

Frequently encountered questions about the NDoc Patient Problems Logic:**• *How do I access the Patient Problems List?***

The Patient Problems List can be accessed from everywhere within NDoc. If you are charting on the patient and want to see the Problems List, double-click on the patient underlined name in the header to display the Patient Summary on the Home Page, then click the “navigate to” dropdown and select “Problems”. If you are charting on a different patient, you can still see this information, by going to the Home icon in the header, which will take you to the main page and selecting the search icon and entering the name of the patient, select the patient and click on the summary button and then navigate to Problems and view the problem list.

• *What if the problem develops after the SOC visit is charted?*

NDoc analyzes the problem list every time you sign-off a visit. New problems are identified through a combination of Current Status field entries and those fields identified with the word “New” such as “New Pain” in Pain management. Identifying a new problem will create a new entry on the Patient Problems List along with the date, visit and clinician whose charting created the entry. The appropriate interventions and outcomes will also become highlighted along with the categories containing them for easy focus. This section is cumulative so as problems are identified by other disciplines you will see the problems listed in this section.

• *How can I tell what fields were charted that created the problem in the first place?*

To easily trace what may have been charted to create a problem on the Patient Problems List, place your cursor over any highlighted intervention or outcome within visit charting and click the HELP button. NDoc will display a list of all associated problems for the field selected.

• *My charting created a problem, but the problem is this patient’s baseline. Since I don’t expect to achieve a different outcome, what do I do now?*

If you chart the applicable outcomes as “chronic but stable problem/protocol identified”, NDoc will resolve the problem, display the outcome resolution reason of “chronic but stable problem/protocol identified” directly on the patient’s Problem List, and the problem will not be triggered again.

• *Do the intervention and outcome categories stay highlighted forever?*

No, categories containing active (unresolved) problems, interventions and outcomes will be highlighted as well as the intervention and outcome fields themselves. Once all problem-related interventions and outcomes are charted, the problem is resolved and the associated highlights will disappear. (Note: you cannot chart the final problem-related outcome until all the problem-related interventions are charted as well). Instructions that are marked as “repeat instructions” will remain yellow to remind you that this has not yet been achieved. Highlighted fields that remain unanswered will become “required” upon discharge, so that all identified problems and their related interventions and outcomes are addressed before the patient is discharged.

• *Where do I add the orders and goals for the Plan of Care (POC)?*

NDoc automatically populates the POC with interventions and outcomes that mirror those on your charting screens. Additional fields, such as Discharge Plan and Rehab Potential, are charted directly in the Assessments and flow to the POC.

• *I want to have the patient’s goals and outcomes to be measured. What can I do to make them specific or measurable?*

NDoc provides the option to use SMART Goal logic. Goals and outcomes can be updated to include Due Dates. These dates will display in the record, within the Problems List, and on reports that provide a listing of a patient’s problems. Additionally, users can track these due dates using the SMART Goals report under Reports>Management/Stats. Finally, settings can be configured to manage SMART Goals within the Employee Dashboard and within Visit Charting. These settings are described under the SMART Goal Charting section of the Managing NDoc Guidance resources.

Agency Notes

Summary of the NDoc Patient Problems Logic: Visit Charting

Category hyperlinks containing problems, interventions and/or outcomes are highlighted so the clinician can easily focus on these areas.

ST.HAVEPATIENCE (M) ADM SSN
01/1929 (90) Acct: 1000054 TM/CM
05/19 (CERT 6) MR: 100064 Disc

History

Search

Patient Alert
Patient Identification
Vital Signs
Pain Mgmt
Medications
Systems Review
CPT Coding
Cardiovascular 3/3
1 2 3
Respiratory
Endo/Hema
Wounds >

The clinician can see the currently defined problems within every charting category in Today's Care.

Neuro/Emotion
Sensory
Musculoskeletal
Activity
Safety
Infection
Wellness/Screenings >
Supplies

Cardiovascular Outcomes
Short Term

Verbalizes S/S of edema and action to take.
Verbalizes S/S of angina and action to take.
Verbalizes S/S of hypertension and action take.

Due: 06/20/20
 Due:
 Due:

Long Term

Demonstrates improved cardiac output.
V/S, weight, CR status within normal range for patient.
Demonstrates understanding/skills re: cardio.
Demonstrates ability to self-manage cardiovascular disease process.
Demonstrates ability to manage pacemaker/defibrillator.

