PointClickCare[®]

Home Care



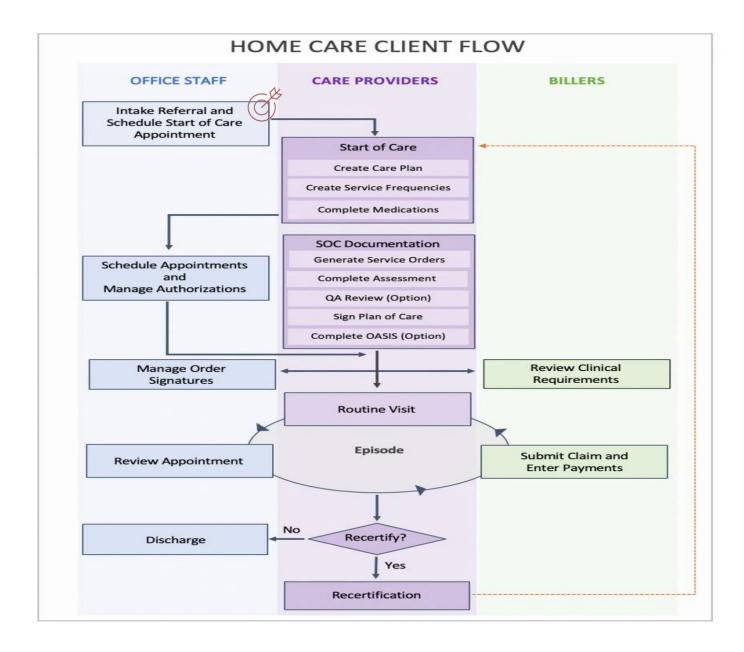
Session Guide:

Start of Care Appointment with OASIS

After this session, clinical staff who conduct start of care appointments will be able to:

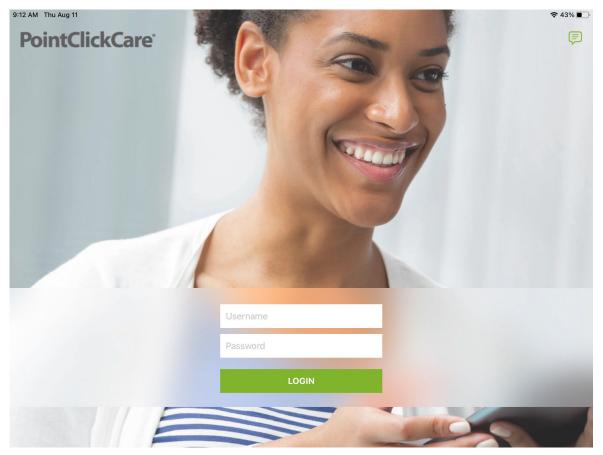
- Log into the Care at Home Clinical app
- Enter Medications
- Complete Skilled Services and Care Plan
- Complete assessment details
- Understand the functionality of locator questions
- Understand how syncing shares information with the Home Health Care web portal.

Start of Care Appointment in Client Flow



Completing a SOC/ROC/Recert Appointment in Care at Home Clinical

- 1. From the mobile device screen, tap the **Care at Home Clinical** icon.
- 2. Enter the Username and Password.



3. Tap Login. The appointments screen appears with scheduled appointments.

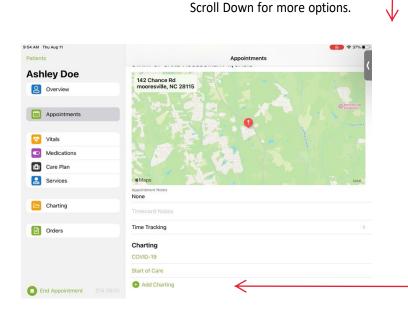
4. In the Care at Home Clinical application, your schedule for any overdue appointments, current and following day appointments will be visible under the appointments tab.

