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 on 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 7 – Ambulatory Healthcare

Chapter 7 introduces the student to documenting in an ambulatory healthcare setting. The student learns the role of an ambulatory nurse, documents in an Office Visit Note, modifies and creates addendums to the note.

Learning Outcomes

After completing Chapter 7, the student will be able to:

7.1 Describe the role of an ambulatory nurse.
7.2 Use SpringCharts to create an office visit note.
7.3 Use SpringCharts to modify an office visit note.
7.4 Carryout preparing an addendum to the office visit note.

Key Terms & Definitions

Terms and abbreviations encountered in Chapter 7:

Addendum: An addendum is a note added subsequent to the original documentation to provide supplemental clinical information.

AMA: American Medical Association. Founded in 1847, the AMA's purpose is to promote the art and science of medicine in order to improve professional and public health concerns in America's healthcare system.

CPT Codes: Current Procedure Terminology Codes. Five digit codes developed by the American Medical Association (AMA); adopted by insurance carriers and managed care companies as the means to identify common procedures, e.g., "82270—Fecal occult blood test."

Drug Formulary: A database of approved medications in drug therapy categories; includes information on preparation, safety, effectiveness, and cost.

H&P: History & Physical. Documentation of the patient's health history and physical examination, typically the initial clinical evaluation and examination of the patient that is updated with subsequent visits.

ICD-9 Codes: International Classification of Diseases, Volume 9. The international standard diagnostic classification for all data dealing with the incidence and prevalence of disease

in large populations and for other health management purposes, e.g., 474.00—Tonsillitis (chronic).

Lab Analyte: Blood test compound subject to specific chemical analysis. A lab panel is composed of multiple analytes that undergo analysis. For example, an electrolyte panel is composed of sodium, potassium, chloride, and carbon dioxide analytes.

AAACN: American Academy of Ambulatory Care Nursing. Founded in 1978, the mission of the AAACN is to advance the specialty of ambulatory nursing. Ambulatory nursing occurs in a variety of settings such as primary care clinics, physician practices, nurse practitioner practices, ambulatory surgery centers, and urgent care centers. It is characterized by brief patient encounters that include intense education to allow the patient and family to manage the patient's health.

AANP: American Academy of Nurse Practitioners. Founded in 1985, the AANP is the professional organization for nurse practitioners with a mission to promote excellence in practice, education, and research. In addition, the AANP influences healthcare policy and promotes the image of nurse practitioners.

NDC: National Drug Code. Ten-digit, three-segment number that serves as a unique identifier for each prescription drug and insulin product and indicates the medication labeler, strength, dosage form, formulation, package size, and type.

Presentation Outline

LO 7.1 The Ambulatory Nurse

Power Point Slides: 1, through 7.

LO 7.2 Building an Office Visit Note

Power Point Slides: 8, through 12.

Concept Checkup 7.1

A. What does the SOAP acronym stands for?
Answer:
S. Subjective
O. Objective
A. Assessment
P. Plan
Rationale: The middle panel of the OV note is the portion where the notes are stored in the SOAP format, containing subjective, objective, assessment, and plan categories.

B. What typically appears in the right panel of the OV screen when a navigation tab has been selected in the Office Visit window?
Answer: Pop-up text relevant to that topic appears.
Rationale: Once a tab has been selected from the navigation panel, a list of pop-up text relevant to that topic appears in the third panel of the screen.

C. What is the function of the [Copy Note] icon in the OV window?
Answer: It is used to copy previous note text to the present note
Rationale: Past encounter notes enable clinicians to refresh their memory of past visits and copy similar notes quickly into the current office visit if necessary. A clinician can highlight previous note text and copy it to the present note by clicking on the Copy Note icon.

D. How many additional custom measurements may be added to the nine basic vitals identified by SpringCharts?
Answer: Three
Rationale: Along with the nine vital signs defined by SpringCharts, three additional custom measurements can be added to the program, such as peak flow rate or oxygen saturation.

E. How do the diagnosis (Dx) and prescription (Rx) navigation tabs differ from other navigation tabs?
Answer: They use a search feature of the database rather than pop-up text
Rationale: The diagnosis (Dx) and prescription (Rx) navigation tabs differ from other navigation tabs by offering a search feature of the database rather than using pop-up text.

