Hospital Daily Progress Note Tutorial

SETMA's Suite of Hospital Templates includes:

- History and Physical Examination completed via the <u>GP Master Suite of Templates</u>
- <u>Admission Orders</u>
- Daily Progress Note Suite of Templates
- Discharge Summary Suite of Templates
- <u>Care Transitions Data Set from Physician Consortium for Performance Improvement</u>
- <u>Telephone Calls Follow-up of Hospital Stay or ER visit</u>
- <u>Hydration</u>
- <u>Nutrition</u>

The **Hospital Daily Progress Note** templates enable an inpatient-hospital note to be completed efficiently and excellently with data being accumulated over the course of an inpatient stay. This data is then automatically aggregated for the Discharge Summary to be completed quickly and completely.

The complexity of this task will become obvious as you review this tutorial. However, the use of the Hospital Daily Progress Note is very much easier than it may seem from the length of this tutorial. Of necessity, the variety of documentation needs for inpatient, daily progress notes is such that the suite of templates will be large, but applied to individual patients, they are manageable and valuable.

In addition, the Hospital Daily Progress Note is the "last piece" in making a patient's care seamless regardless of where the patient is being treated. The inpatient record is not isolated in a patient's hospital chart but through the hospital daily progress note has become a dynamic part of the patient's medical record and contributes to the continuity of care and to the continued building of a detailed, accurate and complete portrait of the patient's health history, condition, care and needs.

How to Begin a Daily Progress Note

There are two different but similar methods for initiating the completion of a Hospital Daily Progress Note. Once you are familiar with these steps, they can be completed in a few seconds.

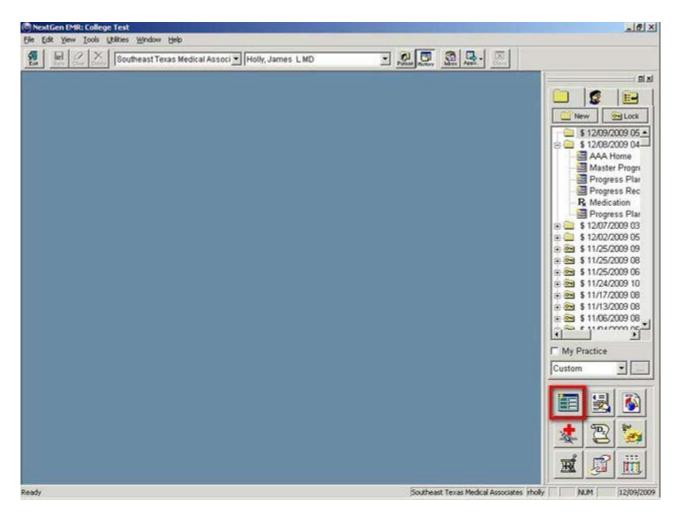
Steps for starting a Hospital Daily Progress Note

- Create a new visit in the EMR
- Open the AAA Home Template
- Save the AAA Home Template
- Drag the Assessment template from the History and Physical Examination or from the previous day's Daily Progress Note
- Open the Hospital Daily Progress Note
- 1. The first way to begin a hospital daily progress note is when it is being completed on the first day after admission in this case, the following four steps need to be taken in order to complete a Hospital Daily Progress Note successfully.
- In the **History Tool Bar**, which is the tool bar to the right hand side of the NextGen screen, you must create a **New Visit** for the day on which the **Hospital Daily Progress Note** is going to be completed.

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You create a **New Visit** by clicking on the **New** button, at the top of the **History Tool Bar**. If you place your cursor over the **New** button and rest it there, the full title of the button will appear which is "**Add a new encounter**."

• You now need to open the AAA Home template. To do this, click the "**Templates**" Button at the bottom of the History Tool Bar. Below it is outlined in red.



• This will pop-up the "Select Template" window. Based on your user preferences yours could look different.

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If you do not have AAA Home in your Preferred list, you will need to select "All" to see it.

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• Select AAA Home and hit Enter or click "Ok"

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• Now that you have created your new visit and opened the AAA Home template, you must go to the '**Save**" button at the top left –hand side of the AAA Home screen and click that button. It is outlined in red below.

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This action will cause AAA Home to appear in the encounter history list, on the History Tool Bar to the right of the screen. It is outlined in red below.

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• Once the new encounter is open and the AAA Home appears in the history list, find the Assessment from the encounter where the history and physical examination was completed.

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Left click your mouse on "assessment;" leave it depressed and drag the assessment to the new encounter, and then release the button and it will drop it on the new encounter. A popup will appear asking you if you want to copy the template to the new encounter. Click 'Yes'.

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You will now be on the Assessment template. Click the "save" button again.

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Now you should see the following in the history screen:

- Encounter Date for the day on which you are completing the Hospital Daily Progress note
- AAA Home
- Assessment
- Go to AAA Home and find the icon for Hospital Daily Progress note. It is outlined in red below and is entitled **Daily Progress**.

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Click the Hospital Daily Progress Note icon and then click the save button again. Now you should see the following in the "history screen":

- Encounter Date for the day on which you are completing the Hospital Daily Progress note
- AAA Home
- Assessment
- Master Progress, the name of the Hospital Daily Progress Note Master Template.

You are now ready to complete the Daily Progress Note.

Go to the "Toggle History Toolbar" at the top of the screen and close the "history toolbar." Your navigation will now be totally through the Master Progress suite of templates until you get to medications, laboratory or allergies.

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• The second way to begin a Daily Progress note is on the second day after admission or on subsequent days after admission. This assumes that a hospital daily progress note was completed in the EMR on the day after admission.

On these occasions, the steps described above will be repeated with one significant difference. The Master Progress template from the previous day's Hospital Daily Progress Note will be dragged forward rather than the assessment from the Admission H&P.

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Completing a Hospital Daily Progress Note in the EMR

The following is a screen shot of the template which is launched when you click on the icon entitled **Master Progress**. The template is entitled **Daily Progress Note** and it is the principle template in the **Hospital Daily Progress Note** suite of templates, which is the starting pint of completing the **Hospital Daily Progress Note**

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	Memorial Hermann Baptist	Diagnoses Fredrickson Type	Ph. M. mark		Status	1.0	Home	I.
Provider	James L. Holly MD	Renal Stage I Chr			Chronic		Recent Events	7
	James Holly	CHF Diastolic Acu		8	Chronic in	DE COLIE	Histories	F
	Telemetry	Hyperten isolated	11		Childric II	DIOVE		F
	Full Code	Anemia Unspecifi			<u> </u>	_	HPI	
	Attending	DM II Renal Manife	Contractory of the local division of the loc	chr	<u> </u>	_	Chronic Conditions	ы
	At Home Alone		10106 01100		<u> </u>		System Review	~
Vital Signs Weight	227.00 lb 103.1 kg				<u> </u>		Physical Exam	7
Height	63.00 in		Addition	al Diagnoses	1		Procedures	F
BM	40.21 kg/m*2	-		into Probler			Laboratory	C
BP	138 / 85 mmHg		seasments	and Problem	LIST		Hydration	2
Pulse	92.00 /min 🔽 Reg 🗆 Irr	eg Admit Date 11/	24/2009	Days T	his Stay	1	Nutrition	Ы
Pulse Ox	95 %	Estimated Discha	rge Date		11/27/20	09	Fall Risk	Ы
Current O2	%, via room air	Days in ICU		(click in box	to edit)	0	Skin Lesions	
Resp Temp (current)	19 Amin 98.60 *F 36.96 *C	Days on IV Antibi				0		2
Route	oral	Days on Ventilato	r <u>Currer</u>	t Settings		0	Renal Failure	님
TMax (24 hrs)	98.80 F	Surgeries This St	ay	Date	De	ys Post	Radiology	늰
Intake (mL)	Output (mL)	-			1		Procedures	ы
Fluid Balance - To					/	_	Guidelines	
Fluid Balance - Ru		r Time		1 /	/ L		Plan/Comments	7
Diet - Past 24 Hour Current Diet	1000 0 - / 200 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Dialysis Status Patient on Dia	lysis C	les 🖸 No			Orders	7
Appette	Diminished	Nephrologist Last Dialysis		Nex	t []]		Note	
Percent Meals Eat	Color procession and the second	and the second second				-		
24 Hr Bowel Hx	Movement within I	Eramingham Risk	CVD 10-1	r > 30 ;	Stroke 10-Y	0		
Current Activity	T OD IN CHIM							
•								

The Master Hospital Daily Progress Note template is organized into three columns.

The first column of the Master Progress template has three sections

The **first section** is demographic information about the patient which identifies seven important facts about the patient:

- Facility this denotes the hospital to which the patient is admitted.
- **Provider** this denotes who the attending physician is for this admission
- **PCP** this denotes who the patient's primary care physician is
- Admit Status this tells if the patient is a full admit, observation or telemetry
- Code Status this denotes whether patient is a full code, DNR, medications code only or other.
- Visit Type this denotes whether the daily progress note is by the attending, consultant, etc.
- **Residence** this alerts the provider to where the patient resides and particularly if he patient lives alone. This function is critical to discharge planning for a patient and needs to be known from the time of admission

Once completed, these fields are brought forward each day automatically when the Hospital Daily Progress Notre is dragged forward from the History Tool Bar each day in preparation to complete the Hospital Daily Progress Note.

		Diagnoses		Status		
	morial Hermann Baptist	Fredrickson Type Ib Hyper	Inconstaine	Status	Home	1
	mes L. Holly MD	Renal Stage Chron Dises	CHICAGO CHICAGO	Chronic	Recent Events	7
	mes Holly	CHF Diastolic Acute	100	Chronic improve	Histories	ы
	lemetry	Hyperten Isolated Systolic		Chickle indicite		E
	I Code	Anemia Unspecified		<u> </u>	HPI	
	tending	DM II Renal Manifestat Uno	ontr	<u> </u>	Chronic Conditions	ы
	Home Alone		-64 B)	<u> </u>	System Review	~
ital Signs	227.00 lb 103.1 kg			<u> </u>	Physical Exam	7
Weight I Height [63.00 in	Addition	nal Diagnose:		Procedures	Г
BMI 1	40.21 kg/m*2		ts into Proble		Laboratory	E
BP [138 / 85 mmHg	Assessmen	ts into Proble	must	Hydration	7
Pulse	92.00 /min 🔽 Reg 🗌 Irreg	Admit Date 11/24/2009	Days T	This Stay 1	Nutrition	E
Pulse Ox	85 %	Estimated Discharge Date		11/27/2009	Fall Risk	E
Current O2	%, via room air	Days in ICU	(click in box	(to edit) 0		
Resp	19 /min	Days on IV Antibiotics		0	Skin Lesions	
	98.60 MF 36.96 MC	Days on Ventilator Qurr	ent Settings	0	Renal Failure	
	98.80 F	Surgeries This Stay	Date	Days Post	Radiology	L
Intake (mL)	Output (mL)			//	Procedures	
Fluid Balance - Toda				//	Guidelines	
Fluid Balance - Run					Plan/Comments	7
iet - Past 24 Hours		Dialysis Status			Orders	7
Current Diet	Cardiac	Patient on Dialysis	Yes 💽 No		1	1
Appette	Diminished	Nephrologist			Note	
Percent Meals Eater	50 to 75%	Last Dialysis /	/ Neo	xt //		
24 Hr Bowel Hx	Movement within I	Eramingham Bisk CVD 10	Yr > 30	Stroke 10-Yr 0		
Current Activity	Up in Chair		Contraction of the local division of the loc			

The **second section** displays 14 vital signs and other data points about the patient's care which are important for the attending to review each day. At present, this information must be entered manually but by 2010, it is hoped that we will have an interface with at least one hospital where this information will be entered electronically and automatically.

	hanna Mata	Seen By MD @ Patient	bollege	Test			
Daily P	Progress Note	1/25/2009 9:25 AM DOB	01/01/192	0 Sex	F		
acility	Memorial Hermann Baptist	- Diagnoses		Status		Home	1
rovider	James L. Holty MD	Fredrickson Type Ib Hype Renal Stage I Chron Dise		Chungle	_	Recent Events	7
P	James Holly	CHF Diastolic Acute	ase	Chronic			2
idmit Status	Telemetry	Hyperten Isolated Systolic		Chronic in	nprove	Histories	늰
Code Status	Full Code	- Anemia Unspecified				HPI	ы
/isit Type	Attending	DM I Renal Manifestat Un	and a	<u> </u>	_	Chronic Conditions	Ы
lesidence.	At Home Alone	Den a Rena marinessa Un	CONT	<u> </u>		System Review	2
ital Signs	227.00 lb 103.1 kg			-		Physical Exam	7
Weight Height	63.00 in	Addition	onal Diagnoses	1		Procedures	F
BM	40.21 kg/m*2		nts into Problem			Laboratory	
BP	138 / 85 mmHg		ale ello Probien	- Lion		Hydration	7
Pulse	92.00 /min I⊽ Reg I In	reg Admit Date 11/24/2009	Days T	his Stay	1	Nutrition	
Pulse Ox	95 %	Estimated Discharge Date		11/27/20		Fall Risk	Ы
Current 02 Resp	%, via room air 19 Amin	Days in ICU	(click in box	to edit)	0	Skin Lesions	
Temp (current	and the second s	Days on IV Antibiotics		_	0	Renal Failure	ы
Route	oral	Days on Ventilator Qui	rent Settings		0		
TMax (24 hrs)	98.80 F	Surgeries This Stay	Date	r	ays Post	Radiology	
Intake (mL)	Output (mL)			/	_	Procedures	
Fluid Balance				/	_	Guidelines	ы
Fluid Balance	- Running Total	er Time	1 /	<u>′</u>		Plan/Comments	2
het - Past 24 H		Dialysis Status Patient on Dialysis	Vec C his			Orders	7
Current Diet Appette	Diminished	Nephrologist		_		Note	
Percent Meals	STATISTICS -	Last Dialysis	// Nex	t //			
24 Hr Bowel H	Contraction of the second seco	Eramingham Risk CVD 10)-Yr > 30 5	Stroke 10-Y	ro		
2411 DOWEIT	y Up in Chair		Summer and				

On **the route of oxygen administration**, there are multiple options. When the box is clicked a pick list appears from which you can select the correct response.

Facility	Memorial Hermann Baptist	Diagnoses		Status	Home	1
Provider	James L. Holly MD	Fredrickson Type Ib H				
PCP	James Holly	Renal Stage II Chron D	lisease	Chronic	Recent Events	F
Admit Status	Telemetry	CHF Diastolic Acute		Chronic improve	Histories	ł
Code Status	Full Code	 Hyperten Isolated Syst 	tolic		HPI	E
Visit Type	Attending	- Anemia Unspecified			Chronic Conditions	ľ
Residence	At Home Alone	DM II Renal Manifestat	Uncontr		System Review	j,
vital Signs		1941			Physical Exam	k
vVeight	227.00 lb 103.11 kg 63.00 in			1	Procedures	ř
Height BMI	the second se	Ad	iditional Diagnose	5	Laboratory	h
BP	40.21 kg/m*2 138 / 85 mmHg	Asses	aments into Proble	m List		
Pulse	92.00 /min IV Reg [1	rreg Admit Date 11/24/2	000 0	This Stay 16	Hydration	F
Pulse Ox	95 %	Admit Date These	Darys	11/27/2009	Nutrition	l
Current O2	%, via room	Oxygen	X (click in box	the second se	Fall Risk	ł
Resp	19 /min		- (cack ar bos		Skin Lesions	ſ
Temp (current)	98.60 rF 36.96	BIPAP CPAP	ent Settings		Renal Failure	Ľ
Route	oral	hood nasal cannula	Date	Days Post	Radiology	E
TMax (24 hrs)	98.80 F	non-rebreather mask			Procedures	ľ
Intake (mL)	Output (mL)	room air		11	Guidelines	Ē
Fluid Balance -		ventilator venti-mask		11	Plan/Comments	K
Fluid Balance - Diet - Past 24 Ho		0.00000000000			Orders	k
Current Diet	Cardiac		Yes @ No	·		1
Appetite	Diminished	Close		in the second	Note	ſ
Percent Meals E	aten 50 to 75%	Lossi Manyara	/ Nec	xt 11		
24 Hr Bowel Ha	Movement within k	Eramingham Risk, CVI	10.40.30	Stroke 10-Yr		
Current Activity	Up in Chair	CLOCK SPIRITUAL CY	210111-000			

When the Box labeled "**Route**" which is just below **Temp (Current)** is clicked the following pop-up appears which allows you to designate how the temperature was taken.

			2009 9:25 AM	DOB	01/01/19		F		
Facility	Memorial Hermann	Baptist	Diagnoses			Status		Home	1
Provider	James L. Holly MD		Fredrickson Ty						7
PCP	James H	folly	Renal Stage I		e	Chronic	and the second se	Recent Events	P
Admit Status	Telemetry		CHF Diastolic /			Chronic	improve	Histories	į.
Code Status	Full Code	0	Hyperten Isola			<u> </u>	_	HPI	L
Visit Type	Attending		Anemia Unspe DM II Renal Ma		-1-	<u> </u>	_	Chronic Conditions	E
Residence	At Home Alone		DWI II Kenai Wa	anifestat Unco	ntr	<u> </u>	_	System Review	7
Vital Signs Weight	227.00 m	103.11 kg	-			<u> </u>	_	Physical Exam	2
Height	63.00 in	i contro ag		Addiso	al Diagnoses			Procedures	E
BM	40.21 kg/m*	2	-	Assessments				Laboratory	E
BP	138 / 8		-	Assessments	s into Problet	ni List		Hydration	7
Pulse		Reg Irreg	Admit Date	11/24/2009	Days T	his Stay	15	Nutrition	F
Pulse Ox	95 %		Estimated Dis	charge Date		11/27/	2009	Fall Risk	F
Current O2	1.0 State - St	room air	Days in ICU		(click in box	(to edit)	0	Skin Lesions	P
Resp Temp (current)	19 /min 98.60 ₩	36.96	Days on IV A	ntibiotics			0		P
Route	oral	Temperature R	oute 🗙	ilator <u>Currer</u>	nt Settings	L	0	Renal Failure	Į.
TMax (24 hrs)	98.80 F	-		s Stay	Date		Days Post	Radiology	į.
intoke (mL)	0	axillary				11		Procedures	Ŀ
Fluid Balance - T	-	ear oral			_	()		Guidelines	E.
Fluid Balance - F		rectal			1 /	11		Plan/Comments	2
Diet - Past 24 Hou	SPECIAL CONTRACTOR OF THE PARTY			us	0.020			Orders	2
Current Diet	Cardiac			bialysis C	res (* No		_	-	1
Appetite	Diminished			COLUMN TO A	Neo	t	1	Note	
Percent Meals E	Contraction of the local division of the loc			vsis / /	Nex	al c			
24 Hr Bowel Hx	Movement		Close	CVD 10-1	/r > 30	Stroke 10-	Yr 0		
Current Activity	Up in Chair								

The **third section** addresses diet, appetite, activity and whether physical therapy is seeing the patient. These fields are also automatically brought forward from the previous days Hospital Daily Progress Note and may be changed and updated if the information changes.

