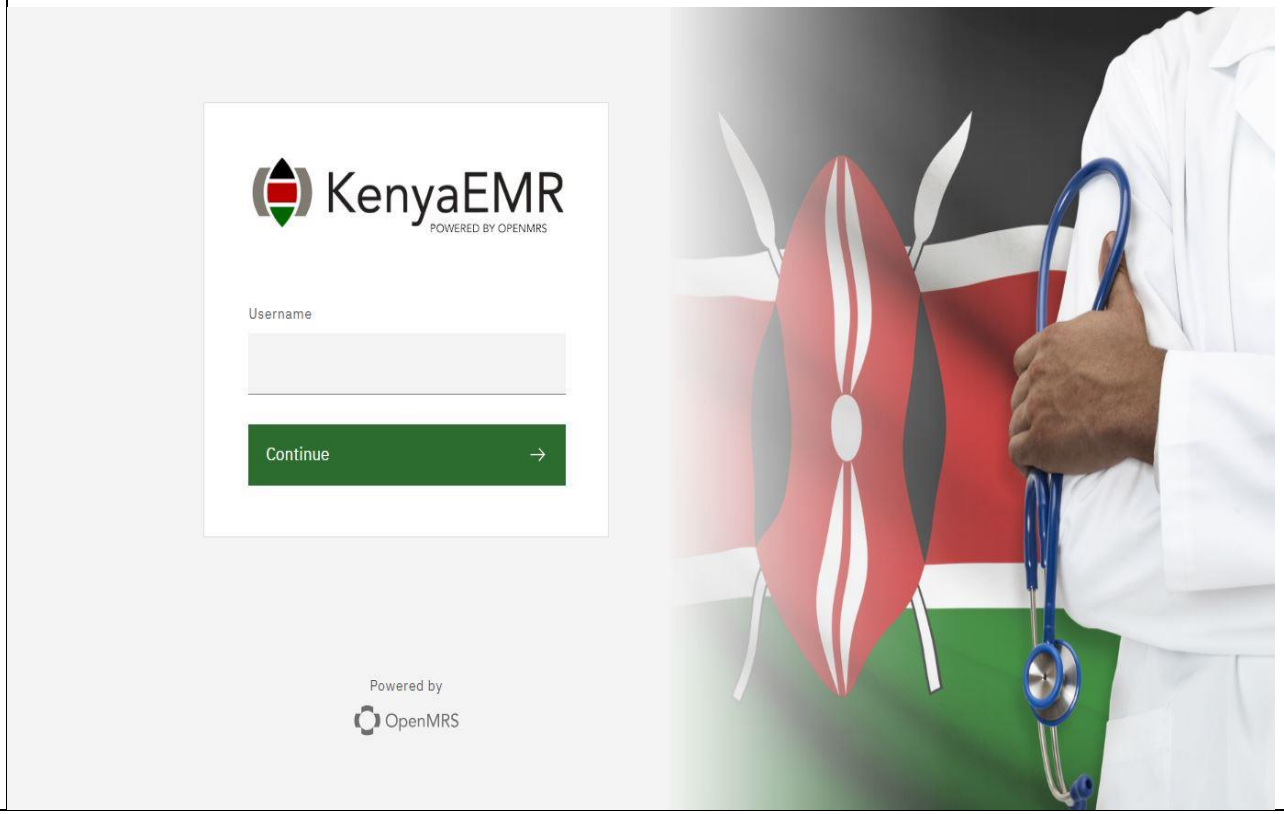
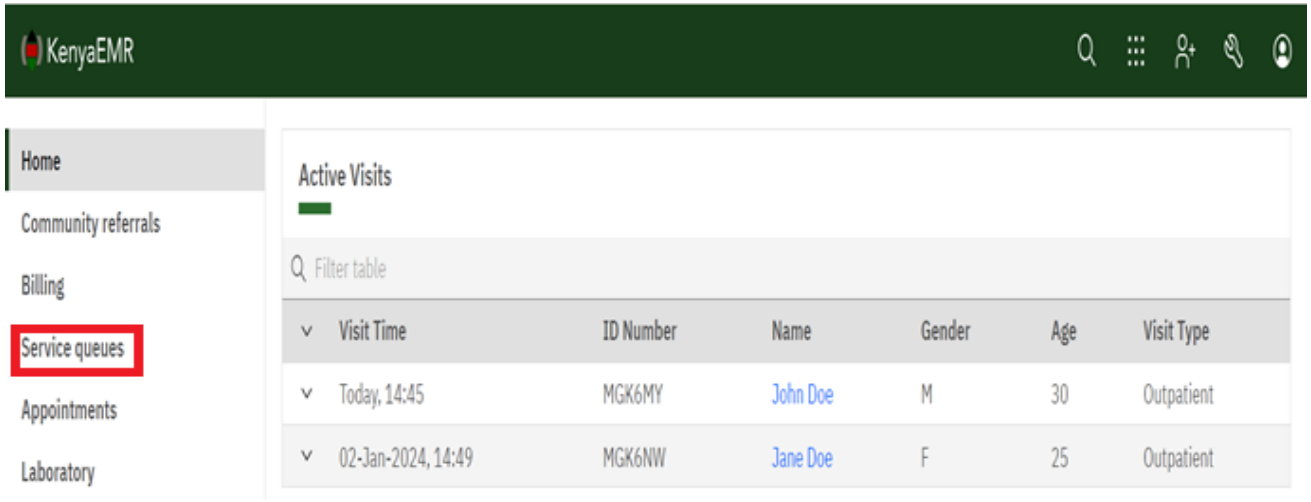
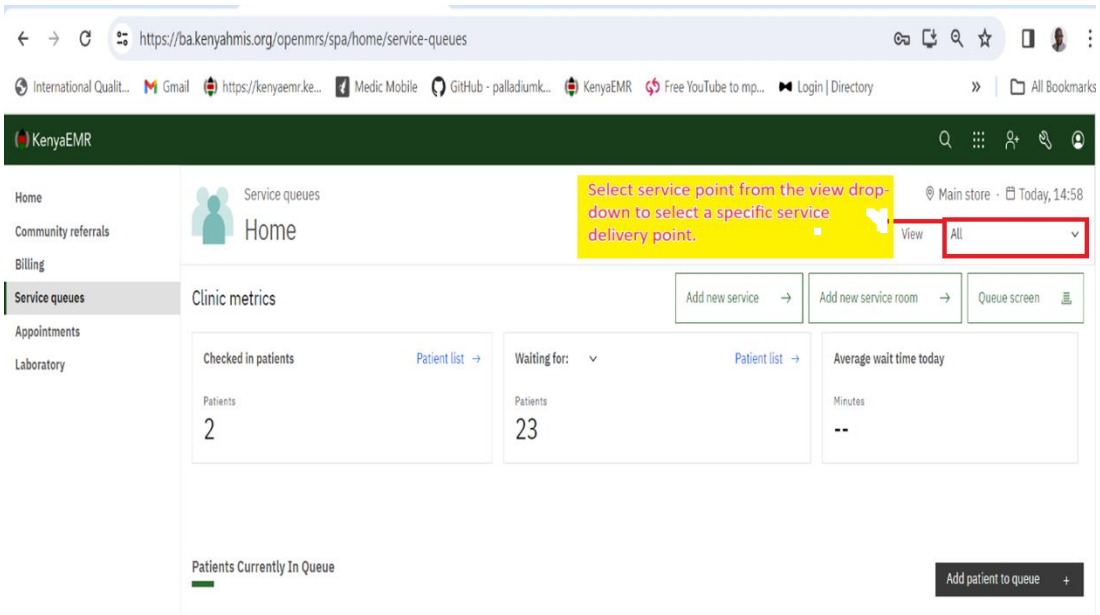
SOP: KenyaEMR3.x Outpatient Clinical Encounter Workflow

