Level 1 – Level one of *Nursing Documentation Using Electronic Health Records* includes chapters 1, 2, 3, and 4. These early chapters deal with the history and development of the EHR and trace the impact of standards development, certification, and the government's involvement with the EHR in the healthcare community. The theory, purpose, and types of nursing documentation are discussed with a focus on the MAR and the relevance of NIC and NOC. In Level one students are introduced to SpringCharts™ and learn essential documentation on an industry standard EHR program. They are introduced to the Nurse Note and are given hands-on practice in documenting chief complaints, vitals, and physical assessment on ten different disease case studies.

Chapter 4 – Nurse Note Documentation – Level 1

Chapter 4 begins Nurse Note documentation. Students work with their diabetic, congestive heart failure, and pneumonia patients and electronically document their chief complaints, vital signs, and physical exam.

Learning Outcomes

After completing Chapter 4, the studentsz will be able to:

4.1 Describe the components of a Nurse Note.
4.2 Carry out documentation of a Nurse Note.
4.3 Use Chief Complaints.
4.4 Carry out documentation of Vitals (Vital Signs).
4.5 Carry out documentation of an Exam (Assessment).

Key Terms & Definitions

Terms and abbreviations encountered in Chapter 4:

Nurse Note: In SpringCharts, documentation of nursing care of a patient within an acute care facility including the patient's chief complaints, vital signs, physical assessment, goals, interventions, etc.

BMI: Body Mass Index. Measurement of choice for studying obesity. Calculated by a mathematical formula that divides weight by height in meters squared. (BMI = kg/m2).

Presentation Outline

LO 4.1 Nurse Note Components

Power Point Slides: 1, 2, 3, 4, 5.

Concept Checkup 4.1

A. The SOAPIER acronym stands for:
Answer:
S. Subjective
O. Objective
A. Assessment
P. Plan
I. Intervention
E. Evaluation
R. Revision
Rationale: The SOAPIER format:
The Subjective component consists of the patient's description of his/her current health condition. It generally includes the symptoms, the history of the present illness, and a review of the patient's body systems as stated by the patient. The Objective component contains the nurse's observations and generally includes the vital signs and findings from the physical assessment.
The Assessment component details the nursing diagnosis(es) (NANDA-I) based on the examination. Nursing diagnoses should be listed in order of priority. The Plan component includes the nursing goals applicable to the patient stated in Nursing Outcomes Classification (NOC) format. In the planning phase, the nurse sets the anticipated time frame for goal attainment. Outcomes are reviewed periodically, typically every shift to determine patient progress. The Intervention component is made up of the list of patient-specific actions that the nurse takes stated in Nursing Intervention Classification (NIC) format. These interventions, including patient education, are designed to positively impact the patient and move the patient toward achieving the planned goals. The Evaluation component involves reviewing the outcomes that have been set and the patient's progress toward achieving these goals. The Revision component, based on the evaluation, involves streamlining, adding, and reassessing goals to continually make them appropriate and achievable for the patient.

B. What icon allows the nurse to view the patient's Face Sheet from the Nurse Note screen?
Answer: Show Chart Summary
Rationale: Upon opening a new Nurse Note form, the Show Chart Summary icon at the bottom right side shows the patient's Face Sheet Overview panel. This panel allows the nurse to access the Patient's Chart without having to exit the Nurse Note window.

LO 4.2 Documenting a Nurse Note - Level 1

Power Point Slides: 6, 7, 8.

Concept Checkup 4.2

A. True or False: When documenting patient care, the nurse must select tabs from the Navigation panels in the order listed.
Answer: False
Rationale: The navigation tabs along the right side of the screen enable the nurse to proceed through the Nurse Note in a logical flow; however, the various panels may be selected in any order.

B. Which icon allows nurses to copy highlighted text from a previous Nurse Note into the current Nurse Note?
Answer: Copy Prev Note
Rationale: The Chief Complaint, Exam, NOC, NIC, Teaching, Evaluation, Reassessment, and Follow-up areas allow the addition of notes from previous encounters in the bottom right window. A clinician can highlight previous note text and copy it to the present note by clicking on the Copy Prev Note icon.

LO 4.3 CC (Chief Complaint)

Power Point Slides: 9, 10

Concept Checkup 4.3

A. How does the nurse move Chief Complaints that are documented to the body of the SOAPIER format?
Answer: By selecting any other navigation tab
Rationale: The selected text is moved into the body of the *SOAPIER* format by clicking on any other navigational tab.

B. True or False: The Chief Complaint pop-up text can be individualized for a specialty area of nursing practice.
Answer: True
Rationale: The Chief Complaint area can also be individualized to allow for symptoms that are specific to a certain area, for example, orthopedics or neurology. In order to individualize pop-up text, the user selects the pencil icon to open the Edit PopUp Text window.

LO 4.4 Vitals (Vital Signs)

Power Point Slides: 11, 12, 13, 14.

Concept Checkup 4.4

A. What two measurements are needed for the BMI to be automatically calculated?
Answer: Height and weight
Rationale: The BMI is automatically calculated for the user based upon the patient's height and weight.

B. What are the four standard measurement graphs in SpringCharts?
Answer:
1. Height
2. Weight
3. Blood Pressure
4. BMI

Rationale: SpringCharts displays four vital charts (Height, Weight, Blood Pressure, and BMI) by accessing the Height/Weight Graph or BP/BMI Graph icons at the top right in the Vitals panel.

LO 4.5 Exam (Physical Assessment)

Power Point Slides: 15, 16

Concept Checkup 4.5

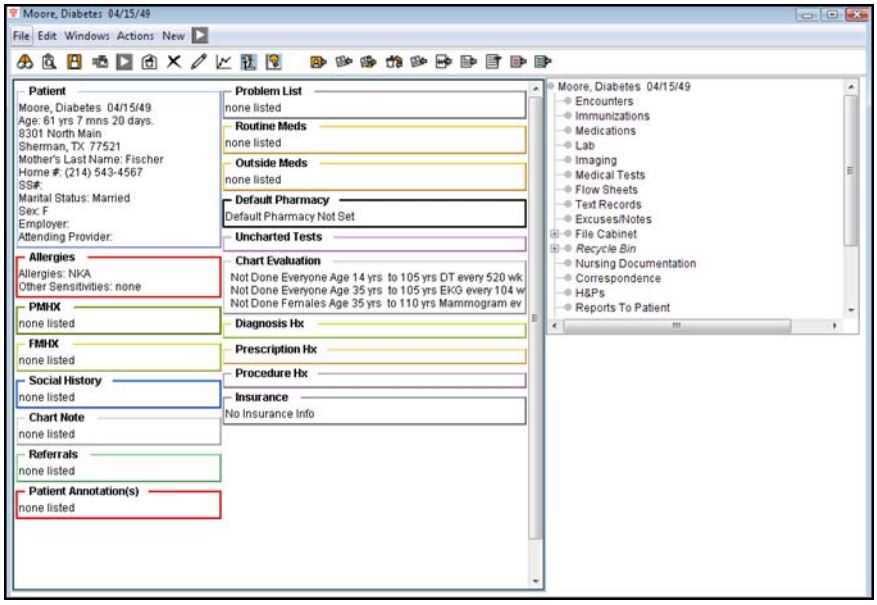
A. True or False: If the nurse is unable to find the appropriate pop-up text to describe an assessment, the nurse can type directly into the Examination field itself.
Answer: True
Rationale: Using the defaulted text, O (Normals), the nurse clicks on systems that are within normal limits upon examination to send that text to the Examination text field in the lower left section of the window. Using the O (Abnormals) drop-down selection box the nurse can easily choose the applicable text and modify it as necessary. The user also has the ability to type text if the desired text is not available by clicking directly into the Examination text field.

B. What is the purpose of permanent sign and lock? When should it be used?
Answer: Permanent sign and lock prevents further changes to an entry, even by the user who locked it. It should be used when an entry is completed.
Rationale: Once the Nurse Note is locked, which is accomplished by clicking the Sign button, then Permanent Sign and Lock, it cannot be unlocked or edited, even by the user who permanently locked it. Nurses should sign and lock each entry as completed to prevent editing of entries by other users.

