

# Intro Level SimEMR® Use Cases

## 1.3 MEDICAL ASSISTANT PROGRAMS

### Introduction

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This lesson will introduce learners to basic components and procedures for charting in an electronic medical record system while reviewing and managing a patient case. The forms and documents within SimEMR®, a system designed exclusively for charting in a clinical simulation context, are a representation of charting elements included in real-world EMR systems.

#### Learning Objectives

- Navigate components of SimEMR®
- Perform basic documentation in an EMR

#### Resources Needed

- SimEMR® login
- Internet access
- Web capable device

#### Content

- Introduction to SimEMR®
- Patient case review

#### Teaching Strategies

- Tutorial review
- Hands on practice
- Documentation of clinical data

#### Time

- *10-15 minutes:* Administration: Patient Profile creation
- *20 minutes:* Learner practice
- *10-15 minutes:* Review & evaluate learner work

# Patient Case & Scenario Overview

## MEDICAL ASSISTANT PROGRAMS

**Patient Profile Name:** Margaret Anthony    **DOB:** 03/30/1982

**Scenario:** Mrs. Anthony is a 37-year-old black female who visits the PCP office for a pre-employment physical exam. She is healthy with no complaints.

**Profile Overview:** The following patient case includes an overview of the scenario, an overview of learner objectives, and administrative steps required to get started. As you review these materials, bear in mind some terms of art. Patient Profile refers to the electronic patient in SimEMR®. Patient case refers to your overall scenario that uses that patient profile.

**Profile Objectives:** Acclimate the MA learner to common documentation practices within an Electronic Medical Record, SimEMR®.

**Applications for learners, will include, but are not limited to:**

- a. Prepare *Vitals Signs* documentation, located under the *Clinical Data* tab
- b. Review past vital signs
- c. Document vital signs
- d. Review *Vitals Sign Trends*
- e. Repeat any documentation for practice and comfortability if needed

### Patient Profile - Margaret Anthony

## Getting Started

1. Review the Patient Kit Addendum on pages 9 – 11.
2. Create the Patient Profile in SimEMR®.

Refer to the How To: Create a Patient Profile guide for more detailed directions. Overview instructions to create a patient profile are as follows:

- a. At the SimEMR® login screen enter your username and password. Select **[LOGIN]**.
- b. On the dashboard, select either the **[PATIENT PROFILES]** button, or **[PATIENT PROFILES]** in the left side menu.
- c. Click **+[+ CREATE NEW PATIENT PROFILES]** in the top right.
- d. Enter Margaret Anthony information. Select **[CREATE]**.
- e. Navigate to your newly created patient, and select the **[⚙️]** on the patients row. Select **[📄 PERMISSIONS]** from the dropdown menu.

- f. Uncheck the *Locked* box. Select **[SAVE]**.
        - g. Navigate back to Margaret, and select the **[⚙️]** on the patient row. Select **[🚩 EDIT]**.
        - h. Select **[+ ADD NEW FORM]** to add all forms according to Margaret's Patient Kit.
3. Identify learner objectives.
4. Create a course to assign the newly created profile to. If you are adding it to an existing course, move to step 5.

Refer to the SimEMR® Quick Start guide pages 2 – 4 for more detailed directions. Overview instructions to create a course are as follows:

- a. On the dashboard, select either the **[MANAGE COURSES]** button, or **[MANAGE COURSES]** in the left side menu.
  - b. Click **[+ CREATE NEW COURSE]** in the top right.
  - c. Enter relevant course information and select **[CREATE]**.
  - d. Navigate to the newly created course, and select the **[⚙️]** on the course row. Using this menu, you can add learners, instructors, and edit the course.
5. Assign the patient profile to learners.

