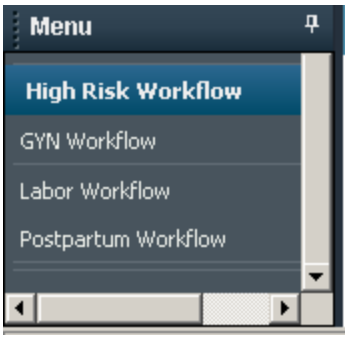
OBGYN Workflows

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

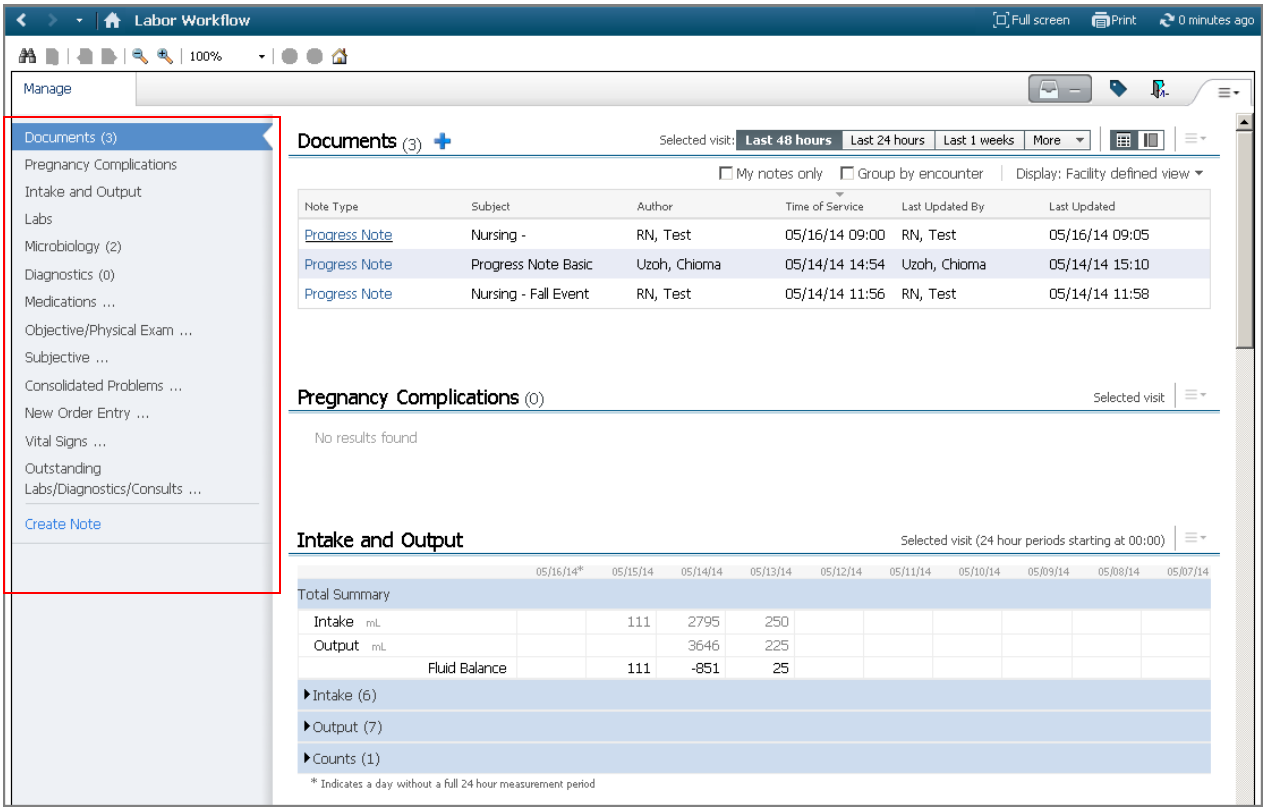
There are four distinct workflows for OB GYN service:

- **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**.



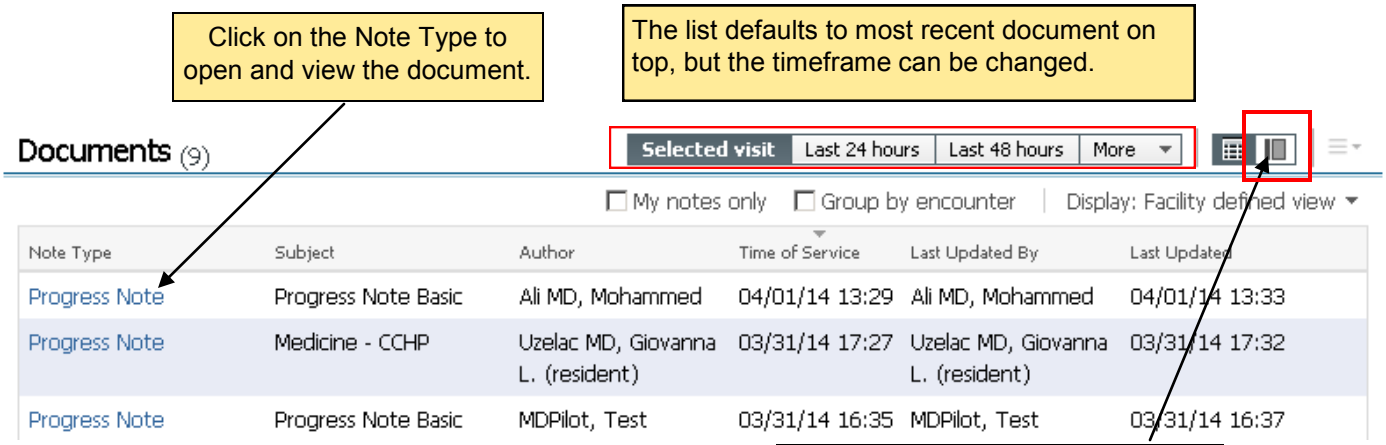
5. Click on each item to jump to that section. You can also scroll down the page to review each section in the workflow.

Sections in OBGYN Workflows

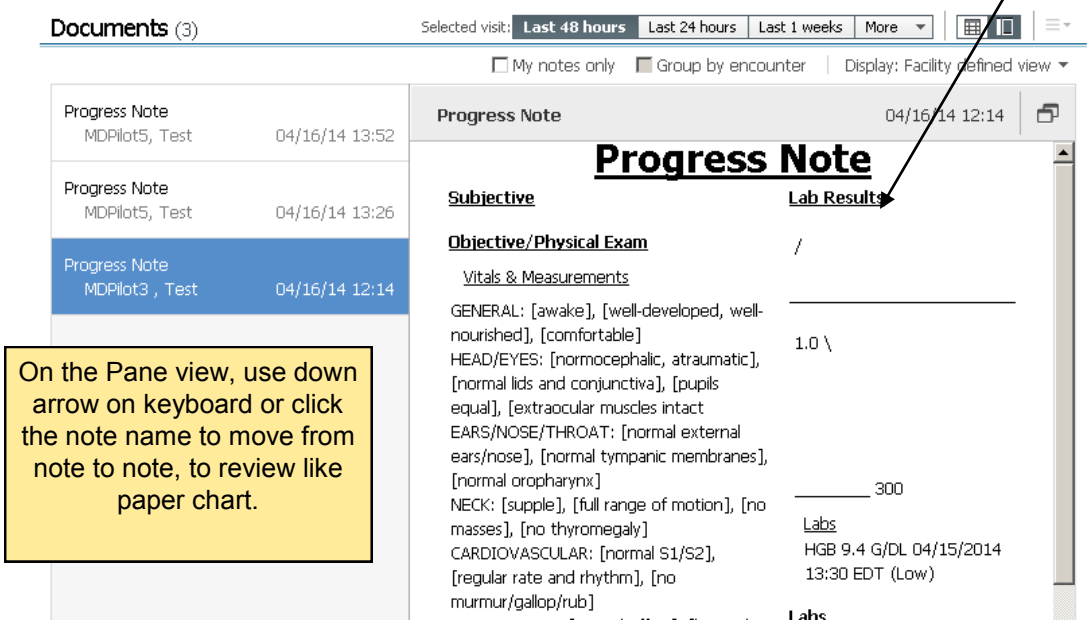
The following sections are present in all workflows, except where noted.

