

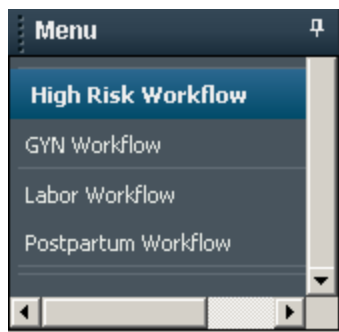
OBGYN Workflows

The new OBGYN workflow pages will make the creation of your progress note a by-product of your normal workflow.

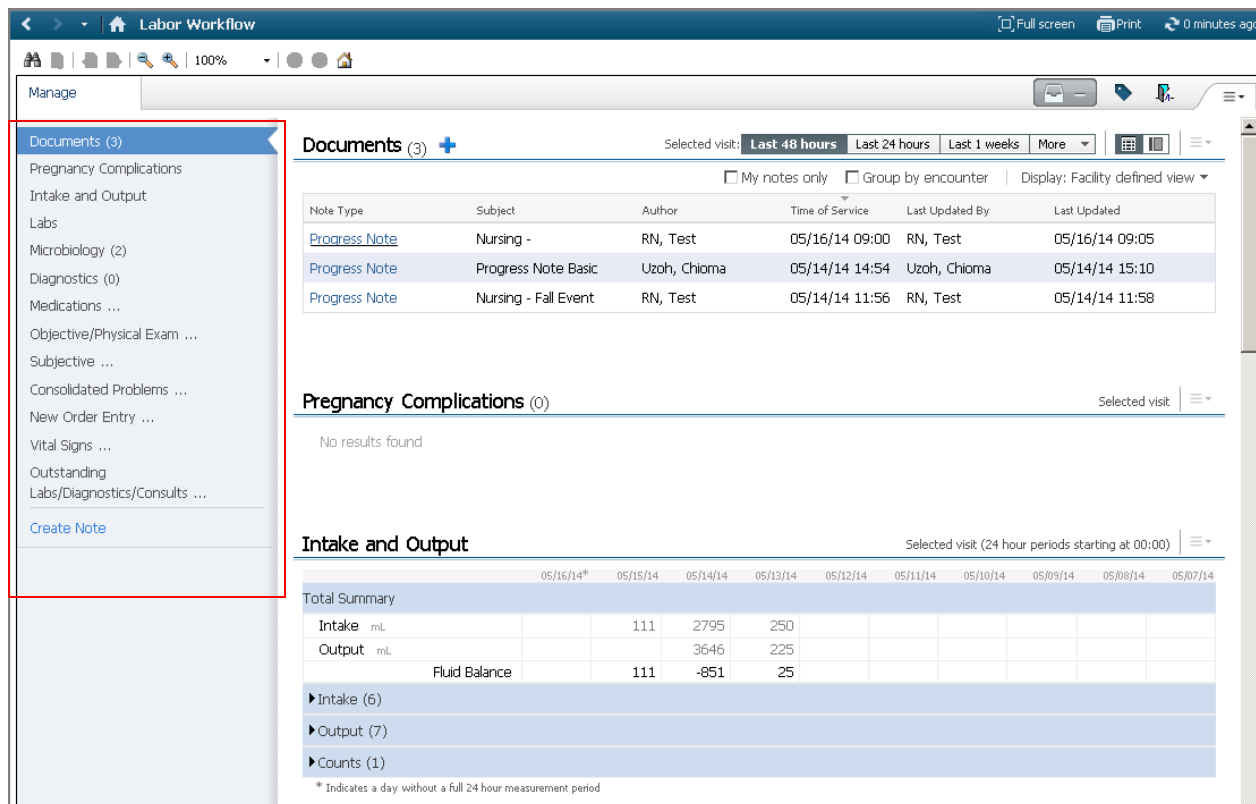
There are four distinct workflows for OB GYN service:

- **High Risk:** used for progress notes on active laboring, antepartum and high risk patients.
- **Labor:** used for progress notes on active laboring, antepartum and high risk patients.
- **Postpartum:** used for postpartum patients
- **GYN:** used for Gyn patients

1. Launch Dragon before accessing a patient's chart, so that it may load while you are reviewing the chart.
2. From the patient list, open the patient's chart.
3. On the Menu, select the workflow you wish to work through.



4. On the left is the **Workflow**.



Documents (3)

Note Type	Subject	Author	Time of Service	Last Updated By	Last Updated
Progress Note	Nursing -	RN, Test	05/16/14 09:00	RN, Test	05/16/14 09:05
Progress Note	Progress Note Basic	Uzoh, Chioma	05/14/14 14:54	Uzoh, Chioma	05/14/14 15:10
Progress Note	Nursing - Fall Event	RN, Test	05/14/14 11:56	RN, Test	05/14/14 11:58

Pregnancy Complications (0)

No results found

Intake and Output

Selected visit (24 hour periods starting at 00:00)

	05/16/14*	05/15/14	05/14/14	05/13/14	05/12/14	05/11/14	05/10/14	05/09/14	05/08/14	05/07/14
Total Summary										
Intake mL		111	2795	250						
Output mL			3646	225						
Fluid Balance		111	-851	25						
► Intake (6)										
► Output (7)										
► Counts (1)										

* Indicates a day without a full 24 hour measurement period

5. Click on each item to jump to that section. You can also scroll down the page to review each section in the workflow.

Sections in OBGYN Workflows Documents

The following sections are present in all workflows, except where noted.

Documents provides a list of previous signed electronic documents for this visit based on the timeframe selected.

Click on the Note Type to open and view the document.

The list defaults to most recent document on top, but the timeframe can be changed.