Refer to the SimEMR® Quick Start guide pages 10 – 14 for more detailed directions. Overview instructions to assign a patient profile to learners are as follows:

- a. On the dashboard, select either the **[PATIENT ASSIGNMENTS]** button, or **[PATIENT ASSIGNMENTS]** in the left side menu.
  - b. Select the course you are assigning Margaret to. Click **[SELECT COURSE]**.
  - c. Locate Margaret and select **[CONTINUE TO NEXT STEP]**.
  - d. Select simulation time. Click **[CONTINUE TO NEXT STEP]**.
  - e. Add any additional goals and options to the profile. Click **[CONTINUE TO NEXT STEP]**.
  - f. Select **[CONFIRM ASSIGNMENT]**.
6. After learners have completed the assigned patient, review their work.

Refer to the SimEMR® Quick Start guide pages 17 – 18 for more detailed directions. Overview instructions to review learner work are as follows:

- a. On the dashboard, select either the **[LEARNER'S WORK]** button, or **[LEARNER'S WORK]** in the left side menu.
  - b. Click **[REVIEW BY PATIENT]** to review all learners in the course at once. Click **[REVIEW BY LEARNER]** to review individual learners.

# Learner Assignment: Patient Profile - Margaret Anthony

This lesson will introduce you to basic components and procedures for charting in an electronic medical record system while reviewing and managing a patient case. The forms and documents within SimEMR®, a system designed exclusively for charting in a clinical simulation context, are a representation of charting elements included in real-world EMR systems.

## Learning Objectives

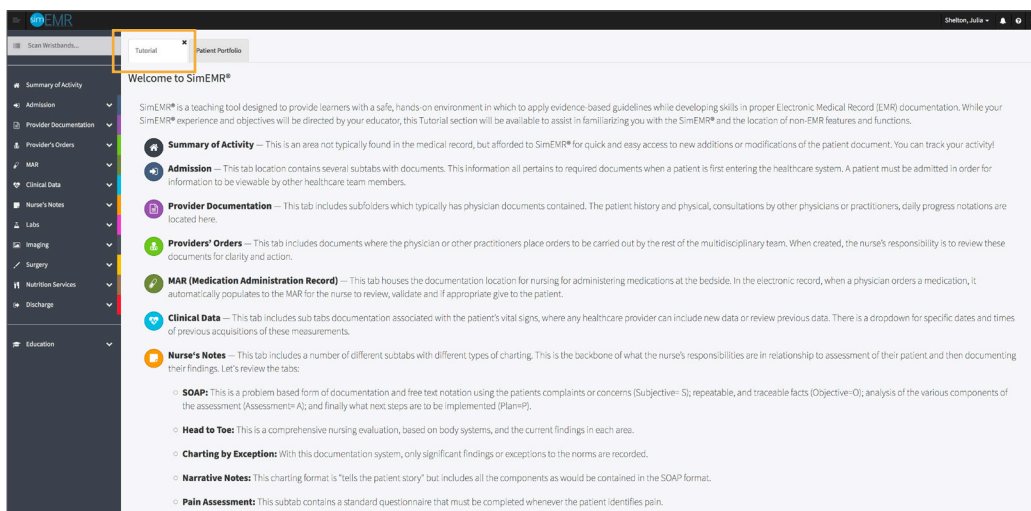
- Navigate components of SimEMR®
- Perform basic documentation in an EMR

## Resources Needed

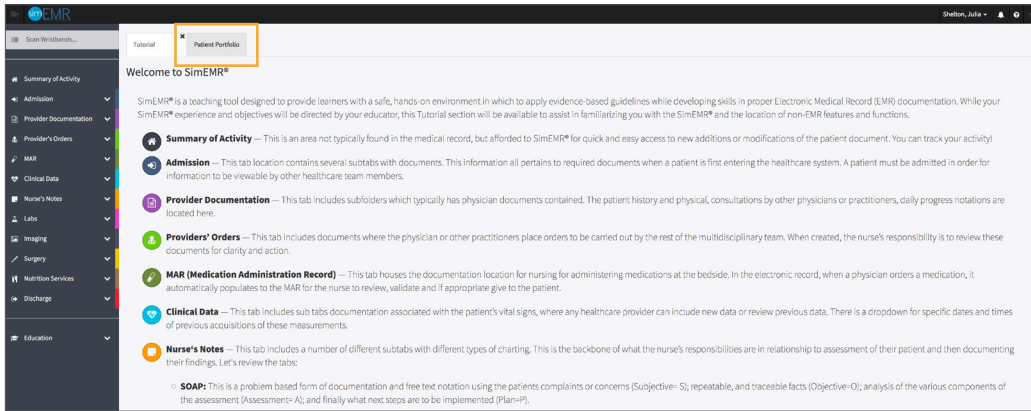
- SimEMR® login
- Internet access
- Web capable device

