How to Set up and Use the Medical Condition Record version 183-184
Setting up and using the Medical Condition Record
(AVImark versions 183 - 184)

Table of Contents

What is the Medical Condition Record ......................................................... 1
Definitions & Terms used with the MCR ....................................................... 1
Overview of the Medical Condition Record ............................................... 2
Advanced Setup ............................................................................................ 3
Advanced Setup for the Problem Area ......................................................... 3
Advanced Setup for the Objective Area ........................................................ 6
Advanced Setup for the Assessment Area .................................................... 9
Using the Medical Condition Record ........................................................... 10
What is the Medical Condition Record

The Medical Condition Record is a comprehensive health record of a patient visit. The receptionist or technician may record the patient’s vital signs and the doctor typically records client communications about the patient’s condition, his or hers observations, a diagnosis, and a treatment plan.

The Medical Condition Record can be used as follows:

1. **As Is**– without any pre-setting up. You may elect to only use parts of the MCR (i.e. to record weight history or other vital signs)

2. **As Is but setting it up “on the fly”** - You don’t set up anything (protocols, etc.) in advance but you set them up as you use the MCR. For instance, if you choose several possible diagnoses on a particular visit, you’d set up the protocols on those diagnoses only. Each time you create a medical condition record, you would continue to attach protocols to diagnoses as you need them.

3. **Advanced setup** – This takes quite a bit of time to set everything up in advance but after that’s done; it could save a lot of time when you’re using the Medical Condition record.

This is a resource guide for Advanced Setup procedures.

Definitions & Terms used with the MCR

**Abnormality** - anything that is abnormal within a body system.

Assess – to evaluate.

**BCS** – the Body Condition Score. This field allows you to assign a rating to the patient’s weight condition. The ratings that are assigned are strictly user defined, and can be graphed by highlighting the BCS field then choosing **Medical Condition…Graph Values.** Each time a new Medical Condition entry is created for a patient, the BCS will default to a blank field.

**Body Subsystems** – subsystems of the main body systems (for example Trachea would be a subsystem of Respiratory).

**Body Systems** – main systems of the body (Circulatory, Respiratory).

**Capillary Refill Time (CRT)** – amount of time it takes for capillaries to refill. This is done by pressing on gums and counting the number of seconds it takes to return to the normal pink color. It is measured by >2 secs and <2 secs.

**Diagnostic** – treatments performed to reach a final diagnosis.

**Diagnostic Protocol** – these are the treatments that the doctors will do to try and diagnose the problem. Once the treatments are done, usually the diagnosis will be found.

**Presenting Problems** – main problems presented upon examination.

**Problem History** – a record of the patient’s current and past problems.
**Recommendations** – other diagnoses, tests, or treatments that can be performed for the chosen problem.

**Rule-outs** – this is the list of tentative diagnoses for a specific problem.

**Tentative Diagnosis** – probable diagnosis.

**Therapeutic** – treatments performed to ease certain symptoms.

**Treatment Protocol** – these are the treatments or items that the doctor will use to treat the diagnosis.

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**Overview of the Medical Condition Record**

When accessing a Medical Condition record for the first time after updating to version 183, the changes and enhancements to this area will be very evident. The tabs which previously made up each area of the SOAP have been removed to provide a continuous-page view of the information stored with the Medical Condition record. Four of the seven areas of the new Medical Condition record are displayed in a tree-style view allowing them to be expanded and collapsed. These four areas are the Problems, Assessment, Plan, and Attachments.

**VITAL SIGNS:** Record the patient’s weight, temperature and other vital signs in this area.

**PROBLEMS:** Select one or more problems associated with this visit. The problem history area displays current and past problems for the patient.

**SUBJECTIVE:** Record the client’s communication about the patient’s condition.

**OBJECTIVE:** Record doctor’s observations about the patient’s condition.

**ASSESSMENT:** Record possible diagnoses (rule-outs) and final diagnoses.

**PLAN:** Record treatments and items for diagnosing and treating the problem.

**ATTACHMENTS:** This area mirrors the medical history attachment window. If you have files attached to the history entry, you will see the attached files in this area. You may also attach files in this area in the same way you attach files to the medical history attachments window.

