

Log-in to Dragon

1. On an AL computer, scan your badge.
2. If prompted on the Vergence log in screen, type your password.
3. On the Launchpad, click **Dragon** (no auto-launch).



4. The DragonBar opens.

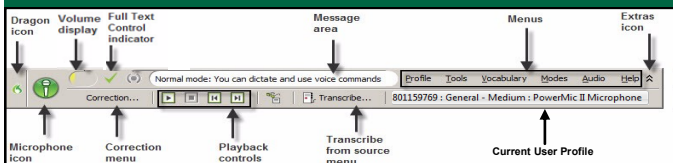
Switch between users

If you badge in while another user's session is open, there will be a delay, while their session closes and yours begins. The DragonBar will display this:



After the other user's session closes, your session will open. Check the DragonBar for the current user profile.

Dragon Bar



Log out of Dragon

REMEMBER!!

When you are finished working in Dragon, log out with the **X** on the Launchpad!

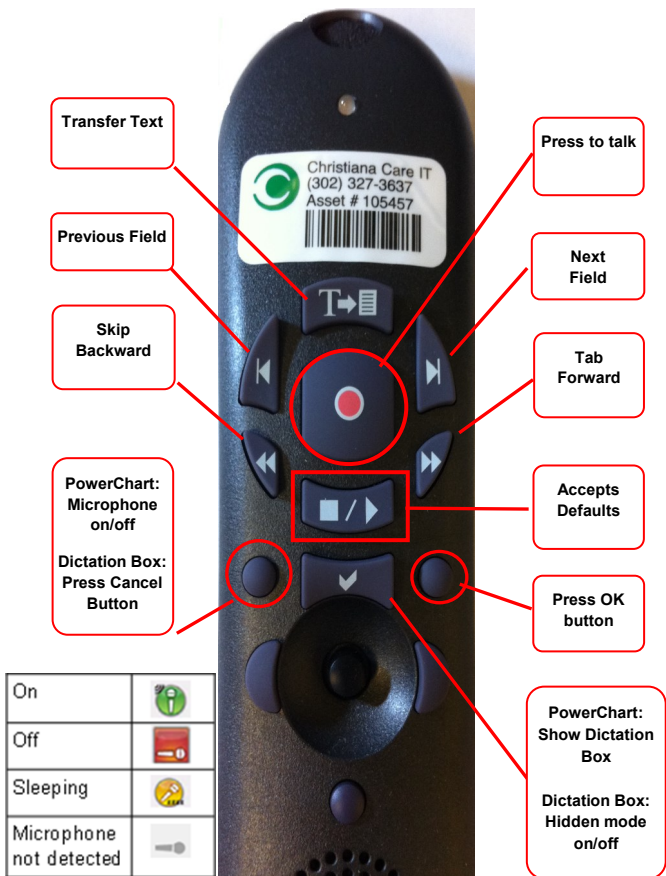
Failure to logout could risk the corruption of your user profile, which could prevent you from logging into a new session, or compromise the performance of Dragon.



If you think your profile has been corrupted, contact the **Help Desk (3637)**.

Repair of your profile could take anywhere from 5 minutes to 2 hours.

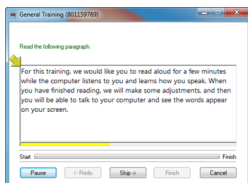
Microphone Settings



Improving Dragon Accuracy

During class, you completed a brief voice training. Improve the accuracy of Dragon by completing additional voice training.

1. In the menu, click **Audio**. Select **Read text to improve accuracy**.
2. The General Training window appears. Click **Go**.
3. Read the text as it appears in the display box.
Note: There is no need to press any buttons on the PowerMic II in this general training.
4. Select the text you would like to read. Suggested: What to Expect from Speech Recognition (Easier Reading: Instructional)
5. Click **OK**.
6. With the microphone positioned near your mouth, begin reading the text as it appears in the display area.
7. When you are finished, the Congratulations screen displays. Click **OK**.



