Northern Light Health

From the Office of Clinical Informatics

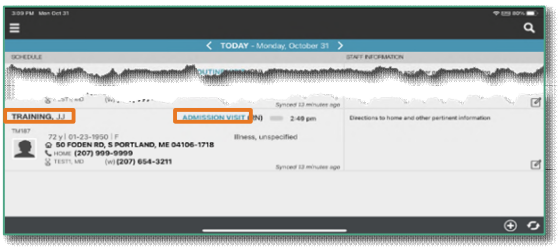
Home Care and Hospice Admission/NTUC Visit

April 4, 2023

Patient Visits have different requirements for documentation. The visit type selected for a patient visit will dictate the required documentation necessary for that visit type.

Admission Visit

On an Admission Visit, several tiles on the charting page indicate required. While not all tiles require documentation, it may require you to review and edit, as necessary.



➢ **Starting & Ending Visit**

STEP 1: Login to **Netsmart Homecare**.

STEP 2: Locate the patient on the **Today** screen and tap the **Patient's name** or **Visit Type**.

STEP 3: Tap **Sync** in the bottom right-hand corner.

STEP 4: From the charting page, tap **Start Visit**.

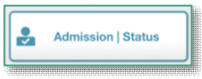
- This logs the current time as the start time for the visit type in the **Time Entry** screen.
- Referral documentation including the Intake Assessment may be reviewed by selecting **Attachments**, this information may be viewed at any time.

STEP 5: The highlighted tiles display, indicating required documentation.

- Tap **End Visit** when leaving the patient home.

- Obtain Signature.
  - If there is a delay leaving, wait to tap **Done** until leaving the residence. This will be the recorded **End Time**.

➢ **Visit Documentation**



STEP 1: Tap **Admissions/Status**.

- Navigate to **Status** and select the drop-down to update the status.
  - If an error appears when updating the patient status line, review **Basic/Demographics** for incomplete fields.

- **If** a patient is **Not Taken Under Care (NTUC)**
  - Time Entry - update Visit Type to **NTUC with Home Visit.**
  - Admission status line appropriately (i.e., Clinical No skill needed).
- Select the **< back arrow** to save the status and return to the charting page.
  - **Sync** the chart by tapping the sync icon at the lower right of the screen.

STEP 2: Tap **Payers/Authorization.**

- Verify Insurance information is correct.
  - If information is not correct, take a picture of the insurance card and send to the Intake team at #VNA-Intake (your location)
- Select the **< back arrow** to return to the charting page.

STEP 3: Tap **Basic/Demographics**.

- Review information on screen for accuracy and completeness. Add **Preferred Name** and/or **Preferred Pronoun** if provided.
- Review the **Notes** text box for further insurance information.
- The navigator displays on the left.
  - Tap **Addresses**. Confirm place of service is correct and **Service Location** is checked.
    - Add pertinent information into **Staff Information box** which will display on the **Today** screen for all clinicians to review.
  - Tap **Demographics** to add or edit fields.
- Select the **< back arrow** to save the information and return to the charting page.

STEP 4: Tap **General Clinical**.

- The navigator displays on the left. Every screen must contain information. Tap each screen to review, update, and add information as applicable. Use the **+** at the top left of screen to add from list or free text information.
- Select the **< back arrow** to save the information and return to the charting page.

STEP 5: Tap **Medications**.

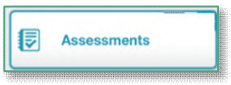
- Toggle between active and discontinued medications to display in the navigator.
- Adding medications:
  - If pending medications display, tap **Pending Medications** and swipe left to include or exclude.
    - Continue until all medications have been added and update the details for the medications, as applicable.
  - If patient is being re-admitted, tap 3 dots at lower right to Re-activate medications that were discontinued at previous discharge.
  - Tap **+ Add** to add any additional medications.
    - Toggle between **Medications** and **Kits.**
    - Start typing the medication name in the search box, scroll and select the appropriate medication.

- Continue until all medications have been entered then select **Next**.
  - If the medication is tapered, tap **Titrate Medication**.

