

Level 2 – Level 2 of *Nursing Documentation Using Electronic Health Records* includes chapters 5, 6, 7, and 8. These chapters take the students deeper into EHR features of documentation and enable them to add to their Nurse Notes using these features. The student is also introduced to documentation in the ambulatory healthcare setting. Exercises are provided for the nurse and nurse practitioner to create an Office Visit Note.

Chapter 6 – Nurse Note Documentation – Level 2

In Chapter 6 the student begins to use NANDA-I nursing diagnoses, identify patient goals, and employ nursing interventions using NIC and NOC verbiage from within the EHR program as they continue to build Nurse Notes on designated patients with different disease processes. Level two of the Nurse Note also deals with documentation on the MAR and I&O forms.

Learning Outcomes

After completing Chapter 6, the students will be able to:

- 6.1** Use NANDA-International (NANDA-I) approved nursing diagnoses to reflect patient needs.
- 6.2** Identify patient specific goals using Nursing Outcomes Classification (NOC).
- 6.3** Identify and document nursing interventions using Nursing Intervention Classification (NIC).
- 6.4** Carry out documentation of medication administration.
- 6.5** Carry out documentation of intake and output (I&O).

Key Terms & Definitions

Terms and abbreviations encountered in Chapter 6:

Medical Diagnosis: Identification of an illness or disease.

Nursing Diagnosis: “Statement that describes the client’s actual or potential response to a health problem that the nurse is licensed and competent to treat” (Potter & Perry, 2009, p. 248). The client may be a person, family, or community.

Objective Data: Information collected by the nurse through observation, auscultation, palpation, or smell. May include information obtained from the health record such as diagnostic results and medical diagnoses.

Subjective Data: Descriptions given by the patient or family about the patient’s condition.

Presentation Outline

LO 6.1 Dx (Nursing Diagnosis)

Power Point Slides: 1 through 11.

Concept Checkup 6.1

- A. List three (3) purposes of standardized nursing language.

Answer:

1. Comparison of nursing activities and outcomes
2. Positive patient outcomes
3. Enhanced quality of patient care

Rationale: In nursing, standard language reflects the nursing process: nursing diagnoses, nursing outcomes, and nursing interventions. In addition to facilitating the use of technology, standard language allows for comparison of nursing activities and outcomes in diverse settings and locations, thereby enabling nursing research to demonstrate the value of nursing in promoting positive patient outcomes. Another benefit of standardized terminology is enhanced quality of patient care through promotion of compliance to standards of care.

- B. True or False: The nurse develops nursing diagnoses based on critical thinking about a patient's assessment, past health history, and social history.

Answer: False

Rationale: NANDA-I defines nursing diagnosis as “a clinical judgment about individual, family, or community experiences and responses to actual or potential health problems and life processes.”

LO 6.2 NOC (Nursing Outcomes)

Power Point Slides: 12, 13

Concept Checkup 6.2

- A. Nursing outcomes may be either _____ or _____ term, and should include a specific _____.

Answer: Short, long, time frame for achievement

Rationale: Once an outcome is selected, the nurse designates a specific time frame for achievement of the goal. Nursing outcomes may be either short-term or long term goals.

- B. True or False: NOC statements cannot be individualized in SpringCharts.

Answer: False

Rationale: The NOC area can be individualized from inside the NOC window to allow for Nursing Outcome Classifications that may not be available in the prebuilt text.

LO 6.3 NIC (Nursing Interventions)

Power Point Slides: 14, 15

Concept Checkup 6.3

- A. What is the purpose of nursing interventions?

Answer: To promote wellness or movement toward wellness

Rationale: Interventions are the activities the nurse provides in order to facilitate wellness or movement toward wellness.

- B. True or False: In the *Edit PopUp Text* area the nurse can modify the intervention list including the order of items in the list.

Answer: True

Rationale: In order to individualize pop-up text, the user selects the pencil icon. This opens the Edit PopUp Text Window where the nurse can add useful text into the open fields. The order of the intervention list may be modified by using the up and down arrows on the left-hand side of the screen.

LO 6.4 MAR (Medication Administration Record)

Power Point Slides: 16, through 20.

Concept Checkup 6.4

- A. List the five components of the medication order that must be entered into the MAR.

Answer:

1. Drug name
2. Route
3. Dosage
4. Frequency
5. Time

Rationale: New medications are typed into the MAR, including the drug name, route, dosage, frequency, and time.

- B. In what area of SpringCharts is the MAR located?

Answer: Under the Nursing Documentation tab in the Care Tree within a patient's chart.

Rationale: The MAR is located within the Nursing Documentation tab within the Care Tree of a patient's chart.

LO 6.5 I & O (Intake and Output)

Power Point Slides: 21, 22.

Concept Checkup 6.5

- A. What tab is used to access the Nursing Documentation Area from within the Nurse Note?
Answer: The Care Tree tab
Rationale: Like the MAR, in SpringCharts *I&O* documentation is in the *Nursing Documentation* area, which is accessed via the *Care Tree* tab in the *Nurse Note*.
- B. When are intake and output (I&O) totals routinely calculated?
Answer: Each shift
Rationale: *I&O* may be documented hourly and shift totals are calculated by the user each shift on the *I&O* form.

Exercise 6.1

Chronic Obstructive Pulmonary Disease

Note: (The MAR document is housed in the EHR Materials folder that was installed with the SpringCharts program. Your instructor or IT staff may need to inform you where this folder is kept.)

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 “COPD” patient and the chart opens.

2. Your patient tells you he has been diagnosed with Chronic Obstructive Pulmonary Disease (COPD) this past week. Click on *PMHx* and it populates the right corner box. Click the *Edit* button below the right corner box and a new window opens.
 - In the space after *Dx* at the upper right portion of the window type COPD and click the search icon. COPD 496 appears in the box below the search button. Click on COPD and it moves to the *Past Medical History* box on the left.

- In the lower left corner of the window, click *Back to Chart*. Your new entry appears in the *PMHX* field.

Moore, COPD 04/15/49

File Edit Windows Actions New

Patient
 Moore, COPD 04/15/49
 Age: 61 yrs 7 mns 20 days.
 8301 North Main
 Sherman, TX 77521
 Mother's Last Name: Fischer
 Home #: (214) 543-4567
 SS#:
 Marital Status: Married
 Sex: M
 Employer:
 Attending Provider:

Allergies
 Allergies: NKA
 Other Sensitivities: none

PMHX
 COPD 496

- You ask your patient about his smoking history and he says he smokes two packs a day and has done so for 24 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 *Social History* click on: Tobacco Use and Packs per Day.
 - In the *Social History* box on the left, click after Packs per Day and enter 2 for 24 years.
 - In lower left corner of the window, click *Back to Chart*. Your new entry appears in the *Social History* field.

Moore, COPD 04/15/49

File Edit Windows Actions New

Patient
 Moore, COPD 04/15/49
 Age: 61 yrs 7 mns 20 days.
 8301 North Main
 Sherman, TX 77521
 Mother's Last Name: Fischer
 Home #: (214) 543-4567
 SS#:
 Marital Status: Married
 Sex: M
 Employer:
 Attending Provider:

Allergies
 Allergies: NKA
 Other Sensitivities: none

PMHX
 COPD 496

FMHX

Social History
 Tobacco Use: 2 Packs per Day: 24 years

4. Open your *Nurse Note*. On the top horizontal toolbar, 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.

Nurse Note 12/05/2010

Tools

Pt Moore, COPD 04/15/49

Chief Complaint Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note

Subjective:

Objective:

Assessment:

Plan:

Interventions:

Evaluation:

Revision:

Date of Service: 12/05/2010

Patient Number: 63 Chart ID: not Charted

Last Modified: 12/05/2010

S Panel

Abdominal pain,

Anxious,

Allergies/Allergic Reaction,

Animal bites/attacks,

Asthma,

Bleeding,

Blood sugar, high

Blood sugar, low

Bruising,

Burn,

Chest pain,

Congestion,

Constipation,

Cough,

Depressed,

Difficulty swallowing,

Diarrhea,

Dizziness,

Fatigue,

Falls,

02/25/2008 Fever onset day(s) ago. Associated symptoms include . Head Ache Ear Ache Neck Pain Shoulder Pain

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Done Edit Print Report Delete Export Spell Sign

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5. Your patient complains of a cough and shortness of breath. Under the *S Panel* (for subjective) in the text box on the right side click on these two items. The text populates in the *Chief Complaint* box on the bottom left of the screen.

Nurse Note 12/05/2010

Tools

Pt Moore, COPD 04/15/49

Chief Complaint Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note

Subjective:

Objective:

Assessment:

Plan:

Interventions:

Evaluation:

Revision:

Date of Service: 12/05/2010

Patient Number: 63 Chart ID: not Charted

Last Modified: 12/05/2010

S Panel

Loss of consciousness,

Memory loss,

Nausea,

Numbness,

Overdose,

Pain,

Palpitations,

Pregnancy/labor,

Psychiatric issues,

Rash,

Rectal bleeding,

Runny nose,

Shortness of breath,

Sore throat,

Stroke/TIA,

Suicide attempt,

Swelling in legs,

Thirst,

Trauma - Gun shot/stabbing,

Trauma - Laceration,

02/25/2008 Fever onset day(s) ago. Associated symptoms include . Head Ache Ear Ache Neck Pain Shoulder Pain

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Cough, Shortness of breath,

Done Edit Print Report Delete Export Spell Sign

SPRINGCHARTS Electronic Health Records

6. Click on the *Vitals* tab located below the *CC* tab in the vertical navigation bar on the right side of the screen. Note your *Chief Complaints* now appear in the Subjective section of the *Nurse Note*.
 - You take your patient's vital signs, height, and weight. Document the following in the boxes on the lower left section of the window: Temp 99.4, Resp 26, Pulse 102, BP 144/80, Ht 66 inches, Wt 200 lbs.
 - You measure your patient's oxygen saturation on room air and find it to be 87%. Document this in the O2Sat field. You start oxygen at 2L/minute per nasal cannula and 5 minutes later his oxygen saturation has increased to 91%. To document this, under the *Vitals* text box on the bottom right side of the window click Oxygen via, and O2 Saturation. To document this, click into the *Notes* box on the left and document your intervention (O2 initiated at 2L/minute per nasal cannula) as well as the reassessment (O2 sat increased to 91%).
 - Under the *Vitals* text box on the right click: BP right arm, Pt position— supine and Temp source— Oral to send this text to the *Notes* box on the left. The Temp source —Oral can be separated 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 click: Pt Complains of pain, Pain location, Pain rating 0–10 scale, Pain Description, Factors affecting pain, and Factors relieving pain to send the text to the *Notes* box on the left. Again, place each on a separate line using the enter key.
 - Fill in the following information in the *Notes* box that your patient conveys to you: Pain location: Right lower chest pain from coughing, Pain rating 0–10 scale: 5 on 0–10 scale, Pain description: aches, Factors affecting pain: coughing, Factors relieving pain: medication.