## Learner Actions: Vital Signs Assessment

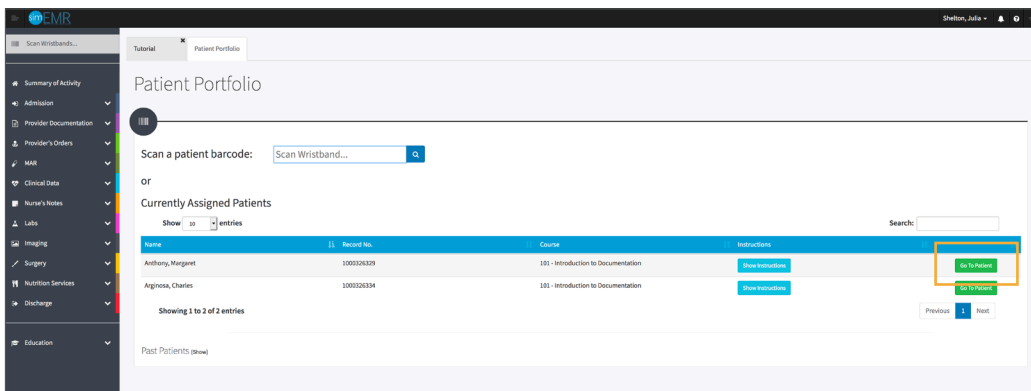
1. Open SimEMR® in a web browser.
2. At the login screen, enter your username and password. Select [\[LOGIN\]](#).
3. If needed, review the tutorial options presented in the *Tutorial* tab.
4. Review and familiarize yourself with the interface and content.



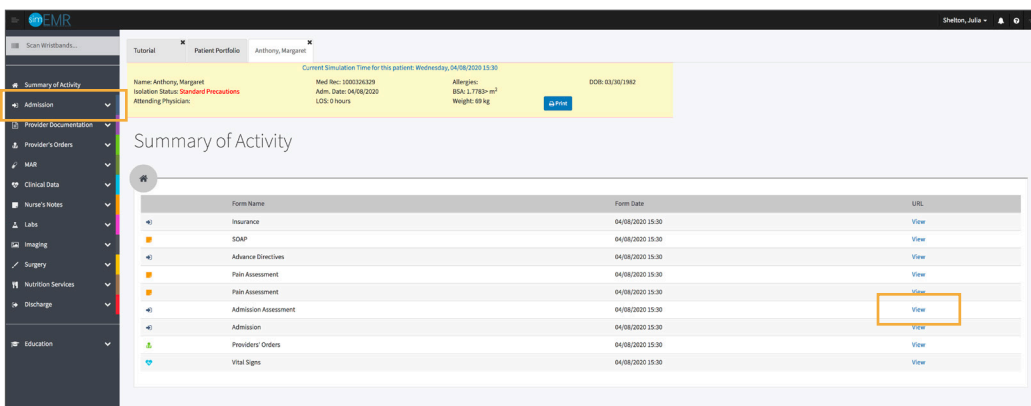
- Select the *Patient Portfolio* tab. Here you will find any patient profiles assigned by your instructor.