o Do Patients Update Now 💽
Scheduled
ASIS Scheduled

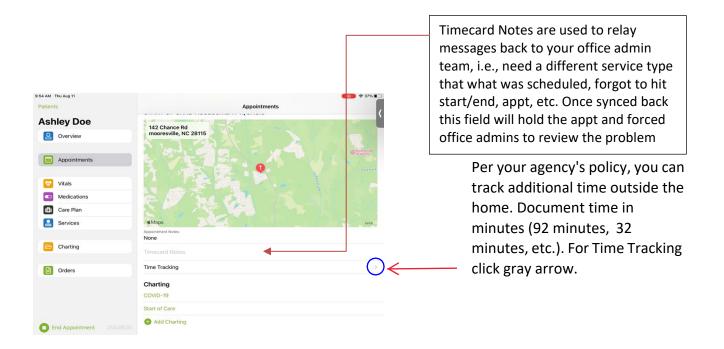
5. Tap the appointment to view patient appointment details.

shley Doe	Appointments
2 Overview	Yesterday · Overdue Today
Appointments	Staff of CaRE. Staff of CaRE. 2:30 PM - 2:30 PM 3:00 AM - 4:00 AM
	START OF CARE ASSESSMENT w/OASIS · Scheduled
Vitals Vitals	142 Chance Rd
Medications	mooresville, NC 28115
Care Plan	
Services	
Charting	
Orders	
	eMaps Level
	Appointment Notes
	None
	Timecard Notes
End Appointment 214:09:	46 Time Tracking

6. Appointment details such as past documentation are located on the left. Click "Overview" to view patient details such as Address, DOB, phone number, EID, Emergency preparedness rating, code status, cert period, Diagnosis, PCP, or alternate MD's.



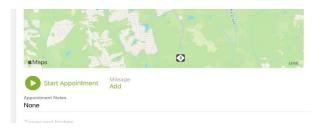
Tip: Assessment forms are automatically loaded in the appointment. If you need to choose a different assessment, tap **Add Charting**, and select another assessment in the appointment screen. Adding charting under the appointment tab will link the charting to the specific appointment.



7. Once you click into the gray arrow to edit time tracking you may complete all needed information here.

11:15 AM Thu Aug 11		* 35% •
Patients	< Appointments	
Ashley Doe		
Overview	Travel Time	
	Pre-Visit Time	To go back to your
Appointments	Post-Visit/Documentation Time	appointment, click on the green
😒 Vitals	Physician Communication Time	"Appointments" and it will take
Medications	Other Time	
Care Plan	Enter minutes for all time tracking.	you back to your patient's
Services		
	Other Time Description	appointment page.
Charting		
Drders		
C End Appointment 215:57:03		

8. To begin the appointment, tap the appointment and press **Start Appointment**.



- 8. After completing as much information as you can in the patient's home, tap **Close and Save draft**.
 - a. Tip: If you delete your draft it will show up as a struck-out document on web version and PointClickCare cannot retrieve deleted documents.
 - ALERT: If you sign document before ending your appointment the end time stamp of your appointment will not show on the print version of the document.
 Please always save draft first, end appointment then sign document.
- 9. Tap **End Appointment**. This GPS locates and date/time stamps the end of the appointment.
- 10. Have your patient use their finger or a stylus to sign in the **Client's Signature** box. Note that your agency may be set up to indicate that a patient is unable to sign.



Tip: Remember that if you've Saved and Closed a document, you can reopen it after the appointment for further work via To-Do List in App.

- 11. Once you have reopened your document and completed the assessment, before you sign, you may Run the **Oasis Scrubber** (only applicable if your agency has an integration with SHP, Tip: when pressing this button, you will need an internet/cell connection since this button takes you to open a new page to login to SHP web site, your agency will provide you a login for SHP.)
- 12. Once you have completed documenting on your note you will tap **close and choose sign.**
- 13. Once you sign the SOC/ROC/Recert document this will push your document into the Pending QA workflow bin. When your document has completed QA review it will be sent back to you for review and corrections. You will complete these corrections via your To-Do list in the app.