Nurse Note 12/05/2010

Tools

Pt: Moore, COPD 04/15/49 Vitals Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note

Subjective:
Cough, Shortness of breath,

Objective:
Vitals: Temp: 99.4 F HR: 102 Resp: 26 BP: 144/80 Wt: 200.0lbs
Ht: 66.0in BMI: 32.28
O2SAT 87 %

Assessment:

Plan:

Interventions:

Evaluation:

Revision:
Date of Service: 12/05/2010
Patient Number: 63 Chart ID: not Charted
Last Modified: 12/05/2010

Previous Vitals

02/25/2008 Temp: 100.9F HR: 96 Resp: 59
BP: 128/89 Wt: 309.9lbs Ht: 65.7in BMI: 50.47

Vitals

Temp source - Oral
Temp source - Rectal
Temp source - Temporal
Temp source - Tympanic
No complaints of pain
Pt Complains of pain
Pain Location
Pain rating 0-10 scale
Pain Radiation
Pain Description
Factors affecting pain
Factors relieving pain
Weight check

Temp: 99.4 F Resp: 26 Pulse: 102
BP: 144 / 80 Ht: 66 in Wt: 200 lbs
HC: in BMI: 32.28 Body Fat: %
O2SAT 87 %

Placed oxygen at 2L/minute per nasal cannula. Oxygen saturation increased to 91%. BP right arm. Pt position -

Done Edit Print Report Delete Export Spell

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Electronic Health Records

Sign

7. Click on the *Exam* button located below the *Vitals*. Notice the *O (Normals)* defaults. In this area select the following systems that are within normal limits when you assess your patient: HEENT Gastrointestinal, Musculoskeletal, Heart sounds, Integumentary, and GU (male). 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: overweight, restless, and tachypneic. Select the *Chest/ABD* section followed by: Respiratory Effort, diminished, wheezes.

- Click in the *Examination* box after Respiratory Effort and delete: increased, intercostals retractions, accessory muscle use, and abdominal retraction so that it reads simply Respiratory Effort, diminished.
- Click after diminished remove the comma and type: with wheezes.
- Click after wheezes and type: throughout. It now reads “diminished with wheezes throughout”.

8. Click the *Dx* button below the Exam button in the vertical navigation bar on the right. Click on the red *NANDA* on the left bottom of the screen. The *Dx* text window populates.
 - Click Breathing Pattern, Ineffective and Gas Exchange, Impaired. Click the [D&T] button to date and time the entry. Click *Done*.
 - Add the related factor (r/t) and as evidenced by (AEB) typing them into the field after each *NANDA* diagnosis. Remember to place each nursing diagnosis on a separate line using the enter key.

9. Click the *NOC* tab in the vertical navigation bar on the right located below the *Dx* button. Notice that your *NANDA* documentation populates the *Nurse Note*.
 - Below the *Nursing Outcomes Classification* in the upper right box select the following:
 - Knowledge—Disease Process: Extent of understanding conveyed about a specific disease process and prevention of complications.
 - Respiratory Status: Movement of air in and out of the lungs and exchange of carbon dioxide and oxygen at the alveolar level.
 - Respiratory Status—Gas Exchange: Alveolar exchange of carbon dioxide and oxygen to maintain arterial gas concentrations.
 - Smoking Cessation Behavior: Personal actions to eliminate tobacco use.
 - Use the Enter key on the keyboard to place each outcome on separate lines to streamline your documentation.
 - Use the up and down arrows to place the nursing diagnoses in order of priority.
 - Individualize the outcome statements for the client by indicating measurable goals and time frames.

10. Click the *NIC* button in the vertical navigation bar on the right below the *NOC* button. Notice that your outcomes populate the *Nurse Note*.
 - Select the following interventions:
 - Medication Administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs.
 - Oxygen Therapy: Administration of oxygen and monitoring of its effectiveness.
 - Respiratory Monitoring: Collection and analysis of patient data to ensure airway patency and adequate gas exchange.
 - Teaching—Disease Process: Assisting the patient to understand information related to a specific disease process.
 - Vital Signs Monitoring: Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications.
 - Click in the *Nursing Interventions Classification* box on the bottom, left side of the window, after the Oxygen Therapy line and type: See *Vitals* documentation.

- Still in the *Nursing Interventions Classification* box click after Teaching: Disease Process and type: Taught pursed lip breathing to patient and significant other. Verbalized understanding and demonstrated technique with verbal cues. Continue to reinforce.

Nurse Note 12/05/2010

Tools: Pt. Moore, COPD 04/15/49 Date: 12/05/2010 last mod: 12/05/2010

Other Dx: Breathing Pattern, Ineffective ART COPD
Other Dx: Gas Exchange, Impaired AEB increased respiratory rate and
Other Dx: decreased SAO2
Other Dx: 12/05/2010 10:43 AM

Plan:
NIC: Respiratory Status: Movement of air in and out of the lungs and exchange of carbon dioxide and oxygen at the alveolar level moderate compromised.
Respiratory Status: Gas Exchange: Alveolar exchange of carbon dioxide and oxygen to maintain arterial gas concentrations moderate compromised.
Knowledge - Disease Process: Extent of understanding conveyed about a specific disease process and prevention of complications minimally informed.
Smoking Cessation Behavior: Personal actions to eliminate tobacco use none at this time.

Interventions:
Evaluation:
Revision:
Date of Service: 12/05/2010
Patient Number: 63 Chart ID: not Charted
Last Modified: 12/05/2010

to ensure airway patency and adequate gas exchange.
Teaching: Disease Process: Assisting the patient to understand information related to a specific disease process. Taught pursed lip breathing to patient and significant other. Verbalized understanding and demonstrated technique with verbal cues. Continue to reinforce.
Vital Signs Monitoring: Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications.

NIC

Respiratory Monitoring: Collection and analysis of patient data
Resuscitation: Administering emergency measures to sustain life
Seizure Precautions: Prevention or minimization of potential seizure activity
Self-Care Assistance: Assisting another to perform activities of daily living
Skin Surveillance: Collection and analysis of patient data to detect early signs of skin problems
Smoking Cessation Assistance: Helping another to stop smoking
Spiritual Support: Assisting the patient to feel balance and harmony
Suicide Prevention: Reducing risk of self-inflicted harm with suicidal ideation
Surgical Preparation: Providing care to a patient immediately before surgery
Teaching: Disease Process: Assisting the patient to understand information related to a specific disease process
Teaching: Prescribed Diet: Preparing a patient to correctly follow a prescribed diet
Teaching: Prescribed Medication: Preparing a patient to safely take prescribed medication
Teaching: Procedure/Treatment: Preparing a patient to understand and cooperate with a procedure or treatment
Traction/Immobilization Care: Management of a patient who is in traction or immobilized
Tube Care: Management of a patient with an external drain
Urinary Catheterization: Insertion of a catheter into the bladder
Ventilation Assistance: Promotion of an optimal spontaneous breathing pattern
Vital Signs Monitoring: Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications
Wound Care: Prevention of wound complications and promotion of wound healing

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Electronic Health Records

11. . Move the Nurse Note by clicking on the minimize icon in the upper right corner. This will bring you back to the patient's chart.
- Click the *New* menu and *Import Items* at the bottom of the list. Select *Import File Cabinet Document* and the *File Cabinet* window appears. Type *MAR* into the Document name. In the *Chart Tab* select the drop down box on the right and choose *Nursing Documentation*. In the *Description* field type *MAR*. Click *Attach*. Select *Existing*. Click *OK*. Click *Done*. The document appears in the *Care Tree* on the right in the *Nursing Documentation* tab.

File Cabinet Document

Created On: 12-05-2010
Last Modified: 12-05-2010
Signed by:

Document Name: MAR
Patient: Moore, COPD 04/15/1949
Chart Tab: Nursing Documentation
Folder: Consult
File: Medication Administration Record.xls
Description: MAR

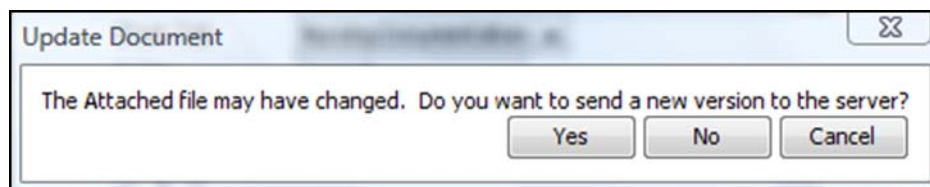
Attach Sign Print Delete Done

- Click on the + in front of *Nursing Documentation*. Highlight the *MAR* and click [Doc] button at the bottom right hand side of the screen. The *MAR* document opens. Enter the Patient, Date of Birth, Date, Admit date, Doctor, and Room #. Initial and sign at the bottom of the *MAR*. Include your credentials.

