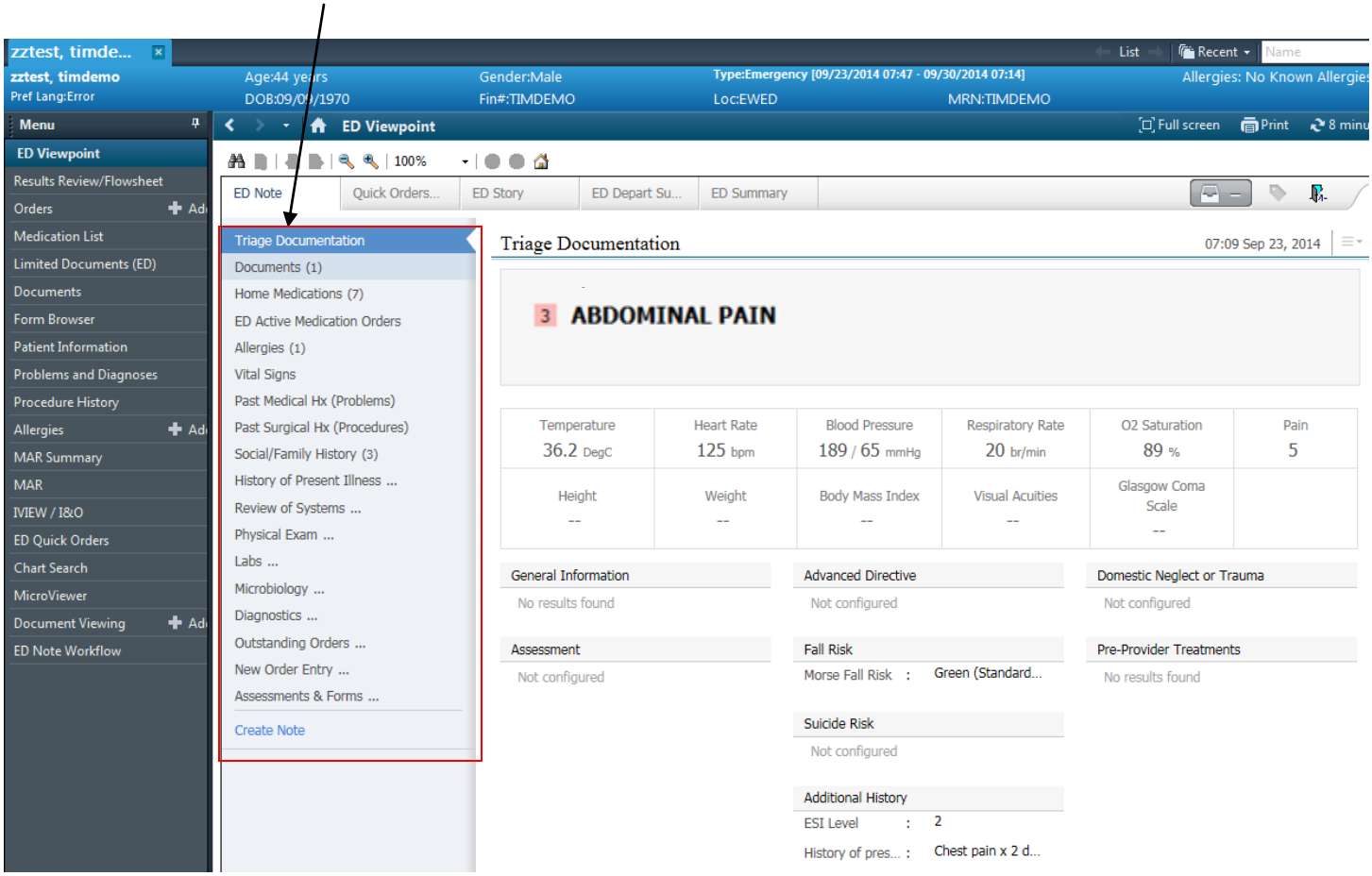
Documentation Workflow

The new Documentation workflow page will make the creation of your notes a by-product of your normal workflow.

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. The **ED Viewpoint** will open to the ED Note Workflow.
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.

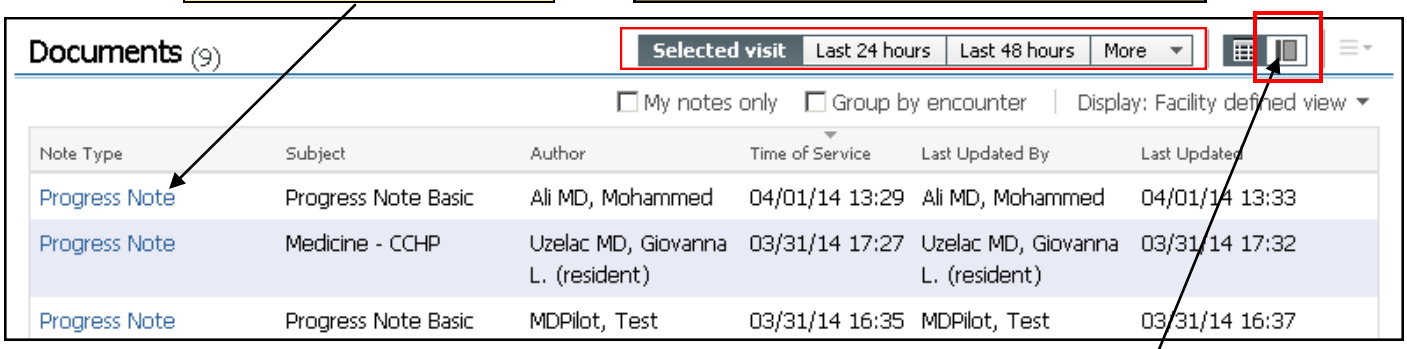
Sections in Workflow

Documents

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

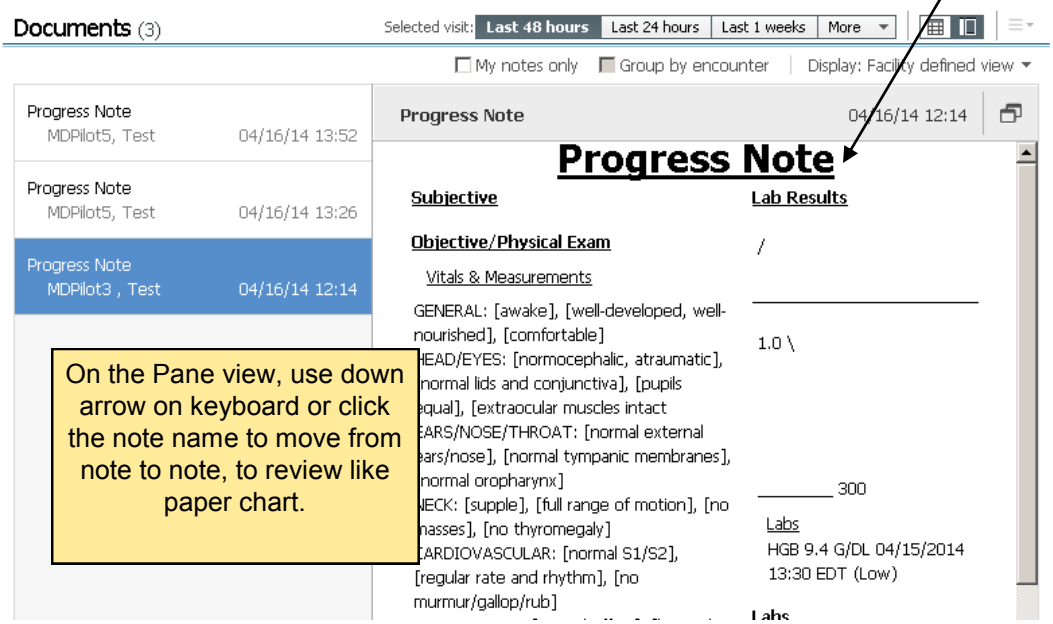
Click on the Note Type to open and view the document.

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



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

Pane View



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.

Visible on Documentation Workflow:
ED Notes
H&P
Consults
OP reports
Stress/Cath and GI reports
Discharge Summaries

To see additional documents, click the section header.

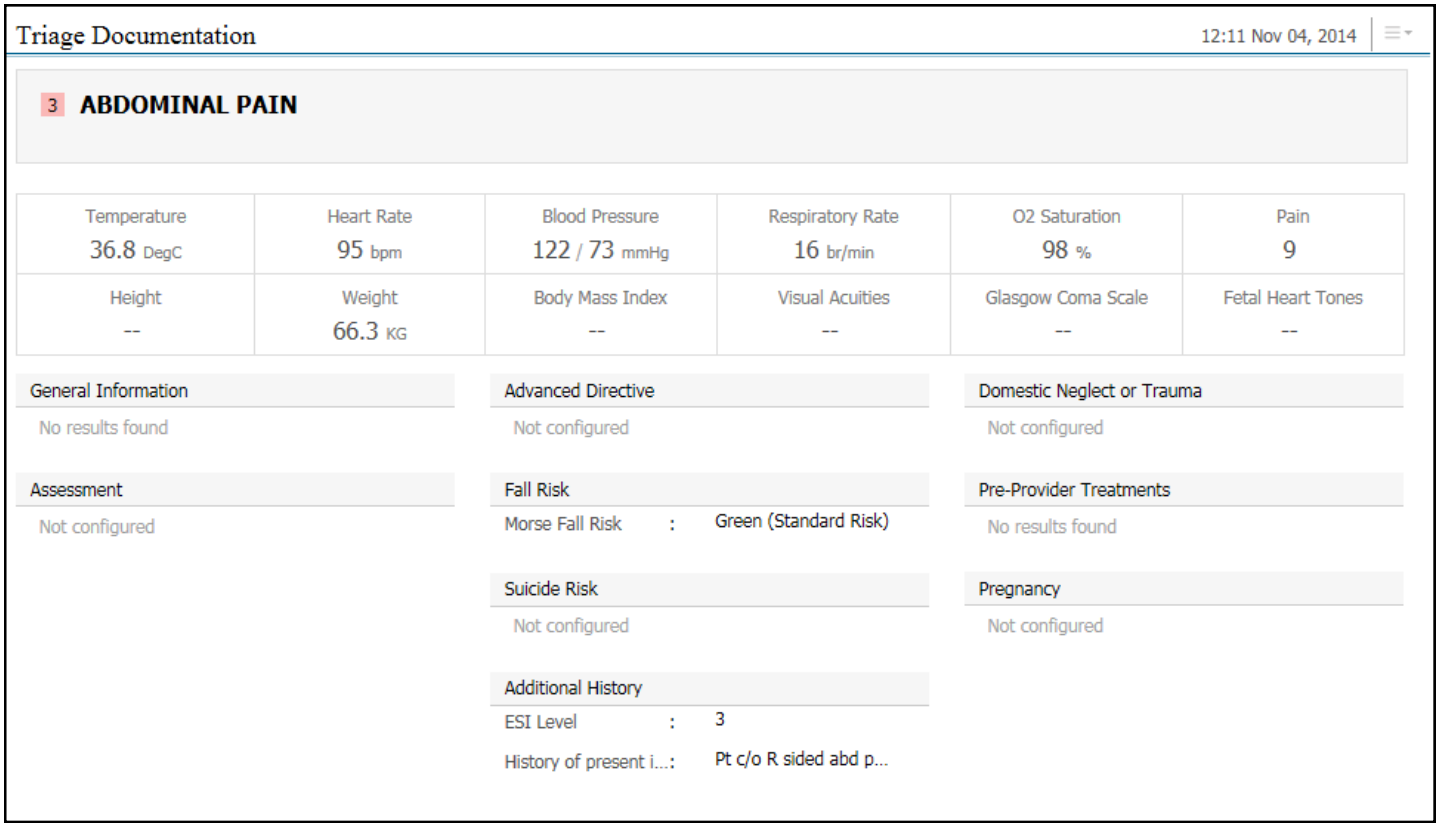
Sections in Workflow

Triage Documentation

Triage Documentation provides a quick summary of Triage information in an easy to read view.