Documents

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

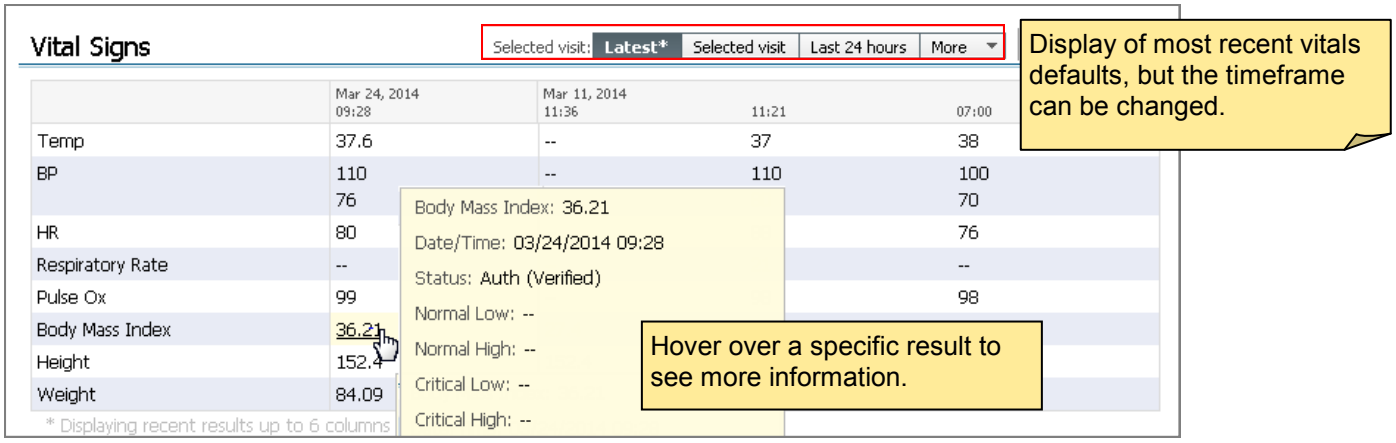


Pane View



Vital Signs

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



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 (8)

	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

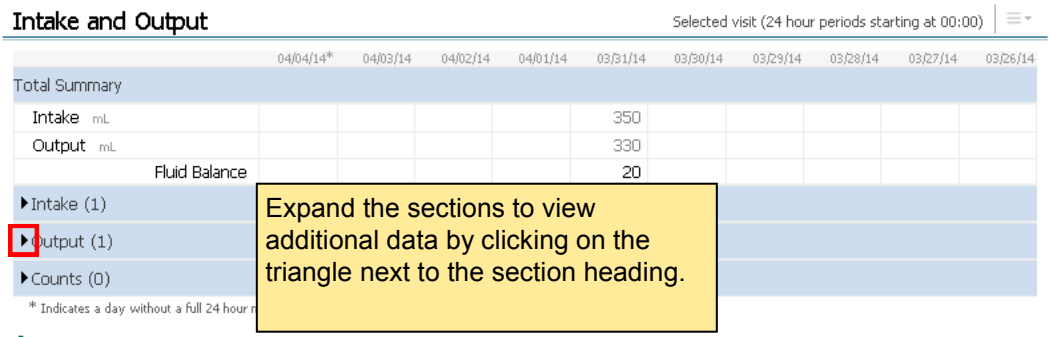
This section contains data that is interface through OBIS and pertinent to daily rounds. Data from here pulls important status on newborn into the note using a specific smart template.

Other Pertinent Data (2)

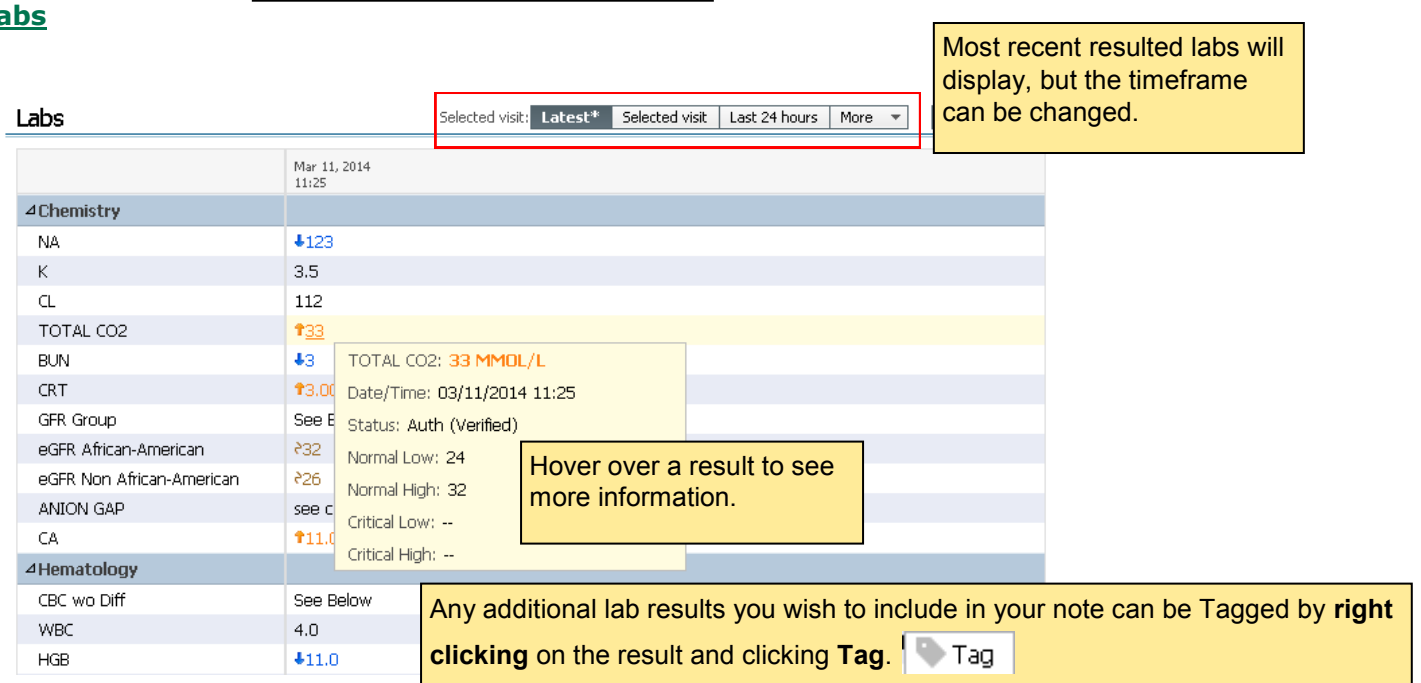
	Result	Date/Time
NICU Immediately-Baby A	No	05/11/14 18:07
Newborn feeding preference	Formula	05/10/14 18:12

Sections in OB GYN Workflows

Intake and Output (I&Os)



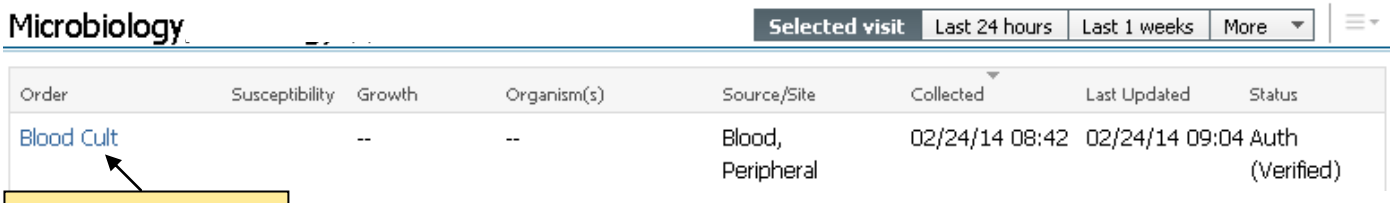
Labs



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

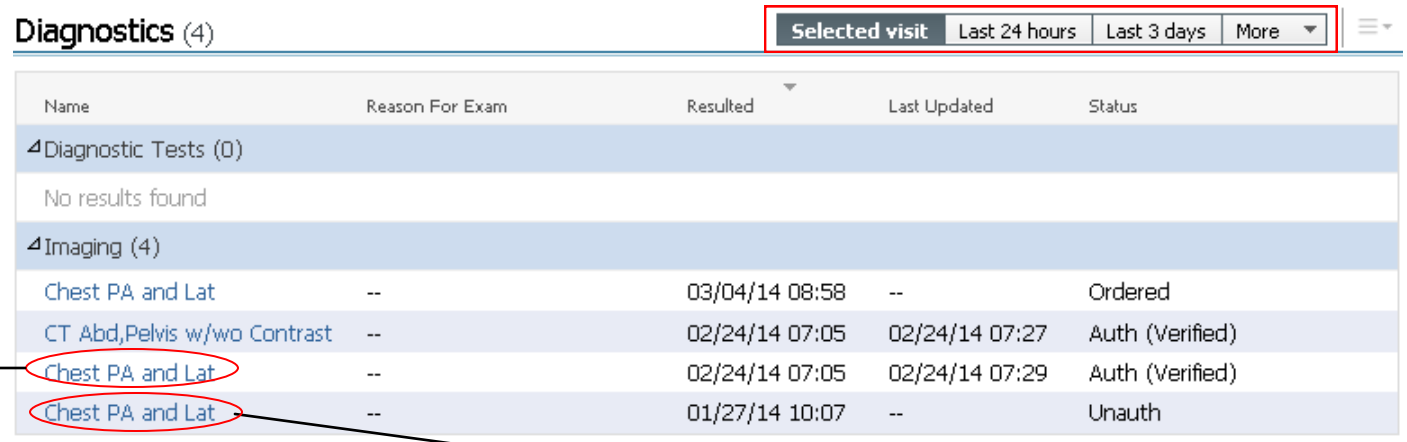


Status	Meaning
Ordered	Order placed but not yet completed
In Progress	Order currently processing
Unauth	Order completed but not yet resulted
Auth (Verified)	Completed order with dictated report available

