Medical, Surgical, ICU Visit, and Health Information Management

Clinical Documentation

Show and demonstrate how nurses and allied health professionals use the system, especially regarding their daily clinical activities. This should include a discussion/presentation around nursing notes, nursing diagnosis documentation, nursing orders or tasks, vital signs and flowsheets, care plans, medication review and the eMAR. The structured format of clinician documentation should generate discrete data such as diagnoses, problems, disease scores, risk scores, medication history, or allergies that create a comprehensive data set used to assess a patient's health status and mobilized to inform clinician decisions on most appropriate care order sets and care pathways, while also identifying risks to patient's health status.

The specific physician documentation that we focus on here is: History & physical examination (H&P), history of present illness (HPI), consult notes, progress notes, discharge note, problems, and diagnoses.

ID	Stage	Y	N	Compliance Statement
Nursing Documentation captured in the EMR:				
67	6			**Vital signs.** Verified by nurse if monitors are interfaced with EMR.
68	6			**Flow sheets**
69	6			**Nursing notes**
70	6			**Risk assessments**
71	6			**Care plans**
72	6			**Electronic medication administration records (eMAR)**
Physician Documentation captured in the EMR:				
73	6			**Doctors** use **structured templates** to document **daily progress notes**.
74	6			**Doctors** use **structured templates** to document **operative notes**.
75	6			**Doctors** use **structured templates** to document **history & physicals**.
76	6			**Doctors** use **structured templates** to document **consult notes**.
77	6			**Doctors** use **structured templates** to document **discharge sum**.
78	6			**Structured templates drive CDS or order sets** Structured templates generate discrete data used to drive CDS or order sets and populates the CDR as discrete data.

ID	Stage	Y	N	Compliance Statement
79	7			**Procedural Suite Time-Out Process** A Procedural Suite Time-Out process is in place to ensure patient safety.
80	7			**Anaesthesia IS interfaced with EMR** An anaesthesia information system is live, in use, and interfaced with the EMR.
81	7			**Complete Nursing Documentation in EMR** Nurses complete documentation in the EMR for all of the following: vital signs (verified by nurse if monitors are interfaced), flow sheets (fluid balance, blood administration), nursing notes, risk assessments, care plans-nursing diagnoses, electronic medication administration records (eMAR).
82	7			**Medication Reconciliation Processes** Medication reconciliation processes occurs at admission, discharge and all unit level transfers, including reconciliation with home medications to be taken/resumed after discharge.
83	7			**Resuscitation meds available in eMAR until patient transfer** Nurses may chart resuscitation medications on paper, but document the medications administered in the eMAR record by the time the patient is transferred to another unit (e.g., ICU).
84	7			**Structured templates for clinician documentation** Clinician documentation uses structured templates for all patient care programs to ensure complete, accurate documentation of Clinician's care for patients.
85	7			**Structured templates for daily progress notes** Clinicians use structured templates to document daily progress notes for all patient care programs.
86	7			**Structured templates - Input to the design - Operative notes** Clinicians have input to the design and use of structured templates to document operative notes for all procedures.
87	7			**Structured templates - Input to the design - History & physicals** Clinicians have input to the design and use of structured templates to document history & physicals.
88	7			**Structured templates - Input to the design - Consult notes** Clinicians have input to the design and use of structured templates to document consult notes.
89	7			**Structured templates - Input to the design - Discharge summary** Clinicians have input to the design and use of structured templates to document discharge summaries.
90	7			**Nursing risk assessments inform standardized care delivery** Nursing risk assessments inform care delivery to ensure patients assessed at high risk receive preventive care to reduce risk and patients assessed at low risk receive care appropriate to low risk care needs. Care delivery is standardized to ensure risks are mitigated.