CalMHSA

California Mental Health Services Authority

Inpatient, Crisis Stabilization Unit, and Residential Services User Guide

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About this User Manual

This user manual is designed to provide a how-to guide of the features and functionality of SmartCare. It will outline how to complete each workflow in a step-by-step format with related screenshots that will make understanding how to complete each workflow easy. Through this guide, you will learn about SmartCare's comprehensive suite of tools and advanced technologies to enter client data securely and efficiently.

We hope that by following these instructions you will gain a better understanding of the capabilities of SmartCare so that you can start using the system right way with confidence.

Audience

This manual is intended for use by anyone who will use the SmartCare EHR to document services provided in an inpatient, residential, or crisis stabilization unit setting. Not all of the following documents and procedures will apply to your facility. If you have questions about which apply to you, speak with your supervisor or program manager for confirmation.

Computer Literacy Assumptions for Understanding this User Manual

- Ability to perform basic word processing such as typing and searching for documents in files
- Understands data entry techniques into electronic forms and documents
- Familiarity with running a windows operating system or other popular programs like Mac OS.
- Basic knowledge of how to use internet browsers like Microsoft Edge and Google Chrome

IT Support Requests

Reach out to your county's System Administrator for assistance. If needed, they will escalate to the CalMHSA Help Desk.

You can also reach CalMHSA's Help Desk at: (916) 214-8348 or submit a live chat question to https://2023.calmhsa.org/

Note: Before beginning to use the system, make sure you have a compatible internet browser like Microsoft Edge and Google Chrome. CalMHSA recommends Google Chrome for best user experience.

LMS Related Support

Please email: moodle@calmhsa.org

Overview of Primary Screens

This section provides an introduction to the primary screens utilized in inpatient, crisis stabilization, and residential settings (IP, CSU, Res, respectively). These screens are designed to manage key functions within IP, CSU, and Res settings. However, not each of these screens will be used in every setting, this will depend on how settings are set up and specific workflow needs. Some of these screens are also discussed in sections below where we will cover specific workflows.

Please keep in mind that while this section provides an overview of the primary screens, it may not encompass every screen that can be utilized.

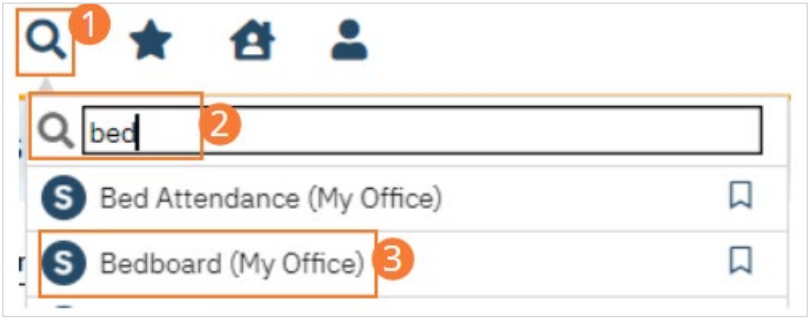
Bedboard

The Bedboard screen is used to manage the beds in inpatient, CSU, and residential, depending on your agency's setup. When you create a Unit in SmartCare, you define whether the unit will display in Bedboard or Bed Census (also known as Residential). The Bedboard list page shows all beds and identifies whether the bed is in use or not. You can use Bedboard to manage new admissions and discharges, clients' attendance, and change beds and programs.

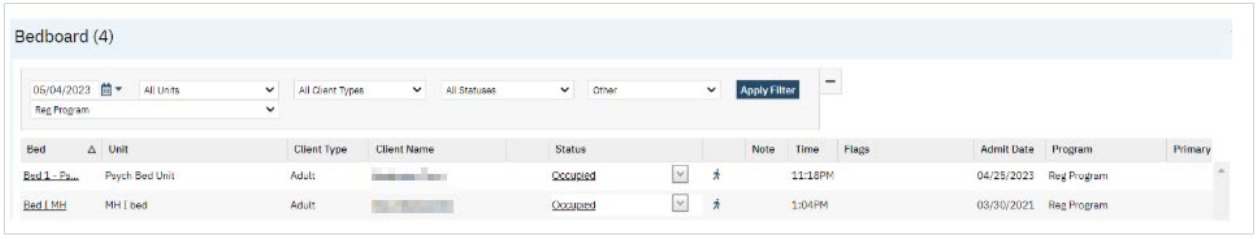
Workflows utilizing this screen are discussed in sections later in this job aid.

How to Display the Bedboard List Page

1. Click the Search icon.
2. Type 'Bedboard' into the search bar.
3. Click to select Bedboard (My Office).



4. The Bedboard screen opens.



How to Change the Bedboard View

Facility types have an associated view on the Bedboard that displays information important to that setting.

1. Begin on the Bedboard screen.
2. Click the Views icon in the tool bar.
3. Select the desired view from the dropdown.

Bedboard (10)

06/01/2023 | All Units | All Client Types | All Statuses | Other | Apply Filter | All Programs

Bed	Unit	Client Name	Status	Note	Flags		Client Type	Admit Date	Admit Time	Program
Bed A			Returned From Leave				Adult	05/15/2023	11:02 AM	MH Residential P...
Bed A			Occupied			@	Adult	05/10/2023	09:53 AM	CSU Program
Bed A			Occupied				Adult	05/15/2023	11:02 AM	MH Residential P...
Bed A			Open							
Bed B			Occupied				Adult	05/15/2023	07:53 AM	CSU Program
Bed B			Occupied				Adult	05/30/2023	07:57 AM	MH Residential P...
Bed B			Open							
Bed C			Open							
Bed C			Open							
Bed C			Open							

Example: Default View

Bedboard (10)

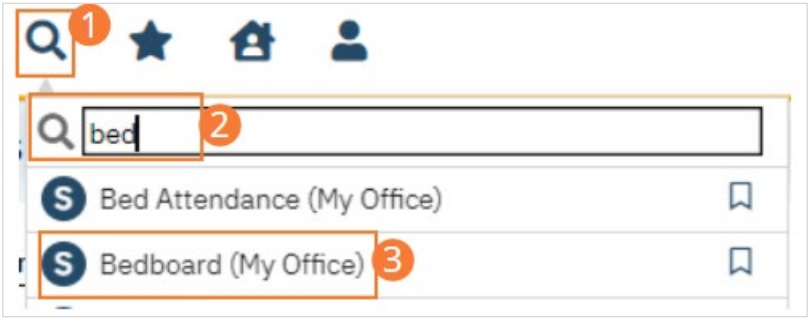
06/01/2023 | All Units | All Client Types | All Statuses | Other | Apply Filter | All Programs

Bed	Client Name	Status	Note	Flags	Client Type	Program		Unit	Admit Date
Bed A		Returned From Leave			Adult	MH Residential P...			05/15/2023
Bed A		Occupied			Adult	CSU Program	@		05/10/2023
Bed A		Occupied			Adult	MH Residential P...			05/15/2023
Bed A		Open							
Bed B		Occupied			Adult	CSU Program			05/15/2023
Bed B		Occupied			Adult	MH Residential P...			05/30/2023
Bed B		Open							
Bed C		Open							
Bed C		Open							
Bed C		Open							

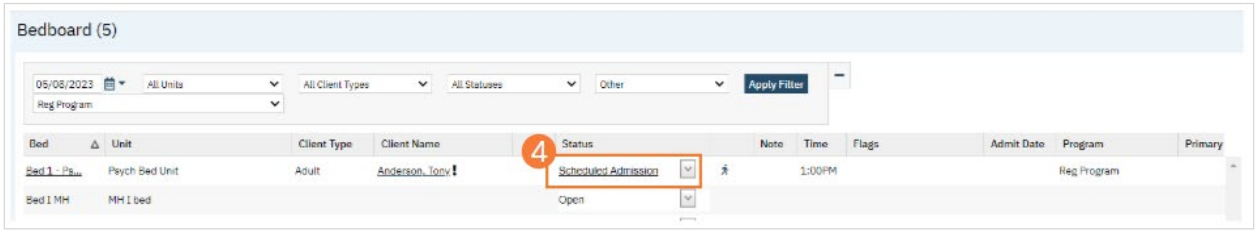
Example: Residential View

How to Search for a Bed

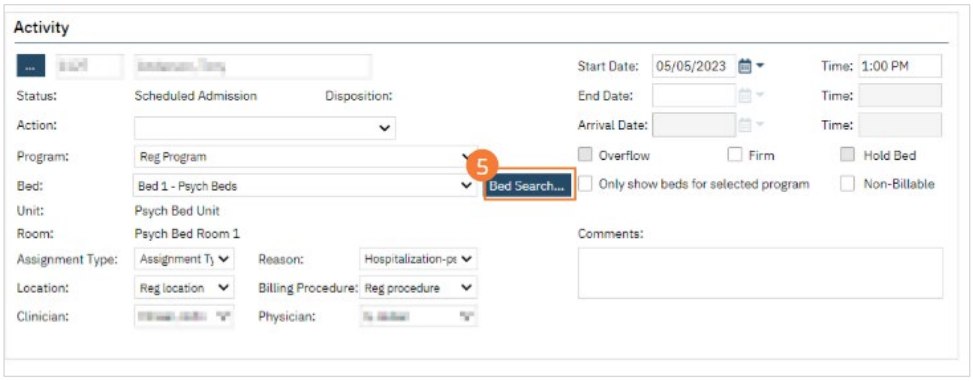
1. Click the Search icon.
2. Type 'Bedboard' into the search bar.
3. Click to select Bedboard (My Office).



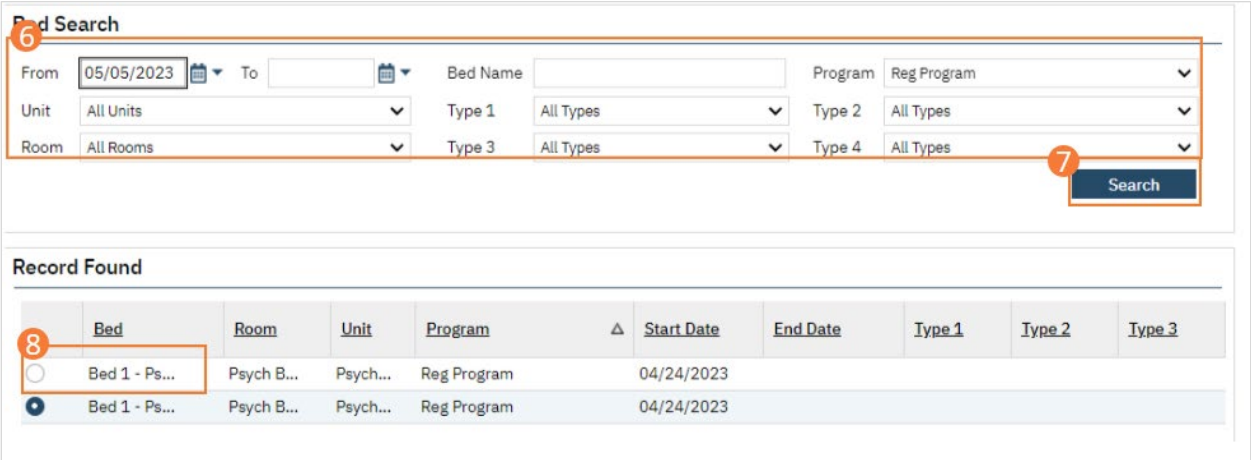
4. Select a Status hyperlink. The Activity Details window will open.



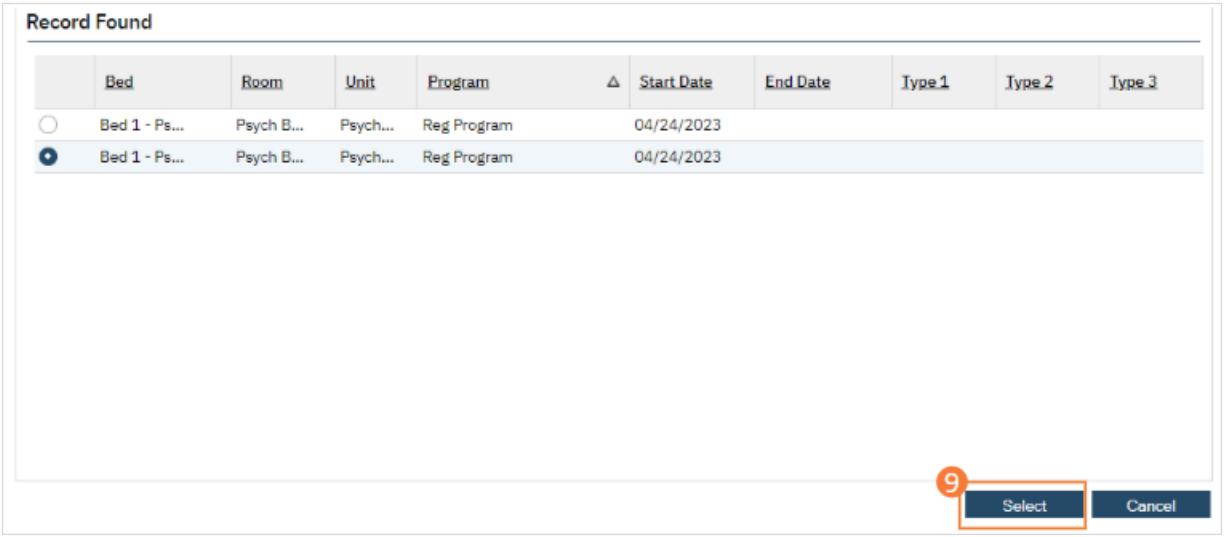
5. In the Activity section, click the Bed Search button. The Bed Search screen opens.



6. Filter the list to determine the records that are shown.
7. Click the Search button to start the search. All records which match the search are shown in the Record Found section.
8. Select the bed by clicking the radio button to the left of the record you want.



9. Click the Select button. The Census Management screen you were working on is reopened.



Residential

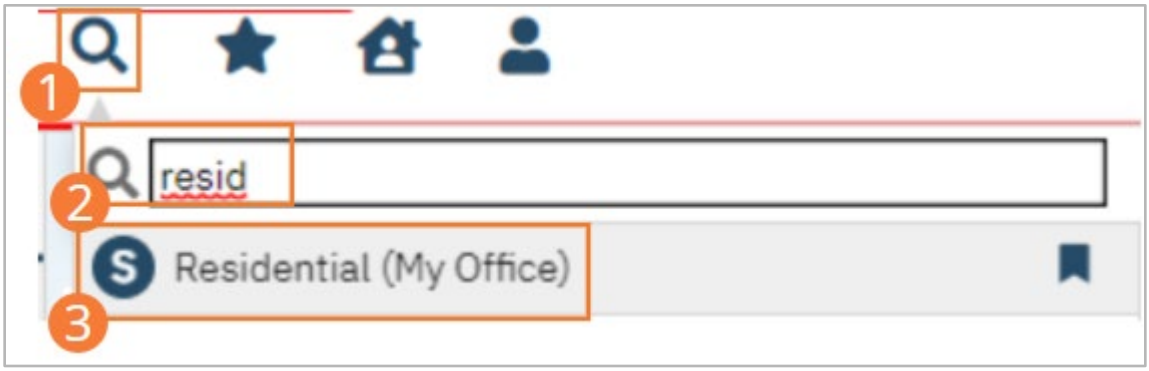
The Residential page is used to manage the beds in a residential facility. Some Residential settings are set up in the Bedboard due to the ability to Swing Bed. See Bedboard section and How to Reallocate an Unoccupied Bed from One Level of Care to Another section for more details. When you create a Unit in SmartCare, you define whether the unit will display in Bedboard or Bed Census (also known as Residential). The Residential list page shows all Residential beds and identifies whether the bed is in use or not. You can use Residential to manage new admissions and discharges, clients' attendance, and change beds.

Note: Residential screen was previously named Bed Census.

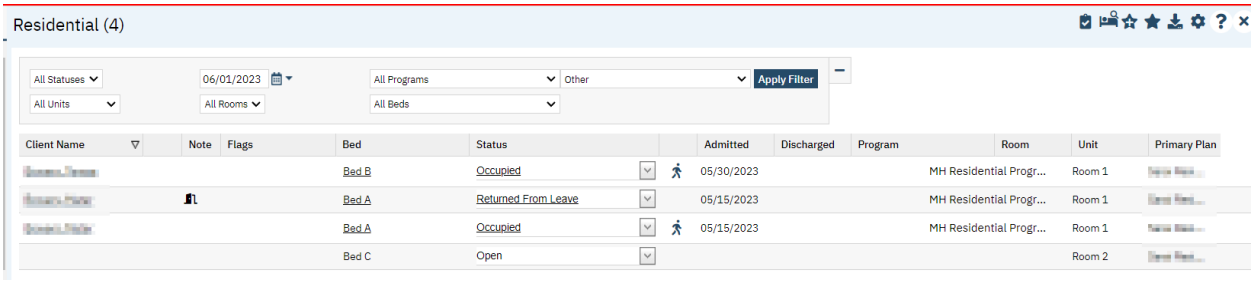
Workflows utilizing this screen are discussed in sections later in this job aid.

How to Display the Residential List Page

1. Click the Search icon.
2. Type 'Residential' into the search bar.
3. Click to select Residential (My Office).



4. The Residential screen opens.



Whiteboard

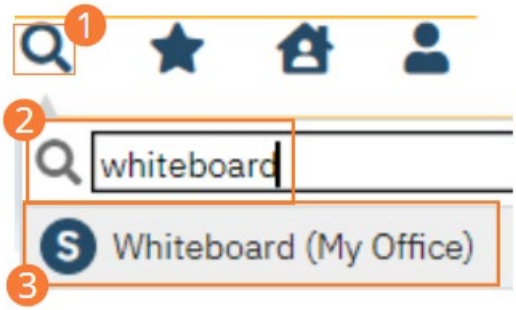
A Whiteboard is a way to communicate client information to staff in a facility environment. The whiteboard communicates key details about the client's admission and current status.

Workflows utilizing this screen are discussed in sections later in this job aid.

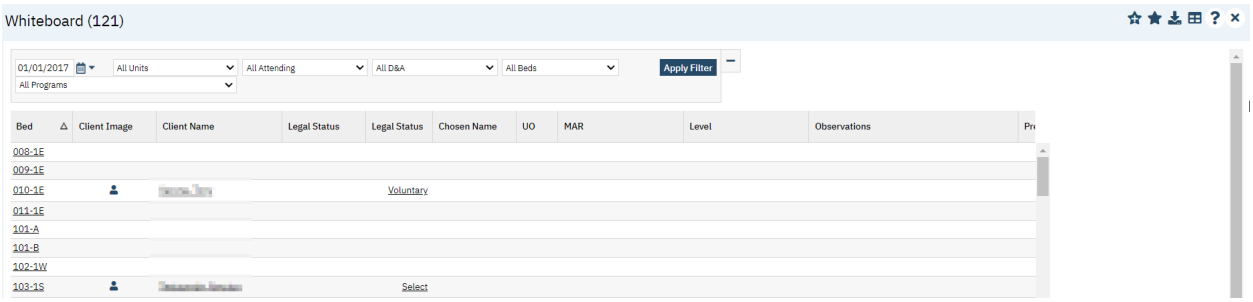
How to Display the Whiteboard List Page

The Whiteboard list page is where Whiteboard actions are taken. Complete the following steps to open the Whiteboard.

1. Click the Search icon.
2. Type 'Whiteboard' into the search bar.
3. Click to select Whiteboard (My Office).



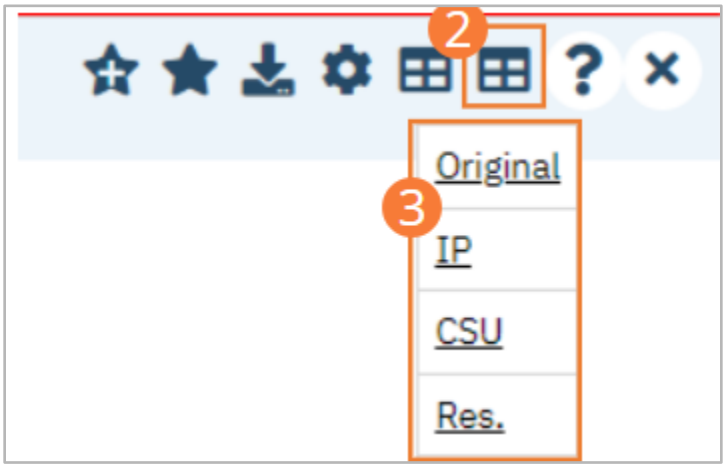
4. The Whiteboard screen opens.

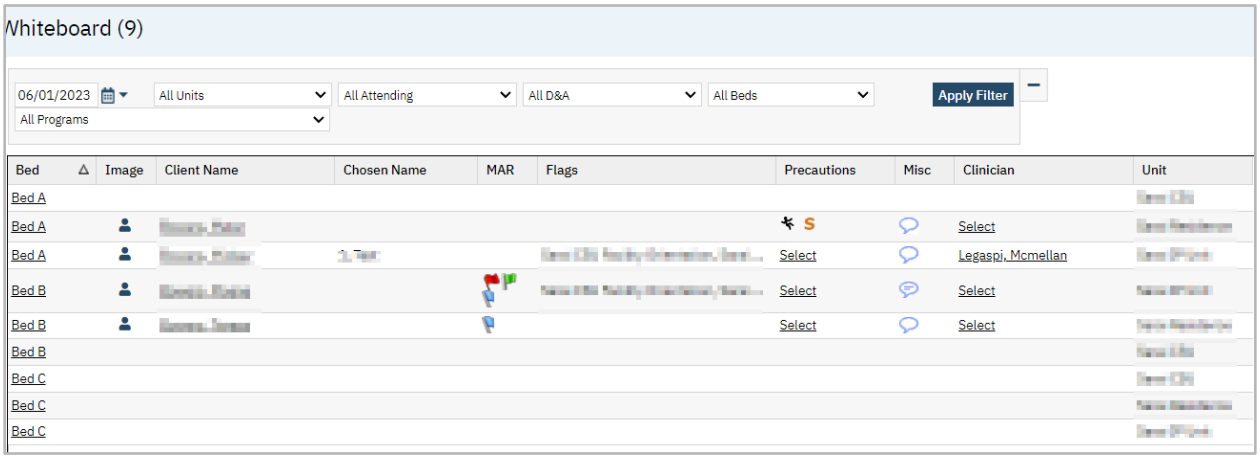


How to Change the Whiteboard View

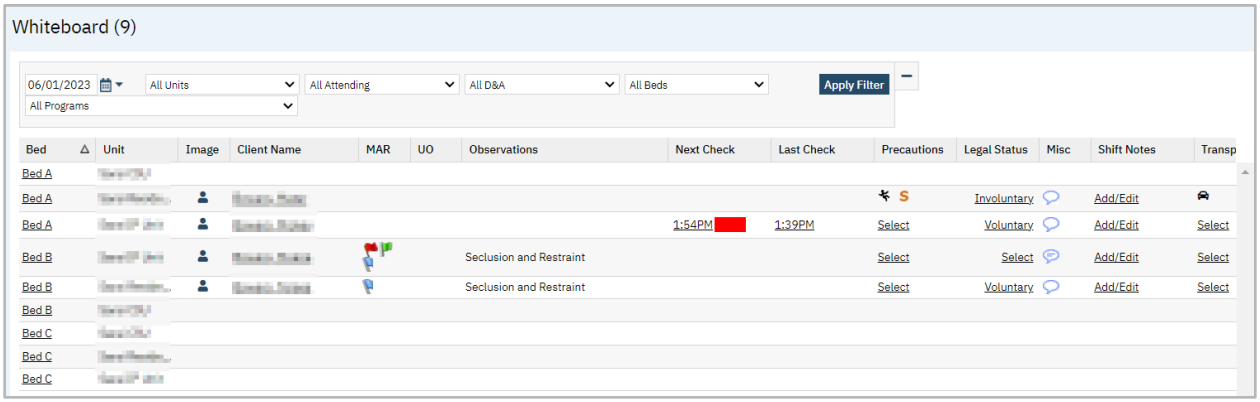
Each facility type has an associated view on the Whiteboard that displays information important to that setting.

4. Begin on the Whiteboard screen.
5. **Click the Views icon** in the tool bar.
6. **Select the desired view** from the dropdown.

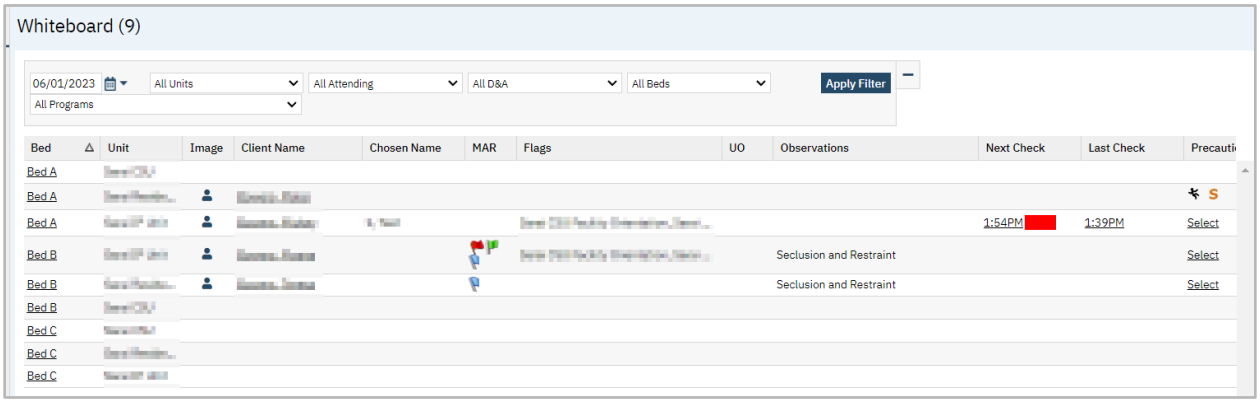




Example: Residential View



Example: Crisis Stabilization Unit View



Example: Inpatient View

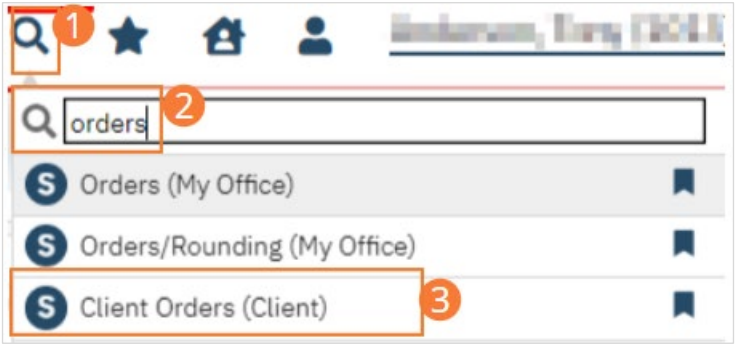
Client Orders

The Client Orders page allows you to see all orders for an active client, including discontinued and completed orders. You can also create new orders for an active client from this screen.

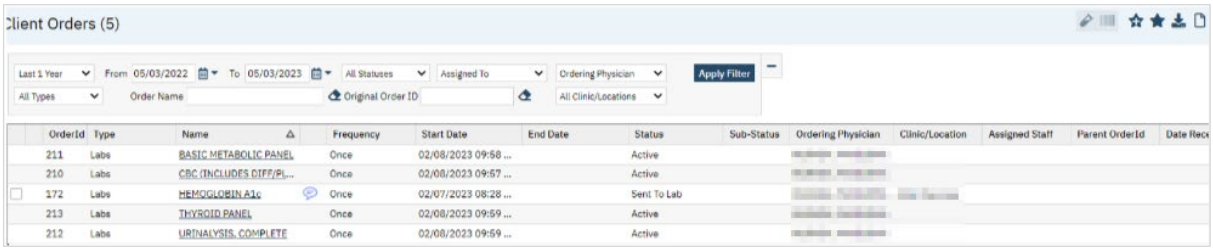
Workflows utilizing this screen are discussed in sections later in this job aid.

How to See Orders for My Active Client

1. You must first have the client open, then **click the Search icon**.
2. **Type "Orders"** into the search bar.
3. **Click to select Client Orders (Client).**



The Client Orders list page opens.



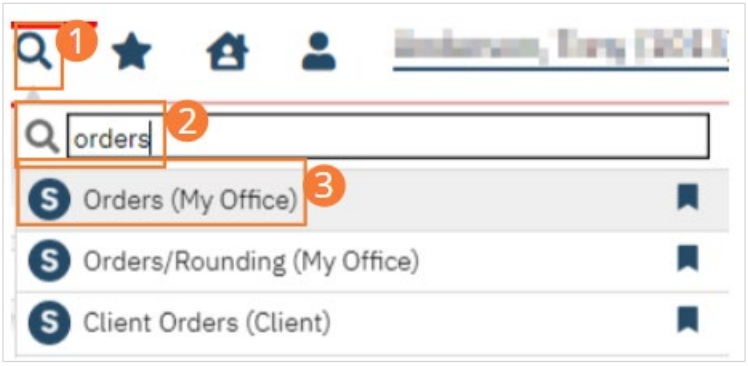
Orders (My Office)

Users may need to view all orders at once, review types of orders, orders for a specific program, or some other subset of orders. To view multiple orders across multiple clients, use the Orders (My Office) screen.

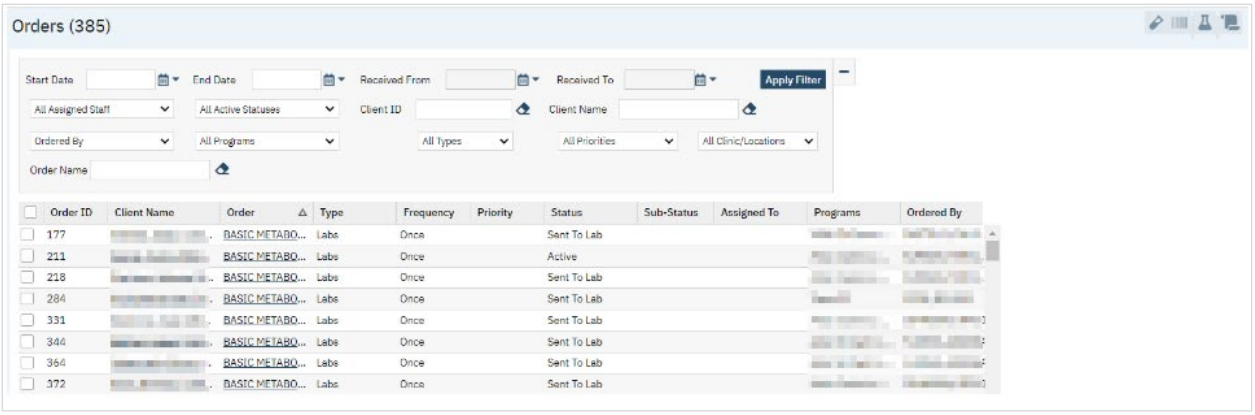
Workflows utilizing this screen are discussed in sections later in this job aid.

How to See All Orders in My Office

1. Click the Search icon.
2. Type "Orders" into the search bar.
3. Click to select Orders (My Office).



The Orders list page opens. Use the filters at the top of the page to find the Orders you wish to review.

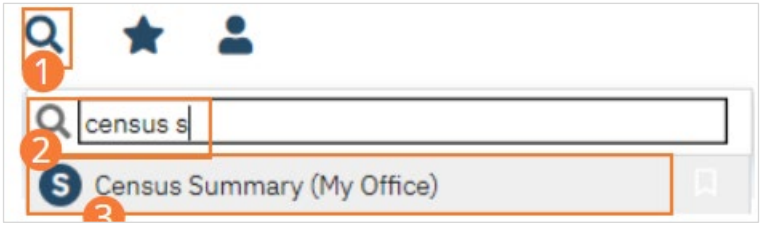


Census Summary

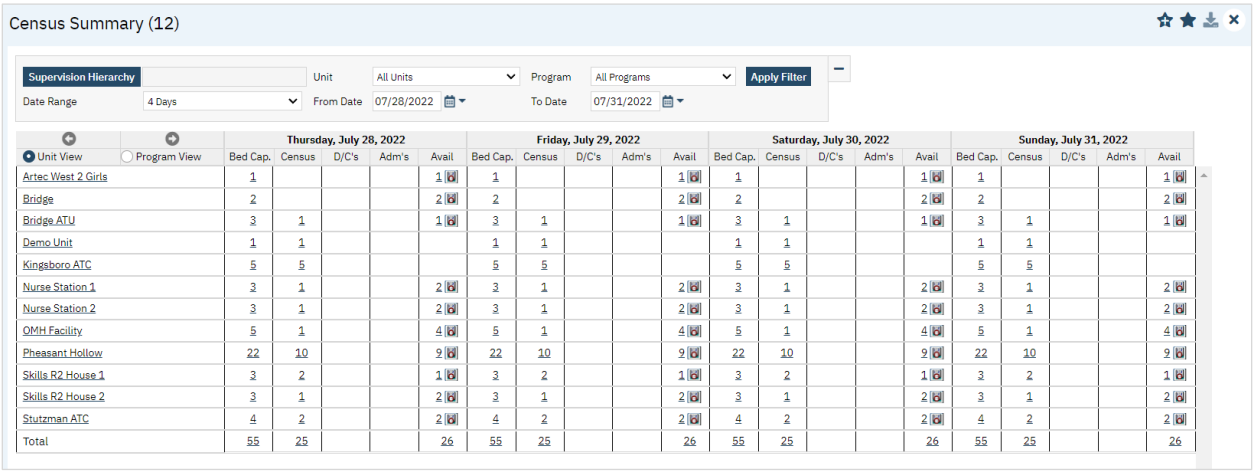
The Census Summary displays all beds and bed capacities for programs and units the user has permissions to work on, within the Bedboard. It summarizes availability of beds and allows for a single click to take the user to the Bedboard with relevant filters.

How to Display the Census Summary List Page

1. Click the Search icon.
2. Type 'Census Summary' into the search bar.
3. Click to select Census Summary (My Office).

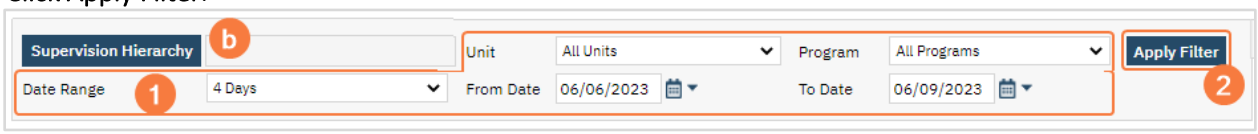


The Census Summary screen opens.

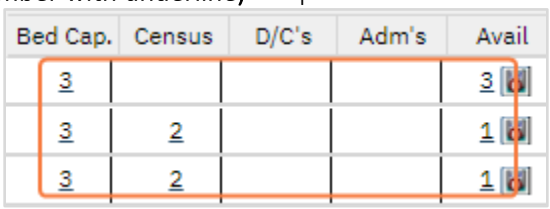


How to Navigate to Beds

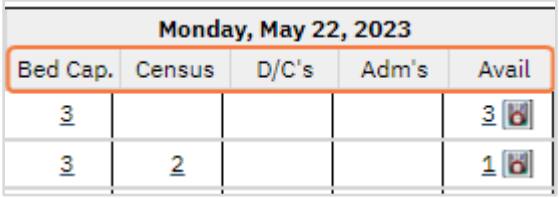
1. Set filters to locate the unit, program, and/or date range you would like to see.
   a. You will only have access to Units you have permissions to see.
   b. Note: Supervision Hierarchy is not set up and the filter should not be used.
2. Click Apply Filter.



3. Click the hyperlinked bed (number with underline) to open the Bedboard.

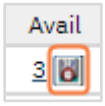


   a. The bedboard will be pre-filtered based on the hyperlink selected.
4. Below are the definitions of different columns listed under the date.



   a. Bed Cap.: the number of total beds available within the unit or program, regardless of the bed status.

b. Census: the number of occupied beds available within the unit or program.
c. D/C's: the number of total scheduled discharges within the unit or program.
d. Adm's: the number of total scheduled admissions within the unit or program.
e. Avail: the number of total beds available within the unit or program.
    i. The icon next to the hyperlink bed total, in this column, will open Census Management - Schedule Admission screen.



    ii. See How to Schedule an Admission section for more details.

Utilizing List Pages

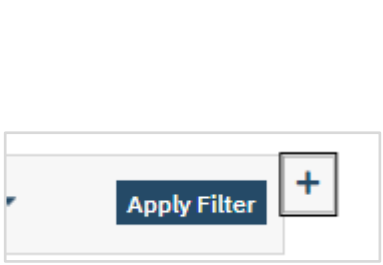
All of the screens mentioned above (Bedboard, Residential, Whiteboard, Client Orders, Orders) are list pages. List pages are found throughout SmartCare. They are referred to as first level reports as they provide information and data. List pages are called such as they list information. Most list pages will have a number of in parentheses next to the screen name, the number indicates the total of items listed, and filters can be used to locate the data that is relevant to the user. Below are items that apply to the list pages and can assist you with optimizing the use of your list pages.

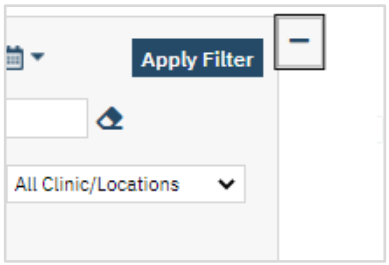
Note:Screenshots are taken from the Orders screen, but this section applies to the majority of list pages.

How to Use Filters

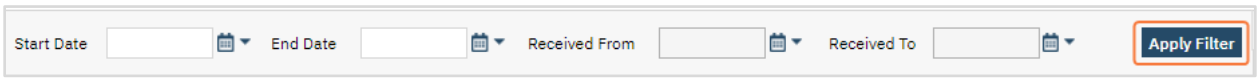
Filters assist you with locating the data that is relevant to the user; filters will vary by list page.

1. Some list pages have multiple filters. In order to reduce the real estate within the screen filter options can be expended and decreased. This can be done by clicking the plus/minus on the upper right corner of the filter area.

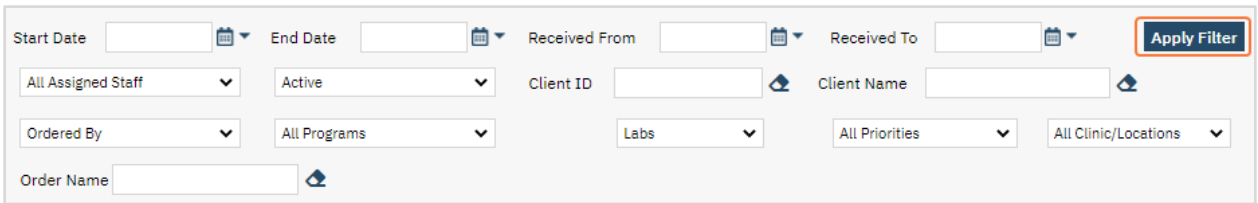




2. When setting filters select options and **click the Apply Filter** button.



3. When there is a date field(s), removing the date will not limit the data but the date.
    a. For example, to see all active lab orders regardless of date, removing the date will display this information.



4. Note: It is very common when expected information is not displayed on the list page the filters are not set correctly.

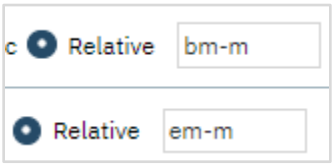
How to Save Filters

As helpful as filters can be it can also be time consuming to continuously change your filters to locate what you are looking for. To avoid this SmartCare has Favorites so they can be stored and easily accessed.

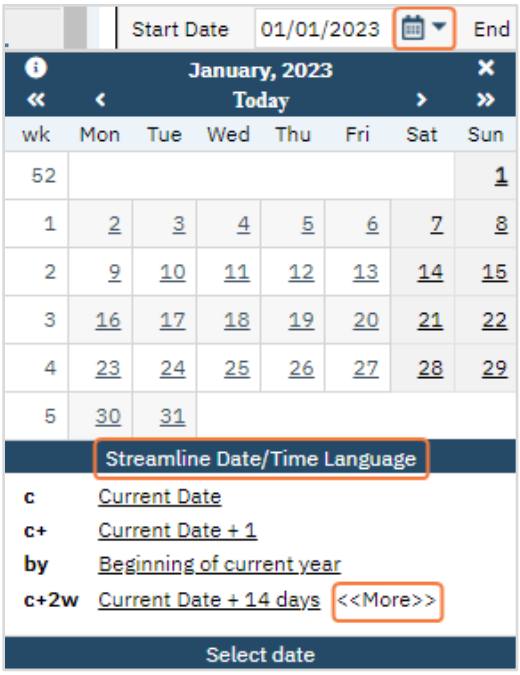
Note: Favorites are also available for report filters and Services.

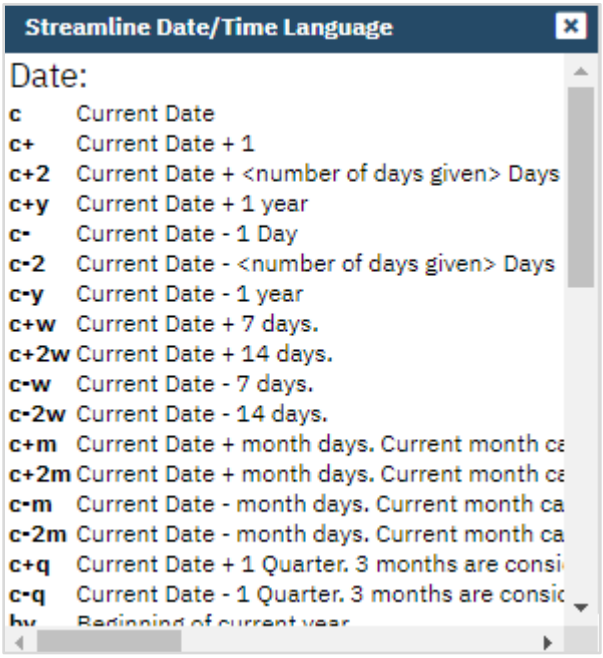
1. To create Favorites you must first set your filters to your preferred view and click Apply Filter.
2. Click the New Favorite(s) icon in the tool bar.

3. This will open a pop-up window.
4. Enter the name of the filter.
    a. Only you can see this filter; it is user specific.
    b. When searching for filters the screen name will automatically be included in parentheses.
        i. See step 7.b and 7.c for more details.
5. If date is present, select the Static or Relative radio button.
    a. These options are only available when filters include a date field(s).
    b. Static means the date field will always present the date that is currently present.
        i. For example, if January 1, 2023 is the start date and January 31, 2023 is the end date, every time this Favorite filter is selected the dates will always be these dates.
    c. Relative allows the date to fluctuate based on how it is set.
        i. For example, if I want the filter to always show the first day of the previous month and the last day of the previous month I would select the Relative radio button and enter “bm-m” in the textfield for start and “em-m ” in the textfield for start.
            1. In this example,the settings tell the system the start date should always be the *beginning of previous month* (bm-m) and the end date should always be the *end of previous month* (em-m).



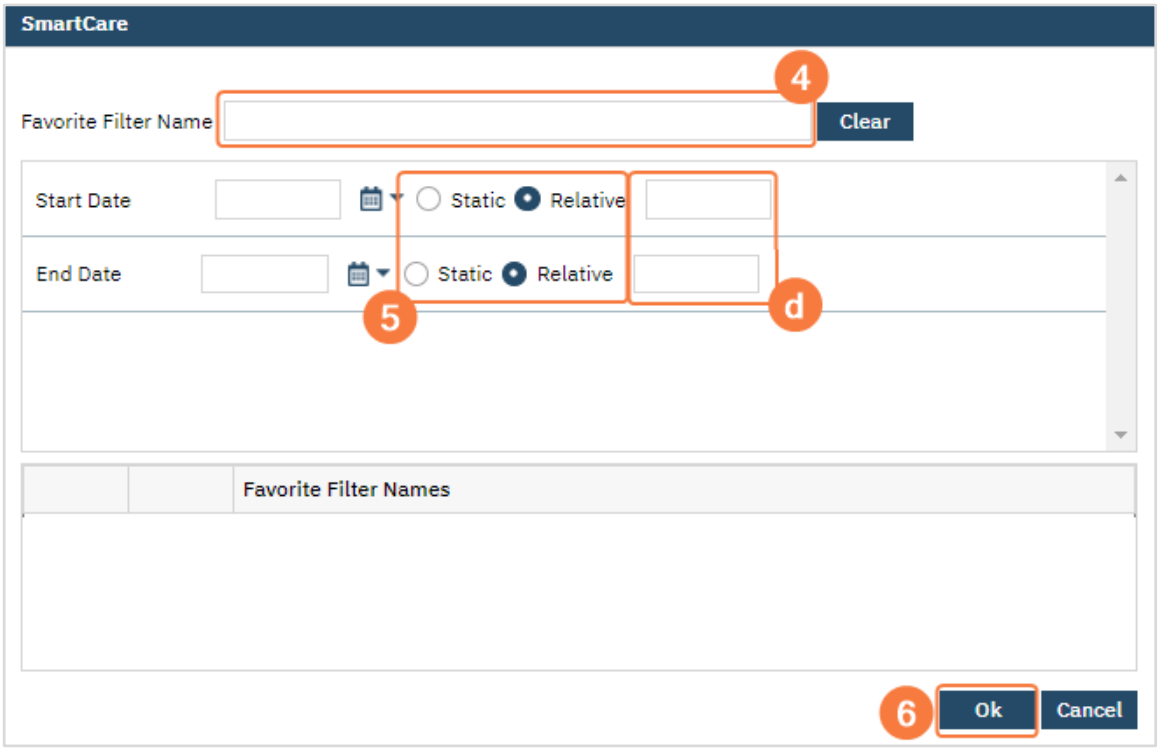
        ii. The date language can be seen by clicking on the calendar icon. Additional options are available by clicking More; a pop-up window will appear.





d. If Relative was selected, **enter the date language in the textfield(s)**.

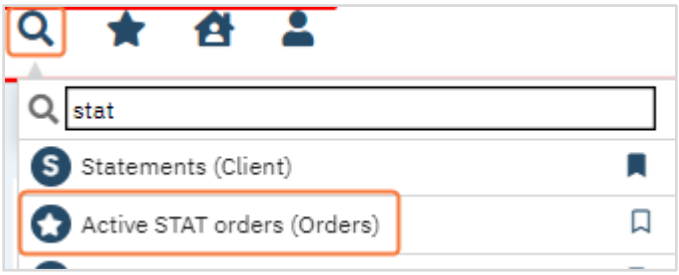
6. **Click the Ok button** to save the Favorite.



7. Filters can be accessed from 4 areas.
   a. Hovering over the Favorites icon will display Favorites associated with the screen. Selecting the Favorite will set and apply all filters associated with it.

i. This will only display the Favorites created for the current screen.

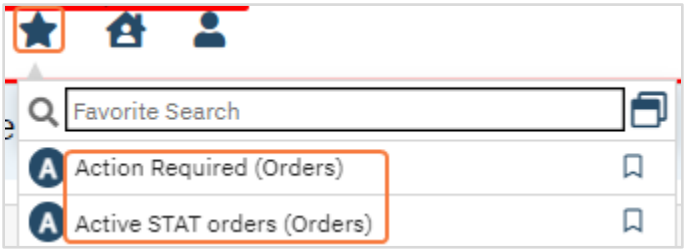
b. Search will display any favorites you have created. Favorites will have a star icon to the left of it. Selecting the favorites will automatically take you to the corresponding screen and set and apply all filters associated with it.



i. Notice the screen name appears in parentheses.
   1. In the screenshot the favorite corresponds to the Orders screen.

ii. The Favorite will display by searching by the order name or the screen name.

c. Favorite Search will display all Favorites you have created. Selecting the favorites will automatically take you to the corresponding screen and set and apply all filters associated with it.



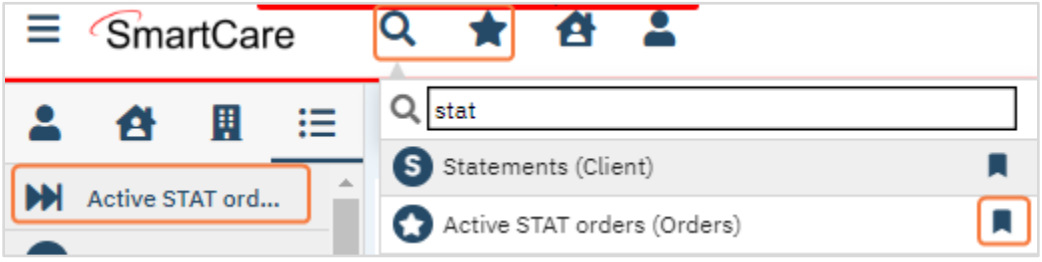
i. You can search by the favorite name or screen name to locate the needed favorite.

ii. Notice the screen name appears in parentheses.
   1. In the screenshot the favorite corresponds to the Orders screen.

iii. Sort By icon will sort alphabetically by the Favorite name or the Screen name.

d. QuickLinks can also be used to access Favorites. Selecting the favorites, through QuickLink, will automatically take you to the corresponding screen and set and apply all filters associated with it.

i. In Search or Favorite Search, clicking the Add QuickLinks icon will create the QuickLink.



How to Sort the Columns

Columns display the data associated with the filters. When viewing the data users are able to sort by the column.

1. Users can click on the column header to sort by it.
    a. In the screenshot below they would be able to sort by ID, Name, Order, Type, etc.
2. The arrow indicates what column the data is being sorted by.

    a. Clicking the column that is currently sorting again will change the sort order (ascending/descending)
3. Arrow pointing up indicates it is sorting by ascending order. Arrow pointing down indicates the data is sorted by descending order.

How to Export Data

Many list pages allow users to export data to excel format. Caution: exporting data will push this data onto your computer. Please ensure you are always compliant with HIPAA regulations and your agency's standards.

1. In the tool bar **select the Export icon**.

2. You will see the export in your downloads.
    a. The name convention is ExportData
3. The ability to export can vary by user and screen as it is based on permission settings.

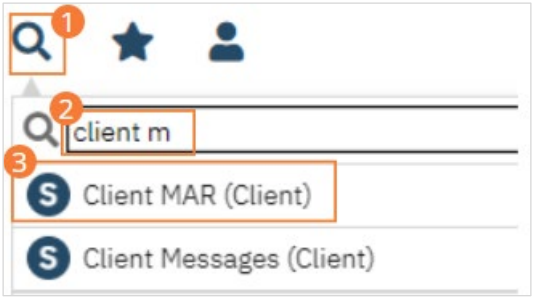
Client MAR

MAR stands for Medication Administration Record and refers to the software modules in SmartCare where you manage the information about administering medications and other orders to clients. Client MAR allows you to work with just one client at a time. In the future, a Group MAR page will allow you to manage administering medications and other orders to all clients grouped by Program and time.

Workflows utilizing this screen are discussed in sections later in this job aid.

How to Display the Client MAR Page

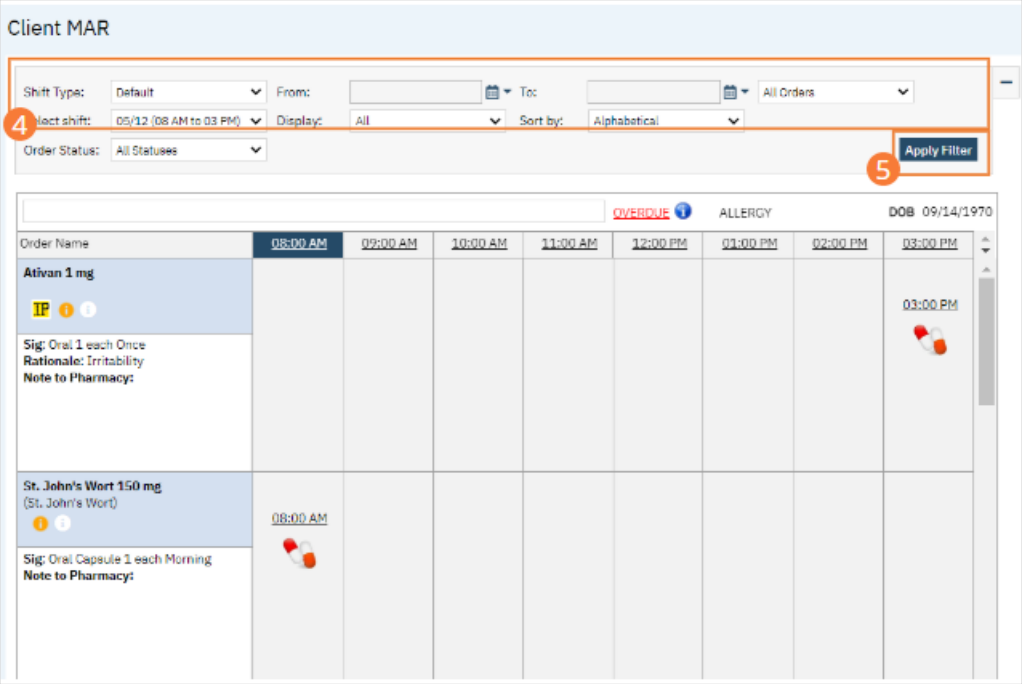
1. With the client whose MAR you want to view active, **click the Search icon**.
2. **Type 'Client MAR'** into the search bar.
3. **Click to select Client MAR (Client).**



The Client MAR screen opens.

4. **Set the fields** in the filter portion of the page to display the records you want to view.

5. Click the Apply Filter button.



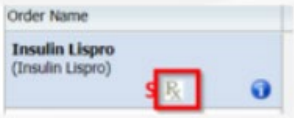
How to Understand the Client MAR Icons

Icons are used to communicate information about medications, orders, and client status on the MAR. While you can hover over each icon for a description of its meaning, knowing each icon at a glance will allow you to more quickly interpret the page.

Red 'S' icon- This indicates that special instructions were noted by the prescriber in either the 'Comment' field of the Order Details or in the 'Instructions' text of the SmartCare Rx pages. Hover your mouse over the S tool to view the instruction text.

Titration icon-indicates dosage changes over time-titrations and tapers

Rx icon-This indicates the medication is not yet dispensed from the pharmacy

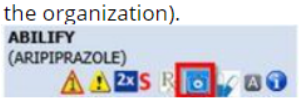


2x icon-This indicates that the order requires dual signature when administered

A icon-This indicates that an ackowledgement of the order is required before the medication can be administered

Yellow Triangle with 1 icon-This indicates that the medication has been identified as a hazardous medication level 1 in the set up of the orders. This only appears if a medication is entered via orders and the medication being ordered is set up in Orders in Administration as being a hazardous medication.

Blue icon-This indicates the medication is from a Stock Medication.
(This means that the organization is using medication that has been designated as a Stock Medication; i.e. is an on-hand medication for the organization).



Blue and White Pills-This indicates the medication has been marked in the order as 'use own supply.' This only appears if a medication is entered as an order and documented as Use Own Supply on the order. (This means the patient/client is providing their own supply of the medication).

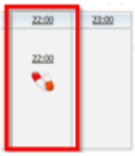
Yellow Triangle with Exclamation Point icon-This indicates a Medication Consent is missing.

If the order was submitted via SmartCare Orders, this icon will appear

If the order was submitted via SmartCare Rx, this icon will appear

If it is not time to dispense or complete a medication order, then the dispense time of the medication is indicated within the grid for the time it is to be dispensed but has a grey checkbox.

When it is within the timeframe to dispense a medication, the grey checkbox changes to two red and white pills.



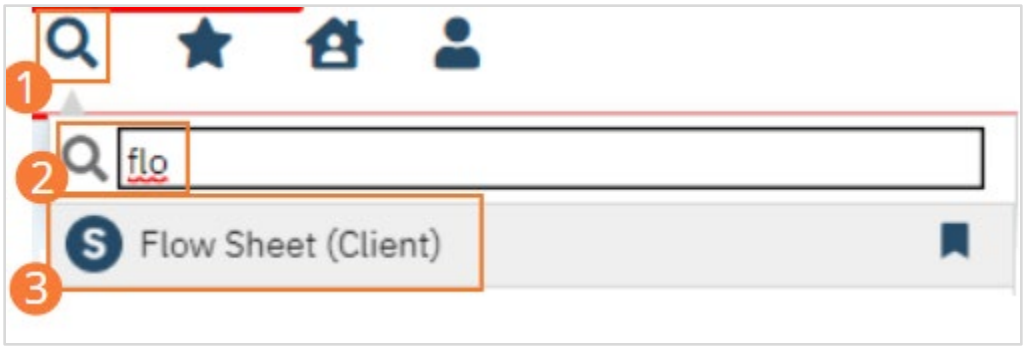
Info-This logo will show the user that created the order on what date and at what specific time on that day. Also, it will show what medication was ordered and the instructions associated with the order.

Flow Sheets

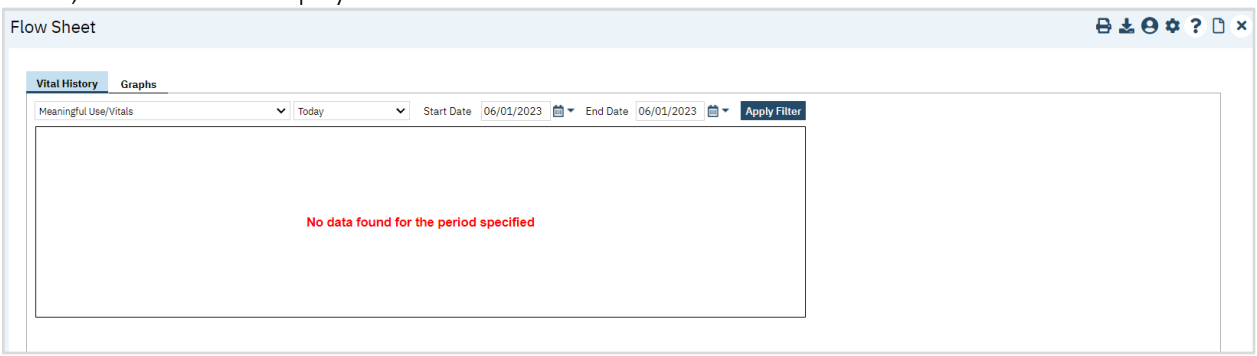
Flow Sheets are used for the entry of data over time, and are frequently used for vitals and other details that are comparable over time. The Flow Sheets page allows you to visualize data using dynamic graphs.

How to See Flow Sheets for an Active Client

1. With an active client selected, click the Search icon.
2. Type "Flow" into the search bar.
3. Click to select Flow Sheet (Client).

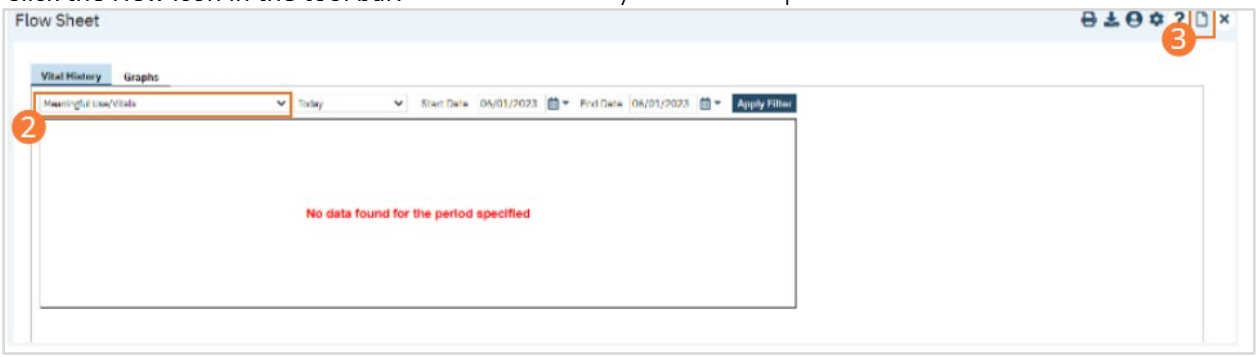


The Flow Sheets page opens. Flow sheet option and date range will default to how the flow sheet is set up. If no sheet is found, an alert will be displayed instead.

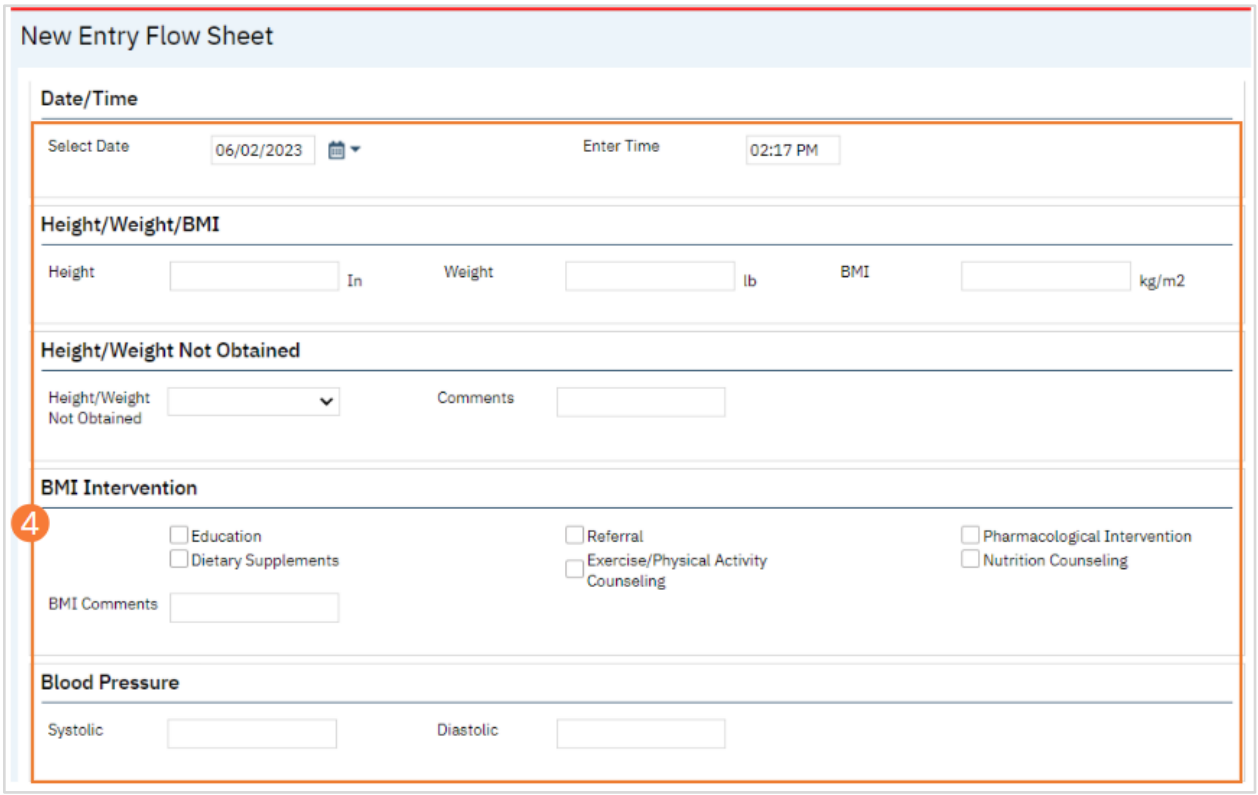


How to Create a New Flow Sheet Entry

1. With an active client selected, begin on the Flow Sheets page.
2. **Select the desired Flow Sheet template from the dropdown**. Templates are created for specific purposes, like gathering vitals or monitoring pregnancy updates.
3. **Click the New icon in the tool bar.** A Flow Sheet Entry screen will open.

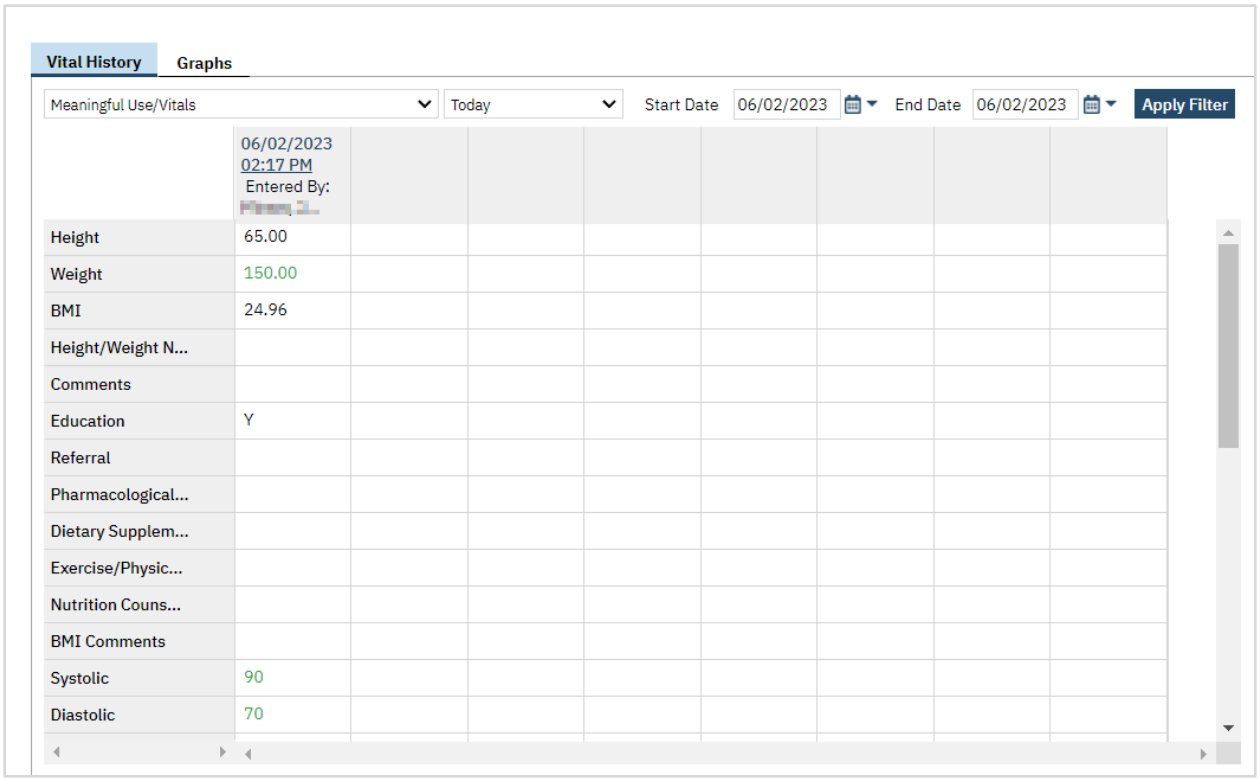


4. **Perform necessary clinical examinations and record results.** Check boxes beside present findings, select options from dropdowns, and type text into appropriate fields. For most flow sheets, you can skip fields for examinations you did not perform or information you do not have. In some cases (for example, if height/weight was not obtained during Vitals), you should record a reason for why the information was not entered.



5. **Click the Save button in the tool bar.**
   a. You cannot "Sign" a flow sheet. However, you can click the Lock icon to keep others from making edits. CalMHSA recommends doing this when you're sure you've entered all the information correctly. You will not be able to unlock this to make edits after locking this screen.
6. **Click the Close icon in the tool bar.** The newly recorded information will appear in the central section of the Flow Sheets page.

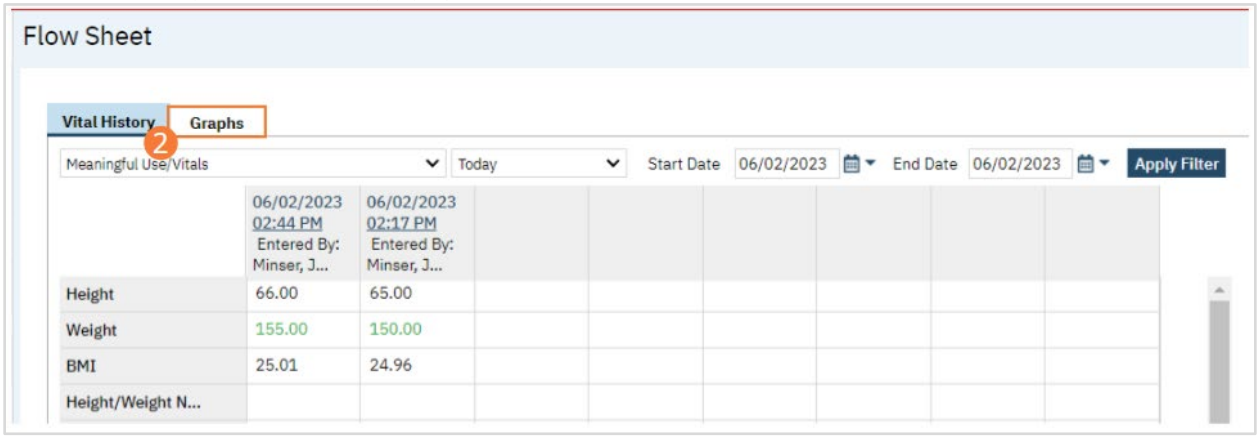
7. You will now see your entry in the Flow Sheet screen.
    a. This is dependent on Filters.



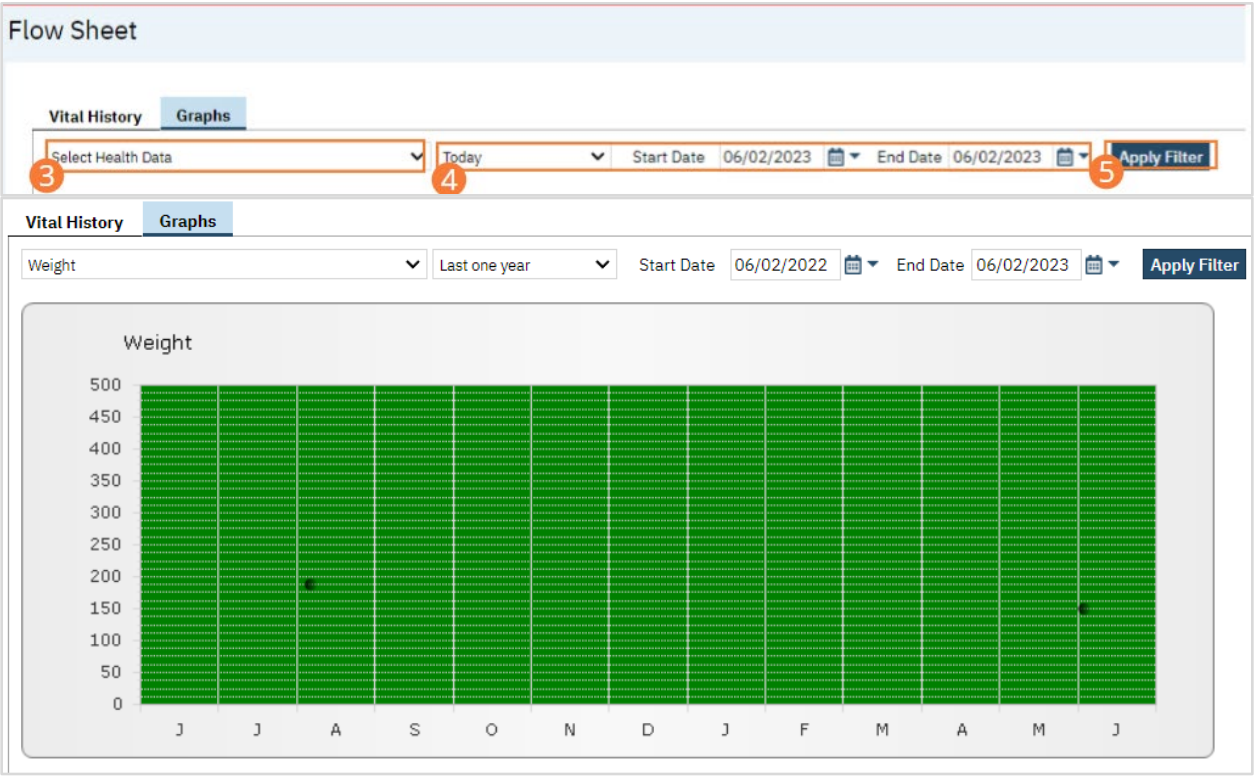
How to Visualize Flow Sheet Data

When more than one entry has been made on a flow sheet type, you can view graphs of the data over time.

1. With an active client selected, begin on the Flow Sheets page.
2. Click on the Graph tab. The Graph page will open.



3. Select a data type from the dropdown.
4. Set a time frame using filters.
5. Click Apply Filter. The graph of the selected data over time will display.



6. Note: Data ability to graph is dependent on set up, so not all data will graph.

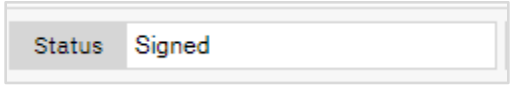
Signature Pane Actions

How to Sign a Document

1. In the document header, **select the Sign button**.

   a. Selecting the sign will automatically save the document and check for validations.
   b. If validations are not met, you will see a pop-up window indicating what needs to be completed before signing.

2. The document will now change to Signed status.



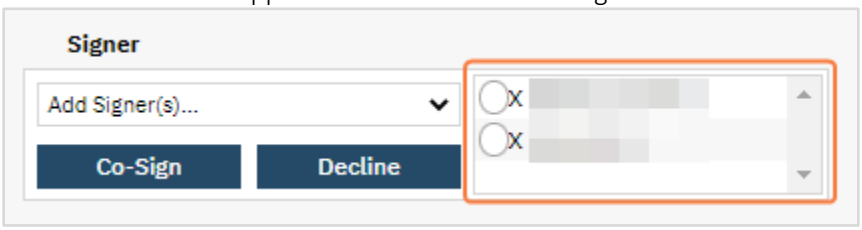
   a. There are some exceptions based on workflow. For example, if you're in a document as a proxy that status will change to To-Sign or if you need a reviewer the status will be To Be Reviewed.

How to Add a Co-Signer

1. To add a co-signer the document can be in any status except New.
   a. However, a co-signer cannot sign until the document status is Signed.
      i. See How To Sign a Document for details.
2. **Click the plus symbol** to expand the document header.

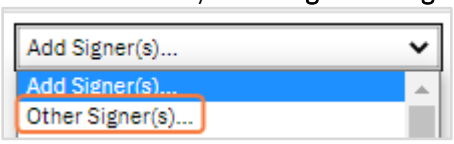
3. **Select a co-signer** from the 'Add Signer(s)' dropdown.

a. The selected user name will appear in the window to the right.

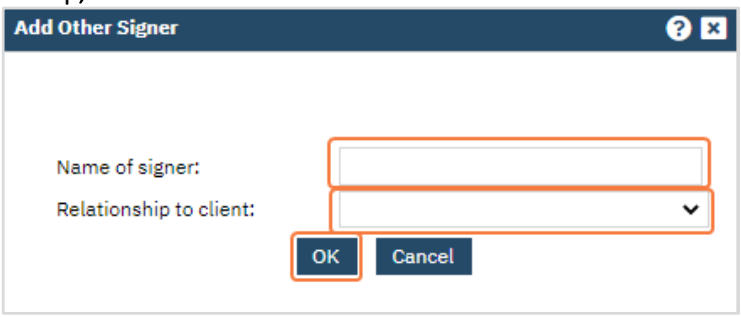


b. User can see what they need to co-sign through their Dashboard (Documents or Assigned Documents widget).

4. You can also add individuals that are not users in SmartCare as a co-signer.
   a. The client's name in the Add Signer(s) dropdown. **Select the client** and they will be added as a co-signer.
   b. Non-clients and non-users can be added by **selecting Other Signer(s)...**

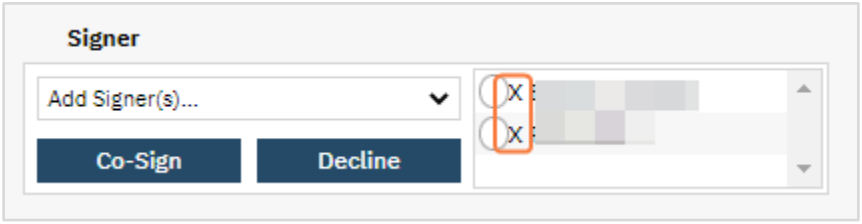


      i. Once selected you will see a pop-up window. **Enter the name of the individual, select the relationship, and click the OK button**.



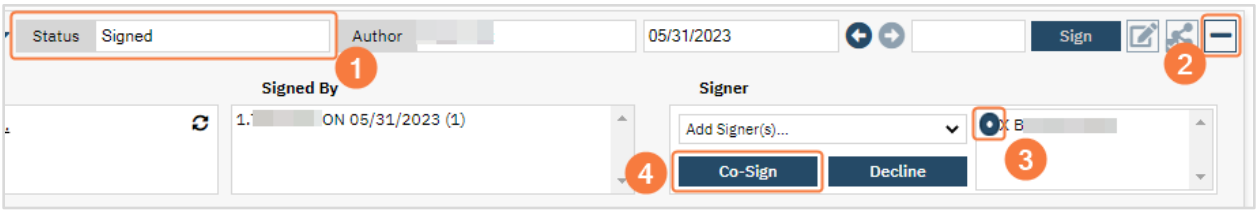
   c. Based on the set up of the document, the client, guardian or healthcare decision maker will automatically be added as a co-signer.

5. To remove a co-signer click the X next to the name.

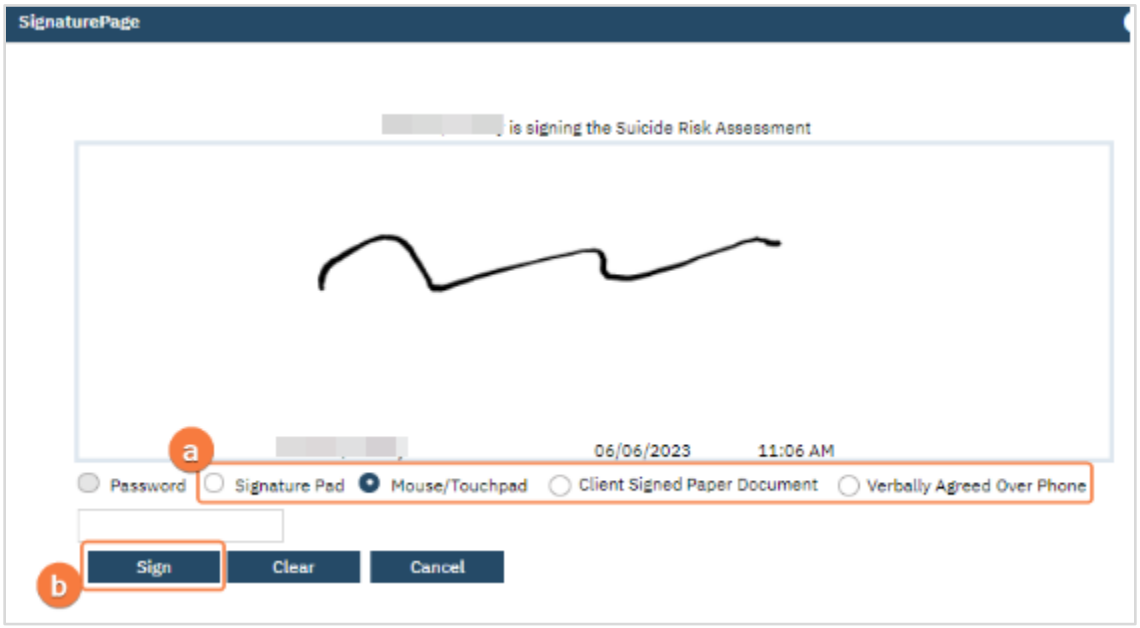


How to Co-Sign a Document

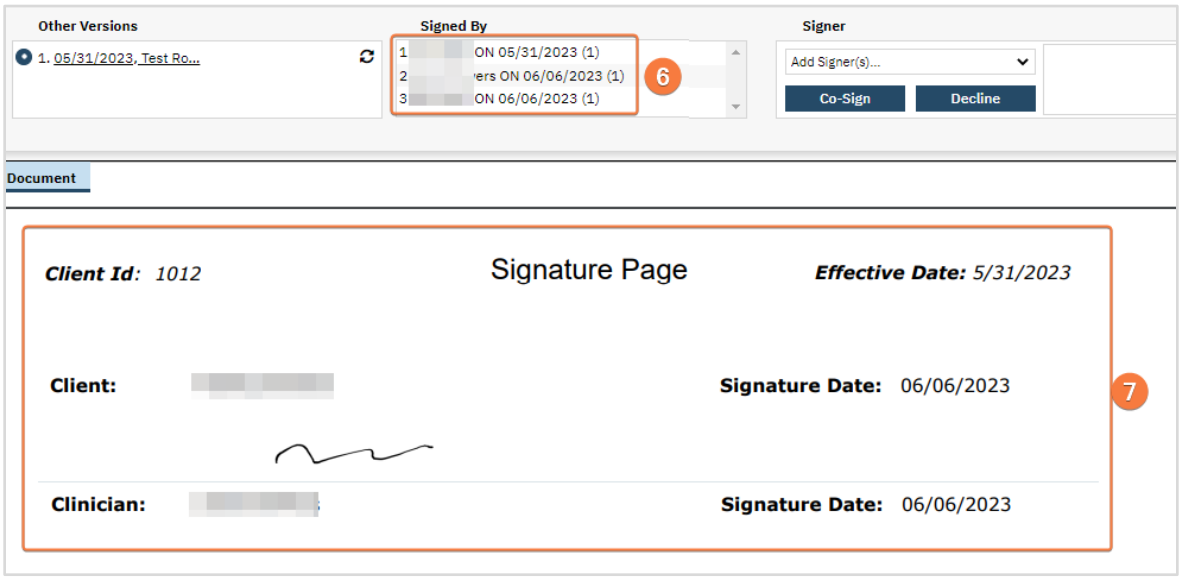
1. Note: A document can only be co-signed when it is in Signed status.
2. **Click the plus symbol** to expand the document header.
   a. Screenshot displays the minus icon, which is what shows once it is expended.
3. **Select the co-signer radio button** from the co-signer list.
4. **Click the Co-Sign button**.



5. When a client or other non-users co-sign a Signature window will appear.
    a. Sign using your preferred method.
    b. Select the Sign button.



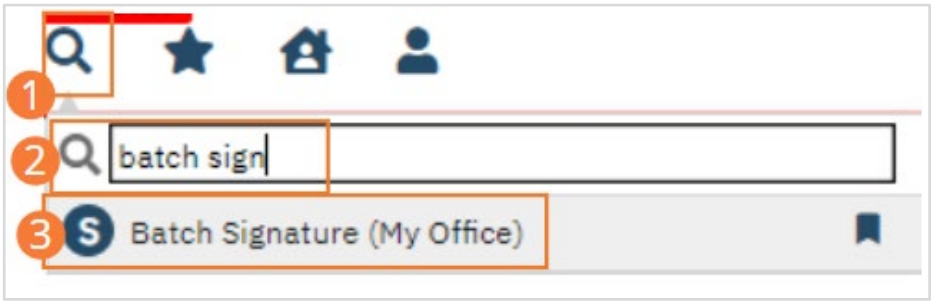
6. All signers (author of document and co-signers) will appear in the Signed By window.
7. Co-signers signatures (users and non-users) will appear in the Signature Page of the PDF.



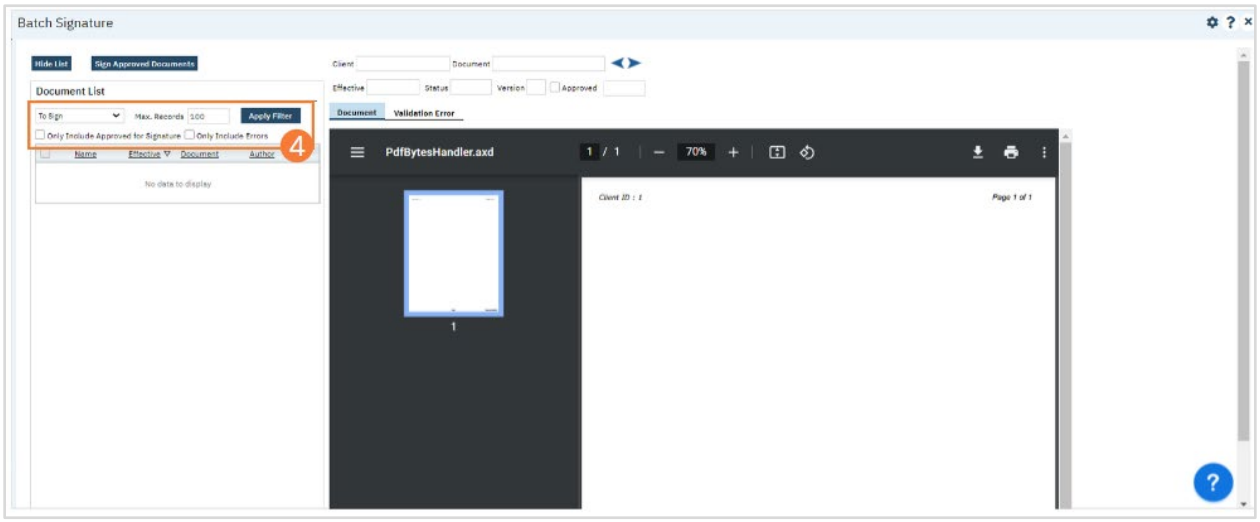
Prescriber: How to Batch Sign Documents

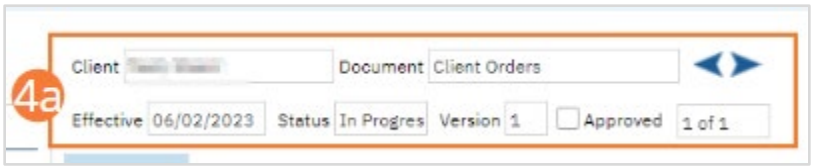
Batch Signature is a SmartCare feature that allows users to sign multiple documents at once. This is typically used by prescribers due to amount of documents they have to co-sign.
Note: Some documents may not be present if the document has been set up to not display in Batch Signature.

1. Click the Search icon.
2. Type “Batch Signature” into the search bar.
3. Click to select Batch Signature (My Office). The Batch Signature page will display.

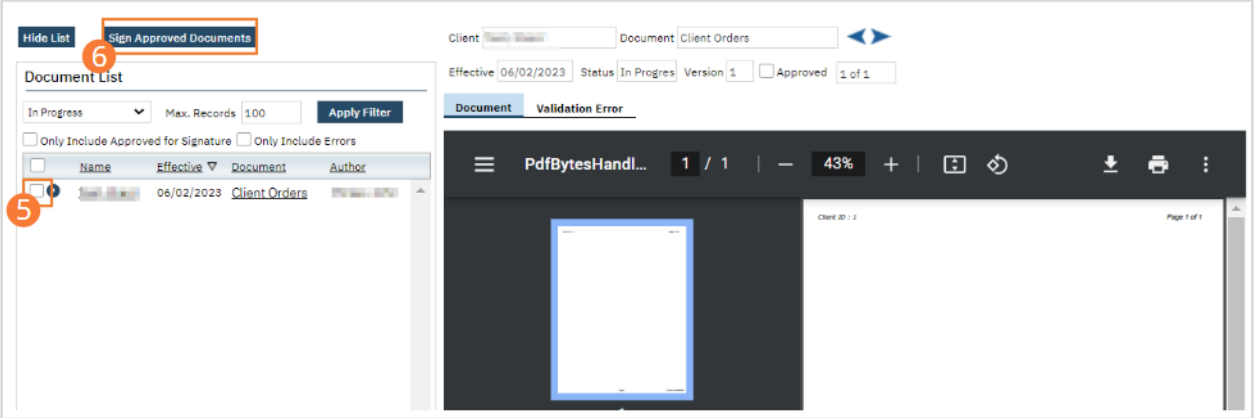


4. Set filters to display desired documents. You can filter for documents you have permission to sign, to co-sign, to acknowledge, or by documents in progress or to be reviewed. You can also filter to include only Errors or only documents Approved for Signature. Click Apply Filters.
    a. You can review displayed documents before signing them. Document information is displayed in the fields above the display window. Use the blue arrows to page between documents.





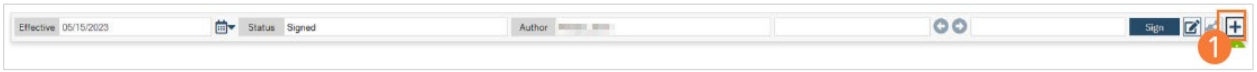
5. Next to each document you wish to sign, click the checkbox to select it.
6. Click the Sign Approved Documents button. A processing message will appear. When signatures are complete, a success message will display.



How to Edit an Existing Version of a Document

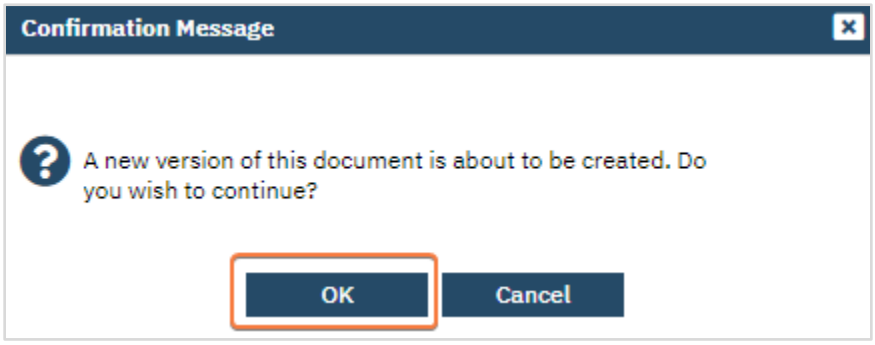
Edit functionality should only be used to correct information in a signed document. If information needs to be updated because it has changed since the document was initially completed, a new document should be completed (clicking New icon in the tool bar); edit should not be used for this scenario.

1. Select the Expand button on the Signature Pane.

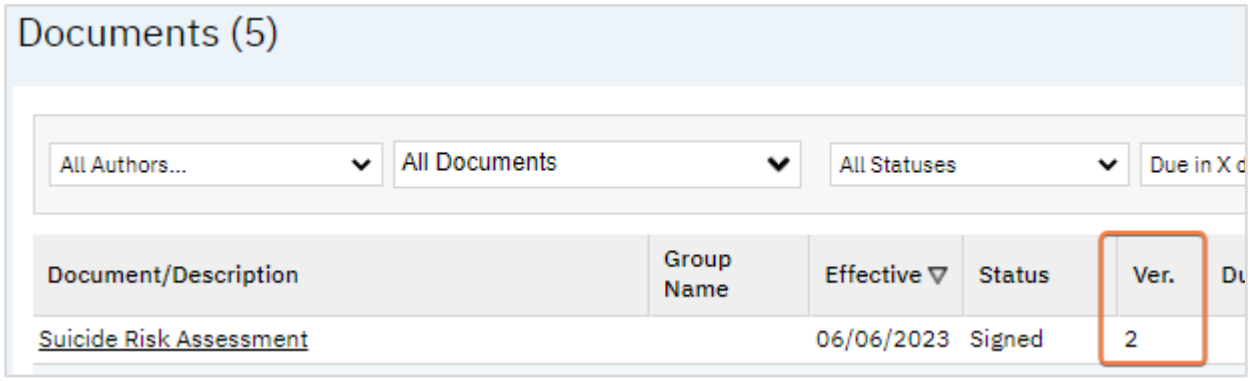


2. Click on the hyperlinked date of the assessment you wish to edit.
3. Click on the Edit icon. This will create a new version of the document.

4. A pop-up window will appear asking if you wish to continue with creating a new version. Click the OK button to continue.



5. A new assessment will open, pre-filled with selections made during the chosen assessment. This will not overwrite the chosen assessment, but will instead create a new version of the assessment dated to the current date.
6. When a document is edited it will display in the Documents list page as one row. However, column Ver. will indicate the total amount of versions.

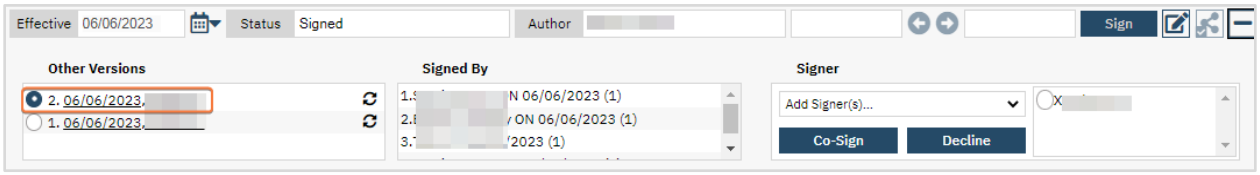


a. Anything over 1 indicates that the document has been edited.

How to View Older Versions of a Document

1. Open the Signature Panel expanded view.

2. Select the desired date from the Other Versions menu.



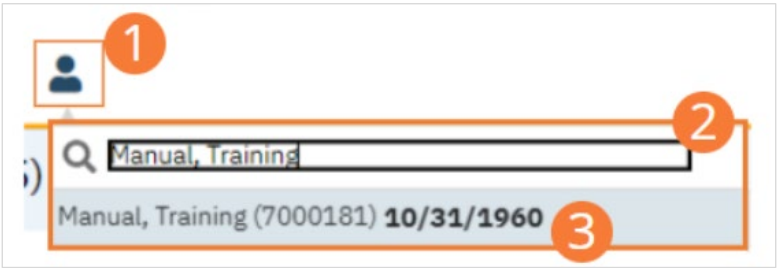
3. Note that the original version is still available for reference.

General Client Search

This process should be followed in situations other than Admission. When admitting a client, use the process found under the Admission section.

How to Select an Active Client

1. Click the Client Search icon.
2. Type the "Client Name (Last Name, First Name)" in the Client Search bar.
   a. You only need three characters of the last name to display options. You can also enter the first name to narrow your search. You do not need to enter the full last name or full first name to display options.
   b. You can also search by client ID. However, the complete client ID is needed to display options.
3. Click to select the "Client Name" from the search results.



4. The client record will open to the default screen. Additionally, the Client Bar will be open.
   a. Clicking the client bar will take you to the default screen.

5. Now, you will be able to search for and open pages that require an active client.

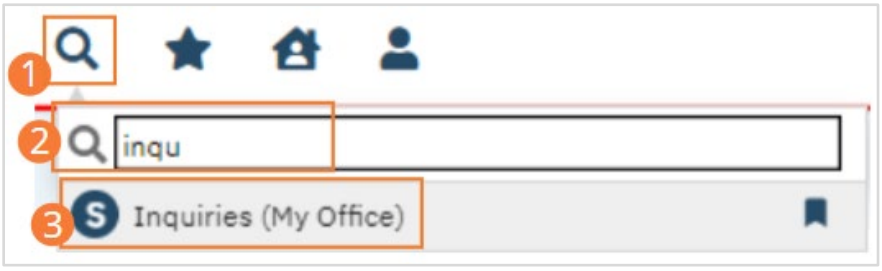
Admission

Admission is a multi-part process, including optional documentation of the referral, enrollment into a Program, and assignment to a bed.

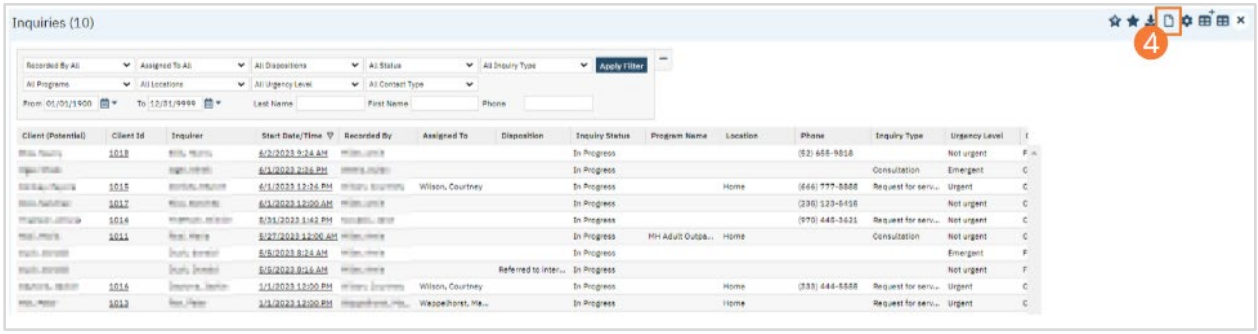
How to Document an Incoming Referral From an External Agency (optional)

Incoming referrals are documented using the Inquiries screen.

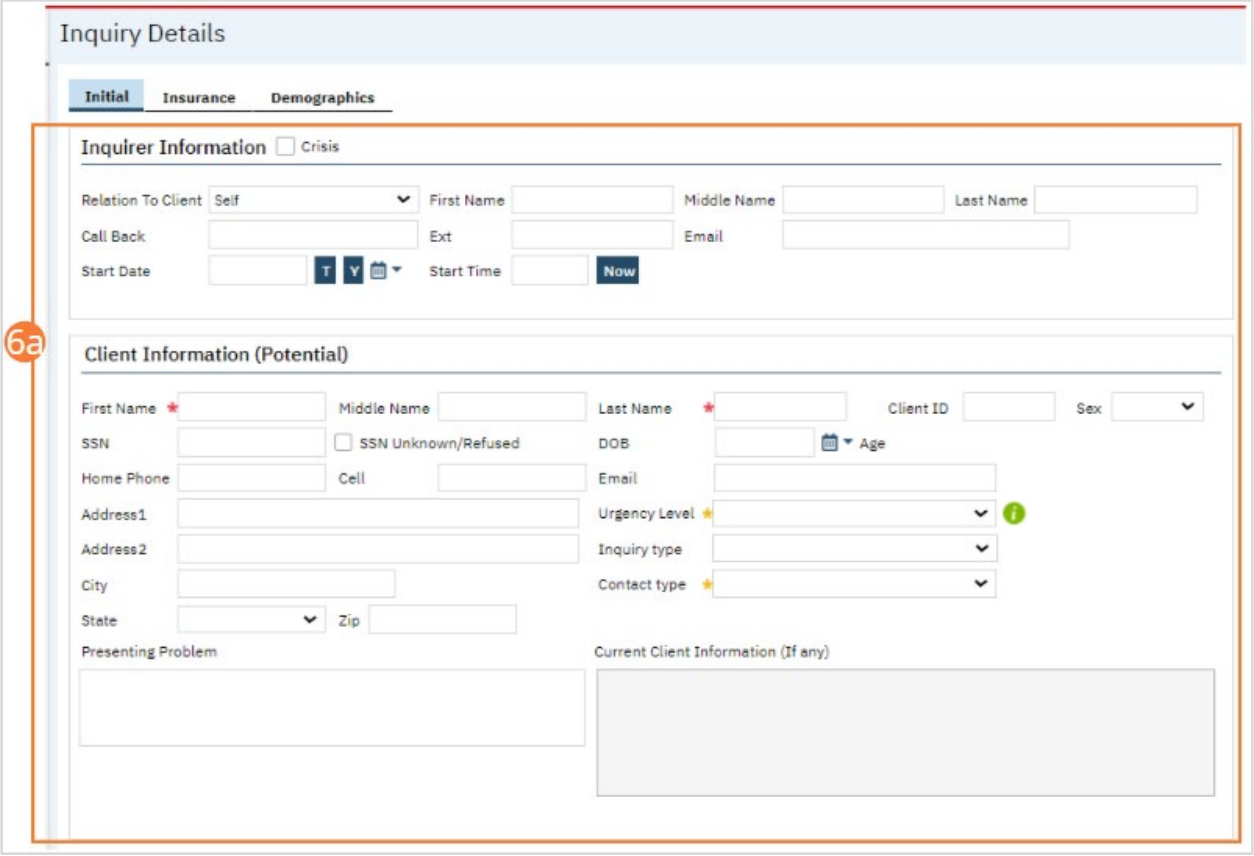
1. Click the Search icon.
2. Type 'Inquiries' into the search bar.
3. Click to select Inquiries (My Office). The Inquiries page opens.



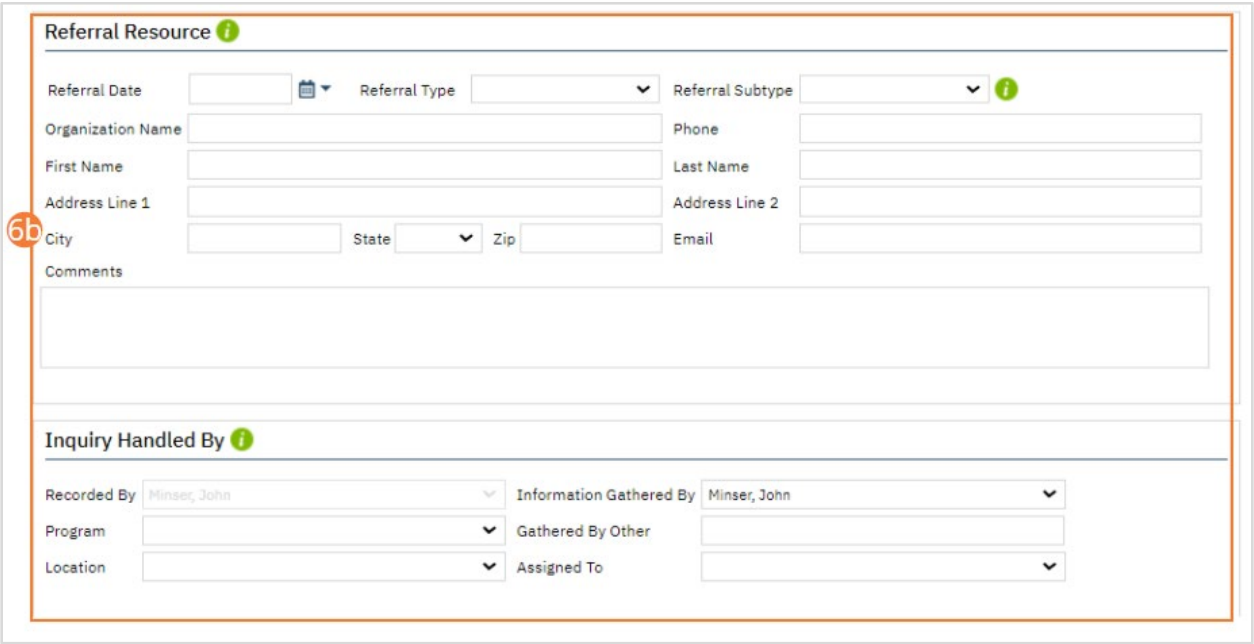
4. Select the New icon from the tool bar. The Client Search pop-up opens.



5. If searching for an existing client, perform a client search according to the steps outlined in How to Search for a Client. Otherwise, select the Inquiry (New Client) button. The Inquiry Details page will open.
    a. Note: Ensure you do not have a client record open. If you do, the system will assume you creating an inquiry for that client.
6. Complete the Initial tab.
    a. Select the relationship of the inquirer to the potential client from the dropdown. Type text into each field. If inquiring during a crisis, click the Crisis checkbox. A Crisis tab will initialize. In the Client Information (Potential) section, enter all known information. Fields marked with an asterisk are required.
        i. Crisis should only be selected after the Inquiry is associated with a client ID.

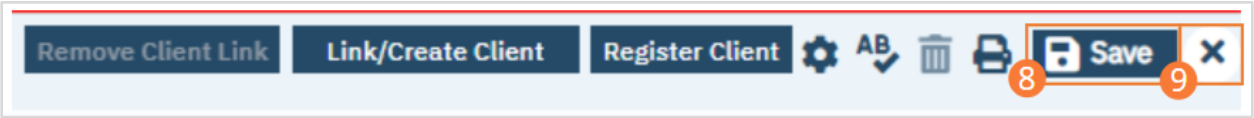


b. Document the external referral in the Referral Resource section. Select or type a referral date. Select a referral type and subtype from the dropdowns. Type information into text fields. Document the inquiry handler information in the Inquiry Handled By section. Select information about the handler from the dropdowns.



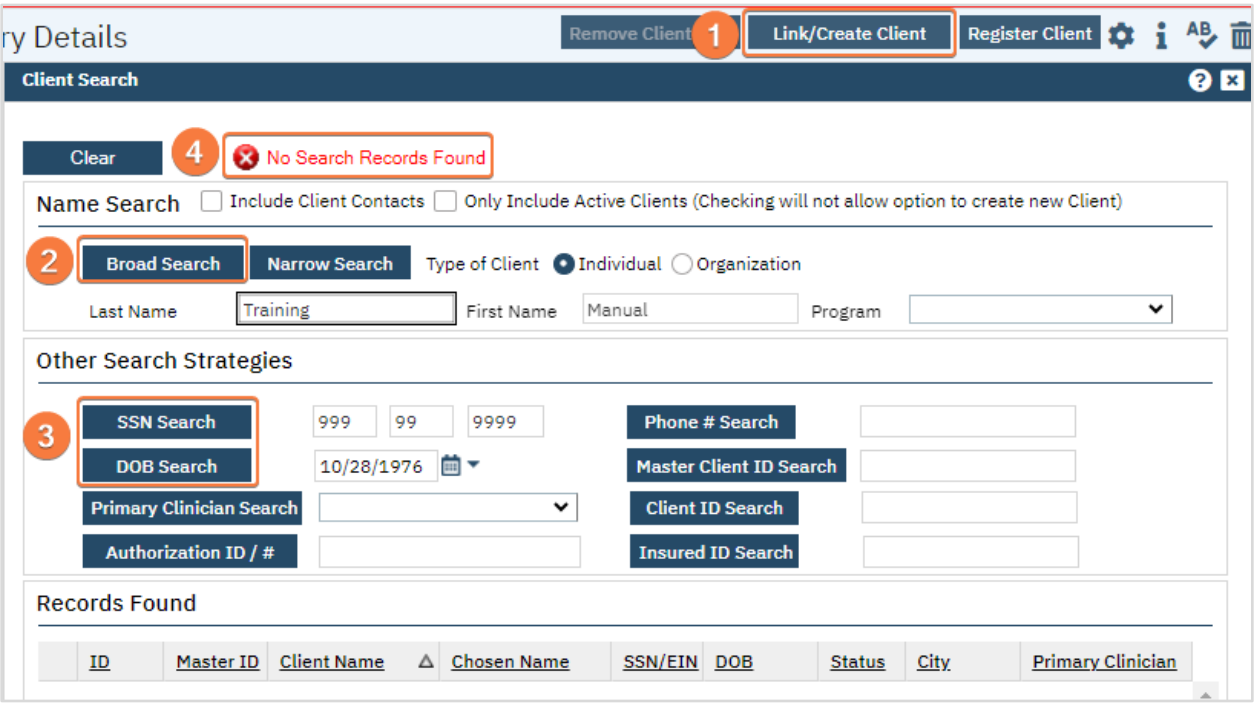
c. Complete remaining sections of the Initial tab according to organizational workflows.

7. Complete remaining tabs according to organizational workflows.
8. Click the Save button in the tool bar.
9. Click the Close icon.

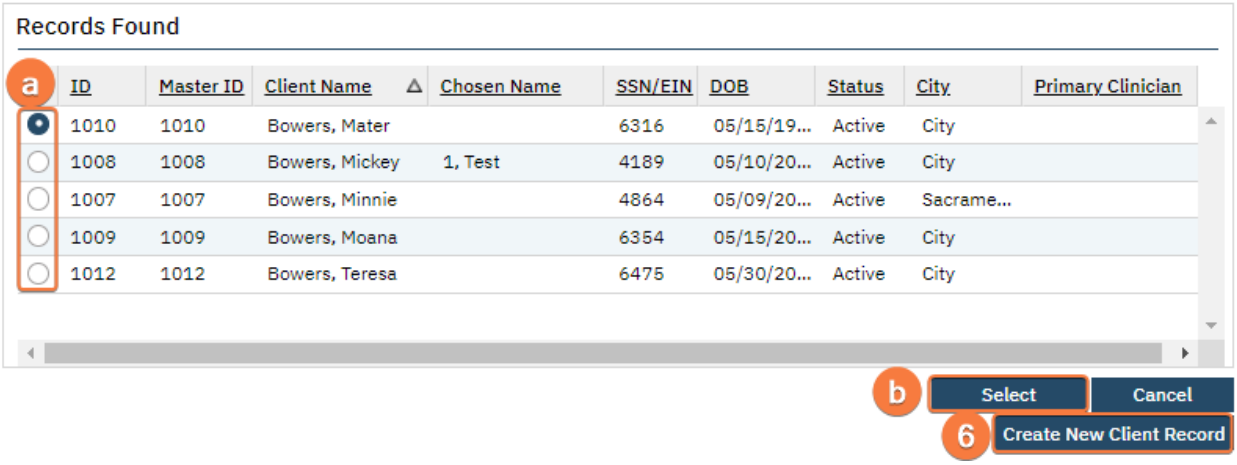


How to Create a Client Through an Inquiry

1. **Select the "Link/Create Client" button**. This will bring up the client search window, with a few extra buttons at the bottom.
2. You must **search by name** by clicking the "Broad Search" button.
3. You must also **search by SSN and DOB** by clicking on those respective buttons.
4. If no records are found based on the search you do, an alert will show at the top of the window.



5. Any search results will show in the "Records Found" area. **Review the Records Found** to determine if the person is already in the system as a client.
    a. If the person is already a client in the system, **select the button next to the appropriate record.**
    b. **Click "Select"** to link the Inquiry to the selected client.
6. If the person is not a client, meaning no records were found matching the client's information, **click "Create New Client Record."**
    a. This will take you back to the Inquiry screen but now a client ID number will be added.



How to Document an Incoming Referral from an Internal Agency (optional)

This will be handled by the Care Coordination module, which is still in development. When a client is referred to your facility, the referrer will request enrollment in your program and document the date of the request. This is done in Client Programs.

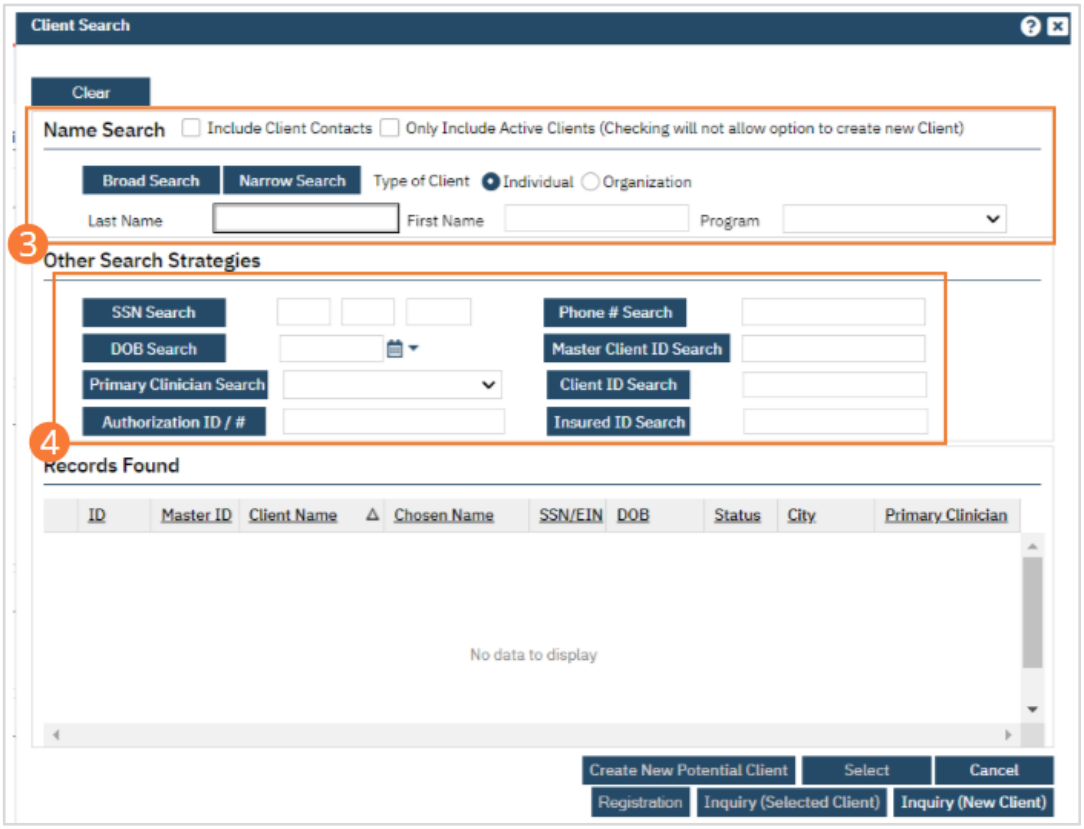
How to Search for a Client

When admitting a client, users should follow these steps to use the Client Search feature when selecting the admitted client. Confirm that the admitted client is the correct client by comparing Date of Birth and other factors to other similarly named clients.

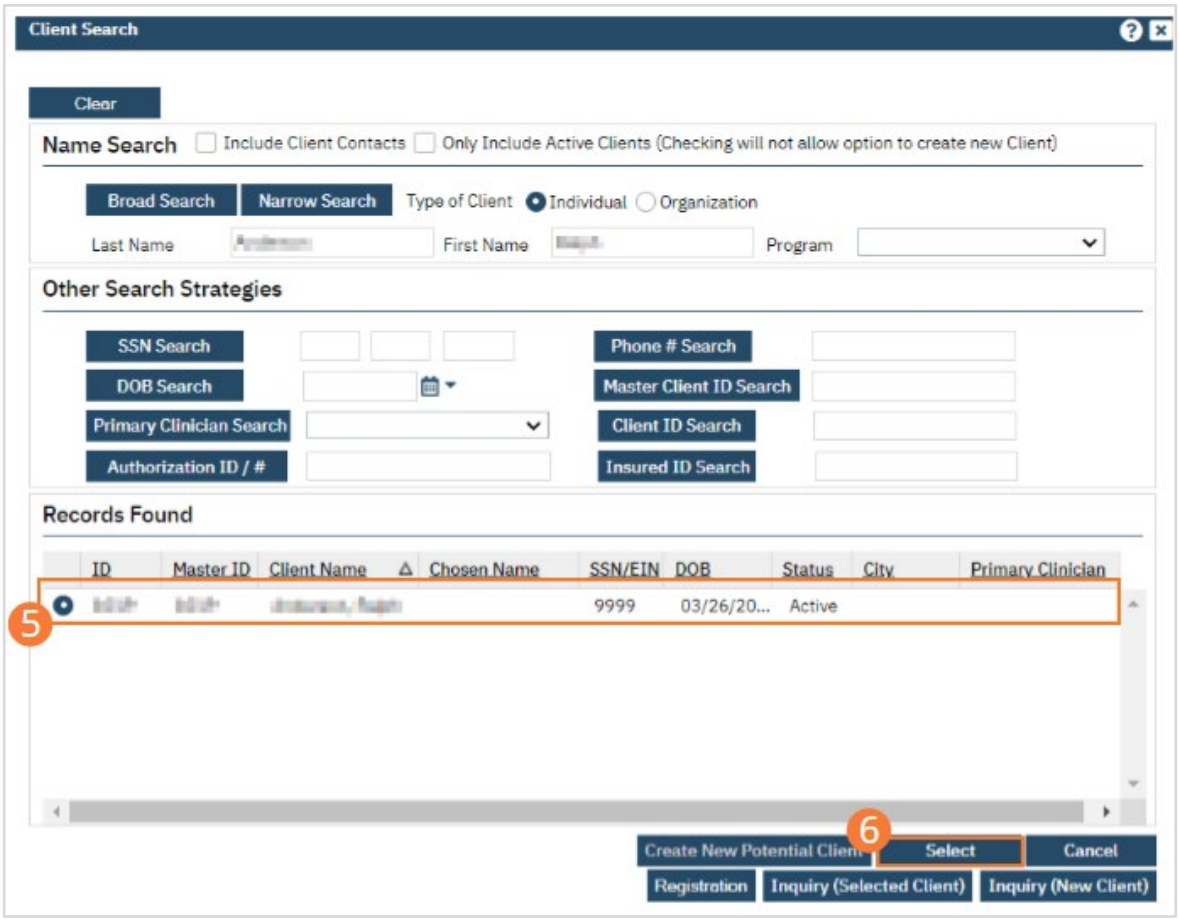
1. Click the Client Search icon.
2. Click the <Client Search> button in the Client Search bar. The Client Search pop-up will appear.

3. If searching for an individual, type the desired name into the Last Name field. If known, enter a name in the First Name field. If searching only Active Clients, select the Only Include Active Clients checkbox. Click the Broad Search button to include clients with names similar to the entered name.
4. Optionally, use other search strategies. Enter known information as text in a selected field, or select a date using the date selector next to the DOB search button. Click the button beside the field you entered information in.
    a. Enter a social security number in the format "XXX XX XXXX" beside the SSN button.
    b. Enter a Date of Birth beside the DOB Search button.
    c. Select a Primary Clinician from the dropdown beside the Primary Clinician Search button.
    d. Enter an Authorization ID Number beside the Authorization ID / # Search button.
    e. Enter a ten-digit phone number beside the Phone # Search button. Parentheses and hyphens are optional.
    f. Enter a Master Client ID number beside the Master Client ID Search button.

g. Enter a Client ID number beside the Client ID Search button.
h. Enter an Insured ID number beside the Insured ID Search button.



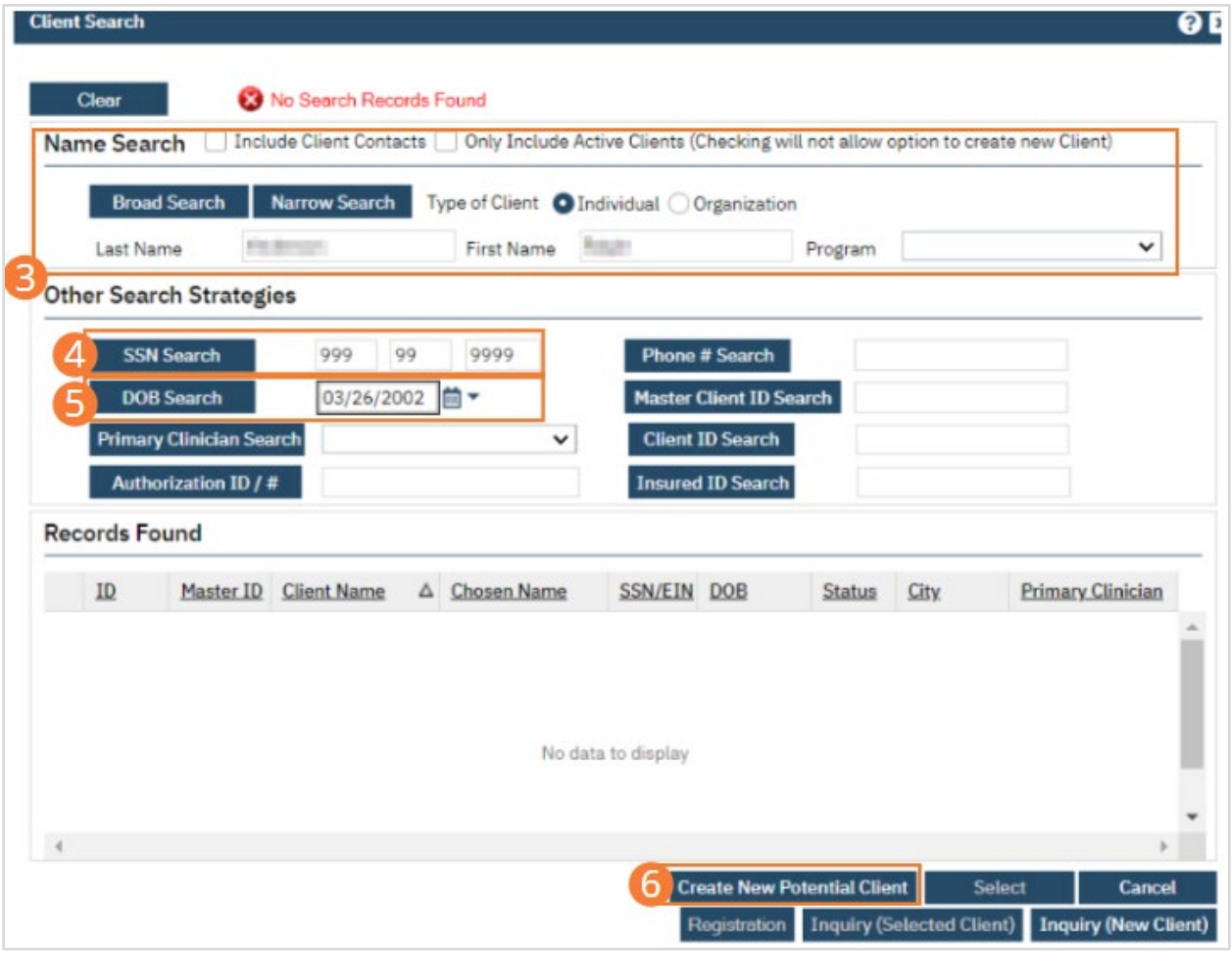
5. The Records Found section will populate. Select the radio button beside the desired client.
6. Click the Select button.



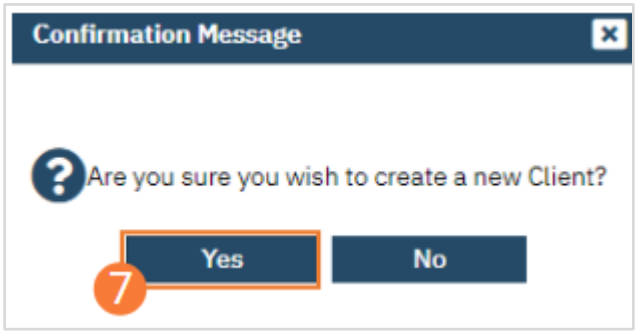
How to Create a New Client

1. Click the Client Search icon.
2. Click the <Client Search> button in the Client Search bar. The Client Search pop-up will appear.

