



Physician PowerChart Orientation

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(x44988)



How to Build Location Specific Patient Lists

Training Video Location: Coming Soon!

Step 1: Click on Patient List



Step 2: Click on Wrench



Step 3: In bottom right corner of "Modify Patient Lists box" click New

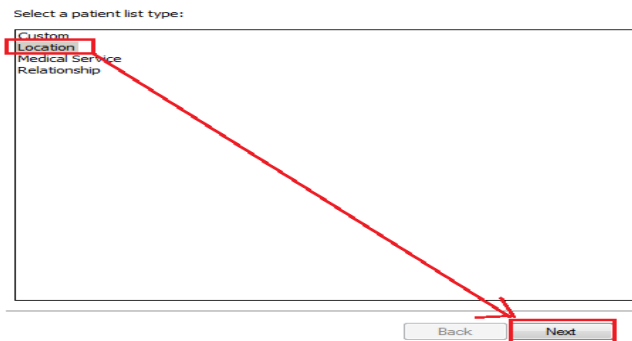


Step 4: Select a patient list type:

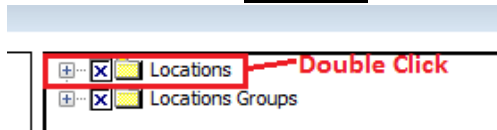
Most common: Location List or Relationship List

Building a Location List:

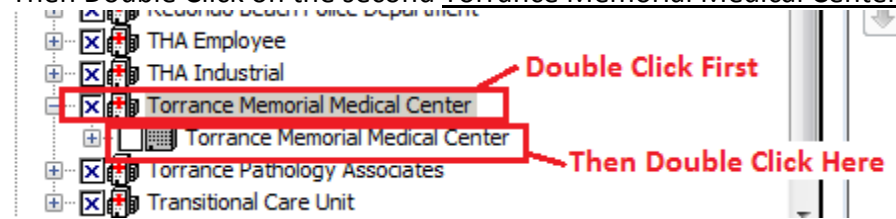
a. Click on Location, then click Next




b. Double click on Locations to show all available locations.



c. Double Click on the Location of Torrance Memorial Medical Center
Then Double Click on the second Torrance Memorial Medical Center

