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 towardwellness
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*.

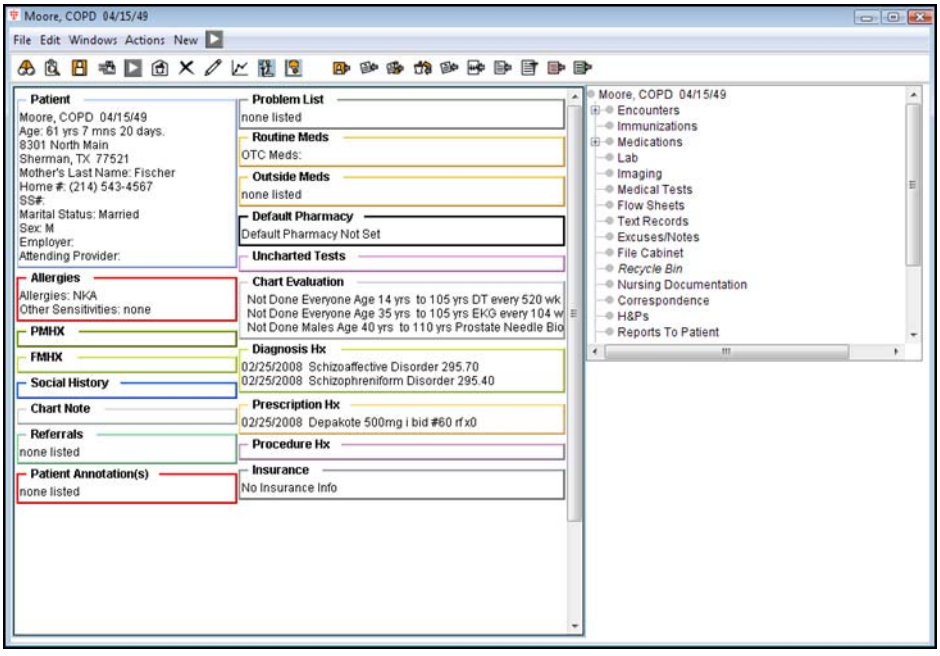
B. When are intake and output (I&O) totals routinely calculated?
Answer: Each shift
Rationale: *I&O* may be documented hourly and shift totals are calculated by the user each shift on the *I&O* form.

Exercise 6.1

Chronic Obstructive Pulmonary Disease

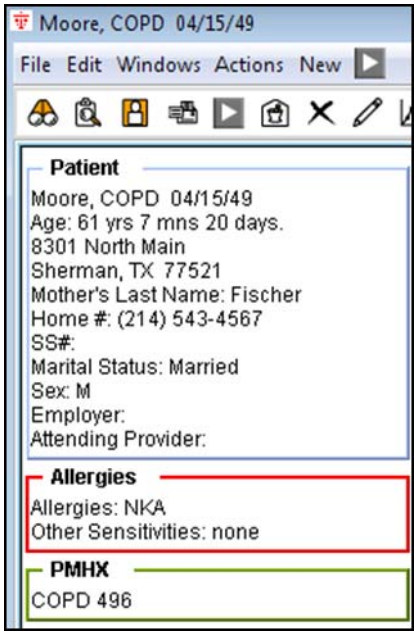
Note: (The MAR document is housed in the EHR Materials folder that was installed with the SpringCharts program. Your instructor or IT staff may need to inform you where this folder is kept.)

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.

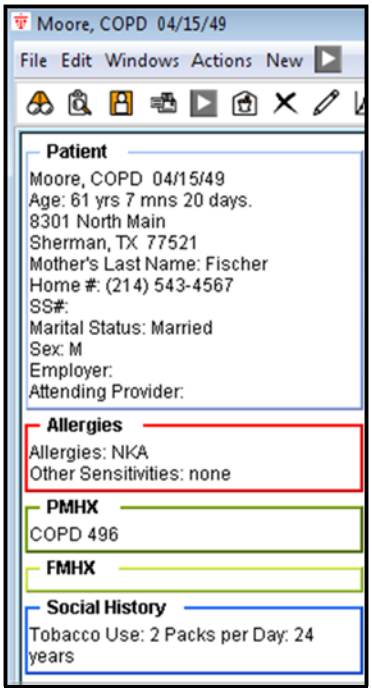


2. Your patient tells you he has been diagnosed with Chronic Obstructive Pulmonary Disease (COPD) this past week. Click on *PMHX* and it populates the right corner box. Click the *Edit* button below the right corner box and a new window opens.
   - In the space after *Dx* at the upper right portion of 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.

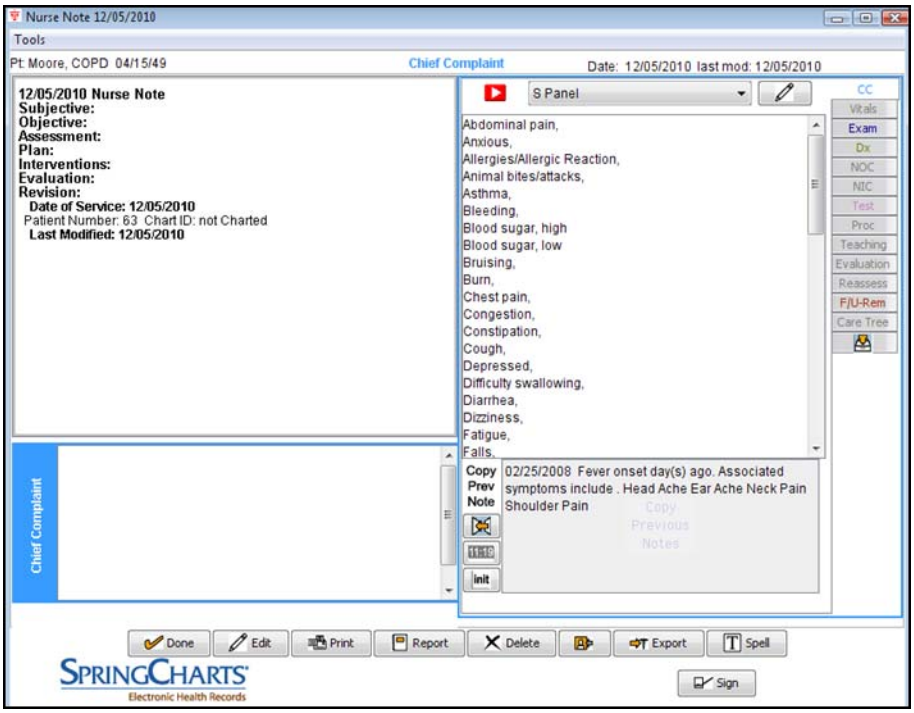
- In the lower left corner of the window, click *Back to Chart*. Your new entry appears in the *PMHX* field.



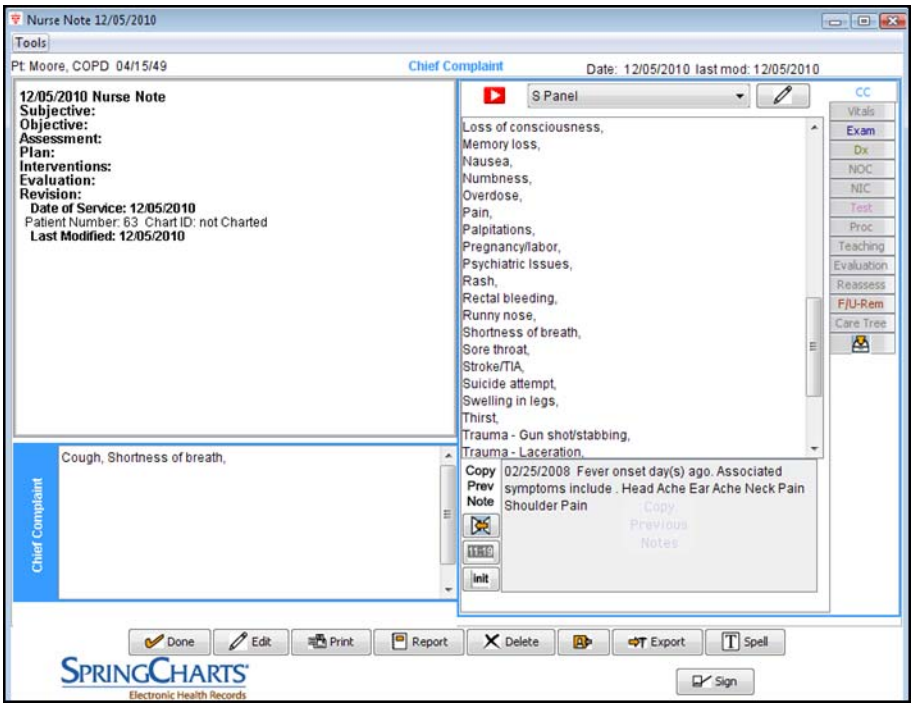
3. You ask your patient about his smoking history and he says he smokes two packs a day and has done so for 24 years. Click on the *Social History* field on the left and it populates the box on the right side of the screen.
   - Click the [Edit] button below the *Social History* box on the right side 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.



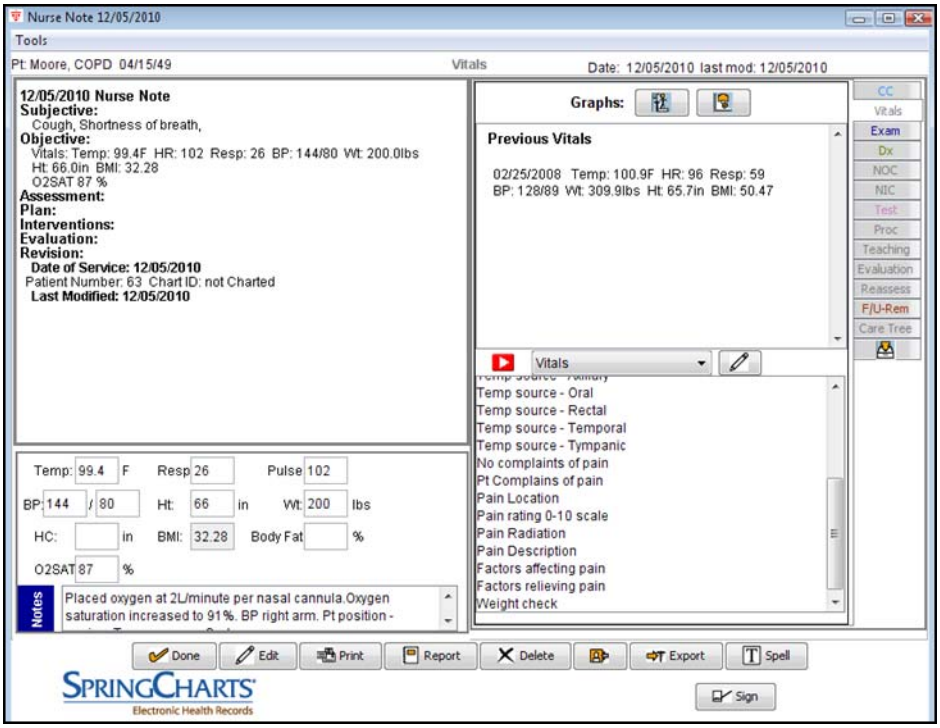
4. Open your *Nurse Note*. On the top horizontal toolbar, click *New, New Nurse Note*. The *Nurse Note* opens to the *Chief Complaint* tab at the top of the vertical navigation bar on the right side of the window.



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.

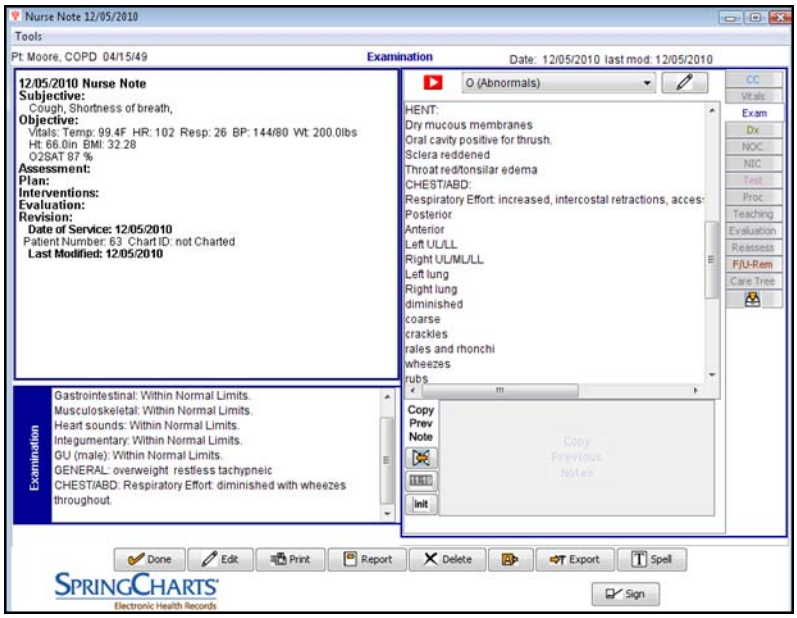


6. Click on the *Vitals* tab located below the *CC* tab in the vertical navigation bar on the right side of the screen. Note your *Chief Complaints* now appear in the Subjective section of the *Nurse Note.*
   - You take your patient's vital signs, height, and weight. Document the following in the boxes 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.

