

**Level 4** – Level 4 of *Nursing Documentation Using Electronic Health Records* includes chapters 12, 13, and 14. In these last chapters, students learn to perform more complex EHR documentation functions. Level 4 contains the EHR capstone section. Chapters 13 and 14 present students with case studies that require them to navigate through all the screens of SpringCharts as they build Nurse Notes for multiple patients with various disease processes.

## Chapter 14 – Learning Assessment

Chapter 14 presents the students with 15 exercises for which they will use the resources of Appendix C. Appendix C contains copies of documents that are typically used in a paper environment. From these records the students gather information and place it in an electronic format within the EHR program. These exercises take students through multiple screens in SpringCharts as they build electronic charts and Nurse Notes from the provided material.

**NOTE:**

The documents in Appendix C do not have a patient name or biographical data. Please use your own name and data.

## Learning Outcomes

*When you complete Chapter 14, you will be able to:*

- 14.1** Use all aspects of the SpringCharts program successfully

### Exercise 14.1

1. Using Source Document 1—Admission Data Base (See Appendix B), complete Allergies and PMHX.

The screenshot shows a software window titled "Moore, Paul 04/15/49". It contains a menu bar (File, Edit, Windows, Actions, New) and a toolbar with icons for file operations and editing. The main content area is divided into three sections: "Patient", "Allergies", and "PMHX".

Patient
Moore, Paul 04/15/49
Age: 61 yrs 7 mns 22 days.
8301 North Main
Sherman, TX 77521
Mother's Last Name: Fischer
Home #: (214) 543-4567
Mobile #: (214) 543-0921
SS#:
Marital Status: Married
Sex: M
Employer: St. John's Hospital
Attending Provider:

  

Allergies
Amoxicillin
Other Sensitivities:
causes hives

  

PMHX
HTN 401.9
Diabetes
Heart Disease

2. Print the face sheet. Record your name on the document and submit to your instructor.

## Exercise 14.2

1. Using Source Document 2—Admission Medication Reconciliation Form (See Appendix B), enter the Routine Meds in SpringCharts.

Moore, Paul 04/15/49

File Edit Windows Actions New

**Patient**  
Moore, Paul 04/15/49  
Age: 61 yrs 7 mns 22 days.  
8301 North Main  
Sherman, TX 77521  
Mother's Last Name: Fischer  
Home #: (214) 543-4567  
Mobile #: (214) 543-0921  
SS#: \_\_\_\_\_  
Marital Status: Married  
Sex: M  
Employer: St. John's Hospital  
Attending Provider: \_\_\_\_\_

**Allergies**  
Amoxicillin  
Other Sensitivities:  
causes hives

**PMHX**  
HTN 401.9  
Diabetes  
Heart Disease

**Problem List**  
none listed

**Routine Meds**  
Lopressor 100 mg i po bid  
HCTZ 50 mg i q am  
K-Dur 10meq i po bid  
Glucophage 500mg i po bid  
Nitrolingual 0.4mg sublingual prn chest pain  
OTC Meds: \_\_\_\_\_

**Outside Meds**  
none listed

**Default Pharmacy**  
Default Pharmacy Not Set

**Uncharted Tests**  
\_\_\_\_\_

**Chart Evaluation**  
Not Done Everyone Age 14 yrs to 105 yrs DT every 520 wk  
Not Done Everyone Age 35 yrs to 105 yrs EKG every 104 w  
Not Done Males Age 40 yrs to 110 yrs Prostate Needle Bio

**Diagnosis**  
\_\_\_\_\_

2. Print the face sheet. Record your name on the document and submit to your instructor.

## Exercise 14.3

1. Using Source Document 1—Admission Data Base (See Appendix B), add the Social History to SpringCharts.

Moore, Paul 04/15/49

File Edit Windows Actions New

**Patient**  
 Moore, Paul 04/15/49  
 Age: 61 yrs 7 mns 22 days.  
 8301 North Main  
 Sherman, TX 77521  
 Mother's Last Name: Fischer  
 Home #: (214) 543-4567  
 Mobile #: (214) 543-0921  
 SS#: \_\_\_\_\_  
 Marital Status: Married  
 Sex: M  
 Employer: St. John's Hospital  
 Attending Provider: \_\_\_\_\_

