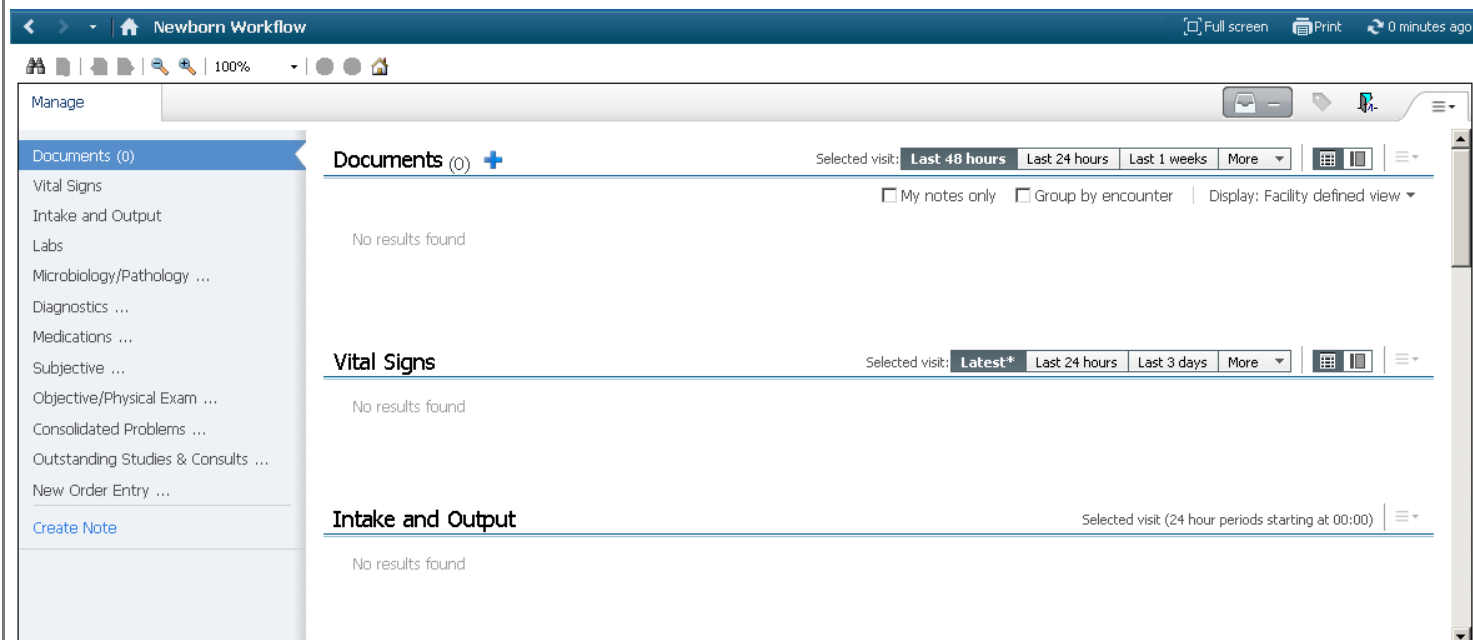


Newborn Workflow

The new Newborn Workflow to document and create Progress Notes can be found in your menu options.

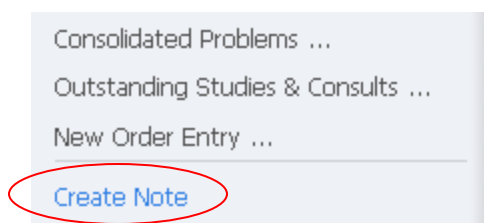
A screenshot of the 'Newborn Workflow' application interface. The top navigation bar shows 'Newborn Workflow' with icons for 'Full screen', 'Print', and '0 minutes ago'. Below the navigation bar is a 'Manage' sidebar with a list of document types: Documents (0), Vital Signs, Intake and Output, Labs, Microbiology/Pathology ..., Diagnostics ..., Medications ..., Subjective ..., Objective/Physical Exam ..., Consolidated Problems ..., Outstanding Studies & Consults ..., and New Order Entry ... There is a 'Create Note' link at the bottom of the sidebar. The main content area displays three sections: 'Documents (0)' with a '+', 'Vital Signs', and 'Intake and Output'. Each section has a 'Selected visit:' dropdown menu and a 'No results found' message. The 'Documents (0)' section has a 'Selected visit:' dropdown with options 'Last 48 hours', 'Last 24 hours', 'Last 1 weeks', and 'More'. The 'Vital Signs' section has a 'Selected visit:' dropdown with options 'Latest*', 'Last 24 hours', 'Last 3 days', and 'More'. The 'Intake and Output' section has a 'Selected visit (24 hour periods starting at 00:00)' dropdown.

