IQI Systems

User Guide for IQI Systems Intuition

Accessing IQI

1. Go to Internet Explorer (or your preferred browser) and enter your website address which is unique to your facility name: https://facilityname.iqisystems.com.

2. Alternatively, click on the IQI Icon installed on your desktop to access the system.

IQI

Logging In

1. The first screen you will see will require you to enter your user name and password. User names and passwords are managed by either IQI Systems and/or your facility administration staff. If you have problems with logging in please contact either IQI Systems or your facility administration.

2. The first time you log in, you will be asked to accept the HIPAA agreement for use of IQI Systems. Clicking on the 'I Agree' button will allow you full access (as provided by your administration/management staff) of all the features included.

Test Account   Current User: Sample

User Agreement

User acknowledges that the use of IQI Systems LLC and access to the IQI Systems Intuition will involve access to highly confidential information. User agrees to ensure that use of IQI Systems Intuition and all information obtained through its use by User is in compliance with all applicable laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all regulations relating thereto and any other laws and regulations governing restricted access to and the confidentiality of patient clinical records and individually identifiable health information. User agrees that User shall not disclose, by any means, such information to any unauthorized person, business, or other entity. User agrees that User shall not permit any unauthorized person, business or entity to review or copy any such information except as provided by law. User will be responsible for violation of any applicable law and for any misuse of that information.

[I Agree]

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Dashboard

1. The first page of the Intuition will show the Dashboard. This area has three major sections: (a) a graph of all Active Infections at your facility and (b) a list of all recent Alerts/Warnings and (c) navigation tabs in the upper right hand section.
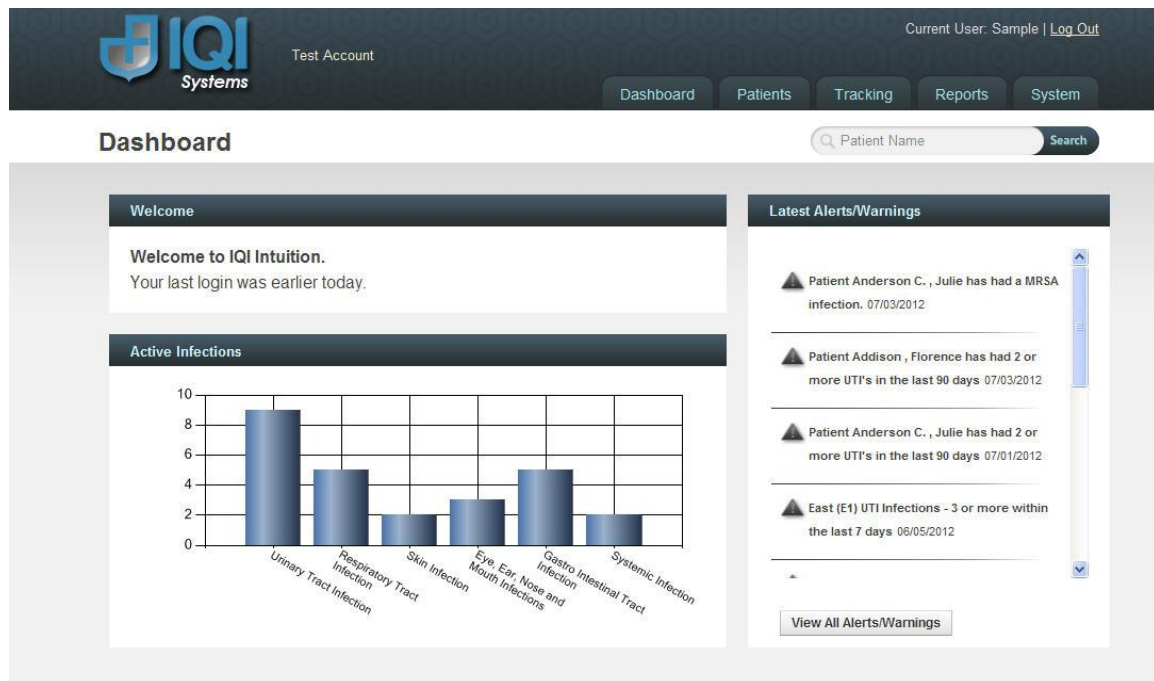

(A) Active Infections – This graph provides a 'snap shot' of all active infections at the facility. Each category is listed and the total number of each type of infection is shown on the graph.

