

#### 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 p	phone, select the Procura icon.
	Figure 1 Procura Icon
Step 2. Select Login with SSO (Single S	Sign On)
	Login with SSO ⑦ 袋 目
	Figure 2 Single Sign on 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:

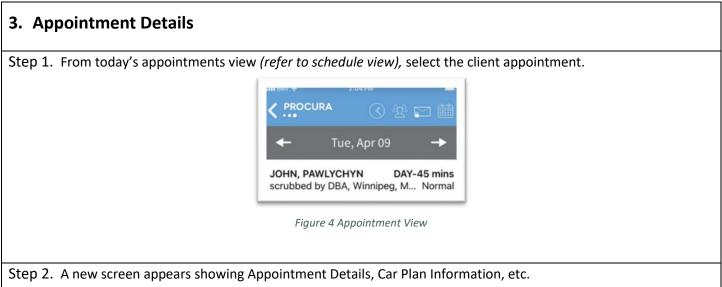
- Client name
- Address
- Duration
- Status

	JRA (	3 샾 🖂 🗄
+	Tue, Ap	r 09 🔶
,		DAY-45 min hipeg, M Norma
		DAY-30 min hipeg, M Norma
		DAY-30 min hipeg, M Norma
		DAY-30 min hipeg, M Norma
		08:00-08:20 hipeg, M Norma
Meal Brea	k-Unpaid	11:30-12:0 Norma
Administra	ative 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.)

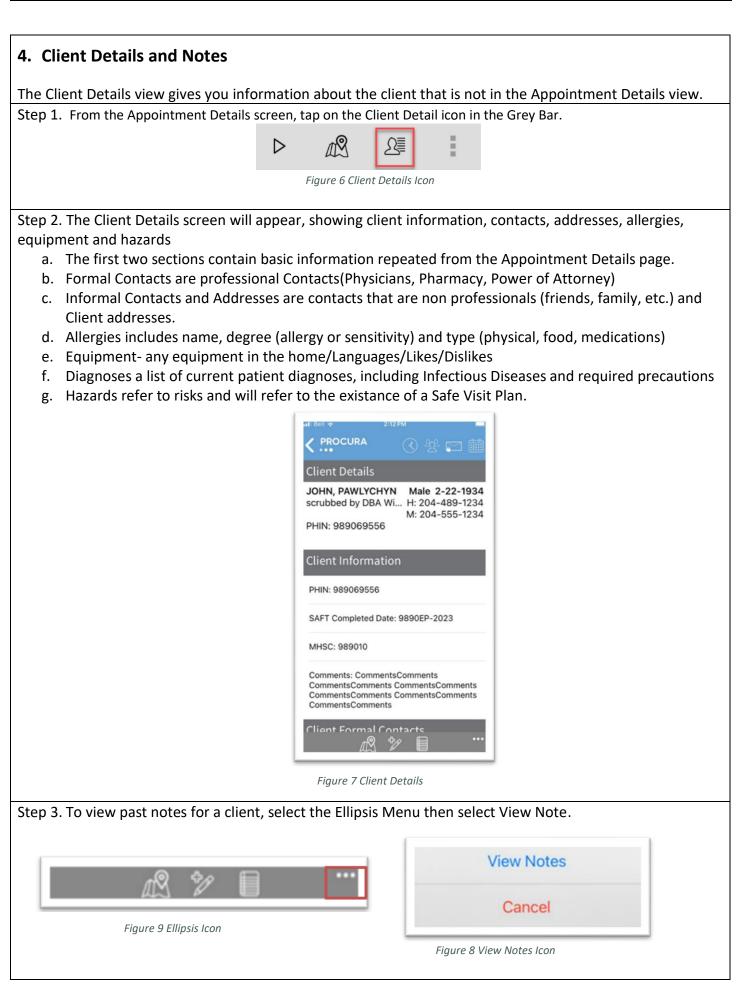
	Status	Description
	New	The client is new to you.
	Normal	The client is known to you with no new updates.
	Updated	Updates have been made to the client record.
	Cancelled	The vist has been cancelled by the back office
	Open	The visit has been started.
	Completed	The visit has been started and completed.
	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.		