	Parrosa Nista	Seen By MD @	Patient	College	Test	()		
Daily P	rogress Note	11/25/2009 9:25 AM	DOB	01/01/192	20 Sex	F		
Facility	Memorial Hermann Baptist	Diagnoses	B. Lb marth		Status	1000	Home	1
Provider	James L. Holly MD	Fredrickson Type Renal Stage II Ch			Chronic		Recent Events	
PCP	James Holly	CHF Diastolic Acu	1.01.01.01.01.01.01.01	•	Chronic is		Of Contract States of Contract	
Admit Status	Telemetry	Hyperten Isolated			Chronic i	nprove	Histories	E
Code Status	Full Code	Anerria Unspecif			<u> </u>		HPI	
Visit Type	Attending	DM I Renal Manif	the state of the s	otr		_	Chronic Conditions	ы
Residence	At Home Alone		COINE CHICO				System Review	2
Vital Signs Weight	227.00 lb 103.1; kt				<u> </u>		Physical Exam	7
Height	63.00 in	-	Addition	al Diagnoses	1		Procedures	Г
BMI	40.21 kg/m*2			into Probler			Laboratory	E
BP	138 / 85 mmHg	A	sesaments	and Problem	List		Hydration	7
Pulse	92.00 /min I⊽ Reg Г	Irreg Admit Date 11	/24/2009	Days T	his Stay	15	Nutrition	Ē
Pulse Ox	95 %	Estimated Discha	rge Date		11/27/2	009	Fall Risk	Ē
Current O2	%, via room air	Days in ICU		(click in bax	to edit)	0	Skin Lesions	F
Resp Temp (current)	procession and procession	Days on IV Antik	iotics		_	0		P
Route	oral	Days on Ventilat	or <u>Curren</u>	t Settings	L	0	Renal Failure	E
TMax (24 hrs)	98.80 F	Surgeries This S	tay	Date		ays Post	Radiology	Þ
Intake (mL)	Output (mL)				1		Procedures	Ŀ
Fluid Balance -	LOCASSO STREET	2		_	1		Guidelines	
		over Time		1 /	1		Plan/Comments	2
Diet - Past 24 He	ours	Dialysis Status					Orders	7
Current Diet	Cardiac	Patient on Di	and the second second	res (* No	1		-	
Appette	Diminished	Nephrologist	100		11		Note	
Percent Meals		Leist Dielysis		Nex	1 11			
DALL Description		Eramingham Risk	CVD 10-1	7 > 30 1	Stroke 10-1	Vr O		
24 Hr Bowel H	y Up in Chair			-				

The second column displays the following

At the top of the screen, there is a button entitled "Seen by MD @." When depressed this notes the date and time that the healthcare provider saw the patient. Until this function is completed multiple reminders will appear to make certain that this crucial piece of data is added to the Daily Progress Note.

Daily Dr	cograded Nota	A DESCRIPTION OF THE OWNER OWNER OF THE OWNER OWN	lege	Test		
Daily PI	Ugress Note 11/25	/2009 9:25 AM DOB 0	1/01/1920	Sex F		
Facility	Memorial Hermann Baptist	Diagnoses	Sta	tus		1
Provider	James L. Holly MD	Fredrickson Type Ib Hyperlipopro	steinen		Home	
PCP	James Holy	Renal Stage II Chron Disease	0	ronic	Recent Events	2
Admit Status	Telemetry	CHF Diastolic Acute	0	ronic improve	Histories	
Code Status	Full Code	Hyperten Isolated Systolic			HPI	Г
Visit Type	Attending	Anemia Unspecified			Chronic Conditions	Е
Residence	At Home Alone	DM II Renal Manifestat Uncontr			System Review	7
Vital Signs	Inner Inner				Physical Exam	~
Weight Height	227.00 lb 103.1; kg 63.00 in	A define of PA		1 0	Procedures	E
BMI	40.21 kg/m*2	Additional Dir Assessments into	-	-	Laboratory	E
BP	138 / 85 mmHg	Assessments into	Problem Li	a	Hydration	7
Pulse	92.00 /min I Reg I Irreg	Admit Date 11/24/2009	Days This	Stay 15	Nutrition	E
Pulse Ox	95 %	Estimated Discharge Date	1	1/27/2009	Fall Risk	E
Current O2	%, via room air	Days in ICU (clic	k in bax to e	sdit) 0	Skin Lesions	F
Resp Temp (current)	98.60 #F 36.96 *C	Days on IV Antibiotics		0		P
Route	oral	Days on Ventilator <u>Current Se</u>	ttings		Renal Failure	P
TMax (24 hrs)	98.80 F	Surgeries This Stay	Date	Days Post	Radiology	Þ
Intake (mL)	Output (mL)		11		Procedures	Ŀ
Fluid Balance -	CONTRACTOR OF THE OWNER		11		Guidelines	
Fluid Balance - I		ine	1 11		Plan/Comments	2
Diet - Past 24 Ho	urs	Dialysis Status	C		Orders	7
Current Diet	Cardiac	Patient on Dialysis C Yes Nephrologist	t• No		-	
Appette	Diminished			11	Note	
Percent Meals E		Last Dialysis / /	Next	11		
24 Hr Bowel Hx	and the second se	Eramingham Risk CVD 10-Yr >	30 Stro	ke 10-Yr 0		
	Up in Chair					

The next section of the second column lists the diagnoses which were brought forward from the **Assessment of the admission H&P** or from the **previous day's hospital daily progress note**. This function allows the provider to bring forward all previous diagnoses and to note whether they are improved, still acute, resolved, or have another status. It also allows for new diagnoses to be added, which, if added, will be brought forward the following day.

This function allows for the automatic displaying of all diagnoses from this admission on the discharge summary which will be quickly and easily completed on the day of discharge, if the Hospital Daily Progress Note has been used each day of the admission.

Deile D	ALC: NO.	Seen By MD @	Patient	College	T	est		
Daily Pi	rogress Note	11/25/2009 9:25 AM	DOB	01/01/192	a se	F F		
Facility	Memorial Hermann Baptist	Diagnoses Fredrickson Typ	oe Ib Huserin		Status		Home	I.
Provider	James L. Holly MD	Renal Stage I			Chroni		Recent Events	7
PCP	James Holly	CHF Diastolic A				c improve	Histories	F
Admit Status	Telemetry	Hyperten Isolate					HPI	2
Code Status	Full Code	Anemia Unspe			<u> </u>	_		
Visit Type	Attending	DM I Renal Mar	and the later of the second second second	tr	<u> </u>	_	Chronic Conditions	
Residence	At Home Alone				<u> </u>	_	System Review	~
Vital Signs Weight	227.00 lb 103.1:	10			<u> </u>	_	Physical Exam	2
Height	63.00 in		1.00	Diagnoses	-	_	Procedures	
BM	40.21 kg/m*2		Additiona				Laboratory	
BP	138 / 85 mmł	1g -	Assessments	into Problem	n List		Hydration	7
Pulse	92.00 /min 🔽 Reg 🛙	Irreg Admit Date	1/24/2009	Days T	his Stay	15	Nutrition	
Pulse Ox	95 %	Estimated Disc	harge Date		11/27	//2009	Fall Risk	Ы
Current O2	%, via room a	ir Days in ICU	1	click in box	to edit)	0		
Resp	19 /min 98.60 ⊭F 36.96	Days on IV An	tibiotics			0	Skin Lesions	
Temp (current)	oral 0	Days on Ventil	ator <u>Ourrent</u>	Settings		0	Renal Failure	
Route TMax (24 hrs)	98.80 F	Surgeries This	Stay	Date		Days Post	Radiology	ы
Intake (mL)	Output (mL)			1	1		Procedures	
Fluid Balance -	COLORADO COLORADO E				1		Guidelines	
Fluid Balance -		o Over Time		1 1	1		Plan/Comments	7
Diet - Past 24 Ho	11100 00 00000000000000000000000000000	Dialysis Statu					Orders	7
Current Diet	Cardiac		Dialysis C Y	es 🕫 No	1			
Appette	Diminished	Nephrolog	Cold Cold		_	100	Note	
Percent Meals E	aten 50 to 75%	Last Dialys	sis //	Nex	t J	H.		5
24 Hr Bowel Hx	Movement within k	Eramingham B	CVD 10-Y	× 30 4	Stroke 1	0.7/0		
	Up in Chair	CTARGEORY CONTRACTOR				0.11[2]		

The next function of the second column is two buttons:

• Additional diagnosis – this allows you to expand your diagnoses list from 8 to 15.

Daily Dra	eres Note	Seen By MD @ Patie	nt College	Test			
Daily Pro	gress Note	/25/2009 9:25 AM DOB	01/01/19	20 Sex	F		
Facility M	emorial Hermann Baptist	Diagnoses		Status		Home	ı.
Provider Ja	whes L. Holly MD	 Fredrickson Type Ib Hyp 			_		7
PCP Je	ames Holly	 Renal Stage II Chron Dis 	ease	Chronic		Recent Events	È.
Admit Status	elemetry	CHF Diastolic Acute		Chronic in	prove	Histories	E.
Code Status	ull Code	- Hyperten Isolated Systol	C	<u> </u>	_	HPI	ы
Visit Type	ttending	Anemia Unspecified DM I Renal Manifestat U		<u> </u>		Chronic Conditions	
Residence A	t Home Alone	DW TRenat Mantestat U	ncontr	<u> </u>	_	System Review	7
Vital Signs Weight	227.00 lb 103.1; kg			-	-	Physical Exam	7
Height	63.00 in	0.44	tional Diagnoses			Procedures	Г
BM	40.21 kg/m*2		ents into Probler			Laboratory	F
BP	138 / 85 mmHg		eras nas Problet	II CISI		Hydration	7
Pulse	92.00 /min IV Reg Irr	eg Admit Date 11/24/200	9 Days T	his Stay	15	Nutrition	F
Pulse Ox	95 %	Estimated Discharge Da	te	11/27/20	09	Fall Risk	F
Current O2 Resp	%, via room air 19 ánin	Days in ICU	(click in box	to edit)	0	Skin Lesions	r
Temp (current)	98.60 *F 36.96 *C	Days on IV Antibiotics	and the second	_	0	Renal Failure	F
Route	oral		rrent Settings	L	0	Radiology	F
TMax (24 hrs)	98.80 F	Surgeries This Stay	Date		ays Post	Procedures	F
Intake (mL)	Output (mL)			1	_	Guidelines	F
Fluid Balance - Too	and the second s			\overline{r}	_	Plan/Comments	7
Fluid Balance - Ru	00.00000000000000000000000000000000000	Dialysis Status					7
Diet - Past 24 Hours Current Diet	Cardiac	Patient on Dialysis	Yes 🗭 No			Orders	1
Appette	Diminished	Nephrologist		12	100	Note	1
Percent Meals Eate	n 50 to 75%	Last Dialysis	11 Nex	t 11		2	8
24 Hr Bowel Hx	Movement within k	Eramingham Risk CVD 1	0 4 30	Stroke 10-Y	. [n]		
	Up in Chair	CIONERSINE CAD I	10-11/2-30	Stroke TO-Y	10		

Assessments into Problem list – this allows you to place a check mark by any diagnosis which you wish to add to the permanent Problem List in NextGen. This then allows you to associate medications with the problems for which they are being prescribed. (This function is described in detail on the HCC Risk Tutorial under the heading "Associating Medications with the RxHCC Risk Diagnosis in the EMR Medication Module." Click <u>Here</u> to review this function)

	Proc	ress Note	Seen By MD @		atient College	Test	_		
	-		11/25/2009 9:25 AM	D	08 01/01/1920	Sex	F	_	
	Proble	mcopy Prog						×	1
er		0	A	-	- Information Parks				5
		Copy	Assessments	to Pr	oblem List i	viodule	¥	Events	鮰
tatus	Sele	of the boxes next d	o the diagnoses listed b	elow to	convithern to Proble	em List mo	dule.	ories	
Status			ur selections, click OK t			UTT LIDY III	- and	1P1	
ype								Conditions	ы
nce	Dail	y Progress Assessme	nts	Chr	onic Assessments			Review	~
gns	E	Fredrickson Type Ib	Hyperlipoprote		DM I Renal Manifest	tat Control		al Exam	7
ht nt	E	Renal Stage I Chron	Disease	Г	CHF Diastolic Chroni	C		soures	Ы
<u> </u>	Г	CHF Diastolic Acute		Г	Renal Stage I Chron	n Disease		ratory	ы
	E	Hyperten Isolated Sy	stolic	Г	Hyperten Benign Es	sential		ration	7
e	Г	Anemia Unspecified		Г	Lipid Hyperchol Pure	Type Ia			F
Ox	Г	DM II Renal Manifest	at Uncontr		Esophagitis Reflux			rtion	늰
nt 02	E			Г	Amputation Above H	(nee Uncom	al C	Risk	
	Г	0		Г	DM II Renal Manifest	at Control	i de la compañía de la	esions	ы
o (cum	E				Angina Pectoris Stal	ble		Falure	
e	F			Г	Cardiac PTCA Stent			ology	
(24 h	Г			Г	CAD Ischemic Heart	Dis Chronic	5 1	adures	
(mL)	F	S		Г	Anemia Unspecified	ł		eines	ы
Balan	Г	0		Г	Zenker's Diverticulu	m		omments	7
Balani ast 2	E			Г	CAD Angioplasty PT	CA Stent		ders	7
ast 2 nt Diet	E			Г	Metab Cardiometabo	lic Risk Syn		Per a	1000
te		360	94/		8.			ote	1

The last seven functions in the second column relate to:

- Length of stays this is automatically calculated each day
- Estimated discharge date
- Days in ICU,
- Days on IV antibiotics
- Days on Ventilator
- Surgeries this stay
- Dialysis status
- Patient on dialysis yes or no
- Nephrologist
- Last Dialysis
 Next Dialysis
- Framingham Cardiovascular and Cerebrovascular Risk

Daily Dree	man Note	Seen By MD @	Patient	College	Test	()		
Daily Prog	gress Note	25/2009 9:25 AM	DOB	01/01/19	20 Sex	F		
Facility Mo	morial Hermann Baptist	Diagnoses			Status	100	Home	1
District and the second s	mes L. Holly MD	Fredrickson Typ						7
PCP Ja	mes Holly	Renal Stage I C	the set of the set of the set of the	e	Chronic		Recent Events	È.
Admit Status	lemetry	CHF Diastolic Ac			Chronic is	nprove	Histories	
Code Status Fu	ll Code	Hyperten Isolate			<u> </u>		HPI	
Visit Type Att	tending	Anemia Unspec	states in the second second second		<u> </u>		Chronic Conditions	
Residence At	Home Alone	DM I Renal Man	festat Unco	ntr	<u> </u>		System Review	7
Vital Signs Weight	227.00 lb 103.1+ kg				<u> </u>		Physical Exam	7
Height	63.00 in		A station	al Diagnoses	1		Procedures	
BM	40.21 kg/m*2			ai Diagnoses s into Probler			Laboratory	C
BP	138 / 85 mmHg		ssessment	s into Probler	n List	_	Hydration	7
Pulse	92.00 /min IV Reg [Irre	9 Admit Date 1	1/24/2009	Days T	his Stay	15	Nutrition	Ы
Pulse Ox	95 %	Estimated Disch	STATUS CONTRACTOR OF THE OWNER		11/27/2		Fall Risk	2
Current O2	%, via room air	Days in ICU		(click in box	to edit)	0		
Resp	19 /min	Days on IV Anti	biotics			0	Skin Lesions	
Temp (current)	98.60 MF 36.96 MC	Days on Ventila	tor <u>Curren</u>	nt Settings		0	Renal Failure	
Route	98.80 F	Surgeries This :	Stay	Date	0	ays Post	Radiology	
TMax (24 hrs)	Output (mL)	-			1		Procedures	
Intake (mL)	Contraction of the local division of the loc				1		Guidelines	
Fluid Balance - Tod Fluid Balance - Run	Sector and the sector of the s	Tree			1	5 m 1	Plan/Comments	7
Diet - Past 24 Hours	0.0000000000000000000000000000000000000	Dialysis Statu:	•				Orders	7
Current Diet	Cardiac	20.000000000000000000000000000000000000		Yes 🕫 No	1		Citacito	
Appette	Diminished	Nephrologis	100 m		_	100	Note	
Percent Meals Eater	n 50 to 75%	Last Dialysi	s I I	Nex	t] 11	1		8
24 Hr Bowel Hx	Movement within k	Eramingham Ris	CVD 10-1	1 > 30	Stroke 10-1	0		
	Up in Chair	C. State of Contractor	orb ros		30 000 10			

Special Functions related to days in ICU, days on IV antibiotics, Days on Ventilator in the above:

If you click within the box next to one of these functions, the following pop-up appears:

alty Me	morial Hermann Baptist	Diagnoses	Status	
	nes L. Holly MD	Fredrickson Type Ib Hyperlipoprotei	nen	Home
1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 - 1977 -	nes Holly	Renal Stage II Chron Disease	Chronic	Recent Events
	ies [noiy	CHF Diastolic Acute	Chronic improve	Histories
nit Status Pro	gress Daily			×
de Status	Berner Wen			10.12
t Type	Da	aily Progress Note Dail	ly Details	
idence		any riogress note but	iy Dolano	
al Signs Neight	Please answer the follo	wing questions to help calculate the d	etails of this nationt's h	nepital star
leight		rang questions to nelly calculate the a	orang of this pensities in	Copical Scoy.
M	Has the patie	nt been in the ICU within the last 24 hours?	C Yes C No	6
3P	11.00 M			
<i>n</i>				
dea .	mas the paper	nt been on IV antibiotics within the last 24 h	ours? C Yes C No	0
Pulse Pulse Ox		nt been on IV antibiotics within the last 24 h nt been on a ventilator within the last 24 ho		р ()
ulse Ox urrent O2				9 6
ilse Ox irrent O2 ssp		nt been on a ventilator within the last 24 ho		5 ()
ulse Ox urrent O2 esp emp (current <mark>)</mark>				5 }
lse Ox irrent O2 isp inp (current) iute		nt been on a ventilator within the last 24 ho		5 17
ulse Ox urrent O2 esp emp (current) oute Max (24 hrs)		nt been on a ventilator within the last 24 ho		8
áse Ox arrent O2 ssp imp (current) xute faax (24 hrs) ske (mL)	Has the paties	nt been on a ventilator within the last 24 ho		Guidelines
ulse Ox urrent O2 esp emp (current) oute Max (24 hrs) take (mL) uid Balance - Tode	Has the paties	nt been on a ventilator within the last 24 hor	urs? CYes CNo	Guidelines
ulise Ox current O2 lesp emp (current) loute Max (24 hrs) take (mL) luid Balance - Todd luid Balance - Rund	Has the paties	Time Dialysis Status	urs? C Yes C No	Plan/Comments
111111	Has the paties	nt been on a ventilator within the last 24 hor	urs? C Yes C No	
Pulse Ox Current O2 Resp Remp (current) Route (Max (24 hrs) ntake (mL) Fluid Balance - Rum the Past 24 Hours Current Diet	Has the patient 	Time Dialysis Status	urs? C Yes C No	Plan/Comments
ulise Ox current O2 lesp emp (current) toute Max (24 hrs) take (mL) huid Balance - Tode huid Balance - Runs t - Past 24 Hours urrent Diet uppetite	Has the paties	Time Dialysis Status Patient on Dialysis (<u>Yes</u>	urs? C Yes C No	Plan/Comments Orders
ulse Ox urrent O2 esp emp (current) oute Max (24 hrs) take (mL) uid Balance - Tode uid Balance - Run t - Past 24 Hours urrent Diet	Has the paties	Time Dialysis Status Nephrologist	urs? C Yes C No	Plan/Comments Orders

For any day that one of the above applies, if you click in the box and then check the box which applies, it will total the days in ICU, on IV antibiotics, and/or on a ventilator. That information will then be transferred to the discharge summary upon the patient's discharge from the hospital.

Additional Special Function related to Days on Ventilator:

Beside the "days on ventilator" function there is a button entitled "Current Settings." If you deploy that button, you can document the patient's current vent settings. There are several other ventilator functions in the Hospital Daily Progress Note which will be discussed later.

