Level 4 – Level 4of *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.

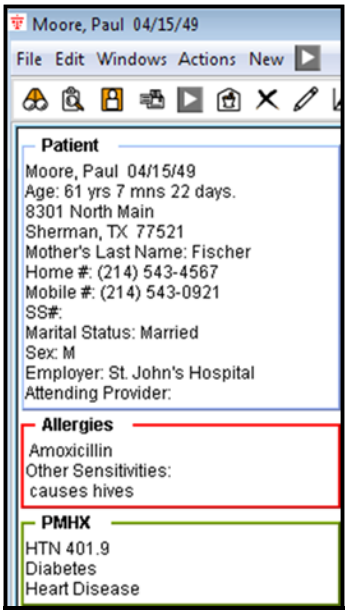
Learning Outcomes

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

14.1 Use all aspects of the SpringCharts program successfully

Exercise 14.1

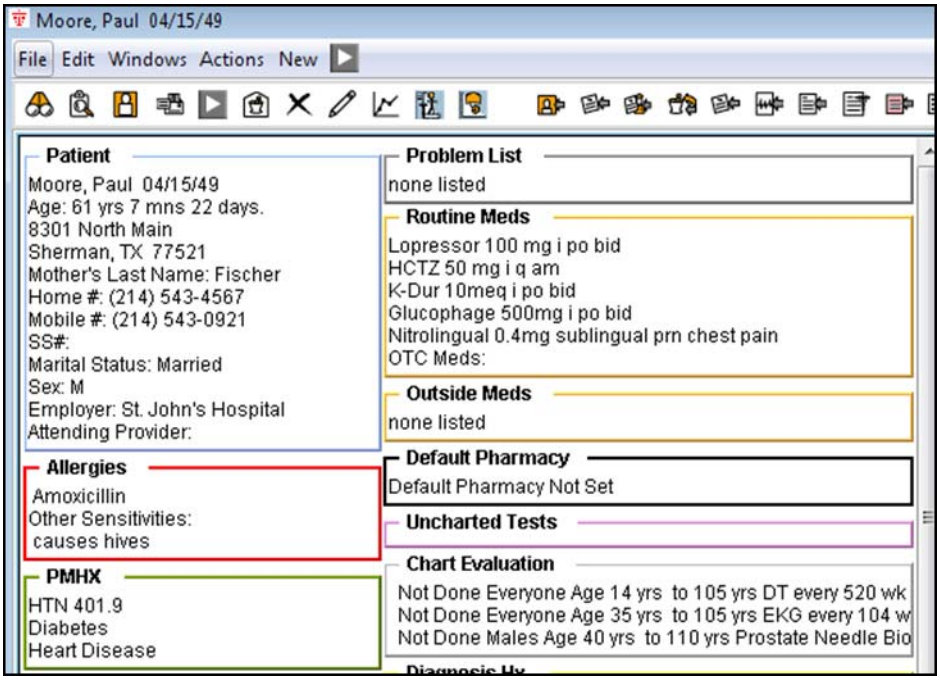
1. *Using Source Document 1—Admission Data Base (See Appendix B)*, complete *Allergies* and *PMHX*.



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

Exercise 14.2

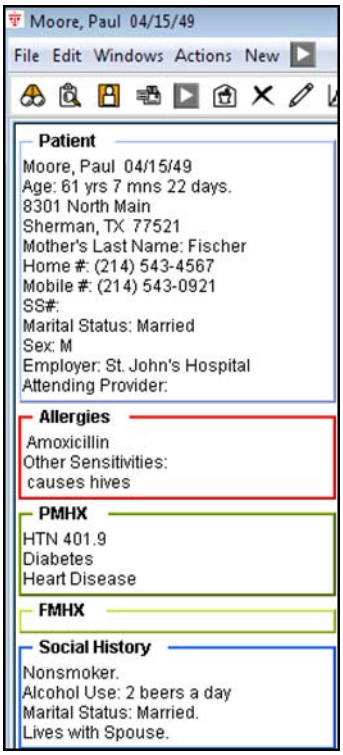
1. *Using Source Document 2—Admission Medication Reconciliation Form (See Appendix B*), enter the *Routine Meds* in SpringCharts.



