

Barnestorm POC Training Guide

Торіс	Navigation / Information	Article Number	Page Number
Section 1	Overview		
Getting Started	This video covers several of the topics on this page, including: Logging into POC, Select a Patient, My Visits, My Schedules, Expiring 485s, Recent Orders, Print Medications, Help, and Sync. <u>Video: 51070</u>	<u>50992</u>	
Knowledgebase	View instructions on how to complete a task or helpful articles on how to troubleshoot issues. You can go to the knowledgebase and enter the article numbers shown in this document in the right column into the Search field to find instructions on how to do all of the activities show here.	<u>50361</u>	6
	Main Menu > Help		
Select Patient	Search for a patient by first name, last name, or chart number. View patient information on main screen, including name, phone number, payer, age, days active, and status.	<u>50404</u>	7
	Main Menu / Select Patient > Select Patient (main screen upon log in)		
My Patients	View at a quick glance your patient list.	<u>50408</u>	8
	Main Screen / Select Patient > My Patients		
My Schedules	View scheduled visits for the employee logged into POC.	<u>50918</u>	9
	Main Screen / Select Patient > My Schedules		
Expiring 485s	View at a quick glance which 485s are due to expire.	<u>50410</u>	8
	Main Screen / Select Patient > Expiring 485s.		
	Reports(New) > 485 > Expiring 485s		
Recent Visits	View recent visits that were completed and the status they are in (completed, locked).	<u>50409</u>	8
	Main Screen / Select Patient > Recent Visits		
Recent Orders	View recent orders and pending orders entered into the Barnestorm system.	<u>50426</u>	10
	Main Screen / Select Patient > Pending and Recent Orders		
Recent CCNs	View recent CCNs enter into the Barnestorm system for your patients.	<u>50427</u>	10
	Main Screen / Select Patient > Recent CCNs		
Patient Info	View information on patients. Click through all buttons (some only show information if you are using Barnestorm POC). This is to view only, it is not to enter, edit, or add information. It's good for anyone who should only check patient information. Print button available for any page shown.	<u>50087</u>	11
	Main Menu > Patient Info		
	Video: <u>51062</u>		
Search	Search all information in Barnestorm to find what you need, such as a doctor, medication, patients info, etc.	<u>50400</u>	13
	Main Menu > Search		
	Video: <u>51063</u>		
	Review / Practice		



Торіс	Navigation / Information		Page Number		
Section 2	Data Entry				
ICD History	Enter ICD codes for each patient—this is done by dates, and the date is	<u>50218</u>	15		
	intended to be a timestamp: each date should have an accurate listing of the patient's condition AT THAT TIME. Enter severity whenever possible. This is	<u>50221</u>			
	where ICD codes should be changed and updated, because they pull from	<u>50220</u>			
	this area into the 485s and OASIS automatically.				
	Main Menu > ICD History				
	Video: <u>51064</u>				
Surgery	Enter surgery codes for each patient – this is done by dates, and the date is	<u>50233</u>	18		
History	intended to be the date of the surgery.	<u>50234</u>			
	4				
	Main Menu > Surgery HIstory				
Medications	Enter medications for each patient, along with dose, frequency and route. Schedule is options but provides a nice schedule printout for patient. This is where medications should be changed and updated, because they pull from	<u>50224</u>	19		
		<u>50226</u>			
this area into the 485s and OASIS automatically. When a dosage changes,		<u>50227</u>			
	use ADD. Edit is only used if there is an error in the entry.	<u>50228</u>			
		<u>50229</u>			
	Main Menu > Med History				
	Video: <u>51065</u> <u>51066</u> <u>51067</u>				
Orders	Enter orders. Most orders are regular verbal orders to mail to the physician,		21		
	but information-only orders are available as well. Enter text at top, Save, and the order goes to the lower left, where you will click on it and then click on the	<u>50219</u>			
	button indicating the type of order you wish to create.	<u>50312</u>			
		<u>50412</u>			
	Main Menu > Orders > Add / Edit Orders				
	Video: <u>51103</u> <u>51071</u>				
	Review / Practice				



Торіс	Navigation / Information	Article Number	Page Number
Section 3	Clinical		
Visits	Create a visit note documenting your patient visit. Detailed instructions	<u>50236</u>	25
	available in the Knowledgebase.	<u>50237</u>	
		<u>50386</u>	
	Main Menu > Visits / Assessments		
	Video: <u>51044</u>		
485	You may create a 485 automatically from a visit note that is marked as a recert or SOC visit.		30
	Main Menu > Visits / Assessments > Finish tab		
	Main Menu > 485		
OASIS	You may create an OASIS automatically from a visit note that is marked as a recert or SOC visit.	<u>50411</u>	30
	Main Menu > Visits / Assessments > Finish tab		
	Main Menu > OASIS		
Aide Plan	You may create the Plan of Care for the aide within your assessment.	<u>50484</u>	32
	Main Menu > Visits / Assessments > Aide Plan		
	Review / Practice		



Торіс	Navigation / Information	Article Number	Page Number
Section 4	Communication		
Messaging	The messaging system in Barnestorm is similar to inter-office email. The intended purpose is to aid in the communication of information between employees who are logged into the Barnestorm system. Messaging may also be used to create reminders for yourself or others.	<u>50318</u>	34
	Main Menu > Messaging		
	Video: <u>51068</u>		
Schedules	Use schedules view your visit schedule. The new schedule option allows you to print these on a daily, weekly, or monthly basis.	<u>50197</u> <u>50918</u>	36
	Main Menu > Schedule		
Time Sheets	Use Barnestorm to help you go paperless with your time sheets. We offer different reports to run that shows the totals per employee.	<u>50099</u> <u>50301</u> <u>50100</u>	41
	Main Menu > Time Sheet		
	Main Menu > Non Visit Entry		
	Video: <u>51069</u> <u>51050</u>		
Care Coordination	This allows you to document communication notes related to patients (phone calls, care conference meetings, calls from patient's family) so that everyone who has access to Barnestorm Office can view them. You can also use this feature to go paperless with other documents. The video linked below only includes the old Care Coordination screen.	<u>50414</u> <u>50417</u> <u>50415</u> <u>50416</u> <u>50107</u>	44
	Main Menu > Care Coordination		
	Video: <u>51365</u>		
Help	In addition to the Knowledgebase where you can find answers to most of your questions and instructions on how to do most tasks in Barnestorm, you can get additional help using the Chat, Call Request, and Email options under Help.	<u>50064</u>	46
	Main Menu > Help		
Syncing	This allows you to send your patient data over to the work server and also retrieves any patient data from other staff. It is CRITICAL that synchronize be done at least once a day. You must be connected, by a cable or wireless connection, to sync.	<u>50364</u>	48
	Main Menu > Synchronize Data > Sync (sends and retrieves)		
	Log in Window > Quick Sync (just sends, does not retrieve)		
Login Security	Tips on logging into Barnestorm Point-of-Care.	<u>50010</u>	49
	Barnestorm POC > Login		
	Review / Practice		



Contents

How to Use the Barnestorm Knowledgebase	6
Select a Patient	7
My Patients	8
My Expiring 485s	
My Recent Visits	
Start an Assessment from Your Scheduled Visits	9
View Recent Orders	
My Recent CCNs	
Patient Info	11
Search for Patient, Doctor, Pharmacy, Medicine, Employee	13
Add ICD Codes for a Patient	15
Edit ICD Codes	16
Change the Order of ICD Codes	17
Delete ICD Codes	17
Add Surgery Codes for a Patient	
Edit Surgery Codes	
Delete Surgery Codes	
Add a Medicine for a Patient	19
Change Dosage for an Existing Medicine	20
Discontinue Medicine	20
Create Verbal Orders	21
Create Informational Orders	22
Create a Medication Verbal Order	23
Create Recert Orders	24
Create Post Hospital Orders	24
Create Discharge Order	24
Create a Visit/Assessment - RN	25
Document a Wound	
Create a 485 from the Assessment	
Create an OASIS from the Assessment	
Enter a Late Entry on a Visit Assessment	
Aide Plan	
Messaging	
Use Schedule Calendar	
Start an Assessment from Your Scheduled Visits	
Non Visit Screen	
Use TimeSheets in POC	
Care Coordination Screen	
Barnestorm Support - Help Button	
Synchronizing Point-of-Care	
Barnestorm POC Patient Security Feature	
	How to Use the Barnestorm Knowledgebase



1. How to Use the Barnestorm Knowledgebase

The **Help** button on the main menu of Barnestorm Office and POC software has two main features; one is to look up information about the Barnestorm software and the other is to get help from a Barnestorm support staff regarding questions or issues. In this article we'll briefly go over how to look up articles in the Knowledgebase. *Please note that you must be connected to the internet in order for the Knowledgebase to work.*

<u>Home</u> The Home menu allows you to see all the menu categories that correspond to Main Menu within your Barnestorm software. Select a category to view the top related articles for that category. Click on the article you want to read. You can also select "Find More Answers to open up the Knowledgebase in a web browser. This will pull up more article options for you to view.

Find Answers - If you know exactly what information you need, such as "Referrals" or "485s", click on that link under "**Find Answers**." The link will take you to a listing of articles related to that topic. Click on the article you want to read. At any time you can right click on the page you're on and click on Back to go to the previous page. If within the listing, you do not see the type of article you need, click the "**Find More Answers Here**" link, listed at bottom of screen. This link will take you directly to the Knowledgebase where you can do a more thorough search.

We also have a section for **Videos**. They are tutorials of different areas in Barnestorm. We are currently working on adding more videos to our library.

What Can We Help You With? - In this section, you can enter a description of the article you need, and a listing will appear beneath that suggestion. Click on the topic to get to the article. If you cannot find an article, by using your target description, use this link to go directly to the <u>Knowledgebase</u> to do a more thorough search. Listed below this Quick Search feature are other options: Latest KB Articles, Barnestorm Office Articles and Barnestorm POC Articles. Click on one of those options, and a listing of articles will appear related to those topics. Click on the article you would like to read. You will be taken directly to the Knowledgebase, where you can Print, Email, or Export articles as PDF.

We would like your feedback! Please rate our articles (while in Knowledgebase) by clicking on the stars that are in the lower, right corner of the article. There are five stars. By clicking just the first star, indicates the article was not very helpful. By clicking the fifth star, indicates the article was very helpful. You also have the opportunity to reply with a message that will be posted on that article. Below the article is a section that says **Add Your Comments**. Enter the information in the text box then click on Add Comments. Your comment will be posted on that article for everyone to read. This could be additional information or resources that you would like to share.

We would also appreciate feedback on articles or videos that you would like to see added to the Knowledgebase. Feel free to send us an e-mail through the Help button letting us know what you would like to see. Include as many details as you would like. You may also reach the Knowledgebase from a browser using this link: http://kb.barnestorm.us/



Select a Patient

From the **Main Menu** in Barnestorm you can search for a patient by entering their last name, first name, or chart number. When you start to enter the data a list of patients with that data will appear. The more you type in the fewer the patients will show up.

