Level 3 – Level 3of *Nursing Documentation Using Electronic Health Records* includes chapters 9, 10, and 11. These chapters take the students deeper into EHR features of documentation and enable them to add on to their Nurse Notes using these features. Student learn such EHR administrative features as working through a 'to do' list, sending and receiving internal messages, etc.. A whole chapter in Level 3 is devoted to patient education in which the student learns patients' rights and nurses' responsibilities. The Nurse Note documentation is taken to a more complex level and the student completes notes that were created in Levels 1 and 2.

Chapter 11 – Nurse Note Documentation–Level 3

Chapter 11 takes the student deeper into the nurse note – continuing to move from simple to complex. The students document the last steps of the SOAPIER outline, adding teaching (Plan), responses (Evaluation), and reassessment (Revision). Nurse Notes are built from working with stroke, cellulitis, and chest pain patients. The students also create 'todo' items and reminders from within the Nurse Note.

Learning Outcomes

After completing Chapter 11, the students will be able to:

11.1 Carry out documentation of patient education and response.
11.2 Identify patient response to interventions.
11.3 Carry out documentation re-assessment/revision of goals.
11.4 Use *Todo/Reminders* within the Nurse Note.

Presentation Outline

LO 11.1 Teaching (Patient Education)

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

Concept Checkup 11.1

A. In which tab is patient education documented in SpringCharts?
Answer: The Teaching tab

Rationale: SpringCharts offers the nurse the ability to document patient education by clicking on the *Teaching* tab on the right side of the screen of the Nurse Note

B. Where is the documentation of patient education placed in the SOAPIER nurse's note?
Answer: Interventions section.

Rationale: When the nurse moves to the next navigation tab, text entered in the teaching tab is automatically placed in the Interventions section of the SOAPIER note.

LO 11.2 Evaluation

Power Point Slides: 5, 6.

Concept Checkup 11.2

A. True or False: The Evaluation tab does not automatically pull the NOC information that was previously selected into the Evaluation field.
Answer: True
Rationale: Since the nurse evaluates the outcomes selected earlier under the NOC tab, it is necessary to copy the outcomes being evaluated into the evaluation area of the nurse's note. To do this, the nurse clicks on the NOC tab and highlights and copies the text in the NOC free text area in the lower section of the screen. After returning to the evaluation tab, the nurse clicks into the text field on the left and pastes the outcomes. At this point, the nurse is prepared to document the patient's progress toward a goal or resolve a goal that has been achieved.

B. List three common statements used to evaluate outcomes.
Answer:
1. Outcome met this shift
2. Outcome not met this shift
3. Ongoing outcome

Rationale: Evaluation pop-up text provides common prebuilt evaluation statements such as Outcome met this shift, Outcome not met this shift, and Ongoing outcome.

LO 11.3 Reassessment

Power Point Slides: 7, 8.

Concept Checkup 11.3

A. Name two items that are frequently reassessed by nurses:
Answer:
1. Vital Signs
2. Pain

Rationale: The patient needs frequent reassessments following a procedure such as a heart catheterization or surgery. This type of reassessment data is best documented in the reassessment tab of SpringCharts. Under the reassessment navigation tab on the right side of the Nurse Note screen is a list of items that are typically reassessed such as vital signs and pain.

LO 11.4 F/U-REM (Follow-up Reminders/ToDo List)

Power Point Slides: 9, 10.

Concept Checkup 11.4

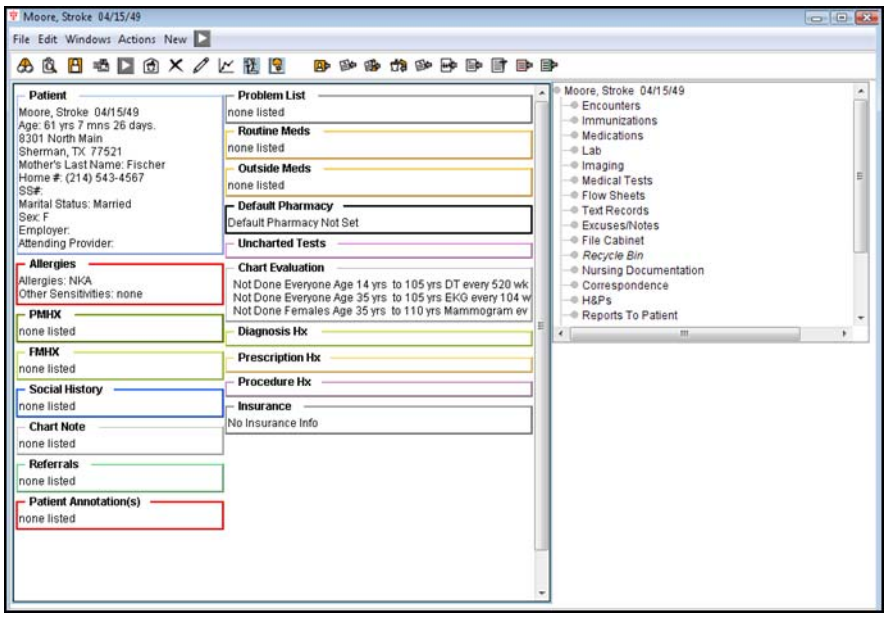
A. Is a new ToDo/Reminder launched from within a patient's chart automatically linked to the patient?
Answer: Yes
Rationale: In the lower left window of f/u panel within an Office Visit or Nurse Note screen, the "create a reminder" icon is available enabling the clinician to set a personal ToDo/Reminder or to send one to another person in the clinic. The ToDo/Reminder is automatically linked to the patient's chart.

B. True or False: A ToDo/Reminder can be sent for a future date.
Answer: True
Rationale: In the New ToDo/Reminder window a user clicks the Send button to send the reminder immediately, or clicks Send Later and designates a future date when the reminder should appear in the recipient's To/Do List.

Exercise 11.1

Stroke

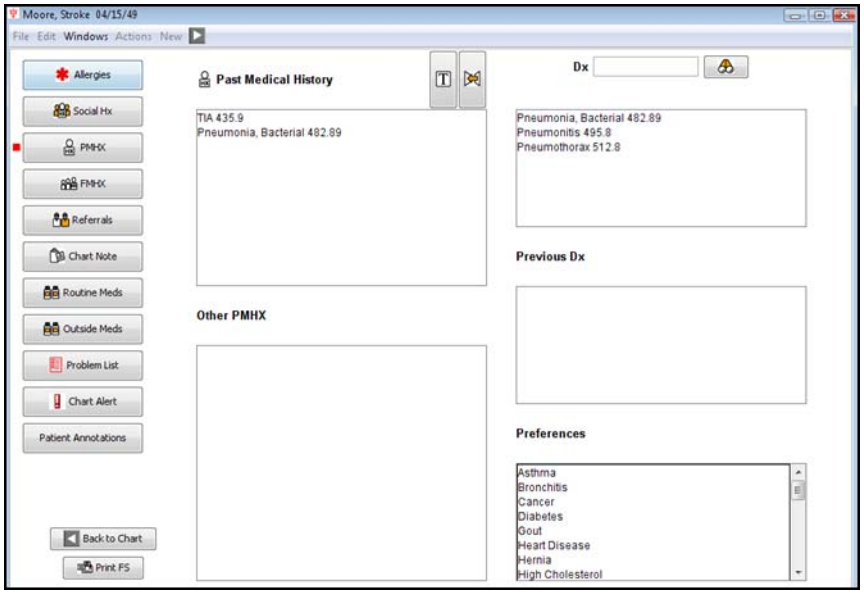
1. After launching SpringCharts, from the top horizontal toolbar, click on *Actions, Open a Chart.* Type in your last name and click the search button. Select your "stroke" patient and the chart opens.



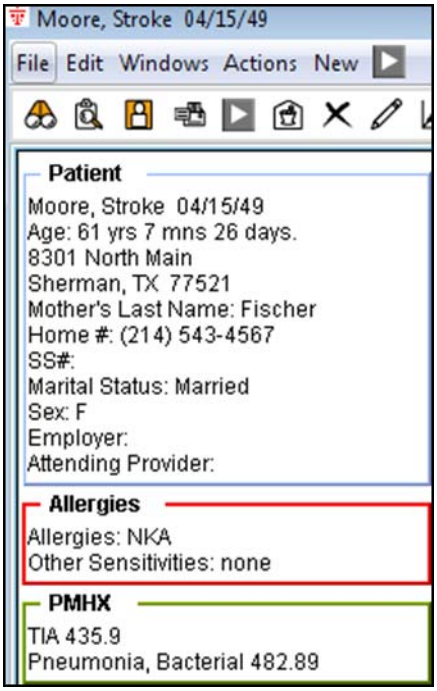
2. Your patient is having difficulty communicating due to the stroke she suffered early this morning. Her significant other tells you she has a past history of Transient Ischemic Attack (TIA) and Pneumonia. Click on *PMHX* and it populates the right lower corner box. Click the [Edit] button below the box and a new window opens.

• In the space after *Dx* at the upper right portion of the window type TIA and click the search button. TIA 435.9 appears in the box below the search button. Click on TIA and it moves to the *Past Medical History* box on the upper left.

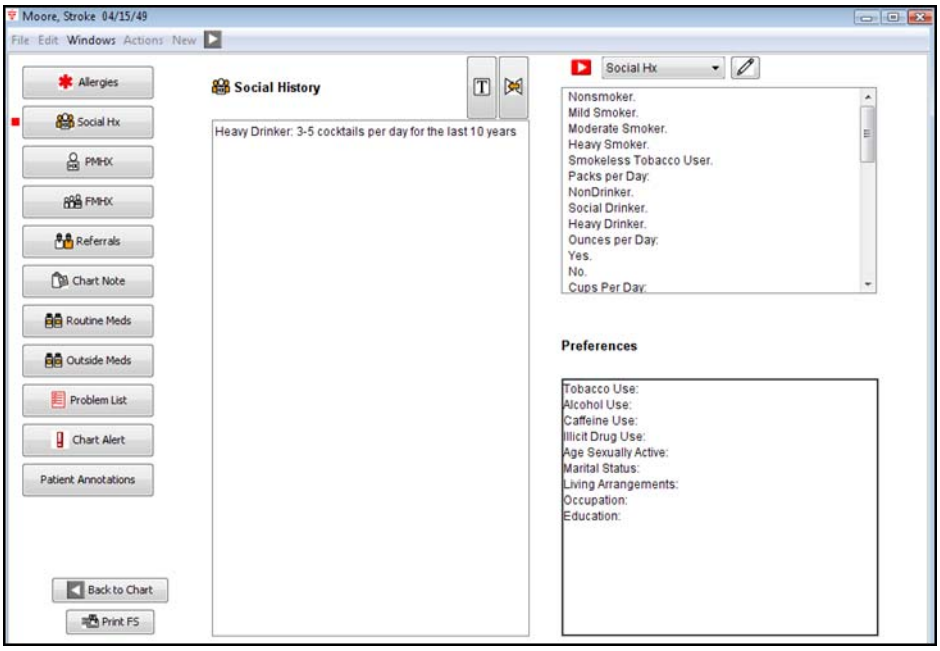
• In the space after *Dx* type Pneu and click the search button. Pneumonia, bacterial 482.89 appears in the box below the search button. Click on Pneumonia, bacterial 482.89 and it moves to the *Past Medical History* box on the left.



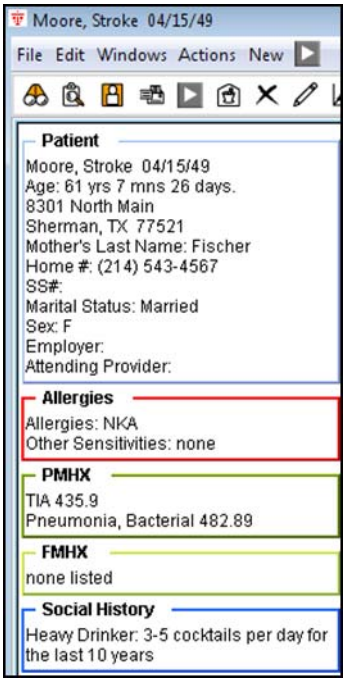
• In the lower left corner of the window, click *Back to Chart.* Note your new entry in the *PMHX* field.



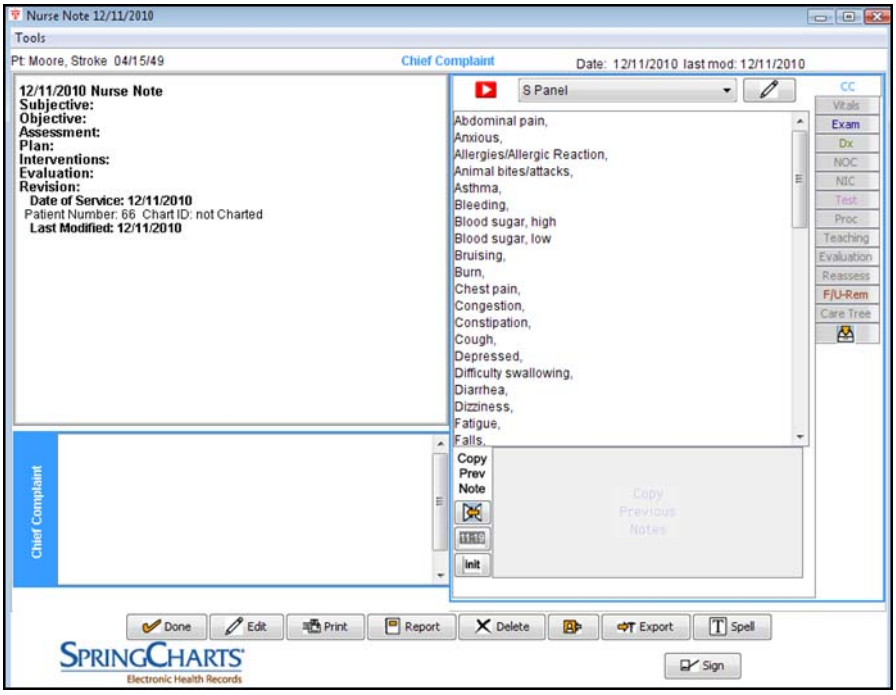
3. You ask the patient's significant other about her social history. He states that she drinks 3 to 5 cocktails a day and has done so for the last 10 years. Click on the *Social History* field on the left and it populates the box on the lower right side of the screen
• Click the *Edit* button and a new window opens.
• In the right upper box below *Social History* click on: Heavy Drinker. Heavy drinker appears in the *Social History* box on the upper left.
• In the *Social History* box on the upper left, click after Heavy Drinker and type: 3–5 cocktails per day for the last 10 years.



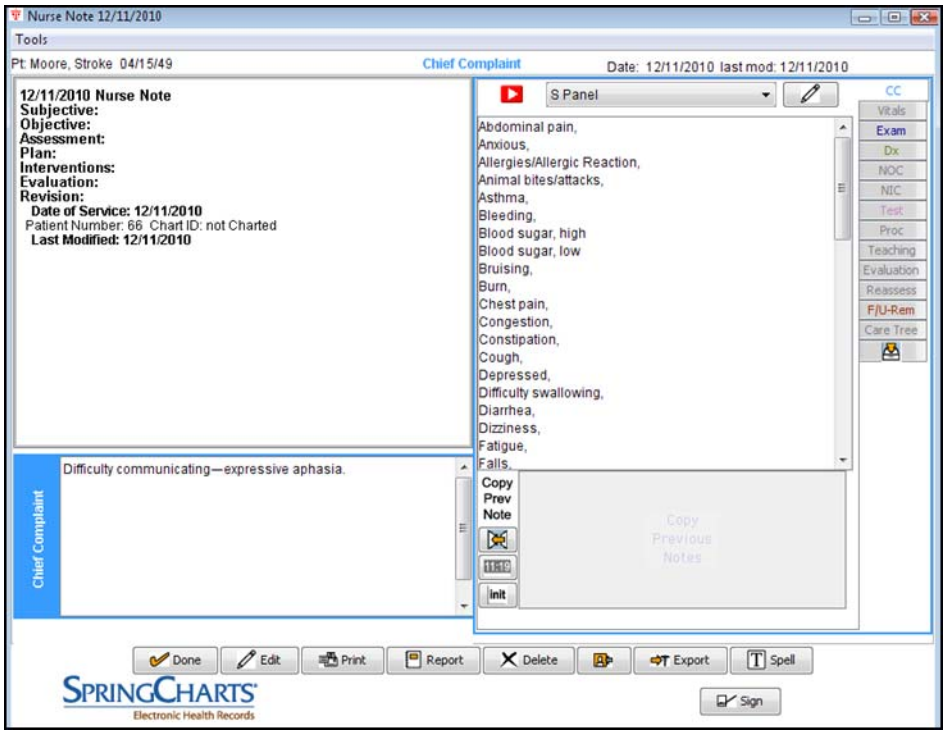
• In lower left corner of the window, click *Back to Chart*. The text you added appears in the *Social History* field.



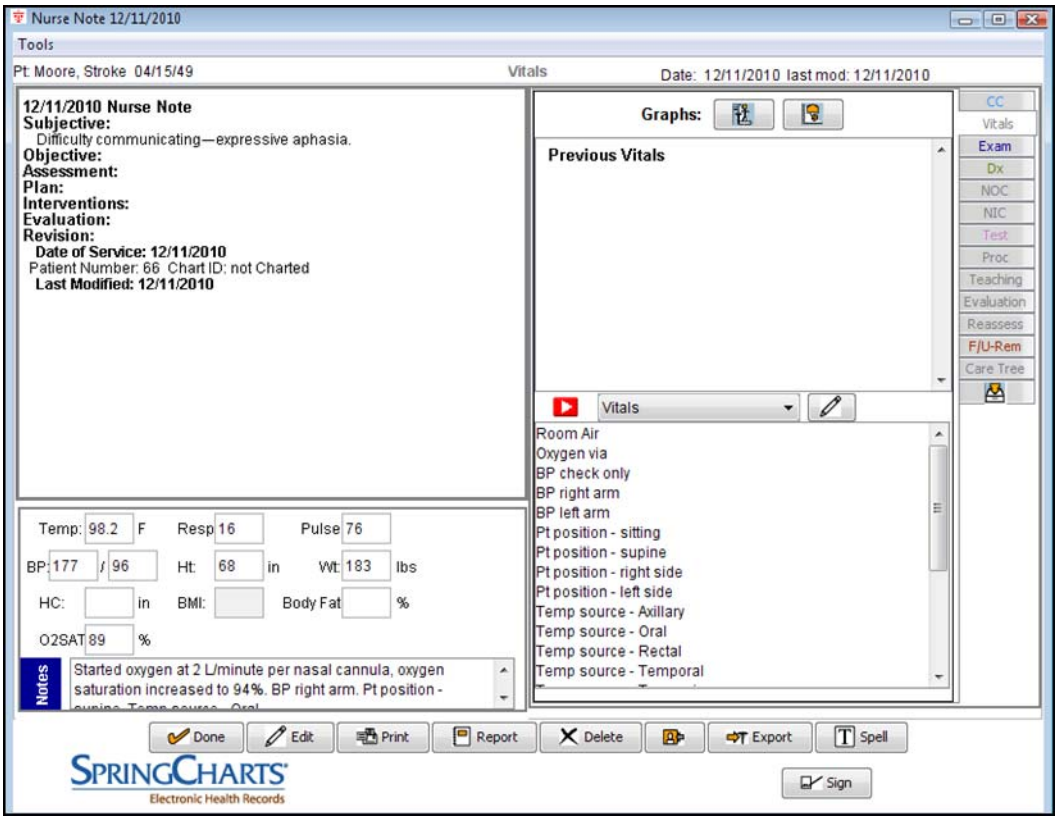
4. Open your *Nurse Note*. On the top horizontal toolbar, click *New, New Nurse Note*. The *Nurse Note* opens to the *Chief Complaint* tab at the top of the vertical navigation bar on the right side of the window.



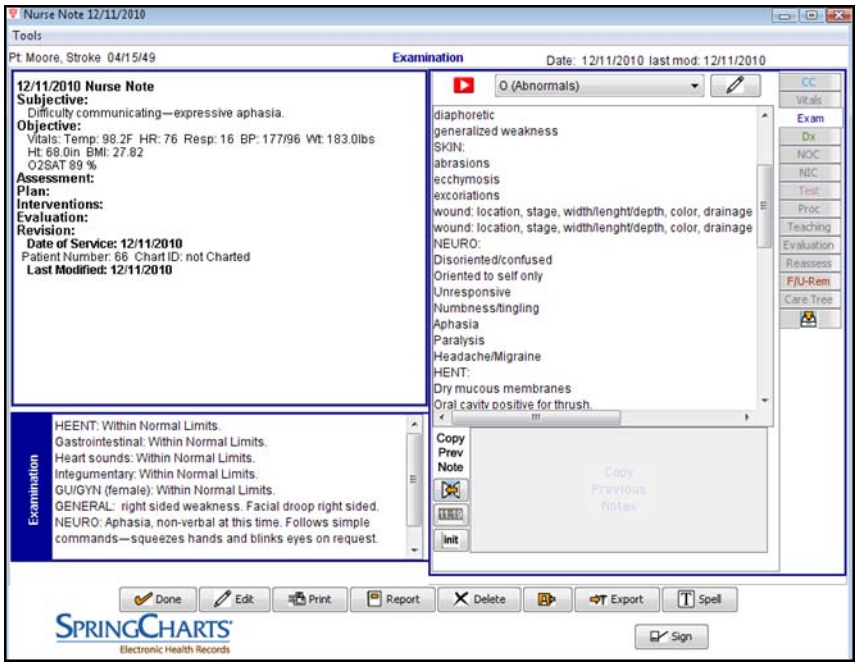
5. Your patient has no verbal complaints due to aphasia.
• Click into the Chief Complaint field in the left lower box and type: Difficulty communicating—expressive aphasia.



6. Click on the *Vitals* button on the located below the *CC* button on the vertical navigation bar on the right side of the screen. Note that your *Chief Complaints* now appear in the Subjective section of the *Nurse Note*.
• You take your patient's vital signs. Document the following in the boxes on the lower left section of the window: Temp 98.2, Resp 16, Pulse 76, BP 177/96, Ht 68 inches, Wt 183 lbs.
• You measure your patient's oxygen saturation on room air and find it to be 89%. Document this in the O2Sat% field. You start oxygen at 2 L/minute per nasal cannula and five minutes later her oxygen saturation has increased to 94%. To document this, click into the Notes box on the left and document your assessment and interventions by typing in the field.
• Under the *Vitals* text box on the right click: BP right arm, Pt position—supine and Temp source—Oral, No complaints of pain. This text is sent to the Notes box on the left. Separate the Temp source—Oral text from the other text by clicking in front of it and striking the enter key on the keyboard.