Sections in OBGYN Workflows

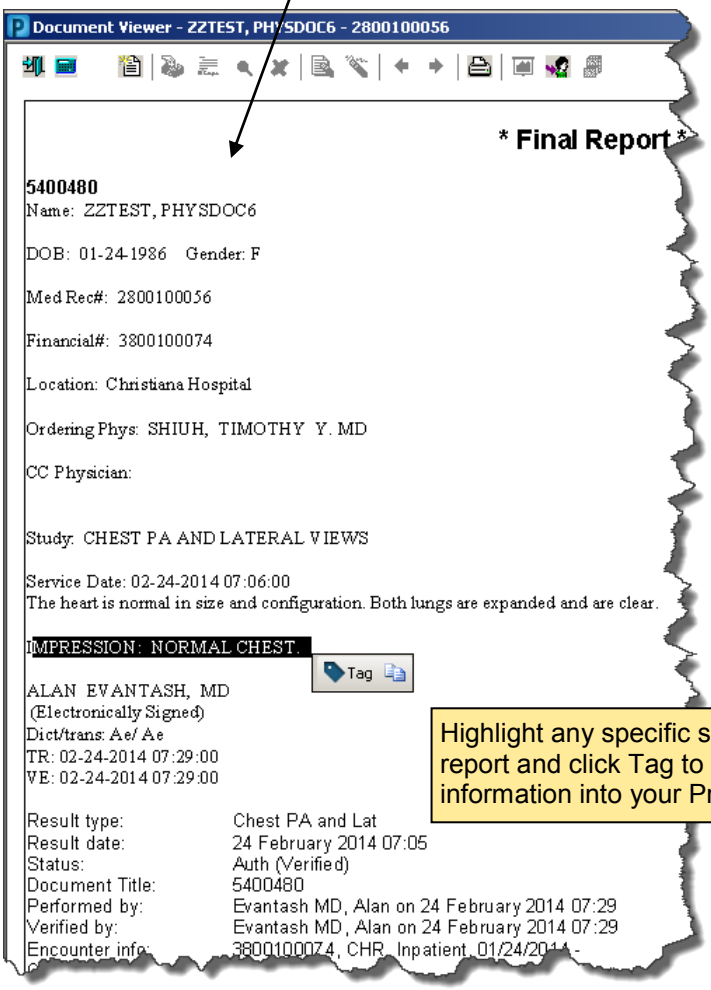
Diagnostics

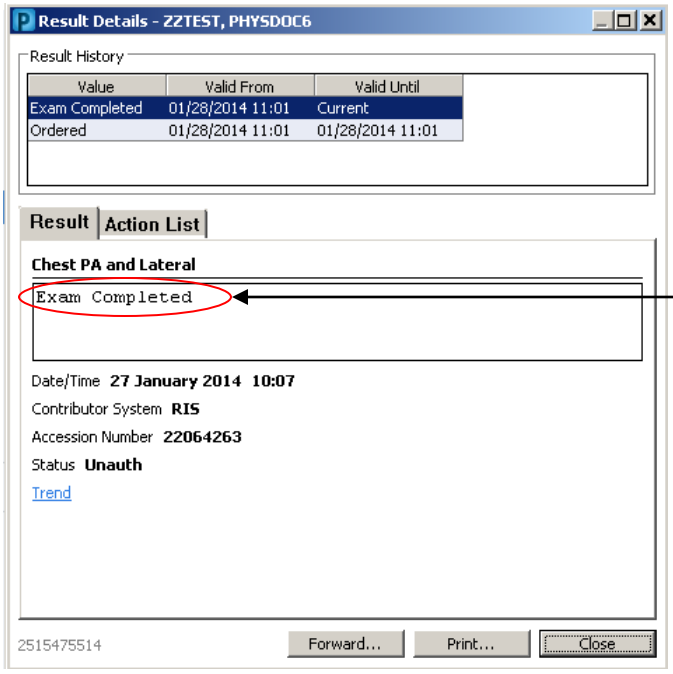
The Diagnostic Tests and Imaging Orders for the selected visit will be displayed, but the timeframe can be changed.



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

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





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

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

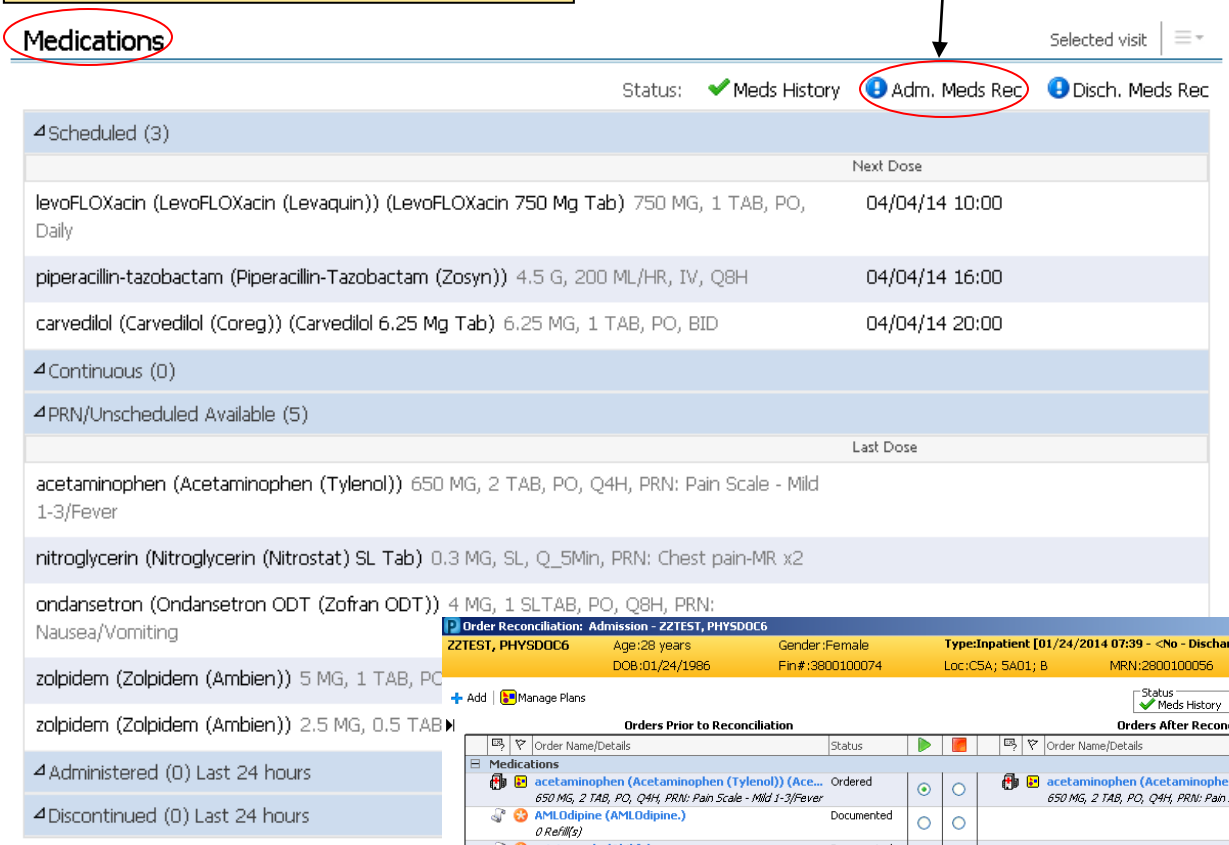
Click the Medications heading to view the MAR Summary screen.