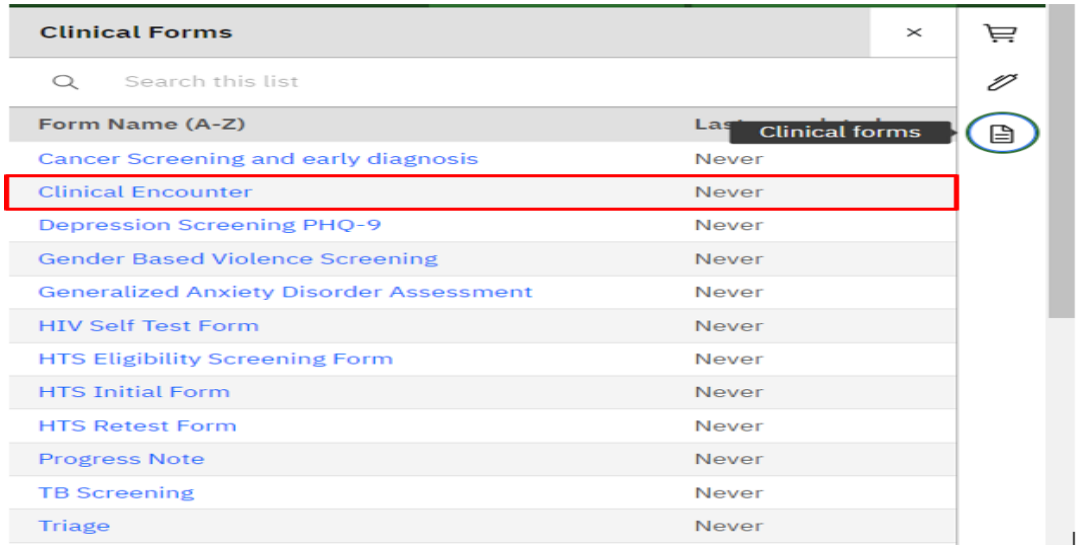
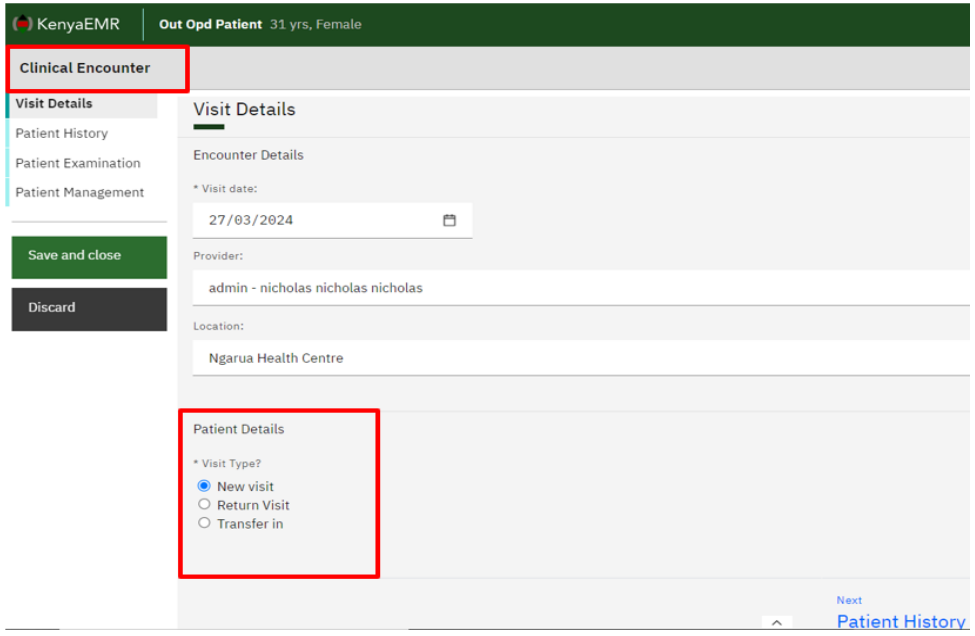
[Last updated: Mar 2024]

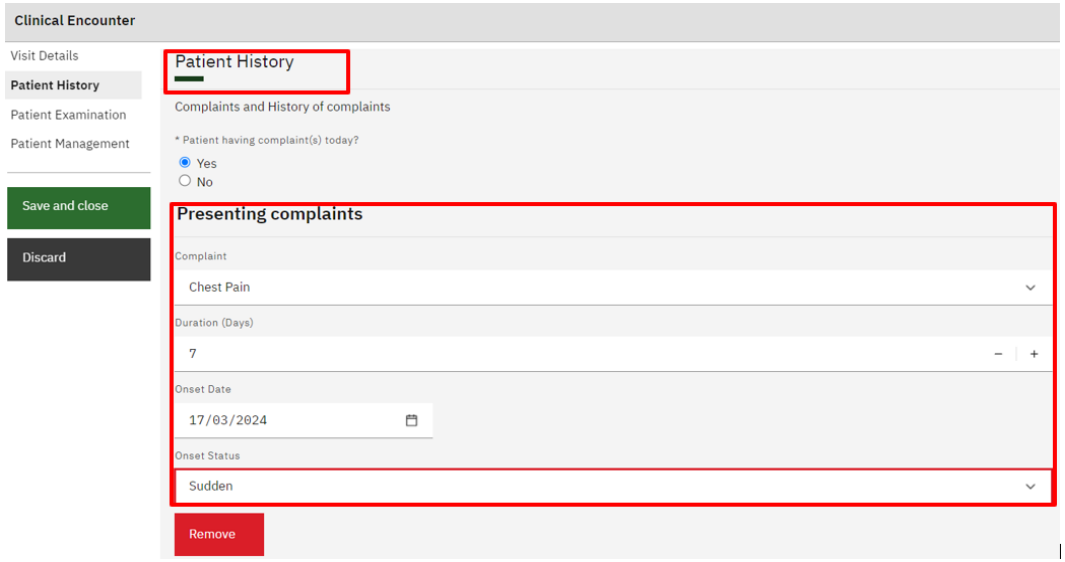
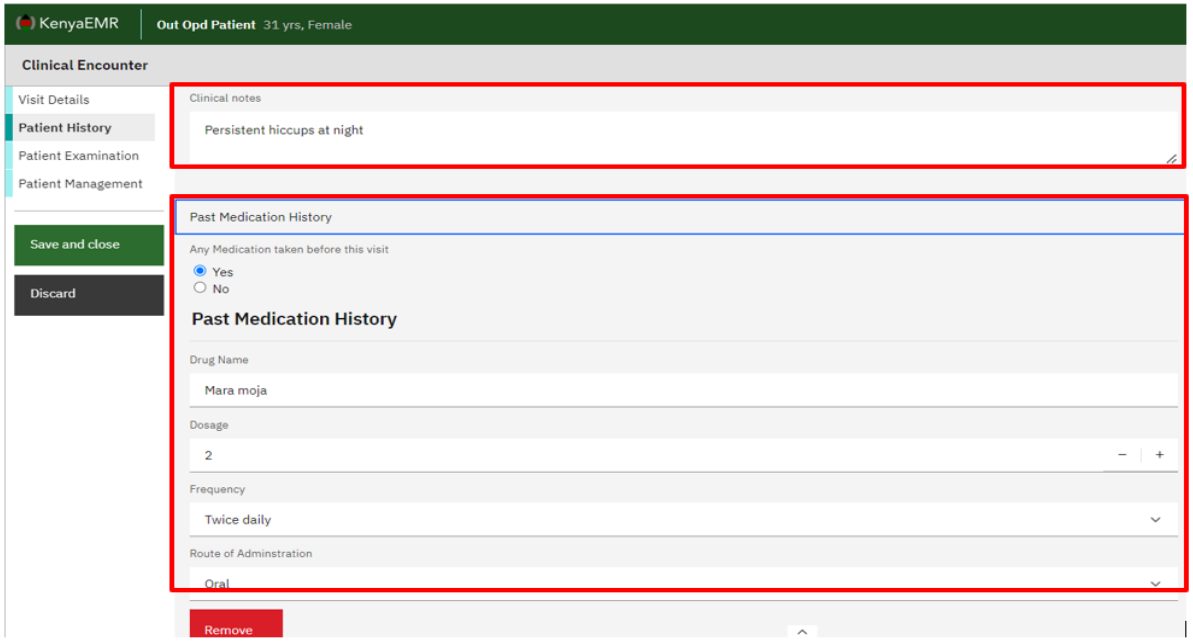
Tasks:	End to end navigation of the OPD Clinical Encounter in KenyaEMR
Objective:	Navigation skills
Who:	EMR users
Required Materials:	Username, password, computer installed with the latest version of KenyaEMR.