Documents (9)

Selected visit Last 24 hours Last 48 hours More

☐ My notes only ☐ Group by encounter Display: Facility defined view

Note Type	Subject	Author	Time of Service	Last Updated By	Last Updated
Progress Note	Progress Note Basic	Ali MD, Mohammed	04/01/14 13:29	Ali MD, Mohammed	04/01/14 13:33
Progress Note	Medicine - CCHP	Uzelac MD, Giovanna L. (resident)	03/31/14 17:27	Uzelac MD, Giovanna L. (resident)	03/31/14 17:32
Progress Note	Progress Note Basic	MDPilot, Test	03/31/14 16:35	MDPilot, Test	03/31/14 16:37

Pane View

Documents (3)

Selected visit: Last 48 hours Last 24 hours Last 1 weeks More

☐ My notes only ☐ Group by encounter Display: Facility defined view

Progress Note

MDPilot5, Test

04/16/14 13:52

Progress Note

MDPilot5, Test

04/16/14 13:26

Progress Note

MDPilot3, Test

04/16/14 12:14

Progress Note

04/16/14 12:14

Progress Note

Subjective

Objective/Physical Exam

Vitals & Measurements

GENERAL: [awake], [well-developed, well-nourished], [comfortable]

HEAD/EYES: [normocephalic, atraumatic], [normal lids and conjunctiva], [pupils equal], [extraocular muscles intact]

EARS/NOSE/THROAT: [normal external ears/nose], [normal tympanic membranes], [normal oropharynx]

NECK: [supple], [full range of motion], [no masses], [no thyromegaly]

CARDIOVASCULAR: [normal S1/S2], [regular rate and rhythm], [no murmur/gallop/rub]

Lab Results

1.0 \

300

Labs

HGB 9.4 G/DL 04/15/2014 13:30 EDT (Low)

Click on Pane Selector to view the documents like a paper chart.

On the Pane view, use down arrow on keyboard or click the note name to move from note to note, to review like paper chart.

Vital Signs

Vital signs are populated by nursing once per shift. If not updated, you can use the PowerForm to enter vitals.

Vital Signs

Selected visit: Latest* Selected visit Last 24 hours More

Display of most recent vitals defaults, but the timeframe can be changed.

	Mar 24, 2014 09:28	Mar 11, 2014 11:36	11:21	07:00
Temp	37.6	--	37	38
BP	110	--	110	100
HR	76			70
Respiratory Rate	80			76
Pulse Ox	--			--
Body Mass Index	99			98
Height	36.21			
Weight	152.4			
	84.09			

* Displaying recent results up to 6 columns

Body Mass Index: 36.21
Date/Time: 03/24/2014 09:28
Status: Auth (Verified)
Normal Low: --
Normal High: --
Critical Low: --
Critical High: --

Hover over a specific result to see more information.

Sections in OBGYN Workflows

Pregnancy Complications: High Risk and Labor Workflows

This section contains data that is interface through OBIS and pertinent to daily rounds. Data from here pulls important maternal information into the note using a specific smart template.

Pregnancy Complications (B)

	Result	Date/Time
History of C/Section	No	05/10/14 19:16
Gestational Diabetes History	No	05/10/14 19:16
Incompetent Cervix	No	05/10/14 19:16
IUGR	No	05/10/14 19:16
Macrosomia	No	05/10/14 19:16
Pregnancy Induced Hypertension	No	05/10/14 19:16
Placenta Previa History	No	05/10/14 19:16
Preterm Labor/PROM	No	05/10/14 19:16

Other Pertinent Data: Postpartum

This section contains data that is interface through OBIS and pertinent to daily rounds. Data from here pulls important status on newborn into the note using a specific smart template.

Other Pertinent Data (2)

	Result	Date/Time
NICU Immediately-Baby A	No	05/11/14 18:07
Newborn feeding preference	Formula	05/10/14 18:12

Sections in OB GYN Workflows

Intake and Output (I&Os)

Intake and Output

Selected visit (24 hour periods starting at 00:00) | ⋮

	04/04/14*	04/03/14	04/02/14	04/01/14	03/31/14	03/30/14	03/29/14	03/28/14	03/27/14	03/26/14
Total Summary										
Intake mL					350					
Output mL					330					
Fluid Balance					20					
▶ Intake (1)										
▶ Output (1)										
▶ Counts (0)										

Expand the sections to view additional data by clicking on the triangle next to the section heading.

Labs

Labs

Selected visit: Latest* Selected visit Last 24 hours More ▾

Most recent resulted labs will display, but the timeframe can be changed.

	Mar 11, 2014 11:25
Chemistry	
NA	↓123
K	3.5
CL	112
TOTAL CO2	↑33
BUN	↓3
CRT	↑3.00
GFR Group	See Below
eGFR African-American	↑32
eGFR Non African-American	↑26
ANION GAP	see c
CA	↑11.0
Hematology	
CBC w/ Diff	See Below
WBC	4.0
HGB	↓11.0

TOTAL CO2: 33 MMOL/L
Date/Time: 03/11/2014 11:25
Status: Auth (Verified)
Normal Low: 24
Normal High: 32
Critical Low: --
Critical High: --

Hover over a result to see more information.

Any additional lab results you wish to include in your note can be Tagged by right clicking on the result and clicking Tag.

The tag icon at the top of the Documentation workflow page turns blue, indicating a tagged result. These results will then pull into your note.

Microbiology

Microbiology

Selected visit Last 24 hours Last 1 weeks More ▾

Order	Susceptibility	Growth	Organism(s)	Source/Site	Collected	Last Updated	Status
Blood Cult		--	--	Blood, Peripheral	02/24/14 08:42	02/24/14 09:04	Auth (Verified)

Click on the order name (in blue) to open the report.

Status	Meaning
Ordered	Order placed but not yet completed
In Progress	Order currently processing
Unauth	Order completed but not yet resulted
Auth (Verified)	Completed order with dictated report available

Sections in OBGYN Workflows

Diagnostics

The Diagnostic Tests and Imaging Orders for the selected visit will be displayed, but the timeframe can be changed.

Diagnostics (4)

Selected visit Last 24 hours Last 3 days More

Name	Reason For Exam	Resulted	Last Updated	Status
Diagnostic Tests (0)				
No results found				
Imaging (4)				
Chest PA and Lat	--	03/04/14 08:58	--	Ordered
CT Abd,Pelvis w/wo Contrast	--	02/24/14 07:05	02/24/14 07:27	Auth (Verified)
Chest PA and Lat	--	02/24/14 07:05	02/24/14 07:29	Auth (Verified)
Chest PA and Lat	--	01/27/14 10:07	--	Unauth

Clicking an **Auth (Verified)** report opens the Final report.

Clicking an **Unauth** report opens the Result Details window with more information about the order.