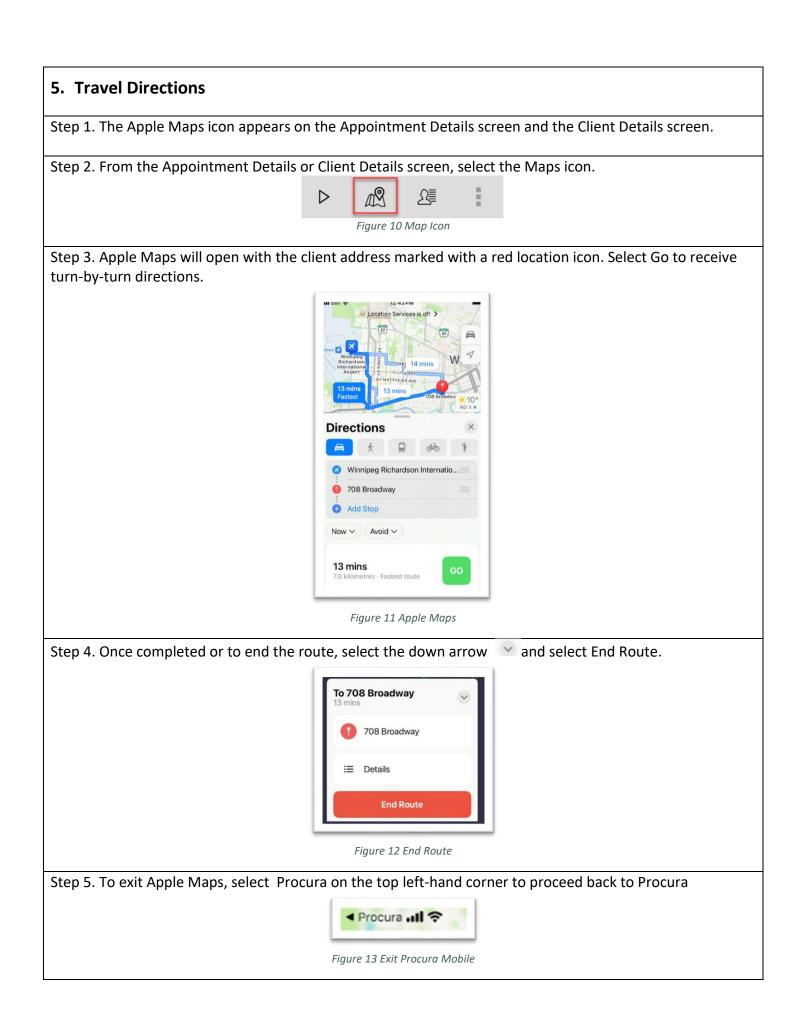
https://ehcr-employeeportal-wrha.sharedhealthmb.ca/

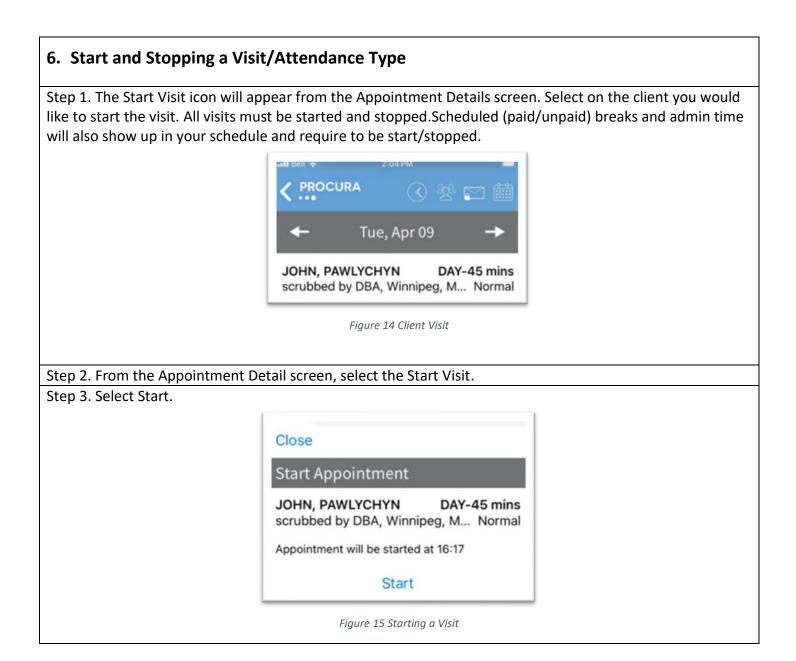


- a. The Appointment Details ribbon displays the visit date, time, duration, address, phone number and status.
- b. The Care Plan Information ribbon serves 3 different purposes:
  - i. Displays the care plan tasks required for the visit
  - ii. Warns if there are Risks on file
- c. Check the Hazards 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… · · · · · · · · · · · · · · · · · · ·
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