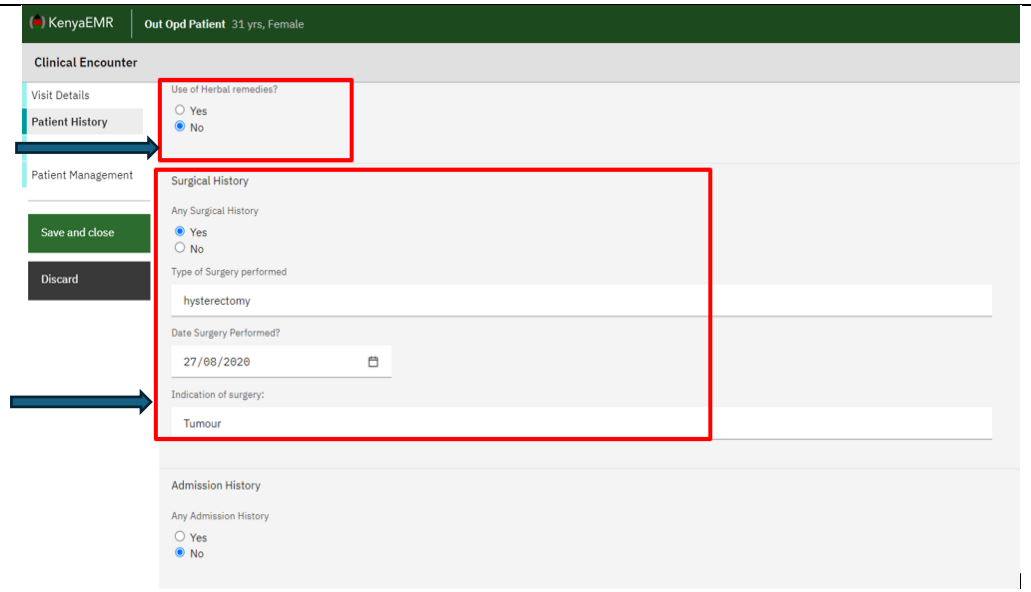
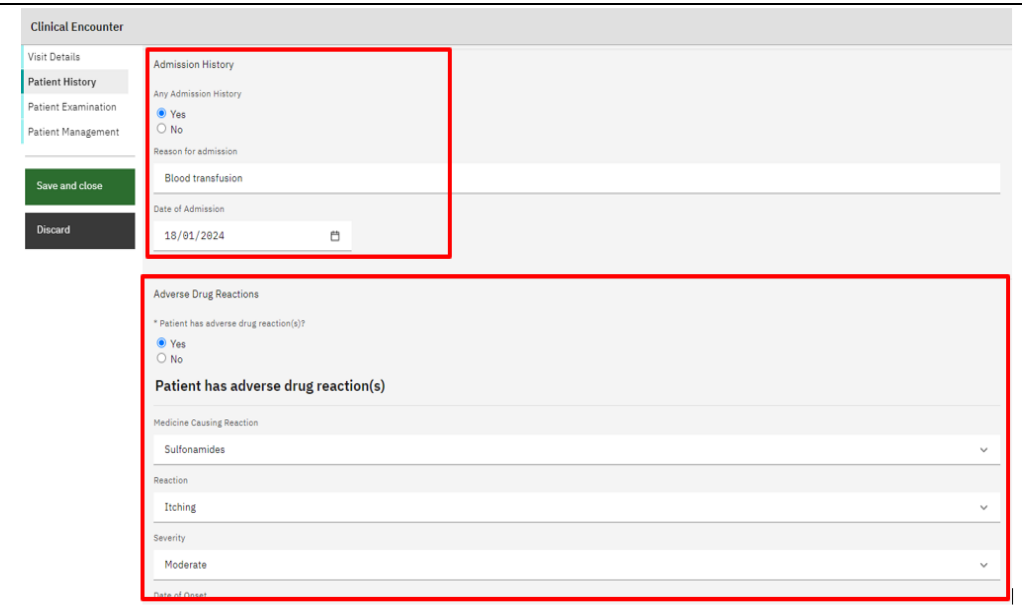
Steps	Description	Illustration
Step 1	**Learning objectives** By the end of this session, you will be able to: • Successfully log into KenyaEMR • Successfully document an Outpatient (OPD) clinical encounter in KenyaEMR	

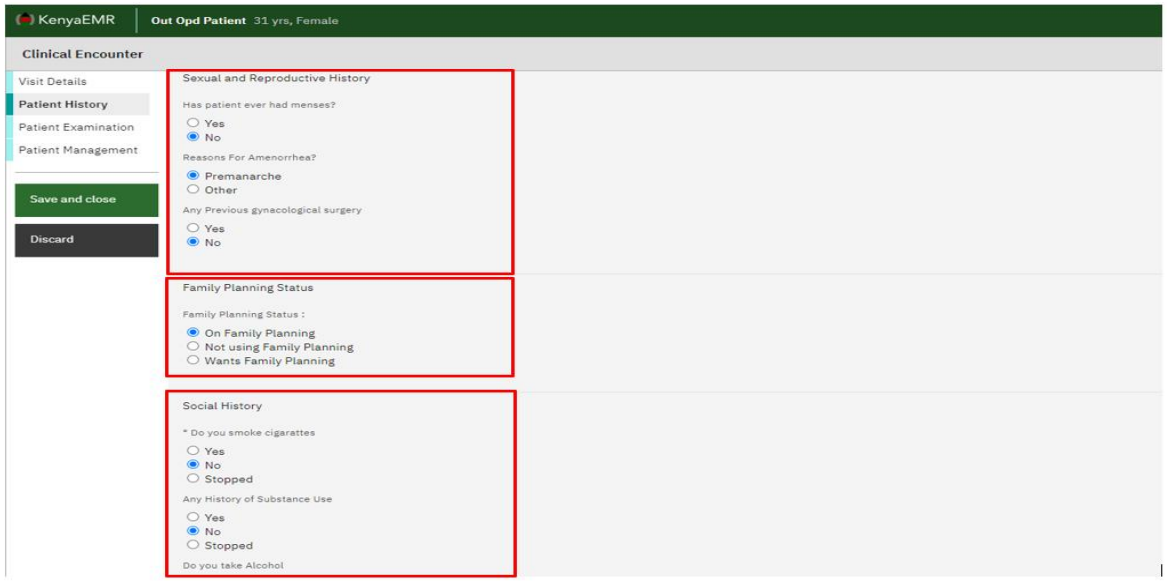
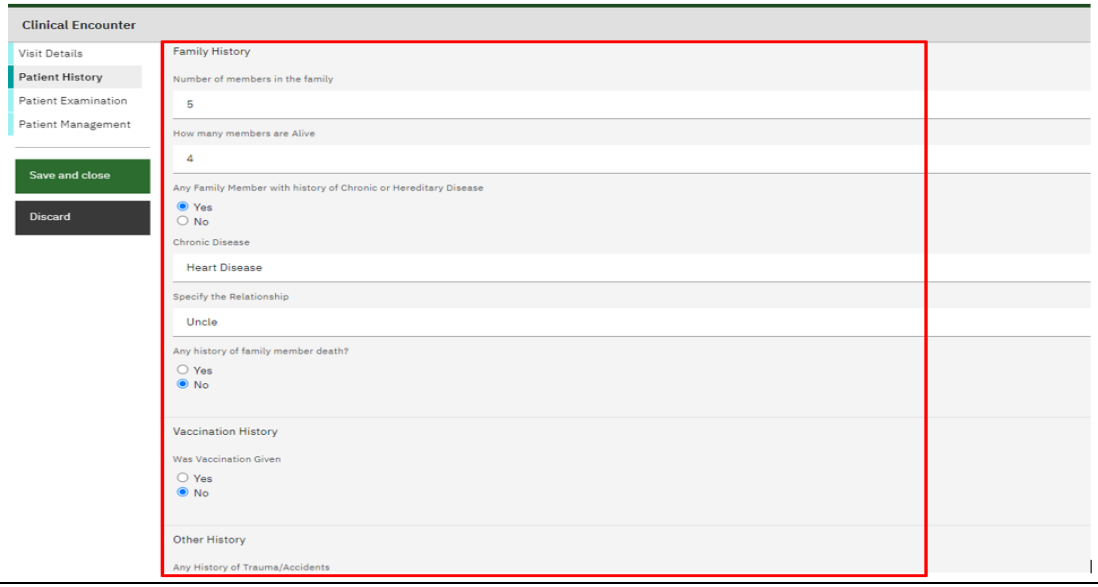
	Login to KenyaEMR Enter the application server URL System localhost:8080/openmrs/spa/login and click on the load button or Enter key from the keyboard. On successful loading, you should be navigated to the system