return Top 100 Results



101 Matches Found

When select the Field and/or Logical Conditons, they will display in a list.



Save F7

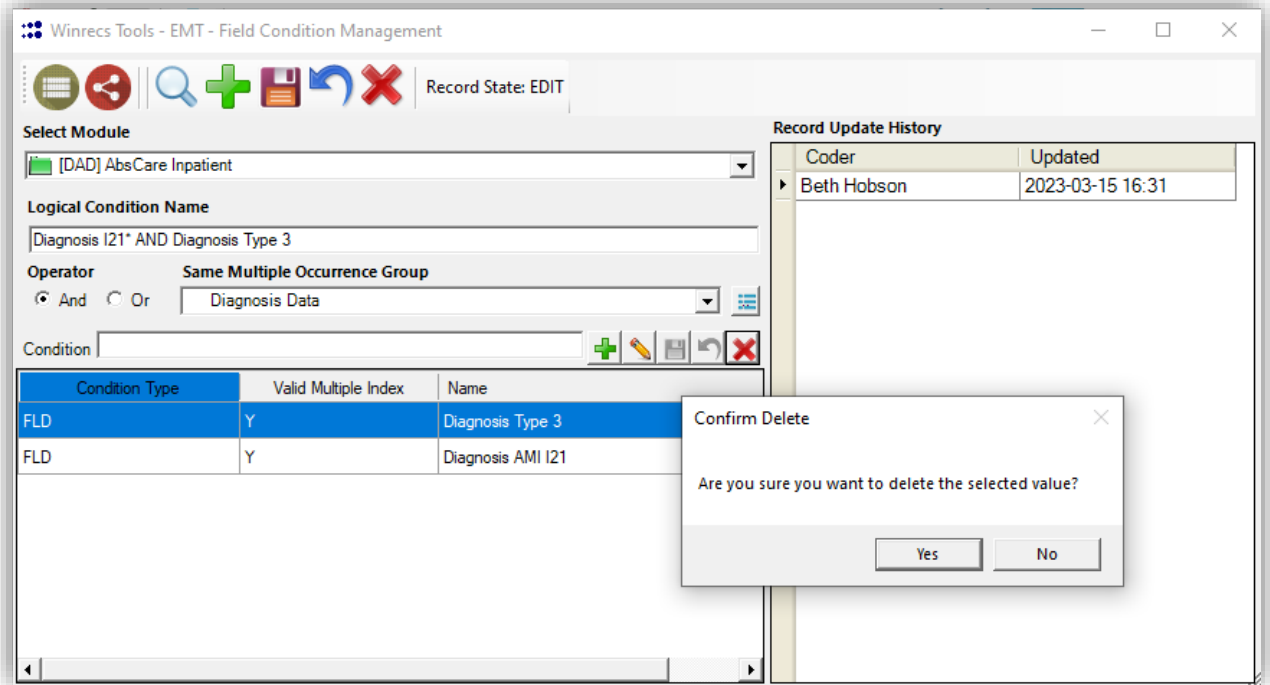


Delete Condition

If the Logical Condition is not for the Same Occurrence, click the Del. Condition button.

F9 Delete

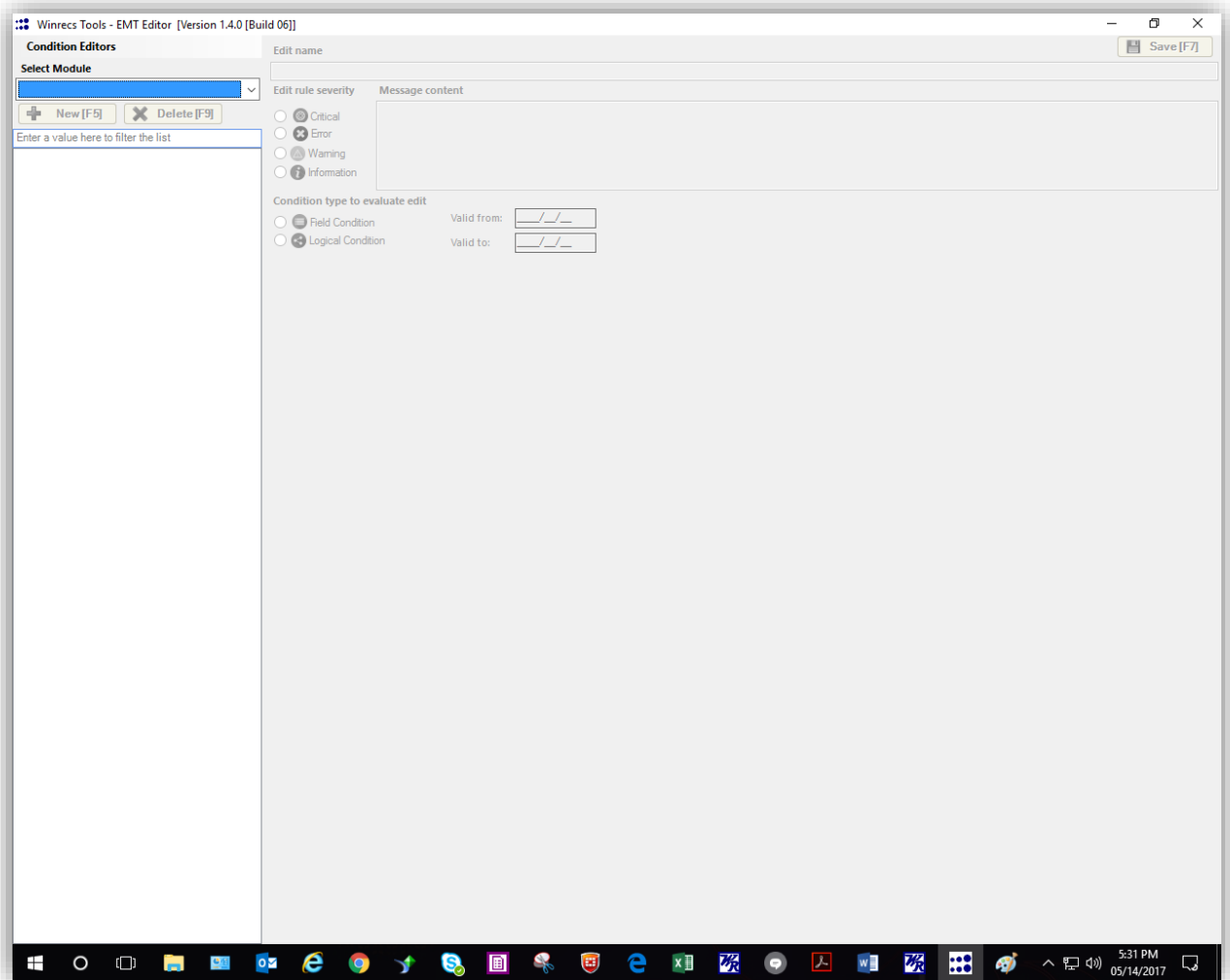




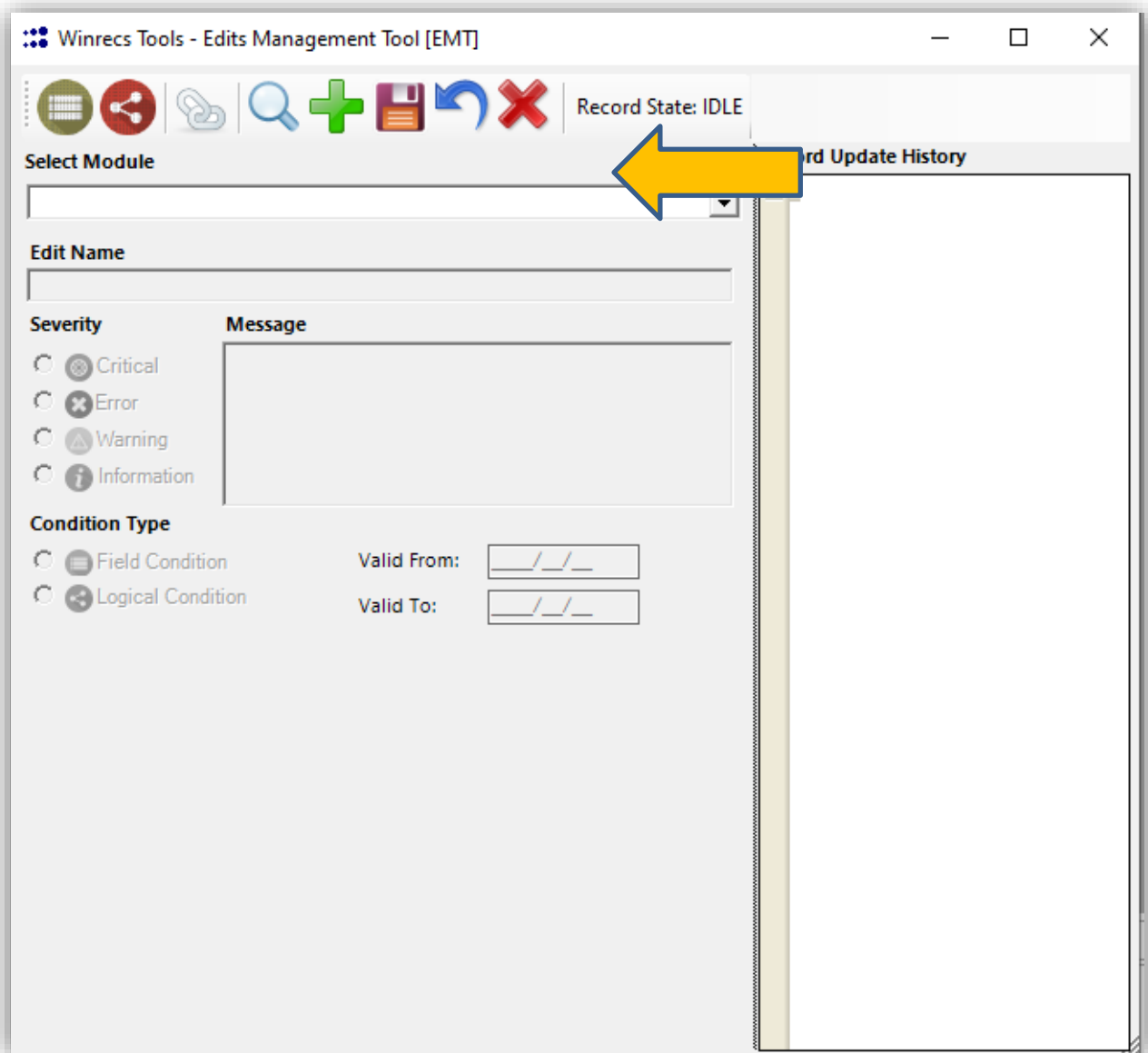
Click Yes to delete this logical condition.

Create Edit Message

Tools>Edits Management Tool (EMT)



Select Module



Winrecs Tools - Edits Management Tool [EMT]

Record State: IDLE

Select Module

Record Update History

Edit Name

Severity

☐ Critical

☐ Error

☐ Warning

☐ Information

Message

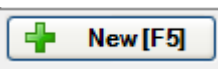
Condition Type

☐ Field Condition

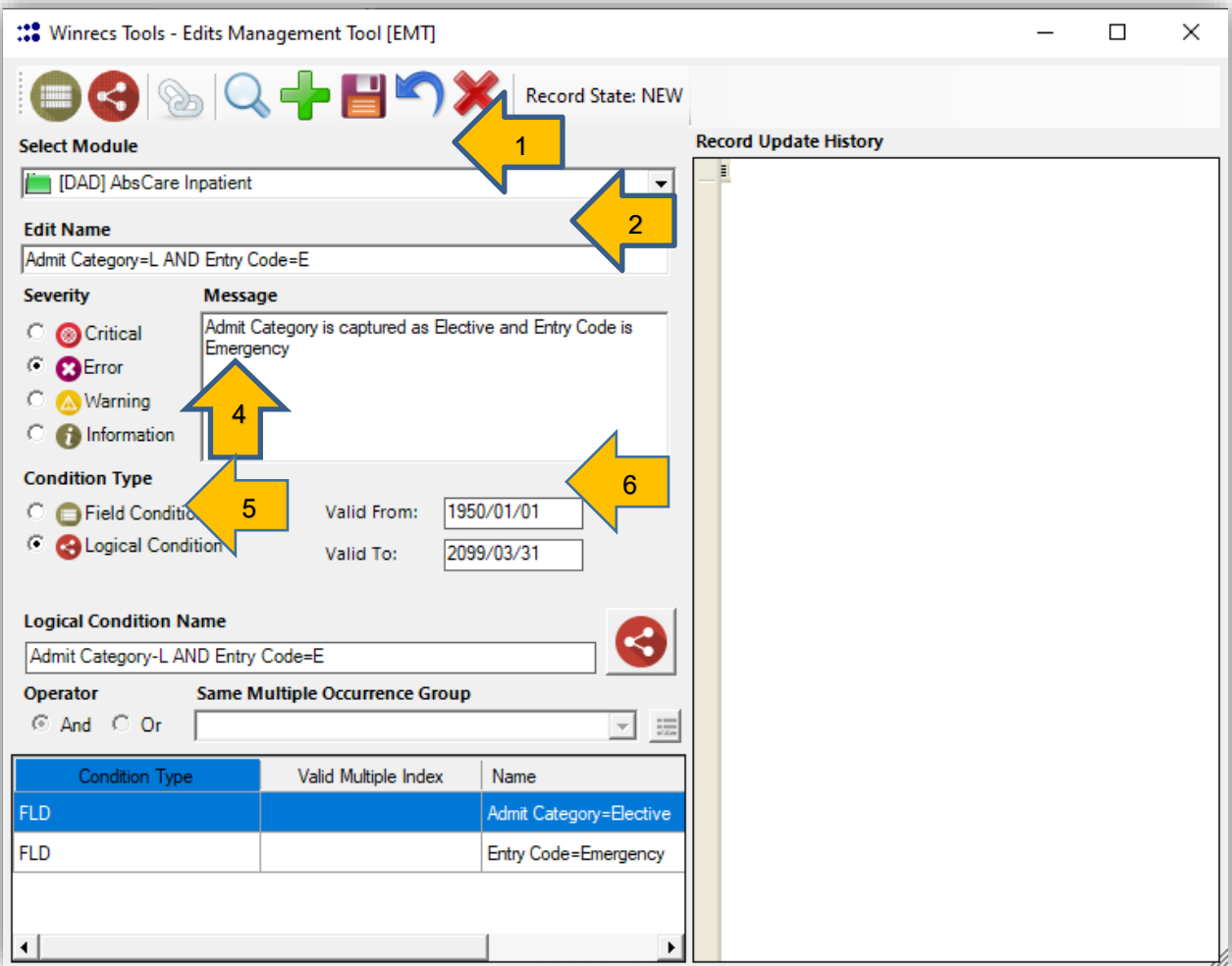
☐ Logical Condition

Valid From: ____/____/____

Valid To: ____/____/____

Click 

Areas of the Edits Management Tool Editor



Winrecs Tools - Edits Management Tool [EMT]

Record State: NEW

Select Module

[DAD] AbsCare Inpatient

Edit Name

Admit Category=L AND Entry Code=E

Severity

☐ Critical
☒ Error
☐ Warning
☐ Information

Message

Admit Category is captured as Elective and Entry Code is Emergency

Condition Type

☐ Field Condition
☒ Logical Condition

Valid From: 1950/01/01

Valid To: 2099/03/31

Logical Condition Name

Admit Category-L AND Entry Code=E

Operator

☒ And
☐ Or

Same Multiple Occurrence Group

Condition Type	Valid Multiple Index	Name
FLD		Admit Category=Elective
FLD		Entry Code=Emergency

1. Select Module
In order to enable the editor, must first select the module. The edit will only display in the module you select.
2. Edit Name
The name usually reflects the fields and conditions involved.
3. Edit Rule Severity Level
In the abstract in the message list box, the content is represented by a severity level. All EMT edit icons will have a turquoise frame.

Dark Red	Critical
Red	Error
Yellow	Warning
Blue	Information

4. Message Content
The content that will display in the abstract.
5. Condition Types
Must create and select the Field and Logical Conditions that will be used in the Edit.
6. Valid From and To date
Edit must have a Valid From and Valid To date in order to generate. The edit will generate based on the key date of the abstract.
7. F4  to search for existing edits

Search F4 for existing edits



Winrecs Tools - Edits Management Tool [EMT]

Select Module

[DAD] AbsCare Inpatient

+ New [F5] X Delete [F9] Select [F7]

Enter a value here to filter the list

A03.9
Admit Category=L AND Entry Code=E
AF: Weight Between 4 and 5 kg (2574)
D_001
Delete Me
Diagnosis OBS with Diagnosis Type 3
Diagnosis Pneumonia and Type <> 1
Edit2 Dx Mitral Stenosis
Edit20 DxCode J44 without J18
Edit3 SCU 50 and Age >=12
Edit4 Death Disposition
Edit5 Postal Code Ottawa and Residence not Ottawa
Edit6 DiagCode J18 without J44
Edit7 PatService51 and IntervProService
Edit8 IntervProvService and PatService
Edit9 DxCodesO03-O07 and O08
Entry Code N-Newborn with Weight>=4.7 kg-Large Baby
Intervention code LIKE 1.A?.35.HA-K0
New Edit Testing Jen
Palliative Edit - Manitoba
PI - Abortion Complication & Service Check
PI - Admit Category Check (gestational age)
PI - CMG test
PI - Diagnosis of Z51.5 without Prefix 8
PI - Intervention Duration
PI - QBP Intervention Code
QR1 QH1 Discharge Nurse Area=REHAB
QR1 QH1-1 QH1-2 AdmitCatL elective and Entry Code E emergency

Creating an Edit

Scenario

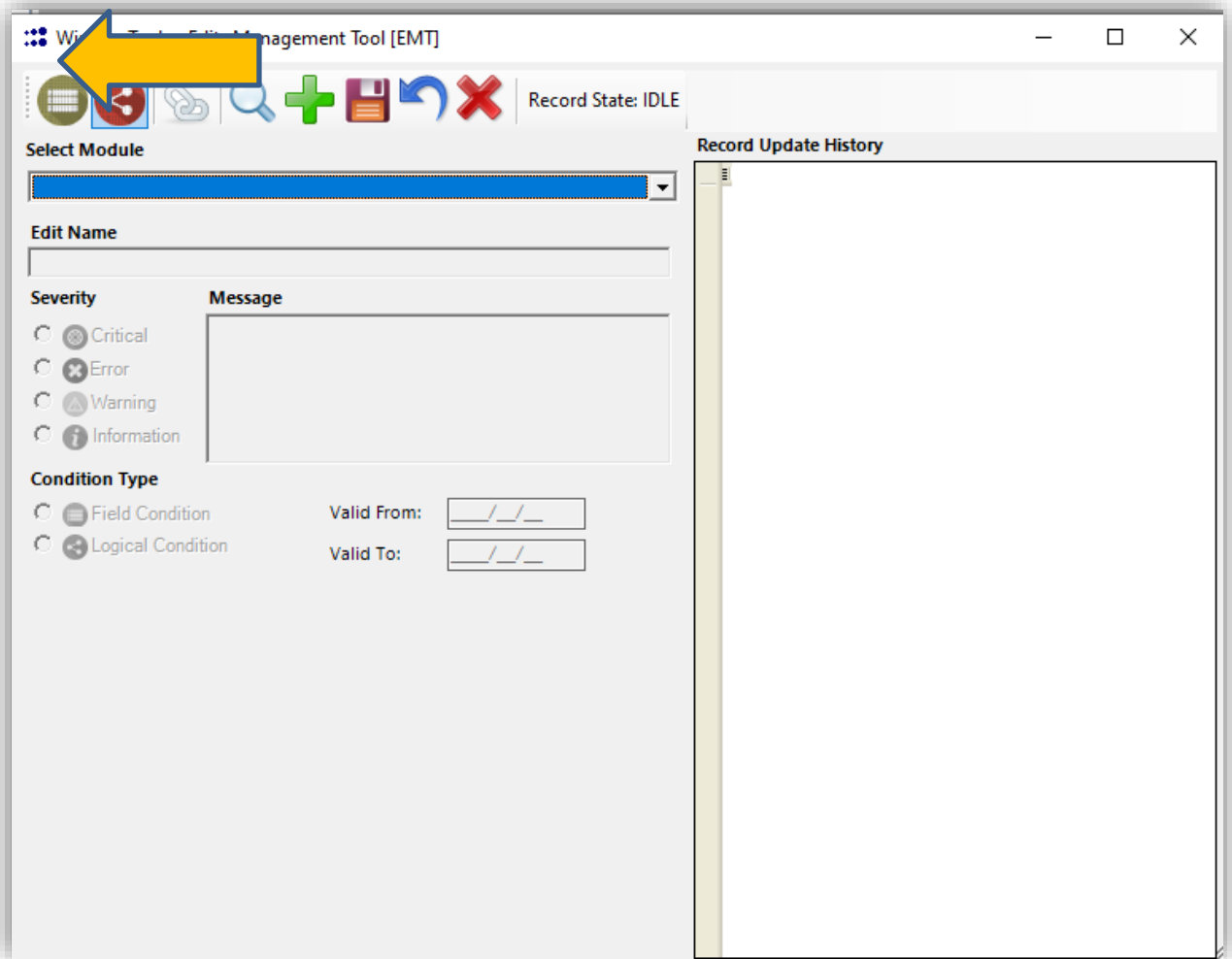
When the ER visit has a Death Disposition Code and the Triage Level is not Resuscitation generate a message.

MESSAGE:

“Death Disposition must have a Triage Level 2”

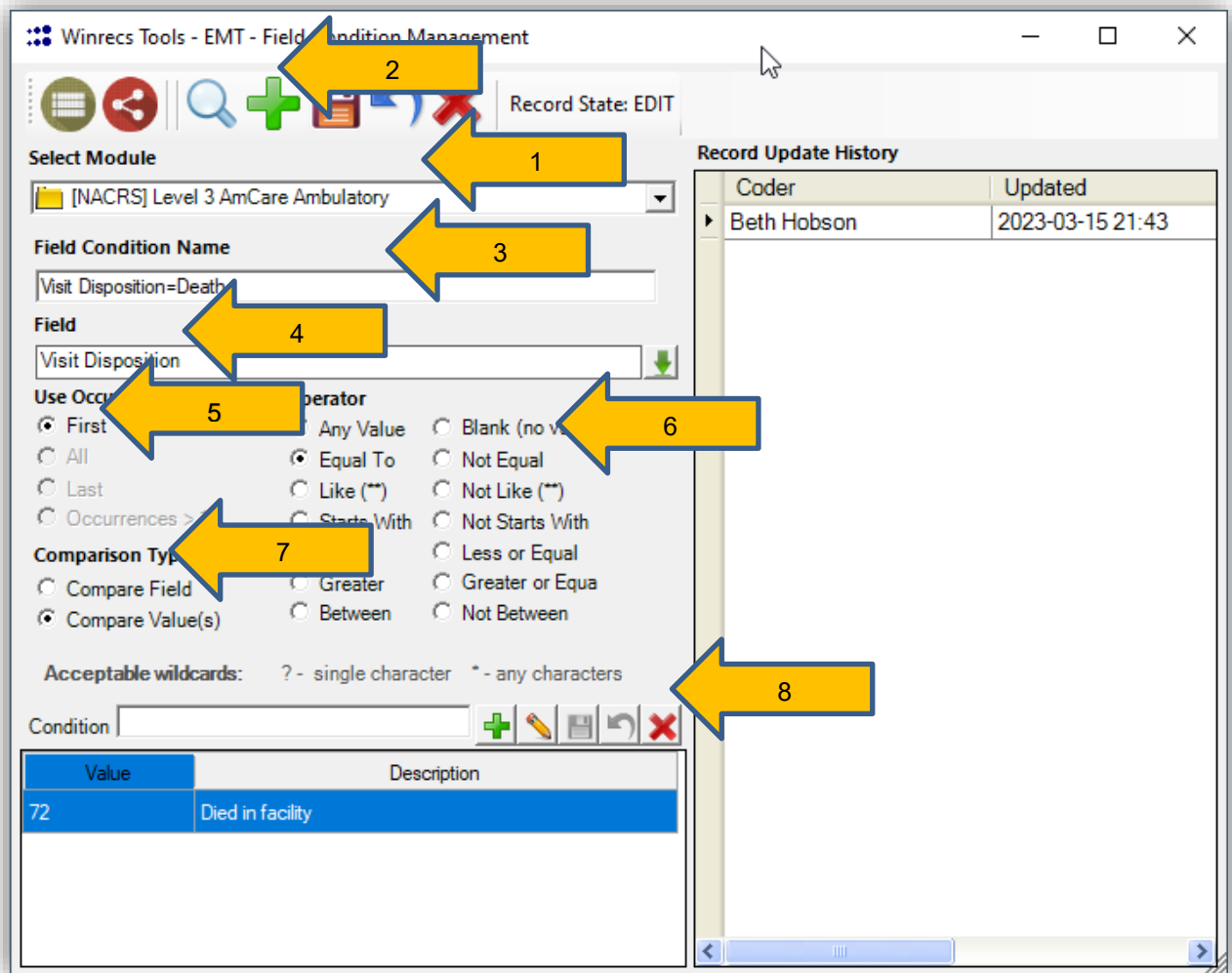
Step 1: Create Field Condition(s)

Click on Field Condition Editor



The screenshot shows the 'WinRecs Field Condition Editor [EMT]' window. The interface includes a toolbar with icons for various actions, a 'Record State: IDLE' indicator, and a 'Select Module' dropdown menu. Below this is an 'Edit Name' text field. The 'Severity' section has four radio buttons: Critical, Error, Warning, and Information. The 'Message' section is a large text area. The 'Condition Type' section has two radio buttons: Field Condition and Logical Condition. To the right of these are 'Valid From' and 'Valid To' date pickers. A yellow arrow points to the 'Field Condition' radio button. On the right side of the window, there is a 'Record Update History' section with a list of records.

1. Select Module
2. Click NEW
3. Name Field Condition
4. Select Field
5. Select Occurrence if necessary
6. Select Operator
7. Select Comparison Type
8. Click PLUS sign and select values



Winrecs Tools - EMT - Field Condition Management

Record State: EDIT

Select Module

[NACRS] Level 3 AmCare Ambulatory

Field Condition Name

Visit Disposition=Death

Field

Visit Disposition

Use Occurrence

☒ First ☐ Any Value ☐ Blank (no value)

☐ All ☒ Equal To ☐ Not Equal

☐ Last ☐ Like (**) ☐ Not Like (**)

☐ Occurrences > ☐ Starts With ☐ Not Starts With

Comparison Type

☐ Compare Field ☐ Greater ☐ Greater or Equal

☒ Compare Value(s) ☐ Between ☐ Not Between

Acceptable wildcards: ? - single character * - any characters

Condition

Value	Description
72	Died in facility

Record Update History

Coder	Updated
Beth Hobson	2023-03-15 21:43

Search Results

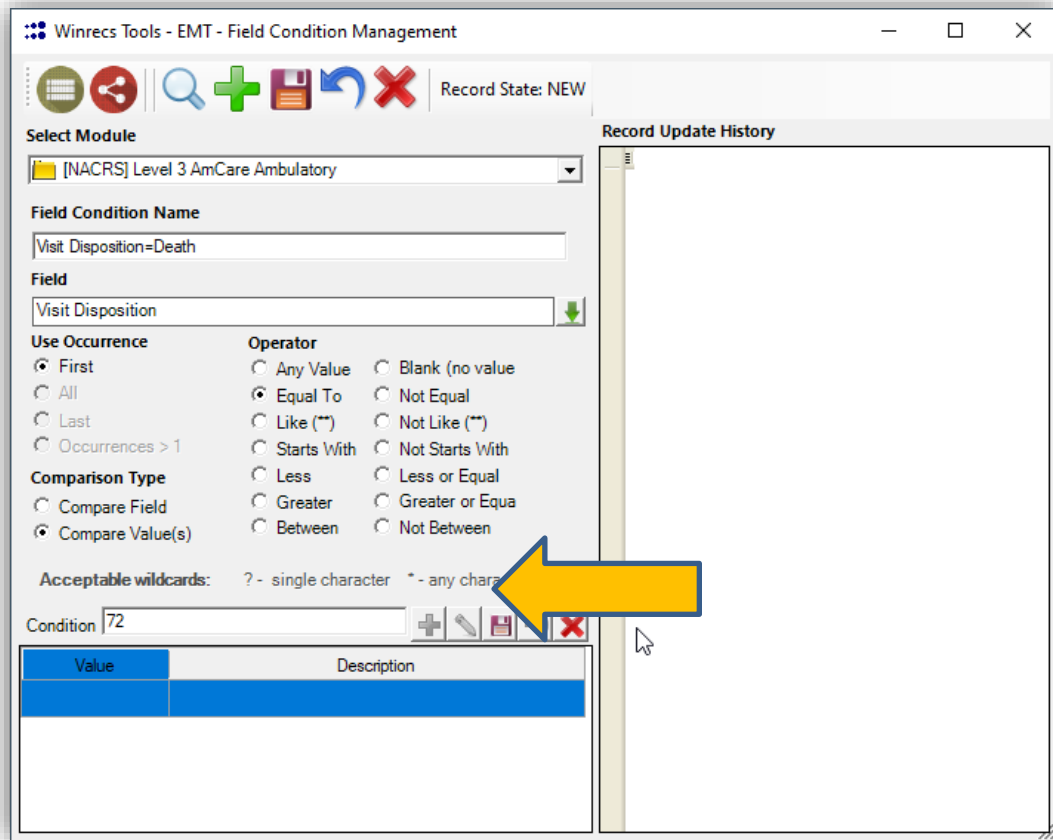
Visit Disposition

User Code	User Description	Validate Code	Validate...	Look Up Note	Valid From	Valid To
06	Admit to reporting facility as...	06	Admit to...	pre-2018: ...	2002-04-01	2099-03-31
07	Admit to reporting facility as...	07	Admit to...	pre-2018: ...	2002-04-01	2099-03-31
08	Transfer to another acute...	08	Transfer to...	pre-2018: ...	2002-04-01	2099-03-31
09	Transfer to another non...	09	Transfer to...	pre-2018: ...	2002-04-01	2099-03-31
12	Intra facility transfer to Day...	12	Intra facility...		2003-04-01	2099-03-31
13	Intra-facility transfer to ED	13	Intra-facility ...	pre-2018: ...	2003-04-01	2099-03-31
14	Intra-facility transfer to Clinic	14	Intra-facility ...		2003-04-01	2099-03-31
16	Discharge to private home,...	16	Discharge to...		2018-04-01	2099-03-31
17	Discharge to private home,...	17	Discharge to...		2018-04-01	2099-03-31
30	Transfer to Residential care	30	Transfer to...		2018-04-01	2099-03-31
40	Transfer to Group/supportive...	40	Transfer to...		2018-04-01	2099-03-31
61	Left at his/her own risk...	61	Left at his/her...		2018-04-01	2099-03-31
62	Left at his/her own risk post...	62	Left at his/her...		2018-04-01	2099-03-31
63	Left after Triage	63	Left after...		2018-04-01	2099-03-31
64	Left after initial assessment	64	Left after...		2018-04-01	2099-03-31
71	Death on Arrival	71	Death on...		2018-04-01	2099-03-31
72	Died in facility	72	Died in facility		2018-04-01	2099-03-31
73	Medical Assistance in Dying...	73	Medical ...		2018-04-01	2099-03-31
74	Suicide in facility	74	Suicide in...		2018-04-01	2099-03-31
90	Transfer to correctional facility	90	Transfer to...		2018-04-01	2099-03-31

20 Matches Found

Select [F7]

Click Save Icon  to save value(s)



Winrecs Tools - EMT - Field Condition Management

Record State: NEW

Select Module
[NACRS] Level 3 AmCare Ambulatory

Field Condition Name
Visit Disposition=Death

Field
Visit Disposition

Use Occurrence
☒ First
☐ All
☐ Last
☐ Occurrences > 1

Operator
☐ Any Value
☒ Equal To
☐ Like (*)
☐ Starts With
☐ Less
☐ Greater
☐ Between
☐ Blank (no value)
☐ Not Equal
☐ Not Like (*)
☐ Not Starts With
☐ Less or Equal
☐ Greater or Equal
☐ Not Between

Comparison Type
☐ Compare Field
☒ Compare Value(s)

Acceptable wildcards: ? - single character * - any character

Condition 72

Value	Description

Field Condition #1

MIS Code =713102000

Condition type to evaluate edit

Field Condition

New [F5]

Field Condition Name

FLD ER MIS Code 713102000

Select Field in Drop Down

Visit MIS Code

User Field Occurrence

First Occurrence

Field Condition Operator

Equal To

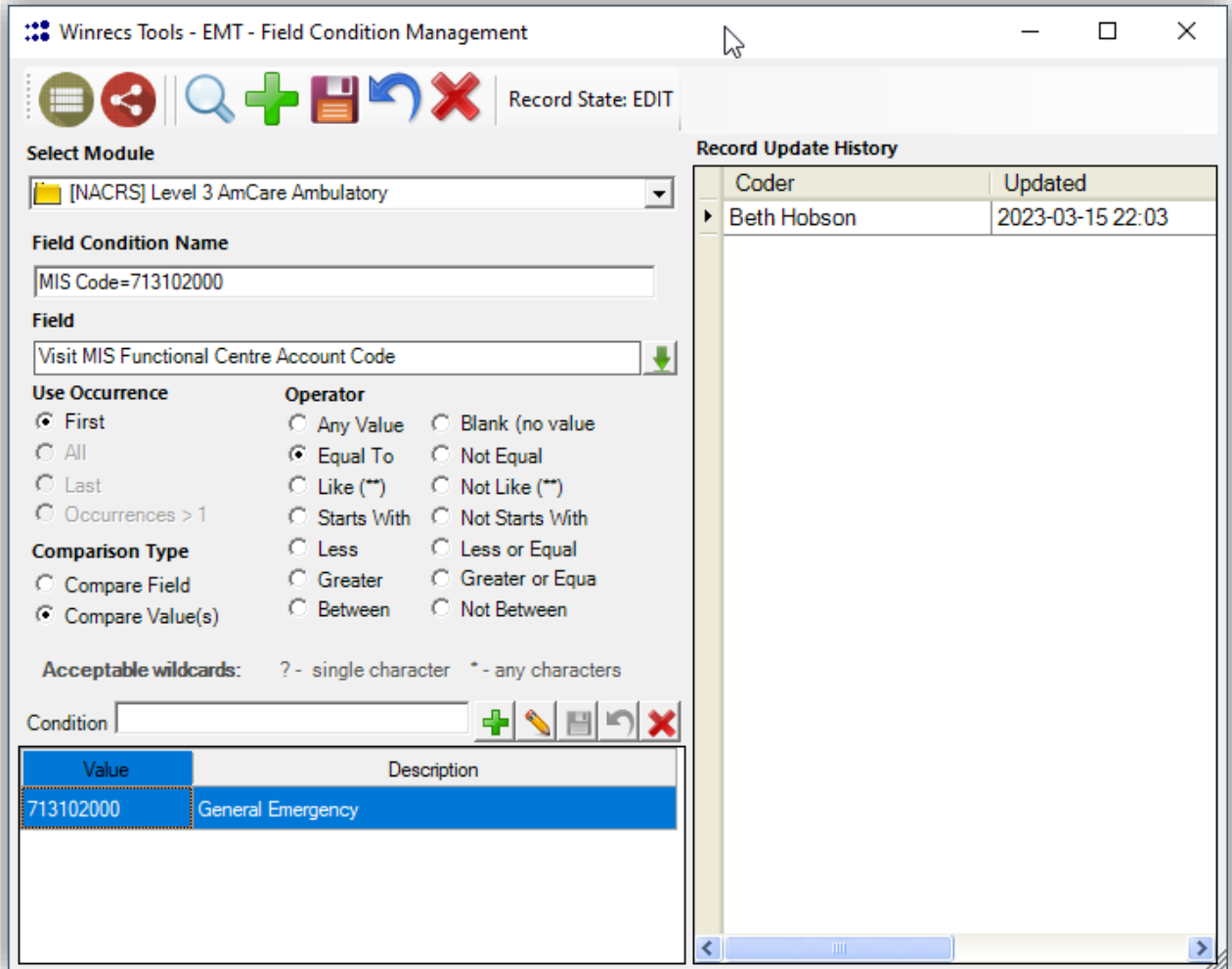
Comparison type

Compare value 713102000

Click Plus Icon  to add value(s)

Click Save Icon  to save value(s)

Save Condition



Winrecs Tools - EMT - Field Condition Management

Record State: EDIT

Select Module: [INACRS] Level 3 AmCare Ambulatory

Field Condition Name: MIS Code=713102000

Field: Visit MIS Functional Centre Account Code

Use Occurrence: ☒ First, ☐ All, ☐ Last, ☐ Occurrences > 1

Operator: ☒ Any Value, ☐ Blank (no value), ☒ Equal To, ☐ Not Equal, ☐ Like (**), ☐ Not Like (**), ☐ Starts With, ☐ Not Starts With, ☐ Less, ☐ Less or Equal, ☐ Greater, ☐ Greater or Equal, ☐ Between, ☐ Not Between

Comparison Type: ☐ Compare Field, ☒ Compare Value(s)

Acceptable wildcards: ? - single character * - any characters

Condition:

Value	Description
713102000	General Emergency

Record Update History

Coder	Updated
Beth Hobson	2023-03-15 22:03

Field Condition #2

Death Disposition = 10 or 11

Condition type to evaluate edit

Field Condition

New [F5]

Field Condition Name

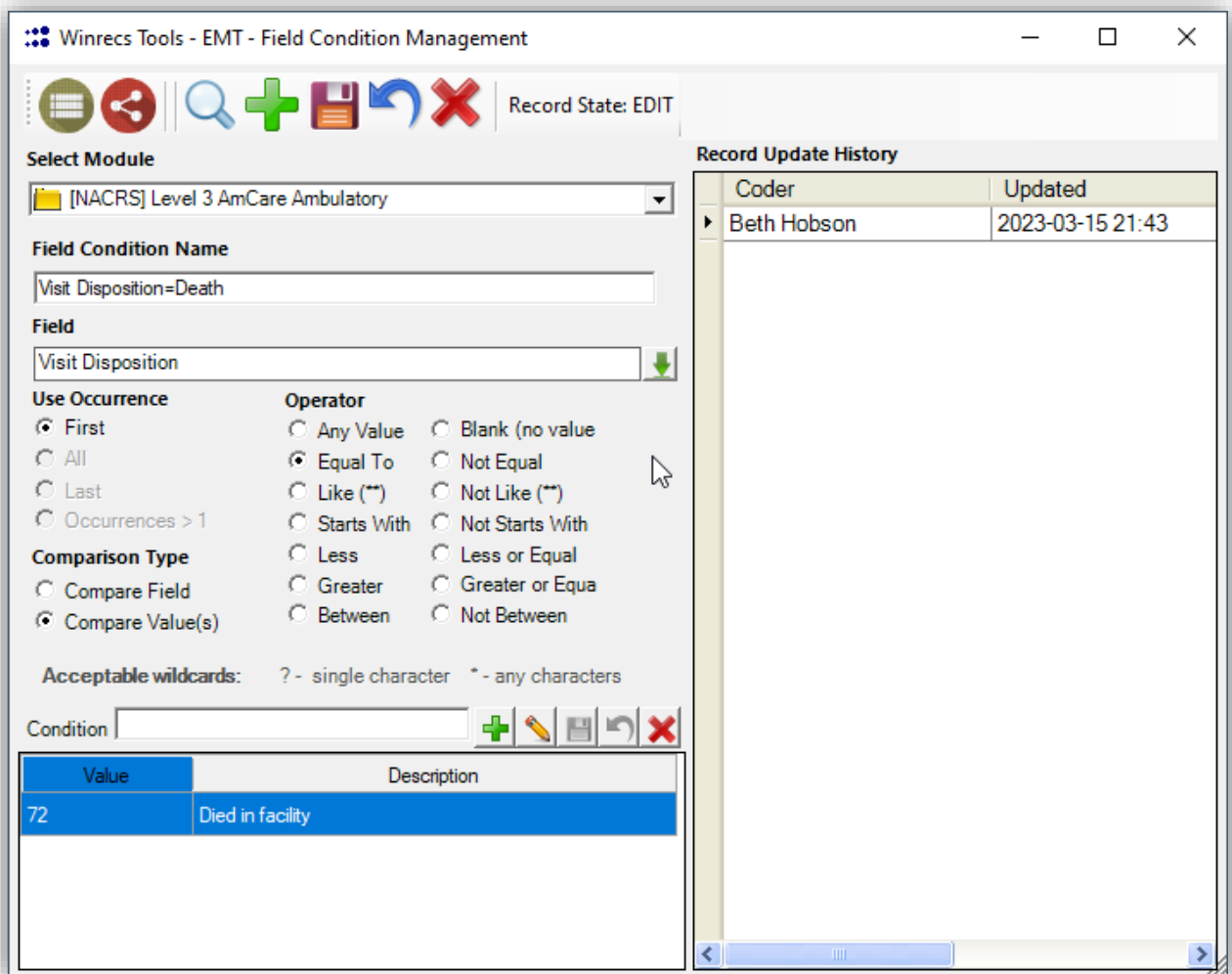
FLD Death Disposition Code 10 or 11

Select Field in Drop Down

Visit Disposition Code

User Field Occurrence

First Occurrence
 Field Condition Operator
 Equal To
 Comparison type
 Compare value 10, 11
 Click Plus Icon  to add value(s)
 Click Save Icon  to save value(s)
 Save [F7]



Winrecs Tools - EMT - Field Condition Management

Record State: EDIT

Select Module
 [NACRS] Level 3 AmCare Ambulatory

Field Condition Name
 Visit Disposition=Death

Field
 Visit Disposition

Use Occurrence
☒ First
☐ All
☐ Last
☐ Occurrences > 1

Operator
☐ Any Value
☒ Equal To
☐ Like (**)
☐ Starts With
☐ Less
☐ Greater
☐ Between
☐ Blank (no value)
☐ Not Equal
☐ Not Like (**)
☐ Not Starts With
☐ Less or Equal
☐ Greater or Equal
☐ Not Between

Comparison Type
☐ Compare Field
☒ Compare Value(s)

Acceptable wildcards: ? - single character * - any characters

Condition     

Value	Description
72	Died in facility

Record Update History

Coder	Updated
Beth Hobson	2023-03-15 21:43

Field Condition #3
Triage Level not 1-Resuscitation
 Condition type to evaluate edit

Field Condition
New [F5]
Field Condition Name
FLD Triage Level not 1-Resusitation
Select Field in Drop Down
Triage Level
User Field Occurrence
First Occurrence
Field Condition Operator
Not Equal To
Comparison type
Compare value 1
Click Plus Icon  to add value(s)
Click Save Icon  to save value(s)
Save [F7]

Winrecs Tools - EMT - Field Condition Management

Record State: EDIT

Select Module
[NACRS] Level 3 AmCare Ambulatory

Field Condition Name
Triage Level <> 1-Resusus

Field
Triage Level (CTAS)

Use Occurrence
☒ First
☐ All
☐ Last
☐ Occurrences > 1

Operator
☐ Any Value
☐ Equal To
☐ Like (**)
☐ Starts With
☐ Less
☐ Greater
☐ Between
☐ Blank (no value)
☒ Not Equal
☐ Not Like (**)
☐ Not Starts With
☐ Less or Equal
☐ Greater or Equal
☐ Not Between

Comparison Type
☐ Compare Field
☒ Compare Value(s)

Acceptable wildcards: ? - single character * - any characters

Condition

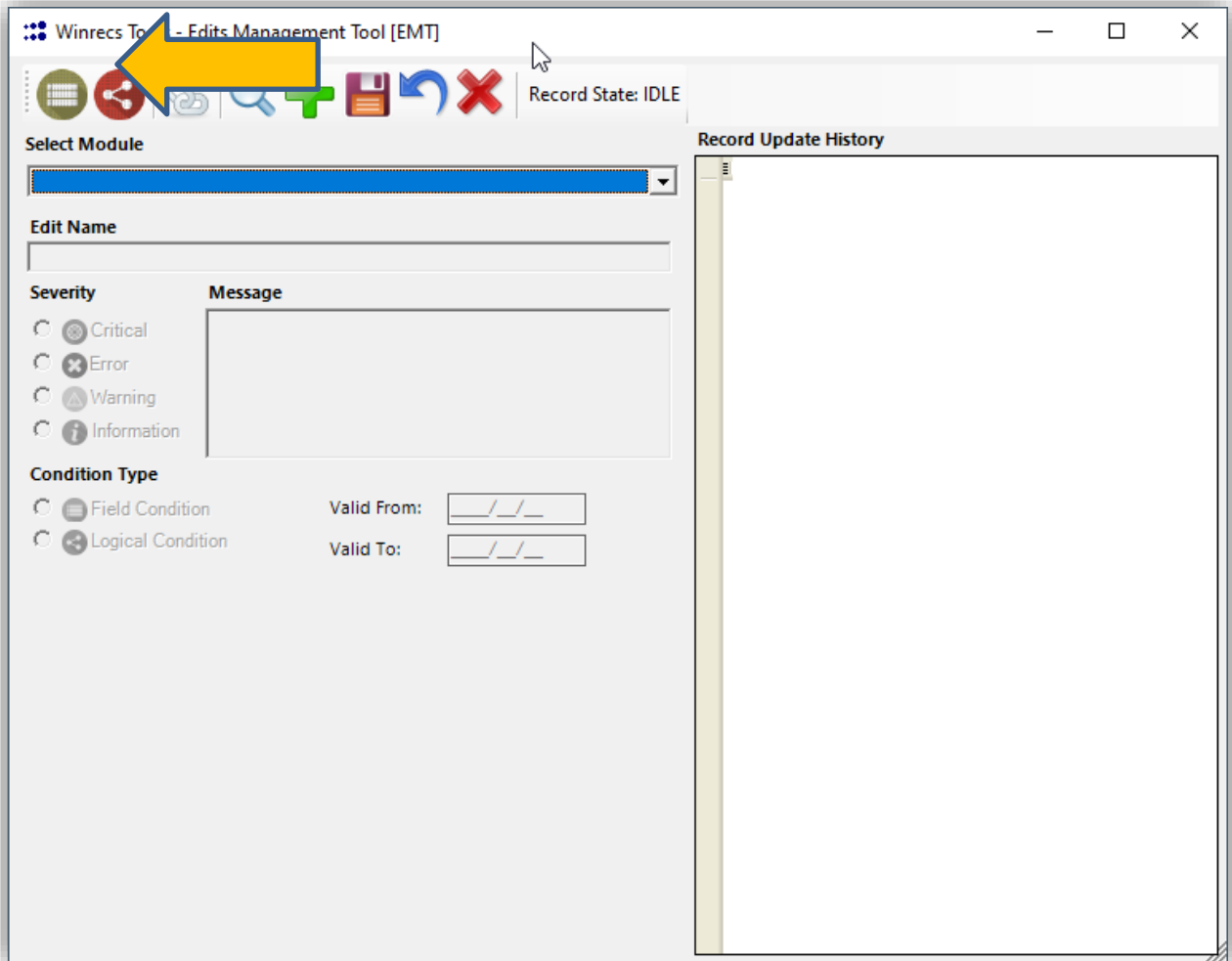
Value	Description
1	Resuscitation

Record Update History

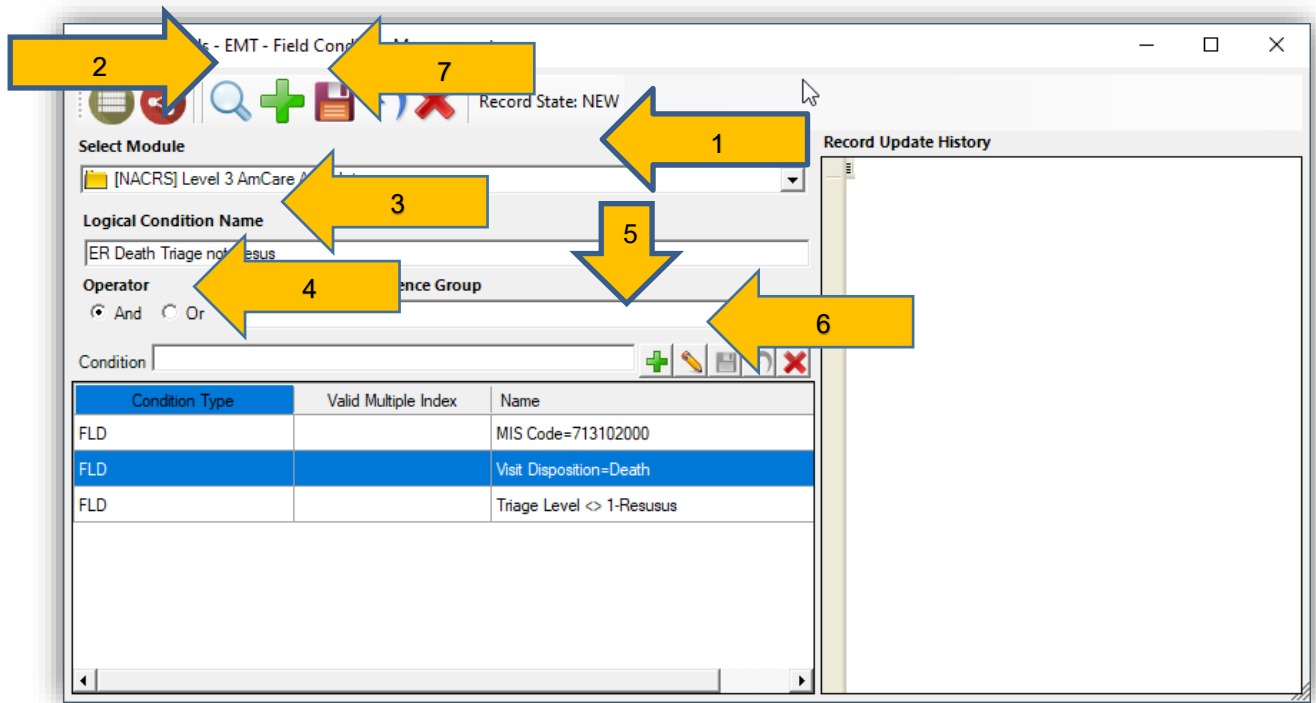
Coder	Updated
Beth Hobson	2023-03-15 22:05

Step 2: Create Logical Condition(s)

Click on Logical Condition Editor



1. Select Module
2. Click NEW
3. Logical Condition Name
4. Select Operator
5. Select PLUS sign to add conditions
6. Click save to save conditions involved
7. Click save in Tool Bar



Record State: NEW

Select Module

[INACRS] Level 3 AmCare Ambulatory

Logical Condition Name

ER Death Triage not Resus

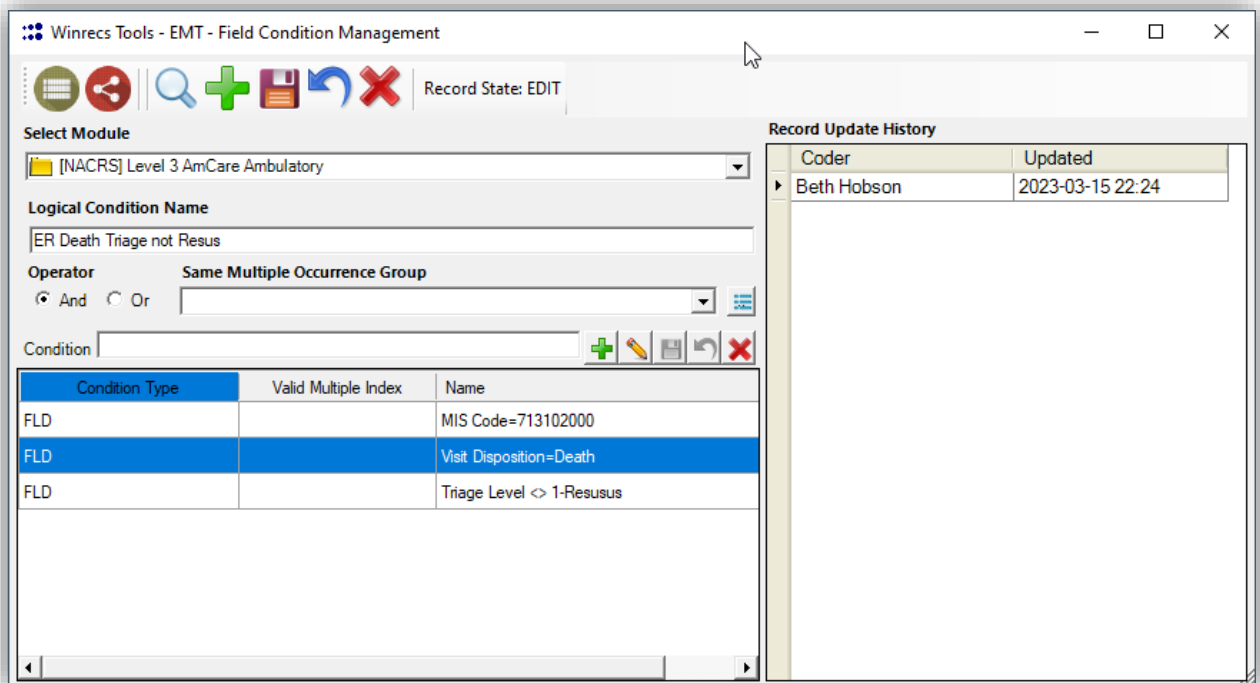
Operator

☒ And ☐ Or

Condition

Condition Type	Valid Multiple Index	Name
FLD		MIS Code=713102000
FLD		Visit Disposition=Death
FLD		Triage Level <> 1-Resus

Record Update History



Winrecs Tools - EMT - Field Condition Management

Record State: EDIT

Select Module

[INACRS] Level 3 AmCare Ambulatory

Logical Condition Name

ER Death Triage not Resus

Operator

☒ And ☐ Or

Same Multiple Occurrence Group

Condition

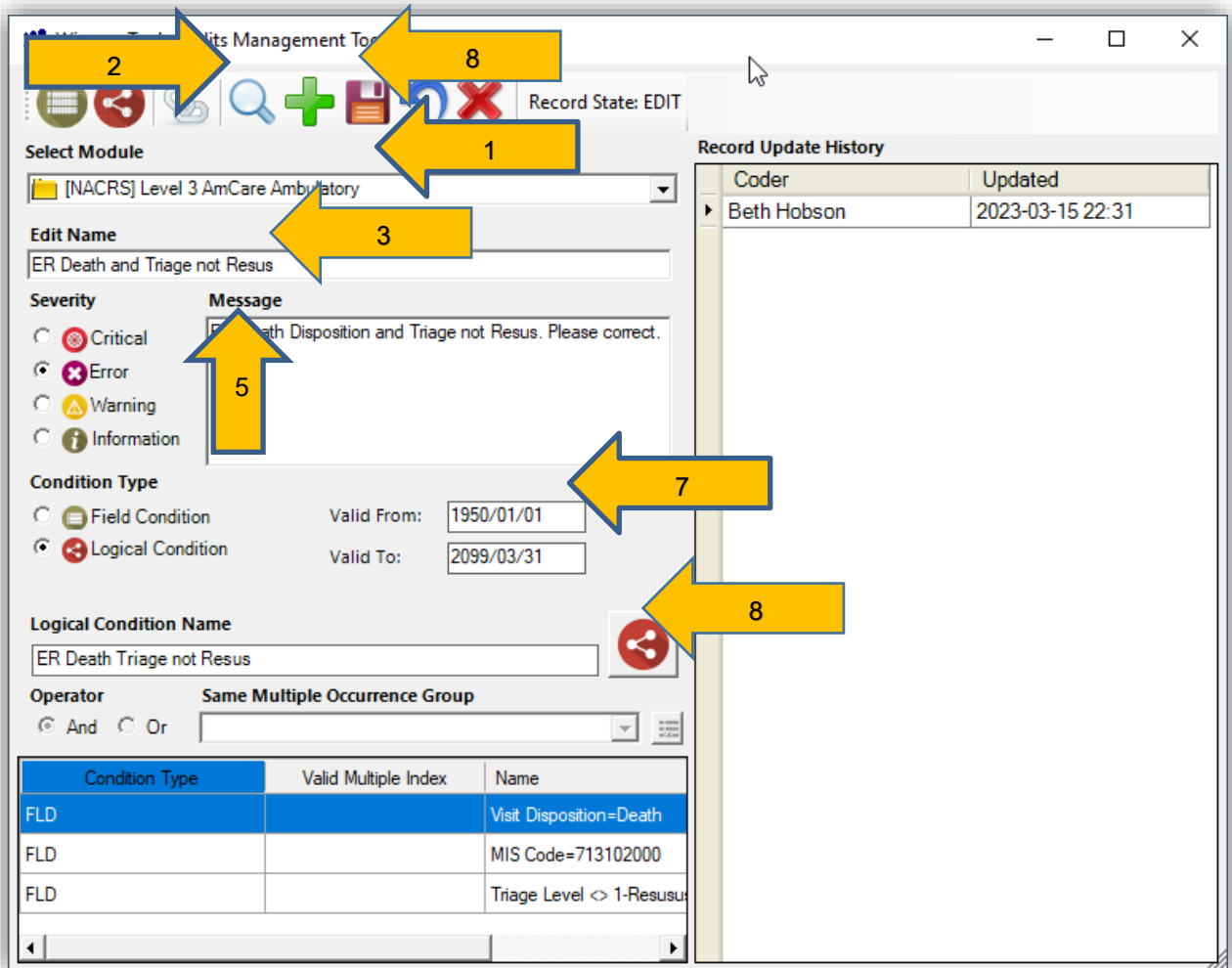
Condition Type	Valid Multiple Index	Name
FLD		MIS Code=713102000
FLD		Visit Disposition=Death
FLD		Triage Level <> 1-Resus

Record Update History

Coder	Updated
Beth Hobson	2023-03-15 22:24

Step 3: Create Edit

1. Select the Module
2. Click New
3. Edit Name
4. Select Severity level
5. Input Message
6. Select Condition Type
7. Enter Valid From and Valid To date
8. Click on Logical Condition icon and select Logical Condition
9. Click save icon to save Edit.



Select Module

[NACRS] Level 3 AmCare Ambulatory

Edit Name

ER Death and Triage not Resus

Severity

☐ Critical

☒ Error

☐ Warning

☐ Information

Message

ER Death Disposition and Triage not Resus. Please correct.

Condition Type

☐ Field Condition

☒ Logical Condition

Valid From: 1950/01/01

Valid To: 2099/03/31

Logical Condition Name

ER Death Triage not Resus

Operator Same Multiple Occurrence Group

☒ And ☐ Or

Condition Type	Valid Multiple Index	Name
FLD		Visit Disposition=Death
FLD		MIS Code=713102000
FLD		Triage Level <> 1-Resus

Record Update History

Coder	Updated
Beth Hobson	2023-03-15 22:31

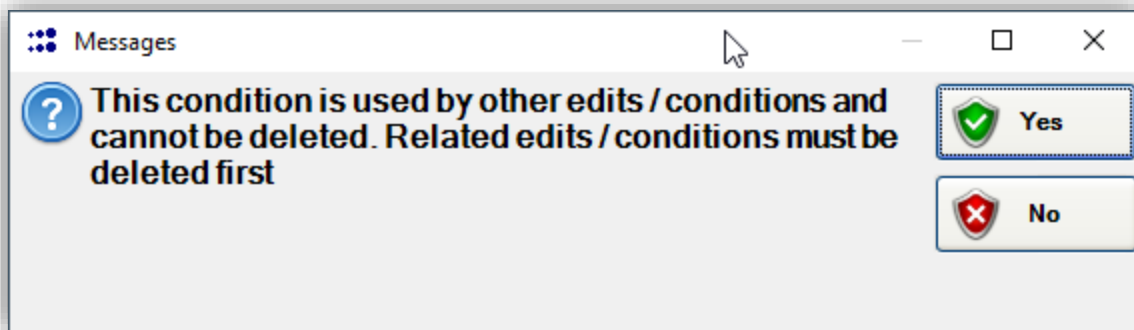
Deleting an Edit

In order to delete an edit so it no longer displays in the abstract, click  F9 Delete

Delete Logical Condition

In order to delete a Logical Condition, it cannot be used in another edit or another

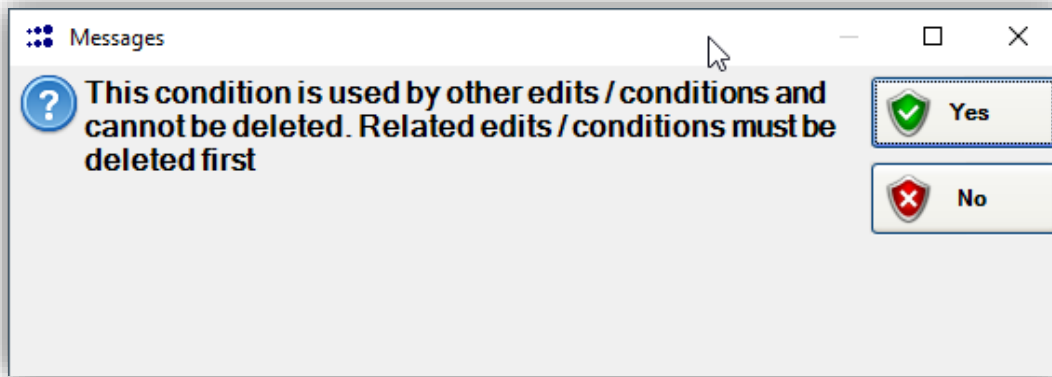
Logical Condition. To delete a Logical Condition click  F9 Delete
If a Logical Condition is used in another edit, a prompt will display.



Delete Field Condition

Field Conditions can only be deleted if not used in a Logical Condition or another

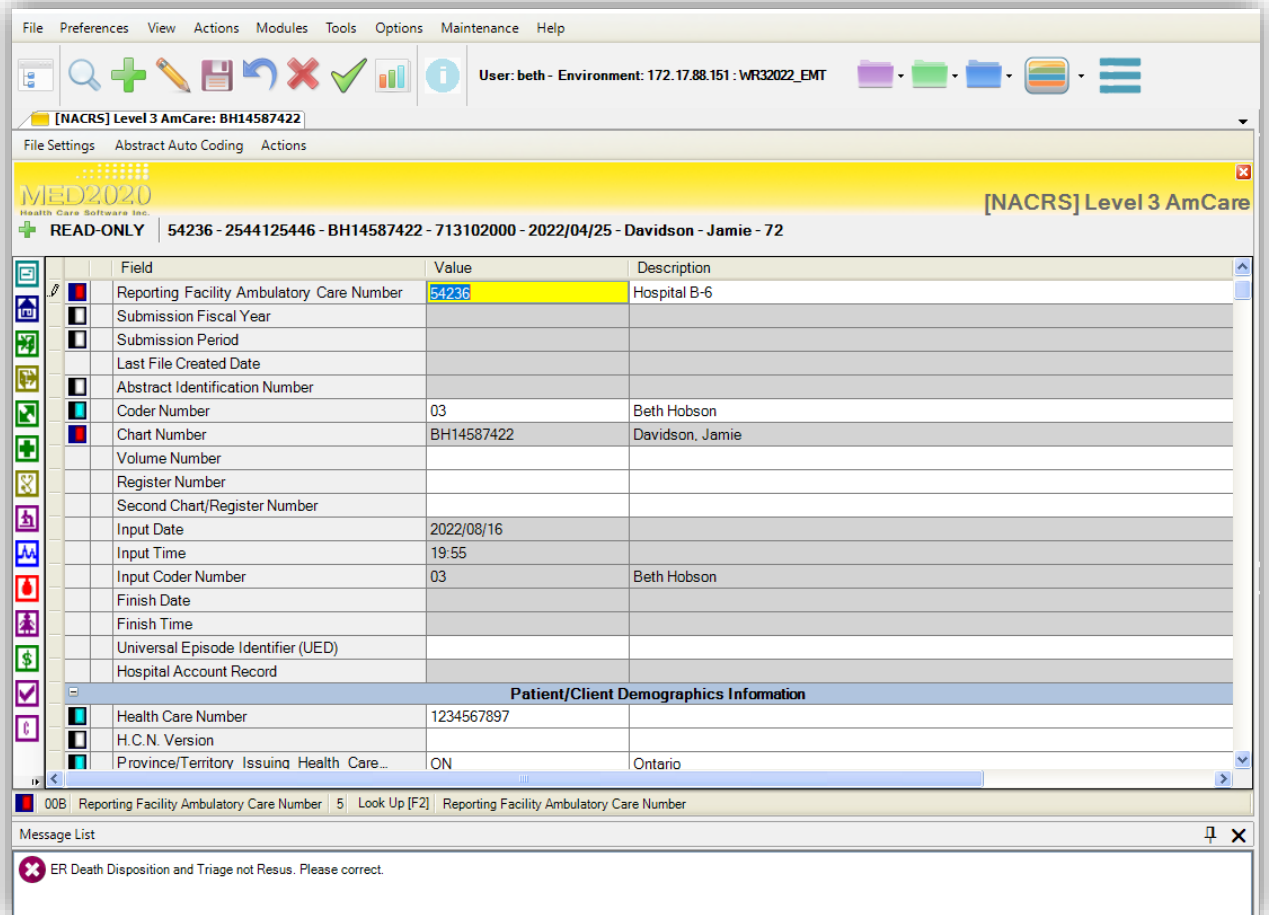
edit. In order to delete a Field Condition click  F9 Delete
If a Field Condition is used in another edit, a prompt will display.



Access visit and verify abstract

Amcare Abstract

Message should generate in message list box. If message does not generate upon load, F11 Verfiy.



Field	Value	Description
Reporting Facility Ambulatory Care Number	54236	Hospital B-6
Submission Fiscal Year		
Submission Period		
Last File Created Date		
Abstract Identification Number		
Coder Number	03	Beth Hobson
Chart Number	BH14587422	Davidson, Jamie
Volume Number		
Register Number		
Second Chart/Register Number		
Input Date	2022/08/16	
Input Time	19:55	
Input Coder Number	03	Beth Hobson
Finish Date		
Finish Time		
Universal Episode Identifier (UED)		
Hospital Account Record		
Patient/Client Demographics Information		
Health Care Number	1234567897	
H.C.N. Version		
Province/Territory Issuing Health Care...	ON	Ontario

00B Reporting Facility Ambulatory Care Number | 5 | Look Up [F2] Reporting Facility Ambulatory Care Number

Message List

ER Death Disposition and Triage not Resus. Please correct.

Is Custom Validated field

In the abstract there is a field called 'Is Custom Validated'. The Valid Values are:

Yes

When there are no EMT messages generated when abstract is verified, the field will populate a Y.

Custom Errors Found

When there are EMT messages that contain errors, the field will populate an E.

Custom Warnings Found

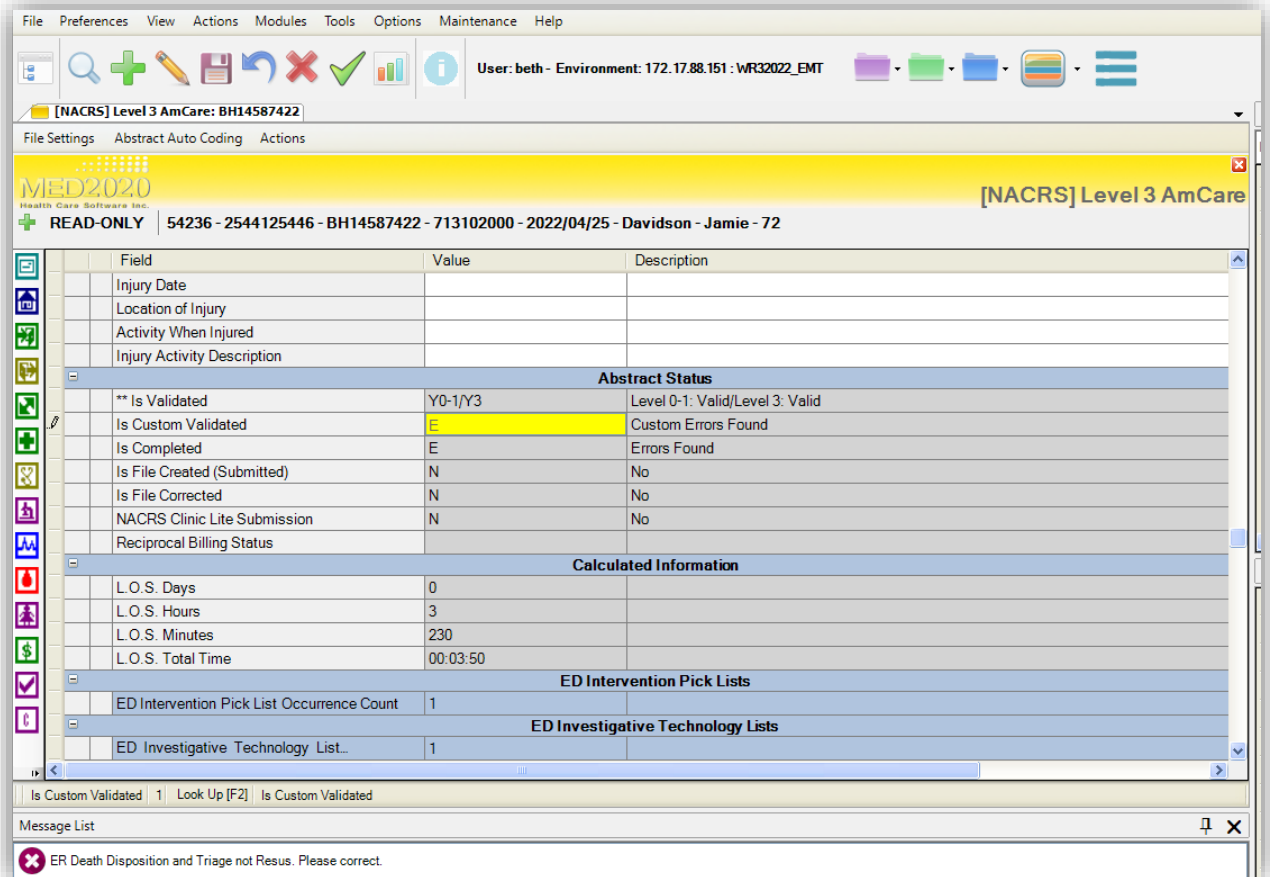
When there are EMT messages that contain warnings, the field will populate a W.

Custom Information Found

When there are EMT message that contains information, the field will populate an I.

No

When EMT message are not yet verified in the abstract, this field will populate an N.



File Preferences View Actions Modules Tools Options Maintenance Help

User: beth - Environment: 172.17.88.151 : WR32022_EMT

[NACRS] Level 3 AmCare: BH14587422

File Settings Abstract Auto Coding Actions

MED2020 Health Care Software Inc. [NACRS] Level 3 AmCare

READ-ONLY | 54236 - 2544125446 - BH14587422 - 713102000 - 2022/04/25 - Davidson - Jamie - 72

Field	Value	Description
Injury Date		
Location of Injury		
Activity When Injured		
Injury Activity Description		
Abstract Status		
** Is Validated	Y0-1/Y3	Level 0-1: Valid/Level 3: Valid
Is Custom Validated	E	Custom Errors Found
Is Completed	E	Errors Found
Is File Created (Submitted)	N	No
Is File Corrected	N	No
NACRS Clinic Lite Submission	N	No
Reciprocal Billing Status		
Calculated Information		
L.O.S. Days	0	
L.O.S. Hours	3	
L.O.S. Minutes	230	
L.O.S. Total Time	00:03:50	
ED Intervention Pick Lists		
ED Intervention Pick List Occurrence Count	1	
ED Investigative Technology Lists		
ED Investigative Technology List...	1	

Is Custom Validated | 1 | Look Up [F2] | Is Custom Validated

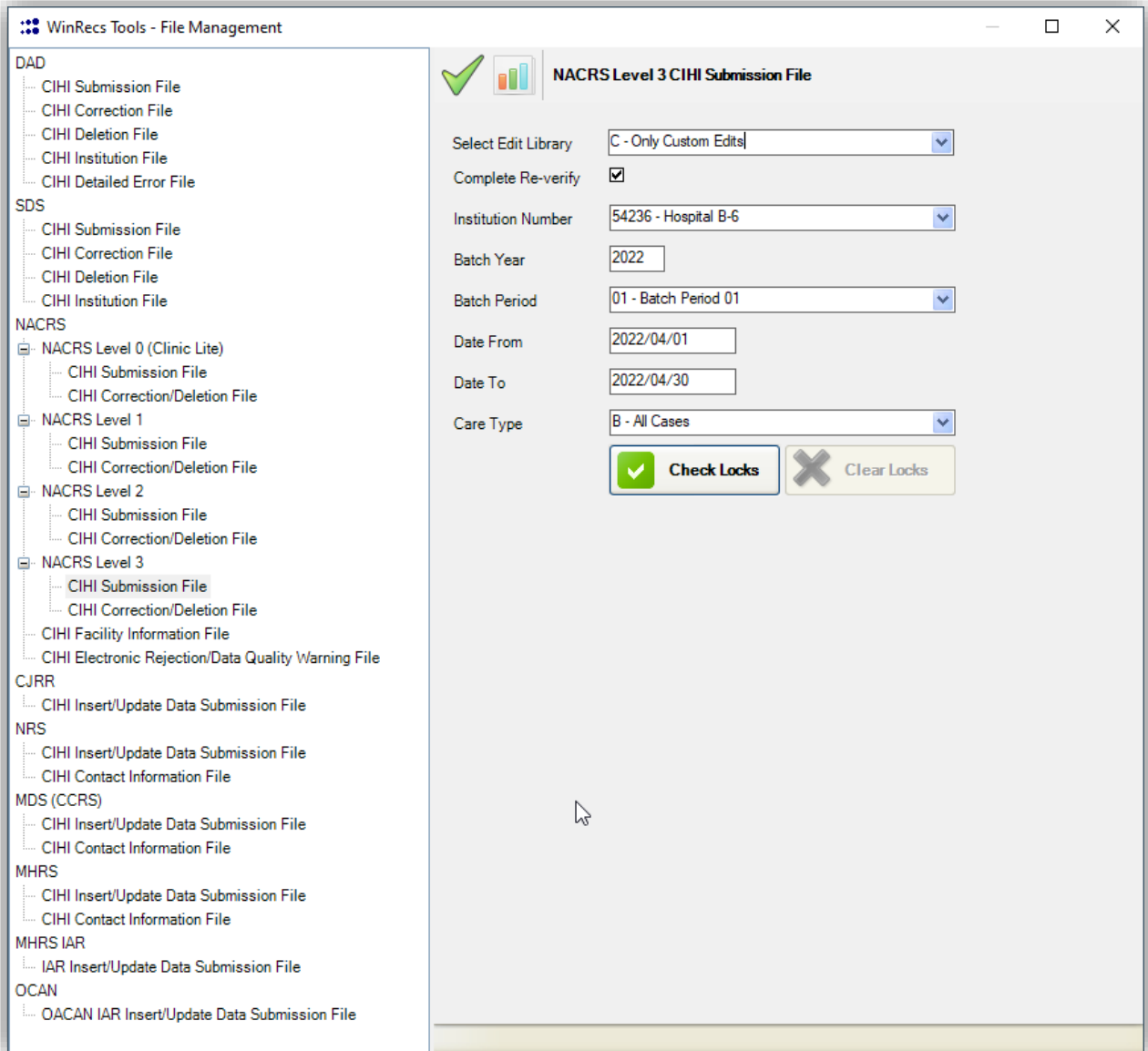
Message List

ER Death Disposition and Triage not Resus. Please correct.

Batch Verify

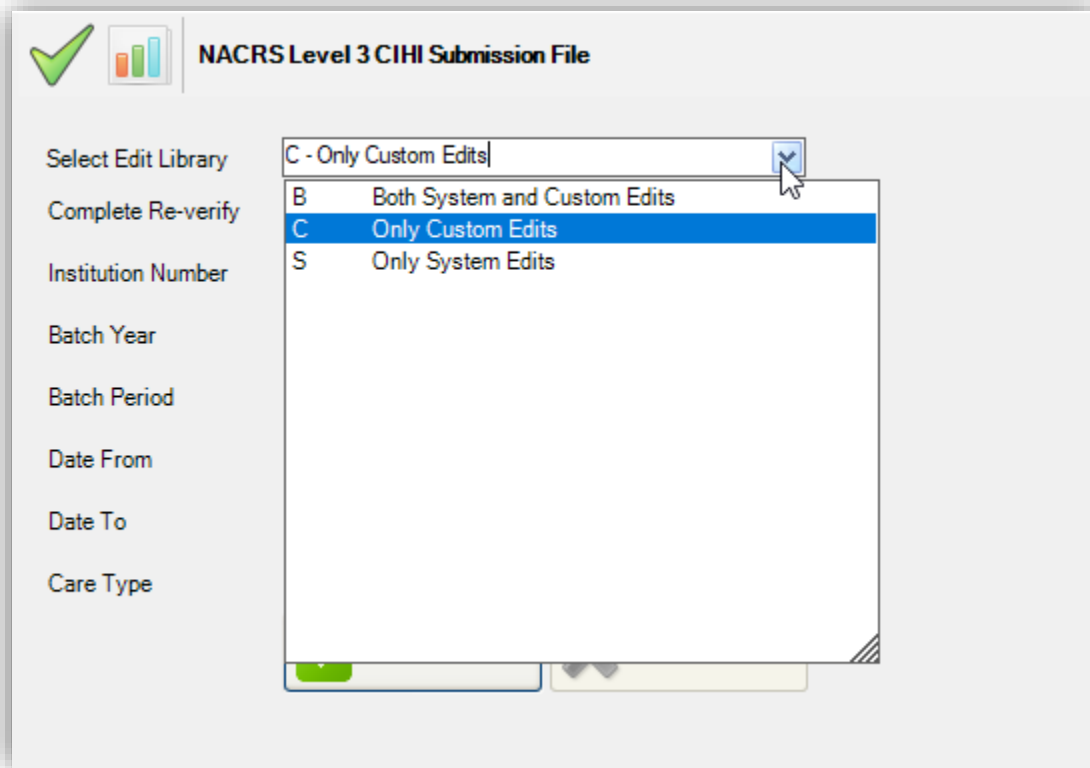
An option to verify all visits to see if EMT edits apply.

Tools>File Management>Submission File



The screenshot shows the 'WinRecs Tools - File Management' window. On the left is a tree view of file categories: DAD, SDS, NACRS (with sub-levels 0, 1, 2, 3), CJRR, NRS, MDS (CCRS), MHRS, MHRS IAR, and OCAN. The 'NACRS Level 3 CIHI Submission File' is selected. The right pane shows configuration options for this file type, including a 'Select Edit Library' dropdown (set to 'C - Only Custom Edits'), a 'Complete Re-verify' checkbox (checked), an 'Institution Number' dropdown (set to '54236 - Hospital B-6'), a 'Batch Year' text box (set to '2022'), a 'Batch Period' dropdown (set to '01 - Batch Period 01'), 'Date From' and 'Date To' text boxes (set to '2022/04/01' and '2022/04/30' respectively), and a 'Care Type' dropdown (set to 'B - All Cases'). At the bottom of the right pane are two buttons: 'Check Locks' (with a green checkmark icon) and 'Clear Locks' (with a grey X icon).

Select Edit Library



The screenshot shows a software window titled "NACRS Level 3 CIHI Submission File". On the left is a sidebar with a green checkmark icon and a bar chart icon, followed by labels: "Select Edit Library", "Complete Re-verify", "Institution Number", "Batch Year", "Batch Period", "Date From", "Date To", and "Care Type". The "Select Edit Library" dropdown menu is open, showing three options: "B Both System and Custom Edits", "C Only Custom Edits" (which is highlighted in blue), and "S Only System Edits". A mouse cursor is pointing at the dropdown arrow.

Both System and Custom Edits

This will perform the verify on the CIHI or provincial edits along with EMT edits at the same time.