Based on the Triage Nursing Documentation for this visit, it includes:

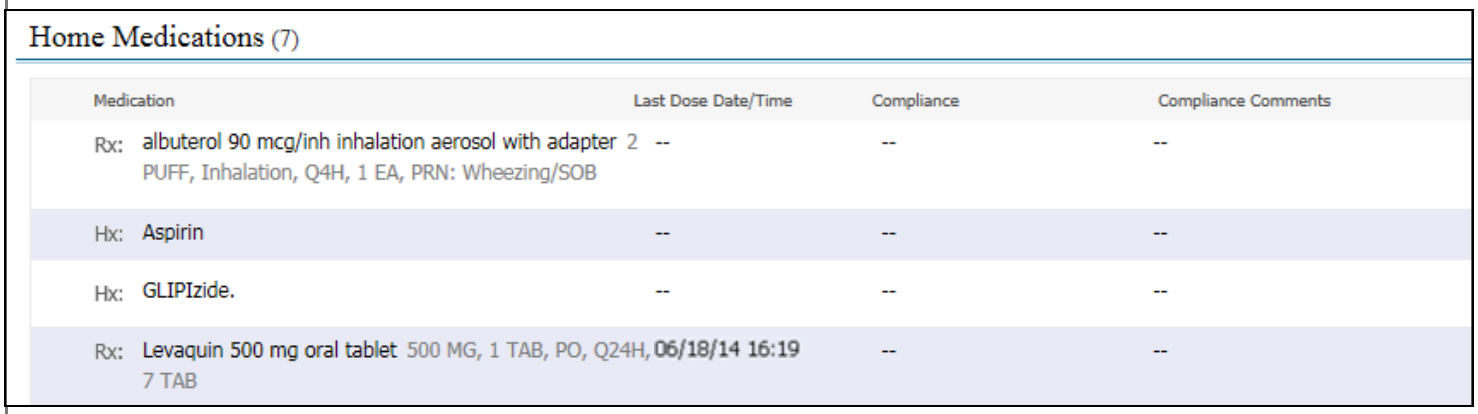
- Chief complaint: This is the Triage Chief complaint.
- Vital signs: Most recent set
- General Information: such as mode of arrival
- Advanced Directive choices
- Domestic Neglect or Trauma details
- Assessment from Triage
- Fall Risk
- Pre-Provider Treatments
- Suicide Risk
- Pregnancy information
- Additional History, like the Acuity level and HPI.



Sections in Workflow

Home Medications

Home Medications carry over from Encounter to Encounter. Although Home Meds may be documented by the ED, ensure they are accurate and do not contraindicate, as this list will populate in your note.

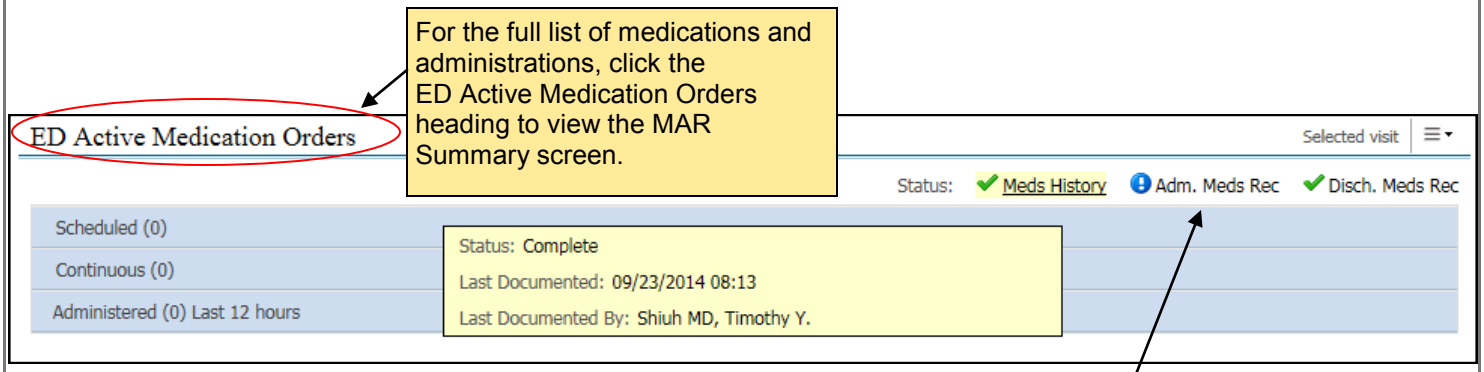


To see if the Med History has been updated for this visit, see the Status in the ED Active Medication Orders section below.

ED Active Medication Orders

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

- Scheduled
- Continuous
- Administered in last 12 hours



Medication Reconciliation Status is easy to determine on the workflow.

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

= Completed

= In Progress

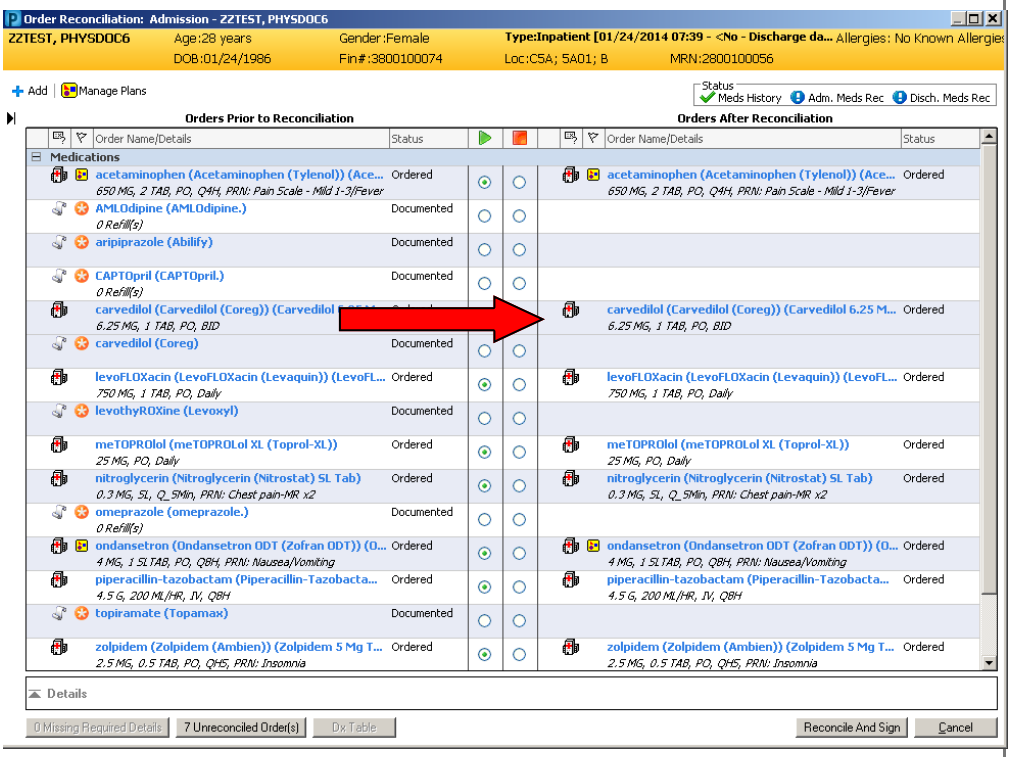
= Not Started

Hover over the status to see the Date/ Time and person who completed the Med Rec.
To complete reconciliation or view the med rec screens, click the status.

Sections in Workflow

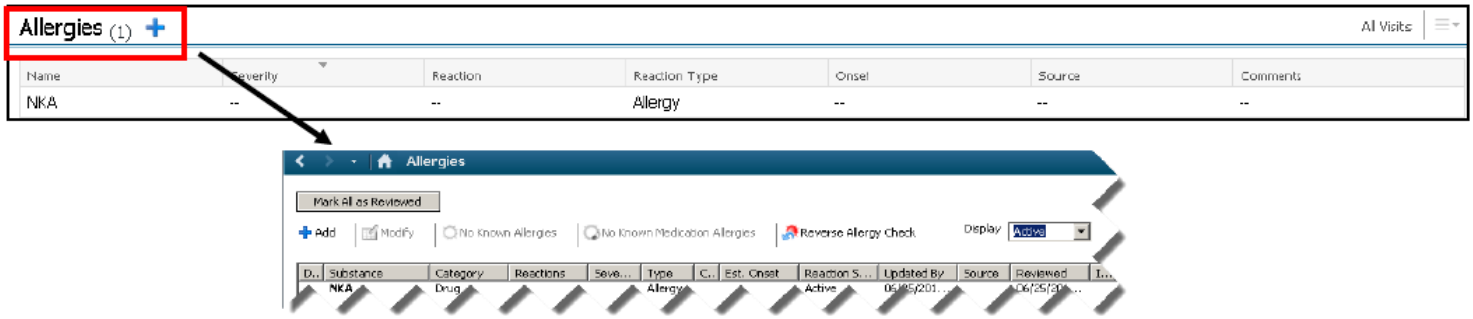
When performing Med Rec, confirm that the information on the right side is correct and that the order includes:

- Name
- Dosage
- Route
- Frequency



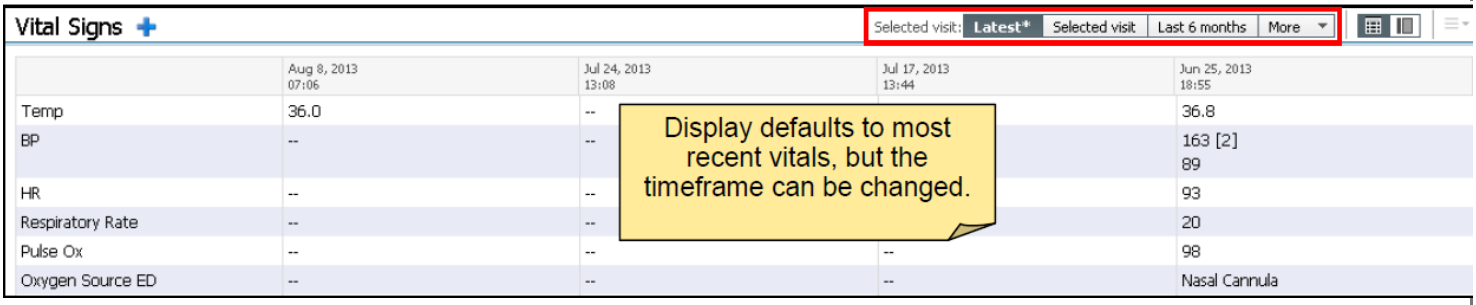
Allergies

Modify Allergies by selecting section header or add an allergy by clicking the plus sign.



Vital Signs

This section only shows vitals from the current encounter. To view vitals from previous encounters, click the header to change the search criteria.