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

Exercise 14.3

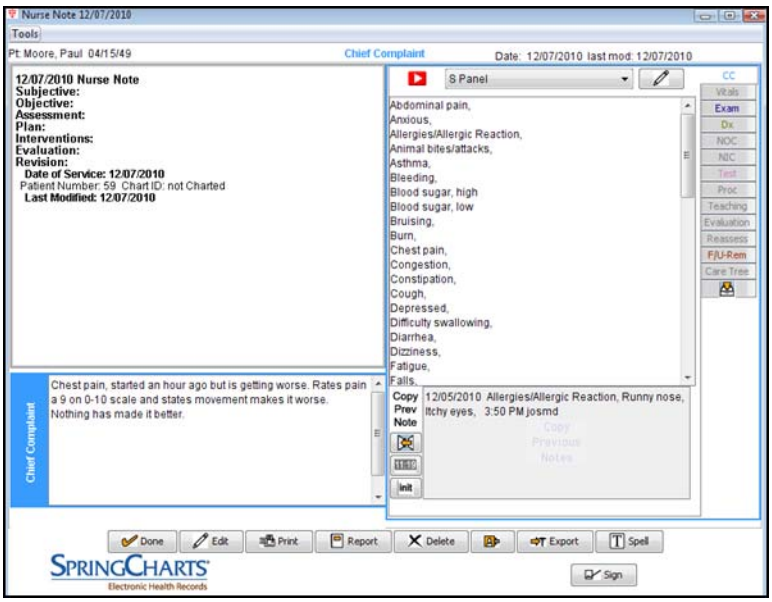
1. *Using Source Document 1—Admission Data Base (See Appendix B)*, add the *Social History* to SpringCharts.



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

Exercise 14.4

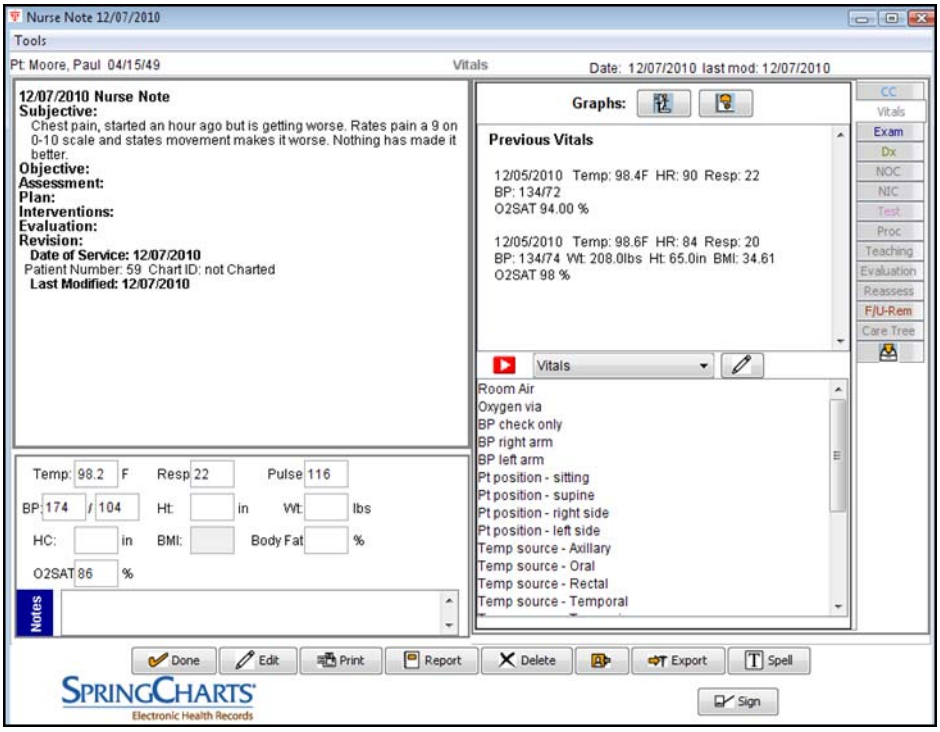
1. *Using Source Document 1—Admission Data Base (See Appendix B)*, add the *Chief Complaint* to SpringCharts.