- o If the patient is active leave the Active bullet selected
- o Otherwise, select the number of days the patient has been discharged
- o Pull up a patient by entering their six digit chart number; or
- o Select Last Name or First Name and start to type in their name
- o This Program# Only will help refine your search to a specific program code

Barnestorm Point-of-Care Select Patient

Last Name:	Active	Program:
Last Name First Name Chart #	Olischarged	

- o If the patient is active leave the Active bullet selected; or
- o Select the Discharged bullet
- o Pull up a patient by entering their six digit chart number; or
- o Select Last Name or First Name and start to type in their name
- o This Program# Only will help refine your search to a specific program code

Click on the patient you want to select. You'll notice the patient's information will appear at the top of the page. This is your way of knowing which patient is currently selected.

Selected Patient 000001 TEST, PATIENT 111 MAIN ST	111-333-4444				
01/004HOME HEALTHMEDICAID JOHN M. SMITH, MD Active	Current patient selected				
Search for a Patient by Name or Chart#	Active				
TES Last Name First Name	O 0-90 Days				
This Program# Only: Save These Settin	lgs O 0-365 Days				
	O 0-9999 Days				
Chart# Patient Name (Admitted DC Da				
000001 TEST, PATIENT	EXINGTON 03/22/16				
01/004 HOME HEALTH MEDICAID	333-4444 485_None				



2. My Patients

From the **Main Menu** in **Barnestorm Point-of-Care** click on **My Patients**. This shows all patients that are assigned to you (in Barnestorm Office > Referrals > Employees tab). They will appear in alphabetical order by patient last name. When you select a patient the bottom panel will list the most recent visits, 485's, and OASIS for that patient. You will have the choice to Edit or Print from here.

3. My Expiring 485s

From the **Main Menu** in **Barnestorm Point-of-Care** click on **My Expiring 485s**. This will give you a list of patients with expiring 485s in order by the **Thru Date**. Use this feature frequently to know which of your patients need a 485 created. You'll also be able to see which patients are on hold and which are active.

Chart# Patient Name	City	Referred Admitted Age	Sex	Days	
000001 PATIENT, A 03/999 MY INSURANCE	NOWHERE 1111111111	01/26/09 01/26/09 87 485 Thru: 03/26/09	F	38	Active
000006 PATIENT, F 03/999 MY INSURANCE	NOWHERE 4444444444	02/05/09 02/05/09 64 485 Thru: 04/05/09	F	28	Active
000004 PATIENT, D 03/999 MY INSURANCE	NOWHERE 7777777777	02/21/09 02/21/09 84 485 Thru: 04/21/09	M	12	Active
000005 PATIENT, E 03/999 MY INSURANCE	NOWHERE 88888888888	03/01/09 03/01/09 109 485 Thru: 04/29/09		4	Active

4. My Recent Visits

From the **Main Menu** in **Barnestorm Point-of-Care** click on **My Recent Visits**. When you click on this button a list of your most recent visits will appear in date and time order. By default the visits will go back 14 days. You can change the number of days to look back by changing the number. You can go back up to 120 days. This is a great way to see which visits are not locked. Visits in the Incomplete or Completed status will show up regardless of the number of days.

Chart# Patient Name	Visit Times	Mi	n Assessment Type	Status
000006 PATIENT, F	Sun 03/01 04:10 pm	05:00 pm 5	0 Scheduled Visit	Completed
000004 PATIENT, D	Sun 03/01 12:20 pm	01:00 pm 4	0 Scheduled Visit	Locked
000002 PATIENT, B	Sun 03/01 12:00 pm	0 <u> </u>	0 Scheduled Visit	Incomplete
000003 PATIENT, C	Sun 03/01 11:20 am	12:00 pm 4	0 Scheduled Visit	Completed
000001 PATIENT, A	Sun 03/01 10:15 am	11:15 am 6	0 Scheduled Visit	Completed
000005 PATIENT, E	Sun 03/01 08:00 am	09:00 am 6	0 Start of Care	Locked
000006 PATIENT, F	Thu 02/26 03:10 pm	04:00 pm 5	0 Scheduled Visit	Locked
000004 PATIENT, D	Thu 02/26 02:00 pm	02:45 pm 4	5 Scheduled Visit	Locked
000003 PATIENT, C	Thu 02/26 12:20 pm	01:15 pm 5	5 Scheduled Visit	Locked
000001 PATIENT, A	Thu 02/26 11:10 am	12:10 pm 6	0 Scheduled Visit	Locked
000002 PATIENT, B	Thu 02/26 10:15 am	11:00 am 4	5 Scheduled Visit	Locked
000004 PATIENT, D	Sat 02/21 02:00 pm	03:00 pm 6	0 Start of Care	Completed
000002 PATIENT, B	Thu 02/12 10:00 am	10:45 am 4	5 Scheduled Visit	Completed
000002 PATIENT, B	Sun 02/01 10:00 am	11:00 am 6	0 Start of Care	Completed



5. Start an Assessment from Your Scheduled Visits

From the **Main Menu** in **Barnestorm Point-of-Care** click on **My Schedules**. When you click on this button, a list will appear that shows your scheduled visits in date and time order, with the soonest listed first.

- To start a visit from here, click on the line of the scheduled visit (shown below) and it will give you the option to **Start Assessment**.
- When you click on **Start Assessment** you will be directed to the Start screen of the assessment to verify or fill in questions about the assessment.
- At this you will want to verify the start date and time.
- Complete your assessment, as required by your agency.



- If you exit the assessment without finishing it, you can select the scheduled visit from the My Schedule button instead of Start Assessment you will see Edit Assessment. You can use this button to pull the assessment up to
 modify it.
- Note: if the Edit Assessment button is NOT active then the assessment has been locked. You will need to unlock the assessment from the Visits / Assessments screen.

😫 Edit Assessment	🤪 New 📝 Edit	Rint Print
Date/Time Chart#	Patient Name	Pg/Pyr Job Typ Comments
Mon 07/22 08:00 888888	PATIENT, SAMPLE B	01/013 002 11
Mon 07/22 10:00 888890	PATIENT3, SAMPLE	01/005 002 11 888888 PATIENT, SAMPLE B
T 07 (33 10.00 888800		95 year old Black Male born on 08/2//1917

- The **New** button allows you to create a new schedule for the current patient selected. This will pull up the Add/Edit Schedule screen.
- The Edit button allows you to edit the currently selected schedule.
- The **Print** button will print the schedule.



6. View Recent Orders

From the **Main Menu** in **Barnestorm Point-of-Care** you have two features to click on to check recent order entries. You can view any pending order regardless of the order date or you can view recent verbal orders within the number of days selected on this screen.

First, select if you want to only view your orders, or your patient orders entered by other employees:

- My Orders/CCNs Only
- My patients not by me

Pending Orders

• This will show all of your pending orders regardless of the order date. This is a good checks-n-balance to make sure you do not miss any orders.

Recent Orders

• This will show all of your recent verbal order entries depending on the number of days you have selected to look back. The default days will go back 14 days. Change the number in the **Days** box to go back further (you'll have to click on My Recent Orders again).

The list gives you the order number, order date, patient and doctor. The beginning of each order will tell you if it has been mailed (M), returned (R), or not mailed (_).

If you click on one it will put it into a Print/Preview format.

7. My Recent CCNs

From the **Main Menu** in **Barnestorm Point-of-Care** click on **My Recent CCNs**. This will list your care coordination notes by date.

First, select if you want to only view your CCNs, or your patient orders entered by other employees:

- My Orders/CCNs Only
- My patients not by me

The default date goes back 14 days. Change the number in the **Days** box to go back further (you'll have to click on My Recent CCNs again).

The list gives you the patient, when (date), who (caller) and the discussion. When you click on one the complete text will appear. If you click on the text area it will take you back to the list of CCNs.



8. Patient Info

Patient Info button is used to view patient information, but not change it. This is the quickest way to find information concerning a specific patient.

You may print any tab under Patient Info by clicking the **Print** button. Some screens will show an itemized list where you are able to select an item to view the full content. To return back to the itemized list click on the text anywhere.

Use the Get Map/Directions button to view a map from your agency to the patient's home.

Copy Feature: This allows you to copy a selected screen from Patient Info and paste it somewhere else.

- Select the patient you want and click on the Patient Info tab.
- Select the tab you want to copy (ie. 60 Day Summary or Patient Info).
- Click on the **Copy** button, you will get a message stating how many characters have been copied. Click on Ok.
- Go to the place where you want to paste the info (ie. 485, Verbal Order, or a Word document).
- Right click in the area you want to paste it and click on Paste.

Different Tabs in the Patient Info screen:

- **Patient Info**: This will take you to the Patient Info screen. It will show all patient demographics, including: current ICD, involved employees, medical history, facility stays and more. You have the option to print a short or long Patient Info sheet. The short report will exclude some of the information like: ICD Codes, weight, height, BMI and employee information.
- ICD History: This will show you all ICD From Dates. Click on a date to view all ICD codes and dates.
- **Medications**: This will show all medications that the patient has taken. If you want to view only active medications, click on the Current Meds Only button. If you select a medication, it will show you the medication instructions for that med.
- Surgeries: This will show you all surgery codes, description, and date of surgery.
- **Facilities**: This will show you all facilities the patient has been in. It shows the facility type, facility name, from and thru dates, and the reason.
- 485: This will show all episodes. Click on the episode and it will show you most of the 485 content (not all).
- Verbal Orders: This will give you a list of the verbal order numbers, date of order, and part of the text inside the order.
- **OASIS**: This will give you a list of OASIS that has been entered. Click on an OASIS to view the MO number, question, and answer. It also shows the HIPPS code and authorization code.
- OASIS-PPS: This will show each OASIS entered. Click on an OASIS and it will show you which OASIS
 questions where used to create the HIPPS code. The first section shows you the first 6 ICD codes used for
 billing. To the left of each code will show the value of the code. The next section shows the rest of the ICD codes
 used for the patient. Next to each code shows the potential value of the code. The third section shows a mixture
 of MO questions and the value of each.
- Pending Orders: This will show all pending orders by date.
- **Discharge Plan**: If the patient has been discharged, this will list the discharge date.



- **60 Day Summary**: This will show vital signs for each 485 episodes. When you click on an episode it shows any of the following information: temperature, respiration, pulse, weight, and blood pressure. It also shows wounds and the measurements, type, and location. This will also show pulse-ox readings.
- **Care Coordination**: Shows a list of all care coordination notes entered. In order by status (open or closed) then by date.
- Scheduled Visits: Shows planned visits by employee, date, type of visit, program/payer code and comments. It will also show if an actual visit was completed for that date or not. The scheduled visit will be compared to the assessments employee and time in. If the employee matches and the time is close then a "OK" will show up next to the scheduled visits.
- Supplies Used: Shows what supplies were used, when, and how many.
- Immunizations: Any immunizations documented will show up here.
- **Clinical Notes**: This shows narrative notes from all assessments, all 60 Day Summary notes, and any CCNs marked as 60 Day Summary. This is a great way to quickly see everything that's going on with the patient. Note that at the top you can set how far back to look in case you want to look back further.