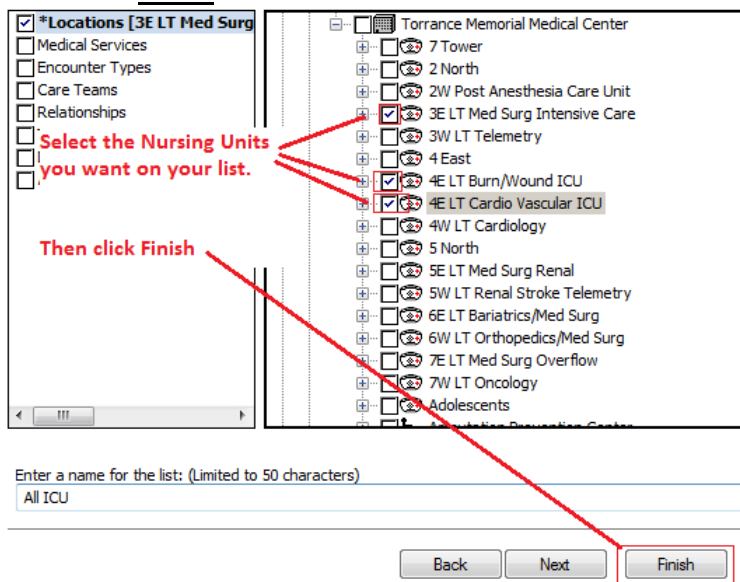


d. Now you are able to access all Nursing Units in the Hospital

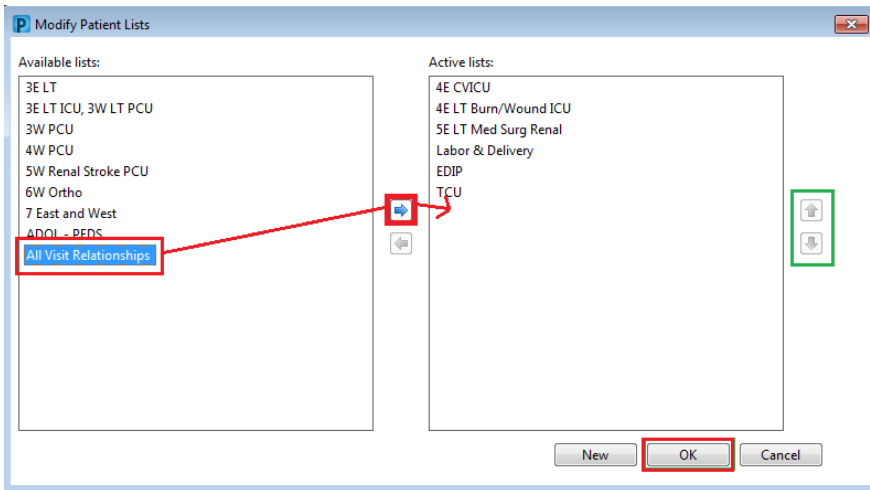
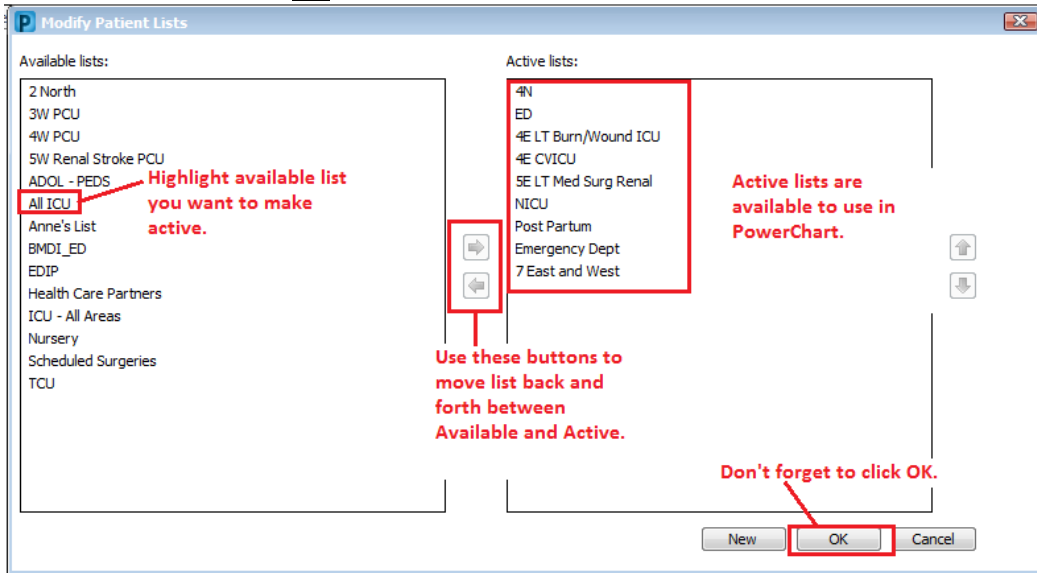
Select the nursing units (denoted with a  icon) you want to include in your list.

In the below example, we have created a list with all three ICU Units. Make sure you name your list appropriately.

Then click Finish.