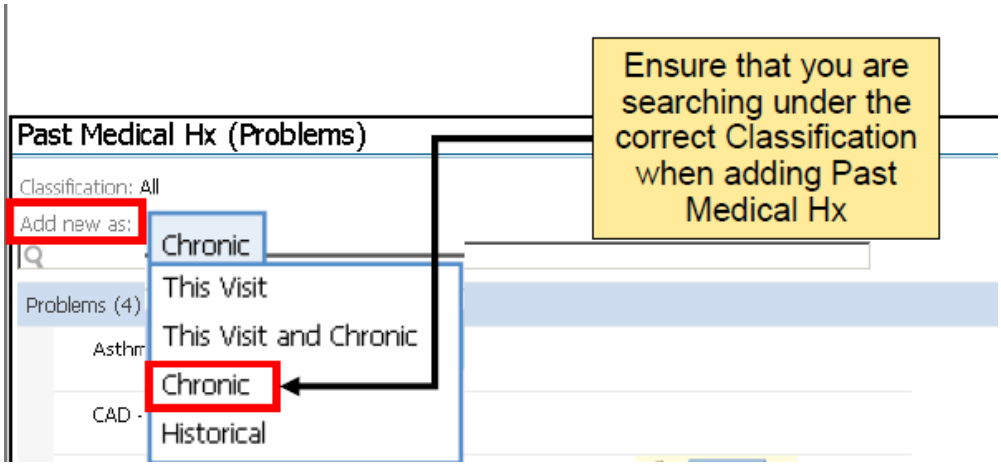


Sections in Workflow

Past Medical Hx (Problems)

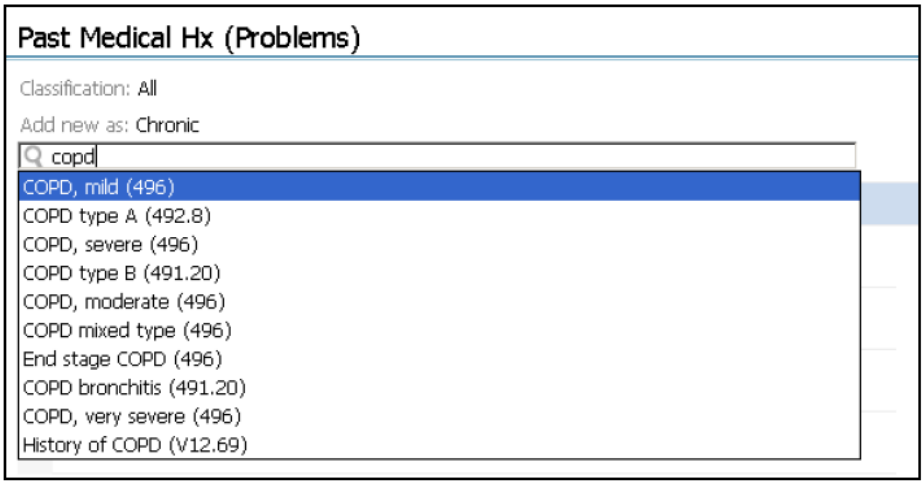
Past Medical Hx (Problems) is a combined list of Past Medical History and Problems.

To add Past Medical History and Problems, change the “Add New As”, located above the Search field, to Chronic.



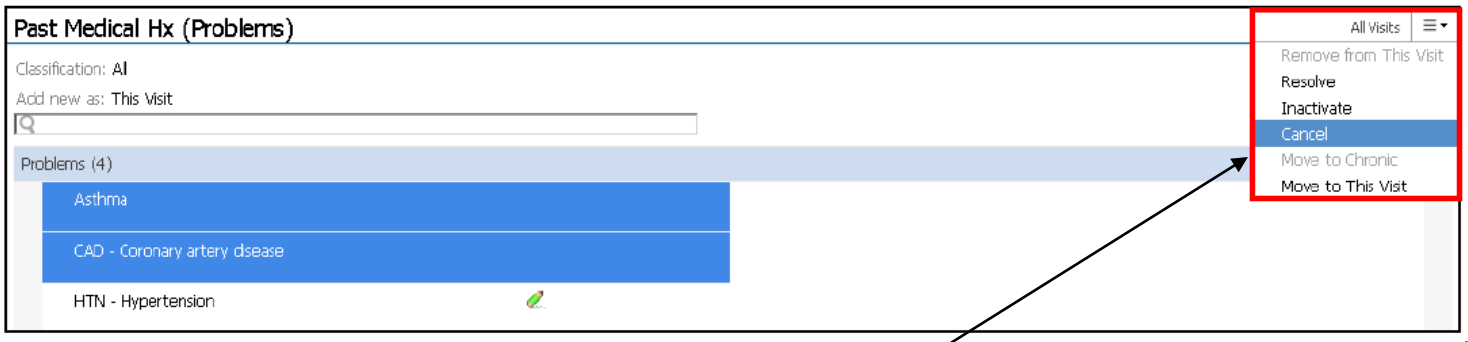
In the Search field, type the problem. This will begin yielding results from which you can choose.

Click the appropriate problem.



Remove a problem

Click the problems you wish to remove. The items selected will turn blue.



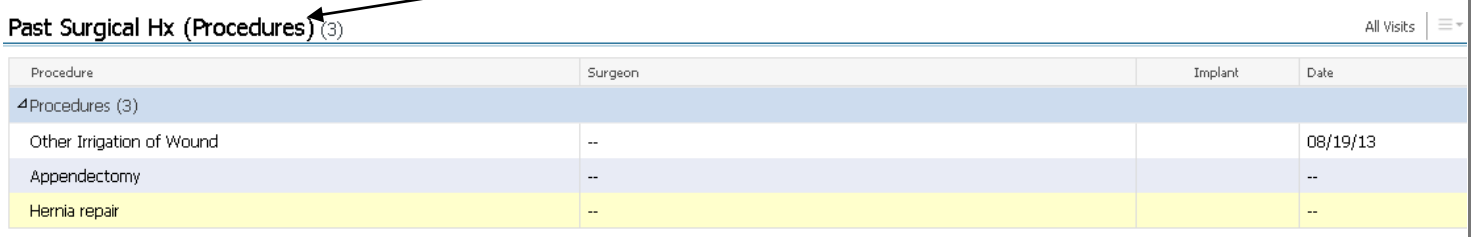
Select the icon on the top right corner and select Cancel or Resolve.

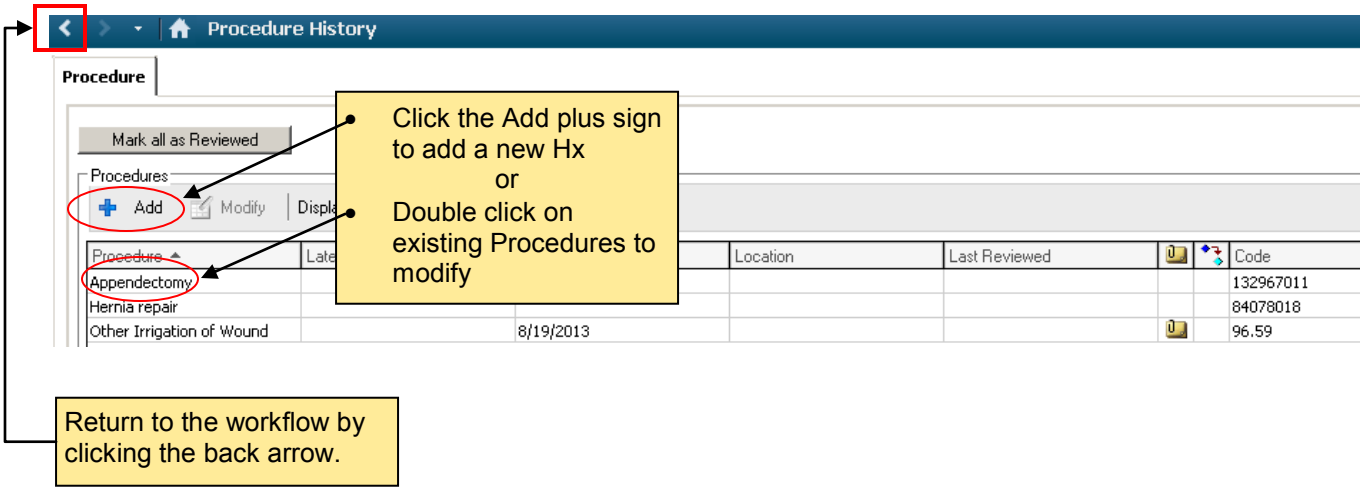
Sections in Workflow

Past Surgical Hx (Procedures)

Past Surgical Hx (Procedures) is a list of past procedures.

To add a new past surgical history, click the header.

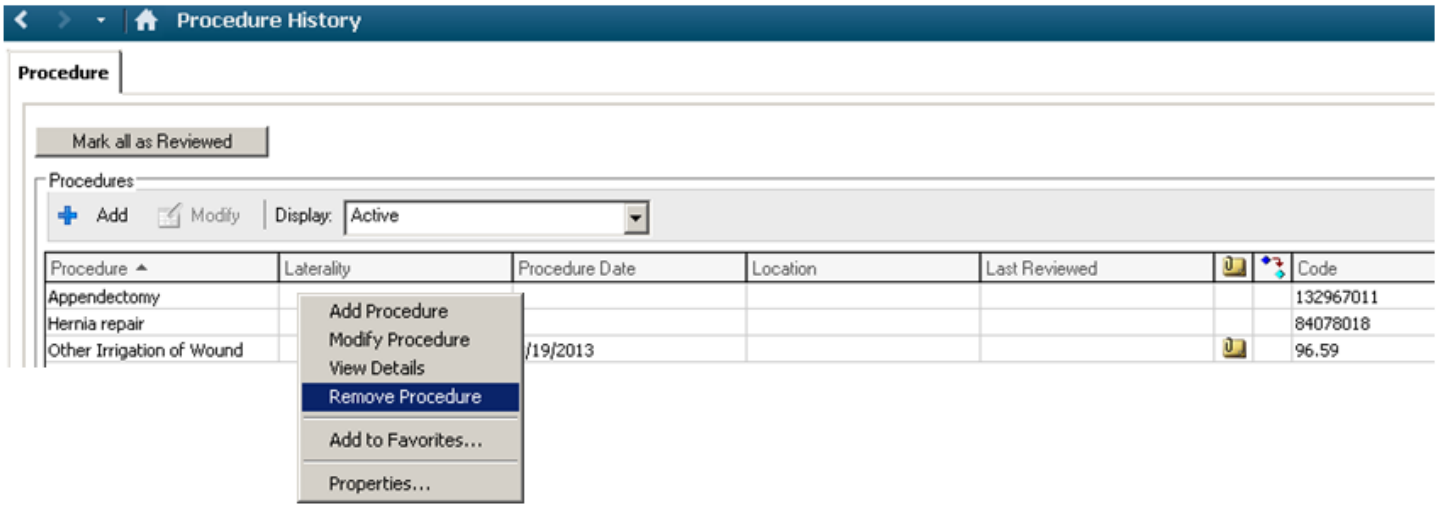




Remove a procedure

Make sure that you are not currently attempting to add a problem.

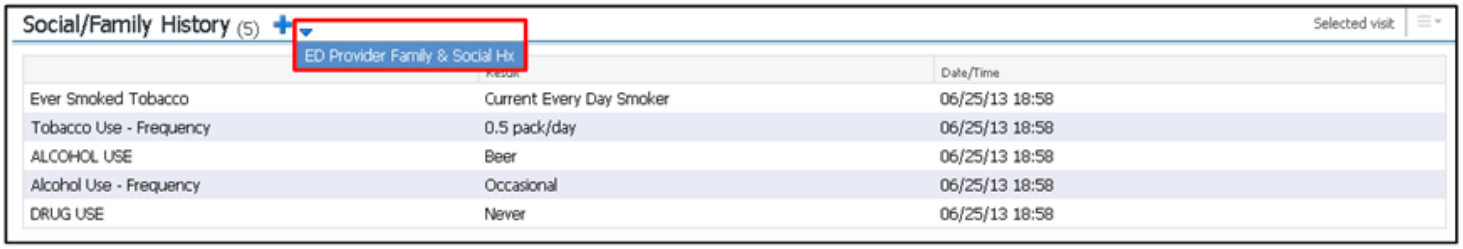
On the main Procedure History window, right click on the procedure you wish to remove. Then select, **Remove Procedure**.