9. Search for Patient, Doctor, Pharmacy, Medicine, Employee

Search for Patients

From the main menu, click the **Search** button.

- Select **Patients**. This screen will allow you to search for patients using specific text in the 485, verbal orders, care coordination notes, or patient information screen.
- If you leave the From and Thru dates as today's date, it will bring up all active patients as of today. Otherwise, you will receive the report for all patients that were active on and between the two dates.
- Type in the text you want to search for in the Text to search for box.
- Check the box 1 Page per Pt if needed.
- You can select which sections of Barnestorm to search for the patient information: 485's, Verbal Orders, Care Coord Notes, and Patient Info. Uncheck the boxes for any areas you wish to exclude from the search.
- Enter the Program, Team, Employee codes if needed. Any items left blank will cause the search to include all codes.
- Click on View. This will generate a list of patients with the criteria you selected.
- To print the list, click the Print button. Click on the Print button from the Print Preview screen.
- Soc. Sec. No.: Search for a patient by social; enter at least the first five digits of the social security number into the text field. Then click on the **Soc. Sec. No.** button.

Here is a list of fields that are searched:

- Patient Info: Emergency contact name, Emergency contact address, Misc Notes
- **485**: 14. DME and Supplies, 15. Safety Measures, 16. Nutritional Requirements, 17. Allergies, 18A. Functional Limitations Other, 18B. Activities Permitted Other, 19. Mental Status Other, 21. Orders
- Verbal Orders: Text of order
- **CCN**: Topic, Text of CCN

Search for Doctors

- From the main menu, click the **Search** button.
- Select **Doctors**.
- Type the first three letters of the doctor's last name. A list of doctors will appear.
- If you want to narrow down the list, you can select the referral type from the list on the right side (00 physician, 01 physician, etc.)
- Click on the doctor's name to select the doctor. This will give you the doctor's demographic information along with some of the identification numbers (i.e. NPI).
- If the doctor has any active patients a list will appear at the bottom of the screen. It will also show how that doctor is affiliated with the patient (ie. primary physician, consulting, ordering, meds)

Search for Pharmacies

- From the main menu, click on the **Search** button.
- Select Pharmacies.
- Type at least the first three letters of the pharmacy name. A list of pharmacies will appear.
- Click on the pharmacy name you want. This will give you the pharmacy demographic information.



Search for Medicines

- From the main menu, click on the Search button.
- Select Medicines.
- Type at least the first three letters of the medicine name. A list will appear.
- Click on the medicine name you want. This will give you the instruction information.

Search for Patients Using a Certain Medication

- 1. After selecting the medicine, you can view Active Patients Only or select a From and Thru date for active patients.
- 2. Click on Search for Patients Taking This Med. A list will appear.
- 3. Click on the Print button if you need to print.

Search for Most Common Medications

- 1. Select Active Patients Only or use the From and Thru dates.
- 2. Click on Most Common Meds. A list of medicines will show with a number of how many patients have used that medicine.

Search for Employees

- From the main menu, click on the Search button.
- Select Employees.
- Enter the first three letters of the employee's first or last name in the Search for an Employee box. A list of employees will show.
- Click on the employee you want to view. The employee demographics will appear.

Pt Documents

You can use Pt Documents to view <u>PDF</u> documents if your agency is setup to use this feature. You must be connected to the network in order for the Pt Documents search to work.

- From the main menu, click the **Search** button.
- Select Pt Documents.
- Select the category from the left pane.
- The right pane will show any documents inside of that category.

O Patients O	Doctors	O Pharma	cies	🔘 Medi	cines	Employees	Pt Documents
Search for a Patient by a Last Name First Name This Pr	 Active 0-90 Days 0-365 Day 0-9999 Days 	Active 888888 PATIENT, SAMPLE B 0-90 Days Adm: 12-25-11 0-365 Days Top level folder for all patient d 0-9999 Days C:\BARNESTORM\DOCUMENTS			atient documents IENTS		
	FileNam	ne	Date	Size	Descrip	tion	
485	12252011	.pdf	01-14-13	69,468			
Aide Diagnostics and Labs Miscellaneous MSW Nurse PT ReferralInfo Wounds							



10. Add ICD Codes for a Patient

- Pull up the patient from the Select Patient screen (Main Menu).
- From Point of Care select the ICD History button.
- Step 1: Adding a New Effective Date
 - Under the ICD Effective Dates label, click on the drop down arrow to select the from date for the new ICD codes. Or type in the date that you desire. This will be the date of the visit to your patient, when you determined that the condition of the patient has changed. This occurs most frequently on a resumption of care after an inpatient stay.
 - **Note:** If you are entering ICD codes for the first time, be sure the From date is at least on or before the patient's admit date. This could cause billing issues.
 - Click the New Date button. This will populate the date selected into the list of ICD From Date in the panel below. If a previous date already exist then the most recent ICD codes will copy into the new ICD From Date.
- Step 2: Add/Change/Remove Diagnosis Code for Selected Effective Date:
 - To add diagnosis: Look up diagnosis code, by Code/Number or by Description. A list of all codes that contain those numbers or description will appear. Select the appropriate code.
 - Select the onset date, O/E, and severity level. (The Onset Date cannot be dated after the ICD From Date.) Click **Save** button after each entry. Proceed with next code entry.
 - When finished entering all codes click on the red **Save All Changes** button and then **Exit**.

1002	30 - TYME, JU	IST N Ad	mitted 09/09/2005	View Codes Only	Save Al	Changes	Help	Exit
Step	1: Select the eff	ective date	If the patient's condition changed, add a new	date. Step 2: Add / change dia	agnoses as need	led.		
Dat cha	CD Effective L tes diagnosis co anged for this pa	odes atient:	To add a new code, click the Add a New Dia To edit a code, select it from the list below, r	gnosis Code button, look up o nake changes, and Save Cha	code, and Save. Inges.			
11	/08/05	~	Code Number	Code Descr	intion			
09/	109/05		ICD Code:	00000000	-puon			
			Add a New Diagnosis Code	Remove Thi	is ICD Code From	the List		
			Severity (OASIS)	Onset or Exacerbat	ion Tracking (48	5)		
		*	◎ 0 ◯1 ◯2 ◯3 ◯4	O=Onset, E=Exacert	bation: 0 0	E o bla	ık	
To : it a	add a new date, nd click New Da	select ite.	Save	Date of O/E: 9/ 9/	2005 -			
11	8/2005		Click the Save All Changes button at the top	right of the screen to save all	I changes.			
	New Date				-			
Rei	move date and o	codes.	Change Order of Diagnosis Codes		-			
	Delete Date		Only the top 6 ICDs will appear on the OASI	B. O Move Up	Move Down	ReOrd	er	
##	Onset Date	Code	Description			O/E Sev		
01	08/01/05	788.30	URINARY INCONTINENCE, UNSPECIFIED			0		
02	09/09/05	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION			0		



11. Edit ICD Codes

- Pull up the patient from the **Select Patient** screen (Main Menu).
- From Point of Care select the ICD History button.
- A list of the ICD History for the selected patient is displayed on the left. Select the date for which you would like to edit the code. The ICD codes, for the date selected, will be displayed at bottom of the screen.
- Click one of the codes to edit it. The code will be highlighted after you click it. Edit the code, onset, O/E, and/or severity as needed.
- Edit the code, onset, O/E, and/or severity as needed.
- Click the **Save** button. Continue with editing of codes, as needed.
- Click the red Save All Changes button when finished. Then click on Exit.



Change the Order of ICD Codes

- Pull up the patient from the **Select Patient** screen (Main Menu).
- From Point of Care select the **ICD History** button.
- A list of the ICD history for the selected patient is displayed. Select the date for which you would like to change the order. The ICD codes for the date selected are displayed.
- You can change the order one of two ways:

ReOrder

- Click the **Reorder Codes** button to change the order of the ICD codes that are listed. A window will pop up with the codes listed on the left.
- Click the most important ICD code from the list on the left. It will be move to the list on the right at the top as the most important.
- Click the second most important code next and it will move to the right, under the first code.
- After you have reordered <u>all</u> of the ICD Codes, click the **Save Changes** button.

Move Up / Move Down

- From the list of ICD codes, click on a code and then click on Move Up or Move Down to move it to the position you want it at.
- After you have reordered the ICD Codes, click on the red **Save** button.

12. Delete ICD Codes

- Pull up the patient from the Select Patient screen (Main Menu).
- From Point of Care select the ICD History button.
- A list of the ICD history for the selected patient is displayed. Select the date for which you would like to change the order. The ICD codes for the date selected are displayed.
- Click one of the codes that need deleted. The code will be highlighted after you click it.
- Click the **Delete** button. The code will disappear from the list.
- After deleting all codes click on the **Save** button.



13. Add Surgery Codes for a Patient

- Select a patient on the first Barnestorm screen by typing in either the patient's chart number or the first 3 letters of their last or first name.
- Click the patient's name to select him or her.
- From Barnestorm POC, click **Surgery History**.
- For the **Surgery Date**, click on the drop down arrow to select the date for the new surgery. Or type in the date that you desire. This will be the date of the visit to your patient, when you determined that the condition of the patient has changed. This occurs most frequently on a resumption of care after an inpatient stay.
- Enter the surgery by number if you know it, or you can type a word into the description and you will get a list of all codes that contain that word.
- Click the Save button and the surgery code should appear in the grid of surgery codes.
- As needed, click on Add a New Surgery Code to add more surgeries. Repeat steps 4 7 to add another code.

14. Edit Surgery Codes

- Select a patient on the first Barnestorm screen by typing in either the patient's chart number or the first 3 letters of their last or first name.
- Click the patient's name to select him or her.
- From Barnestorm POC you will click on Surgery History.
- A list of the Surgery History for the selected patient is displayed. Select the surgery code for which you would like to edit.
- The surgery code will appear at the top of the screen after you click it.
- Modify the information and click on the Save button.
- Note that you cannot change a date for a surgery already listed. You must first delete the code and re-enter it with the appropriate date.

15. Delete Surgery Codes

- Select a patient on the first Barnestorm screen by typing in either the patient's chart number or the first 3 letters of their last or first name.
- Click the patient's name to select him or her.
- From Barnestorm POC you will click on Surgery History.
- A list of the Surgery History for the selected patient is displayed.
- · Click one of the codes to delete it. The code information will show up at the top of the screen after you click it.
- Click the **Delete Code** button.
- A window will pop up asking if you are sure you want to remove the surgery. Click Yes.
- The code will disappear from the list.



