SOP No.: CIP04000

Module: Definition of clinical terminology
Procedure: Definition of clinical terminology for “General Ophthalmology”

Purpose
To define and implement the identified and researched the existing terms codes and abbreviations for the above listed documentation area.

Scope
This SOP applies to the EHR/EMR project: (name)

Responsibility
- Leading physician
- Third party (clinical documentation expert)
- Ifa clinical product specialist

General
The clinical terminology plays an important role for the efficiency and clinical outcome of the EMR system. The goals and concepts have to be defined to implement:
- Clinical guidelines
- Clinical decision support systems
- Clinical research and disease registries

The local terminology should be compliant with the future standards such as ICD10/ICD11, SNOMED, LOINC etc.. The EMR system allows the use of local terms which are mapped with external standards in the background. The existing terms of the EMR system shall be used as a framework. If new terms are defined these should follow the coding guideline to ensure compatible terminology concepts.

Procedure
a. Terms, codes and abbreviations are categorized and defined by the responsible work group member into observation classes:
    - Medical History
        - Past Ocular History
        - Past Medical History
        - Ocular Procedures
        - Eye Medications
        - Systemic Medications
        - Family History
        - Social History
        - Allergies
        - Review of Systems
    - Findings for relevant Observation Classes
        - Anterior Exam
        - Posterior Exam
        - General Exam
    - Test Interpretations
    - Diagnosis (ICD)
    - Treatment Plan
    - Medications
    - Other clinical documentation areas

b. The defined terms, codes and abbreviations are entered into a spread sheet (excel).
c. The responsible work group member identifies regulatory requirements for structured documentation (e.g. ICD/SNOMED for billing, LOINC for lab orders etc.).
d. A complete report is created and submitted for approval by the responsible clinical specialist (complete and correct analysis)
e. The responsible specialist for the final definition and implementation process is identified (see SOP for Definition of clinical terminology).

Related documentation

- Default terms, codes and abbreviations (ifa EMR)
- List of areas (e.g. 100 observation classes) implemented in the ifa EMR
- Coding guidelines
- Relevant checklists