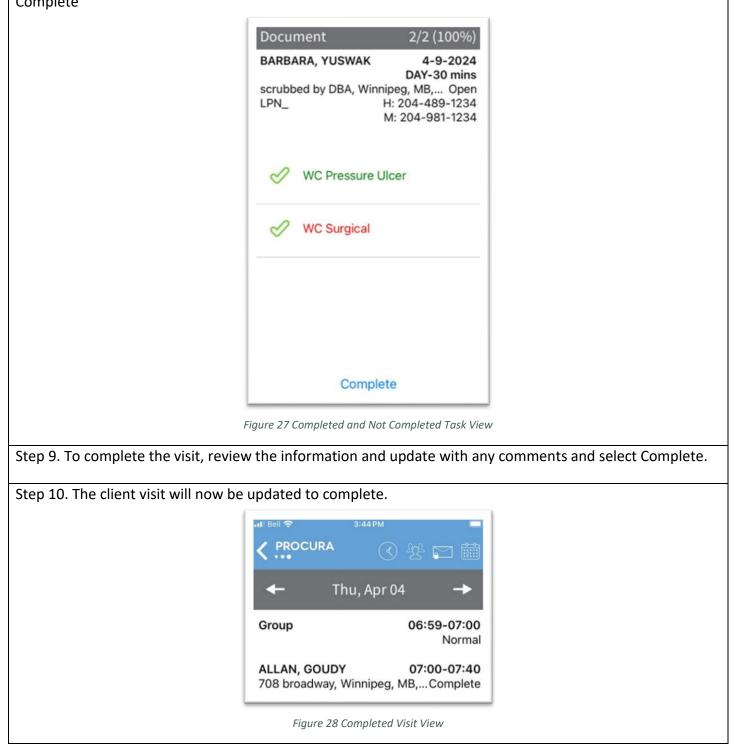
7. Client Identity Verification		
Step 1. The Client Identity Verification	will become available once the	visit has been started.
	Close	
	Start Appointment	
	ALLAN, GOUDY 07:00-07:40 708 broadway, Winnipeg, MB, R Normal	
	Appointment will be started at 14:51	
	Start	
	Figure 16 Starting a Visit	
Step 2. A listing of Client Identifiers w	ill appear. Select the first observa	tion 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 17 Client Identifiers	

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
Figure 18 Documenting Client Identifiers
Step 4. Use the Prev and Next buttons to move to through the activity list. To return to your activity list, tap
the List button at the bottom of the screen.
Prev List Next
LISI Next
Figure 19 Previous and Next Button
Step 5. Once you have completed all the Client 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 HCAH: 204-295-1234
M: 204-555-1234
Full Name
Sector Phin
Address
V Facial Recognition
Complete
Figure 20 Client Identifiers Completed

8. Document Care Plan Tasks	
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 21 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 22 Documenting Tasks

Step 4. If you select Not Complete, a reason will be reason, procced to select OK	required. Select into the red highlighted field to select a
Close	Close
Document Activity	Document Activity
H2 Sponge bath	H2 Sponge bath
Not Complete	Not Complete
Reason	Reason
	Client declined
	Done
Figure 23 Documenting Tasks with Reason Codes	Done
	Constitute completed
	Caregiver completed Client completed
	Client declined
	Equipment Concern
	Medication Issue
Stop 5. Use the Brow and Next buttons to move to t	hrough the activity list. To return to your activity list, tap
the List button at the bottom of the screen.	
Prev	List Next
Einung 2	
Figure 24	4 Navigation Icons
Step 6. If you need to view the details of a care plan	n task prior to beginning the task, return to the
Appointment Details screen by selecting close on the	he top of the screen then tap the care plan activity to
expand the details	
Close	
Document Activity	
Figure 25 Closing t	he Document Details Screen
Step 7. Return back to the Document screen by tapping the Complete Documentation	
St.	
Figure 26 Cor	nplete 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



## 9. 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 29 Note Icons	
Step 2. Select Create Note	
Create Note Cancel	
Figure 30 Creating a Note	
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> Step 4. Select into the red highlighted field to select a reason to write in each section.   Create Note   Type Progress Notes	
Date4/9/2024DepartmentWRHA NursingSubjectContents	
Figure 31 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 32 Save Icon	

10.Viewing Notes and Follow up	
Step 1. Select the Ellipses from the Clie	ent Details screen.
	Figure 33 Ellipses from Client Details
Step 2. Select View Notes	
	View Notes
	Cancel
	Figure 34 View Notes Tab
Step 3. The list of notes for 30 days wi	ll appear. Select each of the notes to review in more detial
	Client Notes
	Testing note 4-18-2024 angelatest
	Test 4-18-2024 angelatest
	ast -18-2024 angelatest
	est note 4-18-2024 angelatest
	Figure 35 Notes for last 30 days view

