Intro Level SimEMR® Use Cases

1.4 MEDICAL ASSISTANT PROGRAMS

Introduction

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 *SOAP Note* documentation, located under the *Nurse's Notes* menu

b. Document a SOAP note

c. Document a *Head to Toe, Charting by Exception,* and *Narrative*

e. Repeat any documentation for practice and comfortability if needed

Patient Profile - Margaret Anthony

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 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

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Learner Actions: Physical Assessment Documentation

There are a number of different nursing documentation forms available for this activity. Follow the directions from your instructor on the specific form for your assignment, but feel free to utilize any of the form options to identify and practice documentation.

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.
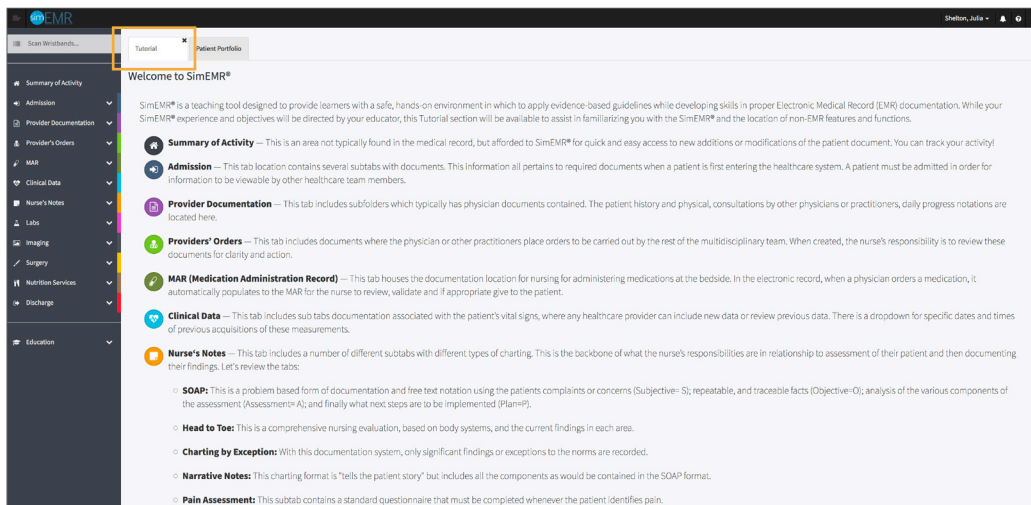
5. Select the *Patient Portfolio* tab. Here you will find any patient profiles assigned by your instructor.
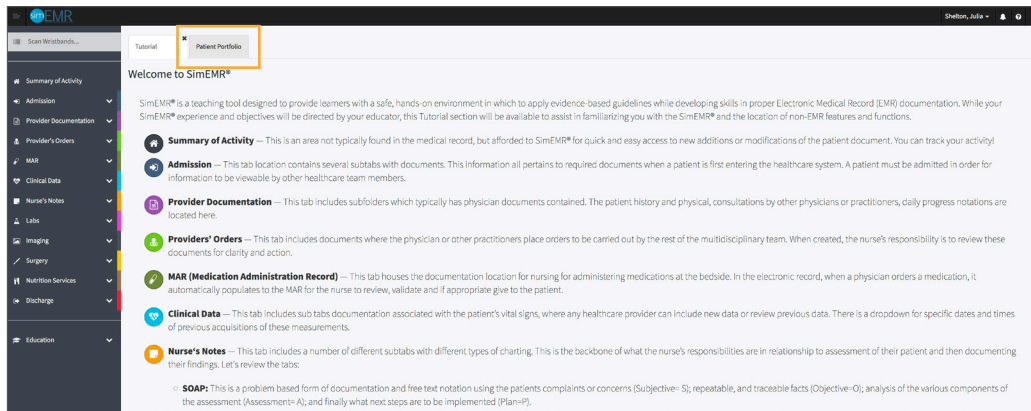
6. Current assignments will be presented at the top, and any past assignments will be located at the bottom for reference. Locate Margaret Anthony and select **[GO TO PATIENT]**.
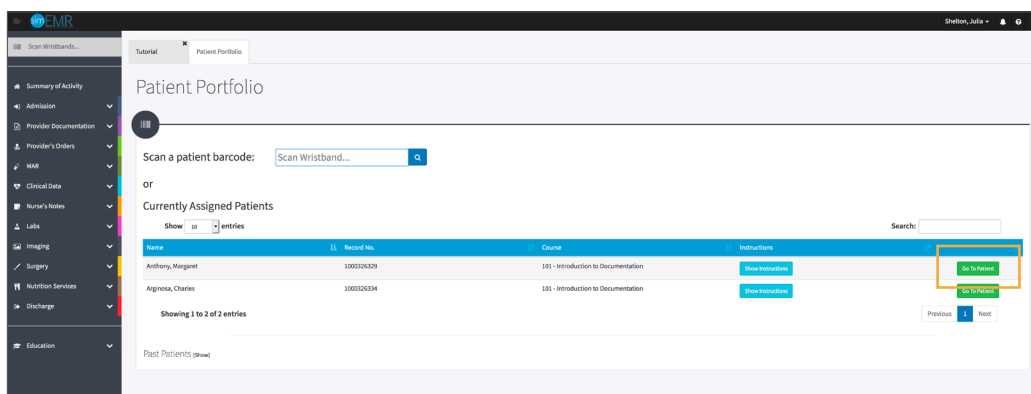
7. Click **[NURSE'S NOTES]** from the left menu and then select **[SOAP]**. You will see the most recent vitals documented. Past data can be located by using the *Select A Date* dropdown.