Start of Care Documentation

Start of care details include:

- 1. Medications
- 2. Skilled Services and Care Plan
- 3. Start of Care with OASIS Assessment
- 4. To-Do List: Unsigned documents, QA workflow, Unsigned Orders

Complete as much information as possible in the patient home. Note that the start of care date entered in the assessment automatically determines the certification period. Any certification periods created outside the signed assessment will be disabled.

Medications

You may review current medications, add new medications, review/edit pending medications, complete a DRR and review medication interactions from this section of your assessment. Information from this section of your document will flow out immediately to tabs with any sync auto or manual.

Review a pending medication:

- a. Tap on pending medication to review details
- b. Make changes if needed
- c. Save as active, keep as a pending medication, or delete the medication.

Close	Kedications	0	Close	< Medications
Liz Langley Skilled Nursing Start of Ca	Medications		Liz Langley Skilled Nursing Start of Ca	Cancel Pending Medication Done Drug Nums Amovicillin-Pot Clavulanate 5r Save as Active
Patient Tracking	Amoxicilin-Pot Clavulanate 500-125 MG		Patient Tracking	Route Crail Keep as Pending
Clinical Record Items	1 tao, twice a day Started 11/22/2022		Clinical Record Items	Total Dose Required for Active
Homebound	Pending medications need to be confirmed as active, or eleted if they should not appear in the active medications list.		Homebound	1 tab ey a fuid not appear in the active
Patient Vitals	Interactions	12	Patient Vitals	Frequency Required for Active Twice a day
Pain Profile	Interactions only apply to active medications.		Pain Profile	Start Date November 22, 2022
Medications	ACTIVE MEDICATIONS		Medications	
Diagnoses	Aspirin 325MG	5	Diagnoses	Per RX Label
Patient History	1 tab, Daily Started 11/01/2022	<u></u>	Patient History	PRN
Living Arrangements	Couradin 2MG 1 tob, Daily	>	Living Arrangements	Reson Optional
Psychosocial	Started 11/08/2022 Active medications represent what the patient is currently taking.		Psychosocial	Instructions Optional
Cognitive/Behavior	DRUG REGIMEN REVIEW		Cognitive/Behavior	Take 1 tab by mouth every morning and every evening
Neurological	Add Drug Regimen Review		Neurological	Classification Optional
Sensory	Start of Care Nov 17, 1:10	D PM	Sensory	Delete Nov 17, 1:10 PM
Cardian	Signed - dani Siebs (RN, HHA, PT, OT)		Cardian	
OASIS Scrubber			OASIS Scrubber	

Add a new medication:

- a. Click "Medication Profile"
- b. Click Add Sign "+".
- c. Type the drug name. Select from potential matches. Always choose a match when available. This allows the system to produce drug-to-drug interactions.
- d. Per agency policy complete Dose, Route, and Frequency. Best practice is to not use abbreviations.

Cancel	New Medication	Done
Drug Harrie Adult Aspirir	Regimen 81 MG	
Oral		
Total Duse		
Frequency		
surtDate November 3	10, 2022	
Per RX Labe	6	0
PRN		0
Reason		Optional
Instructions		Optoral
Classificatio		Optional

Per RX Label:

On routine visits, this option determines if an order is created. If checked, no new supplemental order is created. If not checked, a new supplemental order is created.

PRN:

For medications taken PRN (as needed) you must define a frequency, check the PRN box, and add a Reason.

Instructions:

This section prints out on the medication list that is given to the patient. Classification is not a required field. You can chose from the drop down or free text your information. Follow agency policy for the Classification field.

Working with existing medications

For existing meds on the Medications list, you can Edit or Discontinue.

