

# Intro Level SimEMR® Use Cases

## 2.3 NURSING 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

## NURSING ASSISTANT PROGRAMS

**Patient Profile Name:** Charles Arginosa    **DOB:** 04/07/1946

**Scenario:** Mr. Arginosa is a 74-year-old male who has been hospitalized after a fall at his apartment, from a presumed syncopal event.

**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 NA learner to common documentation practices within an Electronic Medical Record, SimEMR®.

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

- a. Review and compare past I & O forms
- b. Document and understand an Intake form
- c. Document and understand an Outtake form
- d. Repeated practice

### Patient Profile - Charles Arginosa

## Getting Started

1. Review the Patient Kit Addendum on pages 11 – 13.
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 Charles Arginosa 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 Charles, and select the **[⚙️]** on the patient row. Select **[📄 EDIT]**.
        - h. Select **[+ ADD NEW FORM]** to add all forms according to Charles'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 Charles 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 - Charles Arginosa

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

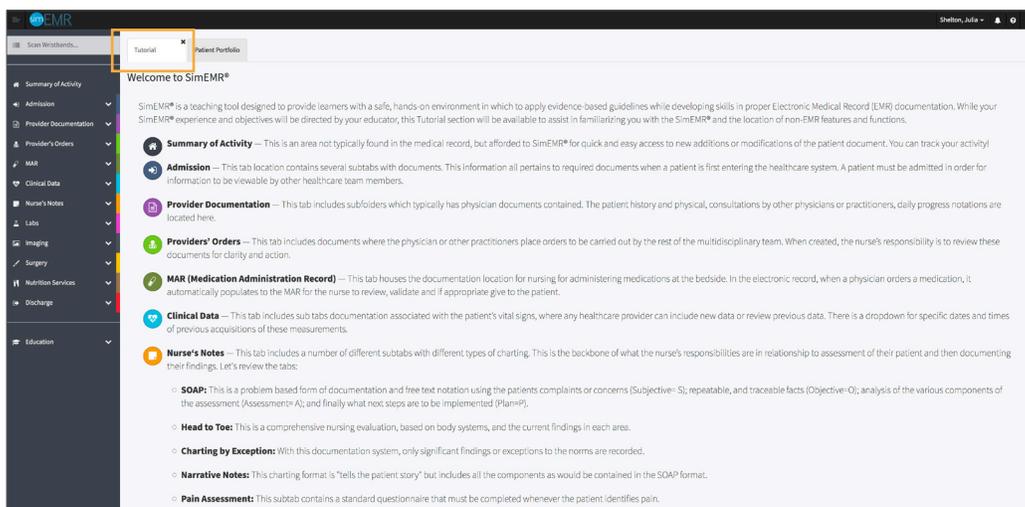
- Navigate components of SimEMR®
- Perform basic documentation in an EMR

## Resources Needed

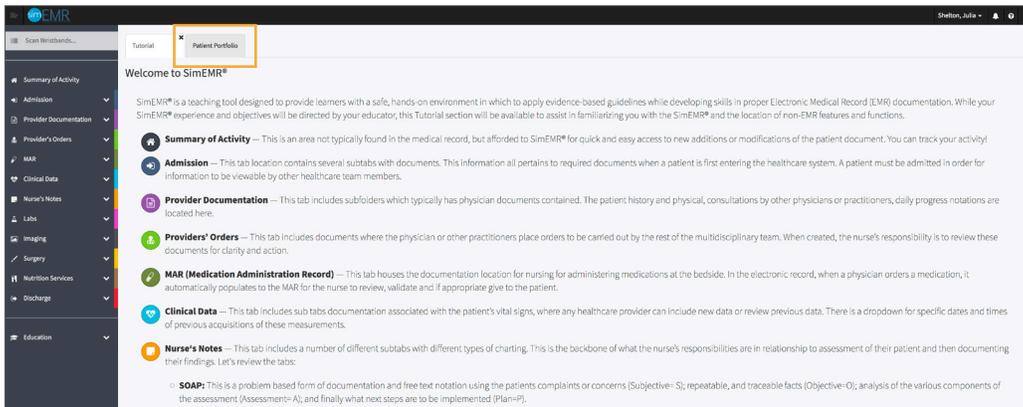
- SimEMR® login
- Internet access
- Web capable device