Newborn Workflow– Documenting History and Physical

When documenting History and Physical for a newborn, go through the Newborn workflow and use the following Dragon commands or auto-text in the Objective section.

Newborn History and Physical Content Macros		
Description	Dragon Command	Auto-text
Comprehensive Male Newborn macro	Male Newborn Exam macro	=newborn_male_history_and_physical
Comprehensive Female Newborn macro	Female Newborn Exam macro	=newborn_female_history_and_physical

After you completed your review and documentation in the workflow, click **Create Note**.



Hide Note Details

1. From the **Type** dropdown list, select **H & P**.

*Type: H&P Position Note Type List

Title: NB Newborn History and Physical

*Date: 6/2/2014 1036

*Author: Walton, Lisa L.

2. Under **Note Templates**, select **NB Newborn History and Physical**. The Title field will update with this name.

*Note Templates

Name	Description
Brief Consult Note	Consultant Initial Brief Note
Consult Note	Consult Note
ED Physician Record	Emergency Department Physician Record
ED Physician Record and Teaching Note	Department Physician Record with Teaching Note
ED Teaching Physician Record	Emergency Department Teaching/Supervisory Note
NB Newborn History and Physical	Newborn History and Physical
NB Progress Note	Newborn Progress Note
NB Progress Note Newborn Discharge	Newborn Discharge Progress Note

3. Click **OK**.

OK Cancel

Newborn Workflow– Documenting History and Physical

This note is unique to Pediatrics. 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.

Newborn History and Physical
List

Tahoma
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Newborn History and Physical

Subjective
Objective/Physical Exam
Vitals & Measurements
Assessment/Plan
Single Liveborn

Documentation you entered on the workflow will pull in here:

- Subjective
- Objective/ Physical Exam
- Vitals

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

Delivery History
Delivery Date - Baby A : 04/16/2014 18:00
Method of Delivery : Vaginal
Presentation-Baby A : Cephalic
Gest Age at Delivery-Baby A : 36.4
Sex-Baby A : Male
Birth Weight (gm)-Baby A : 3500
Length (cm)-Baby A : 53.3
Maternal History Labs
Rh: , Rhogam:
Medication List
Vitamin K-Baby A
Erythromycin-Baby A
Hepatitis A-Hepatitis B Vaccine
acetaminophen
Lab Results
Transcutaneous 88 Milligram/
Bilir
Diagnostic Results

Vitamin K 1 mg IM Given; Left Thigh
Given Both Eyes
1.00 ML
45.00 MG

The following information will pull from the workflow:

- Delivery History (this will always indicate Baby A for a single baby)
- Maternal History Labs
- Active Medication Orders
- Neonatal labs (Fishbone labs, bilirubin, blood type)
- Diagnostic Results

When complete, click **Sign/Submit**.

Note Details: History & Physical, Walton, Lisa L., 05/16/2014 13:48, Newborn History and Physical

Sign/Submit
Save
Save & Close
Cancel

This H&P will display in the Newborn Workflow under Documents.