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

Exercise 14.5

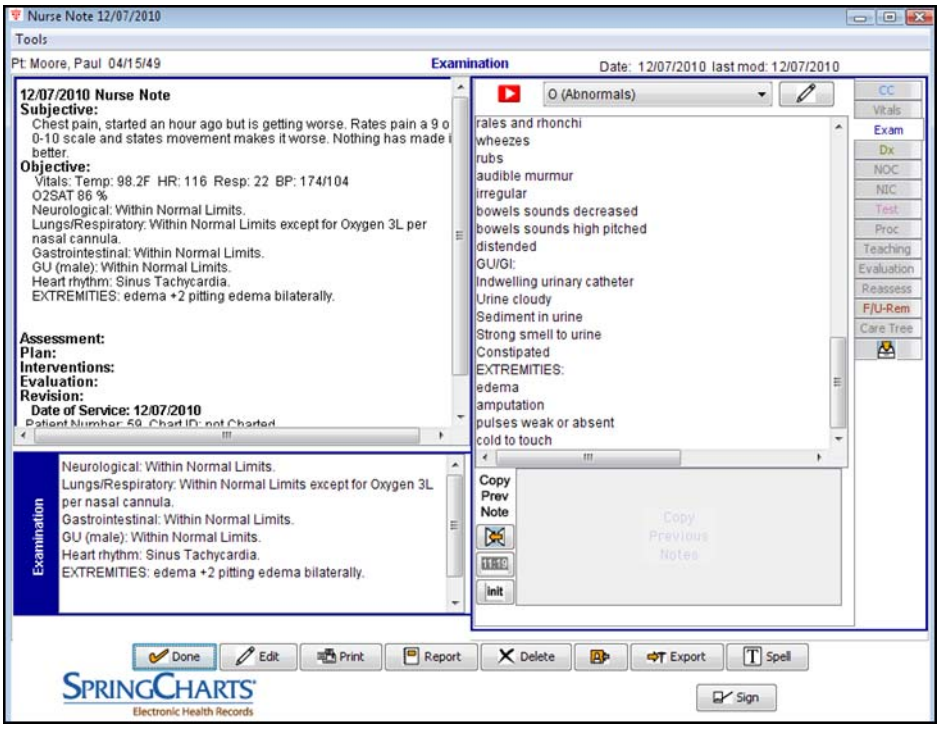
1. *Using Source Document 3—Critical Care Flow Sheet (See Appendix B)*, complete the *Vital Signs* documented at 0700 in the Nurse Note.



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

Exercise 14.6

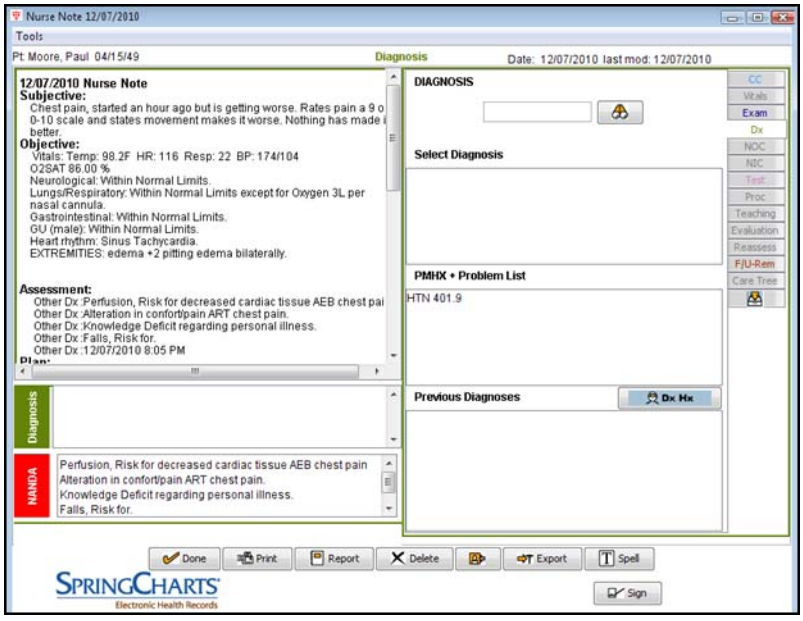
1. *Using Source Document 4—Initial Shift Assessment (See Appendix B)*, add a new *Exam* in SpringCharts.



