

#### HOME CARE ELECTRONIC HOME CARE RECORD STANDARD OPERATING PROCEDURE

SUPERSEDES: N/A

Page 1 of 2

### Procura Mobile User Guide

#### Purpose

The purpose of this document is to describe a process to navigate within Procura Mobile Application.

#### **Groups Applicable to**

Direct Service Nurses in all areas (community areas, Community Intravenous, Palliative, Rapid Response, Respite)

## **1.** Log into Procura Mobile

Step 1. On the Home Screen of your phone, select the Procura icon.



Figure 1 Procura Icon



## 2. Schedule View

Step 1. After logging in, your schedule will display today's appointments. You can only access appointments for today and will also be able to view appointments for the next day. The schedule will give you a mix of timed visits and/or timeless visits

Each scheduled appointment includes the following information:

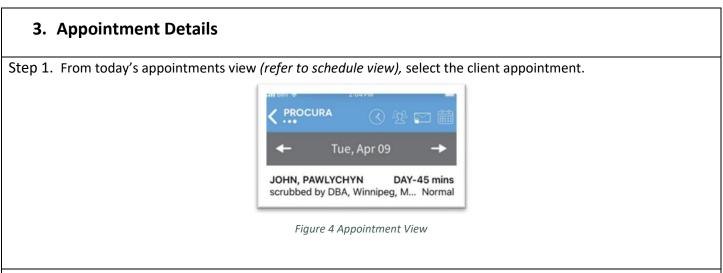
- Client name
- Address
- Duration
- Status

	RA	3 * 🖂 🖩
+	Tue, Apr	09 🔶
,		DAY-45 min ipeg, M Norma
		DAY-30 min ipeg, M Norma
		DAY-30 min ipeg, M Norma
		DAY-30 min ipeg, M Norma
		08:00-08:20 ipeg, M Norma
Meal Breal	k-Unpaid	11:30-12:00 Norma
Administra	tive Time	14:00-14:4 Norma
	S	••

Step 2. There are different status types relevant to the client or visit. Held visits do not appear in Procura Mobile (e.g., hospital stays, family request, etc.)

	Status	Description	
-	New	The client is new to you.	
	Normal	The client is known to you with no new updates.	
	Updated	Updates have been made to the client record.	
	Cancelled	The vist has been cancelled by the back office	
	Open	The visit has been started.	
	Completed	The visit has been started and completed.	
	Start Due	The visit has not been started.	
	Verified	The visit has been processed by a timekeeper	
Step 3. To view an extended list of clients scheduled, go to Schedules in the Procura Portal.			

https://ehcr-employeeportal-wrha.sharedhealthmb.ca/



Step 2. A new screen appears showing Appointment Details, Car Plan Information, etc.

- a. The Appointment Details ribbon displays the visit date, time, duration, address, phone number and status.
- b. The Care Plan Information ribbon serves 3 different purposes:
  - i. Displays the care plan tasks required for the visit
  - ii. Warns if there are Risks on file
- c. Check the Hazards section on the Client Details page
- d. The Appointment Information ribbon displays the Shift code which is used to identify the type of visit for scheduling purposes, and the Pattern (onetime or regular)
- e. The Order Information ribbon displays the Funder, date the funding authorization began, case coordinator and contact information.

all Bell 😚 2:04 PM 🛑
く ④ 投 🖬 🏥
Appointment Details
JOHN, PAWLYCHYN 4-9-2024 DAY-45 mins
scrubbed by DBA, Winnipeg, M Normal LPN_ H: 204-489-1234 M: 204-555-1234
Care Plan Information
WC-P - WC Pressure Ulcer
Appointment Information
Priority: Code 3
Comments: Visit Comments. Visit Comments. Visit Comments. Rebooked from: MHCA, RC 08_N_Anos, Melcho TEST
Figure 5 Appointment Details

# 4. Client Details and Notes

The Client Details view gives you information about the client that is not in the Appointment Details view. Step 1. From the Appointment Details screen, tap on the Client Detail icon in the Grey Bar.

