**Purpose:** To ensure documentation is accurate and efficient to the degree that if someone else looks at the encounter later, the thought process and plan are readily and efficiently evident

**Who:** Providers

**Tools/Supplies Required:** EMR access

*Revised*:

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| **#** | **What** | **How** | **Why** |
| 1 | Link Diagnoses to appropriate orders | Note: Avoid “Associate All” whenever possible |  |
| 2 | Document important treatment changes by writing them. Don’t just rely on the associations | * Include what and *why* the treatment changes were made. Example: “Stop Lisinopril, start Amlodipine because of blood pressure fluctuations” | Epic associations capture action, not the physician’s thinking |
| 3 | Document clear plan and next steps, if appropriate | * Write it in either: * A/P in Problem List * Free Txt at end of Prog Note * Pt instructions | Notes should make clear:   * What you were you thinking * What did you do and why * What’s next |
| 4 | Document when patient should follow-up and why in LOS Section | * Use Speed Buttons (create your own) to help make this efficient | Data entered here can be easily viewed by:   * The patient in the AVS * The MA in Check Out report * The PSRs in the ApptDesk |