

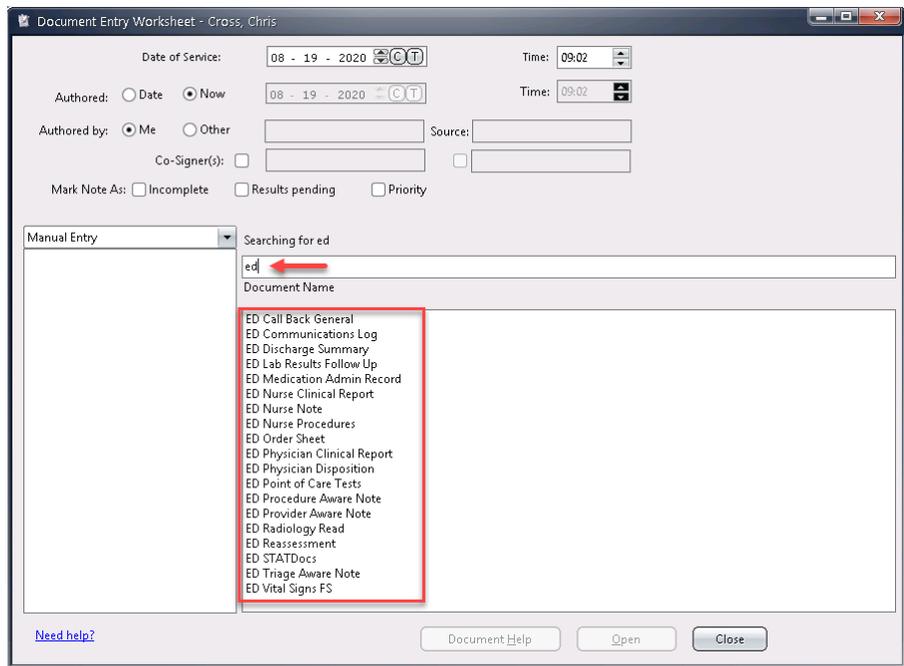
## Documenting Additional Emergency Care Provider Notes

Additional **ED Notes** are available for documentation as needed based on care of the patient or other ED workflow documentation requirements.

**Note:** The routinely used ED documents have been configured to the **Quick Launch Docs** button in the **Status Board** view. However, additional documents that may be used in the ED workflow are accessible via the **Enter Document** toolbar button.

### TO ACCESS DOCUMENTS VIA THE ENTER DOCUMENT TOOLBAR BUTTON:

1. In the Sunrise toolbar, click the **Enter Document**  button.  
*The Document Entry window appears.*
2. In the **Searching for** field, begin typing **ed**.



The screenshot shows the 'Document Entry Worksheet' window for user 'Cross, Chris'. The window includes fields for 'Date of Service' (08 - 19 - 2020), 'Time' (09:02), 'Authored by' (Date/Now), and 'Source'. A search bar labeled 'Searching for ed' has a red arrow pointing to the text 'ed'. Below the search bar is a list of document names, with 'ED Reassessment' highlighted by a red box. The list includes: ED Call Back General, ED Communications Log, ED Discharge Summary, ED Lab Results Follow Up, ED Medication Admin Record, ED Nurse Clinical Report, ED Nurse Note, ED Nurse Procedures, ED Order Sheet, ED Physician Clinical Report, ED Physician Disposition, ED Point of Care Tests, ED Procedure Aware Note, ED Provider Aware Note, ED Radiology Read, ED Reassessment, ED STATDocs, ED Triage Aware Note, and ED Vital Signs FS. At the bottom, there are buttons for 'Need help?', 'Document Help', 'Open', and 'Close'.

3. Select the appropriate document from the list and click **Open**.

## Documenting the ED Reassessment Note

The **ED Reassessment** note may be used to document a detailed reassessment of the patient during the ED visit.

