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 8 – Ambulatory Healthcare Exercises

The last chapter of level two provides the student with eight exercises set in ambulatory healthcare. The student practices documenting in the EHR program using features learned in the previous chapter. They create, modify, and prepare addendums to office visit notes and generate reports and excuse notes.

Learning Outcomes

After completing Chapter 8, the students will be able to:

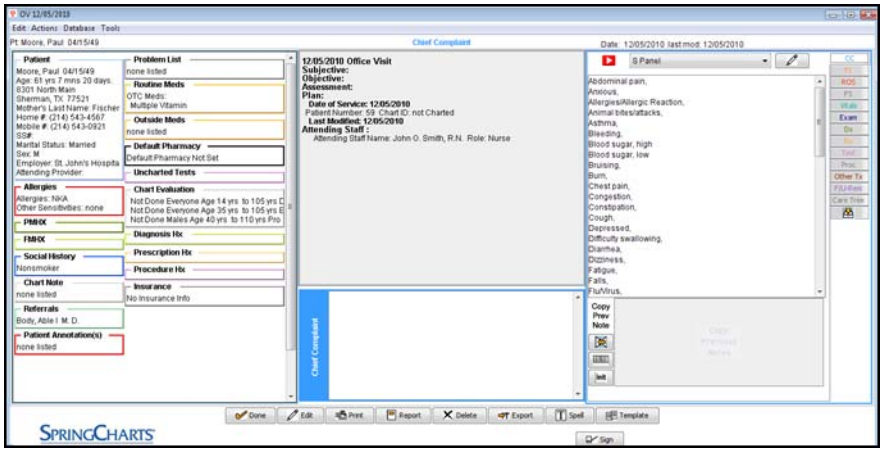
8.1 Use Springcharts to create an office visit note.
8.2 Use Springcharts to modify an office visit note.
8.3 Carryout generating office visit reports.
8.4 Use Springcharts to construct an excuse note.
8.5 Use Springcharts to make an addendum to the office visit note.

Presentation Outline

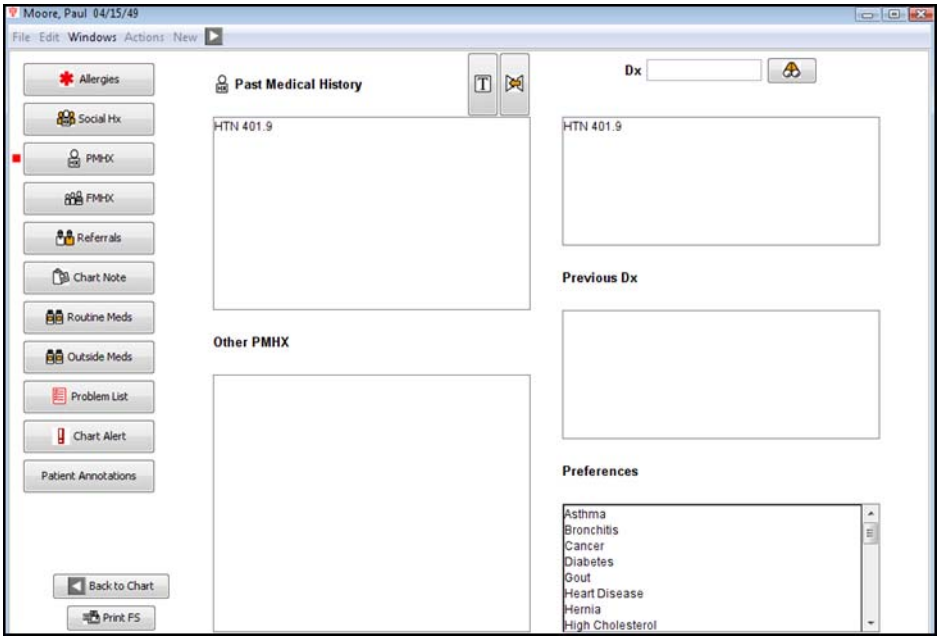
Exercise 8.1

Building an *Office Visit* Note (Part 1—Ambulatory Care Nurse)

1. Open the patient's chart with your name. On the chart menu select *New>New OV*. In the *Office Visit* screen, notice the face sheet information on the left-hand side of the window.

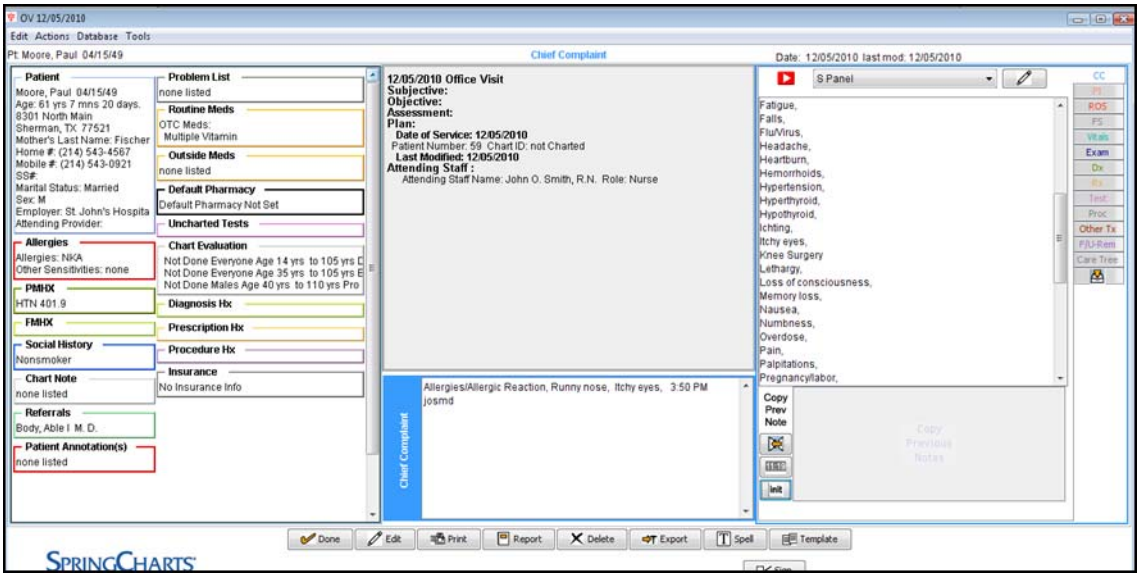


2. Add another past health history item to the face sheet by right-clicking in the *PMHX* section and selecting *Edit*. In the face sheet window, choose another medical condition either from the list of *Preferences* in the lower left or search for a new medical diagnosis in the upper right. Click the [Back to Chart] button in the lower left.

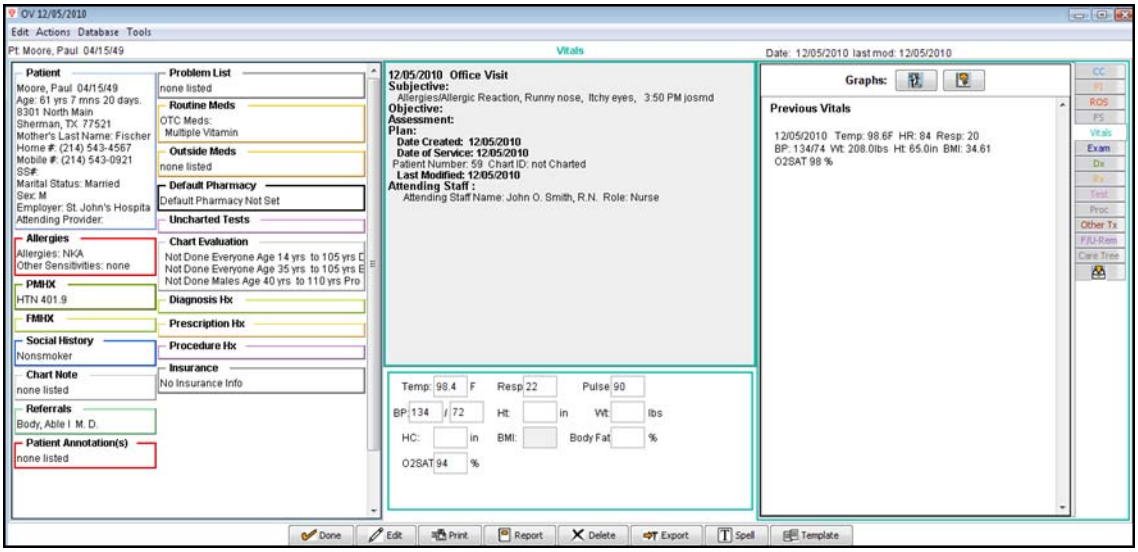


Note: The *OV* screen is positioned behind the patient's chart window; you will see the top portion of the window. To bring it to the foreground simply click on the top edge of the *OV* window.