**Allergies**  
 Amoxicillin  
 Other Sensitivities:  
 causes hives

**PMHX**  
 HTN 401.9  
 Diabetes  
 Heart Disease

**FMHX**

**Social History**  
 Nonsmoker.  
 Alcohol Use: 2 beers a day  
 Marital Status: Married.  
 Lives with Spouse.

2. Print the face sheet. Record your name on the document and submit to your instructor.

## Exercise 14.4

1. Using Source Document 1—Admission Data Base (See Appendix B), add the Chief Complaint to SpringCharts.

Nurse Note 12/07/2010

Pt Moore, Paul 04/15/49

Chief Complaint Date: 12/07/2010 last mod: 12/07/2010

**12/07/2010 Nurse Note**  
**Subjective:**  
**Objective:**  
**Assessment:**  
**Plan:**  
**Interventions:**  
**Evaluation:**  
**Revision:**  
 Date of Service: 12/07/2010  
 Patient Number: 59 Chart ID: not Charted  
 Last Modified: 12/07/2010

**Chief Complaint**  
 Chest pain, started an hour ago but is getting worse. Rates pain a 9 on 0-10 scale and states movement makes it worse. Nothing has made it better.

**S Panel**  
 Abdominal pain,  
 Anxious,  
 Allergies/Allergic Reaction,  
 Animal bites/attacks,  
 Asthma,  
 Bleeding,  
 Blood sugar, high  
 Blood sugar, low  
 Bruising,  
 Burn,  
 Chest pain,  
 Congestion,  
 Constipation,  
 Cough,  
 Depressed,  
 Difficulty swallowing,  
 Diarrhea,  
 Dizziness,  
 Fatigue,  
 Falls,  
 12/05/2010 Allergies/Allergic Reaction, Runny nose, Itchy eyes, 3:50 PM Josmd

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

Copy  
 Prev  
 Note  
 Copy Previous Notes

Done Edit Print Report Delete Export Spell Sign

SPRINGCHARTS  
 Electronic Health Records

- Using the [Print] button, print the Nurse Note. Record your name on the document and submit to your instructor.

## Exercise 14.5

- Using Source Document 3—Critical Care Flow Sheet (See Appendix B), complete the Vital Signs documented at 0700 in the Nurse Note.

**12/07/2010 Nurse Note**  
**Subjective:**  
 Chest pain, started an hour ago but is getting worse. Rates pain a 9 on 0-10 scale and states movement makes it worse. Nothing has made it better.  
**Objective:**  
**Assessment:**  
**Plan:**  
**Interventions:**  
**Evaluation:**  
**Revision:**  
**Date of Service: 12/07/2010**  
 Patient Number: 59 Chart ID: not Charted  
 Last Modified: 12/07/2010

**Previous Vitals**

12/05/2010	Temp: 98.4F	HR: 90	Resp: 22
	BP: 134/72		
	O2SAT 94.00 %		
12/05/2010	Temp: 98.6F	HR: 84	Resp: 20
	BP: 134/74	Wt: 208.0lbs	Ht: 65.0in
	BMI: 34.61		
	O2SAT 98 %		

**Vitals**

- Room Air
- Oxygen via
- BP check only
- BP right arm
- BP left arm
- Pt position - sitting
- Pt position - supine
- Pt position - right side
- Pt position - left side
- Temp source - Axillary
- Temp source - Oral
- Temp source - Rectal
- Temp source - Temporal

Temp: 98.2 F Resp: 22 Pulse: 116  
 BP: 174 / 104 Ht: in Wt: lbs  
 HC: in BMI: Body Fat: %  
 O2SAT 86 %

Done Edit Print Report Delete Export Spell Sign

- Using the [Print] button, print the Nurse Note. Record your name on the document and submit to your instructor.

## Exercise 14.6

- Using Source Document 4—Initial Shift Assessment (See Appendix B), add a new Exam in SpringCharts.

**Nurse Note 12/07/2010**  
Tools: Pt Moore, Paul 04/15/49 Examination Date: 12/07/2010 last mod: 12/07/2010

**12/07/2010 Nurse Note**  
**Subjective:** Chest pain, started an hour ago but is getting worse. Rates pain a 9 on 0-10 scale and states movement makes it worse. Nothing has made it better.  
**Objective:**  
Vitals: Temp: 98.2F HR: 116 Resp: 22 BP: 174/104  
O2SAT 86 %  
Neurological: Within Normal Limits.  
Lungs/Respiratory: Within Normal Limits except for Oxygen 3L per nasal cannula.  
Gastrointestinal: Within Normal Limits.  
GU (male): Within Normal Limits.  
Heart rhythm: Sinus Tachycardia.  
EXTREMITIES: edema +2 pitting edema bilaterally.