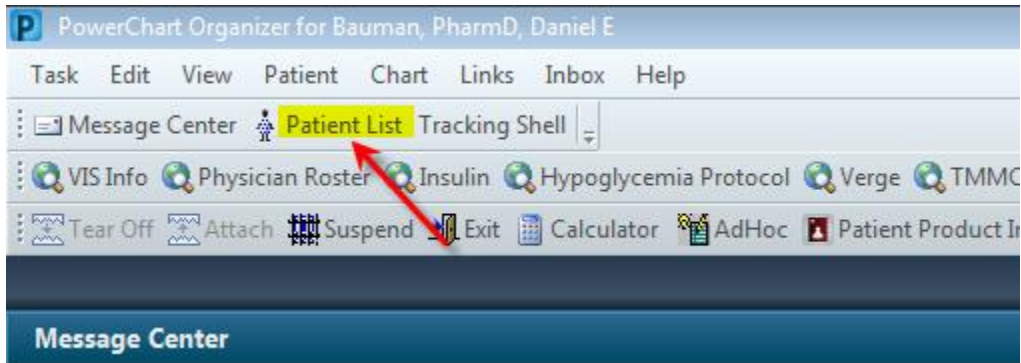


Step 5: Last Step, make sure you highlight and move your newly created list over to the active list column, then click OK.