**Note:** This note is configured to the **Quick Launch Doc(s)** button on the **Status Board**.

Document reassessment details in the appropriate sections:

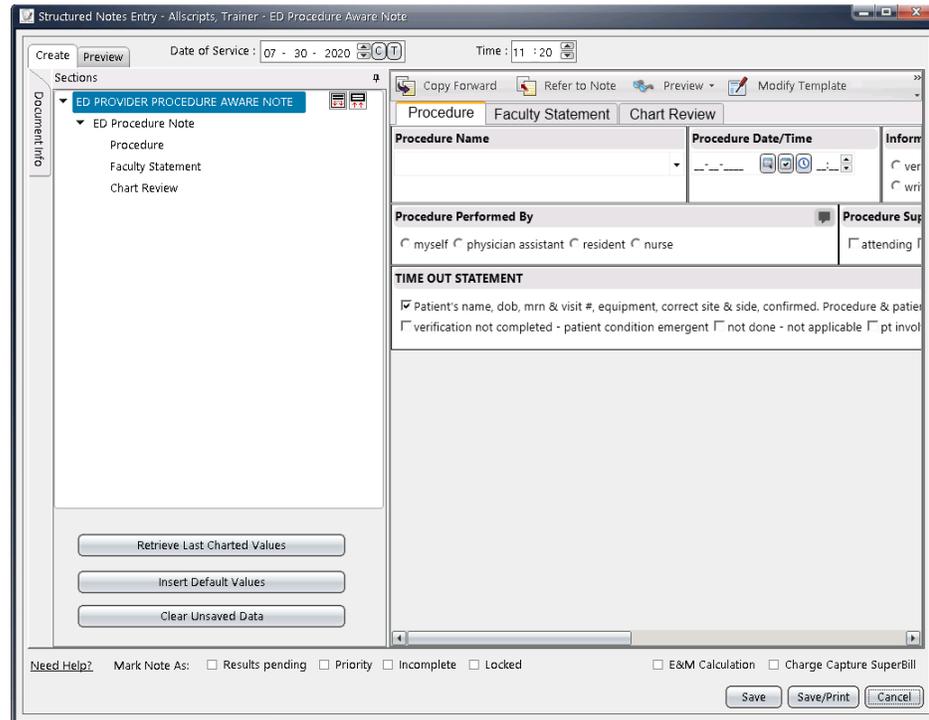
**General Reassessment:** document as appropriate.

**Pain Assessment:** document as appropriate.

**Head to Toe:** Select the assessment problem from the **Template** drop-down. For the parameters assessed, select the respective assessment to expand the assessment observation parameters: **Within defined limits, minimal, comprehensive.**

## Documenting ED Procedure Aware Note

The **ED Procedure Aware Note** may be used by the ED Provider or Nurse for documentation of procedures performed during the ED visit.



Structured Notes Entry - Allscripts, Trainer - ED Procedure Aware Note

Create Preview Date of Service: 07 - 30 - 2020 Time: 11 : 20

Sections: ED PROVIDER PROCEDURE AWARE NOTE

- ED Procedure Note
  - Procedure
  - Faculty Statement
  - Chart Review

Retrieve Last Charted Values

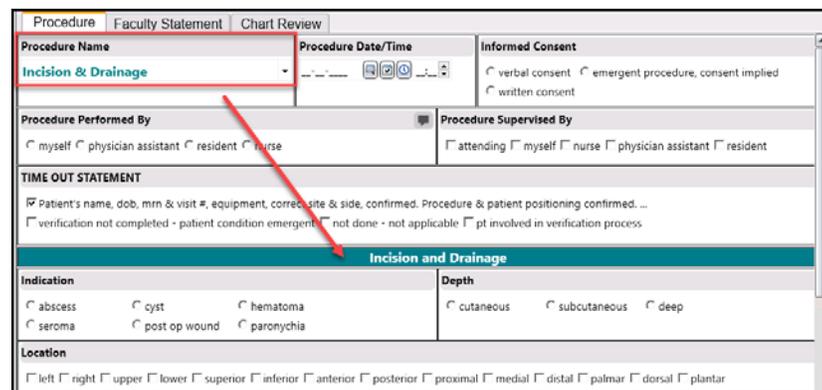
Insert Default Values

Clear Unsaved Data

Need Help? Mark Note As:  Results pending  Priority  Incomplete  Locked  E&M Calculation  Charge Capture SuperBill

Save Save/Print Cancel

**Procedure** tab: Select the **Procedure Name** from the drop-down to expand the respective procedure details.



Procedure Faculty Statement Chart Review

Procedure Name: Incision & Drainage

Procedure Date/Time: --:--:--

Informed Consent:  verbal consent  emergent procedure, consent implied  written consent

Procedure Performed By:  myself  physician assistant  resident  nurse

Procedure Supervised By:  attending  myself  nurse  physician assistant  resident

