KENDALL NOVOA-TAKARA, MD

MARCH 2023

EVERY PATIENT, EVERY TIME

- Short stay
- AMA
- Even when patient dies—per Dr. Matthews in ICU you can title discharge summary/death note and will note have to write a separate death note but must contain ALL PERTINENT INFORMATION
- Observation
- use the discharge summary note in dynamic documentation
- Can be used in place of daily progress note if contains physical exam
- Difficult to determine who will leave sometimes; recommend that you have a separate dc summary and progress note
- My rule of thumb on service—if the patient hasn't left and there is no clear pick up time for SNF from CM by 1600 hours, progress note should be written.

http://adigaskell.org/wp-content/uploads/2016/02/needle-haystack.jpg

DISCHARGE SUMMARIES SHOULD BE COMPLETED ON DAY OF DISCHARGE

- Start your discharge summary before your patient is ready to do
- If you are going to be off and your patient might be discharged in your absence, you should do the discharge summary—just don't sign it
- Whoever discharges the patient should make the necessary changes, sign it and then send it to the attending.

DIAGNOSES, DO I HAVE TO LIST ALL OF THEM??

- YES!!
- Banner bills from the discharge summary
- Two patients come in with a swollen red leg:

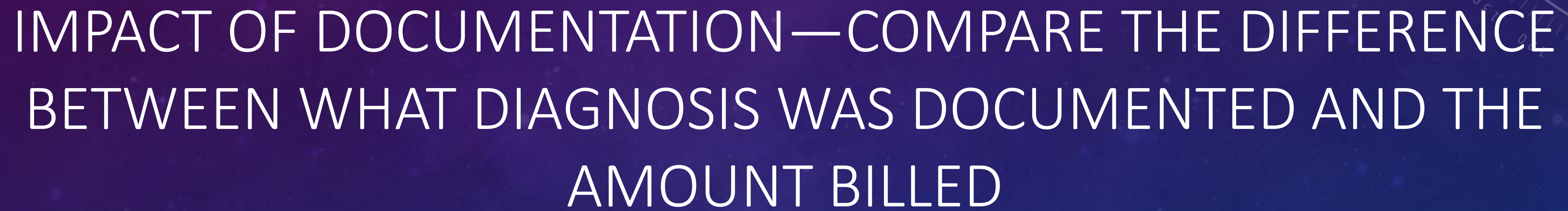
  Patient 1 is 25 years old without underlying medical problems and stepped on a stick in their back yard

  Patient 2 is 75 years old with DM, PVD, venous insufficiency, history of DVT, and being treated for acute leukemia and is neutropenic

  Should you get a higher score/rating (think allowed length of stay or compensation) for patient 2?
- Try to be detailed: acute vs chronic vs acute on chronic, etc
- List their chronic problems because you probably continued to treat those during admission (DM, COPD, hypothyroidism, depression, etc)
- Make sure to include any diagnoses that are in your attending addendums and if any are added from coding queries

USE MCC AND CC IN YOUR CHARTING

- MCC=major complication e.g.aucte decompensated heart failure, acute MI, acute pulmonary embolism, severe sepsis, decubitus ulcer stage 3 or 4 present on admission, metabolic encephalopathy, etc
- CC=comorbid conditions e.g. unstable angina, CHF, chronic, acute blood loss anemia, atelectasis, etc
- Hospitals paid by DRG (diagnosis related groups)
- MCC impact DRG (and subsequently length of stay)
- CCs do not increase DRG BUT may increase SOI (severity of illness) and ROM (risk of mortality)
- Accurately documenting our patient’s SOI and ROM confirms the quality of care given
- SOI will help with increasing length of stay for commercial insurance and Medicaid but not medicare
- Helpful if you document the criteria eg sepsis (T 39C, WBC 12K etc)
- Document causal relationships eg chronic foley POA causing UTI causing severe sepsis etc—your bullet points in assessment and plan does not actually link these things together, that is why attendings push you to connect the diagnoses and explain what diagnoses are secondary to the primary diagnosis
- SEE LIST OF MCC AND CC PROVIDED IN BOOTCAMP PREPARATORY MATERIALS


IMPACT OF DOCUMENTATION—COMPARE THE DIFFERENCE BETWEEN WHAT DIAGNOSIS WAS DOCUMENTED AND THE AMOUNT BILLED

Documentation Specificity Matters

UTI specificity/ CAUTI

MS-DRG	DRG 689 Kidney and Urinary Tract Infections w/ MCC	DRG 698 Other Kidney and Urinary Tract Diagnoses w/ MCC
Principal Diagnosis	• Urinary tract infection, site not specified	• Vancomycin Resistant Urinary Tract Infection related to Foley Catheter
Secondary Diagnoses	• Metabolic encephalopathy • Multiple Sclerosis	• Metabolic encephalopathy • Resistance to Vancomycin • Multiple Sclerosis
Reimbursement calculated using sample base rate of $6000	RW 1.1142 GLOS 3.8 SOI 2 ROM 2 $ 6,685	RW 1.6106 GLOS 4.7 SOI 2 ROM 2 $ 9,664