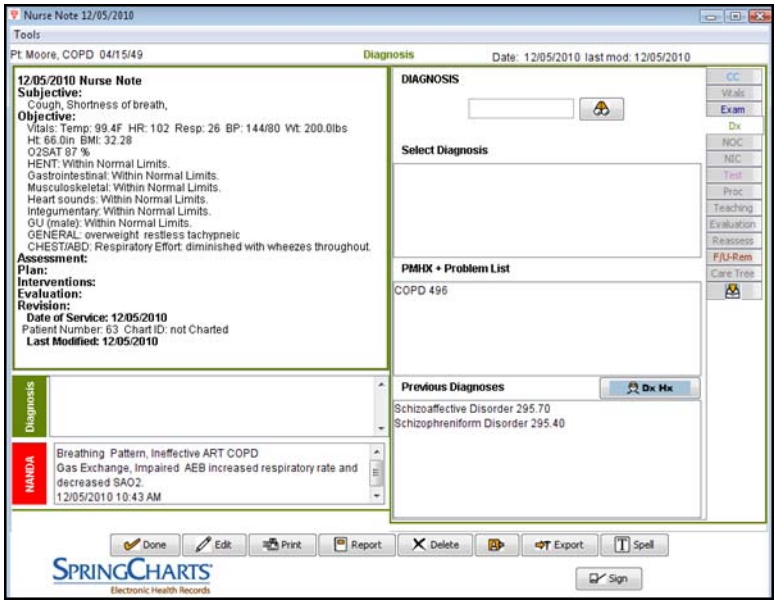


7. Click on the *Exam* button located below the *Vitals*. Notice the *O (Normals)* defaults. In this area select the following systems that are within normal limits when you assess your patient: HEENT Gastrointestinal, Musculoskeletal, Heart sounds, Integumentary, and GU (male). Use the enter key to 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.

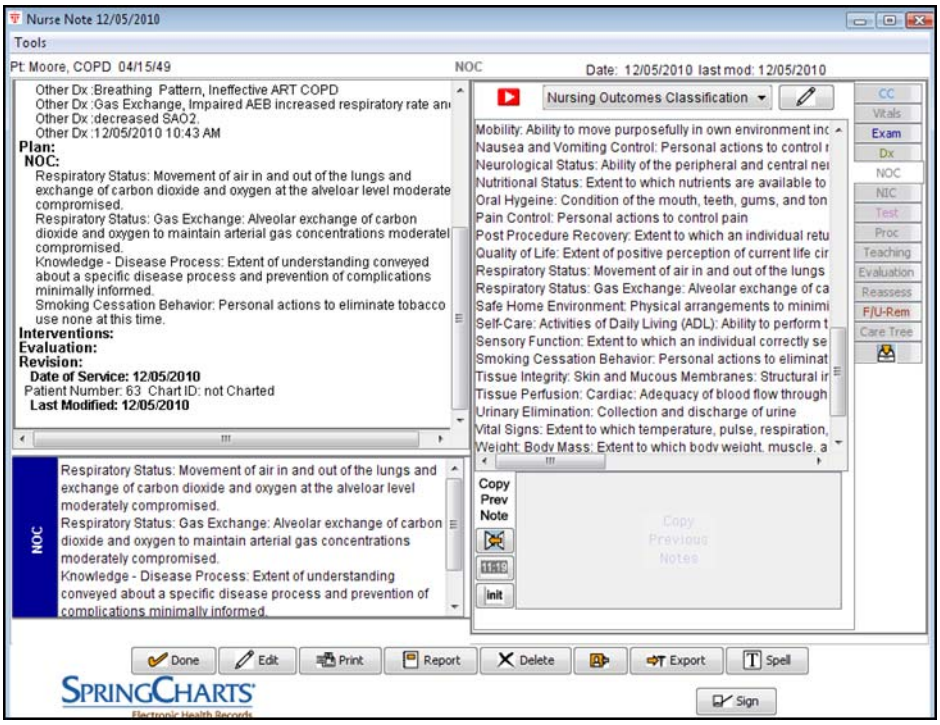
- Click in the *Examination* box after Respiratory Effort and delete: increased, intercostals retractions, accessory muscle use, and abdominal retraction so that it reads simply Respiratory Effort, diminished.
- Click after diminished remove the comma and type: with wheezes.
- Click after wheezes and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

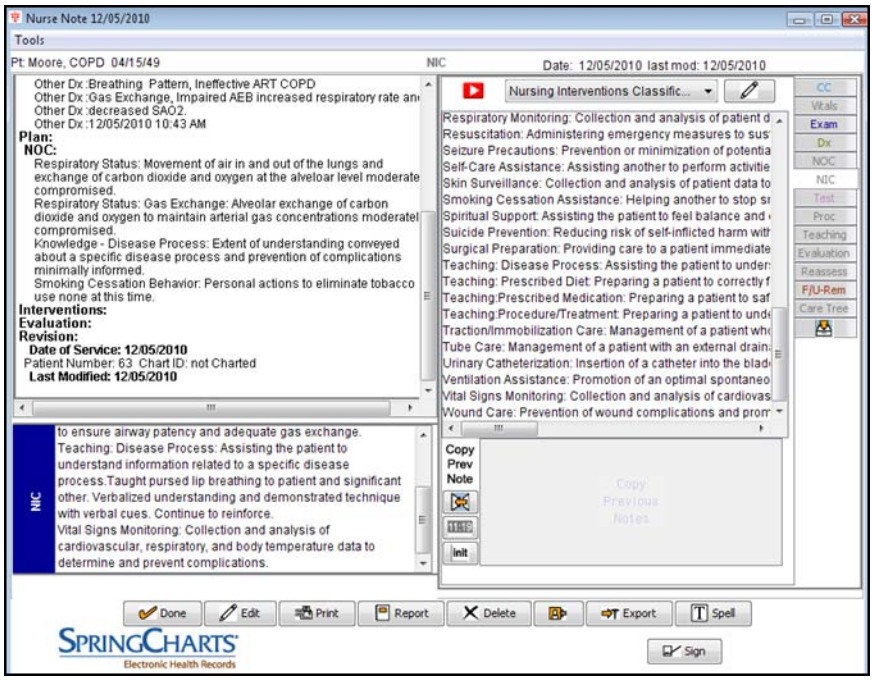


9. Click the *NOC* tab in the vertical navigation bar on the right located below the *Dx* button. Notice that your *NANDA* documentation populates the *Nurse Note*.
   - Below the *Nursing Outcomes Classification* in the upper right box select the following:
     - Knowledge—Disease Process: Extent of 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 measureable goals and time frames.

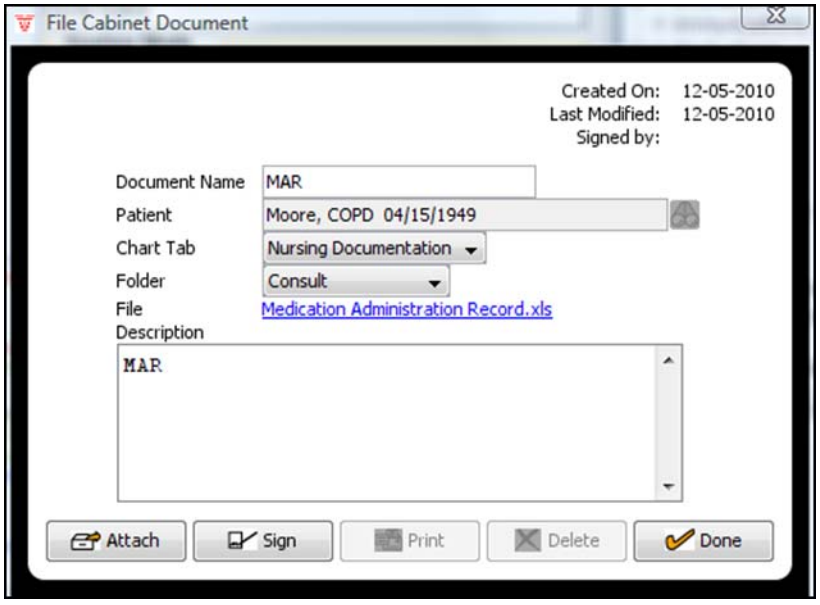


10. Click the *NIC* button in the vertical navigation bar on the right below the *NOC* button. Notice that your outcomes populate the *Nurse Note*.
    - Select the following interventions:
      - Medication Administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription 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.

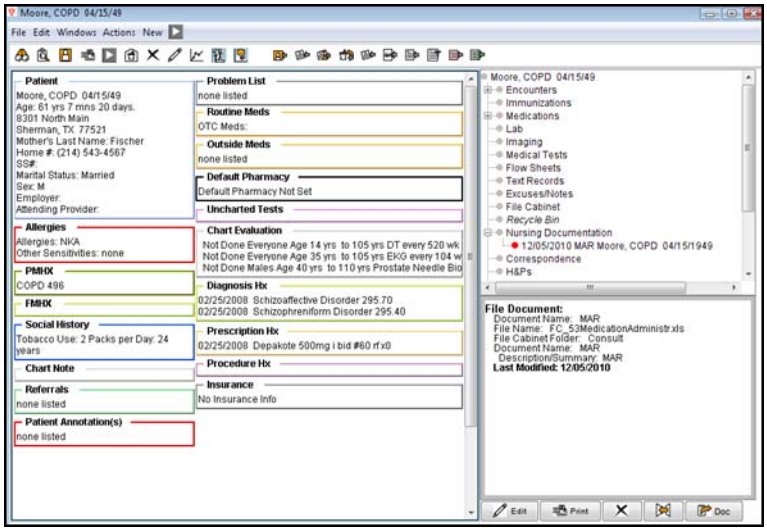
- Still in the *Nursing Interventions Classification* box click after Teaching: Disease Process and type: Taught pursed lip breathing to patient and significant other. Verbalized understanding and demonstrated technique with verbal cues. Continue to reinforce.

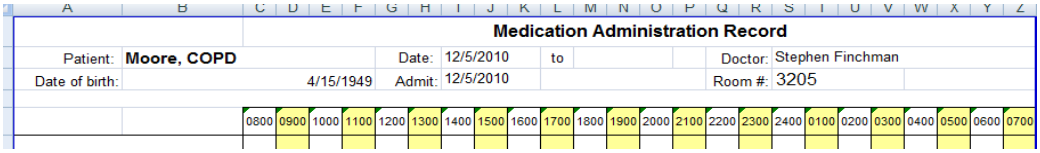


11. . Move the Nurse Note by clicking on the minimize icon in the upper right corner. This will bring you back to the patient's chart.
    - Click the *New* menu and *Import Items* at the bottom of the list. Select *Import File Cabinet Document* and the *File Cabinet* window appears. Type *MAR* into 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.

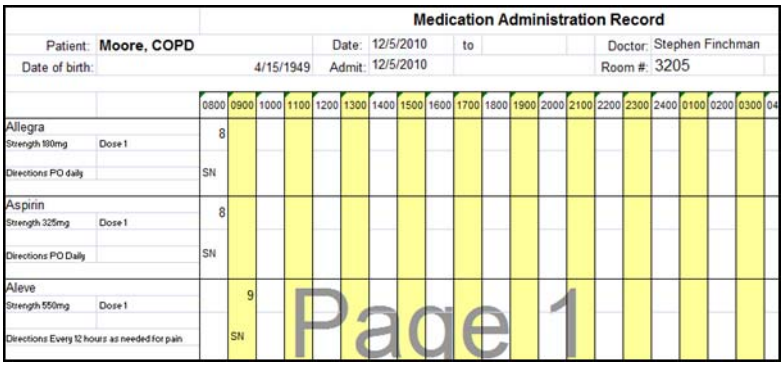


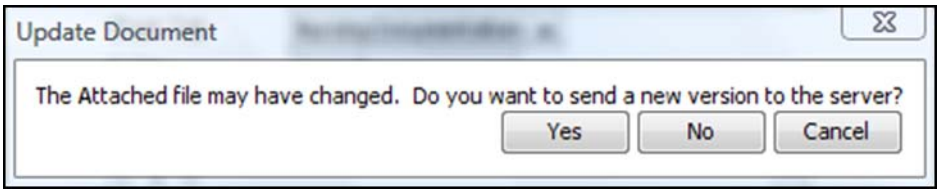
- Click on the + in front of *Nursing Documentation*. Highlight the *MAR* and click [Doc] button at the bottom right hand side of the screen. The *MAR* document opens. Enter the Patient, Date of Birth, Date, Admit date, Doctor, and Room #. Initial and sign at the bottom of the *MAR*. Include your credentials.



