

FAQ – Field Staff

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homecare  homebaseSM



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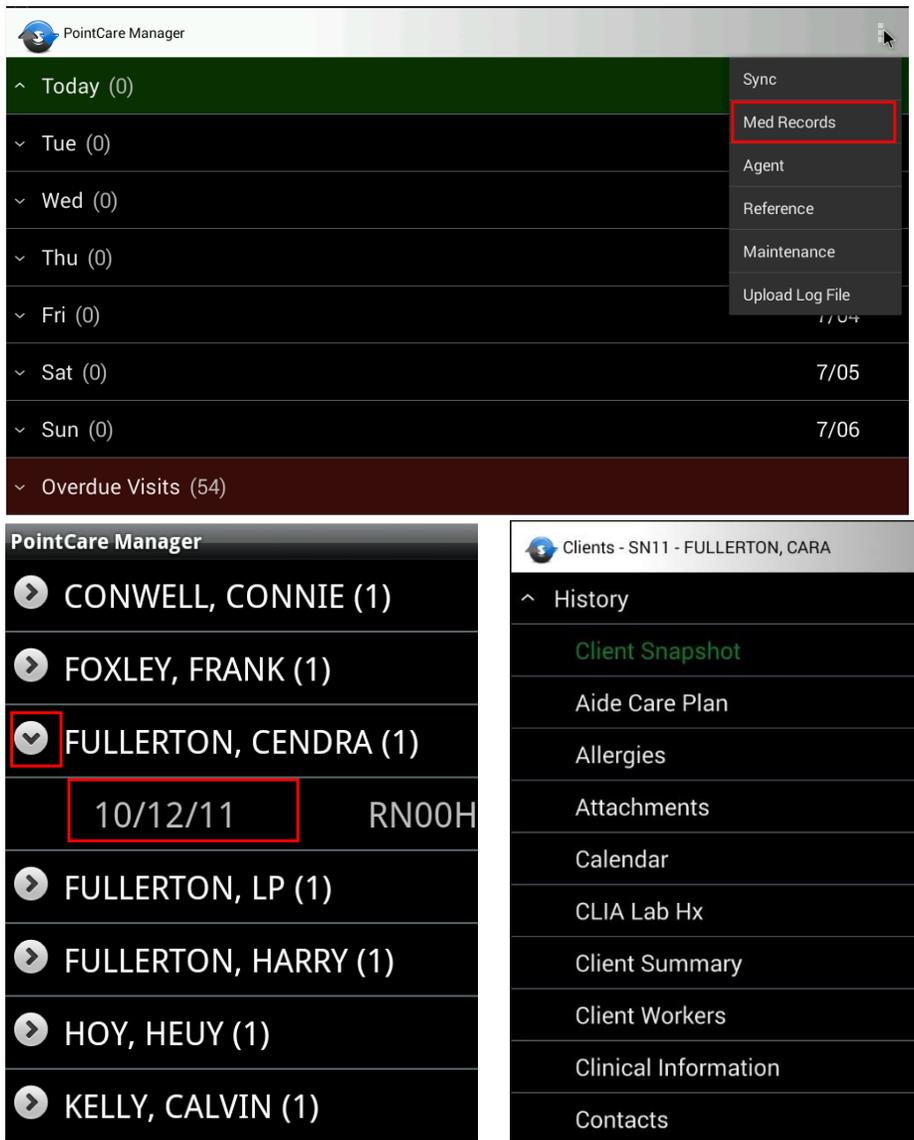


Outside of a Visit

Medical Records

How do I get to the patient's Medical Records?

Tap on Menu > Medical Records > Patient Name > Date

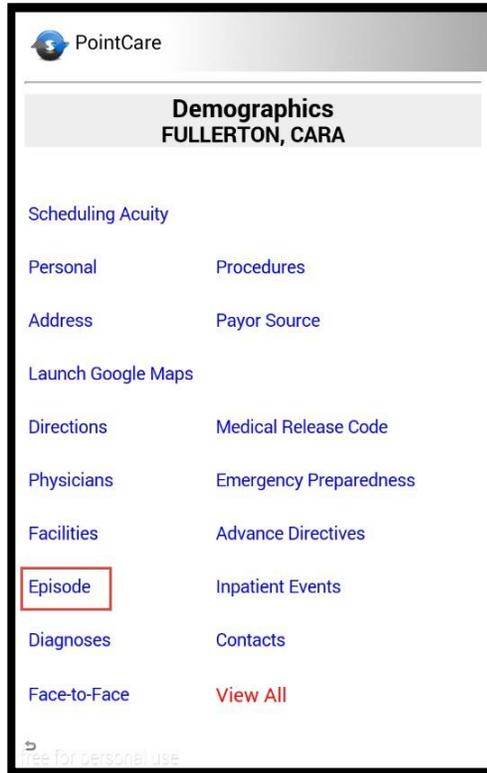




Case Manager

Where can I find the Case Manager for the patient?