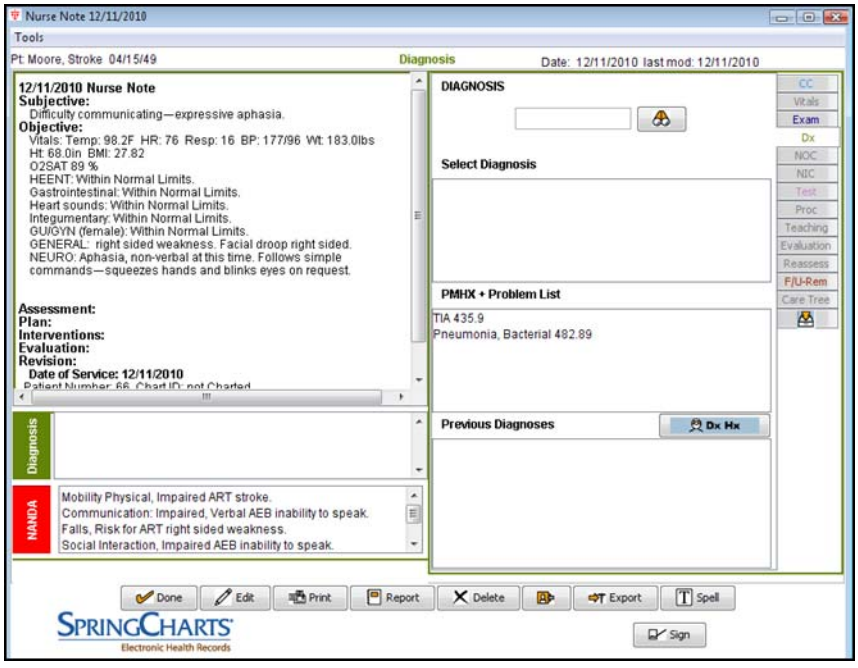


7. Click on the *Exam* button located below the *Vitals* on the vertical navigation bar on the right. Notice the *O (Normals)* defaults in the right upper box. Select the following systems that are within normal limits when you assess your patient: HEENT, Gastrointestinal, Heart sounds, Integumentary, and GU/GYN (female). Remember that you can 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: generalized weakness. Select the *Neuro* section followed by: Aphasia.
• Click in the *Examination* box on the left lower side of the screen after Aphasia and type: non-verbal at this time. Follows simple commands—squeezes hands and blinks eyes on request.
• You are still in the *Examination* box, click in front of generalized weakness. Delete generalized and type: right sided. Type: Facial droop, right sided.

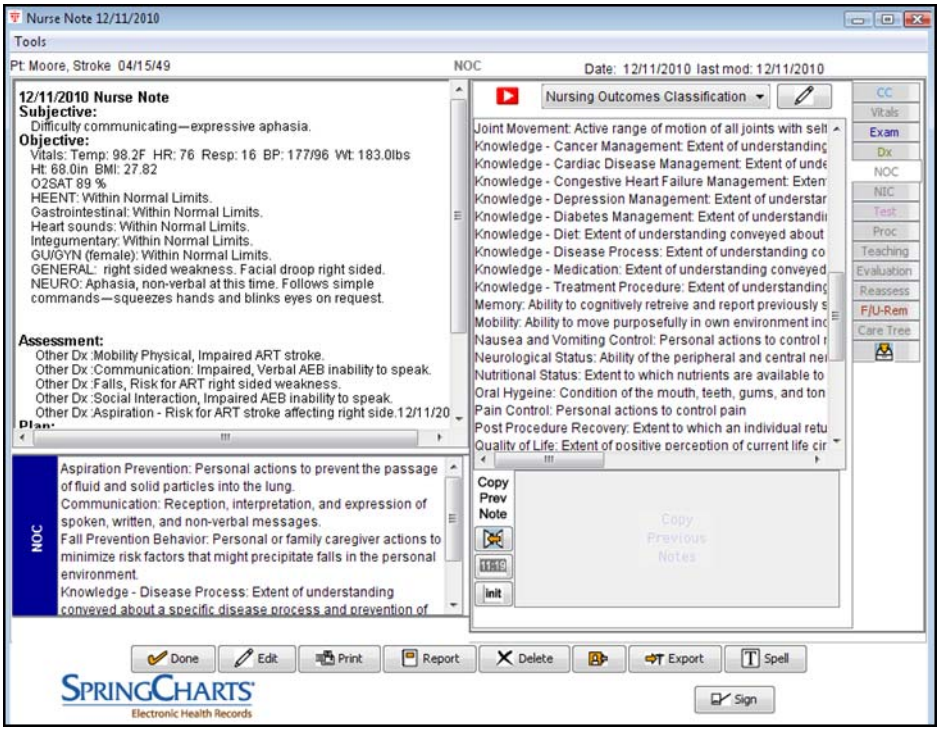


8. Click into the *Dx* button below the Exam button in the vertical navigation bar on the right. Click on the red *NANDA* on the left bottom of the screen. The *Dx* text window populates. Remember to place nursing diagnoses in order of priority. Click the following:

- Mobility Physical, Impaired.
- Communication: Impaired, Verbal
- Falls, Risk for
- Aspiration, Risk for
- Social Interaction, Impaired. Click the [D&T] icon to date and time the entry. Click [Done].
- Add the etiology (related factor) and symptoms (as evidenced by) by typing into the field after each *NANDA* diagnosis.



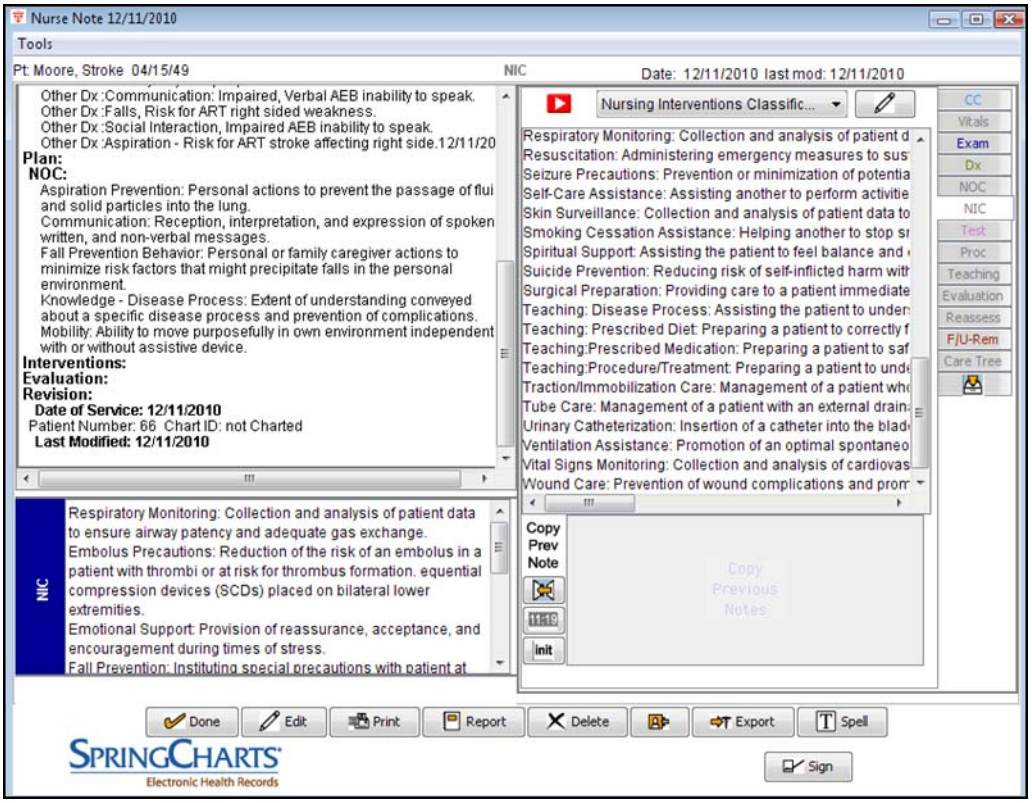
9. Click the *NOC* button in the vertical navigation bar on the right located below the *Dx* button. Notice that your *NANDA* documentation populates the *Nurse Note*.
• Click into the *Nursing Outcomes Classification* text field on the lower left and type:
• Aspiration Prevention: Personal actions to prevent the passage of fluid and solid particles into the lung.
• Below the *Nursing Outcomes Classification* on the right upper side select the following:
- Communication: Reception, interpretation, and expression of spoken, written, and non-verbal messages.
- Fall Prevention Behavior: Personal of family caregiver actions to minimize risk factors that might precipitate falls in the personal environment
- Knowledge—Disease Process: Extent of understanding conveyed about a specific disease process and prevention of complications.
- Mobility: Ability to move purposefully in own environment independently with or without assistive device. Remember that you can use the enter key to put these items on separate lines to streamline your documentation.



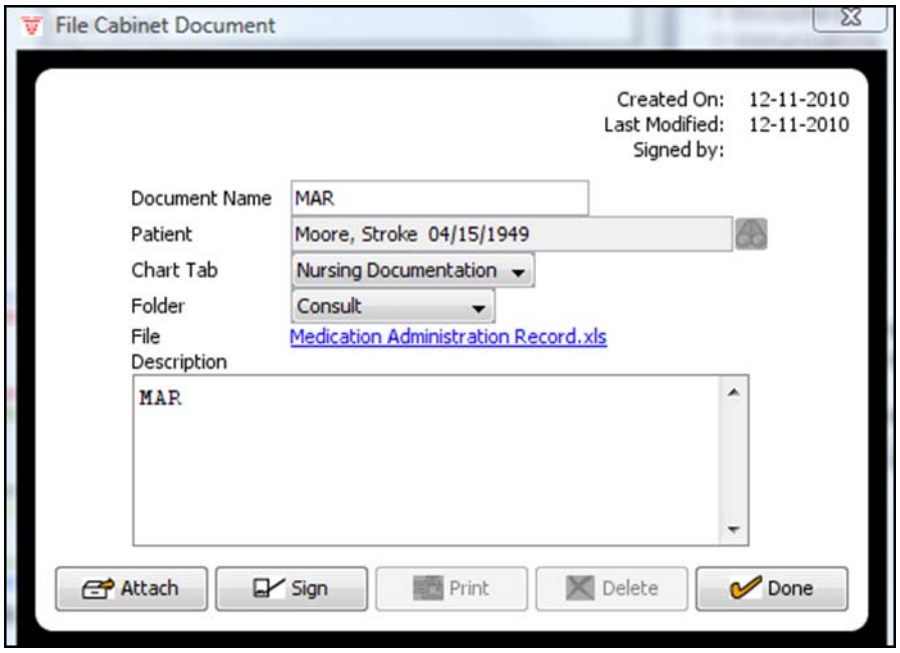
10. Click the *NIC* button on the right below the *NOC* button. Notice that your outcomes populate the *Nurse Note*.
• Select the following interventions:
- Respiratory Monitoring: Collection and analysis of patient data to ensure airway patency and adequate gas exchange.
- Embolus Precautions: Reduction of the risk of an embolus in a patient with thrombi or at risk for thrombus formation.
- Emotional Support: Provision of reassurance, acceptance, and encouragement during times of stress
- Fall Prevention: Instituting special precautions with patient at risk for injury from falling
- Medication Administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs.
- 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.

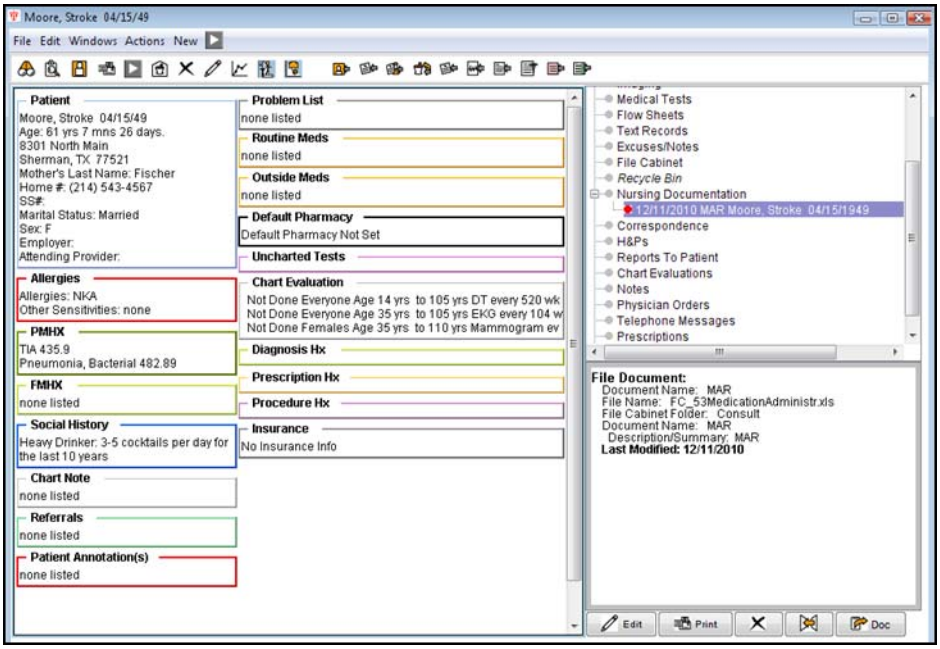
• In the *Nursing Interventions Classifications* box on the lower left click after the Embolus Precautions entry and type: Sequential compression devices (SCDs) placed on bilateral lower extremities
• Click after the Fall Prevention line and type: Fall prevention teaching with family, verbalized understanding. They will inform the nurse when they leave the room or if the patient needs to get out of bed.
• Strike the enter key to put the cursor on a new line. Type: Aspiration Precautions: Prevention or minimization of risk factors in the patient at risk for aspiration



11. Your receive orders for Lovenox 250 (3 mg/kg) subcutaneous every 12 hours. 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. Use the search mechanism to select the blank MAR document. 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.

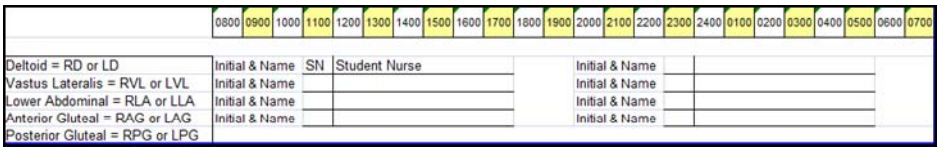


• Click Done. The document appears in the *Care Tree* on the right in the Nursing Documentation tab.
• Click on the + in front of Nursing Documentation.

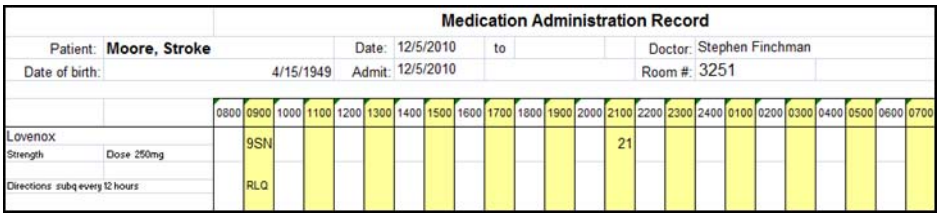


• Highlight the MAR and click Edit at the lower right side of the screen. The *File Cabinet* window appears.
• Click on the blue hyperlink next to the word File. The MAR document opens.
• Enter the Patient, Date of Birth, Date, Admit date, Doctor, and Room #.
• On the left enter the Lovenox on the blank field above Strength and Dose. In the Dose field type 250 mg.
• Under directions type subq every 12 hrs. Indicate the scheduled administration times of 0900 and 2100.

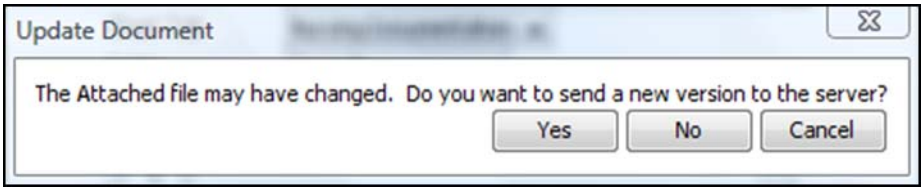
• Type your name and initials in the Initial & Name area at the bottom of the document.



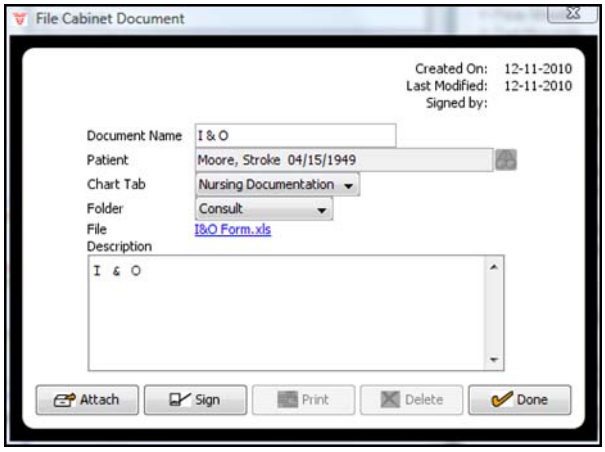
• Type your initials in the 9am top time box and type RLQ (right lower quadrant of abdomen) in the bottom box to indicate the injection location.



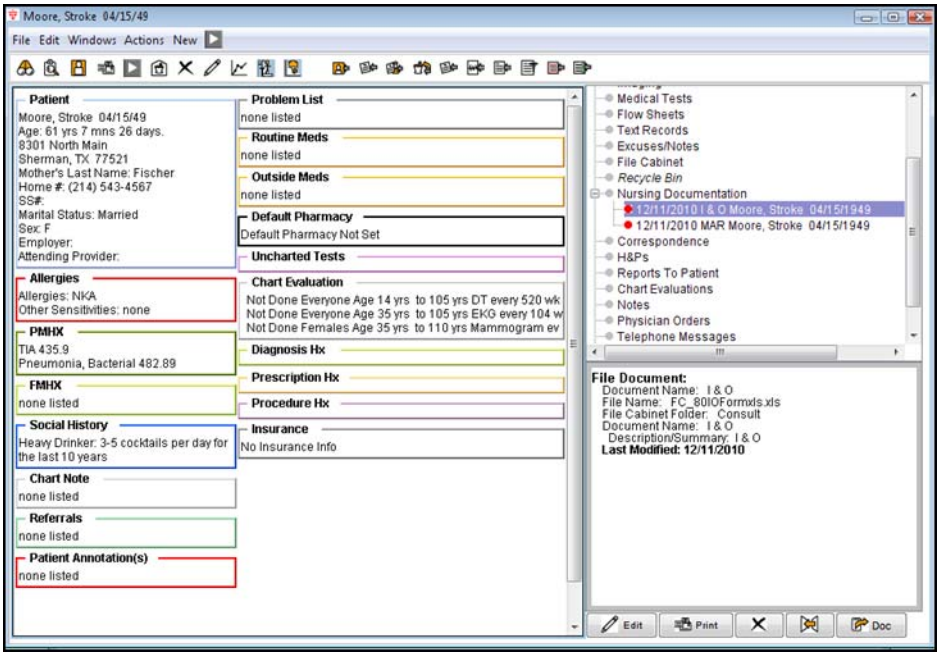
• Click the [save diskette] icon to save your work.
• Click the X on the far right upper corner to close the MAR. A pop up will ask you if you want to save the changes you've made, select yes. The *File Cabinet Window* is still present.
• Click [Done]. A pop-up appears "The Attached file may have changed. Do you want to send a new version to the server?" Click Yes. The window closes.



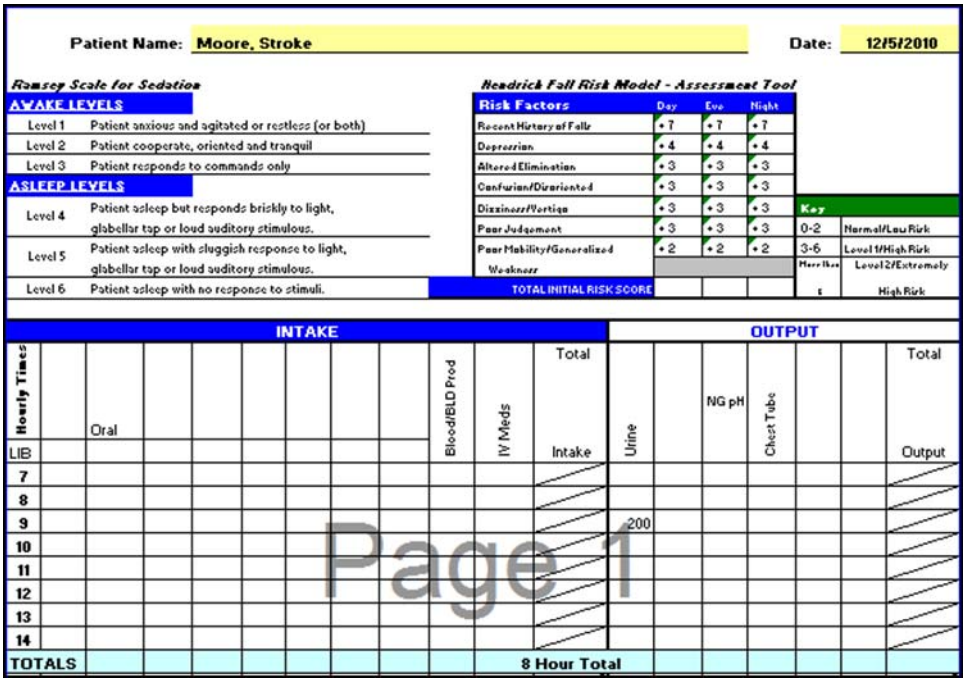
12. Your patient is NPO until a swallowing assessment is completed.
• Click the New menu, Import Items at the bottom of the list.
• Select Import File Cabinet Document and the *File Cabinet* window appears.
• Type Intake and Output into the Document name.
• In the Chart Tab select the drop-down box on 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.



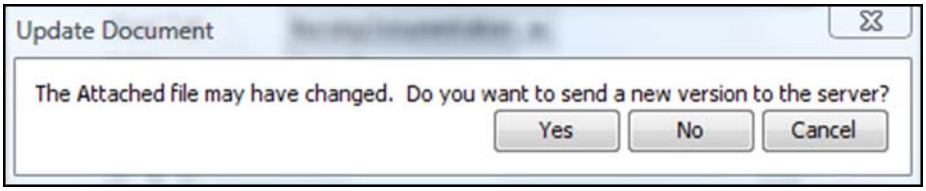
The I&O document is found in the EHR Materials folder.
• Click [Done]. The document appears in the *Care Tree* on the right in the Nursing Documentation tab.
• Click on the + in front of Nursing Documentation.
• Highlight the Intake and Output and click Edit at the lower right side of the screen.