Documentation Specificity Matters

AMS/ Encephalopathy as Secondary Dx

MS-DRG	DRG 192 COPD w/o CC/MCC	DRG 191 COPD w CC	DRG 190 COPD w MCC
Principal Diagnosis	• COPD Exacerbation	• COPD Exacerbation	• COPD Exacerbation
Secondary Diagnoses (comorbidities)	• AMS • Oxygen dependent	• Encephalopathy, unspecified • Chronic Respiratory Failure	• Metabolic Encephalopathy • Chronic Respiratory Failure
Reimbursement calculated using sample base rate of $6000	RW 0.6956 LOS 2.4 SOI 1 ROM 1 $ 4,174	RW 0.8843 LOS 2.9 SOI 2 ROM 2 $ 5,306	RW 1.1251 LOS 3.6 SOI 2 ROM 2 $ 6,751

Banner Health

Documentation Specificity Matters
Nutritional Secondary Dx

MS-DRG	DRG 195 Simple Pneumonia w/o CC/MCC	DRG 194 Simple Pneumonia w/ CC	DRG 193 Simple Pneumonia w/ MCC
Principal Diagnosis	Pneumonia	Pneumonia	Pneumonia
Secondary Diagnoses		• Anorexia • Mild Muscle mass depletion • Mild Malnutrition • BMI 18	• Severe Malnutrition • BMI 15 • Starvation **PAY ATTENTION TO NUTRITION NOTES!!!**
Reimbursement calculated using sample base rate of $6000	RW 0.66580 LOS 2.5 SOI 1 ROM 1 $ 3,995	RW 0.8639 LOS 3.1 SOI 2 ROM 1 $ 5,183	RW 1.31200 LOS 4.1 SOI 2 ROM 2 $ 7,872

Documentation Specificity Matters

PNA Vs. Sepsis with Acuity & Specificity

MS-DRG	DRG 195 SIMPLE PNEUMONIA & PLEURISY WO CC/MCC	DRG 871 SEPTIC OR SEV SEPSIS WO MV >96 HRS W MCC	DRG 871 SEPTIC OR SEV SEPSIS WO MV >96 HRS W MCC
Principal Diagnosis	• Pneumonia	• Sepsis unspecified	• Sepsis due to Pseudomonas
Secondary Diagnoses		• Pneumonia	• Acute Respiratory Failure • Pneumonia due to Pseudomonas
Reimbursement calculated using sample base rate of $6000	RW 0.66580 LOS 2.5 SOI 1 ROM 1 $ 3,995	RW 1.87220 LOS 4.8 SOI 2 ROM 1 $ 11,233	RW 1.87220 LOS 4.8 SOI 3 ROM 3 $ 11,233

HOSPITAL COURSE

- The BIG picture, please
- What really matters to my reader?

http://virtualpminabox.com/wp-content/uploads/2012/10/the-big-picture.jpg

MAKE YOUR HOSPITAL COURSE MEANINGFUL

- Make it sufficiently detailed so it is clear what was done and what needs to be followed
- Make it user friendly….instead of saying abx x 6 weeks, state when end of therapy is (EOT)….will make it easier for all to use (multiple providers don't have to keep counting days and weeks)
- Make it reflect how sick your patient was—example, high risk covid unit for 14 days on Hi Flow nasal cannula 60L/min 50% FiO2
- Avoid jargon/abbreviations (remember reading your first ophthalmology note????) Spell things out: SVT—is that supraventricular tachycardia or is sustained ventricular tachycardia

MAKE IT USEFUL TO BOTH PCP AND HOSPITALISTS

- THINK ABOUT WHAT YOU SEARCHED THROUGH THE CHART FOR FROM A PREVIOUS HOSPITAL STAY WHEN YOU ADMITTED THE PATIENT OR SAW THEM FOR HOSPITAL FOLLOW UP
- Clearly detail why a new medication was started—example, cirrhotic patient started on daily prophylactic cipro but never had sbp…indication=low protein ascitic fluid with high bilirubin
- Clearly detail narcotic regimen if pain was hard to control—example, sickle cell patient requiring PCA. Helpful to have PCA settings outlined in dc summary for the next time the patient gets admitted
- Clearly detail what antibiotics were given and if therapy was completed or why it was stopped before a course of therapy was completed—example patient admitted for 5 days, dx with covid pna, tx with remdesivir but only for two days. Not clearly spelled out on dc summary so admitting provider two days later thought therapy was completed
- Clearly detail if a medication was stopped due to an adverse reaction/side effect
- Detail special instructions: delirium precautions, rounding as a group with attending etc.

MAKE YOUR HOSPITAL COUSE READABLE

- Don’t choose a font that is too small
- Try to make font uniform
- USE PARAGRAPHS to make it easier to read, separate topics and thoughts
- The goal of having one paragraph as the hospital course on anything but an exceptionally simple admission is not realistic! The cognitive load of having many issues addressed in the one paragraph is significant—using paragraphs will help

CONSIDER COPYING AND PASTING FROM YOUR PROGRESS NOTE

- Start with an 'overview' using paragraphs then go into the more details with the individual problems
- Works better if you don't do bullets all the time for the assessment and plan (then you don't have to delete the bullets)
- Benefit-less likely to lose crucial information…some of the running summaries I have seen start loosing critical data, eg repeat EGD for gastric ulcer, etc.
- It may not be as 'pretty' as you are accustomed to seeing…but you can fix it up…but one thing is true, you will probably convey all the necessary information
- I doubt the pcp will mind seeing the progress note type format, it will probably give them a better idea of what went on
- It can save you a tremendous amount of time

