Reclaim Your Voice: Refining Your Medical Narrative
Clinical Documentation in the EHR Era

Tabassum Salam, MD, FACP
PATIENT NAME:  

REGIONAL MEDICAL CENTER - TWIN FALLS, ID 83301  

Patient:  

MR #: M R 0 0 41 Age/Gender: 77y F  

DOS: 9/12/2015 18:01 Acct #: M F 1IIl11. .. .. mmmmm  

PRIVATE PHYS:  

INTERNAL MEDICINE (208)  

CHIEF COMPLAINT:  

Shortness of breath Initial Blue  

Physicians for  

Initials/Date/Time  

Temp (F)  

Rt. Pulse  

Resp  

Syst  

Diast  

Pos.  

02  

02  

Pain  

Sat Del Sc  

VITAL SIGNS  

MKS 9/12/2015  

18:09  

98.4  

0  

75  

20  

131  

84  

S  

92 .R/A 0  

LMS2 9/12/2015  

19:00  

74  

168  

88  

S  

90  

2  

L 0  

LMS2 9/12/2015  

19:30  

98.2  

0  

66  

18  

173  

83  

S  

98  

2  

L 0  

AKA 9/12/2015  

21:02  

98.6  

0  

80  

18  

149  

66  

S  

98  

2  

L 0  

CHIEF COMPLAINT: Pt complains of shortness of breath x 4 days and a wet cough. 20 g IV L AC. Pt received Zofran 4 mg IV and Duoneb. <KCT 09/12/15 18:08>
Airway open and patent. Breathing is spontaneous. Pulses are present. <KCT 09/12/15 18:08> 
Patient is awake and alert. Affect, orientation, and speech are age appropriate. <KCT 09/12/15 18:08>

Arrival: Patient arrived by stretcher via EMS transport from home accompanied by T/paramedic <KCT 9/12/2015 18:08>

Patient has not traveled outside the triage <KCT 09/12/15 18:08> Ready for complete triage <KCT 09/12/15 18:10>

ESI level 3 < KCT 9/12/2015 18:09>

Patient's language is: English. Information received from patient <KCT 9/12/2015 18:09>

Last menstrual period not applicable. <KCT 09/12/15 18:10 > Private physician: <KCT 09/12/15 18:10>

Patient is placed in the treatment area and determined a high risk for falls. Stretcher in low position, wheels locked, and when cares are not being performed, both side rails are to remain up. Call light is within reach of patient caregiver. Patient/caregiver instructed on fall precautions and . They are encouraged to call for assistance to up. <KCT 9/12/2015 18:11>

Current home medications: Cyanocobalamin NAS 1 mg Monthly

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Patient: MF42 05 A
DOB: 09/21/37
ACCT: MF050565845
PATIENT: MF42 05 A
DOB: 09/21/37
ACCT: MF050565845
MED REC#: OM IN REP: 0913-0014 N
EMERGENCY DEPARTMENT REPORT ST. TWIN FALLS, IDAHO
MEDICAL CENTER

Fall Risk Assessment Form <KCT 09/12/15 18:10>

Pt/parent expresses no concerns for safety in current relationships. <KCT 09/12/2015 18:12>
PCT 09/12/2015 18:11 SVC OT: 09/12/15 MED REC#: OM IN REP: 0913-0014 N
EMERGENCY DEPARTMENT REPORT ST. TWIN FALLS, IDAHO
MEDICAL CENTER

Medications

Current home medications: Cyanocobalamin NAS 1 mg Monthly

Allergies

Patient allergies: Demerol Valium < KCT 9/12/2015 18:09> <KCT 09/12/15 18:09>
PCT 09/12/2015 18:11 SVC OT: 09/12/15 MED REC#: OM IN REP: 0913-0014 N
EMERGENCY DEPARTMENT REPORT ST. TWIN FALLS, IDAHO
MEDICAL CENTER

Attnd: THIS REPORT IS CONFIDENTIAL AND NOT TO BE RELEASED WITHOUT PROPER AUTHORIZATION.