Sections in Workflow

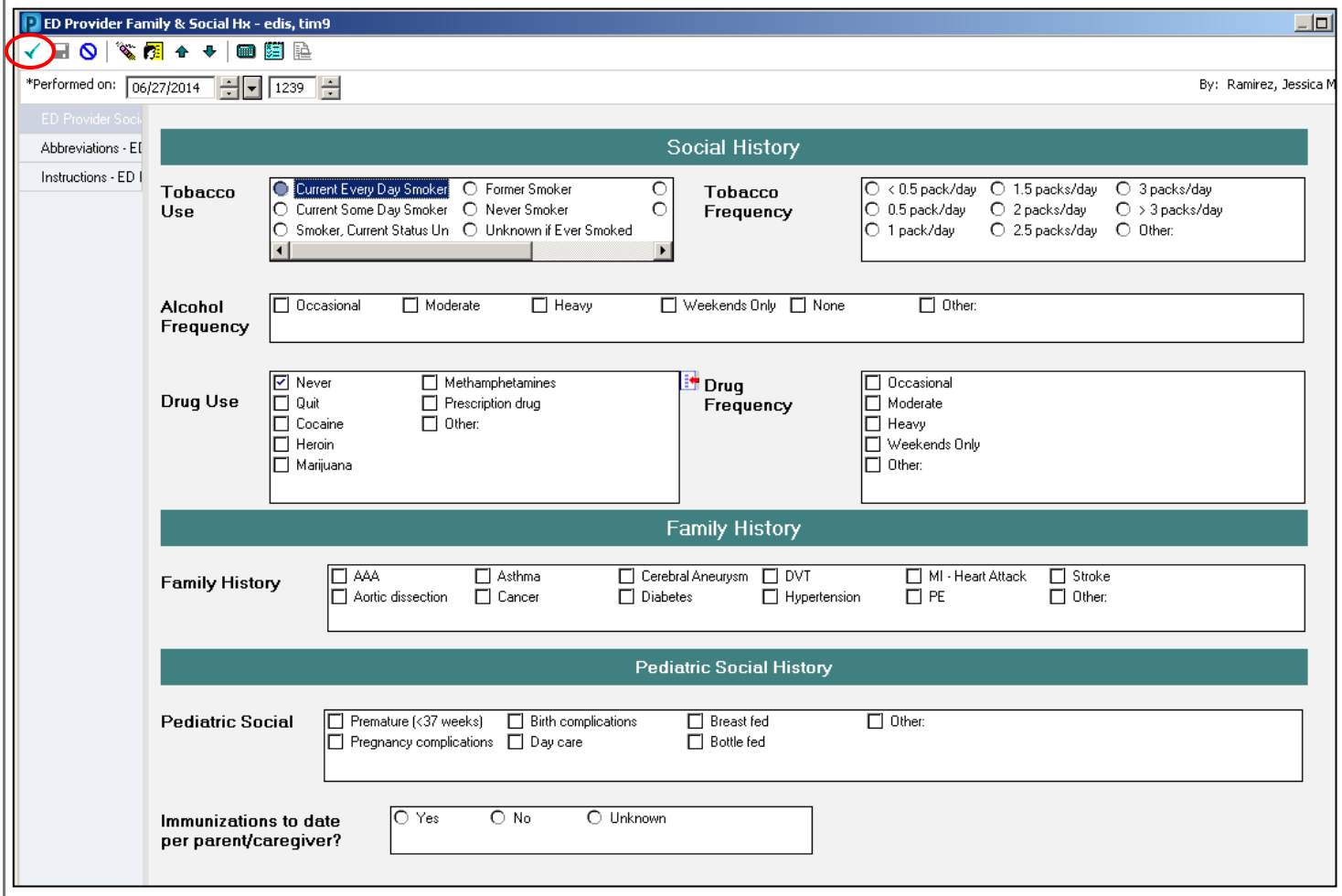
Social/ Family History

This data is captured by ED Nurses during ED Assessment. Ensure the date and time are for a current visit.
If you need to add additional Social/Family History details, click the drop down arrow.
Select **ED Provider Family & Social Hx**.



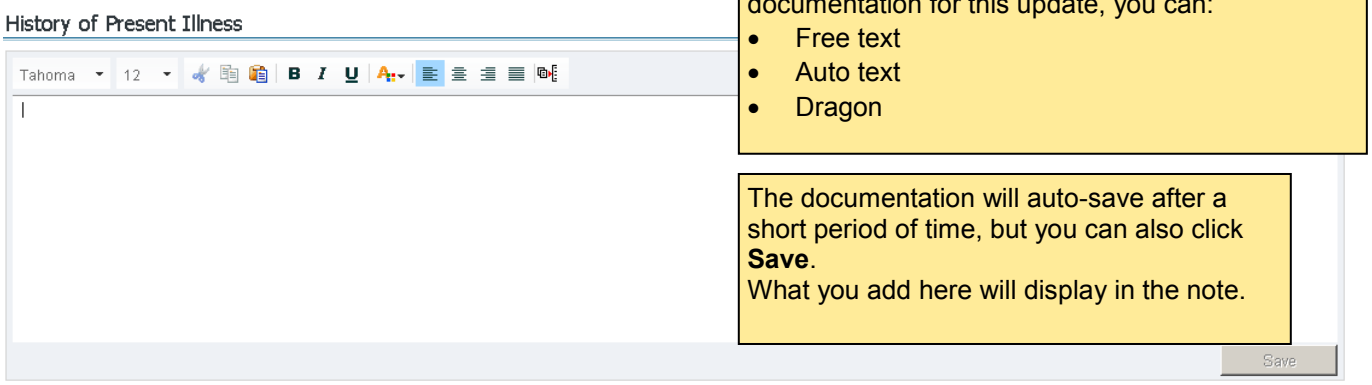
This opens the Social and Family History form. Complete the additional information.

Sign by clicking the green check mark on the top left corner of the form.



Sections in Workflow

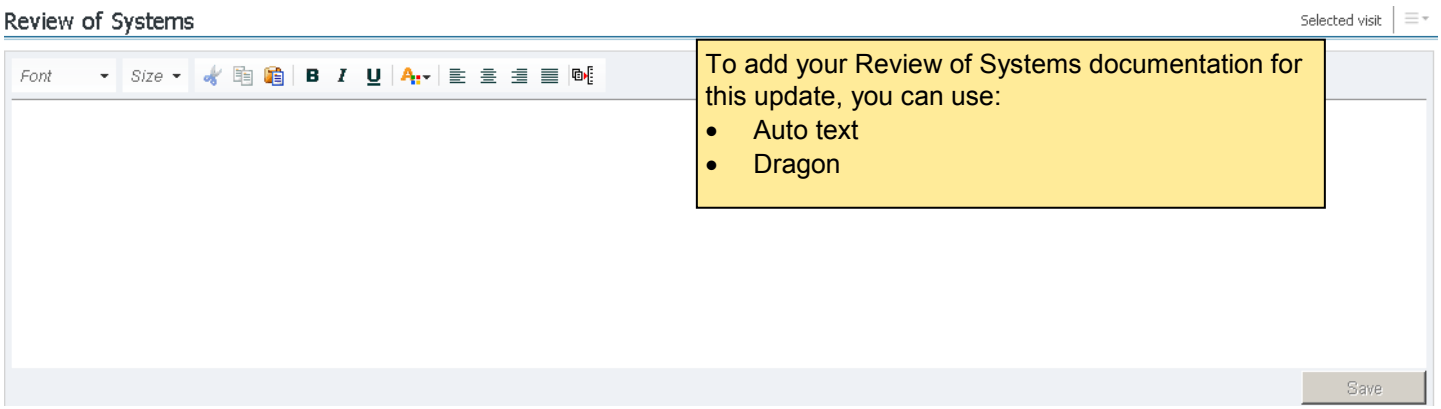
History of Present Illness



To add your History of Present Illness documentation for this update, you can:
- Free text
- Auto text
- Dragon

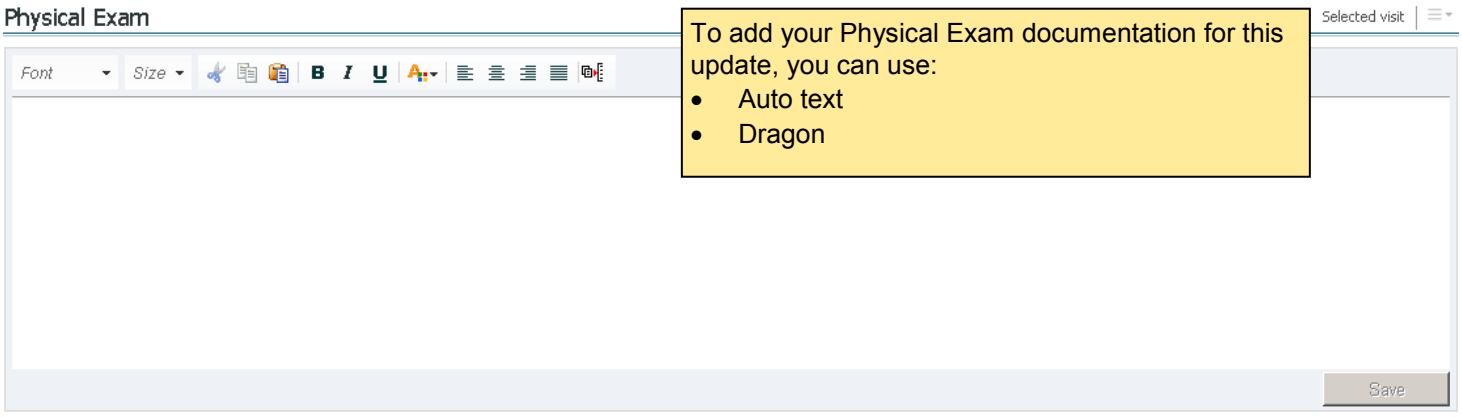
The documentation will auto-save after a short period of time, but you can also click **Save**.
What you add here will display in the note.

Review of Systems



To add your Review of Systems documentation for this update, you can use:
- Auto text
- Dragon

Physical Exam



To add your Physical Exam documentation for this update, you can use:
- Auto text
- Dragon

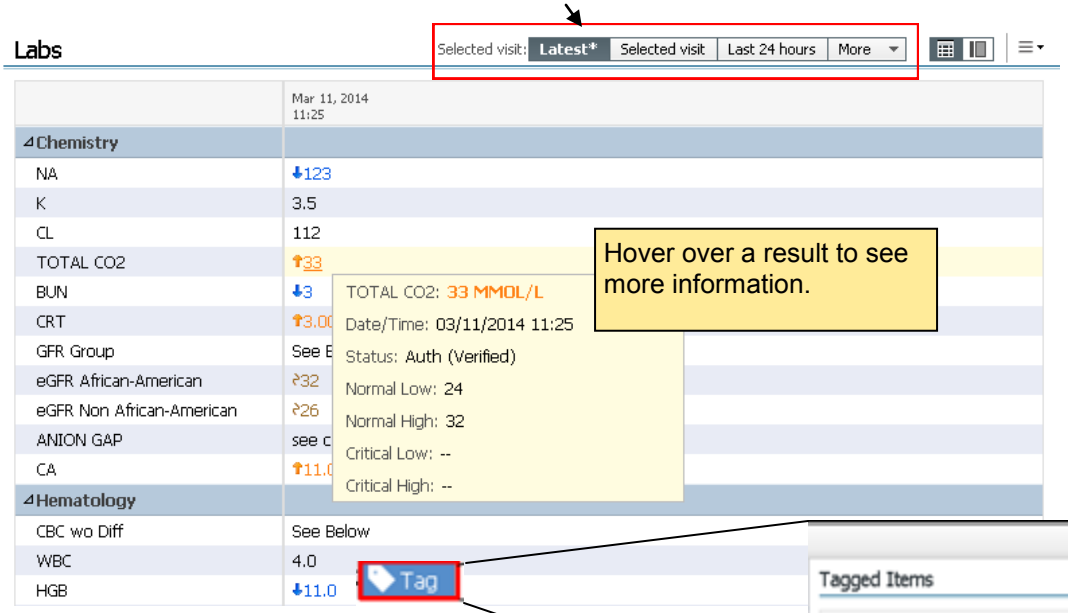
1. Use Dragon commands to add:
   - a template of multi-system exam information
   - a macro of an individual system
2. Use the Dragon **Tab Forward** key, the F3 key on keyboard or say "**Next field**" to move to each bracketed field and dictate your findings.
3. If you have to complete a selection 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.

Sections in Workflow

Labs

This section defaults to the latest labs resulted for this encounter.

Change the search criteria by selecting the look back options for this encounter.

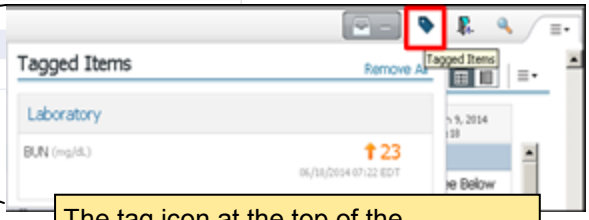


Hover over a result to see more information.

