Chapter Four

Increased
Familiarity with
the Software

Learning Outcomes

After completing this chapter, you should be able to:

◆ Create a new encounter
◆ Document a patient visit
◆ Print a copy of the completed encounter note

Applying Your Knowledge

In this chapter, you will practice documenting patient visits using the Student Edition software. One of the goals in this chapter is to increase your familiarity with the software and thereby increase your speed of data entry. Another is to learn how to print your work. You will learn how to use the print function in Exercise 29.

It is important to remember is that the Student Edition software does not save your entries to the patient’s permanent medical record; therefore, you will keep a record of your work by printing it. Whereas in the previous chapter you could stop exercises at any point, in this chapter it is important to complete the entire exercise and print out your work before stopping. You cannot stop and then resume an exercise where you left off. You can print the encounter note at any time and as often as you like while practicing your exercises. However, remember not to quit or exit the program until you are sure the encounter note has printed. Once you exit, you will lose your work.

In Chapter 3, you learned the basic layout of the screen and the concepts of creating an encounter note, adding findings, editing findings, and adding details to findings. Detailed instructions for scrolling and navigating the lists, which were provided in the previous chapter, should no longer be necessary. From this point forward, simplified instructions will guide you in areas where you are already familiar with the program. Also, red or blue circles will be printed...
in the text as a visual cue to indicate whether to click on a red or blue button to select a finding.

Exercises in this chapter are intended to provide conceptual learning experiences with the software. The encounter notes you will produce will be similar to documents you would create in a medical office. However, they are not intended to represent full and complete medical exams.

**Creating Your First Patient Encounter Note**

In Guided Exercise 28, you will apply what you have learned in Chapter 3 to document Rosa Garcia’s visit. In Guided Exercise 29, you will learn to print out your work to hand in to your instructor. You must complete both exercises in a single session. Do not begin Guided Exercise 28 unless you have enough class time remaining to complete both exercises.

**Guided Exercise 28: Documenting a Visit for Headaches**

The exercise is similar, but not identical to, the cumulative exercises in Chapter 3.

**Case Study**

Rosa Garcia is a 27-year-old female who visits her doctor’s office complaining of headaches for the last five days. She was a heavy coffee drinker who recently stopped all coffee.

**Step 1**

If you have not already done so, start the Student Edition software.

Locate the Medcin icon shown in Chapter 3, Figure 3-1. If you do not see it on the computer desktop, click on the Start button, and look in Programs or All Programs for the program named Medcin Student Edition.

**Step 2**

When the Student Edition login screen is displayed, type into the field either your name or student ID.

When your name or ID is exactly as you want it to be, position the mouse pointer over the button labeled “OK,” and click the mouse. The Student Edition software window will be displayed.

**Step 3**

Position the mouse pointer over the word Select in the menu at the top of the screen and click the mouse button once. A list of the Select menu options will appear.

Click the mouse on the word Patient to invoke the Patient Selection window shown in Figure 4-1.

Locate and click on the patient named Rosa Garcia.

**Step 4**

Again, position the mouse pointer over the word Select, and click the mouse button. Move the mouse pointer vertically down the list until the item New Encounter is highlighted. Click the mouse button.
Using what you have learned in previous chapters, select the reason 10 minute visit from the drop-down list.

You do not have to set the date or time for this exercise; you may use the current date. However, be certain to set the encounter reason correctly.

Compare the Reason field on your screen to Figure 4-2 before clicking on the OK button.

The left pane should now display the Medcin Symptoms list and the right pane should display your student ID and Rosa Garcia’s information. Before proceeding, confirm that the patient, and the reason for the visit displayed in the title of the window are all correct.

Using what you have learned in previous chapters, select the reason 10 minute visit from the drop-down list.

You do not have to set the date or time for this exercise; you may use the current date. However, be certain to set the encounter reason correctly.

Compare the Reason field on your screen to Figure 4-2 before clicking on the OK button.

The left pane should now display the Medcin Symptoms list and the right pane should display your student ID and Rosa Garcia’s information. Before proceeding, confirm that the patient, and the reason for the visit displayed in the title of the window are all correct.

**Note**

The software calculates the patient’s age based on the encounter date. In any exercise where you use today’s date instead of the date in the book, the date of the encounter and the age of the patient will differ from the screen figures in the book. Except for the date and age, you should ensure your work matches the figures.

**Step 5**

Enter the Chief complaint by locating the button in the Toolbar labeled “Chief” and clicking on it.

The Chief complaint window will open; type: “Headaches for more than 5 days.”
Compare your screen to Figure 4-3. If it is correct, click the button labeled “Close the note form.”

