



POINT OF CARE

NURSING VISIT

BUSINESS MODEL SOFTWARE TRAINING


+healthTrust
SOFTWARE

Nursing Visit: Recommended Training Course Agenda

Course Purpose: We recommend using the following training outline to ensure that training participants receive clear instructions on how to perform a nursing visit through the software. The sequence of courses can be changed based on agency training needs and schedule; however the content of each course should remain as stated.

Recommended Course Attendees: Management, Clinical Staff, Administrator, Assistant Administrator

Estimated Duration: 1 hour 30 minutes

TOPIC	DESCRIPTION	
How to Start a Visit	How to enter the Start Date and Time in a visit	<5 Minutes
Additional Documents to Complete	How to select additional documents to be completed during a visit	<5 Minutes
COVID Screening	How to conduct COVID screening for a visit in the system	<5 Minutes
Current Health Status	How to document the patient's current health status	<5 Minutes
Eyes, Ears, Nose, Throat	How to document EENT instructions and procedures completed during a visit.	<5 Minutes
Skin Assessment	How to document skin assessment completed during a visit.	<5 Minutes
Respiratory	Howto document respiratory instructions and procedures completed during a visit.	<5 Minutes
Neurological Assessment	Learn how to document neurological assessment completed during a visit.	<5 Minutes
GI Assessment	How to document GI Assessment completed in the system	<5 Minutes
Infusion	How to document infusion procedures performed during a visit	<5 Minutes
Equipment and Supplies	How to document equipment and supplies used during a visit	<5 Minutes
Flowsheet	How to complete flowsheet documentation during a visit	<5 Minutes
Additional	How to document patient's additional assessments, instructions, procedures, and discharge planning	<5 Minutes
Care Coordination	How to document care coordination during a visit	<5 Minutes
End Visit	How to end a visit	<5 Minutes
Review Sections	How to review and revise any sections re: a patient visit	<5 Minutes

Start a Visit



1

Go to 'Travel Mode' Tab

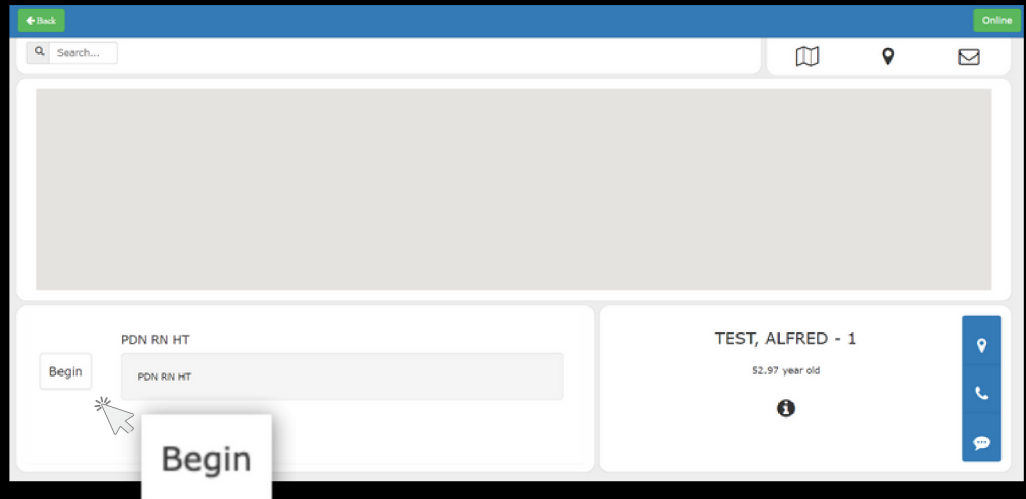
- On your home page, click the 'Travel Mode' tab at the top tool bar.



2

Click on the Scheduled Visit

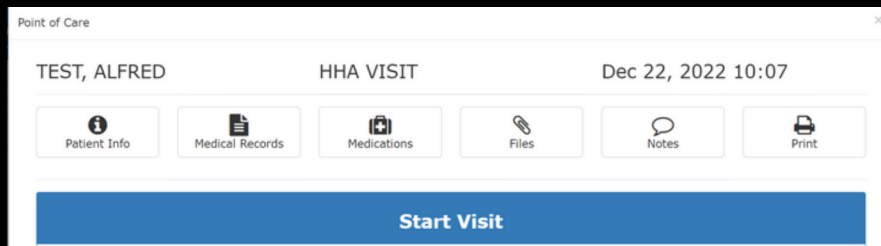
- The page will present a list of your visits for that day. Click on the 'Begin' button next to the scheduled visit with the specific patient you are assessing.