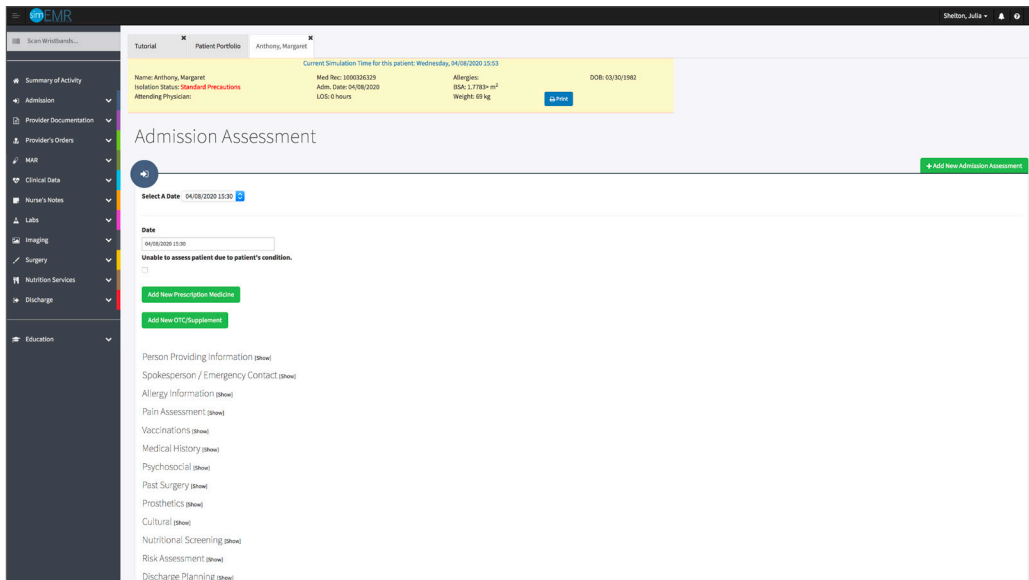
- Current assignments will be presented at the top, and any past assignments will be located at the bottom for reference. Locate Margaret Anthony and select **[GO TO PATIENT]**.



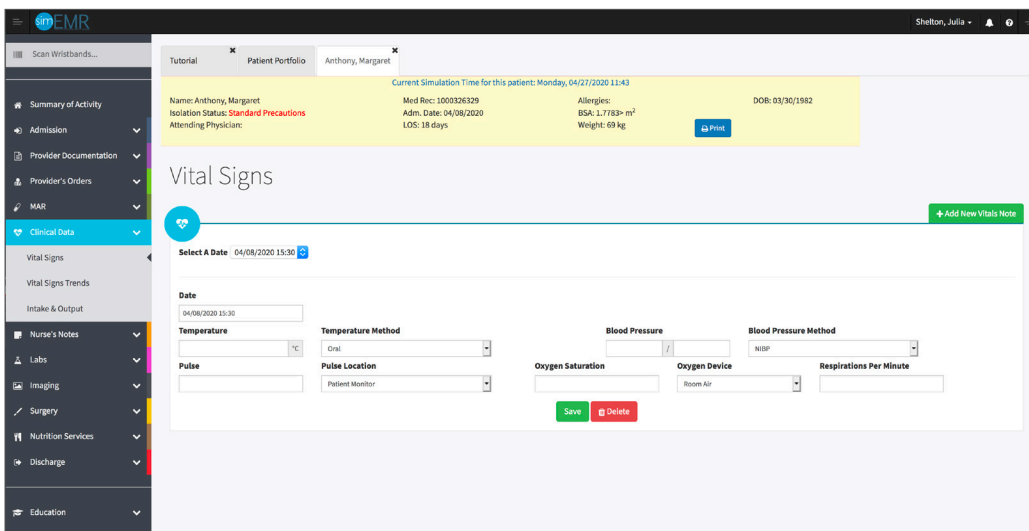
- You will be redirected to the summary page for the patient. To review forms click **[VIEW]** at the far right of the table. Locate Admission Assessment and select **[VIEW]**.