**Assessment:**  
**Plan:**  
**Interventions:**  
**Evaluation:**  
**Revision:**  
**Date of Service: 12/07/2010**  
Patient Number: 59, Chart ID: not Charted

**Examination**  
Neurological: Within Normal Limits.  
Lungs/Respiratory: Within Normal Limits except for Oxygen 3L per nasal cannula.  
Gastrointestinal: Within Normal Limits.  
GU (male): Within Normal Limits.  
Heart rhythm: Sinus Tachycardia.  
EXTREMITIES: edema +2 pitting edema bilaterally.

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

Copy  
Prev  
Note  
Copy  
Previous  
Notes  
Init

Done Edit Print Report Delete Export Spell Sign

**SPRINGCHARTS**  
Electronic Health Records

- Using the [Print] button, print the Nurse Note. Record your name on the document and submit to your instructor.

## Exercise 14.7

- Using Source Document 5—Plan of Care (See Appendix B), document the NANDA-I/Dx in the Nurse Note.

**Nurse Note 12/07/2010**  
Tools: Pt Moore, Paul 04/15/49 Diagnosis Date: 12/07/2010 last mod: 12/07/2010

**12/07/2010 Nurse Note**  
**Subjective:** Chest pain, started an hour ago but is getting worse. Rates pain a 9 on 0-10 scale and states movement makes it worse. Nothing has made it better.  
**Objective:**  
Vitals: Temp: 98.2F HR: 116 Resp: 22 BP: 174/104  
O2SAT 86.00 %  
Neurological: Within Normal Limits.  
Lungs/Respiratory: Within Normal Limits except for Oxygen 3L per nasal cannula.  
Gastrointestinal: Within Normal Limits.  
GU (male): Within Normal Limits.  
Heart rhythm: Sinus Tachycardia.  
EXTREMITIES: edema +2 pitting edema bilaterally.

**Assessment:**  
Other Dx: Perfusion, Risk for decreased cardiac tissue AEB chest pain  
Other Dx: Alteration in comfort/pain ART chest pain.  
Other Dx: Knowledge Deficit regarding personal illness.  
Other Dx: Falls, Risk for.  
Other Dx: 12/07/2010 8:05 PM

**Plan:**

**Diagnosis**  
NANDA Perfusion, Risk for decreased cardiac tissue AEB chest pain  
Alteration in comfort/pain ART chest pain.  
Knowledge Deficit regarding personal illness.  
Falls, Risk for.

**DIAGNOSIS**  
Select Diagnosis  
PMHx + Problem List  
HTN 401.9  
Previous Diagnoses

Done Print Report Delete Export Spell Sign

**SPRINGCHARTS**  
Electronic Health Records

- Using the [Print] button, print the Nurse Note. Record your name on the document and submit to your instructor.

## Exercise 14.8

- Using Source Document 5—Plan of Care (See Appendix B), document the Nursing Outcomes (NOC) in the Nurse Note.

**Nurse Note 12/07/2010**

Tools: Pt Moore, Paul 04/15/49 NOC Date: 12/07/2010 last mod: 12/07/2010

**12/07/2010 Nurse Note**

**Subjective:**  
Chest pain, started an hour ago but is getting worse. Rates pain a 9 on a 0-10 scale and states movement makes it worse. Nothing has made it better.

**Objective:**  
Vitals: Temp: 98.2F HR: 116 Resp: 22 BP: 174/104  
O2SAT 86.00 %  
Neurological: Within Normal Limits.  
Lungs/Respiratory: Within Normal Limits except for Oxygen 3L per nasal cannula.  
Gastrointestinal: Within Normal Limits.  
GU (male): Within Normal Limits.  
Heart rhythm: Sinus Tachycardia.  
EXTREMITIES: edema +2 pitting edema bilaterally.