3

Start Visit

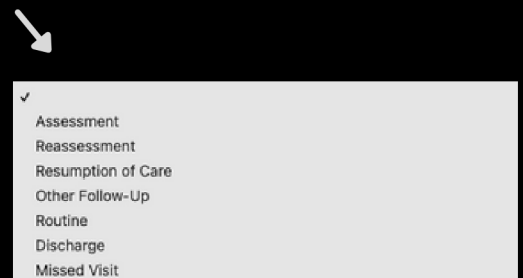
- On the Point of Care page, click the 'Start Visit' button and begin your routine patient visits process.



4

Complete the Start Visit Section

- When you click on 'Start Visit,' there will be drop down open.
- For 'Purpose of Visit' choose 'Routine' from the drop down menu.



Additional Documents to Complete



1 Additional Documents to Complete

- If you click on the 'Additional Documents to Complete' button, a drop down will open. Use the check boxes for any items relevant to the patient assessment.

Additional Documents to Complete	
<input checked="" type="checkbox"/>	Admission Documents
<input type="checkbox"/>	Homebound Assessment
<input type="checkbox"/>	Authorization Request
<input type="checkbox"/>	Employee Supervision
<input type="checkbox"/>	Patient Supervision
<input type="checkbox"/>	Progress Summary
<input type="checkbox"/>	Discharge Summary
<input type="checkbox"/>	Care Coordination Summary
<input checked="" type="checkbox"/>	Create HHA Plan of Care
<input checked="" type="checkbox"/>	OASIS
<input type="checkbox"/>	Hospice Information Set
<input type="checkbox"/>	Bereavement Assessment
<input type="checkbox"/>	Spiritual Assessment

01 - Start of Care (further visits planned)

2 Save Section

- Record the Time you clocked in and the travel information by dragging the toggle buttons.
- Once you have completed the Start Visit items, click 'Save Section'.

Start Visit

Purpose of Visit: Routine

Additional Documents to Complete

Time In: 4:41 PM

Save Section



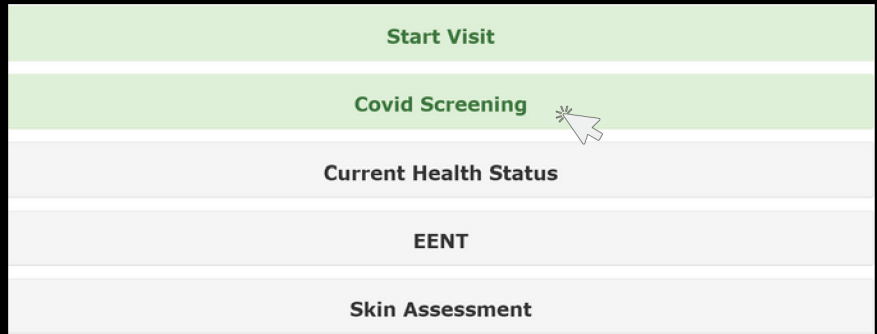
Save Section

COVID Screening



1 COVID Screening

- After you have started the visit, the visit items to go through will be listed. Click on the 'Covid Screening' button.



2 Answer the Screening Questions

- When the 'COVID Screening' section opens, the screening questions will be automatically populated to 'No'. If you select 'Yes' for any of the questions, use the open text box at the bottom to explain.
- Use the open field to input their temperature.
- Once you have completed the screening click the 'Close Section' button.



3 Save 'Covid Screening' Section

- When you click the 'Close Section' button, it will condense. You will repeat the same process for the 'Patient Screening' and 'Family Screening' sections.
- After they are complete, click the red 'Save Section' button.



Save Section

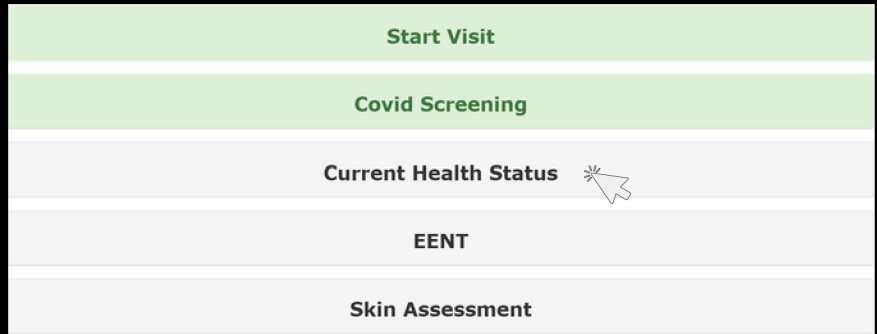
Current Health Status



1

Current Health Status

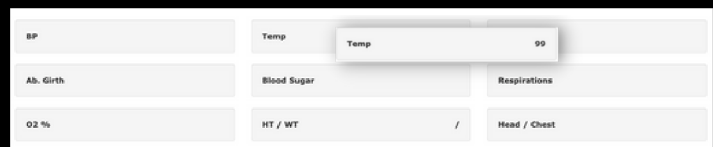
- Click on the 'Current Health Status' button on the visit list.