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

Exercise 14.7

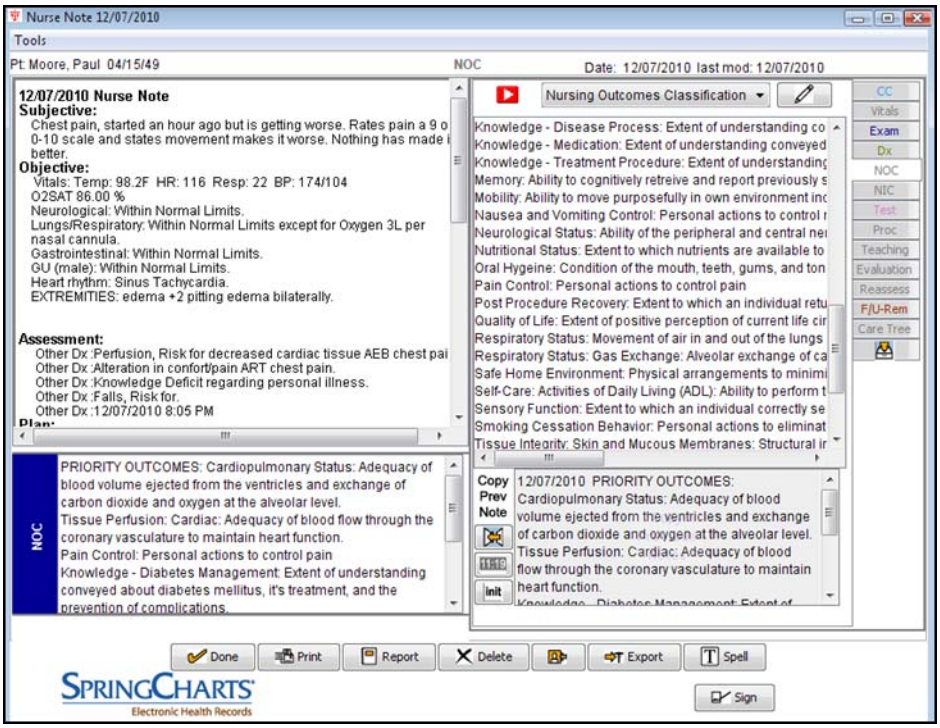
1. *Using Source Document 5—Plan of Care (See Appendix B)*, document the *NANDA-I/Dx* in the Nurse Note.