PENDING RESULTS BELONG TO YOU

- If a test is not resulted, you are responsible for it
- UNLESS you have arranged an alternate way for the patient to get the result
- AND both the patient and provider following up on the result AGREE

MEDICINE LIST

- NEW/CHANGED
- CONTINUED
- DISCONTINUED

(now automatically done if you use the discharge summary template)

http://media.istockphoto.com/photos/confused-senior-woman-with-a-variety-of-pills-picture-id493281145?k=6&m=493281145&s=170667a&w=0&h=taBAlHGXU9St0w5KFdw8Aevr3TsTxGDD817aFUkm3Fo=

CONDITION ON DISCHARGE?? DON'T SAY STABLE

https://www.lungsandyou.com/static/images/content/ipf-patient-oxygen-therapy.jpg

http://www.mayoclinic.org/healthy-lifestyle/healthy-aging/multimedia/walker/sls-20076469?s=4

http://il6.picdn.net/shutterstock/videos/4820963/thumb/1.jpg?i10c=img.resize(height:160)

Stable could mean they are in a coma, stable could mean they are fully ambulatory without any cognitive deficits. Document cognitive issues, ability to ambulate, physical exam findings (physical exam must be listed in order for discharge summary to do double duty as a progress note)

FOLLOW UP APPOINTMENT

- Normally on the discharge summary it is the name of the provider and time frame for follow up
- Doesn’t hurt to have actual appointments listed on the dc summary
- Specifics such as phone numbers, addresses etc are usually on the DEPART
- PCP
- ANTICOAGULATION****
- Best if patient has appointment in hand before leaving the hospital for high risk items or you are afraid they will fall through the cracks

http://www.woodwardmedical.org/images/appointment.jpg

INSTRUCTIONS ON WOUNDS, DIET, ACTIVITY, FLUIDS, WEIGHT

http://s.hswstatic.com/gif/scale1.jpg

http://www.ecouterre.com/wp-content/uploads/2013/08/water-bottle.jpg

https://www.woundcare-today.co.uk/support/uploads/Step%206%20new.jpg

http://www.davidtucker.me/content/paint-it-black/12-salt-shaker/davidtucker-saltshaker-04.jpg

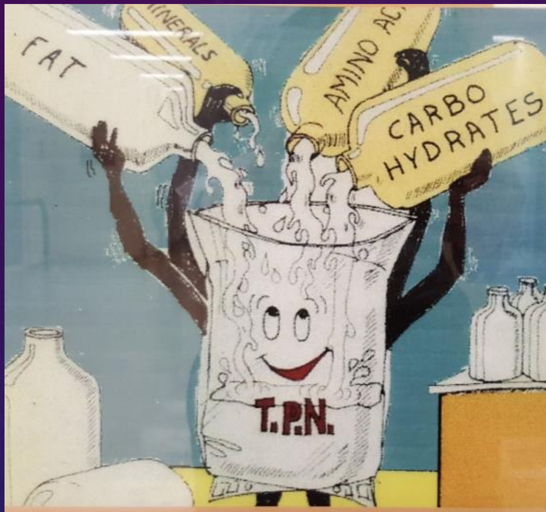
FOLLOW UP INSTRUCTIONS FOR OUTSIDE PROVIDERS

- This is even more important than telling the patient to follow up for cp/sob
- Remember, most patients NEVER see your discharge summary…it's their providers who will see it
- Example: patient hospitalized for acute hepatitis B was discharged with transaminases in the 800s, instruction to PCP was to monitor for seroconversion of hepatitis B surface antibody and if these did not develop of the patient developed liver failure (increasing INR) to refer back to hepatology

HOW TO CONTACT THE HOSPITALIST SERVICE

- Don’t list your pager or cell phone—you could be on vacation, nights etc
- For BUMCP 602-839-8690 during business hours
- Create an autotext for this number
- Patients don’t call often and when they do they have good questions

HOME HEALTH NEEDS



http://www.derangedphysiology.com/main/sites/default/files/sites/default/files/old%20image%20pile/nutrition-and-malnutrition/images/Intestinal%20Failure%20Service%20-%20TPN%20mascot.JPG

http://www.hollywoodhealthservices.com/wp-content/uploads/2015/04/header-physical-therapy.jpg

https://appledrugs.com/wp-content/uploads/2013/02/IMG_2785-e1379941946306-225x300.jpg

https://sc01.alicdn.com/kf/HTB1XAliKXXXXXXnXpXXq6xXFXXXe/Wheelchair.jpg

GET IT TO WHERE IT NEEDS TO GO

Completion is good but getting it to the end users is best

-SNFS will not get it if it is NOT done by discharge—instruct nurse to print and send with patient

-Doctors outside of the Banner system do not have automatic access to cerner and your discharge summary

-consider sending your patient with a copy (tell them to keep one at home and one copy for their doctor)

-consider manually faxing it to the provider's office

https://media1.fdncms.com/clevescene/imager/thieves-swipe-pizza-not-cash-from-delivery-driver/u/slideshow/2513911/1305213948-pizza-delivery.jpg