Document Viewer - ZZTEST, PHYSDOC6 - 2800100056



*** Final Report ***

5400480

Name: ZZTEST, PHYSDOC6

DOB: 01-24-1986 Gender: F

Med Rec#: 2800100056

Financial#: 3800100074

Location: Christiana Hospital

Ordering Phys: SHIUH, TIMOTHY Y. MD

CC Physician:

Study: CHEST PA AND LATERAL VIEWS

Service Date: 02-24-2014 07:06:00

The heart is normal in size and configuration. Both lungs are expanded and are clear.

IMPRESSION: NORMAL CHEST.

ALAN EVANTASH, MD

(Electronically Signed)

Dict/trans: Ae/ Ae

TR: 02-24-2014 07:29:00

VE: 02-24-2014 07:29:00

Result type:

Chest PA and Lat

Result date:

24 February 2014 07:05

Status:

Auth (Verified)

Document Title:

5400480

Performed by:

Evantash MD, Alan on 24 February 2014 07:29

Verified by:

Evantash MD, Alan on 24 February 2014 07:29

Encounter info:

3800100074, CHR Inpatient, 01/24/2014



Highlight any specific section of the report and click Tag to insert this information into your Progress note.

Result Details - ZZTEST, PHYSDOC6

Result History

Value	Valid From	Valid Until
Exam Completed	01/28/2014 11:01	Current
Ordered	01/28/2014 11:01	01/28/2014 11:01

Result Action List

Chest PA and Lateral

Exam Completed

Date/Time 27 January 2014 10:07

Contributor System RIS

Accession Number 22064263

Status Unauth

[Trend](#)

2515475514

Forward...

Print...

Close

Tagging can be used in:

- Documents
- Diagnostics
- Lab Results

Sections in SCCC Workflow

Medications

Medications for the selected visit are displayed in the following categories:

- Scheduled
- Continuous
- PRN/Unscheduled Available
- Administered in last 24 hours
- Discontinued in last 24 hours

Click the Medications heading to view the MAR Summary screen.

Medication Reconciliation Status is easy to determine on the workflow.

- Meds History (Home Medications)
- Adm. Meds Rec
- Disch. Meds Rec

✓ = Completed

🔄 = In Progress

❗ = Not Started

To complete reconciliation or view the med rec screens, click the status.

Medications

Selected visit

Status: ✓ Meds History ❗ Adm. Meds Rec ❗ Disch. Meds Rec

4 Scheduled (3)

Next Dose	
levoFLOXacin (LevoFLOXacin (Levaquin)) (LevoFLOXacin 750 Mg Tab) 750 MG, 1 TAB, PO, Daily	04/04/14 10:00
piperacillin-tazobactam (Piperacillin-Tazobactam (Zosyn)) 4.5 G, 200 ML/HR, IV, Q8H	04/04/14 16:00
carvedilol (Carvedilol (Coreg)) (Carvedilol 6.25 Mg Tab) 6.25 MG, 1 TAB, PO, BID	04/04/14 20:00

4 Continuous (0)

4 PRN/Unscheduled Available (5)

Last Dose	
acetaminophen (Acetaminophen (Tylenol)) 650 MG, 2 TAB, PO, Q4H, PRN: Pain Scale - Mild 1-3/Fever	
nitroglycerin (Nitroglycerin (Nitrostat) SL Tab) 0.3 MG, SL, Q_5Min, PRN: Chest pain-MR x2	
ondansetron (Ondansetron ODT (Zofran ODT)) 4 MG, 1 SLTAB, PO, Q8H, PRN: Nausea/Vomiting	
zolpidem (Zolpidem (Ambien)) 5 MG, 1 TAB, PO, QHS, PRN: Insomnia	
zolpidem (Zolpidem (Ambien)) 2.5 MG, 0.5 TAB, PO, QHS, PRN: Insomnia	

Order Reconciliation: Admission - ZZTEST, PHYSDOC6
ZZTEST, PHYSDOC6 Age: 28 years Gender: Female Type: Inpatient [01/24/2014 07:39 - <No - Discharge da... Allergies: No Known Allergies
DOB: 01/24/1986 Fin#: 3800100074 Loc: CSA; SA01; B MRN: 2800100056

+ Add | Manage Plans

Orders Prior to Reconciliation

Orders After Reconciliation

Order Name/Details	Status		Order Name/Details	Status
acetaminophen (Acetaminophen (Tylenol)) (Ac... 650 MG, 2 TAB, PO, Q4H, PRN: Pain Scale - Mild 1-3/Fever	Ordered	🔄	acetaminophen (Acetaminophen (Tylenol)) (Ac... 650 MG, 2 TAB, PO, Q4H, PRN: Pain Scale - Mild 1-3/Fever	Ordered
amlodipine (Amlodipine (Norvasc)) 0.3 MG, SL, Q_5Min, PRN: Chest pain-MR x2	Documented	🔄		
aripiprazole (Abilify) 0 Refill(s)	Documented	🔄		
CAPTIVOL (CAPTOPRIL) 0 Refill(s)	Documented	🔄		
carvedilol (Carvedilol (Coreg)) (Carvedilol 6.25 M... 6.25 MG, 1 TAB, PO, BID	Ordered	🔄	carvedilol (Carvedilol (Coreg)) (Carvedilol 6.25 M... 6.25 MG, 1 TAB, PO, BID	Ordered
carvedilol (Coreg)	Ordered	🔄		
levoFLOXacin (LevoFLOXacin (Levaquin)) (LevoF... 750 MG, 1 TAB, PO, Daily	Ordered	🔄	levoFLOXacin (LevoFLOXacin (Levaquin)) (LevoF... 750 MG, 1 TAB, PO, Daily	Ordered
levofloxacin (Levofloxacin (Levaquin))	Documented	🔄		
metoprolol (metoprolol XL (Toprol-XL)) 25 MG, PO, Daily	Ordered	🔄	metoprolol (metoprolol XL (Toprol-XL)) 25 MG, PO, Daily	Ordered
nitroglycerin (Nitroglycerin (Nitrostat) SL Tab) 0.3 MG, SL, Q_5Min, PRN: Chest pain-MR x2	Ordered	🔄	nitroglycerin (Nitroglycerin (Nitrostat) SL Tab) 0.3 MG, SL, Q_5Min, PRN: Chest pain-MR x2	Ordered
omeprazole (omeprazole) 0 Refill(s)	Documented	🔄		
ondansetron (Ondansetron ODT (Zofran ODT)) (O... 4 MG, 1 SLTAB, PO, Q8H, PRN: Nausea/Vomiting	Ordered	🔄	ondansetron (Ondansetron ODT (Zofran ODT)) (O... 4 MG, 1 SLTAB, PO, Q8H, PRN: Nausea/Vomiting	Ordered
piperacillin-tazobactam (Piperacillin-Tazobacta... 4.5 G, 200 ML/HR, IV, Q8H	Ordered	🔄	piperacillin-tazobactam (Piperacillin-Tazobacta... 4.5 G, 200 ML/HR, IV, Q8H	Ordered
topiramate (Topamax)	Documented	🔄		
zolpidem (Zolpidem (Ambien)) (Zolpidem 5 Mg T... 2.5 MG, 0.5 TAB, PO, QHS, PRN: Insomnia	Ordered	🔄	zolpidem (Zolpidem (Ambien)) (Zolpidem 5 Mg T... 2.5 MG, 0.5 TAB, PO, QHS, PRN: Insomnia	Ordered

