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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Learning Objectives

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

Resources Needed

- SimEMR[®] login
- Internet access
- Web capable device

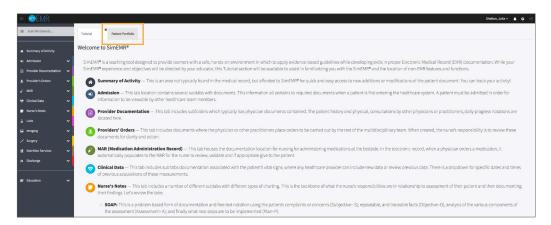
Learner Actions: Physical Assessment Documentation

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.

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| 🗐 Scan Wristbands | Tatorial A Patent Particle |
| L | Welcome to SimEMR® |
| # Summary of Activity | Welcome to Simewick |
| Admission V Provider Documentation | SimEMR® is a tracking tool designed to provide learners with a sole, hands on environment in which to apply evidence based guidelines while developing skills in proper Electronic Medical Record (EMR) documentation. While your SimEMR® experience and objectives will be directed by your educator, this Tutorial section will be available to assist in familiariting your with the SimEMR® and the location of non-EMR features and functions. |
| 🐁 Provider's Orders 🗸 🗸 | 👩 Summary of Activity — This is an area not typically found in the medical record, but afforded to SimEMR® for quick and easy access to new additions or modifications of the patient document. You can track your activity! |
| ρ MAR ✓ | Admission — This tab location contains several subtabs with documents. This information all pertains to required documents when a patient is first entering the healthcare system. A patient must be admitted in order for information to be viewable by other healthcare team members. |
| Nurse's Notes | Provider Documentation — This tab includes subfolders which typically has physician documents contained. The patient history and physical, consultations by other physicians or practitioners, daily progress notations are |
| 🛓 Labs 🗸 🗸 🗸 | Located here. |
| 🖬 Imaging 🗸 🗸 | Providers' Orders — This tab includes documents where the physician or other practitioners place orders to be carried out by the rest of the multidisciplinary team. When created, the nurse's responsibility is to review these documents for clarity and action. |
| / Surgery 🗸 | MAR (Medication Administration Record) — This tab houses the documentation location for nursing for administering medications at the bedside. In the electronic record, when a physician orders a medication, it |
| Nutrition Services V | What (velocation Administration Record) — Inits ab houses the documentation location for hubing for administering medicators at the bedsde. In the electronic record, when a physician orders a medication, it automatically populates to the MAR for the nuse to review, validate and if appropriate give to the patient. |
| | Control Data — This tab includes sub tabs documentation associated with the patient's vital signs, where any healthcare provider can include new data or review previous data. There is a dropdown for specific dates and times of previous acquisitions of these measurements. |
| 🕿 Education 🗸 🗸 | O Nurse's Notes — This tab includes a number of different subtabs with different types of charting. This is the backbone of what the nurse's responsibilities are in relationship to assessment of their patient and then documenting their findings. Let's review the taba: |
| | SOAP: This is a problem based form of documentation and free text notation using the patients complaints or concerns [Subjective= S]; repeatable, and traceable facts (Objective=O); analysis of the various components of the assessment: Assessment: Assessment: AS; and finally what not: steps are to be implemented (Plan=P). |
| | Head to Toe: This is a comprehensive nursing evaluation, based on body systems, and the current findings in each area. |
| | Charting by Exception: With this documentation system, only significant findings or exceptions to the norms are recorded. |
| | Narrative Notes: This charting format is "tells the patient story" but includes all the components as would be contained in the SORP format. |
| | Pain Assessment: This subtab contains a standard questionnaire that must be completed whenever the patient identifies pain. |

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].

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| Scan Wristbands | | Tutorial Patient Portfolio | | | | |
| 🚓 Summary of Activity | | Patient Portfolio | | | | |
| +) Admission | ~ | | | | | |
| Provider Documentation | ~ | | | | | |
| Provider's Orders | ~ | Scan a patient barcode: | Scan Wristband | | | |
| р мак | ~ | | Jean Whiteband | | | |
| 👽 Clinical Data | ~ | or | | | | |
| Nurse's Notes | ~ | Currently Assigned Patien | ts | | | |
| ⊥ Labs | ~ | Show 10 • entries | | | | Search: |
| Sal Imaging | ~ | Narre | 11 Record No. | [] Course | 11 Instructions | 11 |
| Surgery | ~ | Anthony, Margaret | 1000326329 | 101 - Introduction to Documentation | Show Instructions | Go To Patient |
| Nutrition Services | ~ | Arginosa, Charles | 1000326334 | 101 - Introduction to Documentation | Show Instructions | Go To Patient |
| (Discharge | ~ | Showing 1 to 2 of 2 entries | | | | Previous 1 Next |
| e Education | ~ | Past Patients (show) | | | | |
| | | | | | | |

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.