2

Record the Vitals

- A drop down will open. Go through the categories below and record the vitals for each item.
- To update the vital, click on the item so a form opens up.
- Complete the form's fields for that vital and then click the 'Update' button on the bottom right. The vital information will be shown next to the item.
- Repeat this process for the remaining vitals.



Bowel Sounds, Heart Sounds, Peripheral Pulses, Edema, Lung Sounds, and Dyspneic

- Use the toggle button to indicate the patient's Bowel Sounds and Level of Dyspnea
- Use the buttons below to choose the option that reflects the patient's status for the additional line items.

Bowel Sounds: Normal X 4 Other

Heart Sounds: Regular Irregular

Peripheral Pulses: Regular Irregular

Edema: No Yes

Lung Sounds: Clear Adventitious

Dyspneic: Patient is not short of breath 04

Current Health Status Continued



3

Choose Pain Assessment

- The Pain Assessment provides you with different options for assessing the patient's pain level. Simply click on the method you would like to use.

Pain Assessment Tools: 1-10 Smiley Mankoski FLACC

1-10

- For this option, use the toggle button to drag to the number indicating the patient's pain level and Pain Frequency (Interfering With Activity or Movement)
- Use the Comment text boxes to describe the pain location and any comments.

Smiley Scale

- For this option, select the face that best reflects their pain.
- Use the toggle button to drag to the number indicating the patient's Pain Frequency (Interfering With Activity or Movement).
- Use the Comments text box to add any comments.

Mankoski

- If you select Mankoski, it will display a pain scale from 0-10 with the pain level description and suggested treatment associated to that pain level.
- Use the toggle button to drag to the number indicating the patient's Pain Frequency (Interfering With Activity or Movement).
- Use the Comments text box to add any comments.

Mankoski Pain Scale:	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	0	Pain Free	No medication needed								
<input type="checkbox"/>	1	Very minor annoyance - occasional minor twinges	No medication needed								
<input type="checkbox"/>	2	Minor annoyance-occasional strong twinges	No medication needed								
<input type="checkbox"/>	3	Annoying enough to be distracting	Mild painkillers are effective. (aspirin, ibuprofen)								
<input type="checkbox"/>	4	Can be ignored if you are really involved in an activity, but still distracting	Mild painkillers relieve pain for 3 to 4 hours								
<input type="checkbox"/>	5	Can't be ignored for more than 30 minutes	Mild painkillers relieve pain for 3 to 4 hours								
<input type="checkbox"/>	6	Can't be ignored for any length of time, but you can still participate in your normal activities	Stronger painkillers (Codeine, Vicodin) reduce pain for 3 to 4 hours								
<input type="checkbox"/>	7	Makes it difficult to concentrate, interferes with sleep. You can still function with effort	Stronger painkillers are only partially effective. Strongest painkillers relieve pain (Oxycotin, Morphine)								
<input type="checkbox"/>	8	Normal physical activity severely limited. You can converse with effort. Nausea and dizziness set in as factors of pain	Stronger painkillers are minimally effective. Strongest painkillers reduce pain for 3 to 4 hours								
<input type="checkbox"/>	9	Unable to speak. Crying out or moaning uncontrollably - near delirium	Strongest painkillers are only partially effective								
<input type="checkbox"/>	10	Unconscious. Pain makes you pass out	Strongest painkillers are only partially effective								

Pain Frequency (Interfering With Activity or Movement): 00 Doesn't Interfere 04

Comments:

Save Section

Current Health Status Continued



FLACC (Face, Legs, Activity, Cry, Consolability)

- Selecting FLACC will display 5 categories where you will select the patient's actions associated with the category.
- Use the toggle button to drag to the number, indicating the patient's Pain Frequency (Interfering With Activity or Movement).
- Use the Comments text box to add any comments.

Face:

- No particular express/smile
- Occasional grimace or frown, withdrawn, disinterested
- Frequent to constant quivering chin, clenched jaw

Legs:

- Normal position or relaxed
- Uneasy, restless, tense
- Kicking, or legs drawn up

Activity:

- Lying quietly, normal position, moves easily
- Squirming, shifting back and forth, tense
- Arched, rigid or jerking

Cry:

- Content, relaxed
- Reassured by occasional touching, hugging or being talked to, distractible
- Difficult to console or comfort

Consolability:

- Content, Relaxed
- Reassured by occasional touching, hugging or being talked to, distractible
- Difficult to console or comfort

Pain Frequency (Interfering With Activity or Movement): 00 04
Doesn't Interfere

Comments:

Save Section

4

Complete Health Status Items

- Once you have completed the Pain Assessment, use the toggle buttons and status buttons to indicate the remaining items in the Health Status Section.

