

A day in the life of an Ambulatory Nurse

1

GET STARTED

I view the day's appointments on a schedule, and, when a patient arrives, I can jump into their electronic chart.



2

REVIEW

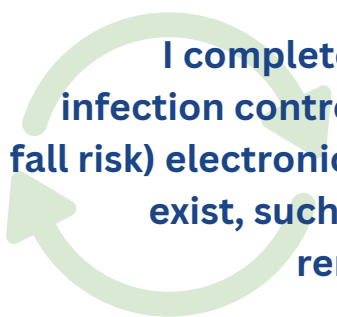
I review patient history and up-to-date content from past clinic visits, hospital stays and ED visits - all in one place!



3

INTAKE

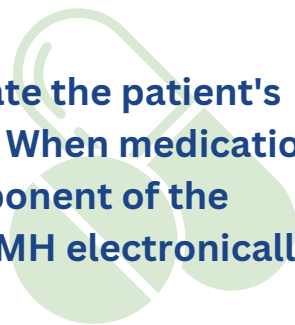
I complete intake documentation (e.g. infection control screening, patient history, fall risk) electronically. If orders for initial care exist, such as a dressing change or cast removal, I can begin that work.



4

UPDATE

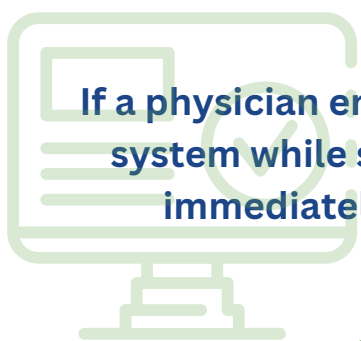
I can easily retrieve and update the patient's medication list at every visit. When medication management is a major component of the patient's care, I complete BPMH electronically.



5

ORDERS

If a physician enters orders directly into the system while seeing a patient, I am able to immediately access and execute them.



6

DOCUMENT

I complete any necessary documentation electronically, and it is visible alongside physician documentation, where it is easily accessible to others caring for the patient.