**Step 6**

Make sure that you have the Sx tab in the left pane selected. If you are uncertain, position the mouse pointer over the Sx tab and click the mouse once. Using the skills you have acquired in previous chapters, navigate the list of findings.

Locate and expand the tree of head-related symptoms:

- Click on the small plus sign next to “head-related symptoms”
- Click on the small plus sign next to “headache”
- Click on the small plus sign next to “timing”
- Click on the small plus sign next to “chronic/recurring"

Locate and click on the red button next to the following finding:

1. (red button) episodes worse recently

Compare your screen to Figure 4-4.

**Step 7**

Add information about the episodes of Ms. Garcia’s headaches by scrolling the nomenclature pane to show more of the findings under the expanded the tree of headache symptoms:

Locate and click on the small plus sign next to “chronic/recurring headaches recently worse”
Figure 4-5 Set frequency to daily.

Locate and click on the red button next to the following finding:
- (red button) daily

Compare your screen to Figure 4-5.

Figure 4-6 Select “inadequately controlled” from the Status drop-down list.
Step 8
Select the finding “Chronic/recurring” for edit by moving your mouse pointer over the words Chronic/recurring headache in the encounter note pane. When the mouse pointer changes to a hand, click the mouse button. The Sx tab in the left pane should be replaced by the Edit tab with “Chronic/recurring headaches recently worse” as the current finding.

Step 9
Locate the Status field in the Entry Details section at the bottom of the screen. Click your mouse on the button with the down arrow in the status field. A drop-down list of status phrases (as shown in Figure 4-6) will appear.

Position your mouse pointer on the status “inadequately controlled” and click the mouse button.

![Figure 4-7 Social history—Daily coffee consumption was 7-8 cups.](image)

Step 10
Position the mouse pointer over the Hx tab and click the mouse once.
Expand the social history tree by locating and clicking on the small plus sign next to “social history.”
Click on the small plus sign next to “behavioral history.”
Click on the small plus sign next to “caffeine use.”
Locate and click on the red button next to the following finding:

- (red button) “coffee consumption (cups/day)”
Step 11
Locate the Value and Unit fields in the Entry Details section at the bottom of the screen. Notice that the Unit field already contains the words “cups per day.”
Click your mouse on the Value field and type the numerals 7-8.
Press the Enter key on your keyboard.
Compare your screen to Figure 4-7.

Step 12
In the left pane, click on the small plus sign next to “Daily coffee consumption was 7-8 cups per day.” This will expand the tree.
Locate and click on the red button next to the following finding:
● (red button) “recently decreased”

► Figure 4-8 Caffeine recently decreased because she stopped all coffee.

Step 13
Locate the free-text field in the first row of the Entry Details section, under the right pane.
Click your mouse in the free-text field. Type “because she stopped all coffee” in the field and then press the Enter key on your keyboard. Compare your screen with Figure 4-8.
Step 14
Locate and click on the button labeled “Forms” in the top row of the Toolbar. The tabs at the bottom screen will automatically change to the Form tab. The Forms Manager window will be invoked.

Locate and double-click on the form labeled “Vitals,” as shown in Figure 4-9.

Step 15
Enter Ms. Garcia’s vital signs into the corresponding fields as follows:

Temperature: 98.6
Respiration: 24
Pulse: 78
BP 120/78
Height: 64
Weight: 140

When you have entered all of the vital signs, compare your screen to Figure 4-10 and then click your mouse on the Encounter tab at the bottom of the screen.

Figure 4-9 Select vitals from Forms Manager.

Figure 4-10 Information for Rosa Garcia entered in Vitals form.
Step 16

Position the mouse pointer over the Px tab and click the mouse once. Notice that the vital signs information has been recorded in the encounter note under the Physical Findings section.

Click on the small plus sign next to “Head” to expand the list.

Locate and click on the blue button next to the following finding:

- (blue button) “Exam for evidence of injury”.

Compare your screen to Figure 4-11.
**Step 17**

Using the mouse, scroll the list of physical examination findings until you see Neurological System. Expand the list by clicking on the small plus sign next to “Neurological System.”

Locate and highlight the finding “Cognitive Functions” by clicking your mouse on the description. Do not click either the red or blue button.

Locate the Result field in the Entry Details section at the bottom of the screen. Click your mouse on the down arrow button within the Result field. A drop-down list will appear (as shown in Figure 4-12).