    SOAP notes are the most common documentation form for Medical Assistants, however there are several nursing specific forms as well as two hand off forms for critical information sharing based on the TeamSTEPPS™ curriculum included in SimEMR® as well.
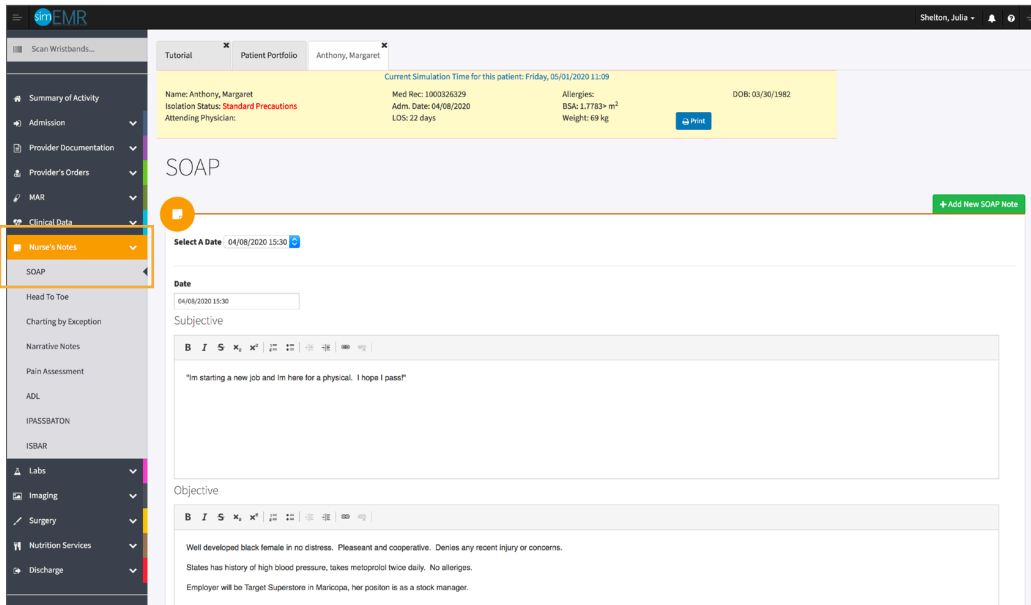
8. Verify Margaret Anthony is the chart you are working in.

9. Select **[+ ADD NEW SOAP NOTE]**.
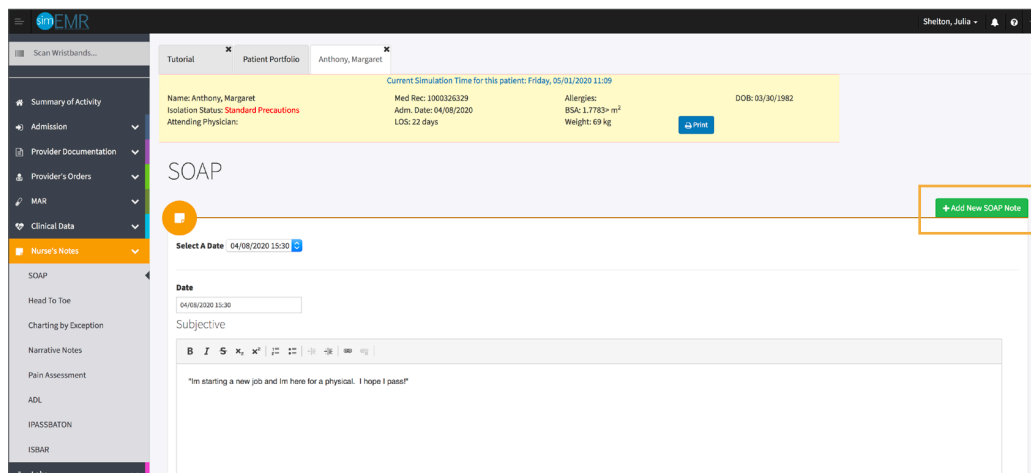
10. You will be redirected to a blank form. Add the current date and time by clicking in the *Date* field.

