POINT OF GARE



BUSINESS MODEL SOFTWARE TRAINING

Good Looking



Point of Care (Therapist): Recommended Training Course Agenda

Course Purpose: We recommend using the following training outline to ensure that training participants receive clear instructions on how a patient would flow 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: Therapists-All disciplines



 \bigcirc : 1 hour 30 minutes to 2 hours

POINT OF CARE (THERAPY VISIT)				
COURSE TITLE	COURSE DESCRIPTION	<u>()</u>		
View Medical Record	Learn how to locate and navigate through a patients medical record.	5 Minutes		
Enter the State Date and Time	Learn how to enter the State Date and Time in a visit.	< 5 Minutes		
Special Features/Previous Answers	Learn how to locate previous answers to questions for a particular patient.	5 Minutes		
Goals and Document Teaching	Learn how to document progress to achieving goals and teaching that was completed during a visit.	5 Minutes		
Patient Signature/Alternate Signing Options	Learn how to locate and allow the patient to sign a visit has been completed.	< 5 Minutes		
Clinician Signature/ Alternate Signing Options	Learn how to locate and complete the clinician signature for a particular visit.	< 5 Minutes		
End Date and Time	Learn how to enter and change the End Date and Time of a visit.	< 5 Minutes		
Saving Incomplete Visit for Later	Learn how to use the red 'X' button to save incomplete documentation.	< 5 Minutes		
Turning in Your Visit	Learn how to finish and turn in a completed visit documentation.	< 5 Minutes		
Correcting Failed Visits	Learn how to review and correct visits that have been failed back.	< 5 Minutes		



IMPORTANT TIPS TO SHARE:

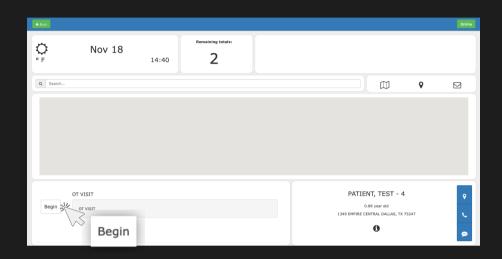
- Explain to participants that there are 2 different way to use the Point of Care program: Offline and Online.
- Offline is the one that they will use to complete their documentation on out in the field and is usually
 downloaded to a computer provided by their agency or a personal laptop. The online version is
 typically used when they are at their home or office and have an internet connection.
- You can only download the offline version to ONE computer! The offline version, when syncing, is only
 communicating with our online servers. It does not communicate with any other downloaded versions
 of the software on other computers! If you download the program on 2 different computers and sync
 them both you could potentially override and lose your documentation!
- · When using the offline version messages are only sent and received when you push the sync button.
- If they do not have a touch screen computer or one that uses a stylus that is ok. They have alternate
 signing options at the bottom of both the patient and clinician signature pages. Real Example: Some of
 our agencies send the field staff with a sign off sheet that gives the date and an area for the patient's
 signature. Then they have their field staff choose 'signature on hardcopy note'.
- Make sure that participants know the End Date and Time for the Clinician Signature Page. They can adjust the time to the time which they left the patients home.
- Show them examples of ways that they may see a failed visit on their schedule. Them making the corrections themselves or having them accept suggestions/corrections)



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

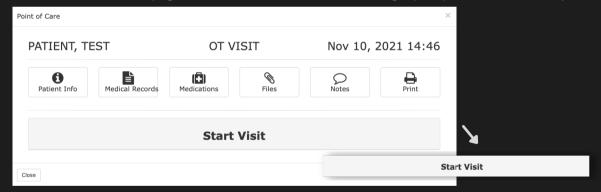


- Click on the Scheduled Visit
 - The page will present a list of your visits for that day. Click on the 'Begin' button next to the scheduled visit with the specific patient you are assessing.



