OVERVIEW OF ESSENTIAL CHARTING ELEMENTS FOR THE EMERGENCY DEPARTMENT

ALL CHARTING NEEDS TO BE FINISHED AT THE END OF YOUR SHIFT PRIOR TO LEAVING THE ED
IF YOU HAVE ANY QUESTIONS, ASK FOR HELP!

All of the following sections must be addressed for a note to be considered complete

BASIC INFORMATION

*** Basic Information** M <Hide Structure> <Use Free Text>

* Provider Contact Time (repeat)	* Date & time=== / ED Attending M / ED Resident / ED NP/PA / MSE / Other
History source	Patient / Caretaker / Significant other / Family+ / EMS / Police / Friend / Interpreter / Other M
Arrival mode	Arrival mode / Private vehicle / Walking / Wheelchair / Ambulance-ground / Ambulance-air / Police / Amb-ALS / Amb-BLS / Other
History limitation	None / Clinical condition M / Physical impairment / Cognitive impairment / Language barrier / Intubated / Sedated / Other M
Additional info	Patient's physician(s)+ / Other

Minimum:
1. Date & time you entered the room
2. ED Attending
3. Your name (ED Resident, ED NP/PA, or other)
4. History limitations (e.g. language barrier, age, etc.)

BEST charts:
- History Source (who else was in the room – be sure to include the interpreter!)
- Arrival mode (e.g. ambulance, walking, etc.)

Good charting habit: If the patient is unable to provide a history, document why under History Limitation. "Clinical condition" is not specific enough, but altered mental status or intoxication is.

HISTORY OF PRESENT ILLNESS

History of Present Illness <Hide Structure> <Use Free Text>

	Fever
Presents with	Fever / Chills / Other
Onset	Just PTA / === mins ago / === hours ago / === days ago / === weeks ago / Unknown / Other
Course/Duration	Constant / Improving / Resolved+ / Worsening / Episodes+ / Fluctuating intensity / Unknown / Other
Associated symptoms >>	None / Chest pain / Shortness of breath / Cough / Rhinorrhea / Ear ache / Sore throat / Nausea / Vomiting / Diarrhea / Abdominal pain / Headache / Rash / Decreased oral intake / Other
Temperature	=== deg C / === deg F / Subjective / Method of detection+ / Other
Risk factors >>	None / DM / Immunocompromised / Transplant hx / Recent surgery / Tick bite / Dialysis pt / HIV / Other
Prior episodes	None / Frequent / Occasional / Rare / Chronic / Multiple ED visits / Other
Therapy today >>	None / Acetaminophen / NSAID / OTC meds+ / Rx meds+ / Drs. office visit / EMS / Degree of relief+ / See nurses notes / Unknown / Other
Additional Hx >>	None / Other Indwelling devices: none / pacemaker / AICD / VP shunt / spinal cord stimulator / pain pump / Other Indwelling lines: none / Foley / suprapubic catheter / PICC / port-o-cath / dialysis catheter / feeding tube / Other
Notes	Notes

Minimum:
1. Please free text the HPI. (Click Use Free Text or enter under Notes.)
2. Please also select 4 or more individual HPI elements.

BEST charts:
- While redundant, coders frequently miss elements in a free text HPI, but clicking elements alone makes the HPI unreadable. Please do both!
- When the history is unobtainable, the reason why and any attempts to obtain it from a source other than the patient should be documented.