11/06/15-14:51 by KKA7
Calcium oral 600 mg unit(s) every day Vitamin C PO 500 mg every day
Norco PO 10/325 mg PRN
Pulmicort INHL- dose unknown BID Prozac PO 40 mg every day
Nitro-Bid sublingual - dose unknown PRN
Formoterol Fumarate Inhalation - dose unknown BID Albuterol INHL 2 puffs PRN
Hydrochlorothiazide PO 12.5 mg every day Metoprolol Tartrate PO 25 mg BID
Oxygen every day
Potassium Chloride PO 10 mEq every day Ambien PO 10 mg PRN
Duoneb INHL QID
< JS19 9/12/2015 18:25>

Any additional medications taken in the PAST 30 DAYS (including all patches, medications/implanted pumps, prescription drugs, injections, OTC products and herbs/supplements). Also, any medications taken on a specific schedule (i.e. monthly, yearly). none < JS19 9/12/2015 18:25>

Meds and allergies were validated by this RN. Method of validation: patient and home list < JS19 9/12/2015 18:25>

Past Medical/Surgical History

PAST MEDICAL/SURGICAL HISTORY Lung resection Crohn's disease Colectomy Chronic Obstructive Pulmonary Disease Angioplasty Hypertension Femoral-popliteal bypass Tonsillectomy < KCT 9/12/2015 18:10>

Patient has not been diagnosed with antibiotic resistant infection. <KCT 09/12/15 18:10>

Social History

Tobacco use: Yes <KCT 09/12/15 18:11>

DOB: 09/21/37 ACCT: MF050565845 SVC OT: 09/12/15 MC: 09/21/37 Rel.: 0913-0014

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EMERGENCY DEPARTMENT REPORT

TWIN FALLS, IDAHO

ST. LUKE'S MAGIC VALLEY PCI (PCI: OE Database MVR)

Run: 11/06/15 14:51 by KKA7
Rhythm strip done, labeled, posted
MKS 09/12/15 18:10 < MKS 9/12/2015 18:10>
ORDERS

Medicine

IV's (implement IV protocol as needed): Insert heparin lock IV or saline lock IV per site

: Prednisone Oral 60mg tabs PO DEC, MD 9/12/2015 18:30>

Lab

CBC, Plt and auto diff [Reference: 5521293-CBCD]

Comprehensive Metabolic Panel [Reference: 5521294-CMP]

C-Reactive Protein [Reference: 5521294-CRP]

B-Type Natriuretic [Reference: 5521297-BN PEPTIDE]

MORPHOLOGY [Reference: 5521293-RBC MORPH]

Troponin-I

Chest Two Views; Indications: Shortness of Breath

#MVR#01683329 [Reference: PATIENT: DOB: 09/21/37 ACCT: MF050565845 REC# OM IN]

(This Report is Confidential and Not to be Released without Proper Authorization.)

Radiology

Run: 11/06/15-14:51 by KKA7
EKG
EKG; 12 lead EKG

Medication Administration

IV's (implement IV protocol as needed): Insert heparin lock IV or saline lock IV per
ordered medication was

site in the left antecubital
20 gauge peripheral catheter

placed in the fluid. The saline lock at this site is assessed and determined patent. Site is flushed w/ 10 ml NS.

JS19 9/12/2015 18:35
: Prednisone Oral 60mg tabs PO 9/12/2015 18:30 Ordered
medication was give 9/12/2015 18:40

JS19 9/12/2015 18:44 RESULTS

Lab

CBC, Plt and auto diff

Test  Flag  Value  Units  Ref.  Range  Status  Lab  Address

HEMOGLOBIN:  9/12/2015 18:34 G/DL  F
HEMATOCRIT  37.5 %  36.0-48.0  F
RBC  3.94 M/UL  3.5-5.5  F
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<th>Value 2</th>
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<td>FL</td>
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<td>31.5</td>
<td>PG</td>
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<tr>
<td>PLATELET COUNT L</td>
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<td>K/UL</td>
<td>140-440</td>
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<tr>
<td>WBC</td>
<td>6.3</td>
<td>K/UL</td>
<td>3.8-11.0</td>
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<tr>
<td>MEAN PLATELET VOLUME</td>
<td>8.7</td>
<td>Fl</td>
<td>7.0-10.0</td>
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<tr>
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<td>%</td>
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<tr>
<td>MONOCYTES, % AUTO</td>
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<td>%</td>
<td>1.0-10.0</td>
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<tr>
<td>EOSINOPHILS, % AUTO</td>
<td>3</td>
<td>%</td>
<td>0.0-3.0</td>
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<tr>
<td>BASOPHILS, % AUTO</td>
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<td>%</td>
<td>0-1</td>
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<tr>
<td>NEUTROPHILS, ABS AUTO</td>
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<td>K/UL</td>
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<tr>
<td>LYMPHOCYTES, L ABS AUTO</td>
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<td>Fl</td>
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Run: 11/06/15-14:51 by KKA7