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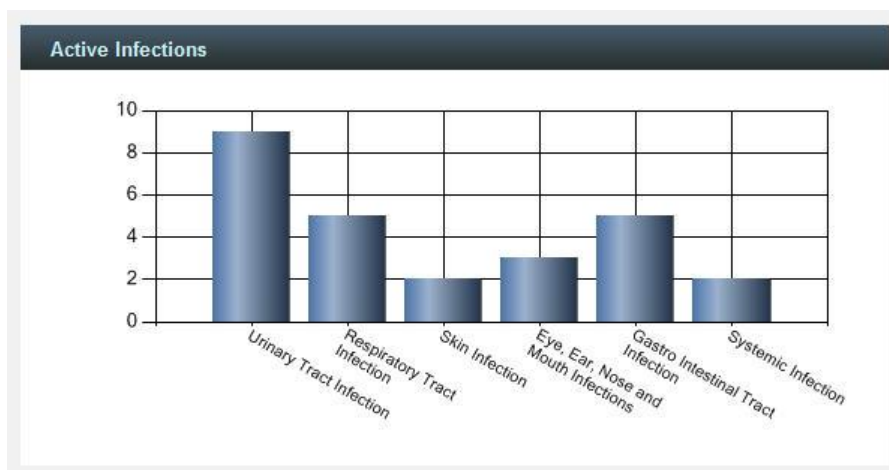
(B) Latest Alerts/Warnings – This area shows the most recent Alerts/Warning that were
generated by Intuition. Each of these provides a link to more details about the Alert/Warning.
Simply hover your cursor over the selected Alert/Warning and then left click your mouse.
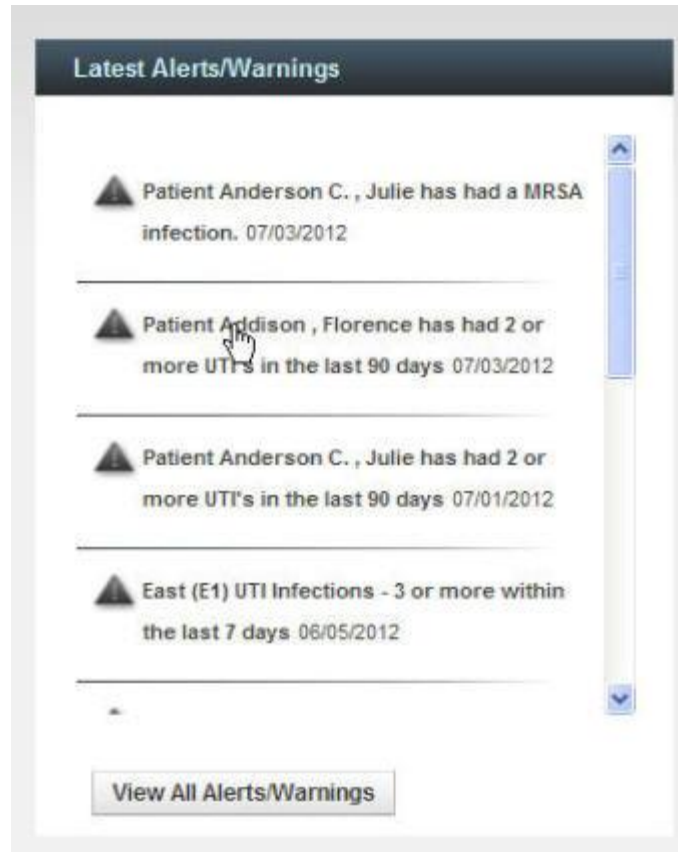
Clicking on the Alert/Warning will bring up another page with details. Each of the highlighted
details is also a link (either patient or the infection) where additional information is available.

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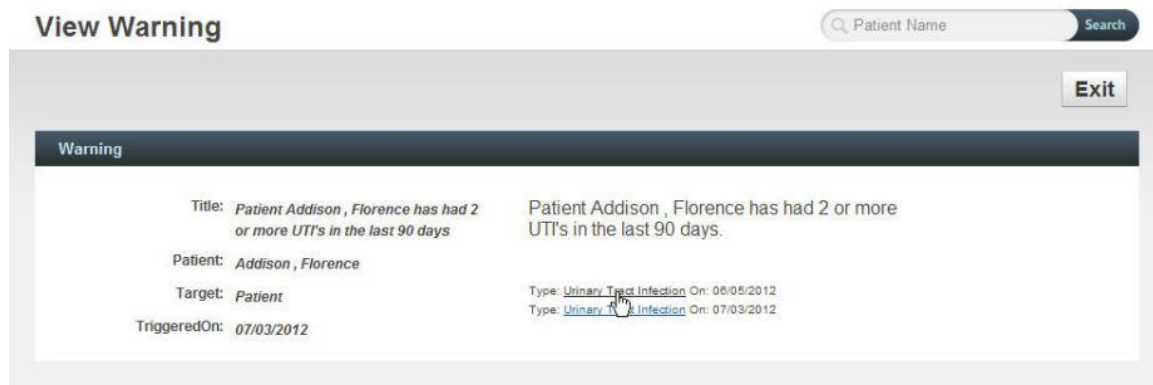
Clicking on the infection (or patient) will bring up detailed information about that specific infection/patient.