Close	K Medications	Edit	Close	K Medications	Coumadin 2MG	Edit (j
Liz Langley Skilled Nursing Start of Ca	Coumadin 2MG anticoagulant	By Selecting edit on	Liz Langley Skilled Nursing Start of Ca.	Nov 8, 2022 Per RicLabel Ves		
Patient Tracking	Tetal Does, Frequency Route the right corner of the specified med you Start Date can make changes Nov 8, 2022 needed.		Patient Tracking			
Clinical Record Items Homebound			Clinical Record Items	take 1 tab by mouth every evening, CALL MD FOR ANY UNUSUAL BRUIS OR BLEEDING Updated by Siebs, dani on Nev 17, 2022		JISING
			Homebound			
Patient Vitals	Yes PRN, Reason		Patient Vitals			
Pain Profile	No. afib		Pain Profile	Interactions		12
Medications	take 1 tab by mouth every evening, CALL OR BLEEDING	MD FOR ANY UNUSUAL BRUISING	Medications 📳	MEDICATION SETUP		
Diagnoses	Updated by Si	ebs, dani on Nov 17, 2022	Diagnoses	Setup By		5
Patient History			Patient History	Administered By		>
Living Arrangements	Interactions	1)	Living Arrangements		By selecting discontinue	
Psychosocial	MEDICATION SETUP		Psychosocial		medication it will prompt y to enter an end date	ou
Cognitive/Behavior	Setup By	>	Cognitive/Behavior	HOURS AND DATES		
Neurological	Administered By	>	Neurological	Add Hours and Dates		
Sensory	Setup Comments		Sensory	(7	
Cardian			OASIS Scrubber		Discontinue Medication	

Add Drug Regimen Review:

ABC				
	Medications	f ♥ 94% ■) ©		
teractions only apply to active me	dications.			
TIVE MEDICATIONS			Medicatio	on Profile
lopurinol 100 MG		>	Ashley Doe	
arted 06/23/2022			Drug Regimen Review MEDICATIONS	
abapentin-MethSal-Men-C as directed, Daily arted 08/11/2022	Capsaic 300 MG	>	Drug Regimen Review 11	le >
isinopril 10MG lab, Daily arted 05/01/2022		>	7	
nethylPREDNISolone 16 MG as directed, As directed tarted 06/23/2022	i	>	Ansv	ver 11 Question Review and
Navix 75 MG Every other day tarted 05/23/2022		>	Sign	Document:
tive medications represent what t	the patient is currently taking.		Close	
RUG REGIMEN REVIEW			Ashley Dee	Drug Regimen Review
dd Drug Regimen Review			Ashley Doe Drug Regimen Review	REQUIRED
rug Regimen Review arted - Training 100 Training 100 (ICNA, ADUA, COTA, HHA, LPN, MSW, OS, OT, PCA, PT	Aug.17, 11:05 AM	Medication Profile	Reason for DRR
	_		Drug Regimen Review	11 Start of Care
ow Previous Medications				Resumption of Care
				Follow-up/Recertification
				Discharge from Agency
				New Medication
				REQUIRED
				Does the client report experiencing one or more significant side effects to currendrug regimen?
				REQUIRED
				Does the client and/or caregiver demonstrate a knowledge deficit related to curr medication use?
				Yes No

Add Service Frequencies for each specialty

Select Add Service.

- 1. Enter **Service Details.** Pay particular attention to the **Payer Plan** and **Signing Care Provider** as they will auto populate the primary on file. If changes are needed, tap in, and make appropriate changes.
- 2. Choose the Visit Type: Frequency, PRN, or EVAL.
- 3. Verify the Start Date matches the start date of the service you are specifying.
- 4. Add Frequencies as necessary. Added frequencies are listed under Defined Services.

