Cerner EHR Tips

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Sorting by type of note in “Documentation”

- The drop-down menu next to “Display” shows All, Only, All Physician Notes, All PowerNotes.
- All will show you every note including the nursing, therapy, social work, and physician notes, etc.
- Your best bet is to just keep the Display set to All and most importantly the nursing notes are key for your subjective of your note and presentation, and the social worker notes and physical therapy notes are key for discharge planning.
Patient chart data reflects a test patient; this is not real patient data.

Intake and Output
1. In TOC, select ‘IView with IO’
2. In newly displayed menu, select ‘Intake and Output’ from near bottom of screen.
Intake and Output

It's important to monitor the in's and out's of your patients, particularly those with heart failure, on surgery those with drains or if you have patients with C. diff and need to monitor their diarrhea. This is also important when you have pediatric patients with failure to thrive, newborns where you have to monitor their numbers of stools and voids, etc.

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**MAR SUMMARY**

- The MAR (medication administration record). This is the section that shows you how much, what medications were given and when. You can also see what fluids the patient is on.

- For example, when you give your presentation and you can say, “she required 3 doses of oxycodone overnight” to give an idea of pain control. Or when you have a septic patient and need to make sure that the antibiotics are given by the nursing staff.
RESULTS REVIEW AND CHANGING THE SEARCH CRITERIA TO SHOW PAST RESULTS

- Results review is where you go to find laboratory results, microbiology, and imaging.
- Right click on the grey bar that shows the date range (in the second picture) and make sure that you change the “from date” to at least a year before this admission so you get baseline data from past admissions for this patient.
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1. Type hospital course here.

WORKFLOW PAGE AND HOSPITAL COURSE
• Keeping the hospital course up to date is a great way to help your team. It is written as a summary of why the patient was in the hospital and what was done for the patient categorized by problem.
• It’s helpful to the team because you or the intern can then use the hospital course as the discharge summary instead of having to look back at all the notes to see all that was done for the patient since admission.
• Start the day of admission and add to it every day.