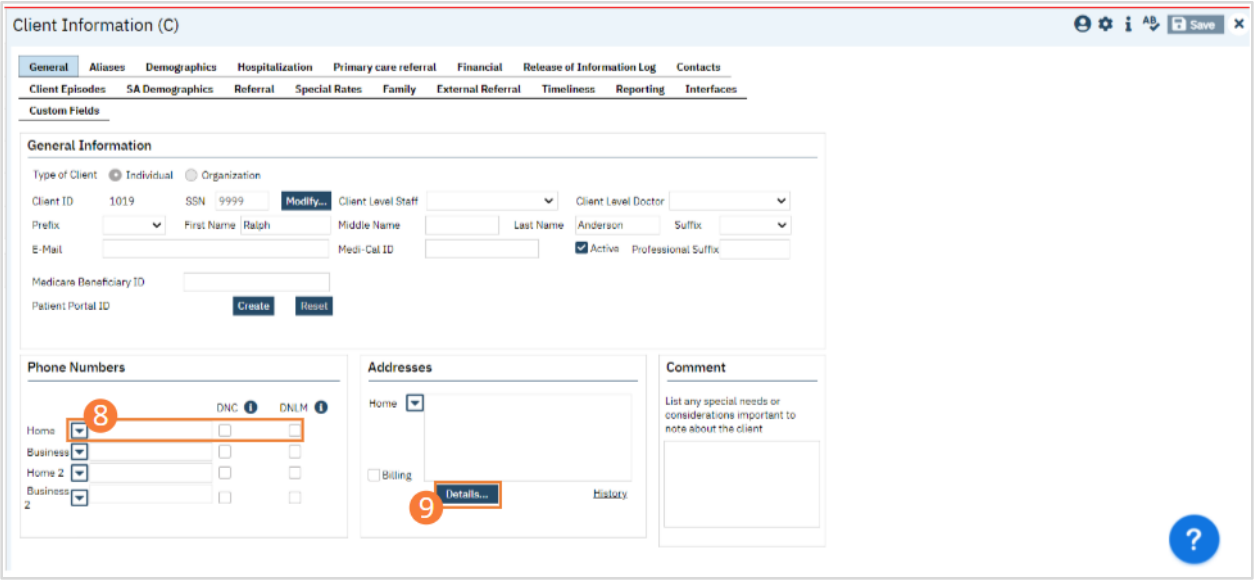
3. Type the desired name into the Last Name field. If known, enter a name in the First Name field. Click 'Broad Search'. If the client exists, select the client using the steps under How to perform a search for and select a client. If the client does not appear in the search, continue to the next step.
4. Enter the new client's social security number in the SSN Search field. Click the SSN Search button. If the client does not appear in the search, continue to the next step.
5. Enter the new client's Date of Birth in the DOB Search field, or use the date selector to choose the date of birth. Click the DOB Search button. If the client does not appear in the search, the New Potential Client button will initialize.
6. Click the New Potential Client button. The confirmation pop-up will open.



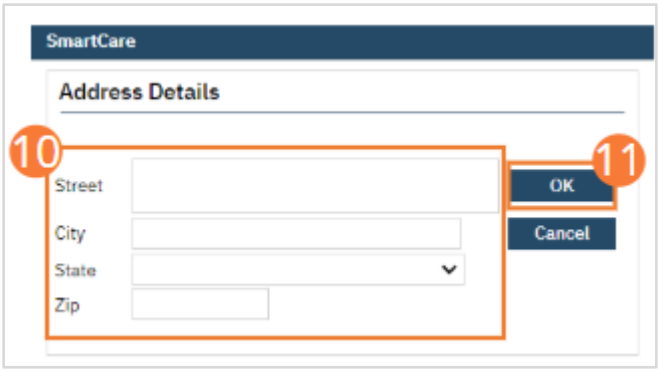
7. Click Yes.



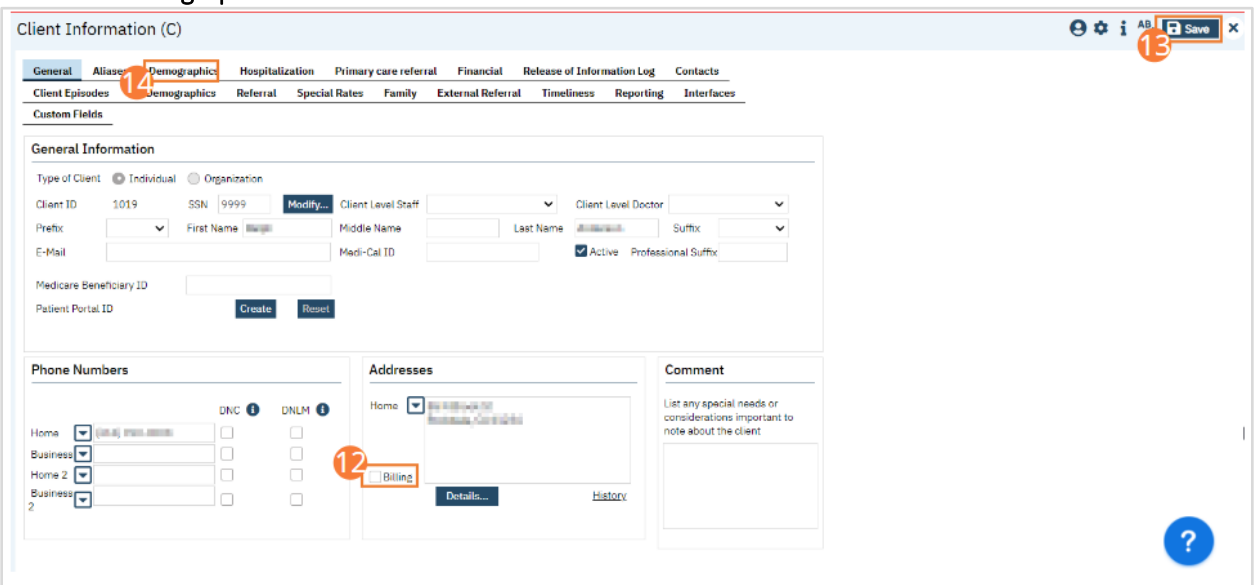
8. Enter a contact phone number in a phone number field. If you need to change the phone type (for example, if the client has no home phone and their primary phone should be listed as 'Mobile'), select the dropdown indicator and select a new phone type. For any phone numbers that should not be called, select the DNC checkbox. For any phone numbers where the staff should not leave a message, click the DNLM checkbox.
9. Click the Details button to enter a contact address. A pop-up will open.



10. Enter contact address information in the fields.
11. Click OK.

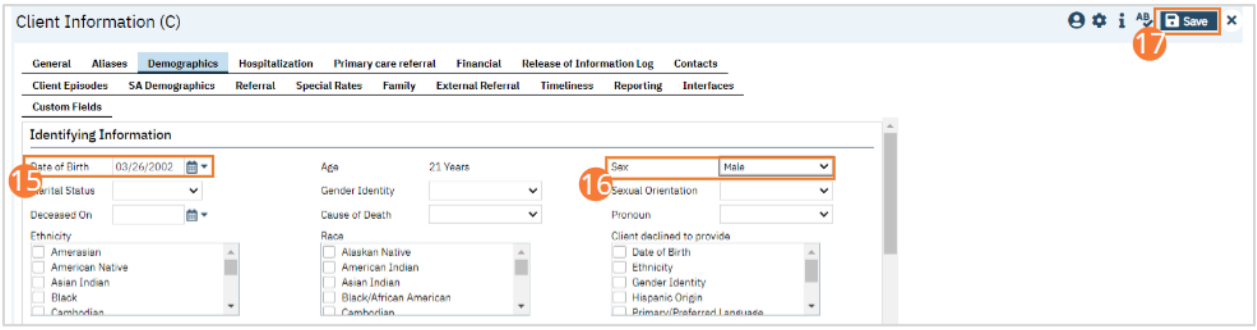


12. If the address is to be used as the client's billing address, select the Billing checkbox. If not, leave the box unchecked.
13. Click the Save button.
14. Click the Demographics tab.



15. On the Demographics tab, confirm that the date of birth searched in the Client Search steps is correct. If it is not, change it to the correct date of birth.
16. Select a Sex from the dropdown.

17. **Click the Save button**.

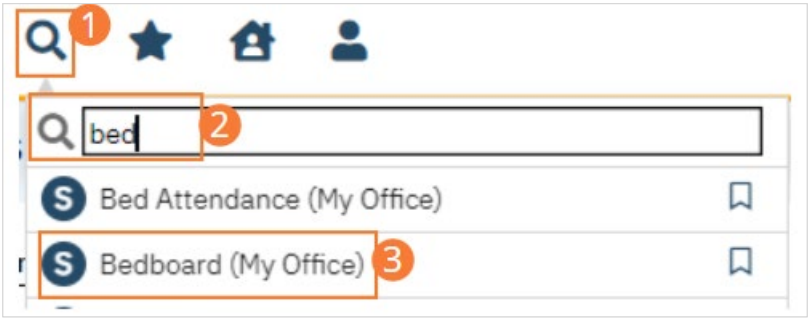


This concludes required steps in creation of a New Client. Other information can be captured on the Client Information tabs, including financial information, information related to the referral, and more. Follow all organizational workflows for the completion and capture of this information.

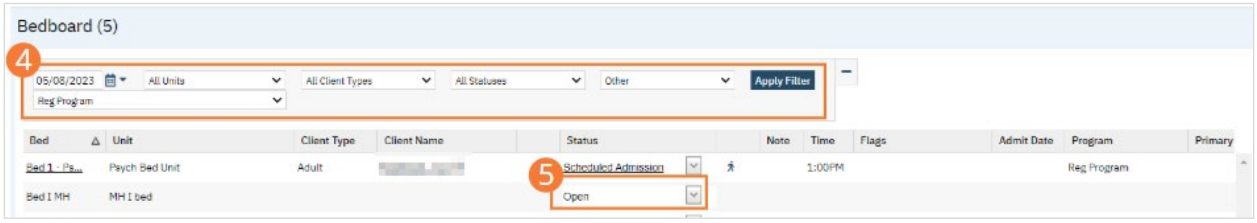
How to Schedule an Admission

These steps should only be followed if the client is not present. If the client is present, instead follow the steps for How to Admit a Client when no Admission was Scheduled. If you need to search for a bed to schedule a client into, follow the steps under How to Search for a Bed. These steps can be performed in Bedboard or Residential/Bed Census.

1. **Click the Search icon**.
2. **Type 'Bedboard'** into the search bar. (Or, 'Residential'.)
3. **Click to select Bedboard (My Office).** [Or, Residential (My Office)].

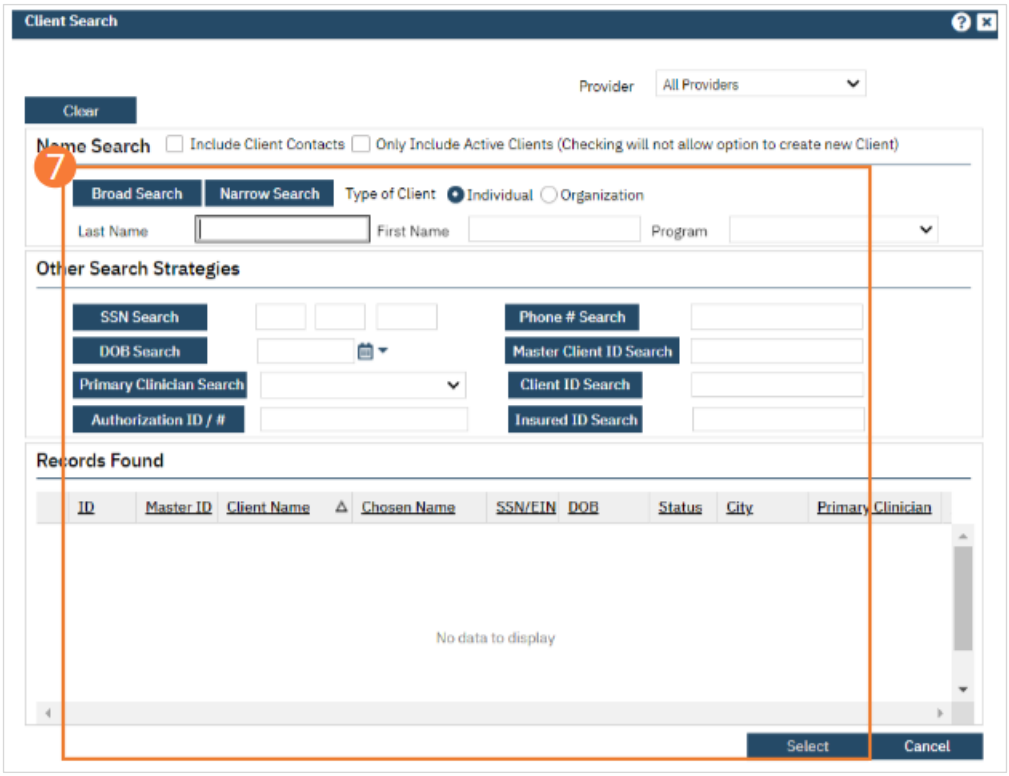


4. If desired, **filter the list** to determine the records that are shown.
5. **Find a bed with a status of Open**.



6. **Click the drop-down arrow** in the Status column of the open bed you want to admit the client to and **select Schedule Admission**. If an active client is selected, you will immediately open the Census Management - Schedule Admission. Otherwise, the Client Search window will open.

7. **Find the client you want to schedule the admission for**. The Census Management - Schedule Admission screen opens.

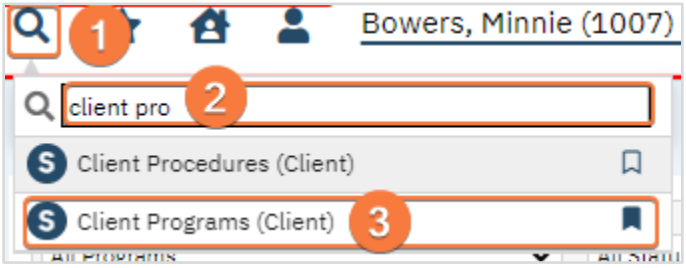


8. **Complete the required and necessary fields** on the Census Management - Schedule Admission screen. NOTE: If the selected client is not the client whose account you wish to make changes to, select the '…' button to open Client Search and select another client.
9. When the screen is complete, **click the Save and Close button** in the tool bar.

How to Request the Client into a Program

Whenever a client is scheduled into a bed they have to be marked as Requested into a Program. This is needed for CDAG.

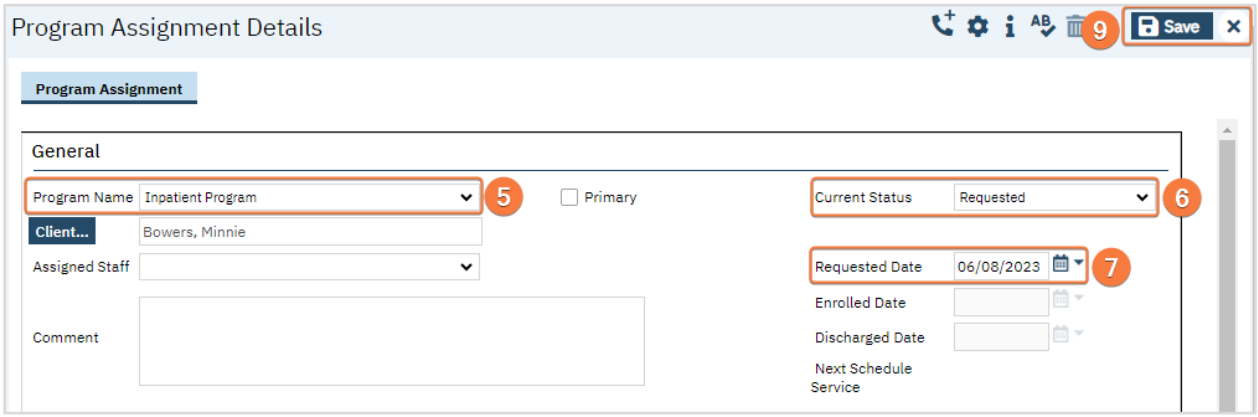
1. With an active client selected, **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type 'Client Programs'** into the search bar.
3. **Click to select Client Programs (Client)**.



4. Once you're in the Client Programs screen, **click the New icon in the tool bar**.

5. Once in Program Assignment Details, **select the program** from Program Name.
6. In the Current Status field, **select Requested**.

7. **Enter the Requested Date**, most of the time this is the current date.
8. Complete any other fields as needed.
9. **Click Save and Close** in the tool bar.



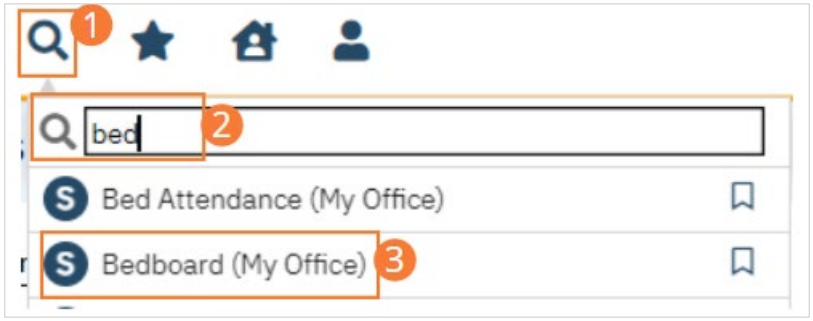
10. The client is now requested into the program.

How to Admit the Client to the Unit and Assign a Bed

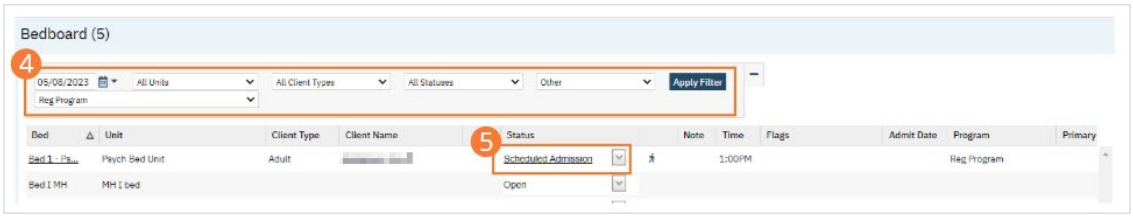
When a client is admitted to a unit and assigned a bed, you will need to select a Program as part of information entry. This will automatically set a client's status in that program to Enrolled. If they were previously set to Requested status, the admission will override that status and set it to Enrolled. These steps can be performed in Bedboard or Residential/Bed Census.

How to Admit a Client with a Scheduled Admission

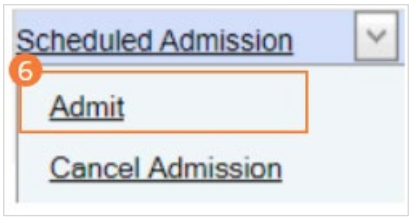
1. **Click the Search icon**.
2. **Type 'Bedboard'** into the search bar. (Or, 'Residential'.)
3. **Click to select Bedboard (My Office).** [Or, Residential (My Office)].



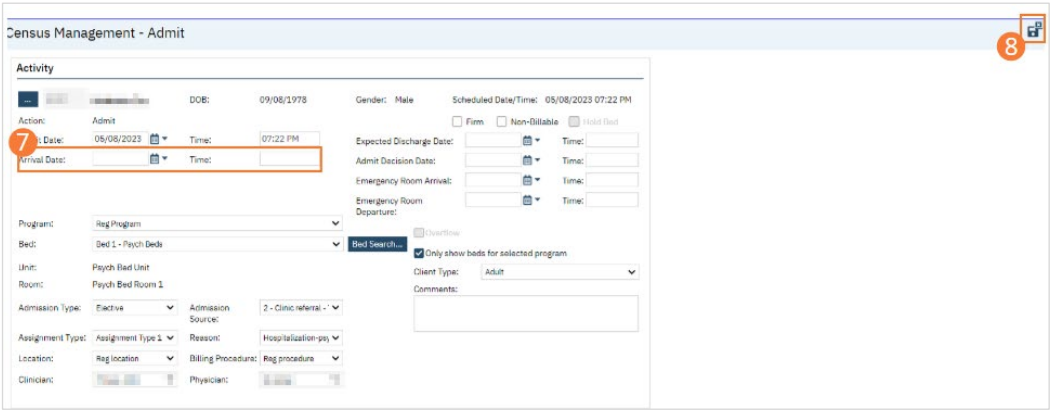
4. If desired, **filter the list** to determine the records that are shown. Be sure you have selected the date of admission.
5. **Find the client** with a scheduled admission who you want to admit



6. On the Bedboard list page, **click on the drop-down arrow** in the Status column and select Admit. The Census Management – Admit screen opens.



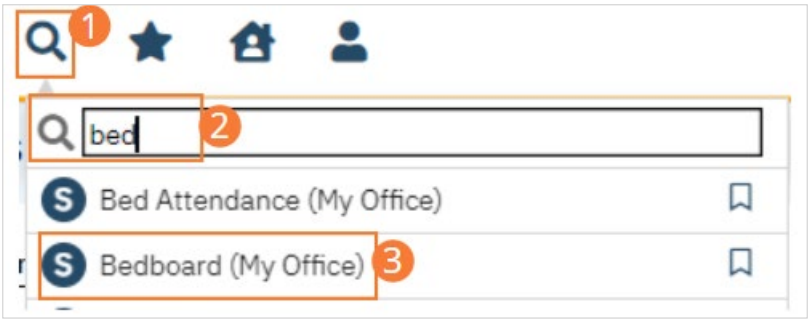
7. **Enter the Arrival Date and Time**. Complete any other known fields.
8. **Click the Save and Close button** in the tool bar.



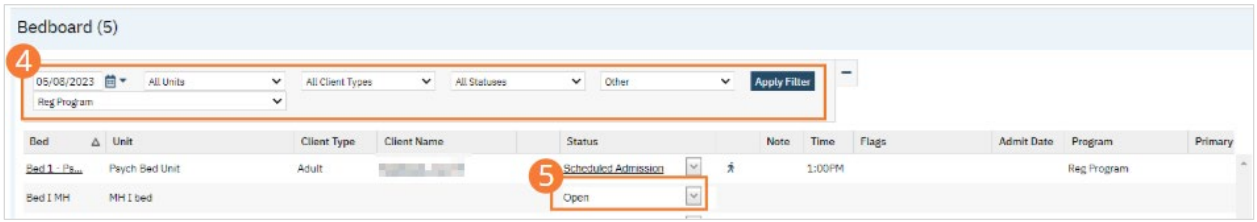
9. The client's program status will automatically change from Requested to Enrolled.

How to Admit a Client when No Admission was Scheduled

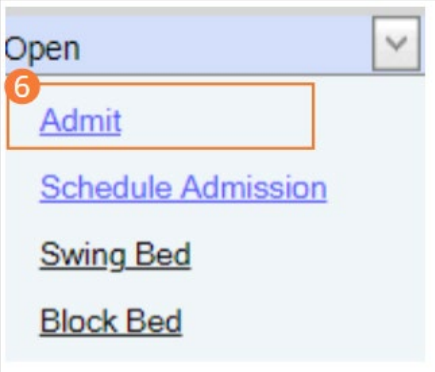
1. **Click the Search icon**.
2. **Type 'Bedboard'** into the search bar. (Or, 'Residential'.)
3. **Click to select Bedboard (My Office).** [Or, Residential (My Office)].



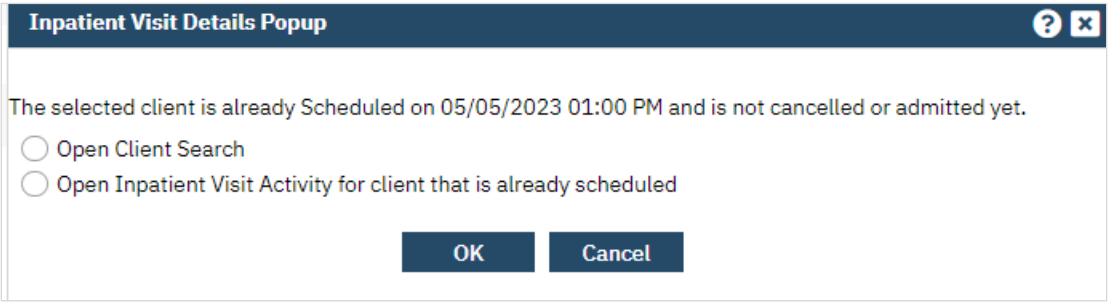
4. If desired, **filter the list** to determine the records that are shown.
5. **Find a bed** with a status of Open



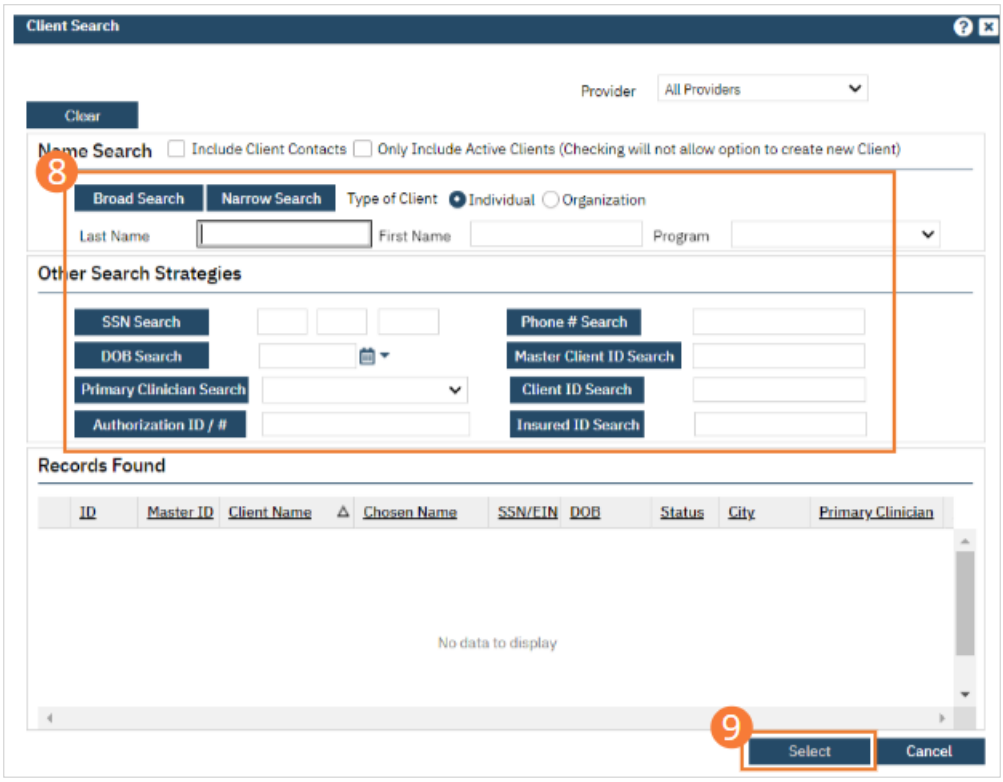
6. **Click the drop-down arrow** in the Status column of the open bed you want to admit the client to and select Admit.



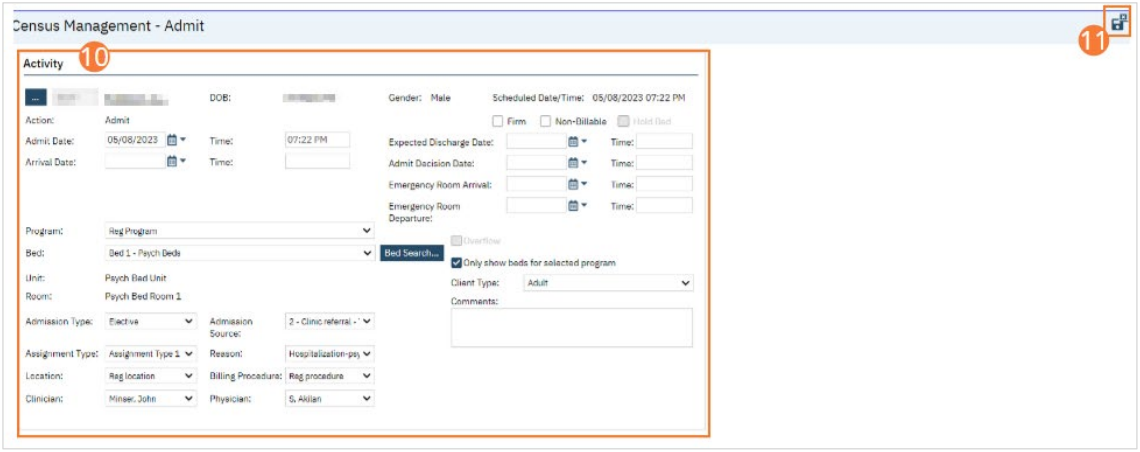
7. If a message window appears, this means a client account is open who is currently admitted to the facility. Notice the second tab in the menu tabs.
    a) a. Answer the prompt in the message window.
    b) b. To admit a different client than is showing on the tab bar, select the Open Client Search option. Or to continue working with the currently open client account, select the Open Inpatient Visit Activity for client that is already admitted option. (See Message Window below)
    c) c. Click the OK button. If no message window appears the Client Search window appears.



8. Search for the client.
9. When you find the client, **select the line and click the Select button**. The Census Management - Admit screen opens.

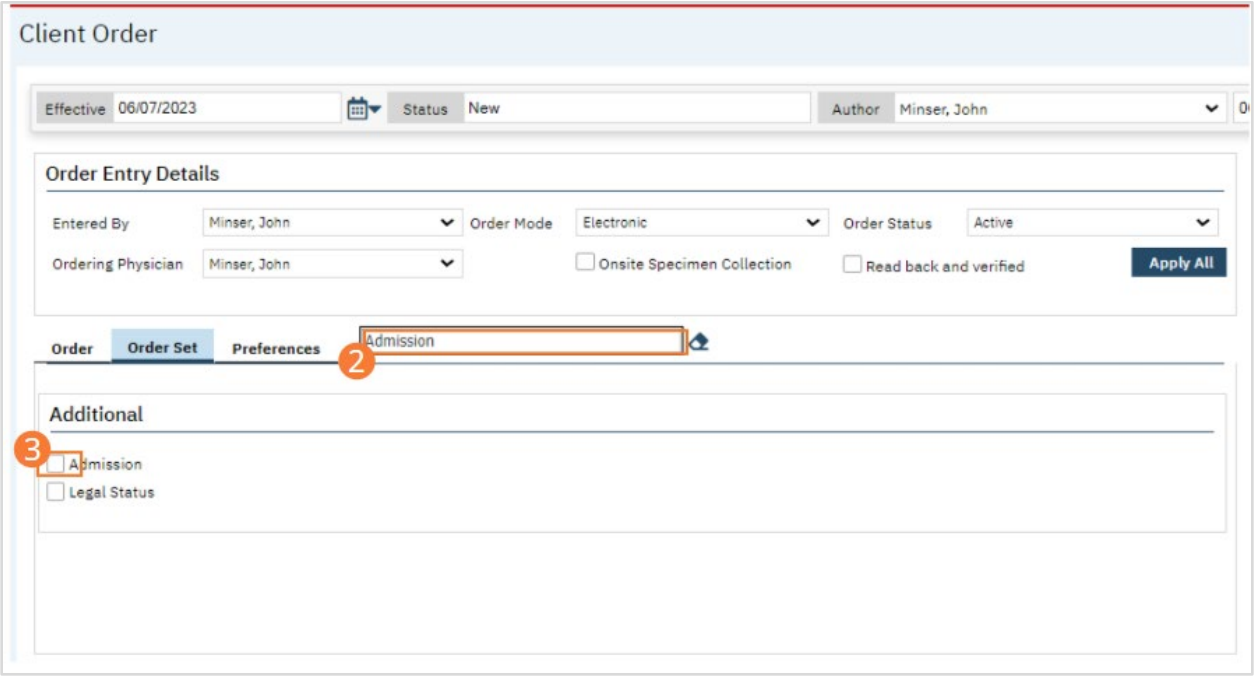


10. **Complete the required and necessary fields** on the Census Management - Admit screen.
11. When the screen is complete, **click the Save and Close button** in the tool bar.

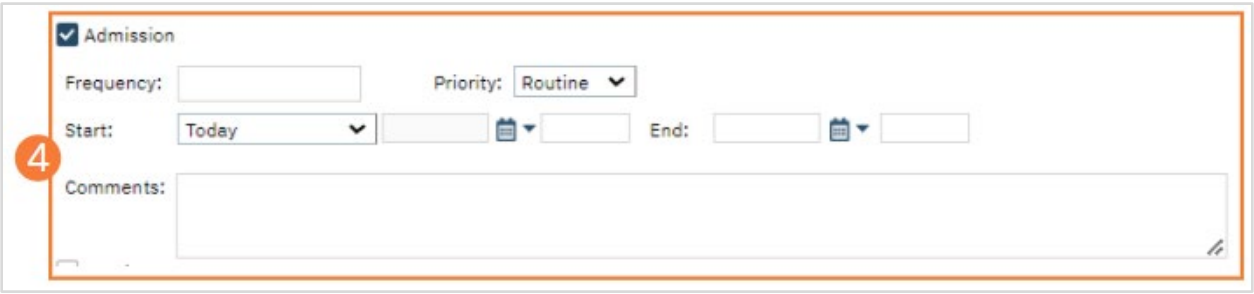


Nurse: How to Document a Verbal Admit Order

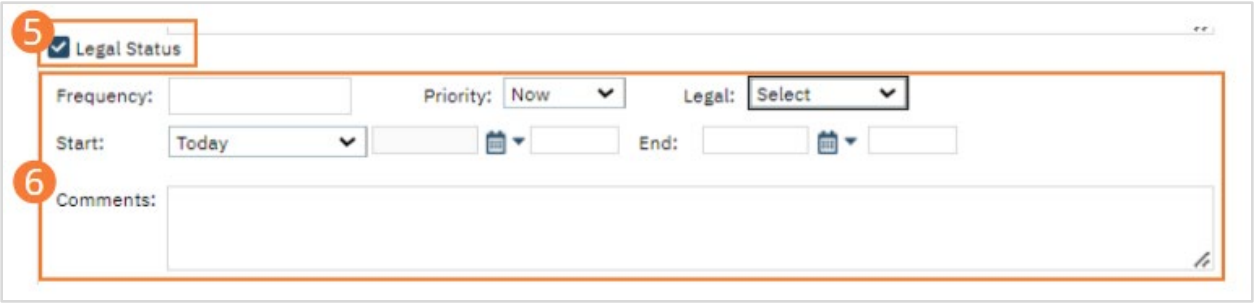
1. **Create a New Order,** using the steps under Order Sets.
2. When selecting the Order Set, **select Admission as the Order type.**
3. **Click the checkbox next to the Admission order.**



4. Complete all required fields for the Admission order.
    a) Set Frequency to "Once" in the dropdown. Other fields are optional.

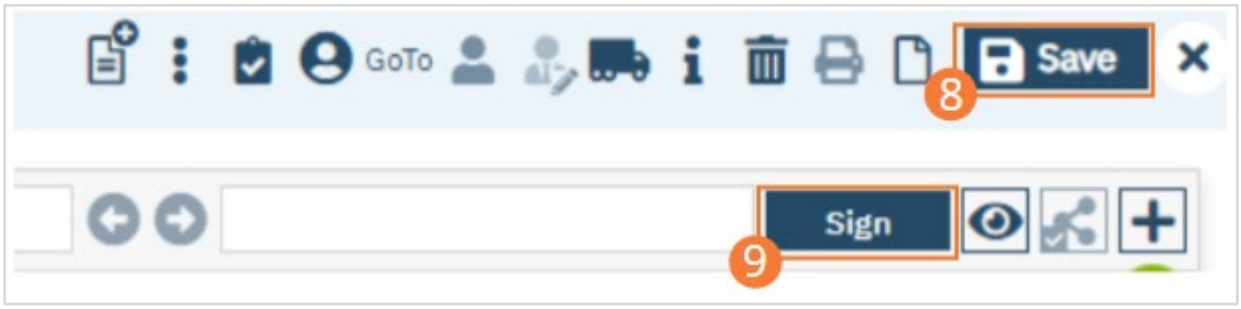


5. Click the checkbox next to the Legal Status order.
6. Complete all required fields for the Legal Status order.
    a) Be sure a status is selected under the Legal dropdown.



7. Select the Insert button. The Orders will be added to the Order List.

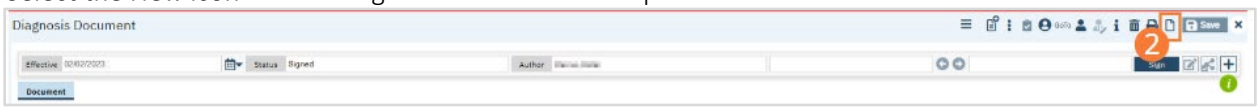
8. Click the Save button.
9. Sign the Orders, following the steps under How to Sign a Document.



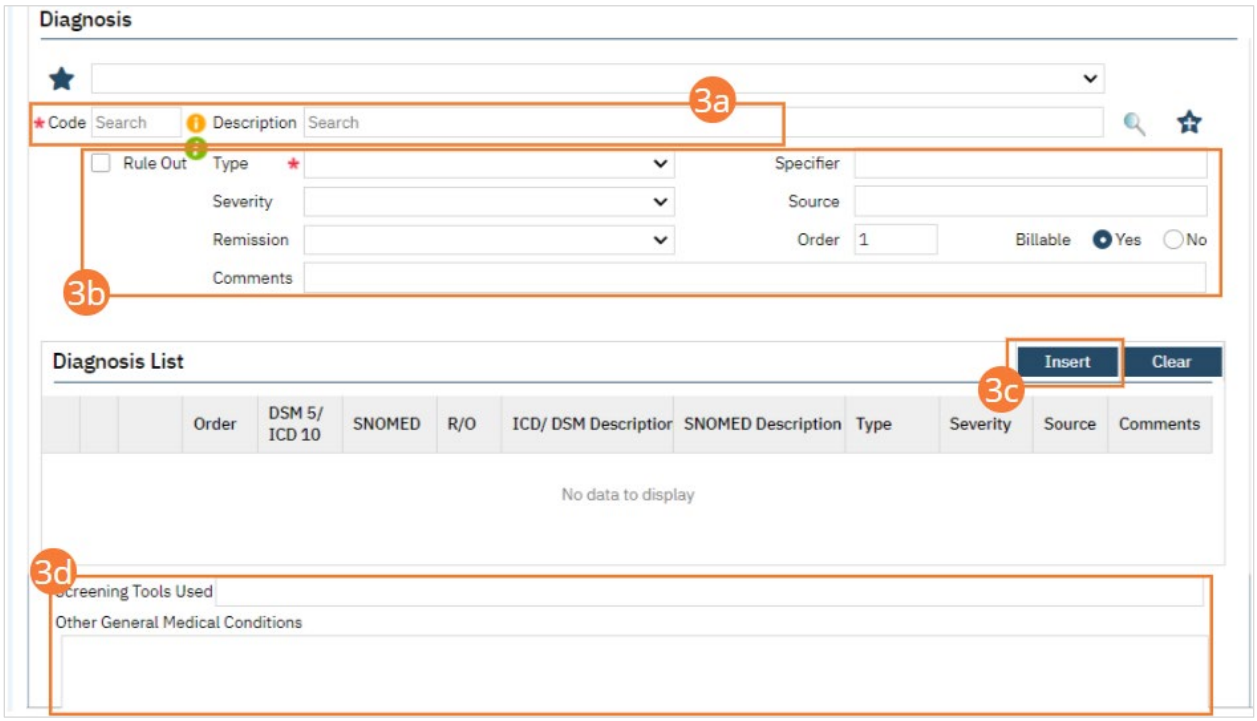
10. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

How to Document the Admit Diagnosis on Behalf of the Prescriber

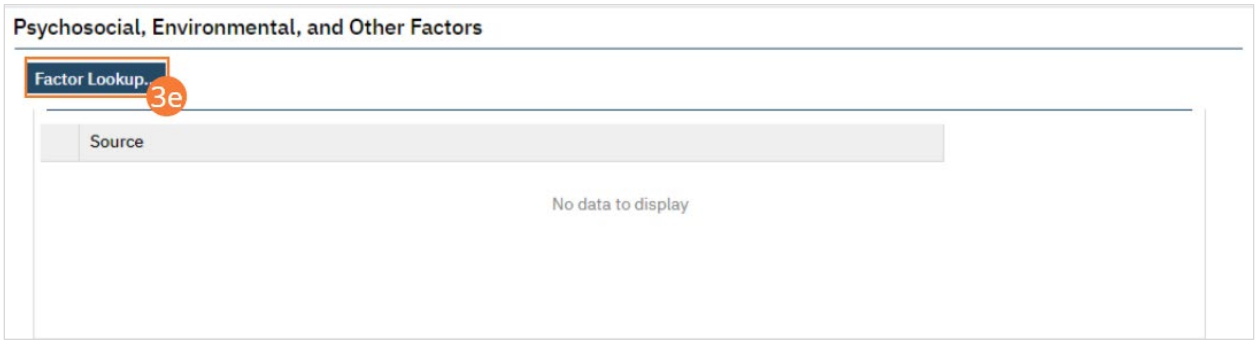
1. Begin on the Diagnosis Document page.
2. Select the New icon. A new Diagnosis Document will open.



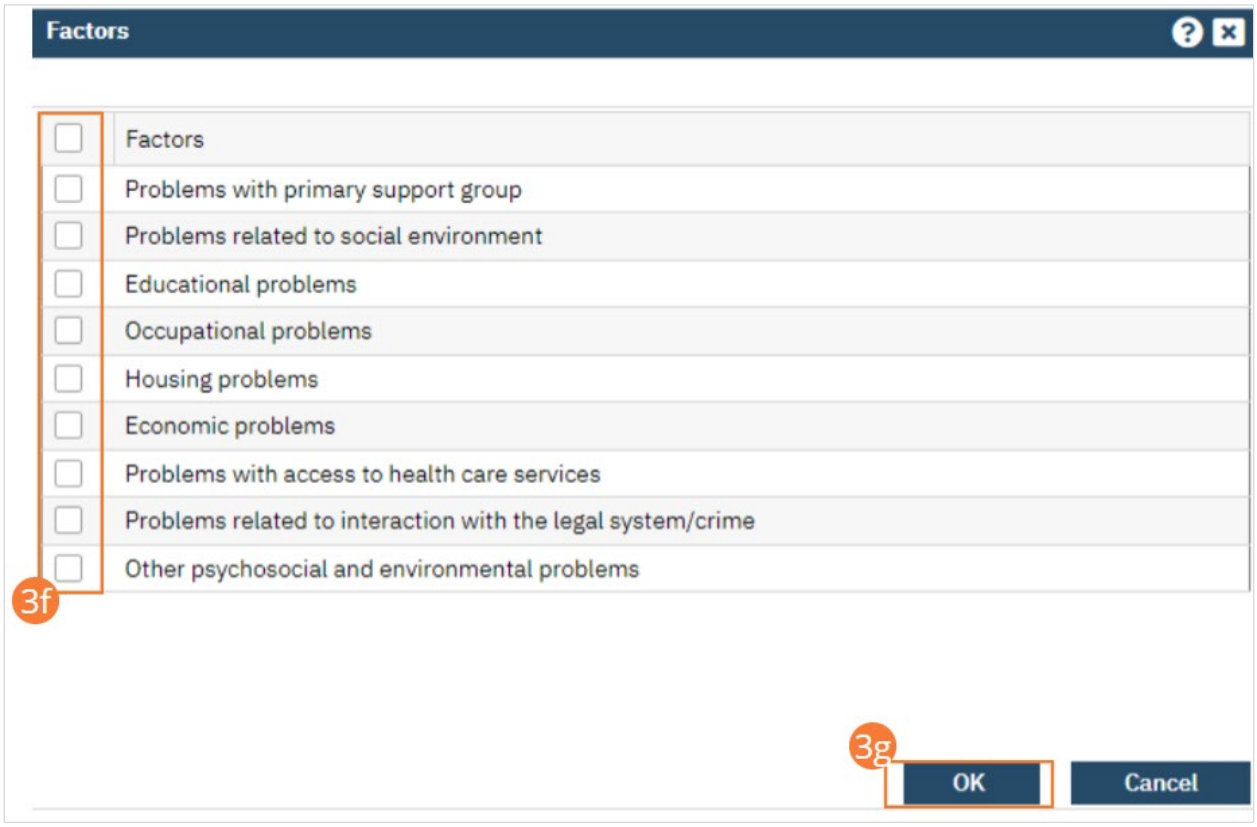
3. Complete required fields.
    a. Search for a diagnosis code or description. Select the chosen diagnosis from the dropdown that appears when you begin entering text. If no diagnosis was determined, select the No Diagnosis checkbox and skip to Step 3e.
    b. Ensure you enter the prescribers name in the Source field. You may complete the additional fields as needed.
    c. Click the Insert button. The diagnosis will be added to the Diagnosis List.
    d. Type text into the Screening Tools Used and Other General Medical Conditions fields, if applicable.



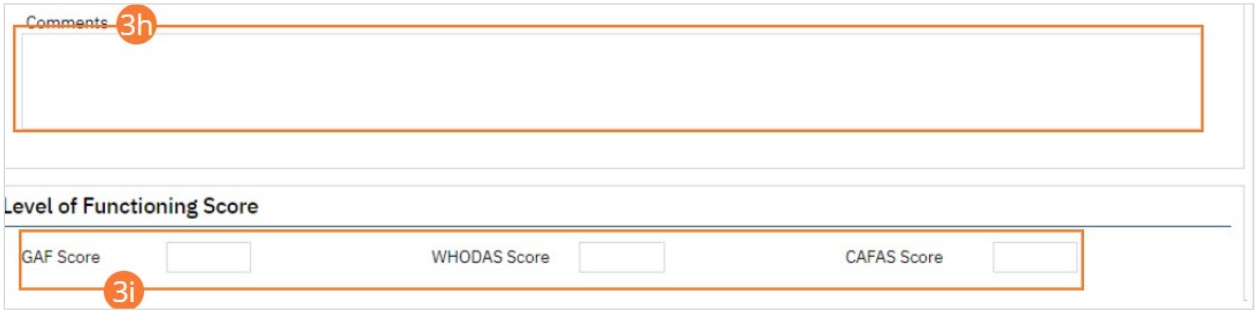
    e. If applicable, in the Psychosocial, Environmental, and Other Factors section, click the Factor Lookup button. A pop-up will appear.



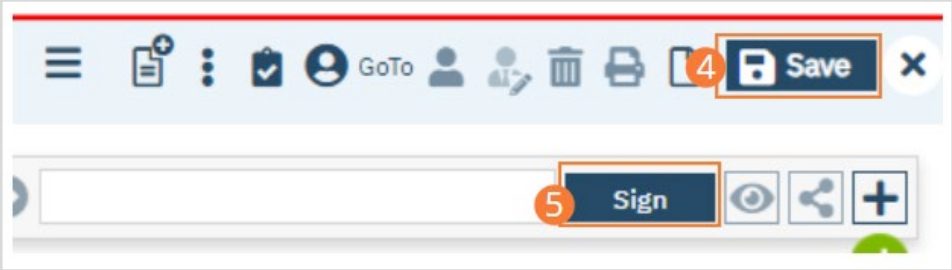
f. Select any or all of the checkboxes that apply.
g. Click the OK button.



h. Enter Comments in the text field.
i. If applicable, enter GAF, WHODAS, or CAFAS scores.



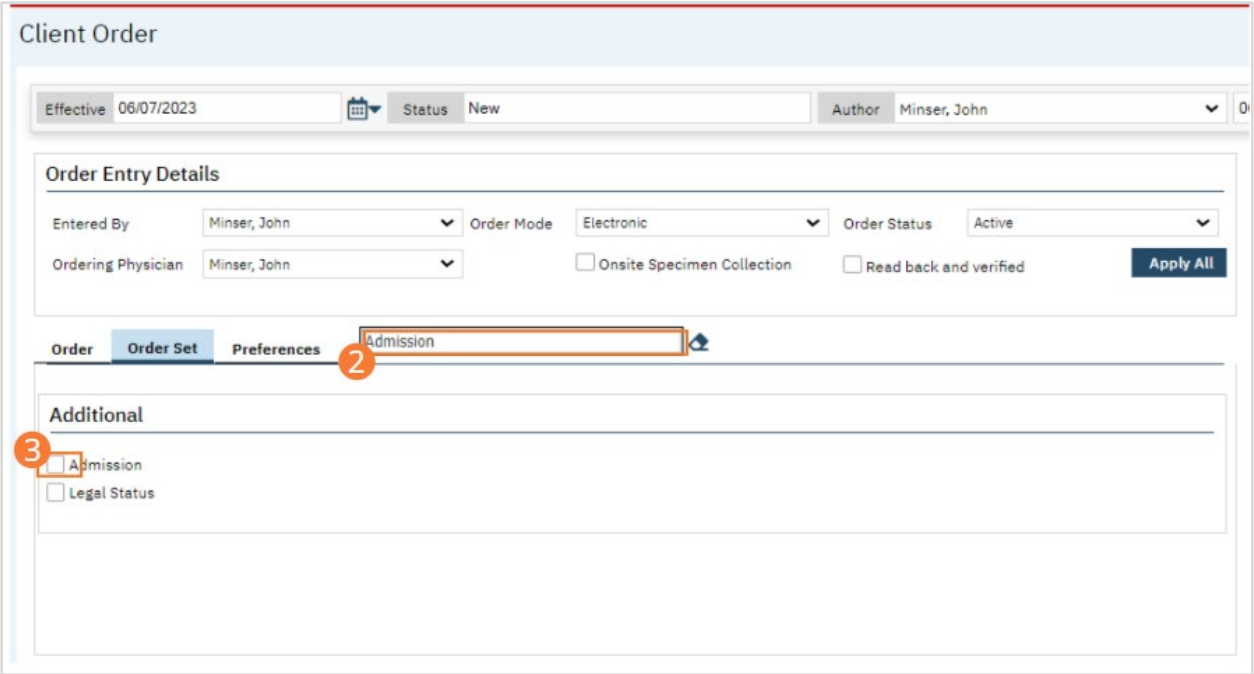
4. Click the Save button.
5. Click Sign and complete signature of the document. For more information, see How to Sign a Document.



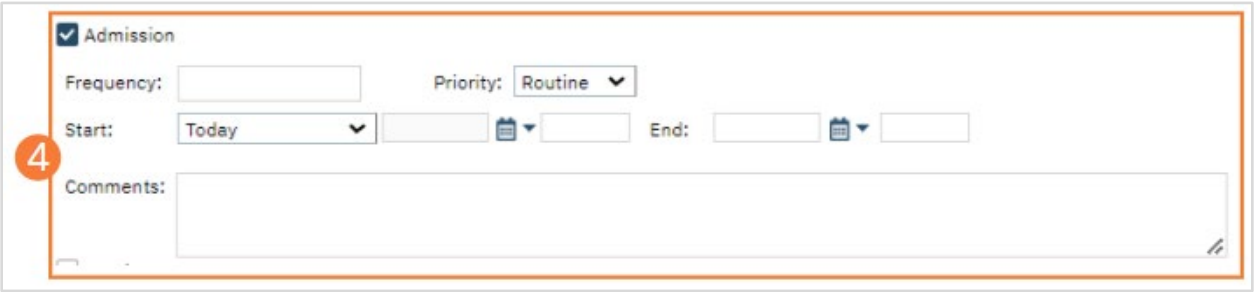
6. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

Prescriber: How to Document an Admit Order

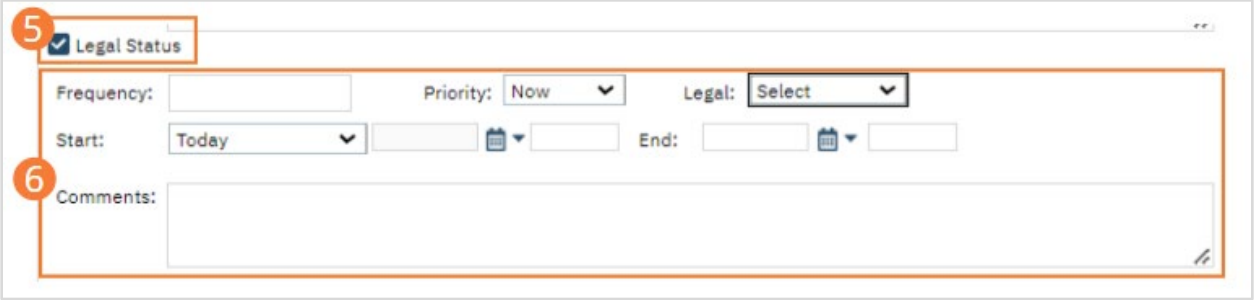
1. **Create a New Order,** using the steps under Order Sets.
2. When selecting the Order Set, **select Admission as the Order type.**
3. **Click the checkbox next to the Admission order.**



4. **Complete all required fields for the Admission order**.
   a) Set Frequency to "Once" in the dropdown. Other fields are optional.

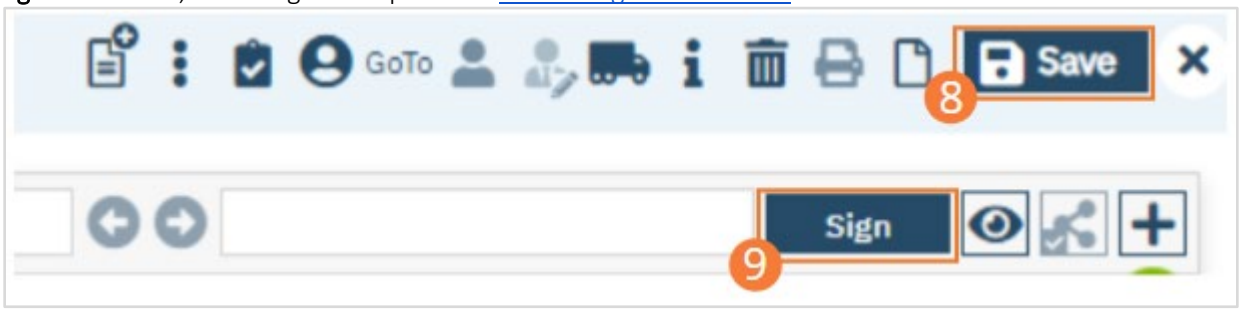


5. **Click the checkbox next to the Legal Status order**.
6. **Complete all required fields for the Legal Status order.**
   a) Be sure a status is selected under the Legal dropdown.



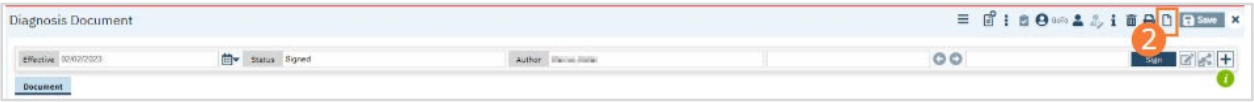
7. **Select the Insert button.** The Orders will be added to the Order List.

8. **Click the Save button.**
9. **Sign the Orders**, following the steps under How to Sign a Document.

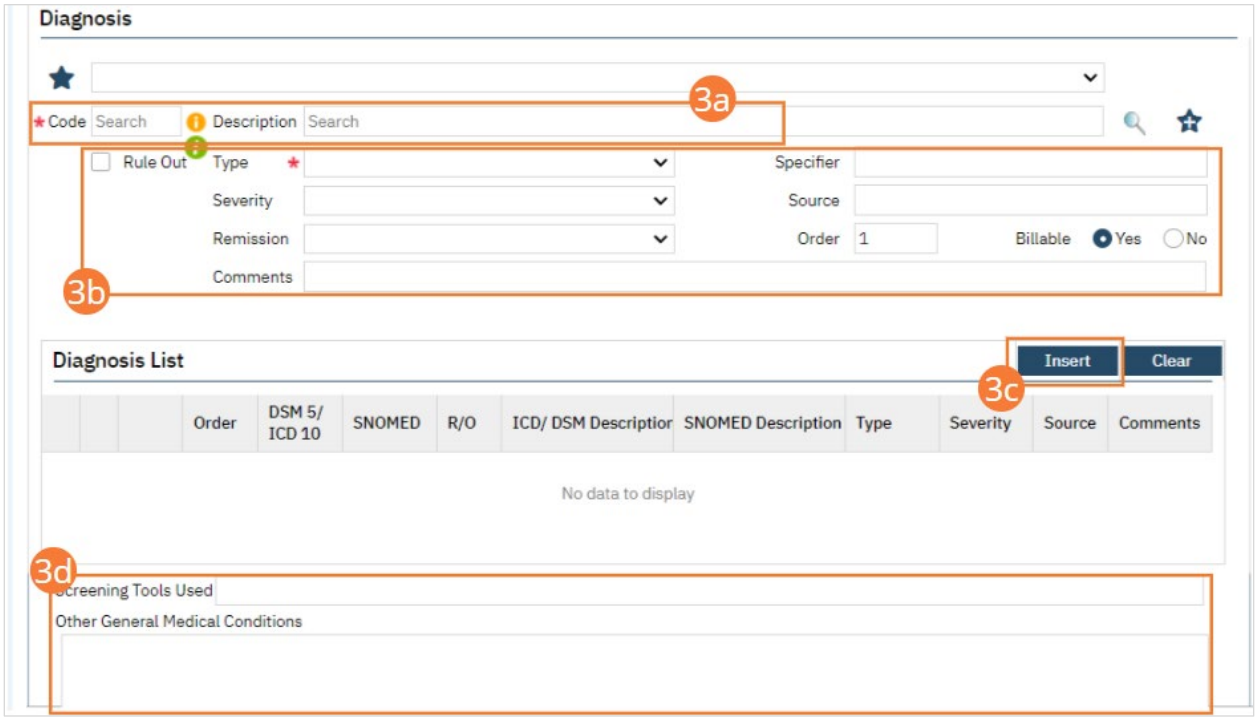


How to Document the Admit Diagnosis

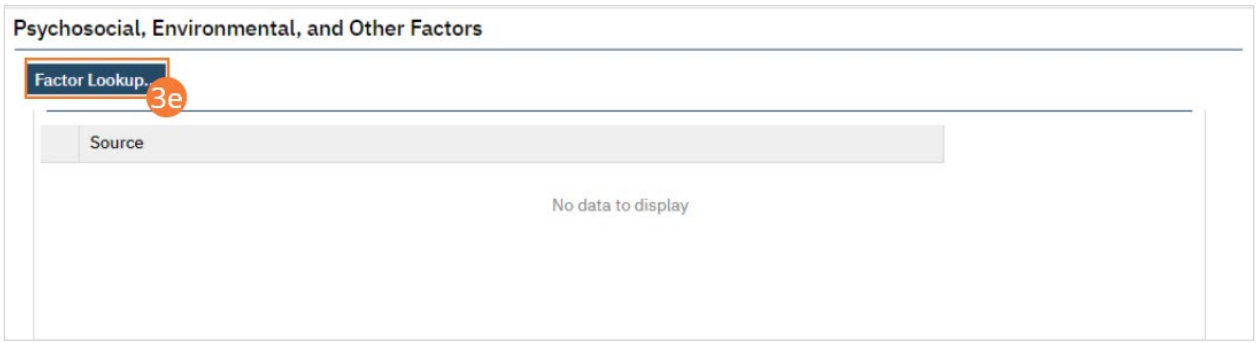
1. Begin on the Diagnosis Document page.
2. **Select the New icon**. A new Diagnosis Document will open.



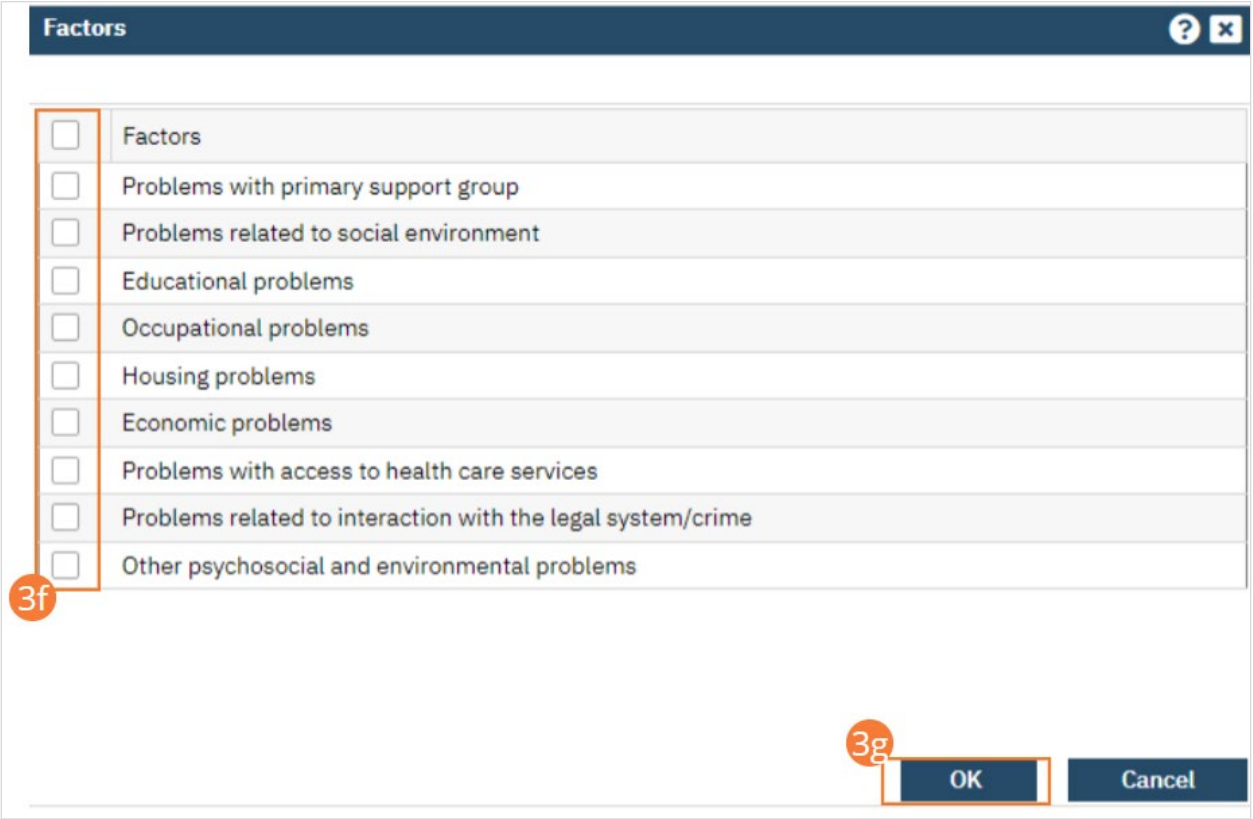
3. **Complete required fields.**
    a. Search for a diagnosis code or description. Select the chosen diagnosis from the dropdown that appears when you begin entering text. If no diagnosis was determined, select the No Diagnosis checkbox and skip to Step 3e.
    b. Select a Type, Severity, and Remission status from the dropdowns. Enter a specifier and source in the text boxes.The Source should be the Prescriber on whose behalf the document is completed. If desired, change the order numeral, change the Billable radio button, and/or set the diagnosis as a Rule Out by selecting the checkbox.
    c. Click the Insert button. The diagnosis will be added to the Diagnosis List.
    d. Type text into the Screening Tools Used and Other General Medical Conditions fields.



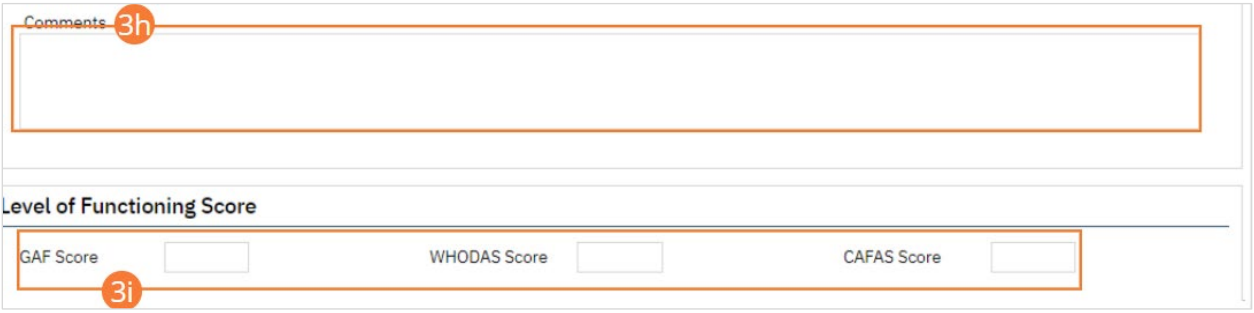
e. In the Psychosocial, Environmental, and Other Factors section, click the Factor Lookup button. A pop-up will appear.



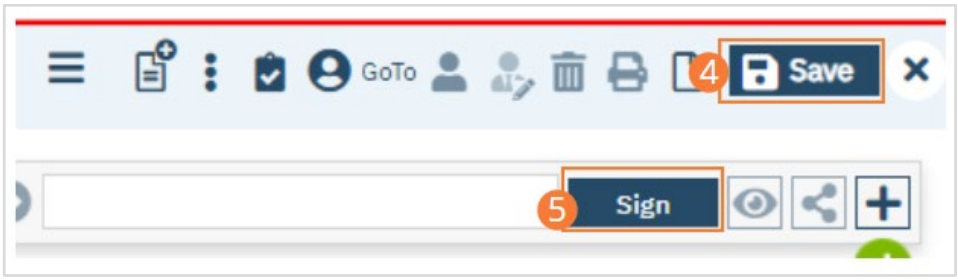
f. Select any or all of the checkboxes that apply.
g. Click the OK button.



h. Enter Comments in the text field.
i. If applicable, enter GAF, WHODAS, or CAFAS scores.



4. Click the Save button.
5. Click Sign and complete signature of the document. For more information, see How to Sign a Document.

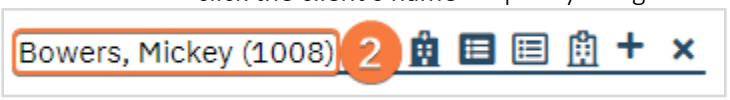


Intake - First Tasks

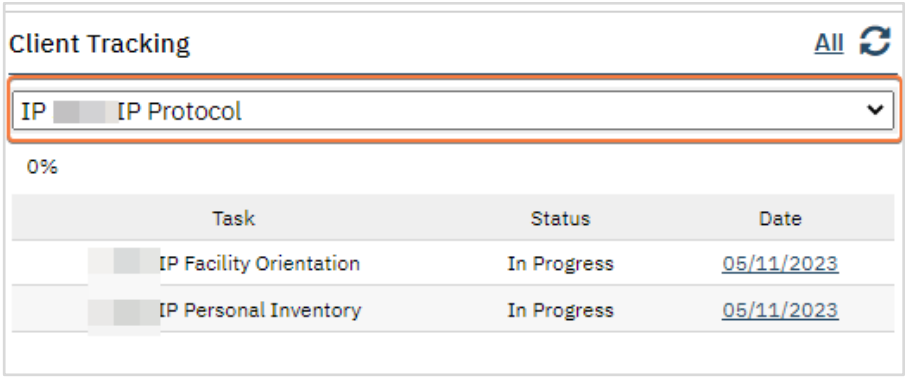
How to View What Intake Documents and Tasks Need to be Completed

Intake documents are set up through Tracking Protocols by your system administrator. If a protocol is set up the specifics of what you will see are likely different then what is displayed in the screenshot.

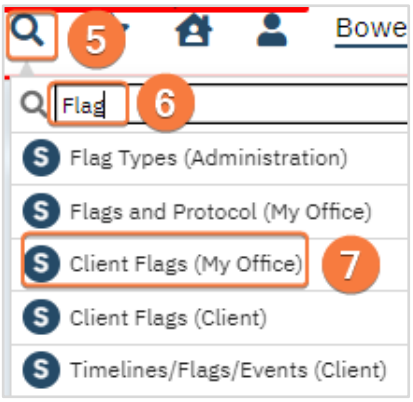
1. You must first have the client open, then **click the Search icon**.
    a. For directions opening a client see General Client Search section.
2. If you are not on the Client Dashboard **click the client's name** to quickly navigate to the Client Dashboard.



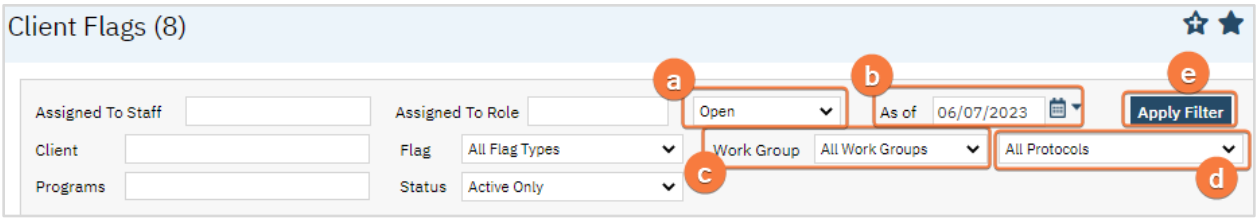
3. Navigate to the "Client Tracking" Widget and **select the protocol from the dropdown menu**.
    a. This shows you all the flags (tasks) associated with that program.



4. Flags, associated with a protocol, but across clients can be seen through Flags (My Office).
5. **Click on the Search icon**.
6. **Type Client Flags**.
7. **Select Client Flags (My Office)**.



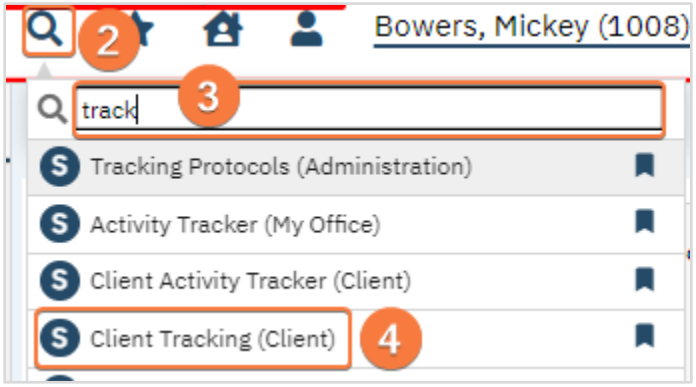
8. Once you are in the list page utilize your filters to identify your due items.
9. Recommended filters to use:
    a. **Select Open from the dropdown.**
    b. **Enter current date in the As of field.**
    c. **Select the work group from the dropdown**.
    d. If you want to limit it to a specific protocol, **select protocol from the dropdown**.
    e. **Click Apply Filter**.
    f. To reduce setting filters used regularly see How to Save Filters section.



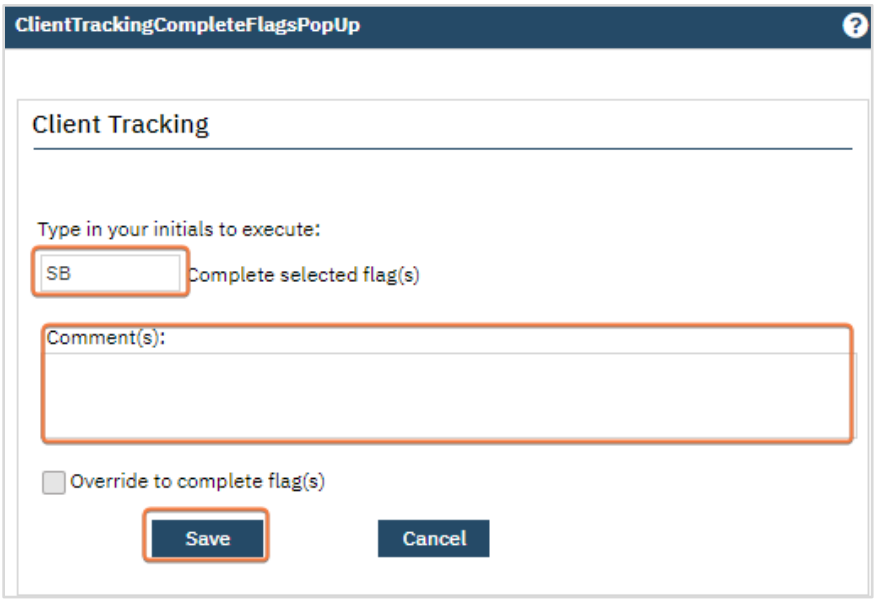
How to Complete Intake Documents Done in SmartCare

Documents, which are associated with flags (which are associated with protocols) are typically associated with a due date and sometimes are recurring. To complete the document, and the flag, follow the steps below.

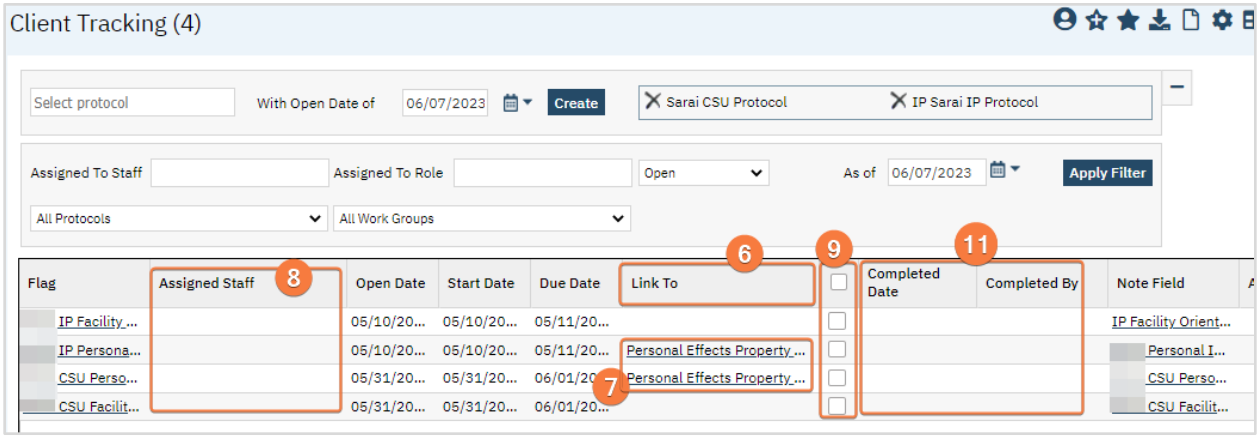
1. You must first have the client open, then **click the Search icon**.
    a. For directions opening a client see General Client Search section.
2. **Click on the Search icon**.
3. **Type Client Tracking**.
4. **Select Client Tracking (Client)**.



5. The list page will show you all flags associated with a protocol including the due dates.
    a. Reference Utilizing List Pages section to ensure your filters are displaying the correct information.
6. Associated documents will display in the Link To column.
7. **Click the document link** to open the document.
8. If you were listed as an assigned staff and you are within the window to complete the document, the flag will automatically complete.
9. If you are not an assigned staff, **click on the checkbox**.
10. You will see a pop-up window. **Enter your initials, add comments** if needed and **Click Save**.



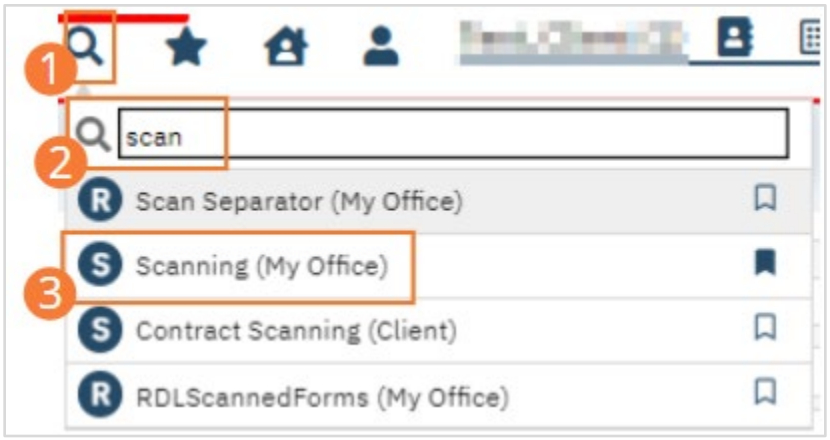
11. Step 8 and 9-10 will add a Complete Date and Completed By with the current date and your name.
    a. The flag may no longer be visible on the list page once it's complete due to the filter settings.



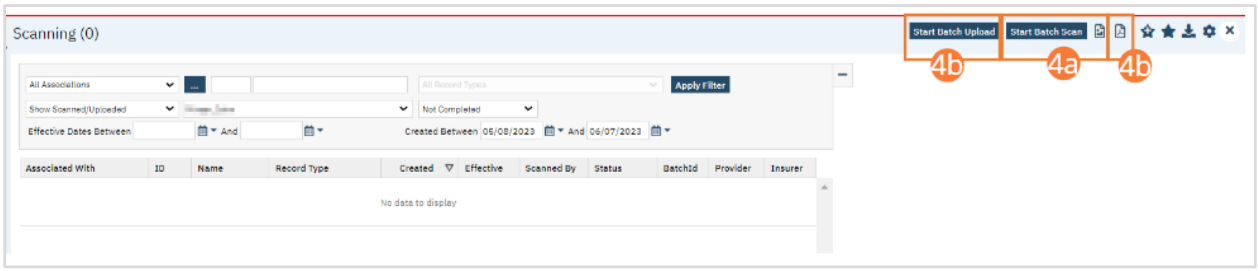
How to Scan/Upload Intake Documents Done Outside of SmartCare

Lab results received from an external source are scanned into the client's documentation using the Scan/Upload feature.

1. Click the Search icon.
2. Type "Scan" into the search bar.
3. Click to select Scanning (My Office). The Scanning list page will open.



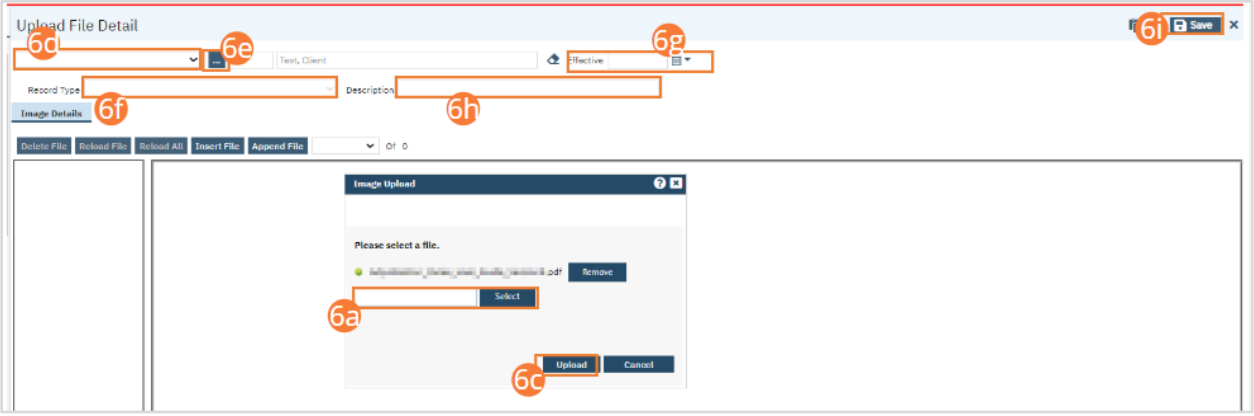
4. Select the icon for the type of document import you wish to perform.
    a. Scan and Batch Scan use scanning hardware to convert paper documents into electronic images and import them into SmartCare.
    b. Upload and Batch Upload take existing electronic files and import them into SmartCare.



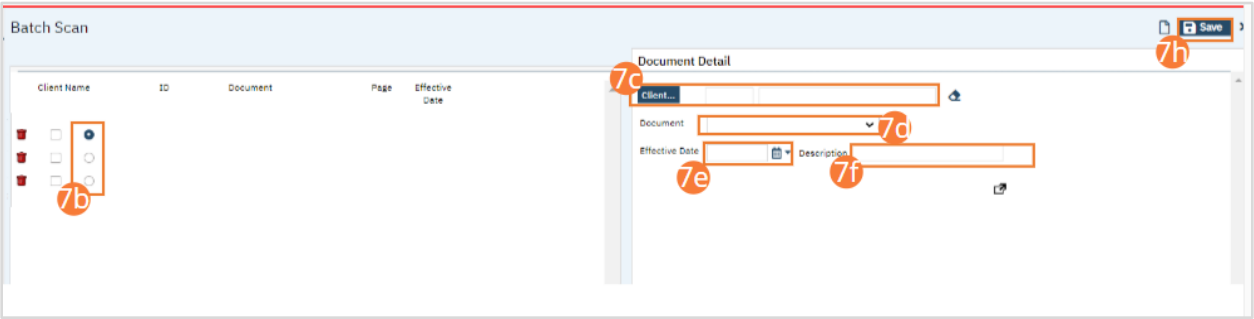
5. If you selected Scan, the Scan page will open.
    a. Your scanning hardware will initialize. Follow organizational workflows to operate your scanning hardware.
    b. An image will display in the center pane when a file has been successfully scanned.
    c. Select a record option from the dropdown.
    d. Click the '...' button to perform a client search using the steps found under How to Search for a Client. This step will be skipped, and a client will be pre-selected, if you opened Scanning (My Office) with an active client. In this cases, select the '...' button to change active clients.
    e. Select a record type from the dropdown.
    f. Set an effective date.
    g. Type a Description into the text field.
    h. Click Save.

6. If you selected Upload, the Upload pop-up will open.
    a. Click Select.
    b. Select your desired file from your computer file browser.
    c. Click Upload. An image will display in the center pane.
    d. Select a record option from the dropdown.

e. Click the '...' button to perform a client search using the steps found under How to Search for a Client. This step will be skipped, and a client will be pre-selected, if you opened Scanning (My Office) with an active client. In this cases, select the '...' button to change active clients.
f. Select a record type from the dropdown.
g. Set an effective date.
h. Type a Description into the text field.
i. Click Save.

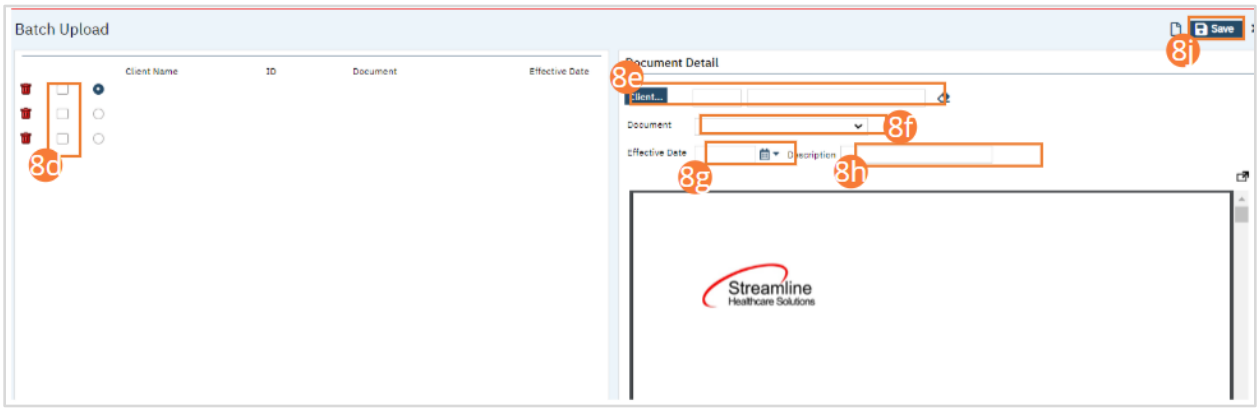


7. NOTE: Before selecting Batch Scan, you will need to print one or more Scan Separators from the Scan Separator (My Office) page. One Separator should be placed between two documents to signal to the system that they should be treated as separate. If you selected Batch Scan, the Batch Scan page will open.
   a. Your scanning hardware will initialize. Follow organizational workflows to operate your scanning hardware. Ensure a Scan Separator is placed between each set of documents.
   b. On the left, you will see multiple documents listed. Select the radio button beside one to display it.
   c. Click the Client button to perform a client search using the steps found under General Client Search.
   d. Select a record type from the dropdown.
   e. Set an effective date.
   f. Type a Description into the text field.
   g. Repeat Steps 7b-7e for each document scanned.
   h. Click Save.

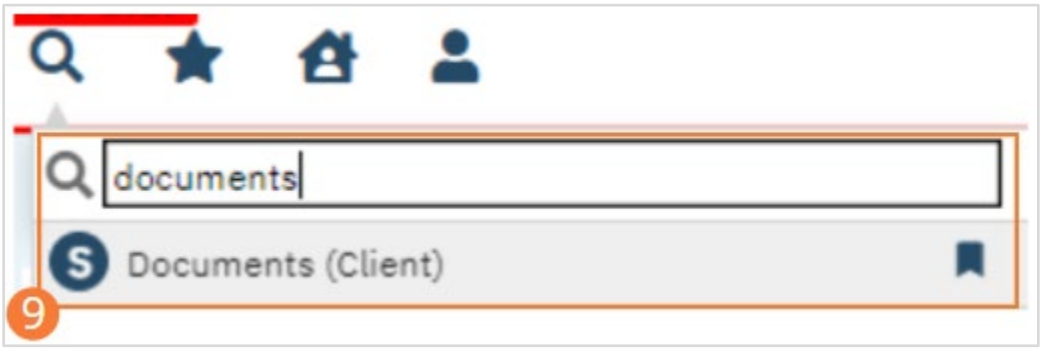


8. If you selected Batch Upload, the Batch Upload window will open.
   a. Click Select.
   b. Select your desired files from your computer file browser. The Batch Upload function supports multiple selections.
   c. Click Upload.

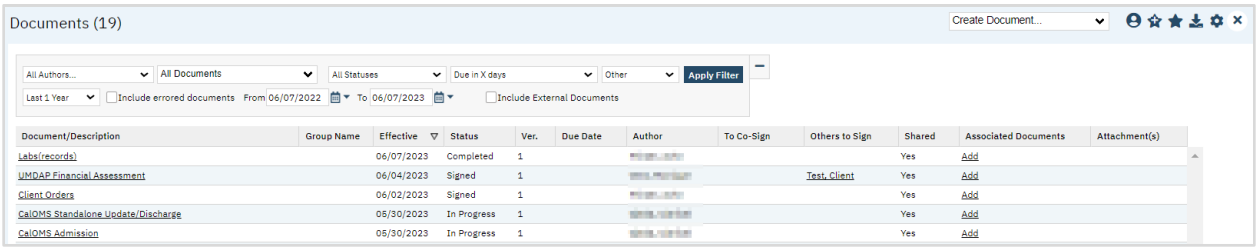
d. On the left, you will see multiple documents listed. Select the radio button beside one to display it.
e. Click the Client button to perform a client search using the steps found under General Client Search.
f. Select a record type from the dropdown.
g. Set an effective date.
h. Type a Description into the text field..
i. Repeat Steps 8d-8h for each document scanned.
j. Click Save.



9. After Saving your associated documents, Search for the Documents (Client) screen and select it.



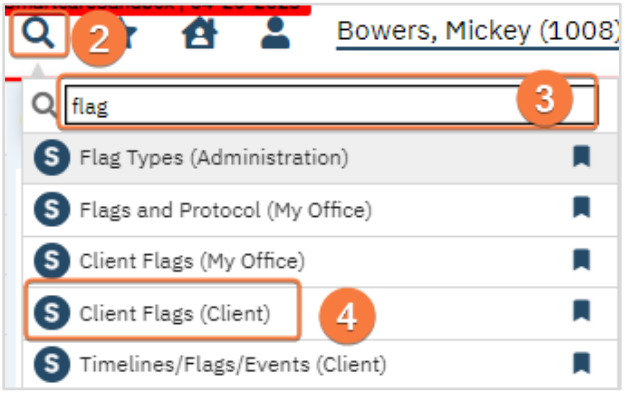
10. Review the documents scanned/uploaded here. If necessary, click the Add hyperlink in the Associated Documents column to upload new documents that should be associated with the selected document.



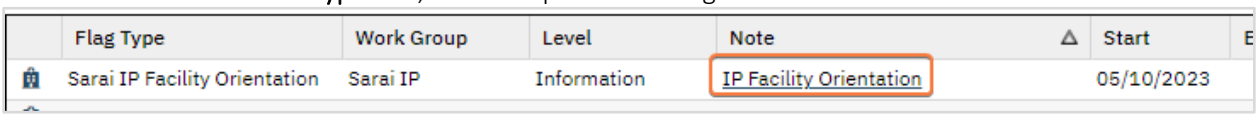
How to Mark a Flag as Complete

If a flag is not associated with a protocol or a document it can be completed manually by completing the steps below.

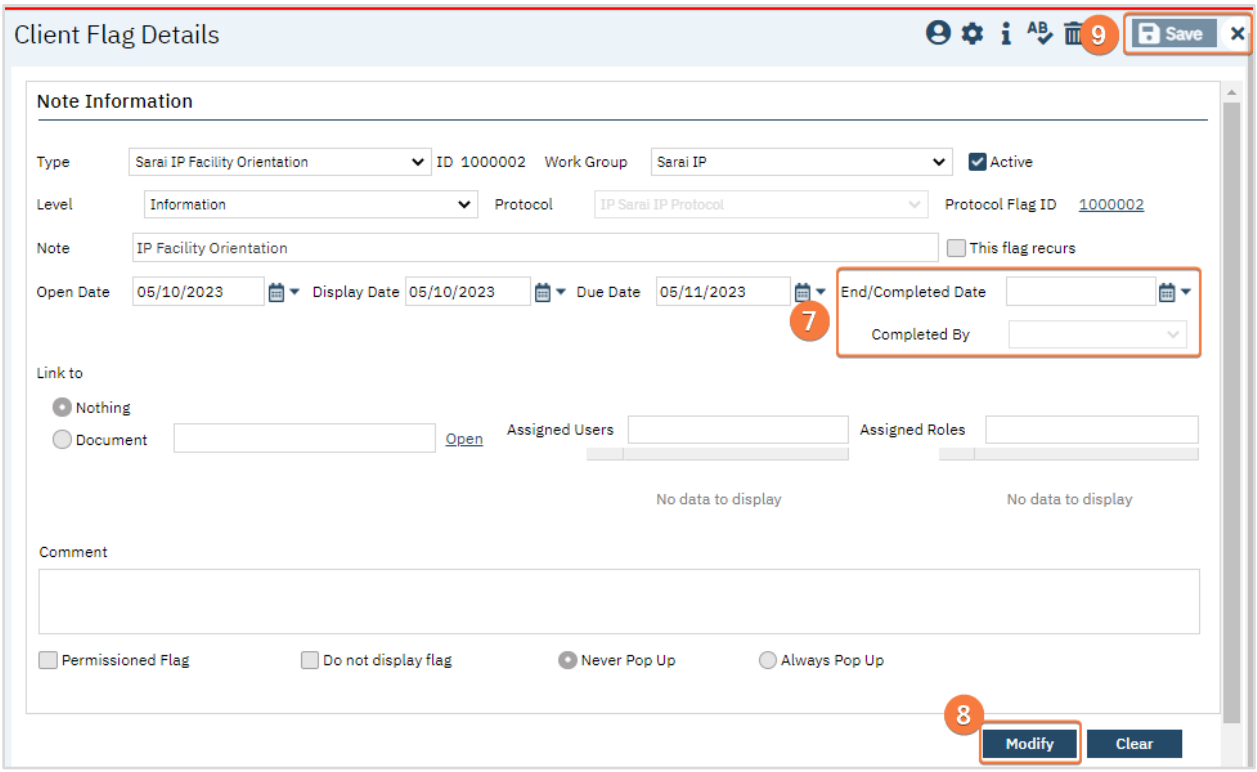
1. You must first have the client open, then **click the Search icon**.
    a. For directions opening a client see General Client Search section.
2. **Click on the Search icon**.
3. **Type Client Flags**.
4. **Select Client Flags (Client)**.



5. Once you are in the List Page use the filters to locate the flag(s) you need to complete.
6. **Click on the Note column hyperlink**, this will open Client Flag Details.



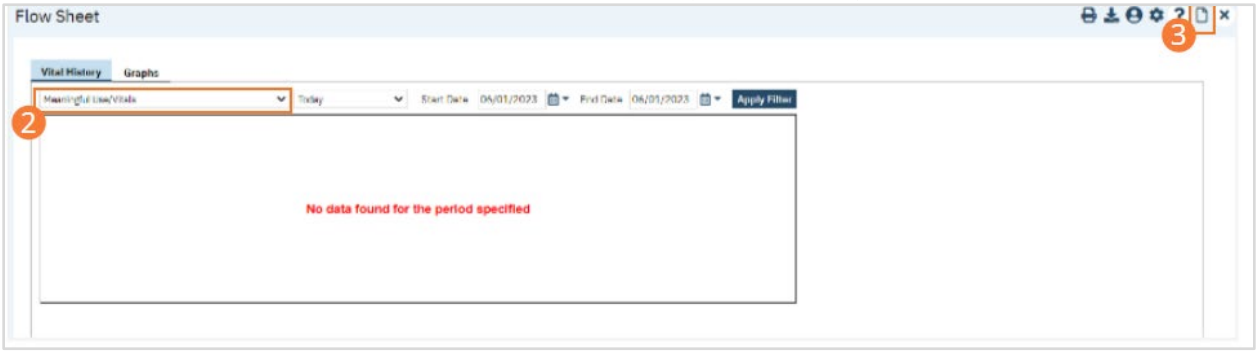
7. **Enter the End/Completed Date and the Completed By field**.
8. **Click the Modify button**. This marks the flag as complete.
9. **Click Save and close** icons in the tool bar.



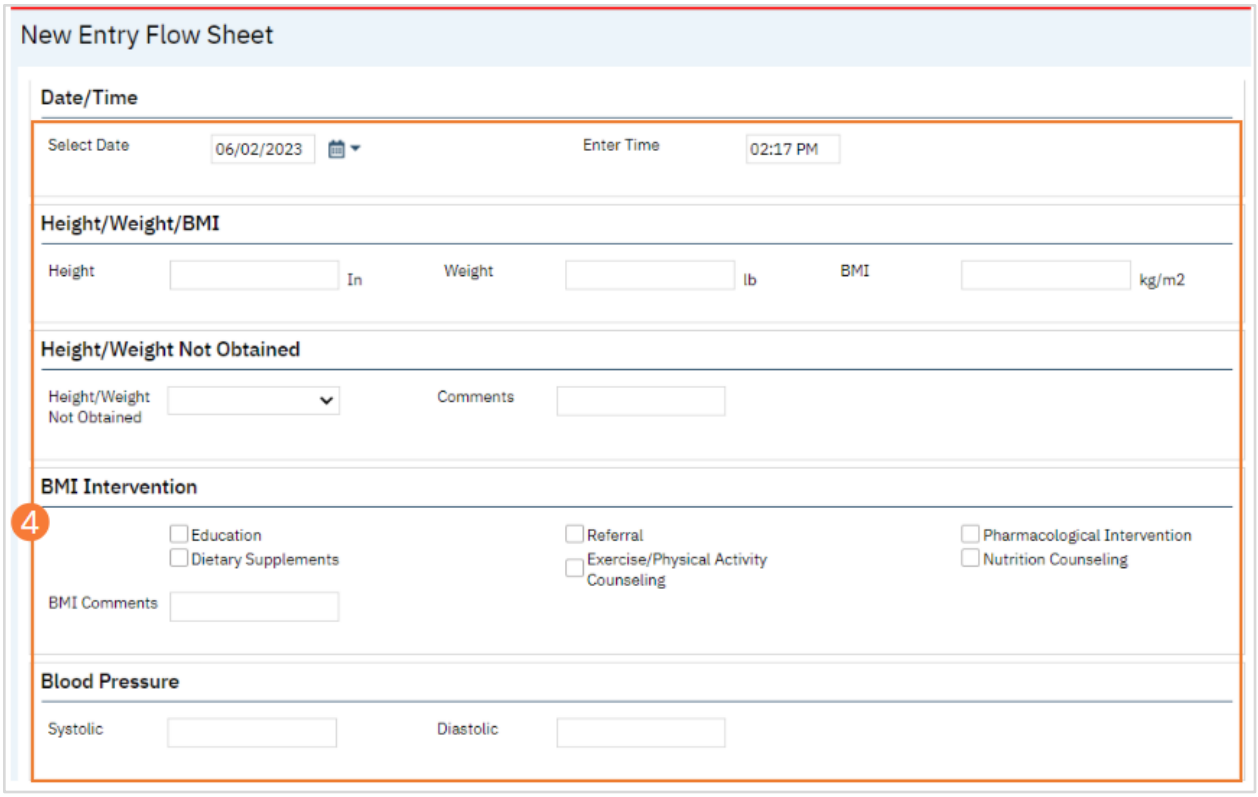
10. Repeat steps 6-9 as needed.

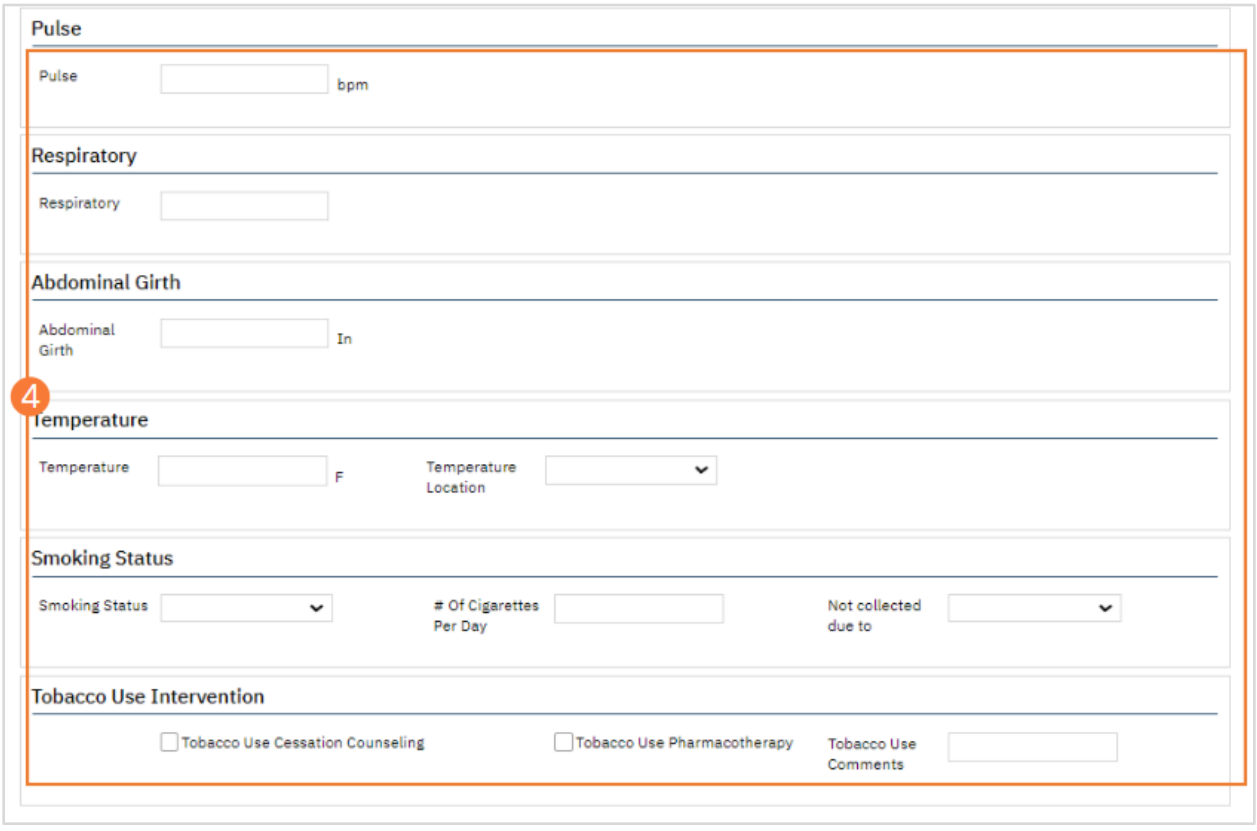
How to Document Vitals

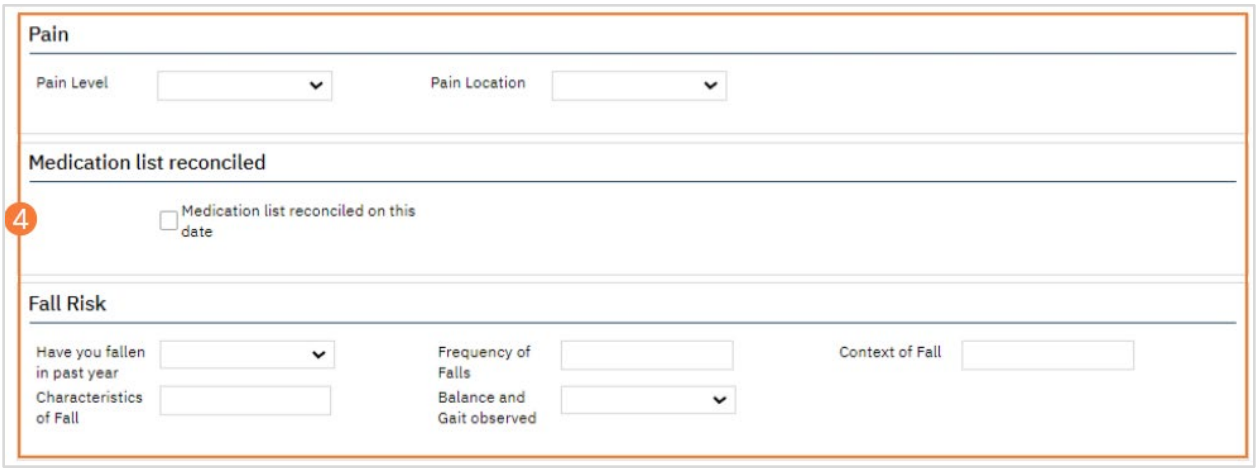
1. With an active client selected, begin on the Flow Sheets page.
    a. See How to See Flow Sheets for an Active Client for details.
2. **Select the Vitals Flow Sheet template from the dropdown**.
3. **Click the New icon in the tool bar.** A Vitals Flow Sheet Entry screen will open.



4. **Perform necessary clinical examinations and record results.** Check boxes beside present findings, select options from dropdowns, and type text into appropriate fields. For most flow sheets, you can skip fields for examinations you did not perform or information you do not have. In some cases (for example, if height/weight was not obtained during Vitals), you should record a reason for why the information was not entered.

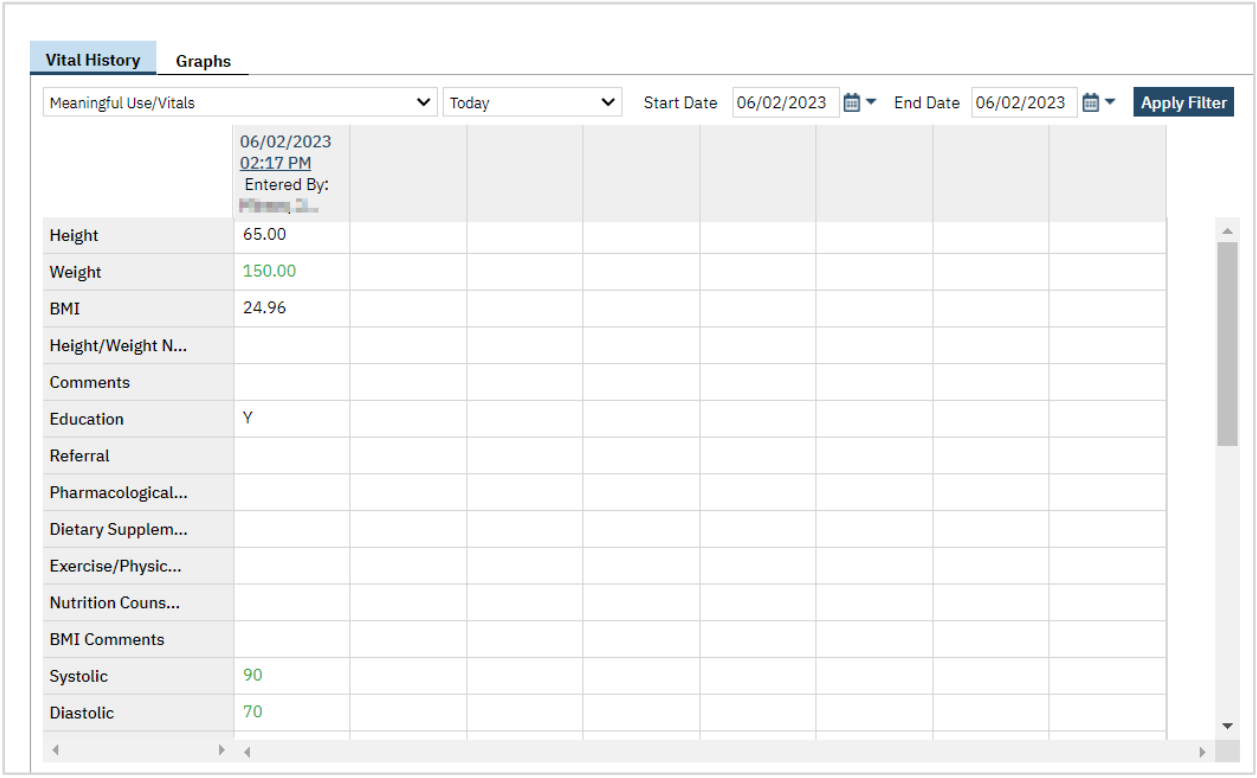

New Entry Flow Sheet
Date/Time
Select Date
06/02/2023
Enter Time
02:17 PM
Height/Weight/BMI
Height
In
Weight
lb
BMI
kg/m2
Height/Weight Not Obtained
Height/Weight Not Obtained
Comments
BMI Intervention
4
Education
Dietary Supplements
Referral
Exercise/Physical Activity Counseling
Pharmacological Intervention
Nutrition Counseling
BMI Comments
Blood Pressure
Systolic
Diastolic


Pulse
Pulse
bpm
Respiratory
Respiratory
Abdominal Girth
Abdominal Girth
In
4
Temperature
Temperature
F
Temperature Location
Smoking Status
Smoking Status
Of Cigarettes Per Day
Not collected due to
Tobacco Use Intervention
Tobacco Use Cessation Counseling
Tobacco Use Pharmacotherapy
Tobacco Use Comments



5. Click the Save button in the tool bar.
6. Click the Close icon in the tool bar. The newly recorded information will appear in the central section of the Flow Sheets page.

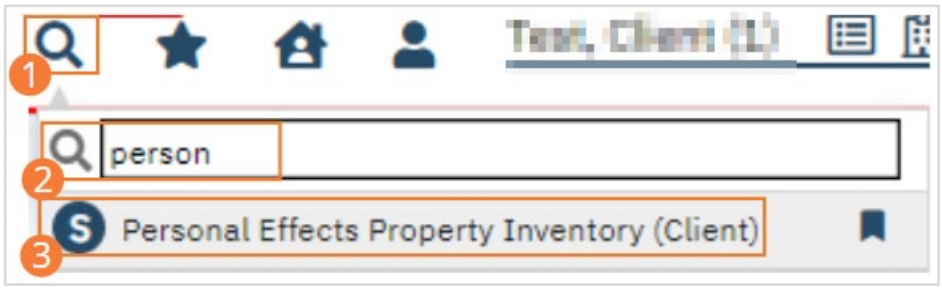
7. You will now see your entry in the Flow Sheet screen.
    a. This is dependent on Filters.



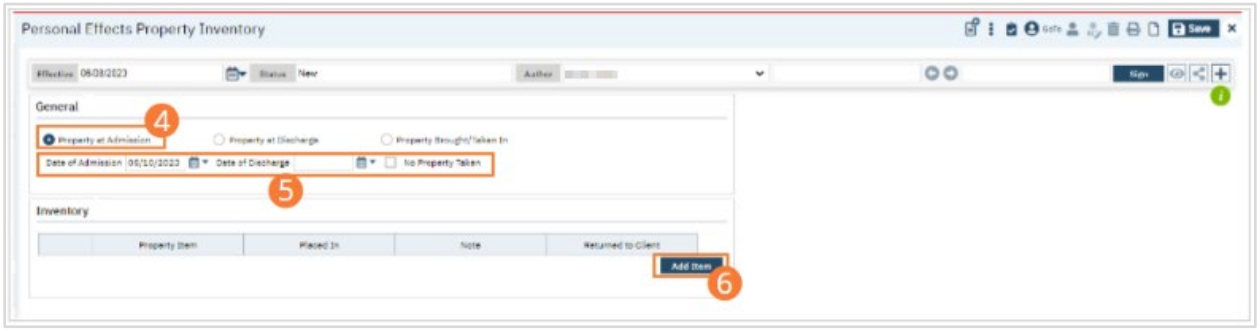
How to Complete the Personal Effects Inventory (PEI)

The PEI at admission represents a record of belongings kept by the organization, as well as a record of belongings returned to the client during their admission. It is later referenced during Discharge when items are returned to clients.

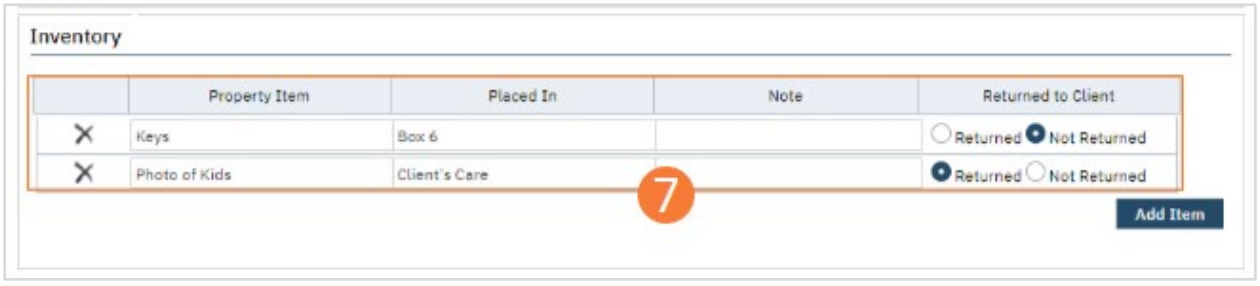
1. With an active client selected, **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type "Personal"** into the search bar.
3. **Click to select Personal Effects Property Inventory (Client).** The PEI list page will open.



4. **Click Property at Admission.**
5. The Date of Admission will populate with today's date. If you wish to change the date, do so now. If the client has no property to record, click the No Property Taken checkbox now and skip down to the Save step.
6. **Click Add Item**. A series of fields will appear in the Inventory section.



7. Record the Property Item, where it was placed, and any notes in the text fields. Record whether it was returned to the client at admission.

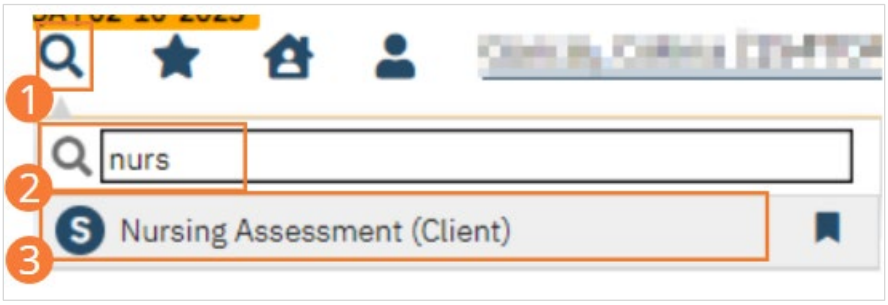


8. Click Add Item and repeat Step 7 for any other items you need to record.
9. **Click Save**.
10. **Click Sign** and complete signature of the document. For more information, see How to Sign a Document.

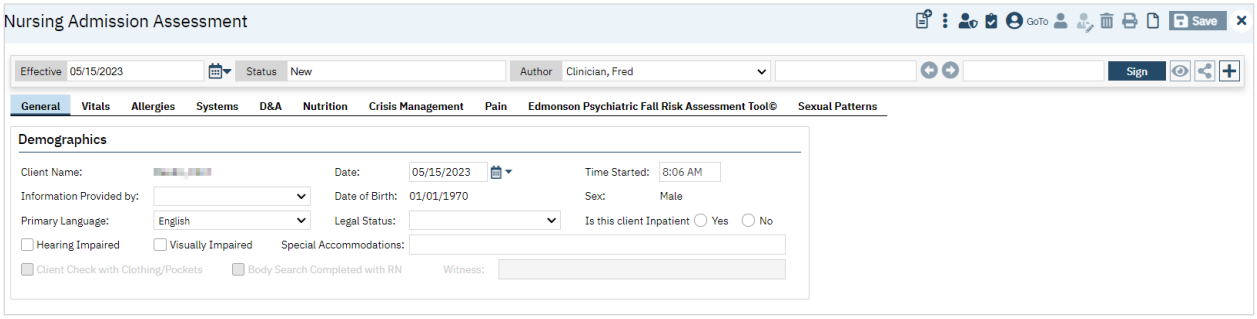
Nurse: How to Complete the Nursing Assessment

How to Display the Nursing Assessment Page

1. With an active client selected, **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type 'Nursing Assessment'** into the search bar.
3. **Click to select Nursing Assessment (Client).**



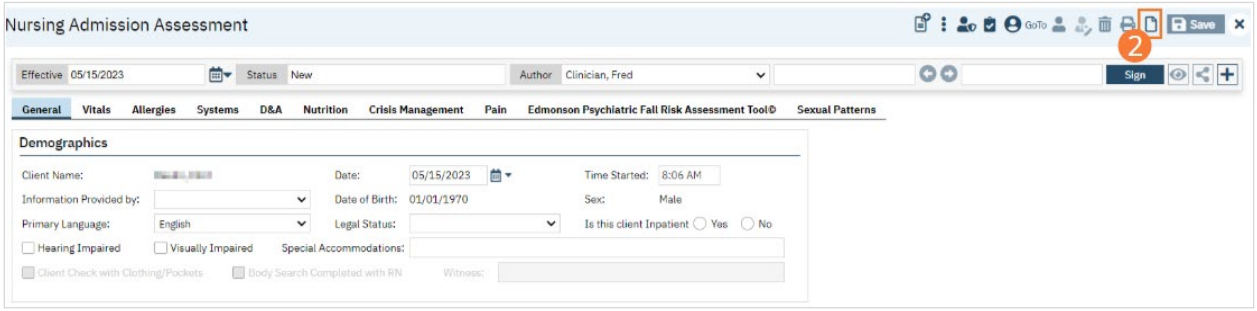
The assessment screen opens.



If a previous assessment exists, a PDF copy of the last completed assessment will be displayed instead.

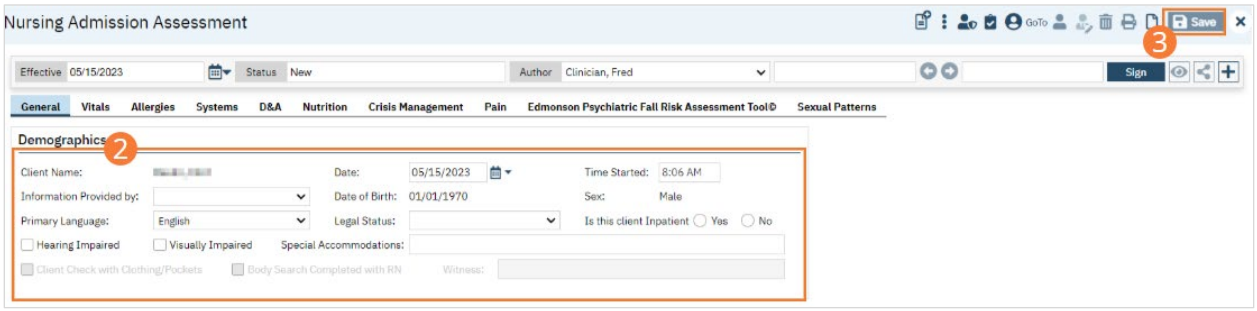
How to Create a New Nursing Assessment

1. Begin on the Nursing assessment page.
2. **Select the New icon**. A new assessment will open.



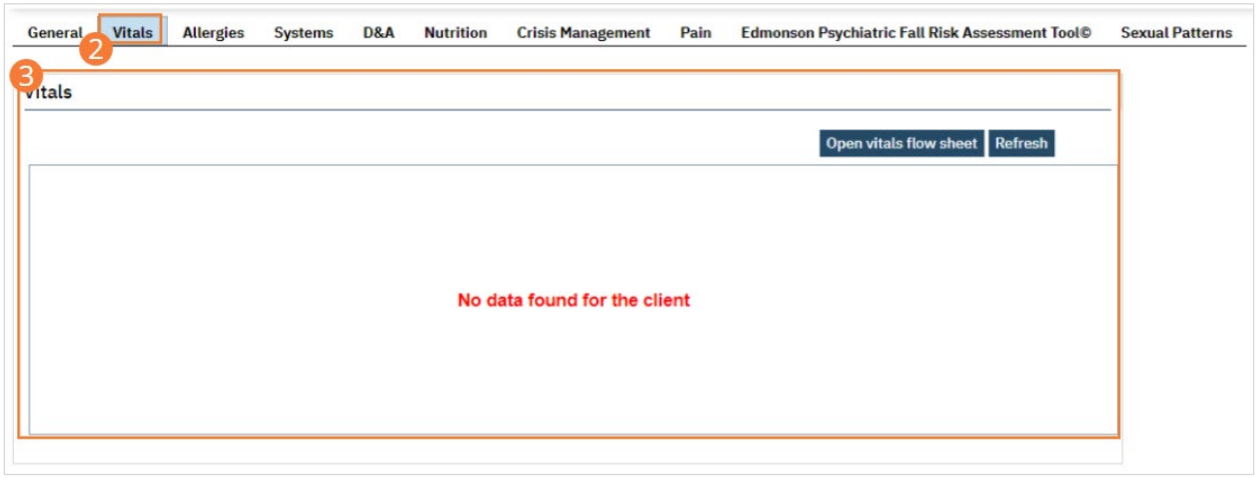
How to Complete the General Tab of the Nursing Assessment

1. Open a new assessment or click to edit an existing assessment. The General tab will open.
2. **Complete the required fields in the Demographics section**. The checkboxes for Client Check with Clothing/Pockets and Body Search Completed with RN, as well as the Witness field, will only initialize if Is this Client Inpatient is set to Yes.
3. **Select the Save icon** and navigate to the next tab.

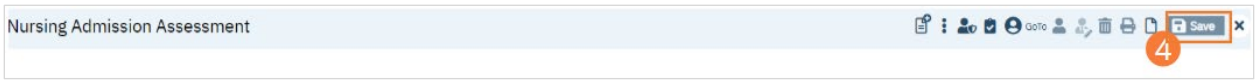


How to Complete the Vitals Tab of the Nursing Assessment

1. Begin on the Nursing Assessment.
2. **Select the Vitals tab**.
3. **Complete required fields in each section** by importing the most recently-completed vitals flow sheet. Click the Open Vitals Flow Sheet button to complete one, if needed. For more information, see Flow Sheets training.

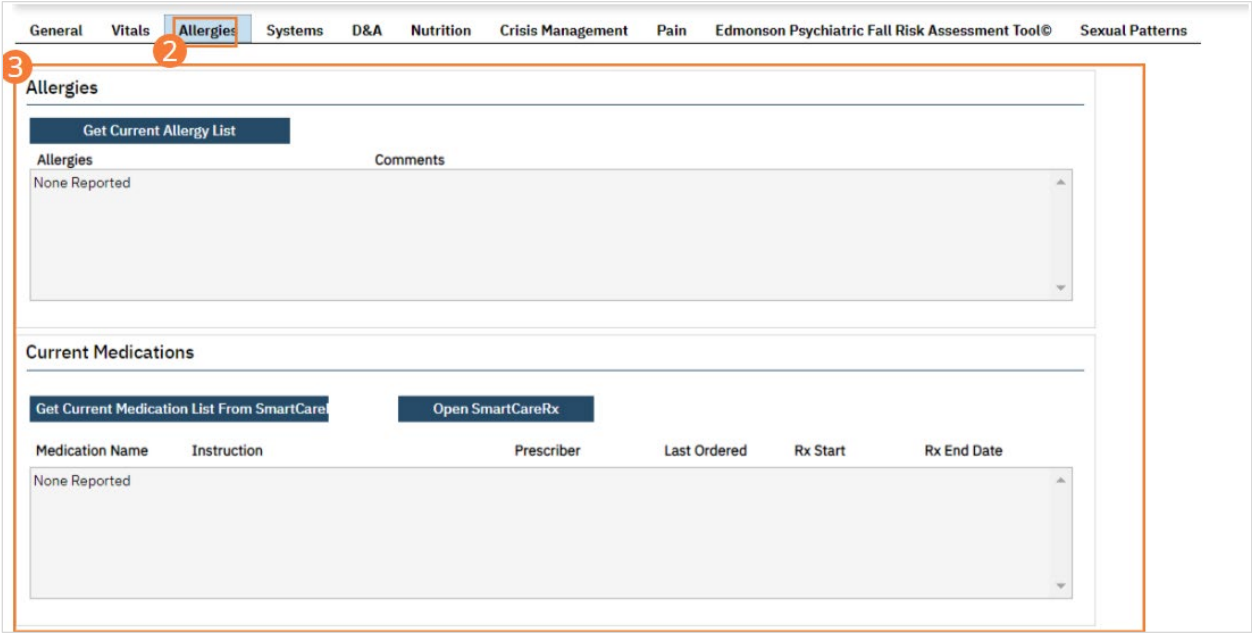


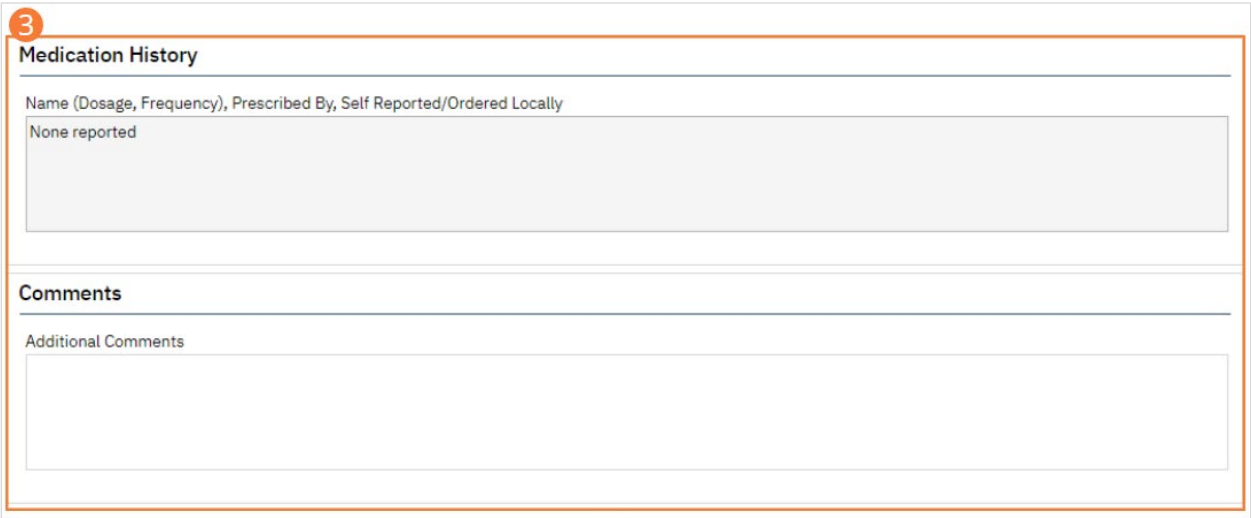
4. **Select the Save icon** and navigate to the next tab



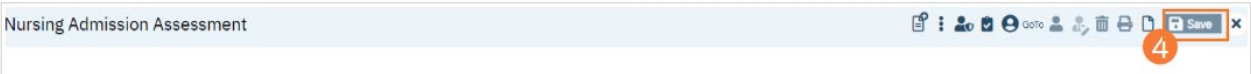
How to Complete the Allergies tab of the Nursing Assessment

1. Begin on the Nursing Assessment.
2. **Select the Allergies tab**.
3. **Complete required fields in each section** by importing Allergies and Current Medications from SmartCare RX. For more information, see SmartCare RX training. Optionally, add comments.