REVIEW OF SYSTEMS

Review of Systems M <Hide Structure> <Use Free Text>

Constitutional >>	Negative / Fever / Chills / Sweats / Weakness / Fatigue / Decreased activity / Other
Skin >>	Negative / Jaundice / Rash / Pruritus / Abrasions / Breakdown / Burns / Dryness / Petechiae / Lesion / Other
Eye >>	Negative / Recent vision problems / Pain / Discharge / Icterus / Diplopia / Blurred vision / Blindness / Other M
ENMT >>	Negative / Ear pain / Sore throat / Nasal congestion / Sinus pain / Other M
Respiratory	Negative / SOB / Orthopnea / Cough / Hemoptysis / Sputum production+ / Stridor / Wheezing / Other
Cardiovascular	Negative / Chest pain / Palpitations / Tachy / Syncope / Diaphoresis / Peripheral edema / Other
Gastrointestinal >>	Negative / Abdominal pain / Nausea / Vomiting / Diarrhea / Constipation / Rectal bleeding / Rectal pain / Other Abdominal pain: mild / moderate / severe / diffuse / RUQ / LUQ / RLQ / LLQ / R flank / L flank / epigastric / periumbilical / suprapubic / pelvic / acute / chronic / sharp / colicky / dull / achy / burning / cramping / pressure / pain / Other
Genitourinary >>	Negative / Dysuria / Hematuria / Vaginal bleeding / Vaginal discharge / Other
Musculoskeletal >>	Negative / Back pain / Muscle pain / Joint pain / Claudication / Other
Neurologic >>	Negative / Headache / Dizziness / Altered LOC / Numbness / Tingling / Weakness / Other
Psychiatric >>	Negative / Anxiety / Depression / Sleeping problems / Substance abuse / Other
Endocrine >>	Negative / Polyuria / Polydipsia / Polyphagia / Hyperglycemia / Hypoglycemia / Other
Heme/Lymph	Negative / Bleeding tendency / Bruising tendency / Petechiae / Gum bleeding / Swollen nodes / Other
Allergy/Immunologic >>	Negative / Seasonal allergies / Food allergies / Recurrent infections / Impaired immunity / Other
Additional ROS info	All systems otherwise negative / ROS reviewed as documented in chart / Unable to obtain due to+ / Other

Minimum:
1. Click on pertinent elements for a review of systems or free text in "other" fields as appropriate.
2. Click "All systems otherwise negative".

BEST charts:
- Level 4 charting needs 2-9 systems
- Level 5 charting needs 10 or more (asking "anything else" counts!)
- You may also use the macro by clicking on the blue M by Review of Systems.

Good charting habit: If the patient is unable to participate in the interview, you may select "Unable to obtain" and then specify why the ROS was unobtainable.

HEALTH STATUS

Health Status M <Hide Structure> <Use Free Text>

Allergies >>	Include allergy profile / NKA / Unable to obtain / Other
Medications	Launch Meds List / None / Unable to obtain / Per nurse's notes / Other M
Immunizations >>	UTD / Include Immunizations / Tetanus UTD / Unable to obtain / Per nurse's notes / Other M
LMP	Per nurse's notes / Menopausal / Hysterectomy / Unknown / Other LMP: date=== / ===day(s) ago / ===week(s) ago / ===months(s) ago / ===year(s) ago / reg / irreg / Other
Pregnancy history	Never pregnant / Currently pregnant / ===weeks / G=== / P=== / Full term=== / Pre-term=== / SAB=== / EAB=== / Other

Minimum:
1. Allergies
2. Medications (you can also use "Launch Meds List" but ask the patient for medication changes in complex patients)
3. Immunizations if relevant

BEST charts:
- Beware that this paragraph is usually collapsed because Cerner auto-imports this data. Click on "Show Structure" (where "Hide Structure" is above) to expand this area to clean up the imported data.

PAST MEDICAL/FAMILY/SOCIAL HISTORY

Past Medical/ Family/ Social History M <Hide Structure> <Use Free Text>

Medical history M >>	Neg / Unable to obtain / Other M CV: HTN / CHF / DVT / a-fib / paced rhythm / hyperlipidemia / Other Resp: asthma / pneumonia / emphysema / bronchitis / PE / Other Endo: DM (Type 1 / Type 2) / DKA / hypothyroid / hyperthyroid / Other GI: GERD / PUD / gastritis / IBS / pancreatitis / hepatitis / biliary disease / SBO / Crohn's / hemorrhoids / Other GU: UTI / pyelonephritis / renal stone / ovarian cyst / ectopic pregnancy / chronic renal insufficiency / STD / PID / Other Neuro: CVA / TIA / migraine / headache / CP / head injury / seizure+ / peripheral neuropathy / Other Psych: depression / anxiety / alcohol abuse / substance abuse / bipolar / schizophrenia / ADHD / PTSD / Other Cancer: colon / lung / breast / leukemia / lymphoma / CNS / bone / ovarian / cervical / skin / Other Musculoskeletal: back pain+ / neck pain+ / ===fracture / chronic pain / fibromyalgia / RA / Other
Medical history >>	Neg / Include medical history / Reviewed in chart / Unable to obtain / Other
Surgical history >>	Neg / Unable to obtain / Appe / Chole / Hyst / BTL / Tonsillectomy / Herniorrhaphy / D&C / Ortho=== / Arthroscopy / C-section / Other M
Surgical history >>	Neg / Include surgical history / Reviewed in chart / Unable to obtain / Other
Family history M >>	Non-contributory / Family history powerform / Unable to obtain / HTN / DM / Other M
Social history >>	Reviewed in chart / Unable to obtain / Secondary smoke exposure / Other M ETOH: none / occasional / regularly / drinks===servings daily / drinks==servings weekly / abuse hx. / Other Tobacco: none / tobacco use / occasionally / regularly / ===ppd / ===cigs per day / for==years / quit==years / Other Drugs: none / drug use-status / amphetamines / drug type / cocaine / heroin / marijuana / methamphetamines / Other Occupation: employed / unemployed / student / Other Family/social situation: married / unmarried / widowed / intact family / lives with parent(s) / lives with relative(s) / group home resident / lives alone / homeless / assisted living resident / school / foster care resident / abuse concerns / neglect concerns / Other M Foreign travel: None / Date / Region/country === / Other Notes: Notes
Social history >>	Negative / Social Hx (ST) / Include smart template / Reviewed in chart / Unable to obtain / Other
Problem list	Include problem list / Per nurse's notes / Other
Additional Past History	Other