  - Enter the details for each medication:
    - Dose
    - Dose Unit
    - Frequency
    - Route
    - Special Instructions – free text box for additional information
    - Ordering Physician
  - Tap **Print on Cert/recert box** and **Hospice Covered** (if applicable) then select **Done**.
  - Tap the arrow at the top left next to Medications.
  - From the tile page, **sync** the chart.

- Tap the 3 dots on the Medications screen to select **Drug-Drug** to run the Drug/Drug interactions.
- Select the **< back arrow** to save the medications and return to the charting page.

STEP 6: Tap **Assessment**.



- The assessments completed for the patient display on the left.
- Tap **+ Add**.
  - Select the **Template** and **Visit Type**.
    - **Resource Type**: your Discipline
    - **Template**: your Discipline
    - **Visit Type**: **Initial Visit** or **Start of Care – further visits planned**
- Complete the required fields in the assessment as indicated by the orange outlines.
  - The sections with required documentation are on the left. To activate a section to document on during this visit or future visits, tap the 3 dots in the lower right while in the assessment and select **Show Details**.
  - Tap the applicable section in the navigator to the left then tap the 3 dots to select **Activate**.
  - Indicate if this is for this assessment only or all future assessments.
    - If necessary, activate additional sections, as necessary.

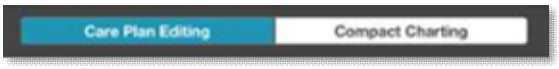
- Tap the 3 dots in the lower right-hand corner to view the predictive modeling for the patient, show the HIPPS scores and to manually validate the assessment, if needed.
- Select the **< back arrow** to save the status and return to the charting page.

STEP 7: Tap **Clinical Monitoring**.

- Tap **+ Add**: Vital Signs, Measurements, Lab results (including O2 Sat).
- Complete the sections as needed. Some sections may require specific documentation to proceed. Tap **Done** once all information is entered.
- Select the **< back arrow** to save the information and return to the charting page.

STEP 8: Tap **Care Plan/Charting**.

- Navigate between Care Plan Editing and Compact Charting, along with the active and discontinued care plans, as necessary.



- **Care Plan Editing** – add, edit, or end Care Plan Goals and Interventions
  - Active Care plans display on the left. If there are active care plans from a previous admission, discontinue them using date of last discharge. Tap **Do not create end sup order** box if available.
  - Tap **+** at lower right to add a Care Plan. Must be on **Care Plan Editing** screen.
  - Search for Care Plan by adding a word in the Search box or scroll down the list. Tap the Care Plan to add. For the Aide Care Plan enter **Home** in Search box to choose.
  - Tap **+** to the right of **Goals** and of **Interventions** to add from each section. All Care Plans require Interventions. To add Aide Care Plan, change Discipline by tapping the box under **Ordering Physician** then choose **AID** in the Discipline box. Also change Discipline to add Goals and Interventions for any other discipline.
  - Tap appropriate boxes to the left of the specific Goal and Intervention to add. If choosing All, must individually tap each box.
  - Tap **Print on Cert/Recert** box if available.

- **Compact Charting** - document on progress of Goals and if Intervention was done during visit based on the required charting as indicated by the orange outlines.
  - Select appropriate choice by tapping circlet next to answer.
    - A **No** response requires a **Milestone**. Tap the drop down to enter.
- Tap the **< back arrow** to save the care plans and return to the charting page.

STEP 9: Tap **Visit Frequency**.

- Active visit frequencies display in the navigator to the left. The certification period displays at the top of the navigator.
- Tap **+ Add**.
- **Verbal Start of Care (VSOC)** is located at the top, enter the **date** and **sign**.
  - **Lupa Threshold** will display under the VSOC.
- Complete the fields applicable for the discipline, entering the high and low number of visits.
  - Tap **Cert/Recert** and **Do Not Create End Order** boxes.
- Tap **PRN** at the lower left to enter any PRN Visit Frequencies.
  - Enter **Discipline**, **Value**, **Physician ID,** and **Reason(s)** for visits.
  - Tap **Cert/Recert** box.
- Select the **< back arrow** to save the information and return to the charting page.
- **Sync** the chart. 