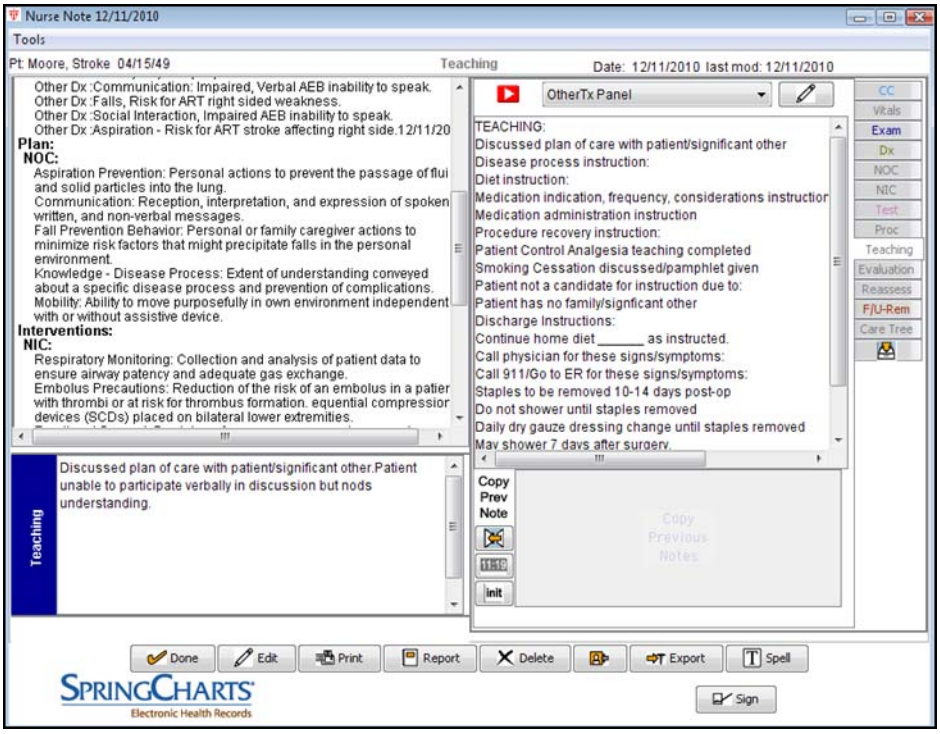
The *File Cabinet* window appears.
• Click on the blue hyperlink next to the word File. The Intake and Output document opens.
• Type in the Patient Name and Date.
• Your patient urinated 200 mLs in the bedpan at 0930. Document this.
• Click the [save diskette] icon to save your work.



• Click the X on the far right upper corner to close the I&O sheet. A pop up will ask you if you want to save the changes you've made, select yes. The *File Cabinet* Window is still present.
• Click [Done]. A pop-up appears "The Attached file may have changed. Do you want to send a new version to the server?" Click [Yes]. The window closes.

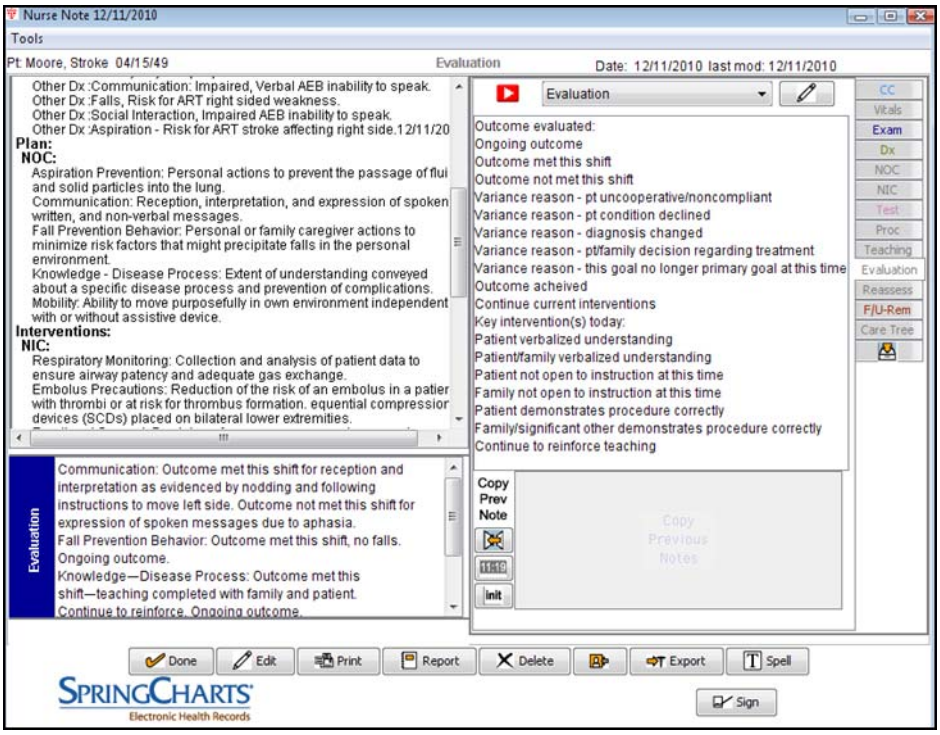


13. Return to the Nurse Note. The nurse note may be located at the bottom of the screen due to minimizing it earlier. Return to the Nurse Note by clicking maximize icon on the right upper side of the nurse note. Click in the *Teaching* button on the vertical navigation bar on the right.
• Under the *Other Tx Panel* at the upper right select the following: Discussed plan of care with patient/significant other.
• Click into the Teaching text box on the lower left of the screen and type: Patient unable to participate verbally in discussion but nods understanding.



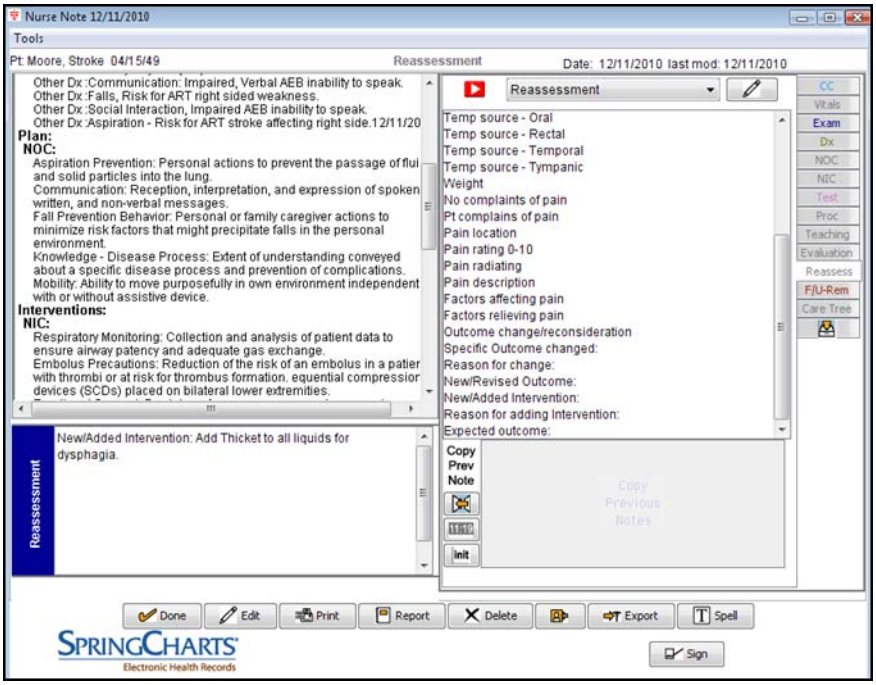
14. Click into *Evaluation* on the vertical navigation bar on the right. Using the *Evaluation* text on the right side, add the text below manually. (The NOC item for the patient is referenced by the first word.)
• Communication: Outcome met this shift for reception and interpretation as evidenced by nodding and following instructions to move left side. Outcome not met this shift for expression of spoken messages due to aphasia.
• Fall Prevention Behavior: Outcome met this shift, no falls. Ongoing outcome.
• Knowledge—Disease Process: Outcome met this shift—teaching completed with family and patient. Continue to reinforce. Ongoing outcome.
• Mobility: Right-sided weakness limits mobility. Bed rest maintained this shift. Ongoing outcome.
• Continue current interventions.

• Use the Enter key on the keyboard to place text on separate lines to streamline your documentation.

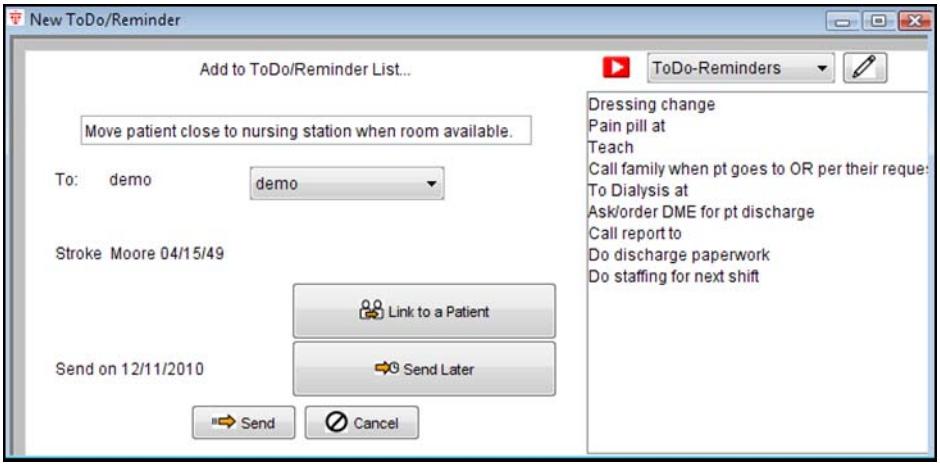


15. Click into *Reassess*. Under the *Reassessment* text box on the right click: New/Added Intervention. The text moves to the *Reassessment* text box on the lower left side of the screen.

• Click after *New/Added Intervention*: and type: Add Thicket to all liquids for dysphagia.



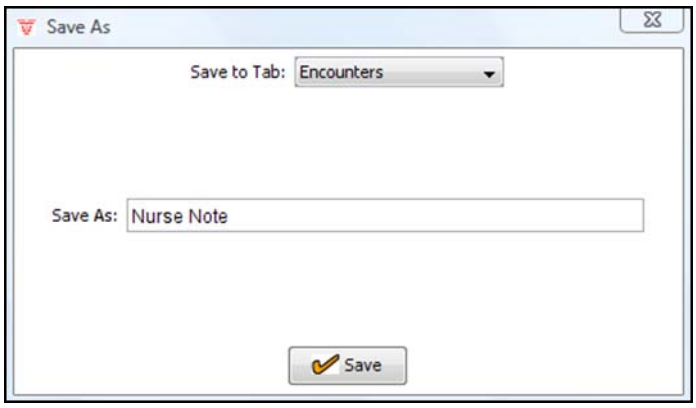
16. Click into *F/U-Rem*. Notice your documentation from the *Reassess* area populates the *Nurse Note*. On the lower left side of the screen below the *F/U-Reminders* text click on the icon of a finger with a piece of string tied around it.
• The *Add to ToDo/Reminder List* . . . window populates. Click into the free text field at the upper left and type: Move patient close to nursing station when room available.
• Notice that your patient's name displays in the middle left side of the window. *F/U-Rem* is linked to a patient when accessed within the *Nurse Note*. Choose your name in the To drop down box.



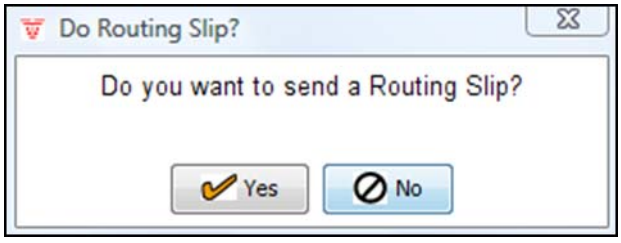
Click [Send].

• Look to the far left of the screen to the SpringCharts fields that are open outside of the *Nurse Note*. Your new entry is visible in the *ToDo List* in dark pink below the calendar.

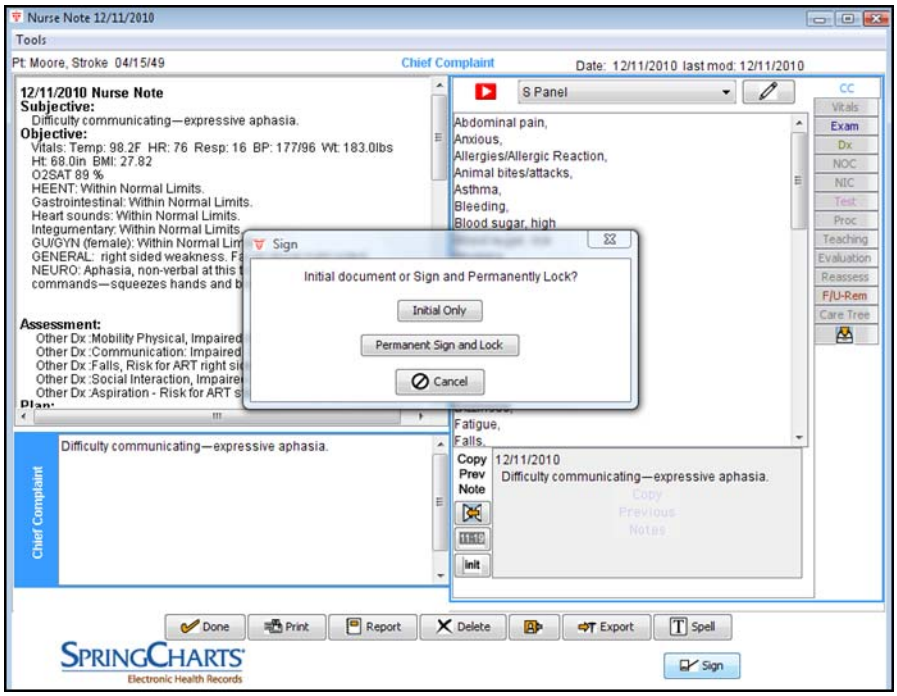
17. Click *Done*. The *Save As* screen populates. Click *Save*.



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



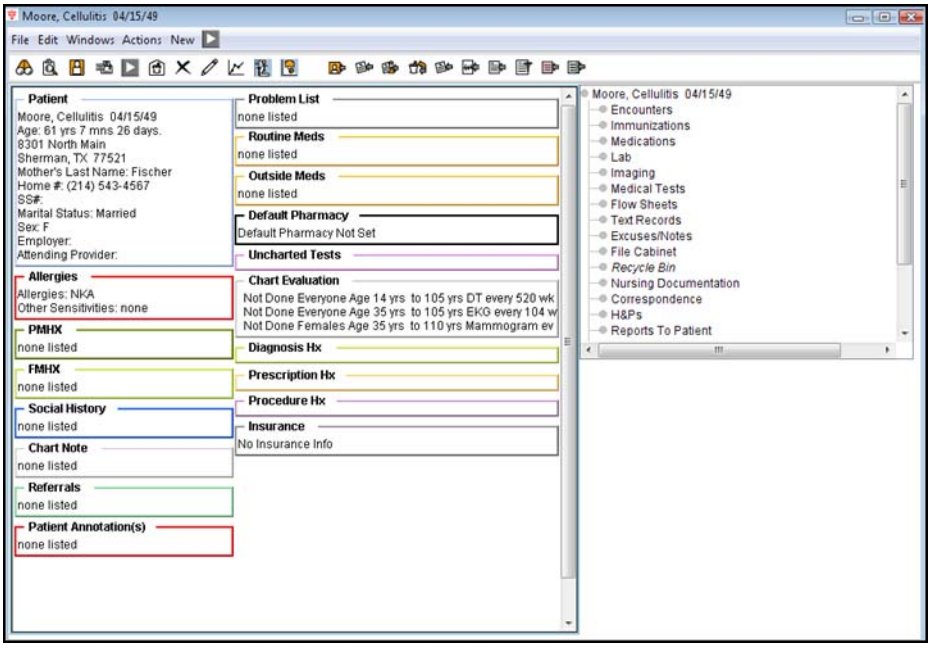
19. In the *Care Tree*, click the + next to *Encounters*. Click on the date of your nurse note and it appears in the bottom right corner box.
• Click [*Edit*]. Click [*Sign*]. Select [*Permanent Sign and Lock*] when finished with your *Nurse Note*.



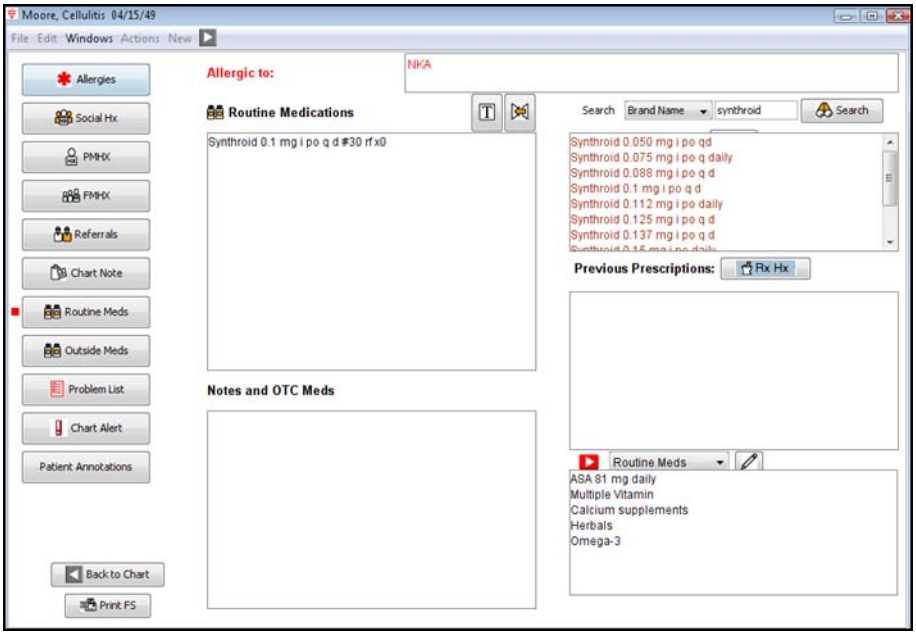
Exercise 11.2

Cellulitis

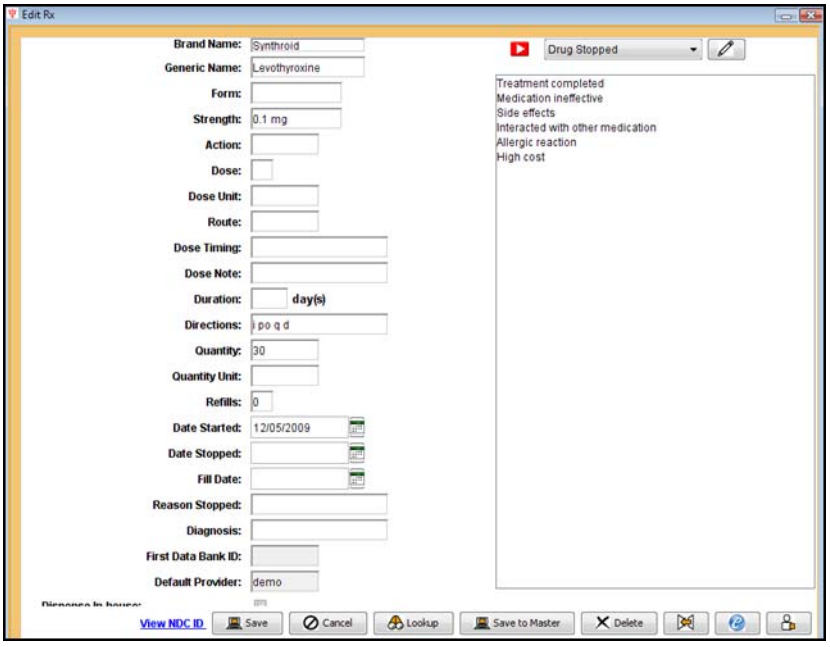
1. After launching SpringCharts, click on *Actions, Open a Chart*. Type in your last name and click the search button. Select your "cellulitis" patient and the chart opens.



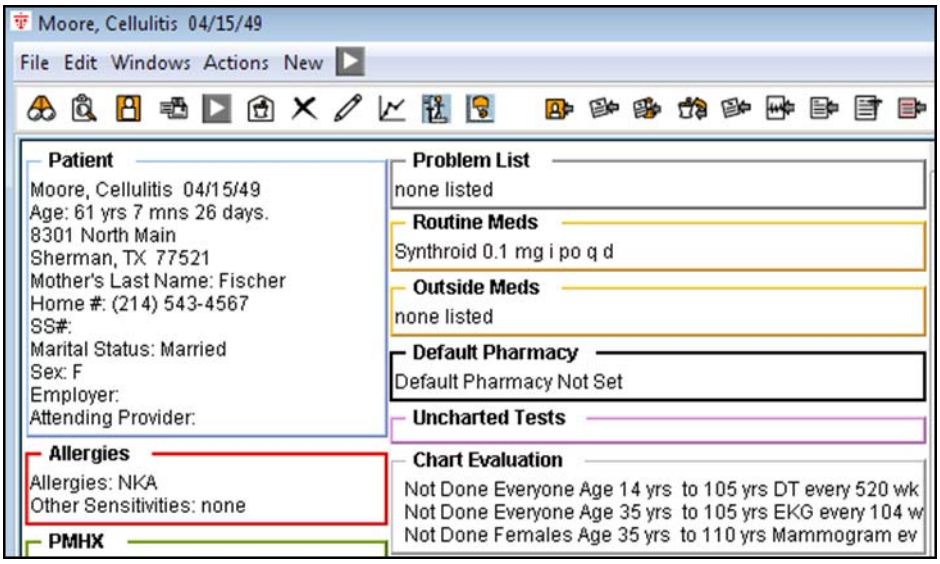
2. Your patient tells you she scraped her arm getting groceries out of her car a week ago and now her entire right arm is infected. She tells you she has taken Synthroid 0.1 mg by mouth daily for the past year. The Synthroid is not in her *Routine Meds* list. You check her chart and find that her physician has ordered this medication to be continued during her hospital stay. Click on *Routine Meds* and it populates in the bottom right corner of the screen. Click *Edit* below this box.
• The *Routine Med* screen populates. In the space after *Brand Name* in the upper right portion of the window type: Synthroid and click the search icon. Options appear in the box below. Click on the Synthroid 0.1mg po daily, which sends the medication information to the *Routine Meds* list at the upper left side of the window.