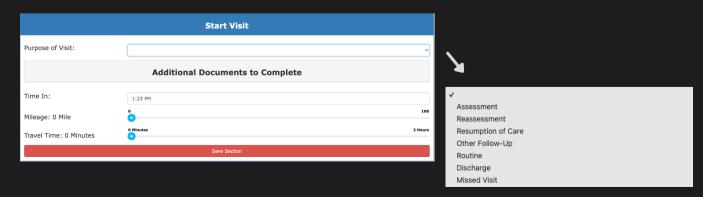
3 Start Visit

• On the Point of Care page, click the 'Start Visit' button and begin your patient assessment process.



4 Complete the Start Visit Section

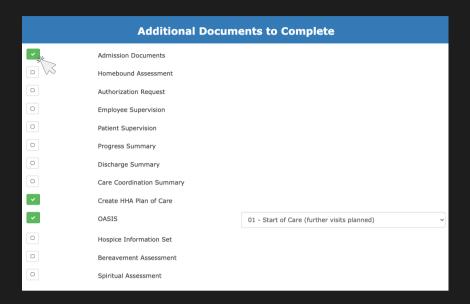
- When you click on 'Start Visit,' there will be drop down open.
- For 'Purpose of Visit' choose 'Routine' from the drop down menu.





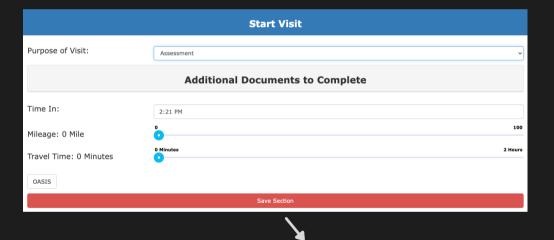
5 Additional Documents to Complete

 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.



6 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 the 'Save Section' button.

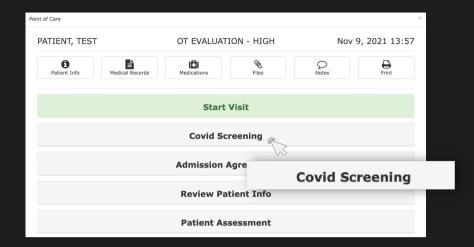




1

COVID Screening

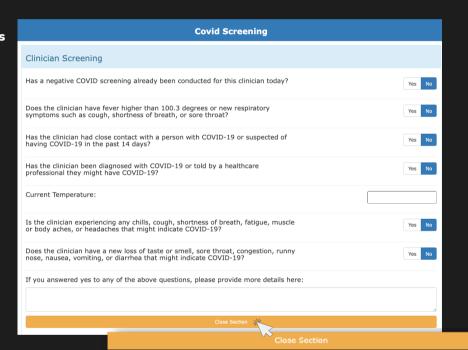
 After you have started the visit, the visit items to go through will be listed. Click on the 'Covid Screening' button.



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.





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.





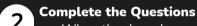




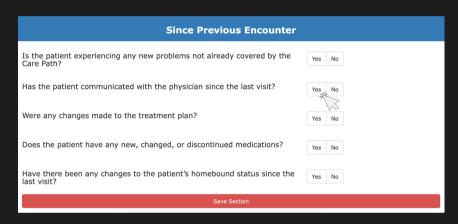
Since Previous Encounter

 Click on the 'Since Previous Encounter' button on the visit list.





- When the drop down opens on the 'Since Previous Encounter', answer the 5 questions by clicking the 'Yes' or 'No' buttons.
- If you click the 'Yes' button, a form will populate where you can provide more information.





	Since Previous Encounter	
Is the patient experiencing any r	Yes No	
Has the patient communicated w	Yes No	
How?		Phone Visit
Why?		
Were any changes made to the t	reatment plan?	Yes No
Does the patient have any new,	Yes No	
Have there been any changes to	Yes No	
	Save Section	



 Once you have answered all questions and completed the required fields, click the red 'Save Section' button.

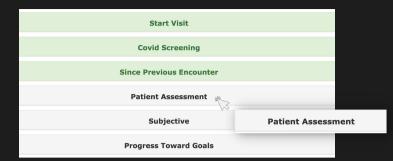






Open Patient Assessment

 Click the 'Patient Assessment' button on the visit list.



