From the Office of Health Informatics

Home Care and Hospice Admission/NTUC Visit

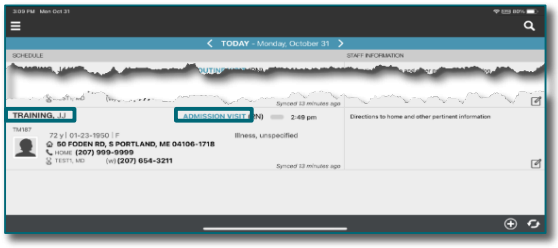
April 21, 2025

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 review and edits 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.

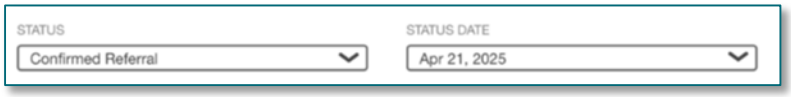
STEP 5: The highlighted tiles display indicating required documentation.

- 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 dropdown to update the status (i.e., **Field Admit (home)**).



  - If an error appears when updating the patient status line, return to charting page then tap **Basic/Demographics** to check **Demographics** screen for incomplete fields.
- Select the **< back arrow** at top left to Save and return to the charting page.
  - **Sync** the chart by tapping the sync icon at the lower right of the screen.

NOTE: If a patient is **Not Taken Under Care (NTUC)** after traveling to home and starting visit.

- Time Entry – update Visit Type to **NTUC with Home Visit**.
- Admission status line – change to appropriate (i.e., **Clinical No skill needed**).

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

- Verify with patient/family 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 (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 then verify **Active**, **Service Location** and **Default** boxes are checked off.
    - 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 ellipsis (three dots) in the lower right to re-activate medications that were discontinued at previous discharge.
  - Tap **+ Add** to add any additional medications.
    - 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** to add steps.

    - Enter the details for each medication:
      - Dose
      - Dose Unit
      - Frequency
      - Route
      - Start Date (today's date)
      - Ordering Physician
      - Optional – Special Instructions – free text box for additional information
    - 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 ellipsis (three 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**: the Discipline.
    - **Template**: the 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 ellipsis (three 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 ellipsis (three dots) 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 ellipsis (three 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 **+** to add **Vital Signs**, **Measurements**, and **Labs** (including Pulse Ox).
- 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 still 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. Common Admission Care Plans start with "**". Tap the Care Plan to add.
- Tap **+** to the far 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** – Care Plan Charting on progress of Goals and whether Interventions were 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 dropdown 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. Update patient status before adding Visit Frequencies.

▪ 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: **Discipline**, **Visits**, **Physician ID and Duration**.
- Visits:
  - Leave **Low** empty if entering specific number of visits.
  - Enter **Low** and **High** if entering a range of visits.
- Duration
  - Default is **Week**. Use dropdown to edit.
  - **For** – enter number based on Duration.
  - **Start Date** will default to first day of cert period Use dropdown to edit.
- Tap **Cert/Recert** and **Do not create end sup 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**

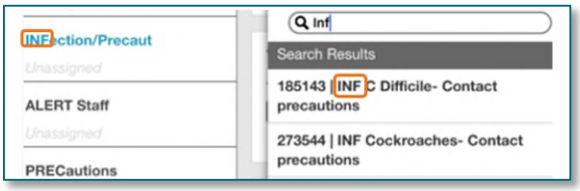
- Visits need to be plotted on the Calendar based on the Visit Frequency order.
- Add Visits
  - Tap **+** at lower right then tap **Visit**.
  - Add one visit.
    - Resource – tap dropdown to change if necessary.
    - **Resource Type** – if not auto populated, tap dropdown to search.
    - Visit **Type** – add using dropdown.
    - **Notes** – free text information to be added to each visit.
    - Tap **Done**.
  - Tap the visit added to open.
  - Tap **Recurring** to add multiple visits based on Visit Frequency order entered.
    - Resource – change to appropriate clinician if necessary
    - Edit **Start date** if necessary.
    - **Recurrence –** add number and **Day** or **Week**.
    - **Service Day** – choose which days to add the visits to the Calendar.
    - **Every –** how often (i.e., 1 x a week would be every 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 **Today** and **Time Entry** screen by tapping **Notes** on the right side of screen,

- Tap arrow at top left to return to tile screen,

STEP 11: Tap **Care Team**.

- The **Care Team types** display on the left in the navigator.
- Locate discipline to add name if continuing to see the patient.
  - Tap the dropdown in the box **Assigned to Role** to enter last name.



- Enter Code Status, Infections, Alerts, Precautions, Funeral Home and other known information.
  - Use capital letters at beginning of Care Team type, such as **INF**, to view all options.
  - To add a second resource under a Care Team type, tap the **+** to the far right.
  - To add a brand-new resource, tap the **+** at the lower right corner.
- 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.
  - Notes with an end date are only visible under **All** tab at lower left.
- Tap **+** to add a new clinical note. Use Code is **I.**
- Use 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**. Change the **End Date** to the date of the visit.
- Tap the **< back arrow** to save the information and return to the charting page.

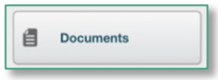
STEP 13: Tap **Family/Friends**.

- Confirm information is correct with patient or family.
  - Tap dropdown in **Name/ID** box to add a new person from the existing database. Add **Relationship to patient**. Use boxes on right to designate roles.
    - To add a second name, tap the **+** in the lower right corner.
  - To add a new resource to the database, tap the **+** next to Name/ID box.
  - If a person should be removed from the chart, contact the manager to remove.

STEP 14: Tap **Adverse Events**

- Falls
  - If patient falls during admission visit, tap **+** 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 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 and current infections using dropdown under **Disease.** If the infection is not listed, do not record.

STEP 15: Review 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 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 Calendar.
  - Add a Start and End time of one minute then add all additional mileage for the day.