CareIT AL Online

User Guide

Everything the care team, nurses, kitchen and administrators need to run a day of assisted living care in CareIT AL Online.

Version	Edition	Audience	Issued
0.7.1	Online	All staff roles	July 2026

Contents

1 About this guide

CareIT AL Online is a care record for assisted living. It holds who your residents are, what care they need, what was actually delivered, and what went wrong when something did.

The guiding idea: documentation should be a by-product of care, not a second job. Wherever this guide describes a screen, the fastest path through it is the one designed for a caregiver holding a phone in one hand.

Who this guide is for

Every role, in one document. Not every chapter applies to every person — the table below is the fastest route to the parts that matter to you.

IF YOU ARE A…	READ
Caregiver	Chapters 2, 3, 4, 5, 6, 8 (capture and post-fall checks), 11 (issuing supplies)
Nurse	All of the above, plus 7, 8 (investigation), 9, 10, 12
Administrator	All chapters, especially 13, 14 and 15
Kitchen / dietary	Chapters 3, 9 and 12
Supply lead	Chapters 3 and 11

What this system is not

Being straight about the boundaries is more useful than a feature list.

IMPORTANT LIMITATIONS

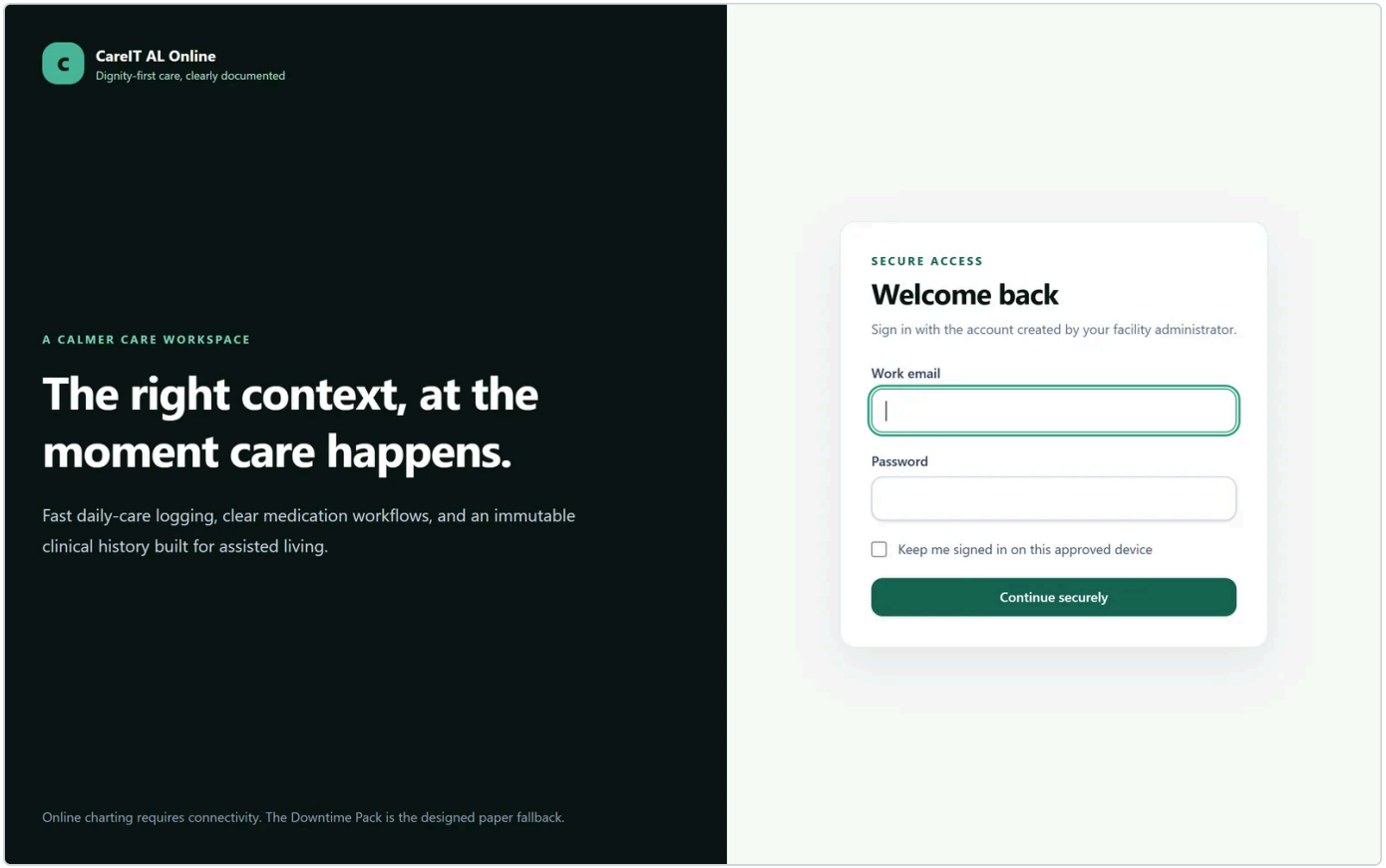
It does not work offline. This is the Online edition. If the connection drops, charting stops and you switch to the printed Downtime Pack (chapter 13). The system will tell you plainly when it is disconnected rather than quietly queueing work you think is saved.

It is not a substitute for clinical judgement. Warnings about allergies and medications are prompts for a human to look, not decisions. The system never blocks care on the strength of a text match.

It is not certified. Nothing here should be represented as HIPAA-certified or as meeting any particular state's licensing requirements without your own review.

2 Signing in

Access to resident information is protected by a password and a second factor. Both are required — there is no way to reach a resident record without them.

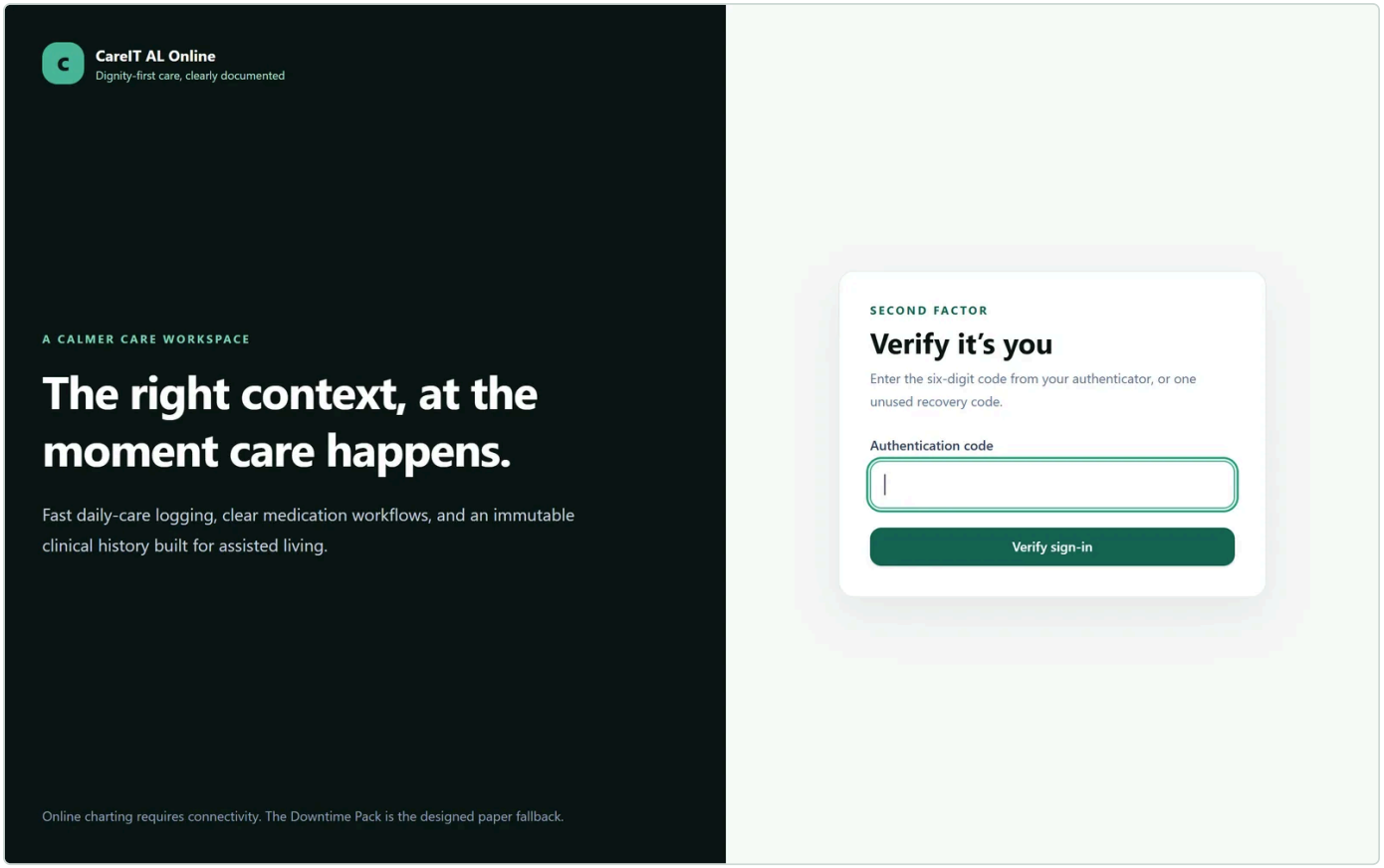


Sign in. Your email address and password. If you have just been given an account, you will be asked to change the password before you can go any further.

Two-factor authentication

The first time you sign in, you will be asked to set up an authenticator app. This is not optional and it is not a formality: it is the control that stops a stolen password from becoming access to every resident's medical history.

1. Install an authenticator app on your phone (Google Authenticator, Microsoft Authenticator, 1Password and Authy all work).
2. In the app, add an account manually and enter the setup secret shown on screen. Choose the time-based (TOTP) option.
3. Type the six-digit code the app shows, and confirm.
4. Store your recovery codes somewhere safe and away from your phone. They are the only way back in if you lose the device.

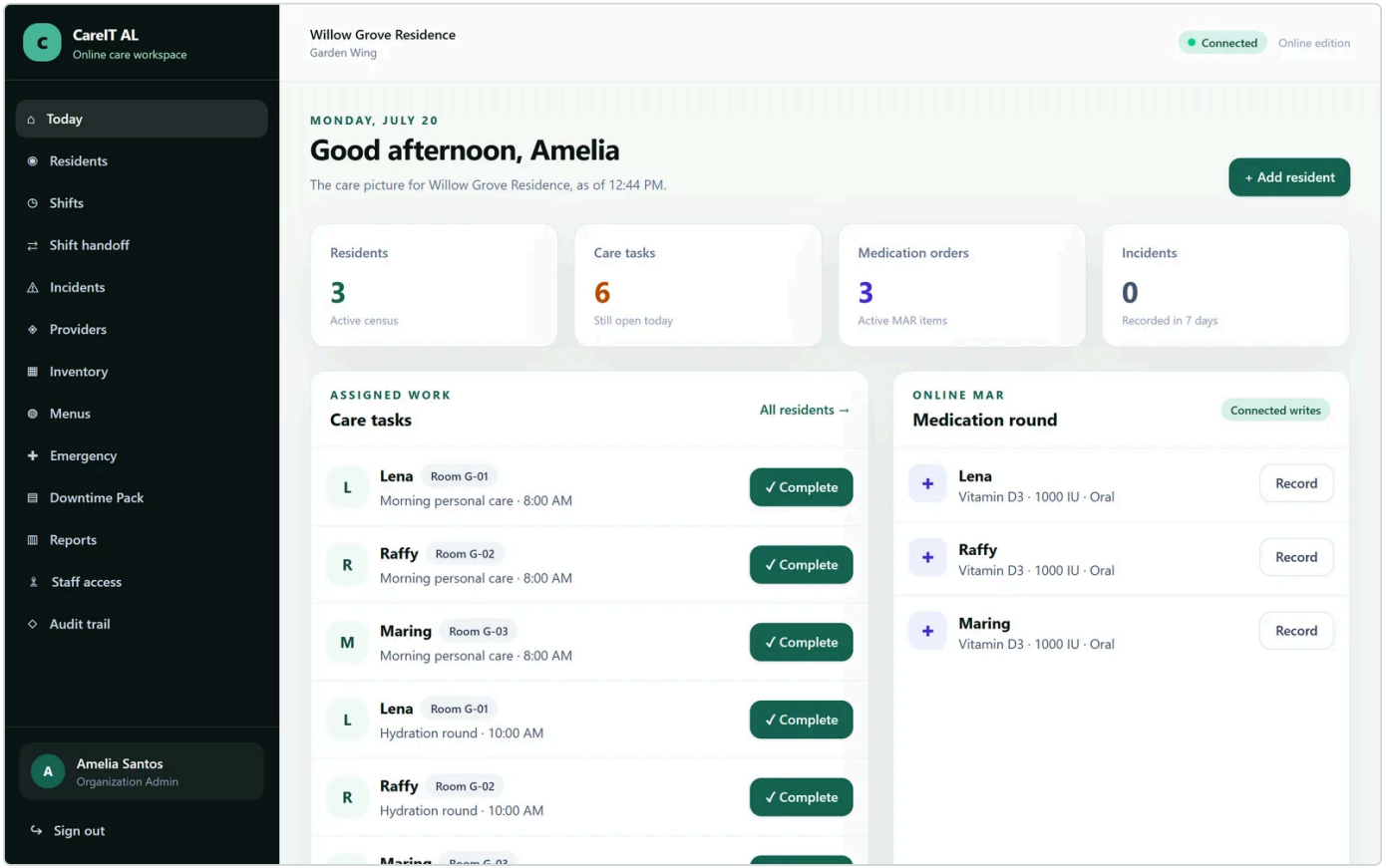


Every later sign-in asks for the current six-digit code. Codes change every 30 seconds; if one is rejected, wait for the next and try again.

> **IF YOU ARE LOCKED OUT**
>
> Use a recovery code. If those are gone too, an administrator must reset your two-factor enrolment — nobody can retrieve the old one, by design.

3 Finding your way around

One sidebar, one workspace. What you can see in the sidebar depends on your role, so your screen may show fewer items than the illustrations in this guide.



Today is where every shift starts. The header names the facility and unit you are working in; the pill on the right shows whether you are connected.