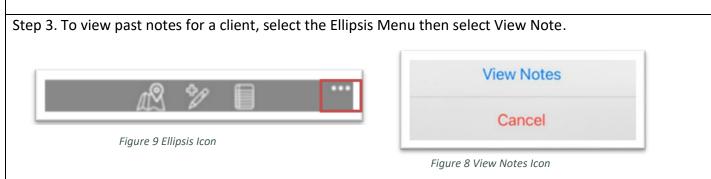


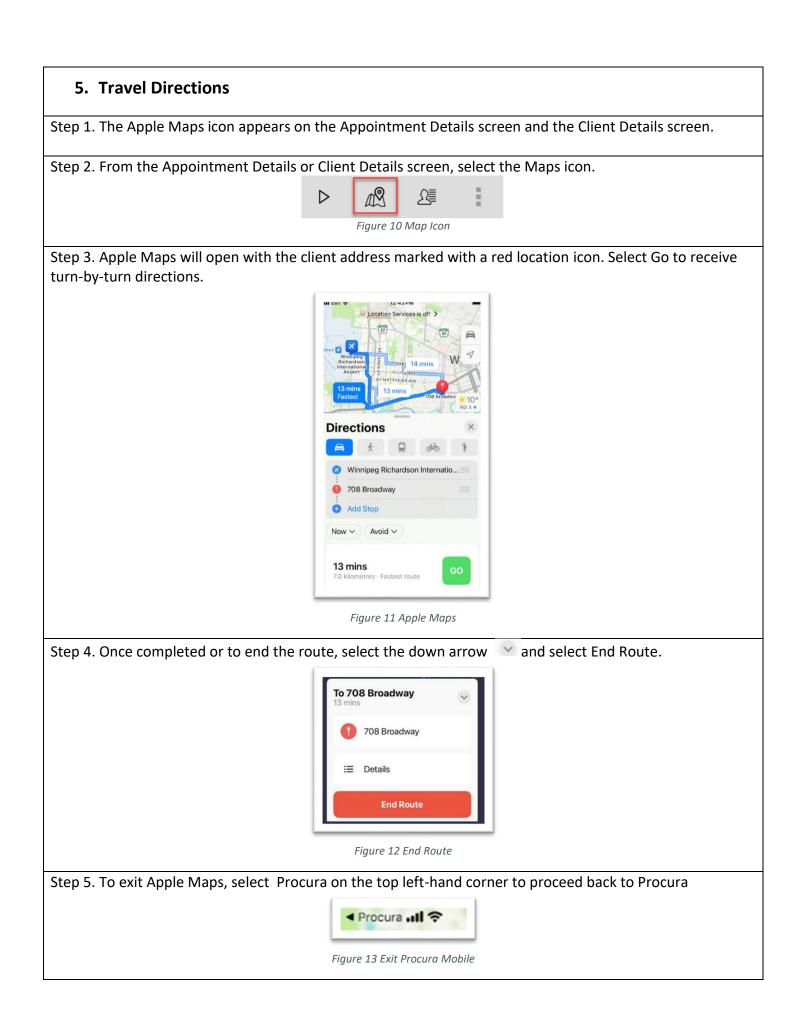
Step 2. The Client Details screen will appear, showing client information, contacts, addresses, allergies, equipment and hazards