Pain Assessment Tools: I-10 Mankoski FLACC

Pain Frequency (Interfering With Activity or Movement): 00 04
No Pain

Current Cognitive Functioning: 00 04
Alert/Oriented

Compliance With Prescribed Diet: Compliant Non-Compliant

Gastrointestinal Status: Regular Impaired

Urinary Status: Normal Abnormal

Abuse / Neglect Indicators: No Yes

Comments:

Save Section

5

Save Health Status Section

- Once you have completed the 'Health Status' section, click the red 'Save Section' button.

Pain Frequency (Interfering With Activity or Movement): 00 04
No Pain

Current Cognitive Functioning: 00 04
Alert/Oriented

Compliance With Prescribed Diet: Compliant Non-Compliant

Gastrointestinal Status: Regular Impaired

Urinary Status: Normal Abnormal

Abuse / Neglect Indicators: No Yes

Comments:

Save Section

Eyes, Ears, Nose, Throat



1

Open 'EENT'

- Click the 'EENT' button in the Evaluation list.

The screenshot shows a vertical list of evaluation categories: 'Start Visit', 'Covid Screening', 'Current Health Status', 'EENT', and 'Skin Assessment'. The 'EENT' button is highlighted in light blue and has a mouse cursor pointing at it.

2

Input Information

- Selecting the 'Impaired' button will open a wizard with checkboxes for common problems.
- If you do not see the problem, please use the 'Other' text box.

The screenshot displays the EENT evaluation wizard with the following sections:

- Eye Problems:** Radio buttons for 'None', 'WNL for Patient', and 'Impaired' (selected). Checkboxes include: PERRL, Cortical Blindness, Infections, Discharge, Itch, Blurred Vision, Entropion, Glasses, Jaundice, Displaced Position, Inflammation, Pain, Epicanthal Folds, and Bitot's spot. An 'Other' text box is present.
- Ear Problems:** Radio buttons for 'None', 'WNL for Patient', and 'Impaired' (selected). Checkboxes include: Left ear Pain, Right ear Pain, Loss of hearing (left ear), Loss of hearing (right ear), Hearing Aid (left ear), Hearing Aid (right ear), Cochlear Implants, Tinnitus, Drainage, and Other. An 'Other' text box is present.
- Nose Problems:** Radio buttons for 'None', 'WNL for Patient', and 'Impaired' (selected). Checkboxes include: Congestion, Epistaxis, Loss of smell, Sinus problems, Patency (Left), Patency (Right), and Other. An 'Other' text box is present.
- Mouth Problems:** Radio buttons for 'None', 'WNL for Patient', and 'Impaired' (selected). Checkboxes include: Abnormal mucosa appearance, Masses or Tumors, Gingivitis, Ulcerations, Gum problems, Toothache, Problem chewing, and Problem swallowing. An 'Other' text box is present.
- Throat Problems:** Radio buttons for 'None', 'WNL for Patient', and 'Impaired' (selected). Checkboxes include: Dysphagia, Hoarseness, Lesions, and Sore throat. An 'Other' text box is present.
- Comments:** A text area labeled 'Comments'.

A red bar at the bottom contains the text 'Save Section'.

3

Save EENT Section

- Once you have completed the EENT evaluation, click the red 'Save Section' button.

Skin Assessment



1 Open Skin Assessment

- Click the 'Skin Assessment' button in the Visit list.

The screenshot shows a vertical list of buttons: 'Start Visit', 'Covid Screening', 'Current Health Status', 'EENT', and 'Skin Assessment'. The 'Skin Assessment' button at the bottom is highlighted in a light blue color, and a mouse cursor is pointing at it.

2 Skin Assessment

- Select the name of the Pressure Ulcer Assessment performed, if any.
- Click on the button that reflects the patient's skin condition. Include any additional comments you have in the open text box.

The screenshot shows the 'Skin Assessment' form. It includes the following sections:

- Pressure Ulcer Assessment:** Radio buttons for 'None', 'Adult Braden', 'Pedi Braden', and 'Norton'.
- Skin Color:** Radio buttons for 'Pink', 'Pale', 'Jaundice', 'Cyanotic', and 'Blackened'.
- Skin Assessment:** Radio buttons for 'Dry', 'Cool', 'Warm', 'Diaphoretic', 'Ostomy', 'Incision', 'Wound', 'Rash', and 'Other'.
- Turgor:** Radio buttons for 'Brisk' and 'Sluggish'.
- Cap Refill:** Radio buttons for 'Brisk' and 'Sluggish'.
- At Risk of Developing Pressure Ulcers:** Radio buttons for 'No' and 'Yes'.
- Comments:** A text input field.