Exercise 4.1

Diabetes

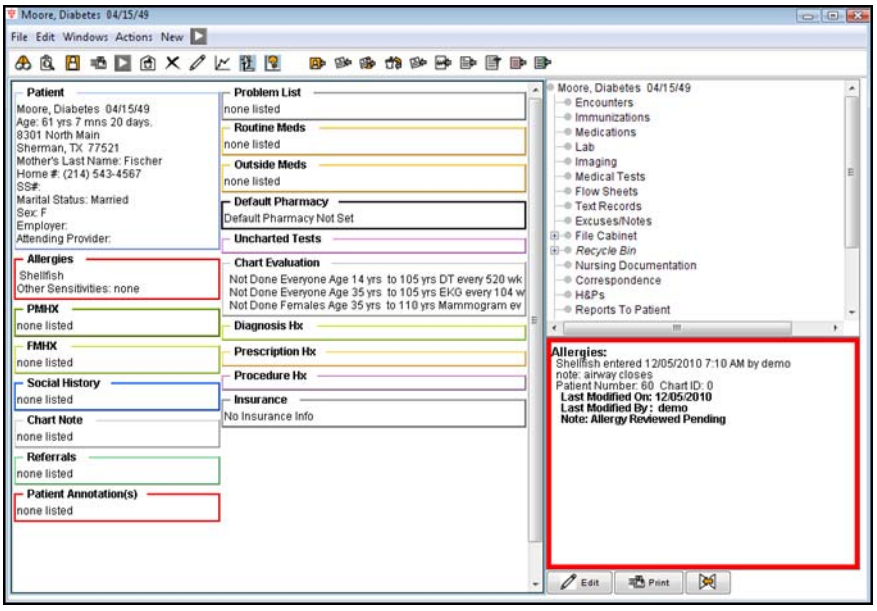
1. After launching SpringCharts, from the top horizontal toolbar click on *Actions, Open a Chart*. Type in your last name and click the search button. Select your "diabetes" patient and the chart opens.



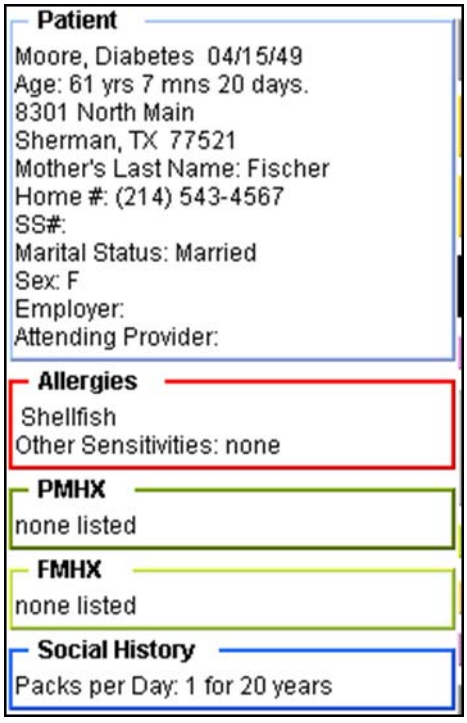
2. Your patient tells you she discovered she has an allergy to shellfish this past week. In the second section of the left side of the chart, click on *Allergies* and it populates the right corner box. Click the *Edit* button below the red *Allergies* box and a new window opens.
   • On the right side of the screen in the "Allergy" field type in shellfish and click the search button. Shellfish appears in the box below the search button. Click on Shellfish and it moves over to the patient's chart on the left.

• Click on the word Shellfish on the left and the *Edit Shellfish* window opens. In the *Adverse Reaction field* type: "airway closes**".** Click *Save*. In lower left corner of the window, click *Back to Chart*.

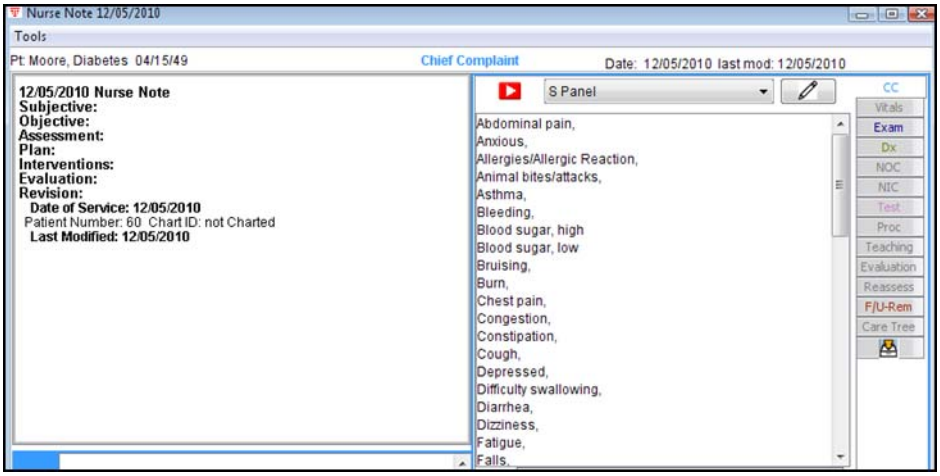
• Click on the *Allergies* field on the left and when it populates the right corner box you can see the note, "airway closes" that you entered.



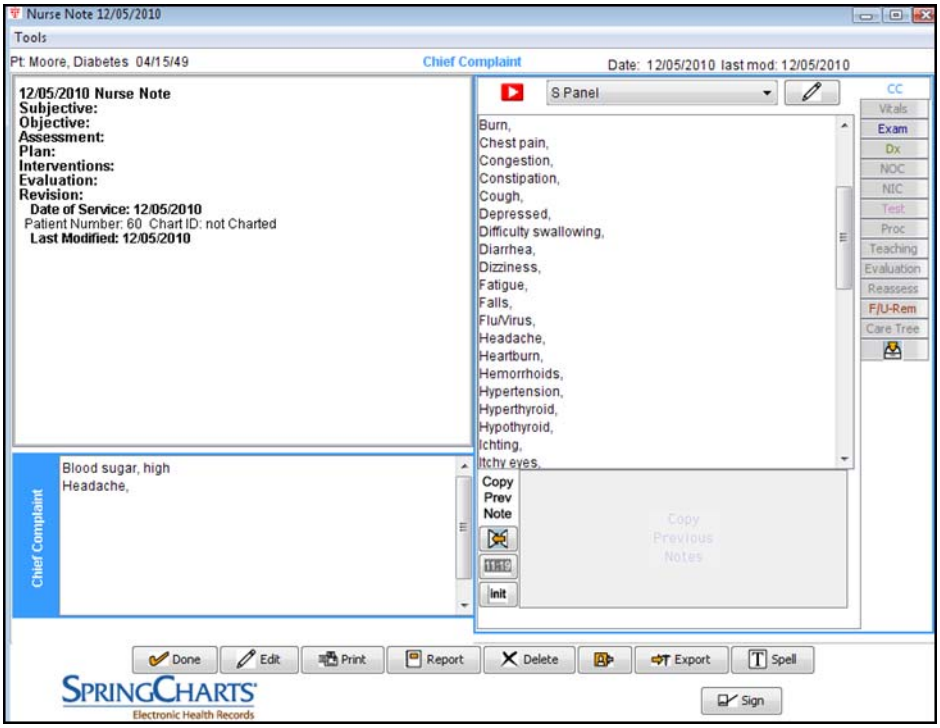
3. You ask your patient about her smoking history and the patient says she smokes a pack a day and has done so for 20 years. Click on the *Social History* field on the left and it populates the box on the right side of the screen.
• Click the *Edit* button below the *Social History* box on the right side of the screen and a new window opens.
• On the right in the list below the *Social History* pop-up text click on: Packs per Day. This text is added to the text in the *Social History* box on the left.
• In the *Social History* box on the left, click after Packs per Day and type 1 for 20 years.
• In lower left corner of the window, click *Back to Chart*. Your new entry appears in the *Social History* field.



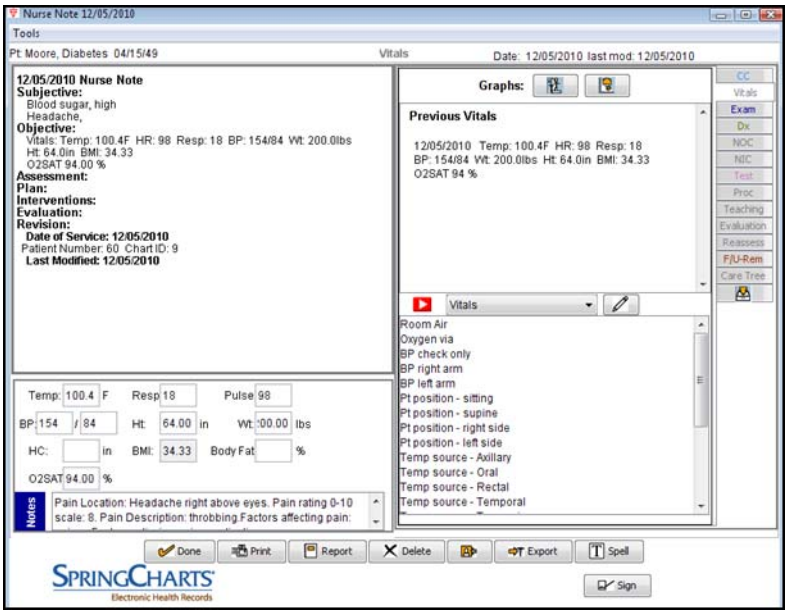
4. Open your Nurse Note. On top menu bar, click *New, New Nurse Note*. The Nurse Note opens to the *Chief Complaint* tab at the top of the vertical navigation bar on the right side of the window.