This report is confidential and not to be released without proper authorization.
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<td>%</td>
<td>36.0-48.0</td>
<td>F</td>
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<td>3.94</td>
<td>M/UL</td>
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<td>F</td>
<td></td>
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<tr>
<td>MCV</td>
<td>F</td>
<td>95.2</td>
<td>FL</td>
<td></td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>MCH</td>
<td>F</td>
<td>31.5</td>
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<td>F</td>
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<td>Fl</td>
<td>7.0-10.0</td>
<td>F</td>
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<tr>
<td>NEUTROPHILS, %</td>
<td>F</td>
<td>75</td>
<td>%</td>
<td>40-76</td>
<td>F</td>
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<tr>
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<td>F</td>
<td>15</td>
<td>%</td>
<td>24-44</td>
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<tr>
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<td>F</td>
<td>7</td>
<td>%</td>
<td>1.0-10.0</td>
<td>F</td>
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<tr>
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<td>F</td>
<td>3</td>
<td>%</td>
<td>0.0-3.0</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>MONOCYTES, %</td>
<td>F</td>
<td>1</td>
<td>%</td>
<td>0-1</td>
<td>F</td>
<td></td>
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<tr>
<td>AUTO</td>
<td>F</td>
<td>1</td>
<td>%</td>
<td>0-1</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>EOSINOPHILS, %</td>
<td>F</td>
<td>1</td>
<td>%</td>
<td>0-1</td>
<td>F</td>
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<tr>
<td>AUTO</td>
<td>F</td>
<td>1</td>
<td>%</td>
<td>0-1</td>
<td>F</td>
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<tr>
<td>BASOPHILS, %</td>
<td>F</td>
<td>1</td>
<td>%</td>
<td>0-1</td>
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</table>

**PATIENT:**
DOB: 09/21/37  
MED REC#: MF050565845

**SVC DT:** 09/12/15  
ADM IN: 09/12/15

**MED RECORD:**
EMERGENCY DEPARTMENT REPORT
REGIONAL MEDICAL CENTER  
TWIN FALLS, IDAHO

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AND NOT TO BE RELEASED WITHOUT PROPER AUTHORIZATION.

(PCI: OE Database MVR)
NEUTROPHILS, 4.67 K/UL 1.9-8.8 F
ABS AUTO
LYMPHOCYTES, 0.91 K/UL 1.0-4.8 F
ABS AUTO
MONOCYTES, ABS 0.44 K/UL 0.1-0.8 F
AUTO
EOSINOPHILS, 0.17 K/UL 0.0-0.5 F
ABS AUTO
BASOPHILS, ABS 0.05 K/UL 0.0-0.1 F
AUTO
MEAN PLATELET VOLUME 8.7 Fl 7.0-10.0 F

Reviewed By: [Redacted] MD 9/12/2015 19:38

Result 9/12/2015 18:49 < User N. Interface 9/12/2015 18:49> Result

completed: 9/12/2015 18:35

Test Flag Value Units Ref. Range Status Lab Address
HEMOGLOBIN 12.4 G/DL 12.0-15.0 F
HEMATOCRIT
RBC 37.94 M/UL 38.0-5850 F F
MCV 95.2 FL 79.0-101.0 F
MCH 31.5 PG 25.0-35.0 F
MCHC
RBC DISTRIBUTION WIDTH-CV 13.7 % 11.0-16.0 F
PLATELET COUNT L 126 K/UL 140-440 F
WBC 6.3 K/UL 3.8-11.0 F
MEAN PLATELET VOLUME 8.7 Fl 7.0-10.0 F
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<th>Comments</th>
<th>La Address</th>
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</thead>
<tbody>
<tr>
<td>CREATININE</td>
<td>H 1.1 mg/dL 0.52-1.0</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GLOMERULAR</td>
<td>46 7.0-10.0</td>
<td>F</td>
<td>This</td>
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<td></td>
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</tbody>
</table>