TIME OUT STATEMENT

Patient's name, dob, mrn & visit #, equipment, correct site & side, confirmed. Procedure & patient positioning confirmed. ...

verification not completed - patient condition emergent  not done - not applicable  pt involved in verification process

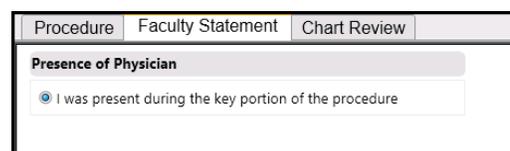
**Incision and Drainage**

Indication:  abscess  cyst  hematoma  seroma  post op wound  paronychia

Depth:  cutaneous  subcutaneous  deep

Location:  left  right  upper  lower  superior  inferior  anterior  posterior  proximal  medial  distal  palmar  dorsal  plantar

**Faculty Statement** tab: Indicate **Presence of Physician** as appropriate.



Procedure Faculty Statement Chart Review

Presence of Physician

I was present during the key portion of the procedure

**Chart Review** tab: Displays a summary preview compilation of details documented in the note.

Procedure	Faculty Statement	Chart Review
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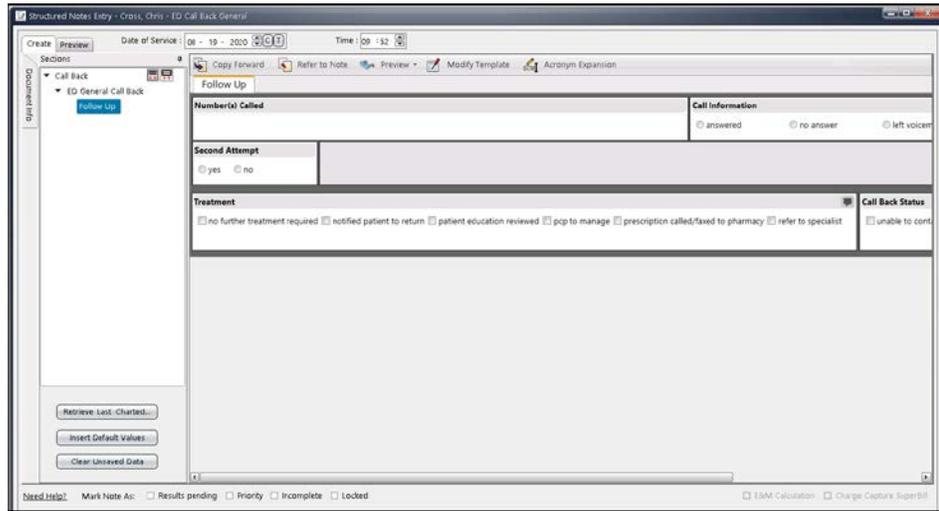
CENTRAL LINE INSERTION

08-19-2020 09:41 TIME OUT STATEMENT: Prior to the start of the procedure the Patient's name, dob, mrm & visit #, equipment, correct site & side, confirmed. Equipment at the bedside. The benefits, risks, and possible complications of the procedure were explained to the patient/caregiver who verbalized understanding performed by myself. I assisted during the procedure.

The indications for the procedure are: emergency venous access . The procedure details are as follows: the location was identified, draped, and prepped in a 4 on the 1st attempt. Post the procedure radiography was not performed. The line terminates in the atrium. A pressure sensor is being utilized. A blood specimen

## Documenting ED Call Back General Note

The **ED Call Back General** note may be used to document patient follow-up/call back post ED discharge.



Structured Notes Entry - Cross, Chris - ED Call Back General

Create [Preview] Date of Service: 08 - 19 - 2020 Time: 09 : 52

Sections: Call Back, ED General Call Back

Follow Up

Number(s) Called	Call Information
<input type="checkbox"/> answered <input type="checkbox"/> no answer <input type="checkbox"/> left voicemail	

Second Attempt

yes  no

Treatment

no further treatment required  notified patient to return  patient education reviewed  pcp to manage  prescription called/faxed to pharmacy  refer to specialist