The connection indicator

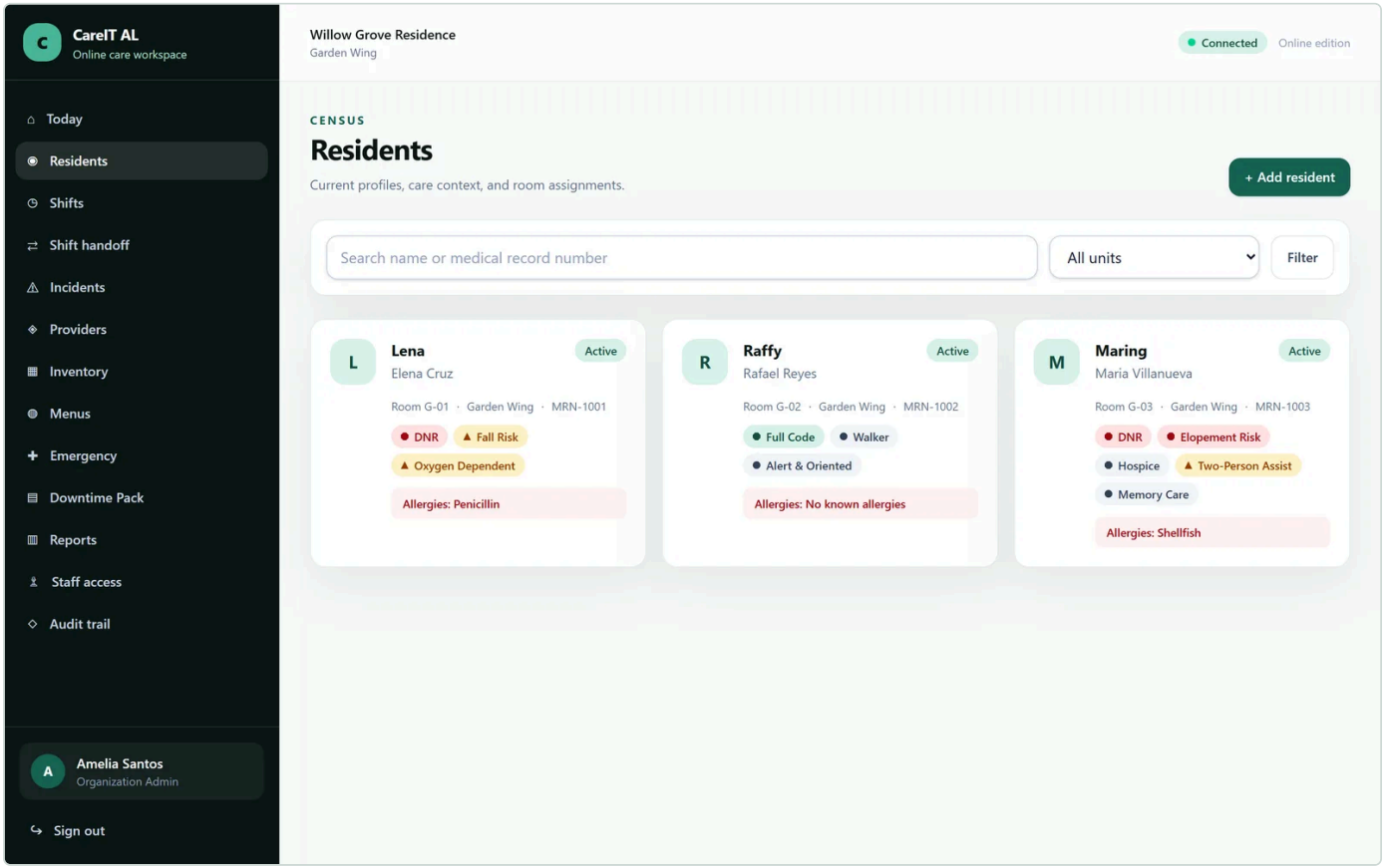
Top right of every screen. **Connected** means your work is saving. If it changes to **Disconnected**, stop charting and read chapter 13 — the system deliberately blocks clinical writes rather than accepting work it cannot save.

Your facility

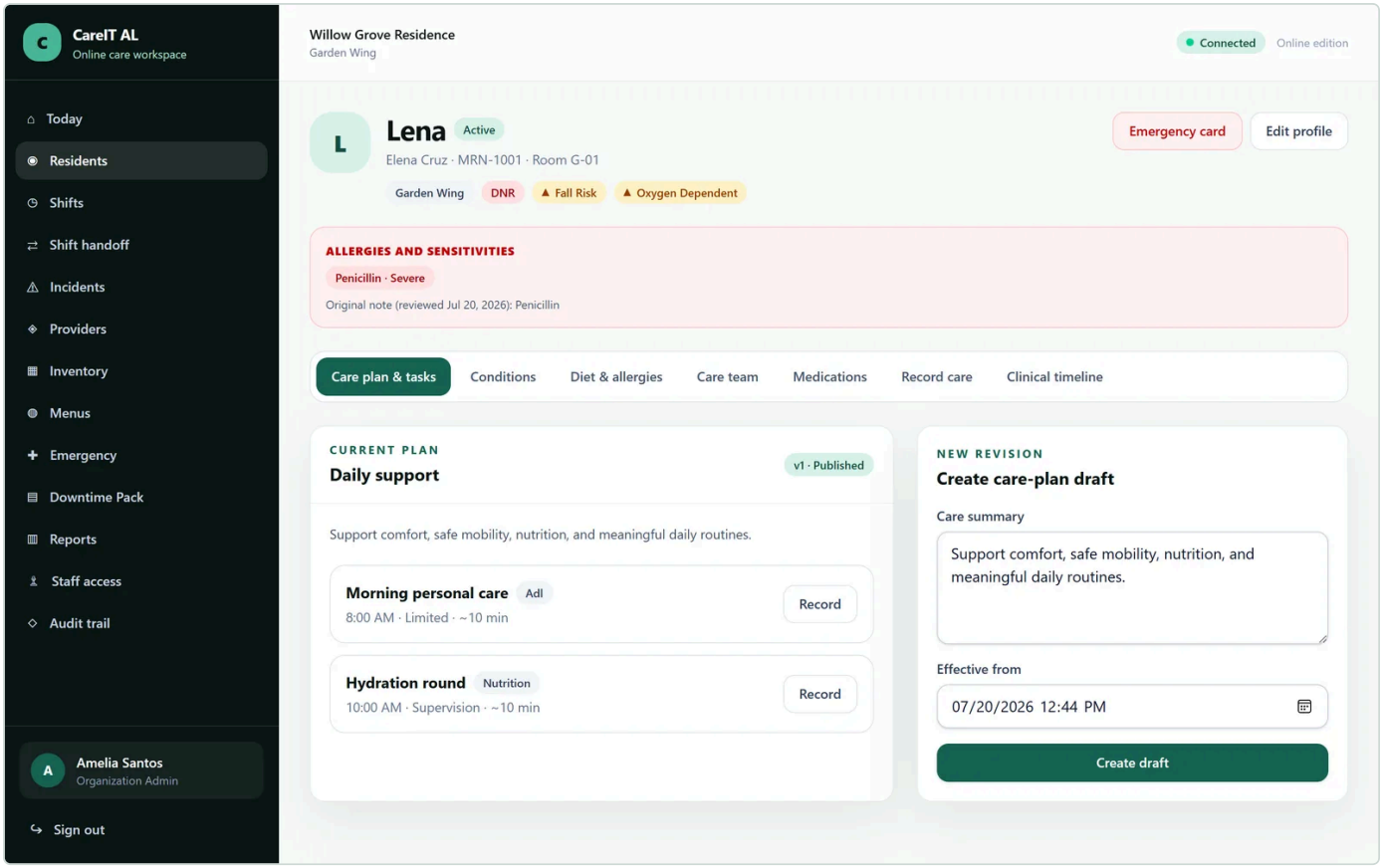
Everything you see belongs to one facility. Residents, incidents, supplies and menus from another facility in the same organisation are not visible to you and cannot be reached, even with a direct link.

4 Residents

The resident record is the spine of the system. It is designed as a briefing rather than an archive: the first thing you see is what you need to care for this person in the next hour.



The roster. Search by name, preferred name or record number. Condition flags appear on each card so you can read the floor at a glance.



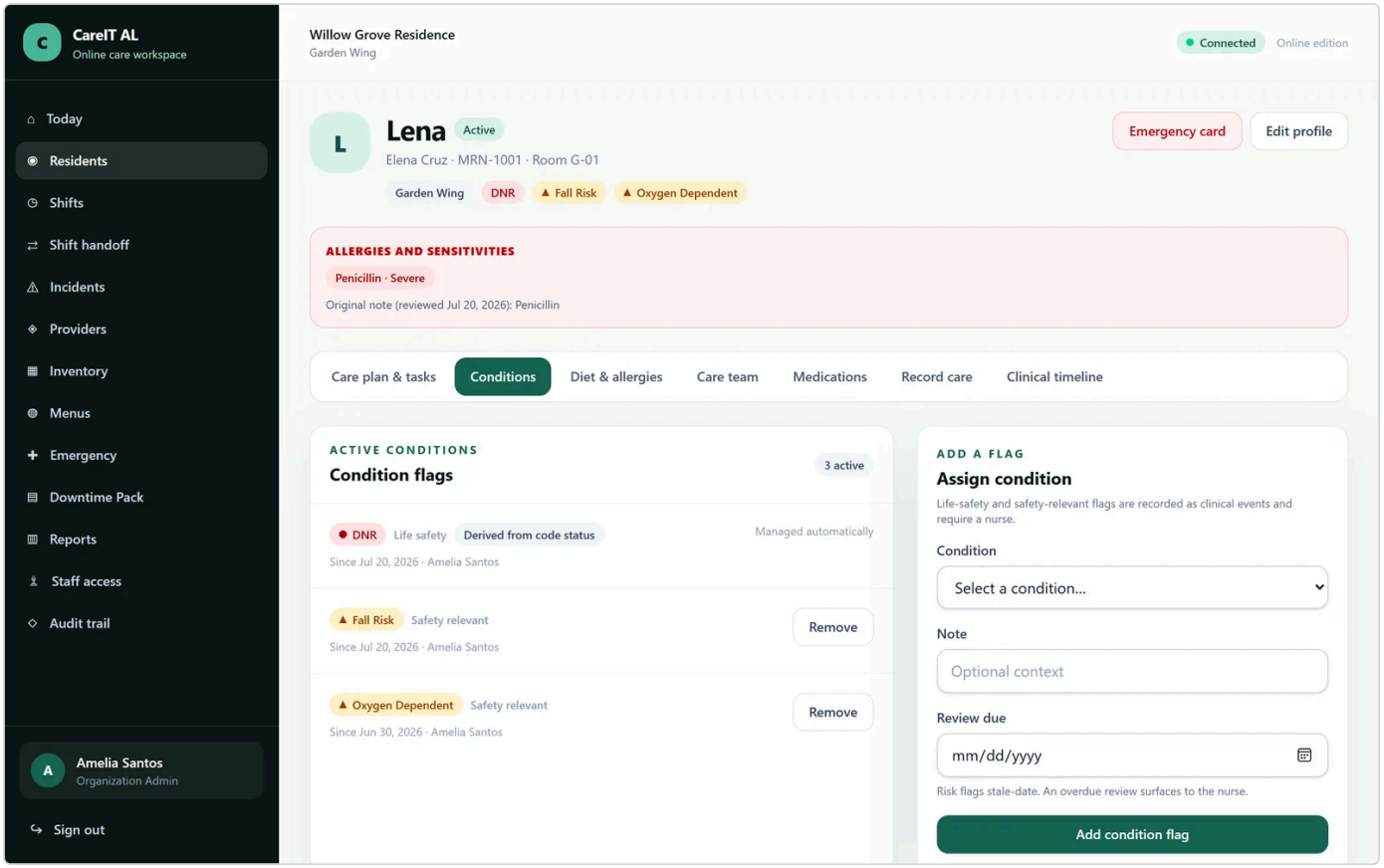
The resident record. Allergies sit in a band at the top — always, on every tab. Code status and condition flags are beside the name.

Condition flags

Flags are the shorthand that lets an agency nurse read a resident safely in ten seconds. They are grouped into four tiers, and the tier decides both how prominently the flag appears and who is allowed to set it.

TIER	LOOKS LIKE	EXAMPLES	WHO CAN SET IT
1 — Life safety	DNR	DNR, Full Code, elopement risk, isolation, hospice	Nurse or administrator
2 — Safety relevant	Fall Risk	Fall risk, two-person assist, Hoyer lift, oxygen, diabetic	Nurse or administrator
3 — Care context	Walker	Walker, wheelchair, memory care, independent	Any care staff
4 — Custom	Custom	Anything your facility adds	Any care staff

> **WHY FLAGS ARE NOT ALL COLOUR-CODED**
>
> Red means danger to a person — nothing else. If every flag were coloured, red would stop meaning anything, and the flag that matters would be lost among twenty that do not. Every flag also carries a shape and a text label, so it still reads correctly in black and white or to someone who is colour-blind.



Conditions tab. Add a flag, set a review date, and see who added each one and when. Removing a flag retires it — the history stays, so it is always possible to establish what staff could see on the day of an incident.

Flags the system manages for you

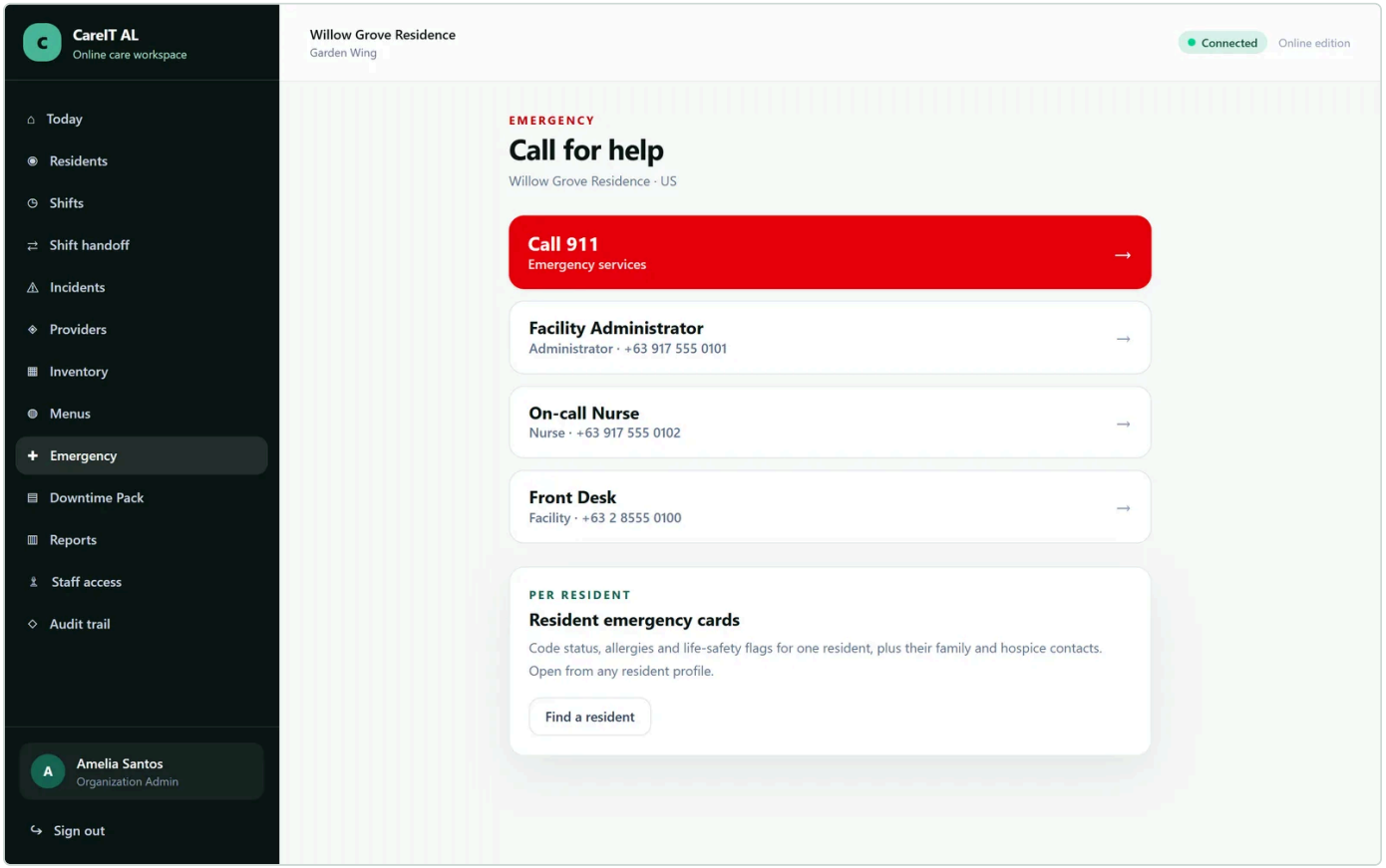
Three flags cannot be added by hand: **DNR**, **Full Code** and **Hospice**. They are projections of facts recorded elsewhere — the code status field and the hospice enrolment. Change the underlying fact and the flag follows. This is deliberate: a resident tagged hospice with no hospice enrolment behind it is exactly the kind of contradiction that gets someone hurt.