Minimum:
1. Medical History
2. Family History (non-contributory is okay)
3. Social History

BEST charts:
- Beware that this paragraph is usually collapsed. Be sure to click on "Show Structure" (where "Hide Structure" is above) to expand this area to clean up the imported data.
- You may also use the macro by clicking on the blue M by Past Medical/Family/Social History.

PHYSICAL EXAM

Physical Examination M <Hide Structure> <Use Free Text>

Vital signs >>	Time === / Include VS from flowsheet / Per nurse's notes / Ht/wt from flowsheet / Document VS+ O2 sat: ===% / Include O2 sat from flowsheet / Other
General >>	Alert / No acute distress / Mild distress / Moderate distress / Severe distress / Anxious / Ill-appearing / Other M
Skin >>	Warm / Dry / Pink / Intact / Moist / No pallor / No rash / Normal for ethnicity / Cyanotic / Cool / Pale / Other
Head >>	Normocephalic / Atraumatic / Other
Eye >>	PERRL / EOMI / Normal conjunctiva / Vision unchanged / Other M
ENMT >>	TM's clear / Oral mucosa moist / No pharyngeal erythema or exudate / Other M
Neck >>	Supple / Trachea midline / No tenderness / No carotid bruit / Other M
Cardiovascular M >>	Regular rate, rhythm / No murmur / Normal peripheral perfusion / No edema / Other M
Respiratory M >>	Lungs CTA / Non-labored respirations / BS equal / Symmetrical expansion / Other M
Chest wall >>	No tenderness / No deformity / Other
Gastrointestinal M >>	Soft / Nontender / Non distended / Normal BS / No organomegaly / Guaiac negative - QC OK / Other
Genitourinary >>	No tenderness / No discharge / Normal external genitalia / No lesions / Other
Back >>	Nontender / Normal ROM / Normal alignment / No step-offs / Other
Musculoskeletal >>	Normal ROM / Normal strength / No tenderness / No swelling / No deformity / Other
Neurological M >>	A/O x 4 / No focal neuro deficits / CN II-XII intact / Normal sensory / Normal motor / Normal speech / Normal coordination / Other M
Lymphatics >>	No lymphadenopathy / Other M
Psychiatric >>	Cooperative / Appropriate mood & affect / Normal judgment / Non-suicidal / Other
Drawings	Full Body+ / Head+ / Eye+ / Upper body+ / RUE+ / LUE+ / Perineum+ / RLE+ / LLE+ / Notes
Additional PE Info	Other / Draw-image

Minimum:
1. Click "Include VS from flowsheet" and "Include O2 sat from flowsheet" to import the triage vital signs and oxygen saturation.
2. Include at least 1 element for each organ system. (You must have 8 organ systems, which are Gen, Eyes, ENT, CV, Resp, GI, GU, MSK, Skin, Neuro, Psych, and Lymph).

BEST charts:
- **You may also use the macro by clicking on the blue M by Physical Examination.**
- This also means you need to perform at least 8 physical exam maneuvers!

MEDICAL DECISION MAKING

Good charting habit: This small section is the "meat" of the note! Put time and thought into it!

