

There are several types of Discharges, each type has specific requirements necessary for the patient record. While not all tiles require documentation, it may require you to review and edit as necessary.

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Starting and Ending a Discharge visit

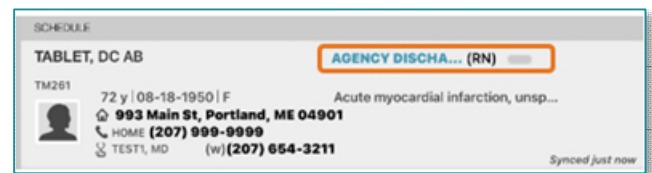
STEP 1: Log into Netsmart Homecare.

STEP 2: Locate the patient on the **Today** screen and tap the **Visit Type**.

STEP 3: In the patient’s home, tap **Start Visit**.


- This logs the current time as the start time for the visit in the **Time Entry** screen.

STEP 4: When leaving the patient’s home after the visit is complete, tap **End Visit** and obtain signature.

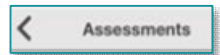


Agency Discharge with Visit

STEP 1: Tap **Assessments**.

- The assessments previously completed for the patient display on the left.
- Tap  in the lower right.
 - Select the **Template** from the drop down and **Visit Type** (**Discharge** or **Routine** visit – if OASIS is not required) if not auto-populated.
 - Tap the box for **D/T Summary** then choose **Discharge from Agency**.
 - If this was not done before Assessment started, tap the three dots in the lower right to tap **D/T Summary** at any time.
 - Tap **Done**.

- Complete the required fields in the assessment as indicated by the orange outlines.
 - To activate a section, tap the three dots in the lower right while in the assessment and tap **Show Details**.
 - Tap the applicable dithered section in the navigator to the left and tap the three dots and tap **Activate**.
 - Indicate this is for this assessment only.
 - If necessary, activate additional dithered sections as necessary.
- When finished or leaving the screen, tap the < **back arrow** in the top left to save the documentation and return to the charting page.



STEP 2: Tap **Care Plan/Charting**.


- Default screen is **Compact Charting**. Tap **Care Plan Editing** in the bottom of the screen.
- Tap ⊕ in lower right of screen.
- Enter **Disc** in the Search box then tap the **Discharge Care Plan** for your Discipline.
- Tap ⊕ to the right of **Interventions**.
 - Tap the box to add **Discharge from home health services** and any other applicable Interventions performed.
 - Tap **Ordering Physician** to select the appropriate Physician.
 - Tap **Done**.
- Tap the three dots in the lower right.
 - Tap **Discontinue**.
 - Tap each Care Plan in left column to discontinue individually.
 - Tap the < **back arrow** in the top left to save the Care Plans / Charting and return to charting page.




STEP 3: Tap **Visit Frequency (VF)**.

- Tap each VF in left column to add discharge date as End Date to all active Visit Frequencies.
 - Tap **Do not created end sup order** box.
- Visit Frequencies starting in the future should have an End Date that matches the Start Date.
 - Tap **Do not created end sup order** box.
- Tap the < **back arrow** to save the information and return to the charting page.

STEP 4: Tap **Clinical Note**.

- The clinical notes completed for the patient display on the left.
 - Navigate between **Active** and **All** clinical notes filter as necessary.
- Tap  to add a new clinical note.
 - Utilize the applicable note template and ensure that all required documentation is complete.
 - Use Code is **D**.
 - Add discharge date as **End Date** and tap **Done**.
- Tap the **< back arrow** to save the information return to the charting page.

STEP 5: Tap **Admissions /Status**.

- Navigate to **Status** and tap the drop-down arrow to choose the applicable Discharge status.
 - For Hospice patients, add **Status Time** (time of death) if applicable.
- Tap the **< back arrow** to save the status and return to the charting page.
- Sync  from the **Today** screen.
- Warning alerts will display:
 - Warning: **All scheduled visits after (today's date) will be removed.**
 - Tap **OK**.
 - Warning: **Care Team will be ended and future end dates will be updated to the Discharge date. Care Team with future start date will be deleted.**
 - Tap **OK**.
 - Warning: **There are active medications for this patient. Please discontinue all active medications before discharge.**
 - Tap **OK**.
 - Go to **Discontinue Medications**.
 - Add **End Physician** (if not auto-populated) by tapping in the box to choose Provider.
 - Tap **Done**.
 - Tap **< back arrow** in the top left to save the documentation.

STEP 6: Sync  from the **Today** screen.

STEP 7: Submit documentation on **Time Entry** screen.

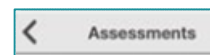
Agency Discharge without Visit / Discharge No OASIS No Visit (if OASIS is not required).

STEP 1: Tap **Assessments**.

- The assessments previously completed for the patient display on the left.

NOTE: This step only applies if an OASIS is required.

