Northern Light Health

From the Office of Clinical Informatics

Netsmart Home Care and Hospice
Routine Visit

May 8, 2023

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

Routine Visit

On a **Routine Visit**, not everything listed may be required and we have provided the various windows that might need to be touched on a **Routine Visit**.

➢ **Getting Started**

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**.

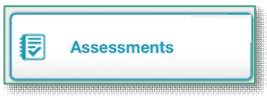
- This logs the current time as the start time for the visit type in the **Time Entry** screen.

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

- Some times may display highlighted to assist users who are still using the laptop for documentation.

➢ **Visit Documentation**

STEP 1: Tap **Assessment**.



- The assessments completed for the patient display on the left.
- Tap **+ Add**.
  - Select the **Template**, **Visit Type**, and **D/T Summary** as needed.
- Complete the required fields in the assessment as indicated by the orange outlines.

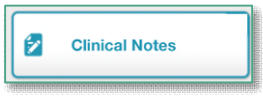
STEP 2: Tap **Care Plan / Charting.**

- The care plans for the patient display on the left.
  - Navigate between care plan editing and compact charting, along with the active and discontinued care plans, as necessary.
- Tap the applicable **Care Plan** to complete care plan charting.
- Complete the required care plan charting as indicated by the orange outlines.

- If a modifier needs to be edited, end the current goal or intervention with the current date and add a new goal or intervention with the new modifier.

- Tap the **< back arrow** to 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** as necessary.
    - Notes with an end date will fall under all, while notes without an end date will fall under active.
- Tap **Add** to add a new clinical note.
  - Complete the required documentation.
  - Enter a **Use Code** of **C**.
    - If your note contains **information related to an order from a Provider**, also include **Use Code O**.
  - Tap **Send to Portal**.
- Tap the **< back arrow** to save the information return to the charting page.

STEP 4: Tap any other applicable tile to document the patient care provided.

STEP 5: 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.