Medical Decision Making <Hide Structure> <Use Free Text>

Fever Diff Dx >>	Fever / Viral syndrome / Pneumonia / Bronchitis / OM / URI / Sinusitis / UTI / Pyelo / Pharyngitis / Gastroenteritis / Sepsis / Bacteremia / Influenza / Cellulitis / Meningitis / Tick-born illness / HIV / Other
Rationale	Notes
Documents reviewed >>	None available / Chief complaint from nursing notes / EMS / Long term care / Prior ED / Prior records / Launch Documents / Other
Orders	Launch Order Profile / Add Powerplans / Other
Results review	Lab results / All Results / Other Interpretation: Labs unremarkable / Normal results / Consistent with previous results / Abnormal results === / Other
CXR (repeat) M >>	Time reported=== / No acute disease process / EP interp / Include Rad interp(flowsheet) / Describe
Radiology results (repeat) M	Time reported === / X-ray / CT / US / MRI / ECHO / Body location === / With contrast / Without contrast / Discussed with radiologist / Reviewed radiology report / No acute disease process / No change from previous / EP interp:=== / Interpretation === / Launch Rad interp (flowsheet) / Other
Notes	Notes / Draw-image

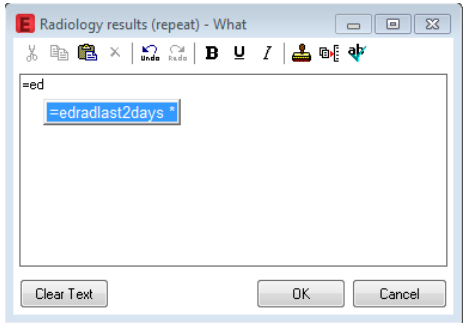
Minimum:
1. **Differential diagnosis**: Click on appropriate elements, adding those not listed under "other".
2. **Rationale:** Free text the reason for your plan. What are you thinking? Why are you testing or not testing? What differential diagnoses are ruled out based on the history and exam alone? Why is the patient safe for discharge?
3. **Documents reviewed**: If you spoke with EMS, looked at previous notes in the EMR, or had records from another ED, document it here. You must include the date of the notes you reviewed, the source, and a brief summary of your findings.
4. **Orders:** Use "Launch Order Profile" and include the orders entered by you or other ED providers. Caution: Only include orders by the ED team if the patient has been admitted. You may have to re-launch this at discharge or admission to include all IV medications given! Make sure the medications say completed.
5. **Results review**: Click "Lab results" to import any labs performed. See below on how to interpret them.
6. **Insert radiology studies**. Click on "Other" in the Radiology results sentence and type "=edradlast2days" in the pop-up box. You will have to clean it up a bit but this is a lot easier than copying/pasting. See below on where to interpret them.
7. **EKG**: Include EKG findings if obtained. You may also use the macro by clicking on the blue M.

After importing labs, interpret them. You should interpret abnormal labs under "Abnormal results".

Interpretation: Labs unremarkable / Normal results / Consistent with previous results / Abnormal results === / Other

Good charting habit:
Look at and interpret all radiologic studies obtained.
Include BOTH your interpretation AND the radiology read!

Radiology read here (under Other)

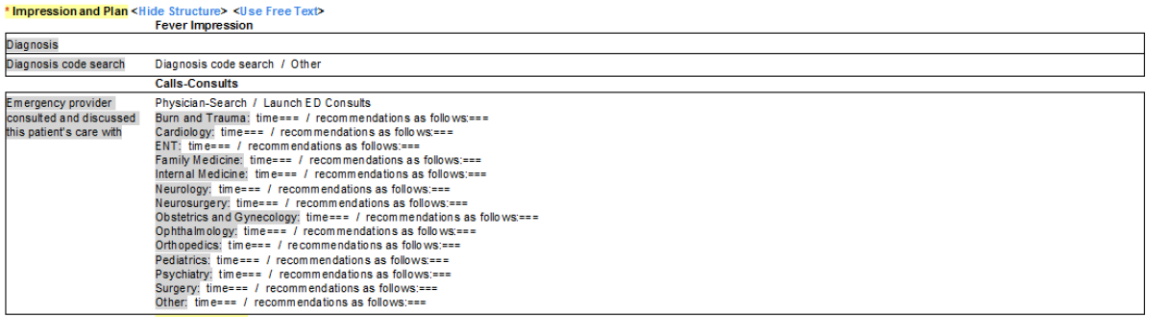


Your read here (under EP interp)
OR using the macro next to the study (e.g. CXR)

CXR (repeat) M >>	Time reported=== / No ac
Pelvis x-ray (repeat) M >>	WNL / Normal alignment
Hip x-ray (repeat) M >>	Time reported=== / Norma
Radiology results (repeat) M	Time reported === / X-ray / EP interp:=== / Interpret

You only need to put the interpretation for one study if there are multiple studies resulted.