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

Exercise 14.8

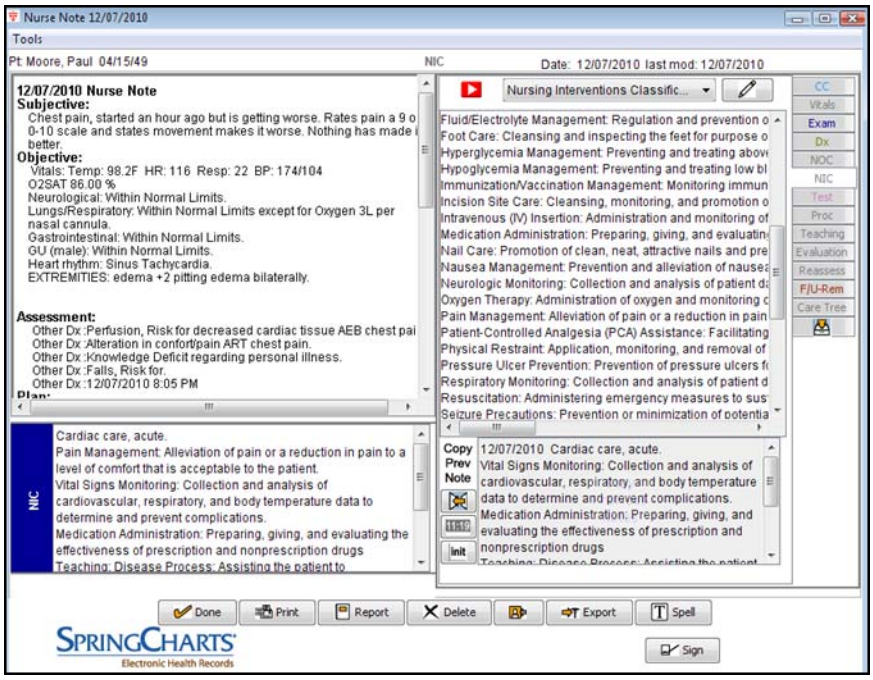
1. *Using Source Document 5—Plan of Care (See Appendix B)*, document the *Nursing Outcomes* (NOC) in the Nurse Note.



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

Exercise 14.9

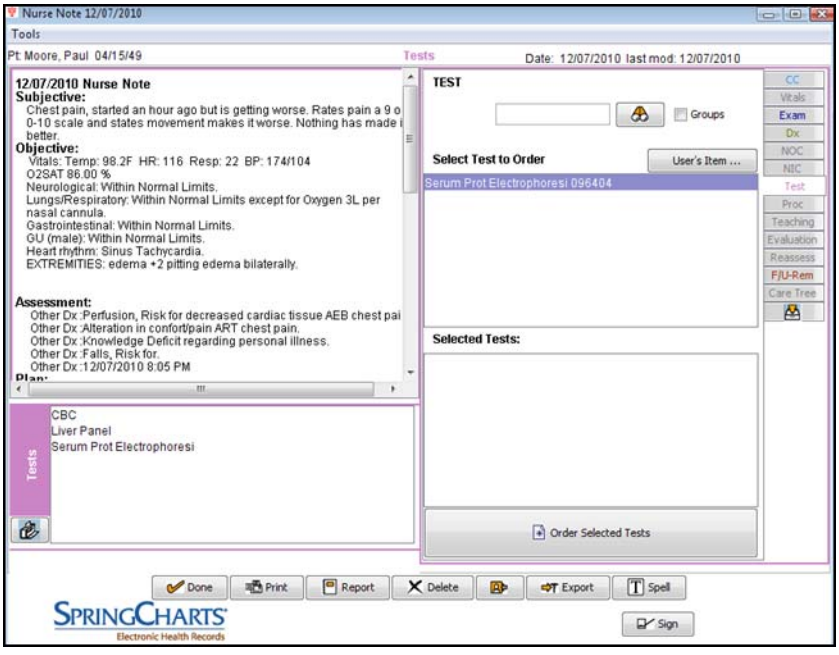
1. *Using Source Document 5—Plan of Care (See Appendix B)*, update the *Nursing Interventions* (NIC) in the patient's chart.