Details

0 Missing Required Details 7 Unreconciled Order(s) Dx Table

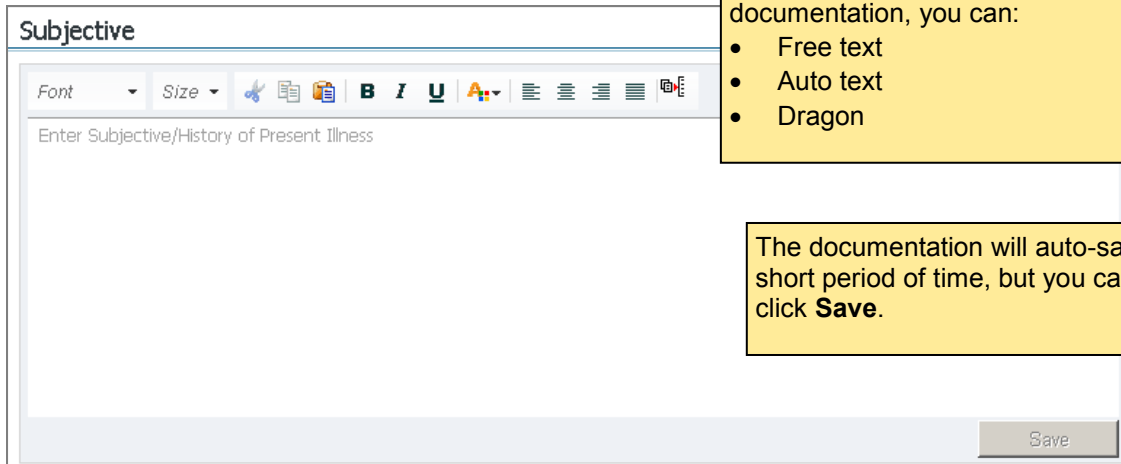
Reconcile And Sign Cancel

When performing Med Rec, confirm that the information on the right side is correct and that the order includes:

- Name
- Dosage
- Route
- Frequency

Sections in OBGYN Workflows

Subjective

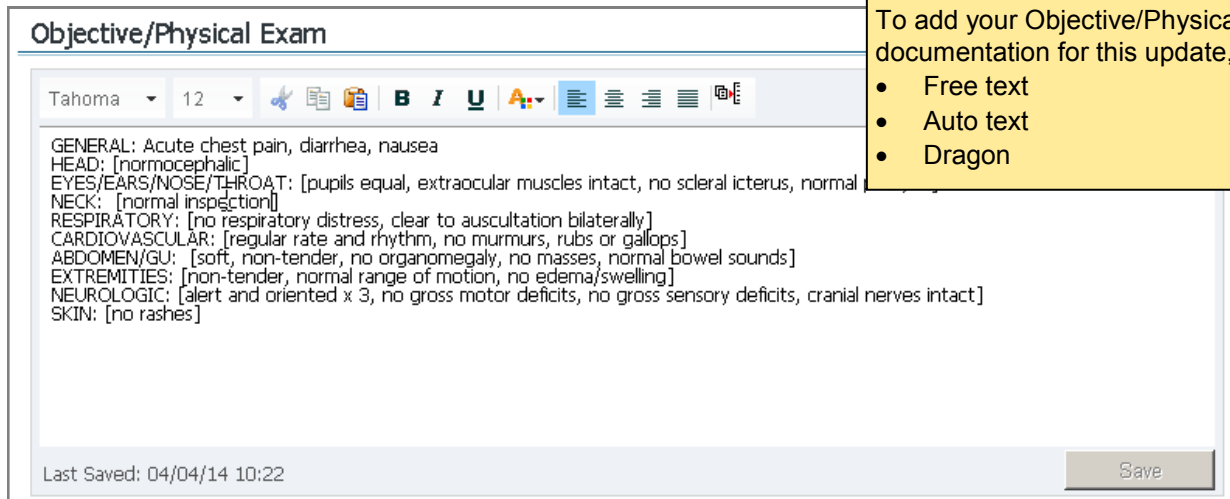


To add your Subjective/ History of Present Illness documentation, you can:

- Free text
- Auto text
- Dragon

The documentation will auto-save after a short period of time, but you can also click **Save**.

Objective/Physical Exam



To add your Objective/Physical Exam documentation for this update, you can:

- Free text
- Auto text
- Dragon

1. Use Dragon commands or auto-text to add information:
 - for example, say “**Labor Exam Macro**” or type **=ob_labor_exam**
2. Use the Dragon **Tab Forward** key (or say “**Next field**”) or the **F3** key to move to each bracketed field and dictate your findings.
3. If you have to complete a selection field in the template or auto-text (by adding an X to select a choice), be sure to use a **capital X**.
4. When complete, press the **Accept Defaults** key on the Dragon mic to remove the brackets.

I’m using Dragon to dictate and it’s not working correctly. What’s going on?

If commands are not working and the beginning of dictated sentences do not start with capital letters, check the **Full text indicator** in the Dragon Bar. It should be a green check mark.



If it is a gray check mark, the VSync between Dragon and PowerChart is not working. Contact the help desk to check your settings.

Sections in OBGYN Workflows

Consolidated Problems

Consolidated Problems list is a combined list of problems and diagnoses.
This is where you'd enter this visit's problems. Active Problems carry forward from day to day.

Consolidated Problems

All Visits 

Classification: All

Add new as: This Visit



Add new problems or diagnosis by typing the name in the search field and selecting from the provided list.

