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.