**NEUTROPHILS,**

Auto

75 % 40-76 F

**LYMPHOCYTES,** % L

Auto

15 % 24-44 F

**MONOCYTES,**

Auto

7 % 1.0-10.0 F

**EOSINOPHILS,**

Auto

3 % 0.0-3.0 F

**BASOPHILS,** %

Auto

1 % 0-1 F

**NEUTROPHILS,**

Abs auto

4.67 K/UL 1.9-8.8 F

**LYMPHOCYTES,** % L

Abs auto

0.91 K/UL 1.0-4.8 F

**MONOCYTES,** Abs auto

0.44 K/UL 0.1-0.8 F

**EOSINOPHILS,** Abs auto

0.17 K/UL 0.0-0.5 F

**BASOPHILS,** Abs auto

0.05 K/UL 0.0-0.1 F

**MEAN PLATELET VOLUME**

8.7 fl 7.0-10.0 F

Reviewed by: [Redacted], MD 9/12/2015 18:55

Comprehensive Metabolic Panel


PATIENT: J

DOB: 09/21/37

SVC DT: 09/12/15

ACCT: MF050565845

MED R E C #:

Twin Falls, Idaho

EMERGENCY DEPARTMENT REPORT

REGIONAL MEDICAL CENTER

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### Filtration Rate

- **Sodium**: 137 mmol/L (135-144 F)
- **Potassium**: 3.8 mmol/L (3.5-5.5 F)
- **Chloride**: 97 mmol/L (98-107 F)
- **HCO₃**: 32 mmol/L (22.0-32 F)
- **Anion Gap**: 8 mmol/L (7-15 F)
- **Osmolality**: 278 mOsm/k (270-300 F)

---

**Result**: The result must be adjusted for the patient's body surface area to be accurate. For an African American patient, multiply the result by 1.21. A calculated GFR less than 60 ml/min/1.73 m² when present for 3 months or more is evidence of Chronic Kidney Disease (CKD).

---

**Run**: 11/06/15-14:51 by KKA7
LC, SERUM

UREA NITROGEN 23 mg/dL 7-17 F
BUN/CREATININ 20 10-20
RATIO
GLUCOSE H 108 mg/dL 60-95 F
CALCUM 9.0 mg/dL 8.4-10.6 F
PROTEIN, TOT 6.7 g/dL 6.3-8.2 F
ALBUMIN 3.5 g/dL 3.5-5.0 F
GLOBULIN 3.2 g/dL 2.5-4.0 F
ALBUMIN/GLOBULIN RATIO 1.1 1.0-3.0 F
BILIRUBIN, TOT 0.6 mg/dL 0.0-1.3 F
ALT 27 U/L 9-52 F
ALKALINE PHOSPHATASE 87 U/L 38-126 F
AST 35 U/L 14-36 F

Reviewed By: Christopher R. Rhead, MD 9/12/2015 19:38

RESULT


Fla Val Units g Ref. Stat Comments La Address
ue : 9/12/2015 18:35 Range bs
CREATININE H 1.1 mg/dL 0.52-1.04 F
GLOMERULAR 46 F This result
FILTRATION RATE must be adjusted for the

PATIENT: MF4205 A
DOB: 09/21/37 ACCT: MF05056845
SVC OT: 09/12/15 MED
EMERGENCY DEPARTMENT REPORT ST. TWIN FALLS, IDAHO
REGIONAL MEDICAL CENTER

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Run: 11/06/15-14:51 by KKA7
Body Surface Area to be accurate.
For an African American patient, multiply the result by 1.21 to calculate the GFR less than 60 ml/min/1.73 m^2 squared when present for 3 months or more is evidence of Chronic Kidney Disease (CKD).