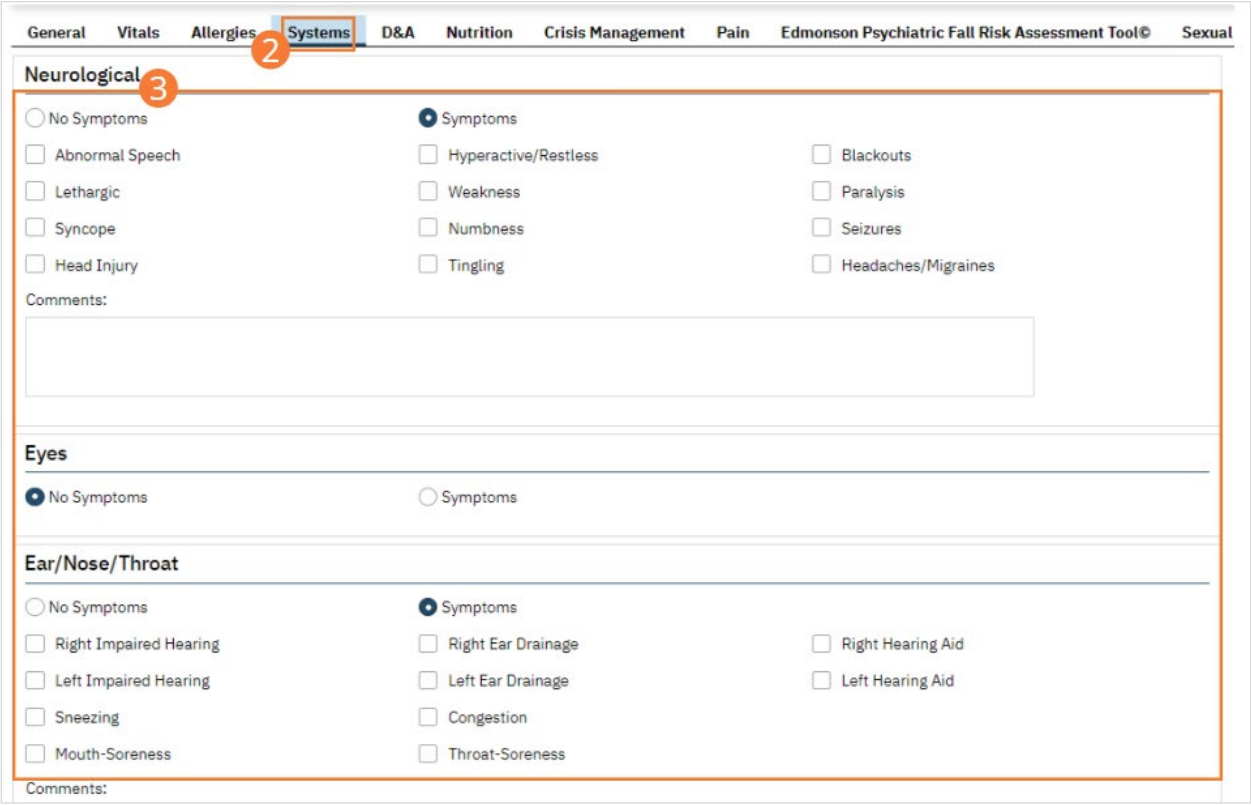


4. **Select the Save icon** and navigate to the next tab.

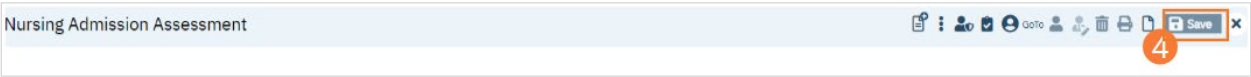


How to Complete the Systems Tab of the Nursing Assessment

1. Begin on the Nursing Assessment.
2. **Select the Systems tab**.
3. **Complete required fields in each section** by selecting a radio button for each system, then selecting relevant checkboxes for each system where symptoms are present. Optionally, complete comments fields.

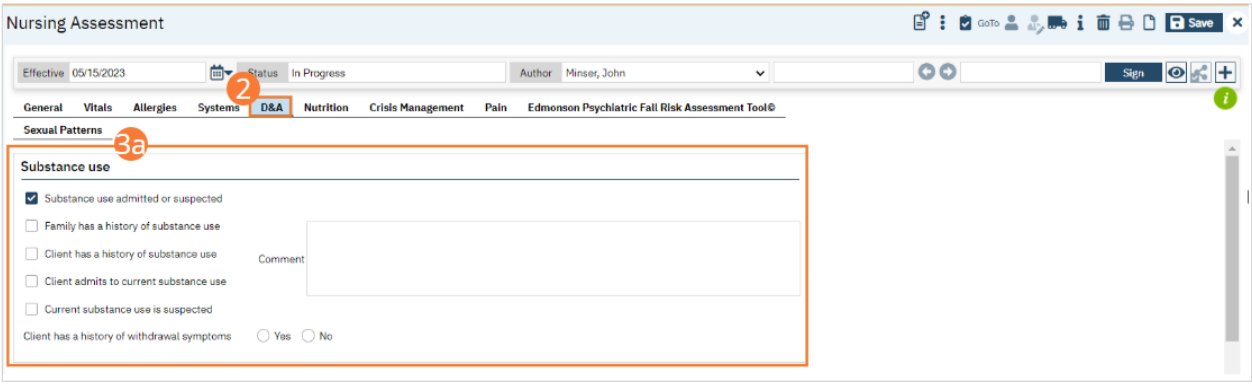


4. Select the Save icon and navigate to the next tab

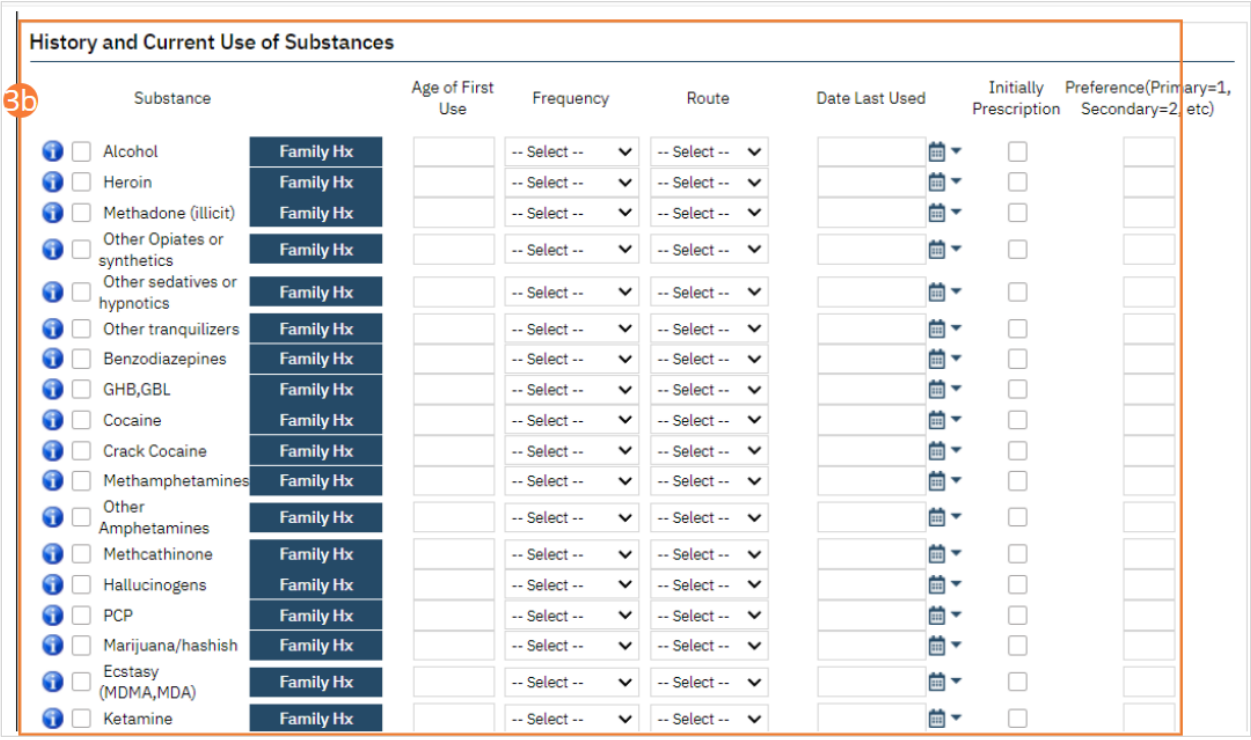


How to Complete the D&A Tab of the Nursing Assessment

1. Begin on the Nursing Assessment
2. Select the D&A tab.
3. Complete required fields in each section.
    a) For the Substance Use section, select a checkbox beside each general statement that the client indicates is true and select a radio button for Client has a history of withdrawal symptoms. Optionally, add comments.



    b) For the History and Current Use of Substances section, select the checkbox beside each drug or drug category the client uses. Select the Family Hx button to add a Family History, if applicable. Type Age of First Use and select a Frequency and Route from the dropdowns. Type or select a Date Last Used, indicate if the drug was initially prescribed by selecting the checkbox for drugs that were initially prescription drugs, and enter a numeral in the Preference field.



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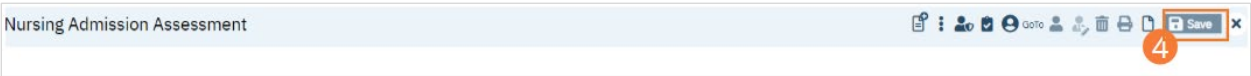
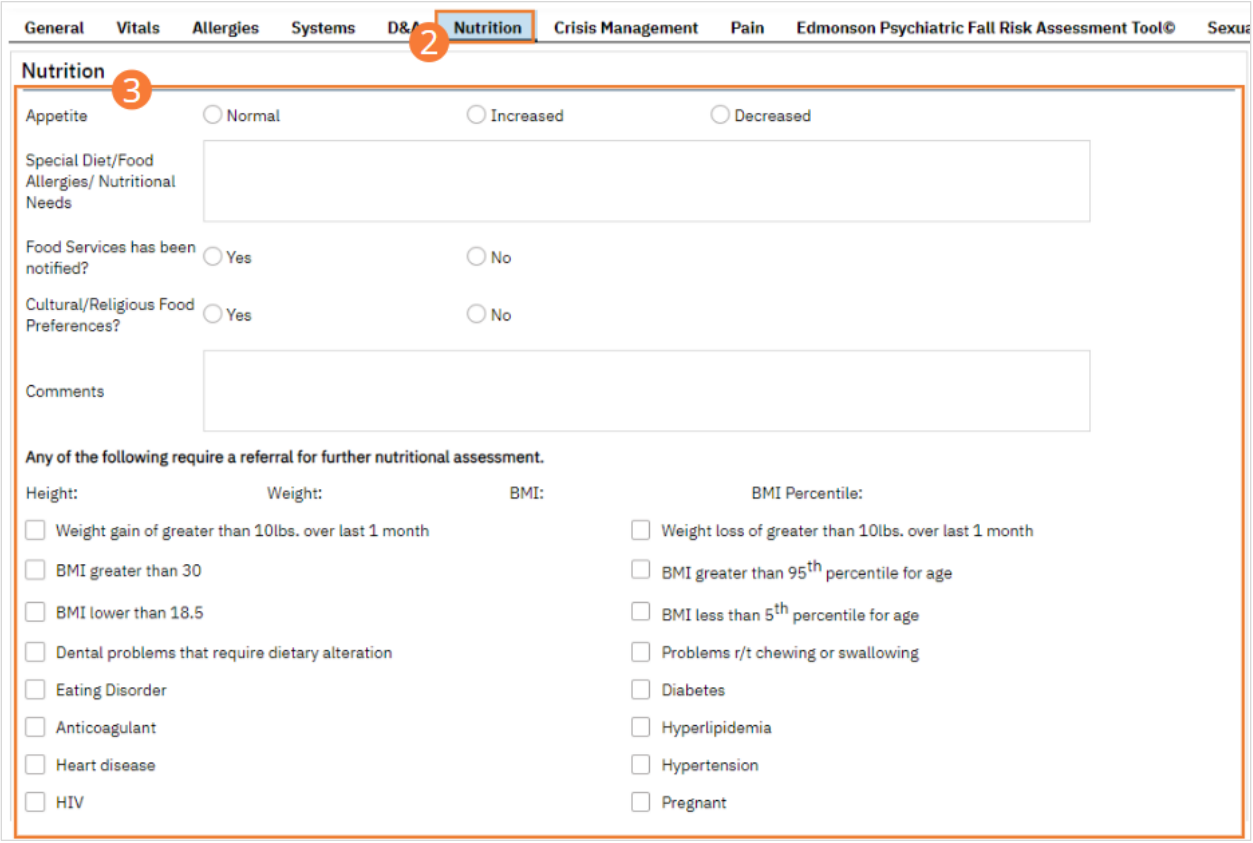
4. Select the Save icon and navigate to the next tab

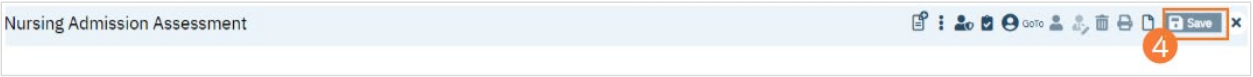


How to Complete the Nutrition Tab of the Nursing Assessment

1. Begin on the Nursing Assessment
2. Select the Nutrition tab.
3. Complete required fields in each section by selecting radio buttons, entering text in text box fields, and selecting checkboxes for appropriate needed referrals.

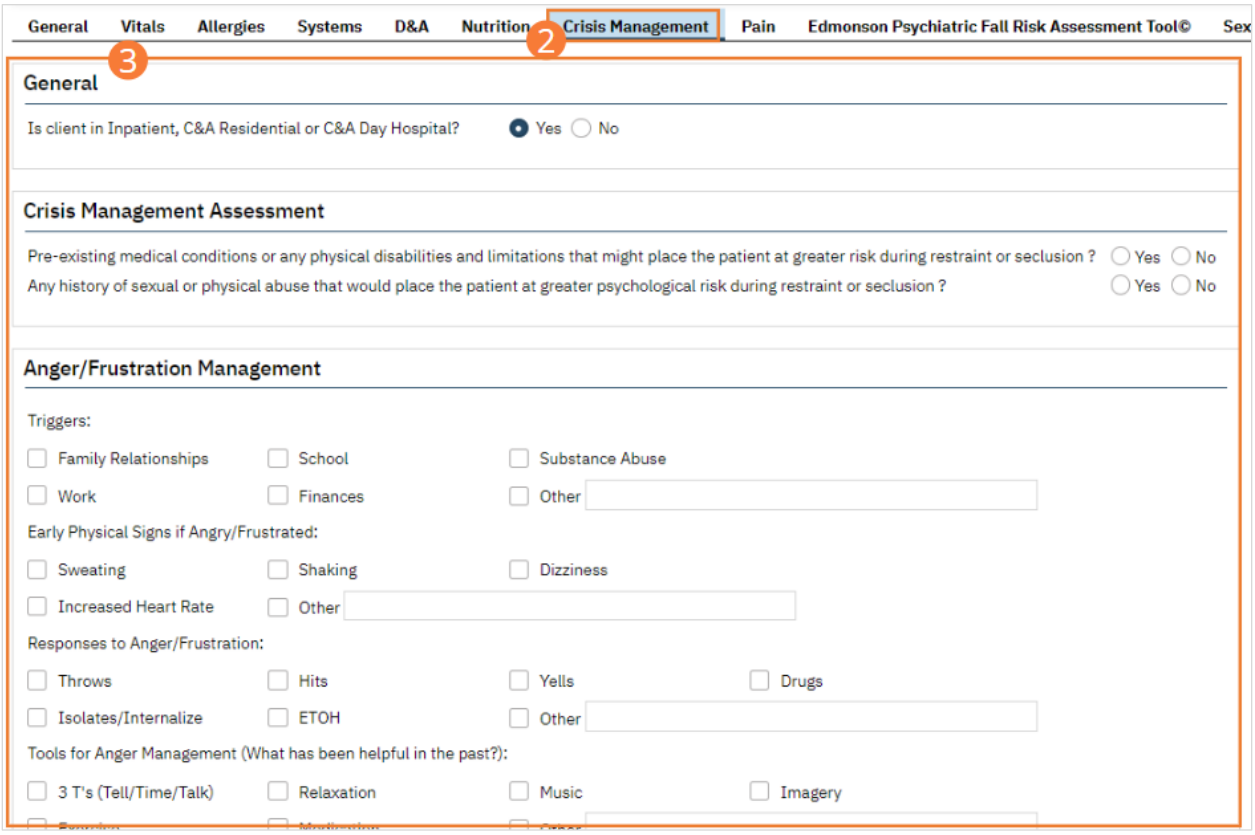


4. Select the Save icon and navigate to the next tab



How to Complete the Crisis Management Tab of the Nursing Assessment

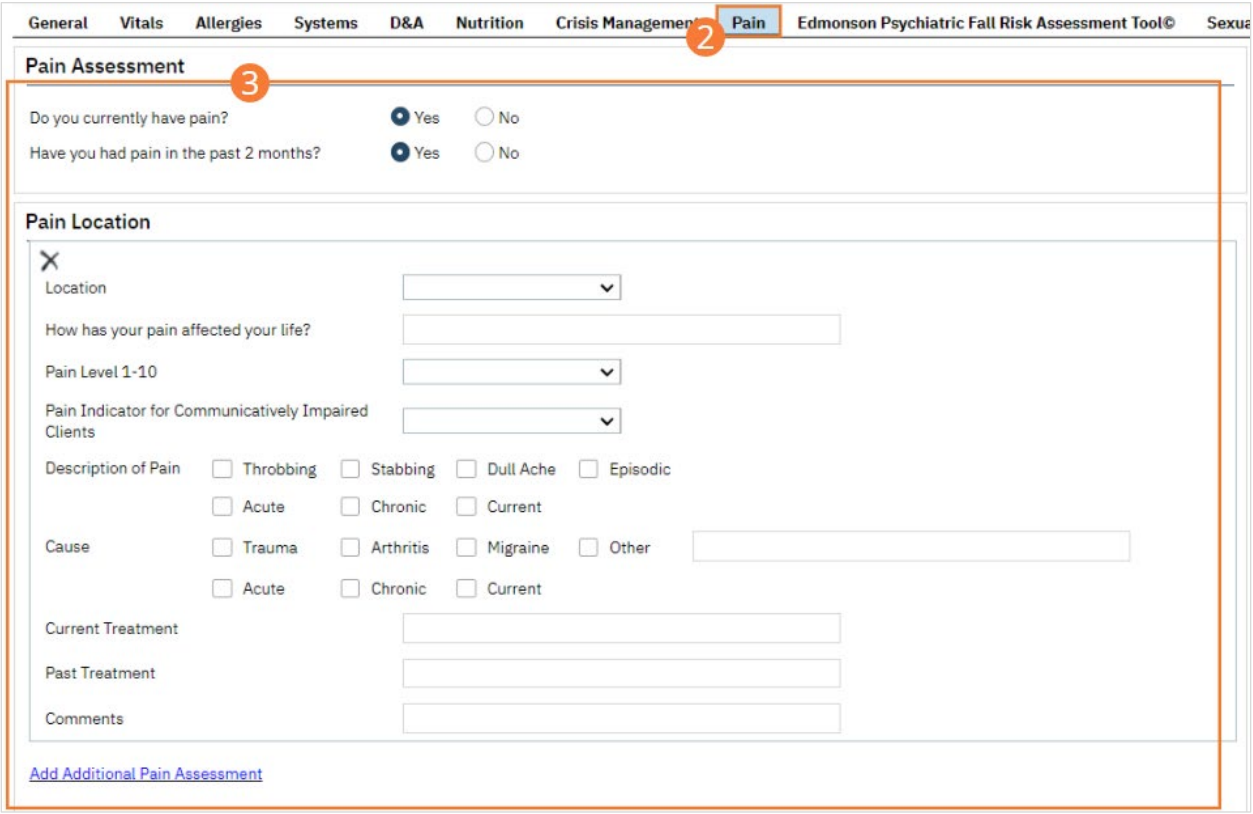
1. Begin on the Nursing Assessment
2. Select the Crisis Management tab.
3. Complete required fields in each section. Fields will only initialize if you set Is client in Inpatient, C&A Residential, or C&A Day Hospital? To Yes. Once initialized, select Radio Buttons, check appropriate checkboxes, and enter comments in comments in text fields where appropriate.



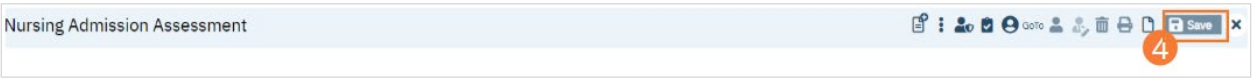
4. Select the Save icon and navigate to the next tab.

How to Complete the Pain Tab of the Nursing Assessment

1. Begin on the Nursing Assessment
2. Select the Pain tab.
3. Complete required fields in each section. Pain Location assessments will only initialize if Yes is selected for either Do you currently have pain? or Have you had pain in the past 2 months? Select from dropdowns, enter text in fields, and select appropriate checkboxes.

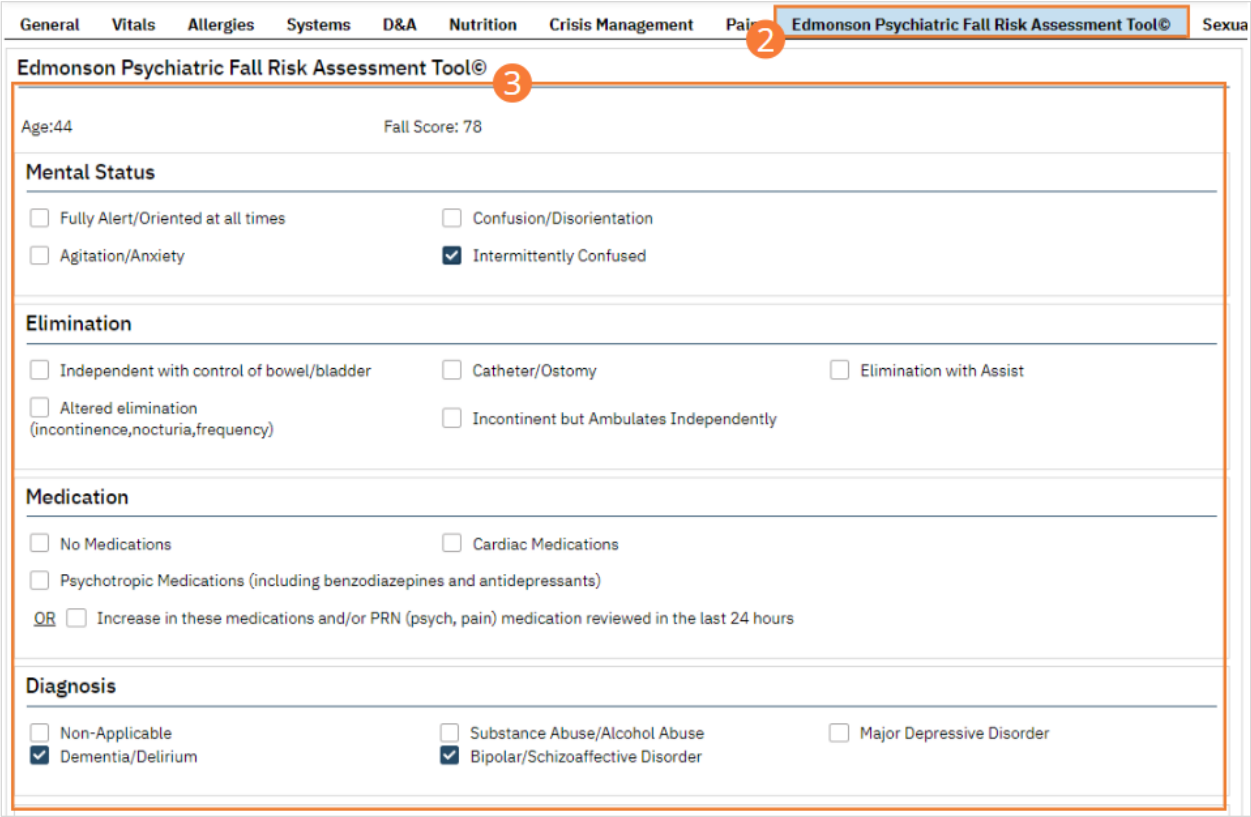


4. Select the Save icon and navigate to the next tab.

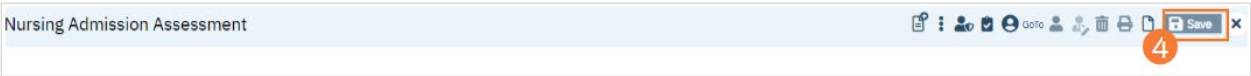


How to Complete the Edmonson Psychiatric Fall Risk Assessment Tool Tab of the Nursing Assessment

1. Begin on the Nursing Assessment
2. Select the Edmonson Psychiatric Fall Risk Assessment Tool tab.
3. Complete required fields in each section. Select all applicable checkboxes. The score will update automatically at the top of the assessment tool.
    a. A score over 90 indicates a risk of falling.

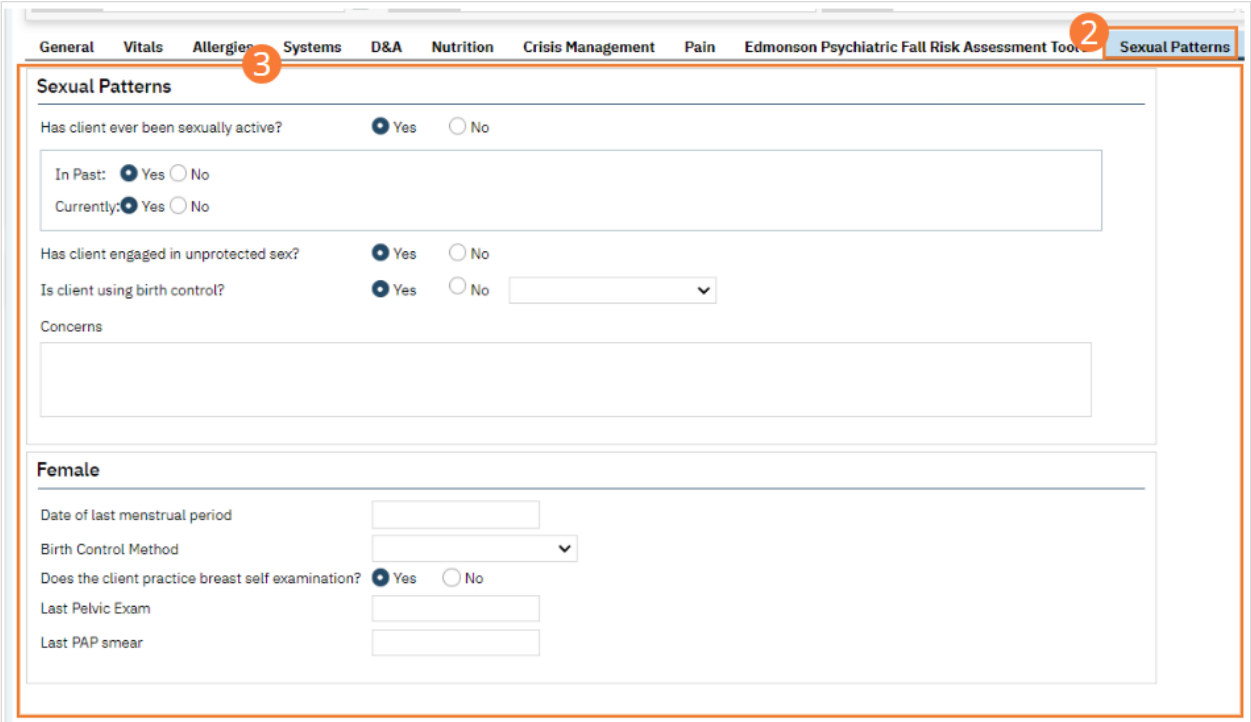


4. Select the Save icon and navigate to the next tab.

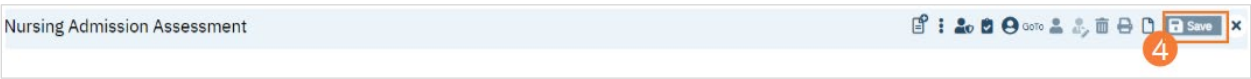


How to Complete the Sexual Patterns Tab of the Nursing Assessment

1. Begin on the Nursing Assessment
2. Select the Sexual Patterns tab.
3. Complete required fields in each section. The In Past/Currently radio buttons only initialize if the Has client ever been sexually active? question is set to Yes. The birth control dropdown selector only initializes if the Is client using birth control? question is set to Yes.



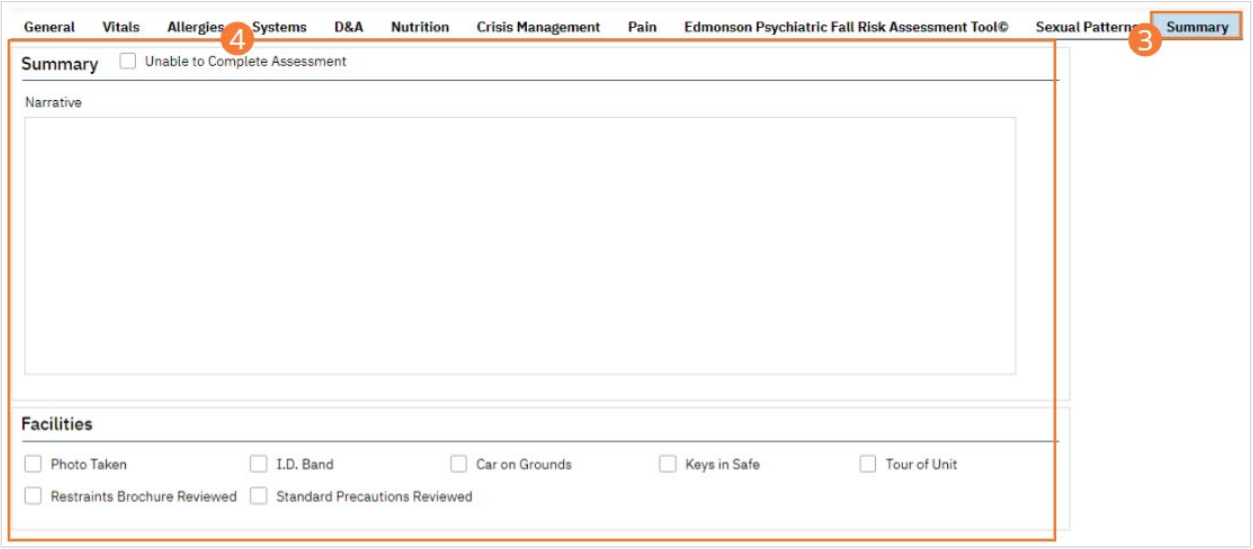
4. Select the Save icon and navigate to a remaining tab, or Sign the assessment.



How to Complete the Summary Tab of the Nursing Assessment

1. Begin on the Nursing Assessment
2. On the General tab, ensure that the 'Is this client Inpatient?' radio button is set to Yes.

3. Select the Summary tab.
4. Complete required fields in each section. Enter text in the Narrative box, or select the Unable to Complete Assessment. Check each Facilities checkbox that has been completed.

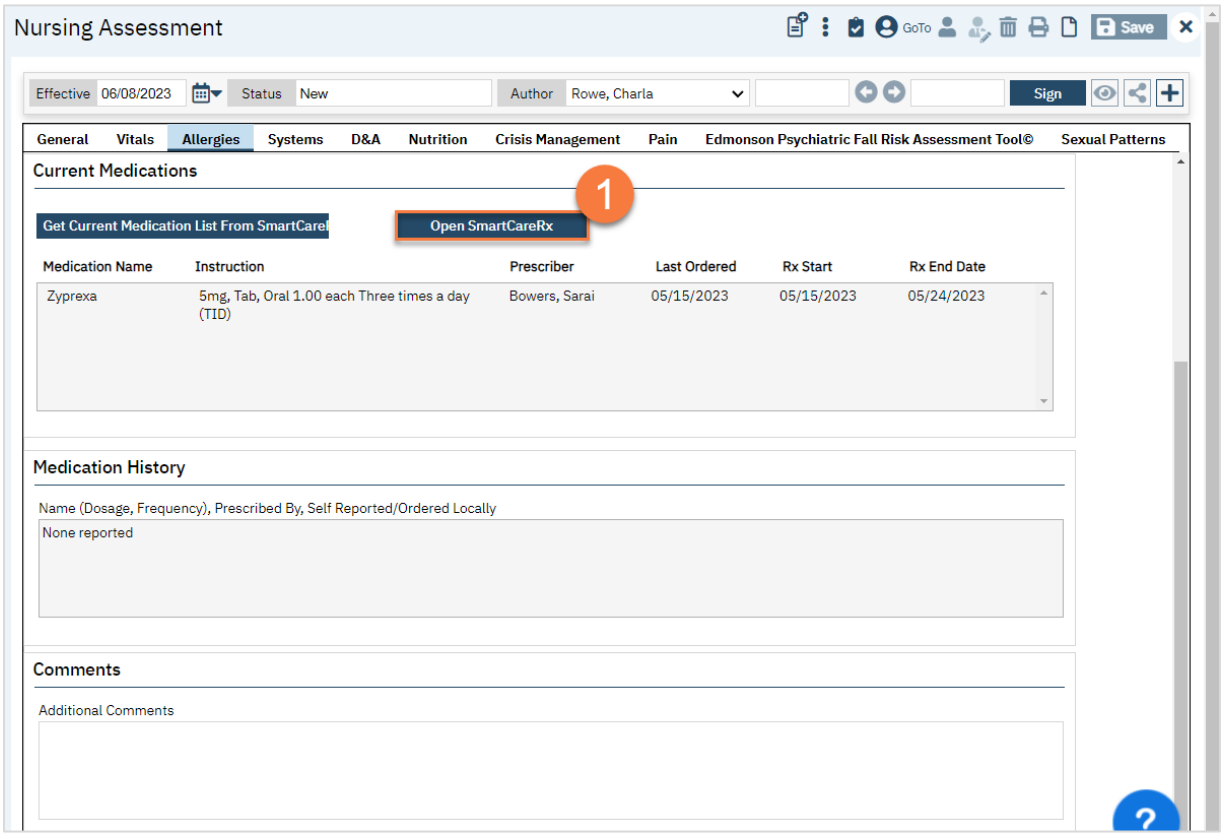


5. **Select the Save icon** and navigate to a remaining tab, or Sign the assessment. For more information, see How to Sign a Document.

How to Do Initial Medication Reconciliation

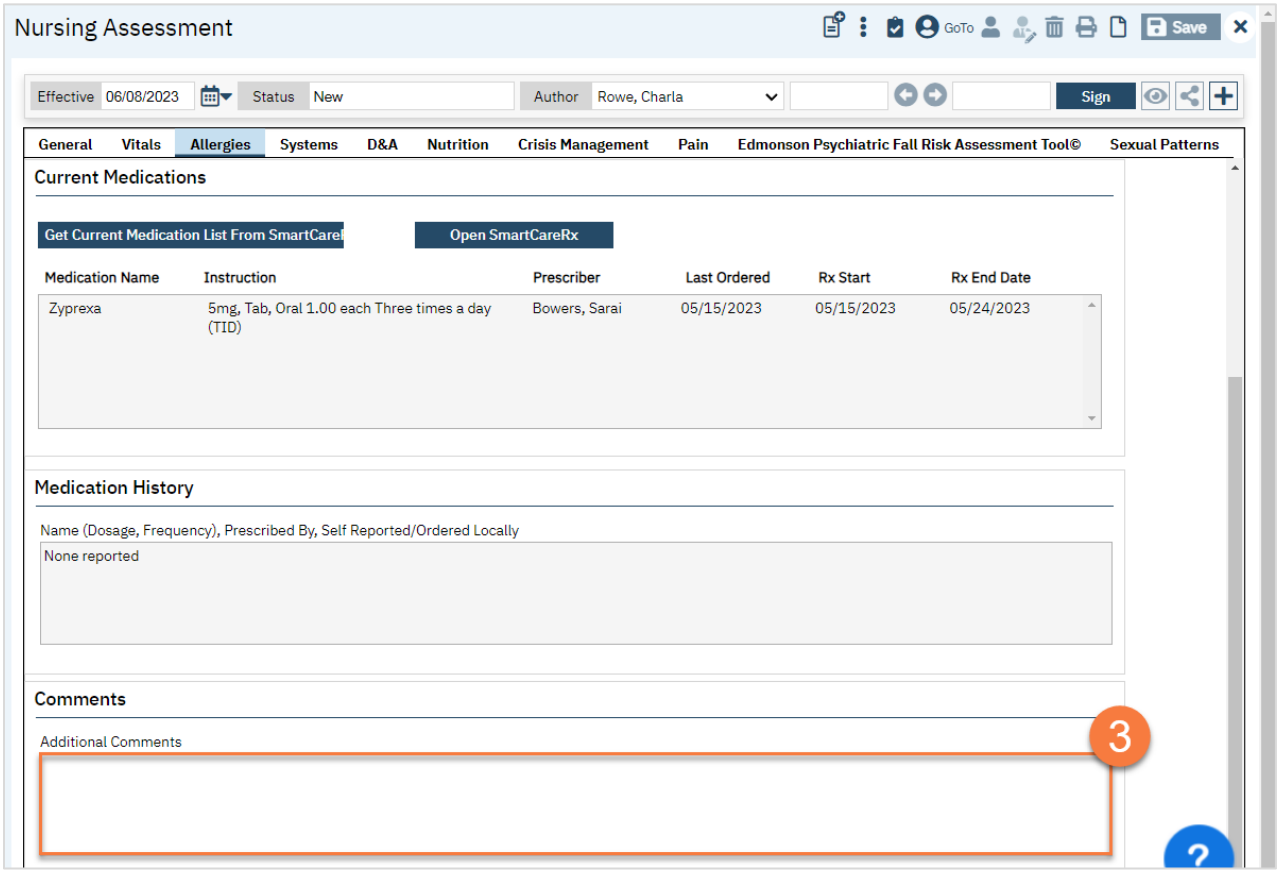
Part of the Nursing Assessment includes reviewing the client's current medications. SmartCare will automatically show you what medications have been entered in SmartCare's Rx module. This includes medications prescribed by outpatient prescribers and self-reported medications. To complete medication reconciliation, review this list with the client and add any additional self-reported medications. Make sure the list of medications is accurate and note any deviations in the comments field.

1. To edit the medications, **click the Open SmartCareRx** button.



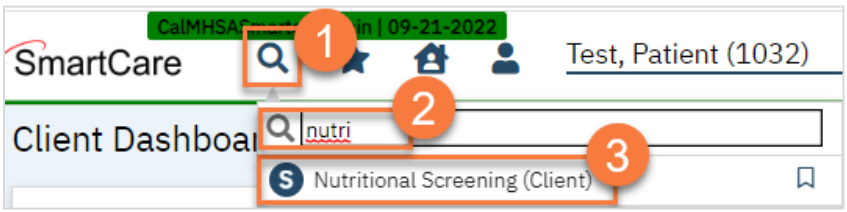
2. This will bring up the Rx module in a new window. You may edit the client's self-reported medications, which are indicated by a black pill bottle icon in Rx.

3. DO NOT alter current outpatient orders, which are indicated by a yellow Rx icon. If the client reports that they are no longer taking these, or have not taken their medication for a few days, note this in the Comments section in the Nursing Assessment.

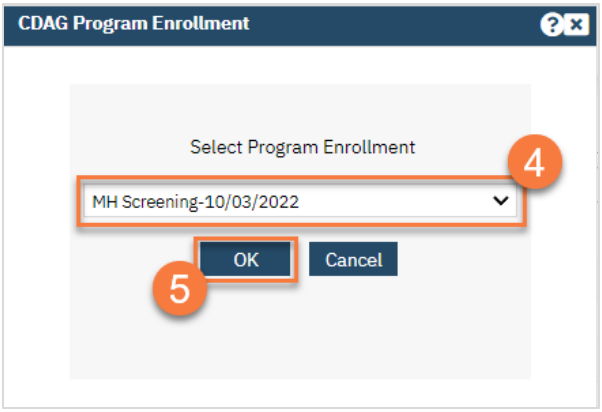


How to Complete the Nutritional Screening

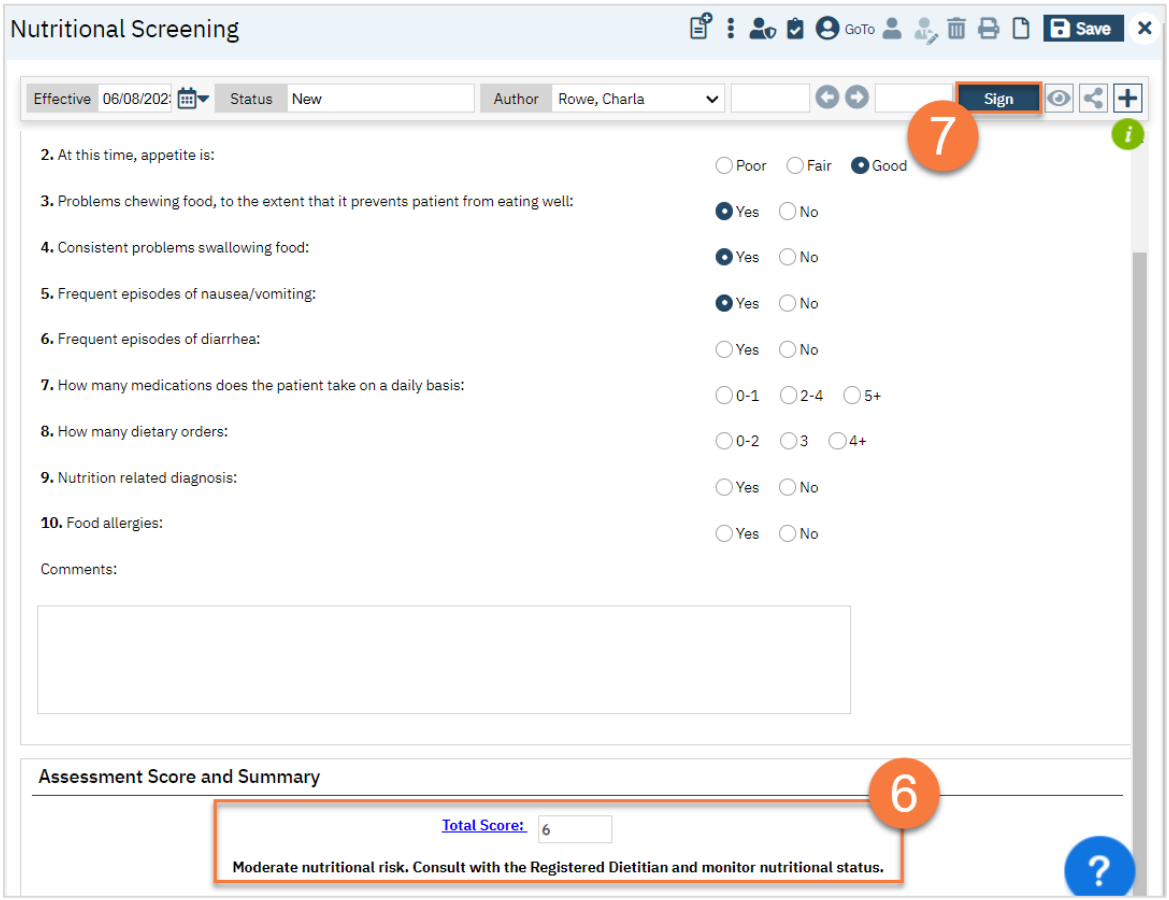
1. With the client open, **click the Search icon**.
2. **Type in 'Nutritional Screening"** in the search bar.
3. **Select "Nutritional Screening (Client)"** from the search results.



4. In the CDAG Program Enrollment window pop-up, click the drop down and click to s**elect the appropriate program**.
5. **Click OK** to continue.



6. This takes you to the Nutritional Screening document. **Answer all questions and add comments as needed**. As you answer questions, the total score will automatically sum and provide recommendations.
7. When you're finished, **click Sign**.



How to Refer the Client to the Registered Dietitian

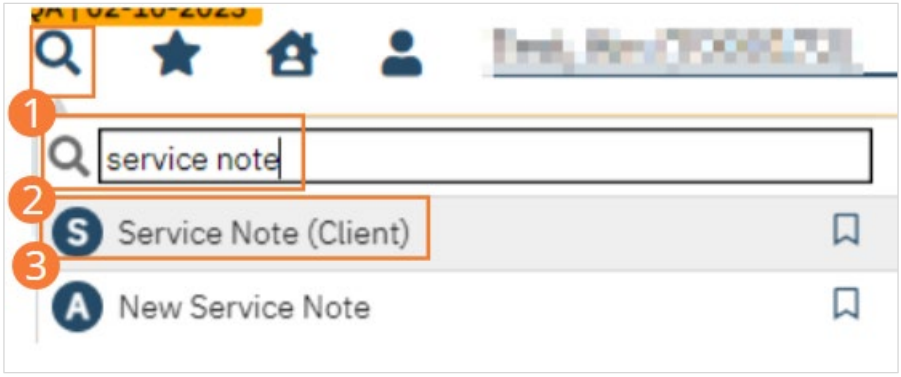
CalMHSA is working on a Care Coordination Module to include referrals in SmartCare but this is currently under development. In the meantime, you can use the messaging feature to send the Dietitian a message in SmartCare, or create a flag that indicates the client needs a full dietary assessment. Consult with your facility manager on how this is being addressed.

Prescriber: How to Complete the Psychiatric Evaluation

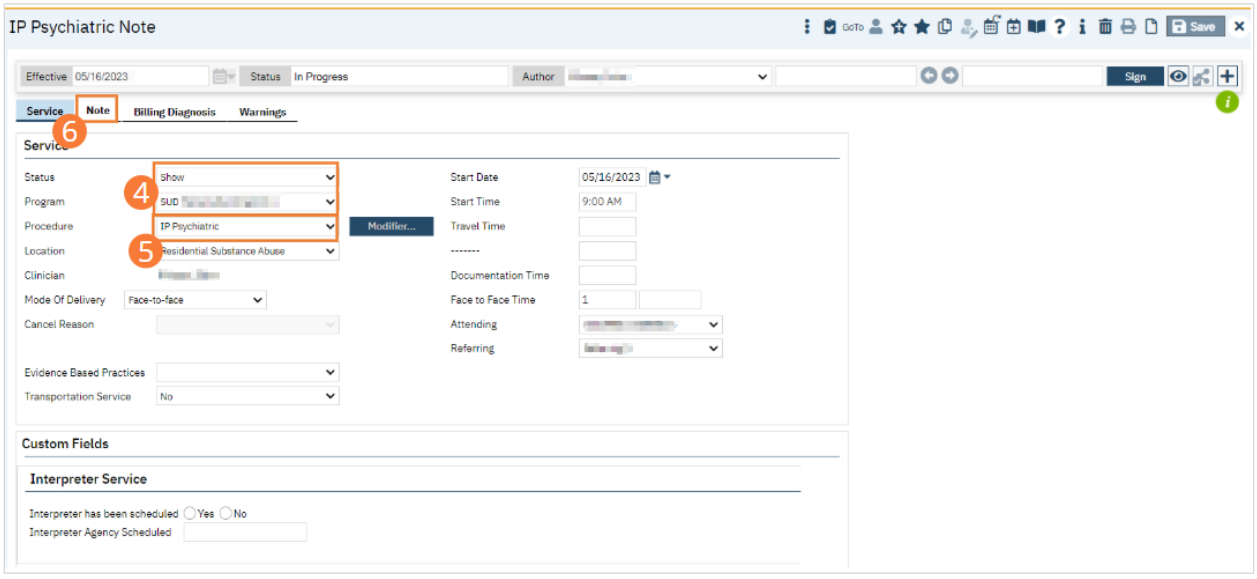
The Inpatient Psychiatric Note is a Service Note created as part of a Service. It is selectable when a procedure that calls for use of the IP Psychiatric Note and is properly linked to the note is selected as part of the creation of a service.

How to Display the IP Psychiatric Note Page

1. With an active client selected, click the Search icon.
2. Type 'Service Note" into the search bar.
3. Click to select Service Note (Client). The Service Note screen opens.



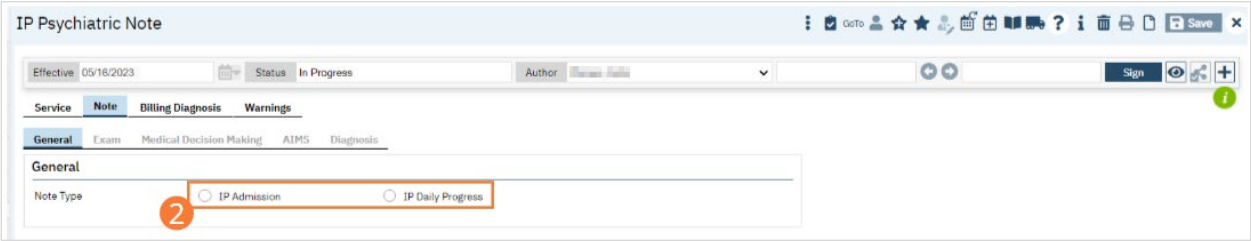
4. Select a Program from the dropdown. Ensure the status is set to Show.
5. Select the Inpatient Psychiatric Procedure from the dropdown.
    a. Different procedures will populate different Notes. The Note tab will initialize.
6. Click the Note tab.



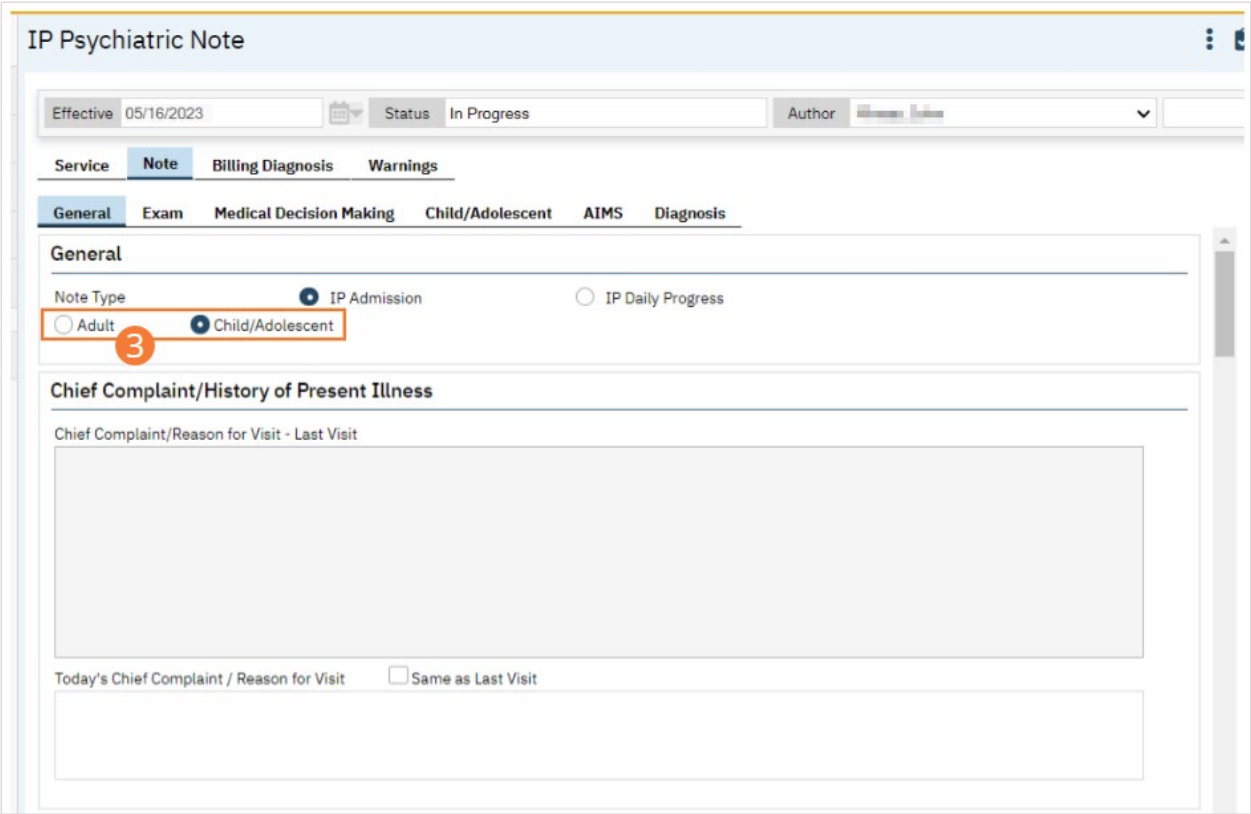
The remaining required fields and tabs will need to be completed as part of Service Note creation. For more information, see Service and Service Note training.

How to Complete the General tab of the IP Psychiatric Note for an Admission Note

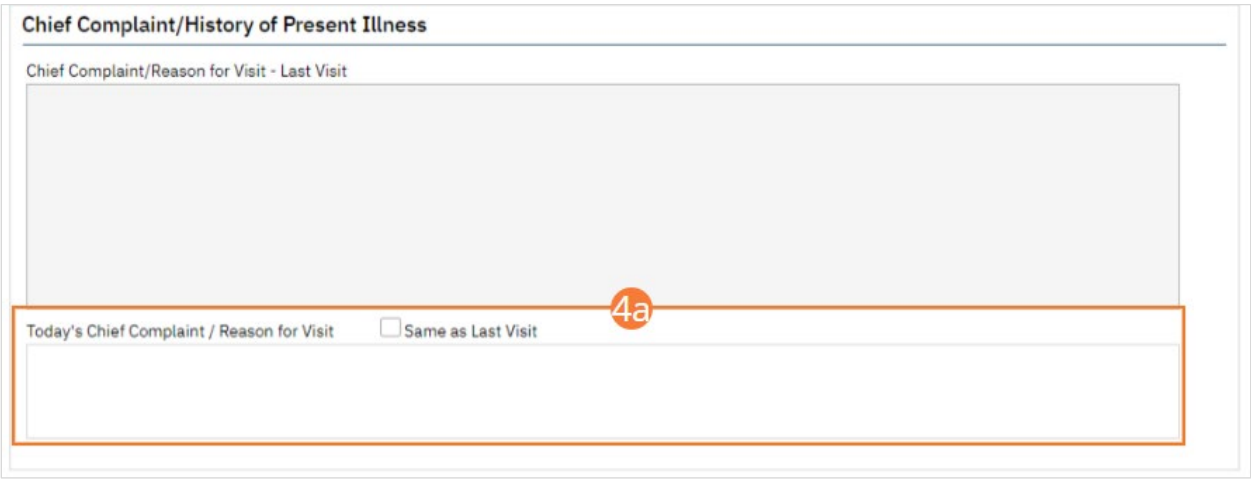
1. Begin on the Note tab of the Service Notes screen. The General tab of the note will be pre-selected.
2. Click the IP Admission radio button to select a note type. Each note type will have a different selection of fields available. The selected note type will initialize.



3. Click a radio button to select Child or Adult. If Adult is selected, the Child/Adolescent tab will be disabled.

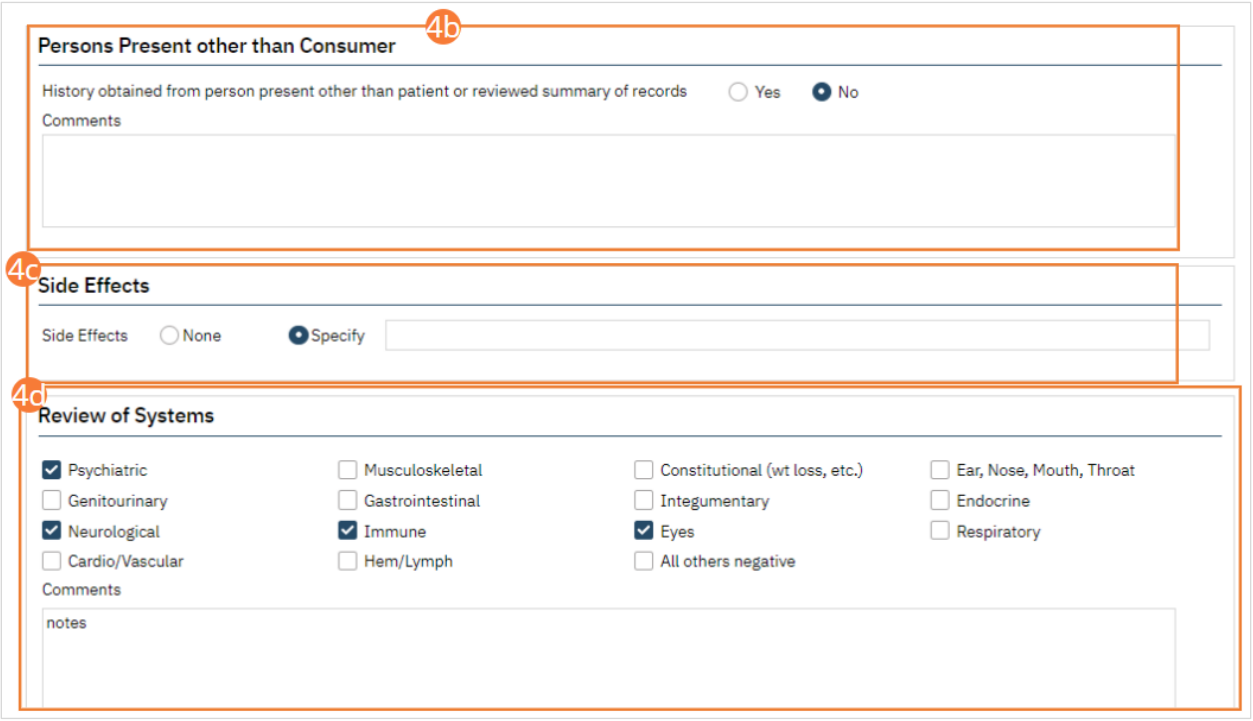


4. Complete required fields.
   a) Enter a Chief Complaint/Reason for Visit. If you have previously entered a Chief Complaint/Reason for Visit, you can select the Same as Last Visit checkbox to copy the data from the previous visit into this visit.

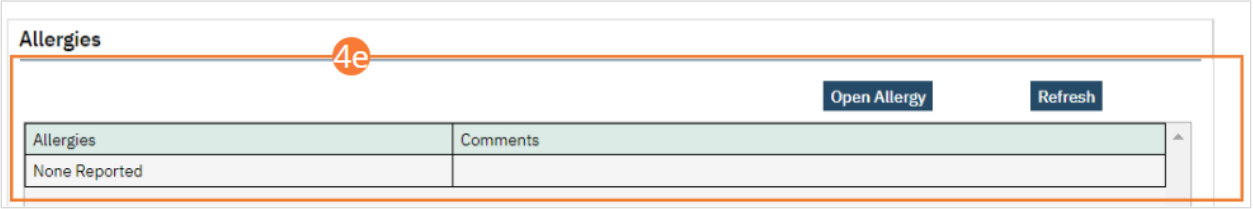


   b) Click a radio button for History obtained from person present other than patient or reviewed summary of records. Enter comments if needed.

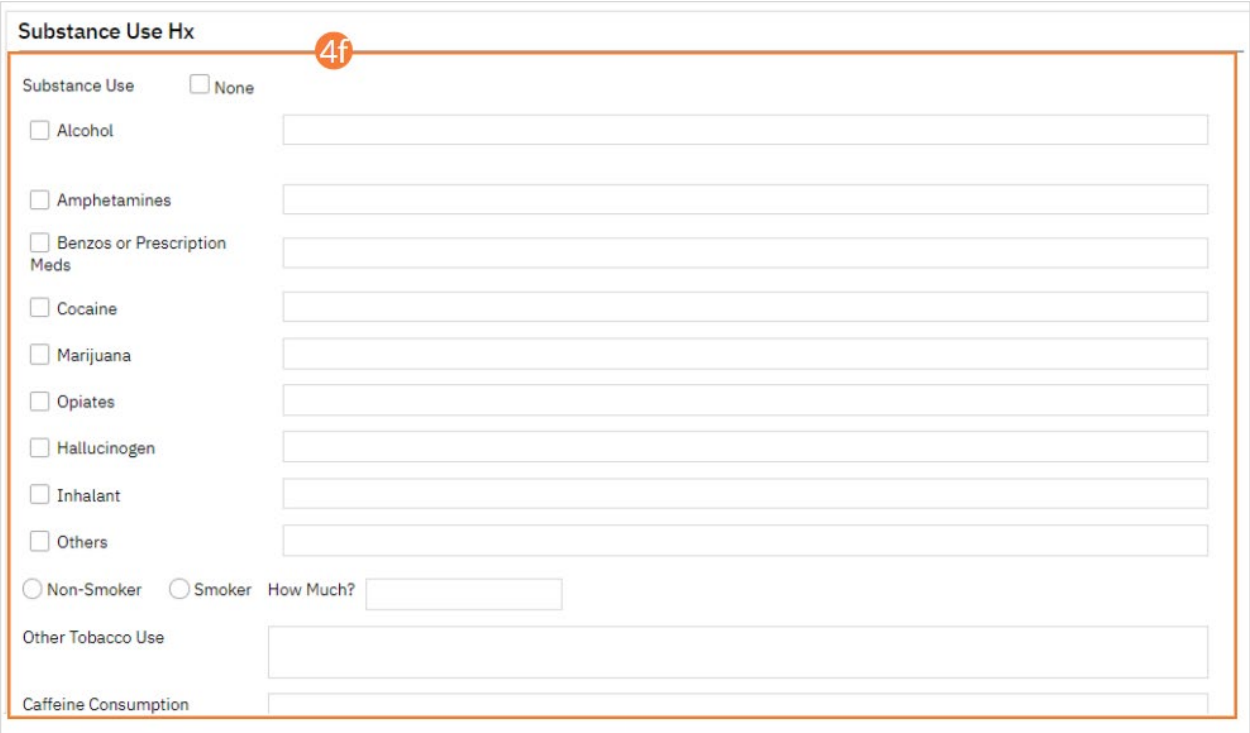
c) Click a radio button for Side Effects. If 'Specify' is chosen, enter specifying comments.
d) Click checkboxes indicating which systems were reviewed. Enter detailed comments in the Comments text field.



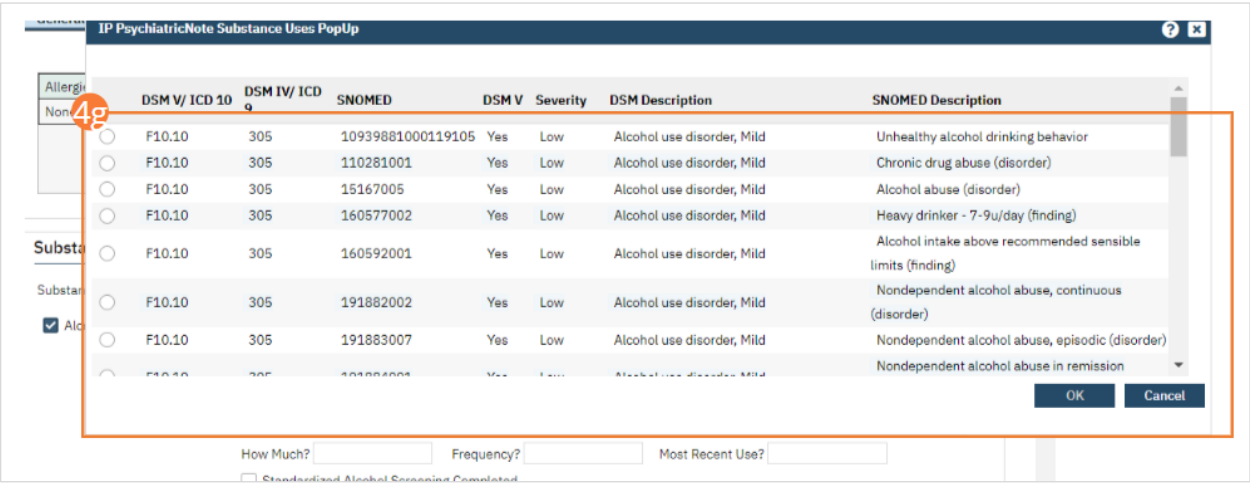
e) Confirm that Allergies are properly imported. If needed, Refresh the field, or open SmartCare Rx with the Open Allery button and add client allergies. For more information, see SmartCare Rx training.



f) Select checkboxes for substances the client has a history of using. If none, check the None checkbox. Add comments to selected substances.

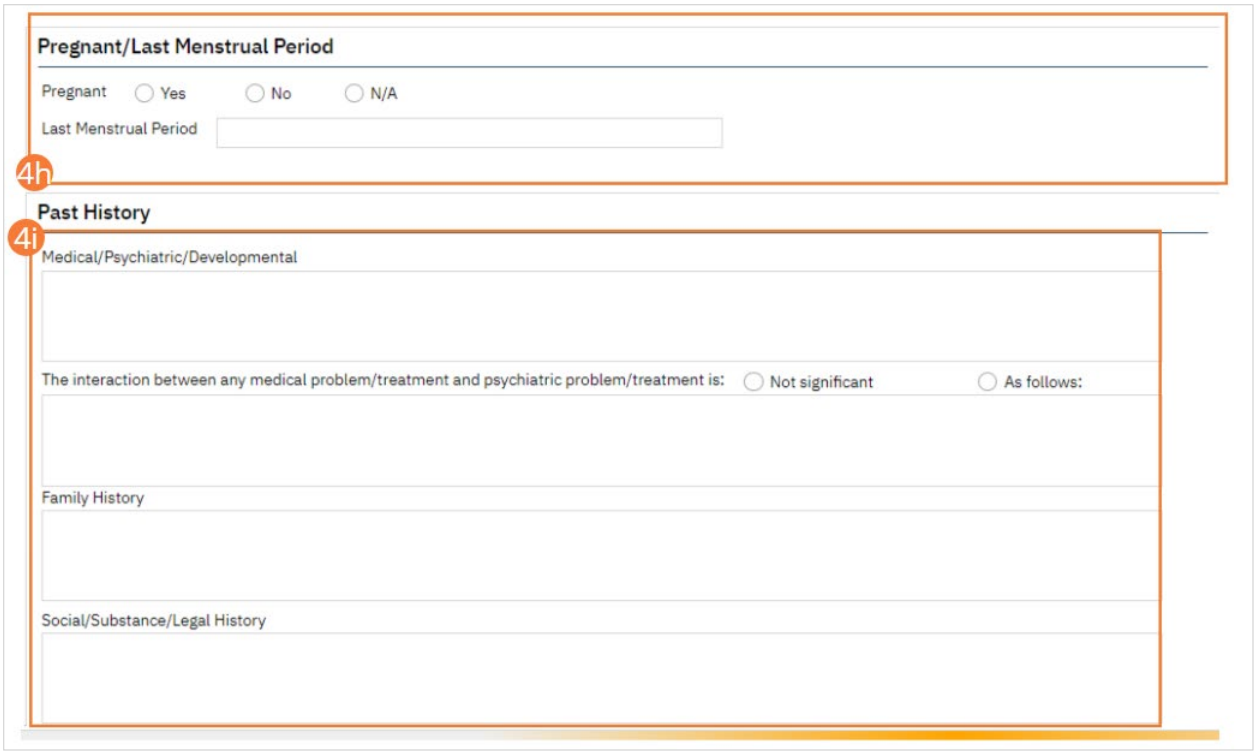


g) When a box is checked, a clinical problems selection window will pop up. Select a radio button for an appropriate clinical problem, then click OK. If use of the substance should not be recorded as a clinical problem, click Cancel. The selected problem will be added to the note.

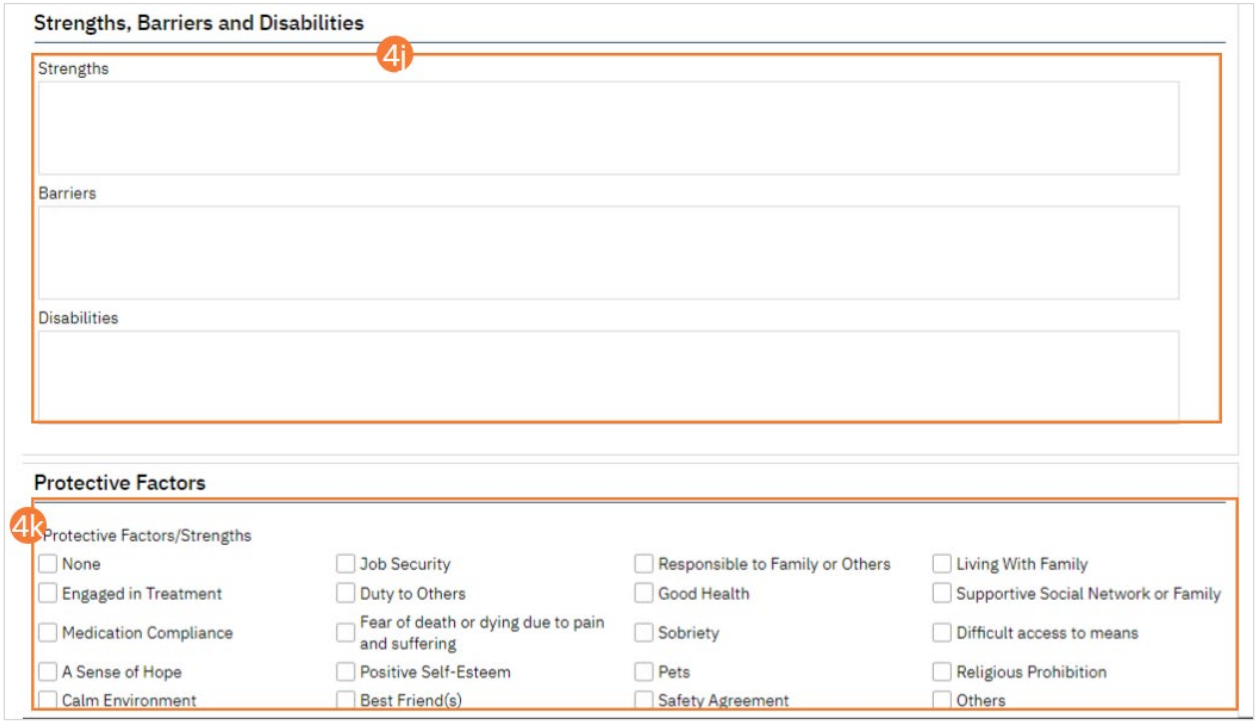


h) Select a radio button for pregnancy. If appropriate, record last menstrual period.

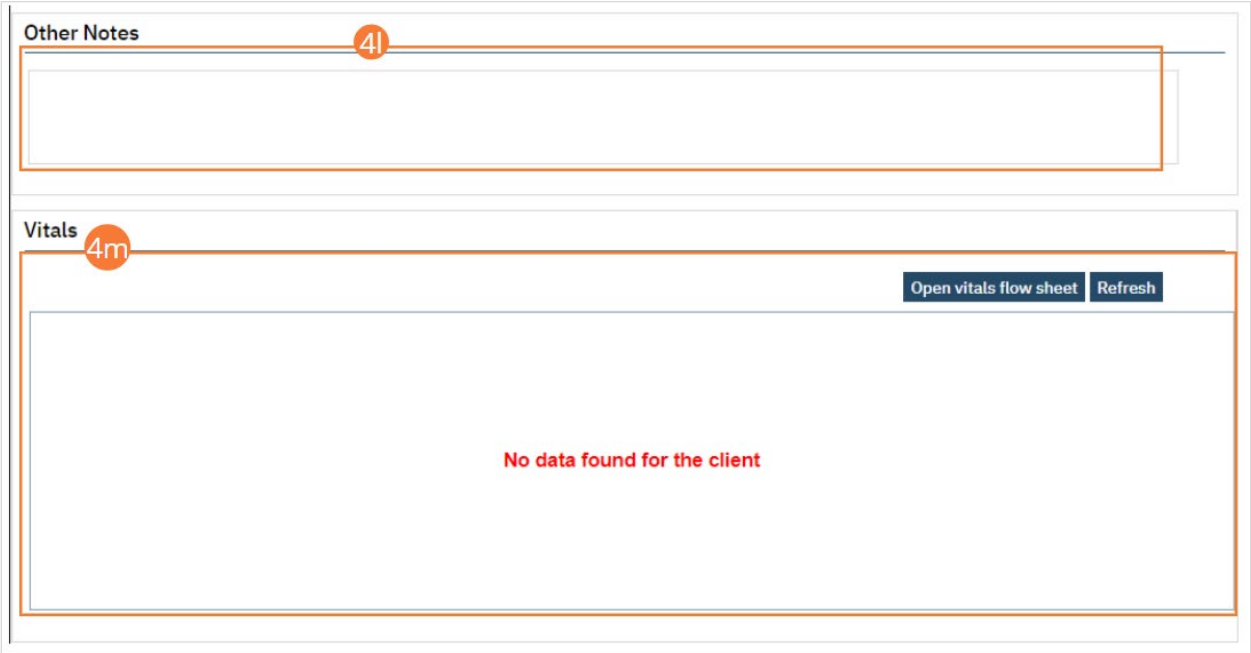
i) Enter text for Past History. Select a radio button for The interaction between any medical problem/treatment and psychiatric problem/treatment is:



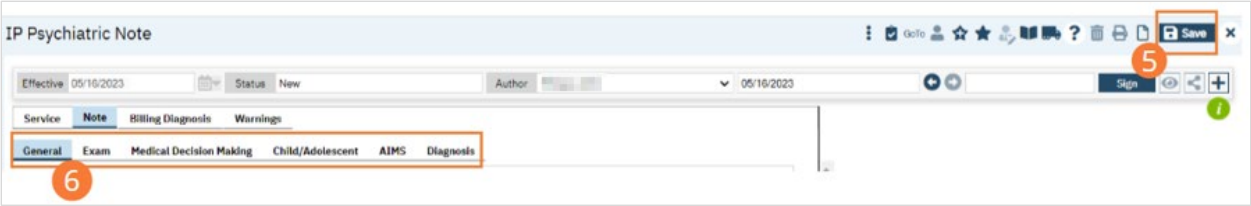
j) Enter text for Strengths, Barriers, and Disabilities.
k) Select all appropriate checkboxes for Protective Factors.



l) Enter text in Other Notes, as appropriate.
m) Ensure that the last completed Vitals assessment is displaying. If necessary, click refresh to bring up the most recent Vitals assessment, or click the Open vitals flow sheet button to complete a new Vitals assessment. For more information, see Flow Sheet training.

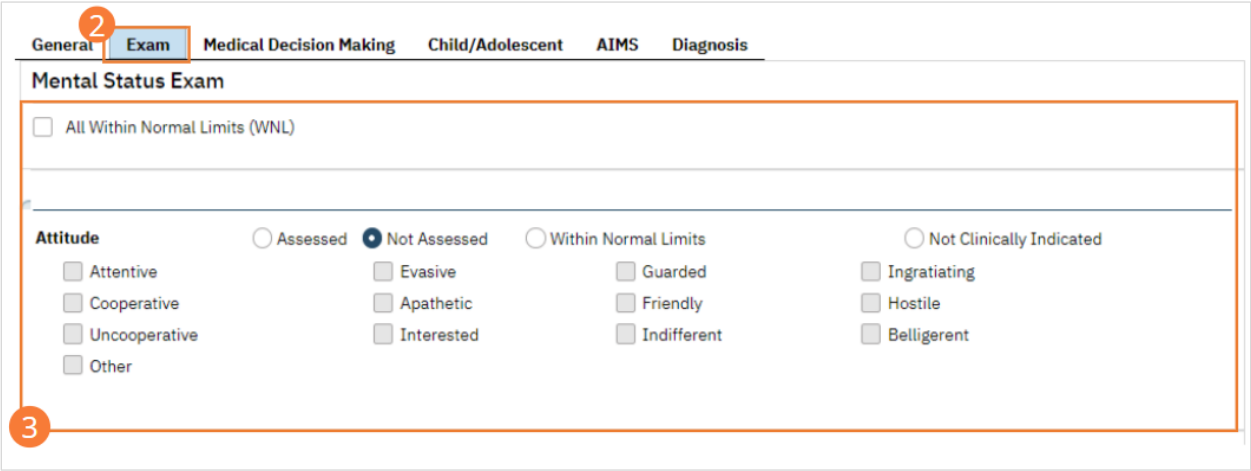


5. Select the Save icon.
6. Navigate to the next tab.

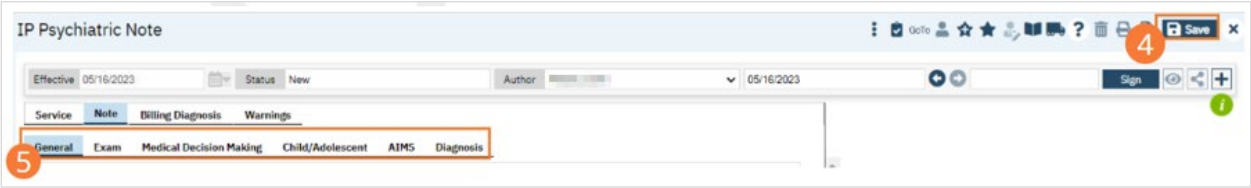


How to Complete the Exam tab of the IP Psychiatric Note for an Admission Note

1. Begin on the IP Psychiatric Note.
2. Select the Exam tab.
3. Complete required fields in each section by selecting a radio button for each system. If Assessed is selected, the sections will initialize. Click each checkbox for which your exam returned significant findings. Alternately, you can select the All Within Normal Limits checkbox to set all systems to Within Normal Limits. Enter text in comment fields and select the appropriate radio buttons as they appear.

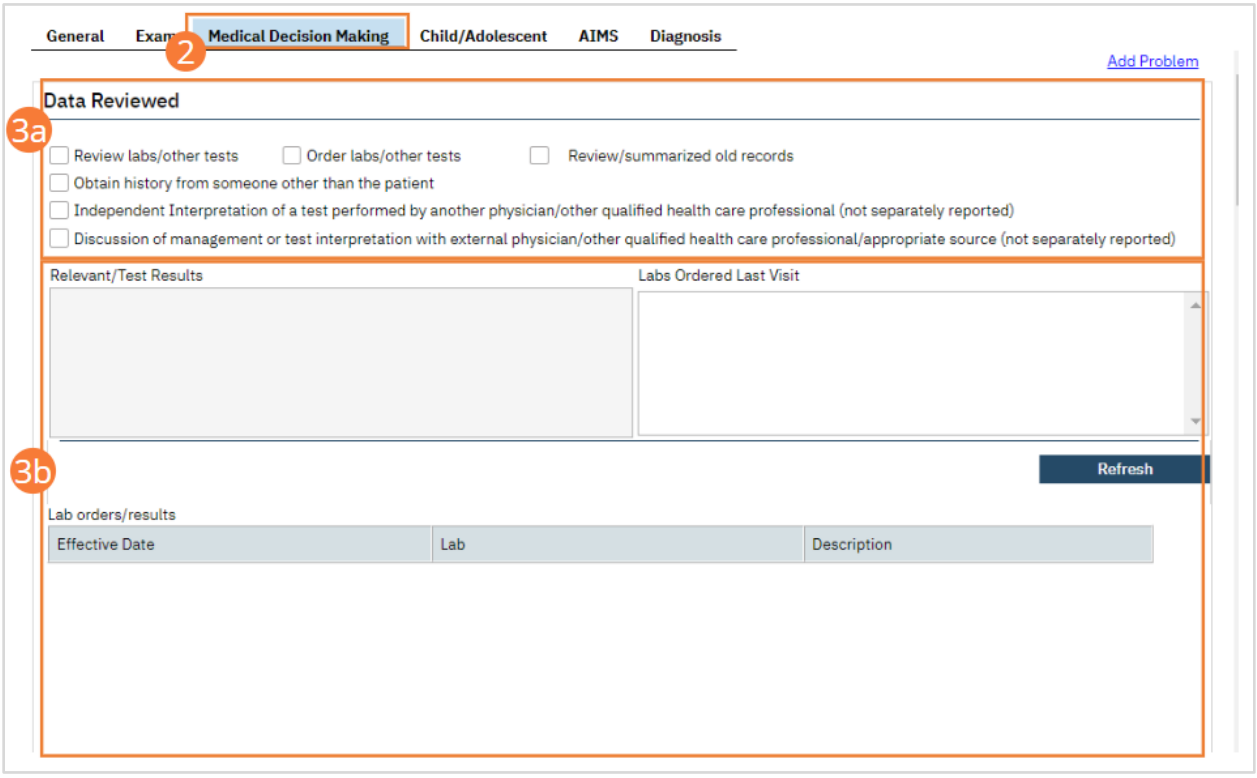


4. Select the Save icon.
5. Navigate to the next tab.

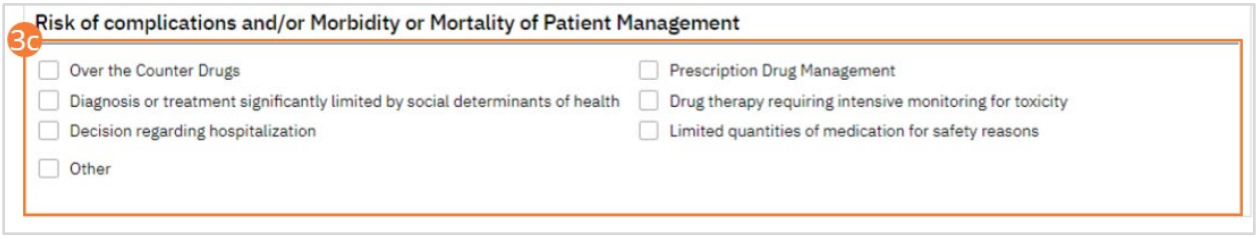


How to Complete the Medical Decision Making tab of the IP Psychiatric Note for an Admission Note

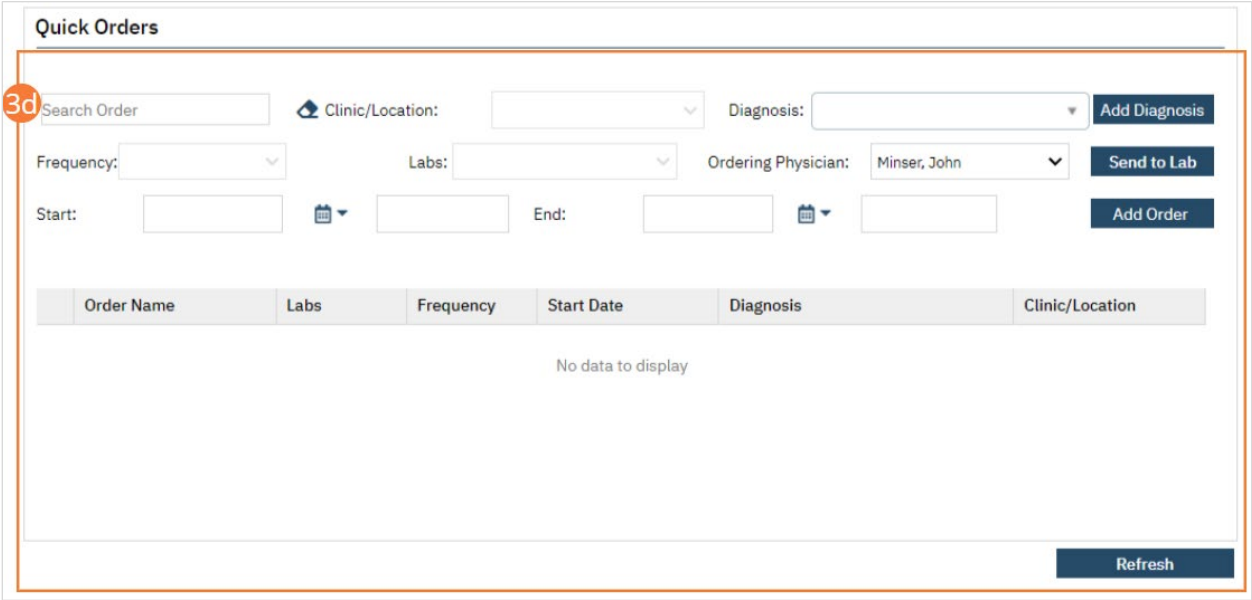
1. Begin on the IP Psychiatric Note.
2. Select the Medical Decision Making tab.
3. Complete required fields.
    a) Check boxes to indicate data you have reviewed.
    b) Enter lab order notes, and confirm previous labs are displayed appropriately. If necessary, click the Refresh button to bring up most recent labs.



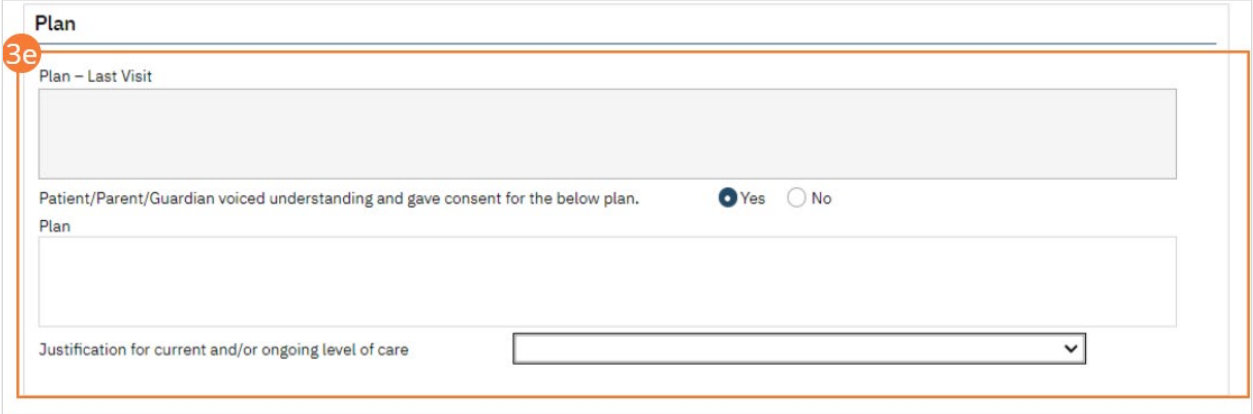
    c) Check all applicable boxes in the Risk of Complications and/or Morbidity or Mortality of Patient Management.



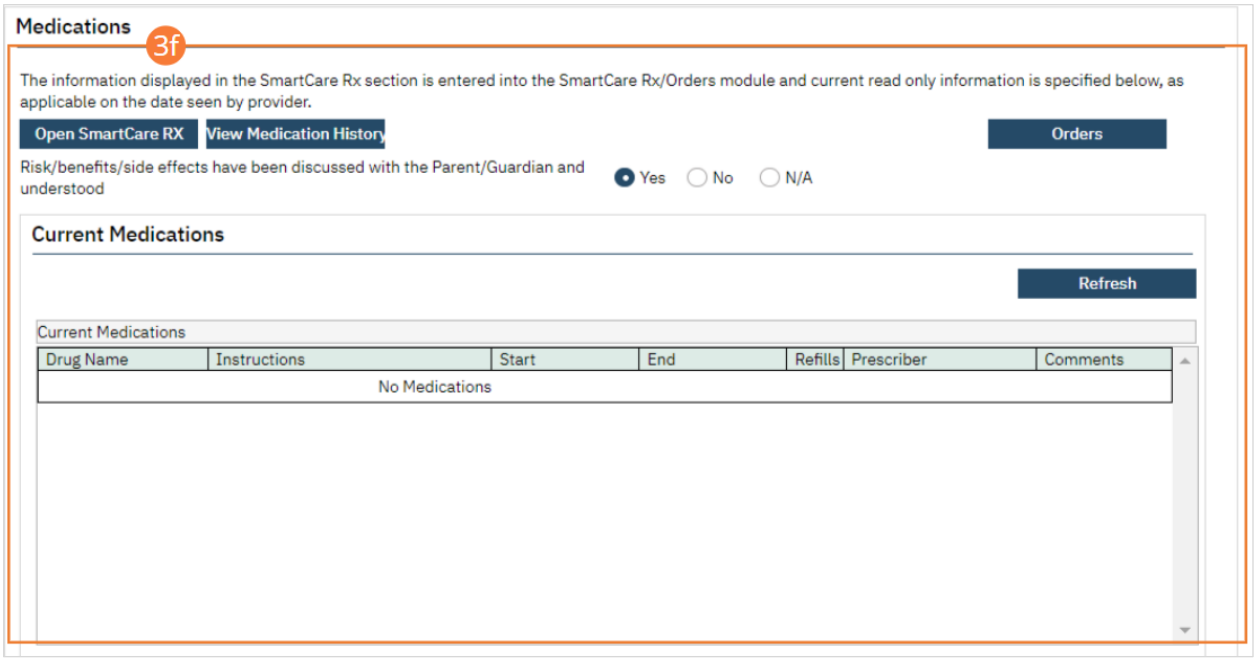
    d) Enter Quick Orders as needed. For more information, see Orders training.



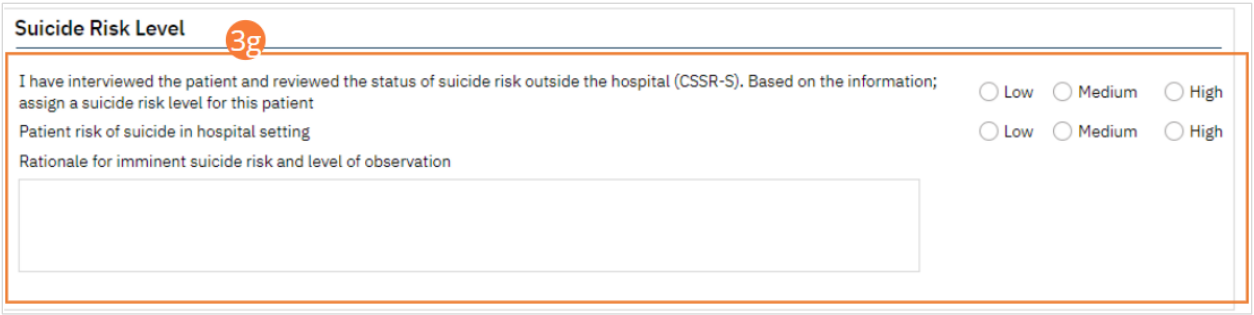
e) Review the previous plan, and update as necessary. Select a Consent radio button, enter comments in the Plan text field, and select a Level of Care justification from the dropdown.



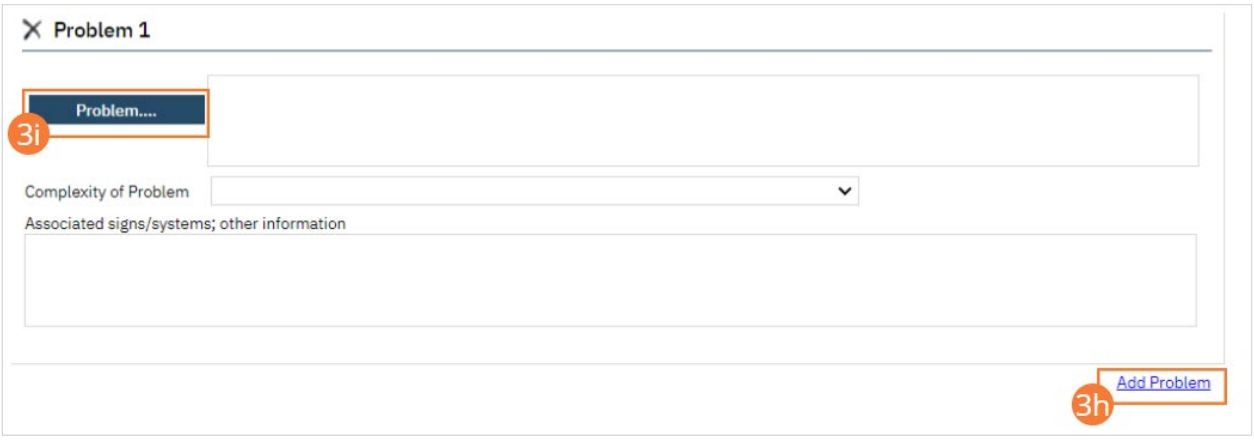
f) Review existing medications and update as necessary. On the Note, select from radio buttons and enter text in fields. Click SmartCare Rx, Medication History, and Orders buttons to link to other functions. For more information on adding medications and orders, see SmartCare Rx and Orders training.



g) Complete the Suicide Risk Level section. Select Low, Medium, or High risk radio buttons for each prompt, and enter text in the Rationale field.



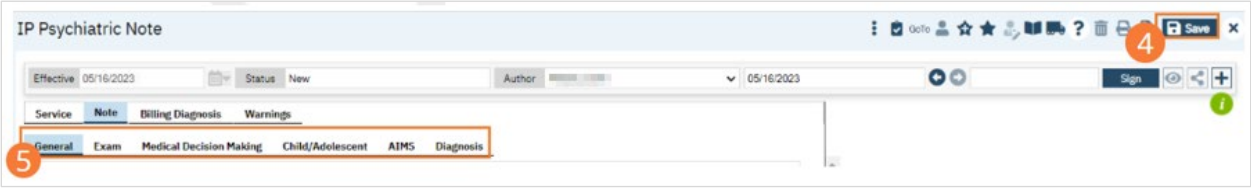
h) Optionally, add a Problem section by selecting the Add Problem hyperlink at the top of the page.
i) Select the Problem button. A pop-up will appear.



j) Select an existing Problem from the pop-up.
k) Click the OK button. The pop-up will close.

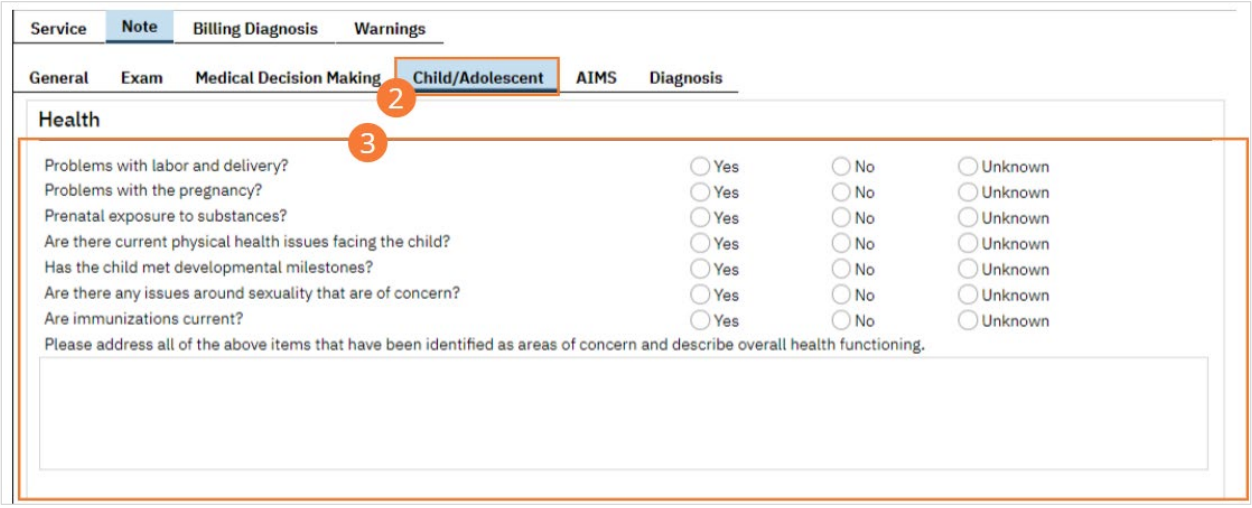
l) Select a complexity from the dropdown and enter comments in the text field. Continue with the tab, or save and navigate to the next tab.

4. Select the Save icon.
5. Navigate to the next tab.

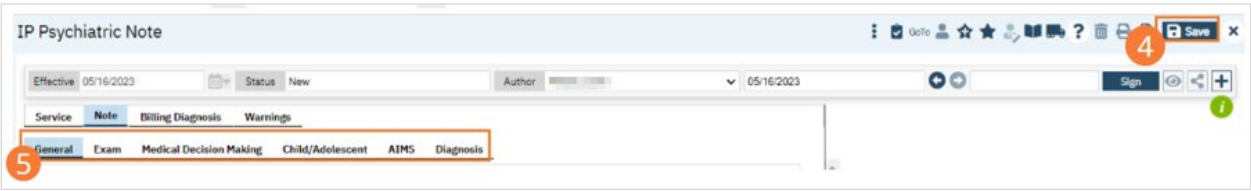


How to Complete the Child/Adolescent tab of the IP Psychiatric Note for an Admission Note

1. Begin on the IP Psychiatric Note.
2. Select the Child/Adolescent Making tab. If the Child/Adolescent tab is not present, ensure that you have selected a Child/Adolescent note on the general tab.
3. Complete required fields. For each section, select the appropriate radio button for each prompt, then enter comments in the text field.

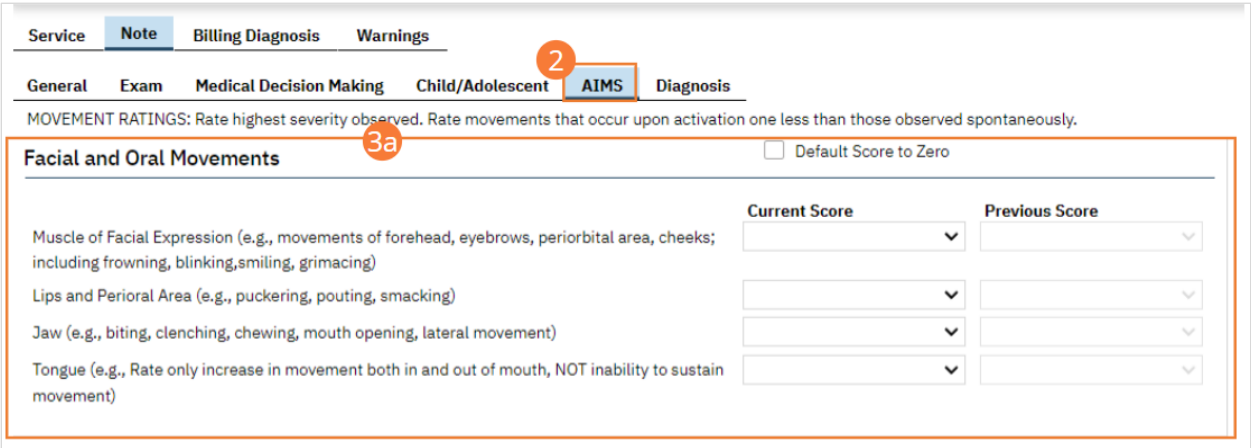


4. Select the Save icon.
5. Navigate to the next tab.

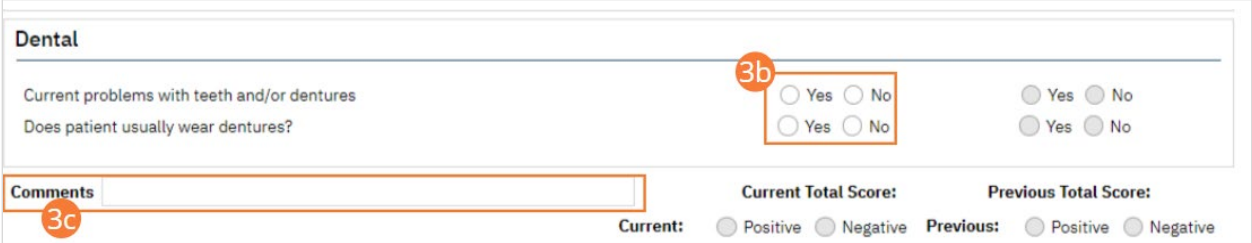


How to Complete the AIMS tab of the IP Psychiatric Note for an Admission Note

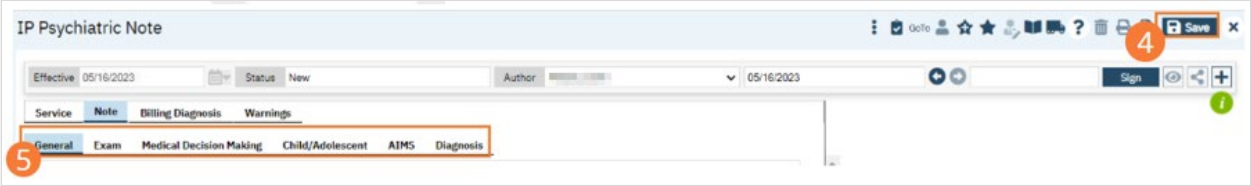
1. Begin on the IP Psychiatric Note.
2. Select the AIMS tab.
3. Complete required fields.
    a) For each section, select a score from the dropdown for each prompt. Note that previous scores will display to the right of each dropdown.



    b) For the Dental section, select a Yes or No radio button for each prompt.
    c) Add Comments in the text field if needed. Note the total score will be displayed to the right.

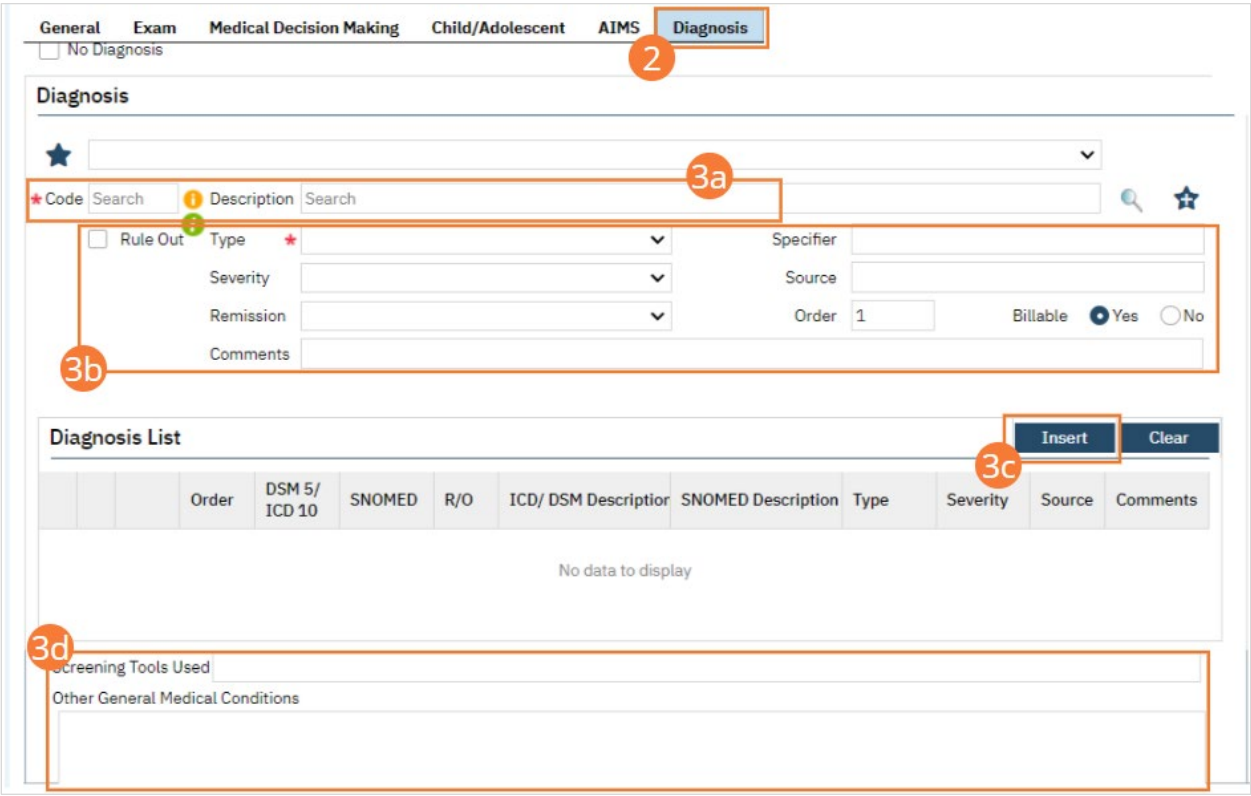


4. Select the Save icon.
5. Navigate to the next tab.

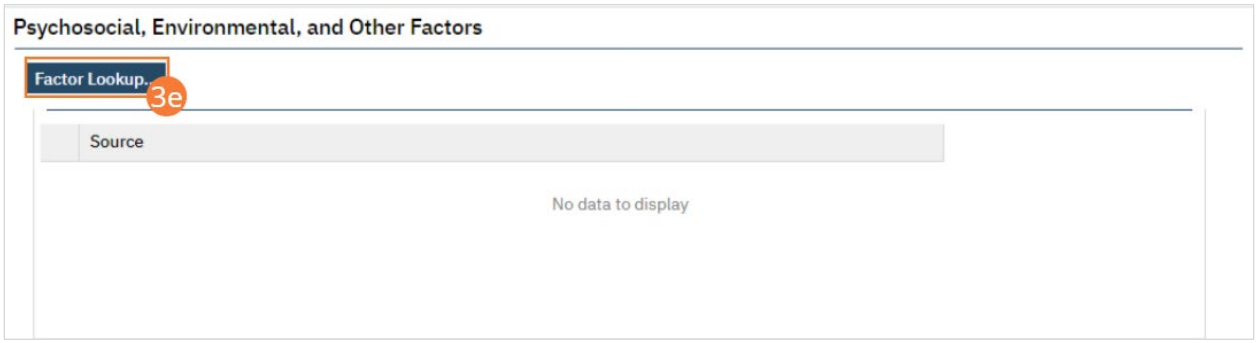


How to Complete the Diagnosis tab of the IP Psychiatric Note for an Admission Note

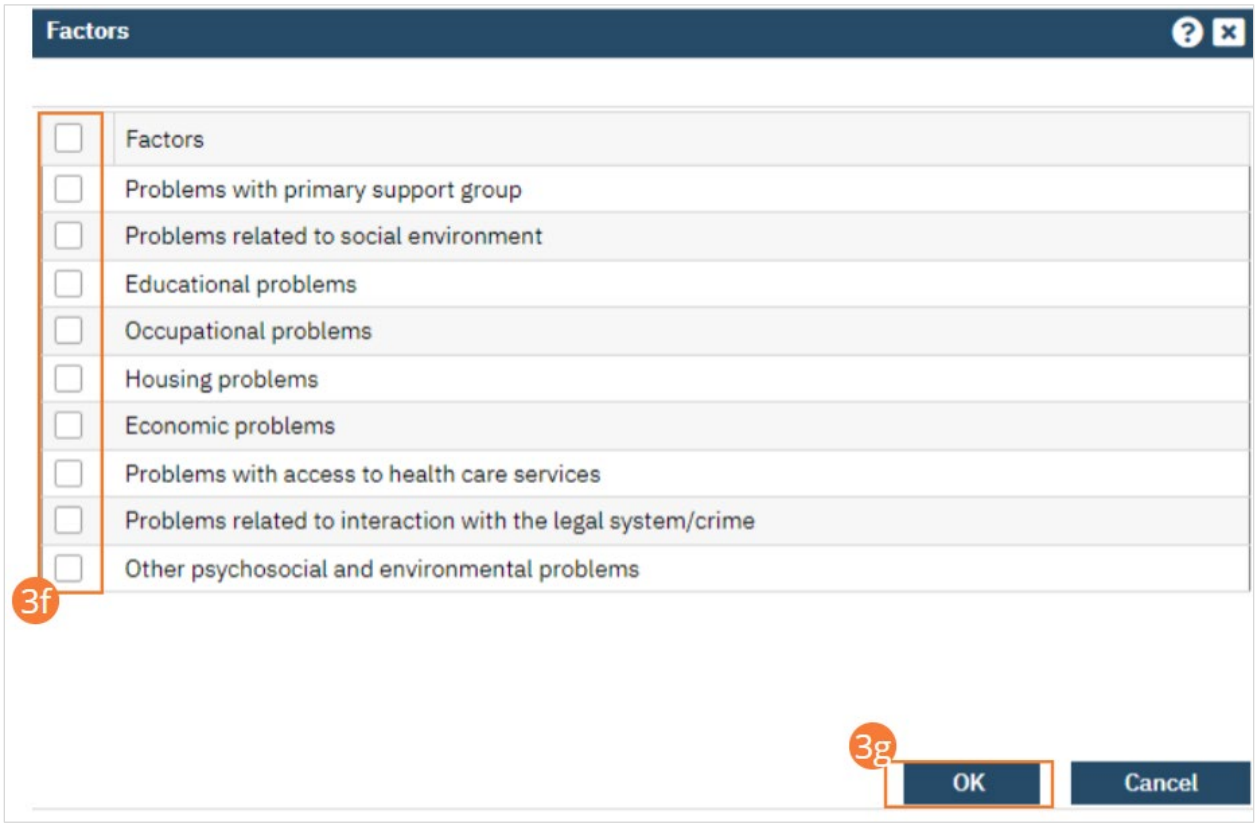
1. Begin on the IP Psychiatric Note.
2. Select the Diagnosis tab.
3. Complete required fields.
    a) Search for a diagnosis code or description. Select the chosen diagnosis from the dropdown that appears when you begin entering text.
    b) Select a Type, Severity, and Remission status from the dropdowns. Enter a specifier and source in the text boxes. If desired, change the order numeral, change the Billable radio button, and/or set the diagnosis as a Rule Out by selecting the checkbox.
    c) Click the Insert button. The diagnosis will be added to the Diagnosis List.
    d) Type text into the Screening Tools Used and Other General Medical Conditions fields.



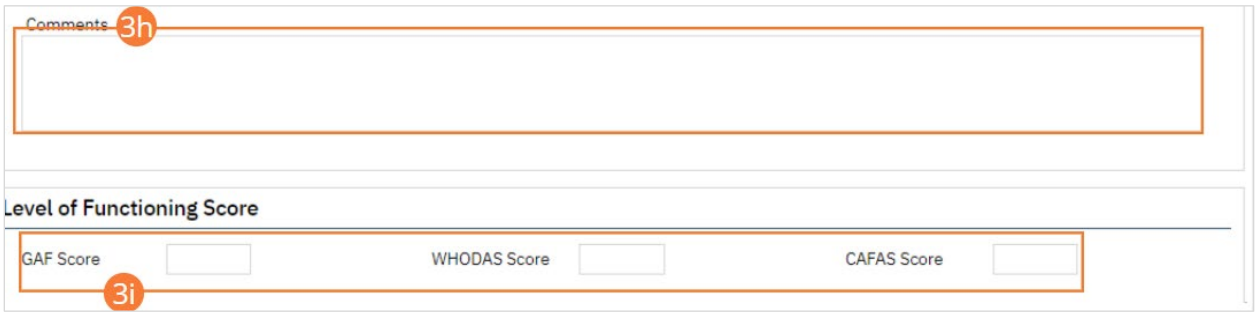
e) In the Psychosocial, Environmental, and Other Factors section, click the Factor Lookup button. A pop-up will appear.



f) Select any or all of the checkboxes that apply.
g) Click the OK button.

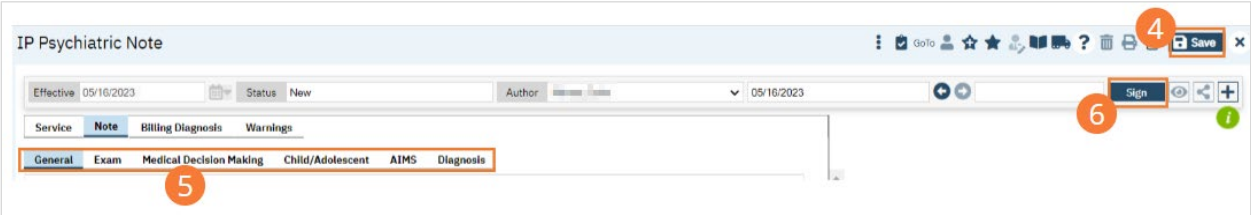


h) Enter Comments in the text field.
i) If applicable, enter GAF, WHODAS, or CAFAS scores.



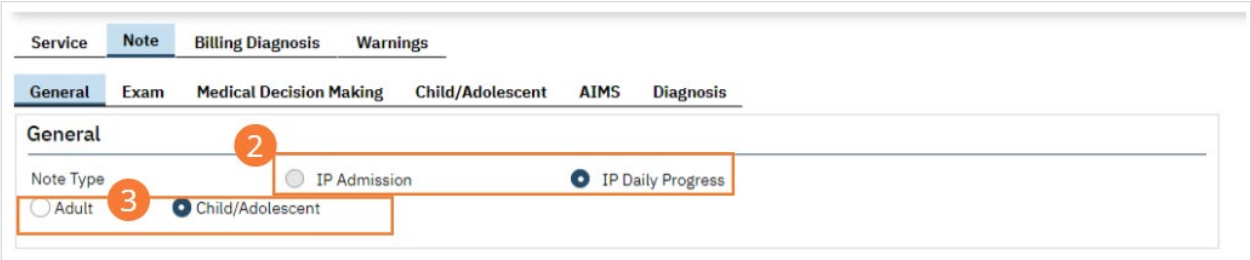
4. Click the Save button.
5. Complete any remaining tabs.

6. **Click the Sign button** to sign the document.



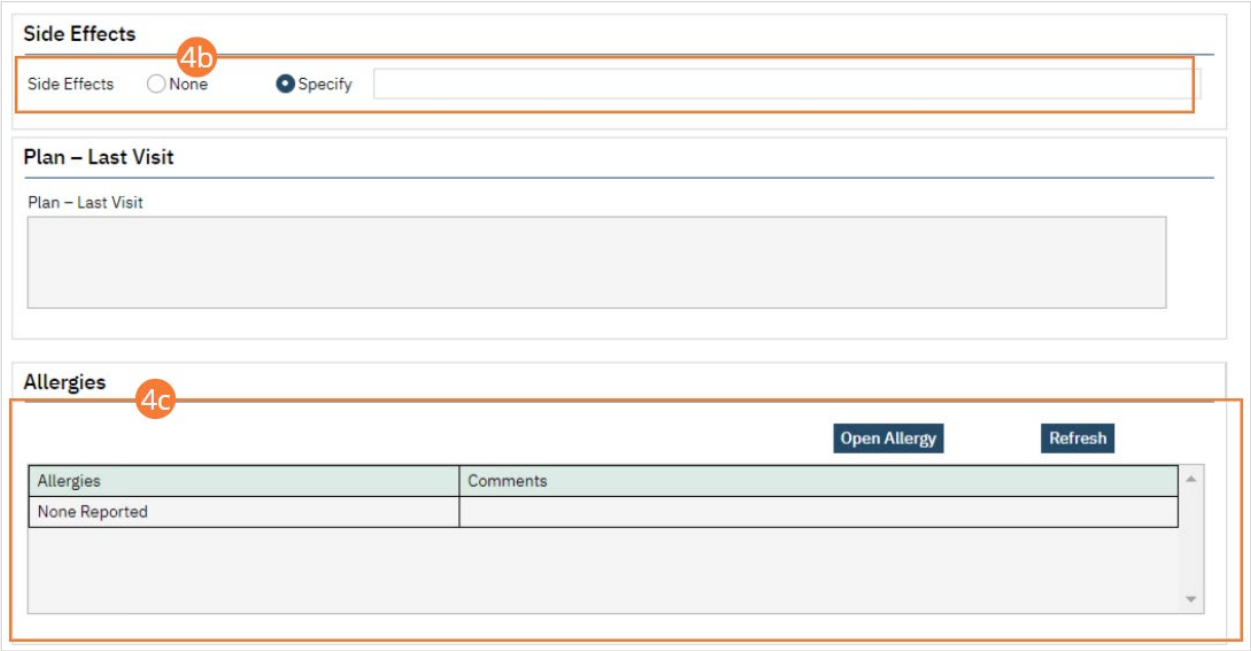
How to Complete the General tab of the IP Psychiatric Note for a Daily Progress Note

1. Begin on the Note tab of the Service Notes screen. The General tab of the note will be pre-selected.
2. **Click the IP Daily Progress radio button to select a note type.** Each note type will have a different selection of fields available. The selected note type will initialize.
3. **Click a radio button to select Child or Adult.** If Adult is selected, the Child/Adolescent tab will be disabled.

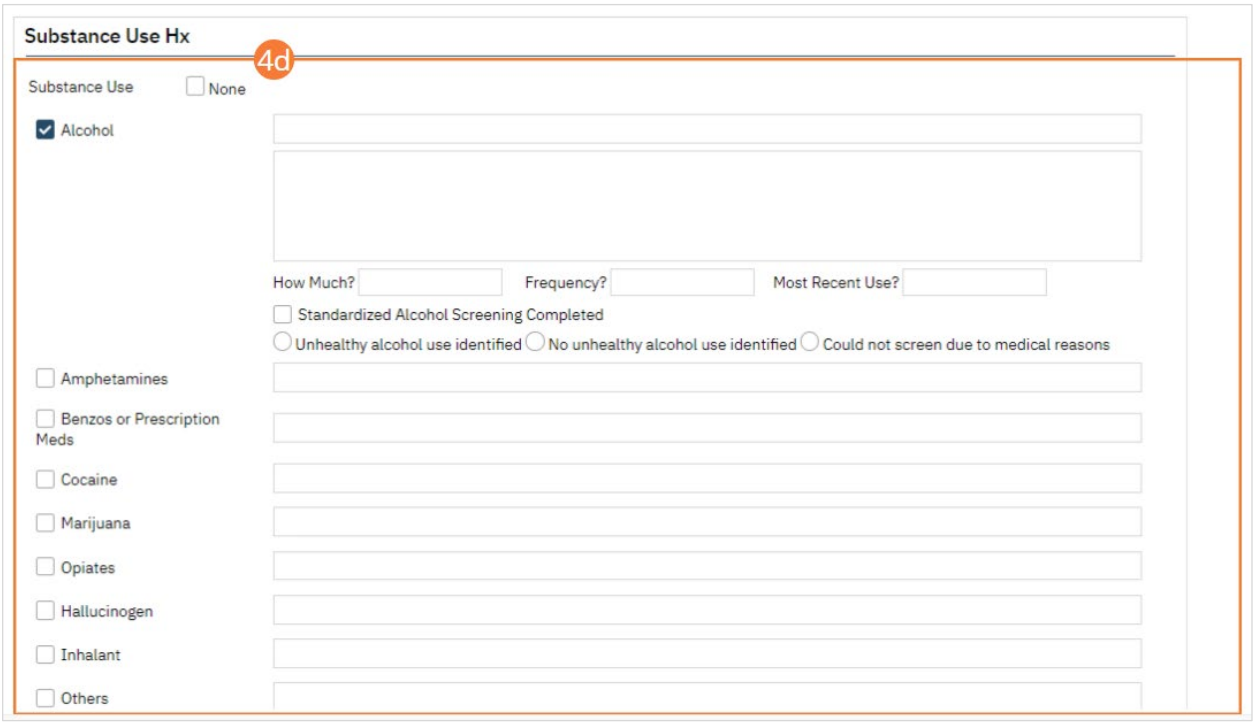


4. **Complete required fields**.
   a) Enter a Chief Complaint/Reason for Visit. If you have previously entered a Chief Complaint/Reason for Visit, you can select the Same as Last Visit checkbox to copy the data from the previous visit into this visit.

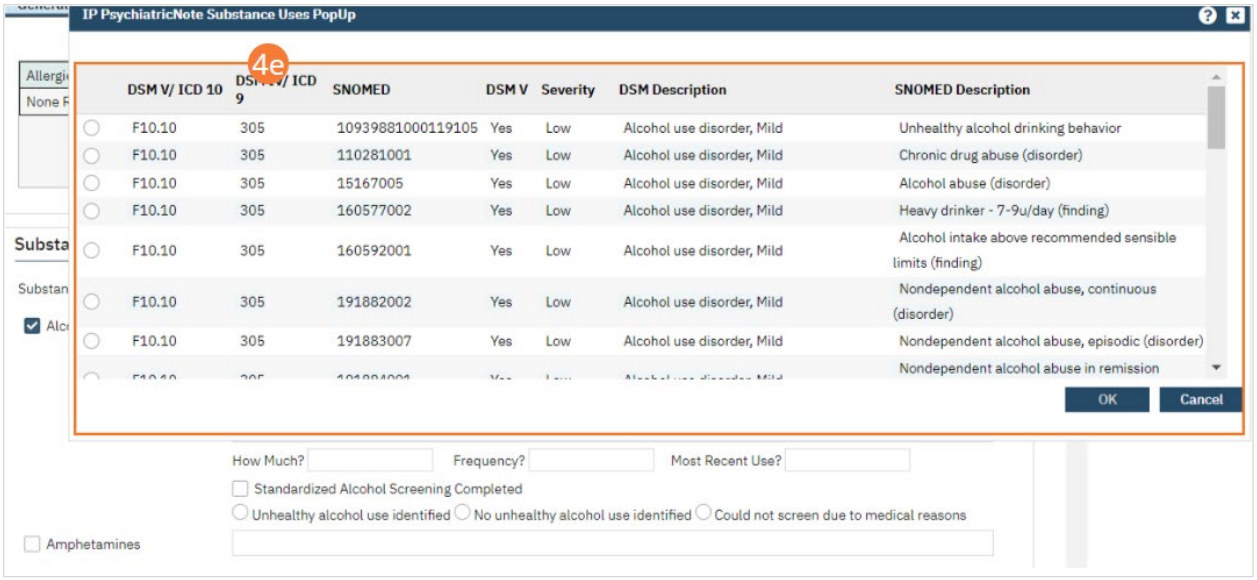
   b) Click a radio button for Side Effects. If 'Specify' is chosen, enter specifying comments.
   c) Confirm that Allergies are properly imported. If needed, Refresh the field, or open SmartCare Rx with the Open Allery button and add client allergies. For more information, see SmartCare Rx training.



d) Select checkboxes for substances the client has a history of using. If none, check the None checkbox. Add comments to selected substances.