Documents (3) +		Selected visit: Last 48 hours Last 1 weeks Last 3 months More				<input type="checkbox"/> My notes only <input type="checkbox"/> Group by encounter Display: Facility defined view			
Note Type	Subject	Author	Time of Service	Last Updated By	Last Updated				
Progress Note	Progress Note Newborn	Kleban, Sharon	05/14/14 17:10	Kleban, Sharon	05/14/14 17:10				
Progress Note ▲	Progress Note Labor	Kleban, Sharon	05/14/14 17:01	Kleban, Sharon	05/14/14 17:10				
Progress Note	Wednesd	Name: Progress Note							
	Wednesd	Status: Modified			05/14/14 16:59				

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Newborn Workflow– Documenting Newborn Progress

1. On subsequent days, review the Newborn Workflow. You will see the H&P and new information to review.
2. Use the following Dragon commands or auto-text in the Objective section.

Content Macros		
Description	Dragon Command	Auto-text
Newborn progress	Newborn Progress macro	=newborn_progress

3. After reviewing, click **Create Note**.
4. From the Type dropdown list, select **Progress Note**.
5. Under Note Templates, select **NB Progress Notes Newborn**. The Title field will update with this name.
6. Click **OK**.
7. The Progress Note Newborn displays. This note is unique to Pediatrics. Information from the workflow and OBIS pulls into the Note. To be compliant, your Progress Note must be different on each Date of Service. While the assessment/plan may not change much from day to day, the vitals and labs will be different.

Progress Note Newborn

Subjective

Objective/Physical Exam
No results found
Vitals & Measurements

Assessment/Plan
Single Liveborn

Documentation you entered on the workflow will pull in here:

- Subjective
- Objective/ Physical Exam
- Vitals

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

Maternal History/Labs
Maternal Urine Drug Screen
U Amphetamine : Negative
U Opiate : Negative
U Cocaine : Negative
U SP GR : 1.010
U PH : 5.5 pH units

27 yo White female, G6, P3025 @ 37.2 weeks gestation

Medication List
Inpatient
Hepatitis A-Hepatitis B Vaccine (Twinrix), 1.0 ML, IM (intramuscular), Once

Lab Results
Transcutaneous 88 Milligram/
Bilir

Diagnostic Results

The following information will pull from the workflow:

- Maternal History
- Active Medication Orders
- Neonatal labs (Fishbone labs, bilirubin, blood type)
- Diagnostic Results

When complete, click **Sign/Submit**.

Note Details: Progress Note, Walton, Lisa L., 05/16/2014 13:59, Progress Note Newborn

Sign/Submit Save Save & Close Cancel

You can also use the following Smart Templates to insert data from PowerChart into your Subjective and Objective sections of Workflow or Progress Note.

Progress Note Newborn Smart Templates		
Description	Dragon Command	Auto-text
Peds Apgar score @ 1, 5 and 10 minutes (from OBIS)	Insert Apgars	.peds_apgar
Peds height and head circumference	Insert Pediatric Measurements	.peds_height_head_circumference
Peds hours of life	Insert Hours of Life	.peds_hours_of_life
Peds Maternal drug screen to Peds chart	Insert Mom Drug Screen	.peds_maternal_drugs_screen
Peds Maternal Prenatal Labs to Peds chart (from OBIS or PowerChart - whichever is most recent)	Insert Mom Prenatal Labs	.peds_maternal_prenatal_labs
Peds Medications administered through OBIS	Insert OBIS Peds Meds	.peds_medications
Peds Maternal admission history to the Pediatric Chart (from OBIS)	Insert Mom Admission history	.peds_mom_adm_hx
Peds: NAS scores and trend (Peds) for past 24 hrs	Insert NAS	.peds_nas_trend
Peds Delivery Complications from maternal chart (from OBIS)	Insert Newborn Complications	.peds_newborn_complications
Peds Delivery history from maternal chart (from OBIS)	Insert Newborn Delivery History	.peds_newborn_delivery_hx
Peds labs - Bili (tot, dir, neo dir, transcutaneous), Retic, Diff, Type & DAT)	Insert Newborn Labs	.peds_newborn_labs
Peds Maternal pregnancy complications to the Peds chart (from OBIS)	Insert Mom Pregnancy Complications	.peds_preg_complications
Peds Weight change from birth with % calculation	Insert Pediatric Weight Change	.peds_weight_change
Peds Hearing screen result	Insert Pediatric Hearing screen result	.peds_hearing_screen_result

