Clinical Documentation

For the best Clinical Experience, use a tablet or laptop and a modern browser like Chrome, Firefox, Safari or Edge with EHR Go. Students can document in EHR Go during or after the clinical day. EHR Go can help if clinical sites need more information about EHR Go and HIPAA-compliance.

The following notes, found on the Notes Tab>New support Clinical Documentation in EHR Go:

Basic Clinical Assessment

Freetext documentation organized in a systems approach

Advanced Clinical Assessment

Charting by exception full clinical head-to-toe

Clinical Head to Toe Assessment

Full head-to-toe clinical assessment without exception charting. Variety of check boxes and freetext.

Clinical Journal

Learning objective-based reflection

Clinical Journal Insight Reflection

Seven reflection questions regarding clinical experience and learning

Clinical Lab & Diagnostic Interpretation

Detailed lab and diagnostic review and result interpretation for clinical patient or other purposes

Clinical Labs, Diagnostics, & Medications (Nursing)

Detailed lab, diagnostic and medication review and result interpretation for clinical patient or other purposes in a single note form

Clinical Medication Review & Interpretation

Detailed medication review and interpretation for clinical patient or other purposes

Clinical Nursing Care of the Adult

Complete clinical assessment using health pattern organization framework. Includes vitals, fall risk assessment, Braden assessment, medication and lab review, and care plan.

Clinical Nursing Care of the Complex Adult

Complete clinical assessment using health pattern organization framework. Includes more intensive physical assessment, no screening tools included, medication and lab review, and care plan.

Clinical Documentation

Clinical Nursing Care of the Laboring Woman

Complete clinical assessment using health pattern organization framework with pregnancy and labor assessments included. Includes vitals, violence screen, labor record with fetal/uterine activity assessment, detailed pain management assessment, medication and lab review, and fall risk assessment.

Clinical Nursing Care of the Newborn

Includes pregnancy and birth data, APGAR, physical examination, reflexes, assessment interpretation, labs, vitals, medications, and full newborn assessment.

Clinical Nursing Care of the Pediatric Patient

Complete clinical assessment using health pattern organization framework. Includes vitals, fall risk assessment, Braden Q Scale assessment, medication and lab review, and developmental assessment.

Clinical Nursing Care of the Postpartum Woman

Complete clinical assessment using health pattern organization framework. Includes pregnancy and birth history, vitals, medication and lab review.

Clinical Nursing: The 10 Minute Assessment

Brief systems-based assessment and safety check.

Nursing Discharge Teaching/Education (Clinical Use)

Follow-up appointments, discharge medications, patient teaching, safety guidance

Clinical Pre-planning

Pre-planning form for clinical preparation. Includes order review, medication and lab result analysis and disease/procedural research for clinical patient.

Plus dozens of other clinically-relevant screening tools and assessment forms, including H&Ps, SOAP notes, and discipline-specific formats. All note templates can be accessed on the Notes Tab in the Search List under the “NEW” button.

Other Optional Clinical Documentation Areas

Accounts Section:

Registration Tab

Use edit to change the name or DOB of the chart. DO NOT use actual patient identifiers here. May choose to name chart by clinical site or clinical instructor. Alternatively, change the name of your EHR session when you close the EHR to a file name to identify the clinical experience.

Clinical Documentation

Encounter, Insurance, Scheduling, Claims, & Ledger Tabs

These tabs in the Accounts Section are not recommended for clinical usage as the data is of a sensitive and non-HIPAA-compliant manner.

Health Section:

Alerts Tab

May add Allergies, Advance Directives, Clinical Warnings- such as Braden, Depression screen or fall risk results, and/or Crisis Alerts.

Problems Tab

May add ICD-10 or freetext problems, directly from the patient's chart, or as identified by the student. Can use Priority field to qualify problem selection. *Good for practicing coding and for creating a differential. Problems can be researched directly from Problem detail view. Click on problem in list and scroll down to access resource look-up.

Vitals Tab

Vitals, Pain, Growth, I&O, Accucheck, and systems-based WNL checklist for each set of vitals. Document as many sets of vitals as needed. No required fields. No abnormal interpretation.

Orders Tab

Orders are best used by advanced practice students documenting their plan of care, writing prescriptions, ordering diagnostics and consultations. It is recommended that undergraduate students interpret orders using the various clinical notes.

Meds Tab

Not applicable to clinical documentation. Various clinical notes should be used to document medications ordered for a patient and/or administered during clinical hours.

Notes Tab

The Notes Tab is heavily used during clinical documentation. There are dozens of clinical assessment and documentation forms available in the notes library to make sure that clinical documentation is efficient, complete, clear, and HIPAA-compliant. *New types of note documentation forms can be added to the EHR Go note library on request.

Care Plans Tab

New Care Plans can be created and existing Care Plans can be evaluated and managed using the Care Plans Tab. Currently, Interventions and Evaluations cannot be edited or removed, but should instead be amended with evaluation and comments feature.

Labs Tab

Lab results can be entered using the labs tab, but are more efficiently entered and interpreted using a Clinical Assessment or Clinical Lab and Diagnostic Review note.