Concept Checkup 7.2

A. When editing prescription information in the Edit Rx window, what information is not changed?
Answer: The system's original medication information is not changed
Rationale: In the *Edit Rx* window, prescribing information, such as the dosage and frequency, can be edited for specific prescriptions without changing the system's original medication information.

B. If a provider has added a personal signature to the SpringCharts program, the digital signature can be automatically added to the _____, which is printed or electronically faxed to the pharmacy.
Answer: Prescription(s)
Rationale: If the provider has added her signature into SpringCharts, the digital signature is printed onto the prescription(s). The prescription can be sent electronically directly to the pharmacy's fax machine from SpringCharts.

C. What allows individuals other than licensed independent providers to order tests within the Office Visit screen?
Answer: Selecting an authorized prescriber in the *User Preferences* window
Rationale: For a non-authorized prescriber to order tests in the Office Visit screen, the user must have first selected an authorized prescriber in the User Preferences window—(File>Preferences>User Preferences). Once set up, the program allows the user to order tests.

D. What is selected first to choose a procedure?
Answer: Procedures are chosen by first selecting the [Proc] navigation tab
Rationale: Procedures are chosen by first selecting the Proc navigation tab then the correct procedure category.

LO 7.3 Modifying the OV Note

Power Point Slides: 13, 14.

Concept Checkup 7.3

A. Who can unlock or edit an Office Visit Note once it is locked by selecting *Permanent Sign & Lock?*
Answer: No one
Rationale: Once the office visit is locked by selecting Permanent Sign & Lock, it cannot be unlocked or edited, even by the individual who permanently locked it. However, an addendum can be placed at the bottom of an existing Office Visit Note, if needed.

B. When an addendum to an OV note is created, where is it placed?
Answer: At the bottom of the existing OV Note.
Rationale: The addendum is placed at the bottom of the existing office visit note. The program automatically places a date-, time-, and initial-stamp on the addendum when it is saved. More than one addendum can be placed in the same Office Visit Note.

LO 7.4 Creating an Addendum

Power Point Slides: 15, 16.

Chapter 7 Review Key

Using Terminology

1. F
2. H
3. J
4. A
5. G
6. I
7. K
8. L
9. D
10. B
11. C
12. E

Rationales:

1. The middle panel of the OV screen in SpringCharts is the portion where the notes are stored in the *SOAP* format, containing subjective, objective, assessment, and plan categories.
2. In SpringCharts, the Body Mass Index (BMI) is automatically calculated based upon the patient's height and weight. BMI is the measurement of choice for studying obesity.
3. The "date of service" is important for billing and must accurately represent the date of the encounter, even if the note itself was created on a date subsequent to the actual encounter with the patient.
4. ICD-9 codes stands for the *International Classification of Diseases, Volume 9*. The ICD has become the international standard diagnostic classification for all health data dealing with the incidence and prevalence of disease in large populations and for other health management purposes.
5. CPT codes stands for *Current Procedure Terminology*. The CPT five-digit codes were developed by the American Medical Association (AMA) and have been adopted by insurance carriers and managed care companies as the means to identify common procedures.
6. A pending test is a diagnostic test that has been ordered in SpringCharts, but does not yet have the results.
7. A lab analyte is a blood test compound that is subject to its own specific chemical analysis. A lab panel is composed of multiple analytes that undergo analysis. For example, an electrolyte panel is composed of sodium, potassium, chloride, and carbon dioxide analytes.
8. The "date created" is the computer system date that is hard coded to the OV note when the note is first created and **cannot be altered**. It provides the legal means of determining the date of documentation.
9. The SpringScripts icon, shown as the last of four buttons in the prescription window,

allows the prescription to be sent electronically to *SureScripts*, a Web-based e-prescribing clearinghouse. SureScripts connects a network of thousands of primary care providers, pharmacists, and payors nationwide enabling them to exchange health information and manage prescriptions paperlessly. Currently, prescribers are able to send e-prescriptions to any of 51,000 retail pharmacies and six of the largest mail order pharmacies through SureScripts.