## Learner Actions: Documentation of Intake & Output

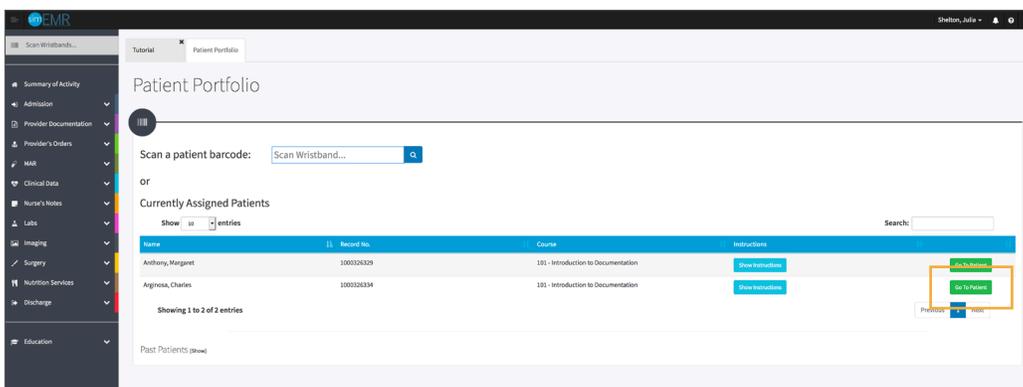
1. Open SimEMR® in a web browser.
2. At the login screen, enter your username and password. Select **[LOGIN]**.
3. If needed, review the tutorial options presented in the *Tutorial* tab.
4. Review and familiarize yourself with the interface and content.



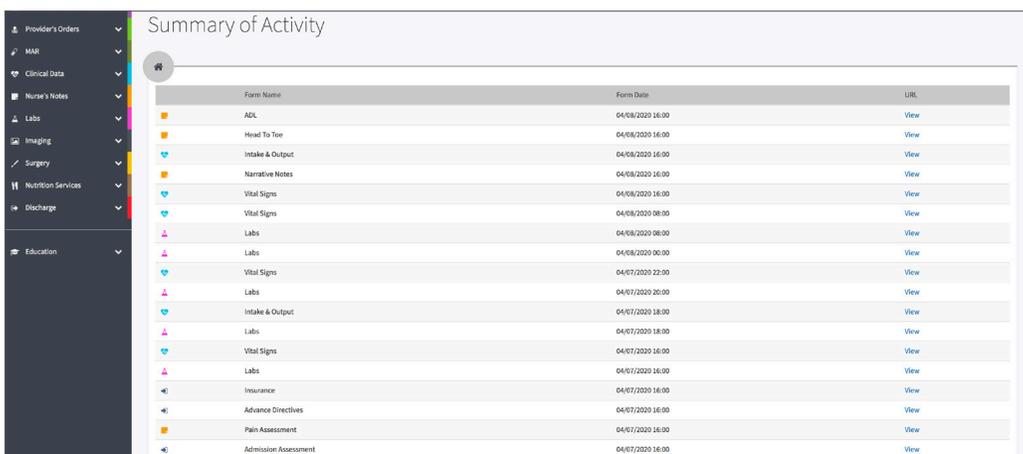
- Select the *Patient Portfolio* tab. Here you will find any patient profiles assigned by your instructor.



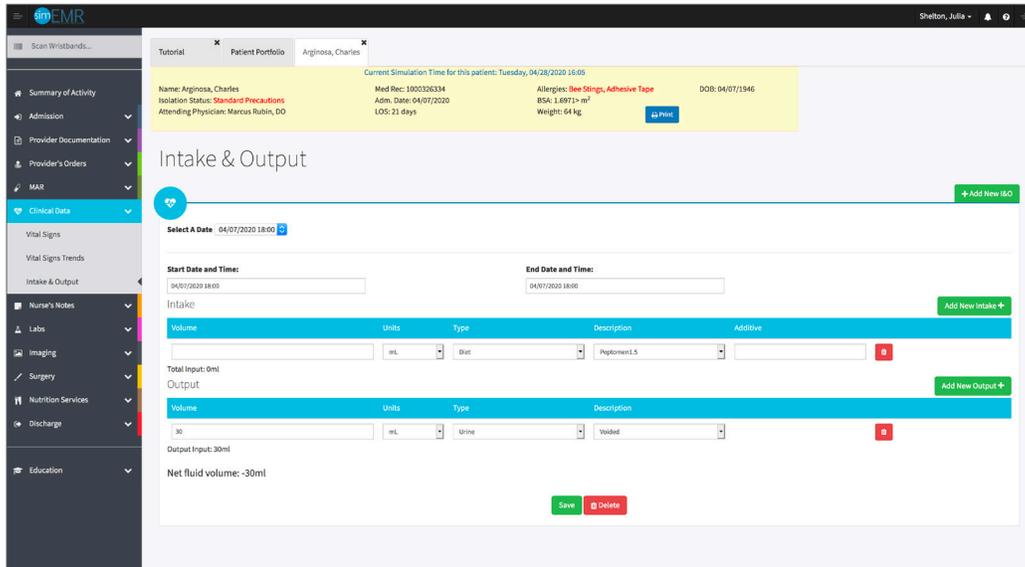
- Current assignments will be presented at the top, and any past assignments will be located at the bottom for reference. Locate Charles Arginosa and select **[GO TO PATIENT]**.