3 Save Skin Assessment Section

- Once you have completed the 'Skin Assessment' section, click the red 'Save Section' button.

The screenshot shows a red button labeled 'Save Section' at the bottom of the page. A white arrow points to the button.

Respiratory



1 Open 'Respiratory'

- Click the 'Respiratory' button in the Evaluation list.

The screenshot shows a vertical list of assessment categories: Skin Assessment, Respiratory, Neurological Assessment, GI Assessment, Infusion, Equipment and Supplies, and Flowsheet. The 'Respiratory' button is highlighted with a mouse cursor.

2 Input Respiratory Problems

- Selecting the 'More Options' button will open a wizard with checkboxes for common respiratory problems.
- Use the 'Dyspneic' toggle to input the patient's level of shortness of breath.

The screenshot shows the 'Respiratory Problems' wizard. It has tabs for 'None', 'WNL for Patient', and 'More Options'. Below are checkboxes for: Clear lung sounds, Dyspnea, Diminished (give location), Wheezing on inspiration (give location), Aspiration, Retractions, Nasal Flaring, Orthopnea, Flushing, Rales (give location), Wheezing on expiration, Adventitious, and Labored Breathing. At the bottom, there is a 'Dyspneic:' slider ranging from 00 to 04, with a green indicator at 00 and the text 'Patient is not short of breath'.

3 Input Cough Information

- Selecting the 'More Options' button will open a wizard with checkboxes for common cough information.

The screenshot shows the 'Cough:' wizard. It has tabs for 'None', 'WNL for Patient', and 'More Options'. Below are checkboxes for: Productive, Unproductive, Cough type, Sputum, Frequency, and Unable to cough/expectorate independently.

4 Input Respiratory Aid Information

- Selecting the 'More Options' button will open a wizard with checkboxes for respiratory aids.

The screenshot shows the 'Respiratory Aids:' wizard. It has tabs for 'None' and 'More Options'. Below are checkboxes for: Suctioning, Oxygen, Nebulizer, Tracheostomy, and Ventilator.

5 Save Respiratory Section

- Use the 'Comments' text box to add any comments.
- Once you have completed the Respiratory evaluation, click the red 'Save Section' button.

The screenshot shows a 'Comments' text box with a rich text editor toolbar. Below the text box is a red 'Save Section' button.



Save Section

Neurological Assessment



1 Open Neurological Assessment

- Click the 'Neurological Assessment' button in the Evaluation list.

A vertical list of assessment categories: Skin Assessment, Respiratory, Neurological Assessment (highlighted with a mouse cursor), GI Assessment, Infusion, Equipment and Supplies, and Flowsheet.

2 Input Mental / Cognitive Status

- Selecting the 'Impaired' button next to Mental / Cognitive Status will open the 'Impaired' menu. Selecting any of the 'Disoriented'; 'Unresponsive'; 'Cognitive Deficit'; or 'Other' options will open a Comment box.

The 'Neurological' form shows 'Mental / Cognitive Status' with 'Alert/Oriented for age' and 'Impaired' buttons. Under 'Impaired:', there are buttons for 'Disoriented', 'Unresponsive', 'Cognitive Deficit', and 'Other'. A 'Disoriented Comment:' field is visible below.

3 Input Current Cognitive Functioning / Confusion / Anxiety Information

- Use the toggle buttons to indicate the patient's level of current cognitive functioning, confusion, and anxiety.

Three horizontal toggle bars are shown. The first is for 'Current Cognitive Functioning' with 'Alert/Oriented' selected. The second is for 'Confusion (Reported / Observed in Last 14 Days)' with 'Never' selected. The third is for 'Anxiety (Reported / Observed in Last 14 Days)' with 'Never' selected. 'NA' (Not Applicable) options are also present.

4 Input Depression Screening

- Selecting the 'PHQ-2' button will bring up toggle buttons. Use these toggle buttons to input the patient's frequency of 'Little interest or pleasure in doing things' and 'Feeling down, depressed, or hopeless'.
- Selecting the 'Other' button will bring up the 'Screening Used' text box and 'Yes' and 'No' buttons for 'Meets Criteria for further evaluation?'.

The 'Depression Screening' form shows 'PHQ-2' selected. Two horizontal toggle bars are visible for 'Little interest or pleasure in doing things' and 'Feeling down, depressed, or hopeless', both with 'Several Days (2-6)' selected.

The 'Depression Screening' form shows 'Other' selected. A 'Screening Used:' text box and 'Meets Criteria for further evaluation?:' buttons ('Yes', 'No') are visible.