10. The American Medical Association (AMA) was founded in 1847 with the purpose of promoting the art and science of medicine.
11. Once the office visit is locked, by selecting *Permanent Sign & Lock*, it cannot be unlocked or edited, even by the individual who permanently locked it. However, an addendum can be placed at the bottom of an office visit note, if needed.
12. Perhaps the most common encounter with the patient in an ambulatory setting is the office visit. The office visit is an encounter with a healthcare provider during which the patient's chief complaints are evaluated.

Checking Your Understanding

13. T
14. F
15. T
16. F
17. F
18. T

Rationales:

13. The navigation tabs along the right side of the screen enable the provider to proceed through the office visit in a logical manner; however, the various tabs may be selected in any order. Tabs include chief complaint (*CC*), history of present illness (*PI*), review of systems (*ROS*), face sheet (*FS*), vitals, exam, diagnosis (*Dx*), prescriptions (*Rx*), tests, procedures (*Proc*), other treatment (*Other Tx*), and follow-up and reminders (*F/U-Rem*).
14. The use of templates is the most rapid way of building documentation in an Office Visit.
15. SpringCharts comes installed with the complete American Medical Association (AMA) library of ICD-9 codes and CPT codes. However, each outpatient clinic must activate specific codes for use based on its specialty. Restricting the number of ICD-9 and CPT codes shortens the selection time for the end user.
16. SpringCharts comes installed with the complete American Medical Association (AMA) library of ICD-9 codes and CPT codes. However, each outpatient clinic must activate specific codes for use based on its specialty. Restricting the number of ICD-9 and CPT codes shortens the selection time for the end user.
17. The installed ICD-9 and CPT libraries are electronic not hardbound.
18. Once the office visit is locked, by selecting *Permanent Sign & Lock*, it cannot be unlocked or edited, even by the individual who permanently locked it. However, an addendum can be placed at the bottom of an Office Visit Note, if needed.

19. S: Subjective
    O: Objective
    A: Assessment
    P: Plan

Rationale:

The middle panel of the OV screen in SpringCharts is the portion where the notes are stored in the *SOAP* format, containing subjective, objective, assessment, and plan categories.

20. B

Rationale:

An OV window has three main sections. Typically, the left-side panel displays the patient's Face Sheet overview. This panel allows the practitioner to view the Face Sheet items without having to exit the Office Visit display. Any of the Face Sheet categories can be added into the Office Visit Note to document that the provider discussed these issues with the patient.

21. A

Rationale:

History & Physical often referred to as an H&P, it is the documentation of the patient's health history combined with the physical exam. The H&P is the initial clinical evaluation and examination of the patient.

22. C

Rationale:

The history of the present illness is an account of the onset, duration, severity, and associated characteristics of the presenting illness. It may include aggravating and alleviating factors. The ambulatory care nurse or the primary care provider may conduct this portion of the interview. During this phase of the assessment, the healthcare professional verbally probes for causes, aggravating factors, relieving factors, and past similar conditions. Because the present illness information is obtained during the interview with the patient, the notation is stored as part of the *subjective* area of the SOAP note.

23. A, B, C

Rationale:

To discontinue a medication that a patient is currently receiving, an *Encounter* must be created in the patient's EHR. Medications may be discontinued from within an Office Visit, Nurse Note, new TC note, messages, or anywhere in SpringCharts where the patient's drug list can be

accessed. To discontinue a patient's medication, the clinician selects the specific prescription and highlights it to open the *Edit Rx* window. This graphic user interface (GUI) enables the practitioner to input a *Date Stopped* and a *Reason Stopped*. The *Reason Stopped* can be selected from preset pop-up text.

24. B

Rationale:

In the lower left window of the F/U section of the OV screen the user will find a [create a reminder] icon that enables a *ToDo/Reminder* item to be sent to another person in the clinic or to be set as a personal reminder.

25. C

Rationale:

The Review of Systems, often abbreviated as ROS, is a critical element of the health history and is conducted during the patient interview. During the review of systems, the nurse questions the patient about each body system to identify a history of abnormal conditions.