<table>
<thead>
<tr>
<th>Parameter</th>
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</thead>
<tbody>
<tr>
<td>Sodium</td>
<td>137 mmol/L</td>
<td>135-144 F</td>
<td>F</td>
</tr>
<tr>
<td>Potassium</td>
<td>3.8 mmol/L</td>
<td>3.5-5.5 F</td>
<td>F</td>
</tr>
<tr>
<td>Chloride</td>
<td>97 mmol/L</td>
<td>98-107 F</td>
<td>F</td>
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<tr>
<td>Creatinine</td>
<td>32 mmol/L</td>
<td>22.0-32 F</td>
<td>F</td>
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<tr>
<td>Anion gap</td>
<td>3 mmol/L</td>
<td>32.0-32 F</td>
<td>F</td>
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<tr>
<td>Osmolality, CA LC, Serum</td>
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<td>270-300 F</td>
<td>F</td>
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<tr>
<td>Urea Nitrogen</td>
<td>23 mg/dL</td>
<td>7-17 F</td>
<td>F</td>
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<tr>
<td>BUN/Creatinin</td>
<td>28</td>
<td>10-20 F</td>
<td>F</td>
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Note: DOB: 09/21/37, SVC DT: 09/12/15, EMERGENCY DEPARTMENT REPORT: 0913-0014

**THIS REPORT IS CONFIDENTIAL AND NOT TO BE RELEASED WITHOUT PROPER AUTHORIZATION.**
E RATIO

GLUCOSE    H 108 mg/dL  60-95   F
CALCIUM    9.0 mg/dL  8.4-10.   F
PROTEIN, TOT  6.7 g/dL  6.3-8.2  F
ALBUMIN    3.5  3.5-5.0   F
GLOBULIN    3.2 g/dL  2.5-4.0  F
ALBUMIN/GLOBULIN    1.1  1.0-3.0  F
BILIRUBIN, TOT  0.6 mg/dL  0.0-1.3  F
ALT        27 U/L  9-52   F
ALKALINE   87 U/L  38-126  F
PHOSPHATASE    35 U/L  14-36  F

Reviewed By: [Redacted] 9/12/2015 19:38

C-Reactive Protein

completed: 9/12/2015 18:35

Test    Flag Value Units Ref. Status Lab Address
C-REACTIVE    H     3.1 mg/dL 0.0-0.9   F

Reviewed By: [Redacted] 9/12/2015 19:38
C-REACTIVE PROTEIN

| Range |  H | 3.1 mg/dL | 0.0-0.9 F |

Reviewed By: [Redacted] MD 9/12/2015 19:38

B-Type Natriuretic Peptide

Result 9/12/2015 19:02 < User N. Interface 9/12/2015 19:02> Result

Test completed: 9/12/2015 18:35

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<th>Valu</th>
<th>Units</th>
<th>Ref. Statu</th>
<th>Comments</th>
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<td>B-TYPE NATRIURETI C PEPTIDE</td>
<td>H</td>
<td>870 pg/mL</td>
<td>0-10 F</td>
<td>0</td>
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</tbody>
</table>

There is a relationship between the severity of the clinical signs and symptoms of CHF and the median BNP concentration, demonstrating that the I-STAT BNP test degrees can be used as an aid in the diagnosis of all severity, including asymptomatic patients.

Reviewed By: [Redacted]

DOB: 09/21/37 ACCT: MF050565845
SVC OT: 09/12/15 MED REC#: [Redacted] Rep: AMC IN

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**PLATELET H** LARGE NORMA F PLATELET COUNT.
**MORPHOLOG** PLATELET
**OVALOCYTE H** PRESENT NONE F

Reviewed By: [Redacted] 9/12/2015 19:38

**Result completed: 9/12/2015 18:35**

**Patient:** [Redacted]
DOB: 09/21/37
ACCT: MF050565845
CC: R
Diet: Cl
SVC DT: 09/12/15
MED REC#: -
ADM# -
ADM IN: 0913-0014
REP: 0913-0014
EMERGENCY DEPARTMENT REPORT
REGIONAL MEDICAL CENTER
TWIN FALLS, IDAHO

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<tr>
<td>TROPONIN -I</td>
<td>F</td>
<td>0.01</td>
<td>ng/m</td>
<td>0.00-0</td>
<td><em><strong>VITROS HIGH SENSITIVITY TEST METHOD</strong></em></td>
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<td></td>
<td>L</td>
<td>.03</td>
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<td>Any Troponin result above 0.10 suggests myocardial ischemia/damage.</td>
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### Differential, Manual