Doe	Cancel		New Servi	ce	I	Done	You should complete the soc date on the clinical record items section
iew	Special	ty			None	e >	1 st to ensure your cert period auto
	Signing	Care Provider		1	BRUCE MATHER	23	populates for you
ntments	Certific	ation Period		6/22/20	022 - 8/20/2022	2 >	
	Payer P	Plan		Medicare - PDGM	(06/01/2022 -)	>	
ations						- 1	
	Add Fre	equency					
Plan						- 1	
es	Add PR	N					
ing						- 1	
ing	Add Eva	aluation				- 1	
s						- 1	
		rbal Order	d, appointments can be add			- 11	
3:09 PM T Patients		-00			হ গাগ 💽		
Patients	s	Cancel	Frequency	Add	♦ 31% ■		
Patients Ash	s		Frequency	Add			
Patients Ash	s Iley Doe Overview			6/22/2022 - 6/25/2022			
Patients Ash	s lley Doe	CURRENT FREQUENCIES		6/22/2022 - 6/25/2022 !3/	٢		
Patients Ash 2	s Iley Doe Overview	CURRENT FREQUENCIES		6/22/2022 - 6/25/2022	٢		Verify the Start Date matches
Patients Ash 2	s ley Doe Overview Appointments	CURRENT FREQUENCIES		6/22/2022 - 6/25/2022 !3/	٢		the start date of the service
Patients Ash 2 1 1 2 1 1 1 1 1 1	S Iley Doe Overview Appointments Vitals Medications Care Plan	CURRENT FREQUENCIES 1W1 NEW FREQUENCY Start Date		6/22/2022 - 6/25/2022 3) Jun 26, 2022	٢		
Patients Ash 2 1 1 2 1 1 1 1 1 1	s ley Doe Overview Appointments Vitals Medications	CURRENT FREQUENCIES 1W1 NEW FREQUENCY Start Date Visits Frequency		6/22/2022 - 6/25/2022 Jun 26, 2022	٢		the start date of the service
Patients Ash 2	Second Se	CURRENT FREQUENCIES 1W1 NEW FREQUENCY Start Date Visits		6/22/2022 - 6/25/2022 Jun 26, 2022	٢		the start date of the service
Patients Ash 2	Iley Doe Overview Appointments Vitals Medications Care Plan Services Charting	CURRENT FREQUENCIES 1W1 NEW FREQUENCY Start Date Visits Frequency Weeks		6/22/2022 - 6/25/2022 Jun 26, 2022 1 - + per Week > 1 - +	٢		the start date of the service
Patients Ash 2	Services	CURRENT FREQUENCIES 1W1 NEW FREQUENCY Start Date Visits Frequency Weeks		6/22/2022 - 6/25/2022 Jun 26, 2022 1 - + per Week > 1 - +	٥		the start date of the service
Patients Ash 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Iley Doe Overview Appointments Vitals Medications Care Plan Services Charting	CURRENT FREQUENCIES 1W1 NEW FREQUENCY Start Date Visits Frequency Weeks		6/22/2022 - 6/25/2022 Jun 26, 2022 1 - + per Week > 1 - +	٥		the start date of the service
Patients Ash 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Iley Doe Overview Appointments Vitals Medications Care Plan Services Charting	CURRENT FREQUENCIES 1W1 NEW FREQUENCY Start Date Visits Frequency Weeks		6/22/2022 - 6/25/2022 Jun 26, 2022 1 - + per Week > 1 - +	٥		the start date of the service

Cancel Verbal Order Date Verbal Order Time Received By Training 100 Training Relayed By	Add Verbal Order	Session Guide: Star Aug 11, 2022 2:34 PM	Enter Verbal Order information. A Verbal Order is required for auto- generation of your authorization so you may schedule future appointments. No VO, no way to schedule or review billable appointments.	2
3:38 PM Thu Aug 11 Patients Ashley Doe Overview Appointments	Services Physical Therapy 2W8 Verbal Order	 ≈ 30% ■ 	Review the Defined Services and verify the service dates are correct and that your verbal order is attached.	