Daily P	rogress Note	Seen By MD @ Patient	College	Test		
Daily F	iogress Note	11/25/2009 9:25 AM DOB	01/01/192	0 Sex F		
Facility	Memorial Hermann Baptist	Diagnoses		Status		t.
Provider	James L. Holly MD	Fredrickson Type Ib Hyperi			Home	-
PCP	James Holly	Renal Stage II Chron Disea:	pe	Chronic	Recent Events	2
Admit Status	Telemetry	CHF Diastolic Acute		Chronic improve	Histories	
Code Status	Full Code	Progress Ventcurr		Ð	с нр	
Visit Type	Attending	Current Venti	lator S	ottinge	Chronic Conditions	
Residence	At Home Alone		Service Statistics	ettings	System Review	7
Vital Signs	227.00 lb 103.14 kg	Last Updated/Chang	jed / / /		Physical Exam	2
Weight Height	227.00 lb 103.14 kg 63.00 in	1	1		Procedures	C.
BM	40.21 ka/m*2	Mode	-		Laboratory	r
BP	138 / 85 mmHg	Rate Tidal Volume	-	Amin	Hydration	7
Pulse	92.00 /min 🔽 Reg 🗆	Peak Flow	i	mL L/min	Nutrition	21
Pulse Ox	95 %	Inspiration/Expiration Ratio	<u> </u>	Can		2
Current O2	%, via room air	FIO2	-		Fall Risk	2
Resp	19 /min 98.60 /F 36.96	Pressure Support	-	2* cm H2O	Skin Lesions	
Temp (current)	98.60 *F 36.96	PEEP		cm H20	Renal Failure	
Route TMax (24 hrs)	98.80 F	Vent Sensitivity	0	cm H20	Radiology	ы
Intake (mL)	Output (mL)	YOR OUTSETRY	1	CIN PLEO	Procedures	
Fluid Balance -	A CONTRACTOR OF THE OWNER OWNE	Comments			Guidelines	E.
Fluid Balance -					Plan/Comments	7
Diet - Past 24 Ho	and a second s				Orders	7
Current Diet	Cardiac	OK	Cancel	t		
Appetite	Diminished		Caricer		Note	
Percent Meals I	and the second se					
24 Hr Bowel Ho	and the second s	Fremingham Rick CVD 10-	Yr > 30 \$	troke 10-Yr 0		
Current Activity	/ Up in Chair					
4						

The third column of the Master Progress template displays 20 Navigation Buttons.

Remember: Once you have the Hospital Daily Progress Note opened, all subsequent navigation should be via these buttons. The following 17 buttons are common to other functions of the EMR. Their function can be found on the tutorial noted beside each:

- Home navigates you back to the AAA Home template
- History GP Master tutorial
- HPI GP Master tutorial
- Chronic conditions GP Master tutorial
- Systems Review GP Master tutorial
- Physical Examination -- GP Master tutorial
- Procedures Discharge Summary tutorial
- Laboratory Discharge summary tutorial
- Hydration Nursing Home tutorial
- Nutrition Nursing Home tutorial
- Fall Risk Nursing Home Tutorial
- Skin Lesions -- Nursing Home Tutorial

- Renal Failure no tutorial for this function at this time
- Radiology GP Master Tutorial
- Procedures GP Master Tutorial
- Guidelines Nursing Home Tutorial
- Note this creates the chart note and the order sheet once the Daily Progress note has been completed.

The following buttons are new and are unique to the **Hospital Master Progress note** and their use will be reviewed in this tutorial:

- Recent Events
- Plan/comments
- Orders

		Diagnoses	Status		
2000 C	Memorial Hermann Baptist	Fredrickson Type Ib Hyperlipoproteiner	in an	Home	
	James L. Holly MD	Renal Stage I Chron Disease	Chronic	Recent Events	2
	James Holly	CHF Diastolic Acute	Chronic improve	Histories	
- The second sec	Telemetry	Hyperten Isolated Systolic		HPI	
Cours Crouds	Full Code	Anemia Unspecified	í I	Chronic Conditions	F
	Attending At Home Alone	DM I Renal Manifestat Uncontr	·		
1.	AL Home Alone			System Review	Ľ
Vital Signs Weight	227.00 lb 103.1; kg			Physical Exam	M
Height	63.00 in	Additional Diagnos	es	Procedures	
BM	40.21 kg/m*2	Assessments into Probl		Laboratory	
BP	138 / 85 mmHg		chi List	Hydration	7
Pulse	92.00 /min I⊽ Reg [Irreg	Admit Date 11/24/2009 Days	This Stay 15	Nutrition	
Pulse Ox	95 %	Estimated Discharge Date	11/27/2009	Fall Risk	Ы
Current O2	%, via room air	Days in ICU (click in bo	ox to edit)		
Resp	19 /min 98.60 #F 38.96 *c	Days on IV Antibiotics	0	Skin Lesions	
Temp (current)	0ral	Days on Ventilator Current Settings	0	Renal Failure	
Route TMax (24 hrs)	98.80 F	Surgeries This Stay Date	Days Post	Radiology	ы
Intake (mL)	Output (mL)	-	11	Procedures	
Fluid Balance - T	1.000		11	Guidelines	
Fluid Balance - R		Terra	11	Plan/Comments	2
Diet - Past 24 Hou		Dialysis Status		Orders	7
Current Diet	Cardiac	Patient on Dialysis 🖉 Yes 💿 N	0		
Appetže	Diminished	Nephrologist		Note	
Percent Meals Ea	ten 50 to 75%	Last Dialysis // N	axt 11		
24 Hr Bowel Hx	Movement within k	Eraminsham Bisk, CVD 10-Yr > 30	Stroke 10-Yr		
	Up in Chair				

The *Recent Events* navigation button opens a template entitled *Pertinent Events of the Past 24 Hours*

The above information and the co.	mments will print at the	e top of the note as the "Current Impression."	Comments	Rehabilitation
ardio/Pulmonary	Status	Gastro/Digestive	Status	
Chest Pain	Improving			
Shortness of Breath	Improving			_
				=
fental.Neurological	Status	Infection/Reaction	Status	
				Transfusion Info
	— <u>;</u>		-i	-
[
		_	_	-
ain/Swelling	Location	Status Other/General	10	Status
□ Pain □ Swelling □ Redness				1
□ Pain □ Swelling □ Redness				
□ Pain □ Swelling □ Redness				
F Pain F Swelling F Redness				- I
□ Pain □ Swelling □ Redness				

The Pertinent Events of the Past 24 Hours template is organized into four sections.

The **first section** at the top contains:

Four radial buttons which allow you to document the patient's current condition as:

- No significant changes or events
- Overall conditions
 - Worsening
 - Stable/no change
 - Improving

Below these options is a note in red which states, "The above information and the comments will print at the top of the daily hospital progress note as the 'Current Impression.'" The importance of this is that the information which consultants and others are most interested in will appear at the beginning of the note. They will not have to turn multiple pages to find what they need. While it is impossible to create an adequate Hospital Daily Progress Note with a one-page

document, it is possible to place on the front page 90% of the information other providers or care-givers will need in order to participate effectively in a patient's care.

ardio/Pulmonary	Status	Gastro/Digestive	Status	
Chest Pain	Improving			
Shortness of Breath	Improving			=
				=
l fental.Neurological	Status	Infection/Reaction	Status	_
				Transfusion Info
				_
-	-i	- i	—i—	-
ſ				
ſ				
	ocation	Status Other/Gener	al	Status
Pain F Swelling F Redness				
Pain Swelling Redness				
Pain Swelling Redness Pain Swelling Redness				
□ Pain □ Swelling □ Redness □				

To the right of the comment about "current impressions" above are two functions:

1. **Comment** – clicking this button launches a box where you can type in a specific comment which does not fit within the structured data responses.

The above information and th	e comments will print at th	e top of the note as the "Current Impression."	Comments	Rehabilitation
ardio/Pulmonary	Status	Gastro.Digestive	Status	
Chest Pain	Improving			
Shortness of Breath	Improving	_	_	-1
P	rogress Recentc		×	-
	Rec	ent Events Comments		-
lental/Neurological				
				Transfusion Info
				_
				-
				-8
				-
ain/Swelling				Status
□ Pain □ Swelling □ Re				Status
Pain Sweling Re	[OK Cancel		í.
	-			i —
Construction of the second of the second s				<u> </u>
□ Pain □ Swelling □ Ro □ Pain □ Swelling □ Ro □ Pain □ Swelling □ Ro				

2. **Rehabilitation** – clicking on this button launches a pop-up which allows the documentation of an inpatient's progress on a rehab service.

Transfer		Walker	
Bed to Chair with		Number of Steps	Return
Bed to Wheelchair with		Assistance Required	Over Time
Wheelchair to Toilet with		Frequency	
		Stability	
Stairs		Contact Guard	—
Number of Steps			
Assistance Required		Modified Independent	-
Frequency	times/day		
Contact Guard		Gait & Balance Normal	
Parrallel Bars		Abnormal	_
Number of Steps		Г	
Assistance Required		Foot Drop	
Frequency	times/day	Left	
Contact Guard		Right	
		dependent (timely, safely) pendent (device)	
		lence tance (subjective - 75% independent) sistance (subjective - 50% independent)	
		dence stance (subjective - 25% independent) nce (subjective - 0% independent)	

The functions on this pop-up are obvious but allow the documentation of quantitative measures as well as qualitative judgment of a patient's rehabilitation progress. To the right of this pop-up is a button entitled "over time" – this allows the display of the assessment of rehabilitation progress over multiple days to be reviewed without going from note to note.

Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Guard	Malker Paraleli Bars Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Quard	Malker Paraleli Bars Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact C	Paralell Bars av Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Guard					and the second se	Steps	(interaction of	Assistance	Contact Guard
Walker Paralell Bars Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Quard	Walker Paralell Bars Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Quard	Valker Paralell Bars Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact C	Paralell Bars av Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Guard									
Valker Paralell Bars Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Guard	Valker Paralell Bars Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Quard	Valker Paralell Bars Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact C	Paralell Bars av Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Guard									
Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Guard	Date & Time Steps Times/Day Assistance Stability Contact C	Date & Time Steps Times/Day Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact	ay Assistance Stability Contact C Date & Time Steps Times/Day Assistance Contact Guard	•L			<u>•</u>					
				alker				Paralell Bars				
				Date & Time	Steps 1	Times/Day Assistance	nce Stability Contact	Date & Time	Steps	Times/Day	Assistance	Contact Guard
							<u>.</u>					

At the bottom of the rehabilitation template is a **legend** of definitions for standardizing the qualitative assessment of progress in rehab.

Transfer		Walker	100 million (100 m
Bed to Chair with		Number of Steps	Return
Bed to Wheelchair with		Assistance Required	Over Time
Wheelchair to Toilet with			
wheelchair to Tollet with T		Frequency I times/c Stability	any
Stairs		Contact Guard	-
Number of Steps		Contact Guard 1	
Assistance Required		Modified Independent	-
Frequency	times/day	Modified independent 1	
Contact Guard		Gait & Balance	
Parrallel Bars		Abnormal	-
		Abroma	-
Number of Steps			
Assistance Required		Foot Drop	-
Frequency	times/day	Left	-
Contact Guard	-	Right	
	6 Modified Inde Modified Depend	dependent (limely, safely) pendent (device) fence	
		stance (subjective - 75% independent) sistance (subjective - 50% independent)	
		idence stance (subjective - 25% independent) nce (subjective - 0% independent)	
	-		

The next three sections of the **Pertinent Events of the Past 24 hours** allow the documentation of specific events in a structure-data format for:

- Cardiopulmonary
- Gastro/digestive
- Mental/Neurological
- Infection/Reaction

Each of these has a place for multiple responses from structured pick-lists which relate to may possible events, complications, or changes in a patient's condition.

No Significant Changes	Progress Cp	Stable/No Chang	e C Improving	Return
The above information and t		rent Impression."	Comments	Rehabilitation
ardio/Pulmonary	No Adverse Events or Problems Arrest, Cardiac	-	Shahan	
Chest Pain	Arrest, Cardiorespiratory	-	Status	-
Shortness of Breath	Arrest, Respiratory			-3
Shortness of Breath	Atrial Fibrilation			-1
	Blood Pressure Controlled Blood Pressure Improved			_
	Blood Pressure Improved Blood Pressure Uncontrolled			1
	Bradycardia			
	Chest Griping Pain			
ental/Neurological	Chest Pain	-	Status	
cinamediological	Chest Pain w/Palpation of Chest Wall Chest Pain w/Respirations	-		Transforder
	Chest Pain, At Rest			Transfusion Info
	Chest Pain, Precordial			_
	Chest Pain, w/Diaphoresis			_
	Chest Pain, w/Nausea Chest Pain, w/o Diaphoresis			
	Chest Pain, w/o Diaphoresis Chest Pain, w/o Nausea			8
	Chest Pain, w/o Radiation			-
in/Swelling	Chest Pain, w/o SOB	Other/General	11/2	Status
NOT REAL PROPERTY AND A DESCRIPTION OF A	Chest Pain, w/Ratiation Into Jaw Chest Pain, w/SOB	Uner/General		Status
Pain Swelling Red	Chest Pressure			<u> </u>
🏳 Pain 🗂 Swelling 🗂 Redi	Chest Tightness			
🏳 Pain 🗌 Swelling 🗐 Redi	Cough, Clear Sputum			
Pain Swelling Red	Cough, Greenish Sputum			
F Pain F Swelling F Red	Cough, Non-Productive Cough, Productive			
	Cough, Yellowish Sputum			
	Episode of Hypotension			
	Episode of Hypotension Resolved			
	Episode of Hypotension w/Fluid Challenge Episode of Hypotension w/Pressor Agent			
	Heart Attack			
	Hemoptysis			
	Intubated and Moved to ICU			
	Pain On Deep Inspiration, LLL			
	Pain On Deep Inspiration, ALL Respiratory Capacity Dimished			
	Respiratory Capacity Dimished Respiratory Failure			
	Shortness of Breath			
	Tachycardia			

To the right of these four options is a button entitled "**Transfusion Info**." This allows the documentation of transfusions. The options allow you to document:

- the number of units,
- the type of blood product and
- the date of the event.

This information will automatically be added to the discharge summary at the end of the inpatient care.

The above information and the comm	nents will print at the top	o of the note as the "Current Impression."	Comments	Rehabilitation
Cardio/Pulmonary	Status	Gastro/Digestive	Status	
Chest Pain	Improving		_	_
Shortness of Breath	Improving			-
	- Progress Trans		×	
	-11	100		-
	-14	Transfusions		-
fental/Neurological				
nemai neurological		s Type Date Bloodproduct	×	Transfusion Info
i	-11			
	-il	Fresh Frozen Pla	sma	-
	-1 -	Packed Cells Platelets		
[-1			
[-11	-		-
ain/Swelling Lo	cati			Status
□ Pain □ Swelling □ Redness □				
F Pain F Swelling F Redness				
Pain Swelling Redness			Close	
Pain Swelling Redness		ок		
□ Pain □ Swelling □ Redness				

The last section of the **Pertinent Events of the past 24 hours** template displays two functions:

• Pain/Swelling/Redness

This provides further opportunity to document precise changes in the patient's condition under headings for "pain, swelling, redness." The provider can click on one of these three and select the proper location from the pick list

No Significant Changes or E	Events Over	Location	X Stable/No Chang	e C Improving	Return
The above information and the o			moression.*	Comments	Rehabilitation
ardio.Pulmonary	Status	Ankle Both		Status	
Chest Pain	Improving	Ankle L			
Shortness of Breath	Improving	Ankle R Arm Both Arm L Arm B			
1		- Elbow Both Elbow L Elbow B			-
l fental/Neurological	Status	Finger All Finger L Finger B		Status	Transfusion Infe
		Foot Both			
		- Foot R Hand Both		-	-
		- Hand L L Hand R Head			_
ain/Swelling	Location	Hip Both Hip L	r/General	de la	Status
F Pain F Swelling F Rednes		Hip R Knee Both			
Pain Swelling Rednes		Knee L			
Pain C Swelling C Rednes		Knee R			
□ Pain □ Swelling □ Rednes		Leg Both	1		
Pain Swelling Rednes	\$	Leg L Leg R			1
		Low back			
		Middle back Multiple Joints			
		Neck			
		Sacrum			
		Shoulder Both Shoulder L			
		Shoulder L Shoulder R			
		Toes All			
		Toes L			
		Toes R			
		Upper back Wrist Both			

• Other/General

This provides further opportunity to document precise changes in the patient condition under headings of "**other/General**"

No Significant Changes or Even	ts Overall C	Condition C Worsening 🕤 Stable/No Chan	ge C Improving	Return
The above information and the comi	ments will print at the	e top of the note as the "Current Impression."	Comments	Rehabilitation
ardio/Pulmonary	Status	Gastro/Digestive	Status	
Chest Pain	Improving			
Shortness of Breath	Improving			-
	-			
lental/Neurological	Status	Infection/Reaction	Status	Transfusion Info
	-i	-	-i	
		-	_	-
i	-iiiiii	- i	Progres	- s Other
	ocation	Status Other/General		
Pain Swelling Redness				lverse Events or Problems Status: Discuss with Famil
Pain Swelling Redness			Code 9	Status: Patient is DNR
Pain Swelling Redness				Status: Patient is Full Code
Pain Swelling Redness				It Sleeping Contusion
□ Pain □ Swelling □ Redness □		J		Fracture
				Laceration o Injury
			Insom	nia
				ds Discontinued t Refused IV
				t Refused Labs
			Patien Patien Patien	t Refused Physical Thera t Refused Procedures t Refused Vital Signs
			Patien Patien Patien Patien	t Refused Physical Thera t Refused Procedures t Refused Vital Signs t Removed IV
			Patien Patien Patien Patien Patien	t Refused Physical Thera t Refused Procedures t Refused Vital Signs

With these tools, it is possible to prepare an accurate and detailed account of the patient's last 24 hours in the hospital.

The Hospital Master Progress Plan Template

The second template which is unique to the **Hospital Master Progress** suite is the **Plan Template**, When you the activate the 18th button in the Navigation list on the **Master Progress template**, which is entitled **Plan/Comment**, it launches a template entitled the **Daily Progress Plan**.

edrickson Type IIb Hyperlipoproteiner edrickson Type IIb Hyperlipoproteiner enal Stage II Chron Disease F Diastolic Acute CHF General improvement. The patient's pulmonary congestion has improved and the perlpheral edema has lessened. Patient is able to lay flat without difficulty and is able to ambulate without SOB. perten Isolated Systolic Hypertension F The patient's current blood pressure is 138/85 mmHg. The patient's blood pressure is classified as High-Normal (Pre-Hypertensive). The patient's blood pressure is improving. The patient has the following memia Unspecified Anemia	Diagnosis	Category		Plan/Comments
F Diastolic Acute CHF General improvement. The patient's pulmonary congestion has improved and the peripheral edema has lessened. Patient is able to lay flat without difficulty and is able to ambulate without SOB. The patient's current blood pressure is 13885 mmHg. The patient's blood pressure is classified as High-Normal (Pre-Hypertensive). The patient's blood pressure is improving. The patient has the following memia Unspecified Anemia	Fredrickson Type Ib Hyperlipoproteiner]		
I or a second and the peripheral edema has bestered. Patient is able to lay flat without difficulty and is able to ambulate without SOB. I approved and the peripheral edema has bestered. Patient is able to lay flat without difficulty and is able to ambulate without SOB. I approved and the peripheral edema has bestered. Patient is able to lay flat without difficulty and is able to ambulate without SOB. I approved and the peripheral edema has bestered. Patient is able to lay flat without difficulty and is able to ambulate without SOB. I approved and the peripheral edema has bestered. Patient is able to lay flat without difficulty and is able to ambulate without SOB. I approved and the peripheral edema has bestered. Patient's blood pressure is classified as High-Normal (Pre-Hypertensive). The patient's blood pressure is improving. The patient has the following imain Unspecified I Anemia I The patient's HighA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	Renal Stage II Chron Disease] [
Interplatents Interplatents Interplatents	CHF Diastolic Acute] [CHF	되 -	improved and the peripheral edema has lessened. Patient is able to
I Renal Manifestat Uncontr Diabetes The patient's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	Hyperten Isolated Systolic	Hypertension	4	blood pressure is classified as High-Normal (Pre-Hypertensive). The
mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	Anemia Unspecified	Anemia		
	DM II Renal Manifestat Uncontr] [Diabetes	되 -	mean plasma glucose of 203 mg/dL. The patient's diabetes is not well
] [
]		I
				1

The purpose of this template is to enable a provider to prepare a **Treatment Plan** for the conditions for which a patient is admitted to the hospital, or for conditions which are co-morbidities of a patient admitted to the hospital.

The **Hospital Daily Progress Plan** template has two sections. The first section which is at the top of the template on the same line as the template's name, has two buttons:

• Additional Diagnoses – this button launches additional diagnoses which can will be completed if the patient has more valid diagnoses than those which appear on the Daily Progress Plan.