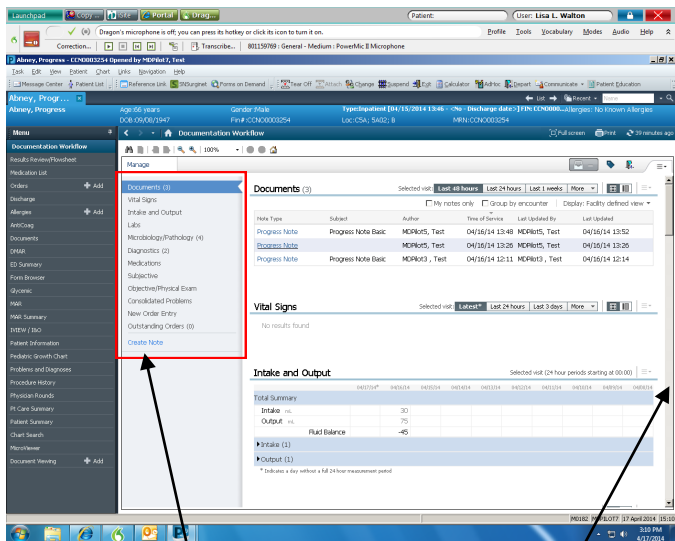
Basic Dragon Commands

Select <text> Select <text> through <text>	Cap that All Caps that No Caps that	New line New paragraph
Correct <text> <ul style="list-style-type: none"> • Select or Type <u>correct word</u> • Select or Say Train • Select or Say Go (May repeat this step 1-2 times) • Select or Say Done 	Go to bottom Go to Top Page up Page down Next field Previous field	Period . Comma , Colon : Semicolon ; Hyphen - Apostrophe '
Scratch that (may repeat more than once to keep erasing previous words/phrases)	Copy that Cut that Paste that Transfer text Insert After <text> Insert Before <text>	Open parenthesis (Close parenthesis) Open bracket [Close bracket] Percent sign %
What Can I Say (open the Dragon sidebar and display common voice commands for your current program, window, or text field)	Delete that Delete <text> Delete from <text> to <text> Delete <text> through <text>	Accept Defaults (clear [delimiters])

Progress Notes

The new Documentation Workflow page will make the creation of your progress note 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 **Documentation Workflow** will open. On the left is the **Workflow**.



The screenshot shows the PowerChart 2014 interface. The left sidebar contains a 'Menu' with 'Documentation Workflow' selected. The main area displays 'Documents (3)' and 'Vital Signs'. A red box highlights the 'Documents (3)' section in the sidebar. Two arrows point from text boxes at the bottom to the 'Documents (3)' section and the 'Intake and Output' section.

Note Type	Subject	Author	Time of Service	Last Updated By	Last Updated
Progress Note	Progress Note Basic	MDR015, Test	04/16/14 13:48	MDR015, Test	04/16/14 13:52
Progress Note		MDR015, Test	04/16/14 13:26	MDR015, Test	04/16/14 13:26
Progress Note	Progress Note Basic	MDR013, Test	04/16/14 12:11	MDR013, Test	04/16/14 12:14

Total Summary	
Intake	Output
30	75
Fluid Balance -45	

Click on each item to jump to that section.

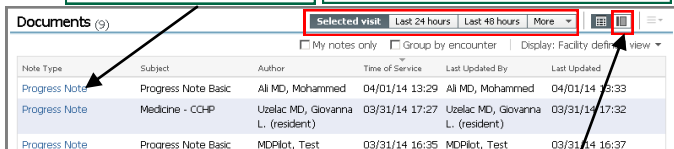
OR you can scroll down the page to review each section.

Documentation Workflow

Documents

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.

