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The most basic ER documentation must include: patient identification, how the patient arrived, care rendered prior to arrival, relevant history, chronological listing of physical examinations including vital signs, and the results of diagnostics, treatments and tests. The physician 's orders and diagnostic analysis should be recorded.

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The American College of Emergency Physicians (ACEP) has developed these ED Facility Level Coding Guidelines (Guidelines) for informational purposes only. These Guidelines have been developed by sources believed to be

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Initial Assessment of Emergency Department Patients (February 2017) Page 2 Introduction Patients who present to the Emergency Department (ED) are typically unselected on arrival, although some may have already been seen by a clinician, or have been directed to the department following a pre-hospital assessment such as NHS111.

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<u>Documentation of EM Encounters</u>

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? Documentation of the plan or intent to order a CT scan was insufficient to support medical necessity. If the handwritten signature is illegible, include a signature log, and if electronic, the protocol should also be submitted. Table 5. CT Scan Resources Resource

Initial Assessment of Emergency Department Patients

Page 4/5 Julv. 27 2024 National guideline for nursing and midwifery quality care-metrics data measurement in acute care 2018 (PDF) Published by Health Service Executive, Republic of Ireland, 17 December 2018. The objective of this guideline is to enable nurses and midwives to engage with and implement Quality Care-Metrics, using a consistent and standardised approach. The guideline provides a framework...

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