login page. Authenticate entry by providing username and password on the fields, then. click “Login” button	

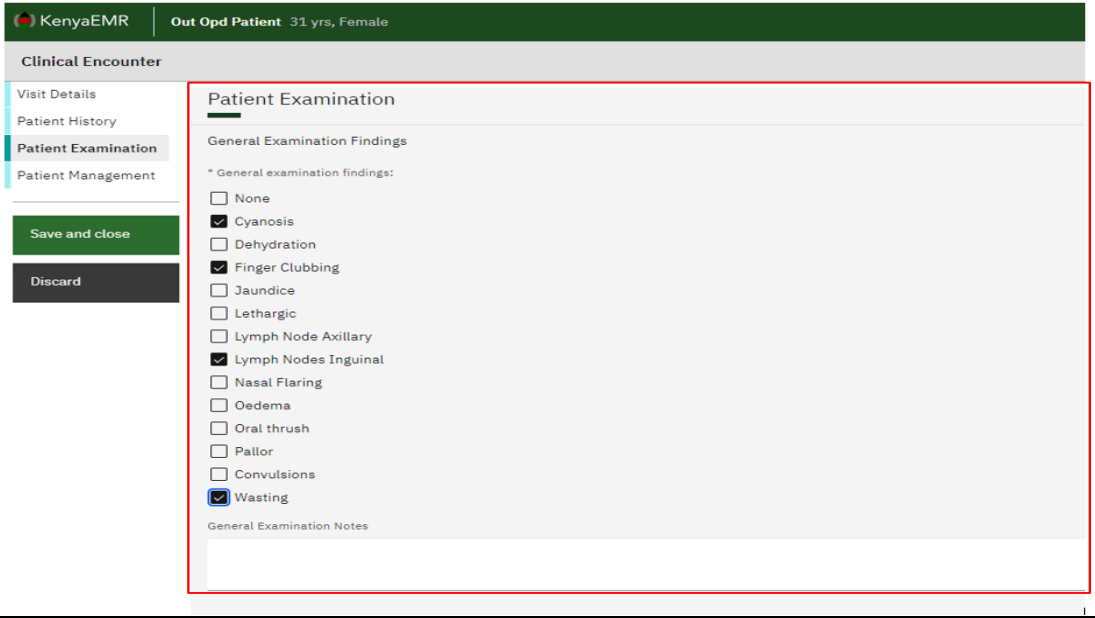
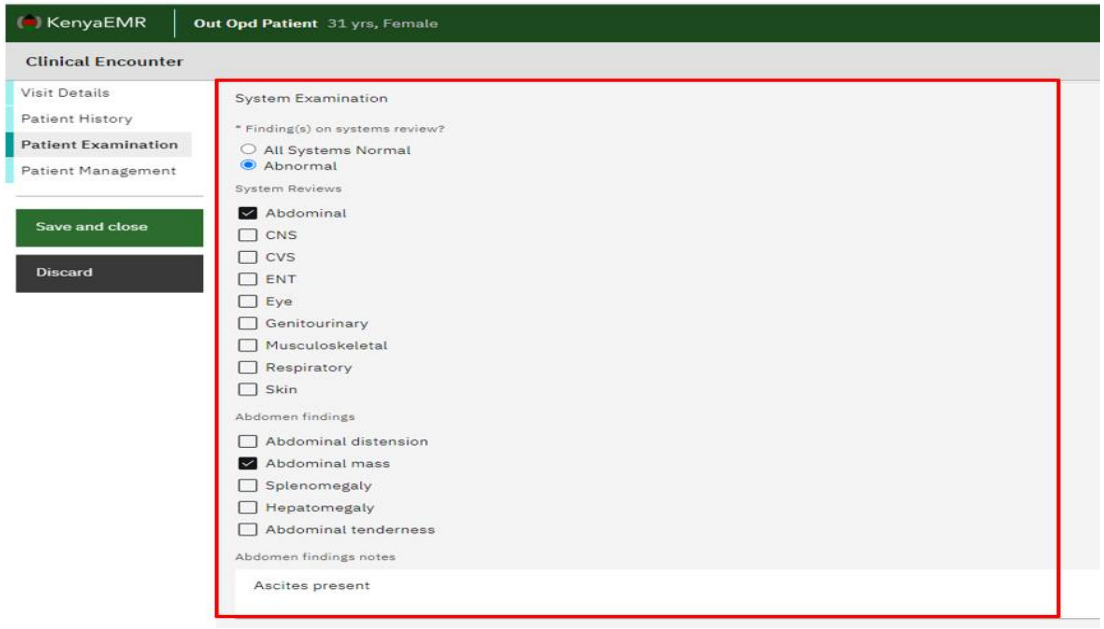
Step 2	Upon successful login, you shall be navigated to the Active visits page of the facility Click on the “Service Queues” option from the menu items available on the left side of the screen to find the client if they are already enrolled and are in queue. If they are not enrolled refer to client’s enrolment manual on how to enrol clients to KenyaEMR	
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.	