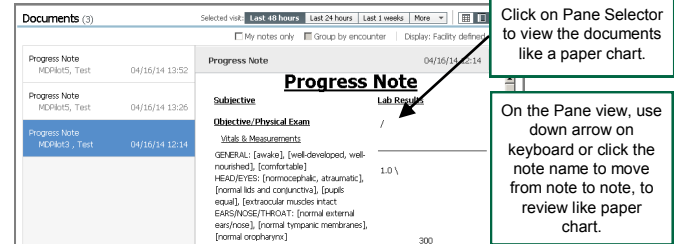


Documents (9)

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	MDPlot, Test	03/31/14 16:35	MDPlot, Test	03/31/14 16:37



Documents (3)

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

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

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]

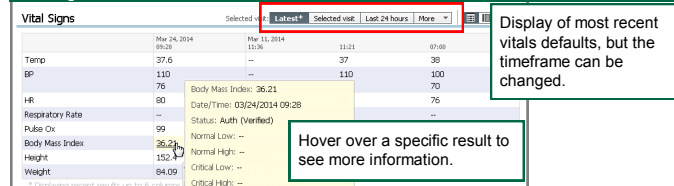
EARS/NOSE/THROAT: [normal external ears/nose], [normal tympanic membranes], [normal oropharynx]

Lab Results

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

Selected visit: Latest Selected visit: Last 24 hours More

	Mar 24, 2014	Mar 11, 2014		
Temp	37.6	37	38	
BP	110/76	110/70	100/70	
HR	80	76		
Respiratory Rate	--	--	--	
Pulse Ox	99			
Body Mass Index	36.21			
Height	152.4			
Weight	84.09			

Body Mass Index: 36.21

Date/Time: 03/24/2014 09:28

Status: Auth (Verified)

Normal Low: --

Normal High: --

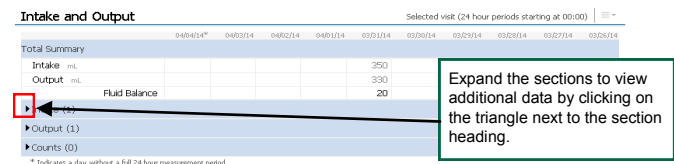
Critical Low: --

Critical High: --

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

Hover over a specific result to see more information.

Intake and Output



Intake and Output

Selected visit (24 hours starting at 00:00)

	04/04/14*	04/03/14	04/02/14	04/01/14	03/31/14	03/29/14	03/27/14	03/26/14	03/25/14
Total Summary									
Intake mL					350				
Output mL					330				
Fluid Balance					20				
Intake (1)									
Output (1)									
Counts (0)									

* Indicates a day without a full 24 hour measurement period

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

Documentation Workflow

Labs

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

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

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


Chemistries and CBCs will automatically pull into your Progress Note displayed as Fishbone labs.


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/ Pathology

Microbiology/Pathology (1) 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 and view the report.

Tag Microbiology/ Pathology information by navigating to **Documents** to locate and open the report. Highlight the information and choose **Tag**.



You may see a separate Progress Note to indicate that an exam **was not** completed, but you will no longer see Progress Notes to indicate an exam was completed. Use **Order Status**.

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

Documentation Workflow

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 - 280010056

*** 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: Aa/Aa
TR: 02-24-2014 07:29:00
VE: 02-24-2014 07:29:00

Result type: Chest
Result date: 24 Feb
Status: Auth
Document Title: 5400
Performed by: Evan
Verified by:
Encounter info: 3800

Tag

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

Documentation 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: 1

Status: ✔ Meds History

Adm. Meds Rec

✔ Disch. Meds Rec

Scheduled (3)

Continuous (0)

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

ondansetron (Ondansetron ODT (Zofran Nausea/Vomiting

zolpidem (Zolpidem (Ambien)) 5 MG, 1

zolpidem (Zolpidem (Ambien)) 2.5 MG, (

Admin

Discon

Order Specifications **Admission - Z77551, PHYS006**
Z77551, PHYS006 Age 33 years Gender: Female Type: Inpatient [01/24/2014 07:39 - 09:00] Discharge: 00- Allergies: No known allergies
 DOB: 01/24/1986 Fm#: 380010074 Loc: CAC, S401, B MRN: 2801010056