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

Exercise 14.10

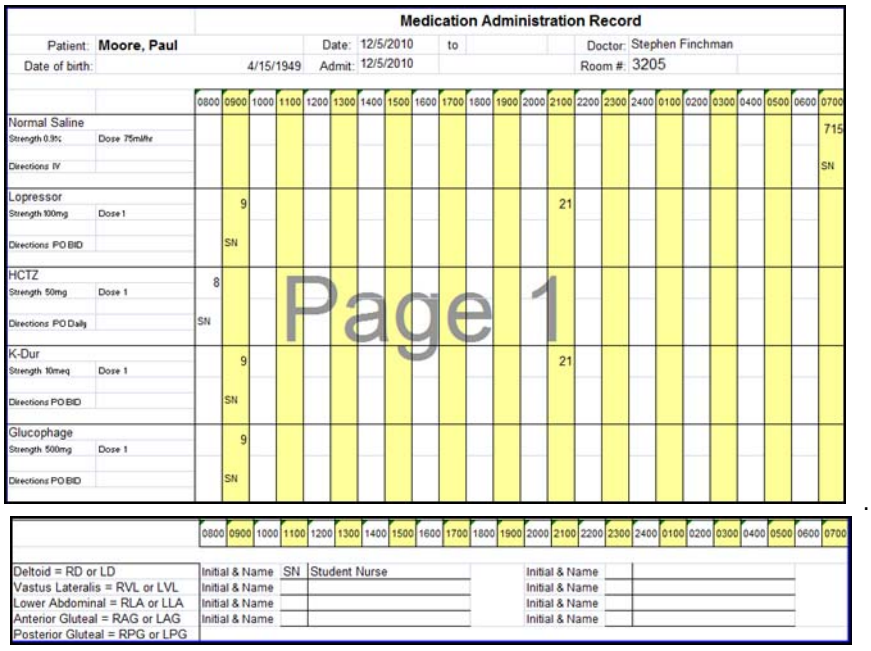
1. *Using Source Document 6—Physician Orders (See Appendix B)*, update the *Test* in the patient's chart.