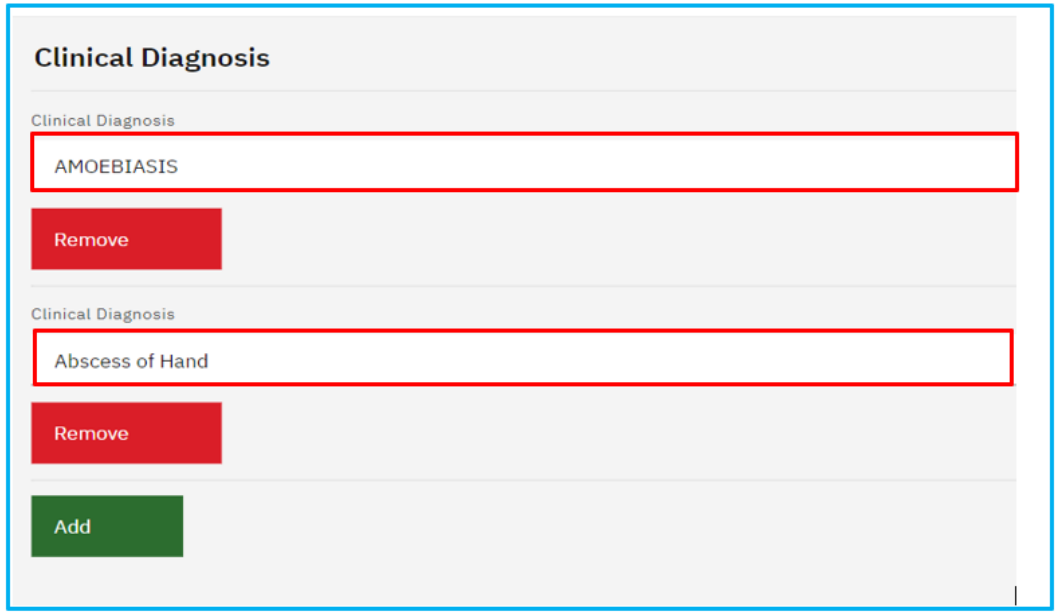
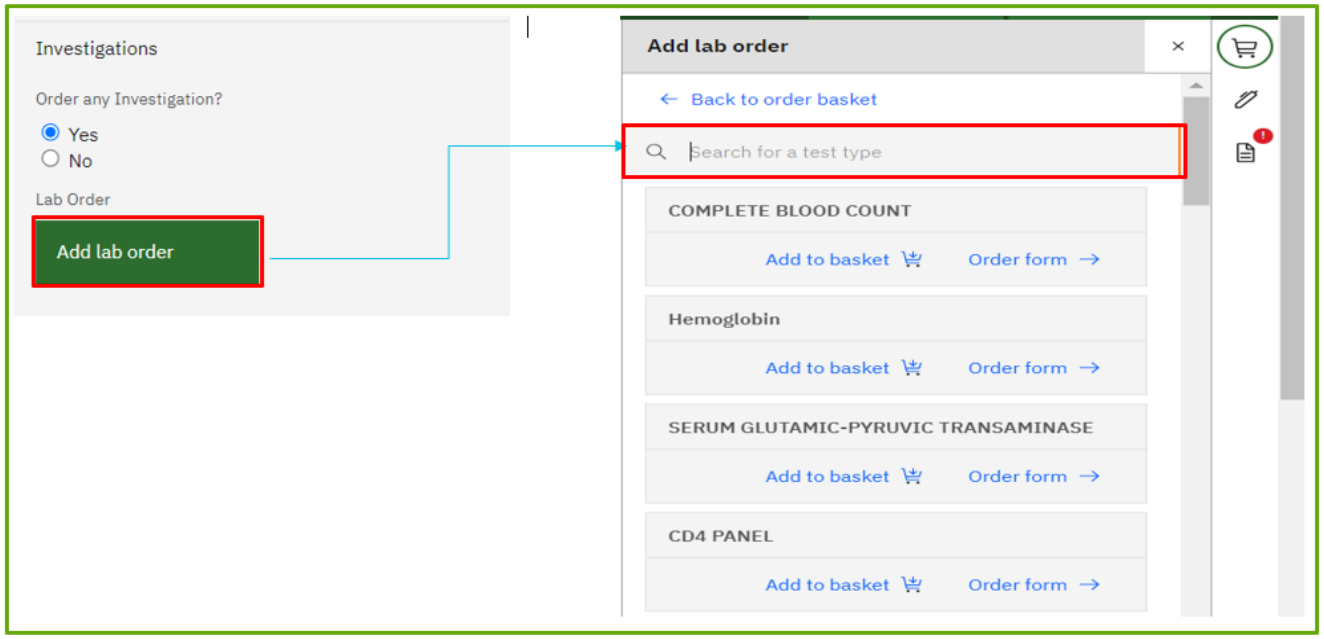
Step 4	**Clinical Encounter Form availability** From the clinical suite of forms, the OPD clinical encounter form is one among the many available forms as captioned on the next column	
Step 5	By default, the form opens with the Visit Details prepopulated. The users can however change this to Reflect the desired details. Fill in the visit type details from the choice of 3 as indicated.	