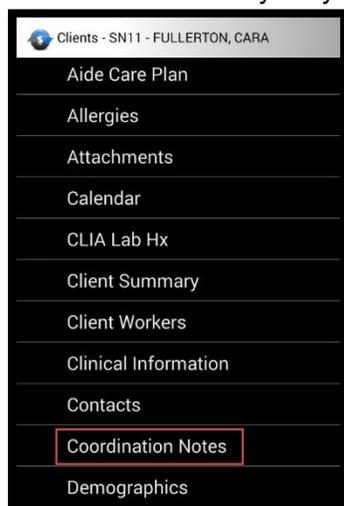
Tap on Medical Records > Patient Name > Date > Demographics > Episode



Patient Notes

Where can I find notes that were entered in during the referral?

Tap on Medical Records > Patient Name > Date > Coordination Notes > Clinical Comment Intake (Coordination Note name may vary with agency)

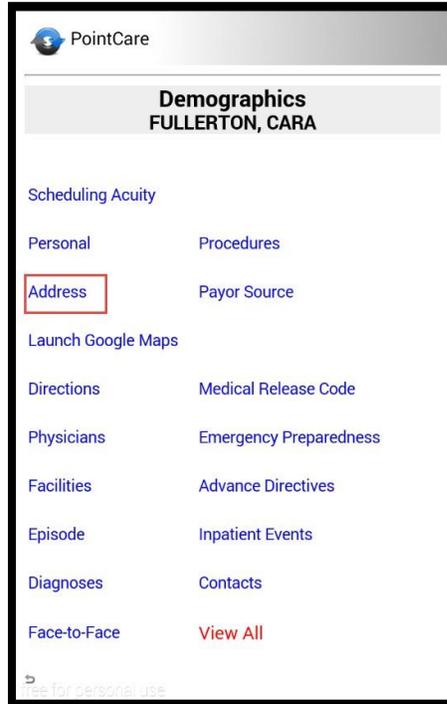




Patient Address

How can I find the patient's address?