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|---|--|--|---|-----------------|----------------|--|--|
| Scan Wristbands | X Tutorial Patient Portfolio | × Anthony, Margaret | | | | | |
| | | Current Simulation Time for this pati | ent: Friday, 05/01/2020 11:09 | | | | |
| Summary of Activity | Name: Anthony, Margaret Isolation Status: Standard Precautions | Med Rec: 1000326329 Adm. Date: 04/08/2020 | Allergies: BSA: 1.7783> m ² | DOB: 03/30/1982 | | | |
| Admission | Attending Physician: | LOS: 22 days | Weight: 69 kg | ⊖ Print | | | |
| Provider Documentation | COAD | | | | | | |
| 🏝 Provider's Orders 🗸 🗸 | SOAP | | | | | | |
| 🖉 MAR 🗸 🗸 | 0 | | | | + Add Ne | | |
| 🐨 Clinical Data 🗸 🗸 | Select A Date 04/08/2020 15:30 | | | | | | |
| 📑 Nurse's Notes 🗸 🗸 | 341441 M Mare 34/08/2020 15:30 | | | | | | |
| SOAP 4 | Date | | | | | | |
| Head To Toe | 04/08/2020 15:30 Subjective | | | | | | |
| Charting by Exception | B I S x ₂ x ²] = := = | | | | | | |
| Pain Assessment | B 1 5 A ₂ X [*] i= i= 1 | t 18 www. 19 | | | | | |
| ADL | "Im starting a new job and Im here fo | r a physical. I hope I pass!" | | | | | |
| IPASSBATON | | | | | | | |
| ISBAR | | | | | | | |
| Labs → | | | | | | | |
| - Imaging V | Objective | | | | | | |
| ∠ Surgery ✓ | B I S ×, ×' ∷ ∷ | E #E 60 mg | | | | | |
| 🕅 Nutrition Services 🗸 🗸 | Well developed black lemale in no distress. Pleaseant and cooperative. Denies any recent injury or concerns. | | | | | | |
| 🕒 Discharge 🗸 🗸 | States has history of high blood pressure, takes metoprotol twice daily. No alleriges. | | | | | | |
| | Employer will be Target Superstore | n Maricopa, her positon is as a stock manager. | | | | | |

8. Verify Margaret Anthony is the chart you are working in.

9. Select [+ ADD NEW SOAP NOTE].

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| Scan Wristbands | Tutorial Patient Portfolio Anthony, Margaret | |
| | Current Simulation Time for this patient: Friday, 05/01/2020 11:09 | |
| # Summary of Activity | Name: Anthony, Margaret Med Rec: 1000326329 Allergies: DOB: 03/30/1982 Isolation Status: Standard Precautions Adm. Date: 04/08/2020 BSA: 1.7783 > m ² | |
| *) Admission 🗸 🗸 | Attending Physician: LOS: 22 days Weight: 69 kg | |
| Provider Documentation 🗸 | | |
| 🏝 Provider's Orders 🗸 🗸 | SOAP | |
| 🖉 MAR 🗸 🗸 | | + Add New SOAP Note |
| 😻 Clinical Data 🛛 🗸 🗸 | | |
| 📰 Nurse's Notes 🗸 🗸 🗸 | Select A Date 04/08/2020 15:30 | |
| SOAP | Date | |
| Head To Toe | 04/08/2020 15:30 | |
| Charting by Exception | Subjective | |
| Narrative Notes | $\mathbf{B} \mathbf{I} \mathbf{S} \mathbf{x}_{\mathbf{c}} \mathbf{x}^{\mathbf{c}} \mathbf{z}^{\mathbf{c}} \mathbf{z}^{\mathbf{c}}$ | |
| Pain Assessment | "Im starting a new job and Im here for a physical. I hope I pass!" | |
| ADL | | |
| IPASSBATON | | |
| ISBAR | | |
| ⊥ Labs 🗸 🗸 | | |

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.

