





SOP: KenyaEMR3.x Outpatient Clinical Encounter Workflow

[Last updated: Mar 2024]

Tasks:	End to end navigation of the OPD Clinical Encounter in KenyaEMR
Objective:	Navigation skills
Who:	EMR users
Required Materials:	Username, password, computer installed with the latest version of KenyaEMR.

Steps	Description	Illustration
Step 1	Learning objectives By the end of this session, you will be able to: • Successfully log into KenyaEMR • Successfully document an Outpatient (OPD) clinical encounter in KenyaEMR	















		(KenyaEMR				Q	₩ 8	۹ 9
Step 2	Upon successful login, you shall be navigated to the Active visits page of the facility Click on the "Service Queues" option from the menu items available on the left side of the screen to find the client if they are already enrolled and are in queue. If they are not enrolled refer to client's enrolment manual on how to enrol clients to KenyaEMR	Home Community referrals Billing Service queues Appointments Laboratory	Active Visits Q. Filter table Visit Time Today, 14:45 V 02-Jan-2024, 14:49	ID Number Na MGK6MY Joi MGK6NW Jar	me Gender hn Doe M ne Doe F	Age 30 25	Visit Type Outpatien Outpatien	t t
Step 3	KenyaEMR Service Queues Page To find clients who are in queue for the different services points. Pick on the client you want to offer service from the service queue.	 ← → C S https:// ⊘ International Qualit M Gmu Meme Community referrals Billing Service queues Appointments Laboratory 	ba kenyahmis.org/openmrs/spa/home/service-queues ai	balladiumk (KenyaEMR Free YouTul Seelect service poi down to select a) delivery point. Add ne Waiting for: Patients 23	be to mp ► Login Directory int (from the view drop-specific service systemice Patient list Patient list Add new service ro	Image: Second secon	e +	







		Clinical Forms	×
		Q Search this list	e
		Form Name (A-Z)	Las Clinical forms
		Cancer Screening and early diagnosis	Never
	Clinical Encounter Form availability	Clinical Encounter	Never
		Depression Screening PHQ-9	Never
	From the clinical suite of forms, the OPD	Gender Based Violence Screening	Never
Step 4	clinical encounter form is one among the	Generalized Anxiety Disorder Assessment	Never
	many available forms as captioned on	HIV Self Test Form	Never
1	the next column	HTS Eligibility Screening Form	Never
		HTS Initial Form	Never
		HTS Retest Form	Never
		Progress Note	Never
		TB Screening	Never
		Triage	Never
By de Detail howe desire	Details prepopulated. The users can however change this to Reflect the desired details.	Visit Details Visit Details Patient History Encounter Details Patient Kamination Encounter Details Patient Management * Visit date: 27/03/2024 Image: Compare the second sec	
	Fill in the visit type details from the choice of 3 as indicated.	Ngarua Health Centre Patient Details * Visit Type? Neturn Visit Return Visit Transfer in	Next A Patient History







Step 6	Document Patient History usually presenting and history of complaints from the select list and add to the grid. Numerous complaints can be added to the grid as reported by the patient. Include the duration of the complaint in days, Onset date and onset status.	Visit Details Patient History Patient History Complaints and History of complaints Patient Management Presenting complaints Obcard Presenting complaints Chest Pain Outcode T/1/03/2024 Onset Status Sudden	
Step 7	Record clinical notes Record any medication taken before the visit detailing drug name, dosage, frequency and route of administration	Clinical solution Visit Details Patient History Patient Management Save and close Any Medication History Øbcand Patient Management Patient Management Patient Management Patient Management Past Medication History Past Medication History Past Medication History Pusy Name Mara moja Docage 2 - + + Frequency - + + Twice dally - Route of Administration - Oral -	







		(=) KenyaEMR	ut Opd Patient 31 yrs, Female
	Screen nationt for use of Herbal	Clinical Encounter	
	remedies and document	Visit Details	Use of Herbal remedies?
		Patient History	O Yes No
			<u></u>
		Patient Management	Surgical History
		Save and close	Any Surgical History
			O No Ture of Surface parformed
		Discard	hysterectomy
Step 8			Date Surgery Performed?
			27/98/2820
			Indication of surgery:
			Tumour
	Document any historical surgical		
	procedure that the patient has		Admission History
	undergone clearly documenting the		Any Admission History
	reason for surgery		No
		Clinical Encounter	
		Patient History	Admission History
		Patient Examination	Any Admission History
		Patient Management	O No Reason for admission
		Save and close	Blood transfusion
	Record any admission history indicating		Date of Admission
	the reason and date of admission.	Discard	18/01/2024
	Document any Adverse drug reactions.	-	
Stop 0	the client might be having. Indicate the		Adverse Drug Reactions
Step 9	causative medicine, reaction type,		Presente drug reaction(s)? • Yes
	severity, date of onset and the action		○ No Patient has adverse drug reaction(s)
	taken. Add as many adverse drugs as		Madrida Availar Baardia
	reported by the patient		Sutionamides V
	· · · / · · · · · ·		Reaction
			Itching 🗸
			Severity
			Moderate 🗸
		L	Table of Desail