5. Your patient complains of a headache and high blood sugar. Under the *S Panel* (for *Subjective*) in the text box on the right side click on blood sugar, high and headache. The text populates the *Chief Complaint* box on the bottom left of the screen. Click before headache in the *Chief Complaint* box on the left bottom of the screen to place the cursor and click the Enter key on your keyboard. This places the two complaints on separate lines.



6. Click on the *Vitals* button located below the *CC* button in the navigation bar on the right side of the screen. Note that your *Chief Complaints* now appears in the Subjective section of the *Nurse Note.*
• You take your patient's vital signs. Document the following in the boxes on the lower left section of the window: Temp 100.4, Resp 18, Pulse 98, BP 154/84, Ht 64 inches, Wt 200 lbs, SaO2 94%.
• Under the *Vitals* text box on the lower right click: BP right arm, Pt position—supine, Temp source—Oral, and Room Air. This sends this text to the *Notes* box on the left. You can separate the Temp source—Oral and then Room Air from the other text by clicking in front of it and striking the enter key on the keyboard.
• Under the *Vitals* text box on the right scroll down to click: Pt complains of pain, Pain location, Pain rating 0–10 scale, Pain Description, Factors affecting pain, and Factors relieving pain. This sends the text to the *Notes* box on the left.
• You question your patient to determine the characteristics of her pain. Type in the following information in the *Notes* box following the appropriate labels: Pain location: Headache right above eyes, Pain rating: 0–10 scale; 8, Pain Description: throbbing, Factors affecting pain: noise, Factors relieving pain: medication. If you make a mistake, you may place your cursor in the lower left *Examination* box and delete unwanted text.
• When you select another tab on the horizontal navigation bar on the right side of the window, the Vitals, including the pain assessment, populate under the objective heading in the upper left box.

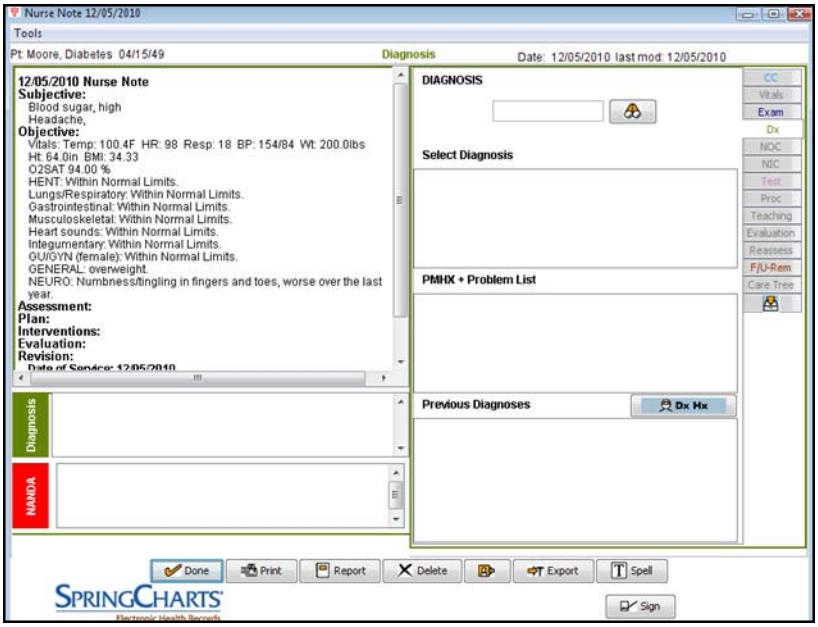


7. You complete your admission physical assessment. To document your findings, click on the *Exam* button located below the *Vitals*. The *O* (*Normals*) defaults in the text box in the upper right box of the window.

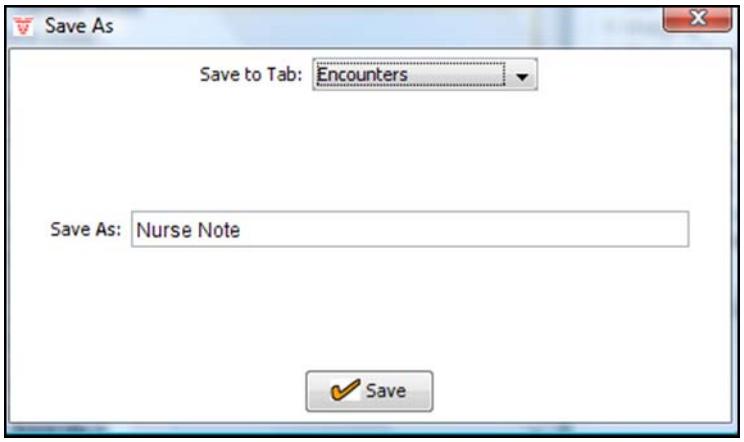
• In this area select the following systems that are within normal limits when you assess your patient: HEENT (Head, Eyes, Ears, Nose, and Throat), Lungs/Respiratory, Gastrointestinal, Musculoskeletal, Heart Sounds, Integumentary, and GU/GYN(Genitourinary/Gynecologic)(female). As you click on each system, the text populates the *Examination* box on the lower left side of the window. Use the enter key to put these items on separate lines to streamline your documentation.

• Click the drop-down arrow next to *O (Normals)* and select *O (Abnormals)*. Select the *General* category followed by: overweight. Select the *Neuro* category followed by: numbness and tingling. If you make a mistake, you may place your cursor in the lower left *Examination* box and delete unwanted text.

• Click in the *Examination* box after numbness and tingling and type: in fingers and toes, worse over the last year.

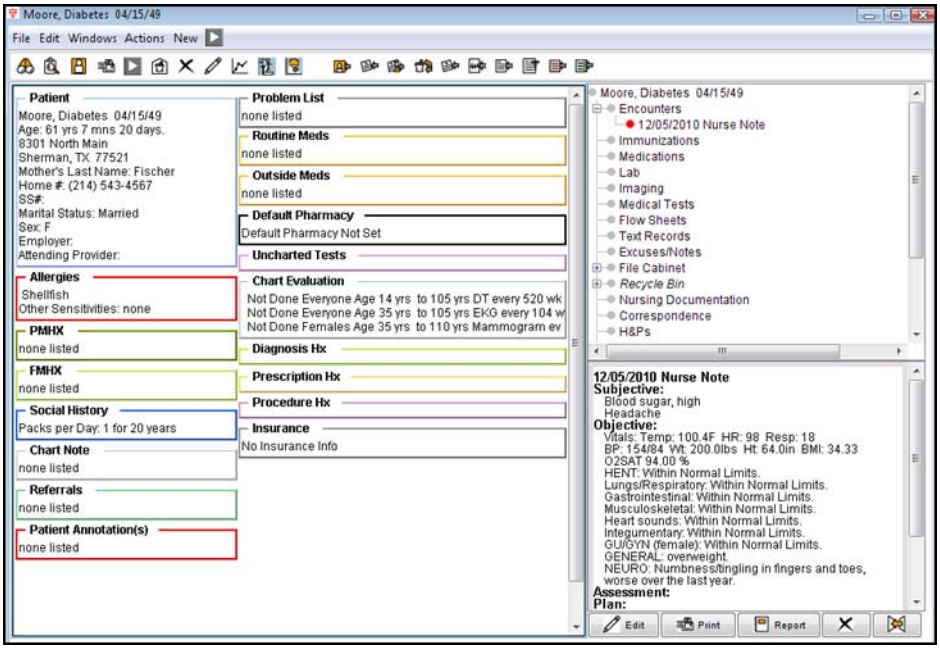


8. Click *Done*. The *Save As* screen populates. Accept the default entries of *Save to Tab*: Encounters and *Save As*: Nurse Note. Click *Save*.