SEND PCP FAX VIA CERNER USING PROVIDER LETTER

I haven't gotten this to work—call to verify it went through

ZZZBGSMC, AP01 - BGSMC99 Opened by NOVOATAKARA MD, KENDALL

Task Edit View Patient Chart Links Notifications Index Documents Help

Patient Education Center MCG Revenue Cycle Chat-EHR Help DMO Antibiograms Lexicomp Lippincott Advisor Lippincott Procedures COVID Toolkit

Home Message Center Patient List Tracking UpToDate mPage Hub Provider Handoff Hospitalist Worklist Dynamic Worklist Auto Text Copy Utility MyExperience Palliative Care eCoach

Messa.: 0 Order.: 0 Resul.: 0

Depart Calculator AdHoc Exit Tear Off Patient Product Inquiry Patient Education Communicate Patient Pharmacy Suspend Charges Scheduling Appointment Book Documents Discern Reporting Portal New Sticky Note View

Message
Reminder
Patient Letter
Provider Letter

ZZZBGSMC, AP01

ZZZBGSMC, AP01
Age:44 years DOB:09/06/1976 Gender:Female
Language:English, Braille, Other: test Weight:45.00 kg (D) 03/15/2021
Allergies: penicillin

Code Status:Full Resuscitation
Advance Directive:Five Wishes
ent FIN: 178638 Reg Dt: 10/21/2015 09:29:00 MST Disch Dt: <No - Discharge date>
Location:01 Test IP ONLY

HealtheLi
Insurance
Clinical R
No XDoc

Menu - All
Acute View
Results Review
PMP Gateway (AZ and NV only)
Orders + Add
Documentation + Add

Clinical Notes

Last 100 Documents : 103 out of 106 documents are accessible. (Document Count) In Error Documents Filtered

March 15, 2021
March 10, 2021
March 04, 2021

Select PCP, select a provider from the list, or enter a provider if you have their fax number and can add it

Choose your document you want to send—e.g. discharge summary

TIMELY

- BEFORE YOU LEAVE FOR THE DAY

SUBINTERNS AND DISCHARGE SUMMARIES

- Officially not allowed to do them
- I encourage them to write them up so you can copy and paste into discharge note—they have a template in the BUMCP IM Student Teams (Microsoft)
- If you use medical student discharge summary as the basis of your discharge summary, please do not have them write it in the chart
- I encourage all sub I s to write discharge summaries on each one of their patients

HOW TO GET ON THE HIMS HIT LIST

FOR ANY ISSUES WITH COMPLETING DELINQUENT RECORDS OR IF YOU WILL BE ON VACATION PLEASE CONTACT DENISE @ 602-839-3205 OR AMY @ 602-839-5120

Dear Dr. Novoatakara:

BANNER UNIVERSITY MEDICAL CENTER-PHOENIX

This is a reminder to inform you of incomplete documentation at Banner University Medical Center-Phoenix. As of today's date, we have medical records which require your attention. Please complete your records in the next 2 days to avoid being placed on Temporary Suspension.

Per the Medical Staff Rules and Regulations, if placed on Temporary Suspension, you will lose privileges including but not limited to admitting, treating, consulting, surgical, and anesthesia privileges (with the exception of emergency patients including imminent/deliveries).

Per Banner University Medical Center's Medical Staff Rules & Regulations, medical record documentation requirements are outlined below:

Emergency Room Report: 24 hours from disposition
History & Physical: 24 hours from admission
Consultation Report: 24 hours from consultation
Post Op Progress Note: Immediately post op
Operative Reports: 24 hours from procedure
Discharge Summary: 24 hours from discharge
Death Summary: 24 hours from discharge
Transfer Summary: Dictated at the time of transfer and no later than 24 hours from transfer
Signature/Authentication Requirements: within 7 days of the report creation
Verbal Orders: Signed/authenticated within 72 hours
Provider Clarification (Query): Within 24 hours of notice

We appreciate your timely completion of medical record documentation.

Please see your Cerner Inbox for a list of your deficiencies. Please note that this is a computer generated reminder. If you have recently completed all the records that were available or feel that this letter has been sent in error, please contact our department at 602-839-3519.

For immediate Cerner/PeriBirth/PeriCalm/NextGen support, call the Service Desk at 602-747-4444, choose **OPTION 3**

Thank you for your cooperation,

If you are scheduled to be on vacation or out of the office for more than a week, please contact the HIMS department so that we can place your records on hold.

WAYS TO GENERATE DISCHARGE SUMMARY

DOCUMENTATION→+Add→dynamic documentation
Choose type: Discharge Summary
Type in title, date will autopopulate as will your name
Select: Discharge note

ZZZBGSMC, AP01
ZZZBGSMC, AP01
Age:44 years DOB:09/06/1976
Language:English, Braille, Other: test Weight:45.00 kg (D) 1
Allergies: penicillin

Menu - All
Acute View
Results Review
PMP Gateway (AZ and NV only)
Orders + Add
Documentation + Add

Documentation
+ Add Submit Forward Provide
List
Display : All

+ Add
New Note X List

Note Type List Filter: Personal
*Type: .Discharge Summary
Title:
*Date: 03/15/2021 1255 MST
*Author: NOVOATAKARA MD, KENDALL