Position your mouse pointer on the result “normal” and click the mouse button. The result field will display the word “normal,” the button next to the finding should be blue, and the text in the encounter note should read “Cognitive functioning was normal.”
Step 18

Position your mouse pointer on the “Dx” tab and click the mouse. The Diagnosis, Syndromes, and Conditions list should be displayed in the left pane of the window.

Scroll the list downward until you see “Neurologic Disorders.” Click on the small plus sign to expand the list.

Locate “Headache Syndromes” in the list and click on the small plus sign.

Scroll the list further downward until you see “Benign syndromes” and then click on the small plus sign.

Scroll the list further downward until you see “Drug-induced headache” and then click on the small plus sign.

Scroll the list further downward until you see “Vasoconstrictor withdrawal headache” and then click on the small plus sign.

Locate and click on the red button next to the following finding:

- (red button) “from caffeine”

Compare your screen to Figure 4-13. The finding “Vasoconstrictor withdrawal headache from caffeine” should be recorded in the encounter note under a new heading: “Assessment.”
Step 19

Position the mouse pointer on the Rx tab and click the mouse button. The Medcin Therapy list will be displayed.

Scroll the list until you see “Free Text,” then and click on the red button next to the finding:

- (red button) “Free Text”

Locate and click on the Finding Note button in the lower right corner of your screen (circled in red in Figure 4-14). A small Finding Note window will be invoked.

Type the following text into the Finding Note window: "Eat regular meals, get plenty of exercise, and limit intake of caffeine, and alcohol."

When you have finished, compare your Finding Note window to the one shown in Figure 4-14. If it is correct, click your mouse on the button labeled “Close the note form.” This will add your text to the encounter note.

You have now successfully created your first complete encounter note. However, do not stop or close the program until you complete the following exercise.
Guided Exercise 29: Printing the Encounter Note

The Student Edition software does not save your entries to the patient’s permanent medical record; therefore, you will keep a record of your work by printing it. In this exercise, you will learn to print the encounter note. You will be asked to give your finished printout to your instructor.

You can use either of two methods to print your work, sending the output to a printer or to a file. The method you will use will be based on the policy of your school. Your instructor will tell you which to use. The choice of printer or file is selected from the Print Dialog window.

Step 20

Position your mouse pointer over the menu item Select at the top of the screen and click your mouse button. A list of the Select menu functions will appear (see Figure 4-15).

Move the mouse pointer vertically down the list until Print Dialog is highlighted and then click the mouse button. The Print Data window (shown in Figure 4-16) will be invoked.

The two panes on the left of the Print Data window list items that are available for printing. A check box selects the items you wish to print. If the box next to “Current Encounter” does not have a check mark, position your mouse pointer over it and click the mouse button. A check mark should appear in the box.

The right pane displays a preview of what is to be printed.

Located below the right pane are two rows of buttons. Those of interest to us are as follows:
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Print and Close

Prints the items selected with check marks to a local or networked printer. This produces a paper copy you can hand in to your instructor.

Export to XPS File

Outputs the items selected with check marks to a file on your local computer. The file can be copied to a disk or flash drive, or e-mailed to your instructor. The XPS file is a Microsoft file that can be viewed with Internet Explorer.

Export to PDF File

Outputs the items selected with check marks to a file on your local computer. The file can be copied to a disk or flash drive, or e-mailed to your instructor. The PDF file is a file that can be viewed with Adobe Acrobat Reader®.

Your instructor will tell you which method is appropriate for your class.

Step 21 Print a Paper Copy of the Encounter Note

If the instructor wants you to export a file, skip this step and proceed to step 22.

If the instructor wants you to print out a paper copy, locate the button labeled “Print and Close” and click the mouse.

Depending on how your computer is set up, an additional print window from the operating system may appear. Figure 4-17 shows an example. Yours may be different, but if you
see a printer dialog similar to this, verify that the printer name is the printer you want to use and then click your mouse on the button labeled “Print.”

If you need assistance printing, ask your instructor.

**Alert**

Some printers may close the print window before the printing has even started. Therefore, do not exit the Student Edition program or go on to another exercise until you have your printout in hand. You could lose your work.

Compare your printout to Figure 4-18. If there are any differences (other than the date and patient age), review the previous steps in the exercise and find your error.

![Printed encounter note for Rosa Garcia.](image)

You may print extra copies by repeating steps 20 and 21 before exiting the Student Edition software.

**Step 22 Print to a File**

Unless the instructor wants you to export to a file, omit this step.

To export to a file instead of printing to paper, click mouse pointer on the appropriate button (either Export to XPS File or Export to PDF File as directed by your instructor.)
The action of either button is to create a file on your computer in the directory named My Documents. The file name will include the student name or ID you entered when you logged in plus the date and time. The file name ends in either “XPS” or “PDF.”