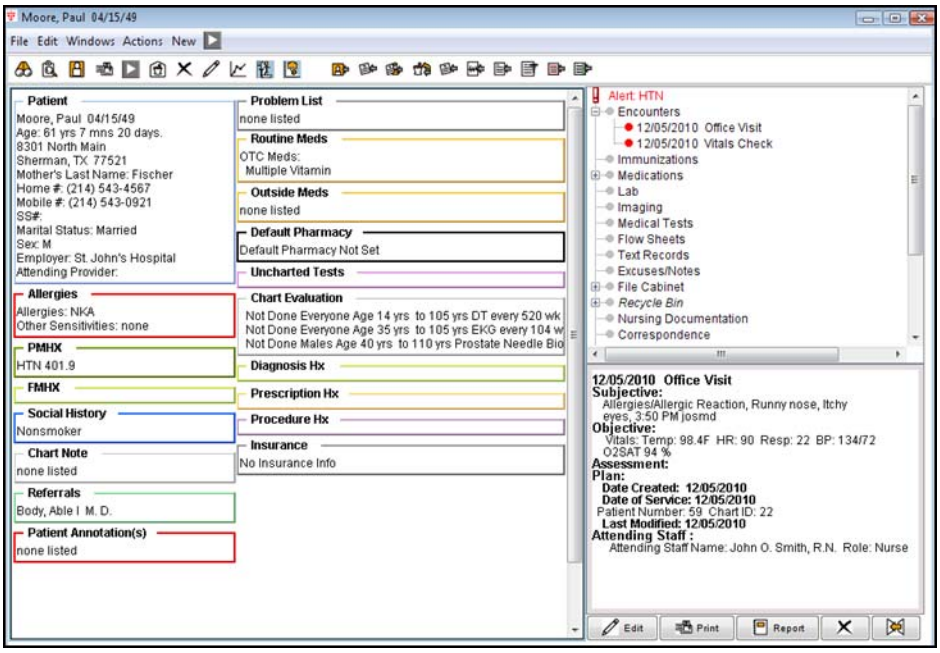
3. A patient is visiting the nurse practitioner because of a flare-up of seasonal allergies and the ambulatory care nurse is performing an initial assessment. Click on the [CC] navigation tab on the right side of the *Office Visit* screen. In the *S Panel* of pop-up text that appears in the right-hand panel select *Allergies/Allergic Reaction, Runny nose, Itchy eyes*. The words are added to the lower middle work area. Click on the [time] and [initial] insert buttons in the lower right section to add the time and your initials to the note.



4. Select the [Vitals] navigation tab on the left. All previously created text is now added to the *SOAP* format. Create and enter vital sign information on your patient. (Documentation of head circumference (HC) is not needed since this is not a pediatric patient.) BMI (body mass index) is grayed out because the program calculates this item from the height and weight.



5. Click on the [Done] button in the *OV* screen. Click the [Save and Skip Billing] button. The note will be finished later and a routing slip created at that time for this office visit. The *OV* note has been added to the list of encounters in the care tree of your patient's chart. Close the chart.

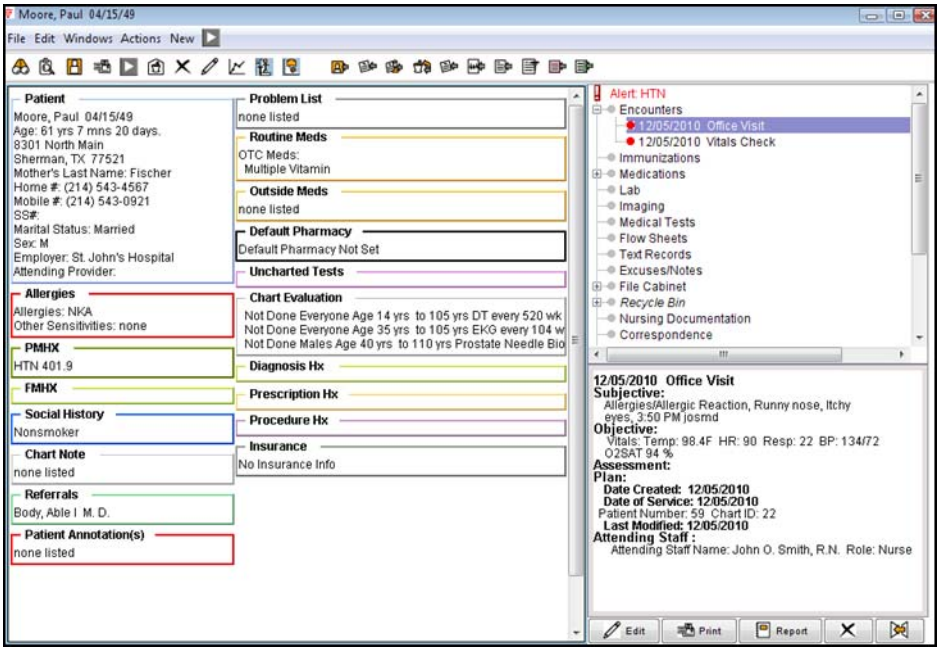


Exercise 8.2

Building an *Office Visit* Note (Part 2—Primary Care Provider)

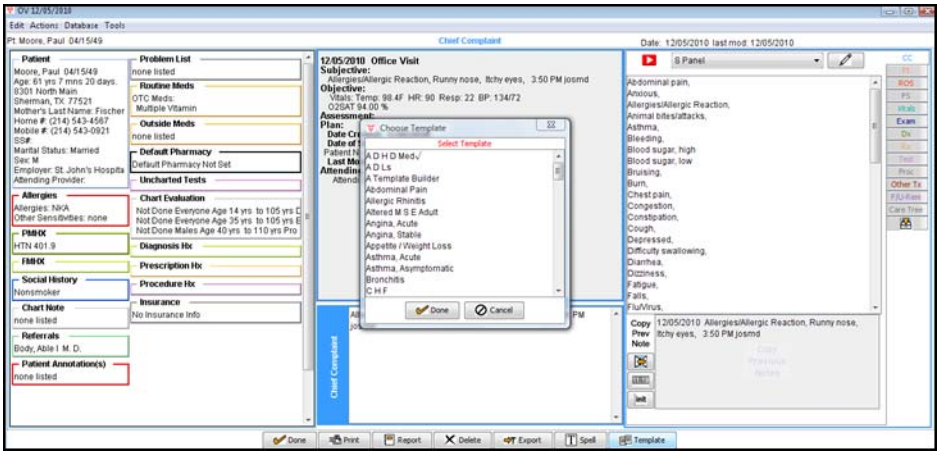
Note: Now that the ambulatory care nurse has completed the initial assessment, the office visit is handed over to the nurse practitioner. The nurse practitioner does not start a new *office visit* note (as the ambulatory care nurse did), but edits the existing *office visit* note.

1. Open your chart. Click on the "+" sign beside the *Encounters* heading in the care tree. Select the office visit entry started in Exercise 8.1. Click on the [Edit] button at the bottom of the window.

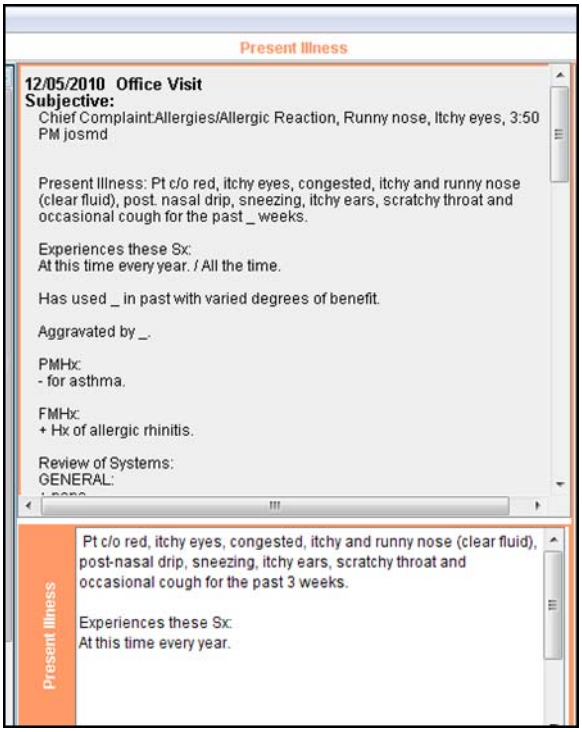


Note: In the office visit screen the provider can view the information already documented by the ambulatory care nurse. SpringCharts has office visit templates for some of the most common ailments, enabling provider to quickly select the appropriate template to populate the office visit note. The provider individualizes the note to reflect this patient's condition.

2. Click on the [Template] button in the bottom right corner of the *office visit* screen. From the displayed list select: *Allergic Rhinitis*. Notice the entire note has been built very quickly.