Problems (2)

Show Historical (1)

1 Sys hypertension (Chronic) This Visit

2 CAD (coronary artery disease) This Visit

If a problem is no longer applicable, it can be removed from this visit.
Select the menu option in the right corner of the Consolidated Problems section.
Then select **Remove from This Visit**.

All Visits 

Remove from This Visit
Resolve
Inactivate
Cancel
Move to Chronic
Move to This Visit

Prioritize the problems.

These will pull into your note under the Assessment/Plan section.

1. Hover over the problem's number.
2. Click the dropdown arrow.
3. From the list, select the new priority.
4. The problem will move on the list to the new assigned priority.

2 CAD (coronary artery disease) This Visit

1 Condition: CAD (coronary artery disease)
2 This Visit - IMO Term: CAD (coronary artery disease) (41108)
3 Recent visits:
4 03/11/2014 Classification: Medical

Sections in OBGYN Workflows

New Order Entry

New Order Entry allows you to quickly add an order from the workflow.

New Order Entry +

Orders may be displayed by a list of your favorites. To order, simply click the Order button next to the order name. The button turns dark gray.

New Order Entry +

You can also search for an order. Type the order details into the search field.

Inpatient ▾

Personal Public Shared

Zolpidem (Ambien)
Zolpidem (Ambien) Dose of 5 MG, PO, QHS, PRN for: Insomnia
Zolpidem (Ambien) Dose of 2.5 MG, PO, QHS, PRN for: Insomnia
Zolpidem (Ambien) *The recommended dose of zolpidem for women is 5 mg.*
Zolpidem (Ambien) *Lower starting doses in the elderly are usually effective.*
Zolpidem (Ambien)
Zolpidem CR (Ambien CR)(P&T SUB)
P&T SUB Zolpidem CR (Ambien CR)
P&T SUB Zolpidem CR (Ambien CR) Click here for P&T Substitution Details

Inpatient ▾

Personal Shared

Favorites

Gen General Admission w/modules MD5000 EKM Order

Surg_Ortho Total Joint Replacement-LWR MD3140 Order

Pulm Pneumonia, Community Acquired Pneumonia MD5159 Order

CBC with diff Once, Stat Order

CBC with diff Daily TIMED, Morning Rounds 0500 -0800, for 5 DAY Order

Use caution!!

Order sentences that begin with an * are not real orders. Do not select these orders on this screen.

Being as specific as possible will return the most correct order:

1. Type the order, dosage, route and frequency.
2. Select the correct order from the list.

Personal Shared

Zolpidem (Ambien) Dose of 2.5 MG, PO, QHS, PRN for: Insomnia

As you make your selections, the Order Inbox in the upper right of the Workflow page turns green and counts the number of orders. Click the **Order inbox**. The **Orders for Signature** window appears.



Remove the order by hovering over the order and clicking the X that appears.

Orders for Signature (1)

Zolpidem (Ambien)
Dose of 2.5 MG, PO, QHS, PRN for: Insomnia

☐ Show Diagnosis Table

Sign Save Modify Cancel

Click **Sign** to complete the order.

Change order information by clicking **Modify**.

Sections in OBGYN Workflows

Outstanding Studies & Consults

Outstanding Studies & Consults have a status of Ordered and have not been completed yet.

Outstanding Studies & Consults (13)		Last 1 months for the selected visit
	Status	Ordered
Ventriculostomy, Open	Ordered	04/30/14 20:36
Ventriculostomy, Level	Ordered	04/30/14 20:35
Ventriculostomy, Dressing	Ordered	04/30/14 20:34
Ventriculostomy, Clamp	Ordered	04/30/14 1
TPN Solution 1500 ML + copper chloride 10 ML + ranitidine 150 MG	Ordered	04/30/14 1
Consult Physician	Ordered	04/29/14 0
Notify Nurse	Ordered	04/22/14 1
Mouth Care: Soft Toothbrush	Ordered	04/22/14 1
Shave: Electric Razor Only	Ordered	04/22/14 1
Initiate CMG: Falls Prevention, Evaluation and Treatment	Ordered	04/22/14 1
Initiate CPG: Bleeding Precautions (Adult)	Ordered	04/22/14 1
Precautions: Bleeding	Ordered	04/22/14 1
Urine Culture	Ordered	04/22/14 1

Hover over a row to see more information, including who ordered the study or consult.

Order: Notify Nurse
Order Details:
of nosebleeds, bleeding gums, headache; or visual signs of blood in urine, emesis or stool, 04/22/2014 12:36
Order Comments: Created from abnormal anticoagulant lab results
Order Date/Time: 04/22/2014 12:36
Start Date/Time: 04/22/2014 12:36
Status: Ordered
Ordered by: SYSTEM, SYSTEM

Attending/Fellow

Selected visit

Create Note

Consolidated Problems ...
Outstanding Studies & Consults ...
New Order Entry ...
Create Note

Now that your review and documentation are complete, click **Create Note**.

Sections in OBGYN Workflows

Progress Note

To create your Progress Note, complete the following:

1. From the **Type** dropdown list, select **Progress Note**.

*Type:

Title:

*Date:

*Author:

*Note Templates

Name	Description
Brief Consult Note	Consultant Initial Brief Note
ED Physician Record	Emergency Department Physician Record
ED Physician Record and Teaching Note	Emergency Department Physician Record and Teaching Note
ED Teaching Physician Record	Emergency Department Teaching Physician Record
NB Newborn History and Physical	Newborn History and Physical
NB Progress Note Newborn	Newborn Progress Note
NB Progress Note Newborn Discharge	Newborn Discharge Progress Note
OB Progress Note GYN	OB GYN Progress Note
OB Progress Note High Risk	OB High Risk Progress Note
OB Progress Note Labor	OB Labor Progress Note
OB Progress Note Postpartum	OB Postpartum Progress Note
Pediatrics Progress Note	Pediatrics Progress Note
Procedure Note	Procedure Note
Procedure Note Bedside	Procedure Note Freetext
Progress Note Basic	Daily Progress Note Basic
Progress Note	Blank Progress Note
Progress Note I&O	Progress Note I&O
Progress Note I&O Med List	Progress I&O and Med List
Progress Note Med List	Progress Note with Medication List
Progress Note Post Surgical	Post Surgical Progress Note
Progress Note Transplant Kidney Donor	Transplant Progress Note Living Kidney Donor

2. Under **Note Templates**, select **Note Template** you wish to document depending on your workflow. The Title field will update with this name.