When the file has been successfully created, a confirmation similar to Figure 4-19 will be displayed.

![Figure 4-19 Export to file confirmation.](image)

Write down the file name shown in the dialog box, then click on the OK button.

Once the file has been created, you can copy it to a disk or e-mail it, as directed by your instructor. Use the computer operating system to locate the file on your computer. It will be located in the directory named “My Documents.” Follow your instructor’s directions for handing in your file.

The instructor can view or print the student XPS file using Internet Explorer as shown in Figure 4-20. The instructor can view or print the student PDF file using Adobe Acrobat Reader (not shown).

![Figure 4-20 Student XPS file displayed with Internet Explorer.](image)
Invoking the Print Dialog Window from the Toolbar

Another way to invoke the Print Dialog window is by clicking the button labeled “Print” on the Toolbar at the top of your screen (highlighted orange in Figure 4-21). You can print out or export copies of the encounter note as frequently as you like, and at anytime during an exercise.

Documenting a Brief Patient Visit

The next exercise will allow you to evaluate your knowledge of the software by using only the features you have learned in Chapters 3 and 4. If you have any difficulty with this exercise, you should review and repeat the exercises in Chapter 3 before continuing with this chapter.

Guided Exercise 30: Documenting a Visit for Common Cold

Using what you have learned so far, document Mr. Baker’s brief exam.

Case Study

Patient Harold Baker feels like he has caught some sort of “bug.” Like many patients who have a cold, he wants to see his doctor, and so the medical office has scheduled a brief 10-minute office visit for him.

Step 1

If you have not already done so, start the Student Edition software.

Click Select on the Menu bar, and then click Patient.

In the Patient Selection window (shown in Figure 4-22), visually locate and double click on patient Harold Baker.

Alternatively, you can always type the patient’s last name, first name in the field at the top of the window as you did in Chapter 3.

Step 2

Click Select on the Menu bar, and then click New Encounter.

Scroll the drop-down list to locate the reason Office visit, as shown in Figure 4-23, and then click on it.

You may use the current date for this exercise, but be certain that you have selected the correct reason before clicking on the OK button.

Step 3

Enter the Chief complaint by locating the button in the Toolbar labeled “Chief” and clicking on it.
In the dialog window that will open, type “Patient reported cold or flu.”

Compare your screen to Figure 4-24 before clicking on the button labeled “Close the note form.”

**Step 4**

The patient reports a headache, runny nose, and sneezing. Enter the patient’s symptoms using the list of findings on the Sx tab.

Expand the tree of Medicin findings.

Locate and click on the small plus sign next to “head-related symptoms.”

Locate and click on the red button next to the following finding:

- (red button) Headache

Compare your screen to Figure 4-25.

**Step 5**

Scroll the list of Sx findings downward to locate “otolaryngeal symptoms.”

Click on the small plus sign next to “otolaryngeal symptoms.”

Expand the tree of findings further.

Locate and click on the small plus sign next to “nose.”
Locate and click on the small plus sign next to “nasal discharge.”
Locate and click on the red button for the following finding:

- (red button) watery

Compare your screen to Figure 4-26.

![Figure 4-26 Symptom—Nasal discharge.]

**Step 6**

Scroll the list of Sx findings further downward to locate and click on the red button for the following finding:

- (red button) Sneezing

Compare your screen to Figure 4-27.

**Step 7**

The patient does not smoke. Enter this fact in the patient’s history.
Click on the Hx tab.
Expand the tree of Medcin findings.
Locate and click on the small plus sign next to “social history.”
Locate and click on the small plus sign next to “behavioral history.”
Locate and click on the blue button next to the following finding:

- (blue button) Tobacco use
The description will change to “No tobacco use.”

Compare your screen to Figure 4-28.

Step 8
Locate and click on the button labeled “Forms” in the top row of the Toolbar. The tabs at the bottom of the screen will automatically change to the Form tab and the Forms Manager window will be invoked.
Locate and double-click on the form labeled “Vitals.” The form shown in Figure 4-29 will be displayed. Enter Mr. Baker’s vital signs in the corresponding fields as follows:

- Temperature: 99.7
- Respiration: 25
- Pulse: 65
- BP: 120/80
- Height: 72
- Weight: 175

When you have entered all of the vital signs, compare your screen to Figure 4-29 and then click your mouse on the Encounter tab at the bottom of the screen.

**Step 9**

The clinician examines the patient’s head, eyes, ears, nose, inside of mouth, and lungs.

Begin recording the Physical Examination by clicking on the Px tab.