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| Admission ✓ | 1 | Attending Physician | ĸ | | LOS: 22 days | Weight: 69 kg | 🕀 Print | | |
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| Nurse's Notes | | Date | | | | | | | |
| SOAP | • | Subjective | | | | | | | |
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| Charting by Exception | | | | | | | | | |
| Narrative Notes | | Allergies: nor | | C & HPI). She presen | its for employment physical. | | | | |
| Pain Assessment | | | History: Hypertension | and GERD | | | | | |
| ADL | | Surgical Histo | ory: None | | | | | | |
| PASSBATON | | Social: Marrie | ad, no children. Denie | s aloohol and drug use | , asserts to smoking less than ½ pa | ack cigarettes per day. Husband is employed | . She recently got hired at local Target store. | | |
| | | DOC: Well de | weinneri hisnic female | in no dietrace Daniae | nain or other concerne | | | | |

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

| | 05/01/2020 11:50 |
|--------------------------|--|
| SOAP | Subjective |
| Head To Toe | B I S x, x ¹ [2 11] 4 4 = 4 |
| Charting by Exception | Patient reports no current issues (CO & HP). She presents for emolythment chysical, |
| Narrative Notes | Patient lepta to canten asses (JC a nr-g, one presenta or englisyment proyecu). Alfreder cone |
| Pain Assessment | Peak Medical History: Hypertinsion and GERD |
| ADL | Burgical History: None |
| IPASSBATON | Social: Married, no children. Denies alcohol and drug use, asserts to emoking less than 19 pack cigarettes per day. Hasband is employed. She recently got hired at local Target store. |
| | BOS: Wall Assalonal Neck famala in no distrate. Danias nain or nither concerne |
| ISBAR | Objective |
| ∆ Labs 🗸 🗸 | B I 5 x, x' # == + + + + + + |
| 🖾 Imaging 🗸 🗸 | Blood pressure 136/78, Heat rate 64, Page rate 16, Temperature 50.9 C. |
| 🖌 Sungery 🗸 🗸 | Respiratory: Lungs clear to ausoutation with lew expiratory whences. Dears with cough. Derive shortness of breath or productive cough. |
| 🎢 Nutrition Services 🗸 🗸 | Cardiovascular: Heart sounds 51, 52, no mumurs or galapos. Patient denies feeling skipped or extra beats. Periphenal pulses full in all entermities. Skin warm and dry to touch, no testors or rashes noted. Albehrle, Denies pain. |
| 🛭 Discharge 🗸 🗸 | GIGU: Address root, bowel sounds aucides. Deries nauses, vomiting, constipation, diamites. Tolerates regular diet but relates history of GERO, which is treated with occasional Tume as needed. States regular bowel habits. Deries abdominal pain. Deries issues with unination, pain, or hestancy. |
| | |

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].

| Plan | |
|---|---|
| B I 5 × x x¹ 2 ≤ 2 ≤ 2 ≤ 2 ≤ 2 ≤ 2 ≤ Physical exam completion by Nation Practitions, follow-up testing if determined, pending exam. | |
| Provide patient with Smaking Cessation educational materials. | |
| | |
| Create | |
| | - |

- 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.

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|--------------------------|---|--|---|-----------------|
| IIII Scan Wristbands | Tutorial Patient Portfolio | * Anthony, Margaret | | |
| | | Current Simulation Time for this pat | ient: Friday, 05/01/2020 15:26 | |
| # Summary of Activity | Name: Anthony, Margaret Isolation Status: Standard Precautions | Med Rec: 1000326329 Adm. Date: 04/08/2020 | Allergies: BSA: 1.7783> m ² | DOB: 03/30/1982 |
| Admission | Attending Physician: | LOS: 22 days | Weight: 69 kg | 🖨 Print |
| Provider Documentation 🗸 | | | | |
| 🍰 Provider's Orders 🛛 🗸 | Head To Toe | | | |
| ∠ µ MAR ✓ | _ | | | |
| 😌 Clinical Data | | | | |
| | Date | | | |
| Nurse's Notes | | | | |
| SOAP | Pain Summary (show) | | | |
| Head To Toe | Neuro (show) | | | |
| Charting by Exception | EENT (Show) | | | |
| Narrative Notes | Cardiovascular (show) | | | |
| Pain Assessment | Peripheral Vascular (show) | | | |
| ADL | Respiratory (show) | | | |
| IPASSBATON | Gastrointestinal (show) | | | |
| ISBAR | Genitourinary [show] | | | |
| ∆ Labs | Integumentary (show) | | | |

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.

