Dynamic Documentation Narrative Summary Note

To be used by all who are using Dynamic Documentation

The template is designed to:

- Also serve as daily progress note
- Leverage information entered elsewhere in the chart to assist in a pre-completed note
- Facilitate communication with other services
- Easily integrate essential regulatory and billing requirements

How is the Note Created?

- All in yellow are required by compliance/regulatory
- Text in red is where the information will pull from and how it functions
- Items which display in black are not required but upon review of notes documented in our system they are included to capture this need.

This will serve as today's daily progress note

Date of Admission: Pulls in the date of admission in Registration

Date of Discharge: Pulls in the date of discharge in Registration; if encounter has not been discharged then it will default to today's date.

Date and Time of evaluation Pulls in current date and time, adjust if needed to record actual date and time the patient is seen

Interval Hx/Subjective: Pulls in documentation entered in Workflow Summary for the following components:

- Subjective/History of Present Illness
- Interval History/Subjective

Hospital Course: Pulls in documentation entered in the Workflow Summary tabs for the Multi-contributor Hospital Course component

Consulting Clinicians: Pulls in any group consultation note documented on that encounter and displays the name

Chronic Problem List: Pulls active chronic problems; does NOT include any problem with the Classification of Confidential

Home Medications: Pulls in active prescriptions; does NOT include any prescription marked as Confidential. If Discharge Med Rec is NOT completed, will display "Discharge med rec needs to be completed before the home medications will display"

Dx/Imaging tests reviewed:

Lab results reviewed:

Concerns of abuse or neglect:

Responses are: NA/Yes – click to remove incorrect response

Procedures/OR Procedures: Pulls in any procedures from the Surgery Intra-Op documented. Displays the date first and then the procedure(s).

Procedures/Lines and Procedures: Pulls in any procedures documented in the Lines and Procedures, PICC and Circumcision powerforms, followed by the date. If there are multiple instances of that procedure, then it will display the procedure once followed by the dates it was charted.

Objective/Review of Systems: Pulls in documentation entered in Workflow Summary for the following components:

Physical Exam: Pulls in documentation entered in Workflow Summary for the following components:

- Objective/Physical Exam
- Physical Exam

Lab Results: Pulls any Lab results that were tagged by the provider in the Workflow Summary.

Pending Lab Studies: Pulls any outstanding (unresulted) lab test for that hospitalization.

Assessment: Pulls in documentation entered in Workflow Summary "this visit" diagnoses from the Problem list and comments added in the assessment section for the following components:

- Assessment (non-confidential)
- Assessment and Plan

Condition on Discharge: This will always default in "Stable"

Plan:

Discharge Orders: Pulls all Discharge Orders that were entered on current hospitalization.

Follow-up: Pulls Future Orders (excluding DME), RTC, Rehab and Referral Orders that are documented on current hospitalization.

Patient Education Provided: Pulls in the title(s) of any patient education items added via the Patient Education component on the Workflow Summary or within Depart.

Visit Time: This will always default in the phrase "___ minutes was spent in preparation for discharge".

Routing: Pulls in the Primary, Referring and any provider listed on the Lifetime Clinical Team.