Locate and click on the small plus sign next to “Head.”

Locate and click on the blue button next to the following finding:

- (blue button) Exam for evidence of injury
The description will change to “No evidence of injury.” Compare your screen to Figure 4-30.

**Step 10**

Scroll the list of Physical findings downward to locate “Eyes.”

Locate and click on the blue button for the following finding:

- (blue button) Eyes

Expand the tree of findings further.

Locate and click on the small plus sign next to “Ears, Nose, and Throat.”

Locate and click on the small plus sign next to “Nose.”

Locate and click on the buttons indicated for the following findings:

- (blue button) Ears
- (red button) Nasal Discharge
- (blue button) Sinus tenderness
- (blue button) Upper airway

Compare your screen to Figure 4-31.
Step 11

Scroll the list of Physical findings further downward to locate “Lungs.”
Locate and click on the blue buttons for the following findings:

- (blue button) Oral cavity
- (blue button) Lungs

Compare your screen to Figure 4-32.

**Step 12**

The clinician concludes the patient has a common cold, and tells him to rest and drink plenty of fluids.

Record the Assessment by clicking on the Dx tab.

Expand the tree of findings.

Locate and click on the small plus sign next to “ENT Disorders.”

Locate and click on the small plus sign next to “Nose.”

Locate and click on the red button for the following finding:

- (red button) Common cold

Compare your screen to Figure 4-33.

**Step 13**

Record the Plan by clicking on the Rx tab.

Expand the tree of findings.

Locate and click on the small plus sign next to “Basic Management Procedures and Services.”

Scroll the list downward until you locate “Nutrition and Hydration Services,” then click on the small plus sign next to it.
Locate and click on the red button for the following finding:
  - (red button) Fluids

Expand the tree of findings further.
Locate and click on the small plus sign next to “Education and Instructions.”
Locate and click on the small plus sign next to “Instructions for Patient.”
Locate and click on the red button for the following finding:
  - (red button) Bed rest

Compare your screen to Figure 4-34.

![Figure 4-34 Therapy plan—Patient instructions.](image)

**Step 14**

Print your completed encounter note.

Click on the Print button on the Toolbar at the top of your screen to invoke the Print Data window.

Look at the upper left pane of the window. If the box next to “Current Encounter” does not have a check mark, position your mouse pointer over it and click the mouse button. A check mark should appear in the box.

Click on either the button labeled “Print and Close,” or “Export to XPS File,” or “Export to PDF File,” as directed by your instructor.
Compare your printout or file output to Figure 4-35. If it is correct, hand it in to your instructor. If there are any differences (other than the date and patient age), review the previous steps in the exercise and find your error.

Once you have successfully completed this exercise, you should be comfortable with the general process of locating findings and expanding the tree to view additional findings. Future exercises in this book will instruct you to expand the tree by listing multiple findings for which you will click the small plus signs.
Real-Life Story
A Nurse’s Notes

By Sharyl Beal, RN

Sharyl Beal is a registered nurse with a master’s degree in nursing and a subspecialty in nursing informatics. Sharyl has over 35 years nursing experience. She served as a nurse and a department head for 16 years before becoming a clinical systems analyst at a 500-bed hospital in the Midwest where she was involved in creating and implementing electronic medical records for the nursing and ancillary departments, as well as training the nurses and doctors to use the clinical systems. She currently serves as a project manager for the Clinical Information Systems department and is co-author of the book, Electronic Health Records and Nursing.

Our hospital has successfully transitioned all nursing units to computerized patient charts. We rolled it out very slowly, one unit at a time, taking three years to implement all the areas. Today, all inpatient units are online, including our behavioral health units. We do not print nursing reports—everyone works online. These are some of my experiences and observations from this project.

We did med/surg first because it is the broadest definition and fits the majority of patients. When that model was in operation, we went to the next unit and asked, “With this as a model, what do we need to do to make it work for you?” We did a fair amount of redesign as we added units, but sometimes they were minor changes like adding descriptors that had not been necessary for another unit.

The first thing we did for all departments was to spend considerable time flowcharting all their processes; how they get their patients, how they communicate about their patients, with whom, what it looks like. We created a “life in the day of” scenario for every skill level in the unit; then we designed their charting based on their patient population.

The last unit to go online was Behavioral Health. Behavioral Health was challenging because this department’s charts contain more abstract observations describing mental reactions, emotional reactions, and so on. But the most problematic unit was the Obstetrics (OB) Department.