- Tap ⊕ in the lower right.
 - Select the **Template** from the drop down and the **Visit Type** (Discharge) if not auto-populated.
 - Tap the box for **D/T Summary** then choose **Discharge from Agency**.
 - If this was not done before Assessment started, tap the three dots in the lower right to tap D/T Summary at any time.
 - Tap **Done**.
- Complete the required fields in the assessment as indicated by the orange outlines.
 - To activate a section, tap the three dots in the lower right while in the assessment and tap **Show Details**.
 - Tap the applicable dithered section in the navigator to the left and tap the three dots and tap **Activate**.
 - Indicate this is for this assessment only.
 - If necessary, activate additional dithered sections as necessary.
- When finished or leaving the screen, tap the < **back arrow** in the top left to save the documentation and return to the charting page.



STEP 2: Tap **Care Plan/Charting**.

- Default screen is **Compact Charting**. Tap **Care Plan Editing** in the bottom of the screen.
- Tap ⊕ in lower right of screen.
- Enter **Disc** in the Search box then tap the **Discharge Care Plan** for your Discipline.
- Tap ⊕ to the right of **Interventions**.
 - Tap the box to add **Discharge from home health services** and any other applicable Interventions performed.
 - Tap **Ordering Physician** to select the appropriate Physician.
 - Tap **Done**.
- Tap the three dots in the lower right.
 - Tap **Discontinue**.
 - Tap each Care Plan in left column to discontinue individually.




- Tap the < **back arrow** in the top left to save the Care Plans/Charting and return to charting page.


STEP 3: Tap **Visit Frequency**.

- Tap each VF in left column to add discharge date as End Date to all active Visit Frequencies.
 - Tap **Do not created end sup order** box.
- Visit Frequencies starting in the future should have an End Date that matches the Start Date.
 - Tap **Do not created end sup order** box.
- Tap the < **back arrow** to save the information and return to the charting page.

STEP 4: Tap **Clinical Note**.

- The clinical notes completed for the patient display on the left.
 - Navigate between **Active** and **All** clinical notes filter as necessary.
- Tap  to add a new clinical note.
 - Utilize the applicable note template and ensure that all required documentation is complete.
 - Use Code is **D**.
 - Add discharge date as **End Date** and tap **Done**.
- Tap the < **back arrow** to save the information return to the charting page.

STEP 5: Tap **Admissions /Status**.

- Navigate to **Status** and tap the drop-down arrow to choose the applicable Discharge status.
 - For Hospice patients, add **Status Time** (time of death) if applicable.
- Tap the < **back arrow** to save the status and return to the charting page.
- Sync  from the **Today** screen.
- Warning alerts will display:
 - Warning: **All scheduled visits after (today's date) will be removed.**
 - Tap OK.
 - Warning: **Care Team will be ended and future end dates will be updated to the Discharge date. Care Team with future start date will be deleted.**
 - Tap OK.
 - Warning: **There are active medications for this patient. Please discontinue all active medications before discharge.**
 - Tap OK.


- Go to **Discontinue Medications**.
 - Add **End Physician** (if not auto-populated) by tapping in the box to choose Provider.
 - Tap **Done**.
- Tap < **back arrow** in top left to save the documentation.

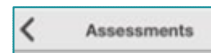
STEP 6: Tap **Sync** in the bottom right-hand corner.

STEP 7: Submit documentation on **Time Entry** screen.



Discipline Discharge with Visit

STEP 1: Tap **Assessments**.

- The assessments previously completed for the patient display on the left.
- Tap  in the lower right.
 - Select the **Template** from the drop down and the **Visit Type** (Routine) if not auto-populated.
 - Tap **Done**.
- Complete the required fields in the assessment as indicated by the orange outlines.
 - To activate a section, tap the three dots in the lower right while in the assessment and tap **Show Details**.
 - Tap the applicable dithered section in the navigator to the left and tap the three dots and tap **Activate**.
 - Indicate this is for this assessment only.
 - If necessary, activate additional dithered sections as necessary.
- When finished or leaving the screen, tap the < **back arrow** in the top left to save the documentation and return to the charting page.



STEP 2: Tap **Care Plan/Charting**.

- Default screen is **Compact Charting**. Tap **Care Plan Editing** in the bottom of the screen.
- Tap  in lower right of screen.
- Enter **Disc** in the Search box then tap the **Discharge Care Plan** for your Discipline.
- Tap  to the right of **Interventions**.
 - Tap the box to add **Discharge from home health services** and any other applicable Interventions performed.




- Tap **Ordering Physician** to select the appropriate Physician.
- Tap **Done**.
- Tap the three dots in the lower right.
 - Tap **Discontinue**.
 - Tap each Care Plan in left column to discontinue individually.
 - Tap the < **back arrow** in the top left to save the Care Plans/Charting and return to charting page.

STEP 3: Tap **Visit Frequency**.

- Tap each VF in left column to add discharge date as End Date to all active Visit Frequencies.
 - Tap **Do not created end sup order** box.
- Visit Frequencies starting in the future should have an End Date that matches the Start Date.
 - Tap **Do not created end sup order** box.
- Tap the < **back arrow** to save the information and return to the charting page.