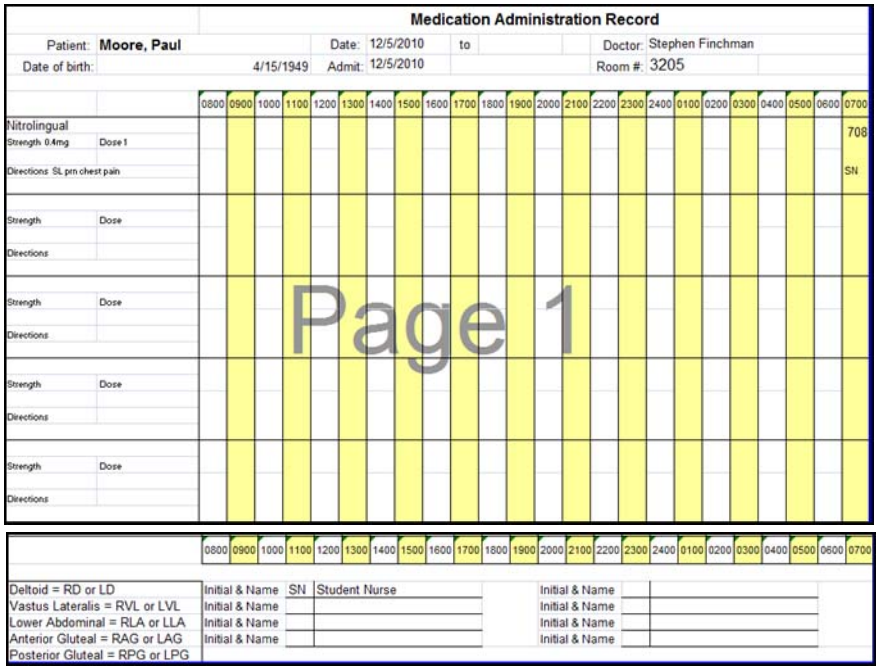


2. Using the [Print] button, print the Nurse Note. Record your name on the document and submit to your instructor.

Exercise 14.11

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

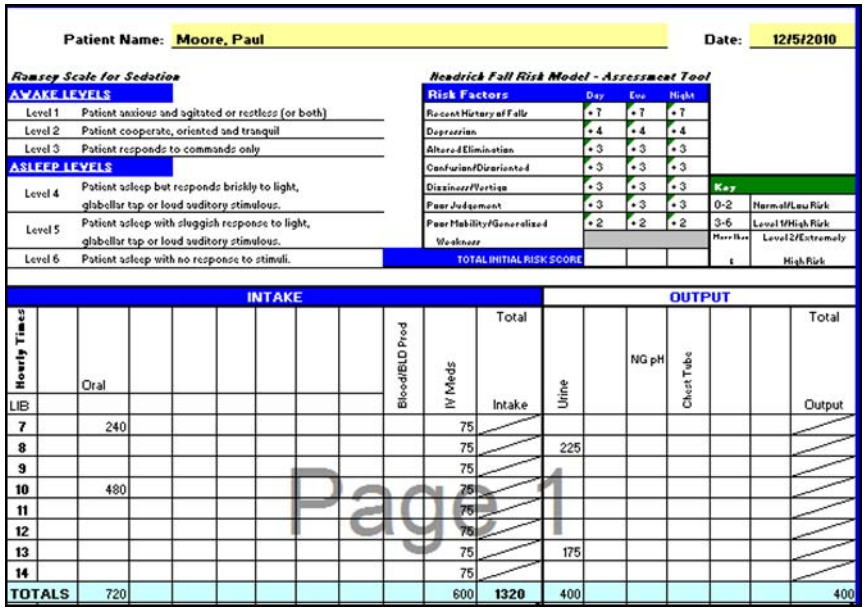




2. Using the [Print] button, print the MAR. Record your name on the document and submit to your instructor.

Exercise 14.12

1. *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: Moore, Paul 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			

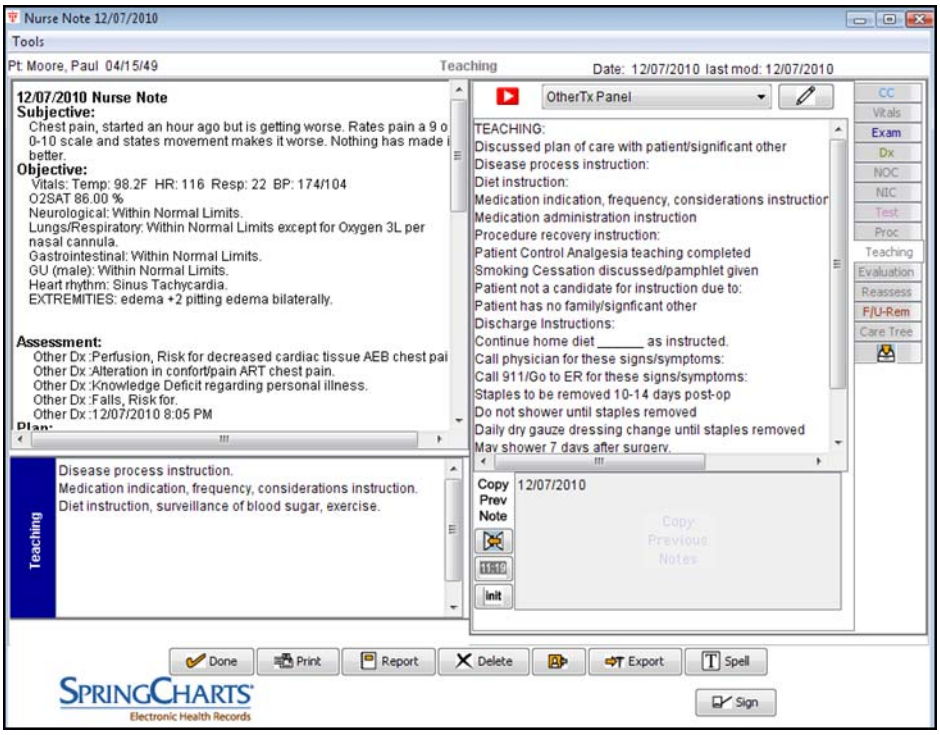
Key	
0-2	Normal/Low Risk
3-6	Level 1/High Risk
More than 6	Level 2/Extremely High Risk