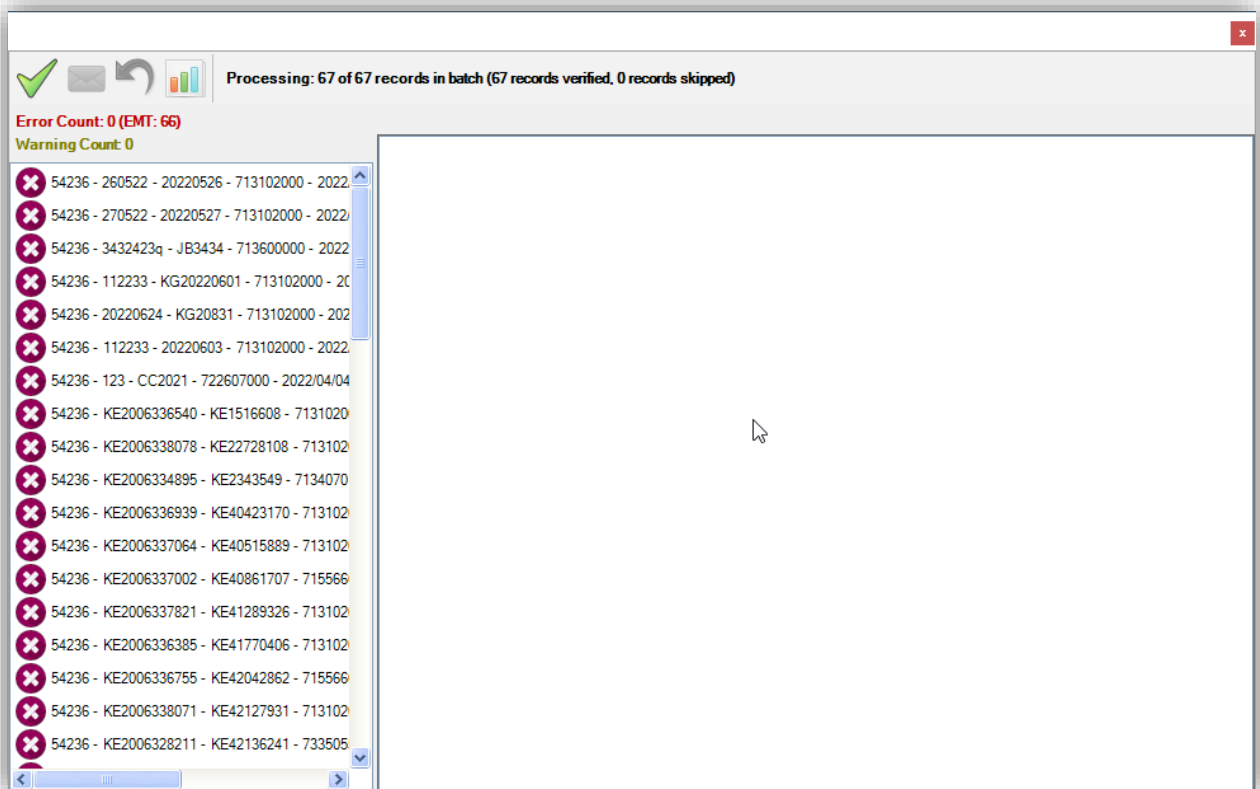
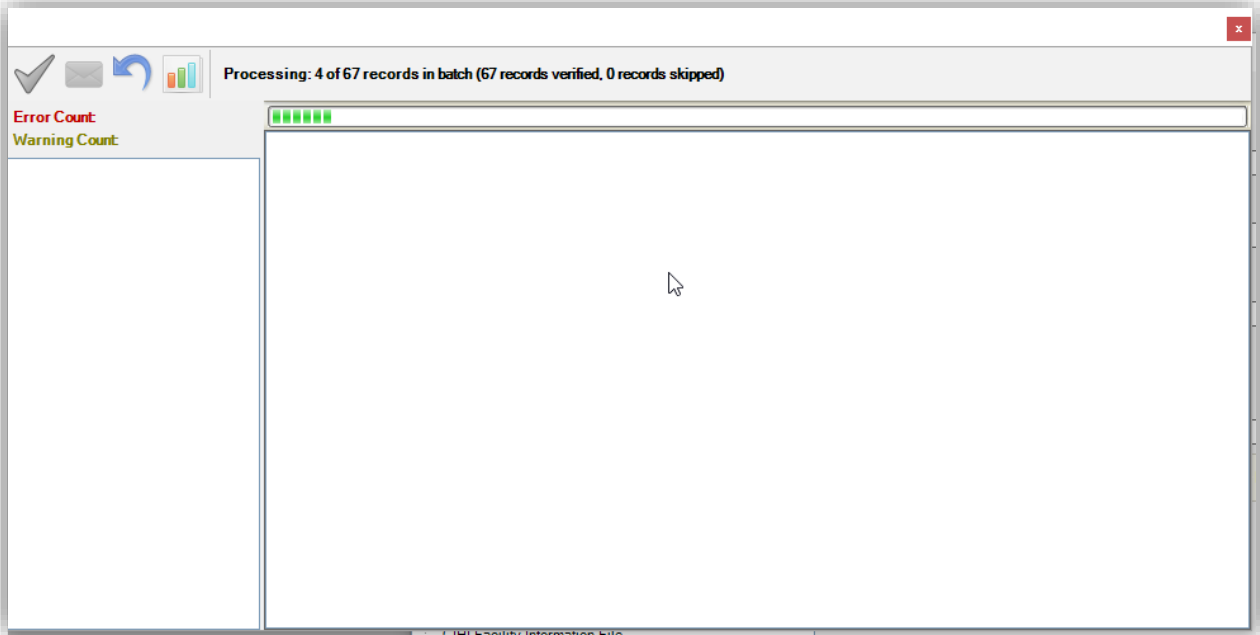
Only Custom Edits

This will perform the verify on the EMT edits only.

Only System Edits

This will perform the verify on the CIHI and provincial edits only.

When click Verify



Report Generator

Existing views have been modified

AbstractingErrorsWarnings_VR

Message Level: Custom Errors

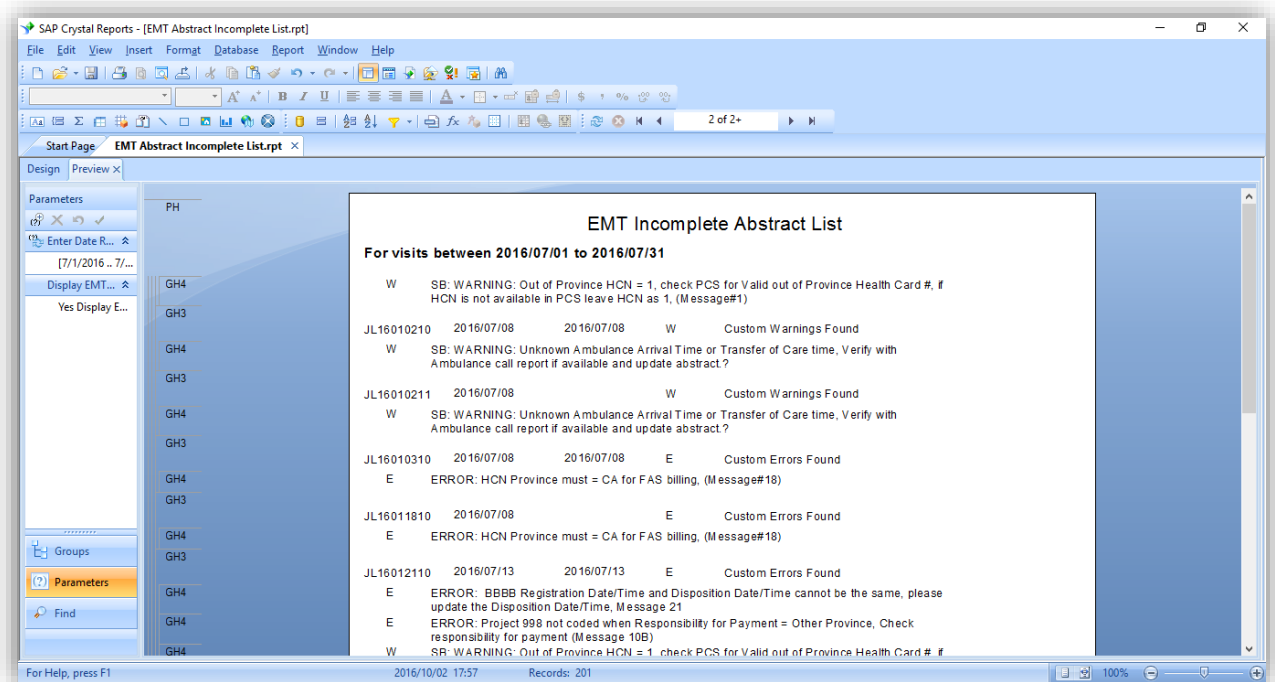
Custom Warnings

Custom Information

I10 views

The 'Is Custom Validated' field has been added to all the I10 views.

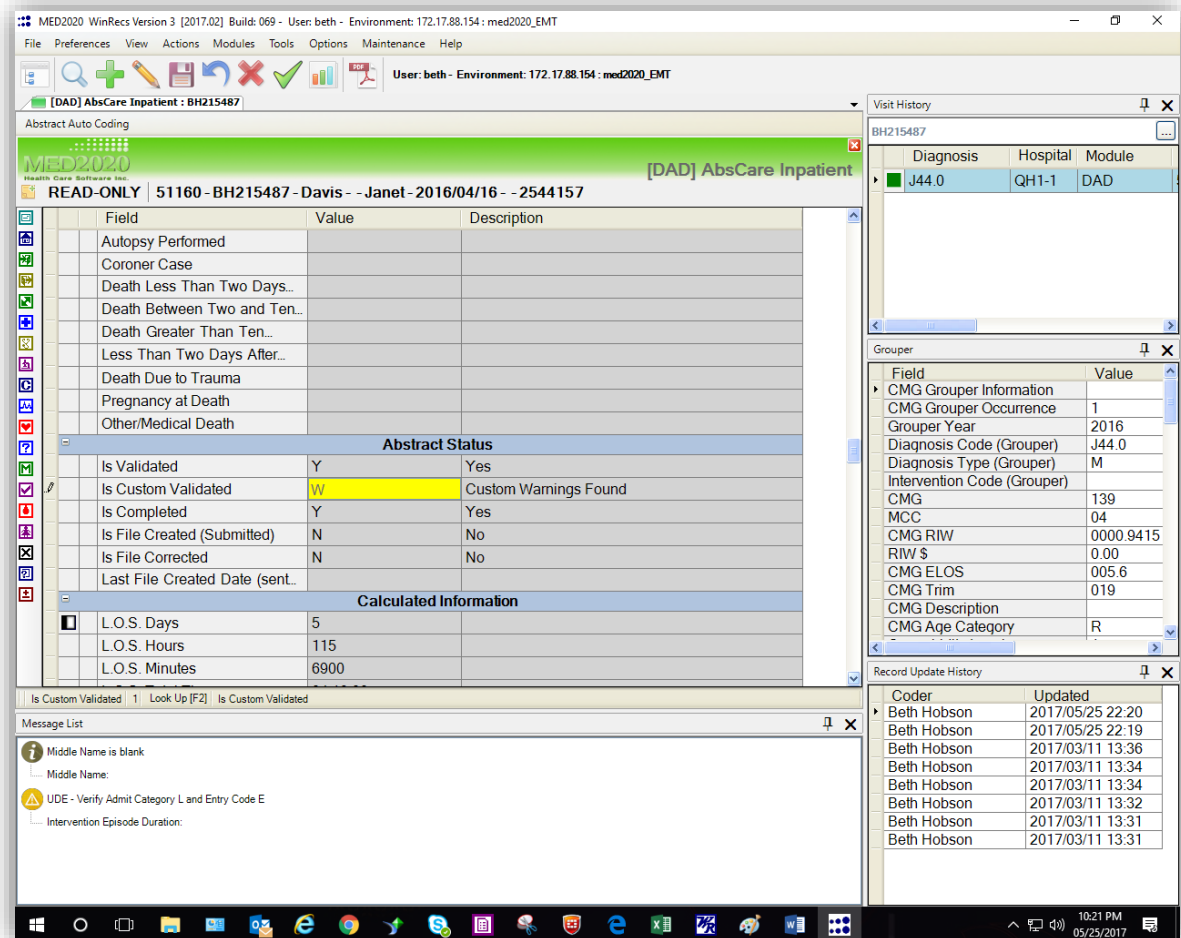
A report called EMT Incomplete Abstract List has been developed.



Access Visit and Verify Abstract

Amcare Abstract

Message should generate in message list box. If message does not generate upon load, F11 Verify.



Abstract Auto Coding

[DAD] AbsCare Inpatient : BH215487

READ-ONLY 51160 - BH215487 - Davis - - Janet - 2016/04/16 - - 2544157

Field	Value	Description
Autopsy Performed		
Coroner Case		
Death Less Than Two Days...		
Death Between Two and Ten...		
Death Greater Than Ten...		
Less Than Two Days After...		
Death Due to Trauma		
Pregnancy at Death		
Other/Medical Death		

Abstract Status

Field	Value	Description
Is Validated	Y	Yes
Is Custom Validated	W	Custom Warnings Found
Is Completed	Y	Yes
Is File Created (Submitted)	N	No
Is File Corrected	N	No
Last File Created Date (sent...		

Calculated Information

Field	Value
L.O.S. Days	5
L.O.S. Hours	115
L.O.S. Minutes	6900

Message List

- Middle Name is blank
- Middle Name:
- UDE - Verify Admit Category L and Entry Code E
- Intervention Episode Duration:

Visit History

Diagnosis	Hospital	Module
J44.0	QH1-1	DAD

Grouper

Field	Value
CMG Grouper Information	
CMG Grouper Occurrence	1
Grouper Year	2016
Diagnosis Code (Grouper)	J44.0
Diagnosis Type (Grouper)	M
Intervention Code (Grouper)	
CMG	139
MCC	04
CMG RIW	0000.9415
RIW \$	0.00
CMG ELOS	005.6
CMG Trim	019
CMG Description	
CMG Age Category	R

Record Update History

Coder	Updated
Beth Hobson	2017/05/25 22:20
Beth Hobson	2017/05/25 22:19
Beth Hobson	2017/03/11 13:36
Beth Hobson	2017/03/11 13:34
Beth Hobson	2017/03/11 13:34
Beth Hobson	2017/03/11 13:32
Beth Hobson	2017/03/11 13:31
Beth Hobson	2017/03/11 13:31

Is Custom Validated field

In the abstract, there is a field called 'Is Custom Validated'. The Valid Values are:

Yes

When there are no EMT messages generated when abstract is verified, the field will populate a Y.

Custom Errors Found

When there are EMT messages that contain errors, the field will populate an E.

Custom Warnings Found

When there are EMT messages that contain warnings, the field will populate a W.

Custom Information Found

When there are EMT message that contains information, the field will populate an I.

No

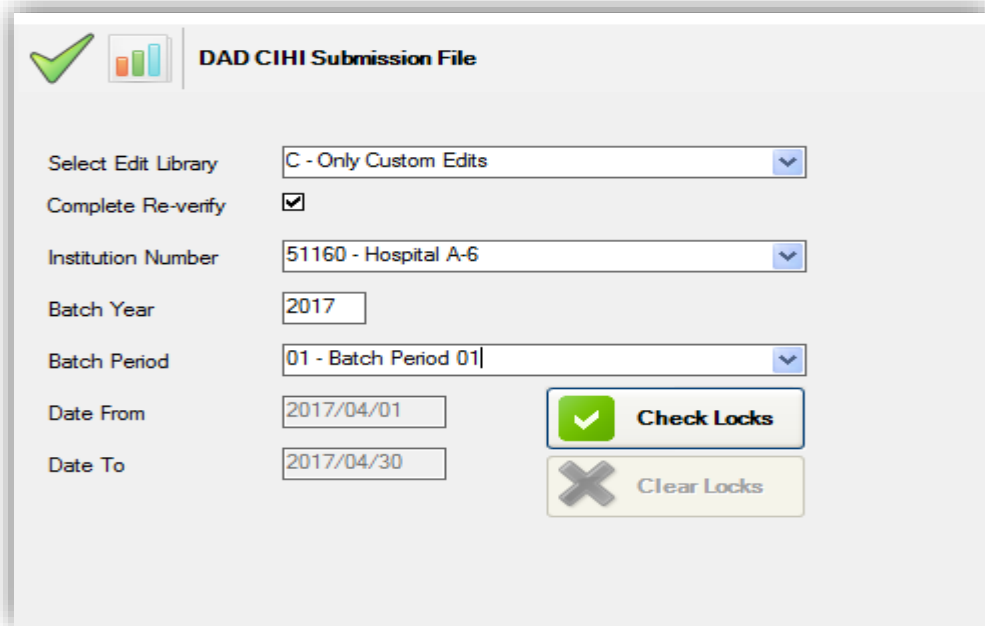
When EMT message are not yet verified in the abstract, this field will populate an N.

Abstract Status			
	Is Validated	Y	Yes
	Is Custom Validated	W	Custom Warnings Found
	Is Completed	Y	Yes
	Is File Created (Submitted)	N	No
	Is File Corrected	N	No
	Last File Created Date (sent..		
Calculated Information			
	L.O.S. Days	5	
	L.O.S. Hours	115	
	L.O.S. Minutes	6900	

Batch Verify

An option to verify all visits to see if EMT edits apply.

Tools>File Management>DAD>CIHI File Submission



DAD CIHI Submission File

Select Edit Library: C - Only Custom Edits

Complete Re-verify: ☒

Institution Number: 51160 - Hospital A-6

Batch Year: 2017

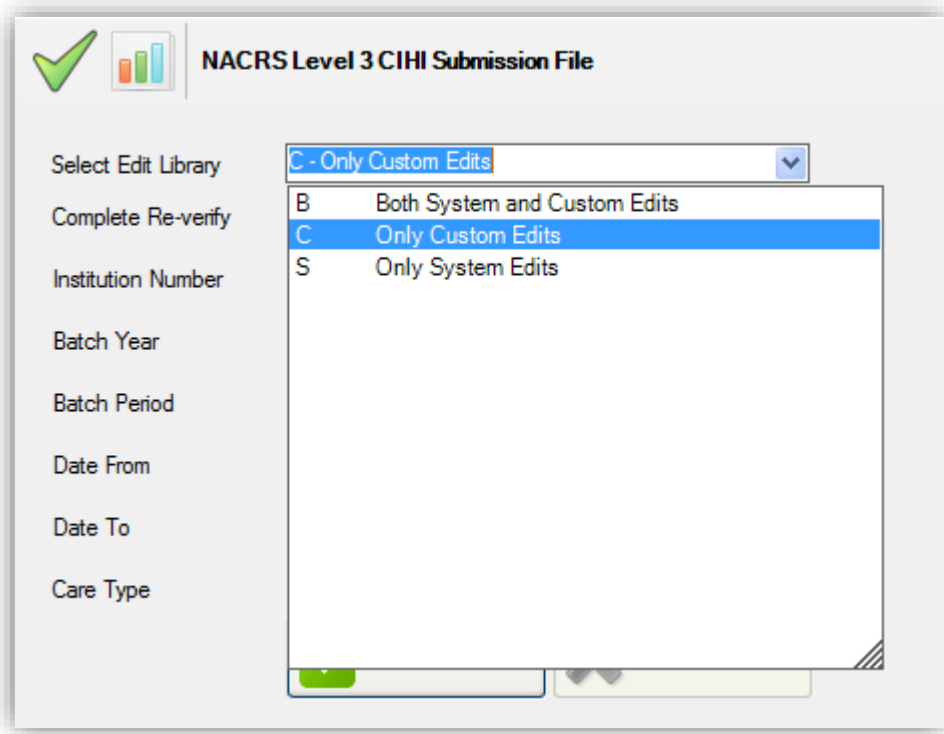
Batch Period: 01 - Batch Period 01

Date From: 2017/04/01

Date To: 2017/04/30

Please Note: For Amare select Tools>File Management>NACRS Level 3>CIHI File Submission

Select Edit Library



Both System and Custom Edits

This will perform the verify on the CIHI or provincial edits along with EMT edits at the same time.

Only Custom Edits

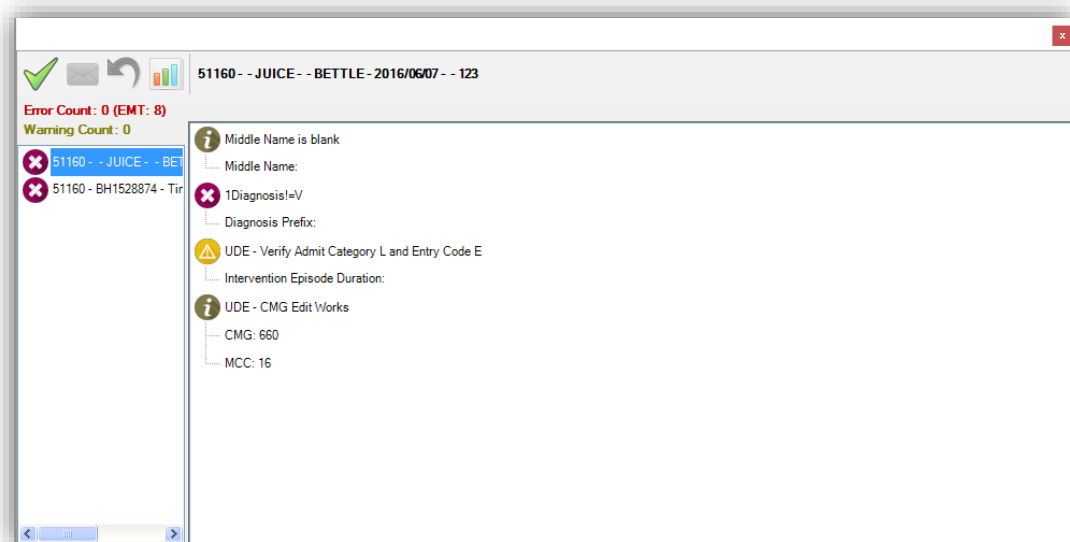
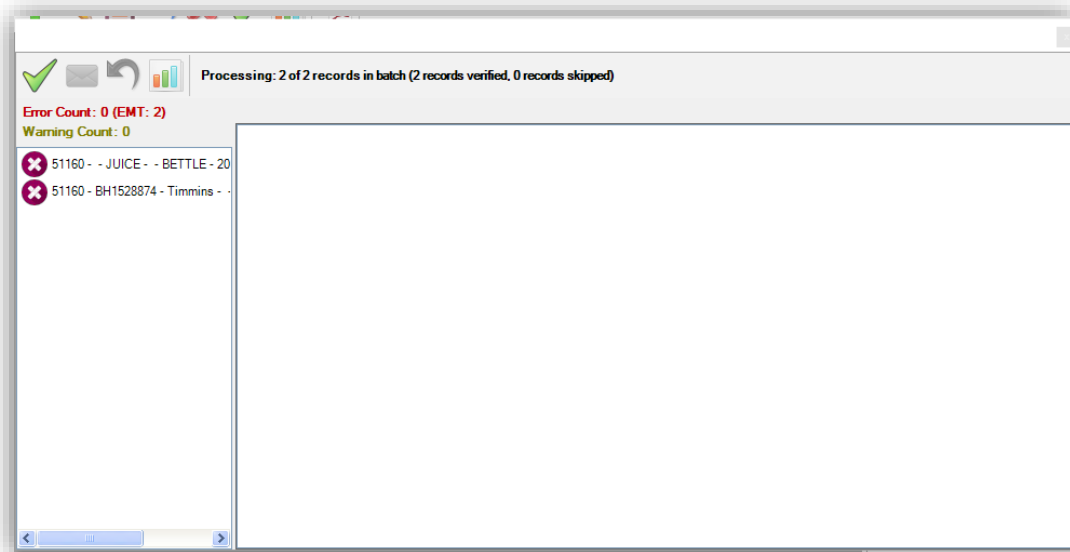
This will perform the verify on the EMT edits only.

Only System Edits

This will perform the verify on the CIHI and provincial edits only.



When click [F11] Verify



Report Generator

Existing views have been modified:

AbstractingErrorsWarnings_VR

Message Level:

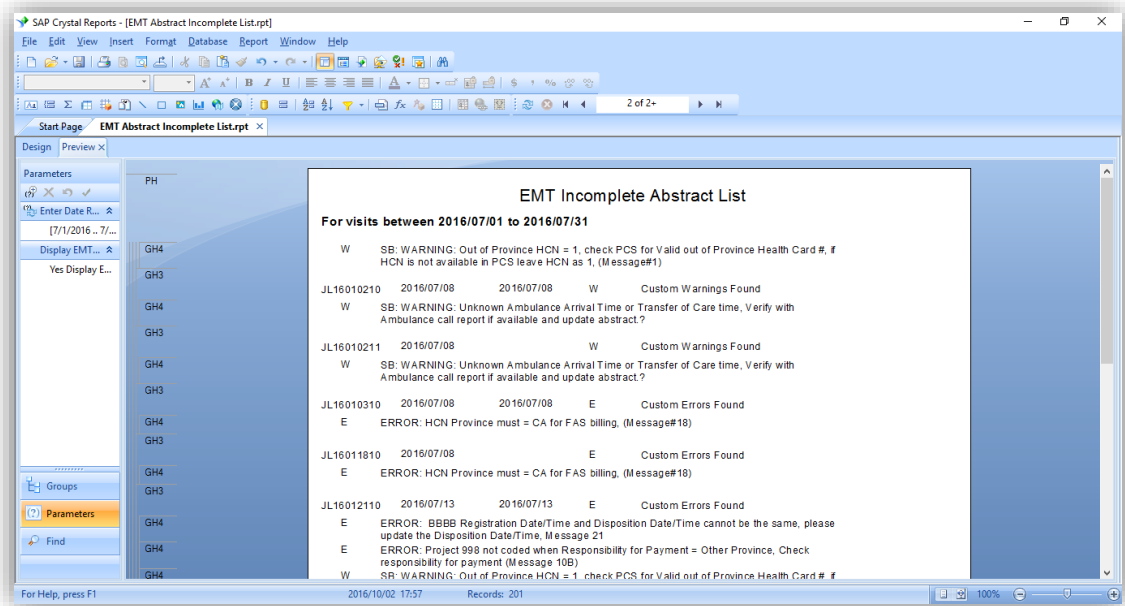
Custom Errors

Custom Warnings

Custom Information

I10 views - The 'Is Custom Validated' field has been added to all the I10 views.

A report called EMT Incomplete Abstract List has been developed.



5. Using WinRecs

WinRecs uses common features throughout the application. This section will explain how to use these features.

5.1 Searching for a Record

The Search feature allows you to look for a record in WinRecs. Most facilities that have a batch or HL7 interface transferring records into WinRecs will use this to locate records.

The Record Search window

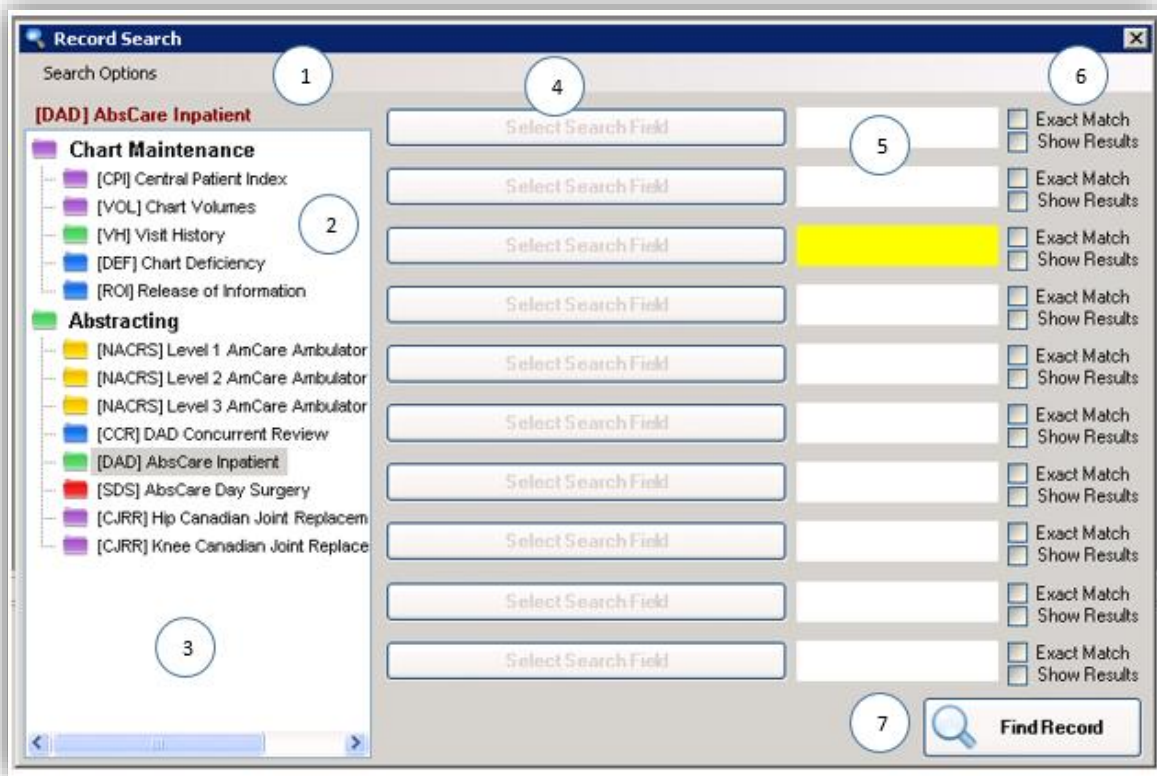


Figure 203 - Record Search Window

1. Search Options menu – Allows you to toggle to the “View Deleted Records” option.
2. Search module title – This displays the records types that will be searched. In our examples the **[DAD] AbsCare Inpatient** records will be searched.
3. Search module menu – This panel allows the user to select the module that will be searched.
4. Select Search Field – These ten (10) buttons allow the user to select which field(s) will be queried, e.g. “Last name”. These fields give you the ability to refine your search.
5. Search criteria textbox – In the textbox the user will enter the search criteria, e.g. “Smith”.
6. Field Search option – These checkboxes allow the user to tailor the search for each field selected. Details of these options are discussed in the section, [Field Search Options](#)

7. Find Record – When pressed, this button will start the search. If results are found they will be displayed in the **Search Result** window. If no records are found, the criteria textbox background will be displayed in red, indicating that no records were found.

To Search

- Press **[F4]**.
 - or —
- Select the menu option **Actions** → **Find**.
 - or —
- Click the Search button on the toolbar .

Step 1 – Select the module on which you would like to perform the search.

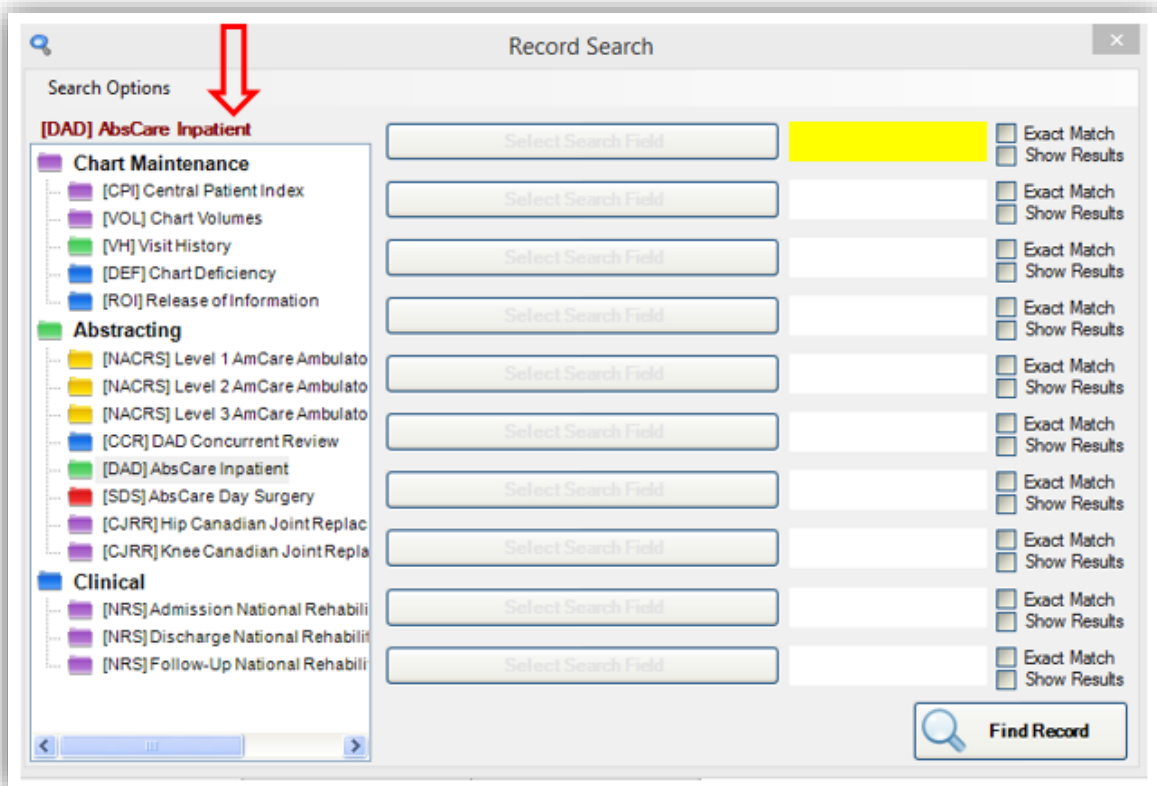


Figure 204 - Search Step 1

Step 2 – Click the Select Search Field.

Step 3 – Select the first field on which you would like to search.

To quickly move through the list you can type the first letter of the field name, e.g. to move near “Last Name”; type “L”. (Pressing a letter repeatedly will move you alphabetically through the choices beginning with that letter).

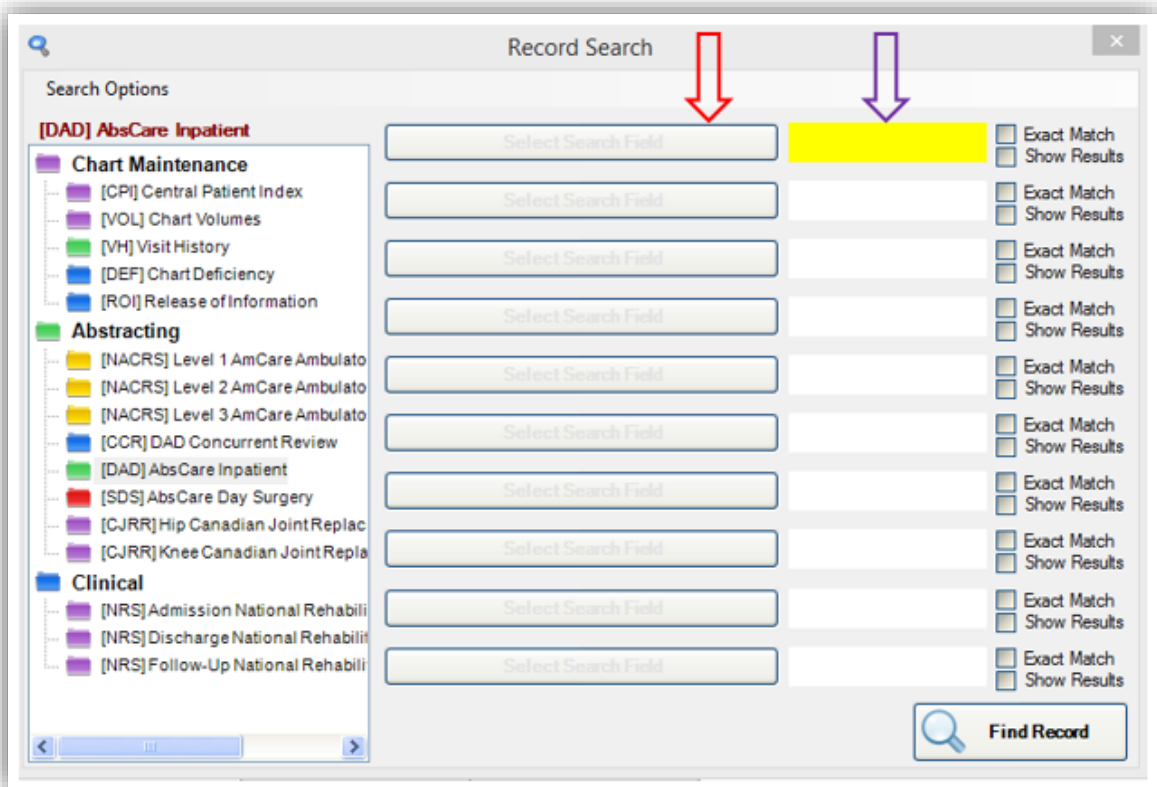


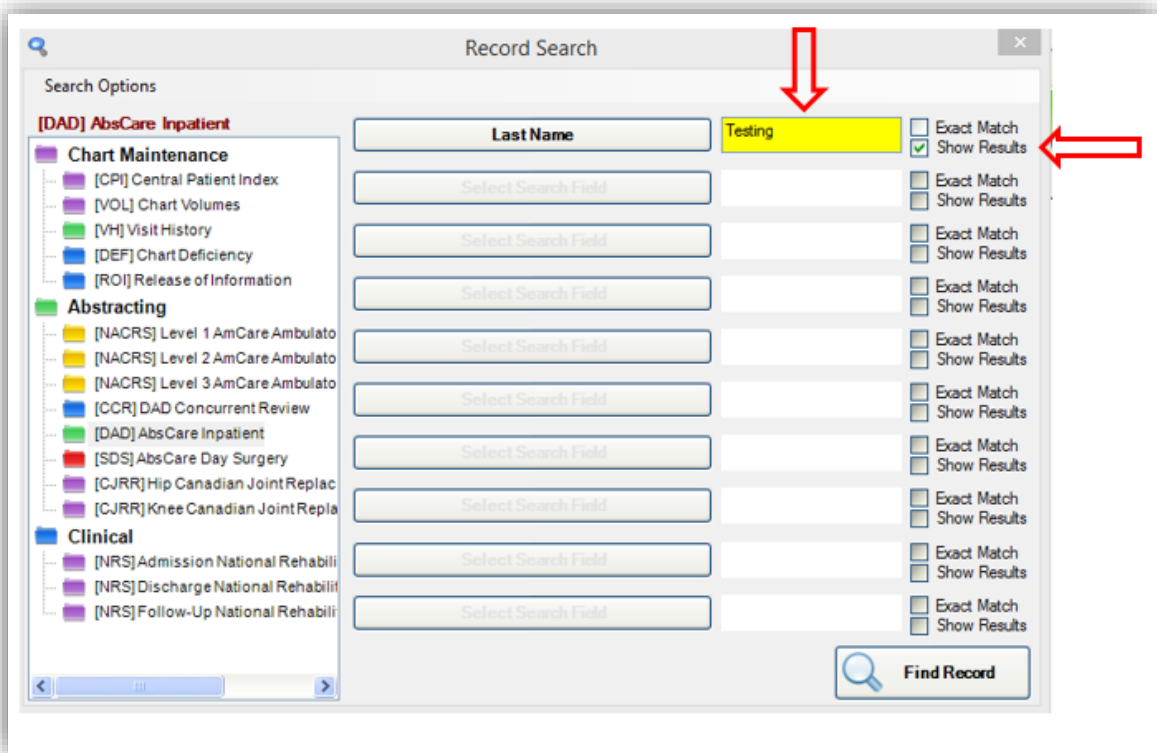
Figure 205 - Search Steps 2 & 3

When searching a date field only the year and the month entered will be used. E.g. searching “Date of Visit” with “2013/04/00” will yield all admissions from the month of April 2013. To locate a specific date, select the Exact Match checkbox which will then match on the day field as well as the year and month.



Good Practice – When searching for a birth date you should always use exact match.

Step 4 – Enter the criteria for your search and select your search option for this field.



The screenshot shows the 'Record Search' window. On the left, there is a 'Search Options' panel with a tree view containing categories like 'Chart Maintenance', 'Abstracting', and 'Clinical'. The 'Abstracting' category is expanded, showing various search options. The main area of the window has a table with columns for 'Last Name' and 'Testing'. The 'Testing' column is highlighted in yellow. To the right of the table, there are checkboxes for 'Exact Match' and 'Show Results'. A red arrow points to the 'Testing' column, and another red arrow points to the 'Show Results' checkbox. At the bottom right, there is a 'Find Record' button with a magnifying glass icon.

Figure 206 - Search Step 4

This example will search for all patients that have “Testing” in their last name.

The Search is interactive. When the Search window is open you cannot interact with any other portion of the application until the Search window is closed.

Field Search Options

Exact Match – When this check box is selected ☒ it will force the search to look for the exact value entered, excluding case sensitivity. “Last” and “last” will return the same result. This option should be used to restrain the size of the results list when the exact value is known, e.g. Chart Number.



A good use of exact match is looking for a specific chart number.

Show Results – When this check box is selected ☒ the field searched will be displayed in the Search Results window.

Search Results

The Search Results window will be displayed if records matching the criteria are found.

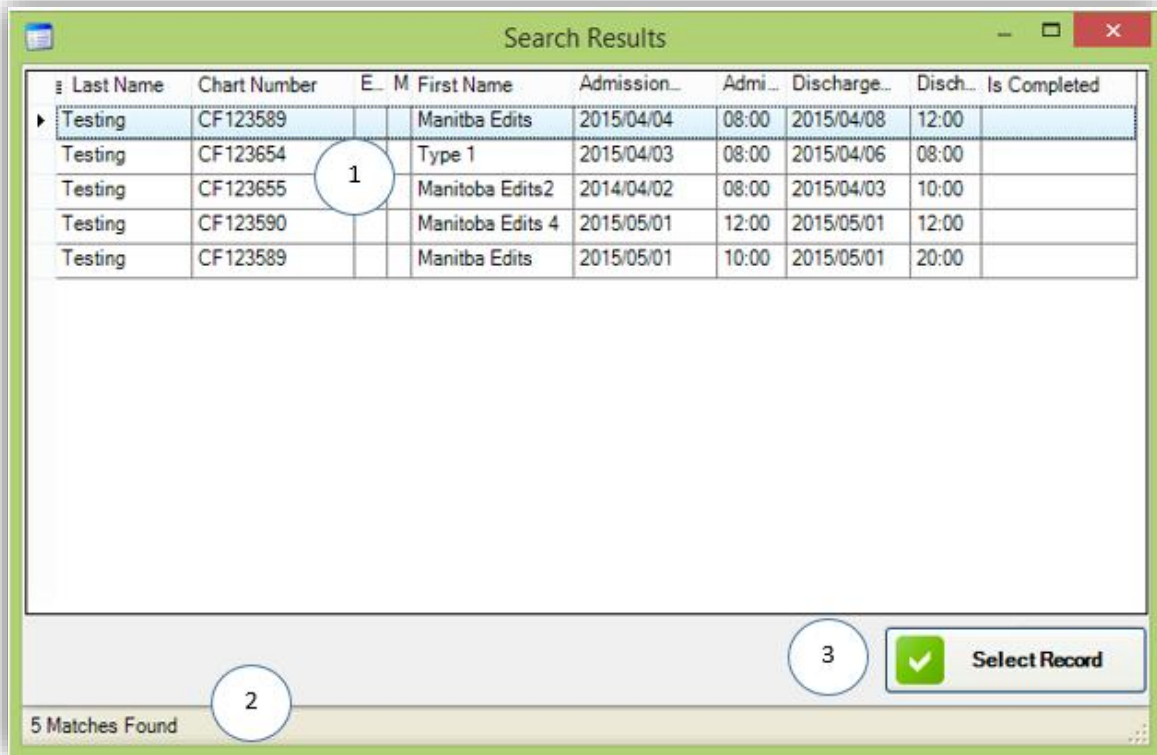


Figure 207 - Search Results

1. The grid displays the search results.
2. The records found indicator. In our example 5 records were found.
3. Select Record button – To select the desired record

Double click the record you want to open.

— or —

- a. Select the record you want to open.
- b. Click the **Select Record** button.



If too many records are found, refine your search by adding criteria.

The search result grid can be tailored as described in the section Grid Manipulation.

5.2 Creating a New Record

Creating a new record in a module will create a module specific record, but the steps to create a new record in the WinRecs modules are common to all of them. This section will describe the steps to create a new record in the WinRecs modules. CPI MODULE will be used as the example; the steps are similar for the abstracting modules. The difference between CPI MODULE and the abstracting modules will also be depicted.

To create a new record not in the CPI MODULE

- Press **[F5]**.
— or —
- Select the menu option **Actions** → **New**.
— or —
- Click the New button on the toolbar  .

To select the module in which the new record will be created

If no module is selected the Select module window will be displayed; select the module in which you would like to create the new record.

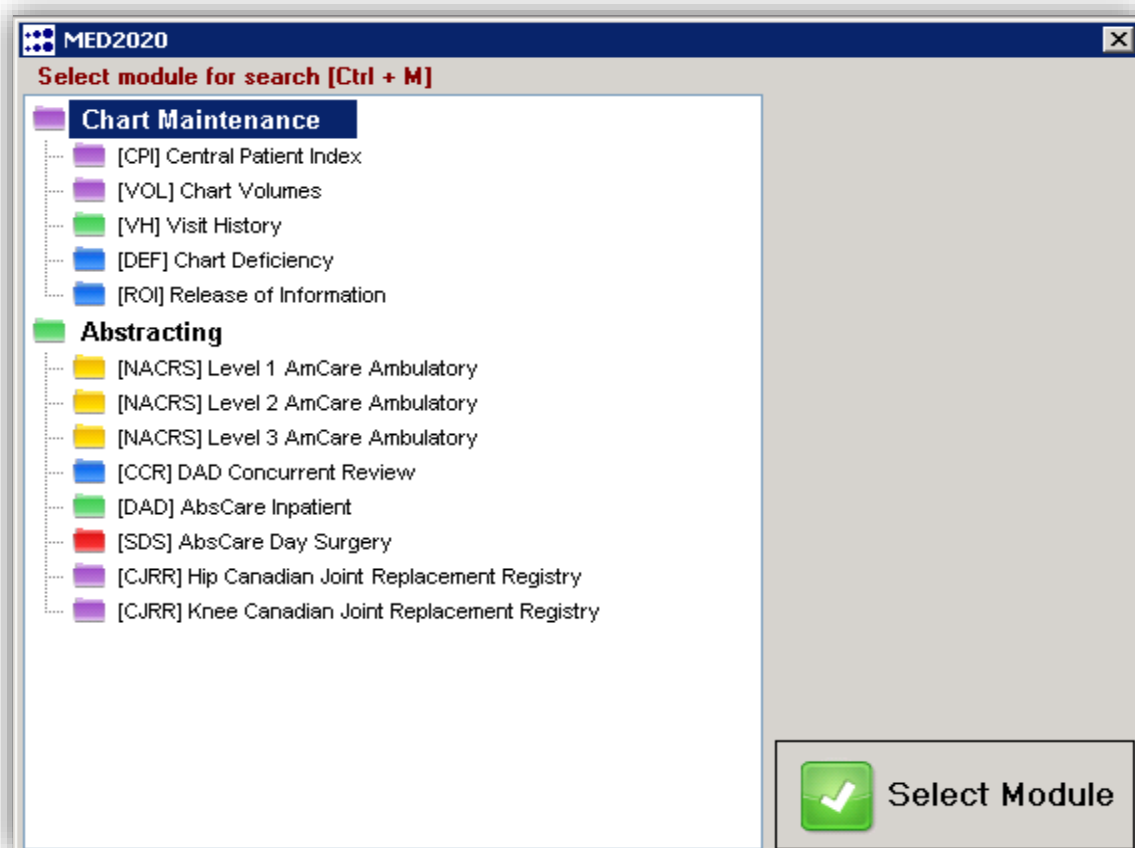
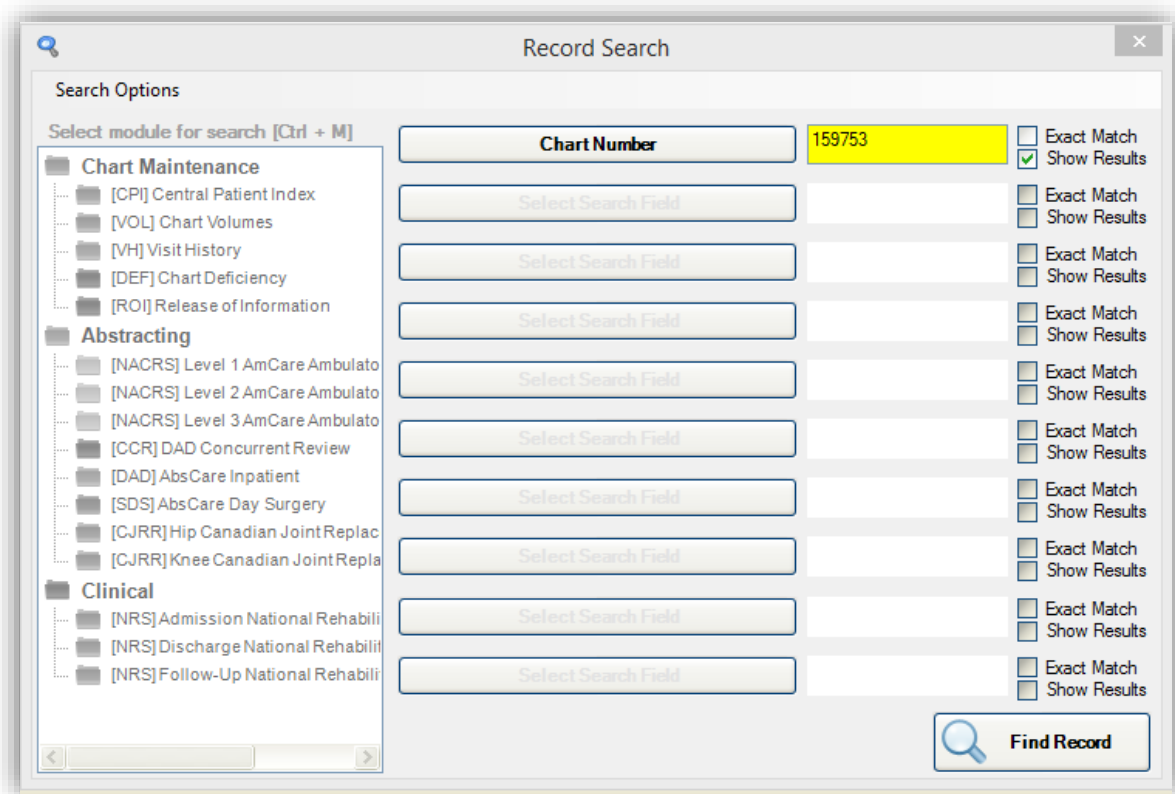


Figure 208 - Select Module

If the CPI MODULE module is selected, a new CPI MODULE record is created and the focus is automatically placed on the first field where data can be entered.

If an abstracting module is selected and the patient is not in the CPI MODULE:

A record search window will pop up, enter the chart number, patient name or whatever you are searching by:



The screenshot shows the 'Record Search' window. On the left, under 'Search Options', there is a tree view for 'Select module for search [Ctrl + M]'. The tree has three main categories: 'Chart Maintenance', 'Abstracting', and 'Clinical'. Under 'Chart Maintenance' are '[CPI] Central Patient Index', '[VOL] Chart Volumes', '[VH] Visit History', '[DEF] Chart Deficiency', and '[ROI] Release of Information'. Under 'Abstracting' are '[NACRS] Level 1 AmCare Ambulato', '[NACRS] Level 2 AmCare Ambulato', '[NACRS] Level 3 AmCare Ambulato', '[CCR] DAD Concurrent Review', '[DAD] AbsCare Inpatient', '[SDS] AbsCare Day Surgery', '[CJRR] Hip Canadian Joint Replac', and '[CJRR] Knee Canadian Joint Repla'. Under 'Clinical' are '[NRS] Admission National Rehabili', '[NRS] Discharge National Rehabili', and '[NRS] Follow-Up National Rehabili'. In the center, there are eight search fields. The first field is labeled 'Chart Number' and contains the value '159753'. The other seven fields are labeled 'Select Search Field'. On the right, there are checkboxes for 'Exact Match' and 'Show Results' for each search field. The 'Exact Match' checkbox for the first field is checked. At the bottom right, there is a 'Find Record' button with a magnifying glass icon.

Figure 209 – Record Search Window

- Press **Find Record** or press **Enter**
- WinRecs will search for the chart number in the **CPI MODULE**, if the chart number has never been entered into WinRecs the following will happen:

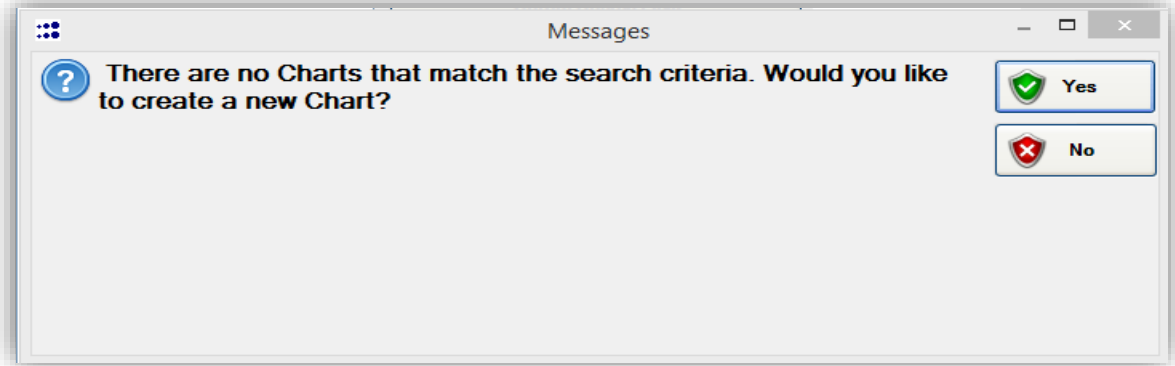
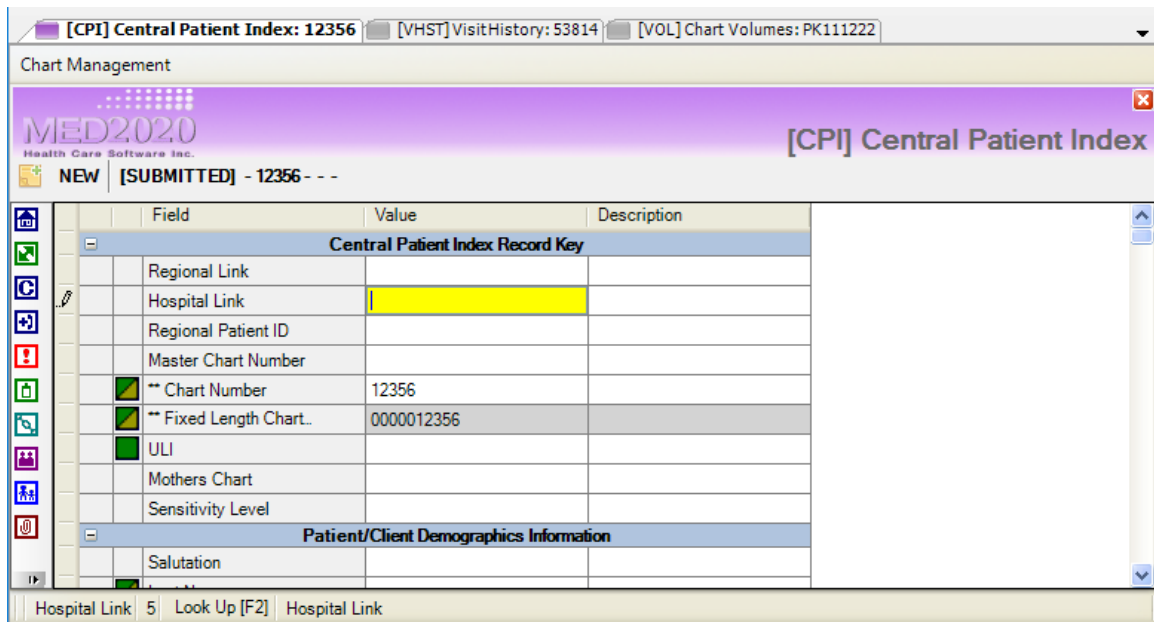


Figure 210 – Create a new chart message

- Pressing **No**, will take you back to the search record screen
- Pressing **Yes**, will take you to the CPI MODULE to create the record. The Chart Number field will populate with the new chart number entered on the search screen.



Field	Value	Description
Central Patient Index Record Key		
Regional Link		
Hospital Link		
Regional Patient ID		
Master Chart Number		
** Chart Number	12356	
** Fixed Length Chart..	0000012356	
ULI		
Mothers Chart		
Sensitivity Level		
Patient/Client Demographics Information		
Salutation		

Figure 211 – Create New Chart in CPI MODULE

- Enter the following fields Last Name, First Name, Birth Date and Gender in the CPI MODULE and any other fields required.
- Press **F6/F7**.

- Click on the **[DAD] AbsCare Inpatient** tab



Figure 212 – [DAD] AbsCare Inpatient

- Press **[F5]**
— or —
- Select the menu option **Actions** → **New**.
— or —
- Click the New button on the toolbar 
- The information you had entered should populate in this case the chart number:

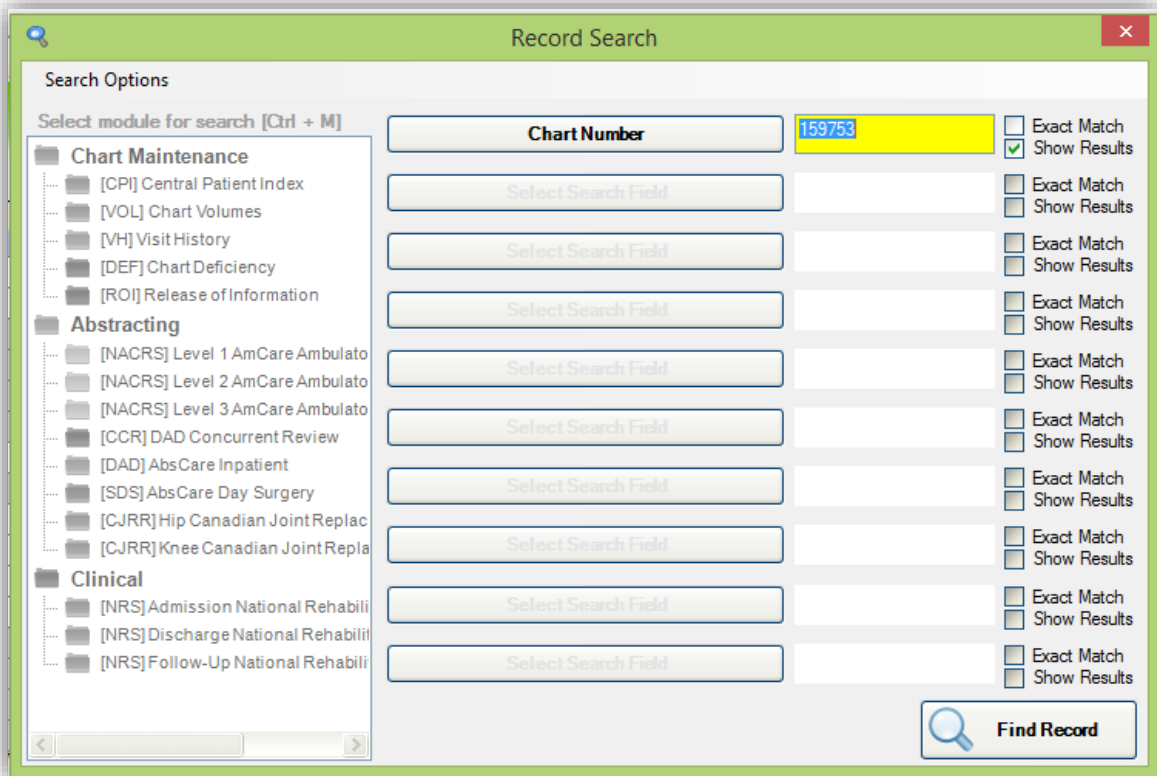


Figure 213 – Record Search Window

- Press **Find Record** and the **Search Results** screen will appear.

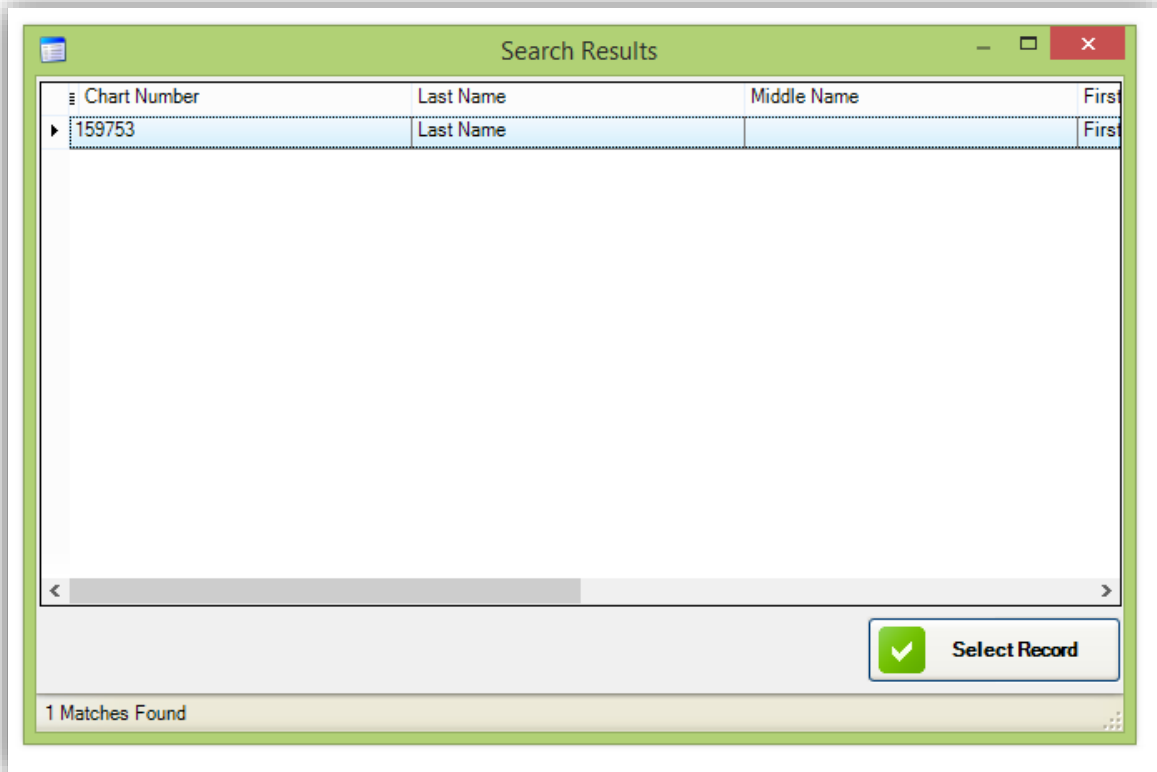


Figure 214 – Create new record selection

To select the desired record:

- Double click the record you want to open.
- or —
- Select the record you want to open and click the **Select Record** button
- A new record will display a status of “New” in the header.

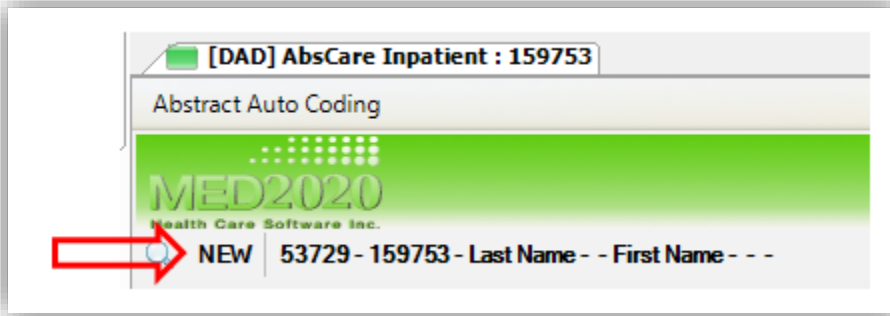


Figure 215 - Record in New Module

The information entered in the CPI MODULE and any default information will populate the record. Enter the abstract as per your usual data collection as per your Hospital Policy and CIHI guidelines.

When saving the abstract, please ensure the key fields are entered into the Abstract, they include Institution Number, Discharge Date and Discharge Time (for DAD) and Registration Date & Time (NACRS). If any of these three fields are not entered, a critical message will occur and the record will not be saved.

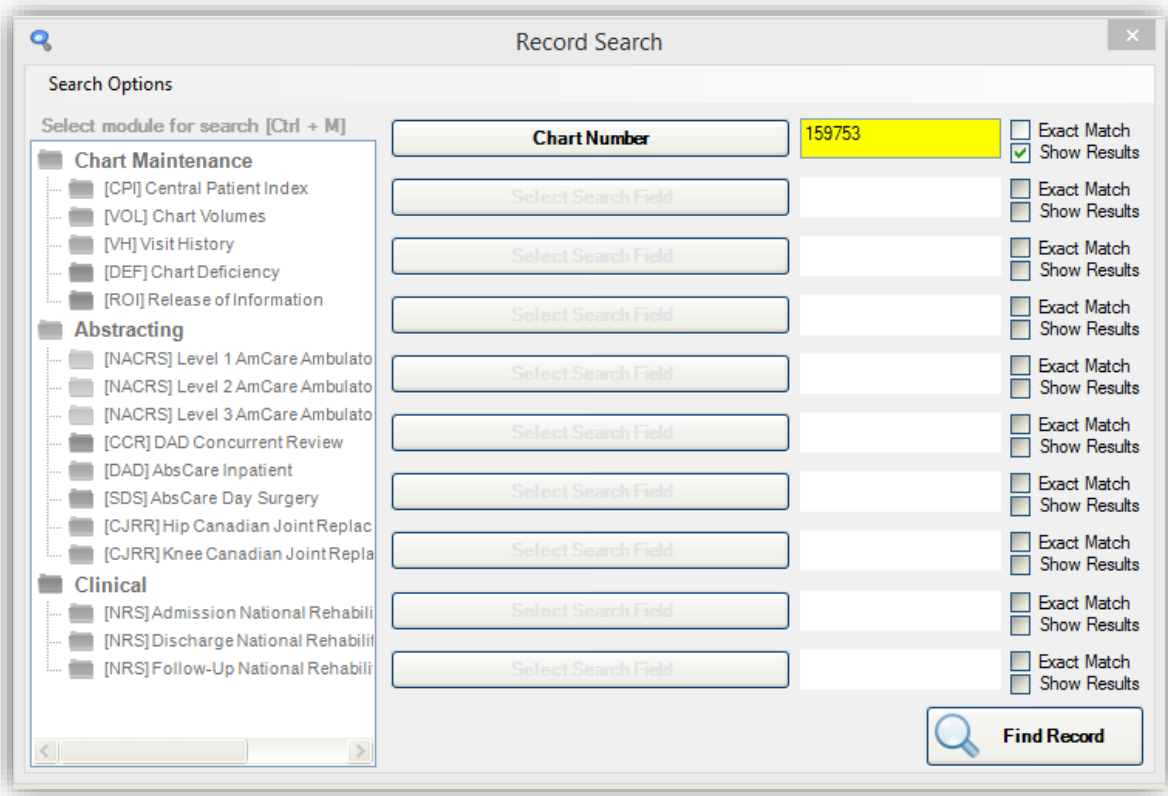


The feature of creating a new record should not happen often as an abstract will be brought over by your HL7 or Batch Interface.

Create a new abstract already in the CPI MODULE

- Press **[F5]**.
- or —
- Select the menu option **Actions** → **New**.
- or —
- Click the New button on the toolbar 

A record search window will pop up, enter the chart number:



The screenshot shows the 'Record Search' window. On the left, under 'Search Options', there is a tree view for 'Select module for search [Ctrl + M]'. The tree includes 'Chart Maintenance' (with sub-items: [CPI] Central Patient Index, [VOL] Chart Volumes, [VH] Visit History, [DEF] Chart Deficiency, [ROI] Release of Information), 'Abstracting' (with sub-items: [NACRS] Level 1 AmCare Ambulato, [NACRS] Level 2 AmCare Ambulato, [NACRS] Level 3 AmCare Ambulato, [CCR] DAD Concurrent Review, [DAD] AbsCare Inpatient, [SDS] AbsCare Day Surgery, [CJRR] Hip Canadian Joint Replac, [CJRR] Knee Canadian Joint Repla), and 'Clinical' (with sub-items: [NRS] Admission National Rehabili, [NRS] Discharge National Rehabili, [NRS] Follow-Up National Rehabili). The 'Chart Maintenance' module is selected. In the center, there is a table with 8 rows. The first row has 'Chart Number' in the first column and '159753' in the second column. The other 7 rows have 'Select Search Field' in the first column and an empty field in the second column. On the right, there are checkboxes for 'Exact Match' and 'Show Results' for each row. The 'Show Results' checkbox for the first row is checked. At the bottom right, there is a 'Find Record' button with a magnifying glass icon.

Figure 216 - Create New Abstract Search Window

WinRecs will search for the chart number in the **CPI MODULE**, if the chart number has been entered into WinRecs the following will happen

- Press **Find Record**.
- or —
- Press enter.

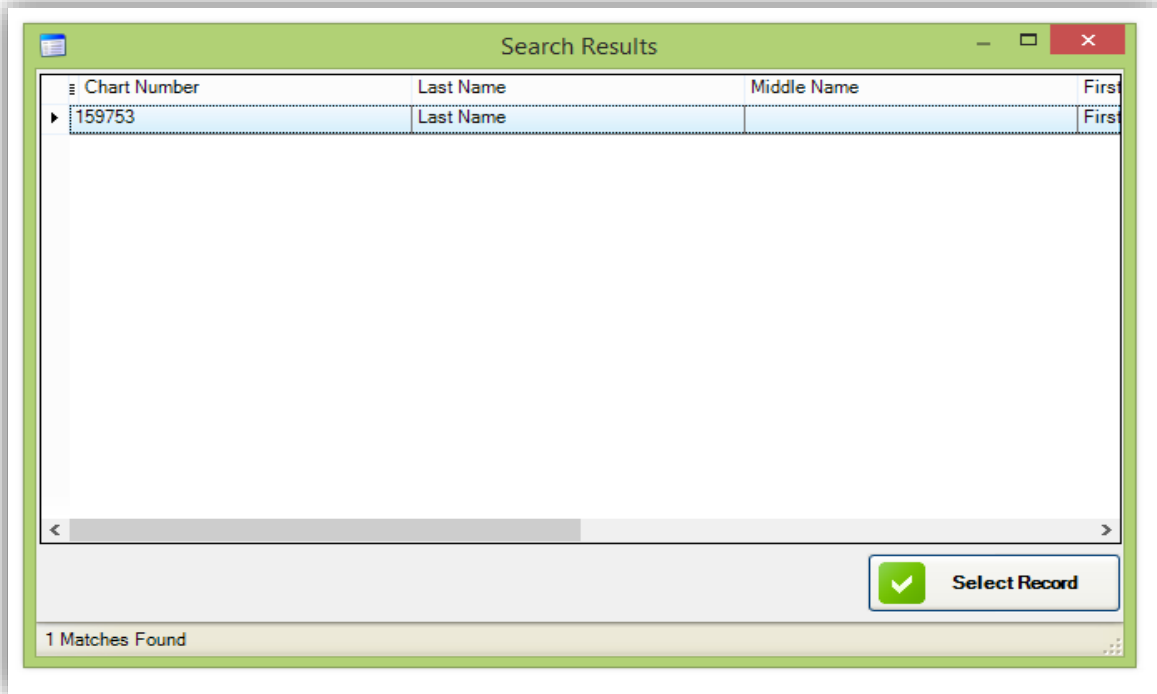


Figure 217 – Create New Abstract Search Results

- To select the desired record:
 - Double click the record you want to open.
 - or —
 - Select the record you want to open and click the **Select Record** button
- A new record will display a status of “**New**” in the header.

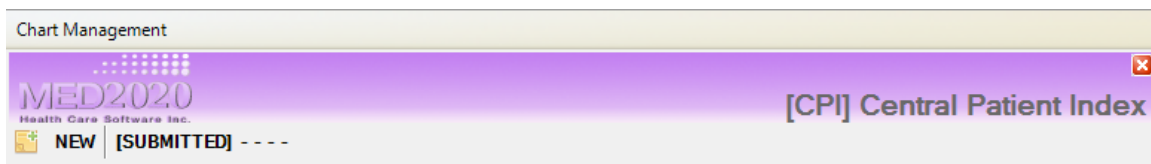


Figure 218 - Record in New Module

The information entered in the CPI MODULE and any default information will populate the record. Enter the abstract as per your usual data collection as per your Hospital Policy and CIHI guidelines.

5.3 Editing an Existing Record

A record will always open in **READ-ONLY** mode, you can enter information in **Read-Only** mode, but will need to put the record into **Edit** mode to save the record.

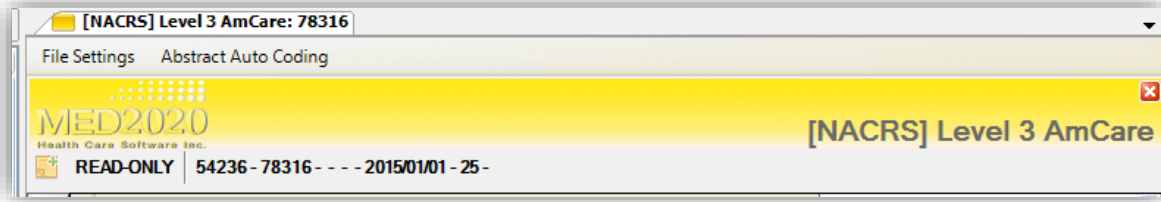


Figure 219 - Record in Read-Only mode

In order to save the modification of a **Read-Only** record you must set it to **Edit** mode.

To edit a read-only record

- Press **[F6]**.
— or —
- Select the menu option **Actions** → **Edit**.
— or —
- Click the Edit button on the toolbar .

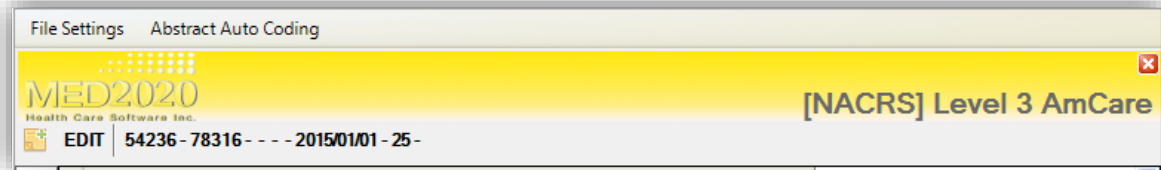


Figure 220 - Record in edit mode

Once the record is saved, it will revert back to Read-Only.



You can enter data in the **READ ONLY** mode, when you are ready to save it is suggested to press **Edit** then **Save (F6/F7)**.

When you make changes to a record and Save **[F7]** in 'Read-Only' mode will result in the following question prompt:

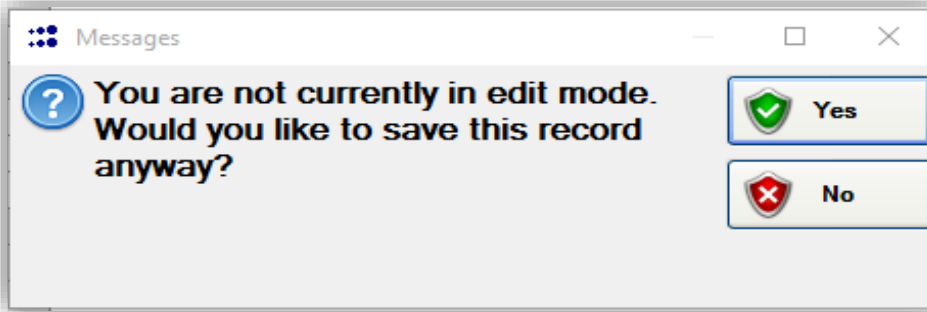


Figure 221 – Message when chart is in Read-Only Mode

- Click **Yes** to save the record.
- Click **No** to discard the changes.
- or —
- Highlight **Yes** using the **[TAB]** key, then press **[ENTER]** to save the record.
- Highlight **No** using the **[TAB]** key, then press **[ENTER]** to discard the changes.

5.4 Adding Notes to the Abstract

To make notes to an abstract the following icon will display when the abstract is open:

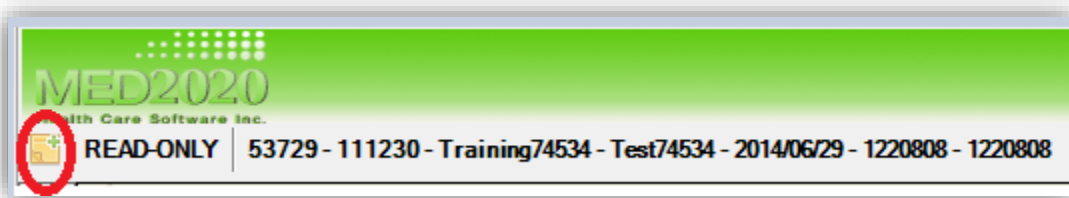


Figure 222 – Notes Icon

- When there are no notes for the record the icon will have a Plus sign.



- When there are notes for the record the icon will have no Plus sign.



Notes Window

- Open an abstract in any module

- Select the Module Notes  or use the shortcut key to access the notes window is **[Alt + F3]** and the Notes Window will open.

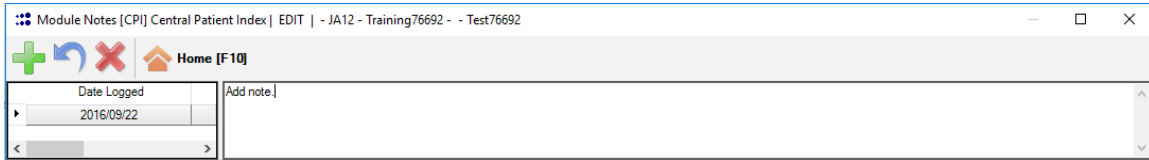
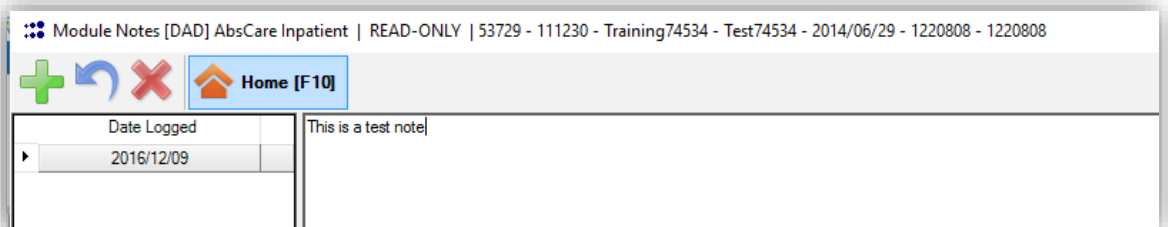


Figure 223 – Notes Window

- The Notes Window has a toolbar with the following icons:
 - to create a new note  **[F5]**,
 - undo changes  **[F8]**,
 - delete changes  **[F9]**
 - to return the home page  **[F10]**.
- There is a Date Logged panel which displays the list of dates which notes were logged.
- When selecting a date, the note entered will populate on the screen, by default the last note will be populated.

To create a note:

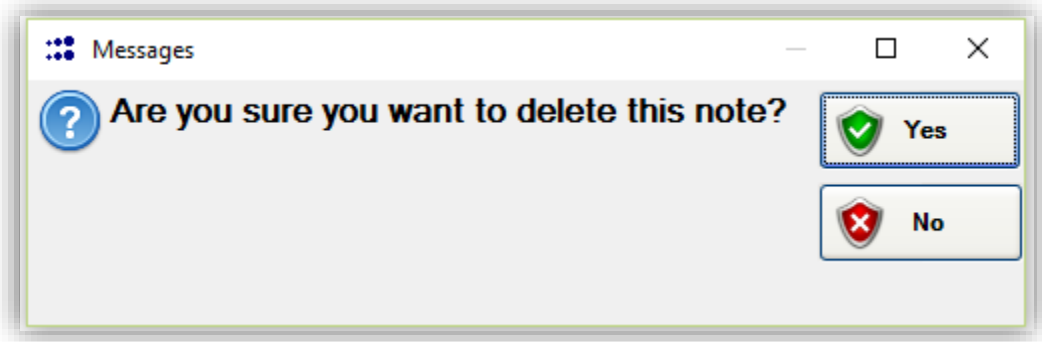
- Press the  or **[F5]**
- The date, time and coder who logged the note will populate.
- Click on the second column and type your note



- Press  **Home [F10]** to go back to the screen and your note is saved

To delete a note:

- With an abstract open click on the note icon 
- Highlight the Date Logged (there can be more than one date, highlight the one to be deleted)
- Press  or [F9]
- A message will display



- Click Yes to delete or Click No to not delete.