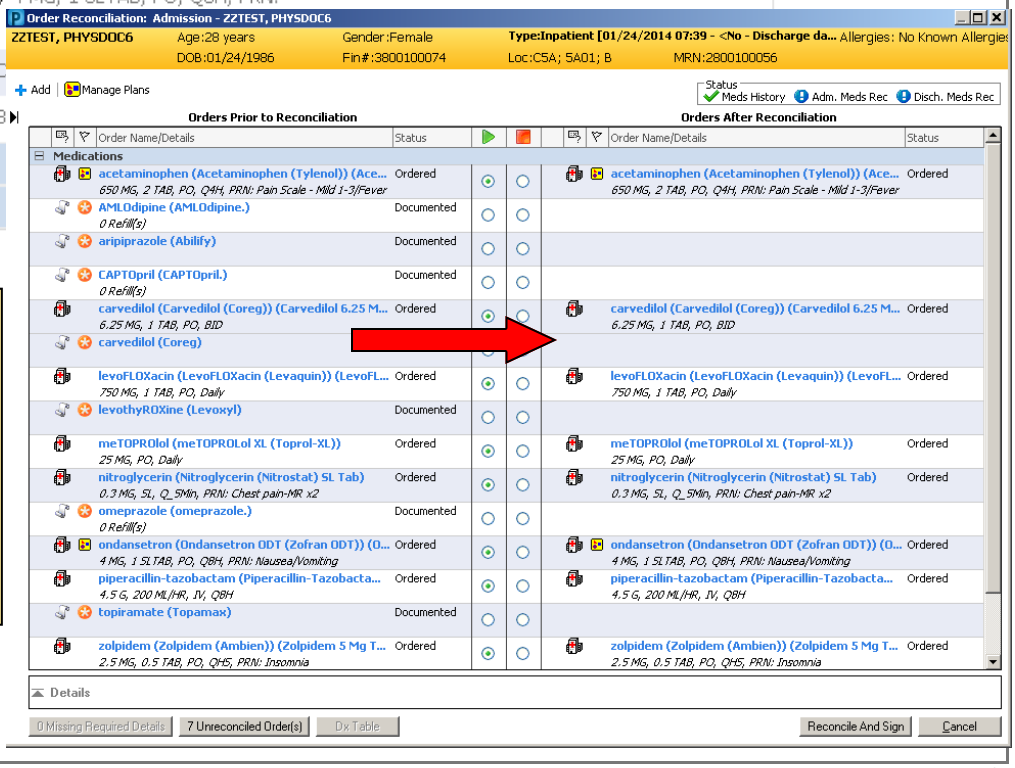
Medication Reconciliation Status is easy to determine on the workflow.

- 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.



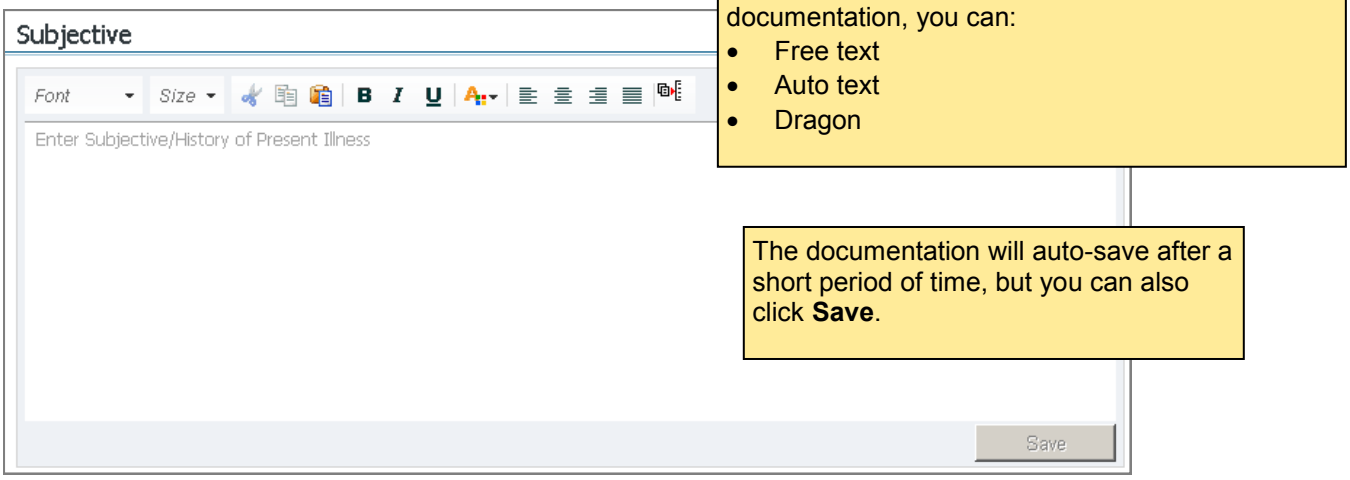


When performing Med Rec, confirm that the information on the right side is correct and that the order includes:

- Name
- Dosage
- Route
- Frequency

Sections in OBGYN Workflows

Subjective

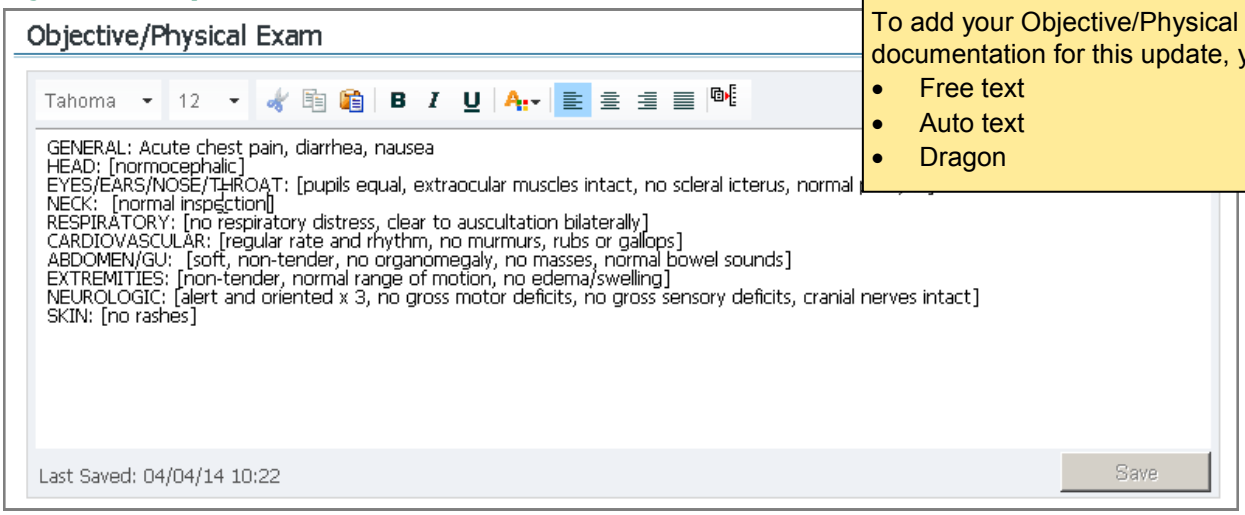


To add your Subjective/ History of Present Illness documentation, you can:

- 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



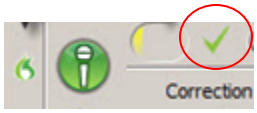
To add your Objective/Physical Exam documentation for this update, you can:

- 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.