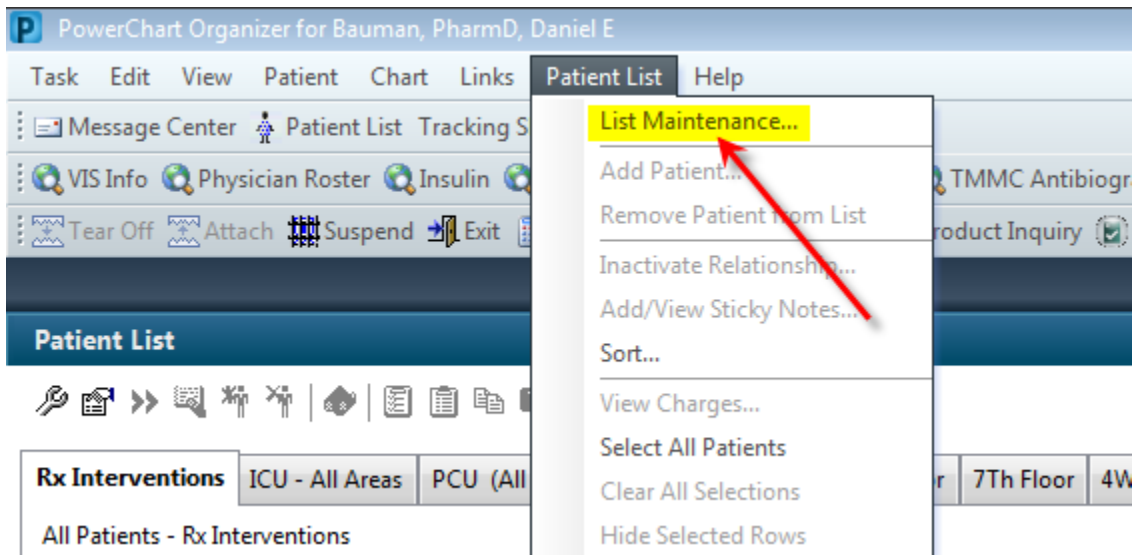


How to Build a Relationship Based Patient List

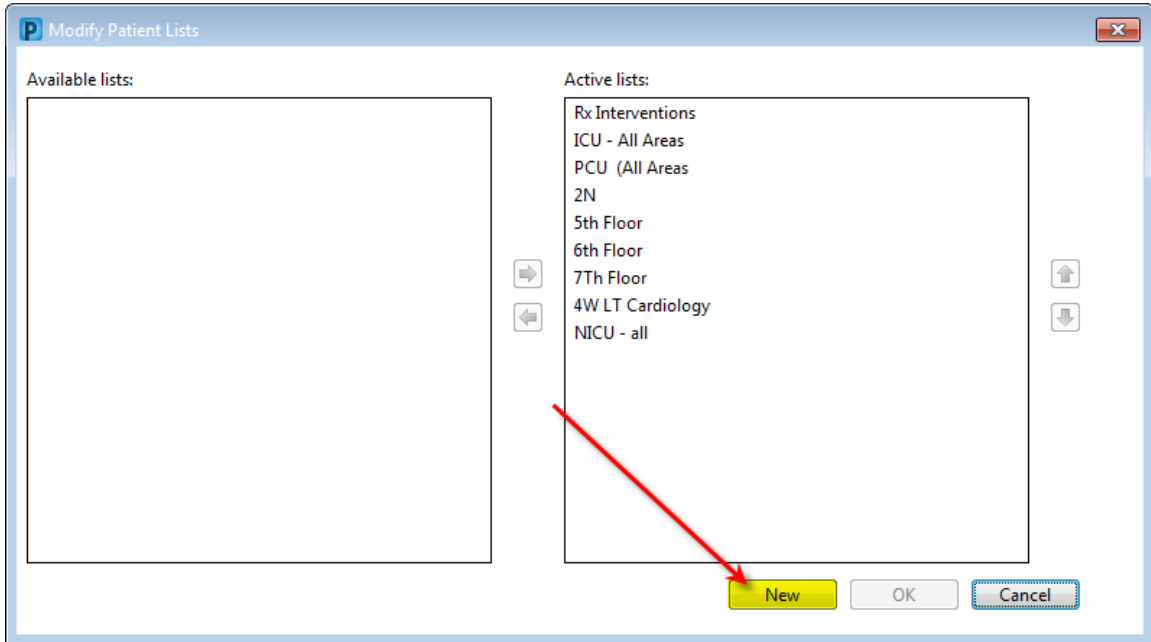
Click on “Patient List”.



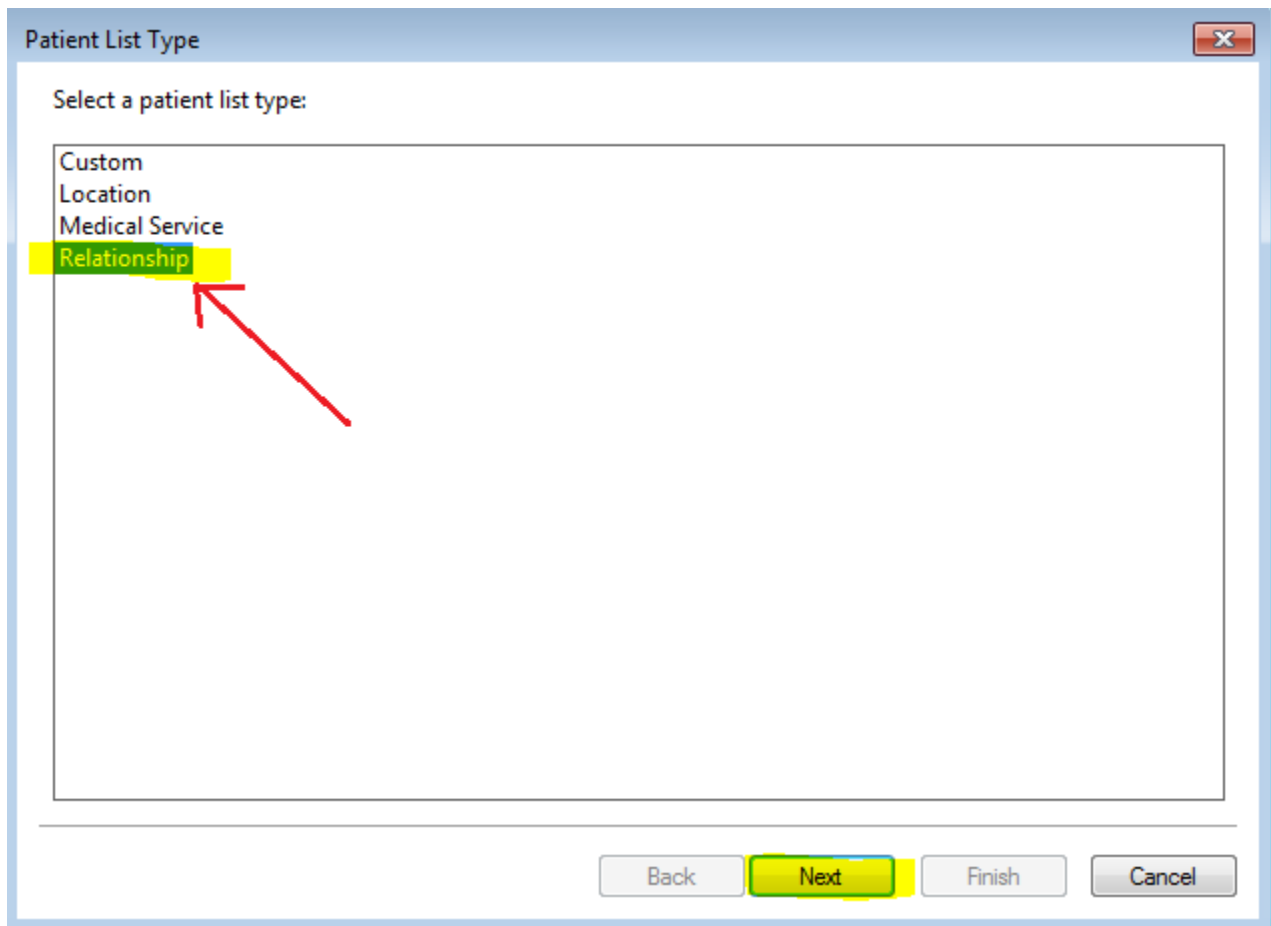
Go to “Patient List” in the toolbar and select “List Maintenance” from the drop-down.