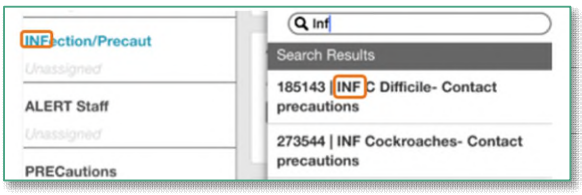
STEP 10: **Tap Calendar**

- Visits need to be plotted on the Calendar based on the Visit Frequency order.
- Tap **+** at lower right.
- Tap **Recurring** to add multiple visits based on Visit Frequency order entered.
  - Resource - change to appropriate clinician.
  - Edit **Start date** if necessary.
  - **Recurrence** -add **Day** or **Week**.
  - **Every – how often (i.e., 2 x a week).**
  - **For – how long (i. e. 4 weeks).**
  - Add **Resource Type** if not auto populated.
  - Add appropriate **Visit Type.** If Insurance authorization is required and not yet approved for visits, enter **Non Billable Supervisor Use only.**
  - Add a **Note** (optional) which may be viewed on the **Time Entry** screen.
  - Tap arrow at top left to return to tile screen.

STEP 11: Tap **Care Team**.

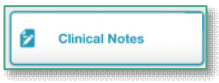
- The disciplines display on the left in the navigator.
- Locate your discipline and ensure that your name as the **Admitting Clinician** and for your discipline if you will continue to see the patient.

- Enter code status, infections, alerts, precautions, and other known information.
  - Use capital letters at beginning of Care Team type, such as Inf, to search more easily.



- Select the **< back arrow** to save the information and return to the charting page.

STEP 12: Tap **Clinical Note**.



- The clinical notes completed for the patient display on the left.
  - Navigate between **Active** and **All** clinical notes, as necessary.
    - Notes with an end date are under **All** and notes without an end date are under **Active**.
- Tap **+** to add a new clinical note. Use Code is **I.**
- Utilize the applicable note template and ensure that all required documentation is complete.
- Tap **Include intermediate summary to Cert/Recert orders** and **Send to Portal.**
- For **Certification Item#,** select **Assessment Information for Physician Review.**
- Add **Ordering Physician** and **End Physician**.
- Tap the **< back arrow** to save the information return to the charting page.

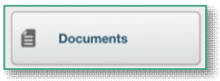
STEP 13: Tap **Family/Friends**

- Confirm information is correct with patient or family.
  - Tap **+** at lower right to add a new person. Use boxes on right to designate roles.
  - If a person should be removed from the chart, contact your manager to remove.

STEP 14: Tap **Adverse Events**

- Falls
  - If patient falls during a visit, document using + at lower right.
    - Injuries: default is **None Apparent**. Tap a box if injuries are apparent.
    - Reported by: tap **Observed by Clinician**
    - **Physician**: Provider overseeing plan of care
    - **Notified by**: free text your name
- **Infections:** do not record during admission. Document during later visit if new infection diagnosed while under care.
- **Infectious Diseases**
  - Tap + at lower right to add.
  - Document history of or current infections using drop down under **Disease.**

STEP 15: **Review your documentation.** tap **Documents**.



- The navigator displays with the different document types.
- Tap **Active Orders**. Review documentation for accuracy as it will be sent to the Provider for signature.

Post Visit Workflow

Additional steps are needed to ensure that all documentation for a visit has been completed and submitted to the host server for the whole care team to review.

- **Navigate to Open Charts (from Menu ☰). Confirm all required documentation is complete and connected to visit 100%.**
  - If not, tap on name of documentation to re-enter the screen in the chart to complete or connect to visit.
- **Navigate to Time Entry (from Menu ☰).**
  - Add duration for Indirect Time if applicable.
  - To delete mileage if added incorrectly by the system, clear and replace with a zero.
  - To add additional miles, add the Activity Travel-extra mileage entry to your Calendar.
    - Add a Start and End time of 1 minute then add all additional mileage for the day.