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<tr>
<td>PMN, MR</td>
<td>70</td>
<td>%</td>
<td>F</td>
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<tr>
<td>BAND, MR H</td>
<td>6</td>
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<td>21</td>
<td>%</td>
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<tr>
<td>LYMPHOCYTE L</td>
<td>3</td>
<td>%</td>
<td>1-10</td>
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<td>PLT</td>
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<td>OVALO CYTES H</td>
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Reviewed By: [Redacted] 9/12/2015 19:38


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PATIENT: 
DOB: 09/21/37 ACCT: SVC OT: 09/12/15
MED REC# ADM IN EMERGENCY DEPARTMENT REPORT ST.
RE050565845 0913-0014 REGIONAL MEDICAL CENTER
TWIN FALLS, IDAHO

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[Redacted] PCI (PCI: OE Database MVRI
Run: 11/06/15-14:51 by KKA7
BAND, MR H 6 0-4 F
LYMPHOCYTE L, MR 21 24-44 F
MONOCYTE, MR 3 % 1-10 F

PLATELET H LARGE NORMA F
MORPHOLOGY PLATELET L

OVALOCYTES H PRESENT

Reviewed By: C. R. C. MD 9/12/2015 19:38 Radiology

Chest Two Views; Indications: shortness of breath

  completed: 9/12/2015 19:12

Chest Two Views; Indications: shortness of breath

Patient Name:
Unit No: MR00008541

EXAM# TYPE/EXAM
001683329 RAD/CHEST TWO VIEWS

THIS REPORT IS CONFIDENTIAL AND NOT TO BE RELEASED WITHOUT PROPER AUTHORIZATION.
COMPARISON STUDIES: December 4, 2014 and CT chest September 13, 2013

FINDINGS:
2 views of the chest demonstrate markedly hyperexpanded lung volumes with suture material involving bilateral upper lobes. The lungs are otherwise clear. No pleural effusion or pneumothorax. Cardiac and mediastinal contours appear normal. No acute bony changes are present. Upper thoracic kyphoplasty noted.

IMPRESSION: SEVERE COPD/EMPHYSEMA WITH REMOTE HISTORY OF BILATERAL UPPER LOBE SURGICAL RESECTIONS.

No EVIDENCE OF ACUTE CARDIA PULMONARY PROCESS.

Interpreted By: Joshua E Hall, MD
signed on 9/12/2015 7:12 PM by Joshua E Hall, MD

** REPORT SIGNED IN OTHER VENDOR SYSTEM 09/12/2015 **

Reported By: JOSHUA EDWARD HALL, MD
CC: Eric S Cas

Technologist: AMBER KEMMERER, RT (R) Transcribed
Date/Time: 09/12/2015 (1915) Transcriptionist: DISIG
Printed Date/Time: 09/12/2015 (1915)

PAGE 1 Signed Report

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<td>Pain</td>
<td>Sat Del</td>
<td>Sc</td>
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<tr>
<td>18:09</td>
<td>92</td>
<td>80</td>
<td>20 131 84</td>
<td>s</td>
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Run: 11/06/15-14:51 by KKA7
09/12/15 18:10 Rhythm strip done, labeled, posted
   Entered: <MKS 9/12/2015 18:10>

09/12/15 18:10 Patient undressed and placed in a gown Entered:
   <MKS 9/12/2015 18:10>

09/12/15 18:10 Monitoring: The patient is being monitored with automatic BP cuff,
cardiac monitor and 02 sat monitor ,
   to order Entered: <MKS 9/12/2015 18:10>

09/12/15 18:25 MAR: Ordered medication was via an intravenous route, at
   the site in the left antecubital through a 20
gauge peripheral catheter that was
   in the field. The saline lock at this site is assessed and
determined patent. Site is flushed w/ 10 ml NS. Entered:
   <JS19/9/12/2015 18:35> TV's (implement IV protocol as needed):
   insert lock IV or saline lock IV per site

09/12/15 18:27 Pulse/Pacemaker rate within the related
   Normal skin color and temperature. No Dizziness
   Entered: <JS19 9/12/2015 18:27>


09/12/15 18:28 Cough Entered: <JS19 9/12/2015 18:28>

09/12/15 18:28 Onset, frequency, duration: Symptoms began gradually 4 day(s)
   ago. Symptoms are constant. Entered: <JS19 9/12/2015 18:28>

09/12/15 18:29 Description: Cough is mild and productive (mildly
   productive) Entered: <JS19 9/12/2015 18:29>