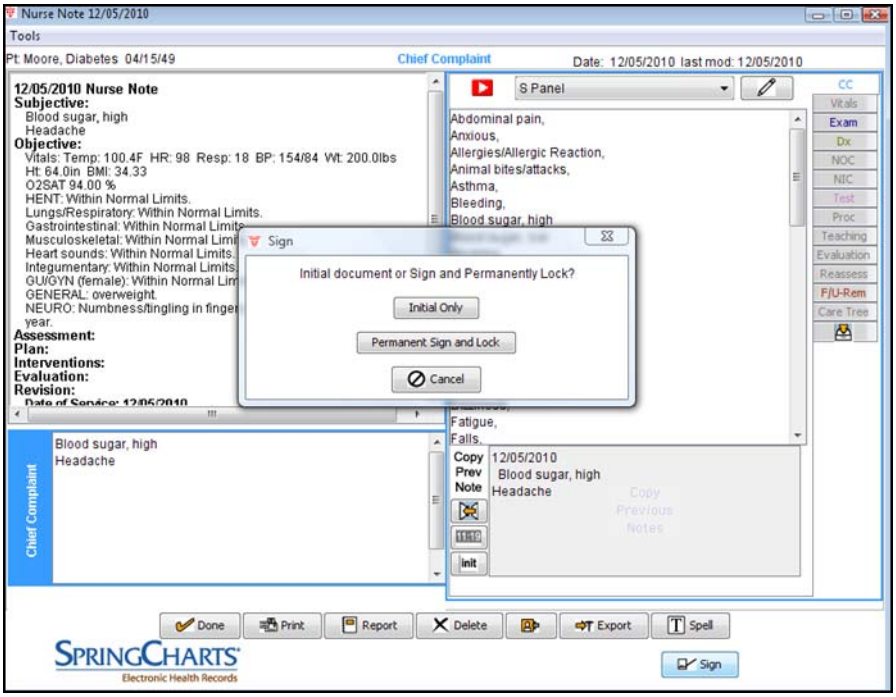


9. A pop-up appears asking if you want to create a routing slip. Click *No*.

10. In the *Care Tree,* in the upper right corner of the chart window, click the + next to *Encounters*. Click on the date of your nurse note to view it in the bottom right corner box.



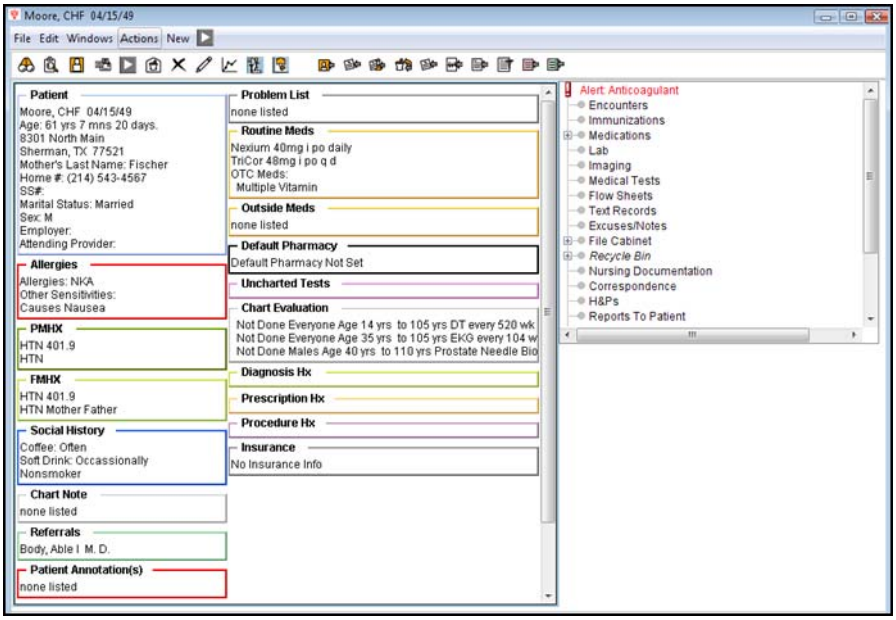
11. Click *Edit* below the bottom right box. Click *Sign*. Select *Permanent Sign and Lock* when finished with your *Nurse Note*.



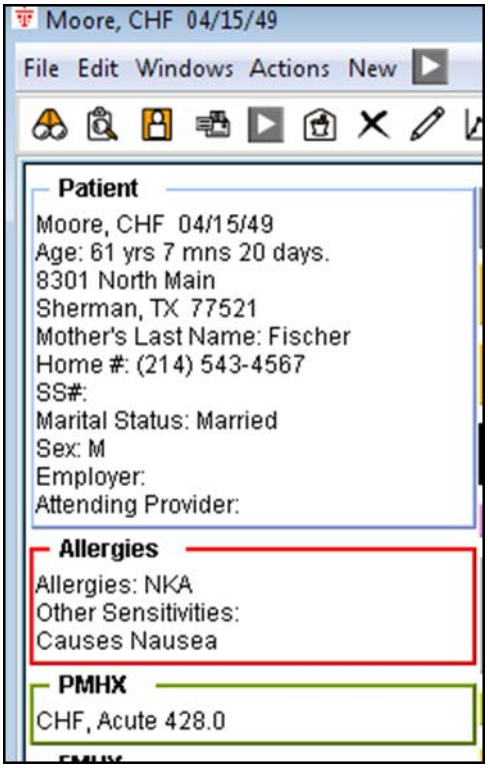
Exercise 4.2

Congestive Heart Failure

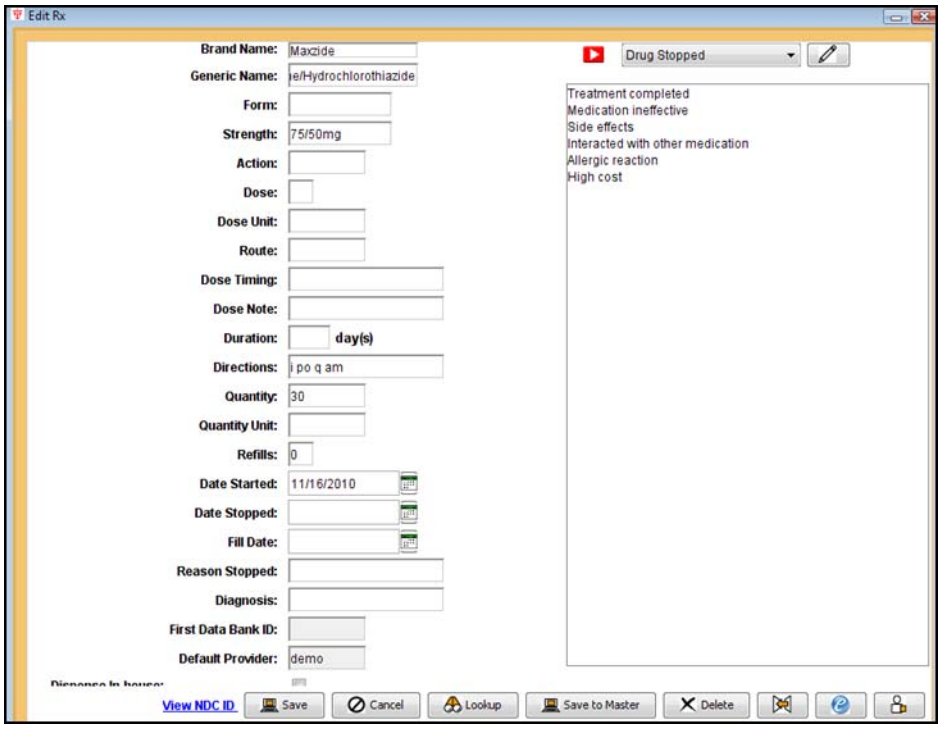
1. After launching SpringCharts, from the top menu toolbar click on *Actions*, *Open a Chart*. Type in your last name and click the search button. Select your "CHF" patient and the chart opens.



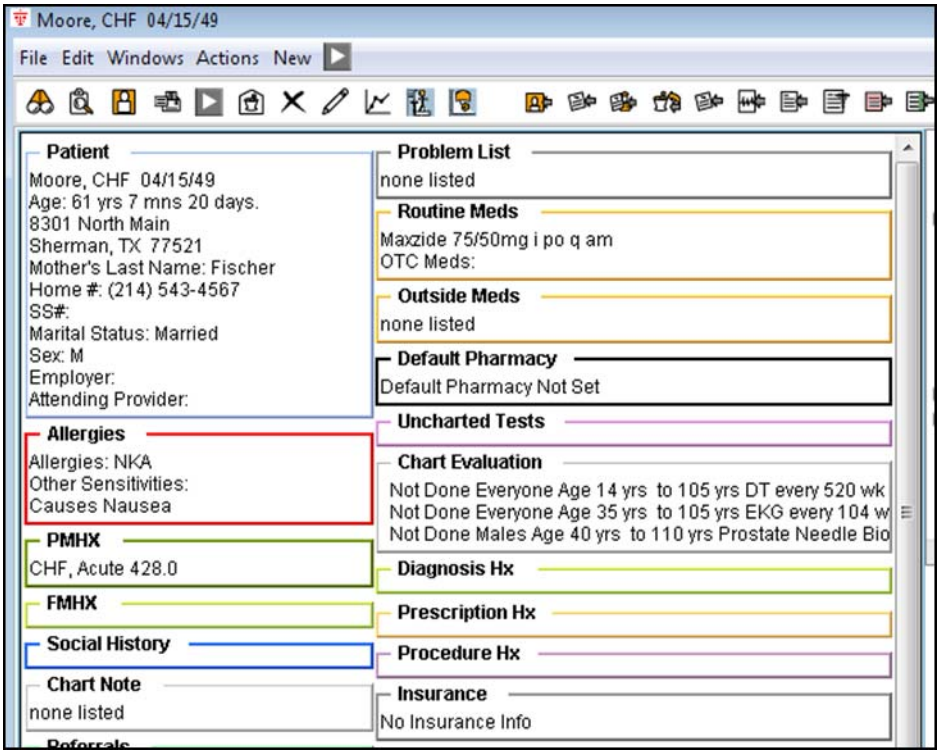
2. Your patient tells you he was diagnosed with Congestive Heart Failure while on vacation last month in Florida. Click on *PMHX* on the left and the past medical history populates the box on the right lower side of the screen. Click *Edit* below that box.
• The *Past Medical History* screen opens and populates in a new window. In the field after Dx in the upper right of the window, type: CHF and click the search icon. Options appear in the box below. Click on the CHF, Acute 428.0, which sends this to the Past Medical History list on the upper left side of the window.
• Click *Back to Chart* in the lower left corner of the window. The information you added appears in the *PMHX* box.