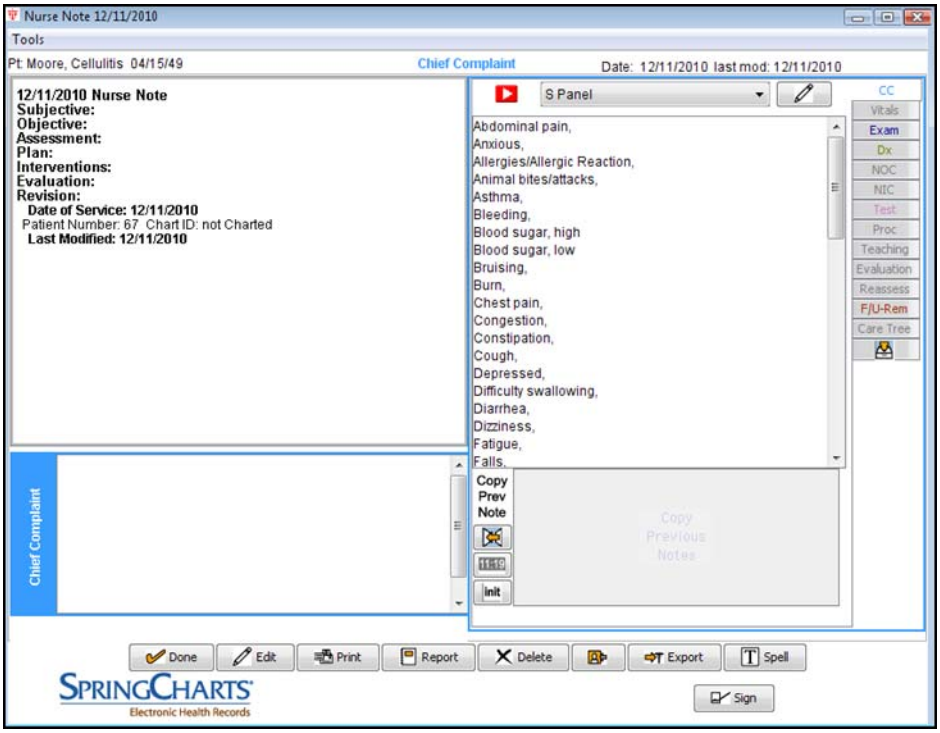
• Click on the Synthroid in the *Routine Meds* field on the left side of the screen. The *Edit Rx* window opens. Put a date of one year ago in the *Date Started* and click *Save*.



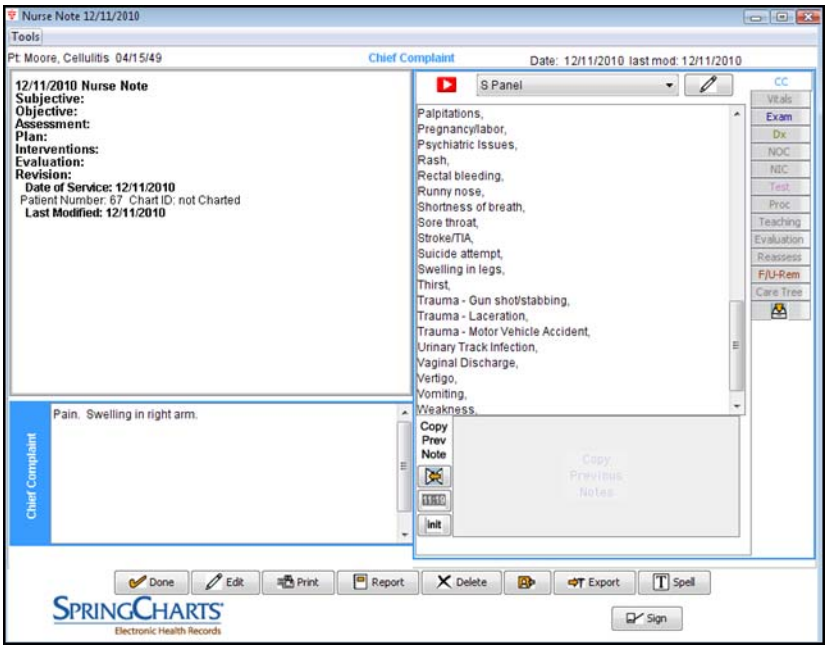
• In the left lower portion of the window, click *Back to Chart*. Your entry appears in the *Routine Meds* field.



3. 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.



4. Your patient complains of pain and swelling in her right arm. Select Pain and select Swelling in legs in the *S Panel* text and it populates the *Chief Complaint* box on the bottom left of the screen. Click in to the *Chief Complaint* box after Swelling in legs and delete legs and type: right arm.



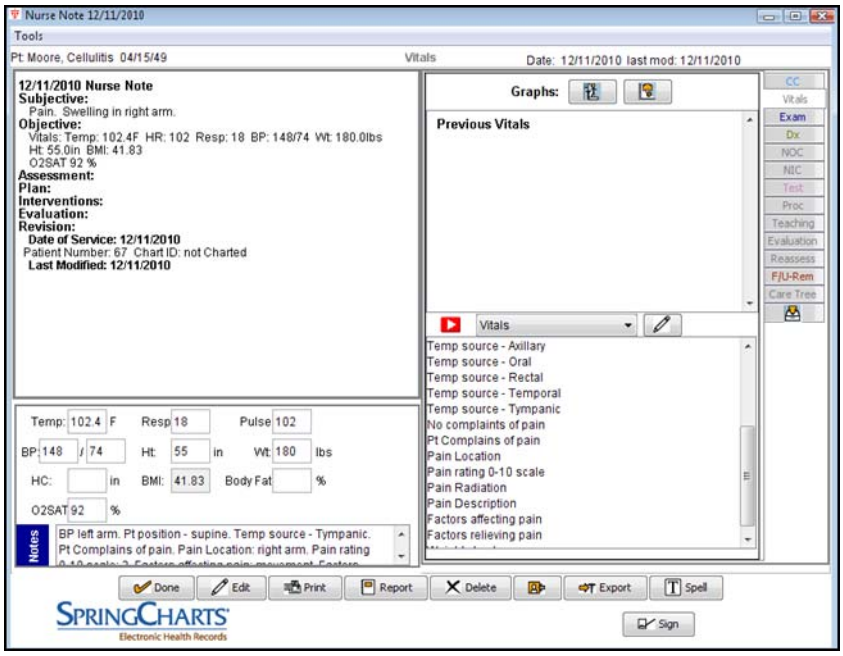
5. Click on the *Vitals* button on the located below the *CC* button in the vertical navigation bar on the right side of the screen. Note that your *Chief Complaints* now appear in the Subjective section of the *Nurse Note*.

• You take your patient's vital signs. Document the following: Temp 102.4, Resp 18, Pulse 102, BP 148/74, Ht 55 inches, Wt 180 lbs., O2Sa% 92.

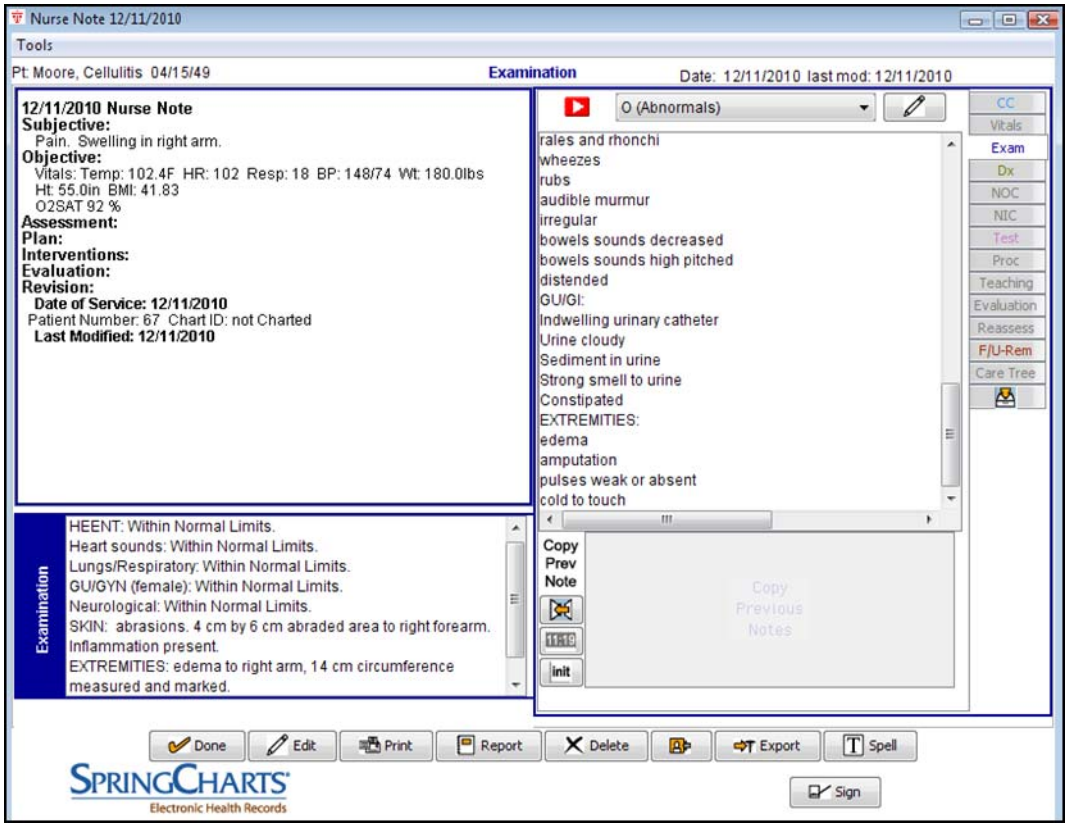
• Also select: BP left arm, Pt position—supine and Temp source—tympanic.

• 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. The text is sent to the *Notes* box on the left. Use the enter key to place each entry on a separate line.

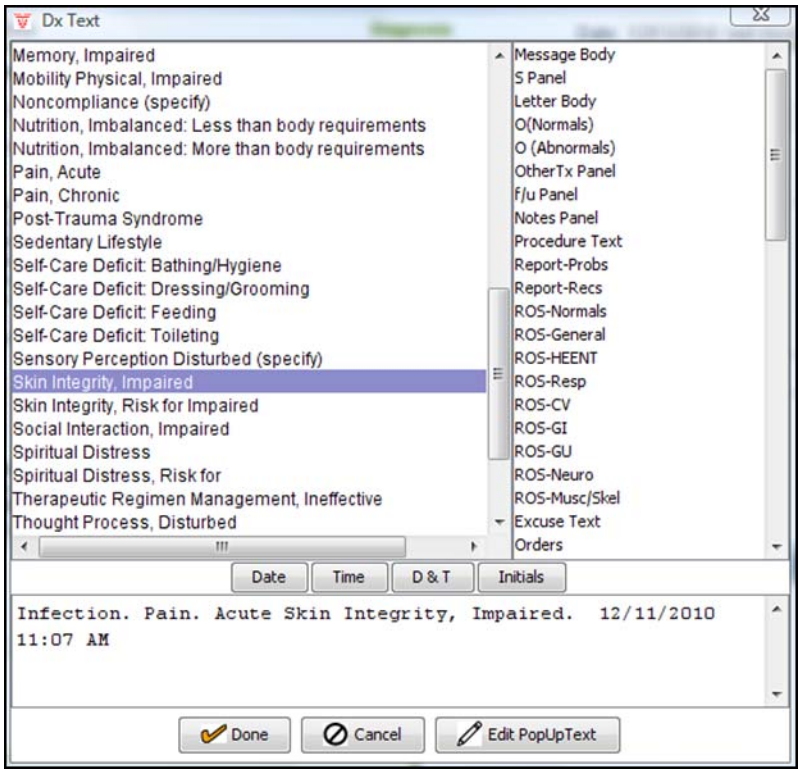
• Fill in the following information in the *Notes* box that your patient conveys to you: Pain location: Right arm pain, Pain rating 0–10 scale: 3, Description: aching, Factors affecting pain: movement, Factors relieving pain: aspirin.



6. Click on the *Exam* tab located below the Vitals. Notice the *O (Normals)* defaults in the right upper box. In this area select the following systems that are within normal limits when you assess your patient: HEENT, Heart sounds, Lungs/Respiratory, GU/GYN (female), and Neurological.
• Click the drop-down arrow next to *O (Normals)* in the right upper box and select *O (Abnormals)*. Select the Skin section followed by: abrasions. Select the *Extremities* section followed by: edema
• Click into the *Examination* box on the lower left after abrasions and type: 4 cm by 6 cm abraded area to right forearm. Inflammation present. After edema type: to right arm, 14 cm circumference measured and marked.



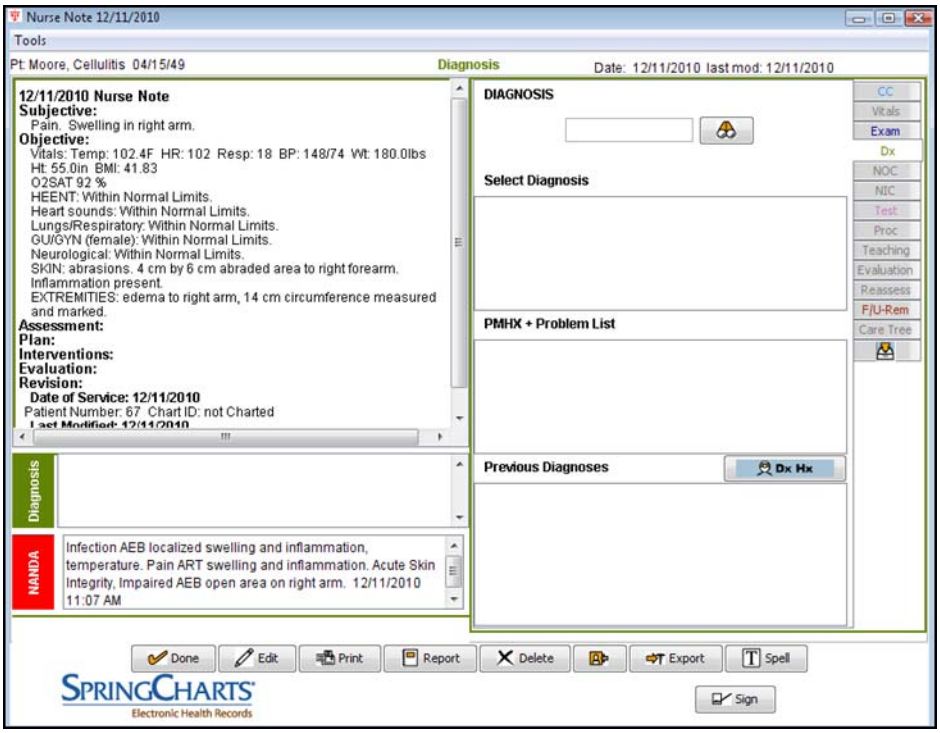
7. Click into the *Dx* button below the *Exam* button in the vertical navigation bar on the right. Click on the red *NANDA* on the left bottom of the screen. The [Dx] text window populates.
• Click Infection, Risk for: Pain, Acute; Skin Integrity, Impaired. Remove the "Risk for" after Infection as this is an actual problem. Click the *D&T* icon to date and time the entry. Click *Done*.



Use the enter key to place each nursing diagnosis on a separate line. Consider your assessment data and add one additional nursing diagnosis.

• Add the etiology (related factor) and symptoms (as evidenced by) by typing them into the field after each Nursing diagnosis to individualize the diagnosis for your patient.

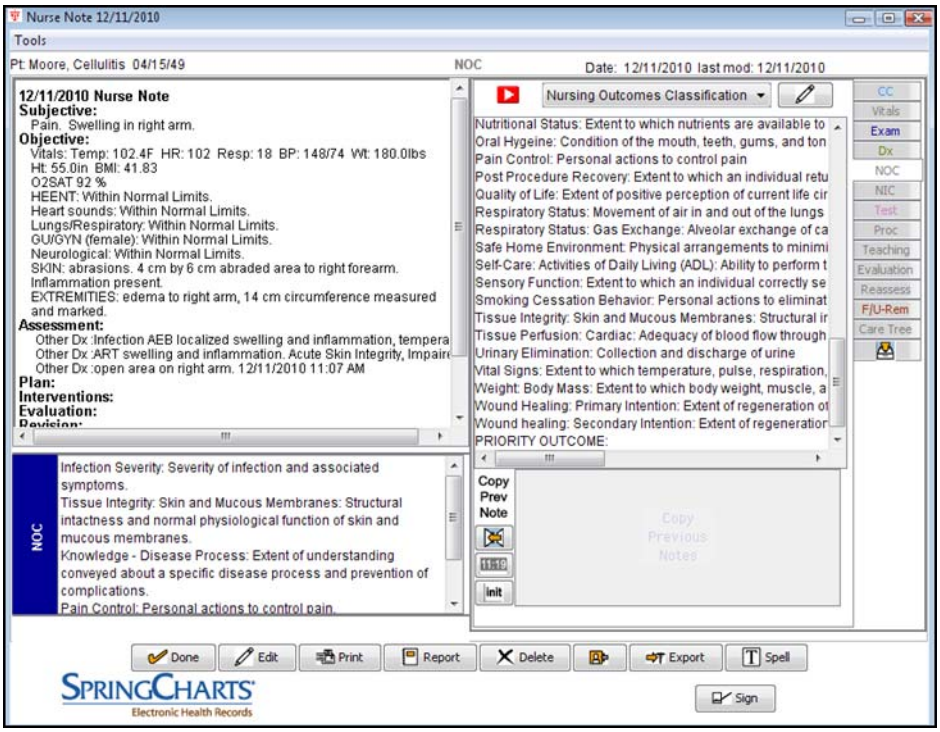
• Place the nursing diagnoses in order of priority.



8. Click the *NOC* tab on the right located below the *Dx* tab. Notice that your nursing documentation populates the Nurse Note.

• Below the *Nursing Outcomes Classification* at the upper right select the following:

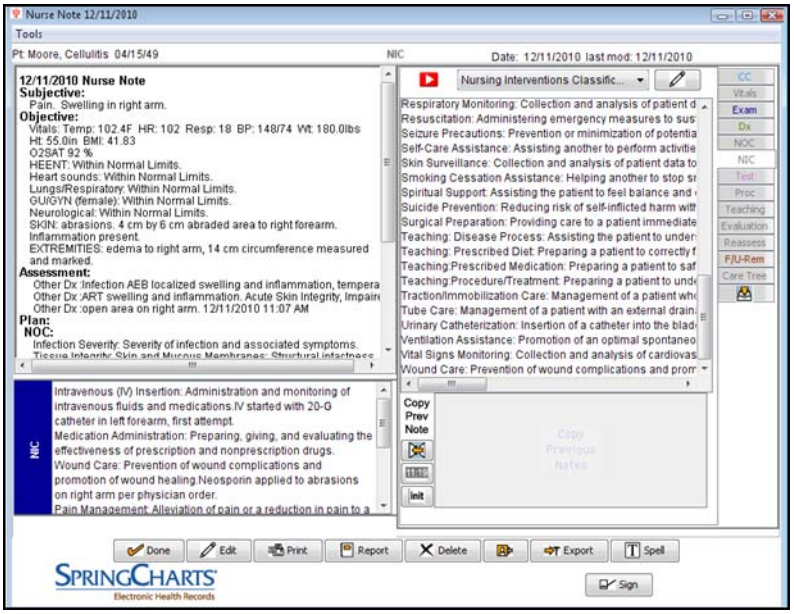
- Infection Severity: Severity of infection and associated symptoms
- Tissue Integrity: Skin and Mucous Membranes: Structural intactness and normal physiological function of skin and mucous membranes.
- Knowledge—Disease Process: Extent of understanding conveyed about a specific disease process and prevention of complications.
- Pain Control: Personal actions to control pain.
- Vital Signs: Extent to which temperature, pulse, respiration, and blood pressure are within normal range.
- Consider the nursing diagnoses above and add other NOCs as indicated.
- Use the Enter key on the keyboard to place text on 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*.

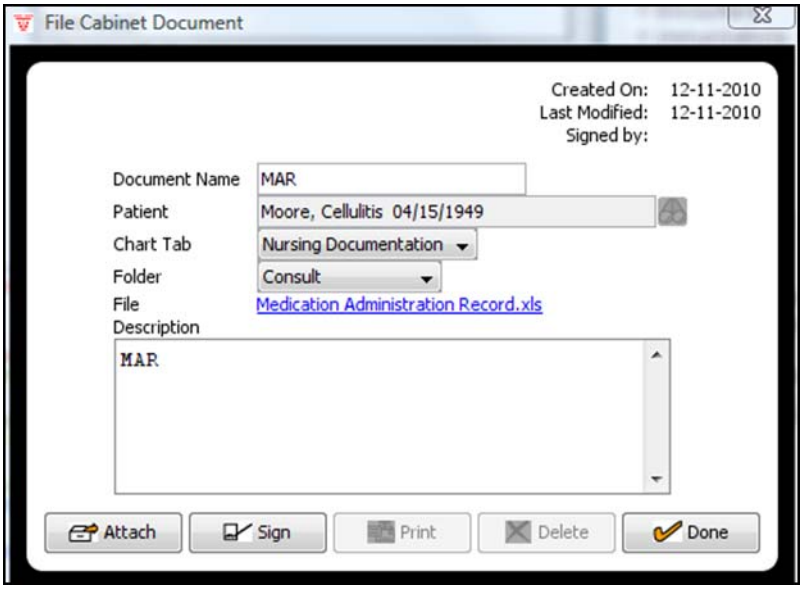
- Select the following interventions:
- Intravenous (IV) Insertion: Administration and monitoring of intravenous fluids and medications
- Medication Administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs
- Pain Management: Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient
- Skin Surveillance: Collection and analysis of patient data to maintain skin and mucous membrane integrity
- 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
- Click after the Intravenous (IV) Insertion line and type: IV started with 20-G catheter in left forearm, first attempt.

- Click after the Wound Care line and type: Neosporin applied to abrasions on right arm per physician order.
- Consider the nursing diagnoses and outcomes above and add other interventions as indicated.

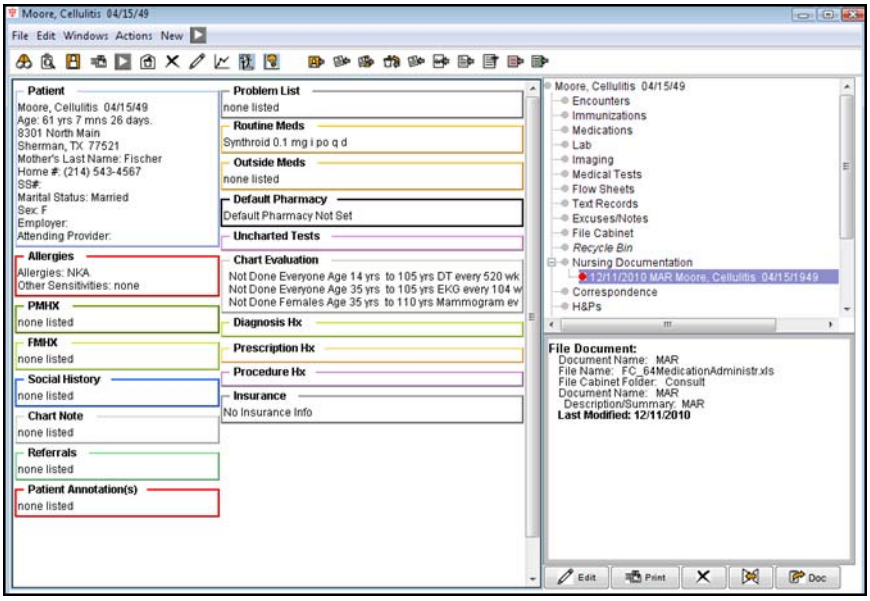


10. Your patient is NPO so you do not administer her oral medication. Move the nurse note by clicking on the minimize icon in the upper right corner. This will bring you back to the patient's chart.