Tap on Menu > Medical Records > Patient Name > Date > Demographics > Address

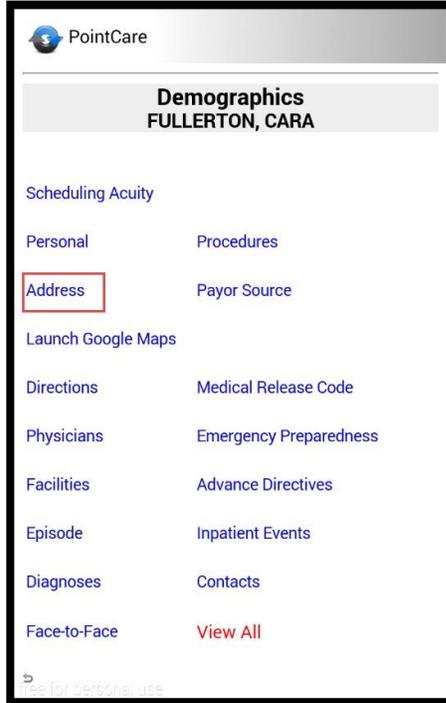




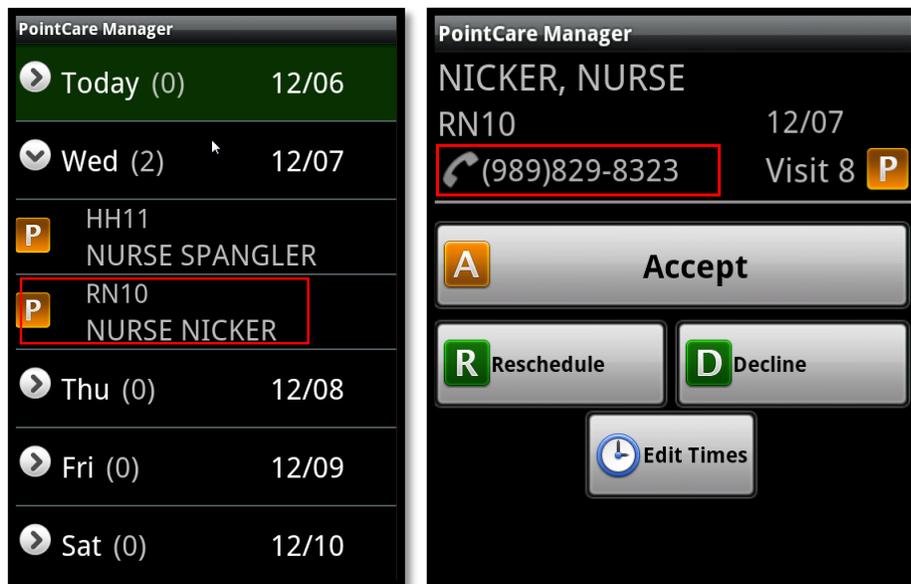
Patient Phone Number

Where can I find the phone number of the patient?

Tap on Menu > Medical Records > Patient Name > Date > Demographics > Address



From your 7 day rolling calendar, tap on the patient’s name and the phone number will display on the top of the screen.





Patient Medical Record Number

Where can I find the patient's Medical Record number?

Medical Records > Patient Name > Date > Demographics > Personal

The image displays two screenshots from the PointCare system. The left screenshot shows the 'Demographics FULLERTON, CARA' menu with 'Personal' highlighted. The right screenshot shows the 'Personal Info' section with the 'Med Record' field highlighted, displaying the number 01000004421601.

Demographics FULLERTON, CARA	
Scheduling Acuity	
Personal	Procedures
Address	Payor Source
Launch Google Maps	
Directions	Medical Release Code
Physicians	Emergency Preparedness
Facilities	Advance Directives
Episode	Inpatient Events
Diagnoses	Contacts
Face-to-Face	View All

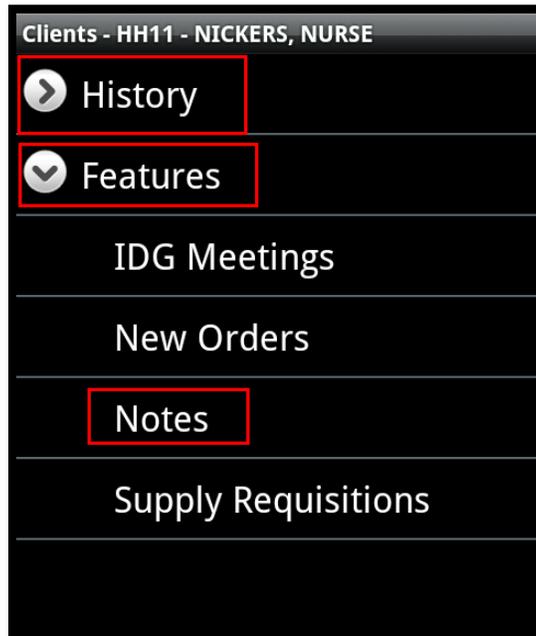
Demographics FULLERTON, CARA	
Personal Info	
SSN	
DOB	11/7/1939
Age	76
Gender	M
Med Record	01000004421601
HEIGHT	0.0
WEIGHT	0.0
Primary Diagnosis	
I50.23 ACUTE ON CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE	



Adding a Visit Note – Outside Visit

How do I add a note from outside of a visit?

Tap on Menu > Med Records > Patient Name > Date > tap on History (this is the VERY first thing at the top of the page) > Features > tap on Notes > Add