2

History and Mental Status

- When the drop down opens, input the patient's background information and the community resources.
- Indiciate their Mental/Cognitive Status by clicking on the button to the left of that line item.

Patient Assessment					
Background Info/Medical History:	Comment				
Prior History of Therapy:	Comment				
Community Resources:	Comment				
Mental/Cognitive Status:	Alert/Oriented for age Impaired				

3

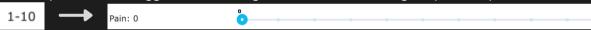
Pain Assessment

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.



1-10

• For this option, use the toggle button to drag to the number indicating the patient's pain level.



Smiley Scale

• For this option, select the face that best reflects their pain.



Mankoski

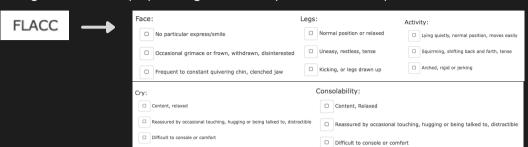
• If you select Mankoski, it will display a pain scale from 0-10 with the pain level description and suggested treatment associated to that pain level.

Mankoski Mankos	ski Pain Scale:	0	Pain Free	No medication needed
	0		Very minor annoyance - occasional minor twinges	No medication needed
	0		Minor annoyance-occasional strong twinges	No medication needed
	0	3	Annoying enough to be distracting	Mild painkillers are effective. (aspirin, ibuprofen)
	0		Can be ignored if you are really involved in an activity, but still distracting	Mild painkillers relieve pain for 3 to 4 hours
	0		Can't be ignored for more than 30 minutes	Mild painkillers relieve pain for 3 to 4 hours
	0		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
	0		Makes it difficult to concentrate, interferes with sleep. You can still function with effort	Stronger painkillers are only partially effective. Strongest painkillers relieve pain (Oxycontin, Morphine)
			Normal physical activity severly 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
	0		Unable to speak. Crying out or moaning uncontrollably - near delirium	Strongest painkillers are only partially effective
	0	10	Unconscious. Pain makes you pass out	Strongest painkillers are only partially effective



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

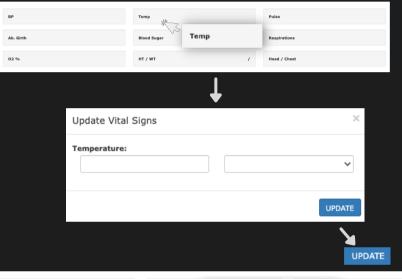
• Selecting FLACC will display 5 categories where you will select the patient's actions associated with the category.





Record the Vitals

- Once you have completed the pain assessment, 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 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.

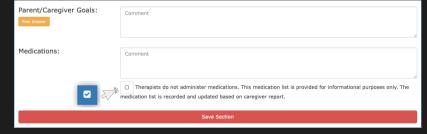






Input Goals & Medications

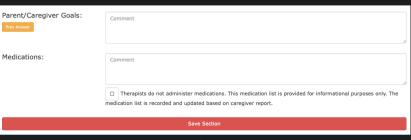
- Type the goals for the Parent/Caregiver in the comment text box to the right.
- Record any medications by typing those in the comment box as well.
- Make sure to acknowledge the statement below the medication comments by clicking the open check box.





Save Assessment Section

 Once you have completed the entire Patient Assessment section, click the red 'Save Section' button.









Open Subjective

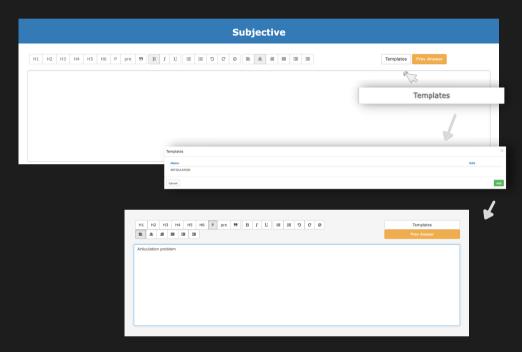
 Move onto the next section by clicking on the 'Subjective' button.