	Norman Make	Seen By MD @	Patient	College	Test			
Daily P	rogress Note	11/25/2009 9:25 AM	DOB	01.01/19:	20 Sex	F		
	International Provint			5	Status			
Facility	Memorial Hermann Baptist James L. Holly MD	- Fredrickson Typ	pe lib Hyperli		[_	Home	L
Provider	James L. Holly MD	Renal Stage II C	Chron Diseas	e	Chronic		Recent Events	P
XCP	Telemetry	CHF Diastolic A	cute		Chronic in	nprove	Histories	E
Admit Status Code Status	Full Code	Hyperten Isolate	ed Systolic		<u> </u>		HPI	Г
/isit Type	Attending	Anemia Unspe	cified		[Chronic Conditions	F
lesidence	Progress Acutedx					×	System Review	7
ital Signs							Physical Exam	7
vVeight	Daily Proc	gress Note Add	litional	Diagn	oses		Procedures	F
Height								F
BMI BP			-				Laboratory	-
Pulse			-1-				Hydration	Ľ
Pulse Ox			-1-				Nutrition	1
Current O2							Fall Risk	E
Resp							Skin Lesions	E
Temp (current)			-1-				Renal Failure	E
Route							Radiology	r
TMax (24 hrs)			194			ost	Procedures	r
ntake (mL)			· · · · · ·			H	Guidelines	F
Fluid Balance -		OK C	ancel			H	Plan/Comments	V
Fluid Balance -	222					ľ	Orders	7
iet - Past 24 He Current Diet	Cardiac	Patient on	Dialysis C	Yes 🖸 No			Urders	1
Appetite	Diminished	Nephrologi	st 🗌		44	i di sa	Note	1
	Eaten 50 to 75%	Last Dialys	is /	/ Nex	1 11		3 	1
Percent Meals								
	x Movement within I	Ereminaham Ri	CMD 10.3	24 × 30 - 10	Stroke 10-Y			

• **Orders** – this button launches the same template as is activated by depressing the 19th Navigation button in column three of the Master Progress template. The "**Order**" template will be described in detail below (**to review this template click here**)

Specific Plans for all or some of the diagnoses

The second section of the **Daily Progress Note** template displays the first eight diagnoses which appear on the Master Progress template. The next seven diagnoses, if there are more than 8, up to a maximum of 15, appear when the "**additional diagnoses**" button is launched as described above.

Here it is possible to type specific plans which apply to each diagnosis. The idea of the Master Progress Plan function is to make it possible to complete precise, detailed and complete evaluations of the patient's status and progress while in the hospital.

There is also another way of completing this section and that is with the "Categories" function.

redrickson Type IIb Hyperlipoproteinerr Image: Stage II Chron Disease Itenal Stage II Chron Disease Image: Stage II Chron Disease HF Diastolic Acute Image: CHF Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Disease Image: Stage II Chron Diseas	iagnosis	Category		Plan/Comments
HF Diastolic Acute CHF Image: CHF General improvement. The patient's pulmonary congestion has improved and the peripheral edema has lessened. Patient is able to lay flat without difficulty and is able to ambulate without SOB. Nyperten Isolated Systolic Hypertension Image: CHF The patient's current blood pressure is 138.85 mmHg. The patient's blood pressure is 138.85 mmHg. The patient's blood pressure is classified as High-Normal (Pre-Hypertensive). The patient's blood pressure is improving. The patient has the following Image: I	Fredrickson Type IIb Hyperlipoproteiner			FAILCOMMENTS
Consistence of the period	Renal Stage II Chron Disease			,
M II Renal Manifestat Uncontr	CHF Diestolic Acute] Tohe	되 -	improved and the peripheral edema has lessened. Patient is able to
M II Renal Manifestat Uncontr Diabetes V The patient's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	Hyperten Isolated Systolic	Hypertension	4	blood pressure is classified as High-Normal (Pre-Hypertensive). The
mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	Anemia Unspecified	Anemia		
	DM II Renal Manifestat Uncontr	Diabetes		mean plasma glucose of 203 mg/dL. The patient's diabetes is not well
		J		

Next to each diagnosis is a box under the heading of "Category." If you click in that box, **a list of 16 diagnostic categories** appear for which we have built a set of structured options for:

- symptoms,
- physical findings
- condition status
- Laboratory studies
- Procedures
- Medications

Diagnosis	Category	Plan/Comments		
Fredrickson Type Ib Hyperlipoproteiner	π 🖌	Picklist Category	×	
		Altered Mental Status		
Renal Stage II Chron Disease		Anemia Angina	1 20091118 was 7.9 %	which translates to a
		CHF D-Dimer, Elevated	203 mg/dL. The patient's plood sugar is improving	
CHF Diastolic Acute	CHF	Dehydration Diabetes	he patient's pulmonary of	
		Hyperkalemia Hypertension	eral edema has lessened is able to ambulate with	. Patient is able to lay
Hyperten Isolated Systolic	Hypertension	Hypokalemia Hyponatremia Malnutrition Pneumonia	od pressure is 138/85 m led as High-Normal (Pre- is improving. The patient	Hypertensive). The
Anemia Unspecified	Anemia	Post Surgical Respiratory Failure Syncope		
DM II Renal Manifestat Uncontr	Diabetes	Close	20091118 was 7.9 %	which translates to a
			se of 203 mg/dL. The patient's ent's blood sugar is improving	
2				
5. Contract of the second s				
	-			
<[

These are common and complex problems facing clinicians every day. It is SETMA's intend to add numerous other categories up to a potential of 100 or more. The goal is to give providers the facility to document daily progress notes with precision, granularity and efficiency.

A Description of the 16 Categories of Templates on the Master Progress Plan

The function of each of these diagnostic categories will be obvious as they are reviewed. The following description of each will be limited to unique functions which are not obvious, or which are not visible from a screen shot of the template.

Altered Mental Status

Progress Altmental		×
Daily Progress Note Altered Mental Status	Type of Altered Mental Status Annesia Dementia, Primary Delirium Dementia, Secondary	Causes
Patient's Living Arrangements Alone With partner In care facility Other Dizziness Syncope Vertigo Clumsiness	Physical Exam Orientation Normal Other Speech Loud Shouting Mumbling Unresponsive Thought Coherent yes no Logical yes no Delusions yes no	Laboratory Acetaminophen CMP Alcohol, blood level Drug Screen Ammonia, serum Folate Apo E Prealbumin B12, serum Salicylate Carbon Monoxide Thyroid profile CBC VDRL Other Procedures Consults KG Neurology
Clumsiness Clumsiness Cluss of consciousness Cluss of consciousness Coma Coma Combative Combativ	Paranoid yes no Status Mental status has improved Mental status has worsened Patient remains confused Depression excluded as cause No evidence of seizure No evidence of CVA	EEG Psychiatry MRI of head CT of head Spinal Tap Spinal Tap Medications Dosing Help Sedatives Lorazepam Neuroleptics Haldol Droperidol Droperidol Atypical Antipsychotics Resperidone Antidotes Naloxone

This template is name **Daily Progress Note Altered Mental Status**. It has two unique functions which are not obvious:

• At the top of the template next to the **Type of Altered Mental Status**, there is a button entitled "**Causes**." When this button is depressed, the following pop-up appears which is entitled "**Causes of Altered Mental Status**."

Da Alte	is Altmental ally Progress No ered Mental Stat gress Altmentalc	I Amnesia I Demenda,	Primary <u>Couses</u> Secondary	
		Causes of Altere		
1	🗖 Amnesia	🗖 Delirium	🗖 Dementia, Primary	🗂 Dementia, Secondary
	Head trauma Korsakoff syndrome Transient global amresia Traveler amresia	Intoxication Alcohol Medications Hallucinogens Toxins Occut Infection Cerebralitis Sepsis Acute mania or other psych etiology Cerebral vascular accident Endocrine crisis Head trauma Inflammation (systemic lupus erythematosus) Liver failure Respiratory dysfunction (hypoxia, hypercarbia) Seizure disorder Shock Sundowning syndrome	Alzheimers Frontotemporal dementia (FTD) Avitominosis Autoimmune disease Psychiatric illness Protein Calorie Mainutrition Parkinsonism Chronic endocrinopathies	Cerebrovascular disease Chronic CNS infection CNS trauma Increased ICP (e.g. neoplasia, mass effec hydrocephalus) Autoimmune disease Psychiatric illness

This allows the provider to document very specifically what the cause of AMS is or is suspected of being. All of the choices which are selected will appear in the box next to "**Causes**" on the **Daily Progress Note Altered Mental Status** and will also appear on the daily progress note next to the diagnosis of Altered Mental Status.

Diagnosis Category Plan/Comments Fredrickson Type IIb Hyperlipoproteiner Altered Mental Star Potient lives alone. The following are negative from the review of systems: disztiness, disorientation, Laks ordered. Procedures ordered. See orders sheet. Renal Stage II Chron Disease Ignemia If The patient's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dl The patient's diabetes is not well controlled. The patient's blood sugar is improving. Ketosis is absent. CHF Diastolic Acute CHF If General improvement. The patient's pulmonary congestion has improved and the peripheral edema has lessened. Patient is able to law flat without difficulty and is able to ambulate without SOB. Duresis Hyperten Isolated Systolic Hypertension If The patient's current blood pressure is 138/85 mmHg. The patient's blood pressure is classified as High-Normal (Pre-Hypertensive). The patient's blood pressure is improving. The patient has the following Anemia Unspecified Anemia If DM II Renal Manifestat Uncontr Diabetes If The patient's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dl The patient's diabetes is not well controlled. The patient's blood sugar is improving. Ketosis is absent.	Fredrickson Type IIb Hyperlipoproteinerr Altered Mental Sta Image: Patient lives alone. The following are negative from the review of systems: dizziness, disorientation, Labs ordered. Procedures ordered. See orders sheet. Renal Stage II Chron Disease Image: Image	Daily Progress	s Plan	_	Additional Dx	Orders		Return
Renal Stage II Chron Disease Immin Immin Imminia <	Renal Stage II Chron Disease Image: Anemia Image: Systems: discrimination, Labs ordered. Procedures ordered. See orders sheet. Renal Stage II Chron Disease Image: Anemia Image: The patient's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dL. The patient's diabetes is not well controlled. The patient's blood sugar is improving. Ketosis is absent. CHF Diastolic Acute CHF Image: CHF	Diagnosis	Category	-	Plan/Comment	8		
Interpretent singlection of 2003 mg/dt, The patient's diabetes is not well mean plasma glucose of 203 mg/dt, The patient's diabetes is not well controlled. The patient's diabetes is not well controlled. The patient's diabetes is not well improved and the peripheral edems has lessened. Patient is able to lay flat without difficulty and is able to ambulate without SOB. Divresis Hyperten Isolated Systolic Hypertension Image: The patient's current blood pressure is 138.65 mmHg. The patient's blood pressure is classified as High-Normal (Pre-Hypertensive). The patient's blood pressure is improving. The patient has the following Anemia Unspecified Anemia Image: The patient's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dt. The patient's diabetes is not well	Interplating update development Interplating update development Interplating update Interplating update CHF Diastolic Acute CHF Image development The platient's blood sugar is improving. Ketosis is absent. CHF Diastolic Acute CHF Image development The patient's blood sugar is improving. Ketosis is absent. CHF Diastolic Acute CHF Image development The patient's blood sugar is improving. Ketosis is absent. Hyperten Isolated Systolic Hypertension Image development The patient's current blood pressure is 138.05 mmHg. The patient's blood pressure is classified as Hgh-Normal (Pre-Hypertensive). The patient's blood pressure is improving. The patient has the following Anemia Image development DM II Renal Manifestat Uncontr Diabetes Image development's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	Fredrickson Type IIb Hyperlipoproteinen	Altered Mental Star	4	systems: dizzin	ess, disorientat		
International Constraints International Constraints International Constraints Internatinglong Constraints	Image: Second System Image: Second System Hyperten Isolated System Image: Second System Anemia Image: Second System Anemia Image: Second System DM II Renal Manifestat Uncontr Diabetes Image: Second System Image: Second System Image: Second System	Renal Stage II Chron Disease	Anemia	2	mean plasma gl	ucose of 203 m	g/dL. The patient'	's diabetes is not well
Anemia Unspecified Anemia DM Il Renal Manifestat Uncontr Diabetes	Image: Construction of Constructing Construction of Construction of Constructin	CHF Diastolic Acute	CHF	4	improved and th	ne peripheral ed	iema has lessene	d. Patient is able to lay
DM II Renal Manifestat Uncontr Diabetes IV The patient's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	DM II Renal Manifestat Uncontr Diabetes IV The patient's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	Hyperten Isolated Systolic	Hypertension	4	blood pressure	is classified as	High-Normal (Pre	-Hypertensive). The
mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	mean plasma glucose of 203 mg/dL. The patient's diabetes is not well	Anemia Unspecified	Anemia	Γ				
		DM II Renal Manifestat Uncontr	Diabetes	4	mean plasma gl	ucose of 203 m	g/dL. The patient'	s diabetes is not well
		[]		Г				

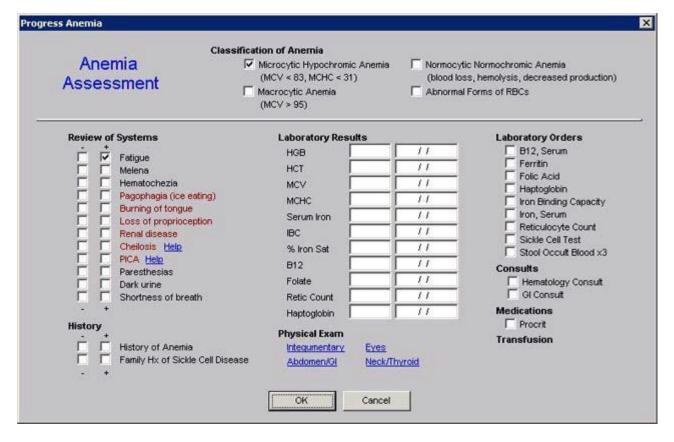
• Near the right hand bottom of the Altered Mental Status template is a button entitled "Dosing Help." When launched this displays a template entitled Altered Mental Status Medication Help. It gives indications and dosing for five medications often used for Altered Mental Status.



The other elements of the Altered Mental Status pop-up are obvious.

Anemia

When you click in the box labeled as **Categories** and select the choice entitled **Anemia**, the following pop-up appears. This template addresses some of the common issues related to symptoms and laboratory evaluation of anemia, orders and consults.



All of the functions of this template are straightforward.

Angina

When you click in the box labeled as **Categories** and select the choice entitled **Angina** the following pop-up appears.

Progress Angina				×
	Daily Progres	s Note Chest Pa	in Assessment	
Status Chest pain has resolved Chest pain has improved Chest pain has worsened Quality of Pain	Type of Chest Pain Typical Atypical Non-cardiac chest pa	Type of Angina Stable Unstable - Rest Angina in Unstable - New Onset Unstable - Increasing	Standards of Care (Consortium Data Set) Patient recieved antipiatelet therapy Patient recieved a statin Patient recieved Beta Blocker Smoking cessation discussed	Info
Grip-Like Heaviness in chest Pressure-Like Squeezing Suffocating	CCSC Class of Angina Class I Class Class II Class Lab Results	s IV Help	The following are predictive of CAD + S3 or S4 sound or gallop Mitral regurgitant murmur Paradoxically split S2	
Pain Described As Radiation absent Radiation to arms Radiation to epigastrum	Troponin		Bibasilar rales Chest wall heave that disappears when pain subsides Perscardial rub Chest wall heave that disappears chest wall heav	
Radiation to jaw Radiation to neck Substernal Sharp pain lasting a few sec Pain Aggravated By	C-Reactive Protein	Homocysteine	Palpation of chest wall for tenderness Sternum Ribs (1-3) Ribs (4-7) Ribs (8-12)	
Exertion Nothing	Calcium D-Dimer Hemoglobin A1C	Sed Rate Thyroid Profile	CAD Risk Factors Elevated blood pressure	E
Angina Equivalents + - Shortness of breath	Procedures Echocardiogram EKG		Retinal exudates Non-coronary atherosclerotic disease increase likelihood of CAD	sthe
Diaphoresis Nausea Indigestion Light headedness	Consults Cardiology consult or Cardiology consult re		Carotid bruit Diminished pedal pulses Abdominal anuerysm	LLL
		OK Cancel		

This pop-up is a summary of the material contained in the Disease Management tool entitled **Angina** (you can review that material by clicking here). Its use can be reviewed in that tutorial which is found under the Disease Management materials in this section of this website..

In the second column of this pop-up there is a place for the documentation of the **Class of Angina**. It is entitled CCSA, which stands for **Canadian Cardiovascular Society Classification System for Angina**.

Progress Angina		X
	Daily Progress Note Chest Pair	n Assessment
Status Chest pain has resolved Chest pain has improved Chest pain has worsened Quality of Pain	Type of Chest Pain Type of Angina Typical Stable Atypical Unstable - Rest Angina Non-cardiac chest pain Unstable - New Onset Unstable - Increasing Unstable - Increasing	Standards of Care (Consortium Data Set) Patient recieved antiplatelet therapy Patient recieved a statin Patient recieved Beta Blocker Smoking cessation discussed
Grip-Like Heaviness in chest Pressure-Like Squeezing	CCSC Class of Angina Class I Class II Help Class II Class IV Lab Results	The following are predictive of CAD + . S3 or S4 sound or gallop Mitral regurgitant mumur Paradoxically splt S2 Bibasilar rales Chart well beaue that disappears
Pain Described As Radiation absent Radiation to arms Radiation to epigastrum Radiation to pigw Radiation to neck Substernal Sharp pain lasting a few sec Pain Aggravated By Emotion Exertion Nothing	C-Reactive Protein Calcium Calcium Calcium Coloriner Coloriner Hemoglobin A1C Colorine Color	Peracardial rub Palpation of chest wall for tenderness Sternum Ribs (1-3) Ribs (4-7) Ribs (8-12) CAB Risk Factors Elevated blood pressure Xanthonas
Angina Equivalents + - Shortness of breath □ □ Diaphoresis □ □ Nausea □ □ Indigestion □ □ Light headedness □ □	Procedures Chocardiogram KG Consults Cardiology consult ordered Cardiology consult report reviewed OK Cancel	Retinal exudates

When the button entitled **Help** is activated, the following appears.

Help Anginagrade
Grading of Angina Pectoris by the Canadian Cardiovascular Society Classification System
Class I Ordinary physical activity does not cause angina, such as walking, climbing stairs. Angina occurs with strenuous, rapid or prolonged exertion at work or recreation.
Class II Slight limitation of ordinary activity. Angina occurs on walking or climbing stairs rapidly, walking uphil, walking stair climbing after meals, or in cold, or in wind or under emotional stress, or only during the few hours after awakening. Angina occurs with walking over two blocks on the level, and climbing more than one level of ordinary stairs at a normal pace and in normal conditions.
Class II Marked limitation of ordinary activity. Angina occurs when walking one to two blocks on the level and climbing one flight of stairs in normal conditions and at a normal pace.
Class IV Inability to carry on any physical activity without discomfort angina symptoms may be present at rest.
Cancel

This enables the grading of the class of angina to be standardized and it also enables the provider to fulfill one of the quality measures of the Physician Consortium for Performance Improvement (PCPI) which is to have determined the class by a standard measure.

In the fourth column of this template there is a summary of the PCPI under the heading "Standards of Care."