OB charting is not difficult, but it is very meticulous. Our OB Department had a lot of rules and regulations about what had to be charted and how it was to be worded. The hospital legal department had to review all of our designs before the nurses could begin using them; they then reviewed samples of what was actually being documented once the department went online. We had to do some redesign to let the nurses better describe things, but we finally got it to everyone’s satisfaction.

That was our design process; implementation was another matter. Our methodology of bringing one unit online at a time allowed us to provide plenty of support when the unit went online. I think that was key. Clinical Informatics personnel were scheduled in shifts that overlapped the nursing shifts. We were in the unit, with the nurses, 24 hours a day for the first two weeks. Whenever new users were struggling, someone was right at their elbow to calmly guide them through, to make sure they were successful. Even with that level of support, there were some concerns that remained constant through the last unit of the rollout.

Nurses are very accustomed to being in control, confident in their expertise and their skills; when their department becomes computerized, all of a sudden everything they know has to be translated through the limitations of a computer. The most common reaction when we rolled out charting into a new unit was that the nurses were extremely apprehensive their first day of charting. The universal complaint was that they could not sleep the night before.

My experience was that at the end of the first day they were still not feeling good about it, but when they came back the second day they had figured out how to get through it and they had very few questions. By the third day, they were usually doing very well. They still did not feel confident about finding the information, but they knew they could do it.

The nurses’ biggest fear was that they would spend all their time taking care of the computer instead of their patients. They verbalized that idea for months afterwards, but that really is not reality. Research has repeatedly shown that nurses spend 50 to 70% of their time documenting. In short, nurses already spend an enormous amount of their work life documenting, but it takes them a long time to feel like they are spending less time on the computer than on their patients.

The real issue was that they felt like they were cut off from the information; they could not just flip open a chart and see what they were looking for. They had to remember how to find it and that was time out of their day. I have had them cry; I have had them yell, venting their frustration. But the good part was that they were all in the same boat together, so their peers readily understood what they were going through because they were all going through it together.

The nurses who had the easiest time transitioning were nurses who were accustomed to taking the time to write everything
down as they went through their workday. The majority of nurses do not do that. Most nurses have notes stuffed in their pockets and tons of information in their head. They tend to store it up and write it all down when they come back from lunch at the end of their shift. When they try to follow that same model with a computer, but they are not yet comfortable with the computer; it is twice as hard because they have a lot to remember and they have to figure out what to do with it. Nurses who normally charted as their day progressed did not have to remember as much so they seem to learn faster.

In nursing school students have to chart as it happens— instructors insist on it. This meant that nurses who just came out of nursing school had an advantage because they came to the job with good habits. Additionally, most of the new nurses grew up with computers and were more familiar with them.

We found that the ancillary departments— respiratory therapy, physical therapy, dietary, and so on—were also easy to implement. Their documentation is much more concrete, limited in its focus, so it was much easier to adapt from paper to computer. They were almost self-sufficient from the very beginning.

The doctors, however, were another story. You have to spend time up front making sure the doctors can get the information, and most doctors cannot give up enough time in their day to learn a computer. The nurses trained for 8 hours for the computer but the doctors only for about 15 minutes. We balanced this by trying to be attentive to any doctor who came on the floor. We would often say, “Let me help you find the information. The nurses are now charting on the computer. As of today you are not going to find that information on a piece of paper.” We don’t print anything. The doctors have adapted to the readily available information so well that on the rare occasion when we have downtime, it is usually the physicians who are the most upset.

Critical Thinking Exercise 31: A Patient with Sinusitis

This exercise will help you evaluate how well you can use the Student Edition software to create an encounter note. The exercise provides step-by-step instructions, but does not provide screen figures for reference. The exercises in Chapter 3 covered each feature used in this exercise. If you have difficulty at any step during this exercise, refer to the Chapter 3 Summary, where a table lists each feature and the corresponding exercise for that feature.

Case Study
Patient Charles Green has been experiencing stuffy sinus pain. The medical office has scheduled a brief office visit for him to see the nurse practitioner. Using what you have learned so far, document Mr. Green’s brief exam.

Step 1
If you have not already done so, start the Student Edition software.
Click Select on the Menu bar, and then click Patient.

In the Patient Selection window, locate and click on Charles Green.

**Step 2**
Click Select on the Menu bar, and then click New Encounter.

Select the reason **Office visit** from the drop-down list.

Make sure you have selected the reason correctly. You may use the current date for this exercise.

**Step 3**
Enter the Chief complaint by locating the button in the Toolbar labeled “Chief” and clicking on it. In the dialog window which will open, type “**Stuffy sinus.**”

Click on the button labeled “Close the note form.”

