From the Office of Health Informatics

Home Care and Hospice
Routine Visit / Nursing Assessment

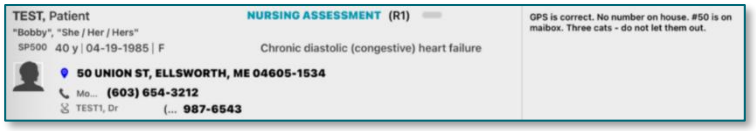
November 12, 2025

Patients who have been admitted will be scheduled for regular visits. Therapy visits, Social Work and Hospice Nursing visits are assigned as the Visit Type Routine Visit. Home Health Nursing visits are assigned as the Visit Type Nursing Assessment.

Routine Visit / Nursing Assessment

These visits have required documentation highlighted in the patient chart. Any other screen requiring documentation (ex. Visit Frequency) can be documented on and submitted in addition to the required documentation.

➢ Getting Started



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** once.

- This logs the current time as the start time for the visit type in the **Time Entry** screen.
- It will take moment for the End Visit button to appear. If the End Visit button is inadvertently tapped before the visit is complete, edit the time on **Time Entry** screen.

STEP 5: The highlighted tiles display to indicate required documentation and review for this visit.

Visit Documentation

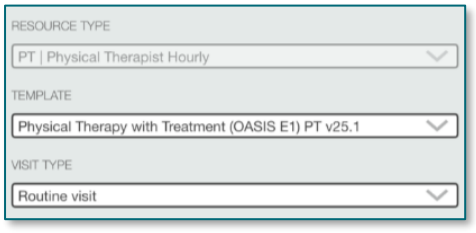
➢ Assessments

The assessments completed for the patient display on the left.

STEP 1: Tap + Add.

STEP 2: New Assessment box should auto populate with the following information for a Routine visit:

- **Resource Type** – your discipline.
- **Template** – your discipline & **OASIS (**for **SN, PT, OT, SLP)** or **HOPE (SN)**.
- **Visit Type** – Routine visit.



STEP 3: Tap **Done** to open assessment.

STEP 4: Tap each active section in left column.

STEP 5: Tap the **+** to open subsections.

STEP 6: Complete the required fields in the assessment as indicated by the orange outlines.

Clinical Monitoring

If Vital Signs, Measurements or Labs (INR or Pulse Ox) are obtained, document on this screen using the **+** at the lower right to add.

- To review additional education on Clinical Monitoring, please click here.

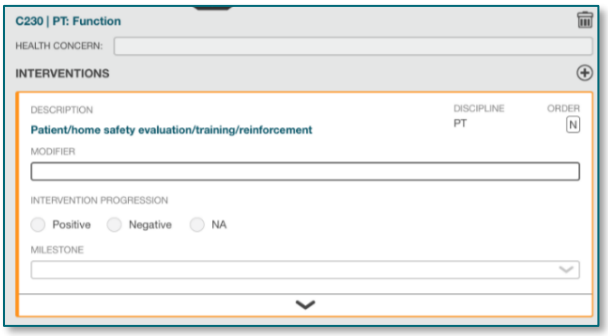
Care Plan / Charting

The active Care Plans for your discipline the patient display on the left.

STEP 1: Default screen is **Compact Charting**. Navigate to **Care Plan Editing** tab at end of screen to add or discontinue Care Plans.

STEP 2: Tap the applicable **Care Plan** to open care plan charting.

STEP 3: Complete the required care plan charting as indicated by the orange outlines.



- Answering P**ositive** or **NR/NA** does not require selecting a Modifier. It is required to select a Milestone when answering **Negative**.
- If a modifier needs to be edited, add an End Date to the current Goal or Intervention then add a new Goal or Intervention with the new modifier.

STEP 4: Tap the **< back arrow** to return to the charting page.

Clinical Note

The Clinical Notes previously completed display on the left.

STEP 1: Navigate between **Active** and **All** (includes notes with an End date) tabs at the lower left as necessary.

STEP 2: Tap **+** to add a new clinical note.

STEP 3: **Use Code** is **C**. Add Code **O** if orders were obtained during the visit.

STEP 4: Edit date if visit was not done today.

STEP 5: Add Note. Use template (if applicable).

STEP 6: Tap **Send to Portal**.

STEP 7: Tap the **< back arrow** to save the information return to the charting page.

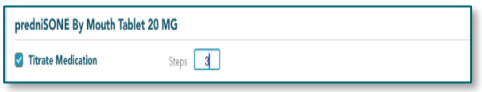
Medications

Review Medications to determine if patient has started new medications or is no longer taking medications.

➢ **Adding medications:**

STEP 1: Tap **+ Add** to add new medications.

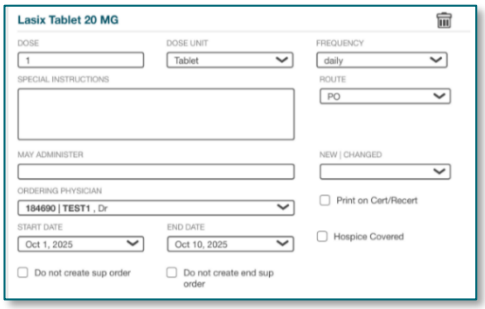
STEP 2: Start typing the medication name in the search box, scroll and select the appropriate medication. If the medication is tapered, tap **Titrate Medication** to add steps.



STEP 3: Continue until all new medications have been entered then select **Next**.

STEP 4: 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

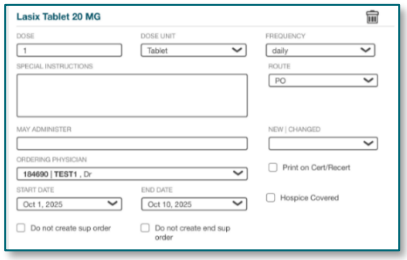
STEP 5: Tap **Print on Cert/recert box** and **Hospice Covered** (if applicable).

STEP 6: Tap **Done**.

STEP 7: From the tile page, **sync** the chart.

STEP 8: Tap **Medications** tile again.

STEP 9: After adding and synching a medication, tap the **3 dots** at lower right then tap **Drug-Drug** to check Interactions.



➢ **Ending Medications**

STEP 1: To end a medication patient is no longer taking, add an **End Date**.

STEP 2: To end multiple or all medications, tap the **3 dots menu** at the lower right then tap **Discontinue**.

- Tap **Select All Medications.** If a medication should not be discontinued, tap the box next to it to remove the checkmark.
- Add the **End Physician**.
- Tap **Do not Create End Sup Order** box.