Progress Angina				×
	Daily Progress	Note Chest Pair	Assessment	
Chest pain has resolved Chest pain has improved Chest pain has worsened Quality of Pain	Typical Atypical Non-cardiac chest pain	ype of Angina Stable Unstable - Rest Angina Unstable - New Onset Unstable - Increasing	Standards of Care (Consortium Data Set) Patient recieved antiplatelet therapy Patient recieved a statin Patient recieved Beta Blocker Help Smoking cessation discussed	Drug Info
Heaviness in chest Pressure-Like Squeezing Suffocating	CCSC Class of Angina Class I Class II Class I Class II Lab Results	Helo	The following are predictive of CAD S3 or S4 sound or gallop Mitral regurgitant murmur Paradoxically split S2	
Pain Described As Radiation absent Radiation to arms Radiation to epigastrum			Bibasilar rales Chest wall heave that disappears when pain subsides Peracardial rub	FF
Radiation to jaw Radiation to neck Substernal Sharp pain lasting a few secs Pain Aggravated By Emotion Exertion	Lab Orders AMI g6 hours x3 [BNP [C.Reactive Protein [Calcium [D-Dimer [Homocysteine Lipid Panel Magriesium Sed Rate Thyroid Profile	Palpation of chest wall for tenderness Sternum Ribs (1-3) Ribs (4-7) Ribs (8-12) CAD Risk Factors Elevated blood pressure	
Nothing Angina Equivalents + - Shortness of breath	I Hemoglobin A1C I Procedures I Echocardiogram I EKG Consults Cardiology consult order		Xanthomas Retinal exudates Non-coronary atherosclerotic disease incr likelihood of CAD Carotid bruit Diminished pedal pulses	eases the
	Cardiology consult order		Diminished pedal pulses Abdominal anuerysm	FF

Next to the **Standards of Care** is a button entitled **Help – Drug Info**. When depressed this button displays the following template which is entitled **Medications for use in Chronic Stable Angina**.

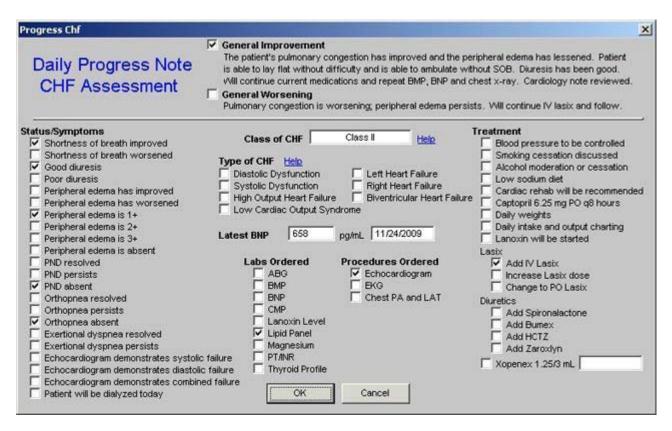
m Csa Drugs						1
	Medica	ations for Use in	Chronic Sta	able Angina		
C Beta-Ad C Glycopr C HMG-Co	elets mbotic Agents irrenergic Blockers otein IIA/IB Inhibitors A Reductase Inhibitors n Inhibitors	2. Sek	ect a medication.			
3. Review the General	Dosing	Contraindications	Interactions	Pregnancy	Precautions	
	** Pediatric Dose Not	Established	Cancel			

When a category of drugs is selected and when a specific drug in that category is selected this template displays information about that drug in six categories: General, Dosing, Contraindications, Interactions, Pregnancy, and Precautions.

	Medication	s for Use in C	Chronic Stable	Angina	
1. Select a category.		2. Select	a medication.		
C Antiplatelets C Antithrombotic A Beta-Adrenergi C Glycoprotein IIA C HMG-CoA Redu C Thrombin Inhibit C Vasodilators 3. Review the availab	c Blockers AIB Inhibitors ctase Inhibitors ors	© M C N	enolol etoprotol adolol opranolol		
	ie morniouon.				
eneral	Dosing	Contraindications	Interactions	Pregnancy	Precautions

CHF

When the **CHF** choice is selected under **Categories** the following template is displayed which is entitled, "**Daily Progress Note CHF Assessment**."



There are three unique features of this pop-up.

The first feature is two summary statements which can be selected at the top of the template. When the box next to either is checked, the language in the statement will appear in the **Plan/Comment Box** on the **Daily Progress Plan** Template and then will also print on the **Daily Progress Note**..

Progress Chf			×
Daily Progress Note CHF Assessment	is able to lay flat without d vVill continue current medic General Worsening	ifficulty and is able to ambulate wit cations and repeat BMP, BNP and o	rripheral edema has lessened. Patient thout SOB. Diuresis has been good. chest x-ray. Cardiology note reviewed. sts. Will continue IV lasix and follow.
Status/Symptoms Shortness of breath improved Shortness of breath worsened Good diuresis Poor diuresis Peripheral edema has improved Peripheral edema has worsened Peripheral edema is 1+ Peripheral edema is 2+ Peripheral edema is 3+ Peripheral edema is absent PND resolved PND persists PND absent Orthopnea resolved Orthopnea persists Orthopnea persists Orthopnea persists Corthopnea desent Exertional dyspnea resolved Echocardiogram demonstrates diastol Echocardiogram demonstrates combin Patient will be dialyzed today	c failure 🔲 Thyroid Profile	Class II Heip	Treatment Blood pressure to be controlled Smoking cessation discussed Alcohol moderation or cessation Low sodium diet Cardiac rehab will be recommended Daily weights Daily weights Daily intake and output charting Lanoxin will be started Lasix Add IV Lasix Increase Lasix dose Change to PO Lasix Duretics Add Spironalactone Add HCTZ Add Zaroxlyn Xopenex 1.25/3 mL

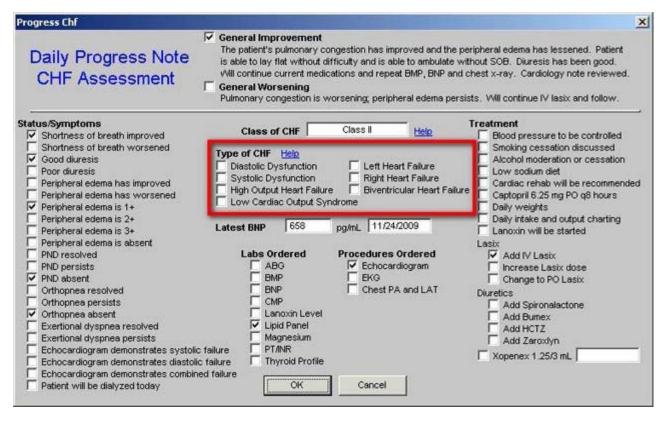
The second feature is found in the second column and is entitled **Class of CHF**. The pick list which appears in the box when the cursor is clicked in that box allows a choice of Class I through Class IV.

Progress Chf			×
Daily Progress Note CHF Assessment	is able to lay flat without o v/III continue current medi General Worsening	ifficulty and is able to ambulat cations and repeat BMP, BNP a	e peripheral edema has lessened. Patient e without SOB. Diuresis has been good. and chest x-ray. Cardiology note reviewed. ersists. Will continue IV lasix and follow.
Status/Symptoms Shortness of breath improved Shortness of breath improved Shortness of breath worsened God diuresis Peripheral edema has improved Peripheral edema has worsened Peripheral edema is 1+ Peripheral edema is 2+ Peripheral edema is 3+ Peripheral edema is absent PND resolved PND persists PND absent Orthopnea resolved Orthopnea persists Orthopnea desent Exertional dyspnea resolved Exertional dyspnea persists Echocardiogram demonstrates systolic Echocardiogram demonstrates combine Patient will be dialyzed today	failure Thyroid Profile		Treatment □ Blood pressure to be controlled □ Smoking cessation discussed □ Alcohol moderation or cessation □ Low sodium diet □ Cardiac rehab will be recommended □ Captopril 6.25 mg PO q8 hours □ Daily weights □ Daily intake and output charting □ Lanoxin will be started Lasix □ □ Add IV Lasix □ Increase Lasix dose □ Change to PO Lasix Diuretics □ □ Add Spironalactone □ Add Bumex □ Add Zaroxlyn □ Xopenex 1.25/3 mL

Beside this box is a button entitled **Help**. When that button is depressed, a pop-up appears which gives definition to the four classes of CHF and allows for the box next to the appropriate class to be selected.

Help Chf Classes			x
	Classes of Conges	stive Heart Failure	
Class I - Patients with docu	mented heart disease of any type who are con	ompletely symptom free	
Class II - Slight limitation of p	hysical activity because symptoms (shortness	ss of breath, chest pain) occur only with more than ordinary physical	activity
Class II - Marked limitation o	f physical activity because symptoms occur e	even with ordinary physical activity (e.g., eating meals)	
Class IV - Severe limitation	of physical activity because symptoms occur e	reven at rest (e.g., in a sitting or lying position)	
	OK	Cancel	
	Lannana		

The third feature is also found in the second column and it is entitled Type of CHF. There are seven options:



It is also possible to select the radial button next to the **Type of CHF** which will then also appear on the **Daily Progress Note CHF Assessment** template. Next to the Type of CHF is a Help button which when depressed presents a pop-up on which the **Types of CHF** are defined and described.

	Classification of Heart Failure
	physiological state in which an abnormality of cardiac function is responsible for failure of the heart rate with metabolic requirements or to do so only from an elevated filling pressure.
Туре С	haracteristics
Diastolic Dysfunction	Normal myocardial contractility, left ventricular volume, and ejection fraction; impaired myocardial relaxation; diminished early diastolic filling. The heart is stiff and does not relax normally after contracting. Even though it may be able to pump a normal amount of blood out of the ventricles, the stiff heart does not allow as much blood to enter its chambers from the veins. As in systolic dysfunction, the blood returning to the heart then accumulates in the veins.
Systolic Dysfunction	Absolute or relative impairment of myocardial contractility, low ejection fraction. In systolic dysfunction, the heart contracts less forcefully and cannot pump out as much of the blood that is returned to it as it normally does. As a result, more blood remains in the lower chambers of the heart (ventricles). Blood then accumulates in the veins.
High Output Heart Failure	Bounding pulses, wide pulse pressure, accentuated heart sounds, peripheral vasodilatation, increased cardiac output and ejection fraction, moderate four-chamber enlargement.
Low Cardiac Output Syndrome	Fatigue, loss of lean body mass, prerenal azotemia, peripheral vasoconstriction, reduced left or right contractility.
TRight Heart Failure	Dependent edems, jugular venous distention, right atrial and ventricular dilatation, reduced right-sided contractility. This occurs when the left ventricle functions poorly. Water may build up within the lungs causing shortness of breath or coughing. The shortness of breath can occur during physical exertion (eg, climbing a flight of stairs), while straining (eg, lifting a heavy object), or can happen when lying down. An individual may be awakened from sleep by this shortness of breath and start coughing. Feeling tired or weak can also occur.
Left Heart Failure	Dyspnea, pulmonary vascular congestion, reduced left-sided contractility. This occurs when the right ventricle functions poorly. The volume of blood returning to the heart is decreased, causing swelling (edema) of the body. This fluid build-up is usually first noted in the ankles but can progress up the legs and into other parts of the body. Weight gain can also occur because of the extra water retained within the body.
Eiventricular Heart Failure	Dyspnea, dependent edema, jugular venous distention, pulmonary vascular congestion, bilateral reduced contractility. CHF is usually a combination of both RIGHT-SIDED and LEFT-SIDED Heart Failure.

D-D imer Elevated

When the **D-Dimer Elevated** option is selected from the pick list in the **Categories** box, the following template is launched.

view	of Systems	Laboratory Results	· · · · · · · · · · · · · · · · · · ·	Laboratory Orders
г г г	Chest pain at rest Chest pain w/exertion Shortness of breath Cough Peripheral edema	D-Dimer Calcium Magnesium Ca/Mg Ratio		D-Dimer Fibrinogen Titer Platelet Count PT/NR PTT
+ hysic	Calf tenderness - al Exam Respiratory Cardiovascular	Creatinine BUN PT INR Platelet Count		Procedure Orders
-	Extremity			Vendus Doppier
		V/Q Lung Scan Results Low probability of PE Moderate probability of PE High probability of PE Other	CT Angiogram Chest Results Low probability of PE Moderate probability of PE High probability of PE Other	Medications Aspirin Cournadin Lovenox

This evaluation is straight forward with three features which are potentially unique to providers. In the second column, laboratory results are listed. Three lab tests are:

- Calcium which promotes blood clotting
- Magnesium which promotes fibrinolysis
- **Ca++/Mg++ ratio** which reflects the balance between clotting and fibrinooysis. If the ratio is above 4, the patient has a higher probability of thrombosis abnormalities.

Dehydration

When this option is selected, the following pop-up appears.

sk Factors	Physical Signs and Symp Skin Turgor	toms	Calculations Click Here to Upde Serum Osmolality
Febrile 98.60 *F	Buccal Mucosa		Serum Osmolarity Anion Gap Est Creatinine Clearance
Recent weight loss Impaction Decreased appetite Change in mental status Paralysis Inability to feed self Diabetes Mellitus On diuretics	Urine output < 30 cc/r Laboratory Results Urine Spec Grav Glucose Sodium	r / / / / / /	Laboratory Orders
 Hypoalburninemia Age over 60 Nursing home resident Nausea Nausea w/vomiting Diarrhea Unable to turn and position 	Potassium Chloride HCO3 BUN Creatinine	11 11 11 11 11 11 11	Status C Good C Marginal C Adequate C Dehydrate

This is straight forward but a tutorial for this can be found elsewhere in the EPM section of this site (click here to review that tutorial on Hydration).

Diabetes

When the Diabetes option is made, the following pop-up appears.

		Dai	ly Progress Not	e Diał	betes Assessment
			HgbA1C 7.9 11/18/200		an Plasma Glucose 203
Blood Pressure Highest Blood Sugar (Current Diet Change Diet To Review of Systems	Card	Hours	Elood sugar impl Y Ketosis present	′es €N roving? ′es €N	No C-Peptide HgbA1C Vic Lipid Panel
Gastrointestinal Constipation Diarrhea Nausea Vomiting Endocrine Hyperkalemia Hypokalemia Hypocalcemia Hypocalcemia Hypernatremia Polyolipsia Polyolipsia Polyophagia		יאסטאי אארררררר	Cardiovascular Chest Pain Difficulty Breathing Peripheral Vascular Coldness of extremities Hair loss on extremities Cyanosis Intermittent Claudication Peripheral Edema Statis Ulcers Varicose Veins		Urine, 24 Hour Protein Procedures Pneumovax Flu Shot Medications Begin Aspirin, 325 mg Continue Aspirin Insulin dosing changed Medications reviewed for Diabetes Medications reviewed for Hypertension Consults Endocrinology consult ordered Endocrinology consult report reviewed Smoking cessation discussed

This template is straight forward.

Hyperkalemia

When the Hyperkalemia option is made the following pop-up appears

Potassium 0 mEq/L //	Severity of Hyperkaler	nia C Mid C Moderate C Severe	5.3-6.0 mEq/L 6.0-6.5 mEq/L >6.5 mEq/L
Calculate Creatinine Clearance Calculate >>> mL/min Follow-Up Lab Serum Potassium in 2 hours Procedures EKG	Laboratory Aldosterone <u>Help</u> ALT CBC CMP CCPK LDH Phosphate Plasma Renin Activity <u>Help</u> Serum Cortisol	Urine, Osm Urine, Pota	ofile tr Creatinine Clearance nolality <u>Help</u> assium lium tr Potassium <u>Help</u>
Treatment Administer intravenous calcium gluconate 1 Regular Insulin 10 U IV and 50 mL D50W bo NaHCO3 50 mEq slow IVP (If patinet has n Nebulized Albuterol 10 mg Kayexalate retention enema 50 G (in sorbito) Kayexalate 60 mg (in sorbito) PO Discontinue oral and parenteral potassium s Remove potassium-containing salt substitut Change the diet to a low-potassium tube fe Stat consult to SETMA Nephrology for Emer	lus netabolic acidosis and/or EKG changes) ol). Irrigate with tap water after enema to p supplements es ed or a 2-g potassium ad-lib diet if patient o	revent necrosis	cardiac toxicity, if present

This template also appears in the **Hospital Orders** template and the tutorial for Hyperkalemia can be found there.

Hypertension

When the Hypertension option is made the following pop-up appears

			gress Note Hypertension	
	-		85 mmHg High-Normal (Pre	
Blood Pressure	Is [Well corr Poorly C		Medications will be changed.
Review of Systems		528	Medications	
Headache	Ē	V	ACE Inhibitor	Smoking cessation discussed
Dizziness	E	V	(If also Diabetes or proteinuria)	Stress reduction discussed
Fatigue	2	F	Alpha Blocker	Alcohol consumption reduction discuss
Palpations	E.	E.	(If also prostate enlargement)	Dietary consult for
Malaise	E.	È.	Angiotensin Receptor Blocker	Increase potassium intake
Nosebleeds	E.	5	Beta Blocker	Maintain adequate magnesium intake
/Veight loss	E.	F	(If also angina)	Increase fish oil intake
Swelling in the legs	1	F	Thiazide Diuretic	Reduce sodium intake < 2.4 grams/day
Weakness	E	F	(If also elderly or isolated Systolic	Laboratory Orders
Frequent urination	E.	-	Hypertension)	BMP
Increased thirst	E.	E.	☐ Vasodilator	CBC CMP
Enlarged, round or "moon" fac		E	Procedure/Imaging Orders	Lipid Panel
Excess body or facial hair	Γ	Γ	Ambulatory BP Monitoring EKG Echocardiogram	✓ Micral Strip Plasma Renin Activity Spot A/C Ratio
OK	Cancel		Renal Ultrasound	Thyroid Profile

This template is self-explanatory except that the Blood Pressure Classification is automatically displayed when the blood pressure value is documented on the template.

Hypokalemia

When the Hypokaemia option is selected, the following template appears.

Progress Hypokal			×
Hypokalemia Assessment	Latest Potassium	Severity of Hypokalemia Mild Severe	3.0 - 3.5 mEq/L 2.5 - 3.0 mEq/L < 2.5 mEq/L
Review of Systems	Physical Exam Cardiovascular Laboratory Orders ABG Digoxin BMP Potassium Calcium Magnesium Calcium Magnesium CMP Phosphate Creatinine Procedures Electrocardiogram	Treat diarrhea or vomitin	retics iuretics if diuretic therapy is required ase nasogastric suction losses glycosuria is present
Paresthesias Abdominal crapming + -		OK	Cancel

There are two unique functions on this template.

The first is the selection of the **severity of hypokalemia** at the top right of the template.

Progress Hypokal			×
Hypokal Assessr		Latest Potassium	Severity of Hypokalemia Mild 3.0 - 3.5 mEq/L Moderate 2.5 - 3.0 mEq/L Severe < 2.5 mEq/L
Review of Systems	•	Physical Exam	Treatment
Palpitatio Palpitatio Palpitatio Polyuria Polyuri	ation 1 ia ationis	Cardiovascular Laboratory Orders ABG Digoxin BMP Potassium Calcium Magnesium Calcium Magnesium CMP Phosphate Creatinine Procedures	Control hyperglycemia if glycosuria is present
Paralysi		Electrocardiogram	OK Cancel

The second is in the third column and is entitled **Repletion of Potassium Losses**. Next to this is a **Help** button which displays a tutorial on the same subject and with the same title.

Progress Hypokalh

	Repletion of Potassium Losses
	oximation, for every decrease in serum potassium of 1 mEq/L, the potassium deficit is approximately 200-400 mEq. r in mind that many factors in addition to the total body potassium stores contribute to the serum potassium concentration
	is absorbed readily. Relatively large doses can be given safely. Oral administration is limited by patient tolerance individuals develop nausea or even gastrointestinal ulceration with enteral potassium formulations.
	tassium is less well tolerated because it can be highly irritating to veins and can be given only in relatively small Iy 10 mEq/h. Under close cardiac supervision in emergent circumstances, as much as 40 mEq/h can be administered ral line.
Oral and paren	teral potassium can be used safely simultaneously.
Take ongoing p	otassium losses into consideration by measuring the volume and potassium concentration of body fluid losses.
If the patient is into the cells.	severely hypokalemic, avoid glucose-containing parenteral fluids to prevent an insulin-induced shift of potassium
If the patient is	acidotic, correct the potassium first to prevent an alkali-induced shift of potassium into the cells.
Replete magne	sium if low.
congestive hea inhibitors, and a reabsorbed at f	t to the individual patient. For example, if diuretics cannot be discontinued due to an underlying disorder such as art failure, institute potassium-sparing therapies such as a low-sodium diet, potassium-sparing diuretics, ACE angiotensin receptor blockers. The low-sodium diet and potassium-sparing diuretics limit the amount of sodium the cortical collecting tubule, thus limiting the amount of potassium secreted. ACE inhibitors and angiotensin ers inhibit the release of aldosterone, thus blocking the kaliuretic effects of that hormone.
	OK Cancel

Hyponatremia

When the Hyponatremia option is made, a top-up appears entitled Hyponatremia Assessment.