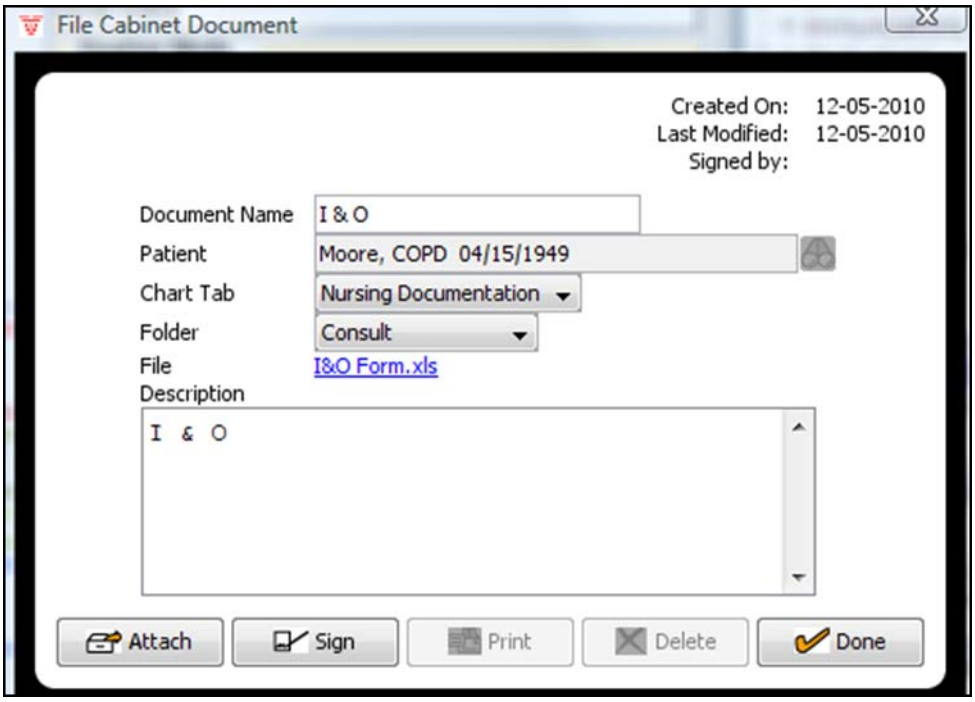


- The primary care provider writes an order to continue the patient's Allegra 180 mg by mouth daily and Aspirin 325 mg by mouth daily. Add the medications to the *MAR* by typing the name of the medication, strength, dose, and directions into the form.. Document that you gave the Allegra and Aspirin as 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?"

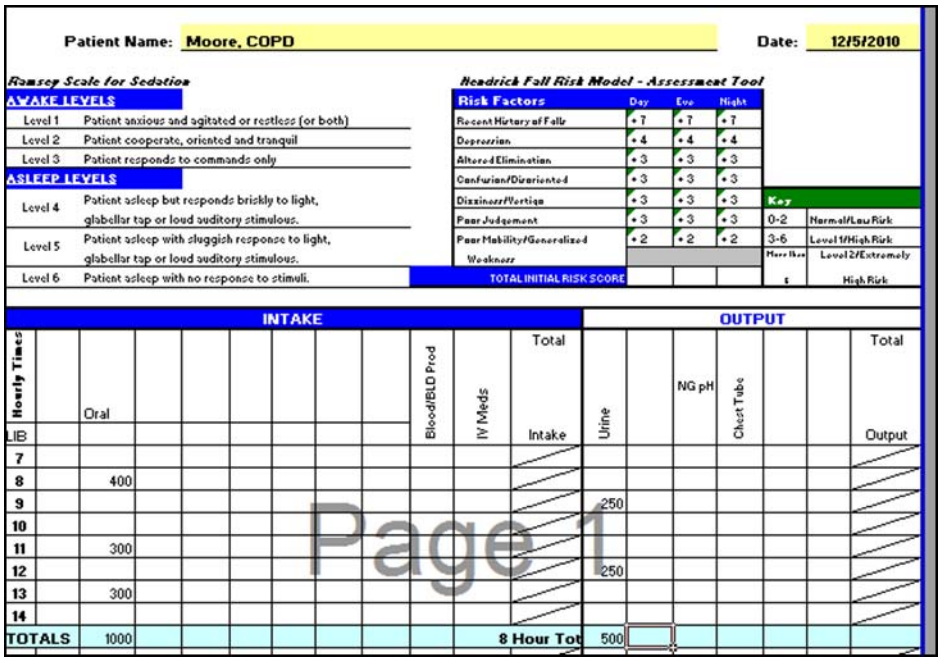


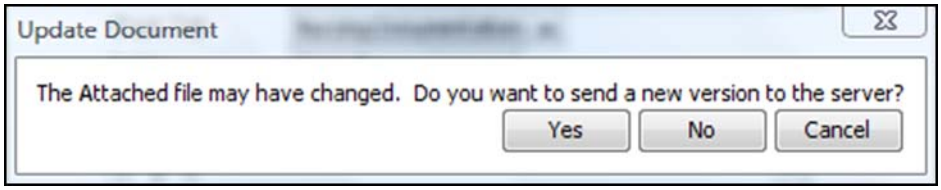


12. You are still in the *Nursing Documentation* area.
    - Click the New menu, select *Import File Cabinet Document* and the *File Cabinet* window appears. Type *Intake and Output* into the Document name. In the *Chart Tab* select the drop down box on the right and choose *Nursing Documentation*. In 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.

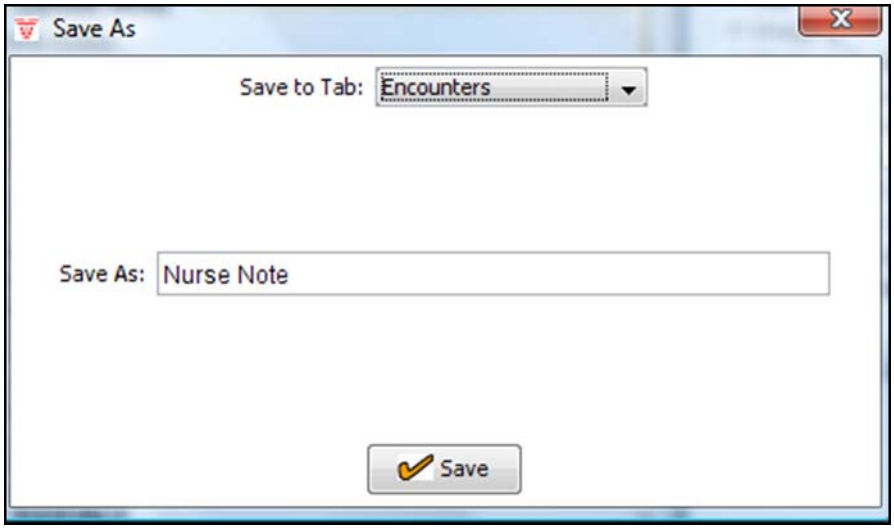


- Click on the + in front of Nursing Documentation. Highlight the Intake and Output and click Edit at the bottom right hand side of the screen. The File Cabinet window appears. Click on the blue hyperlink next to the word File. The Intake and Output document opens. Type in the Patient Name and Date.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



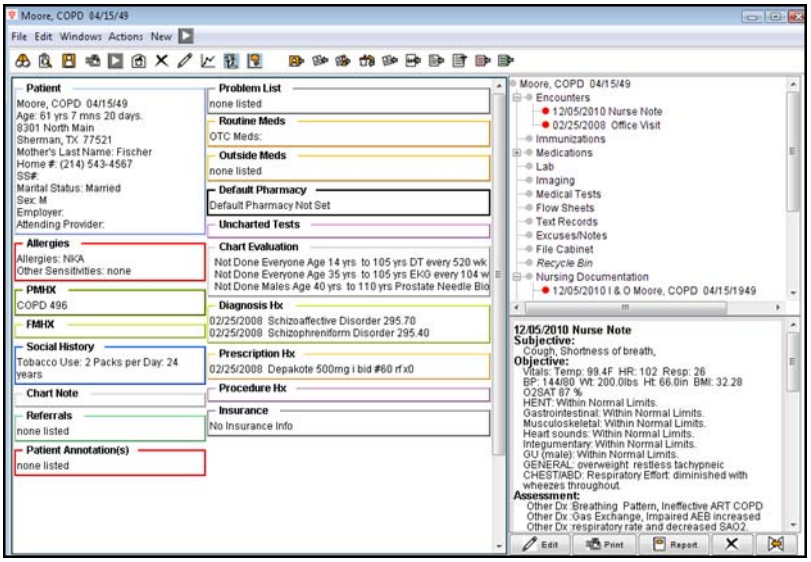


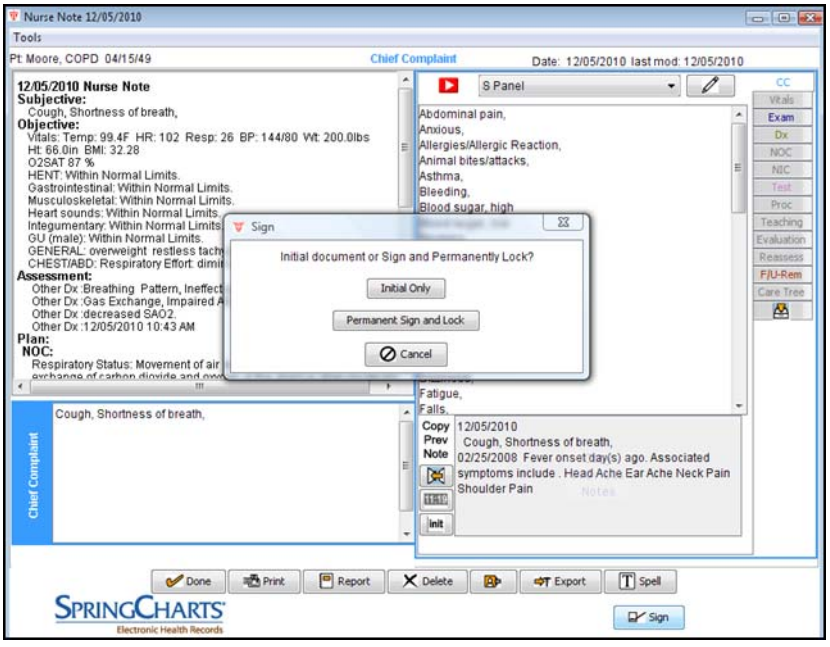
13. Return to the Nurse Note. The Nurse Note may be located at the bottom of the screen due to minimizing it earlier. Return to the Nurse Note by clicking maximize icon on the right upper side of the Nurse Note. In the *Nurse Note* click *Done*. The *Save As* screen populates. Click *Save*.



14. 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*.

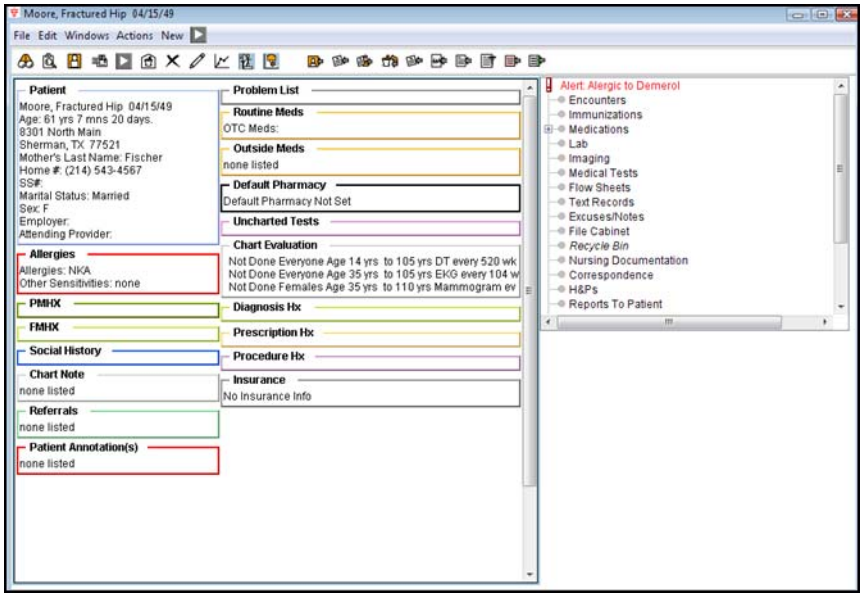




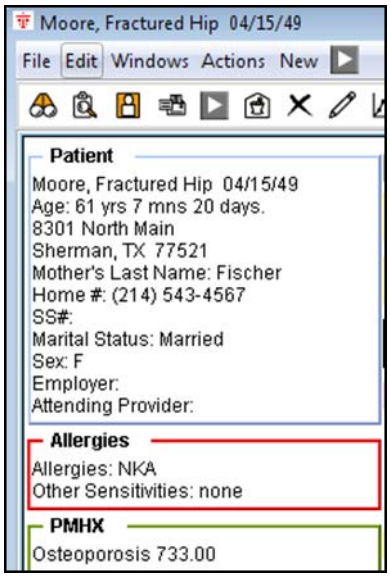
Exercise 6.2

Fractured Hip

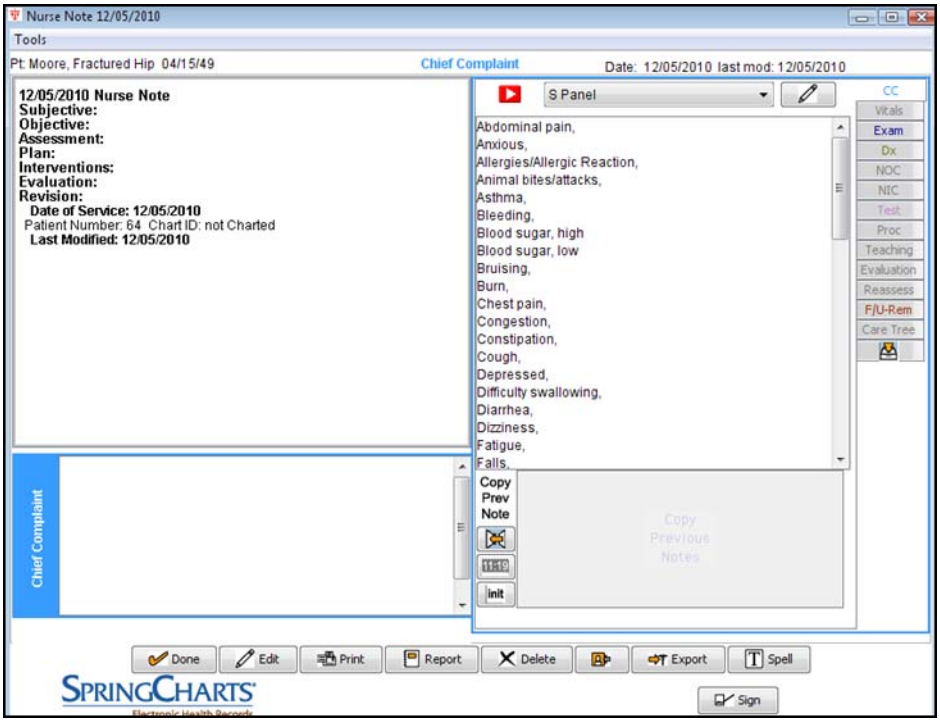
1. After launching SpringCharts, click on Actions, Open a Chart. Type in your last name and click the search button. Select your “fractured hip” patient and the chart opens.