11. The first free text field is *Subjective*, the information the patient tells you. This can include the following:

Chief Complaint: reason for seeking healthcare assistance for the current problem

HPI (History of Present Illness): how long the problem has existed, any therapies to date

Past Medical History: allergies, surgeries, family

Social History: family, personal, occupation, alcohol and drug use

ROS (Review of Symptoms): review of symptoms related to the concern

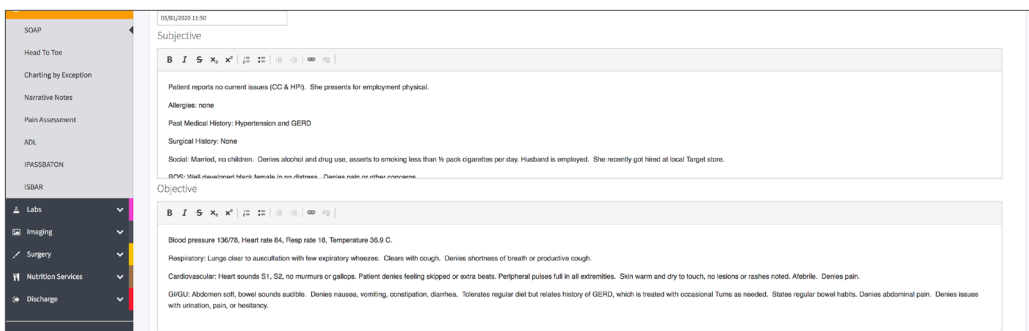Complete the following documentation in the *Subjective* field:

a. Patient reports no current issues (CC & HPI). She presents for employment physical.

b. Allergies: none

c. Past Medical History: Hypertension and GERD

d. Surgical History: None

e. Social: Married, no children. Denies alcohol and drug use, asserts to smoking less than ½ pack cigarettes per day. Husband is employed. She recently got hired at local Target store.

f. ROS: Well developed black female in no distress. Denies pain or other concerns.
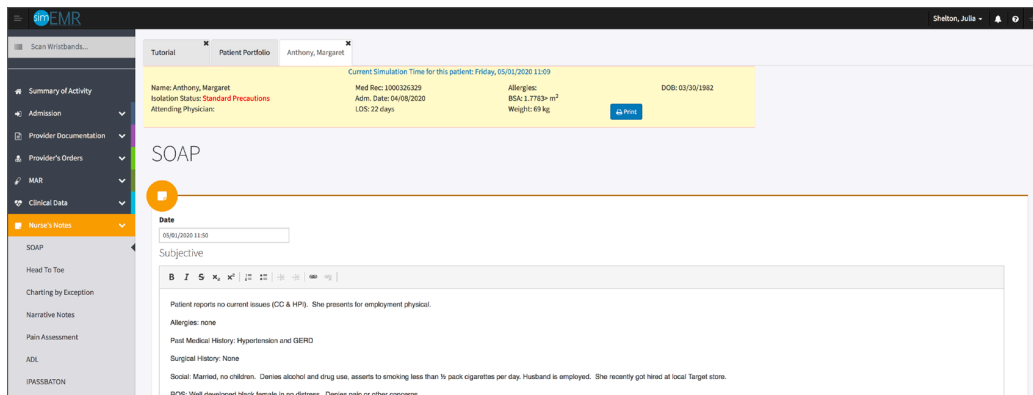
12. The next free text field is *Objective*, the measurable and observable information about the patient. This can include Vital Signs, focused physical assessments, laboratory tests, or procedures.

Complete the following documentation in the *Objective* field:

a. Blood pressure: 136/78, Heart rate: 84, Resp rate: 18, Temperature 36.9 C

b. Respiratory: lungs clear to auscultation with few expiratory wheezes, clears with cough. Denies shortness of breath or productive cough.

c. Cardiovascular: Heart sounds S1, S2, no murmurs or gallops. Patient denies feeling skipped or extra beats. Peripheral pulses full in all extremities. Skin warm and dry to touch, no lesions or rashes noted. Afebrile. Denies pain.

d. GI/GU: Abdomen soft, bowel sounds audible. Denies nausea, vomiting, constipation, diarrhea. Tolerates regular diet but relates history of GERD, which is treated with occasional Tums as needed. States regular bowel habits. Denies abdominal pain. Denies issues with urination, pain, or hesitancy

13. The next free text field is *Assessment*, your impression of what is going on with the patient based on objective findings.