Code status

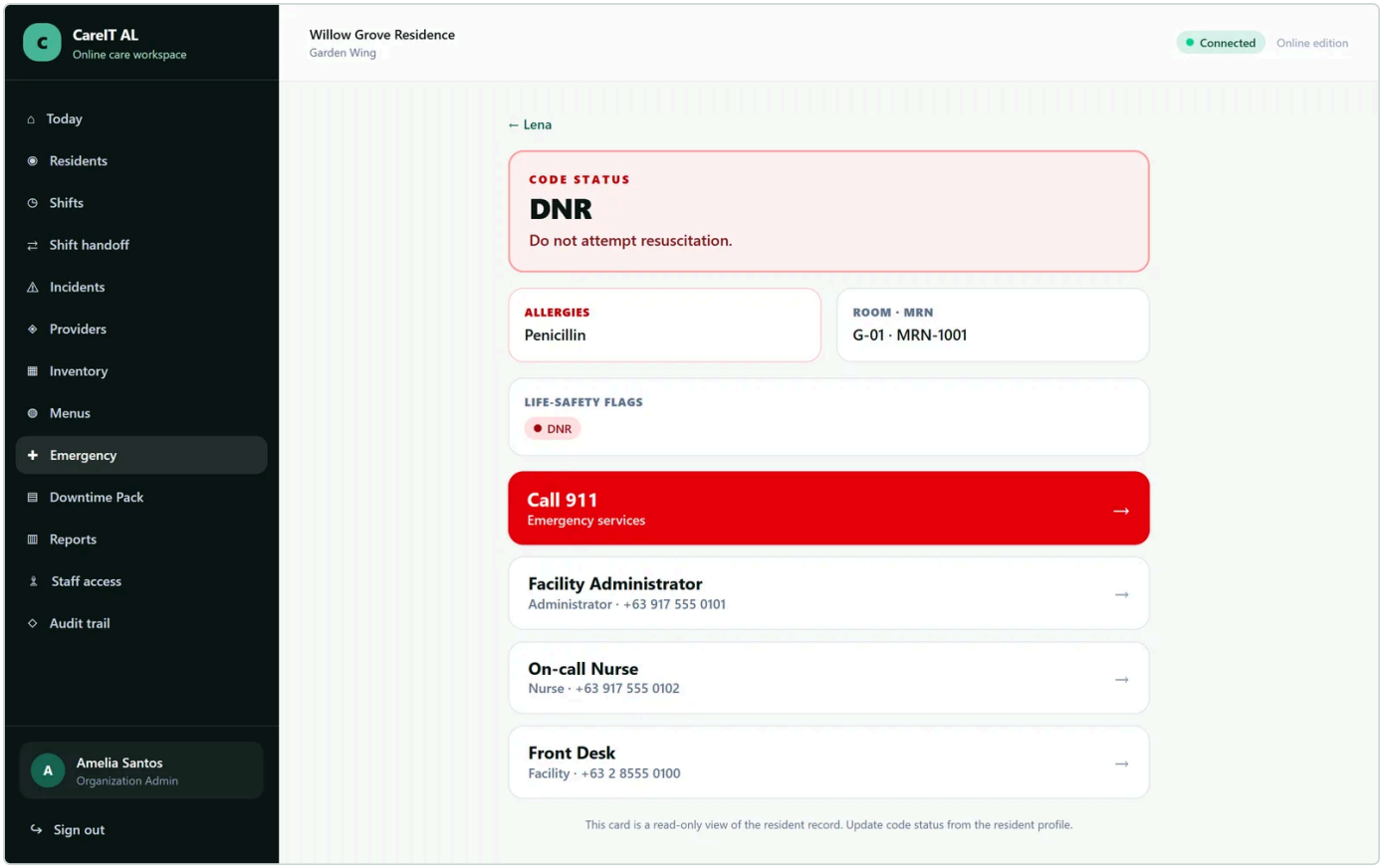
Chosen from a fixed list, never typed free-hand: **DNR**, **Full Code**, **Limited Intervention**, **Comfort Care**, or **Other** with a mandatory note. It appears beside the resident's name, on the emergency card, and in the Downtime Pack.

5 In an emergency

In a crisis nobody browses. These two screens exist so the directive and the phone number are one tap away, in large type, with nothing else competing for attention.



Emergency centre. Every button dials directly from a phone. The emergency services number comes from the facility's country and is not editable in the app — a misconfigured 911 is not a risk worth accepting for the convenience of editing it.



Resident emergency card. Reachable from any resident record. Code status leads, in the largest type on the page, followed by allergies and life-safety flags.

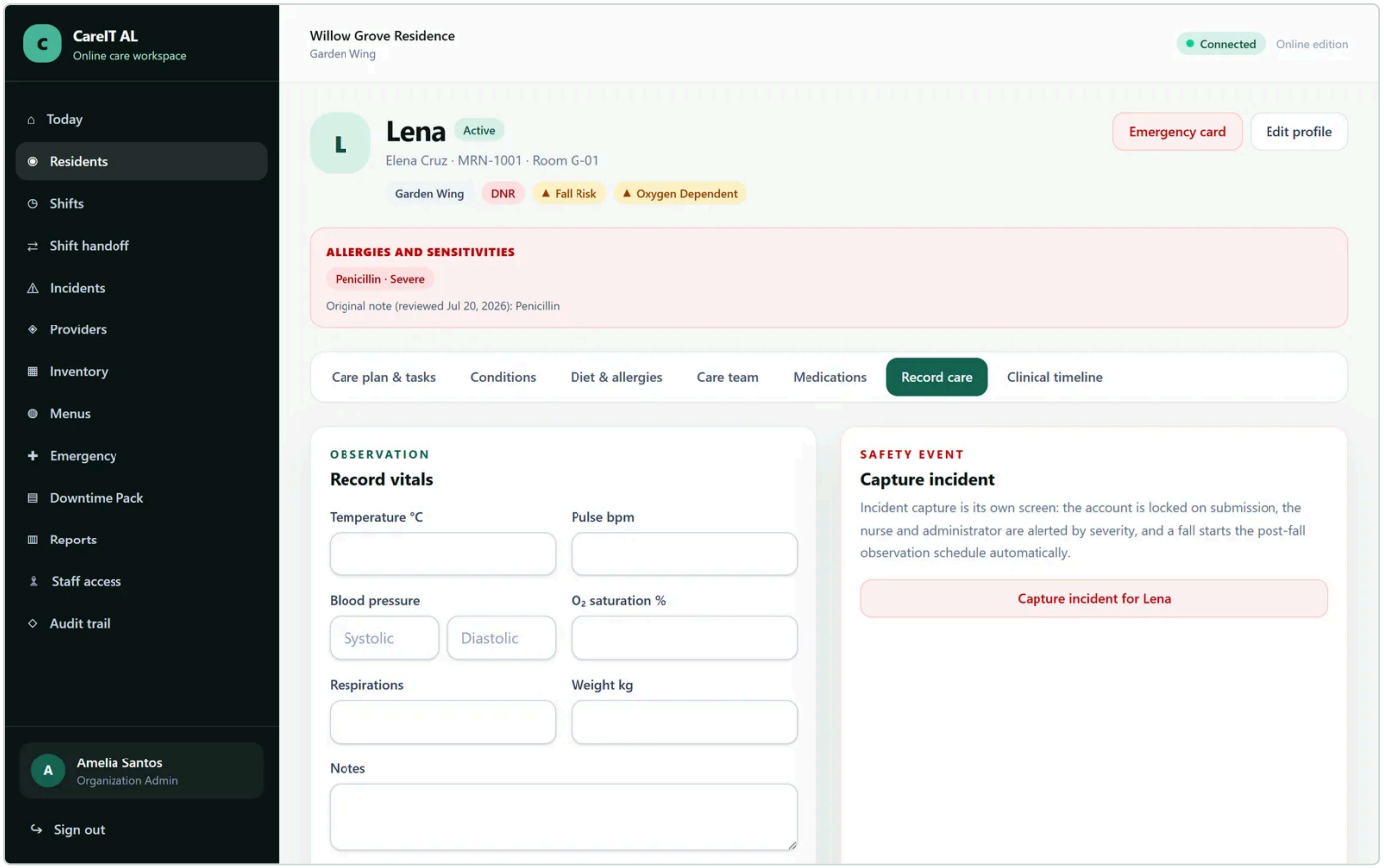
> **IF NO CODE STATUS IS RECORDED**
>
> The card says **"Not recorded"** and tells you to follow facility policy and escalate to the nurse. It never guesses and never leaves the space blank in a way you might read as "nothing to worry about".

6 Daily care

Care plans generate the work; recording it should take seconds.

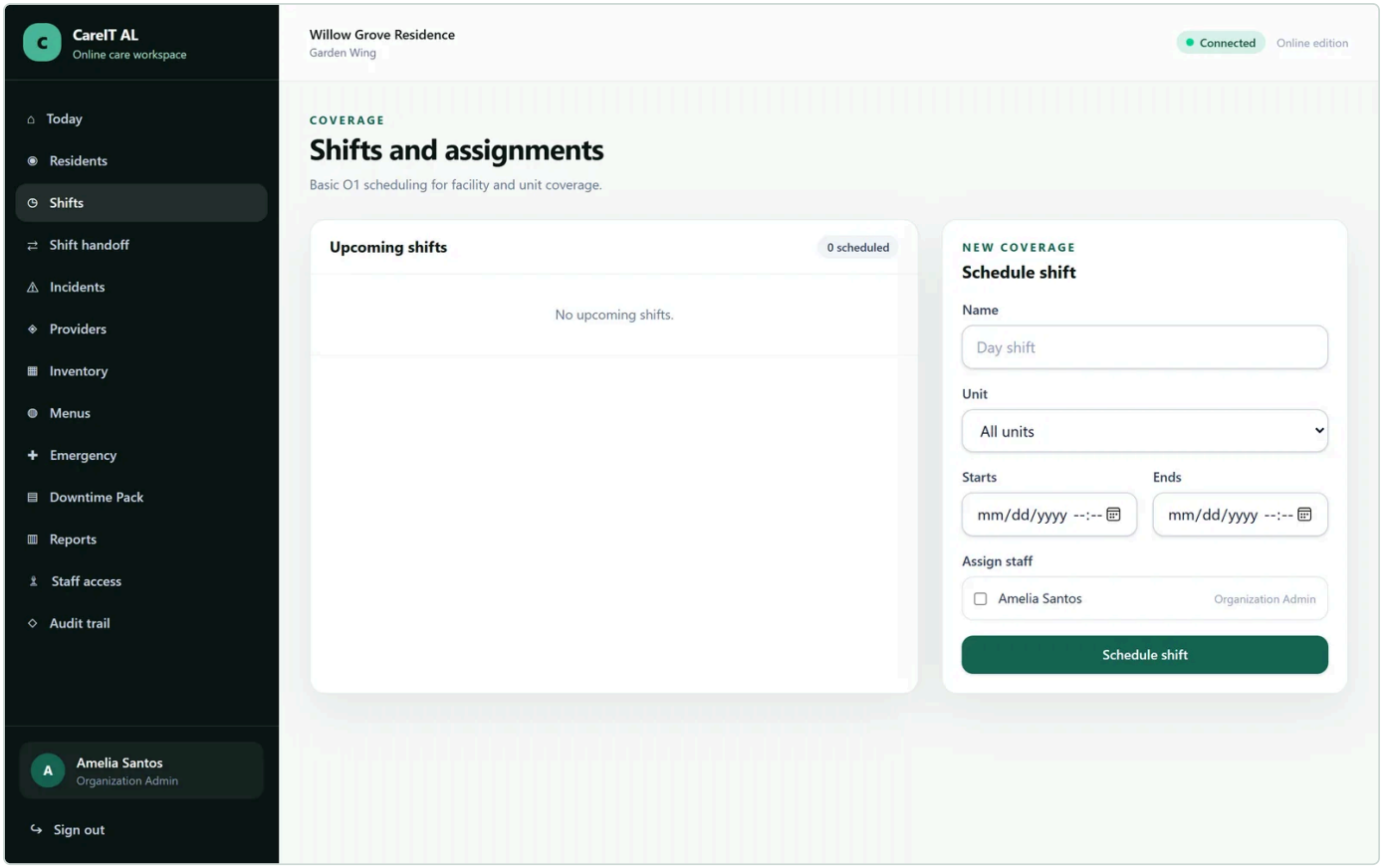
Care plans and tasks

A care plan is a task generator, not a document. Every intervention a nurse writes becomes a scheduled, checkable task. Plans are versioned: publishing a new version creates a permanent record rather than overwriting the old one.

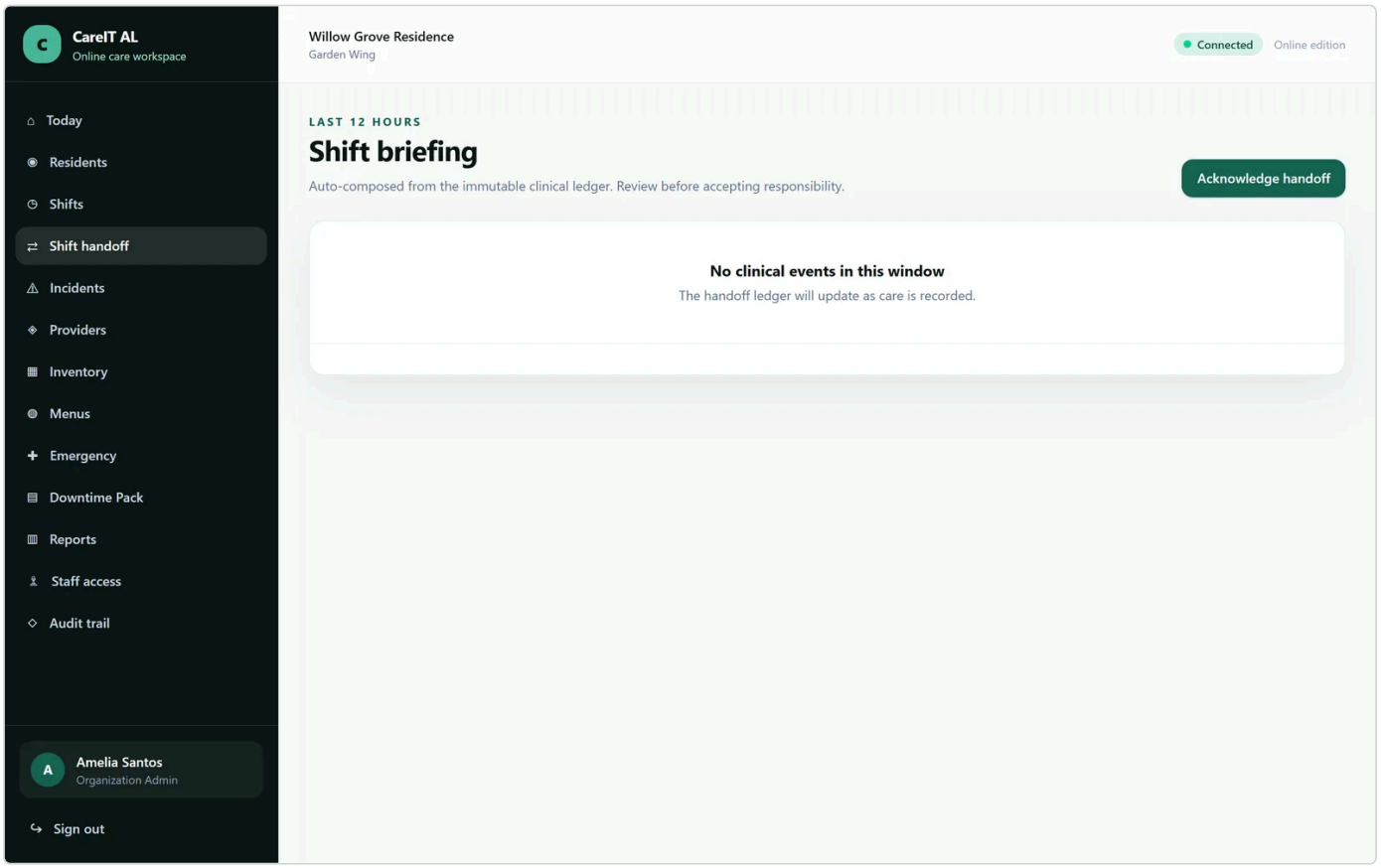


Record care. Vitals use large numeric fields; care events are recorded against the task with an outcome and, only when something differed, a reason.