Due:
 Due:
 Due: 06/20/20
 Due: 06/20/20
 Due:

Cardio Problems:

chest pain **associated problem added in error** **associated problem = baseline condition**
 edema **associated problem added in error** **associated problem = baseline condition**
 hypertension **associated problem added in error** **associated problem = baseline condition**
 pacemaker/ICD **associated problem added in error** **associated problem = baseline condition**
 knowledge/skill deficit: pt **associated problem added in error** **associated problem = baseline condition**
 knowledge/skill deficit: cg **associated problem added in error** **associated problem = baseline condition**

Users have an option to manage problems triggered in error or problems considered baseline with two "Problem Override" options. Specifically, each active problem displays "associated problem added in error" and "associated problem=baseline condition" checkboxes. If a problem is active, then the new option can be used to manage associated instructions/outcomes. If checked, then all instructions are charted with "N/A: not required" and all outcomes are populated with the corresponding value (i.e., associated problem added in error" or "associated problem=baseline condition" respectively). NOTE: If "associated problem=baseline condition" is selected the problem will not re-trigger.

Visit Charting Details/Options:

As users document and identify patient problems (within OASIS, HIS and Today's Care), the problems along with their associated interventions and outcomes are triggered and begin forming the basis of the patient's plan of care. Users can also identify specific issues to be addressed in the AIO section as described in the FASTForm for Additional Assess/Instruct/Outcome (AIO) Statements. These will then appear on the Problems List in Patient Summary along with the other problems identified, once you have signed off the visit. Note that all charting follows the same flow. It begins with a patient history related to the category (if applicable), a family history, followed by a current status, followed by the identification of knowledge/skill deficits, instruction and outcomes (where applicable) as well as a display of any active problems contained in the category. In the case of Assessments, OASIS Questions fall between the current status and identification of knowledge/skill deficits.

AT TIME OF VISIT SIGN-OFF NDoc automatically analyzes the charted data and creates/updates the customized Patient Care Plan consisting of Problems, Interventions and Outcomes. Once a problem is defined, the following things also automatically take place.

- The identified problem appears on the Patient Problems List along with the date it was identified (Add Date).
- All categories containing a problem or its associated interventions and outcomes will be highlighted in yellow for easy identification and charting focus.
- All instruction and outcome fields associated with the problem will be highlighted in yellow.
- Any un-addressed problem as well as its related interventions and outcomes will change from yellow (highlight) to pink (required) at time of discharge, for charting compliance.
- Pre-defined POC orders and short and long-term goals related to the problem print on the POC and mirror the interventions and outcomes on the charting screens.
- All resolved problems appear on the Problems List with the appropriate Resolved Date.
- If the "Problem Override" option is used to manage a problem triggered in error or a baseline problem, then all instructions are charted with "N/A: not required" and all outcomes are populated with the corresponding value (i.e., associated problem added in error" or "associated problem=baseline condition" respectively). NOTE: If "associated problem=baseline condition" is selected the problem will not re-trigger.

Due date options are available for measuring goals using SMART Goal logic. The due date is only required when agencies configure the settings to make them required. See the SMART Goal Charting section of the Managing NDoc Guidance resources for details on these settings.

Patient Summary > Problems List

• Problems display in categories that mirror those in Today's Care.

• Use the + or – to expand or collapse the applicable interventions.

Account History > Account Summary
Problems

(Navigate to) ↗

JENTEST,BEPATIENT [ADM] Current Account Homecare Patient

Acct: 1002075 DOB: 08/01/1949 (69)
MR: 101620 SOC: 05/15/19 (CERT 1)
Sex: M SSN: 369-25-8159

Team: CRN CM: Thornberry,JenB
DNR: Y Co: Home Health Care
HHRG: C2F1S1 Loc: Lancaster West

Problems

Type	Description	Added	Resolved
Dx	E11.65 Type 2 diabetes mellitus with hyperglycemia I50.22 Chronic systolic (congestive) heart failure I67.2 Cerebral atherosclerosis N40.0 Benign prostatic hyperplasia without lower urinary tract symptoms	05/01/19 O 05/01/19 O 05/01/19 O 05/01/19 O	
+ Endo/Hema	newly diagnosed diabetes knowledge/skill deficit: pt knowledge/skill deficit: cg	05/15/19 05/15/19 05/15/19	05/23/19 05/23/19 05/23/19
+ Activity	ADL assistance required knowledge/skill deficit: pt knowledge/skill deficit: cg	05/15/19 05/15/19 05/15/19	

