



GROUP PROJECT – MILESTONE 1

System Analysis and Design

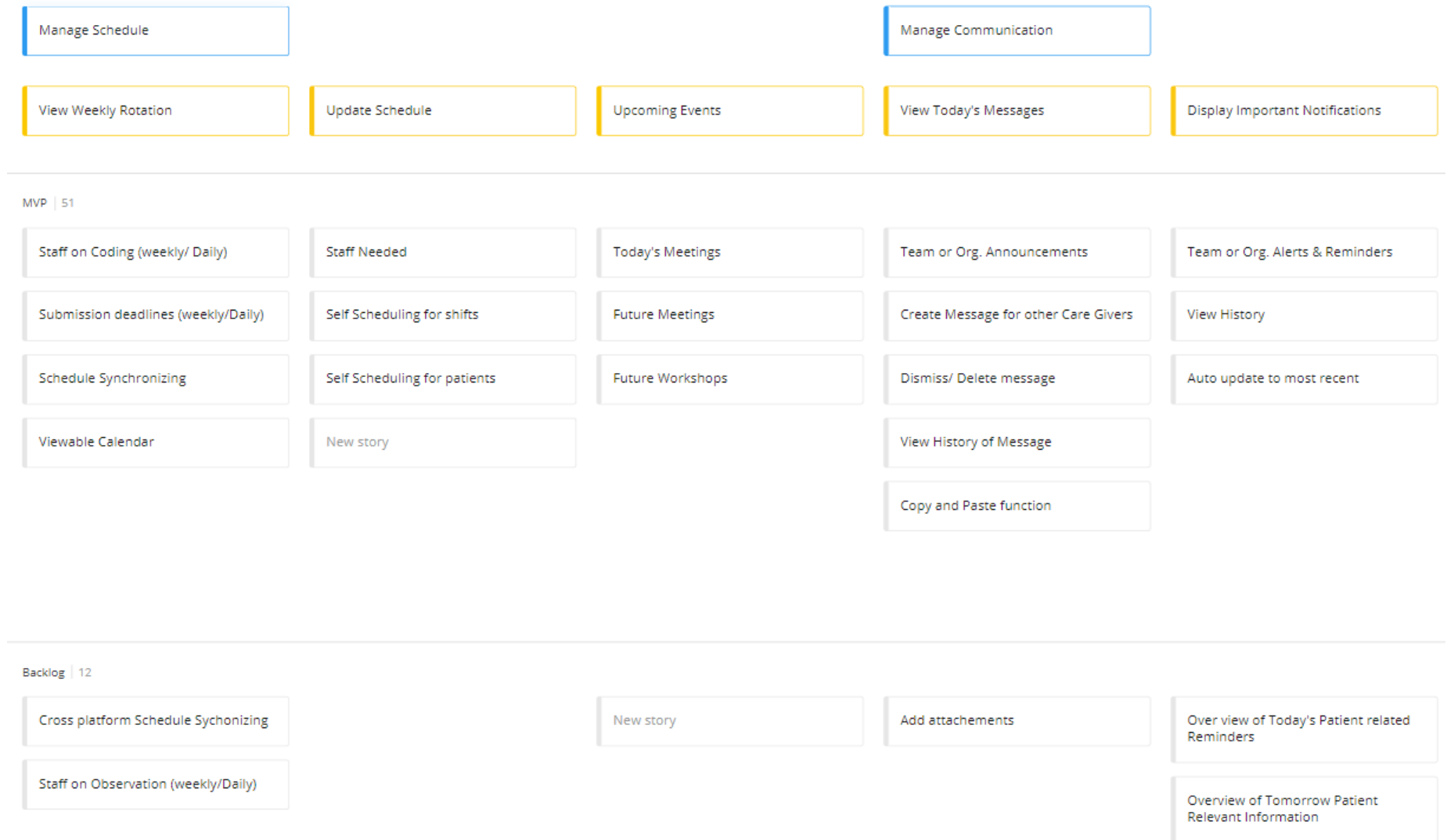
Alice Gao & Sabrina Ma

1. Target Audience	PSW*	Rai Coordinator*	Nurses and Care planners
2. Solution Name			<u>Inter-Care</u>
3. Top-level Vision Statement	Better process to flowsheet, recording, and observation reliability.	Improving scheduling, coordination, and communication between care teams.	Improving efficiency and centralization of patient information and painting an accurate picture of patient care for care planning.
Functional Goals	<p>- Questionnaire option of selecting among RAIMDS PACS/RAPs with relevant fields that are appended on the page for entry based on question answers instead of flipping between pages. I.e. this website: https://jgthms.com/web-design-in-4-minutes/#centering</p> <p>-Under assumption that this RAI Program extends beyond LTC facility- fast self-scheduling option that syncs up to employer scheduling system >option to sign up for shifts/ repeat patients to build relation & information reliability- and self-removal from those residents if necessary</p>	<p>- Scheduling landing page where everyone can see the weekly rotation (observation, coding, submission etc) that loads quickly and responsively to changes</p> <p>- Readily available address book that's easy to search through by name, email, number, automatically links to email clients for ease of communication</p>	<p>- Flexible auto populate function for repetitive unchanging cases, that's intuitively adjustable for changing cases. (i.e. a question path: Has Patient John Doe's condition changed in: clear list of care conditions)</p> <p>- Easily seen custom note/notification button - that's responsive when needed and unobstructive when not.</p>
	- Alerts/bulletin options that is easily disposable and non-repetitive unless		

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	otherwise chosen by user.
4. Quality of System (non - functional) goals	<ul style="list-style-type: none">-Responsive pages, menus, and options that are fast loading<ul style="list-style-type: none">• Navigation should be intuitive and easy to see in the entire process of any tasks (be it coding/ observation/ note taking/scheduling/searches & results)• Visual design of pages and options that is focused and adjustable (i.e. increasing text size- accessibility level)

5. User story map



Managing Observations/ RAIMDS process

Organizing Care Plan

Search

Start New Observation or MDS

Revaluation Observations or MDS

Manage Current Level of Care Plan

View Patient Medical History

Manage Highlighted Information

Search under Patient/Communication/Schedule tab

Choose section(s)