5.5 Verifying a Record

Before saving a record, the user should always verify the data that has been entered. The result of the verification will be displayed in the **Message List** window. The error messages are displayed as the data is entered and removed as the errors are corrected. In some instances, some messages are related to multiple fields; modifying one field may modify the message of the other field.

- Press [F11].
— or —
- Select the menu option **Actions** → **Verify**.
— or —
- Click the Verify button on the toolbar .

When a record is verified the messages or edits for the record will be displayed in the Message List.

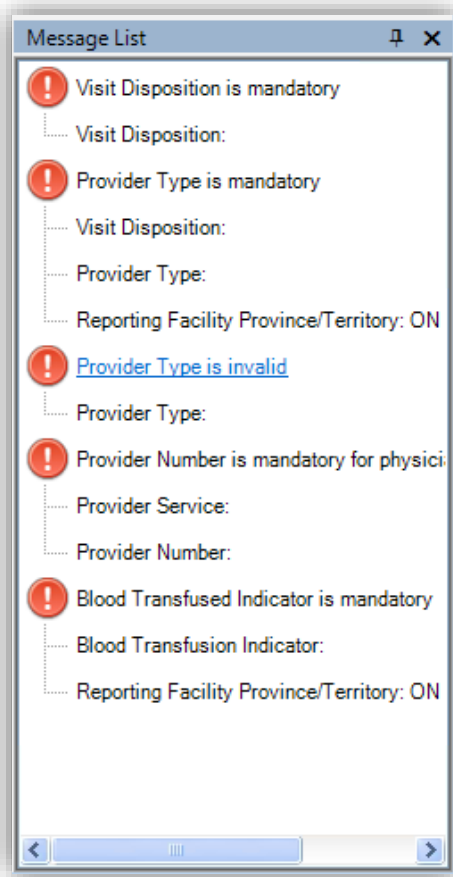


Figure 224 - Message List showing verification results

5.6 Saving a Record

New or modified records should be saved before closing the window in which the record is displayed. To save a new or modified record:

- Press **[F7]**.
— or —
- Select the menu option **Actions** → **Save**.
— or —
- Click the Save button on the toolbar .

When a user tries to close a new or modified record before saving it, WinRecs will display a message asking the user to save or discard the changes. The message box will be as follows.

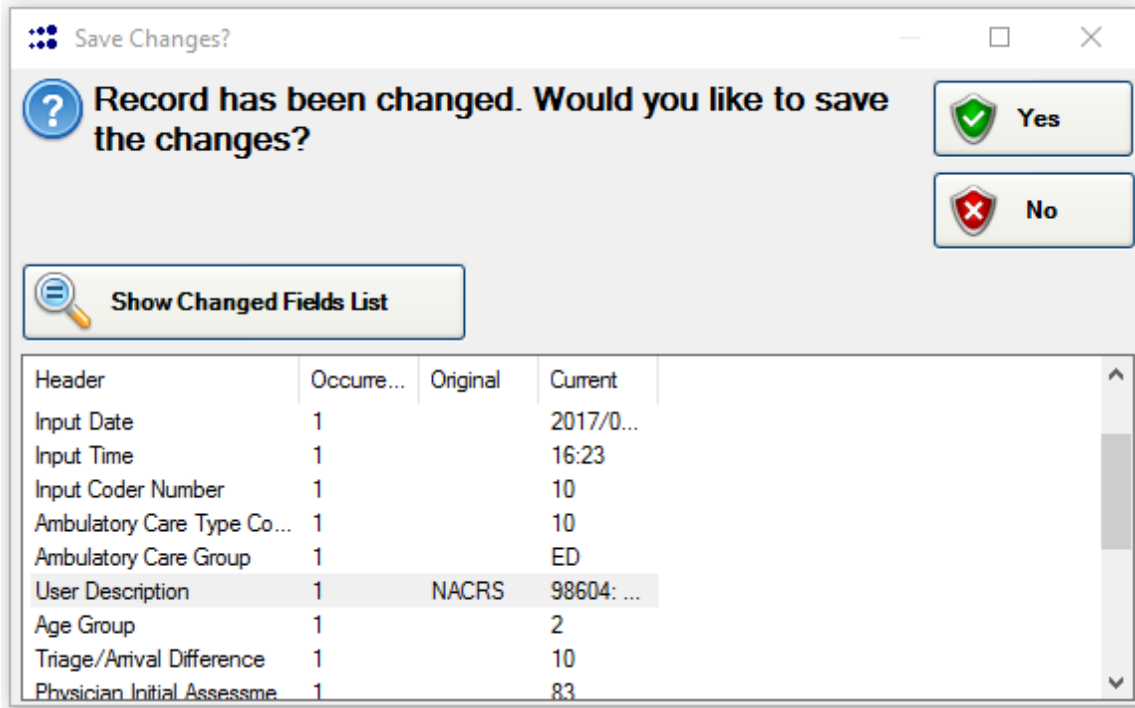


Figure 225 - Saving a Record

- Click **Yes** to save the record.
- Click **No** to discard the changes.
- or —
- Highlight **Yes** using the **[TAB]** key, then press **[ENTER]** to save the record.
- Highlight **No** using the **[TAB]** key, then press **[ENTER]** to discard the changes.
- Click the "Show Changed Fields List" button to display all fields that have been changed.

5.7 Undoing a Record

In some instances, changes may need to be undone. In this case, you can undo all the changes done since the last time the record was saved or since the record was opened. To undo changes:

- Press **[F8]**.
— or —
- Select the menu option **Actions** → **Undo**.
— or —
- Click the Undo button on the toolbar  .

After activating the Undo feature the system will prompt you to confirm the action.

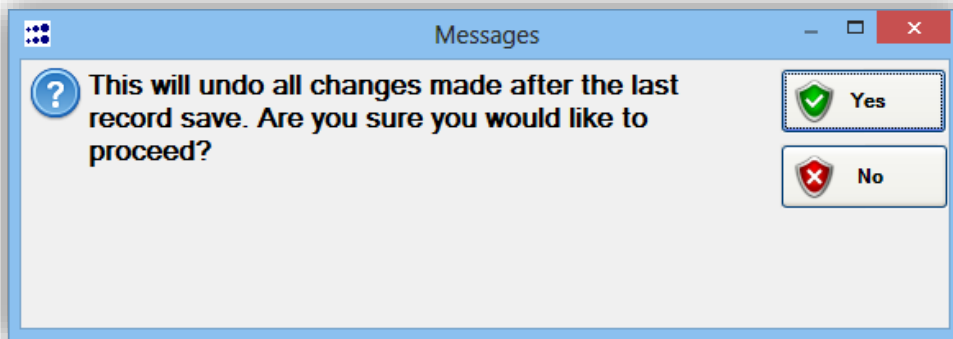


Figure 226 - Undo confirmation

All unsaved changes will be lost after confirming the undo action.

- Click **Yes** to undo the changes.
- Click **No** to keep the modified data.
— or —
- Highlight **Yes** using the **[TAB]** key, then press **[ENTER]** to undo the changes.
- Highlight **No** using the **[TAB]** key, then press **[ENTER]** to keep the modified data.

5.8 Deleting a Record

This function deletes the entire abstract, occurrence or item in the module the program is focused on. If the entire abstract or CPI MODULE entry is deleted it will be stored in the Purge module until it is completely purged from the system. To delete a record:

- Press **[F9]**.
— or —
- Select the menu option **Actions** → **Delete**.
— or —
- Click the Delete button on the toolbar .

After selecting the Delete action, the system will generate a prompt to confirm the action.

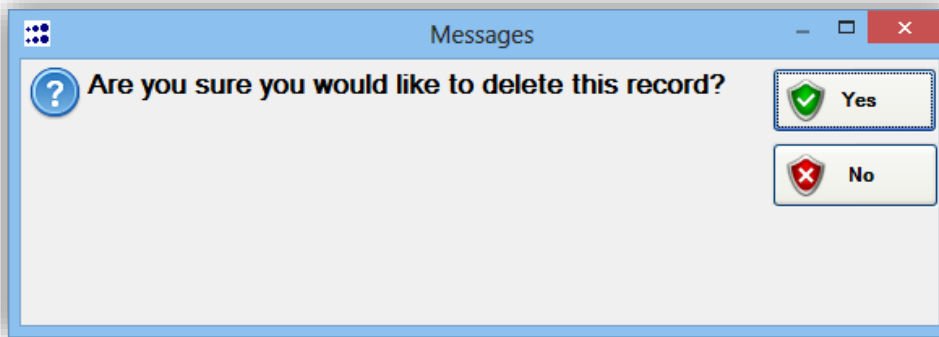


Figure 227 - Deletion confirmation

Deleted abstracts or CPI entries are moved to the purge module and will show up on reports as they are still in the database. Users will need to create a Purge procedure with the deletions to ensure reports are accurate. See PURGE/RECOVER

- Click **Yes** to delete the record.
- Click **No** to keep the record.
— or —
- Highlight **Yes** using the **[TAB]** key, then press **[ENTER]** to delete the record.
- Highlight **No** using the **[TAB]** key, then press **[ENTER]** to keep the record.

Deleted records are moved to the purge module and are only removed from the system if a purge is performed.

5.9 Message List Window

The Message List window is used to display warnings, errors and information.

The following statements may be seen in the Message List window.

	Critical: displays when there's a critical error on a specific field. The record will not be saved and submission will fail.
	Error: displays when there's an error on a specific field. The record will be saved, but submission will fail.
	Warning: displays when there's a warning on a specific field. The record will be saved and submitted.
	Exception: displays when an exception occurred on a field.
	Question: displays when a question requires an answer from the user.
	Information: displays when more information is available for the user.

Table 13 - Message List Icons with Descriptions

An example of the Message List window showing various types of warnings and errors is as follows:

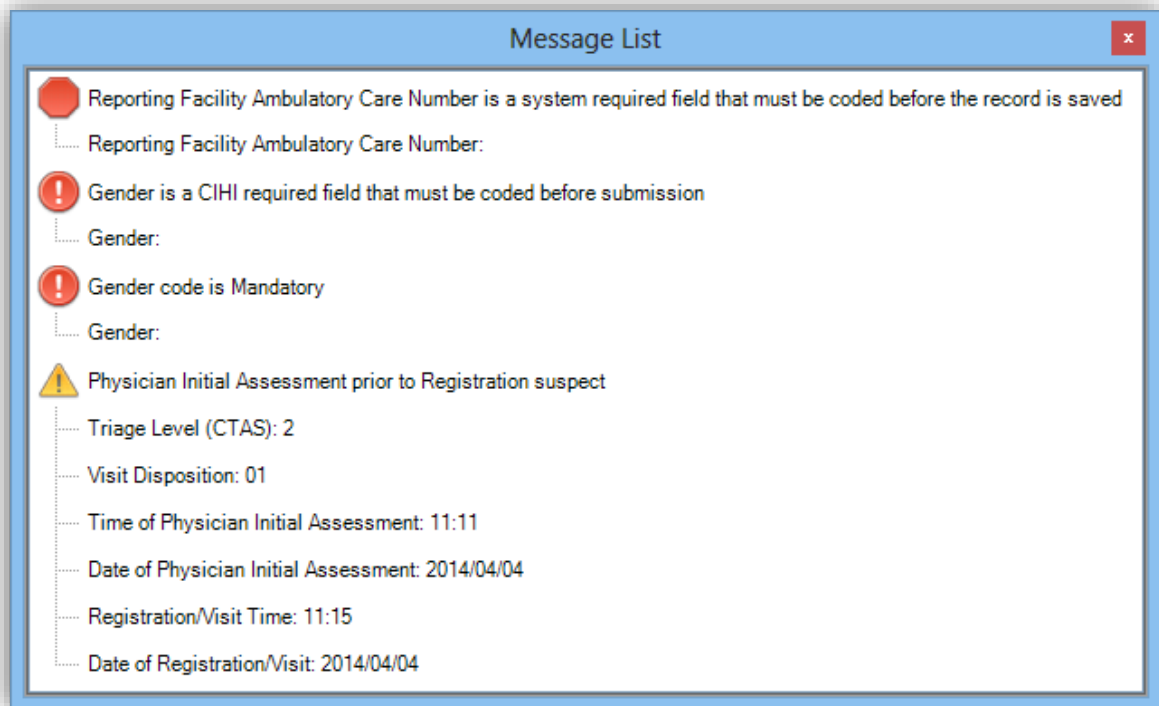


Figure 228 - Message List example

Clicking a specific field in a message will automatically set the focus of the application to that field. For example, clicking on **Gender** will set the focus of the application on the **Gender** field in

the abstract, allowing you to select a gender. If the field with the error is part of a multi-form the multi-form will be opened.

The icon can be clicked to collapse a specific message. The message will still be displayed but the field details will no longer be visible.

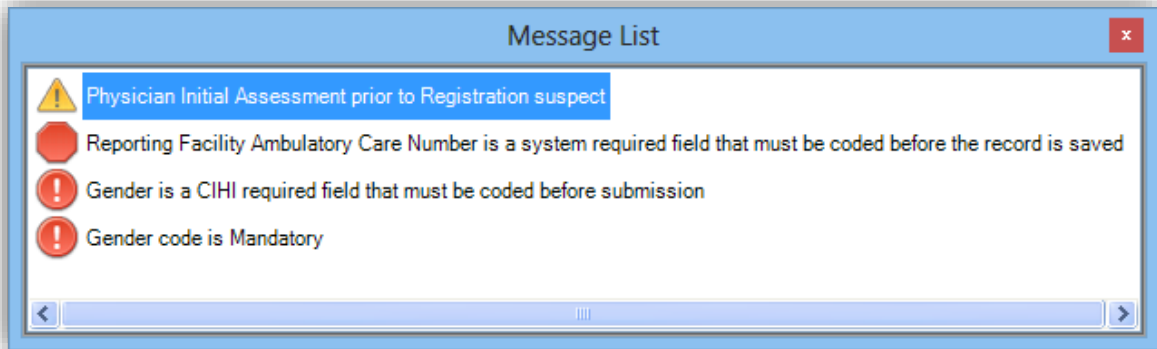


Figure 229 - Message List example with messages collapsed

5.10 Patient Visit History

The Patient Visit History displays abstracted and non-abstracted visits.

Visit History					
BH125478					
	Diagnosis	Hospital	Module	Institution	Visit Date
▶			NACRS B...	54236	
▶			DAD	53729	
▶	K29.0		NACRS B...	54236	2014/11/06
▶	K29.0		DAD	53729	2014/04/22
▶	I34.2		DAD	53729	2014/04/19
▶	T00.1		NACRS B...	54236	2014/04/15
▶	K29.0		DAD	53729	2014/04/13
▶	K29.0		NACRS B...	54236	2014/04/11

Figure 230 – Patient Visit History

The color graphic represents the status of the abstract in the visit history as follows:



Abstract is saved and complete



Abstract is saved with errors



Abstract is saved with warnings



Abstract is not complete and has not been saved

5.11 WinRecs Navigation

Moving from fields to fields can be done by:

- Pressing [ENTER] – to move to the next field
— or —
- Click on the desired field
— or —
- Using the keyboard arrows to move up or down

Field background description

		Fixed Length Chart Number	Read-only field
		First Name	Edited field

Table 14 - Field Background Description

Footer

The footer displays information about the currently selected field on the field grid.

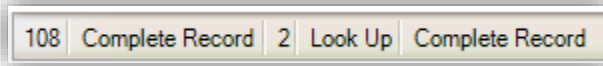


Figure 231 - Module footer

The following information's are displayed in the footer:

108	CIHI Field ID – this field displays the identification number of the CIHI field
Complete Record	User defined description – same as on the grid.
2	Field length – this is the maximum length of the field
Look Up	Field type – this is the type of field. The possible values are look up, date, time, numeric or text. Each field type will dictate the information you are allowed to enter in the field. The format are described below in Table 15 - Footer Field Information
	Field type format
Complete Record	CIHI Field description – this field displays the description of the CIHI field

Table 15 - Footer Field Information

Field type format

The field types determine the formats and valid values that can be entered in the field.

Look up	This type of field only accepts values for a redefined list. E.g. the Gender field can only accept the values F, M, O, or U. To view or select the value from the list of valid values press [F2]
Date	This type of field only accepts date values. The format is YYYY/MM/DD
Time	This type of field only accepts time values. The format is HH:MM
Numeric	This type of field only accepts numeric values; 0-9.
Text	This type of field only accepts text values. A-z, A-Z. 0-9

Table 16 - Field Type Format

Group Field List

The group field list allows the user to quickly navigate through the list of fields of a record. When a group is expanded the list of fields for that group will be displayed.

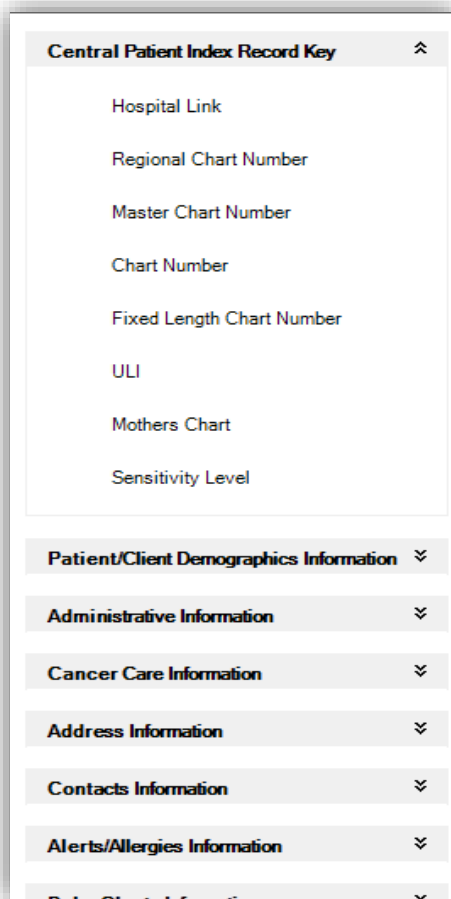


Figure 232 - Group field list

Expanding/Collapsing a group

- To expand a group click 
- or —
- To collapse a group click 

To select a field in a group

Selecting a field in a group will navigate to that field in the grid.

- Expand the desired group by click the 
- Click the desired field in the group.

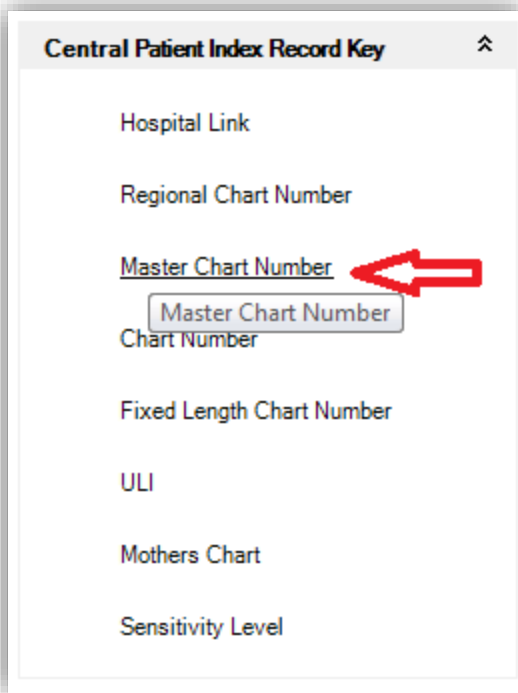


Figure 233 - Group field list selection

Selecting a field that is part of a multi-form will open the multi-form window.

Fields grid parts

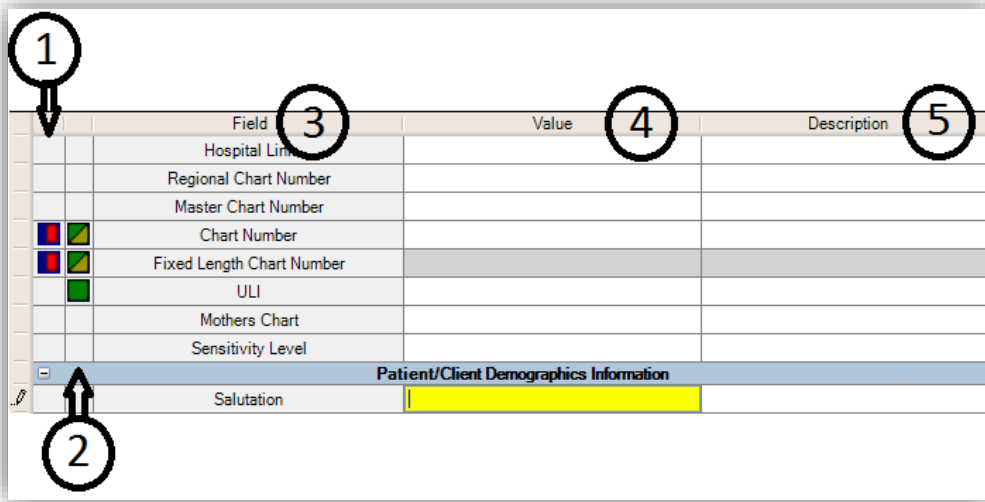


Figure 234 - Fields grid parts

1. **Required fields** – system mandatory fields each symbol has a different meaning.

	System Required: WinRecs required field. Must have data entered to save.
	CIHI Required: Mandatory data element for submission to CIHI.
	CIHI Submitted: Data entered in field submitted to CIHI.
	Provincial or Module Required. Mandatory data element for Provincial or Module
	Hospital Required: Required field. Must have data entered to save.
	Hospital Error: Mandatory data element for submission to CIHI.
	Hospital Warning: Hospital warning. Record will save and submit.

Table 17 - Entry Grid Icon Description

2. **Field usage** - Field usage icon meaning varies based on the module that is open. Here's the description of the icon by module.

CPI MODULE:

	The valued is copied from CPI MODULE to DAD abstract
	The valued is copied from CPI MODULE to NACRS abstract
	The valued is copied from CPI MODULE to both DAD and NACRS abstract

Table 18 - CPI MODULE Field Usage Icons

DAD:

	This field is used for grouper
	Not Used
	Not Used

Table 19 - DAD Field Usage Icons

NACRS:

	This field is used for grouper
	Not Used
	Not Used

Table 20 - NACRS Field Usage Icons

3. **Field** – This is name of the field that needs to be entered.
4. **Value** – This is where the value is entered.
5. **Description** – This is the description of the value.

Group fields section expand/collapse

Group field section can be expanded or collapsed. This will allow the user to view more of a specific section.

To collapse a group field section

- Click the  icon to collapse the section header

	Field	Value	Description
	Central Patient Index Record Key		
	Hospital Link		
	Regional Chart Number		
	Master Chart Number		
	Chart Number		
	Fixed Length Chart Number		
	ULI		
	Mothers Chart		
	Sensitivity Level		
	Patient/Client Demographics Information		
	Salutation		
	Last Name		
	Middle Name		
	First Name		
	Maiden Name		
	Name at Birth		

Figure 235 - Group field section expanded

To expand a group field section

- Click the  icon to open the section header

	Field	Value	Description
	Central Patient Index Record Key		
	Patient/Client Demographics Information		
	Salutation		
	Last Name		
	Middle Name		
	First Name		
	Maiden Name		
	Name at Birth		

Figure 236 - Group field section collapsed

The section that has the focus will not collapse. E.g. In the Figure above the section “Patient/Client Demographics Information” can NOT be collapsed.

Fields grid quick search [F3]

Use the fields grid quick search to quickly navigate to a field.

To access the fields, grid quick search

- Press [F3].

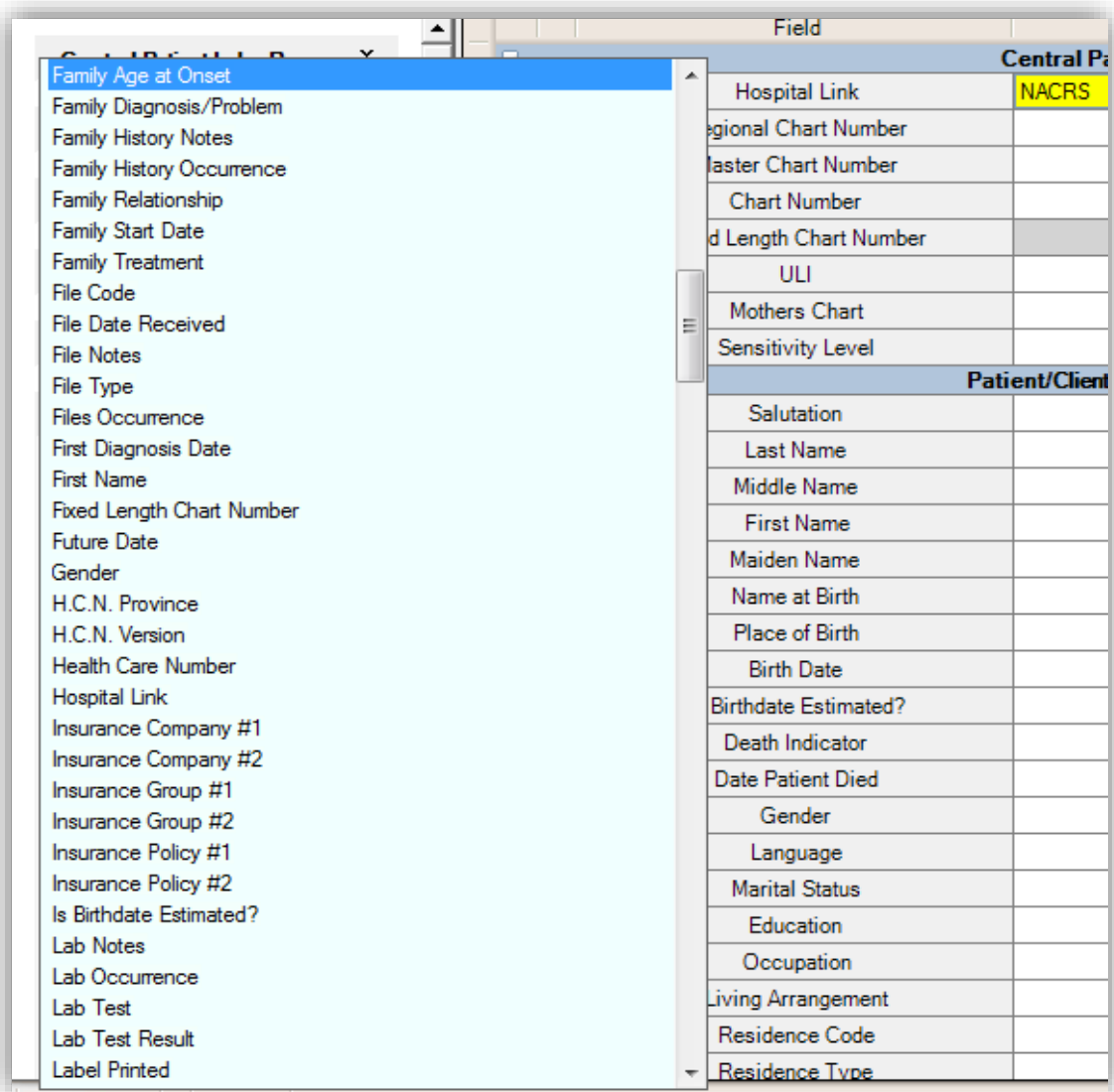


Figure 237 - Fields grid quick search

To navigate on the fields, grid quick search

- Click on the field you want to navigate to.
— or —
- To quickly move through the list, you can type the first letter of the field name. E.g. to move near “First Name”; type “f”. (Pressing a letter repeatedly will move you through choices beginning with that letter).

	Field	Value	Description
Central Patient Index Record Key			
	Hospital Link	NACRS	
	Regional Chart Number		
	Master Chart Number		
	Chart Number	453098	
	Fixed Length Chart Number		
	ULI		
	Mothers Chart	186500	
	Sensitivity Level		
Patient/Client Demographics Information			
	Salutation		
	Last Name	Last 453098	
	Middle Name	FEMALE	
	First Name	First 453098	
	Maiden Name		
	Name at Birth		
	Place of Birth		
	Birth Date	2012/05/11	
	Is Birthdate Estimated?		
	Death Indicator		
	Date Patient Died		
	Gender	F	Female
	Language		
	Marital Status		
	Education		
	Occupation		
	Living Arrangement		
	Residence Code		
	Residence Type		

Figure 238 - Fields grid quick search result

Fields grid multi-form sections

Multi occurrence section, like “**Provider Data**” cannot be expanded. Double-clicking the header of a multi-occurrence section will open the multi-form associated with the section.

To open a multi-form from the Section header

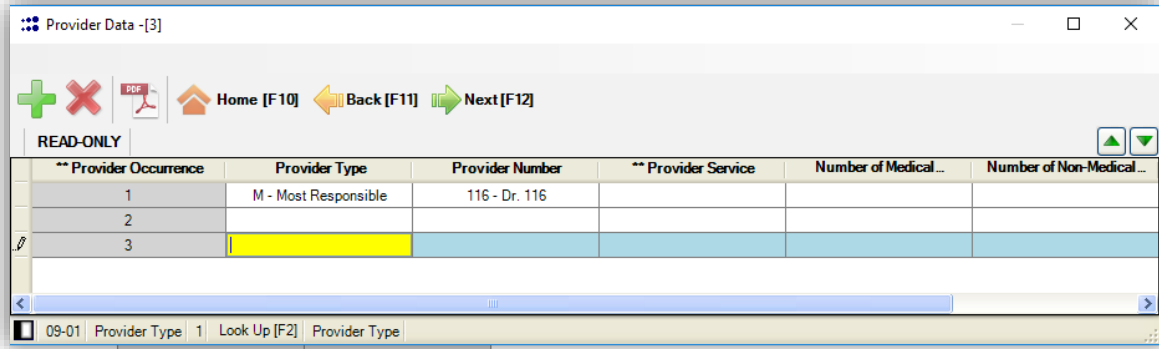
- Double-click the section header.

	Field	Value	Description
[-]	Cancer Care Information		
	Method of Diagnosis		
	First Diagnosis Date		
	Future Date		
	Medical Referral Date		
	Radiation Referral Date		
	Supportive Care Referral...		
[-]	Address Information		
[-]	Contacts Information		
[-]	Alerts/Allergies Information		
[-]	Baby Charts Information		
[-]	Chart Links Information		
[-]	Alias Information		
[-]	Family History of Disease Information		
[-]	Attached Files Information		
[-]	Lab History Information		
[-]	Risk Factors Information		
[-]	User Fields Information - Set 1		

Figure 239 - Multi-form form section header

5.12 Multi-forms

Multi-Forms are embedded in a module's main grid and allows multiple occurrences, for example, the Diagnosis, Intervention, Providers. Since more than one diagnosis, intervention, provider may be entered for an abstract the multi-form is used.



** Provider Occurrence	Provider Type	Provider Number	** Provider Service	Number of Medical...	Number of Non-Medical...
1	M - Most Responsible	116 - Dr. 116			
2					
3					

Figure 240 - Multi-form

The following are images of the different toolbars for the multi-forms. The generic toolbar image shows what most of the multi-form tools look like. The intervention and diagnosis multi-forms have different tool available to them.



Figure 241 - Generic Multi-Form Toolbar

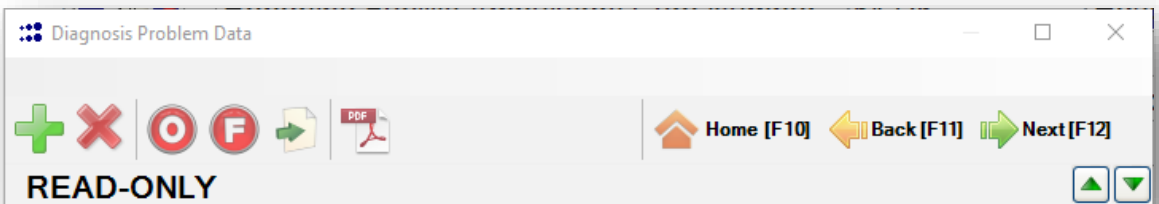


Figure 242 - Diagnosis Data Multi - Form Toolbar

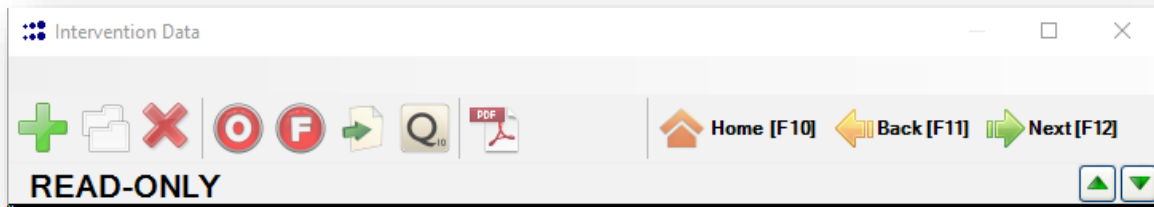


Figure 243 - Intervention Data Multi-Form Toolbar

Chart outlining the Multi-form toolbar icons, shortcut keys and description of the functionalities.

 or [F5]	Adds an entry row to the grid allowing the user to enter a new set of fields.
 or [F9]	Deletes the current row.
	Copy feature - Intervention multi-form only – Ability to copy the intervention information from the previous occurrence.
 or [F7]	Opens another linked encoder application (only available in Diagnosis and Intervention multi-forms) and if encoder information is filled in Hospital Profile
	Launch Candian Classification Browser – This will open the Canadian Classification website. Available in Diagnosis and Intervention multi-forms only.
	Opens the CIHI Folio (only available in Diagnosis and Intervention multi-forms). The File/Folder Paths/Folio paths need to be entered in the User Profile .
	Import Folio File feature - Opens a Dialog window to allow user to import a Folio Code Basket File into WinRecs Diagnosis or Intervention multi-forms.
 or [F6]	Quick Hint – Intervention Data Multi-Form only – Displays the most recent common Intervention codes that have been used.
	Opens the PDF File Viewer
 or [F10]	Closes the multi-form and places the focus back on the main grid of abstract.
 or [F11]	Opens the previous field that uses a multi-form.
 or [F12]	Opens the next field that uses a multi-form.

Table 21 - Multi-Form Toolbar

To access the multi-forms

- When entering data in an abstract or the CPI MODULE grid, pressing the **[ENTER]** key to move to the next field will open the multi-form if the next field can have multiple occurrences.
- or —
- Click a specific multi-occurrence field in the field navigation list.

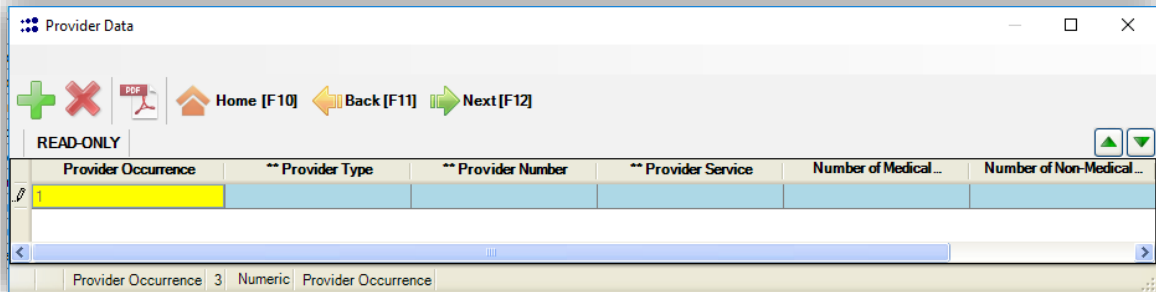


Figure 244 - Accessing a multi-form

To enter data in a multi-form

When a multi-form is open, the focus is on the first field of the first row. Enter the data required in the first field. Pressing **[ENTER]** will move the focus to the next field to the right.

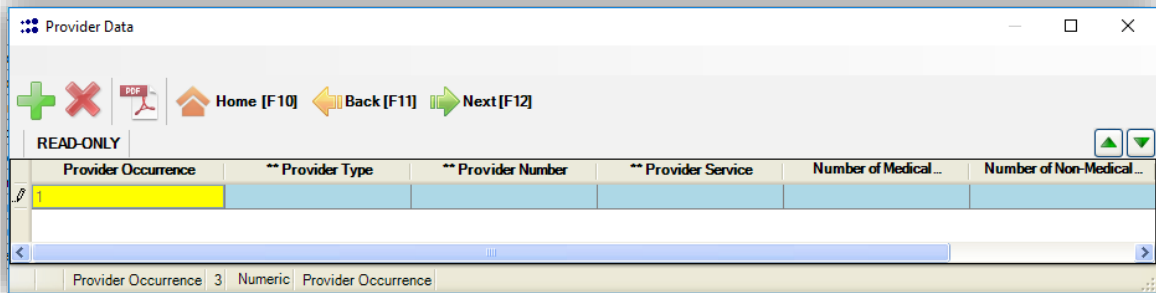
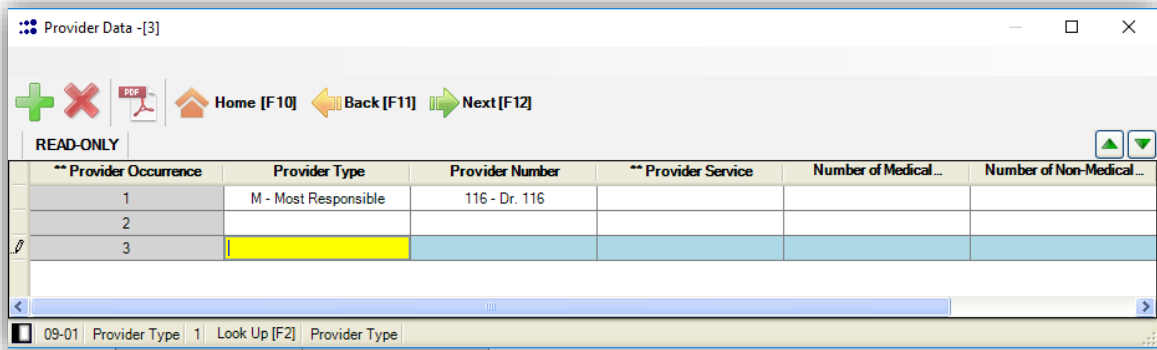


Figure 245 - Entering data in a multi-form

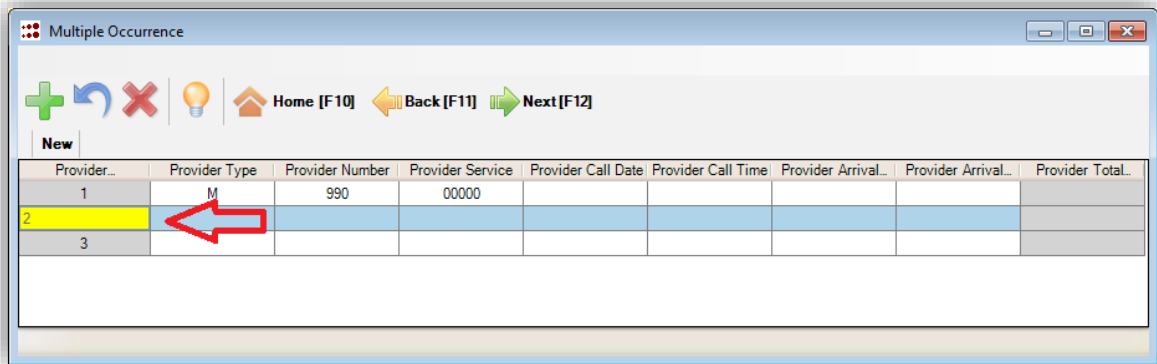
To add a new row of data

- To enter another row of data, press the  icon on the toolbar.
- The focus will be set to the first field of the new row.



** Provider Occurrence	Provider Type	Provider Number	** Provider Service	Number of Medical...	Number of Non-Medical...
1	M - Most Responsible	116 - Dr. 116			
2					
3					

Figure 246 - Multi-form multiple rows



Provider...	Provider Type	Provider Number	Provider Service	Provider Call Date	Provider Call Time	Provider Arrival...	Provider Arrival...	Provider Total...
1	M	990	00000					
2								
3								

Figure 247 - Multi-form row selected for undo

To delete the data entered and the row

- Click on the header of the row (as shown by the arrow on the figure below)
- Click on the Delete icon  on the toolbar

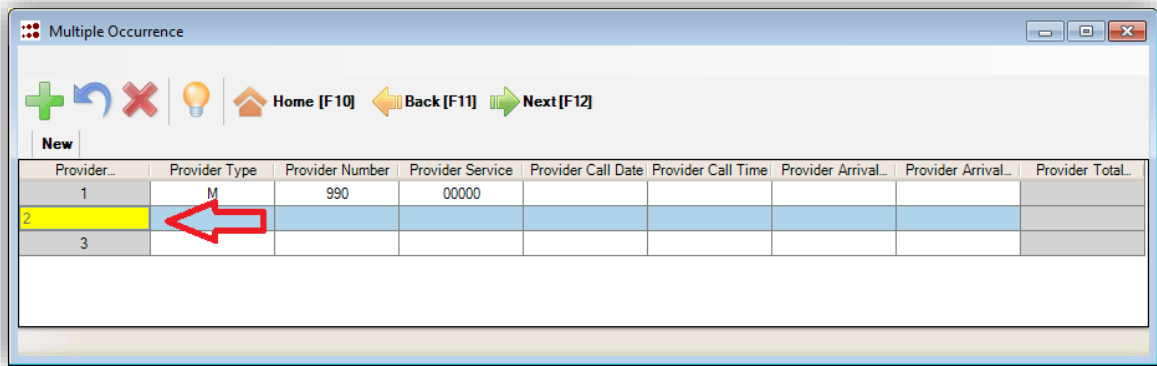


Figure 248 - Multi-form row selected for delete

To close the multi-form and navigate back to the Main window

When the entry is complete navigate back to the Main window.

- Press **[F10]**.

— or —

- Click the Home  icon on the toolbar.

Using the Home function will set the focus to the first field of the entry grid on the Main window.

To navigate automatically to the next field

When the entry is completed, navigate to the next field. If the next field is a multi-occurrence field the multi-form will stay open and the next multi-occurrence field will be displayed by the multi-form; otherwise the multi-form will be closed and the next field of the main grid will have the focus.

- Press **[F12]**.

— or —

- Click the Next  icon on the toolbar.

To navigate automatically to the previous field

Once the entry is completed, navigate to the previous field. If the previous field is a multi-occurrence field the multi-form will stay open and the previous multi-occurrence field will be displayed in the multi-form; otherwise the multi-form will be closed and the previous field of the main grid will have the focus.

- Press **[F11]**.

— or —

- Click the Previous  icon on the toolbar.

Diagnosis Code

In the Diagnosis Code field, the search function are as follows:

- By partial Diagnosis Code eg: I50 and a search screen with all codes with I50 will display
- By Full Diagnosis Code eg: I500 or I50.0 will fill in the diagnosis code
- By partial/full diagnosis code and partial description eg: I50 Congestive – will populate the code or a search screen of all codes with search will display.

Copy Function – Intervention Multi-Form

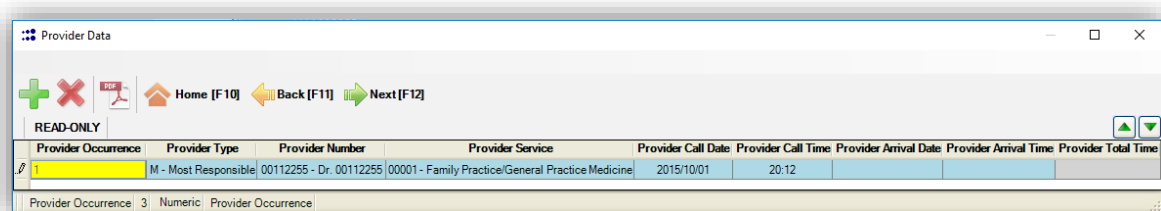
Gives the user the ability to copy Intervention information from the previous occurrence in Inpatient and Amcare records.

- Fill in occurrence 1 with the required information
- Create occurrence 2, click on the Copy Function 
- Pressing this will populate all fields from the previous occurrence except the Intervention Code. Any changes can be done manually
- If needed, the user may copy data for occurrence 3 and this will populate from occurrence 2.

Descriptions – Multi-Forms

Descriptions are now displayed in the same cell as the selected item for the given field. All multi-forms with fields that have a description associated with the field will appears as follows; Field Value – Value Description.

The following example shows each column for the Provider Data Multi-Form. User will see the value of each selected field followed by the description.



Provider Occurrence	Provider Type	Provider Number	Provider Service	Provider Call Date	Provider Call Time	Provider Arrival Date	Provider Arrival Time	Provider Total Time
1	M - Most Responsible	00112255 - Dr. 00112255	00001 - Family Practice/General Practice Medicine	2015/10/01	20:12			
3	Numeric	Provider Occurrence						

Figure 249 - Provider Data Multi-Form

Provider Type	Provider Number	Provider Service
M - Most Responsible	00112255 - Dr. 00112255	00001 - Family Practice/General Practice Medicine

Figure 250 - Close up View

When the user selects a field on a multi-form the status bar will show the description of the selected item, while the cell shows the selected value.

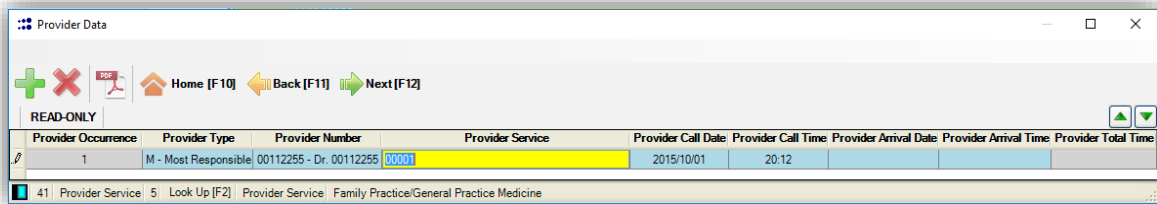


Figure 251 - Provider Data - Provider Service and Description

Provider Type	Provider Number	Provider Service
M - Most Responsible	00112255 - Dr. 00112255	00001
5	Look Up [F2]	Provider Service Family Practice/General Practice Medicine

Figure 252 - Close up View of the Selected Field

5.13 Look up

Field of type Look Up can only accept values from a predefined list of values. This list can be maintained via the **Maintenance → Look Up Code Maintenance** menu.

When you are on a field that is of type Look Up you can access the list of valid code by pressing **[F2]**

To enter a valid value from the Look Up List

- Type in the value. E.g. for a male gender you can just type in the field *m*

To access the Look Up list

- Press **[F2]** – this will only display the look up list if the currently selected field is of type **Look Up**

To select a value from the Look Up List

- Click on the desired value on the list, then click the **"Select Record"** button

— or —

- Double-click the desired value on the list.

To close the Look Up List without selecting a value

- Click the  in the window title bar.

— or —

- Press **[ESC]** twice in a row

Look up lists size

Look up list will only display the first 100 results. The look up window will display the message:

“There may be more results. Consider refining your search”, as shown below.

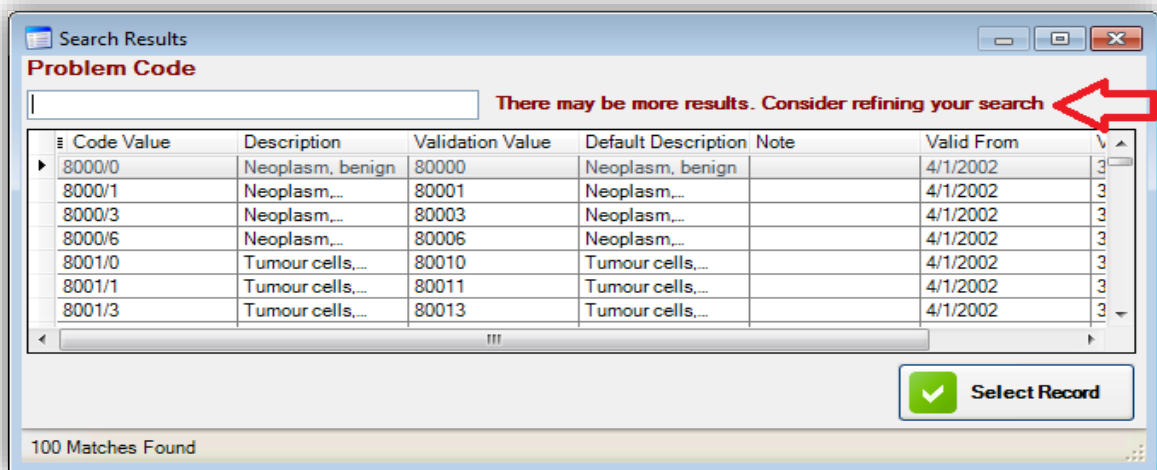


Figure 253 - Look up list size

In this case you should filter your list

To filter the Look Up List

Some look up lists are very long, filter the list by:

- In the field enter your filter criteria, the press **[ENTER]**. E.g. for the language field you can type *en*

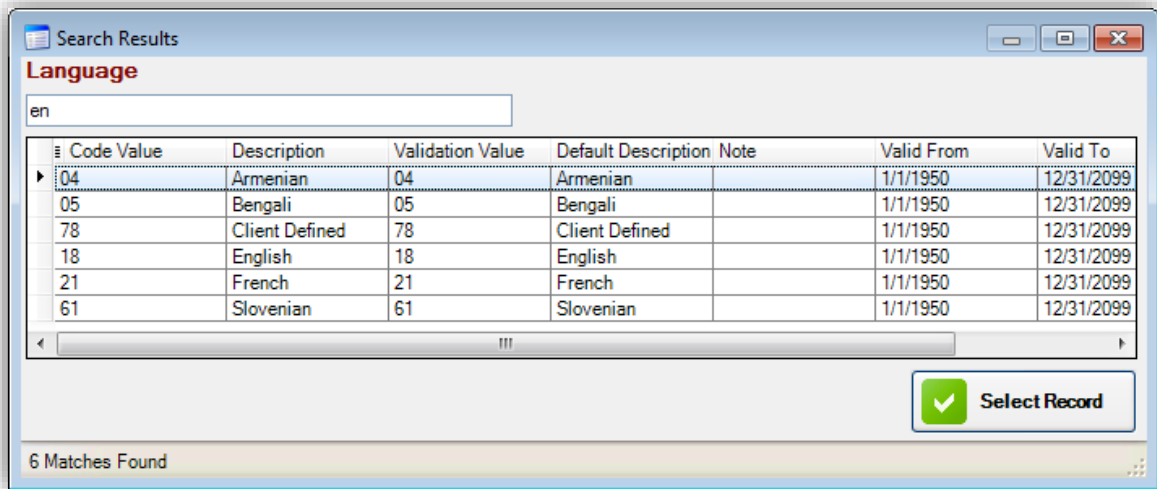


Figure 254 - Look up list pre-filtered

— or —

- Open the Look up list by pressing **[F2]**.
- In the search text box, on the upper left corner of the window, type in your filter criteria.
- Press **[ENTER]**.

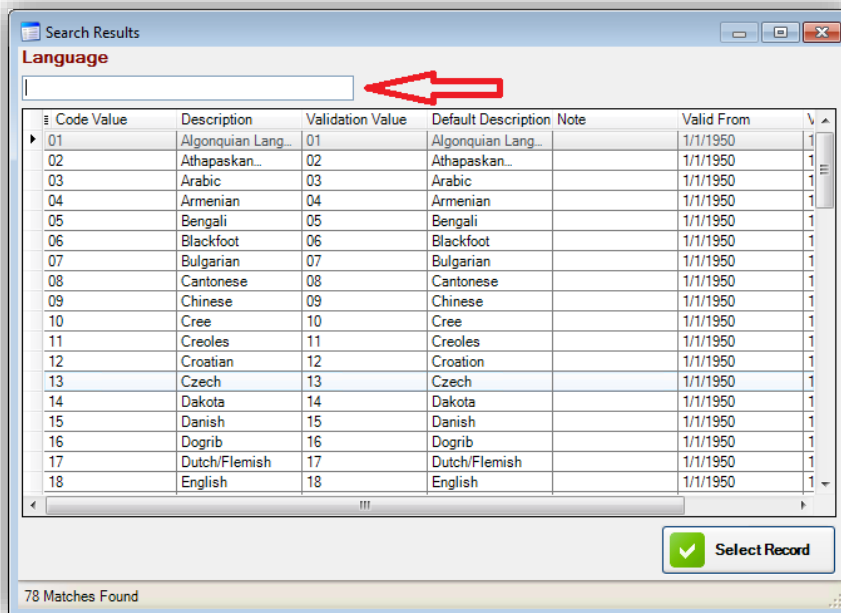


Figure 255 - Look up list filtering step 1

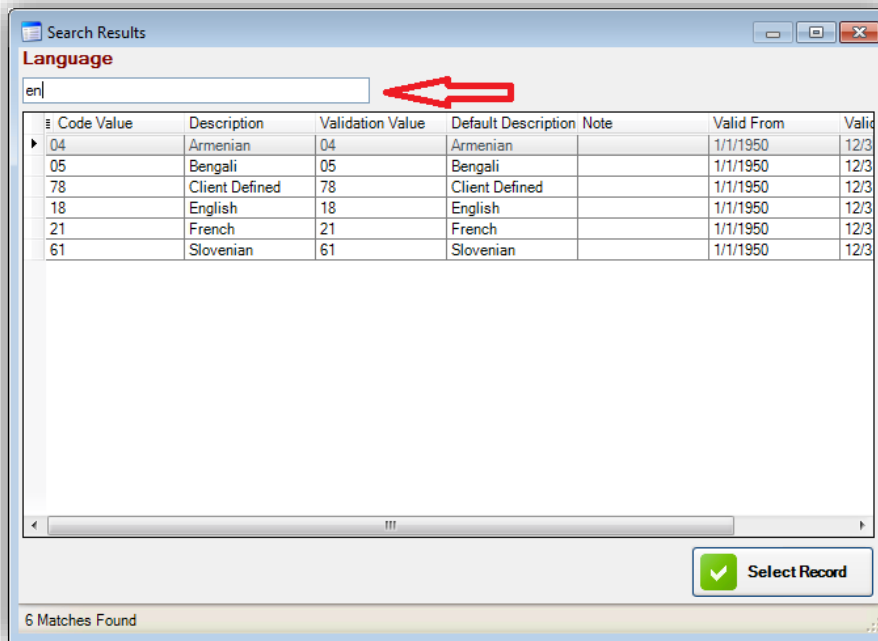


Figure 256 - Look up list filtering step 2

Look Up Maintenance Report

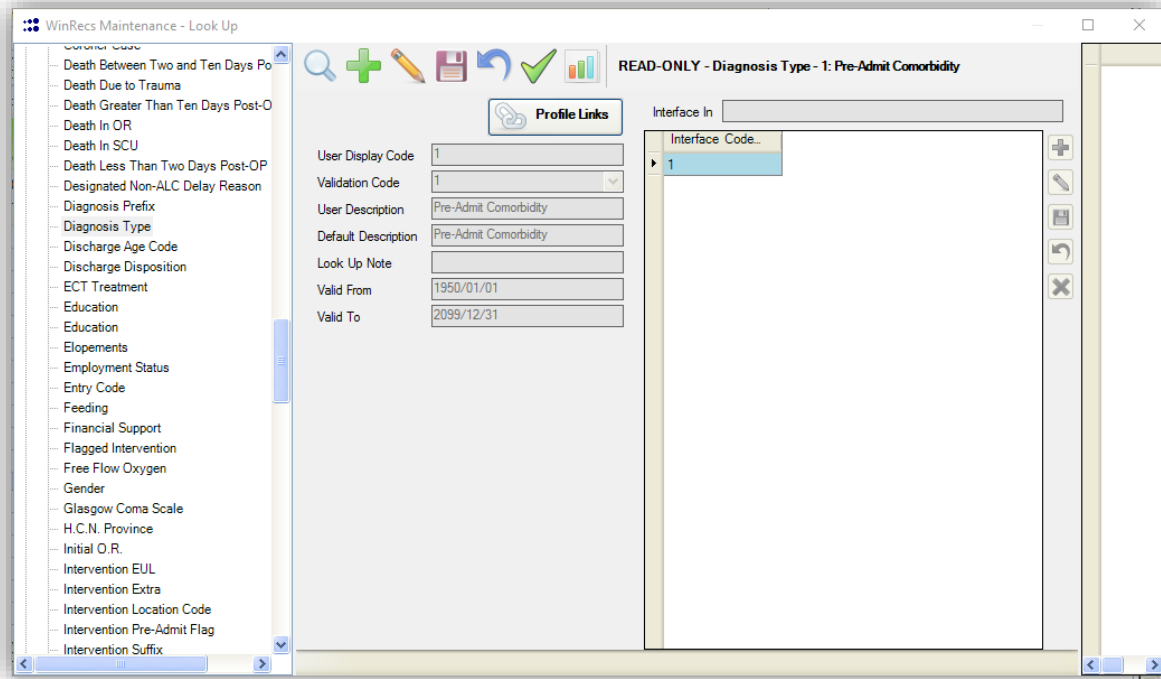
The Look Up Maintenance Report is a report that will list all the look up values available for a field. The report will need to be set up in the Report Maintenance module [see Reports](#)

To run the report:

- Click on the Look Up Field



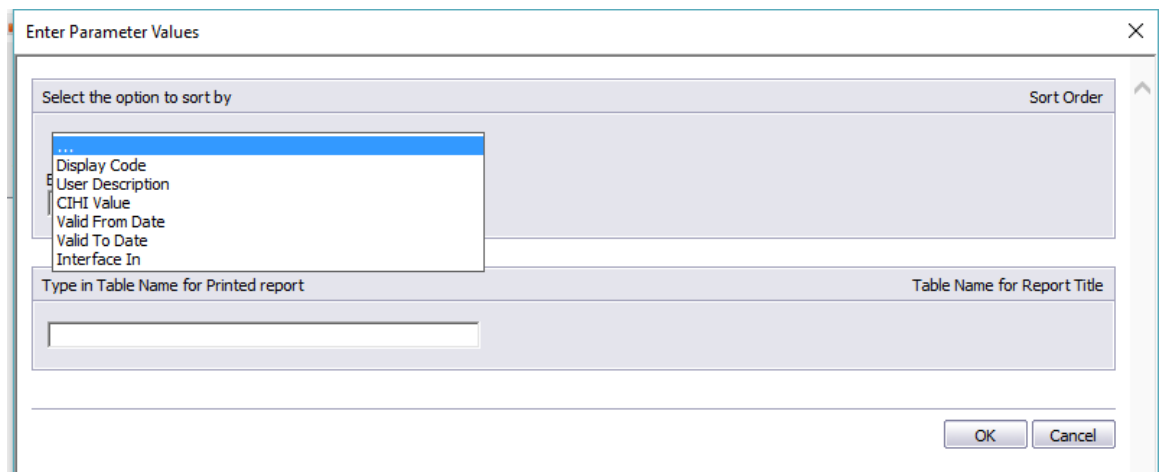
- Press the **[F4]** and search for the value



The screenshot shows the 'WinRecs Maintenance - Look Up' window. On the left is a tree view with categories like 'Death Between Two and Ten Days Post-Op', 'Death Due to Trauma', etc. The main area is titled 'READ-ONLY - Diagnosis Type - 1: Pre-Admit Comorbidity'. It contains a 'Profile Links' section with fields for 'User Display Code' (1), 'Validation Code' (1), 'User Description' (Pre-Admit Comorbidity), 'Default Description' (Pre-Admit Comorbidity), 'Look Up Note', 'Valid From' (1950/01/01), and 'Valid To' (2099/12/31). To the right is a table with one row: 'Interface Code...' with value '1'.

Figure 257 – Look Up Vale

- Press  or [F10]
- Click on the Report Name for Look Up Maintenance Report
- Enter the Parameters



The screenshot shows the 'Enter Parameter Values' dialog box. It has a 'Select the option to sort by' section with a dropdown menu showing options: 'Display Code', 'User Description', 'CIHI Value', 'Valid From Date', 'Valid To Date', and 'Interface In'. The 'Sort Order' is set to 'Ascending'. Below this is a 'Type in Table Name for Printed report' field and a 'Table Name for Report Title' field. At the bottom are 'OK' and 'Cancel' buttons.

Figure 258 – Report Print Parameters

- Press Ok and the list of look up values for the specified fields will display

Display Code	Hospital Link	User Description	Default Description	CIHI Value	Valid From	Valid To	Interface
0		Optional/NB Via CS	Newborn Diagnosis	0	2001/04/01	2001/03/31	
0		Newborn/C-Section Code	Newborn/C-Section Code	0	1950/01/01	2099/12/31	
1		Pre-Admit Comorbidity	Pre-Admit Comorbidity	1	1950/01/01	2099/12/31	
2		Post-Admit Comorbidity	Post-Admit Comorbidity	2	1950/01/01	2099/12/31	
3		Secondary	Secondary Diagnosis	3	1950/01/01	2099/12/31	
4		Morphology	Morphology Code	4	1950/01/01	2099/12/31	
5		Admitting Diagnosis when different than Most Responsible Diagnosis	Admitting Diagnosis	5	2005/04/01	2099/12/31	
5		Optional	Optional	5	1950/01/01	2005/03/31	
6		Proxy Diagnosis (Asterisk code used for CMG Assignment)	Proxy Most Responsible Diagnosis (MRDx)	6	2005/04/01	2099/12/31	
6		Optional	Optional	6	1950/01/01	2005/03/31	
7		Optional	Optional	7	1950/01/01	2011/03/31	
8		Optional	Optional	8	1950/01/01	2011/03/31	
9		E-Code	External Cause of Injury Code	9	1950/01/01	2099/12/31	
M		Most Responsible	Most Responsible Diagnosis (MRDx)	M	1950/01/01	2099/12/31	
W		First Transfer Diagnosis	First Transfer Diagnosis	W	1950/01/01	2099/12/31	
X		Second Transfer Diagnosis	Second Transfer	X	1950/01/01	2099/12/31	
Y		Third Transfer Diagnosis	Third Transfer Provider Diagnosis	Y	1950/01/01	2099/12/31	

Report Printed On: 12/16/2016

Figure 259 – Look Up Values Report

5.14 Reports

Reports are set up through the Maintenance/Report Maintenance

To open the Report Manager

- Press **[F10]**.
— or —
- Select the menu option **Actions** → **Report Manager**.
— or —
- Click the Report Manager button on the toolbar .
- The Select Report window will open with the reports available for this module
- 2. or -

- Go to 'Report File:' – press **[F2]** and a directory window will pop up for you to go to the list of reports

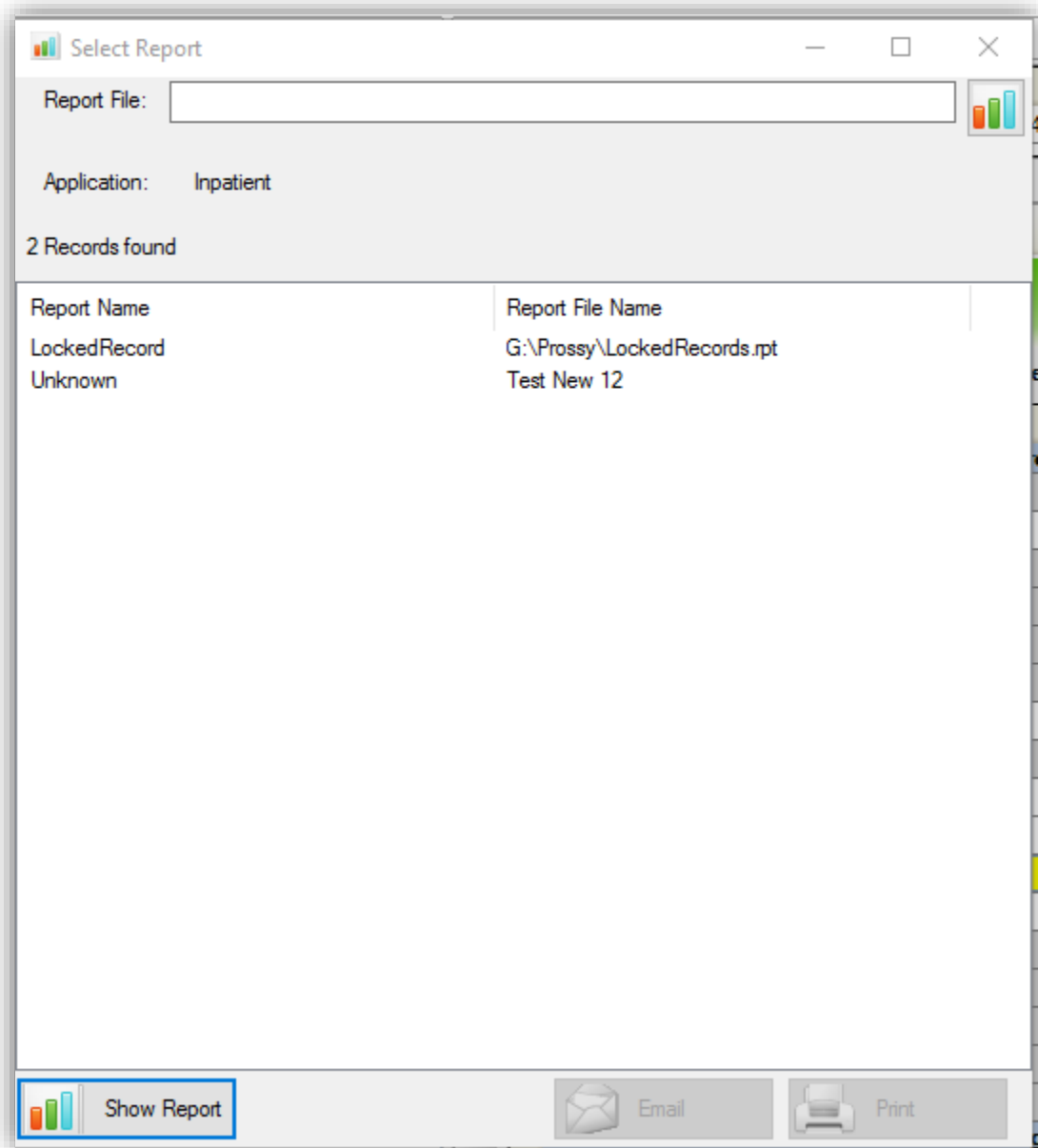
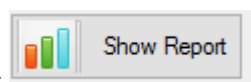
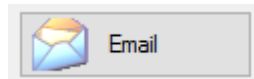


Figure 260 - Select Report Screen

- Press Show Report



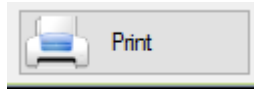
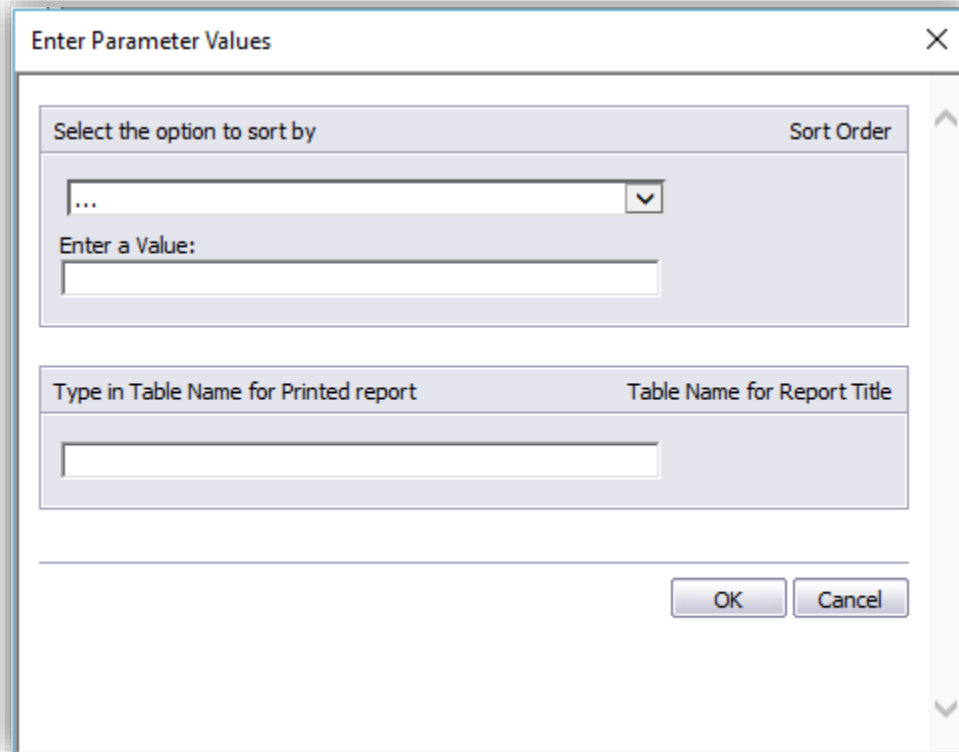
- The report can also be emailed



which is set up in

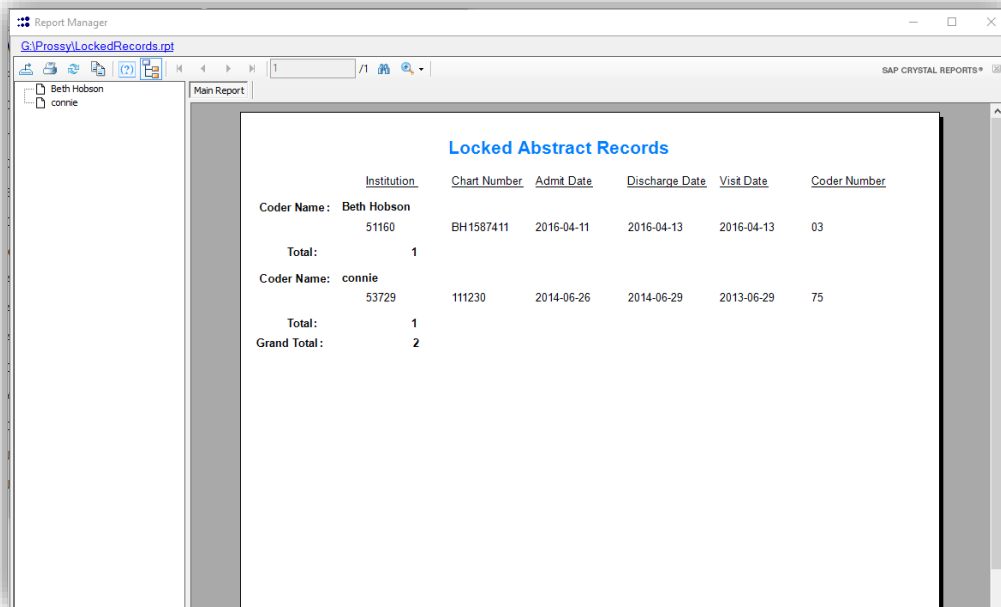
Report Maintenance

- The report can also be printed
- Report Manager will open depending on the report parameters may be needed or if no parameters the report will open.

The dialog box is titled "Enter Parameter Values" and has a close button (X) in the top right corner. It contains two main sections. The first section is labeled "Select the option to sort by" and "Sort Order". It features a dropdown menu with a downward arrow and a label "Enter a Value:" followed by a text input field. The second section is labeled "Type in Table Name for Printed report" and "Table Name for Report Title". It features a single text input field. At the bottom right of the dialog box are "OK" and "Cancel" buttons.

Figure 261 – Parameter Screen



Locked Abstract Records						
	<u>Institution</u>	<u>Chart Number</u>	<u>Admit Date</u>	<u>Discharge Date</u>	<u>Visit Date</u>	<u>Coder Number</u>
Coder Name:	Beth Hobson					
	51160	BH1587411	2016-04-11	2016-04-13	2016-04-13	03
Total:		1				
Coder Name:	connie					
	53729	111230	2014-06-26	2014-06-29	2013-06-29	75
Total:		1				
Grand Total:		2				

Figure 262 – Opened Report

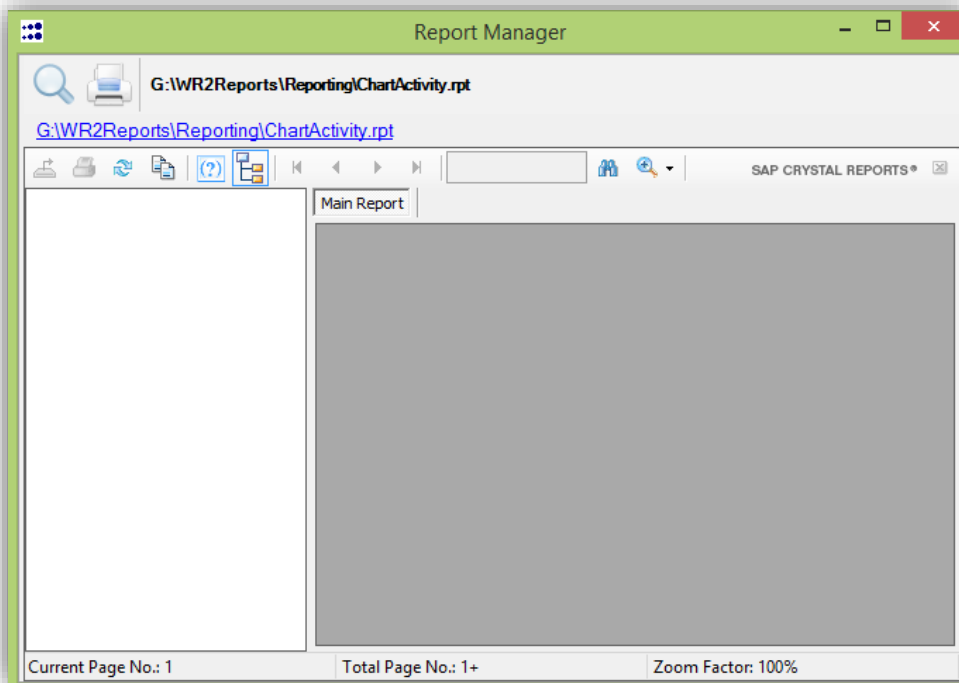


Figure 263 – Report Manager Window

5.15 Interfacing with Folio Views Code Basket

WinRecs has incorporated the ability to interface with the Folio Views application software through the Code basket functionality.

Note: For information of how to use Code Basket functionality please contact CIHI.

To configure

- Go to Options → User Profile → File/Folder Paths → Find User → Edit

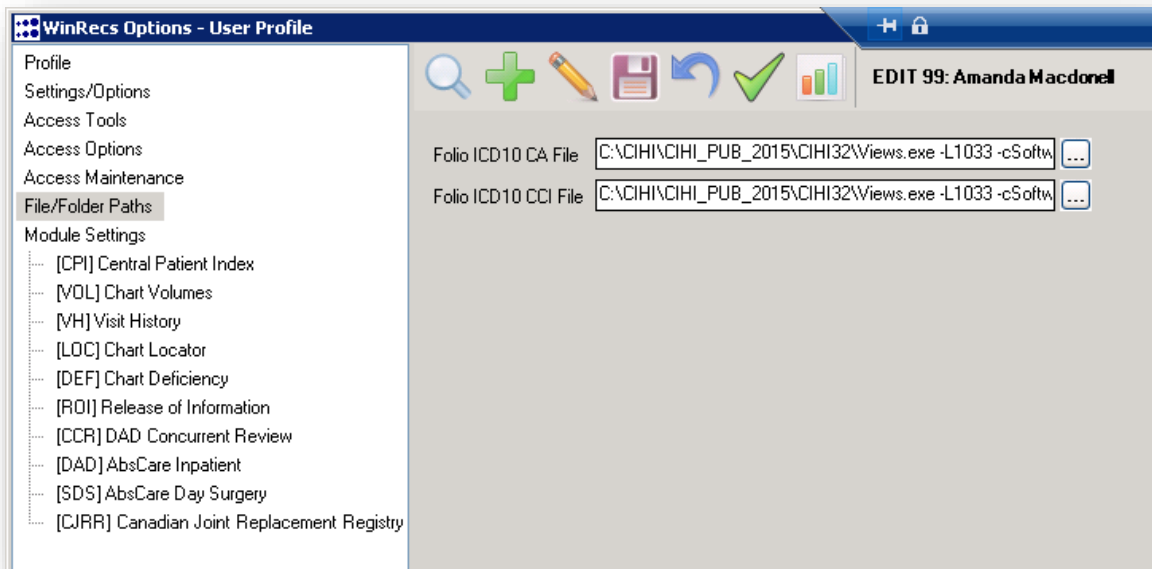


Figure 264 - Configure Code Basket

Skeleton File Paths

ICD10-CA:

C:\CIHI\CIHI_PUB_2015\CIHI32\Views.exe -L1033 -
cSoftware\CIHI\2015\ICD10_CodeBasket\English -
i"C:\CIHI\CIHI_PUB_2015\SDW\icd_2015_eng.sdw" -r"C:\CIHI\CIHI_PUB_2015\cb_en.txt"

CCI:

C:\CIHI\CIHI_PUB_2015\CIHI32\Views.exe -L1033 -
cSoftware\CIHI\2015\ICD10_CodeBasket\English -
i"C:\CIHI\CIHI_PUB_2015\SDW\cci_2015_eng.sdw" -r"C:\CIHI\CIHI_PUB_2015\cb_en.txt"

Note: These file paths may need to be modified, depending on location of software.

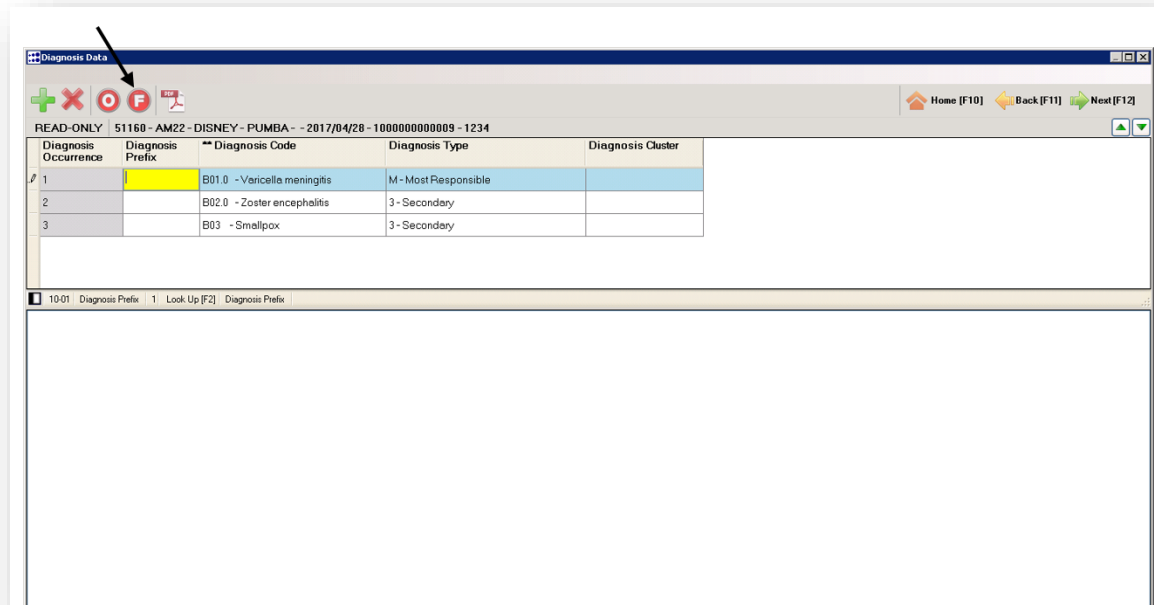
A temporary file is created when importing the codes, and where it's written to is determined by the last part of each file path (in bold below). You can determine a location that you have write access to that you'd like to have the temporary files write to and update the path to reflect that. These are temporary files, that will delete once the codes are imported into WinRecs.