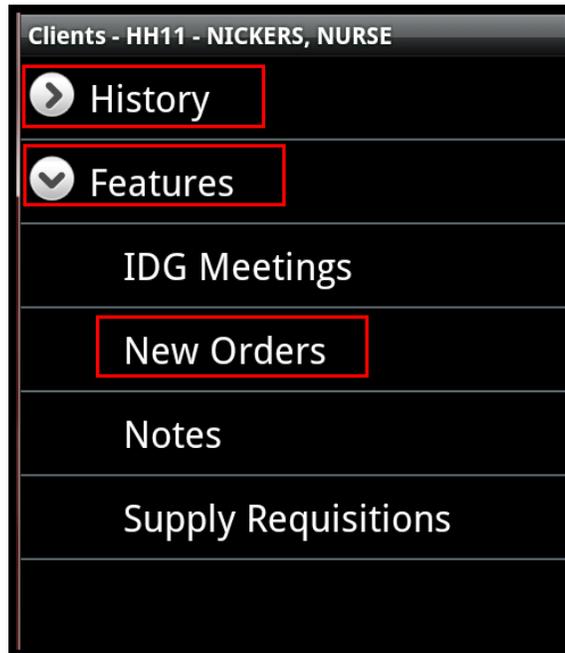




Adding Order/Supply

What if I get a call from the doctor to add an order or supply for the patient after I already synched back the visit?

Tap on Menu > Patient Name > Date > History > Features > Orders > Add



Patient Refuse Service

What if I call before going out to the patient's house for the SOC and they refuse services before I even make it out there?

1. Send the visit back as Missed-Patient refused services
2. The office has the ability to NON-ADMIT the patient

PRN Visit

If I need a PRN visit for a patient what do I do?

1. Two scenarios for this. First is if this occurs during regular office hours:
 - You will need to call the scheduler who can then move the PRN visits that are plotted for that patient onto your calendar for today. You will then need to re-synch your device and accept the visit and synch again.
2. Second scenario is if you are on-call:



- You will need to go into the R2 on your on-call laptop, go into the scheduling console, search for the patient that you need, go to their calendar, and find the PRN visits (they should be on the last Saturday of the patient's cert period), and move one of these visits to the day you need it and schedule it out to yourself. Synch your device, accept the visit, and synch again.