Input your Comments

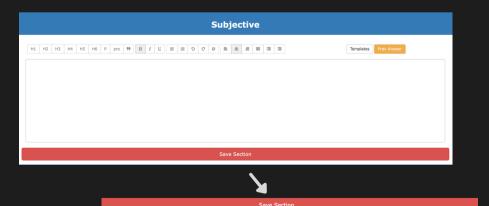
- When the drop down opens, you will see an open text box where you will input your comments.
- To add a template click on the 'Templates' button on the top right of the text box.
- A window will open with your templates. Select the one you would like to input and it will populate into the comments box.





Save Subjective Section

 Once you have completed the Subjective section, click the red 'Save Section' button.







Open Progress Towards Goals

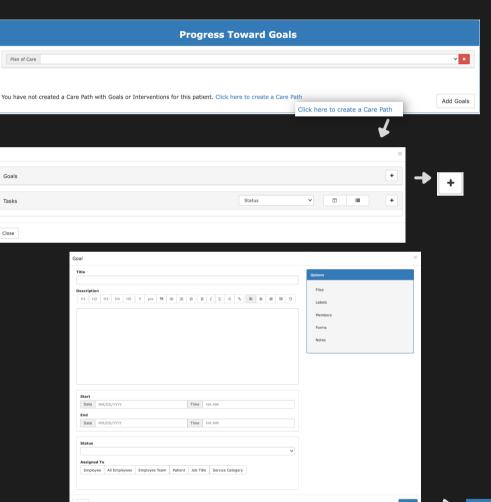
• Click the 'Progress Towards Goals' button in the visit list.



2

Select Plan of Care

- When the section opens, you will see a drop down line item that you can open to select from the existing plans of care you have input.
- If you have not created one, you will click on the 'Click here to create a Care Path' button.
- A form will open listing Goals and Tasks. Click on the '+' button to the far right of the line item and a secondary form will open.
- Input the required information in the form's fields. Once you have completed the form, click the 'Submit' button.
- Perform this process for the tasks as well.





Confirm Information

• Once you have confirmed the information in the Progress Towards Goal, you can condense that section and move on.





Open Interventions

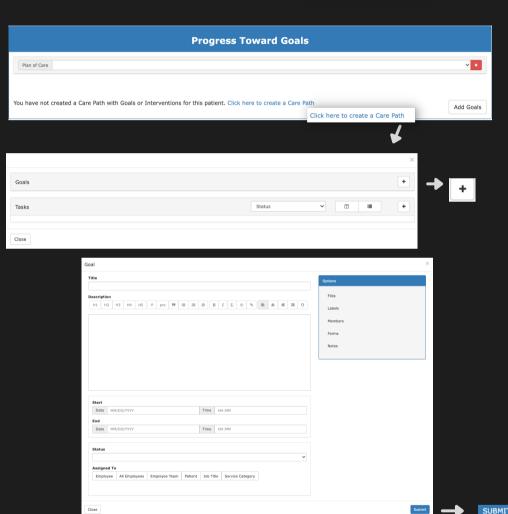
• Click the 'Interventions' button in the visit list.



2

Select Plan of Care

- When the section opens, you will see a drop down line item that you can open to select from the existing plans of care you have input.
- If you have not created one, you will click on the 'Click here to create a Care Path' button.
- A form will open listing Goals and Tasks. Click on the '+' button to the far right of the line item and a secondary form will open.
- Input the required information in the form's fields. Once you have completed the form, click the 'Submit button.
- Perform this process for the tasks as well.



3 Confirm Information

 Once you have confirmed the information in the Interventions, you can condense that section and move on.





Open Objective

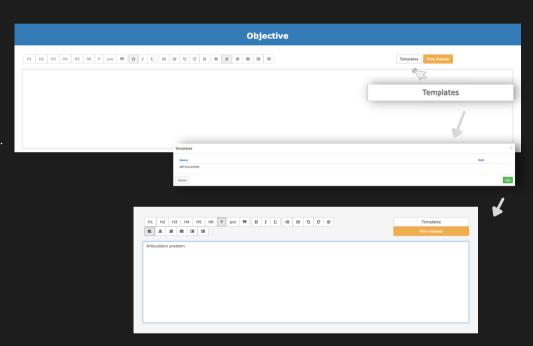
 Move onto the next section by clicking on the 'Objective' button.