All (61) Favorites (1)

*Note Templates

Name	Description
Consult Note	Consultation Note Template
Critical Care Progress Note	Critical Care Progress Note Template
Discharge Note	Discharge Note Template
Discharge Note - Short Stay	Short Stay - under 48h DC Note Template
ED Note	Emergency Department Note Template
Free Text Note	Free Text Note Template
Home Visit Note	Home Visit Note Template
IME Report	IME Report Note Template
Immediate Post Op Note	Immediate Post Op Note Template

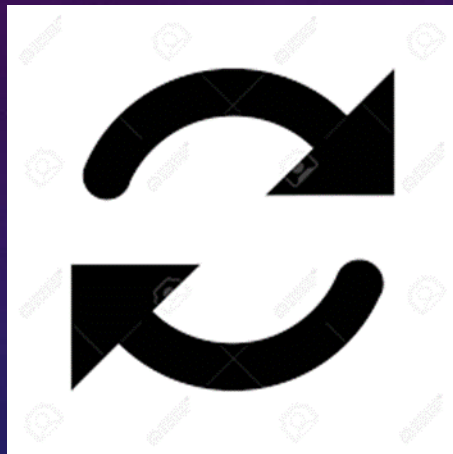
THE FOLLOWING WITH AUTOPOPULATE

Discharge diagnosis
Consults ordered
Labs for past 24 hours
Hospital course by problem—delete this, is just a list of problems and no other text is associated with it
Vitals on that day
Code status
Discharge medications
Pending results

WHAT YOU HAVE TO PUT IN

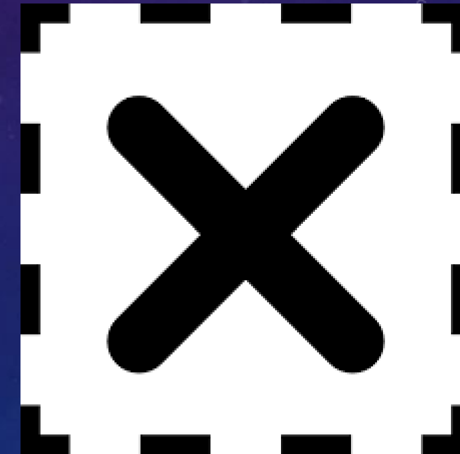
Date of discharge
Brief HPI and reason for hospitalization
Consults ordered
Procedures
Significant imaging results
Significant labs results
Hospital course
Physical exam at discharge
Disposition
Special activity/diet
Appointments—does not autopopulate from depart
Home health/services/DME
PCP Communication
Labs, imaging, or studies recommended for PCP to order after discharge
Who to contact with questions—use the discharge line 602-839-8690

CLEAN UP THE DISCHARGE SUMMARY



Refresh a section—good for labs, vitals, medications

Insert free text



Delete-a line or a section: duplicate hospital course by problem, pending labs that aren't really pending, anything else that seems redundant

DON'T SIGN IT BEFORE THEY LEAVE THE BUILDING

- You can keep it and use it as the discharge summary in subsequent days if they don't leave as planned
- You can refresh the areas that autopopulate: vitals, medications, labs
- You can CHANGE the date on the discharge summary (see next slides)

CHANGING THE TIME AND DATE ON THE DISCHARGE SUMMARY…IF YOU OR YOUR ATTENDING DIDN'T ALREADY SIGN IT

CLICK ON THE LIGHT BLUE TEXT AT THE BOTTOM

AKI-not thought to be HRS, on HD. awaiting renal recovery. Tunnell

Acute hypoxic respiratory failure- much improved. Likely due to CF,

CF pulmonary exacerbation-unable to take home meds due to insura
2/3/19 Agressive airway clearance with 7% inhaled saline. and ves

unspec sev pcm-started TPN 1/10, regular diet, weight up 57.1 kg u

Pancreatic insufficiency-continue pancreatic enzymes

Vitamin A/D/E deficiency-continueADEKS bid, cholecalciferol 5000 u

severe sepsis-resolved

Hospital Course by Problem

1. Chest pain
2. Hypertension
3. Acute chest pain
4. Leukocytosis

Condition

VITALS

Weight - 45.00 kg 12/19/2019 08:50
Heart Rate - 120 bpm 10/22/2018 10:08
Respiratory Rate - 24 br/mi 12/19/2019 08:54
Mean Arterial Pressure - 120 mmHg 12/23/2019 12:27
Systolic Blood Pressure - 120 mmHg 12/23/2019 12:25
Diastolic Blood Pressure - 50 mmHg 12/23/2019 12:25
SpO2 - 89 % 12/19/2019 08:54
Oxygen Therapy - Nasal cannula 12/19/2019 08:54
Oxygen Flow Rate - 3 L/min 12/19/2019 08:54
Temperature Tympanic - 37.9 DegC 12/19/2019 08:54

Note Details: .Discharge Summary, NOVOATAKARA MD, KENDALL, 03/15/2021 12:55 MST, Discharge Note

Note Details

*Type: .Discharge Summary
Note Type List Filter: Personal
*Author: NOVOATAKARA MD, KENDALL
Title: Discharge Note
*Date: 03/15/2021 1255 MST

OK Cancel

CHANGE THE DATE

ANOTHER METHOD…NOT RECOMMENDED, YOU CAN’T MAKE CHANGES!!!!