**Assessment:**  
Other Dx: Perfusion, Risk for decreased cardiac tissue AEB chest pain  
Other Dx: Alteration in comfort/pain ART chest pain.  
Other Dx: Knowledge Deficit regarding personal illness.  
Other Dx: Falls, Risk for.  
Other Dx: 12/07/2010 8:05 PM

**NOC**

**PRIORITY OUTCOMES:** Cardiopulmonary Status: Adequacy of blood volume ejected from the ventricles and exchange of carbon dioxide and oxygen at the alveolar level.  
Tissue Perfusion: Cardiac: Adequacy of blood flow through the coronary vasculature to maintain heart function.  
Pain Control: Personal actions to control pain  
Knowledge - Diabetes Management: Extent of understanding conveyed about diabetes mellitus, it's treatment, and the prevention of complications.

**12/07/2010 PRIORITY OUTCOMES:**  
Cardiopulmonary Status: Adequacy of blood volume ejected from the ventricles and exchange of carbon dioxide and oxygen at the alveolar level.  
Tissue Perfusion: Cardiac: Adequacy of blood flow through the coronary vasculature to maintain heart function.  
Knowledge - Diabetes Management: Extent of

Done Print Report Delete Export Spell Sign

- Using the [Print] button, print the Nurse Note. Record your name on the document and submit to your instructor.

## Exercise 14.9

- Using Source Document 5—Plan of Care (See Appendix B), update the Nursing Interventions (NIC) in the patient's chart.



**Nurse Note 12/07/2010**  
 Tools: Pt. Moore, Paul 04/15/49 Date: 12/07/2010 last mod: 12/07/2010

**12/07/2010 Nurse Note**  
**Subjective:**  
 Chest pain, started an hour ago but is getting worse. Rates pain a 9 on a 0-10 scale and states movement makes it worse. Nothing has made it better.  
**Objective:**  
 Vitals: Temp: 98.2F HR: 116 Resp: 22 BP: 174/104  
 O2SAT 86.00 %  
 Neurological: Within Normal Limits.  
 Lungs/Respiratory: Within Normal Limits except for Oxygen 3L per nasal cannula.  
 Gastrointestinal: Within Normal Limits.  
 GU (male): Within Normal Limits.  
 Heart rhythm: Sinus Tachycardia.  
 EXTREMITIES: edema +2 pitting edema bilaterally.  
**Assessment:**  
 Other Dx: Perfusion, Risk for decreased cardiac tissue AEB chest pain  
 Other Dx: Alteration in comfort/pain ART chest pain.  
 Other Dx: Knowledge Deficit regarding personal illness.  
 Other Dx: Falls, Risk for.  
 Other Dx: 12/07/2010 8:05 PM  
**Plan:**  
 Cardiac care, acute.  
 Pain Management: Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient.  
 Vital Signs Monitoring: Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications.  
 Medication Administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs  
 Teaching: Disease Process: Assisting the patient to

**Nursing Interventions Classification:**  
 Fluid/Electrolyte Management: Regulation and prevention of fluid and electrolyte imbalances  
 Foot Care: Cleansing and inspecting the feet for purpose of preventing foot problems  
 Hyperglycemia Management: Preventing and treating above normal blood glucose levels  
 Hypoglycemia Management: Preventing and treating low blood glucose levels  
 Immunization/Vaccination Management: Monitoring immunization status and administering vaccines  
 Incision Site Care: Cleansing, monitoring, and promotion of healing  
 Intravenous (IV) Insertion: Administration and monitoring of intravenous therapy  
 Medication Administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs  
 Nail Care: Promotion of clean, neat, attractive nails and prevention of nail problems  
 Nausea Management: Prevention and alleviation of nausea and vomiting  
 Neurologic Monitoring: Collection and analysis of patient data to determine and prevent complications  
 Oxygen Therapy: Administration of oxygen and monitoring of oxygenation  
 Pain Management: Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient  
 Patient-Controlled Analgesia (PCA) Assistance: Facilitating the use of patient-controlled analgesia  
 Physical Restraint Application, monitoring, and removal of physical restraints  
 Pressure Ulcer Prevention: Prevention of pressure ulcers from immobility  
 Respiratory Monitoring: Collection and analysis of patient data to determine and prevent complications  
 Resuscitation: Administering emergency measures to sustain life  
 Seizure Precautions: Prevention or minimization of potential seizure activity

Buttons: Done, Print, Report, Delete, Export, Spell, Sign

- Using the [Print] button, print the Nurse Note. Record your name on the document and submit to your instructor.