✔ Status ✔ Meds History ✔ Adm. Meds Rec ✔ Disch. Meds Rec

Orders Prior to Reconciliation

Medications	Status
acetaminophen (Acetaminophen (Tylenol)) (Acetaminophen 650 MG, 2 TAB, PO, Q4H, PRN: Pain Scale - Mild 1-3/Fever)	Ordered
nitroglycerin (Nitroglycerin (Nitrostat)) (Nitroglycerin 0.4 mg SL)	Documented
ondansetron (Ondansetron (Zofran ODT)) (Ondansetron 4 mg SL, Q 4H, PRN: Nausea/Vomiting)	Documented
zolpidem (Zolpidem (Ambien)) (Zolpidem 5 mg SL, Q 4H, PRN: Insomnia)	Documented

Orders After Reconciliation

Medications	Status
acetaminophen (Acetaminophen (Tylenol)) (Acetaminophen 650 MG, 2 TAB, PO, Q4H, PRN: Pain Scale - Mild 1-3/Fever)	Ordered
carvedilol (Carvedilol (Coreg)) (Carvedilol 6.25 MG, 1 TAB, PO, BID)	Ordered
ondansetron (Ondansetron (Zofran ODT)) (Ondansetron 4 mg SL, Q 4H, PRN: Nausea/Vomiting)	Ordered
zolpidem (Zolpidem (Ambien)) (Zolpidem 5 mg SL, Q 4H, PRN: Insomnia)	Ordered

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

- Name
- Dosage
- Route
- Frequency

Documentation Workflow

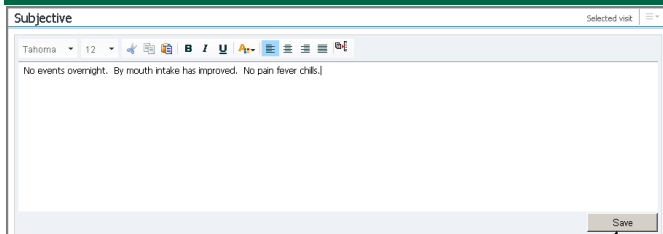
Subjective and Objective/ Physical Exam is where documentation begins.

Document, in most cases:

- Chief complaint
- Review of Systems (ROS)
- History of Present Illness (HPI)
- Past Family or Social History

Complete documentation is critical for records and billing.

Subjective



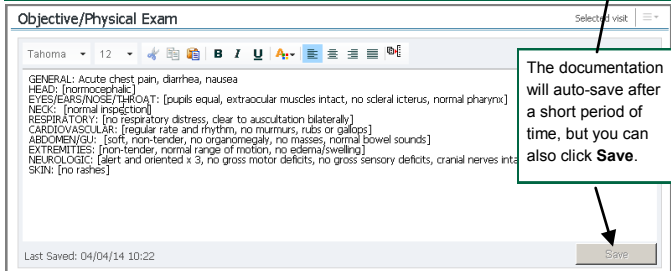
Subjective

Tahoma 12

No events overnight. By mouth intake has improved. No pain fever chills.

Save

Objective/Physical Exam



Objective/Physical Exam

Tahoma 12

GENERAL: Acute chest pain, diarrhea, nausea
HEAD: [normocephalic]
EYES/EARS/NOSE/THROAT: [pupils equal, extraocular muscles intact, no scleral icterus, normal pharynx]
NECK: [normal inspection]
RESPIRATORY: [no respiratory distress, clear to auscultation bilaterally]
CARDIOVASCULAR: [regular rate and rhythm, no murmurs, rubs or gallops]
ABDOMEN/GU: [soft, non-tender, no organomegaly, no masses, normal bowel sounds]
EXTREMITIES: [non-tender, normal range of motion, no edema/swelling]
NEUROLOGIC: [alert and oriented x 3, no gross motor deficits, no gross sensory deficits, cranial nerves intact]
SKIN: [no rashes]

Last Saved: 04/04/14 10:22

Save

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

Documentation Workflow

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

Free text

Click inside the text box and begin typing.