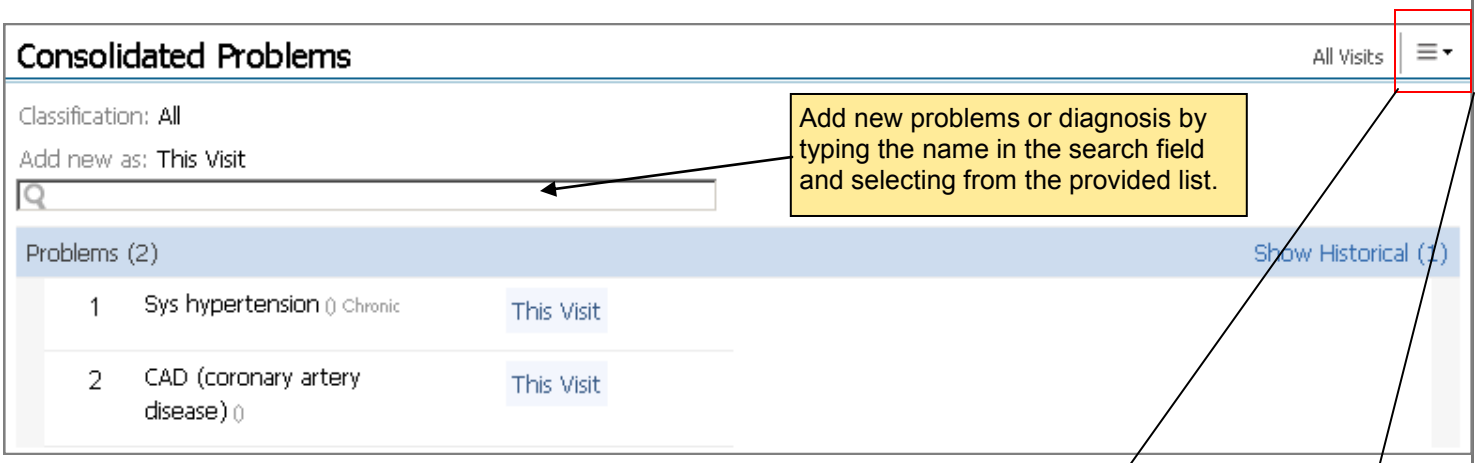


If it is a gray check mark, the VSync between Dragon and PowerChart is not working.
Contact the help desk to check your settings.

Sections in OBGYN Workflows

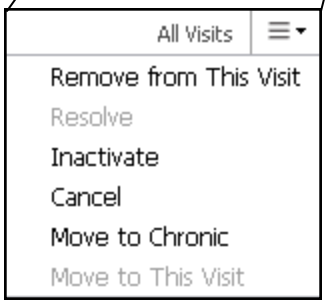
Consolidated Problems

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.



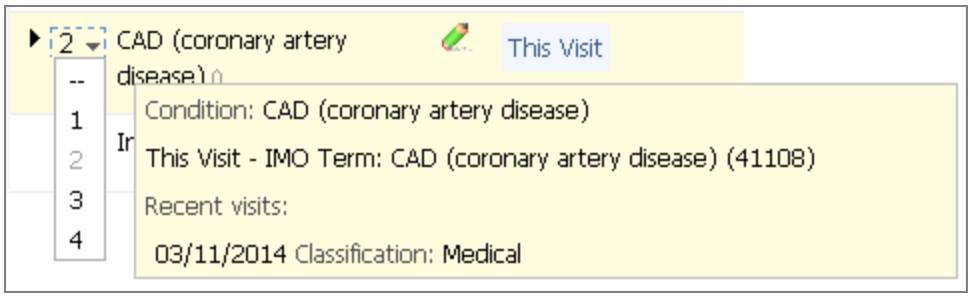
Add new problems or diagnosis by typing the name in the search field and selecting from the provided list.

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**.



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

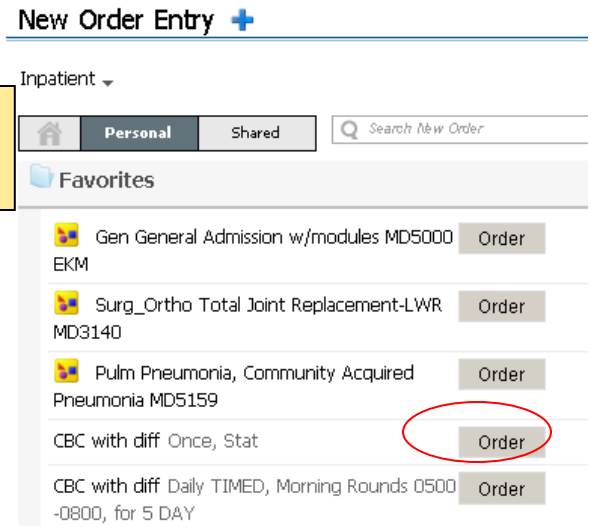
1. Hover over the problem's number.
2. Click the dropdown arrow.
3. From the list, select the new priority.
4. The problem will move on the list to the new assigned priority.



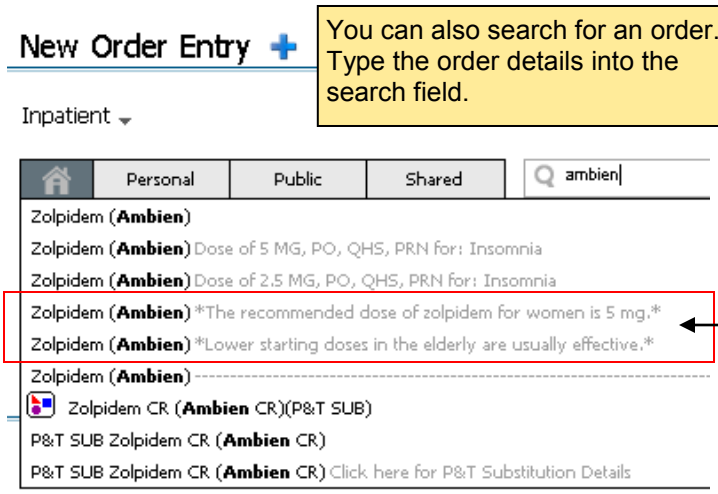
Sections in OBGYN Workflows

New Order Entry

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



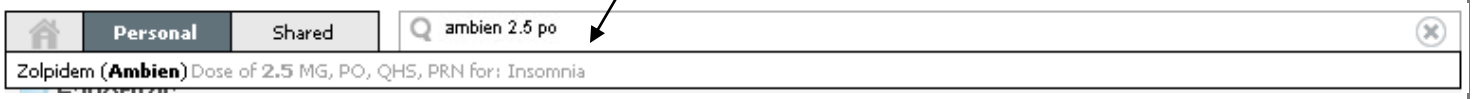
Orders may be displayed by a list of your favorites. To order, simply click the Order button next to the order name. The button turns dark gray.



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

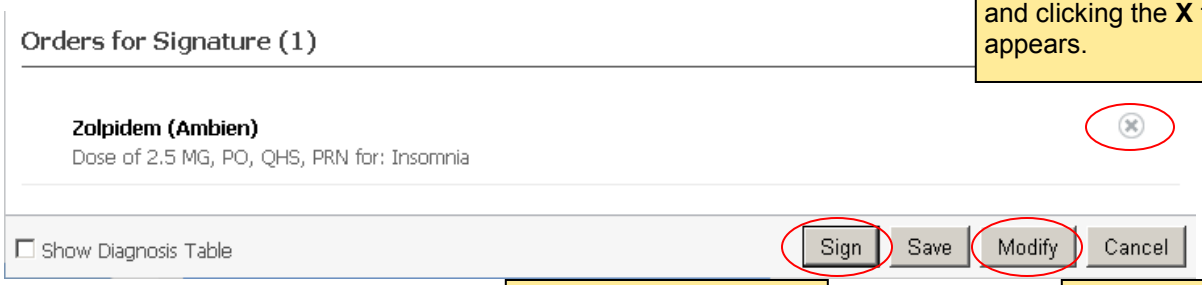
Use caution!!
Order sentences that begin with an * are not real orders. Do not select these orders on this screen.

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.



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.