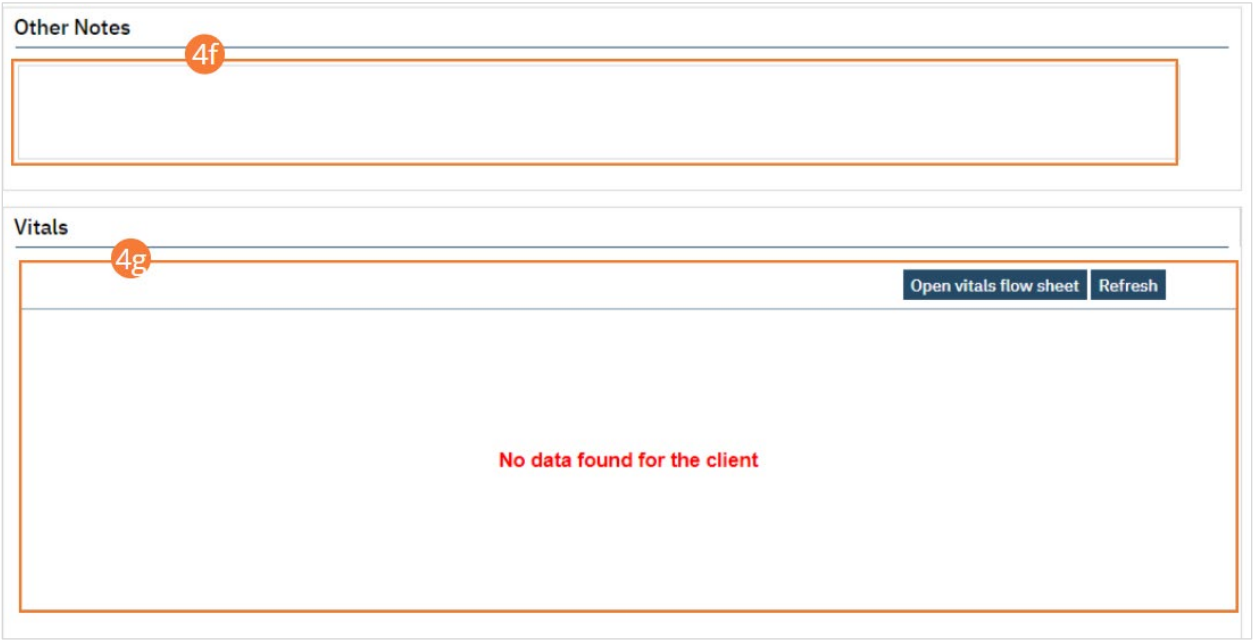


e) When a box is checked, a clinical problems selection window will pop up. Select a radio button for an appropriate clinical problem, then click OK. If use of the substance should not be recorded as a clinical problem, click Cancel. The selected problem will be added to the note.

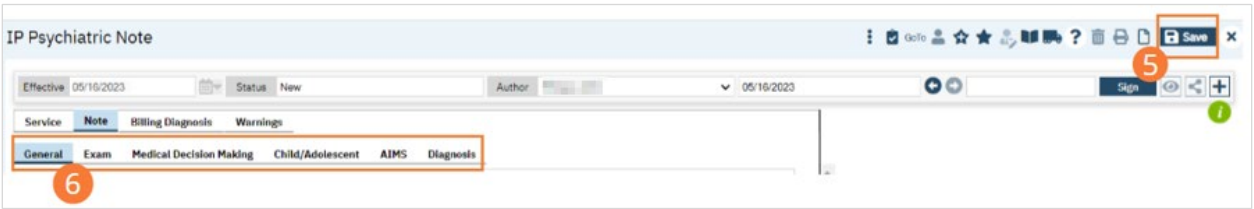


f) Enter text in Other Notes, as appropriate.

g) Ensure that the last completed Vitals assessment is displaying. If necessary, click refresh to bring up the most recent Vitals assessment, or click the Open vitals flow sheet button to complete a new Vitals assessment. For more information, see Flow Sheet training.



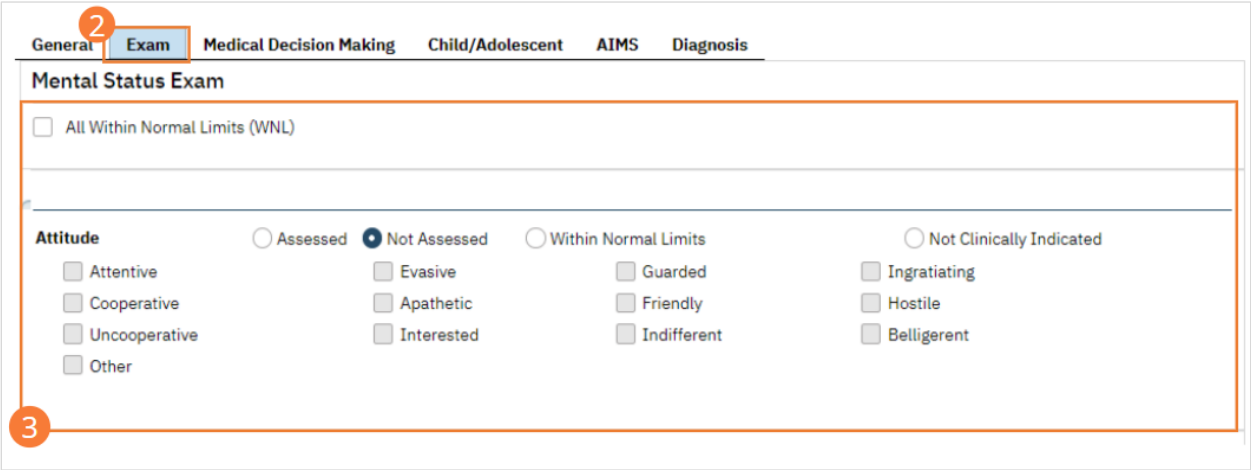
5. Select the Save icon.
6. Navigate to the next tab.



How to Complete the Exam tab of the IP Psychiatric Note for a Daily Progress Note

1. Begin on the IP Psychiatric Note.

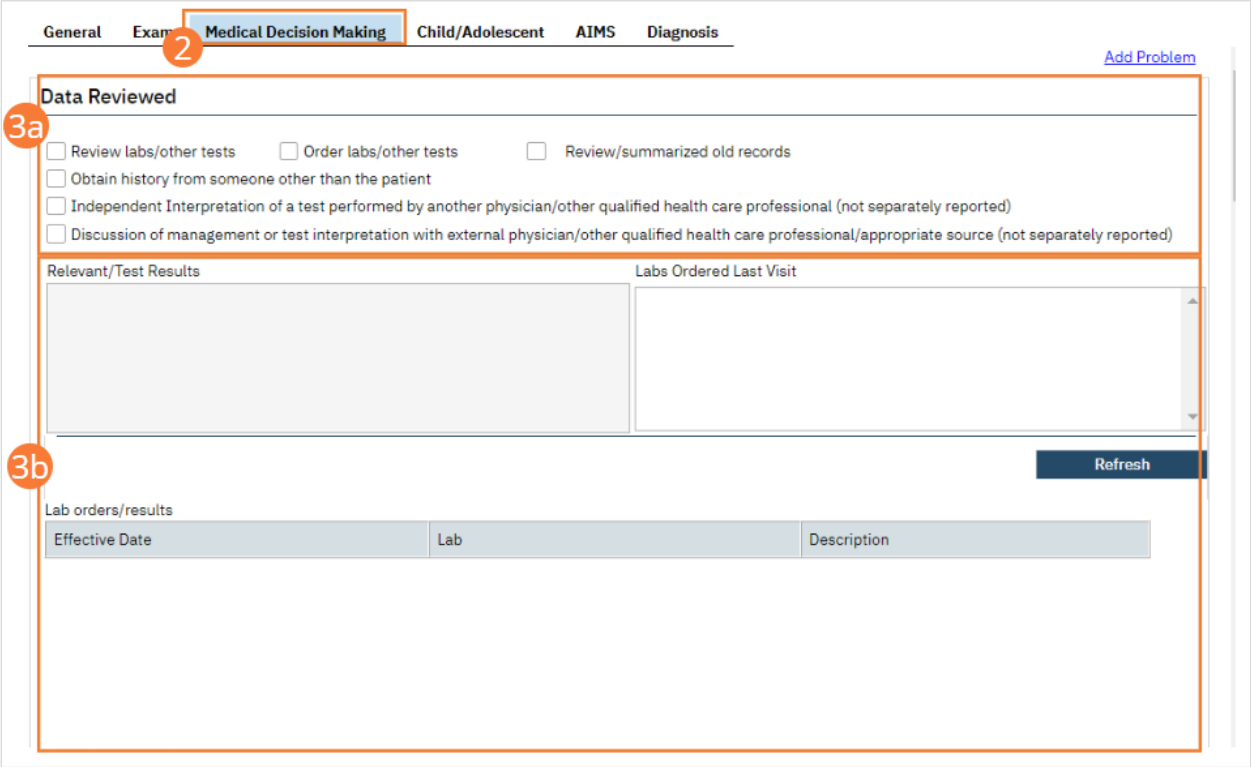
2. Select the Exam tab.
3. Complete required fields in each section by selecting a radio button for each system. If Assessed is selected, the sections will initialize. Click each checkbox for which your exam returned significant findings. Alternately, you can select the All Within Normal Limits checkbox to set all systems to Within Normal Limits. Enter text in comment fields and select the appropriate radio buttons as they appear.



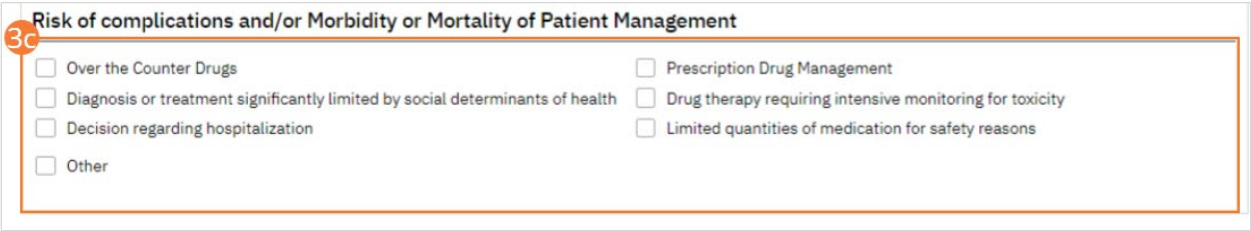
4. Select the Save icon.
5. Navigate to the next tab.

How to Complete the Medical Decision Making tab of the IP Psychiatric Note for a Daily Progress Note

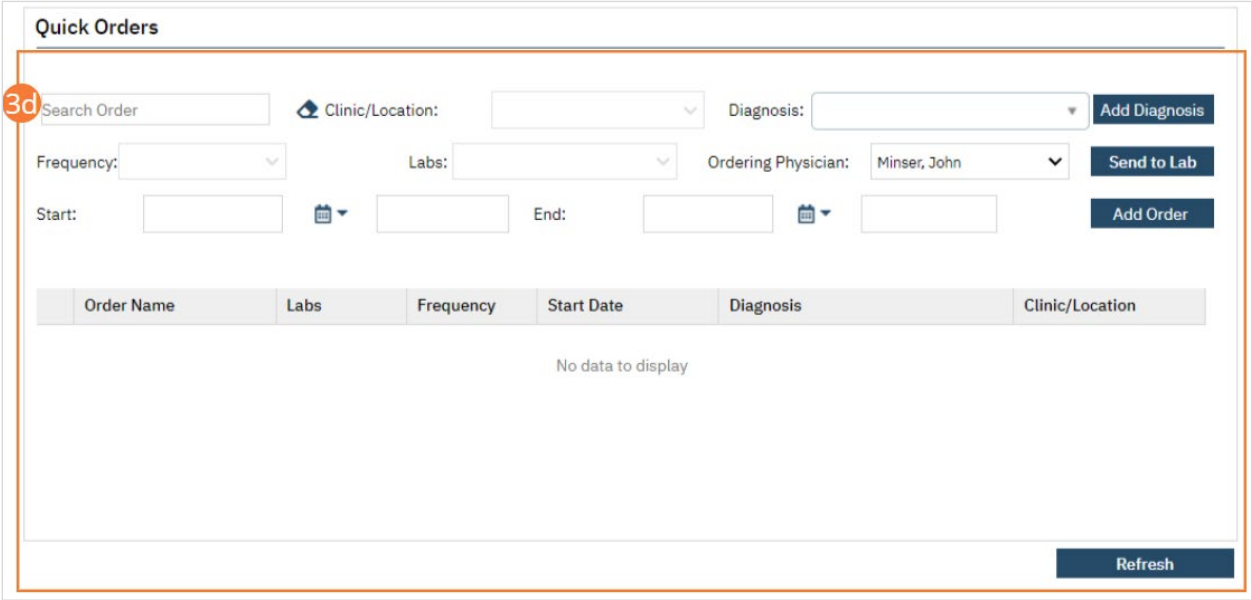
1. Begin on the IP Psychiatric Note.
2. Select the Medical Decision Making tab.
3. Complete required fields.
    a) Check boxes to indicate data you have reviewed.
    b) Enter lab order notes, and confirm previous labs are displayed appropriately. If necessary, click the Refresh button to bring up most recent labs.



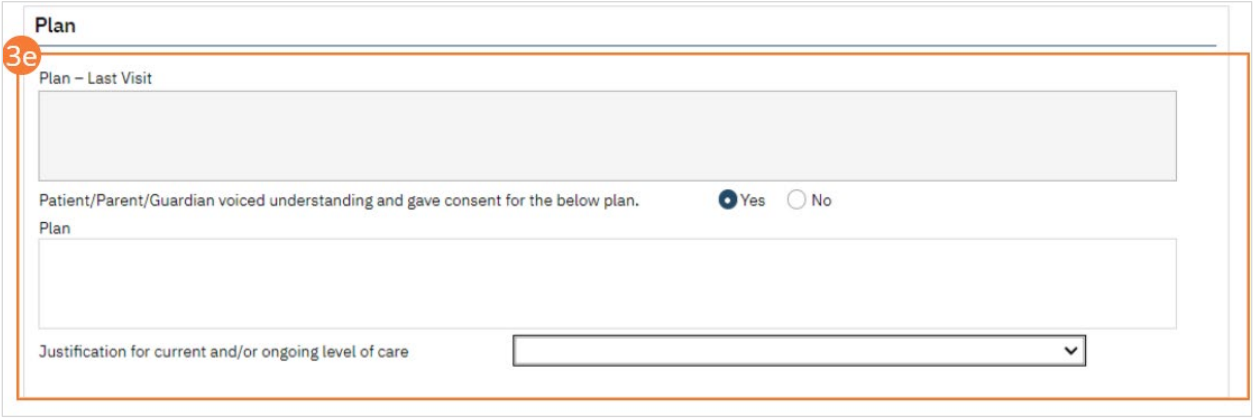
c) Check all applicable boxes in the Risk of Complications and/or Morbidity or Mortality of Patient Management.



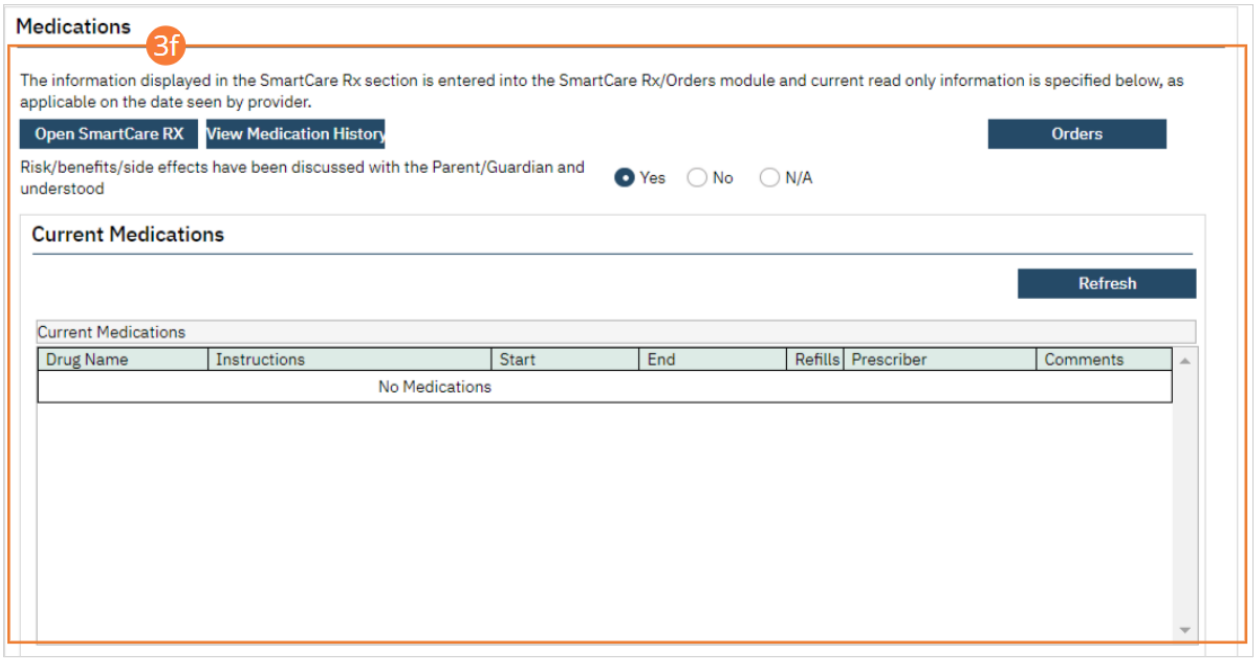
d) Enter Quick Orders as needed. For more information, see Orders training.



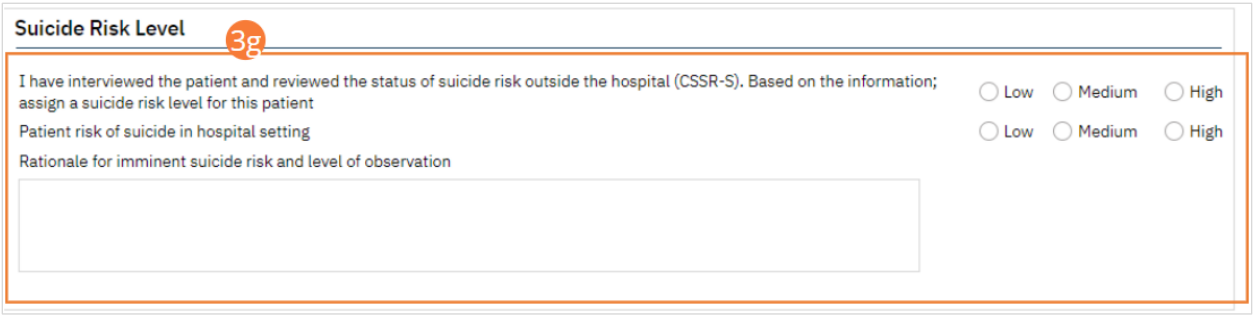
e) Review the previous plan, and update as necessary. Select a Consent radio button, enter comments in the Plan text field, and select a Level of Care justification from the dropdown.



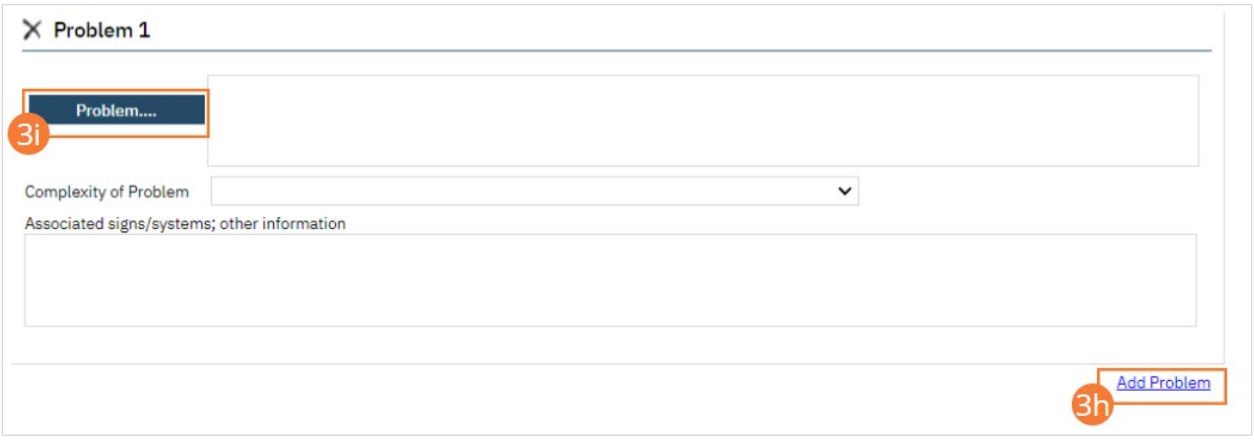
f) Review existing medications and update as necessary. On the Note, select from radio buttons and enter text in fields. Click SmartCare Rx, Medication History, and Orders buttons to link to other functions. For more information on adding medications and orders, see SmartCare Rx and Orders training.



g) Complete the Suicide Risk Level section. Select Low, Medium, or High risk radio buttons for each prompt, and enter text in the Rationale field.



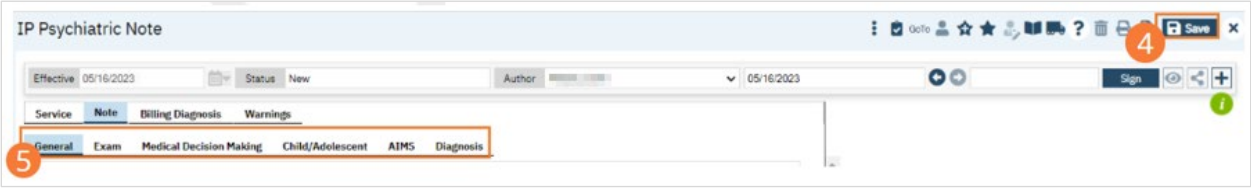
h) Optionally, add a Problem section by selecting the Add Problem hyperlink at the top of the page.
i) Select the Problem button. A pop-up will appear.



j) Select an existing Problem from the pop-up.
k) Click the OK button. The pop-up will close.

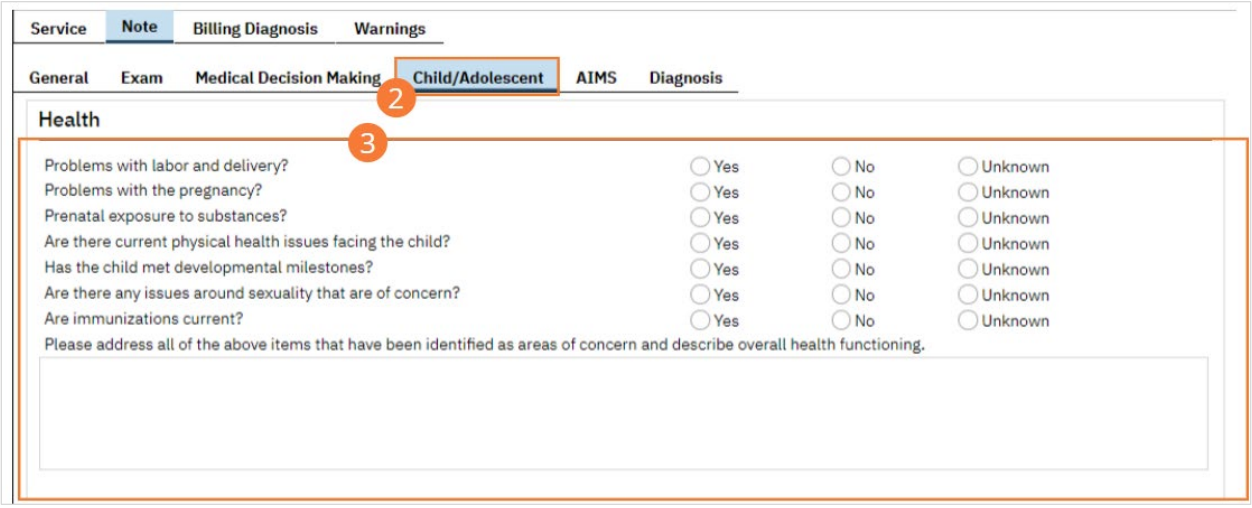
l) Select a complexity from the dropdown and enter comments in the text field. Continue with the tab, or save and navigate to the next tab.

4. Select the Save icon.
5. Navigate to the next tab.

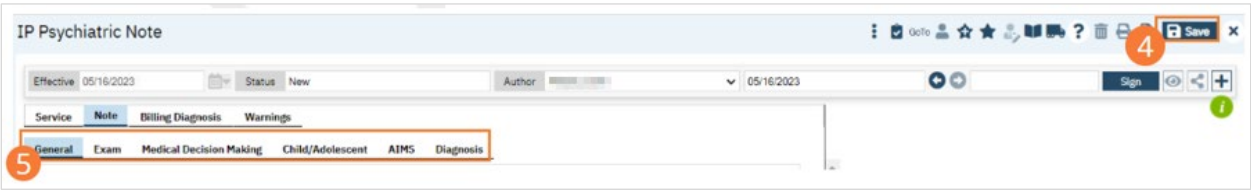


How to Complete the Child/Adolescent tab of the IP Psychiatric Note for a Daily Progress Note

1. Begin on the IP Psychiatric Note.
2. Select the Child/Adolescent Making tab. If the Child/Adolescent tab is not present, ensure that you have selected a Child/Adolescent note on the general tab.
3. Complete required fields. For each section, select the appropriate radio button for each prompt, then enter comments in the text field.

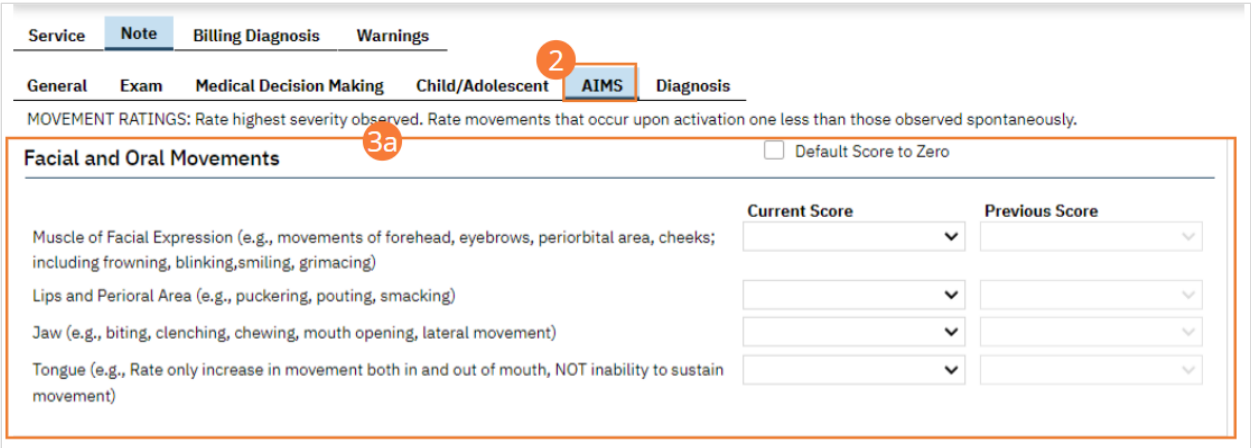


4. Select the Save icon.
5. Navigate to the next tab.

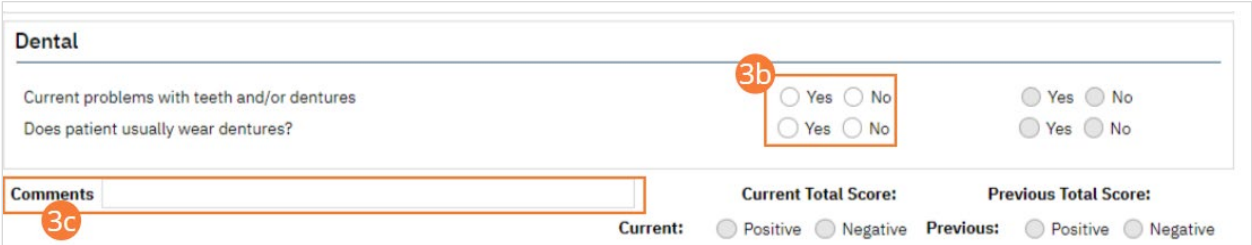


How to Complete the AIMS tab of the IP Psychiatric Note for a Daily Progress Note

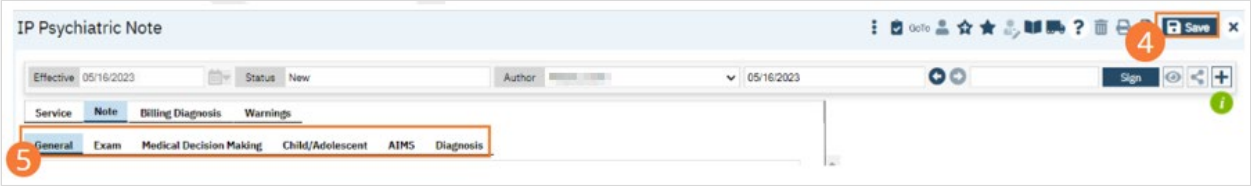
1. Begin on the IP Psychiatric Note.
2. Select the AIMS tab.
3. Complete required fields.
    a) For each section, select a score from the dropdown for each prompt. Note that previous scores will display to the right of each dropdown.



    b) For the Dental section, select a Yes or No radio button for each prompt.
    c) Add Comments in the text field if needed. Note the total score will be displayed to the right.

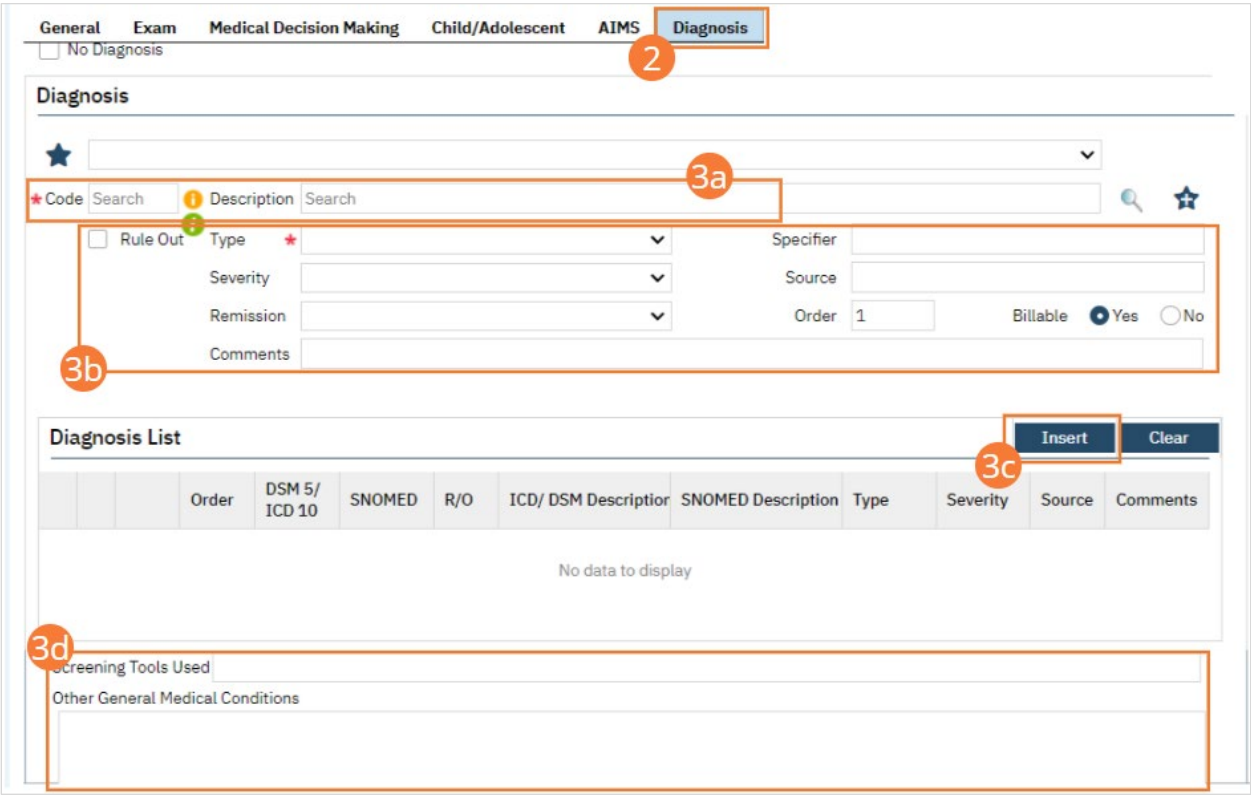


4. Select the Save icon.
5. Navigate to the next tab.

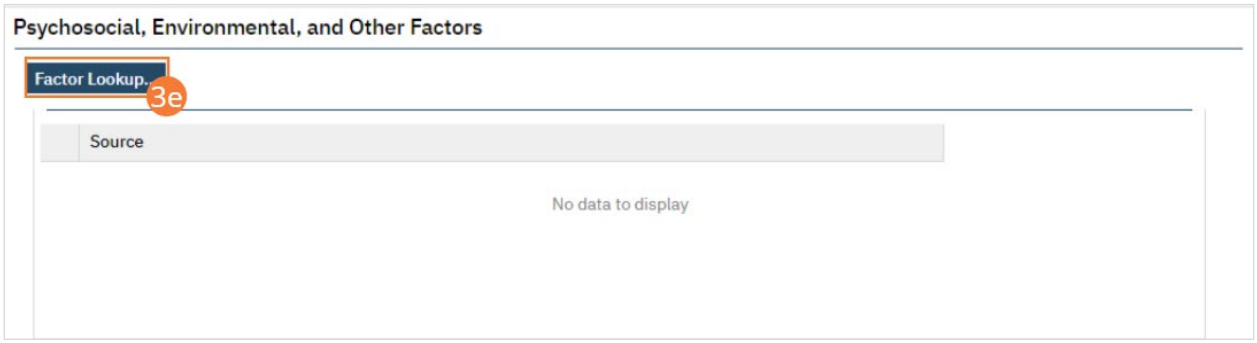


How to Complete the Diagnosis tab of the IP Psychiatric Note for a Daily Progress Note

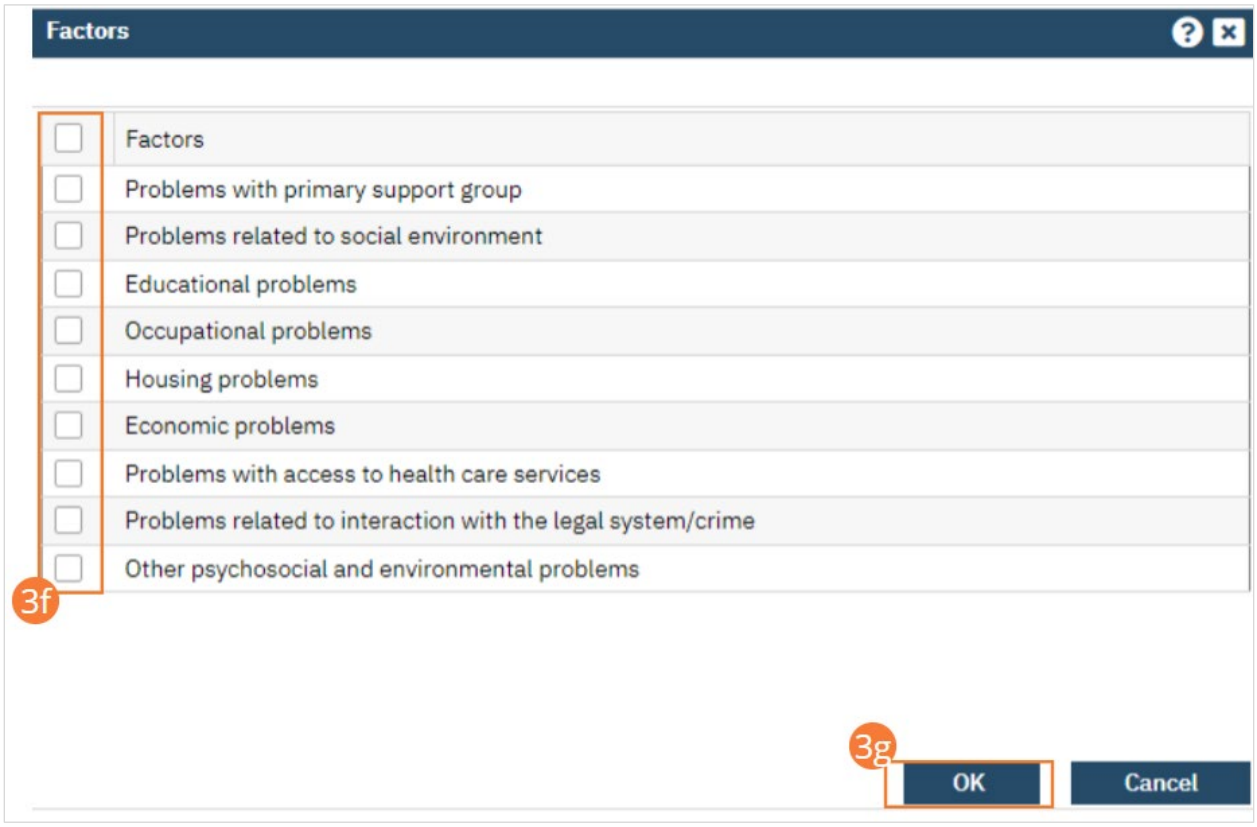
1. Begin on the IP Psychiatric Note.
2. Select the Diagnosis tab.
3. Complete required fields.
    a) Search for a diagnosis code or description. Select the chosen diagnosis from the dropdown that appears when you begin entering text.
    b) Select a Type, Severity, and Remission status from the dropdowns. Enter a specifier and source in the text boxes. If desired, change the order numeral, change the Billable radio button, and/or set the diagnosis as a Rule Out by selecting the checkbox.
    c) Click the Insert button. The diagnosis will be added to the Diagnosis List.
    d) Type text into the Screening Tools Used and Other General Medical Conditions fields.



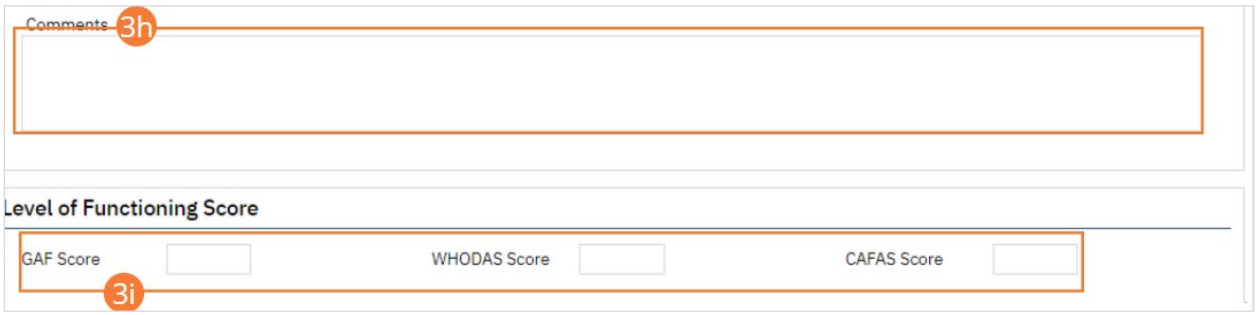
e) In the Psychosocial, Environmental, and Other Factors section, click the Factor Lookup button. A pop-up will appear.



f) Select any or all of the checkboxes that apply.
g) Click the OK button.

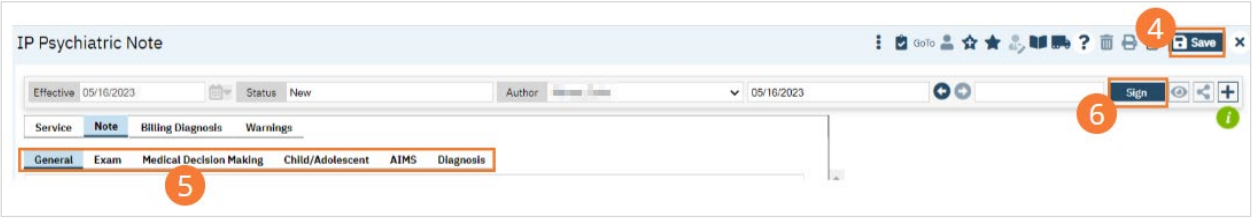


h) Enter Comments in the text field.
i) If applicable, enter GAF, WHODAS, or CAFAS scores.



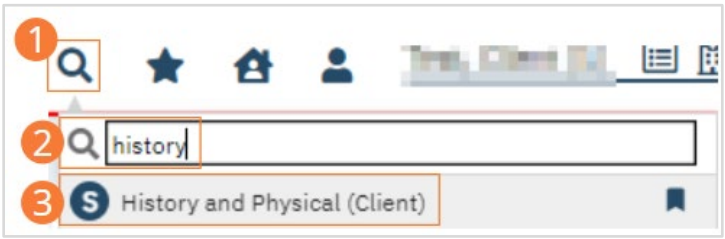
4. Click the Save button.
5. Complete any remaining tabs.

6. **Click the Sign button** to sign the document according to the steps outlined in How to Sign a Document.



Prescriber: How to Complete the History & Physical

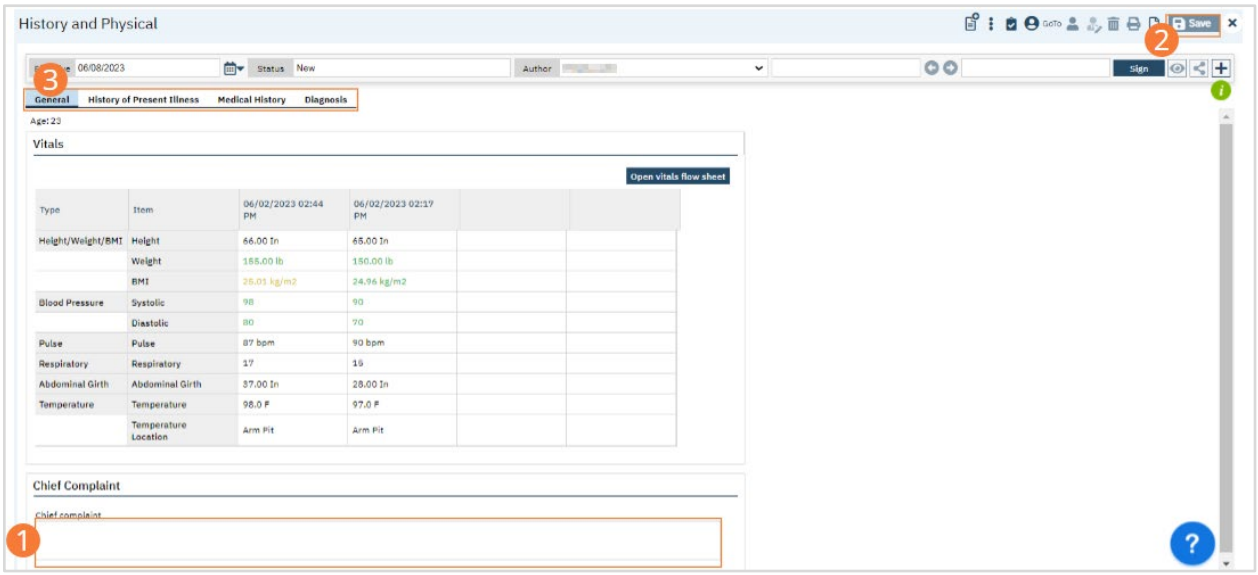
1. With an active client selected, **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type 'History'** into the search bar.
3. **Click to select History and Physical (Client).** The History and Physical assessment will open to the General tab.



How to Complete the General Tab of the History and Physical

Begin on the General tab of the History and Physical. Review the Vitals section, which is populated by the most recent Vitals flow sheets.

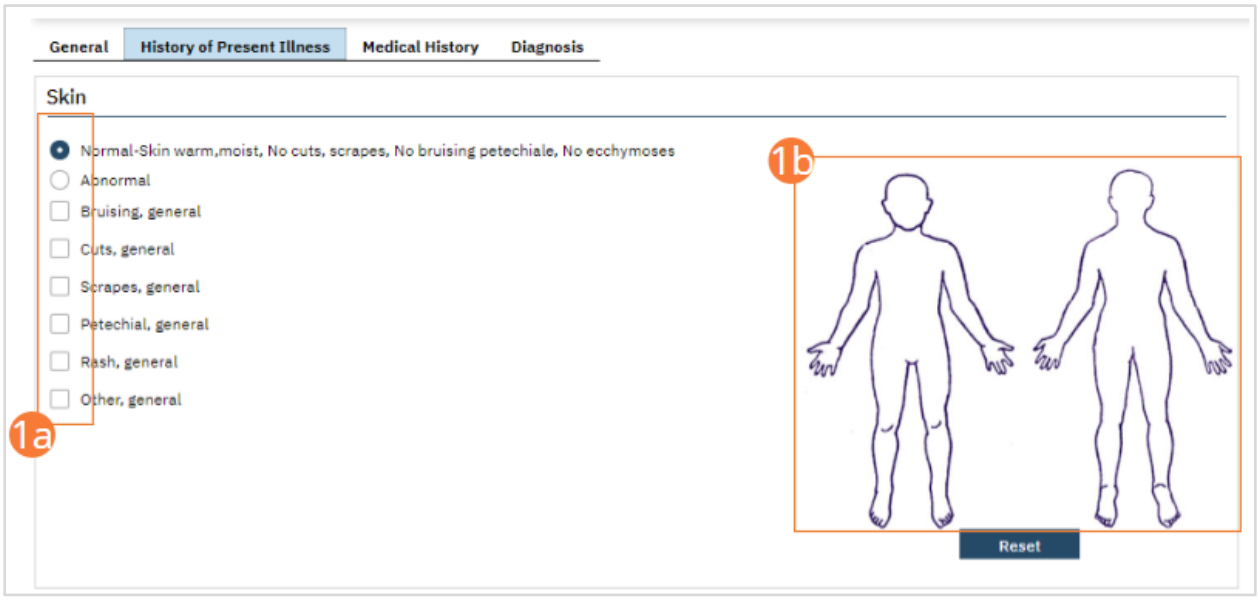
1. Type the Chief Complaint into the text field.
2. Click Save.
3. Navigate to the next tab.

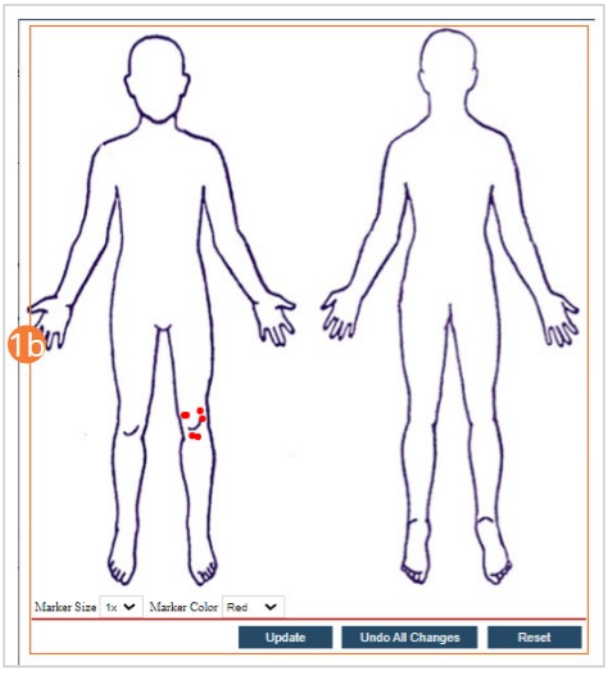


How to Complete the History of Present Illness Tab of the History and Physical

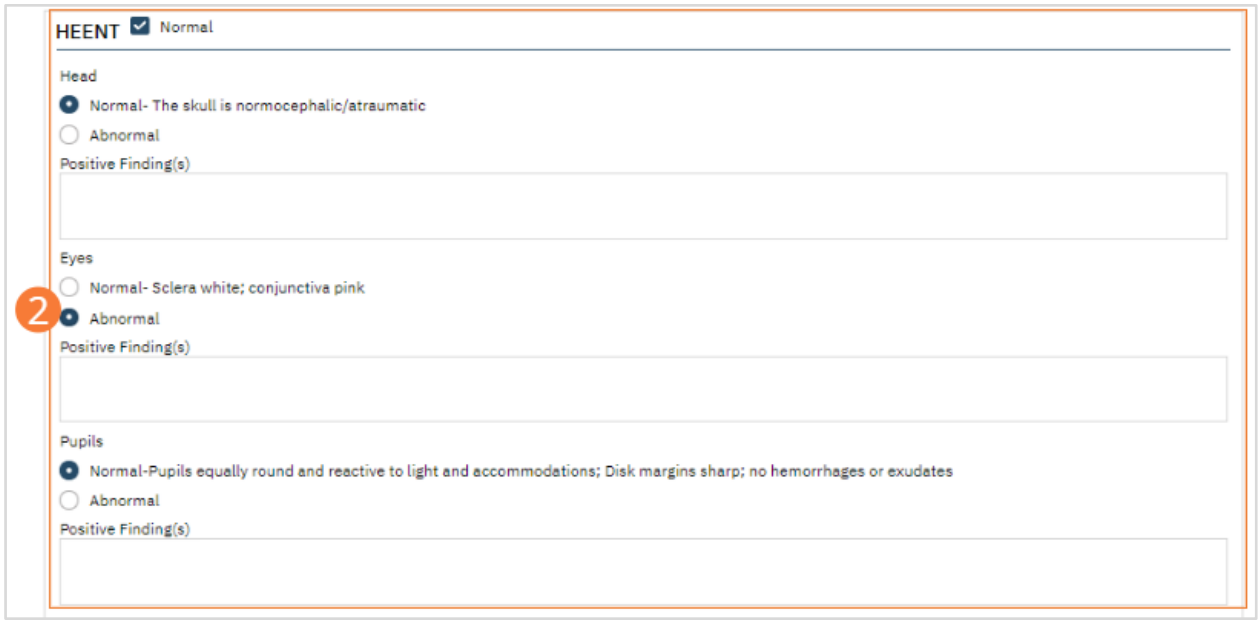
Begin on the History of Present Illness tab of the History and Physical. As you perform the assessments, complete each section.

1. Complete the Skin section.
    a. Click the Radio button at the top to determine if the findings are Normal or Abnormal. For each positive finding, click the checkbox to open a text field. Enter findings in the text field.
    b. Where a figure is seen, click it to perform markup. Select your markup tool from the dropdowns, then click on the figure to identify areas of concern. Click Update to add the markup to the assessment.

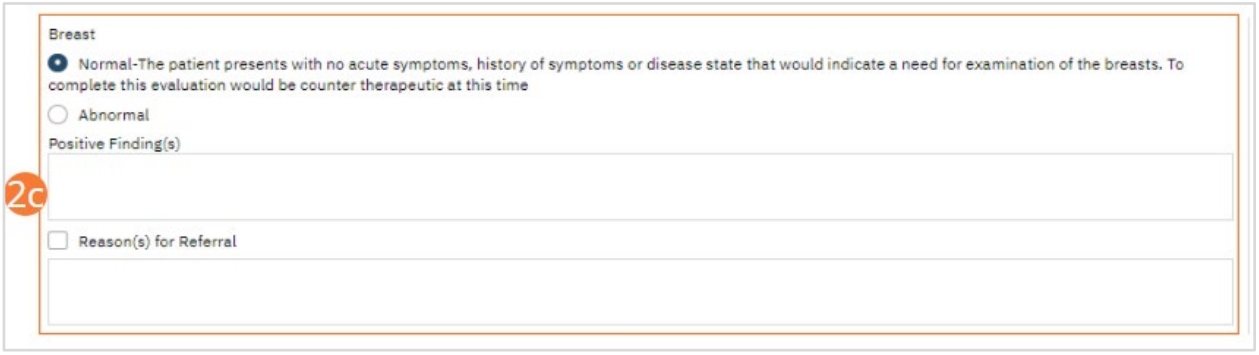




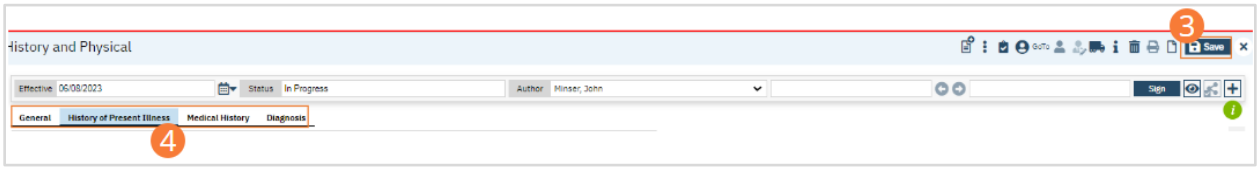
2. Complete the review of systems sections in a similar manner.
    a. For each subsection, select a Normal or Abnormal radio button, then record positive findings in the text box.
    b. Alternatively, you can click the Normal checkbox to record all areas as Normal.



c. For some subsections, additional checkboxes and/or text fields may be available. For example, the Breast subsection includes a reason for referral option. Record information appropriately as needed.



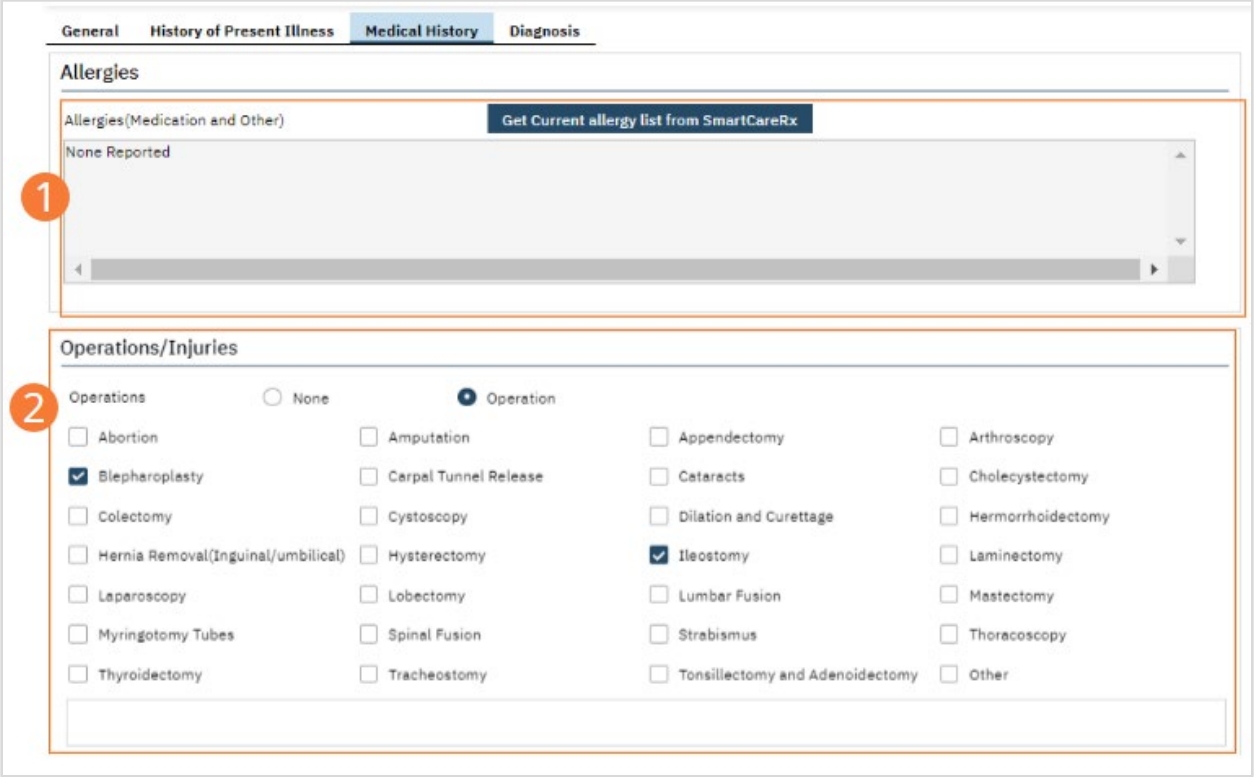
3. Once all systems are reviewed and findings are recorded, click Save.
4. Navigate to the next tab.



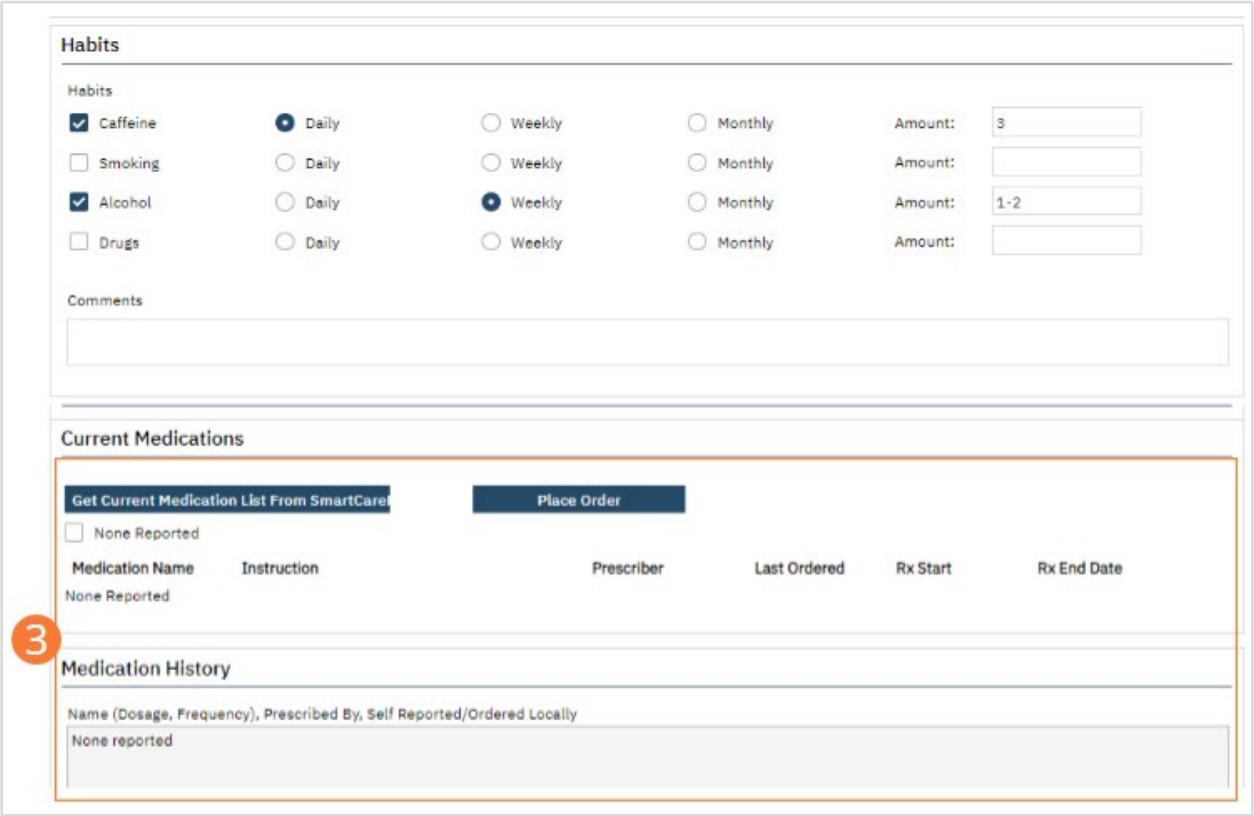
How to Complete the Medical History Tab of the History and Physical

Begin on the Medical History tab of the History and Physical. As you perform the assessments, complete each section.

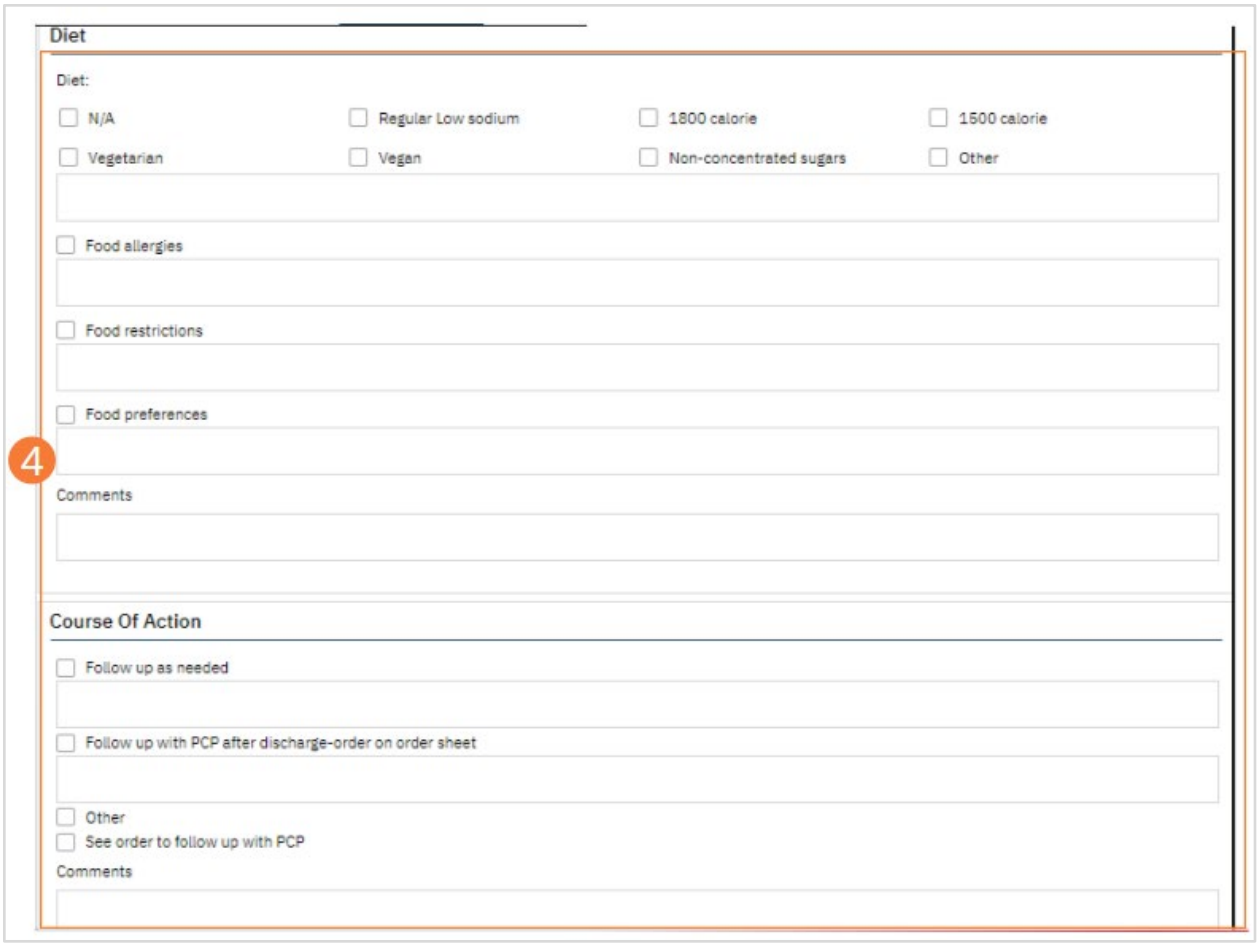
1. Review the Allergy section. If required, click the Get Current Allergies button to refresh the display using data from SmartCare Rx.
2. Complete each subsection of the Medical History.
    a. Select a radio button to indicate positive or abnormal findings.
    b. Where applicable, select checkboxes to indicate specifics. Enter comments into comment fields.



3. Review the Current Medications section and, if required, click the Get Current Medication List button to refresh the display using data from SmartCare Rx. You can also click Place Order to immediately navigate to Medication Orders.



4. Complete the Diet and Course of Action sections by selecting checkboxes next to applicable options and recording details in text fields.

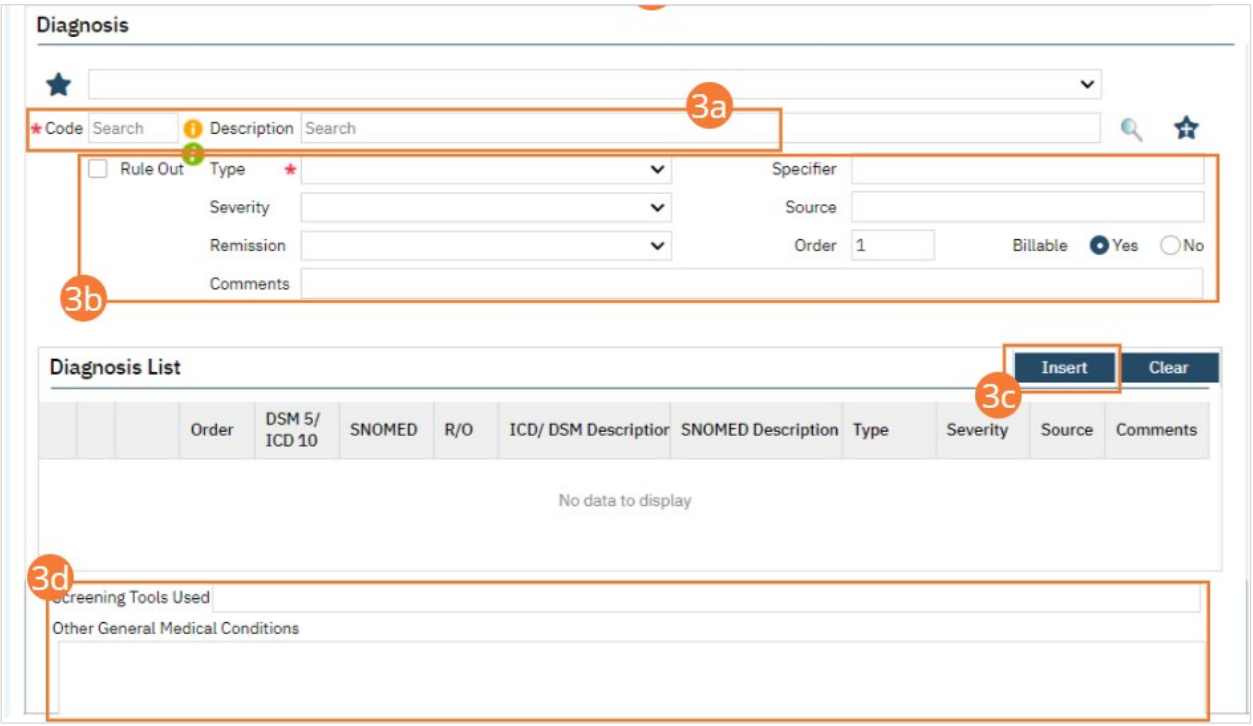


5. Click Save.
6. Navigate to the next tab.

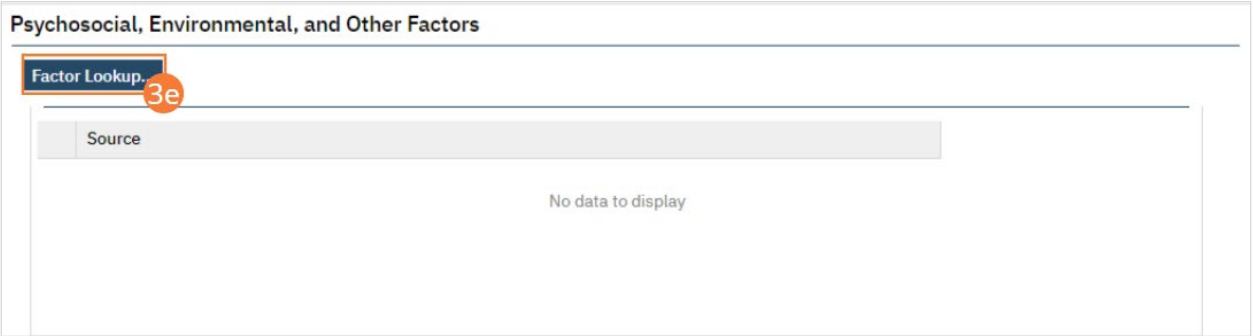
How to Complete the Diagnosis Tab of the History and Physical

1. Begin on the Diagnosis Tab.
2. If there is no diagnosis made, select the No Diagnosis checkbox and skip to the Signature step.

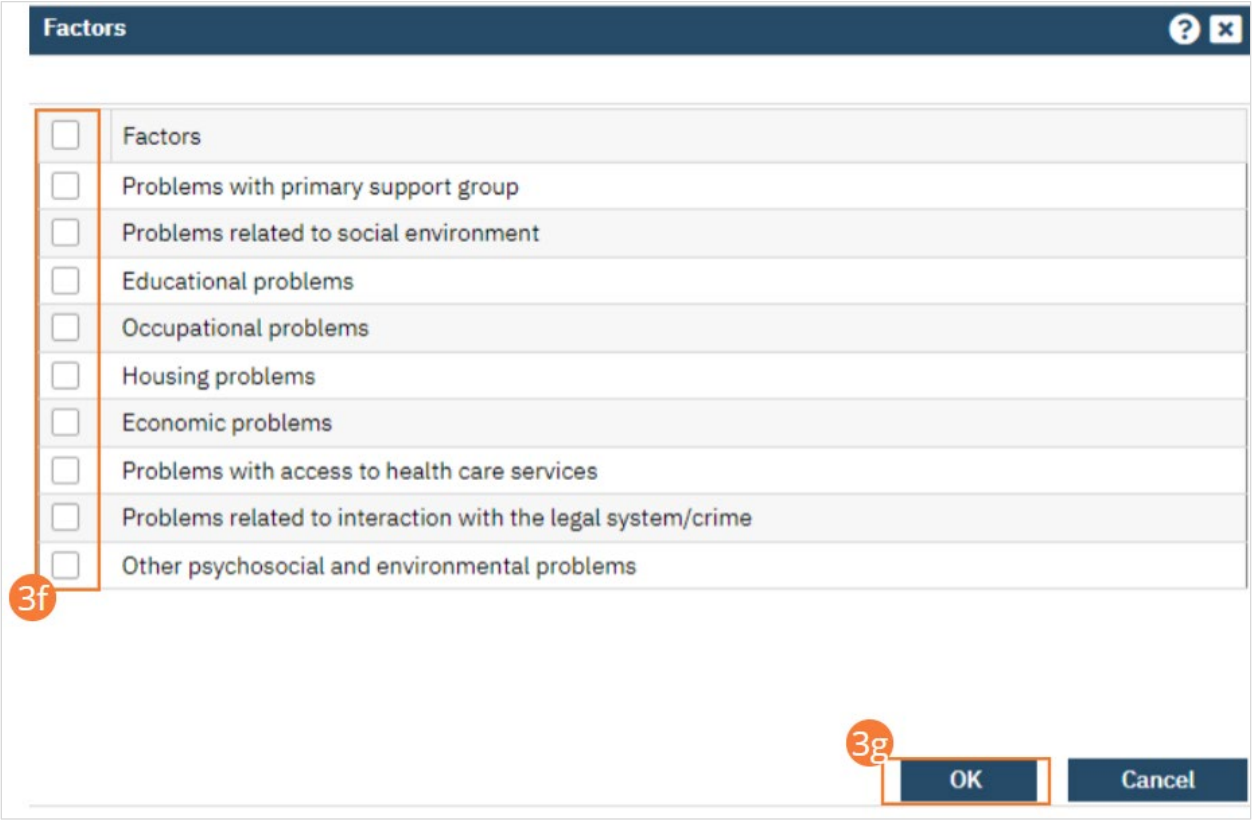
3. Complete required fields.
    a. Search for a diagnosis code or description. Select the chosen diagnosis from the dropdown that appears when you begin entering text.
    b. Select a Type, Severity, and Remission status from the dropdowns. Enter a specifier and source in the text boxes. If desired, change the order numeral, change the Billable radio button, and/or set the diagnosis as a Rule Out by selecting the checkbox.
    c. Click the Insert button. The diagnosis will be added to the Diagnosis List.
    d. Type text into the Screening Tools Used and Other General Medical Conditions fields.



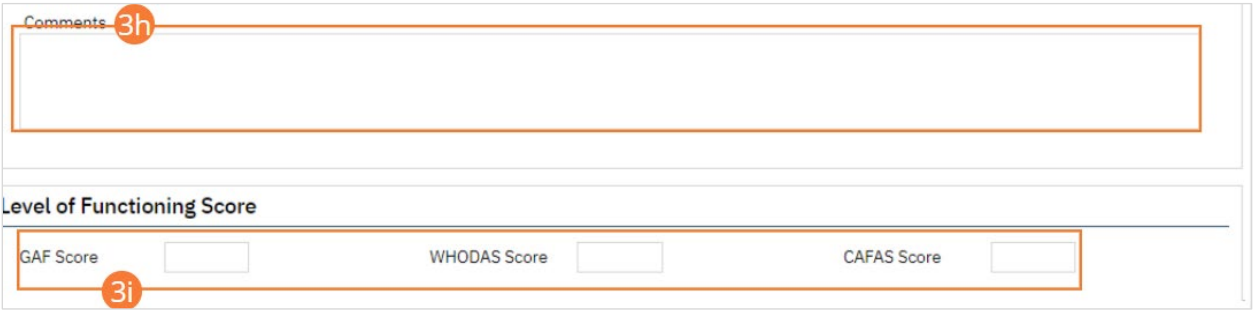
e. In the Psychosocial, Environmental, and Other Factors section, click the Factor Lookup button. A pop-up will appear.



f. Select any or all of the checkboxes that apply.
g. Click the OK button.



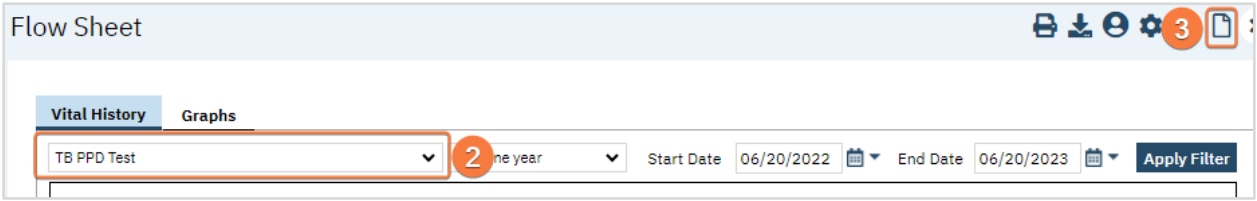
h. Enter Comments in the text field.
i. If applicable, enter GAF, WHODAS, or CAFAS scores.



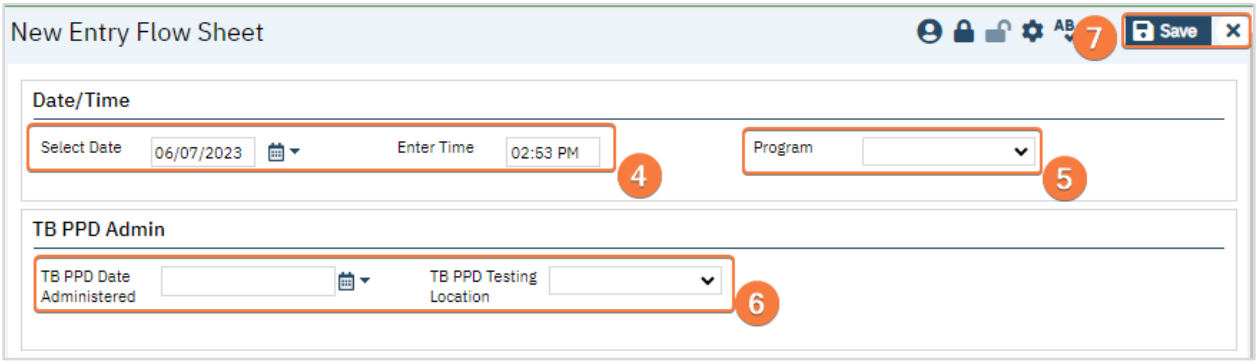
4. Click the Save button.
5. Complete any remaining tabs.
6. Click the Sign button to sign the document according to the steps outlined in How to Sign a Document.

How to Document a TB PPD Test

1. With an active client selected, begin on the Flow Sheets page.
   a. See General Client Search for details on opening the active client's record.
   b. See How to See Flow Sheets for an Active Client for details on accessing flow sheets.
2. Select the TB PPD Test Flow Sheet template from the dropdown.
3. Click the New icon in the tool bar. A TB PPD Test Flow Sheet Entry screen will open.



4. The date and time will automatically populate to the current date and time. If this needs to be updated, you may do so.
5. **Enter the program** associated with this entry.
6. **Enter the Date Administered and Testing Location in the corresponding fields.**
7. **Click the Save button and the close button** in the tool bar.

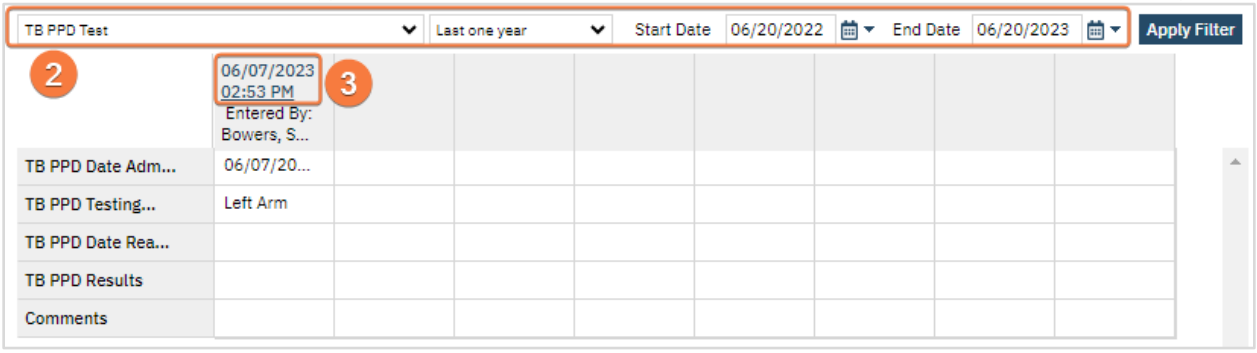


8. You will now see your entry in the Flow Sheet screen.
    a. This is dependent on Filters.
9. **Click the Save button and the close button** in the tool bar.

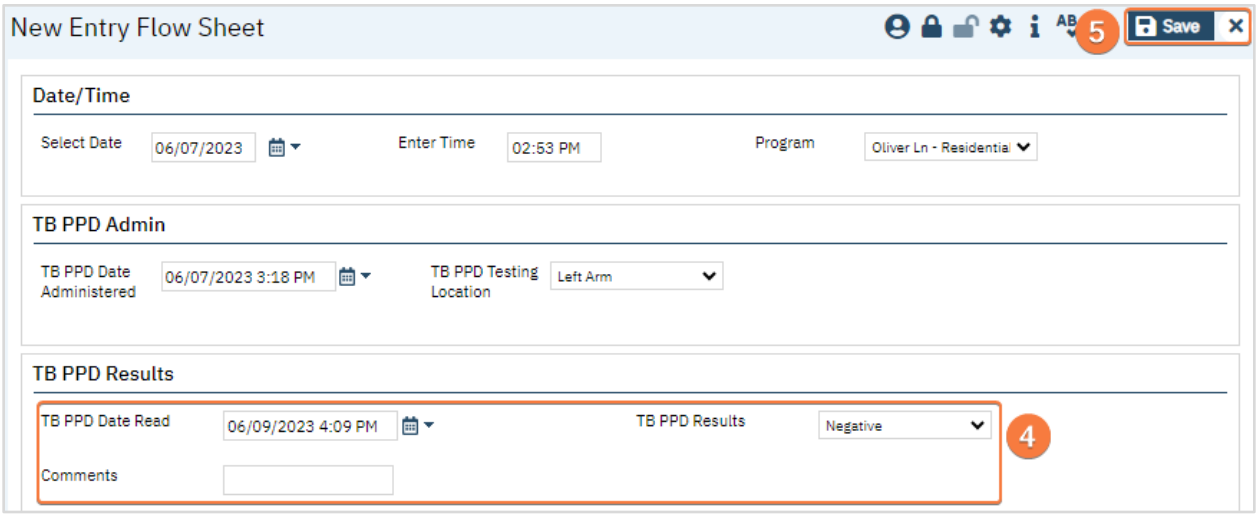
How to Enter your TB Results

Results will be entered in the same flow sheet that was created to enter the TB test was done.

1. Open Flow Sheets for the correct client.
    a. See General Client Search for details on opening the active client's record.
    b. See How to See Flow Sheets for an Active Client for details on accessing flow sheets.
2. If not already present, **select TB PPD Test from the drop down** menu.
    a. Ensure your date filters are set to display the date the test was performed.
3. Select the date and time hyperlink of the flow sheet. The TB PPD Test Flow Sheet Entry screen will open.



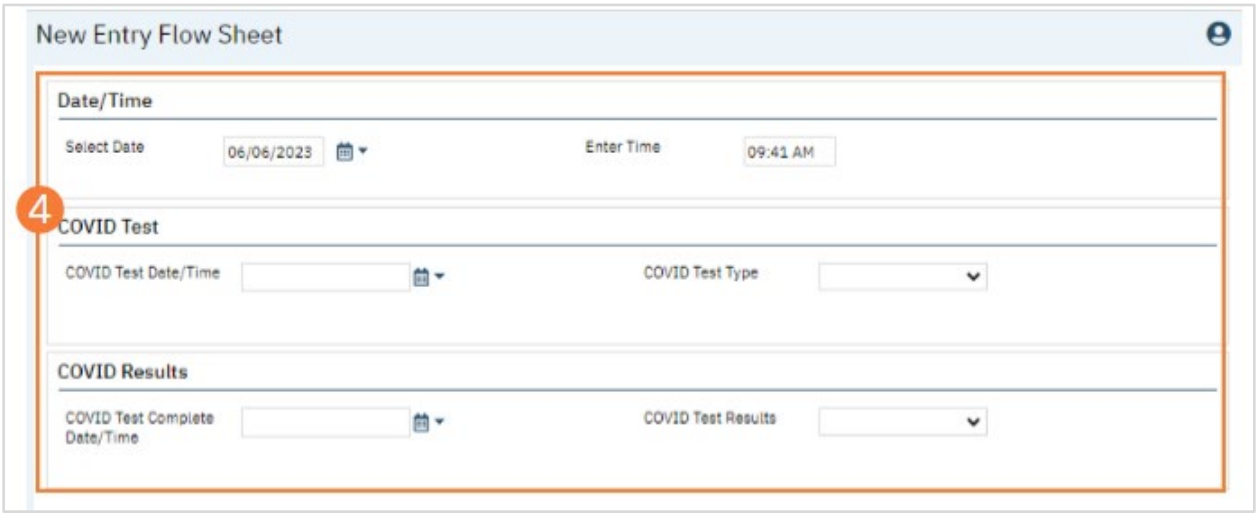
4. **Enter the date read, results, and comments** if needed.
5. **Click the Save button and the close button** in the tool bar.



How to Document a COVID Test

1. With an active client selected, begin on the Flow Sheets page.
    a. See General Client Search for details on opening the active client's record.
    b. See How to See Flow Sheets for an Active Client for details on accessing flow sheets.
2. **Select the COVID Test Flow Sheet template from the dropdown**.
3. **Click the New icon in the tool bar.** A COVID Test Flow Sheet Entry screen will open.

4. **Perform necessary clinical examinations and record results.** Check boxes beside present findings, select options from dropdowns, and type text into appropriate fields. For most flow sheets, you can skip fields for examinations you did not perform or information you do not have. In some cases, you should record a reason for why the information was not entered.



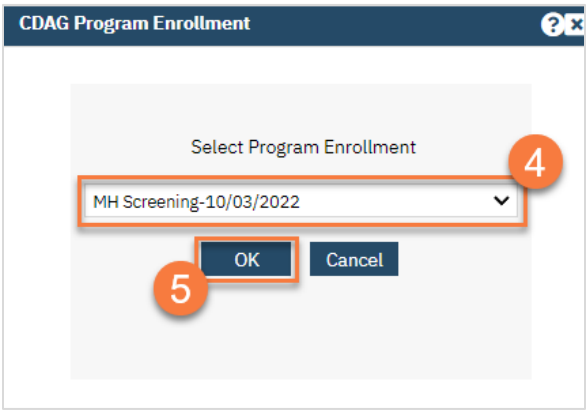
5. **Click the Save button in the tool bar.**
6. **Click the Close icon in the tool bar.** The newly recorded information will appear in the central section of the Flow Sheets page.

7. You will now see your entry in the Flow Sheet screen.
    a. This is dependent on Filters.

How to Complete the Interdisciplinary Treatment Plan

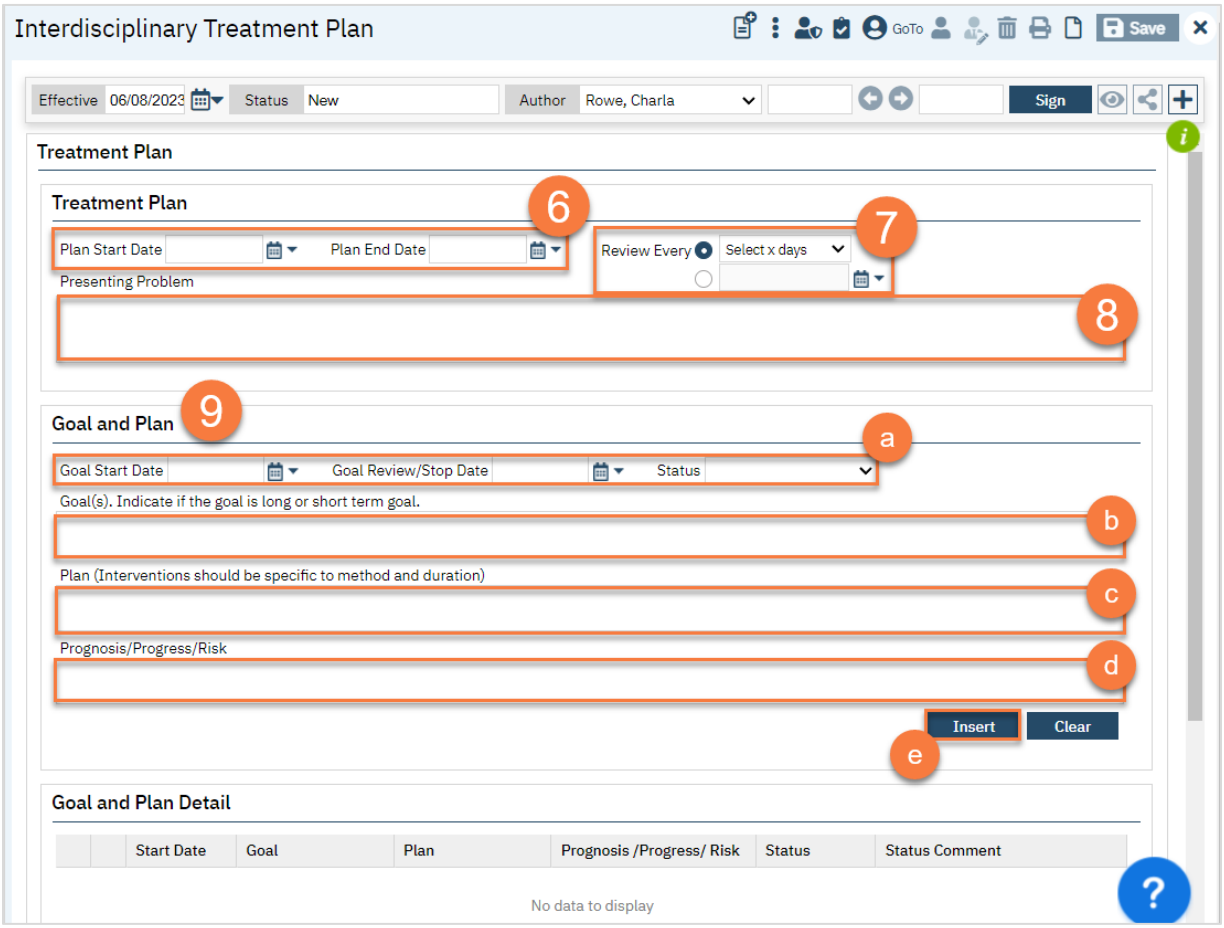
1. With the client open, **click the search icon**.
2. **Type in "Interdisciplinary Treatment Plan"** in the search bar.
3. **Select "Interdisciplinary Treatment Plan (Client)"** from the search results.

4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.

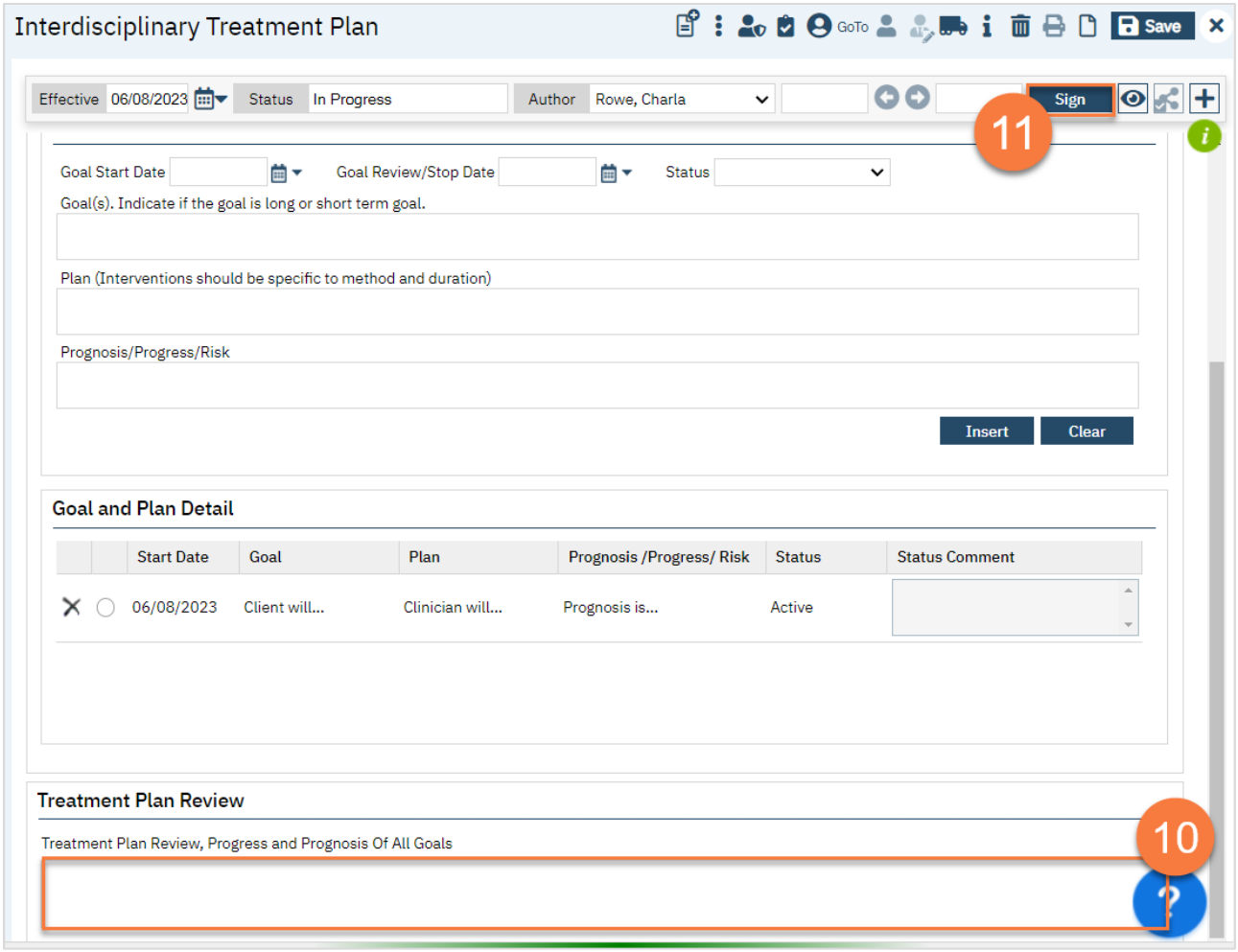


6. This opens the Interdisciplinary Treatment Plan screen. **Enter the start date of the treatment plan**. Enter the end date, if applicable.
7. **Select when the treatment plan is due for review**. You can select a specific date or can a relative number of days from the start date.
8. **Enter a description of the client's presenting problem/chief complaint.** Your facility may have additional regulations, such as including the diagnosis, the client's strengths, anticipated length of stay, etc. Enter all the necessary and pertinent information in this field.
9. In the Goal and Plan section, **add goals and interventions to the plan**.
    a. **Enter the start date for the goal, the end date (if applicable), and the current status** of the goal.
    b. **Enter a description of the goal**. Your facility may have additional regulations, such as indicating whether this is a long-term or short-term goal. Enter all the necessary and pertinent information in this field.
    c. **Enter the planned interventions that will help the client reach this goal.** Interventions are not separated out into different fields, so if you have multiple planned interventions for this goal, include them all in this field. Your facility may have additional regulations, such as indicating who is responsible for each intervention. Enter all the necessary and pertinent information in this field.

d. **Enter the prognosis for this goal.** Include any risk factors and include strengths as applicable.
e. **Click Insert** to add this goal to the treatment plan.

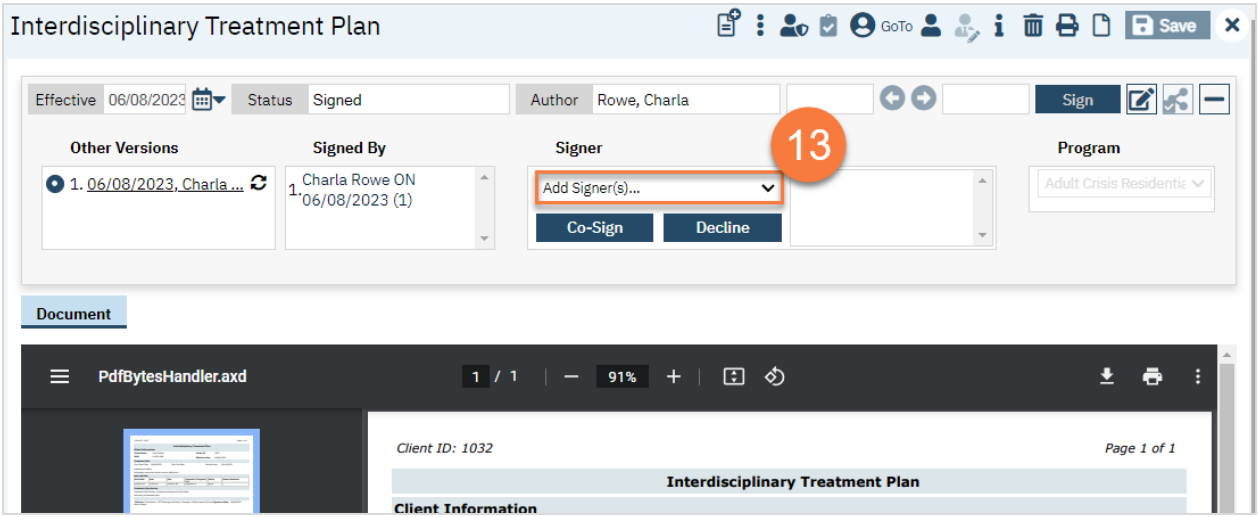


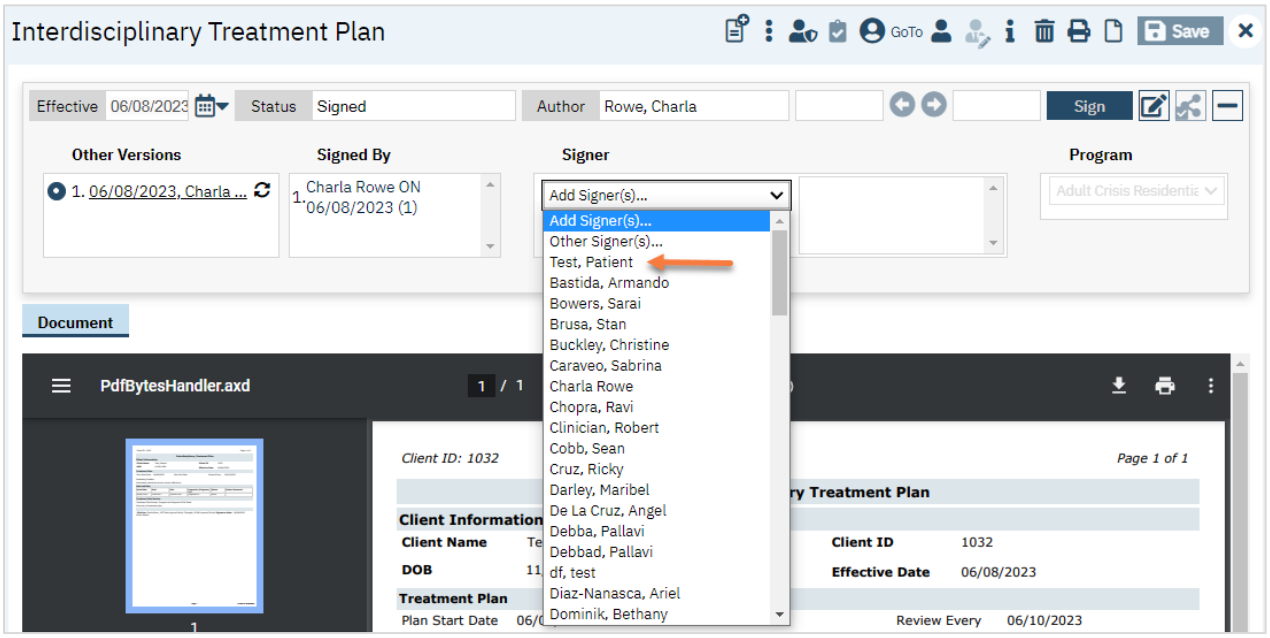
10. Once you've added all your goals, **complete the Treatment Plan Review section**. This is a summary of the overall prognosis of the client.
11. **Click Sign.**



12. If you need **to add co-signers, click on the Plus icon** to expand the document ribbon.

13. This expands the ribbon. **Click on the dropdown to select a cosigner**. You can also add staff or the client as a cosigner; the client will always show first if they're not already listed as a cosigner. After selecting your cosigner it will show in the cosigner section. Once they've signed the document, the person will move to the Signed By section.

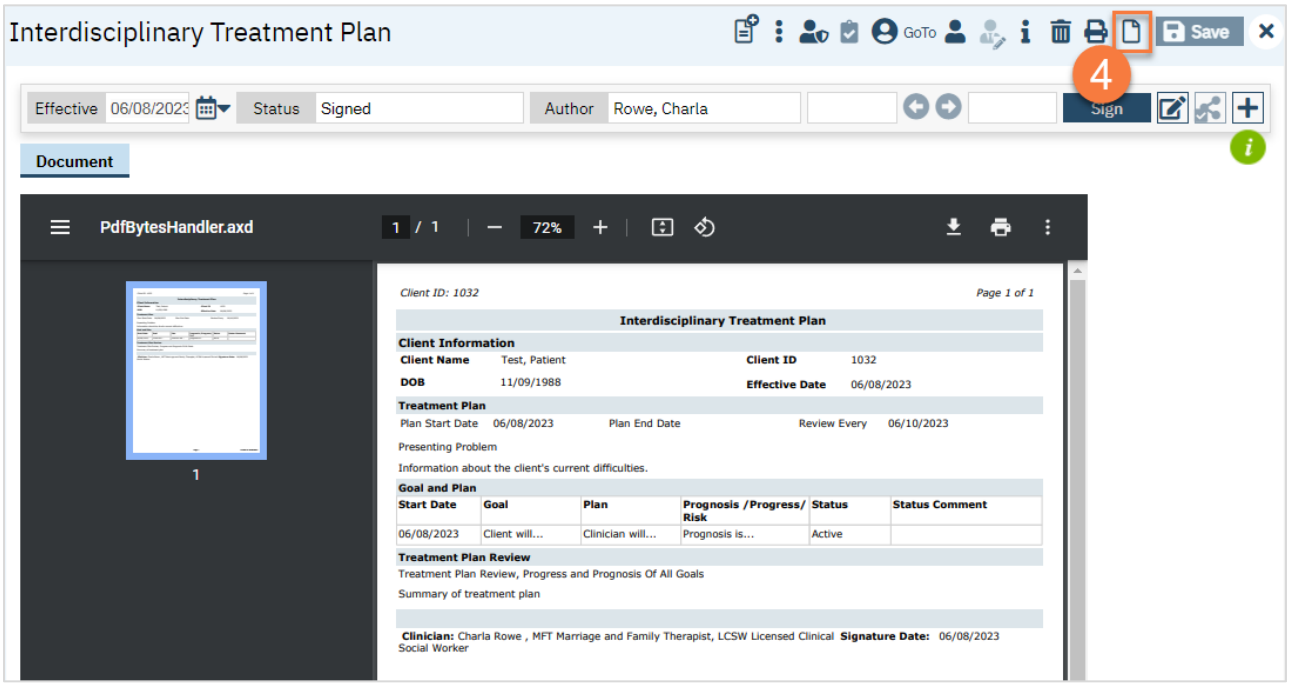




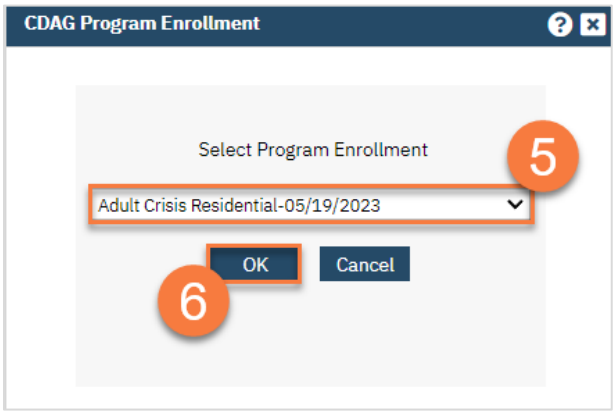
How to Update the Interdisciplinary Treatment Plan

1. With the client open, **click the search icon**.
2. **Type in "Interdisciplinary Treatment Plan"** in the search bar.
3. **Select "Interdisciplinary Treatment Plan (Client)"** from the search results.

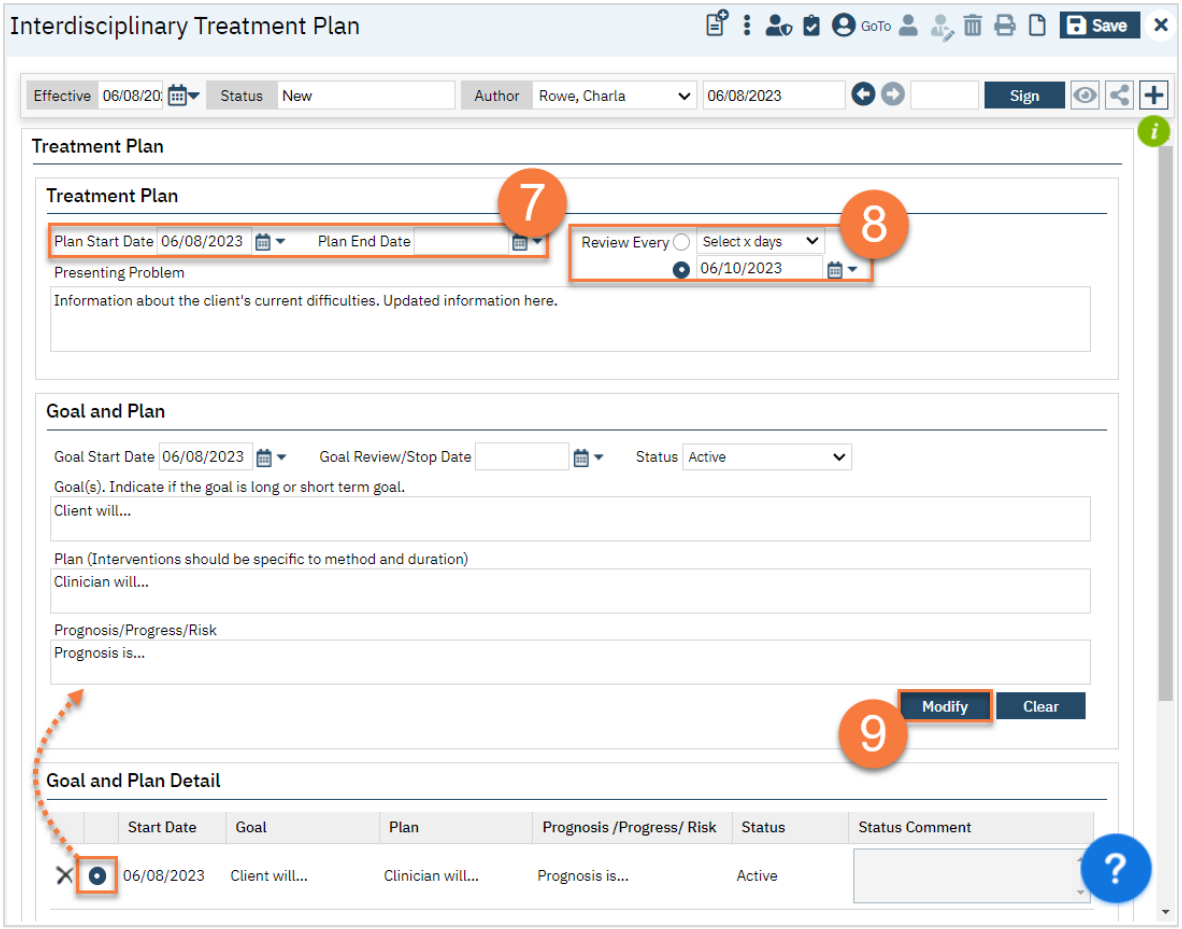
4. This opens the Interdisciplinary Treatment Plan screen. The current plan will show as a PDF. **Click on the New icon.**



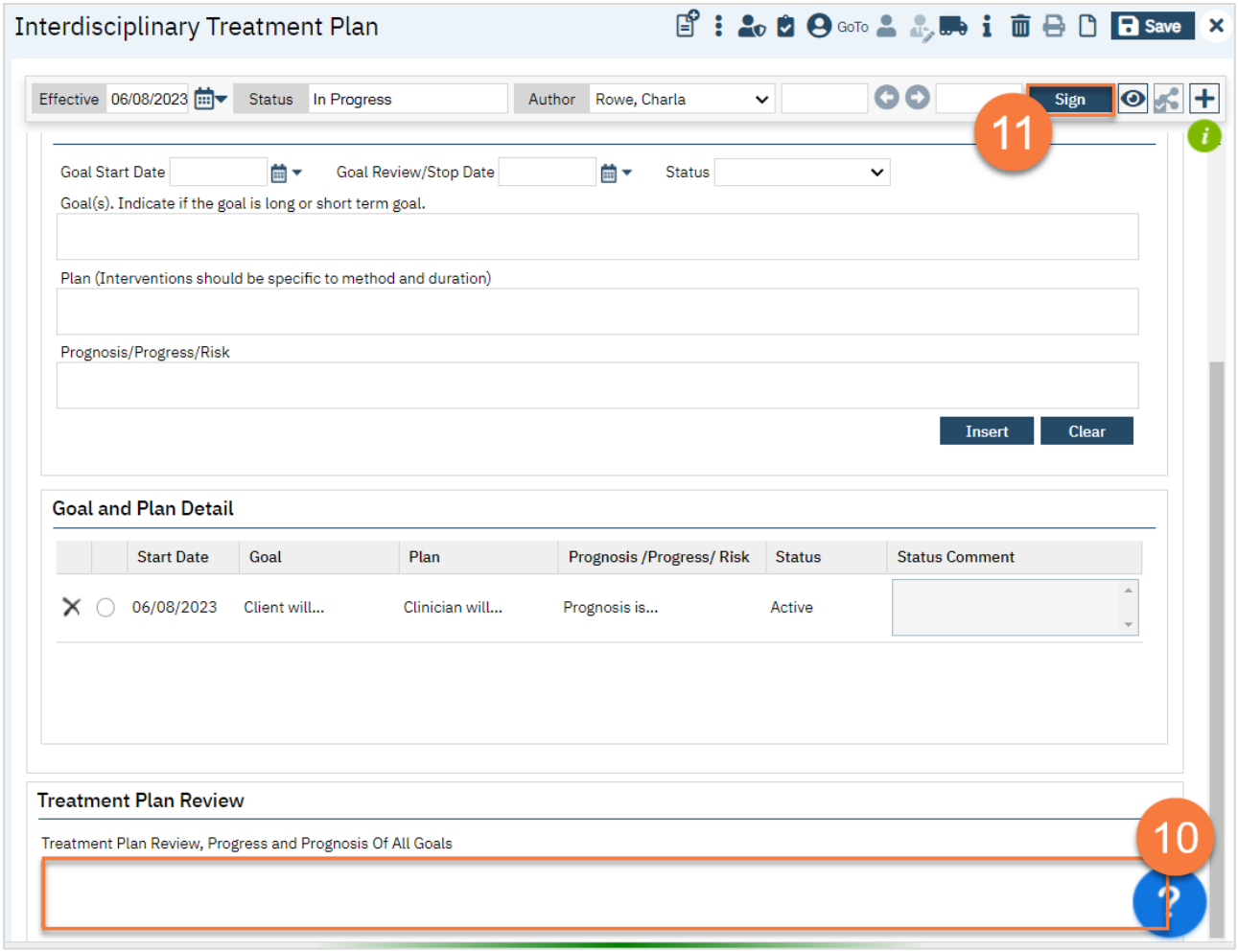
5. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
6. **Click OK** to continue.



7. This will create a new treatment plan. The old plan's information will have pulled forward. **Enter the start date of the new treatment plan**. Enter the end date, if applicable.
8. **Select when the treatment plan is due for review**. You can select a specific date or can a relative number of days from the start date. Make updates to the Presenting Problem field as necessary.
9. To update a current goal, **select the goal** from the list at the bottom. This will bring the information to the Goal and Plan section. **Make changes and then click Modify**.

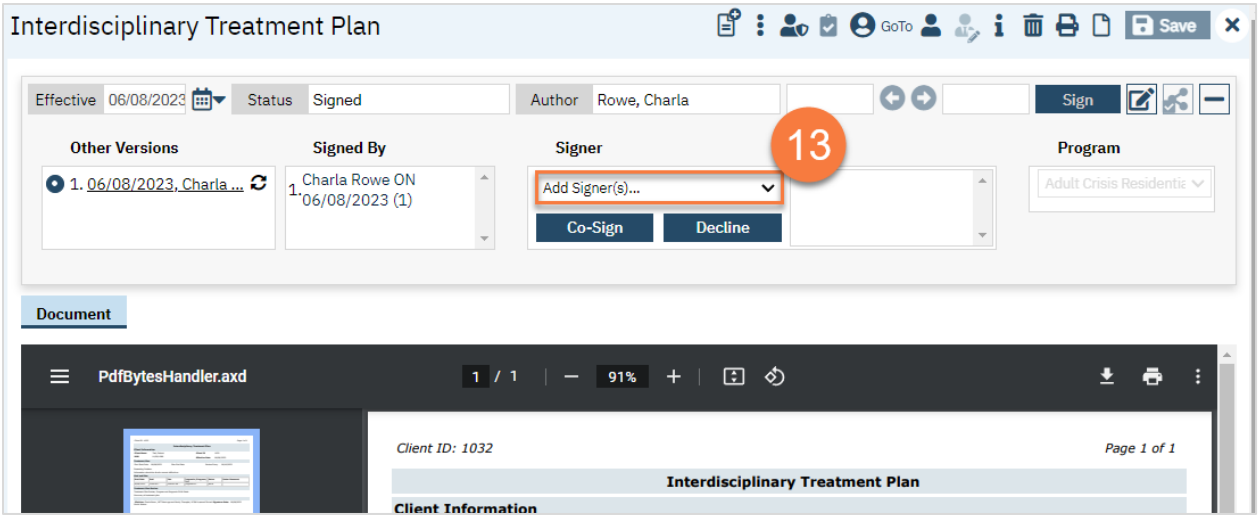


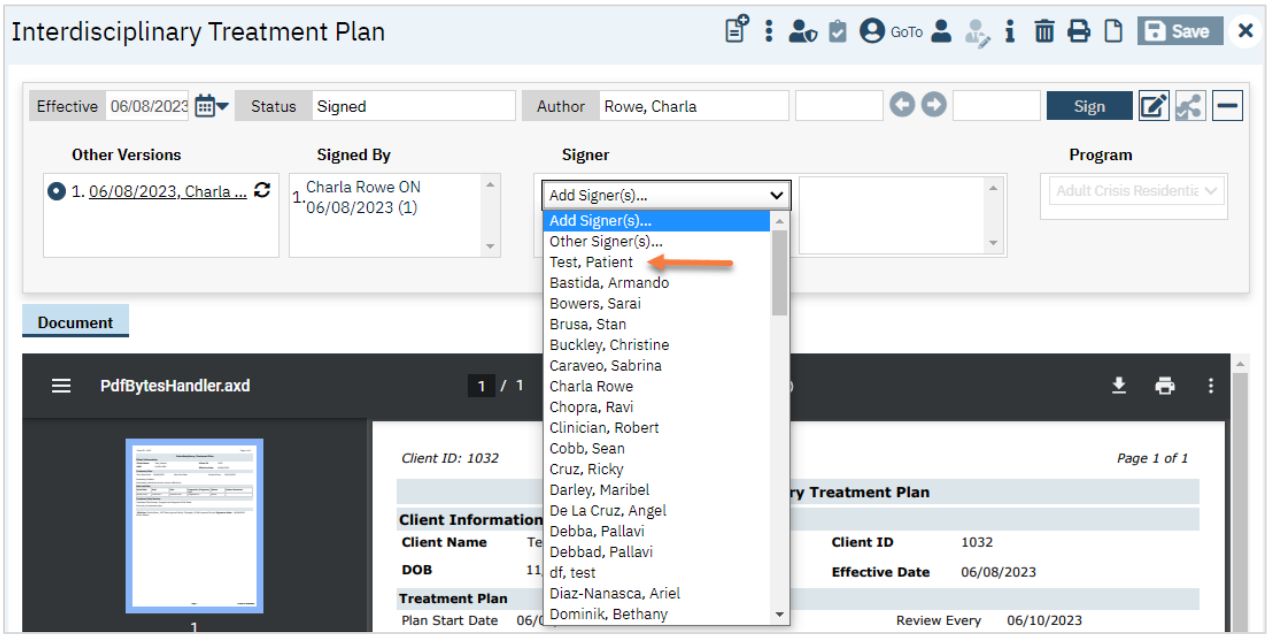
10. **Complete the Treatment Plan Review section**. This field does NOT pull forward. This is a summary of the overall prognosis of the client, as well as any progress the client has made.
11. **Click Sign.**



12. If you need **to add co-signers, click on the Plus icon** to expand the document ribbon.

13. This expands the ribbon. **Click on the dropdown to select a cosigner**. You can also add staff or the client as a cosigner; the client will always show first if they're not already listed as a cosigner. After selecting your cosigner it will show in the cosigner section. Once they've signed the document, the person will move to the Signed By section.





How to Document Other Information Gathered

During the Intake and Assessment phase, staff may be gathering additional information, including from sources other than the client themselves. Document this information in service notes using the appropriate procedure code. Your System Administrator will set up your facility to only bill services that are allowed. For some facilities that bill a bundled rate per day, additional service notes with other procedure codes will not be billed but will still be available for you to use.

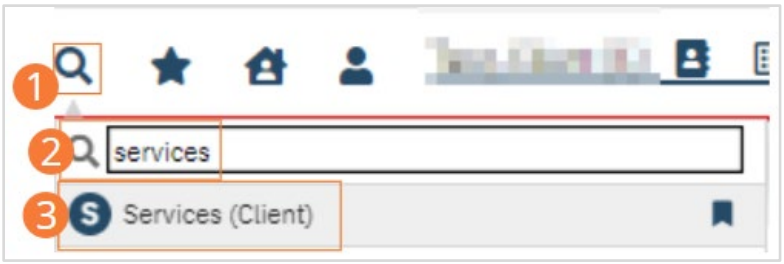
Services

How to Manually Document the Type of Bed Day to be Billed

Typically, bed services are created automatically. However, in some instances it is not best practice or should not be used (e.g. CSU setting due to being limited within 23 hours and bundling needs). Manual documentation of the Bed Day Type is completed by creating a Service for the day. A service can be created in various ways. See items below for creating manual services.

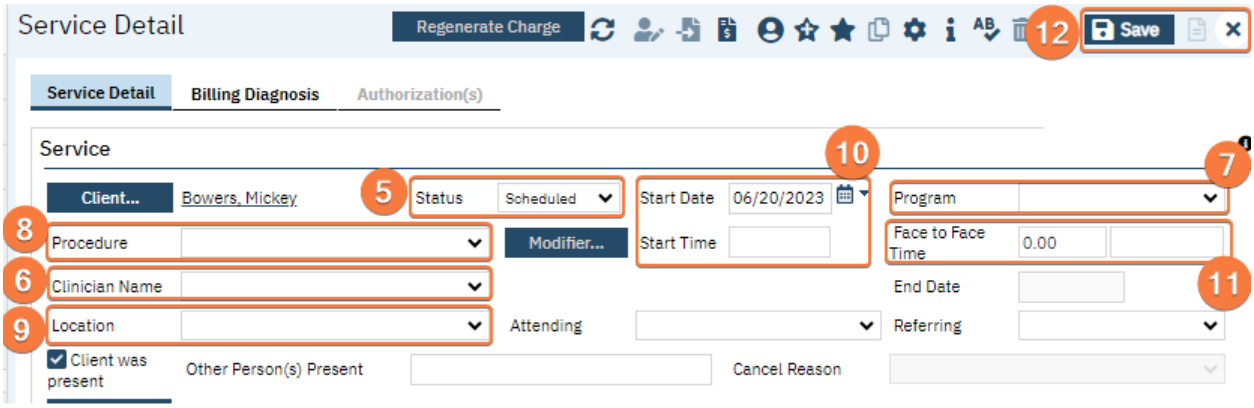
How to Create a Service

1. With an active client selected, **Click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type 'Services'** into the search bar.
3. **Click to select Services (Client).** The Services list page will open.



4. **Select the New icon from the tool bar.** A new Service Detail page opens.

5. **Change the status to Show**.
6. **Select the Clinician, 'System, BedDay', from the dropdown**.
    a. We understand bed services are not associated with a clinician. However, SmartCare structure requires a clinician for all services, even when it does not go out in the claim.
7. **Select the Program from the dropdown**.
    a. The Procedure will determine the Bed Day type. Administrative options will include "-Admin" in their displayed name.
8. **Select the Procedure from the dropdown**.
    a. This is where you should select the bed procedure.
9. **Select the Location** from the dropdown.
10. **Complete the start time and date**.
11. **Enter Face to Face time**.
    a. Note, the field is face to face but is the total of the entry type. For example: if the procedure is set up as hours it would be the total hours.
12. **Enter the attending**. This is required for institutional claims.
13. **Click the Save and Close buttons**.

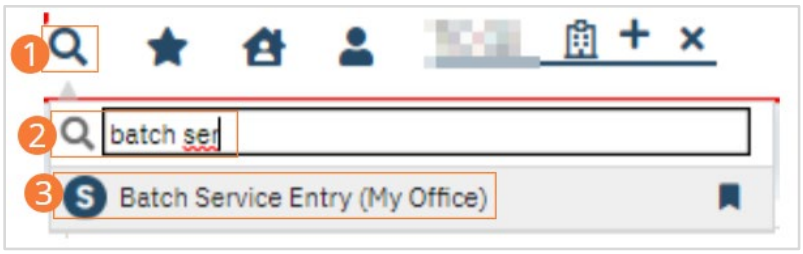


14. The service is now created and billing jobs will complete the service. Additional steps by jobs and billing staff will have this service sent out as a claim.

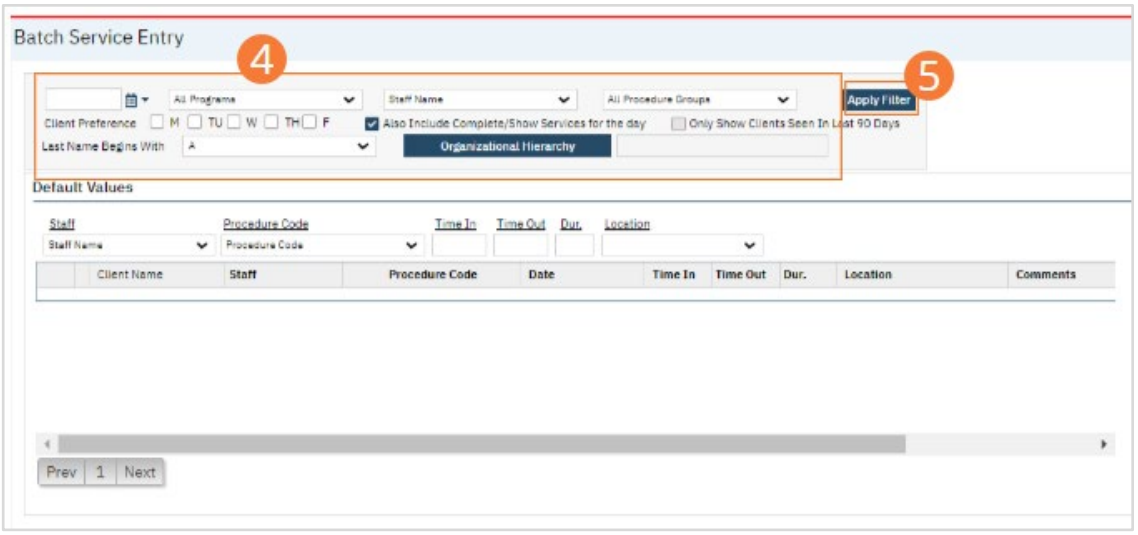
How to Enter a Batch of Services

Batch Services are typically entered after a service has already occurred. It helps to assign staff and procedures to clients quickly and in large numbers from a single screen.