Use the discharge summary template in dynamic documentation if you like

ZZZBGSMC, AP01 - BGSMC99 Opened by NOVOATAKARA MD, KENDALL

Task Edit View Patient Chart Links Notifications Navigation Help

Patient Education Center | MCG | Revenue Cycle | Chat-EHR Help | Home | Message Center | Patient List | Tracking | UpToDate | mPage Hub | Provider Handoff | MyExperience

Depart | Calculator | AdHoc | Exit | Tear Off | Patient Product Inquiry | Patient Education | Communicate | Patient Pharmacy | Suspend | Charges | Scheduling Appointment Book | Documents

ZZZBGSMC, AP01 | List | Recent | Name

ZZZBGSMC, AP01
Age:42 years | DOB:09/06/1976 | Gender:Female | PCP: | MRN:BGSMC99 | HealtheLife Portal:
Language:Japanese | Weight:40.00 kg (D) 02/13/2019 | Encounter:Inpatient | FIN:178638 | Clinical Research:
Allergies: penicillin | Location:01 Test IP ONLY | LOS:1238 days | BHN Plan:

Menu - All

- Acute View
- Results Review
- PMP Gateway (AZ and NV only)
- Orders + Add
- Documentation + Add
- New Results
- Advance Directives
- Allergies + Add
- Chart Summary
- Clinical Media + Add
- Clinical Notes
- Clinical Research
- Diagnoses and Problems
- Form Browser
- Health Maintenance
- Histories
- Immunization Schedule
- Interactive View and I & O
- Lines/Tubes/Drains Summary
- MAR Summary
- Medication List + Add
- mPages
- Patient Information
- Patient Schedule

Acute View | Full screen | Print | 0 minutes ago

100%

ICU Graph | Summary | Inpatient Wo... | Hospitalist Q... | Acute QO | Discharge | Watch

Documents (1)

Last 50 Notes | Last 1 months | Last 6 months

My notes only | Group by encounter | Display: All

Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By
02/13/19 14:59	Weight Dosing	ED Nursing Documents	Best, Lori A	02/13/19 14:59	Best, Lori A

* Displaying up to the last 50 recent notes for the last 1 months

Labs

Latest* | Last 1 months | Last 6 months

Display: Facility defined view

No results found

Microbiology (0)

Last 50 Reports | Last 3 months | Last 6 months

No results found

Medical Imaging (0)

Last 1 months | Last 6 months | Last 12 months

No results found

Order Profile (10)

Selected visit

Pending Orders (10) | Group by: Clinical Category | Show: All Active Orders

Type	Order	Start	Status	Status Updated	Ordering Provider
ADT/Activity/CODE (3)					

P1805 | KNOVOATAKARA | March 12, 2019 | 7:59 MST

Copy from your progress note to populate hospital course

PMP Gateway (AZ and NV only)
Orders + Add
Documentation + Add
New Results
Advance Directives
Allergies + Add
Chart Summary
Clinical Media + Add
Clinical Notes
Clinical Research
Diagnoses and Problems
Form Browser
Health Maintenance
Histories
Immunization Schedule
Interactive View and I & O
Lines/Tubes/Drains Summary
MAR Summary
Medication List + Add
mPages
Patient Information
Patient Schedule

Last 800 Documents : 784 out of 803 documents are accessible. (Document Count) In Error Documents Filtered

February 14, 2019
February 13, 2019
February 12, 2019
February 11, 2019
February 10, 2019
February 09, 2019
February 08, 2019
February 07, 2019
23:12 MST Deli
23:12 MST Mo
19:54 MST .Phy
16:29 MST .Cas
14:44 MST .Phy
12:35 MST Deli
12:31 MST Mo
12:14 MST .Mc
11:54 MST Pha
11:38 MST Pha
11:19 MST Nut
11:18 MST .Phy
10:54 MST .Blo
8:52 MST .Phys
7:40 MST .Phys
February 06, 2019
February 05, 2019
February 04, 2019

By type
By status
By date
Performed by
By encounter

transferred back to the floor on 1/29/19

doing OK. just got back from tunnelled HD cathter placement

R tunnelled HD catheter, L PICC. abdomen not distended. no pedal edema.
addomen less distended

cefepime 1/7-1/10
zosyn 1/11-1/23
vancomycin iv 1/7-1/9, 1/11-1/15
vancomycin oral 1/11-1/13
metronidazole 1/12/-1/13
micafungin 1/13-1/22
fluconazole 1/22-2/3
meroopenem 1/24-2/4
ceftriaxone 2/5-

Portal vein thrombus/occludedstent-reviewed films with radiology/IR 2/4. One end of shunt is in IVC, the other does not appear to be in a target vessel. Target (mesnteric vessel) may have sclerosed; that being the case IR does not think there is benefit in shunt study. TIPS vs denver shunt would be indicated for refractory UGIB and very difficult to manage ascites. We'll monitor the reaccumulation of his ascitic fluid and perform paracentesis as needed. Paracentesis 2/5, ANC still high. SBOP

MSSA/Achromobacter PNA, SBP, possible invasive fungal infection-appreciate ID consultation. Shunt will not be placed, meropenem d/c 2/4 and fluconazole dc 2/3. Still meets criteria for SBP by cell count on 2/5, will plan to repeat paracentesis on Monday. Continue cetriaxone per ID

Acute alcoholic hepatitis/ CF liver disease with SBP-SBP is resolved, will need to be on SBP prophylaxis after dc of abx. Continue urosiol 600mg po bid. Outpatient fibroscan in 2-3 months hepatology clinic.

