June 2023

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Known Issues

OT Discharge Assessment template

➢ **Question: K0520 Nutritional Approaches.**

- The system will not allow answering column 4, Last 7 Days and column 5, At Discharge.

- Document information in column 5.

  - If column 4 should have different answers, email **#HCH QA RNs & Coders** with Patient Name, Patient ID, date and correct information for column 4.

ST Start of Care Assessment template

➢ **Care Coordination/Physician Contact.**

- The system will not allow documentation unless is checked off first.

- Tap **No contact required/made** then tap/check the correct answers.

- Tap the box for **No contact required/made** again to remove the checkmark.

Updates

Flyers

The following flyers have been updated, tap the link to see the updated workflow.

- [Admission Visit](#)
- [Resumption of Care](#)
- [Routine Visit](#)
- [How to Reset Cache](#)
- [Secondary Eval](#)

OnBase Resources

➢ **It is very important to search for a patient using their Patient ID to ensure that the document is filed to the correct medical record. This is included on all documentation that is scanned and can be referenced as necessary.**

- [Written instructions for viewing and uploading documents.](#)

- [Video instruction for viewing patient documents](#).

- [Video instruction for uploading documents.](#)

Infections and Infectious Diseases

➢ **Infections and Infectious Diseases are recorded in Adverse Events and allows the care team with possible opportunities to improve care and prevent infections.**

- Infections are documented that develop 48 hours after admission to home care services and are monitored as part of the Infection Surveillance and Prevention Plan. This is documented if a patient is diagnosed with an infection while they are under care.

- Infectious Diseases are medical infections that a patient may or may not be receiving treatment for.

➢ **A visual indicator will display on the Today screen and the patient's banner bar to indicate an Adverse Event occurred. Please reference the Adverse Events tab for more information.**

[**Tap here for more information on how to document an Adverse Event.**](#)

Reminders

Start and End Visit Updates

➢ **If End Visit is not tapped prior to starting the next visit of the day, an alert will populate indicating the previous visit will be ended one minute prior to the Start Visit time for the current patient.**

➢ **If the last visit of the day was not ended, and the first visit of the next day is started, an alert will populate indicating that yesterday's visit will be ended at 11:59 for the previous day.**
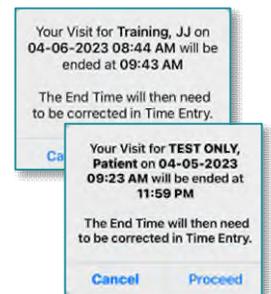
> **IMPORTANT:** If these do occur, update the end time on time entry and enter a task to indicate why the time is being updated.

Managing Tasks

➢ **The status of Decline will leave tasks on your task list and should not be used.**

Synchronizing (Synch) vs. Submitting

➢ **Information that can be pushed or automatically updated when the app refreshes is called synchronizing.**

➢ **Information that is tablet specific until it is manually sent to host and signed is called Submitting.**

Marking a Visit Unmade

➢ Prior to checking **Unmade** on **Time Entry**, remove the **Start** and **End** time as necessary.

- Add a Clinical Note to indicate why the visit was **Unmade**.
- If **Start Visit** was tapped, the visit needs to be marked **Unmade**. Navigate back to the **Today** screen to tap undo ↩ within the patient visit box.
- Mark the visit as Unmade on Time Entry.
    - If the Unmade visit is synchronized and times are associated, reach out to your manager to remove the times, sync the iPad, then mark the visit unmade again.

Attaching Documentation to a Visit

➢ **Assessments**

- Tap the **Assessment**, then tap the ellipsis (…). Tap **Connect to Visit/Phone Call** then tap your visit from the list.

➢ **Clinical Note**

- Tap the **Applicable** note, tap **Copy** note in the bottom right corner.
- Tap **Add** to add a new note, within the Note section, tap twice and tap **Paste**. Add **Visit Date** and **Use Code**.
- Navigate to the note below (note not attached to the visit) and scroll to the bottom and tap the trash can.

➢ **Care Plan Charting**

- Go to **Open Charts** and tap **Care Plan Charting**.
- Change a charted response to a different response and then tap the progression response as originally documented. Example: (Tap any circle for **No**, then tap the circle to change the answer back to **Yes**).

Finishing the Day

➢ Have you managed **Open Patients** – no number on the menu?

➢ Have you submitted your visit(s) from **Time Entry**?

➢ Have your **Activities** synchronized – are they in gray font on the **Today** screen?

➢ Do you see the **green** checkmark on the **Today** screen to indicate the visit was sent to host?

CI Assistance

Cheat Sheets

➢ [Clinical Informatics Education (https://ci.northernlighthealth.org/netsmart):](https://ci.northernlighthealth.org/netsmart) To ensure you always have the most up-to-date information, be sure to access **Cheat Sheets** on the Clinical Informatics Netsmart Education Portal.

Support

➢ CI provides **virtual rounding** on a daily basis, Monday through Friday, with time slots alternating between morning and afternoon.

   • Please refer to your Outlook Calendar invite and plan to attend and ask questions related to the Netsmart clinical EHR.

➢ If not able to attend a virtual rounding session, please **submit a Help Desk ticket** through the **Self-Service Portal** or by calling the **Help Desk 207-973-7728 or 1-888-827-7728**.

For questions regarding process and/or policies, please contact your unit's Clinical Educator or Clinical Informaticist. For any other questions please contact the Customer Support Center at:
207-973-7728 or 1-888-827-7728.

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