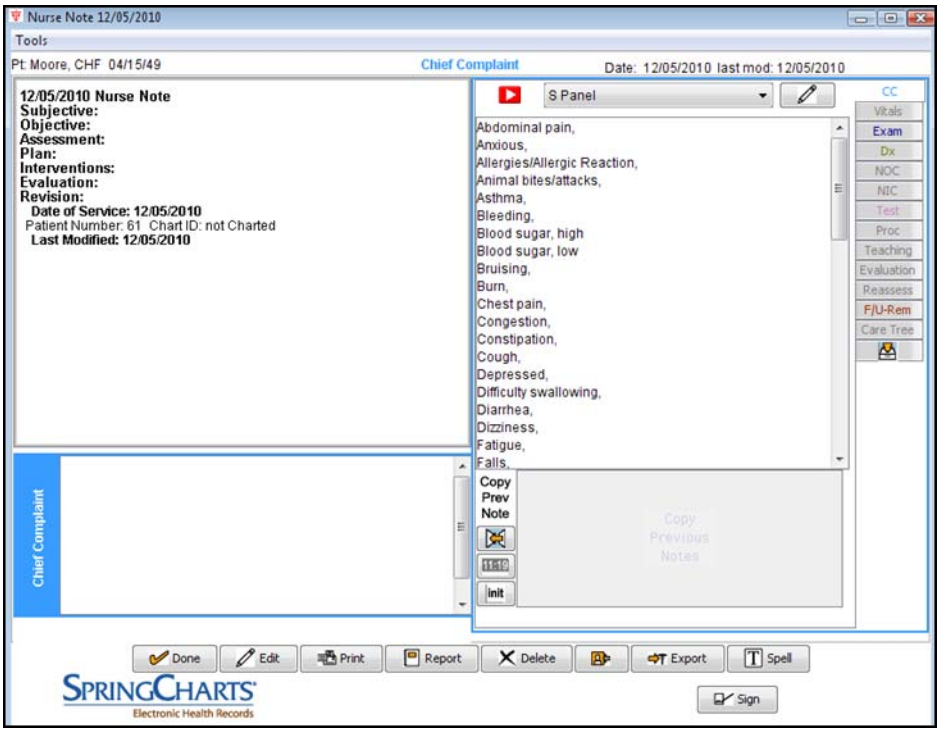
3. Your patient also informs you the physician in Florida started him on Maxzide 75/50 mg one pill by mouth daily (every AM) at the time of his CHF diagnosis. Click on the *Routine Meds* box and it populates in the bottom right corner. Click *Edit* and a new window opens.
• Click in the field after *Brand Name* on the upper right side of the window and type: Maxzide. Click Search. Click on the correct dosage. This adds the medication to the *Routine Medications* list in the upper left box of the window.
• Click on the Maxzide that is in the *Routine Medications* list in the upper left. The *Edit Rx* window opens. Click on the calendar to the right of *Date Started* in the left column and choose a date one month ago. Click *Save*.



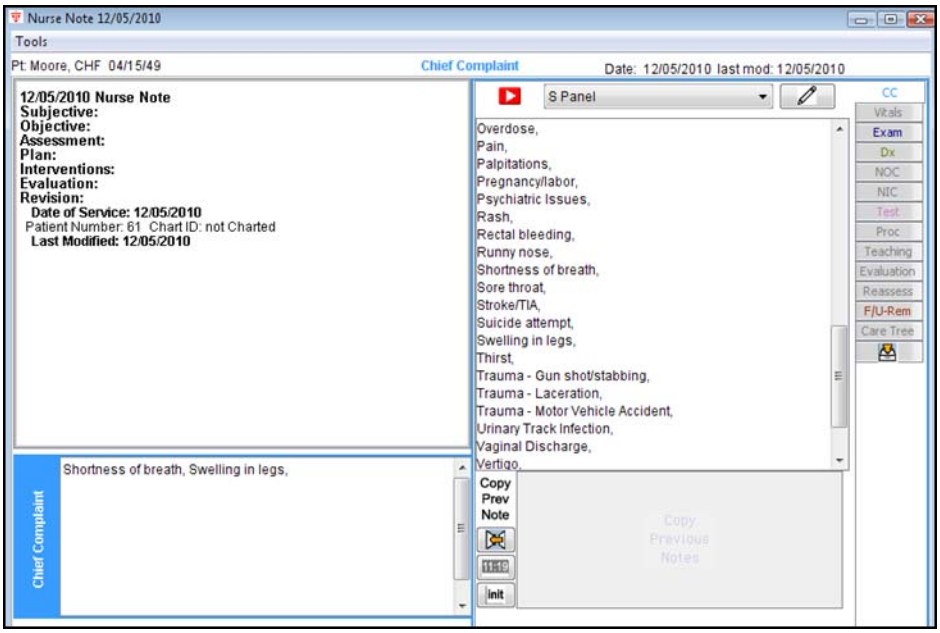
• Click *Back to Chart* at the lower left side of the window. The Maxzide is now listed in the *Routine Meds*.



4. Open your *Nurse Note*. Click *New, New Nurse Note*.

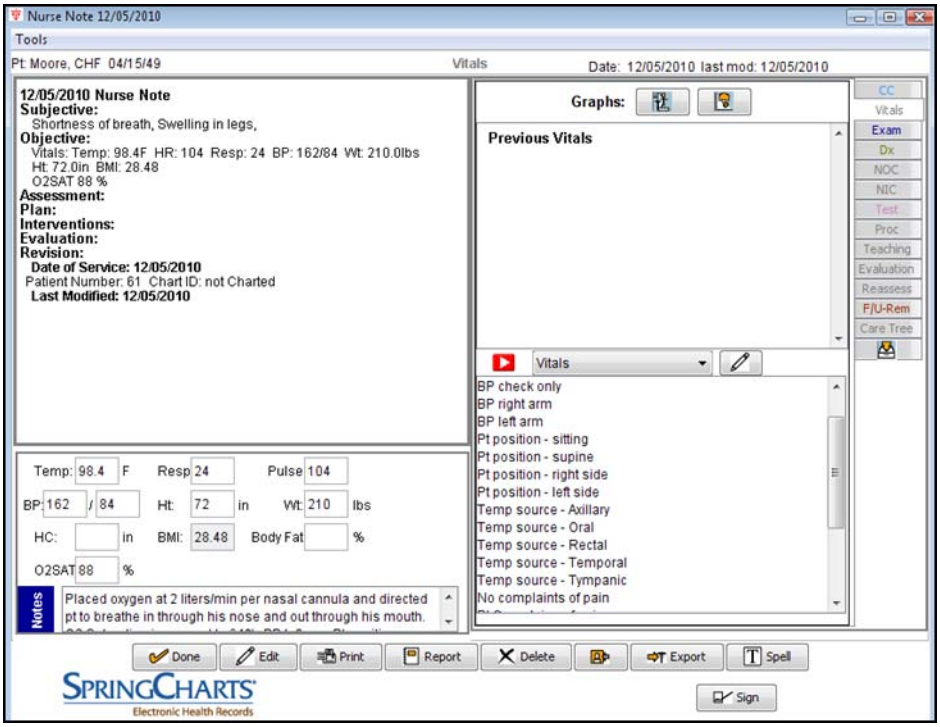


5. Your patient complains of shortness of breath and says he has swelling in his legs. Select these two items in the *S Panel* text and they populate the *Chief Complaint* box on the bottom left of the screen.