16. Add a Medicine for a Patient

- Select a patient on the first Barnestorm screen by typing in either the patient's chart number or the first 3 letters of their last or first name.
- Click the patient's name to select him or her.
- From Barnestorm POC you will click on Med History.
- Click the Add Medicine button.
- The Add / Edit Medicine Code window will pop up, allowing you to enter a medicine and the related information.
- Enter the medicine by typing a few letters of the medicine into the **Medicine** box and you will get a list of all medicines that contain those letters.
- Select the medicine you want by clicking on it.
- Next, enter the Effective Date to indicate when the medication has or will start.
- Click the N if the medicine is new or C if the medication is being changed.
- By default the primary employee and physician are filled in, but you may change either or both of these as needed.
- Type in a **Dose / Frequency / Route**. You must type this information—the medication cannot be saved without it.
- Type in what the medication is treating in the **Treatment** area if needed.
- Under Schedule, click button(s) as needed to indicate when the patient should take this medication.
- Click the **Save and Exit** or **Save, then prepare for another medicine** button. The window will close or refresh the screen for another new medicine entry.
- The panel will display the list of medicines for that patient.

You can also use the Medication Builder to enter medication information. This can help ensure that each required section of the medication is entered.

- When you click on New Medicine, New Dose/Freq/Router or Edit Entry, check the box "Show Structured Dose/Freq/Rte Builder".
- Enter and select the required dose, freq and route information.
- All other boxes are optional.
- There's an option to translate the abbreviations to words or to make all letters uppercase.
- Click on Build Dose/Freq/Rte button.
- An error message will appear if any required boxes were left out.
- The information will show up in a Dose/Freq/Route format.
- Save the medication when finished.



17. Change Dosage for an Existing Medicine

To change the dosage or some other aspect of a medicine of a medicine, you need to make a new entry for the medicine. You would only <u>edit a medicine</u> if you made an error when you entered it.

- Select a patient on the first Barnestorm screen by typing in either the patient's chart number or the first 3 letters of their last or first name.
- Click the patient's name to select him or her.
- From Barnestorm POC you will click on Med History.
- A list of the medicines for the selected patient is displayed.
- Click one of the medicines to add a new entry for it. The medicine will be highlighted after you click it.
- Click the New Entry button. The Add / Edit Medicine Code window will pop up.
- Click the C to indicate that this is a medicine change.
- Edit the dose, schedule, or other information as needed.
- Click the Save and Exit button. The window will close.
- When you click this medicine, it will now have an additional entry to indicate the change.

18. Discontinue Medicine

- Select a patient on the first Barnestorm screen by typing in either the patient's chart number or the first 3 letters of their last or first name.
- Click the patient's name to select him or her.
- From Barnestorm POC you will click on Med History.
- A list of the medicines for the selected patient is displayed.
- Click one of the codes to discontinue it. The code will be highlighted after you click it.
- Click the Add New Dose button.
- Change the date to the dc date and then click the **Discontinue** button on the right side of the page.
- The window will close. Note that the medicine will be gone from the list of medicines.
- To see all medicines, even discontinued ones, click the **Show All Meds** button.
- If you click on a discontinued medicine, it will list the discontinued date along with the word "STOP".



19. Create Verbal Orders

- Select a patient on the first Barnestorm screen by typing in either the first 3 digits of the patient's chart number or the first 3 letters of their last or first name.
- Click the patient's name to select him or her.
- From Point of Care select the **Orders** button.

Orders: Spell Check Left Message Received Order	You begin here by entering the order info Save as Pending Order button.	ormation and clicking on the	*
	Save as Pending Order	Cancel	
Pending Orders	Click the order in the panel below, then click the Create Order button. Show Orders - VO Not Needed	View Verbal Orders from the Past 125 Days Empl# 0114 Show All	
Create Order		Order # Issued Dr# Type 011400579 06-15-12 0612 This is another test verbal 011400580 06-14-12 0612 The patient needs a med cha	or nge
Preview Orders			
Create VO (FYI)	Once you save the information from above,	Orders that show up here have been turned into a	
No VO Needed	the pending order shows here. These orders	verbal order or an information order and has a	
Edit Order	are still pending. A verbal order has not been	number assigned to it.	
Delete Order	created yet.		
Previous Next	<u> </u>	-	*
From: 12/25/2011			
Thru: 2/22/2012	Applies to Visits Starting: 9/27/2012	Preview Edit Copy Delete	Exit

- Change the Order Date as needed.
- The default doctor and employee will already be filled in. Change them as needed. *Note: Each agency defines the max number of days an order can be backdated and future dates.
- Select the type of order from the **Type** dropdown list, as needed.
- In the large text box on the top half of the screen, type in the orders.
- To the left of the box where you type the orders, there is a button with a large **T** on it. This button allows you to see orders that your agency has entered as standard orders, and to select them rather than having to type frequently used orders. To use standard orders view the article **Add [T] Box Items**.
- You can date and time stamp the order by clicking on **Received Order**. This will stamp the order with the current date, time, who is writing the order, and who gave the order (this one needs entered by you).
- Click the **Save as Pending Order** button in the upper right. Notice that when you click the **Save** button, the order goes into the lower left panel, which is labeled **Pending Orders**.
- Click on the new order in the **Pending Orders** panel.



- Note that, if your order needs to be dated for the upcoming/new certification period, you can use Applies to Visits Starting: and put in the first date of the new cert period. This will date the order for the new certification period.
- Click the button labeled **Create Order**. This indicates that this is a standard verbal order requiring a signature from the nurse and the doctor. A window will open with the print preview of the verbal order, which includes the agency information, doctor information, patient information, the orders, nurse signature, and a place for the doctor's signature.
- To print this page, click the **Print** button in the upper left.
- IMPORTANT: Once you print this document, someone in the office will need to mail or fax it to the doctor.
- Close the print window. When you close the print window, you will see that the verbal order has now moved to the right panel, labeled **Show Verbal Orders During the Past 125 Days**. Orders on this side are those that have been mailed or queued to mail.

20. Create Informational Orders

- Select a patient on the first Barnestorm Office screen by typing in either the first 3 digits of the patient's chart number or the first 3 letters of their last or first name.
- Click the patient's name to select him or her.
- From Point of Care select the **Orders** screen.
- Watch as the **Orders** screen opens. The doctor and employee will already be filled in.
- In the large text box on the top half of the screen, type in any informational orders.
- An example of when you would use an informational order would be to document things like a new medicine found in the home that was ordered by the primary physician. This information does not require a signed order, but it needs to be documented and sent to the physician.
- Click the **Save** button in the upper right. Notice that when you click the **Save** button, the order goes into the lower left panel, which is labeled **Create Verbal Order**.
- Click on the new order in the Create Verbal Order panel.
- Click the button labeled **Create VO (FYI)**. This indicates that this information does not require a signed order, but it needs to be documented and sent to the physician.
- A window will open with the print preview of the verbal order, which includes the agency information, doctor information, patient information, the orders, and the nurse signature.
- To print this page, click the **Print** button in the upper left.
- IMPORTANT: Once you print this document, you will need to mail or fax it to the doctor, as needed.
- Close the print window. When you close the print window, you will see that the verbal order has now moved to the right panel, labeled **Show Verbal Orders During the Past 125 Days**. Orders on this side should be those that have been mailed.



21. Create a Medication Verbal Order

This is a great Barnestorm feature that helps to eliminate duplicate work and data entry error. This process must be done in the correct order.

When you update a patient's medication information in the medication history, you can copy that information into a Verbal Order with a couple of clicks.

1) Enter the new/changed medication information in the medication history.

2) After all medications are entered click on Orders > Add/Edit Orders (for Office users) > Dropdown list for Type

> Medication > Create Med Order. Any medications that were entered or changed in Office or Point of Care will appear.

The employee and doctor on the verbal order must match the employee and doctor on the medication history. If they do not match then the medication changes will not show up.

**Note: you must use this feature the same day the medication was entered.

See Create Verbal Order to see complete instructions on how to enter a verbal order.

Change from the Med History screen

COUMA	DIN		Info
Effective	Date New / Cha 13 V N C	nge Add multiple dose/freq change	ges today
Employe	e		
0901	HHNURSE		
Doctor			
0613	Dr. MY DOCTOR		
Show	// Hide Med Builder 🛛 🕢		
Dose / F	Frequency / Route		
5 mg qq	i po		

Creating the medication order from the Orders screen

Order Date:	3/26/201	3 🗸	2	Show Doctors		Show Wound History	Go To ICD History
Doctor:	0612	DR. YO	OUR DOCTOR	R		View Open Orders	Go To Med History
Employee:	0901	HHNU	RSE				
Туре:	Crea	ate Me	d Order]			
Orders:	Effect 5 mg g	ive 03 d po	3/26/2013,	Medication:	COUMADIN		
5	Effect 200 MG	ive 03 PRN I	3/26/2013, PO	Medication:	TYLENOL		
Left Message	Effect 180 MG	ive 03 QD PO	3/26/2013, 0	Medication:	VERAPAMIL	SR	



22. Create Recert Orders

From **Orders**, click the dropdown list for **Type**; Select **Post Hospital** / **Recert Orders**, enter the number of days to look back and pull information, Click on **Create Recert Orders**.

The following is the information that will be pulled:

- A statement to continue the next certification period
- The phrase "Date Faxed______" with a blank line for you to write in a date
- Current ICD codes, as of verbal order date
- Current medication, as of verbal order date
- Enters a template for Frequency of Visits, to let you fill in what the orders will be
- Gets the orders text from most recent 485
- Looks thru assessments for orders and goals written on a visit between most recent 485 from date thru the order date that were not completed by the current employee or were assessment type 01 or 04
- Gets the goals text from most recent 485

23. Create Post Hospital Orders

From Orders click on the dropdown list for Type:, click on Post Hospital / Recert Orders, enter the number of days to

look back and pull information, click on Create Post Hospital Orders. The following is the information that will be pulled:

- Details of facility history from newest to oldest
- Current ICD codes
- Current medication
- Put template in for Frequency of Visits, to let you fill in what the orders will be
- Get orders text from most recent 485
- Look thru assessments for orders written on a visit between most recent 485 from date thru the order date
- Get goals text from most recent 485
- Look thru assessments for goals written on a visit between most recent 485 from date thru the order date
- **Note: If no facility information has been entered then you will receive a message telling you to enter it first.

24. Create Discharge Order

After the discharge information has been entered in the referral screen you can create a discharge order for the doctor.

- Pull up the patient from Select Patient screen
- Click on Orders
- Change the date as needed
- Click on the drop down list Type and select Discharge
- If Add Admin Thru D/C summary is checked then all information that shows up on the 60 Day Summary will appear on the Discharge Order
- Click on the **Create D/C** bullet
- When you have finished the order click **Save** and create the Order.

*Note: Any of the information that appears can be deleted or changed.



25. Create a Visit/Assessment - RN

*Note: Most required fields change based on the agency needs. The required fields mentioned below are common, but your agency's may be different. Not all screens are reviewed in this article, only a few to show you how the screens work.

1. To create a visit, login to Barnestorm Point of Care.

2. To begin, select a patient by either searching the first or last name or chart number. You could also click **My Patients** or **My Recent Visits**.