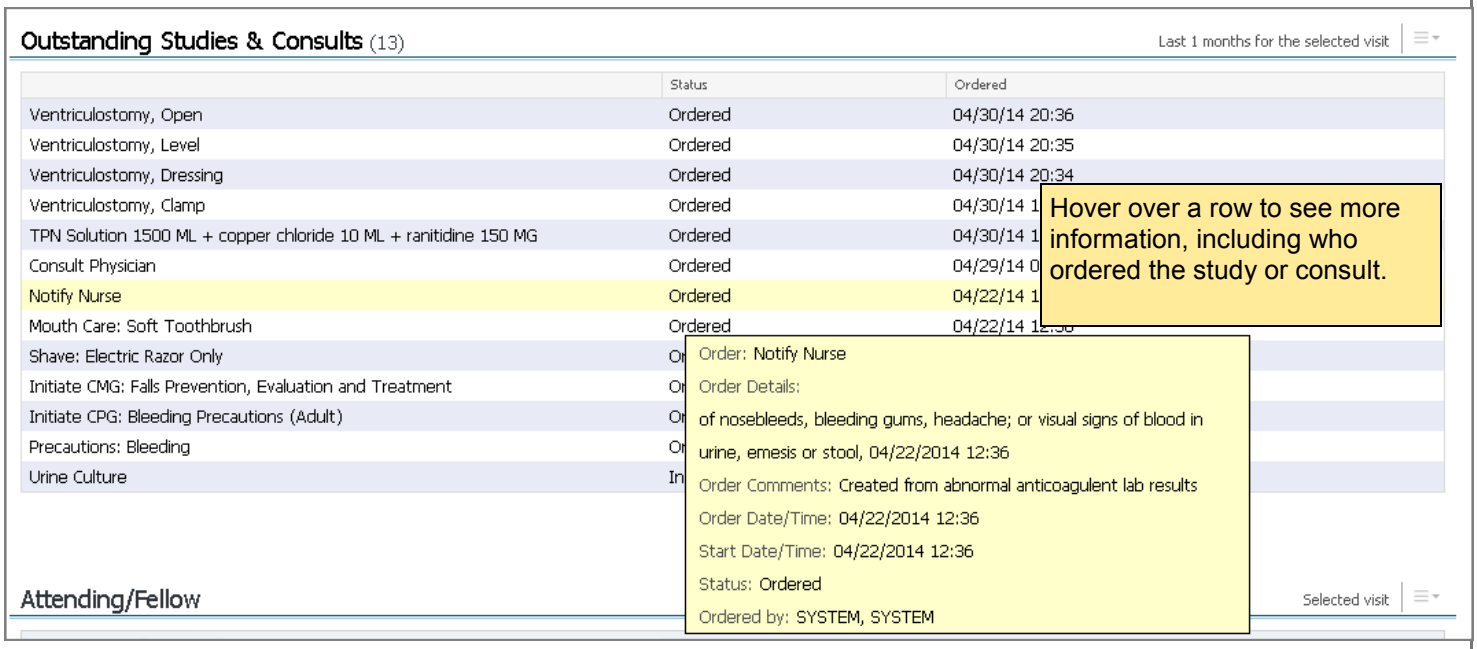
Click **Sign** to complete the order.

Change order information by clicking **Modify.**

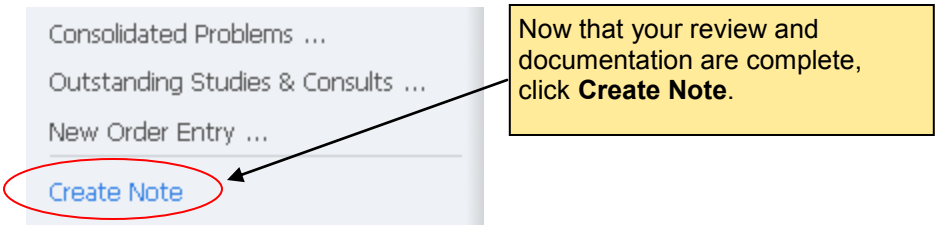
Sections in OBGYN Workflows

Outstanding Studies & Consults

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



Create Note

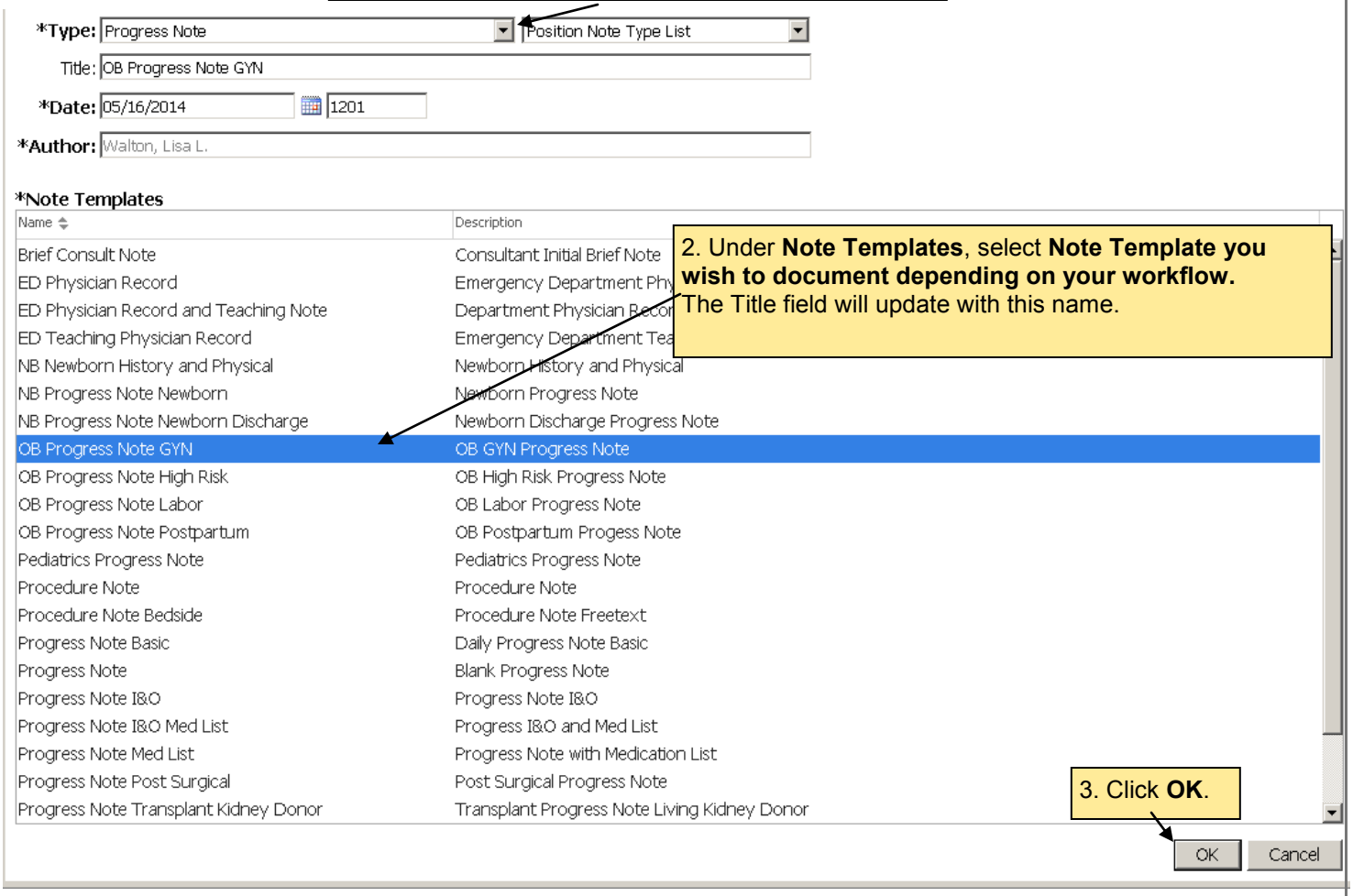


Sections in OBGYN Workflows

Progress Note

To create your Progress Note, complete the following:

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



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

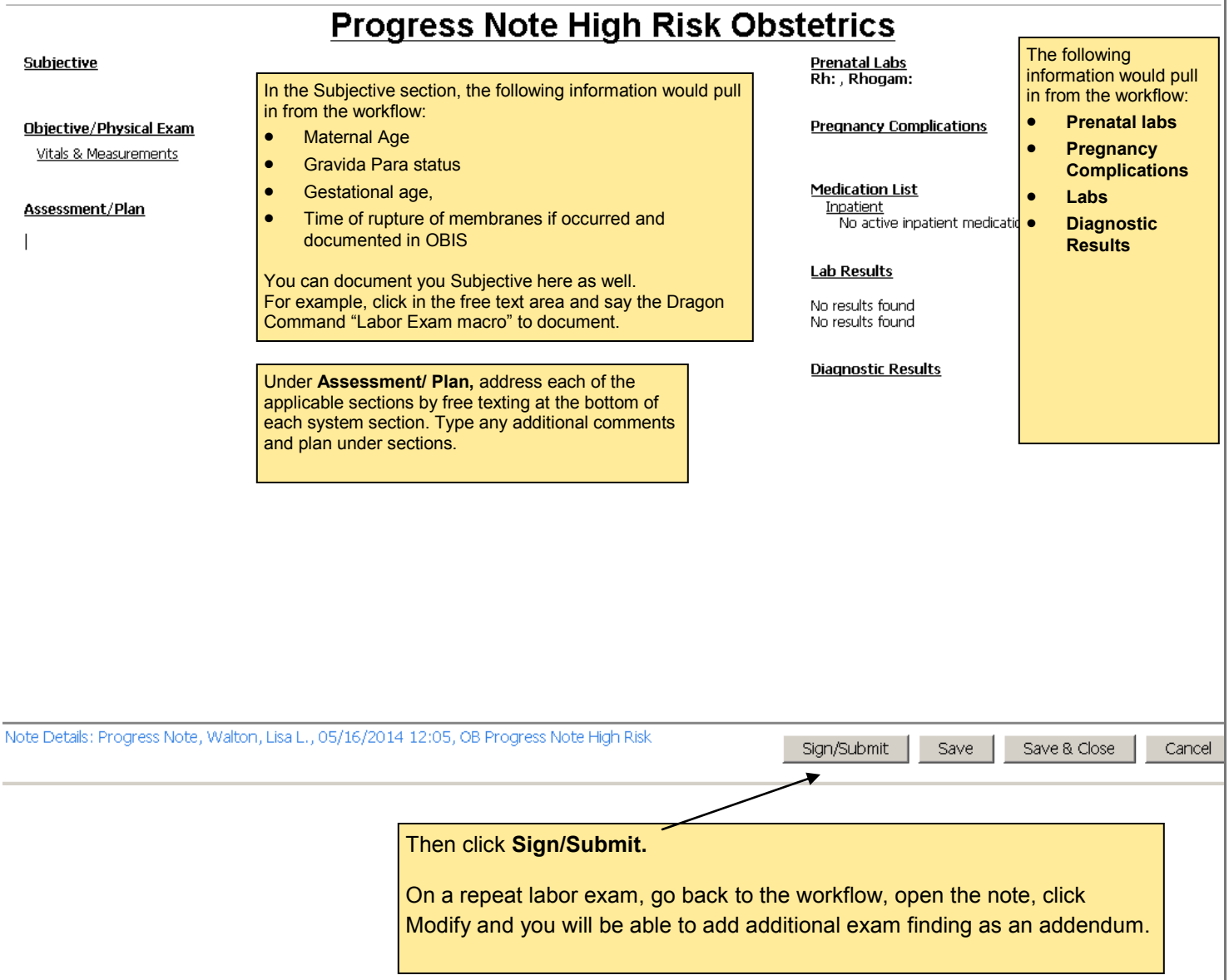
3. Click **OK**.