Medication Administration Record																									
Patient: Moore, COPD		Date: 12/5/2010 to		Doctor: Stephen Finchman																					
Date of birth: 4/15/1949		Admit: 12/5/2010		Room #: 3205																					
		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700

- The primary care provider writes an order to continue the patient's Allegra 180 mg by mouth daily and Aspirin 325 mg by mouth daily. Add the medications to the *MAR* by typing the name of the medication, strength, dose, and directions into the form.. Document that you gave the Allegra and Aspirin as ordered by typing your initials into the correct time box on the form. Initial and sign at the bottom of the *MAR*. Include your credentials.
- Your patient requests Aleve for the pain he is having in his chest due to his cough. You confirm that the physician has ordered Aleve 550 milligrams by mouth every 12 hours as needed for pain. Add this medication to the *MAR* and document administration. Close the *MAR* by clicking the ' X ' on the top right corner of the form. A pop up will ask you if you want to save the changes you've made, select yes. A pop up will ask you if you want to save the changes you've made, select *yes*.. The *Update Document* window appears. Answer yes to the question, "Do you want to send a new version to the server?"

Medication Administration Record																								
Patient: Moore, COPD		Date: 12/5/2010 to		Doctor: Stephen Finchman																				
Date of birth: 4/15/1949		Admit: 12/5/2010		Room #: 3205																				
		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400		
Allegra																								
Strength 180mg	Dose 1	8																						
Directions PO daily		SN																						
Aspirin																								
Strength 325mg	Dose 1	8																						
Directions PO Daily		SN																						
Aleve																								
Strength 550mg	Dose 1	9																						
Directions Every 12 hours as needed for pain		SN																						



12. You are still in the *Nursing Documentation* area.

- Click the New menu, select *Import File Cabinet Document* and the *File Cabinet* window appears. Type *Intake and Output* into the Document name. In the *Chart Tab* select the drop down box on the right and choose *Nursing Documentation*. In the *Description* field type *Intake and Output*. Click *Attach*. Select Existing. Use the search mechanism to select the blank Intake and Output document from the EHR Materials folder. Click OK. Click Done. The document appears in the *Care Tree* on the right in the *Nursing Documentation* tab.

- Click on the + in front of Nursing Documentation. Highlight the Intake and Output and click Edit at the bottom right hand side of the screen. The File Cabinet window appears. Click on the blue hyperlink next to the word File. The Intake and Output document opens. Type in the Patient Name and Date.
- Your patient has taken in 1000 milliliters (mL) of fluid orally, 400 mL at 0800, 300 mL at 1100, and 300 mL at 1300. He voided 500 mL, 250 mL at 0930, and 250 mL at 1230. Document your shift totals. (Document the number of milliliters only; you do not need to type in mls.) Close the I&O form by clicking the "X" on the top right corner of the form. A pop up will ask you if you want to save the changes you've made, select yes. The File Cabinet Document window appears. Click Done. The Update Document window appears. Answer yes to the question, "Do you want to send a new version to the server?"

Patient Name: **Moore, COPD** Date: **12/5/2010**

Ramsey Scale for Sedation

AWAKE LEVELS

Level 1 Patient anxious and agitated or restless (or both)

Level 2 Patient cooperative, oriented and tranquil

Level 3 Patient responds to commands only

ASLEEP LEVELS

Level 4 Patient asleep but responds briskly to light, glabellar tap or loud auditory stimulus.

Level 5 Patient asleep with sluggish response to light, glabellar tap or loud auditory stimulus.

Level 6 Patient asleep with no response to stimuli.

Headrick Fall Risk Model - Assessment Tool

Risk Factors	Day	Even	Night
Recent History of Fall	+7	+7	+7
Depression	+4	+4	+4
Altered Elimination	+3	+3	+3
Confused/Oriented	+3	+3	+3
Dizziness/Fatigue	+3	+3	+3
Poor Judgment	+3	+3	+3
Poor Mobility/Generalized Weakness	+2	+2	+2

Key

0-2 Normal/Low Risk

3-6 Level 1/High Risk

7-10 Level 2/Extremely High Risk

TOTAL INITIAL RISK SCORE

INTAKE						OUTPUT					
Hourly Time	Oral	Blood/Field Prod	IV Meds	Total Intake	Urine	NG pH	Chest Tube	Total Output			
7											
8	400										
9					250						
10											
11	300										
12					250						
13	300										
14											
TOTALS	1000			8 Hour Tot	500						

Update Document

The Attached file may have changed. Do you want to send a new version to the server?

Yes No Cancel

- Return to the Nurse Note. The Nurse Note may be located at the bottom of the screen due to minimizing it earlier. Return to the Nurse Note by clicking maximize icon on the right upper side of the Nurse Note. In the *Nurse Note* click *Done*. The *Save As* screen populates. Click *Save*.

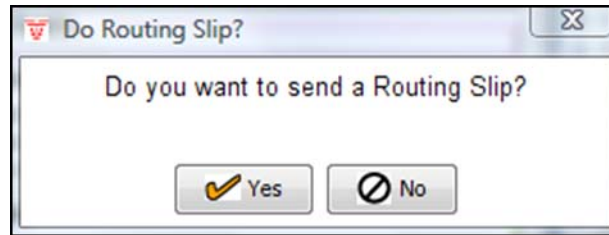
Save As

Save to Tab: **Encounters**

Save As: **Nurse Note**

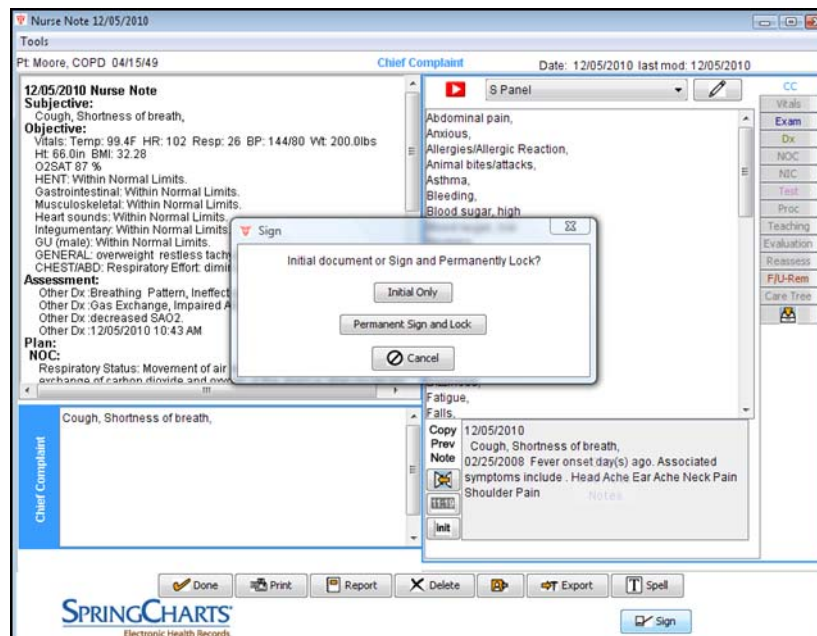
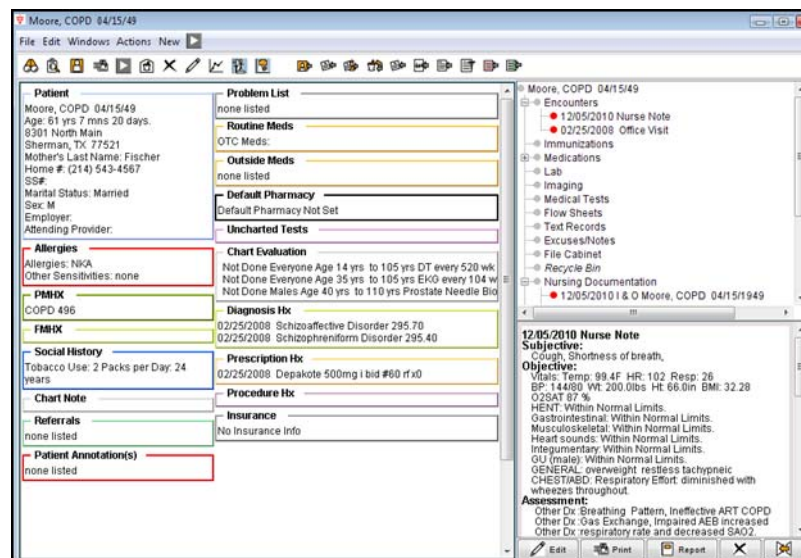
Save

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



15. In the *Care Tree*, click the + next to *Encounters*. Click on the date of your *Nurse Note* and it appears in the bottom right corner box.

- Click *Edit* below the bottom right corner box. The *Nurse Note* window opens. Click *Sign* at the lower right side of the window. The *Sign* window opens. Select *Permanent Sign and Lock* when finished with your *Nurse Note*.



Exercise 6.2

Fractured Hip

1. After launching SpringCharts, click on Actions, Open a Chart. Type in your last name and click the search button. Select your "fractured hip" patient and the chart opens.

2. Your patient has been admitted for a broken right hip. She tells you she has a history of osteoporosis. Click on PMHX on the left and the past medical history populates the box on the right lower side of the screen. Click Edit.
 - The Past Medical History screen populates. In the space after Dx type: osteo and click the search icon. Options appear in the box below. Click on the osteoporosis 733.0, which sends this to the Past Medical History list.
 - Click Back to Chart. The information you added appears in the PMHX box.

- Open your Nurse Note. Click New, New Nurse Note.