## Exercise 14.10

- Using Source Document 6—Physician Orders (See Appendix B), update the Test in the patient's chart.

**Nurse Note 12/07/2010**  
 Tools: Pt. Moore, Paul 04/15/49 Date: 12/07/2010 last mod: 12/07/2010

**12/07/2010 Nurse Note**  
**Subjective:**  
 Chest pain, started an hour ago but is getting worse. Rates pain a 9 on a 0-10 scale and states movement makes it worse. Nothing has made it better.  
**Objective:**  
 Vitals: Temp: 98.2F HR: 116 Resp: 22 BP: 174/104  
 O2SAT 86.00 %  
 Neurological: Within Normal Limits.  
 Lungs/Respiratory: Within Normal Limits except for Oxygen 3L per nasal cannula.  
 Gastrointestinal: Within Normal Limits.  
 GU (male): Within Normal Limits.  
 Heart rhythm: Sinus Tachycardia.  
 EXTREMITIES: edema +2 pitting edema bilaterally.  
**Assessment:**  
 Other Dx: Perfusion, Risk for decreased cardiac tissue AEB chest pain  
 Other Dx: Alteration in comfort/pain ART chest pain.  
 Other Dx: Knowledge Deficit regarding personal illness.  
 Other Dx: Falls, Risk for.  
 Other Dx: 12/07/2010 8:05 PM  
**Plan:**  
 CBC  
 Liver Panel  
 Serum Prot Electrophoresis

**TESTS**  
 TEST  
 Select Test to Order  
 Serum Prot Electrophoresis 096404  
 Selected Tests:  
 Order Selected Tests

Buttons: Done, Print, Report, Delete, Export, Spell, Sign

- Using the [Print] button, print the Nurse Note. Record your name on the document and submit to your instructor.

## Exercise 14.11

- Using *Source Document 7—Medication Administration Record (See Appendix B)*, record the notation into a MAR in a patient's Care Tree

Medication Administration Record		Patient: <b>Moore, Paul</b>		Date: 12/5/2010 to		Doctor: Stephen Finchman																			
Date of birth: 4/15/1949		Admit: 12/5/2010		Room #: 3205																					
		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700
Normal Saline	Strength 0.9% Dose 75ml/hr																								715
Directions IV																									SN
Lopressor	Strength 150mg Dose 1															21									
Directions PO BID																									
HCTZ	Strength 50mg Dose 1																								
Directions PO Daily																									
K-Dur	Strength 10meq Dose 1															21									
Directions PO BID																									
Glucophage	Strength 500mg Dose 1																								
Directions PO BID																									

		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700
Deltoid = RD or LD	Initial & Name SN Student Nurse																								
Vastus Lateralis = RVL or LVL	Initial & Name																								
Lower Abdominal = RLA or LLA	Initial & Name																								
Anterior Gluteal = RAG or LAG	Initial & Name																								
Posterior Gluteal = RPG or LPG	Initial & Name																								

Medication Administration Record		Patient: <b>Moore, Paul</b>		Date: 12/5/2010 to		Doctor: Stephen Finchman																			
Date of birth: 4/15/1949		Admit: 12/5/2010		Room #: 3205																					
		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700
Nitroglingual	Strength 0.4mg Dose 1																								708
Directions SL prn chest pain																									SN
Strength	Dose																								
Directions																									
Strength	Dose																								
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		0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700
Deltoid = RD or LD	Initial & Name SN Student Nurse																								
Vastus Lateralis = RVL or LVL	Initial & Name																								
Lower Abdominal = RLA or LLA	Initial & Name																								
Anterior Gluteal = RAG or LAG	Initial & Name																								
Posterior Gluteal = RPG or LPG	Initial & Name																								



- Using the [Print] button, print the MAR. Record your name on the document and submit to your instructor.

## Exercise 14.12

- Using Source Document 8—Intake and Output Record (See Appendix B), record the notation into an I&O form in a patient's Care Tree.