C:\CIHI\CIHI_PUB_2015\CIHI32\Views.exe -L 1033 -
cSoftware\CIHI\2015\ICD10_CodeBasket\English -i "X:\SHADOWFILES2015\ICD2015-
Merged.sdw" -r "C:\CIHI\CIHI_PUB_2015\cb_en.txt"

Folio Paths can also be set up at the Regional Profile / Hospital Profile Level for all users.

Importing from Folio Code Basket into WinRecs

- From within the Diagnosis or Intervention screen select the Folio button on the tool bar.



Note: User doesn't need to be on the Diagnosis Code or Intervention Code fields when launching Folio.

- o When Folio launches, WinRecs displays a dialog that the Coder will use to indicate the Folio session is complete, allowing WinRecs to pull the selected codes from the Code Basket. Do not close ('OK', 'Cancel', or 'X') this dialog box until the codes have been added to the Code Basket – this is what triggers the import into WinRecs, if it is closed prior to adding the codes, there will be nothing to trigger the import once they have been added, and you will need to launch a new Folio to prompt the dialog box again.

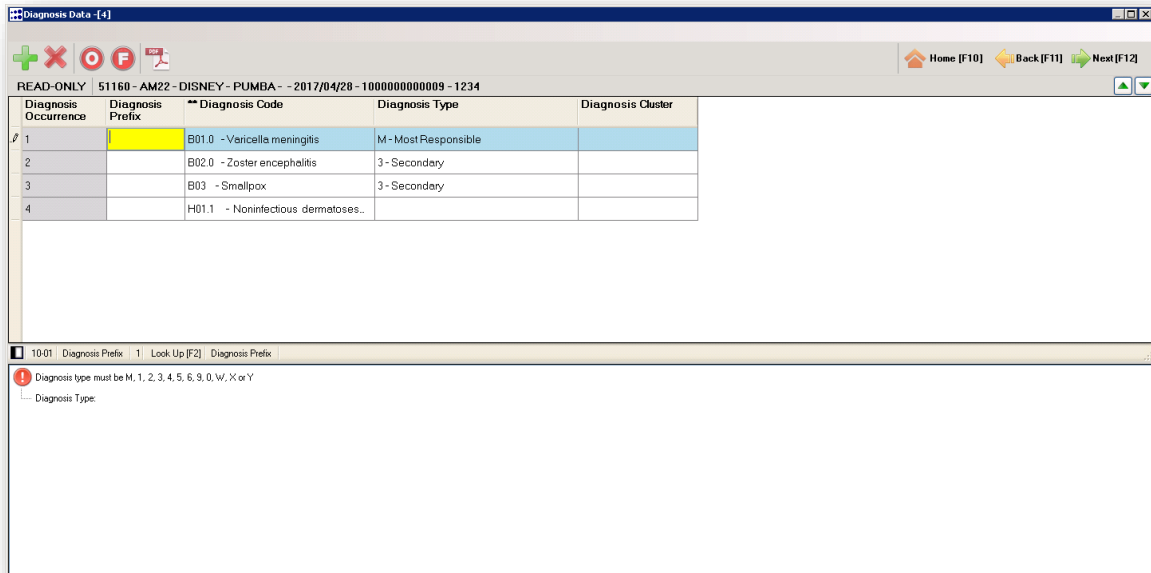


- o In Folio, load codes into Folio Code Basket, as per instructions from CIHI.
- o When the code basket has the codes needed, you can close Folio.
- o Then you can click on OK, to trigger the import of the codes into WinRecs



Note: If you no longer want to import the codes and want to leave the abstract as it was prior to opening Code Basket, you can select Cancel.

- All codes that were in the code basket will now display in the abstract:



The screenshot shows the 'Diagnosis Data' window in WinRecs. The window title is 'Diagnosis Data - [4]'. It has a toolbar with icons for adding, deleting, and saving. The main area contains a table with the following columns: 'Diagnosis Occurrence', 'Diagnosis Prefix', 'Diagnosis Code', 'Diagnosis Type', and 'Diagnosis Cluster'. The table has 4 rows of data:

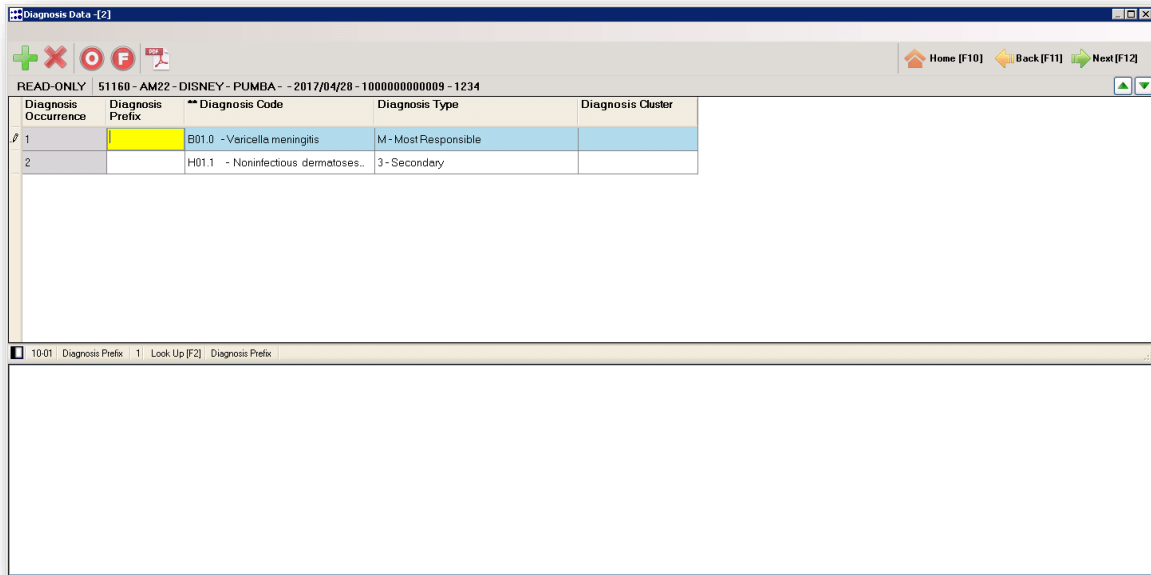
Diagnosis Occurrence	Diagnosis Prefix	Diagnosis Code	Diagnosis Type	Diagnosis Cluster
1		B01.0 - Varicella meningitis	M - Most Responsible	
2		B02.0 - Zoster encephalitis	3 - Secondary	
3		B03 - Smallpox	3 - Secondary	
4		H01.1 - Noninfectious dermatoses..		

Below the table, there is a status bar with the text '10-01 Diagnosis Prefix | 1 | Look Up [F2] | Diagnosis Prefix'. At the bottom, there is a message box that says 'Diagnosis type must be M, 1, 2, 3, 4, 5, 6, 8, 9, 0, W, X or Y' and 'Diagnosis Type:'.

It's also possible to remove previously selected codes from WinRecs, via Folio, if they are no longer deemed relevant.

- Go to Code basket as you would to import a code.
- Delete code from Folio Code Basket (as per instructions from CIHI). Once you've deleted any codes you'd like to, you can close folio.
- Once back in WinRecs, select OK on the dialog box.

When the dialog is closed, WinRecs imports the 2 selected codes and removes the 2 deleted codes:

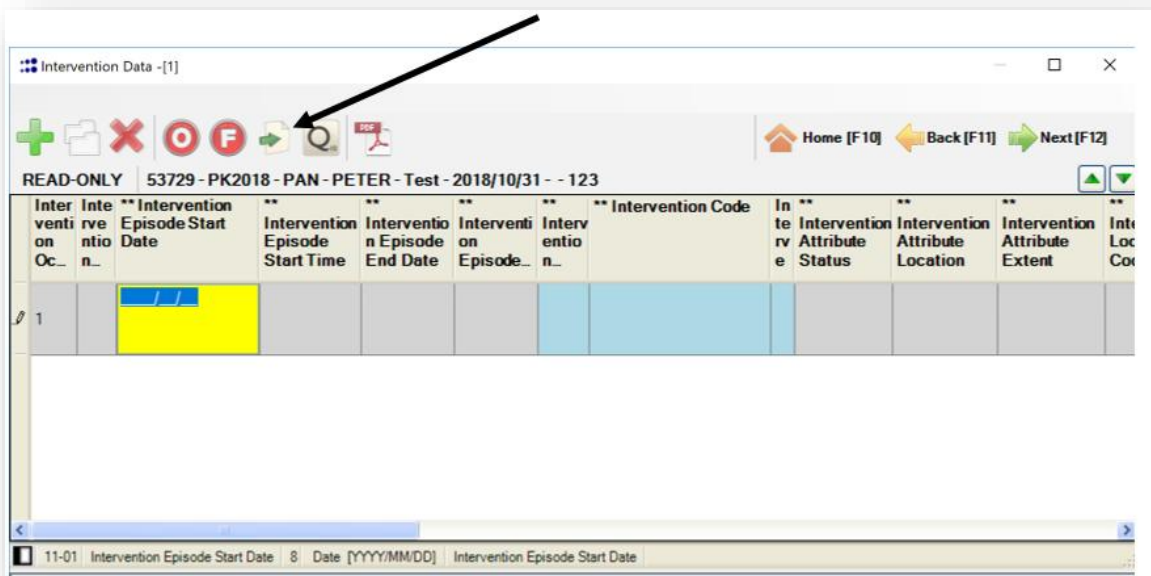


Diagnosis Occurrence	Diagnosis Prefix	** Diagnosis Code	Diagnosis Type	Diagnosis Cluster
1		B01.0 - Varicella meningitis	M - Most Responsible	
2		H01.1 - Noninfectious dermatoses..	3 - Secondary	

Importing a Folio Code Basket File

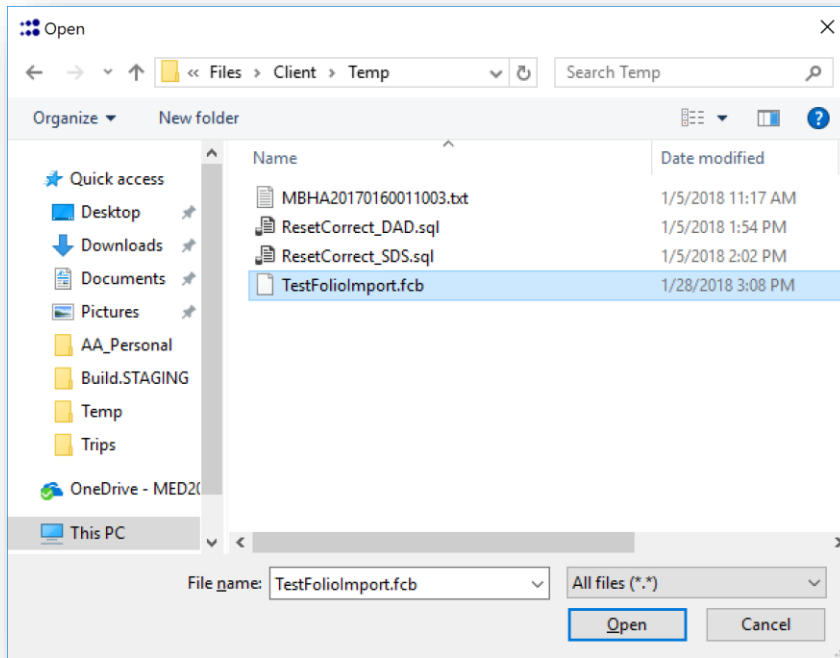
The file(s) will need to be created from Folio Views before following the instructions below. Please consult CIHI for instructions about saving files from Folio Code Basket.

- From the Diagnosis or Intervention screen, select the import icon:

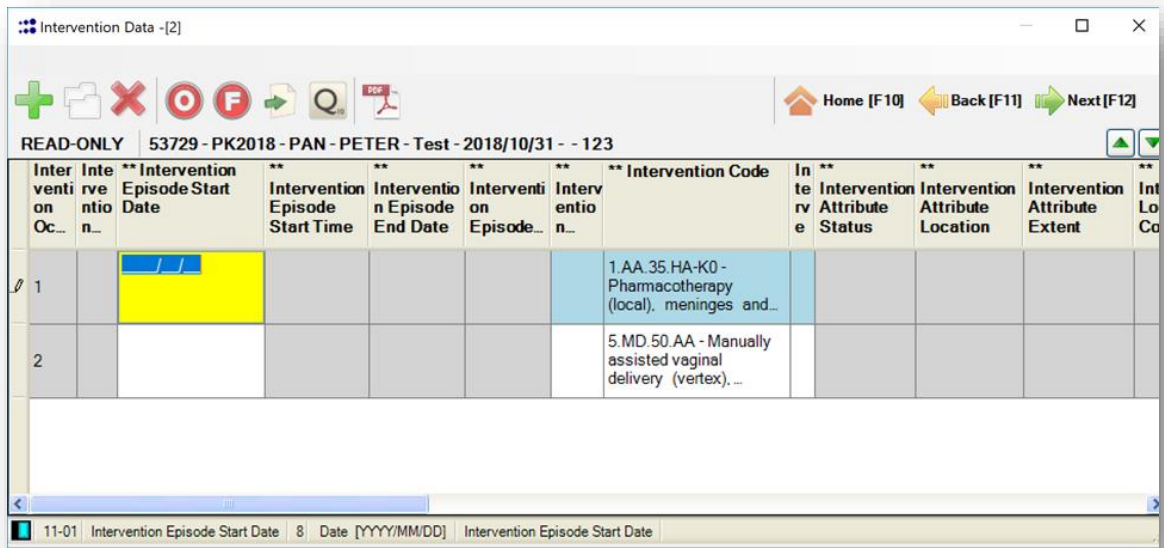


Intervention Occurrence	Intervention Date	** Intervention Episode Start Date	** Intervention Episode Start Time	** Intervention Episode End Date	** Intervention Episode	** Intervention Code	Intervention Attribute Status	Intervention Attribute Location	Intervention Attribute Extent	Intervention Location
1										

- Select the File (WinRecs will remember the last location)



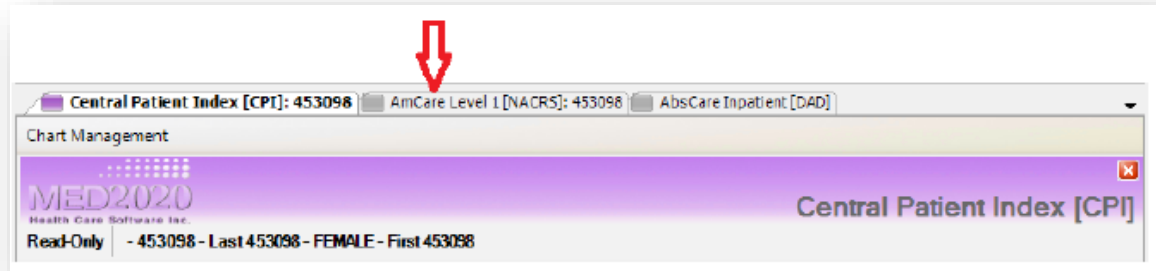
- The contents from the saved file will load into WinRecs



6. WinRecs Modules

WinRecs module windows are displayed in the main area of the application. To allow maximum flexibility and better navigation, you can open multiple records from different modules at the same time. This will allow the user to quickly toggle between records.

The text on the tab helps to identify the record that is open. The information displayed on the tab is configurable in the Control File.



6.1 Chart Maintenance

The Chart Maintenance Module Consists of the **CPI MODULE**, **Chart Volumes**, **Visit History**, **Chart Locator**, **Chart Deficiency** and **Release of Information** modules.

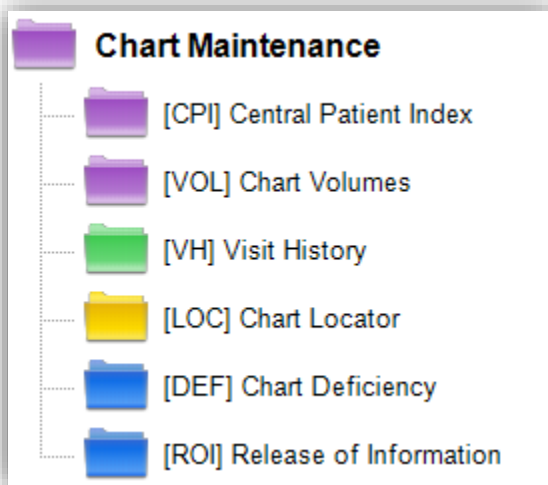


Figure 265 – Chart Maintenance Modules

6.1.1 Central Patient Index [CPI MODULE] Module

The Central Patient Index [CPI MODULE] stores patient demographic information such as record key, patient demographics and user field information. Included in the **CPI MODULE** is the **Chart Management** features which modifies chart information.

To open the CPI MODULE

- Select the menu option **Module → Chart Maintenance → [CPI MODULE] Central Patient Index**
— or —
- Select **WinRecs Module Menu → Chart Maintenance → [CPI MODULE] Central Patient Index**

Module Header

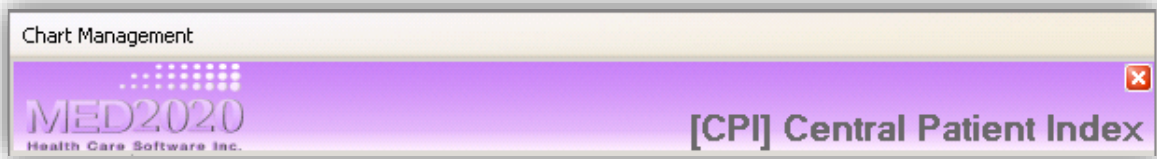


Figure 266 - CPI MODULE Header

Chart Management

- Click on the chart management menu item on the CPI MODULE header.

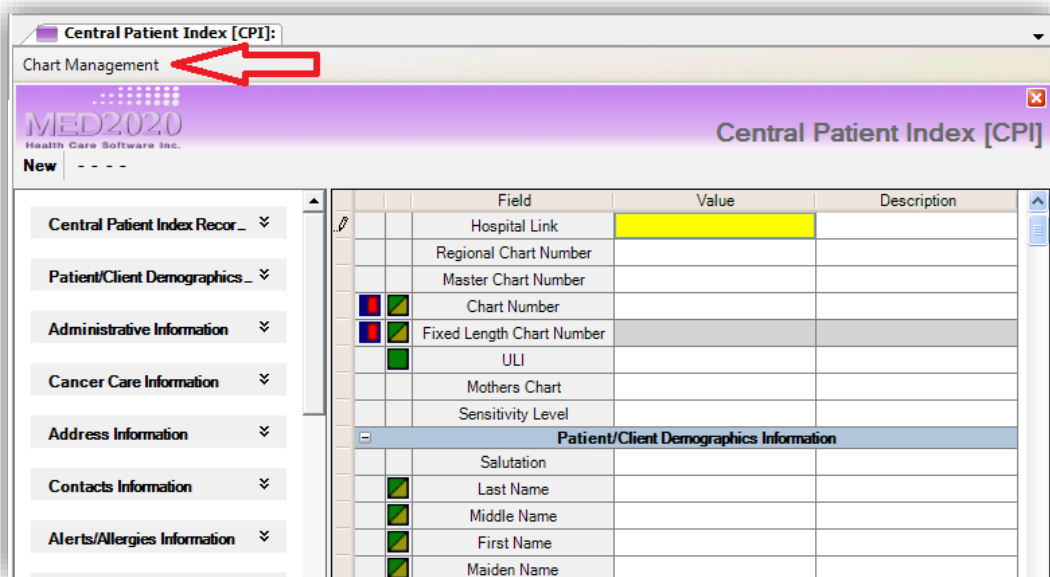


Figure 267 - Chart management menu

- Click the Modify item

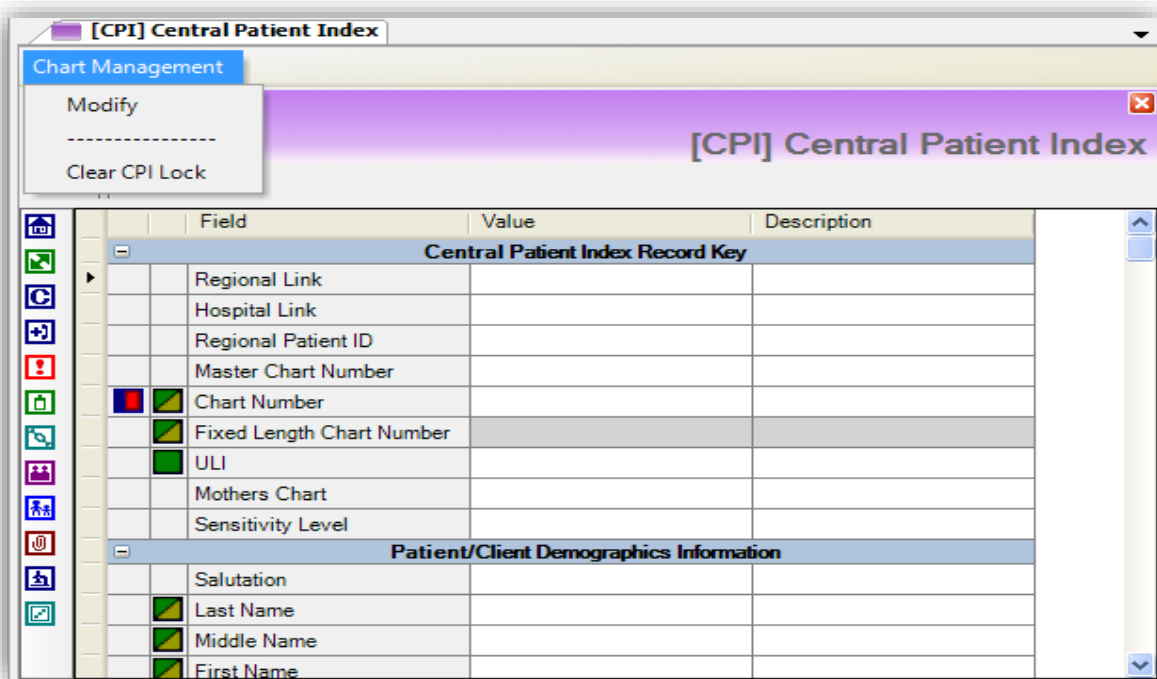


Figure 268 - Chart management menu open

The **WinRecs Chart Management - Modify** screen has 4 options to choose from:

1. Change Chart Number
2. Merge Charts
3. Unmerge Chart
4. Relocate Visits

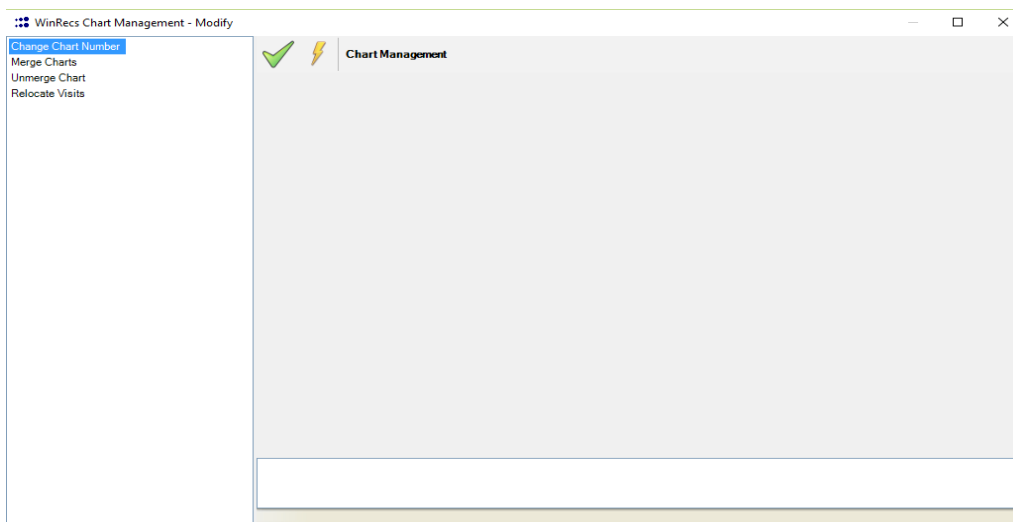


Figure 269 - Chart management window



- Verify or Press **[F11]**



- Execute or Press **[F12]**

Source Chart Number – the chart number that is changing or no longer using (child)

Target Chart Number – the chart number that is being kept (parent)

If Modify a Chart is not displayed in the CPI module, the user may not have the necessary permissions. Contact your WinRecs system administrator.

Change Chart Number

This is used to change one chart number to another chart number, the target chart number CANNOT exist in the CPI MODULE.

- In the CPI MODULE, do a chart search on the Source Chart Number (the number not being kept)
- Click on **Chart Management/Modify**
- Click on Change Chart Number
- The Source Chart Number will populate with the CPI MODULE number and all the visits will populate below the chart numbers
- Enter the Target Chart Number – this number should NOT be in the CPI MODULE, if the chart number already exists, you will get a pop up message stating:

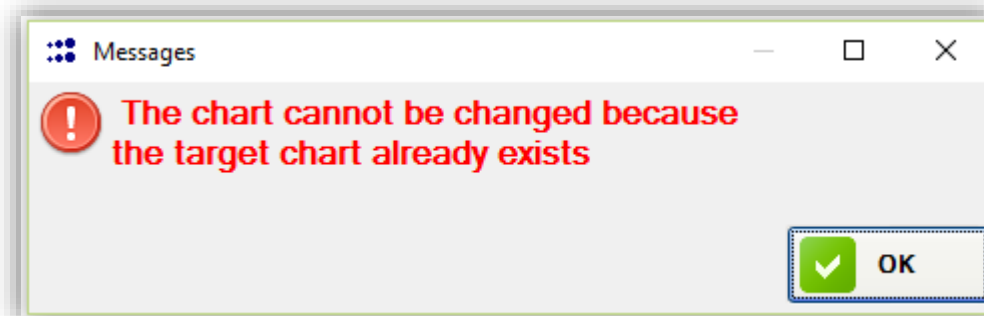


Figure 270 – Change Chart Number Message



- Press  or **[F12]** to execute. (If there are charts that have been submitted to CIHI [see Submitted Records](#) at the end of this section.)

- A pop up message will state, pressing Yes will continue, No will take you back to the main screen:

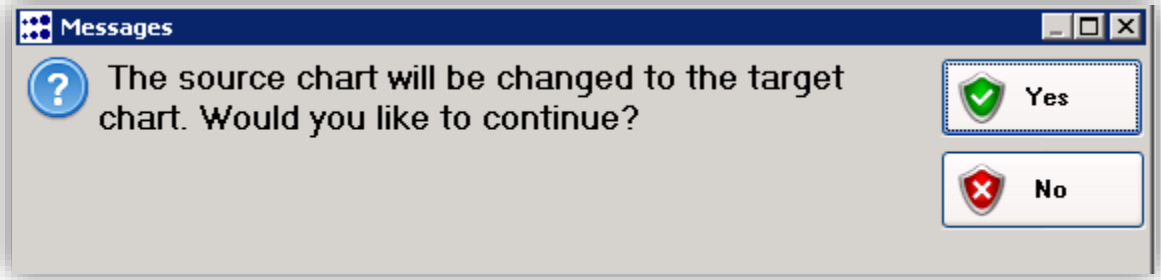


Figure 271 – Change Chart message

- A message will pop up stating:

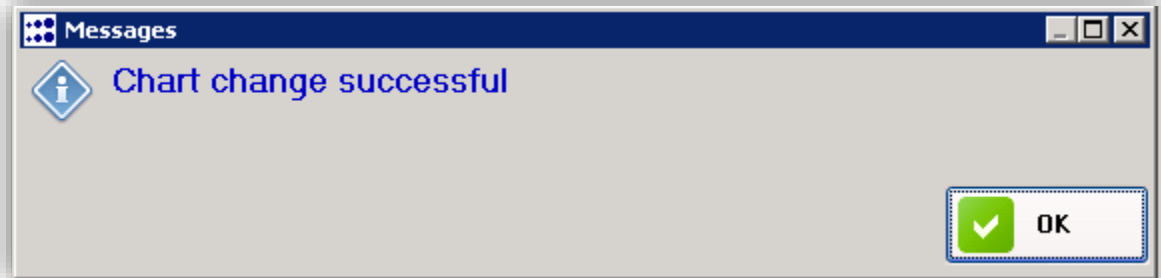


Figure 272 – Change Chart Successful Message

The example below displays chart #1234 (Source) to chart #4567 (Destination). All visits will be moved to chart #4567.

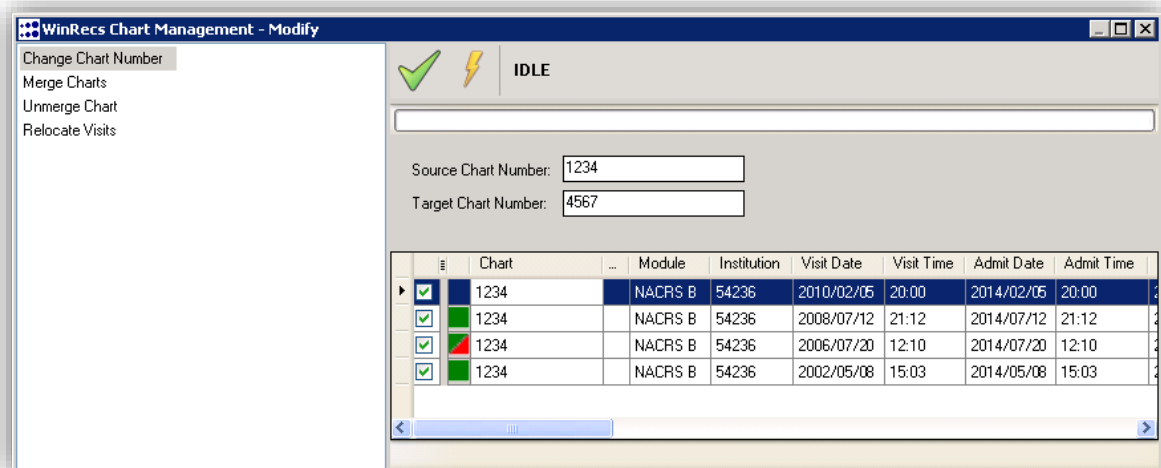


Figure 273 – Change Chart Example

Merge Charts

Used to move all visits from the Source Chart Number to the Target Chart Number. The Target Chart Number will already be in the **CPI MODULE**.

- In the CPI MODULE, do a chart search on the Source Chart Number (the number not being kept)
- Click on **Chart Management/Modify**
- Click on **Merge Charts**
- The Source Chart Number will populate with the CPI MODULE number and all the visits will populate below the chart numbers
- Enter the Target Chart Number – this number has to be in the CPI MODULE
- Press  or **[F12]** to execute. (If there are charts that have been submitted to CIHI [see Submitted Records](#) at the end of this section.)
- A pop up message will state, pressing Yes will continue, No will take you back to the main screen:

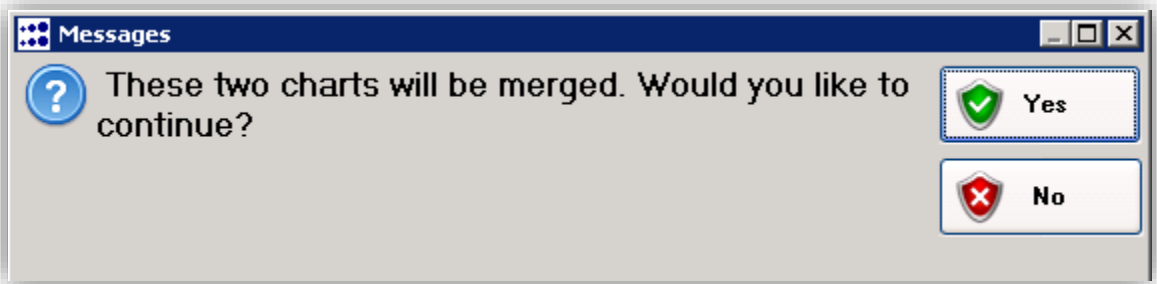


Figure 274 – Merge Chart Message

- A message will pop up stating:

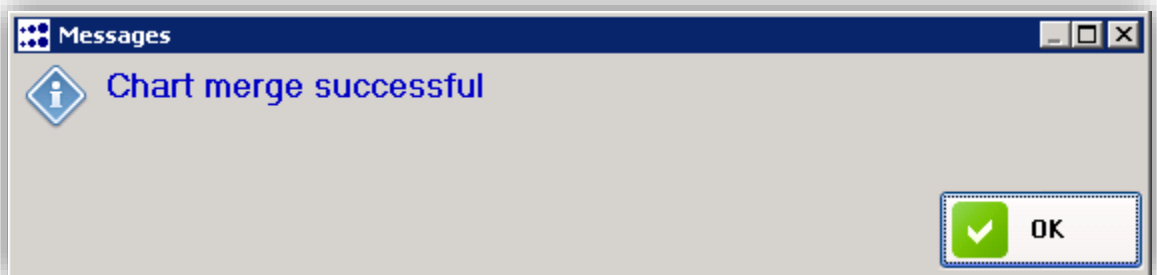


Figure 275 – Merge Chart Successful Message

The example below displays chart #T5679 (Source) merge to chart #CF12345678 (Target). All visits will be moved to chart #CF12345678.

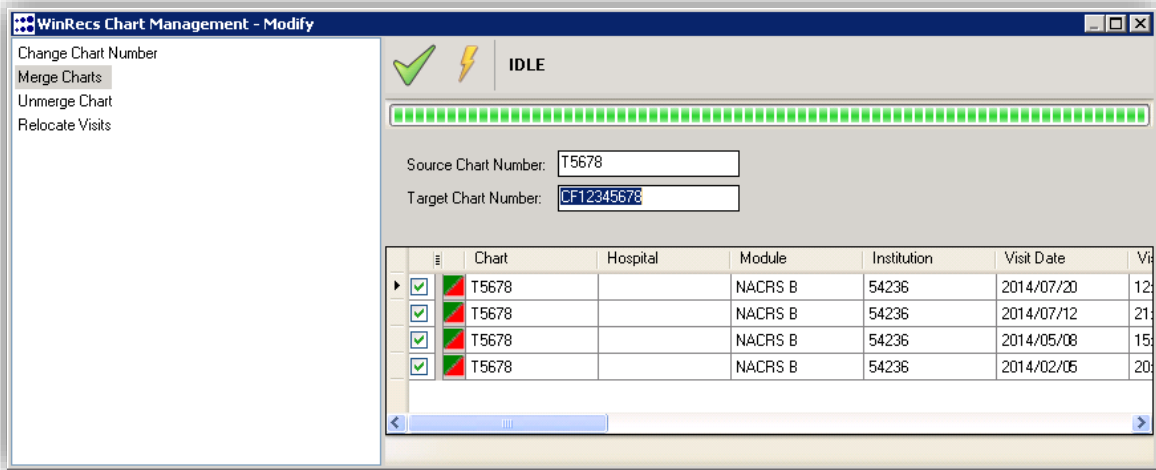


Figure 276 – Change Merge Example

Unmerge Charts

This option will unmerge previously merged charts.

If the following error appears when trying to unmerge charts and the “Chart Number Can be Re-Issued?” in the Hospital Profile needs to be unchecked:

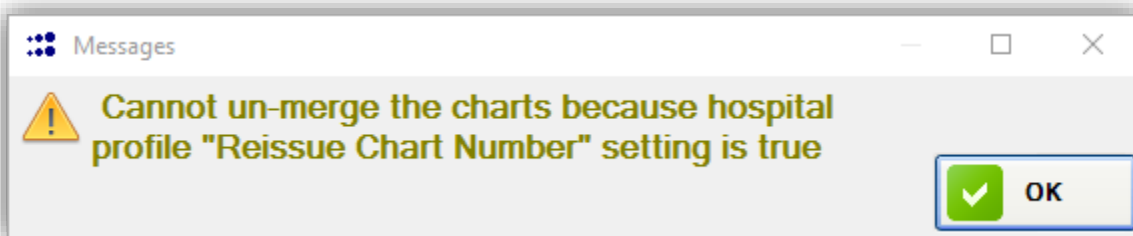


Figure 277 – Un-Merge Charts Error message

Chart Number Can be Re-Issued? – Unchecked:

The Hospital and Regional Profile both have settings for the Module Options, [CPI MODULE] Central Patient Index called “Chart Number Can be Re-Issued?” If this option is checked the unmerge function will not work.

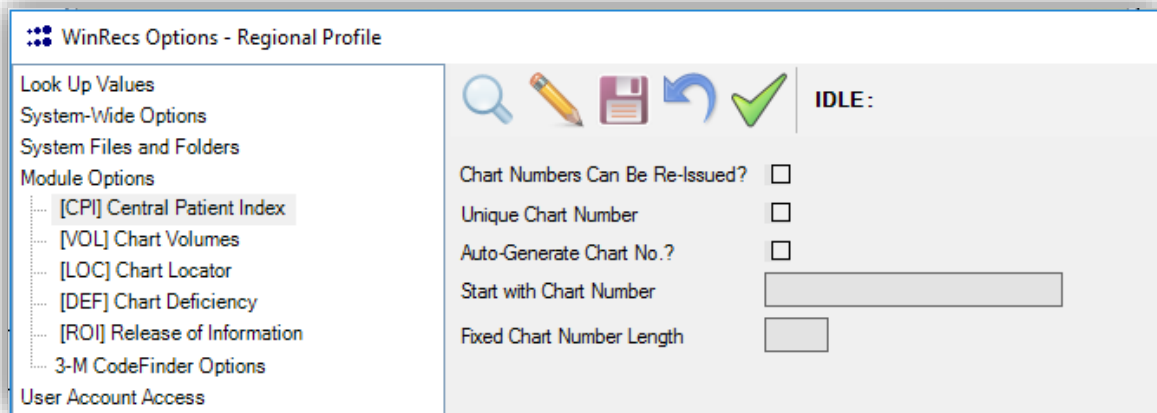


Figure 278 - Options - Regional Profile Setup

In the CPI MODULE, do a chart search on the Target Chart (the number kept)

- In the CPI MODULE, do a chart search on the Source Chart Number (the number not being kept)
- Click on **Chart Management/Modify**
- Click on **Unmerge Charts**
- The Chart Number will populate with the CPI MODULE number and all chart or charts will populate in the Merge List
- Highlight the chart number that you want to unmerge
- Press  or **[F12]** to execute.
- A pop up message will state, pressing Yes will continue, No will go back to the unmerge screen:

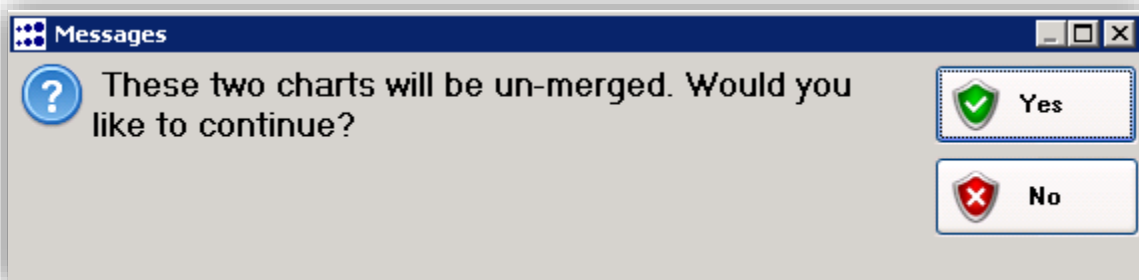


Figure 279 – Change Un-Merge Message

- A message will pop up with the following message.

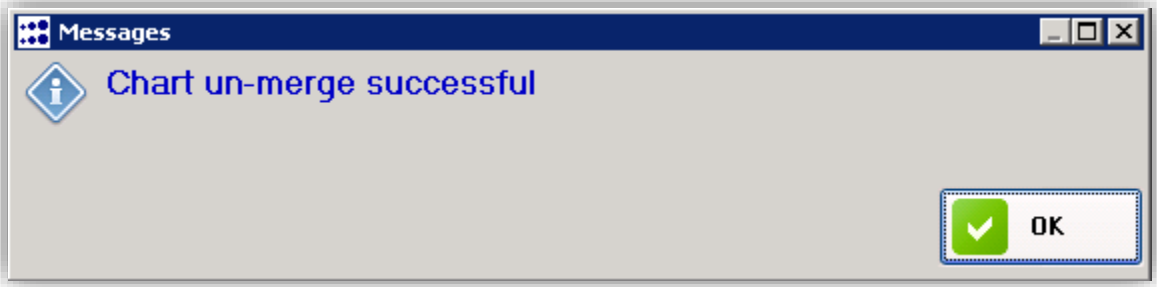


Figure 280 – Chart Un-merge Successful message

In the example below, the chart number that was merged to is *CF12345678*(Target Chart), in the **Merge List** the chart number (Source Chart) is the chart that merged into the Target Chart. Executing this will unmerge these two charts.

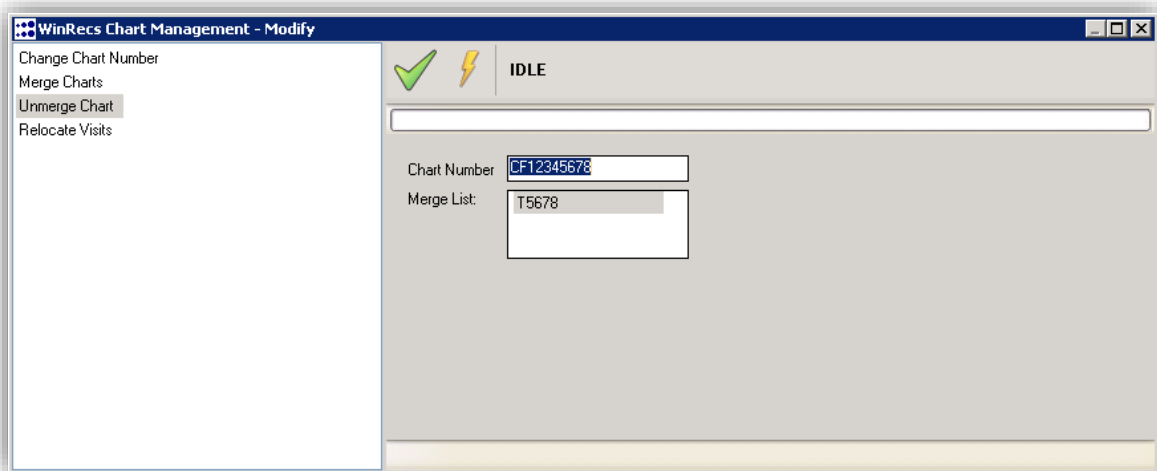


Figure 281 – Chart Un-Merge Example

Relocate Visits

Used to move only selected visits from one chart to another. The Source Chart Number will display all visits for the chart. Select the Target Chart Number and the selected visits will move to this chart number. This cannot be undone.

- In the **CPI MODULE**, do a chart search on the Source Chart Number (the number you want to move the visit(s) from)
- Click on **Chart Management/Modify**
- Click on **Relocate Visits**

- The Source Chart Number will populate with the CPI MODULE number and all visits related to that chart number will populate below.
- Enter the Target Chart Number
- Put a check mark by the visits that need to be moved from the Source Chart to the Target Chart.
- Press  or **[F12]** to execute. (If there are charts that have been submitted to CIHI [see Submitted Records](#) at the end of this section.)
- A pop up message will state, pressing Yes will continue, No will go back to the unmerge screen:

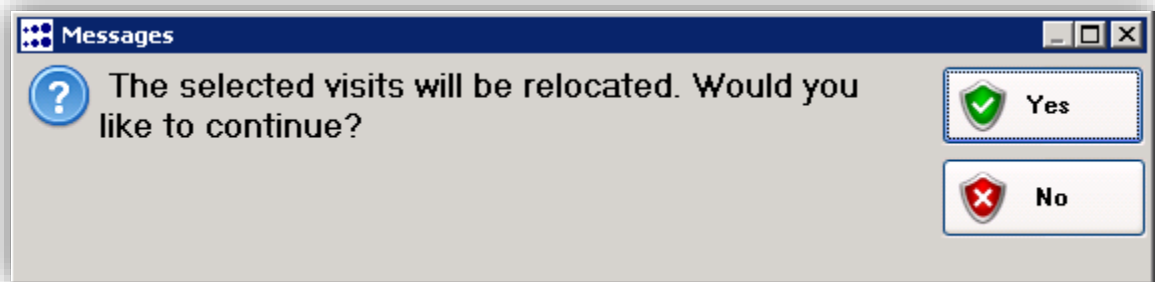


Figure 282 – Relocate Visits Message

- A message will pop up with the following message.

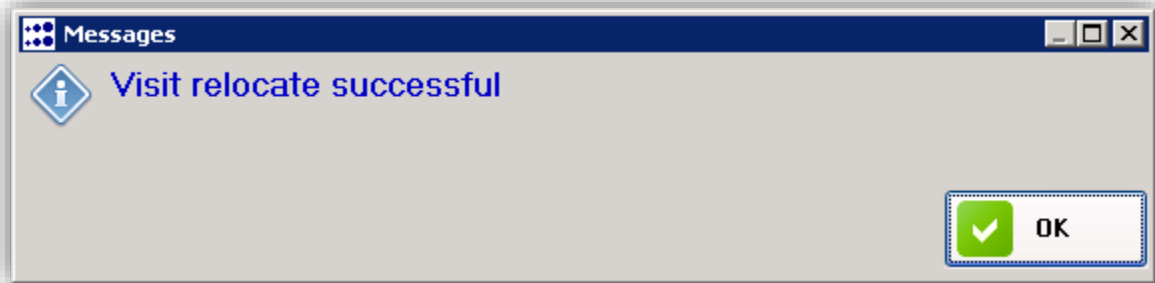


Figure 283 – Relocate Visits Successful Message

In the example, below the Source chart is 165557, the visit from 2015/04/10 is check marked and will be moved to the Target Chart Number 99165.

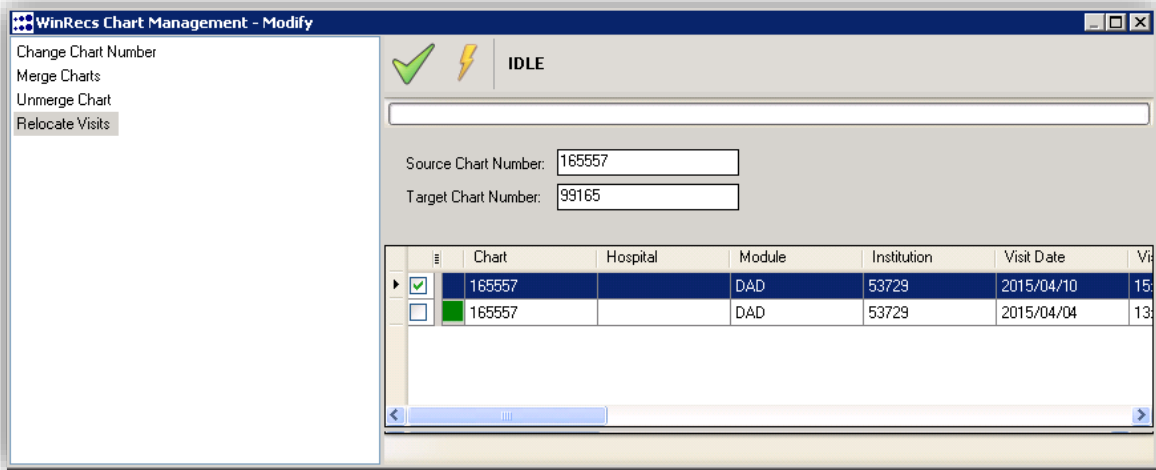


Figure 284 – Relocate Visits Example

CPI Lock

CPI Lock clears any locks that may be caused by merge/unmerge functions

To Activate Clear CPI Lock functions:

- Options/User Profile/Module Settings/CPI/Clear CPI Lock

To clear a locked record in the CPI Module:

- Chart Management in the CPI Module
- Click on “Clear CPI Lock” option. (To activate this option, go to Options/User Profile/Module Settings/CPI/Clear CPI Lock)

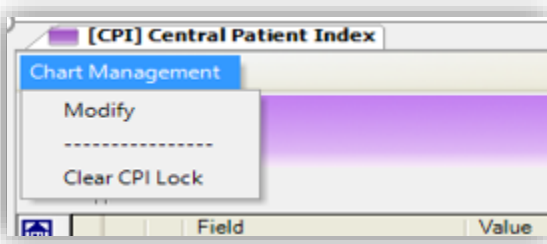


Figure 285 - Chart Management Menu

- The following message will appear

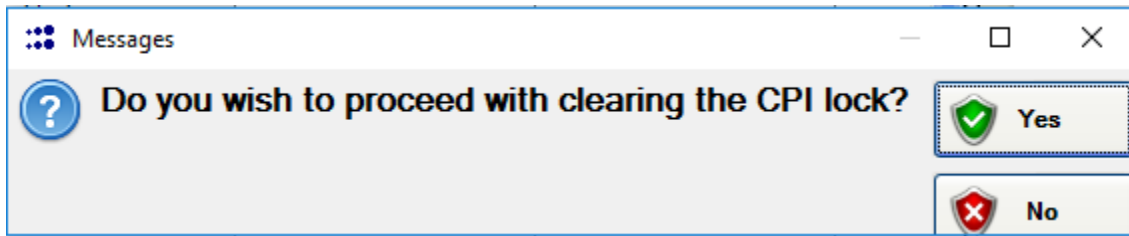


Figure 286 - Chart Clear CPI MODULE Lock message

- Select yes to continue or no cancel the request.
- If user selects yes, the following message appears:

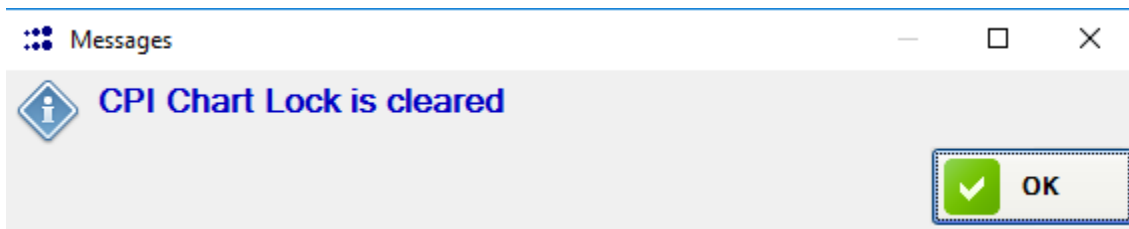
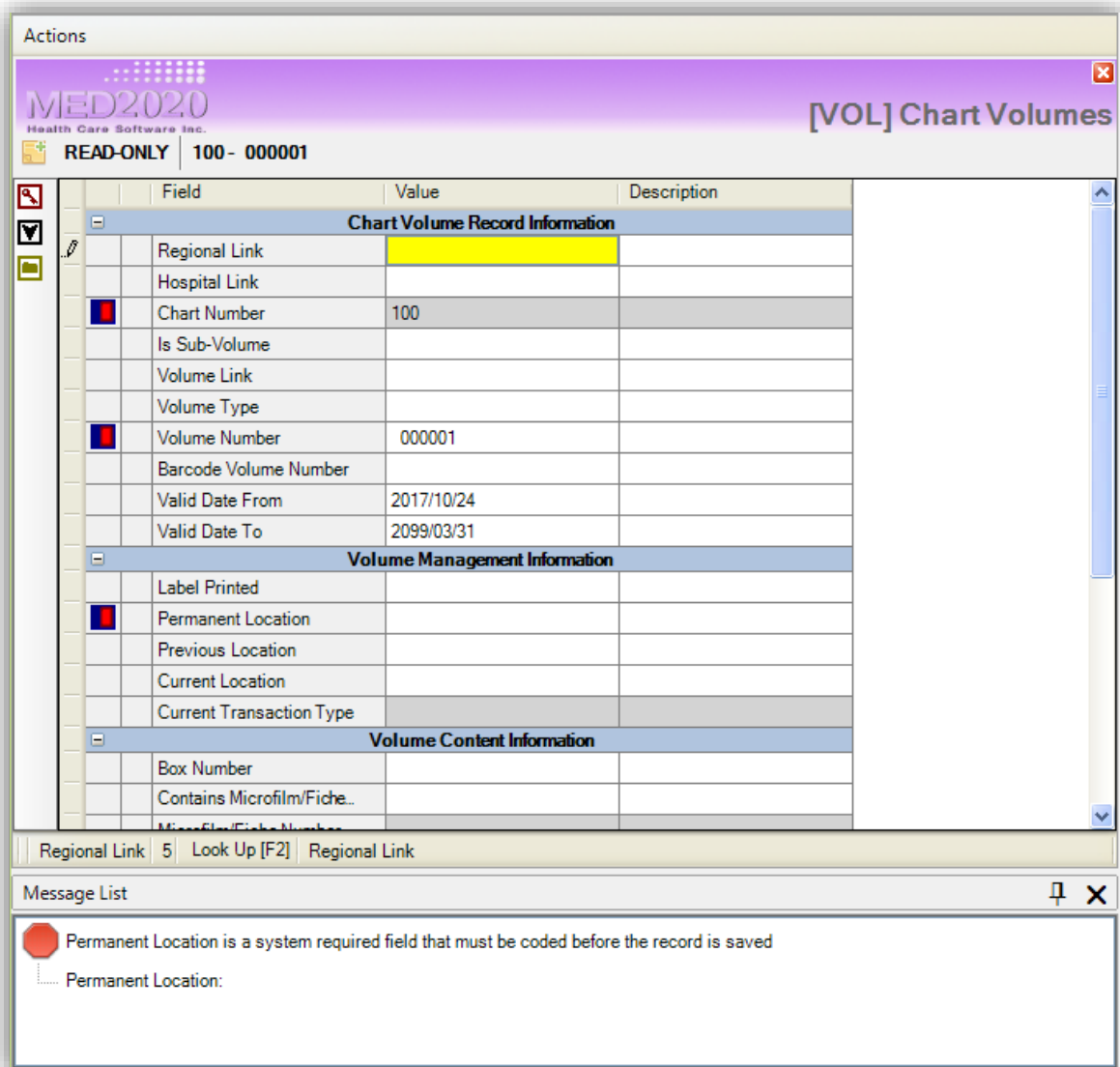


Figure 287 - Chart Clear CPI MODULE Lock Completed message

6.1.2 [VOL] Chart Volumes Module

The Chart Volumes module records and displays all the volumes of a specific chart.



Field	Value	Description
Chart Volume Record Information		
Regional Link		
Hospital Link		
Chart Number	100	
Is Sub-Volume		
Volume Link		
Volume Type		
Volume Number	000001	
Barcode Volume Number		
Valid Date From	2017/10/24	
Valid Date To	2099/03/31	
Volume Management Information		
Label Printed		
Permanent Location		
Previous Location		
Current Location		
Current Transaction Type		
Volume Content Information		
Box Number		
Contains Microfilm/Fiche...		
Microfilm/Fiche Number		

Regional Link 5 Look Up [F2] Regional Link

Message List

Permanent Location is a system required field that must be coded before the record is saved

Permanent Location:

Figure 288 – Chart Volumes Module

The Chart Volume Module is broken up into 3 sections:

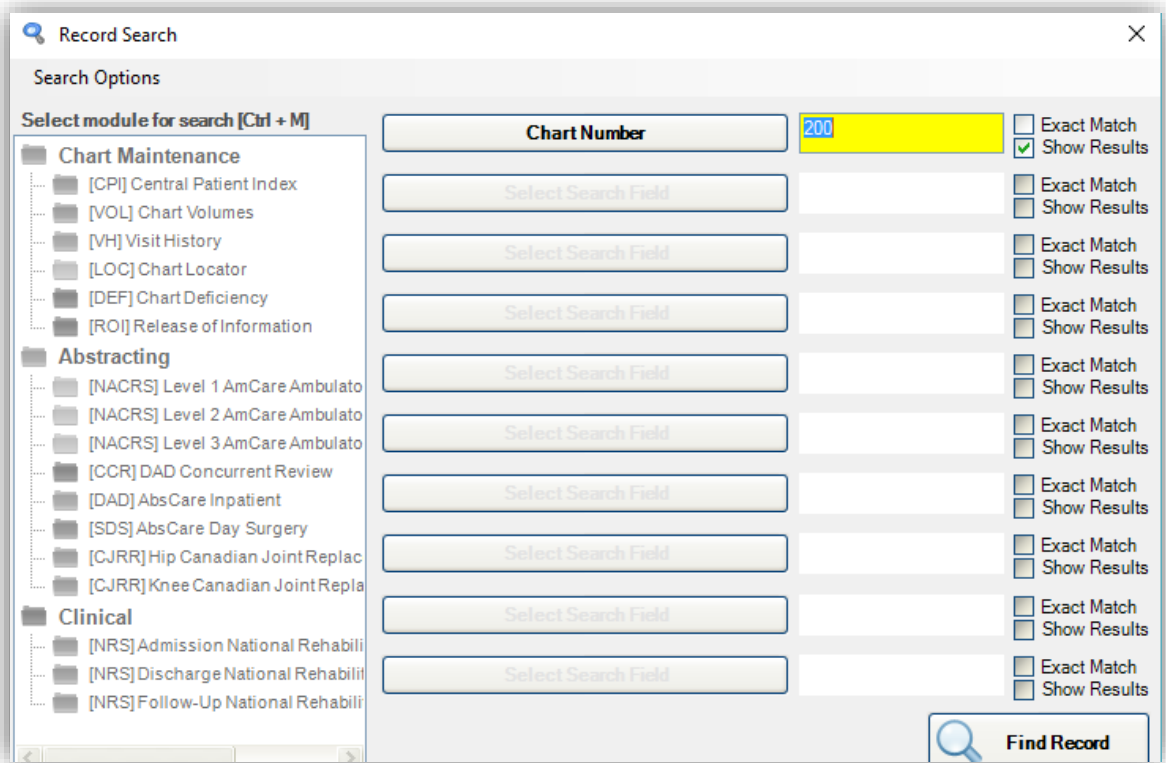
1. **Chart Volume Record Information** – Describes the volume of the record and what visit dates are included in the volume
2. **Volume Management Information** – Describes where the volume is located
3. **Volume Content Information** – Describes what is contained within in each volume

Creating a new Volume

- Go to WinRecs Module Menu or on the Menu Bar go to Module/Chart Maintenance/[VOL] Chart Volume



- Press  or **[F5]** to create a new volume
- Record Search window will pop up – enter the chart you would like to create a volume and press Find Chart or press Enter and select your chart.



The screenshot shows the 'Record Search' window. On the left, under 'Select module for search [Ctrl + M]', there is a tree view with categories: Chart Maintenance, Abstracting, and Clinical. Under 'Chart Maintenance', '[VOL] Chart Volumes' is selected. In the center, there are several 'Select Search Field' buttons. The first one is active and shows 'Chart Number' with the value '200' entered. To the right of these fields are checkboxes for 'Exact Match' and 'Show Results'. The 'Show Results' checkbox for the first field is checked. At the bottom right, there is a 'Find Record' button with a magnifying glass icon.

Figure 289 – Chart Volumes Record Search for New Volume

- Chart Volume Record Information** enter the information pertaining to your volume
 - Regional Link – Enter or will populate if using a regional system
 - Hospital Link – Enter or will populate if using a regional system
 - Chart Number – automatically populates
 - Is Sub-Volume – 'Y' or 'N' field – Yes if there are sub-volumes of this volume, N or leave blank if there are no sub-volumes
 - Volume Link –
 - Volume Type – Press **[F2]** for the options: 1. Temporary or 2. Permanent

- Volume Number – This is a mandatory field and need to be entered.
- Barcode Volume Number –
- Valid Date From – The date the volume starts (visit date or admission date)
- Valid Date To – The date the volume ends (visit date or discharge date of last visit) For current charts – leave blank or future date (2099/03/31)
- **Volume Management Information**
 - Label Printed – Y – Yes, N- No, P-Pending
 - Permanent Location – This is mandatory field – Press **[F2]** for look up or type in location. Look Up Fields can be added via Look Up Maintenance/Chart Locator/Loan Locator
 - Previous Location – Linked to Chart Locator, displays the previous location the chart was signed out to
 - Current Location – Linked to Chart Locator, displays were the chart is currently signed out to.
 - Current Transaction Type – Linked to Chart Locator – displays the most **current transaction type as displayed in Chart Locator.**
- **Volume Content Information** – additional information if required but not mandatory
 - Box Number –
 - Contains Microfilm/Fiche Data – Y or N
 - Microfile/Fiche Number – the number associated with the Microfile/Fiche
 - Contains Digital Data – Y or N
 - Contains DAD (Inpatient) Data – Y or N
 - Contains SDS Data – Y or N
 - Contains NACRS Data – Y or N
 - Contains NRS Data – Y or N
 - Contains MDS (CCRS) Data – Y or N
 - Contains MHRS Data – Y or N
 - Contains CJRR Data – Y or N
 - Contains Cancer Care Data – Y or N
 - Contains Outpatient Data – Y or N
 - Volume Note – Ability to collect any note by clicking on the . A pop up screen will display type the note, press Select. To edit the note double click on the field.
- Once the required fields are completed, press **[F6]/[F7]** to save.

Editing a Volume

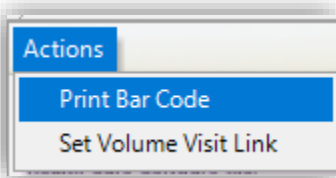


- Press  or **[F4]** to bring up the Record Search Box
- Enter your search parameters in the box and press Enter or Find Record
- A Search Result Box will display, highlight the record you want to pick and press Select Record and the record will populate the Chart Volumes module.
- Edit as required and press **[F6]/[F7]** to save.

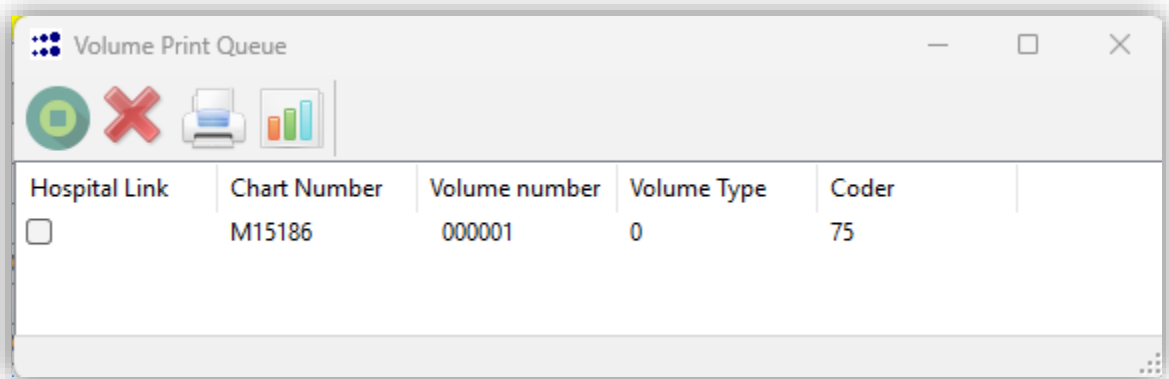
Print Bar Code

This feature gives the user the ability to print a label to put on the Chart Volume. Go to Chart Volumes module

- Search for the chart number and volume
- Go to Actions/Print Bar Code



- The following window will display:



-  - Purge all or F8 – This will remove all charts from the queue.



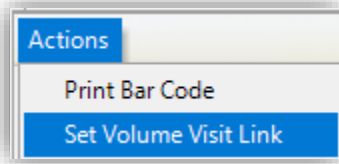
-  - Delete or F9 – This will remove charts that are selected (a checkmark beside Chart Number).

-  - Print or F12 – This will print the selected charts.
-  - Report or F10 – This will display the Report Manager
- Bottom Screen – These are the chart volumes that are available to print. Choosing the visits (clicking on the box on the left hand side and will display a checkmark) will allow a user to Delete or Print.

Volume Visit Link

This feature gives the user the ability to link visits to the volume. When a user is looking for a chart, a report can be run, and it will display which volume the visit is in and where the chart is located.

- Go to Chart Volumes module
- Search for the chart number and volume
- Go to Actions/Set Volume Visit Link



- The following window will display:

Chart Number

M15186

Permanent Location

Region

Current Location

Hospital

Valid From

2020/05/11

Volume Type

Valid To

2099/03/31

Volume Number

000001

- Chart Number – automatically populates
- Region – Automatically populates if chart number is attached to a chart number
- Hospital – Automatically populates if chart number is attached to Institution
- Volume Type – Press **[F2]** for the options
- Volume Number – automatically populates
- Permanent Location – Automatically populates if chart is in permanent location
- Current Location– Automatically populates the current location if the chart is signed out.
- Valid From – The date the chart volume starts
- Valid To – The date the chart volume is valid to.
- Bottom Screen – These are all visits that are attached to the chart. Choosing the visits (clicking on the box on the left hand side and will display a checkmark) that are included in the volume.



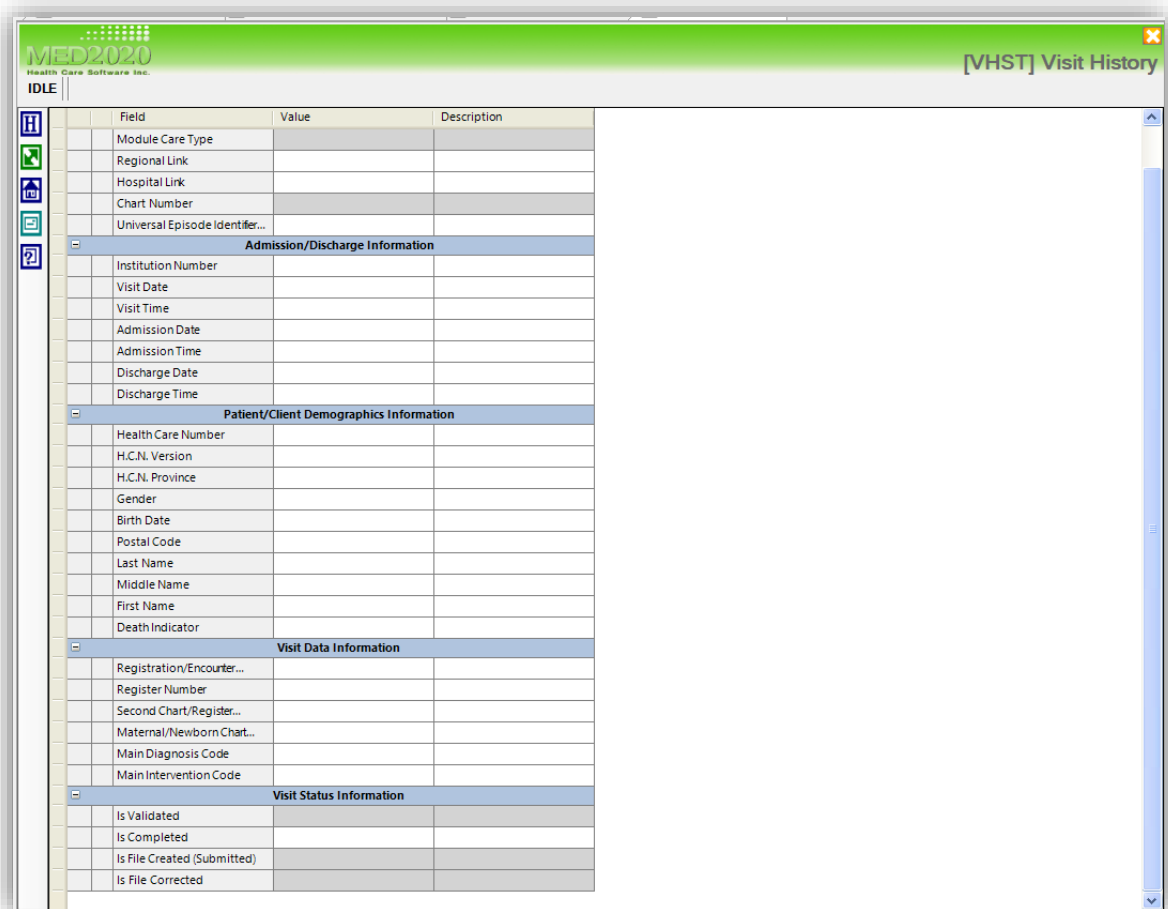
- Press the  to save those visits to the volume.

6.1.3 [VH] Visit History

The Visit History module is used mainly for chart management within a hospital or facility. Visit history captures both abstracted records and non-abstracted (paper) records.

The Visit History module contains patient / client demographics, admission / discharge information, visit information, and record information.

Note: This is a READ-ONLY module. Changes that need to be made to a patient record should be made in the C.P.I. or the appropriate module.



Field	Value	Description
Module Care Type		
Regional Link		
Hospital Link		
Chart Number		
Universal Episode Identifier...		
Admission/Discharge Information		
Institution Number		
Visit Date		
Visit Time		
Admission Date		
Admission Time		
Discharge Date		
Discharge Time		
Patient/Client Demographics Information		
Health Care Number		
H.C.N. Version		
H.C.N. Province		
Gender		
Birth Date		
Postal Code		
Last Name		
Middle Name		
First Name		
Death Indicator		
Visit Data Information		
Registration/Encounter...		
Register Number		
Second Chart/Register...		
Maternal/Newborn Chart...		
Main Diagnosis Code		
Main Intervention Code		
Visit Status Information		
Is Validated		
Is Completed		
Is File Created (Submitted)		
Is File Corrected		

Figure 290 – Visit History Module

Visit History Setup

The following setup must be completed before using the Visit History module. For a complete description of the setup required and the steps to complete please refer to “**Section 6 - System Maintenance**” in the WinRecs User Guide.

- Look Up Field Maintenance: The following tables must have entries in them before creating a Visit History entry.
 - Gender
 - Patient Type
 - M.I.S. Code
 - Clinic/Nursing Unit
 - Attending Provider
 - Referring Provider
 - Main Diagnosis Code
 - Main Intervention Code
- User Profile: Users must have rights to access the Visit History module.
- Control File Settings: The Control File specifies default settings for fields, determining if fields are visible or enabled within the Visit History module.

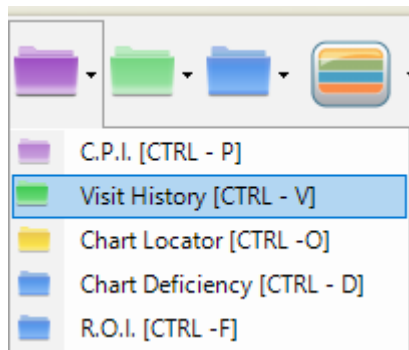
Accessing the Visit History Module

The Visit History module is one of the modules within Chart Maintenance. The option to use can depend on what is to be performed within the module. The options are:

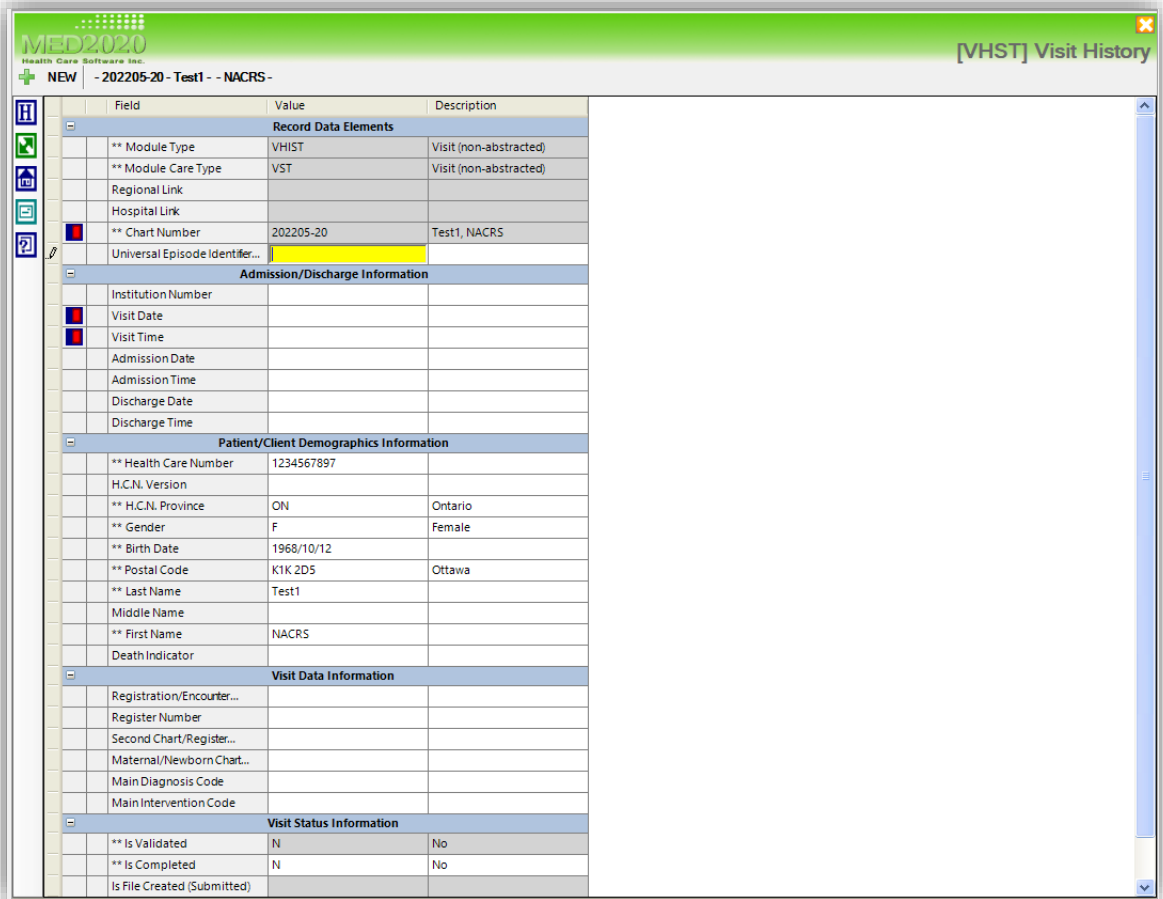
Option 1: From the Central Patient Index (CPI)

When accessed using this option, the chart number and any other relevant fields are populated from the CPI. Therefore, if adding visit history information, this method is recommended. To access the Visit History module from the CPI:

1. From the WinRecs Application Menu, select Chart Maintenance/[CPI]Central Patient Index.
2. Search for the patient in the CPI.
If the CPI does not open in Search mode, press **F4** to display the search dialog then search for the required chart.
3. Double-click on the required chart to display it in the CPI.
4. When the chart displays, hot-link to the Visit History module using the Hot Link button on the toolbar.



5. The Visit History window displays.



Field	Value	Description
Record Data Elements		
** Module Type	VHIST	Visit (non-abstracted)
** Module Care Type	VST	Visit (non-abstracted)
Regional Link		
Hospital Link		
** Chart Number	202205-20	Test1, NACRS
Universal Episode Identifier...		
Admission/Discharge Information		
Institution Number		
Visit Date		
Visit Time		
Admission Date		
Admission Time		
Discharge Date		
Discharge Time		
Patient/Client Demographics Information		
** Health Care Number	1234567897	
H.C.N. Version		
** H.C.N. Province	ON	Ontario
** Gender	F	Female
** Birth Date	1968/10/12	
** Postal Code	K1K 2D5	Ottawa
** Last Name	Test1	
Middle Name		
** First Name	NACRS	
Death Indicator		
Visit Data Information		
Registration/Encounter...		
Register Number		
Second Chart/Register...		
Maternal/Newborn Chart...		
Main Diagnosis Code		
Main Intervention Code		
Visit Status Information		
** Is Validated	N	No
** Is Completed	N	No
Is File Created (Submitted)		

Figure 291 – Visit History

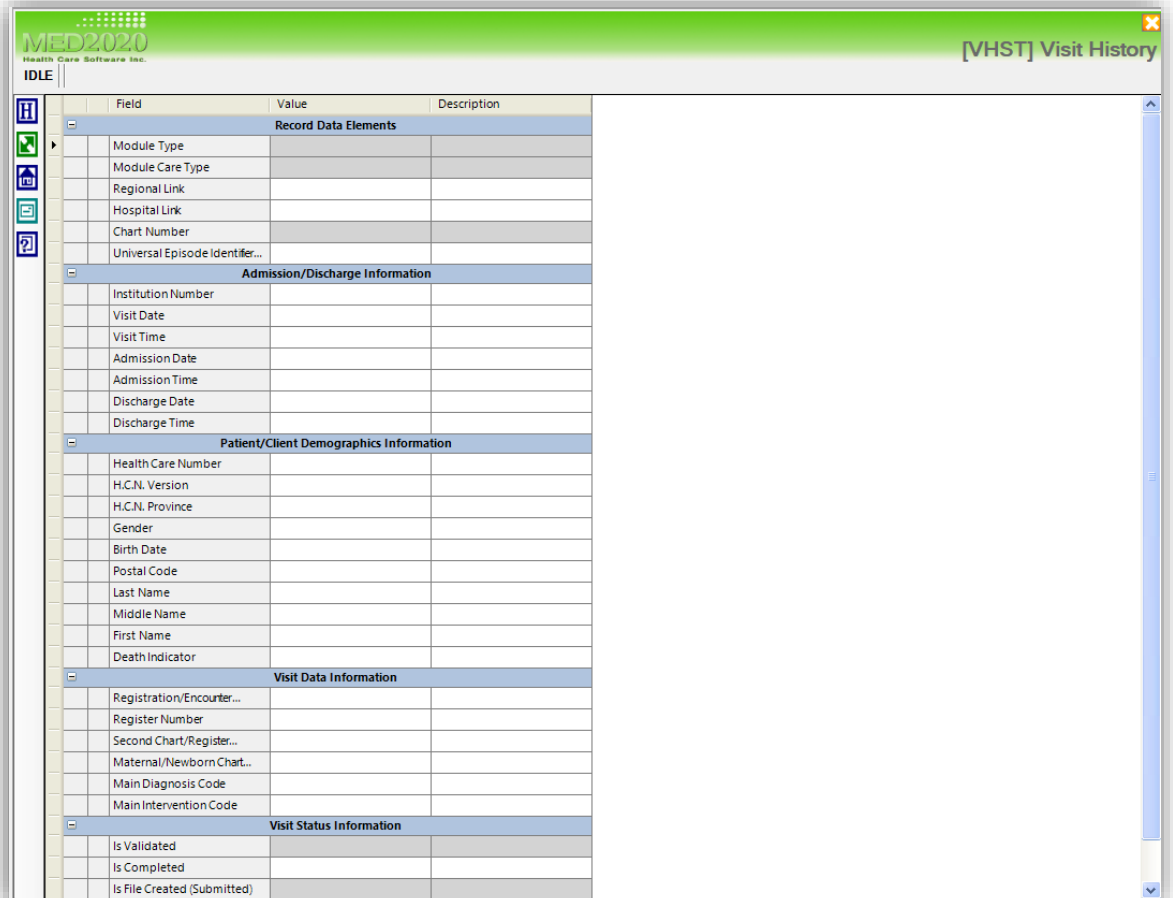
6. With this method, all available information from the CPI populates all relevant fields.

Option 2: From the WinRecs Application Menu

With this method there is no auto-populating of fields so the Visit History window does not contain any information.

To access the Visit History module using the WinRecs Application Menu:

1. From the WinRecs Application Menu, select **Chart Maintenance – [VOL] Visit History**.
The Visit History window displays with no information populating fields.