Nurse Note 12/05/2010

Tools

Pt Moore, Fractured Hip 04/15/49

Chief Complaint

Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note

Subjective:

Objective:

Assessment:

Plan:

Interventions:

Evaluation:

Revision:

Date of Service: 12/05/2010

Patient Number: 64 Chart ID: not Charted

Last Modified: 12/05/2010

S Panel

Abdominal pain,

Anxious,

Allergies/Allergic Reaction,

Animal bites/attacks,

Asthma,

Bleeding,

Blood sugar, high

Blood sugar, low

Bruising,

Burn,

Chest pain,

Congestion,

Constipation,

Cough,

Depressed,

Difficulty swallowing,

Diarrhea,

Dizziness,

Fatigue,

Falls,

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Note

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Done Edit Print Report Delete Export Spell Sign

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- Your patient complains of pain in her right hip. Select Pain in the S Panel text and it populates the Chief Complaint box on the bottom left of the screen. Click in the Chief Complaint box after Pain, and type: right hip.

Nurse Note 12/05/2010

Tools

Pt Moore, Fractured Hip 04/15/49

Chief Complaint

Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note

Subjective:

Objective:

Assessment:

Plan:

Interventions:

Evaluation:

Revision:

Date of Service: 12/05/2010

Patient Number: 64 Chart ID: not Charted

Last Modified: 12/05/2010

S Panel

Hyperthyroid,

Hypothyroid,

Ichting,

Itchy eyes,

Knee Surgery

Lethargy,

Loss of consciousness,

Memory loss,

Nausea,

Numbness,

Overdose,

Pain,

Palpitations,

Pregnancy/labor,

Psychiatric Issues,

Rash,

Rectal bleeding,

Runny nose,

Shortness of breath,

Sore throat,

Copy

Prev

Note

Copy Previous Notes

init

Done Edit Print Report Delete Export Spell Sign

SPRINGCHARTS

Electronic Health Records

5. 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 Complaint now appears in the Subjective section of the Nurse Note.
 - You take your patient's vital signs. Document the following: Temp 98.4, Resp 16, Pulse 114, BP 162/94, Ht 60 inches, Wt 130 lbs, O2SAT% 94.
 - Also select: BP left arm, Pt position—supine and Temp source—Tympanic.
 - Under the Vitals text box on the lower right click: Pt Complains of pain, Pain location, Pain rating 0–10 scale, Pain Description, Factors affecting pain, and Factors relieving pain to send the text to the Notes box on the left.
 - Fill in the following information in the Notes box that your patient conveys to you: Right hip pain, 4 on 0–10 scale (she received morphine 4 mg IV in the ED one hour ago), Description: stabbing, Factors affecting: movement, Factors relieving: medication.

Nurse Note 12/05/2010

Pt: Moore, Fractured Hip 04/15/49 Vitals Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note
Subjective:
 Pain right hip,
Objective:
 Vitals: Temp: 98.4 F HR: 114 Resp: 16 BP: 162/94 Wt: 130.0lbs
 Ht: 60.0in BMI: 25.39
 O2SAT 94 %
Assessment:
Plan:
Interventions:
Evaluation:
Revision:
 Date of Service: 12/05/2010
 Patient Number: 64 Chart ID: not Charted
 Last Modified: 12/05/2010

Vitals

Temp: 98.4 F Resp: 16 Pulse: 114
 BP: 162 / 94 Ht: 60 in Wt: 130 lbs
 HC: in BMI: 25.39 Body Fat: %
 O2SAT: 94 %

Notes

BP left arm. Pt position - supine. Temp source: - Tympanic.
 Pt Complains of pain. Pain Location: Right hip. Pain rating 4 on 0-10 scale (she received morphine 4 mg IV in the ED one hour ago), Description: stabbing, Factors affecting: movement, Factors relieving: medication.

Previous Vitals

Vitals

Temp source - Oral
 Temp source - Rectal
 Temp source - Temporal
 Temp source - Tympanic
 No complaints of pain
 Pt Complains of pain
 Pain Location
 Pain rating 0-10 scale
 Pain Radiation
 Pain Description
 Factors affecting pain
 Factors relieving pain
 Weight check

Done Edit Print Report Delete Export Spell Sign

SPRINGCHARTS
Electronic Health Records

6. Click on the Exam button located below the Vitals. The O (Normals) defaults in the right upper box. Select the following systems that are within normal limits when you assess your patient: HEENT, Heart sounds, Lungs/Respiratory, Integumentary, and Neurological.
 - Click the drop down arrow next to O (Normals) and select O (Abnormals). Select the General section followed by: avoiding movement. Select the GI/ GU section followed by: indwelling urinary catheter. Select the Extremities section followed by: edema.
 - Click into the Examination box on the lower left after indwelling urinary catheter and type: inserted in ED. Click after edema and type: right hip. Right leg shortened.

Nurse Note 12/05/2010
Tools
Pt: Moore, Fractured Hip 04/15/49
Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note
Subjective:
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Objective:
Vitals: Temp: 98.4F HR: 114 Resp: 16 BP: 162/94 Wt: 130.0lbs
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O2SAT 94 %
Assessment:
Plan:
Interventions:
Evaluation:
Revision:
Date of Service: 12/05/2010
Patient Number: 64 Chart ID: not Charted
Last Modified: 12/05/2010

Examination
HENT: Within Normal Limits.
Heart sounds: Within Normal Limits.
Lungs/Respiratory: Within Normal Limits.
Integumentary: Within Normal Limits.
Neurological: Within Normal Limits.
GENERAL: avoiding movement.
GU/GI: Indwelling urinary catheter, inserted in ED.
EXTREMITIES: edema right hip. Right leg shortened.

Examination
rales and rhonchi
wheezes
rubs
audible murmur
irregular
bowels sounds decreased
bowels sounds high pitched
distended
GU/GI:
Indwelling urinary catheter
Urine cloudy
Sediment in urine
Strong smell to urine
Constipated
EXTREMITIES:
edema
amputation
pulses weak or absent
cold to touch

Dx
Vitals
Exam
Dx
NOC
NIC
Test
Proc
Teaching
Evaluation
Reassess
F/U-Rem
Care Tree

Done Edit Print Report Delete Export Spell Sign

7. Click into the Dx button below the Exam button on the right. Click on the red NANDA on the left bottom of the screen. The Dx text window populates.
 - Click Falls, risk for; Pain, acute; Urinary elimination, impaired; Physical mobility, impaired. Click the D&T icon to date and time the entry. Click Done.
 - Add the related factor (r/t) and as evidenced (AEB) statement by typing them into the field after the NANDA diagnosis.
 - Place the nursing diagnoses in order of priority.

Nurse Note 12/05/2010
Tools
Pt: Moore, Fractured Hip 04/15/49
Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note
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Vitals: Temp: 98.4F HR: 114 Resp: 16 BP: 162/94 Wt: 130.0lbs
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EXTREMITIES: edema right hip. Right leg shortened.
Assessment:
Plan:
Interventions:
Evaluation:
Revision:
Date of Service: 12/05/2010
Patient Number: 64 Chart ID: not Charted
Last Modified: 12/05/2010

Diagnosis
NANDA
Mobility Physical, Impaired ART fractured hip.
Falls, Risk for ART fractured hip
Urinary Elimination, Impaired AEB indwelling foley catheter.
12/05/2010 12:38 PM

DIAGNOSIS
Select Diagnosis
PMHX - Problem List
Osteoporosis 733.00
Previous Diagnoses

Dx
Vitals
Exam
Dx
NOC
NIC
Test
Proc
Teaching
Evaluation
Reassess
F/U-Rem
Care Tree

Done Edit Print Report Delete Export Spell Sign

8. Click the NOC button on the right located below the Dx button. The NANDA documentation populates the Nurse Note.
 - Below the Nursing Outcomes Classification select the following:
 - Fall Prevention Behavior: Personal or family caregiver actions to minimize risk factors that might precipitate falls in the personal environment.
 - Knowledge—Treatment Procedure: Extent of understanding conveyed about a procedure required as part of a treatment regimen.
 - Mobility: Ability to move purposefully in own environment independently with or without assistive device.
 - Pain Control: Personal actions to control pain.
 - Urinary Elimination: Collection and discharge of urine.
 - Use the Enter key on the keyboard to place text on the separate lines to streamline your documentation.

9. Click the NIC button on the right below the NOC button. Notice that your outcomes populate the Nurse Note.
 - Select the following interventions:
 - Fall Prevention: Instituting special precautions with patient at risk for injury from falling.
 - Pain Management: Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient.
 - Surgical Preparation: Providing care to a patient immediately prior to surgery and verifying required procedures/tests and documentation in the clinical record.
 - Teaching: Procedure/Treatment: Preparing a patient to understand and mentally prepare for a prescribed procedure or treatment.
 - Urinary Catheterization: Insertion of a catheter into the bladder for temporary or permanent drainage of urine.
 - Vital Signs Monitoring: Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications.
 - Click in to the Fall Prevention line and type: Patient instructed that she is on bed rest and should not attempt to get out of bed, verbalizes understanding. Call light within reach.

- Click in to the Surgical Preparation line and type: Glasses and jewelry removed. Hibiclens scrub to right side completed.