Acites-para 1/26 and para 2.5 with 1.2 L removed. Ascites does not seem to reaccumulating as quickly as previous.

Hepatitis A (1/9) and B (1/19) non immune. . Twinrix 1ml given 2/3/19, discussed with hepatology, should probably get high dose hepatitis b vaccine. Which means he should get another dose in 1 month and then repeat in 4 months (dosing schedule 0,1,2,6 month). Due to the higher dose needed for heb b vaccination, he cannot use twinrix. He should probably get hep A in 4 months (6 months from original). He should have post vaccination testing for immunity.

AKI-not thought to be HRS, on HD. awaiting renal recovery. Tunnelled HD catheter placed 2/6, start outpatient HD placement

Acute hypoxic respiratory failure- much improved. Likely due to CF, achromobacter pna, severe sepsis. No hypoxia with ambulation.

CF pulmonary exacerbation-unable to take home meds due to insurance. sputum AFB negative, viral respiratory panel negative, sputum culture MSSA and achromobacter (sensitive to zosyn). Aspergilus M3 IgE 4. FEV 1 1/7/19 34-->32. 2/4/19 27-->28 Finished meropenem 2/4/19 and fluconazole 2/3/19
Agressive airway clearance with 7% inhaled saline. and vest.

unspec sev pcm-started TPN 1/10, regular diet, weight up 57.1 kg up from 51.2 kg on admission. Nephro TID. pt to stay on TPN until discharge.

Pancreatic insufficiency-continue pancreatic enzymes

Vitamin A/D/E deficiency-continueADEKS bid, cholecalciferol 5000 units daily, vit E 400 units daily, and vit A 10,000 units daily now that he is eating.

severe sepsis-resolved

Paste here and edit--add anything info

ZZZBGSMC. AP01
Age:42 years DOB:09/06/1976 Gender:Female
Language:Japanese Weight:40.00 kg (D) 02/13/2019
Allergies: penicillin

PCP:
Encounter:Inpatient
Location:01 Test IP ONLY

MRN:BGSMC99
FIN:178638
LOS:1238 days

HealtheLife Portal:
Clinical Research:
BHN Plan:

Menu - All

Acute View
Results Review
PMP Gateway (AZ and NV only)
Orders + Add
Documentation + Add
New Results
Advance Directives
Allergies + Add
Chart Summary
Clinical Media + Add
Clinical Notes
Clinical Research
Diagnoses and Problems
Form Browser
Health Maintenance
Histories
Immunization Schedule
Interactive View and I & O
Lines/Tubes/Drains Summary
MAR Summary
Medication List + Add
mPages
Patient Information
Patient Schedule

Acute View | Full screen | Print | 9 minutes ago

100%

ICU Graph | Summary | Inpatient Wo... | Hospitalist Q... | Acute QO | Discharge | Watch

Hospital Course for D/C Note

Selected visit

Acites-para 1/26 and para 2.5 with 1.2 L removed. Ascites does not seem to reaccumulating as quickly as previous.

Hepatitis A (1/9) and B (1/19) non immune. . Twinrix 1ml given 2/3/19, discussed with hepatology, should probably get high dose hepatitis b vaccine. Which means he should get another dose in 1 month and then repeat in 4 months (dosing schedule 0,1,2,6 month). Due to the higher dose needed for heb b vaccination, he cannot use twinrix. He should probably get hep A in 4 months (6 months from original). He should have post vaccination testing for immunity.

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severe sepsis-resolved

Click on Create Note→Discharge Note. Once you have done this, can't edit further

ZZZBGSMC. AP01
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Menu - All
Acute View
Full screen
Print
9 minutes ago

- Acute View
- Results Review
- PMP Gateway (AZ and NV only)
- Orders + Add
- Documentation + Add
- New Results
- Advance Directives
- Allergies + Add
- Chart Summary
- Clinical Media + Add
- Clinical Notes
- Clinical Research
- Diagnoses and Problems
- Form Browser
- Health Maintenance
- Histories
- Immunization Schedule
- Interactive View and I & O
- Lines/Tubes/Drains Summary
- MAR Summary
- Medication List + Add
- mPages
- Patient Information
- Patient Schedule

100%

ICU Graph | Summary | Inpatient Wo... | Hospitali... Q... | Acute QO | Discharge | Watch