×

rogress Hyponatremia			<u>×</u>
Hyponatremia Latest S Assessment	odium Severity o Mid Mid Modera Severe	130 - 135 mg/dL ite 125 - 129 mg/dL	Status of Hyponatremia Acute < 48 hours Chronic > 48 hours
Review of Systems Confusion/Disorientation Ataxia Headache Seizure + Risk Factors for CNS Damage		mmol/L/hour until symptoms reso hypertonic saline (3%) 0.5-1.0 im above 120. e present and status is Chronic	Ived Enter IV Orders Here
Elderly (70+) Malnutrition Alcoholism Premenopausal woman Laboratory Orders EMP CMP	If no symptoms or risk factors If Hypovolemic Stop diuretics. Restore intravascular volume with 0.9% (normal) saline.	are present If Normovolemic Exclude hypothyroidism. Exclude glucocorticoid diffic Restrict fluid intake. Give Demeclocycline. (600-1200 mg/day) Cancel	☐ If Hypervolemic Restrict salt and water intake liency. Give diuretics. Treat underlying condition Heart Liver Kidney

The treatment options for hyponatremia address the speed of correction and the fluid-volume status of the patient. There is also a navigation button on this template entitled, **Enter IV Orders Here**, which carries you directly to the "orders template" which will be addressed below (**click here to review that function**).

Malnutrition

When the **Malnutrition** option is chosen, the following template is displayed.

		A		
	wanutruon	Assessment		
Risk Factors Inappropriate food intake Poverty Social isolation Dependence or disability Acute or chronic diseases/conditions Chronic medication use Advanced age (80+) Late-life paranola Swallowing disorders Oral problems Nosocomial infection Wandering or other dementia-related behavior Hyperthyroidism/hypercalcemia/hyperadrenalism Enteric problems	Physical Signs/Symptoms Involuntary weight loss - 5% in 30 days Involuntary weight loss - 10% in 180 days Wasting of fat/muscle tissue Flaking dermatitis Sparse, thin hair that pulls out easily Transverse lines on nails Abdominal distention Hepatomegaly Parotid gland enlargement Depression 25% of food left uneaten at two thirds of me Body Mass Index 40.21 Body Fat Percent 32.9		CBC Prealburnin CMP Transferrin Creatinine Consults Dietary Consult for	
Inability to feed self Eating problems Low salt, low cholesterol dief Stones (choleithiasis) Depression Unable to turn and position self	Laboratory Result Albumin Presibumin Cholesterol Hemoglobin Transferrin		Total Protein Magnesium Calcium Blood Urea Ntrogen Urine Urea Ntrogen Creatinine	11 11 11 11 11 11 11

Malnutrition is a larger problem that often not recognized particularly in the geriatric and pediatric populations. The tutorial for this function can be found elsewhere on this site. (click <u>here</u> to review the Nutrition Tutorial)

Pneumonia

When this option is made from the **Categories** pick list, a template is displayed which is entitled **Daily Progress Note Pneumonia Assessment**.

Progress Pneumonia	And in case of the local division of the loc		×
Daily Progress Note Pneumonia Assess	Doctorio	nia Status Acute Improving Sub-acute Vorsenir Stable	
vvBC .0 II HGB .0 II Sputum Culture II Sputum Culture III TMax (24 hours) 98.80 % Blood Pressure 138 85 mmHg Puise 92.00 beats/min mmHg Respirations 19 /min current Ventilator Settings Current Ventilator Setting Chest pain (rest) III III Chest pain (rest) III IIII IIII Dyspnea IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	History + - Patient smokes Smoking cessation discussed On chemotherapy History of COPD Respiratory Physical Exam Bronchial Breath Bronchial Breath Sounds Easehony Nasai Flairing Cyanosis Cyanosis Cyanosis Chest X-Ray Infiltrate Yes No Location Plueral Effusion Plueral Effusion Lung Mass OK	Arterial Blood Gas Blood Culture x2 BMP CBC CBC DDimer	

This template's use is straightforward.

Post-Surgical

When this option is selected, the following template is displayed.

Progress Postsurg		×
Procedure Surgeon Date // Days Post Temperature 98.60 F Temp Max 98.80 F (24 hours) Blood Pressure 138 / 85 mmHg Current Diet Cardiac Current Activity Up in Chair Patient tolerating activity? yes no Incision Site Location Sutures Staples Retention sutures Open to air for secondary closure Drainage Amount None Snall Serous Large Pus Increasing	Post Surgical Assessment Wound Inspection Ste Appearance Edges	Laboratory Orders BMP Prealburnin CBC VUrinalysis CMP Cultures Cultures Wound Care Consult Bilateral sequential compression device TED Hose Remove sutures Apply steristrips Decubitus precautions Assess for breakdown Turn patient q 2 hours KEN air bed
Percutaneous Drains	OK Cancel	Physical Therapy Orders Diet/Intake Orders

There are two unique features on this template.

The first is at the bottom of the third column and is entitled **Physical Therapy Orders**. When that button is depressed, the following template appears which allows the ordering of appropriate PT. This same function also launches from the Master Progress Plan template.

Progress Act	×
Acti∨ity/T	herapy Orders
 Ambulate BID Buck's Traction Dangle Feet to Bedside Elevate Head of Bed 6 Inches Fall-Risk Precautions Non Weight Bearing Left Leg/Ankle Right Leg/Ankle 	Physical Therapy Location(s) Range of Motion Strengthening Ambulation Pulmonary Rehabilitation Cccupational Therapy Speech Therapy
 Out of Bed PRN Sit in Chair 3x per day 4x per day Soft Physical Restraints Turn Patient Every 2 Hours vVarm/Moist Soaks Right Arm Left Arm Right Calf Left Calf 	Comments
O	

The second unique feature is entitled **Diet/Intake** orders when this button is depressed, the following template appears:

Progress Diet	×
Diet/Intake	Orders
 All Meals Out of Bed Begin/Continue Intake and Output Documentation Begin/Continue Daily Calorie Count Daily Weights 	Change Diet To
 Encourage PO Fluids Fluid Restriction - 1000 mL q 24 hours including meals Modified Barium Swallow 	Order Dietary Consult for
Comments	
OK	Cancel

This allows for a precise and appropriate diet and intake to be selected. SETMA believes that there are three ways to survive a hospital stay:

Get up – get out of bed. Eat up – maintain your nutrition. Get out – don't overstay your health's welcome.

Proper diet and activity while in the hospital are key to a patient's well being.

Respiratory Failure

When this option is made, the following pop-up appears.

Progress Respfail					×
Daily Progress Note Respiratory Failure	Type of Respir Which type o Progres	t talure?	Acute, Type I (p Acute, Type II (p Chronic (pH > 7	H < 7.3)	uspected Cause
Vital Signs Blood Pressure 138 Pulse 92.00 Pulse 0x 95 Respirations 19 FiO2 % Review of Systems * Cough Review of Systems * Cough Rhinorrhea Dyspnea Dyspnea Shortness of breath Fever PND Orthopnea Peripheral edema Peuritic chest pain Veakness Help History of stroke History of	(if × 100, Physical Exam Cardiovascult Respiratory E Current Ventile Lab Results pH Pa02 Pa02 Pa02 HC03 HGB	PAP) Preathing Rate atory Force Breathing Index cannot extubate ar Exam Neuri xam Cons	Construction of the local division of the lo	2 Contraction of the second	

This template has a number of special features:

• At the top of the template is a function entitled **Which Type of Failure**? When that button is depressed the following appears:

Progress Respfaila	×
Туре о	Respiratory Failure
	pH > 7.3
Acute, Type I Failure	Acute, Type 2 Failure
pH < 7.3	pH < 7.3
Low oxygen AND normal-to-low PaC	2 Low oxygen and PaCO2 between 55 - 60
respiratory failure develops over several of in bicarbonate concentration. Therefore, th acute and chronic hypoxemic respiratory f The clinical markers of chronic hypoxemia disorder.	ops over minutes to hours; therefore, pH is less than 7.3. Chronic ys or longer, allowing time for renal compensation and an increase pH usually is only slightly decreased. The distinction between ilure cannot readily be made on the basis of arterial blood gases. such as polycythemia or cor pulmonale, suggest a long-standing OK Cancel

This allows for a designation of the kind of respiratory failure.

• To the right of the **Which Type of Failure** button is a button entitled **Causes**. When that button is depressed a pop-up appears which is entitled, **Common Causes of Acute Respiratory Failure**.

Progress Respfailc Common Causes of Ac Type I Failure (hypoxemic) Chronic bronchitis and emphysema (COPD) Pneumonia Pulmonary edema Pulmonary fibrosis Asthma Pneumothorax Pulmonary embolism Pulmonary artery hypertension Pneumoconiosis Granulomatous lung diseases Cyanotic congenital heart disease Adult respiratory distress syndrome Fat embolism syndrome Kyphoscholiosis Obesity	ute Respiratory Failure Type II Failure (hypercapnic) Chronic bronchitis and emphysema (COPD) Severe asthma Drug overdose Poisonings Myasthenia gravis Polyneuropathy Poliomyelitis Primary muscle disorders Porphyria Cervical cordotomy Head and cervical cord injury Primary alveolar hypoventilation Obesity hypoventilation syndrome Constipation Pulmonary edema Adult respiratory distress syndrome	
ОК	Myxedema Tetanus Heroin overdose Guillan-Barre syndrome Chest wall deformities	

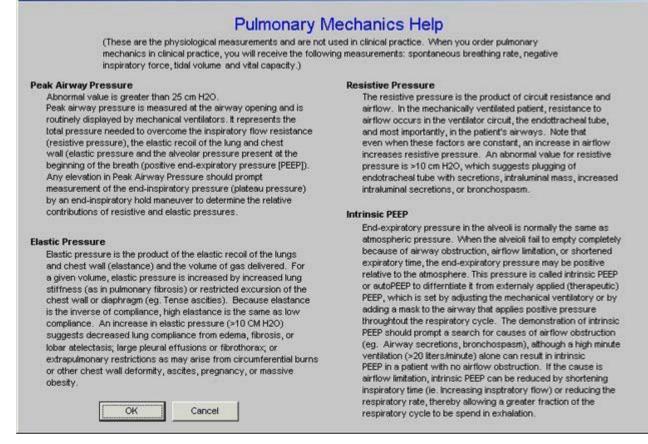
This function allows the provider to designate whether the patient has Type I or Type II respiratory failure and what the cause is believed to be.

• Immediately under the **Type of Failure** is a button which is entitled **Progress**.

Progress Respfailp				×
Respir	ratory	Failur	e Progress	
Current Values		%	Goals	
Fi02		1		
Minute Ventilation		L/min	Goal is less than 10. Normal is 5.	
Peak Airway Pressure		cm H2O	Goal is less than 35. Normal is 5. Below 40 is mandatory.	
Mean Airway Pressure	I	cm H2O	Goal is less than 8-12	
	OK	C 0	ancel	

This allows for the patient's progress toward extubation to be monitored and quantified.

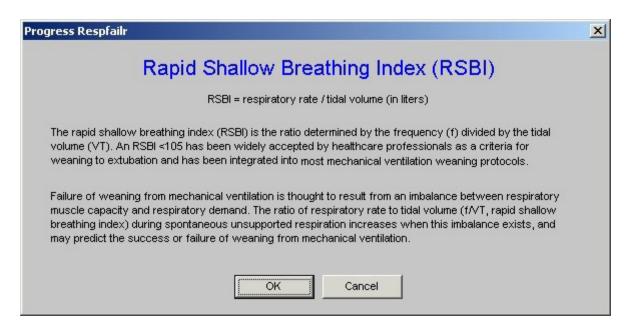
• The next unique function is immediately below the first and third functions and is entitled **Pulmonary Mechanics Help.**



This pop-up describes the physiology of pulmonary mechanics and describes the elements of pulmonary mechanics which will indicate whether the patient is ready for extubation. The pulmonary mechanics necessary for determining if the patient is ready for extubation are:

- o spontaneous breathing rate,
- o negative inspiratory pressure,
- tidal volume and
- vital capacity.
- The fifth unique feature of the Daily Progress Note Respiratory Failure template is entitled **Rapid Shallow Breathing Index** (RSBI).

×



If the RSBI is above 100 the patient cannot be extubated. The RSBI is calculated automatically by the EMR.

	New Ventilate	or Settings
Mode Rate Tidal Volume Suggested Tidal Volume = 8.9 mL/kg = 918 Peak Flow Inspiration/Expiration Ratio Help FiO2 Pressure Support Help PEEP Vent Sensitivity	Amin mL 3 L/min % cm H2O cm H2O cm H2O cm H2O	Post Intubation Orders Titrate FIO2 to keep saturation >= CXR portable STAT ABGs in 20 minutes Continuous pulse oximetry Sedation Morphine sulfate 2-10 mg IV q 1 hour PRN agitation If morphine allergy or MAP<60 mm Hg, tentanyl 25-500 mcg IVP q 1 hour PRN agitation Diprivan IV 5-10 cc initial bolus and titrate as need for agitation unrelieved by PRN narcotic use Comments
"If patient ventilated in SIMV mode, respiratory to add pressure support to result in spontaneo volume of at least 6 cc/kg ideal body weight. I mode chosen and patient has no spontaneous H2O pressure support.	bus tidal if SIMV	Cancel

• At the bottom of the third column is a function entitled New Ventilator Settings

This allows a provider to create new ventilator settings which will print out on the order set and which then can be placed on the inpatient chart.

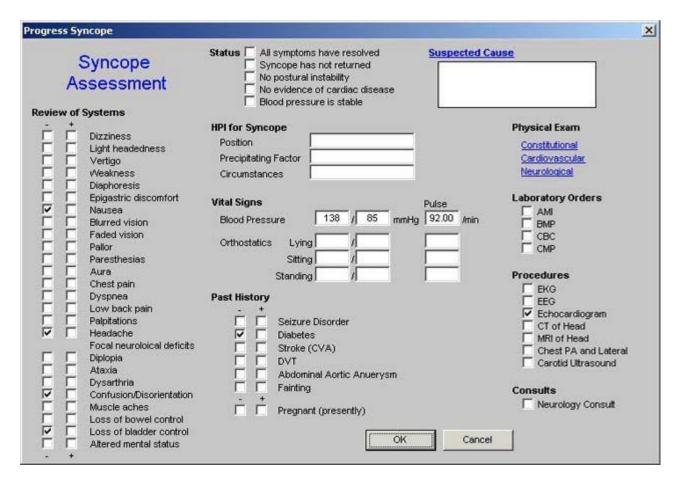
• The seventh and last unique feature of the **Daily Progress Note Respiratory Failure** template is launched by clicking the last button in the third column which is entitled **Preparation for Extubation**.

Preparatior	n for Extubation	
se provide responses to the highlighted question	(s) below	
Criteria	Value	Criteria Met
1. Underlying condition has been addressed?	C Stable C Resolved C Unresolved	
2. PaO2/FiO2 ratio > 150	0	
3. pH > 7.25		
4. FiO2 < 40		
5. PEEP < 5 cm H2O		
 Minute ventilation < 10 L/min 	0	
7. Patient is capable to initiate respiratory effort?	Yes O No	
3. PaO2 > 60		
9. Heart rate < 140	92.00	Yes
I0. Afebrile (temperature < 100.4 F)	98.60	Yes
11. Hemoglobin > 8.9		
12. Stable electrolytes?	C Yes C No	

This template gives the criteria which need to be met before extubation can be undertaken.

Syncope

If the Syncope option is selected from the **Categories**, the following template is displayed:



This template has one unique function which is found at the top right of the template and is entitled "**Suspected Causes.**" When this button is depressed, the following pop-up appears.

Causes of	Syncope
Cardiac Causes	Metabolic Causes
Structural Cardiac or Pulmonary Disease Aortic Stenosis Mitral Stenosis Pulmonary Stenosis Left Atrial Myxoma Aortic Dissection Acute Myocardial Infarction Cardiac Tamponade Pulmonary Embolism Obstructive Cardiomyopathy Cardiac Arrythmias Bradyarrythmias Bradyarrythmias Neurally Mediated Syncopal Syndrome Neurocardiogenic Syncope Carotid Sinus Syncope Situational Syncope Orthostatic (or postural) hypotension	 Hypoxia Hypoglycemia Hyperventilation Psychiatric Causes Somatisation Disorders Hysteria Panic Fright Neurologic Causes Seizure Disorders Transient Ischaemic Disorders Subclavian Steal Syndrome Normal Pressure Hydrocephalus

This template displays and allows the provider to select from cardiovascular, metabolic, psychiatric or neurological causes of syncope.

Master Progress Order Template

As previously noted, of the 20 navigation buttons on the Master Progress template only three are unique to the Master Progress. They are

- Recent Events
- Plan/comments
- Orders

We have reviewed the **Recent Events and Plan/comments** templates. All of the information which is documented on these three templates will appear on the Hospital Daily Progress Note, or on the Hospital Orders Note, both of which are generated at the end of this process.

The **Master Progress Order** template will bring together any orders which have been initiated in any of the current 16 categories templates reviewed under the **Plans/Comment** section of this tutorial.

Discharge Planning Transfer To Discus		Discusse	Code Status Patient Condition With Family Progress Medical Po						Return	
				Tests and Pr	ocedures	Contract of Contra	of Attorney	100 million (100 m		Comments
Social Service	Consult	Orders	1					1.62		Plan-Only Note
Durtuella Ca	New Determine	Gen	eral, O2, IV	Г L	17	Critic	al Care	F		
Protective Services Referral		PRN	Medications	Imaging			Ventilat	or Settings		
1	1		DietAntake		ocedures	dures 🔽	Hyperkalemia		F	
Discharge			PT/OT/Speech		Family			g Scale		
Discharge	e Instructions		Гт	bacco cessation	materials to be	given to	patient.			
ledications (E	ouble-click to A	dd/Edit)		Discon	tinue Medica	tions		Discontin	ue	
fedications will p			Update ALL me	ds here. These v	vill print in addi	tion to th		C Oxyge		Urinary Catheter
Brand Name	Dose	Start Da	te	 med list 	to ensure they	y are stop	oped.	Monito		V Fluids
HM NIACIN	100MG	12/08/20	009	11 C				Courne		IV Antibiotics
COREG	6.25MG	11/25/20	009					C Dilanti	n.	Hep Lock
LIPITOR	20MG	11/25/20	009							
ALDACTONE	25MG	11/24/20	909			-				
and the second se	6-0111-V	11124120	000				E	Notify Physic	cian if.	
<u>. </u>	2.000	1112412		<u>با</u> ا			Г	And the second second second		 logical/mental status
∢ Consults				and the second	David Da			* Change in * SBP < 90	neuro or > 16	logical/mental status
Consults Last Name	First Name	Date	Reason	Status	Report Rev			* Change in * SBP < 90 * Temp > 10	neuro or > 16 11.4	logical/mental status
∢ Consults		Date		Status	·	Yes		* Change in * SBP < 90 (* Temp > 10 * SpO2 < 88	neuro or > 16 11.4	logical/mental status 50
Consults Last Name	First Name	Date 11/25/2009	Reason	Status C Old @ New C Old C New		Yes Yes		* Change in * SBP < 90 (* Temp > 10 * SpO2 < 88	neuro or > 16 11.4	logical/mental status
Consults Last Name	First Name	Date 11/25/2009 ///	Reason	Status C Old C New C Old C New C Old C New		Yes Yes Yes		* Change in * SBP < 90 (* Temp > 10 * SpO2 < 88	neuro or > 16 11.4	logical/mental status 50
Consults Last Name	First Name	Date 11/25/2009 11 11 11	Reason	Status C Old C New C Old C New C Old C New C Old C New		Yes Yes Yes Yes		* Change in * SBP < 90 (* Temp > 10 * SpO2 < 88	neuro or > 16 11.4	logical/mental status 50
Consults Last Name	First Name	Date 11/25/2009 11 11 11 11 11	Reason	Status C Old C New C Old C New C Old C New C Old C New C Old C New		Yes Yes Yes Yes Yes		* Change in * SBP < 90 (* Temp > 10 * SpO2 < 88	neuro or > 16 11.4	logical/mental status 50
Consults Last Name	First Name	Date 11/25/2009 11 11 11	Reason	Status C Old C New C Old C New C Old C New C Old C New		Yes Yes Yes Yes		* Change in * SBP < 90 (* Temp > 10 * SpO2 < 88	neuro or > 16 11.4	logical/mental status 50

The following is the **Master Progress Order** template.