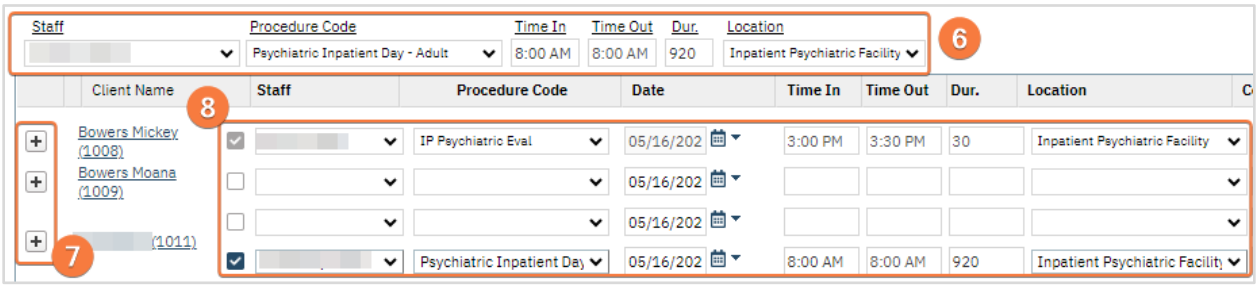
1. Click the Search icon.
2. Type 'Batch Service' into the search bar.
3. Click to select Batch Service Entry (My Office). The Batch Service Entry page opens.



4. Set filters to determine the day and clients you wish to create services for.
    a. Set a single date for which services should be created.
    b. Select a Program (or All Programs).
    c. Select a Staff Name or leave this dropdown alone for all staff.
    d. Select a Procedure Group to restrict displayed procedures (or select All Procedures).
    e. Be sure you select the last initial of the clients you wish to display, or select All Clients.
5. Click the Apply Filters button.



6. Fill out service information for each desired client.
    a. Select a Staff service provider. For bed service select, 'System, BedDay'.
    b. Select a procedure code, this is the bed procedure.
    c. Enter time in and a duration. Time out will autopopulate.
        i. Note: Duration is measured according to the settings determined on the original Procedure Code. Units can vary, and inaccurate entry can vastly misrepresent the service. To see what unit is in use, hover your cursor over the duration field and view the pop-up.
    d. Select a location, and any comments desired.
7. Use the Plus icon beside a client's name to enter multiple services for that client on a given date.
8. To use Defaults, enter a value in each desired dropdown under Default Values. Beside service entry lines that should have those default values, click the checkbox.
    a. This will immediately import the selected Default Values into the service entry line. These can then be changed as desired, or you can uncheck the checkbox to clear the values for that service entry line completely.



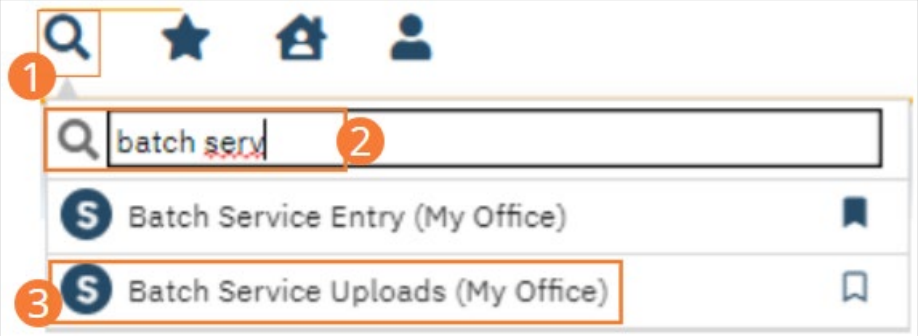
9. Click Save in the tool bar to save all Services.

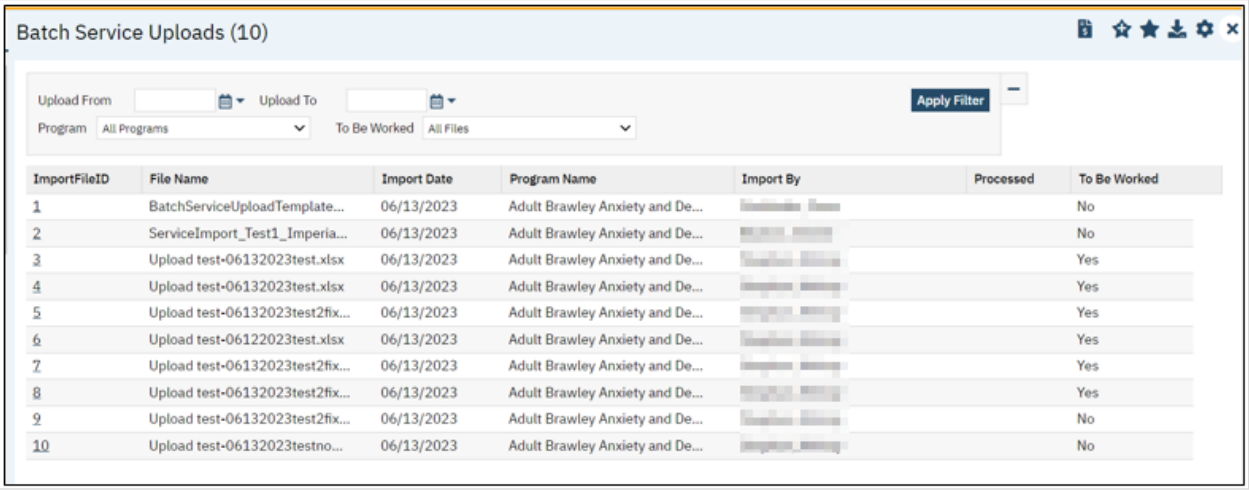
How to Import a Batch of Services from a Contract Provider

The Batch Service Upload feature is used when an organization receives service reports via spreadsheet and needs to upload those reports into SmartCare for processing.

How to Display the Batch Service Upload Page

1. Click the Search icon.
2. Type 'Batch Service' into the search bar.
3. Click to select Batch Service Uploads (My Office). The Batch Service Uploads screen will open.





How to Complete an Upload Template

Generally, users processing a Batch Service Upload will receive complete spreadsheets from partner organizations. This section is included to assist with troubleshooting.

1. Download a copy of the BatchServiceUploadsTemplate as an Excel file.
2. Open the BatchServiceUploadsTemplate and enter data according to the table below.

Column Letter	Column Name	Required? Y/N	Value, Formatting, and Additional Information
A	ClientID	Y	Client's SmartCare ID
B	ClinicianID	Y	This is the ID for the clinician that performed the service
C	ProcedureCodeID	Y	ID associated to the Procedure Code performed
D	LocationID	Y	ID associated to the Location for the service
E	DateOfService	Y	Requires the date AND start time of the service The formatting must be: MM/DD/YY 08:00 AM (or PM) Example: 5/23/23 08:00 PM
F	EndDateOfService	N	This column is not required. If using it, it requires the date AND end time of the service

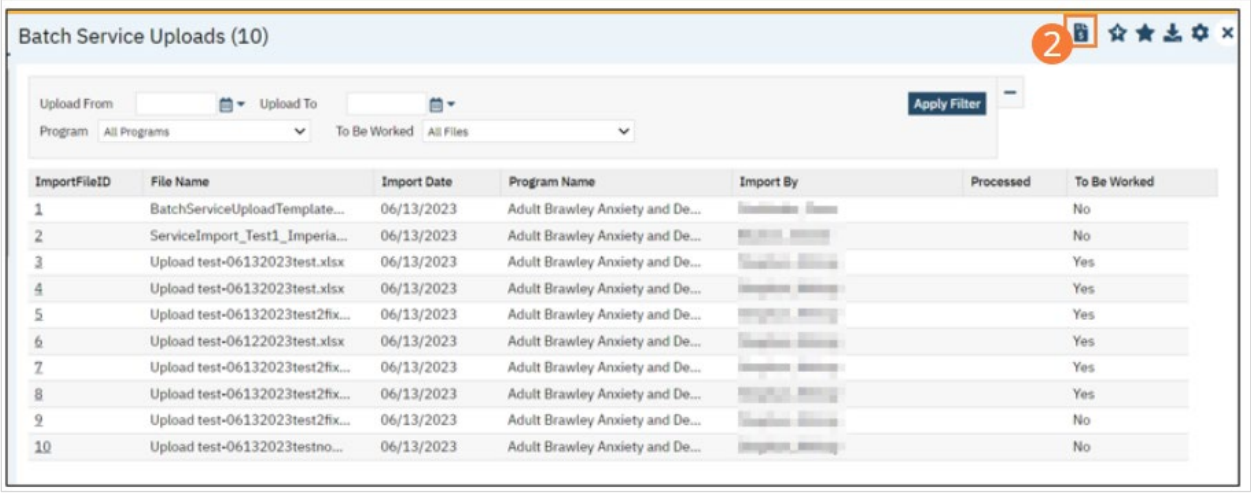
			The formatting must be: MM/DD/YY 08:00 AM (or PM) Example: 5/23/23 09:00 PM
G	FaceToFaceTime	Y	This is the duration of the service The duration must match the service entry unit defined on the Procedure (minutes, hours, days, etc.)
H	TravelTime	N	This is the travel time associated with the service if applicable
I	DocumentationTime	N	This is the documentation time associated with the service if applicable
J	AttendingID	N	Enter the ClinicianID for the Attending Provider if applicable
K	ReferringId	N	
L	EmergencyIndicator	N	If the procedure for the service requires an Emergency Indicator, complete this field The Code ID from the EMERGENCYINDICATOR Global Code must be used: See Global Code Information at the end of this document for the Code IDs
M	EvidenceBasedPractices	N	If the service requires an Evidence Based Practice be reported, complete this field The Code ID from the EVIDENCEPRACTICES Global Code must be used: See Global Code Information at the end of this document for the Code IDs
N	TransportationService	N	If the service requires a Transportation Service designation, complete this field The Code ID from the TRANSPORTATIONSERVIC Global Code must be used: See Global Code Information at the end of this document for the Code IDs
O	Billing Diagnosis Position 1	N	ICD-10 Use a decimal Example: F43.25
P	Billing Diagnosis 1 Present On Admission	N	If the service will be billed via the 837i or UB04 claim formats, enter the POA indicator for the primary diagnosis The Code ID from the ServiceDxPOA Global Code must be used:

			See Global Code information at the end of this document for the Code IDs
Q	Billing Diagnosis Position 2	N	ICD-10 Use a decimal Example: F43.25
R	Billing Diagnosis Position 3	N	ICD-10 Use a decimal Example: F43.25
S	Billing Diagnosis Position 4	N	ICD-10 Use a decimal Example: F43.25
T	AddOnProcedureCodeId	N	If the service has an add-on code enter the ID associated to the add-on Procedure Code performed
U	AddOnProcedureStartTime	N	Requires the date AND start time of the add-on service The formatting must be: MM/DD/YY 08:00 AM (or PM) Example: 5/23/23 08:00 PM
V	AddOnProcedureUnits	N	Enter the number of units for the add-on service
W	OverrideError	N	Use this field to notate if the Override Errors checkbox on the Service Details screen should be selected Enter Y or leave blank for N

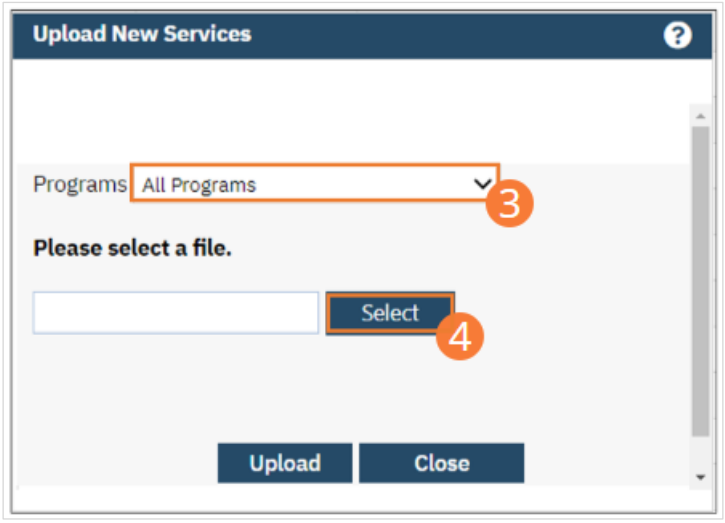
Note: Data should be entered in columns.

How to Upload Batch Services

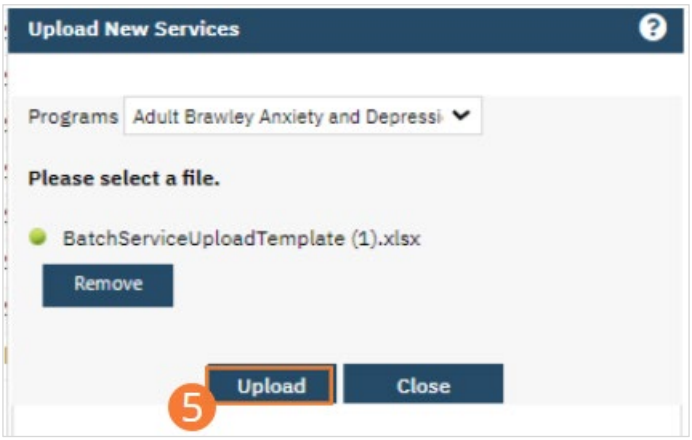
1. Begin on the Batch Service Uploads page.
2. Click the Upload icon in the tool bar. An upload window will open.



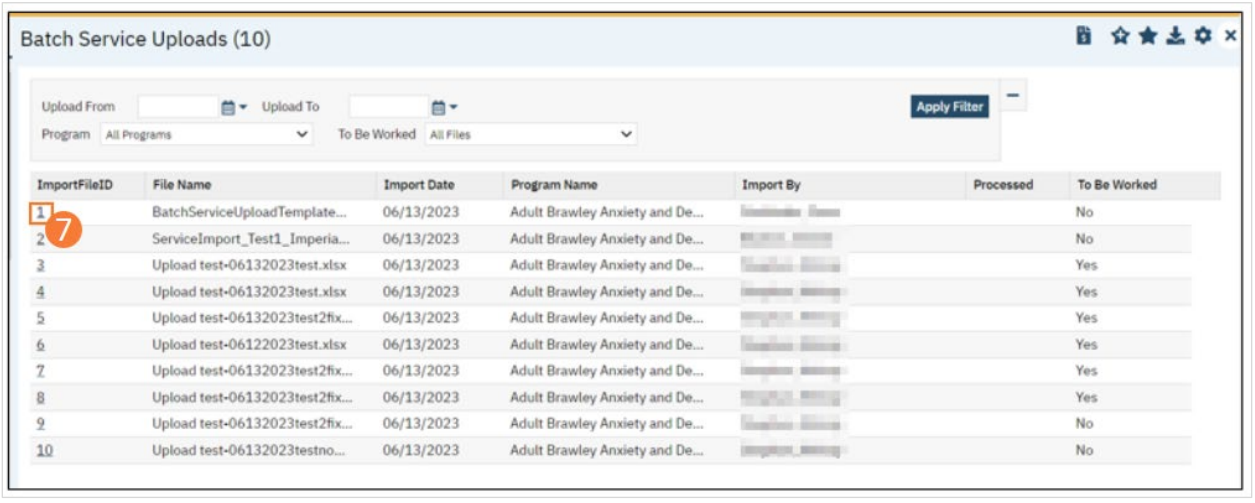
3. **Select a Program the Services should upload into from the dropdown.** The listed Programs are determined by the user's CDAG profile.
4. **Click Select** and choose a file from your computer file structure.



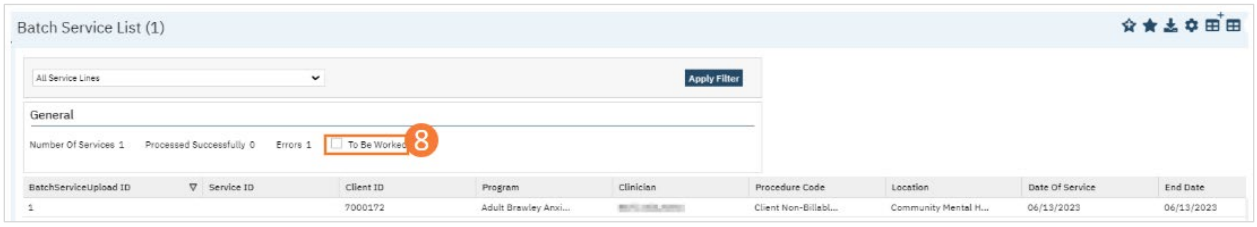
5. **Click Upload**.



6. Once the Upload is complete, the Batch will be added to the List Page. Overnight, a job will run that will import the contents of the file.
7. When the file has been uploaded, you can **return to the List Page and click the Batch ID number** to open the Batch Service List.



8. The contents of the file are displayed in a human-readable format. The final column contains error information. **Optionally, you can click the To Be Worked checkbox to mark the batch as requiring user attention and possible correction.**

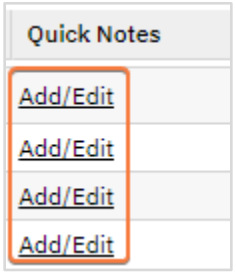


How to Document Quick Notes During a Shift

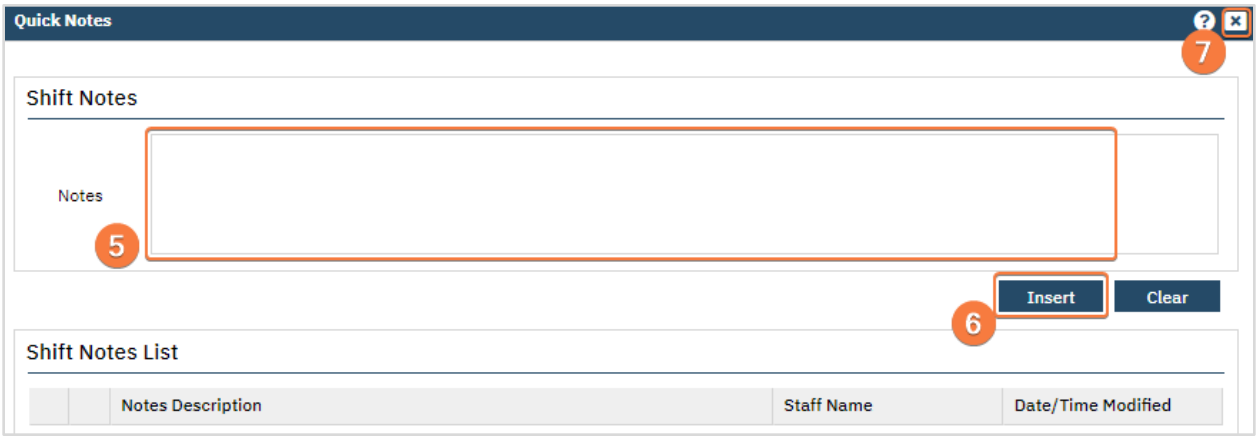
Quick Notes allow you to track notes within the Whiteboard. These can be viewed by staff that have access to Quick Notes. These are not billable and not considered a service.

Note: SmartCare calls these Shift Notes but will be used by agencies as Quick Notes. For information on shift notes see How to Document an End of Shift Summary section.

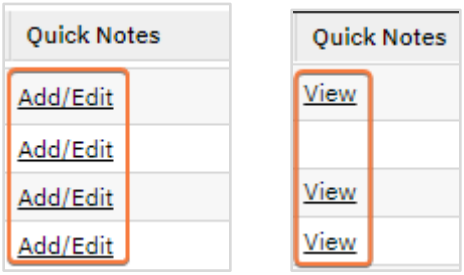
1. Quick Notes are accessible through the Whiteboard.
    a. See How to Display the Whiteboard List Page section for directions on how to navigate to the Whiteboard.
2. Locate the Quick Notes column.
    a. Columns will appear in different areas based on view. See How to Change the Whiteboard View for details.
3. Any rows that have a client, the Quick Notes column will display Add/Edit options or a View options if the Whiteboard is filtered by a past date.
4. **Click the Add/Edit option** to add a note, pop-up window will appear.



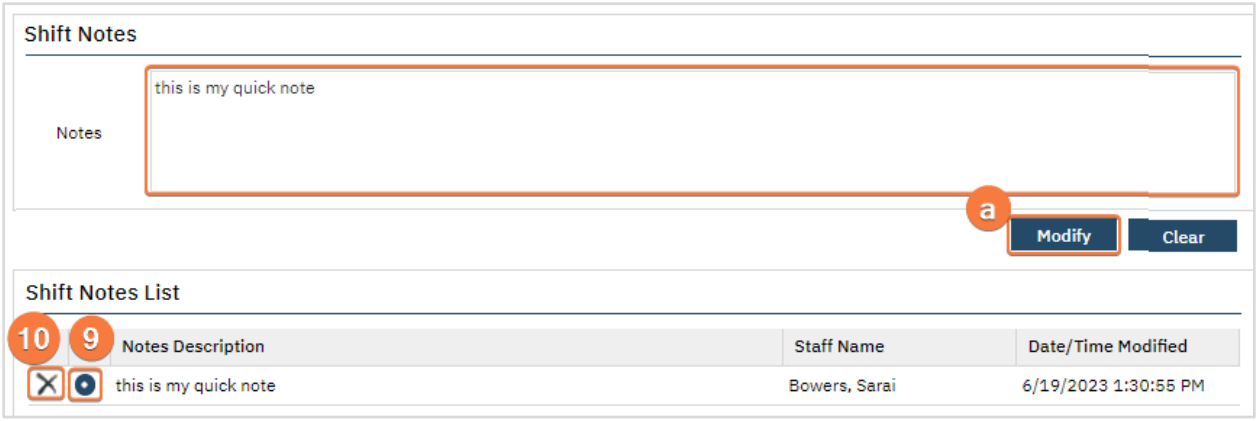
5. In the Notes field, **type your Quick Note**.
6. **Click Insert**, note will be added to the list.
    a. Insert button is inactive for past dates.
7. **Click the Close button**.



8. To view a Quick Note, **click the Add/Edit or View hyperlink**. A pop-up window will appear.
    a. View appears if filtering for a past date.



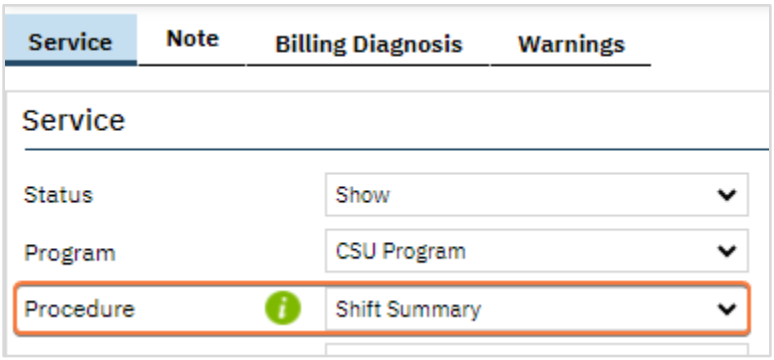
9. The note can be read within the list, Notes Description column, or **radio button can be selected**.
    a. Note will display in the Notes field. If changes are needed make needed changes and click Modify.
10. To delete a note, **click the 'X' next to the note**.



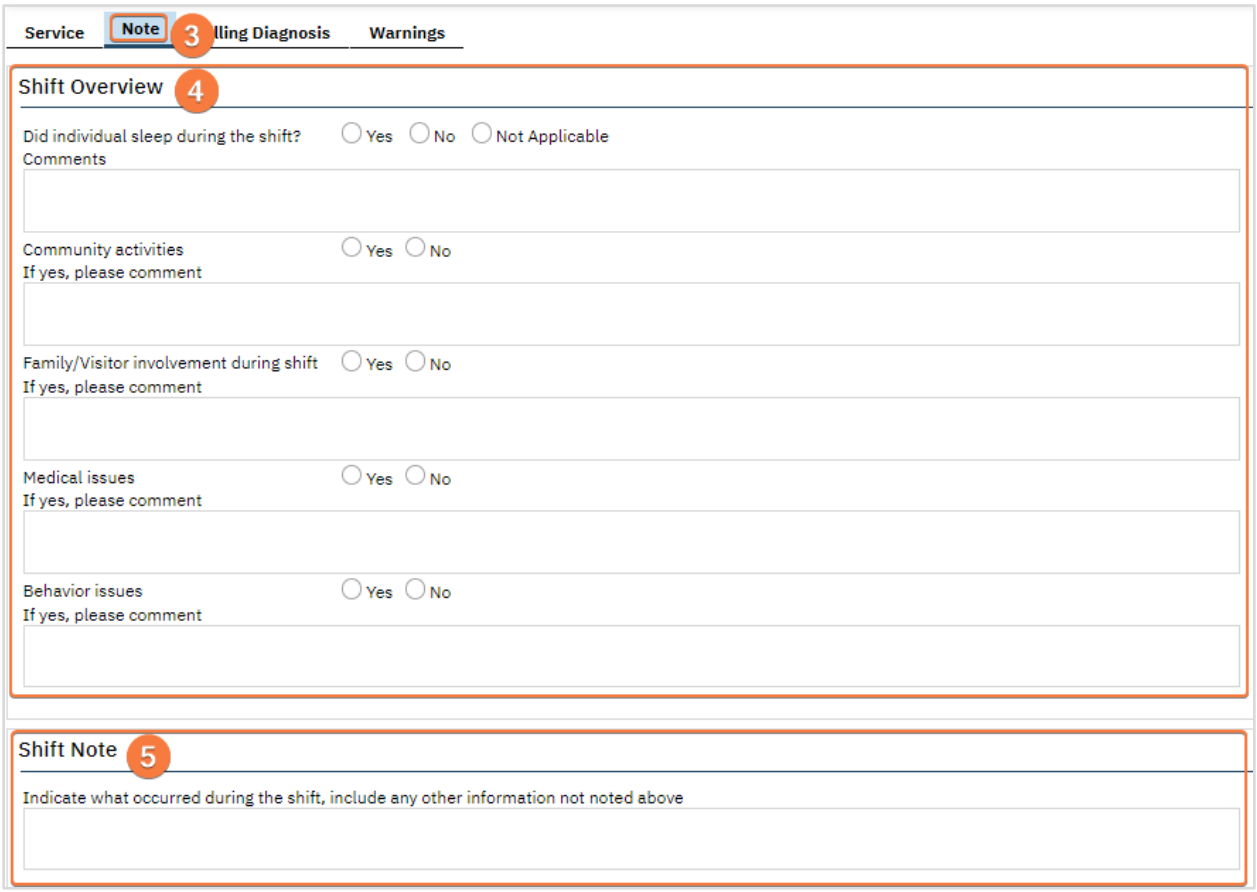
How to Document an End of Shift Summary

A Shift Summary is a service and is documented as a service note, however this note is not billable.

1. To access the Shift Summary, create a service for a client.
    a. See How to Document Additional Services section for details.
2. In the Procedure field, Service tab, **select Shift Summary**.
    a. Seeing this option is based on set up, e.g. program or degrees. It may not be available to all.



3. Once all fields in the Service tab are completed, **click the Note tab**.
4. **Complete items in the Shift Overview section**.
    a. Comment fields for Community activities through Behavior issues are needed if Yes is selected.
5. **Complete Shift Note section**.



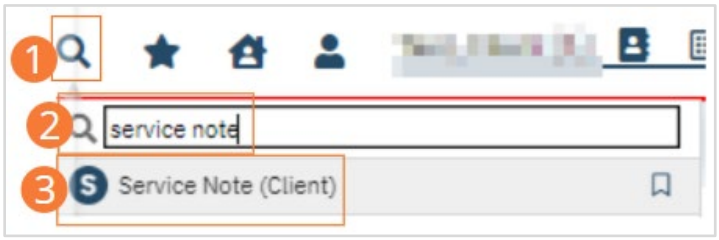
6. **Click Sign in the tool bar**, upper right corner, to complete the note.
    a. See How to Sign a Document for details on signing.

How to Document Additional Services

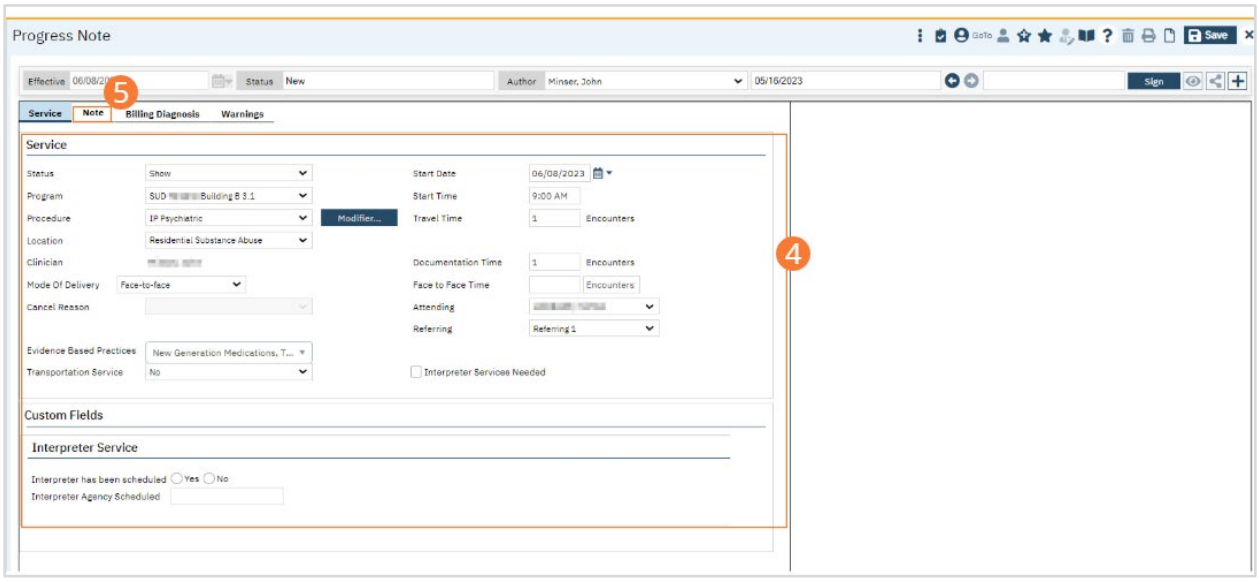
Procedures not covered by the situations described above, and which require documentation, will instead be entered using the Service Note feature. This allows you to record both a service and its documentation in one area. This includes both clinical and non-clinical documentable services.

1. With an active client selected, **click the Search icon**.
2. **Type 'Service Note'** into the search bar.

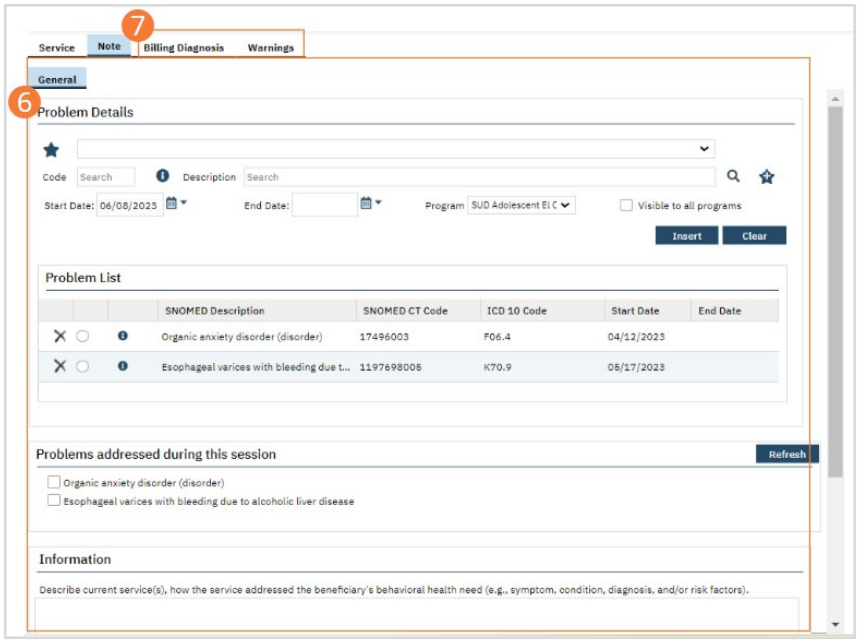
3. **Click to select Service Note (Client).** The Service Note page opens.



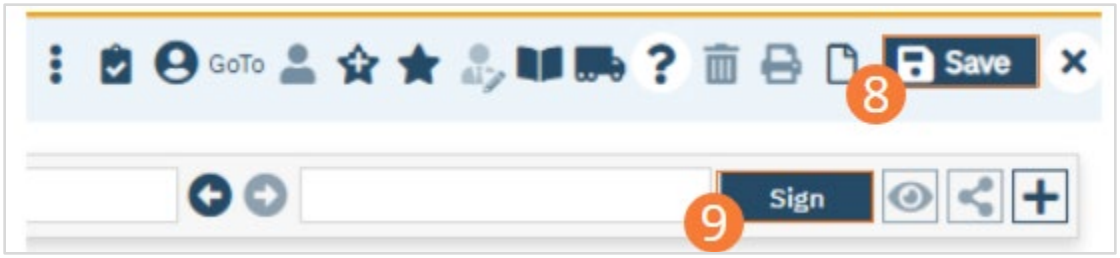
4. **Enter Service information**.
    a. Select the Program from the dropdown. Based on these choices, options for Procedure and Location will populate. Select the Procedure and Location.
    b. Complete the start time and date.
    c. Select an Attending and Referral option, if applicable.
    d. The Status field defaults to Show. This will immediately initialize the Note tab. If the Service is in the future, select Scheduled instead.
    e. Complete other fields as appropriate.
5. **Click the Note tab**.



6. **Complete the note tab** according to clinical and organizational workflows. For Inpatient/Residential Psychiatric Notes, see How to Complete the Psychiatric Evaluation.
7. Complete the Billing Diagnosis and Warnings tab, if necessary.



8. **Click Save**.
9. **Click the Sign button** to sign the document according to the steps outlined in How to Sign a Document.



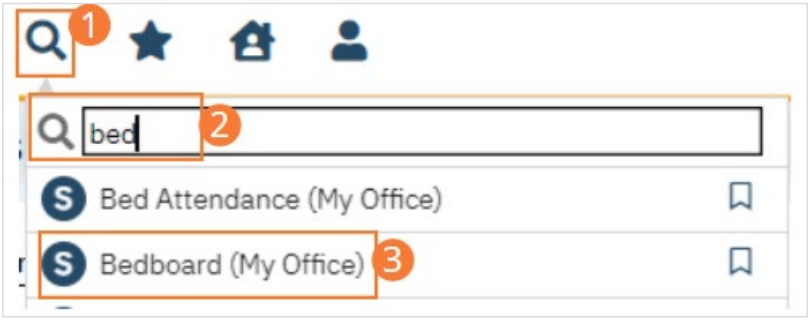
Managing a Client's Placement

How to Reallocate an Unoccupied Bed from One Level of Care to Another

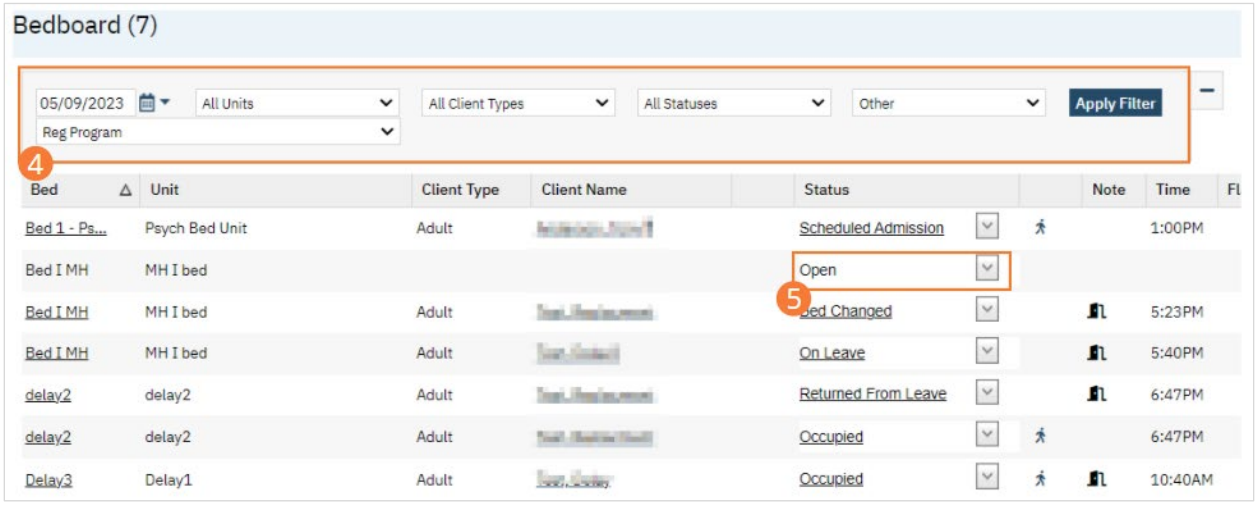
The Swing Bed option gives you the ability to change bed details, including Level of Care (i.e. program associated with the bed), for an open bed from the Bedboard list page. When you make changes using Swing Bed, the changes are updated on the Bedboard list page and also on the Units/Rooms/Bed list page in Administration. This function is only available in Bedboard.

How to Reallocate a Bed

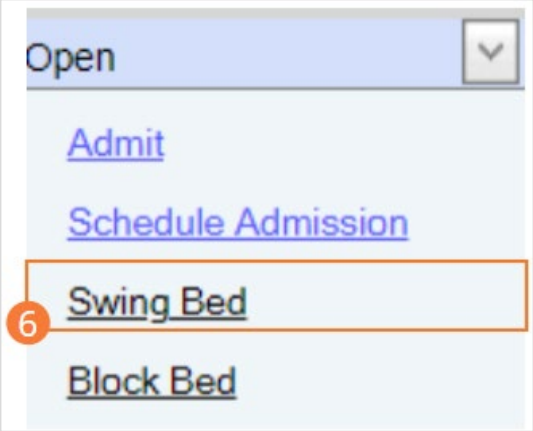
1. Click the Search icon.
2. Type 'Bedboard' into the search bar.
3. Click to select Bedboard (My Office).



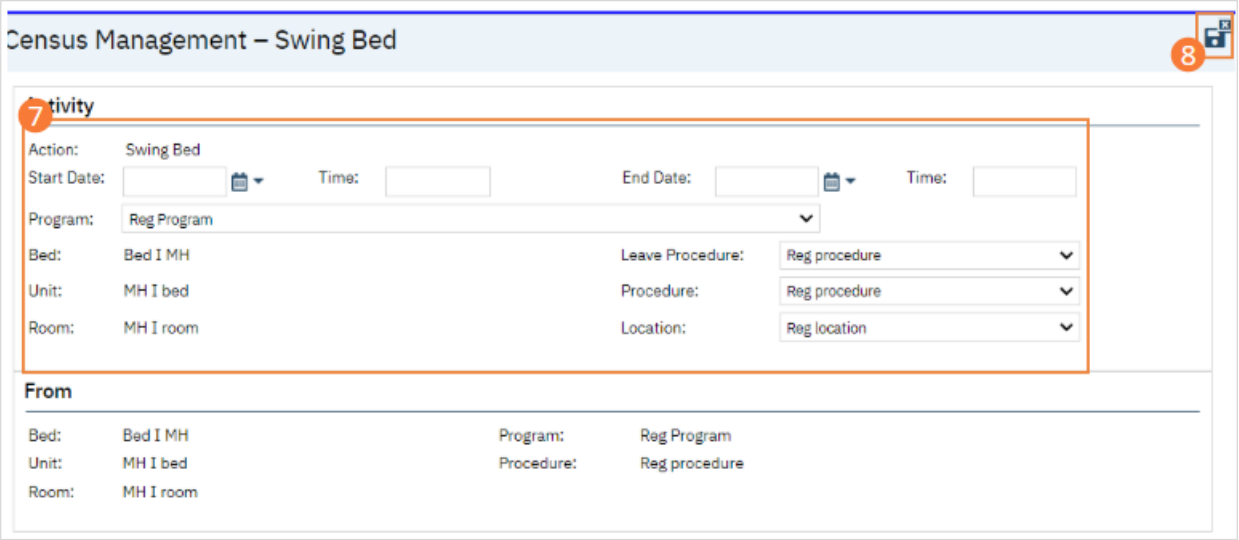
4. If desired, filter the list to determine the records that are shown.
5. Find the bed you want to change. It must have a status of Open



6. Click the drop-down arrow in the Status column of the open bed you want to swing and select Swing Bed. The Census Management - Swing Bed screen opens.



7. **Complete the required and necessary fields** on the screen. Select a new Program to assign the bed a new Level of Care.
8. When the screen is complete, **click the Save and Close button** in the tool bar. A record of the change is shown on both the Bedboard list page and the Units/Rooms/Bed list page in the Administration tab.



How to Transfer the Client from One Level of Care to Another

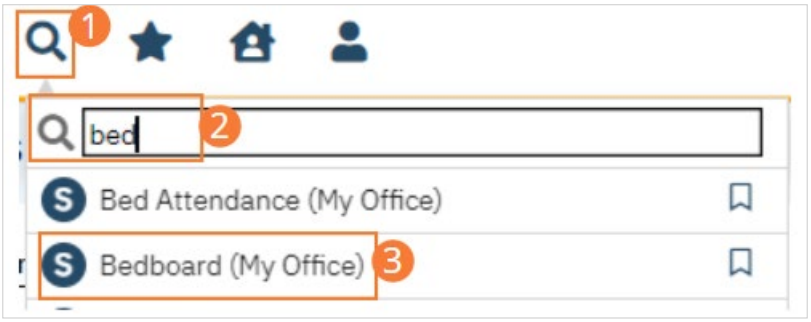
Schedule or complete a transfer for a client who is being admitted to a different Program. If you need to transfer the client to a new bed in the same Program, use the Bed Change directions. These steps can be performed in Bedboard or Residential/Bed Census.

How to Schedule a Transfer

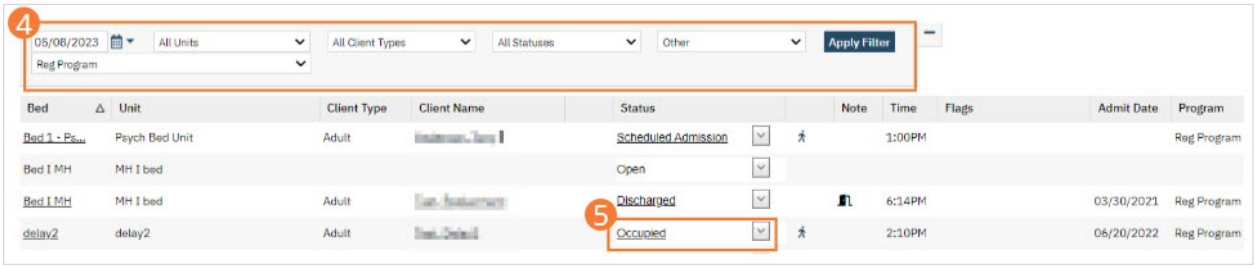
Make sure the client is requested in the new Program before scheduling the transfer. See How to Request the Client into a Program for details.

Note: Scheduling a Transfer will not actually complete the transfer on the scheduled date and time. The user will still need to complete the transfer. See How to Transfer a Client for details.

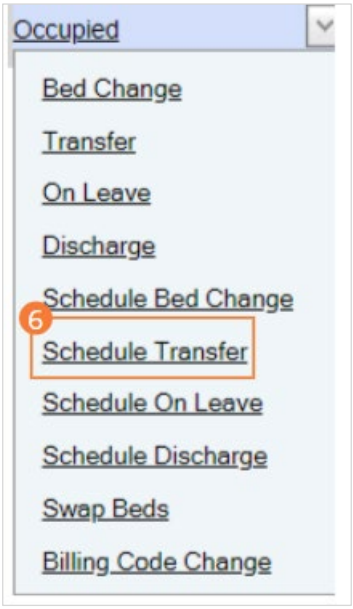
1. **Click the Search icon**.
2. **Type 'Bedboard'** into the search bar. (Or, 'Residential'.)
3. **Click to select Bedboard (My Office).** [Or, Residential (My Office)].



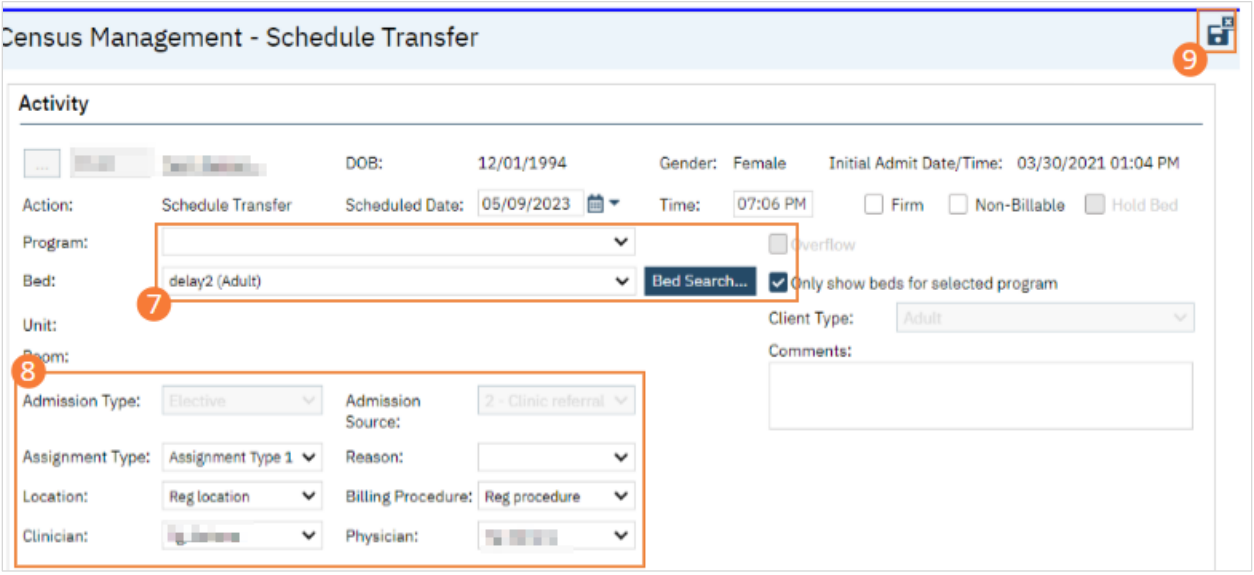
4. If desired, **filter the list** to determine the records that are shown.
5. Find the client on the Bedboard list page. Tip: Click the Client Name column heading to place all the clients in alphabetical order and find the client.



6. **Click the drop-down arrow in the Status column and select Schedule Transfer**. The Census Management - Schedule Transfer screen opens.

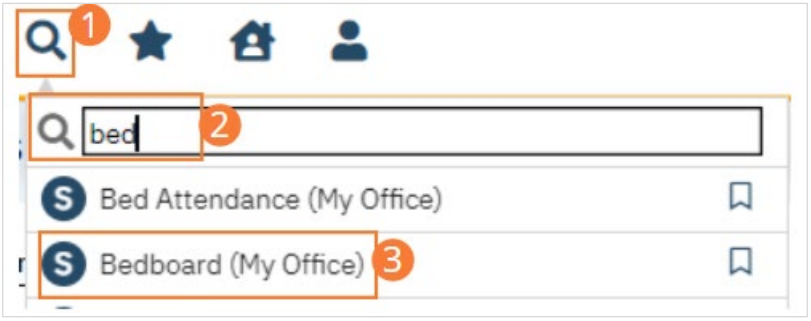


7. **Select the Program** the client will be transferred into. If a different bed is needed, you can select it from the Bed dropdown or use Bed Search.
8. **Complete the remaining required and necessary fields** on the screen.
9. When the screen is complete, **click the Save and Close button** in the tool bar.

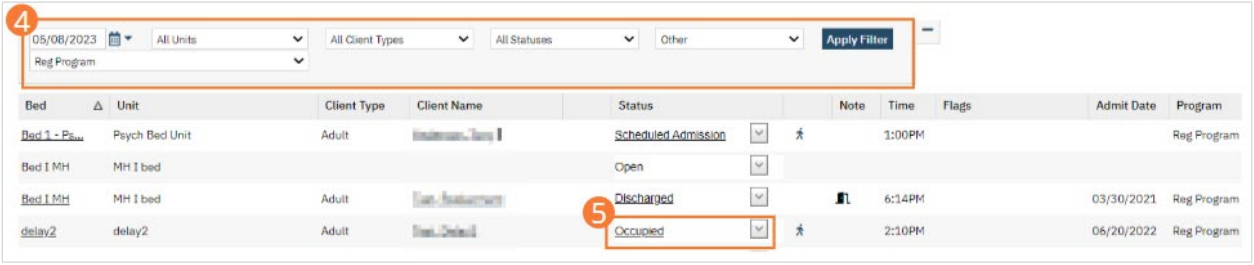


How to Transfer a Client

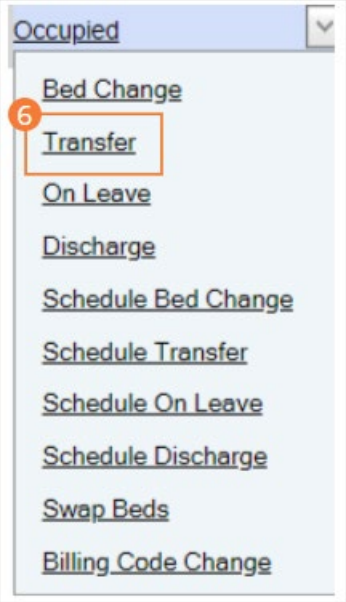
1. Click the Search icon.
2. Type 'Bedboard' into the search bar. (Or, 'Residential'.)
3. Click to select Bedboard (My Office). [Or, Residential (My Office)].



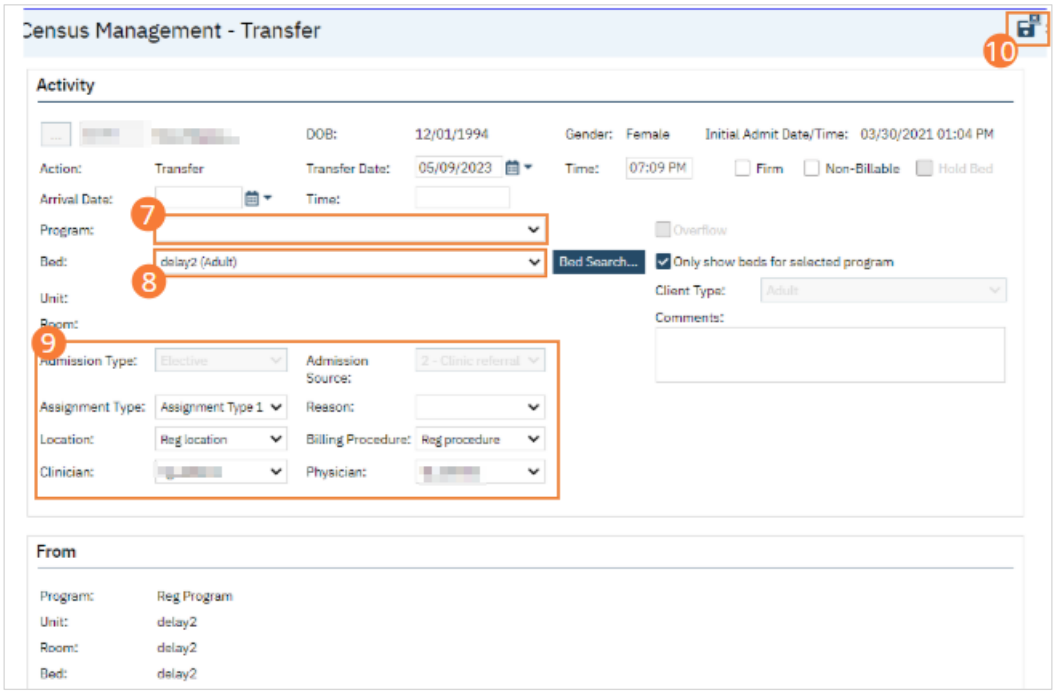
4. If desired, filter the list to determine the records that are shown.
5. Find the client on the Bedboard list page. Tip: Click on the Client Name heading in the column to arrange the clients' names alphabetically.



6. Click the drop-down arrow in the Status column and select Transfer. The Census Management - Transfer screen opens.

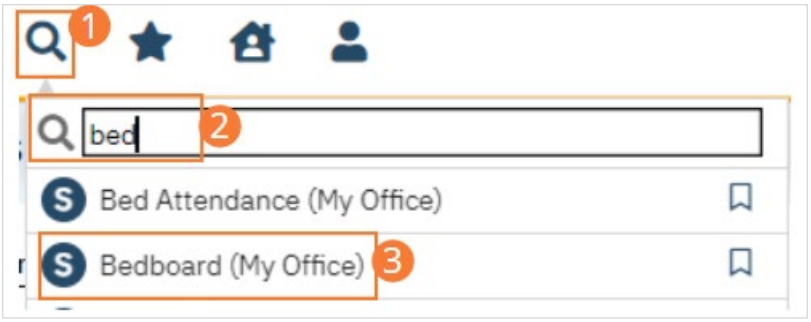


7. In the Program field, **select the new program to transfer the client to**.
8. **Search for and select an open bed in the new program** if this is needed.
9. **Complete the remaining fields** on the Census Management - Transfer page.
10. When the screen is complete, **click the Save and Close button** in the tool bar. The list page opens.

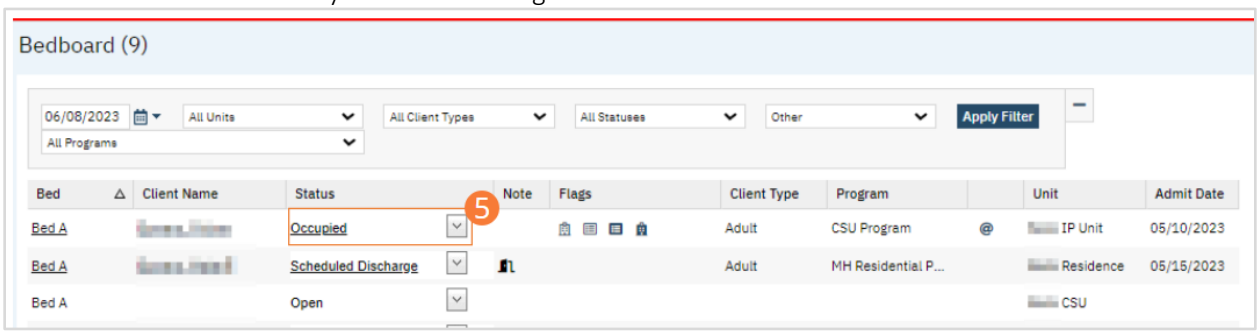


How to Change the Automatic Billing Code from Acute to Administrative (or Vice Versa)

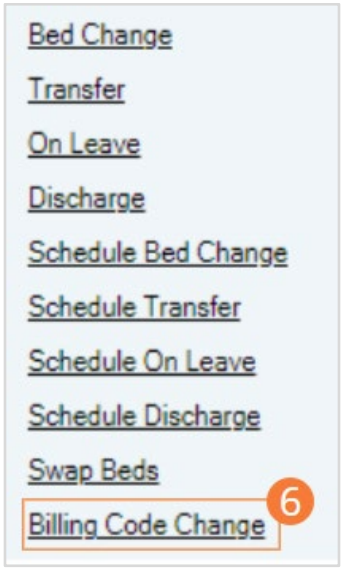
1. **Click the Search icon**.
2. **Type 'Bedboard'** into the search bar. (Or, 'Residential'.)
3. **Click to select Bedboard (My Office).** [Or, Residential (My Office)].



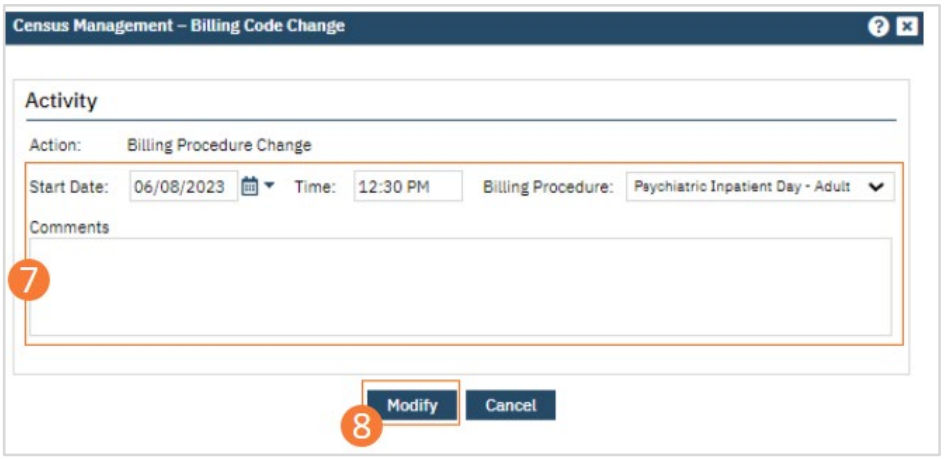
4. If desired, **filter the list** to determine the records that are shown.
5. Find the client whose code you want to change.



6. **Click the drop-down arrow in the Status column of the client you want to edit and select Billing Code Change**. The Billing Code Change window opens.



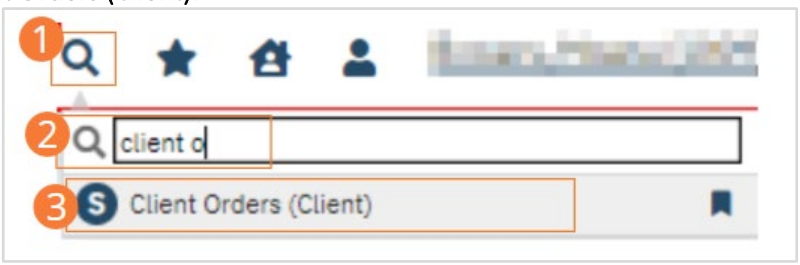
7. **Complete the required and necessary fields** in the window. Be sure to select the appropriate Billing Procedure from the dropdown. Administrative codes are listed with 'Admin' in the name.
8. **Click Modify**. The client's status has been updated on a new line to Billing Code Changed.



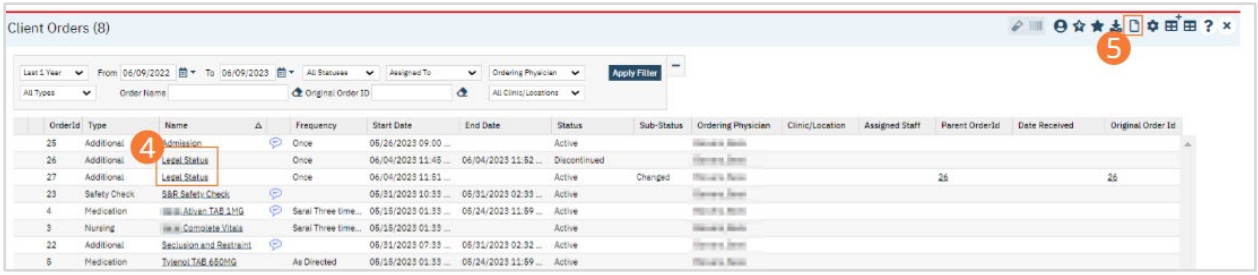
How to Change the Client's Legal Status

A client's legal status is managed through Legal Status orders. To change Legal Status, you will modify the existing Legal Status order.

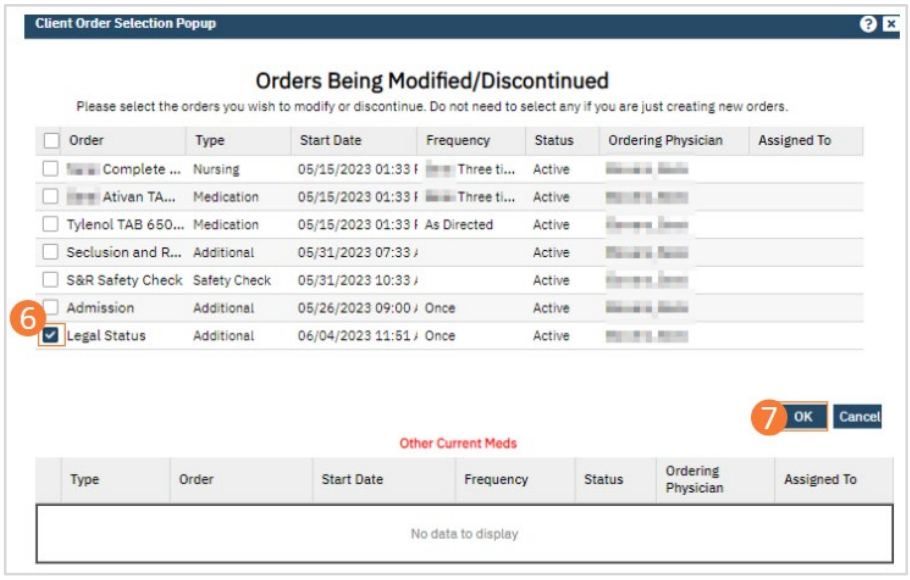
1. With an active client selected, **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type "Client Orders"** into the search bar.
3. **Click to select Client Orders (Client).**



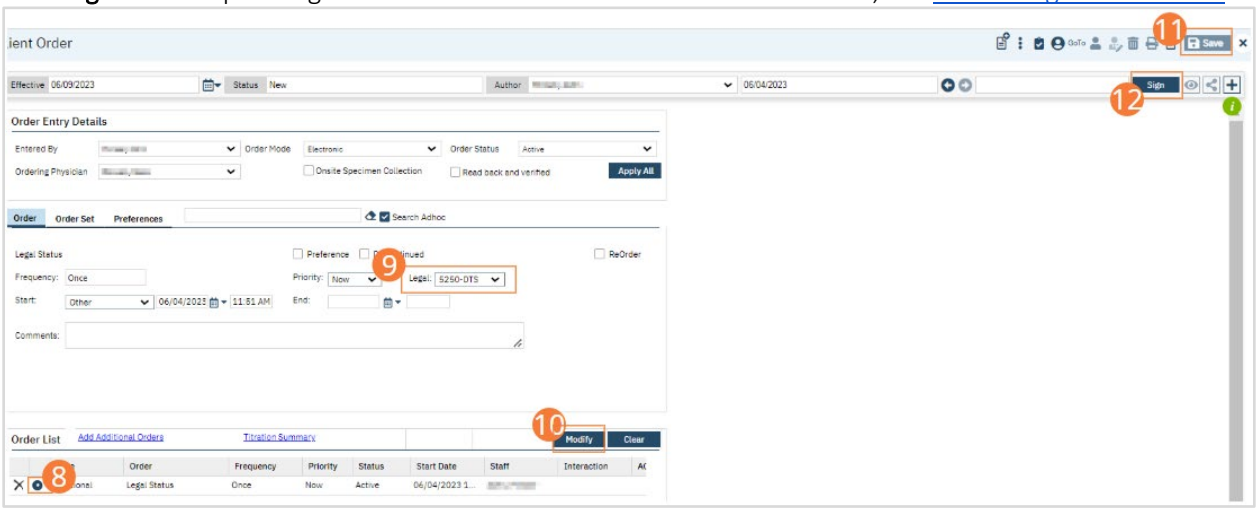
4. Ensure that a Legal Status order exists on the Client Orders list.
5. **Click the New icon** in the tool bar.



6. The Modify/Discontinue Orders window will open. **Click the checkbox** next to the Legal Status order.
7. **Click OK**. The Order Details page will open.



8. Click the radio button beside the Legal Status order.
9. Change the Legal option by selecting a new Legal Status from the dropdown.
10. Click Modify.
11. Click Save.
12. Click Sign and complete signature of the document. For more information, see How to Sign a Document.



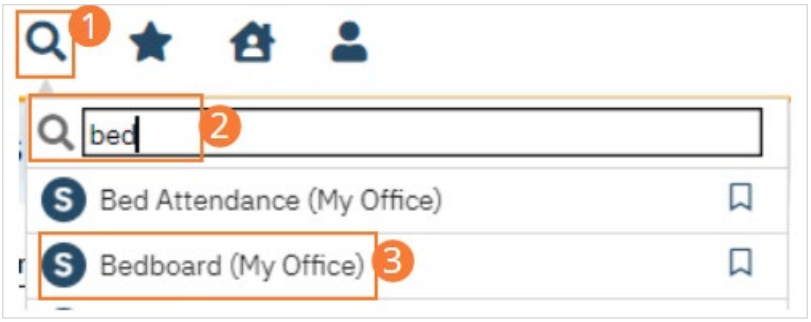
13. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.
14. As a reminder, Legal Status is a column within the Whiteboard. The updated legal status will be reflected on the column.

How to Mark a Client "On Leave"

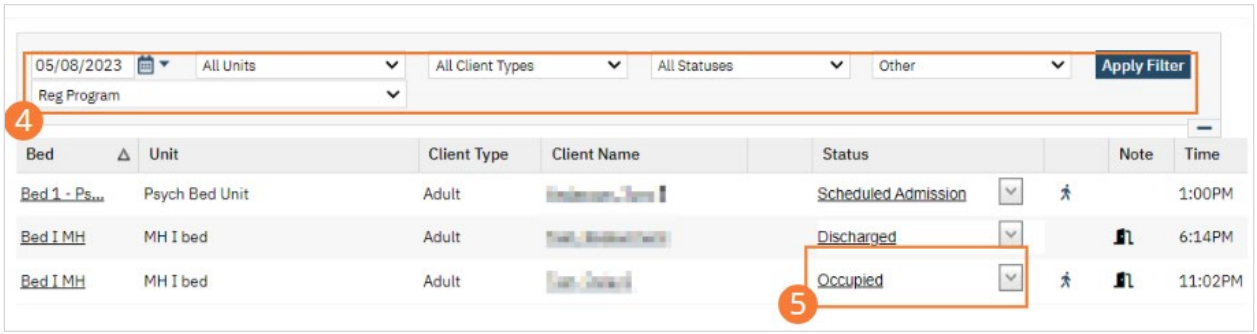
How to Schedule a Client Leave

The client must have a status of Occupied before you can schedule the client On Leave.

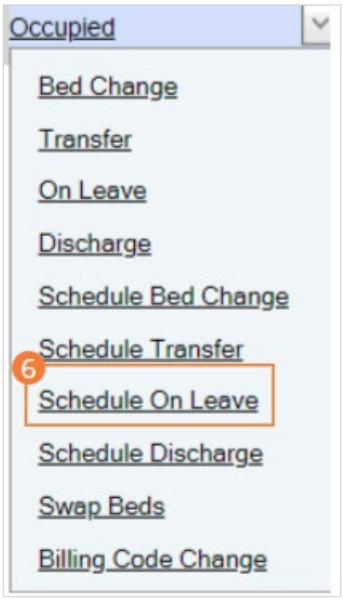
1. Click the Search icon.
2. Type 'Bedboard' into the search bar. (Or, 'Residential'.)
3. Click to select Bedboard (My Office). [Or, Residential (My Office)].



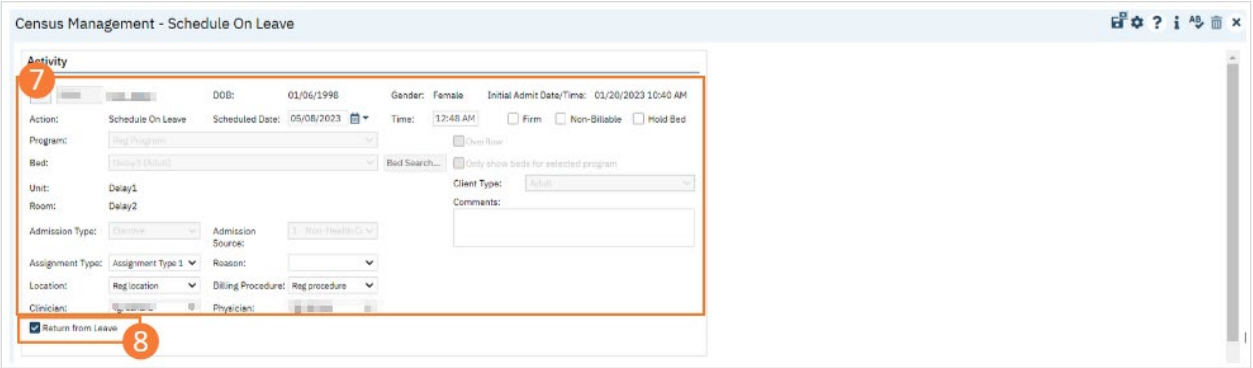
4. If desired, **filter the list** to determine the records that are shown.
5. Find the client who you want to set on leave.



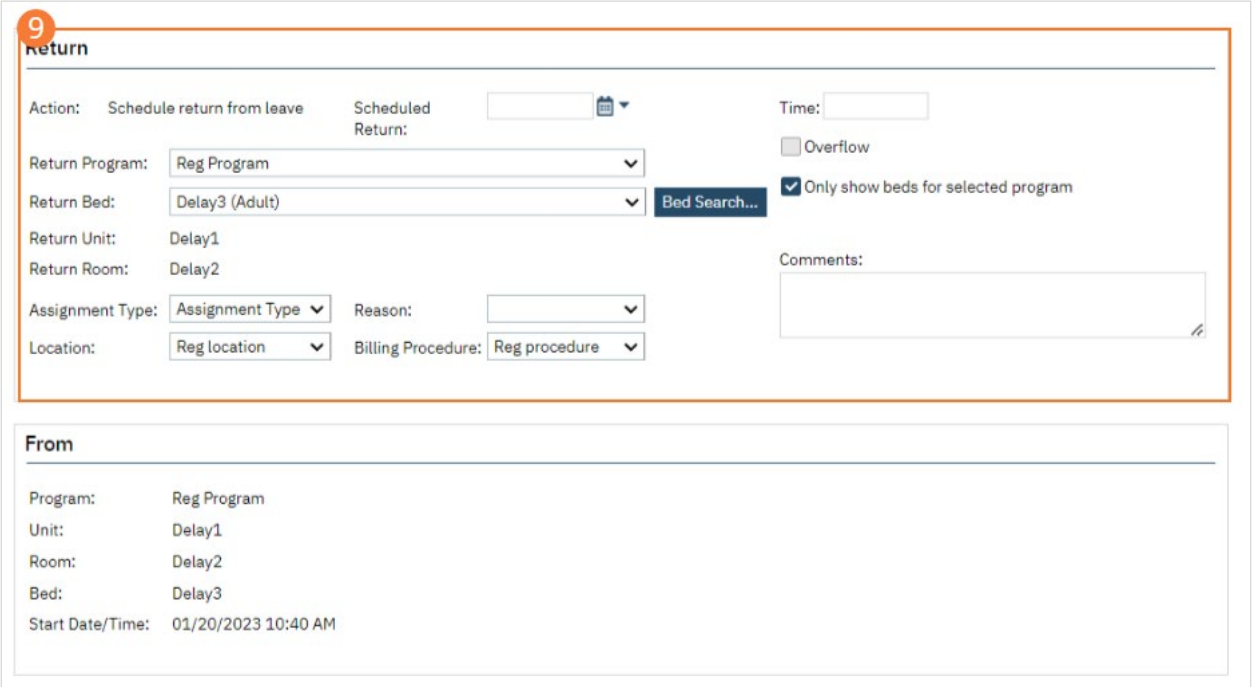
6. **Click the drop-down arrow** in the Status column of the client you want to schedule on leave and **select Schedule On Leave**. The Census Management - Schedule On Leave screen opens.



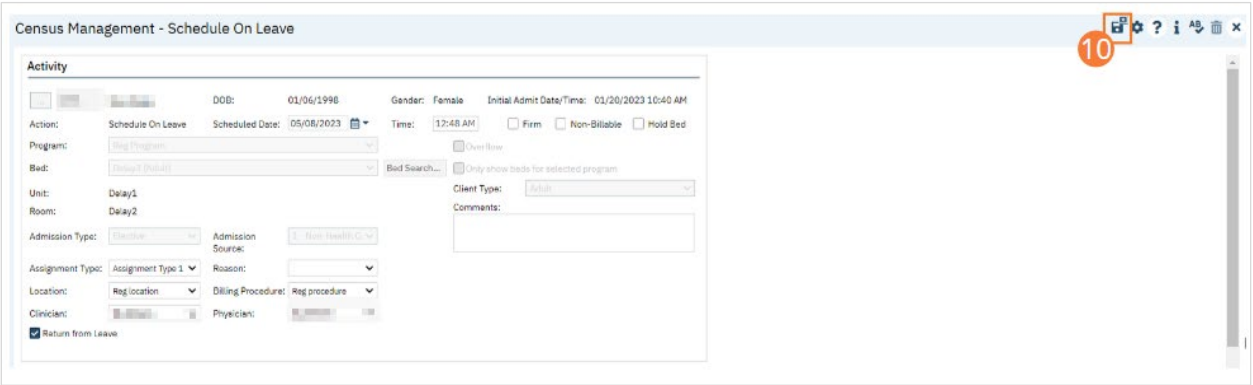
7. **Complete the required and necessary fields** on the screen
8. To Schedule Return from Leave for this client at this time, **select the Return from Leave check box**. The Return section appears at the bottom of the Census Management - Schedule Return On Leave screen.



9. Complete the Return section



10. When the page is complete, click the Save and Close button in the tool bar.

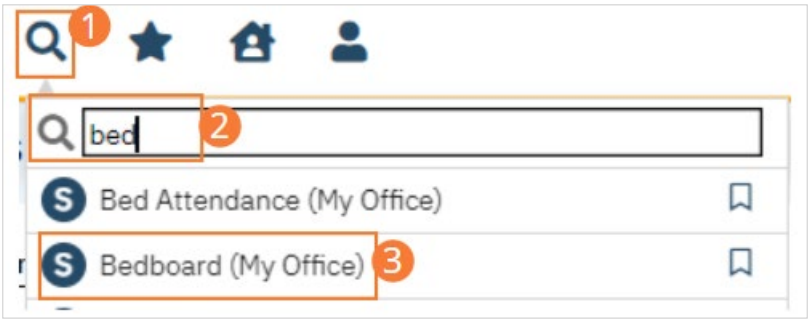


How to Set a Client on Leave

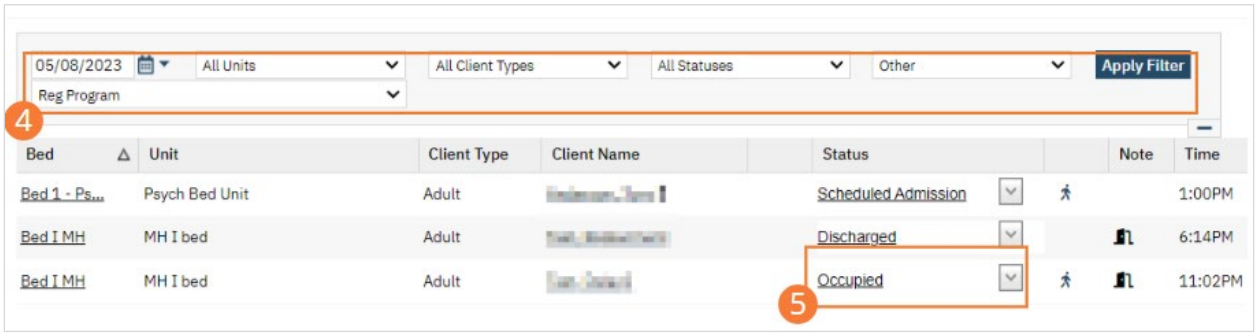
The client must be admitted to a bed with a status of Occupied or Scheduled On Leave before you can put the client On Leave.

1. Click the Search icon.
2. Type 'Bedboard' into the search bar. (Or, 'Residential'.)

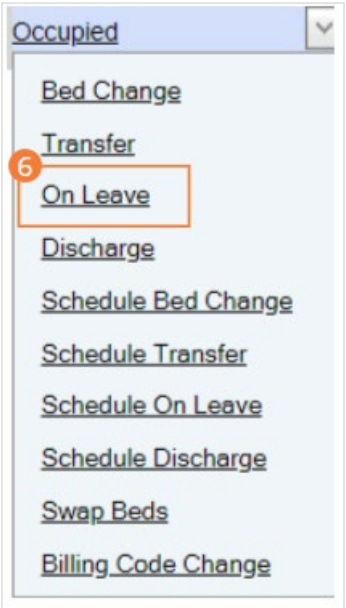
3. **Click to select Bedboard (My Office).** [Or, Residential (My Office)].



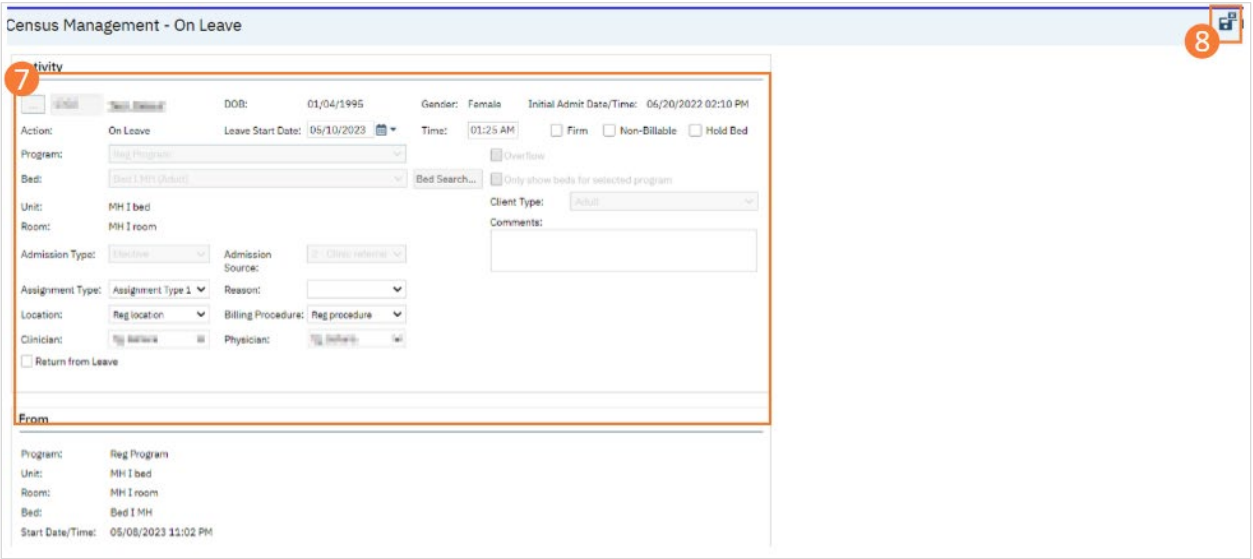
4. If desired, **filter the list** to determine the records that are shown.
5. Find the client who you want to set On Leave.



6. **Click the drop-down arrow in the Status column of the client you want to set to On Leave and select On Leave.** The Census Management - On Leave screen opens.



7. **Complete the required and necessary fields** on the Census Management - On Leave screen.
8. When the screen is complete, **click the Save and Close button** in the tool bar. The list page opens. A second record for the client is shown with the status of On Leave.

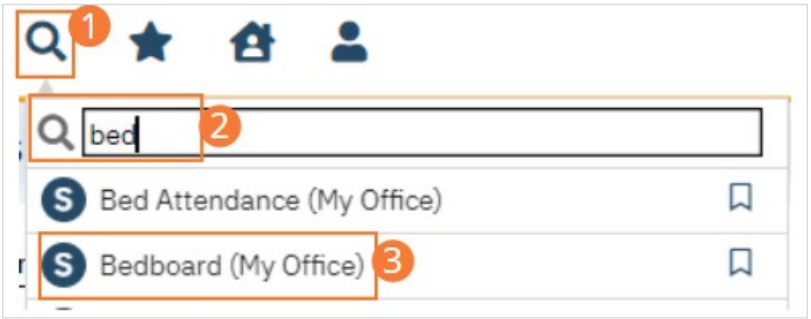


How to Move a Client to Another Bed

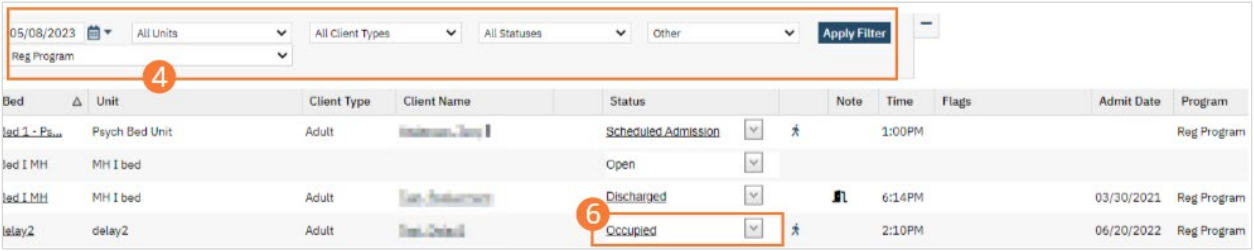
You can schedule a bed change for a client to occur on a future date. You can schedule a bed change for a client who is already admitted to a bed. A scheduled bed change means you are setting a date and time in the future when the client will be moved to the different bed.

How to Schedule a Bed Change

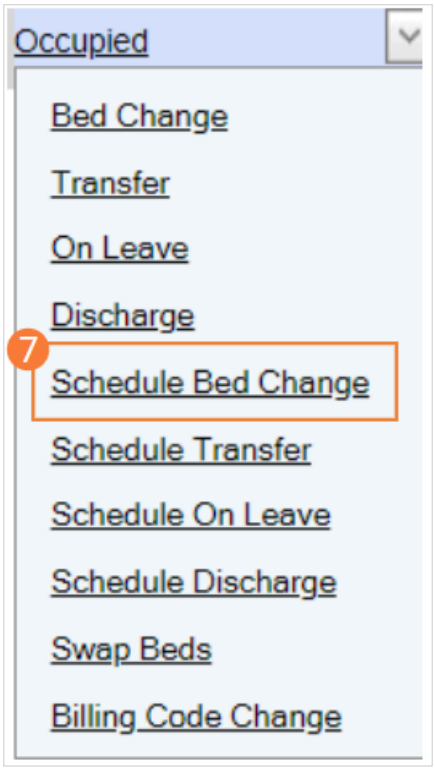
1. Click the Search icon.
2. Type 'Bedboard' into the search bar. (Or, 'Residential'.)
3. Click to select Bedboard (My Office). [Or, Residential (My Office)].



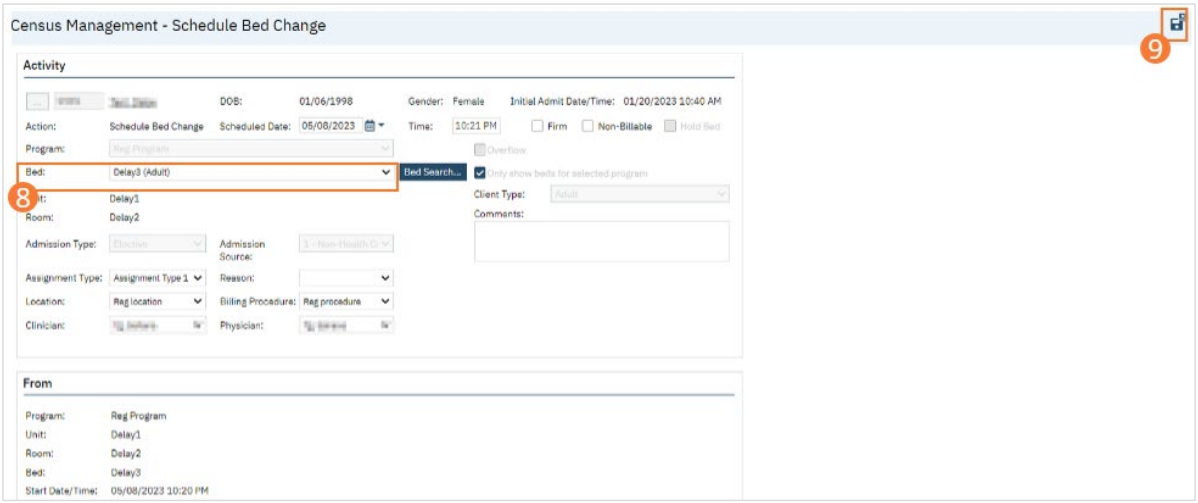
4. If desired, filter the list to determine the records that are shown.
5. Find the client on the Bedboard list page.
6. Click the drop-down arrow in the Status column for the client.



7. Select Schedule Bed Change from the drop-down list. The Census Management - Schedule Bed Change screen opens.

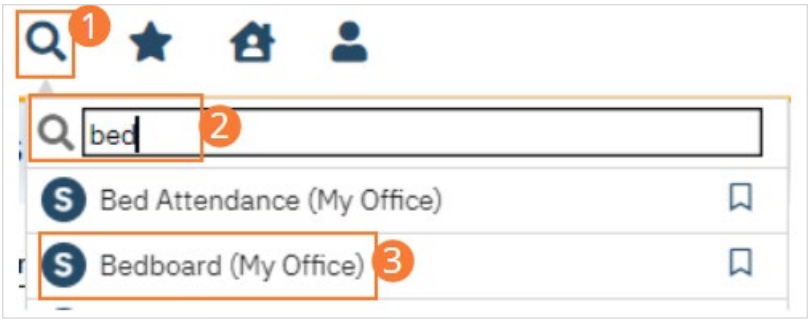


8. **Select the new bed from the drop-down list** in the Bed field.
9. **Click the Save and Close button** in the tool bar. The list page opens. Notice that the Status on the client's record is changed to Scheduled Bed Change. A new record is created with a status of Scheduled Bed Change, but for the scheduled date of change. To view the new status, change the filter on the list page to the scheduled bed change date.

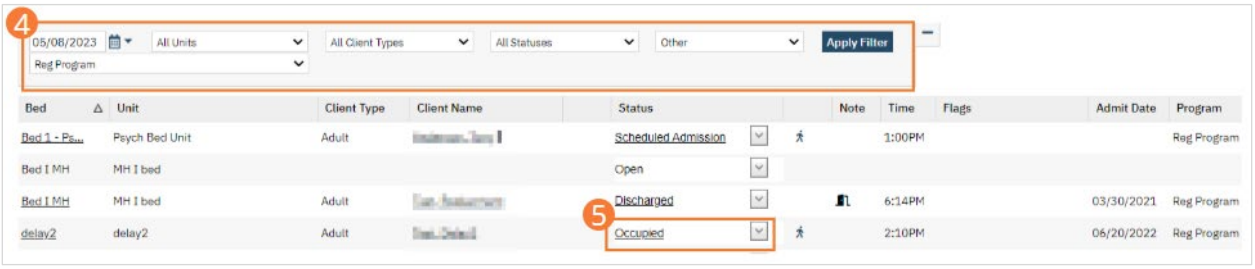


How to Change a Bed Assignment

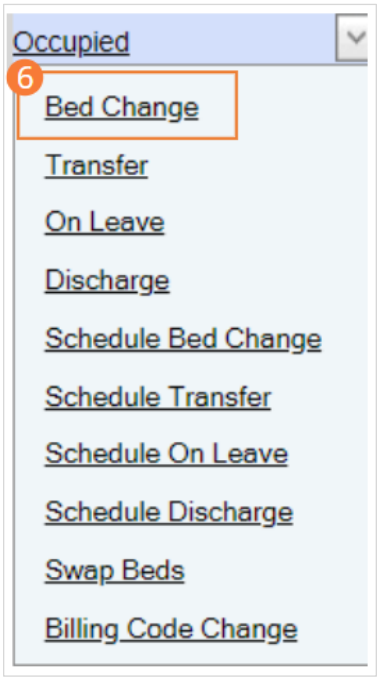
1. **Click the Search icon**.
2. **Type 'Bedboard'** into the search bar. (Or, 'Residential'.)
3. **Click to select Bedboard (My Office).** [Or, Residential (My Office)].



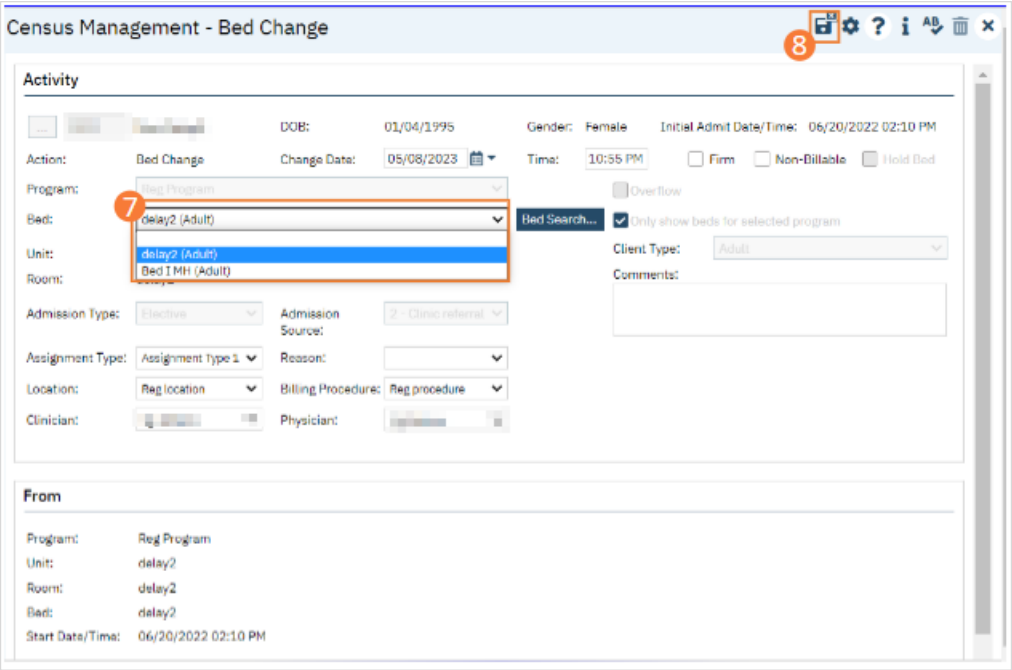
4. If desired, **filter the list** to determine the records that are shown.
5. **Click the drop-down arrow** in the Status column for the client who is changing beds.



6. **Select Bed Change from the drop-down list**. The Census Management - Bed Change screen opens.



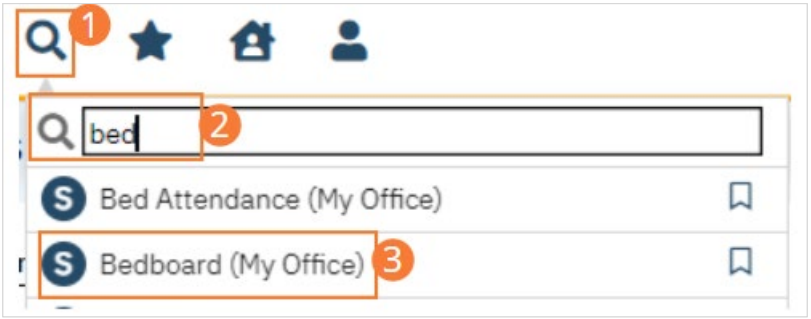
7. **Select the new bed** from the drop-down list in the Bed field
8. **Click the Save and Close button** in the tool bar. The list page opens. Notice that the Status on the client's record is changed to Bed Changed. A second record line appears below which shows the new bed with a status of Occupied



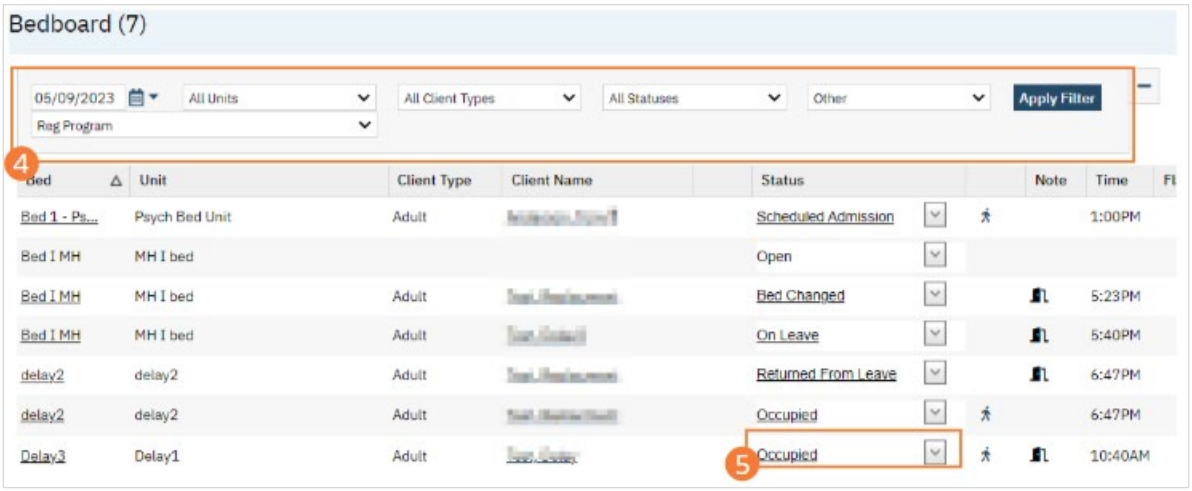
How to Swap Beds

Two clients currently occupying beds can swap those beds using the following directions. You need to know the clients' names and bed IDs to complete any of these procedures. Both clients must have a status of Occupied.

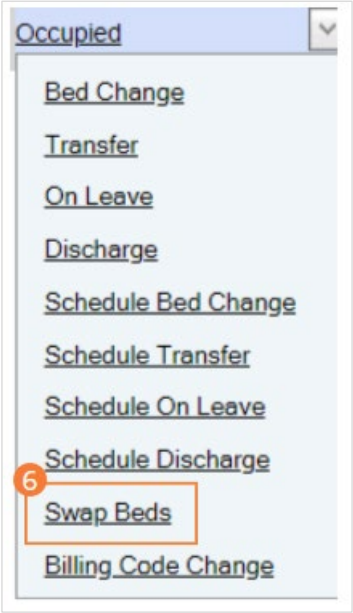
1. Click the Search icon.
2. Type 'Bedboard' into the search bar. (Or, 'Residential'.)
3. Click to select Bedboard (My Office). [Or, Residential (My Office)].



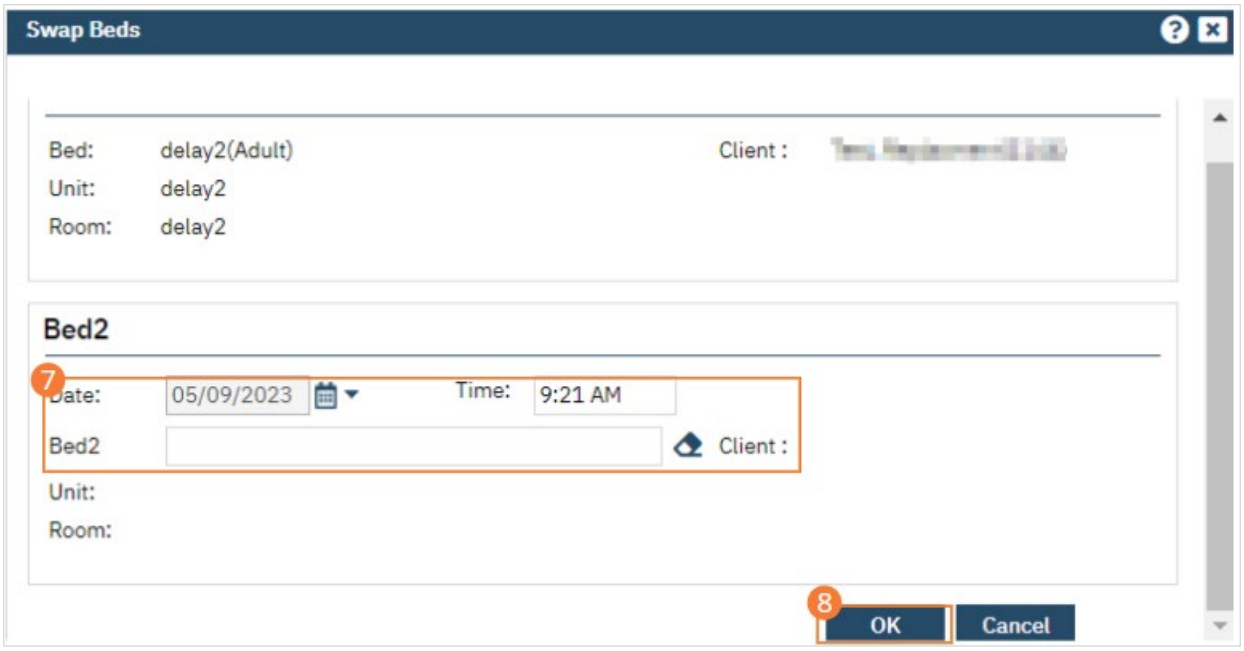
4. If desired, filter the list to determine the records that are shown.
5. Find one of the clients who wants to swap beds. Tip: Click on the hyperlinked heading in the Client Name column to arrange the clients in alphabetical order.



6. **Click the drop-down arrow in the Status column for the client who is swapping a bed and select Swap Beds**. The Swap Beds window appears. The Bed1 section displays the client's information you selected on the list page.



7. **Complete the Bed2 section** with the information on the second client who wants to swap beds.
8. **Click the OK button** to save the changes. The list page opens with the original client's occupied bed listed with a status of Bed Changed and a second listing with the second client shown in that bed with a status of Occupied.

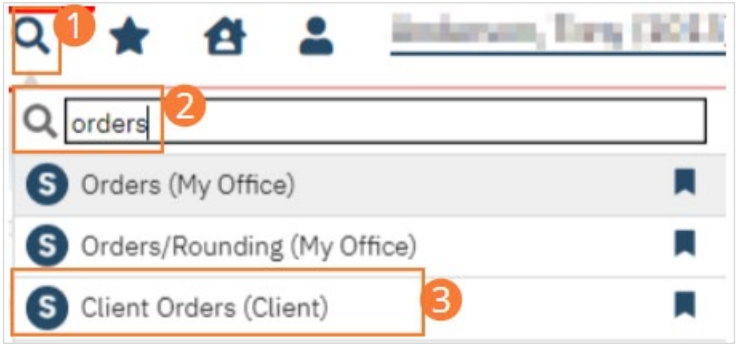

Swap Beds
Bed: delay2(Adult)
Client :
Unit: delay2
Room: delay2
Bed2
7
Date: 05/09/2023
Time: 9:21 AM
Bed2
Client :
Unit:
Room:
8
OK
Cancel

Orders

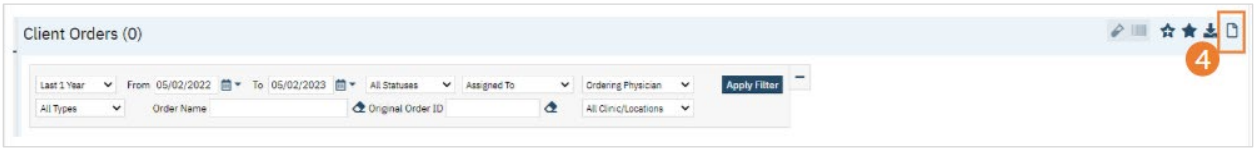
How to Create an Order

How to Create a New Order for a Client

1. You must first have the client open, then **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type "Orders"** into the search bar.
3. **Click to select "Client Orders (Client)"** from the search results.

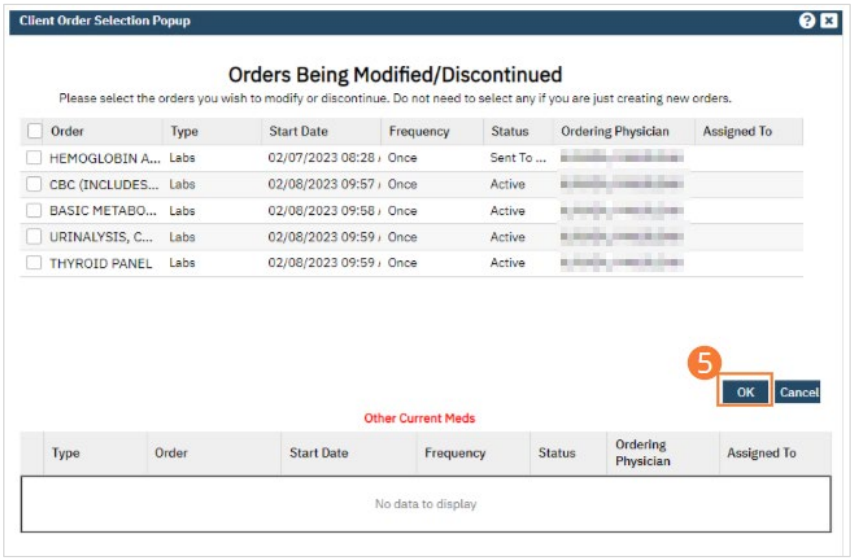


4. The client Orders list page will open. **Click on the New icon.**

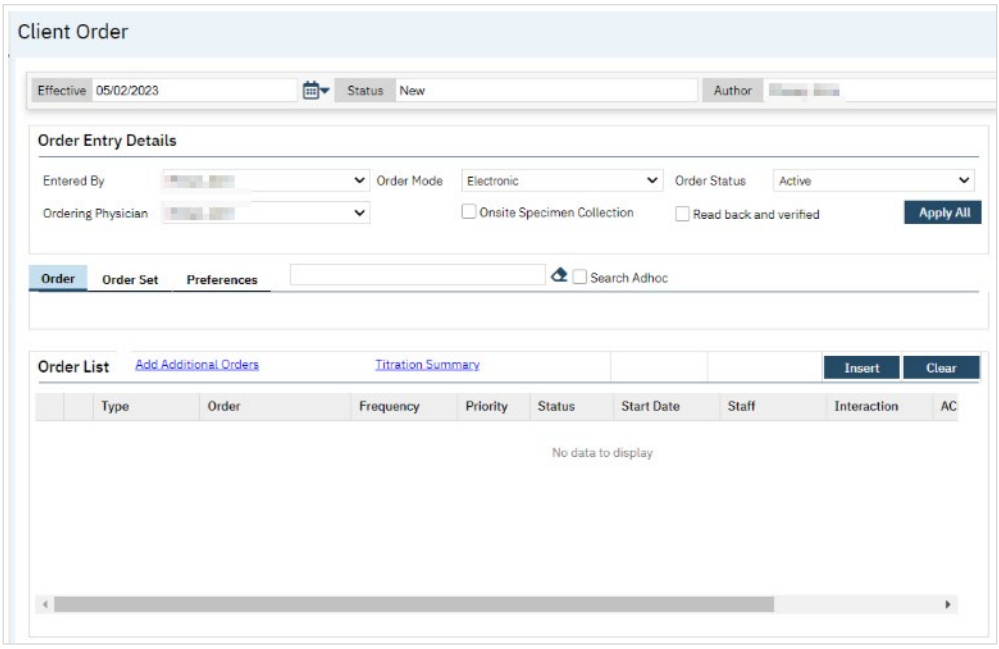


5. This takes you to the Orders Being Modified/Discontinued window. Without selecting any orders listed in the top half of the window, **click the OK button**.

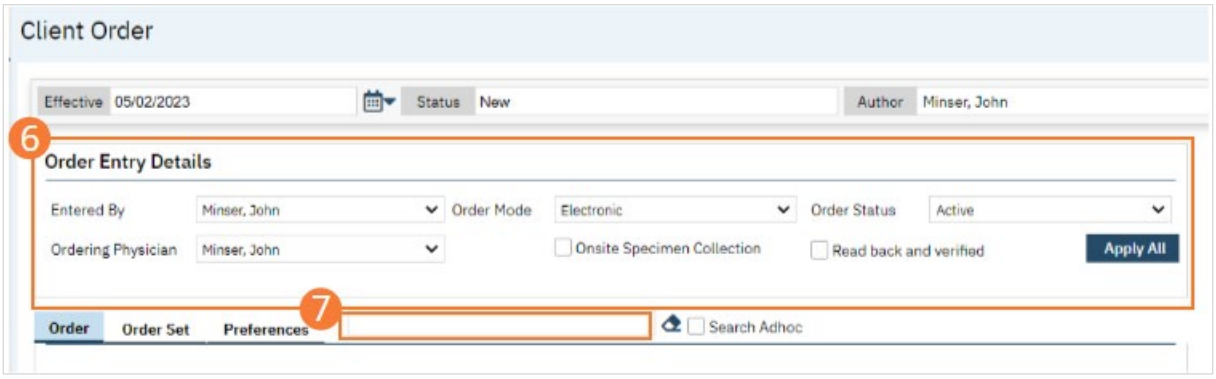
   Note: If you select an order listed in the top half of the window and click OK, you can modify or discontinue the selected order. Refer to Modify an Order or Discontinue an Order for instructions.



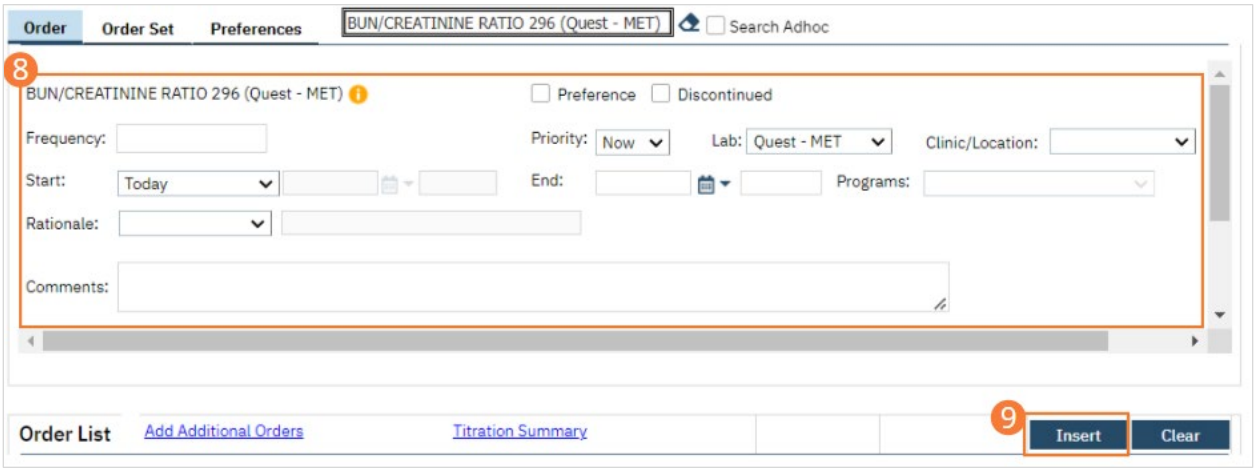
   A blank Client Order page opens where you can create a new order.



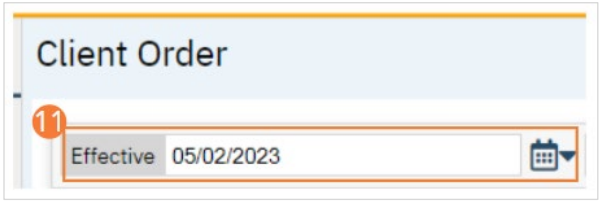
6. **Complete the fields** in the Order Entry Details section.
    a. Note: Order Mode does not have any associated logic; it is strictly for documentation.
7. **Type the name of the Order or partially type the name of the Order in the blank field next to the Preferences tab** to display the order you need.
   Note: **If you are unable to find a Medication order you need, click the Search Adhoc check box**. The Create Adhoc Order button appears. Refer to How to Create an Ad Hoc Order for instructions.



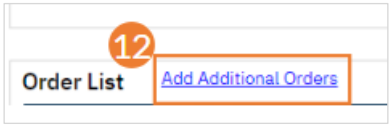
8. When the fields in the Order tab appear, **complete the fields**.
    a. See Nurse: How to Document a Verbal Order or Prescriber: How to Add an Order for details on these fields.
9. **Click the Insert button** in the Order tab section. The information appears in the Order List section.



10. To add another order, repeat steps 5 through 9.
11. When you have added all the orders, **enter a date** in the Effective field.



12. To view existing orders for this client, **click the Add Additional Orders hyperlink**.

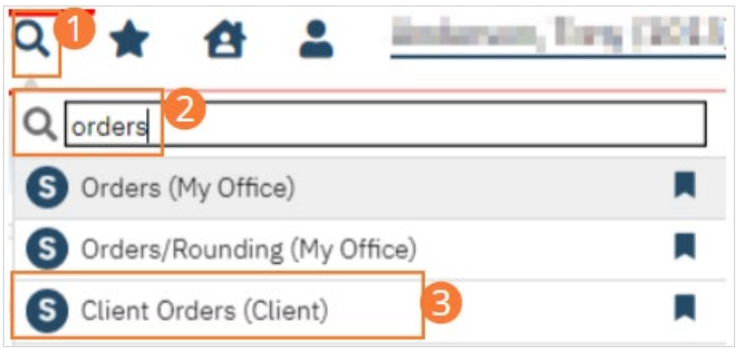


13. **Sign the order(s)** using the steps found under How to Sign a Document.

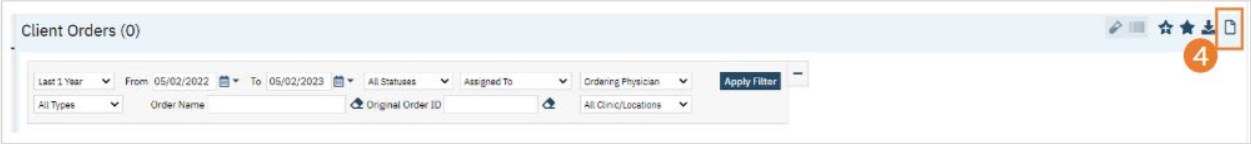
How to Create an Ad Hoc Order

An ad hoc order is one that you create as you work because no existing order can be found in the system. Creating an ad hoc order lets you create an order for immediate use in the Client Order page.

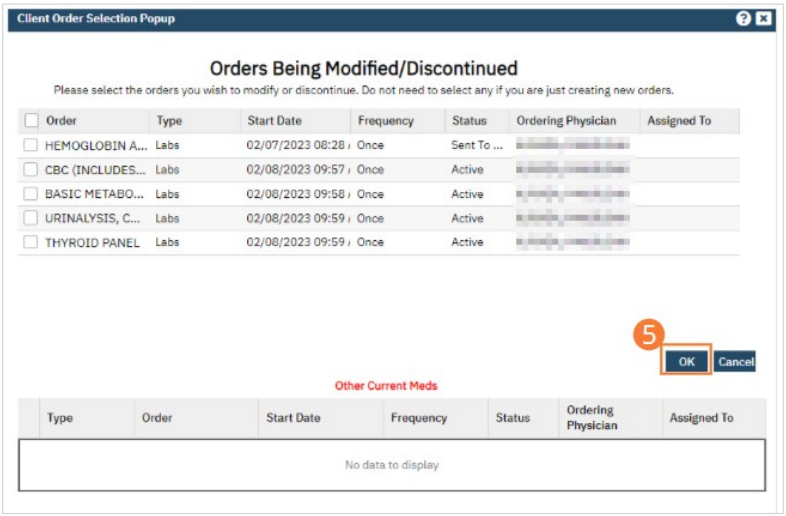
1. You must first have the client open, then **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type "Orders"** into the search bar.
3. **Click to select "Client Orders (Client)"** from the search results.



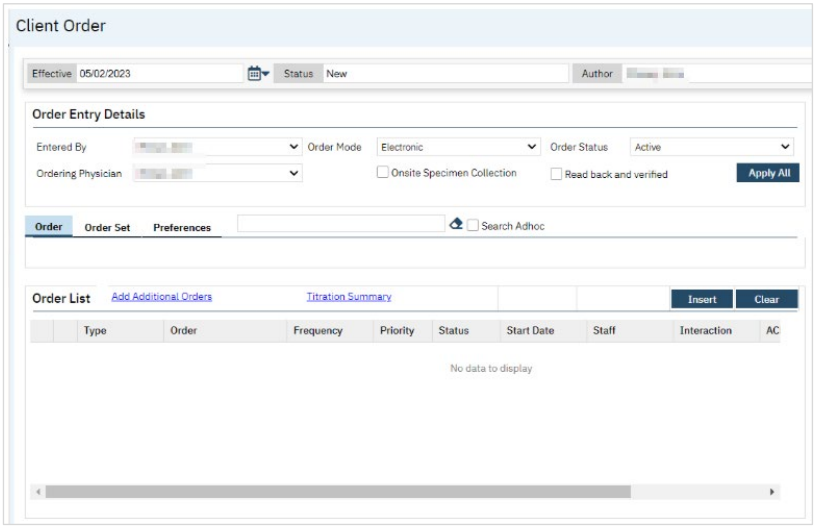
4. The client Orders list page will open. **Click on the New icon.**



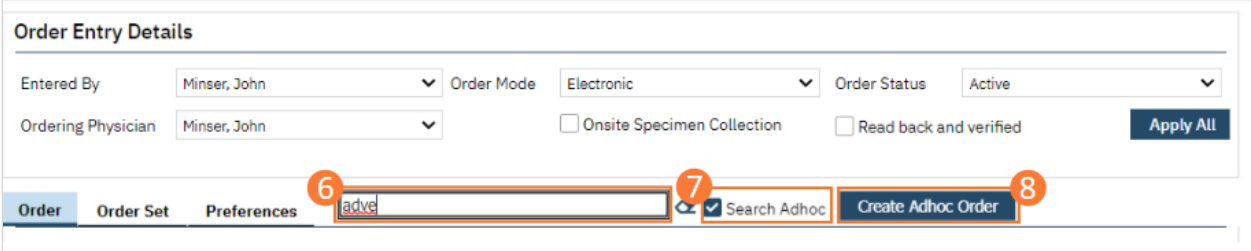
5. This takes you to the Orders Being Modified/Discontinued window. Without selecting any orders listed in the top half of the window, **click the OK button**.
   Note: If you select an order listed in the top half of the window and click OK, you can modify or discontinue the selected order. Refer to Modify an Order (See page 44) or Discontinue an Order (See page 41) for instructions.



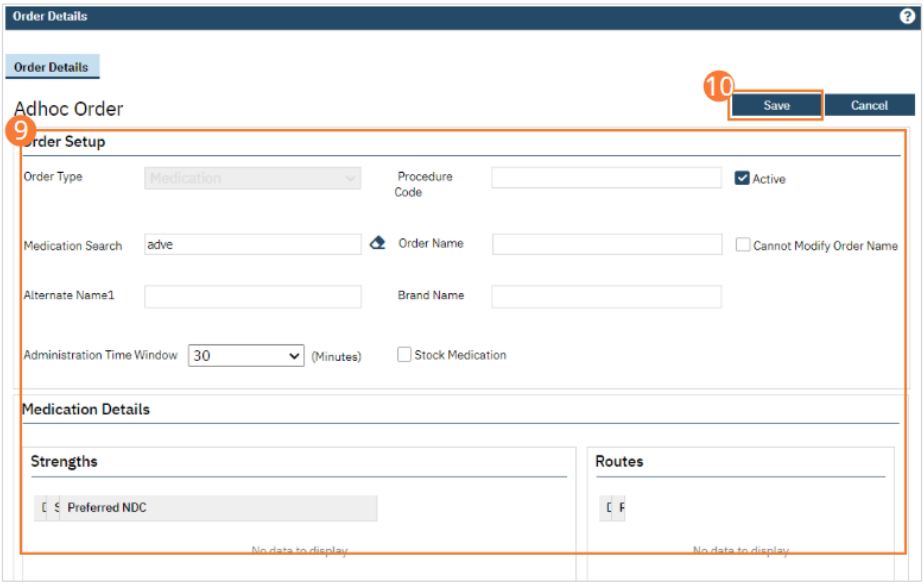
A blank Client Order page opens where you can create a new order.



6. **Type the name of the Order or partially type the name of the desired Order in the blank field next to the Preferences tab**. If an Order is found, instead complete the steps under How to Create a New Order for a Client.
7. If the system does not find a match, the Create Adhoc Order button appears.
8. **Click the Create Adhoc Order button**. The Adhoc Order window opens.

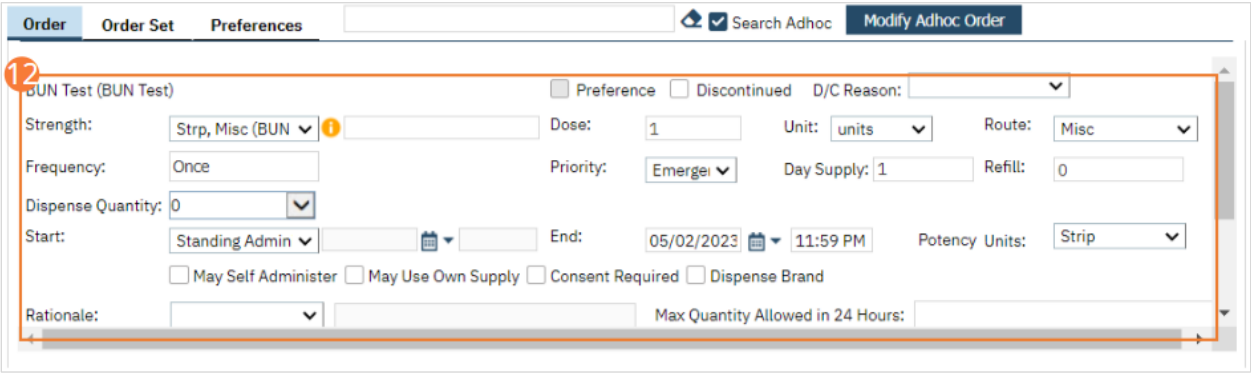


9. **Complete the fields**.
10. **Click the Save button** in the window



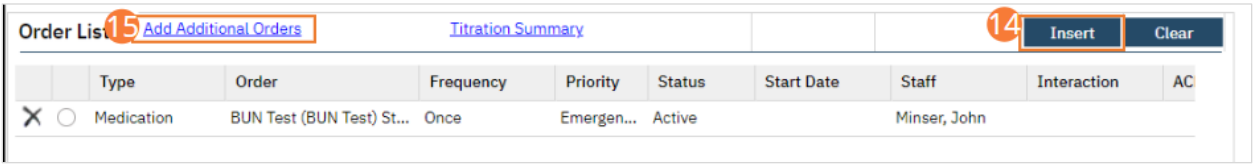
11. When you are finished, **click the Close icon** in the window. The fields appear in the middle section of the Client Order page.

12. When the fields in the Order tab appear, **complete the fields**.
    a. See Nurse: How to Document a Verbal Order or Prescriber: How to Add an Order for details on these fields.



13. **Click the Save button** in the tool bar.

14. **Click the Insert button** in the Order tab section. The information appears in the Order List section.
15. To add another order, click the Add Additional Orders hyperlink. Repeat steps 5 through 10.

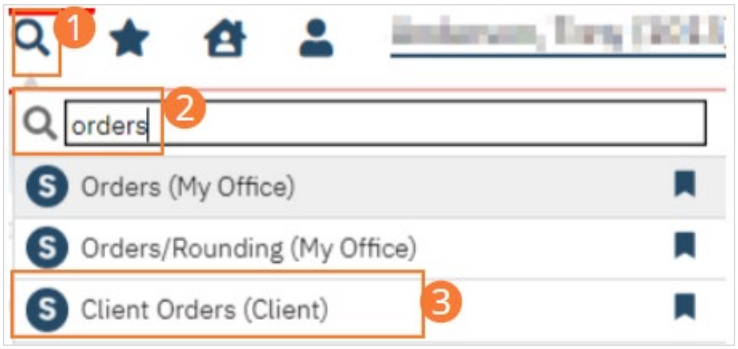


16. **Sign the order(s)** using the steps found under How to Sign a Document.

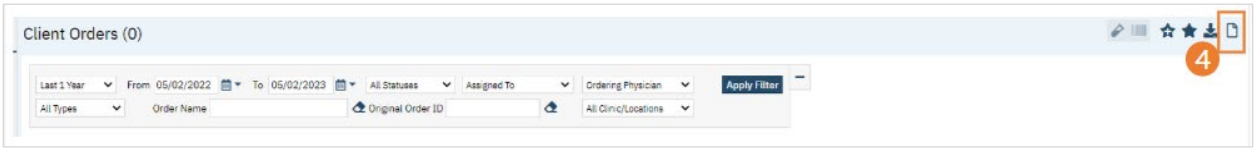
How to Access Order Sets

These steps show you the orders in the Order Set so you can pick just the specific orders you want, or all the orders in a set. After you prescribe the order set, set the specific instructions for each order individually.

1. You must first have the client open, then **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type "Orders"** into the search bar.
3. **Click to select "Client Orders (Client)"** from the search results.