		(KenyaEMR	KenyaEMR Out Opd Patient 31 yrs, Female		
		Clinical Encounter	Clinical Encounter		
		Visit Details	Sexual and Reproductive History		
		Patient History	Has patient ever had menses?		
		Patient Examination	O Yes		
	Document the Sexual and Reproductive	Patient Management	Reasons For Amenorrhea?		
	History if the client is female and of		Premanarche Other		
	roproductivo ago	Save and close	Any Previous gynacological surgery		
	reproductive age.	Discard	⊖ Yes ● No		
Stop 10	Document client's family planning		Family Planning Status		
Step IO	status.		Family Planning Status :		
			On Family Planning Not using Family Planning Wrote Family Planning		
	Droba client for Smoking Substance		• wants raining		
	Probe client for Shloking, Substance		Social History		
	abuse, Alcoholism and history of recent		* Do you smoke cigarattes		
	travel and document		O Yes ● No		
			O Stopped		
			O Yes		
			 No Stopped 		
			Do you take Alcohol		
		Clinical Encounter			
		Visit Details	Family History		
		Patient History	Number of members in the family		
		Patient Examination	5		
	Document the client's family history	Fatient Management	How many members are Alive		
	some mising of Number of formity	Save and close	4		
	comprising of Number of family		Any Family Member with history of Chronic or Hereditary Disease Yes		
	members, members alive, family	Discard	O No		
C1	members with history of chronic or		Chronic Disease		
Step 11	hereditary disease and their relationship		Specify the Belationship		
	to the index client. History of family		Uncle		
	to the index client. History of failing		Any history of family member death?		
	members who have died and clients		O Yes		
	vaccination history		No		
			Vaccination History		
			Was Vaccination Given		
			○ Yes ● No		
			○ Yes ● No		
			○ Yes ● No Other History		







		(KenyaEMR Ou	t Opd Patient 31 yrs, Female
		Clinical Encounter	
		Visit Details	Patient Examination
		Patient History	Consel Examination Endings
		Patient Examination	General examination Findings
		Patient Management	* General examination findings:
			✓ Cyanosis
	Patient Examination	Save and close	Dehydration
Ston 12	Document the General Examination	Discard	Inger Clubbing Jaundice
nep 12	Findings as outlined and make additional		
	notes not captured in the multi select list		Lymph Node Axillary
	·		Vuynph Nodes Inguinal
			Oedema
			Oral thrush
			Pallor Convolution
			Vasting
			General Examination Notes
		(KenyaEMR	Out Opd Patient 31 yrs, Female
		Clinical Encounter	
		Visit Details	System Examination
		Patient History	* Finding(s) on systems review?
		Patient Management	 All Systems Normal Abnormal
			System Reviews
	System Examinations	Save and close	Abdominal
	After conducting systems review on the		
	After conducting systems review on the	Discard	ENT
step 13	client, document all the finding as per		Eye
	screening tool. Type down notes to		Musculoskeletal
	elaborate further the systems findings.		Respiratory
			Skin
			Abdominal distension
			Abdominal mass
			Splenomegaly
			Abdominal tenderness
			Abdomen findings notes
			Ascites present







Step 14	Clinical Diagnosis From the available ICD 11 diagnosis picker, Select the ailments that client has been diagnosed with during this visit empirically, based on the presenting conditions.	Clinical Diagnosis Clinical Diagnosis Remove Clinical Diagnosis Abscess of Hand Remove Add	
Step 15	Investigations opens a window for the lab order to pop up to allow for ordering of requisite investigative tests as depicted	Investigations Order any Investigation? ● Yes ○ No Lab Order Add lab order Add lab order COMPLETE BLOOD COUNT Add to basket \overlaphi Order form → Hemoglobin Add to basket \overlaphi Order form → SERUM GLUTAMIC-PYRUVIC TRANSAMINASE Add to basket \overlaphi Order form → CD4 PANEL Add to basket \overlaphi Order form →	







Step 16	Patient Management allows for the documentation of the final diagnosis derived from laboratory investigation. ICD 11 diagnosis is utilised	Clinical Encounter Visit Details Patient Management Patient History Diagnosis Patient Examination Final Diagnosis Final Diagnosis Final Diagnosis Save and close Cellulitis Discard Remove Add Add
Step17	Add Drug Order The Drug order button populates the drug order form as depicted. Select the drugs to prescribe from the select list	Clinical Encounter Add drug order × ↓ Visit Details Treatment/Management Plan Q Para × ↓ Patient History Drug Order Drug Order > 31 results for "Para" Clear Results Patient Examination Add drug order Add drug order S00mg/30mg - Ecold Plus - Smg/4mg / S00mg/30mg - tablet > > Patient Management Add to basket 👾 Order form → > Paracetamol / Aceclofenac 500/100mg - Zyrtal Plus - 500/100mg - tablet Paracetamol / Aceclofenac Each gram contains Aceclofenac bp -1.5% menthol usp - 5% - Zyrtal Plus - each gram contains aceclofenac bp -1.5% menthol usp - 5% - Tablet







After ordering drugs back to the clinical encounter to finalise visit. Document any therapies, Counsellin procedures prescribe	Add drug order × Phenylephrine Chlorphenamine Maleate Paracetamol (2. Prescription duration Start date 03/27/2024 Duration Duration Duration Start date 03/27/2024 Duration Duration Duration Quantity to dispense Prescription refitts 0 - Indication b.g. "Hypertension"	Clinical Encounter Visit Details Patient History Patient Examination Behavioral Therapy Patient Management Clipestore Save and close Physiotherapy Discard Discard Parin Management Occupational Therapy Discard Patient Management Physiotherapy Discard Patient Management Physiotherapy Discard Patient Management Physiotherapy Discard Patient Physiotherapy Discard Patient Physiotherapy Other Any Counselling prescribed? None Family Counseling Vuritional and Diatary Psychosocial therapy Substance Abuse Counseling Other Any Procedures prescribed? Yes None Pamily Course Ordered
Document any proce prescribed. Specify the patient of Step 19 Add appointments to appointment's modu Save, close and Exit the Clinical encounter	edures Save and close Any Proc Yes No Name of Discard Patient O Refe Adm Refe Dece Adm Add a	edures prescribed? Procedures Ordered. opsy Cannulation Jutcome assed Home nit erral assed appointments