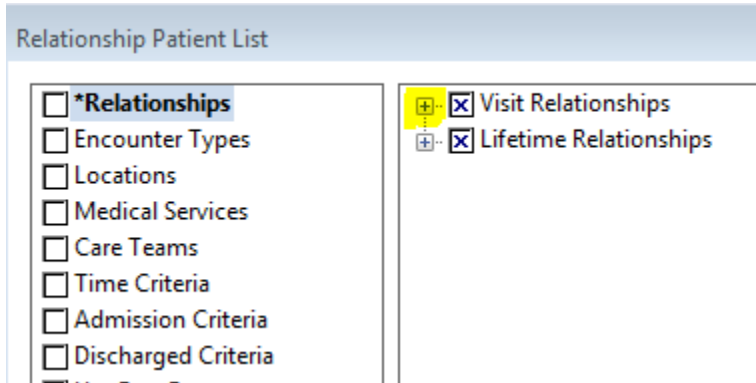
Click on the “New” button.



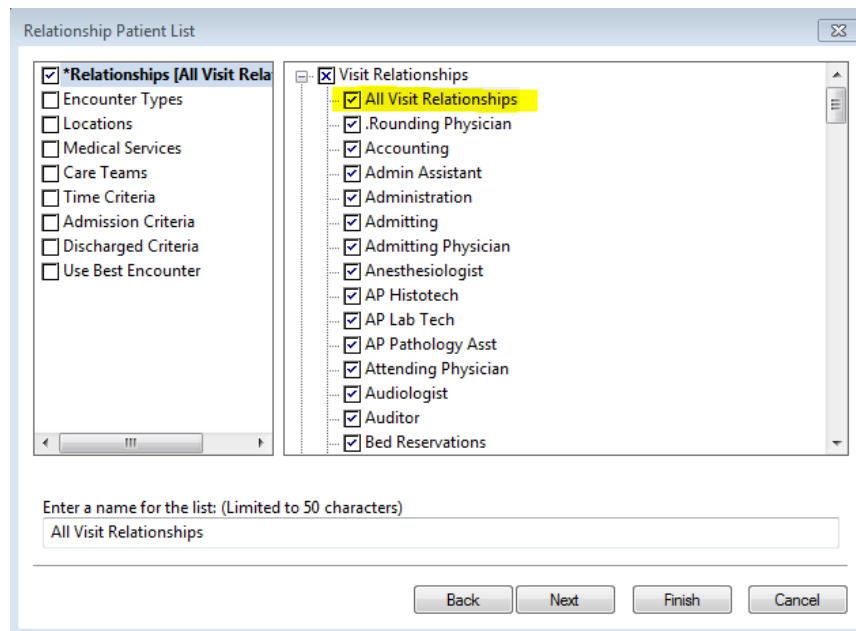
Select "Relationship". Then Click "Next".