(C) Navigation Tabs – This area allows users to access Patient Searches, Add Patients, Add Census information, Track Infections and Alerts/Warnings, Access Facility Reports, review Resource materials and (with management access) add/delete/update users, provide addition user tools, and review current Alert/Warning criteria.
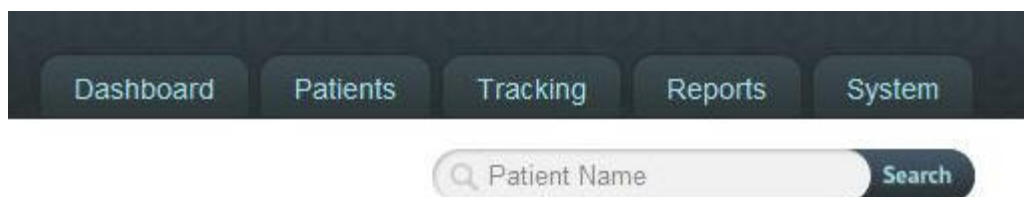
Navigation Tabs

(1) Dashboard – This tab will return you to the Dashboard.
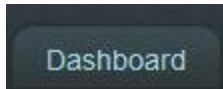
(2) Patients – This tab will allow you allow access to Patient Search, Adding New Patients and Adding Census Information.

Hovering over the Patients Tab will show a drop down box with several options:

(a) Clicking on the Add link will allow users to enter new patient information. A new page will appear:

Users will be required to enter all information about a new patient. Note that you will have to enter a date of birth (DOB) and an admission date. Floor/Wing/Unit/Room Numbers are listed as drop down boxes. If your facility has only a single floor, the default listing will be 1st Floor.

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(b) Clicking on the Search link will open a list of all currently admitted patients at the facility.

View Patients

○ Show All   ⊙ Show Admitted Only   **Add New Patient**

Last Name ⇕	First Name	Date of Birth	Wing	Room	Status
Abelmann	Kristina	07/31/1931	West (W1)	138	Admitted
Adams	Jim	02/02/1932	East (E1)	101	Admitted
Adams	Abigail	02/24/1932	East (E2)	201	Admitted
Addison	Florence	07/04/1923	East (E1)	104	Admitted
Anderson	Julie	09/09/1949	East (E2)	205	Admitted
Austino	Daniel	05/28/1921	West (W2)	231	Admitted
Ballard	Lucille	05/12/1931	East (E1)	124	Admitted
Barclay	William	02/14/1935	West (W1)	148	Admitted
Barthome	Linda	07/07/1937	East (E2)	208	Admitted
Beckham	Betty	12/25/1938	West (W1)	146	Admitted

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Patients are listed in columns by Last Name, First Name, Date of Birth, Wing, Room and there is also a Status column. Each of the columns (except Status) is sortable.

Clicking on any specific patient will bring up all historical infection information regarding the selected patient and allow users to track a new infection also.

Patient Chart

Patient Information

Name: **Ballard , Lucille**   Status: **Admitted**
Date of Birth: **05/12/1931**   Wing: **First Floor - East (E1)**
Current Age: **81**   Room: **124**
Physician: **John Hopkins**

Edit

Concerns

Warnings/Alerts:
No recent warnings

Active Precautions:
No active precautions

Additional Information   Infections   Admission History

Type	First Noted ⇕	Reason for Entry	Date Resolved
Urinary Tract Infection	01/17/2012	Fever (>=100°F) OR (fever greater than 2 degrees above baseline) or chills New flank/suprapubic pain or tenderness Change in character of urine	1/28/2012

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Track New Infection

If you wish to review a specific previous infection, simply hover over that infection and click.

Clicking on any particular infection will bring up all details for review.

With all patients, there is an Edit link available to change specific patient information such as a change in primary physician or a floor/unit/wing/room number or Status.