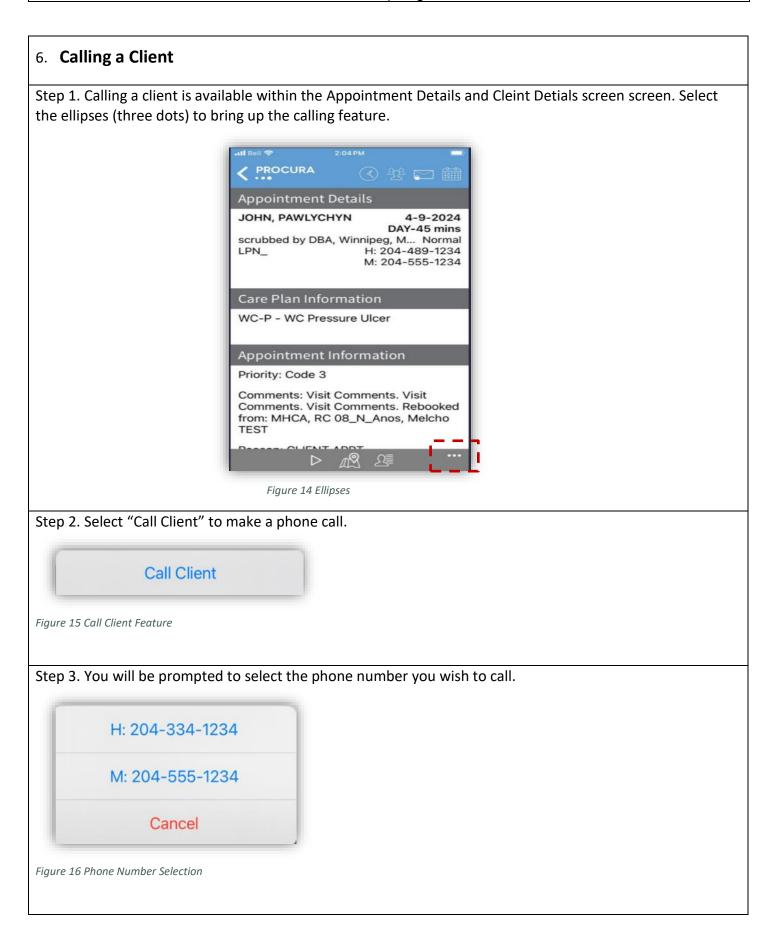
- a. The first two sections contain basic information repeated from the Appointment Details page.
- b. Formal Contacts are professional Contacts(Physicians, Pharmacy, Power of Attorney)
- c. Informal Contacts and Addresses are contacts that are non professionals (friends, family, etc.) and Client addresses.
- d. Allergies includes name, degree (allergy or sensitivity) and type (physical, food, medications)
- e. Equipment- any equipment in the home/Languages/Likes/Dislikes
- f. Diagnoses a list of current patient diagnoses, including Infectious Diseases and required precautions
- g. Hazards refer to risks and will refer to the existance of a Safe Visit Plan.