Labs that will automatically pull into the note include:

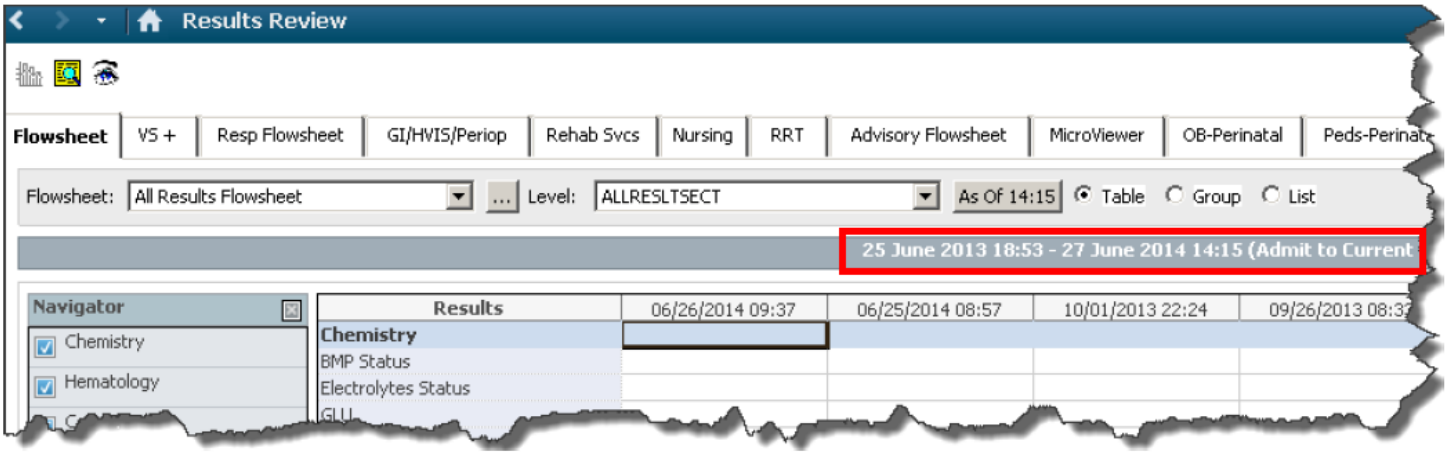
Fishbone Labs: CBC/BMP, Troponin, BNP, D-dimer, Mg, Ca, LFT's, Lipase, Ammonia, Lactate, TSH, PT/INR, PTT, Sed Rate/ CRP, Type/Rh, HCG Quant, ASA, Tylenol, ETOH, Valproic, Depakote, Phenytoin, Lithium, Urine Studies: UA, HCG, Urine Tox

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.

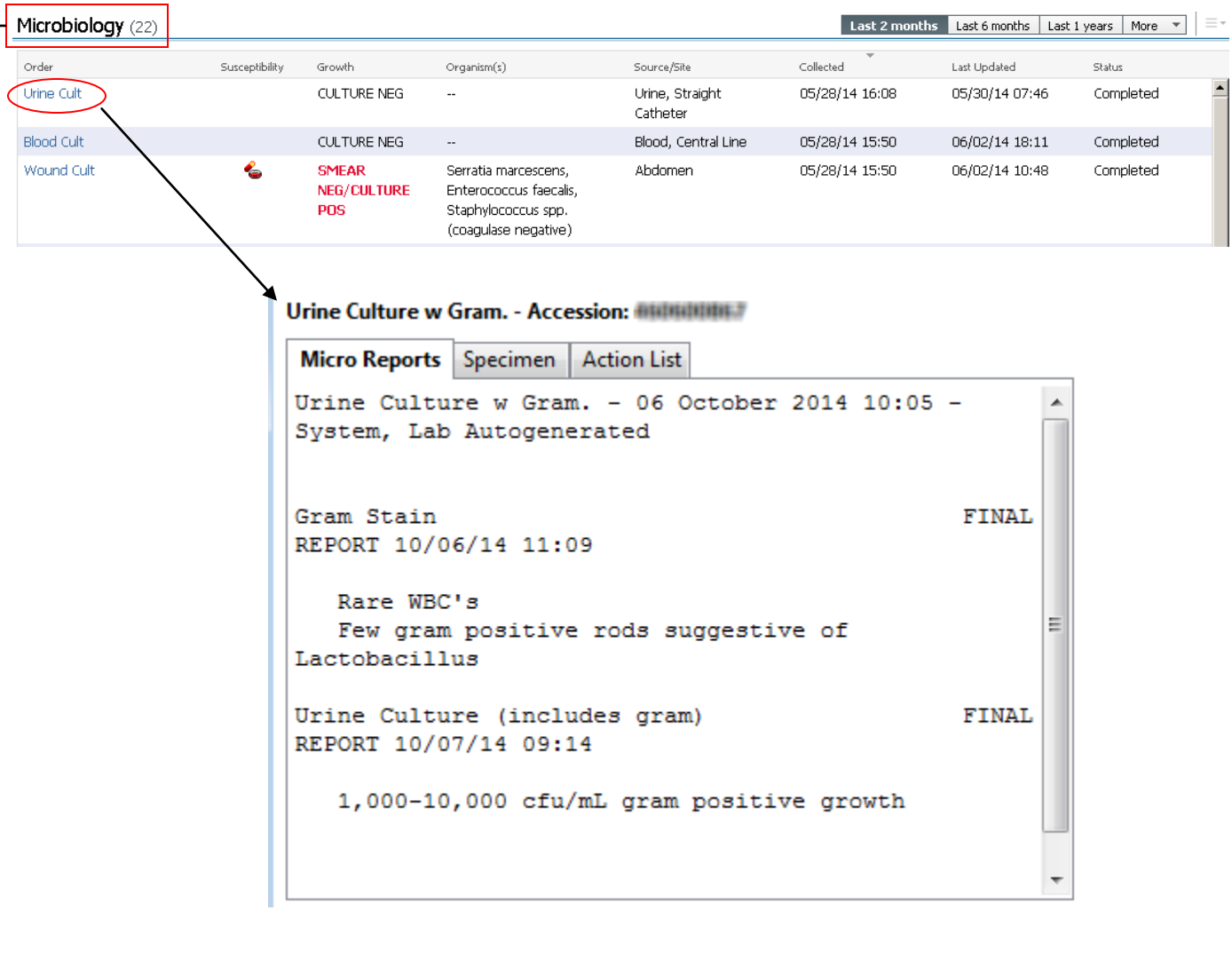
To view labs from past encounters, click the **Labs** Heading. The Results Review Flowsheet will open.
Change the search criteria to see past encounters.

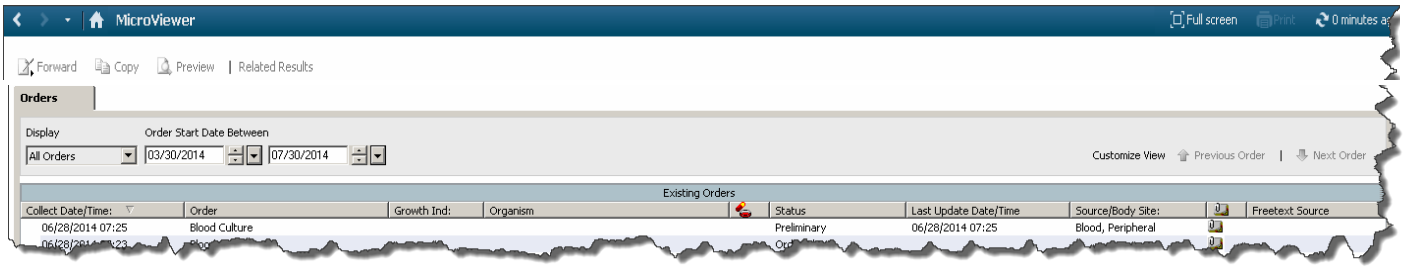


Sections in Workflow

Microbiology

View results by selecting the Microbiology Heading to open the MicroViewer or clicking on the Order name (in blue) to open the full report.

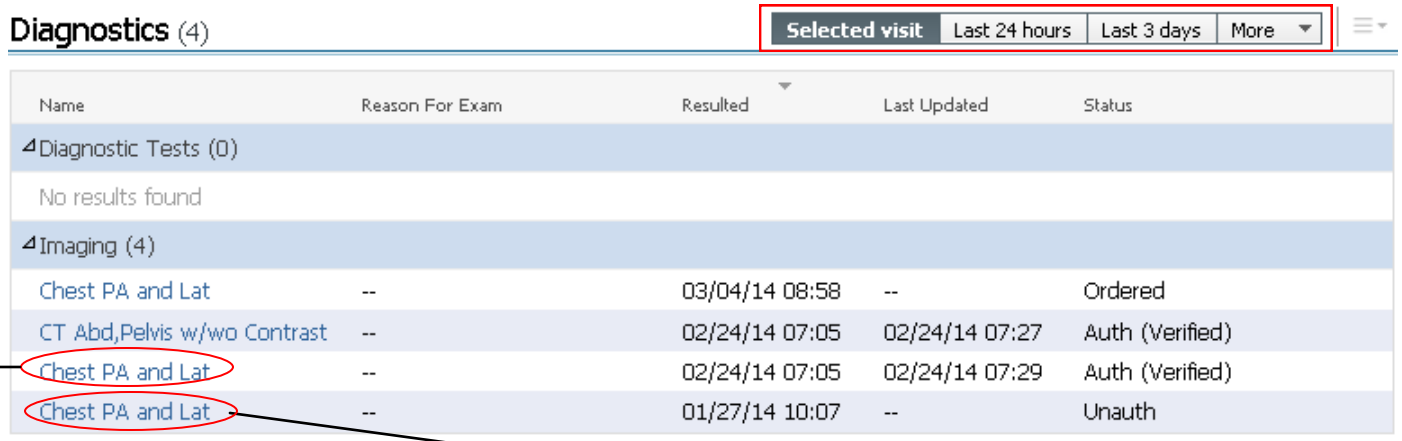




Sections in Workflow

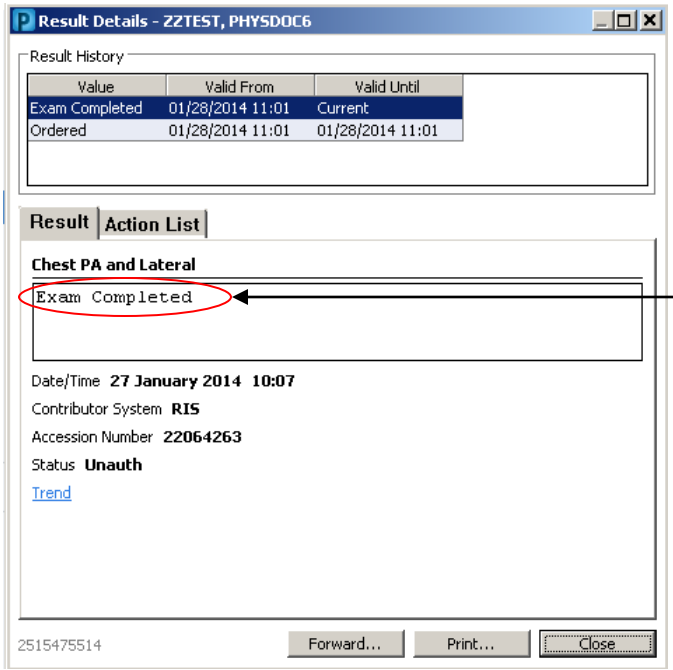
Diagnostics

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.