Call Back Status

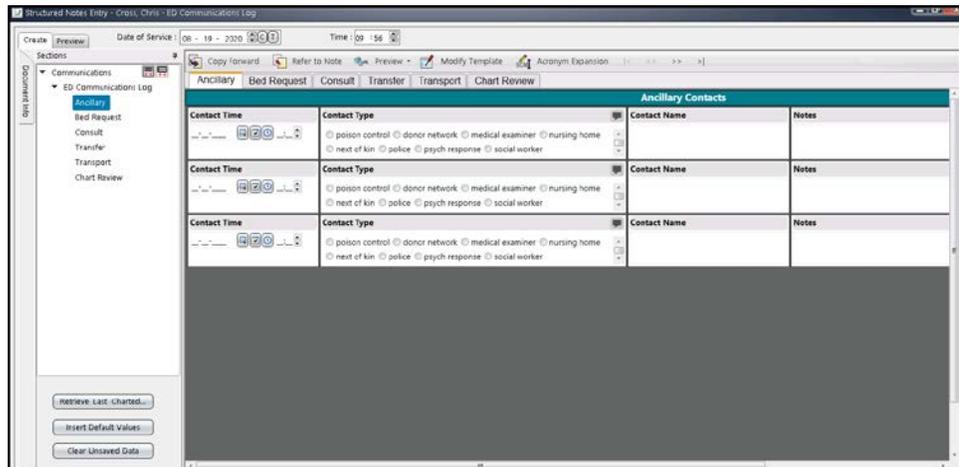
unable to contact

Buttons: Retrieve Last Charted..., Insert Default Values, Clear Unsaved Data

Mark Note As:  Results pending  Priority  Incomplete  Locked

## Documenting ED Communications Log Note

The **ED Communications Log** note may be used to document communications for requests: **Ancillary, Bed Request, Consult, Transfer, Transport.**



Structured Notes Entry - Cross, Chris - ED Communications Log

Create [Preview] Date of Service: 08 - 19 - 2020 Time: 09 : 56

Sections: Communications, ED Communications Log

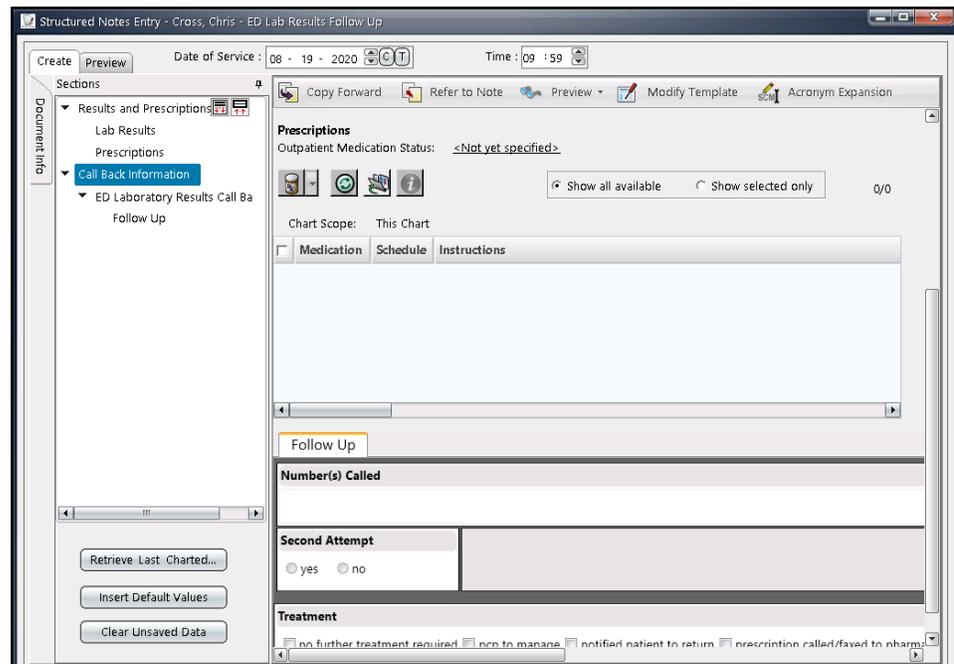
Ancillary | Bed Request | Consult | Transfer | Transport | Chart Review

Ancillary Contacts			
Contact Time	Contact Type	Contact Name	Notes
---	<input type="checkbox"/> poison control <input type="checkbox"/> donor network <input type="checkbox"/> medical examiner <input type="checkbox"/> nursing home <input type="checkbox"/> next of kin <input type="checkbox"/> police <input type="checkbox"/> psych response <input type="checkbox"/> social worker		
---	<input type="checkbox"/> poison control <input type="checkbox"/> donor network <input type="checkbox"/> medical examiner <input type="checkbox"/> nursing home <input type="checkbox"/> next of kin <input type="checkbox"/> police <input type="checkbox"/> psych response <input type="checkbox"/> social worker		
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Buttons: Retrieve Last Charted..., Insert Default Values, Clear Unsaved Data

## Documenting ED Lab Results Follow Up Note

The **ED Lab Results Follow Up** note may be used to document patient follow-up for lab results post ED discharge.