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Patient Information

Name: **Ballard , Lucille**   Status: **Admitted**
Date of Birth: **05/12/1931**   Wing: **First Floor - East (E1)**
Current Age: **81**   Room: **124**
Physician: **John Hopkins**

Edit

Clicking on the Edit button will allow users to make necessary changes. You can edit Floor/Unit/Wing/Room information and change primary physician by using this link. You can also change the Status of the patient to Discharged/Expired as necessary.

Two notes: (a) There is an option to Show All patients which will then add discharged/expired patients to the list and (b) an Add New Patient button.

(a) Show All Patients – Located in the upper left hand area. This option will allow users to list all patients within the last six months if they wish to review previous infection records for discharged/expired patients.

○ Show All   ⊙ Show Admitted Only

(b) Add New Patient – Located in the upper right hand area. This allows users to add a new patient to Intuition.

Add New Patient

When clicking on this button a new page will appear. This is identical to the Add link from the Dashboard. Users will be required to enter all information about a new patient. Note that you will have to enter a date of birth (DOB) and an admission date. Floor/Wing/Unit/Room Numbers are listed as drop down boxes. If your facility has only a single floor, the default listing will be 1st Floor.

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Add New Patient

Users will be required to enter all information about a new patient. Note that you will have to enter a date of birth (DOB) and an admission date. Floor/Wing/Unit/Room Numbers are listed as drop down boxes. If your facility has only a single floor, the default listing will be 1st Floor.

(c) Census Information – This area is required to calculate the infection rate based on CDC guidelines. You have the option of either entering the total patient days or the average census for any given month.

Patient Census Data

Year	Month	Patient Days
2012	7	0
2012	6	0
2012	5	2920
2012	4	2895
2012	3	2976
2012	2	2784
2012	1	3050
2011	12	3045
2011	11	2985
2011	10	3098

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Select the month/year you wish to enter. Another page will appear.

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If you enter an Average Patient Census, the system will calculate the Total Patient Days. Likewise, if you enter Total Patient Days, the system will calculate the Average Patient Census.

Once you enter the information click on Save.

The information you enter will be used to calculate your 'per thousand patient days' infection rate.

This calculation is updated on a daily basis.

Entering a New Suspected/Confirmed Infection

When a new suspected/confirmed infection needs to be entered click on the Track New Infection link in the lower right hand corner of the Patient Chart:

Once this link is clicked you will have access to multiple areas/tabs for information:

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Tab 1 – Criteria

(a) Confirm Room Number/Unit/Wing – This area is in the upper left hand section of the initial page. You will have an option to change these areas as needed. These are all drop down boxes for your convenience.

(b) Enter information for 'Infection first noted on':

A calendar box will appear where you can click on the date.

NOTE: If the patient was hospitalized due to this infection there is a box you can click to include that information.

Tab 1 - Select the Type of Infection:

Depending on the Type of Infection selected, there may be multiple conditions offered for each Type of infection. Some of the various options are listed below:

   (1) Urinary Tract Infections:

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Criteria

Type:
Urinary Tract Infection

Condition:

UTI with catheter
UTI without catheter

Criteria

(2) Respiratory Tract Infection:

Criteria

Type:
Respiratory Tract Infection

Condition:

Common Cold Syndrome
Influenza-like Illness
Other lower respiratory
Pneumonia

Criteria

(3) Skin Infection:

Criteria

Type:
Skin Infection

Condition:

Cellulitis
Fungal skin infection
Herpes Simplex
Herpes Zoster (Shingles)
Pressure/Statis Ulcer
Scabies
Soft tissue
Wound

Criteria

(4) Other Types of infection have similar 'condition' options available.

(5) Once the Type and Condition are selected, a list of the McGeer's criteria will appear with check boxes. If the criteria for an infection is not met, you have the option of selecting No Infection or Admission Hospital Diagnosed.

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Criteria

Type:
Urinary Tract Infection

Condition:
UTI without catheter

Classification:
No Infection
No Infection
Admission Hospital Diagnosed

Criteria

MUST HAVE at least 3 of the following:

☐ Fever (>=100°F) OR (fever greater than 2 degrees above baseline) or chills
☐ New or increased burning, pain on urination, frequency, urgency or difficulty with urination.
☐ New flank/suprapubic pain or tenderness
☐ Change in character of urine
☐ Worsening of mental or functional status

Comments

This category includes only symptomatic urinary tract infections. Because many residents have bacteria in their urine as a baseline status, surveillance for asymptomatic bacteriuria is not recommended.