**Step 4**
The patient reports a sinus pain, stuffy nose, and nasal discharge. Enter the patient’s symptoms using the list of findings on the Sx tab.

Locate “Head-related symptoms” and click on the small plus sign next to it to expand the tree of Medcin findings.

Locate and click on the red button next to the following finding:

- (red button) Sinus pain

**Step 5**
Scroll the list of Sx findings downward to locate “otolaryngeal symptoms.”

Expand the tree by clicking on the small plus sign next to “otolaryngeal symptoms.”

Locate and click on the small plus sign next to “nose” to expand the tree of findings further.

Locate and click on the red buttons for the following findings:

- (red button) nasal discharge
- (red button) nasal passage blockage (stuffiness)

**Step 6**
The patient reports smoking a pack of cigarettes a day. Enter this fact in the patient’s history.

Click on the Hx tab.

Locate and click on the small plus sign next to “social history.”
Locate and click on the small plus sign next to “behavioral history.”
Locate and click on the small plus sign next to “Tobacco use.”
Locate and click on the small plus sign next to “current smoker.”
Locate and click on the red button next to the following finding:
  • (red button) cigarettes

**Step 7**
Locate the **value** field in the Entry Details section at the bottom of the screen.

Type 1 in the field and press the Enter key.

The description will change to “Cigarette smoking 1 pack(s)/day.”

**Step 8**
Enter the patient’s vital signs using the Vitals form.

Locate and click on the button labeled “Forms” in the Toolbar at the top of your screen to invoke the Forms Manager window.

Locate and click on the Form name “Vitals” in the list.

Enter Mr. Green’s vital signs in the corresponding fields as follows:

- **Temperature:** 96.7
- **Respiration:** 27
- **Pulse:** 67
- **BP:** 120/88
- **Height:** 68
- **Weight:** 177

When you have entered all of the vital signs, click your mouse on the Encounter tab at the bottom of the screen.

**Step 9**
The nurse practitioner examines the patient’s head, eyes, ears, nose, inside of mouth, and lungs.

Begin recording the Physical Examination by clicking on the Px tab.

Locate and click on the small plus sign next to “Head.”

Locate and click on the blue button next to the following finding:
  • (blue button) Exam for evidence of injury

The description will change to “No evidence of injury.”

**Step 10**
Scroll the list of Physical findings downward to locate “Eyes.”

Locate and click on the blue button for the following finding:
  • (blue button) Eyes
Locate and click on the small plus sign next to “Ears, Nose, and Throat.”
Locate and click on the small plus sign next to “nose.”
Locate and click on the buttons indicated for the following findings:

- (blue button) Ears
- (red button) Nasal Discharge
- (red button) Sinus tenderness
- (blue button) Oral cavity
- (blue button) Pharynx

**Step 11**
Scroll the list of Physical findings further downward to locate and click on the small plus sign next to “Lungs.”
Locate and click on the blue button for the following finding:

- (blue button) Percussion

**Step 12**
The nurse practitioner concludes the patient has acute sinusitis that is already improving.
Record the Assessment by clicking on the Dx tab.
Locate and click on the small plus sign next to “ENT Disorders.”
Locate and click on the small plus sign next to “Nose.”
Locate and click on the small plus sign next to “Sinusitis.”
Locate and click on the red button for the following finding:

- (red button) Acute

**Step 13**
Locate the status field in the Entry Details section at the bottom of the screen. Click your mouse on the button with the down arrow in the field. A drop-down list of choices will appear.
Locate and click on the status: **improving**.
The assessment will change to read: “Acute sinusitis which is improving”

**Step 14**
The nurse advises Mr. Green to continue taking over-the-counter antihistamines, drink plenty of fluids, and to abstain from smoking.
Record the Plan by clicking on the Rx tab.
Locate and click on the small plus sign next to “Basic Management Procedures and Services.”
Scroll the list downward until you locate “Nutrition and Hydration Services,” then click on the small plus sign next to it.

Locate and click on the red button for the following finding:
- (red button) Fluids

Scroll the list downward until you locate “Education and Instructions,” then click on the small plus sign next to it.

Locate and click on the small plus sign next to “Instructions to Patient.”

Locate and click on the red button for the following finding:
- (red button) Abstinence from smoking

Scroll the list downward until you locate “Medications and vaccines,” then click on the small plus sign next to it.

Locate and highlight the medicine **Antihistamines** (do not click the red or blue button.)

Locate the prefix field in the Entry Details section at the bottom of the screen. Click your mouse on the button with the down arrow in the field. A drop-down list of choices will appear.

Locate and click on the status: **continue**.