Newborn Workflow– Documenting Newborn Discharge

1. On the day of anticipated discharge, review the Newborn Workflow.
2. Use the following Dragon commands or auto-text in the Subjective section.
3. If the infant doesn't require a formal discharge summary, after reviewing, click **Create Note**.
4. From the Type dropdown list, select **Progress Note**.
5. Under Note Templates, select **NB Progress Notes Newborn Discharge**. The Title field will update with this name.
6. Click **OK**.
7. The Progress Note Newborn Discharge displays. This note is unique to Pediatrics. Information from the workflow and OBIS pulls into the Note.
8. This note will be faxed to the PCP so any additional notes to communicate should be documented in this section.

Progress Note Newborn Disc...
List

Tahoma
12

Progress Note Newborn Discharge

Subjective

Objective/Physical Exam

No results found
Vitals & Measurements

Assessment/Plan

Single Liveborn

Documentation you entered on the workflow will pull in here:

- Subjective
- Objective/ Physical Exam
- Vitals

Under **Assessment/ Plan**, use Dragon, auto-text or free text to populate pertinent discharge information.

Maternal History/Labs

Maternal Urine Drug Screen

U Amphetamine : Negative
U Opiate : Negative
U Cocaine : Negative
U SP GR : 1.010
U PH : 5.5 pH units

27 yo White female, G6, P3025 @ 37.2 weeks gestation

Medications Administered

Vitamin K 1 mg IM Given; Left Thigh
Given Both Eyes
1.00 ML
45.00 MG

Lab Results

Transcutaneous 88 Milligram/
Bilir

Diagnostic Results

Content Macros

Description	Dragon Command	Auto-text
Newborn Discharge	Newborn Discharge macro	=newborn_discharge

The following information will pull from the workflow:

- Maternal History
- Comprehensive Inpatient Medication List
- Neonatal labs (Fishbone labs, last ordered bilirubin level, blood type)
- Diagnostic Results

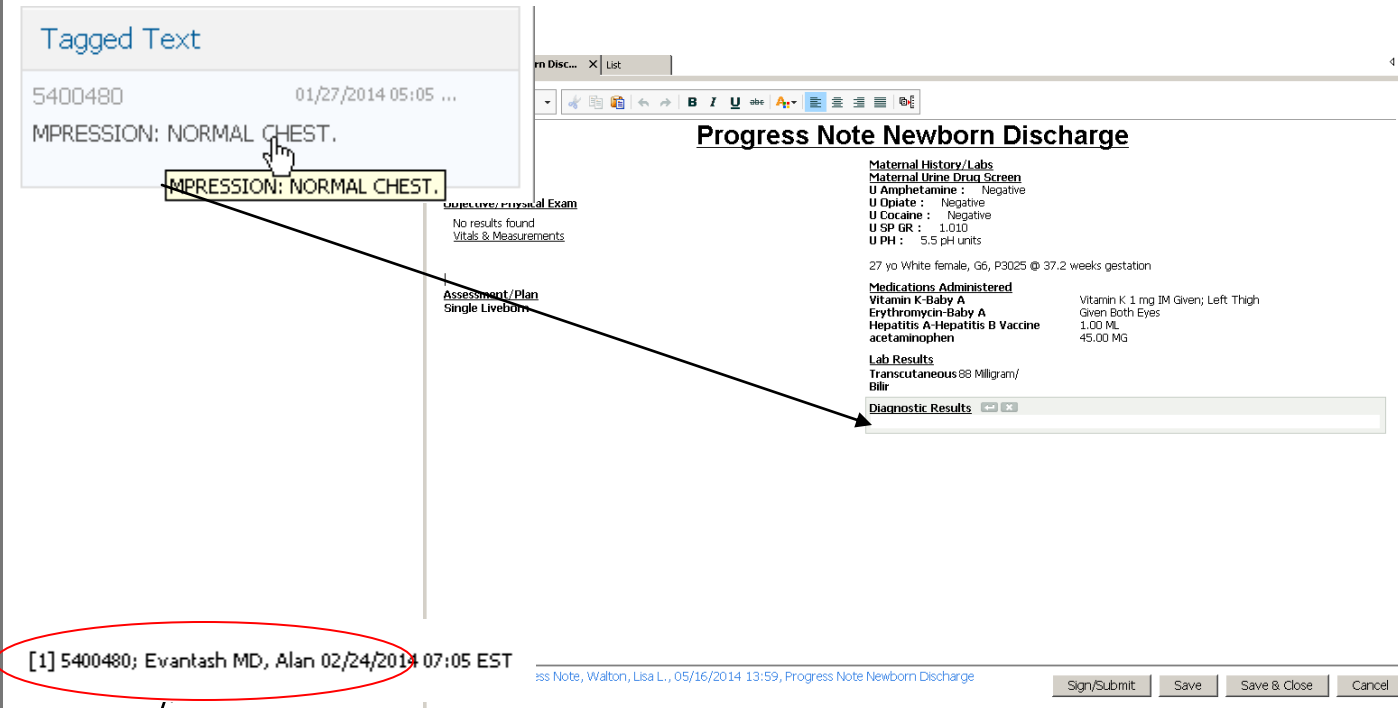
Note Details: Progress Note, Walton, Lisa L., 05/1