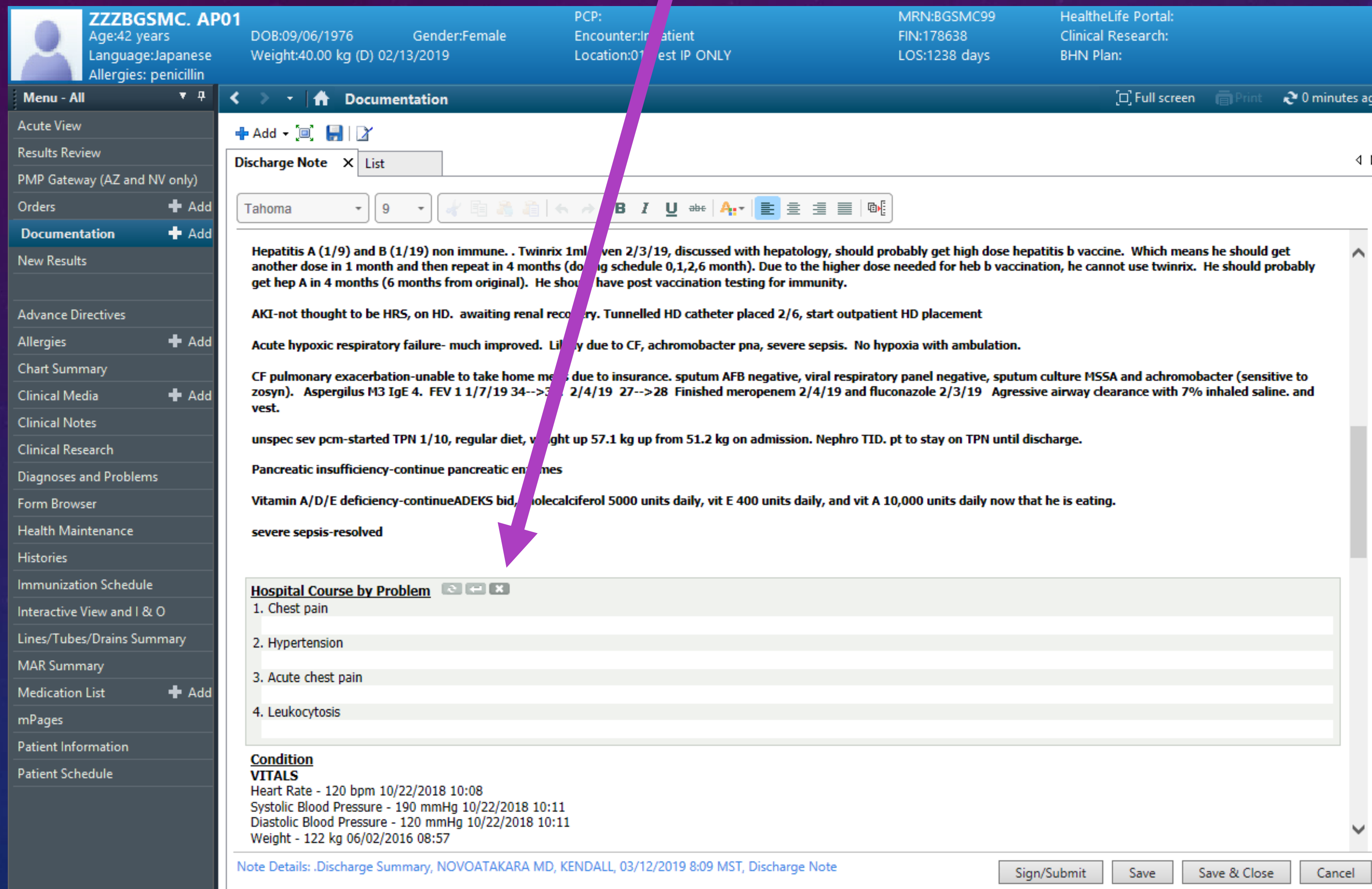
Last 30 days | Last 3 months | Last 6 months

- Documents (1)
- Labs
- Microbiology (0)
- Medical Imaging (0)
- Order Profile (10)
- Outstanding Orders (0)
- New Order Entry
- Home Medications (5)
- Problem List
- Hospital Course by Problem
- Hospital Course for D/C Note
- Patient Education
- Follow Up
- Discharge Planning (1)
- Patient Information
- Reminders (1)
- Health Concerns
- Goals and Interventions
- Care Team
- Media Gallery (0)

Create Note
- Discharge Note
- Select Other Note

tion | Inactivate | Rename | Review
Search
Size:

Delete fields that are repetitive or not needed by clicking on the X (visible if you hover)



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- System News
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- Customer Experience
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- Banner's 20th Anniversary
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>> BHSystem >> Departments >> Clinical Education >> Dragon

Dragon Resources

If You Need Support Call 602.747.4444 Option 3

Read this FAQ!

Dragon Medical One Reference Guide

- PowerMic Mobile (PMM) Installation and Configuration
- Dynamic Documentation Using Dragon
- Device Use in Different Citrix Environments
- Pin Program to Task Bar or Create a Shortcut
- Important Tips

Dragon Dictation with Smart Phones

- PowerMic Mobile
- Log in Instructions from Banner Portal
- Log in Instructions from Desktop
- Create a Command Auto Text

Request Dragon access through Banner Service Hub

Performance Management

CERNER RESOURCE CENTER

DIVERSITY & INCLUSION

MY WELL-BEING

MVP RECOGNITION ★ PROGRAM ★

Intranet Statistics:
13058 hits since 1:29 PM

IN CLASS EXERCISE

- Read the discharge summary
- Reading the discharge summary alone, would you be able to easily assume care of the patient?
- What is good about it?
- What needs is improvement?
- Report back