The organization of this template is not as systematic as some but it does have a structure. There are **administrative and clinical features to this template**. The administrative features appear in somewhat if a right angle moving from the Discharge Instructions up and across to the Medical Power of Attorney.

Continue Pres Discharge Pla Transfer To	sent Course inning		Discusser		de Status ndition ogress sts and Proc	With	Family Medical P of Attorn		Return
Social Service (Consult	OTHERS		3 10	sta di la Prov	COUR OS	01 250001		Plan-Only Note
Protective Serv	ices Referral	Gen	eral, O2, IV Medications	F		aging	Ventil	tical Care	Plate-Only Note
1	1		DietAntake			Procedures 🗹 Hype			
Discharge	15	Activity	PT/OT/Speech		F	anily [Sk	ting Scale	
Discharge I	Instructions		Гто	bacco c	essation ma	terials to be give	en to patient.		
edications (Do edications will pri	int EXACTLY a	s listed here. I		ds here.	These will	ue Medication print in addition	to the current		Urinary Catheter
Brand Name	Dose	Start Da		*	med ast to	ensure they are	s stopped.	Cournadin	V Fluids
HM NIACIN	100MG	12/08/20			-			Diantin	Hep Lock
COREG	6.25MG	11/25/20			-			1 Determin	1 Thep Lock
LIPITOR	20MG	11/25/20							
ALDACTONE	25MG	11/24/20	009	<u>ات</u> ،	1		E F	Notify Physician	H
onsults Last Name	First Name	Date	Reason	Status		Report Review	red Today	* Change in neu * SBP < 90 or > * Temp > 101.4	rological/mental status 160
Ahmed	Jehanara	11/25/2009	Diabetes cor	Cold	New	□ Ye	\$	* SpO2 < 88	
12		11		Cold	C New	□ Ye	s	* Urine Output <	30 cc/hr or < 240 cc/shift
		11		Cold	C New	□ Ye	s		
		11		Cold	C New	□ Ye	s		
		11		100,000,000	CNew	□ Ye	s		
		11	<u> </u>		C New	T Ye			
				COLUMN STORY &	CONTRACTOR ON THE		5.A		
-	1	11		COM	C New	□ Ye	10		

In the middle of this section of the template is a function which allows the provider to document that he/she discussed one or more of the following with the patient, family or medical power of attorney:

- code status,
- condition,
- progress,
- laboratory results and
- procedure results

At the top left of the template, functions are displayed which allows the provider to document that the patient's condition is unchanged and/or discharge planning including:

- Patient transfer to another unit (ICU, Medical, Rehabilitation, Nursing Home, Surgical, Telemetry)
- Social Service consult (discharge planning, nursing home, hospice LTAC) and/or
- referral to protective services (adult or child)

The final element in this section is the designation that this patient is going to be discharged on the current date.

Beneath the check box for indicating that the patient will be discharged is a button entitled "**Discharge**." When that button is launched, the following template appears:

Up t Hospital Follow-Up Instructions BMP, CBC, UA in 10 days Bring ALL medications to next office appointment Code - Full Code - Meds Code - No
BMP, CBC, UA in 10 days Bring ALL medications to next office appointment Code - Full Code - Meds
Continue medications per Post Hospital Follow-up document Continue medications per Post Hospital Follow-up document Dist
Stop antibiotics in
Weight Loss Alert
CONTRACTOR SOS

This template is shared with the **Master Discharge Template**. It allows for a series of orders to be generated for every patient who is being discharged to the Nursing Home or to the Home.

At the bottom left of this template there are boxes for creating a standard set of orders for discharge to both the Nursing Home and to the Home.

The following are screen shots of the Hospital Follow-up Template first with the order set for discharge to the Nursing Home and then with the order set for discharge to home displayed.

Discharge to Nursing Home

Instructions Hosp	×
Hospital Foll	ow-Up
Hospital Discharge Instructions Consult Home Health agency Consult MediHome Health Discussed condition, medications, and follow-up care with patient and/or family Ø Discussed condition, medications, and follow-up care with patient and/or family Ø Discussed condition, medications, and follow-up care with patient and/or family Ø Discussed condition, medications, and follow-up care with patient and/or family Ø Discharge to Nursing Home Falsee Oaks Give a copy of the Post Hospital Follow-up Document Home Speech Therapy Insure patient understands follow-up instructions Insure patient knows how to make follow-up appointment Review all follow-up instructions with patient Review all follow-up instructions with patient Review and ischarge summary, HP and consults to nursing home with patient ✓ Transport by Ambulance ✓ Follow Up with Image:	Post Hospital Follow-Up Instructions Ø BMP, CBC, UA in 10 days Bring ALL medications to next office appointment Code - Full Code - No Continue medications per Post Hospital Follow-up document Daily Weight - if patient gains more than 3lbs in one day call MD Diet Diet Help Desk Discontinue smoking Elevate Limb Ø Fall Risk Assessment Ø Hydration Alert Notify Family of Readmission Ø Notify CFNP of Readmission Ø PriNR in Repeat labs in Repeat labs in
Comments	Stop antibiotics in Sutures out in Vielant Loss Alert
Standard Nursing Home Discharge Orders	Cancel

Discharge to Home

Linewitel F	allowed by
Hospital F	ollow-Op
Despital Discharge Instructions Consult Home Health agency Consult MediHome Health Discussed condition, medications, and follow-up care with patient and/or fail Discussed condition, medications, and follow-up care with patient and/or fail Discussed condition, medications, and follow-up care with patient and/or fail Discussed condition, medications, and follow-up care with patient and/or fail Discussed condition, medications, and follow-up care with patient and/or fail Give a copy of the Post Hospital Follow-up Document Home Speech Therapy Insure patient understands follow-up instructions Insure patient knows how to make follow-up appointment Review all follow-up instructions with patient before discharge Send discharge summary, HP and consults to nursing home with patient Transport by Ambulance Follow Up with Image: Send discharge summary, HP and consults to nursing home with patient Transport by Ambulance Follow Up with Image: Send discharge summary, HP and consults to nursing home with patient Transport by Ambulance Follow Up with Image: Send discharge summary	Post Hospital Follow-Up Instructions BMP, CBC, UA in 10 days Bring ALL medications to next office appointment
	Sutures out in
	Veight Loss Alert

One special function on the **Hospital Follow-up Template** is regarding **Diet**. When the provider clicks in the box next to **diet** in the second column, the following pick list appears

Instructions Hosp		2
Hospital Follo	ow-Up	
Hospital Discharge Instructions Consult Home Health agency Consult MediHome Health Discussed condition, medications, and follow-up care with patient and/or family Discharge to Nursing Home Give a copy of the Post Hospital Follow-up Document Home Rehab Home Speech Therapy Insure patient understands follow-up instructions Insure patient knows how to make follow-up appointment Review all follow-up instructions with patient Review medications with patient before discharge Send discharge summary, H ⁰ and consults to nursing home with patient Transport by Ambulance Follow Up with Implicit Implic	Diet 1 Discontinue smoking Elevate Limb Fal Risk Assessment Follow SETMA Guidelines as p Hydration Alert Notify Family of Readmission Notify CFNP of Readmission Portable Chest x-ray in 10 day PT/NR in Repeat labs in	office appointment
Comments	Skin Care Stop antibiotics in Sutures out in	strict vegetarian wt gain program wt loss program
Standard Nursing Home Discharge Orders ✓ Standard Home Discharge Orders OK C	Weight Loss Alert	Close

Next to the above box is a button entitled **Help**. This button launches a pop-up which describes a number of types of diets to help the provider designate the proper nutrition.

	Diet Help Desk	
Ensure	250 cal per 8 oz can Complete, balanced nutrition	
Ensure Plus	360 cal per 8 oz can complete, balanced nutrition	
Diabetia Source		
Glucerna (Diebetics)	1.0 kcalorie per ml For people with abnormal glucose tolerance	
Glytrol		
Jevity	1.06 kcalorie per ml ideal for long and short-term tube feeding	
Jevity Plus	1.2 kcalorie Per ml ideal for long and short-term tube feeding	
Nepro	 kcal per ml for patients requiring electrolyte and fluid restrictions (Higher in protein for dialysis patient) 	
Nutrena		
Osmolite	1.06 kcalorie Per ml For tube-feeding patients sensitive to hyperosmolar feedings	
Perative	 3 kcal per ml for metabilically stress patients such as with malabsorption problems 	
Promote	1.0 kcal per ml for patients with high-protein and low-calorie needs	
Pulmocare	 5 kcal per ml Designed to reduce C02 production, specialized nutrition for pulmonary patients 	
Suplena (Renal)	2.0 kcal per ml For patients with protein, electrolyte and fluid restrictions (Pre-dialysis because of being lower in protein)	
Two-Cal HN	 2.0 kcalorie per ml For patients with elevated energy and protein needs, fluid restriction, or volume intolerance 	

All of the material will print on the Hospital Order set which will give the hospital nursing staff, the family and patient, and/or also the nursing home staff precise directions for transitioning the patient's care from the hospital to the nursing home, or to home.

Below the Discharge instructions, and the across the bottom of the template, a number of functions are provided:

Transfer To	Discussed Co Transfer To Terminal Discussed Terminal Discussed Discussed Discussed Terminal Discussed Terminal Discussed Discusse			de Status notition ligress sts and Procedures of Attorne			200 million (199		Return Comments			
Protective Services Referral PRN Me DietA		Orders General, 02, IV PRN Medications		Im	oratory laging cedures	2 7 13	Ventila	cal Care tor Settings trkalemia	F	Plan-Only Note		
			Activity PT/OT/Speech			amily	F	Sliding Scale				
Discharge In	nstructions 🔽	Contraction of the	Гто	bacco c	essation ma	aterials to b	e given to	patient.				
Medications (Dou Medications will prin	t EXACTLY as	listed here. Up		ls here	These will	nue Media Il print in ad	dition to th		Disconti C Oxyg	en	Urinary Catheter	
Brand Name	Dose	Start Date		*	and a set to	CHARLE DI	0) 00 0 310	Macor.	Courn		V Fluids	
HM NIACIN COREG	100MG 6.25MG	12/08/200		_	-		- 3		Diant		Hep Lock	
LIPITOR	20MG	11/25/200		-11	-		-1		Section.			
ALDACTONE	25MG	11/24/200		-1				1.00				
1	* on o	1112-112-04		•	-				Notify Physi			
provide the second seco		and strength of the strength of the strength of the	Reason	Status		Report R	eviewed	Today	* Change in neurological/mental status * SBP < 90 or > 160 * Temp > 101.4			
Ahmed	Jehanara		Diabetes cor		I 🕶 New		Yes		* SpO2 < 8			
1		11			I C New	ſ	Yes		* Unne Out	put < 34) cc/hr or < 240 cc/shift	
		11		00-0020	I C New	ſ	Yes					
		11	-	COL	I C New	r	Yes					
1	(i	11	S		I C New	୍ରା	Yes					
		11			I C New		Yes					
3	1 1	11		COL	I C New	ा	Yes					
				0	lear							

In this section, it is possible to add medications, document consultations, document discontinued medications and to discontinue other points of care.

Finally, in the center of the Plan Template there are twelve buttons which provide the opportunity to order a number of different types of care.

Transfer To	se	Discussed	Cor Pro	ie Status ndition gress its and Prov	cedures	with	Patient Family Medical Pow of Attorney			Return Comments	
Social Service Consult Protective Services Referr Discharge Discharge Instructions	el PRN M Div Activity I	Orders General, 02, IV PRN Medications Diet/Intake Activity PT/OT/Speech		Laboratory Imaging Procedures Family		Ventilate		cal Care for Settings rkalemia ng Scale		Plan-Only Note	
Aedications (Double-click to fedications will print EXACTL)	Add/Edit)			Discontin These wil	nue Media	ations	destinate -	Disconti		E una catala	
Brand Name Dose	Start Dat		ap nore.		ensure th			C Oxyg		Urinary Catheter	
HM NIACIN 100MC								Courn	20 C C	V Antibiotics	
COREG 6.25M	and the second s		_	<u> </u>		- 8		T Dilant	'n	Hep Lock	
LIPITOR 20MG	11/25/20			<u> </u>		-3					
ALDACTONE 25MG	11/24/20		-	<u></u>			-		ano ar		
•			•	1				Votify Physi			
Consults Last Name First Name	second production of the local division of t	Reason Diabetes coi	Status			eviewed	Today	* SBP < 90 * Temp > 10	or > 16 01.4	logical/mental status 0	
Ahmed Jehanara	11/25/2009	Diabetes coi	100000	• New		Yes		* SpO2 < 8		0 cc/hr or < 240 cc/shift	
2	11		200 2000	C New	1	Yes		On the Out	100 - 00	Contract < 240 CONTRACT	
	11		10-0000	C New	1	Yes					
	11		304/03030	C New	1	Yes					
	11		Cold	C New	1	Yes					
	11			C New		Yes					
	11		Cold	C New	1	Yes					

Each of the templates launched by these twelve buttons will be displayed here and an explanation of any unique functions will be described.

General, O2, IV

This button launches a template called **Routine Orders** and is self-explanatory.

Progress Planord	×
Routine Orders Clear All	
Vital Sign Measurements Foley Catheter to Gravity Peak Flows Nasogastric Tube to Intermittent Suction Incentive Spirometry Check for Fecal Impaction Incentive Spirometry Enemas Until Clear Nebulizer Treatment Accuchecks Use SETMA Sliding Scale Insulin Protocol	
Supplemental Oxygen Pulse Ox on Current Oxygen Level	
Via at L/min	
Percent Oxygen	
IPAP cm H2O Titrate FiO2 to keep SpO2	
EPAP cm H2O	
CPAP cm H2O	
KCI mEq/L MgSO4 grams/L Regular human insulin units/L Sodium Bicarbonate amps/L Add thiamine 100 mg, folic acid 1mg, and MVI 1 ampule to first bag of IVF daily. Other	nours
Comments	
OK Cancel	

PRN Medications

This button launches a template called **PRN Medications**. Each box by a category has a pick list of medications which can be selected for the patient orders.

Progress Prnmeds		X
PRI	N Medications	Clear All
Fever	Anxiety	
Obtain blood cultures x2 if not drawn in past 72 hours CXR portable upright & sputum for gram stain and culture if not done in past 48 hours	Sedation	
Urinalysis and culture if not done is past 72 hours Acetaminophen 500mg q4 hours PRN if Temp>101F	T Nausea	
Cooling blanket if temp>103.5F until temp<103F	Indigestion	
☐ Pain	Diarrhea	
Acetaminophen 500mg q4 hours PRN if Temp>101F	Constipation	
OK	Cancel	

Diet/Intake Orders

This button launches a template of the same name. The box for the **Change-diet-to** and **Order-dietary-consult-for** both have pick list from which the proper response can be selected by the provider.

Progress Diet	×
Diet/Intake	Orders
 All Meals Out of Bed Begin/Continue Intake and Output Documentation Begin/Continue Daily Calorie Count Daily Weights Encourage PO Fluids Fluid Restriction - 1000 mL q 24 hours including meals Modified Barium Swallow 	Change Diet To
Comments	Cancel

Progress Diet		X
	Diet/Intake	e Orders
All Meals Out of Bed Begin/Continue Intake (Begin/Continue Daily C Daily Weights Encourage PO Fluids Fluid Restriction - 1000 Modified Barium Swalle	Dietary Consult Calorie Intake Increase DASH Diabetes Fat Reduction Fluid Restriction Protien Restriction Renal Sodium Restriction	Change Diet To
	Close	
	ок	Cancel

Activity PT/OT Speech

This button launches a template entitled Activity/Therapy Orders.

Progress Act		×
Acti∨ity/Tl	herapy Orders	
 Ambulate BID Buck's Traction Dangle Feet to Bedside Elevate Head of Bed 6 Inches Fall-Risk Precautions Non Weight Bearing Left Leg/Ankle Right Leg/Ankle Out of Bed PRN 	Physical Therapy Location(s) Range of Motion	
Sit in Chair 3x per day 4x per day Soft Physical Restraints Turn Patient Every 2 Hours Warm/Moist Soaks Right Arm Eff Arm Right Calf Left Calf	Comments	
ок		

Laboratory

This launches the Laboratory Orders template.

Progress Labs				×
		Laboratory Ord	ers	
Acetaminophen Aldosterone Alcohol Level ALT AMI Ammonia, Serum Amylase ANA Anti Cardiolipin Anti Cardiolipin Anti DSDNA Apo E Arterial Blood Gas B12 BMP BNP Calcium CBC CMP C-Difficile C-Peptide C-Reactive Protein Calcium, Ionized	Carbon Monoxide Cortisol, AM Cortisol, PM Cortisol, Total CPK Creatinine D-Dimer Digoxin Dilantin Level Drug Screen Ferritin Fibrinogen Titer Folic Acid H Pylori, Breath H Pylori, Serum Iron Binding Capacity Iron, Serum Haptoglobin Henoglobin A1C Hepatitis B Hepatitis B Hepatitis C	 ☐ HGB/HCT ☐ HIV ☐ Homocysteine ☐ Iron Binding Capacity ☐ Lanoxin Level ☐ LDH ☐ Legionella Urinary Antigen ☐ Lipase ☐ Lipid Panel ☐ Magnesium ☑ Micral Strip ☐ Osmolarity, Serum ☐ Phenobarbital Level ☐ Phosphate ☐ Plasma Renin Activity ☐ Platelet Count ☐ Potassium ☐ Prealburnin ☐ PT/NR ☐ PTH ☐ PT ☐ PSA ☐ RA 	Reticulocyte Count Recurring Salicylate AMI q6 hours x3 Sed Rate BMP qAM x3 days Sickle Cell CMP qAM x3 days Spot A/C Ratio CBC qAM x3 days Strep Screen PT/INR qAM x3 days Transferrin UA qAM x3 days Transferrin Stool Occult Blood TSH Stool Occult Blood Urine Chloride Urine Osmolaity Urine Osmolaity Urine Osmolaity Urine Spot Potassium Urine Spot Potassium Urine Spot Potassium Urine, 24 Hr Creatinine Clearance Urine, 24 Hr Creatinine Clearance Urine, 24 Hr Protein Vancomycin Peak and Trough VAncomycin Peak and Trough	s s ays
Cultures ☐ Blood x2 C ☐ Sputum ☐ ☐	Other Cultures	Gram Stain Other Lak	Comments	

Imaging

This launches the Imaging Orders template

gress Imaging		
	Imaging Orders	
X-Ray	MRI	_
		_
Chest X-Ray qAM		
Ultrasound	ст	Contrast
		□ With □ Without □ With □ Without
		Vith Vithout
Comments	6	_
	OK Cancel	

Procedures

This launches a template of the same name

	Procedures	
 Ambulatory BP Monitoring Bronchoscopy Colonoscopy 	Arteriogram	_
Cytoscopy Cytoscopy Echocardiogram EEG	Biopsies	-
EGD EKG ERCP	Other	
Modified Barium Swallow Pulmonary Function Testing Pulmonary Mechanics Pulmonary Physiotherapy Spinal Tap	Comments	-
Thoracentesis		

Each of the boxes has a pick list attached.

Family

This launches a template named **Family Conference** which creates an order to schedule a family conference.