IMPRESSION



* Impression and Plan <Hide Structure> <Use Free Text>	Fever Impression
Diagnosis	
Diagnosis code search	Diagnosis code search / Other
	Calls-Consults
Emergency provider consulted and discussed this patient's care with	Physician-Search / Launch ED Consults Burn and Trauma: time=== / recommendations as follows:=== Cardiology: time=== / recommendations as follows:=== ENT: time=== / recommendations as follows:=== Family Medicine: time=== / recommendations as follows:=== Internal Medicine: time=== / recommendations as follows:=== Neurology: time=== / recommendations as follows:=== Neurosurgery: time=== / recommendations as follows:=== Obstetrics and Gynecology: time=== / recommendations as follows:=== Ophthalmology: time=== / recommendations as follows:=== Orthopedics: time=== / recommendations as follows:=== Pediatrics: time=== / recommendations as follows:=== Psychiatry: time=== / recommendations as follows:=== Surgery: time=== / recommendations as follows:=== Other: time=== / recommendations as follows:===

Minimum:
1. For diagnosis, click "Other" and free-text your suspected diagnosis. If you don't know what to put, ask the attending!
2. Any consultants you spoke with, including the time and the general discussion you had with them.

BEST charts:
- The diagnosis should include acuity, laterality and modifying factors.
- The name of the specialist you spoke with.

DISCHARGE PLAN

	* Discharge plan
Condition M	Unchanged / Improved / Stable / Guarded / Unstable / Critical / Expired / Other
* Disposition M >>	Disposition Type / Patient requested discharge prior to medical stabilization / Time=== / AMA / LWBS / Eloped / Expired / ME notified / Referral to=== / Other * Medical Screening Exam Determination (repeat): *Time=== / emergent medical condition exists / emergent medical condition stabilized / medical screening exam determination ongoing / emergent medical condition does not exist Discharge (emergent medical condition stabilized or does not exist): time === / home / rehab / police / foster care / Other Admit: time === / Inpt / Obs / Inpt Tele / Obs Tele / ICU / CCU / Surgery / Physician-Search / Other Transfer: time === / Facility name:=== / Accepted by:=== / Room #=== / ICU / Other Pt care transitioned to: time === / Physician-Search / Other Reason for delay: pt/family refusal / cardiopulmonary arrest / hemodynamic instability / wait pending consult / no bed availability / observation / Other Dispositioned by: time === / Physician-Search M / Other Supervision provided by M : Physician-Search M / time=== / Other
Prescriptions	Prescription Writer / Rx provided / Other
Pt. education	Pt. education / Other M
Limitations	Limited activity / Limited work / No work / No school / No sports / No heavy lifting / No sexual intercourse / === days / Other
Follow up M	Launch Follow-up / Launch ED appointments and referrals / Return to ED / Primary Care Physician / Physician-Search / Other In: === hours / === day(s) / === week(s) / as needed / Other
Counseled M	Patient / Family / Friend / Regarding dx / Regarding diagnostic results / Regarding tx plan / Regarding Rx / Patient understood / Other M
Pregnancy prophylaxis	Discussed / Declined / Accepted / Other
Notes	Notes

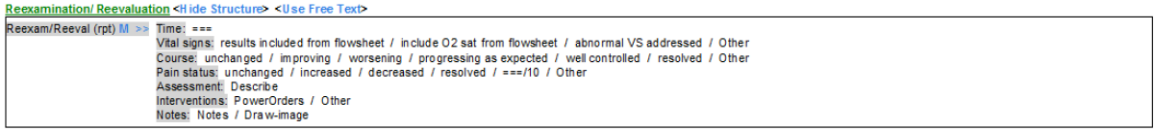
Minimum:
1. A disposition (e.g. "home" if discharging home, "Inpt" if admitted to the floor, "Surgery" if admitted to the OR, or "Obs" if admitted to the observation unit).
2. Prescription Writer" for any prescriptions (or free text the script you wrote). "Rx provided" is not sufficient.
3. Pt. education (see tips on next page).
4. Follow-up (e.g. "see PCP in 2-3 days"). At a minimum include f/u with PCP in 1 week as needed.