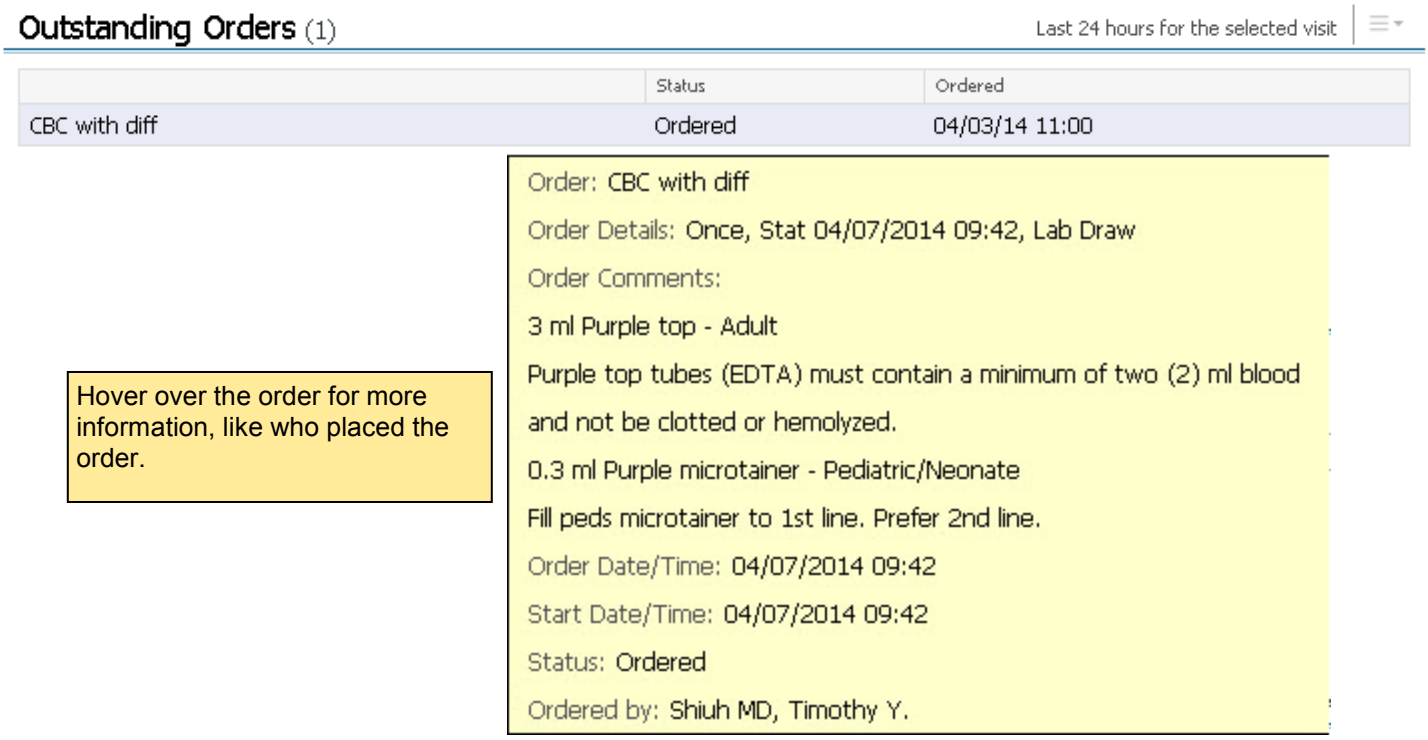
Tagging can be used in:

- Documents
- Diagnostics
- Lab Results

Sections in Documentation Workflow

Outstanding Orders

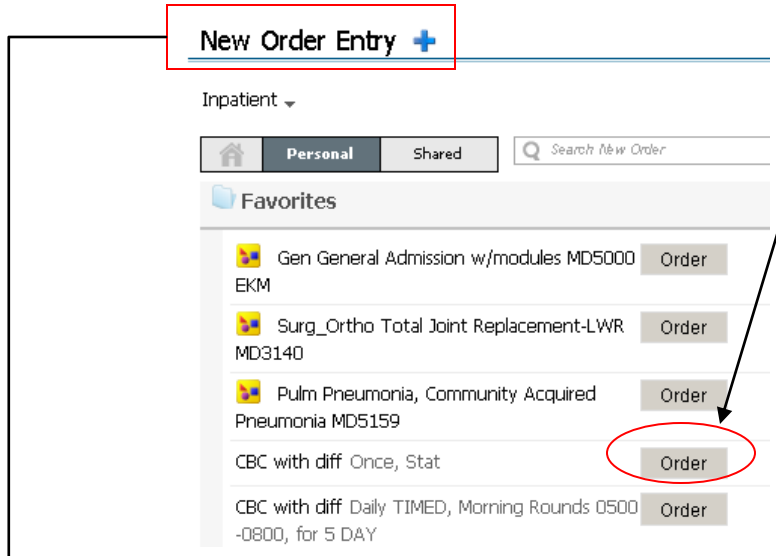
Outstanding orders are orders which have not been completed yet.



Hover over the order for more information, like who placed the order.

New Order Entry

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



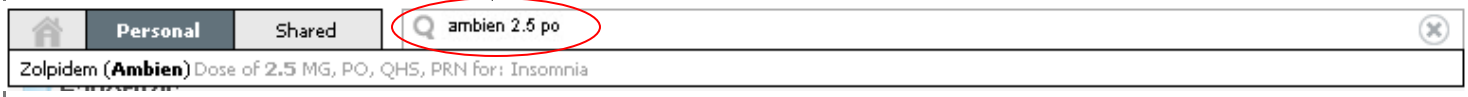
Orders may be displayed by a list of your favorites.
To order, simply click the Order button next to the order name. The button turns dark gray.

To access the Quick Orders screen click the New Order Entry heading or the plus sign for the order window.

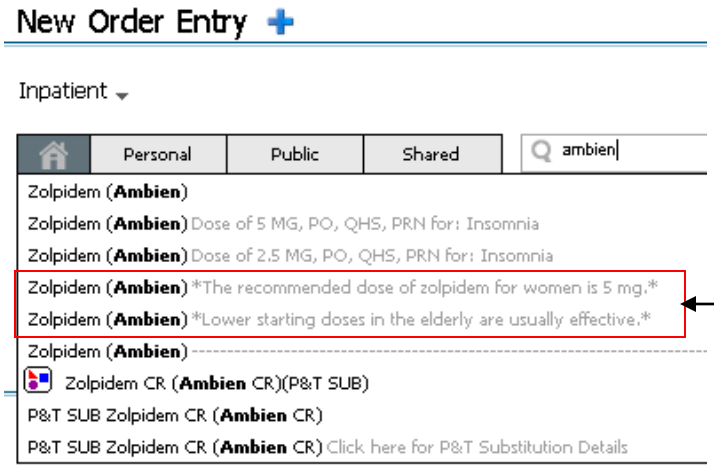
Sections in Documentation Workflow

New Order Entry– Quick Search

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



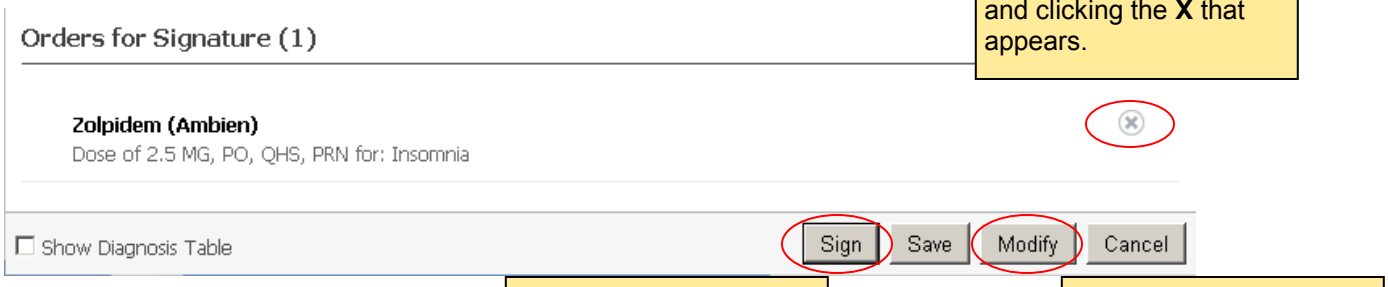
Being as specific as possible will return the most correct order:
1. Type the order, dosage, route and frequency.
2. Select the correct order from the list.



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

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.



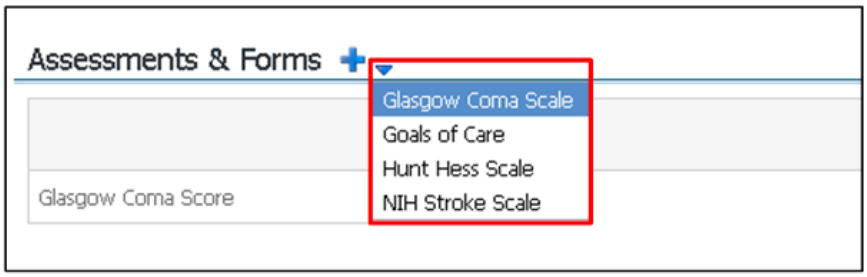
Click **Sign** to complete the order.

Change order information by clicking **Modify.**

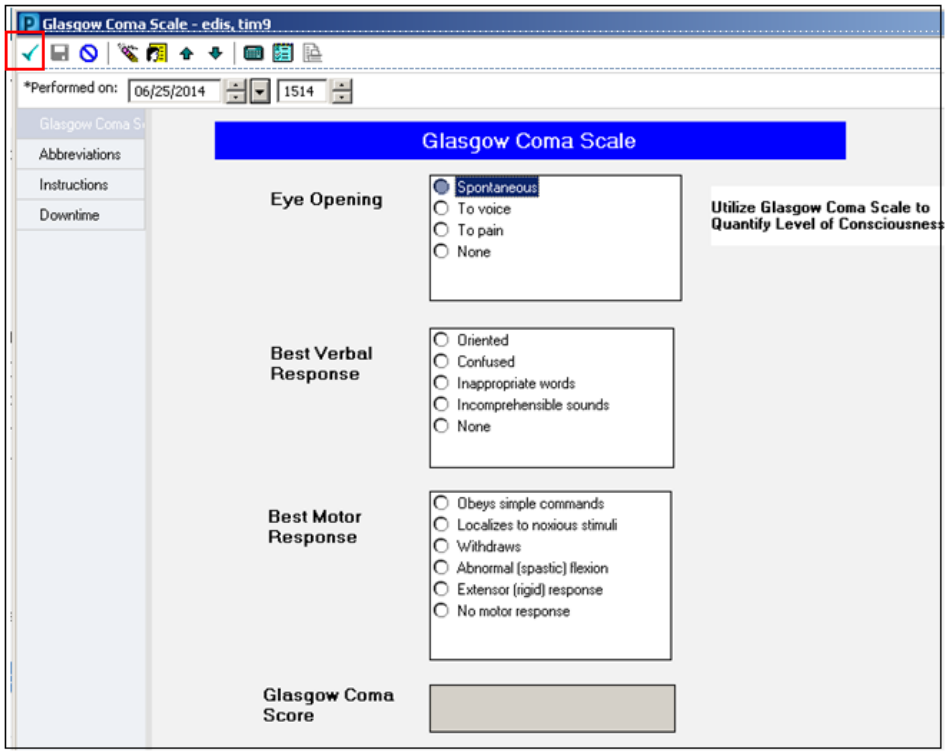
Sections in Documentation Workflow

Assessments & Forms

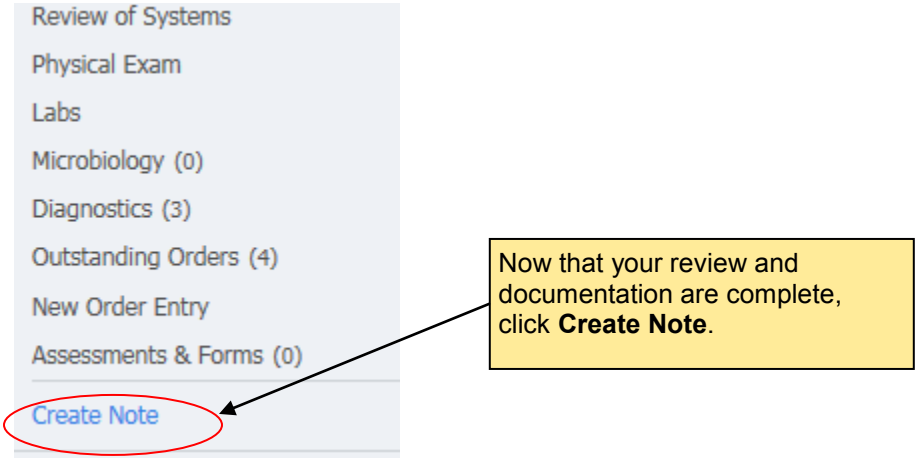
Click the down arrow to view the forms that are available. Select the form from the list.