- Activity ADL assistance required 05/15/19

Assess
Assess ability to perform ADL/IADLs
Assess caregiver functioning
Instructions
Instr: coping mechanisms pt method
Instr: coping mechanisms pt comp
Instr: coping mechanisms cg method
Instr: coping mechanisms cg comp
05/15/19 Instr: ADLs pt method: verbal instruction
05/15/19 Instr: ADLs pt comp: verbalized
05/15/19 Instr: ADLs cg method: verbal instruction
05/15/19 Instr: ADLs cg comp: verbalized
05/15/19 Instr: measures to promote functional/self-care ability pt method: verbal instruction
05/15/19 Instr: measures to promote functional/self-care ability pt comp: verbalized
05/15/19 Instr: measures to promote functional/self-care ability cg method: verbal instruction
05/15/19 Instr: measures to promote functional/self-care ability cg comp: verbalized
Instr: community svcs/support pt method
Instr: community svcs/support pt comp
Outcomes
Verbalizes coping strategies to deal w/lifestyle chgs
Receives ADL assistance: in progress (Due Date: 06/23/19)
Demos ability to manage ADLs/IADLs w/ or w/o assist: in progress (Due Date: 06/30/19)

knowledge/skill deficit: pt 05/15/19

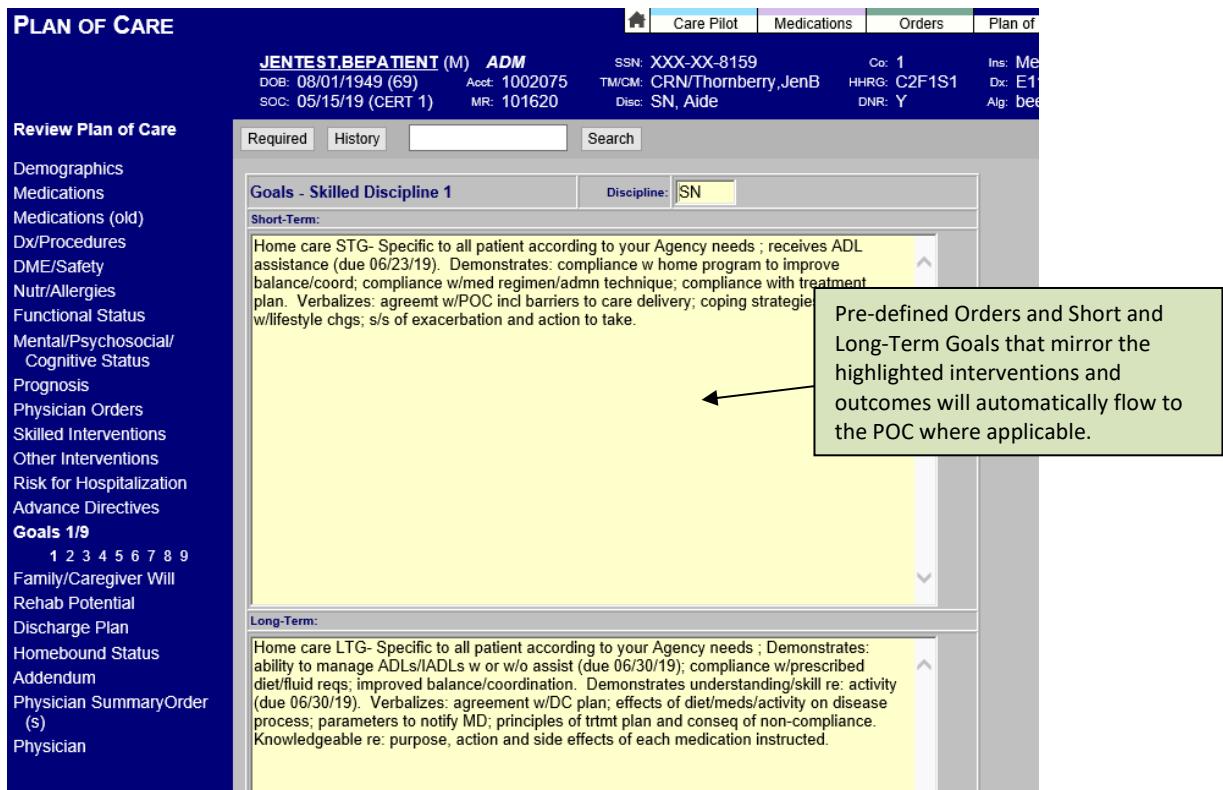
Assess
Assess patient understanding/skills
Outcomes
Demos understanding/skill re: activity: in progress (Due Date: 06/30/19)