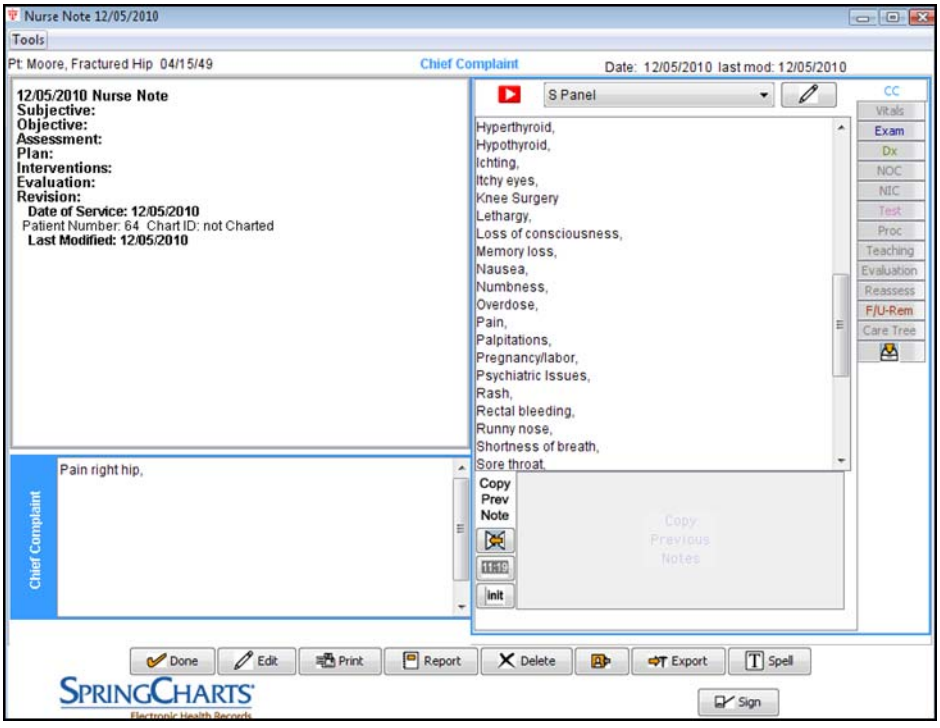
2. Your patient has been admitted for a broken right hip. She tells you she has a history of osteoporosis. Click on PMHX on the left and the past medical history populates the box on the right lower side of the screen. Click Edit.
   - The Past Medical History screen populates. In the space after Dx 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.



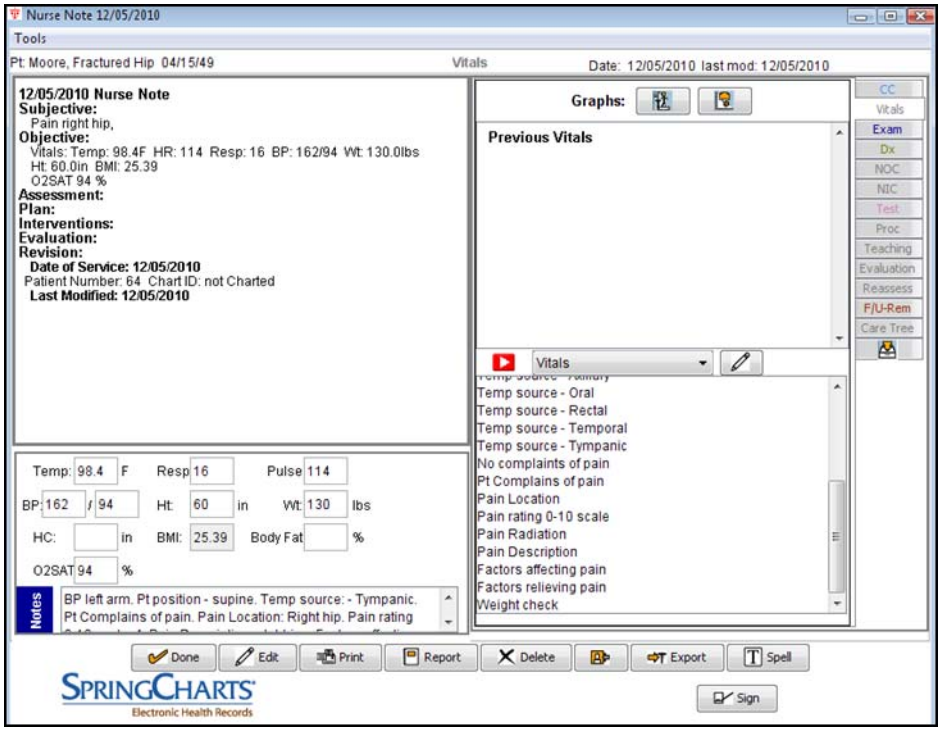
3. Open your Nurse Note. Click New, New Nurse Note.



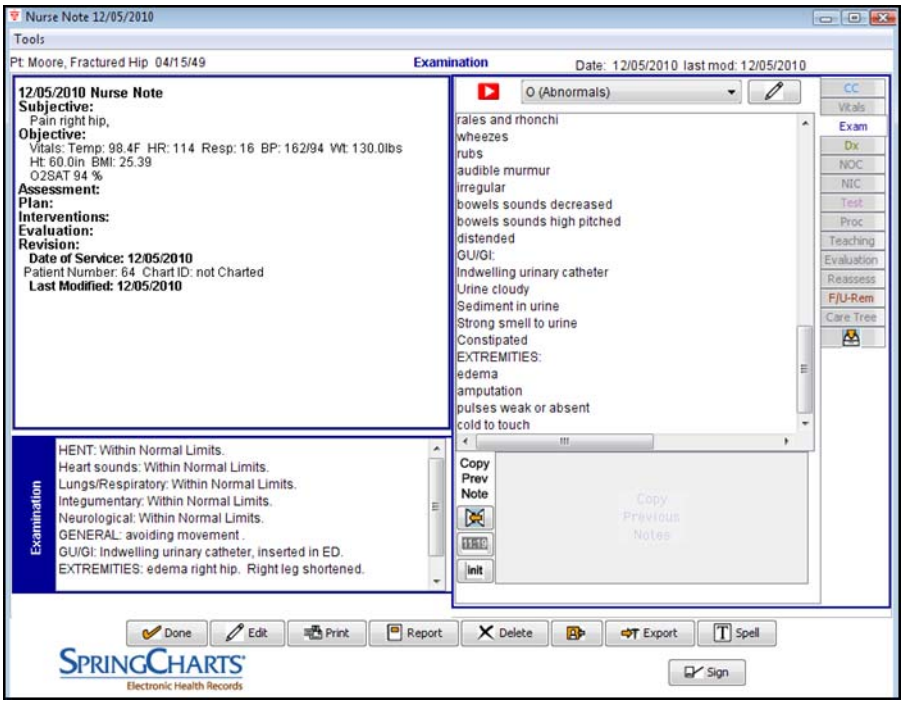
4. Your patient complains of pain in her right hip. Select Pain in the S Panel text and it populates the Chief Complaint box on the bottom left of the screen. Click in the Chief Complaint box after Pain, and type: right hip.



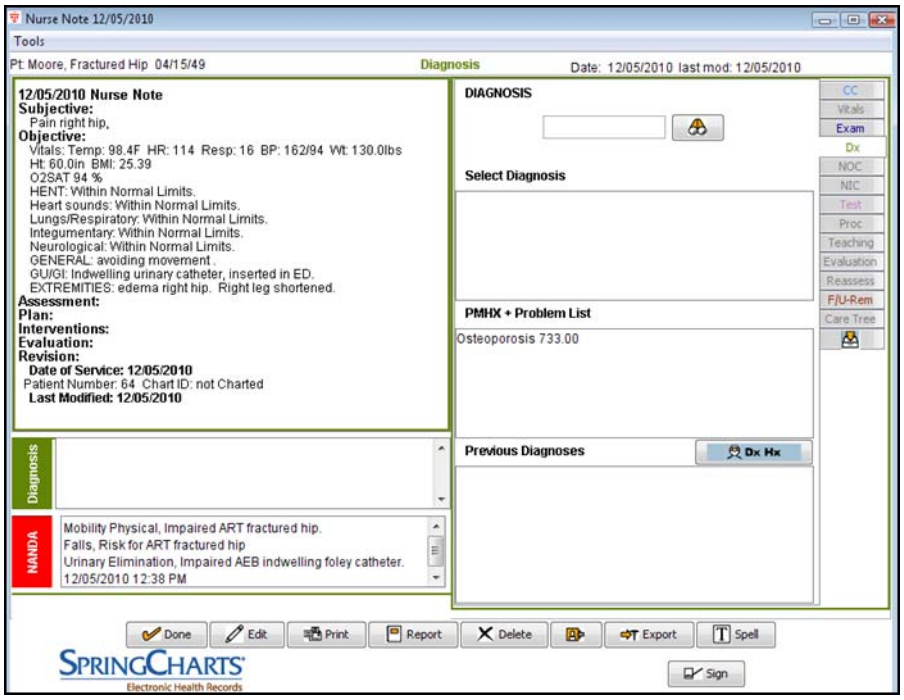
5. Click on the Vitals button located below the CC button in the navigation bar on the right side of the screen. Note that your Chief Complaint now appears in the Subjective section of the Nurse Note.
   - You take your patient's vital signs. Document the following: Temp 98.4, Resp 16, Pulse 114, BP 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.



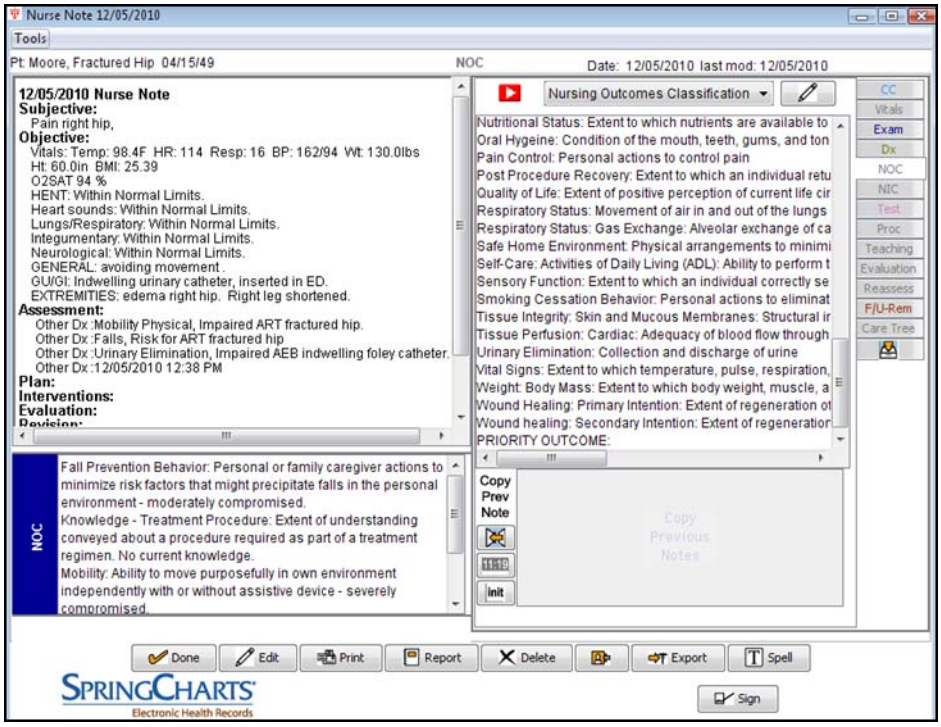
6. Click on the Exam button located below the Vitals. The O (Normals) defaults in the right upper box. Select the following systems that are within normal limits when you assess your patient: HEENT, Heart sounds, Lungs/Respiratory, Integumentary, and Neurological.
   - Click the drop down arrow next 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.



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.