Auto-text

1. In the text field, type the special character of the auto-text you want to enter. You can also type the first few letters to shorten the list that returns.
2. In the list, double click on the auto-text.
3. Press **F3** on the keyboard to move to the first field.
4. Type the appropriate information.
5. Press **F3** to move to the next field.
6. If adding an X to select an option, be sure to use a capital X.
7. Continue this process until all of the appropriate fields are completed.

Dragon

1. In the text field, say the name of the Dragon command you want to enter.
2. Use the Dragon **Next Field key** (or say "Next field") to move to each bracketed field and dictate your findings.
3. If adding an X to select an option, 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 my Subjective and Objective 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.

You can also complete additional voice training to improve Dragon Accuracy. See page 3 for steps to complete.

Documentation Workflow

Consolidated Problems

Consolidated Problems list is a combined list of **problems and diagnoses**.

Active Problems carry forward from day to day.

Consolidated Problems

Classification: All

Add new as: This Visit

Q

Problems (2)

1 Sys hypertension (0) Chronic

This Visit

2 CAD (coronary artery disease) (0)



Chronic

This Visit

Inactive

Historical

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

Chronic problems also display and can be converted to a This Visit problem by hovering over the description and select the type.

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

Show Historical (1)

All Visits

Remove from This Visit

Resolve

Inactivate

Cancel

Move to Chronic

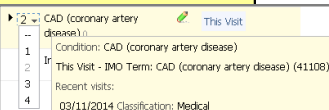
Move to This Visit

Prioritize the problems/diagnoses.

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

THE FIRST ON THE LIST SHOULD BE THE CHIEF COMPLAINT.

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) (0) This Visit

1 Condition: CAD (coronary artery disease)

2 This Visit - IMO Term: CAD (coronary artery disease) (41108)

3 Recent visits: 03/11/2014 Classification: Medical

4

Documentation Workflow

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.

New Order Entry +

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

New Order Entry +

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

Click **Sign** to complete the order.

Change order information by clicking **Modify**.

Documentation Workflow

Outstanding Orders

Outstanding orders are orders which have not been completed yet.

Outstanding Orders (1)

Last 24 hours for the selected visit

	Status	Ordered
CBC with diff	Ordered	04/03/14 11:00

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

Order: CBC with diff
Order Details: Once, Stat 04/07/2014 09:42, Lab Draw
Order Comments:
3 ml Purple top - Adult
Purple top tubes (EDTA) must contain a minimum of two (2) ml blood and not be clotted or hemolyzed.
0.3 ml Purple microtainer - Pediatric/Neonate
Fill peds microtainer to 1st line. Prefer 2nd line.
Order Date/Time: 04/07/2014 09:42
Start Date/Time: 04/07/2014 09:42
Status: Ordered
Ordered by: Shuh MD, Timothy Y.

Create Note

Documents (0)

Vital Signs

Intake and Output

Labs

Microbiology/Pathology (1)

Diagnostics (0)

Medications

Subjective

Objective/Physical Exam

Consolidated Problems

New Order Entry

Outstanding Orders (0)

Create Note

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

Progress Notes

To create your Progress Note, complete the following:

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

*Type: Progress Note
Title: Specialty
*Date: 4/21/2014 10:15
*Author: DOCTORPHYSDOC, Test

2. In the **Title** field, type or dictate your **specialty**.

*Note Templates

Name

- Brief Consult Note
- ED Physician Record
- ED Physician Record and Teaching Note
- ED Teaching Physician Record
- Procedure Note Bedside
- Progress Note Basic**
- Progress Note
- Emergency Department Physician Record with Teaching Note
- Emergency Department Teaching/Supervisory Note
- Bedside Procedure Note
- Daily Progress Note Basic
- Free Text Note Template

3. Under **Note Templates**, select the **note type**.

4. Click **OK**.

OK Cancel

Note Template Type	In addition to Subjective, Objective, Assessment Plan, also pulls in:
Progress Notes Basic	Vital Signs, Fish Bone Labs
Free-text Progress Note	None; blank text field for free text.
Procedure Note w/ Headers	None
Brief Consult Note	None
Progress Note with I/O	Vital Signs, Fish Bone Labs, I/O
Progress Note with Med List	Vital Signs, Fish Bone Labs, Medication List
Progress Note with Med List and I/O	Vital Signs, Fish Bone Labs, Medication List, I/O
There are a variety of department specific Note Templates. Please see your department Progress Notes Job Aid or refer to the PowerChart website listed below.	