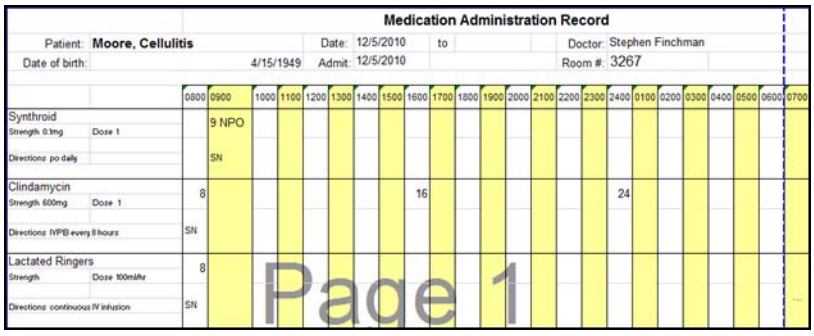
• To document this, click the *New* menu, *Import Items* at the bottom of the list.
• Select Import *File Cabinet Document* and the *File Cabinet* window appears.
• Type MAR into the Document name.
• In the Chart Tab select the drop-down box on the right and choose Nursing Documentation. In the Description field, type MAR.
• Click Attach. Select Existing. Use the search mechanism to select the blank MAR document as before.



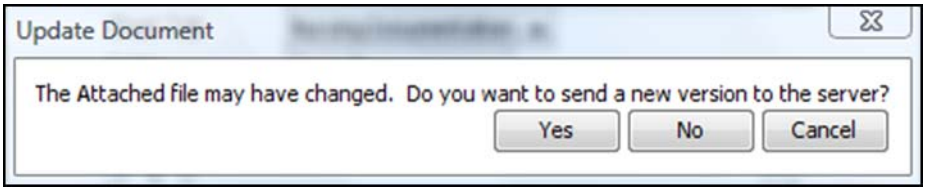
• Click [Done]. The document appears in the Care Tree on the right in the Nursing Documentation tab.
• Click on the + in front of Nursing Documentation.



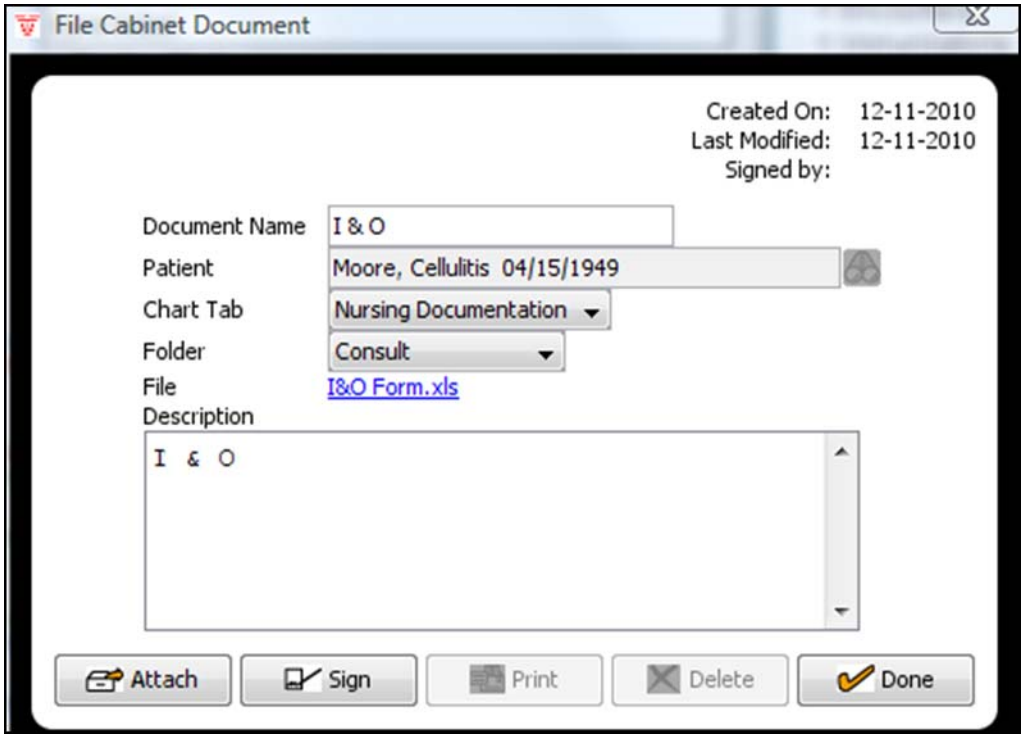
Highlight the MAR and click [Edit] at the bottom right-hand side of the screen. The *File Cabinet* window appears.
• Click on the blue hyperlink next to the word File. The MAR document opens.
• Enter the Patient, Date of Birth, Date, Admit date, Doctor, and Room #.
• On the left enter the Synthroid on the blank field above Strength and Dose.
• In the Strength field type 0.1 mg and in the Dose field type 1. Under directions type po daily. Add 0900 as scheduled administration type.
• Type your name and initials in the Initial & Name area at the bottom of the document.
• Type NPO in the 0900 top time box and your initials in the bottom box.
• Click the [save diskette] icon to save your work. Your shift coordinator receives an order for Lactated Ringers at 100 mL/hr IV and Clindamycin 600 mg IVPB every 8 hours from the physician.
• On the left enter the Clindamycin on a blank field above Strength and Dose. In the Strength field type 600 mg and in the Dose field type 1.
• Under directions type IVPB every 8 hours. Add 0800, 1600, and 2400 as scheduled administration times.
• Type your initials in the 8am top field to indicate the time you initiated the Clindamycin.
• Click the save diskette icon to save your work.
• On the left enter the Lactated Ringers on a blank field above Strength and Dose. In the Dose field type 100 mL/hr. Under directions, type continuous IV infusion.
• Type your initials in the 8am top field to indicate the time you initiated the Lactated Ringers.
• Click the [save diskette] icon to save your work.



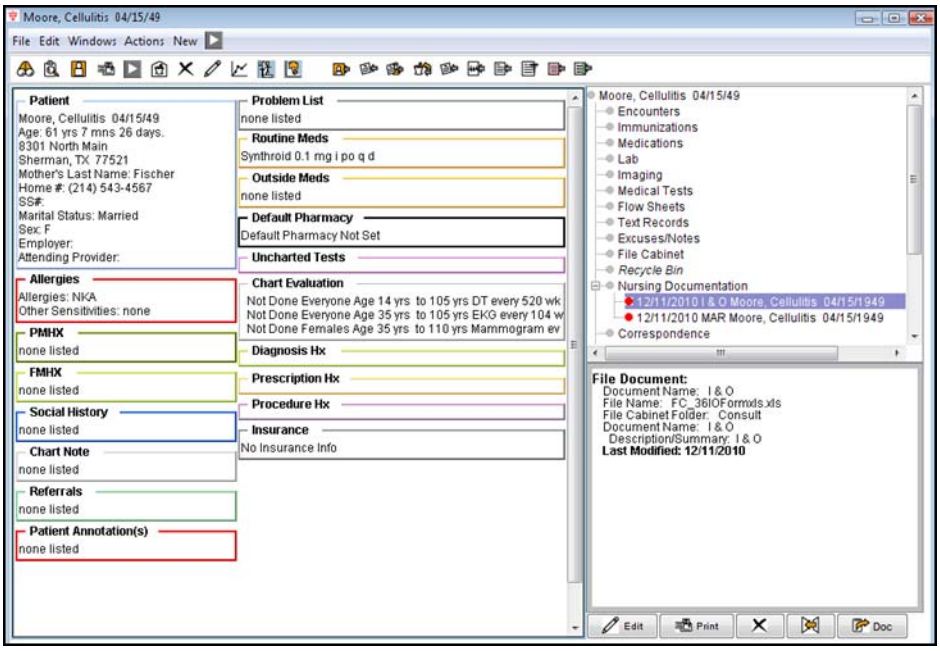
• Click the X on the far right upper corner to close the MAR. A pop up will ask you if you want to save the changes you've made, select yes. The *File Cabinet* Window is still present.
• Click [Done]. A pop-up appears stating "The Attached file may have changed. Do you want to send a new version to the server?" Click [Yes]. The window closes.



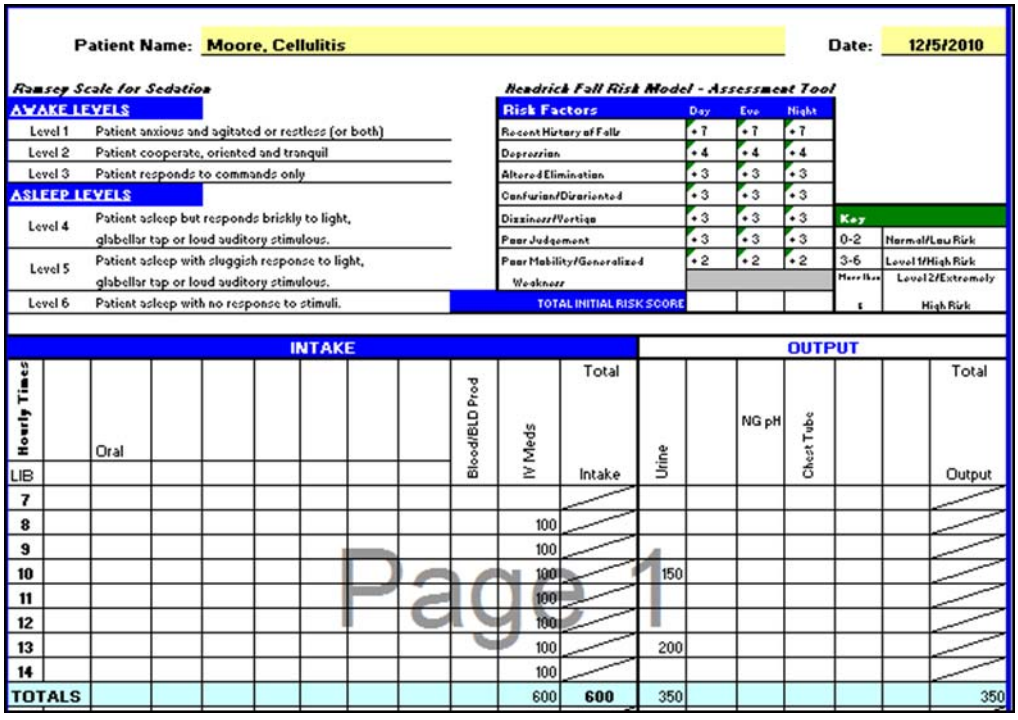
11. Your patient remains NPO, so she has no oral intake during your shift. In order to document intake and output, import the I&O form.
• Click the New menu, Import Items at the bottom of the list.
• Select Import File Cabinet Document and the *File Cabinet* window appears.
• Type Intake and Output into 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 as before.



• 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 the Patient Name and Date.
• She has received 600 mLs of Lactated Ringers since 0800, and it is currently 1400, so document the intake including the shift total.
• Your patient has voided 350 mLs over the course of the shift, 150 mLs at 1000 hours and 200 mLs at 1330 hours. Document her output, including the shift total.



Patient Name: Moore, Cellulitis **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.

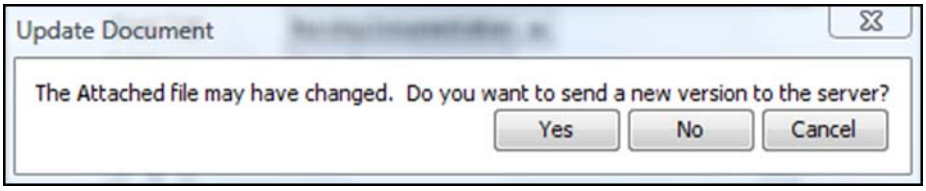
Hendrick Fall Risk Model - Assessment Tool

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			

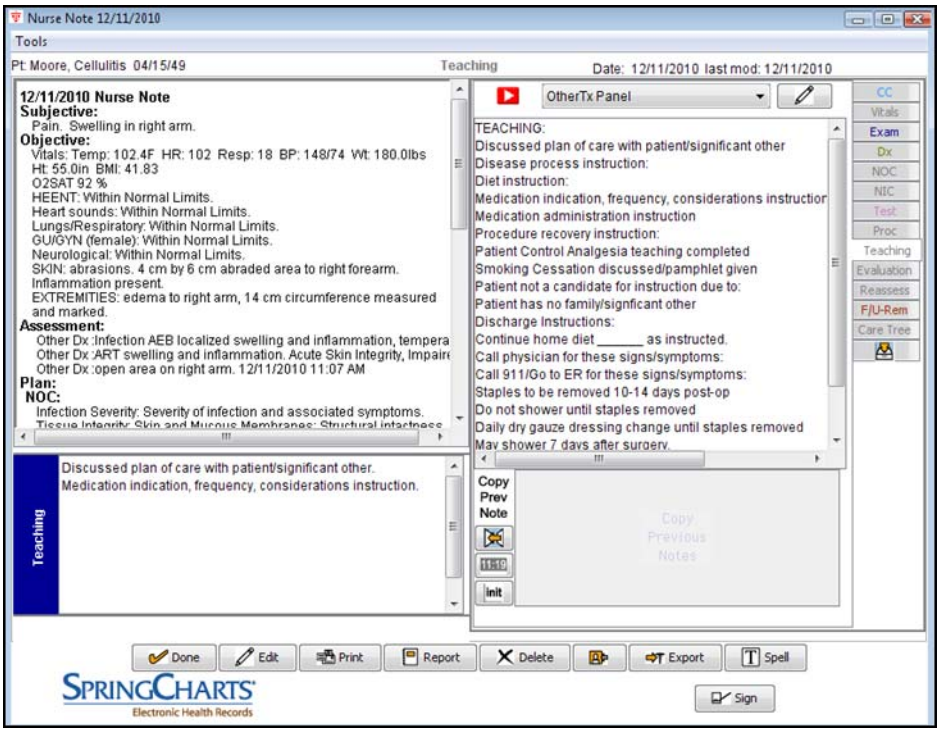
Key	
0-2	Normal/Low Risk
3-6	Level 1/High Risk
More than 6	Level 2/Extremely High Risk

	INTAKE											OUTPUT						
Hourly Times		Oral							Blood/BLD Prod	IV Meds	Total Intake	Urine		NG pH	Chest Tubs			Total Output
LIB																		
7																		
8										100								
9										100								
10										100		150						
11										100								
12										100								
13										100		200						
14										100								
TOTALS										600	600	350						350

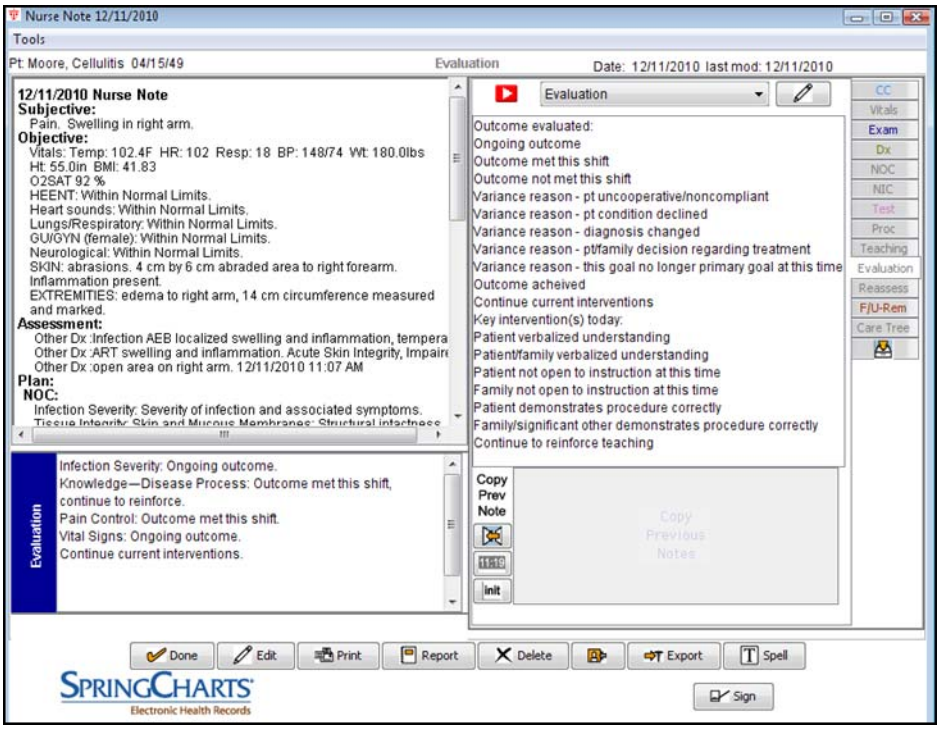
• Click the [save diskette] icon to save your work. Click the X on the far right upper corner to close the MAR. A pop up will ask you if you want to save the changes you've made, select yes.
The *File Cabinet* Window is still present.
• Click [Done]. A pop-up appears stating "The Attached file may have changed. Do you want to send a new version to the server?" Click Yes. The window closes.



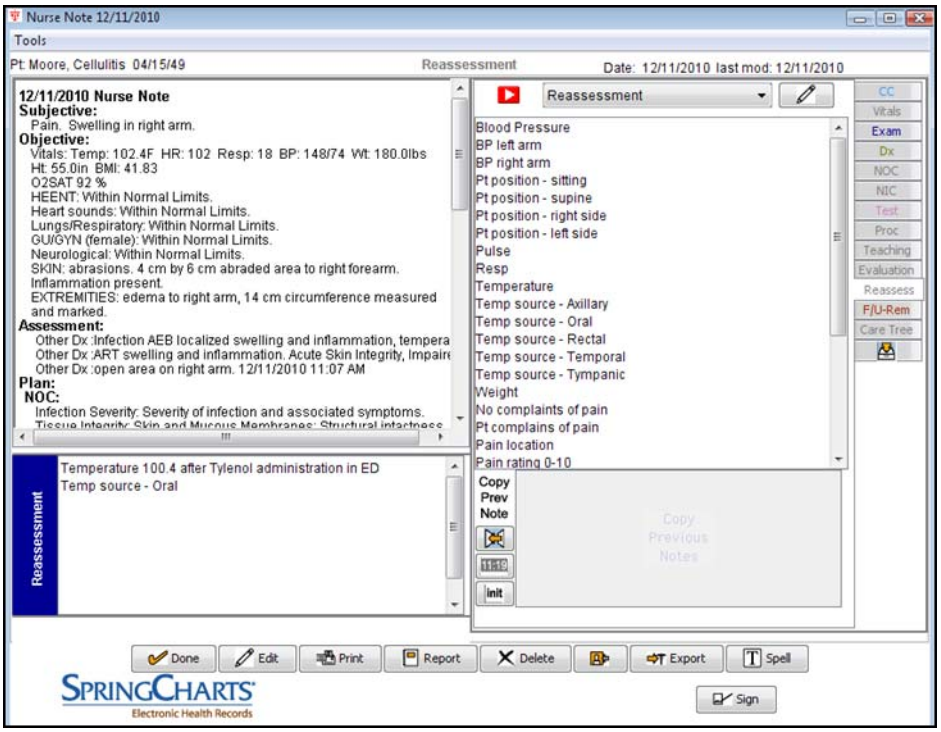
12. Click into the Nurse Note. The nurse note may be located at the bottom of the screen due to minimizing it earlier. Return to the Nurse Note by clicking maximize icon on the right upper side of the nurse note. Click in the *Teaching* button on the right.
• Under the *Other Tx Panel* at the upper right select the following: Discussed plan of care with patient/significant other.
• Medication indication, frequency, considerations instruction.



13. Click into *Evaluation* on the right. Using the Evaluation text on the right, add the text below by clicking on it. (The NOC item for the patient is referenced by the first word.) Add text manually where directed to type.
• Infection Severity: Ongoing outcome.
• Knowledge—Disease Process: Outcome met this shift. Type: continue to reinforce.
• Pain Control: Outcome met this shift.
• Vital Signs: Ongoing outcome.
• Add an outcome for the nursing diagnosis that you added earlier.
• Continue current interventions.

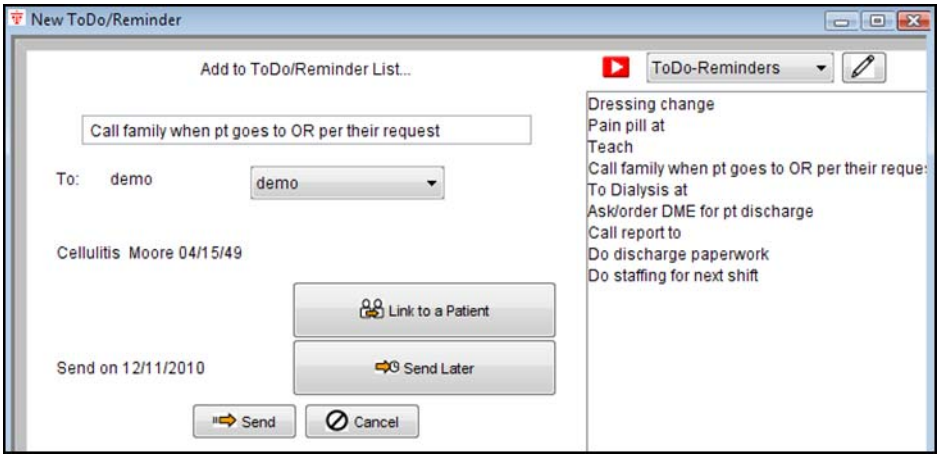


14. Click into *Reassess*. Click into the *Reassessment* text box on the left and click: Temperature and Temp source: Oral. Click into the *Reassessment* box on the left and separate the two entries by using the enter key. After temperature type: 100.4 after Tylenol administration in ED.



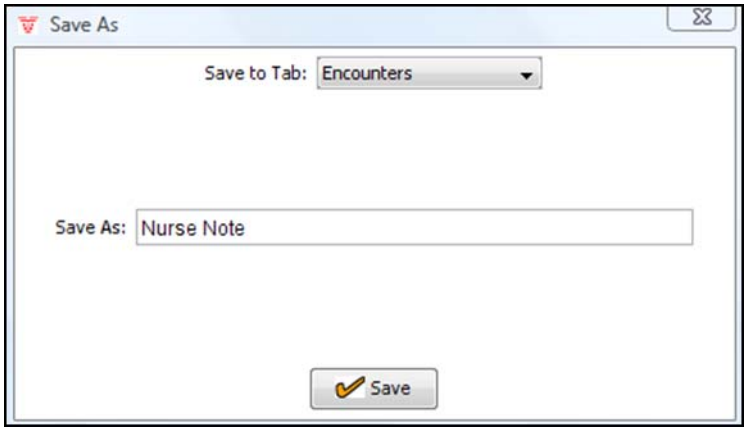
15. The family has gone to the cafeteria to get something to eat but they want to accompany your patient to surgery and wait in the surgical waiting room.