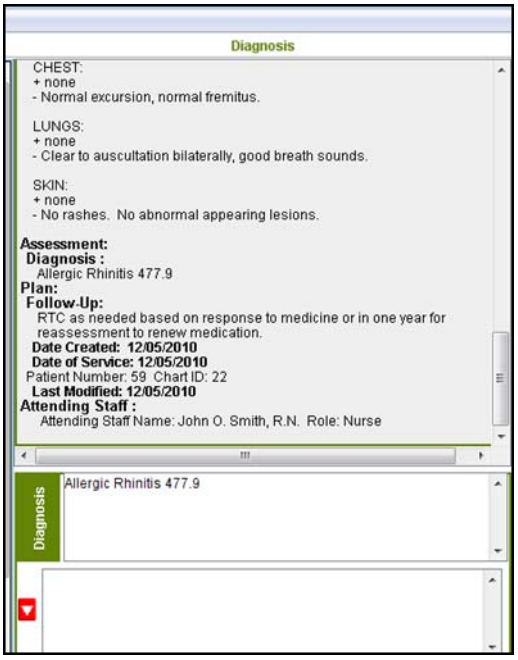


3. The nurse practitioner completes the note for this patient. Click on the *PI* navigation tab on the right side. The text from the template appears in the lower middle work area. Move the scroll bar to the top of this window and complete the following sentence: *Pt c/o red, itchy eyes, congested, itchy and runny nose (clear fluid), post-nasal drip, sneezing, itchy ears, scratchy throat and occasional cough for the past weeks*. Place your curser in front of the word weeks, highlight the underscore mark and type: 3. Complete the missing information in the remainder on the *PI* section by either adding or deleting information.

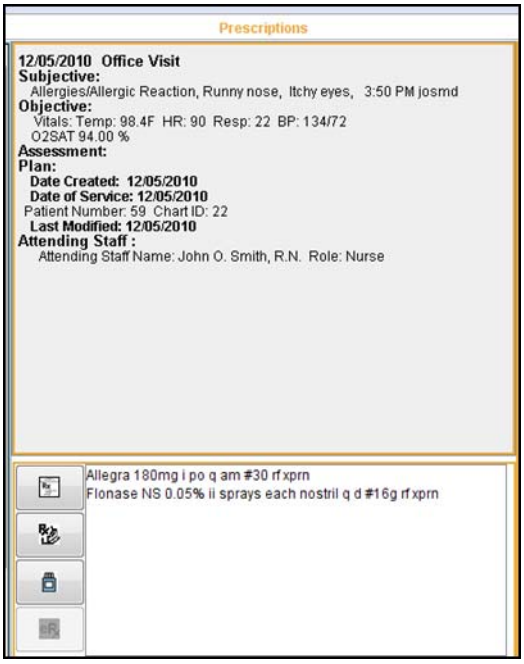


Note: The primary care provider continues through the entire note making changes and additions where necessary for this specific patient.

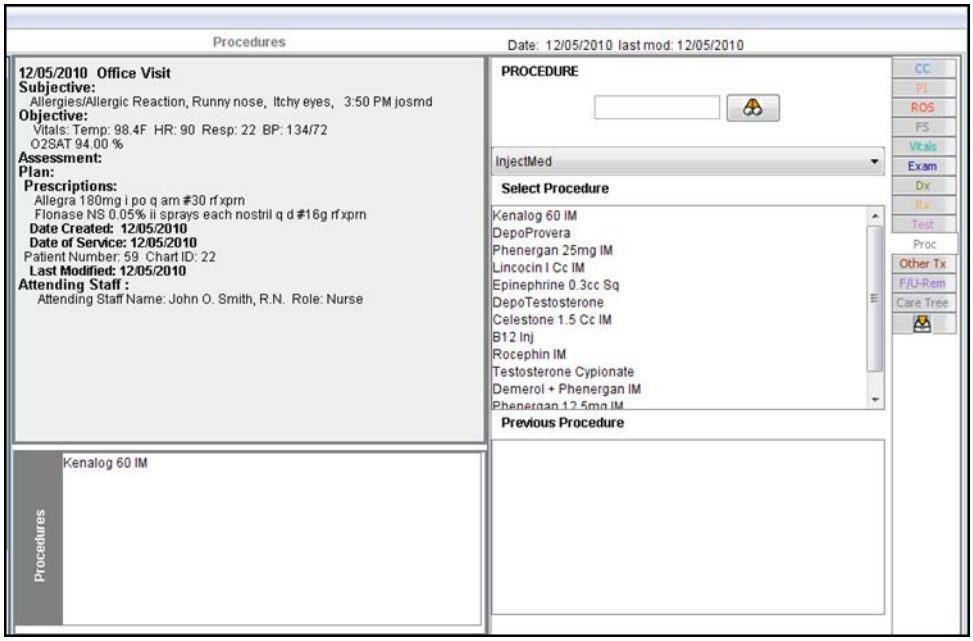
4. A diagnosis must be added. Click on the *Dx* navigation tab on the right side. This patient has had allergies in the past. The diagnosis is in the *Previous Diagnoses* window in the lower right corner. Select *Allergic Rhinitis 477.9* from this list.



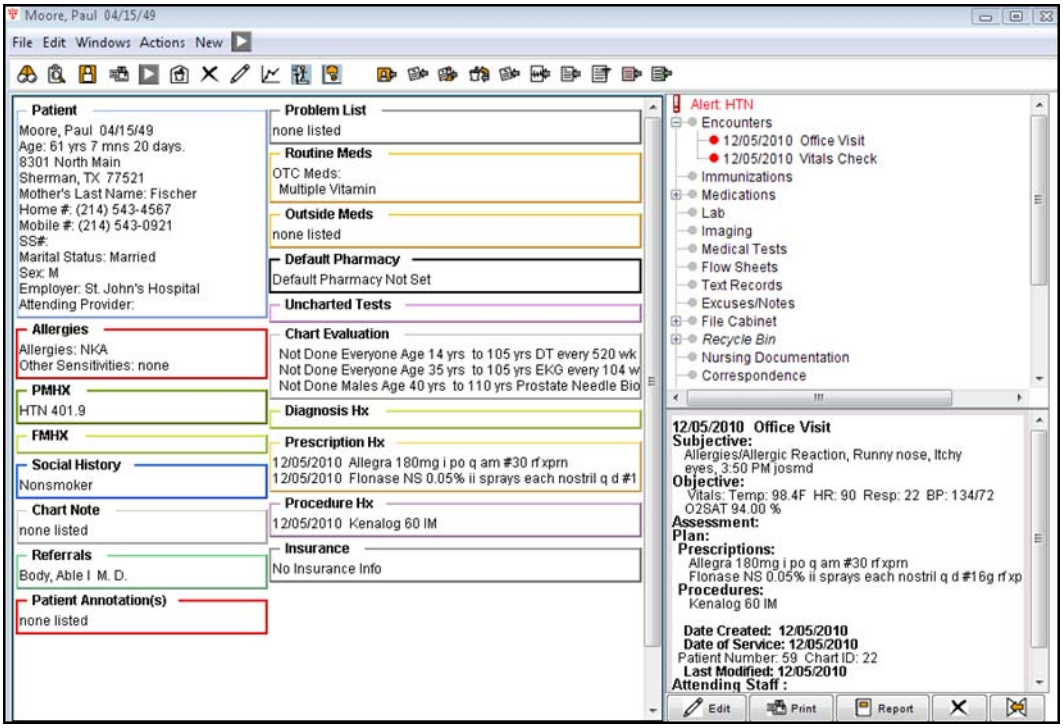
5. Next the nurse practitioner prescribes a medication. Click on the *Rx* navigation tab. Once again, medications for allergies have been prescribed in the past. Select *Allegra* and *Flonase* from the *Previous Prescription* window in the lower right corner.



6. The nurse practitioner wants the ambulatory care nurse to administer a subcutaneous allergy injection. Choose the *Proc* navigation tab on the right side. Click on the drop-down arrow beside the *All* category on the upper right side. Select the category: *InjectMed*. From the list displayed below, choose *Kenalog 60 IM.*



7. Click on the [Done] button in the *OV* screen. Click the [Save and Skip Billing] button. The *OV* note has been added to the list of encounters in the care tree of the patient's chart. Close the chart.

