

# EPR Core and Clinical Documentation Foundation

## Progress Note - Comprehensive


### Quick Reference Guide

This **Quick Reference Guide (QRG)** provides step-by-step instructions on how to complete the **Progress Note-Comprehensive**, a structured electronic document used by care providers to document ongoing patient information.

A new **Progress Note** is created for each chart entry. For example, if a user needs to document information about the patient at several different times throughout the day, a new Progress Note should be selected for each entry.

This document is designed to support more comprehensive and detailed documentation than the **Progress Note – General**, offering additional sections for enhanced charting. Users may complete whichever sections are appropriate based on the charting requirements for the specific situation or episode of patient care.


### How to Document in a Progress Note-Comprehensive

<p><b>Place the Patient into Context and Open the Document</b></p>	<ul style="list-style-type: none"> <li>Find the patient using <b>Status Board</b>, <b>Patient List</b> or the <b>Find Patient</b> functionality and place the patient visit into context</li> <li>Click on the Enter Document icon  on the <b>Main Toolbar</b> and select the <b>Progress Note - Comprehensive</b> document.</li> </ul>
<p><b>Documenting in the Progress Note-Comprehensive</b></p>	<ul style="list-style-type: none"> <li>Choose the discipline the note is related to from the <b>Note Related to</b> drop down <u>OR</u> type into the free text back below. This is the title of the document.</li> </ul> <div style="border: 1px solid green; padding: 5px; margin: 10px 0;"> <p><b>Note:</b> Entering a detailed description in the <b>Note Related to</b> free-text, makes it easier to identify the note when it appears among other completed documents in the <b>Documents</b> tab.</p> </div> <div style="border: 1px solid gray; padding: 5px; margin: 10px 0;"> <p>Note Related To</p> <div style="border: 1px solid blue; padding: 2px;"> <span style="background-color: #0056b3; color: white; padding: 2px;">Note related to:</span> </div> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acute Care Surgery Service</li> <li><input type="checkbox"/> Acute Pain Service</li> <li><input type="checkbox"/> Anaesthesia</li> <li><input type="checkbox"/> Audiology</li> <li><input type="checkbox"/> Audiology Newborn Screening</li> <li><input type="checkbox"/> Cardiac Surgery</li> <li><input type="checkbox"/> Cardiology</li> <li><input type="checkbox"/> Cardiology Electrophysiology</li> </ul> </div> <ul style="list-style-type: none"> <li>Free-text your note into the <b>Progress Note</b> free-text field</li> </ul>

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<p><b>Health History</b></p>	<ul style="list-style-type: none"> <li>• If applicable, check off any existing <b>Health Issues</b> as entered for the <b>Medical History, Chronic Problems, Surgical History, and Past Family Medical History</b> <ul style="list-style-type: none"> <li>○ If not already available or updates are required, add and modify <b>Health Issues</b> by clicking the <b>Health Issues Manager</b> icon  and selecting applicable problems</li> </ul> </li> </ul>
<p><b>Vital Signs</b></p>	<ul style="list-style-type: none"> <li>• Click on Retrieve Last Charted Values in the lower left-hand side of the window</li> </ul> <div style="border: 1px solid green; padding: 5px; margin-top: 10px;"> <p><b>Note:</b> The <b>Retrieve Last Charted Values</b> button will pull any <b>Vital Signs</b> recorded in the <b>last 8 hours</b>. Height from the last 6 months and weight from the <b>last 24 hours</b> from this visit only.</p> </div>
<p><b>Social History</b></p>	<ul style="list-style-type: none"> <li>• Click <b>Retrieve Last Charted Values</b> in the lower left-hand corner of the window to check whether any information is available for retrieval <ul style="list-style-type: none"> <li>○ If values are returned, review and validate all content</li> <li>○ If no information is available, manually enter the patient's Social History according to your assessment requirements</li> </ul> </li> </ul> <div style="border: 1px solid green; padding: 5px; margin-top: 10px;"> <p><b>Note:</b> The <b>Retrieve Last Charted Values</b> button will pull <b>Living Situation, Employment, and Other Social History</b> from as far back as 12 months. Tobacco and Alcohol as far back as 3 months.</p> </div>
<p><b>Physical Exam</b></p>	<ul style="list-style-type: none"> <li>• Allows for a detailed examination of different systems</li> </ul>
<p><b>Obstetrical and Labour Record</b></p>	<ul style="list-style-type: none"> <li>• Content will be visible <u>only</u> if assessments are entered on the Obstetrical and Labour Record Flowsheet.</li> </ul>
<p><b>Body Images</b></p>	<ul style="list-style-type: none"> <li>• Body Images is the section to incorporate various body images into your documentation. To do so: <ul style="list-style-type: none"> <li>○ Click on the body image you want to draw on</li> <li>○ Type in any measurements or comments that may apply to the diagram</li> <li>○ Click <b>OK</b> when you are finished</li> </ul> </li> </ul>

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<p><b>Lab Results</b></p>	<ul style="list-style-type: none"> <li>• <b>Lab – Content:</b> Lists the specific lab results that will automatically populate in the Lab Results section if they are available in EPR</li> <li>• <b>Lab – Results:</b> Allows you to view and select lab results to pull into your document. Only results within the selected range will be available to check off.</li> <li>• <b>Lab Results Comments:</b> This is a free-text field for any additional lab information</li> </ul>
<p><b>Diagnostic Results</b></p>	<ul style="list-style-type: none"> <li>• Type in any comments you wish to add regarding any <b>Diagnostic Results</b></li> </ul>
<p><b>Impression and Plan</b></p>	<ul style="list-style-type: none"> <li>• This section allows a user to identify health issues/problems with their respective assessments and plans.</li> <li>• The <b>Impression</b> field is a free-text box to document the impression of the patient's assessment/problems</li> <li>• If not already available or updates are required to the patient's <b>Current Problem/Surgery Current:</b> <ol style="list-style-type: none"> <li>1. Add and modify <b>Health Issues</b> by clicking the <b>Health Issues Manager</b> icon </li> <li>2. Copy the Problem List by selecting one of the radio button selections within the <b>Problem/Assessment/Plan</b></li> <li>3. Once problems have been entered, you can prioritize them by moving them up or down your list using the up/down/clear options on the right side</li> <li>4. Document the assessment and plan for the respective problems</li> </ol> </li> </ul>
<p><b>Summary</b></p>	<ul style="list-style-type: none"> <li>• This section is a free-text field to document a summary of your note</li> </ul>
<p><b>Save the Progress Note- Comprehensive</b></p>	<ul style="list-style-type: none"> <li>• Click the Save/Close button             <ul style="list-style-type: none"> <li>○ Click <b>Submit as Final</b> if your note is complete</li> <li>○ Click <b>Submit as Incomplete</b> for the document to remain modifiable</li> </ul> </li> </ul>