

EPR Core and Clinical Documentation Foundation

Progress Note - General


Quick Reference Guide

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

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.

Note: In addition to the **Progress Note – General**, the Electronic Patient Record (EPR) also includes the option to document using a **Progress Note – Comprehensive**. This document is designed to support more detailed and extensive documentation than the **Progress Note – General**, offering additional sections to enhance charting. Users should select the document that is most appropriate based on the charting needs of the specific situation or episode of care.


How to Document in a Progress Note - General

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

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<p>Impression and Plan</p>	<ul style="list-style-type: none"> • This section allows a user to identify health issues/problems with their respective assessments and plans. • The Impression field is a free-text box to document the impression of the patient's assessment/problems • If not already available or updates are required to the patient's Current Problems/Surgery Current: <ol style="list-style-type: none"> 1. Add and modify Health Issues by clicking the Health Issues Manager icon  2. Copy the Problem List by selecting one of the radio button selections within the Problem/Assessment/Plan 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 4. Document assessment and plan for the respective problems
<p>Summary</p>	<ul style="list-style-type: none"> • This section is a free-text field to document a summary of your note
<p>Save the Progress Note - General</p>	<ul style="list-style-type: none"> • Click the Save/Close button <ul style="list-style-type: none"> ○ Click Submit as Final if your note is complete ○ Click Submit as Incomplete for the document to remain modifiable