Patient Name: <b>Moore, Paul</b>		Date: <b>12/5/2010</b>																																																																																																																
<b>Ramsay Scale for Sedation</b> <b>AWAKE LEVELS</b> Level 1 Patient anxious and agitated or restless (or both) Level 2 Patient cooperative, oriented and tranquil Level 3 Patient responds to commands only <b>ASLEEP LEVELS</b> Level 4 Patient asleep but responds briskly to light, glabellar tap or loud auditory stimulus. Level 5 Patient asleep with sluggish response to light, glabellar tap or loud auditory stimulus. Level 6 Patient asleep with no response to stimuli.		<b>Hendrick Fall Risk Model - Assessment Tool</b> <table border="1"> <thead> <tr> <th>Risk Factors</th> <th>Day</th> <th>Even</th> <th>Night</th> </tr> </thead> <tbody> <tr> <td>Recent History of Falls</td> <td>+1</td> <td>+1</td> <td>+1</td> </tr> <tr> <td>Depression</td> <td>+4</td> <td>+4</td> <td>+4</td> </tr> <tr> <td>Altered Elimination</td> <td>+3</td> <td>+3</td> <td>+3</td> </tr> <tr> <td>Confusion/Oriented</td> <td>+3</td> <td>+3</td> <td>+3</td> </tr> <tr> <td>Dizziness/Vertigo</td> <td>+3</td> <td>+3</td> <td>+3</td> </tr> <tr> <td>Poor Judgement</td> <td>+3</td> <td>+3</td> <td>+3</td> </tr> <tr> <td>Poor Mobility/Generalized Weakness</td> <td>+2</td> <td>+2</td> <td>+2</td> </tr> <tr> <td><b>TOTAL INITIAL RISK SCORE</b></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Score</th> <th>Risk Level</th> </tr> </thead> <tbody> <tr> <td>0-2</td> <td>Normal/Low Risk</td> </tr> <tr> <td>3-5</td> <td>Level 1/High Risk</td> </tr> <tr> <td>6-8</td> <td>Level 2/Extremely High Risk</td> </tr> </tbody> </table>		Risk Factors	Day	Even	Night	Recent History of Falls	+1	+1	+1	Depression	+4	+4	+4	Altered Elimination	+3	+3	+3	Confusion/Oriented	+3	+3	+3	Dizziness/Vertigo	+3	+3	+3	Poor Judgement	+3	+3	+3	Poor Mobility/Generalized Weakness	+2	+2	+2	<b>TOTAL INITIAL RISK SCORE</b>				Score	Risk Level	0-2	Normal/Low Risk	3-5	Level 1/High Risk	6-8	Level 2/Extremely High Risk																																																																			
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Dizziness/Vertigo	+3	+3	+3																																																																																																															
Poor Judgement	+3	+3	+3																																																																																																															
Poor Mobility/Generalized Weakness	+2	+2	+2																																																																																																															
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- Using the [Print] button, print the Intake and Output document. Record your name on the document and submit to your instructor.

## Exercise 14.13

- Using Source Document 9—Interdisciplinary Education (See Appendix B), record the notation into the Teaching area of the Nurse Note.

**Nurse Note 12/07/2010**

Pt. Moore, Paul 04/15/49 Date: 12/07/2010 last mod: 12/07/2010

**12/07/2010 Nurse Note**

**Subjective:**  
Chest pain, started an hour ago but is getting worse. Rates pain a 9 on 0-10 scale and states movement makes it worse. Nothing has made it better.

**Objective:**  
Vitals: Temp: 98.2F HR: 116 Resp: 22 BP: 174/104  
O2SAT 86.00 %  
Neurological: Within Normal Limits.  
Lungs/Respiratory: Within Normal Limits except for Oxygen 3L per nasal cannula.  
Gastrointestinal: Within Normal Limits.  
GU (male): Within Normal Limits.  
Heart rhythm: Sinus Tachycardia.  
EXTREMITIES: edema +2 pitting edema bilaterally.

**Assessment:**  
Other Dx: Perfusion, Risk for decreased cardiac tissue AEB chest pain  
Other Dx: Alteration in comfort/pain ART chest pain.  
Other Dx: Knowledge Deficit regarding personal illness.  
Other Dx: Falls, Risk for.  
Other Dx: 12/07/2010 8:05 PM

**Plan:**  
Disease process instruction.  
Medication indication, frequency, considerations instruction.  
Diet instruction, surveillance of blood sugar, exercise.