Shifts and handoff



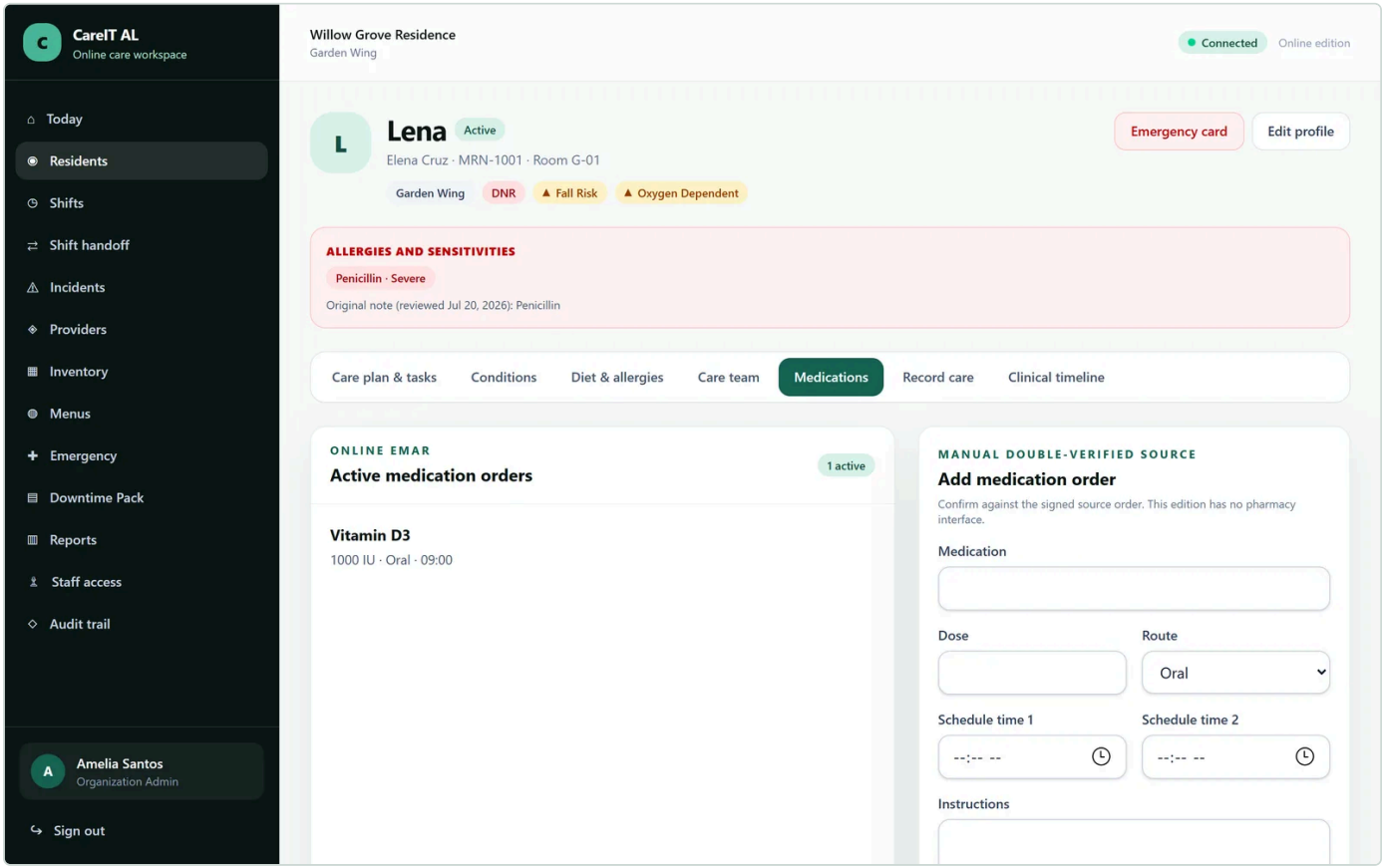
Shifts. Who is on, and which residents they are assigned to.



Shift handoff collects what changed, so the oncoming shift reads deltas rather than the whole day. It supplements the verbal handoff; it does not replace it.

7 Medications

Medication orders and administration, with a manual double-verified entry path. This edition has no pharmacy interface — orders are entered from the signed source order.



Medications. Active orders with dose, route, schedule and flags for PRN and controlled substances.

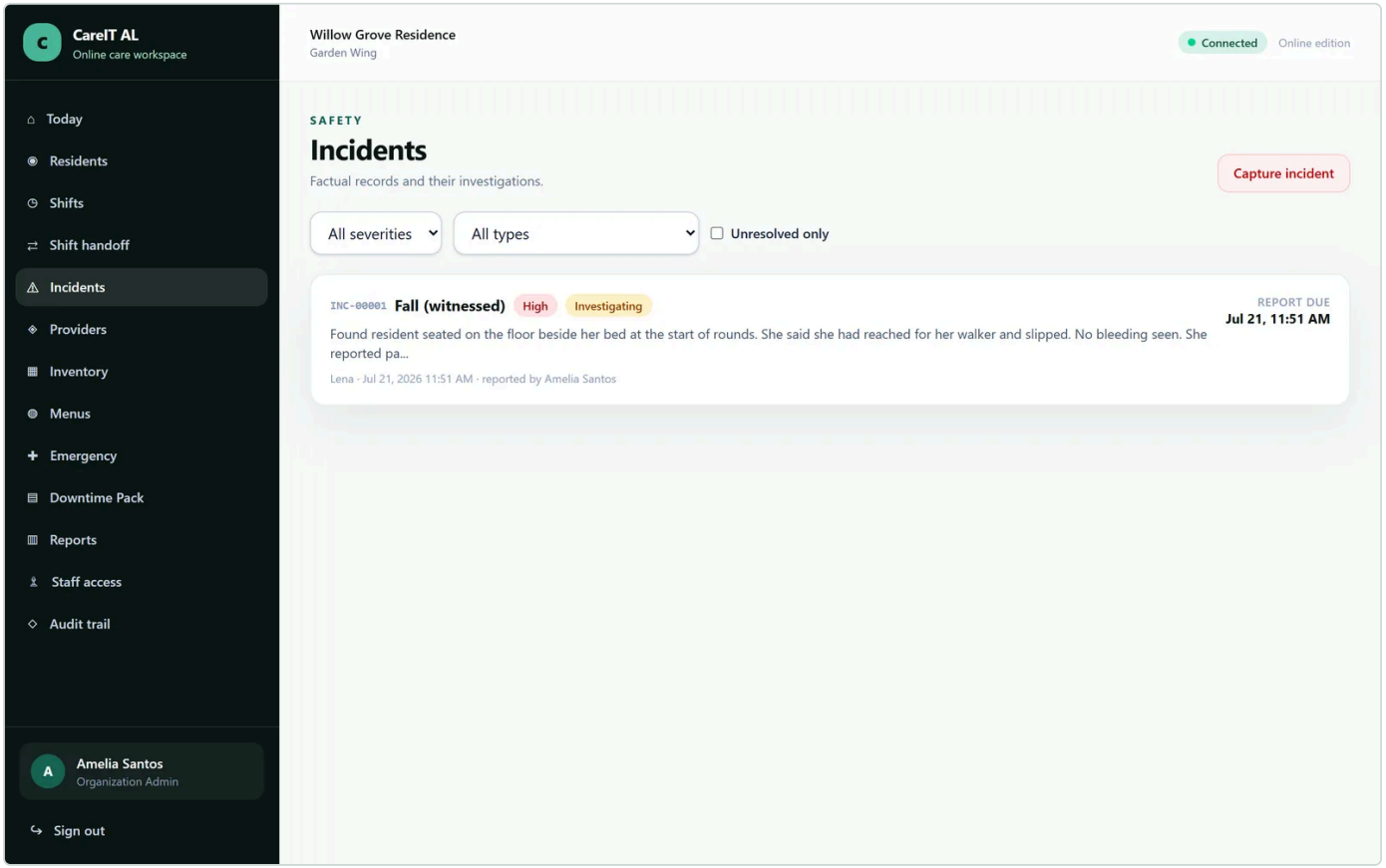
ALLERGY CROSS-CHECK

When you add an order, the system compares the medication name against the resident's recorded **medication** allergies and warns you if it sees a match. It **warns and lets the order through** — it does not block.

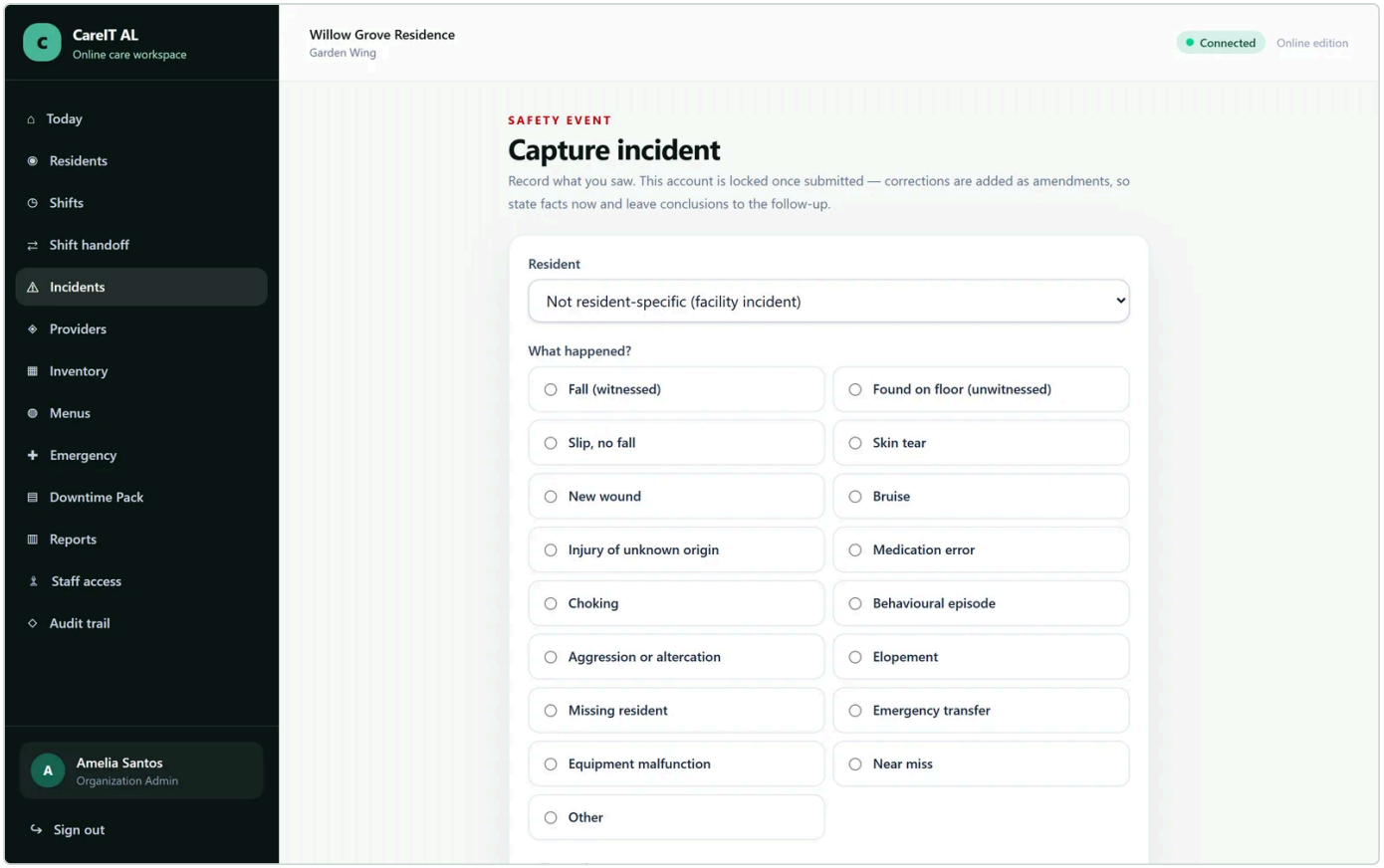
That is deliberate. The check is simple text matching: it cannot know that a brand name contains an allergen, so it will miss things. A system that hard-stops on imperfect matching teaches staff to click through warnings without reading them, and then the real warning gets clicked through too. Read it, and use your judgement.

8 Incidents

The person who witnessed the incident is usually also the person managing it. Capture is built to be finishable at the scene, in about a minute, so the record is contemporaneous rather than reconstructed from memory hours later.



Incidents. Filter by severity, type, or unresolved only. Each row shows the reporting deadline, turning red once passed.



Capture. Pick what happened, describe what you saw, say when and where, and triage the resident's immediate status. Everything else is optional and can be added later.

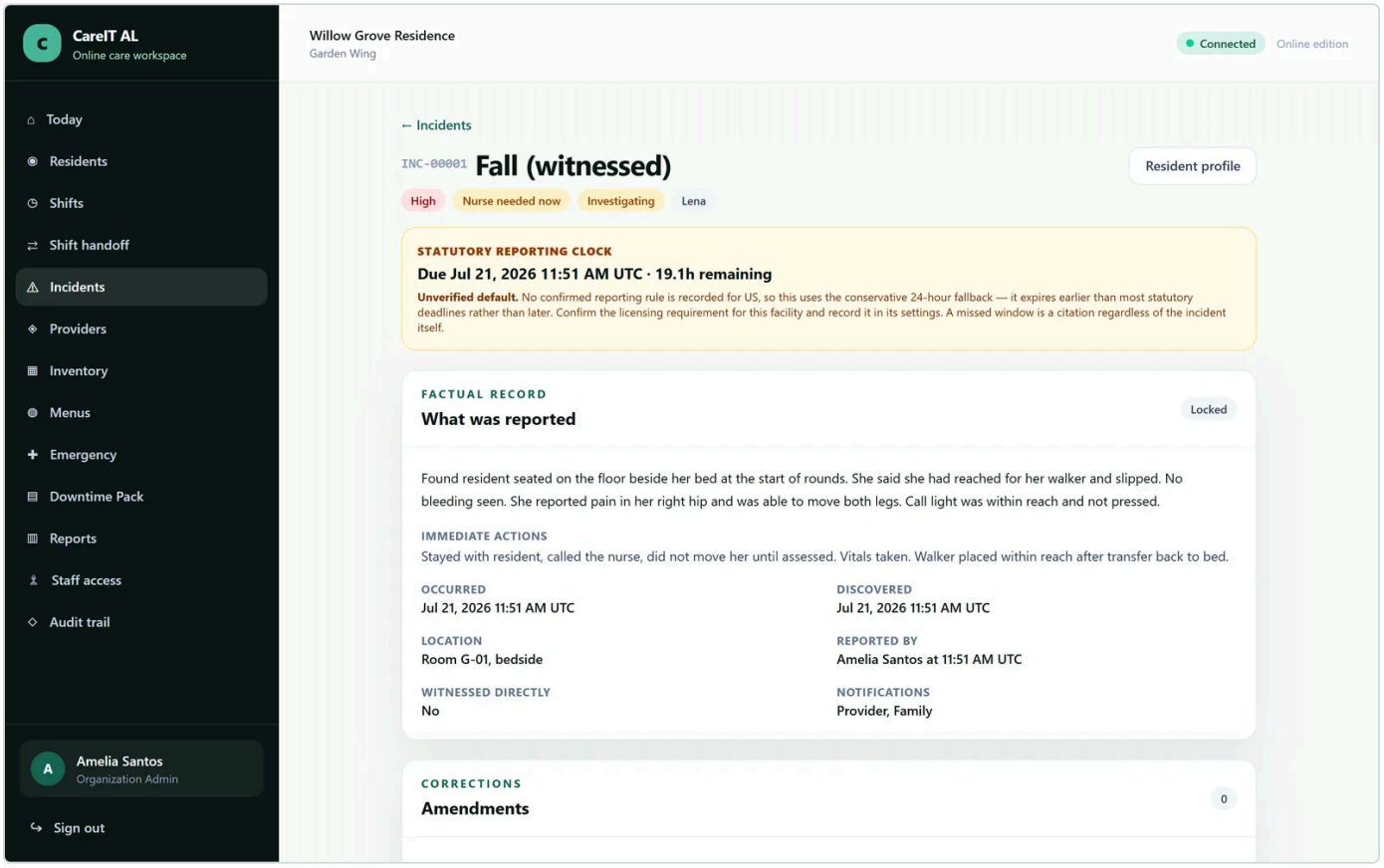
Write what you saw

The prompt says "Tell me what you saw" for a reason. Record observations — position found, what the resident said, what was visible. Leave conclusions about why it happened to the investigation, which is a separate record.

> **SUBMITTING LOCKS THE ACCOUNT**
>
> Once you submit, the narrative cannot be edited by anyone. If you need to correct or add something, record an **amendment** — it appears alongside the original with your name and the time, and the original stays exactly as written.
>
> This protects you. A contemporaneous account that was never altered is far stronger evidence than one that could have been.