knowledge/skill deficit: cg 05/15/19

Assess
Assess caregiver understanding/skills
Outcomes
Demos understanding/skill re: activity: in progress (Due Date: 06/30/19)

The patient's Problems List can be viewed by selecting "Problems" from the (Navigate to) dropdown. You can view any patient summary by searching the patient on the home page, selecting the patient and selecting the "Summary" button.

- Each defined problem appears on the list with the date it was defined as a problem (Added) and the date resolved. A problem becomes resolved once all associated interventions and outcomes have been charted as Achieved, Varianced, Baseline, Error or Other.
- The charted values display with each instruction/outcome.
- If a Due Date is charted for a particular Outcome/Goal the due date will be listed.
- Hovering over the date added will show you who charted and identified this problem and on which visit. If the "Problem Override" option is used, hovertext will indicate that the override was used to resolve and the name of the user that completed that action.
- To the left of the instructions and outcomes you will see a date once these have been resolved. Hovering over this date will show you who charted and resolved the problem and on which visit.

Plan of Care –


PLAN OF CARE

JENTEST,BEPATIENT (M) ADM
 DOB: 08/01/1949 (69) Add: 1002075 SSN: XXX-XX-8159 Co: 1 Ins: Me
 Soc: 05/15/19 (CERT 1) MR: 101620 T/M/C: CRN/Thornberry,JenB HHRG: C2F1S1 Dx: E1
 Disc: SN, Aide DNR: Y Alg: bebe

Review Plan of Care

Demographics
 Medications
 Medications (old)
 Dx/Procedures
 DME/Safety
 Nutr/Allergies
 Functional Status
 Mental/Psychosocial/
 Cognitive Status
 Prognosis
 Physician Orders
 Skilled Interventions
 Other Interventions
 Risk for Hospitalization
 Advance Directives
Goals 1/9
 1 2 3 4 5 6 7 8 9
 Family/Caregiver Will
 Rehab Potential
 Discharge Plan
 Homebound Status
 Addendum
 Physician Summary Order
 (s)
 Physician

Goals - Skilled Discipline 1 Discipline: SN

Short-Term:
 Home care STG- Specific to all patient according to your Agency needs ; receives ADL assistance (due 06/23/19). Demonstrates: compliance w/ home program to improve balance/coord; compliance w/med regimen/admn technique; compliance with treatment plan. Verbalizes: agreement w/POC incl barriers to care delivery; coping strategies w/lifestyle chgs; s/s of exacerbation and action to take.

Long-Term:
 Home care LTG- Specific to all patient according to your Agency needs ; Demonstrates: ability to manage ADLs/IADLs w or w/o assist (due 06/30/19); compliance w/prescribed diet/fluid reqs; improved balance/coordination. Demonstrates understanding/skill re: activity (due 06/30/19). Verbalizes: agreement w/DC plan; effects of diet/meds/activity on disease process; parameters to notify MD; principles of trtmt plan and conseq of non-compliance. Knowledgeable re: purpose, action and side effects of each medication instructed.

Pre-defined Orders and Short and Long-Term Goals that mirror the highlighted interventions and outcomes will automatically flow to the POC where applicable.

Special Problem Logic Considerations:

In addition to embedded Goals/Outcome options, agencies should also refer to the problem logic related features described below:

SMART (Specific, Measurable, Agreeable, Relevant, Time-bound) Goals - Users have the option to chart due dates for Goals and Outcomes as a tool to try to track patient progress. These Due Dates will flow to the POC and based on settings can be set as required or flow to dashboards. The settings are details within the SMART Goal Charting section of the Managing NDoc Guidance resources.