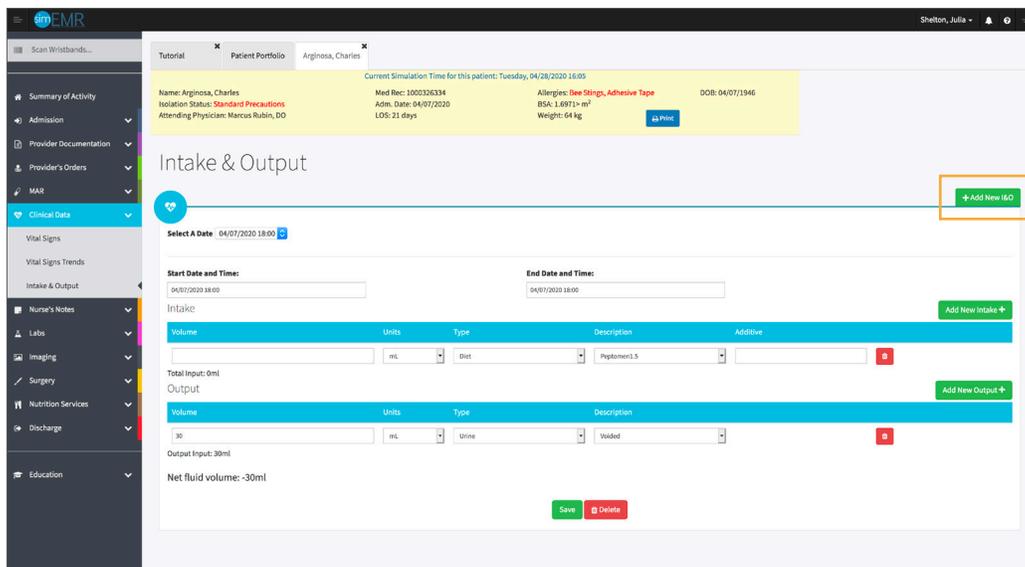
- You will be redirected to the summary page for the patient. To review forms click **[VIEW]** at the far right of the table.



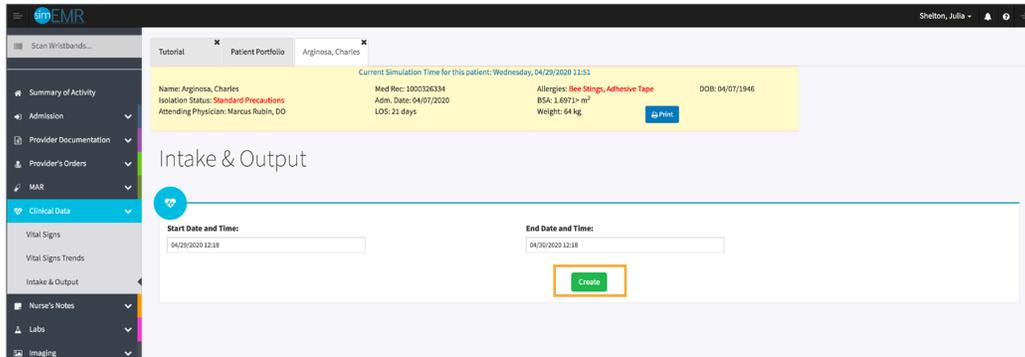
- Click **[CLINICAL DATA]** from the left menu and then select **[INTAKE & OUTPUT]**. You will see the most recent Intake & Output data documented.