Summary of Prev Assessment

One Page Summary of most Recent changes

view patient history by time frame

Current Medication/ Drug doses

Search patient name

Start assessment

Start Re-assess

Main interventions

update individual history

Patient specific Alert and Reminder

Search patient information

Questionnaire process

Add new Protocol in existing section

Prioritize by highest level of care

Demographics information

Special needs

Search Event

Finish Assessment

Add new protocol in new section

Prioritize by recent level of care

Allergy information

Specific instructions

Search Key Term

New story

Questionnaire process

Edit all fields

Key Medication Info

New story

Search Date

Finish Assessment

Search by Time/Shift

Print current Observations

Print Previous Observations

New story

search through patient history

Print Current MDS

Print Previous MDS

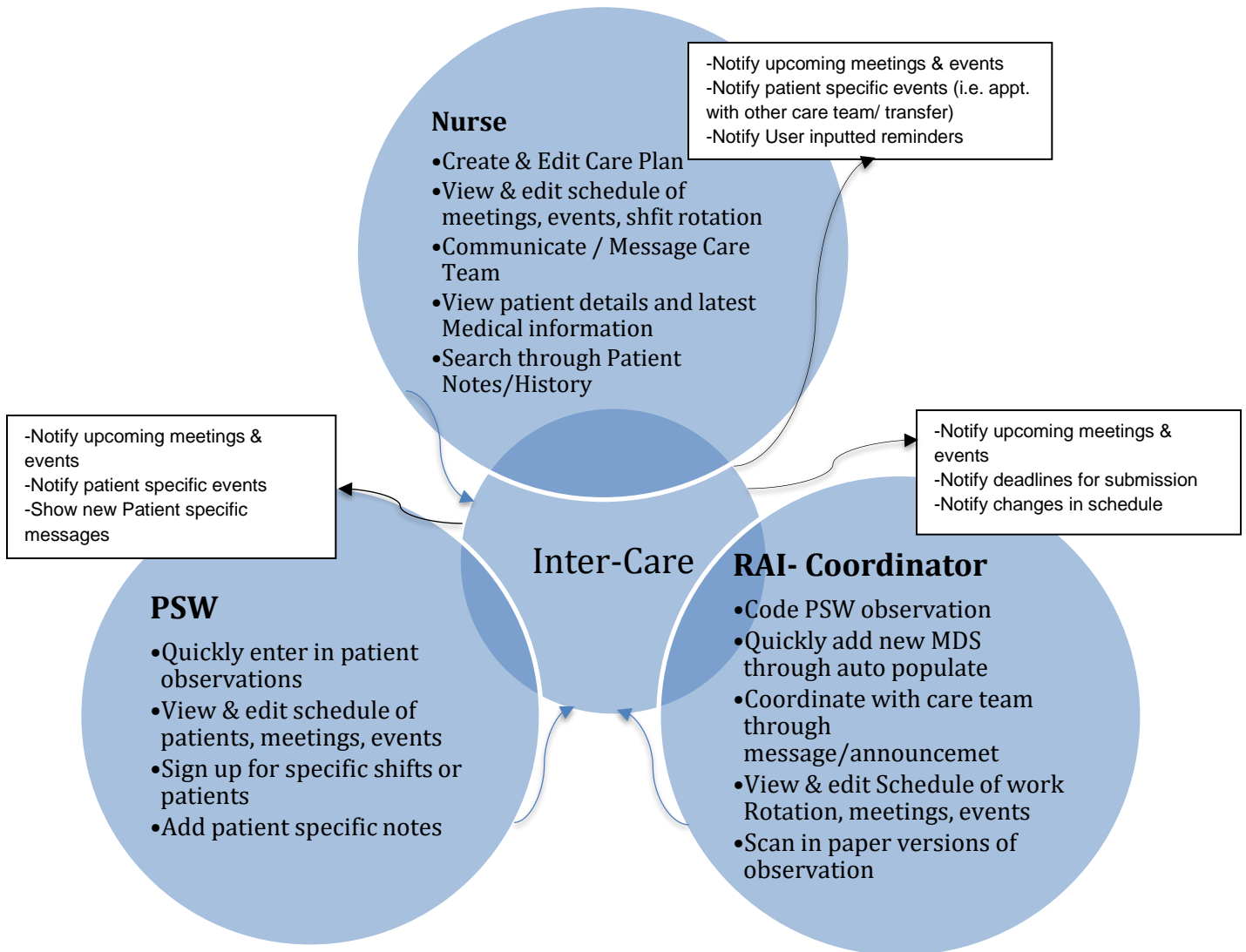
Scanning auto populate for paper process

6. End to end Assessment scenarios

Case 1: Mr.Z was admitted recently for a stroke. It has affected his left side and he has difficulty communicating, making assessment in many areas difficult. In the first week of observations, the PSWs and Nurse record Mr. Z as lethargic and passive. He also has high blood pressure and CAS (coronary artery spasm). He accepted all care from staff in the beginning, however, recently he's been acting up, and putting up a struggle to the nurse assistants & PSWs. On second week of care, Mr. Z's nurse noticed that he lashes out when approached from the left side, but the right side is fine. On a positive note, Mr. Z is starting to have a good response to environmental stimuli. He also has shown promise in his physical therapy and in range of motion exercises. Mr. Z requires further evaluation regarding his Care plan, such as any new approaches to nursing care, ophthalmology evaluation on any visual deficits, and a speech therapy referral. The team will discuss his care at a group meeting tomorrow and develop a fresh plan to address some of these issues.