3. Click **OK**.

OK

Cancel

There are many Note Template types for you to choose depending on what you want to document. See pages 19-22 for more types you will use.

Progress Note—High Risk

The Progress Note High Risk Obstetrics displays. The notes are unique to OBGYN. Information from the workflow pulls into the Note.

To be compliant, your Progress Note must be different on each Date of Service.

While the assessment/plan may not change much from day to today, the vitals and labs will be different.

Progress Note High Risk Obstetrics

Subjective

Objective/Physical Exam

Vitals & Measurements

Assessment/Plan

In the Subjective section, the following information would pull in from the workflow:

- Maternal Age
- Gravida Para status
- Gestational age,
- Time of rupture of membranes if occurred and documented in OBIS

You can document you Subjective here as well.
For example, click in the free text area and say the Dragon Command "Labor Exam macro" to document.

Under **Assessment/ Plan**, address each of the applicable sections by free texting at the bottom of each system section. Type any additional comments and plan under sections.

Prenatal Labs

Rh: , Rhogam:

Pregnancy Complications

Medication List

Inpatient

No active inpatient medication

Lab Results

No results found

No results found

Diagnostic Results

The following information would pull in from the workflow:

- **Prenatal labs**
- **Pregnancy Complications**
- **Labs**
- **Diagnostic Results**

Note Details: Progress Note, Walton, Lisa L., 05/16/2014 12:05, OB Progress Note High Risk

Sign/Submit

Save

Save & Close

Cancel

Then click **Sign/Submit**.

On a repeat labor exam, go back to the workflow, open the note, click Modify and you will be able to add additional exam finding as an addendum.

Progress Note—Labor

The Progress Note Labor displays. The notes are unique to OBGYN. Information from the workflow pulls into the Note.

To be compliant, your Progress Note must be different on each Date of Service.

While the assessment/plan may not change much from day to day, the vitals and labs will be different.

Progress Note Labor

Subjective

Objective/Physical Exam

Vitals & Measurements

Assessment/Plan

In the Subjective section, the following information would pull in from the workflow:

- Maternal Age
- Gravida Para status
- Gestational age,
- Time of rupture of membranes if occurred and documented in OBIS

You can document you Subjective here as well.
For example, click in the free text area and say the Dragon Command "Labor Progress macro" to document.

Under **Assessment/ Plan**, address each of the applicable sections by free texting at the bottom of each system section. Type any additional comments and plan under sections.

Prenatal Labs
Rh: , Rhogam:

Pregnancy Complications

Medication List

Inpatient
No active inpatient medication

Lab Results

No results found
No results found

Diagnostic Results

The following information would pull in from the workflow:

- **Prenatal labs**
- **Pregnancy Complications**
- **Labs**
- **Diagnostic Results**

Note Details: Progress Note, Walton, Lisa L., 05/16/2014 12:05, OB Progress Note Labor

Sign/Submit

Save

Save & Close

Cancel

Then click **Sign/Submit**.

On a repeat labor exam, go back to the workflow, open the note, click Modify and you will be able to add additional exam finding as an addendum.

Progress Note—Postpartum

The Progress Note Post Partum displays. The notes are unique to OBGYN. Information from the workflow pulls into the Note.

To be compliant, your Progress Note must be different on each Date of Service.

While the assessment/plan may not change much from day to today, the vitals and labs will be different.

Progress Note Post Partum

Subjective

25 yo Black female, G1, P0000 @ 39.3 weeks gestation, ROM 05/10/2014 21:30

Post Partum Day # 3
C-Section delivery of a Female on 05/11/2014 16:16
Doing well, pain controlled

Objective/Physical Exam

Vitals & Measurements

T: 37.0 (Oral) TMIN: 36.8 (Oral) TMAX: 39.0 (Oral) HR: 104 RR: 18 BP: 115/62

General: _appears well, _no apparent distress
Lungs: _clear to auscultation bilaterally, _no rales or rhonchi
Cardiovascular: _regular rate without murmurs gallops or rubs
Abdomen: _soft, nontender, nondistended, _positive bowel sounds
Uterus: _firm at U _
_Incision: The incision is clean dry and intact
Extremities: _no erythema, _1+ edema bilateral lower extremities, _no cords

Assessment/Plan

25 yo Black female, G1, P0000 @ 39.3 weeks gestation, ROM 05/10/2014 21:30

Post Partum Day # 3
C-Section delivery of a Female on 05/11/2014 16:16
Doing well, pain controlled
Cesarean delivery delivered

In the Subjective section, the following information would pull in from the workflow:

- Maternal Age
- Maternal race
- Postpartum day
- Number and type of delivery
- Time of rupture of membranes if occurred and documented in OBIS

You can document your Subjective here as well.

For example, click in the free text area and say the Dragon Command "Postpartum Progress macro" to document.

Pregnancy Complications

Medication List

Inpatient

acetaminophen - OXYCODONE (Percocet) 325/5
Bisacodyl (Dulcolax) Supp, 10.0 MG, 1.0 SUPP, P
Diphenhydramine (Benadryl), 25.0 MG, 1.0 CAP
Docusate-Senna (Senokot S), 2.0 TAB, PO, BID
Enoxaparin (Lovenox), 40.0 MG, 0.4 ML, SubQ,
Ibuprofen (Motrin / Advil), 800.0 MG, 1.0 TAB, I
Magnesium Hydroxide (Milk of Magnesia), 15.0 M
Ondansetron (Zofran) Inj, 4.0 MG, 2.0 ML, IV, C
Simethicone (Mylcon), 160.0 MG, 2.0 TAB, PO,

Lab Results

Diagnostic Results

The following information would pull in from the workflow:

- **Pregnancy Complications**
- **Active Medication List**
- **Labs**
- **Diagnostic Results**

Address the **Assessment/ Plan** by free texting or using Dragon.

For example, you may say "Postpartum plan macro".

Type any additional comments.

Then click **Sign/Submit**.

Progress Note—GYN

The GYN Progress Note displays. The notes are unique to OBGYN. Information from the workflow pulls into the Note.

To be compliant, your Progress Note must be different on each Date of Service.