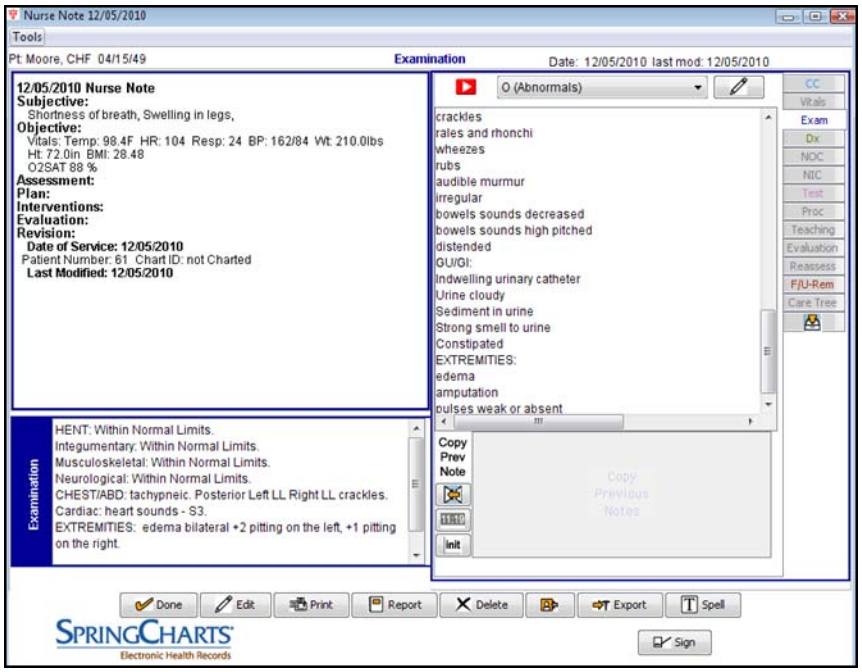


6. Click on the *Vitals* button located below the CC button on the right side of the screen. The *Chief Complaints* now appear in the *Subjective* section of the *Nurse Note*.
• You take your patient's vital signs. Document the following in the boxes on the lower left section of the window: Temp 98.4, Resp 24, Pulse 104, BP 162/84, Ht 72 inches, Wt 210 lbs.

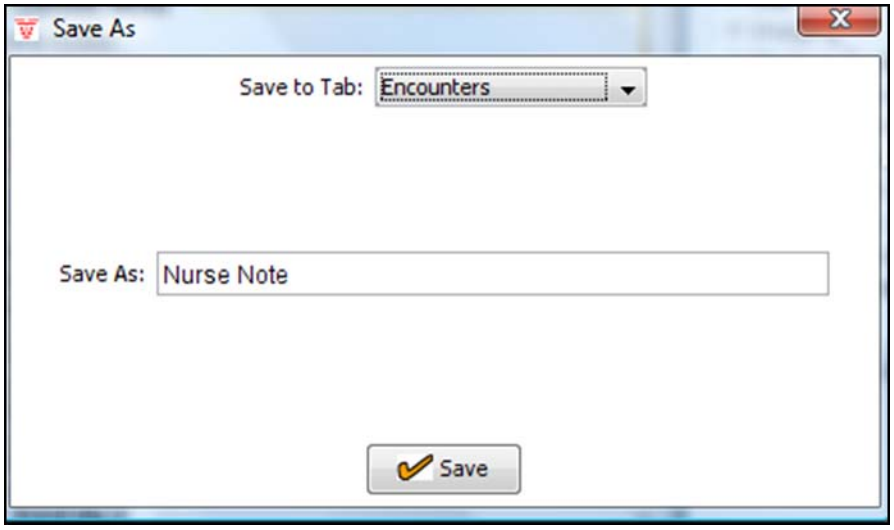
• When you take the pulse oximetry reading, your patient's oxygen saturation is 88%. Enter this value in the 02SAT (SaO2) field. You start oxygen at 2 liters/min per nasal cannula and direct him to breathe in through his nose and out through his mouth. His O2 Saturation increases to 94%. Under the *Vitals* text box on the right click: O2 Saturation. Click into the Notes box and type the text explaining your assessment and intervention.
• From the *Vitals* box on the lower right side of the window, also select: BP left arm, Pt position—Supine and Temp source—Tympanic and No complaints of pain.



7. You complete your admission physical assessment. To document your findings, click on the *Exam* button located below the *Vitals*. Notice the *O (Normals)* defaults in the text box in the upper right box of the window. In this area select the following systems that are within normal limits when you assess your patient: HEENT, Integumentary, Musculoskeletal, GU (male), and Neurological. As you click on each system, the text populates the *Examination* box on the lower left side of the window. Use the enter key to put these items on separate lines to streamline your documentation.
• Click the drop down arrow next to *O (Normals)* and select *O (Abnormals)*. Select *Chest/ABD* followed by: tachypneic, Posterior Left UL/LL Right UL/ML/LL crackles.
• Click into the *Examination* box on the lower left and delete the UL on the Left and the UL/ML on the right so that it reads Posterior Left LL Right LL crackles. Click your Enter key on your keyboard to put the cursor on the next line.
• Type: Cardiac: heart sounds—S3.
• From the *O (Abnormals)* select *Extremities* followed by: edema. Click into the *Examination* box and type: bilateral LE +2 pitting on left, +1 pitting on right.

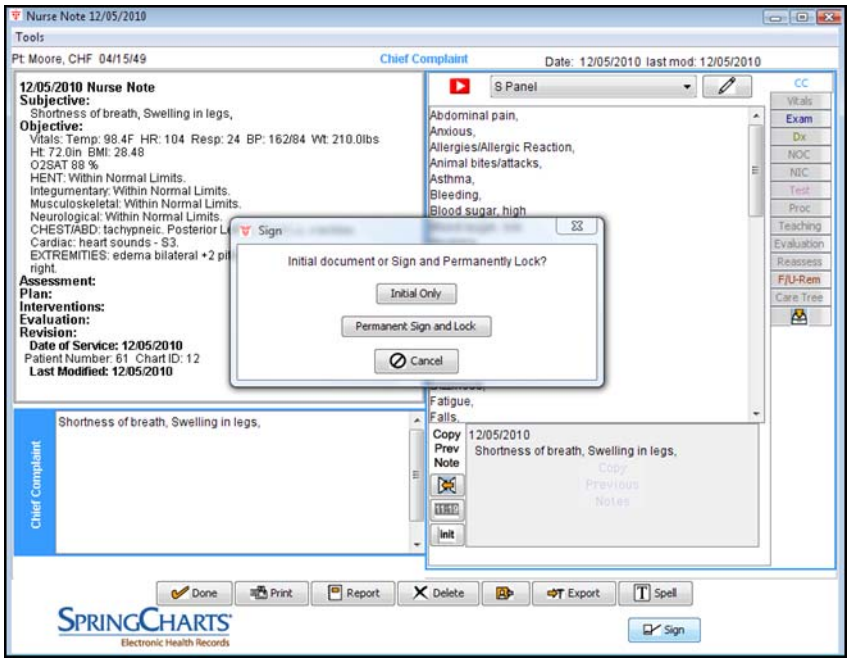


8. Click *Done*. The *Save As* screen populates. Accept the default entries of *Save to Tab*: Encounters and *Save As*: Nurse Note. Click *Save*.



9. A pop-up appears asking if you want to create a routing slip. Click *No*.

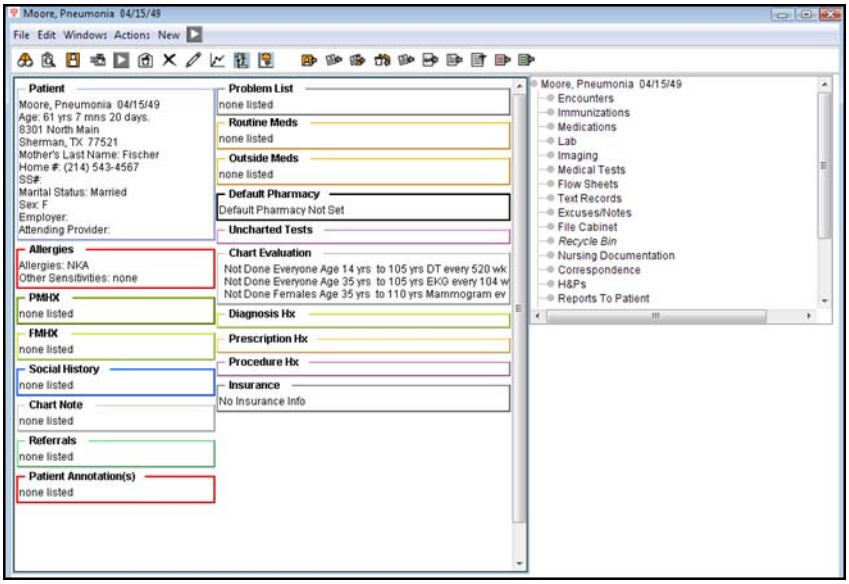
10. In the *Care Tree* in the upper right corner of the chart window, click the +next to *Encounters*. Click on the date of your nurse note to view it in the bottom right corner box.
• Click *Edit*. Click *Sign*. Select *Permanent Sign and Lock* when finished with your *Nurse Note*.