5 Input Seizure Information

- Use the toggle bar to input the frequency of patient's seizures.
- Use the 'Seizures Comment' text box to add any comments.

The 'Seizures' form shows a horizontal toggle bar with 'Monthly' selected. A 'Seizures Comment:' text box is visible below.

Neurological Assessment Continued



6 Input Psychiatric Nursing Services Information

- Select either the 'Yes' or 'No' button to the right of: 'Is this patient receiving psychiatric Nursing Services at home provided by a qualified psychiatric Nurse?'

Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?:

No Yes

7 Input Behavior Symptoms Noted Information

- Selecting the 'Yes' button will open up more behavior symptoms options.
- Select the button that corresponds to patient's behavior symptoms
- Use the toggle bar to describe the frequency of behavior symptoms.
- Select 'Yes' or 'No' button to the right of: 'Controlled by Meds?'
- Use the 'Mental Health Provider' text box to input the name of patient's mental health provider. Select the 'None' button if patient does not have a mental health provider.
- Use the 'Comments' text box to add any comments.

Behavior Symptoms Noted?: No Yes

Behavior Symptoms: Memory Deficit Impaired Decision Making Verbal Disruption Physical Aggression
Disruptive/Inappropriate Behavior Delusional / Paranoid None

Frequency Of Symptoms: 00 05
Never

Controlled by Meds?: Yes No

Mental Health Provider:
 None

Comments:

8 Save Neurological Section

- Once you have completed the Neurological evaluation, click the red 'Save Section' button.



Save Section



GI Assessment

1 Open GI Assessment

- Click the 'GI Assessment' button in the Evaluation list.

Menu options:

- Skin Assessment
- Respiratory
- Neurological Assessment
- GI Assessment** (highlighted)
- Infusion
- Equipment and Supplies
- Flowsheet

2 Complete Sections

- When the drop down opens, you will have a list of categories. In the first section, 'Nutrition' use the toggle buttons to indicate the patients status.
- In the remaining sections, simply click on the buttons that reflect the patient's status. Answer any additional questions that appear once a button has been pressed.
- Input any additional comments you have.

Nutrition

Nutritional Status: 0 (Good) to 2

Feeding / Eating: 00 (Independent) to 05

Diet: Regular | Impaired/Modified

Diet:

By Mouth | IV/Infusion | Enteral | Parenteral

Appetite: Good | Poor | N/A

Gastrointestinal

Regular | Impaired

Pain

Diarrhea

Vomiting

Nausea

Constipation

Comments

Bowel Sounds: 0 (Normal) to 3

X 4 | Other

Urinary Status

Regular | Impaired

Urgency | Retention | Polyuria

Hesitancy | Oliguria | Other

Treated For UTI in Past 14 days

Patient On Prophylactic UTI Treatment

Incontinence: No | Yes

Comments

GI Assessment Continued



Urine

Unable To Assess

Color:

Clarity:

Odor:

Amount:

Comments

Catheter

Type

Size

Balloon

Irrigation

Frequency of Change

Date of Last Change

Genitalia

Comments

Bowel Elimination

Does Patient Have Bowel Incontinence?

Last Void

3

Save GI Assessment

- Once you have completed all categories in the GI Assessment section, click the red 'Save Section' button.



Save Section

Infusion



1 Open Infusion

- Click the 'Infusion' button in the Evaluation list.

A vertical list of assessment categories: Skin Assessment, Respiratory, Neurological Assessment, GI Assessment, Infusion (highlighted with a mouse cursor), Equipment and Supplies, and Flowsheet.

2 Choose the Infusion

- When the drop down opens, you will see a line item titled 'Infusion' and you will click on the drop down and see a list of options to choose from.
- Click the appropriate option and a form will appear.

The 'Infusion' dropdown menu is open, showing a list of options: None, Central, Arterial VAD, Intrathecal, Peripheral, Midline, Venous VAD, Epidural Catheter, PICC, Hickman, Peritoneal VAD, and Other. An 'Add' button is visible below the list.

The 'Infusion' form is displayed with 'Central' selected in the dropdown. Below the dropdown is a 'Location' field with a 'Prev Answer' button. Further down are three date input fields: 'Date Last Accessed: MM/DD/YYYY', 'Date Inserted: MM/DD/YYYY', and 'Date Dressing Changed: MM/DD/YYYY'.

3 Save Medications Administered

- Selecting the 'Add' button under 'Medications Administered' will allow you to input information about medications administered to the patient.

The 'Medications Administered' form shows an 'Add' button and a section for 'Drug 1'. The section contains input fields for Drug, Dose, Dilution, Route, Freq, and Duration.