While the assessment/plan may not change much from day to day, the vitals and labs will be different.

GYN Progress Note

Subjective

Post Partum Day # 3

Doing well, pain controlled

Objective/Physical Exam

Vitals & Measurements

T: 37.0 (Oral) TMIN: 36.8 (Oral) TMAX: 39.0 (Oral) HR: 104 RR: 18 BP: 115/62

General: _appears well, _no apparent distress

Lungs: _clear to auscultation bilaterally, _no rales or rhonchi

Cardiovascular: _regular rate without murmurs gallops or rubs

Abdomen: _soft, nontender, nondistended, _positive bowel sounds

Uterus: _firm at U _

_Incision: The incision is clean dry and intact

Extremities: _no erythema, _1+ edema bilateral lower extremities, _no cords

Assessment/Plan

Cesarean delivery delivered

In the Subjective section, the following information would pull in from the workflow:

- Postpartum days and post-op days

You can document your Subjective here as well.

For example, click in the free text area and say the Dragon Command "OB GYN Exam macro" to document.

I&O

24 hour Intake/Output

TOTAL INTAKE	800
Continuous Infusions	800

TOTAL OUTPUT	1501
Urine Catheter	0 ml
Stool/ Count	1
Urine Void	1500
Emesis Volume	0 ml

Medication List



Lab Results

Diagnostic Results

The following information would pull in from the workflow:

- I&O
- Active Medication List
- Labs
- Diagnostic Results

Address the **Assessment/ Plan** by free texting or using Dragon.
Type any additional comments.

Then click **Sign/Submit**.

Progress Note– Adding tagged text

1. To add the Tagged Text to the Progress Note, click and hold the Tagged Text.
2. Then drag it to the desired section of the note.

Tagged Text

5400480 01/27/2014 05:05 ...

MPRESSION: NORMAL CHEST.

MPRESSION: NORMAL CHEST.

GYN Progress Note

Subjective

Post Partum Day # 8

Doing well, pain controlled

Objective/Physical Exam

Vitals & Measurements

T: 37.0 (Oral) TMIN: 36.8 (Oral) TMAX: 39.0 (Oral) HR: 104 RR: 18 BP: 115/62

General: _appears well, _no apparent distress

Lungs: _clear to auscultation bilaterally, _no rales or rhonchi

Cardiovascular: _regular rate without murmurs gallops or rubs

Abdomen: _soft, nontender, nondistended, _positive bowel sounds

Uterus: _firm at U _

Incision: The incision is clean dry and intact

Extremities: _no erythema, _1+ edema bilateral lower extremities, _no cords

Assessment/Plan

Cesarean delivery delivered

[1] 5400480; Evantash MD, Alan 02/24/2014 07:05 EST

I&O

24 hour Intake/Output

TOTAL INTAKE	800
Continuous Infusions ...	800
TOTAL OUTPUT	1504
Urine Catheter	0 ml
Stool/ Count	1
Urine Void	150(
Emesis Volume	0 ml

Medication List

Lab Results

Diagnostic Results

3. A footnote appears at the bottom of the note, attributing the tagged information to the original document.

Progress Note–Refreshing/Free text fields/Deleting

Parts of the Progress Note, like Lab Result can be refreshed to import the most recent information.

Hover over the title and click the **Refresh** icon that displays.

Add a free text field to document additional information.

Hover over the title and click the **Insert Free Text field** icon.

Information added here does not update on the Documentation Workflow.


Sections can be deleted if that information is not pertinent to your progress note.

Hover over the title and click the **Delete** icon that displays.

Consultations– Removing Diagnosis fields

If you are consulting on a patient and do not need to document plan of care for each diagnosis in your note, hover over the diagnosis name and click the X to remove it from your note.

Assessment/Plan

CAD (coronary artery disease) 

[_ Better controlled today. Most likely secondary to non compliance. Will continue home Coreg and Lisinopril.]

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Completing the Note

- Once you have completed your note, click **Sign & Submit**.
No more changes can be made to the original note; only an addendum can be added. The note will display in the patient's chart under Documents and can be seen on the Documents list in Documentation Workflow. The status is **Auth (Verified)**.
- To save the information without closing or signing, click **Save**.
- To save the information and close the note without signing, click **Save & Close**. On the Documentation Workflow under Documents, the note displays as (In Progress). The Status is **Ordered**. Only the author should open and modify.
- Click **Cancel** to discontinue the note. All changes will be lost.




Modifying a Saved Note

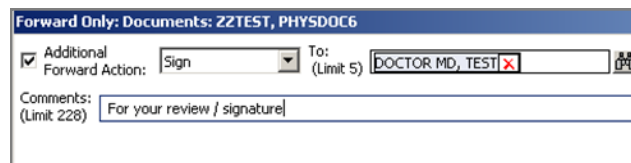
If you saved your note, click on the note in the Documents list of Documentation Workflow to open it for editing.

Modifying a Signed Note


- On Documentation Workflow in the patient's chart, the Documents section will list the notes.
- Click on the note you wish to modify. The note opens.
- Right click and select **Modify**, or in the toolbar, click the **Modify** icon.
- At the bottom of the note, you will see ***Insert Addendum here:**.
You cannot change the portion of the note that has already been signed.
- Add your information.
- Click **Sign**. Your name, the date and the time will be added with your information.

My Note needs to be co-signed. What do I need to do?

- Create your note.** Best practice is to list the name of the responsible signatory physician if you know this in advance; for example: "Cardiology Progress – Dr. Smith" if Dr. Smith is your preceptor.
- Complete your note for review.** You have two options:
 - Save your note, so that your attending or preceptor can review and advise.
 - Sign your note.
- Forward the note** to the co-signor. From Documentation Workflow:
 - Under Documents, open the note to forward by clicking it.
 - Click the **Forward** icon just above the body of the note. 
 - Select **Sign** or **Review** from the first yellow drop down.
 - Enter co-signor's name in the **To:** box.
 - Enter any relevant comments, then click the **OK** button.
- If you saved your note, once the co-signor has reviewed, you will need to open your note, make any recommended changes, and sign the note. If you choose to save again, instead of final sign, you should manually add your name, date/time to the bottom of the note so the end of your documentation is clear.



I need to review and co-sign a note. What do I do?