Nurse Note 12/05/2010

Tools
Pt. Moore, Fractured Hip 04/15/49
Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note
Subjective:
Pain right hip.
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Neurological: Within Normal Limits.
GENERAL: avoiding movement.
GU/GI: Indwelling urinary catheter, inserted in ED.
EXTREMITIES: edema right hip. Right leg shortened.
Assessment:
Other Dx: Mobility Physical, Impaired ART fractured hip.
Other Dx: Falls, Risk for ART fractured hip.
Other Dx: Urinary Elimination, Impaired AEB indwelling foley catheter.
Other Dx: 12/05/2010 12:38 PM
Plan:
NOC:
Fall Prevention Behavior: Personal or family caregiver actions to minimize risk factors that might precipitate falls in the personal

NIC
Fall Prevention: Instituting special precautions with patient at risk for injury from falling.
Pain Management: Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient.
Surgical Preparation: Providing care to a patient immediately prior to surgery and verifying required procedures/tests and documentation in the clinical record.
Teaching Procedure/Treatment: Preparing a patient to understand and mentally prepare for a prescribed procedure or

Nursing Interventions Classification
Respiratory Monitoring: Collection and analysis of patient d
Resuscitation: Administering emergency measures to sus
Seizure Precautions: Prevention or minimization of potentia
Self-Care Assistance: Assisting another to perform activitie
Skin Surveillance: Collection and analysis of patient data to
Smoking Cessation Assistance: Helping another to stop sm
Spiritual Support: Assisting the patient to feel balance and
Suicide Prevention: Reducing risk of self-inflicted harm with
Surgical Preparation: Providing care to a patient immediate
Teaching: Disease Process: Assisting the patient to under
Teaching: Prescribed Diet: Preparing a patient to correctly f
Teaching: Prescribed Medication: Preparing a patient to saf
Teaching: Procedure/Treatment: Preparing a patient to unde
Traction/Immobilization Care: Management of a patient who
Tube Care: Management of a patient with an external drain
Urinary Catheterization: Insertion of a catheter into the blad
Ventilation Assistance: Promotion of an optimal spontaneo
Vital Signs Monitoring: Collection and analysis of cardiovas
Wound Care: Prevention of wound complications and prom

Copy
Prev
Note
Copy
Previous
Notes
init

Done Edit Print Report Delete Export Spell Sign

- Move the Nurse Note by clicking on the minimize icon in the upper right corner. This will bring you back to the patient's chart.
- Click the New menu and Import Items at the bottom of the list. Select Import File Cabinet Document and the File Cabinet window appears. Type MAR into the Document name. In the Chart Tab select the drop down box on the right and choose Nursing Documentation. In the Description field type MAR. Click Attach. Select Existing. Click OK. Click Done. The document appears in the Care Tree on the right in the Nursing Documentation tab.

File Cabinet Document

Created On: 12-05-2010
Last Modified: 12-05-2010
Signed by:

Document Name: MAR
Patient: Moore, Fractured Hip 04/15/1949
Chart Tab: Nursing Documentation
Folder: Consult
File: FC_56MedicationAdminstr.xls
Description: MAR

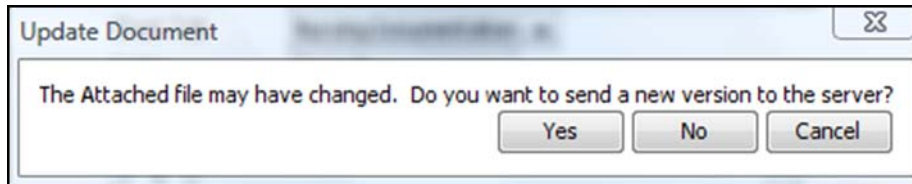
Attach Sign Print Delete Done

- Click on the + in front of Nursing Documentation. Highlight the MAR and click Edit at the bottom right hand side of the screen. The File Cabinet window appears. Click on the blue hyperlink next to the word File. The MAR document opens. Enter the Patient, Date of Birth, Date, Admit date, Doctor, and Room #.

		Medication Administration Record																							
Patient: Moore, Fractured Hip		Date: 12/5/2010 to		Doctor: Stephen Finchman																					
Date of birth: 4/15/1949		Admit: 12/5/2010		Room #: 3206																					
		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700
Strength	Dose																								
Directions																									

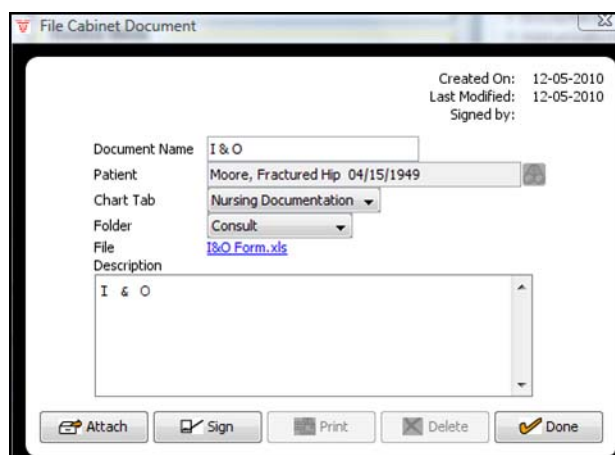
- Add the medications to the MAR by typing the name of the medication, dosage, route, frequency, and scheduled administration time into the form. Document that you did not give the patient's routine medications by typing NPO and your initials in the correct time box for each medication. Close the MAR by clicking the X on the top right corner of the form. A pop up will ask you if you want to save the changes you've made, select yes.
- The File Cabinet Document window appears. Click Done. The Update Document window appears. Answer yes to the question, do you want to send a new version to the server.

		Medication Administration Record																							
Patient: Moore, Fractured Hip		Date: 12/5/2010 to		Doctor: Stephen Finchman																					
Date of birth: 4/15/1949		Admit: 12/5/2010		Room #: 3206																					
		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700
Strength	Dose																								
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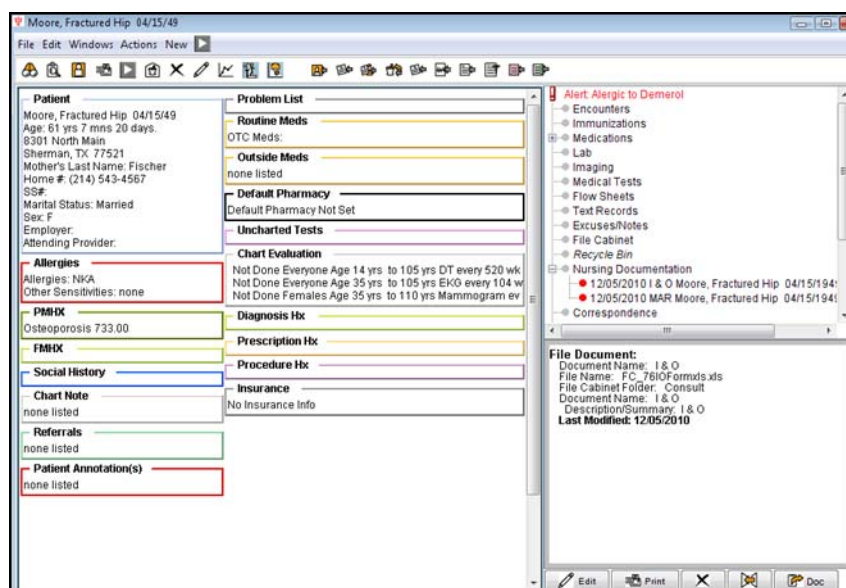


11. You are still in the *Nursing Documentation* area.

- Click the New menu, select Import File Cabinet Document and the File Cabinet window appears. Type Intake and Output into the Document name. In the Chart Tab select the drop down box on the right and choose Nursing Documentation. In the Description field type Intake and Output. Click Attach. Select Existing. Use the search mechanism to select the blank Intake and Output document. The I&O document is found in the EHR Materials folder. Click OK. Click Done. The document appears in the Care Tree on the right in the Nursing Documentation tab.



- Click on the + in front of Nursing Documentation. Highlight the Intake and Output and click Edit at the bottom right hand side of the screen. The File Cabinet window appears. Click on the blue hyperlink next to the word File. The Intake and Output document opens.



- Your patient has been NPO. It is the end of the shift; you empty her indwelling urinary catheter drainage bag of 400 mL of clear, yellow urine. Document your patient's I&O including shift totals. Close the I&O form by clicking the X on the top right corner of the form. A pop up will ask you if you want to save the changes you've made, select yes. The File Cabinet Document window appears. Click Done. The Update Document window appears. Answer yes to the question, "Do you want to send a new version to the server?"