What happens automatically

TRIGGER	WHAT THE SYSTEM DOES
Any incident submitted	Opens an investigation record and notifies by severity
Severity high or critical	Alerts the on-shift nurse and the administrator immediately
Triage set to "nurse needed" or "emergency services called"	Alerts the nurse regardless of severity
A fall, or a resident found on the floor	Schedules the full post-fall observation sequence
Any incident	Starts the statutory reporting countdown



The incident record. Factual account on top, locked. Amendments, post-fall checks and the investigation follow beneath it.

Post-fall observations

A fall — including an unwitnessed one where a resident is found on the floor — schedules neurological checks as dated, assignable items: every 15 minutes four times, then hourly four times, then every four hours through 72 hours. Delayed head injury is what this catches, and paper tracking of a three-day schedule reliably fails at shift change.

Recording a check takes one screen. Tick what you observed. **Anything other than "alert oriented" escalates to the nurse automatically.**

> **UNWITNESSED FALLS**
>
> "Found on floor" is its own incident type, separate from a witnessed fall, and it triggers the same observation protocol. An unwitnessed fall carries *more* uncertainty about head injury, not less.

The reporting countdown

Each incident shows how long remains to make any required report, turning red once passed. A missed reporting window is a citation regardless of the incident itself, which is why the clock is on the screen rather than in somebody's diary.

> **CONFIRM THIS AGAINST YOUR STATE**
>
> Unless your facility's windows have been configured, the countdown uses a deliberately conservative 24-hour default for every severity, and the screen says so. Assisted living is licensed state by state and there is no national standard, so **this default is not your state's rule** — it is a placeholder chosen to expire earlier than any realistic deadline.
>
> Ask your administrator to record your state's actual requirement against the facility. Once set, the incident screen names the jurisdiction instead of warning you.

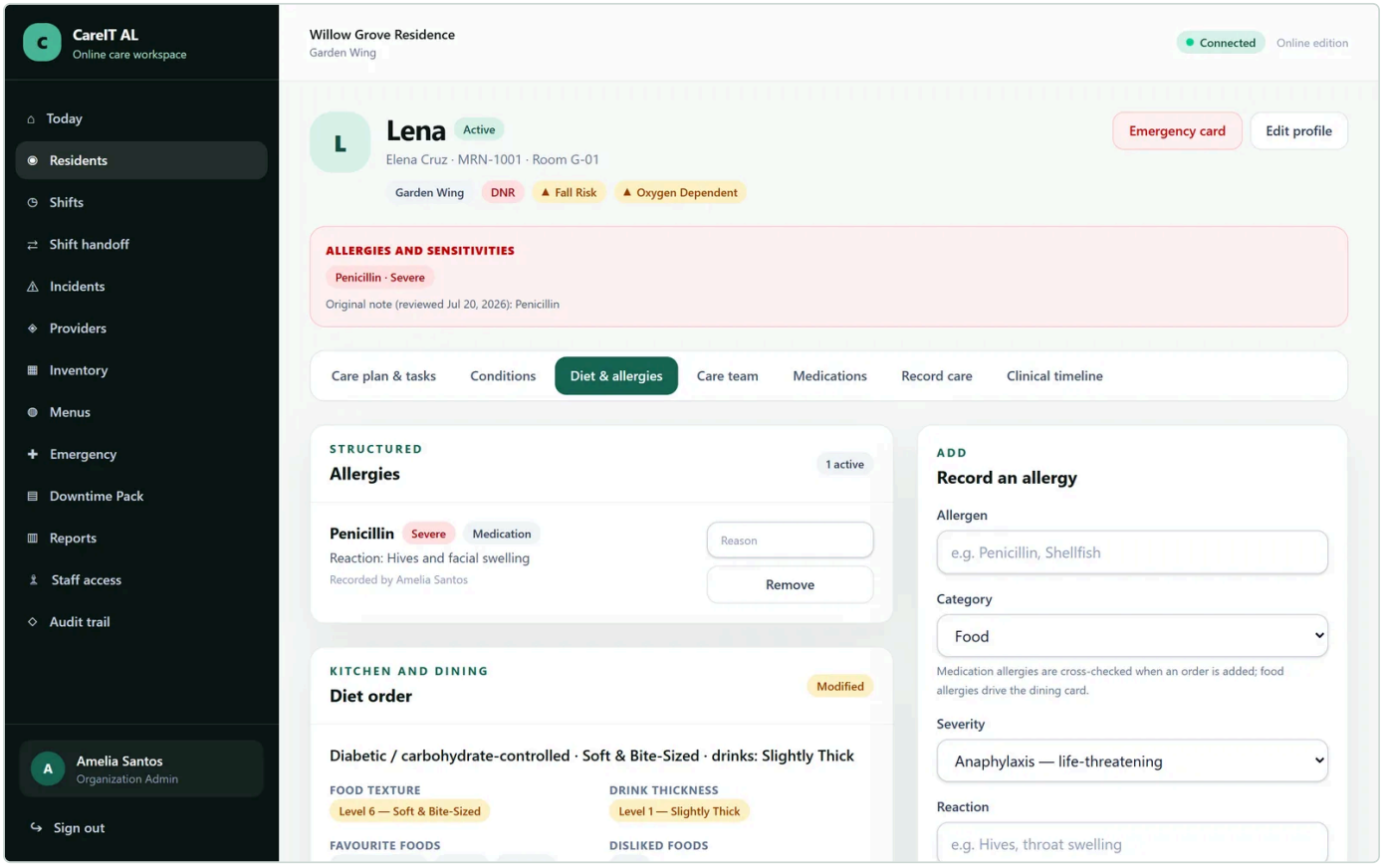
Investigation and closing

The investigation is a separate, editable record: findings, contributing factors, corrective actions. Keeping it apart from the factual account is a legal discipline, not a filing preference.

To close an incident you must record either **a care-plan change** or **an explicit reason no change was needed**. Prevention is the point of an incident report; most systems simply file them.

9 Diet and allergies

This chapter is the difference between a meal service that is safe and one that relies on the kitchen remembering forty diets.



Diet and allergies. Structured allergies on the left, the diet order beneath, and the forms to update both on the right.

Allergies

Each allergy is recorded with a category (food, medication, environmental, other), a severity, and the reaction it causes. Category matters: food allergies drive the dining card, medication allergies drive the check when an order is added.

Severe and anaphylactic allergies require a described reaction. "Anaphylaxis to something, details unknown" cannot be acted on safely, so the system will not accept it.

Removing an allergy retires it with a reason. The record is kept.

> **UNREVIEWED ALLERGY NOTES**
>
> Residents added before structured allergies existed may have a free-text note instead. The system **does not parse it** — no script and no AI reads that text, because a mis-read allergy can kill someone.
>
> Instead the note stays visible, labelled as authoritative, until a nurse reads it, records each allergy properly, and confirms. Until then, treat the note as the truth and the structured list as incomplete.

Diet orders

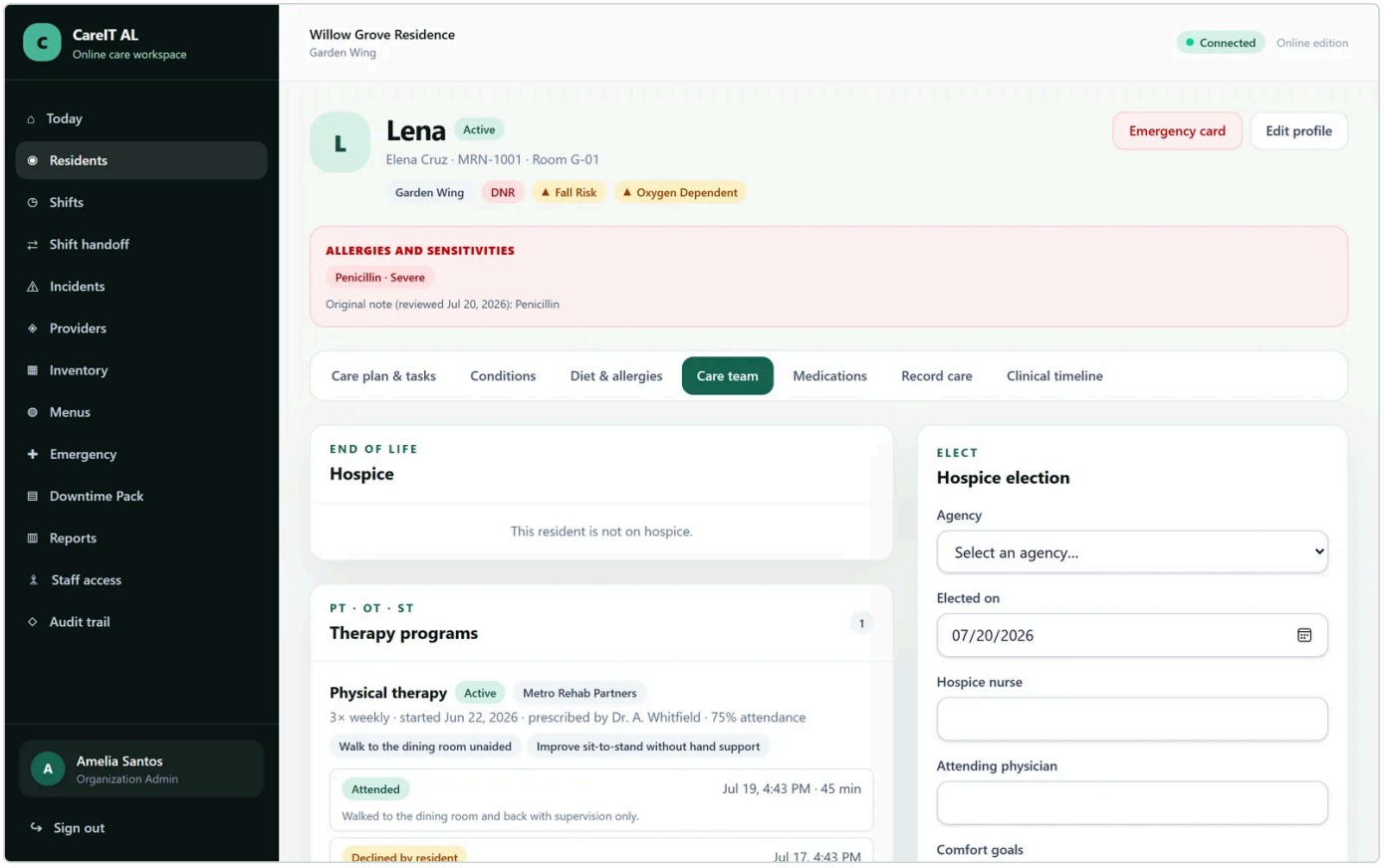
The diet order carries the diet type, texture, likes and dislikes, religious and cultural requirements, adaptive equipment and any fluid restriction. It appears on the kitchen board and on every dining card.

Food textures and drink thicknesses are recorded on the **IDDSI** framework, which uses two separate scales — foods run levels 3 to 7, drinks 0 to 4 (appendix C). They are recorded separately because a resident routinely needs different levels of each, and because a texture error is a choking event.

NPO (nothing by mouth) overrides everything. An NPO resident is excluded from tray counts entirely and shown separately, so no tray is ever prepared for someone who must not receive one.

10 The wider care team

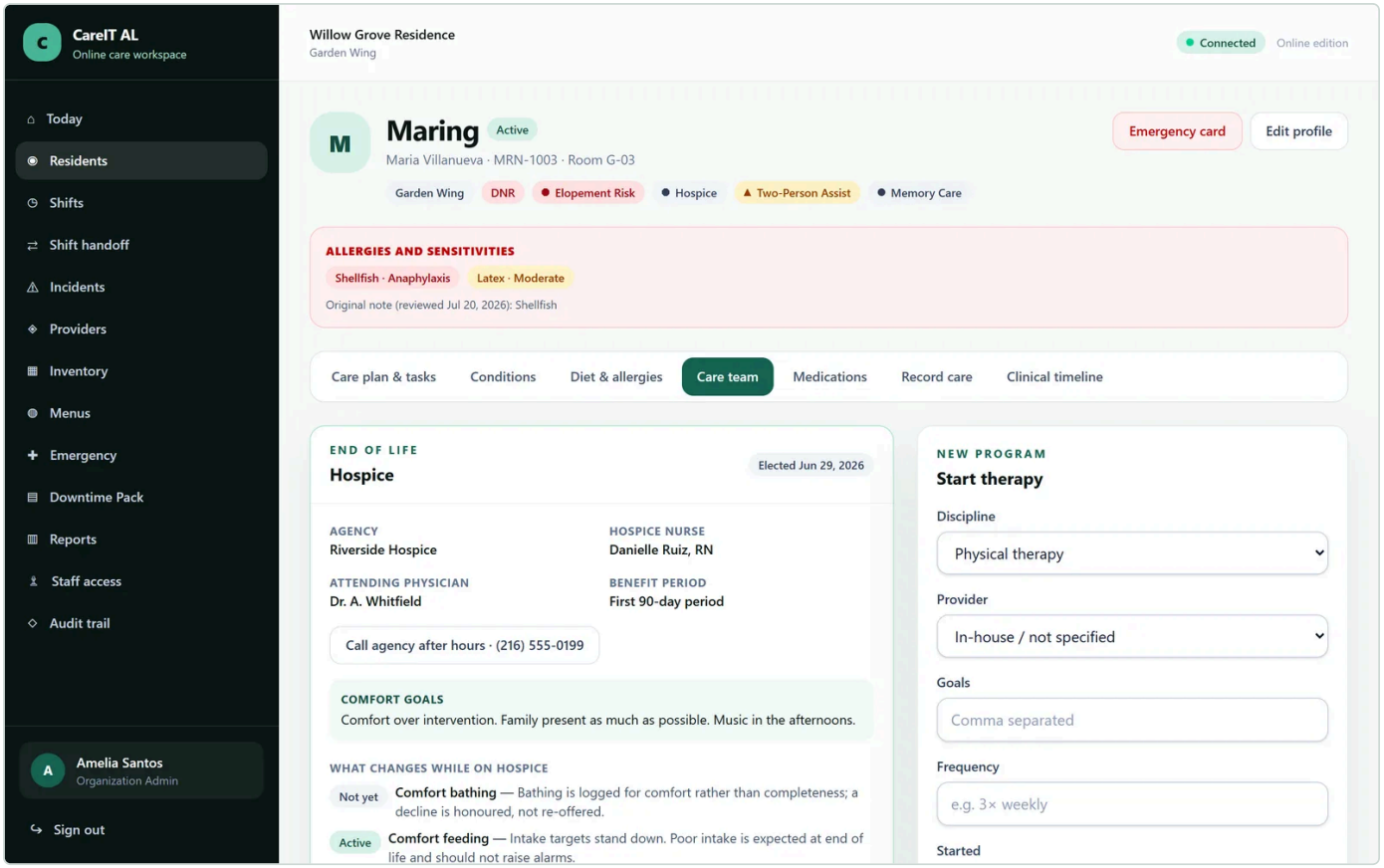
Much of the care delivered in assisted living comes from people who do not work for the facility. This chapter covers all of them.



Care team. Hospice, therapy programmes and outside provider visits for one resident, in one place.

Hospice

Hospice is a co-management relationship: an outside agency shares clinical responsibility with your staff. Recording an election captures the agency, the hospice nurse, the attending physician, the benefit period and the comfort goals — plus an after-hours number that dials directly, because 3 a.m. is when it matters.

