Progress Note Inpatient
Fact Sheet

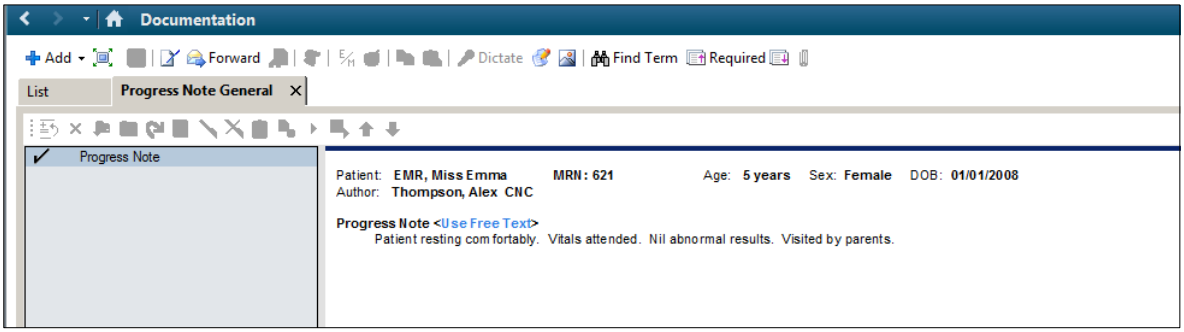
Overview

Progress notes are used as the main communication / information tool between different disciplines involved in the care of the patient. They aim to capture the 'story' of the patient's hospital visit from admission to discharge and are seen as a way for staff to obtain an understanding of the patient history while supporting holistic care.

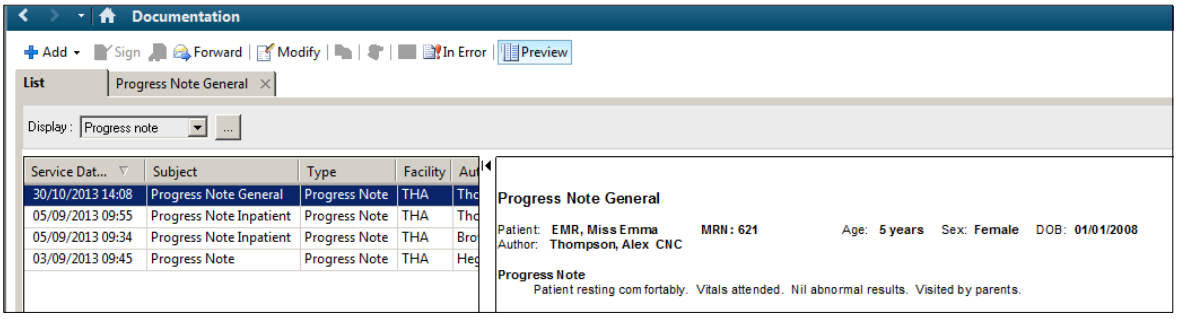
An electronic Progress Note has been developed to allow clinicians to capture progress note entries directly into the eMR. This progress note entry is then immediately available in the eMR for all clinical staff to view via the patient's chart.

The Progress Note will provide clinicians with the ability to:

- Create electronic progress note entries
- Enter information in an unstructured free text format
- Use and apply structured templates when required
- Automatically include author name and designation
- Apply formatting and spell check functionality



- View a list of progress note entries in a chronological order
- Provide a verification process for student/supervised entries



The electronic Progress Note has been designed in consultation with state-wide clinical reference groups, the Ministry of Health and Cerner to meet the standards outlined under the Health Care Records – Documentation and Management Policy (PD2012_069).

Moving forward: The eMR program is currently developing a module that will display progress notes for clinicians in a single consolidated chronological view. This view will include features such as a scrolling, search function and filtering of entry types to be viewed.