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.

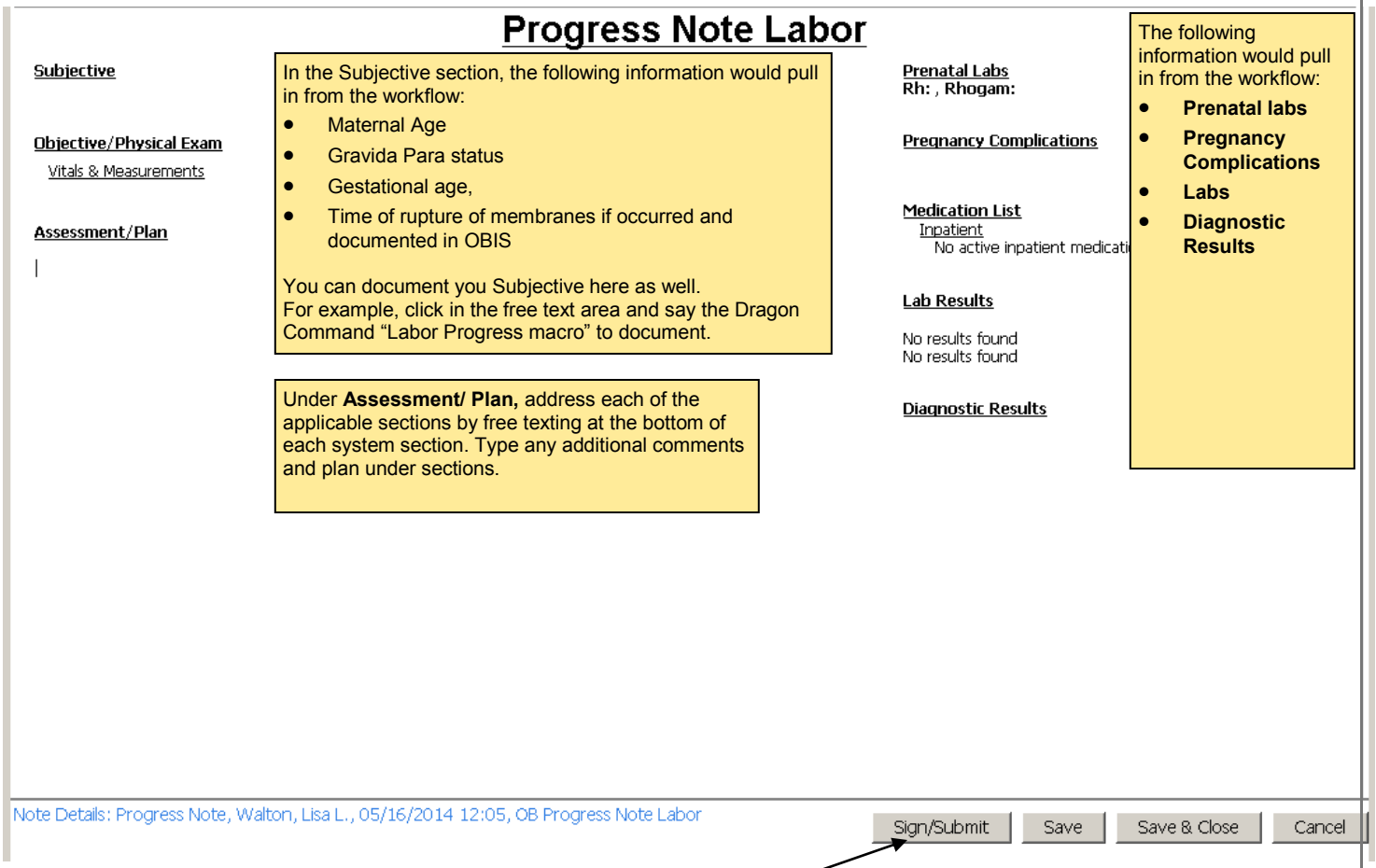
To be compliant, your Progress Note must be different on each Date of Service.
While the assessment/plan may not change much from day to today, the vitals and labs will be different.



Progress Note—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 today, the vitals and labs will be different.



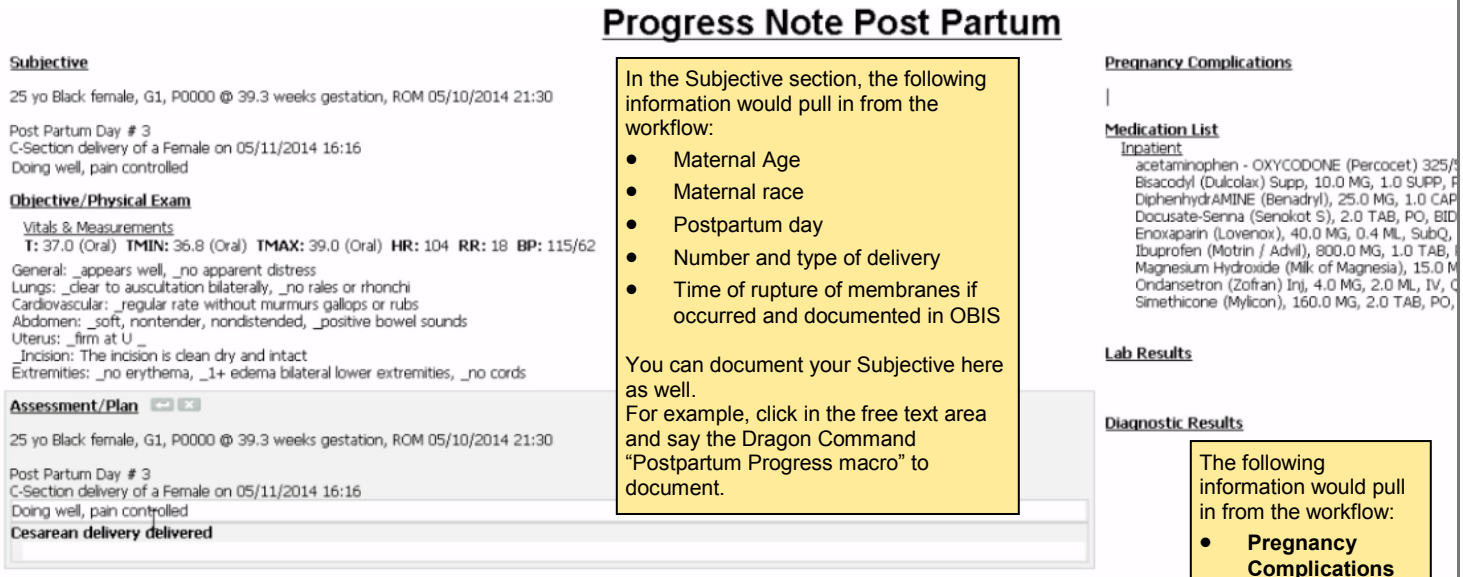
Then click **Sign/Submit.**

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.