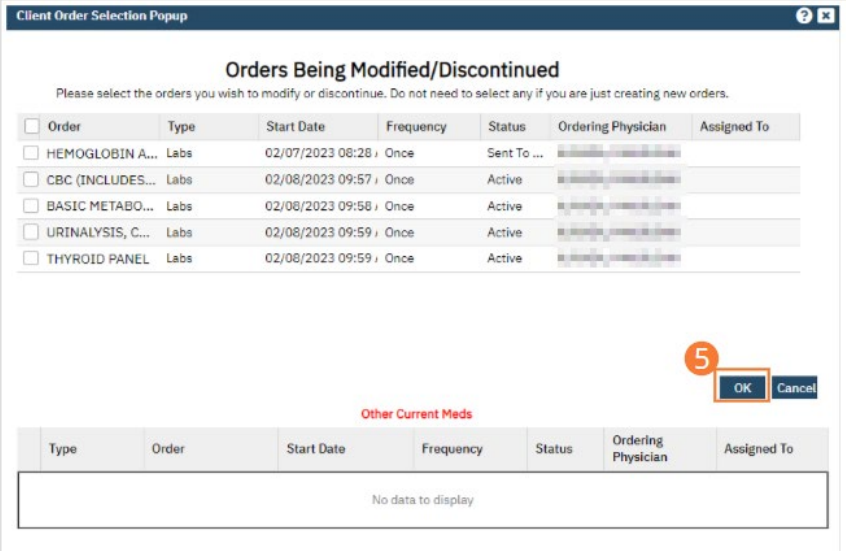


4. The client Orders list page will open. **Click on the New icon.**

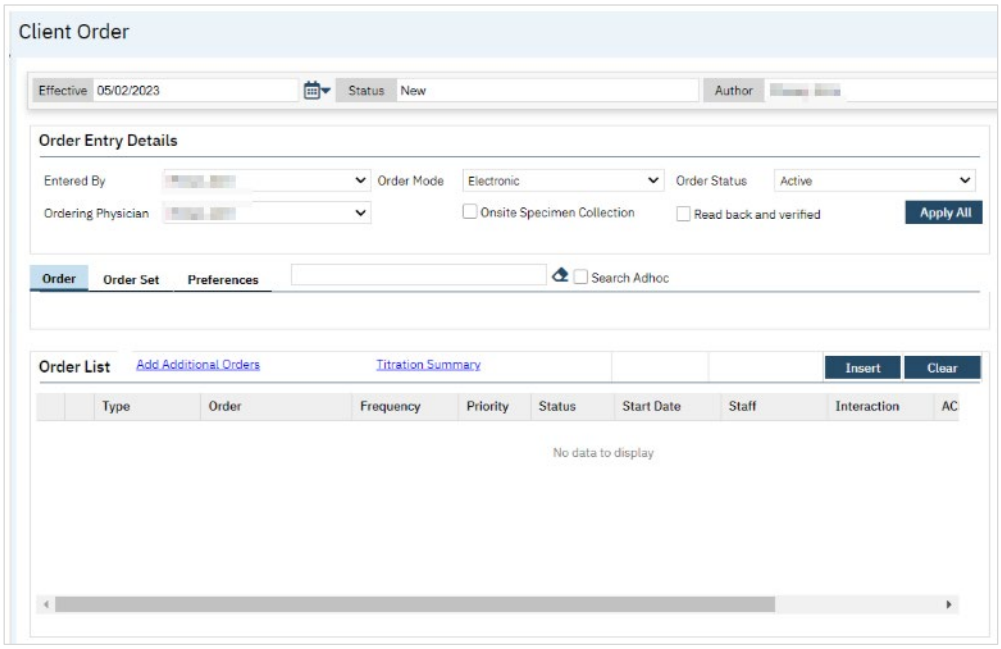


5. This takes you to the Orders Being Modified/Discontinued window. Without selecting any orders listed in the top half of the window, **click the OK button**.

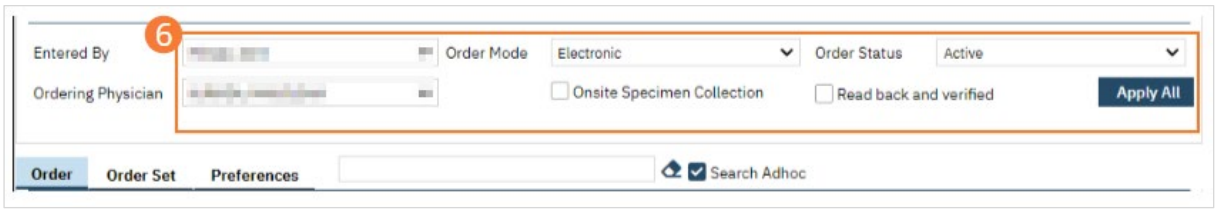
    Note: If you select an order listed in the top half of the window and click OK, you can modify or discontinue the selected order. Refer to Modify an Order or Discontinue an Order for instructions.



A blank Client Order page opens where you can create a new order.



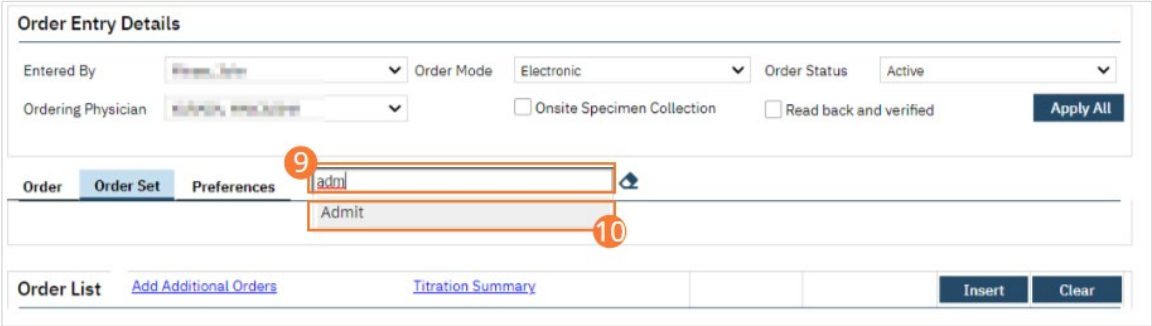
6. Complete the Order Entry Details section.



7. Click the Save button in the tool bar.

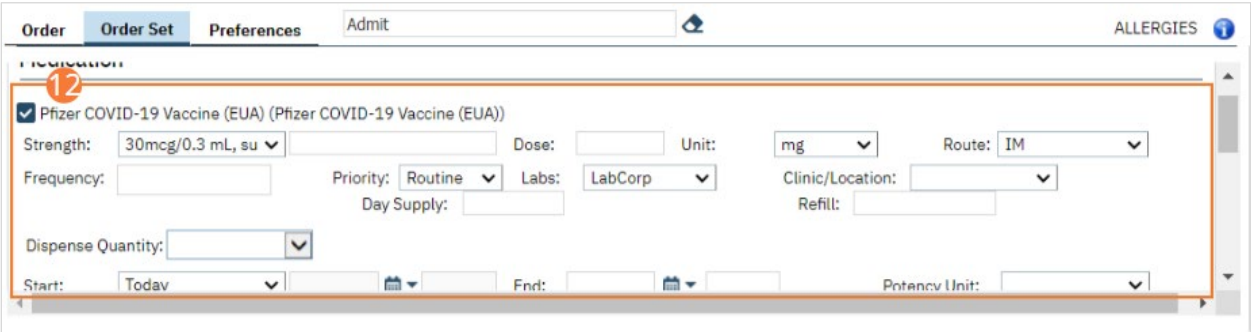
8. Click the Order Set tab.

9. In the blank data entry field, **type part or all of the order set** you want to prescribe.
10. **Select the highlighted option** in the drop down list.

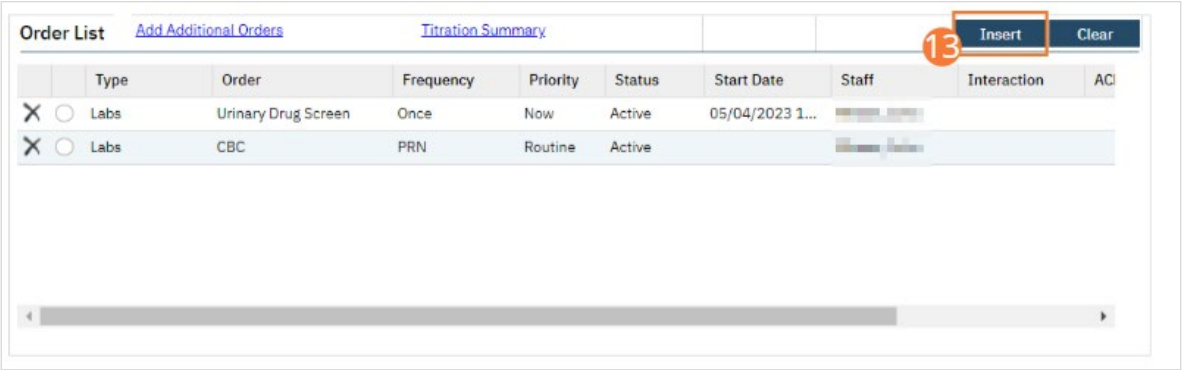


11. The orders in the order set appear below the Order tab.

12. **Select the check box next to each order you want to prescribe** to the client. If you do not want to prescribe an order, simply leave the check box unchecked.
    a. Complete the fields for each order you wish to include.
    b. See Nurse: How to Document a Verbal Order or Prescriber: How to Add an Order for details on these fields.



13. **Click the Insert button**.



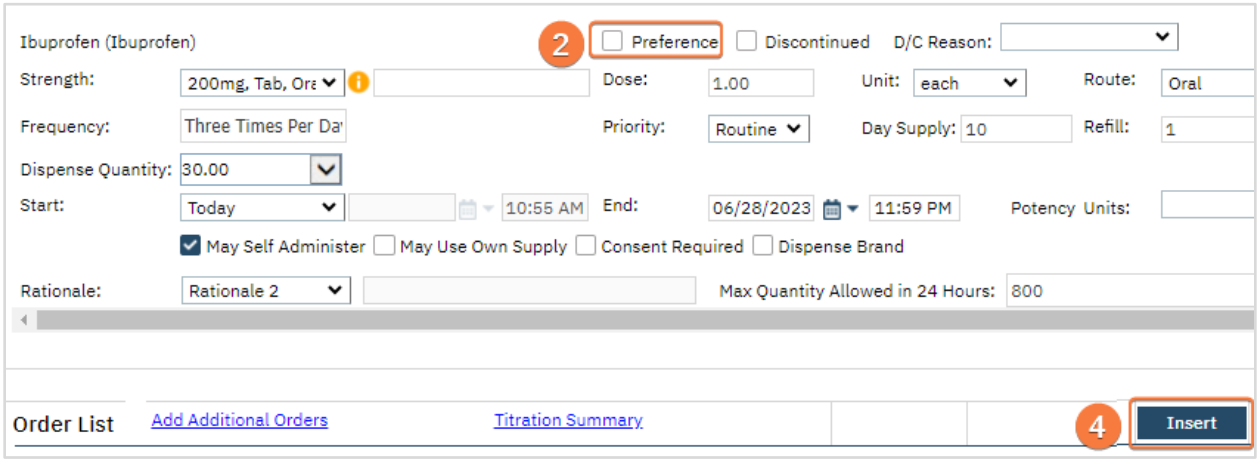
14. **Click the Save button** in the tool bar.

15. **Sign the Order(s)** according to the steps outlined in How to Sign a Document.

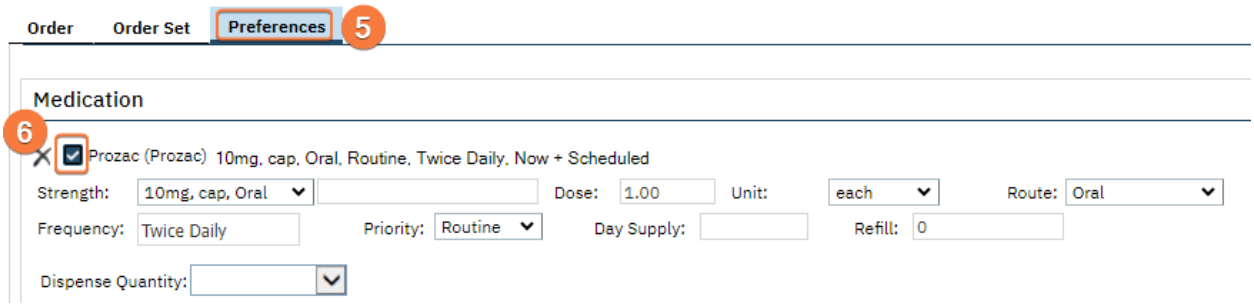
How to Create Order Preferences

Order preferences allow users to save their options within an order. Preferences are specific to users, can only be created by a user and can be accessed by that user. Each user should create their own preferences. Follow the steps below to create preferences.

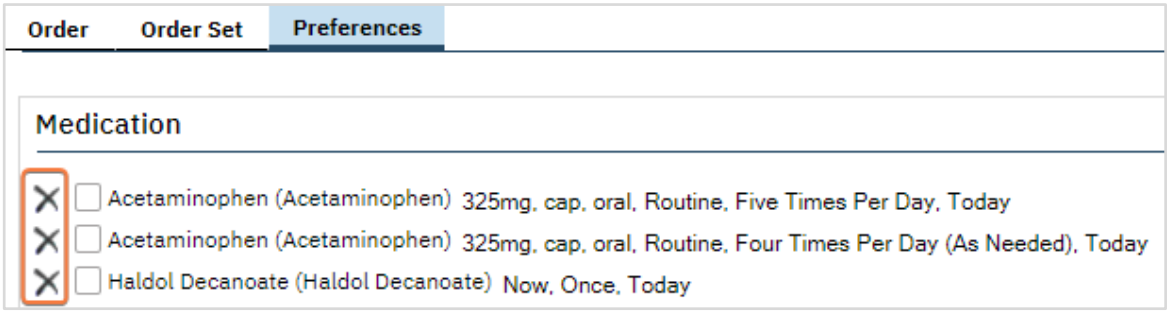
1. Ensure you are in a Client Order and an order is opened.
    a. See How to Create a New Order for a Client for details.
    b. Preferences cannot be used in Order Sets.
2. **Select the Preference checkbox**.
3. Complete all other fields.
    a. Fields present will vary by order type and set up.
4. **Insert the order and click save**. The preferences now exist.



    a. You may have multiple preferences for the same order.
5. To access preferences, **click on the Preferences tab**.
    a. Orders will be grouped according to Order Type.
6. **Select the checkbox next to the desired order(s)** preference.



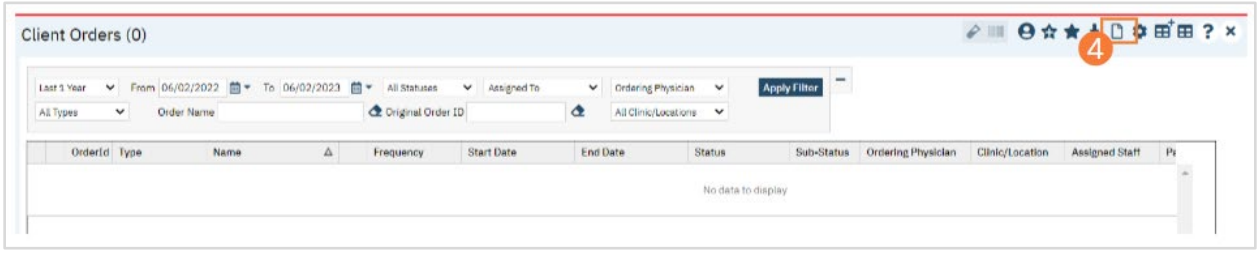
7. Fields corresponding to the order will display.
    a. **Update fields as needed**.
    b. Note: Some fields will not populate to ensure they are reviewed, e.g. Day Supply for medication.
8. The '*X*' next to the Order will delete the preference.



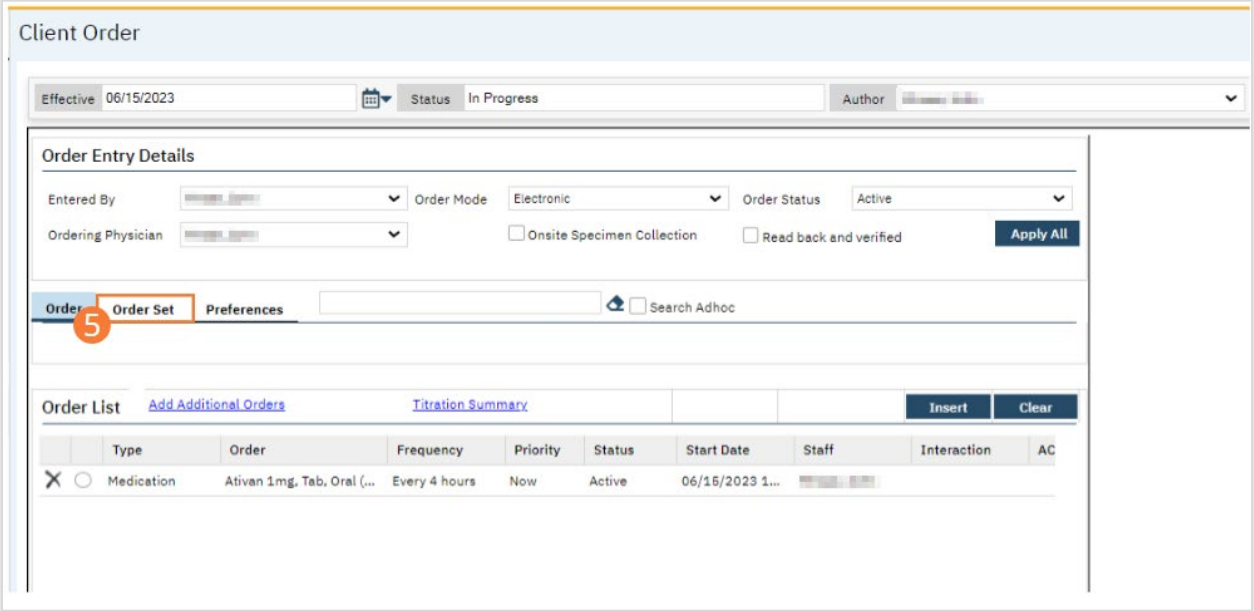
Nurse: How to Document Seclusion and Restraints

1. With an active client selected, **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type 'Orders'** into the search bar.
3. **Click to select Client Orders (Client).** The Client Orders list page screen will open.

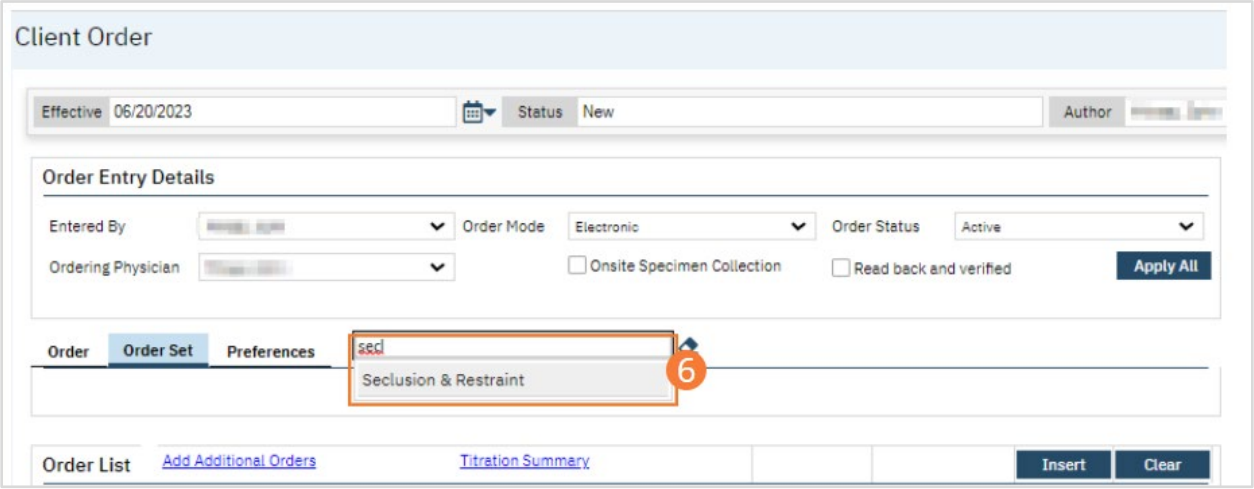
4. Click on the New icon in the tool bar. The Order Detail screen will open.



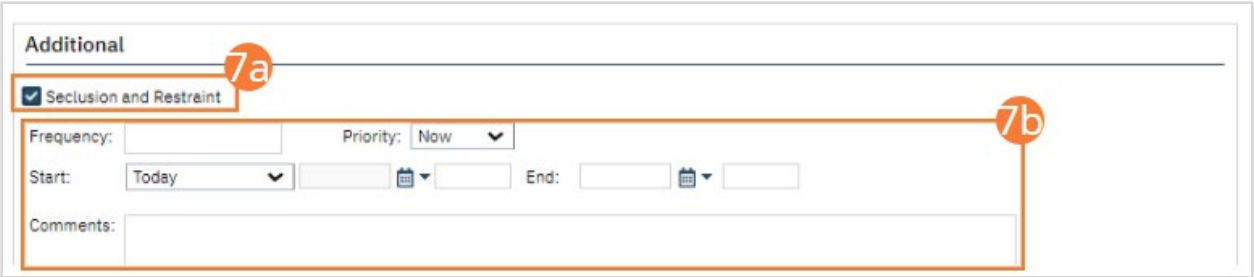
5. Click the **Order Set** tab.

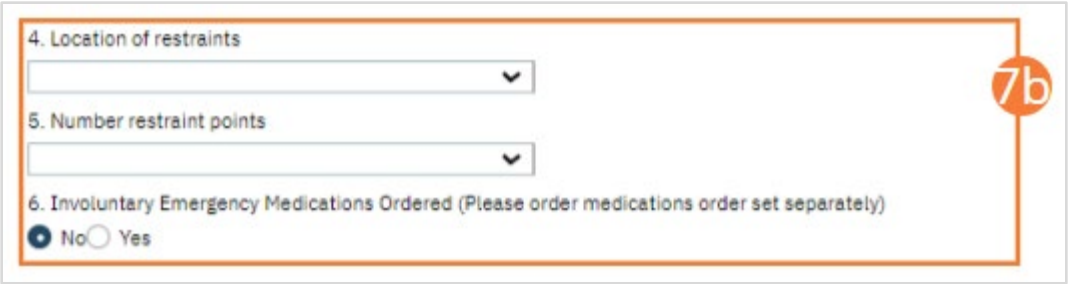


6. In the Order Set Search field, **type 'Seclusion and Restraint' and select the option** when it appears.



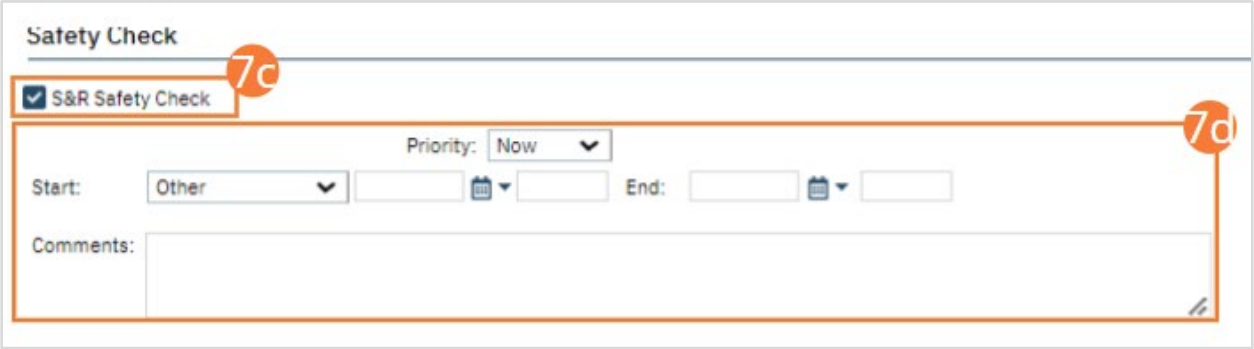
7. **Complete the Order Set details**.
    a. Select the Seclusion and Restraint checkbox to include the Seclusion and Restraint order in the order set.
    b. Complete all applicable order specifications. Select a frequency by searching for a frequency in the search box and selecting the desired option from the dropdown. Select a priority from the dropdown. Select a start date and time and an end date and time. (Note: S&R orders typically begin with a 4-hour period. Your workflow may differ.) Optionally, type comments in the text box. Select a clinical indication checkbox. Type text into the Preceding Behavior field. Select checkboxes for forms of S&R measures. If restraints were selected, select location and number of restraints from the dropdowns. Select a radio button indicating if medications are being ordered as part of the Seclusion and Restraint overall group of orders. (Note: Medication orders related to S&R may or may not be part of the Order Set as it is dependant or your organization set up and may have organization-specific workflows.)



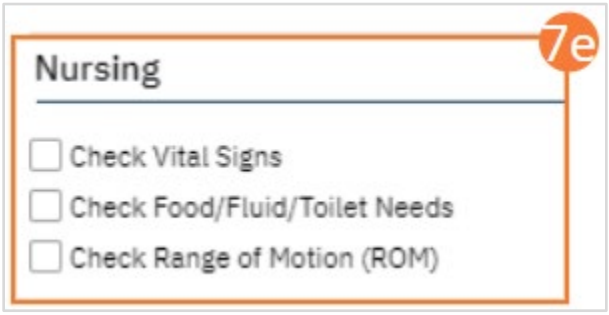


c. Select the Safety Check checkbox to include Safety Check in the order set.

d. Complete all applicable order specifications. Select a priority from the dropdown. Select a start date and time and an end date and time. (Note: Safety Checks usually coincide with the length of the S&R Order.)

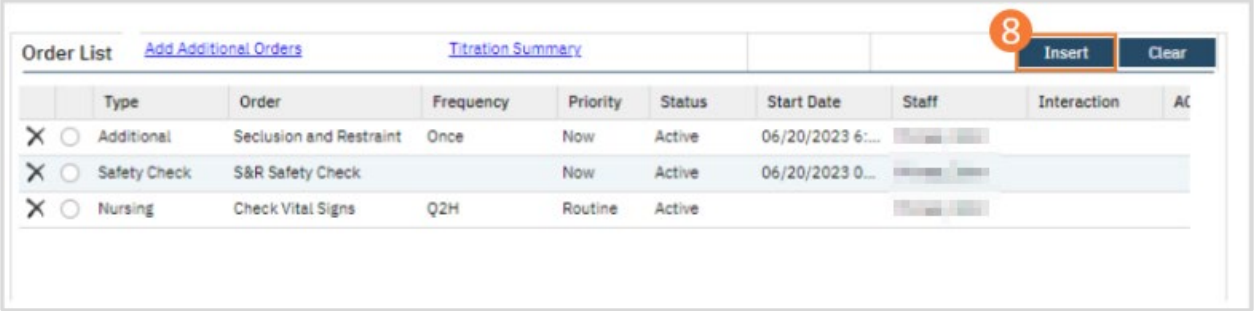


e. Depending on the needs of the client and your workflow, optionally select one or more of the nursing order checkboxes.

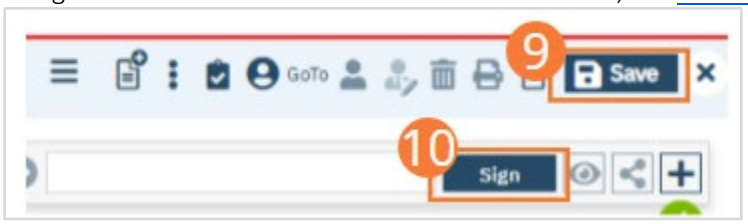


f. For each Nursing order selected, complete the questions, including frequency, priority, and start and end dates and times.

8. Click Insert to add the order set to the Order List.



9. Click Save.
10. Click Sign and complete signature of the document. For more information, see How to Sign a Document.

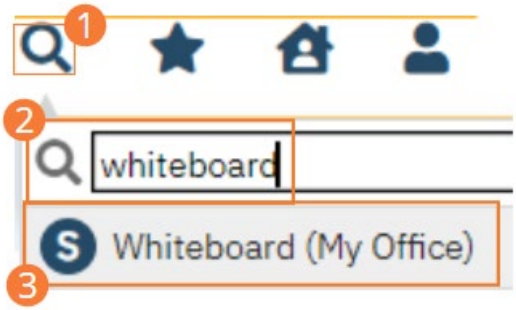


11. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

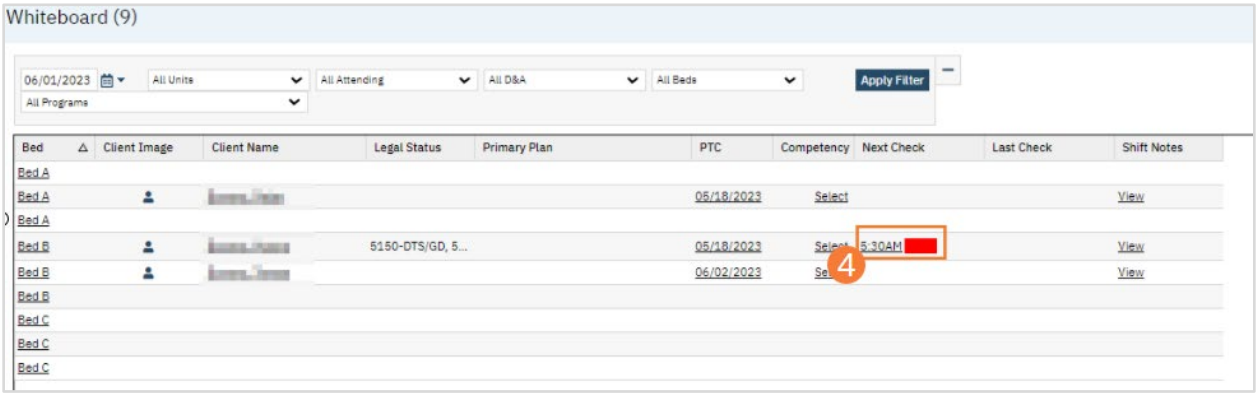
How to Document a 1-Hour Follow-Up on a Seclusion and/or Restraint Order

The S&R Safety Check automatically sets up follow-up checks that are visible on the Whiteboard and tracked as a Flow Sheet. Follow these steps to document a follow-up.

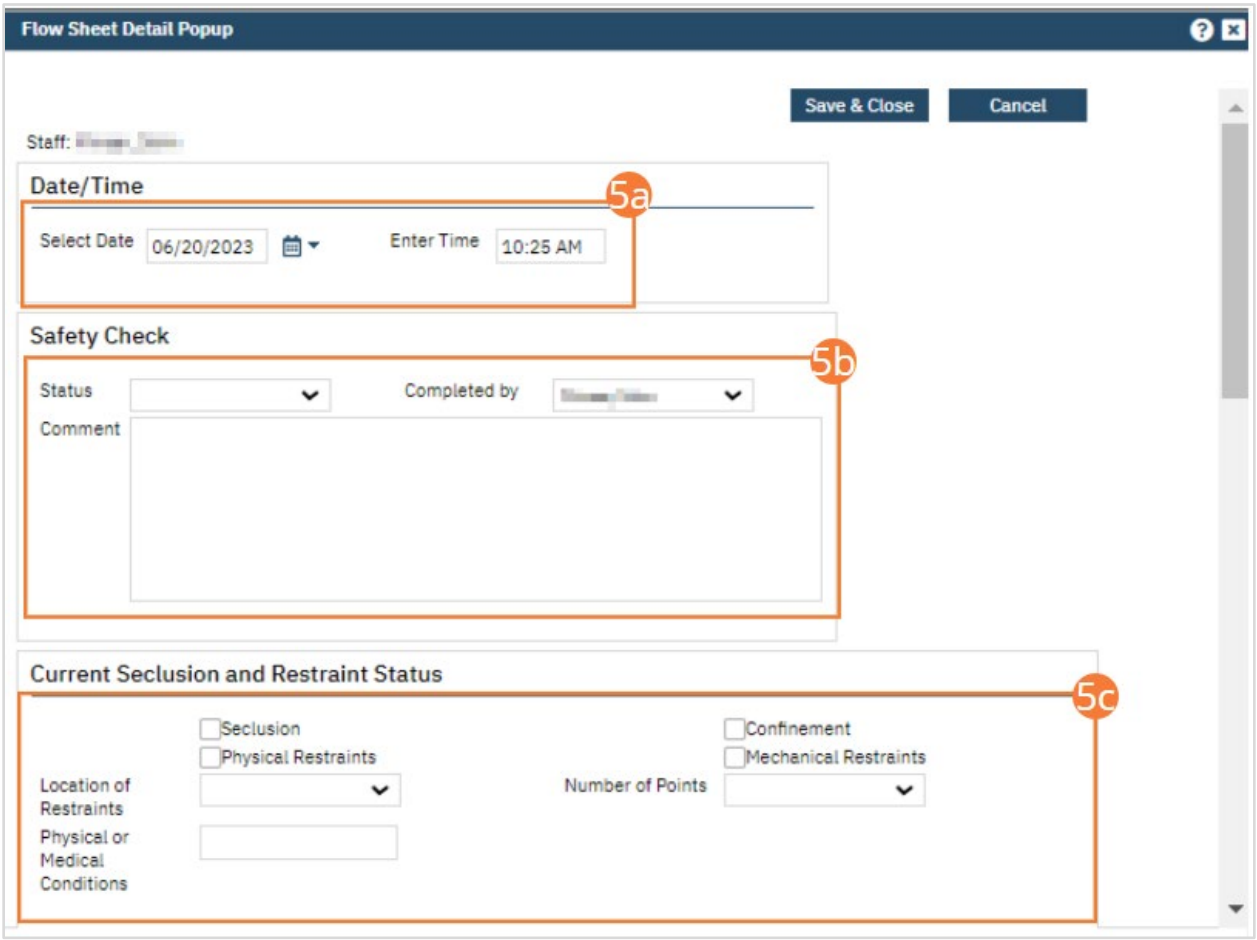
1. Click the Search icon.
2. Type 'Whiteboard' into the search bar.
3. Click to select Whiteboard (My Office).



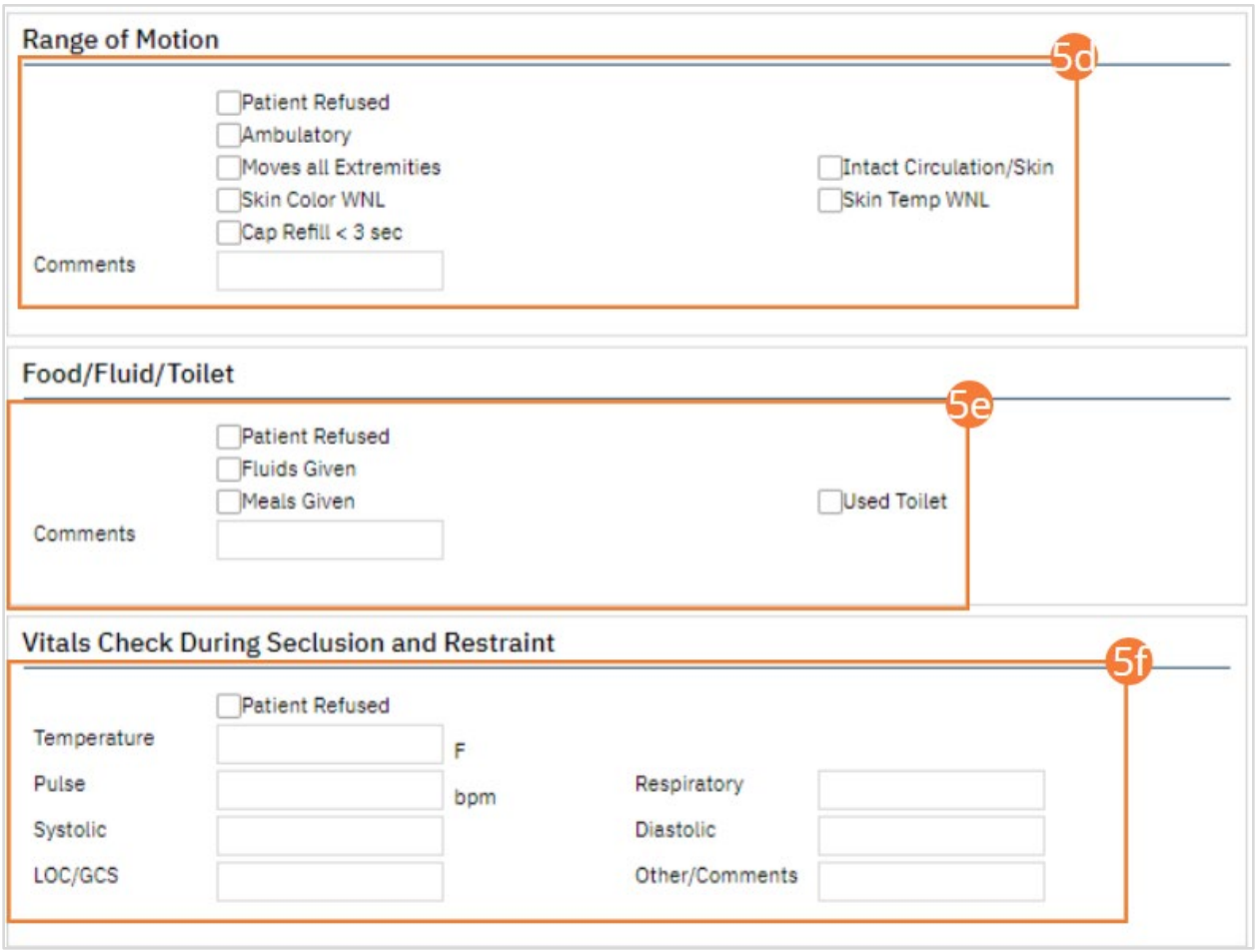
4. Locate the Next Check column and click the displayed time hyperlink. The follow-up window opens.
    a. Note: the time indicates when the next check should occur. Red next to the time indicates it is past due.



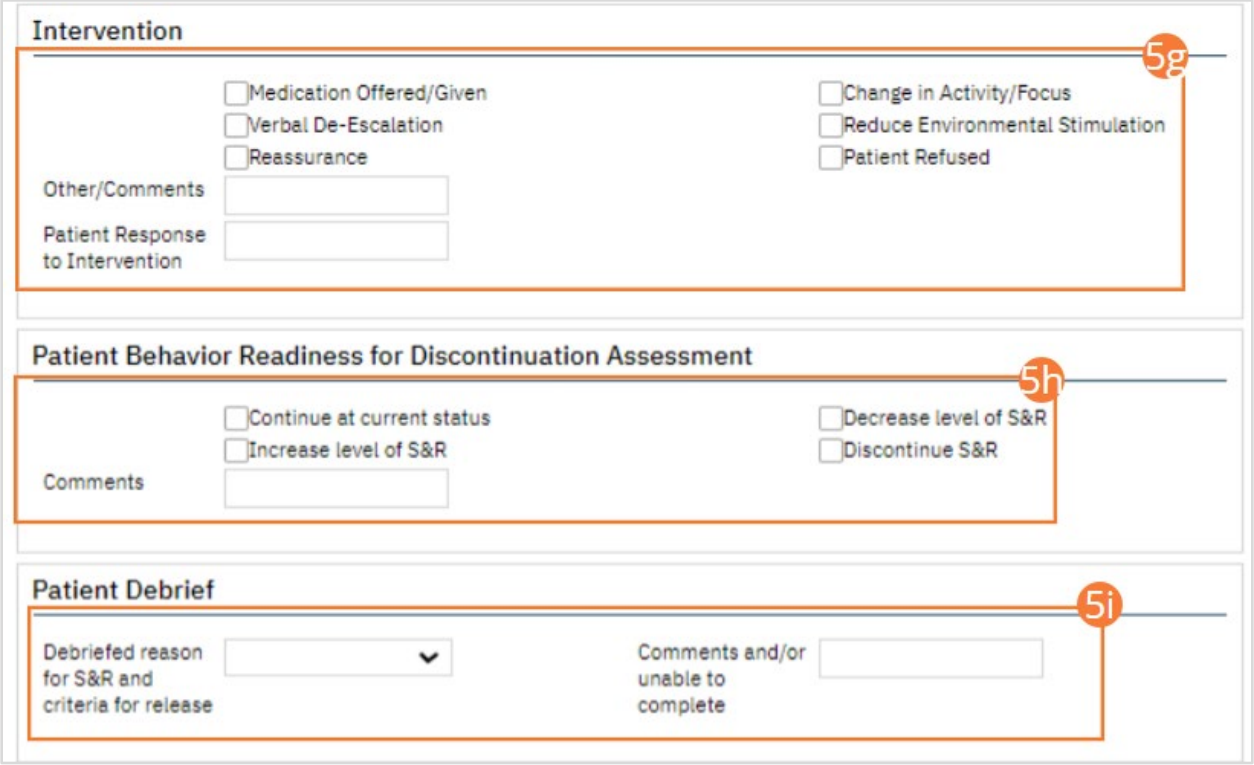
5. **Complete the Safety Check sections**, as needed. This may be completed by non-medical staff. If so, they would complete areas associated with their responsibilities and within their scope of practice.
    a. Confirm date and time are accurate and correct if necessary.
    b. Select a status for the safety check. Add a comment if applicable.
    c. Click the checkboxes next to the seclusion/restraint options used. Select Location and Points from the dropdowns. Type physical or medical conditions into the field.



    d. If Range of Motion was monitored, click the checkbox next to Range of Motion options assessed and enter comments in the text field as needed.
    e. If Food/Fluid/Toilet was monitored, click the checkbox next to Food/Fluid/Toilet options performed and enter comments in the text field as needed.
    f. If Vitals was monitored, enter assessment results in the text field beside each factor assessed, or click the Patient Refused checkbox if the patient refused Vitals.



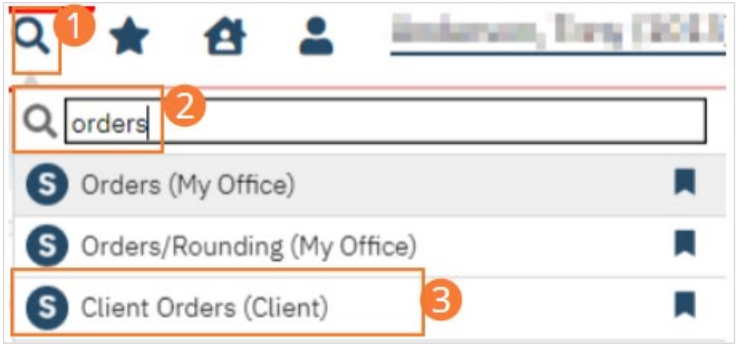
g. Click the checkbox next to Intervention options performed and enter comments in the text fields as needed.
h. Click the checkbox next to Discontinuation options taken and enter comments in the text fields as needed.
i. Select a debrief option from the dropdown and/or enter text in the comment field as required.
    i. This would only be completed at the end of S&R.



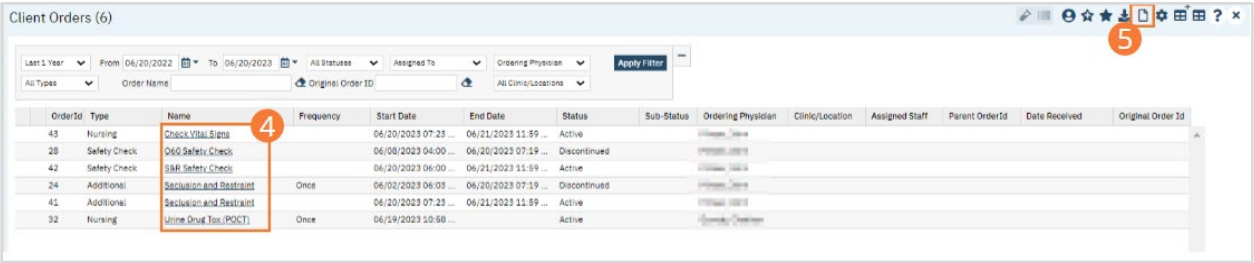
6. **Click Save and Close** to return to the Whiteboard.

How to Document Discontinuation of a Seclusion and/or Restraint Order

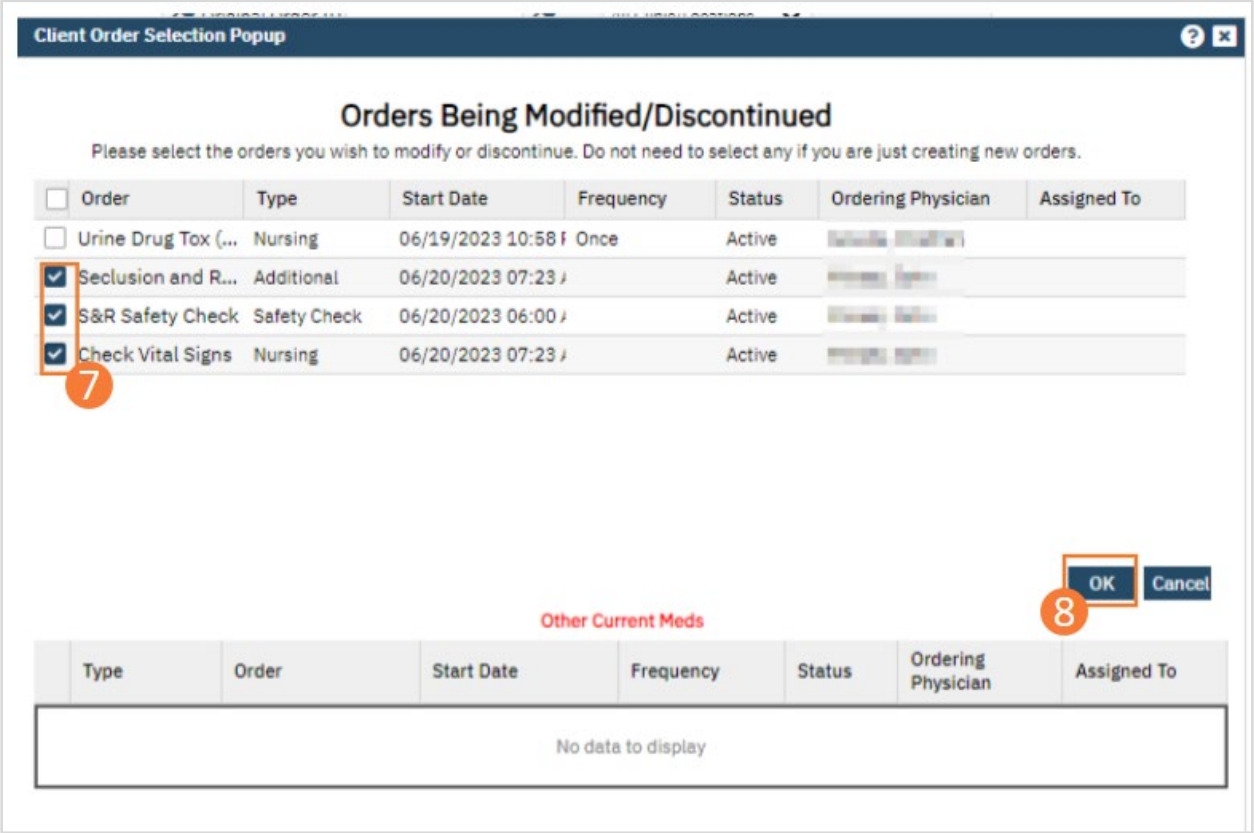
1. With an active client selected, **click the Search icon**.
   a. See General Client Search for details on opening the active client's record.
2. **Type "Orders"** into the search bar.
3. **Click to select Client Orders (Client).**



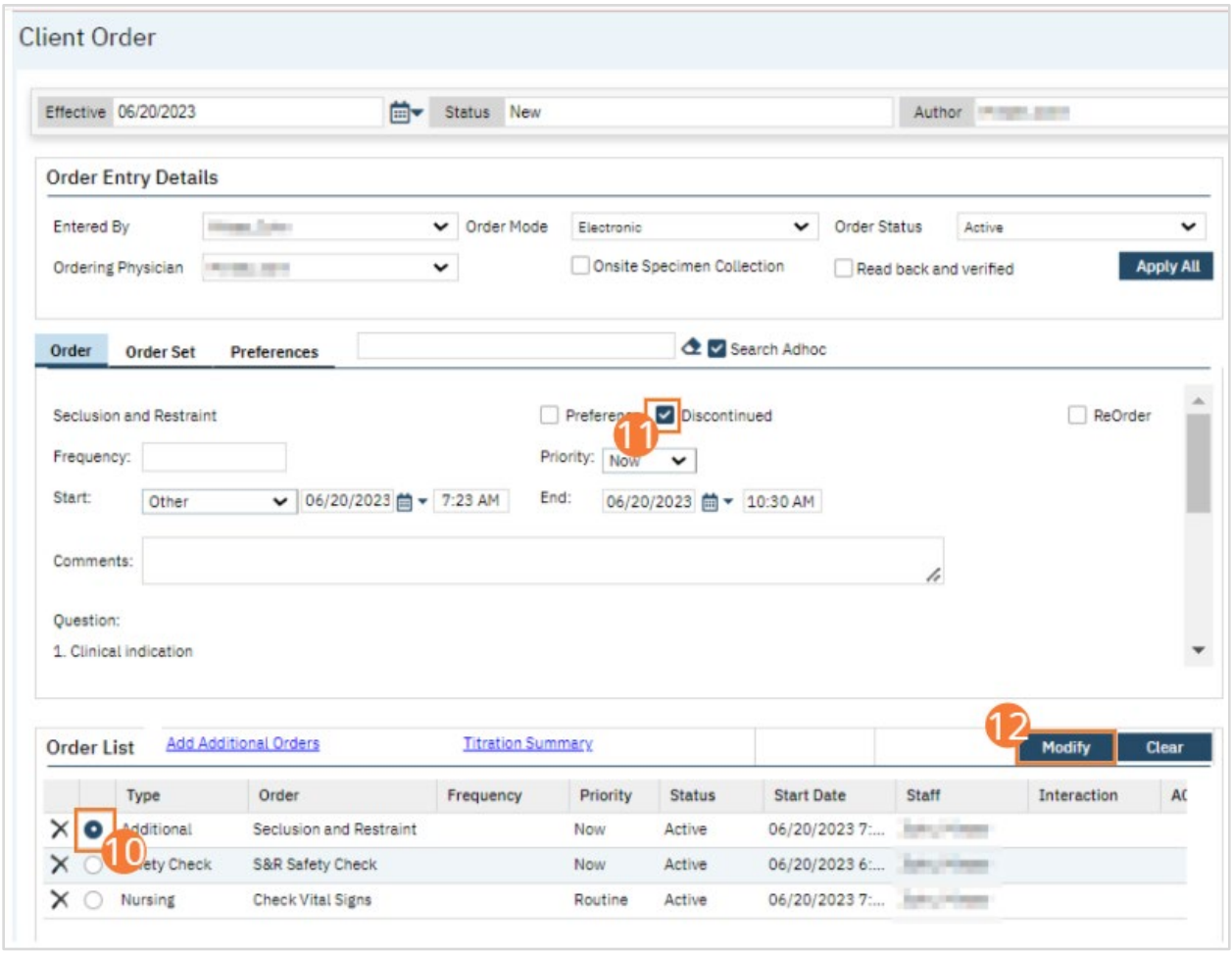
4. The Client Orders list page opens. Confirm that the Orders associated with the Seclusion and Restraint Order Set you wish to discontinue appear.
5. **Click on the New icon.** The Orders Being Modified/Discontinued window opens.



6. Locate the orders you want to discontinue in the top half of the window.
7. **Select the checkboxes** of the orders you want to discontinue. In a typical workflow, you should discontinue all orders associated with the initial S&R Order Set, including conditional orders. Medication orders may or may not be included when discontinuing an S&R Order Set.
8. **Click the OK button**. The Client Order screen opens.



9. Find the Seclusion and Restraint order in the Order List section of the page.
10. **Click the radio button** on the line of the order. The order information appears in the middle portion of the page.
11. **Select the Discontinued check box**.
12. **Click the Modify button** to save your changes.



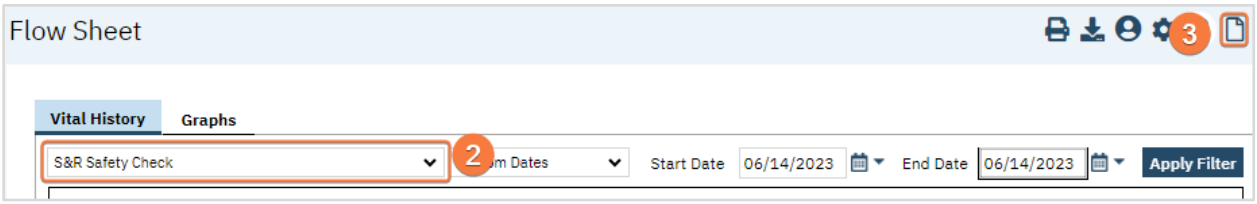
13. **Repeat Steps 10 - 12 for the Safety Check order and any continental orders being discontinued.**
14. **Click the Save button** in the tool bar.
15. **Click Sign** and complete signature of the document. For more information, see How to Sign a Document.

16. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

How to Document the Client Debrief After the Discontinuation of an S&R Order

A client debrief is available within the Safety Check on the Whiteboard. However, once the order is discontinued the Safety Check will no longer be available. To document a debrief after the order has been discontinued, complete the following steps.

1. Navigate to the client's flow sheets. See How to See Flow Sheets for an Active Client for details.
2. In the dropdown menu **select S&R Safety Check**.
3. **Click the New icon** in the toolbar. This will open the S&R Safety Check New Entry Flow Sheet.



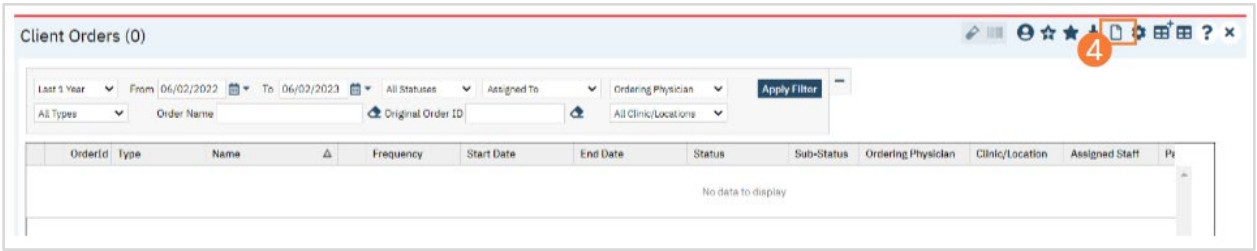
4. Date and time will automatically populate with the current date and time. If needed, update date and time the debrief occurred.
5. Navigate to the final section, Patient Debrief. **Select Debrief reason and add needed comments**.

6. **Click Save and Close** in the tool bar.

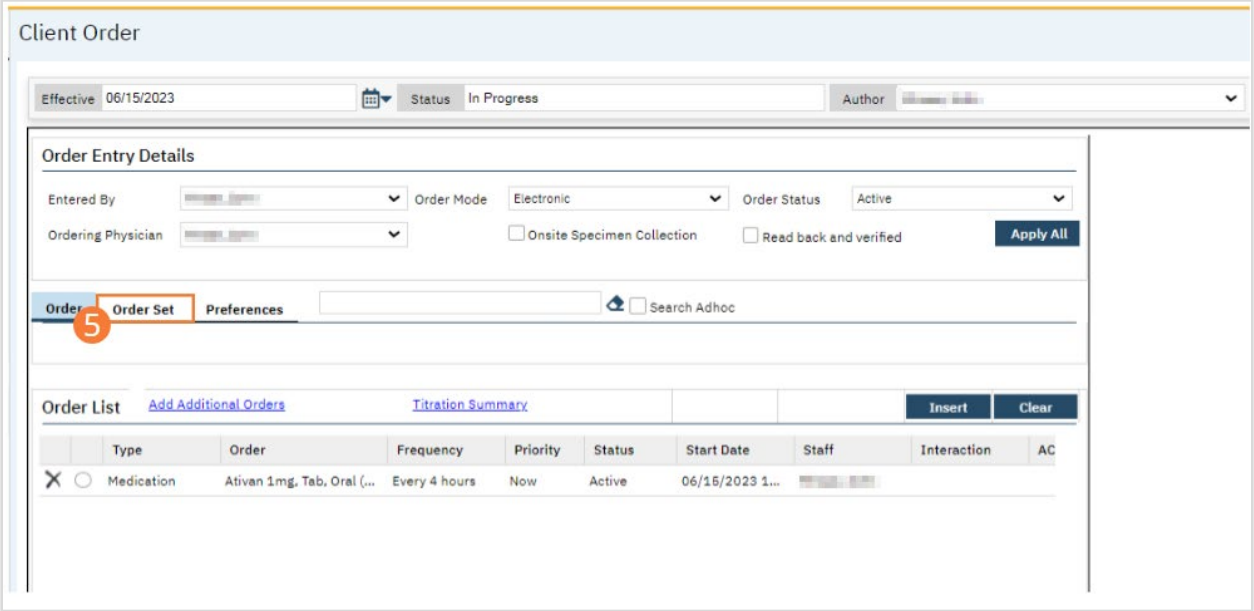
Prescriber: How to Order a Seclusion and/or Restraint

1. **With an active client selected, click the Search icon**.
2. **Type 'Orders'** into the search bar.
3. **Click to select Client Orders (Client).** The Client Orders list page screen will open.

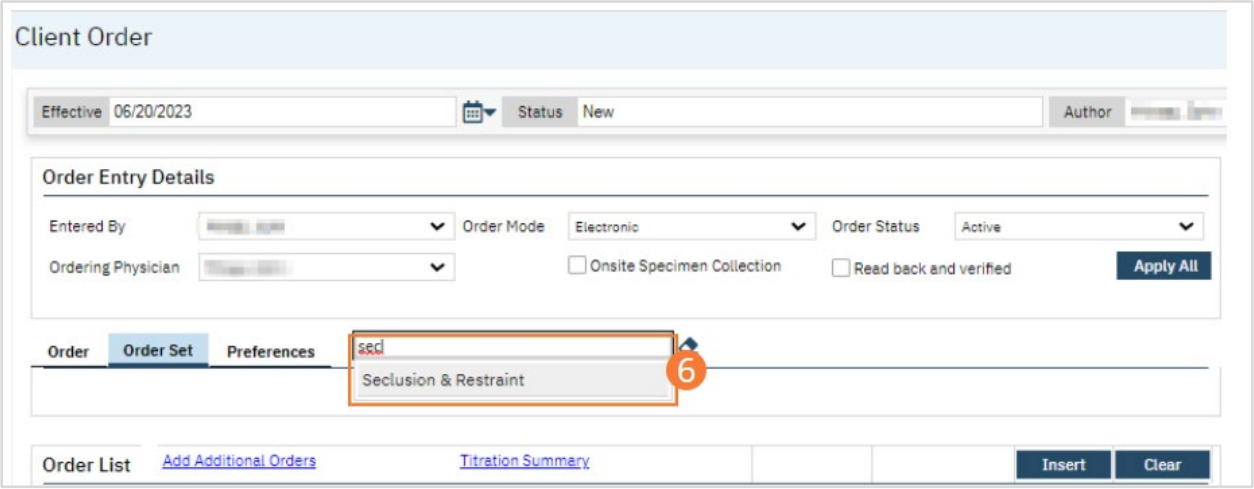
4. Click on the New icon in the tool bar. The Order Detail screen will open.



5. Click the **Order Set** tab.

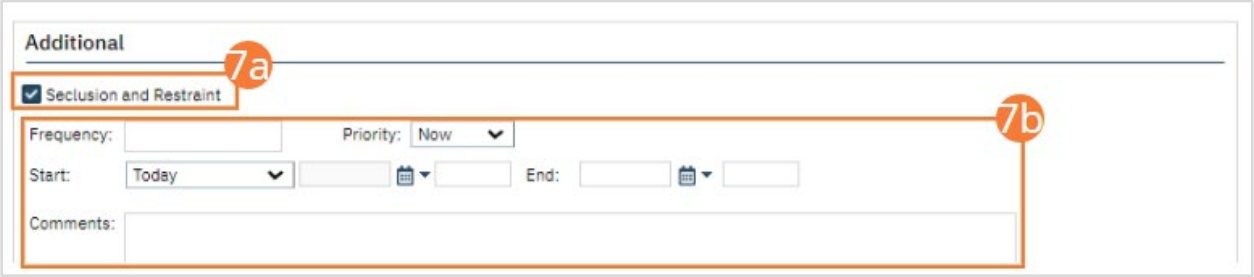


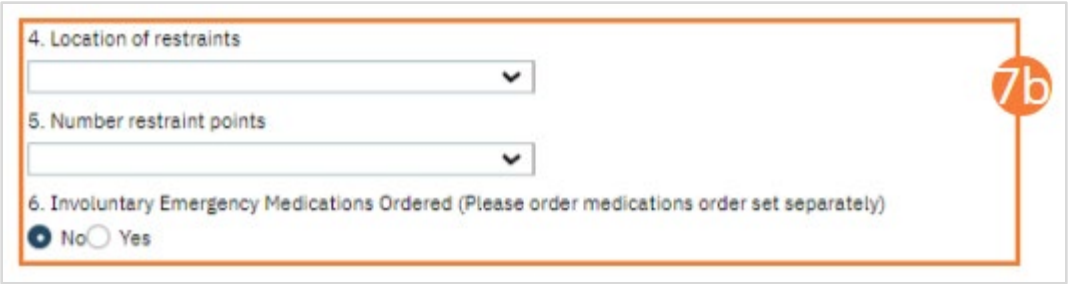
6. In the Order Set Search field, **type 'Seclusion and Restraint' and select the option** when it appears.



7. **Complete the Order Set details**.
   a) Select the Seclusion and Restraint checkbox to include the Seclusion and Restraint order in the order set.

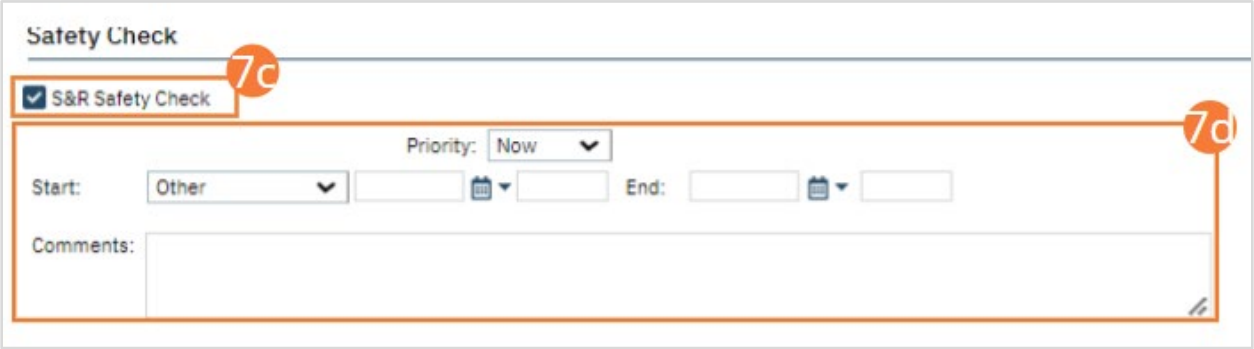
   b) Complete all applicable order specifications. Select a frequency by searching for a frequency in the search box and selecting the desired option from the dropdown. Select a priority from the dropdown. Select a start date and time and an end date and time. (Note: S&R orders typically begin with a 4-hour period. Your workflow may differ.) Optionally, type comments in the text box. Select a clinical indication checkbox. Type text into the Preceding Behavior field. Select checkboxes for forms of S&R measures. If restraints were selected, select location and number of restraints from the dropdowns. Select a radio button indicating if medications are being ordered as part of the Seclusion and Restraint overall group of orders. (Note: Medication orders related to S&R are ordered separately from the Order Set and may have organization-specific workflows.)



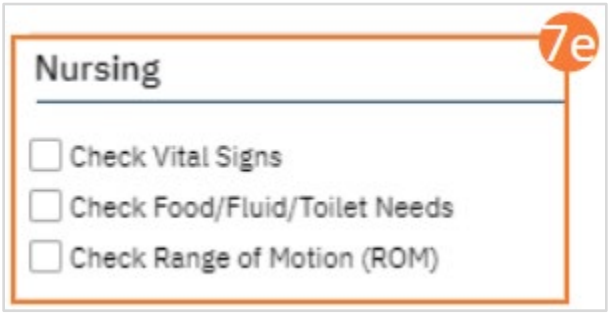


c) Select the Safety Check checkbox to include Safety Check in the order set.

d) Complete all applicable order specifications. Select a priority from the dropdown. Select a start date and time and an end date and time. (Note: Safety Checks usually coincide with the length of the S&R Order.)

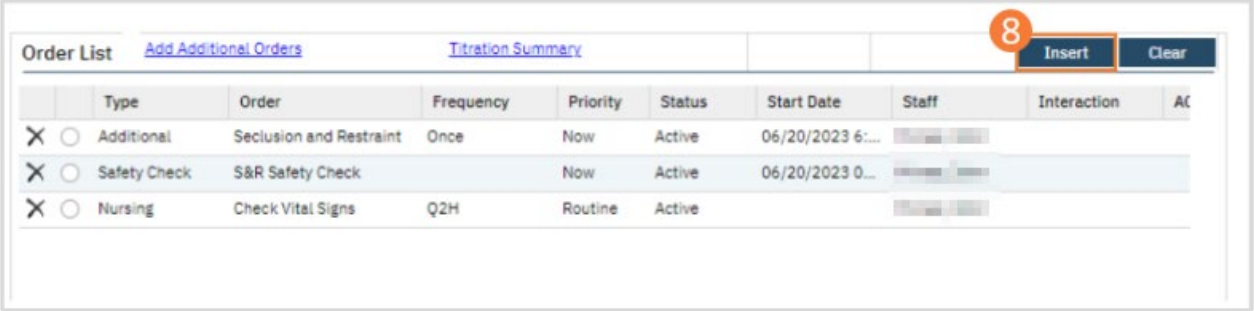


e) Depending on the needs of the client and your workflow, optionally select one or more of the nursing order checkboxes.

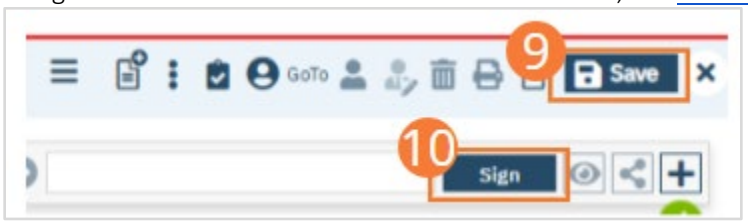


f) For each Nursing order selected, complete the questions, including frequency, priority, and start and end dates and times.

8. Click Insert to add the order set to the Order List.



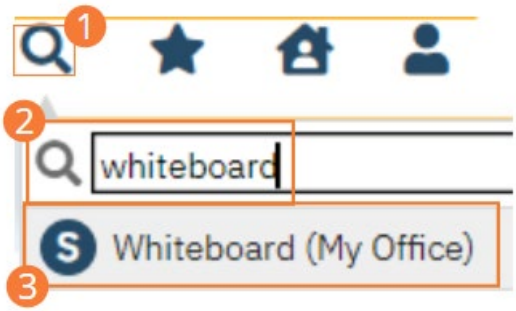
9. Click Save.
10. Click Sign and complete signature of the document. For more information, see How to Sign a Document.



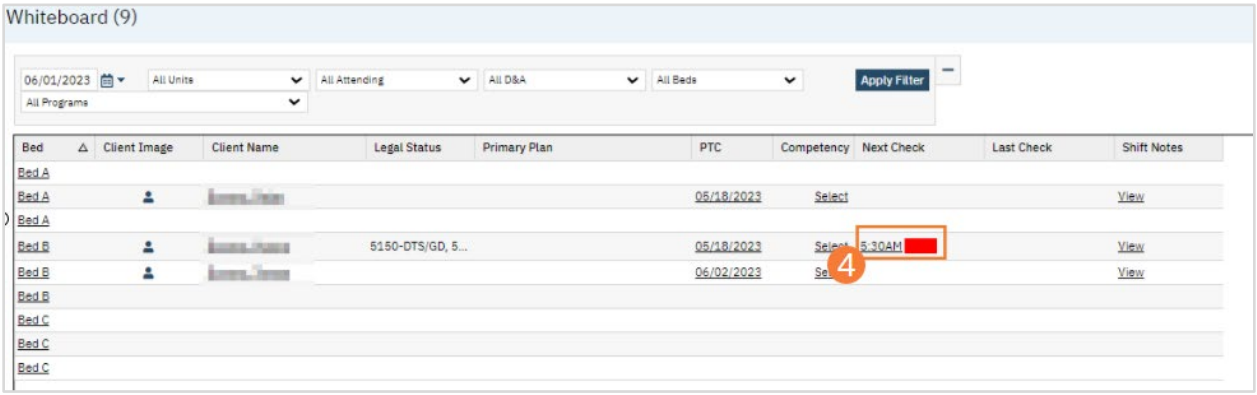
How to Document a 1-Hour Follow-Up on a Seclusion and/or Restraint Order

The S&R Safety Check automatically sets up follow-up checks that are visible on the Whiteboard and tracked as a Flow Sheet. Follow these steps to document a follow-up.

7. Click the Search icon.
8. Type 'Whiteboard' into the search bar.
9. Click to select Whiteboard (My Office).

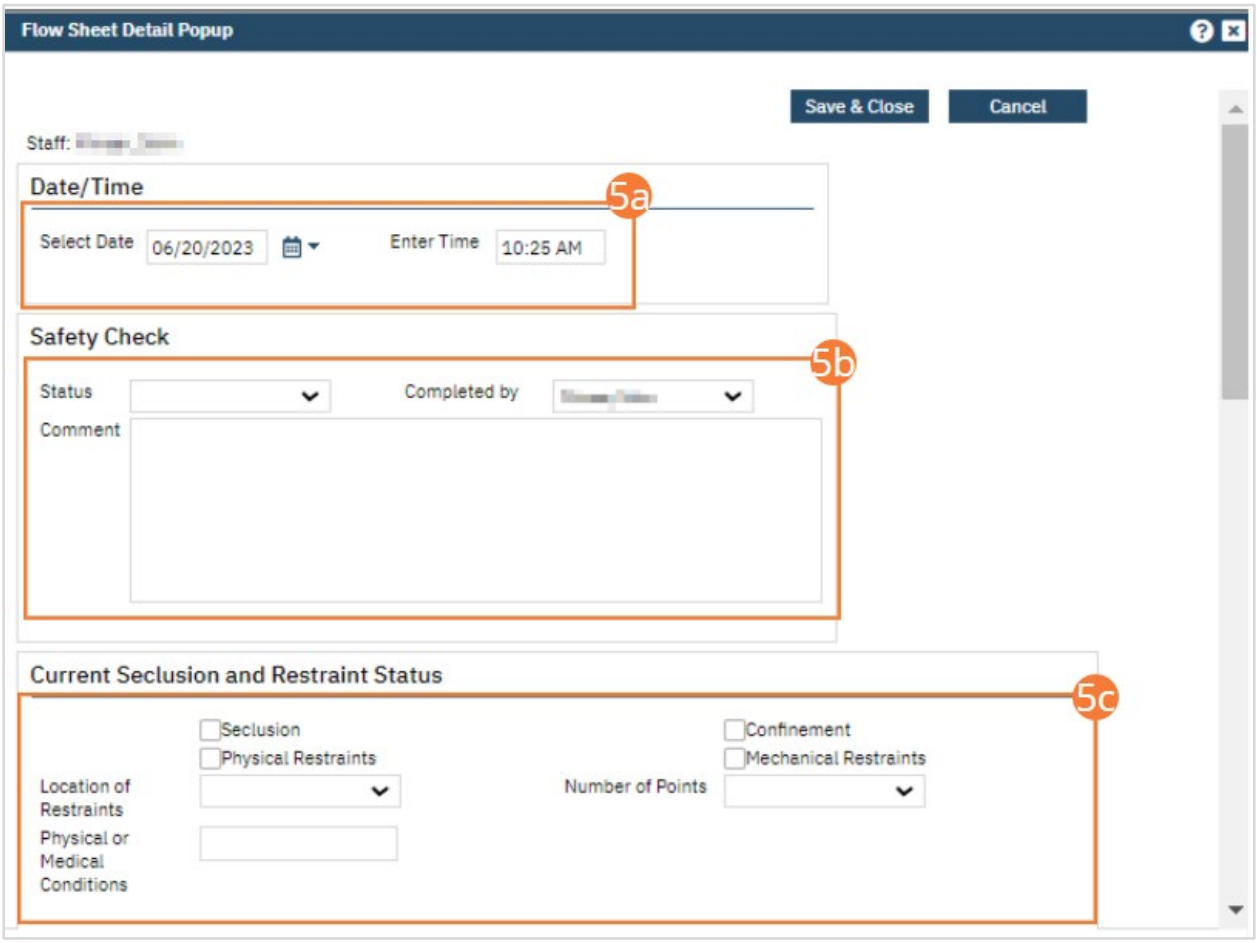


10. Locate the Next Check column and click the displayed time hyperlink. The follow-up window opens.
    a. Note: the time indicates when the next check should occur. Red next to the time indicates it is past due.

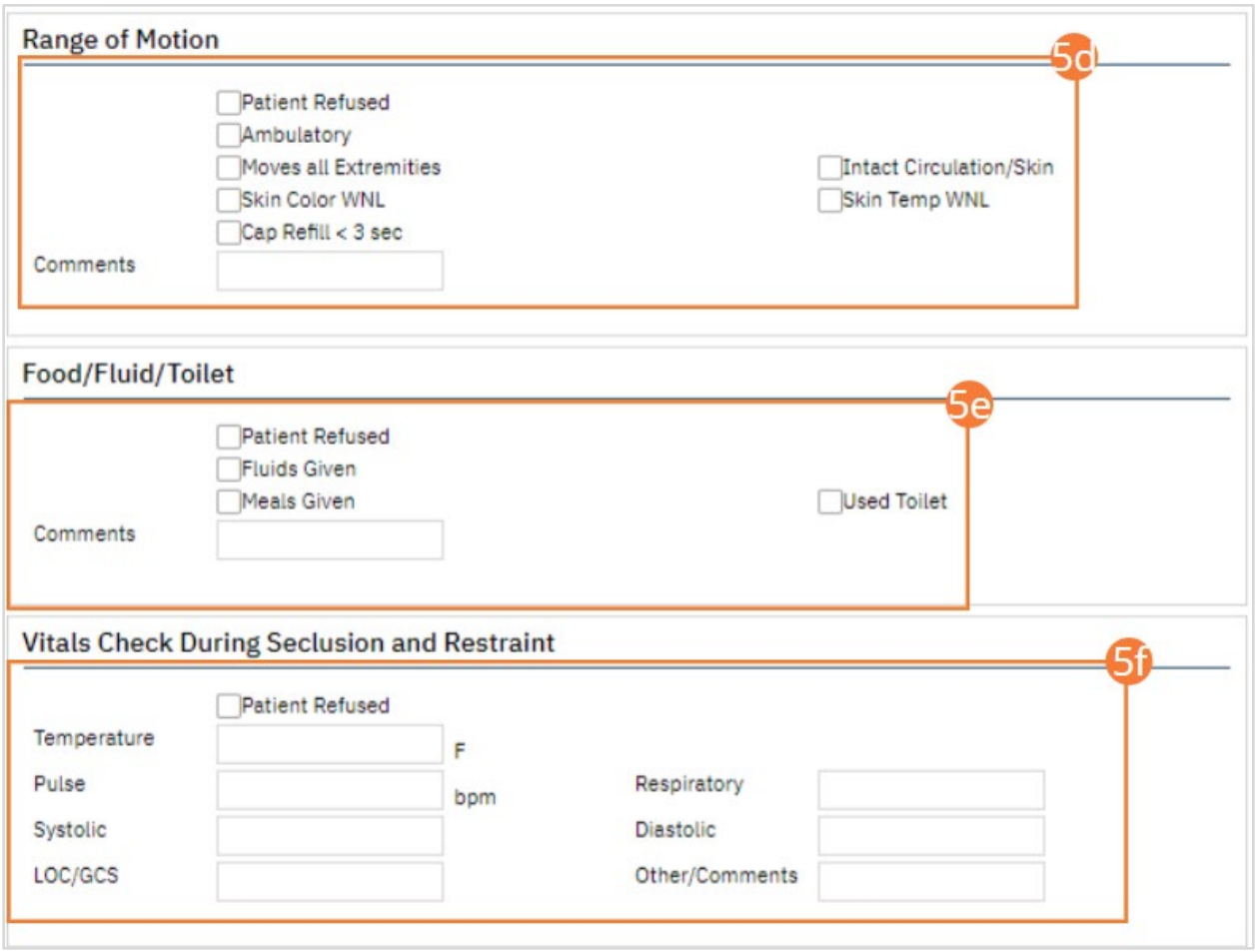


11. Complete the Safety Check sections, as needed.
    a. Confirm date and time are accurate and correct if necessary.

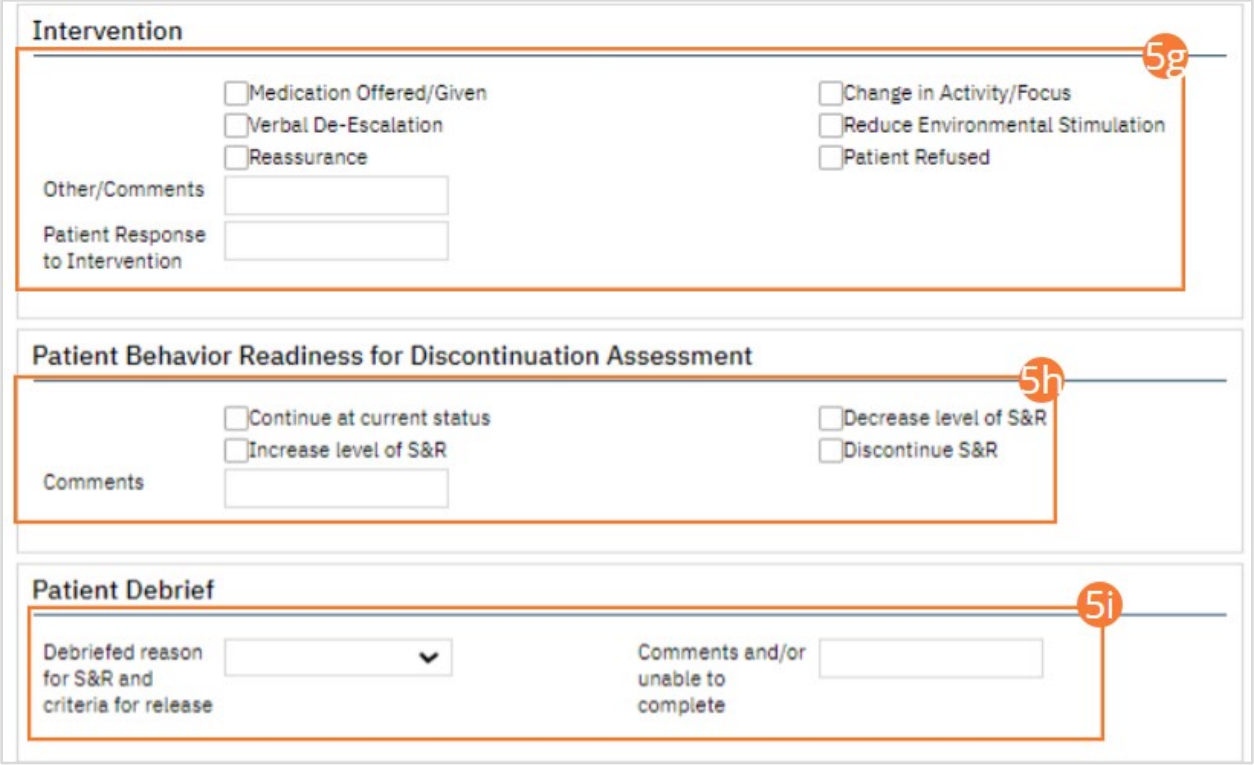
b. Select a status for the safety check. Add a comment if applicable.
c. Click the checkboxes next to the seclusion/restraint options used. Select Location and Points from the dropdowns. Type physical or medical conditions into the field.



d. If Range of Motion was monitored, click the checkbox next to Range of Motion options assessed and enter comments in the text field as needed.
e. If Food/Fluid/Toilet was monitored, click the checkbox next to Food/Fluid/Toilet options performed and enter comments in the text field as needed.
f. If Vitals was monitored, enter assessment results in the text field beside each factor assessed, or click the Patient Refused checkbox if the patient refused Vitals.



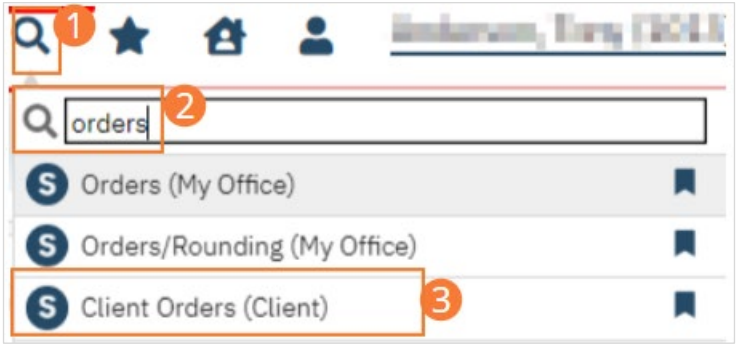
g. Click the checkbox next to Intervention options performed and enter comments in the text fields as needed.
h. Click the checkbox next to Discontinuation options taken and enter comments in the text fields as needed.
i. Select a debrief option from the dropdown and/or enter text in the comment field as required.
    i. This would only be completed at the end of S&R.



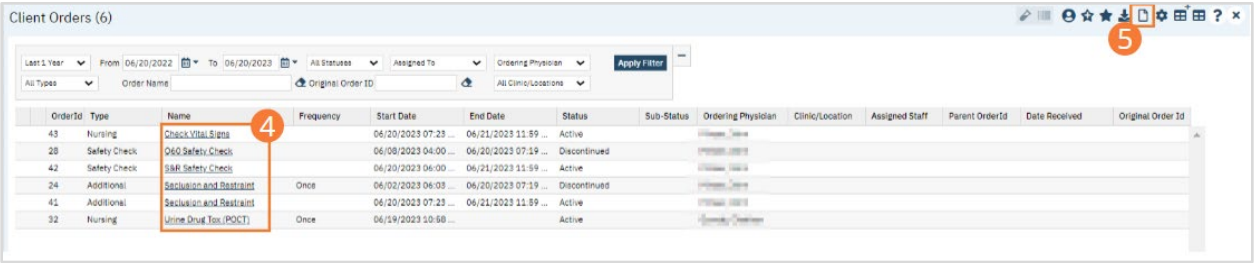
12. **Click Save and Close** to return to the Whiteboard.

How to Document Discontinuation of a Seclusion and/or Restraint Order

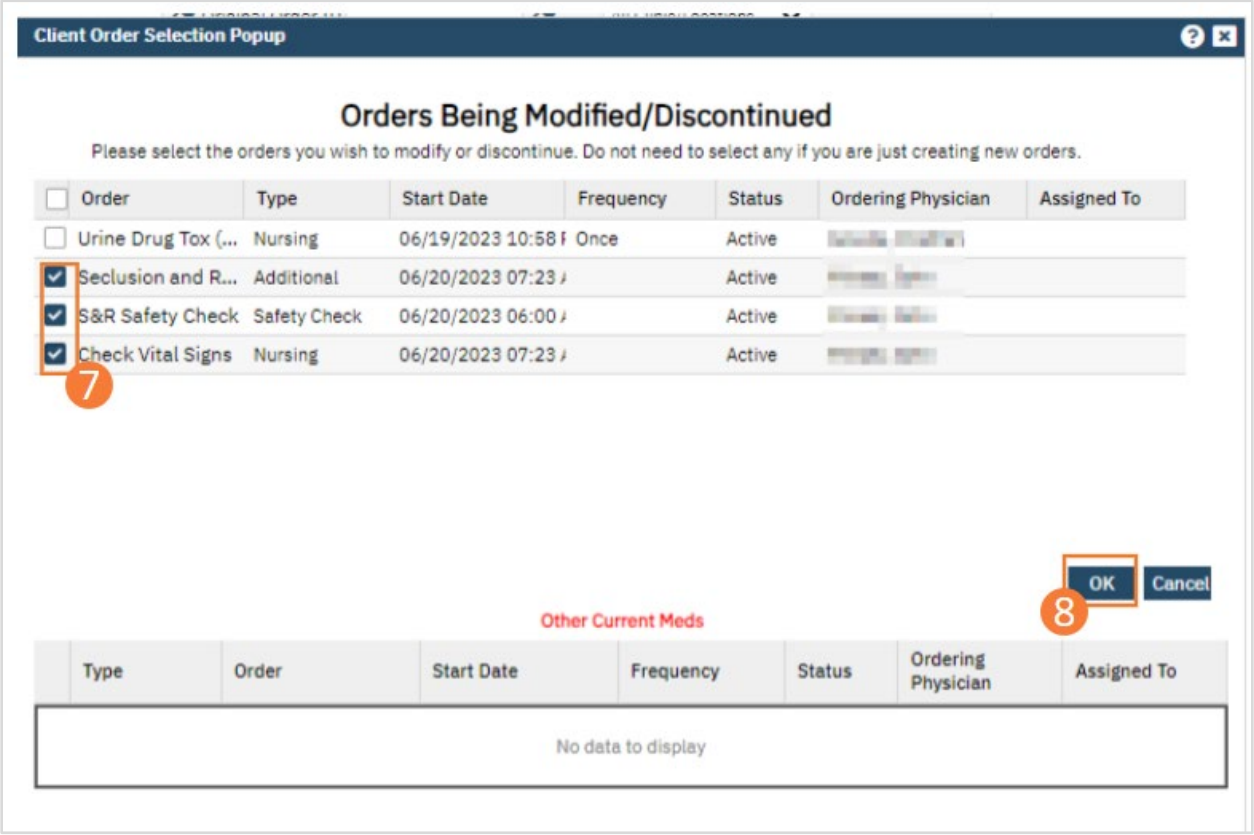
17. With an active client selected, **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
18. **Type "Orders"** into the search bar.
19. **Click to select Client Orders (Client).**



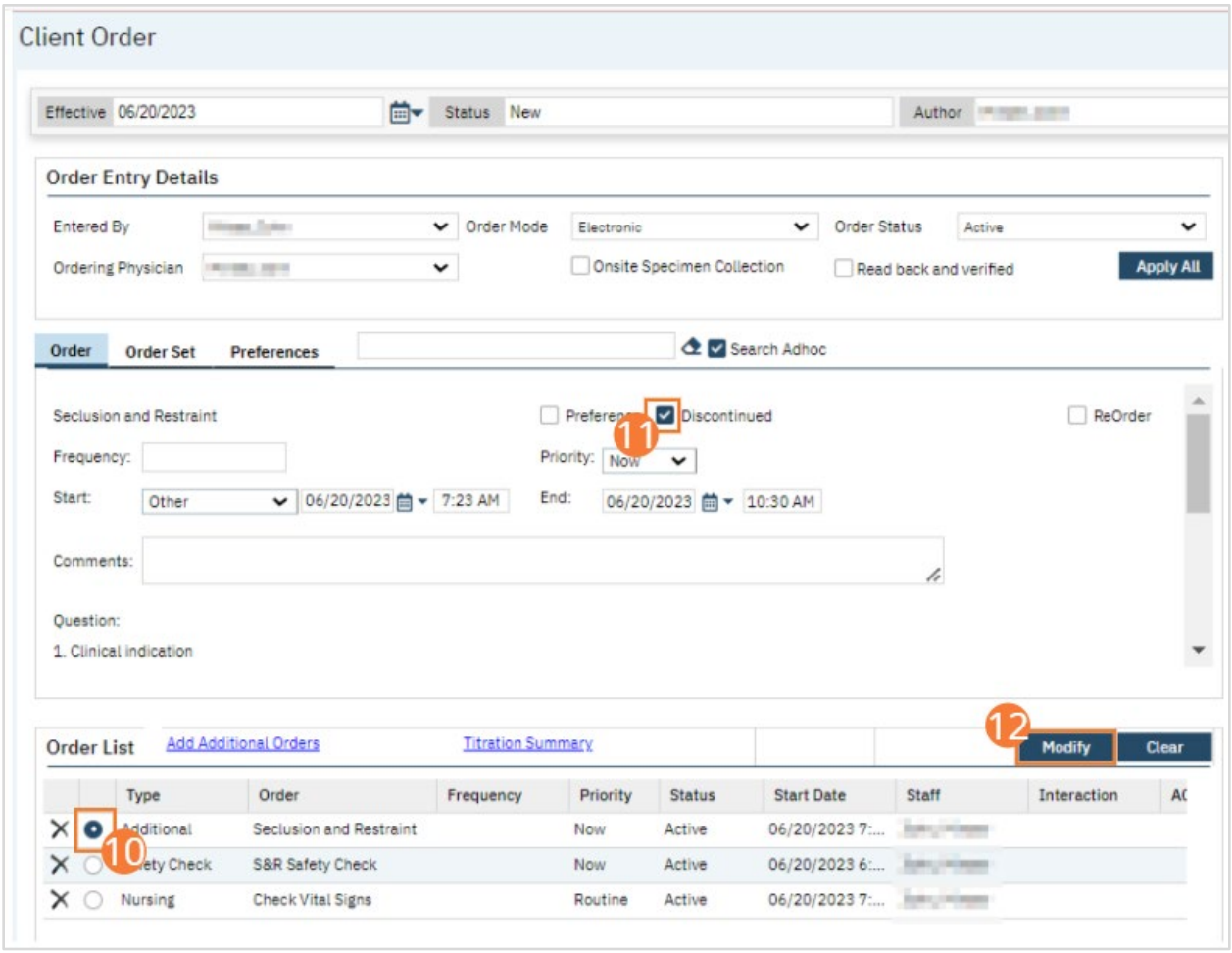
20. The Client Orders list page opens. Confirm that the Orders associated with the Seclusion and Restraint Order Set you wish to discontinue appear.
21. **Click on the New icon.** The Orders Being Modified/Discontinued window opens.



22. Locate the orders you want to discontinue in the top half of the window.
23. **Select the checkboxes** of the orders you want to discontinue. In a typical workflow, you should discontinue all orders associated with the initial S&R Order Set, including conditional orders. Medication orders may or may not be included when discontinuing an S&R Order Set.
24. **Click the OK button**. The Client Order screen opens.



25. Find the Seclusion and Restraint order in the Order List section of the page.
26. **Click the radio button** on the line of the order. The order information appears in the middle portion of the page.
27. **Select the Discontinued check box**.
28. **Click the Modify button** to save your changes.



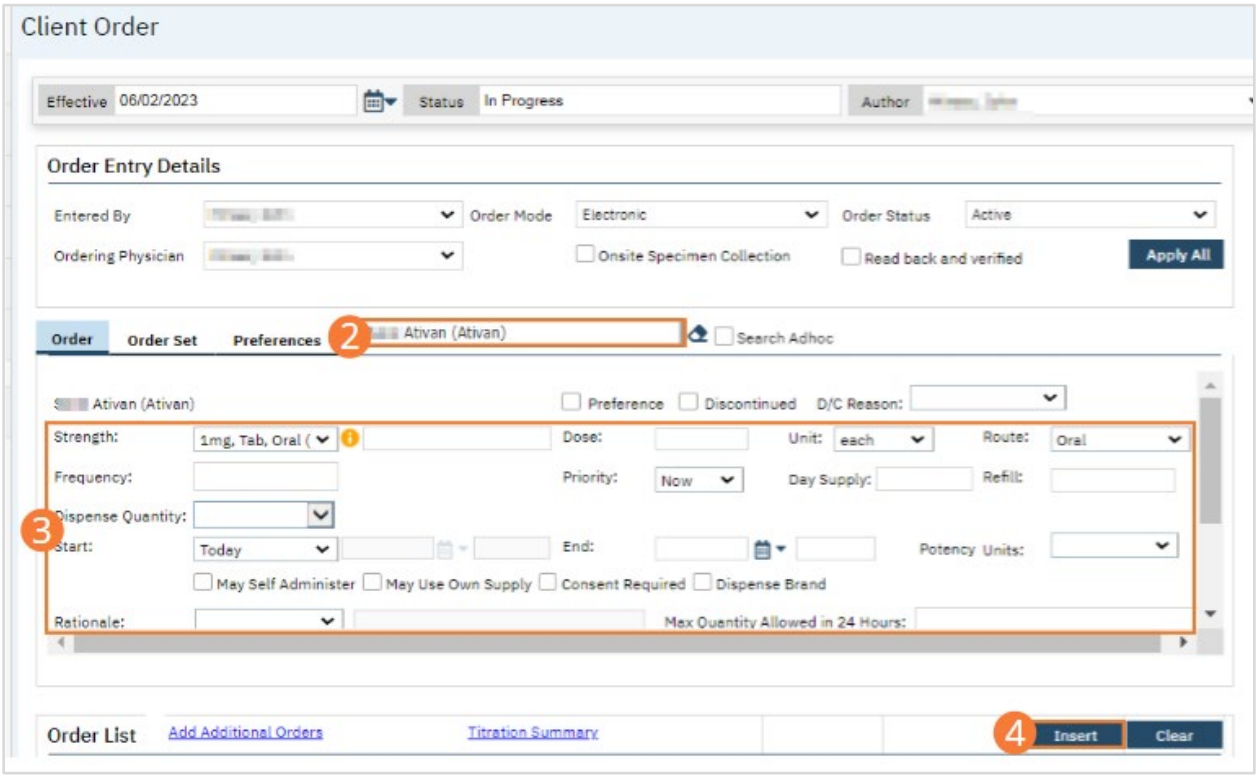
29. **Repeat Steps 10 - 12 for the Safety Check order and any continental orders being discontinued.**
30. **Click the Save button** in the tool bar.
31. **Click Sign** and complete signature of the document. For more information, see How to Sign a Document.

Nurse: How to Document a Verbal Order

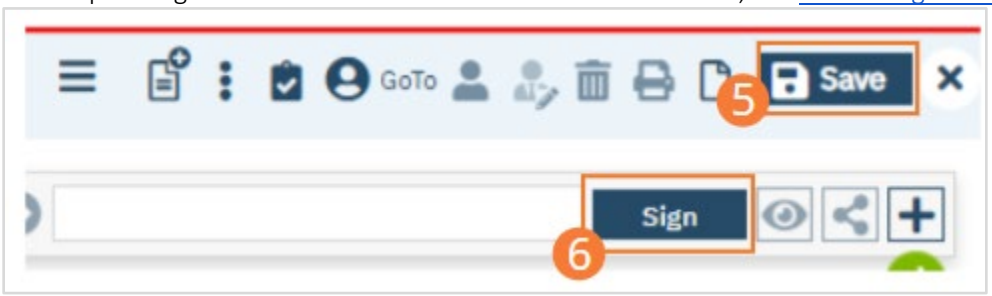
Medication Order

1. **Create a New Order,** using the steps under How to Create a New Order for a Client.
2. When selecting an Order, **select a desired medication as the Order type.**
3. **Complete required fields.**
    a. Select a Strength from the dropdown. Enter a Dose and if necessary edit the Unit and Route. Enter a Frequency into the search field and select it from the dropdown. Select a priority, day supply, and refill number, select a dispense number, and set start date and time. If applicable, set an end date and time. Select potency units from the dropdown. Click the checkboxes next to any order options you wish to include. Select a rationale and enter max quantity in a 24 hour period. Optionally, add instruction text or comments. If applicable, complete questions related to the specific medication order.

4. Click Insert to add the Order to the Order List.



5. Click Save.
6. Click Sign and complete signature of the document. For more information, see How to Sign a Document.



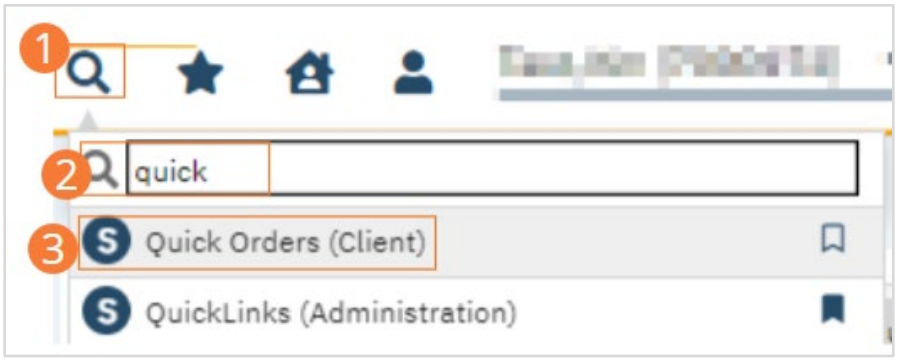
7. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

Lab Order

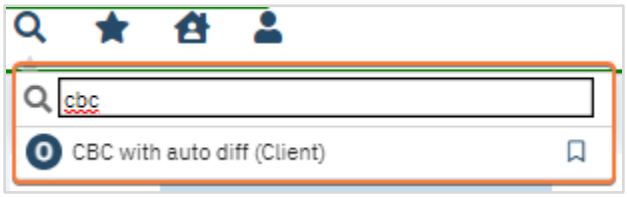
Optionally, lab orders can be completed through the Orders page. If you choose to order labs this way, reference the other order types for general guidelines.

More often, lab orders are completed through Quick Orders. Directions for completing labs through Quick Orders follow.

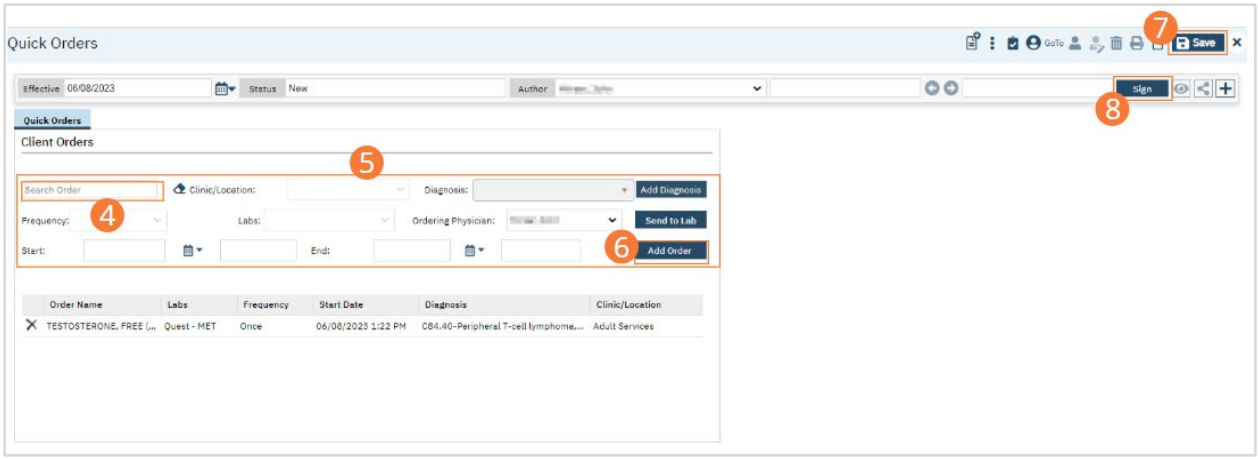
8. With an active client selected, click the Search icon.
9. Type "Quick" into the search bar.
10. Click to select Quick Orders (Client). The Quick Orders page will open.



a. Additionally, you can enter the name of the order itself. It will open the Quick Order and populate the order name.
    i. Quick Orders will display with an 'O' preceding the order name.



11. Type the name of the test you wish to order in the Search field and select it from the dropdown.
12. Complete the specifics of the lab order.
    a. Select a Clinic/Location from the dropdown. Select one or more diagnoses from the Diagnosis dropdown. If the intended diagnosis is not found, click the Add Diagnosis button to open a diagnosis search. Select a Frequency. Select the Lab you wish to send the order to. Select a start time and date, and if necessary, an end time and date. If the Service Note for this client already exists, you can send the order immediately to the lab using the Send to Lab button. Otherwise, move on to the next step.
13. Click Add Order to add the order to the Order List. Optionally, search for another order and repeat these steps to add multiple orders.
14. Click Save.
15. Click Sign and complete signature of the document. For more information, see How to Sign a Document.

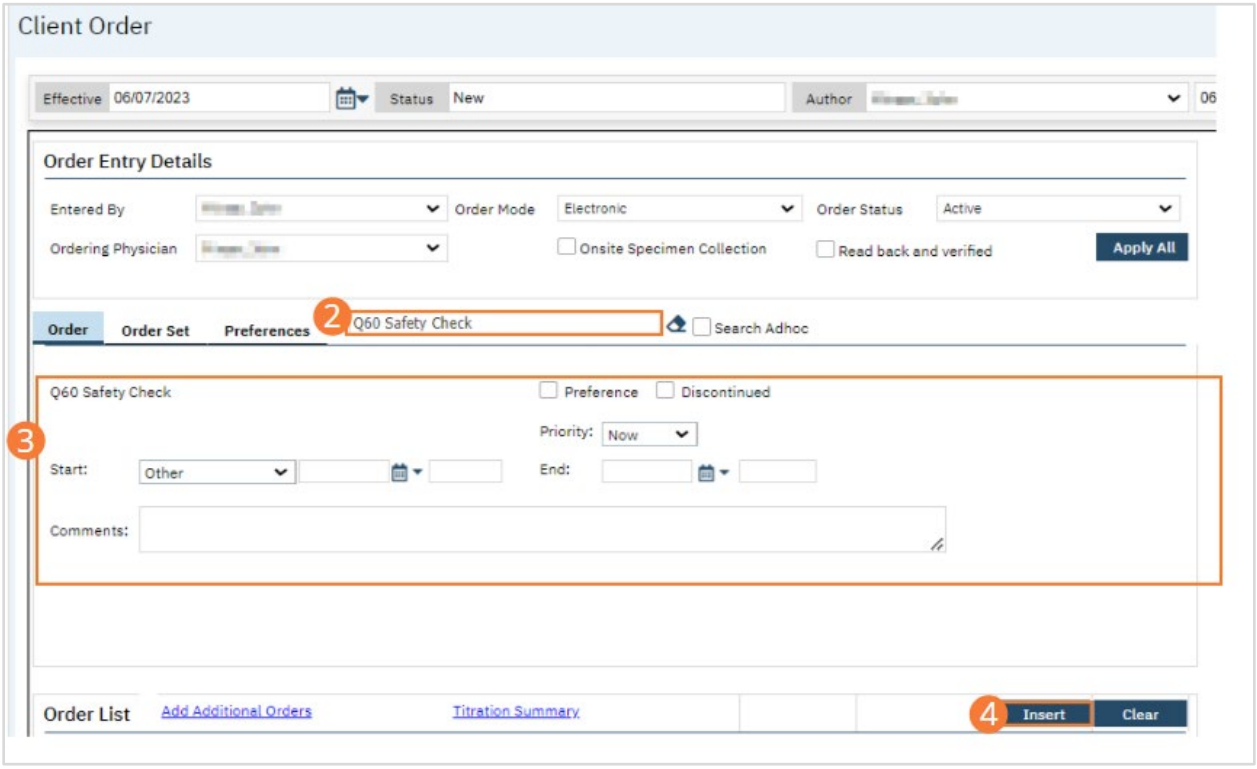


16. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

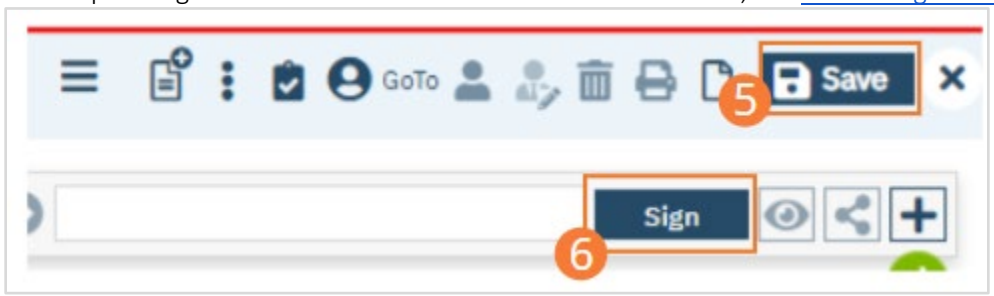
Safety Check Order

Signed Safety Check orders will populate on the Whiteboard and MAR, allowing assigned staff to easily see when check times are approaching.

1. **Create a New Order,** using the steps under How to Create a New Order for a Client.
2. When selecting an Order, **select a recurring Safety Check or S&R Safety Check as the Order type.**
3. **Complete required fields.**
    a) Select a priority and set start date and time. If applicable, set an end date and time. Optionally, add comments.
4. **Click Insert to add the Order to the Order List.**



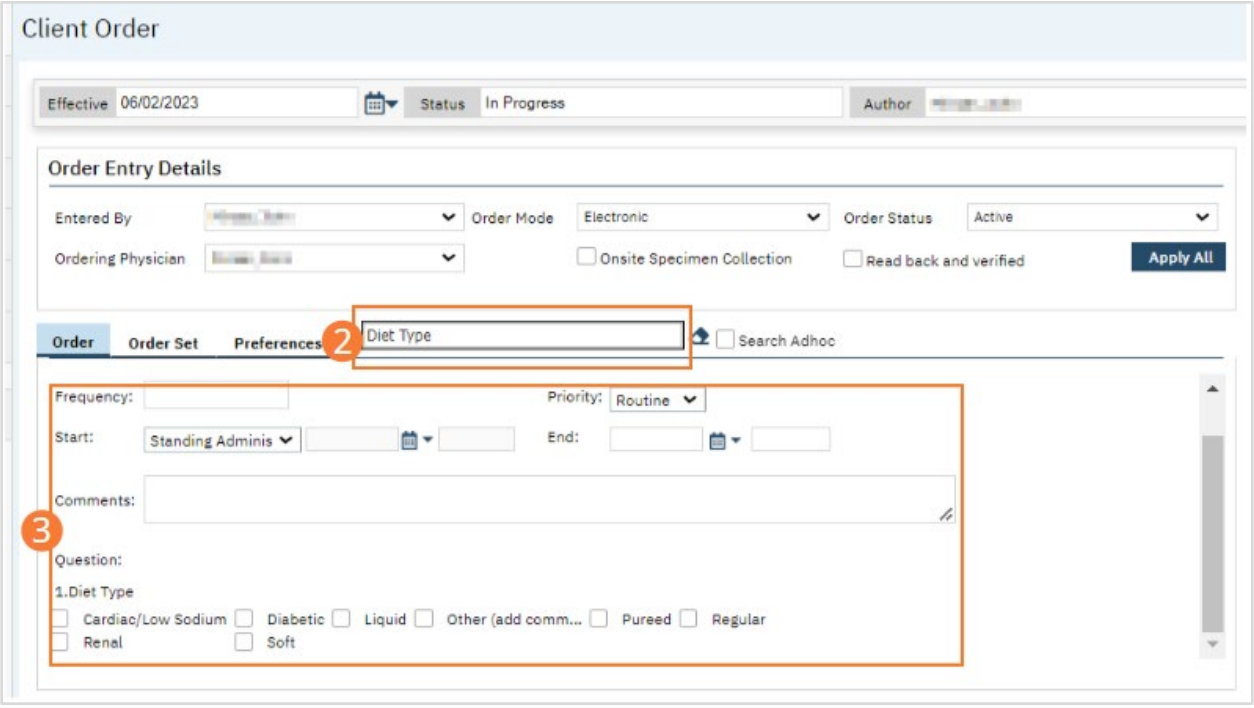
5. **Click Save.**
6. **Click Sign** and complete signature of the document. For more information, see How to Sign a Document.



7. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

Dietary Order

1. **Create a New Order,** using the steps under How to Create a New Order for a Client.
2. When selecting an Order, **select a desired dietary order as the Order type.**
3. **Complete required fields.**
    a. Type a Frequency into the search field and select it from the dropdown.
        i. If you are unsure of available frequencies, put your cursor in the Frequency field and press backspace on your keyboard to see all available options.
    b. Select a priority and set start date and time. If applicable, set an end date and time. Optionally, add comments. Complete questions related to the dietary order.



4. Click Insert to add the Order to the Order List.

5. Click Save.
6. Click Sign and complete signature of the document. For more information, see How to Sign a Document.

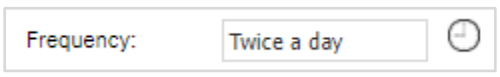
7. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

Other Order Fields

Depending on setup options, different Orders will include different fields. It is always best practice to include as much specific information as is possible during the creation of Orders. Ensure that fields are completed to the best of your ability during the Order creation process.

For many search fields in Orders, you can view all currently-available options by clicking in the search field, then pressing the Backspace key.

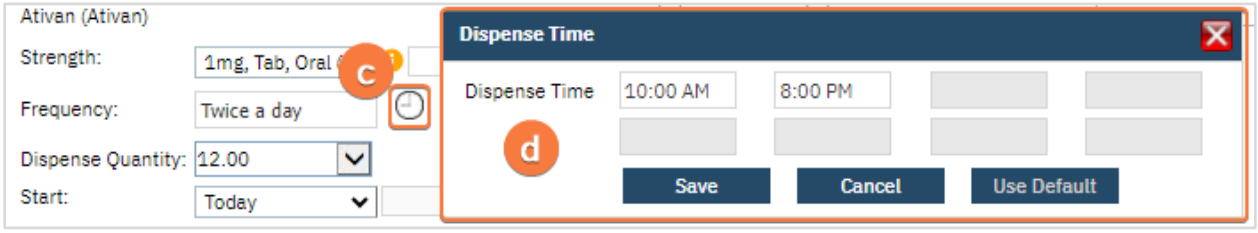
1. Frequency: Frequencies represent directions to the person carrying out the order. For example, Once versus twice a day.
    a. Frequencies tie to the MAR, if the order is indicated to show on the MAR. Non-PRN or frequencies more than once will tie to times to administer on the MAR.



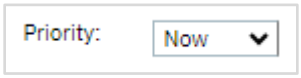
    b. Frequencies will indicate dispense based on set up not the frequency name.

i. For example, a frequency of Q4H will not consider the start time, step 4. It will always consider time associated with the frequency. If the frequency of Q4H is set up as 1:00 am, 5:00 am, 9:00 am, 1:00 pm, 5:00 pm, 9:00 pm and order start time is 3:00 pm, the MAR will not indicate to administer until 5:00 pm. The exception to this is Now and Scheduled, see 3.b.
ii. If you would like administration to begin at time or order and continue every four hours you would need to use the clock icon. See 1.c -1.d for details.

c. To view the associated times **click on the clock icon**. This will open the Dispense Time pop-up window.
d. If needed, times can be updated. Click Save if they are updated.
i. Keep in mind, changes may not correspond with med dispense rounds.



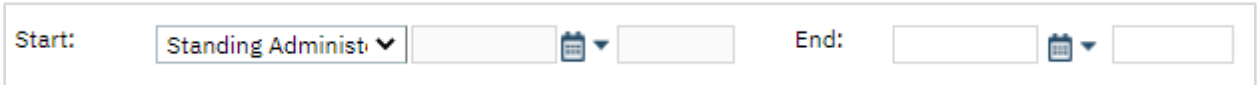
2. Priority: Priorities identify the rank of the order in proportion to other orders for end users. This does not affect logic within the SmartCare system.



3. Start: Based on schedule dropdown options the Start and End fields will change or have carry over logic.
a. Today: Start date and time are inactive for the user.
i. Start date and time will default to date and time the order is created after it is signed.

b. Now and Scheduled: Start date and time are inactive for the user.
i. This option is used for orders that will appear on the MAR (Medication Administration Record).
ii. When selected it will queue an administration at the current time before reverting to set up of the frequency.
1. See Frequency section for details.
iii. For example, TID medication is scheduled for administration at 8:00 am, 1:00 pm, and 8:00 pm. If the order is entered at 9:00 pm and Now + Scheduled is selected, the MAR will show administration for 9:00 pm and will then revert to regular TID frequency.

c. Standing Administered Once: Start date and time are inactive for the user.
i. Start date and time will default to date and time the order is created after it is signed.
ii. This is used for orders that need to have action taken once and apply through the admission.
1. For example, providing a walker. The walker is provided to the client and remains with the client until discharge.



d. Other: Start and End date and time are active and can be entered by the user.

e. When equipment is received: Start and End date and time are active and can be entered by the user.
    i. This should be used if order is dependent on equipment. There is no logic associated with this but used to identify this dependency.

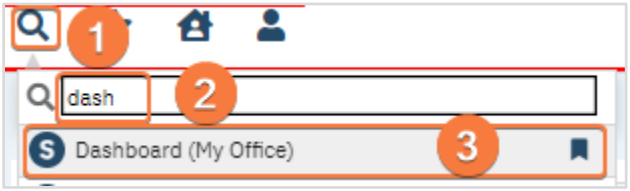
f. Users should enter a start date and time, when system allows, and an end date if applicable.
    i. Note: If the end date is added, after the end date the order will no longer indicate to administer. However, the order is still active. To inactivate the order it has to be discontinued. See Nurse: How to Discontinue an Order and Prescriber: How to Discontinue an Order.

Prescriber: How to Sign and Acknowledge Verbal Order

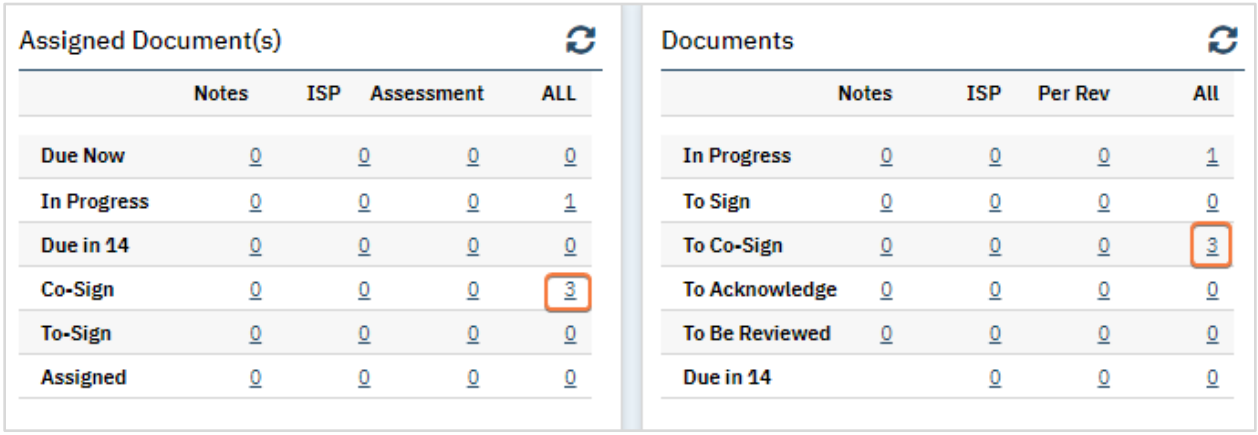
How to Sign Verbal Orders

All verbal orders entered by a nurse will include adding the prescriber as a co-signer. All documents to co-sign, orders or not, will display in the Dashboard.

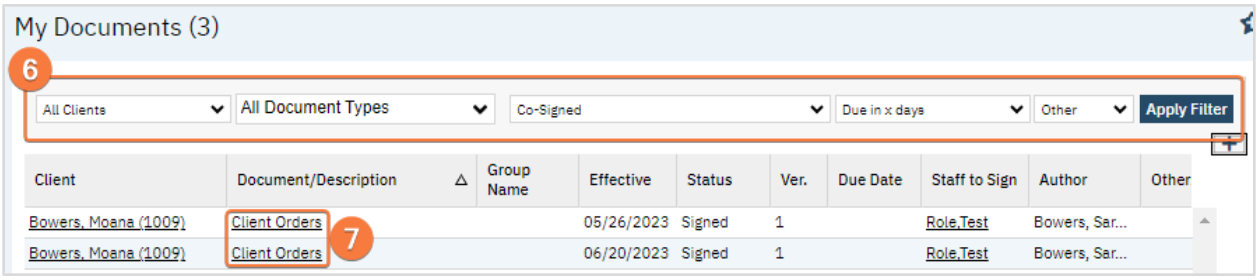
1. Click the Search icon.
2. Search for 'Dashboard'.
3. Select Dashboard (My Office).



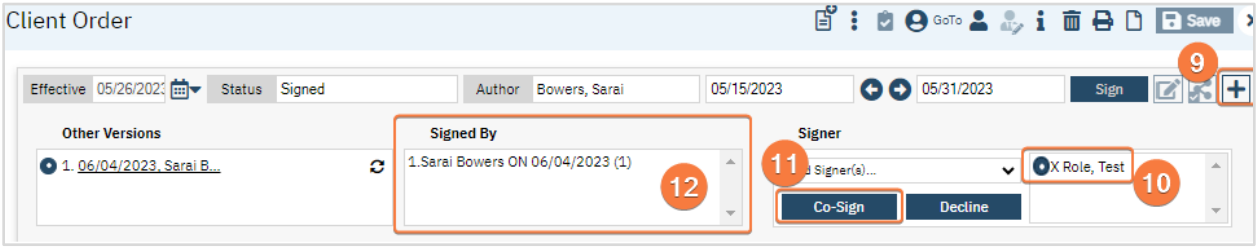
4. Once on the Dashboard locate the Documents or Assigned Documents widget.
    a. Based on your permissions and set up you may see one widget or another.
5. In the Co-Sign or To Co-Sign row, select the hyperlink number under ALL column. The My Documents screen will open.



6. Utilize filters or column headers to locate orders. Note: filter is already filtered by Co-Signed.
    a. See Utilizing List Pages section for more details.
7. Select the Client Orders Document hyperlink.



8. The Order document will open. Review the order as needed.
9. **Click the plus icon** to expand the header section.
10. **Select the radio button next to your name**, in the Signer section.
11. **Click the Co-Sign button**, in the Signer section.
12. Your name will appear in the Signed By section and will be added to the PDF in the signature page.

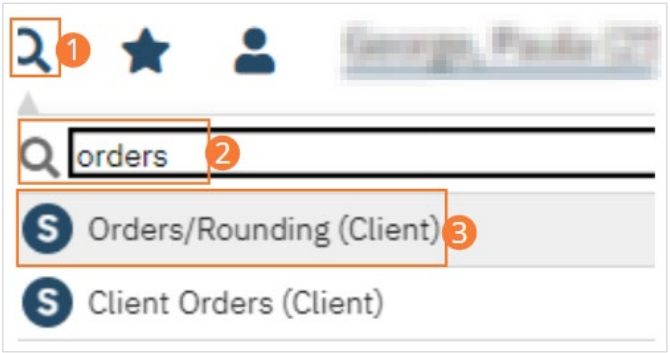


13. As a reminder, Batch signing can be used to sign Orders as well. See Prescriber: How to Batch Sign Documents section for details.

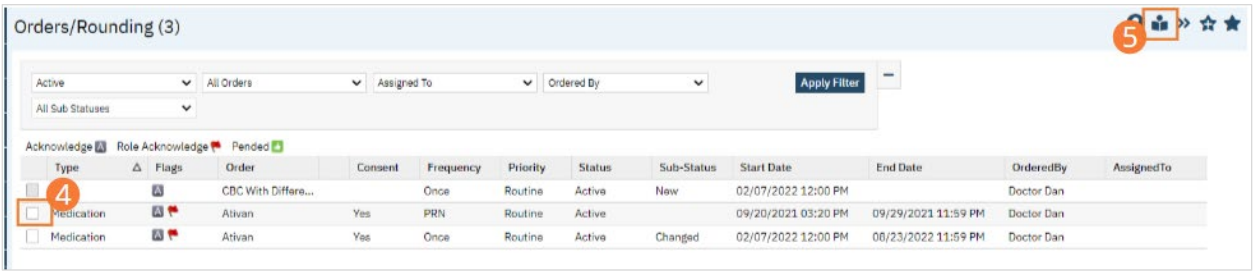
How to Acknowledge/Authorize Orders

System administrators can configure certain orders to need acknowledgment. Users with the proper roles can acknowledge these orders, which will not be actionable until acknowledged.

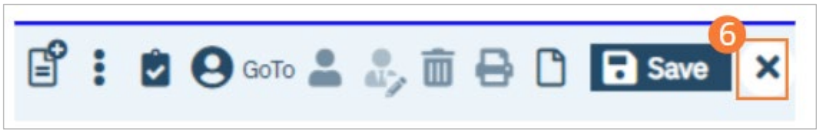
1. You must first have the client open, then **click the Search icon**.
2. **Type "Orders"** into the search bar.
3. **Click to select Orders/Rounding (Client).**



4. **Select the check box** in the left column in the list portion of the page to identify the clients whose pended orders you want to release.
5. **Select the Acknowledge Order icon**.



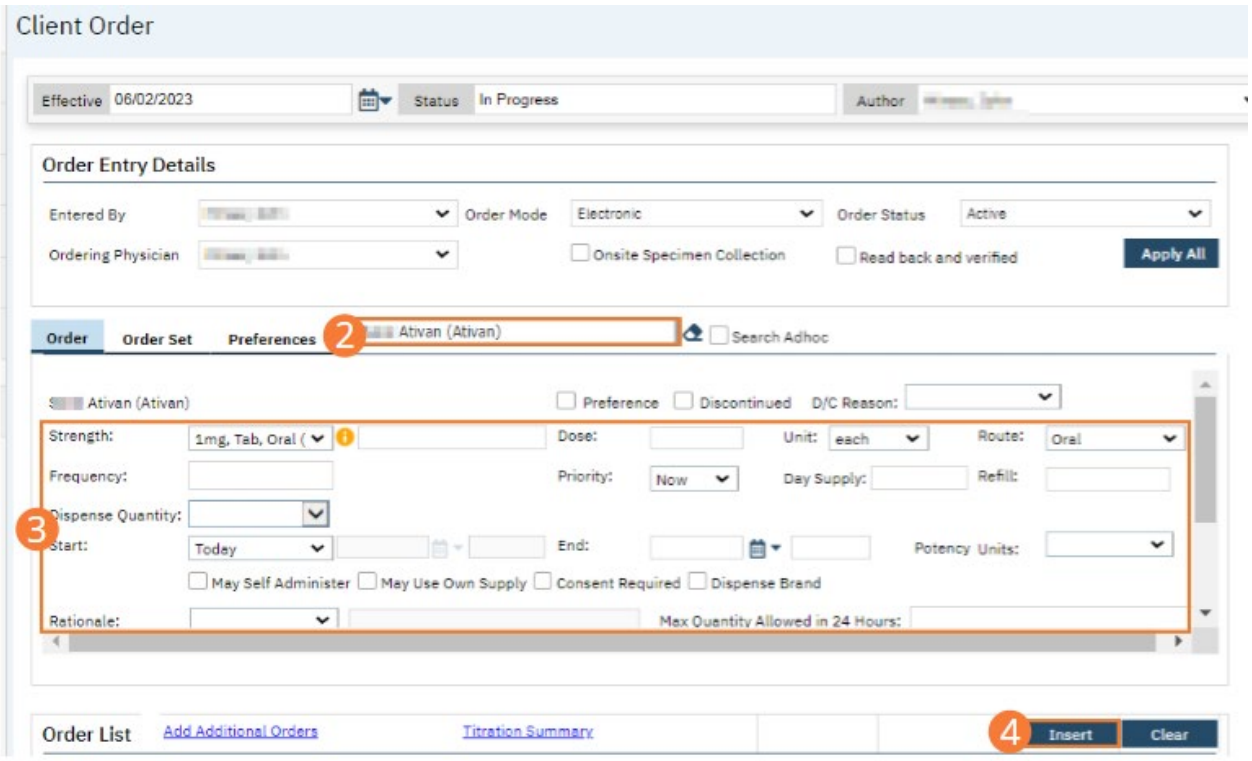
6. Click the Close icon in the tool bar.