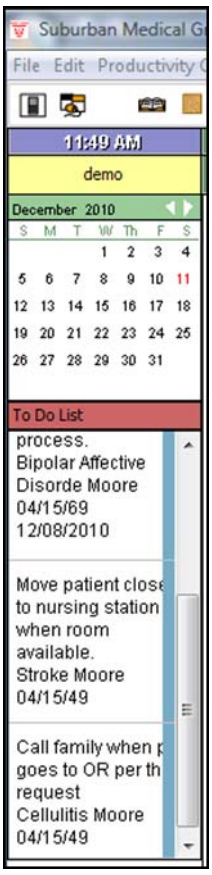
• Click into *F/U-Rem*. Notice your documentation from the *Reassess* area populates the Nurse Note. On the lower left side of the screen below the F/U-Reminders text click on the icon of a finger with a piece of string tied around it.
• The *Add to ToDo/Reminder List* window populates. Under the *ToDo-Reminders* text field on the right click on: Call family when pt. goes to OR per their request. This populates into the text field on the left. Notice your patient's name displays in the middle left section of this window. *F/U-Rem* is linked to a patient when accessed within the *Nurse Note*. Select your name in the To drop down box.



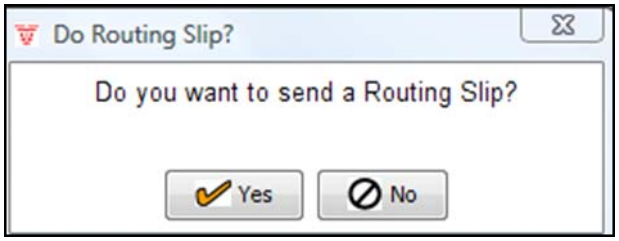
Click [*Send*].
• Look to the far left of the software, to the SpringCharts fields that are open outside of the *Nurse Note*. You will see the dark pink *ToDo List* below the calendar with your new entry visible below it.

16. Click [Done] at the bottom left of the screen. The *Save As* screen populates. Click [Save]

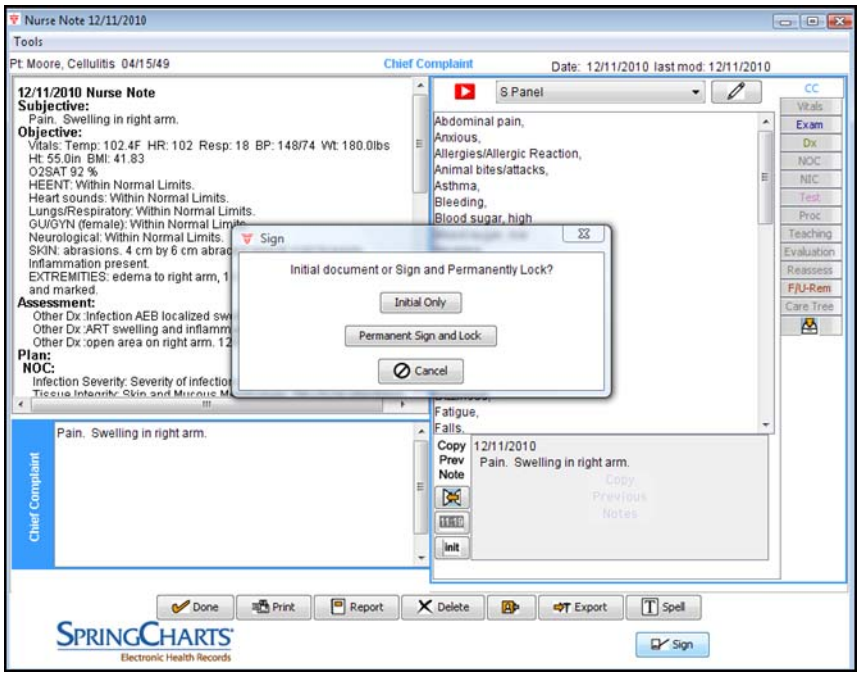




17. A pop-up appears asking if you want to create a routing slip. Click [No].



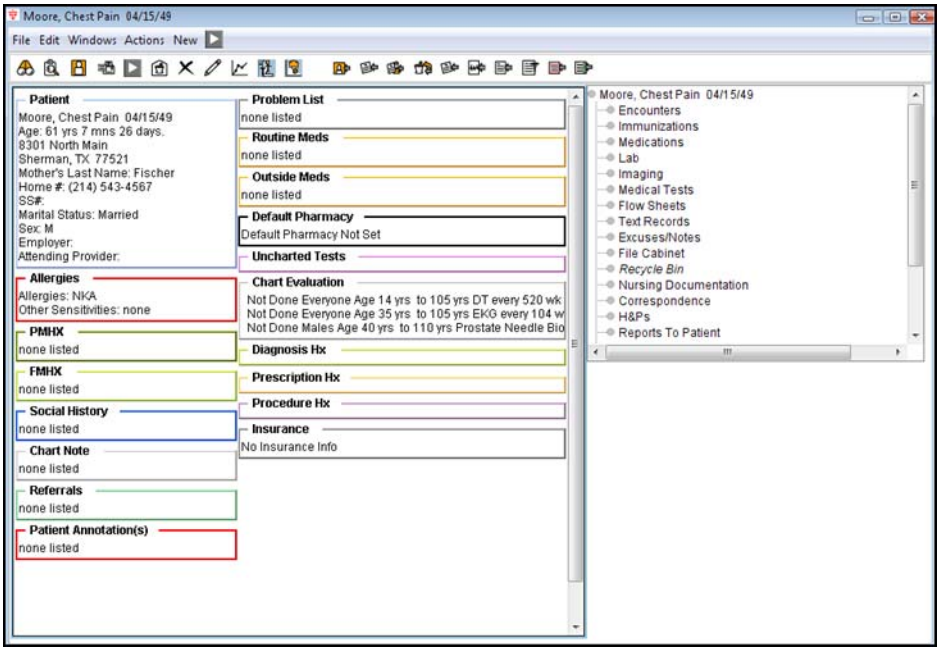
18. In the *Care Tree*, click the + next to *Encounters*. Click on the date of your nurse note and it appears in the bottom right corner box.
• Click [Edit]. Click [*Sign*]. Select *Permanent Sign and Lock* when finished with your *Nurse Note*.



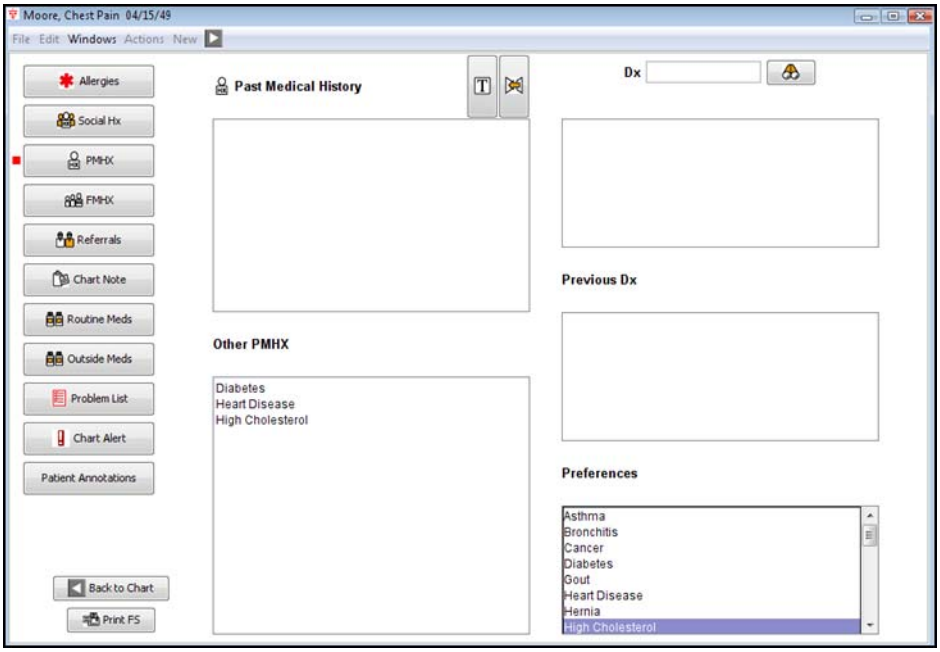
Exercise 11.3

Chest Pain

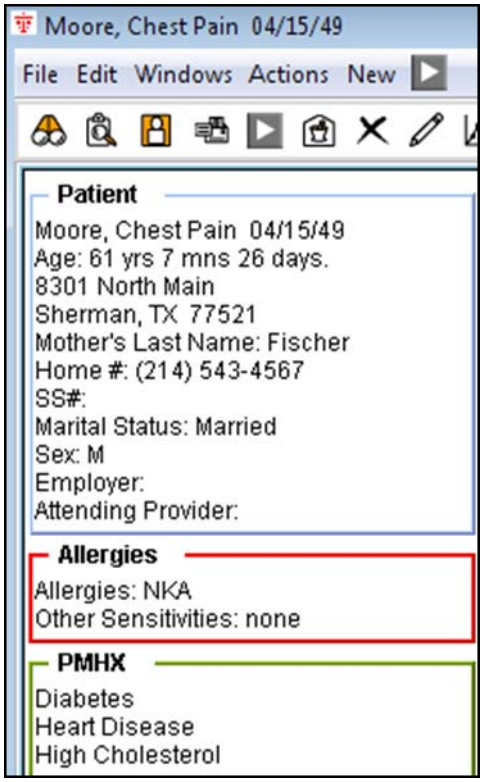
1. After launching SpringCharts, click on *Actions, Open a Chart*. Type in your last name and click the search button. Select your "chest pain" patient and the chart opens.



2. Your patient informs you he has heart disease, Diabetes, and high cholesterol. Click on the *PMHX* box and it populates in the bottom right corner. Click [Edit].
• In the *Preferences* box on the far right bottom of the screen click the three conditions your patient related. They appear under other *PMHX* on the left.

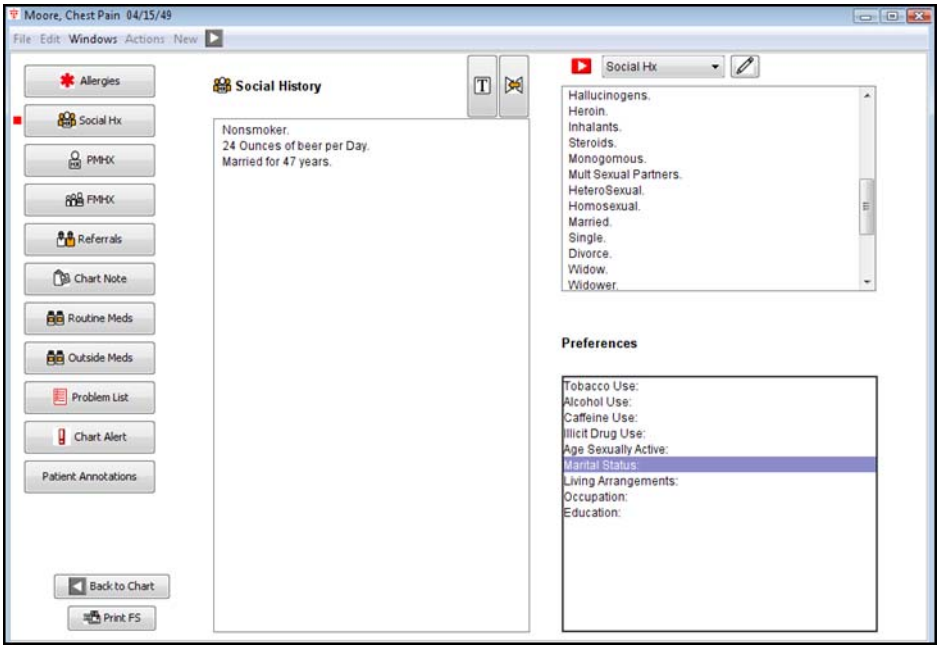


• Click *Back to Chart*. The items are now listed in the *PMHX*.

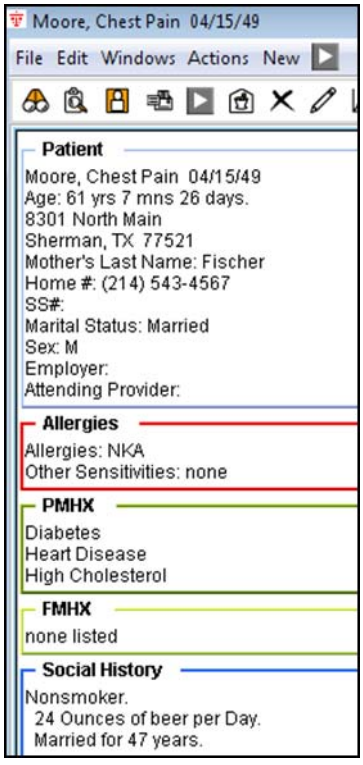


3. Your patient has been married for 47 years. He is a nonsmoker and drinks 24 ounces of beer a day.

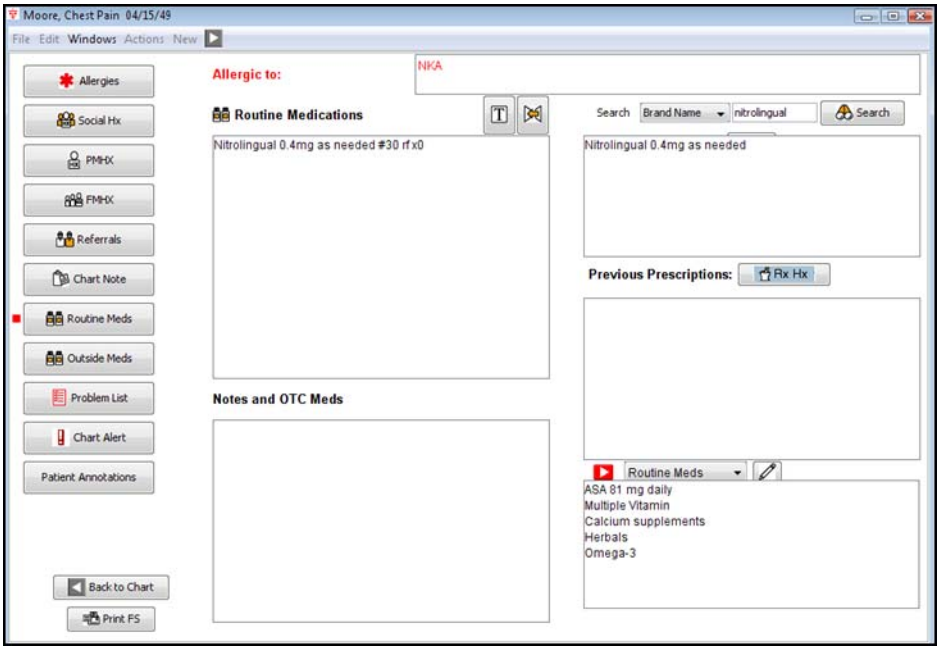
• Click in the *Social History* box. The box appears on the far bottom right hand side of the screen. Click [Edit].
• Under *Social History* click Nonsmoker, Ounces per day, and Married. The items appear on the left side of the screen under Social History. Click into the area and type the information into the field as your patient related it to you. Use the enter key to move each item to a separate line.



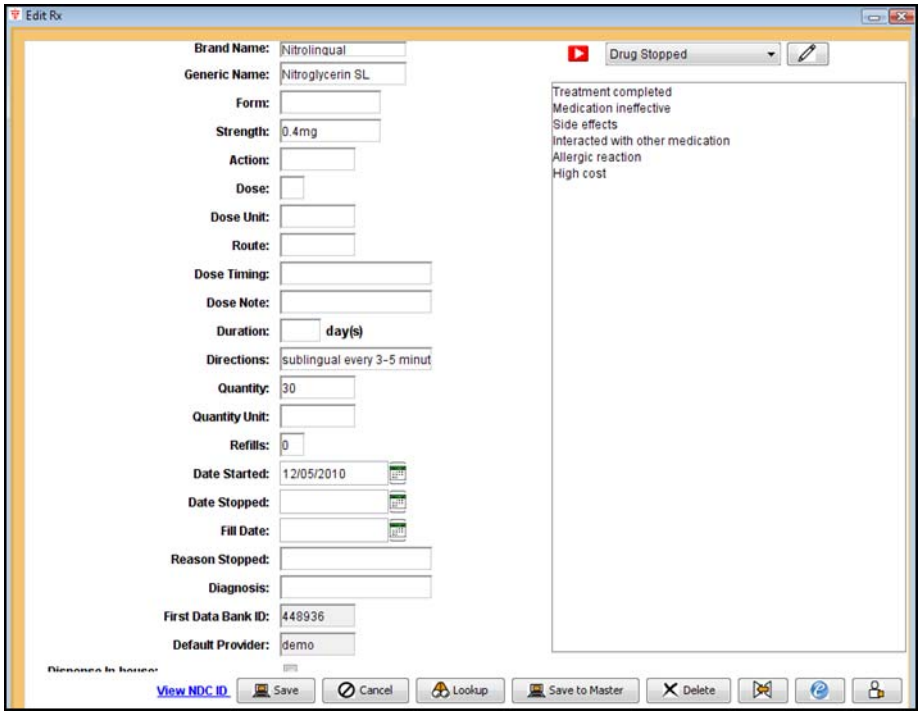
• Click [Back to Chart].



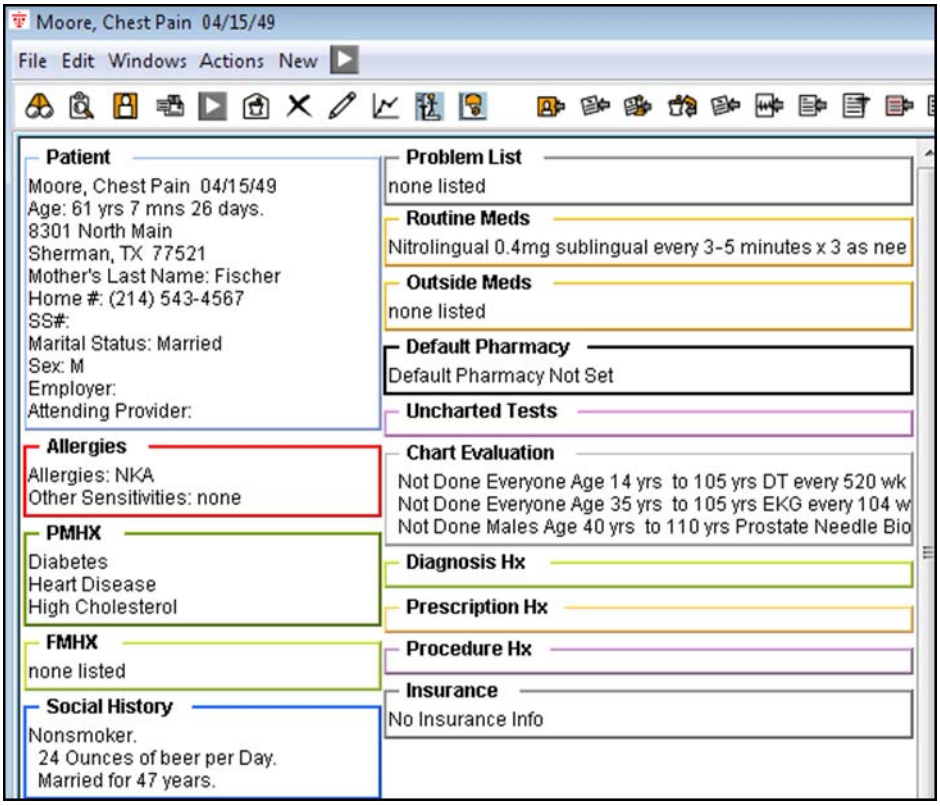
4. Your patient has been taking Nitrolingual 0.4 mg sublingual every 3–5 minutes x3 doses prn chest pain for the last month. Click on the *Routine Meds* box and it populates in the bottom right corner. Click [Edit].
• Click in the space after Brand Name and type: Nitro. Click the search icon.
• Click on the Nitrolingual 0.4 mg to send the medication to the *Routine Medications* list.



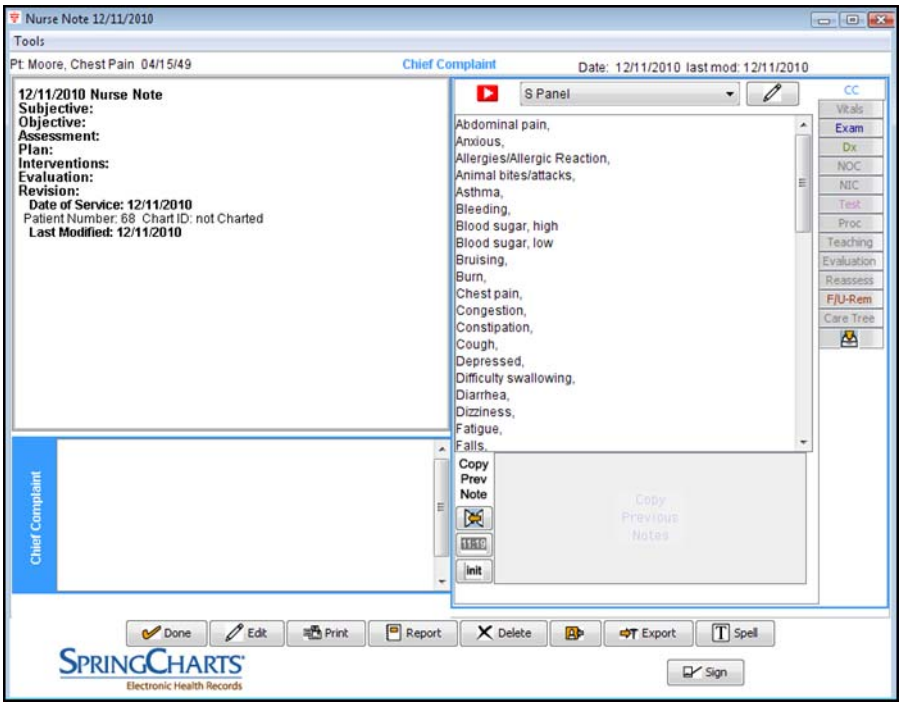
• Click on the Nitrolingual 0.4 mg in the *Routine Medications* list. The *Edit Rx* window opens. Click into Directions and type: sublingual every 3–5 minutes x 3 as needed for chest pain. Click in the calendar to the right of *Date Started* and choose a date one month ago.