3. Select a patient by clicking on the line that has his or her name and chart number.

4. The patient's name will appear in the top window under **Currently Selected Patient**.

5. With the patient selected, click the **Visits/Assessments** button on the left menu bar.

6. The visits for the selected patient will be displayed in date order.

7. Notice that all of the buttons at the top of the screen except the **New** button are not highlighted. This is because there is not a visit selected.

8. Click a visit note to select it. If you created the note, you can select any of the options at the top of the screen.

9. To create a new note, click the **New** button.

10. Areas that appear in red are required. The **Assessment Type** is required. Select a type by clicking on it. Notice that the **Assessment Type** panel has now been collapsed. You will be able to change this later if needed.

11. Select the payer for this visit.

12. Select the job code for this visit.

13. Select the visit status code for this visit.

14. After filling in the 4 required fields to begin a visit, the visit screen will open more options:

• The visit start date and time (this is required before you can enter information about the visit).

 \cdot The visit end date and time (this will be completed at the end of the assessment).

 \cdot A short description of the patient. If this does not match the patient that you are visiting, start again by closing out of this screen by clicking the **X** button in the upper right.

· Any visit comments that you wish to type in.

15. The visit start time is an essential piece of information. When you are ready to start the visit, put in the correct date and time and click the **Start** button.

16. Notice that after you click the **Start** button, two drop-down menus will appear on the left. One menu has the required screens and the other has optional.

17. Click on the Required menu, you'll notice all the screens pop up that need attention.

18. Let's enter some information about the vital signs. To do so, click the **Vital Signs** button.



19. The vital signs screen will appear. Items in red are required if you are taking the vital signs. Items in blue are optional.

20. Enter the temperature of the patient in the **Temperature** box.

21. Select the method used to take the temperature. Notice that the field turns green, meaning that it is completed and that you can move on to the next field. While the field turns green, this does not mean that your clinical documentation is done. It means that the item has been completed.

22. Enter the pulse. Select **Regular** or **Irregular** to complete the pulse.

23. Enter the respirations. Select **Regular** or **Irregular**.

24. After entering the blood pressure in the appropriate field, fill in any other fields that were recorded.

25. You can type in vital sign comments here.

26. The history of vital signs readings entered for this patient is displayed at the bottom, and can be used to recognize a pattern. You can also view vital signs here from other visit staff assessments.

27. Click the **EENTM** button on the left menu.

28. Note that the **Vital Signs** button has turned green to show that you have completed that section. You may click on the **Vital Signs** button again if you need to add more information to that screen.

29. To expand a panel within the EENTM, click the (+) button to the left of the name. This will display the pertinent information to be collected about that topic.

30. After selecting an answer, the panel will turn green.

31. Expand each section and select the choice that applies.

32. Next, click the **Pain** button on the left menu.

33. This screen has several tabs at the top of the screen. From the **Main** tab answer the OASIS questions and enter a comment as needed.

34. Click on the next tab, **Pain Locations**.

35. To specify the location of pain, you can either type in a location, or click on the * button.

36. When you click the * button, it will bring up this screen.

37. Select either **Anterior** or **Posterior**.

38. Then, select a location on the body that corresponds to the location of the pain. You can click on the image to select the area.

39. After the general location has been selected, you can choose a specific location by using the pulldown menu.

40. With the specific location selected, you can then click the **OK** button. The pain location is filled in.

41. After specifying a location for the pain, you can select more details regarding this location.

42. Fill in the intensity and description about the pain.

43. You can also add information about any exacerbation and alleviation dealing with this particular pain.

44. You can type in the blank white boxes with any comments you have about this particular pain.



45. To add more pain locations, click on the **Pain Location #2** tab at the top.

46. Click on the next tab, Pain Meds.

47. Barnestorm will list any medications that the patient is currently taking that are analgesic, antiinflammatory, NSAID or hypnotic at the bottom of the page.

48. After selecting a medication from the bottom list, you will notice the information fills in at the top with the medication name and the dose/freq/route. You will need to type in when the medication was last taken.

49. Complete the short surveyor related to how the patient reacts to that medication.

50. Click on the **Nonverbal Pain Assessment** button.

51. From here click on all answers that apply to each category. You'll notice the score will add up while answering the questions. Click on **Definitions** to view the details about the answer. Click on **Definition** again to collapse it.

52. Click on Pain Comments to enter general comments.

53. Click on **Teaching** to select from standard teaching or type in your own teaching description.

54. Click on **History** to view the past answers for this patients pain assessment. You can view the most recent sever, first seven, or all assessment information.

55. To continue your visit note, simply select a button on the left menu. The visit is not complete if there are red buttons on the left menu bar, indicating that required information has not been entered. When there are no more red buttons on the left, and all the information from your assessment is documented, the visit is complete. Use the comments section on the **Start** panel to document any notes for which you cannot find a specific title or entry area.

56. Click the **Finish** button to finish the visit note.

57. Please take a moment to double-check the date, start time, and end time to ensure that the times and dates reflected are accurate. Click the **Set End Time** button to set the end time of the visit.

58. Click the **Preview** button to preview the visit note as it will print.

59. When you are certain that all information is entered and accurate for this note, click the **Lock** button on the Finish panel. The **Lock** indicates that the note is ready to be sent for billing. Billing cannot be completed until the note is locked.



26. Document a Wound

1. To begin the creation of a visit, login to Barnestorm Point of Care.

2. To begin, select a patient by either searching the first or last name or chart number. You could also click **My Patients** or **My Recent Visits**.

3. Select a patient by clicking on the line that has his or her name and chart number.

4. The patient's name will appear in the top window under Currently Selected Patient.

5. With the patient selected, click the Visits/Assessments button on the left menu bar.

6. The visits for the selected patient will be displayed in date order.

7. If you have already created a visit note for the patient, you can add wound information to it by clicking on the visit and then clicking the **Edit** button. If you do not have a visit, click the **New** button.

8. Click the **Wound Assess** button on the left menu bar to create an assessment of the wound.

9. If you have already started on a wound, you can select it by clicking the **Select a Wound** button.

10. If the <u>selected</u> wound has any information on any other notes, it will be displayed when you click the **Show Wound History** button.

11. To create a new assessment for a wound, click the New Wound button.

12. After you click the **New Wound** button you will notice that the wound has been assigned a number at the top of the screen.

13. Type in the description of the wound.

14. Select the type of wound by clicking on one of the type options. If the type is not listed, you can enter it in the text box. You must specify wound type.

15. If the wound is a pressure wound, you may select the stage of the wound. If you do not remember the stages, click the **Show Stages** button. The stages of the wounds will be displayed. After you figure out which one you require, click the **Hide Stages** button.

16. Select the appropriate stage.

17. To specify the location of the wound, you can either type in a location, or click on the * button beside the location box . The screen below will pop up when you click the * button.

18. Select either Anterior or Posterior.

19. Then, select a location on the body that corresponds to the location of the wound. You can click on the image to select the area.

20. After the general location has been selected, you can choose a specific location by using the pull-down menu.

21. With the specific location selected, you can then click the OK button. The wound location is filled in.

22. A wound location can also be typed in instead of using the * button.

23. At this point you have filled in all the required fields for this wound. The rest of the fields are optional.

24. If you measured the wound on this visit, enter the dimensions.

25. You may also enter how the patient tolerated the dressing change.

26. You can specify whether the wound is inflamed or not.

27. You will notice that the description at the top of the screen is filled in with the options that you have selected.

28. If you took the patient's temperature on this visit, you can enter it here.

29. Select a pain scale to document the pain level of the patient.

30. There are some optional buttons to help you quickly enter more information about the wound. Click on any button that matches information you wish to enter.



31. Click the **Edges** button. The **Edges** screen will be displayed. The intent of this screen is to save time by clicking on buttons instead of typing. But, if you wish to type in a description of edges, do so, and then click the **OK** button. Otherwise click the buttons that describe the edges and then click the **OK** button.

32. You can type in additional text about the edges or just click OK.

- 33. After you click the **OK** button, you are taken back to the wound screen.
- 34. Click the Drainage button.
- 35. Click buttons to describe the drainage and then click the **OK** button.
- 36. Click the Odor button.
- 37. Click the Peri Skin button.
- 38. Select the button the describes the skin and then click the OK button.
- 39. Click the **Tunneling** button.

40. As you enter information in the gray area for Tunneling, Undermining, and Sinus Track the text will show above noting which category it came from.

- 41. Select the button that describes the odor and then click the OK button.
- 42. Click the **Teaching** button.

43. Click buttons for the subjects that were taught. As always, you can type in any teachings that that do not appear on buttons.

44. Select whether the teaching was verbalized or demonstrated and the patient's understanding if applicable. You can select the percentage of the teaching that has been completed.

45. You can select a Status for the wound as well.

46. At the bottom of the screen, you can type any comments that you have about this wound.

47. Click the Preview button, which will also save the information you have entered.

48. The print preview shows all of the information that collected about the wound. If you wish to change any information, close the **Print Preview** window and change information as needed under **Wound Assessment**. Otherwise you can add any other applicable areas to the note by clicking on their buttons to the left, or just click **Finish** to complete the note.



27. Create a 485 from the Assessment

You can create a 485 from a Start of Care or <u>Recertification</u> assessment. (This allows the assessment information to be fully utilized, and also eliminates re-typing.)

- After the visit assessment is complete go to the Finish screen and set the end time.
- At that point the **Build 485 Document** tab will activate. Click on the **Build 485 Document** button. On the next screen, verify that the from date is correct, change the number of days in cert period, and apply the verbal SOC date as needed.
- Click the **Create** button. A message will appear saying the 485 Document has been created.
- Click the **Preview** button to view what the printed document would look like and to verify the data entry of information.

If you need to go back into the visit assessment to make changes to 485 information, be sure to **Rebuild the 485** from the Finish screen. This will copy the changed information to the 485. Repeat the steps above. Instead of Create, the button will say **Rebuild.** When you click on **Rebuild** a message will pop up asking if you want to replace the information on the 485. Click on **Yes**.

28. Create an OASIS from the Assessment

You can **ONLY** create an OASIS from a Start of Care, <u>Recertification</u>, Resumption, Special Followup or Discharge assessment.

These instructions describe how to create an OASIS from within your visit assessment (Visits/Assessments).

- After the visit assessment is complete, go to the **Finish** screen and set the end time.
- At that point, the **Build OASIS Document** button will activate. Click on the **Build OASIS Document** button. (NOTE: If payer is not selected, on start screen, this tab will not activate.)
- On the next screen answer M2200, M0110 and M0090 and then click on Create.
- A message will appear saying the OASIS Document has been created.
- Click on **Review and Verify All Data** to make sure all the questions are answered appropriately. Depending on your agency procedure you can **Lock the OASIS**, if complete.

IMPORTANT Note: If you go back into the visit assessment to make changes to OASIS questions, be sure to **Rebuild** the OASIS from the **Finish** screen.

This will copy the changed answers to the OASIS. To rebuild, follow same steps from above. Instead of clicking on Create, you will click on **Rebuild**.