Fill out the details and sign the form by clicking the green check mark.

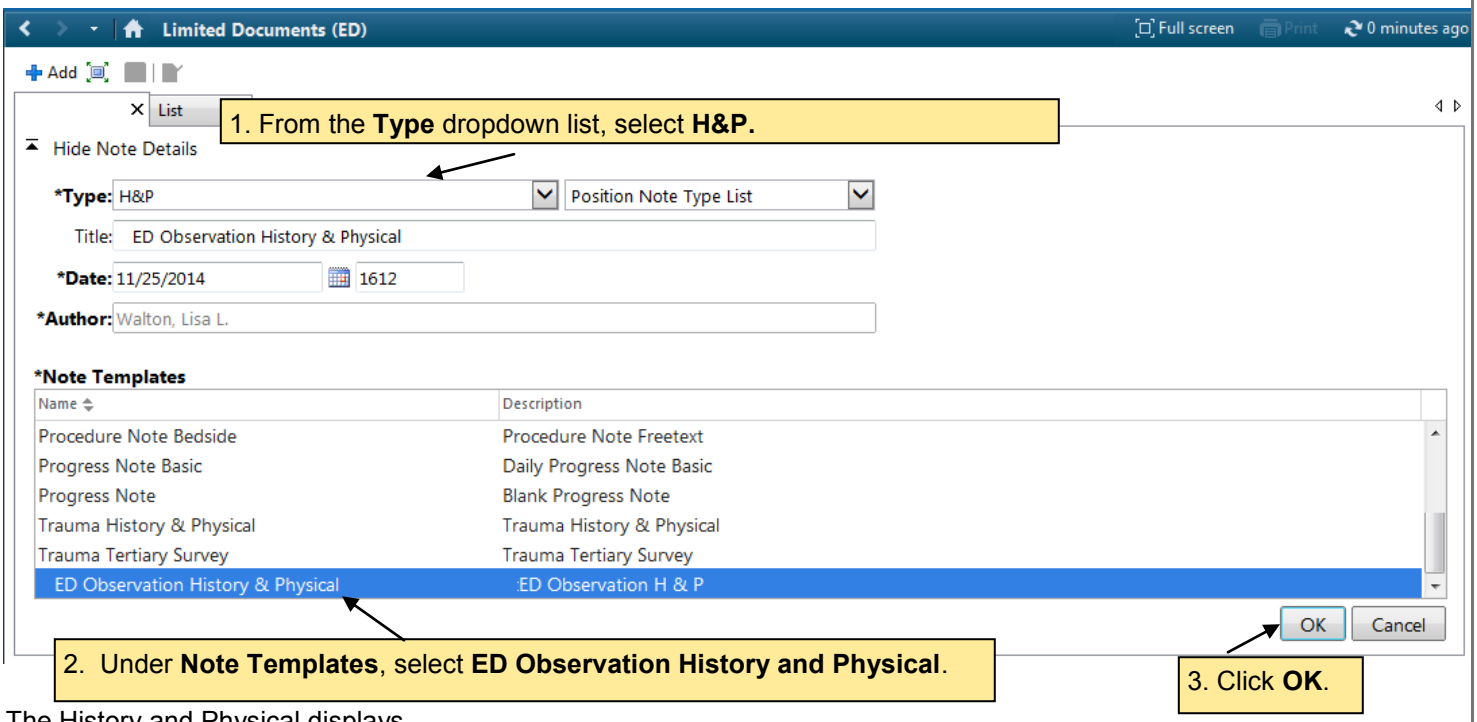


Create Note



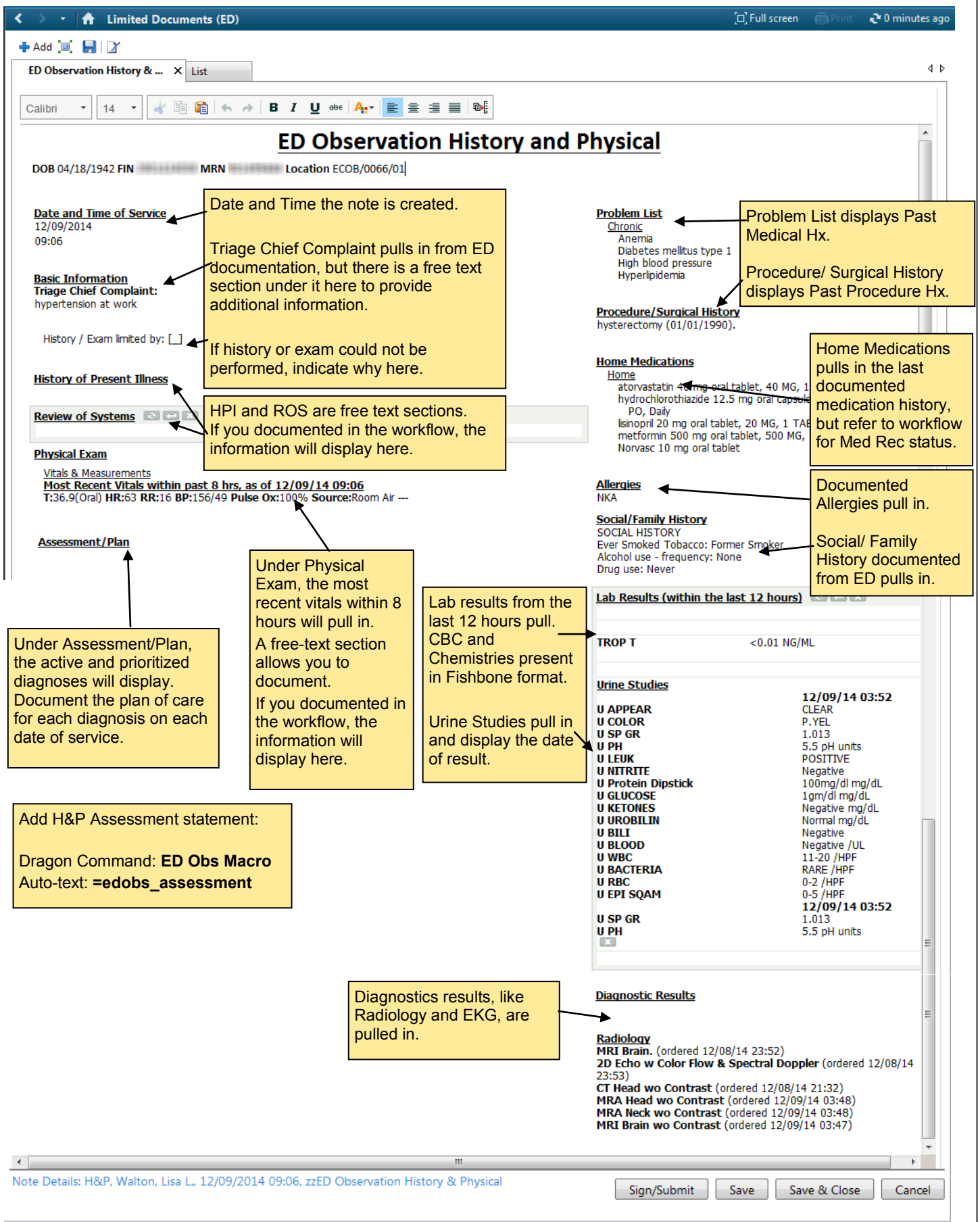
History and Physical

To create your History and Physical, complete the following:



The History and Physical displays.

History and Physical



Date and Time the note is created.

Triage Chief Complaint pulls in from ED documentation, but there is a free text section under it here to provide additional information.

If history or exam could not be performed, indicate why here.

HPI and ROS are free text sections. If you documented in the workflow, the information will display here.

Problem List displays Past Medical Hx.

Procedure/ Surgical History displays Past Procedure Hx.

Home Medications pulls in the last documented medication history, but refer to workflow for Med Rec status.

Documented Allergies pull in.

Social/ Family History documented from ED pulls in.

Under Physical Exam, the most recent vitals within 8 hours will pull in.

A free-text section allows you to document.

If you documented in the workflow, the information will display here.

Lab results from the last 12 hours pull. CBC and Chemistries present in Fishbone format.

Urine Studies pull in and display the date of result.

Under Assessment/Plan, the active and prioritized diagnoses will display. Document the plan of care for each diagnosis on each date of service.

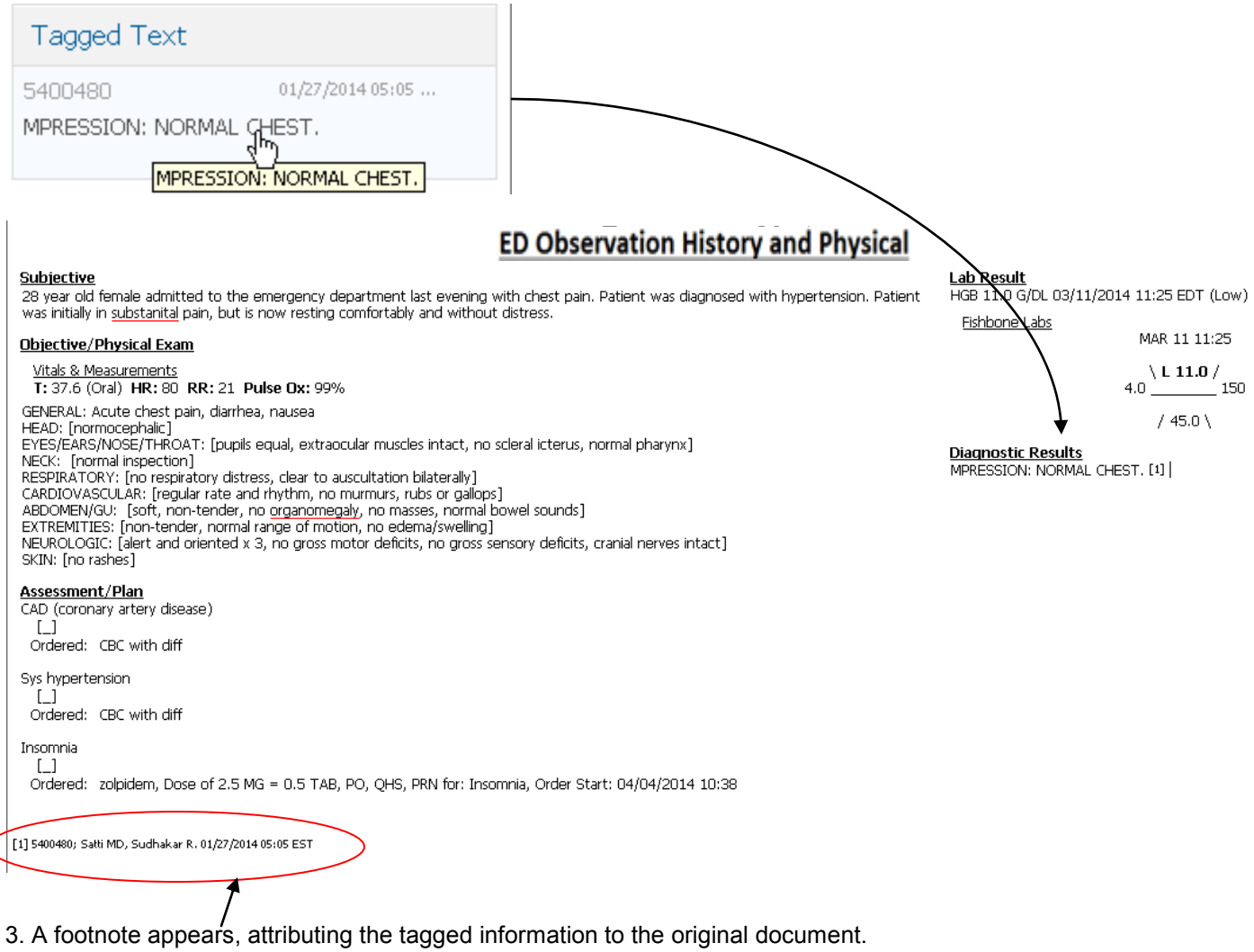
Add H&P Assessment statement:

Dragon Command: **ED Obs Macro**
Auto-text: **=edobs_assessment**

Diagnostics results, like Radiology and EKG, are pulled in.