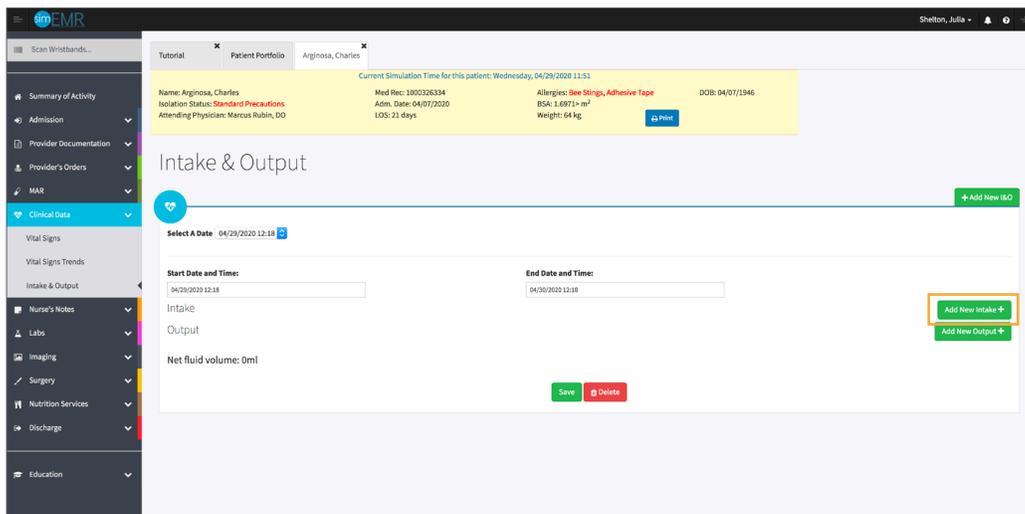
- Validate Charles Arginosa is the chart you are working in.
- Note any previous data documented using the *Select A Date* dropdown. If a form was already created, additional volume items could be added.
- Select **[+ ADD NEW I&O]** to add a new Intake & Output form.



12. You will be redirected to a page to select a *Start Date & Time* and a *Stop Date & Time*. These can be set according to organizational standards as most I & O forms span 24 hours, but could be limited to just what happened on the current shift if desired.



13. Select **[CREATE]**.
14. Select **[ADD NEW INTAKE +]**.



15. Document the following Intake data:
- Enter "200" in the *Volume* field. This is the liquid ingested or infused into the patient.
  - Select "mL" in the *Units* field. This is the metric unit of volume.
  - Select "Diet" in the *Type* dropdown. The 3 options here are Diet (what the patient consumed, IV (intravenous therapy, which is typically added by the nurse), or Blood (blood product transfusions, also added by the nurse).
  - Select "Oral Intake" in the *Description* dropdown. The dropdown includes a list of common nutritional replacement feedings.

e. Enter "Ice water" in the *Additives* field, which identifies what the patient consumed.

16. Select **[SAVE]**.

The screenshot shows the 'Intake & Output' form in the EMR system. The patient's name is Arginosa, Charles. The form includes a table for recording intake and output. The table has columns for Volume, Units, Type, Description, and Additive. A single row of intake data is visible, with a volume of 200, units of mL, type of Diet, description of Oral Intake, and additive of Ice water. The 'Save' button is highlighted with a red box.

Volume	Units	Type	Description	Additive
200	mL	Diet	Oral Intake	Ice water

14. Select **[ADD NEW OUTPUT +]**.

This screenshot is identical to the previous one, but the 'Add New Output +' button is highlighted with a red box. The 'Save' button is no longer highlighted.

15. Document the following Output data:

a. Enter "135" in the *Volume* field. This is the liquid expelled from the patient (urine, melena, etc).

b. Select "mL" in the *Units* field.

c. Select "Urine" in the *Type* dropdown. This is a dropdown of common outputs (Urine, Nasogastric tube drainage, Emesis, or any drains the patient has for blood or other fluids being monitored).

d. Select "Voided" in the *Description* dropdown. Since Urine is selected in the *Type* dropdown, the options here directly relate to that. Selecting other drainage types yields no options.