29. Enter a Late Entry on a Visit Assessment

After the note has been reviewed and locked you can add a late entry. From **Barnestorm Office** or **Point-of-Care** pull up

the patient and click on the visit from the Visit/Assessment screen.

- Click on Late Entry
- Place the cursor in the right column under today's date
- Type the description of the late entry
- Click on Save.
- Click on today's date under the Late Entries column
- Click on Preview. You can print the late entry from here or Print/Preview the note and it will be added to the end of the note.

While you have the visit highlighted on the Visit/Assessment screen you'll notice the number of late entries for that note (ie. Late Entry (1).

To Delete a Late Entry:

- Select the assessment that has the late entry
- Click on the Late Entry
- Replace the description with the word "delete"
- Click on Save
- A message will pop up asking if you want to delete the entry. Click on Yes.

A case manager can enter a late entry on other employee visit notes. The case manager must be the first employee listed in the Referral > Employees screen.

Physical Therapist can enter late entries on physical therapist assistant if:

- 1) The PT is employee number one or two on the Referral > Employees screen.
- 2) The PT has a revenue code of 0420 or 0421.
- 3) The PTA has a revenue code of 0429.



30. Aide Plan

In this document, you will find instructions for creating a plan of care for a patient, to be performed by an aide. Nurses typically create the aide plans. Only one panel shows at a time.

1. Select a patient by clicking the **Select Patient** button from the main menu and then typing the chart number or the first 3 letters of the patient's first or last name. Then, select the patient from the list.

2. From Point of Care you can pull this screen up from the Aide Plan tab on the main menu or you can go to the Aide POC screen within the assessment.

3. The name of the patient appears at the top of the screen. There are 4 panels at the top: **Scheduled Task, Current**

Status and Precautionary Information, Vital Sign Parameters to Notify Case Manager, and Special Instructions.

4. To select items, click on them. They will turn blue, indicating that they are selected. To unselect, click again. When you have selected each item that applies, you can click on another bar to add more information. Note that if you need to add any precautionary item or instruction that is not listed here, you may type it in the **Special Instructions** panel.

Scheduled Tasks: this is where you select the tasks that the Aide will perform.

- Specify the duration of this aide plan:
 - a. The Weeks box allows you to indicate how many weeks this plan applies to.
 - b. The **Start** allows you to indicate when this plan should start.
 - c. The End allows you to indicate when this plan should end.
 - d. The Freq shows you the freq format with the information from Weeks, Start, and End.
- Select each task for the aide. You may click them in any order you wish. The selected task will appear as blue.
- At the bottom of the panel is a calendar week, which allows you to plan the weekly aide tasks.
- When you have selected all of the tasks you wish the Aide to perform on a given day, you can click on any of the selected (blue) items, hold your mouse button down, and drag your mouse to the day when you wish those tasks to be performed. While your mouse is on the correct day, release the mouse button. The tasks will appear in a list on that day.
- If the list of tasks is the same for another day, just select any blue item and drag the list to another day. The same list will appear for that day.
- You can change the selected tasks by clicking on more tasks, or by clicking on a blue task to deselect it if you do NOT wish for it to be performed.
- You can drag and drop the updated list onto whichever day applies.
- If you have placed a task on the weekly calendar by accident, you can place your mouse cursor over that task, and click the RIGHT mouse button one time to remove it.
- Note that if you have already placed tasks on a day and wish to add just one more, you will need to deselect the checkbox under the task area on the right that says "Drag all checked items". When this box is NOT checked, you can drag just one item at a time onto the calendar.



Current Status and Precautionary Information: this is background information about the patient that the Aide may need to know. You only need to fill in this information once and it will appear in the notes for the Aide.

Vital Sign Parameters to Notify Case Manager: you can set an upper and lower limit for vital signs so that the Aide knows to inform the Case Manager if the vital sign exceed or drop below the limits you set. Click the **Fill Defaults** button to automatically fill in each vital sign with the default answers. ***Note:** See article Aide Visit Note to see how this impacts charting.

Special Instructions – allows you to type any additional instructions or information for the Aide as needed.

5. Click on Print to select preview options that allow you to view the plan in different ways:

a. Week View that shows a five day week. Check "Include Weekend" to show a seven day week.

b. Month View shows 4 weeks

c. Day View shows just one day

d. Text Only view lists the tasks and patient information in text-only form.

e. **CM Sign** - when this is checked the a line will appear for the case manager to sign. When this is unchecked it will have a place for the aide coordinator to sign.

o Once you click on one of the preview buttons it will show you the preview of the form.

o The printer icon is in the upper left corner of this screen.

o Click on the **Close** button to exit the preview screen.

6. If you plan on using the Aide Schedule and Aide Visit Note feature in Barnestorm to create assessments, complete the **Billing Info** tab. This will place the program/payer, job code, and time in/out into each scheduled visit that will be created.

7. Once you have completed the weekly schedule, click the Save button on the left.

8. When you click on **Save** a schedule will be created with task information inside of it. It will show for the amount of time that you selected in the frequency weeks, start, and end. *Note: See the article on Aide Schedule and Aide Visit Note for information.



31. Messaging

The messaging system in Barnestorm is similar to inter-office email. The intended purpose is to aid in the communication of information between employees that are logged into the Barnestorm system. Message recipients are notified that they have a new message by a pop-up in the lower right hand corner of their screen and also, a red banner notification across the **Select Patient** screen. Messaging will only work when employees are actually logged into the Barnestorm system. Point of Care users must synchronize before receiving any new messages. *Messaging will also allow you to choose if you want to send the message via text message or email.*

Creating new messages

New messages can be created from several points within the software, including the Referral screen, Scheduling screen and the Messaging screen.

	Employee: 0001	Add Recipients		
>> Send	Employee: 0013	HURST, EMPLOYEE	Active Patient	
	Patient: 600287	LEMON, ROBERT		
Subject	Text Subject		Barnestom Message	
Messages shou	uld be delivered immed	iately	◯ Email ◯ Text Message	

- To create a new message from the Messaging screen, from the main menu, click **Messaging**. Click the **New Message** button. This screen will appear:
- Recipient, subject and message text are required, the chart number is optional. Uncheck "Active Patients Only" to search for discharged patients.
- Send To options will include One or more employees, All Employees (this will select ALL active Barnestorm employees), or a Team of employees that has been setup under codes. See Employee Team Codes article on how to setup teams.
- Messages can be sent and delivered at a future date. This is particularly useful for visits or reminders that need to happen in the future. To create a message that will send in the future, uncheck the box that says **Messages should be delivered immediately**. Then fill in the date and time that the message should be delivered.
- Select how the message should be sent to the user; Barnestorm Message, Email, or Text Message. See the attached article on how to setup Email and Text.
- To send the message, click **Send**.
- *Point of Care users will have to sync to send their messages.



Receiving Messages

Once a message has been sent to you, a notification will pop up in the lower right hand corner of your screen and across the Messaging button from the Main Menu. It will look like this:

Barn	estorm Reminder	×
3	Subject: Test Mess	age
Clic	k to dismiss this remi	inder

n Supplies
1 New Unread Msg(s)
Schedule Entry

- Clicking the text at the bottom that says **Click to confirm receipt of this message** will mark the message as *Read* and it will not pop up any more.
- The message will continue to pop up until you mark the message as *Read* or delete it from the messaging screen.
- Clicking the text that contains the sender and the subject will display the message for you in this window:

All	Reply Forward	turn Off Delete
From: To:	EMPLOYEE SUNFLOWER EMPLOYEE BRIARPATCH EMPLOYEE HUR ST	Sent: 12/29/2016 8:40:00 AM
Chart: Subject: Message:	ROBERT LEMON (600287) Text Subject	
Message: Type you	r message here.	

- This window is a read-only view of the message that you just received.
- To mark this message as *Read* and discontinue the notifications associated with this message, click **Mark as Read**.
- To reply to the sender with a new message, click **Reply** or **All** to reply to all employees.
- To discontinue receiving future messages, click **Turn Off Alerts**.
- *Point of Care users will have to sync to receive and send new messages.



32. Use Schedule Calendar

This article explain show to use the Schedule screen in Barnestorm from Employee Activity >Schedule Calendar.

The first thing that you will notice is the 7 tabs at the top of screen. These tabs allow you to view your schedule in different views. Before we get into the tabs, lets briefly go over the settings:

<u>Top Menu</u>

Scheo	dule Entr	y Day View Week View	Month View	Directions\Map Cas	e Load Settings	
A	0	January 2013	31	Print Schedule	Employee: 0114	NURSE, MY
9		1001	Pri	nt Calendar 🔘 Print Text	Employee Patient	2
Sho	w Unas	signed Items 🗌 Show Cert				Scheduled: 39 hrs

From each view of the calendar the main menu will show up to select specific information.

The forward and back arrow will scroll through the day, week or months. The **Print Schedule** will allow you to print the information on the screen; either in a calendar view or a text view. You can view one employee or one patient's schedule at a time.

Show Unassigned Items will only pull up patients that do not have an employee assigned to a scheduled visit. **Show Cert** will only work from the when you have the patient bullet selected, with a chart number entered. When you check the Show Cert bullet the most recent or current episode dates will appear at the top. You can view the scheduled entries for different cert periods. This will also show the five day window at the end of the episode in red; for 485 and OASIS data collection.

Schedule Entry

This tab displays a grid of scheduled appointments. Any scheduled item can be clicked which will invoke the **Add/Edit Schedule** (more on this later).

Filtering the grid:

You can use the forward and back arrow buttons to scroll through different weeks.

The filter icon lets you apply a filter on any item within the grid. You can click the filter icon to apply a filter to any of the columns that you have displayed. For example, you may want to only see scheduled items with a visit status code of 020. To do this, click the filter icon. In the drop down that is displayed, you would click **020** to apply the filter.

To remove a filter that you have applied, you would click the Filter icon and then click the **(AII)** option. There are also several other options for applying filters including a **Custom Filter**.



(Filter Grid screen shot)

Job 7	7 Vst	Ϋ Time In 🖓	Time Out 🔽	— Filter
061	(All)	1400	1430	lcons
061	(Custom)	1130	1300	
061	(Blanks)	0708	0930	
	020			Filter options
Job 5	7 026	Time In 🐨	Time Out 🗸	optiono
061	020	0930	1330	
061	020	0730	0800	

Day View, Week View and Month View

The appointments displayed in the calendar will be displayed like this:

	07 Monda	y 08 Tuesday	09 Wednesday
8 am	PATIENT,		
9 00	PATIENT2, SAMPLE	Drop off 🔩	Ì
10 00		9:00am-10:00am	
11 00	PATIENT4, SAMPLE	PATIENT2, SAMPLE (888889)	PATIENT5, SAMPLE
		Scheduled Visit Beware of dog	
12 pm	PATIENT5, SAMPLE	in front yard at times.	

Non-patient based appointments are identified by a thumbtack. Appointments can be moved to different days or different parts of the day by clicking and dragging the appointments. Appointments can also be resized, meaning that that start and end time of the appointment will be adjusted. To adjust the appointment, click it once, then mouse over the white box at either the top or bottom and resize the appointment to the desired height. Appointments are automatically saved when you move or resize them, so there is no need to hit a save button.