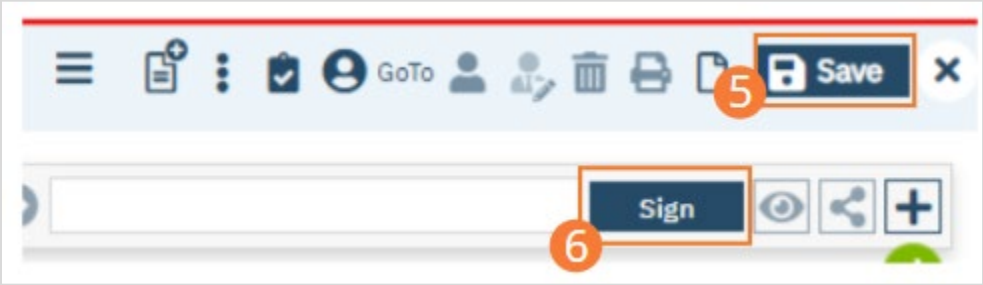
Prescriber: How to Add an Order

Medication

1. Create a New Order, using the steps under How to Create a New Order for a Client.
2. When selecting an Order, select a desired medication as the Order type.
3. Complete required fields.
   a) Select a Strength from the dropdown. Enter a Dose and if necessary edit the Unit and Route. Enter a Frequency into the search field and select it from the dropdown. Select a priority, day supply, and refill number, select a dispense number, and set start date and time. If applicable, set an end date and time. Select potency units from the dropdown. Click the checkboxes next to any order options you wish to include. Select a rationale and enter max quantity in a 24 hour period. Optionally, add instruction text or comments. If applicable, complete questions related to the specific medication order.
4. Click Insert to add the Order to the Order List.



5. Click Save.
6. Click Sign and complete signature of the document. For more information, see How to Sign a Document.

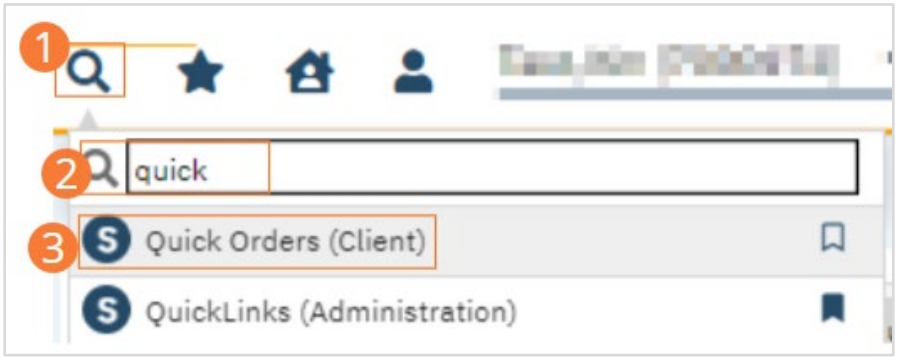


Lab

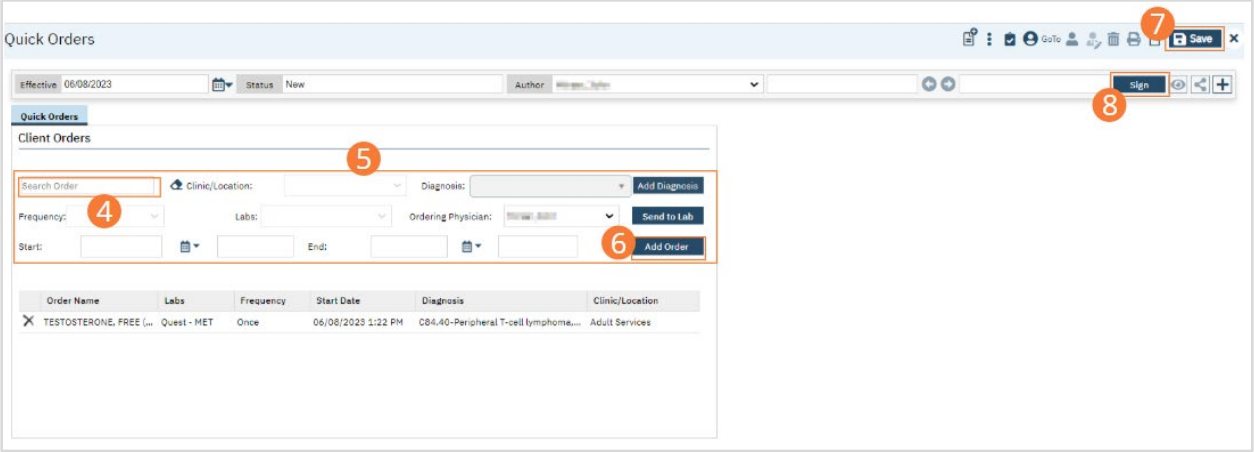
Optionally, lab orders can be completed through the Orders page. If you choose to order labs this way, reference the other order types for general guidelines.

More often, lab orders are completed through Quick Orders. Directions for completing labs through Quick Orders follow.

1. With an active client selected, **click the Search icon**.
2. **Type "Quick"** into the search bar.
3. **Click to select Quick Orders (Client).** The Quick Orders page will open.



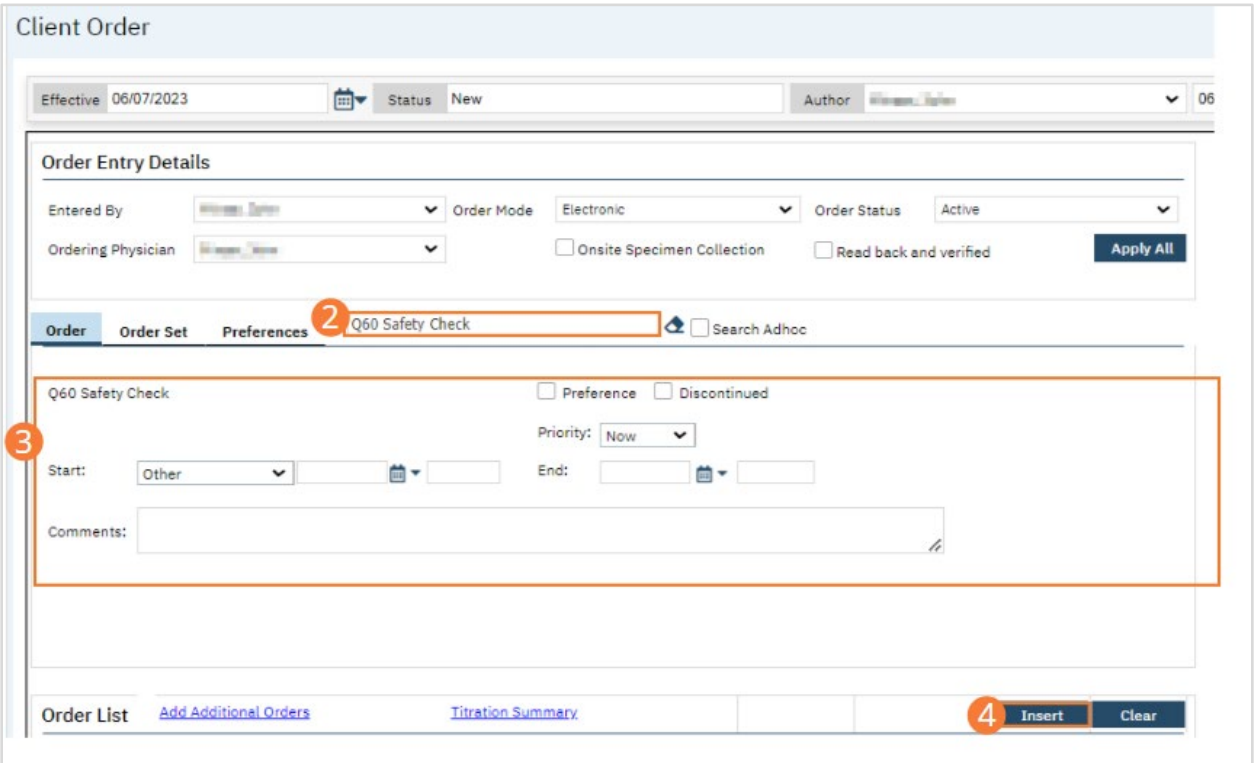
4. Type the name of the test you wish to order in the Search field and select it from the dropdown.
5. Complete the specifics of the lab order.
    a. Select a Clinic/Location from the dropdown. Select one or more diagnoses from the Diagnosis dropdown. If the intended diagnosis is not found, click the Add Diagnosis button to open a diagnosis search. Select a Frequency. Select the Lab you wish to send the order to. Select a start time and date, and if necessary, an end time and date. If the Service Note for this client already exists, you can send the order immediately to the lab using the Send to Lab button. Otherwise, move on to the next step.
6. Click Add Order to add the order to the Order List. Optionally, search for another order and repeat these steps to add multiple orders.
7. Click Save.
8. Click **Click Sign** and complete signature of the document. For more information, see How to Sign a Document.



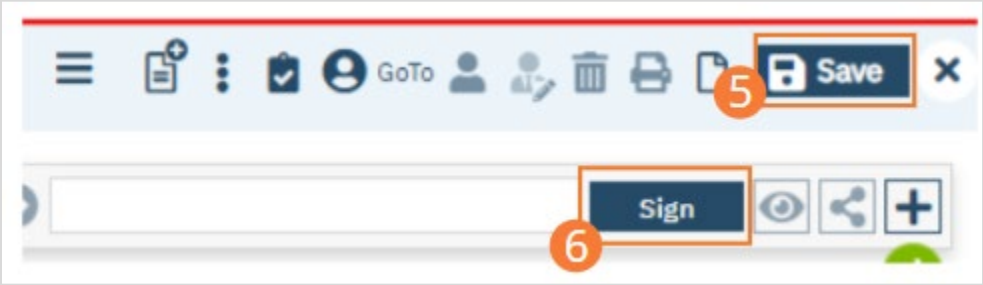
Safety Check

Signed Safety Check orders will populate on the Whiteboard and MAR, allowing assigned staff to easily see when check times are approaching.

1. **Create a New Order,** using the steps under How to Create a New Order for a Client.
2. When selecting an Order, **select a recurring Safety Check or S&R Safety Check as the Order type.**
3. **Complete required fields.**
    a) Select a priority and set start date and time. If applicable, set an end date and time. Optionally, add comments.
4. **Click Insert to add the Order to the Order List.**

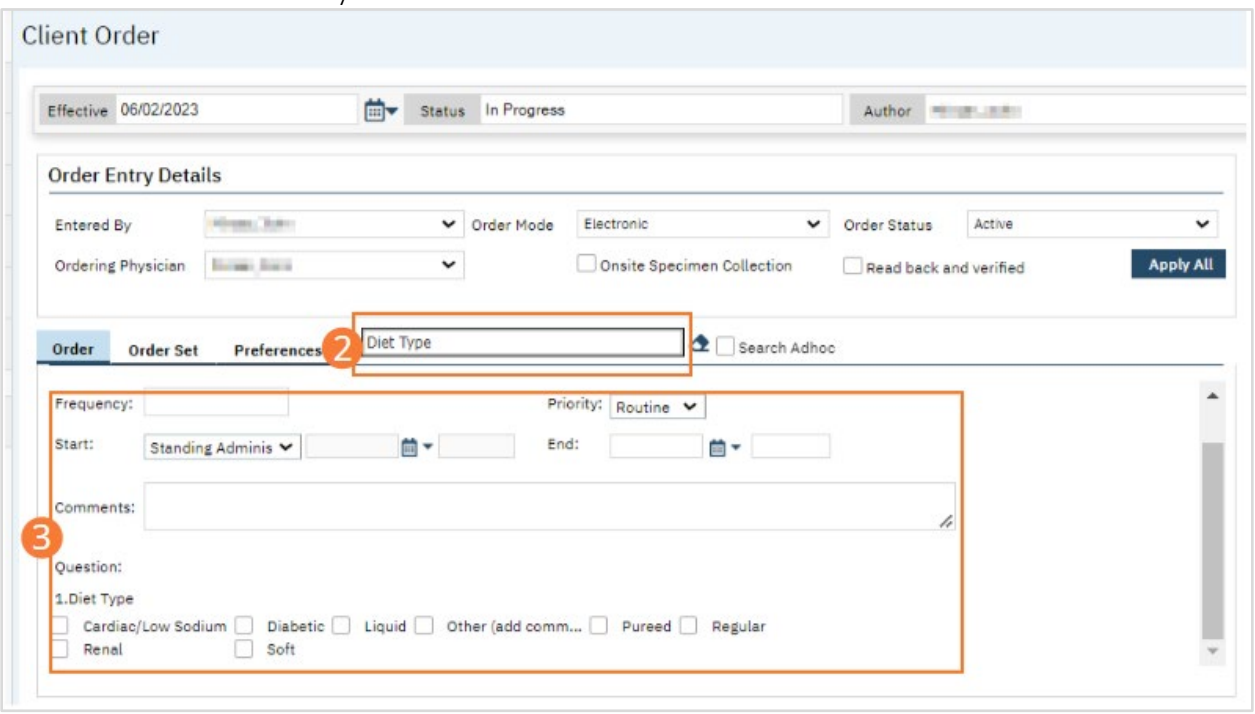


5. **Click Save.**
6. **Click Sign** and complete signature of the document. For more information, see How to Sign a Document.



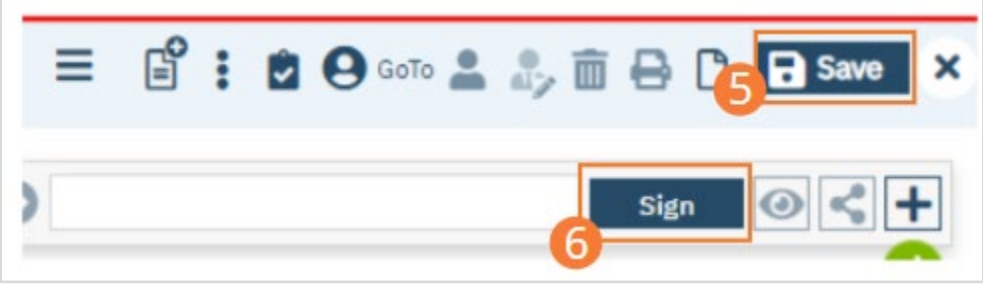
Dietary

1. Create a New Order, using the steps under How to Create a New Order for a Client.
2. When selecting an Order, select a desired dietary order as the Order type.
3. Complete required fields.
    a) Type a Frequency into the search field and select it from the dropdown. Select a priority and set start date and time. If applicable, set an end date and time. Optionally, add comments. Complete questions related to the dietary order.



4. Click Insert to add the Order to the Order List.

5. Click Save.
6. Click Sign and complete signature of the document. For more information, see How to Sign a Document.



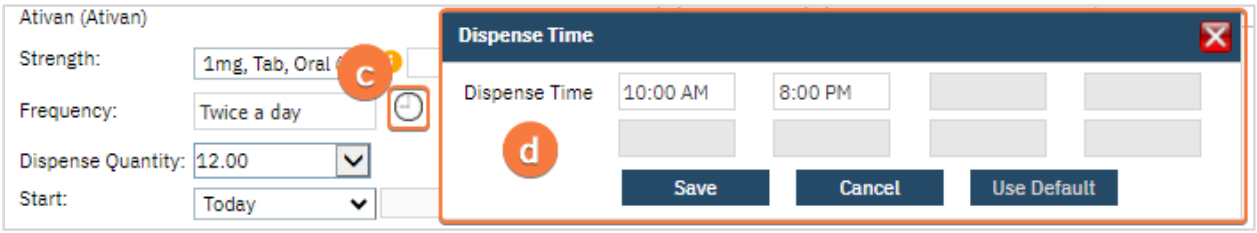
Other Order Fields

Depending on setup options, different Orders will include different fields. It is always best practice to include as much specific information as is possible during the creation of Orders. Ensure that fields are completed to the best of your ability during the Order creation process.

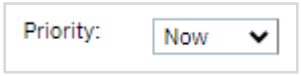
For many search fields in Orders, you can view all currently-available options by clicking in the search field, then pressing the Backspace key.

4. Frequency: Frequencies represent directions to the person carrying out the order. For example, Once versus twice a day.
    a. Frequencies tie to the MAR, if the order is indicated to show on the MAR. Non-PRN or frequencies more than once will tie to times to administer on the MAR.

    b. Frequencies will indicate dispense based on set up not the frequency name.
        i. For example, a frequency of Q4H will not consider the start time, step 4. It will always consider time associated with the frequency. If the frequency of Q4H is set up as 1:00 am, 5:00 am, 9:00 am, 1:00 pm, 5:00 pm, 9:00 pm and order start time is 3:00 pm, the MAR will not indicate to administer until 5:00 pm. The exception to this is Now and Scheduled, see 3.b.
        ii. If you would like administration to begin at time or order and continue every four hours you would need to use the clock icon. See 1.c -1.d for details.
    c. To view the associated times **click on the clock icon**. This will open the Dispense Time pop-up window.
    d. If needed, times can be updated. Click Save if they are updated.
        i. Keep in mind, changes may not correspond with med dispense rounds.



5. Priority: Priorities identify the rank of the order in proportion to other orders for end users. This does not affect logic within the SmartCare system.



6. Start: Based on schedule dropdown options the Start and End fields will change or have carry over logic.
    g. Today: Start date and time are inactive for the user.
        i. Start date and time will default to date and time the order is created after it is signed.

    h. Now and Scheduled: Start date and time are inactive for the user.
        i. This option is used for orders that will appear on the MAR (Medication Administration Record).
        ii. When selected it will queue an administration at the current time before reverting to set up of the frequency.
            1. See Frequency section for details.

iii. For example, TID medication is scheduled for administration at 8:00 am, 1:00 pm, and 8:00 pm. If the order is entered at 9:00 pm and Now + Scheduled is selected, the MAR will show administration for 9:00 pm and will then revert to regular TID frequency.

i. Standing Administered Once: Start date and time are inactive for the user.
   i. Start date and time will default to date and time the order is created after it is signed.
   ii. This is used for orders that need to have action taken once and apply through the admission.
      1. For example, providing a walker. The walker is provided to the client and remains with the client until discharge.

j. Other: Start and End date and time are active and can be entered by the user.

k. When equipment is received: Start and End date and time are active and can be entered by the user.
   i. This should be used if order is dependent on equipment. There is no logic associated with this but used to identify this dependency.

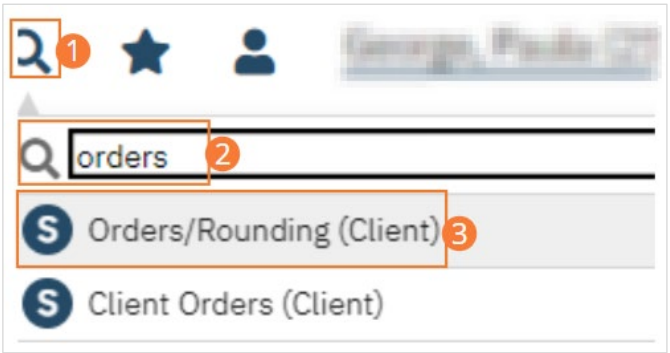
l. Users should enter a start date and time, when system allows, and an end date if applicable.
   i. Note: If the end date is added, after the end date the order will no longer indicate to administer. However, the order is still active. To inactivate the order it has to be discontinued. See Nurse: How to Discontinue an Order and Prescriber: How to Discontinue an Order.

Nurse: How to Document Follow-Up on an Order

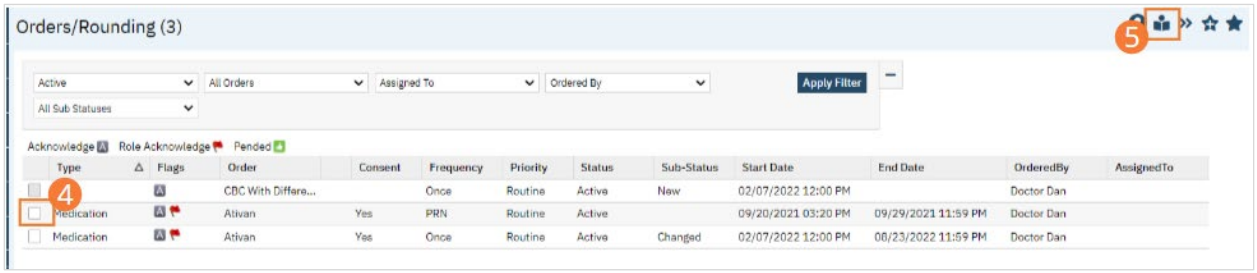
How to Acknowledge/Authorize Orders

System administrators can configure certain orders to need acknowledgment. Users with the proper roles can acknowledge these orders, which will not be actionable until acknowledged.

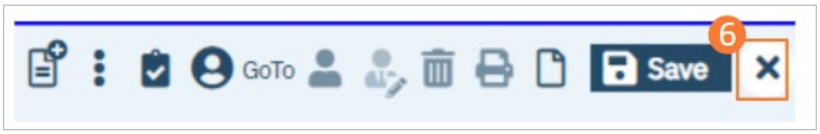
1. You must first have the client open, then **click the Search icon**.
2. **Type "Orders"** into the search bar.
3. **Click to select Orders/Rounding (Client).**



4. **Select the check box** in the left column in the list portion of the page to identify the clients whose orders you want to release.
5. **Select the Acknowledge Order icon**.



6. **Click the Close icon** in the tool bar.

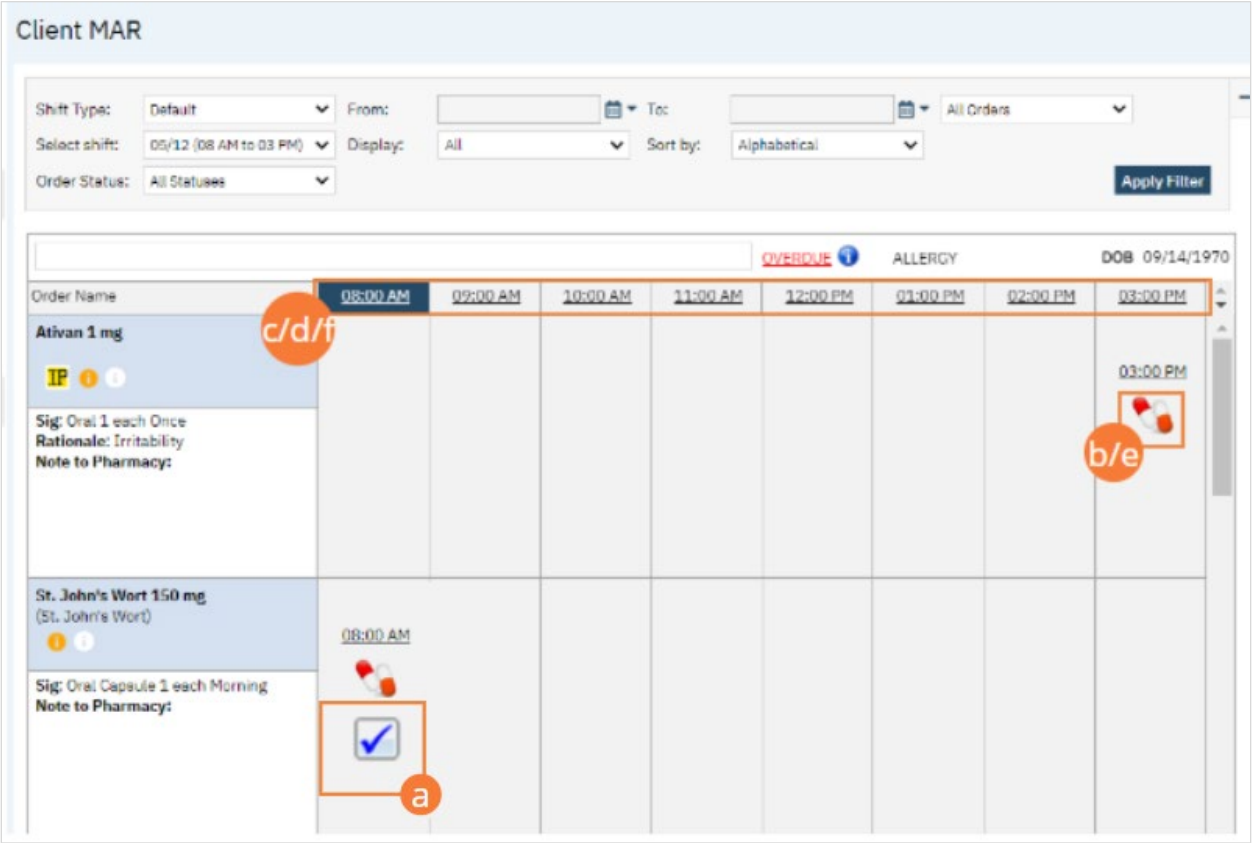


How to Administer Items on the MAR

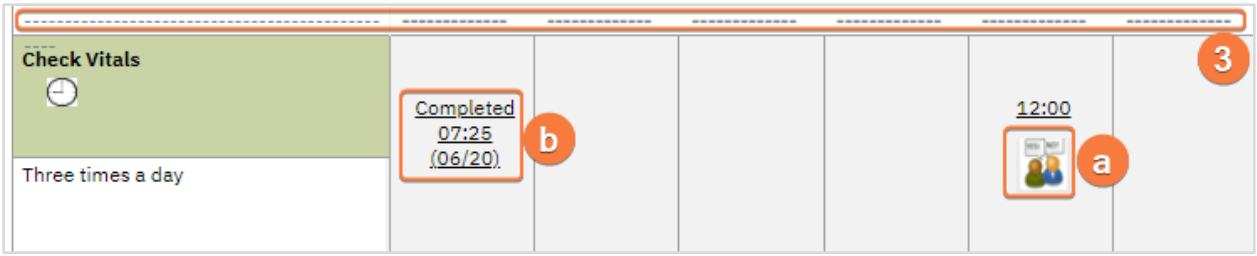
The MAR stands for Medication Administration Record, but it does not only include Medications. Other items, such as safety checks and follow-ups, are also administered on the MAR. Items are administered in similar ways, regardless of type

How To Document Administering Items

1. Begin on the Client MAR page with the client you wish to administer.
    a. See How to Display the Client MAR Page section for details.
2. **If you need administer the MAR to…**
    a. A status of “Self-Administration”:
        i. **Click the blue check mark**
    b. A status of "Given":
        i. **Click the red and white capsule icon**
    c. A status other than "Given":
        i. **Click the time in the header column**
    d. Multiple medications:
        i. **Click the time in the header column**
        ii. Note: Only medications within the administration window will be available to administer.
    e. Questions on the order for one medication:
        i. **Click the red and white capsule icon**
        ii. Questions set up to show on administration will always appear.
    f. Questions on the order for multiple medications:
        i. **Click the time in the header column**



3. The Client MAR includes non-medication items; these appear beneath the dotted line.
    a. To administer/complete the item **click the people icon**.
        i. The icon only appears when the order is non-PRN. For PRN order see How to Enter Status and Date…Includes PRN) section.
    b. When the icon is selected, it will automatically be marked as Completed.

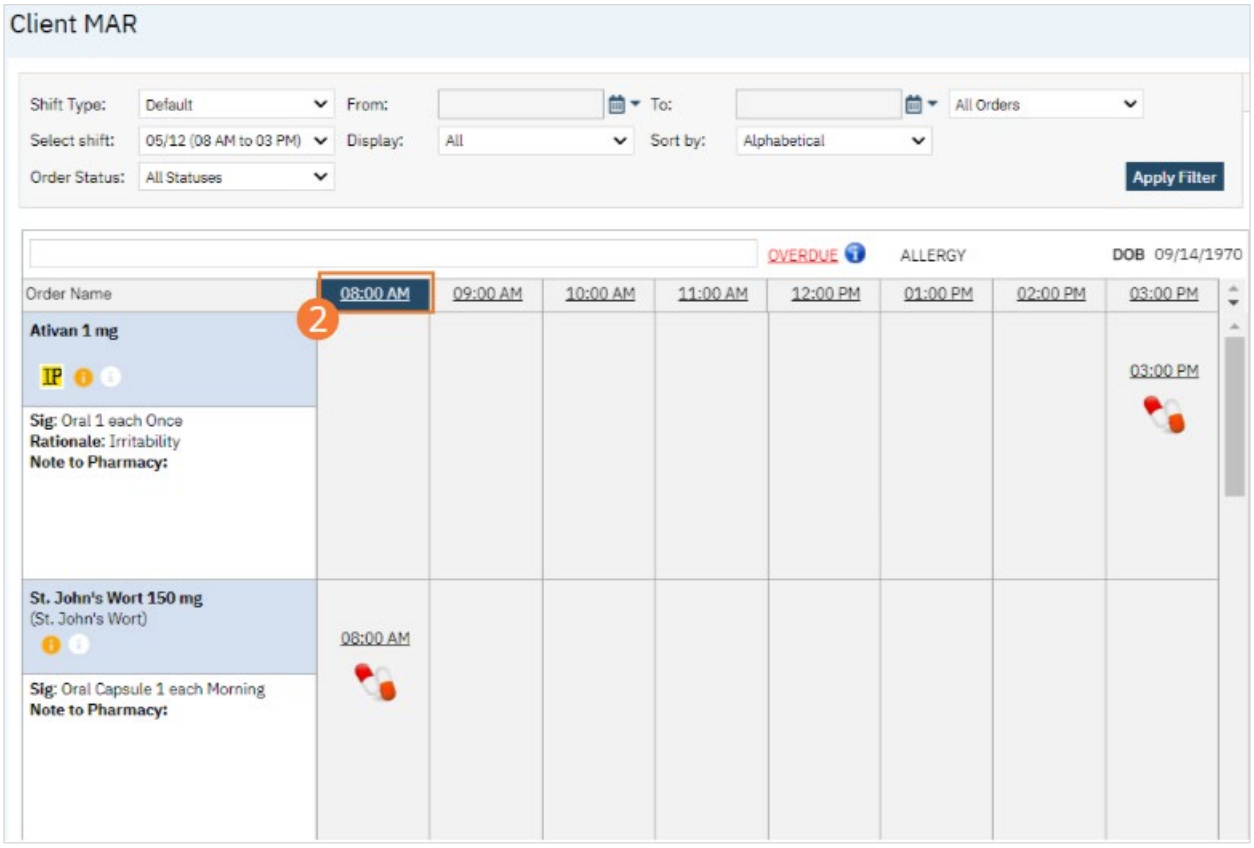


4. As a reminder, MAR has various icons under the order. For details on this, please see How to Understand the Client MAR Icons sections.

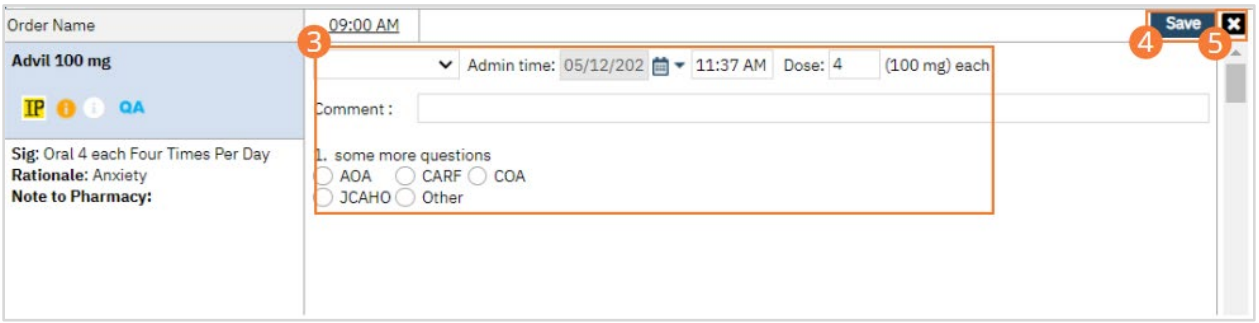
How to Enter Status and Date, Time and Dosage (Includes PRN)

Use these directions to add a status other than the default, if there are multiple items to be administered, or for any PRN items.

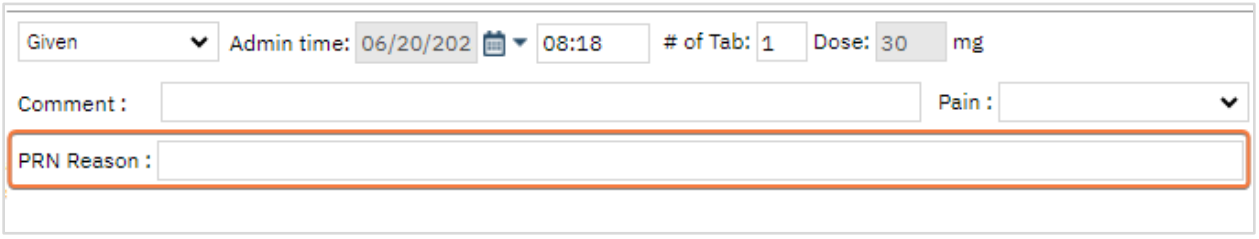
1. Begin on the Client MAR page with the client you wish to make changes for.
2. **Click on the time in the column header** of the item you want to document.



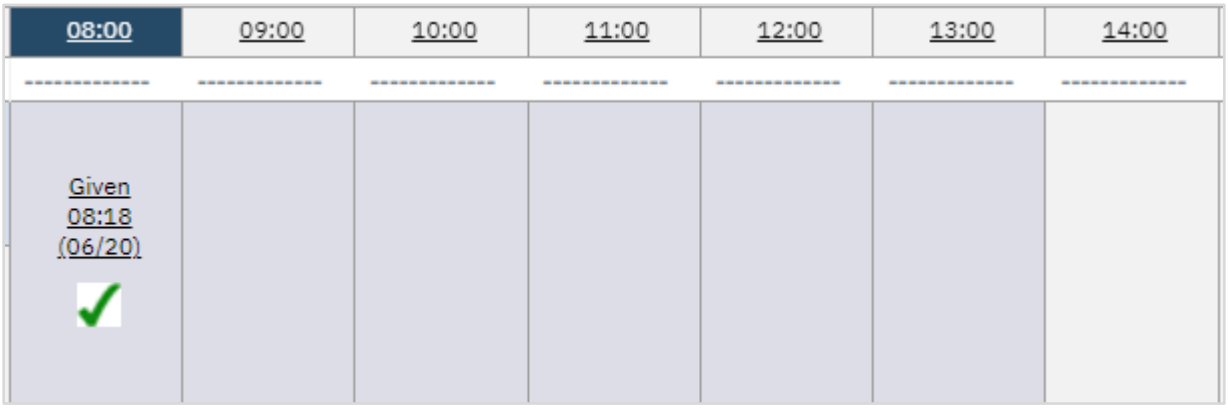
3. **Complete the fields** in the right-hand column.
    a. Note, there are many more options than Given.
    b. This may or may not include questions, based on order set up.
4. **Click the Save button.**
5. **Click the Close icon** to return to the time grid.



6. All PRN medications appear below a dotted line.
    a. The same steps as above should be followed for PRN medications.
    b. However, a PRN reason textfield will appear. **Enter the reason for PRN medication**.

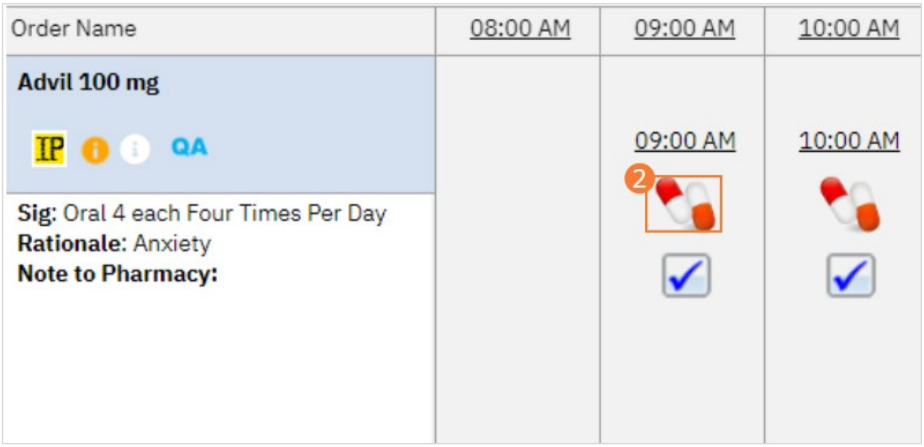


7. When a PRN medication is administered and if it does have a frequency associated with it, e.g. Q2H PRN, the system will not allow administering the medication again until 2 hours have passed. A darker gray overlay will appear on times the PRN medication cannot be administered.
    a. In the screenshot below, the medication cannot be administered again until 14:00.

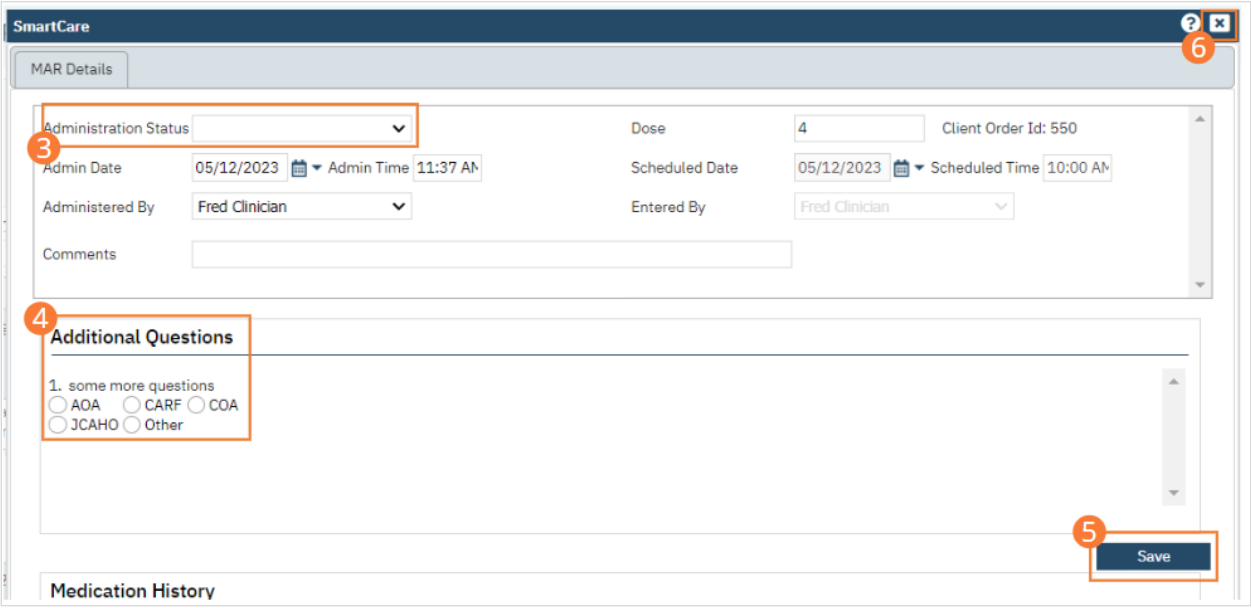


How to Document Administration of Medication for an Order with Questions

1. Begin on the Client MAR page with the client you wish to make changes for set as the active client.
2. Click on the red and white capsules of the medication you want to document.

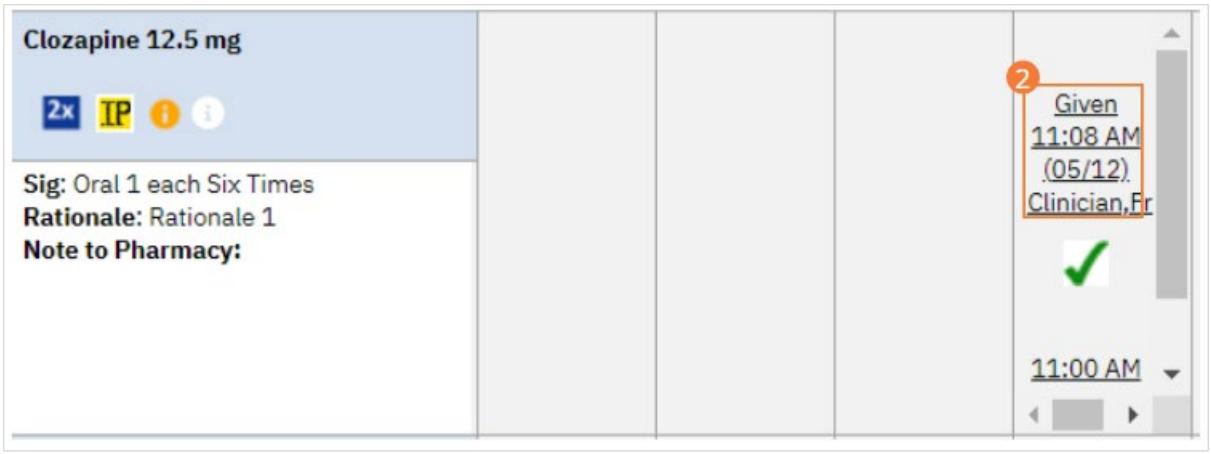


3. Select Administration Status in the drop down list in the MAR Details section.
4. Complete the fields in the Additional Questions section, if displayed.
    a) Additional questions appearing are dependent on how the order is set up by your agency.
5. Click the Save button.
6. Click the Close icon to return to the time grid.

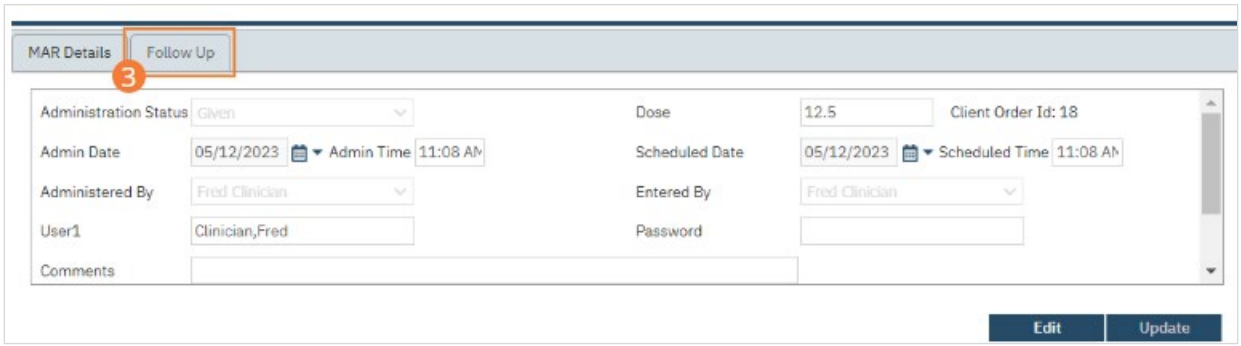


Nurse: How to Document a 1-Hour Follow-Up After Administering a PRN Medication

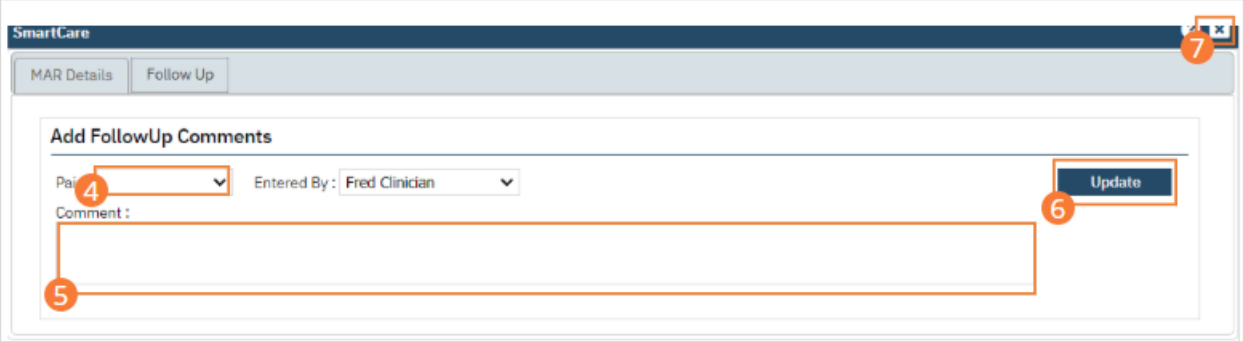
1. Begin on the Client MAR page with the client you wish to make changes for set as the active client.
2. Click on the word "Given" in the column header of the medication you want to correct. Or, click on the hyperlinked time in the column header. The MAR Details window is displayed.



3. Click the Follow Up tab to make it active.

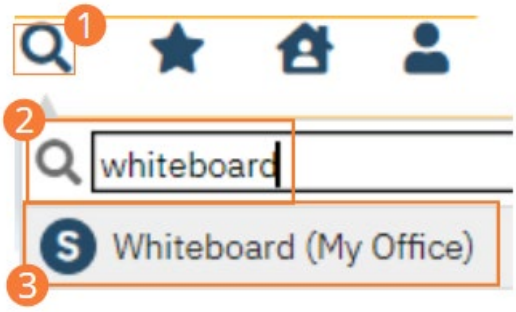


4. If needed, complete the Pain drop down list.
5. Type the comment in the Comment field.
6. Click the Update button.
7. Click the Close icon.

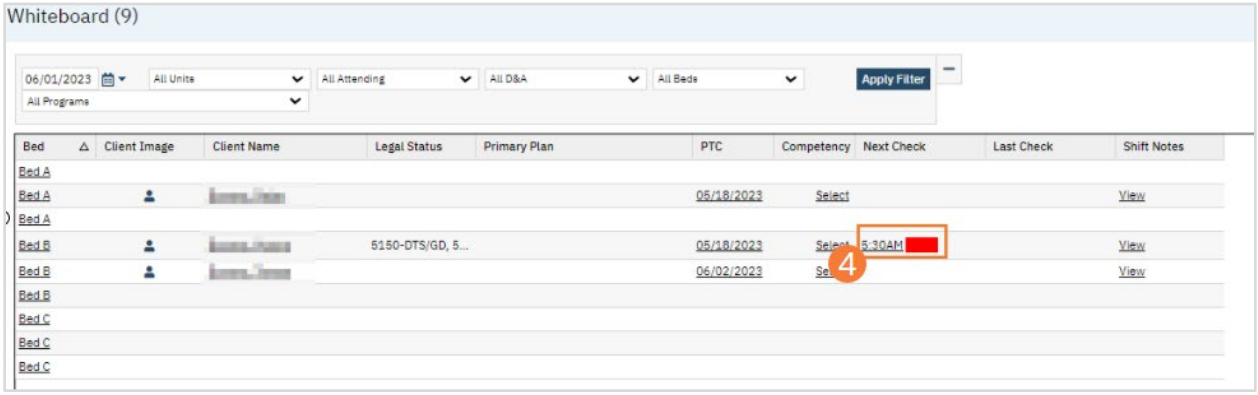


Nurse: How to Document Completion of a Safety Check

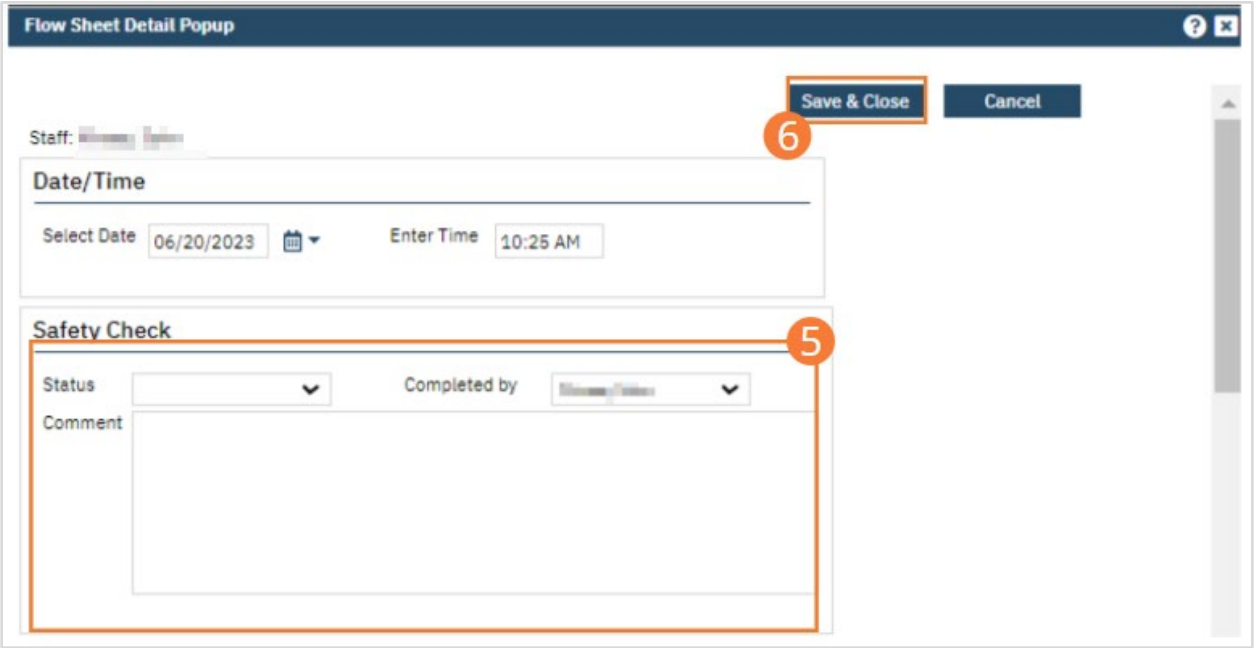
1. Click the Search icon.
2. Type 'Whiteboard' into the search bar.
3. Click to select Whiteboard (My Office).



4. Locate the Next Check column and click the displayed time hyperlink. The follow-up window opens.



5. Complete the Safety Check section.
    a. Select a Status from the dropdown. Type comments into the text field if applicable.
6. Click Save and Close to return to the Whiteboard.

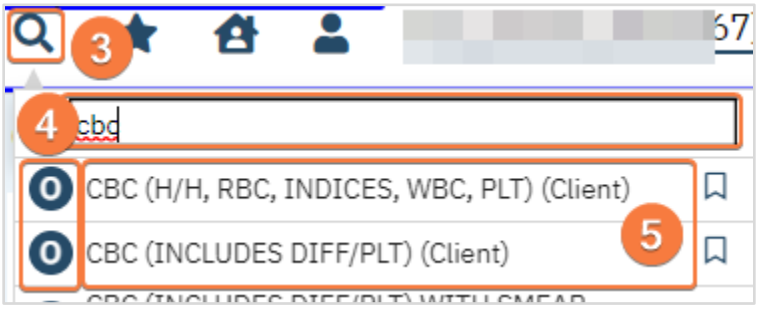


Nurse: How to Document Lab Results

Lab Interface

If your county has a lab interface, lab orders placed in SmartCare can automatically be sent to the lab.

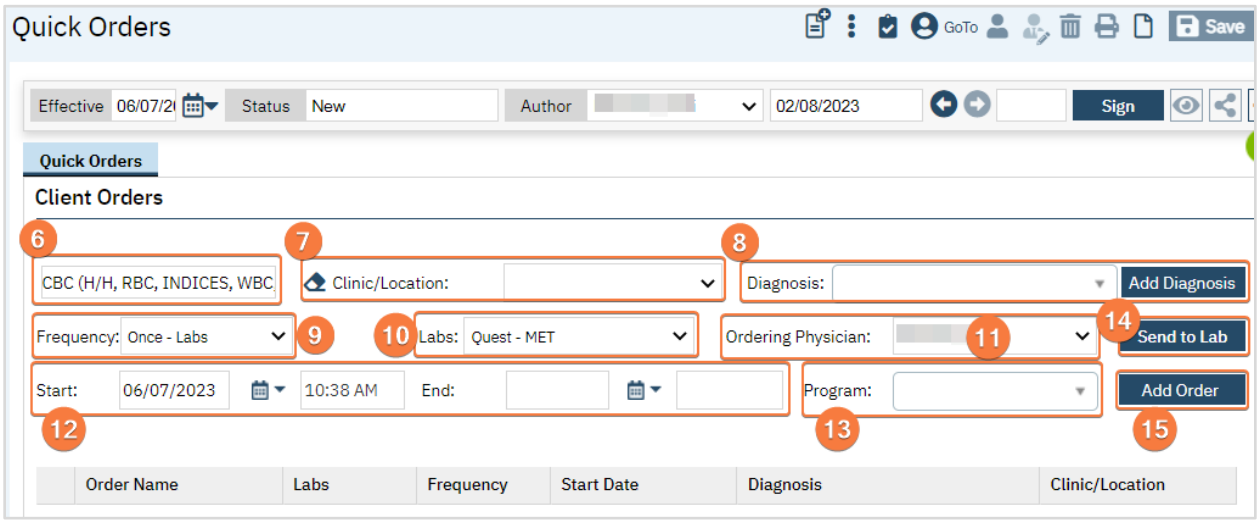
1. Lab orders have been set up as Quick Orders. This means they can be entered without having to go through the entire How to Create a New Order for a Client process.
    a. Note: Orders set up as Quick Orders cannot be added to Order Sets.
2. Before completing a lab order you should ensure you have a client record open. See General Client Search section.
3. **Click the Search icon**.
4. In the Search bar **enter the lab order name**.
    a. Quick Orders can be accessed directly through Search and have an "O" to the left of the order name.
    b. For my example I am using CBC
5. **Select the lab order** from the list, this will open the Quick Order document.



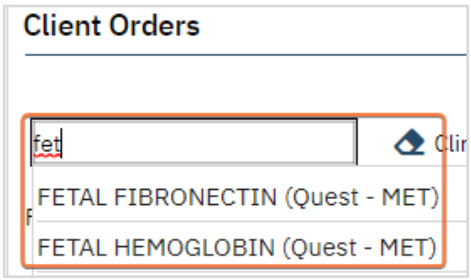
6. The selected order will populate to the Order field.
7. You may **select the Clinic/Location from the dropdown** as needed.
8. **Select diagnosis from the dropdown**.
    a. If you need to add a diagnosis click the Add Diagnosis button and search for diagnosis within the pop-up window.
        i. This will add the diagnosis to the order, not the client's record.
9. Frequency will default to Once.

a. Future Functionality: if order has other frequency options (e.g. weekly) **select the option from the dropdown**. You must enter a Start and End date; see step 12 and 12.a below. The order will automatically generate new lab orders based on the frequency.

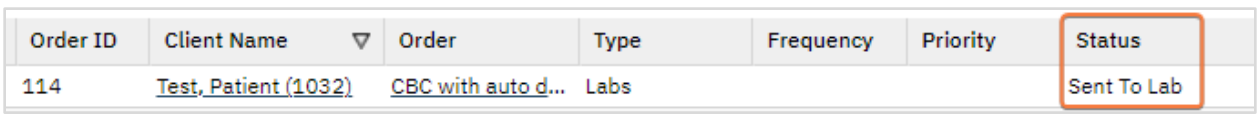
10. Labs will display the Lab this order will be sent to. If you have multiple interfaces to different labs, ensure this has the correct option.
11. **Select the Ordering Physician from the dropdown**.
12. Start date and time will default to the current time. Make changes if needed.
    a. Future Functionality: End date and time are required if frequency is more than once. See step 9.a above for details.
13. **Select Program from the dropdown**; this is a multi-select field.
14. Clicking the Send to Lab button will send the order to the lab. However, this is not regularly used as labs get sent to the lab once the document is signed, step 18 below.
15. Click Add Order to add the order to the list.



16. You can add additional lab orders by **entering the name in the order field**. This field is a typable-search field, as you type options will appear.
    a. Select the correct order.



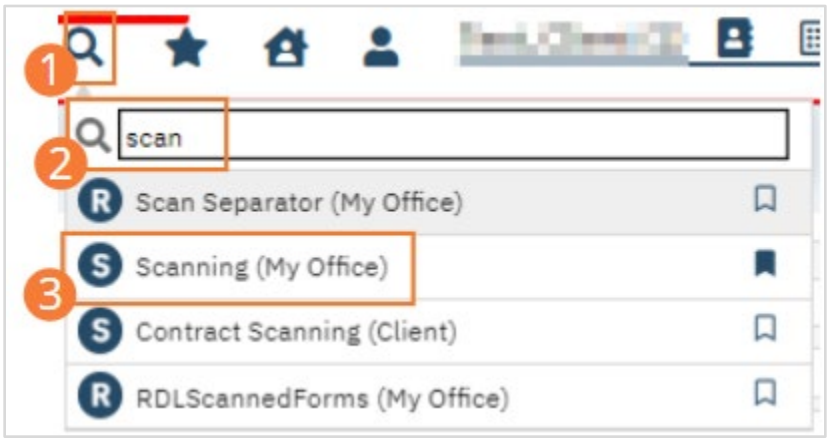
17. Repeat steps 7-15.
18. **Sign the Order** using the steps found under How to Sign a Document. As soon as the document is signed, the order will be sent to the pharmacy.
    a. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.
19. Order will have a status of Sent to Lab.



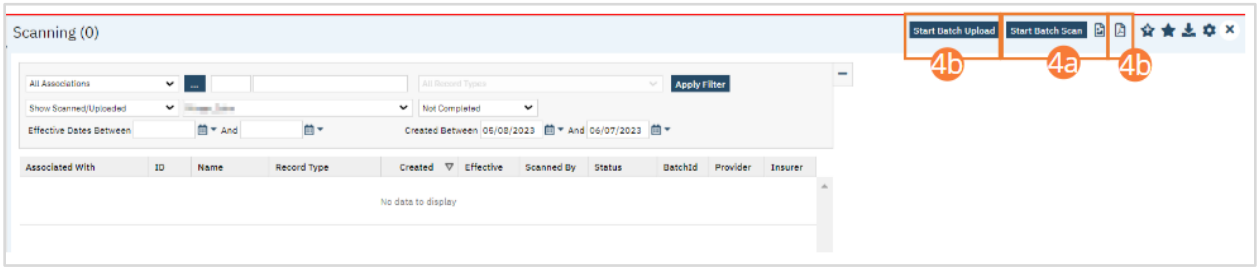
Non-Interface Lab Results

Lab results received from a lab that does not have an interface are scanned into the client's documentation using the Scan/Upload feature.

1. Click the Search icon.
2. Type "Scan" into the search bar.
3. Click to select Scanning (My Office). The Scanning list page will open.

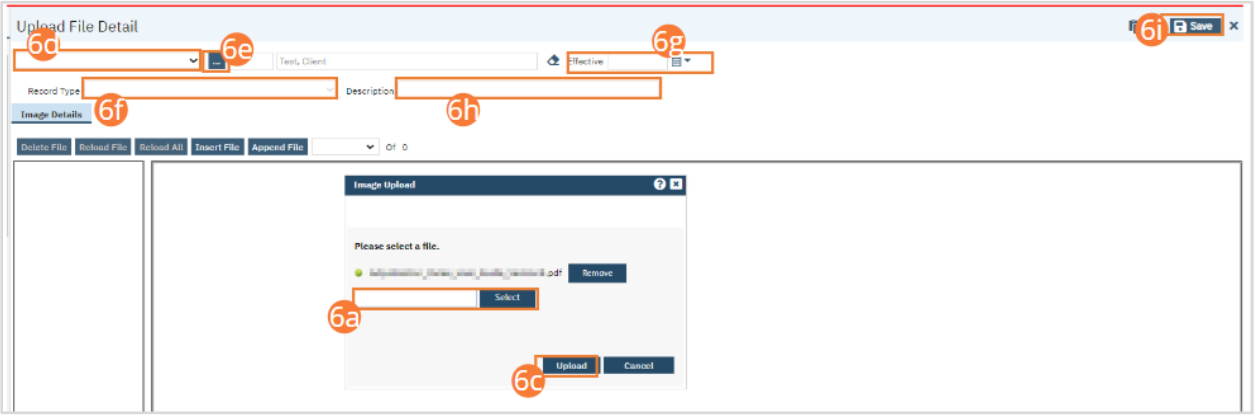


4. Select the icon for the type of document import you wish to perform.
    a. Scan and Batch Scan use scanning hardware to convert paper documents into electronic images and import them into SmartCare.
    b. Upload and Batch Upload take existing electronic files and import them into SmartCare.

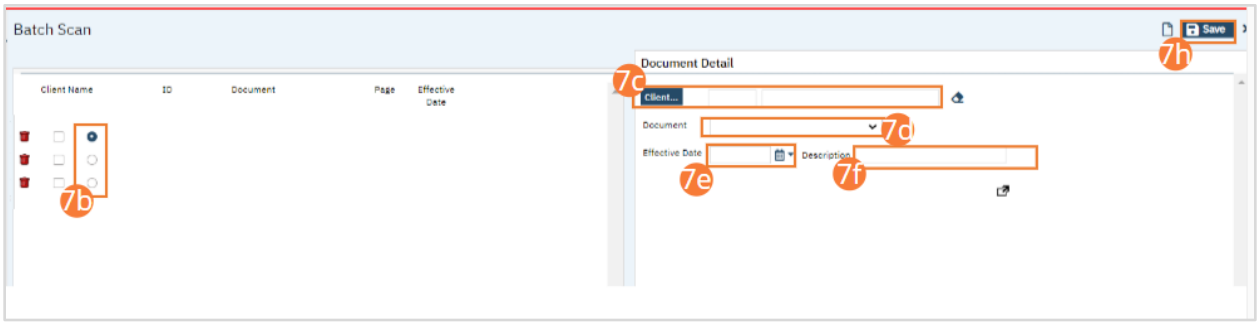


5. If you selected Scan, the Scan page will open.
    a. Your scanning hardware will initialize. Follow organizational workflows to operate your scanning hardware.
    b. An image will display in the center pane when a file has been successfully scanned.
    c. Select a record option from the dropdown.
    d. Click the '...' button to perform a client search using the steps found under How to Search for a Client. This step will be skipped, and a client will be pre-selected, if you opened Scanning (My Office) with an active client. In this case, select the '...' button to change active clients.
    e. Select a record type from the dropdown. This will be set to "Labs" or one of the Lab Results options for lab results.
    f. Set an effective date.
    g. Type a Description into the text field.
    h. Click Save.

6. If you selected Upload, the Upload pop-up will open.
    a. Click Select.
    b. Select your desired file from your computer file browser.
    c. Click Upload. An image will display in the center pane.
    d. Select a record option from the dropdown.
    e. Click the '...' button to perform a client search using the steps found under How to Search for a Client. This step will be skipped, and a client will be pre-selected, if you opened Scanning (My Office) with an active client. In this cases, select the '...' button to change active clients.
    f. Select a record type from the dropdown. This will be set to "Labs" or one of the Lab Results options for lab results.
    g. Set an effective date.
    h. Type a Description into the text field.
    i. Click Save.

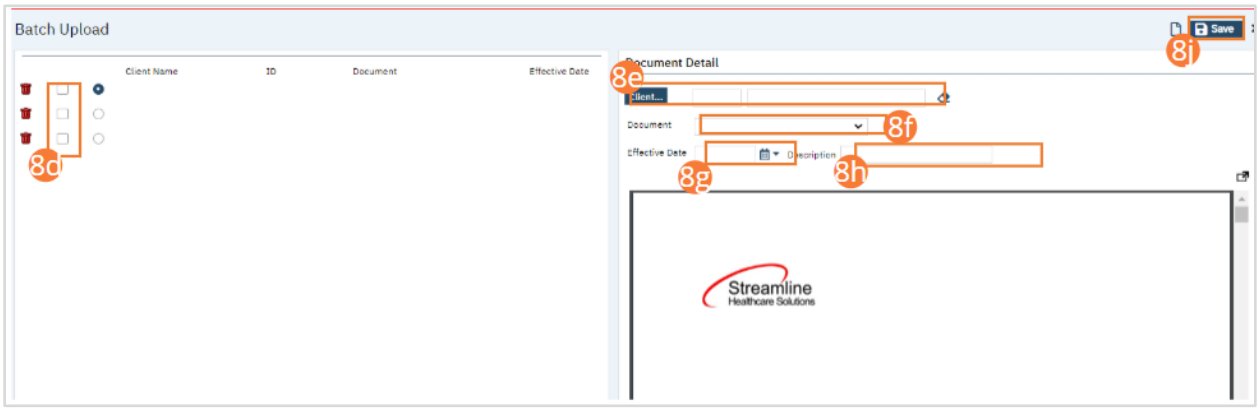


7. NOTE: Before selecting Batch Scan, you will need to print one or more Scan Separators from the Scan Separator (My Office) page. One Separator should be placed between two documents to signal to the system that they should be treated as separate. If you selected Batch Scan, the Batch Scan page will open.
    a. Your scanning hardware will initialize. Follow organizational workflows to operate your scanning hardware. Ensure a Scan Separator is placed between each set of documents.
    b. On the left, you will see multiple documents listed. Select the radio button beside one to display it.
    c. Click the Client button to perform a client search using the steps found under General Client Search.
    d. Select a record type from the dropdown. This will be set to "Labs" or one of the Lab Result options for lab results.
    e. Set an effective date.
    f. Type a Description into the text field.
    g. Repeat Steps 7b-7e for each document scanned.
    h. Click Save.

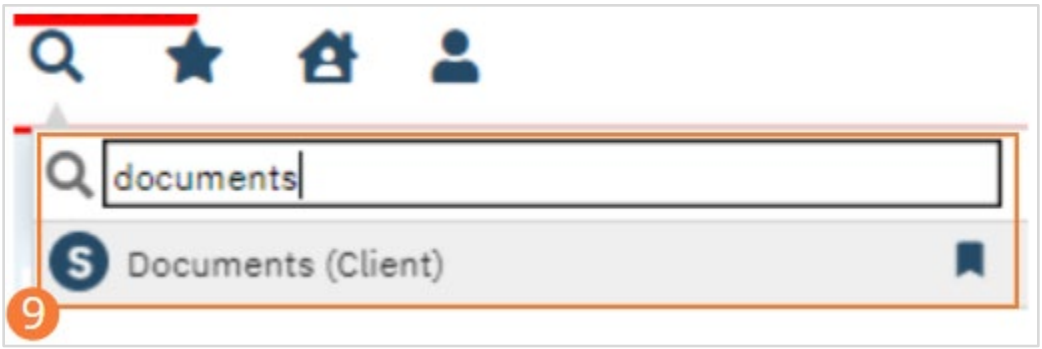


8. If you selected Batch Upload, the Batch Upload window will open.
    a. Click Select.
    b. Select your desired files from your computer file browser. The Batch Upload function supports multiple selections.
    c. Click Upload.

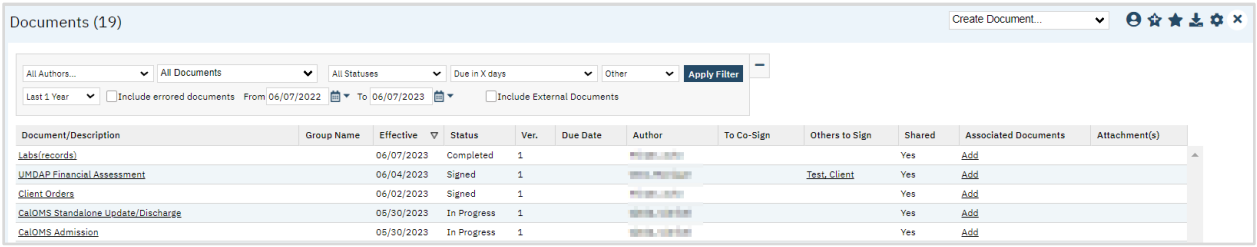
    d. On the left, you will see multiple documents listed. Select the radio button beside one to display it.
    e. Click the Client button to perform a client search using the steps found under General Client Search.
    f. Select a record type from the dropdown. This will be set to “Labs” or one of the Lab Result options for lab results.
    g. Set an effective date.
    h. Type a Description into the text field.
    i. Repeat Steps 8d-8h for each document scanned.
    j. Click Save.



9. After Saving your associated documents, Search for the Documents (Client) screen and select it.



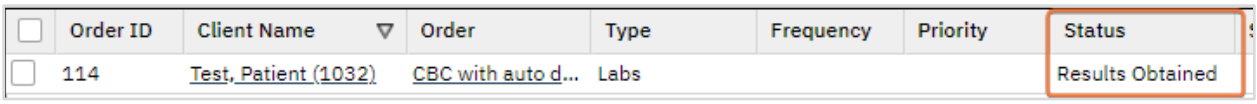
10. Review the documents scanned/uploaded here. If necessary, click the Add hyperlink in the Associated Documents column to upload new documents that should be associated with the selected document.



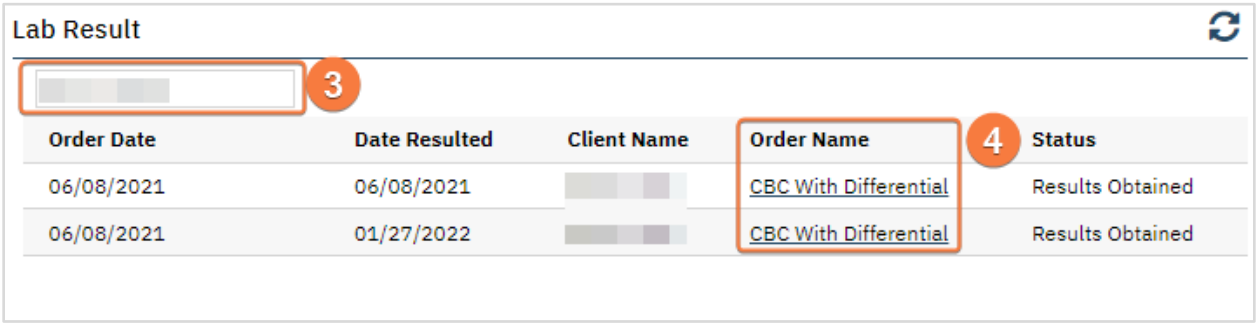
Interface Lab Results

When there is a bidirectional lab interface, results will automatically come into the system.

1. When results are sent from the lab the order will have Results Obtained Status in the Order list pages; Orders(My Office) and Client Orders (Client).

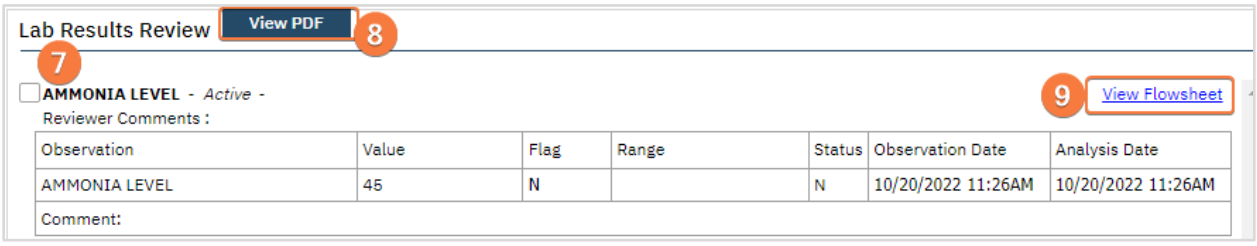


2. Additionally, results will appear in the Lab Results widget. This widget is available in the Dashboard.
3. Enter the ordering physician's name. This is a typable-search field, as you type the name options will appear.
    a. The field will default to your name but will only show results based on the ordering physician name. You can only have one name at a time.
    b. The widget will display any lab orders for the ordering physician with Results Obtained status.
4. Click the Order Name hyperlink to review the results.

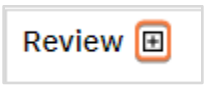


5. You will be in the Lab Results Review screen.
6. Results will appear in the Lab Results Review section.
7. Clicking the View PDF button will display the PDF within the same section.
    a. Button will change to View Results.
    b. Not all results will have a PDF, this is dependent on the interface.
8. View Flowsheet hyperlink will open the flow sheet associated with this lab.

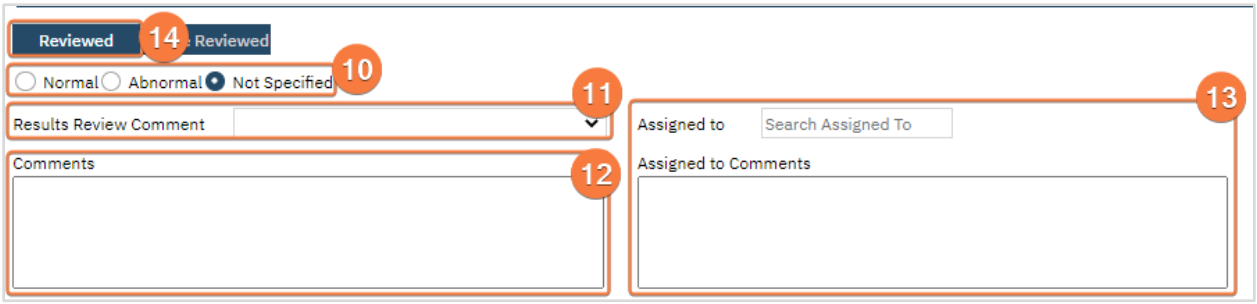
a. See step 16 below for details.



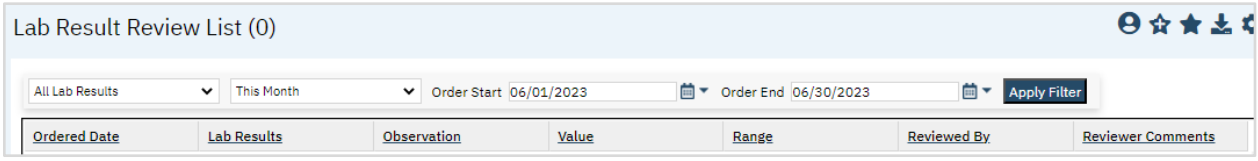
9. **Click the expand icon** next to Review to view additional fields.



10. **Select between Normal, Abnormal, and Not Specified radio buttons**.
11. **Select Results Review Comments** to select a standard comment.
12. **Enter comments into the textbox**, if needed.
13. **Enter a user's name into the Assigned to field** if you would like to assign these results to someone.
    a. Assigned orders can be seen and tracked in Orders (My Office).
    b. **Enter Assigned to Comments** if the order was assigned to someone.
14. **Select Nurse Reviewed button**.
    a. This button is only active when the individual is not set up as a prescriber.



15. This review information can be seen and tracked in the The Lab Results and Review List.
    a. This list page is for this specific client.



16. All lab results will also populate into a flow sheet automatically.
    a. See Flow Sheets section on directions for accessing this screen.

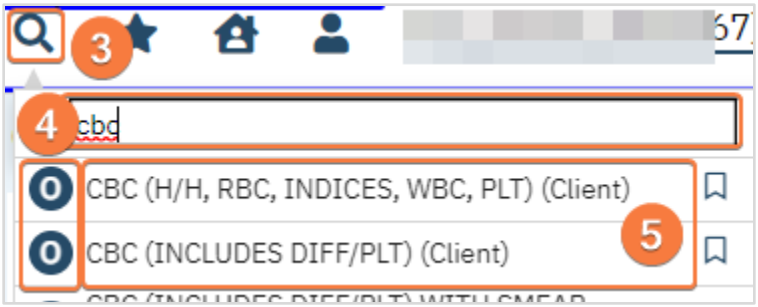
Prescriber: How to Document Lab Results

Lab Interface

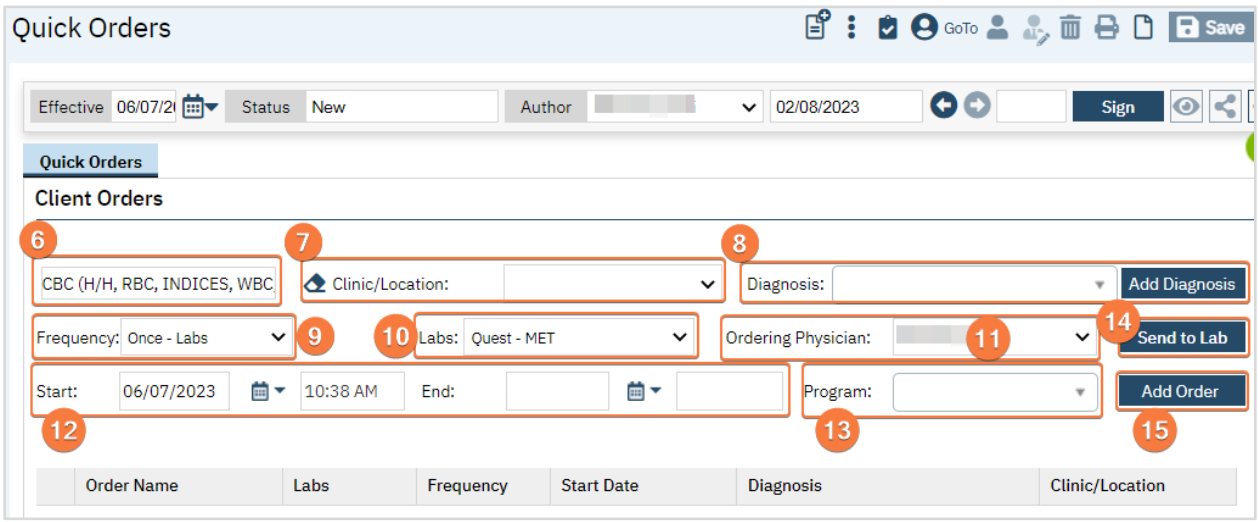
If your county has a lab interface, lab orders placed in SmartCare can automatically be sent to the lab.

1. Lab orders have been set up as Quick Orders. This means they can be entered without having to go through the entire How to Create a New Order for a Client process.
    a. Note: Orders set up as Quick Orders cannot be added to Order Sets.
2. Before completing a lab order you should ensure you have a client record open. See General Client Search section.

3. Click the Search icon.
4. In the Search bar enter the lab order name.
    a. Quick Orders can be accessed directly through Search and have an "O" to the left of the order name.
    b. For my example I am using CBC
5. Select the lab order from the list, this will open the Quick Order document.

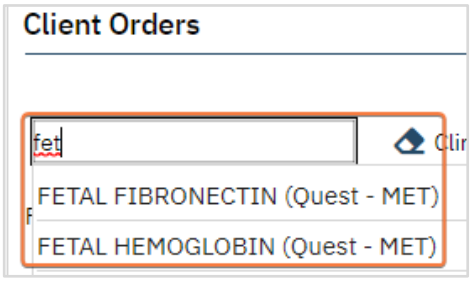


6. The selected order will populate to the Order field.
7. You may select the Clinic/Location from the dropdown as needed.
8. Select diagnosis from the dropdown.
    a. If you need to add a diagnosis click the Add Diagnosis button and search for diagnosis within the pop-up window.
        i. This will add the diagnosis to the order, not the client's record.
9. Frequency will default to Once.
    a. Future Functionality: if order has other frequency options (e.g. weekly) select the option from the dropdown. You must enter a Start and End date; see step 12 and 12.a below. The order will automatically generate new lab orders based on the frequency.
10. Labs will display the Lab this order will be sent to. If you have multiple interfaces to different labs, ensure this has the correct option.
11. The Ordering Physician field will display your name.
12. Start date and time will default to the current time. Make changes if needed.
    a. Future Functionality: End date and time are required if frequency is more than once. See step 9.a above for details.
13. Select Program from the dropdown; this is a multi-select field.
14. Clicking the Send to Lab button will send the order to the lab. However, this is not regularly used as labs get sent to the lab once the document is signed, step 18 below.
15. Click Add Order to add the order to the list.

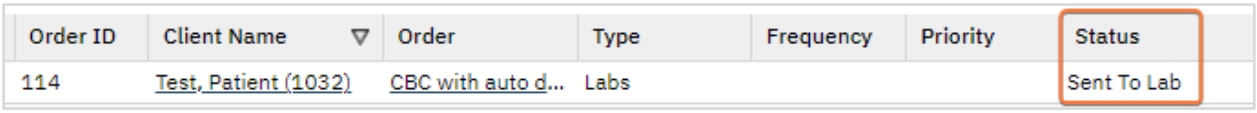


16. You can add additional lab orders by entering the name in the order field. This field is a typable-search field, as you type options will appear.

a. Select the correct order.



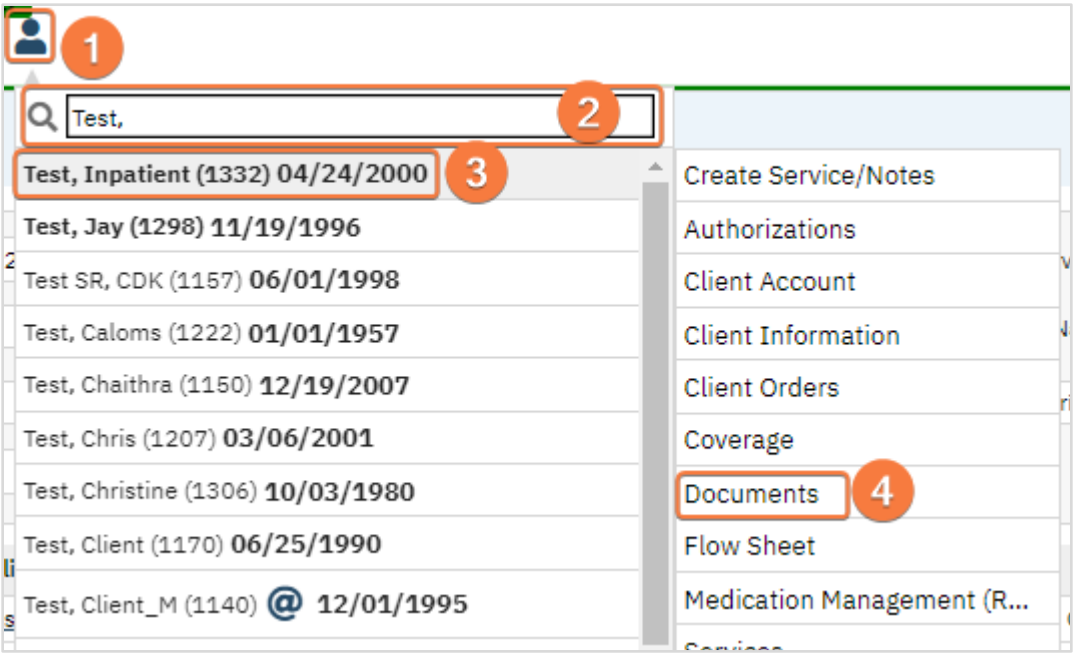
17. Repeat steps 7-15.
18. **Sign the Order** using the steps found under How to Sign a Document. As soon as the document is signed, the order will be sent to the pharmacy.
19. Order will have a status of Sent to Lab.



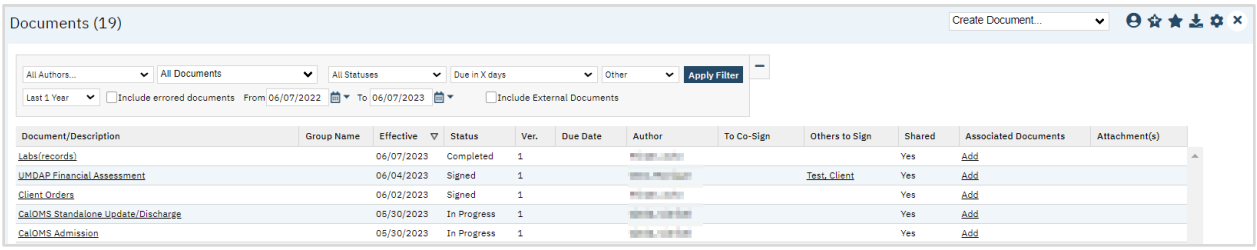
Non-Interface Lab Results

Lab results received from a lab that does not have an interface are scanned into the client's documentation.

1. To navigate to the client's Document list page **click the Client Search icon**.
2. Use the search bar to locate the client.
   a. For details on this reference the General Client Search section.
3. Once the client is located, **hover over their name and move the cursor to the menu on the right**.
4. **Select Documents from the menu,** this will open the Documents list page.



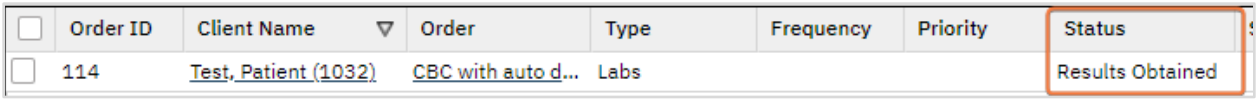
5. Select the scanned lab order to see the results.
   a. As a reminder, the options displayed are based on the filters.



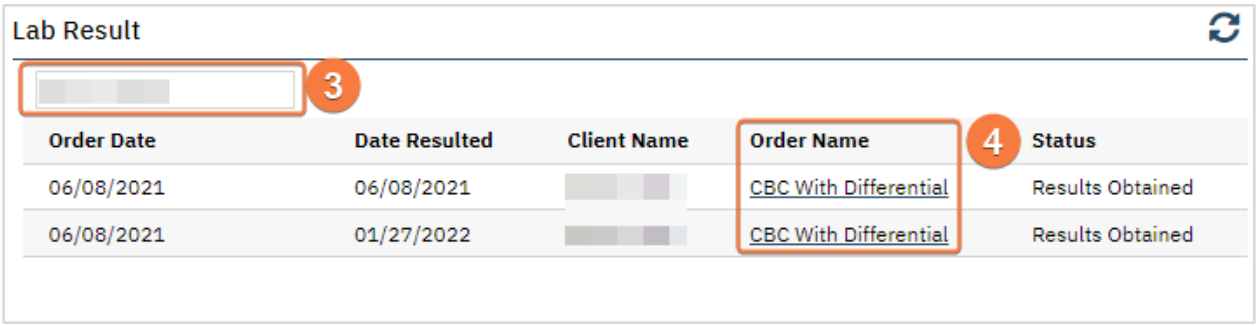
Interface Lab Results

When there is a bidirectional lab interface, results will automatically come into the system.

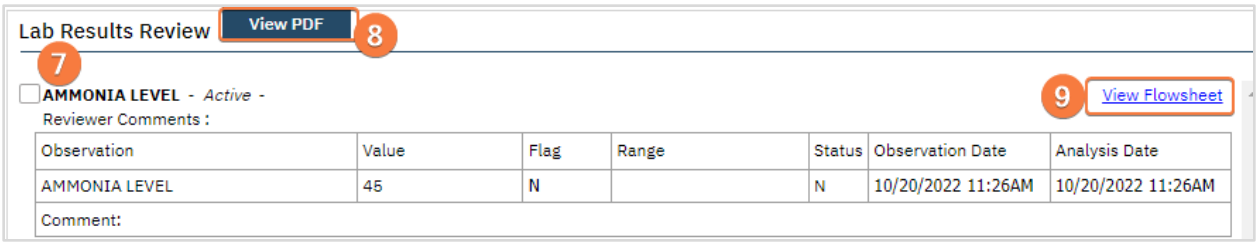
1. When results are sent from the lab the order will have Results Obtained Status in the Order list pages; Orders(My Office) and Client Orders (Client).
    a. Note: If a nurse has reviewed an order and assigned it to you, you can filter by Assigned To to locate items under your name.



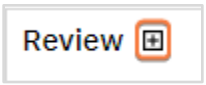
2. Additionally, results will appear in the Lab Results widget. This widget is available in the Dashboard.
    a. The widget will display any lab orders you ordered and have the Results Obtained status.
3. If you need to see orders for a different Ordering Physician enter their name into the field.
    a. This is a typable-search field, as you type options will display.
4. Click the Order Name hyperlink to review the results.



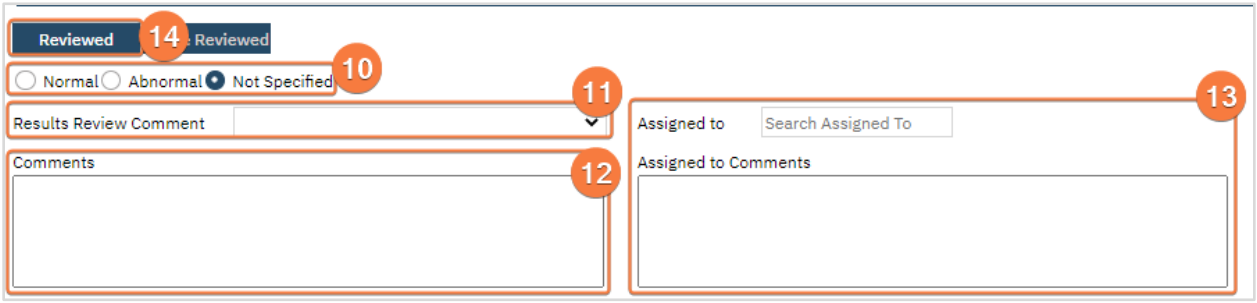
5. You will be in the Lab Results Review screen.
6. Results will appear in the Lab Results Review section.
7. Clicking the View PDF button will display the PDF within the same section.
    a. Button will change to View Results.
    b. Not all results will have a PDF, this is dependent on the interface.
8. View Flowsheet hyperlink will open the flow sheet associated with this lab.
    a. See step 16 below for details.



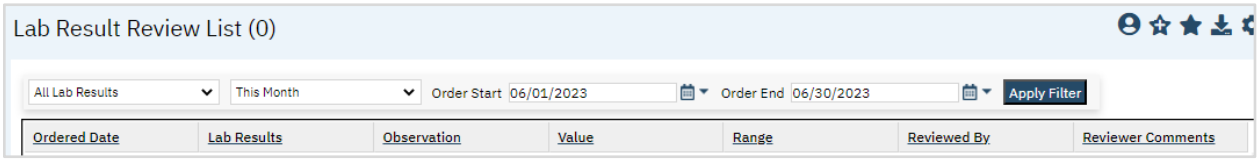
9. Click the expand icon next to Review to view additional fields.



10. **Select between Normal, Abnormal, and Not Specified radio buttons**.
11. **Select Results Review Comments** to select a standard comment. View Flowsheet hyperlink
12. **Enter comments into the textbox**, if needed.
13. **Enter a user's name into the Assigned to field** if you would like to assign these results to someone.
    a. Assigned orders can be seen and tracked in Orders (My Office).
    b. **Enter Assigned to Comments** if the order was assigned to someone.
14. **Select Reviewed button**.
    a. This button is only active when the individual is set up as a prescriber.



15. This review information can be seen and tracked in the The Lab Results and Review List.
    a. This list page is for this specific client.

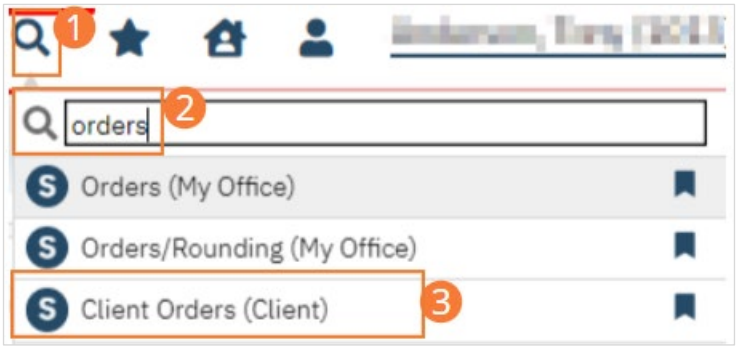


16. All lab results will also populate into a flow sheet automatically.
    a. See Flow Sheets section on directions for accessing this screen.

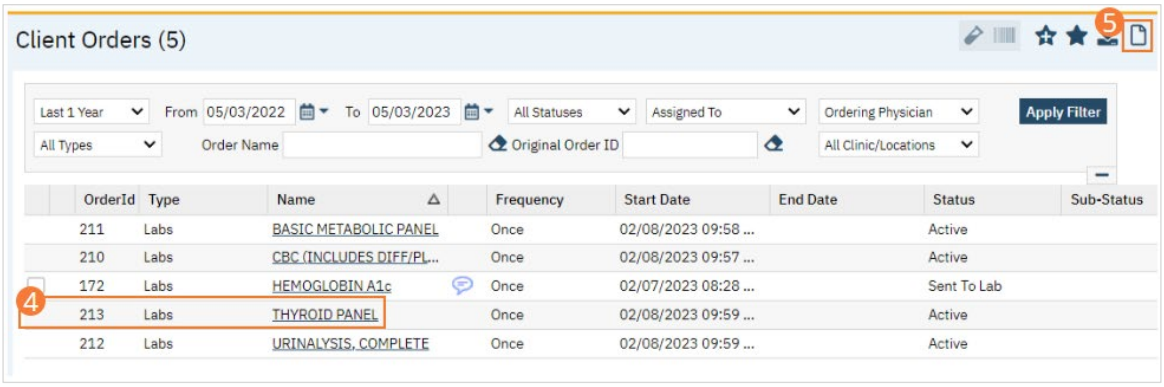
Nurse: How to Discontinue an Order

If the Prescriber requests a discontinuation of an order for a client, access the order and change the status from Active to Discontinued.

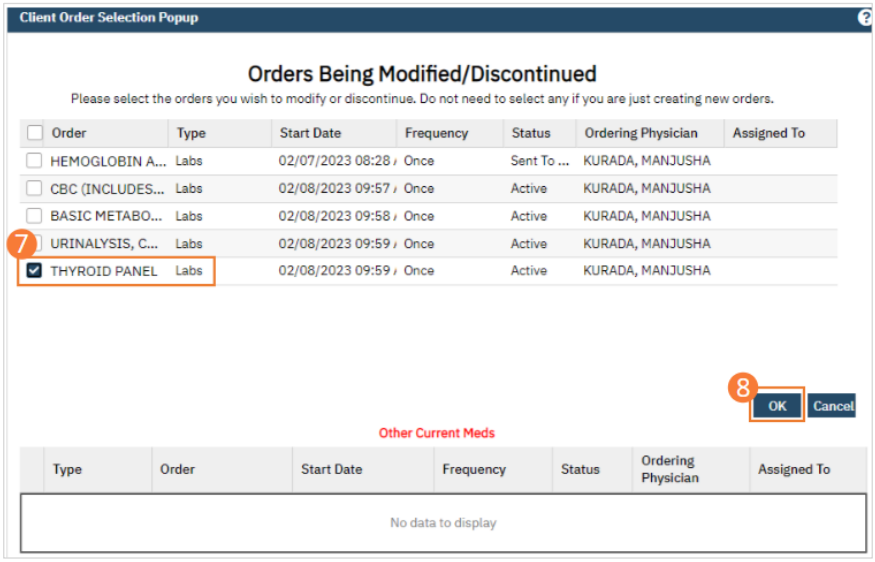
1. You must first have the client open, then **click the Search icon**.
2. **Type "Orders"** into the search bar.
3. **Click to select Client Orders (Client).**



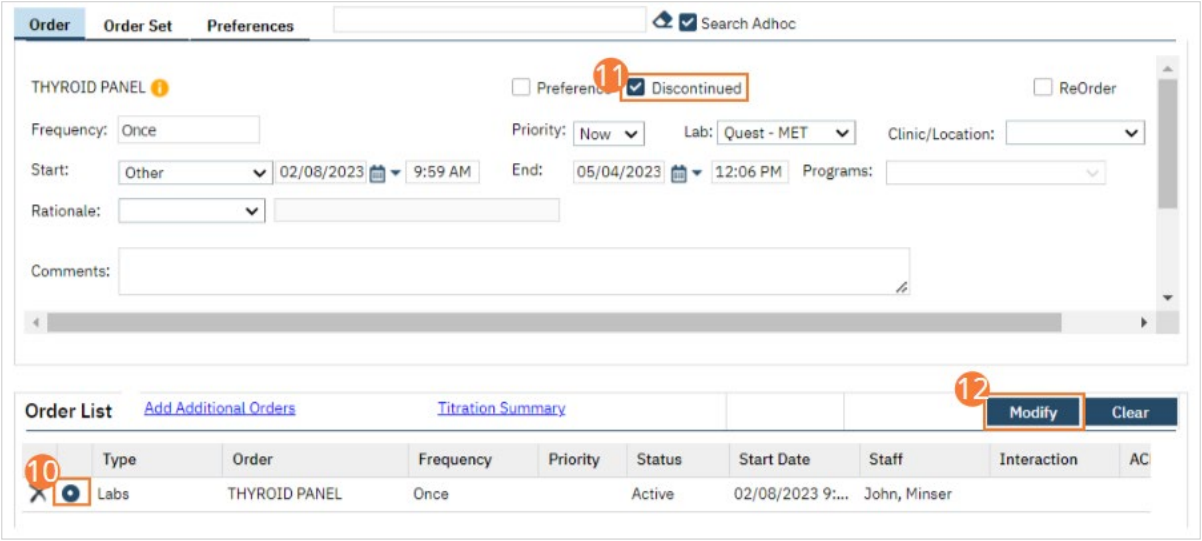
4. The Client Orders list page opens. Confirm that the Order you wish to discontinue appears.
5. **Click on the New icon.** The Orders Being Modified/Discontinued window opens.



6. Locate the order you want to discontinue in the top half of the window.
7. Select the check box of the order(s) you want to discontinue.
8. Click the OK button. The Client Order document opens.
    a. Ensure you select the correct Ordering Physician in Order Entry Details section.



9. Find the order in the Order List section of the page.
10. Click the radio button on the line of the order you want to discontinue. The order information appears in the middle portion of the page.
11. Select the Discontinued check box.
    a. Based on order type you may see a discontinue reason drop-down.
12. Click the Modify button to save your changes.

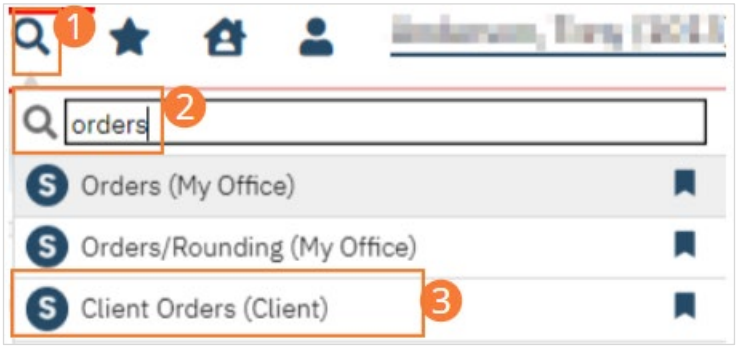


13. **Click the Save button** in the tool bar.
14. Repeat steps 10-12 if discontinuing multiple orders.
15. **Sign the Order** using the steps found under How to Sign a Document.
16. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

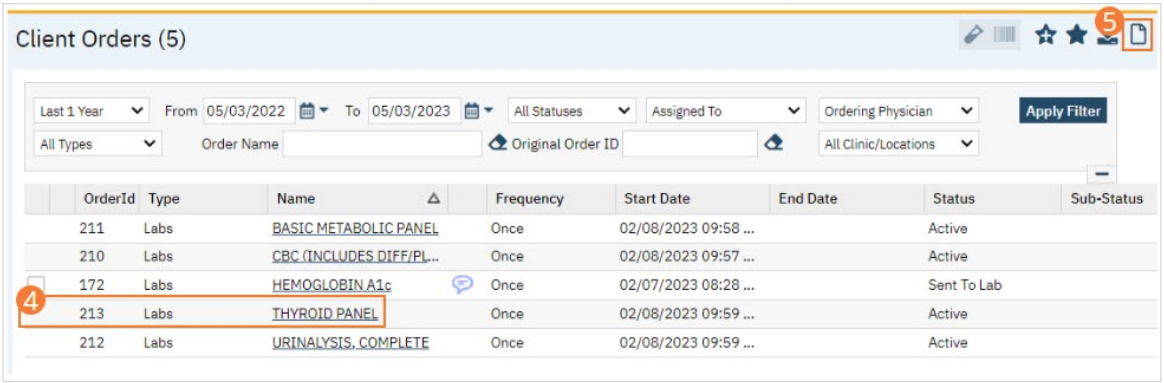
Prescriber: How to Discontinue an Order

Access the order and change the status from Active to Discontinued.

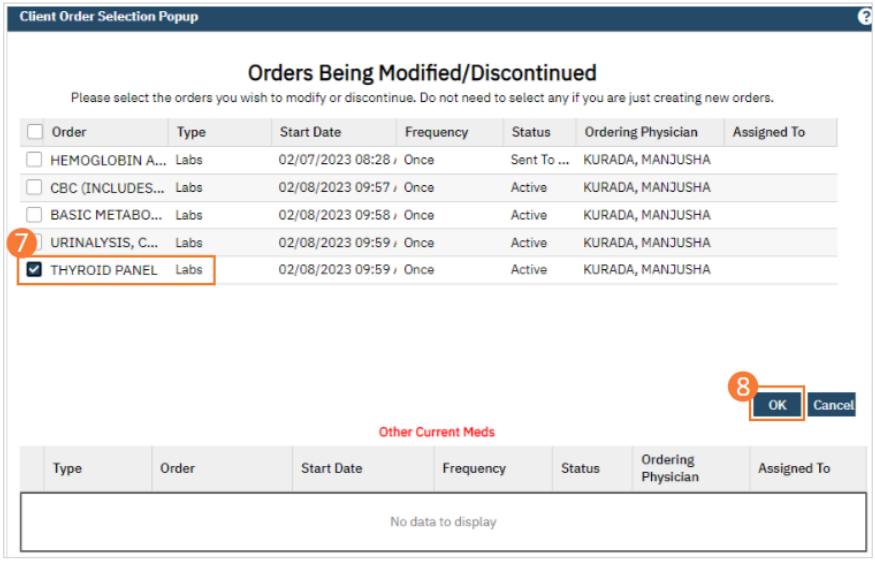
1. You must first have the client open, then **click the Search icon**.
2. **Type "Orders"** into the search bar.
3. **Click to select Client Orders (Client).**



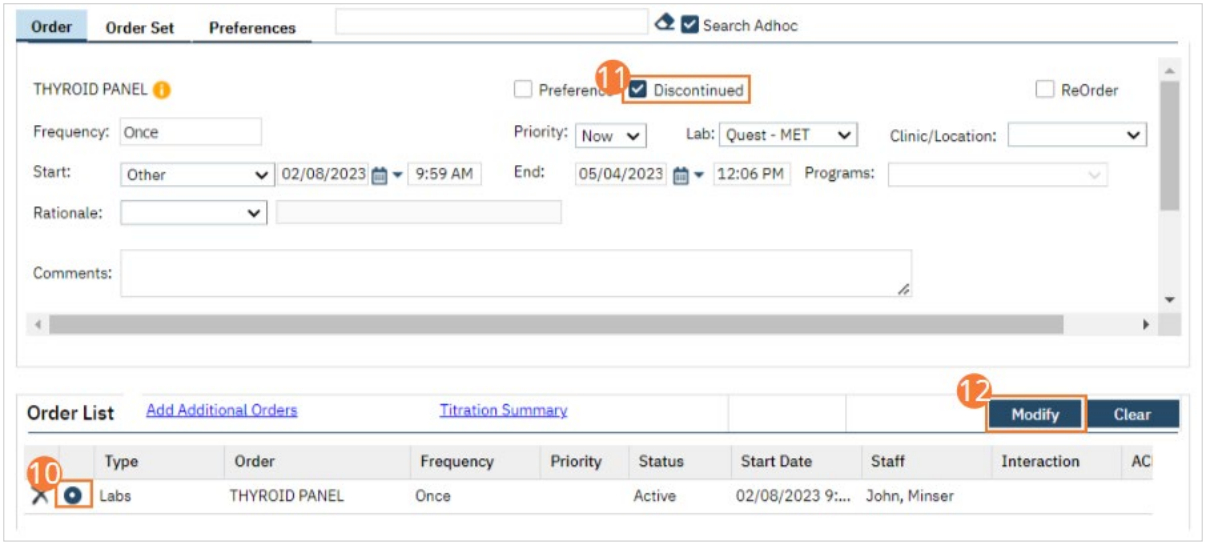
4. The Client Orders list page opens. Confirm that the Order you wish to discontinue appears.
5. **Click on the New icon.** The Orders Being Modified/Discontinued window opens.



6. Locate the order you want to discontinue in the top half of the window.
7. **Select the checkbox** of the order(s) you want to discontinue.
8. **Click the OK button**. The Client Order document opens.
    a. Ensure you select the correct Ordering Physician in Order Entry Details section.



9. Find the order in the Order List section of the page.
10. **Click the radio button** on the line of the order you want to discontinue. The order information appears in the middle portion of the page.
11. **Select the Discontinued check box**.
    a. Based on order type you may see a discontinue reason drop-down.
12. **Click the Modify button** to save your changes.

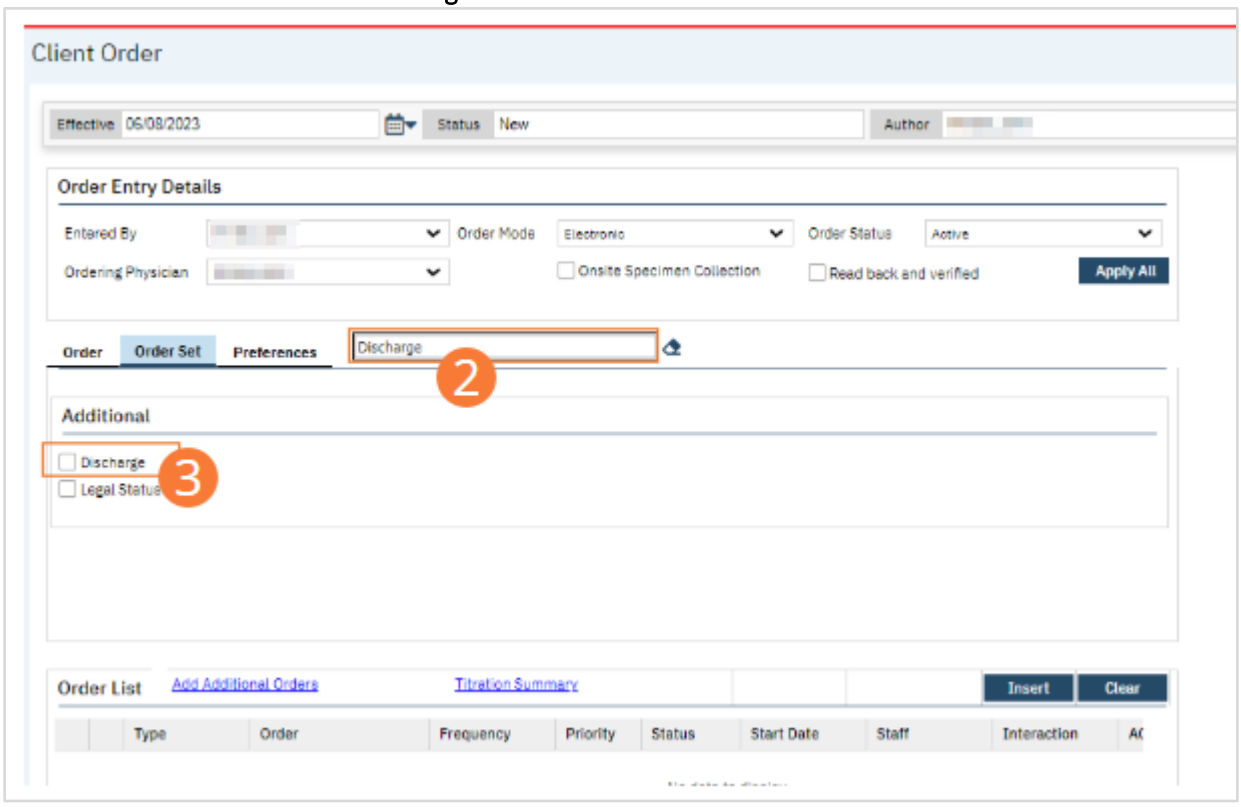


13. **Click the Save button** in the tool bar.
14. Repeat steps 10-12 if discontinuing multiple orders.
15. **Sign the Order** using the steps found under How to Sign a Document.

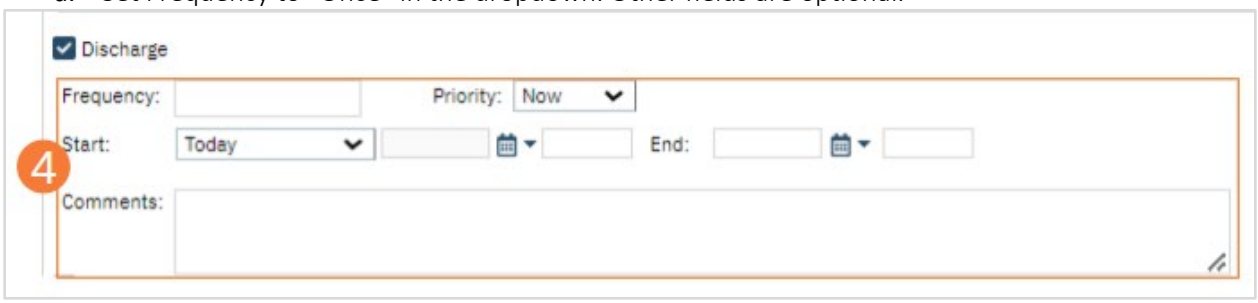
Discharge/Transfer

Nurse: How to Document a Discharge Order

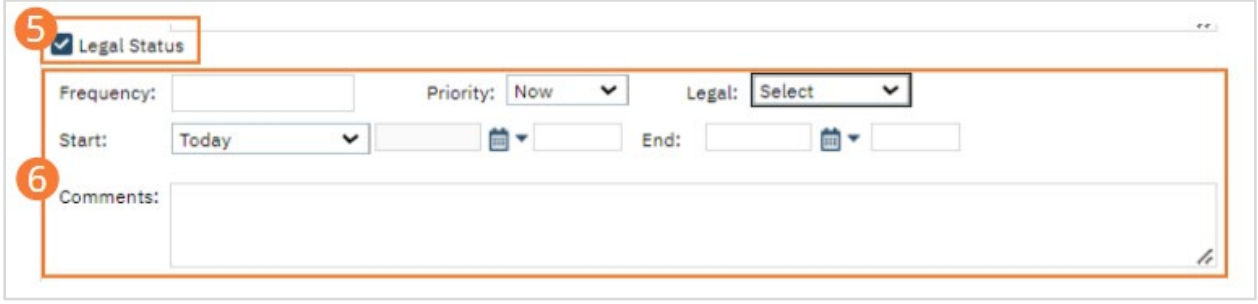
1. **Create a New Order,** using the steps under Order Sets.
2. When selecting the Order Set, **select Discharge as the Order type.**
3. **Click the checkbox next to the Discharge order.**



4. **Complete all required fields for the Discharge order**.
   a. Set Frequency to "Once" in the dropdown. Other fields are optional.

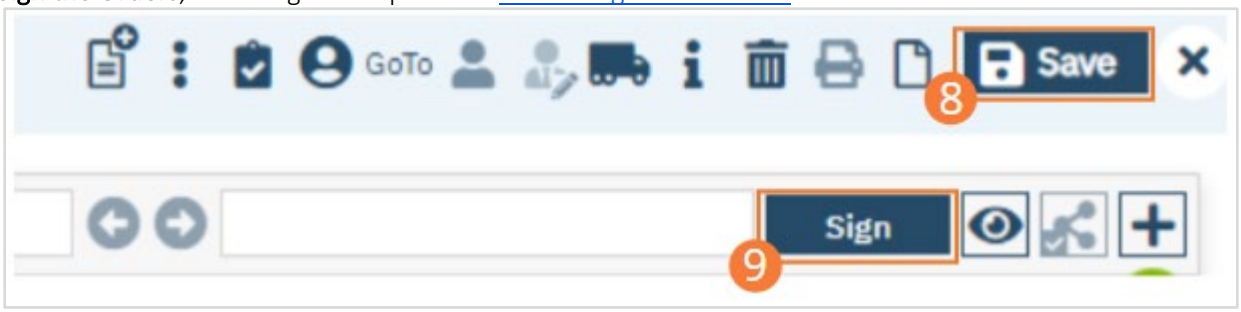


5. **Click the checkbox next to the Legal Status order**.
6. **Complete all required fields for the Legal Status order.**
   a. Be sure a status is selected under the Legal dropdown.



7. **Select the Insert button.** The Orders will be added to the Order List.

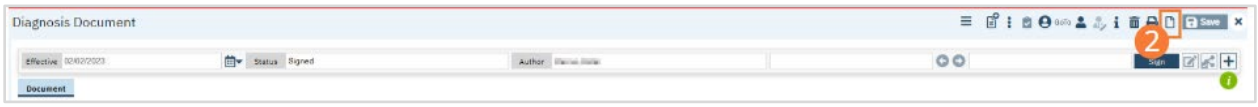
8. **Click the Save button.**
9. **Sign the Orders**, following the steps under How to Sign a Document.



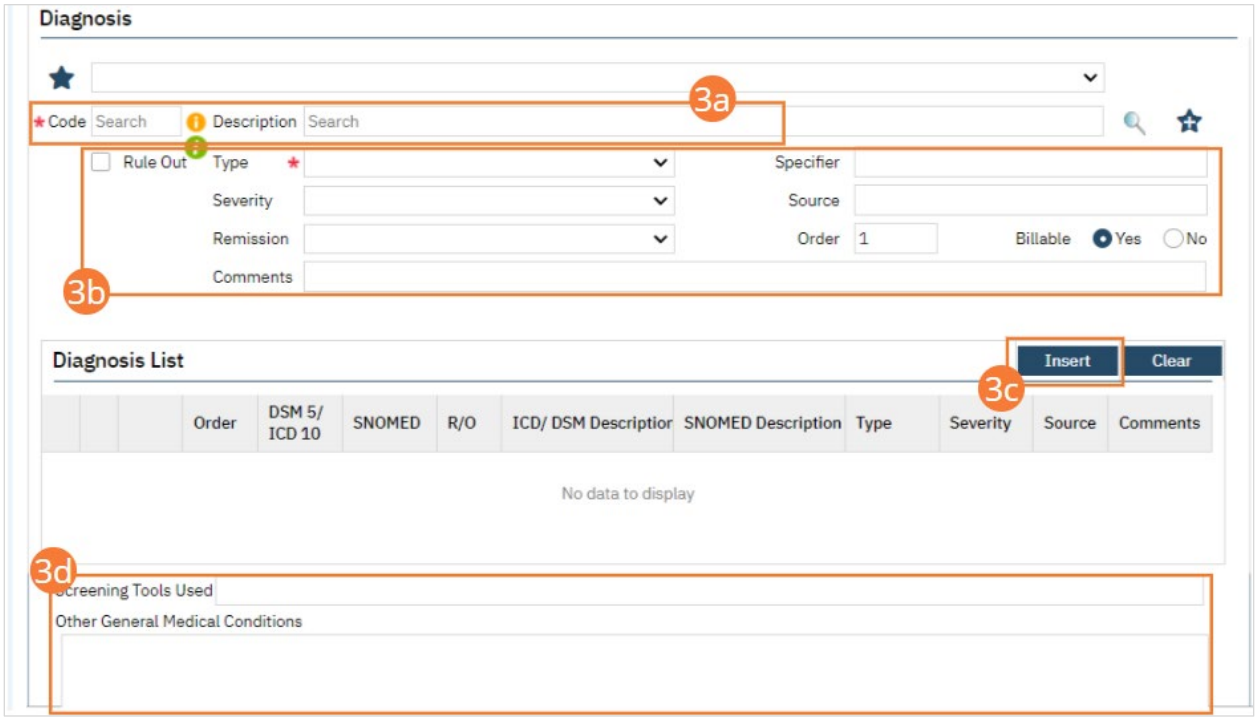
10. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

How to Document the Discharge Diagnosis on Behalf of the Prescriber

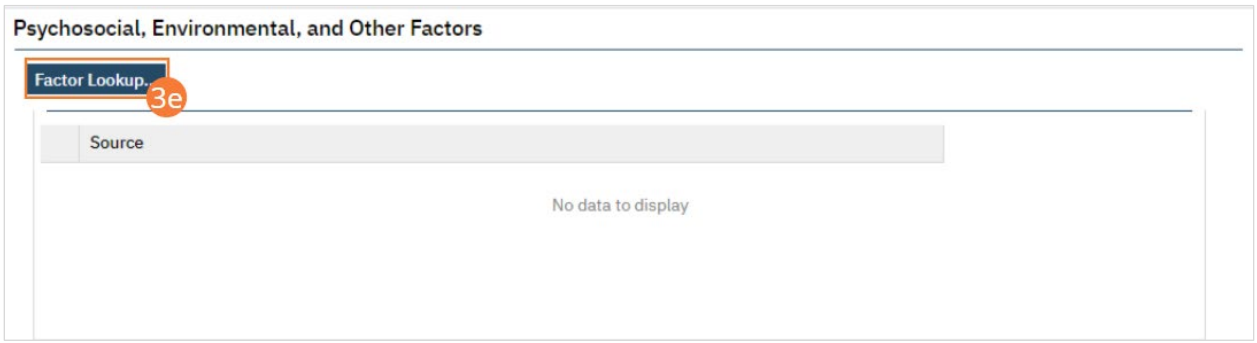
1. Begin on the Diagnosis Document page.
2. **Select the New icon**. A new Diagnosis Document will open, which will post-date the Admission Diagnosis Document.



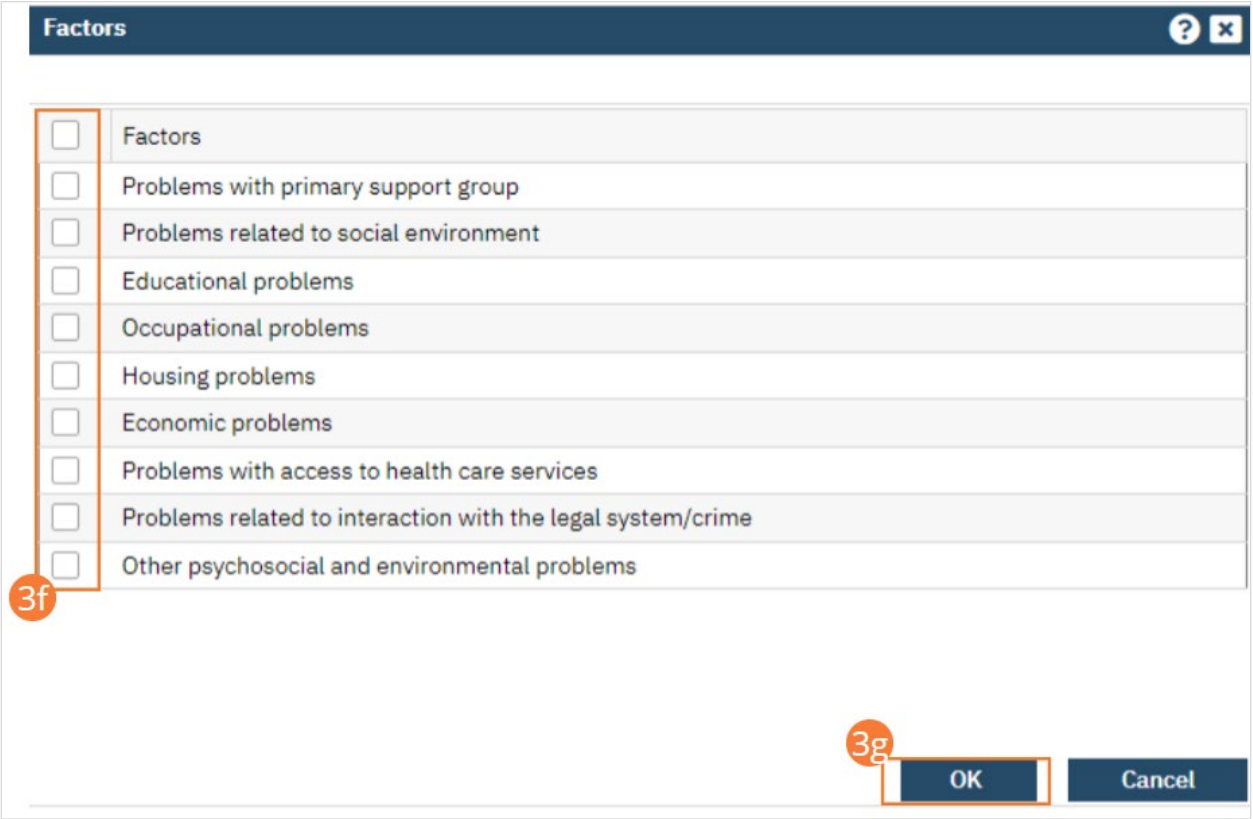
3. **Complete required fields.**
    a. **Search for a diagnosis code or description**. Select the chosen diagnosis from the dropdown that appears when you begin entering text. If no diagnosis was determined, select the No Diagnosis checkbox and skip to Step 3e.
    b. Ensure you **enter the prescribers name in the Source field**. You may complete the additional fields as needed.
    c. **Click the Insert button**. The diagnosis will be added to the Diagnosis List.
    d. Type text into the Screening Tools Used and Other General Medical Conditions fields, if applicable.