Progress Notes

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 ...

IMPRESSION: NORMAL CHEST.

IMPRESSION: NORMAL CHEST.

Progress Note

Subjective
25 year old female admitted to the emergency department last evening with chest pain. Patient was diagnosed with hypertension. Patient was initially in substantial pain, but is now resting comfortably and without distress.

Objective/Physical Exam

Vitals & Measurements
T: 37.0 (Oral) HR: 60 RR: 21 Pulse O2: 99%

GENERAL: Acute chest pain, diaphoresis, nausea

HEAD: [nonmoose-hat]

EYES/EARS/NOSE/THROAT: [pupils equal, extraocular muscles intact, no scleral icterus, normal pharynx]

NECK: [normal inspection]

RESPIRATORY: [no respiratory distress, clear to auscultation bilaterally]

CARDIOVASCULAR: [regular rate and rhythm, no murmurs, rubs or gallops]

ABDOMEN/GU: [soft, non-tender, no organomegaly, no masses, normal bowel sounds]

EXTREMITIES: [non-tender, normal range of motion, no edema/swelling]

NEUROLOGIC: [alert and oriented x 3, no gross motor deficits, no gross sensory deficits, cranial nerves intact]

SKIN: [no rashes]

Assessment/Plan

CAD [coronary artery disease]
[]
Ordered: CBC with diff

Sys hypertension
[]
Ordered: CBC with diff

Insomnia
[]
Ordered: zolpidem, Dose of 2.5 MG = 0.5 TAB, PO, QHS, PRN for: Insomnia, Order Start: 04/04/2014 10:38

[1] 5400480: S48 MD, Sudhakar R, 01/27/2014 05:05 EST

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

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.

Progress Notes

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.]

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

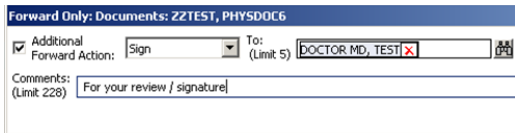
- On Documentation Workflow in the patient's chart, the Documents section will list the notes.
- Click on the note you wish to modify. The note opens.
- Right click and select Modify, or in the toolbar, click the **Modify** icon.
- At the bottom of the note, you will see ***Insert Addendum here:**.
You 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.

Progress Notes



Co-signature Process

My note needs to be cosigned. 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.



Forward Only: Documents: ZZTEST, PHYSDOC6

☒ Additional Forward Action: Sign To: (Limit 5) DOCTOR MD, TEST  


Comments: (Limit 228) For your review / signature

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.

Progress Notes

Co-signature Process

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.

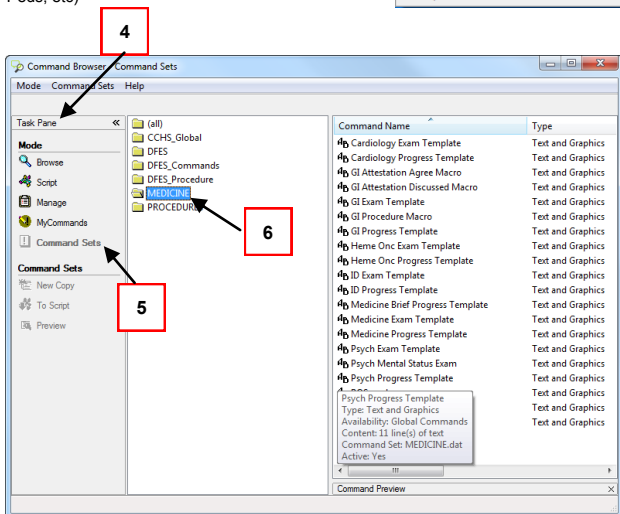
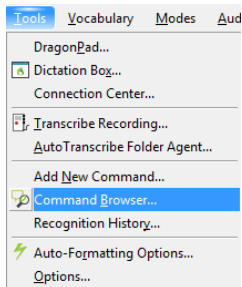
Dragon Command	Auto-text
Attending Agree Macro	=attending_attestation_agree
Attending Present Macro	=attending_attestation_present
Attending Agree Except Macro	=attending_attestation_except
Attending Reviewed Macro	=attending_attestation_reviewed
Attending Split Macro	=attending_attestation_split