09/12/15 18:29 Shortness of breath/dyspnea Entered: <JS19 9/12/2015 18:29>
09/12/15 18:40 M.R: Ordered medication was given. Entered:
<JS199/12/2015 18:44> Prednisone Oral tabs PO
sample Action: obtained by lab
Row/Site: venipuncture

09/12/15 18:40 Specimen: blood
tech/phlebotomist. and
Tubes/Forms: A "rainbow" was drawn per site policy. and site
prepped with alcohol. Tolerated: well. lab specimens sent
Entered: <ZH2 9/12/2015 18:40>

09/12/15 18:41 Patient to X-ray Entered: <JS19 9/12/2015 18:44> 09/12/15
18:45 12 lead EKGper orde MD
Entered: <LMS2 9/12/2015 18:45>

09/12/15 18:52 Lab contacted about add-on labs.
Entered: <CH7 9/12/2015 18:52>
Temp(F) 98.5 0 64 18 169 78 S 99 2 L 0
09/12/15 18:53 Patient to X-ray Entered: <AK7 9/12/2015 18:53>
19:32>
09/12/15 Temp(F) 74 168 88 S 98 2 L 0
Entered: <LMS2 9/12/2015
19:30
20:06>
09/12/15 19:42 Rounding is
applicable or in
position the patient/care for Position was allowed to avoid
getting up and moving
around without notification of the staff. for the
09/12/15 Temp(F) 98.2 0 66 18 173 83 S 98 2 L 0
Entered: <LMS2 9/12/2015
19:57

PATIENT: MF4205-A
DOB: 09/21/37 ACCT: MF050565845
SVC OT: 09/12/15 MED RE REP: 0913-0014
EMERGENCY DEPARTMENT REPO
ER: 09/12/15 09/12/15
REGIONAL MEDICAL CENTER
TWIN FALLS, IDAHO
Diet: Attnd: ST. LUKE'S MAGIC VALLEY PCI (PCI: OE Database MVR)
IS CONFIDENTIAL AND NOT TO BE RELEASED WITHOUT PROPER AUTHORIZATION.
Run: 11/06/15-14:51 by KKA7
09/12/15 20:20 Admission bed: requested

20:21 Safety plan discussed, while assisting patient to walk

or stand (if applicable), if patient becomes faint or dizzy, staff
will lower the patient to secure surface. Staff will remain within
arms reach and visualization of patient when ambulating.

Ambulated in hallway, staff assisted with stand-by assist (walker
used for assistance). Tolerated well. Pt able to use walker with
observational stand by assistance. Pt's O2 stayed in 70's with
exertion on 21 C2. Pt O2 was bumped up to 3

which brought her up to 94 while standing. RN and provider

aware. Pt sits well on 21 when

09/12/15 Temp(R) Resp Syst Diast Pos. O2 O2 Pain

21:02 98.6 18 149 66 S

09/12/15 20:35 Admission bed: requested Room number 4205 ready CARDIO

Entered: <AKA 9/12/2015 21:03>

Rounding is performed at this time. Pain level is not applicable

or no pain is reported. Position of

in a sitting position is offered and

declined Possession(s) are moved to nearby the patient/caregiver

(if condition allows) to avoid the need of frequently getting up

and moving around without notification of staff.

Entered: <AKA 9/12/2015 21:03>

DISPOSITION

Physician

condition: stable Admission type: admit patient as

Admitting Diagnosis: COPD Exacerbation

status

Physician is:

PATIENT:

DOB: 09/21/37 ACCT: MF050565845

SVC DT: 09/12/15 MED R

EC#.

A D M IN

MF4205-A

EMERGENCY DEPARTMENT REPORT

TWIN FALLS, IDAHO

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Run: 11/06/15-14:51 by KKA7
Nursing

Patient's vital signs and pain levels have been reassessed per protocol. <JS19 09/12/2015 20:43>

Admission Checklist: The items have been carried out: Orders written, armband on, allergy banding applied or addressed, floor ready to accept patient and report called to floor. The patient's belongings/valuables have been sent to the floor with the patient. <JS19 09/12/2015 21:21>

Transportation to room: Patient was transferred to a bed by an Transport via stretcher. Equipment in use includes oxygen <JS19 09/12/2015 20:44>

Admission form lock: left in. <JS19 09/12/2015 21:22> DIAGNOSIS COPD exacerbation