Locate the free-text field in the Entry Details section at the bottom of the screen. (It is located just above the button labeled Episode.)

Type **OTC** in the field and press the enter key. OTC means over-the-counter.

The description should now read “Continue antihistamines OTC.”

---

**Alert**

Do not close or exit the encounter until you have a printed copy in your hand. You will lose your work if you exit before printing.

---

**Step 15**

Print your completed encounter note.

Click on the Print button on the Toolbar at the top of your screen to invoke the Print Data window.

Be certain there is a check mark in the box next to “Current Encounter” and then click on either the appropriate button to print or export a file, as directed by your instructor.
Student: your name or ID here  
Patient: Charles Green: M: 5/06/1979: 5/03/2012 02:15PM

Chief complaint
The Chief Complaint is: Stuffy sinus.

History of present illness
Charles Green is a 32 year old male.
He reported: Sinus pain.
Nasal discharge and nasal passage blockage.

Personal history
Behavioral: Cigarette smoking 1 pack(s)/day.

Physical findings

Vital signs:

<table>
<thead>
<tr>
<th>Vital Signs/Measurements</th>
<th>Value</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral temperature</td>
<td>96.7 F</td>
<td>97.6 - 99.6</td>
</tr>
<tr>
<td>RR</td>
<td>27 breaths/min</td>
<td>18 - 26</td>
</tr>
<tr>
<td>PR</td>
<td>67 bpm</td>
<td>50 - 100</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>120/88 mmHg</td>
<td>100-120/60-80</td>
</tr>
<tr>
<td>Weight</td>
<td>177 lbs</td>
<td>125 - 225</td>
</tr>
<tr>
<td>Height</td>
<td>68 in</td>
<td>65.35 - 74.02</td>
</tr>
</tbody>
</table>

Head:
Injuries: * No evidence of a head injury.

Eyes:
General/bilateral:
  ° Eyes: normal.

Ears:
General/bilateral:
  ° Ears: normal.

Nose:
General/bilateral:
Discharge: • Nasal discharge seen.
Sinus Tenderness: • Tenderness of sinuses.

Oral Cavity:
  ° Normal.

Pharynx:
  ° Normal.

Lungs:
  ° Chest was normal to percussion.

Assessment
• Acute sinusitis which is improving

Therapy
• Fluids.
• Continue antihistamines OTC.

Counseling/Education
• Abstinence from smoking

Compare your printout or exported file to Figure 4-36. If it is correct, hand it in to your instructor. If there are any differences (other than the date and patient age), review the previous steps in the exercise and find your error.
Chapter Four Summary

In this chapter you have performed exercises intended to increase your familiarity with the Student Edition software and thereby increase your speed of data entry. You have also learned to print out encounter notes or export them as files. You can print the encounter note at any time and as often as you like while practicing your exercises. However, remember not to quit or exit the program until you are sure the encounter note has printed. Once you exit, you will lose your work.

As you continue through the course, you can refer to the Guided Exercise 29 in this chapter if you need to remember how to print or export a file. You can also repeat any of the exercises in this chapter to increase your skills using the software. You should not proceed with the remainder of the text until you can perform the exercises in this chapter with ease.

In these and many subsequent exercises you are permitted to use the current date instead of setting it to a specific date. Remember when you do that, the date of the encounter and the patient’s age will differ from the samples printed in the book. However, all of the other items in your printout or file should match the figures in the book.

<table>
<thead>
<tr>
<th>Task</th>
<th>Guided Exercise(s)</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printing or exporting an XPS or PDF file of the encounter note</td>
<td>29</td>
<td>130</td>
</tr>
</tbody>
</table>

Testing Your Knowledge of Chapter 4

1. Why is it important to print your work before exiting?
2. What does the Export PDF button do?
3. How many cups of coffee per day had Rosa Garcia been drinking before she quit?
4. How long had Rosa Garcia been having headaches?
5. What Entry Details field was used to record that Rosa’s headaches were inadequately controlled?
6. How long was Harold’s office visit scheduled for?
7. Which of Harold Baker’s symptoms did you record under otolaryngeal symptoms?
8. Does Harold smoke?
9. Did Harold report sinus pain or tenderness?
10. What was the doctor’s assessment (diagnosis) of Harold’s condition?
11. What was the doctor’s plan (Rx) for Harold Baker?
12. What was Charles Green’s chief complaint?
13. On what tab did you record that he smoked?
14. What does the acronym OTC stand for?
15. You should have produced three narrative documents of patient encounters, which you printed. If you have not already done so, hand it in to your instructor with this test. The printed encounter notes will count as a portion of your grade.