Patient Name: Moore, Fractured Hip		Date: 12/5/2010																																																																																																																
Ramsay Scale for Sedation AWAKE LEVELS Level 1 Patient anxious and agitated or restless (or both) Level 2 Patient cooperative, oriented and tranquil Level 3 Patient responds to commands only ASLEEP LEVELS Level 4 Patient asleep but responds briskly to light, glabellar tap or loud auditory stimulus. Level 5 Patient asleep with sluggish response to light, glabellar tap or loud auditory stimulus. Level 6 Patient asleep with no response to stimuli.		Hendrick Fall Risk Model - Assessment Tool <table border="1"> <tr> <th>Risk Factors</th> <th>Day</th> <th>Even</th> <th>Night</th> </tr> <tr> <td>Recent History of Falls</td> <td>+ 7</td> <td>+ 7</td> <td>+ 7</td> </tr> <tr> <td>Depression</td> <td>+ 4</td> <td>+ 4</td> <td>+ 4</td> </tr> <tr> <td>Altered Elimination</td> <td>+ 3</td> <td>+ 3</td> <td>+ 3</td> </tr> <tr> <td>Confusion/Deranged</td> <td>+ 3</td> <td>+ 3</td> <td>+ 3</td> </tr> <tr> <td>Dizziness/Vertigo</td> <td>+ 3</td> <td>+ 3</td> <td>+ 3</td> </tr> <tr> <td>Poor Judgement</td> <td>+ 3</td> <td>+ 3</td> <td>+ 3</td> </tr> <tr> <td>Poor Mobility/Generalized Weakness</td> <td>+ 2</td> <td>+ 2</td> <td>+ 2</td> </tr> <tr> <td>TOTAL INITIAL RISK SCORE</td> <td></td> <td></td> <td></td> </tr> </table> <table border="1"> <tr> <th>Score</th> <th>Risk Level</th> </tr> <tr> <td>0-2</td> <td>Normal/Low Risk</td> </tr> <tr> <td>3-6</td> <td>Level 1/High Risk</td> </tr> <tr> <td>7-10</td> <td>Level 2/Extremely High Risk</td> </tr> </table>		Risk Factors	Day	Even	Night	Recent History of Falls	+ 7	+ 7	+ 7	Depression	+ 4	+ 4	+ 4	Altered Elimination	+ 3	+ 3	+ 3	Confusion/Deranged	+ 3	+ 3	+ 3	Dizziness/Vertigo	+ 3	+ 3	+ 3	Poor Judgement	+ 3	+ 3	+ 3	Poor Mobility/Generalized Weakness	+ 2	+ 2	+ 2	TOTAL INITIAL RISK SCORE				Score	Risk Level	0-2	Normal/Low Risk	3-6	Level 1/High Risk	7-10	Level 2/Extremely High Risk																																																																			
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<table border="1"> <thead> <tr> <th colspan="6">INTAKE</th> <th colspan="6">OUTPUT</th> </tr> <tr> <th>Hourly Times</th> <th>Oral</th> <th>Blood/BLD Prod</th> <th>IV Meds</th> <th>Total Intake</th> <th>Urine</th> <th>NG pH</th> <th>Chest Tube</th> <th>Total Output</th> </tr> </thead> <tbody> <tr> <td>LIB</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>7</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>8</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>9</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>10</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>11</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>12</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>13</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>14</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>TOTALS</td> <td>NPO</td> <td></td> <td></td> <td>8 Hour Tot</td> <td>400</td> <td></td> <td></td> <td>400</td> </tr> </tbody> </table>				INTAKE						OUTPUT						Hourly Times	Oral	Blood/BLD Prod	IV Meds	Total Intake	Urine	NG pH	Chest Tube	Total Output	LIB									7									8									9									10									11									12									13									14									TOTALS	NPO			8 Hour Tot	400			400
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Update Document

The Attached file may have changed. Do you want to send a new version to the server?

Yes
No
Cancel

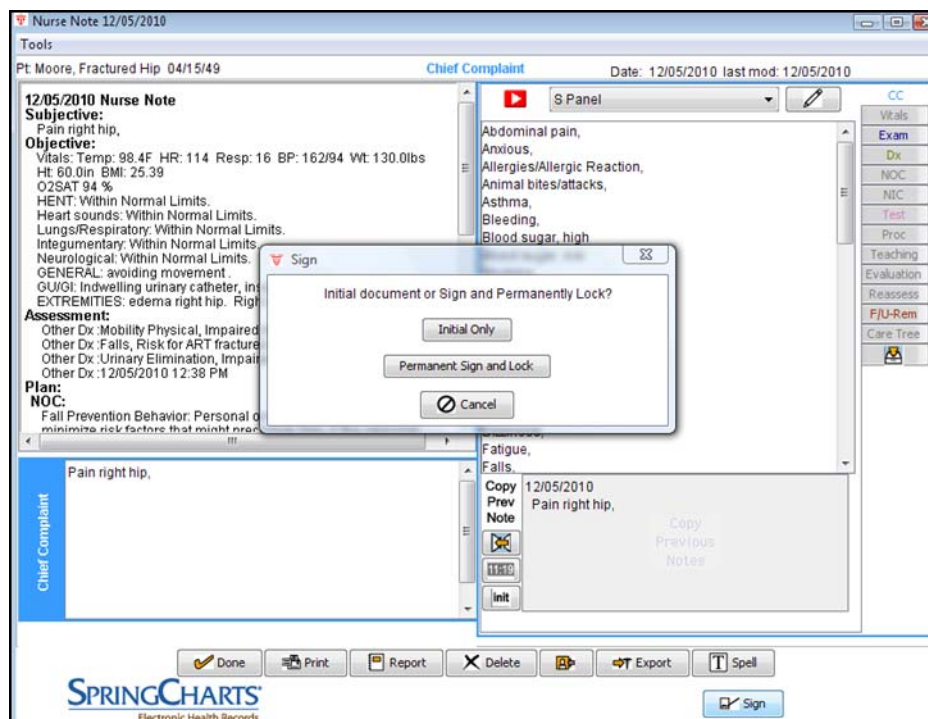
- Return to the Nurse Note. The Nurse Note may be located at the bottom of the screen due to minimizing it earlier. Return to the Nurse Note by clicking maximize icon on the right upper side of the Nurse Note. In the Nurse Note click Done. The Save As screen populates. Click Save.
- A pop-up appears asking if you want to create a routing slip. Click No.

Do Routing Slip?

Do you want to send a Routing Slip?

Yes
No

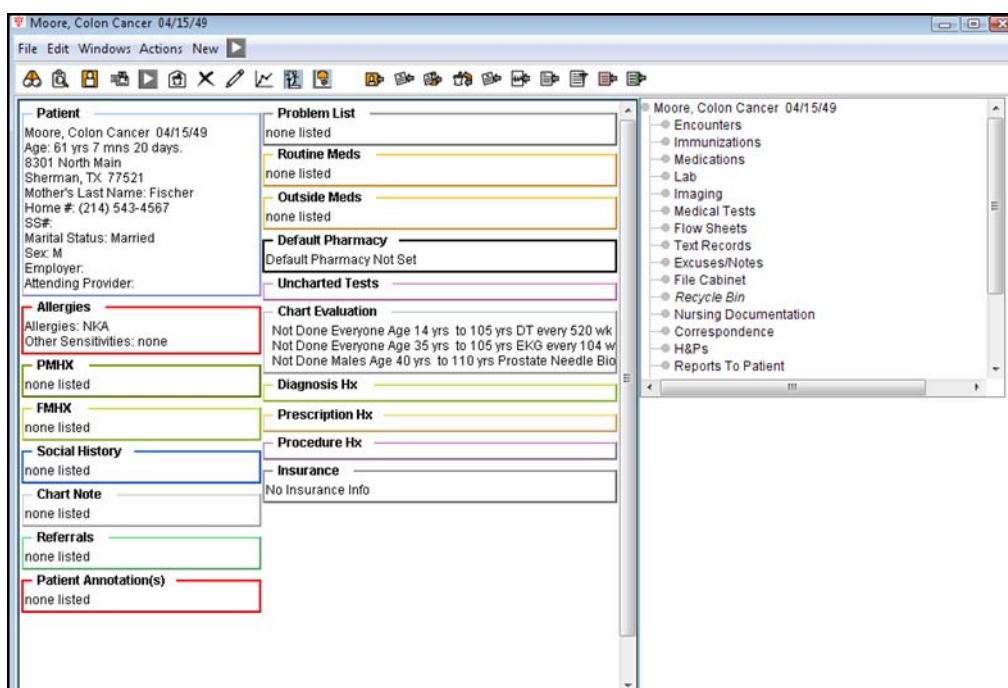
- In the care tree, click the + next to Encounters. Click on the date of your Nurse Note and it appears in the bottom right corner box.
 - Click Edit. Click Sign. Select Permanent Sign and Lock when finished with your Nurse Note.



Exercise 6.3

Colon Cancer

1. After launching SpringCharts, click on Actions, Open a Chart. Type in your last name and click the search button. Select your "colon cancer" patient and the chart opens.



2. Your patient tells you he recently discovered he was allergic to Dilaudid after his colectomy. He tells you he broke out in hives all over his body. Click on Allergies in the red box on the left side of the screen and a red Allergies box opens in the lower right corner of the window. Click Edit below this box. A new window opens.
 - Click into the space after Allergy in the text box in the upper right side of the window and enter Dilaudid. Click the Search icon. Options appear in the box below. Click on Dilaudid and it moves to the Allergies field to the left.
 - Click on Dilaudid in the Allergies field. The Edit Dilaudid window opens. Enter Hives in the Adverse Reaction field. Click Save at the bottom of the window.
 - Click Back to Chart at the lower left corner of the window. The information you added appears in the Allergies box.

Moore, Colon Cancer 04/15/49

File Edit Windows Actions New

Patient
 Moore, Colon Cancer 04/15/49
 Age: 61 yrs 7 mns 20 days.
 8301 North Main
 Sherman, TX 77521
 Mother's Last Name: Fischer
 Home #: (214) 543-4567
 SS#: _____
 Marital Status: Married
 Sex: M
 Employer: _____
 Attending Provider: _____

Allergies
 Dilaudid
 Other Sensitivities:
 causes hives

3. Your patient had a colectomy six months ago for colon cancer. Click on the PMHX box and it populates in the bottom right corner. Click Edit below the box.
 - Click in the space after Dx at the upper right of the screen and type: colon. Click the Search icon. Colon CA 153.9 appears in the box below.
 - Click on Colon CA 153.9 and it moves to the Past Medical History field to the left. Click into the Other PMHX box on the bottom left of the screen. Type: Colectomy 2009.
 - Click Back to Chart. The colon CA and colectomy are now listed in the PMHX.

Moore, Colon Cancer 04/15/49

File Edit Windows Actions New

Patient
 Moore, Colon Cancer 04/15/49
 Age: 61 yrs 7 mns 20 days.
 8301 North Main
 Sherman, TX 77521
 Mother's Last Name: Fischer
 Home #: (214) 543-4567
 SS#: _____
 Marital Status: Married
 Sex: M
 Employer: _____
 Attending Provider: _____

Allergies
 Dilaudid
 Other Sensitivities:
 causes hives

PMHX
 Colon CA 153.9
 Colectomy 2009

4. Your patient tells you he takes Zofran 8 mg po prn for nausea related to his chemotherapy. Click on the Routine Meds box and it populates in the bottom right corner. Click Edit.
 - Click in the space after Brand Name and type: Zofran. Click the search icon.
 - Click on the Zofran 8 mg to send the medication to the Routine Medications list.
 - Click on the Zofran 8 mg. The Edit Rx window opens. Click into the Directions field and type: po prn nausea b.i.d. Click in the calendar to the right of Date Started and choose a date six months ago. Click Save.
 - Click Back to Chart. The Zofran is now listed in the Routine Meds.