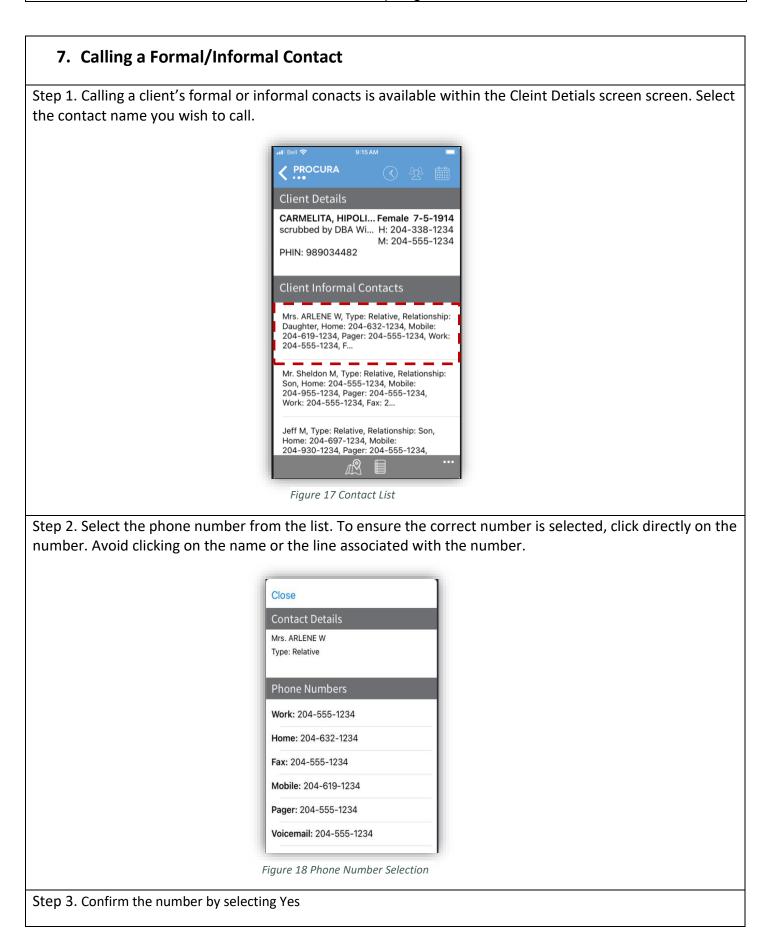


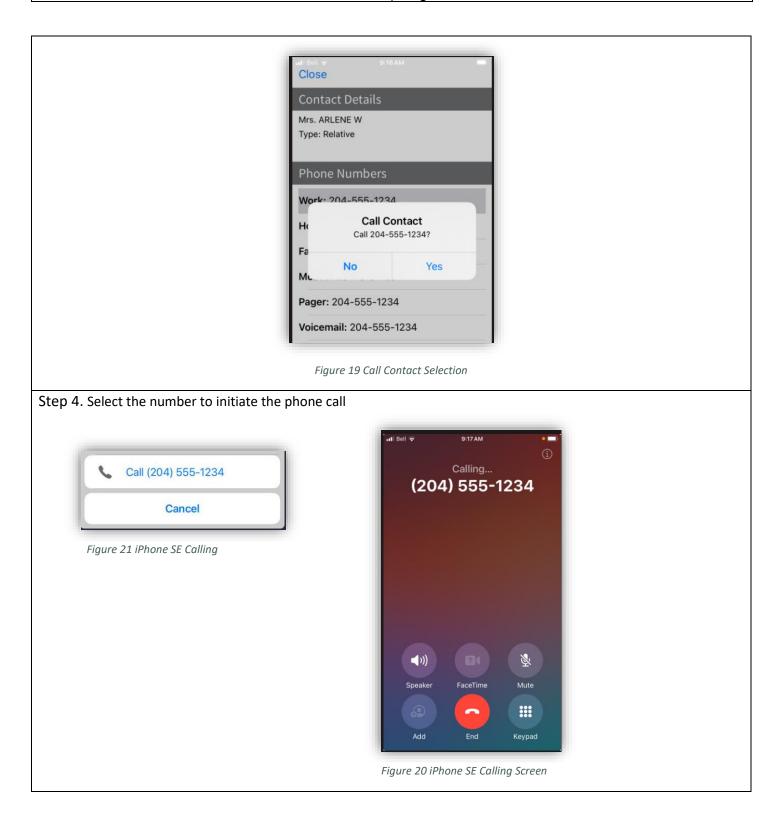
Figure 7 Client Details





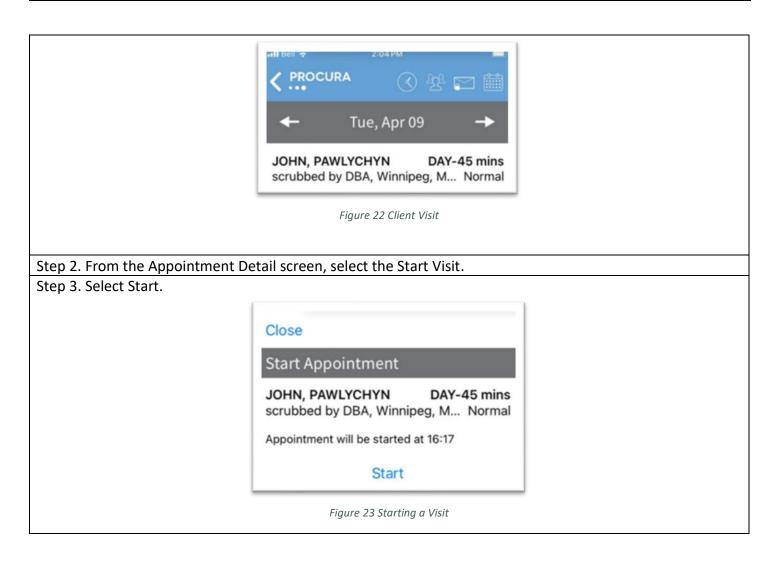






## 8. Start and Stopping a Visit/Attendance Type

Step 1. The Start Visit icon will appear from the Appointment Details screen. Select on the client you would like to start the visit. All visits must be started and stopped.Scheduled (paid/unpaid) breaks and admin time will also show up in your schedule and require to be start/stopped.



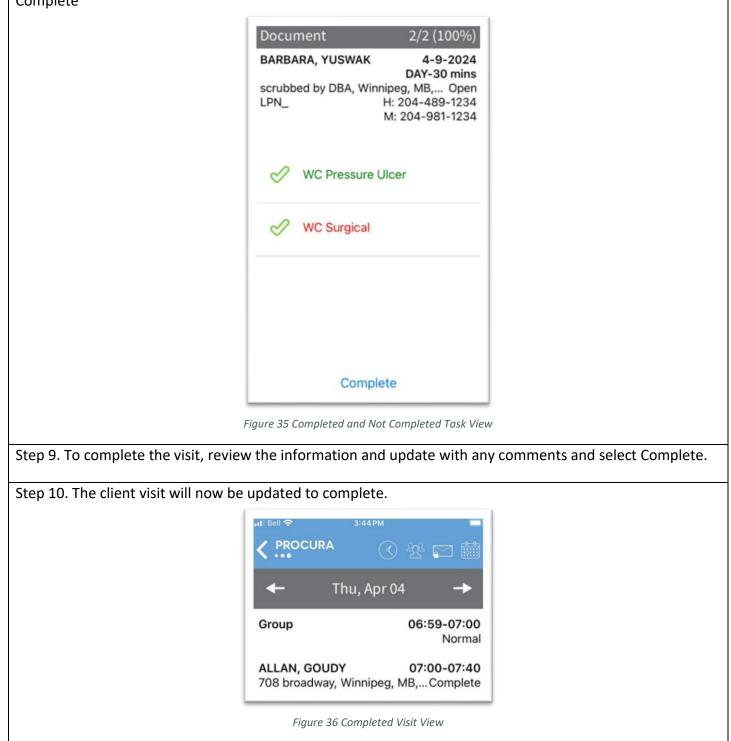
9. Client Identity Verification		
Step 1. The Client Identity Verification	will become available once the	visit has been started.
	Close Start Appointment ALLAN, GOUDY 07:00-07:40 708 broadway, Winnipeg, MB, R Normal Appointment will be started at 14:51 Start	
l	Figure 24 Starting a Visit	
Step 2. A listing of Client Identifiers w	ill appear. Select the first observa	ition in the list.
	Close           Observations           ALLAN, GOUDY         4-4-2024           07:00-07:40 (40 mins)           708 broadway, Winnipeg, MB, R3 Open           HCA_         H: 204-295-1234           M: 204-555-1234	
	Address	
	Facial Recognition	
	Caregiver Present to Identify Client	
	Date of Birth	
	Complete	
	Figure 25 Client Identifiers	

		<u> </u>
Step 3. Select into the red highlighted field	and select Yes or No. Complete this	for all listed client identifers.
	Close	
	Client Identfiers	
	Address	
· · · · · · · · · · · · · · · · · · ·		
	Done	
	Yes	
	No	
Fig	ire 26 Documenting Client Identifiers	
Step 4. Use the Prev and Next buttons to	nove to through the activity list. To r	eturn to your activity list, tap
the List button at the bottom of the scree		
Pre	/ List Next	
	igure 27 Previous and Next Button	
Step 5. Once you have completed all the (	lient Idenitifers, select to go back to	the List. from this view you
will be able to select Complete.		
	Close	
	Observations ALLAN, GOUDY 4-4-2024	
	07:00-07:40 (40 mins) 708 broadway, Winnipeg, MB, R3 Open	
	HCA_ H: 204-295-1234 M: 204-555-1234	
	Sull Name	
	PHIN	
	· · · · · · · · · · · · · · · · · · ·	
	Address	
	Sacial Recognition	
	Complete	
Fi	gure 28 Client Identifiers Completed	

