



# Navigation of Medical Records

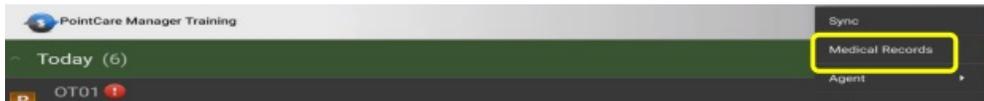
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## Purpose:

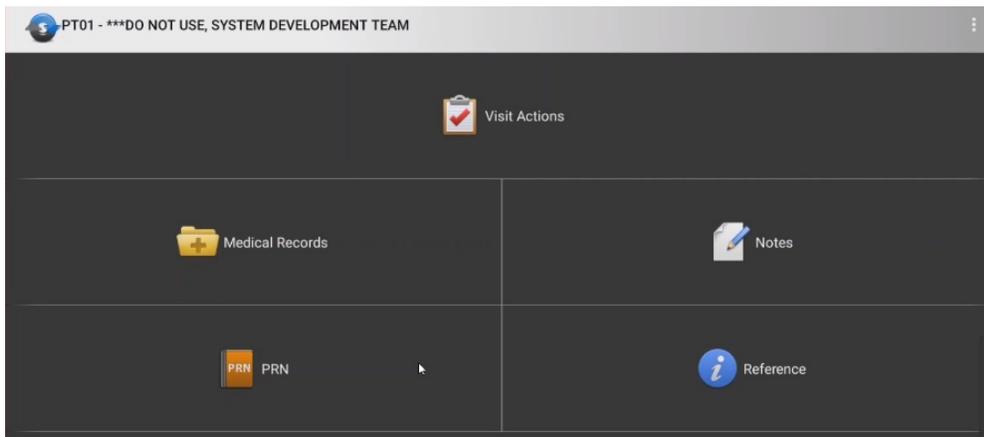
To provide an overview of the common areas of the Medical Record. 'Medical Records' in the Pointcare application is divided into two sections (History & Features), these are best remembered by the saying 'History is for viewing and Features is for doing'. **History** is where attachments from other EMRs/relevant documents as well as documentation, notes, orders, etc. from Homecare Homebase reside for viewing. **Features** is where action can be taken to add Notes, Orders, or other content to the Medical Record without the need to be documenting within a billable visit. Below is a breakdown of the commonly used sections in 'History' and 'Features':

## Overview:

Medical Records can be accessed in two ways. If not within a visit for the patient, Medical Records can be entered through the top right menu in the Rolling Calendar and selecting 'Medical Records'. This will have both the 'History' and 'Features' options:



If within a visit, Medical Records is one of the Primary tile options. This portion will only have the 'History' as all of the 'Features' actions can be completed elsewhere from the visit:



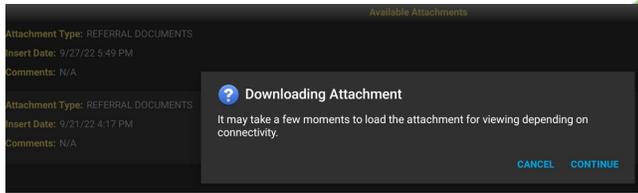
Below is a summary of the most relevant portions of the Medical Record:

## History:

- **Client Snapshot** provides a 'snapshot' of the patient inclusive of demographics (address & phone), Visit Alerts, Protocols, Patient Goals (subjective from SOC), Diagnosis History, Medications, Allergies, and Religion. Additionally, hyperlinks to other portions of the Medical Record reside on the bottom of this section (screenshot below).

- |  |   |
|--|---|
| <a href="#">Order History</a>          | <a href="#">Advance Directives</a>                |
| <a href="#">Case Manager/Care Team</a> | <a href="#">Interventions &amp; Goals History</a> |
| <a href="#">QI Events</a>              | <a href="#">Narrative Notes</a>                   |
| <a href="#">Physicians</a>             | <a href="#">Calendar</a>                          |
| <a href="#">Vital Sign Alerts</a>      | <a href="#">Patient Program</a>                   |
| <a href="#">Visit Alerts</a>           | <a href="#">Facility Protocols</a>                |
| <a href="#">Contacts</a>               | <a href="#">Physician Protocols</a>               |
| ◦ <a href="#">Related Facilities</a>   |   |

- **Attachments** stores files loaded to the Medical Record. This is where common discharge paperwork and records from previous Hospitalizations or other medical events are stored.
  - **Note** – To download the attachments you press and hold on the document which will present a pop-up (image below). Select 'Continue' to download the attachment to your device for review:

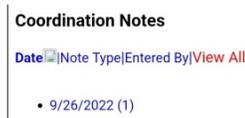


- Calendar presents the completed and scheduled visits per discipline in a monthly calendar format. For additional information on the service codes and disciplines 'View All' can be selected (image below).