16. Select **[SAVE]**.

Current Simulation Time for this patient: Wednesday, 04/29/2020 11:51

Name: Arginosa, Charles    Med Rec: 1000326334    Allergies: Bee Stings, Adhesive Tape    DOB: 04/07/1946  
Isolation Status: Standard Precautions    Adm. Date: 04/07/2020    BSA: 1.6971 m<sup>2</sup>  
Attending Physician: Marcus Rubin, DO    LOS: 21 days    Weight: 64 kg

### Intake & Output

Select A Date: 04/29/2020 12:18

Start Date and Time: 04/29/2020 12:18    End Date and Time: 04/30/2020 12:18

**Intake**

Volume	Units	Type	Description	Additive
200	mL	Diet	Oral Intake	Ice water

Total Input: 200ml

**Output**

Volume	Units	Type	Description
135	mL	Urine	Voided

Output Input: 0ml

Net fluid volume: 200ml

Save    Delete

17. After you have selected **[SAVE]**, note that the indication for Net Fluid Volume is revealed. This is auto-calculated by the program, so the clinician has ongoing knowledge of the patient's fluid volume status. As this is a critical measure, accuracy is key!

Current Simulation Time for this patient: Wednesday, 04/29/2020 13:21

Name: Arginosa, Charles    Med Rec: 1000326334    Allergies: Bee Stings, Adhesive Tape    DOB: 04/07/1946  
Isolation Status: Standard Precautions    Adm. Date: 04/07/2020    BSA: 1.6971 m<sup>2</sup>  
Attending Physician: Marcus Rubin, DO    LOS: 21 days    Weight: 64 kg

### Intake & Output

Select A Date: 04/29/2020 12:18

Start Date and Time: 04/29/2020 12:18    End Date and Time: 04/30/2020 12:18

**Intake**

Volume	Units	Type	Description	Additive
200	mL	Diet	Oral Intake	Ice water

Total Input: 200ml

**Output**

Volume	Units	Type	Description
135	mL	Urine	Voided

Output Input: 135ml

Net fluid volume: 65ml

18. Repeat the steps as often as you like with different variations to gain comfort with the form.
19. Close the patient chart by clicking the X on the *Charles Arginosa* tab.
20. Logout by locating the dropdown with your name at the top right of the page, select *Sign Out*.

# Patient Kit Addendum

## CHARLES ARGINOSA

**Name:** Charles Arginosa      **DOB:** 4/7/1946      **Gender:** M  F       **Age:** 74  
**Race:** Hispanic      **Weight:** 62 kg/136 lbs      **Height:** 162 cm/5'4"  
**Religion:**      **CODE STATUS:**      **Advance Directive:** Y  N  X   
**Major Support:** Celina, Daughter      **Phone:**      **Isolation Status:** N/A

**Allergies & Reactions:** BEE STINGS – Hives, ADHESIVE TAPE – Skin tears

**Immunizations:**

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

**Primary Diagnosis:** S/P Fall, R/o Syncopal event

**History of Present Illness:** Found at apartment on floor after fall, hit head, doesn't remember event or prodromal symptoms

**PMH:** Hypertension, Type 2 Diabetes

**Surgeries/Procedures:** NONE

**Social History:** Denies tobacco, alcohol or drug use. Widower of 6 months, married for 46 years. Lives in apartment alone on first floor, has been independent with ADLs's. No use of DME to date. Has 2 children, not living in area. Daughter Celena is closest and is traveling to hospital.

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

**Review of Systems:**

**CNS:** PERRLA, follows commands. Relates unsure of what happened to cause fall, amnesic to the event. Handgrasps = and moderate. Gait not tested at this time.

**Cardiovascular:** Heart rate regular rhythm, no murmurs, rubs, or gallops on auscultation. Peripheral pulses = and moderate. No edema noted. Denies chest pain prior to event or current.

**Pulmonary:** Lungs clear to auscultation, no oxygen in use. Denies shortness of breath or cough. SpO2 92+ %.

**Gastrointestinal:** Abdomen flat, soft. Hyperactive bowel sounds noted in all quads. Denis N/V/C/D. States appetite has been low since wife's passing.

**Hepato/Renal:** States voids without difficulty.

**Endocrine:** Type 2 Diabetic, diet controlled initially. Doesn't check blood sugars by report.

**Hematologic:** Non-contributory

**Musculoskeletal:** Some petechiae noted to lower extremities. Moderate ecchymosis to right front-temporal region with swelling noted. Pt states 4/10 pain at palpation.