1. From the Message Center, Documentation Workflow or Documents tab, locate and open the note to be reviewed and signed.
2. Click **Modify** in the toolbar. 
3. At the bottom of the note, you will see ***Insert Addendum here:.**
4. Use the Dragon commands or auto-text below to enter your attestation information and any additional documentation or findings you want to include in the progress note.

Attestations		
Description	Dragon Command	Auto-text
Attending Attestation Agree	Attending Agree Macro	=attending_attestation_agree
Attending Attestation Present	Attending Present Macro	=attending_attestation_present
Attending Attestation Except	Attending Agree Except Macro	=attending_attestation_except
Attending Attestation Reviewed	Attending Reviewed Macro	=attending_attestation_reviewed
Attending Attestation Split/Share MLP	Attending Split Macro	=attending_attestation_split

5. When finished, click **Sign**.

OBGYN– High Risk Note Templates

Type	In addition to Subjective, Objective/ Exam and Assessment Plan, also pulls in:
OB Progress Notes High Risk	Vital Signs, Medication List, Lab Results, Pregnancy Complications

OBGYN—High Risk Content Macros

Description	Dragon Command	Auto-text
Labor Exam	Labor exam macro	=ob_labor_exam

OBGYN– High Risk Smart Templates

Description	Dragon Command	Auto-text
OB GYN labs (CBC, Mg, LFT, DIC Panel) - last 24 hours	Insert OB Labs	.ob_labs_24hrs
OB GYN labs (CBC, Mg, LFT, DIC Panel) - last from encounter	Insert OB Labs Last	.ob_labs_last
OB Current Oxytocin Rate	Insert Oxytocin Rate	.ob_oxytocin_rate
OB PIH Screen labs: CBC, LD, ALT, AST, Creatinine	Insert PIH Labs	.ob_pih_screen_labs
OB Pulls Mom's pregnancy complications to the Mom's chart	Insert OB Pregnancy Complications	.ob_preg_complications
OB Prenatal Labs (from OBIS or PowerChart - whichever is most recent)	Insert OB Prenatal Labs	.ob_prenatal_labs

OBGYN– Labor Note Templates	
Type	In addition to Subjective, Objective/ Exam and Assessment Plan, also pulls in:
OB Progress Notes Labor	Vital Signs, Medication List, Lab Results, Pregnancy Complications

OBGYN—Labor Content Macros		
Description	Dragon Command	Auto-text
Labor Progress	Labor progress macro	=ob_labor_progress

OBGYN– Labor Smart Templates		
Description	Dragon Command	Auto-text
OB Maternal and Past pregnancy delivery history	Insert OB Admission History	.ob_admission_history

OBGYN– Postpartum Note Templates

Type	In addition to Subjective, Objective/ Exam and Assessment Plan, also pulls in:
OB Progress Notes Postpartum	Vital Signs, Medication List, Lab results, Pregnancy Complications, Postpartum day #

OBGYN—Postpartum Content Macros

Description	Dragon Command	Auto-text
Post-Partum Progress Exam	Post partum progress macro	=ob_postpartum_progress
Post-Partum Plan	Post partum plan macro	=ob_postpartum_plan

OBGYN– Postpartum Smart Templates

Description	Dragon Command	Auto-text
OB Post-partum day	Insert Post-partum Day	.ob_postpartum_day
OB Details of this delivery	Insert OB Delivery History	.ob_delivery_history

OBGYN– Surgery Note Templates

Type	In addition to Resident/Exam Attending/ Fellow Exam, Assessment Plan, also pulls in:
OB Progress Notes GYN	Vital Signs, CBC/BMP (Fishbone Labs), Med List
Progress Note Post Surgical	Post-op Day, I/O, Vital Signs, CBC/BMP (Fishbone Labs) * Resident Exam, Attending/Fellow Exam, Assessment Plan do not pull into the note.
Procedure Note	None; blank field for free-text
Procedure Note Bedside	None; blank field for free-text
Brief Consult Note	None; blank field for free-text

OBGYN—Surgery Content Macros

Description	Dragon Command	Auto-text
OB GYN Exam	OB GYN Exam macro	=ob_gyn_exam
OB GYN ROS	OB GYN ROS macro	=ob_gyn_ros

OBGYN– Surgery Smart Templates

Description	Dragon Command	Auto-text
Intake and Output	Insert I and O	.io
Output from any drains recorded in I/O	Insert Drain Output	.drain_output
Post-op Day# and Procedure Name	Insert Post-op Day	.post_op_day

How do I customize existing specialty Dragon commands?

Some commands have already been created for your specialty and you can modify and customize those commands (macros) to suit your needs.

1. Open Dragon.
2. On the Dragon toolbar, click **Tools** and select **Command Browser** or say “**Command Browser**”. The Command Browser window opens.
3. Click **Command Sets**.
4. Select your specialty folder.
5. Right click on the Command name (macro) you wish to modify.
6. Select **New Copy**.
7. The My Commands Editor dialog box appears.
8. You can change the name of the command in the My CommandName field.
9. Modify any of the existing information in the Content section.
10. Leave the Plain Text box checked.
11. When finished, click **Save**.
12. The new, saved copy will be located under Modes>MyCommands in the Task Pane, in the same folder name.

How do I make my own Dragon commands?

1. Open PowerChart and dictate the information.
2. Say “Select All” to select the text you just dictated.
3. Say “Make that a command.”
4. Select text appears in Content section of The My Commands Editor dialog box.
5. Make sure the cursor is in the My CommandName box.
6. Dictate the name for your new command.
7. Say “Plain text” to select the Plain text check box.
8. When finished, click Save.

Recommended:


- Use command names that are two to four words in length.
- If you decide to type the command name, be sure to use spaces between multiple words.
- Do not use special characters like: *, @, #, \$, % or _.

How do I make my own auto-text?

For every Dragon Command, an auto-text has been configured, but you can create your own customized auto-text as well.

1. In **PowerChart**, open the Documentation workflow to a text field.
2. From the text editor toolbar, click the **Manage Auto Text** button.
3. On the Manage Auto-text window, click the icon for **New Phrase**.



4. Enter an abbreviation and description for your text in the Abbreviation and Description boxes.
5. Click the **Add Text** icon. 
6. The Formatted Text Entry window opens. Enter your text entry in the HTML section (bottom section) of the Formatted Auto Text dialog box.
7. Click **OK**.
8. Click **Save**, then click **Close**.