When complete, click **Sign/Submit**.

Sign/Submit Save Save & Close Cancel

Progress Note– Adding tagged text

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



Tagged Text

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

MPRESSION: NORMAL CHEST.

MPRESSION: NORMAL CHEST.

Assessment/Plan
Single Liveborn

Maternal History/Labs
Maternal Urine Drug Screen
U Amphetamine : Negative
U Opiate : Negative
U Cocaine : Negative
U SP GR : 1.010
U PH : 5.5 pH units

27 yo White female, G6, P3025 @ 37.2 weeks gestation

Medications Administered
Vitamin K-Baby A
Erythromycin-Baby A
Hepatitis A-Hepatitis B Vaccine
acetaminophen

Lab Results
Transcutaneous 88 Milligram/
Bilir

Diagnostic Results

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

ss Note, Walton, Lisa L., 05/16/2014 13:59, Progress Note Newborn Discharge

Sign/Submit Save Save & Close Cancel

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

Progress Note–Refreshing/Free text fields/Deleting



Parts of the Progress Note, like Lab Result can be refreshed to import the most recent information.
Hover over the title and click the **Refresh** icon that displays.

Add a free text field to document additional information.
Hover over the title and click the **Insert Free Text field** icon.
Information added here does not update on the Documentation Workflow.

Sections can be deleted if that information is not pertinent to your progress note.
Hover over the title and click the **Delete** icon that displays.

Consultations– Removing Diagnosis fields

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

Assessment/Plan

CAD (coronary artery disease)



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

Completing the Note

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




Modifying a Saved Note

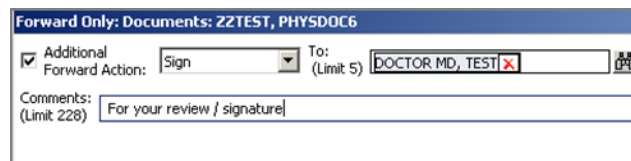
If you saved your note, click on the note in the Documents list of Documentation Workflow to open it for editing.

Modifying a Signed Note


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

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

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

A screenshot of a web-based dialog box titled 'Forward Only: Documents: ZZTEST, PHYSDOC6'. It contains a checkbox labeled 'Additional Forward Action:' which is checked, with a dropdown menu showing 'Sign'. To the right is a 'To:' field with '(Limit 5)' and the text 'DOCTOR MD, TEST' followed by a red 'X' icon. Below this is a 'Comments:' field with '(Limit 228)' and the placeholder text 'For your review / signature'. There is an 'OK' button in the bottom right corner.

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
Newborn Attending	Newborn Attending macro	=newborn_attending

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

How do I customize existing specialty Dragon commands?

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

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

How do I make my own Dragon commands?

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

Recommended:


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

How do I make my own auto-text?

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

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



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