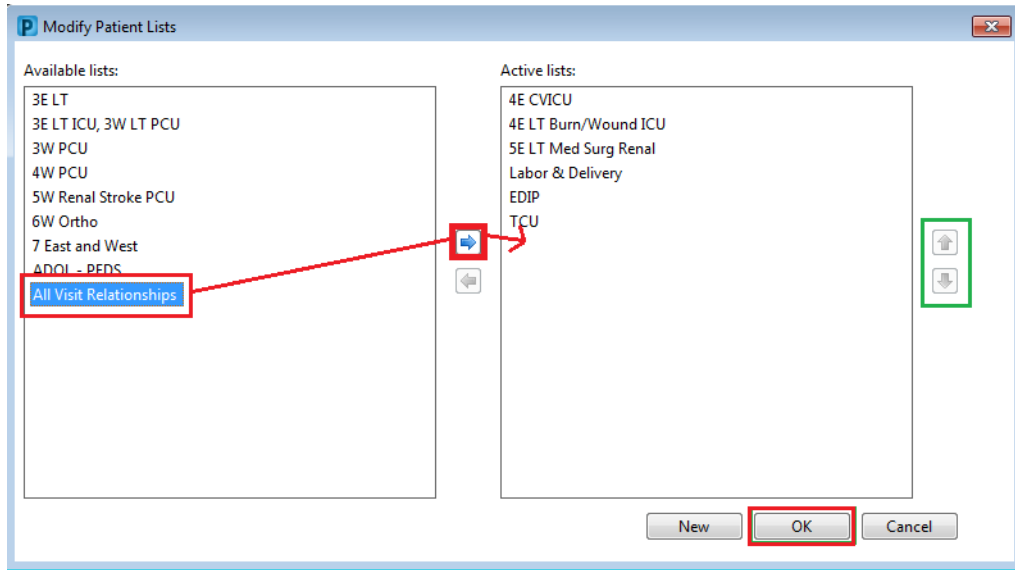
Use Plus to open “Visit Relationships”



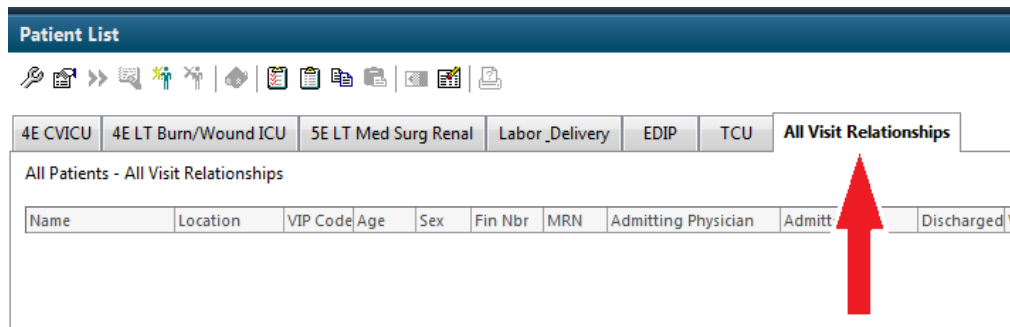
Put a check mark in All Visit Relationships. Click Finish.



Click on the new “All Visit Relationships” list name and then click on the arrow to pull the new list into the “Active lists” in the right pane and then click “OK”. The order of the tabs can be changed by highlighting the tab and clicking the up and down arrows on the right.