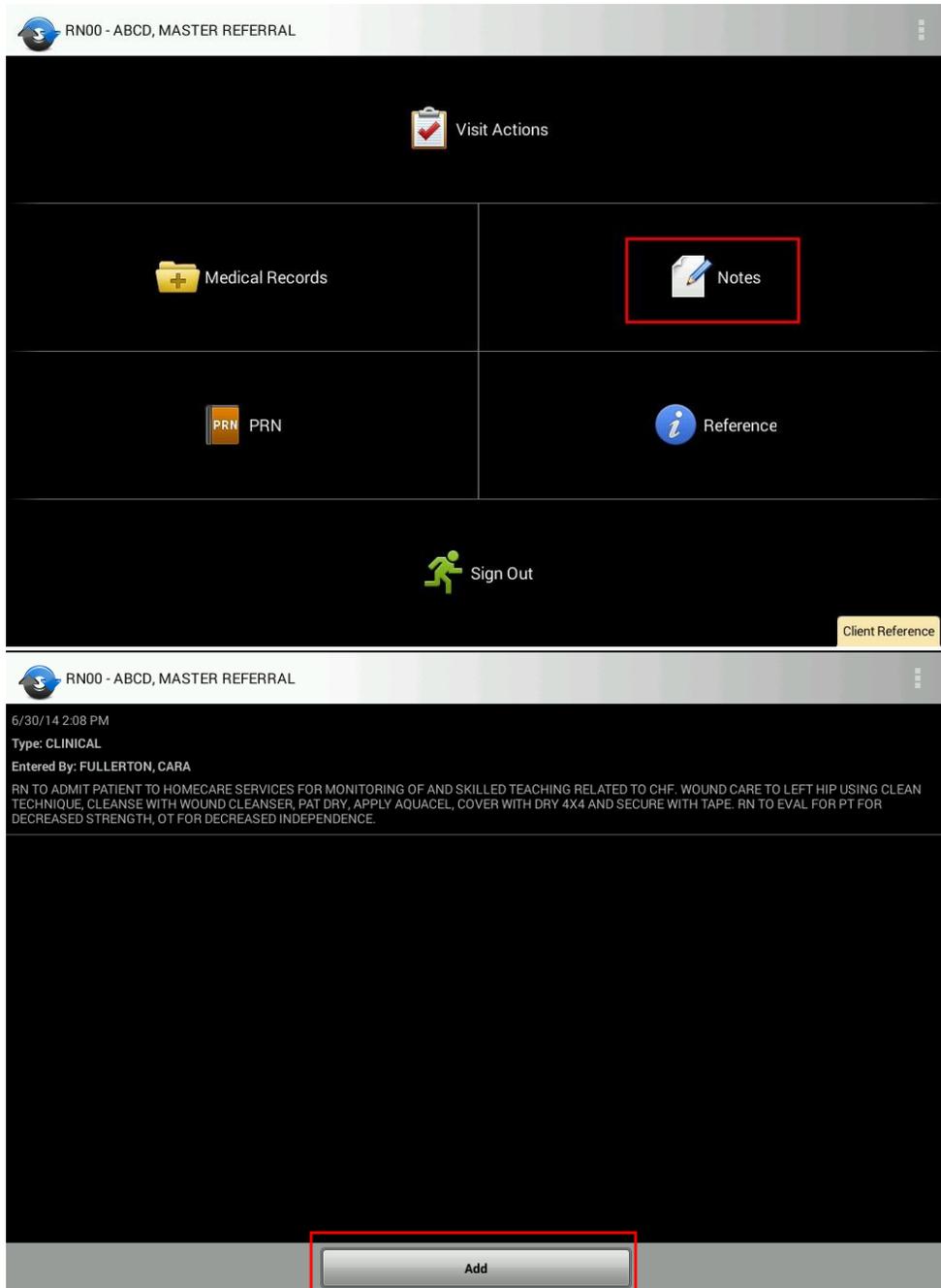


Inside of a Visit

Adding Visit Note – Inside Visit

How do I add a note from inside of a visit?