- Open your Nurse Note. Click New, New Nurse Note.

Nurse Note 12/05/2010

Tools: Pt Moore, Colon Cancer 04/15/49 Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note
Subjective:
Objective:
Assessment:
Plan:
Interventions:
Evaluation:
Revision:
Date of Service: 12/05/2010
Patient Number: 65 **Chart ID:** not Charted
Last Modified: 12/05/2010

Chief Complaint

S Panel

- Abdominal pain,
- Anxious,
- Allergies/Allergic Reaction,
- Animal bites/attacks,
- Asthma,
- Bleeding,
- Blood sugar, high
- Blood sugar, low
- Bruising,
- Burn,
- Chest pain,
- Congestion,
- Constipation,
- Cough,
- Depressed,
- Difficulty swallowing,
- Diarrhea,
- Dizziness,
- Fatigue,
- Falls,

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Done **Edit** **Print** **Report** **Delete** **Export** **Spell** **Sign**

SPRINGCHARTS
Electronic Health Records

- Your patient complains of nausea and vomiting. He had a chemotherapy treatment earlier this week. Select nausea and vomiting from the S Panel text and they populate the Chief Complaint box on the bottom left of the screen.

Nurse Note 12/05/2010

Tools: Pt Moore, Colon Cancer 04/15/49 Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note
Subjective:
Objective:
Assessment:
Plan:
Interventions:
Evaluation:
Revision:
Date of Service: 12/05/2010
Patient Number: 65 **Chart ID:** not Charted
Last Modified: 12/05/2010

Chief Complaint

Nausea, Vomiting,

S Panel

- Psychiatric Issues,
- Rash,
- Rectal bleeding,
- Runny nose,
- Shortness of breath,
- Sore throat,
- Stroke/TIA,
- Suicide attempt,
- Swelling in legs,
- Thirst,
- Trauma - Gun shot/stabbing,
- Trauma - Laceration,
- Trauma - Motor Vehicle Accident,
- Urinary Tract Infection,
- Vaginal Discharge,
- Vertigo,
- Vomiting,
- Weakness,
- Weight gain,
- Weight loss,

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Done **Edit** **Print** **Report** **Delete** **Export** **Spell** **Sign**

SPRINGCHARTS
Electronic Health Records

7. Click on the Vitals button on the 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: Temp 100.2, Resp 20, Pulse 114, BP 110/72, Ht 70 inches, Wt 170 lbs, O2SAT% 98.
 - Under the Vitals text box on the right click: BP left arm, Pt position— supine and Temp source— Oral and No complaints of pain.

8. Click on the Exam button located below the Vitals. The O (Normals) defaults. Select the following systems that are within normal limits when you assess your patient: Heart sounds, Musculoskeletal, GU (male), Lungs/ Respiratory, and Neurological.
 - Click the drop down arrow next to O (Normals) and select O (Abnormals). Select the HEENT followed by: Dry mucous membranes.
 - Click into the Examination field and type: pt vomited 200 ml green emesis. Bowel sounds hyperactive. Click after Dry mucous membranes and type: tenting of skin.

9. Click into the Dx button below the Exam button on the right. Click on the red NANDA on the left bottom of the screen. The Dx text window populates.
 - Click Fluid Volume, Deficient and Infection, Risk for. Click the D&T icon to date and time the entry. Click Done.
 - Add the related factor (r/t) and as evidenced (AEB) statement by typing it into the field after each NANDA diagnosis.
 - Use the Enter key on the keyboard to place text on separate lines to streamline your documentation.

Nurse Note 12/05/2010

Tools: Pt. Moore, Colon Cancer 04/15/49 **Diagnosis** Date: 12/05/2010 last mod: 12/05/2010

12/05/2010 Nurse Note
Subjective:
 Nausea, Vomiting,
Objective:
 Vitals: Temp: 100.2F HR: 114 Resp: 20 BP: 110/72 Wt: 170.0lbs
 Ht: 70.0in BMI: 24.39
 O2SAT 98 %
 Heart sounds: Within Normal Limits.
 Musculoskeletal: Within Normal Limits.
 GU (male): Within Normal Limits.
 Lungs/Respiratory: Within Normal Limits.
 Neurological: Within Normal Limits.
 HENT: Dry mucous membranes, tenting of skin. Pt vomited 200 ml green emesis. Bowel sounds hyperactive.

Assessment:
Plan:
Interventions:
Evaluation:
Revision:
 Date of Service: 12/05/2010
 Patient Number: 65 Chart ID: not Charted
 Last Modified: 12/05/2010

DIAGNOSIS

Select Diagnosis

PMHx + Problem List
 Colon CA 153.9

Previous Diagnoses **Dx Hx**

NANDA Fluid Volume, Deficient AEB dry mucous membranes and tenting of skin. 12/05/2010 2:24 PM

Done Edit Print Report Delete Export Spell Sign

SPRINGCHARTS

10. Click the NOC button on the right located below the Dx button. The NANDA documentation populates the Nurse Note.
 - Below the Nursing Outcomes Classification select the following:
 - Fluid Balance: Water balance in the intracellular and extracellular components of the body.
 - Knowledge—Disease Process: Extent of understanding conveyed about a specific disease process and prevention of complications.
 - Nausea and Vomiting Control: Personal actions to control nausea, retching, and vomiting symptoms.
 - Vital Signs: Extent to which temperature, pulse, respiration, and blood pressure are within normal range.
 - Use the Enter key on the keyboard to place text on separate lines to streamline your documentation.

12/05/2010 Nurse Note
Subjective: Nausea, Vomiting.
Objective: Vitals: Temp: 100.2F HR: 114 Resp: 20 BP: 110/72 Wt: 170.0lbs
 Ht: 70.0in BMI: 24.39
 O2SAT 98 %
 Heart sounds: Within Normal Limits.
 Musculoskeletal: Within Normal Limits.
 GU (male): Within Normal Limits.
 Lungs/Respiratory: Within Normal Limits.
 Neurological: Within Normal Limits.
 HENT: Dry mucous membranes, tenting of skin. Pt vomited 200 ml green emesis. Bowel sounds hyperactive.
Assessment: Other Dx: Fluid Volume, Deficient AEB dry mucous membranes and tenting of skin.
 Other Dx: skin. 12/05/2010 2:24 PM
Plan:
Interventions:
Evaluation:
Revision:
Date of Service: 12/05/2010
 Patient Number: 65 Chart ID: not Charted
 Last Modified: 12/05/2010

NOC

Fluid Balance: Water balance in the intracellular and extracellular components of the body - severely compromised.
 Knowledge - Disease Process: Extent of understanding conveyed about a specific disease process and prevention of complications - pt with good base of knowledge.
 Nausea and Vomiting Control: Personal actions to control nausea, retching, and vomiting symptoms - severely compromised.
 Vital Signs: Extent to which temperature, pulse, respiration, and

Nursing Outcomes Classification

Nutritional Status: Extent to which nutrients are available to the body.
 Oral Hygiene: Condition of the mouth, teeth, gums, and tonsils.
 Pain Control: Personal actions to control pain.
 Post Procedure Recovery: Extent to which an individual returns to baseline.
 Quality of Life: Extent of positive perception of current life circumstances.
 Respiratory Status: Movement of air in and out of the lungs.
 Respiratory Status: Gas Exchange: Alveolar exchange of gases.
 Safe Home Environment: Physical arrangements to minimize risk of injury or illness.
 Self-Care: Activities of Daily Living (ADL): Ability to perform tasks of daily living.
 Sensory Function: Extent to which an individual correctly senses and interprets stimuli.
 Smoking Cessation Behavior: Personal actions to eliminate or reduce tobacco use.
 Tissue Integrity: Skin and Mucous Membranes: Structural integrity.
 Tissue Perfusion: Cardiac: Adequacy of blood flow through the body.
 Urinary Elimination: Collection and discharge of urine.
 Vital Signs: Extent to which temperature, pulse, respiration, and blood pressure are within normal limits.
 Weight: Body Mass: Extent to which body weight, muscle, and fat are within normal limits.
 Wound Healing: Primary Intention: Extent of regeneration of tissue.
 Wound healing: Secondary Intention: Extent of regeneration of tissue.

PRIORITY OUTCOME:

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Done Edit Print Report Delete Export Spell Sign

11. Click the NIC button on the right below the NOC button. The outcomes populate the Nurse Note.

- Select the following interventions:
 - Fluid/Electrolyte Management: Regulation and prevention of complications from altered fluid and/or electrolyte levels.
 - Medication Administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs.
 - Vital Signs Monitoring: Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications.

12/05/2010 Nurse Note
Subjective: Nausea, Vomiting.
Objective: Vitals: Temp: 100.2F HR: 114 Resp: 20 BP: 110/72 Wt: 170.0lbs
 Ht: 70.0in BMI: 24.39
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Plan:
Interventions:
Evaluation:
Revision:
Date of Service: 12/05/2010
 Patient Number: 65 Chart ID: not Charted
 Last Modified: 12/05/2010

NIC

Fluid/Electrolyte Management: Regulation and prevention of complications from altered fluid and/or electrolyte levels.
 Medication Administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs.
 Vital Signs Monitoring: Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications.