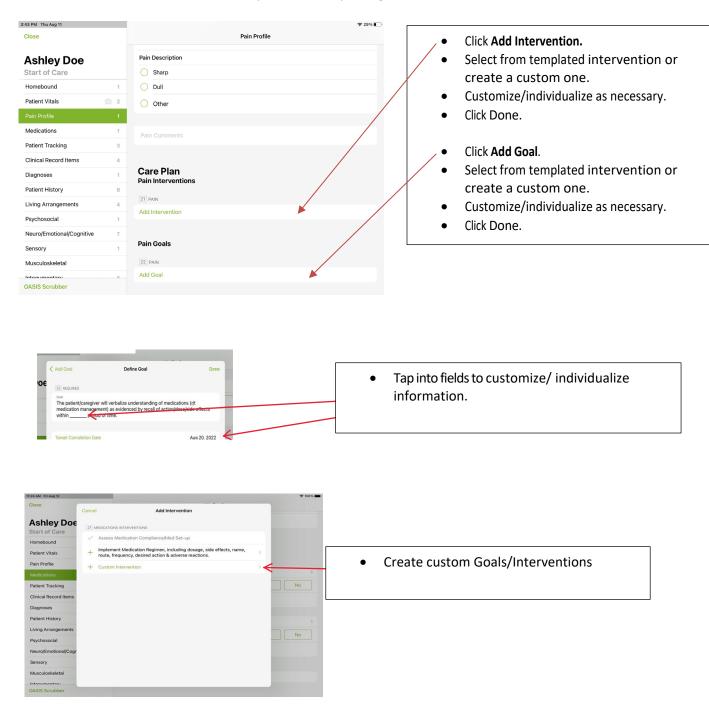
5. Continue adding services for all required specialties, including HHA. (Tip: Create HHA care plans outside of this note on the care plan tab in the app.) (see HHA Care plan guide)

Care Plan

Care planning items are available throughout the tabs categorized by the section headers. Select "add intervention/goal" you will see a list of templated interventions/goals, agency specific ones or you can create custom ones. You can select those that are applicable to your patient and customize/individualize as necessary.

To add a Care Plan:

• In each section of the assessment, you can select specific goals and interventions.



• You may document against your care plan after you have added it under the **Documentation** section. This information will be viewable in future assessments as historical documentation with clinician and date/time stamping.

58 AM Mon Aug 15 Close		
Ashley Doe Start of Care	Care Plan Medications Interventions	 Enter documentation details
lomebound	Assess Medication Compliance/Med Set-up	Documentation field on
atient Vitals	B 2 Performed Intervention Yes No	Documentation neiù on
n Profile		Interventions and goals
lications	Bu 1 Documentation	
tient Tracking	3	
ical Record Items	4 Implement Medication Regimen, including dosage, side effects, name, route, frequency, desired action & adverse reactions.	
gnoses	1 Performed Intervention Yes No	
nt History	8	
g Arrangements	4 Documentation	
chosocial	1 21 MEDICATIONS	
euro/Emotional/Cognitive	7 Add Intervention	
insory	1	
usculoskeletal	Medications Goals	 Mark Interventions as Performance
tanimantani		
ASIS Scrubber	The patient/caregiver will verbalize understanding of medications (r/t medication	"Yes" or "No"

• To view documentation history, tap on a specific intervention or goal to view the details and history of documentation.

Patient History	8			
Living Arrangements	4	The patient/caregiver will verbalize understanding of medications (r/t medication management) as evidenced by recall of action/dose/side effects within		
Psychosocial	1	period of time. Target Date 08/20/2022	Ashley Doe	INTERVENTION
Neuro/Emotional/Cognitive	7	Evaluated Yes No	Start of Care Homebound	Implement Medication Regimen, including dosage, side effects, name, route, frequency, desired action & adverse reactions.
Sensory	1		Patient Vitals 2	HISTORY & DOCUMENTATION
			Pain Profile	
			Medications	Aug 12
			Patient Tracking 3	New 08/12/2022 - Draft Training 100 Training
			01-1-10-1-10-1	

To discontinue an intervention or goal, tap into the goal/intervention. Select
 "Discontinue Goal/Intervention". Then enter a reason for the discontinuation of goal/intervention, keep in mind
 reason for discontinuation could be goal/intervention complete/met. You may also mark a Goal as met by sliding
 the toggle to 100%.