Tap on Notes > Add

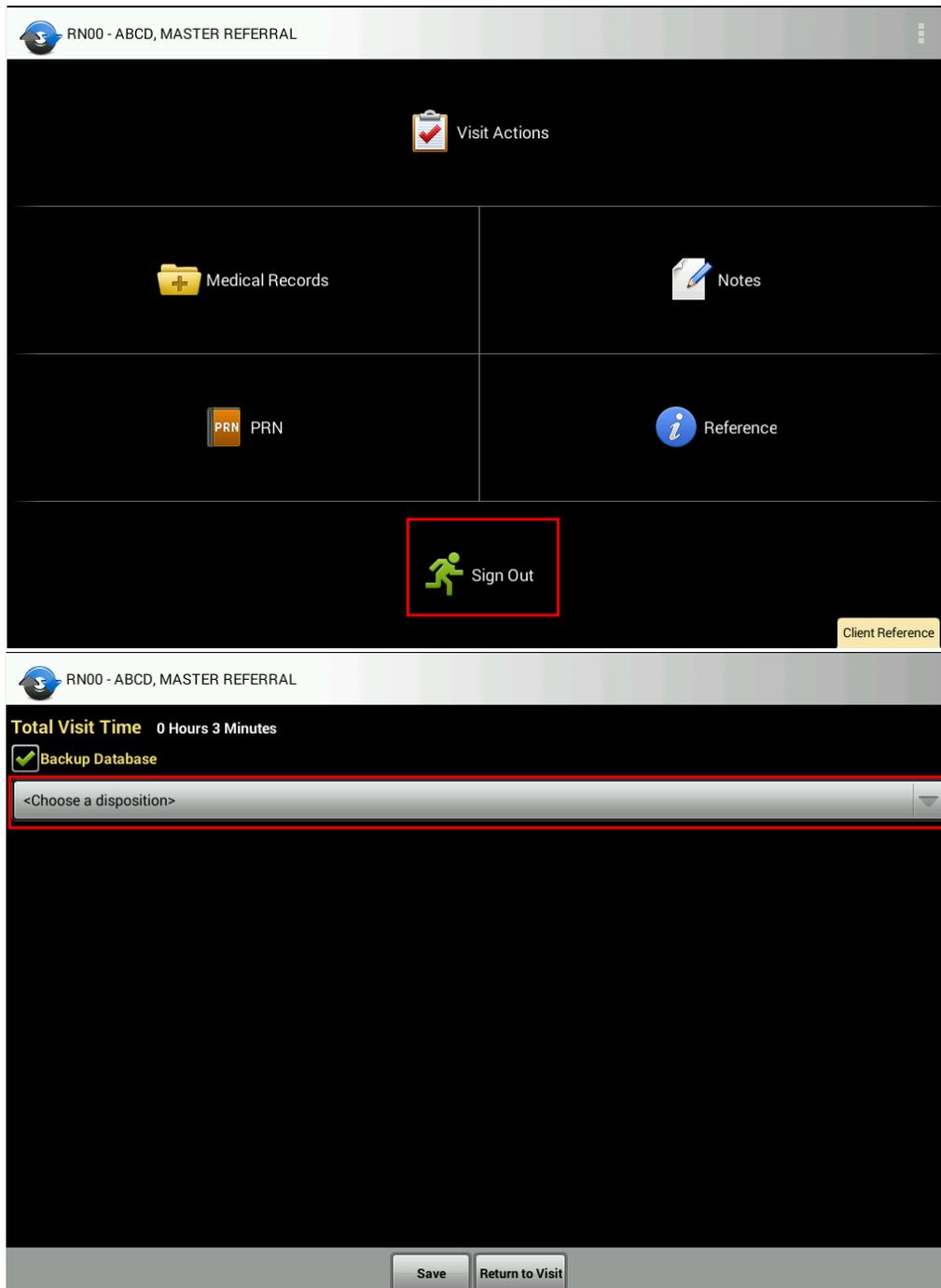




Sign Out of Visit

How do I sign out of a visit?

Make sure you are on your Visit Command Center screen > tap Sign Out > choose a Disposition > MAKE SURE THAT THE PATIENT SIGNS BEFORE LEAVING THE HOUSE