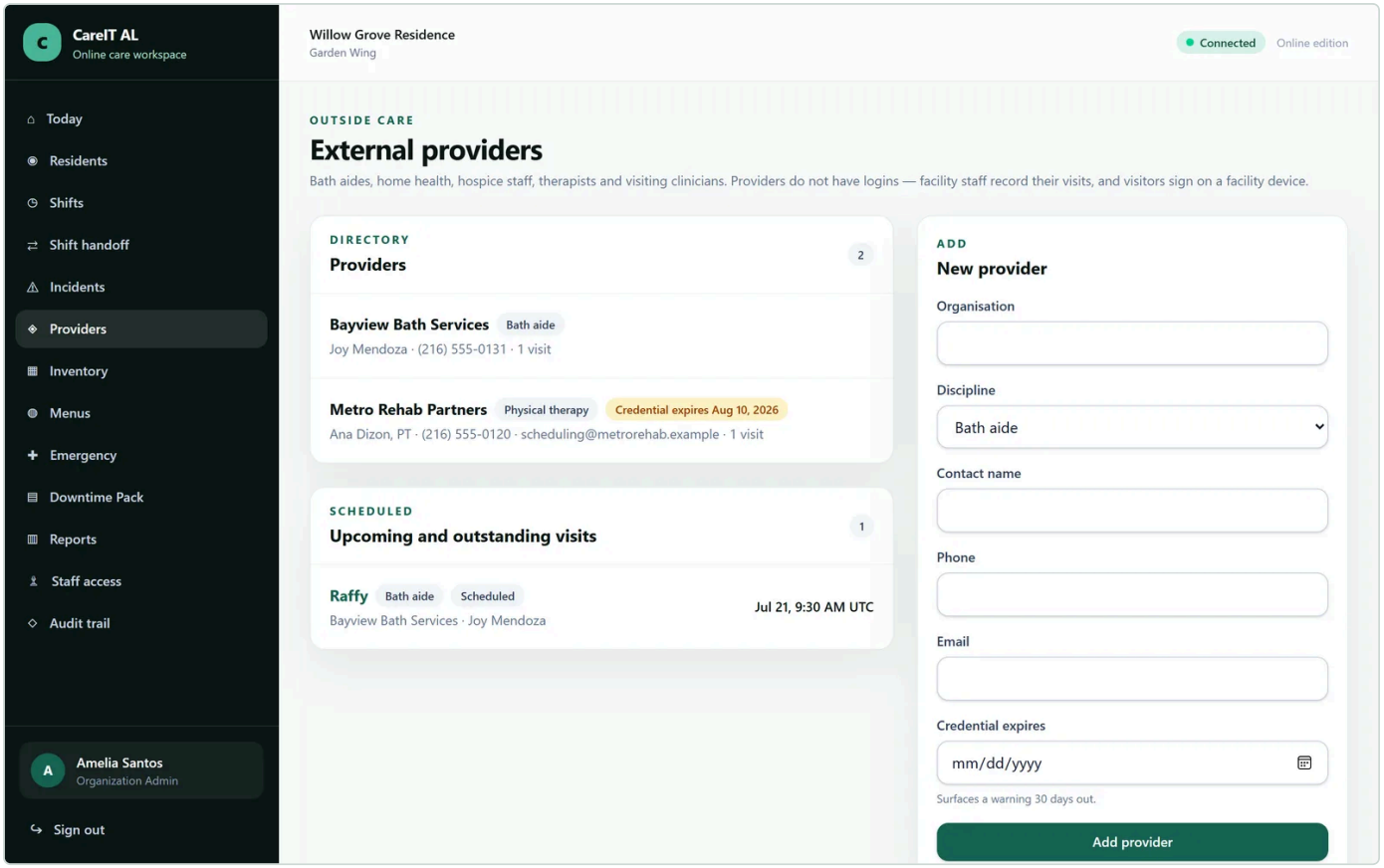


Hospice. Notes record whether the author was the agency or the facility, so it is always clear who wrote what. Hospice notes are permanent once recorded.

The screen also lists **what changes while a resident is on hospice**, and is honest about which of those the software currently enforces and which are documented intentions for your own policy to carry. It does not imply the system is doing something it is not.

> **HOSPICE MEDICATIONS**
>
> Hospice-ordered medications go in the same medication list as everything else, marked with their source. There is deliberately no separate hospice medication list — a second list is how residents get double-dosed.

Outside providers



Providers. Bath aides, home health, therapists, visiting clinicians. Credential expiry is flagged 30 days ahead and again once it has passed.

Providers do not have logins. Facility staff record the visit — who attended, when they arrived and left, what was done — and the visitor can sign on your device. This keeps outside access to resident records at zero while still producing a complete visit record.

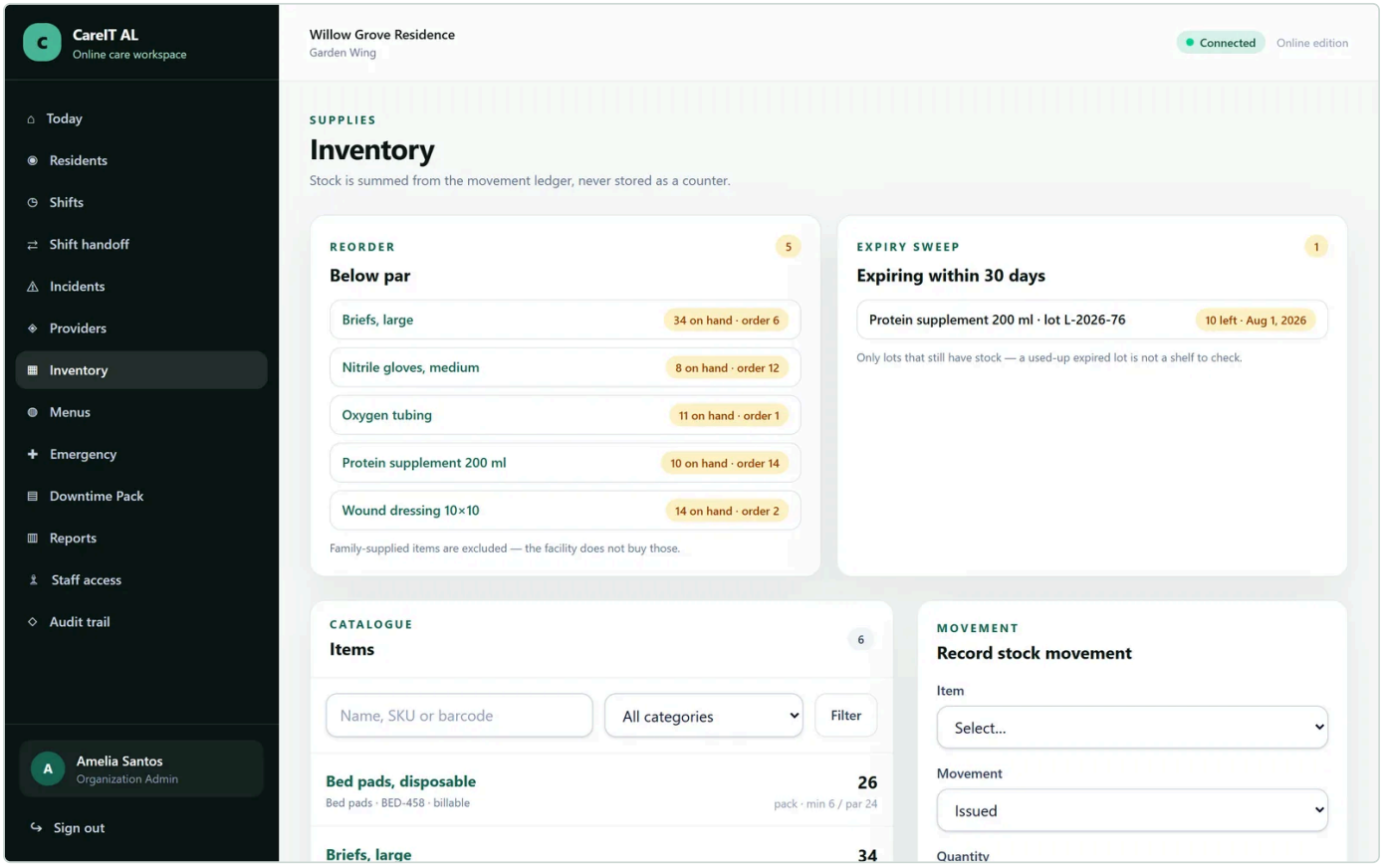
Therapy

PT, OT and ST programmes record goals, frequency, the provider and each session's attendance and progress. A programme can be put **on hold** — during a hospitalisation, say — which stops the expectation without deleting the prescribed plan.

Three missed sessions in a row flags the programme for a care-plan review. An attended session resets the count: three misses spread over a good month is a different signal from three in a row.

11 Inventory

Gloves, briefs, bed pads, wound care, nutrition supplements, oxygen supplies and equipment — what you have, what you used, and what to reorder.



Inventory. Reorder and expiry panels at the top answer the two questions worth asking daily; the catalogue and the movement form sit beneath.

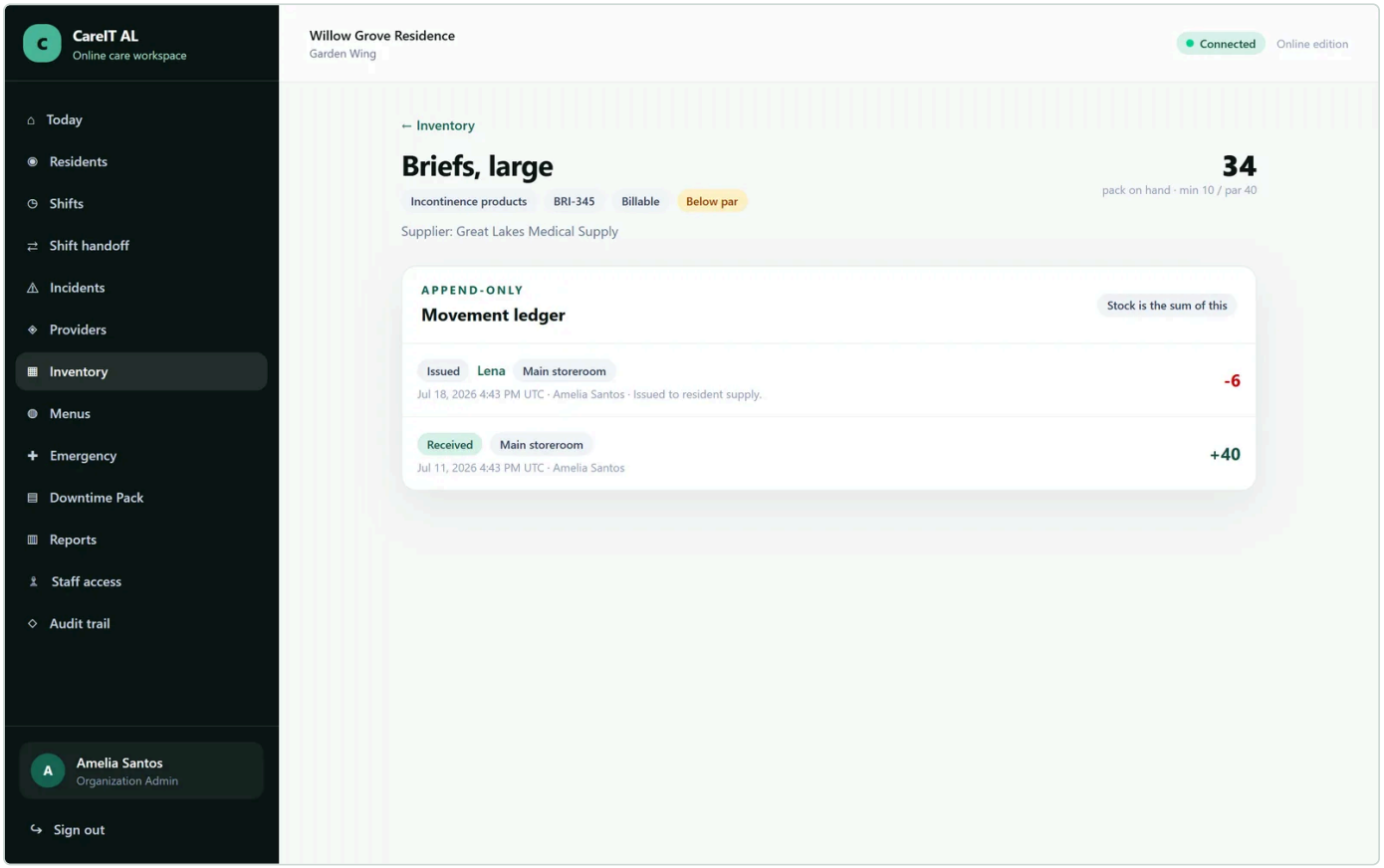
Recording movements

MOVEMENT	USE IT WHEN	EFFECT
Received	Stock arrives	Adds
Issued	Stock goes to a resident or a cart	Subtracts
Returned	Unused stock comes back	Adds
Wasted / expired	Stock is discarded	Subtracts
Count adjustment	The shelf disagrees with the system	Either — may be negative

Issuing to a **named resident** is what makes per-resident consumption reportable, and what supports a billable supply charge. It takes one extra field.

STOCK CANNOT GO NEGATIVE

If you try to issue more than the system holds, it stops you and tells you how many are on hand. That is not obstruction: it means the shelf and the record have diverged, and the honest fix is a count adjustment with a reason — which leaves a trail — rather than a quiet issue that makes the number look right.



Item detail. Stock on hand is always the sum of the movement ledger below it, never a stored number. Lots and expiry dates appear for tracked items.

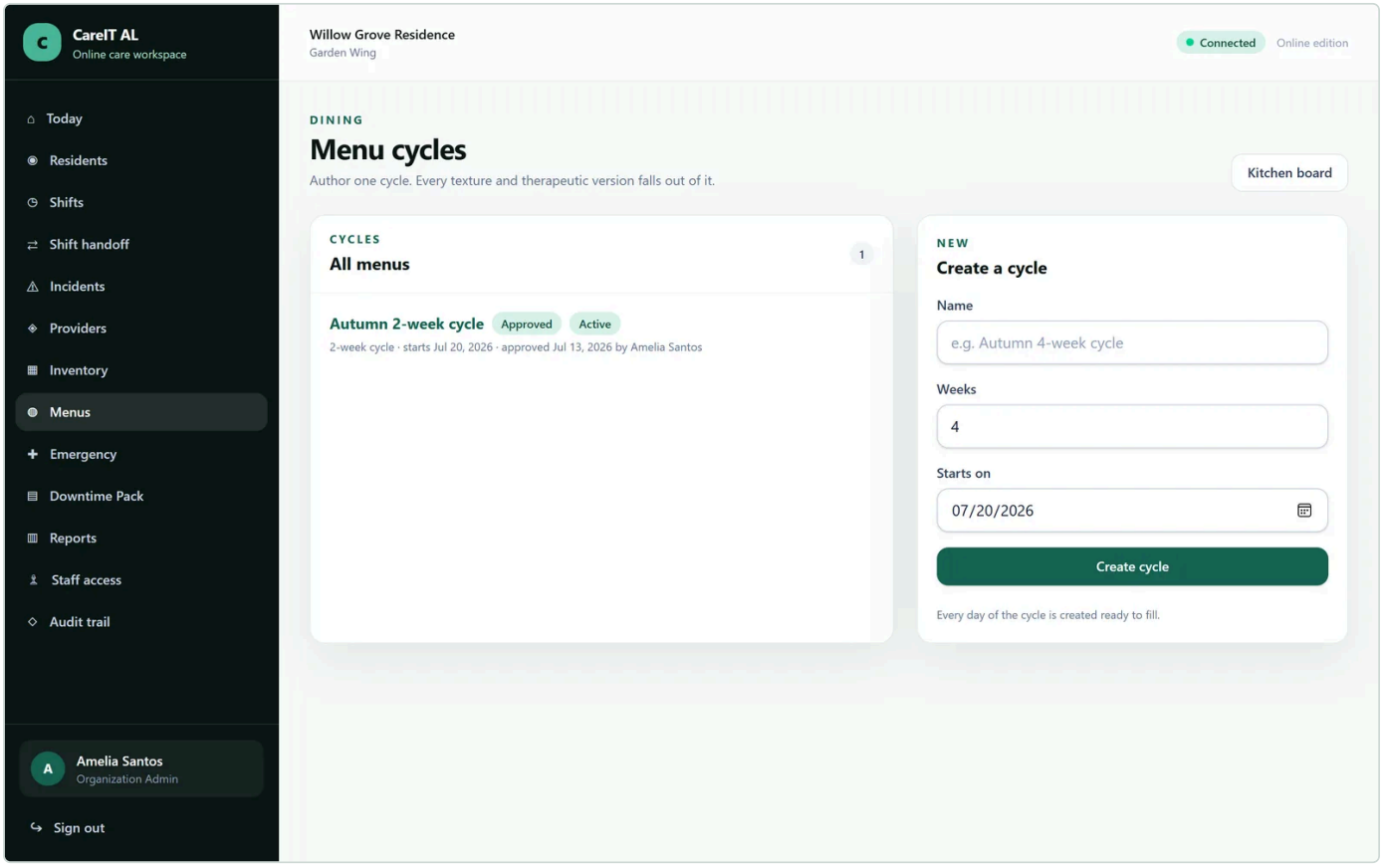
Reordering and expiry

Items below their par level appear as reorder proposals with a suggested quantity. **Family-supplied items are excluded** — the facility does not buy those, and proposing a purchase order for them is how a family ends up billed for briefs they already delivered.