	INTAKE											OUTPUT						
Hourly Times		Oral							Blood/BLD Prod	IV Meds	Total Intake	Urine		NG pH	Chest Tube			Total Output
LIB																		
7		240								75								
8										75		225						
9										75								
10		480								75								
11										75								
12										75								
13										75		175						
14										75								
TOTALS		720								600	1320	400						400

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

Exercise 14.13

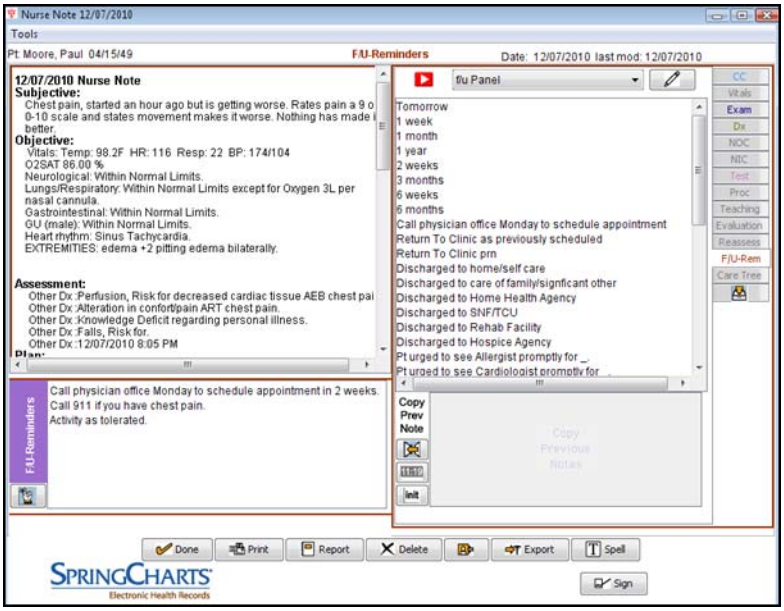
1. *Using Source Document 9—Interdisciplinary Education (See Appendix B)*, record the notation into the *Teaching* area of the Nurse Note.



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

Exercise 14.14

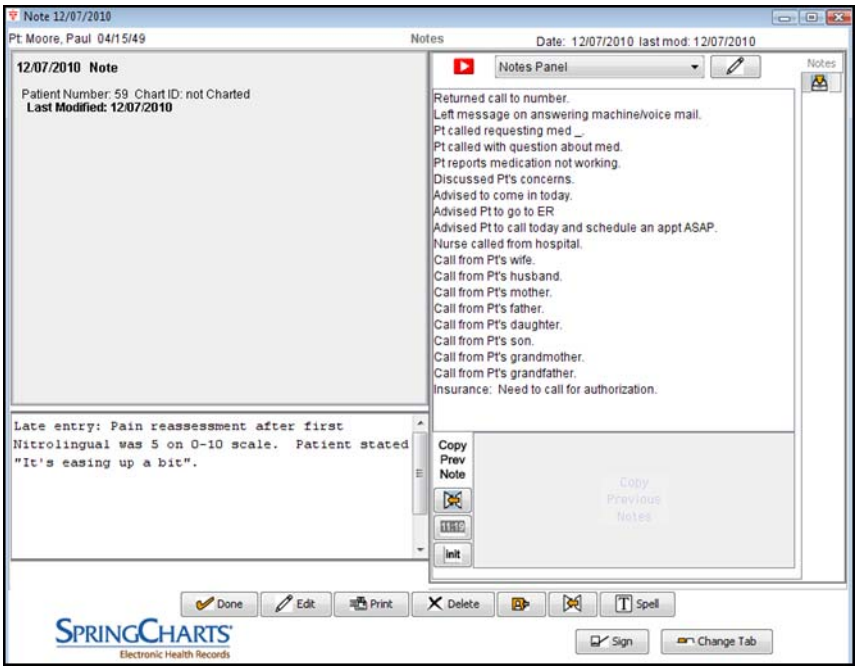
1. *Using Source Document 10—Discharge Paperwork (See Appendix B)*, create a *F/U-Rem* for the patient within the patient's chart.



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.



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