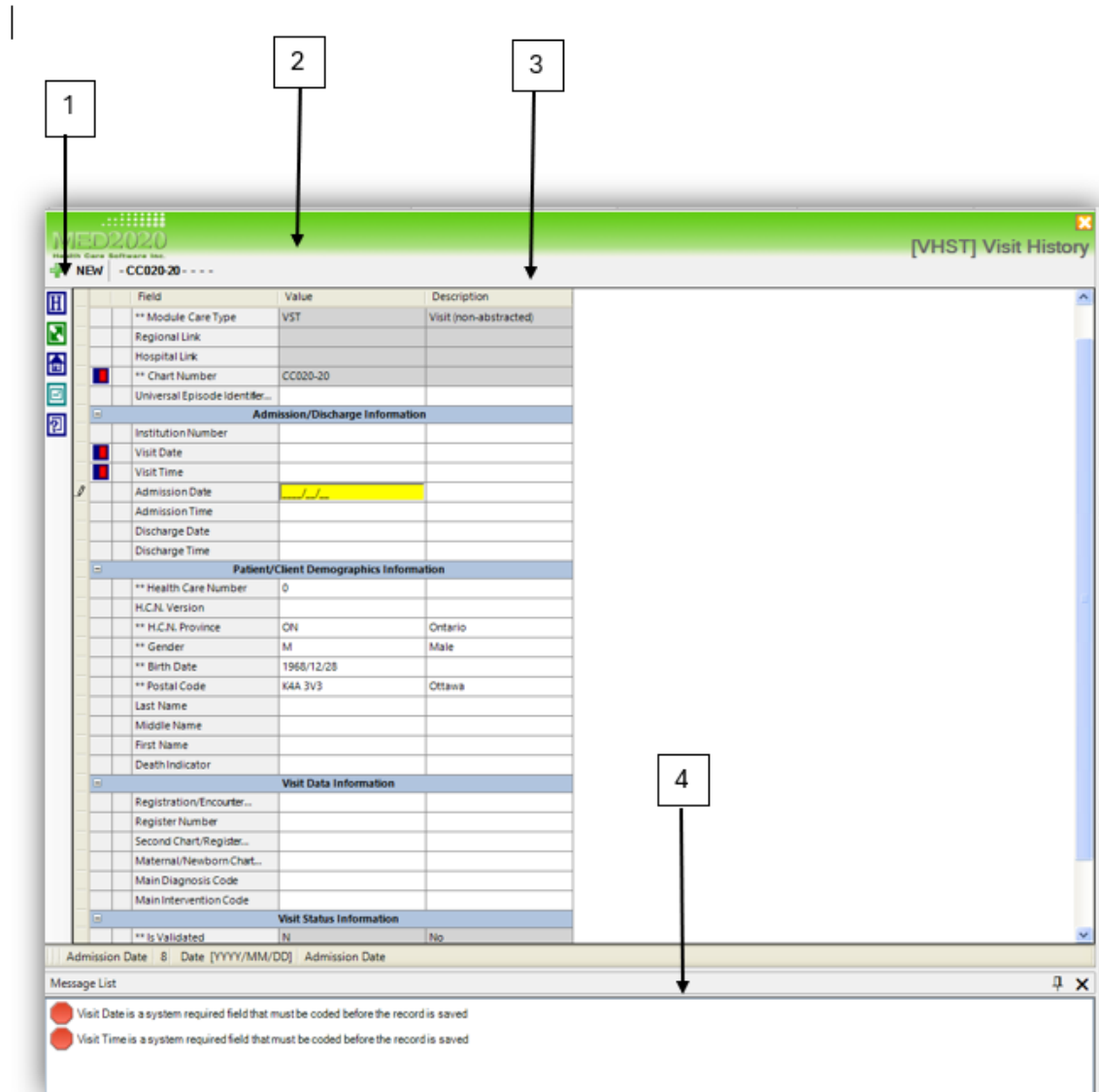
Field	Value	Description
Record Data Elements		
Module Type		
Module Care Type		
Regional Link		
Hospital Link		
Chart Number		
Universal Episode Identifier...		
Admission/Discharge Information		
Institution Number		
Visit Date		
Visit Time		
Admission Date		
Admission Time		
Discharge Date		
Discharge Time		
Patient/Client Demographics Information		
Health Care Number		
H.C.N. Version		
H.C.N. Province		
Gender		
Birth Date		
Postal Code		
Last Name		
Middle Name		
First Name		
Death Indicator		
Visit Data Information		
Registration/Encounter...		
Register Number		
Second Chart/Register...		
Maternal/Newborn Chart...		
Main Diagnosis Code		
Main Intervention Code		
Visit Status Information		
Is Validated		
Is Completed		
Is File Created (Submitted)		

2. Use the relevant options as described in this chapter to maintain visit history and related information.

Using the Visit History Module

The Visit History module is used mainly for chart management within a hospital or facility. Visit history captures both abstracted records and non-abstracted (paper) records.

The Visit History module contains patient / client demographics, admission / discharge information, visit information, and record information.



The screenshot shows the MED2020 [VHST] Visit History window. The window has a green header bar with the MED2020 logo and the title "[VHST] Visit History". Below the header bar is a main grid area with columns for Field, Value, and Description. The grid contains sections for Admission/Discharge Information, Patient/Client Demographics Information, Visit Data Information, and Visit Status Information. A data entry box is located on the right side of the grid. A message list is at the bottom of the window. Callouts 1, 2, 3, and 4 point to the header bar, the main grid area, the data entry box, and the message list, respectively.

Field	Value	Description
** Module Care Type	VST	Visit (non-abstracted)
Regional Link		
Hospital Link		
** Chart Number	CC020-20	
Universal Episode Identifier...		
Admission/Discharge Information		
Institution Number		
Visit Date		
Visit Time		
Admission Date		
Admission Time		
Discharge Date		
Discharge Time		
Patient/Client Demographics Information		
** Health Care Number	0	
H.C.N. Version		
** H.C.N. Province	ON	Ontario
** Gender	M	Male
** Birth Date	1968/12/28	
** Postal Code	K4A 3V3	Ottawa
Last Name		
Middle Name		
First Name		
Death Indicator		
Visit Data Information		
Registration/Encounter...		
Register Number		
Second Chart/Register...		
Maternal/Newborn Chart...		
Main Diagnosis Code		
Main Intervention Code		
Visit Status Information		
** Is Validated	No	No

Admission Date: 8 Date: [YYYY/MM/DD] Admission Date

Message List

- Visit Date is a system required field that must be coded before the record is saved
- Visit Time is a system required field that must be coded before the record is saved

Figure 292 – Visit History Sections

The main components of the Visit History window are the Main Grid, Data Entry Box and 4 bookmarks. The main parts of the Visit History window are described in the table below. The REF# field for each row relates to the callouts shown in the above image.

Note that there are no bookmarks in Visit History.

REF#	Description
1	Bookmarks: Clicking on the Bookmarks will take you to the header within the Main Grid.
2	Data Entry Box: The Data Entry Box is used to enter or edit information displaying in the Main Grid. Click on a field in the Main Grid and the field name displays on the left and the cursor is positioned in the box ready for entry.
3	Main Grid: The Main Grid shows the information for the currently selected visit history entry (or is empty when first creating entries). To add or modify information in the Main Grid, select the row and the field name displays beside the Data Entry Box and the data may be changed by typing in the Data Entry Box. The information in the Main Grid is organized under headings and can be accessed by scrolling through the grid to move the grid to the section within the associated heading.
4	Message List: Displays any fields that are mandatory or warning that still need to be populated.

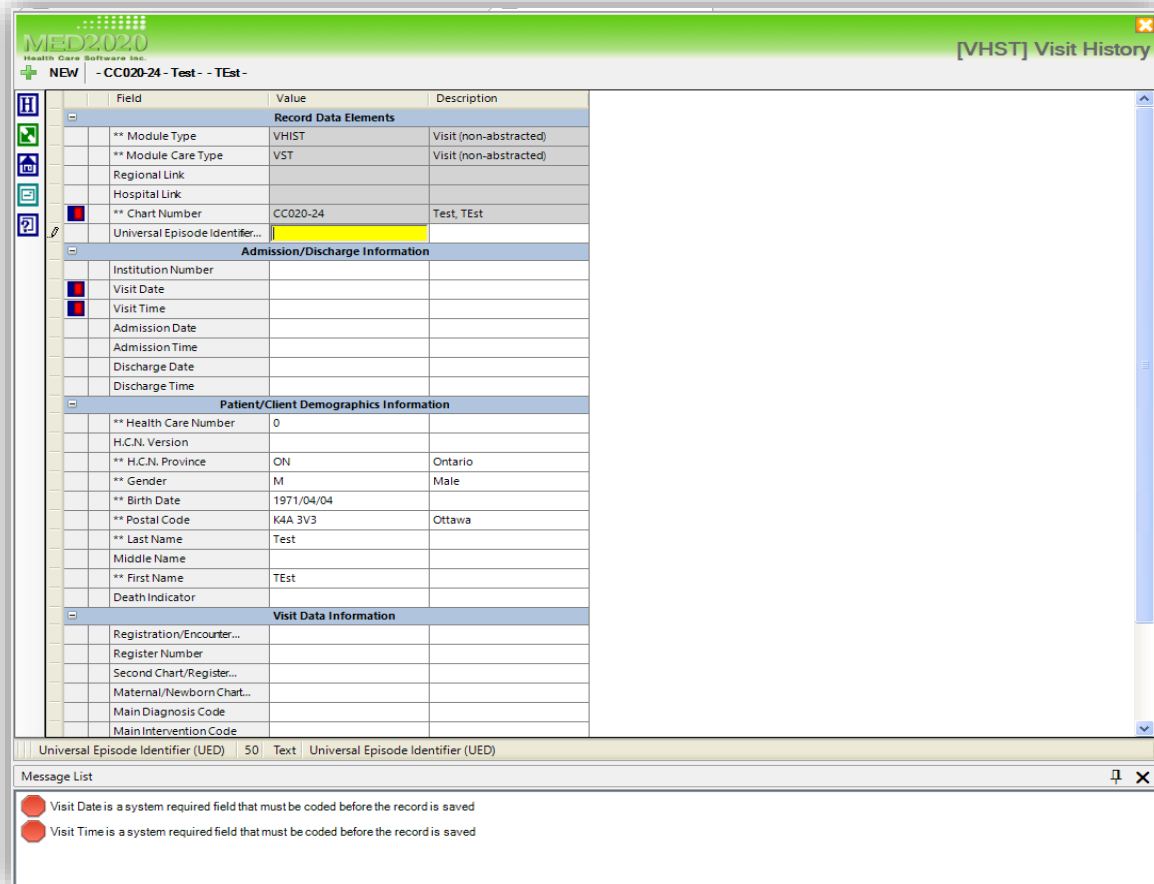
Creating Visit History Entries

Before creating visit history entries, the patient should first exist within WinRecs as the patient data can be used to populate information within the Visit History module. If the patient exists, the Visit History Search may be used to locate the required patient chart and related demographics.

To create visit history entries:

From Visit History click
Search for the record





Enter information in all the fields that apply. Only Visit Date and Time are mandatory. Press **Enter** after each field to move to the next field. Fields highlighted as grey cannot be adjusted.

Record Data Elements:

Module Type:	V HIST – Visit (non-abstracted) – automatically populated
Module Care Type:	VST – Visit (non-abstracted)- automatically populated
Regional Link:	Will display the regional link (if there is one)
Hospital Link:	Will display the hospital link (if there is one)
Chart Number:	Populated from the record chosen
Universal Episode Identifier:	Enter Universal Episode Identifier if there is one.

Admission/Discharge Information:

Institution Number:	Enter Institution Number the visit would be linked to (not mandatory)
Visit Date:	The date of patient visit (mandatory field)
Visit Time:	The time of patient visit (mandatory field)
Admission Date:	The date patient was admitted.
Admission Time:	The time patient was admitted.
Discharge Date:	The date the patient was discharged.

Discharge Time:	The time the patient was discharged.
------------------------	--------------------------------------

Patient/Client Demographics Information:

Health Care Number:	The patient Health Care Number.
H.C.N Version:	The Health Care Number Version.
H.C.N. Province:	The Health Care Number Province.
Gender:	The gender of the patient
Birth Date:	The Birth Date of the patient.
Postal Code:	The Postal Code of the patient.
Last Name:	Patient Last Name
Middle Name:	Patient Middle Name
First Name:	Patient First Name
Death Indicator:	Press F2 to choose Death Indicator if there is one. Can be blank if 'N'.

Visit Data Information:

Registration/Encounter Number:	The registration/encounter number.
Register Number:	The register number.
Second Chart Register Number:	The second Chart Register Number
Maternal/Newborn Chart Number:	The Maternal/Newborn Chart Number.
Main Diagnosis Code:	The Main Diagnosis Code.
Main Intervention Code:	The Main Intervention Code

Visit Status Information:

Is Validated:	Will display Validated Status
Is Completed:	Will display Completed Status
Is File Created(submitted):	Will display Is File Created Submitted Status
Is File Corrected:	Will display the Is File Corrected Status.



When complete click

- or - Press **F7**.

The information is saved and displays in the Main Grid.

Modifying Visit History

Visit History information may be modified as required.

To modify visit history:



From Visit History click

- or - Press **F4**.

The Visit History Search dialog displays.

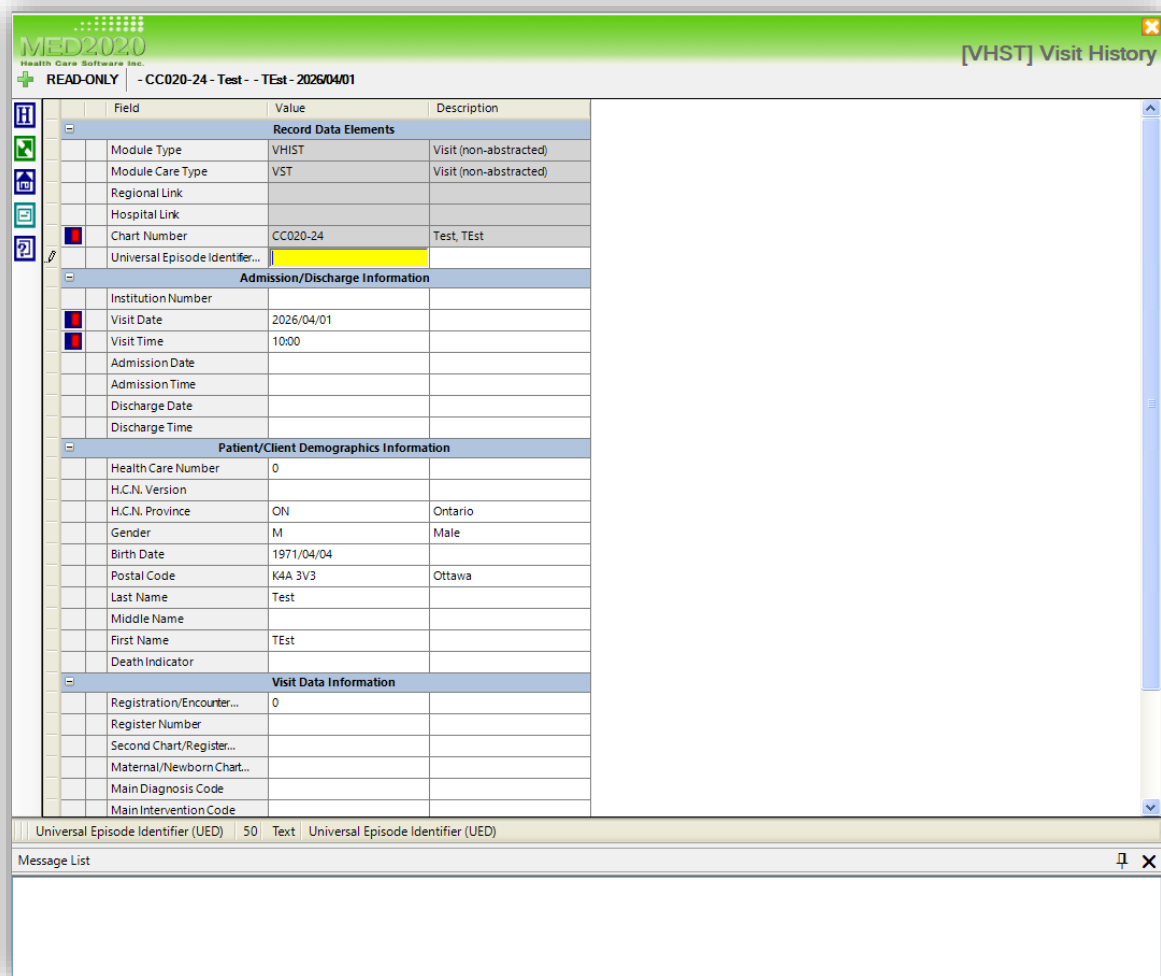
Use the search fields in the Visit History Search to display all charts.

Double-click in the Visit History Search on the entry containing the information to update.
- or - Select the required entry and press **Enter**.
The Visit History window displays the visit history information for the selected entry.

Make the required changes.

When complete click 
- or Press **F7**.

The information is saved and displays in the main grid.



Field	Value	Description
Record Data Elements		
Module Type	VHIST	Visit (non-abstracted)
Module Care Type	VST	Visit (non-abstracted)
Regional Link		
Hospital Link		
Chart Number	CC020-24	Test, TEst
Universal Episode Identifier...		
Admission/Discharge Information		
Institution Number		
Visit Date	2026/04/01	
Visit Time	10:00	
Admission Date		
Admission Time		
Discharge Date		
Discharge Time		
Patient/Client Demographics Information		
Health Care Number	0	
H.C.N. Version		
H.C.N. Province	ON	Ontario
Gender	M	Male
Birth Date	1971/04/04	
Postal Code	K4A 3V3	Ottawa
Last Name	Test	
Middle Name		
First Name	TEst	
Death Indicator		
Visit Data Information		
Registration/Encounter...	0	
Register Number		
Second Chart/Register...		
Maternal/Newborn Chart...		
Main Diagnosis Code		
Main Intervention Code		

Universal Episode Identifier (UED) 50 Text Universal Episode Identifier (UED)

Message List

Figure 293 – Modifying Visit History

Deleting Visit History

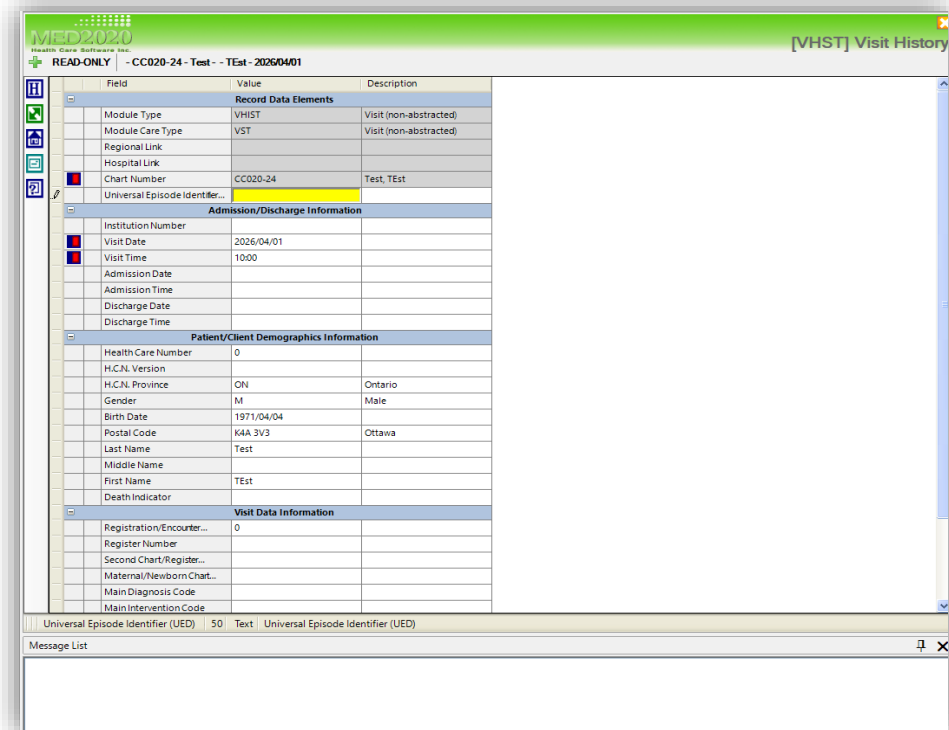
Visit History information may be deleted as required.

Note: Records can only be deleted from this module if the visit is not linked to any other modules; in other words, the module name value must have a value of Non Abs (Non Abstracted).

To delete visit history information:



1. From Visit History click  - or - Press **F4**.
The Visit History Search dialog displays.
2. Use the search fields in the Visit History Search to display Visit History information.
3. Double-click in the Visit History Search on the entry containing the visit history information to remove.
- or - Select the required entry and press **Enter**.
The Visit History window displays the visit history information for the selected entry.



The screenshot shows the MED2020 [VHST] Visit History window. The window title is "[VHST] Visit History". The status bar at the top indicates "READ-ONLY" and "CC020-24 - Test - TEst - 20260401". The main area contains a table with the following data:

Field	Value	Description
Record Data Elements		
Module Type	VHIST	Visit (non-abstracted)
Module Care Type	VST	Visit (non-abstracted)
Regional Link		
Hospital Link		
Chart Number	CC020-24	Test, TEst
Universal Episode Identifier...		
Admission/Discharge Information		
Institution Number		
Visit Date	2026/04/01	
Visit Time	1000	
Admission Date		
Admission Time		
Discharge Date		
Discharge Time		
Patient/Client Demographics Information		
Health Care Number	0	
H.C.N. Version		
H.C.N. Province	ON	Ontario
Gender	M	Male
Birth Date	1971/04/04	
Postal Code	K4A 3V3	Ottawa
Last Name	Test	
Middle Name		
First Name	TEst	
Death Indicator		
Visit Data Information		
Registration/Encounter...	0	
Register Number		
Second Chart/Register...		
Maternal/Newborn Chart...		
Main Diagnosis Code		
Main Intervention Code		

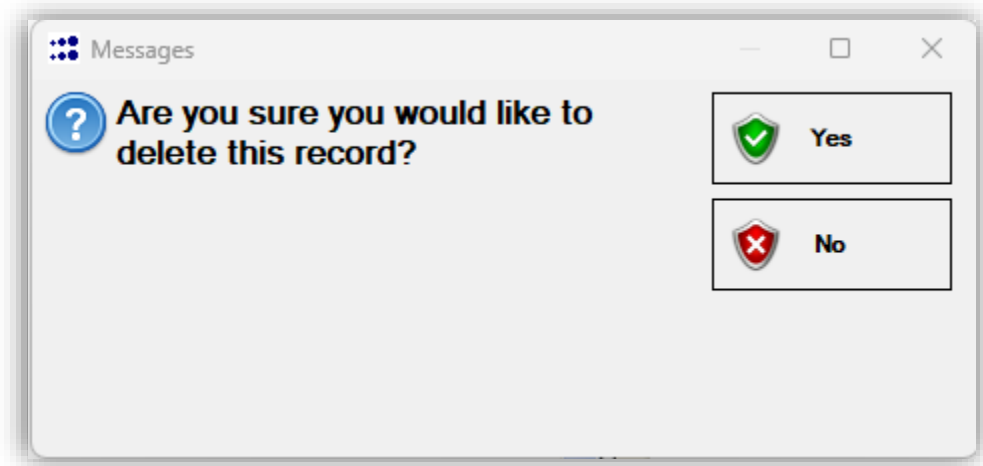
At the bottom of the window, there is a status bar showing "Universal Episode Identifier (UED) | 50 | Text | Universal Episode Identifier (UED)". Below the status bar is a "Message List" section.

Figure 294 – Visit History Deletion

4. Ensure the correct visit history displays.

5. Click 

The Delete confirmation dialog displays.



6. Click **Yes**.

The selected visit history is removed from the Visit History module.

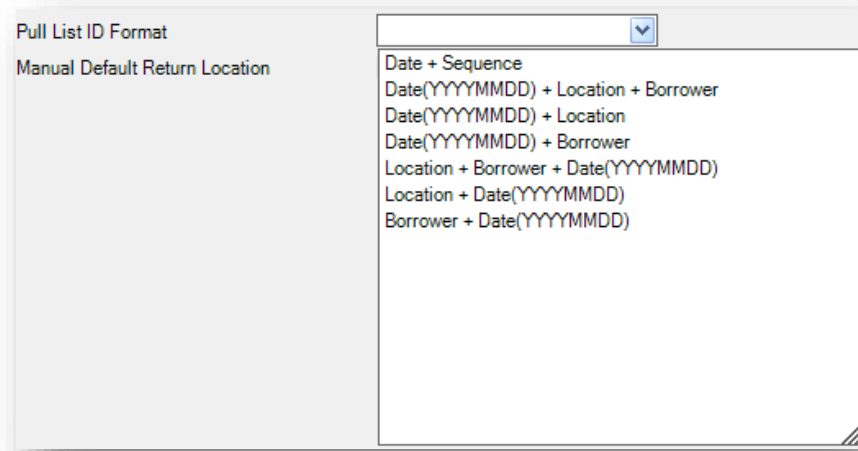
6.1.4 [LOC] Chart Locator

The chart locator module is used for tracking and locating the paper copy of the patient record. Using the key identifier fields entered into the patient record in other modules the chart location can provide an up to date report on the chart's location within the facility.

Chart Locator Set up

The following setup must be completed or reviewed before using the Chart Locator module:

- **Regional/Hospital Profile** – Check the Module Options/[LOC] Chart Locator fields for configuration
 - Module Options→[LOC] Chart Locator
 - Pull List ID Format-When a Pull List is created, have an options to configure the format as:



- Manual Default Return Location-When the box is checked and chart is returned to Health Records, user can manually select from a list of Health Records locations
- **Look Up Code Maintenance** – Look up fields under the [LOC] Chart Locator are configured
 - Loan Hospital
 - Loan Location
 - Loan Location Type
 - Request Priority
- **User Profile** – Check Module Settings/[LOC] Chart Locator – set the permissions for Chart Locator
- **Control File** – set the appropriate default setting, as well as disable, enable fields as required

Accessing Chart Locator

WinRecs Module Menu → Chart Maintenance → [LOC] Chart Locator

- Or -

Modules → Chart Maintenance → [LOC] Chart Locator

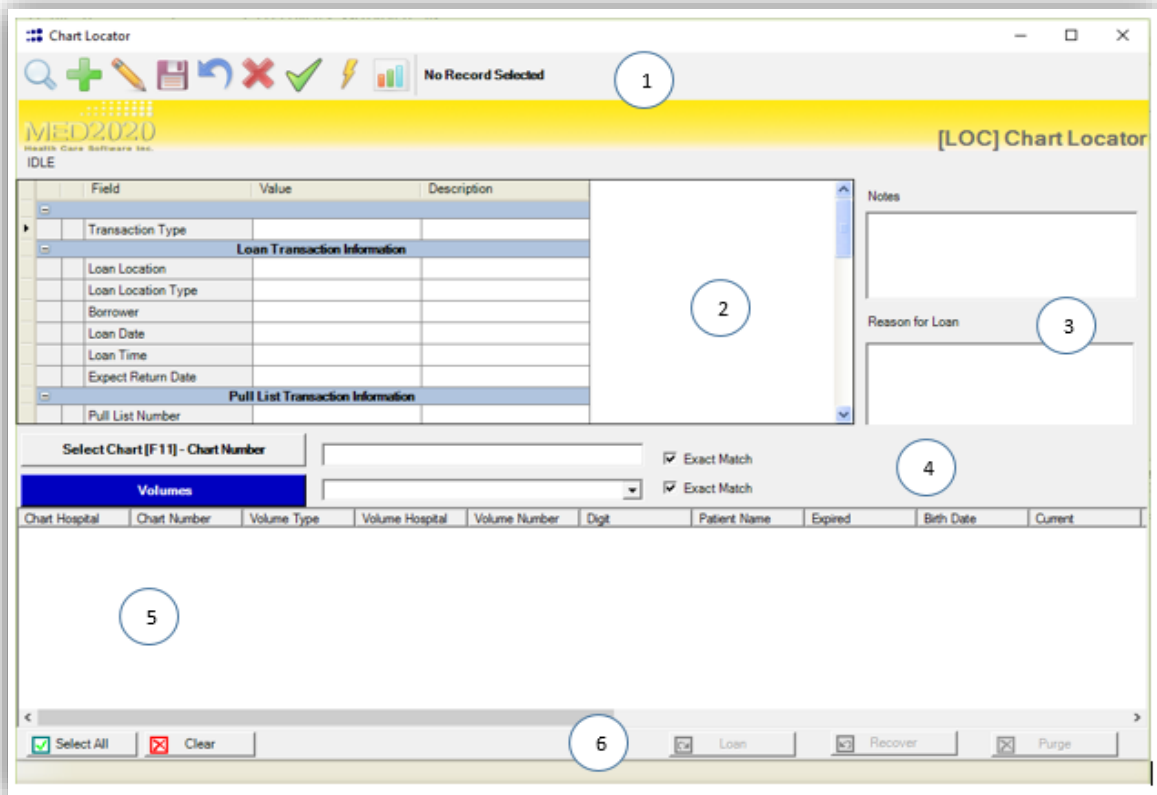
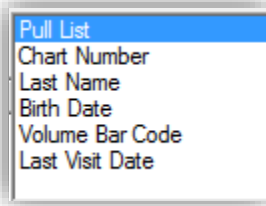


Figure 295 – Chart Locator Module

1. **Tool Bar** – see [Tool Bars](#)
2. **Transaction Information** – The Section included in this area are:
 - Transaction Type – there are 6 transaction types and depending on the type you choose will determine which sections will display
 - **Loan Transaction Information**
 - **Pull List Transaction Information** – fields in this section are only be available if Transaction Type – Pull List is chosen
 - **Return Transaction Information** – fields in this section are only available if Transaction Type – Return is chosen
 - **Mass Move Transaction Information** – fields in this section are only available if Transaction Type – Mass Move is chosen
 - **Request Header Information**
3. **Notes and Reason for Loan** – free text field for user to enter notes
4. **Select Chart & Volumes**
 - Select Chart [F11] – Clicking on this or pressing [F11] will give you the following options to search for a record:



5. **Chart Information** – This represents the charts that have been signed out:
 - Chart number in **Blue** indicates there is an outstanding request for this chart
 - Chart number in **Red** indicates the chart is out on loan
 - Chart number in **Purple** indicates the chart is already signed out to the location chosen
6. **Tool Buttons**

Chart Request Transaction

Ability to request a chart that is currently out on loan. On the chart's return a notice will be create to notify of the user of the new location.

- To create a new Chart Request, press the  or **[F5]**
- Enter Transaction Type C- Chart Request – the Request Header Information field will be displayed
 - Request Location – Press **[F2]** to choose the location the chart is going - mandatory
 - Request Location Type – is linked to the Request Location
 - Request Borrower – identifies the borrower (a specific person) for the Request Location
 - Request Date – The date auto populates – mandatory
 - Request Time – The time auto populates - mandatory
 - Request Priority – Press **[F2]** to chose - Request priorities are set up in Maintenance/Look Up/[LOC] Chart Locator/Request Priority
- Under Select Chart – Choose chart number (or whatever search that is chosen)
- Enter the chart number being requested, if the chart only has one volume press enter and the chart will display in the information box. If there is more than one volume a pop up screen will populate with the chart and volumes:

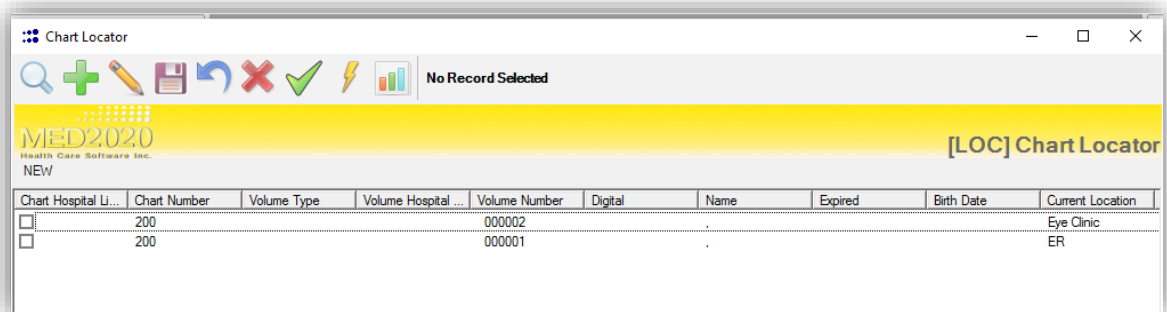


Figure 296 – Chart Locator Volume Screen

- Put a check mark in the chart you would like to select and press Enter
- This will populate in Chart Information Box

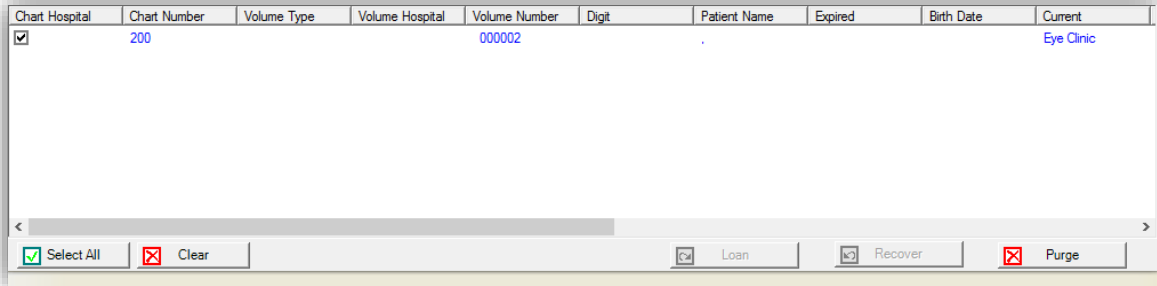


Figure 297 – Chart Locator Chart Information Box

- Press  or [F7] to save.
- When the chart is returned from the current location the following message will prompt when you return it:

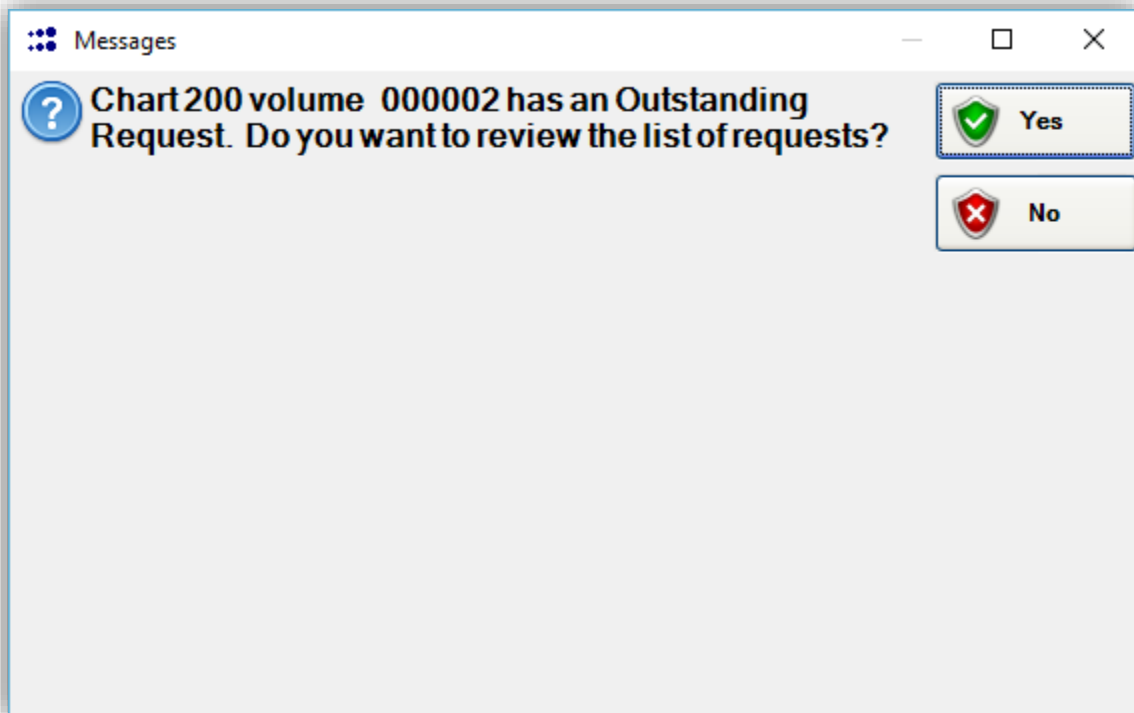
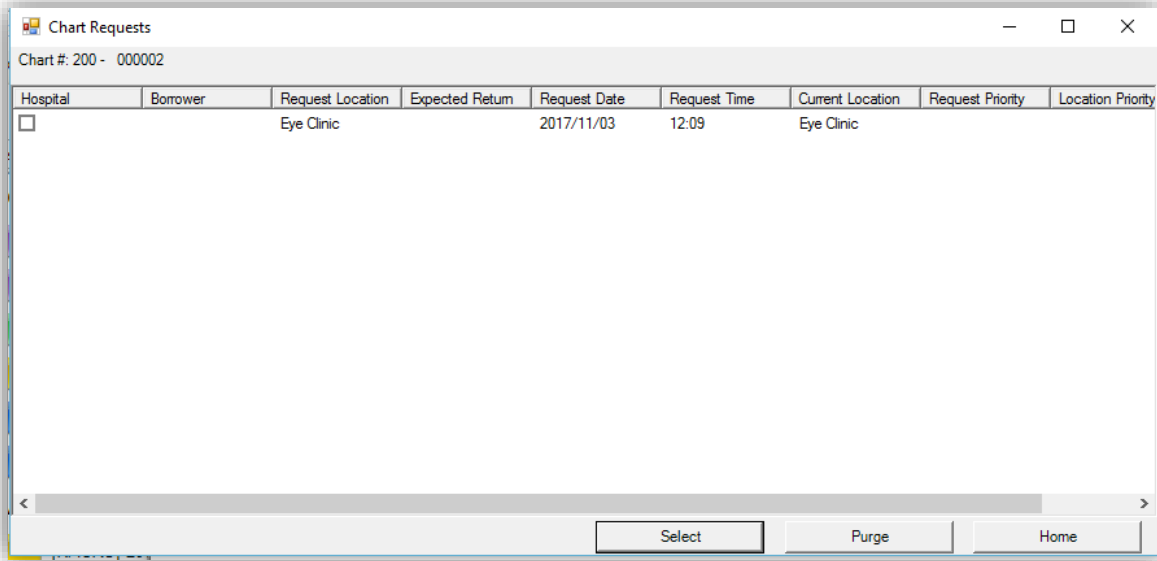


Figure 298 – Chart Locator – Outstanding Request

- Select Yes to view and the following window pops up:



Hospital	Borrower	Request Location	Expected Return	Request Date	Request Time	Current Location	Request Priority	Location Priority
☐		Eye Clinic		2017/11/03	12:09	Eye Clinic		

Buttons: Select, Purge, Home

Figure 299 – Chart Locator – Chart Requests

- To move it to the Request Location, enter the check mark and press **Select** and the chart will be moved to the requested location.
- To remove the request, enter the check mark and press **Purge**

Loan Transaction

Ability to loan charts out to different areas within the department or facility.

- To create a new Loan Transaction, press the  or **[F5]**
- Enter Transaction Type L- Loan - the Loan Transaction Information header will be displayed
 - Loan Location – press **[F2]** to choose the location the chart is going – mandatory
 - Loan Location Type – is linked to Loan Location
 - Borrower – the person that is linked to that location
 - Loan date – The date the loan -automatically populated – mandatory
 - Loan time – the time of the loan – automatically populated – mandatory
 - Expected Return Date – The date the chart is expected to return. This is determined in the Look-up for Loan Location.
- Under Select Chart – Choose chart number (or whatever search that is chosen)
- Enter the chart number being requested, if the chart only has one volume press enter and the chart will display in the information box. If there is more than one volume a pop up screen will populate with the chart and volumes:

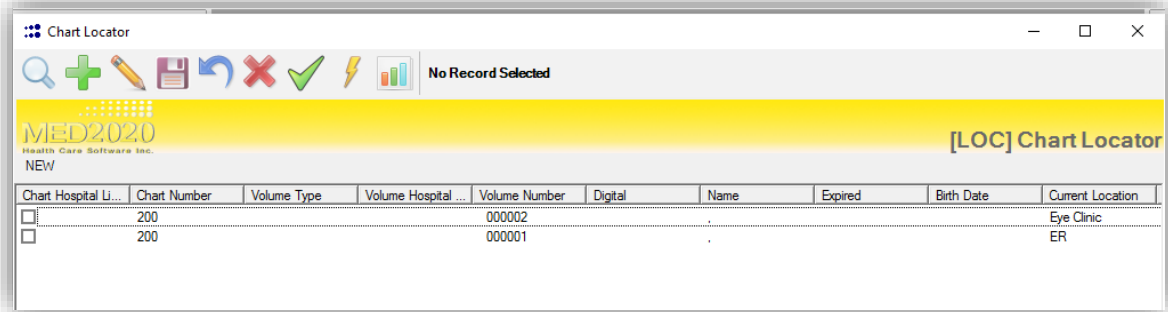


Figure 300 – Chart Locator Volume Screen

- Put a check mark in the chart you would like to select and press Enter
- This will populate in Chart Information Box

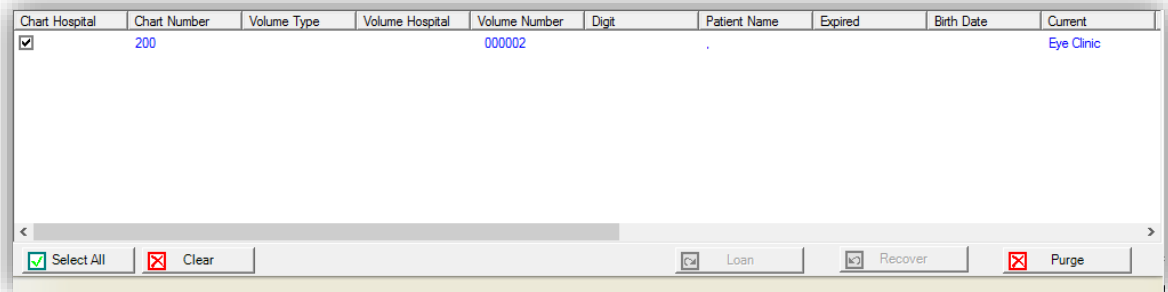


Figure 301 – Chart Locator Chart Information Box

- Press  or [F7] to save.

Mass Move Transaction

Used to move a large number of charts to a new location

- To create a new Mass Move, press the  or [F5]
- Enter Transaction Type M- Mass Move - the Mass Move Transaction Information header will be displayed
 - Move Location – press [F2] to choose the location the chart is currently at – mandatory
 - Move date – Auto populates the date – mandatory
 - Loan time – Auto populated the time – mandatory
 - New Perm Location – press [F2] to choose the new location - mandatory
 - Box Number – enter the box number if the chart is in the box

- Under Select Chart – Choose chart number (or whatever search that is chosen)
- Enter the chart number being requested, if the chart only has one volume press enter and the chart will display in the information box. If there is more than one volume a pop up screen will populate with the chart and volumes:

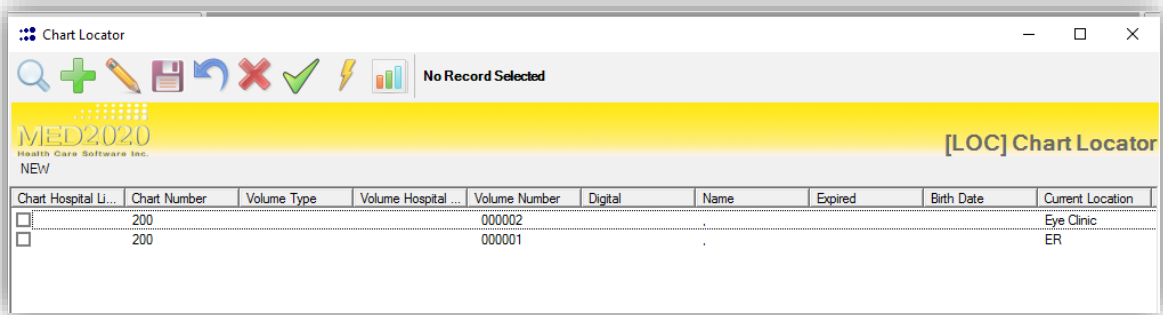


Figure 302 – Chart Locator Volume Screen

- Put a check mark in the chart you would like to select and press Enter
- This will populate in Chart Information Box

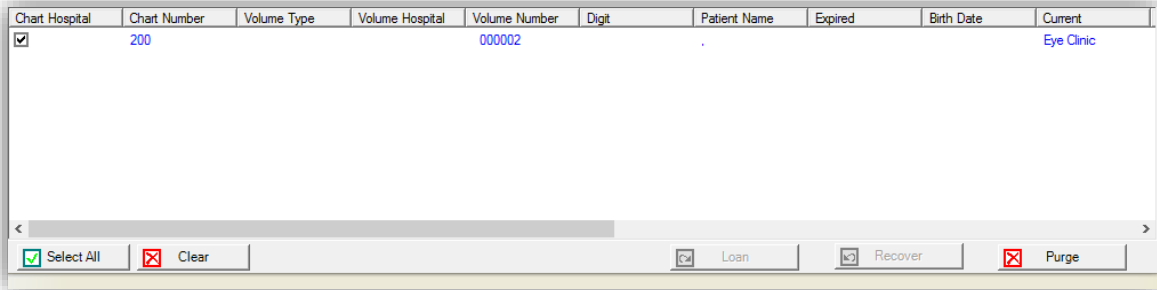


Figure 303 – Chart Locator Chart Information Box

- Press  or [F7] to save.

Pull List Transaction

Used to create pull lists for clinics, etc. Can be created manually or a Batch Interface.

- To create a new Pull List, press the  or [F5]
- Enter Transaction Type P- Pull List – the Pull List Transaction Information header will be displayed

- Pull List Number –auto populates with a Pull List Number – mandatory
 - Request Location – Press **[F2]** to choose the location – mandatory
 - Request Location Type – is linked to the Request Location and will populate
 - Borrower – the person who is borrowing the charts (if known)
 - Request Date – Auto populates the date – mandatory
 - Request Time – Auto populated the time – mandatory
 - Request Priority – Press **[F2]** to chose the priority if desired
 - Pull Date – Auto populates the date but can be changed if date is different
 - Pull Time – Auto populated the time but can be changed it time is different
 - Expect Return Date – The date auto populated the expected return based on request location
- Under Select Chart – Choose Chart Number
 - Enter the chart number being requested, if the chart only has one volume press enter and the chart will display in the information box. If there is more than one volume a pop up screen will populate with the chart and volumes:

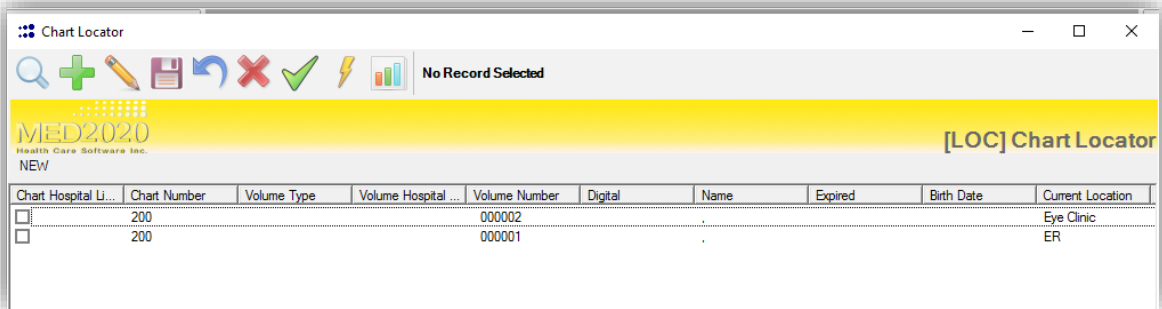


Figure 304 – Chart Locator Volume Screen

- Put a check mark in the chart you would like to select and press Enter
- This will populate in Chart Information Box

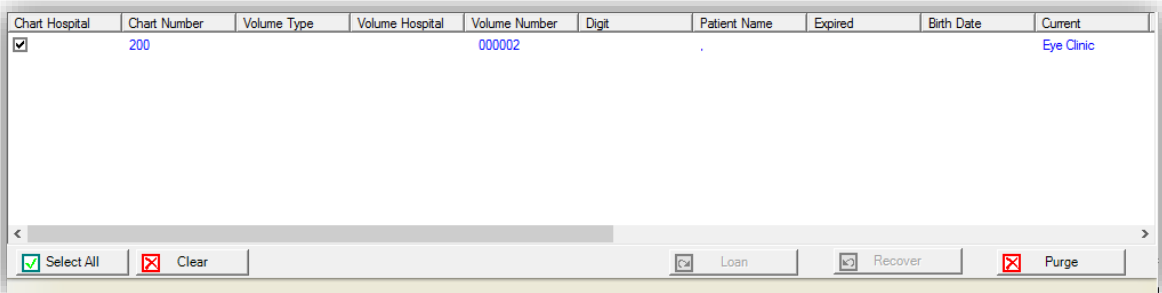


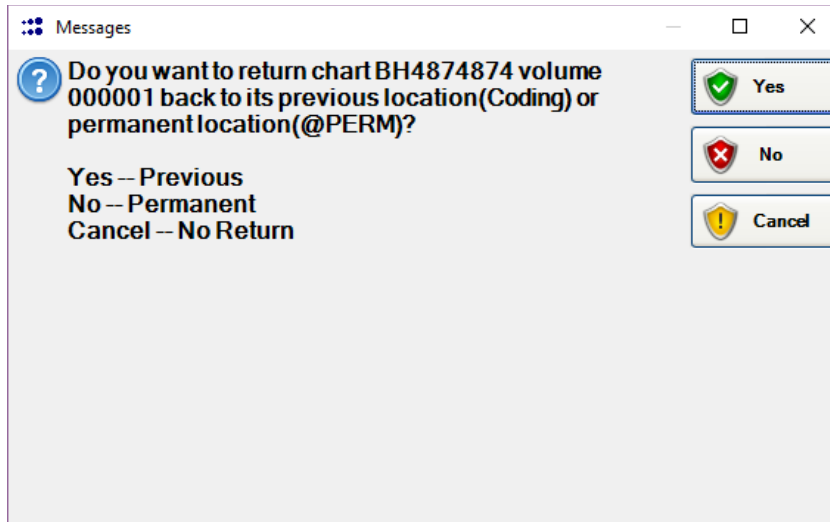
Figure 305 – Chart Locator Chart Information Box

- Press  or **[F7]** to save.

Return Transaction

Used to return loaned charts to either the previous location or the chart's designated permanent location.

- To create a new Return, press the  or [F5]
- Enter Transaction Type R-Return - the Return Transaction Information header will be displayed
 - Return Location – press [F2] to choose the location the chart is being returned to
 - Cursor will jump to Return Location to select from a list of internal locations.
- If Return Location is blank, user can select the charts to be returned and locator will determine if chart will be returned to Previous Location or Permanent Location. If chart was in a previous location that was NOT permanent, a prompt will display.



- Under Select Chart – Choose chart number (or whatever search that is chosen)
 - Enter the chart number being requested, if the chart only has one volume press enter and the chart will display in the information box. If there is more than one volume a pop up screen will populate with the chart and volumes:

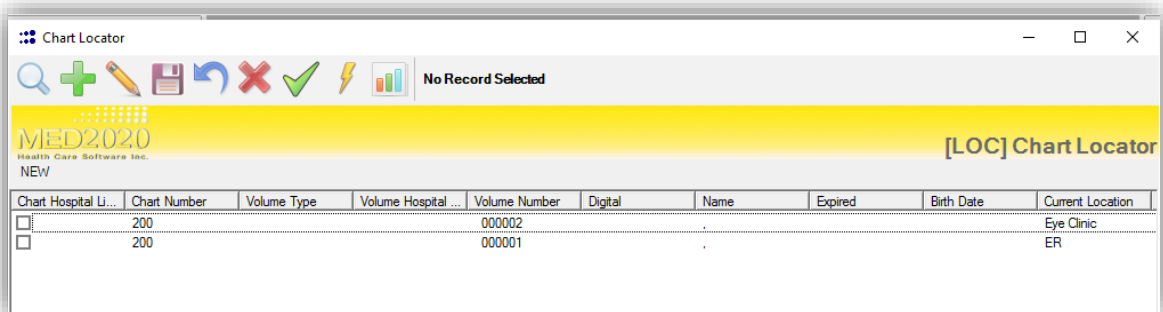


Figure 306 – Chart Locator Volume Screen

- Put a check mark in the chart you would like to select and press Enter
- This will populate in Chart Information Box

Chart Hospital	Chart Number	Volume Type	Volume Hospital	Volume Number	Digit	Patient Name	Expired	Birth Date	Current
☒	200			000002		.			Eye Clinic

☒ Select All
 ☒ Clear

☒ Purge

Figure 307 – Chart Locator Volume Screen

- Press  or [F7] to save.

Cancel Transaction

The ability to cancel transaction created in error and return the chart to the previous location.

- To create a new Return, press the  or [F5]
- Enter Transaction Type X-Cancel
- Under Select Chart – Choose chart number (or whatever search that is chosen)
 - Enter the chart number being requested, if the chart only has one volume press enter and the chart will display in the information box. If there is more than one volume a pop up screen will populate with the chart and volumes:

Chart Locator










 No Record Selected

MED2020 Health Care Software Inc.

NEW

[LOC] Chart Locator

Chart Hospital Li...	Chart Number	Volume Type	Volume Hospital ...	Volume Number	Digital	Name	Expired	Birth Date	Current Location
☐	200			000002		.			Eye Clinic
☐	200			000001		.			ER

Figure 308 – Chart Locator Volume Screen

- Put a check mark in the chart you would like to select and press Enter
- This will populate in Chart Information Box

Chart Hospital	Chart Number	Volume Type	Volume Hospital	Volume Number	Digit	Patient Name	Expired	Birth Date	Current
☒	200			000002					Eye Clinic

☒ Select All
 ☒ Clear

☒ Purge

Figure 309 – Chart Locator Chart Information Box

- Press  or [F7] to save.

Updating Pull List Transactions

- To add records or update a Pull List transaction, press the  or [F4]
- The record search window will display and the list of search options are displayed in the window:

Record Search

Search Options

Select module for search [Ctrl + M]

Chart Maintenance

[CPI] Central Patient Index

[VOL] Chart Volumes

[VH] Visit History

[LOC] Chart Locator

[DEF] Chart Deficiency

[ROI] Release of Information

Abstracting

[NACRS] Level 1 AmCare Ambulato

[NACRS] Level 2 AmCare Ambulato

[NACRS] Level 3 AmCare Ambulato

[CCR] DAD Concurrent Review

[DAD] AbsCare Inpatient

[SDS] AbsCare Day Surgery

[CJRR] Hip Canadian Joint Replac

[CJRR] Knee Canadian Joint Repla

Clinical

[NRS] Admission National Rehabili

[NRS] Discharge National Rehabili

[NRS] Follow-Up National Rehabili

Pull List Number

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

<none>

Borrower

Hospital Link

Pull List Number

Regional Link

Request Date

Request Location

Request Priority

Request Time

Site Number

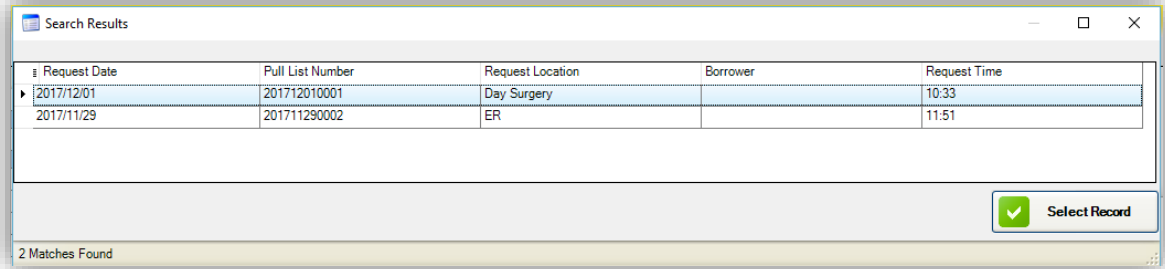
 Find Record

Figure 310 – Chart Locator Record Search

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- Choose the search option and enter the required information.
- Depending on the search option, if there is more than one option a search results page will display with the pull lists associated with that search. Highlight the search and press Select Record.



#	Request Date	Pull List Number	Request Location	Borrower	Request Time
▶	2017/12/01	201712010001	Day Surgery		10:33
	2017/11/29	201711290002	ER		11:51

2 Matches Found

Select Record

Figure 311 – Chart Locator Search Results

- Press  or [F7] to save.

6.1.5 [DEF] Chart Deficiency

Overview

The Chart Deficiency module provides Health Information Management (HIM) departments the ability to track all activity required to complete a patient's chart.

Once a chart is returned to the HIM department, it is collated, sorted and analyzed to determine if any deficiencies exist. These can be entered quickly and easily via the Chart Deficiency module – either manually or using bar code technology. WinRecs generates a deficiency letter per delinquent visit.

As the physician(s) completes the deficient items, the chart can be updated in one of several ways:

- If only some deficiencies are complete, those individual items can be entered and new deficiency letter printed, showing only the outstanding deficiencies
- If all deficiencies are completed by a physician, the physician number can be entered, and all charts will be updated to a status of "C" (Complete). If the physician has completed all items, only one reference number must be entered.

Main Features

- Deficiency codes are profile driven (Please refer to Look Up Code Maintenance).

- Bar Code Technology allows for quick and accurate entry of key information, as well as quick removal of completed deficiencies.
- Delinquent count is done electronically.
- Printing the Deficiency Letter by Provider/Visit Date once the entry has been completed and saved.
- Deficiency Color code tabs can be assigned to each provider for easy identification of where deficiencies are noted within the chart. The colors can be printed on the deficiency letter. Each provider will have a different colored tab to denote their deficiencies.

Chart Deficiency Set Up

The following set up must be completed before using the Chart Deficiency module:

- **Regional/Hospital Profile:** Completion of Module Options/[DEF] Chart Deficiency fields
 - Deficiency Add Days-When deficiency are created, to determine when to start counting the deficiency days. Example: 1 means to start counting deficiency days tomorrow
 - Minimum Deficiency Count-minimum number of deficiencies for a letter to be generated
- **Control File:** Enabling, Disabling, making fields Visible moving of fields around the Chart Deficiency module
- **Provider Maintenance:** Check Chart Deficiency area and ensure appropriate fields are completed such as language and address fields
 - Provider Status
 - Current Provider Level
 - Last Level Letter Issue
 - Last Level Letter Date
 - Resident
 - Max Deficiency Level
 - Minimum Deficiencies
- **Look Up Code Maintenance:** Look up fields under the [DEF] Chart Deficiency are configured
 - Colour Code
 - Deficiency Code
 - Deficiency Code Type
 - Header Status (Level)
 - Message Box
 - Resident

- **Deficiency Letters:** Letters are created using the Report Generator module.

Accessing Chart Deficiency

WinRecs Module Menu → Chart Maintenance → [DEF] Chart Deficiency

- Or -

Modules → Chart Maintenance → [DEF] Chart Deficiency

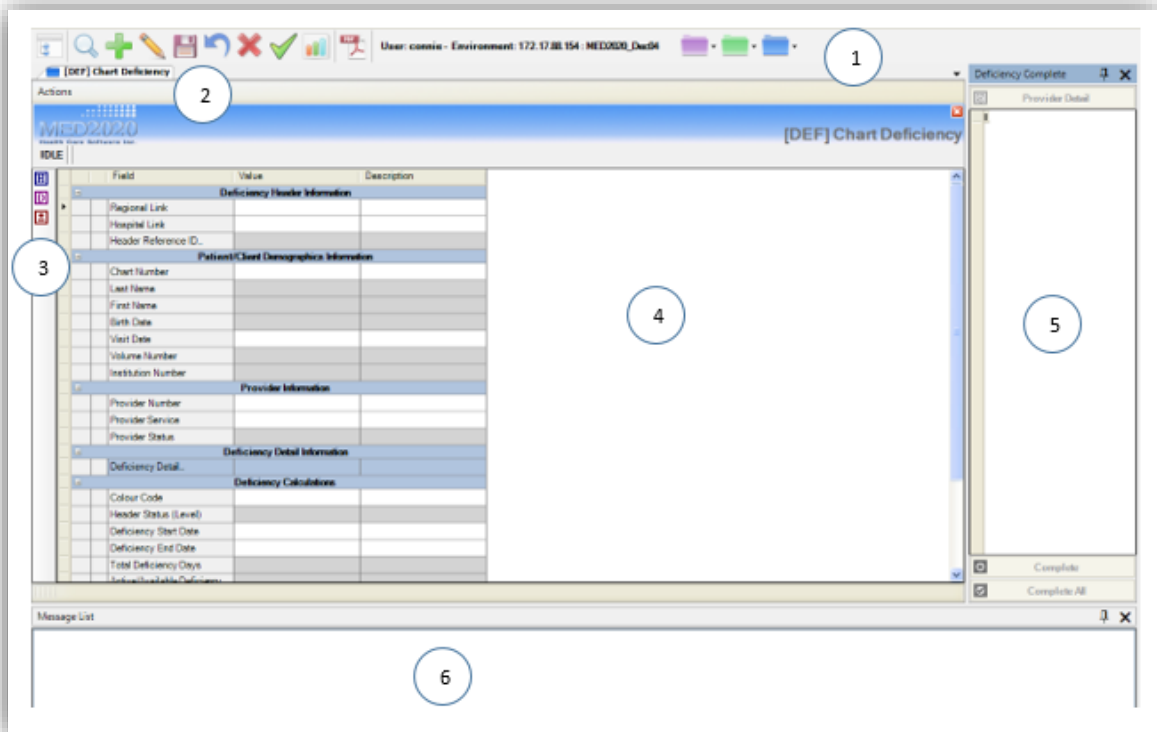


Figure 312 – Chart Deficiency Module

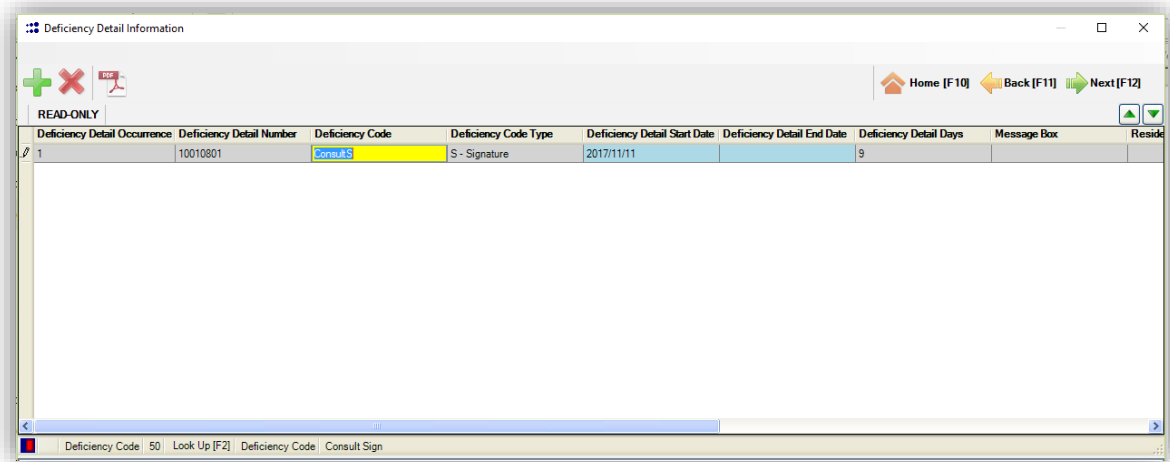
1. **Tool Bar** – see [Tool Bars](#)
2. **Actions** –
 - Deficiency Letters
 - Calculate Deficiency Days
 - Batch Complete
 - Transfer – transfer the deficiency to a different provider
 - Incomplete
 - New Provider [F8]
3. **Bookmarks** – Quick links to the Section Headers
 -  - Deficiency Header Information – main grid
 -  - Deficiency Detail Information - multiform
 -  - Deficiency Calculations

4. **Transaction Information** – The Sections included in this area are:
 - **Deficiency Header Information** -
 - **Patient/Chart Demographics Information**
 - **Provider Information**
 - **Deficiency Detail Information**
 - **Deficiency Calculations**
5. **Deficiency Complete** – this area displays the deficiencies that have been created and where you go to complete them. Can also access the Provider Maintenance module by clicking on Provider Detail.
6. **Messages** – displays a message of any fields that need to be entered, the fields will disappear as they are filled in

Creating a Chart Deficiency

- Open up Chart Deficiency module and the Record Search window pop up, enter the chart number (or whatever type of search)
- To create a new Chart Deficiency, press the  or **[F5]**
- **Deficiency Header Information**
 - **Regional Link** – will populate if user is assigned to Regional Link, can press **[F2]** to look up
 - **Hospital Link** – will populate if user is assigned to Hospital Link, can press **[F2]** to look up
 - **Header Reference ID Number** – mandatory - a unique identifier for each deficiency. This is automatically entered.
- **Patient/Client Demographics Information**
 - **Chart Number** – mandatory - enter the Chart Number or press **[F2]** to search for the chart
 - **Last Name** – populates the patient last name
 - **First Name** – populate the patient first name
 - **Birth Date** – populates the patient birthdate
 - **Visit Date** – this will be the date of the visit that is deficient, will populate with most recent visit. Press **[F2]** to look up other visits and double click on the visit.
 - **Volume Number** – provides a link to all charts for a patient. The volume indicates the hospital where the patient has a chart, where the chart is currently located at each hospital, the volume type, and the date the chart starts and ends. To select a different volume, press **[F2]** to display the volume look up and select a volume. If a volume is not displaying, update the chart in the Chart Volumes module.
 - **Institution Number** – the Institution Number associated with Visit Date
- **Provider Information**

- Provider Number – mandatory – a unique identifier for each provider, press **[F2]** to display the list of providers. If the first few letters of the provider name or number is entered, press [F2] will display only those providers matching what was entered.
- Provider Service – will populate the service of the provider can press **[F2]** to change if provider has more than one service
- Provider Status – will populate the status from Provider Maintenance, Unavailability multiform.
- **Deficiency Detail Information** – this multiform allows the user to assign one or more deficiencies to the provider



Deficiency Detail Occurrence	Deficiency Detail Number	Deficiency Code	Deficiency Code Type	Deficiency Detail Start Date	Deficiency Detail End Date	Deficiency Detail Days	Message Box	Resident
1	10010801	Consults	S - Signature	2017/11/11		9		

Figure 313 – Chart Deficiency – Deficiency Detail Information

- Deficiency Detail Occurrence – automatically populates with the occurrence number
- Deficiency Detail Number – automatically populates the number
- Deficiency Code – mandatory – enter the deficiency code or press **[F2]** to look up the code.
- Deficiency Code Type – automatically populate the code type attached to the Deficiency Code
- Deficiency Start Date – automatically populates today's date
- Deficiency End Date – automatically populates when the deficiency is complete
- Deficiency Detail Days – calculated fields of the number of day the deficiency has been deficient
- Message Box – any comments
- Resident – populated if the provider is a resident populated from Provider Maintenance
- Completed By – the user who completed the deficiency
- Detail Status – the status of the deficiency.
- Job Number – can enter the job number
- Detail Comments – free text field to enter comments

- To create a new deficiency, press  to add a new occurrence.
- To delete an existing deficiency that was created in error press .
- To go back to Home press the  **Home [F10]** or **[F10]** to go back to main grid
- Press  **Back [F11]** or **[F11]** to go back to previous field or multiform
- Press  **Next [F12]** or **[F12]** to go forward to the next field or multiform

• Deficiency Calculations

- Color Code – press **[F2]** to choose a color to assign the deficiency to a provider, optional
 - Header Status (Level) – the level is the type of letter the provider will receive for the deficiency
 - Deficiency Start Date – populates with today's date
 - Deficiency End Date – populates the end date when the deficiency is complete
 - Total Deficiency Days – the number of days the chart has been deficient (calculated)
 - Active/Available Deficiency Days – (calculated)
 - Hold Start Date
 - Hold End Date
 - Hold Days
 - Manual Days
 - Unavailable Days – the number of days the provider has been unavailable
 - Header Notes – free text field to add additional notes
- Press **[F6] & [F7]** to save

New Provider

If a chart has more than one provider that has a deficiency, go to:

- **Actions/New Provider [F8]** or press **[F8]**

This will create a new chart deficiency screen and the deficiency may be entered for the new provider

Printing or Emailing a Chart Deficiency

The user has the ability to print out a chart deficiency to put on the chart or email the deficiency to a provider

- With the record open in the chart deficiency module Press **[F10]** or the  button

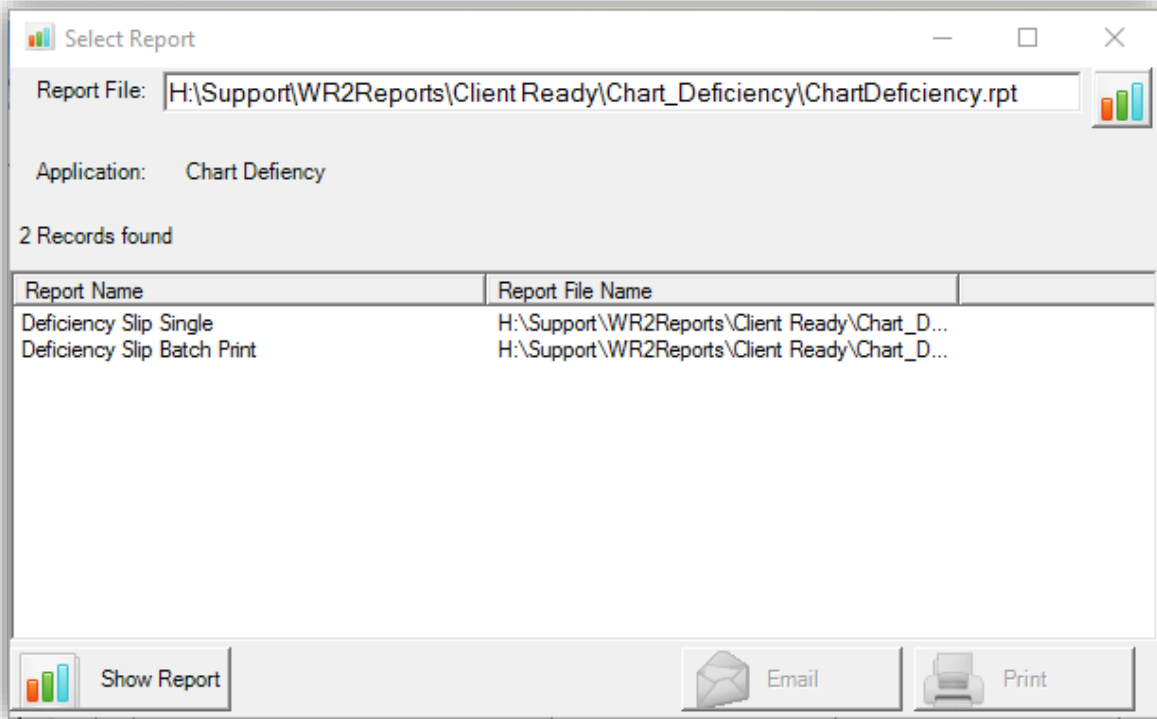


Figure 314 – Chart Deficiency – Printing/Emailing

- There are 3 options to printing the report:
 - Selecting the report from the file directory by double clicking in box next to *Report File*:. This will open the file directory to look for the Chart Deficiency report that needs to be printed.
 - Press the  to open the report and print from there
 - Highlighting the list of reports that are displayed in the middle of the screen (this is set up in **Maintenance/Report Maintenance**)

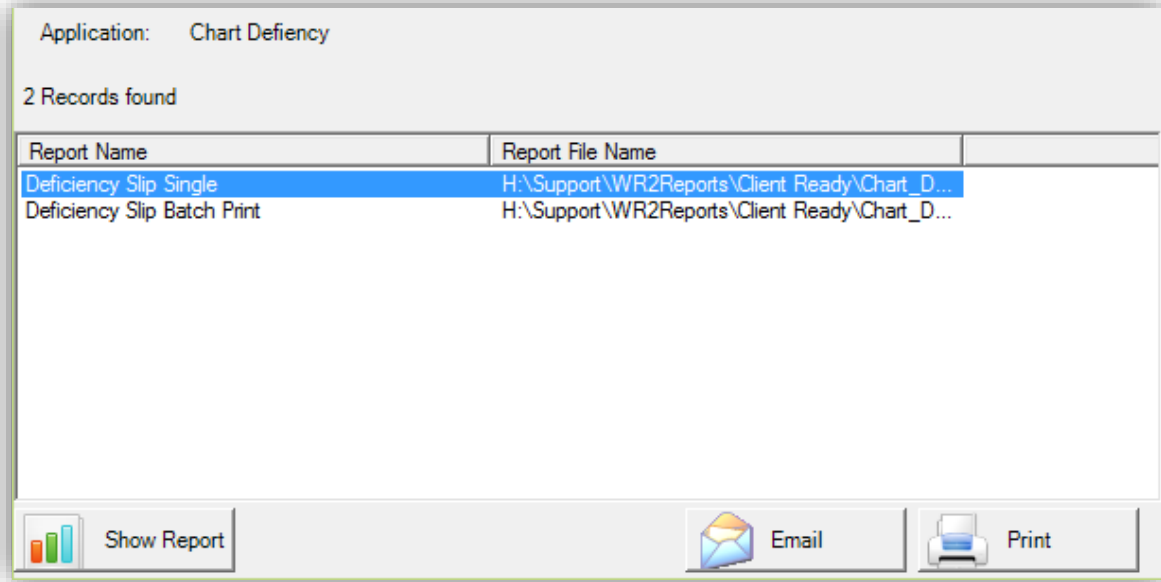
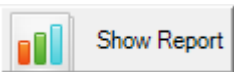
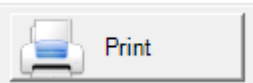
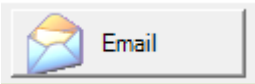


Figure 315 – Chart Deficiency – Printing/Emailing

- Press  to display the report and print from there OR
- Press 
- To Email the report, press 

Completing a Chart Deficiency

WinRecs allows for single deficiencies to be completed, one at time or in batches.

- Open up Chart Deficiency module and the Record Search window pop up, enter the chart number (or whatever type of search)
- If the chart number has more than one provider the search results will show each provider that has an outstanding deficiency. Choose the provider you wish to complete the deficiency.

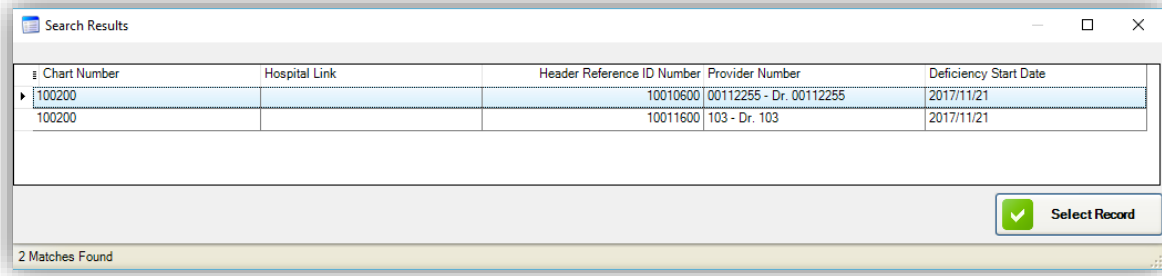


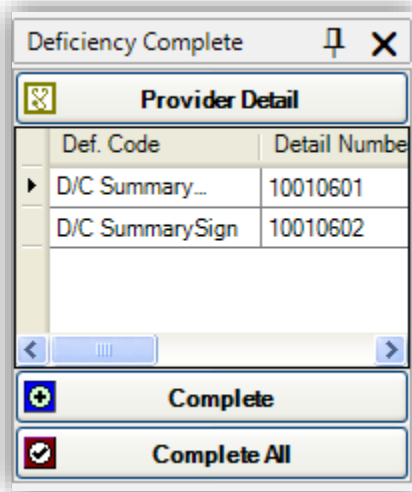
Chart Number	Hospital Link	Header Reference ID Number	Provider Number	Deficiency Start Date
100200		10010600	00112255 - Dr. 00112255	2017/11/21
100200		10011600	103 - Dr. 103	2017/11/21

2 Matches Found

Select Record

Figure 316 – Chart Deficiency – Deficiency Detail Information

- The Deficiency Complete tab will display the deficiencies



Deficiency Complete

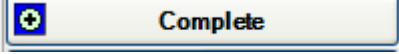
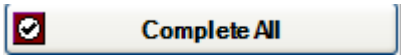
Provider Detail

Def. Code	Detail Number
D/C Summary...	10010601
D/C SummarySign	10010602

Complete

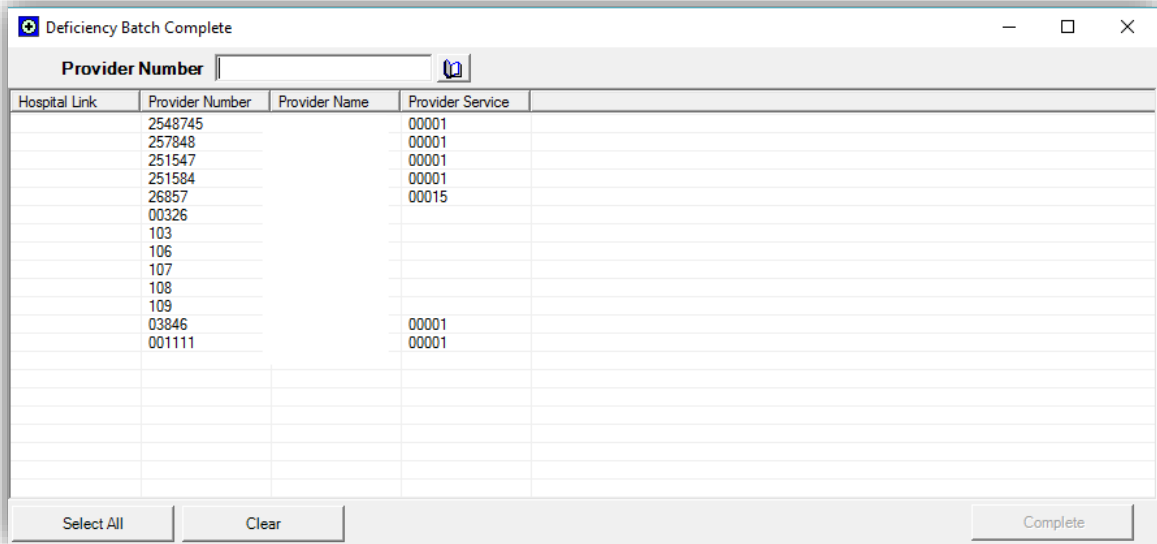
Complete All

Figure 317 – Chart Deficiency – Deficiency Complete

- To complete one deficiency, click on the deficiency, a black arrow will appear.  then press 
 - If there is only one deficiency to be completed, the Deficiency End Date in the Deficiency Calculation will be populated with date the deficiency was completed, as well as the Deficiency Detail End Date will populate in the deficiency Detail Information.
 - If there are two deficiencies on the chart and only one is completed, only the Deficiency Detail End Date will populate for the completed deficiency.
- To complete all deficiencies for one chart press 
 - When all deficiencies are completed using complete All, the Deficiency End Date in the Deficiency Calculation will be populated with date the deficiency was

completed, as well as the Deficiency Detail End Date will populate in the deficiency Detail Information.