Provider has signed up for patient. CRR 09/12/2015 18:10

Initial provider contact complete. Additional work-up and evaluation may still be required to complete assessment for emergency conditions. CRR 09/12/2015 18:10

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Run: 11/06/15-14:51 by KKA7
Objectives

- Describe the current state – Categorize types of deficiencies
- Identify drivers of poor documentation
- Describe the rationale for better notes
- Present best practices – The 10 Commandments
Primary Goals of Documentation

- Inclusion of a descriptive narrative of the particular patient and the relevant points of their presentation, medical history and social context

- Impression, differential diagnosis and plan for the future reference by the physician, benefit of consultants, and use by other caregivers
First recorded physician notes:

- Greece – 5th century BC
- Organized as stories
- Kept in a physician journal of their day rather than a chart

“There were exacerbations of the fever; the bowels passed practically nothing of the food taken; the urine was thin and scanty. No sleep. About the 14th day from his taking to bed, after a rigor he grew hot; wildly delirious, shouting, in distress, much rambling, followed by calm; the coma came on at this time.”

The Evolution of the Note

- 17th Century – Notes more detailed due to ability to recognize patterns, link sx to diseases, and more advanced observations (e.g., stethoscope)
- 18th - 19th century – Unstructured narratives
- 1900 – Hospitals begin to implement structured documentation

The Evolution of the Note

- The EHR Era

“The doctor will be in shortly to type on the computer and update your chart. If he has time, he will ask how you’re feeling and take a look at your rash.”
Deficient Notes - Categories

- Information Overload
- Loss of the Story
- Inaccurate Documentation
- Deceptive Documentation
Categories of Deficient Notes – Information Overload

- Compendium of prior notes
- Importation of irrelevant data
- Mandatory templates
- Laboratory / Radiologic studies
- Medication lists
Categories of Deficient Notes – Loss of the Story

- Poor in history
- Minimizing clinical reasoning
- Lacking humanistic elements of physician-patient relationship
Categories of Deficient Notes – Inaccurate Documentation
Categories of Deficient Notes – Deceptive Documentation
Categories of Deficient Notes

From the ACP Case Files:

An elderly woman was admitted to the hospital for a GI bleed. The admission exam listed:

**Rectal exam – unremarkable**

Hematology consult requested. While obtaining the patient’s story, the consultant discovered that no one had performed a rectal exam.

GI documented “hemorrhoidal bleed,” but had not performed a rectal exam. The patient was seen by 6 physicians during her stay. The patient was subsequently diagnosed with rectal cancer.
Drivers of Poor Documentation

- Software
- Time
- Measures
- Medicolegal
- Reimbursement
The Imperative for Addressing the Current State of Notes

Insufficient information → Lack of a narrative
The Imperative for Addressing the Current State of Notes

Excessive information

Distracting, cumbersome, time-consuming, dangerous
The Imperative for Addressing the Current State of Notes

Confining data entry into specific fields

Suppresses clinical critical thinking
The Imperative for Addressing the Current State of Notes

Focus needed when using the computer

Decreased physician-patient interaction
Bemoan

Own
THE 10 COMMANDMENTS OF ELECTRONIC DOCUMENTATION

- Remember the primary objective - Communicate clinical findings and reasoning to the healthcare team
- Tell the patient’s story – Evolution and contributing factors to the condition and management options
- Be concise
- Be accurate - Avoid creating or perpetuating documentation errors
- Do not copy/paste without attribution
THE 10 COMMANDMENTS OF ELECTRONIC DOCUMENTATION

- Use templates judiciously
- Include supplemental data only when adds value
- Avoid unhelpful or redundant text
- Consider using “APSO” format (Assessment & Plan / Recommendations first)
- Commit to improvement - Provide/receive feedback from peers, engage in your local EHR optimization efforts
TAKE HOME POINTS

- Notes are often bloated, inaccurate, and do not include a cohesive narrative
- Drivers include poor EHR design, requirements to insert items for quality review purposes, and time constraints
- Follow the 10 Commandments (tell the patient’s story, be concise, be accurate)
- Commit to improve - Join ACP in recreating a culture of high expectations for clinical documentation
A final reminder

“The clinical record should include the patient's story in as much detail as is required to retell the story.”