- fever (oral temp > than 100 degrees F or 2 degrees above resident's baseline)
- change in character or urine; new bloody urine, foul smell, amount of sediment, lab report = new pyuria or hematuria, positive leukocyte estrase and nitrates via urine dipstick.
- worsening mental/functional status; confusion, lethargy, new or increased incontinence, decreased activity, decreased appetite, falls.

If the criteria is met for a confirmed infection, you have the option of selecting Admission or Health Care Associated Infection (HAI).

Criteria

Type:
Urinary Tract Infection

Condition:
UTI without catheter

Classification:
Admission
Admission
Health Care Associated Infection

Criteria

MUST HAVE at least 3 of the following:

☑ Fever (>=100°F) OR (fever greater than 2 degrees above baseline) or chills
☑ New or increased burning, pain on urination, frequency, urgency or difficulty with urination.
☑ New flank/suprapubic pain or tenderness
☐ Change in character of urine
☐ Worsening of mental or functional status

Comments

This category includes only symptomatic urinary tract infections. Because many residents have bacteria in their urine as a baseline status, surveillance for asymptomatic bacteriuria is not recommended.

- fever (oral temp > than 100 degrees F or 2 degrees above resident's baseline)
- change in character or urine; new bloody urine, foul smell, amount of sediment, lab report = new pyuria or hematuria, positive leukocyte estrase and nitrates via urine dipstick.
- worsening mental/functional status; confusion, lethargy, new or increased incontinence, decreased activity, decreased appetite, falls.

Tab 2 – Risk Factors

Users may select as many of the general Risk Factors as necessary. In addition, there is a free text box where users may enter additional risk factors not included in the established list.

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| | Criteria | Risk Factors | Treatment | Precautions | Labs | X-ray | Notes |

Risk Factors

- [ ] Actively dying
- [ ] Altered mental state
- [ ] Comprimised immune system
- [ ] COPD or other lung disease
- [ ] Dehydration
- [ ] Failure to thrive
- [ ] G-tube

- [ ] Heart disease
- [ ] Hospice
- [ ] Hyperglycemia
- [ ] Incontinence
- [ ] Inflammatory condition of the skin
- [ ] IV
- [ ] Limited functional status

- [ ] Medications (Immunosuppressants, anticholinergic, agents that decrease gastric pH, etc.)
- [ ] N/G tube
- [ ] Non-intact skin (wound / cut / laceration / abrasion / etc.)
- [ ] Obesity
- [ ] Poor oral intake
- [ ] Poor personal hygiene
- [ ] Pre-exisiting infection

- [ ] Recent antibiotic therapy
- [ ] Recent hospitalization
- [ ] Supine position
- [ ] Trach
- [ ] Urinary catheter

Additional Risk Factors

[   ]

Tab 3 – Treatment

The Treatment Tab has multiple areas where information can be entered. There are two separate areas. The first is for antibiotic/antimicrobial information and the second is for any additional treatment that users may want to record.

(a) Antibiotic/Antimicrobial Treatment:

This section is to record any antibiotic/antimicrobial treatment for the suspected/confirmed infection and includes multiple areas for data entry.

Treatment

Antibiotic/Antimicrobial Treatment

Treatment	Date	MD name	Dosage	Units	Frequency	Duration	Route
		John Hopkins					

Special Instructions

[   ]   **Add**

(1) Treatment – this area is a 'drop down' box of the most common antibiotic/antimicrobial treatments. Simply start typing in the first few letters of any given treatment and users will receive a selection to choose from. If the treatment is not included in the list, users always have the option of free texting.

(2) Date – a calendar box will open when you click on this field.

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(3) MD Name – This field will default to the primary physician of record. If the actual ordering physician is different, users may free text another name into this field.

MD name

John Hopkins

(4) Dosage/Units – These fields are free text areas.

Dosage   Units

(5) Frequency – This field is a drop down box. Start typing in the frequency and a list of options will appear. If the desired frequency does not appear, users have the option of free texting information.

Frequency

q

q 1 hour
q 2 hour
q 3 hour
q 4 hour
q 5 hour
q 6 hour
q 7 hour
q 8 hour

(6) Duration – This field is a drop down box. Start typing in the duration and a list of options will appear. If the desired duration does not appear, users have the option of free texting information.

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Duration

d|

Daily

2 days

3 days

4 days

5 days

6 days

7 days

10 days

(7) Route - This field is a drop down box. Start typing in the route method and a list of options will appear. If the desired duration does not appear, users have the option of free texting information.