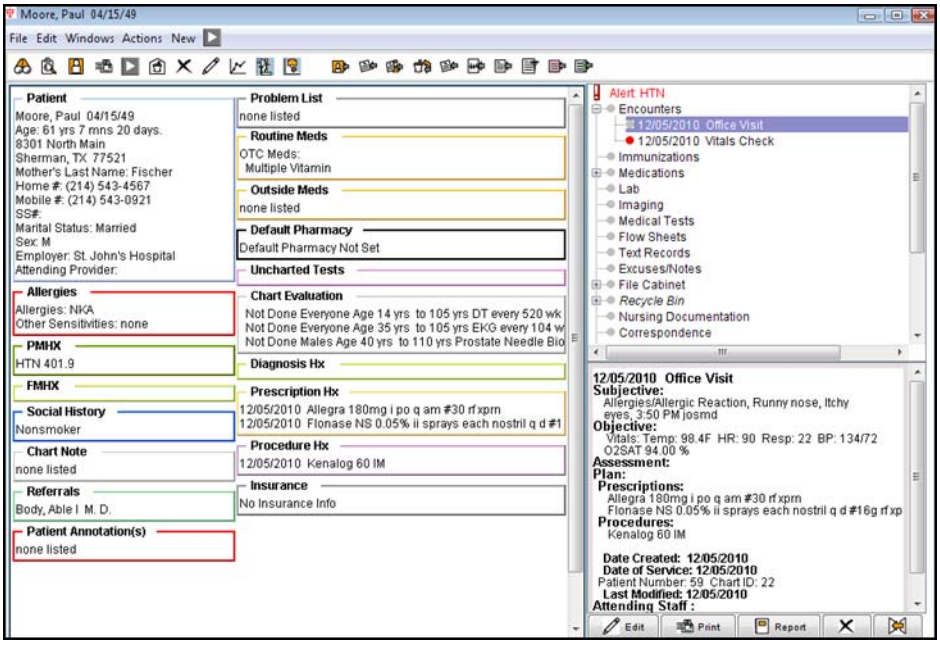


Exercise 8.3

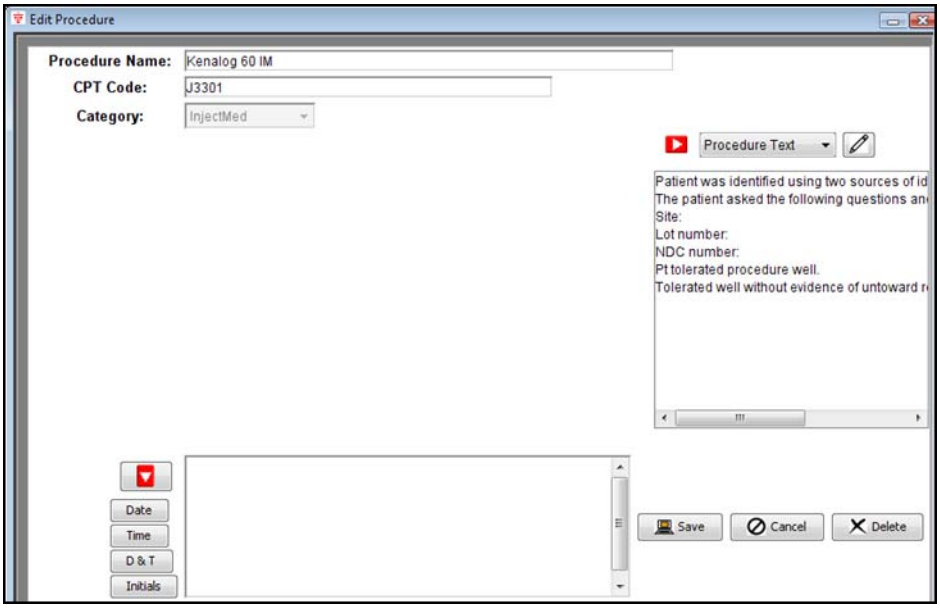
Building an *Office Visit* Note (Part 3—Ambulatory Care Nurse)

Note: The nurse practitioner communicates with the ambulatory care nurse regarding administration of the allergy injection.

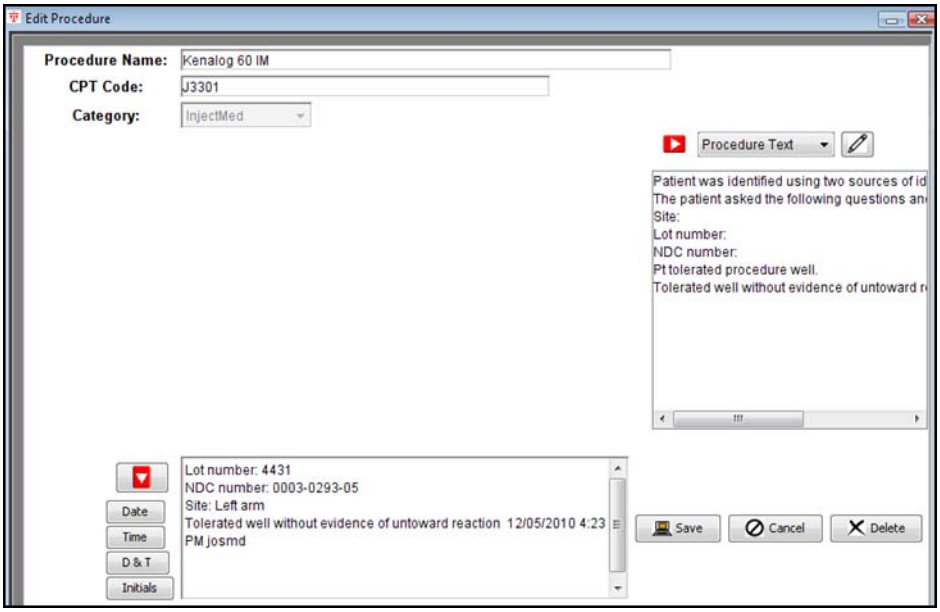
1. Open your chart. Click on the "+" sign beside the *Encounters* heading in the care tree. Select the *office visit* note you edited in Exercise 8.2. Click on the [Edit] button at the bottom of the window.



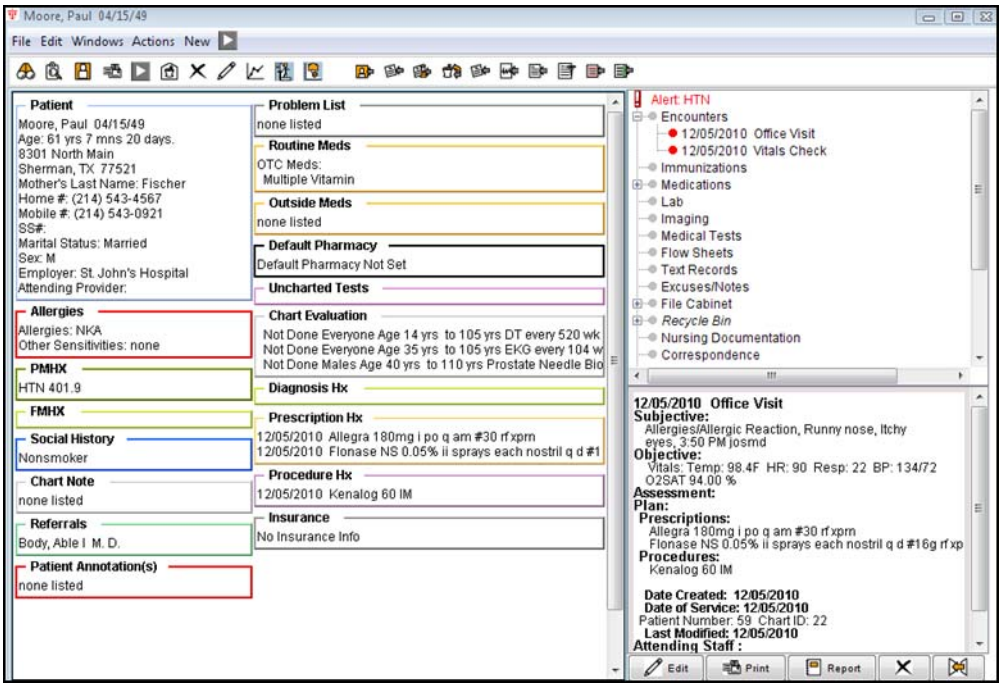
2. Click on the *Proc* navigation tab on the right side. Click on *Kenalog* injection in the lower center work area.



3. In the *Edit Procedure* window document the injection that you just administered. Choose the pop-up text: *Lot number* and type in the lot number (4331). On the next line select the pop-up text: *NDC number* and type the National Drug Code (0003-0293-05). On the next line choose the pop-up text: *Site* and type: *Left arm*. On a new line document the patient's response to the injection; select the pop-up text: *Tolerated well without evidence of untoward reaction.* Click on the [D & T] button and the [Initials] button. Click the [Save] button.