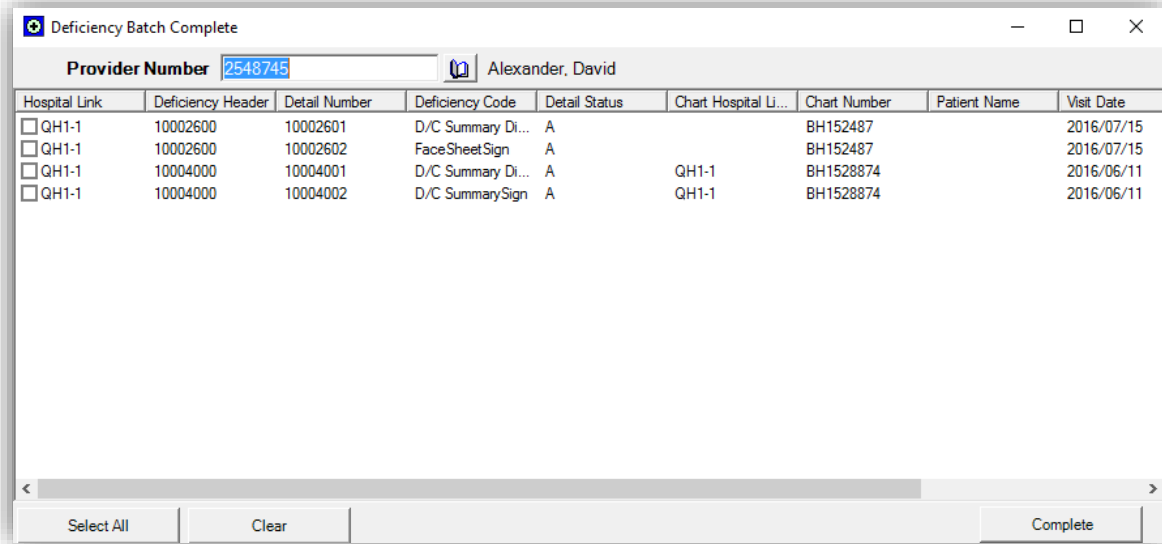
- To complete all deficiencies in a batch, a provider has completed many charts at one time.
- **Actions/Batch Complete** – a list of all physicians with deficiencies will display



Hospital Link	Provider Number	Provider Name	Provider Service
	2548745		00001
	257848		00001
	251547		00001
	251584		00001
	26857		00015
	00326		
	103		
	106		
	107		
	108		
	109		
	03846		00001
	001111		00001

Figure 318 – Chart Deficiency – Deficiency Batch Complete

- Enter Provider Number in the box provided and it will only bring up that provider or double click on the provider in the list below
- A Screen will display all the charts with deficiencies for that provider



Hospital Link	Deficiency Header	Detail Number	Deficiency Code	Detail Status	Chart Hospital Li...	Chart Number	Patient Name	Visit Date
☐ QH1-1	10002600	10002601	D/C Summary Di...	A		BH152487		2016/07/15
☐ QH1-1	10002600	10002602	FaceSheetSign	A		BH152487		2016/07/15
☐ QH1-1	10004000	10004001	D/C Summary Di...	A	QH1-1	BH1528874		2016/06/11
☐ QH1-1	10004000	10004002	D/C SummarySign	A	QH1-1	BH1528874		2016/06/11

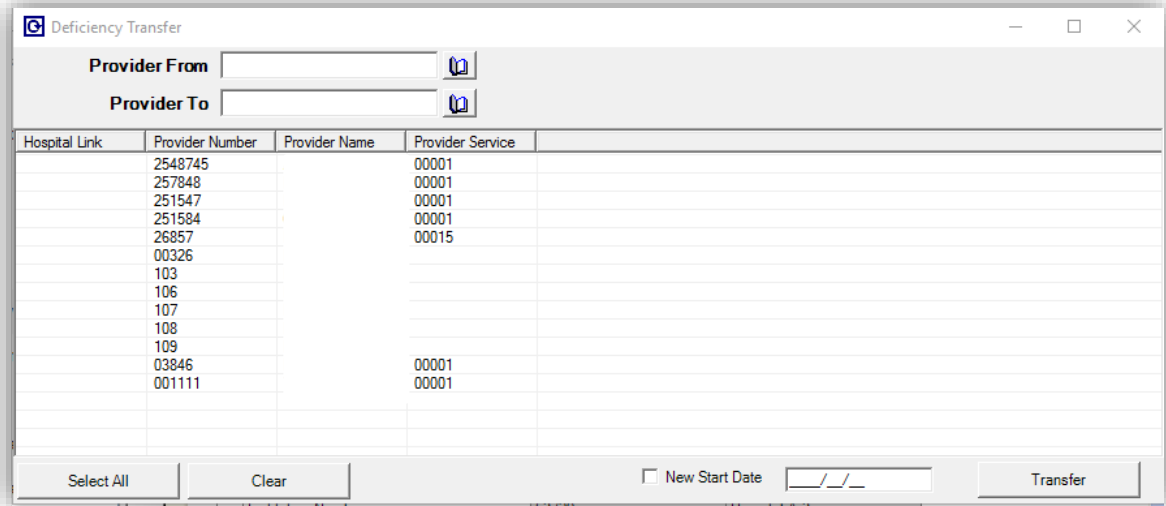
Figure 319 – Chart Deficiency – Batch Complete Provider Deficiencies

- Either click on the box to choose the deficiencies you would like to batch complete or Click on Select All to check them all. 
- If you would like to clear the check marks press Clear
- Press Complete to finish the deficiencies with a check mark.
- **Actions/Batch Complete** – a list of all physicians with deficiencies will display
- **Action/Incomplete** – If you complete a provider deficiency in error, you can go to **Action/Incomplete** and will make the deficiency(deficiencies) incomplete.

Transfer Deficiency to Another Provider

Deficiencies may be transferred to another provider as required. A new start date for the deficiency may be entered.

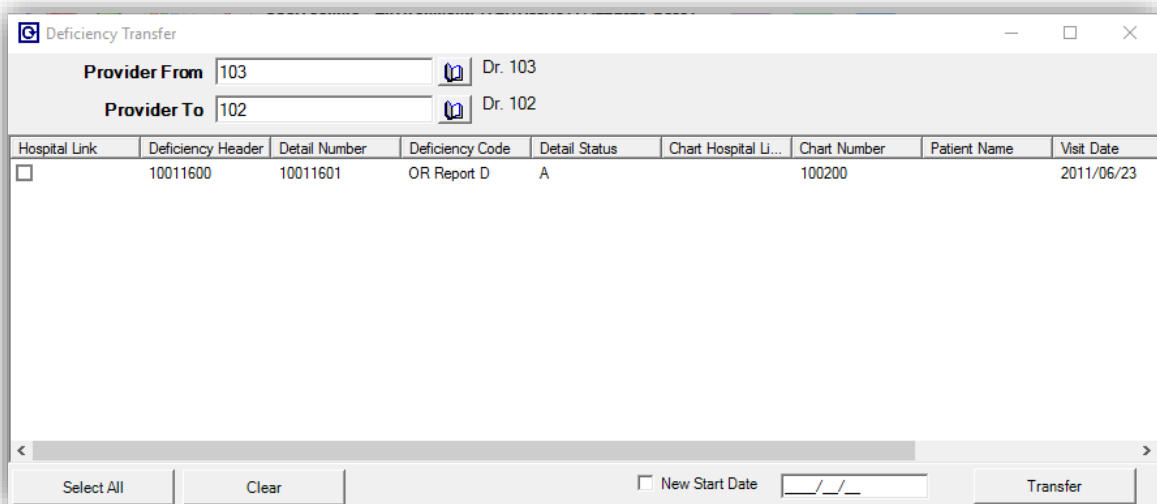
- From the chart deficiency that needs to be transferred, go to **Actions/Transfer** and the Deficiency Transfer will display with the list of providers who have active deficiencies.



Hospital Link	Provider Number	Provider Name	Provider Service
	2548745		00001
	257848		00001
	251547		00001
	251584		00001
	26857		00015
	00326		
	103		
	106		
	107		
	108		
	109		
	03846		00001
	001111		00001

Figure 320 – Chart Deficiency – Deficiency Transfer

- To choose the **Provider From** – enter the provider or number or double click from the list below
- To choose **Provider To** – enter the provider number the deficiency is being transferred to
- A screen will show all the deficiencies that can be transferred from one provider to the other Provider



Hospital Link	Deficiency Header	Detail Number	Deficiency Code	Detail Status	Chart Hospital U...	Chart Number	Patient Name	Visit Date
☐	10011600	10011601	OR Report D	A		100200		2011/06/23

Figure 321 – Chart Deficiency – Deficiency Transfer – Charts to be Transferred

- Either click on the box to choose the deficiencies you would like to transfer or Click on  Select All to check them all.
- If you would like to clear the check marks press Clear
- **New Start Date** – if you would like the deficiency to start counting on a new date, put a check mark in the New Start Date and add the date you would like it to start.
- Press Transfer to transfer the deficiencies with a check mark

Deficiency Letters

The Chart Deficiency module can auto-generate deficiency letters to providers to notify them for chart completion. The can be up to five deficiency levels which are defined by the site, each level represents the number of days the chart is deficient.

6.1.6 [ROI] Release of Information

The Release of Information module is used to maintain and store all Release of Information requests received by a facility. It can be used to track turn-around time, authorizations, workload measurement as well as invoicing and payments, if desired.

The requests are chart-based, so a request must relate to an existing record in the Central Patient Index.

Release of Information Setup

The following setup must be completed before using the Release of Information module.

- **Regional/Hospital Profile:** Completion of **Module Options/[ROI] Release of Information** fields
 - GST Number
 - Tax Rate 1
 - Tax Rate 2
- **Control File:** Enabling, Disabling, making fields Visible moving of fields around the Release of Information module
- **Look Up Code Maintenance:** The [ROI] Release of Information has the following fields that must be populated (all other fields are optional)
 - Action Type
 - Age Code
 - Authorization Received
 - Authorization Required
 - Authorization Signed by
 - Authorization Type

- Chargeable
- Confidential
- Contact
- Document Code
- Extension Notice Required?
- Fee Level
- Item Code
- Item Tax Type
- Next Action
- Payment Method
- Request Method
- Request Type
- Requester Billing Country
- Requester Billing Province
- Requester Country
- Requester ID
- Requester Province
- Requester Type
- ROI Status
- Sent by (Couriers)
- Urgency of Request

- **Report Maintenance** – to set up reports to be run using **[F10]** or 

Accessing Release of Information

WinRecs Module Menu → Chart Maintenance → [ROI] Release of Information

- Or -

Modules → Chart Maintenance → [ROI] Release of Information

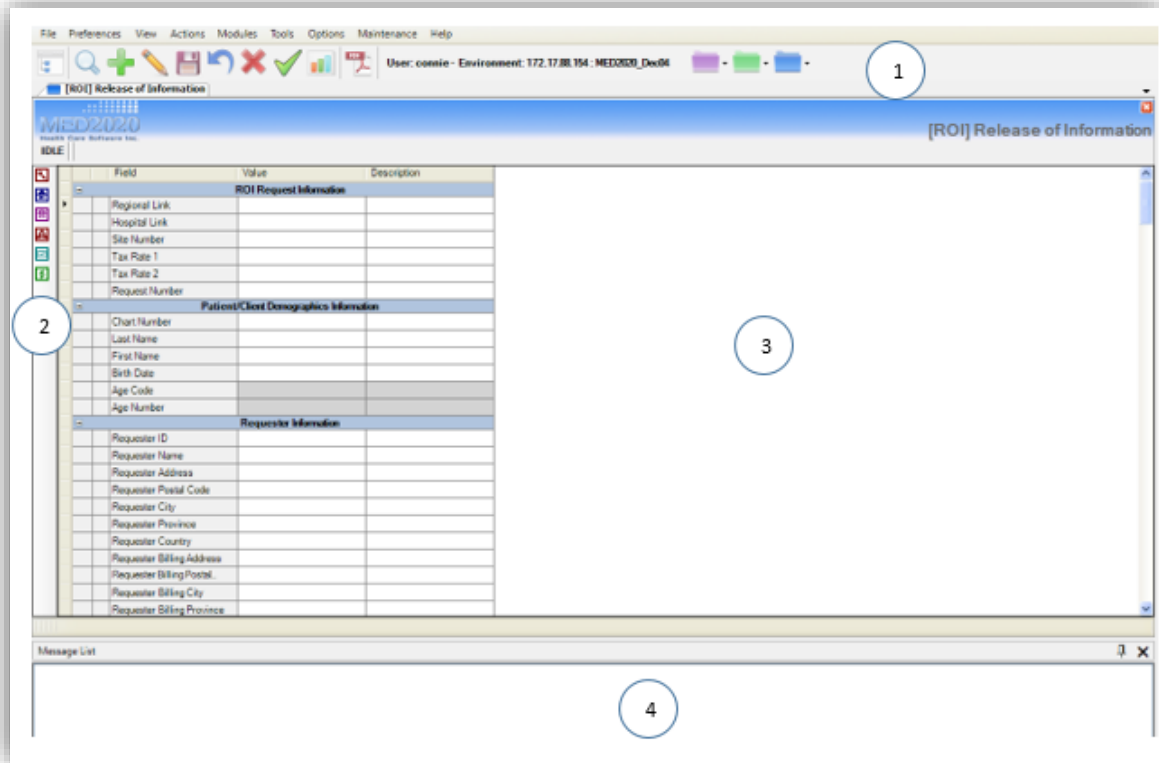


Figure 322 – Release of Information Module

1. **Tool Bar** – see [Tool Bars](#)
2. **Bookmarks** – Quick links to the Section Headers
 -  - ROI Request Information
 -  - Patient/Client Demographics Information
 -  - Contact Information
 -  - Action Data
 -  - Sent Information
 -  - Invoice Information
3. **Transaction Information** – The Sections included in this area are:
 - Patient/Chart Demographics Information
 - Requestor Information
 - Request Information
 - Contact Information
 - Action Data – multiform
 - Document Information – multiform
 - Sent Information
 - Items Sent - multiform
 - Invoice Information
 - Payments Information – multiform

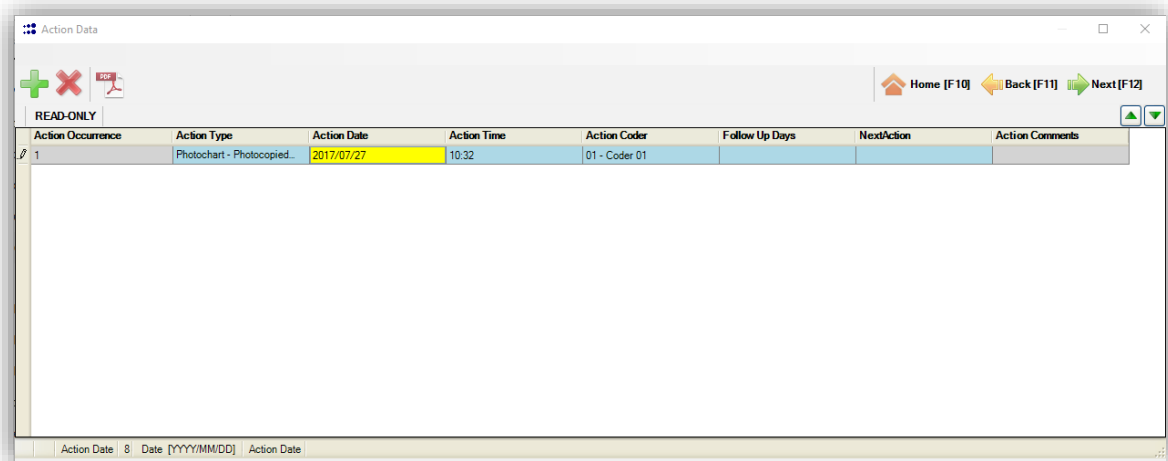
- User Fields Information – Set 1
 - User Fields Information – Set 2
 - User Fields Information – Set 3
 - User Fields Information – Set 4
 - User Fields Information – Set 5
4. **Messages** – displays a message of any fields that need to be entered, the fields will disappear as they are filled in

Creating a New Release of Information Transaction

- Open up Release of Information Module and close the Record Search window pop up
- To create a new Release of Information Transaction, press the  or **[F5]**
- **ROI Request Information**
 - Regional Link – will populate if user is assigned to Regional Link, can press **[F2]** to look up
 - Hospital Link – will populate if user is assigned to Hospital Link, can press **[F2]** to look up
 - Site Number – Enter the site, can press **[F2]** to look up available sites
 - Tax Rate 1 – used to calculate the GST
 - Tax Rate 2 – used to calculate the PST
 - Request Number – A unique alphanumeric identifier for the request. The first digit must be numeric. Can be generated automatically
- **Patient/Client Demographics Information**
 - Chart Number – enter the chart number
 - Last Name – populates the patient last name
 - First Name – populate the patient first name
 - Birth Date – populates the birth date
 - Age Code – the age in 'Y'- years, 'M' – months, 'D'- days will populate
 - Age Number – the number will populate
- **Requester Information**
 - Requester ID – Mandatory – The ID of the person or organization requesting the information. Press **[F2]** to display the list of requestors from the look up
 - Requester Name – The name of the Requester
 - Requester Address – will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Postal Code - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered

- Requester City - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Province - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Country - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Billing Address - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Billing Postal Code - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Billing City - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Billing Province - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Billing Country - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Phone Number - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Phone Extension - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Fax Number - will auto-populate if fields populated in the Requester ID Look up table or can be manually entered
 - Requester Type – type of information being requested, press F2 to display the list of types from the look up table
- **Request Information**
 - Request Dated – the actual date on the request. The number of days between the Request Received Date and the Request Dated are used to calculate the Duration Since Request Received
 - Request Received Date – mandatory – the date the request was received, press **[Spacebar] [Enter]** to enter today's date
 - Request Received Time – the time the request was received, press **[Spacebar] [Enter]** to enter the current time
 - Request Coder – the ID of the person entering the request, press **[F2]** to display the coder
 - Request Method – The way in which the request was received, press **[F2]** to display the look up list of Request Methods
 - Request Type – The type of information requested. Press **[F2]** to display the look up list of Request Types

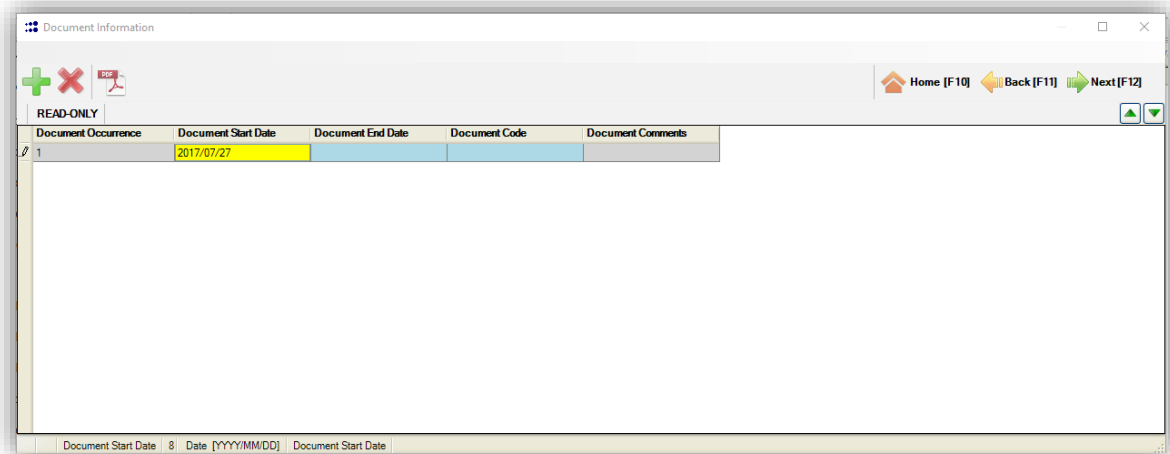
- Chargeable – Indicates if the request is chargeable ('Y' or 'N'). If Chargeable Request is 'N', the Fee Level field, Invoice Information & Payment Multiform are disabled.
- Request Duration – The number of days between the Request Received Date and the Sent Date are used to calculate Request Duration.
- Urgency of Request – Indicates the urgency of the request, can press F2 to display the look up list of Urgencies.
- Fee Level – This is connected to the Requester ID. If the requester has a fee level assigned, the Fee Level is entered automatically.
- Request Comments – Used to enter any required comments.
- **Contact Information**
 - Contact – The code for the contact. This is linked to the Requester ID.
 - Contact Name – The name of the contact
 - Contact Email – email of the contact
 - Contact Phone Number – phone number of the contact
 - Contact Phone Extension – phone extension of the contact
 - Contact Fax Number – fax number of the contact
 - Authorization Required – Indicates if authorization is required ('Y' or 'N'). If 'N' is entered then Authorization Received and Authorization Signed By are disabled.
 - Authorization Received – If Authorization Required is 'Y', this field will open and a ('Y' or 'N') will be required
 - Authorization Type – the type of authorization that was received, press F2 to display the look up list of types.
 - Authorization Signed By – who signed the authorization
- **Action Data – multiform – what was done with the chart**



Action Occurrence	Action Type	Action Date	Action Time	Action Code	Follow Up Days	NextAction	Action Comments
1	Photochart - Photocopied...	2017/07/27	10:32	01 - Coder 01			

Figure 323 – ROI – Action Data Multiform

- Action Occurrence – The unique occurrence number of the action done. This is incremented automatically
 - Action Type – The field indicates the action taken. As the table containing this information is user-defined, actions can be customized to fit your own departmental workflow and procedures. Press **[F2]** to display the look up of Types.
 - Action Date – the date the action occurred, can enter date or press **[Spacebar] [Enter]** to enter the date
 - Action Time – the time the action occurred, can enter date or press **[Spacebar] [Enter]** to enter the date
 - Action Coder – The user who performed the action. Press **[F2]** to display the list of users.
 - Follow Up Days – The number of days in which the action needs to be completed. In combination with a report, this can produce workload information
 - Next Action – indicates what the next action (if any) may be
 - Action Comments – any additional comments
- **Document Information** – multiform – the document and dates send from the chart



Document Occurrence	Document Start Date	Document End Date	Document Code	Document Comments
1	2017/07/27			

Figure 324 – ROI – Document Information

- Document Occurrence - The unique occurrence number of the document information. This is incremented automatically
- Document Start Date – the start date of the document information
- Document End Date – the end date of the document information
- Document Code – the type of document

- Document Comments – any additional comments
- **Sent Information**
 - ROI Status – The status of the request. Press **[F2]** to display the list ROI Status
 - Sent Date – the date the information was sent **[Spacebar] [Enter]** to populate today's date
 - Sent Time – the time the information was sent. **[Spacebar] [Enter]** to populate the current time
 - Sent Coder – The ID of the person who sent the request. Press **[F2]** to display the list of coders.
 - Sent By (Couriers) – Indicates the method of delivery of the request. This is normally a courier name, press **[F2]** to display list of couriers
 - Tracking Number – The tacking number assigned by the courier for following the information sent
 - Special Handling Instructions – Enter any special instructions for handling the item
 - Extension Notice Required? – Indicates if extension notice is required ('Y' or 'N')
 - Extension Days – Number of days for extension
 - Sent Item Comments – any additional comments
- **Items Sent - multiform**
 - Item Sent Occurrence – This is a unique number, generated automatically to identify the occurrence of the item sent.
 - Item Sent Date – The date of information sent request. A date is required. Can press **[Spacebar] [Enter]** to populate todays date
 - Item Quantity – the number of items sent with this occurrence, such as number of photocopied papers, etc.
 - Item Code – Required – The code identifying the item, based on tables set up by the facility. Press **[F2]** to look up the item code.
 - Item Price – The item price. This defaults from the Item Code, but can be entered manually as well
 - Item Tax Type – The tax type (GST, PST, ect) of the item. The value in this field defaults from the Item Code, if applicable. Press **[F2]** to display the list of types.
 - Item Total Amount – The total amount of the items being sent.
 - Sent Item Comments – any additional comments
- **Invoice Information**
 - Invoice Number – the invoice number

- Invoice Date – the date the invoice was created. Press **[Spacebar] [Enter]** to enter today's date
- Invoice Time – the time the invoice was created. Press **[Spacebar] [Enter]** to enter the current time
- Invoice Total – the total amount of the invoice including applicable taxes
- Account Number – the account number of requester
- GST Number – The hospital's GST number can be entered here. This can be set up in the Control File default to avoid repetitive entry
- Amount Paid to Date – the amount paid to date
- Total Amount Due – the total due. The field adjusts as payments are made and recorded in the Payments multiform
- Due Date – the date the Total Amount Due must be paid.
- **Payment Information** – multiform – Multiple payments may be recorded for each ROI request. This allows for installment payments to be recorded and fields to record information for invoicing purposes. The entire section is enabled if the 'Chargeable Request' Field is 'Y'
 - Payment Occurrence – This is a unique number, generated automatically to identify the occurrence of the payment
 - Payment Date – The date the payment is received. **[Spacebar] [Enter]** to enter today's date
 - Payment Time – The time the payment was received. **[Spacebar] [Enter]** to enter the current time.
 - Payment Method – The method used to make the payment, such as cheque, cash, etc.
 - Payment Amount – The amount of this payment
 - Cheque No – enter the cheque number if paid by cheque
 - Payment Comments – any additional comments
- **User Fields Information** – Set 1 – 5 – the User Fields Information provides 6 types of fields where data can be collected. In each set there are 5 of these fields types available.
 - Date Fields
 - Time Fields
 - Look Up Fields – can create look up fields in look up maintenance
 - Numeric Fields – 10 character numeric
 - Text – 50 characters free text
 - Note – 255 characters

Modifying Release of Information Transactions

Release of Information transactions may be modified as required.

- Open up Release of Information Module and the Record Search window will pop up, enter the chart number (or whatever type of Release of Information search option is preferred).

- Or -



- Press **[F4]** or  to bring up the search window
- A window will display if there are multiple choices to make, double click on the transaction desired and the Release of Information Screen will display with the pertinent information.

Deleting Release of Information Transactions

- Open the Release of Information Transaction that needs to be deleted



- Press **F5** or the  to delete the transaction.
- The following message will appear:

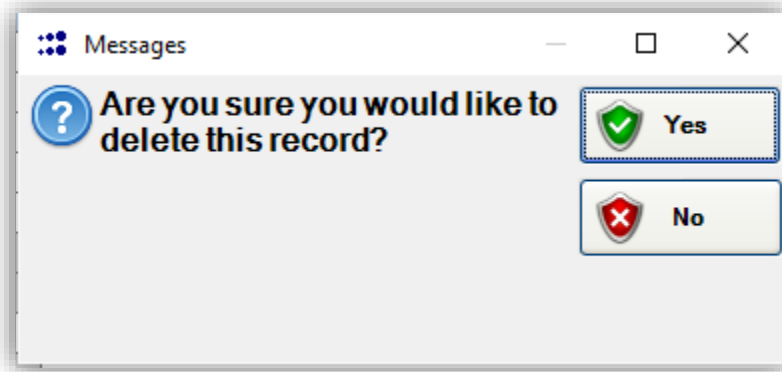


Figure 325 – Release of Information – Delete Chart Record

- Press Yes to delete or No to not delete.
- The deleted record will go into the Purge/Recover module, where the user has the option to Purge the transaction or Recover the transaction. Please refer to Purge/Recover

Release of Information Reports

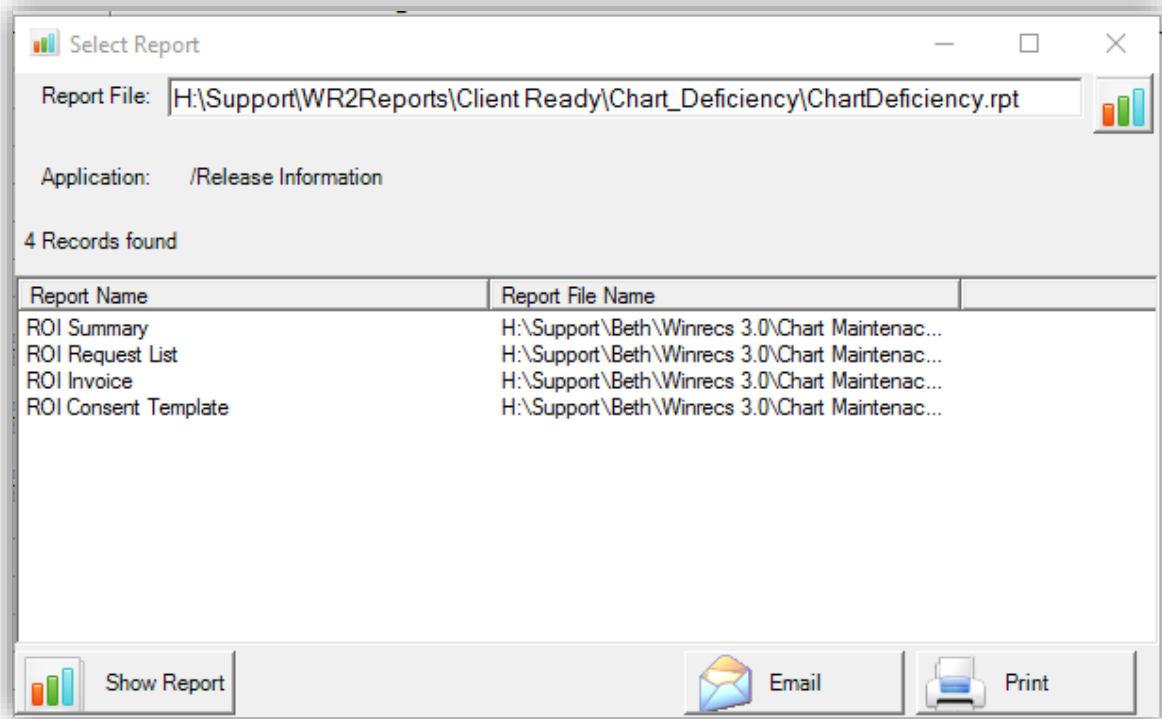
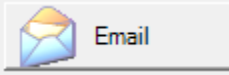
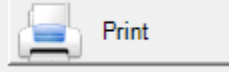


Figure 326 – Release of Information – Printing/Emailing Reports

- To print or view ROI reports press [F10] or  button
- A Select Report window will pop up giving the user the following two options:
 - Double clicking in the Report File rectangular window and searching for the ROI report to be printed
 - Press the  beside the rectangular window to display the report
- Choose the report in the list and highlight the report and the following 3 options are:
 -  to view the report
 -  to email the report
 -  to print the report

6.2 Abstracting – [DAD] AbsCare Inpatient

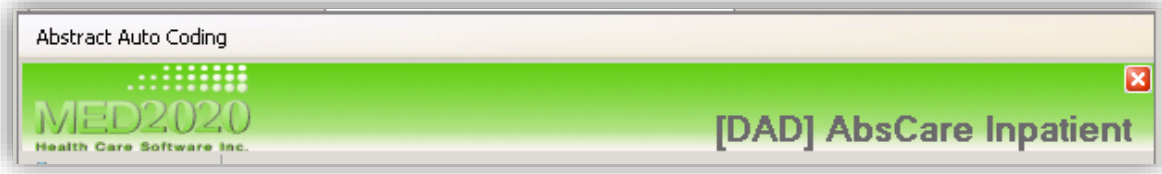


Figure 327 – [DAD] AbsCare Inpatient Header

The **DAD – AbsCare Inpatient** module is part of Abstracting Suite. This module is used to collect Inpatient Hospital data as per the CIHI – DAD Abstracting Manual.

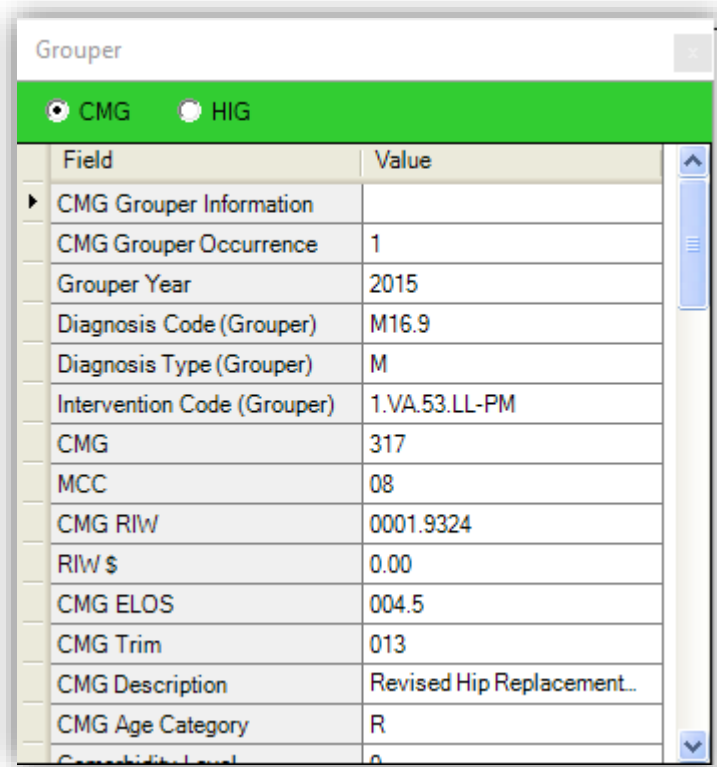
To open the [DAD] AbsCare Inpatient module

- Select the menu option **Module → Abstracting → [DAD] AbsCare Inpatient**
— or —
- Select **WinRecs Module Menu → Abstracting → [DAD] AbsCare Inpatient**

The following **System Mandatory** fields must be completed in order to save: Chart Number, Institution Number, Discharge Date and Discharge Time field entered.

CMG Calculation

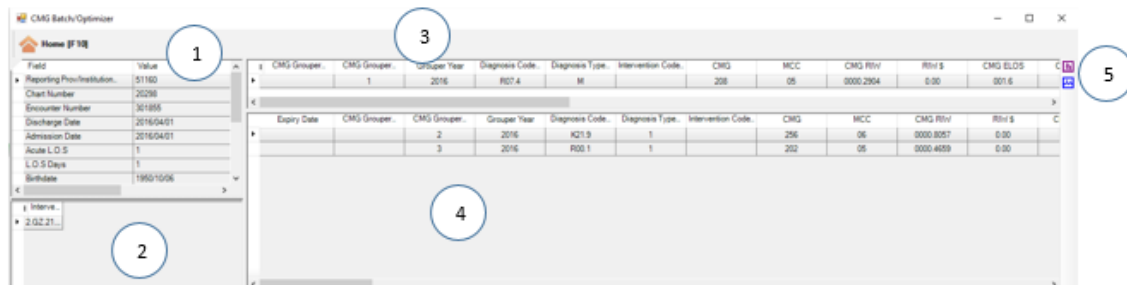
The CMG Calculation can be found in the dockable window called **Grouper**. This provides the user with all the grouper information related to the abstract.



Field	Value
CMG Grouper Information	
CMG Grouper Occurrence	1
Grouper Year	2015
Diagnosis Code (Grouper)	M16.9
Diagnosis Type (Grouper)	M
Intervention Code (Grouper)	1.VA.53.LL-PM
CMG	317
MCC	08
CMG RIW	0001.9324
RIW \$	0.00
CMG ELOS	004.5
CMG Trim	013
CMG Description	Revised Hip Replacement..
CMG Age Category	R
Comorbidity Level	0

Figure 328 – CMG Grouper – Dockable Window

Double-click on any of the fields in the Grouper pane to open the CMG Batch/Optimizer window.



CMG Group	Grouper Year	Diagnosis Code	Diagnosis Type	Intervention Code	CMG	MCC	CMG RIW	RIW \$	CMG ELOS	CMG Trim
1	2015	R07.4	M		208	08	0000.2954	0.00	001.6	

Intervention Code	Description	CMG	MCC	CMG RIW	RIW \$	CMG ELOS	CMG Trim
R07.4	Revised Hip Replacement..	256	06	0000.8057	0.00		
R00.1		202	08	0000.4089	0.00		

Figure 329 - CMG Batch/Optimizer window

1. Displays fields and values from the main grid that relate to the grouper
2. Displays the intervention codes and descriptions.

3. Displays the grouper values for the Most Responsible Diagnosis. The grouper values are automatically calculated and are based on the current fiscal year.
4. Displays the grouper values for each diagnosis other than the Most Responsible diagnosis. The values shown are what the grouper values would be if that diagnosis was to be selected as the Most Responsible Diagnosis.
5. Pressing these buttons will navigate to the Diagnosis and Interventions multiform and gives the ability to change the order of the diagnosis or intervention.

Optimized data shown on the Batch Optimizing form is not stored in the database (unless the Batch Grouper has already been run), and is for information purposes only. The option of storing optimized data is given when the Batch Grouper is run.

6.3 Abstracting – [CCR] DAD Concurrent Review



Figure 330 [CCR] - Concurrent Review Inpatient Header

The **Concurrent Review** module is used to abstract patient data during the patient's hospitalization.

The module can be used in Conjunction with the CMG+™ grouper to determine expected length of stays (ELOS) and predict expected dates of discharge.

Data entry is completed the same as other abstracting modules. The more data collected during the hospitalization, the more complete the abstract will be on discharge. Once the **Discharge Date** is populated, the chart will move from the **CCR** module **Inpatient** module.

To open the [CCR] DAD Concurrent review module

- Select the menu option **Module → Abstracting → [CCR] DAD Concurrent Review**
— or —
- Select **WinRecs Module Menu → Abstracting → [CCR] DAD Concurrent Review**

Reporting [CCR] DAD Concurrent Review

Data entered into **CCR** can be used in the **Report Manager** to prepare statistical reports on current inpatients.

To report the LOS in the **Concurrent Review Module**, do not use the LOS in the Abstract Grid as the LOS is based on the discharge date. Since **CCR** does not have a discharge date the LOS is not updated. For reporting purposes in Crystal Report, do not use the LOS field in the Abstracting views, use the custom formula that uses the Admit Date and the Current Date. A sample is provided below:

Create the formula below with the name 'LOS Calculation'

If {I10_Abstracting.AdmissionDate} = CurrentDate then 1 else DateDiff
('d', {I10_Abstracting.AdmissionDate} , CurrentDate)

Place the formula as the LOS field in the report.

In order to save the record, the abstract must have the Institution Number, Chart Number and Admit Date.

6.4 Abstracting – [SDS] AbsCare Day Surgery

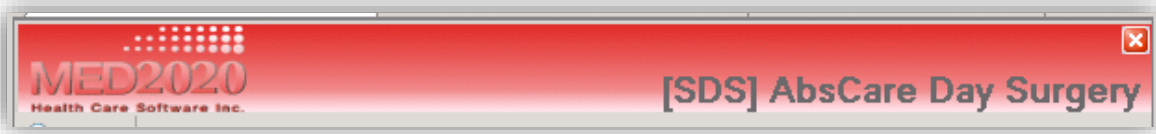


Figure 331 – [SDS] AbsCare Day Surgery Header

The **SDS – AbsCare Day Surgery** module is used to collect Day Surgery data as per the CIHI – DAD/SDS Abstracting Manual.

The Same Day Surgery Abstracting is completed in this separate module for all clients except Ontario clients where SDS is completed using the **[NACRS] Level 3 AmCare Ambulatory** module.

To open the [SDS] AbsCare Day Surgery module

- Select the menu option **Module → Abstracting → [SDS] AbsCare Day Surgery**
— or —
- Select **WinRecs Module Menu → Abstracting → [SDS] AbsCare Day Surgery**

The following System Mandatory fields must be completed in order to save: Chart Number, Institution Number, Discharge Date and Discharge Time field entered.

6.5 Abstracting – [NACRS] Level 0 (Clinic Lite) AmCare Ambulatory

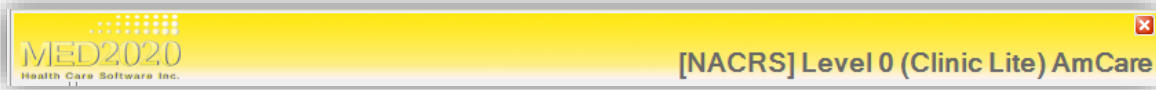


Figure 332 – [NACRS] Level 0(Clinic Lite) AmCare Header

The [NACRS] Level 0 (Clinic Lite) AmCare Ambulatory module is used to collect Clinic Lite data. Records in Clinic Lite include Ambulatory Care Groups CL, DI, and OT. A field has been created to identify the Clinic Lite records called 'NACRS Clinic Lite Submission':

- 'F' means the chart is flagged and will be submitted
- 'Y' means the chart has been submitted
- 'N' means the chart will not be submitted as Clinic Lite record

Please note: If the Ambulatory Care Group CL is submitted as Level 3 then be sure to create the record in [NACRS] Level 3 AmCare.

Changing Unsubmitted Level 0 chart to Level 3

If an unsubmitted record is abstracted in Level 0 but should be a Level 3:

- Open [NACRS] Level 3 AmCare
- Search for the record
- A warning message will display:

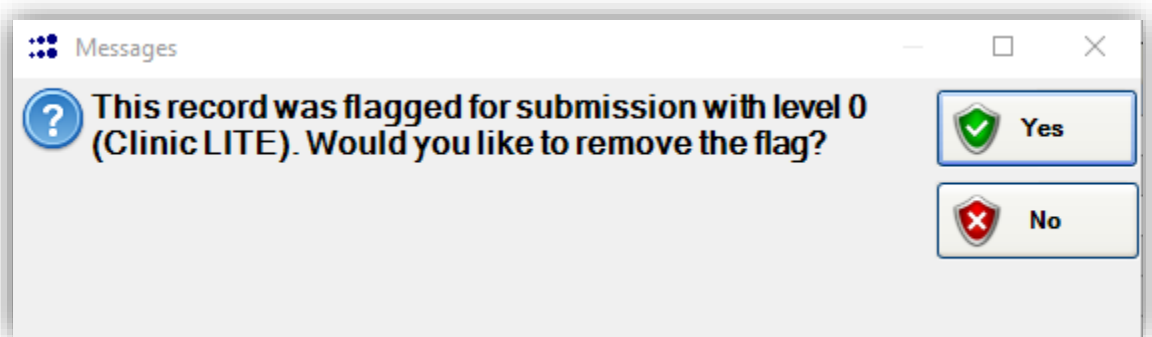


Figure 333 – Changing Level 0 to Level 3 message

- Click Yes to save the record or No to not save
- Save the record in Level 3 and it will now be submitted as Level 3.

Changing Unsubmitted Level 3 to Level 0

- Open [NACRS] Level 0 Amcare
- Search for the record
- Save the record and the 'NACRS Clinic Lite Submission' will be flagged with "F"

6.6 Abstracting – [NACRS] Level 2 AmCare Ambulatory

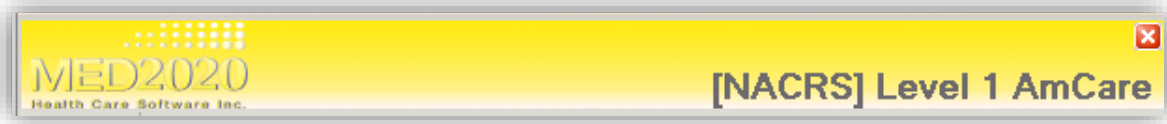


Figure 334 – [NACRS] Level 2 AmCare Header

The [NACRS] Level 2 AmCare Ambulatory module is used to collect Emergency (NACRS) data as per the CIHI – NACRS Abstracting Manual. As per CIHI Level 2 includes data elements required for ED wait time, also allows for optional collection of Presenting Complaint and ED Discharge Diagnosis (as directed by region/province).

Using this module will display Level 2 edits only.

To open the [NACRS] Level 2 AmCare Ambulatory module

- Select the menu option **Module → Abstracting → [NACRS] Level 2 AmCare Ambulatory**
— or —
- Select **WinRecs Module Menu → Abstracting → [NACRS] Level 2 AmCare Ambulatory**

6.7 Abstracting – [NACRS] Level 2 AmCare Ambulatory

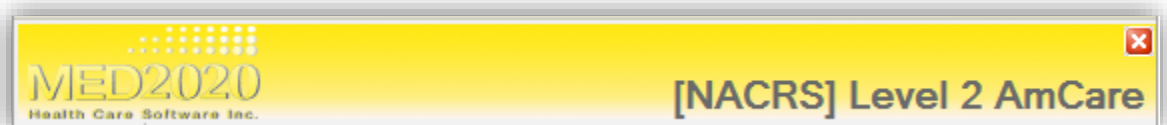


Figure 335 – [NACRS] Level 2 AmCare Header

The [NACRS] Level 2 AmCare Ambulatory module is used to collect Emergency (NACRS) data as per the CIHI – NACRS Abstracting Manual.

As per CIHI Level 2 includes data elements required for ED wait time and the collection of one of Presenting Complaint and ED Discharge Diagnosis is mandatory.

Using this module will display Level 2 edits only.

To open the [NACRS] Level 2 AmCare Ambulatory module

- Select the menu option **Module → Abstracting → [NACRS] Level 2 AmCare Ambulatory**
— or —

- Select WinRecs Module Menu → Abstracting → [NACRS] Level 2 AmCare Ambulatory

6.8 Abstracting – [NACRS] Level 3 AmCare Ambulatory

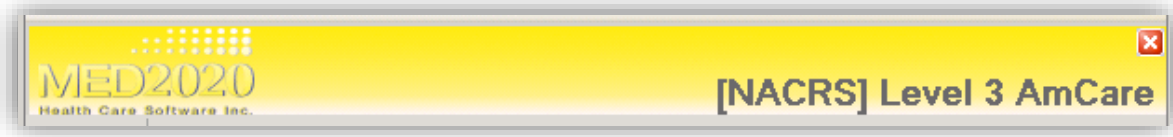


Figure 336 – [NACRS] Level 3 AmCare Header

The **[NACRS] Level 3 AmCare Ambulatory** module is used to collect Emergency (NACRS), Clinical and Surgical Daycare (Ontario only) data as per the CIHI – NACRS Abstracting Manual.

As per CIHI Level 2 includes all mandatory and optional data elements. It is mandatory to capture ICD-10-CA/CCI Diagnosis and Intervention information.

Using this module will display Level 3 edits only, Level 2 and 2 data will flow over to the Level 3 abstract.

To open the [NACRS] Level 3 AmCare Ambulatory module

- Select the menu option **Module → Abstracting → [NACRS] Level 3 AmCare Ambulatory**
— or —
- Select **WinRecs Module Menu → Abstracting → [NACRS] Level 3 AmCare Ambulatory**

The following System Mandatory fields must be completed in order to save for all NACRS Levels: Chart Number, Institution Number, Registration Visit Date and Registration Visit Time field entered.

6.9 Abstract Auto Coding

Within each Abstracting Module (except CCR), there is an option of **Abstract Auto Coding** just above the module header.

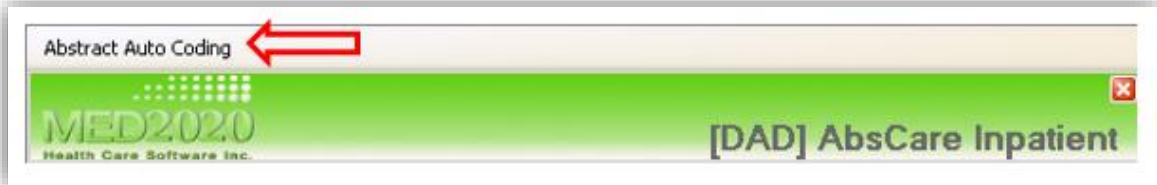


Figure 337 – Abstract Auto Coding

There are two options:

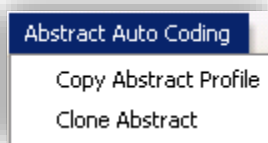


Figure 338 – Abstract Auto Coding Options

Copy Abstract Profile

Copy Abstract Profile is used to create generic abstracts in Amcare, Inpatient & Day Surgery modules. Profiles are used for abstracts with the same type of admission/diagnosis/intervention.

Create an Abstract Profile

- Go to **Tools→Abstract Profile**
- Click on **Abstract Profile** and the following screen will populate

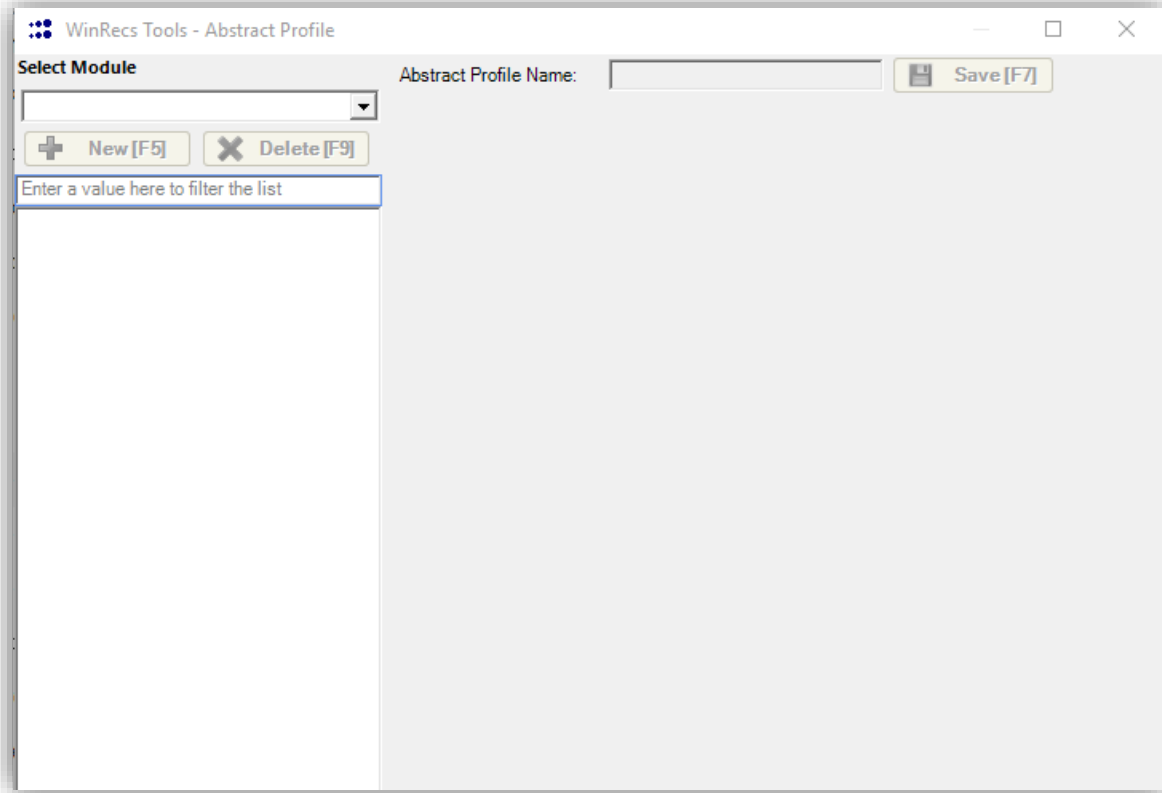


Figure 339 – Abstract Profile Screen

- Under **Select Module** – click on the drop-down menu and the list of modules will display, choose the appropriate module.

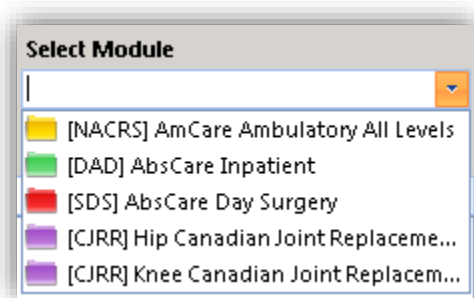


Figure 340 – Abstract Profile – Select Module Options

- The module fields will be displayed on the right-hand side.

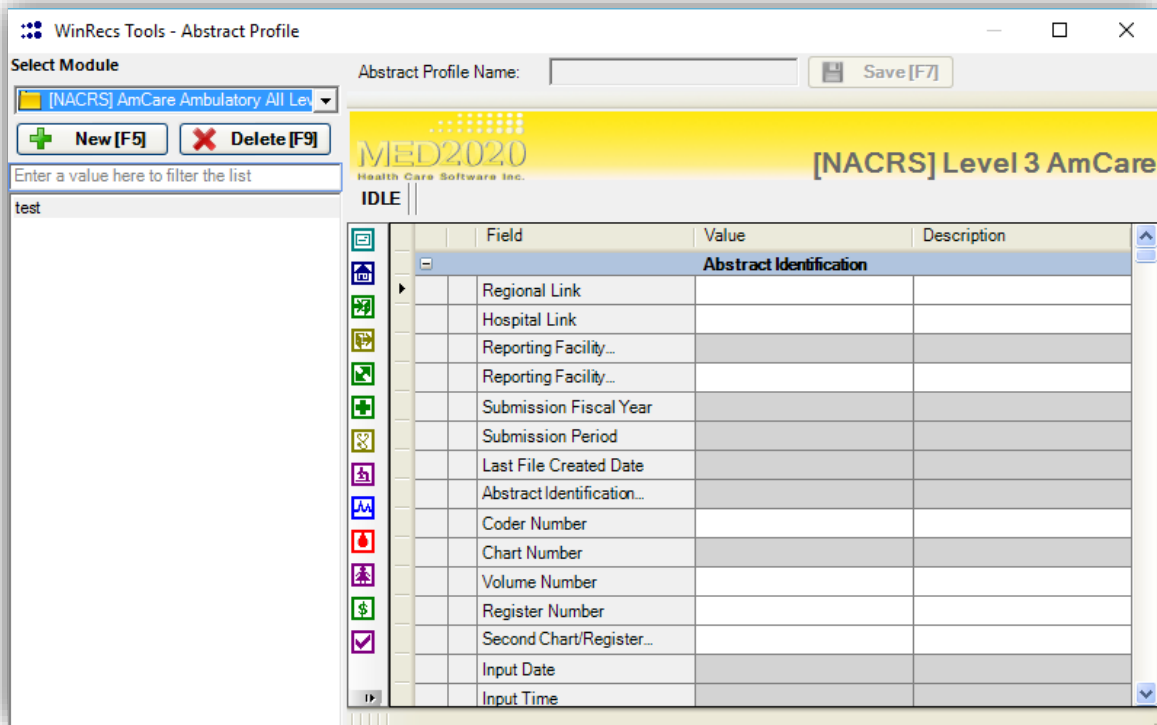
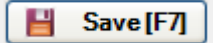


Figure 341 – Abstract Profile – Module Fields

- Click on New Profile
- Abstract Profile Name will open along the top, type in the *Profile Name*
- Enter the fields in the abstract that are the same for each profile such as dx, intervention. The user can put in as many or as little fields as required.
- Once completed press 

If Abstract Profile does not display in the Tool menu, this option will need to be set up in User Profile/Access Tools. Please contact your WinRecs System Administrator.

Edit an Abstract Profile

- Go to **Tools→Abstract Profile**

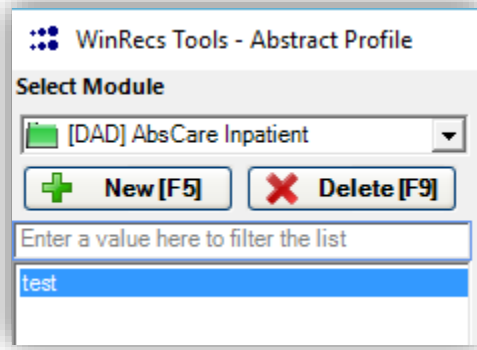


Figure 342 – Abstract Profile – Editing Abstract Module

Under **Select Module**, choose the module of the profile that needs editing

- If there are multiple profiles, filter in the "Enter a value here to filter the list"
- Double click on the profile that needs editing.
- The abstract profile will load on the right-hand side and make the necessary changes
- When done press **Save Profile**

Delete an Abstract Profile

- Under **Select Module**, choose the module of the profile that needs editing
- If there are multiple profiles, filter in the "Enter a value here to filter the list"
- Highlight on the profile
- Press 
- A message will pop up "**Are you sure you would like to delete this record?**" **Yes** will delete it and **No** will not delete.

Using an Abstract Profile

- Go to Abstracting and choose the module where the abstract profile resides
- Search for the abstract that the abstract profile will be copied to
- When the abstract is up, choose **Abstract Auto Coding/Copy Abstract Profile**

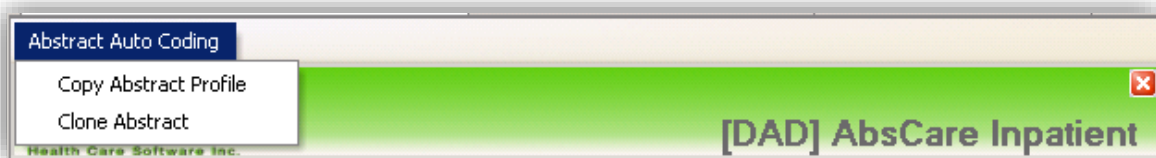


Figure 343 – Copy Abstract Profile

- Choose from the list of on the **Find Record Clone** screen and press **Select Record**

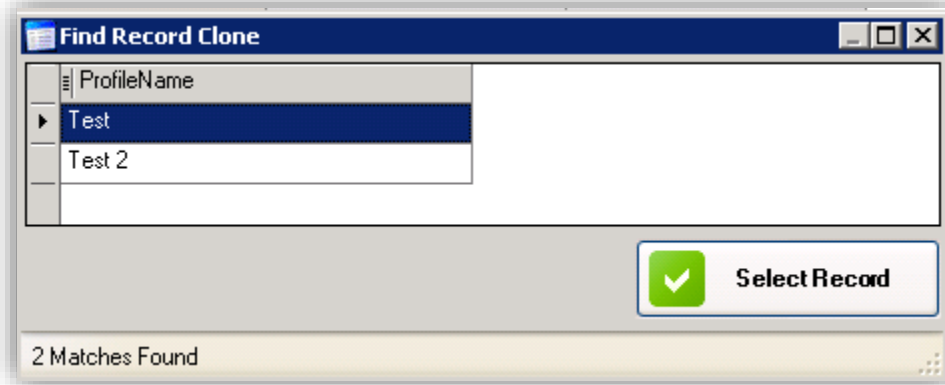


Figure 344 – Abstract Profile List

A message will pop up stating:

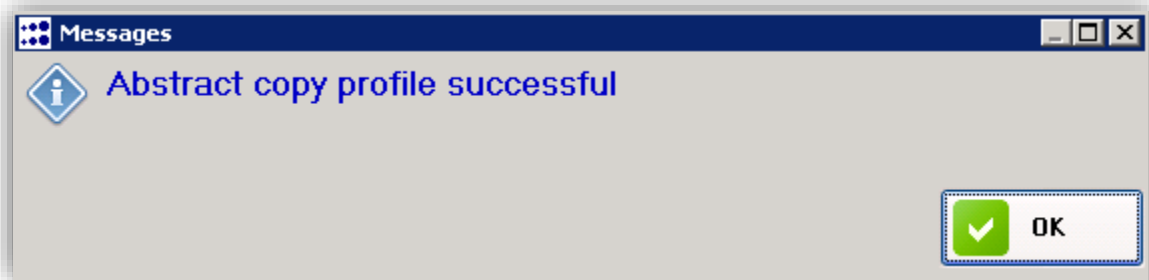


Figure 345 - Abstract Profile Successful Message

- The information in the abstract profile will populate the abstract.

If a field already has data in it, the Abstract Profile will not overwrite this.

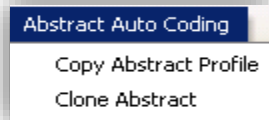
Clone Abstract

Clone Abstract accelerates the data entry process when working with a patient that has many of the same visits. For example, the information for a patient receiving chemotherapy or radiation treatment is the same for the majority of the abstract, using clone will speed up the data entry process.

Using Clone Feature

- If the abstract has been brought over by **HL7** or **Batch Interface** do a search on the abstract needed to be coded

- If the abstract is being created from New, enter the following fields:
 - Registration Visit Date/Time for **Amcare** and Discharge Date/Time for **Inpatient**
 - MIS Code for Amcare – Adding the MIS code will only bring up the similar MIS codes when looking for cloning. Leaving the MIS code blank will pull up all visits.
- Go to Abstract Auto Coding/Clone Abstract



- A list of Abstracts will display all the available visits, select the visit to be used for the cloned abstract.
- The following message will display

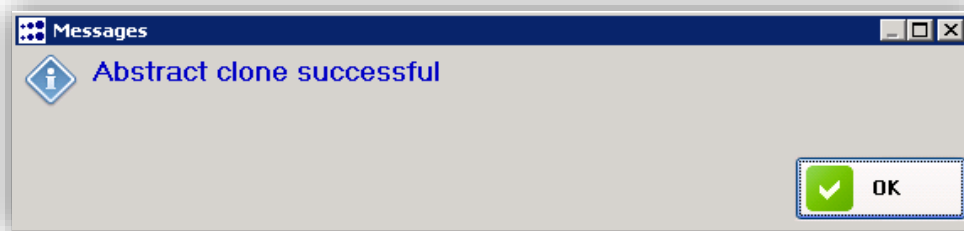


Figure 346 – Abstract Clone Successful Message

- WinRecs will copy the data from the selected abstract to the new abstracts, Date and Time Fields will be NOT be populated. All remainder of the fields will be populated.
- Review the record for any changes or updates that are needed

If a field already has data in it, the Clone Abstract will not overwrite this.

6.10 Abstract Queue

The Abstract Queue module is integrated with MED2020's chart abstracting software, WinRecs. The Abstract Queue:

1. Is available for AmCare (NACRS) and Inpatient (DAD) modules.
2. Lists visits that have not been accessed, that contain errors or that have been created by a user.
3. Provides assign capability by the Coder to themselves or by an Administrator to a Coder.

Opening the Abstract Queue

To access the Abstract Queue, the icon  is available in the icon bar in WinRecs. The Abstract Queue can be used to search for AmCare or Inpatient records.

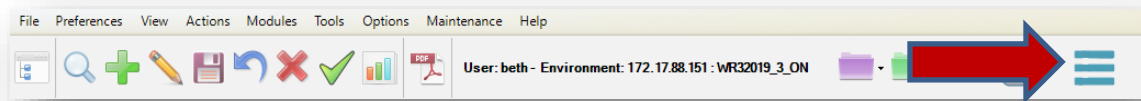


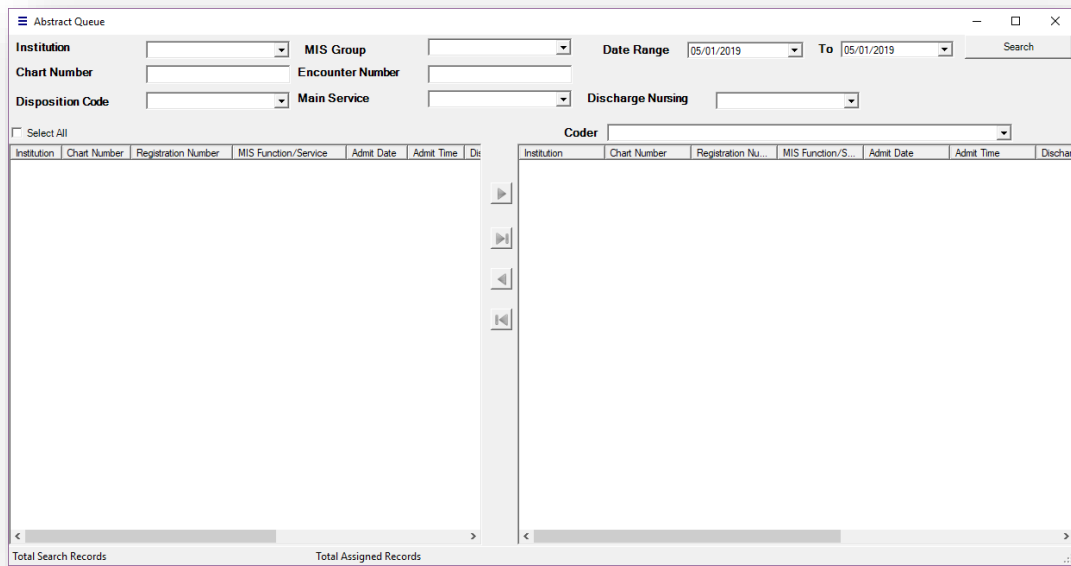
Figure 347 - Abstract Queue

To enable the Abstract Queue Icon, go to the Hospital Profile, System Wide Options and update field "Use Abstract Queue" to Yes. Save this value and then users must log out of WinRecs and back in for the change.

Use Abstract Queue



Click on the Abstract Queue icon to open the Abstract Queue window.



The screenshot shows the 'Abstract Queue' window. At the top, there are search filters: Institution, MIS Group, Date Range (05/01/2019 to 05/01/2019), Chart Number, Encounter Number, Disposition Code, Main Service, and Discharge Nursing. A 'Search' button is on the right. Below the filters is a 'Select All' checkbox and a 'Coder' dropdown. The main area is divided into two panes. The left pane has a table header with columns: Institution, Chart Number, Registration Number, MIS Function/Service, Admit Date, Admit Time, and Discharge. The right pane has a table header with columns: Institution, Chart Number, Registration Nu..., MIS Function/S..., Admit Date, Admit Time, and Dischar. Both panes are currently empty. At the bottom, there are two progress bars and labels: 'Total Search Records' and 'Total Assigned Records'.

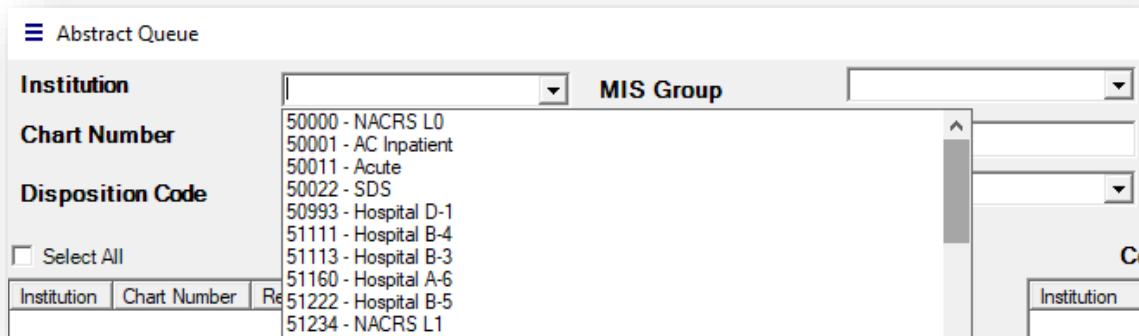
Figure 348 Abstract Queue Window

Searching for Records

The Abstract Queue allows filtering by Institution Number, MIS Group (Ambulatory Care Group), Date Range and Chart Number, Encounter Number, Disposition Code, Main Service, Discharge Nursing. Click the **Search** button once you've entered the parameters in the fields to run the search.

Search by Institution Number

All Institution Numbers are available to search on and are presented in a drop-down list. Use the mouse to highlight the desired Institution Number or the arrow keys to select it from the list.



The screenshot shows the 'Abstract Queue' search interface. The 'Institution' dropdown menu is open, displaying a list of institutions with their codes and names. The list includes:

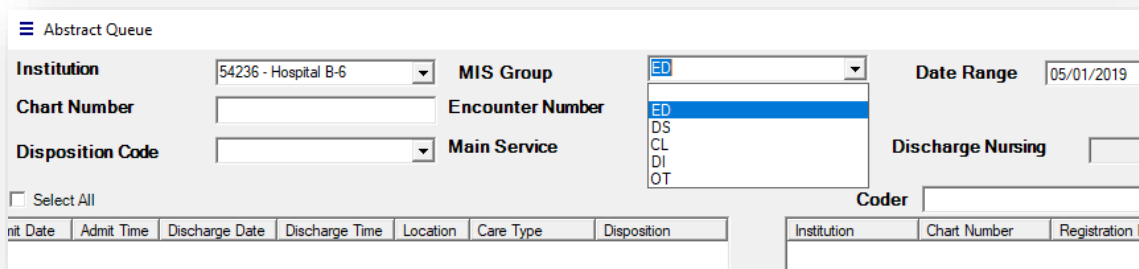
- 50000 - NACRS L0
- 50001 - AC Inpatient
- 50011 - Acute
- 50022 - SDS
- 50993 - Hospital D-1
- 51111 - Hospital B-4
- 51113 - Hospital B-3
- 51160 - Hospital A-6
- 51222 - Hospital B-5
- 51234 - NACRS L1

Other visible fields include 'MIS Group', 'Chart Number', 'Disposition Code', and a 'Select All' checkbox. A table at the bottom shows columns for 'Institution', 'Chart Number', and 'Re'.

Figure 349 Abstract Queue - Search by Institution Number

Search by MIS Group

AmCare Institution Numbers can be further filtered by selecting the Ambulatory Care Group – Emergency Department (ED), Day Surgery (DS), Clinic (CL), Ophthalmology (OT), or Diagnostic Imaging (DI).



The screenshot shows the 'Abstract Queue' search interface with the 'MIS Group' dropdown menu open. The list of ambulatory care groups includes:

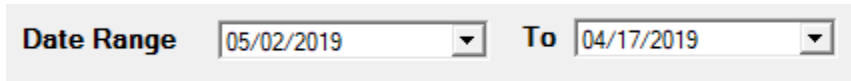
- ED
- DS
- CL
- DI
- OT

Other visible fields include 'Institution' (set to '54236 - Hospital B-6'), 'Date Range' (set to '05/01/2019'), 'Chart Number', 'Encounter Number', 'Main Service', 'Disposition Code', 'Discharge Nursing', and a 'Select All' checkbox. A table at the bottom shows columns for 'Institution', 'Chart Number', and 'Registration'.

Figure 350 Abstract Queue - Search by MIS Group

Search by Date Range

The date format is presented as YYYY-MM-DD. The first date field indicates the start date for the search; the second field the end date for the search.



Type a date directly into the Date Range fields or use the arrow  to open the calendar and select a date. Forward and back arrows shown on either side of the name of the month let you move forward and back through the calendar one month at a time.

Click on **'Today'** at the bottom of the calendar to quickly fill today's date into the Date Range fields.

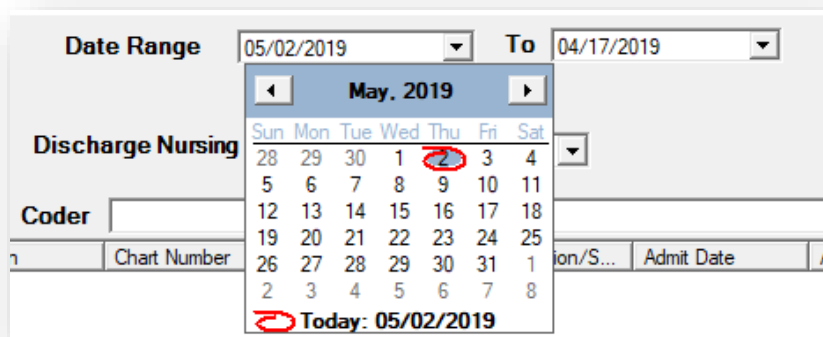
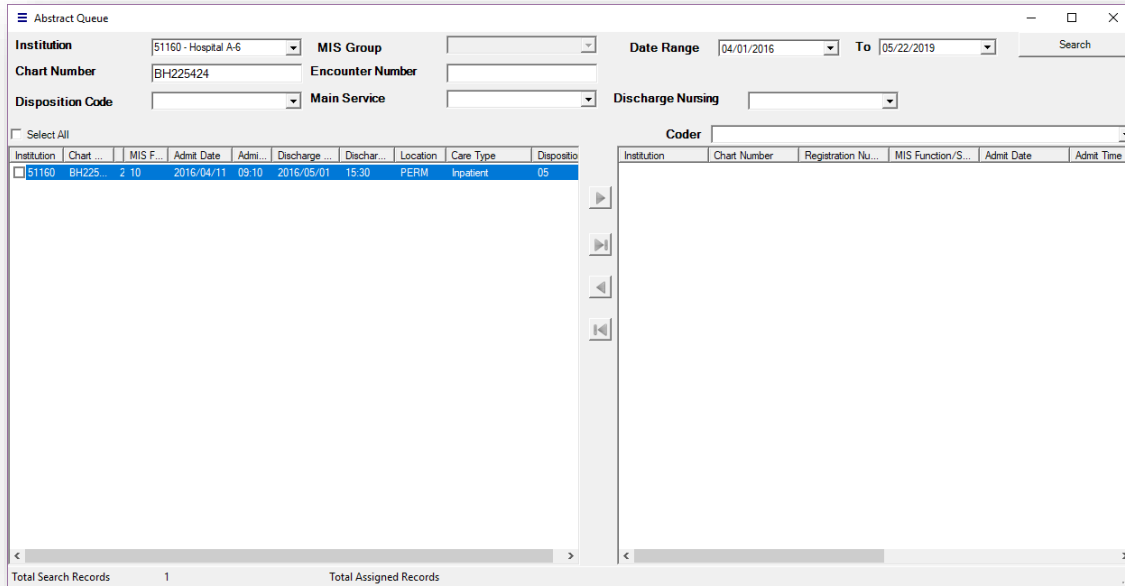


Figure 351 Abstract Queue - Search by Date Range

Search by Chart Number

Enter a chart number into the **Chart Number** field. Chart Numbers must be an exact match to locate the record; records with a partial match to the chart number will not be returned.



The screenshot shows the 'Abstract Queue' window with the following search criteria:

- Institution:** 51160 - Hospital A-6
- Chart Number:** BH225424
- Date Range:** 04/01/2016 To 05/22/2019

The search results table is as follows:

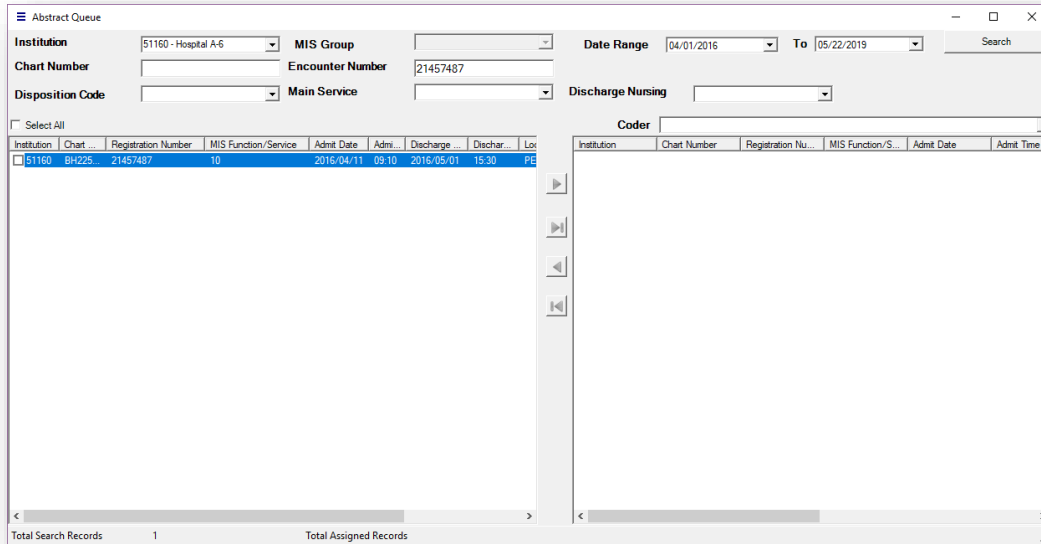
Institution	Chart ...	MIS F...	Admit Date	Admi...	Discharge...	Dischar...	Location	Care Type	Dispositio
51160	BH225	2 10	2016/04/11	09:10	2016/05/01	15:30	PERM	Inpatient	05

The status bar at the bottom indicates: Total Search Records: 1, Total Assigned Records: 0.

Figure 352 Abstract Queue - Search by Chart Number

Search by Encounter Number

Enter an encounter number into the **Encounter Number** field. Encounter Numbers must be an exact match to locate the record; records with a partial match to the chart number will not be returned.



The screenshot shows the 'Abstract Queue' window with the following search criteria: Institution: 51160 - Hospital A-6, MIS Group: (empty), Date Range: 04/01/2016 to 05/22/2019, Chart Number: (empty), Encounter Number: 21457487, Disposition Code: (empty), Main Service: (empty), Discharge Nursing: (empty), and a 'Select All' checkbox. The search results table on the left contains one record:

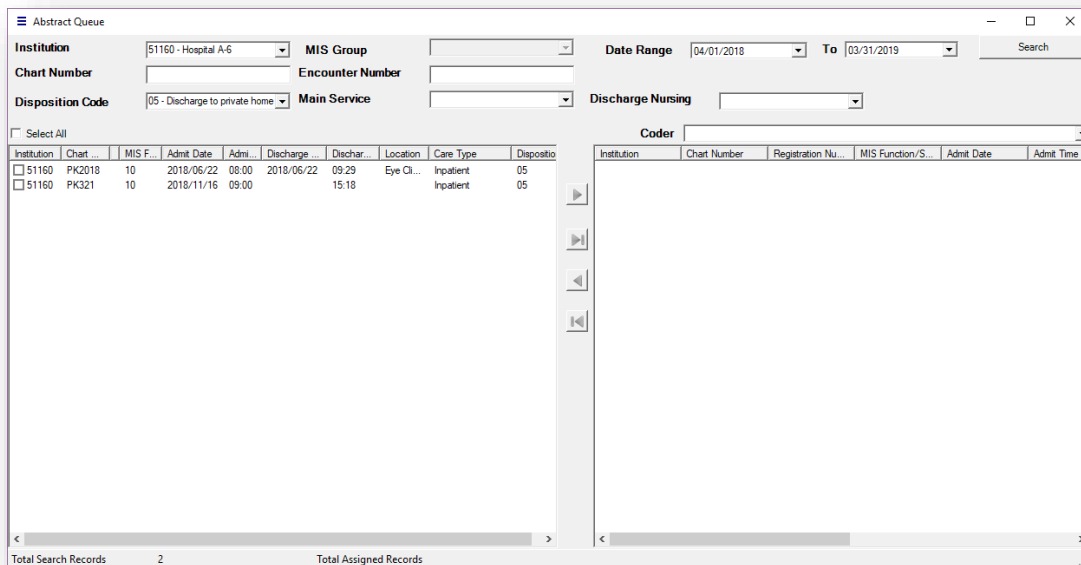
Institution	Chart	Registration Number	MIS Function/Service	Admit Date	Admi	Discharge	Dischar...	Lo
51160	BK225	21457487	10	2016/04/11	09:10	2016/05/01	15:30	PE

The status bar at the bottom indicates 'Total Search Records: 1' and 'Total Assigned Records: 1'.

Figure 353 Abstract Queue - Search by Encounter Number

Search by Disposition Code

Can search by Disposition and select from a drop-down list



The screenshot shows the 'Abstract Queue' window with the following search criteria: Institution: 51160 - Hospital A-6, MIS Group: (empty), Date Range: 04/01/2018 to 03/31/2019, Chart Number: (empty), Encounter Number: (empty), Disposition Code: 05 - Discharge to private home, Main Service: (empty), Discharge Nursing: (empty), and a 'Select All' checkbox. The search results table on the left contains two records:

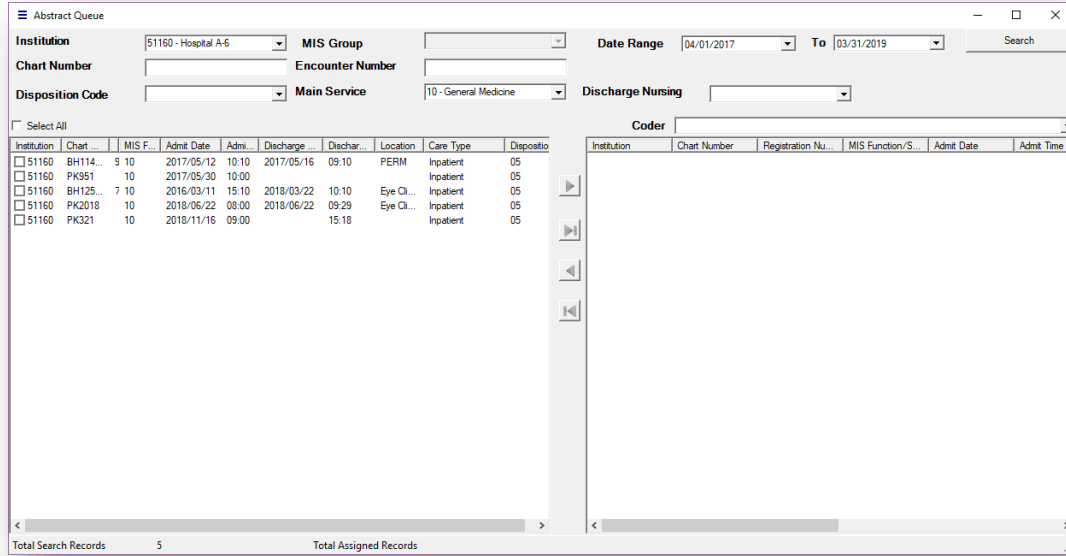
Institution	Chart	MIS F...	Admit Date	Admi	Discharge	Dischar...	Location	Care Type	Dispositio
51160	PK2018	10	2018/06/22	08:00	2018/06/22	09:29	Eye Cl...	Inpatient	05
51160	PK321	10	2018/11/16	09:00		15:18		Inpatient	05

The status bar at the bottom indicates 'Total Search Records: 2' and 'Total Assigned Records: 2'.