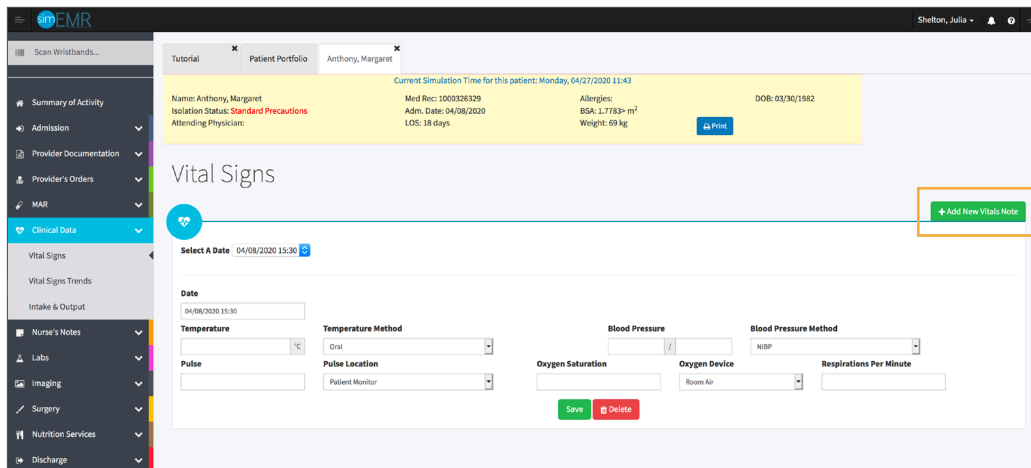
8. You will be redirected to a list of Admission Assessment options for review. Click through the list to familiarize yourself by clicking **[SHOW]** on each.



9. Click **[CLINICAL DATA]** from the left menu and then select **[VITAL SIGNS]**. You will see the most recent vitals documented. Past data can be located by using the *Select A Date* dropdown.



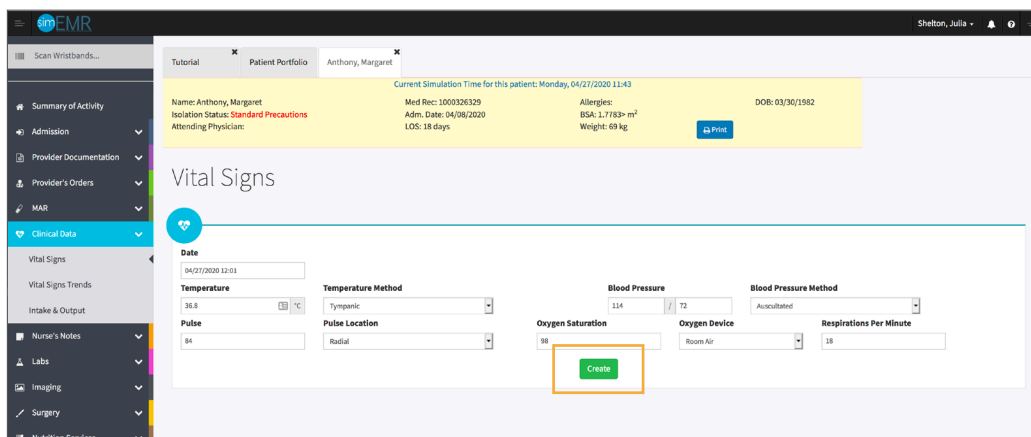
10. Select **[+ ADD NEW VITALS]**.



