Intro Level SimEMR® Use Cases

2.4 NURSING 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
- *10-15 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. Document Ambulation Activity in the *Narrative Note*

b. Repeated practice

Patient Profile - Charles Arginosa

Getting Started

1.   Review the Patient Kit Addendum on pages 8 – 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 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

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## Learner Actions: Documentation of Ambulation Activity in a Narrative Note

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.
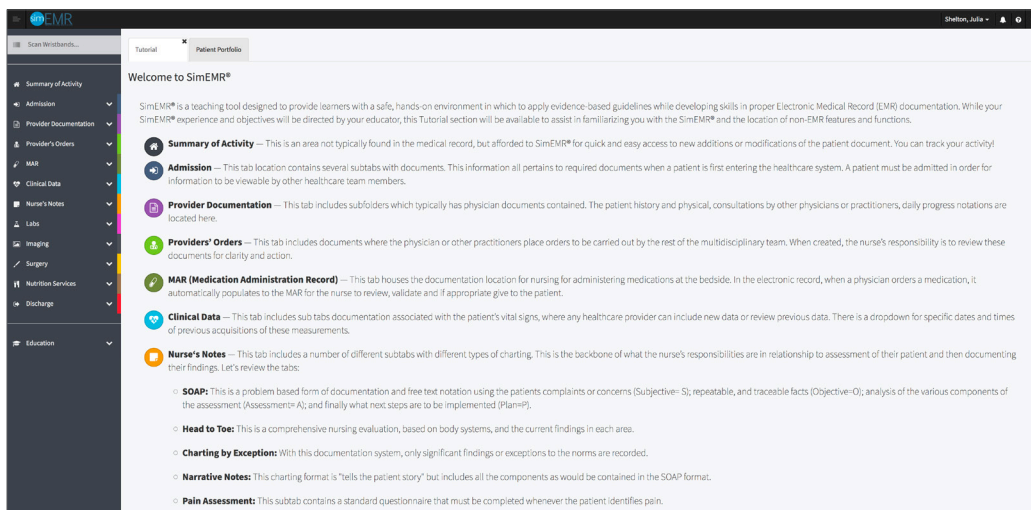
5. Select the *Patient Portfolio* tab. Here you will find any patient profiles assigned by your instructor.
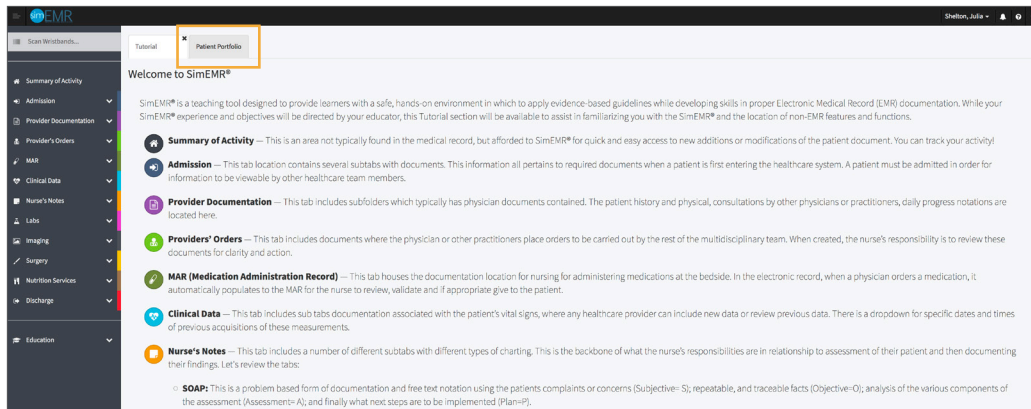
6. Current assignments will be presented at the top, and any past assignments will be located at the bottom for reference. Locate Charles Arginosa and select **[GO TO PATIENT]**.
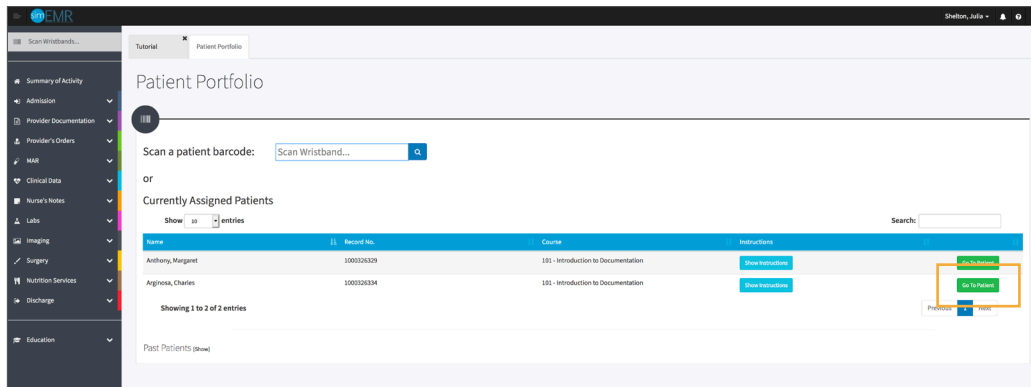

7. Click **[NURSE'S NOTES]** from the left menu and then select **[NARRATIVE NOTES]**. You will see the most recent Narrative Note data documented.