10/18/2022  
 RN00 (SN) - RN OASIS ADMISSION (SOC)  
 Worker: N/A  
 Cell Phone: N/A  
 Work Phone: N/A  
 PT01 (PT) - PT ADD-ON EVALUATION (ADD-ON)  
 Worker: N/A  
 Cell Phone: N/A  
 Work Phone: N/A

- Client Summary stores a variety of patient and Medical Record information similar to Client Snapshot. Address, phone number, Allergies, Advance Directives, Visit Diagnoses, Diagnosis History, Physician Report, Medical Director, Medications, Payor Source, Visit History, Interventions & Goals, and Intervention Details/Comments can be found in this section.
- Coordination Notes stores all Notes entered into the Medical Record by direct care and back office staff in a chronological format. The presentation of this section can be filtered by 'Date', 'Note Type', 'Entered By', or 'View All' (image below)



- HH Interventions & Goals summarizes the Interventions Provided & Interventions Not Provided as well as the Goals Met and Goals Not Met. It is important to understand that these interventions and goals ties to the Pathways/Problem Statements added to the Plan of Care and are not the customized Orders and Goals written by assessing Clinicians and sent to Provider as Orders.
- Medications lists the patient's medications with the options to view Discontinued Medications and to Check For Drug Interactions. You can click on the blue 'Education Monograph' hyperlink for deals on Uses, How to Use, Side Effects, Precautions, Drug Interactions, etc.

[Discontinued Medications](#)  
[Check for drug interactions](#)

**Belsomra 10 mg tablet**  
 Per instructions,  
 Start  
 8/18/2022  
 Route  
 oral  
 Classification  
 Central Nervous System Agents  
 Medication Understanding  
 Purpose N  
 Directions for Use N  
 Side effects / Interactions N  
[Education Monograph](#)

neomycin 3.5 mg-polymyxin 10,000 unit-hydrocort 10 mg/mL eye drop,susp  
 Per instructions,

- Order History stores all Orders created for the patient. By selecting 'View All' the customized Orders and Goals for the Patient's plan of care can be viewed. This is important for all Paraprofessionals to review prior to their first visit for a patient and for Registered Therapists to document progress towards in their Reassessment and Discharge documentation.

Orders in red denote wound care orders.

Date	Type	Associated Wounds
11/19/2021 02:16 PM	PHYSICIAN ORDER - UNAPPROVED	
10/25/2021 02:42 PM	ADD ON DISCIPLINE - UNAPPROVED	
10/25/2021 10:17 AM	485 ORDERS - UNAPPROVED	#1 HEEL, LT - PU STAGE II
10/25/2021 09:39 AM	ADD ON DISCIPLINE - UNAPPROVED	

[View All](#)

- Physicians will list the Primary Provider and any other relevant Providers associated with the patient's episode.
- SOAP Notes stores the Subjective, Objective (via documentation toward Interventions), Assessment, and Plan documentation from each visit in a concise and readable format. Select the Service Code blue hyperlink in the 'Svc Code' column to load the visit summary in this format.



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Therapy SOAP Notes BORZZIACK, MARCELINE		
Date	Svc Code	
9/26/22	OT11	DANZ, SAMANTHA
9/21/22	OT01	DANZ, SAMANTHA
9/21/22	PT11	DULL (FOX), TARA
9/19/22	PT01	DULL (FOX), TARA

- **Therapy History** holds the most recent 'status' as well as the Short Term Goal, Long Term Goal (if applicable) and Dates of the associated goals from the Therapy Goals/Status function for all

Therapy disciplines. This is a nice summary of the items addressed in the Therapy Care Plans, their current level of function, and anticipated goals.

Therapy Goals/Status History

FUNCTIONAL (OT)  
FUNCTIONAL TESTS (OT)

FUNCTIONAL (PT)  
BED MOBILITY (PT)  
TRANSFERS (PT)  
FUNCTIONAL TESTS (PT)  
MOBILITY/GAIT

Therapy Goals/Status History

**BED MOBILITY (PT)**  
ITEM: SIT TO LYING

Status	MD	STG Date	Comments
STG		10/17/22	
CSA		10/17/22	Comments
LTG		11/7/22	
SUP			

**ITEM: LYING TO SIT SIDE OF BED**

Status	MD	STG Date	Comments
STG		10/17/22	
CSA		10/17/22	Comments
LTG		11/7/22	
SUP			

- **Therapy Visit Summary** tracks the Last Reassessment Completed, calculating when the next 30 day Reassessment visit is due and shares the Visit that is closest to the 'due date'.