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

General and Custom Dragon Commands

A list of general and custom created commands are available in Dragon's Command Browser. To view the list, follow these steps:

1. Open Dragon.
2. On the Dragon toolbar, click **Tools** and select **Command Browser** or say "Command Browser".
3. The Command Browser window opens.
4. On the left, click **Task Pane** to expand it so you can see the Modes.
5. Click **Command Sets**.
6. Click a folder type to see what commands are available by specialty (DFES, Medicine, Surgery, Peds, etc)



How do I make my own Dragon commands?

1. In **PowerChart**, dictate the information in a text field.
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 field.
6. Dictate the name for your new command.
7. Say "Plain text" to select the Plain text check box.
8. When finished, click **Save**.

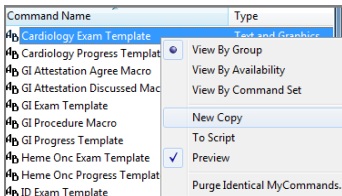
Recommended:

- 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.

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 auto-text?

Auto-text can be used anywhere you'd use a Dragon command and can be used in the event that Dragon is not available. 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**.
9. Click **Close**.

Recommended:

- Begin with special characters
- All words should be lowercase.
- Separate words with underscores, not spaces.

General Smart Templates

Smart templates pull information contained in PowerChart into the note.

Dragon Command	Auto-text	Description
Insert Antibiotic Orders	.antibiotic orders	For each antibiotic, # of days that antibiotic type has been administered (regardless of dose/ route changes) and current order detail
Insert Bipap	.bipap	Bipap settings
Insert Central Line	.central_line_day	Central Line - Number of days a central line has been present
Insert Code status	.code_status	DNR order - active
Insert Drain Output	.drain_output	Output from any drains recorded in I/O
Insert Hospital Day	.hospital_day	Hospital Day #
Insert I and O	.io	Intake and Output from last 24 hours (midnight to midnight)
Insert My Name	.my_name	My name
Insert Pain Score Trend	.pain_score_trend	Pain scores, Last 24 hrs
Insert Post op Day	.post_op_day_procedure	Post-op Day# and Name of procedure
Insert Post Void Residual	.post_void_residual	Post void residual volumes
Insert Pressors	.pressors	List of active inotrope or pressor orders
Insert Signature	.sign	Name, Date, Time
Insert Stress Ulcer prophylaxis	.stress_ulcer_prophylaxis	Stress ulcer prophylaxis medication orders
Insert Urine Output	.urine_output_last_8hrs	Urine output over last 8 hours

General Smart Templates– continued

Dragon Command	Auto-text	Description
Insert Vent Settings	.vent_settings	Vent Settings: Most recent vent settings (documented in Powerchart)
Insert Vent Weaning Parameters	.vent_weaning_parameters	Vent Weaning: Most recent vent weaning parameters (documented in Powerchart)
Insert VTE Prophylaxis	.vte_prophylaxis	VTE Risk, Medications ordered, contraindications to prophylaxis
Insert Vitals	.vitals_4hrs	Vitals: last set within previous 4 hrs
Insert Vitals Last	.vitals_8hrs	Vitals: last set within previous 8 hrs
Insert Vitals min max	.vitals_min_max	Vitals: last set of vitals with min/max for each result from the past 24 hrs
Insert Weight Change	.weight_change	Weight change from last documented weight this encounter

Labs Smart Templates

Smart templates pull information contained in PowerChart into the note.