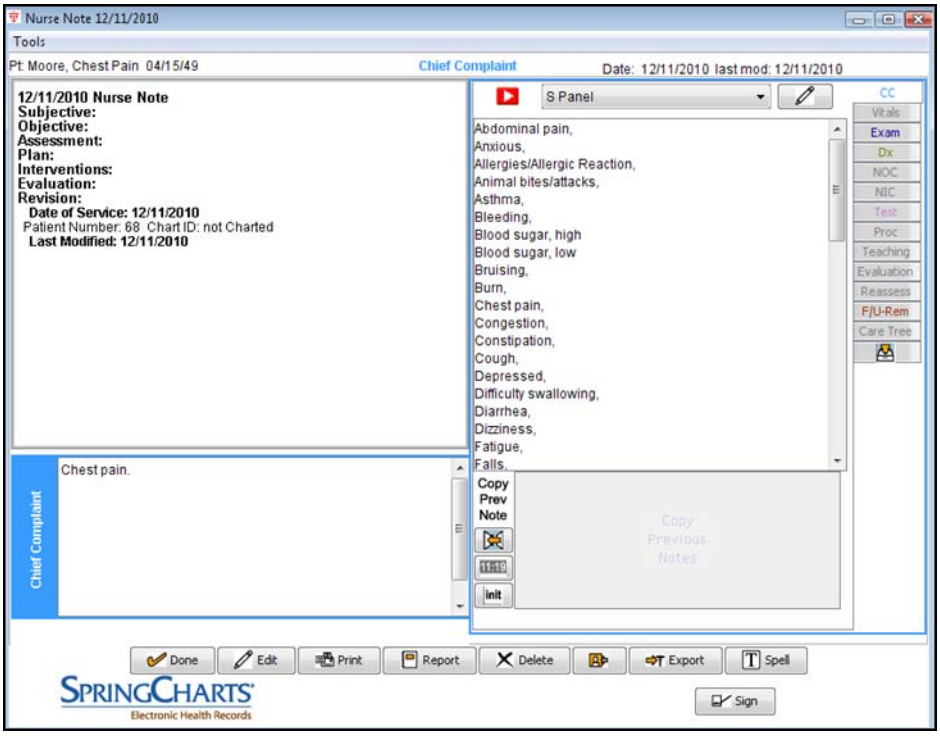
Click Save.
• Click [*Back to Chart*]. The Nitrolingual 0.4 mg is now listed in the Routine Meds.



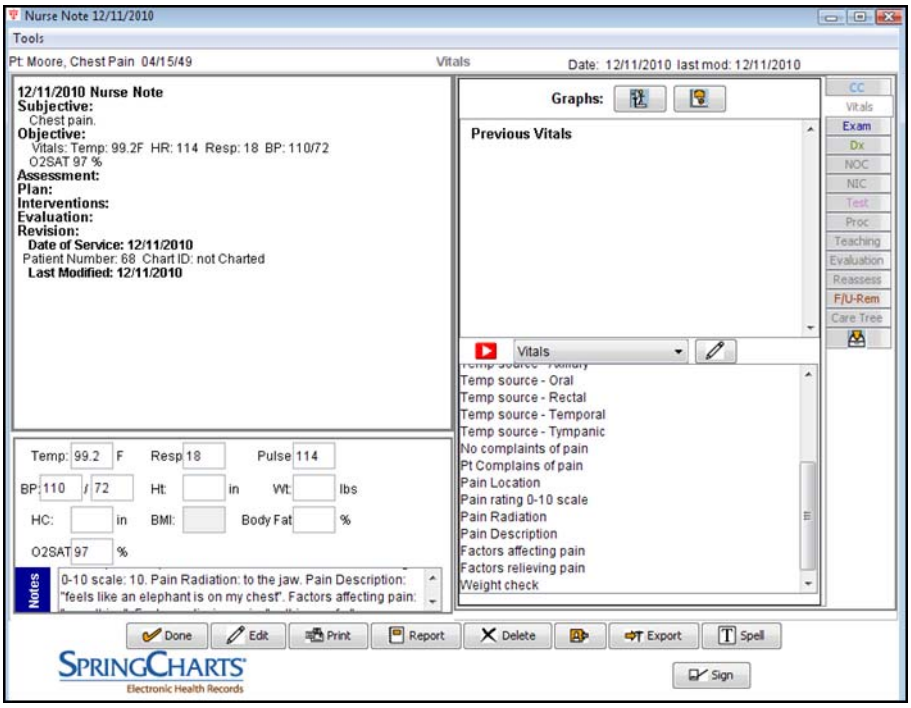
5. Open your *Nurse Note*. Click *New, New Nurse Note*.



6. Your patient complains of chest pain. Select Chest pain from the *S Panel* text and it populates the *Chief Complaint* box on the bottom left of the screen.



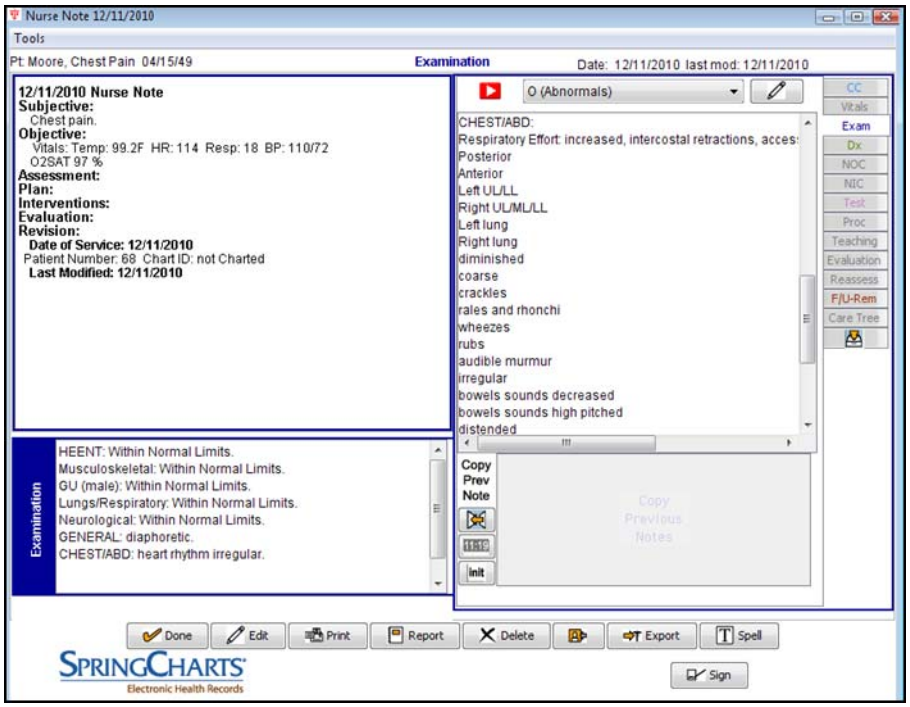
7. Sensing the urgency of responding to your patient's chest pain, you assess his vital signs and pain level. Click on the *Vitals* button on the located below the *CC* button on the vertical navigation bar on the right side of the screen. Note that your *Chief Complaints* now appear in the Subjective section of the *Nurse Note*.
   • You take your patient's vital signs. Document the following: Temp 99.2, Resp 18, Pulse 114, BP 110/72, O2SAT% 97. You defer measuring height and weight due to the patient's chest pain.
   • Under the *Vitals* text box on the right click: BP left arm, Pt position—supine and Temp source—Oral. These items populate the *Notes* textbox on her left.
   • Under the *Vitals* text box on the right click: Pt Complains of pain, Pain Location, Pain rating 0–10 scale, Pain Radiation, Pain Description, Factors affecting pain, and Factors relieving pain.
   • Click into the *Notes* section on the left and add the following information: pain location substernal, 10 on 0–10 scale, radiating to the jaw, description "feels like an elephant is on my chest", Factors affecting pain—"everything," Factors relieving pain—"nothing so far."



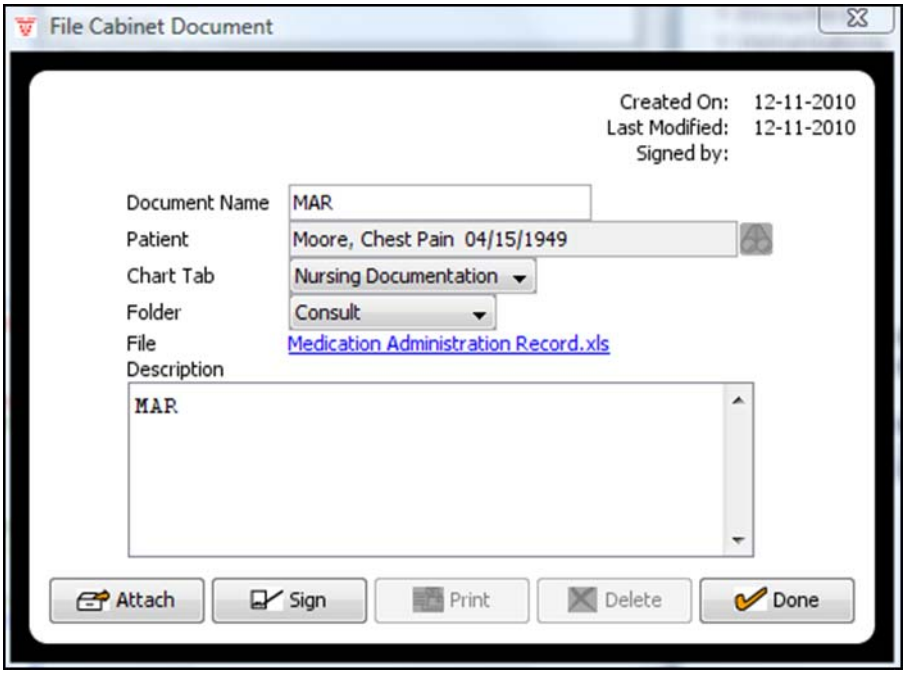
8. You quickly assess your patient while another nurse obtains his Nitrolingual. Click on the *Exam* button located below the *Vitals*. Notice the *O (Normals)* defaults. In this area select the following systems that are within normal limits when you assess your patient: HEENT, Musculoskeletal, GU (male), Lungs/Respiratory, and Neurological.

• Click the drop-down arrow next to *O (Normals)* and select *O (Abnormals)*. Select the *General* section followed by: diaphoretic. Select the *Chest/ABD* section followed by: irregular

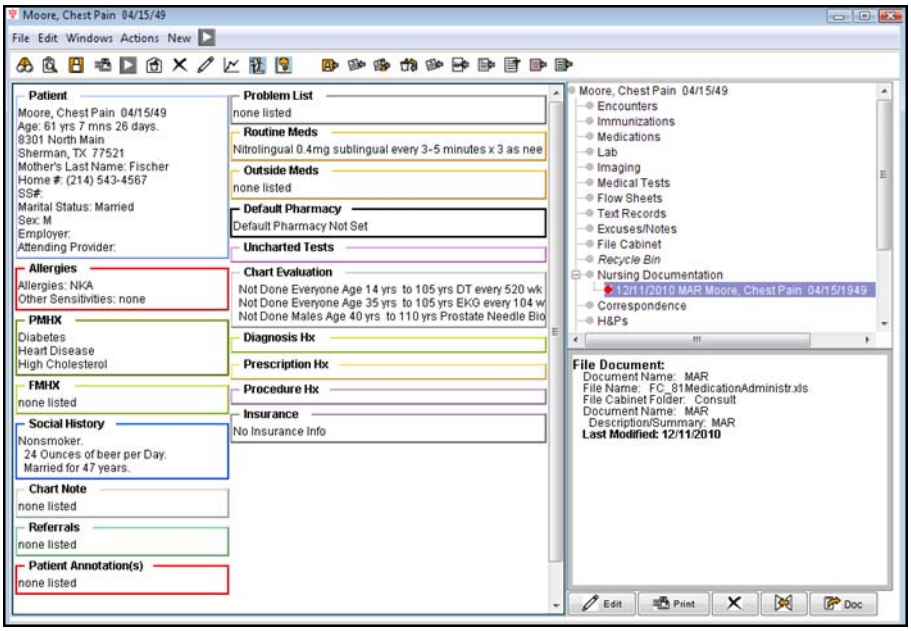
• Click into the *Examination* field in front of irregular and type: heart rhythm



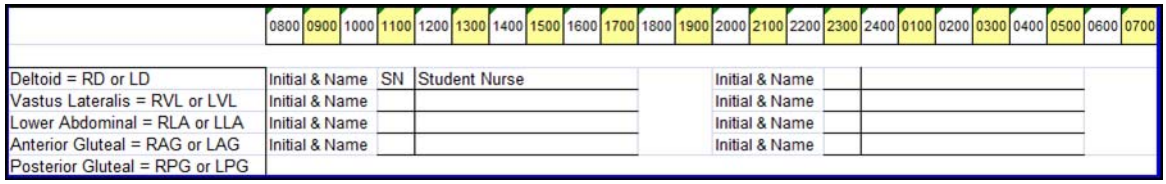
9. You administer the Nitrolingual to your patient for his chest pain. Move the nurse note by clicking on the minimize icon in the upper right corner. This will bring you back to the patient's chart.
• In order to document, click the New menu, Import Items at the bottom of the list.
• Select Import *File Cabinet Document* and the File Cabinet window appears.
• Type MAR into the Document name. In the Chart Tab, select the dropdown box on the right and choose Nursing Documentation.
Click Attach. Select Existing. Use the search mechanism to select the blank MAR document as before.



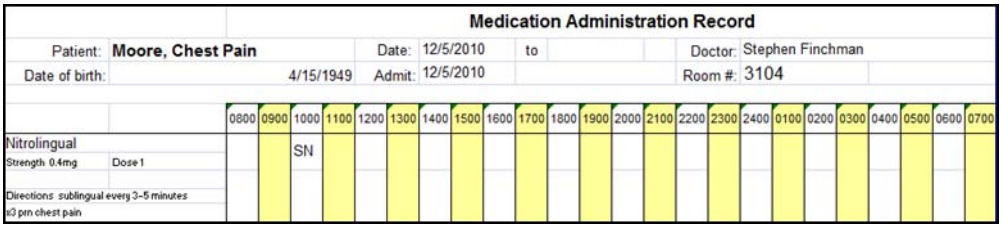
• Click [Done]. The document appears in the Care Tree on the right in the Nursing Documentation tab.
• Click on the + in front of Nursing Documentation.



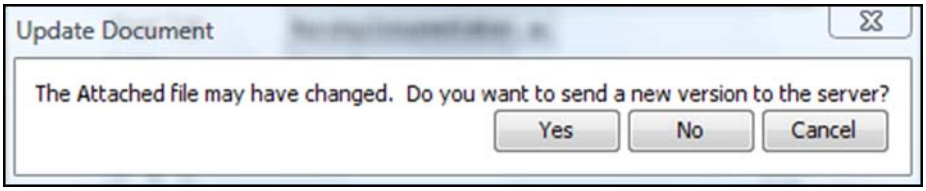
• Highlight the MAR and click Edit at the bottom right of the screen. The *File Cabinet* window appears.
• Click on the blue hyperlink next to the word File. The MAR document opens.
• Enter the Patient, Date of Birth, Date, Admit date, Doctor, and Room #.
• On the left enter the Nitrolingual on the blank field above Strength and Dose. In the Strength field type 0.4 mg and in the Dose field type 1.
• Under directions type sublingual every 3–5 minutes x3 doses prn chest pain.
• Type your name and initials in the Initial & Name area at the bottom of the document.



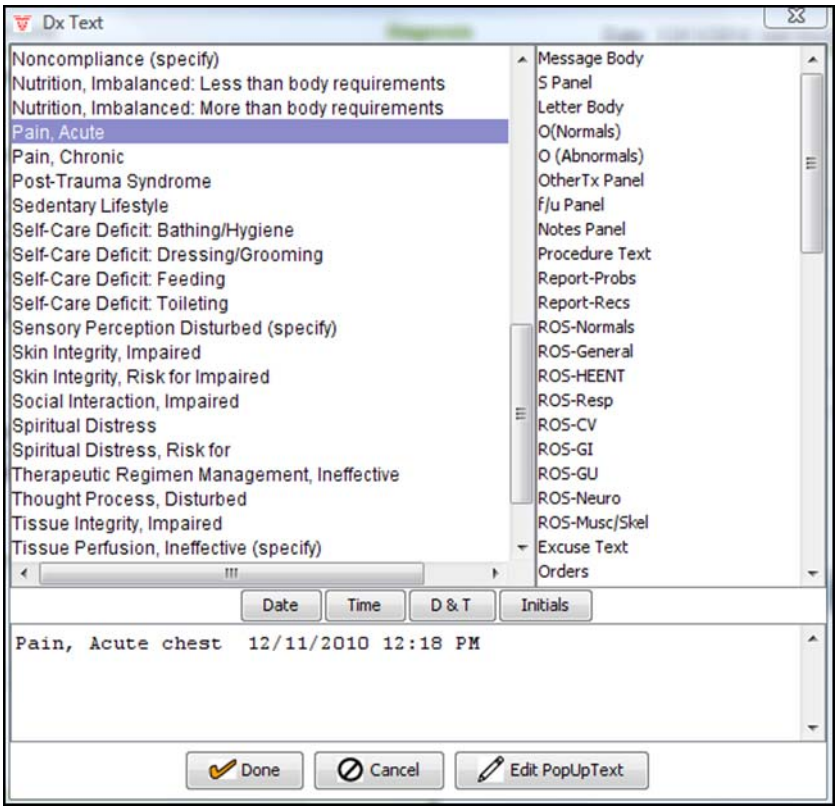
• Type your initials in the 10am top time box. Click the save diskette icon to save your work.



• Click the X on the far right upper corner to close the MAR. A pop up will ask you if you want to save the changes you've made, select yes. The *File Cabinet* Window is still present.
• Click [Done]. A pop-up appears "The Attached file may have changed. Do you want to send a new version to the server?" Click [Yes]. The window closes.

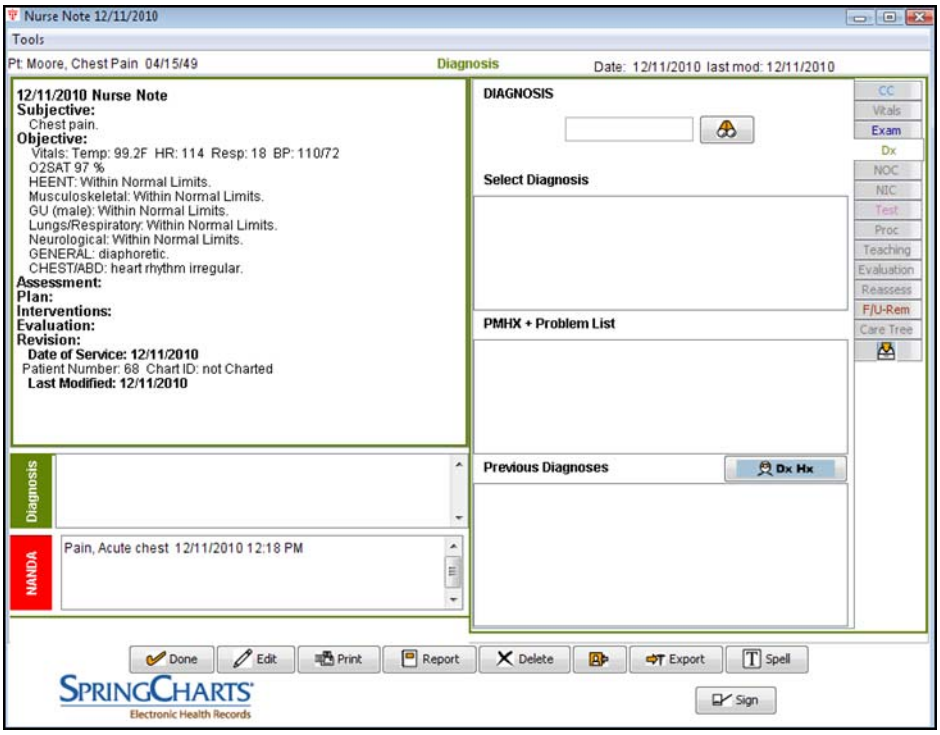


10. Your patient's chest pain is relieved after the initial dose of Nitrolingual so you develop his plan of care. The nurse note may be located at the bottom of the screen due to minimizing it earlier. Return to the Nurse Note by clicking maximize icon on the right upper side of the nurse note. Click into the *Dx* button below the Exam button on the right. Click on the red *NANDA* lettering on the left bottom of the screen. The *Dx* text window populates.
• Click Pain, Acute. Click into the text field after acute and type: chest.
Click the [D&T] icon to date and time the entry.



Click [Done].

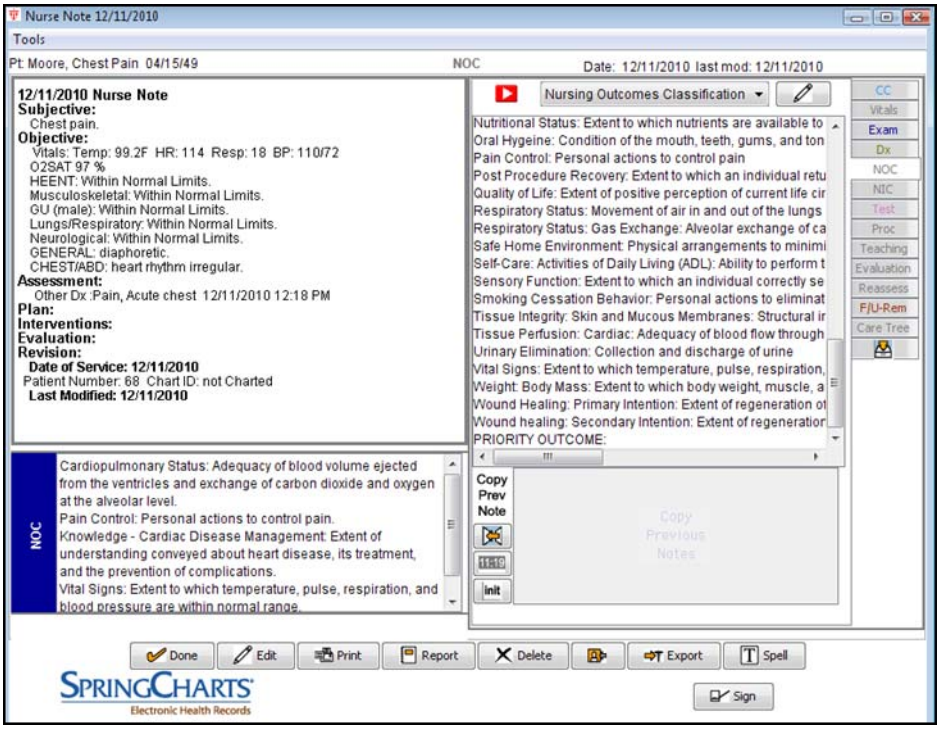
• Add the etiology (related factor) and symptoms (as evidenced by) by typing them into the field after the nursing diagnosis to individualize the nursing diagnosis.



11. Click the *NOC* tab on the right located below the *Dx* tab in the vertical navigation bar on the right. Notice that your *NANDA* documentation populates the *Nurse Note*.