Figure 354 Abstract Queue - Search by Disposition Code

Search by Main Patient Service

Can search by Main Patient Service and select from a drop-down list



The screenshot shows the 'Abstract Queue' window with the following search filters:

- Institution:** 51160 - Hospital A-6
- MIS Group:** (empty)
- Date Range:** 04/01/2017 To 03/31/2019
- Chart Number:** (empty)
- Encounter Number:** (empty)
- Disposition Code:** (empty)
- Main Service:** 10 - General Medicine
- Discharge Nursing:** (empty)

The 'Select All' checkbox is unchecked. The table below shows the search results:

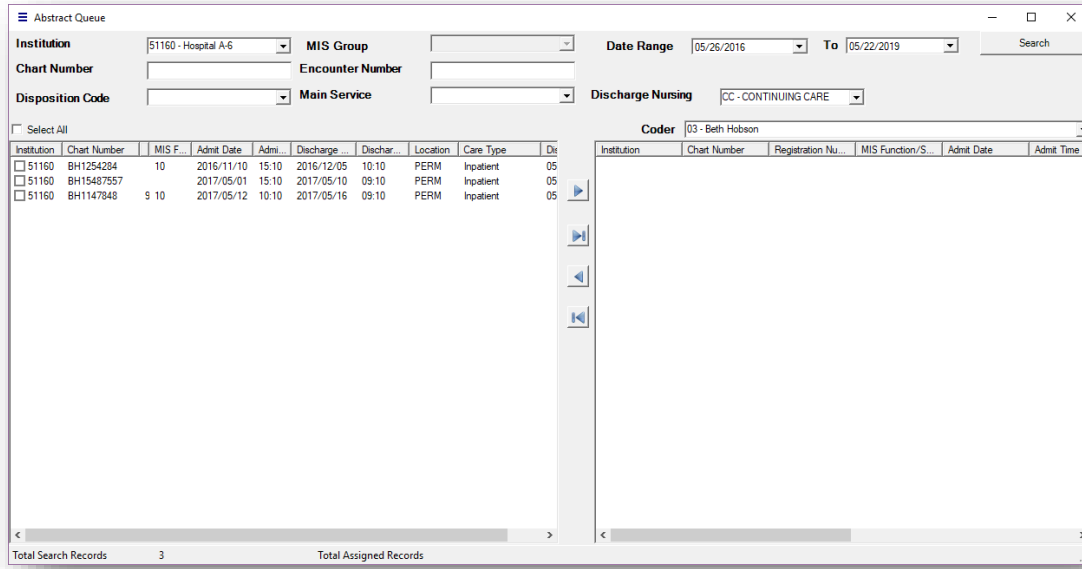
Institution	Chart	MIS F...	Admit Date	Admi...	Discharge...	Dischar...	Location	Care Type	Dispositio
☐ 51160	BH114	9 10	2017/05/12	10:10	2017/05/16	09:10	PERM	Inpatient	05
☐ 51160	PK951	10	2017/05/30	10:00				Inpatient	05
☐ 51160	BH125	7 10	2016/03/11	15:10	2018/03/22	10:10	Eye Cl...	Inpatient	05
☐ 51160	PK2018	10	2018/06/22	08:00	2018/06/22	09:29	Eye Cl...	Inpatient	05
☐ 51160	PK321	10	2018/11/16	09:00		15:18		Inpatient	05

The bottom status bar shows: Total Search Records: 5, Total Assigned Records: (empty).

Figure 355 Abstract Queue - Search by Patient Service

Search by Discharge Nursing Area

Can search by Discharge Nursing Area and select from a drop-down list



Abstract Queue

Institution: 51160 - Hospital A-6 **MIS Group:** **Date Range:** 05/26/2016 To 05/22/2019 **Search**

Chart Number: **Encounter Number:**

Disposition Code: **Main Service:** **Discharge Nursing:** CC - CONTINUING CARE

☐ Select All

Institution	Chart Number	MIS F...	Admit Date	Admi...	Discharge...	Dischar...	Location	Care Type	Di...
☐ 51160	BH1254284	10	2016/11/10	15:10	2016/12/05	10:10	PERM	Inpatient	05
☐ 51160	BH15487557		2017/05/01	15:10	2017/05/10	09:10	PERM	Inpatient	05
☐ 51160	BH1147848	9 10	2017/05/12	10:10	2017/05/16	09:10	PERM	Inpatient	05

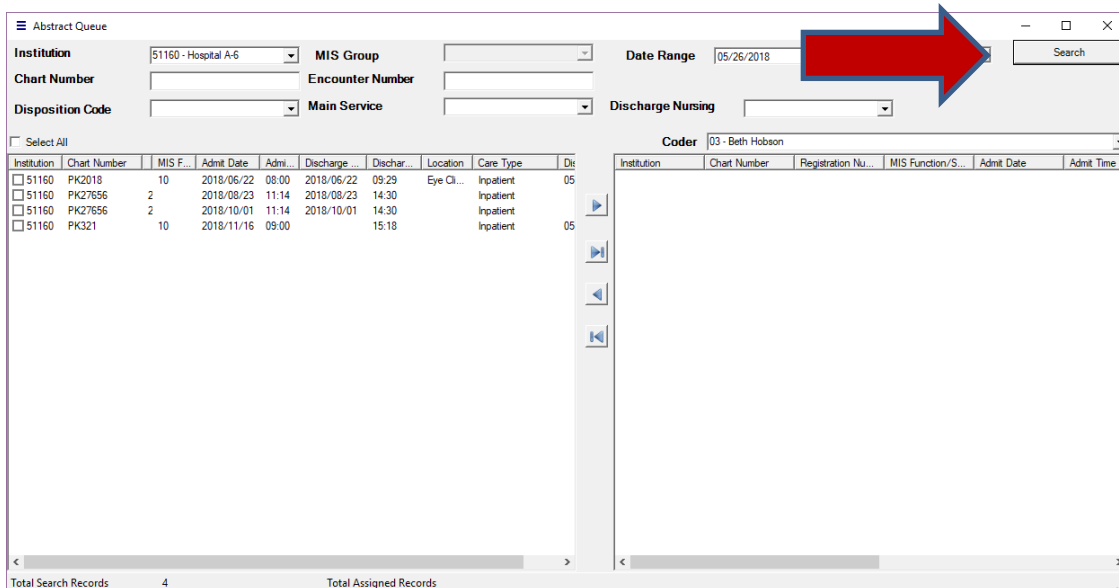
Coder: 03 - Beth Hobson

Institution	Chart Number	Registration Nu...	MIS Function/S...	Admit Date	Admit Time
-------------	--------------	--------------------	-------------------	------------	------------

Total Search Records: 3 Total Assigned Records:

Figure 356 Abstract Queue - Search by Discharge Nursing Area

Click the **Search** button to search based on the parameters entered in the search fields. The search parameters entered are saved from one session to the next.



Abstract Queue

Institution: 51160 - Hospital A-6 **MIS Group:** **Date Range:** 05/26/2018 **Search**

Chart Number: **Encounter Number:**

Disposition Code: **Main Service:** **Discharge Nursing:**

☐ Select All

Institution	Chart Number	MIS F...	Admit Date	Admi...	Discharge...	Dischar...	Location	Care Type	Di...
☐ 51160	PK2018	10	2018/06/22	08:00	2018/06/22	09:29	Eye Cl...	Inpatient	05
☐ 51160	PK27656	2	2018/08/23	11:14	2018/08/23	14:30		Inpatient	
☐ 51160	PK27656	2	2018/10/01	11:14	2018/10/01	14:30		Inpatient	
☐ 51160	PK321	10	2018/11/16	09:00		15:18		Inpatient	05

Coder: 03 - Beth Hobson

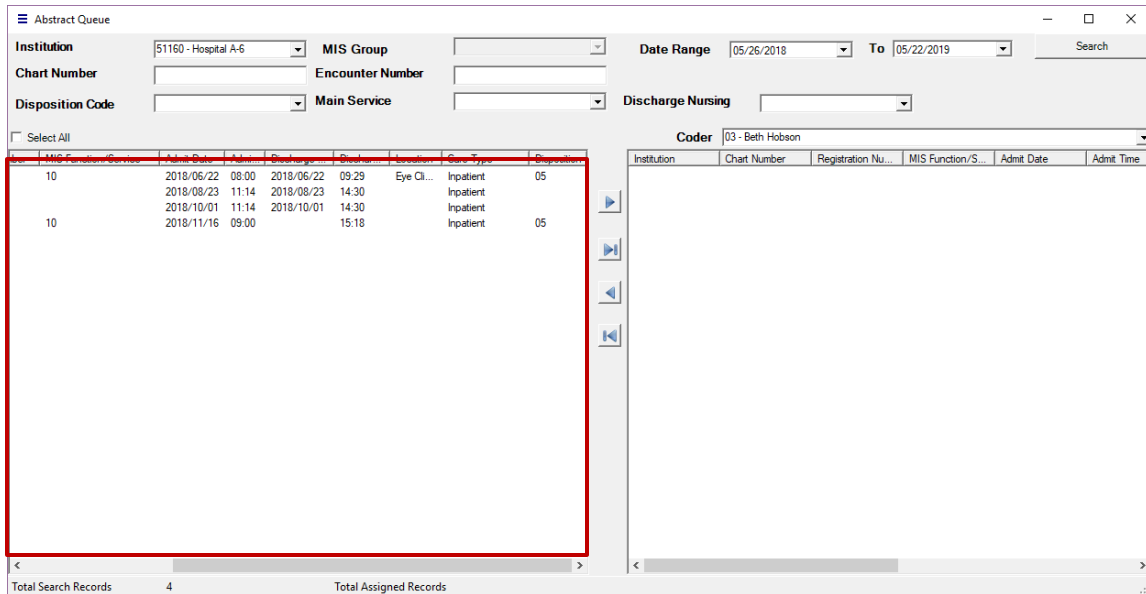
Institution	Chart Number	Registration Nu...	MIS Function/S...	Admit Date	Admit Time
-------------	--------------	--------------------	-------------------	------------	------------

Total Search Records: 4 Total Assigned Records:

Search Results

Charts returned by the Search will be shown in the search results panel on the left side of the Abstract Queue window. The search will return incomplete records for the date range entered. The following information is given for each result:

- Institution Number
- Chart Number
- Registration Number
- MIS Functional Centre/Service
- Admit Date
- Admit Time
- Discharge Date
- Discharge Time
- Location – Current Location for Chart Locator module
- Care Type
- Disposition Code



Institution	Chart Number	Registration Number	MIS Function/S...	Admit Date	Admit Time	Discharge Date	Discharge Time	Location	Care Type	Disposition Code
10				2018/06/22	08:00	2018/06/22	09:29	Eye Cl...	Inpatient	05
				2018/08/23	11:14	2018/08/23	14:30		Inpatient	
				2018/10/01	11:14	2018/10/01	14:30		Inpatient	
10				2018/11/16	09:00		15:18		Inpatient	05

Figure 357 Abstract Queue - Search Results

Assigning Records to Coders

Charts can be assigned by a Coder to themselves or can be assigned to other Coders by an Administrator. Users must have proper permissions for to assign visits.

Selecting a Coder

If a User is **not** an Administrator, the Coder field will allow the user to select only their own profile (User number) and name from the drop-down list in order to assign records to themselves for completion.

If a User is an Administrator, all Users will be shown in the Coder list. The Administrator can then click the dropdown arrow next to the Coder list and use the mouse to select a Coder to assign records. The arrow keys can also be used to move through the Coder list.

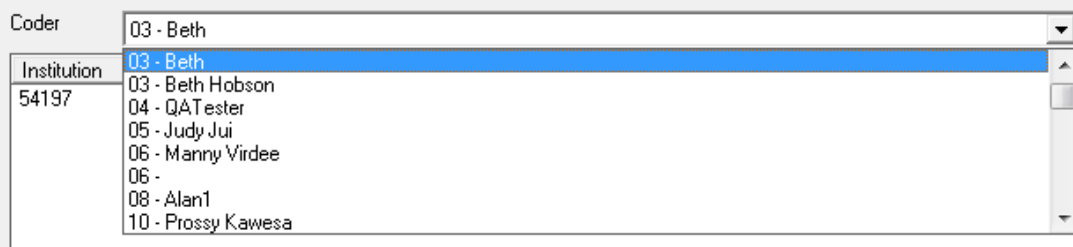


Figure 358 Abstract Queue - Selecting a coder

A coder must be selected from the Coder list before records can be assigned to them. This also applies for users who are not Administrators; a user must select their own user number and name from the Coder list before they can begin assigning records to themselves.

When a user is selected from the Coder list, the Abstract Queue window will show any incomplete records that are currently assigned to that Coder.

Assigning a Record to a Coder

To assign a record to a Coder, select the record or records returned by the Search from the left side of the



Abstract Queue window and use the arrow to move the selected record(s) under the Coder name on the right side of the Abstract Queue window.



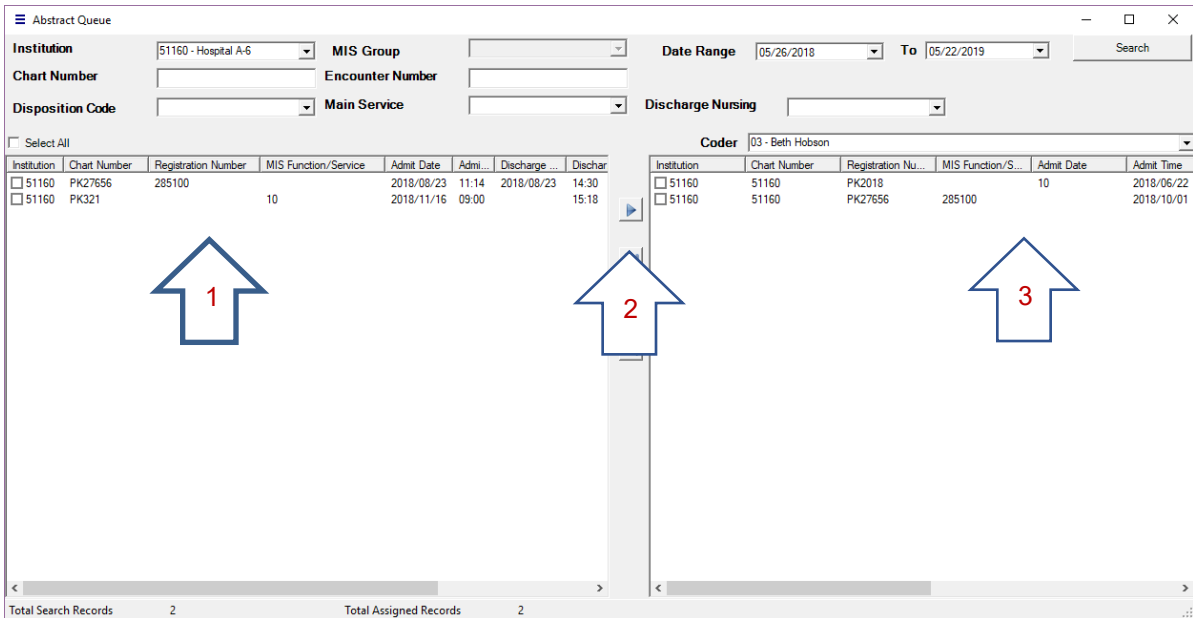
The arrow can be used to assign all records showing in the search results to the selected Coder at once.

Once abstracts are assigned to a Coder, the information for that record no longer appears in the left side of the Abstract Queue window and now only appears on the right under the Coder's name. The Abstract Queue will automatically save this information to the database.

Any abstracts that have been assigned to a Coder will remain assigned to them until the abstract is complete (i.e. verified and saved).

Selecting a Coder from the Coder list will show any previously assigned records that are not complete.

Steps to Assign a Record to a Coder:



The screenshot shows the 'Abstract Queue' window. The left panel contains search filters and a table of search results. The right panel shows a list of records assigned to the selected coder (03 - Beth Hobson). Three blue arrows with red numbers 1, 2, and 3 point to the search results table, the arrow buttons between the panels, and the coder's assigned list, respectively.

Institution	Chart Number	Registration Number	MIS Function/Service	Admit Date	Admi...	Discharge ...	Dischar
51160	PK27656	285100		2018/08/23	11:14	2018/08/23	14:30
51160	PK321		10	2018/11/16	09:00		15:18

Institution	Chart Number	Registration Nu...	MIS Function/S...	Admit Date	Admit Time
51160	51160	PK2018	10	2018/06/22	
51160	51160	PK27656	285100	2018/10/01	

1	Select the record from the search results in the left panel of the Abstract Queue.
2	Click the single arrow  to move only the selected record(s) or the double arrow  to move all records over to the Coder's assigned list.
3	The selected records now appear on the right panel under the selected Coder's name.

In the event more than one User tries to assign the same abstract to themselves at the same time, the second user who is attempting to assign the record will be presented with a message that the selected record will be removed from their list.

Abstracting Queue Conflict							
Some Abstracts have been assigned to other coder. They will be removed from this list.							
Institution	Chart Num...	MIS Code	Admission ...	Admission ...	Discharge...	Discharge...	Assigned Coder
51160	PK413204		2014-04-08	13:16	2014-04-08	13:17	03 - Beth Hobson
51160	PK413204		2014-04-16	10:13	2014-04-16	10:13	03 - Beth Hobson

Opening an Assigned Record

Records that have been assigned to a Coder can be quickly opened in the appropriate module by double-clicking on the record in the assigned area of the Abstract Queue window. The Coder can now begin completing the record.

Once the abstract is complete (i.e. verified and saved), it will be removed it from the Coder's assigned list in the Abstract Queue window.

Removing an Assigned Record

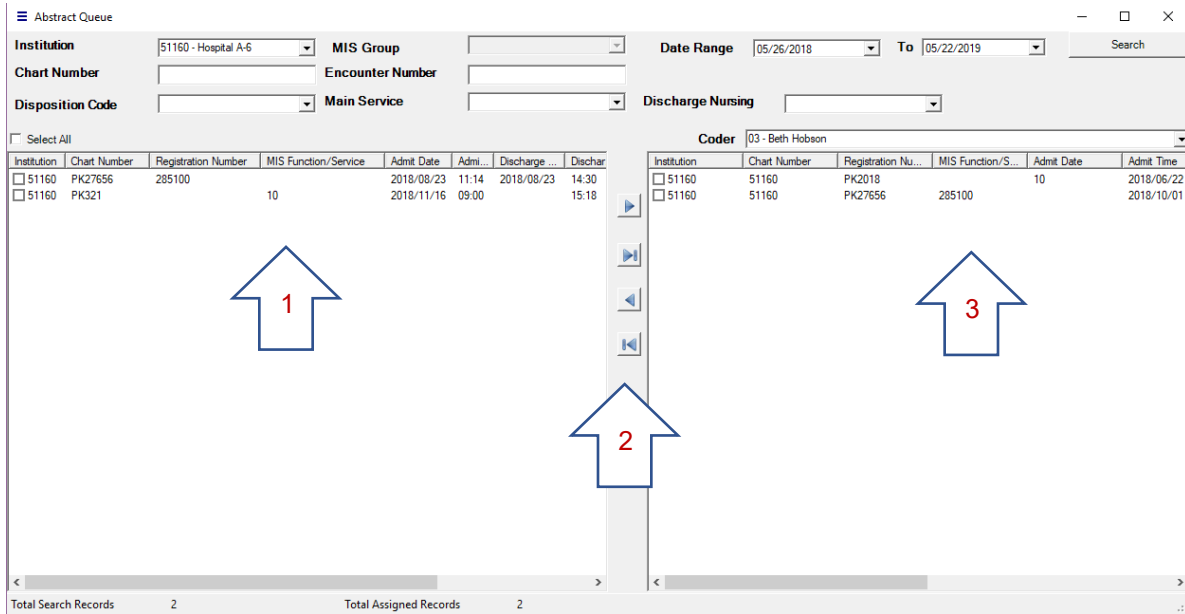
Similar to the process for assigning records, a Coder can remove an incomplete record from their

assigned list in the Abstract Queue window by using the  arrow. All records assigned to a

coder can be removed using the  arrow.

Records that are removed from a Coder's assigned list on the right panel are returned to the left search results panel.

Steps to Remove an Assigned Record from a Coder:



Abstract Queue

Institution: 51160 - Hospital A-6 MIS Group: Date Range: 05/26/2018 To: 05/22/2019 Search

Chart Number: Encounter Number:

Disposition Code: Main Service: Discharge Nursing:

Select All

Institution	Chart Number	Registration Number	MIS Function/Service	Admit Date	Admi...	Discharge...	Dischar
☐ 51160	PK27656	285100	10	2018/08/23 11:14	2018/08/23 14:30		
☐ 51160	PK321			2018/11/16 09:00		15:18	

Coder: 03 - Beth Hobson

Institution	Chart Number	Registration Nu...	MIS Function/S...	Admit Date	Admit Time
☐ 51160	51160	PK2018	285100	10	2018/06/22
☐ 51160	51160	PK27656			2018/10/01

Total Search Records: 2 Total Assigned Records: 2

1	Select the record to be removed from the Coder's assigned record list in the right panel of the Abstract Queue.
2	Click the single arrow  to remove only the selected record(s) or the double arrow  to move all records back to the search panel.
3	The records are returned to the left panel.

Enable Abstract Queue

An Admin user can define whether a Coder will be able to choose any abstract on the queue or only the next available by check/uncheck in the field 'Select abstracts in Abstract Queue' In their User Profile. A Coder will be allowed to select abstracts from the queue if the field is checked. If the user's permission is unchecked, the coder can only select next available abstracts in the Queue. All other abstracts will be disabled.

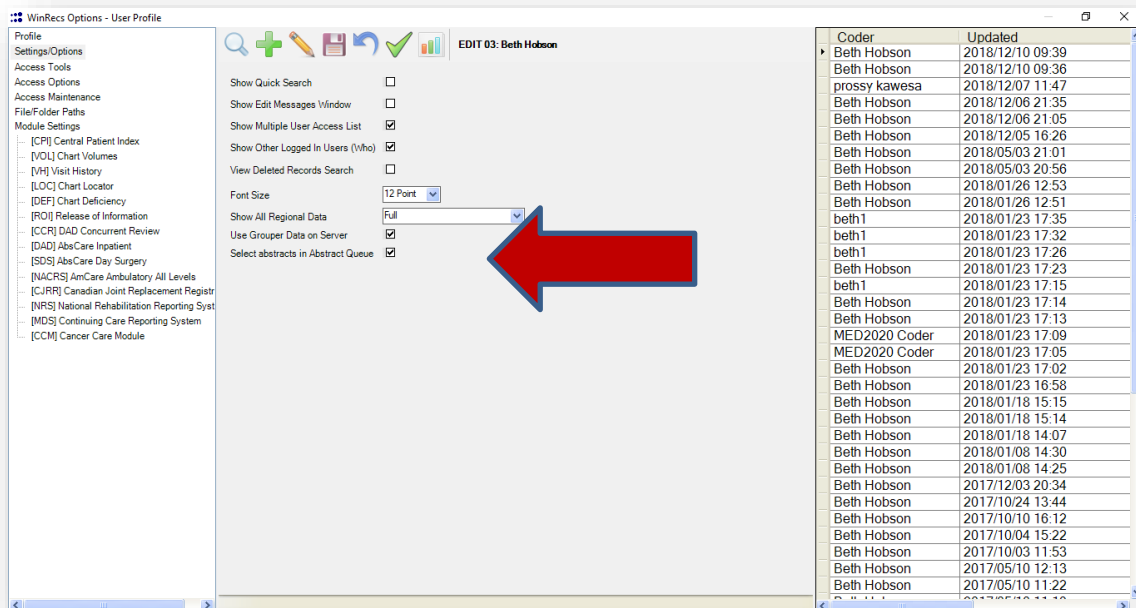


Figure 359 Abstract Queue - User Profile

Assigning Next Available Abstract

Scenario 1: *Is Administrator* = Checked and *Can Select abstracts in Abstract Queue* = Checked
Allows the User to see ALL Coder and assign abstracts from Queue to Coder task list.

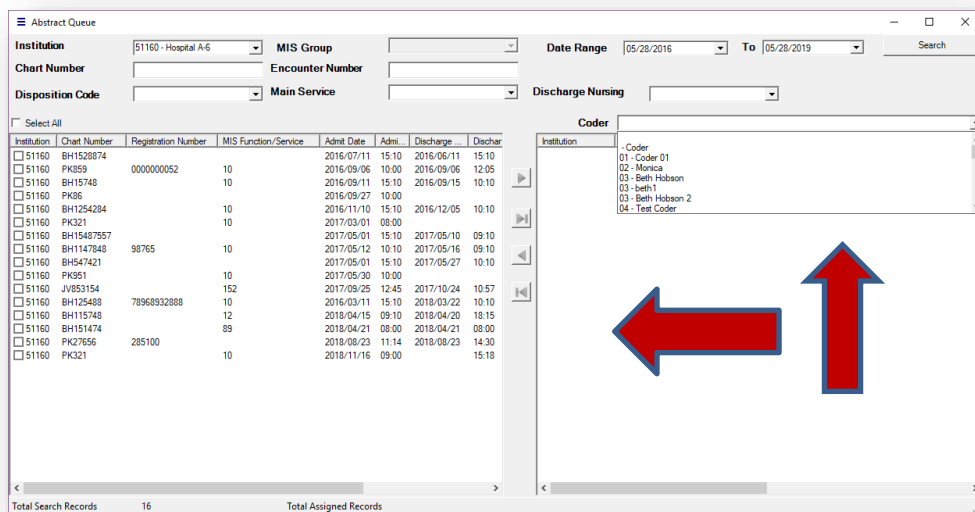
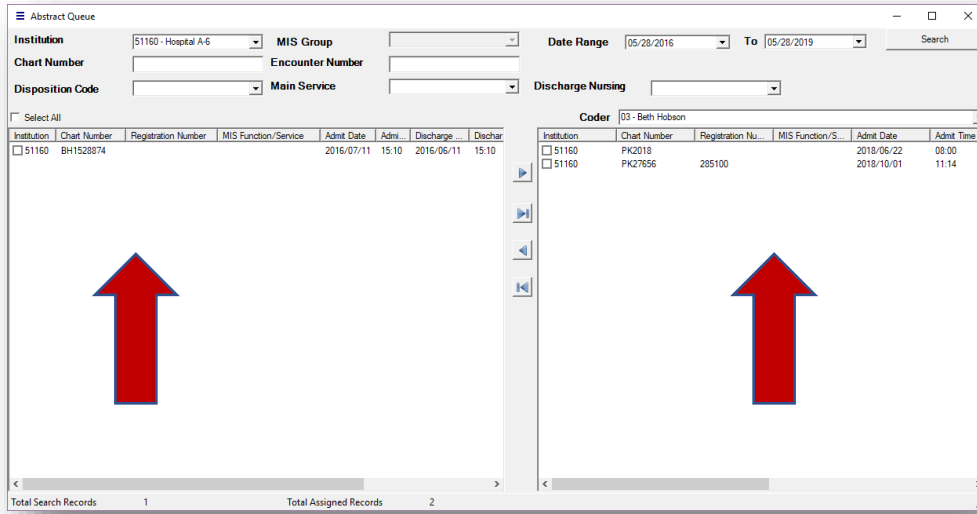


Figure 360 Abstract Queue - Assigning Next Available Abstract Scenario 1

Scenario 2: Is Administrator = Unchecked and Can Select abstracts in Abstract Queue = Unchecked

User can only see the next available abstract in the Queue and transfer abstract to their task list. All other abstracts in the Queue will not display.



The screenshot shows the 'Abstract Queue' window with the following search filters:

- Institution: 51160 - Hospital A-6
- MIS Group: (empty)
- Date Range: 05/28/2016 To 05/28/2019
- Chart Number: (empty)
- Encounter Number: (empty)
- Disposition Code: (empty)
- Main Service: (empty)
- Discharge Nursing: (empty)

Below the filters are two tables. The left table is titled 'Select All' and the right table is titled 'Coder: 03 - Beth Hobson'.

Institution	Chart Number	Registration Number	MIS Function/Service	Admit Date	Admit Time	Discharge Date	Discharge Time
51160	BH1528874			2016/07/11	15:10	2016/05/11	15:10

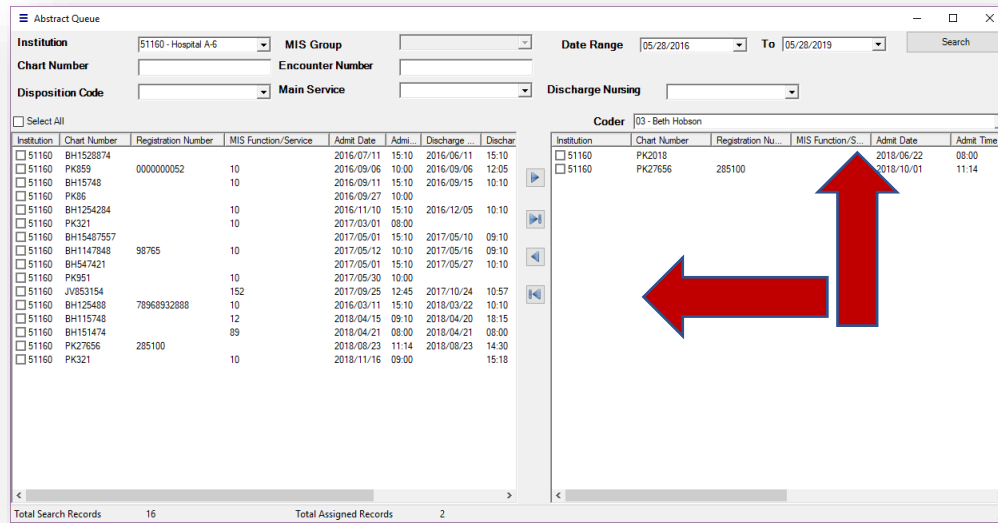
Institution	Chart Number	Registration Number	MIS Function/Service	Admit Date	Admit Time
51160	PK2018			2018/05/22	08:00
51160	PK27556	285100		2018/10/01	11:14

At the bottom of the window, the status bar shows: Total Search Records: 1, Total Assigned Records: 2.

Figure 361 Abstract Queue - Assigning Next Available Abstract Scenario 2

Scenario 3: *Is Administrator = Unchecked and Can Select abstracts in Abstract Queue? = Checked*

User can only select abstract for their own coder number.



Abstract Queue

Institution: [51160 - Hospital A-6] MIS Group: [] Date Range: [05/28/2016] To: [05/28/2019] Search

Chart Number: [] Encounter Number: []

Disposition Code: [] Main Service: [] Discharge Nursing: []

☐ Select All

Institution	Chart Number	Registration Number	MIS Function/Service	Admit Date	Admi.	Discharge	Dischar
☐ 51160	BH1528874			2016/07/11	15:10	2016/06/11	15:10
☐ 51160	PK359	0000000052	10	2016/09/06	10:00	2016/09/06	12:05
☐ 51160	BH15748		10	2016/09/11	15:10	2016/09/15	10:10
☐ 51160	PK26			2016/09/27	10:00		
☐ 51160	BH1254284		10	2016/11/10	15:10	2016/12/05	10:10
☐ 51160	PK321		10	2017/03/01	08:00		
☐ 51160	BH15487557			2017/05/01	15:10	2017/05/10	09:10
☐ 51160	BH1147848	98765	10	2017/05/12	10:10	2017/05/16	09:10
☐ 51160	BH547421			2017/05/01	15:10	2017/05/27	10:10
☐ 51160	PK351		10	2017/05/30	10:00		
☐ 51160	JV353154		152	2017/09/25	12:45	2017/10/24	10:57
☐ 51160	BH125488	78968932888	10	2016/03/11	15:10	2018/03/22	10:10
☐ 51160	BH115748		12	2018/04/15	09:10	2018/04/20	18:15
☐ 51160	BH151474		89	2018/04/21	08:00	2018/04/21	08:00
☐ 51160	PK27656	285100		2018/08/23	11:14	2018/08/23	14:30
☐ 51160	PK321		10	2018/11/16	09:00		15:18

Total Search Records: 16 Total Assigned Records: 2

Coder [03 - Beth Hobson]

Institution	Chart Number	Registration Nu...	MIS Function/S...	Admit Date	Admit Time
☐ 51160	PK2018			2018/06/22	08:00
☐ 51160	PK27656	285100		2018/10/01	11:14

Figure 362 Abstract Queue - Assigning Next Available Abstract Scenario 3

6.11 CJRR – Hips & Knees

The **Canadian Joint Replacement Registry (CJRR)** module is a data collection tool within WinRecs suite of modules that allows for the specific collection of joint replacement data as set out by the Canadian Institute for Health Information for their CJRR Registry. This registry focuses exclusively on gathering data related to knee and hip interventions as captured by the following CCI codes:

- 1.VA.53.^ – Implantation of internal device, hip joint
- 1.SQ.53.^ – Implantation of internal device, pelvis
- 1.VG.53.^ - Implantation of internal device, knee joint
- 1.VP.53.^ - Implantation of internal device, patella

Each facility must supply CIHI with a list of their orthopedic surgeons prior to using CJRR. CIHI assigns a unique CJRR Surgeon ID, that identifies the surgeon regardless of where the surgery is done. This number is placed in [Provider Maintenance](#).

6.11.1 CJRR Legacy

CJRR records can be created in one of three ways:

1. Creating manually through the CJRR modules
2. Creating through a DAD or NACRS abstract
3. Creating through a Batch interface or HL7 from an OR system

Creating Manually Through the CJRR Modules

- Go to **WinRecs Module Menu** → **[CJRR] Hip Canadian Joint Replacement** or **[CJRR] Knee Canadian Joint Replacement**
 - Or –
- **Modules** → **Abstracting** → **[CJRR] Hip Canadian Joint Replacement** or **[CJRR] Knee Canadian Joint Replacement**
- Press **[F5]** to create a new record or **[F4]** for an already existing CJRR record
- The abstract will come up with any common data elements from the **CPI MODULE**
- Move through the abstract and fill any fields that are required.
- Error messages will display for mandatory elements in the message list box.

Creating Through a DAD or NACRS Abstract

1. Complete a **DAD/SDS/NACRS** abstract
2. The following Criteria must be met in order for a **CJRR** form to be triggered:
 - Intervention code is one of the following:
 - 1.VA.53.^ – Implantation of internal device, hip joint

- 1.SQ.53.^ - Implantation of internal device, pelvis
- 1.VG.53.^ - Implantation of internal device, knee joint
- 1.VP.53.^ - Implantation of internal device, patella
- o Includes Knee and Hip replacements that are:
 - Emergency or elective
 - Total or partial
 - Primary or revision
- o Intervention date must be greater than or equal to April 1, 2012
- o Intervention Attribute Status does not equal "A" – Abandon after onset
- o If the above criteria are met the following message will pop up when you save the record:

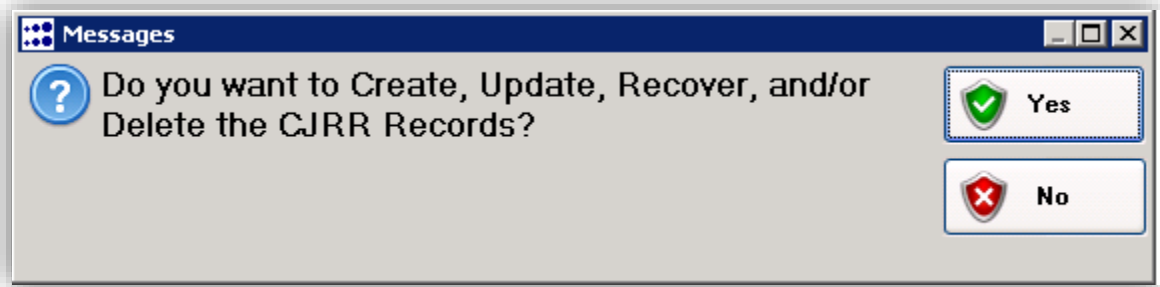
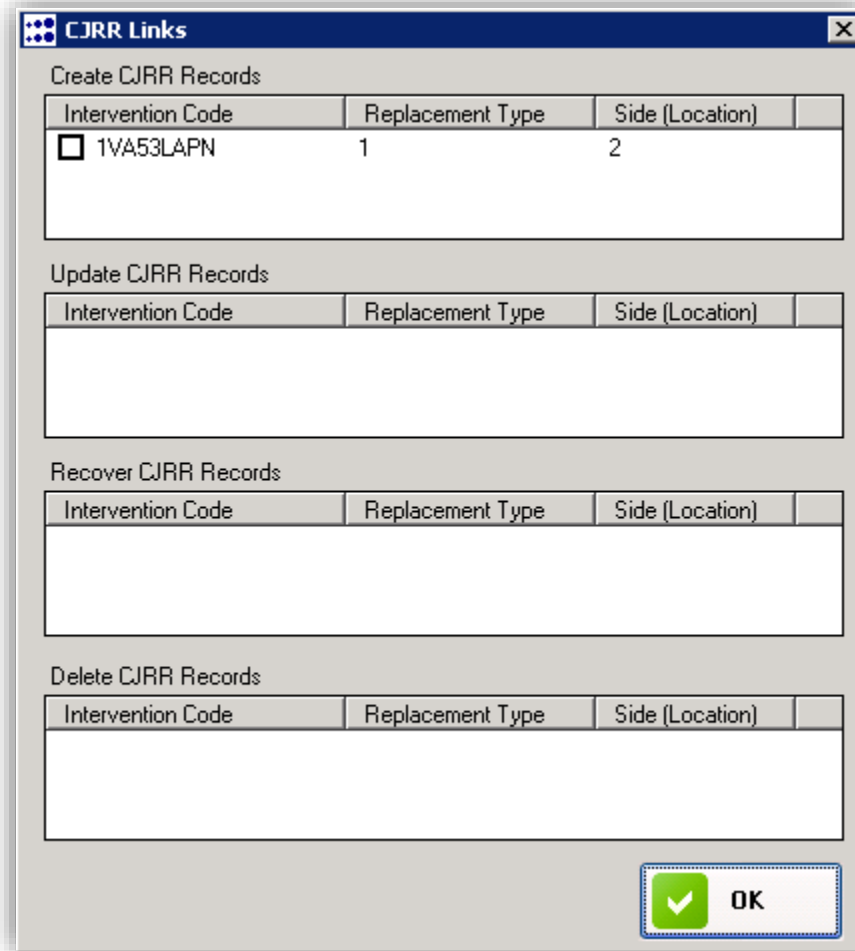


Figure 363 – CJRR Record Message

- o Clicking 'No' will take you back to the abstract, clicking 'Yes' will take you to the CJRR Links Screen:



Intervention Code	Replacement Type	Side (Location)
☒ 1VA53LAPN	1	2

Intervention Code	Replacement Type	Side (Location)
-------------------	------------------	-----------------

Intervention Code	Replacement Type	Side (Location)
-------------------	------------------	-----------------

Intervention Code	Replacement Type	Side (Location)
-------------------	------------------	-----------------

OK

Figure 364 – CJRR Links

- **Create** – this section is used to create a new **CJRR** record. The box must be checked in order for the **CJRR** form to open up (depending on the intervention code). If the box is not checked the record will be flagged as incomplete and placed on the Incomplete Report. Press OK to confirm the response.
- **Update** – this section is used to update an existing **CJRR** record and there has been a change on the **DAD/SDS/NACRS** record. The box must be checked in order for the **CJRR** form to open up. If the box is not checked the record will be flagged as incomplete and placed on the Incomplete Report. Press OK to confirm the response.
- **Recover** – this section is used when you have deleted a **CJRR** record and want to recover it from the purge file. This is useful when the **CJRR** record has been accidentally deleted and need to recover it. The box must be checked in order to recover it.
- **Delete** – this section is used for deleting the records and moving them to the purge file
- Click **OK** button with nothing checked will take you back to abstract. If the file is checked in the **Create** and **Update** mode, the appropriate **CJRR** record will display.

- The information from the abstract will populate the appropriate fields and the user will need to populate the OR fields as required. The record can be saved with mandatory fields missing and the errors will be displayed in the Message List box.

Link CJRR Record to an Abstract

- The abstract (DAD or NACRS) to be linked to the CJRR record should already be created and the CJRR record should also already exist with the same criteria as listed:
 - Chart Number
 - Institution Number
 - Admissions Date
 - Admissions Time
- Open the CJRR Record.
- From the CJRR Menu options select Action - Link CJRR Record to Abstract.

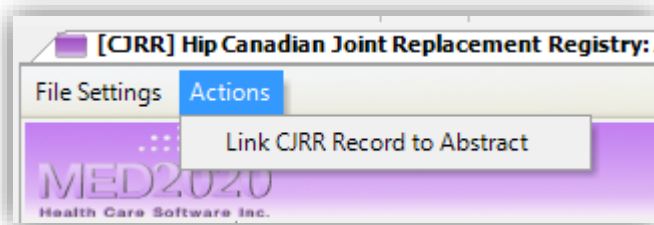


Figure 365 - CJRR Actions Menu

- A window will open with the list of valid abstracts to link to the CJRR Record. Choose the abstract that is to be linked to the CJRR Records and Click OK.

CJRR Links

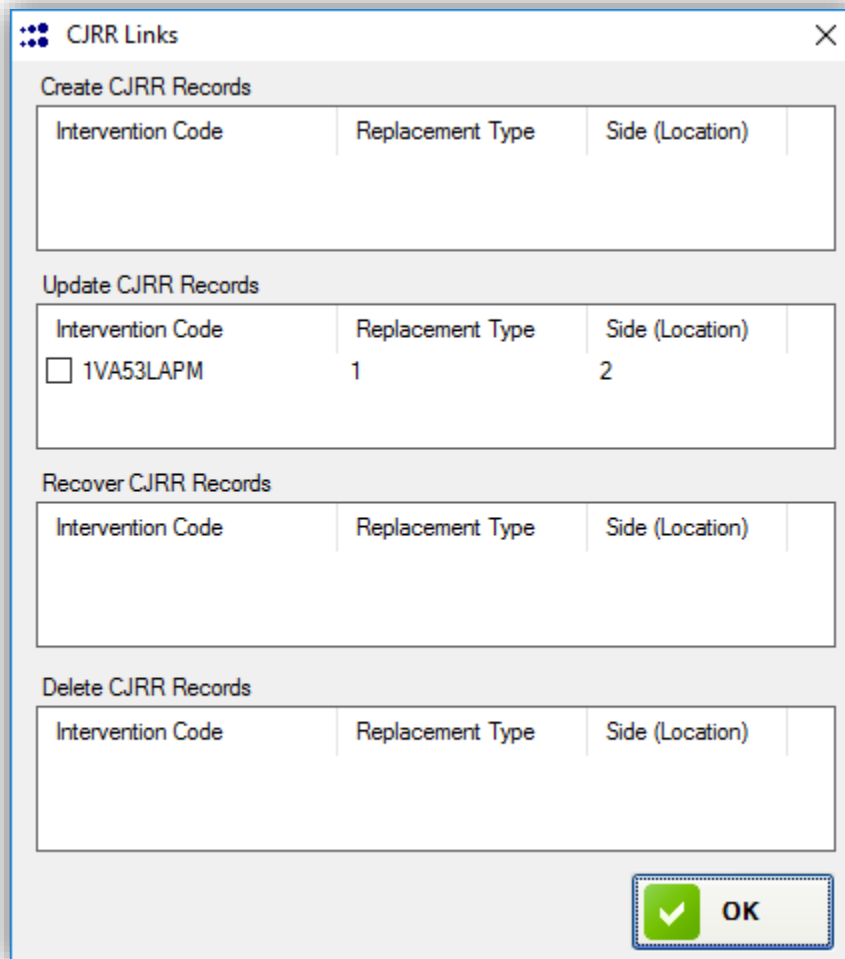
Abstract Visits

Hosp Link	Inst No	Admit Date	Disch Date
☒	51113	2016/04/04	2016/05/05
☐	59999		
☐	50011	2016/07/07	2016/07/08
☐	56987	2016/05/05	2016/06/10
☐	54236	2016/04/04	2016/04/06
☐	90002	2015/06/06	2015/06/07
☐	54236	2014/05/01	2014/05/01
☐	51111	2014/04/01	2014/04/01

OK

Figure 366 - CJRR List of Abstracts

- User is then presented with the following screen to update the CJRR Record. Select the intervention code and click ok. The Abstract and CJRR Records are now linked.



Create CJRR Records		
Intervention Code	Replacement Type	Side (Location)

Update CJRR Records		
Intervention Code	Replacement Type	Side (Location)
☐ 1VA53LAPM	1	2

Recover CJRR Records		
Intervention Code	Replacement Type	Side (Location)

Delete CJRR Records		
Intervention Code	Replacement Type	Side (Location)

Figure 367 - CJRR Link window

Creating Through a Batch Interface or HL7 from an OR system

- Batch Interface (BI)

MED2020 provides a standardized file layout of a flat file that must be followed. The clients Operating Room (OR) system will generate a file based on the specifications provided by MED2020 and will load the file into a centralized location accessible to the WinRecs application. This will be loaded into WinRecs via the Tools/Batch Interface.

- HL7

The ADT HL7 feed will send across demographic only information as well as the record type entered into ZZ-Segment. MED2020 will work with the organization to determine which ZZ-Segment will need to be populated in order for the record type to be populated correctly. MED2020 will provide the record type values in an Excel Spreadsheet.

6.11.2 CJRR DAD (Discharge Abstract Database)

Enable CJRR Multiform

To enable the CJRR Multiform got to:

- **Options → Institution Profile → Settings**



- Press  or **[F4]** to find the facility the CJRR multiform is to be added and double click on the facility



- Press  or **[F6]** to edit
- Click on the box next to 'Use CJRR Worksheet' and ensure there is a checkmark

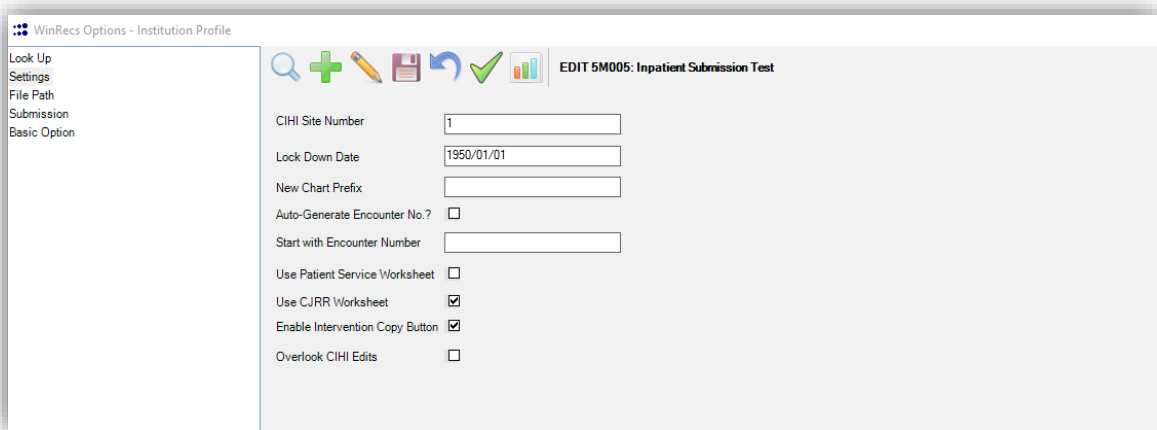


Figure 368 – Use CJRR Worksheet

- **Options → Control File**



- Press  or **[F4]** to choose the user or user profile, double click on the user
- Click on **[DAD] AbsCare Inpatient**



- Click on  - Group Headers
- On the left-hand side find and click on the header **Canadian Joint Replacement Registry (CJRR)**
- Ensure the Enabled and Visible fields have a checkmark beside them



- If desired, to move the header/multi-form to a different area of the abstract press the  and place on top or below the desired header. It is suggested to place the CJRR multiform after the **Intervention Data** header.

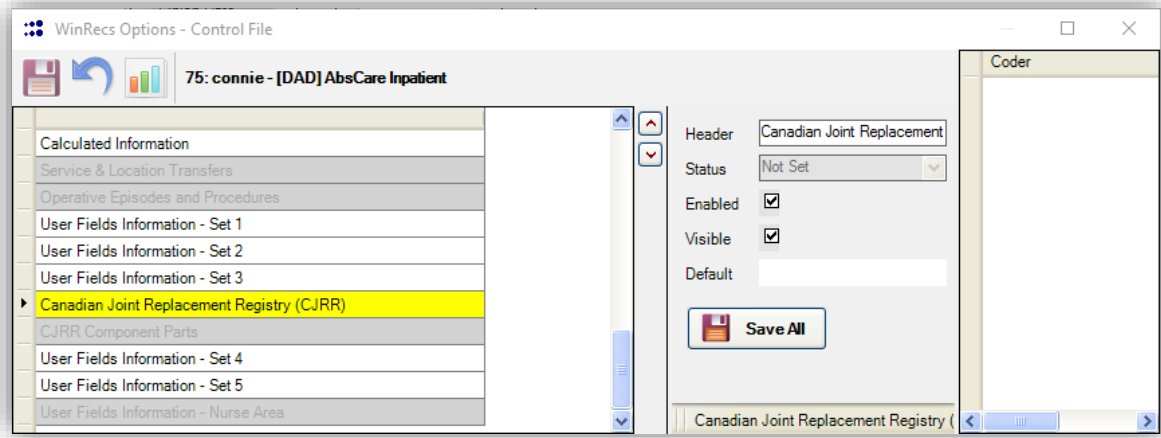


Figure 369 – CJRR Multiform – Enable and Visible

- Press  to save or Press  **Save All** to save for all users.

Activate CJRR Multiform

The following criteria and fields from the Intervention Data multiform must be met in order for a **CJRR** multiform to be triggered:

- Intervention code is one of the followings:
 - 1.VA.53.^ – Implantation of internal device, hip joint
 - 1.SQ.53.^ – Implantation of internal device, pelvis
 - 1.VG.53.^ - Implantation of internal device, knee joint
 - 1.VP.53.^ - Implantation of internal device, patella
- Includes Knee and Hip replacements that are:
 - Emergency or elective
 - Total or partial
 - Primary or revision
- Intervention date must be greater than or equal to April 1, 2018
- Intervention Attribute Status does not equal “A” – Abandon after onset
- The field ‘Intervention Joint Identifier’ must be populated with a ‘1’, if there are 2 CJRR intervention codes, then the second intervention will be populated with a ‘2’. The 1 and 2 values cannot be entered more than once.
- If there is a Revision coded, ‘Revision Reason’ field must be populated.

If the **CJRR multiform** is placed after the Intervention Data multiform, then press F12 Next to open the **CJRR multiform**

Or

Go to the main grid and double click on **Canadian Joint Replacement Registry (CJRR)** header.

Canadian Joint Replacement Registry (CJRR) Multiform

Please see CIHI guidelines on how fields are to be completed:

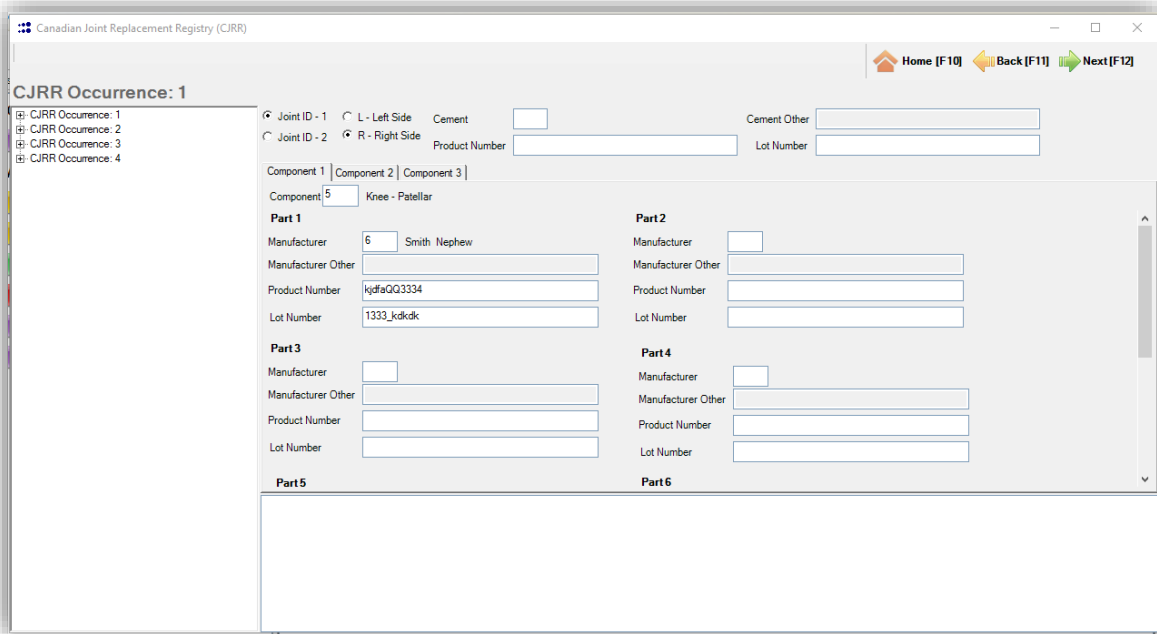


Figure 370 – Canadian Joint Replacement Registry (CJRR) Multiform

6.11.3 CJRR NACRS (National Ambulatory Care Reporting System)

Enable CJRR Multiform

To enable the CJRR Multiform got to:

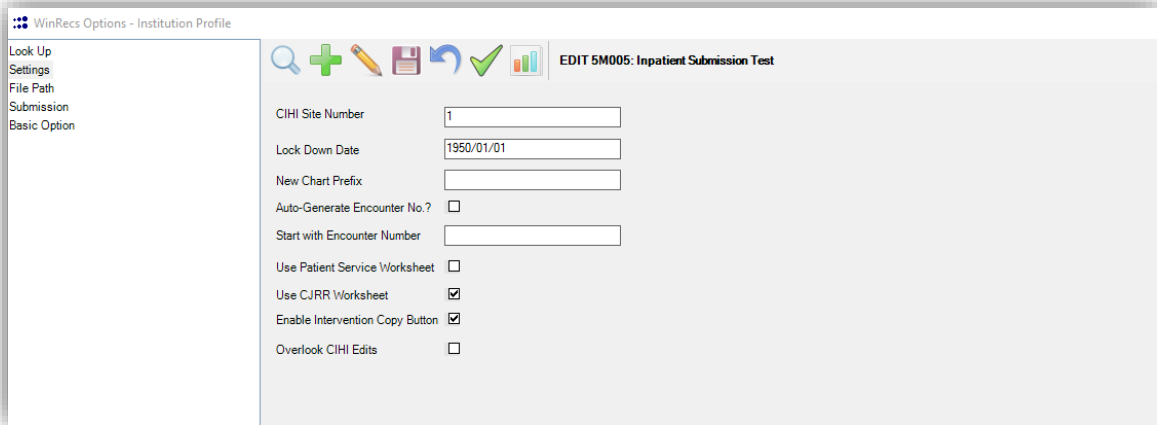
- Options → Institution Profile → Settings



- Press **[F4]** to find the facility the CJRR multiform is to be added and double click on the facility



- Press **[F6]** to edit
- Click on the box next to 'Use CJRR Worksheet' and ensure there is a checkmark



WinRecs Options - Institution Profile

Look Up
Settings
File Path
Submission
Basic Option

EDIT 5M005: Inpatient Submission Test

CIHI Site Number: 1

Lock Down Date: 1950/01/01

New Chart Prefix:

Auto-Generate Encounter No.? ☐

Start with Encounter Number:

Use Patient Service Worksheet ☐

Use CJRR Worksheet ☒

Enable Intervention Copy Button ☒

Overlook CIHI Edits ☐

Figure 371 – Use CJRR Worksheet

Options → Control File



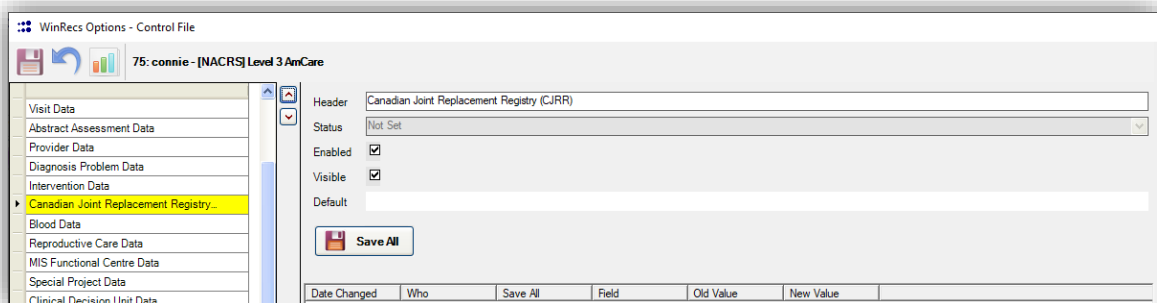
- Press **[F4]** to choose the user or user profile, double click on the user
- Click on **Abstracting/[NACRS] Level 3 AmCare Ambulatory**



- Click on **Group Headers**
- On the left-hand side find and click on the header **Canadian Joint Replacement Registry (CJRR)**
- Ensure the Enabled and Visible fields have a checkmark beside them



- If desired, to move the header/multi-form to a different area of the abstract press the **Up** and **Down** arrows and place on top or below the desired header. It is suggested to place the CJRR multiform after the **Intervention Data** header.



WinRecs Options - Control File

75: connie - [NACRS] Level 3 AmCare

Visit Data
Abstract Assessment Data
Provider Data
Diagnosis Problem Data
Intervention Data
Canadian Joint Replacement Registry...
Blood Data
Reproductive Care Data
MIS Functional Centre Data
Special Project Data
Clinical Decision Unit Data

Header: Canadian Joint Replacement Registry (CJRR)

Status: Not Set

Enabled: ☒

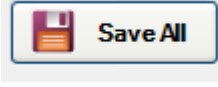
Visible: ☒

Default:

Save All

Date Changed	Who	Save All	Field	Old Value	New Value
--------------	-----	----------	-------	-----------	-----------

Figure 372 – CJRR Multiform – Enable and Visible

- Press  to save or Press  to save for all users.

Activate CJRR Multiform

The following criteria and fields from the Intervention Data multiform must be met in order for a **CJRR** multiform to be triggered:

- Intervention code is one of the followings:
 - 1.VA.53.^ - Implantation of internal device, hip joint
 - 1.SQ.53.^ - Implantation of internal device, pelvis
 - 1.VG.53.^ - Implantation of internal device, knee joint
 - 1.VP.53.^ - Implantation of internal device, patella
- Includes Knee and Hip replacements that are:
 - Emergency or elective
 - Total or partial
 - Primary or revision
- Intervention date must be greater than or equal to April 1, 2022
- Intervention Attribute Status does not equal "A" – Abandon after onset

If the **CJRR multiform** is placed after the Intervention Data multiform, then press F12 Next to open the **CJRR multiform**

Or

Go to the main grid and double click on **Canadian Joint Replacement Registry (CJRR)** header.

Canadian Joint Replacement Registry (CJRR) Multiform

Please see CIHI guidelines on how fields are to be completed:

Canadian Joint Replacement Registry (CJRR)

CJRR Occurrence: 1 - [1SQ53LAPNQ] [LOC: B] [STAT: R]

☒ CJRR Occurrence: 1
☐ CJRR Occurrence: 2

☒ L - Left Side Cement 4 Cerafix
☐ R - Right Side Product Number 254-5874-56 Lot Number 25698-856

Component 1 | Component 2 | Component 3 |
 Component: 1 Hip - Femoral

Part 1

Manufacturer 4 Zimmer/Sulzer/Centerpulse
 Manufacturer Other
 Product Number 2564-586
 Lot Number 85433-88

Part 2

Manufacturer 11 Tecres Medical
 Manufacturer Other
 Product Number 26+6513
 Lot Number 2556-6545

Part 3

Manufacturer
 Manufacturer Other
 Product Number
 Lot Number

Part 4

Manufacturer
 Manufacturer Other
 Product Number
 Lot Number

Part 5

Manufacturer
 Manufacturer Other
 Product Number

Part 6

Manufacturer
 Manufacturer Other
 Product Number

CJ03 | Cement | 3 | Look Up [F2] | Cement

Figure 373 – Canadian Joint Replacement Registry (CJRR) Multiform

6.12 Specialized Fields

Some regions/sites have specialized fields that are required by their province, health region or individual site.

Manitoba – Multi-forms

All Manitoba multi-forms are to be filled out as per Manitoba Health guidelines. The multi-forms will function the same as all other multi-forms. [See Multi-forms](#)

MADE Patient Transfer Service Worksheet

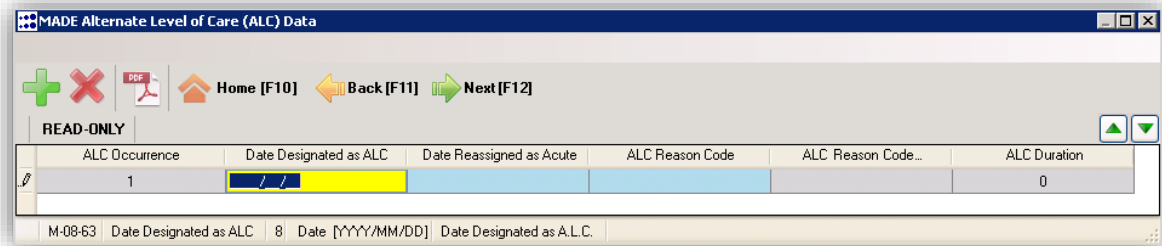


Figure 374 – MADE Patient Transfer Service Worksheet Multi-form

MADE Alternate Level of Care (ALC) Data

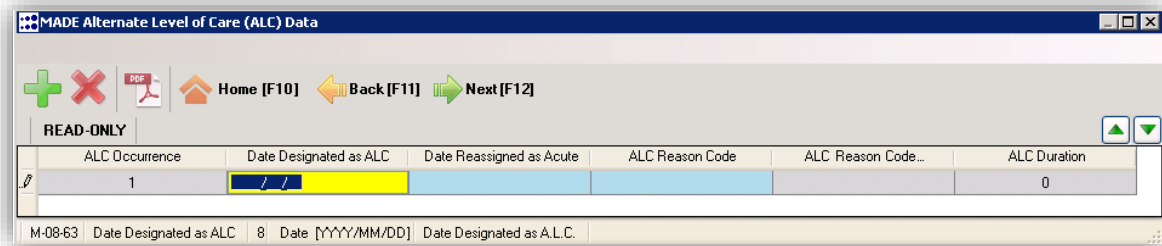


Figure 375 – MADE Alternate Level of Care (ALC) Data Multi-Form

MADE Designation non-ALC Delay Data

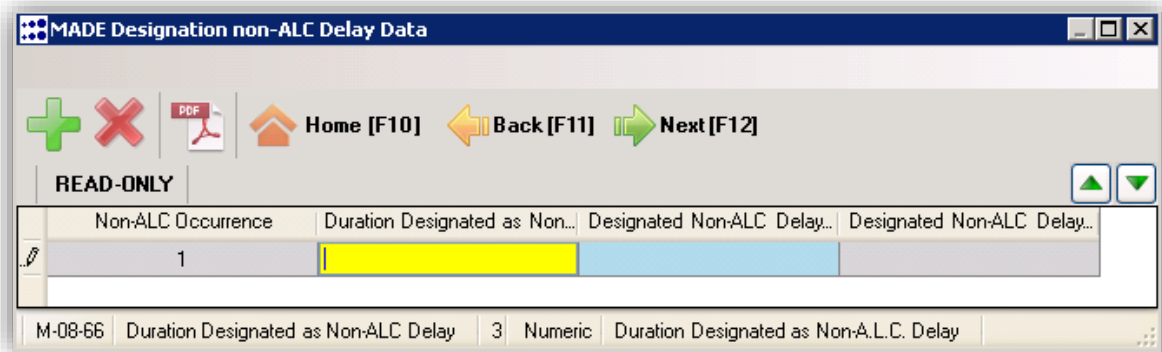


Figure 376 – MADE Designation non-ALC Delay Data Multi-Form

MADE Supplemental (Facility Study) Data

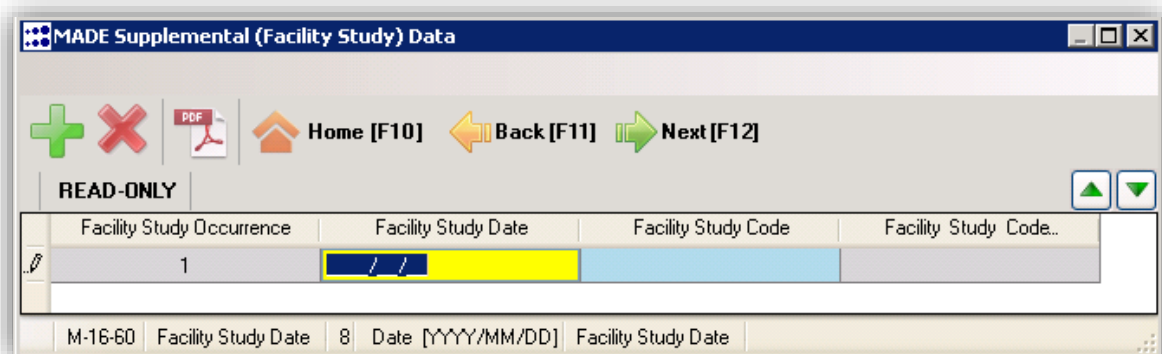


Figure 377 – MADE Supplemental (Facility Study Data) Multi- Form

Manitoba – Main Grid

All fields are to be filled out as per Manitoba Health Guidelines. Data Entry into these fields are the same as [WinRecs Navigation](#) and [Look Up](#) Section. These fields can also be moved elsewhere within the main grid of the abstract as described [Changing Sort Order – Main Grid](#).

MADE Abstract Data

MADE Abstract Data			
	Abstract Type		
	Declaration Number		
	ER Date of Arrival		
	ER Time of Arrival		
	Transfer From Facility...		
	Transfer To Facility Number		
	Elolements		
	Leave Certificates		
	Autopsy		
	** ALC Duration	0	

Figure 378 – MADE Abstract Data – Main Grid

MADE Demographic Data

MADE Demographic Data			
	Previous Name		
	Telephone Number		
	Declaration Home Address...		
	Declaration Home Address...		
	Patient/Registrant Employer		
	Registrant Surname		
	Registrant Given Name		

Figure 379 – MADE Demographic Data – Main Grid

MADE Obstetrical Data

MADE Obstetrical Data			
☐	Analgesic/Anesthetic during Labor		
☐	Date of First Prenatal Visit		
☐	Number of Prenatal Visits (old)		
☐	Number of Prenatal Visits		
☐	Gravida		
☐	Para		
☐	Weight(grams)		
☐	Education		
☐	Smoking Cigarettes/Day		
☐	Smoking Quit Date		
☐	Alcohol Use During Pregnancy		
☐	# of Days/Week Alcohol is Consumed		
☐	# of Drinks/Day		
☐	Pre-Conception Folic Acid		
☐	Post-Conception Vitamins/Folic Acid		
☐	Start Date of First Stage of Labour		
☐	Start Time of First Stage of Labour		
☐	Duration of First Stage of Labour		
☐	Start Date of Second Stage of Labour		
☐	Start Time of Second Stage of Labour		
☐	Duration of Second Stage of Labour		

Figure 380 – MADE Obstetrical Data – Main Grid

MADE Newborn Data

MADE Newborn Data			
☐	Presentation at Delivery (old)		
☐	Presentation at Delivery		
☐	Position at Delivery		
☐	Routine Care		
☐	Free Flow Oxygen		
☐	Bag + Mask Ventilation for Resuscitation		
☐	Intubation for Reasons Other than...		
☐	Medications Administered for...		
☐	Narcan/Naloxone Administration		
☐	Chest Compression		
☐	Feeding		
☐	Meconium		
☐	Apgar 1 Minute		
☐	Apgar 5 Minute		
☐	Gestation		
☐	Mothers PHIN number		

Figure 381 – MADE Newborn Data – Main Grid

6.13 Cancer Care Module – (CCM)

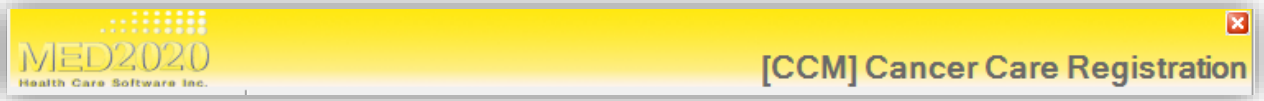


Figure 382 - Cancer Care Module Header

The Cancer Care module is a data collection tool within the WinRecs suite of modules, sharing a common Central Patient Index and allowing the collection of cancer care data specific to the Disease Registration

To clarify, a patient is not registered with Cancer Care Ontario on each visit. They are registered once with Cancer Care Ontario per Primary Disease which is captured in the CCM module. Once the registration is received and processed, what Cancer Care Ontario gets sent is updates to the registration or disease information or the visit related information which is referred to as ALR reporting information (Activity Level Reporting) which is captured in NACRS.

Please refer to the **Basic WinRecs Functionality** section of the User Guide for details on the record layout and functionality.

To open the [CCM] Cancer Care Registration

- Select the menu option Module Abstracting → [CCM] Cancer Care Registration

— or —

- Select WinRecs Module Menu → Abstracting→ [CCM] Cancer Care Registration

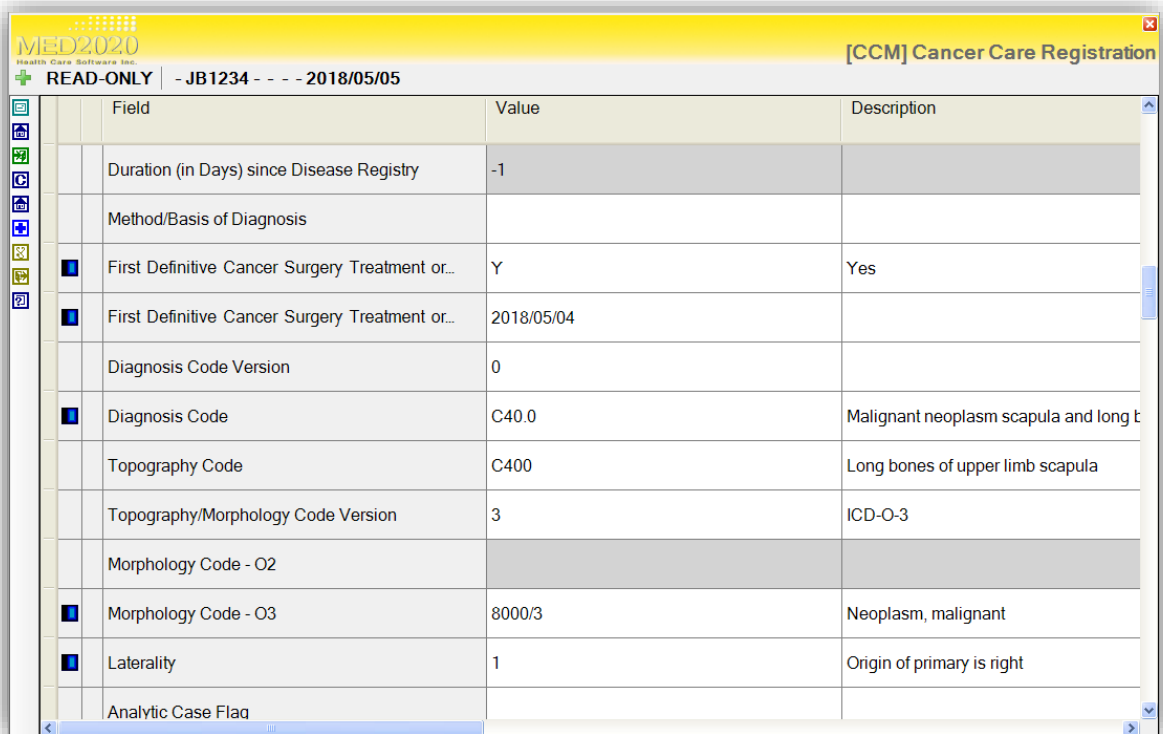
Go to Cancer Care Module

F4 and search for an Interfaced in patient

F5 and create a NEW entry for this disease registration

F7 SAVE your registration

CCM Disease Registration



Field	Value	Description
Duration (in Days) since Disease Registry	-1	
Method/Basis of Diagnosis		
First Definitive Cancer Surgery Treatment or...	Y	Yes
First Definitive Cancer Surgery Treatment or...	2018/05/04	
Diagnosis Code Version	0	
Diagnosis Code	C40.0	Malignant neoplasm scapula and long b
Topography Code	C400	Long bones of upper limb scapula
Topography/Morphology Code Version	3	ICD-O-3
Morphology Code - O2		
Morphology Code - O3	8000/3	Neoplasm, malignant
Laterality	1	Origin of primary is right
Analytic Case Flag		

Figure 383 - Cancer Care Module – Disease Registration

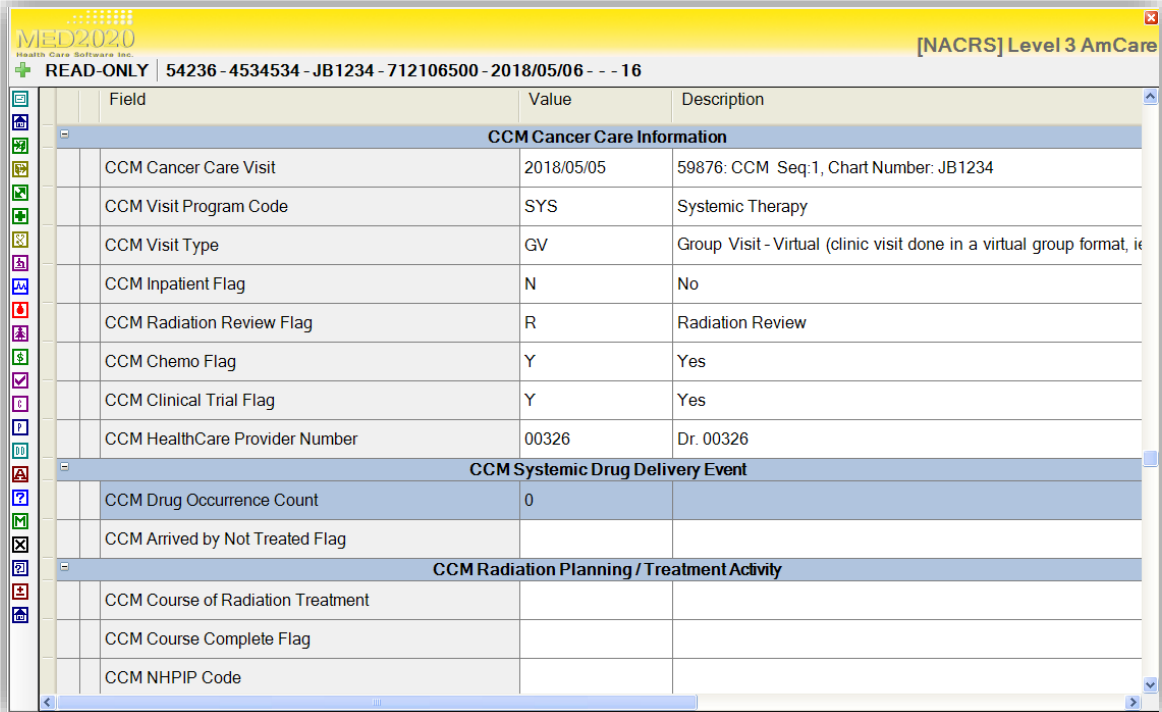
The disease registration is captured in the CCM module. Mandatory fields required to save an CCM record are:

- Chart Number
- Master Hospital Number
- Disease Registration Date.

In the CCM record, this is where the disease registration is collected which includes; the demographic information, providers, disease details, Dates of Referrals and Staging information.

CCM Activity Level Reporting (NACRS)

Patient visits for the disease registration will be created in the NACRS module. Additional Cancer Care fields have been added to the standard NACRS module to allow you to enter the Chemo and Radiation Treatment fields required for visit level reporting.



Field	Value	Description
CCM Cancer Care Information		
CCM Cancer Care Visit	2018/05/05	59876: CCM Seq:1, Chart Number: JB1234
CCM Visit Program Code	SYS	Systemic Therapy
CCM Visit Type	GV	Group Visit - Virtual (clinic visit done in a virtual group format, ic
CCM Inpatient Flag	N	No
CCM Radiation Review Flag	R	Radiation Review
CCM Chemo Flag	Y	Yes
CCM Clinical Trial Flag	Y	Yes
CCM HealthCare Provider Number	00326	Dr. 00326
CCM Systemic Drug Delivery Event		
CCM Drug Occurrence Count	0	
CCM Arrived by Not Treated Flag		
CCM Radiation Planning / Treatment Activity		
CCM Course of Radiation Treatment		
CCM Course Complete Flag		
CCM NHPIP Code		

Figure 384 - Cancer Care Module – Activity Level Reporting

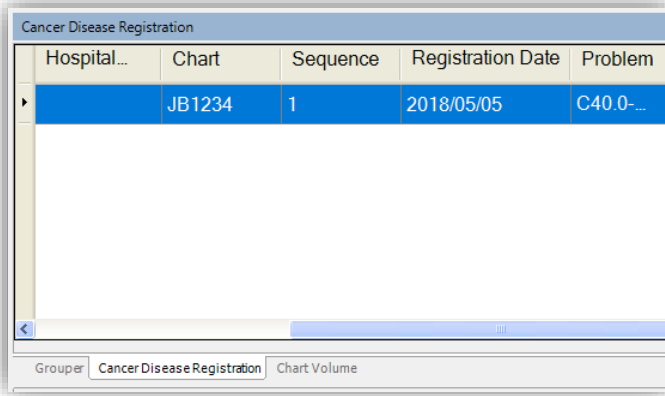
The NACRS CCM portion of the record is enabled when an applicable CCM MIS code is entered.

	Visit MIS Functional Centre Account Code	712106500	Oncology Medical Nursing Unit
---	--	-----------	-------------------------------

Next, the activity level reporting captured through NACRS is linked to the Cancer Care Module disease registration sequence. To link a NACRS record to a CCM registration, select the disease sequence from the field "CCM Cancer Care Visit." If a patient has multiple disease registrations, the disease selected will be the disease that the NACRS visit is applicable to.

CCM Cancer Care Information		
CCM Cancer Care Visit	2018/05/05	59876: CCM Seq:1, Chart Number: JB1234

After the record has been linked to the CCM registration using the “CCM Cancer Care Visit” field, the CCM link will show up in the NACRS side bar



Hospital...	Chart	Sequence	Registration Date	Problem
	JB1234	1	2018/05/05	C40.0-...

Figure 385 - Cancer Care Module Linking

Once a NACRS visit is linked to the CCM record using the “CCM Cancer Care Visit” field. The remaining CCM fields are enabled where the treatment details can be collected. This includes the drug and radiation treatments used during that hospital visit.

Submitting Data

Cancer Care Module Extract & Submission to CCO

See the Data Book for frequency expected in reporting and to confirm the extract required is what is within the Crystal Report.

Creation of submission files is performed via the WinRecs Report Generator. Data is extracted based on the parameter values presented and entered.

Specific submission reports for:

- 1) Disease Entity
- 2) NDFP Enrollment
- 3) Provider's Entity
- 4) Patient Entity

...are available to run and export to the desired application, such as Microsoft Excel.

See the Report Manager section of the WinRecs User Guide for details on how to generate reports.

Pre-Designed Reports

These reports were developed in Crystal 8, specifically for use with the Cancer Care Module and for the purpose of providing a means to submit data following the Data Submission Specifications in the CCO Database 2007 – 2008.

CCM HealthCare Professional Submission Report.rpt – This report used to extract the data from the Cancer Care Module for the Healthcare Professionals Data Submission requirements as per the CCO Databook 2007 - 2008. View is selecting on HCP Program Code, HCP Status, and Main Provider Specialty. It is suggested report be set up to generate from the Provider Maintenance using Report Selection List. Once the report has been generated it is to be exported to Excel.