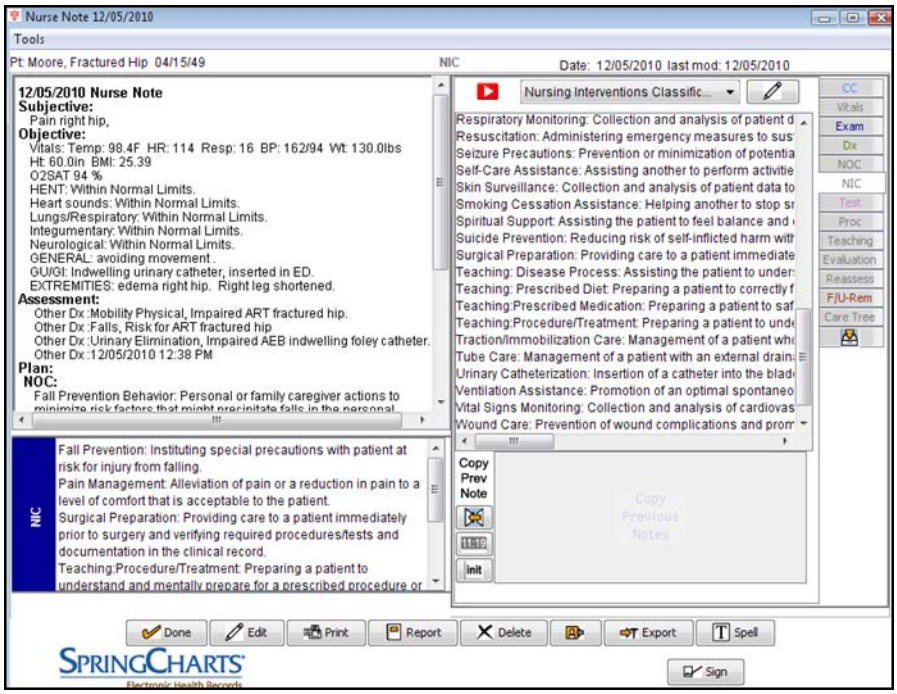


8. Click the NOC button on the right located below the Dx button. The NANDA documentation populates the Nurse Note.
   - Below the Nursing Outcomes Classification select the following:
     - Fall Prevention Behavior: Personal or family caregiver actions to minimize risk factors that might precipitate 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.

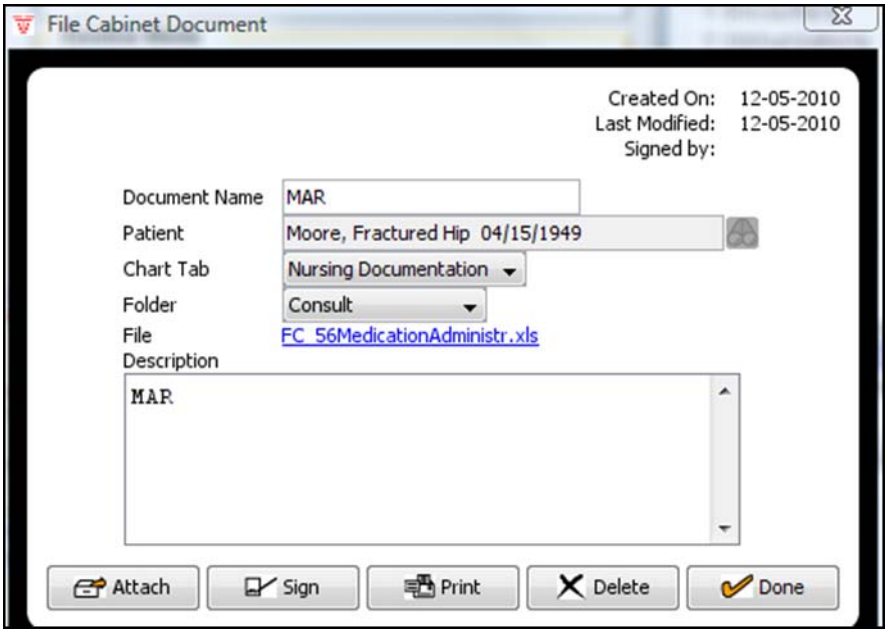


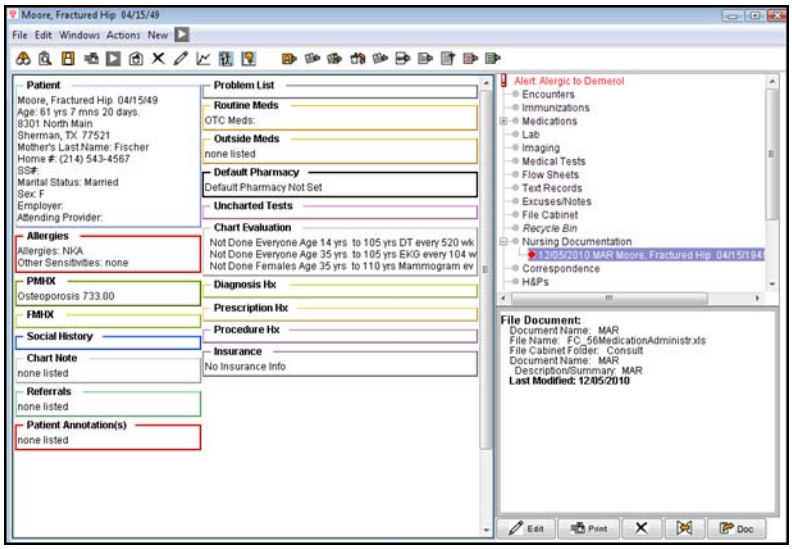
9. Click the NIC button on the right below the NOC button. Notice that your outcomes populate the Nurse Note.
   - Select the following interventions:
     - Fall Prevention: Instituting special precautions with patient at risk for injury from falling.
     - Pain Management: Alleviation of pain or a 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.

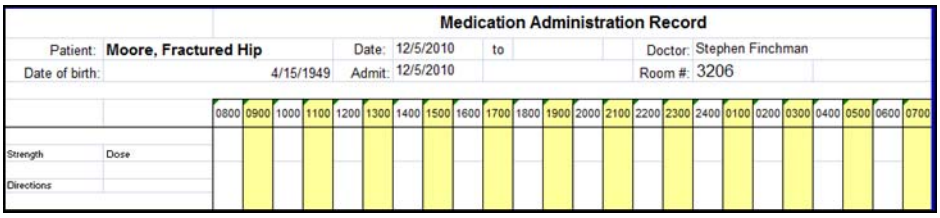


10. Move the Nurse Note by clicking on the minimize icon in the upper right corner. This will bring you back to the patient's chart.
    - Click the New menu and Import Items at the bottom of the list. Select Import File Cabinet Document and the File Cabinet window appears. Type MAR into the Document 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.

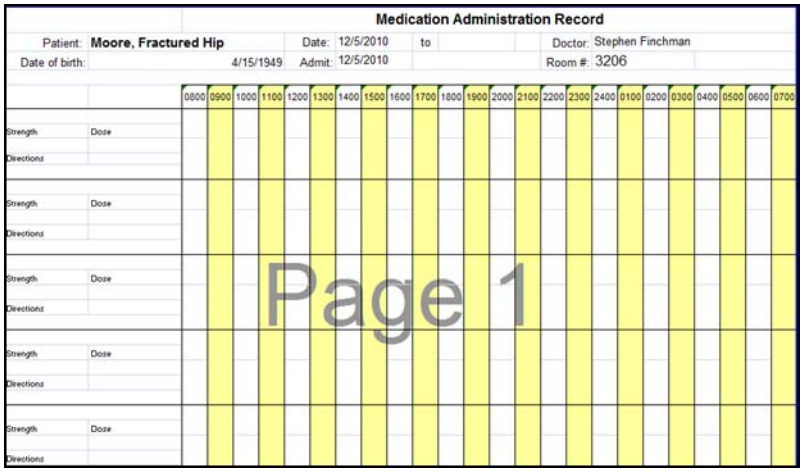


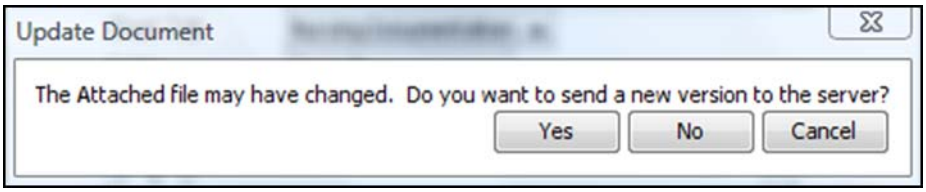


- Click on the + in front of Nursing Documentation. Highlight the MAR and click Edit at the bottom right hand side of the screen. The File Cabinet window appears. Click on the blue hyperlink next to the word File. The MAR document opens. Enter the Patient, Date of Birth, Date, Admit date, Doctor, and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

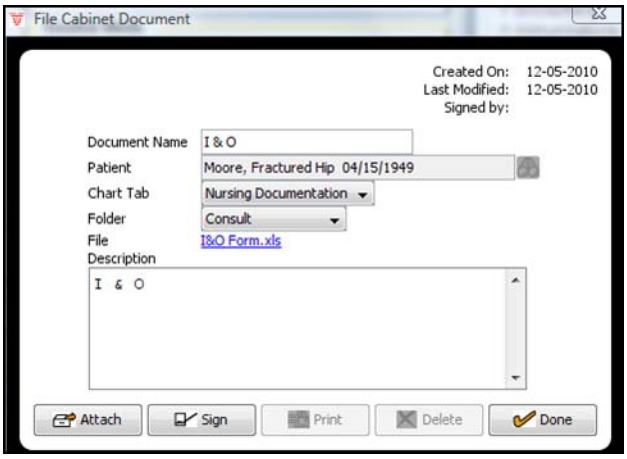


- Add the medications to the *MAR* by typing the name of the medication, dosage, route, frequency, and scheduled administration time into the form. Document that you did not give the patient's routine medications by typing NPO and your initials in the correct time box for each medication. Close the MAR 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.

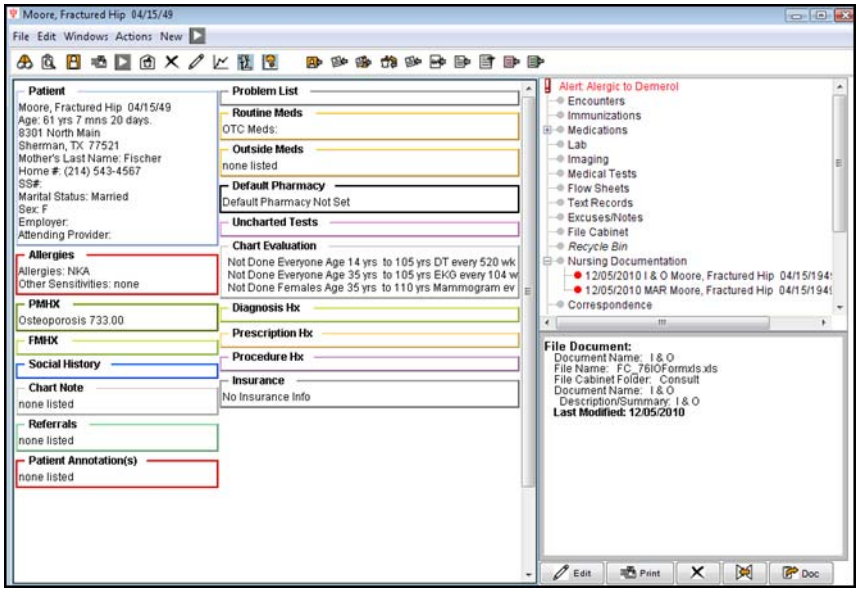




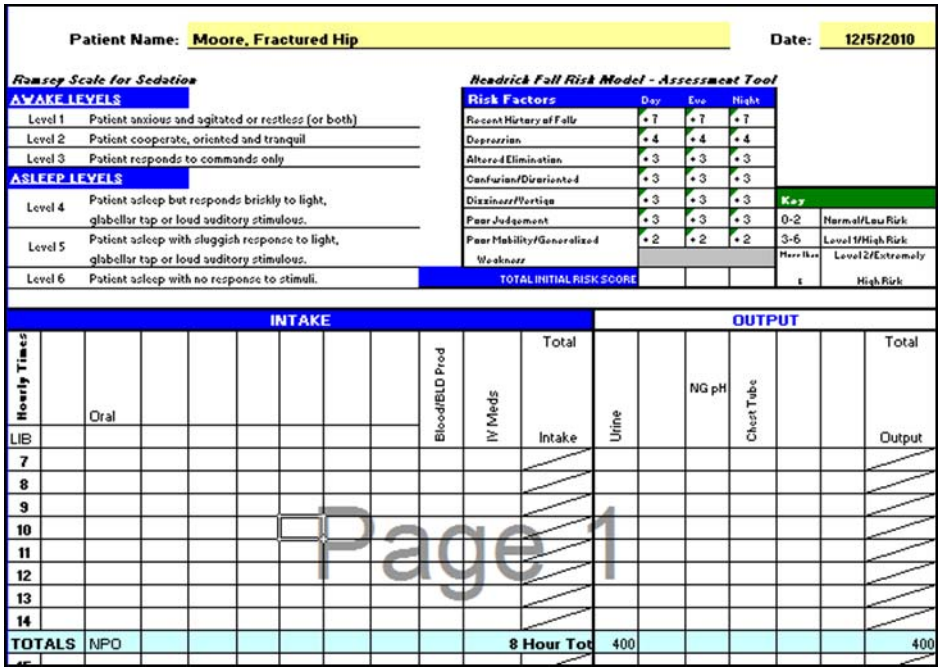
11. You are still in the *Nursing Documentation* area.
    - Click the New menu, select Import File Cabinet Document and the File Cabinet window appears. Type Intake and Output into the Document name. In the Chart Tab select the drop down box on the right and choose Nursing Documentation. In the Description 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. Type in the Patient Name and Date.