Adding/Editing appointments

To add an appointment, ideally you will find the spot on the calendar that you would like the appointment to appear and mouse over an empty spot for 1 second. The **Click to Add** indicator will appear. Clicking this option will invoke the **Schedule Editor** which can be used to create an appointment. To edit an existing appointment, click it once to select it, then click it again to invoke the **Schedule Editor**.

Employee:	0095	YOU	AN	IS, LAURA				Save and Close
Patient:	000002	PA	TIE	NT, TEST				Save
Program/Payer Job Code:	01/001 001	MEDI	CAI	RE HOME H	EALT	H		Remove Appointment
Visit Status:	I.						3	Set Reminder
Time In:	08/17/2	2008	-	07:00 AM	•		En	Recurrence
Time Out:	08/17/2	2008	-	09:30 AM	+	0.00		efault to Save

Only employees with the correct employee security will be able to add/edit schedules for employees other than themselves. In this example, the employee does not have sufficient permissions to change the employee on the schedule, so, it is disabled. When adding or editing a visit, the time slot on the calendar that is clicked will be the filled in automatically for you, or you can change it once you are in the schedule editor. Add as much or little information as you wish, the only requirement for Patient related appointments is a patient. The only requirement for Non-Patient related appointments is a subject.

Comments are a way to attach snippets of text to a scheduled visit, for example, "Dog is in the yard, be careful". These comments will appear below the appointment items on the schedule (if it is large enough to see it), on the tool tip that is displayed when you mouse over the appointment item and in the notes section when the calendar is printed.

Enter or tab can be used to navigate through the items on the screen (except for Comments, have to tab out of that one). Instead of searching for a description by typing, you can press the down arrow key to pull up a list associated with the field you are in - this will work in the employee, patient, program/payer, job code and visit status fields. If **Default to Save and Close** is checked then, then the last item in the tab sequence will be the **Save and Close** button. Clicking this button will Save the appointment and close the **Schedule Editor** box. If unchecked, the last stop in the tab sequence will be the **Save** button. Clicking this button will save the appointment on the screen and prepare for anew one. This is useful if you have several schedule items that you would like to enter. Clicking **Remove Appointment** will remove the selected appointment. Clicking **Set Reminder** will set a reminder within the system which will pop up and give you a reminder of your scheduled appointment. The default Reminder time is 15 minutes and can beset in the **Schedule Settings.** Clicking the **Recurrence** button will allow you to copy the selected visit to a selected recurrence. This dialog is similar to the one used in Microsoft Outlook and behaves the same.



Directions\Map

To use the directions/map feature, first click a visit on the day view, week view or month view calendar. Then click the **Directions/Map** tab. It will calculate the directions from the first visit, to the next, etc., on until the last visit. This can be used to optimize the trips in between patients.

*Note: You will need an internet connection for this feature.

Case Load

Use this feature to compare the scheduled visit load for each employee during a one week period. To select your week, click on any visit from the Day, Week or Month view. Then click on the Case Load tab. Each employee will be assigned a color for the graph. You will also have a chart that shows the number of visits for each employee, per day.

Chart for number of visits

判	Employee	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
> A	NDE, MY	0	4	4	2	2	2	1
H	IOMEHEALTH, NURSE	0	4	4	4	3	3	3
N	IURSE, MY	0	7	6	4	1	1	5
Н	IHNURSE	0	1	1	0	0	0	0
N	IURSE, MY	0	1	1	1	1	0	0
otal	S	22			10	- 15) - 200		
		Sum = 0	Sum = 17	Sum = 16	Sum = 11	Sum = 7	Sum = 6	Sum = 9

Settings

The Settings are a group of options that allow you to configure many things on the schedule screen. A lot of the settings will be saved for each user and loaded up each time the user returns. For example, if a user prefers to enter time in military time instead of standard, the user can check the Military checkbox and that setting will be saved for future visits to the schedule screen.



33. Start an Assessment from Your Scheduled Visits

From the **Main Menu** in **Barnestorm Point-of-Care** click on **My Schedules**. When you click on this button, a list will appear that shows your scheduled visits in date and time order, with the soonest listed first.

- To start a visit from here, click on the line of the scheduled visit (shown below) and it will give you the option to **Start Assessment**.
- When you click on **Start Assessment** you will be directed to the Start screen of the assessment to verify or fill in questions about the assessment.
- At this you will want to verify the start date and time.
- Complete your assessment, as required by your agency.



- If you exit the assessment without finishing it, you can select the scheduled visit from the My Schedule button instead of Start Assessment you will see Edit Assessment. You can use this button to pull the assessment up to
 modify it.
- Note: if the Edit Assessment button is NOT active then the assessment has been locked. You will need to unlock
 the assessment from the Visits / Assessments screen.

😫 Edit Assessment	🤪 New 🦯 Edit	Rent Print
Date/Time Chart#	Patient Name	Pg/Pyr Job Typ Comments
Mon 07/22 08:00 888888	PATIENT, SAMPLE B	01/013 002 11
Mon 07/22 10:00 888890	PATIENT3, SAMPLE	01/005 002 11 888888 PATIENT, SAMPLE B
T 07 (33 10.00 888800	DATTENTS CANDLE	95 year old Black Male born on 08/27/1917

- The **New** button allows you to create a new schedule for the current patient selected. This will pull up the Add/Edit Schedule screen.
- The Edit button allows you to edit the currently selected schedule.
- The **Print** button will print the schedule.



34. Non Visit Screen

	New Entr	y/Cancel		Time Shee	t		Exit
Employee 0096	BARNES, CLARE			Data Entry Setti Time	Old N ings Mileage	on-Visit Entry Screen Rounding	
Time Code	✓ Round	Total Time	Show All	 ○ Total Time ● Time In/Out 	 ○ Total Miles ● Odometer ○ N/A 	Round .05 Round .25 N/A	How does this screen work
Time Out Mileage	to	Total Miles		Total Hours	Visit Time	Other Hours	Make This Screen
Save This Entry	Save This Da	ite		On Call Time	Travel Time	Miles	NonVisit Entry Screen
Meeting Fees	Meals	Misc Expense	Comm	ents			
From Sun 01-20-13	Date	On Call Travel	Other Charge	d ## VxNotes #	# Work Hours	Miles	^
Show Daily Totals -1 Week + 1 Week Print	Sun 01-20-13 Mon 01-21-13 Tue 01-22-13 Wed 01-23-13 Thu 01-24-13 Fri 01-25-13 Sat 01-26-13	$\begin{array}{ccccc} 0.00 & 0.00 \\ 0.00 & 0.00 \\ 0.00 & 0.00 \\ 0.00 & 0.00 \\ 0.00 & 0.00 \\ 0.00 & 0.00 \\ 0.00 & 0.00 \end{array}$	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	$\begin{array}{cccc} 0 & 0.00 \\ 2 & 1.00 \\ 0 & 0.00 \\ 0 & 0.00 \\ 0 & 0.00 \\ 0 & 0.00 \\ 0 & 0.00 \end{array}$	0 0 0 0 0 0	
Print by Program 0-Sun 1-Mon 2-Tue To select a different firs 3-Wed 4-Thu 4-Thu week, click 5-Fri 6-Sat in the box to the left.	Week Totals	0.00 0.00	1.00 0.0	0 0 1.30	2 1.00	0	
Check for Overlapping	_						¥
Times Visit Notes							~

Barnestorm POC: from the main menu, click Non-Visit Time.

The bottom panel always shows one week of dates. To add or change time for past or future dates (up to 30 days in the future) click on the **-1 Week** or **1 Week** button to change the week being displayed.

- Click on the date to be added/changed in the large white bottom panel. The display in the bottom panel will
 change to show you the detail of entries for that date. Charges show the visits that were manually entered from
 Barnestorm Office. Visits will show the assessments that visiting staff enter using Barnestorm Point-of-Care.
 Clinical staff will see their visits for that day at the bottom of the screen next to Visit Notes.
- To add a new entry, click at the top on the New Entry button, then enter the new data. If you don't know the codes, then enter the description in the text box to the right (for example, you could enter "TRA" and that would bring up options for Travel). Then enter Time In, Time Out, and Mileage if applicable. You can also add a comment (for example: travel from patient A to patient B). Then click the button for Save This Entry. ** Use the [Enter] or [Tab] key as you move to each entry. This will fill in the description and calculate each field appropriately.
- To change an entry, click on it in the bottom panel and it will be displayed at the top. Enter thru the fields on the screen, making changes as needed, and when you hit [Enter] on the **Save This Entry** button, it will mark the set



of entries as needing to be saved by turning the **Save This Date** button red. Click **Save This Date** when you are completely done with that day.

- The bottom panel always shows one week of dates. If a date has * beside it, that means there are duplicated entries for that date. You will need to go into that day that has the * beside it and the easiest way to get rid of the * is to Delete everything for that day and then the * should be gone.
- To delete an entry click on the entry and type in **DELETE** into the comments. Click **Save This Entry** and you will see Delete next to the entry in the bottom panel. When you are done **click Save This Date**.
- To add or change time for past or future dates (up to 30 days in the future) click on the **-1 Week** or **1 Week** button to change the week being displayed. Click on the date to be added/changed in the bottom panel. Enter the non-visit time and mileage. Click on the **Save This Entry** button.
- You can enter multiple entries in a row for the same date hit [Enter] or click on the **Save This Entry** button for each time/mileage entry.
- Be sure to click the **Save This Date** button before exiting out of the screen. If you try to exit without saving, you will get a message asking if you want to save that date.
- Data Entry Settings (on the right side of the upper screen):

•You can decide if you enter a total time or an actual time in/time out.

·You can decide if you want to enter total miles, an odometer reading, or N/A.

•You can decide how you want to round off the time, by .05, .25, or N/A.

If you have an entry for, let say, education and you need to get reimbursed for mileage and/or expenses. You can enter in your time for the education, mileage and you can also enter in amounts for Meeting Fees, Meals and Misc. Expenses, along with comments. These boxes are located under the Save This Entry and Save This Date buttons. This information will not show up on your time sheet but you can run a separate report. Go to Reports > Employees > 02.08 Mileage Reimbursement report. You can print this report which will list all the information that is needed to be reimbursed, sign it and you can hand this in as part of your documentation to get reimbursed. If you are entering this in POC you can ask your office staff using Barnestorm Office to print it out for you.

* If additional non-visit codes need added to the system, go to Codes > Program Related Codes > Non Visit Time Codes to add them.