Complete the following documentation in the *Assessment* field:

a. Patient is a pleasant middle-aged female who relates no urgent complaints, presenting for pre-employment physical exam

14. The final free text field is *Plan*, or follow-up steps to be undertaken by the patient after this encounter. This can include changes to the plan of care, laboratory or other testing, medications, education, or other provider consultations.

Complete the following documentation in the *Assessment* field:

a. Physical exam completion by Nurse Practitioner, possible follow-up testing, pending exam.

b. Provide patient with Smoking Cessation educational materials.

15.   Select **[SAVE]**.
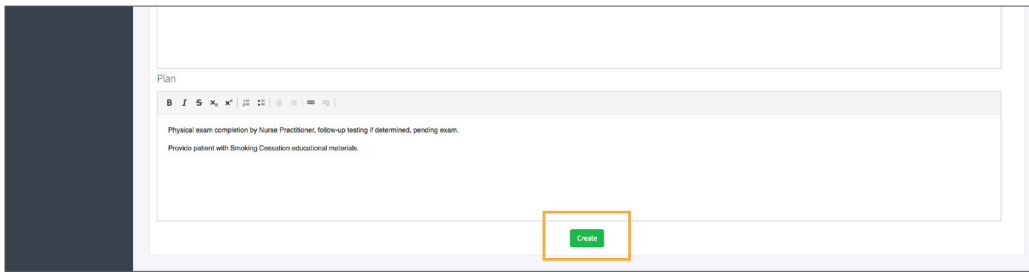
16.   Repeat the above steps with any vital information until you are comfortable with the form.

17.   Close the patient chart by clicking the X on the *Margaret Anthony* tab.

18.   Logout by locating the dropdown with your name at the top right of the page, select *Sign Out*.

Additional Documentation Practice

For each of the following forms, you will follow the same process of selecting the green **[✚ ADD NEW]** at the top right of the form to open up a new document. The purpose of these forms are to add physical assessment information as desired for practice.

Head to Toe Assessment

Description: Complete documentation of the physical assessment based on individual components and serves as another option for completing documentation in a format more consistent to inpatient care. Each section reveals a subset of assessment variables both normal and aberrant, to be revealed by the *Show/Hide* options.
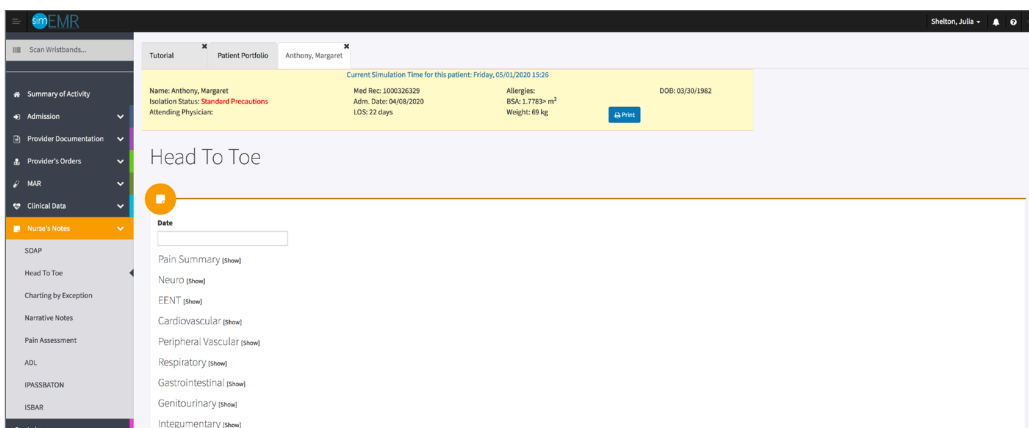
Charting by Exception

Description: List of physical systems with common assessment documentation within each section. The option to select from two radio buttons, *Normal* or *Abnormal*, prompts an empty text field for documentation of the abnormal finding. A useful form for mid and end-of-shift assessment after the head-to-toe was completed at the beginning of shift.

Narrative Notes

Description: Free text field to allow "telling of the patient's story". This form is helpful for intermittent updates, bridges to hand off of providers or change in service, or ancillary service inclusions where a form is not currently available. Content is similar to a SOAP note.

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	Opiods:
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 ℹ️

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