Additional features that work alongside the Attachments area is the Medical Condition…Report Card menu option and the Report Card button. Selecting these options will display an Open window that allows a Word form or document to be opened, modified, and saved. Modifying and saving these forms or documents will allow them to be assigned a unique name, saved to the Attachment directory specified in the Advanced Options, and then linked to the Attachments area of the Medical Condition record as well as the Medical History Attachments area from the CID.

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2
Advanced Setup

We’ll walk through the advanced setup required for the Problem, Objective, and Assessment areas. There is no advanced setup required for the Plan area.

Please note: The images and instructions below do not contain descriptions of actual treatments, items, problems, diagnoses, abnormalities or body subsystems. The instructions are examples of how to set up and use the Medical Condition Record.

Advanced Setup for the Problem Area

1. Set up Diagnostic Protocols on Problems
   a. Go to Work With: Problem List.
   b. Locate the problem.
   c. Right click on the problem and click Diagnostic protocols.
   d. In the Diagnosis Protocols window, right click and click Choose Treatments or Items. Choose one or more treatments and/or items that you want to use to diagnose the problem. You may also Enter Recommendation Notes if desired by clicking the Recommendations button in the lower left corner of the window to open the Recommendation notes window.
2. **Set up Rule-Outs on Problems**

   a. Go to Work With: Problem List.
   
   b. Locate the problem.
   
   c. Right click on the problem and click Rule-outs.
d. In the Rule Outs window right click Choose Diagnosis and choose one or more possible diagnoses for this problem. You may also Enter Recommendation Notes if desired by clicking the Recommendations button in the lower left corner of the window to open the Recommendation notes window.
Advanced Setup for the Objective Area

The Abnormalities shown in the Objective area are set up in the Abnormalities and Body Subsystems System Tables.

You may customize the Objective area of the Medical Condition Record by removing or changing any of the entries in this table and you may add new ones.

Note: If you’ve recorded information on any of the current and then remove them from system tables or if you change the code of the abnormality, you will lose that recorded information. If this happens, you can re-enter the code into the table and the lost data will again be available.

1. Set up Abnormalities

   a. Go to Work With: System Tables: Abnormality Table.

   b. Click the Abnormalities Table.

   c. Enter the Major Body Systems or other data that you want to display as Abnormalities in the Objective area of the Medical Condition Record.
2. Set up Body Subsystems (optional)
   
a. Go to Work With: System Tables.
   
b. Click the Body Subsystems Table.
   
c. Enter all the subsystems you want to attach to various body systems.
   
   d. Write down the codes of all the body subsystems or print the Body Subsystem Table (you’ll need it for Step 3)
3. **Attach Body Subsystems to Abnormalities** (optional)

   a. Go to Work With: System Tables.

   b. Click the Abnormalities Table.

   c. Highlight a Body System and then right click: SubSystems.

   d. Right click New and enter the first code of the Body Subsystem (use the printed subsystem table or your handwritten list of codes). Attach as many subsystems as you wish in the same manner.
Advanced Setup for the Assessment Area

1. Set up Treatment Protocols on Diagnoses
   a. Go to Work With: Diagnosis List.
   b. Locate the diagnosis.
   c. Right click on the diagnosis and click Treatment Protocol.
   d. In the Protocol window, right click Choose and choose one or more Treatments and/or Items. You may also Enter Recommendation Notes if desired by clicking the Recommendations button in the lower left corner of the window to open the Recommendation notes window.
Using the Medical Condition Record

You may use the parts of the Medical Condition Record in any way you wish but the instructions below provide an orderly way to enter information.

1. **Enter Vital Signs**
   
   a. Enter Weight, Temp, Heart rate, Resp. rate, CRT (capillary refill time), BCS and any „Other” information) by tabbing through the fields in order.

Holding your cursor over the **Weight** field will display a tooltip window with the entire weight history of the selected patient. This tooltip will list the date each weight was taken and the weight that was recorded for each date.

The BCS and Other vital sign fields have a second field that allows a High score or value to be specified. Example: If you score your patients’ BCS on a scale of 1 to 5, you can specify the patient’s actual BCS in the first field and the high value (5) in the second. You can specify a default „high” value in the Options Maintenance window.
The Admitted By field will default to contain the doctor assigned to the patient’s check-in.

  b. Enter client communications in the Subjective area (previously named Chief Complaint and Client Communications).