BEST charts :
- Add "Condition".
- Include a "Reason for delay" under Disposition if indicated.
- If you sign the patient out to another provider, use "Pt care transitioned to" and put the provider's name who is taking over the patient's care.

ADDITIONAL HELPFUL CERNER CHARTING TIPS!

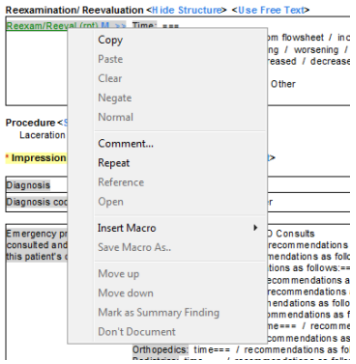
REEXAMINATION

Minimum: Anytime you go back into a patient room or there is a condition change, you should chart the time you rechecked the patient and your assessment. This is great for when you take over the care of a patient and for documenting new vital signs.

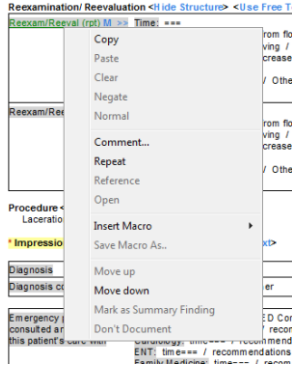


Reexamination/ Reevaluation <Hide Structure> <Use Free Text>	
Reexam/Reeval (rpt) M >>	Time: === Vital signs: results included from flowsheet / include O2 sat from flowsheet / abnormal VS addressed / Other Course: unchanged / improving / worsening / progressing as expected / well controlled / resolved / Other Pain status: unchanged / increased / decreased / resolved / ===/10 / Other Assessment: Describe Interventions: PowerOrders / Other Notes: Notes / Draw-image

REEXAMINATION: Repeat



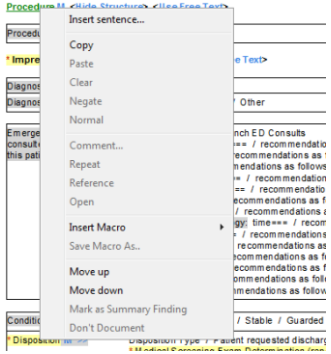
REEXAMINATION: Move-up or Move-down



Good charting habit: If you reexamine the patient more than once, you can repeat this field. Just right click on "Reexam/Reeval (rpt)" and the above drop-down box appears. Click on "Repeat" and another reexamination box will appear below the first.

If someone else puts in a reexamination before you can chart yours or if you need to reorder the reexaminations, you can use the same drop-down box to move your reexamination up or down using "Move up" or "Move down" to reorder them.

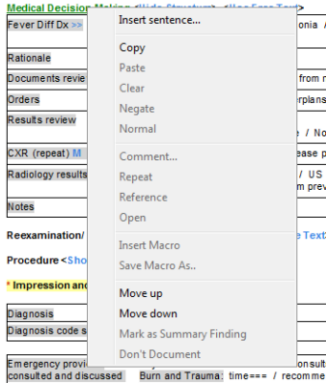
PROCEDURES

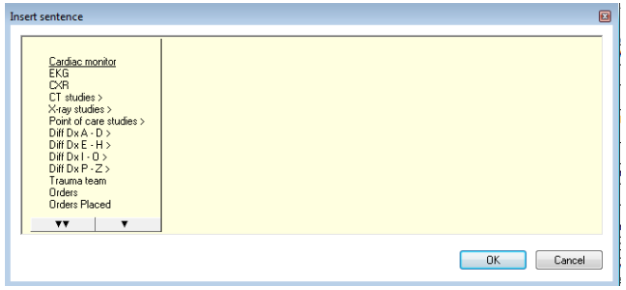


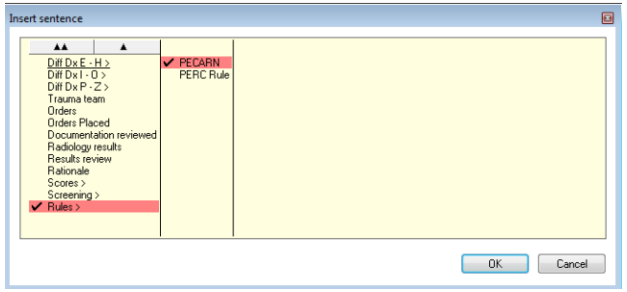
Right click on “Procedures” and use “Insert sentence…” to locate templates for common procedures (e.g. laceration repair, procedural sedation, etc.)