10.Document Care Plan Tas	ks
Step 1. After you have completed th Care Plan Tasks for the client.	e Client Identity Document, the Document screen appears with a list of
Step 2.In the Document screen, sele	ct the task you want to document.
	Document       0/2 (0%)         BARBARA, YUSWAK       4-9-2024 DAY-30 mins         scrubbed by DBA, Winnipeg, MB, Open LPN_       H: 204-489-1234 M: 204-981-1234         WC Pressure Ulcer
	WC Surgical Figure 29 Document Screen
Step 3. Select into the red highlighte	d field and select Complete or Not Complete, then select done
	Document Activity WC Pressure Ulcer Complete
	Done
	Complete Not Complete
	Figure 30 Documenting Tasks

Step 4. If you select Not Complete, a reason will be required. Select into the red highlighted field to select a reason, procced to select OK		
Close	Close	
Document Activity	Document Activity	
H2 Sponge bath	H2 Sponge bath	
Not Complete	Not Complete	
Reason	Reason	
	Client declined	
	Done	
Figure 31 Documenting Tasks with Reason Codes	Done	
	Constitute completed	
	Caregiver completed Client completed	
	Client declined	
	Equipment Concern	
	Medication Issue	
Stop 5. Use the Broy and Next buttons to move to t	through the activity list. To return to your activity list, tap	
the List button at the bottom of the screen.		
Prev	List Next	
Linua 3		
Figure 3.	2 Navigation Icons	
Step 6. If you need to view the details of a care pla	n task prior to beginning the task, return to the	
Appointment Details screen by selecting close on t	he top of the screen then tap the care plan activity to	
expand the details		
Close		
Document Activity		
Figure 33 Closing the Document Details Screen		
Step 7. Return back to the Document screen by tapping the Complete Documentation		
Star - Star		
Figure 34 Col	mplete Documentation	

Step 8. The list will update based on whether the task was Completed or Not Completed. All documented tasks will have a green check mark. An entry in red indicates the activity was marked Not Complete. Select Complete



Procura Mobile User Guide

Page 15 of 2

# 11.Create a Note

Notes are used to document client observations not captured in the Care Plan. These notes are saved to the client file and can be seen by the back office. Creating a note is an optional activity that should be completed before finalizing or completing the client visit.

Step 1. The note icon will appear from the Appointment Details screen and in the Client Details screen

Figure 37 Note Icons	
tep 2. Select Create Note	
Create Note Cancel	
Figure 38 Creating a Note	
<ul> <li>Step 3. The Create Note Screen appears. From here you are able to enter the note details <ul> <li>a. Note Type</li> <li>b. Subject</li> <li>c. Contents</li> </ul> </li> <li>Step 4. Select into the red highlighted field to select a reason to write in each section.</li> </ul>	
Create Note         Type       Progress Notes         Date       4/9/2024         Department       WRHA Nursing         Subject       Contents         Figure 39 Creating a Dated Note	
Step 5. Select Save when your note is completed. This note is now visible to other Home Care staff when they access View Notes from Client Details.	
Save	
Figure 40 Save Icon	

12.Viewing Notes and Follow up	
Step 1. Select the Ellipses from the	Client Details screen.
	Figure 41 Ellipses from Client Details
Step 2. Select View Notes	
	View Notes
	Cancel
	Figure 42 View Notes Tab
Step 3. The list of notes for 30 days	s will appear. Select each of the notes to review in more detial
	Testing note 4-18-2024 angelatest
	Test 4-18-2024 angelatest
	-18-2024 angelatest
	4-18-2024 angelatest
다 Figure 43 Notes for last 30 days view	