The expiry sweep lists lots expiring within 30 days **that still have stock**. A used-up expired lot is not a shelf anyone needs to walk to.

12 Menus and the kitchen

One menu is authored once and resolves into every plate in the building, because the diet orders do the mapping.



Menu cycles. A cycle is a repeating block of weeks. Creating one lays out every day ready to fill.

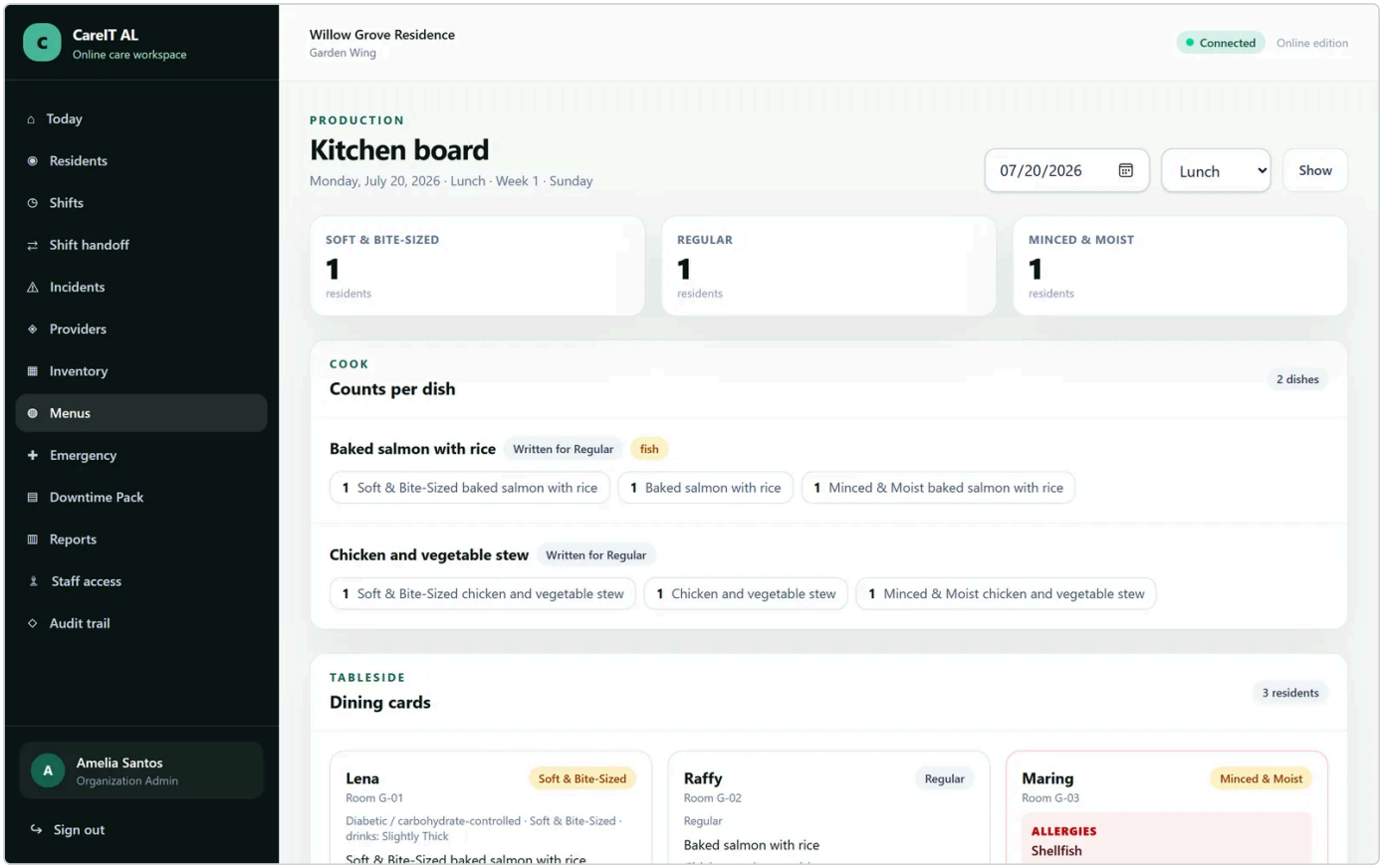
Authoring once, serving many

Write a dish at its normal texture — "Baked salmon with rice". The system derives the versions for every other texture automatically, so the same entry *is* the minced order and the puréed order. You only create an override when the kitchen genuinely wants something different, such as a soup instead of a puréed casserole.

Where both apply, a diet-specific override beats a texture-only one: a renal purée is more specific than any purée.

Dietitian approval

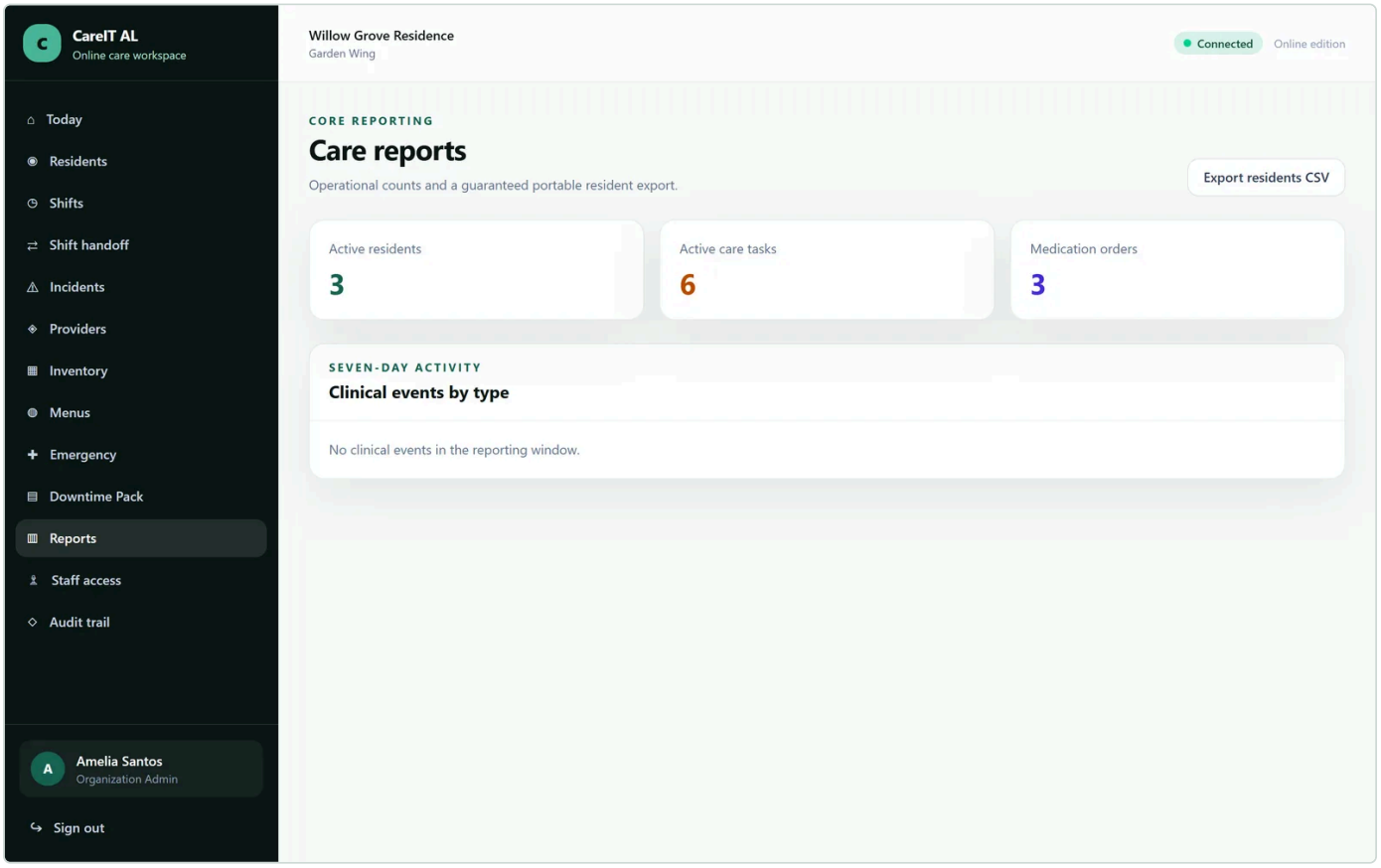
Menus are approved with a name and a timestamp, replacing the emailed-PDF ritual that cannot be audited. Anything served afterwards that differs from the approved menu is recorded as a substitution with a reason — permanently. That record is exactly what a surveyor asks to see.



The kitchen board. Counts per texture at the top, then counts per dish, then a dining card for every resident. NPO residents appear as a separate figure and never as a tray.

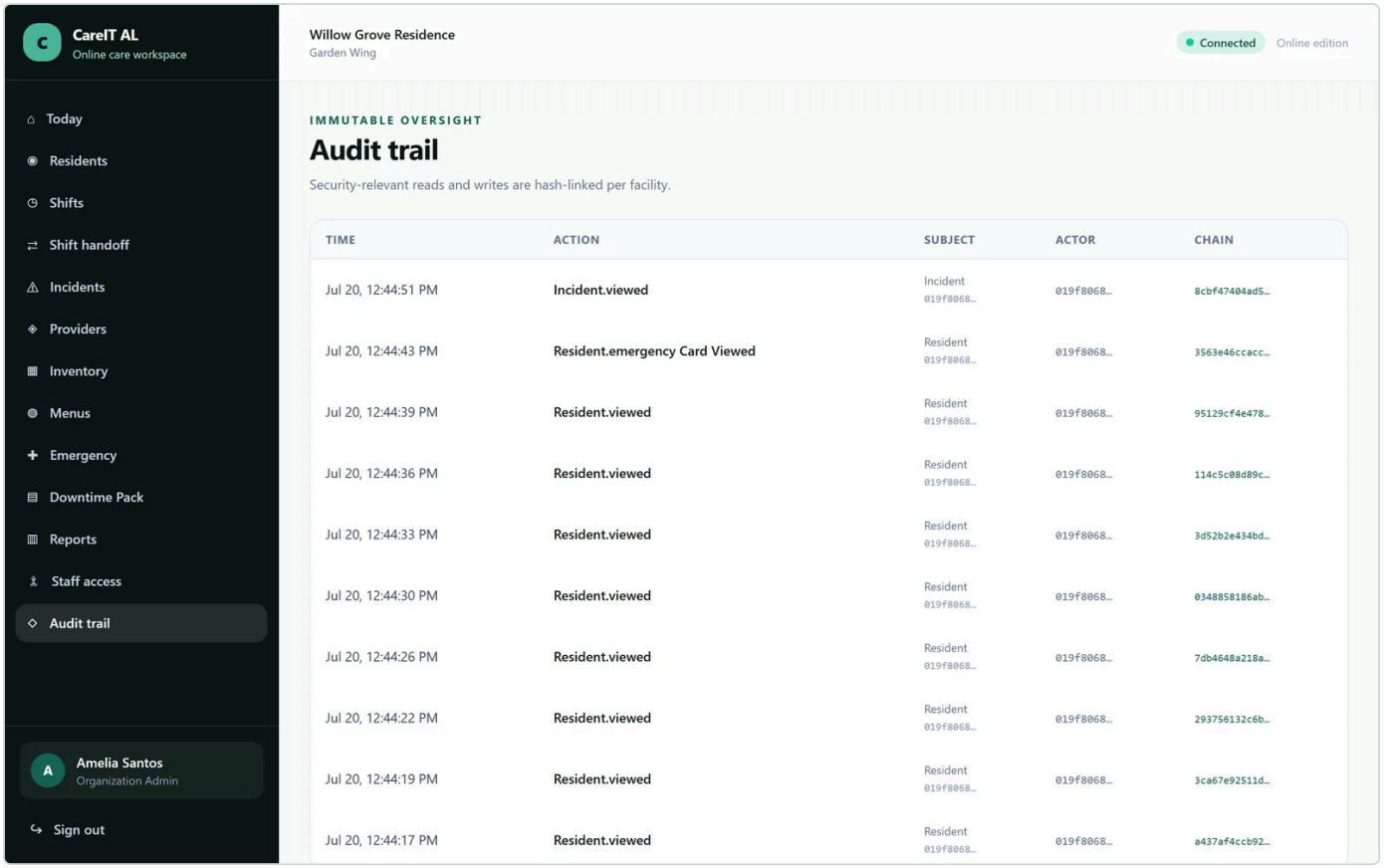
> **DO NOT SERVE TO**
>
> Where a dish's allergens match a resident's recorded **food** allergies, the board names that resident and their room directly beneath the dish, and the dining card repeats it. This is the last line of defence before a tray reaches a table.
>
> It matches on whole words, so a fish dish does not warn for a shellfish allergy — those are different allergies to different proteins, and a warning that fires when it should not is a warning people learn to ignore.

13 Reports, audit and downtime



Reports. Exports for the questions asked most often, including a resident CSV.

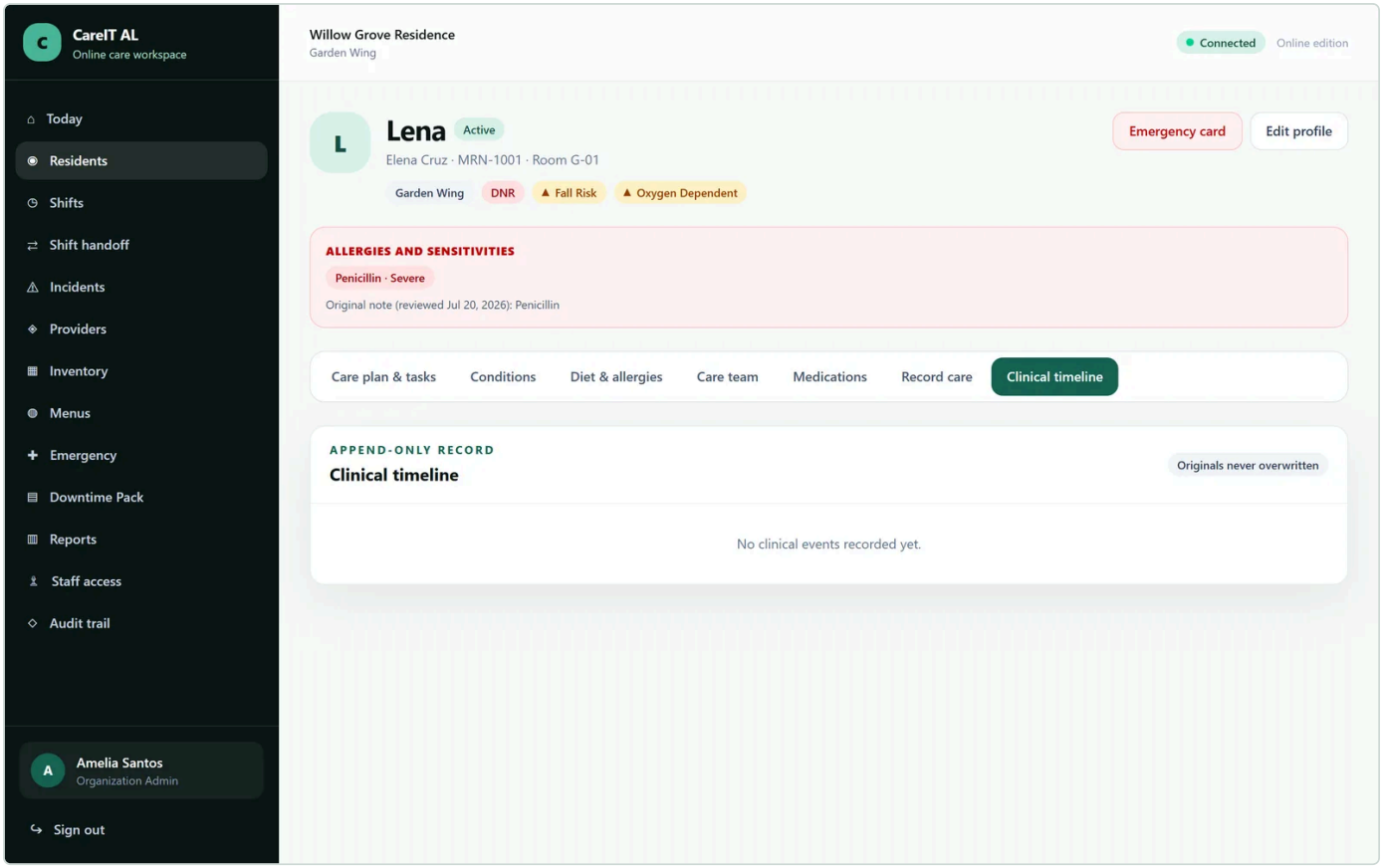
The audit trail



Audit trail. Who looked at what, and when. Viewing a resident record is itself recorded.