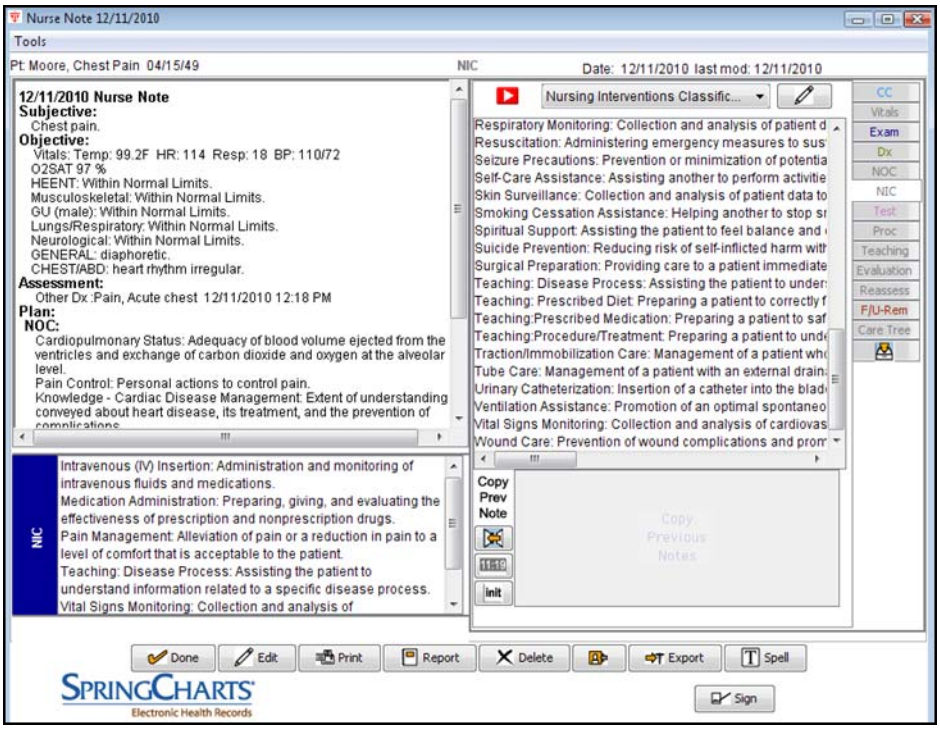
Below the *Nursing Outcomes Classification* select the following:

- Cardiopulmonary Status: Adequacy of blood volume ejected from the ventricles and exchange of carbon dioxide and oxygen at the alveolar level.
- Pain Control: Personal actions to control pain.
- Knowledge—Cardiac Disease Management: Extent of understanding conveyed about heart disease, its treatment, and the prevention of complications
- Vital Signs: Extent to which temperature, pulse, respiration, and blood pressure are within normal range.
- Use the Enter key to place text on separate lines to streamline your documentation.



12. Click the *NIC* button on the right below the *NOC* button. Notice that your outcomes populate the *Nurse Note*.

- Select the following interventions:
- Intravenous (IV) Insertion: Administration and monitoring of intravenous fluids and medications.
- Medication Administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs.
- Pain Management: Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient.
- 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.

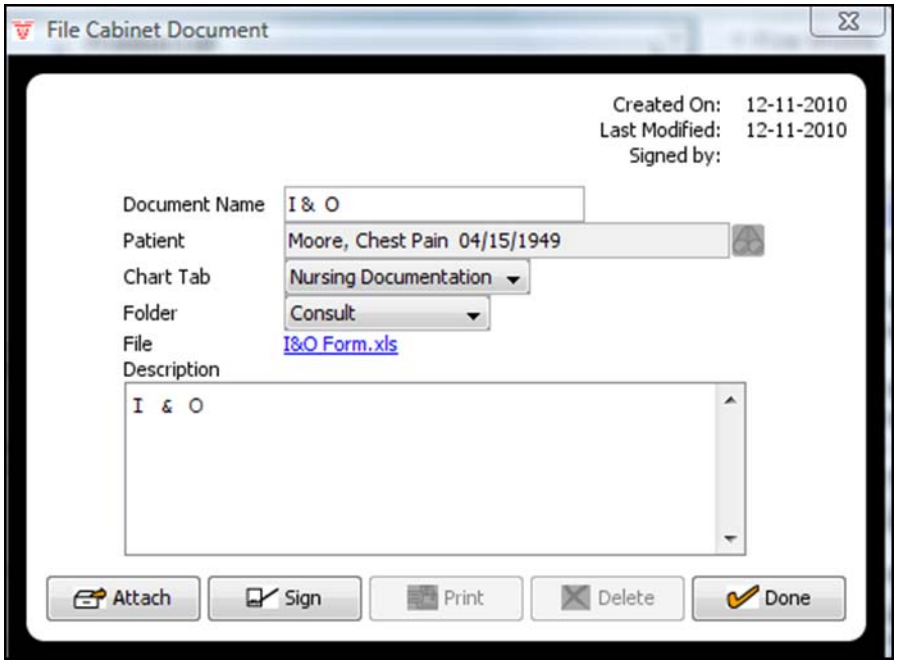


13. In order to document intake and output, import the I&O form. Move the nurse note by clicking on the minimize icon in the upper right corner. This will bring you back to the patient's chart.

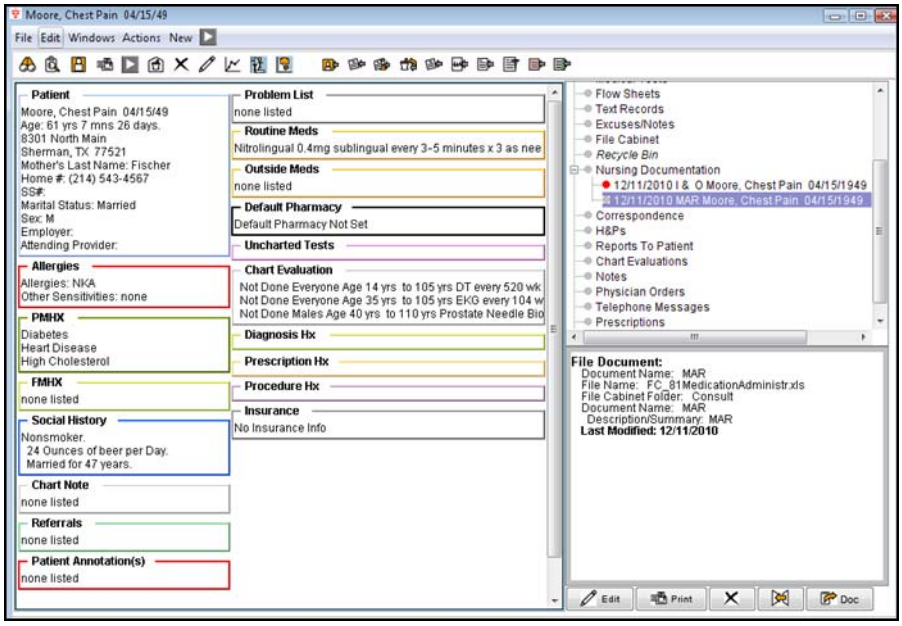
• Click the *New* menu, Import Items at the bottom of the list. Select Import *File Cabine*t Document and the *File Cabinet* window appears.

• Type Intake and Output into the Document name. In the Chart Tab select the drop-down box on the right and choose Nursing Documentation.

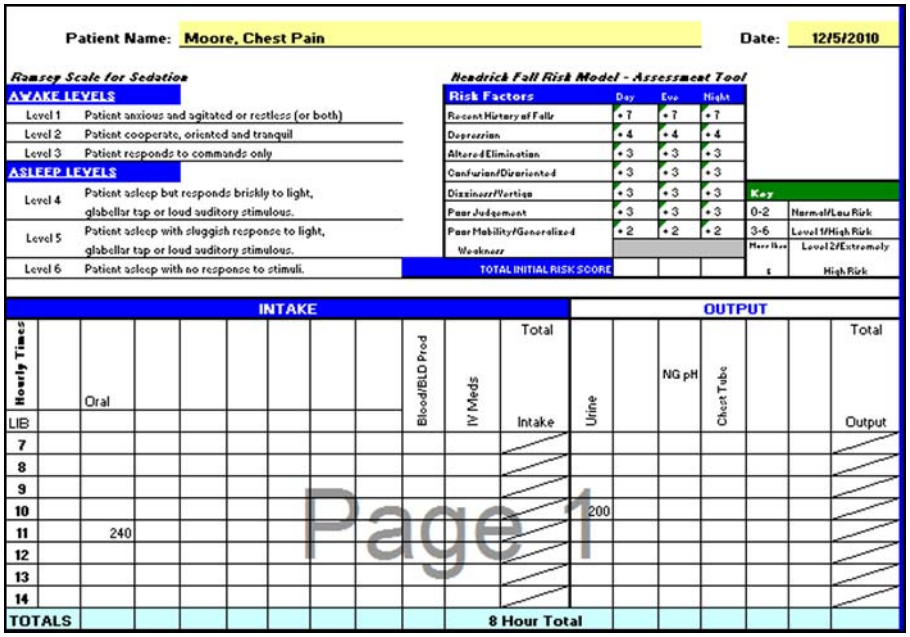
• In the Description field type Intake and Output. Click [Attach]. Select Existing. Use the search mechanism to select the blank Intake and Output document.



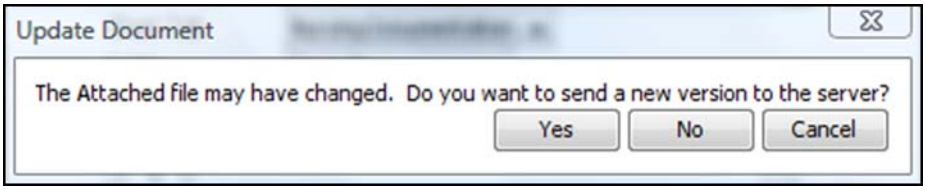
• Click [Done]. The document appears in the Care Tree on the right in the Nursing Documentation tab.
• Click on the + in front of Nursing Documentation.



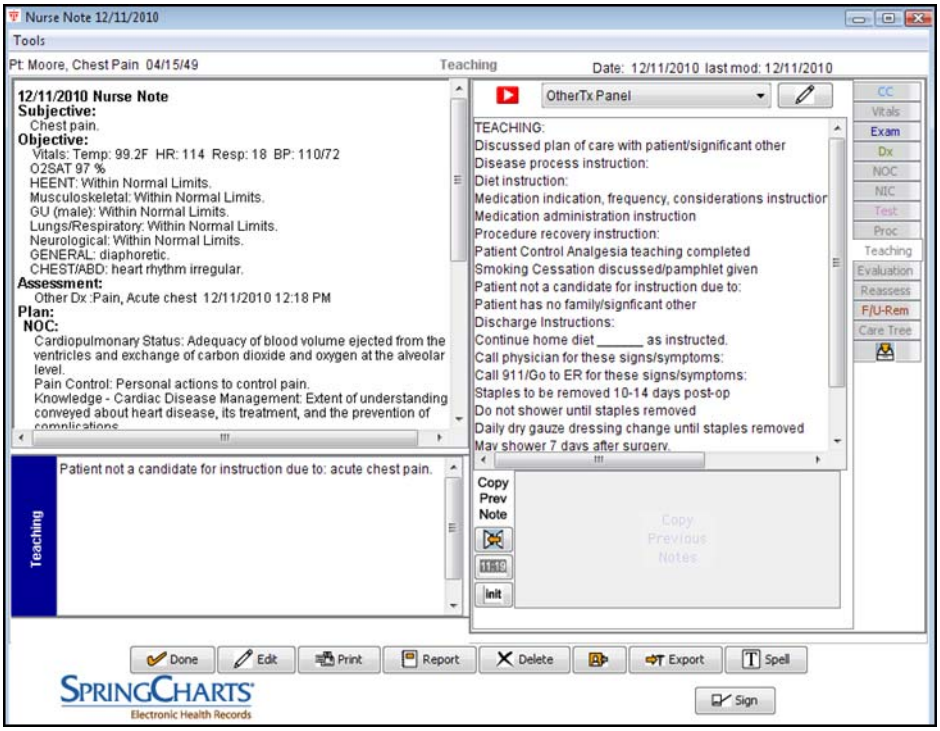
Highlight the Intake and Output and click Edit at the bottom right-hand side of the screen. The *File Cabinet* window appears.
• Click on the blue hyperlink next to the word File. The Intake and Output document opens.
• Type in the Patient Name and Date.
• Your patient consumed 240 mLs orally today at 1130. He voided 200 mLs at 1000 when he first arrived. Document these items. Your shift is not over, so don't fill in shift totals at this time.
• Type in the Patient Name and Date.
• Your patient consumed 240 mLs orally today at 1130. He voided 200 mLs at 1000 when he first arrived. Document these items. Your shift is not over, so don't fill in shift totals at this time.



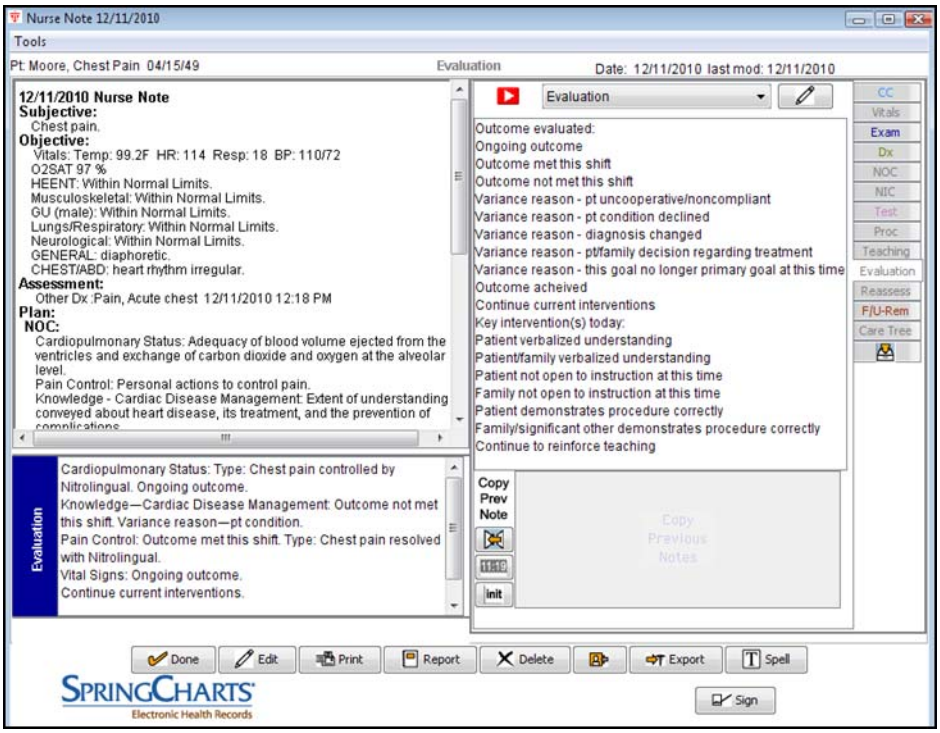
• Click the [save diskette] icon to save your work. Click the X on the far right upper corner to close the MAR. A pop up will ask you if you want to save the changes you've made, select yes. The *File Cabinet* Window is still present.
• Click [Done]. A pop up appears "The Attached file may have changed. Do you want to send a new version to the server?" Click [Yes]. The window closes.



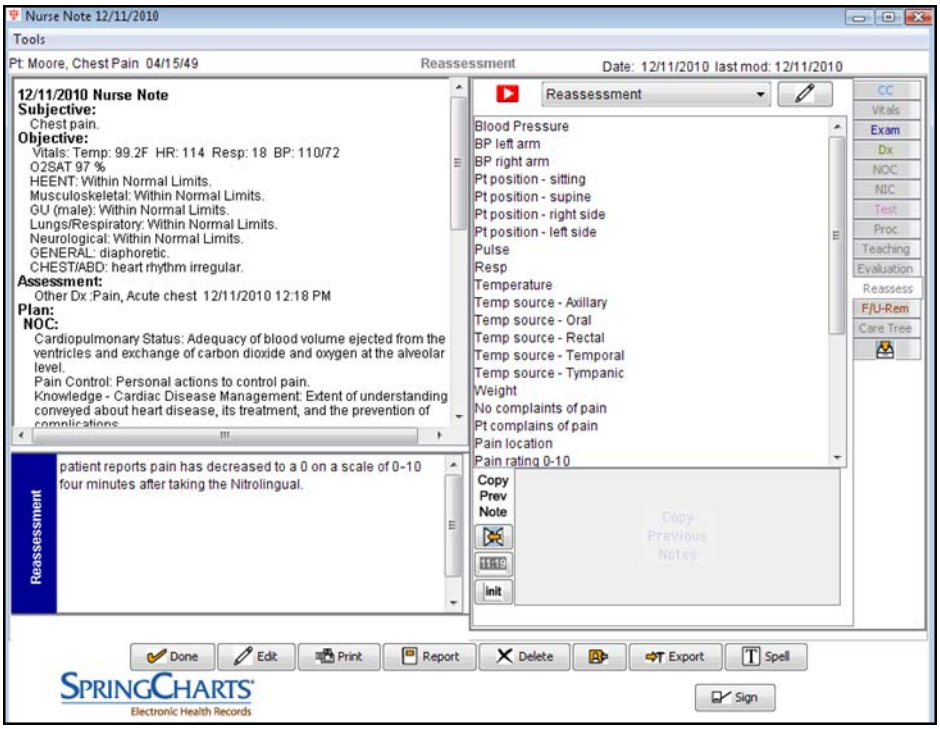
14. The nurse note may be located at the bottom of the screen due to minimizing it earlier. Return to the Nurse Note by clicking maximize icon on the right upper side of the nurse note. Click in the *Teaching* button on the right.
• Under the *Other Tx Panel* select the following: Patient not a candidate for instruction due to: and it populates into the *Teaching* area on the left of the screen.
• Click into the *Teaching* area after the selected text and type: acute chest pain.



15. Click into *Evaluation* on the right. Using the *Evaluation* text on the right side, add the text below by clicking on it. (The NOC item for the patient is referenced by the first word.) Add text manually where directed to type.
• Cardiopulmonary Status: Type: Chest pain controlled by Nitrolingual. Ongoing outcome.
• Knowledge—Cardiac Disease Management: Outcome not met this shift. Variance reason—pt condition.
• Pain Control: Outcome met this shift. Type: Chest pain resolved with Nitrolingual.
• Vital Signs: Ongoing outcome.
• Continue current interventions.

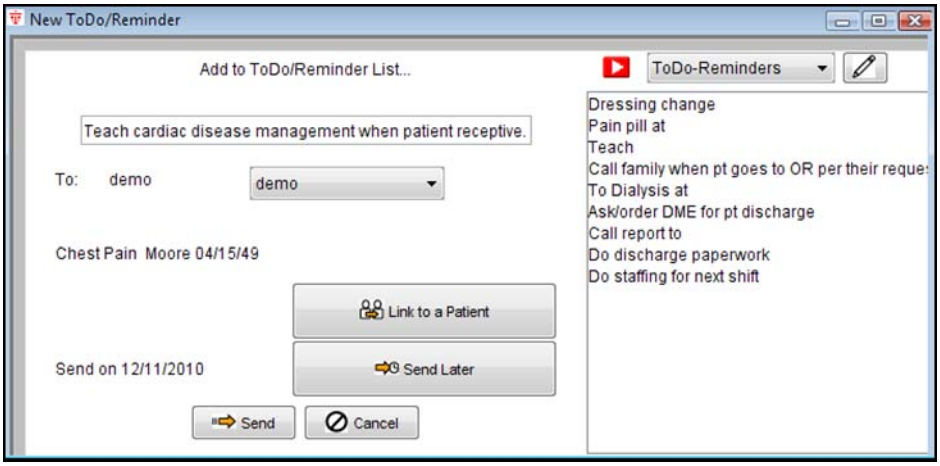


16. Click into *Reassess*. Click into the *Reassessment* text box on the left and type: patient reports his pain has decreased to a 0 on a scale of 0–10 four minutes after taking the Nitrolingual.

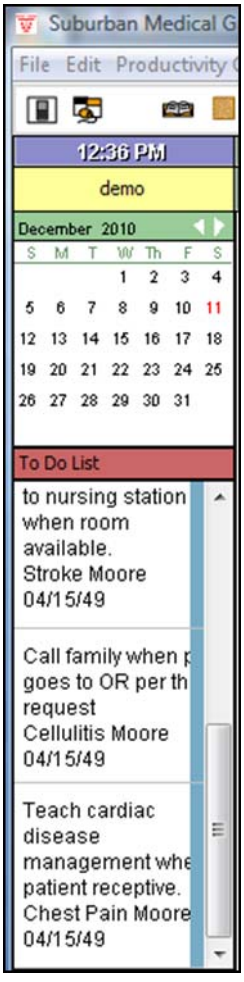


17. Click into *F/U-Rem*. Notice your documentation from the *Reassess* area populates the *Nurse Note*. On the left side of the screen below the *F/UReminders* text, click on the icon of a finger with a piece of string tied around it.

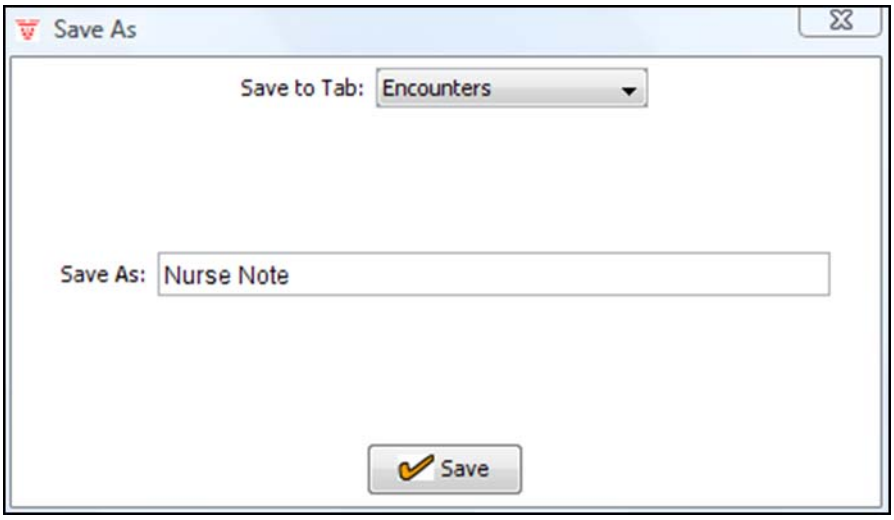
• The *Add to ToDo/Reminder List* . . . window populates. Under the *ToDo-Reminders* text field on the right click on: Teach. It populates into the text field on the left.
• Click after the word Teach and type: cardiac disease management when patient receptive. Select your name in the To drop down.



• Notice that your patient's name displays in the middle left portion of the screen. Click [Send].
• Look to the far left of the software, to the SpringCharts fields that are open outside of the *Nurse Note*. Your entry appears in the dark pink *ToDoList* below the calendar.



18. Click [Done]. The [Save As] screen populates. Click [Save].



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

20. 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.