Nursing Interventions Classification

Respiratory Monitoring: Collection and analysis of patient data.
 Resuscitation: Administering emergency measures to sustain life.
 Seizure Precautions: Prevention or minimization of potential seizure activity.
 Self-Care Assistance: Assisting another to perform activities of daily living.
 Skin Surveillance: Collection and analysis of patient data to detect skin problems.
 Smoking Cessation Assistance: Helping another to stop smoking.
 Spiritual Support: Assisting the patient to feel balance and harmony.
 Suicide Prevention: Reducing risk of self-inflicted harm with suicidal ideation.
 Surgical Preparation: Providing care to a patient immediately before surgery.
 Teaching: Disease Process: Assisting the patient to understand the disease process.
 Teaching: Prescribed Diet: Preparing a patient to correctly follow a prescribed diet.
 Teaching: Prescribed Medication: Preparing a patient to safely take prescribed medication.
 Teaching: Procedure/Treatment: Preparing a patient to undergo a procedure or treatment.
 Traction/Immobilization Care: Management of a patient who is in traction or immobilized.
 Tube Care: Management of a patient with an external drain.
 Urinary Catheterization: Insertion of a catheter into the bladder.
 Ventilation Assistance: Promotion of an optimal spontaneous breathing pattern.
 Vital Signs Monitoring: Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications.
 Wound Care: Prevention of wound complications and promotion of wound healing.

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Done Edit Print Report Delete Export Spell Sign

12. The physician orders Zofran 4mg IV x 1 dose for nausea. Move the Nurse Note by clicking on the minimize icon in the upper right corner. This will bring you back to the patient's chart.
 - Click the New menu and Import Items at the bottom of the list. Select Import File Cabinet Document and the File Cabinet window appears. Type MAR into the Document name. In the Chart Tab select the drop down box on the right and choose Nursing Documentation. In the Description field type MAR. Click Attach. Select Existing. Click OK. Click Done. The document appears in the Care Tree on the right in the Nursing Documentation tab.

File Cabinet Document

Created On: 12-05-2010
Last Modified: 12-05-2010
Signed by:

Document Name:

Patient:

Chart Tab:

Folder:

File: [Medication Administration Record.xls](#)

Description:

Moore, Colon Cancer 04/15/49

File Edit Windows Actions New

Patient
Moore, Colon Cancer 04/15/49
Age: 61 yrs 7 mns 20 days.
8301 North Main
Sherman, TX 77521
Mother's Last Name: Fischer
Home #: (214) 543-4567
SS#:
Marital Status: Married
Sex: M
Employer:
Attending Provider:
Allergies
Dilaudid
Other Sensitivities:
causes hives
PMH
Colon CA 153.9
Colectomy 2009
FMMH
none listed
Social History
none listed
Chart Note
none listed
Referrals
none listed
Patient Annotation(s)
none listed

Problem List
none listed
Routine Meds
Zofran 8mg po prn nausea BID
Outside Meds
none listed
Default Pharmacy
Default Pharmacy Not Set
Uncharted Tests
Chart Evaluation
Not Done Everyone Age 14 yrs to 105 yrs DT every 520 wk
Not Done Everyone Age 35 yrs to 105 yrs EKG every 104 w
Not Done Males Age 40 yrs to 110 yrs Prostate Needle Bio
Diagnosis Hx
Prescription Hx
Procedure Hx
Insurance
No Insurance Info

Moore, Colon Cancer 04/15/49
Encounters
Immunizations
Medications
Lab
Imaging
Medical Tests
Flow Sheets
Text Records
Excuses/Notes
File Cabinet
Recycle Bin
Nursing Documentation
12/05/2010 MAR Moore, Colon Cancer 04/15/194
Correspondence
H&Ps

File Document:
Document Name: MAR
File Name: FC_53MedicationAdminstr.xls
File Cabinet Folder: Consult
Document Name: MAR
Description/Summary: MAR
Last Modified: 12/05/2010

- Click on the + in front of Nursing Documentation. Highlight the MAR and click Edit at the bottom right hand side of the screen. The File Cabinet window appears. Click on the blue hyperlink next to the word File. The MAR document opens. Enter the Patient, Date of Birth, Date, Admit date, Doctor, and Room #. Add the Zofran on the left in the first open medication slot. Complete the strength, dose, and directions fields. Document that you gave the Zofran by typing your initials in the correct time box for the medication. Close the MAR by *clicking the X on the top right corner of the form*. A pop up will ask you if you want to save the changes you've made, select yes. The File Cabinet Document window appears. Click Done. The Update Document window appears. Answer yes to the question "Do you want to send a new version to the server?"

		Medication Administration Record																							
Patient: Moore, Colon Cancer		Date: 12/5/2010		to		Doctor: Stephen Finchman																			
Date of birth: 4/15/1949		Admit: 12/5/2010				Room #: 3203																			
Zofran		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700
Strength 4mg	Dose xl				10																				
Directions IV x1 for nausea					SN																				
Strength	Dose																								

Update Document

The Attached file may have changed. Do you want to send a new version to the server?

Yes

No

Cancel

13. You are still in the Nursing Documentation area.
- Click the New menu, select Import File Cabinet Document and the File Cabinet window appears. Type Intake and Output into the Document name. In the Chart Tab select the drop down box on the right and choose Nursing Documentation. In the Description field type Intake and Output. Click Attach. Select Existing. Use the search mechanism to select the blank Intake and Output document. The I&O document is found in the EHR Materials folder. Click OK. Click Done. The document appears in the Care Tree on the right in the Nursing Documentation tab.

File Cabinet Document

Created On: 12-05-2010

Last Modified: 12-05-2010

Signed by:

Document Name

I & O

Patient

Moore, Colon Cancer 04/15/1949

Chart Tab

Nursing Documentation

Folder

Consult

File

[I&O Form.xls](#)

Description

I & O

Attach

Sign

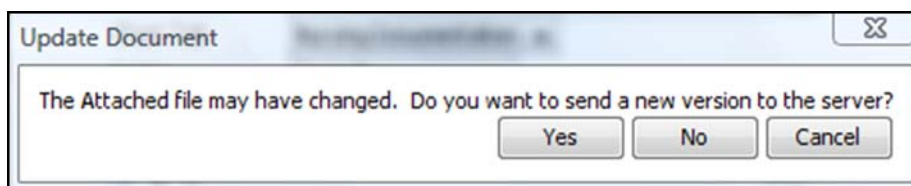
Print

Delete

Done

- Click on the + in front of Nursing Documentation. Highlight the Intake and Output and click Edit at the bottom right hand side of the screen. The File Cabinet window appears. Click on the blue hyperlink next to the word File. The Intake and Output document opens. Type in the Patient Name and Date.
- Your patient has vomited 240 mL of emesis this shift, 120 mL at 1500 and 120 mL at 1700. Add emesis to one of the columns at the top of the form and enter the emesis as output. Your patient has been NPO due to his nausea and vomiting. He has received 1000 mL of IV fluid since admission. Make sure you document your shift totals. Close the I&O form by clicking the X on the top right corner of the form. A pop up will ask you if you want to save the changes you've made, select yes. The File Cabinet Document window appears. Click Done. The Update Document window appears. Answer yes to the question, do you want to send a new version to the server.

Patient Name: Moore, Colon Cancer										Date: 12/5/2010																																	
Ramsay Scale for Sedation AWAKE-LEVELS Level 1 Patient anxious and agitated or restless (or both) Level 2 Patient cooperative, oriented and tranquil Level 3 Patient responds to commands only ASLEEP-LEVELS Level 4 Patient asleep but responds briskly to light, glabellar tap or loud auditory stimulus. Level 5 Patient asleep with sluggish response to light, glabellar tap or loud auditory stimulus. Level 6 Patient asleep with no response to stimuli.																																											
Rodriguez Fall Risk Model - Assessment Tool <table border="1"> <thead> <tr> <th>Risk Factors</th> <th>Day</th> <th>Even</th> <th>Night</th> </tr> </thead> <tbody> <tr> <td>Recent History of Falls</td> <td>+7</td> <td>+7</td> <td>+7</td> </tr> <tr> <td>Depression</td> <td>+4</td> <td>+4</td> <td>+4</td> </tr> <tr> <td>Altered Elimination</td> <td>+3</td> <td>+3</td> <td>+3</td> </tr> <tr> <td>Confusion/Oriented</td> <td>+3</td> <td>+3</td> <td>+3</td> </tr> <tr> <td>Disinjury/Fatigue</td> <td>+3</td> <td>+3</td> <td>+3</td> </tr> <tr> <td>Poor Judgement</td> <td>+3</td> <td>+3</td> <td>+3</td> </tr> <tr> <td>Poor Mobility/Generalized Weakness</td> <td>+2</td> <td>+2</td> <td>+2</td> </tr> </tbody> </table>												Risk Factors	Day	Even	Night	Recent History of Falls	+7	+7	+7	Depression	+4	+4	+4	Altered Elimination	+3	+3	+3	Confusion/Oriented	+3	+3	+3	Disinjury/Fatigue	+3	+3	+3	Poor Judgement	+3	+3	+3	Poor Mobility/Generalized Weakness	+2	+2	+2
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INTAKE Oral Blood/ELD Prod IV Meds Intake Urine Emesis NG pH Chart Tube Output										8 Hour Total 120 120 240																																	
TOTALS 1000 Hour Total										240																																	



14. Return to the Nurse Note. The Nurse Note may be located at the bottom of the screen due to minimizing it earlier. Return to the Nurse Note by clicking maximize icon on the right upper side of the Nurse Note. In the Nurse Note click Done. The Save As screen populates. Click Save.
15. A pop-up appears asking if you want to create a routing slip. Click No.
16. In the Care Tree, click the + next to Encounters. Click on the date of your *Nurse Note* and it appears in the bottom right corner box.
 - Click Edit. Click Sign. Select Permanent Sign and Lock when finished with your Nurse Note.