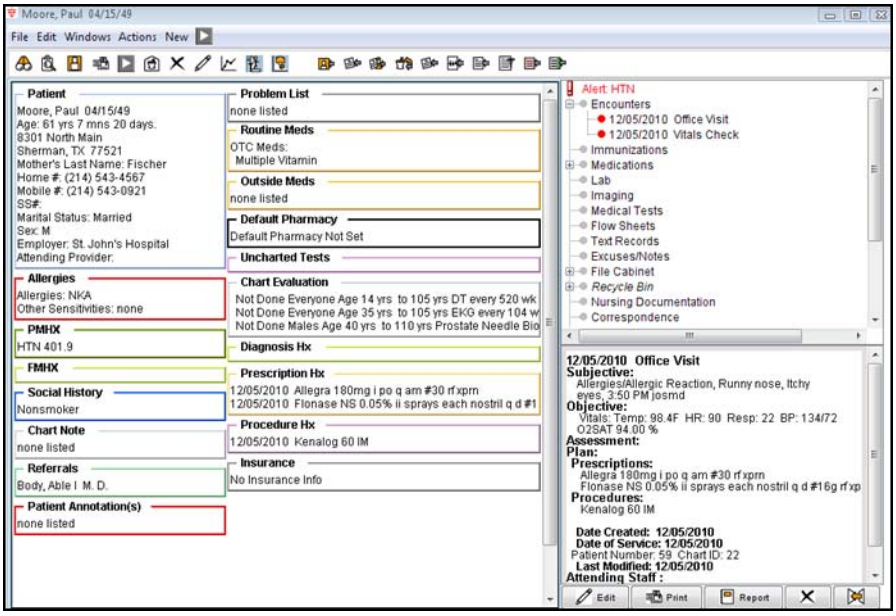
4. Click on the [Done] button in the *OV* screen. Click the [Save and Skip Billing] button. It is the nurse practitioner's responsibility to complete the routing slip and bill for the encounter. The *OV* note has been added to the list of encounters in the care tree of your patient's chart. Close the chart.



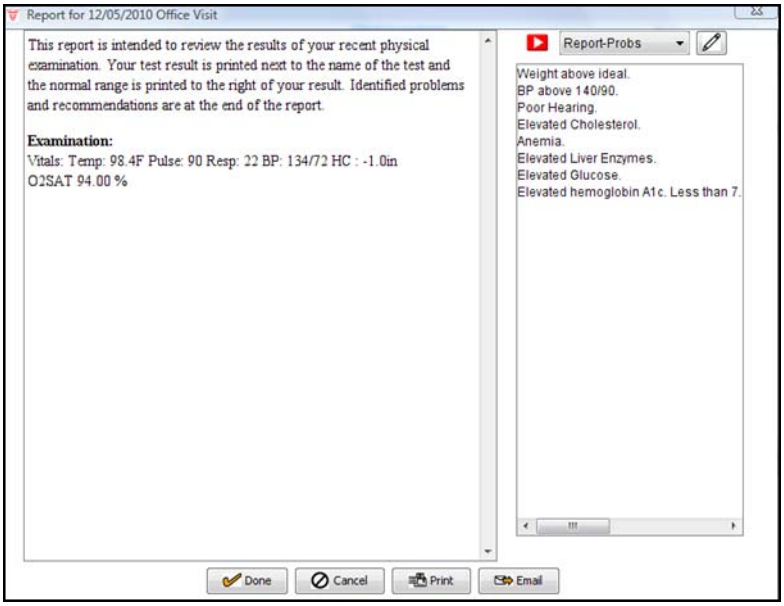
Exercise 8.4

Creating an Examination Report

1. Open your patient's chart. Highlight the recent *office visit* note. Click on the [Report] button at the bottom of the patient's chart screen. The program automatically opens the *OV* window and displays the examination report on the screen.



2. Print the report by clicking on the [Print] button in the report window. SpringCharts automatically places the letterhead, patient's name and address, the greeting, and introduction in the report letter. If you are sending an electronic document to your instructor, choose the pdf printer and email the document.

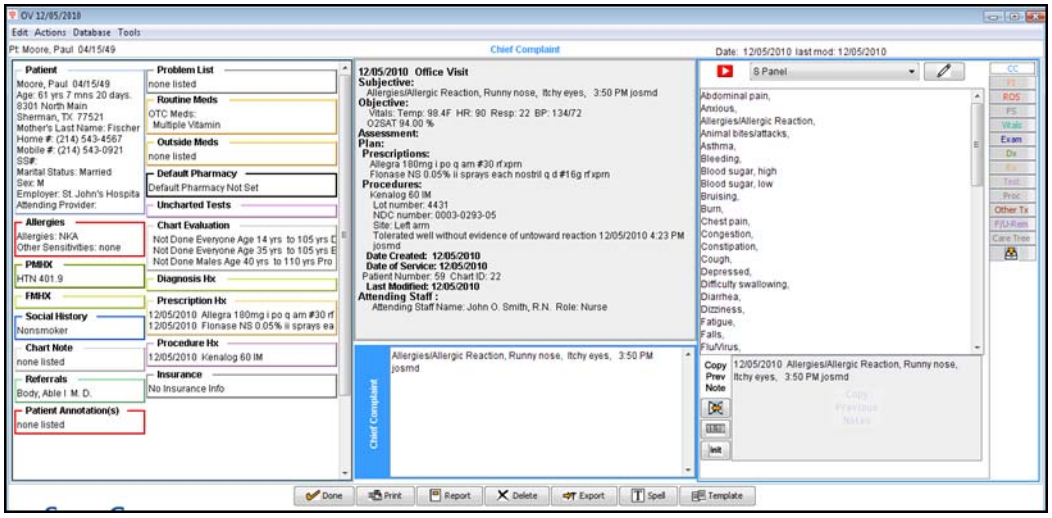


3. Close the report window. Submit the printed report to your instructor.

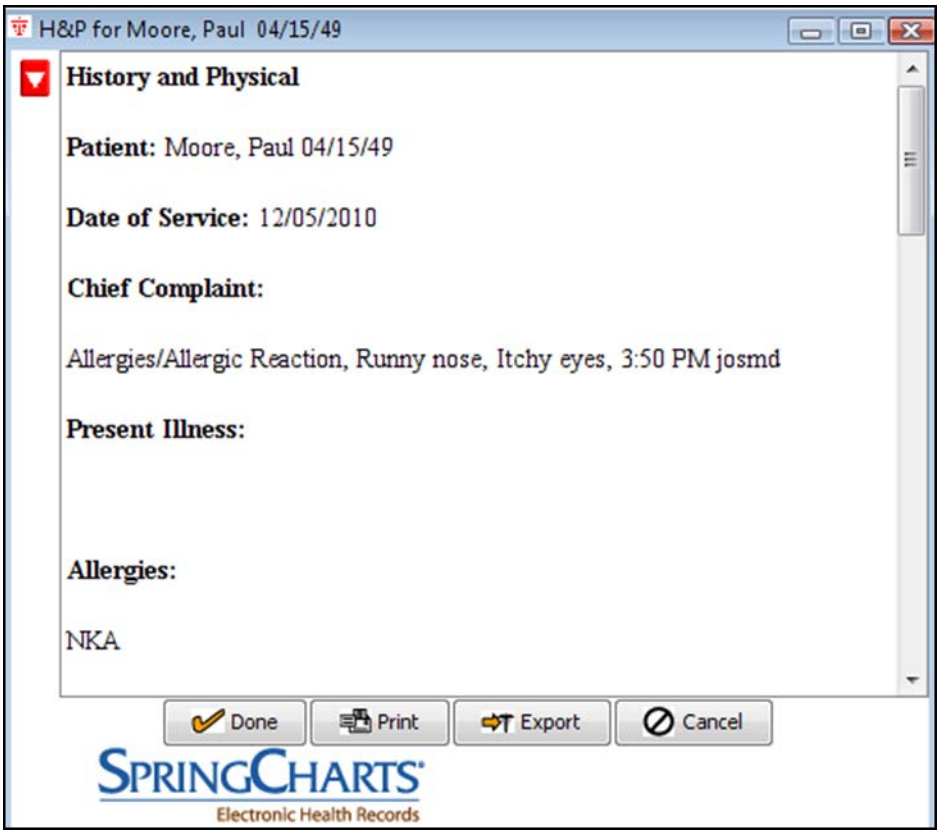
Exercise 8.5

Creating an H&P Report

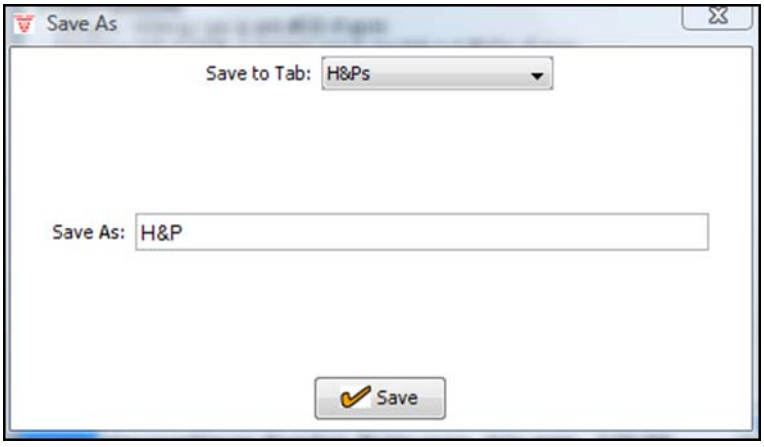
1. In the *OV* window, click on the Tools menu and select *H&P.* The H&P contains relevant information from the current physical exam as well as documentation from the patient's face sheet.