Therapy Visit Summary

30 DAY REASSESS STATUS and FORECAST

OT		
LAST REASSESSMENT COMPLETED		9/21/22
REASSESSMENT VALID UNTIL		10/21/22
VISIT CLOSEST TO VALID UNTIL DATE		Not Met

PT		
LAST REASSESSMENT COMPLETED		9/19/22
REASSESSMENT VALID UNTIL		10/19/22
VISIT CLOSEST TO VALID UNTIL DATE		Not Met

- **Vaccination History** stores all vaccinations documented within the Homecare Homebase medical record. You can click 'View All' or the blue name of the vaccine to receive additional information.

Vaccination History  
BORZZIACK, MARCELINE

[View All](#)

INFLUENZA	TIV (INACTIVATED)	
PNEUMOCOCCAL (PPV)		PPV
COVID-19 DOSE #1	MRNA-MULTI DOSE #1	
COVID-19 DOSE #2	MRNA-MULTI DOSE #2	
COVID-19 BOOSTER	BOOSTER	

- **Visit History** stores the visits completed by the care team with options to filter by Date, Discipline, or Service Code. Clicking on the 'Visit Type' in blue will open the documentation from that visit for review.

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Date	DSPLN Code	Service Code	Visit Type
9/26/22	OT	OT11	SUBSEQUENT
9/26/22	SN	SN11	SUBSEQUENT
9/21/22	OT	OT01	ADD-ON
9/21/22	PT	PT11	SUBSEQUENT
9/19/22	SN	RN00	SOC
9/19/22	PT	PT01	ADD-ON

- **Vital Signs History** shares the Vital Signs collected at visits and can be filtered by Date/Time as well as Type (Temperature, Pulse, Respirations, Blood Pressure, etc.). This is a convenient location to view historical vitals. Below is an image of Vital Signs History filtered by Blood Pressure:

**Vital Signs History**

\* Readings highlighted in red generated an outside of parameter alert at the Date/Time of reading.

Date/Time/Type/View All

Type: Systolic/Diastolic Blood Pressure

Date/Time	Type	Reading
9/26/22 11:00 AM	Blood Pressure	138/73
9/26/22 10:21 AM	Blood Pressure	134/78
9/21/22 4:44 PM	Blood Pressure	148/80
9/21/22 2:28 PM	Blood Pressure	179/86
9/19/22 4:40 PM	Blood Pressure	122/64

- **Vital Signs Parameters** shows the parameters for the patient. These parameters are auto-populated with our agency parameters and can be customized as needed when Evaluating/Assessing your patient.

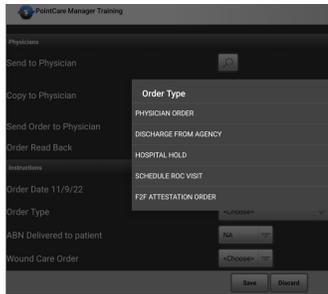


Vital Sign Parameters		
	Min	Max
Temperature	95.0	101.0
Pulse	50	100
Respirations	12	24
Systolic Blood Pressure	90	180
Diastolic Blood Pressure	50	90
Ankle Circumference (cms)		
BMI (%)		
Calf Circumference (cms)		
FAST		
FBS		
RBS	60	400
Girth (ins)		
Girth (cms)		
Head Circumference (cms)		
INR Level		
Instep Circumference (cms)		
Karmofsky (%)		
MUAC (cms)		
NYHA		
O2 Saturation (%)	90.0	
Pain		7
PPS (%)		
Prothrombin Time (secs)		
Thigh Circumference (cms)		
Weight (lbs)		

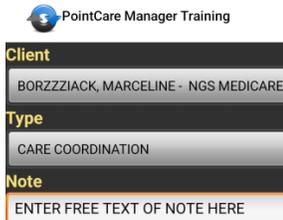


## Features:

- **New Orders** from the features menu in Medical Records presents the user with the opportunity to enter orders for the patient without being within visit documentation. To add an Order the User will select 'Medical Records à Features à New Orders à Add' and will customize the appropriate order. The Order Types available are listed in the screenshot below:



- **Notes** from the features menu in Medical Records presents the user with the opportunity to enter any Note type for the patient. To add a Note the User will select 'Medical Records à Features à Notes à Add' and will select the relevant Note Type and enter the free text into the note.



From article: Navigation of Medical Records | Last Modified on 08/16/2024 11:16 am EDT