Documentation – Diagnosis, Problems & Alerts

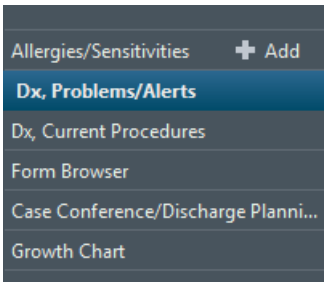
Digital Health
CONNECTING BEST CARE

Digital Health
Quick Reference Guide

This Quick Reference Guide will explain how to:

Document diagnosis, problems and alerts.

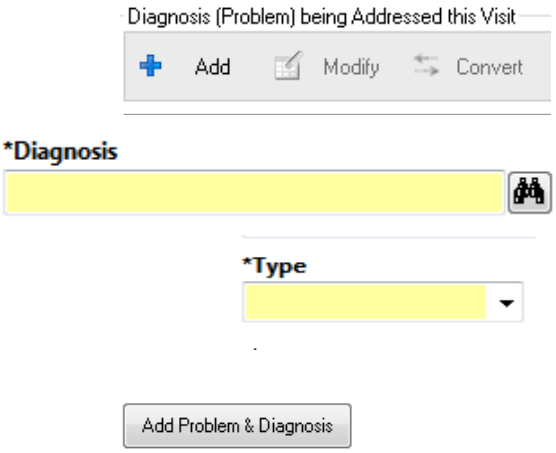
1. Navigate to Dx Problems/Alert.
   The screen is split into “Diagnosis” and “Problems”.



In Cerner language –
“**Diagnosis**” means the problem/s being addressed during the current admission, aka a list of current issues.

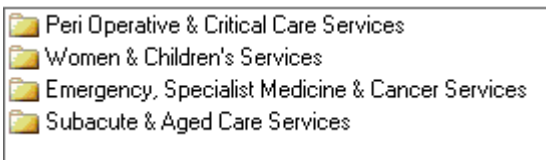
“**Problems**” include care alerts and past medical history, including conditions that are still active and those that have been resolved.

2. To add a diagnosis, click “Add”
3. Type the diagnosis into the yellow field and click the binoculars to see a list of options with SNOMED codes attached
4. Select the appropriate diagnosis and click “OK”
5. Click the drop down list next to “Type” and choose if this diagnosis is Principal, Additional or a Complication.
6. Choose whether this is a Final, Working or Differential diagnosis under “Confirmation”.
7. Click “Add Problem & Diagnosis” if you want to add this issue to the patient’s chronic history as well.



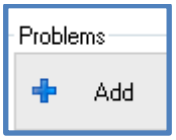
Examples:

- **A patient is admitted with a UTI = <u>diagnosis.</u>**
- **A patient has chronic hypertension which is under control and the inpatient team do not have to address it during the admission = <u>problem.</u>**
- **A patient has poorly controlled T2DM which the inpatient team need to address = <u>problem & diagnosis.</u>**

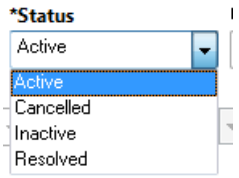


8. Common diagnoses can also be found in Folders.

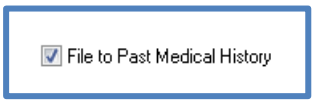
9. Problems and care alerts are added in a similar manner.



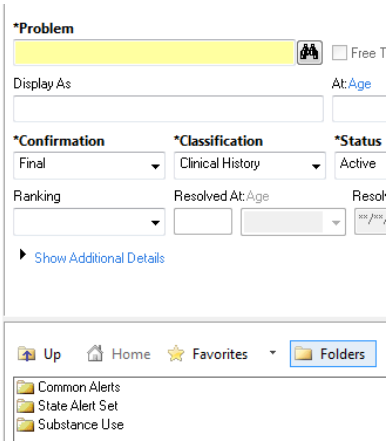
10. Select the appropriate status for each problem – Active, Cancelled (entered incorrectly), Inactive or Resolved.



11. Click the “File to Past Medical History” button if appropriate. **This means that the problem will auto-populate on the patient’s medical record for all future encounters.**

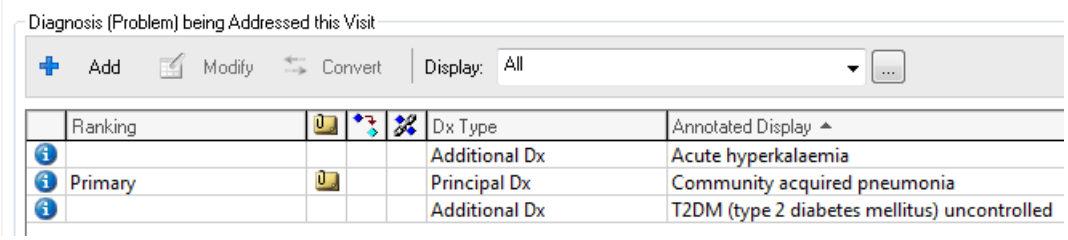


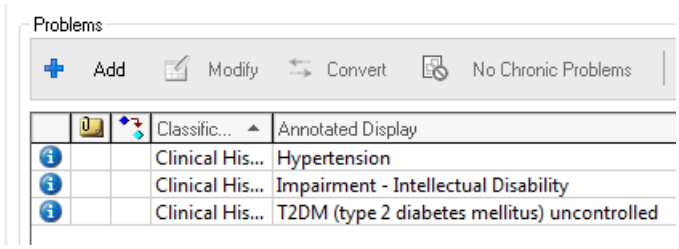
12. Care alerts **must** be added from the “Common Alerts” folder in order to display as “Recorded” in the banner bar.



Example scenario:

Patient is admitted with CAP.
Past history: HTN, poorly controlled T2DM, intellectual impairment.
During admission, the patient develops acute hyperkalaemia and erratic BSLs.





On the Admit & Manage pages, diagnoses are marked as “This Visit” and problems as “Chronic”.

When a ward round note is created, the diagnoses have been auto-populated in the Assessment/Plan section:

Assessment/Plan
1. Community acquired pneumonia

2. T2DM (type 2 diabetes mellitus) uncontrolled

3. Acute hyperkalaemia

Assessment/Plan
1. Community acquired pneumonia
   Continue IV antibiotics
   Repeat CRP over weekend
2. T2DM (type 2 diabetes mellitus) uncontrolled
   Sliding scale
   Endocrine review
3. Acute hyperkalaemia
   Resolving
   No ECG changes
   Repeat K this evening