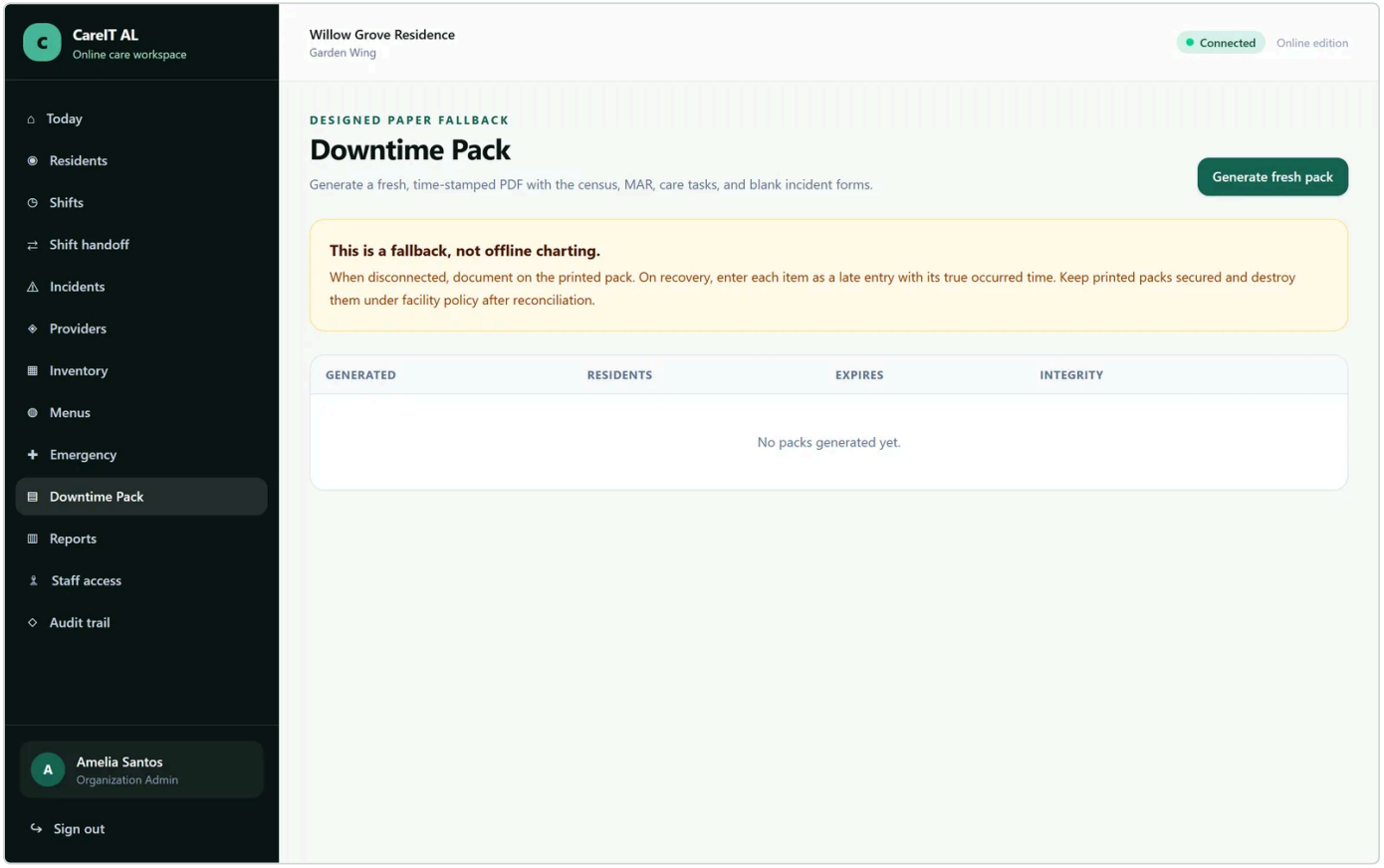
The clinical timeline

Each resident has a chronological record of everything clinical: care events, vitals, medication events, incidents, diet changes, therapy sessions. Entries are **append-only** — corrections are added as amendments and the original stays. Every entry is linked by a cryptographic chain, so a silently altered record is detectable.



Clinical timeline. Originals are never overwritten.

The Downtime Pack

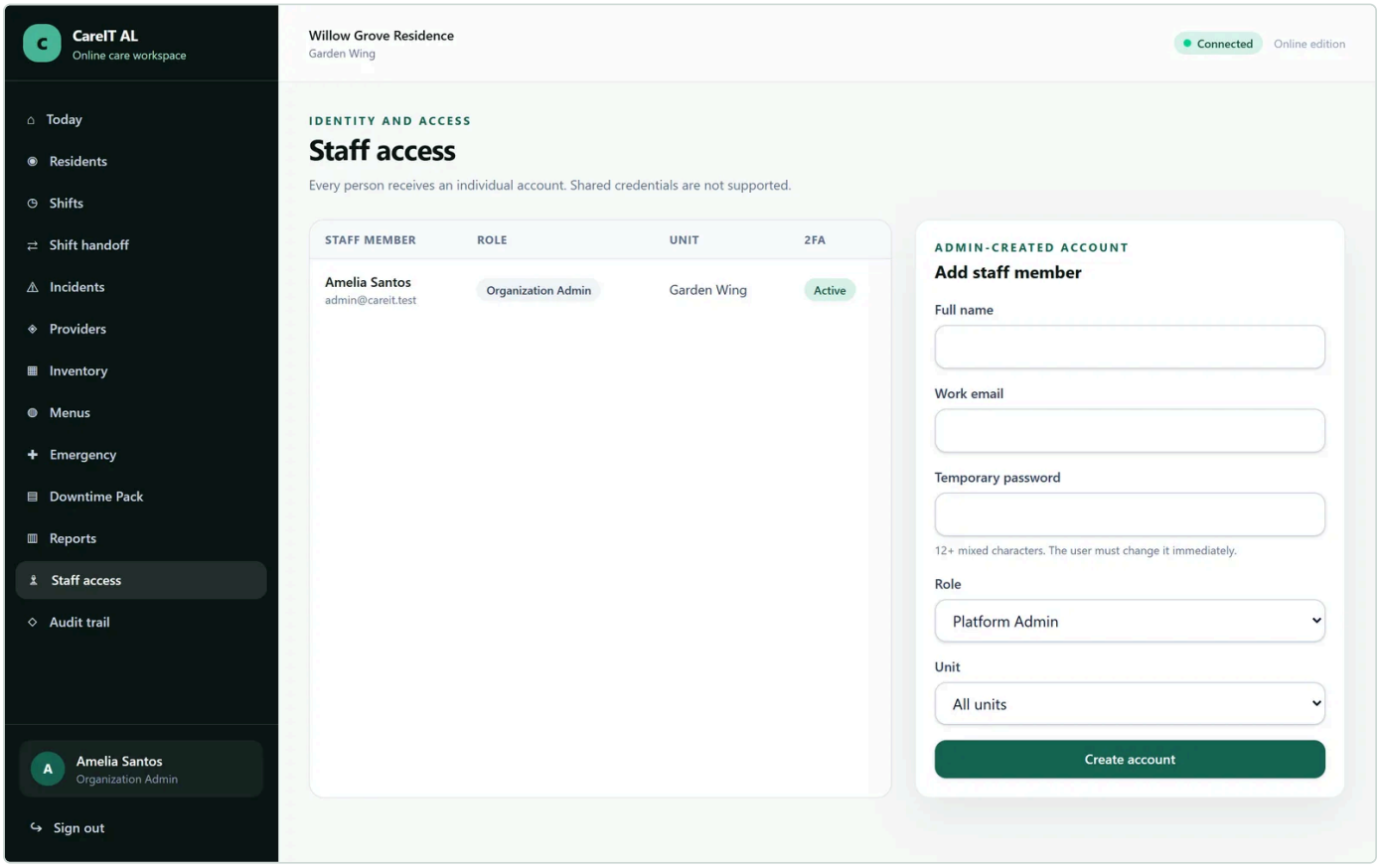


Downtime Pack. A printable PDF of everything needed to run on paper: resident face sheets with allergies and diet, task sheets, a backup medication record and blank incident forms.

GENERATE IT BEFORE YOU NEED IT

The Downtime Pack has to be generated while the system is up. A pack you can only produce when the system is working is no use during an outage — print a current one on a schedule and keep it where the shift can find it.

14 Administration



Staff access. Accounts, roles and facility assignment.

Roles

Roles are assigned per facility, not per person globally: the same individual can be a nurse at one facility and have no access at another. See appendix A for the full permission matrix.

Facility settings

Each facility carries its own timezone, country, currency and — importantly — its own statutory reporting windows.

> **TIMEZONE IS NOT COSMETIC**
>
> Incident times are interpreted in the facility's timezone. A facility set to the wrong zone will misdate its clinical records by that offset. Check it before the first resident is admitted.

15 Rules the system enforces

A short list of things the software will not let you do, and why. Knowing the reasoning makes the guardrails feel less arbitrary when you meet one mid-shift.

THE RULE	WHY IT EXISTS
Clinical records cannot be edited or deleted — only amended	A record that could have been altered is worth far less than one that could not. Amendments protect the person who wrote the original.
Charting stops when the connection drops	Better an obvious stop than work that looks saved and is not. Use the Downtime Pack.
Allergy and medication warnings never block	Text matching is imperfect. Systems that hard-stop on imperfect matching train staff to dismiss warnings without reading them.
Free-text allergy notes are never auto-parsed	A mis-read allergy can be fatal. A nurse reads it, records it, and confirms.
Stock cannot be driven negative	Keeps the ledger a believable account of the shelf. Discrepancies surface as adjustments with reasons.
An incident cannot be resolved without a care-plan change or a stated reason	The purpose of an incident report is prevention, not filing.
DNR, Full Code and Hospice flags cannot be set by hand	They follow the underlying record, so the flag and the fact can never disagree.
Two-factor authentication is mandatory	A stolen password should not become access to every resident's medical history.
Resident data is never visible across facilities	Enforced on every query, not by hiding links.

16 Troubleshooting

WHAT YOU SEE	WHAT TO DO
"Disconnected — clinical writes are blocked"	Stop charting. Keep the page open, switch to the Downtime Pack, and back-enter as late entries once restored.
Your two-factor code is rejected	Wait for the next code. If it keeps failing, your phone's clock has drifted — enable automatic time.
A resident is missing from the roster	Check the unit filter and the search box, then whether they are discharged. Residents at other facilities are never visible.
You cannot add a DNR or Hospice flag	These follow the code status field and the hospice enrolment. Change those instead.
"Only N on hand"	The shelf and the record disagree. Count, then record a count adjustment with a reason.
The kitchen board is empty	No approved menu cycle is active. A menu must be created, approved and made active.
An incident narrative has a mistake	Add an amendment. The original cannot be edited by anyone, including administrators.
A resident shows "Unreviewed original note"	Their allergies have not been transcribed yet. A nurse should record them and confirm.

A Roles and permissions

CAPABILITY	CAREGIVER	NURSE	FACILITY ADMIN	SCHEDULER	AUDITOR
View residents	●	●	●	●	●
Record care and vitals	●	●	●	—	—
Set care-context flags (tier 3–4)	●	●	●	—	—
Set clinical flags (tier 1–2)	—	●	●	—	—
Capture an incident	●	●	●	—	—
Investigate and close incidents	—	●	●	—	—
Manage medication orders	—	●	●	—	—
Manage diet orders and allergies	—	●	●	—	—
Manage hospice, providers, therapy	—	●	●	—	—
Record a provider visit	●	●	●	—	—
Issue inventory	●	●	●	—	—
Manage the inventory catalogue	—	●	●	—	—
Author and approve menus	—	●	●	—	—
Manage shifts	—	—	●	●	—
View reports	—	●	●	—	●
View the audit trail	—	—	●	—	●
Manage staff accounts	—	—	●	—	—

Organization administrators hold every permission across every facility in the organisation.

B Condition flag reference

FLAG	TIER	NOTES
DNR	1	Follows code status — not set by hand
Full Code	1	Follows code status; shown green, not red — it is not a danger
Comfort Care	1	Follows code status
Limited Intervention	1	Follows code status
Hospice	1	Follows hospice enrolment
Elopement Risk	1	
Isolation	1	
Fall Risk	2	Set a review date; risk changes week to week
Two-Person Assist	2	Mutually exclusive with other assist levels
Hoyer Lift Required	2	Mutually exclusive with other assist levels
Oxygen Dependent	2	
Diabetic	2	
Bedridden	2	Mutually exclusive with other mobility flags
One-Person Assist / Independent	3	Mutually exclusive with other assist levels
Wheelchair / Walker / Cane	3	Mutually exclusive with each other
Memory Care	3	
Alert & Oriented / Non-Alert	3	Mutually exclusive with each other

Mutually exclusive means setting one automatically retires the other — a resident cannot be both independent and two-person assist.

C IDDSI reference

The International Dysphagia Diet Standardisation Initiative framework. Foods and drinks use separate scales; a resident commonly needs a different level of each.

Food textures

LEVEL	NAME	IN PRACTICE
3	Liquidised	Smooth, no lumps, drunk or taken from a spoon
4	Puréed	Holds shape on a spoon; no chewing needed
5	Minced & Moist	Soft small lumps, easily mashed with the tongue
6	Soft & Bite-Sized	Soft, tender, cut to bite size
7	Regular	Everyday food, no texture modification

Drink thickness

LEVEL	NAME	IN PRACTICE
0	Thin	Flows like water
1	Slightly Thick	Thicker than water; flows through a straw
2	Mildly Thick	Sippable; pours quickly from a spoon
3	Moderately Thick	Drunk from a cup; effort needed through a straw
4	Extremely Thick	Taken with a spoon; holds shape

D Glossary

Amendment	A correction added alongside a clinical record. The original is never changed.
Append-only	A record that can be added to but never edited or deleted.
Clinical timeline	The chronological record of everything clinical for one resident.
Code status	The resuscitation directive: DNR, Full Code, Limited Intervention, Comfort Care or Other.
Condition flag	A short label on a resident conveying something staff must know quickly.
Derived flag	A flag that follows another record rather than being set by hand.
Dining card	The per-resident card the server reads at the table: texture, diet, allergies, plates.
Downtime Pack	The printable paper fallback used when the system is unavailable.
IDDSI	The international framework for food texture and drink thickness levels.
NPO	*Nil per os* — nothing by mouth.
Par level	The stock level an item should be topped back up to when reordering.
PRN	*Pro re nata* — a medication given as needed rather than on a schedule.
Post-fall protocol	The scheduled neurological observations following a fall.
Reporting window	The time allowed to make a required report about an incident.
Substitution	Serving something other than the approved menu; permanently recorded with a reason.

ABOUT THIS DOCUMENT

CareIT AL Online v0.7.1. Screenshots are taken from a running system with demonstration data; your screens will show your own residents and will vary with your role.

This guide describes how the software behaves. It is not legal or clinical advice, and it does not establish that any facility meets its licensing requirements.