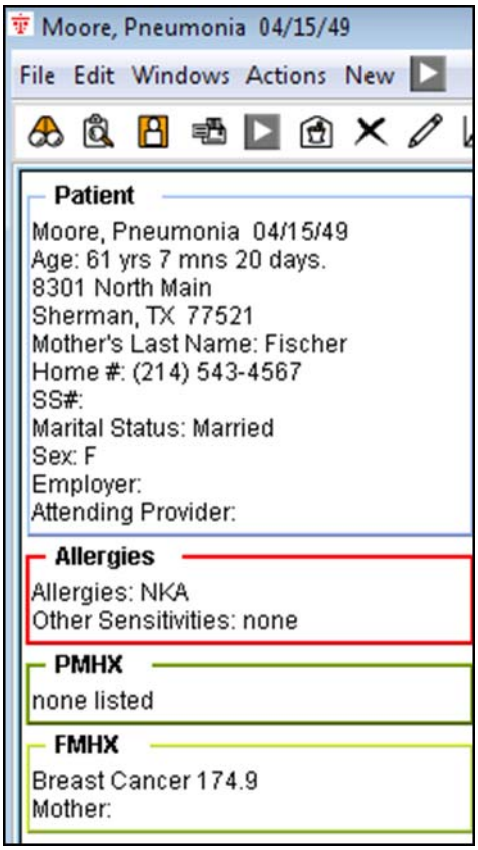
Exercise 4.3

Pneumonia

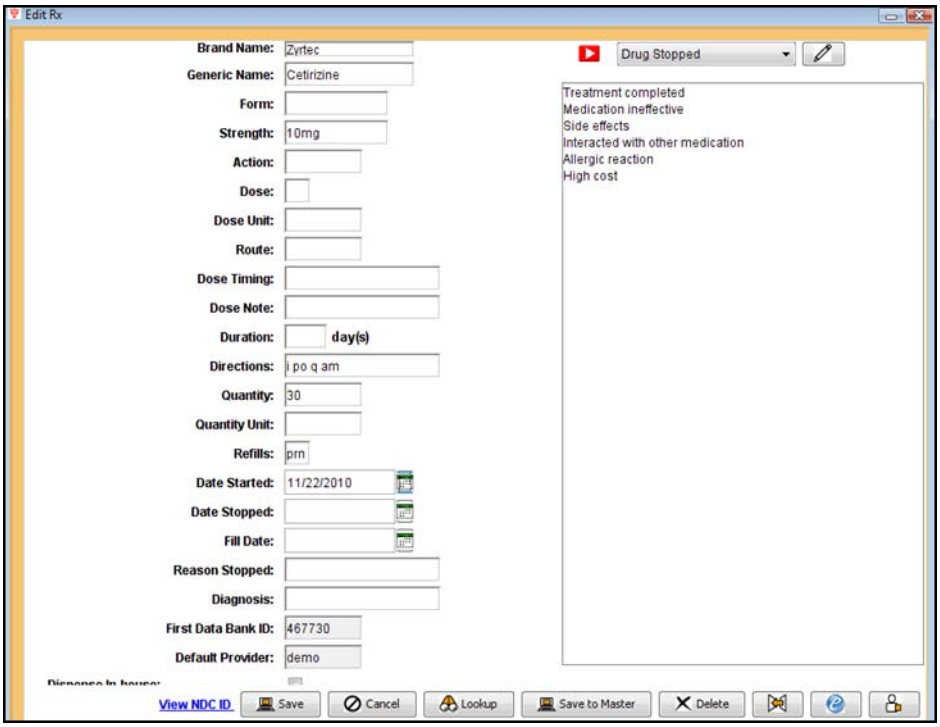
1. After launching SpringCharts, from the top menu toolbar click on *Actions, Open a Chart*. Type in your last name and click the search button. Select your “pneumonia” patient and the chart opens.



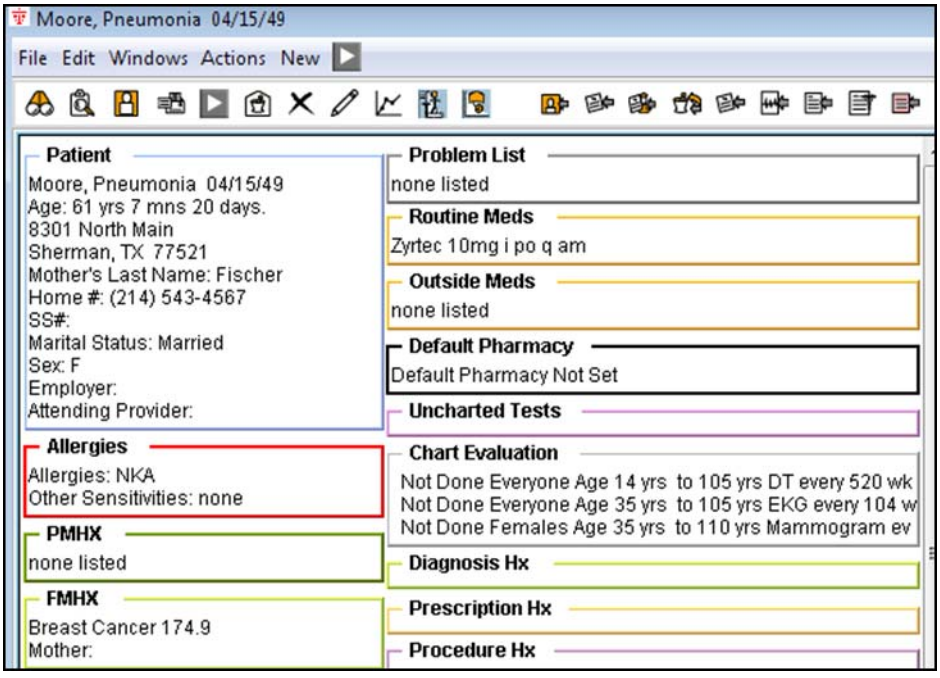
2. Your patient tells you her mother was recently diagnosed with breast cancer. Click on *FMHX* on the left and the *FMHX* populates the box on the right lower side of the screen. Click *Edit* below that box.
• The *Family Medical History* window opens. In the space after *Dx* at the top right type: breast cancer and click the search button. Breast Cancer 174.9 appears in the box below. Click on the listing, which sends this to the *Family Medical History* list on the left upper box in the window.
• Click Mother under the *Preference* section in the lower right box.
• Click *Back to Chart* at the lower left side of the window. The information you added appears in the *FMHX* box.



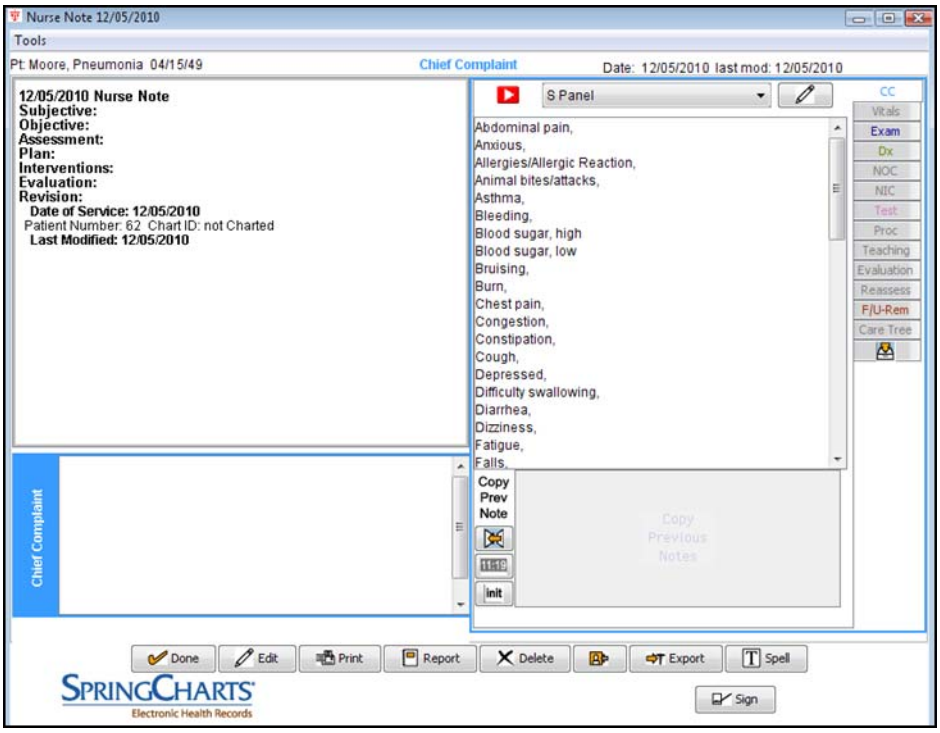
3. Your patient also informs you she takes the over-the-counter medication Zyrtec® 10 mg by mouth daily for allergies she has been having for the last 2 weeks. Click on the *Routine Meds* box and it populates in the bottom right corner. Click *Edit* below that box.
• Click in the field after *Brand Name* on the upper right side of the window and type: Zyrtec. Click Search. Click on the correct dosage/frequency. This sends the medication to the *Routine Medications* list at the upper left.
• Click on the Zyrtec that is in the *Routine Medications* list at the upper left. The *Edit Rx* window opens. Click in the calendar to the right of *Date Started* in the left column and choose a date 2 weeks ago. Click *Save*.