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.

The following information would pull in from the workflow:

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

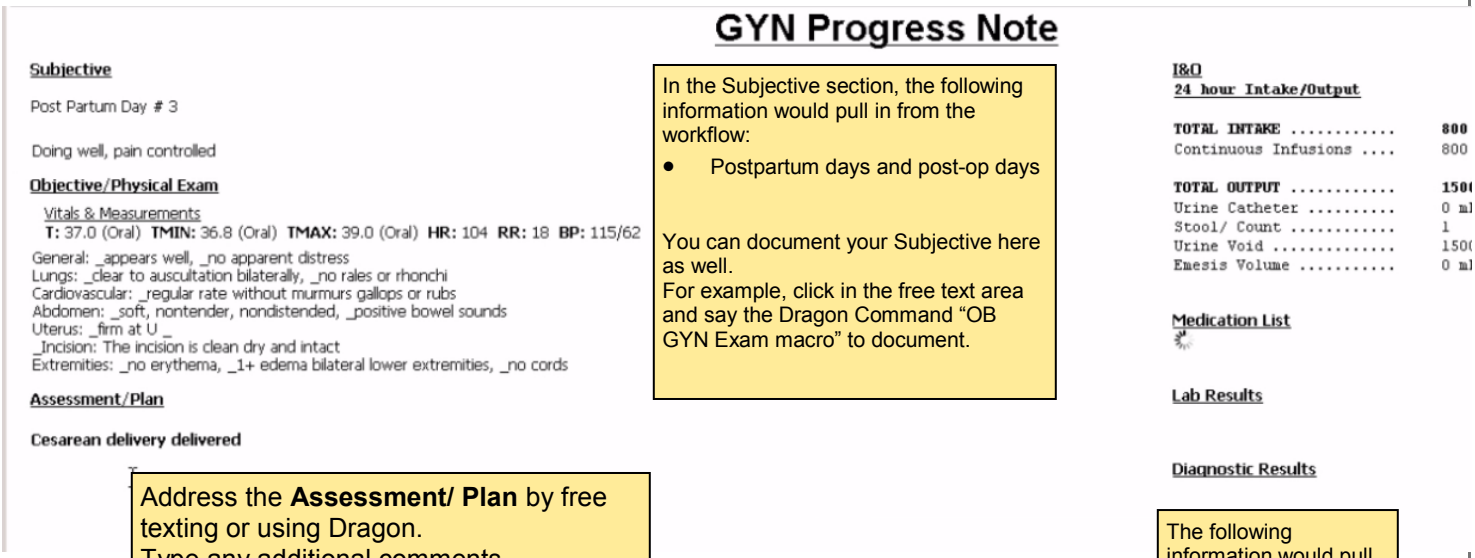
Address the **Assessment/ Plan** by free texting or using Dragon.
For example, you may say "Postpartum plan macro".
Type any additional comments.

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 today, 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

I&O
24 hour Intake/Output

TOTAL INTAKE 800
Continuous Infusions 800

TOTAL OUTPUT 150
Urine Catheter ..... 0 ml
Stool/ Count 1
Urine Void 150
Emesis Volume ..... 0 ml

Medication List

Lab Results

Diagnostic Results

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.

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

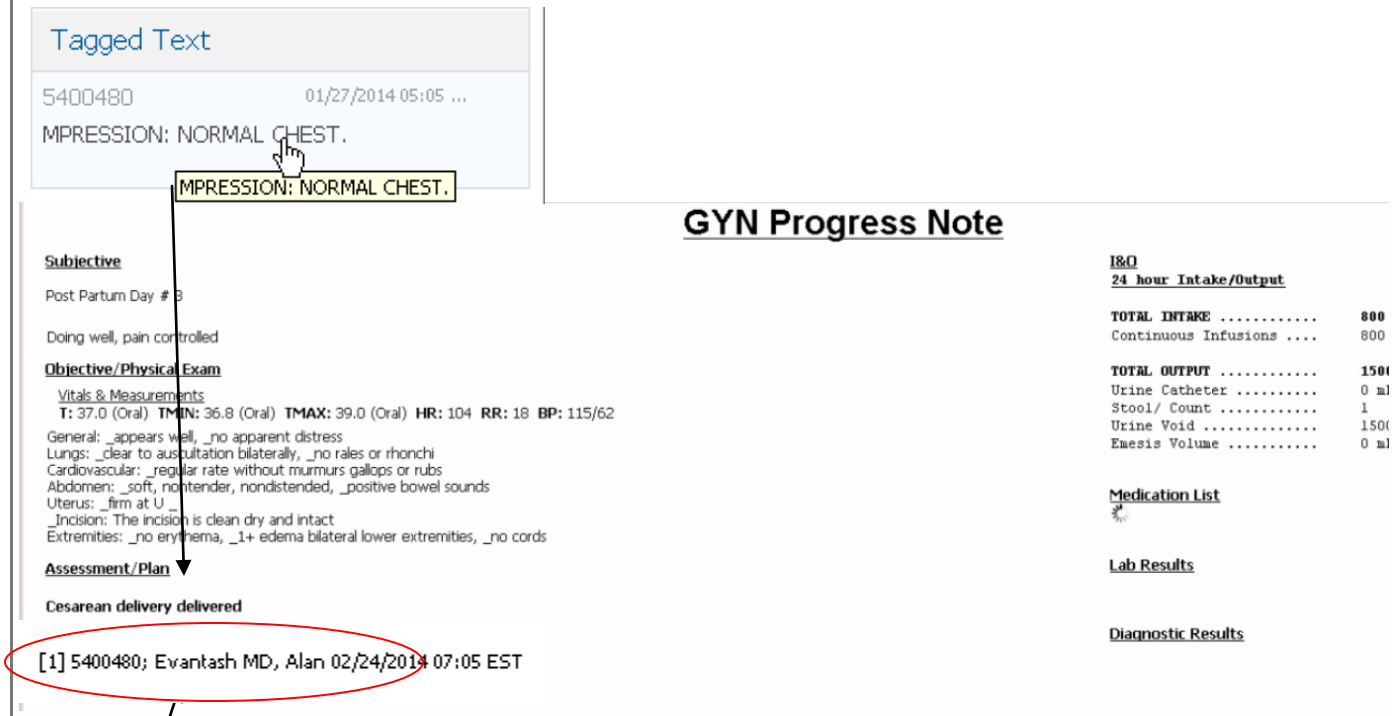
The following information would pull in from the workflow:

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

Then click **Sign/Submit.**

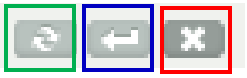
Progress Note– Adding tagged text

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.



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

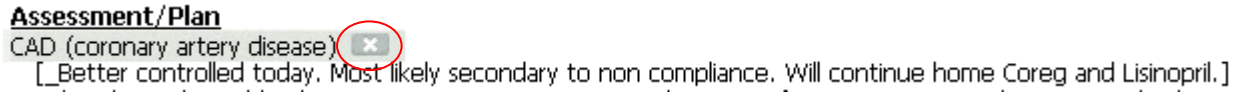
Progress Note—Refreshing/Free text fields/Deleting



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.

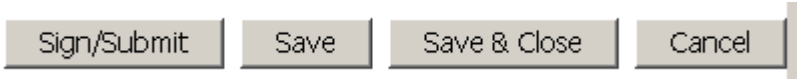
Consultations– Removing Diagnosis fields

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.



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

1. On Documentation Workflow in the patient's chart, the Documents section will list the notes.
2. Click on the note you wish to modify. The note opens.
3. Right click and select **Modify**, or in the toolbar, click the **Modify** icon.
4. 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.
5. Add your information.
6. 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?

1. **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.
2. **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.
3. **Forward the note** to the co-signor. From Documentation Workflow:

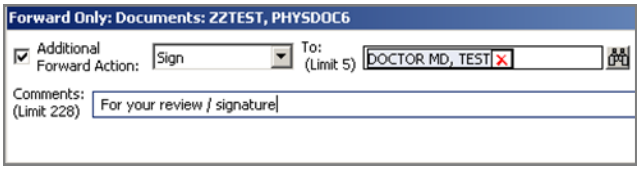
   a. Under Documents, open the note to forward by clicking it.

   b. Click the **Forward** icon just above the body of the note.

   c. Select **Sign** or **Review** from the first yellow drop down.

   d. Enter co-signor's name in the **To**: box.

   e. Enter any relevant comments, then click the **OK** button.



4. 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 fours 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**.