Φ 82%	12.56 PM Thu Aug 18	P 82% 🔳)
Care Plan	Patients	al Done
GOAL	Ashley Doe	ai Uone
The patient/caregiver will verbalize understanding of medications (r/t medication management) as evidenced by recall of action/dose/side effects within period of time.	Cverview Reason for Discontinuation	/t medication hin period
Target Date 08/20/2022	Appointmenta	
HISTORY 100	Vitais	100
	Medications	50
Aug 12 Aug 13 Aug 14 Aug 18 Aug 19 Aug 19 Aug 19 Aug 19 Aug 20	Care Plan	Aug 10 Aug 20
08/72/2022 Training 100 Training 100 Goal evaluated at 5016	Services	ning 100 Training 100
Discontinue Goal	Charting	ning 100 Training 100
	D Orders	
	Care Plan Cox. The patient/complexe will recharter standing of medications (in medication	Care Plan Soci. Assisting of madications of

Clinician QA Workflow

- Find your QA review documents in your To-Do list in the Application under "QA Review Complete" at the bottom of the To-Do List
- Tap on the document to view QA reviewer requested changes
- Tap {Show QA} to see changes requested

Close Jessica B Fall Report	show QA	Details
Details Close Hide QA Jessica Brickers	1 Details	Details XXXXXXXXX
Fall Report Document Details	REQUIRED Details XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	

- Tap on each item,
 - Make edits if applicable
 - o Reply to QA team if needed,
 - Mark accept or reject for each change requested
- Run Oasis Scrubber again if needed
- Tap {save and close} to come back later to finish or {Sign} if completed with changes
- These QA documents can go back and forth between QA team and clinician as many times as needed until the QA team locks the assessment
- Once QA is complete and assessment is locked your POC/485 order will populate your To-Do List under Unsigned orders.
 POC/485 orders can be viewed on the app but not singed. Please go to web version to review and sign your POC/485

Documentation

- Follow skip logic and answer all required questions prior to signing. If you miss any required questions the application will warn you and then also highlight them in red so you may go back and answer them.
- Add additional details to any sections necessary.
- Follow agency policy and procedures for required documentation.

Tips, Tricks and Reminders:

- Care at Home Clinical application will continuously auto-sync every 5 minutes when there is a connection to cell service or Wi-Fi. If no connection, the application will hold data until it finds a connection again.
- At the end of every day please do the following in chronological order for optimum performance:
 - Ensure under the person icon in the app (top right) that a full sync has completed and has a date/time stamp and that all documents have synced. If not, perform a manual sync by pressing on the Sync button and waiting for it complete the sync before closing the app.
 - Close the app by double tapping the home button and swiping the app off the page.
 - Plug iPad into power.
 - Connect iPad to wi-fi to ensure any overnight updates may take place.
- If you run into any issue while using the Care at Home clinical app you should send logs to PointClickCare by going to the login screen of the app and at the top right, tap on the chat box. In the chat box please give details including date/time issue happened, ensure you have a connection then and tap send. Please also notify your agency admin of the issue so they may also submit a support ticket to PointClickCare for review of the issue.
- DO NOT DELETE AND REINSTALL THE APP, unless advised to do so by a PointClickCare liaison. This could cause data loss and require you to re-document notes.

Workflow Considerations

- How does the clinician alert the rest of the care team that the client has been successfully admitted? Intake Coordinator should then Complete the Intake, so all staff are aware client is now Open.
- Consider agency policy on timely completion of documentation. Remember that the appointment will not reflect that it has been done until it is Synced from the mobile application.
- Consider agency policy regarding coding of the assessment. Remember that at least 1 diagnosis code must be entered to sign the assessment. If QA Review is on, these codes can be updated by your agency coder once it is signed and submitted for review.