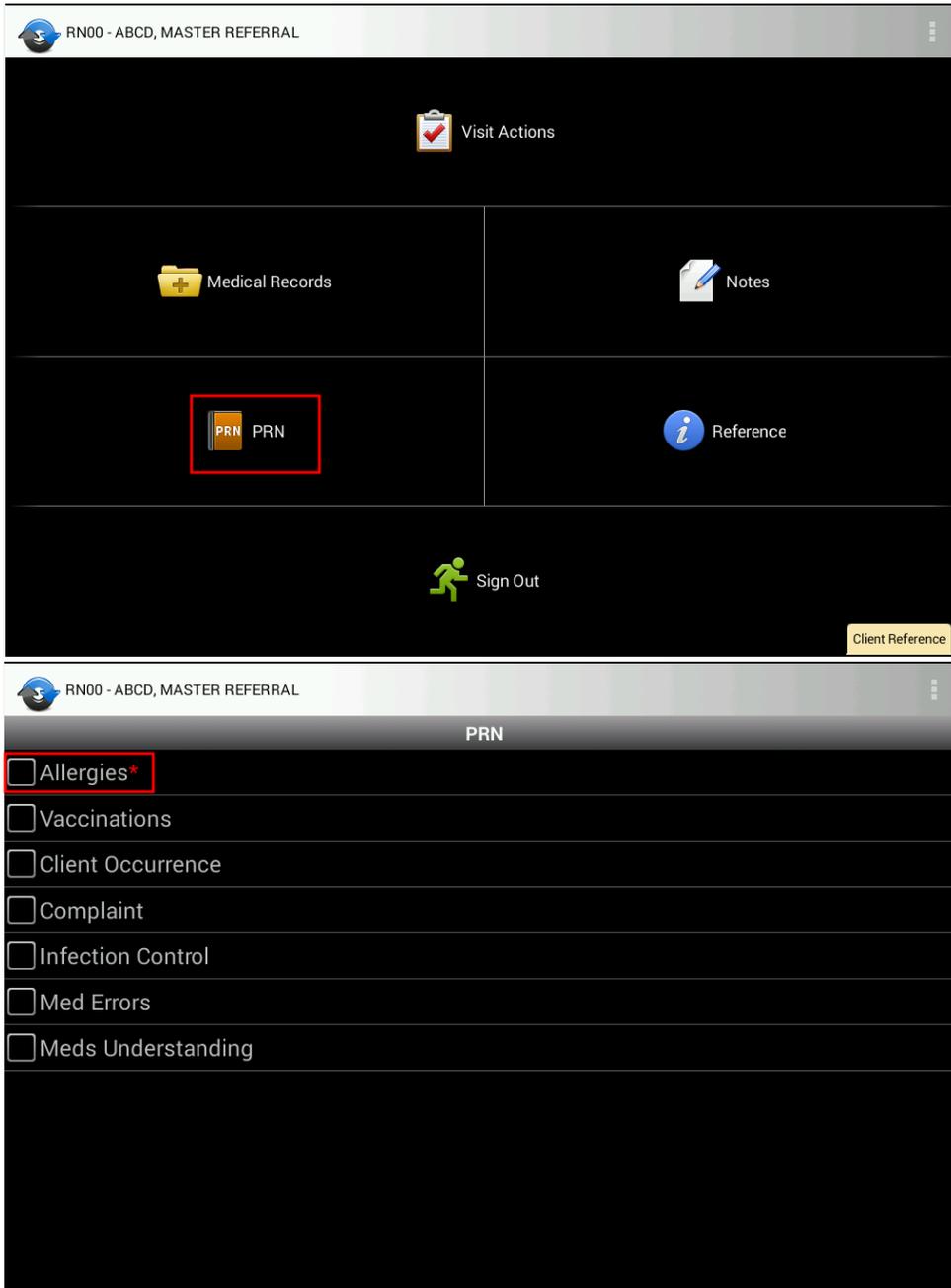




Allergies

Where can I find the Allergies section?

Tap on PRN > Allergies > if it is an allergy that is not listed then you can type in OTHER and enter the unlisted allergy





Items to Complete in Patient Home

What is required to complete in the patient’s home?

If you forget how to navigate through a visit the three things you need to make sure and do are:

1. Start your In-Home time
2. Document the patient’s vitals (these are time stamped)
3. Sign out of the visit when your leave (GET THE PATIENT’S SIGNATURE).

Coordination Note

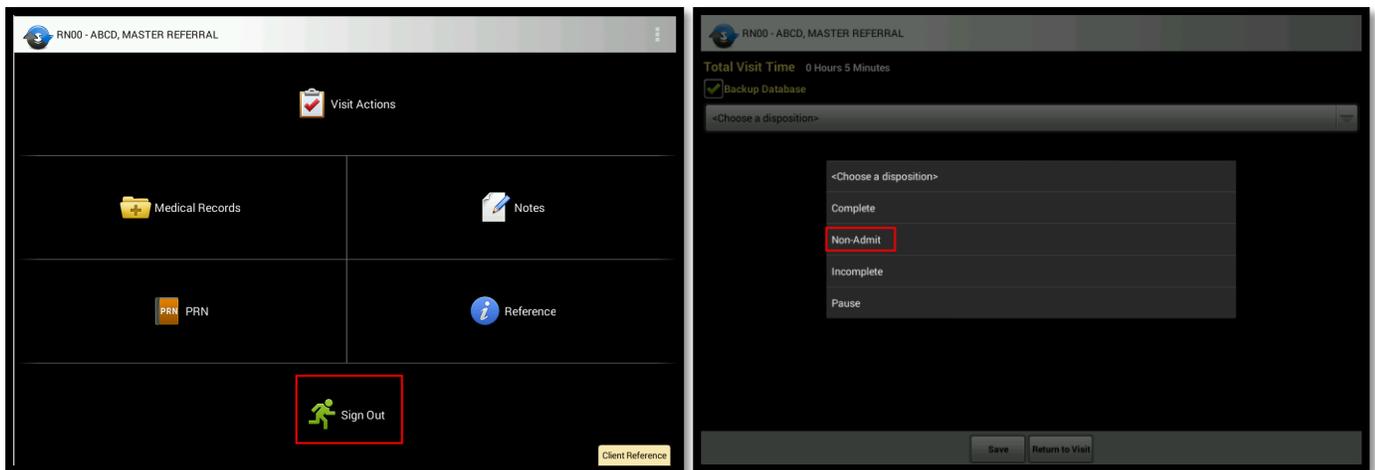
What if I want to document on something that wasn’t a choice with in the visit?

Any additional documentation can be entered in a NARRATIVE Coordination Note (this note will tie itself to that visit).

Non-Admit Patient

How do I non-admit a patient after starting the visit?

Go to sign out of the visit and choose the disposition of NON-ADMIT



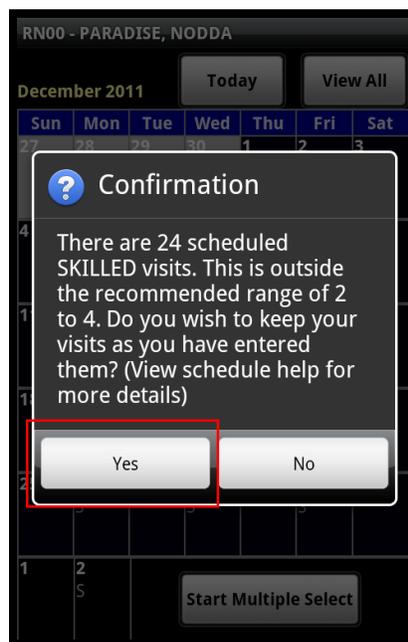


Editing the Calendar

Recommended Range pop-up

What do I do if I am plotting out my visits and a pop-up appears telling me I am outside of the recommended range for this patient?