- Be sure to include the name of the person performing the procedure!
- Remember that procedures done by nursing and techs count such as splint applications.

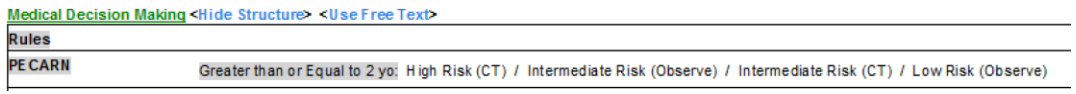
SCORES, SCREENING AND RULES





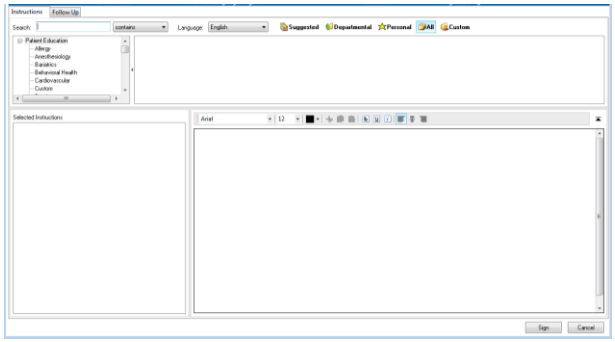


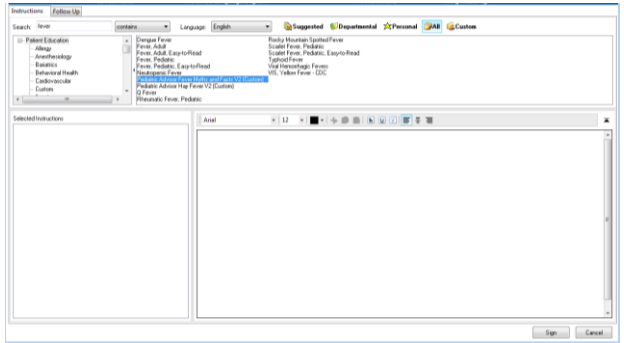
Right click on “Medical Decision Making” and use “Insert sentence…” to add a decision score, screening or rule. Then click the double down arrow or scroll to the bottom. The PECARN rule is shown below.



PATIENT EDUCATION

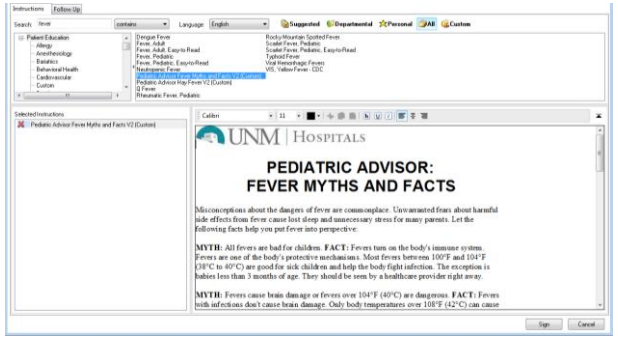
IF THE PATIENT WAS SEDATED: THIS SECTION MUST INCLUDE PROCEDURAL SEDATION DISCHARGE INSTRUCTIONS





In the DISCHARGE PLAN section there is an area for Patient Education which should be done for all discharged patients. Use the search box to find an appropriate discharge instruction (be sure the ALL button is selected). The above search is for “fever.” Double click on the desired form.