Dragon Command	Auto-text	Description
Insert ABG	.abg_last_12hrs	Labs: ABG - Last result within past 12 hours
Insert ABG Last	.abg_last_24hrs	Labs: ABG - Last result within past 24 hours
Insert ABG Last Three	.abg_last_3_results	Labs: ABGs last 3 results (3 sets)
Insert Anemia Labs	.anemia labs	Labs: Anemia (Bili, Direct Bili, Direct Coombs, Ferritin, Haptoglobin, TIBC, SPEP, Folate, LDH, Retic)
Insert Body Fluid Analysis	.body_fluid_labs	Labs: Last results for body fluid analysis, this encounter only
Insert Cardiac Labs	.cardiac_labs_12hrs	Labs: Cardiac enzymes + BNP (most recent within last 12 hrs)
Insert Cardiac Labs Last	.cardiac_labs_last	Labs: Cardiac enzymes + BNP (last resulted for this encounter)
Insert Coags	.coag_labs_12hrs	Labs: PT, INR, PTT, DIC, Fibrinogen, Thrombin Time - within last 12 hours
Insert Coags Last	.coag_labs_last	Labs: PT, INR, PTT, DIC, Fibrinogen, Thrombin Time - last from encounter
Insert CSF	.csf_labs	Labs: Lab testing for CSF analysis
Insert D Dimer	.d_dimer_labs	Labs: D Dimer
Insert Differential	.differential_24hrs	Labs: Differential (WBC) - within last 24hrs
Insert Differential Last	.differential_last	Labs: Differential (WBC) - last from encounter
Insert Electrolytes Other	.electrolytes_other	Labs: electrolytes, other (Mg, Phos, Ca)
Insert Fishbone Labs	.fishbone_labs	Labs: Chem7 and CBC in a fishbone format

Labs Smart Templates—continued

Dragon Command	Auto-text	Description
Insert GI Labs	.gi_labs_12hrs	Labs: GI Labs (LFTs, Lipase, ammonia, amylase) - within last 12 hrs
Insert GI Labs Last	.gi_labs_last	Labs: GI Labs (LFTs, Lipase, ammonia, amylase) - last from encounter
Insert Glycemic Trend	.glycemic_trend	Labs: Glycemic trend - glucose results from today and previous day
Insert Heme Onc levels	.hem_onc_levels	Labs: Tacrolimus and Cyclosporine levels
Insert Hepatitis Labs	.hepatitis_labs	Labs: Hepatitis lab results
Insert H and H trend	.hh_trend	Labs: Last 3 Hemoglobin & Hematocrit results
Insert Lactate	.lactate_12hrs	Labs: Serum lactate level - within last 12 hours
Insert Lactate Last	.lactate_last	Labs: Serum lactate level - last from encounter
Insert LFT	.lft_12hrs	Labs: Liver Function Tests - within last 12 hours
Insert LFT Last	.lft_last	Labs: Liver Function Tests - last from encounter
Insert Lipids	.lipid_profile_labs	Labs: Lipid Profile
Insert Tacrolimus Trend	.tacrolimus_trend	Labs: Tacro trend (Last 3 Tacrolimus results)
Insert Thyroid Labs	.thyroid_labs	Labs: TSH, Free T4
Insert Tox Labs	.tox_labs	Labs: Toxicology (Aspirin, Tylenol, ETOH levels, Urine Drug Screen)
Insert Troponin Trend	.troponin_trend	Labs: Troponin Trend (Last 3 Troponin results)

Labs Smart Templates—continued

Dragon Command	Auto-text	Description
Insert Urine Studies	.urine_studies	Labs: U/A, HCG, Drug Screen (If both Point of care and Lab studies, will result most recent set)
Insert VBG	.VBG_12hrs	Labs: VBG - Last result within past 12 hours
Insert VBG Last	.VBG_24hrs	Labs: VBG - Last result within past 24 hours
Insert VBG Last Three	.VBG_last_3_results	Labs: VBGs last 3 results (3 sets)
Insert WBC	.wbc_only	Labs: WBC only