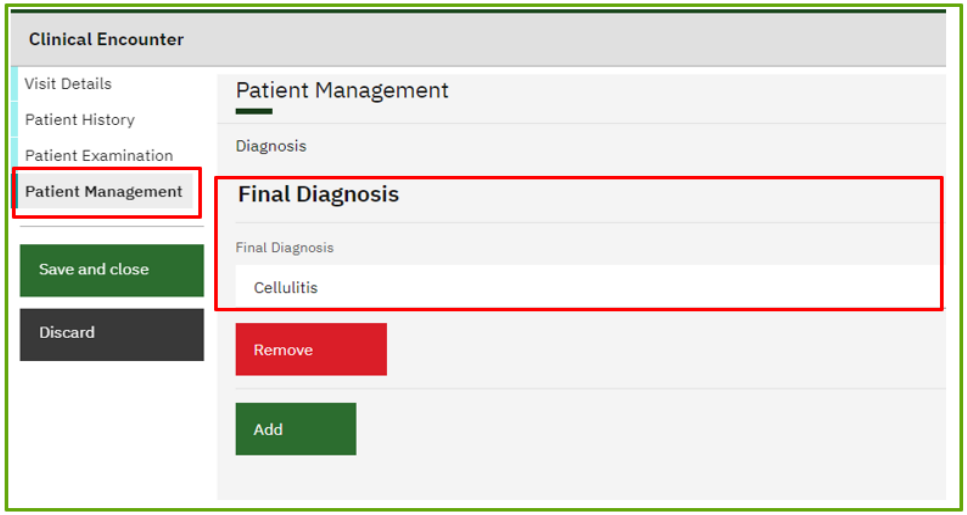
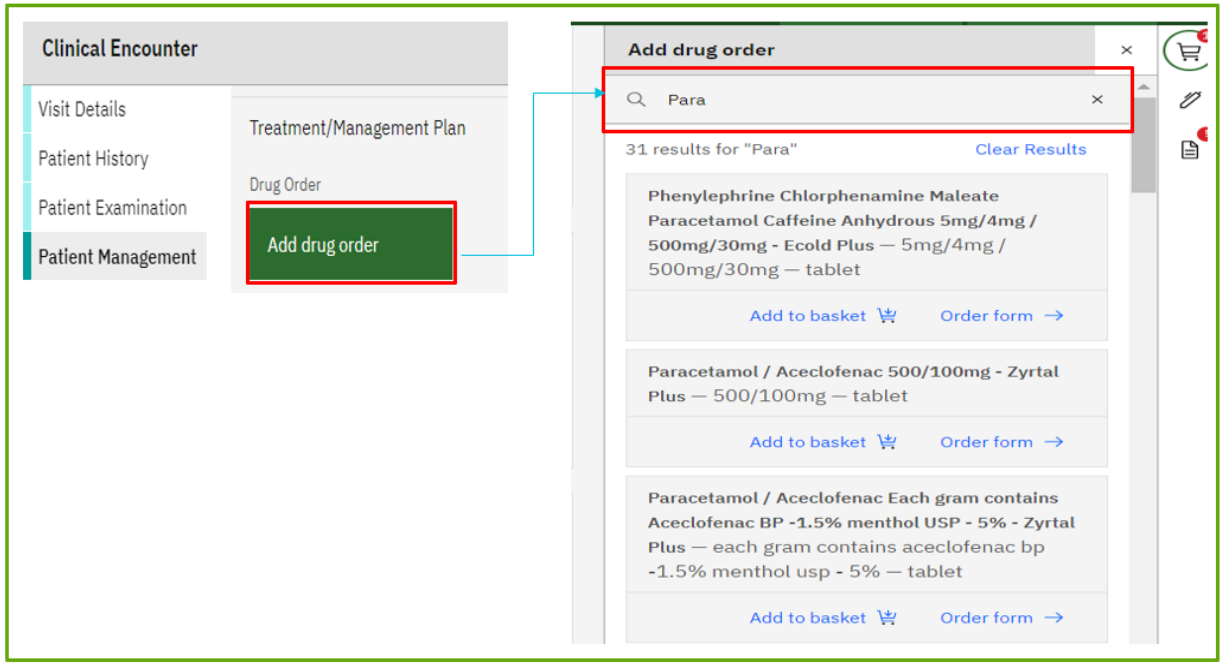
Step 6	Document Patient History usually presenting and history of complaints from the select list and add to the grid. Numerous complaints can be added to the grid as reported by the patient. Include the duration of the complaint in days, Onset date and onset status.	