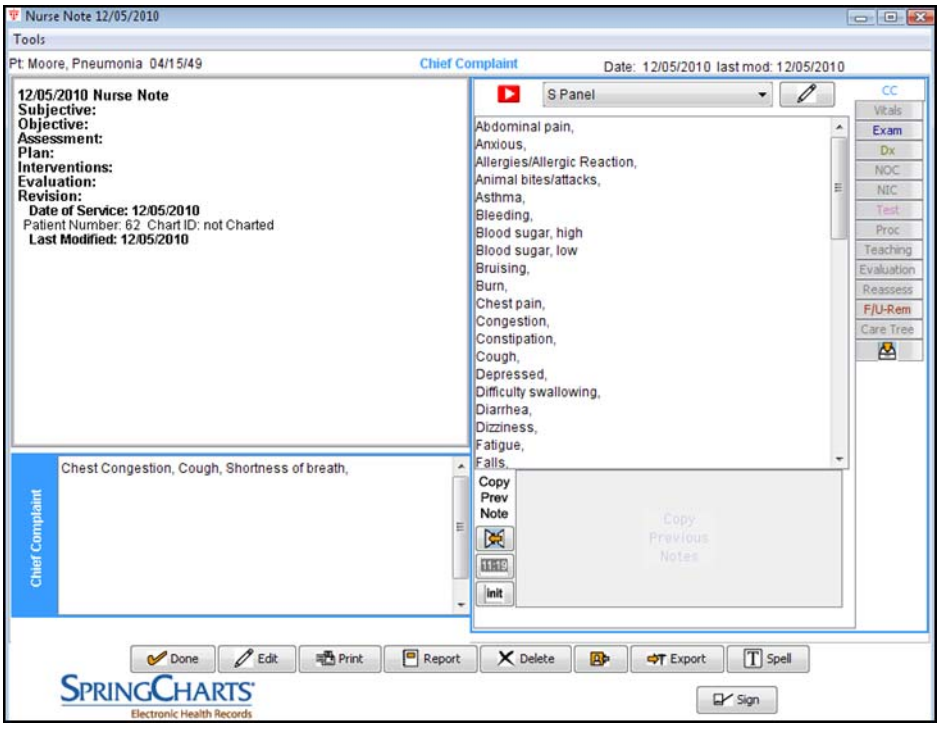
• Click *Back to Chart* at the lower left side of the window. The Zyrtec is now listed in the *Routine Meds*.



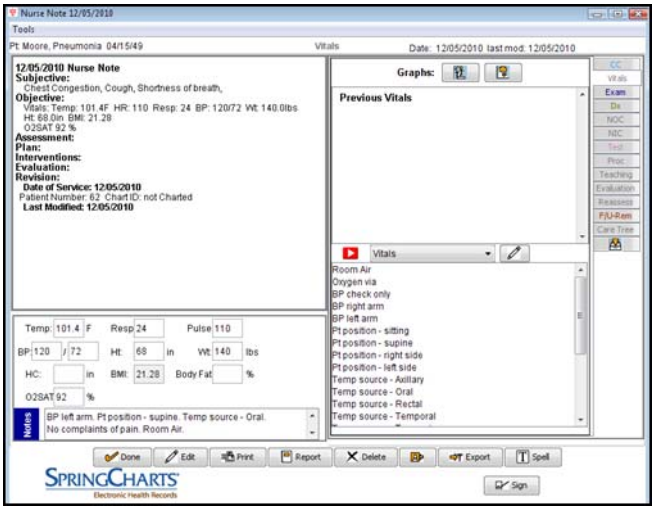
4. Open your *Nurse Note*. Click *New, New Nurse Note*.



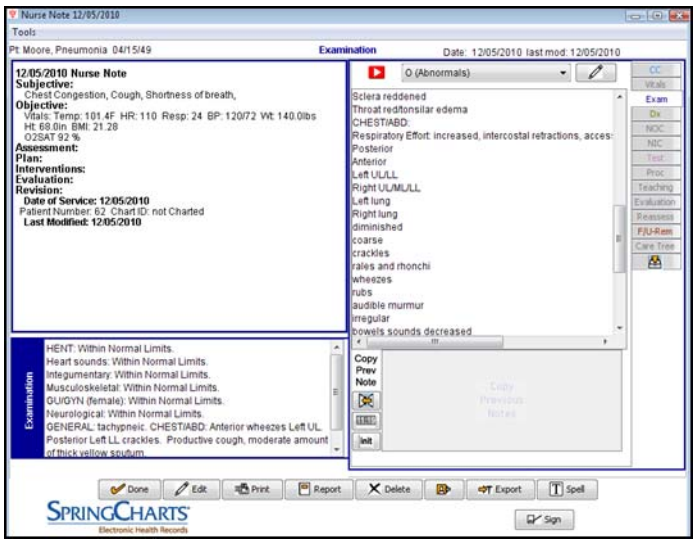
5. Your patient complains of chest congestion, a terrible cough, and shortness of breath. Select these three items in the *S Panel* list at the upper right and they populate the *Chief Complaint* box on the bottom left of the screen.



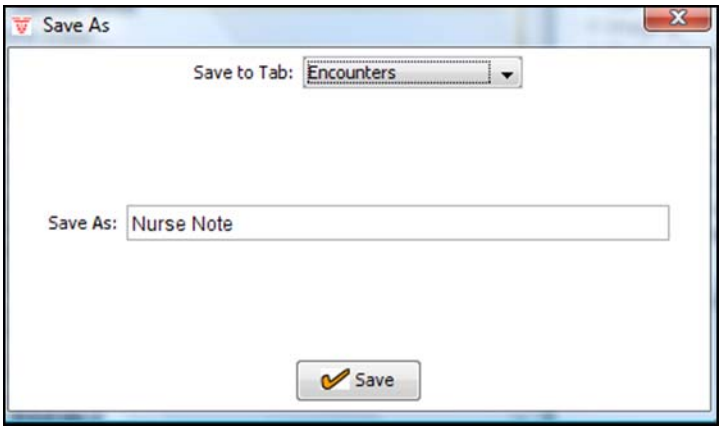
6. Click on the *Vitals* button located below the *CC* button on the vertical navigation bar on right side of the screen. The *Chief Complaints* now appear in the Subjective section of the *Nurse Note*.
• You take your patient's vital signs. Document the following in the boxes on the lower left section of the window: Temp 101.4, Resp 24, Pulse 110, BP 120/72, Ht 68 inches, Wt 140 lbs, SaO2 92%.
• Also select: BP left arm, Pt position—Supine, Temp source—Oral, No complaints of pain, and Room Air.



7. You complete your admission physical assessment. To document your findings click on the *Exam* button located below the *Vitals*. The *O (Normals)* defaults in the text box in the upper right box of the window. In this area select the following systems that are within normal limits when you assess your patient: HENT, Heart Sounds, Integumentary, Musculoskeletal, GU/GYN (female), and Neurological. As you click on each system, the text populates the *Examination* box on the lower left side of the window. Use the enter key to put these items on separate lines to streamline your documentation.
• Click the drop down arrow next to *O (Normals)* and select *O (Abnormals)*. Select the *General* section followed by: tachypneic. Select the *Chest/ABD* section followed by: Anterior wheezes Left UL/LL Posterior Left UL/LL crackles.
• Click into the *Examination* box on the left. Delete the LL on the anterior left and delete the UL after the Posterior Left so that it reads: Anterior wheezes Left UL Posterior Left LL crackles
• In the same area, click after crackles and select Enter on the keyboard. Type in: Productive cough, moderate amount of thick yellow sputum.



8. Click *Done*. The *Save As* screen populates. Accept the default entries of *Save to Tab*: Encounters and *Save As*: Nurse Note. Click *Save*.



9. A pop-up appears asking if you want to create a routing slip. Click *No*.

10. In the *Care Tree*, click the + next to *Encounters*. Click on the date of your nurse note to view it in the bottom right corner box.
• Click *Edit*. Click *Sign*. Select *Permanent Sign and Lock* when finished with your *Nurse Note*.