Northern Light Health

From the Office of Clinical Informatics

Netsmart Home Care and Hospice
Resumption of Care

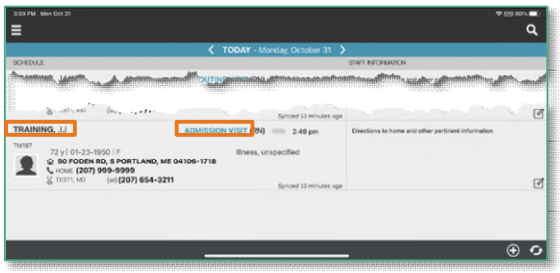
May 8, 2023

A Resumption of Care (ROC) assessment is required any time the patient is admitted inpatient for 24 hours of more for other than diagnostic tests and returns to home care.

Resumption of Care

On a **Resumption of Care**, 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 and Ending a Visit**



STEP 1: Log into **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**.

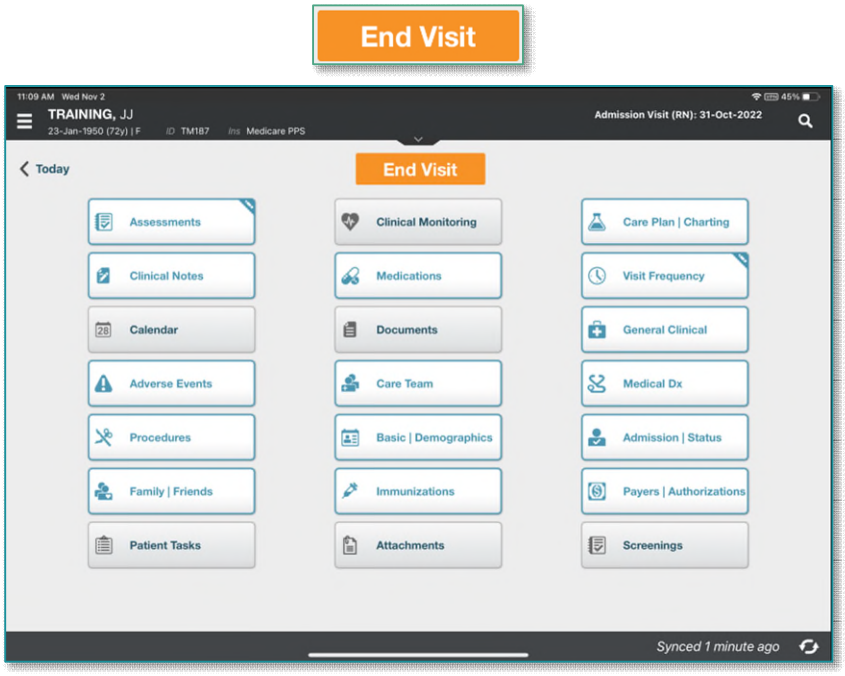
- This logs the current time as the start time for the visit type in the **Time Entry** screen.

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

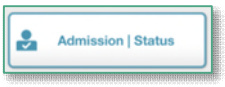
- Some tiles may display highlighted, this is to assist users who are still using the laptop for documentation.
- As a reminder, the intake assessment can be viewed prior to starting the visit by selecting **Attachments** prior to hitting start visit.

STEP 6: Tap **End Visit**.

- This logs the current time as the end time for the visit type in the **Time Entry** screen.
- If required documentation stills needs to be completed, select the required documentation from **Open Charts** and complete the documentation.



➢ **Visit Documentation**



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

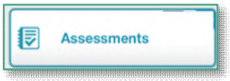
- Update the patient status and date of visit.
- Select the **< back arrow** to save the status and return to the charting page.

STEP 2: Tap **Medications**.

- Toggle between active and discontinued medications to display in the navigator.
- Adding medications:
  - Tap the three dots to **Reactivate** any medicatiosn that were discontinued during Transfer steps.
  - If pending medications displays, tap **Pending Medications** and swipe left to include or exclude.
  - Continue until all medications are added
    - Update the details for the medications, as applicable.
    - Tap **Print on Cert/Recert** and **Hospice Covered**, if applicable.
    - Tap **Done**.
  - Activate any medications that have been discontinued.
  - 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 medications.
      - Continue until all medications are entered and select **Next**.
    - Enter the details for each medication:
      - Dose
      - Dose Unit
      - Frequency
      - Route
      - Special Instructions – free text box for additional information
      - Ordering PhysicianTap Print on Cert/Recert box andHospiced Covered, if applicable. .
    - Tap **Print on Cert/Recert** and **Hospice Covered**, if applicable.
    - Tap **Done**
- Tap the three dots and select **Drug-Drug** to run the Drug/Drug interactions.

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

STEP 3: Tap **Assessment**.



- The assessments completed for the patient display on the left.
- Tap **+ Add**.
  - Select the **Template** and **Visit Type**.
- 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 select **Show Details.**
  - Tap the applicable dithered section in the navigator to the left and tap the three dots and select **Activate**.
  - Indicate if this is for this assessment only or all future assessments.
    - If necessary, activate additional dithered sections as necessary.
- Tap the 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 4: Tap **Care Plan/Charting**.

- Navigate between care plan editing and compact charting, along with the active and discontinued care plans, as necessary.
  - Active Care Plans display on the left. If there are any active Care Plans, discontinue them.
- Tap **Add** to add a Care Plan.
  - You must be on Care Plan editing for add to display.
- Complete the required care plan charting as indicated by the orange outlines.
- Tap the **< back arrow** to save the care plans and return to the charting page.

STEP 5: Tap **Visit Frequency**.

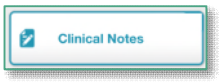
- Active visit frequencies display in the navigator to the left.
- Tap **+ Add**.
- **Verbal Start of Care (VSOC)** is located at the top, enter the **date** and **sign.**
  - Lupa Threshold displays under the VSOC.
- Complete the fields applicable for the discipline, entering the high and low number of visits.
  - The certification period displays at the top of the navigator.
  - Tap **Cert/Recert** and **Do Not Create End Order**.

- Enter any PRN visits for the patient.
- Select the **< back arrow** to save the information and return to the charting page.

STEP 6: Tap **Care Team**.

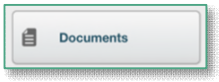
- The disciplines display on the left in the navigator.
- Locate your discipline and ensure that your name is the **Admitting Clinician** and for your discipline if you will continue to see the patient.
- Enter code status, infections, alerts, precautions, and other known information.
  - Use capital letters, such as VAX, to search easily.
- Select the **< back arrow** to save the information and return to the charting page.

STEP 7: 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 **Add** to add a new clinical note.
  - Enter a **Use Code of O and C**.
  - Tap **Send to Portal**.
- Utilize the applicable note template and ensure that all required documentation is complete.
- Tap the **< back arrow** to save the information return to the charting page.

STEP 8: Tap **Documents**.



- The navigator displays with the different document types.
- Tap **Active Orders**.
  - Confirm the **certification**, **plan of care** and **all appropriate information** is present.

STEP 9: Tap any other applicable tile to document the patient care provided.

STEP 10: Tap **End Visit**.

- This logs the current time as the end time for the visit type in the **Time Entry** screen.
- If required documentation stills needs to be completed, select the required documentation from **Open Charts** and complete the documentation.