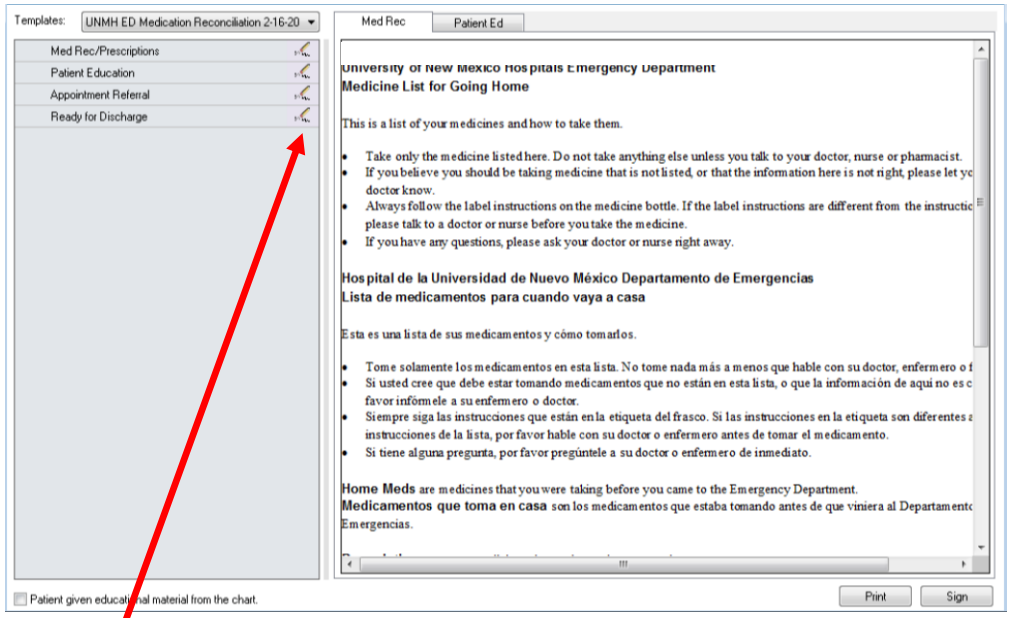
Good charting habit: You can search for clinics to give the patient a map and phone number to their clinic!



This will drop the instructions into the field on the left. You can modify anything in the instructions. An example is: “Dave was seen for X. He has Y. Please do [insert instructions for treatment]. Please see his regular doctor in [insert a time]. If he has [conditions to return] or if you have any other concerns, please see a doctor or return to the emergency department.”

PATIENT DISCHARGE

Good charting habit: It is best to complete the Impression and Discharge Plan in the note before this next step. It makes it a lot easier. When the patient is ready to go home, click on "Depart" for the following screen.



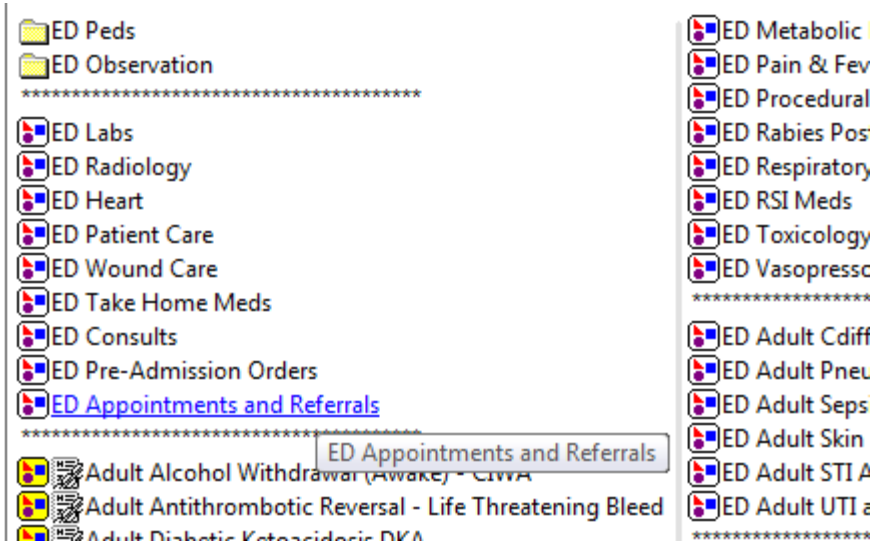
Click on the pencil icons next to the four items listed on the left: "Med Rec/Prescriptions," "Patient Education," "Appointment Referral," and "Ready for Discharge." If you have finished the Impression and Discharge Plan in the note, the Patient Education box will already be done!

The pencil icon next to Med Rec/Prescriptions is used to complete medication reconciliation.
The pencil icon next to Appointment Referral is used to adhoc for follow up appointments.
The pencil icon next to Ready for Discharge puts the discharge order in.

Click Print and then Sign. The paperwork will print out, which you should put on the chart. Ask where to put the chart to communicate with nursing that the patient is ready to go!

PATIENT REFERRAL

If you need to make a referral for an outpatient clinic, click on the pencil icon next to Appointment Referral in Depart. The Power Orders Menu will appear. Select the ED Appointments and Referrals careset.



Select the appropriate clinic and fill out the consult form. This signals to the clinic that you have requested an appointment and they will call the patient. It is important to give the patient information on how to get to the clinic and the clinic phone number, which can easily be done under PATIENT EDUCATION (see earlier tip).