- 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

Ramsey Scale for Sedation

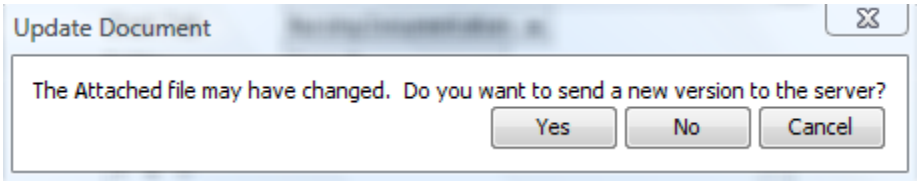
AWAKE LEVELS	
Level 1	Patient anxious and agitated or restless (or both)
Level 2	Patient cooperate, oriented and tranquil
Level 3	Patient responds to commands only
ASLEEP LEVELS	
Level 4	Patient asleep but responds briskly to light, glabellar tap or loud auditory stimulous.
Level 5	Patient asleep with sluggish response to light, glabellar tap or loud auditory stimulous.
Level 6	Patient asleep with no response to stimuli.

Hendrick Fall Risk Model - Assessment Tool

Risk Factors	Day	Eve	Night
Recent History of Falls	+7	+7	+7
Depression	+4	+4	+4
Altered Elimination	+3	+3	+3
Confusion/Disoriented	+3	+3	+3
Dizziness/Vertigo	+3	+3	+3
Poor Judgement	+3	+3	+3
Poor Mobility/Generalized Weakness	+2	+2	+2
TOTAL INITIAL RISK SCORE			

Key	
0-2	Normal/Low Risk
3-6	Level 1/High Risk
	Level 2/Extremely High Risk

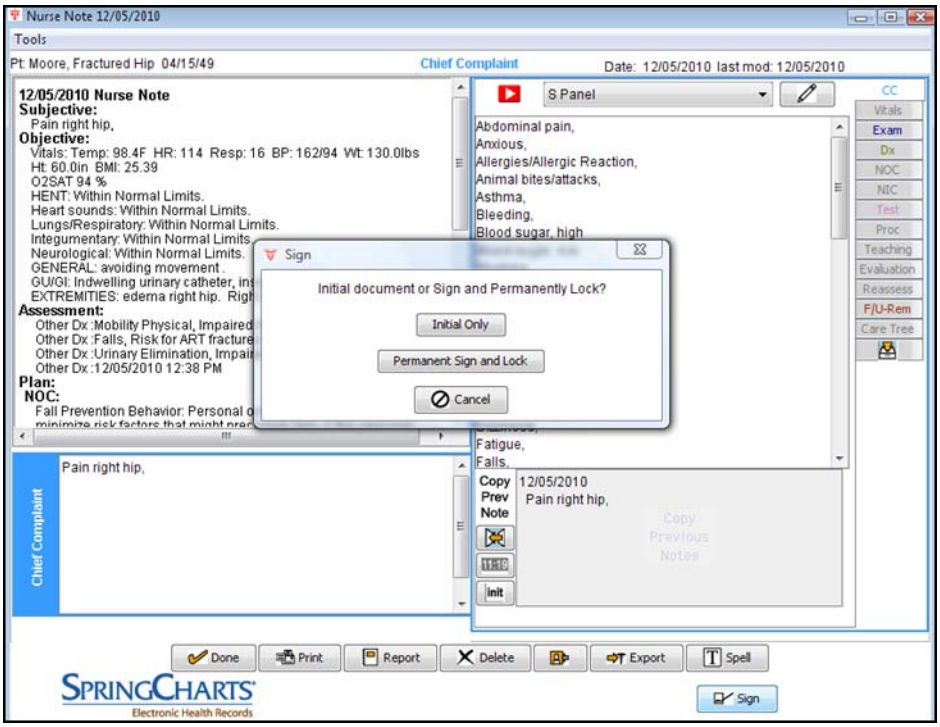
INTAKE												OUTPUT						
Hourly Times		Oral							Blood/BLD Prod	IV Meds	Total Intake	Urine		NG pH	Chest Tubs			Total Output
LIB																		
7																		
8																		
9																		
10																		
11																		
12																		
13																		
14																		
TOTALS		NPO									8 Hour Tot	400						400



12. 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.

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

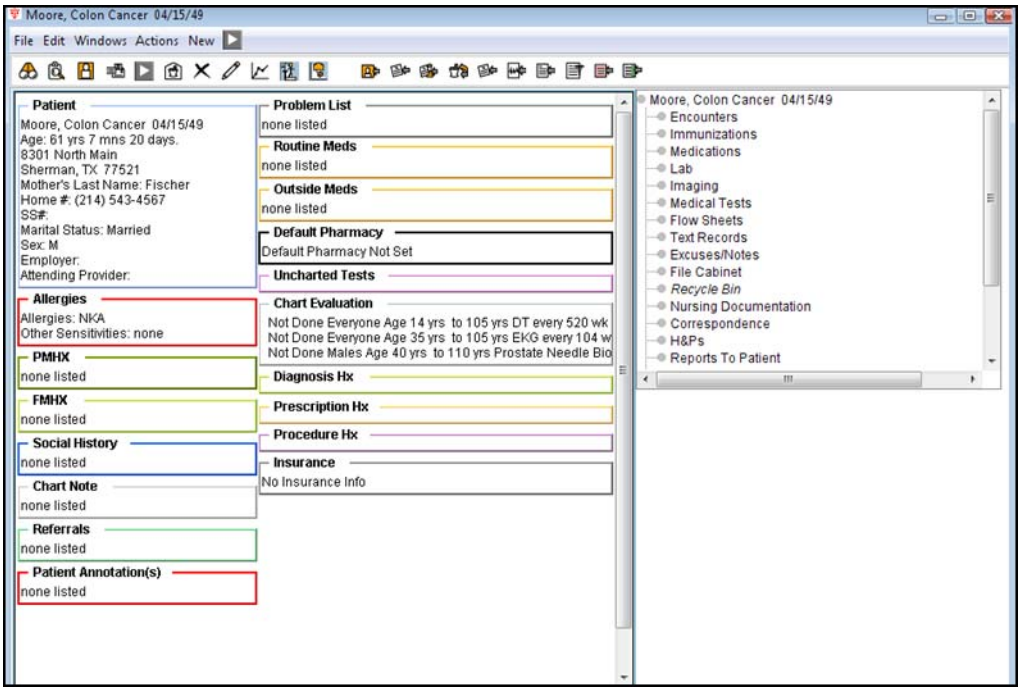
14. In the care tree, click the + next to Encounters. Click on the date of your *Nurse Note* and it appears in the bottom right corner box.
    - Click Edit. Click Sign. Select Permanent Sign and Lock when finished with your Nurse Note.



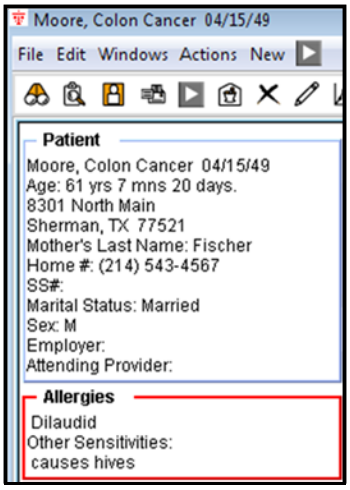
Exercise 6.3

Colon Cancer

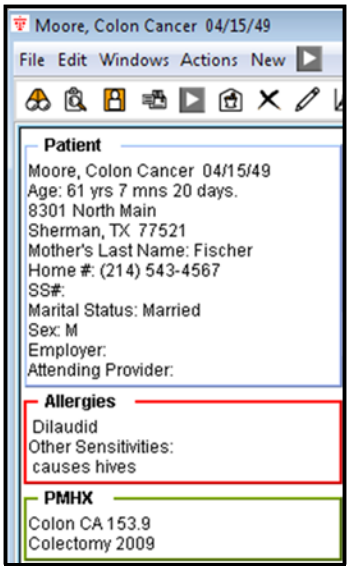
1. After launching SpringCharts, click on Actions, Open a Chart. Type in your last name and click the search button. Select your “colon cancer” patient and the chart opens.



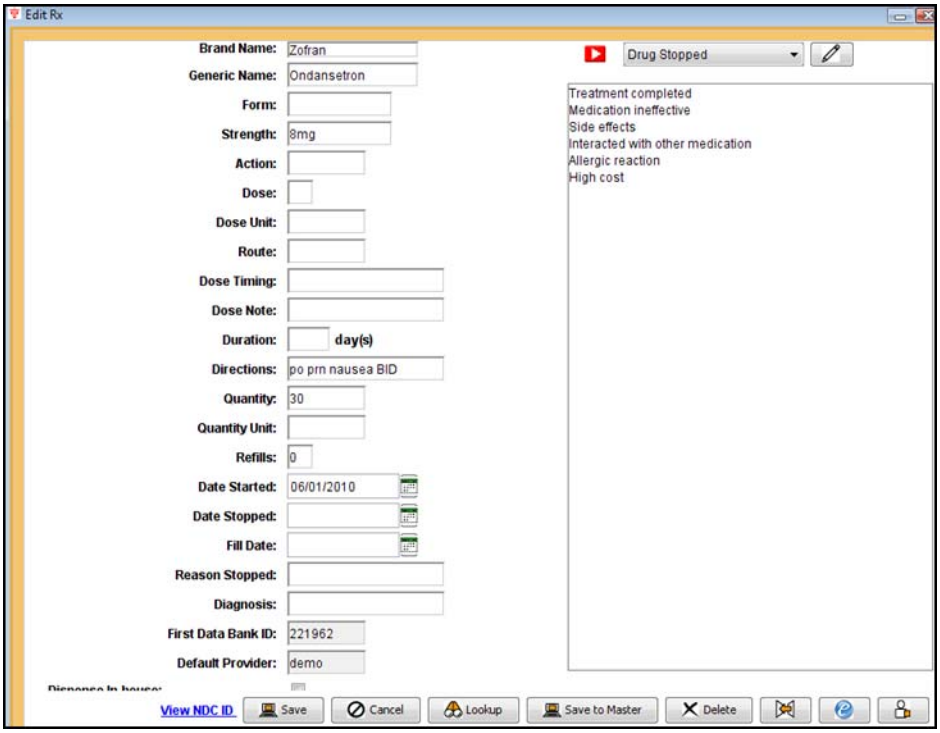
2. Your patient tells you he recently discovered he was allergic to Dilaudid after his colectomy. He tells you he broke out in hives all over his body. Click on Allergies in the red box on the left side of the screen and a red Allergies box opens in the lower right corner of the window. Click Edit below 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.

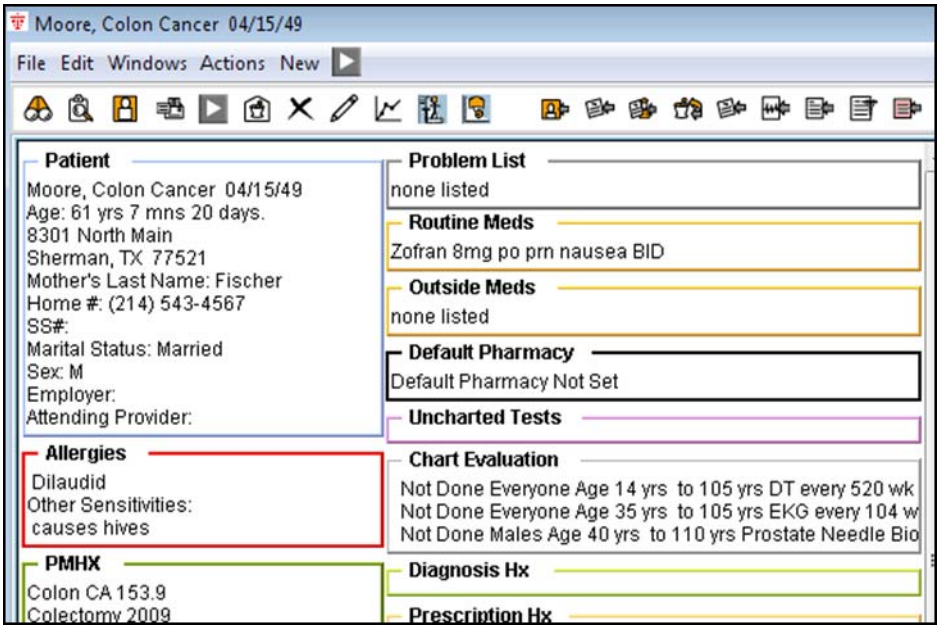


3. Your patient had a colectomy six months ago for colon cancer. Click on the PMHX box and it populates in the bottom right corner. Click Edit below the box.
   - Click in the space after Dx at the upper right of the screen and type: colon. Click the Search icon. Colon CA 153.9 appears in the box below.
   - 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.