Route

o

Ear Drops

Eye Drops

Oral

Topical

(8) Special Instructions – This field is a drop down box. Start typing in the description and a list of options will appear. If the desired duration does not appear, users have the option of free texting information.

Special Instructions

(9) When finished adding information, click on the Add button and all data entered will be placed in the patient record.

Add

(b) Additional Treatments:

This area is essentially identical to the Antibiotic/Antimicrobial Treatment section but is used to record additional treatments such as Increase Fluids, Probiotic, etc. The fields follow the same format as above.

SPECIAL NOTES:

    (1) Each of the Treatment areas allows users to add multiple 'treatments' as needed. Users may add/remove treatments as needed also.

    (2) None of the fields in either Treatment area are 'required' but the more information that can be entered, the more complete the record.

Tab 4 – Precautions

This tab allows users to document any special Precautions needed.

Simply click on the appropriate box and the selected Precaution will be included in the patient record. Additionally, a link will appear with the CDC guidelines for the selected Precaution as a reference.

Tab 5 – Labs

This tab is used to record any laboratory testing related to the infection.

The first field is Type of Test. Clicking on the drop down box arrow will bring up a list of laboratory tests.

Click on the appropriate test.

The second field is Date Completed. Clicking on this box opens up a Calendar for date selection.

The final field is Result. Clicking on the drop down box will provide a list of possible results. Click on the appropriate one to add to the patient record. (NOTE: The Result drop down box will vary depending on the type of test selected.)

When finished completing all three field click on the Add Result button.

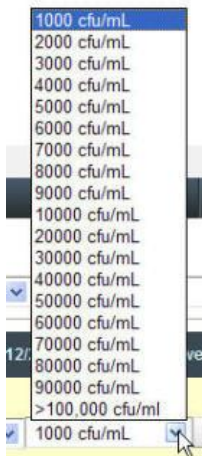A new area will appear with the test name and the result.

If positive, fields will appear where you can enter the laboratory results. The first field is Pathogen/Organism and has a drop down box accessed by clicking on the down arrow.

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Acinetobacter baumanii
Acinetobacter species
Aerococcus species
Citrobacter species
Dipthroids
Enterobacter species
Enterococcus species
Escherichia coli
Gram negative cocci
Gram negative rods
Gram positive cocci in chains
Gram positive cocci in clusters
Gram positive rods
Grp A Strep
Grp B strep
Klebsiella oxytoca
Klebsiella pneumoniae
Klebsiella species
Lactobacillus
Morganella morganii
MRSA
N/A
Neisseria species
Peptococcus species
Peptostrepcoccus species
Proteus mirabilis
Proteus species
Pseudomonas aeruginosa
Pseudomonas species
See Notes

Acinetobacter baumanii

The second field is Quantity. Here, again, a drop down box with results is accessed by clicking on the down arrow.

1000 cfu/mL
2000 cfu/mL
3000 cfu/mL
4000 cfu/mL
5000 cfu/mL
6000 cfu/mL
7000 cfu/mL
8000 cfu/mL
9000 cfu/mL
10000 cfu/mL
20000 cfu/mL
30000 cfu/mL
40000 cfu/mL
50000 cfu/mL
60000 cfu/mL
70000 cfu/mL
80000 cfu/mL
90000 cfu/mL
>100,000 cfu/ml

1000 cfu/mL

After entering the Pathogen/Organism and the Quantity click on the Add button to document this information in the patient record.
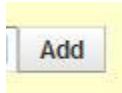
SPECIAL NOTES:

(1) If the Result entered is not Positive (i.e. Negative, No Growth, Normal Flora, etc.) only a Notes field will appear where users can free text in additional information.

(2) More than one test can be entered and, if Positive, additional results may be entered also as in the example below.

Tab 6 – X-ray

This tab allows users to enter X-ray results.

Location Information

Floor: First

Wing: East (E1)

Room: 124

General Information

☐ Resident hospitalized due to this infection.:

Infection first noted on:

Resolved?: ☐ On:

| Criteria | Risk Factors | Treatment | Precautions | Labs | X-ray | Notes |

X-ray

Chest X-ray completed?: ☐ On:

Results:

Clicking on the Chest X-ray completed? box activates the calendar box to the right.

After entering the appropriate date, the result(s) can be free texted.

X-ray

Chest X-ray completed?: ☑ On: 07/12/2012

Results:

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Tab 7 – Notes

This tab allows users to enter additional information regarding the infection. Free text information into the box and then hit the Add Notes button to include the Notes in the patient record.