Progress Famliy	×
Family Conferen	nce
Family Conference Planned For:	
Date 11	
Time	
Location	
[1
OK Cancel	

Critical Care

This button launches an order template of the same name

ess Critio		
	Critical Care	Clear /
For any	acute occurrence of any of the following:	
	If SBP < 90 mm HG then give NS 500cc IV bolus over 15 minutes; if SBP<90 mm Hg after bolus, begin Levophed IV (titrate to 70 <map<60) and="" call="" md.<="" td=""><td></td></map<60)>	
	If SBP >180 mm Hg, then give 0.1 mg clonodine PO or 0.625 mg enalaprilat IV × 1 q 4 hours PRN (may repeat × 1 in 1 hour if SBP remains >180 mm Hg). If SBP>180 mm Hg after second dose of PRN antihypertensive, call MD.	
	If heart rate<40 and patient is symptomatic (i.e. light headed/presyncopal/loss of consciousness), give 0.5 mg atropine IV STAT (may repeat × 1) and call MD. If heart rate > 140 beats per minutes for more than 5 minutes, call MD.	
	For VF or pulseless VT, defibrilate with 200 J, then 300 J, then 360 J as needed; call CODE BLUE and notify attending MD immediately.	
Γ	If RR≺8 call MD. If RR>30 with respiratory distress, call MD.	
	If urine output < 60 cc over 2 hours (not resolved by repositioning /flushing Foley catheter) and SBP>110, give Lasix 40mg IVP. If no response in 30 minutes, call MD.	
Comment	ts	
		-
	OK Cancel	

Ventilator Settings

This launches a template entitled New Ventilator Settings

1	New Ventilat	or Settings
Mode Rate Rate Tidal Volume Suggested Tidal Volume = 8.9 mL/kg = 918. Peak Flow Inspiration/Expiration Ratio Inspiration/Expiration Ratio Help FiO2 Pressure Support PEEP Vent Sensitivity	Amin mL LAmin % cm H2O cm H2O cm H2O	Post Intubation Orders Thrate FIO2 to keep saturation >= CXR portable STAT ABOs in 20 minutes Continuous pulse oximetry Sedation Morphine sulfate 2-10 mg IV q 1 hour PRN agitation If morphine allergy or MAP<60 mm Hg, fentanyl 25-500 mcg IVP q 1 hour PRN agitation Diprivan IV 5-10 cc initial bolus and thrate as need for agitation unrelieved by PRN narcotic use Comments
*If patient ventilated in SIMV mode, respiratory to add pressure support to result in spontaneous volume of at least 6 cc/kg ideal body weight. I mode chosen and patient has no spontaneous H2O pressure support.	us tidal fSMV	Cancel

The **Pressure Support** designation has a **Help** button which when depressed launches the following pop-up:

Progress Planventp			×
	Pressure	Support	
See below for rec	ommended pressure supp	port values, based on the endotracheal tube.	
	Endotracheal Tube	Pressure Support	
	8	8	
	7.5	9	
	7	10	
	6.5	11	
	6	12	
		Cancel	
		Cancer	

Hyperkalemia

This button launches the **Daily Progress Note Hyperkalemia** which has been reviewed previously on this tutorial and also is found on the **Hospital Admission Orders**.

Mild Moderate Severe Thyroid Pro Uric Acid Urine, 24 Hr Urine, 26 md Urine, Potas	file r Creatinine Clearance
Thyroid Pro Uric Acid Urine, 24 Hr Urine, Osmo Urine, Potas	file r Creatinine Clearance
Thyroid Pro Uric Acid Urine, 24 Hr Urine, Osmo Urine, Potas	file r Creatinine Clearance
Urine, 24 Hr Urine, Osmo Urine, Potas	
Unine, Potas	total frances of
the second	A CONTRACTOR OF A CONTRACTOR O
I Unne, Sodu	
Urine, Spot	1970 A 19
Urine, Spot	Understand and the second s
to ameliorate c	ardiac toxicity, if prese
d passesis	
it necrosis	

On this template there are seven **Help** buttons for:

- Hyperkalemia types
- Aldosterone
- Plasma Renin Activity
- Serum Osmolarity
- Serum Osmolality
- Urine, spot potassium
- Urine, spot sodium

Info Hyperkalemia

Hyperkalemia

Severe hyperkalemia is a medical emergency

- * Neuromuscular signs (weakness, ascending paralysis, respiratory failure) * Progressive ECG changes (peaked T waves, flattened P waves, prolonged PR interval, idioventricular rhythm and widened
- GRS complex, "sine wave" pattern, V fib)

Pseudohyperkalemia

- * Hemolysis
- * Thrombocytosis >1,000,000
- * WBC > 200,000
- * Redistribution
- * Acidosis
- * Digitalis overdose
- * AD hyperkalemic periodic paralysis

Impaired Potassium Secretion

- * Aldosterone deficiency
- * Adrenal failure
- * Syndrome of hyporeninemic hypoaldosteronism (SHH)
- * Tubular unresponsiveness
- * Renal failure
- * GFR < 10 20% of normal

- Treatment (1)
 - * Stop potassium!
 - * Get and ECG
 - * Hyperkalemia with ECG changes is a medical emergency

Treatment (2)

- * First phase is emergency treatment to counteract the effects of hyperkalemia
- * IV Calcium
- * Temporizing treatment to drive the potassium into the cells
- * Glucose plus insulin
- * Beta2 agonist
- * NaHCO3

Treatment (3)

- * Therapy directed at actual removal of potassium from the body
- * Sodium polystyrene sulfonate (Kayexalate)
- * Dialysis

Determine and correct the underlying cause!

OK Cancel ×

Aldosterone

This test is performed to investigate hard to control blood pressure, orthostatic hypotension and certain fluid and electrolyte disorders.

Aldosterone is a hormone released by the adrenal glands. It is part of the complex mechanism used by the body to regulate blood pressure. Aldosterone is the main sodium retaining hormone from the adrenal gland. It increases the reabsorption of sodium and water along with the excretion of potassium in the distal tubules of the kidneys. This action raises blood pressure.

Frequently, blood aldosterone levels are combined with other blood tests (plasma renin activity) or provocative tests (captopril test, intravenous saline infusion test or ACTH infusion test) in order to diagnosis over or under production of the hormone.

Normal Values

- * supine: 2 to 16 ng/dl
- * upright: 5 to 41 ng/dl

Greater-than-normal levels of aldosterone may indicate

- * primary hyperaldosteronism (rare)
- * Bartter syndrome (extremely rare)
- * Secondary hyperaldosteronism from cardiac or kidney disease
- * Cushing's syndrome (rare)
- * Very low sodium diet
- * Pregnancy

Lower-than-normal levels of aldosterone may indicate

- * Addison's disease (rare)
- * Very high sodium diet
- * Congenital adrenal hyperplasia
- * Hyporeninemic hypoaldosteronism



96 of 106

×

Renin

Plasma renin activity (PRA) is measured as part of the diagnosis and treatment of hypertension.

- * Patients with primary hyperaldosteronism will have an increased addosterone production associated with a decreased PRA. * Patients with secondary hyperaldosteronism (that is, caused by renal disease or renal vascular disease) will have increased
- plasma levels of renin and aldosterone.

Essential Hypertension and Salt Sensitivity

- * Patients may also have renin and aldosterone levels checked in essential hypertension to evaluate if patients are salt sensitive.
- * This will cause a low renin with normal aldosterone levels, and this helps to guide the physician in choosing the correct medication for these patients.
- * Patients with low renin hypertension, who are salt sensitive, respond well to diuretic medications.

Renin

- * Is an enzyme released by specialized cells of the kidney into the blood. It is in response to sodium depletion and/or low blood volume.
- * Renin converts angiotensinogen (a protein released into the blood by the liver) to angiotensin I.
- * Angiotensin I is converted to angiotensin II by an enzyme in the veins of the lungs. Angiotensin II acts on the adrenal cortex to stimulate the release of aldosterone. Aldosterone acts on the distal tubules of the kidneys to decrease the loss of sodium ions and secondary fluids.
- * This has the effect of increasing blood pressure.
- * In addition, angiotensin causes constriction of small blood vessels, which also increases blood pressure.

Normal values range from 1.9 to 3.7 ng/ml/hour.

Greater-than-normal levels may indicate

- * Addison's disease
- * Cirrhosis
- * Essential hypertension
- * Hemorrhage (bleeding)
- * Hypokalemia
- * Malignant hypertension
- * Renin-producing renal tumors
- * Renovascular hypertension

Lower-than-normal levels may indicate

- * Salt-retaining steroid therapy
- * ADH therapy
- * Salt sensitive essential hypertension

Additional conditions under which the test may be performed

* Primary hyperaldosteronism



×

Serum Osmolarity

Osmolality measures the concentration of particles in solution. Osmolality increases with dehydration and decreases with overhydration.

In normal people, increased osmolality in the blood will stimulate secretion of ADH (antidiuretic hormone). This will result in increased water reabsorption, more concentrated urine, and less concentrated plasma.

A low serum osmolality will suppress the release of ADH, resulting in decreased water reabsorption and more concentrated plasma.

Normal values range from 280 to 303 mOsm/kg. (milliosmoles per kilogram)

Greater than normal levels may indicate

- * Dehydration
- * Diabetes insipidus
- * Head trauma resulting in deficient ADH secretion
- * Hyperglycemia
- * Hypernatremia
- * Consumption of alcohol
- * Consumption of methanol

Lower than normal levels may indicate

- * Excess fluid intake
- * Hyponatremia
- * Overhydration
- * Paraneoplastic syndromes associated with lung cancer
- * Syndrome of inappropriate ADH secretion

Additional conditions under which the test may be performed

- * Complicated UTI (pyelonephritis)
- * Diabetic hyperglycemic hyperosmolar coma
- * Hepatorenal syndrome
- * Interstitial nephritis



* Consumption of ethylene glycol

- * Renal tubular necrosis
- * Severe pyelonephritis
- * Shock
- * Stroke resulting in deficient ADH secretion
- * Uremia

х

Info Urineosmolal

Urine Osmolality

Osmolality measures the concentration of particles in a solution (in this case, urine). Osmolality (particles/kg water) and osmolarity (particles/liter of solution) are sometimes confused -- but for dilute fluids (such as urine), they are essentially synonymous.

Osmolality is a more exact measurement of urine concentration than specific gravity because specific gravity depends on the precise nature of the molecules present in the urine. Specific gravity also requires correction for the presence of glucose or protein.

Normal values are as follows

- * Random specimen: 50 to 1400 mOsm/kg
- * 12 to 14 hour fluid restriction: greater than 850 mOsm/kg (mOsm/kg = milliosmoles per kilogram)

Greater-than-normal measurements may indicate

- * Addison's disease (rare)
- * Congestive heart failure
- * Shock
- * Syndrome of inappropriate ADH secretion

Lower-than-normal measurements may indicate

- * Aldosteronism (very rare)
- * Diabetes insipidus (rare)
- * Excess fluid intake
- * Renal tubular necrosis
- * Severe pyelonephritis

Additional conditions under which the test may be performed

- * Complicated UTI (pyelonephritis)
- * Dilutional hyponatremia (SIADH)



X

Info UrineK

Urine Potassium

This test is usually performed to detect or confirm the presence of conditions that affect body fluids (for example, dehydration, vomiting, diarrhea) or disorders of the kidneys or adrenal glands, which are the source of the aldosterone.

The serum (blood) and urine potassium depend on many factors.

- * Aldosterone is a steroid hormone that plays a major role in regulating potassium levels within the body.
- * Aldosterone increases the loss of potassium in the kidneys.
- * Potassium is also affected by acid/base balance because potassium exchanges with hydrogen, to some extent, across cell membranes.

Normal Values

- * Spot Urine normal values 40-60 mEq.
- * The usual range for a person on a regular diet is 25 to 120 mEq/L/day.
- * However, lower or higher urinary levels may occur depending on dietary potassium intake and the relative amount of potassium in the body.

Greater-than-normal urine potassium levels may indicate

- * Acute tubular necrosis
- * Cushing's syndrome (rare)
- * Diabetic acidosis and other forms of metabolic acidosis
- * Hyperaldosteronism (very rare)
- * Eating disorders (anorexia, bulimia) and vomiting
- * Low magnesium levels

Additional conditions under which the test may be performed

* Medullary cystic disease



X

Inf	fo UrineNa	×
	Urine Sodium	
	The test is often used to determine hydration status and the kidney's ability to conserve or excrete sodium. This test may also be performed to indirectly indicate the function of the adrenal cortex, or to detect or monitor conditions that result in abnormal urine sodium levels.	
	Aldosterone, a hormone produced by the adrenal gland, plays a major role in regulating sodium levels within the body and urine. Specifically, aldosterone increases the reabsorption of sodium in the kidneys at the expense of potassium and hydrogen loss.	
	Urine Sodium Reabsorption of sodium in turn enhances retention of water in body tissues and the blood stream. It is by this means that aldosterone helps maintain plasma volume and blood pressure. Dehydration and conditions that decrease kidney blood flow stimulate aldosterone production.	
	 Normal values are generally * 15 to 250 mEqL/day, depending on hydration status and daily intake of dietary sodium. * Spot urine sodium of less than 20 generally means dehydration, hypotension or other conditions which have stimulated aldosterone production. 	
	Greater-than-normal urine sodium levels may indicate * Adrenocortical insufficiency * Steroid use * Excessive salt intake	
	Lower-than-normal urine sodium levels may indicate * Aldosteronism * Congestive heart failure * Diarrhea and dehydration states * Renal failure	
	Additional conditions under which the test may be performed * Acute tubular necrosis * Hepatorenal syndrome * Medullary cystic disease * Glomerulonephritis * Prerenal azotemia OK Cancel	

Sliding Scale

This button launches a function entitled **SETMA Sliding Scale Insulin Protocol**. It allows the adjustment of the sliding scale based on the assessment of insulin sensitivity and then prints a sliding scale on the chart based on Patient Sensitivity of : average, resistant, sensitive, very sensitive.

Progress Slide	×
SETMA Sliding Scale Insulin Protocol	
Use SETMA Sliding Scale Insulin Protocol	
Patient Sensitivity	
OK Cancel	

Conclusion

The following is an illustration of what a daily progress note looks like for a patient. Two documents are generated:

- The Daily Progress Note which will be printed and placed on the patient's chart.
- The Physician Orders which will be printed, signed and placed on the patient's chart.



Daily Progress Note

Name	College Test		
Date of Birth	01/01/1920, 89 years of age		
Date and Time	11/25/2009 9:25 AM		
This is the first day of hospitalization.			

Admit Status Code Status Visit Type Telemetry Full Code Attending

Current Impression - Stable

Assessment/Plan

* CHF Diastolic Acute - General improvement. The patient's pulmonary congestion has improved and the peripheral edema has lessened. Patient is able to lay flat without difficulty and is able to ambulate without SOB. Diuresis has been good. Will continue current medications and repeat BMP, BNP and chest x-ray. Cardiology note reviewed. Shortness of breath has improved. Good diuresis. Peripheral edema is 1+. PND absent. Orthopnea absent. The patient has Class II CHF. The patient's BNP was 658 pg/mL on 20091124. Echocardiogram ordered. Add IV Lasix.

p>* **Hyperten Isolated Systolic** - The patient's current blood pressure is 138/85 mmHg. The patient's blood pressure is classified as High-Normal (Pre-Hypertensive). The patient's blood pressure is improving. The patient has the following signs of symptoms of hypertension: fatigue, swelling in the legs,. The patient does NOT have the following signs and symptoms of hypertension: dizziness, nosebleeds,. The following medications have been started: ACE inhibitor, beta blocker, thiazide diuretic,. Echocardiogram ordered.

* DM II Renal Manifestat Uncontr - The patient's HgbA1C on 20091118 was 7.9 % which translates to a mean plasma glucose of 203 mg/dL. The patient's diabetes is not well controlled. The patient's blood sugar is improving. Ketosis is absent. The patient's blood pressure is 138/85 mmHg. The patient's current diet is Cardiac. The patient confirms the following from the review of systems: chest pain, difficulty breathing,. The patient denies the following from the review of systems: constipation, diarrhea, nausea, vomiting, hyperkalemia, hypokalemia,. The following lab tests have been ordered: HgbA1C, Lipid Panel, Micral Strip, Urinalysis,. Endocrinology consult ordered.

General Orders

Continue Present Course

Consults

Last Name First Name Date Reason

Status

Report Reviewed Today

Ahmed Jehanara 11/25/2009 Diabetes control New Consult - Please Notify

Laboratory Orders

Hemoglobin A1C, Lipid Panel, Micral Strip, Urinalysis,

Procedures

Echocardiogram

Estimated Discharge Date - 11/27/2009 Days in ICU this Stay - 0 Days IV Antibiotics this Stay -0 Days Ventilator this Stay - 0

Current Diagnosis

Fredrickson Type IIb Hyperlipoproteinemia Renal Stage II Chron Disease, Chronic CHF Diastolic Acute, Chronic improved Hyperten Isolated Systolic mmHg Anemia Unspecified DM II Renal Manifestat Uncontr

Chronic Conditions

Hyperten Benign Essential Knee Derang Medial Menis Posted Hyperlipidemia, Mixed Epiglottitis Acute No Obstruct Amputation Above Knee Uncompli DM II Renal Manifestat Control Abd Pain RUQ Cardiac PTCA Stent CAD Ischemic Heart Dis Chronic Abn Brain EEG Zenker's Diverticulum CAD Angioplasty PTCA Stent Hyperten Benign Essential Hyperten Benign Essential

Pertinent Events of the Past 24 Hours

Cardio/Pulmonary

Pertinent Events of the Past 24 Hours

+ Chest Pain, Improving + Shortness of Breath, Improving

Surgeries This Stay

<u>Vital Signs</u>

Weight - 227.00 pounds Height - 63.00 inches BMI - 40.21 kg/m² Blood Pressure - 138 / 85 Pulse - 92.00 bpm Pulse Ox - 95 %(room air) Respirations - 19 /min Temperature - 98.60 F TMax (24 Hrs) - 98.80 F

Diet

Current Diet - Cardiac Current Appetite - Diminished Percentage Meals Eaten - 50 to 75% 24 Hour Bowel History - Movement within last 24 hours/td>

All Current Medications

Brand Name	Dose	Sig Codes
Hm Niacin	100mg	
Lipitor	20mg	1 tab po qd
Coreg	6.25mg	po bid
Aldactone	25mg	1 tab po qd
Test Strip		q other week
Lisinopril	10mg	1 po qd.
Singulair	5mg	
Actos	15mg	
Allegra	60mg	
Synthroid	137mcg	
Glyburide-metformin Hcl	5mg-500mg	1 po qd

Review of Systems

There has been no change in the review of systems since the history and physical performed on 11/24/2009.

Allergies Description Onset	009
	.009
Meperidine Hcl 11/03/20	
Preservative Free 11/03/20	.009
Codeine 05/19/20	.009
Iodine 02/23/20	.009
Potassium Iodide 02/23/20	.009
Sodium Iodide 02/23/20	.009
No Known Allergies To Medications 02/23/20	.009
Aspirin 02/19/20	.009
Celecoxib 02/23/20	.009
Sulfa (sulfonamide Antibiotics)06/27/20	008
Egg 11/28/20	007
Penicillin G Potassium 02/12/20	007
Asafetida 01/17/20	007

Physical Exam

<u>Respiratory</u> Inspection - Normal Auscultation - Normal Palpation -Normal Percussion -Normal Cough -Absent <u>Cardiovascular</u> Auscultation - Normal Murmurs - Absent Palpation - Normal JVP - Normal Peripheral Edema - Yes Bilateral - 1+

<u>Cardio Intima Media Thickening</u> Thickening (mm)	Left	Right
Blockage Present		
Perecnt Blocked	0%	0%
<u>Abdomen</u> Inspection - Normal Auscultation - Normal Positive Hepatojugular Reflux - Negative Positive Hepatojugular Reflux - Negative		

The patient's code status, condition, progress, tests and procedures was/were discussed with the patient, .

Approved by James L. Holly MD 11/25/09 Southeast Texas Medical Associates, LLP **Physician Orders**

General Orders Continue Present Course Consults Last Name First Name Date Reason Status Report Reviewed Today Ahmed Jehanara 11/25/2009 Diabetes control New Consult - Please Notify Laboratory Orders Hemoglobin A1C, Lipid Panel, Micral Strip, Urinalysis, Procedures Echocardiogram

Approved by James L. Holly MD 11/25/09 Southeast Texas Medical Associates, LLP