11. You will be redirected to a blank form. Complete the following documentation:

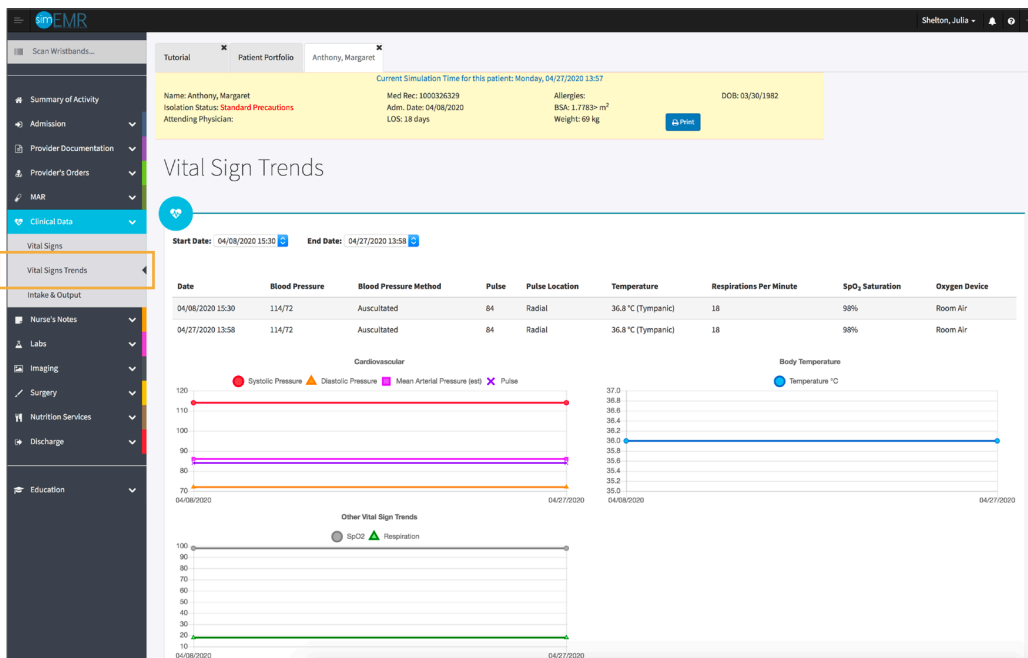
- a. Add the current date and time by clicking in the *Date* field.
- b. Enter 36.8° C in the *Temperature* field and select **[TYMPANIC]** from the *Temperature Method* dropdown.
- c. Enter 84 in the *Pulse* field and select **[RADIAL]** from the *Pulse Location* dropdown.
- d. Enter 114/72 in the *Blood Pressure* field and select **[AUSCULTATED]** from the *Blood Pressure Method* dropdown.
- e. Enter 98 in the *Oxygen Saturation* field and select **[ROOM AIR]** from the *Oxygen Device* dropdown. Enter 21 in the *Respirations Per Minute* field.

12. Select **[SAVE]**.



13. Repeat the above steps with any vital information until you are comfortable with the form.
14. Click **[CLINICAL DATA]** from the left menu and then select **[VITAL SIGNS TRENDS]** to review the and determine the patient's physical status and changes over time.

The most recent data sets are listed chronologically with the most recent being at the top of the list. The graphs represent a variety of different data points, such as SpO2 and pulse.



15. Close the patient chart by clicking the X on the *Margaret Anthony* tab.
16. Logout by locating the dropdown with your name at the top right of the page, select *Sign Out*.



# Patient Kit Addendum

## MARGARET ANTHONY

**Name:** Margaret Anthony      **DOB:** 3/30/1982      **Gender:** M\_\_ F\_\_ X\_\_      **Age:** 37

**Race:** Black      **Weight:** 69 kg/137 lbs      **Height:** 165 cm/5'5"

**Religion:** Bap      **CODE STATUS:**      **Advance Directive:** Y\_\_ N\_\_ X\_\_

**Major Support:** Paul Anthony      **Phone:** 412-555-1212      **Isolation Status:** N/A

**Allergies & Reactions:** Denies

**Immunizations:** Normal Childhood, no boosters to date

**Attending Physician/Team:** PCP John Miller, MD

**Primary Diagnosis:** Denies issues, Pre-Employment Exam

**History of Present Illness:** Denies issues, Pre-Employment Exam

**PMH:** Hypertension, GERD

**Surgeries/Procedures:** NONE

**Social History:** Married to Paul Anthony, live in Maryland in 2 story home. No children, siblings live close by. Margaret has been hired to work at the local Target Store as department manager. Denies alcohol or drug use, smokes half pack of cigarettes/day. Husband is employed at local hospital as a supply chain manager. Margaret is covered by her husband's insurance at this time.