**Teaching**

TEACHING:  
Discussed plan of care with patient/significant other  
Disease process instruction:  
Diet instruction:  
Medication indication, frequency, considerations instruction  
Medication administration instruction  
Procedure recovery instruction:  
Patient Control Analgesia teaching completed  
Smoking Cessation discussed/pamphlet given  
Patient not a candidate for instruction due to:  
Patient has no family/significant other  
Discharge Instructions:  
Continue home diet \_\_\_\_\_ as instructed.  
Call physician for these signs/symptoms:  
Call 911/Go to ER for these signs/symptoms:  
Staples to be removed 10-14 days post-op  
Do not shower until staples removed  
Daily dry gauze dressing change until staples removed  
May shower 7 days after surgery.

Copy Previous Notes

Done Print Report Delete Export Spell Sign

- Using the [Print] button, print the Nurse Note. Record your name on the document and submit to your instructor.

## Exercise 14.14

- Using Source Document 10—Discharge Paperwork (See Appendix B), create a F/U-Rem for the patient within the patient's chart.

**Nurse Note 12/07/2010**

Pt. Moore, Paul 04/15/49 Date: 12/07/2010 last mod: 12/07/2010

**12/07/2010 Nurse Note**

**Subjective:**  
Chest pain, started an hour ago but is getting worse. Rates pain a 9 on 0-10 scale and states movement makes it worse. Nothing has made it better.

**Objective:**  
Vitals: Temp: 98.2F HR: 116 Resp: 22 BP: 174/104  
O2SAT 86.00 %  
Neurological: Within Normal Limits.  
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Gastrointestinal: Within Normal Limits.  
GU (male): Within Normal Limits.  
Heart rhythm: Sinus Tachycardia.  
EXTREMITIES: edema +2 pitting edema bilaterally.

**Assessment:**  
Other Dx: Perfusion, Risk for decreased cardiac tissue AEB chest pain  
Other Dx: Alteration in comfort/pain ART chest pain.  
Other Dx: Knowledge Deficit regarding personal illness.  
Other Dx: Falls, Risk for.  
Other Dx: 12/07/2010 8:05 PM

**Plan:**  
Call physician office Monday to schedule appointment in 2 weeks.  
Call 911 if you have chest pain.  
Activity as tolerated.

**F/U-Reminders**

Tomorrow  
1 week  
1 month  
1 year  
2 weeks  
3 months  
6 weeks  
6 months  
Call physician office Monday to schedule appointment  
Return To Clinic as previously scheduled  
Return To Clinic pri  
Discharged to home/self care  
Discharged to care of family/significant other  
Discharged to Home Health Agency  
Discharged to SNF/TCU  
Discharged to Rehab Facility  
Discharged to Hospice Agency  
Pt urged to see Allergist promptly for  
Pt urged to see Cardiologist promptly for

Copy Previous Notes

Done Print Report Delete Export Spell Sign

2. Print the Reminder. Record your name on the document and submit to your instructor.

## Exercise 14.15

1. Using Source Document 11—Nurses Supplement Record (See Appendix B), create an addendum to a Nurse Note.

The screenshot shows the SpringCharts Electronic Health Records interface. The main window is titled "Note 12/07/2010" and displays a Nurse Note for "Pt Moore, Paul 04/15/49". The note is dated "12/07/2010" and has a "Last Modified" date of "12/07/2010". The note content includes a list of calls and a late entry about pain reassessment.

**12/07/2010 Note**  
 Patient Number: 59 Chart ID: not Charted  
 Last Modified: 12/07/2010

Returned call to number.  
 Left message on answering machine/voice mail.  
 Pt called requesting med.  
 Pt called with question about med.  
 Pt reports medication not working.  
 Discussed Pt's concerns.  
 Advised to come in today.  
 Advised Pt to go to ER.  
 Advised Pt to call today and schedule an appt ASAP.  
 Nurse called from hospital.  
 Call from Pt's wife.  
 Call from Pt's husband.  
 Call from Pt's mother.  
 Call from Pt's father.  
 Call from Pt's daughter.  
 Call from Pt's son.  
 Call from Pt's grandmother.  
 Call from Pt's grandfather.  
 Insurance: Need to call for authorization.

Late entry: Pain reassessment after first Nitrolingual was 5 on 0-10 scale. Patient stated "It's easing up a bit".

The interface includes a "Notes Panel" on the right with a "Copy Previous Notes" button. The bottom toolbar contains buttons for "Done", "Edit", "Print", "Delete", "Sign", and "Change Tab". The SpringCharts logo is visible in the bottom left corner.

2. Using the [Print] button, print the addendum. Record your name on the document and submit to your instructor.