STEP 4: Tap **Clinical Note**.

- The clinical notes completed for the patient display on the left.
 - Navigate between **Active** and **All** clinical notes filter as necessary.
- Tap  to add a new clinical note.
 - Utilize the applicable note template and ensure that all required documentation is complete.
 - Use Code is **OC**.
 - Add discharge date as **End Date** and tap **Done**.
- Tap the < **back arrow** to save the information return to the charting page.

STEP 5: Tap **Care Team**.

- Add **End date** on line with your Discipline.
- Tap the < **back arrow** to save the status and return to the charting page.

STEP 6: On **Today** screen, tap **Sync** in the bottom right-hand corner.

STEP 7: Submit documentation on **Time Entry** screen.

Discipline Discharge No Visit

STEP 1: Tap **Care Plan/Charting**.

- Default screen is **Compact Charting**. Tap **Care Plan Editing** in the bottom of the screen.
-

- Tap ⊕ in lower right of screen.
- Enter **Disc** in the Search box then tap the **Discharge Care Plan** for your Discipline.
- Tap ⊕ to the right of **Interventions**.
 - Tap the box to add **Discharge from home health services** and any other applicable Interventions performed.
 - Tap **Ordering Physician** to select the appropriate Physician.
 - Tap **Done**.
- Tap the three dots in the lower right.
 - Tap **Discontinue**.
 - Tap each Care Plan in left column to discontinue individually.
 - Tap the < **back arrow** in the top left to save the Care Plans/Charting and return to charting page.



STEP 2: Tap **Visit Frequency**.

- Tap each VF in left column to add discharge date as End Date to all active Visit Frequencies.
 - Tap **Do not created end sup order** box.
- Visit Frequencies starting in the future should have an End Date that matches the Start Date.
 - Tap **Do not created end sup order** box.
- Tap the < **back arrow** to save the information and return to the charting page.

STEP 3: Tap **Clinical Note**.

- The clinical notes completed for the patient display on the left.
 - Navigate between **Active** and **All** clinical notes filter as necessary.
- Tap ⊕ to add a new clinical note.
 - Utilize the applicable note template and ensure that all required documentation is complete.
 - Use Code is **OC**.
 - Add discharge date as **End Date** and tap **Done**.
- Tap the < **back arrow** to save the information return to the charting page.

STEP 4: Tap **Care Team**.

- Add **End date** on line with your Discipline.
- Tap the < **back arrow** to save the status and return to the charting page.

STEP 5: On **Today** screen, tap **Sync** in the bottom right-hand corner.

STEP 6: Submit documentation on **Time Entry** screen.

How to change the Visit Type

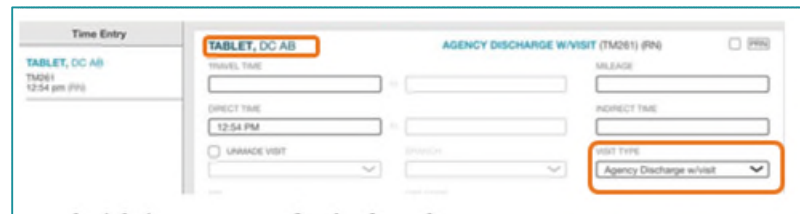
➤ Visit not started

- Update the visit type on the patient calendar for that patient visit and tap **Done**.

➤ Visit that has already Started

STEP 1: From the menu, tap **Time Entry**.

STEP 2: Tap the patient's name in the left column then update the **Visit Type** using the drop-down arrow.

A screenshot of the 'Time Entry' screen in a medical software interface. The screen is divided into two main sections. The left section is titled 'TABLET, DC AB' and shows a patient's name 'TM261' and a time '12:54 pm (P)'. The right section is titled 'AGENCY DISCHARGE W/VISIT (TM261) (PN)' and contains several input fields: 'TRAVEL TIME', 'DIRECT TIME' (with '12:54 PM' entered), 'ARRIVAL TIME', and 'DEPART TIME'. Below these fields are two dropdown menus: 'VISIT TYPE' (set to 'Agency Discharge w/visit') and 'SPECIFY'. The 'VISIT TYPE' dropdown is highlighted with an orange box.

STEP 3: Tap the patient's name in the left column then tap the current **Visit Type**.

- Tap the patient's name (above **Travel Time**) to return to the patient chart.


Add an Oasis Only Assessment to a Visit

If an Assessment has been completed and OASIS questions need to be added, add an **OASIS only** Assessment to visit to document the OASIS questions.

➤ Patient Calendar

- Add **new** visit with the Visit Type **Documentation Patient Call**.
 - Select **OASIS Visit Non-Billable** only if a separate visit is made to complete the Assessment.
- Do not add a Start time.
- Tap **Done**.

➤ Patient chart

- Tap **Assessments**.
- Tap  to add new Assessment.
 - Click drop-down arrow under Template to tap **OASIS Only**.
 - Under **Visit Type**, select the appropriate visit type requiring an OASIS Assessment.
- Tap **Done**.
- Complete the Assessment.