2. Print the report and submit to your instructor or choose the pdf printer and email the document to your instructor.



3. Click the [Done] button and save the H&P under the *H&Ps* category in the care tree.

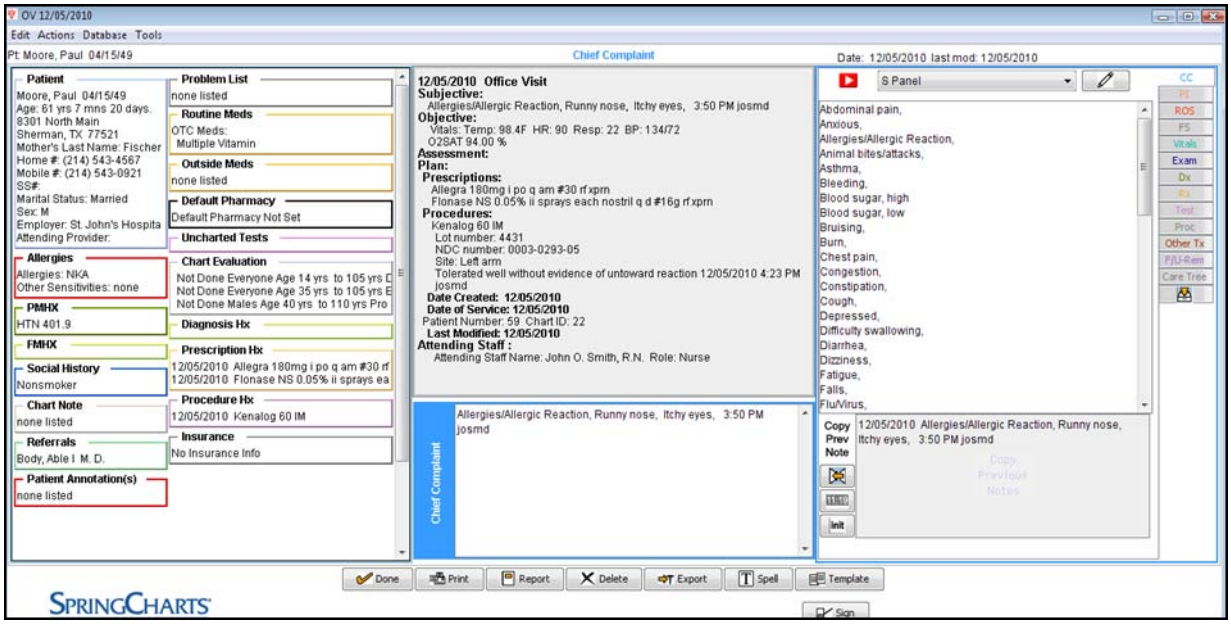


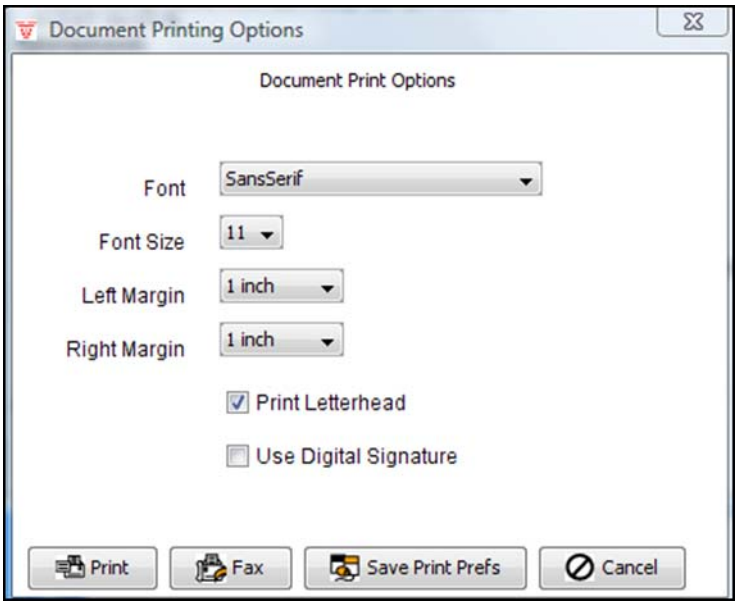
(See Appendix A—*Sample Documents*; Document 7. *History & Physical Report*)

Exercise 8.6

Creating an OV Note Report

1. With your *office visit* window still open, click on the [Print] button and print the entire *office visit* note. (To submit your coursework electronically please see section Submitting Assignments Electronically on page xxvii in the front matter of the text.) The *OV* note is not pre-addressed to any entity and may be sent to a referring primary care provider or other consultant.

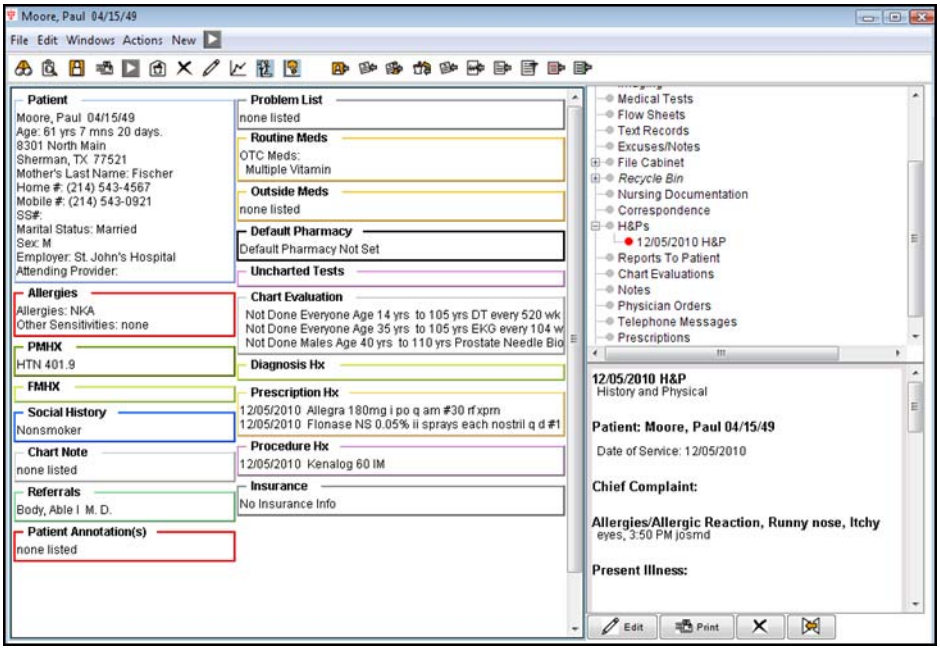




2. Submit the printed *OV* note to your instructor. *Office visit* notes can be added to the body of a letter and printed, faxed, or e-mailed to the patient or others.

3. Close the *OV* window.

4. In the patient's chart, the *Report to Patient* and the *Office Visit* saved as *Encounters* in the care tree and the *H&P* saved under the *H&P* category in the care tree. Click on the "+" sign beside the *H&P* category and highlight the recently created H&P report. The report is seen in the lower right quadrant where it can be edited and printed.



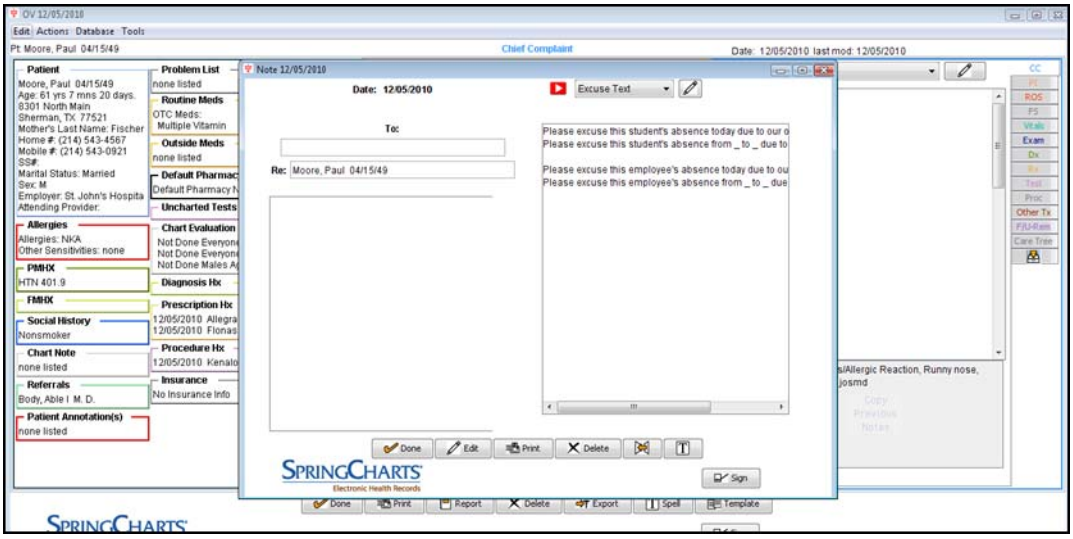
5. Close the patient's chart.