4 Complete Open Fields

- Use the open text boxes to input the information for 'Labs Drawn' and any other comments you want to include.
- Select the 'Save Section' button when finished.

The 'Labs Drawn' and 'Comments' sections are shown. Each section has a toolbar with icons for undo, redo, bold, italic, and text color, along with a 'Templates' dropdown and a 'Prev Answer' button. A 'Save Section' button is located at the bottom of the page.



Save Section

Equipment and Supplies



1 Open Equipment and Supplies

- Click the 'Equipment and Supplies' button in the Visit list.

A vertical list of buttons: Skin Assessment, Respiratory, Neurological Assessment, GI Assessment, Infusion, Equipment and Supplies (highlighted with a mouse cursor), and Flowsheet.

2 Input Equipment Information

- When the drop down opens, you will click on the 'Equipment' button and a secondary drop down will appear.
- Use the search bar to input the equipment they used for the visit, the equipment needed, and the quantities.
- Use the 'Yes' or 'No' buttons to indicate if the equipment was cleaned before and after the encounter.

A blue header bar labeled 'Equipment and Supplies'. Below it is a light blue button labeled 'Equipment' with a mouse cursor. At the bottom is a red bar labeled 'Save Section'.



A light blue header bar labeled 'Equipment'. Below it are two sections: 'Equipment used:' and 'Equipment needed:'. Each section has a search bar and a 'Qty' input field. At the bottom are two rows of 'Yes/No' buttons for 'Equipment Cleaned Before Encounter' and 'Equipment Cleaned After Encounter'. A red bar labeled 'Save Section' is at the bottom.

3 Save Equipment & Supplies Section

- Once you have input the equipment used and needed, click the red 'Save Section' button.



A red bar with the text 'Save Section' in white.

Flowsheet



1

Open Flowsheet

- Click the 'Flowsheet' button in the Visit list.
- A drop down menu will open.

Skin Assessment

Respiratory

Neurological Assessment

GI Assessment

Infusion

Equipment and Supplies

Flowsheet

2

Add Flowsheet Items

- In the listed options, you can select the item type you want to add.
- Click the button of the item you want to add. A form will open.
- Complete the required fields in the form and then click the 'Submit' button.

Flowsheet

MAR

Treatment

Narrative

Intake

Output

Vitals

Seizure

Vent

Save Section



Intake

Intake Type:

Time:

10:38

Amount:

Close

Submit

3

Save Flowsheet Section

- Once you have recorded the Flowsheet information, click the red 'Save Section' button.



Save Section

Additional



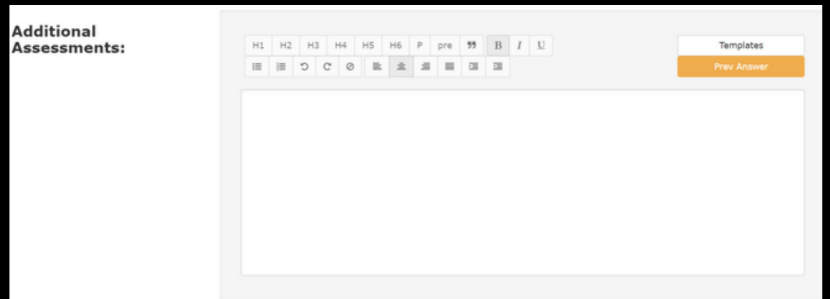
1 Open 'Additional'

- Click the 'Additional' button in the Evaluation list.
- A drop down will open



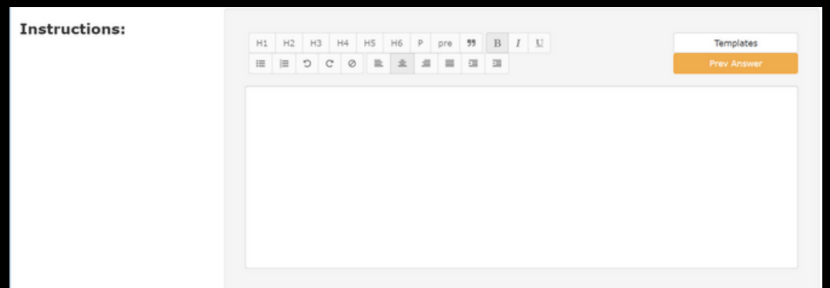
2 Input Additional Assessments

- Use the 'Additional Assessment' text box to write out any additional assessments performed on patient.