**Data:** Blood pressure: 142/92, Heart Rate: 85, Respirations: 22, Temp: 37.0° C

**Review of Systems:** Normal physical exam data

**CNS:** Alert, calm

**Cardiovascular:** Heart rate regular rhythm, Pulses full and = throughout

**Pulmonary:** "smokers" cough, lungs clear, no supplemental O2, no SOB

**Gastrointestinal:** GERD, ABD soft round, nontender

**Hepato/Renal:** Denies issues

**Endocrine:** Denies issues

**Hematologic:** Denies issues

**Musculoskeletal:** Denies issues

**Integumentary:** Dry skin, otherwise intact, Capillary refill WNL

**Developmental:** Non- contributory

**Psychological:** Pleasant, talkative, excited for new job, denies concerns for risks or depressive symptoms

## Current Medications:

Medication (Generic/Trade)	Dose Available	Dose Ordered	Route	Frequency	Parameters/ Instructions	Provider Ordering
Metoprolol		25 mg	PO	BID		Miller, MD
Melatonin		1 cap	PO	HS	OTC	self

## Laboratory Values, Radiology, or Diagnostic Testing:

Arterial Blood Gas	Chemistry	Chemistry	Hematology	Microbiology	Toxicology
pH:	Na:	AST:	WBC:	Blood C/S:	Dig:
paO2:	K:	ALT:	Hgb:	Urine C/S	ETOH:
pcO2:	Cl:	Amylase:	Hct:	Sput C/S	Opioids:
HCO3:	Co2:	Lipase:	Platelets:	VRE:	Coc:
BE/D:	BUN:	Tot Prot:	ESR:	MRSA:	Amph/Meth:
Lactate:	Cr:	Albumin:	Other:	C-Diff:	PCP;
PA Sat:	Ca:	LDL:		GNR:	THC:
Coagulation	Mg:	HDL:	Other Tests	MDRO:	Lidocaine:
PT:	Phos:	Trig:	CBS:	VDRL:	MetHgb:
PTT:	Gluc:	CPK total:		GBS:	
INR:	HgA1C:	CPK MB:			
d-Dimer	Lactate:	Troponin:			

CXR:

CT/MRI:

US:

EEG:

ECG:

Other:

## SimEMR® Forms

Below contains an explanation of how the patient is entered into SimEMR®, as well as the reasoning behind each of the patient forms created as a part of that process.

### LAB TIP



*Simulation Start* is the time the student first begins the encounter. This notation is part of SimEMR's innovative SimTime™ system. *Simulation Start* will be replaced in the patient's chart by whatever time the encounter begins, and all other dates are described relative to that time. For example, if an encounter begins 04/15/2017 at 13:00, an event with a time of 1 day before simulation start would display a date of 04/14/2017.

### Admission

at *Simulation Start*

**Description:** Blank form for learner input

**Purpose:** Allows the learner to collect basic patient information and document admission accurately

### Admission Assessment

at *Simulation Start*

**Description:** Blank form for learner input

**Purpose:** Allows the learner to collect necessary information to document admission accurately. Learners may collect demographic information, visit-specific information, as well as family medical history, allergies, vaccinations, and other important information that may impact patient care later.

### Insurance

at *Simulation Start*

**Description:** Blank form for learner input

**Purpose:** Allows the learner to collect insurance information from patient Margaret

### SOAP

at *Simulation Start*

**Description:** Blank form for learner input

**Purpose:** Allows the learner to collect assessment information from patient Margaret

### Pain Assessment

at *Simulation Start*

**Description:** Blank form for learner input

**Purpose:** Allows the learner to collect Pain Assessment information from patient Margaret

### Advance Directive

at *Simulation Start*

**Description:** Blank form for learner input

**Purpose:** Allows the learner to collect Advance Directive information from patient Margaret

### Provider's Orders

at *Simulation Start*

**Description:** Order for urine sample, vital signs, height and weight

**Purpose:** Allows the learner to check things typically required for a physical examination

### Vital Signs

at *Simulation Start*

**Description:** Blank form for learner input

**Purpose:** Allows the learner to check vitals