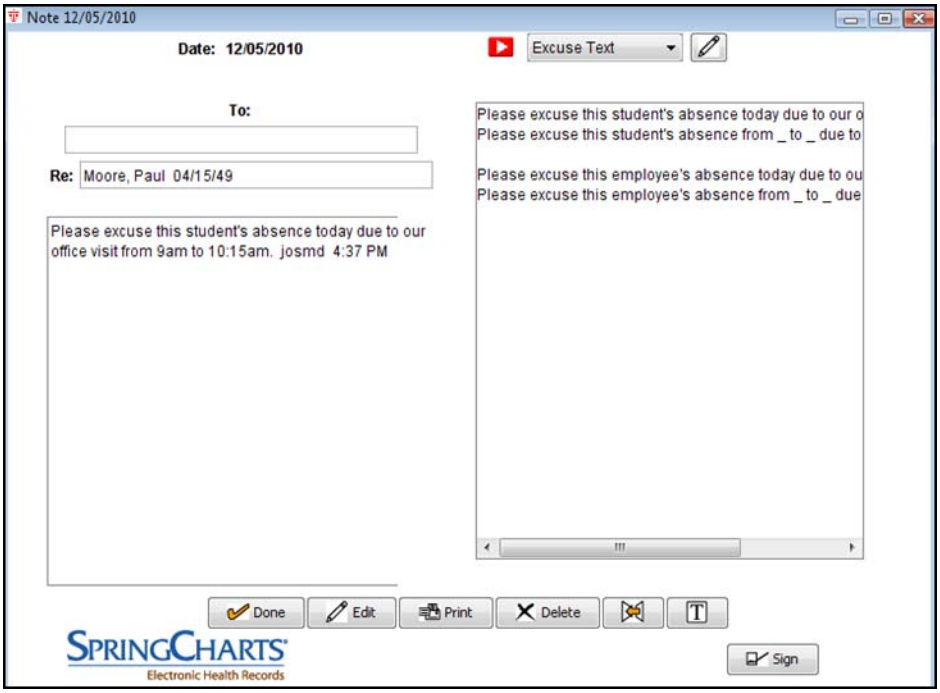
(See Appendix A—*Sample Documents;* Document 8. *Office Visit Report.*

Exercise 8.7

Creating an *Excuse* Note

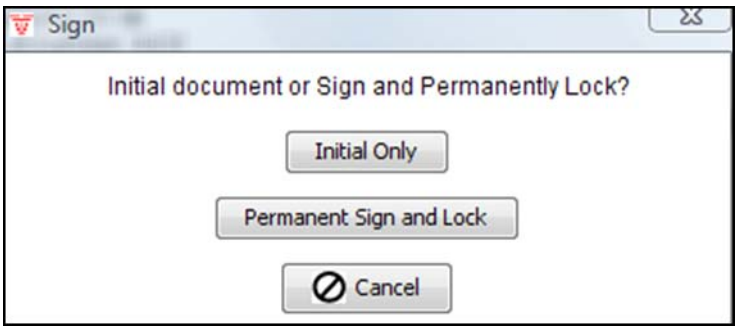
1. Open your patient's chart. Open the recent office visit note by clicking on the '+' next to Encounters. Click on the office visit and click Edit below. Click on the *Tools* menu inside the office visit screen and select *New Excuse/Note/Order* then *New Excuse/Note*. In the *To* area type "To whom it may concern". In the *Note* window select pop-up text to compose an excuse for the student's absence from college for the time that the student was at the doctor's office. Complete the missing information. Add your initials to the note by selecting the [Sign] button.

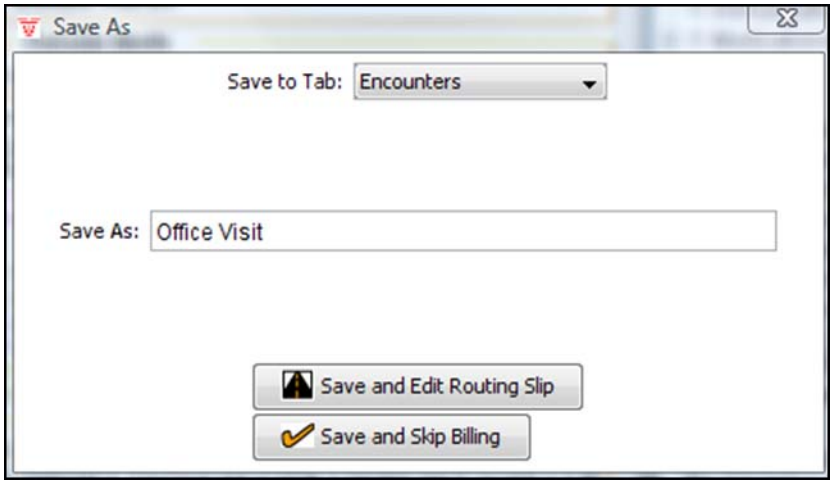




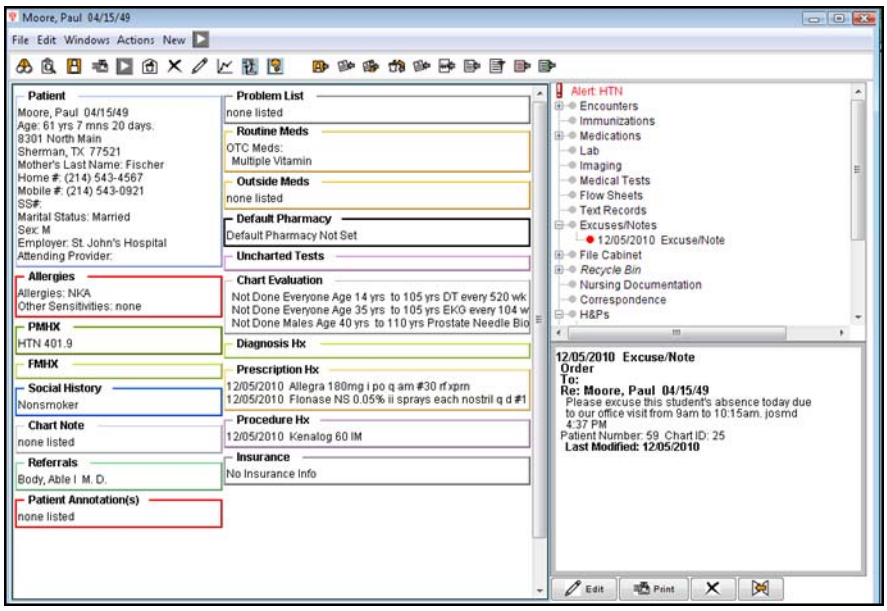
1. Print the excuse note and submit to your instructor or choose the pdf printer and email the document to your instructor. Click on the [Done] button.

2. Click on the [Sign] button in the lower right section of the OV screen. Select *Permanent Sign and Lock.* Click the [Done] button and skip billing.

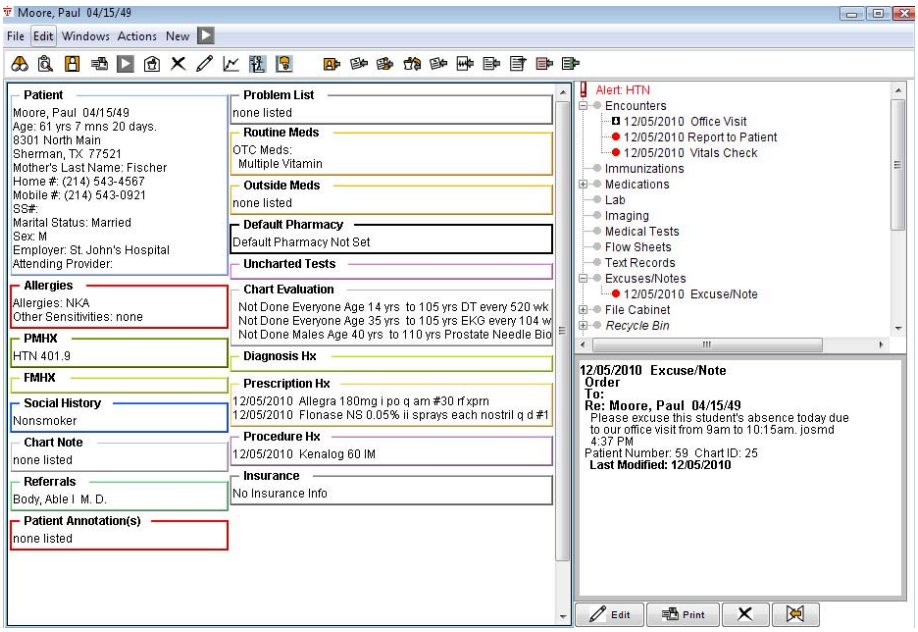




3. Click on the "+" sign to the left of the *Excuses Notes* category in the care tree and see the saved note. The note is displayed in the lower right window.