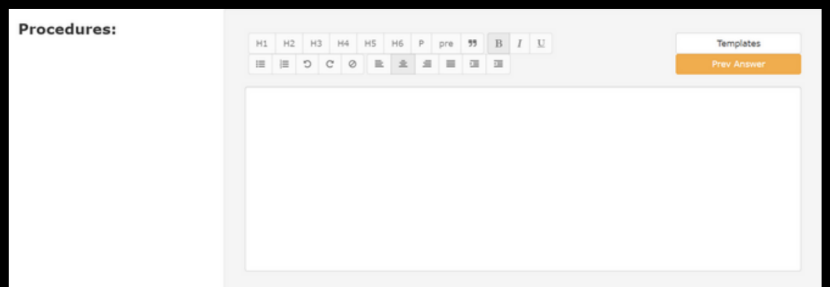
3 Input Additional Instructions

- Use the 'Instructions' text box to write out any additional instructions for the patient.



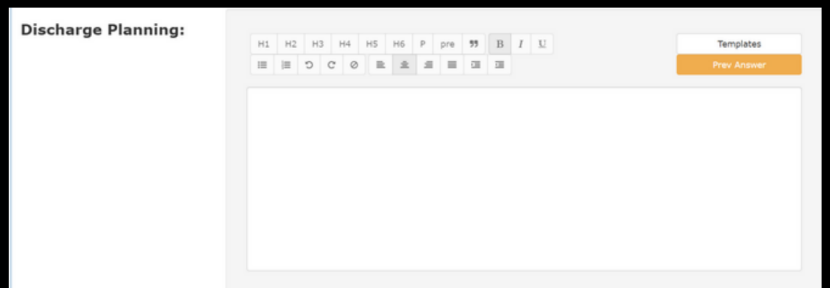
4 Input Additional Procedures

- Use the 'Procedures' text box to write out any additional procedures provided to the patient.



5 Input Additional Discharge Planning

- Use the 'Discharge Planning' text box to write out any additional discharge planning for the patient.



6 Save Additional Section

- Once you have completed inputting the 'Additional' information, click the red 'Save Section' button.



Save Section

Care Coordination



1 Open Care Coordination

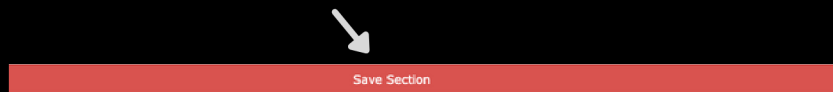
- Click the 'Care Coordination' button in the Visit list.
- A drop down will open.

2 Input Care Coordination Info

- In the listed options, you can select who the care coordination is with by clicking on the check box.
- You can input any comments you have in the open comments box below.
- Indicate whether there are any problems to monitor or anything else that needs to be reported to the care team members by using the 'Yes' or 'No' buttons. If you click, 'Yes', a text box will open where you can input the information.

3 Save Care Coordination Section

- Once you have completed the Care Coordination section, click the red 'Save Section' button.





End Visit

1

Open 'End Visit'

- Click the 'End Visit' button in the Evaluation list.
- A drop down will open.

2

Input Signatures

- Next to the 'Patient Signature' item, click the 'Sign Patient Signature' button. A form will open.
- Using the mouse, the patient or caregiver will sign the open box. Click the 'Submit' button in the bottom right.
- Click the 'Patient Signature Options' drop down and select who signed for this visit.

3

Employee Signature

- Next to the 'Employee Signature' item, click the 'E-Sign' button to the left of the open field. A pop-up message will open.
- It will ask if you are sure you want to electronically sign the document. Click the 'Ok' button. Your electronic signature will be populated into the Employee Signature Field.

4

Finish the Form & Save the End Visit Section

- Input the required information in the form's remaining line items.
- Once every field is complete and all signatures have been included, click the red 'Save Section' button.





Review Sections

1

Review Sections

- Once you have gone through every section, they will be highlighted green.
- You are able to review any section simply by clicking on the button and it will drop down.

The screenshot shows a web application window titled "Point of Care". At the top, it displays patient information: "TEST, ALFRED", "PDN RN HT - MDCP", and the date/time "Dec 22, 2022 10:33". Below this is a navigation bar with six buttons: "Patient Info", "Medical Records", "Medications", "Files", "Notes", and "Print". The main area contains a vertical list of 14 green buttons, each representing a section to be reviewed: "Start Visit", "Covid Screening", "Current Health Status", "EENT", "Skin Assessment", "Respiratory", "Neurological Assessment", "GI Assessment", "Infusion", "Equipment and Supplies", "Flowsheet", "Additional", "Care Coordination", and "End Visit". At the bottom left is a "Close" button, and at the bottom right is a "Save + Submit" button.

2

Save & Submit

- When you are ready, click the 'Save + Submit' button on the bottom right.

Save + Submit



The screenshot shows a success message dialog box with a green border. Inside, it says "★ Visit has been Completed Successfully!" with a green star icon below the text. At the bottom center, there is a green button with a white arrow and the text "Return".