35. Use Time Sheets in POC

- Click the **Time Sheets** button on the main menu.
- Your name will appear at the top left corner.
- Below your name is a list of weekly time sheets. By default, this list will show the most recent 10 time sheets.
- When you first go into the time sheet screen, your most recent time sheet created should appear.
- To create the next time sheet, click the **Create** button. The dates next to the **Create** button will be the next time sheet to be created. After you click the **Create** button, those dates are added to the list of **Time Sheets**.
- The top middle section provides the totals for visits, non-visits, and miles for the week selected.
- In the bottom large panel, will show the entries that you entered in along with your visits. Some of these are color coded.
 - Green is On-Call Time
 - Blue is locked visit
 - Red is an unlocked visit. Go into Visits/Assessments to verify and lock your visit
 - Grey is non-visit time
 - Dark Grey total time for that day
- If you need to edit your non-visit time, click on the Edit Time button. This will take you to your Non-Visit
 Entry screen (see Non-Visit Entry documentation as needed).
- When you are finished with your time sheet for the work week, click the **Save/Sign** button. This will give you a message stating that you will not be able to make changes, and asking if you want to continue. Click on **Yes** to complete the time sheet.
- If you wish to print the time sheet, click the Print button. The bottom of the printed page will show your electronic signature (if it has been captured in the system) and the date and time stamp indicating when you clicked on Save/Sign.
- If you need to edit your non visit time after you have already clicked on save/sign, ask your supervisor to unlock your time sheet.

5 Time Sheets -												
Employee: 00	96 BARNE	S, CLARE			Nex	ct Time She	et	01/27/13		Current Time Sheet	t	
Time Chest						Create	Thru	01/21/13		01/20/2013 - 01/26/2 Status: In Progress	013	
20130120 - 20	0130126	Δ D	elete	Time	Range	Totals	Tinu	02/02/13				
20130113 - 20	0130119		of Time	8:00	AM ≑	Visit	Non-Visi	t <u>Miles</u>				- 1
20130100 - 20	0130105	SI	neets	to		1.5	2.50	30		Save / Sign	Print	
20121223 - 20 20121216 - 20	0121229 0121222		10	5:00	DM 🛋	Total Hou	<u>rs</u>				Edit Time	
20121209 - 20	20121209 - 20121215 V 3.00 PM V 4											
T)	otals)	1.00 OnCa	11	0.00	No Pay	1.50 N	onVisit	1.50	Visit	4.00 Total		
Date	Time In	Time Out	Prog	Code	Description	on		Hours	Miles	Patients/Comments		
Mon 01/21	00:00 AM	01:00 AM	01	058	On-Call			1.00	0			
Mon 01/21	09:00 AM	10:00 AM	01	062	EDUCATION			1.00	0			
Mon 01/21	12:30 PM	01:00 PM	01	071	TRAVEL PT	. RELATED	1	0.50	30			
Mon 01/21	01:00 PM	02:00 PM	01	035	SUBSEQUEN	г		1.00		108499-SUNFLOWER,	JAN	
Mon 01/21	03:30 PM	04:00 PM	01	034	ASSESSMEN	г		0.50		106107-SUNFLOWER,	AERON	
					Totals			4.00	30			



36. Care Coordination Screen

Care Coordination Notes (CCNs) allow you to document patient-related information that is not part of a visit. For example, conversations with the doctor or caregiver.

1. Select a patient from the **Select Patient** screen in Barnestorm by typing in either the first 3 digits of the patient's chart number or the first 3 letters of their last or first name.

2. Click the patient's name to select him or her.

3. Click the Care Coordination button on the Main Menu.

4. Watch as the Add/Edit CCNs screen opens. The patient and employee will already be filled in.

5. To create a new care coordination note for this patient, click the **New** button in the upper left corner.

IMPORTANT NOTE: If the NEW button is <u>RED</u>, you have NOT clicked it and anything you add will NOT BE SAVED!

The NEW button will be <u>GREEN</u> if you have clicked it to start a new care coordination note. Make sure the New button is <u>green</u> before you add information about a new care coordination note to this screen.

6. The employee who is filled in will show as the person who is logged in, but you can change the employee to enter a care coordination note that someone else gave or received.

7. Under the employee is the **When** area. Fill in the date and time that the communication (call, conversation, letter, fax) occurred. Also fill in how long it took in the blank that allows you to fill in minutes (optional).

8. Below the **When** items, there are boxes for **To** and **From**. If you made the call (or sent the fax, etc.), then check the **To** box. If someone else contacted you, click the **From** box.

9. Next, click the **Select From/To** button. This will pull up a list of the people associated with this patient, including the doctors, emergency contact, caregiver, nurse, and any person associated with this patient.

10. You can select a person from the list that came up when you clicked **Select From/To**. Select the person by clicking on their name. Or, if the person you need is not on that list, you can type in the name in the box beside the **To** and **From** boxes.

You can include as many people as needed in the Whom box.

11. Next, click on a **Topic** button. Select a topic from the list that appears. If you need to specify a different topic, click the **Other** item and the text box will become activated. You may type the topic into this area.

12. The **Status** area indicates whether the status of this note is **Open** (meaning unresolved or uncompleted) or **Finished** (meaning resolved or completed).

13. To include this care coordination note on the patient's 60 day summary, check the **Add to 60 Day Summary** box near the top (beside the **When** items).



Discussion:		
Tro		
cc: Staff		
cc: Select		
Spell Check		

14. Next, add the information that was communicated in the box called **Discussion** near the bottom of the screen.

15. If the doctor is communicating orders, you may click the **T** button (Text Items) and you will see a list of common orders pop up at the bottom of the screen. If you need to select more than one of these orders, you can click the box beside **Multi-Select**. Then, click as many orders as you need.

16. When you finish selecting orders, click the **Insert Select Text** button above the list of orders.

17. The list of orders will close and you will see that the orders you selected appeared in the **Discussion** panel.

18. You may edit, add and change the text in the **Discussion** panel as needed.

19. To copy other staff members on this care coordination note, click the **cc: Staff** button to the left of the **Discussion** panel.

All staff involved will be able to retrieve the note. If you only want select staff to retrieve the note then click on cc: Select.

A list of all employees will appear for you to select from. A cc note will appear at the bottom of the Discussion panel, and other staff members will be able to retrieve the notes (instructions for this are available under "Receive Care Coordination Notes Copied to You").

🔲 Landscape	🔲 Pt's BirthDate	🔲 Large Font	Print This CCN	Save

20. When you have completed the care coordination note, you may print a copy of it by clicking the **Print This CCN** button the bottom of the screen. You also have the option of printing the note in landscape, add the patient's date of birth, or print large font.

A print preview window will appear, and you can click the printer icon in the upper left corner to print the page. Click the X in the upper right corner to close the print preview and return to the care coordination screen.

21. Click the **Save** button in the bottom right. Be sure to mark the note as finished when it is complete and save the note again.

* Note: you can use digital or the employee's signature. See the related article below on how to change options.



37. Barnestorm Support - Help Button

When you click the Help button on the main menu of Barnestorm, a page comes up with a variety of options.

<u>**Requests**</u> feature allows you to request a call from Barnestorm online. This saves you time because you don't have to call and leave a message—you can just enter your request while you are in the Barnestorm software and we will call you back as soon as possible!

Request Meds When you don't find a medication you need in the Barnestorm software, you can submit a request for the medication to be added to the software.

Don't forget to import new medications regularly--we may have already added the med you need. From Barnestorm Office, click on **Codes** > **Other Basic Codes** > **Medicines**. Click on **Import New Medicines**.

<u>Chat</u> is for technical support that allows you to type your question in with a live Barnestorm support representative. This option is great for getting quick answers to questions—you'll be surprised how much faster it is than calling!!

<u>Knowledgebase</u> is for technical support that allows you to search our extensive database of articles about Barnestorm software. We have instructions for every task that you can do in Barnestorm, and you can print them out or even email them. We also have tips and tricks from other users that we record when users call in to ask questions.

<u>Contact</u> A new toll-free support number (this number replaces the 800 number you have been using): 1-877-999-1171.

This number allows you to select which product or area you need support on, so that we may help you more efficiently.

Choosing Your Technical Support Method

Questions involving instruction and training: Search the Knowledgebase to find instructions on how to do anything in Barnestorm.

Questions involving errors or problems: For example: "I can't start Barnestorm." Use Barnestorm Chat for an immediate answer

Issues involving inability to use the software, inability to bill or get paid: For example: "I am having an issue with billing." Call us at 1-877-999-1171

Issues involving printing, error messages, inability to do normal work functions:



For example: "I tried to go into this screen and the software beeped at me." If an answer is needed immediately, Submit a Request, otherwise enter a Tracker item

Issues involving software enhancements/requests:

For example: "I wish Barnestorm software would do this for me" Submit a Request

and we'll put the item into our development log.

Please note that software change requests are subject to our policy on customization development:

http://kb.barnestorm.biz/KnowledgebaseArticle50669.aspx



38. Synchronizing Point-of-Care

You should synchronize your Barnestorm Point of Care as often as possible. You can click on **Synchronize** from the Main Menu in **Point of Care**.

If you're in a hurry you have a choice to send your data to the server only and not retrieve any other data. Click on the button **Send My Updates and Quit**.

Click on **Test Connection** and then **Start Sync** to begin synchronizing. You'll see two numbers separated by a forward slash, ie. 558,998/570,244. The first number represents the last log number that has been processed on the server, and the second number represents the total number of log entries that are to be processed. After those two numbers match up then it starts to send over your information to the server, and the two numbers will represent your local server's log numbers. Towards the end it deletes all patient data that is at least 120 days old (from your local database - not the server). The number of days may be different to reflect the agency needs.

After the sync is finished two buttons will appear. One is to retrieve any missing active patients and the other is to retrieve missing data for one patient. When you click on the missing active patients button a message will appear letting you know if all active patients are already loaded or if there are any active patients on the network server that could not be found on your local server. To retrieve missing data for one chart number click on the button **Recover 1 Selected Patient by Chart #**. Enter the chart number then click on the button again. A message will appear after finished. You can also retrieve any missing active patients by clicking the **Recover Missing Active Patients** button. If you notice a patient is missing click on this button and it will retrieve that patient. A message will pop up saying "All active patients are available" or "# Patients Added".

After the sync has finished click on the button **Speed up**. This will shrink your sync files so that it will sync faster next time you sync. Run this as recommended to help with loading your screens faster within Point of Care (switching from screen to screen or pulling up patients).





39. Barnestorm POC Patient Security Feature

There is a security feature of Barnestorm Point of Care software that is activated when a user logs in three times incorrectly.

If this happens, the software will remove all of the patients from the tablet database. All of the information collected on the tablet will be retained, but, the vital patient data needing to be secured will be removed. If the user is able to remember the password and eventually get logged in, there will be no patients to search from, thus restricting access to areas of the software that are patient-specific.

• Once this feature has been activated, the only way to recover the patient information is to connect to the original network on which the main server resides. Once connected, a Barnestorm Office Admin user can unlock the profile from the Employee Activity screen so that the user can login and complete a sync; or start a chat for a rebuild of the database. The sync/rebuild will send across any information that was collected on the tablet, then the patient recovery mode will be activated. This will recover all the patients and insert them back into the database on the tablet.

*Note: If a user is habitually forgetting the password, the password can be changed.