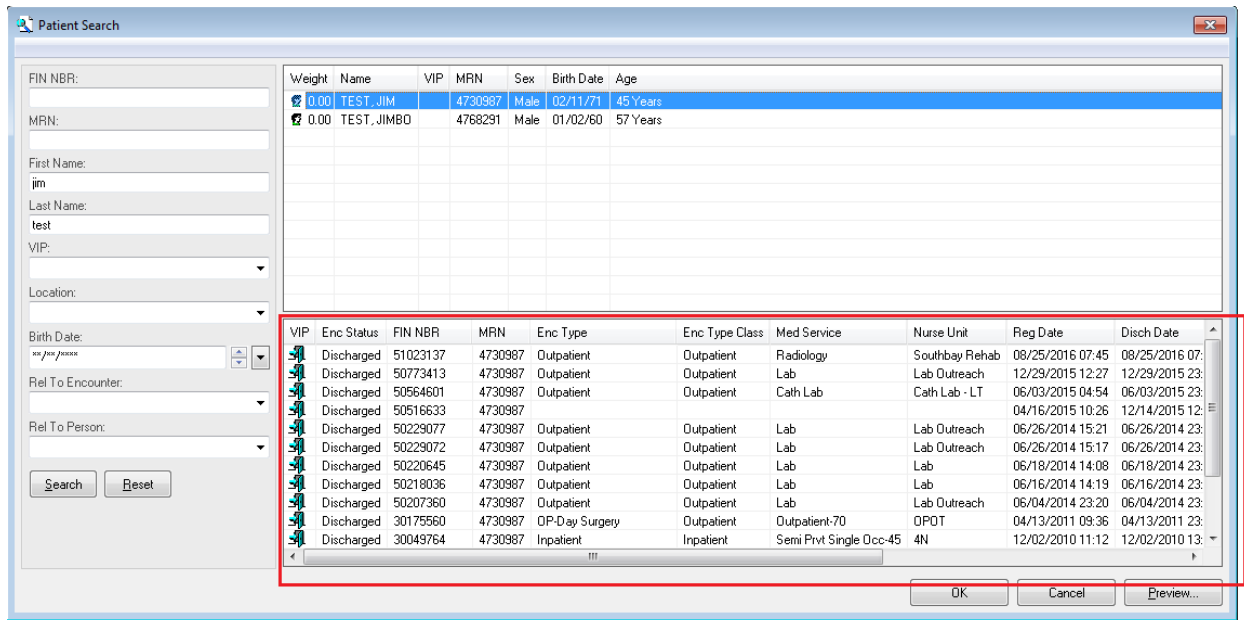
The new custom tab will appear on the patient list.



Critical: Opening/Documenting in the Correct Chart!

Medical Record Number (MRN): Unique patient specific number associated to all of the patients charts.

Financial Number or Encounter Number (FIN): Chart specific number. Each FIN number is associated only to one chart.



Inside the red box above are all of the charts for patient: Test, Jim.

You must NOT just double click on the patient’s name, please be sure to pick the correct chart from the red boxed area. You can look at type, registration date, or nursing unit to assist you in picking the correct chart. Once chart is located, double click on the chart.

Once a chart is open you can use the Banner Bar to determine if you are about to document in the correct chart.



Dynamic Documentation - Physician Quick Tips

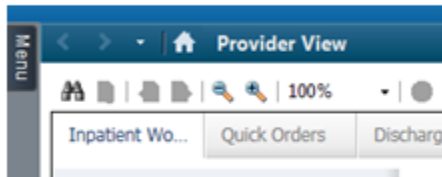


Navigating the Chart:

Menu vs. Provider View MPage

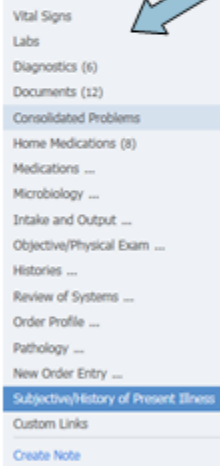
The familiar Menu tab is still available but streamlined to promote ease of use / reduce clutter.