Additional Assess/Instruct/Outcome Statements (AIO) - Additional assess/instruct/outcome statements are new fields in the POC/Synopsis category that give agencies the ability to enter more detail to the patient's care plan in those rare cases when additional specifics are needed. The specifics of these options are covered in the FASTForm for Additional Assess/Instruct/Outcome Statements.

Protocols – NDoc provides agencies the option to set protocols for managing certain conditions. These protocols then result in certain problem triggers, etc. For details on protocols, refer to the NDoc Reference for Managing Protocols.

Troubleshooting Tips for the NDoc Patient Problems Logic:

- I charted an outcome for the patient's problem of edema, but now the problem has re-occurred.*
 The first time the problem of edema appears on the Patient Problems List it will display with the appropriate Add Date and Resolved Date. By identifying the problem a second time, a new entry of edema will appear on the Patient Problems List with an Add Date of today. This identifies edema as a recurring problem and makes the associated outcomes "required" again. It also highlights the Cardio category in Today's Care. NOTE: The Problem List displays in visit date order, so the recurring problem will display at the bottom of the Problem List.
- I charted a problem in error. How do I remove it from the list?*
 If the error is discovered prior to signing off the visit, you can unchart the problem by removing the charted entry in the field that created the problem. If the error is discovered after signing off the visit, it must be "marked as an error" (similar to a medication charted in error). This is done by charting the outcome with an entry of "associated problem ID'd in error". Users may also use the Problem Override option described under the summary section to auto-populate the instructions/outcomes.

- *What do I need to know with regard to NDoc's Patient Problems Logic and my charting?*

Patient Problems Logic Rules:

1. Once a problem has been defined, it cannot be removed from the list until all integrated interventions and outcomes have been charted.
2. The final outcome related to a problem cannot be charted until all the associated interventions are charted.
3. If a problem has been "resolved" through charting an Outcome and reoccurs, simply chart the problem as a new problem under the appropriate category's Current Status field.

Examples of how NDoc's Patient Problems Logic Rules help ensure documentation compliance.

Example 1

Visit 1: Chest Pain identified when charting Current Cardio Status field in SOC Assessment.

Visit 4: User attempts to chart a Current Cardio Status of "no significant problems".

NDoc will not allow the response on Visit 4. Instead, the user will be prompted to complete all associated interventions and outcomes to resolve the previously identified problem.

Example 2

Visit 1: Frequent pain identified as a result of charting M1242 in SOC Assessment.

Visit 2: Pain status monitored. Patient instructed re: pain management and symptom control. Instruction intervention charted.

Visit 3: Patient verbalizes acceptable level of pain control and demonstrates ability to manage pain independently. Outcomes charted and Frequent Pain problem resolved.

Visit 4-8: Pain status monitored no change in status.

Visit 9: Frequent Pain recurs and user charts an entry of Frequent Pain within the "New Pain" field.

NDoc allows the user to chart recurring problems. In this example, once the user signs off Visit 9, a second entry of Frequent Pain will appear on the Patient's Problem List beneath the one previously resolved. This way all clinicians can quickly see that not only does the patient have a problem with Frequent Pain, but that it has been resolved and recurred.

NOTE: The Problem List displays in visit date order under the system category, so in this case, the recurring problem will display at the bottom of the patient's existing problems for pain.

Example 3

Visit 1: Dyspneic with minimal exertion is identified when charting M1400 in SOC Assessment.

Visit 6: User has instructed all but one intervention and attempts to chart outcome entitled Demonstrates stable respiratory status.

NDoc will not allow the response on Visit 6. Instead the user will be prompted to complete the associated interventions prior to charting the final outcome related to the problem.

Example 4

Visit 1: Dyspneic with minimal exertion is identified when charting M1400 in SOC Assessment.

Visit 2: Oxygen Treatments in Home was identified when charting "Resp Treatments in Home" field. User realizes this mistake and attempts to "uncheck" the box within the "Oxygen Treatments in Home" field.

NDoc allows this action because the user has not yet signed off the visit.

Example 5

Visit 1: Diabetic foot lesion is marked under current status when charting SOC assessment.

Visit 2: You realized that Diabetic foot ulcer was selected by mistake.

NDoc will not allow the problem to be cleared. You must Chart the instructions as NA not required and outcomes as associated problem ID'd in error. This will then remove the problem. On the patient summary, it will have the NA not required and the associated problem ID'd in error next to the statements and the date resolved.