CCM Patient Submission Report.rpt – This report used to extract the data from the Cancer Care Module for the Patient Entity Submission data requirements as per the CCO Databook 2007 - 2008. The report uses a Registration date range parameter to select the date range for the data submission. Once the report has been generated it is to be exported to Excel.

CCM Disease Submission Report.rpt – This report used to extract the data from the Cancer Care Module for the Disease Entity Submission data requirements as per the CCO Databook 2007 - 2008. The report uses a Registration date range parameter to select the date range for the data submission. Once the report has been generated it is to be exported to Excel.

CCM Incomplete Staging Data.rpt – This report extracts abstracts if the Clinical Staging at Diagnosis OR Pathological Staging at Diagnosis fields are not completed and are required as per the Diagnosis Code. Records grouped by Group Option parameter, ie: Data Entry/Coder, Registration Month or None. Detailed listing displaying Chart #, Full Name, Registration Date, Diagnosis Code and Description, Clinical and Pathological Staging fields with summary data on number of abstracts by Group and Grand Total.

CCM Incomplete Abstracts Report.rpt – This report extracts abstracts if the IsAbstractValidated is not equal to "Y". Records grouped by Group Option parameter, ie: Data Entry/Coder, Registration Month, Incomplete Status or None. Detailed listing displaying Chart #, Full Name, Registration Date, Diagnosis Code and Description and incomplete status description with summary data on number of abstracts by Group and Grand Total.

CCM Patient Listing with Referral Dates.rpt – This report extracts Cancer Care Module abstracts within the Registration Date Range. The records are sorted by Registration Date. The detailed listing displays, Chart #, Full Name, Registration Date, Diagnosis Code and description, Clinical Staging at Diagnosis, Pathological Staging at Diagnosis, Medical Oncologist Referral Date, Radiation Oncologist Referral Date, Surgical Referral Date and Other Support Care Referral Date.

6.14 Clinical – MDS (Continuing Care Reporting System – CCRS)

CCRS is a clinical module used to collect clinical and demographic information on residents who receive services from hospital-based continuing care (extended, chronic care or complex care beds) or 24-hour residential care beds.

To open the Clinical Modules – [MDS-XX] Assessments

- Select the menu option **Module → Clinical → [MDS-XX]**
— or —
- Select **WinRecs Module Menu → Clinical → [MDS-XX]**

The module has 10 assessment types listed below:

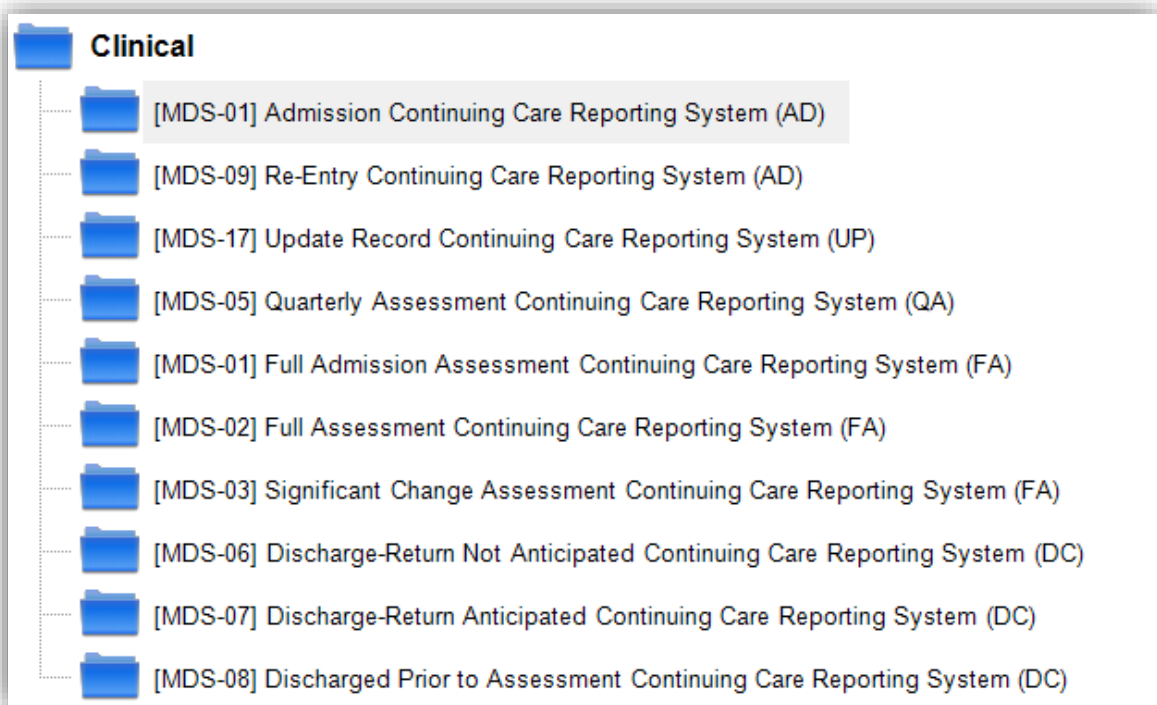


Figure 386 – Clinical MDS - Assessments

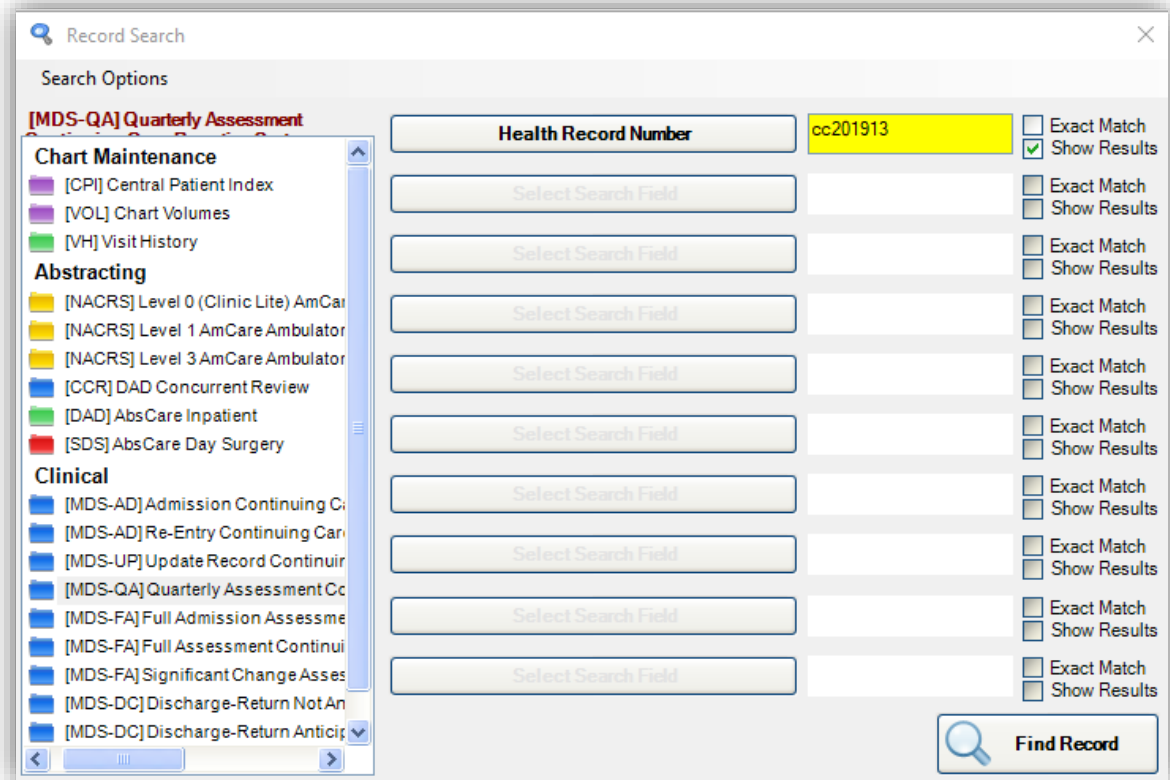
Assessment Type & Description

1. [MDS-01] Admission Continuing Care Reporting System (AD)
 - To be completed at any stage if changes or corrections to demographic information are required.
2. [MDS-09] Re-Entry Continuing Care Reporting System (AD)
 - Used when a resident is readmitted following a previous discharge from the facility. Certain conditions must be met.
3. [MDS-17] Update Record Continuing Care Reporting System (UP)

- To be completed at any stage if changes or corrections to demographic information are required.
4. [MDS-05] Quarterly Assessment Continuing Care Reporting System (QA)
 - Used to track resident status between Full Assessments, and to facilitate monitoring of critical indicators relating to changes in the resident's status. The Quarterly Assessment must be completed within 92 days of the last Full or Quarterly Assessment. To be completed at any stage if changes or corrections to demographic information are required.
 5. [MDS-01] Full Admission Assessment Continuing Care Reporting System (FA)
 - To be completed by the 14th calendar day of the resident's admission to the facility if this is the resident's first stay in the facility or if the resident returns to the facility after being discharged and the conditions for use of the Re-entry Form do not apply. The 1st calendar day of admission = 0, i.e. If patient was admitted on January 1st, then the full admit should be completed by January 15.
 6. [MDS-02] Full Assessment Continuing Care Reporting System (FA)
 - To be completed within 366 days of the Assessment Reference Date (Element A3) from the last Full Assessment.
 7. [MDS-03] Significant Change Assessment Continuing Care Reporting System (FA)
 - Required if there is a significant change in Resident's status. Complete a Full Assessment within 14 days of the day determination of a significant change has occurred.
 8. [MDS-06] Discharge Return Not Anticipated Continuing Care Reporting System (DC)
 - Required whenever a resident dies or is discharged from the facility. This is the only record that must be completed at the time of any discharge or death. Complete the No Return (06) if no return to the facility is anticipated.
 9. [MDS-07] Discharge Return Anticipated Continuing Care Reporting System (DC)
 - Complete the Return Anticipated (07) if a return to the facility is anticipated.
 10. [MDS-08] Discharge Prior to Assessment Continuing Care Reporting System (DC)
 - Discharged prior to completing initial assessment.

Searching for a Clinical MDS Visit

- Click on any of the Assessments and press F4 to search for the record (Please see section [5.1 Searching for a Record](#)).



Health Record Number	Select Search Field	Exact Match	Show Results
cc201913		☐	☒
	Select Search Field	☐	☐
	Select Search Field	☐	☐
	Select Search Field	☐	☐
	Select Search Field	☐	☐
	Select Search Field	☐	☐
	Select Search Field	☐	☐
	Select Search Field	☐	☐
	Select Search Field	☐	☐
	Select Search Field	☐	☐
	Select Search Field	☐	☐
	Select Search Field	☐	☐

Figure 387 – Clinical MDS - Searching

- The ability to search on any field within that assessment. For example: if the [MDS-QA] Quarterly Assessment Continuing Care Reporting System is chosen, a search can be done on any of the fields in that assessment by clicking on the field name in the middle column. As well a search can be performed on more than one assessment. When the search results screen is displayed all assessments for that search option will display.
- When a search is made by Health Record Number or Patient Name all the assessments will display for that patient.

Search Results								
Health Record Number	Hospital Link	Unique Registration Identifier	Last Name	Middle Name	First Name	Admission Type	Is...	Visit Date
CC201906		50001201910290000010				1	Y	2019-05-10
CC201906		50001201910290000010				2	Y	2019-06-30
CC201906		50001201910290000010				3	Y	2019-06-15
CC201906		50001201910290000010				5	Y	2019-06-01
CC201906		50001201910290000010				8	Y	2019-04-27
CC201906		50001201910290000010				9	Y	2019-05-01
CC201906		50001201910290000010				A	Y	2019-04-20

Figure 388 – Clinical MDS – Search Patient Display

- Double click on the assessment that needs to be accessed.
- When the assessment displays all fields previously inputted with display.
- To go to other assessments, click on the other assessments displayed in the Patient Visit History.

Facility Identifier	Health Record...	Last Name	First Name	Middle Name	Visit Date
50001	CC201903				2019/04/10

[MDS-FA] Full Admission Assessment Continuing Care Reporting System: CC201903

[MDS-AD] Admission Continuing Care Reporting System

[MDS-AD]

[MDS-FA] Full Admission Assessment Continuing Care Reporting System

READ-ONLY 50001 - CC201903 - - - 2019/04/10

Field	Value	Description
Section AA and A - Identification Information		
Record Type	FA	Full assessment
Regional Link		
Hospital Link		
Reason for Assessment	1	Admission assessment.
Admission/Re-entry Date	2019/04/02	
Facility Identifier	50001	CCRS Vendor Testing
Unique Registration Identifier	50001201910240000007	
Unit		
Room Number		
Assessment Reference Date	2019-04-10	
Next Assessment Date	2019/07/09	
Health Record Number	CC201903	
Sex	F	Female

A3 Assessment Reference Date | 8 | Date [YYYY-MM-DD] | Assessment Reference Date

Message List

CC201903

Hospital Module

MDS 07

MDS 02

MDS 01

MDS 0A

Ch... Visit... Requ... Other...

Grouping

RUG 44 RUG 34

Field

ADL

Top CMI Weight

Second Top CMI Weight

Top RUG Group Description

Second Top RUG Group...

Record Update History

Coder Updated

Connie 2019/11/14 18:28

Connie 2019/11/14 17:49

Connie 2019/11/08 13:58

Connie 2019/10/24 18:26

Connie 2019/10/24 17:46

Figure 389 – Clinical MDS – Patient Assessment

Facilities that have a batch or HL7 (real-time) interface transferring records into the WinRecs program will use the F4 search function to locate the assessment records they need to complete.

Creating a New Assessment for a Clinical MDS Visit

- Click on the Assessment Type that needs to be created and press New [F5] (See [5.2 Creating a New Record](#))

A facility that does not have an interface to transfer the patient visit information into WinRecs ® will use the F5 (new) function to create a new assessment record.

Auto-Completion of Fields

Depending on the assessment section, some fields will auto-populate with values based on a key question. If 'Y' is typed in the '*None of the below*' fields, the remaining fields' values will grey out and default to No. This assists with the completion of assessment fields where the section does not apply to that patient yet must be completed based on data submission requirements. This requires less key stroking for data entry and consistency in the quality of data entered in the abstract.

An example from **Section C – Communication/Hearing Patterns**, a 'Y' was inputted into the field 'None of the below' and the fields below auto-completed and the fields greyed out. Leave the field 'None of the below' blank results in each of the fields needing to be populated.

Section C - Communication/ Hearing Patterns			
☒	Hearing	0	Hears Adequately
☐	None of the below	Y	Yes
☐	Hearing aid, present and used regularly	0	No
☐	Hearing aid, present and not used regularly	0	No
☐	Other receptive communication techniques	0	No

Figure 390 – Clinical MDS – Auto-Completion of Fields

Copy Data from Latest Assessment

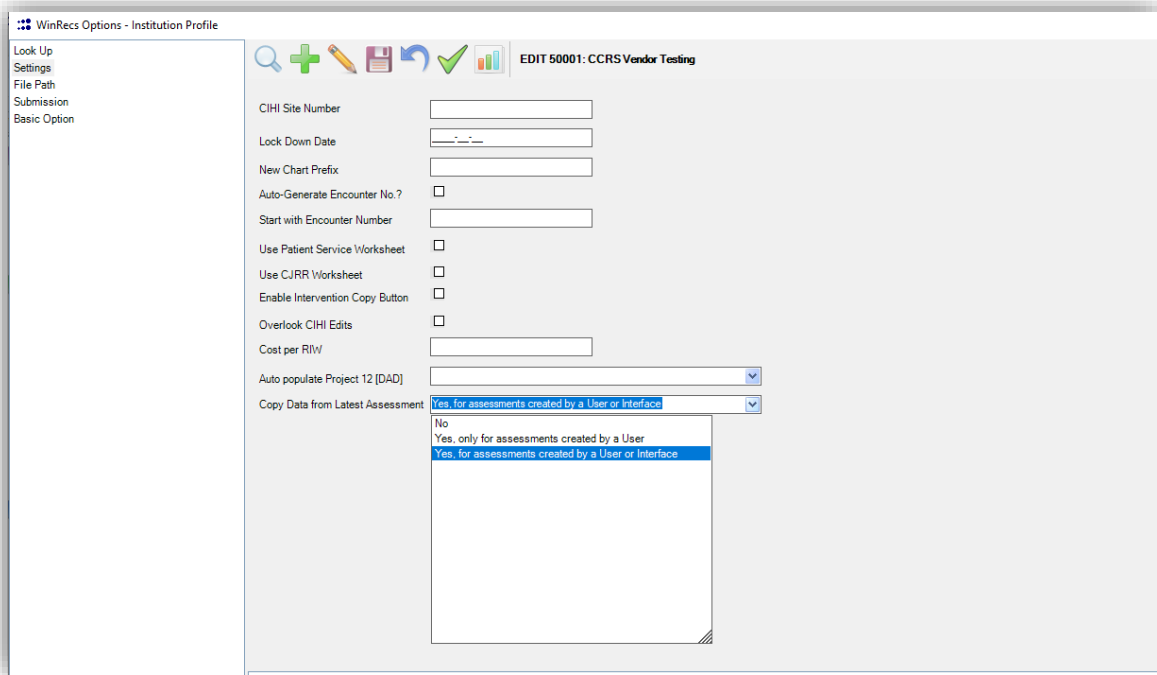
This feature allows the information from one assessment copy to another assessment, creating less keystrokes for data entry. The user would only need to go into the fields that have changed, not enter the whole assessment again. The following assessments will copy to each other:

- Full Admission Assessment to:
 - Quarterly Assessment
 - Full Assessment
- Full Assessment to:
 - Quarterly Assessment
 - Full Assessment
- Quarterly Assessment to:
 - Full Assessment
 - Quarterly Assessment

For this feature to work the following must be completed within the **Institution Profile & Control File**:

Institution Profile/Settings:

- The field named 'Copy Data from Latest Assessment' in the Institution Profile/Settings needs to be set to either:
 - Yes, for assessments created by user or interface
 - Yes, only for assessments created by user



The screenshot shows the 'WinRecs Options - Institution Profile' window. The left sidebar contains a tree view with 'Look Up', 'Settings', 'File Path', 'Submission', and 'Basic Option'. The main area is titled 'EDIT 50001: CCRS Vendor Testing'. It contains several input fields and checkboxes: 'CIHI Site Number', 'Lock Down Date', 'New Chart Prefix', 'Auto-Generate Encounter No.?' (checkbox), 'Start with Encounter Number', 'Use Patient Service Worksheet' (checkbox), 'Use CJRR Worksheet' (checkbox), 'Enable Intervention Copy Button' (checkbox), 'Overlook CIHI Edits' (checkbox), 'Cost per RIW', 'Auto populate Project 12 [DAD]' (dropdown), and 'Copy Data from Latest Assessment' (dropdown). The 'Copy Data from Latest Assessment' dropdown is open, showing three options: 'No', 'Yes, only for assessments created by a User', and 'Yes, for assessments created by a User or Interface'. The third option is selected.

Figure 391 – Clinical MDS – Copy Data from latest assessment – Institution Profile

Control File:

- 1 – Choose [MDS-05] Quarterly Assessment Continuing Care Reporting System.
- 2 – **Select Field Group** Section AA and A - Identification Information
- 3 – Choose 'Facility Number'
- 4 – Under 'Default' enter Facility Number

 Press  to save and Repeat for [MDS-01] Full Assessment Continuing Care Reporting System

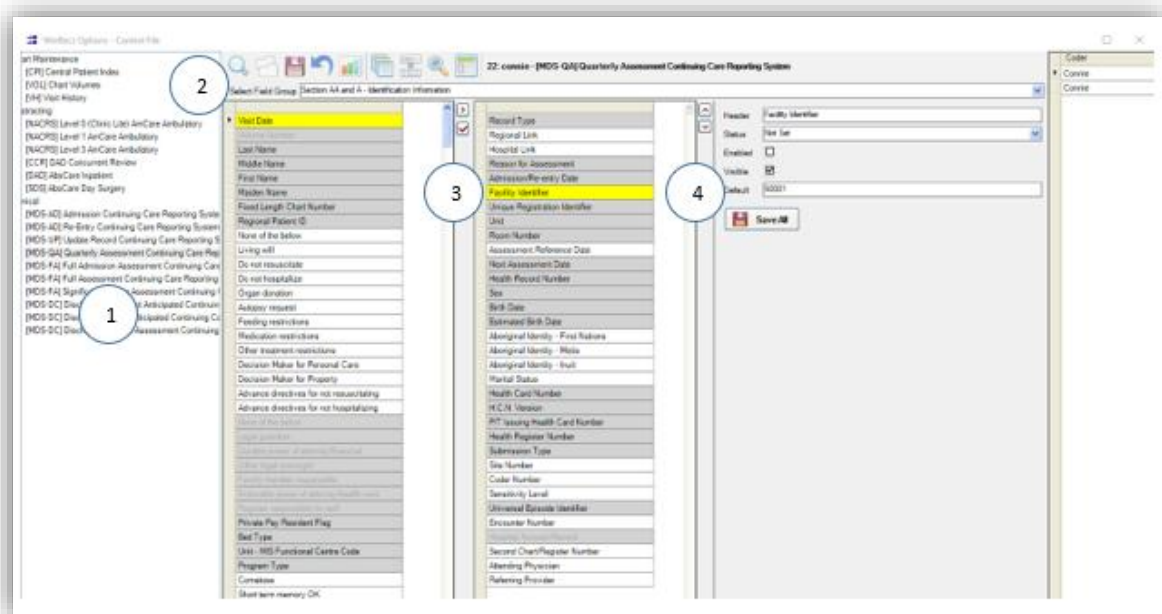
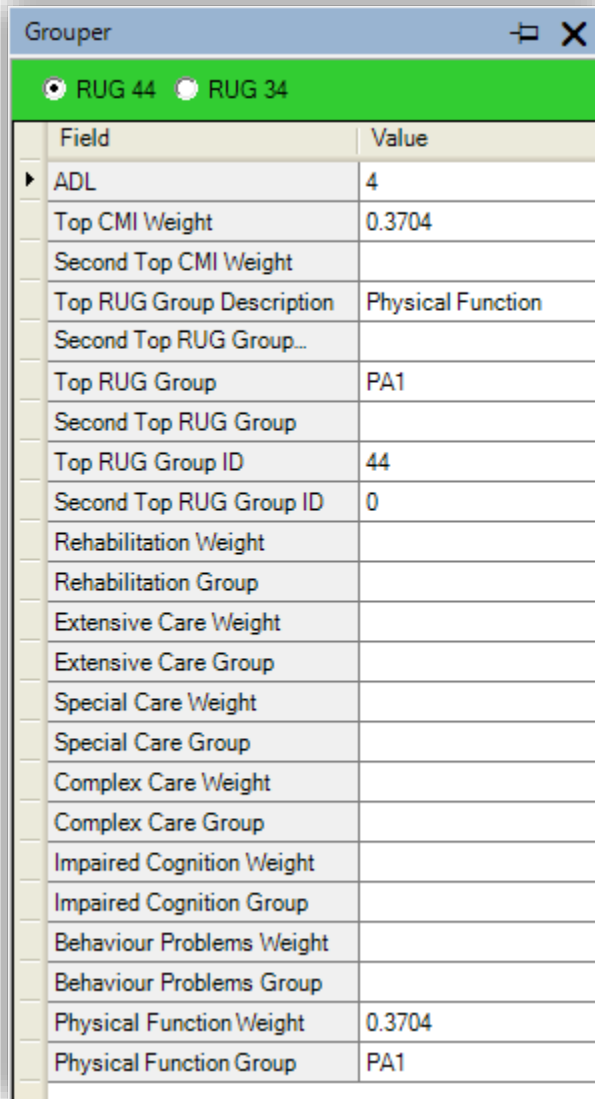


Figure 392 – Clinical MDS – Copy Data from Latest Assessment – Control File

RUGS Grouper



The screenshot shows the 'Grouper' window with 'RUG 44' selected. Below the selection bar is a table with the following data:

Field	Value
ADL	4
Top CMI Weight	0.3704
Second Top CMI Weight	
Top RUG Group Description	Physical Function
Second Top RUG Group...	
Top RUG Group	PA1
Second Top RUG Group	
Top RUG Group ID	44
Second Top RUG Group ID	0
Rehabilitation Weight	
Rehabilitation Group	
Extensive Care Weight	
Extensive Care Group	
Special Care Weight	
Special Care Group	
Complex Care Weight	
Complex Care Group	
Impaired Cognition Weight	
Impaired Cognition Group	
Behaviour Problems Weight	
Behaviour Problems Group	
Physical Function Weight	0.3704
Physical Function Group	PA1

Figure 393 – Clinical MDS – RUGS Grouper

- **Rehabilitation** - Identifies Rehab RUG-III group the client has been assigned to. The table displays the RUG-III code and level as well as the Case Mix Index Value.
- **Extensive Care** - Identifies Rehab RUG-III group the client has been assigned to. The table displays the RUG-III code and level as well as the Case Mix Index Value.
- **Special Care** - Identifies Rehab RUG-III group the client has been assigned to. The table displays the RUG-III code and level as well as the Case Mix Index Value.
- **Complex Care** - Identifies the Clinically Complex Care RUG-III group the client has been assigned to. The table will display the RUG-III code and level as well as the Case Mix Index Value.

- **Impaired Cognition**-Identifies the Impaired Cognition RUG-III group the client has been assigned to. The table will display the RUG-III code and level as well as the Case Mix Index Value.
- **Behaviour Problems** -Identifies the Behaviour Problems RUG-III group the client has been assigned to. The table will display the RUG-III code and level as well as the Case Mix Index Value.
- **Physical Function**-Identifies the Reduced Physical Function RUG-III group the client has been assigned to. The table will display the RUG-III code and level as well as the Case Mix Index Value.

6.15 Clinical – NRS (National Rehabilitation Reporting System)

The Rehabilitation module is a diagnostic tool to keep track of individual patients and their progress once transferred to a specialized rehabilitation facility.

To open the Clinical Modules – [NRS]-XX National Rehabilitation Reporting System

- Select the menu option **Module → Clinical → [MDS]-XX National Rehabilitation Reporting System**
— or —
- Select **WinRecs Module Menu → Clinical → [MDS]-XX National Rehabilitation Reporting System**

The National Rehabilitation Reporting System modules has the following assessment types:

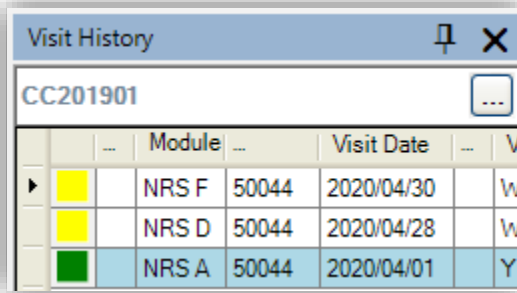


Figure 394 – Clinical NRS – Assessment Types

- NRS A – 1 - Admission National Rehabilitation Reporting System
- NRS D – 2 - Discharge National Rehabilitation Reporting System
- NRS F - 3 – Follow up National Rehabilitation Reporting System

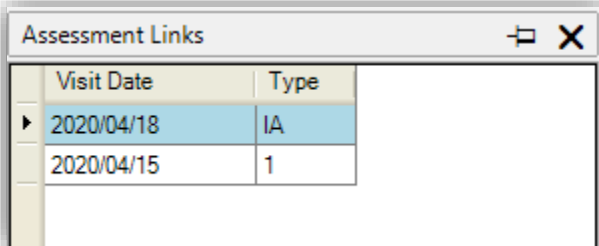
- NRS I - IA – Interim National Rehabilitation Reporting System
- NRS P - PD – Post Discharge National Rehabilitation Reporting System

All the assessment types will display in the Patient Visit History and Rehabilitation Visit boxes except for the Interim Assessment and Post Discharge Assessment which will display only in the Assessment Links Tab. If the Assessment Links tab is not displayed go to View/Assessment Links.



Module	Visit Date	
NRS F 50044	2020/04/30	W
NRS D 50044	2020/04/28	W
NRS A 50044	2020/04/01	Y

Figure 395 – Clinical NRS – Visit History



Visit Date	Type
2020/04/18	IA
2020/04/15	1

Figure 396 – Clinical NRS – Assessment Links

Searching for a Clinical NRS Visit

- Click on any of the Assessments and press F4 to search for the record (Please see section [5.1 Searching for a Record](#)).

Record Search

Search Options

[NRS] Admission National Rehabilitation

Chart Maintenance

Initial

[NRS] National Rehabilitation Report

[NRS] Admission National Rehabilitation

[NRS] Interim National Rehabilitation Report

[NRS] Discharge National Rehabilitation Report

[NRS] Post Discharge National Rehabilitation Report

[NRS] Follow-Up National Rehabilitation Report

Chart Number

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

Select Search Field

☐ Exact Match
☒ Show Results

☐ Exact Match
☐ Show Results

☐ Exact Match
☐ Show Results

☐ Exact Match
☐ Show Results

☐ Exact Match
☐ Show Results

☐ Exact Match
☐ Show Results

☐ Exact Match
☐ Show Results

☐ Exact Match
☐ Show Results

☐ Exact Match
☐ Show Results

☐ Exact Match
☐ Show Results

Find Record

Figure 397 – Clinical NRS – Searching for an Assessment

- The ability to search on any field within that assessment. For example: if the [NRS] Discharge National Rehabilitation Reporting System is chosen, a search can be done on any of the fields in that assessment by clicking on the field name in the middle column. When the search results screen is displayed all assessments for that search option will display.
- When a search is made by Health Record Number or Patient Name all the assessments will display for that patient.

Health Record Number	Hospital Link	Unique Registration Identifier	Last Name	Middle Name	First Name	Admission Type	Is...	Visit Date
CC201906		50001201910290000010				1	Y	2019-05-10
CC201906		50001201910290000010				2	Y	2019-06-30
CC201906		50001201910290000010				3	Y	2019-06-15
CC201906		50001201910290000010				5	Y	2019-06-01
CC201906		50001201910290000010				8	Y	2019-04-27
CC201906		50001201910290000010				9	Y	2019-05-01
CC201906		50001201910290000010				A	Y	2019-04-20

Figure 398 – Clinical NRS – Search Patient Display

- Double click on the assessment that needs to be accessed.
- When the assessment displays all fields previously inputted with display.
- To go to other assessments, click on the other assessments displayed in the Patient Visit History.

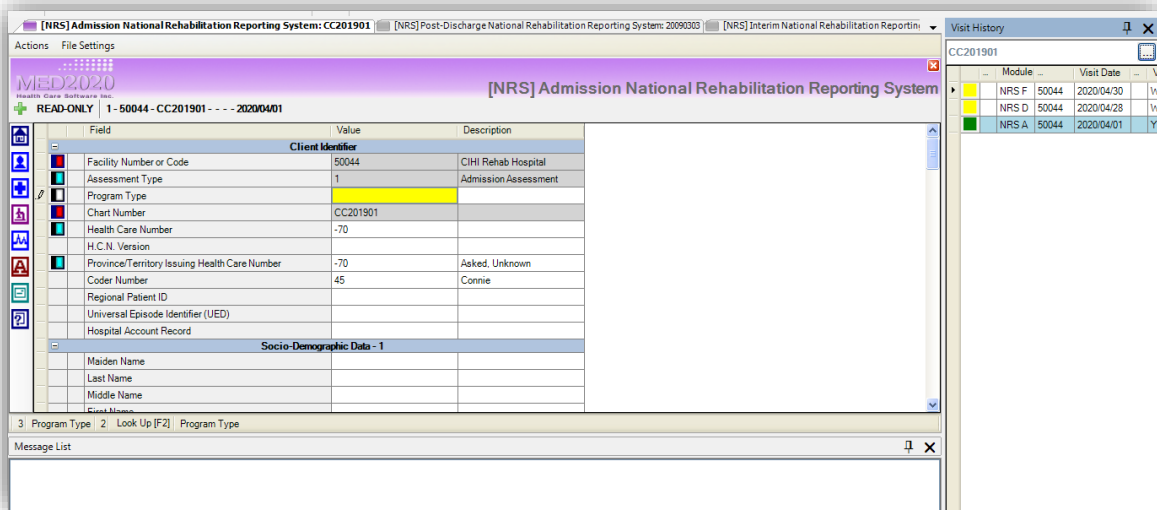


Figure 399 – Clinical NRS – Patient Assessment

Facilities that have a batch or HL7 (real-time) interface transferring records into the WinRecs program will use the F4 search function to locate the assessment records they need to complete.

Creating a New Assessment for a Clinical NRS Visit

- Click on the Assessment Type that needs to be created and press New [F5] (See [5.2 Creating a New Record](#))

A facility that does not have an interface to transfer the patient visit information into WinRecs ® will use the F5 (new) function to create a new assessment record.

- When creating a discharge assessment some assessment values (as per CIHI Guidelines) are carried over from the admission assessment. Several of these fields will be disabled (greyed out) with data in the fields. These fields contain data provided in the Admission Assessment can cannot be changed.
- An Admission Assessment must be completed before a Discharge Assessment. It is optional to record a Follow-Up Assessment once the Discharge Assessment has been completed.
- A Discharge Assessment must not be deleted without first deleting its associated Follow-Up Assessment (if applicable). Likewise, an Admission Assessment must not be deleted without deleting its associated Discharge Assessment.
- A Post Discharge Assessment can only be created if there is an existing Discharge Assessment. The Post Discharge Assessment is not submitted to CIHI .
- If an Admission Class field 4 (unplanned discharge without assessment) is used in the Admission Assessment the system will not allow you to create a Discharge Assessment.

Defaulting of Diagnosis Condition Type

The Main Health Condition type (occurrence 1) currently defaults to M. Diagnosis condition types for pre-admit and post-admit conditions will now default as follows:

- Admission Assessments - For any diagnosis occurrence greater than 1, the diagnosis condition type will always default to 1 (to represent Pre-admit Health Conditions).
- Discharge Assessments - For any diagnosis occurrence greater than 1, the diagnosis condition type will always default to 2 (to represent Post-Admit Health Conditions).

Note that Transfer or Death Health Conditions (diagnosis condition type of W) will still need to be manually assigned.

FIM – Functional Independence Measure

Functional Independence Measure is the sum of all scores/values entered on fields 41 – 58 which denotes a GREEN COLOUR Icon in the Field Requirements Bar. They can be found under the section Activities and Participation. The FIM instrument includes the following data elements:

- | | |
|---------------------------------------|---------------------------------|
| 41. Eating | 50. Transfers: toilet |
| 42. Grooming | 51. Transfers: tub or shower |
| 43. Bathing | 52. Locomotion: walk/wheelchair |
| 44. Dressing – Upper Body | 53. Locomotion: stairs |
| 45. Dressing – Lower Body | 54. Comprehension |
| 46. Toileting | 55. Expression |
| 47. Bladder Management | 56. Social Interaction |
| 48. Bowel Management | 57. Problem Solving |
| 49. Transfers: bed, chair, wheelchair | 58. Memory |

FIM calculates as each field is entered. FIM values are not carried over to the Discharge Assessment.

Activities and Participation			
☐	Eating	5	Supervision or Setup
☐	Grooming	5	Supervision or Setup
☐	Bathing	5	Supervision or Setup
☐	Dressing-Upper Body	5	Supervision or Setup
☐	Dressing-Lower Body	5	Supervision or Setup
☐	Toileting	5	Supervision or Setup
☐	Bladder Management	1	Total Assistance
☐	Bowel Management	1	Total Assistance
☐	Transfers: Bed, Chair, Wheelchair	1	Total Assistance
☐	Transfers: Toilet	1	Total Assistance
☐	Transfers: Tub or Shower	2	Maximal Assistance
☐	Locomotion: Walk/Wheelchair	3	Moderate Assistance
☐	Locomotion: Walk/Wheelchair-Mode	3	Both
☐	Locomotion: Stairs	4	Minimal Contact Assistance
☐	Comprehension	4	Minimal Prompting
☐	Comprehension-Mode	1	Auditory
☐	Expression	3	Moderate Prompting
☐	Expression-Mode	3	Both
☐	Social Interaction	3	Moderate Direction
☐	Problem-Solving	3	Moderate Direction
☐	Memory	5	Supervision

Figure 400 – Clinical NRS – FIM Values

On the Assessment grid, once a FIM field is highlighted, press the F2 function key or double-click. The usual look-up table will then display. The relevant information for that value displays in the Look Up Notes field.

Search Results

Eating

User Code	User Description	Validate Code	Validate..	Look Up Note
1	Total Assistance	1	Total Assistance	Client performs less than 25% of eating tasks. Or, the individual relies on parenteral or gastrostomy feedings, and does not...
2	Maximal...	2	Maximal...	Client performs 25% to 49% of eating tasks. Example: Helper scoops every bite and helps lift.
3	Moderate...	3	Moderate...	Client performs 50% to 74% of eating tasks. Example: Helper puts every bite on spoon. Client takes food to mouth; chews and...
4	Minimal Contact...	4	Minimal Contact...	Client performs 75% or more of eating tasks. Examples: Helper checks for pocketing of food; or helper physically assists picking...
5	Supervision or...	5	Supervision/Exos...	Client requires supervision (e.g. standing by, cueing, or coaxing) or setup from helper (application of orthoses or assistive/adaptive...
6	Modified...	6	Modified...	Client requires an assistive device, more time to eat, or modified food consistency, or there are safety considerations. If relies on...
7	Complete...	7	Complete...	Client eats from a dish, and drinks from a cup with the meal on a table or tray. The client opens containers, and uses a spoon or...

Figure 401 – Clinical NRS – FIM

Record Validation and Submission Date

- CIHI mandates that as of their annually-specified date, any assessments not already submitted that fall into the previous fiscal year, MUST be submitted under the new fiscal year edits/requirements.
- To accommodate this requirement, WinRecs has a setting in the Rehab institution profile where this annual date is entered. This field is the “Record Validation and Submission Date.” (Please see the section on NRS Submissions for more information).
- When an assessment is being completed in WinRecs, if it belongs to the previous fiscal year’s data, and the current system date is AFTER the Record Validation and Submission Date, the most current fiscal year edits/requirements will be applied to the assessment.
- This may result in some unexpected error messages appearing at the bottom of the screen – but these will be relevant to the current fiscal year’s edit requirements and must be completed correctly.

NRS RPG Grouper

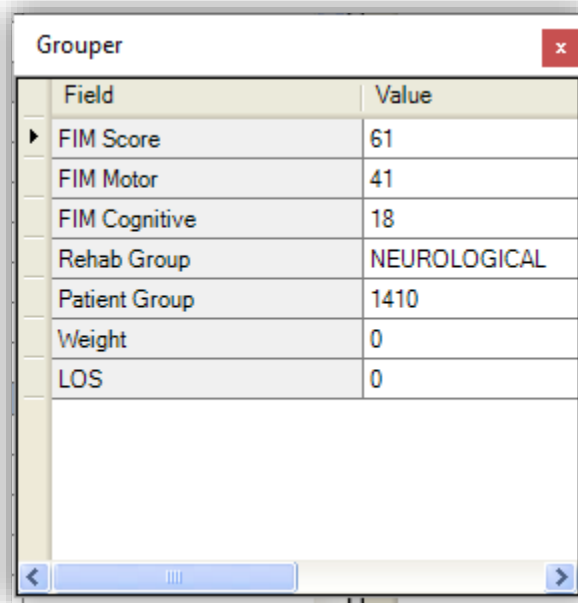
- To provide an integrated grouper and weighting methodology for adult inpatient rehabilitation care within the MED2020 National Rehabilitation Reporting System (NRS) module.
- The embedded grouper and weighting methodology will allow MED2020 Clients to account for adult rehabilitation care data into their funding formula which is then reported to Canadian Institute for Health Information (CIHI) and eventually their Provincial counterparts. Of note, currently, Ontario is the sole province where adult rehabilitation reporting is mandated. Data calculated by the rehabilitation grouper will be stored within the WinRecs database, allowing users to report on the data by use of accompanying pre-designed reports or ad-hoc reports created by the user facility by means of Crystal Reports™.
- The Rehabilitation Cost Weight (RCW) represents an average relative resource use for patients in an RPG. The data used to develop cost weights for the RPG was drawn from two sources of Ontario data: the National Rehabilitation System (NRS) and the Ontario Cost Distribution Methodology (OCDM).

- At discharge, each patient episode is assigned an RCW. The RCW depends on the assigned RPG and the length of stay (LOS) of the episode of care.

Using the NRS RPG Grouper

Once the facility has purchased the NRS Grouper and the WinRecs Update has been applied to their WinRecs database, any user with permissions to the NRS Module will be able to view the NRS Grouper information in the FIM/RPG grid of admission and/or discharge assessments.

- When the Admission assessment has had adequate data entered to complete the calculation, the grouper data will display in the relevant cells in the FIM table.
- Initial values are displayed at completion of the Admission Assessment however the full calculation is applied to the FIM grid once the Discharge Assessment has been completed.



Field	Value
FIM Score	61
FIM Motor	41
FIM Cognitive	18
Rehab Group	NEUROLOGICAL
Patient Group	1410
Weight	0
LOS	0

Figure 402 – Clinical NRS – RPG Grouper

Batch Grouper

Batch Grouping Batch Grouping of NRS RPG data is available using the Batch Grouping functionality in the Utilities menu. Please see Using the Batch Grouper section in this User Guide for detailed information on the steps required.

6.16 Clinical – OMHRS (Ontario Mental Health Reporting System)

The Ontario Mental Health Reporting System (OMHRS) serves to standardize the capture of mental health clinical and administrative information.

To open the Clinical Modules – [OMHRS]-XX Ontario Mental Health Registry System

- Select the menu option **Module → Clinical → [MHRs]Mental Health Registry System**
— or —
- Select **WinRecs Module Menu → Clinical→ [MHRs]Mental Health Registry System**

The Ontario Mental Health Registry System module has the following assessment types:



Figure 403 – OMHRS – Assessment Types

Assessment Types

- MHRs- FA – Record Type 3 - Full Admission Assessment
- MHRs-SS – Record Type 7 – Short Stay Assessment
- MHRs-CS – Record Type 6 – Change in Status Assessment
- MHRs-QA – Record Type 4 – Quarterly Assessment
- MHRs – DA – Record Type 5 – Discharge Assessment

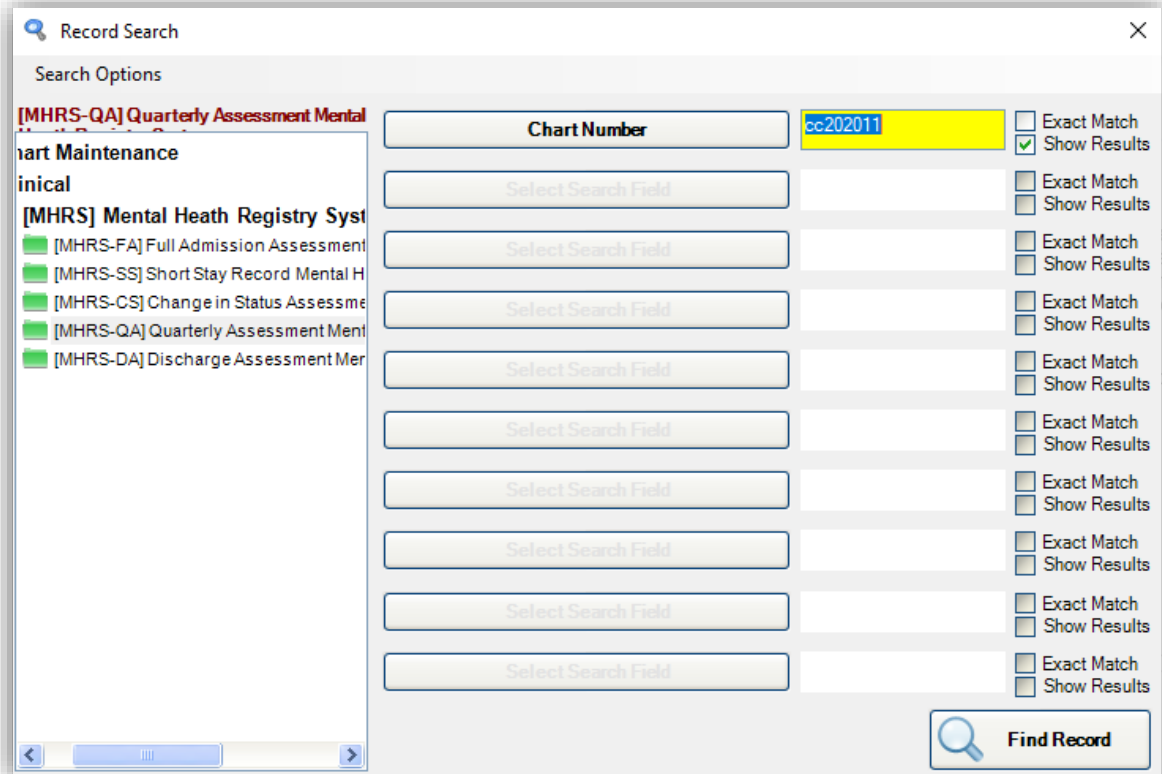
All the assessment types will display in the Patient Visit History.

Visit History ✕				
CC2-0200-3 ...				
	...	Module	Institution	Visit Date
☐		MHRS S	52020	2020/04/16
☒		MHRS D	52020	2020/04/14
☐		MHRS C	52020	2020/04/13
☐		MHRS Q	52020	2020/04/12
☐		MHRS F	52020	2020/04/01

Figure 404 – Clinical OMHRS – Patient History Assessment Types

Searching for a Clinical OMHRS Visit

- Click on any of the Assessments and press F4 to search for the record (Please see section [5.1 Searching for a Record](#)).
- The ability to search on any field within that assessment. For example: if the [MHRS] Mental Health Reporting System is chosen, a search can be done on any of the fields in that assessment by clicking on the field name in the middle column. When the search results screen is displayed all assessments for that search option will display.
- When a search is made by Health Record Number or Patient Name all the assessments will display for that patient.



Record Search

Search Options

[MHRS-QA] Quarterly Assessment Mental Health Registry System

Chart Maintenance

Initial

[MHRS] Mental Health Registry System

- [MHRS-FA] Full Admission Assessment
- [MHRS-SS] Short Stay Record Mental Health
- [MHRS-CS] Change in Status Assessment
- [MHRS-QA] Quarterly Assessment Mental Health
- [MHRS-DA] Discharge Assessment Mental Health

Chart Number cc202011

☐ Exact Match

☒ Show Results

Select Search Field

☐ Exact Match

☐ Show Results

Select Search Field

☐ Exact Match

☐ Show Results

Select Search Field

☐ Exact Match

☐ Show Results

Select Search Field

☐ Exact Match

☐ Show Results

Select Search Field

☐ Exact Match

☐ Show Results

Select Search Field

☐ Exact Match

☐ Show Results

Select Search Field

☐ Exact Match

☐ Show Results

Select Search Field

☐ Exact Match

☐ Show Results

Find Record

Figure 405 – Clinical OMHRS – Record Search

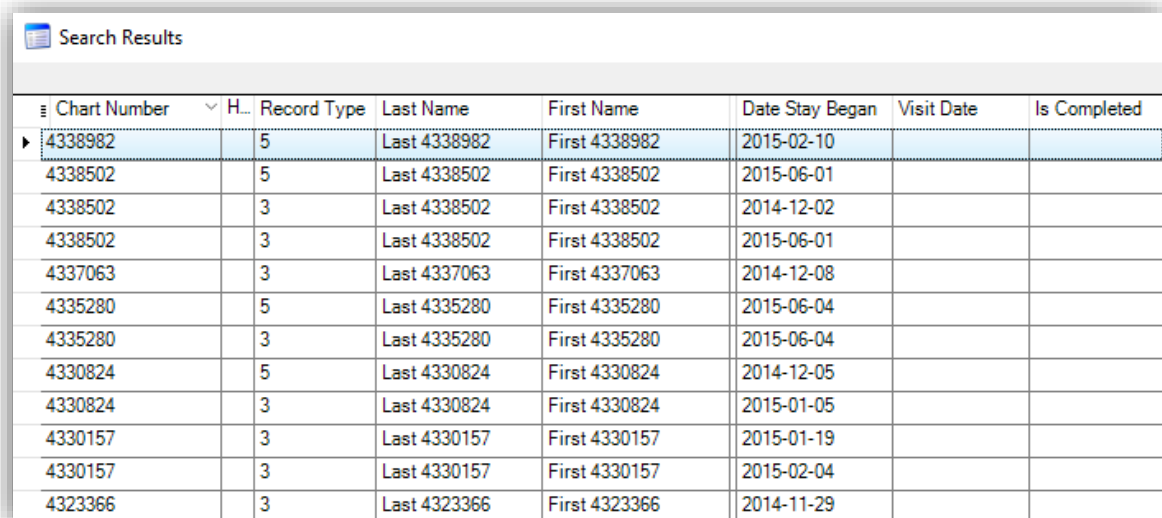


Chart Number	H.	Record Type	Last Name	First Name	Date Stay Began	Visit Date	Is Completed
4338982	5		Last 4338982	First 4338982	2015-02-10		
4338502	5		Last 4338502	First 4338502	2015-06-01		
4338502	3		Last 4338502	First 4338502	2014-12-02		
4338502	3		Last 4338502	First 4338502	2015-06-01		
4337063	3		Last 4337063	First 4337063	2014-12-08		
4335280	5		Last 4335280	First 4335280	2015-06-04		
4335280	3		Last 4335280	First 4335280	2015-06-04		
4330824	5		Last 4330824	First 4330824	2014-12-05		
4330824	3		Last 4330824	First 4330824	2015-01-05		
4330157	3		Last 4330157	First 4330157	2015-01-19		
4330157	3		Last 4330157	First 4330157	2015-02-04		
4323366	3		Last 4323366	First 4323366	2014-11-29		

Figure 406 – Clinical OMHRS – Search Patient Display

- Double click on the assessment that needs to be accessed.
- When the assessment displays all fields previously inputted will display.
- To go to other assessments, click on the other assessments displayed in the Patient Visit History.

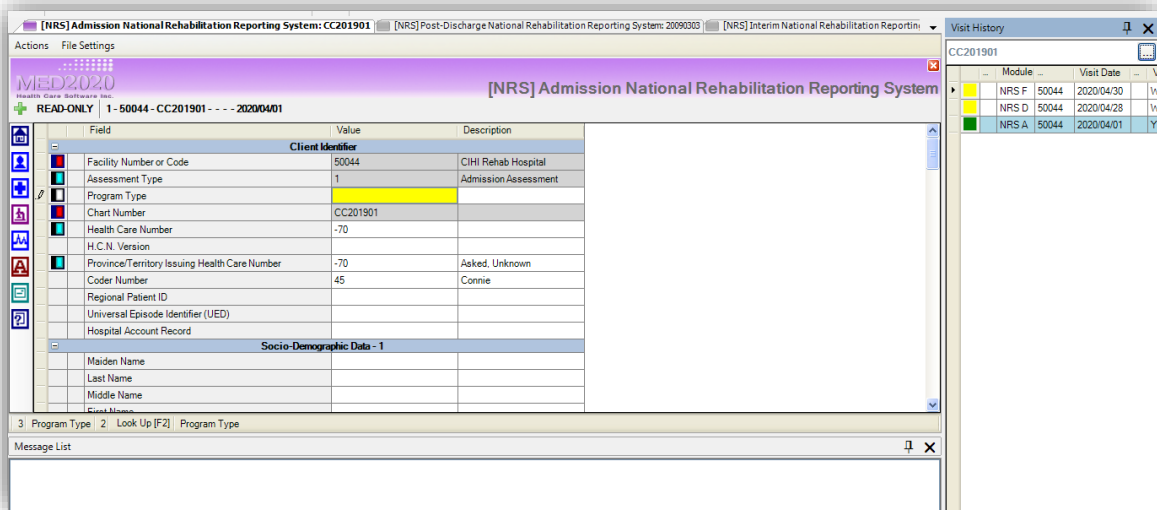


Figure 407 – Clinical NRS – Patient Assessment

Facilities that have a batch or HL7 (real-time) interface transferring records into the WinRecs program will use the F4 search function to locate the assessment records they need to complete.

Creating a New Assessment for a Clinical OMHRS Visit

There will be 2 occasions when an assessment will need to be manually created within WinRecs. One is the Quarterly assessment, the other is the Change in Status assessment. Both assessments are created the same way and follow the same steps.

- A Quarterly assessment is required when a patient has stayed more than 92 days since the last assessment was done.
- A Change In Status assessment is required when “a patient has had a major physical, mental, or social change/event that would render the current assessment and care plan invalid” (CIHI 2006).
- Click on the Assessment Type that needs to be created and press New [F5] (See [5.2 Creating a New Record](#))

A facility that does not have an interface to transfer the patient visit information into WinRecs ® will use the F5 (*new*) function to create a new assessment record.

SCIPP Grouper (System for the Classification of In-Patient Psychiatry)

The System for the Classification of In-Patient Psychiatry grouper is available to clients to purchase in addition to the OHMRS module. The SCIPP grouper data can be found in the right-hand display panel of the OMHRS module, if you are unable to see the Grouper Calculator, go to View/Grouper Calculator. An associated "auto-calculate SCIPP Grouper" option has been added to the User Profile. SCIPP Grouper pre-designed reports have been made available.

The SCIPP Grouper is only available to clients who have purchased this functionality in addition to the OHMRS module.

Batch Grouper

Batch Grouping Batch Grouping of SCIPP data is available using the Batch Grouping functionality in the Utilities menu. Please see Using the Batch Grouper section in this User Guide for detailed information on the steps required.

6.17 Clinical – [IRRS] Integrated interRAI Reporting System - LTCF

To open the Clinical Modules – [IRRS]-Integrated interRAI Reporting

- Select the menu option **Module → Clinical → [IRRS]-Integrated interRAI Reporting**
— or —
- Select **WinRecs Module Menu → Clinical → [IRRS]-Integrated interRAI Reporting**

The module contains the following assessments:

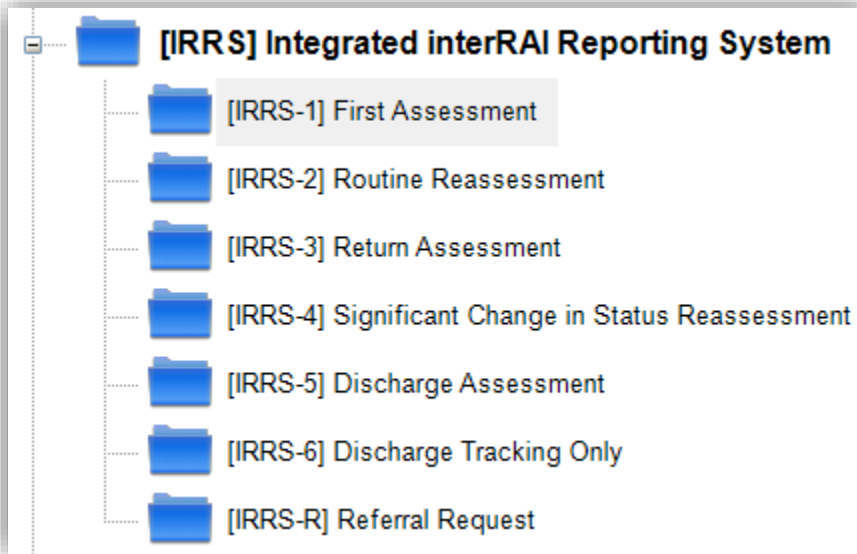


Figure 408 – IRRS – Assessment Types

Assessment Types:

- First Assessment
- Routine Assessment
- Return Assessment
- Significant Change in Status Assessment
- Discharge Assessment
- Discharge Tracking Only – within the assessment is a field called 'Discharge Tracking Type' where you choose Regular, First or Return
- Referral Request – used by Receiving facility when person is transferred to facility from other InterRai facility.

Creating a New IRRS Assessment

- To create a new assessment for First Assessment, Routine Assessment, Return Assessment, Significant Change Assessment, Discharge Assessment (Regular, Return), Discharge Tracking (Regular, Return):
 - Click on the Assessment Type that needs to be created and press New [F5] (See [5.2 Creating a New Record](#))
- To create a new assessment for Discharge Assessment First or Discharge Tracking First.
 - Create a new or search for the First Assessment
 - Go to Actions/Change Assessment Type
 - Choose which Discharge First you would like to complete, and the First Assessment will change to that Discharge Assessment first or Discharge Tracking First:

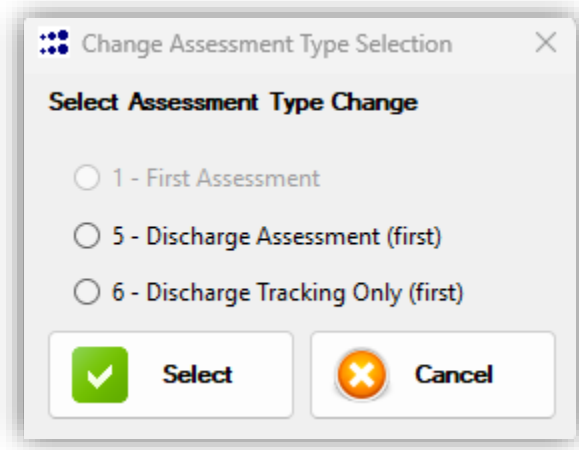


Figure 409 – IRRS – Creating Discharge Assessment/Discharge Tracking First

Important: Discharge Assessment First and Discharge Tracking First must be created from the First Assessment by opening the First Assessment go to Actions/Change Assessment Type and choose the appropriate Discharge.

Searching for a IRRS Visit

- Click on any of the Assessments and press F4 to search for the record (Please see section [5.1 Searching for a Record](#)).
- The ability to search any field within that assessment. For example: if the [IRRS] Integrated interRAI Reporting System is chosen, a search can be done on any of the fields in that assessment by clicking on the field name in the middle column. When the search results screen is displayed all assessments for that search option will display.
- When a search is made by Health Record Number or Patient Name all the assessments will display for that patient.
- Double click on the Assessment to upload it.
- Press F6/F7 to save. A pop up will display asking 'Is this record ready to send for submission?' Pressing Yes will send submit the record if user is connected to CIHI Service or will wait till connection to the service occurs. Pressing No will put the assessment in the IRRS Submit Approve List.

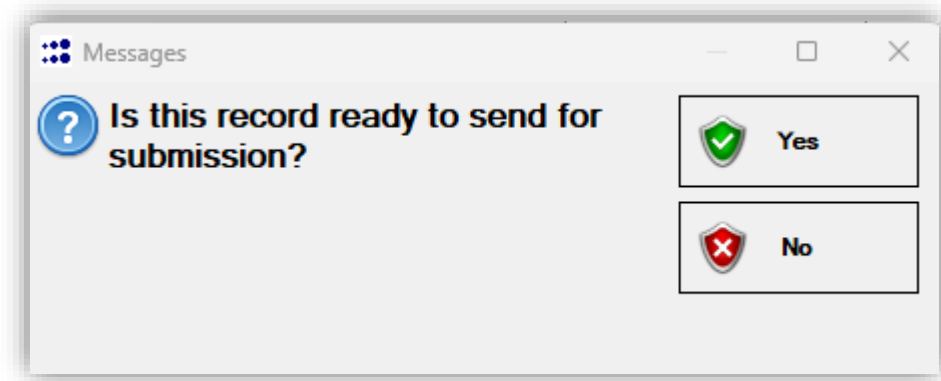


Figure 410 – IRRS – CIHI Submission Message

IRRS Actions Menu

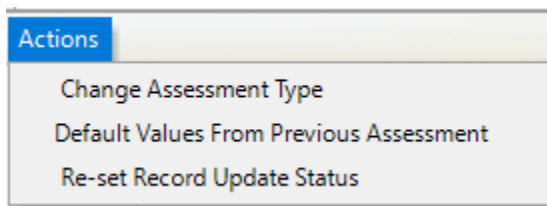


Figure 411 – IRRS – Action Menu

Change Assessment Type

Used to change First Assessment to Discharge Assessment First or Discharge Tracking First

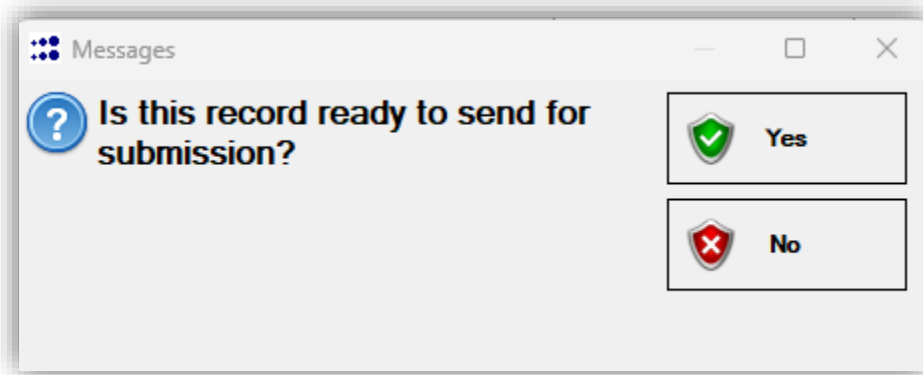
Default Values from Previous Assessment – when chosen will populate values from the previous assessment. Cannot be used for First Assessments. Can also auto populate from the previous assessment by going to Options/Institution Profile/Settings/Copy Data from Latest Assessment – change this field to Yes, for assessment created by User or Interface. This will auto populate that assessment.

Re-set Record Update Status – When a user saves a record that has been interfaced in the records is flagged as not being able to update if the interface is run again. This will remove the flag and allow fields to be updated if the interface is run again.

IRRS Submissions

1. **System Registration** – to submit assessments to CIHI, sites must first contact CIHI to complete the System Registration.
 - Once registration is confirmed, the site will need to download the ASCII file and the exe will be run on the server to allow connection to CIHI via a service.
2. **Submitting to CIHI**

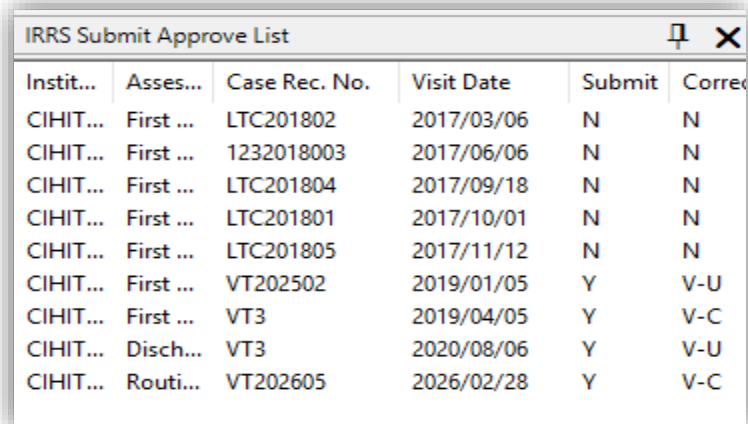
- Once an Assessment is Validated and Completed without any errors, a message will pop up asking:



- Selecting Yes – if the user is connected to the service this will submit the assessment to CIHI. If the user is not connected to the service, once you connect the assessment will be submitted.
 - When selecting 'Yes' the screen will clear and opening 'IRRS Submit Viewer' will show if the Transactions if PASS or FAIL. If the screen does not clear, the service is not connected to WinRecs.
 - Clicking on the transaction and choosing 'Select' will reload the assessment.
- Selecting No – will put the assessment on the 'IRRS Submit Approve List'.

3. Submission Windows:

- IRRS Submit Approve List** – Go to **View/IRRS Submit Approve List** – this will display just like the Visit History
 - This will list all the records where it has been Validated and Completed but have not been submitted to CIHI
 - Double-click on the record and it will load. Resave the record and select "Y" and the record will be sent to CIHI.

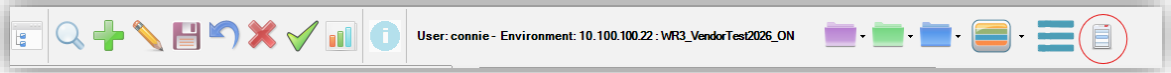


Instit...	Asses...	Case Rec. No.	Visit Date	Submit	Correc
CIHIT...	First ...	LTC201802	2017/03/06	N	N
CIHIT...	First ...	1232018003	2017/06/06	N	N
CIHIT...	First ...	LTC201804	2017/09/18	N	N
CIHIT...	First ...	LTC201801	2017/10/01	N	N
CIHIT...	First ...	LTC201805	2017/11/12	N	N
CIHIT...	First ...	VT202502	2019/01/05	Y	V-U
CIHIT...	First ...	VT3	2019/04/05	Y	V-C
CIHIT...	Disch...	VT3	2020/08/06	Y	V-U
CIHIT...	Routi...	VT202605	2026/02/28	Y	V-C

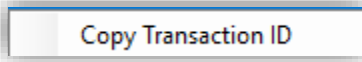
Figure 412 – IRRS Submit/Approve List

• IRRS Submit Viewer

- Icon is circled in red below



- Displays all the Successful and Failed transactions sent to CIHI.
- Enter the Inst Number, Date From and Date To (this is date submitted), Press Search to display the transactions. Additional Fields to sort on is Nursing Unit/Area and Coder Number.
- Click on a transaction below and Click 'Select' and it will open the assessment.
- Right clicking on the transaction will display 'Copy Transaction ID'. CIHI may ask for this Transaction ID if there is an issue and they need to review the transaction.



View Successful:

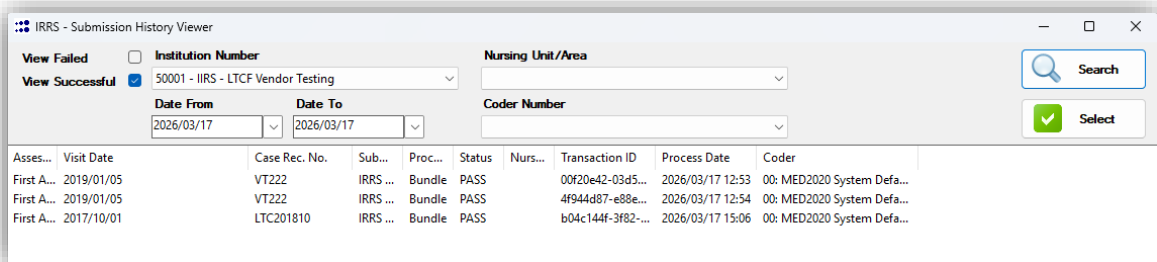
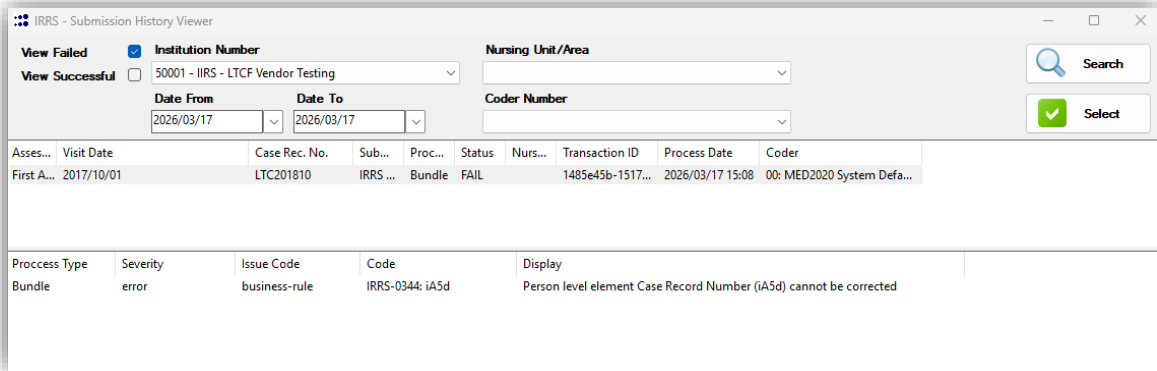


Figure 413 – IRRS – Submission History Viewer – Successful Submissions

View Failed:

- When you click on the FAIL transaction the bottom will show what the error is and the error code.
- Only displays the most recent error, once the assessment is complete and submitted successfully the FAIL transaction will disappear.



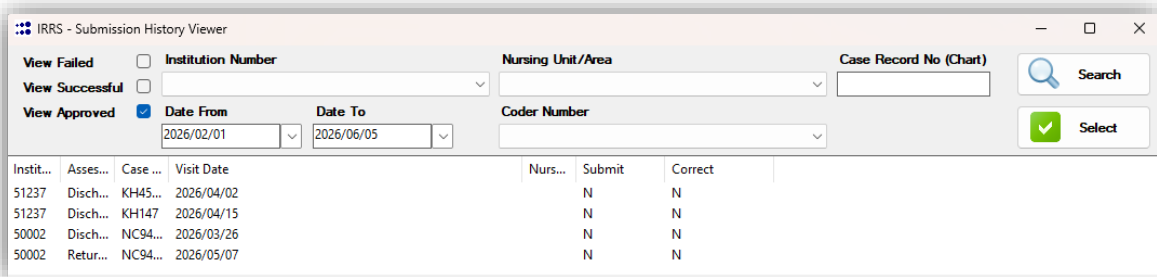
Asses...	Visit Date	Case Rec. No.	Sub...	Proc...	Status	Nurs...	Transaction ID	Process Date	Coder
First A...	2017/10/01	LTC201810	IIRS ...	Bundle	FAIL		1485e45b-1517...	2026/03/17 15:08	00: MED2020 System Defa...

Process Type	Severity	Issue Code	Code	Display
Bundle	error	business-rule	IIRS-0344: iA5d	Person level element Case Record Number (iA5d) cannot be corrected

Figure 414 – IRRS – Submission History Viewer – Failed Submissions

View Approved:

- Displays all records that are completed and still need to be submitted.



Instit...	Asses...	Case ...	Visit Date	Nurs...	Submit	Correct
51237	Disch...	KH45...	2026/04/02		N	N
51237	Disch...	KH147	2026/04/15		N	N
50002	Disch...	NC94...	2026/03/26		N	N
50002	Retur...	NC94...	2026/05/07		N	N

Figure 415 – IRRS – Submission History Viewer – View Approved

• IRRS Failed Submit List

- Under View/IRRS Failed Submit List
- Displays all Failed Submissions (Just like the IRRS Submit Viewer).
- Click on a transaction and the error message will display below.
- Once the file has been submitted successfully the transaction will disappear.

IRRS Failed Submit List					
Assess...	Sub...	Proc...	Case Rec. ...	Status	Transaction ID
First As...	IRRS ...	Bundle	201801	FAIL	f992c9c0-ef51-
Dischar...	IRRS ...	Bundle	VT202503	FAIL	809434a5-7be8.
Return ...	IRRS ...	Bundle	VT1	FAIL	1dbaec8e-4a0..
Proc...	Sever...	Issue Code		Code	Display
Bundle	error	business-r...		IRRS-0344: iA5d	Person level el

Figure 416 – IRRS Failed Submit List

4. Submission Control Data Elements:

The following are created after a successful submission:

- CIHI Patient ID – is the patient also known as Client ID – is the patient ID is associated with the administrative fields that are submitted to CIHI. The patient ID will always be the same for each patient unless it is discharged. Also know as Patient Information.
- CIHI Encounter ID – encounter ID will be the same from the First Assessment to Discharge, if patient comes back after a discharge, it is a new encounter ID.
- CIHI Assessment ID – each assessment will have its own Assessment ID
- Transaction ID – is the ID for that submission found on the Submit Viewer for transactions that have a PASS or FAIL. Right clicking on the ID will copy. CIHI may ask for this when troubleshooting.

5. Corrections and Updates

Updates

- Some fields can be sent as a correction or an update. If the fields are combined with fields that can only be sent as a correction, then these fields will be sent as a correction. If you would like to send as an update, then it will need to be done separately.
- The following pop up will display when the only fields can be Updated or Corrected:

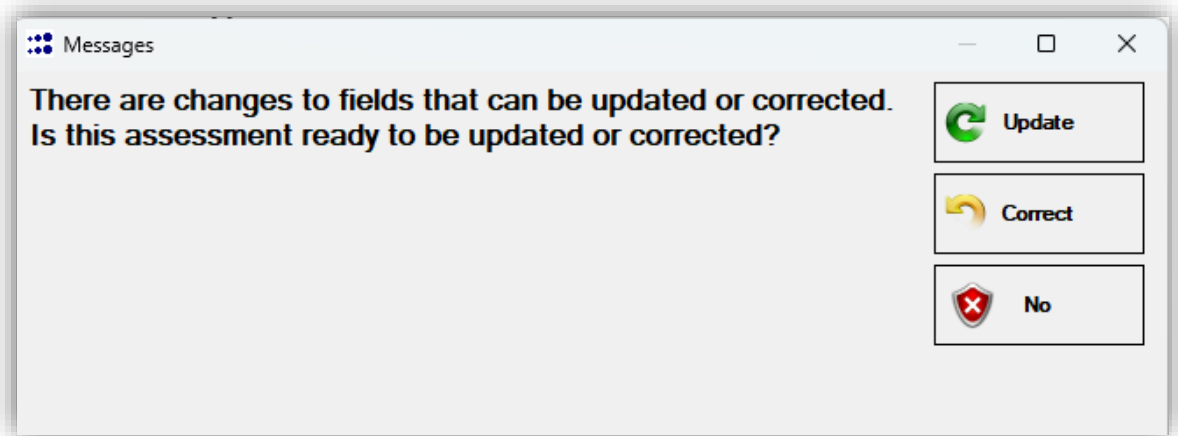


Figure 417 – IRRS – Update/Correction Message

- Update – sends the field as an update to CIHI
- Correct – sends the field as a correction to CIHI
- No – will not send the file

Correction

- Fields that are sent as a correction the following will display:

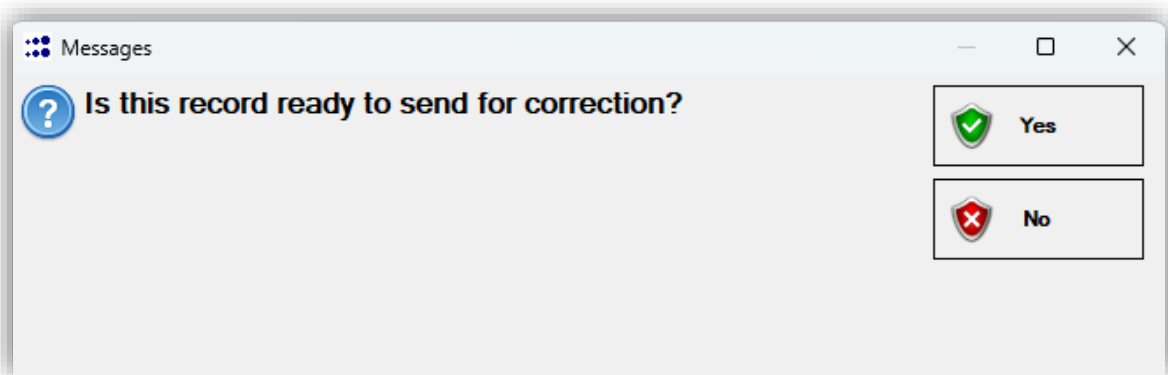


Figure 418 – IRRS – Correction message

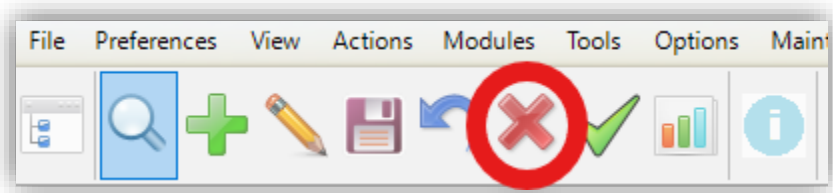
Update/Correction sent to CIHI

- When the update or correction is sent to CIHI, the assessment will clear.
- Clicking on the 'IRRS Submit Viewer' will display if the assessment was a PASS or FAIL or the ability to reload the assessment.

6. Deletions

Deleting requires the most recent assessment being deleted then back to the First Assessment. When sending in a First Assessment, encounter and patient information will be deleted as well.

- To delete an assessment press on the red x in the tool bar.



- **Unsubmitted Assessments** – will go the Purge/Recover Records
- **Submitted Assessment** – will be submitted to CIHI, screen will go blank when submission occurs.

7. WinRecs Regional Solution

A Regional Solution is defined as a WinRecs implementation for a group of health regions, hospitals or sites using one single WinRecs installation. In this environment, each hospital can store and work with patient data independently from other sites in the regional solution. Regional users can be defined for situations where a user, regardless of physical location requires access to records belonging to a different site.

The Regional Solutions is determined by the one icon:

- Profile Links



Figure 419 – Regional Solution – Profile Links Icon

- Clicking on Profile Links will open the following window:

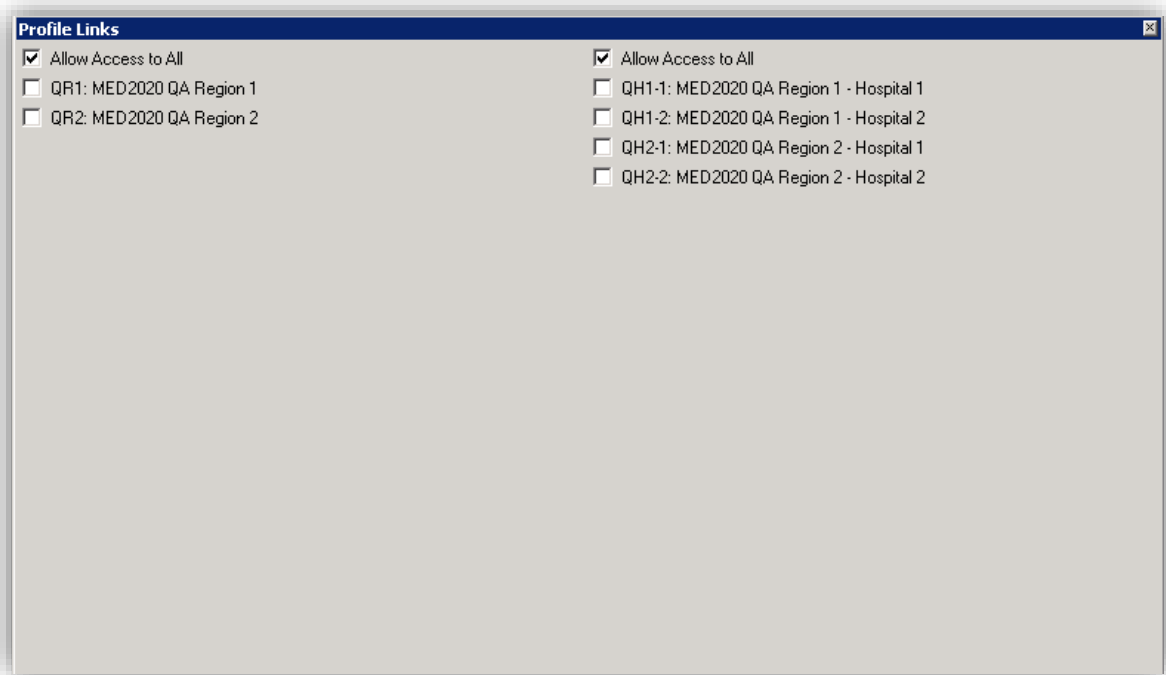


Figure 420 – Regional Solution – Profile Links Screen

- The left hand side lists all the Regions and the Right Hand Side lists all the Hospitals.
- For each module that has the Profile Links, able to assign a user, field, project etc. to a specified region(s) or hospital(s)

8. Glossary

Abstracting

Procedure whereby a coder captures electronically, with WinRecs, records of a single in-patient or out-patient episode (visit event) that is usually sent to CIHI and the appropriate provincial ministry of health, after the patient is discharged.

CCR (Concurrent Review)

The process of starting to abstract prior to patient discharge.

Submission

The process of submitting abstracted information to CIHI.

CCI

Canadian Classification of Health Interventions.

CIHI

Canadian Institute for Health Information, the organization that defines and manages healthcare information in Canada.

DAD

Discharge Abstract Database

ICD-10-CA

International Statistical Classification of Diseases and Related Health Problems Tenth Revision, Canada.

NACRS

National Ambulatory Care Reporting System

Occurrence

Certain data elements can occur multiple times per visit. These are tracked as occurrences. A patient may have multiple diagnoses and interventions during a hospital visit. Occurrences are handled in WinRecs using multi-forms.

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