2. **Select one or more Problems**

  a. Click the Green right-pointing Arrow to expand the Problem tree and display the Presenting Problem and Problem History areas.

Before Expanding

![Before Expanding](image1.png)

After expanding

![After expanding](image2.png)

b. You may choose problems in one of three ways:

  i. In the Presenting problems field or the box below it right click Choose problem to go to the Problem List and select the problem(s).
ii. Type at least the first three letters of the problem. It acts as a “find” field and will drop down a list to choose from.

iii. If you’re seeing the patient for a problem that is already in their problem history, you can right click on the problem in the Problem History area and click Add To Problems.

c. You will be prompted to post this problem to the patient’s Medical History, click yes. (If you selected more than one problem, additional prompts will appear.)
This will also enter the problem in the patient’s Problem Histories window.

3. **Record examination findings in the Objective area**

   a. If you have Abnormalities set up, you can check the appropriate abnormality boxes. The comment field will default to contain the words “Not Examined” until you click a box and then it will default to “Normal” as a finding. You may also type a note in the field or right click in the field and click Notes to open a standard note window.

   b. If you also have Body Subsystems attached to Abnormalities and you check an Abnormality box, the Body Subsystem box will appear below the Abnormality for you to check if you’ve also examined that body subsystem.

If body sub-systems were used within your SOAP records prior to updating to version 183, but due to the changes are not longer needed, an option is available that allows the displaying of the sub-systems to be turned off. Setting the new Advanced Option **Show Body Sub-systems** to False will prevent all sub-systems (on past and future SOAP records) from being displayed.

4. **Review and Accept Diagnostic Protocol** (treatments and items used to diagnose the problem).

   a. Right click on the problem and click Review protocol.

c. If you want to perform the treatments and items listed in the Diagnostic Protocol window, right click on the Problem and click Accept protocol.
The Plan section will automatically expand and the protocols for this problem will appear as Diagnostic treatments and items (identified in light violet color).

You may remove any of these codes from the Plan section or you may choose other treatments and items to assist you in making a final diagnosis by right-clicking in this area and choosing the appropriate entry. You may also Decline codes, Create or Choose an Estimate, make Entry notes, post to the Whiteboard etc.
5. **Review and Accept Rule-Outs** (possible diagnoses)

   a. Right click on the Problem and click Review rule-outs.

   b. The Rule-outs window for that problem will appear for your review. If you wish to view Recommendations, click the Recommendations button. When finished, click Done.
c. Right click on the Problem and click Accept rule-outs.

The Assessment section will automatically expand and the Rule-outs (possible diagnoses) for this problem will appear in light violet color.
You may remove any of these codes from the Assessment section or you may choose other possible rule-outs by right-clicking in this area and choosing the appropriate entry. You may also Reject or Re-activate a rule-out etc.

6. **Post Diagnostic treatments/items to medical history.** As you perform a Treatment or dispense an Item in an effort to diagnose the problem you will right click on that code and post it to Medical History.

After the number of times the treatment or item has been administered (posted) meets the specified number of times it was to be administered (quantity), the treatment or item will appear grayed out in the list.
7. **Eliminate rule-outs** (possible diagnoses). To reject a rule out right click on the rule out in the Assessment section and click Reject Rule-out. You may also right click on the diagnosis and enter Rule-out notes (why you rejected this diagnosis).

![Assessment table]

8. **Accept a final diagnosis**
   a. When you’ve arrived at a final diagnosis, right click on the diagnosis in the Assessment section and click Accept as Diagnosis. You’ll be asked to confirm this action, click Yes.

![Assessment table]

The final diagnosis will appear in dark violet color.

![Assessment table]
b. Right click on the final Diagnosis and click Review protocol (these are treatments and items used to treat the problem).

The Treatment Protocol window for that diagnosis will appear for your review. If you wish to review Recommendations click the Recommendations button. When finished, click Done.

c. Right click again and click Accept Protocol.
This will add the Treatments & Items from the Protocol onto the PLAN tab and the entries will appear in dark violet color.

9. **Post Therapeutic treatments/items to medical history.** As treatments are performed and items are dispensed, right click on the code and click Post to post to medical history.