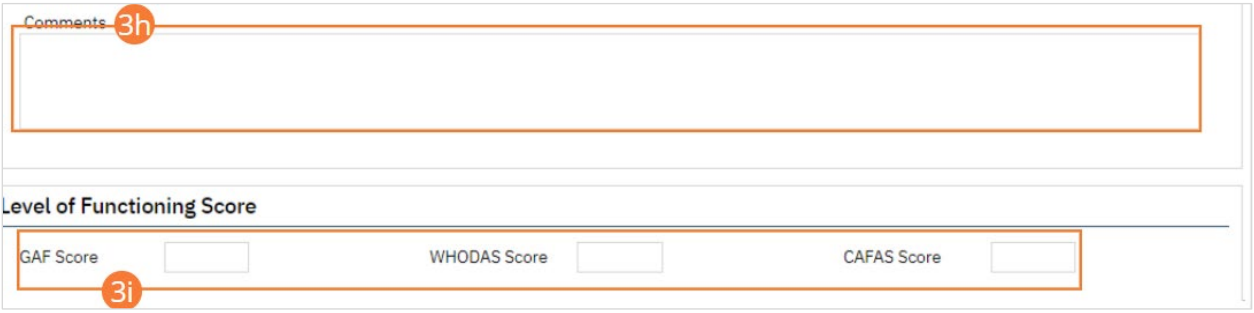
e. In the Psychosocial, Environmental, and Other Factors section, click the Factor Lookup button. A pop-up will appear.



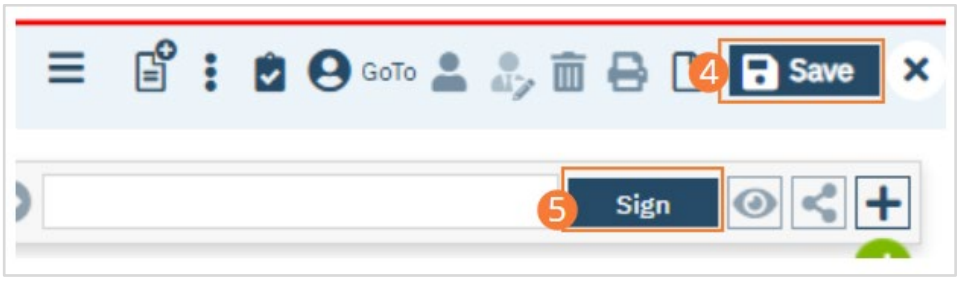
f. Select any or all of the checkboxes that apply.
g. Click the OK button.



h. Enter Comments in the text field.
i. If applicable, enter GAF, WHODAS, or CAFAS scores.



4. Click the Save button.
5. Click Sign and complete signature of the document. For more information, see How to Sign a Document.

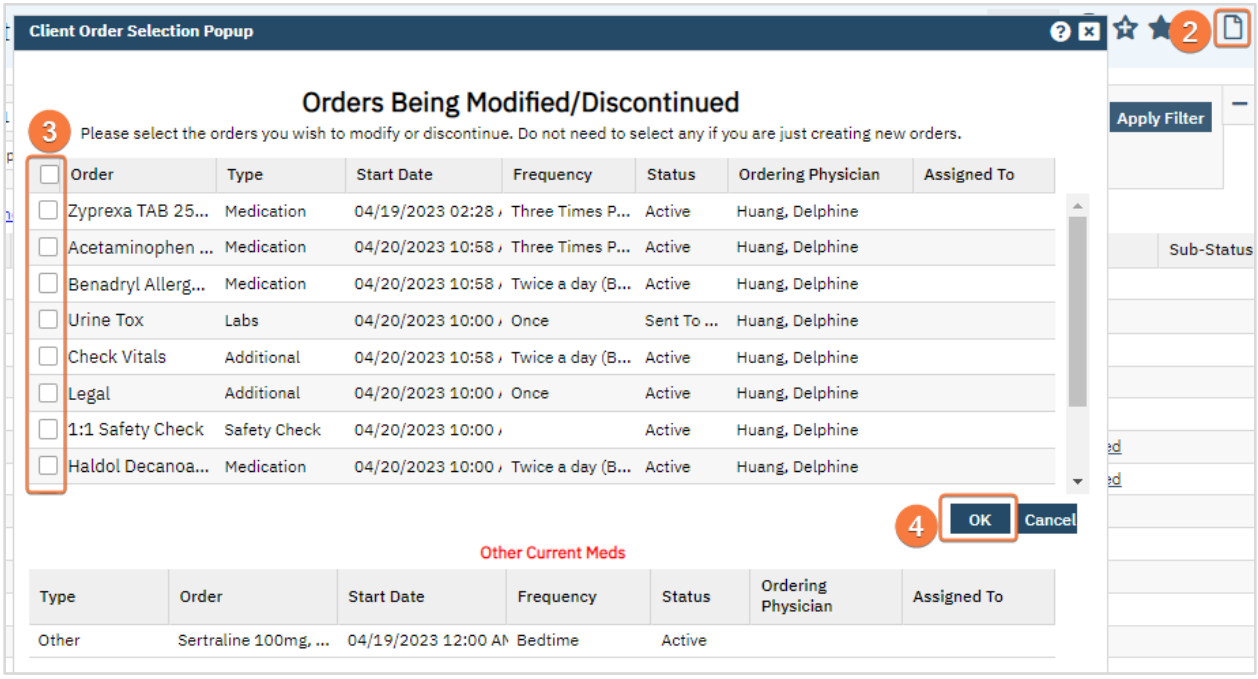


6. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.

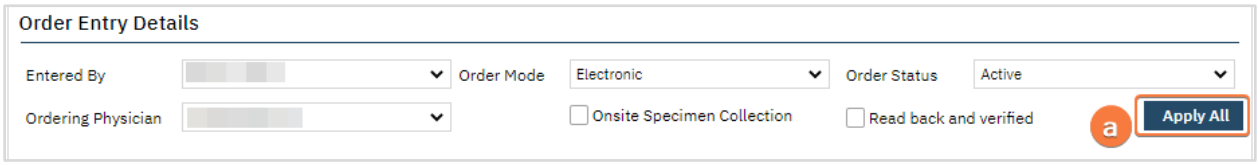
How to Order Discharge Medications

At discharge a client may have medication that should be picked up at a pharmacy, this may include a pharmacy that is onsite. In order to do this the following steps should be followed.

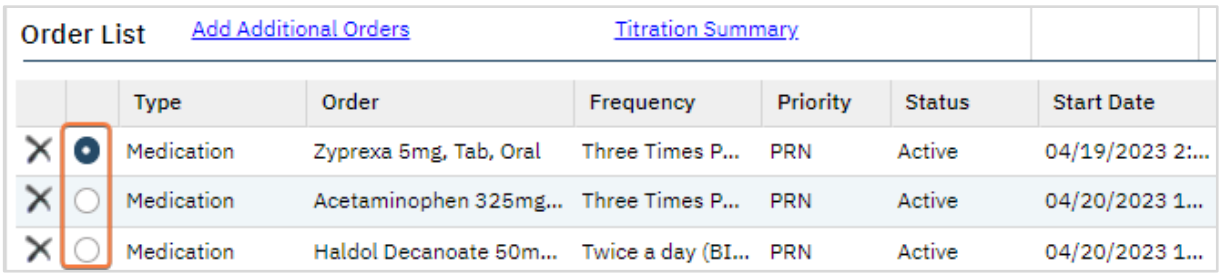
1. Navigate to Client Orders (Client), see How to see Orders for my Active Client section for directions on how to do this.
2. **Click on the New icon.** The Orders Being Modified/Discontinued pop-up window opens.
3. **Select the check box** of the order(s) you want to discontinue.
    a. This can include non-medication orders. However, steps below are specific to Medication orders. For details on discontinuing non-medication orders see Prescriber: How to Discontinue an Order.
    b. Selecting the checkbox next to the Order column header will select all orders.
4. **Click the OK button**. The Client Order document opens.



5. Find the order in the Order List section of the page.
6. **Update fields in Order Entry Details** as needed.
    a. **Click Apply All** if changes were made.

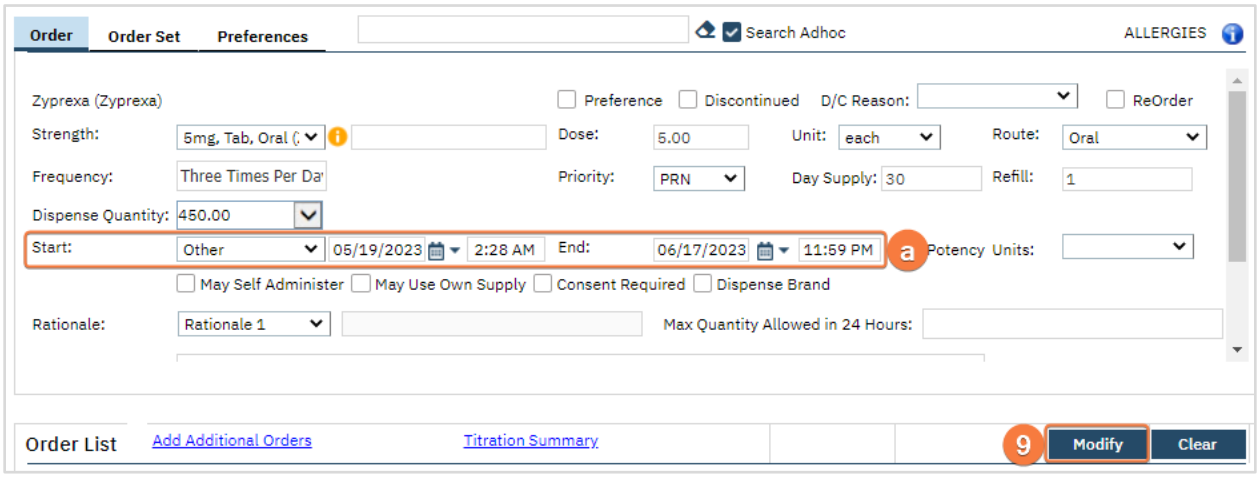


7. In Order List, **click the radio button** on the line of the order you want to discontinue.

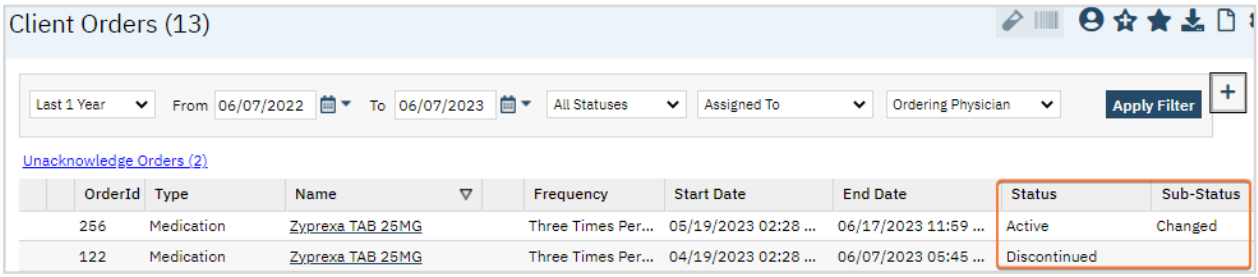


    a. The order information appears in the middle portion of the page.

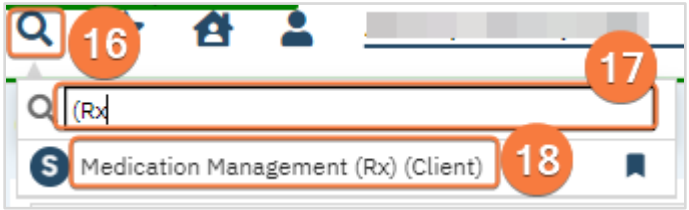
8. **Update needed fields to reflect what would go on script to pharmacy**, e.g. strength, frequency, day supply, etc.
    a. Ensure the Start and End date are updated.
9. **Click the Modify button** to save your changes.



10. **Click the Save button** in the tool bar.
11. Repeat steps 7-9 if discontinuing multiple medication orders.
12. If needed, new orders or order sets, i.e Discharge order can be added at this time.
    a. See How to Document a Discharge Order for details.
13. **Sign the Order** using the steps found under How to Sign a Document.
    a. When documenting an order on behalf of a Prescriber, the Prescriber must be added as a co-signer and must complete their co-signature. For more information, see How to Co-sign a Document.
14. Once signed, there will be an active order(s) with a start date of the date on the medication and a discontinued order of the same medication.
    a. The list page will show a Changed sub-status on the active order.



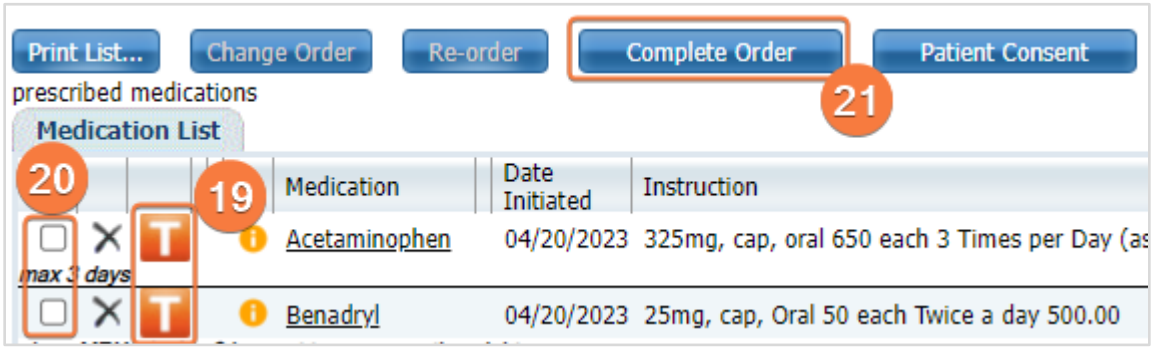
15. To send the order to the pharmacy the order needs to be completed in Rx.
16. **Click the Search icon**.
17. **Type Medication Management (Rx) (Client)** into the search.
    a. Only three characters are needed for options to display.
18. **Select Medication Management (Rx) (Client)**.



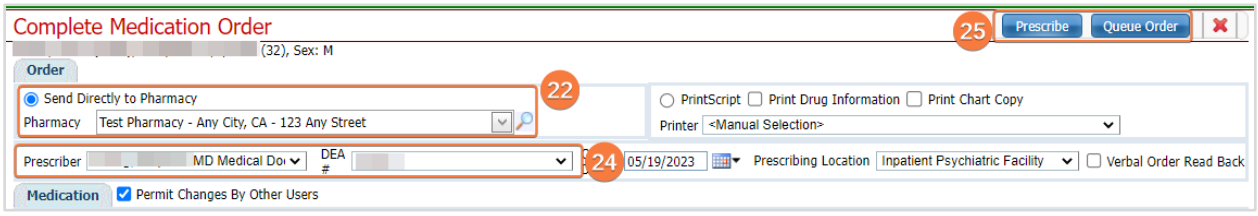
    a. Rx > Patient Summary Page will open. This is actually another window.
19. In the Medication List section you will see medications that have been ordered through Client Orders, the icon is an orange box with a white 'T'.

a. You may also see other medications listed here, these could have been prescribed through an outpatient provider or medication they are taking from a prescriber outside of the agency.

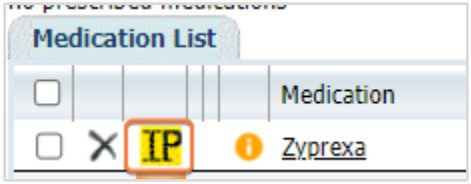
20. **Select the check box(es) next to the Client Order medications** that need to go to the pharmacy.
21. **Click the Complete Order button**; this will open the Complete Medication Order screen.
    a. Note: Complete Order button only becomes active when a Client Order medication is selected.



22. Ensure you are sending to the correct pharmacy; Pharmacy field.
23. If any changes need to be made do so.
24. Note: Prescriber field will have the Ordering Physician from the order.
25. **Click Prescribe or Queue Order** based on your program's workflow.
    a. Queued orders will only go to the pharmacy after the prescriber has approved them.

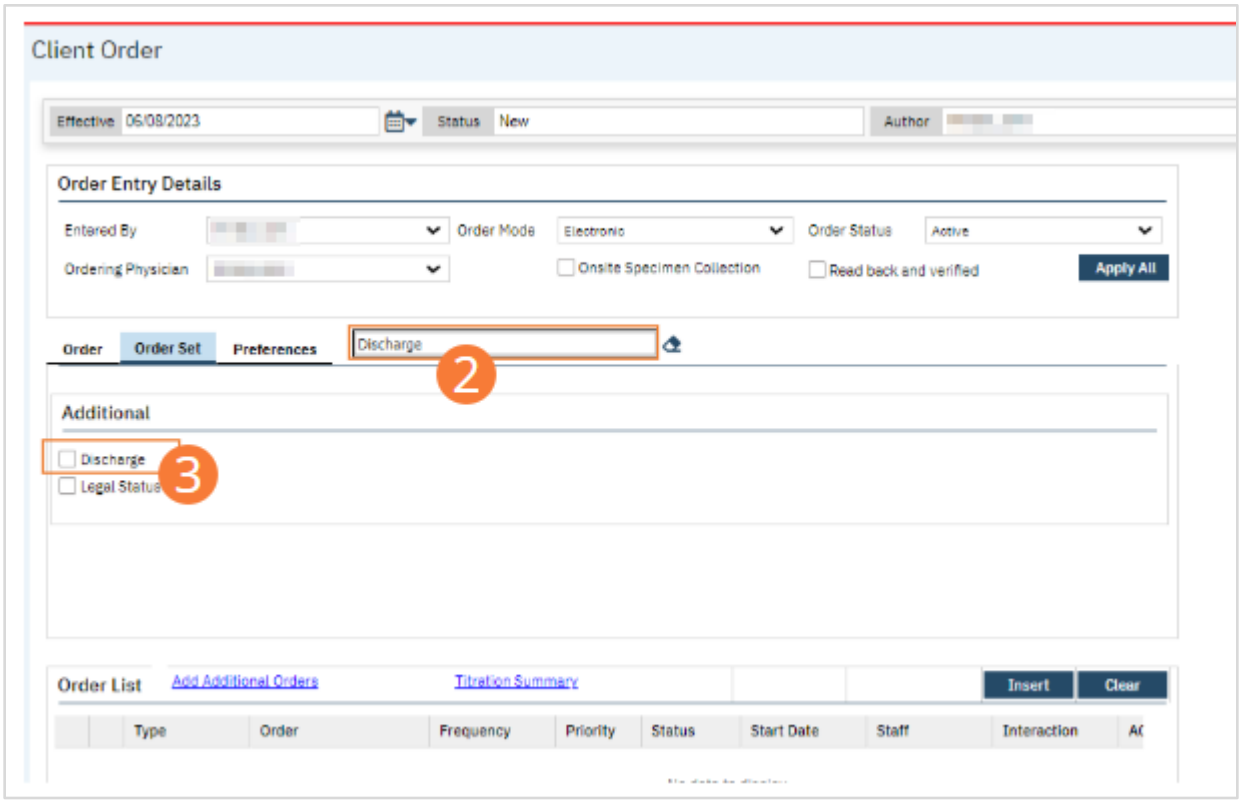


26. For more details on prescribing and other Rx features please see the Prescriber User Guide or Prescriber Video Guides in https://2023.calmhsa.org/psychiatry-documentation/.
27. Once the medication order(s) has been sent to the pharmacy, the icon will be a yellow box with black 'IP'.

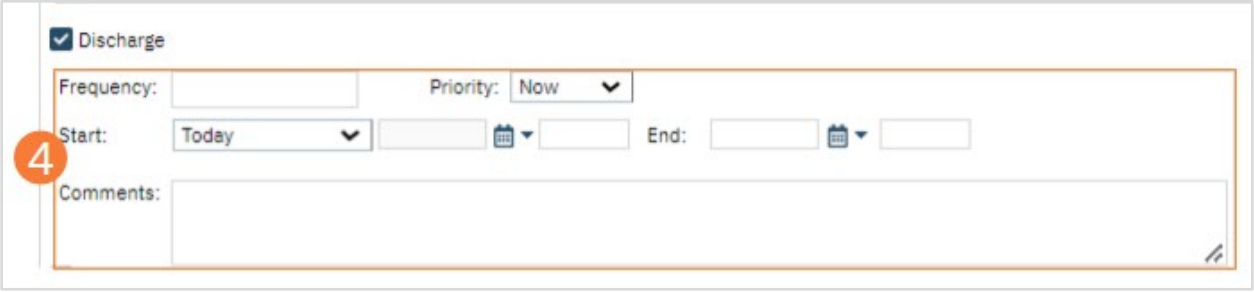


Prescriber: How to Document a Discharge Order

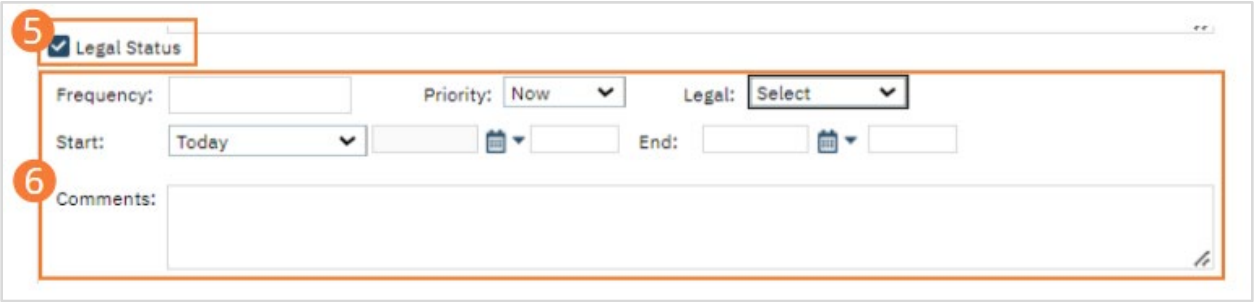
1. **Create a New Order,** using the steps under Order Sets.
2. When selecting the Order Set, **select Discharge as the Order type.**
3. **Click the checkbox next to the Discharge order.**



4. Complete all required fields for the Discharge order.
    a) Set Frequency to "Once" in the dropdown. Other fields are optional.

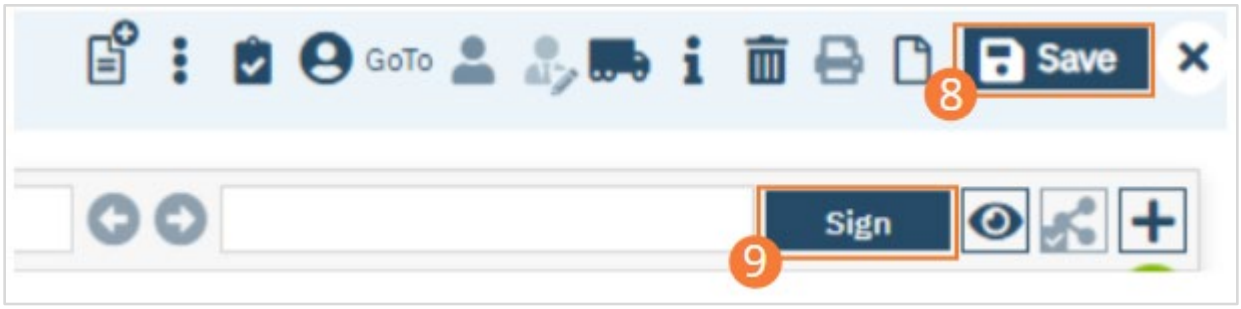


5. Click the checkbox next to the Legal Status order.
6. Complete all required fields for the Legal Status order.
    a) Be sure a status is selected under the Legal dropdown.



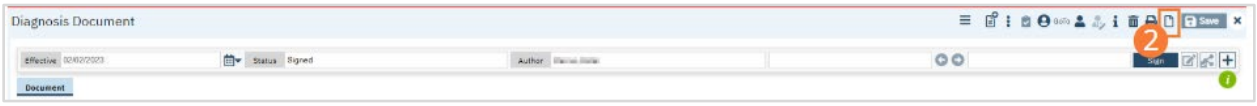
7. Select the Insert button. The Orders will be added to the Order List.

8. Click the Save button.
9. Sign the Orders, following the steps under How to Sign a Document.

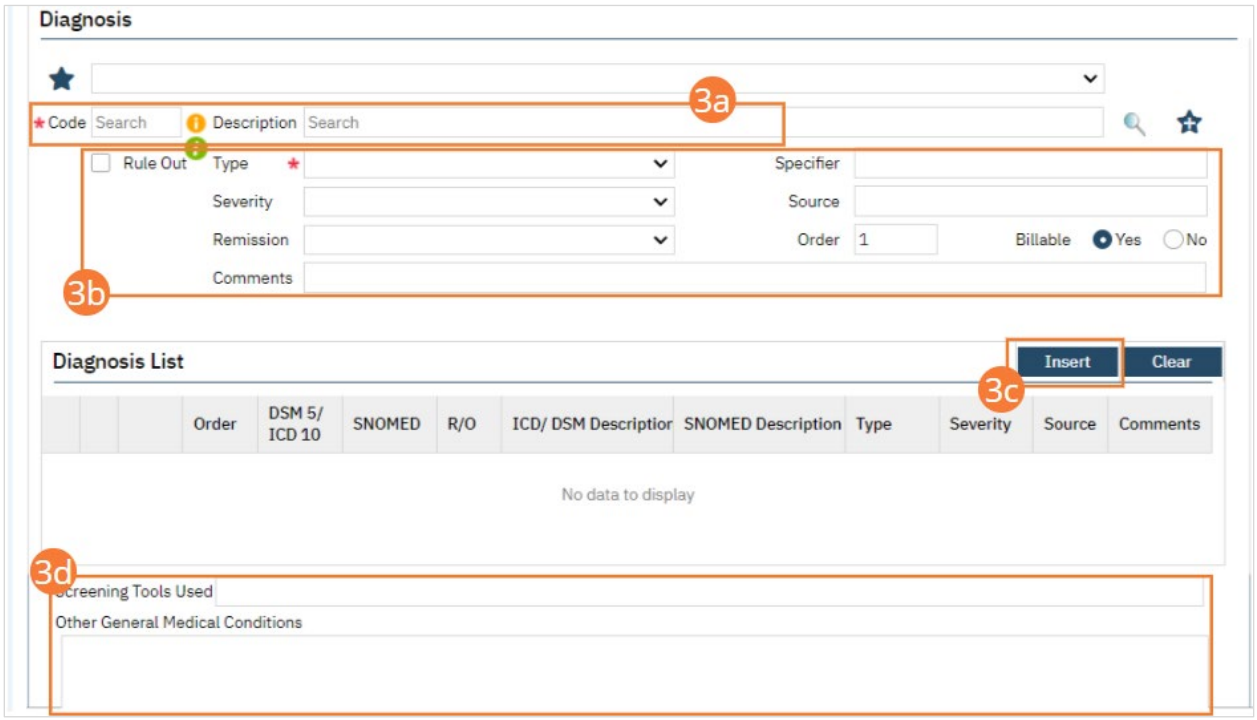


How to Document the Discharge Diagnosis

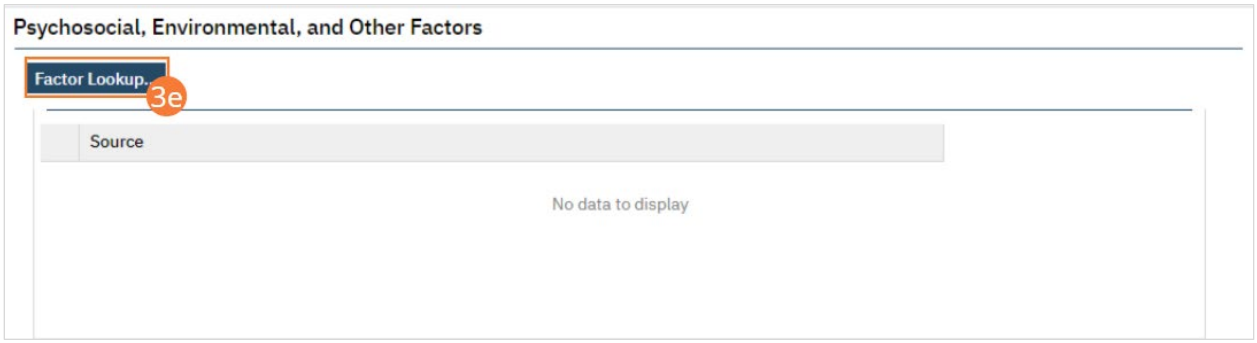
1. Begin on the Diagnosis Document page.
2. Select the New icon. A new Diagnosis Document will open, which will post-date the Admission Diagnosis Document.



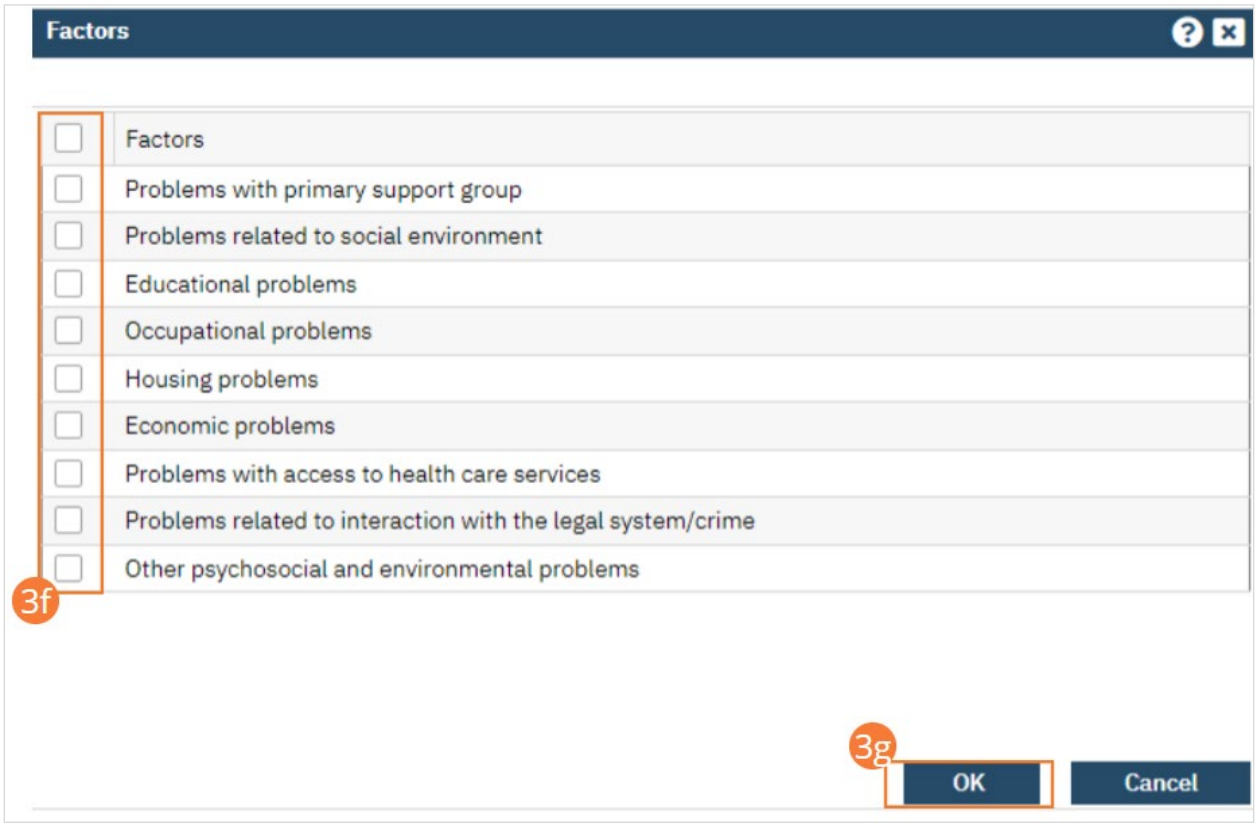
3. Complete required fields.
   a) Search for a diagnosis code or description. Select the chosen diagnosis from the dropdown that appears when you begin entering text. If no diagnosis was determined, select the No Diagnosis checkbox and skip to Step 3e.
   b) Select a Type, Severity, and Remission status from the dropdowns. Enter a specifier and source in the text boxes.The Source should be the Prescriber on whose behalf the document is completed. If desired, change the order numeral, change the Billable radio button, and/or set the diagnosis as a Rule Out by selecting the checkbox.
   c) Click the Insert button. The diagnosis will be added to the Diagnosis List.
   d) Type text into the Screening Tools Used and Other General Medical Conditions fields.



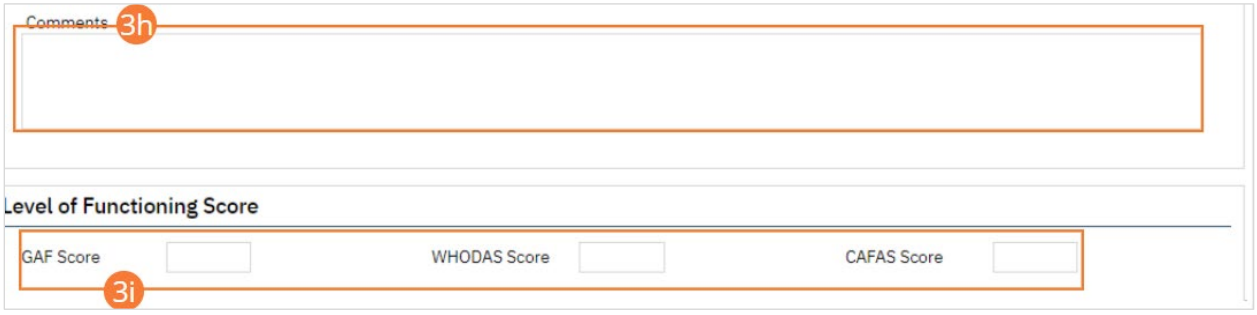
   e) In the Psychosocial, Environmental, and Other Factors section, click the Factor Lookup button. A pop-up will appear.



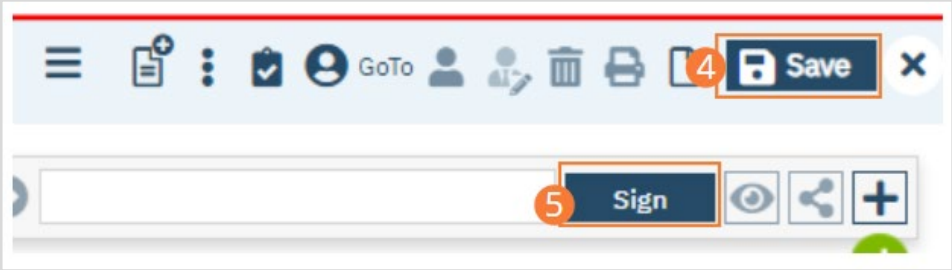
f) Select any or all of the checkboxes that apply.
g) Click the OK button.



h) Enter Comments in the text field.
i) If applicable, enter GAF, WHODAS, or CAFAS scores.



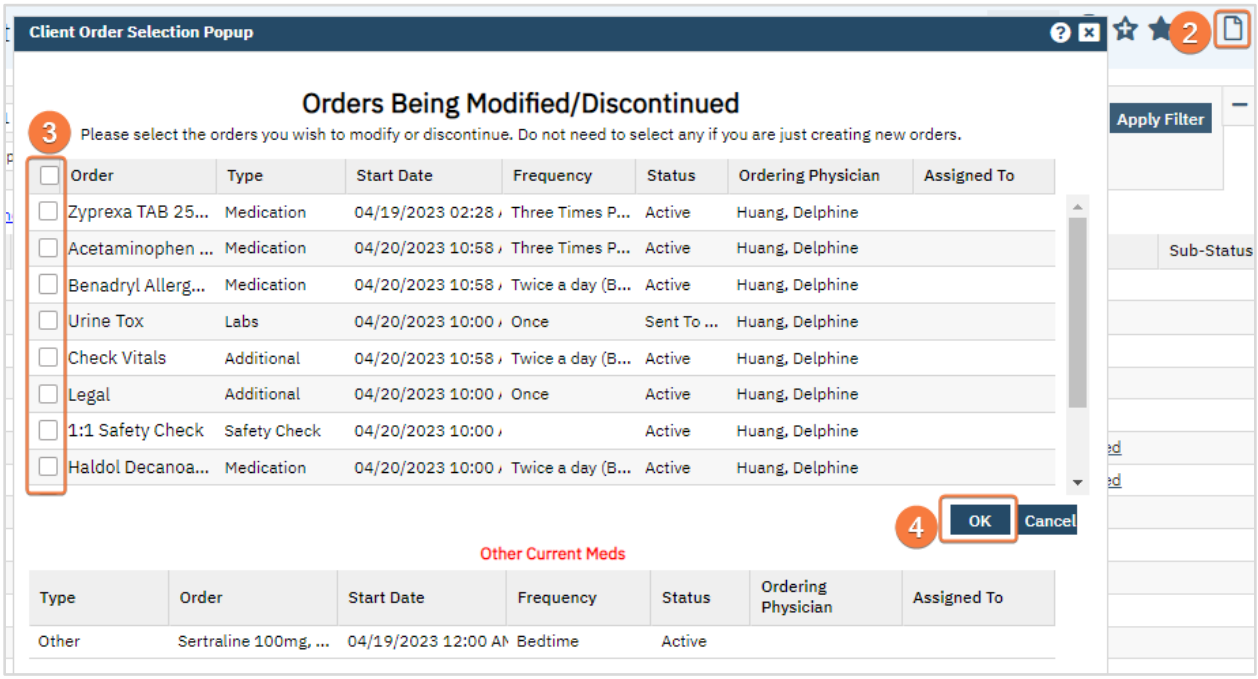
4. Click the Save button.
5. Click Sign and complete signature of the document. For more information, see How to Sign a Document.



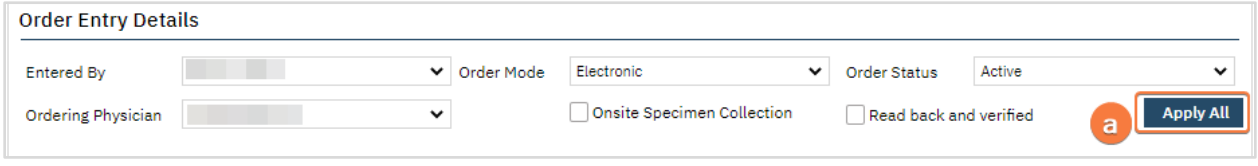
How to Order Discharge Medications

At discharge a client may have medication that should be picked up at a pharmacy, this may include a pharmacy that is onsite. In order to do this the following steps should be followed.

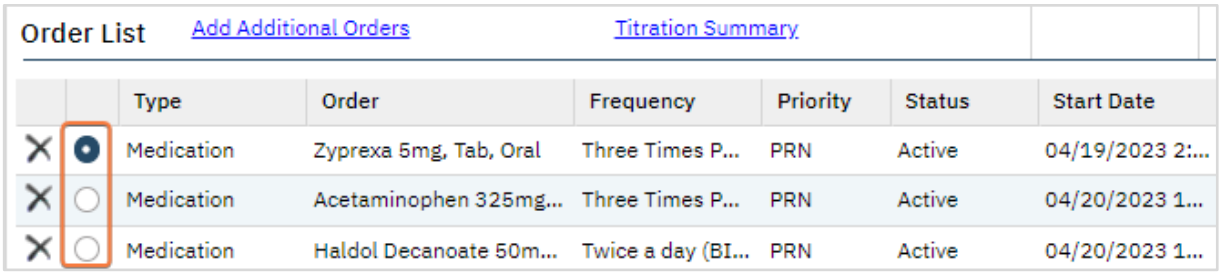
1. Navigate to Client Orders (Client), see How to see Orders for my Active Client section for directions on how to do this.
2. **Click on the New icon.** The Orders Being Modified/Discontinued pop-up window opens.
3. **Select the check box** of the order(s) you want to discontinue.
    a. This can include non-medication orders. However, steps below are specific to Medication orders. For details on discontinuing non-medication orders see Nurse: How to Discontinue an Order.
    b. Selecting the checkbox next to the Order column header will select all orders.
4. **Click the OK button**. The Client Order document opens.



5. Find the order in the Order List section of the page.
6. **Update fields in Order Entry Details** as needed.
    a. **Click Apply All** if changes were made.

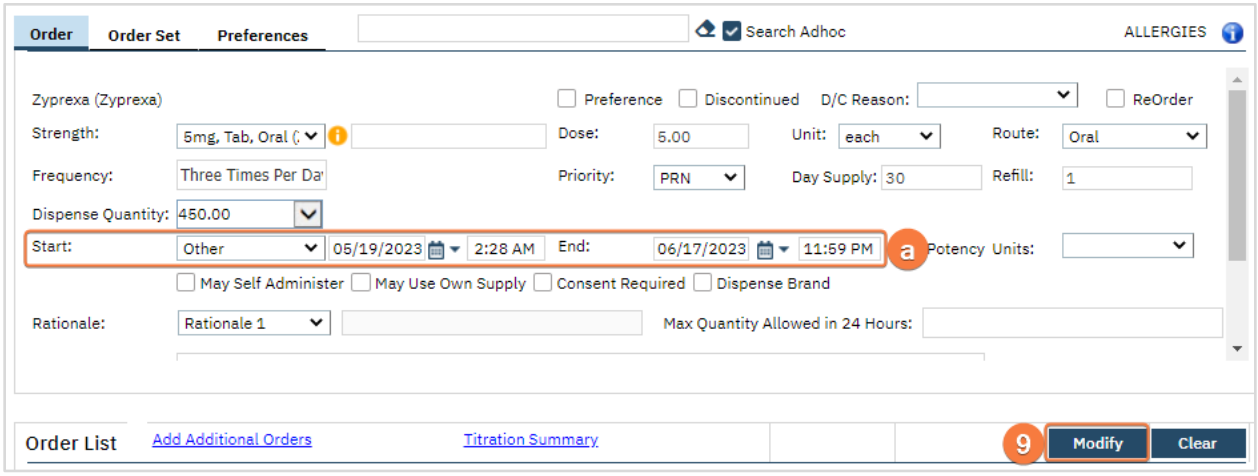


7. In Order List, **click the radio button** on the line of the order you want to discontinue.

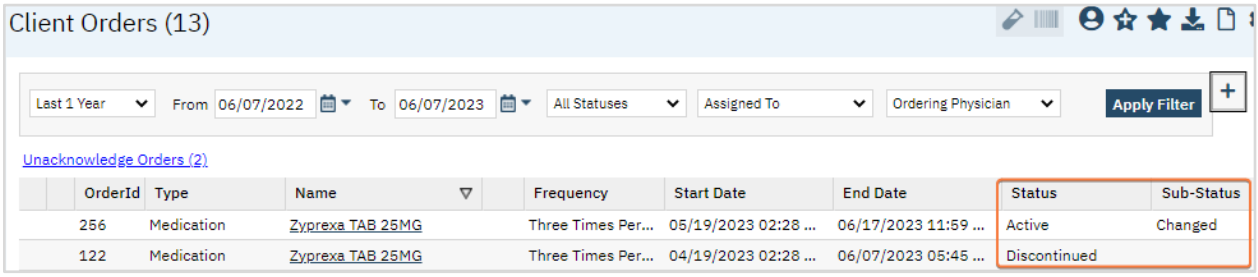


a. The order information appears in the middle portion of the page.

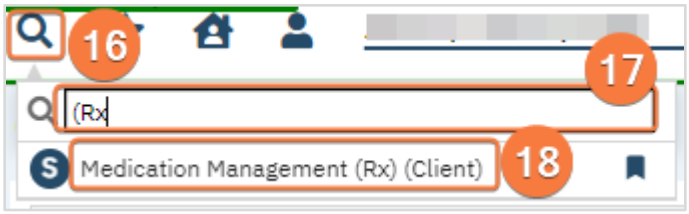
8. **Update needed fields to reflect what would go on script to pharmacy**, e.g. strength, frequency, day supply, etc.
    a. Ensure the Start and End date are updated.
9. **Click the Modify button** to save your changes.



10. **Click the Save button** in the tool bar.
11. Repeat steps 7-9 if discontinuing multiple medication orders.
12. If needed, new orders or order sets, i.e. Discharge order can be added at this time.
    a. See How to Document a Discharge Order for details.
13. **Sign the Order** using the steps found under How to Sign a Document.
14. Once signed, there will be an active order(s) with a start date of the date on the medication and a discontinued order of the same medication.
    a. The list page will show a Changed sub-status on the active order.

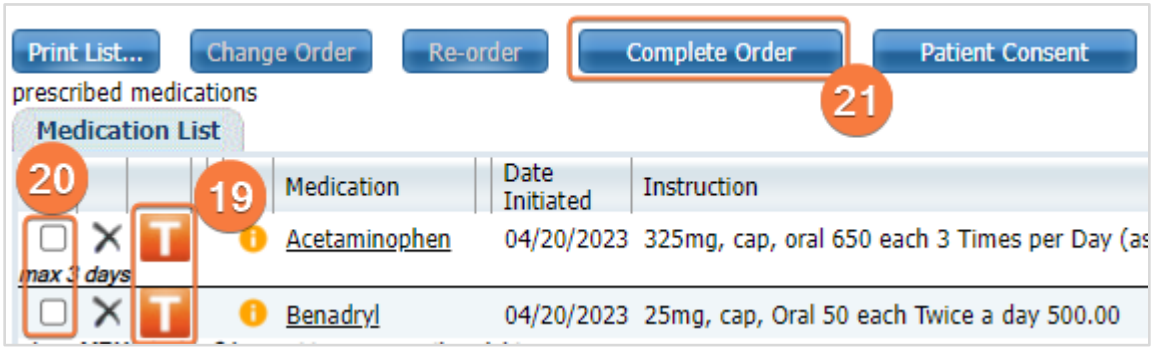


15. To send the order to the pharmacy the order needs to be completed in Rx.
16. **Click the Search icon**.
17. **Type Medication Management (Rx) (Client)** into the search.
    a. Only three characters are needed for options to display.
18. **Select Medication Management (Rx) (Client)**.

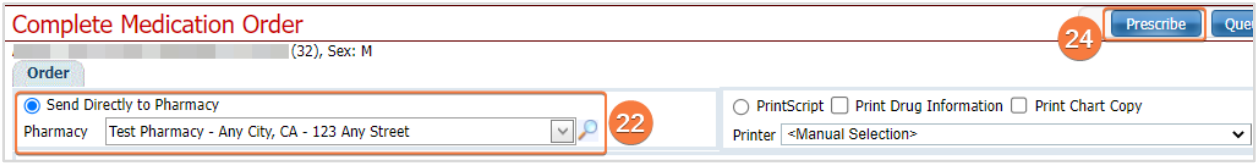


a. Rx > Patient Summary Page will open. This is actually another window.

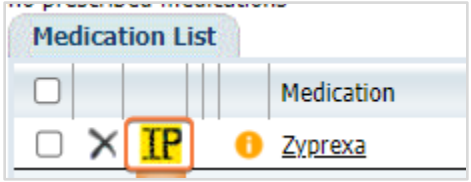
19. In the Medication List section you will see medications that have been ordered through Client Orders, the icon is an orange box with a white 'T'.
    a. You may also see other medications listed here, these could have been prescribed through an outpatient provider or medication they are taking from a prescriber outside of the agency.
20. **Select the check box(es) next to the Client Order medications** that need to go to the pharmacy.
21. **Click the Complete Order button**; this will open the Complete Medication Order screen.
    a. Note: Complete Order button only becomes active when a Client Order medication is selected.



22. Ensure you are sending to the correct pharmacy; Pharmacy field.
23. If any changes need to be made, do so.
24. **Click the Prescribe button**.



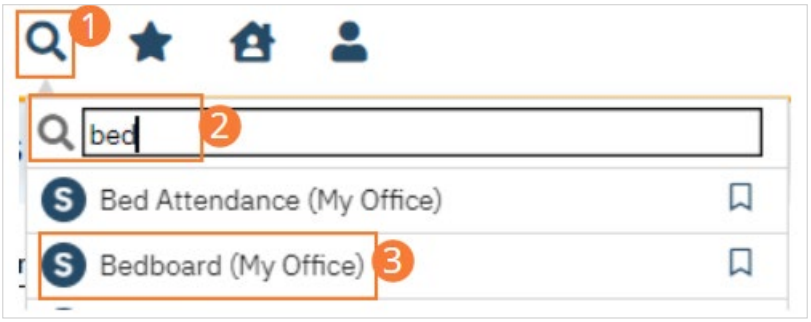
25. For more details on prescribing and other Rx features please see the Prescriber User Guide or Prescriber Video Guides in https://2023.calmhsa.org/psychiatry-documentation/.
26. Once the medication order(s) has been sent to the pharmacy, the icon will be a yellow box with black 'IP'.



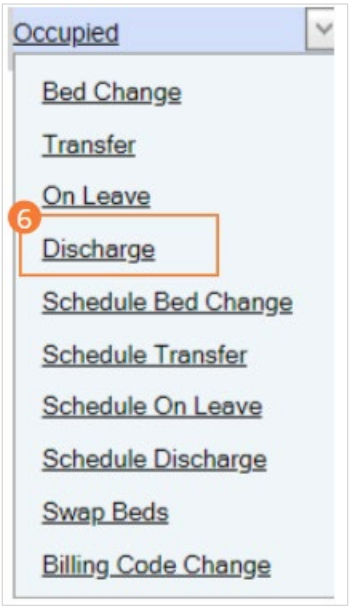
How to Discharge the Client from the Unit and Bed

These steps can be performed from the Bedboard or the Residential/Bed Census page. When performing this action, the client's status will change to Discharged with relation to the Unit and Bed, and SmartCare will also automatically discharge them from the Program.

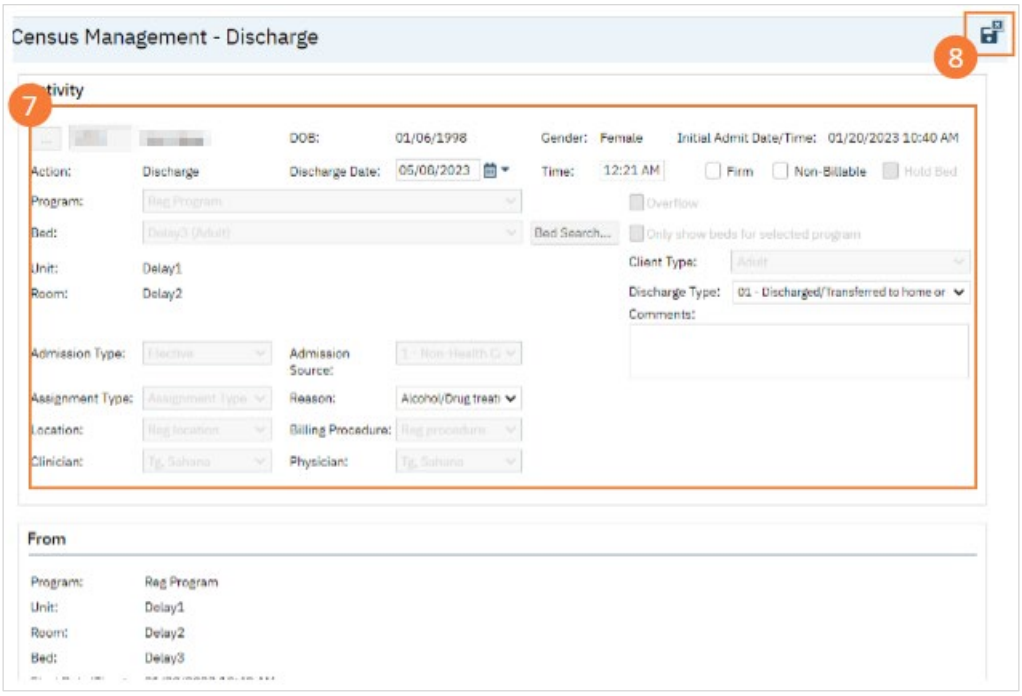
1. **Click the Search icon**.
2. **Type 'Bedboard'** into the search bar. (Or, 'Residential'.)
3. **Click to select Bedboard (My Office).** [Or, Residential (My Office)].



4. If desired, **filter the list** to determine the records that are shown.
5. Find the client you want to discharge. Note: You can only discharge a patient with a status of Occupied or On Leave.
6. **Click the drop-down arrow in the Status column of the client you want to discharge and select Discharge**. The Census Management - Discharge screen opens.



7. **Complete the required and necessary fields** on the Census Management - Discharge screen. Be sure to select the Discharge Type.
8. When the screen is complete, **click the Save and Close button** in the tool bar. The Bedboard list page opens. The client's record now lists a status of Discharged.

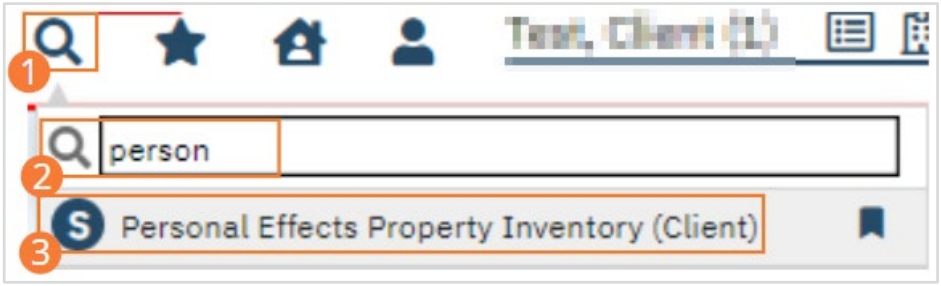


9. Discharging a client from the bed will also discharge the client from the program.

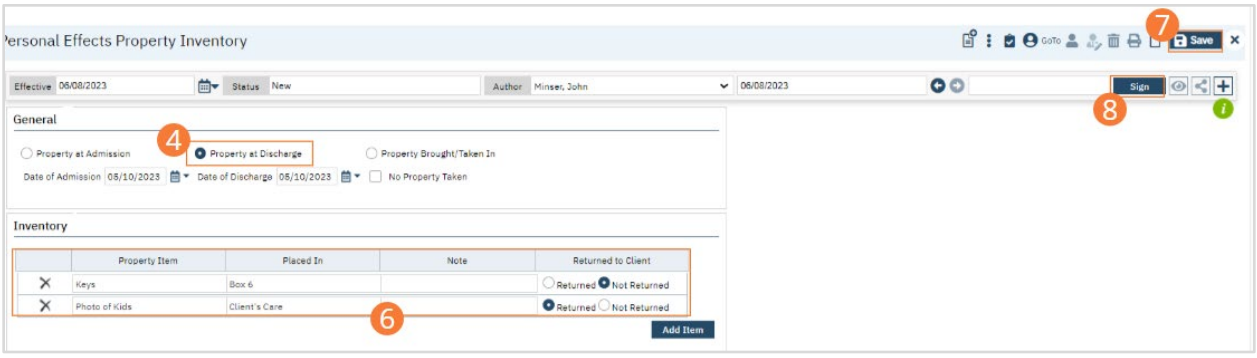
How to Complete the Personal Effects Inventory at Discharge

The PEI at admission represents a record of belongings kept by the organization, as well as a record of belongings returned to the client during their admission. It is later referenced during Discharge when items are returned to clients.

1. With an active client selected, **click the Search icon**.
    a. See General Client Search for details on opening the active client's record.
2. **Type "Personal"** into the search bar.
3. **Click to select Personal Effects Property Inventory (Client).** The PEI list page will open.



4. **Click Property at Discharge.**
5. The Date of Admission will populate, and the Date of Discharge will populate with today's date. If you wish to change these dates, do so now. Items previously recorded upon Admission will also populate. If the client has no property to record, click the No Property Taken checkbox now and skip down to the Save step.
6. **Edit each Item**. Returned property should be marked as Returned. Items discarded or retained may be marked as Not Returned.
7. **Click Save**.
8. **Click Sign** and complete signature of the document. For more information, see How to Sign a Document.

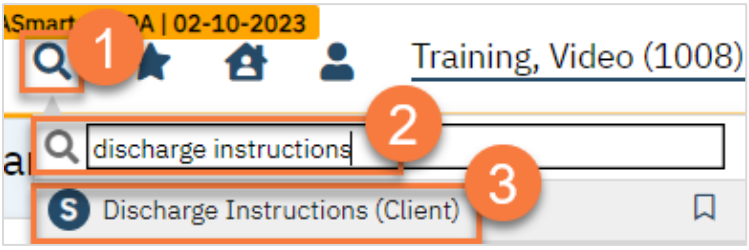


How to Complete the Inpatient Coding Document

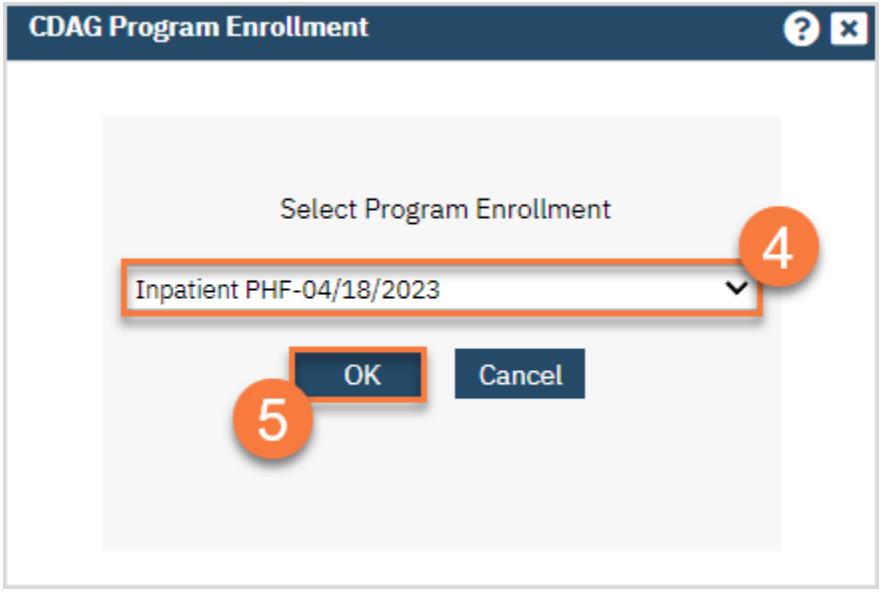
Under Construction

How to Complete the Discharge Instructions

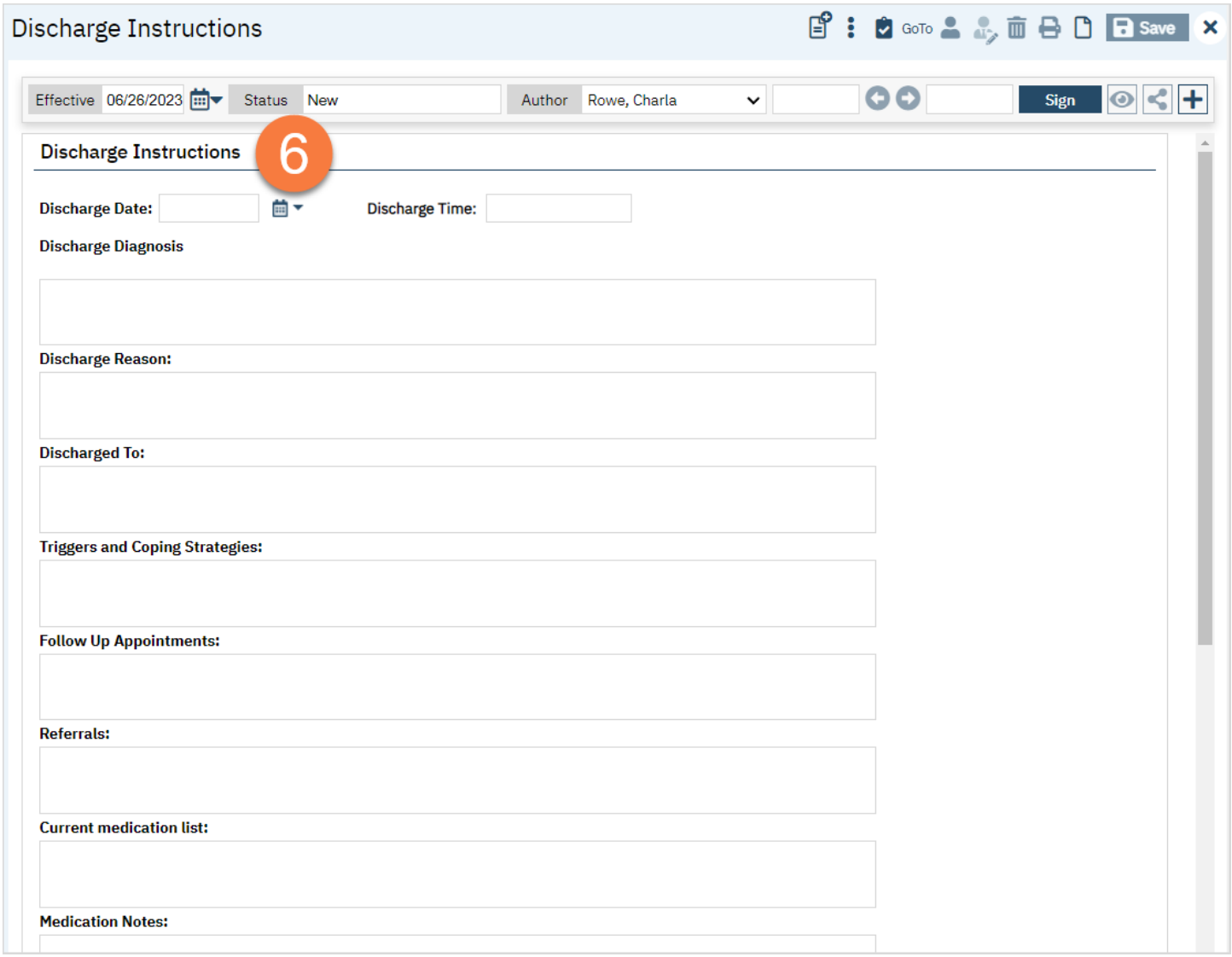
1. With the client open, **click the search icon**.
2. **Type in "Discharge Instructions"** in the search bar.
3. **Select "Discharge Instructions (Client)"** from the search results.



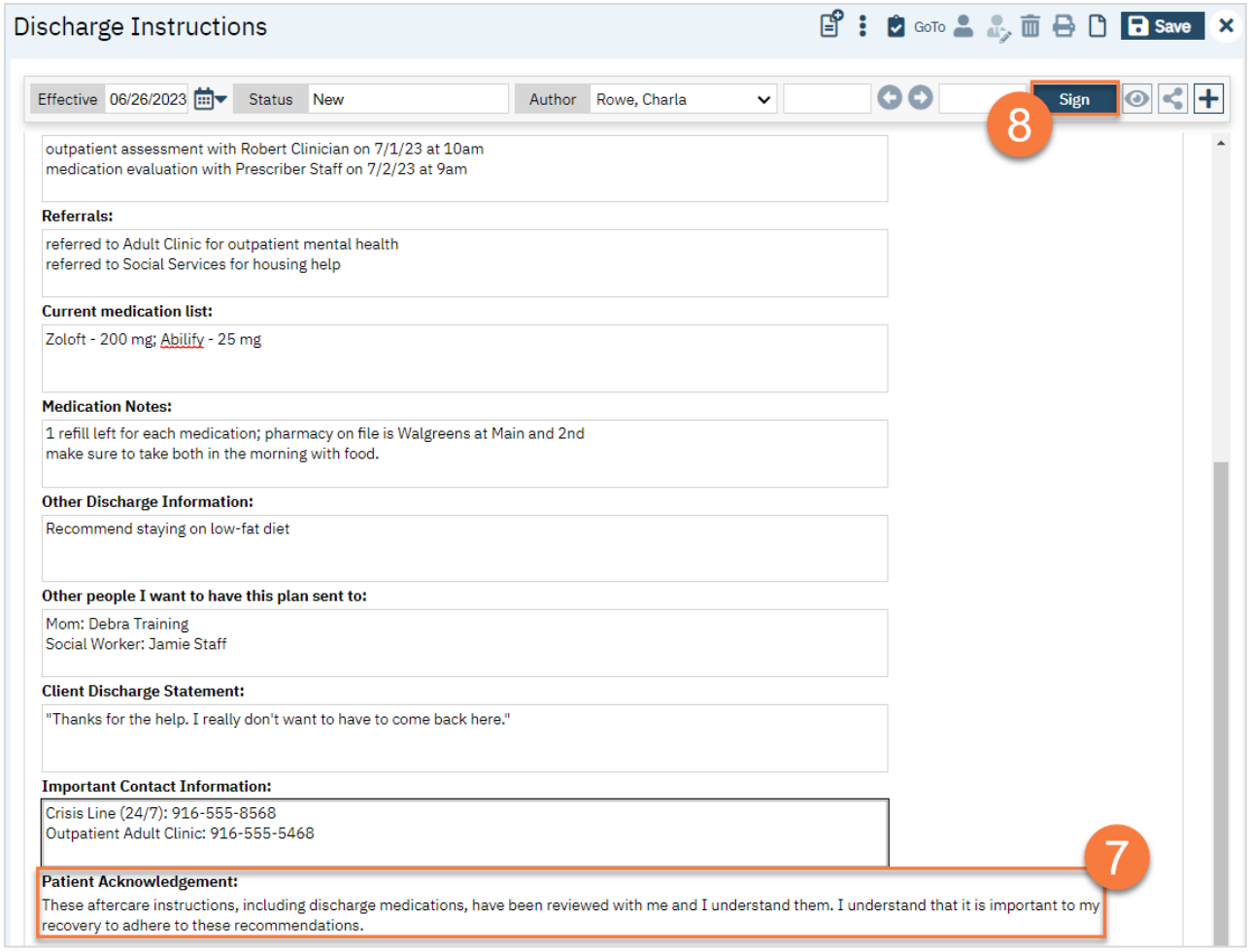
4. This brings up a CDAG window. **Select the program** this document is associated with.
5. **Click OK**.



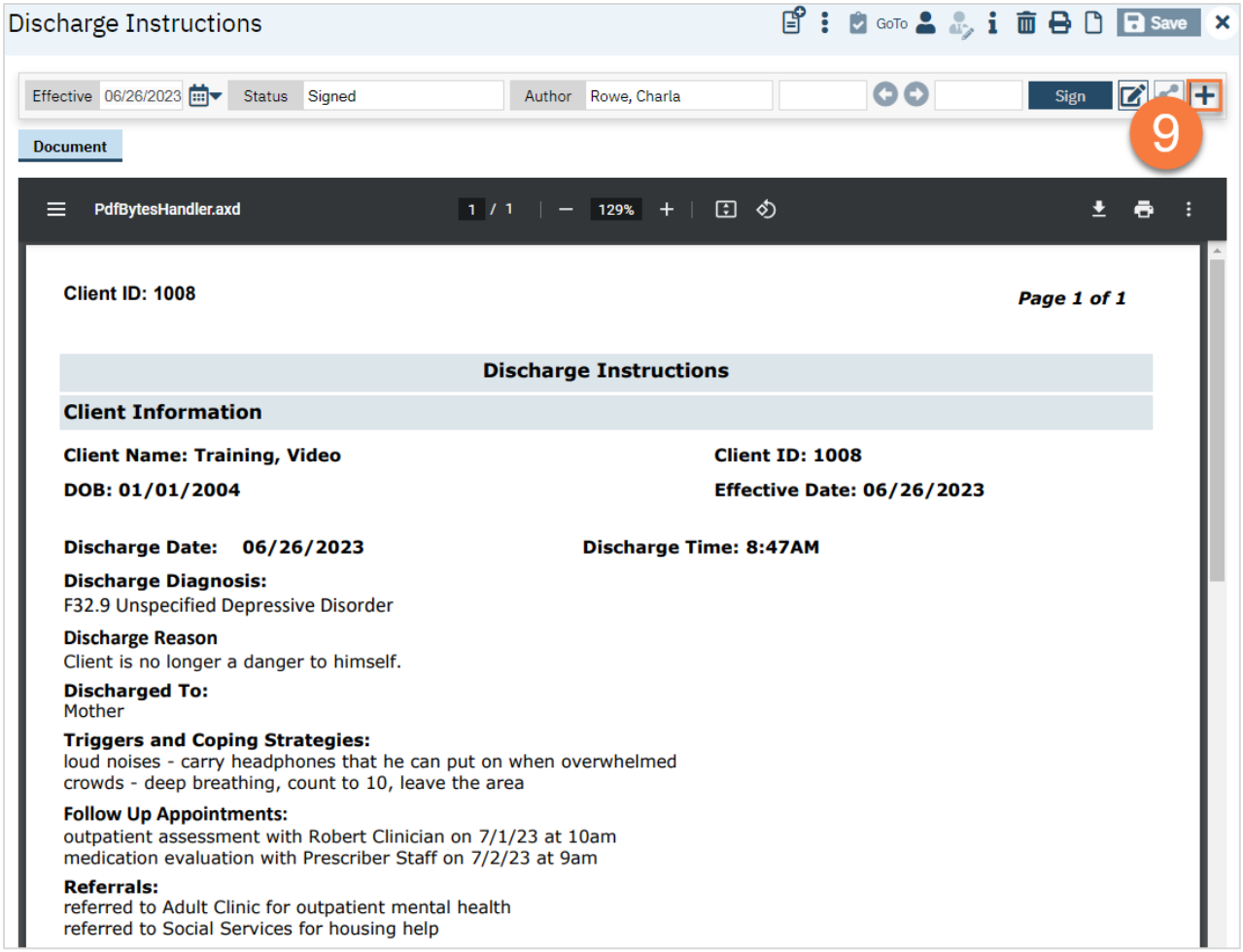
6. This brings up the document. **Fill out the document with the appropriate clinical information**.



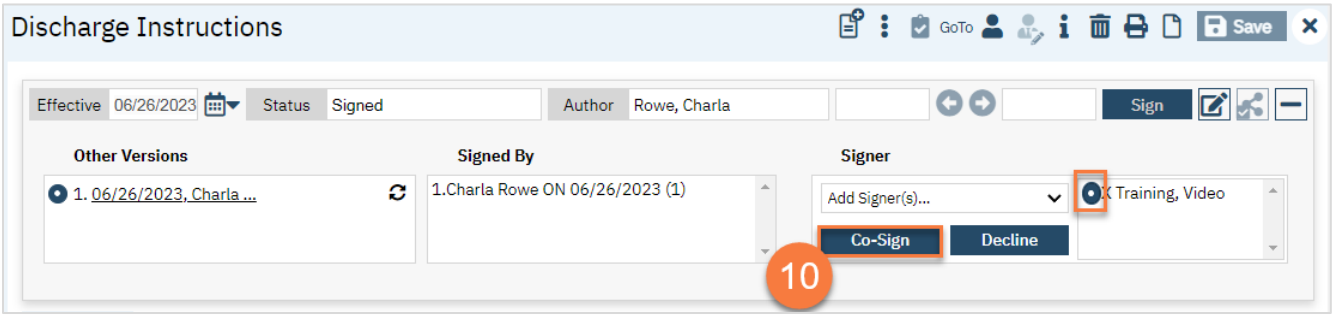
7. At the bottom of the document is an acknowledgement statement.
8. Once finished, **click Sign**. This will populate the pdf.



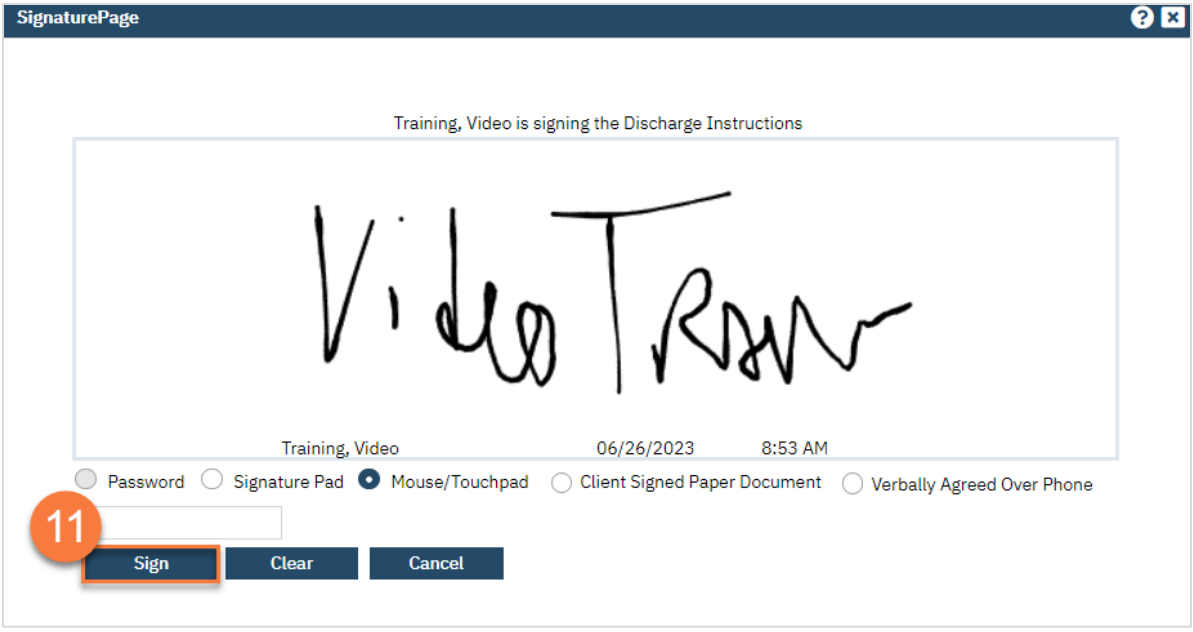
9. Click the Plus icon to expand the document ribbon.



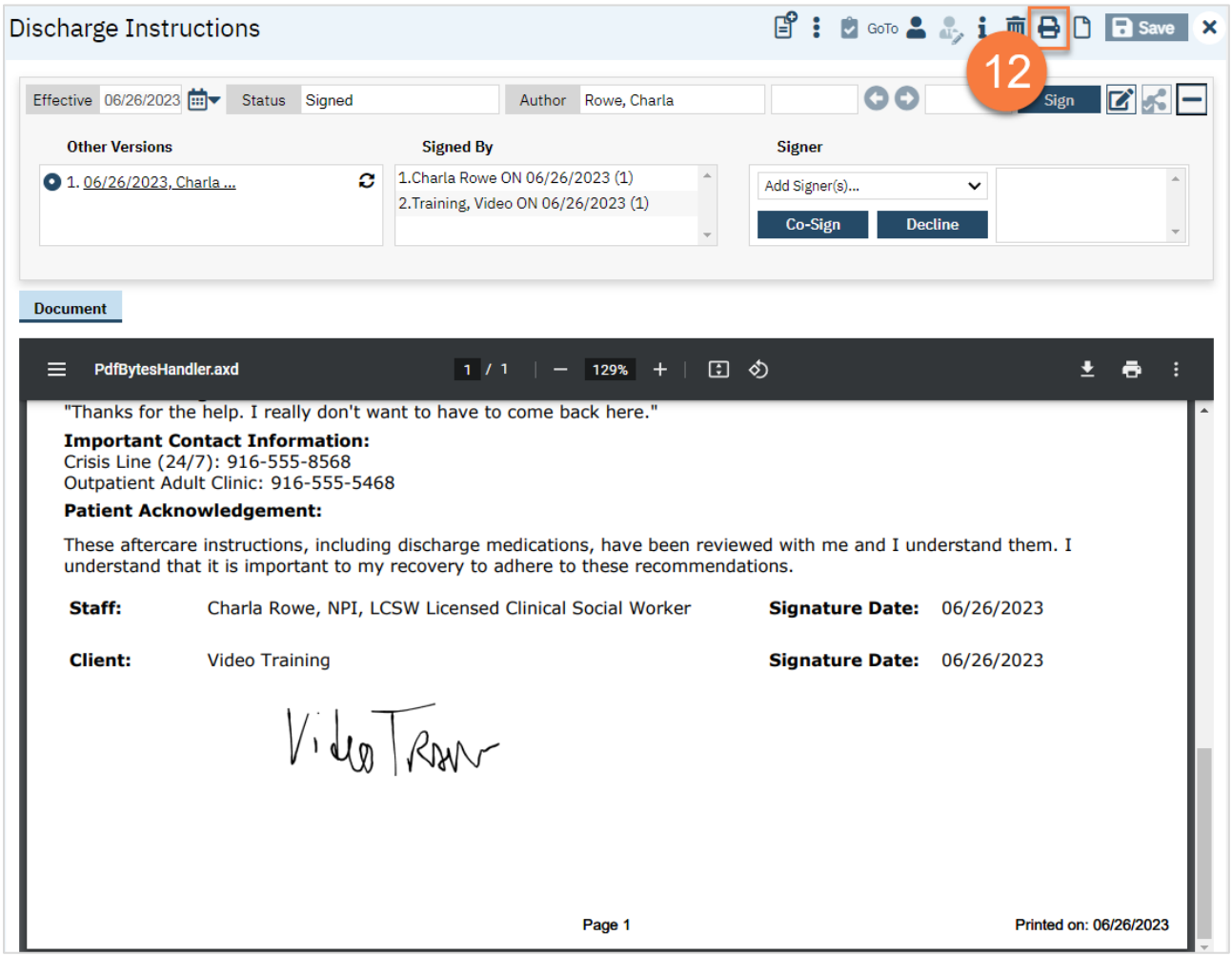
10. The client is automatically added as a cosigner. Select the client and click Cosign.



11. This brings up the signature window. Document the client's signature and click Sign.

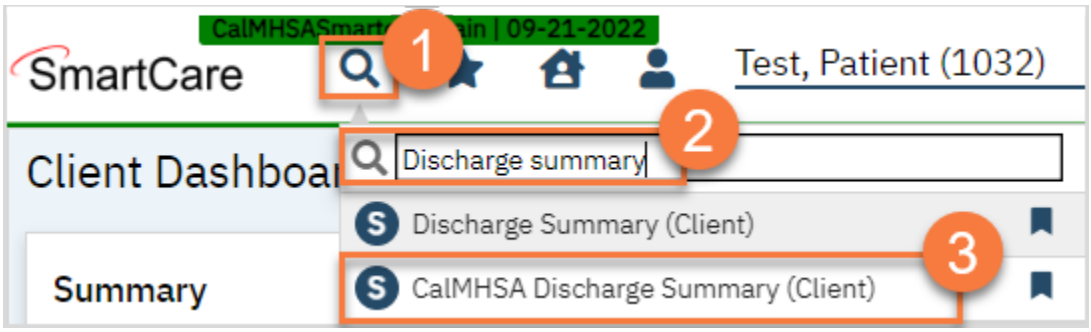


12. This adds the client's signature to the bottom of the document. To print this out for the client, **click the Print icon**.

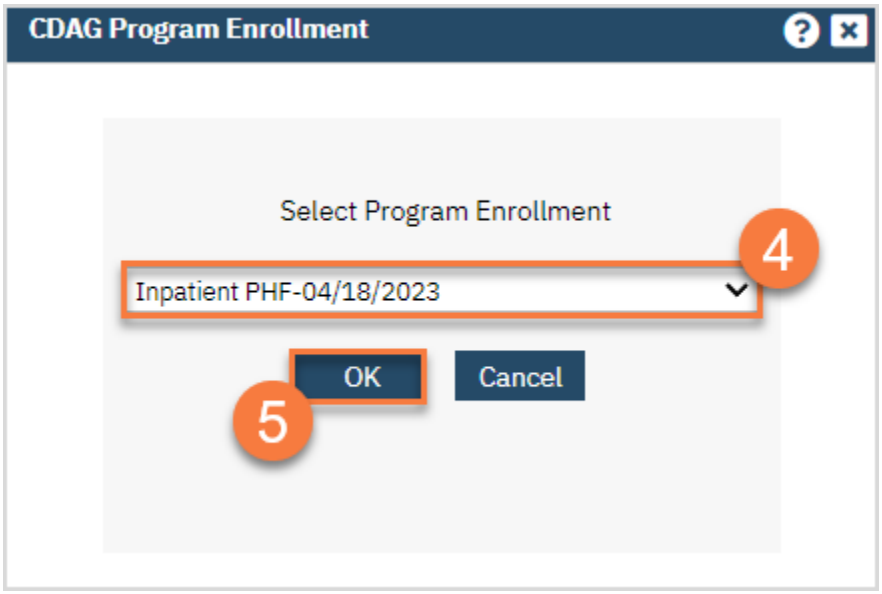


How to Complete the Discharge Summary

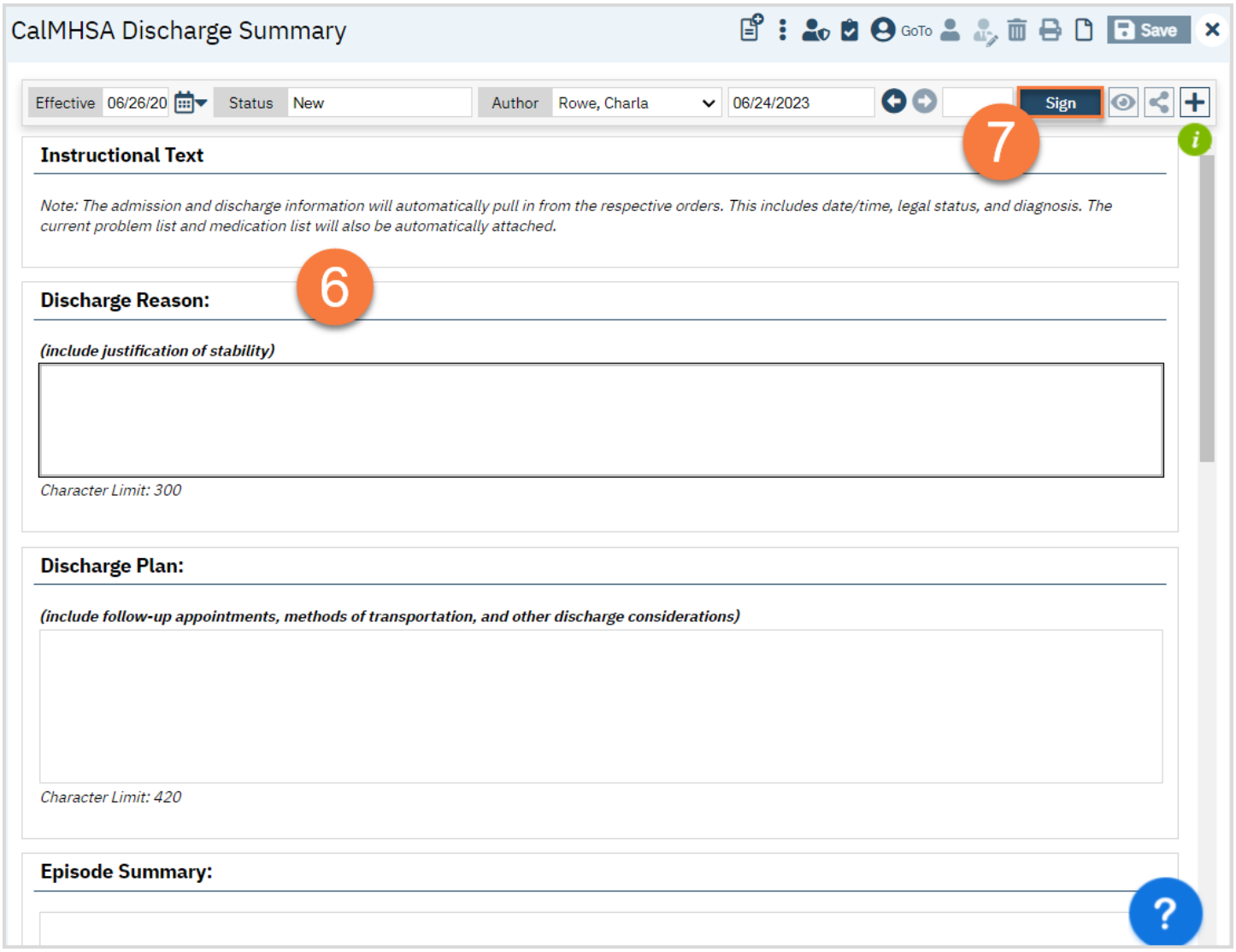
1. With the client open, **click the search icon**.
2. **Type in "CalMHSA Discharge Summary"** in the search bar.
3. **Select "CalMHSA Discharge Summary (Client)"** from the search results.



4. This brings up a CDAG window. **Select the program** this document is associated with.
5. **Click OK**.

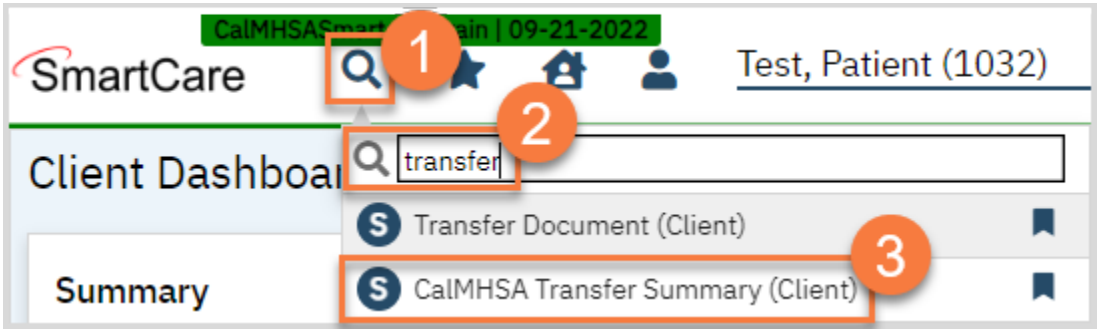


6. This brings up the document. **Fill out the document with the appropriate clinical information**. Note that some basic information will pull into the PDF once signed.
7. When you've finished entering in all the information, **click Sign**. This produces the PDF. You can now close the document.

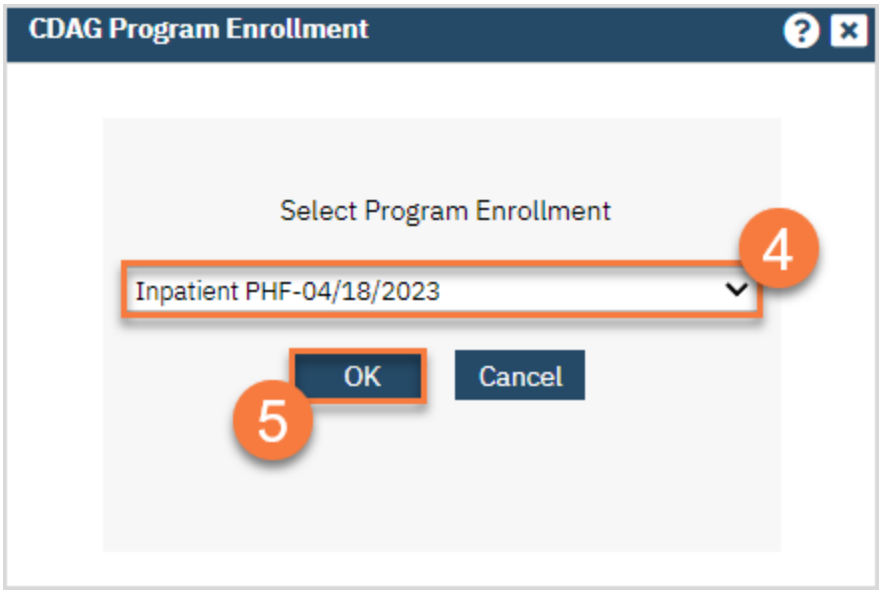


How to Complete the Transfer Summary

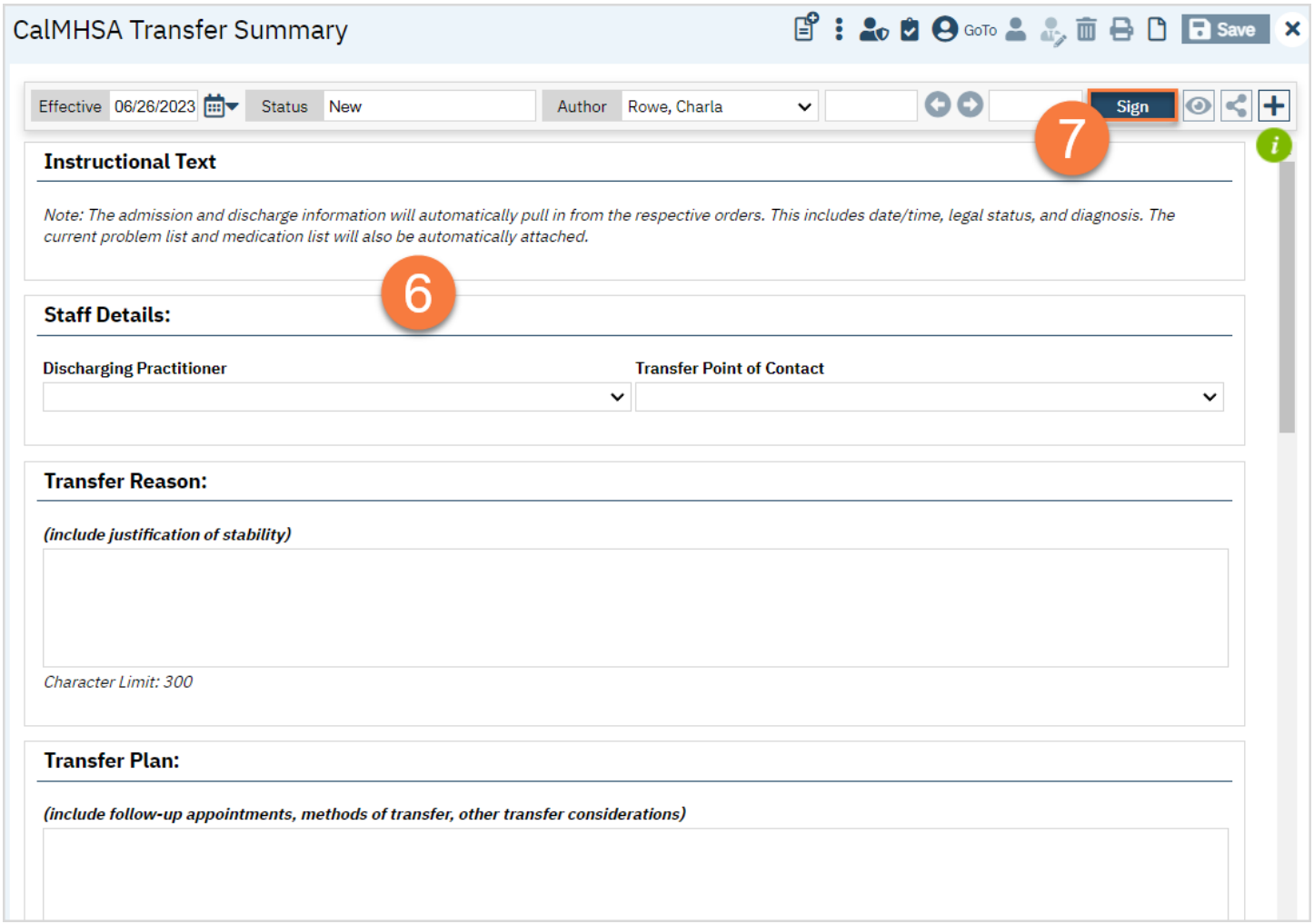
1. With the client open, click the search icon.
2. Type in "CalMHSA Transfer Summary" in the search bar.
3. Select "CalMHSA Transfer Summary (Client)" from the search results.



4. This brings up a CDAG window. Select the program this document is associated with.
5. Click OK.



6. This brings up the document. **Fill out the document with the appropriate clinical information**. Note that some basic information will pull into the PDF once signed.
7. When you've finished entering in all the information, **click Sign**. This produces the PDF. You can now close the document.



Care Coordination

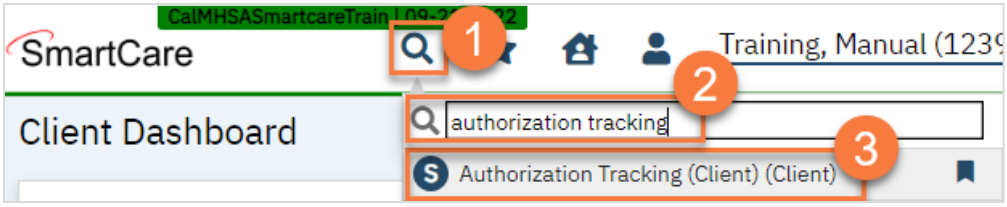
As part of treatment, clients often are seen in multiple programs. In this section, we'll review how to refer to different programs, refer to external agencies, and request authorization.

CalMHSA is working on development that will greatly improve care coordination in SmartCare. For now, this section will include information on how these are addressed currently in SmartCare. Some processes may still occur outside of SmartCare, depending on your county's processes.

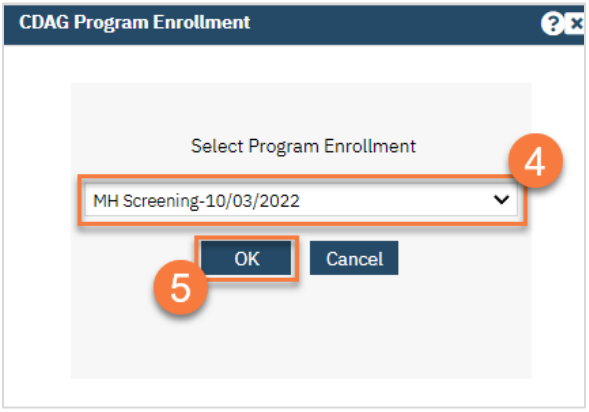
How to Request Authorization for Services

In the future, this will be handled using the Care Coordination module, which is still in development. In the meantime, CalMHSA has created a basic authorization tracking document to track authorization requests.

1. **Click the Search icon**.
2. **Type "Authorization Tracking"** in the search bar.
3. **Select "Authorization Tracking (Client)"** from the search results.



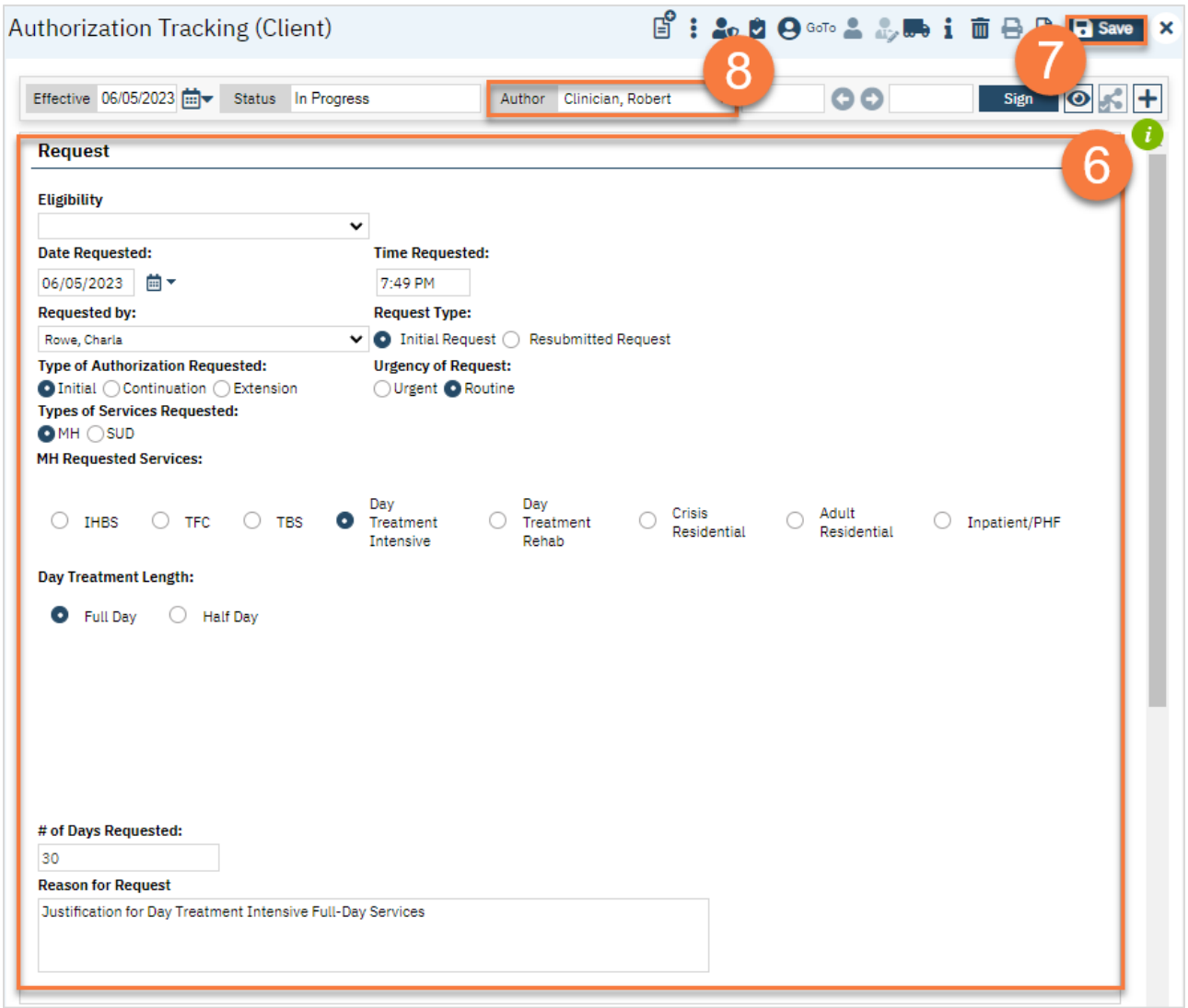
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



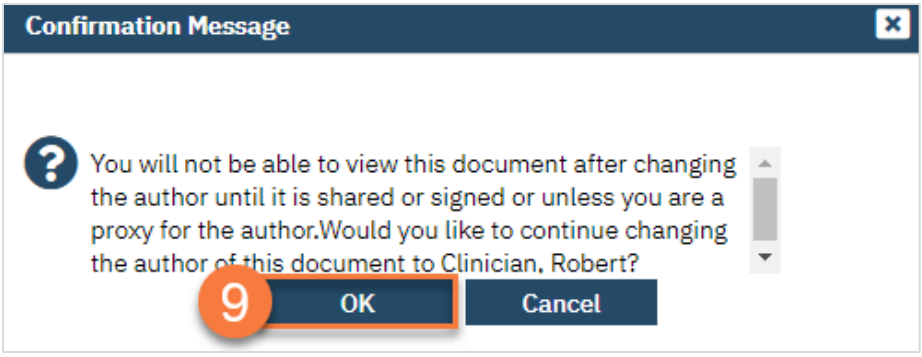
6. This takes you to the Authorization Tracking screen. **Complete the Request section**.
    a. Eligibility – select the client's payor information that this request is under.
    b. Date Requested – This is the date you are requesting this authorization.
    c. Time Requested – This is the time you are requesting this authorization. This is required for urgent requests.
    d. Requested by – Enter your name here.
    e. Request Type – If this is your first time putting in this request, select "Initial Request". If you've previously attempted to request this authorization but it was sent back for corrections or more information, select "Resubmitted Request".
    f. Type of Authorization Requested – Select whether this is an initial request for these services, a request to continue services previously authorized, or whether you're asking for an extension on a current request for services.

g. Urgency of Request – Select whether this request is urgent or routine.
h. Types of Services Requested – Select whether you're requesting Mental Health (MH) or Substance Use Disorder (SUD) services. Making this selection will open up additional options. Select the specific service you're requesting. Some services require additional questions. Example: Day Treatment Services require you to enter whether you're requesting full-day or half-day services.
i. # of Days Requested – Enter the number of days you want this service to be authorized for. Some services may have some limits on the number of days that can be requested. Make sure you know what the regulations around the requested services are.
j. Reason for Request – Enter the reason you're requesting these services. For services that require specific requirements, make sure to include your justification for the client meeting these requirements.

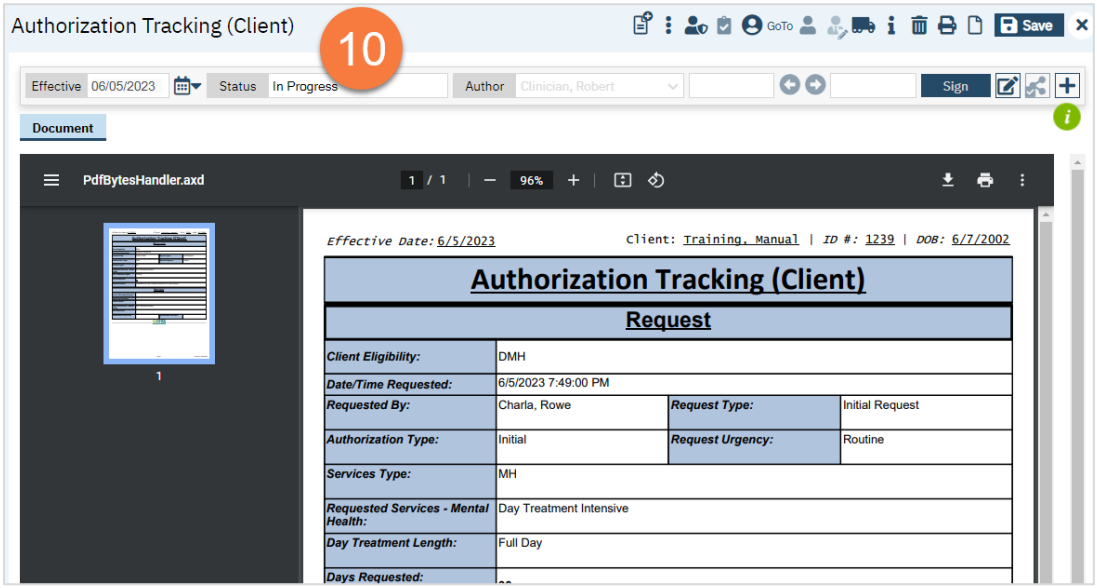
7. Click Save. DO NOT SIGN.
8. Change the Author of the document to whomever reviews these authorization requests for your county. Click on the dropdown in the Author field and select the new author.



9. You will receive a pop-up confirmation window. Please note that after you've changed the author, you won't be able to make edits to this document anymore. Click OK.



10. Now, the document will show as a PDF. You have submitted this authorization request. When the person reviewing the document signs it, you may be required to co-sign, since you were an author of the document at one point.

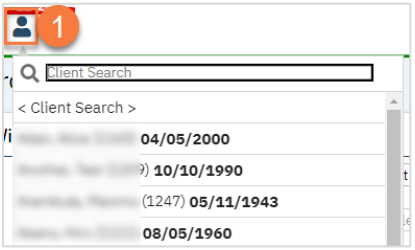


How to Refer to an Additional Program

Depending on your county processes, you may have a specific referral form you use. CalMHSA is currently developing a process called “Care Coordination” which will address referrals both internal and external. However, this process is still in development. We recommend using your current forms for referring to additional programs and services if applicable.

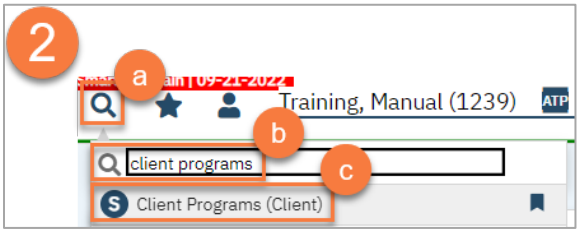
We also recommend using the “Request Program Enrollment” process in SmartCare to track these requests.

1. Open the client’s record, if not already done so. You can do this using the Client Search screen.

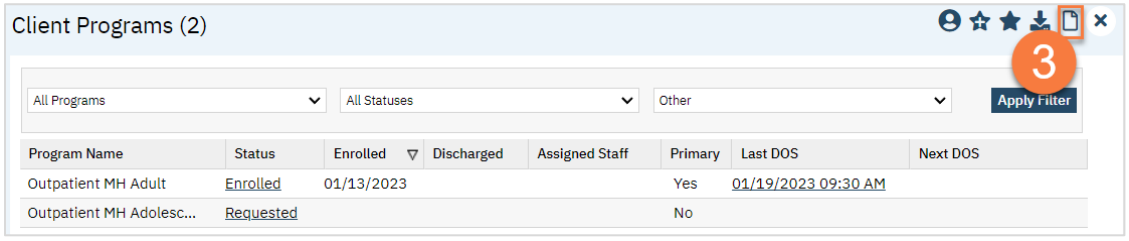


2. Open the Client Programs list page.

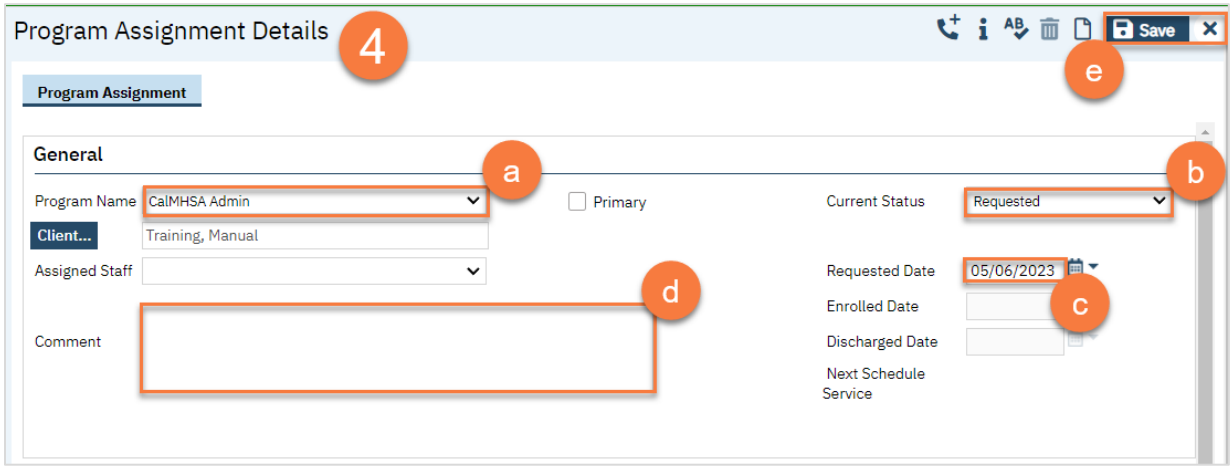
a. **Click the Search icon**.
b. **Type "Client Program"** in the search bar.
c. **Select "Client Programs (Client)"** from the search results.



3. This opens the Client Programs list page**. Click on the New icon**.



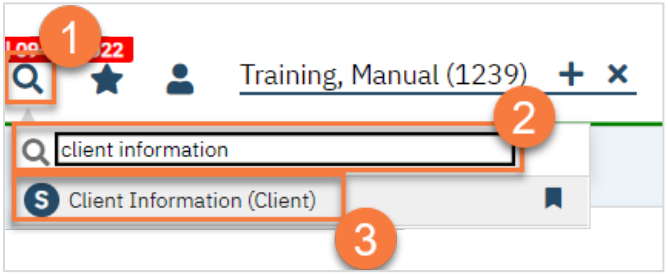
4. Complete the Client Program Details screen.
    a. **Select the program** from the dropdown menu.
    b. **Enter the status of the program as "requested".**
    c. **Enter the requested date.** This will be today's date.
    d. **Enter any comments related to this program request**.
    e. **Click Save and close.**



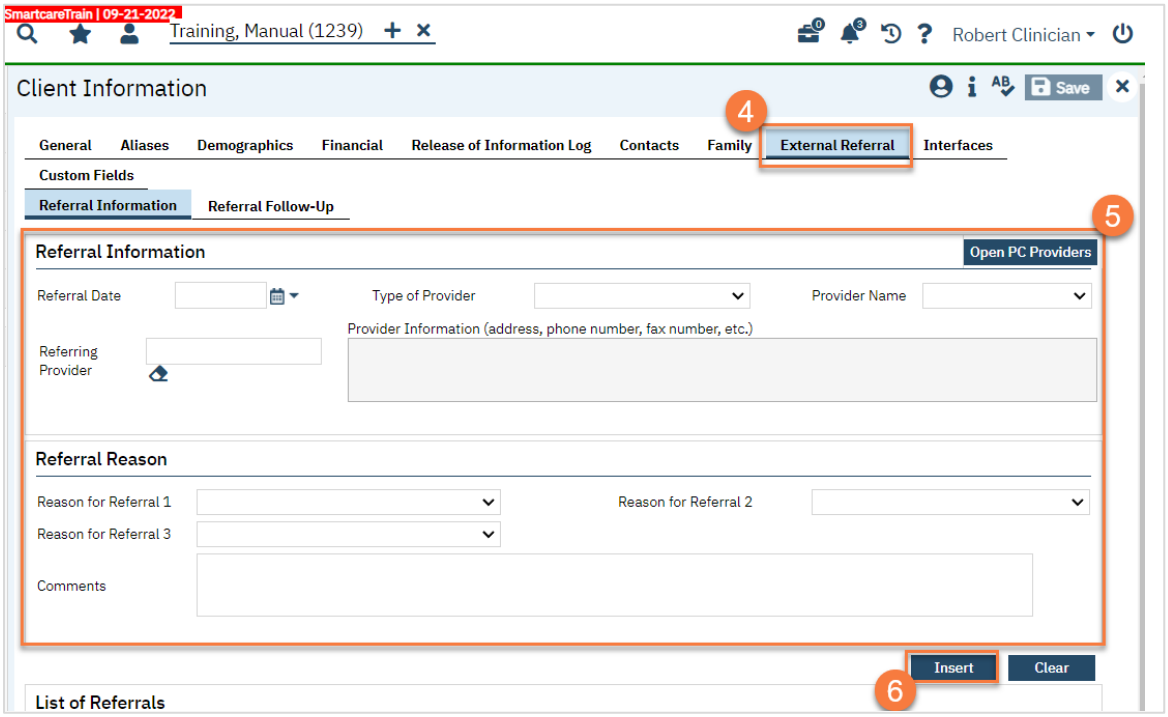
How to Refer the Client to Additional Services, Such a Primary Care Physician

If the screening indicates you need to refer to additional services with providers that do not use your county's instance of SmartCare, follow your county's procedures for sending these referrals.

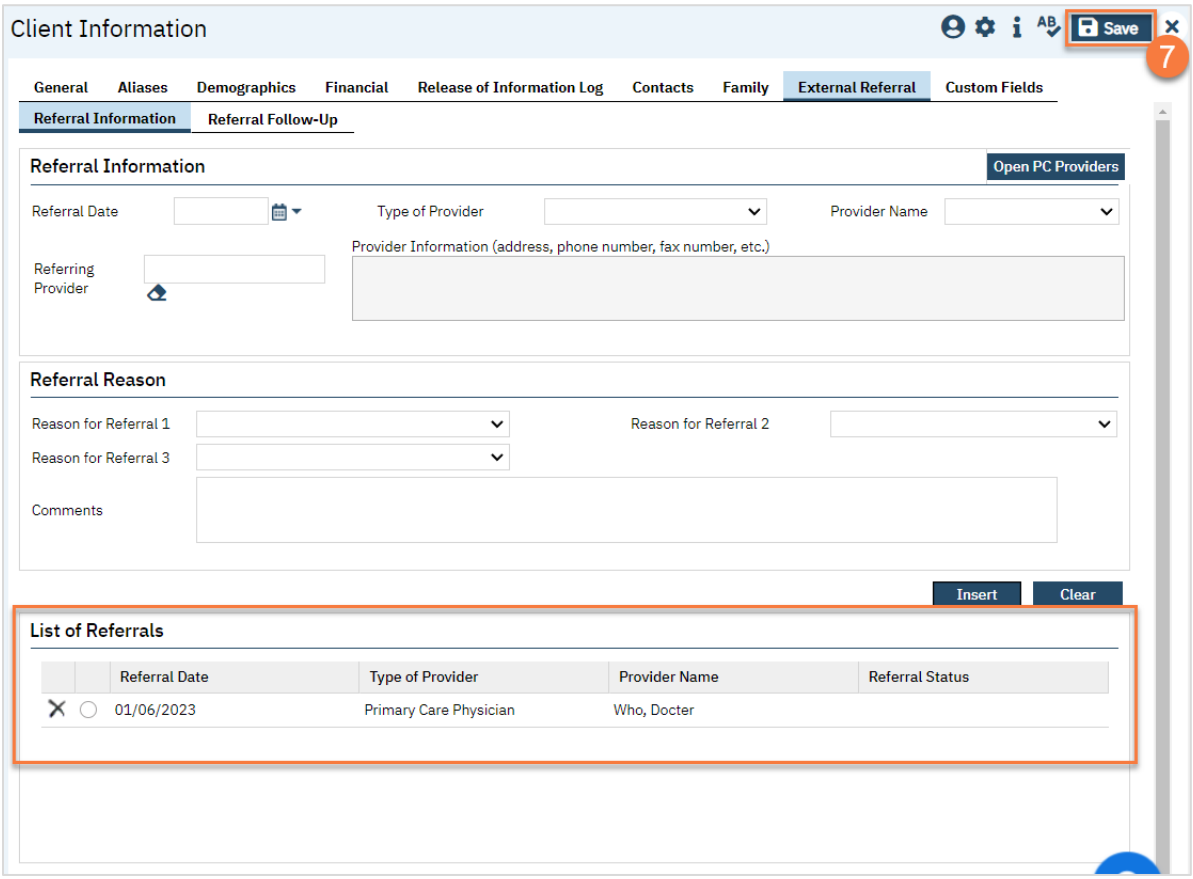
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Information** into the search bar.
3. **Click to select Client Information (Client).**



4. Navigate to the “External Referral” tab.
5. Complete the information about the referral you’re providing. Put yourself as the Referring Provider.
6. Click “Insert”.

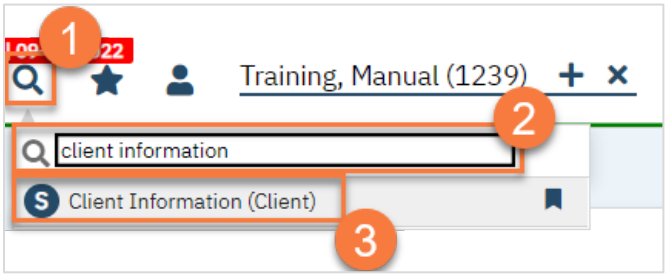


7. Your referral should now show in the List of Referrals section. Click Save.

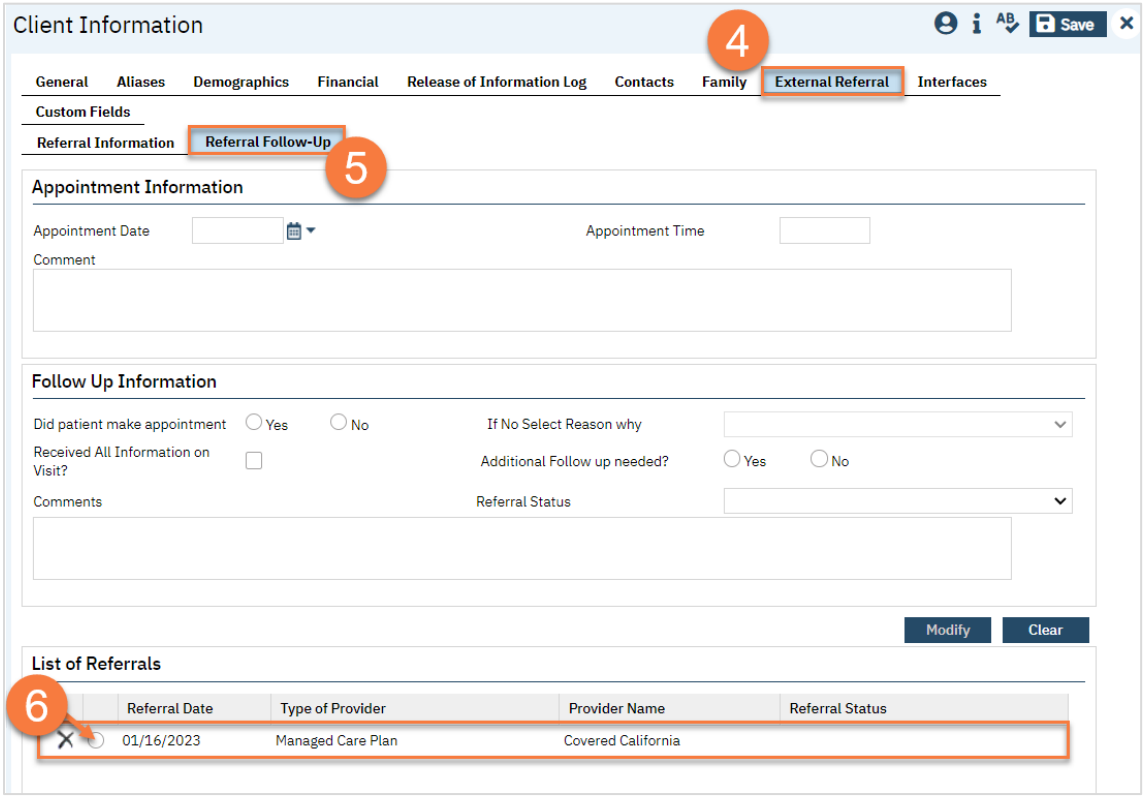
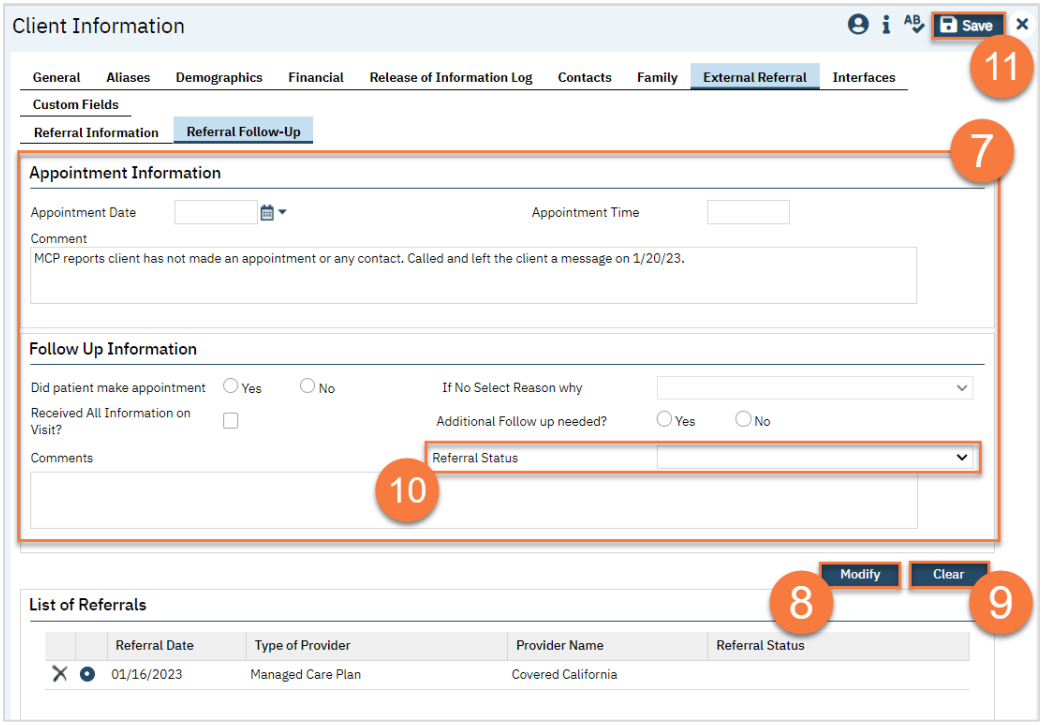
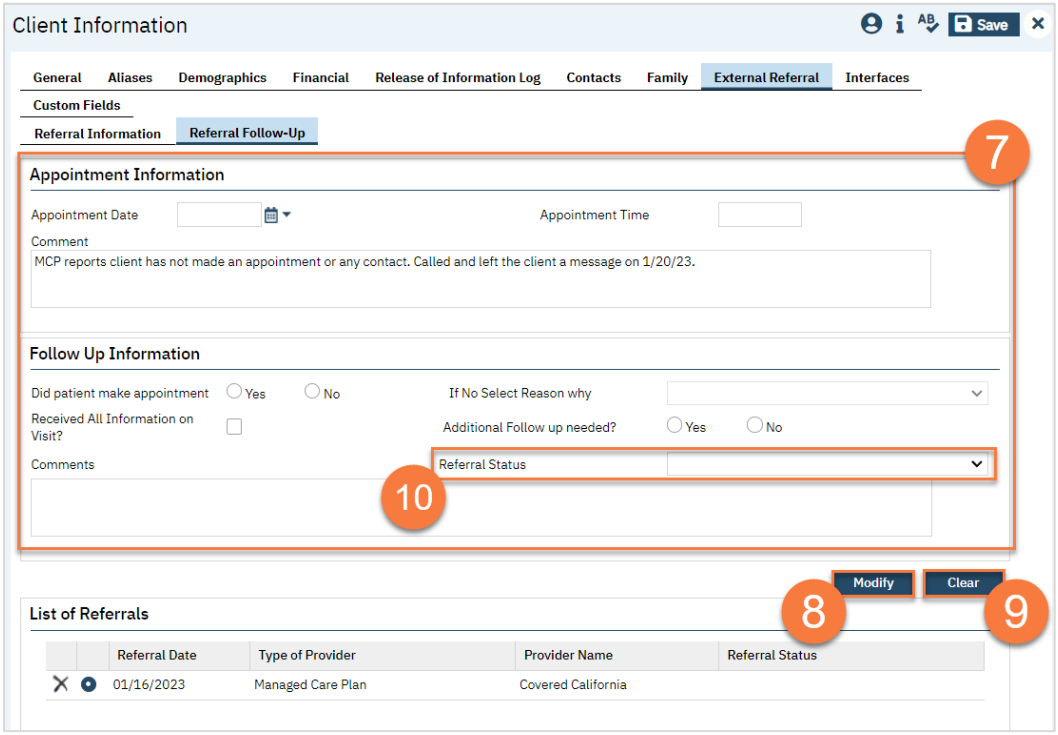


How to Document Follow-up Done on an External Referral

1. To document follow-up on an external referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Information** into the search bar.
3. **Click to select Client Information (Client).**



4. **Navigate to the "External Referral" tab.**
5. **Click on the Referral Follow-Up tab.**
6. **Select the referral you want to follow up on from the List of Referrals.**



7. If there's any information already added to this referral, it brings up the information in the top part of the screen. From here, **enter your follow up information.**
8. **Click Modify** to save your changes.
9. If you selected the wrong referral, click clear.
10. Once the client has successfully completed the referral process, enter "Complete" in the Referral Status.
11. Once you've finished entering any follow ups, **click Save**.