    This information can also be included in the ADL form, previously covered in Activity 2.3.
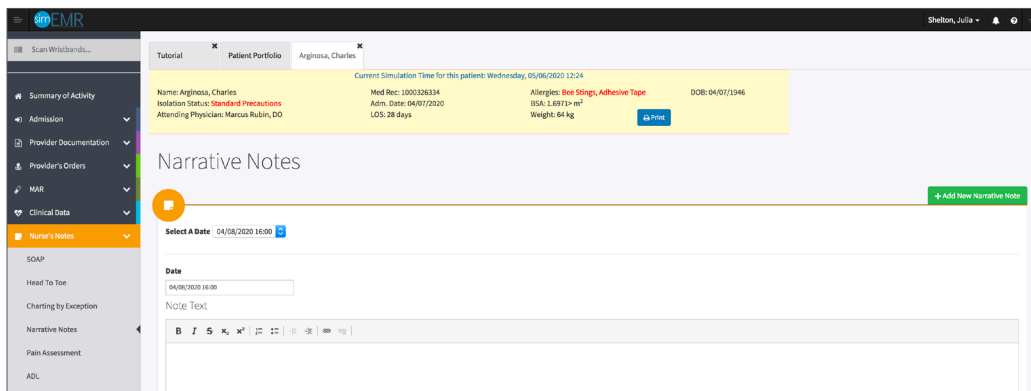
8.   Validate Charles Arginosa is the chart you are working in.

9.   Note any previous data documented using the *Select A Date* dropdown.

10. Select **[+ ADD NEW NARRATIVE NOTE]** to add a new Narrative Note.
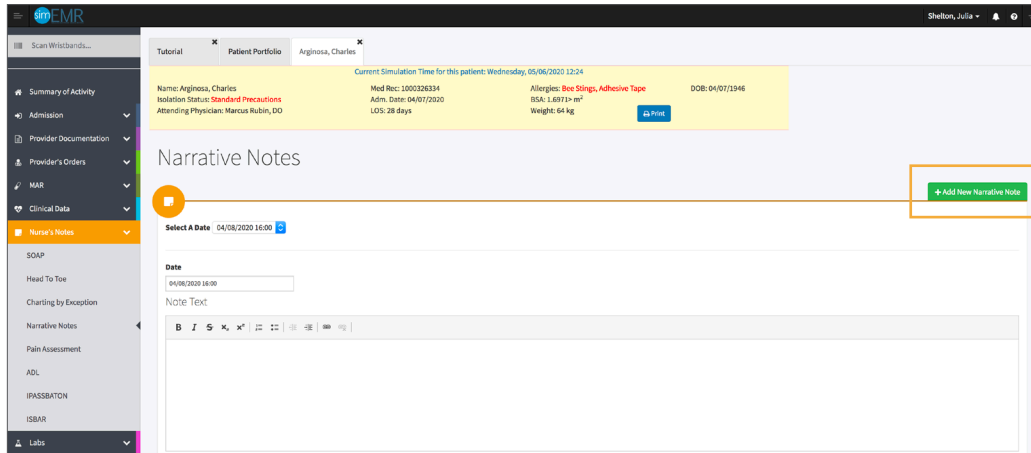
11. You will be redirected to a blank *Narrative Note.*
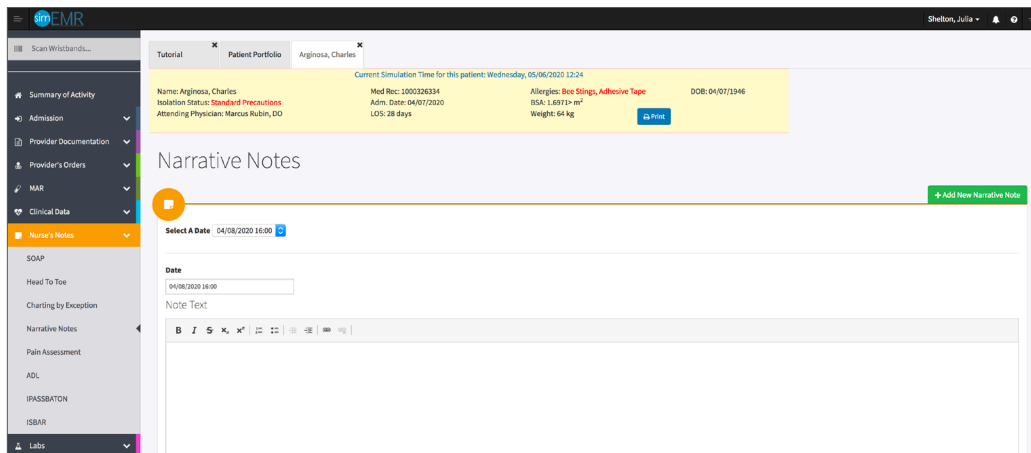
12. Select a *Date.*

13. Document the following Intake data:

     Patient assisted with AM care, participated in partial completion at bedside. Patient assisted to bathroom, quad cane used with some unsteadiness noted. Patient ordered OOB with assist. Ambulation in room approximately 50 feet total in room. Attempt to hall walk deferred, physical therapy to begin session at this time.

14.   Select **[CREATE]**.

15.   Repeat the steps as often as you like with different variations to gain comfort with the form.

16.   Close the patient chart by clicking the X on the *Charles Arginosa* tab.

17.   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 **x** 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, amnestic 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:	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:

US:

ECG:

CT/MRI: HEAD: Negative for pathology

EEG:

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.

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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.