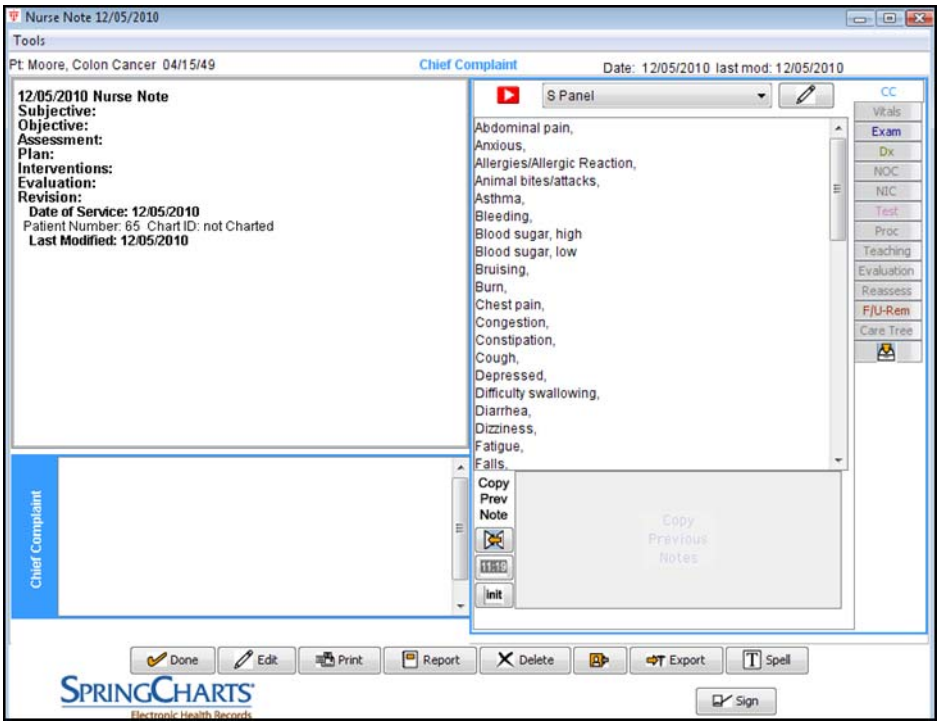


4. Your patient tells you he takes Zofran 8 mg po prn for nausea related to his chemotherapy. Click on the Routine Meds box and it populates in the bottom right corner. Click Edit.
   - Click in the space after Brand Name and type: Zofran. Click the search icon.
   - Click on the Zofran 8 mg to send 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.

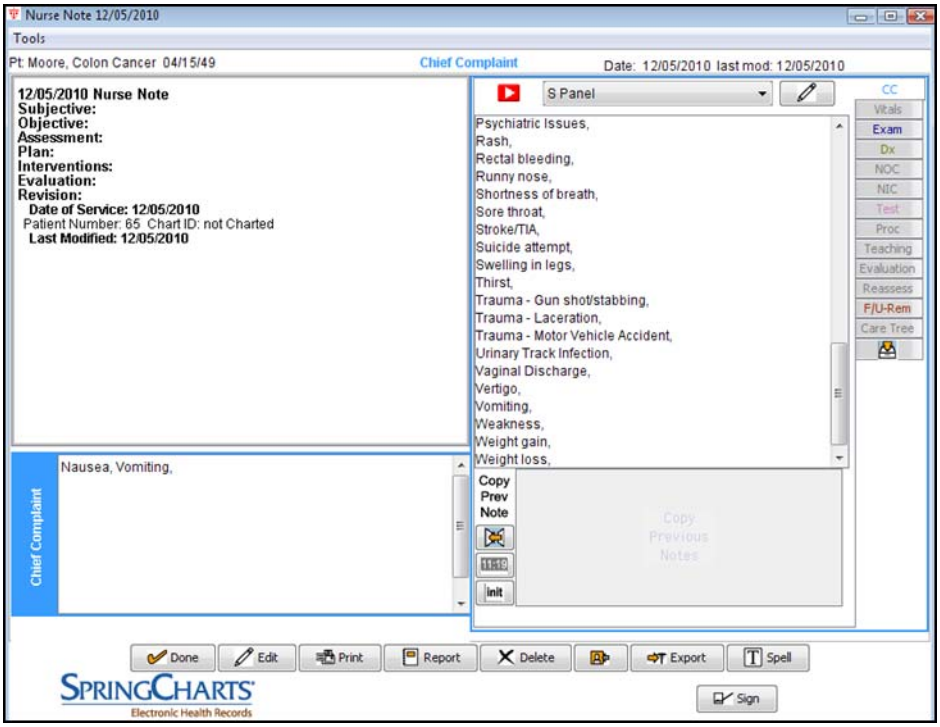




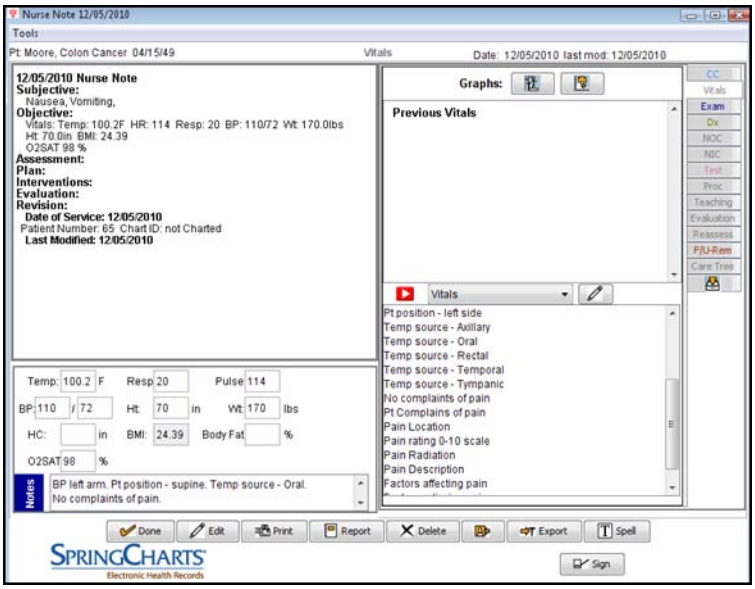
5. Open your Nurse Note. Click New, New Nurse Note.



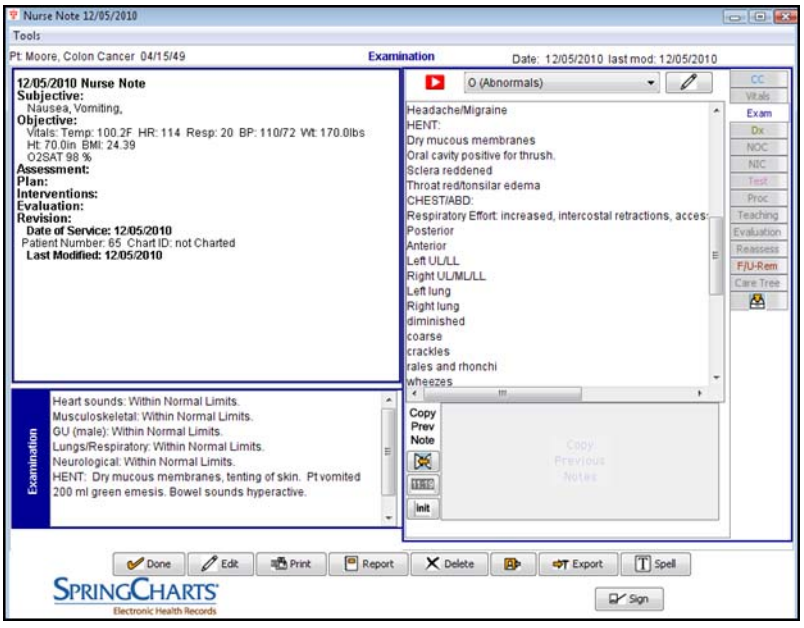
6. Your patient complains of nausea and vomiting. He had a chemotherapy treatment earlier this week. Select nausea and vomiting from the S Panel text and they populate the Chief Complaint box on the bottom left of the screen.



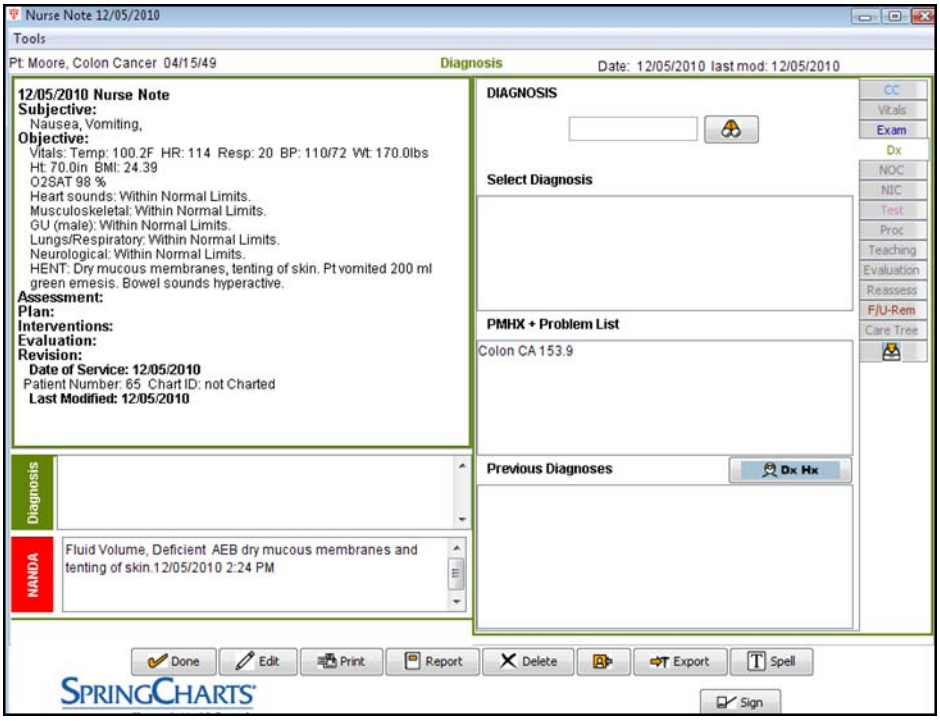
7. Click on the Vitals button on the located below the CC button on the right side of the screen. The Chief Complaints now appear in the Subjective section of the Nurse Note.
   - You take your patient's vital signs. Document the following: Temp 100.2, Resp 20, Pulse 114, BP 110/72, Ht 70 inches, Wt 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.



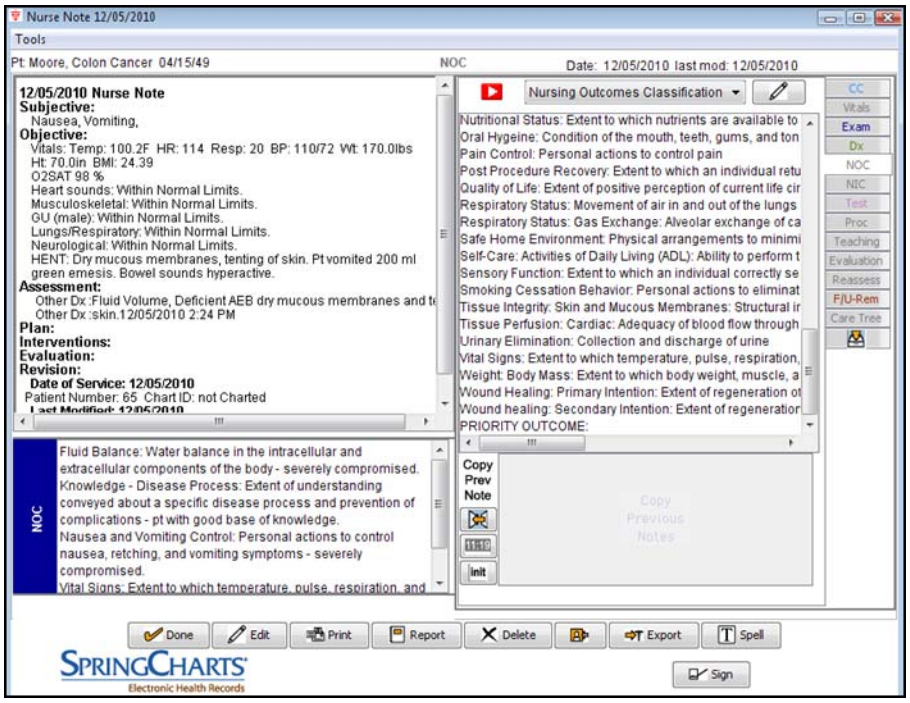
8. Click on the Exam button located below the Vitals. The O (Normals) defaults. Select the following systems that are within normal limits when you assess your patient: Heart sounds, Musculoskeletal, GU (male), Lungs/ Respiratory, and Neurological.
   - Click the drop down arrow next to O (Normals) and 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.



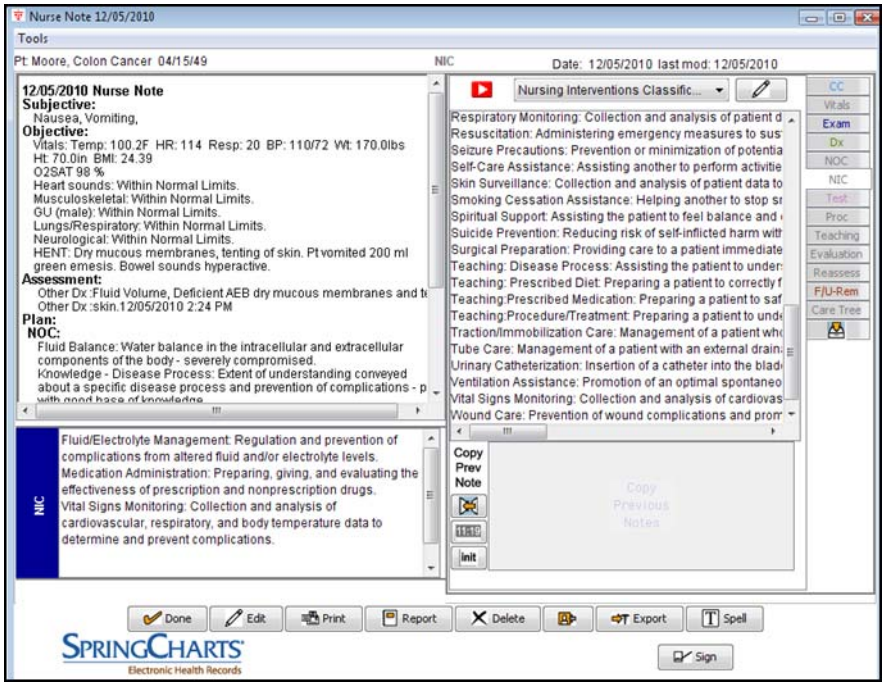
9. Click into the Dx button below the Exam button on the right. Click on the red NANDA on the left bottom of the screen. The Dx text window populates.
   - Click Fluid Volume, Deficient and Infection, Risk for. Click the D&T icon to date and time the entry. Click Done.
   - Add the related factor (r/t) 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.