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| IIII Scan Wristbands | Yutorial Patient Portfolio Anthony, Margaret | | |
| | Current Simulation Time for this patient: Friday, 05/01/203 | 0 15:26 | |
| # Summary of Activity | Name: Anthony, Margaret Med Rec: 1000326329 Allerg | | |
| •) Admission 🗸 🗸 | | 7783> m ² ≥ 69 kg ⊖ Print | |
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| 🖌 MAR 🗸 🗸 | | | |
| | | | + Add New Charting By Exception |
| 😌 Clinical Data 🛛 🗸 | | | |
| | Select A Date 05/01/2020 15:27 🗘 | | |
| SOAP | | | |
| Head To Toe | Date Available: | | |
| need to toe | 05/01/2020 15:27 | | |
| Charting by Exception 4 | Neurological Assessment Alert and oriented to person, place & time. Speech and behavior appropriate to situation. Speech clear and coherent | Pupils equal & | |
| Narrative Notes | reactive to light. Active ROM of all extremities with symmetry of strength. No paresthesia. Protective reflexes intact. S without coughing or choking on liquids or solids. | | Abnormal |
| Pain Assessment | | | |
| | Cardiovascular Assessment Heart sounds clear and regular with no extra heart sounds audible. HR 60-100 bpm. If monitored, rhythm is normal si | une united and | |
| ADL | ectopy. No edema and/or JVD. Denies chest pain or associated symptoms. BP within normal limits. | Normal | Abnormal |
| IPASSBATON | Perioheral / Vascular Assessment | | |
| ISBAR | Peripheral y vascular Assessment Peripheral pulses palpable and equal bilaterally. Capillary refill 3 sec. Temperature, color, sensation and movement o | limbs WNL. No | |
| ∆ Labs 🗸 🗸 | cali tenderness. | Normal | Abnormal |
| <u>∧</u> uos v | Desniratory Assassment | | |

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.

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| III Scan Wristbands | Tutorial X Patere Portfolio Authory, Marguret | | | |
| ♣ Summary of Activity ♠ Admission | Current Simulation Time Vet bis patient: Fréday, SSI02,2020 13:28 Inster: Anthony, Marganet Mel Res: 1000288239 Allergies: DOIE: 03/03/1382 Isolation Standard Prezultions Adm. back (VMIR220) BISL: 1773 m ² DOIE: 03/03/1382 Attending Physician: LOS: 22 days Weight: 69 kg Bible: | | | |
| Provider Documentation ✓ ▲ Provider's Orders ✓ ✓ MAR ✓ | Narrative Notes | | | |
| 🗢 Clinical Data 🗸 🗸 | Die | | | 1 |
| SCAP | Note Text | | | |
| Head To Toe Charting by Exception | B I S x, x' 1 1 1 1 1 1 1 1 1 1 | | | |
| Narrative Notes | | | | |
| Pain Assessment | | | | |

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 Childhoo | d, no boosters to date | | |
| Attending Physician/Team: PCP | John Miller, MD | | |
| Primary Diagnosis: Denies issues, | Pre-Employment Exam | | |
| History of Present Illness: Denies | ssues, Pre-Employment Exa | m | |
| PMH: Hypertension, GERD | | | |
| Surgeries/Procedures: NONE | | | |
| close by. Margaret has been hir Denies alcohol or drug use, smo hospital as a supply chain manc Data: Blood pressure: 142/92, He | kes half pack of cigarettes/ Iger. Margaret is covered b | day. Husband is employed o y her husband's insurance a | at local |
| Review of Systems: Normal physi | cal exam data | | |
| CNS: Alert, calm | | | |
| Cardiovascular: Heart rate regul | ar rhythm, Pulses full and = | throughout | |
| Pulmonary: "smokers" cough, lui | ngs 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, otherwis | se intact, Capillary refill WNI | - | |
| Developmental: Non- contributo | bry | | |
| Psychological: Pleasant, talkativ | e, excited for new job, den | ies concerns for risks or depr | essive symptoms |

Current Medications:

| Medication (Generic/Trade) | Dose Available | Dose Ordered | Route | Frequency | Parameters/ Instructions | Provider Ordering |
|--------------------------------------|-------------------|-----------------|-------|-----------|-----------------------------|----------------------|
| Metoprolol | | 25 mg | РО | 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: | К: | ALT: | Hgb: | Urine C/S | ETOH: |
| pcO2: | CI: | 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: | СРК МВ: | | | |
| 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

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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