When you enter in your pathways the system automatically generates a recommended range of visits that this patient may benefit from. As a skilled clinician, you always have the right to come up with the frequency that you think is best. If you want to keep your visits the way they are, then answer “YES” to that pop-up.



Deleting a Visit

How do I delete a visit if I did not mean to add it?

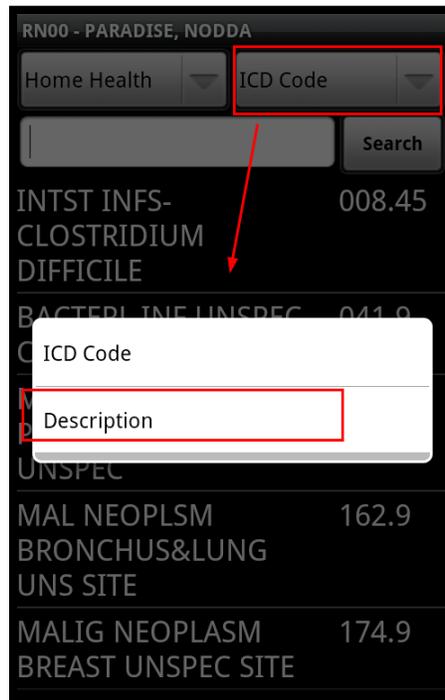
Tap on the visit you want to delete and a pop-up will appear and give you a choice to delete the visit.



Diagnosis

How do I search for a diagnosis?

Remember that you can choose to search for the ICD Code or a description. If searching for a description, remember that less is more. For example if you are searching for Total Knee Replacement and type in “total knee” it will not find it. It is put into the system as “TOT KNEE”.



Wound

If my patient does not have a wound would I still have to go into the Integumentary Command Center?

No, if your patient does not have a wound then the only thing you need to complete for the Integumentary section is the “OPEN FORM” part of that section



Hospice

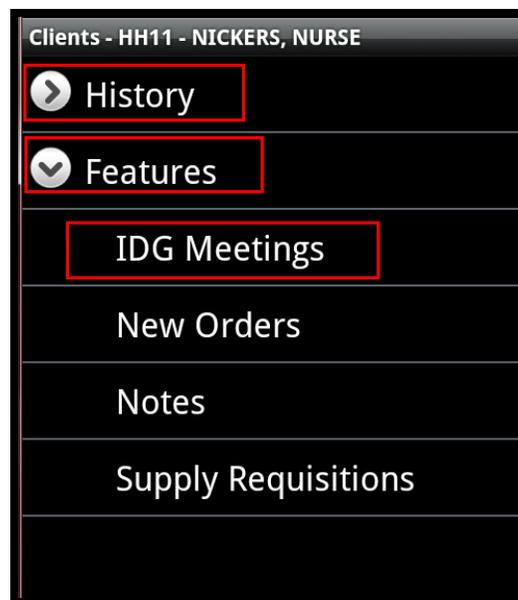
IDG Notes

If I have not seen the patient yet but need to complete an IDG Meeting note how do I do this?

- You will need to call the Scheduler and have them send you a 98H visit service code. You will need to complete this visit and then you will be able to enter in a note.
- This is a dummy visit and will not actually be billable or be a real visit.

How do I enter in an IDG note for a patient from the device?

- From the 7 day rolling calendar screen tap Menu>Med Records>Patient Name>Date>History>Features>IDG Meetings>and choose a patient name.
- To sign the note after making your edits tap Menu>Sign Details



Couch Visits

If I see an RN04H/CH40H/SW40H on my device what does this mean?

- This is a couch visit. It is not an actual visit to the patient and needs to be completed in order to transition the hospice patients over to HCHB.
- Make sure to take note of the date these Hospice patients will be switching to HCHB. You will want to start plotting the calendar for those patients starting on that specified date.



- This means if you see this patient again tomorrow, you will still be doing that visit on paper. It won't switch this patient over to the device until that specified date.

Assessing Bereavement

How do I assess the contact for Bereavement Risk Assessment?

Inside of a visit you need to tap on Visit Actions > Demographics > tap and hold on Contacts > Edit > tap and hold on the contact name>and you will see the option for risk assessment.