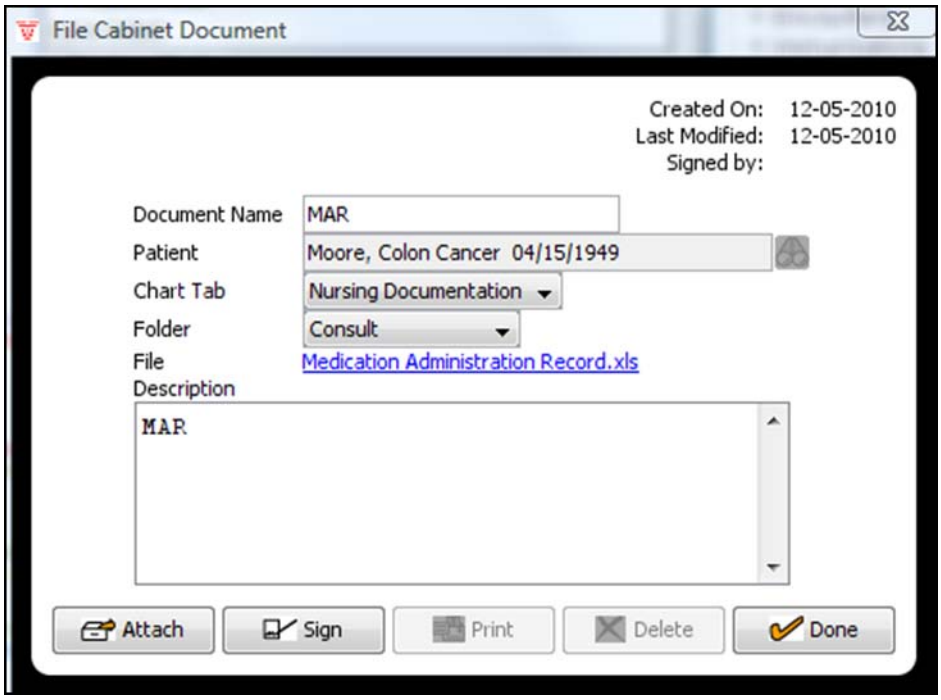
10. Click the NOC button on the right located below the Dx button. The NANDA documentation populates the Nurse Note.
    - Below the Nursing Outcomes Classification select the following:
      - Fluid Balance: Water balance in the intracellular and extracellular components of the body.
      - Knowledge—Disease 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.

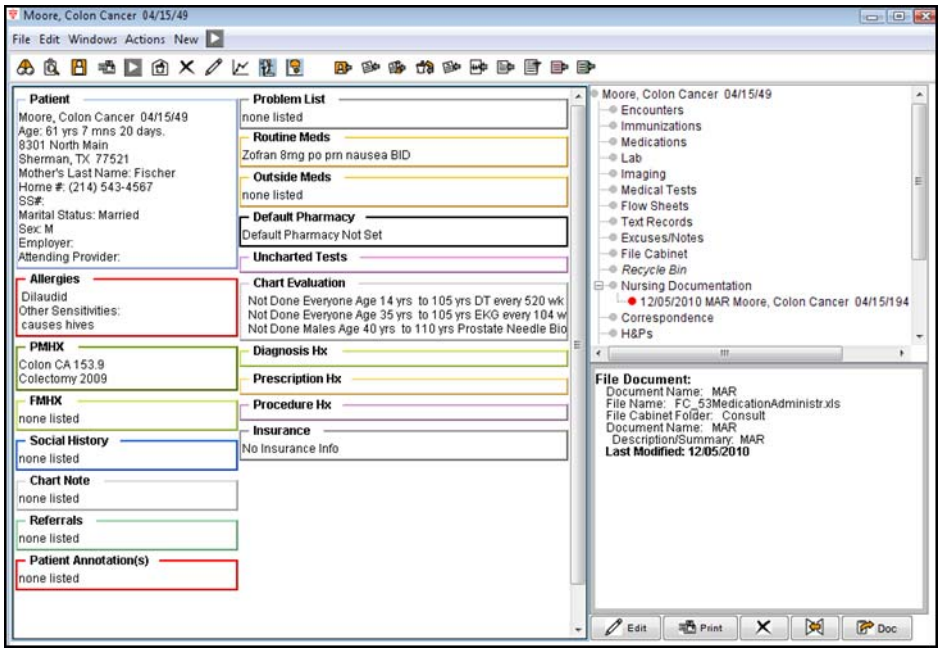


11. Click the NIC button on the right below the NOC button. The outcomes populate the Nurse Note.
    - Select the following interventions:
        - Fluid/Electrolyte Management: Regulation and prevention of complications from altered fluid and/or electrolyte levels.
        - Medication Administration: 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.

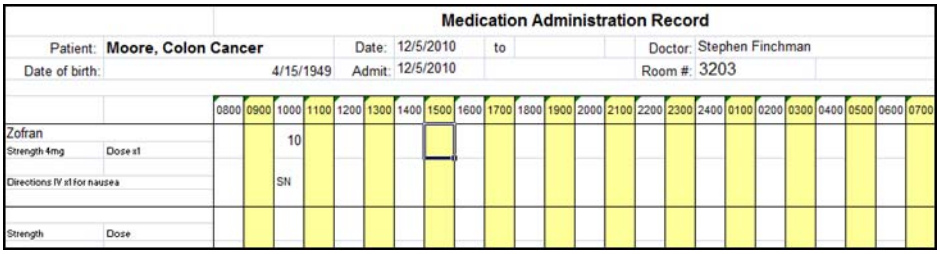


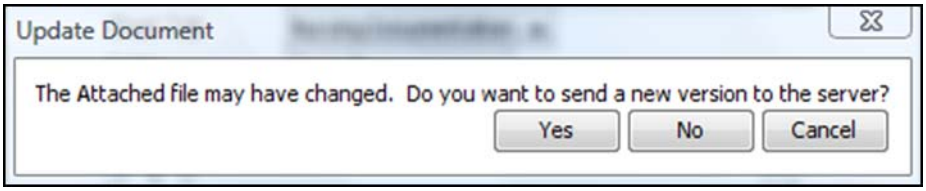
12. The physician orders Zofran 4mg IV x 1 dose for nausea. Move the Nurse Note by clicking on the minimize icon in the upper right corner. This will bring you back to the patient's chart.
    - Click the New menu and Import Items at the bottom of the list. Select Import File Cabinet Document and the 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.



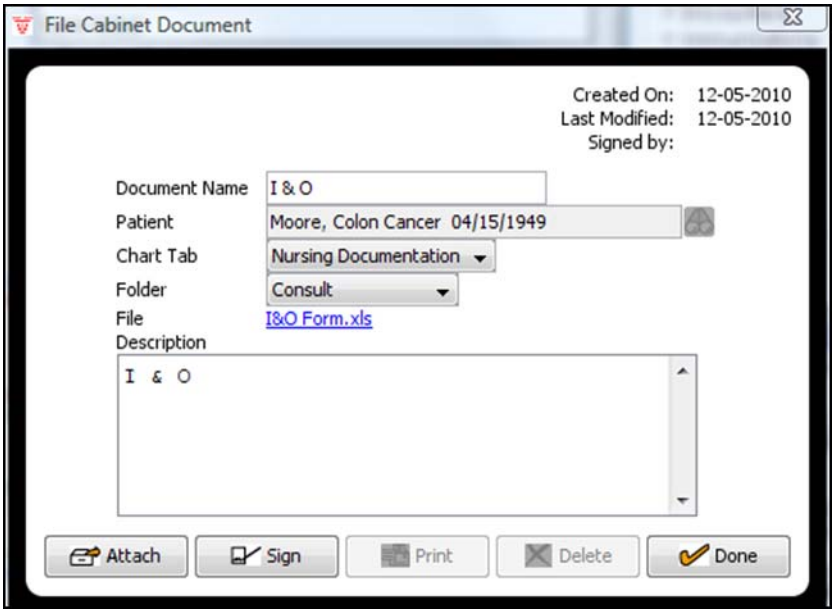


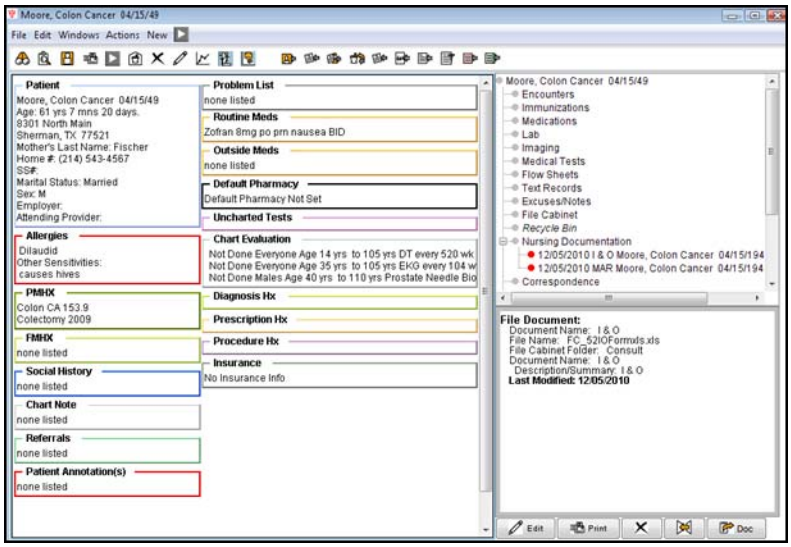
- Click on the + in front of Nursing Documentation. Highlight the MAR and click Edit at the bottom right hand side of the screen. The File Cabinet window appears. Click on the blue hyperlink next to the word File. The MAR document opens. Enter the Patient, Date of Birth, Date, Admit date, Doctor, and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





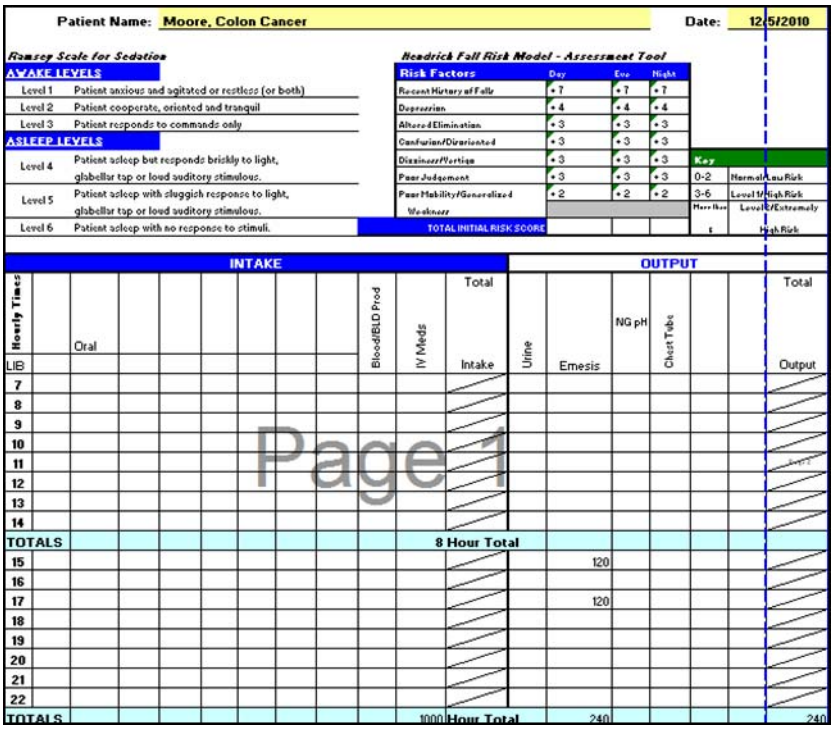
13. You are still in the Nursing Documentation area.
    - Click the New menu,select Import File Cabinet Document and the File Cabinet window appears. Type Intake and Output into the Document name. In the Chart Tab select the drop down box on the right and choose Nursing Documentation. In the Description 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.

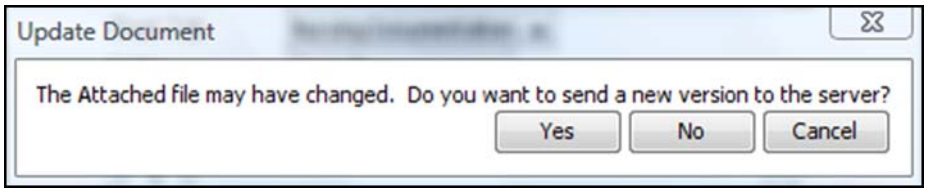




- Click on the + in front of Nursing Documentation. Highlight the Intake and Output and click Edit at the bottom right hand side of the screen. The File Cabinet window appears. Click on the blue hyperlink next to the word File. The Intake and Output document opens. Type in the Patient Name and Date.

- 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.





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.