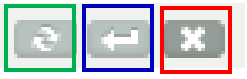
Adding tagged text

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



3. A footnote appears, attributing the tagged information to the original document.

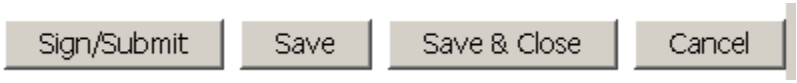
Refreshing/Free text fields/Deleting



Parts of the 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.

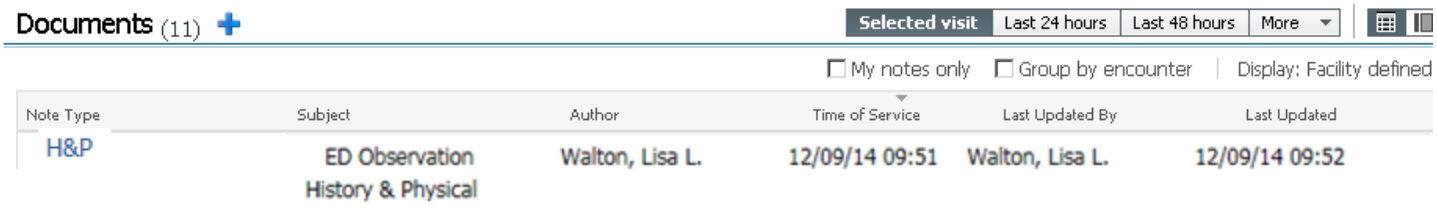
Completing your note

1. Once you have completed your note, click **Sign & Submit. No more changes can be made.**

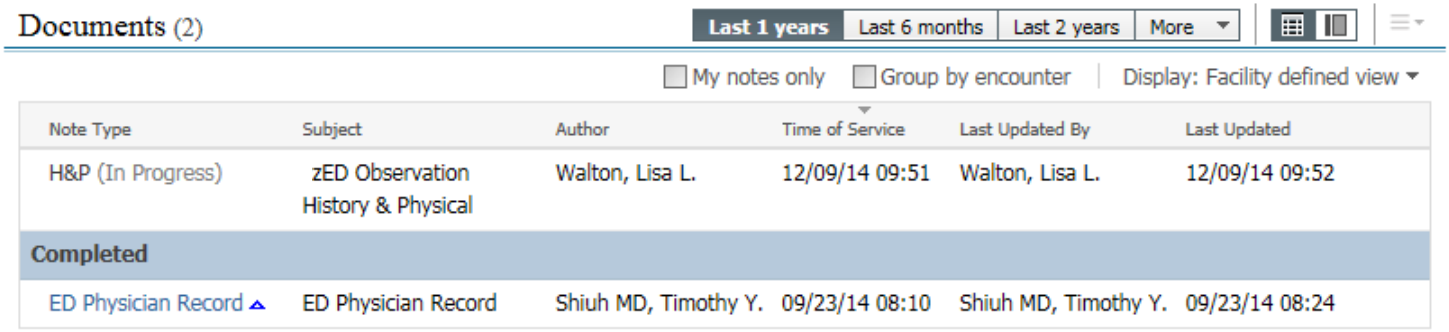


- To save the information without closing or signing, click **Save**.
- To save the information and close the note without signing, click **Save & Close**.
- Click **Cancel** to discontinue the note.

2. The Signed and Saved note will display in the patient's chart under Documents.

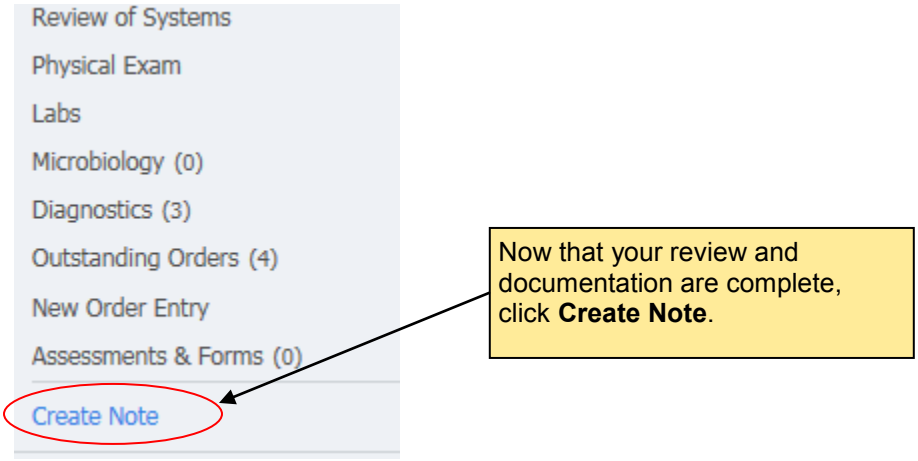


3. If you had Saved and Closed, the note would indicate (In Progress) and could be opened and modified.

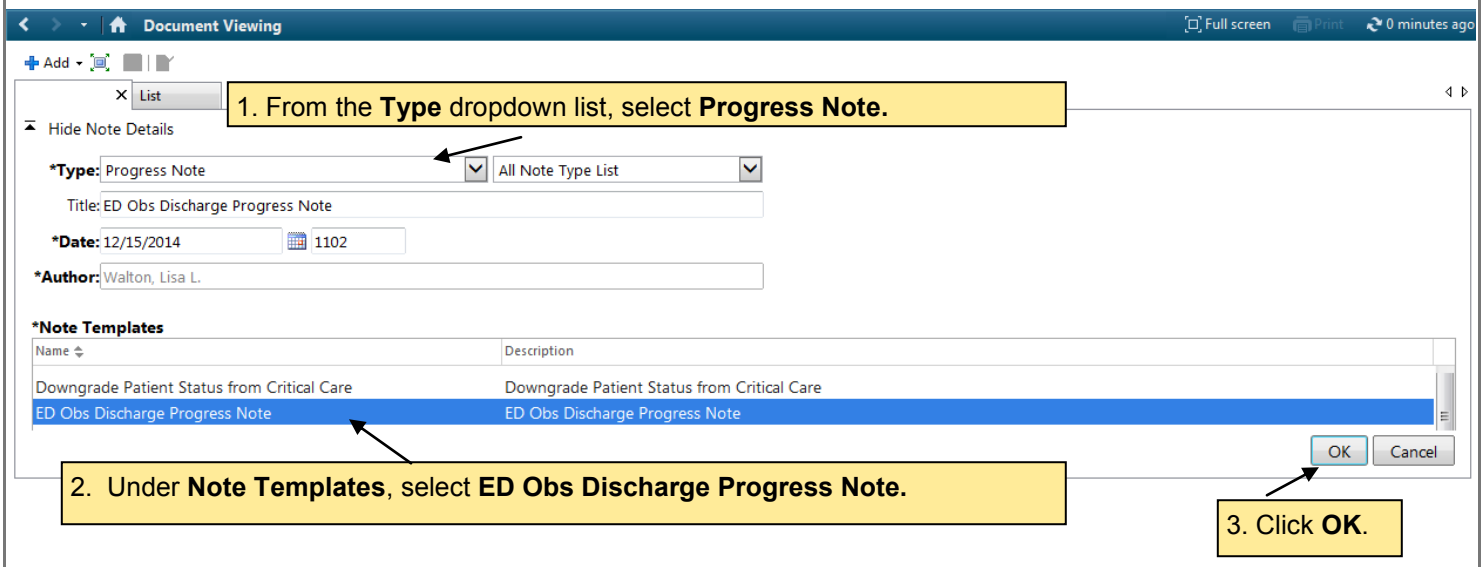


Discharge Note

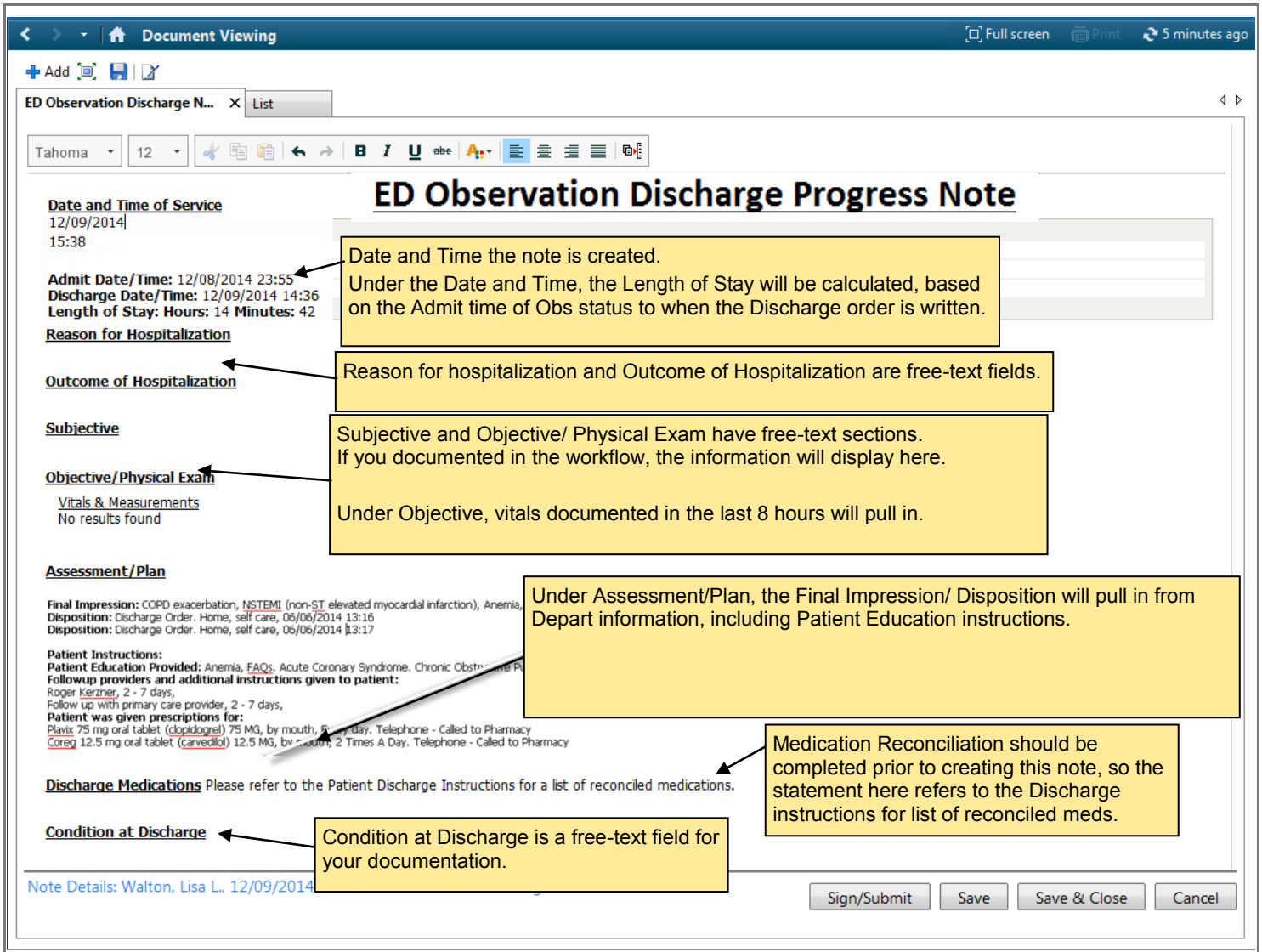
After the Depart process has been completed, you can create a Discharge Note.
Click Create Note on the Workflow.



To create your Discharge Note, complete the following:

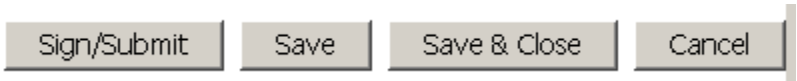


The Discharge Note displays.



Completing your note

1. Once you have completed your note, click **Sign & Submit. No more changes can be made.**



- To save the information without closing or signing, click **Save**.
- To save the information and close the note without signing, click **Save & Close**.
- Click **Cancel** to discontinue the note.

The Signed and Saved note will display in the patient's chart under Documents.