Step 7	**Record clinical notes** Record any medication taken before the visit detailing drug name, dosage, frequency and route of administration	

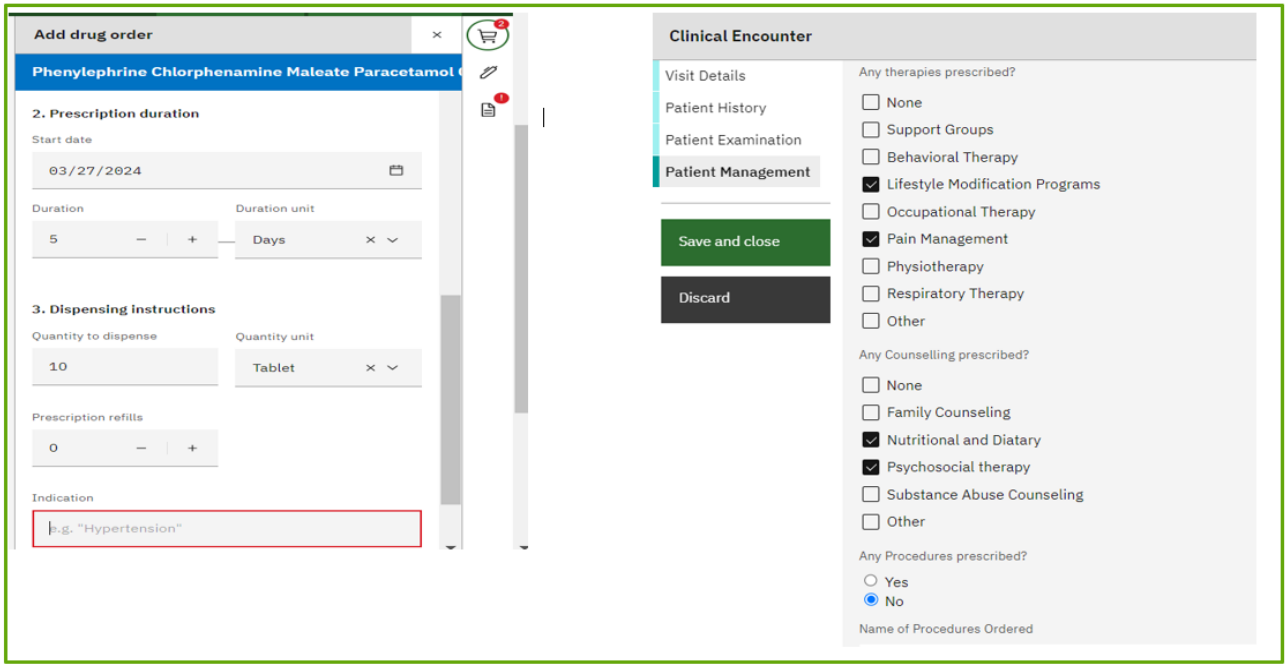
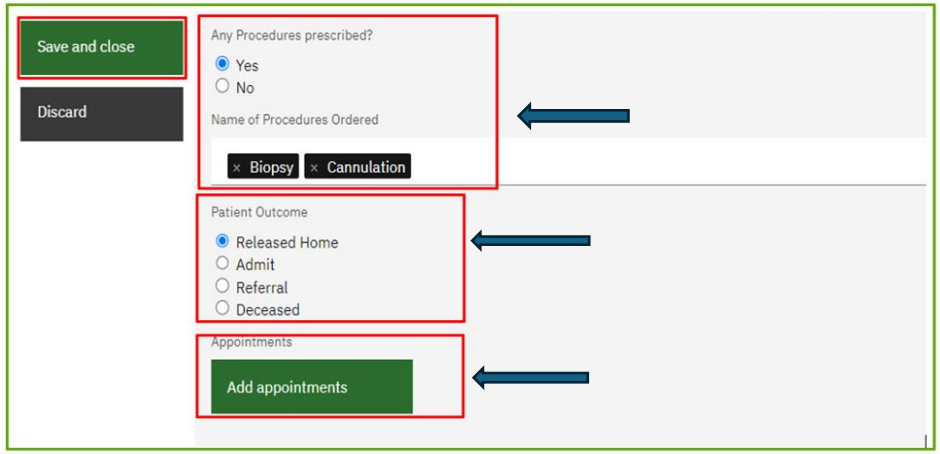
Step 8	Screen patient for use of Herbal remedies and document. Document any historical surgical procedure that the patient has undergone clearly documenting the reason for surgery	
Step 9	Record any admission history indicating the reason and date of admission. Document any Adverse drug reactions. the client might be having. Indicate the causative medicine, reaction type, severity, date of onset and the action taken. Add as many adverse drugs as reported by the patient	

Step 10	Document the Sexual and Reproductive History if the client is female and of reproductive age. Document client's family planning status. Probe client for Smoking, Substance abuse, Alcoholism and history of recent travel and document	
Step 11	Document the client's family history comprising of Number of family members, members alive, family members with history of chronic or hereditary disease and their relationship to the index client. History of family members who have died and clients vaccination history	

Step 12	**Patient Examination** Document the General Examination Findings as outlined and make additional notes not captured in the multi select list	
Step 13	**System Examinations** After conducting systems review on the client, document all the finding as per screening tool. Type down notes to elaborate further the systems findings.	

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.	
Step 15	Investigations opens a window for the lab order to pop up to allow for ordering of requisite investigative tests as depicted	

Step 16	Patient Management allows for the documentation of the final diagnosis derived from laboratory investigation. ICD 11 diagnosis is utilised	
Step17	**Add Drug Order** The Drug order button populates the drug order form as depicted. Select the drugs to prescribe from the select list	

Step 18	After ordering drugs get back to the clinical encounter to finalise the visit. Document any therapies, Counselling and procedures prescribed	
Step 19	Document any procedures prescribed. Specify the patient outcome. Add appointments to the appointment's module. **Save, close and Exit the Clinical encounter**	

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