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

**Developmental:** N/A

**Psychological:** Calm at present, flat affect; quiet and reserved in speech and activity. Wants to go home ASAP. Denies depressive symptoms..."I just miss my wife terribly."

## Current Medications:

Patient is a poor historian, will need to reconcile with EMR.

Medication (Generic/Trade)	Dose Available	Dose Ordered	Route	Frequency	Parameters/ Instructions	Provider Ordering
Metformin			PO	Daily		
Norvasc			PO	Daily		
Geritol (MVI)				Daily		

## 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:
<b>Coagulation</b>	Mg:	HDL:	<b>Other Tests</b>	MDRO:	Lidocaine:
PT:	Phos:	Trig:	CBS:	VDRL:	MetHgb:
PTT:	Gluc:	CPK total:		GBS:	
INR:	HgA1C:	CPK MB:			
d-Dimer	Lactate:	Troponin:			

CXR:

CT/MRI: HEAD: Negative for pathology

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.

### 1 Day Before Simulation Start

**Purpose:** All activities are designed to allow the learner to evaluate initial findings

#### Insurance

**Description:** Black, unable to attain from patient

#### Advance Directives

**Description:** Info selected include *Yes* radio button under *Unable to obtain information from patient and family is not available*, selected *Yes* radio button under *Registered Nurse*

#### Admission Assessment

**Description:** Info collected from patient include *Allergy Information, Pain Assessment, Medical History, Psychosocial, Past Surgery, Prosthetics, Cultural, Risk Assessment, and Discharge Planning*.

#### Admission

**Description:** Info selected include *Standard Precautions* check box under *Isolation Status*, The admitting physicians and diagnosis (*S/p Fall with possible concussion, R/O syncopal event*), as well as *Patient Information, Allergy Information, and In Case of Emergency Information*

#### Provider's Orders

**Description:** Data entered include *Order Details* for an overview for the learner as well as ordered medications (*650 mg Acetaminophen 325mg*

*Suppository, 1 Demo Dose® MVit 1mg Tablet, 1000 mL Normal Saline 0.9% Solution, 25 mg Demo Dose® Lopre 25mg Tablet*) as well as instructions

#### Labs

**Description:** Capillary Blood Glucose is 79

#### Vital Signs

**Description:** Vital inputs for Charles include *Temperature (36° C), Temperature Method (Axillary), Blood Pressure (146/100), Blood Pressure Method (NIBP), Pulse (100), Pulse Location (Apical), Oxygen Saturation (95), Oxygen Device (Room Air), Respirations per Minute (24)*

### 22 Hours Before Simulation Start

**Purpose:** Activities are designed to allow the learner to evaluate, review, and compare findings

#### Intake & Output

**Description:** Intake and Output data collected

#### Labs

**Description:** *Hematology* lab data collected

### 20 Hours Before Simulation Start

**Purpose:** Activities are designed to allow the learner to evaluate, review, and compare lab findings

#### Labs

**Description:** *Chemistry* lab data, such as *Sodium* is now recorded

## 18 Hours Before Simulation Start

**Purpose:** Activities are designed to allow the learner to evaluate, review, and compare vital sign findings

### Vital Signs

**Description:** Vital inputs for Charles include *Temperature (36.4° C), Temperature Method (Axillary), Blood Pressure (136/98), Blood Pressure Method (NIBP), Pulse (100), Pulse Location (Apical), Oxygen Saturation (96), Oxygen Device (Room Air), Respirations per Minute (22)*

## 16 Hours Before Simulation Start

**Purpose:** Activities are designed to allow the learner to evaluate, review, and compare lab findings

### Labs

**Description:** Capillary Blood Glucose is 104

## 8 Hours Before Simulation Start

**Purpose:** Activities are designed to allow the learner to evaluate, review, and compare findings

### Labs

**Description:** Capillary Blood Glucose is 96

### Vital Signs

**Description:** Vital inputs for Charles include *Temperature (36.6° C), Temperature Method (Axillary), Blood Pressure (132/86), Blood Pressure Method (NIBP), Pulse (100), Pulse Location (Apical), Oxygen Saturation (96), Oxygen Device (Room Air), Respirations per Minute (22)*

## At Simulation Start

**Purpose:** Activities are blank to allow learner to review past data and collect new data to determine if Charles can be released.