Case 2: Mrs. A is an 80-year-old-woman, who is admitted to ABC long term care facility with diagnosis of Alzheimer's disease and hearing problems. It has been 3 days since the date her nurse documented that she has been acting differently. For instance, she is easily distracted by things. She did not pay attention to activities such as eating, drinking, and rarely talking to her friends. Also, she sleeps a lot during daytime and night. The care plan for Mrs. A is continue to observe her daily activities, discuss with the team for a new care strategy to encourage Mrs. A joining conversation with others, as well as rating and improving her level of depression, and adjusting her meal plans.

7. Context Diagram



Extra: Some Basic/ Rough UI mock ups

Care plan rough look

Patient name

Care Plan level
-Dgdrggf-
Dfgfdgdfgdg
-

interventions

diagnosis

Medical history

Start RAIMDS Assessment Page for Nurse/ Rai Coordinator

Loading page for New Patient:

Assessment Care Plan

New MDS

A. Identification Information	K. Oral/Nutritional Status
B. Cognitive Patterns	L. Oral/Dental Status
C. Communication/Hearing Patterns	M. Skin Condition
D. Vision Patterns	N. Activity Pursuit Patterns
E. Mood and Behaviour Patterns	O. Medications
F. Psychosocial Well-Being	P. Special Treatments and Procedures
G. Physical Functioning and Structural Problems	Q. Discharge Potential and Overall Status
H. Continence	R. Assessment Information
I. Disease Diagnoses	U. Medication List
J. Health Conditions	

Start

Start Observation Page for Nurse/ PSW

Loading page for New Patient:

Assessment Care Plan

New Observation

A. Identification Information	K. Oral/Nutritional Status
B. Cognitive Patterns	L. Oral/Dental Status
C. Communication/Hearing Patterns	M. Skin Condition
D. Vision Patterns	N. Activity Pursuit Patterns
E. Mood and Behaviour Patterns	O. Medications
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J. Health Conditions	

Start

Can Ctrl+ click to select multiple sections- start assessment goes to questionnaire process of determining relevant areas to observations/ MDS section.

RAIMDS Assessment page for patient with past assessments completed

Loading page for Existing

Assessment

Care Plan

Clinical Assessment Protocols

A: Functional Performance CAPs

Assessment Protocol	Previous	Current	CP
ADL1: Prevent decline	Yes	Yes	A
ADL2: Facilitate Improvement	No	No	A
Physical Restraints: ability to perform ADLs	No	No	New
Physical Restraints: inability to perform ADLs	No	No	New

Created at 10:14:32 in 218ms. 4 of 4 Rows Displayed.

B: Cognition/Mental Health CAPs

Assessment Protocol	Previous	Current	CP
Behaviour: prevent daily occurrences	No	No	New
Behaviour: reduce daily occurrence	No	No	New
Cognitive Loss: prevent decline	No	No	New
Cognitive Loss: risk of decline	Yes	Yes	New
Communication: potential	No	Yes	New

Reassess

RAIMDS Assessment page after Reassess button has been clicked. Blue and Red check boxes for noting changes or no changes, with capability to add to each section or new areas of care.

In progress MDS assessment:

Assessment

Care Plan

Clinical Assessment Protocols

A: Functional Performance CAPs

Assessment Protocol	Previous	Current
ADL1: Prevent decline	Yes	<input type="checkbox"/> <input type="checkbox"/>
ADL2: Facilitate Improvement	No	<input type="checkbox"/> <input type="checkbox"/>
Physical Restraints: ability to perform ADLs	No	<input type="checkbox"/> <input type="checkbox"/>
Physical Restraints: inability to perform ADLs	No	<input type="checkbox"/> <input type="checkbox"/>

B: Cognition/Mental Health CAPs

Assessment Protocol	Previous	Current
Behaviour: prevent daily occurrences	No	<input type="checkbox"/> <input type="checkbox"/>
Behaviour: reduce daily occurrence	No	<input type="checkbox"/> <input type="checkbox"/>
Cognitive Loss: prevent decline	No	<input type="checkbox"/> <input type="checkbox"/>
Cognitive Loss: risk of decline	Yes	<input type="checkbox"/> <input type="checkbox"/>

☐ Existing ☐ Add New

Add New Protocol

Finish Assessment