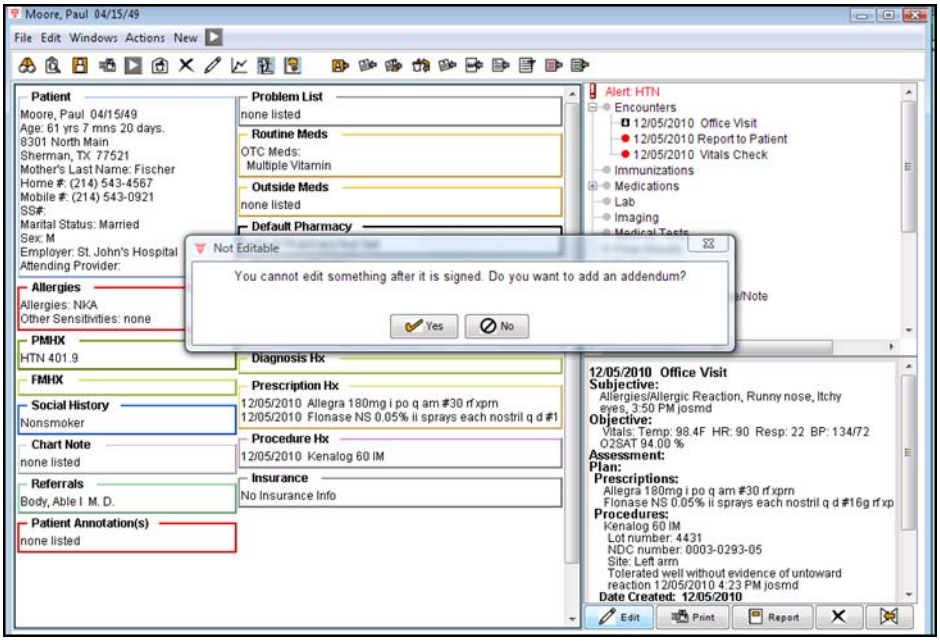
4. Click on the "+" sign to the left of *Encounters.* A black "lock" icon is present to the left of the recent *office visit* note. No user is able to modify a locked *office visit* note.



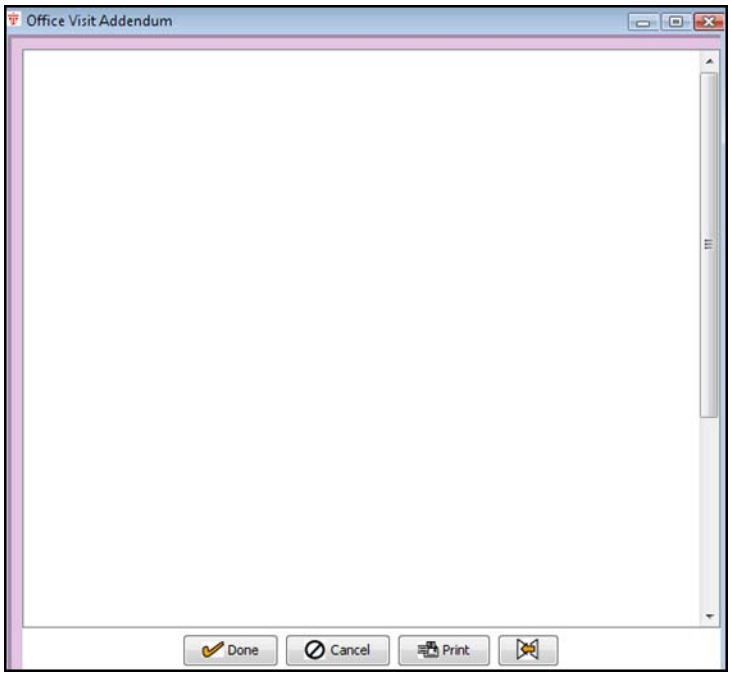
Exercise 8.8

Preparing an Addendum

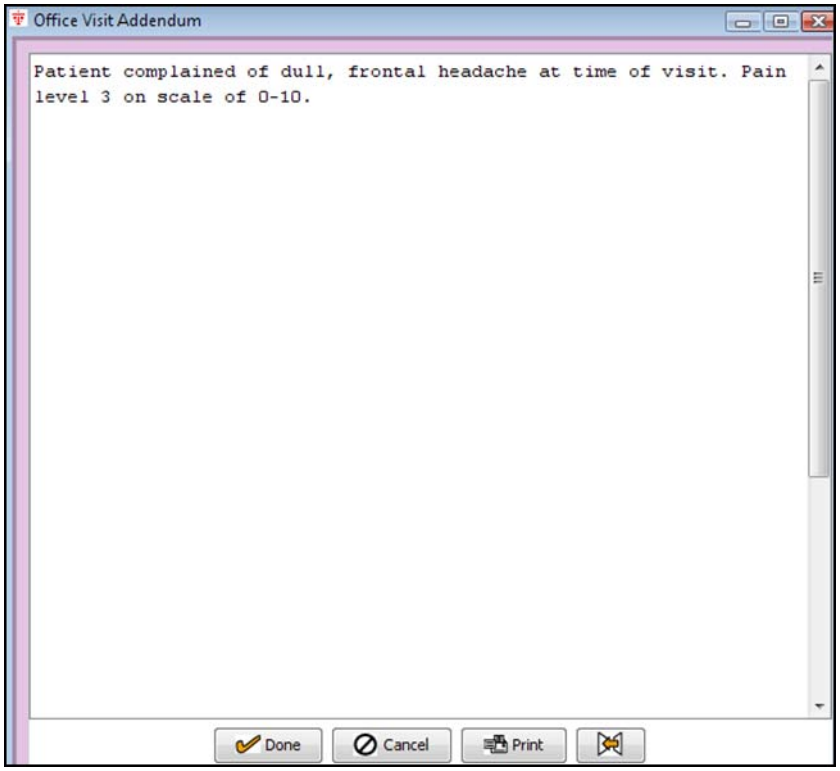
1. Open your patient's chart. Open the recent office visit note that you signed and locked by clicking on the [Edit] button at the bottom of the screen.



2. A warning note appears stating that you are not able to edit this note. Create an addendum. Click the [Yes] option.

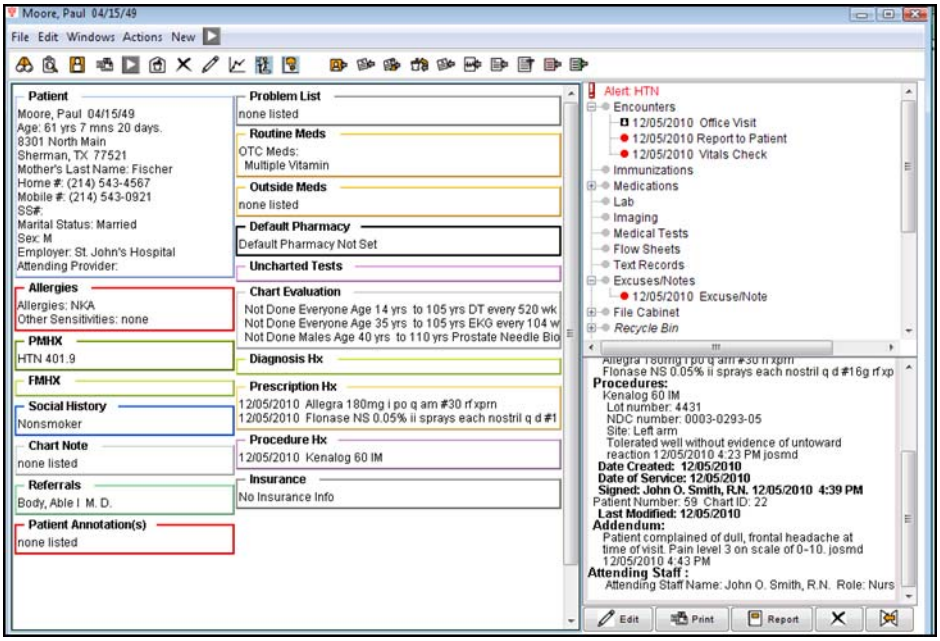


3. In the *Office Visit Addendum* window add the following comment: *Patient complained of dull, frontal headache at time of visit. Pain level 3 on scale of 0–10.*



4. Click on the [Done] button. Close the office visit screen.

5. Scroll to the bottom of the office visit note in the lower right corner of the patient's chart. The addendum appears at the end of the OV note. The addendum is automatically signed and dated.



6. Using the [Print] button located at the bottom of the window, print the OV note and submit to your instructor. If you are transmitting an electronic document to your instructor, choose the pdf printer and send the document as an e-mail. Close the patient's chart.