The screenshot shows a software interface for entering structured notes. The window title is "Structured Notes Entry - Cross, Chris - ED Lab Results Follow Up". The date of service is set to 08 - 19 - 2020 and the time is 09 : 59. On the left, a "Document Info" sidebar shows a tree view of sections: "Results and Prescriptions" (with sub-sections "Lab Results" and "Prescriptions"), "Call Back Information" (highlighted in blue), and "ED Laboratory Results Call Back Follow Up". The main area contains a toolbar with "Copy Forward", "Refer to Note", "Preview", "Modify Template", and "Acronym Expansion". Below the toolbar, the "Prescriptions" section is active, showing "Outpatient Medication Status: <Not yet specified>" and a "Show all available" / "Show selected only" filter. A "Chart Scope: This Chart" section is visible, with tabs for "Medication", "Schedule", and "Instructions". Below this is a "Follow Up" section with a "Number(s) Called" field. The "Second Attempt" section has radio buttons for "yes" and "no". The "Treatment" section at the bottom has checkboxes for "no further treatment required", "npo to manage", "notified patient to return", and "prescription called/faxed to pharmacy". At the bottom left, there are buttons for "Retrieve Last Charted...", "Insert Default Values", and "Clear Unsaved Data".

## Documenting ED Point of Care Tests Note

The **ED Point of Care Tests** note may be used by ED Nurse to document Point of Care Tests (POCT) results.

Structured Notes Entry - Cross, Chris - ED Point of Care Tests

Create Preview Date of Service: 08 - 19 - 2020 Time: 10 : 02

Sections

- POCT
  - ED Point of Care Tests
    - ABG
    - BMP
    - Blood Glucose
    - Coagulation
    - Hemoglobin
    - Rapid Flu
    - Rapid HIV
    - Rapid Strep
    - Troponin
    - Urine Dipstick
    - Urine Pregnancy
    - Visual Acuity

Retrieve Last Charted...  
Insert Default Values  
Clear Unsaved Data

Copy Forward Refer to Note Preview Modify Template Acronym Expansion

ABG BMP Blood Glucose Coagulation Hemoglobin Rapid Flu Rapid HIV

**ARTERIAL BLOOD GAS**

PaO2 (mm Hg)	PaCO2 (mm Hg)	pH
HCO3 (mEq/L)	Base Excess ( mEq/L)	SaO2 (%)

## Documenting ED Radiology Read Note

The **ED Radiology Read** note may be used by ED Provider to document preliminary read of radiology results.

Structured Notes Entry - Cross, Chris - ED Radiology Read

Create Preview Date of Service: 08 - 19 - 2020 Time: 10 : 06

Sections

- ED Radiology Read
  - ED Radiology Read
    - X-RAY
    - Chart Review

Retrieve Last Charted...  
Insert Default Values  
Clear Unsaved Data

Copy Forward Refer to Note Preview Modify Template Acronym Expansion

X-RAY Chart Review

**HEAD/NECK**

ORBITS	SKULL	MANDIBLE	FACIAL	NASAL
<input type="radio"/> Details <input type="radio"/> Negative				

**SPINE**

C-SPINE	T-SPINE	LUMBAR SPINE	SACR
<input type="radio"/> Details <input type="radio"/> Negative			

**TRUNK**

CXR 1	CXR 2	CXR 3	CXR
<input type="radio"/> Details <input type="radio"/> Negative			

STERNUM / RIBS	KUB	PELVIS	IVP
<input type="radio"/> Details <input type="radio"/> Negative			

**UPPER EXTREMITY**

CLAVICLE	SCAPULA	SHOULDER	HUMERUS
<input type="radio"/> Details	<input type="radio"/> Details	<input type="radio"/> Details	<input type="radio"/> Details