Input your Comments

- When the drop down opens, you will see an open text box where you will input your comments.
- To add a template click on the 'Templates' button on the top right of the text box.
- A window will open with your templates. Select the one you would like to input and it will populate into the comments box.





Save Objective Section

 Once you have completed the Objective section, click the red 'Save Section' button.

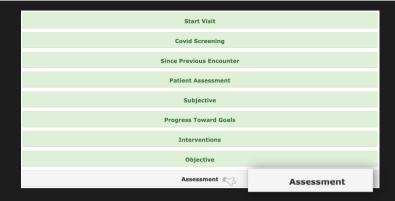




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Open Assessment

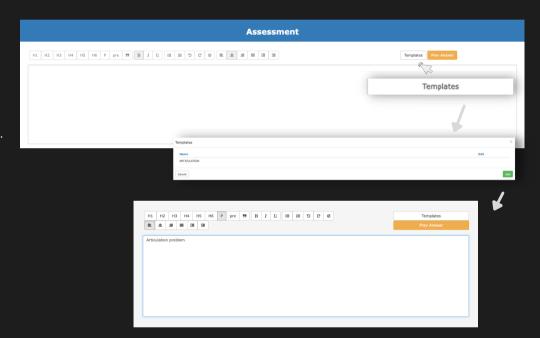
• Click on the 'Assessment' button in the visit list.



2

Input your Comments

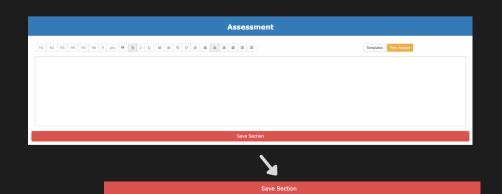
- When the drop down opens, you will see an open text box where you will input your comments.
- To add a template click on the 'Templates' button on the top right of the text box.
- A window will open with your templates. Select the one you would like to input and it will populate into the comments box.



3

Save Assessment Section

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





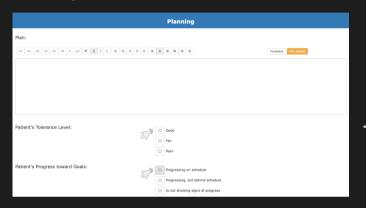
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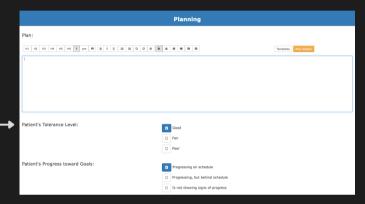
Open Planning

 Click on the 'Planning' button in the visit list.



- **2** s
 - Select Patient's Tolerance/Progress
 - When the drop down opens, you will see an open text box where you will type in your plan for the patient.
 - Below the text box, you will click the check boxes to indicate the Patient's Tolerance Level and their Progress Towards Goals.





- 3 Discharge Plan
 - Answer the Discharge Plan questions by clicking on the check boxes next to the appropriate line item.
 - Input your Discharge Plan by typing it into the open text box.

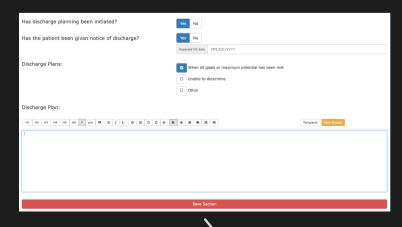




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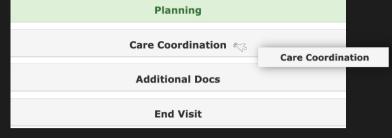
Save Planning Section

 Once you have completed the Planning section, click the red 'Save Section' button.





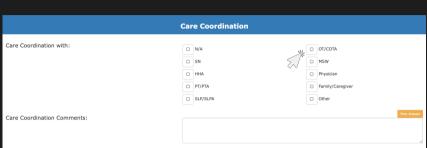
- 1 Open 'Care Coordination'
 Click the 'Care Coordina
 - Click the 'Care Coordination' button in the visit list.
 - A drop down will open.



2 "

Input Personnel & Comments

- Select who the coordination will be done with by clicking the open check box.
- Include your Care Coordination comments in the text box below.



3

Answer Care Coordination Questions

- Answer the care coordination questions listed by clicking the 'Yes' or 'No' buttons.
- Make sure to reference the Care Coordination Statement included at the bottom text box.

Any problems to monitor?		No Yes	***
Anything else to report to other mem	bers of the care team?	No Yes	
Care Coordination Statement:	Results and recommendations were discussed with the patient's mother and father who demonstrated good verbal understanding and were in agreement with the recommendation for skilled speech therapy services. Assessment results and recommendations in this evaluation will be shared with the treating OT and supervising SLP. Additionally, the patient's plan of care will be sent to his/her PCP.		
Save Section			



Save Care Coordination Section

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

Any problems to monitor?		No	Yes		
Anything else to report to other members of the care team?		No	Yes		
Care Coordination Statement:	Results and recommendations were discussed with the patient's mother and father who demonst agreement with the recommendation for skilled speech therapy services. Assessment results and shared with the treating OT and supervising SLP. Additionally, the patient's plan of care will be se		ed speech therapy services. Assessment results and recommendations in this evaluation will be		
Save Section					

A

Save Section





Open 'Additional Docs'

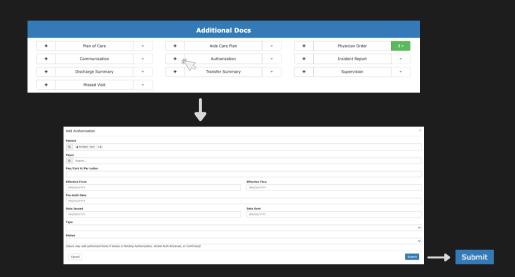
- Click the 'Additional Docs' button in the visit list.
- A drop down will open.





Add Documents

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





Save Additional Docs Section

 Once you have included all documents and input their information in the Additional Docs section, click the red 'Save Section' button.





Save Section

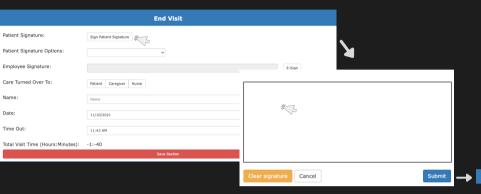


- **1** °
 - Open 'End Visit'
 - Click the 'End Visit' button in the visit list.
 - A drop down will open.



- 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.

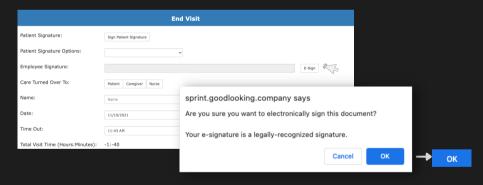






3 Employee Signature

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



4 ^F

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.

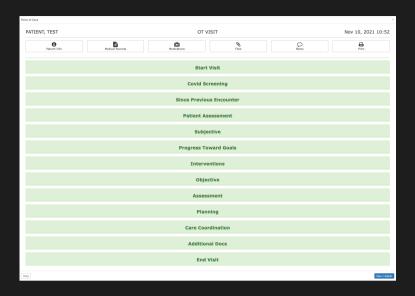
End Visit				
Patient Signature:	Edit Patient Signature			
Patient Signature Options:	Signed by Patient			
Employee Signature:	E-SIGNED BY KIERSTEN RATHKE ON 2021-11-10 11:44:27	Unsign		
Care Turned Over To:	Patient Caregiver Nurse			
Name:	Patient 4			
Date:	11/10/2021			
Time Out:	11:43 AM			
Total Visit Time (Hours:Minutes):	-1:-40			
	Save Section			



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.



2

Save & Submit

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