The Biggest change is the new Provider View MPage. This will act as the hub of navigating the chart putting everything a physician needs to see right at their fingertips.



Two Ways of Navigating:

1. Use Table of contents to quickly scroll through MPage.



2. By clicking on an item header you will be taken to that particular area of the chart. Example: Clicking on Diagnostics will take you to that tab in All Results. You may also click and drag to re-sequence.

Diagnostics (6)

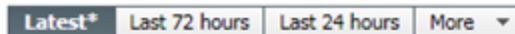
3. Navigating back: as with a web browser you may click the "back" arrow to return to most recent page.

If you want to jump back to the Provider View MPage

the "house" icon will always take you there directly.



4. Physicians may adjust viewable ranges with the click of a button.



Consolidated Problem List:

Located within the Physician View MPage the Consolidated Problem list is a collection of "this visit" and "chronic" problems for this patient.

It is important to maintain an up to date Consolidated Problem List to support ICD coded documentation.

Items added to this list as "This Visit" will be automatically pulled into the Assessment and Plan / Dx. section of your note.

Conditions added as "Chronic" or "Historical" will pull into the Problem List / Past Medical History sections of your notes.

Common Definitions:

This Visit = ICD coded diagnoses for this encounter

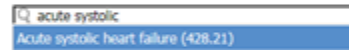
Chronic = SNOMED coded problems, will cross between encounters

Adding a New Consolidated Problem:

1. Set "Add New As" to what you are trying to add.

Add new as: This Visit

2. Search for and select the Consolidated Problem.



Common Consolidated Problem List Functions:

Click to highlight the existing Consolidated Problems to modify.

Modify each type (This Visit vs. Chronic) separately, you may multi-select within each type.

Use modify drop-down to make changes quickly and easily.



Historical = Mark this visit or chronic problems as historical when they are no longer impacting the patient.

Resolved = Used for chronic problems only to move from Consolidated Problem List to Historical. Will not remove a "this visit" diagnosis from the list.

Inactive = Chronic problems can be made inactive, indicating they are not impacting the patient.

Cancel = Removes Chronic Problems entirely.

Remove from This Visit = Removes This Visit diagnoses entirely from this encounter.

Note: The Consolidated Problem List is shared list amongst all providers.

Creating a New Note:

1. Click "Create Note" from Provider View MPage.

Create Note

2. Choose a Note Type. This will determine where this note will file in the patient's record.

New Note x List

Hide Note Details

*Type: [dropdown menu]

Title: [text field] template below ***

*Date: [text field] 1440

*Author: [text field]

[dropdown menu]

- History and Physical
- Progress Note-Generic
- Consultation Note - Generic
- Transfer Summary
- Discharge Summary
- Death Summary

3. Enter a specific title of the document if needed for improved communication. Otherwise, the name of the template will become the title of the document.

Title: Admission H & P

4. Ensure document Date/Time are Correct.

*Date: 06/09/2015 [calendar icon] 1440

5. Double-click a reference template from the bottom of the page. A new note opens.

***Note Templates**

| Name | Description |
|--|-------------|
| *** Please choose correct template below *** | *** Ple |
| Admission H & P | Admiss |
| Consult Note | Consul |

6. There is a free-text template available to physicians to use if they simply want to dictate or type the entire note. This note is also available to those whose entire note can be inserted with an AutoText.

General Note Free Text Note Template

Signing vs. Saving:

For each note you have the option of Signing or Saving. When a note is signed, it becomes a permanent part of the medical record and can only be added. If a note is saved it is available for editing from Message Center or from the documents section in the Provider View MPage, simply open the saved document.

Saved documents are available to be seen in the record as a "Preliminary Report".

Canceling an unsigned document will delete it from the record entirely. You may not cancel a signed note.

Sign/Submit Save Save & Close Cancel

Adding / Voiding a Note:

If you need to edit a signed document you may edit / add an addenda from the documents section.

1. Click on the Documents header in the Provider View MPage. This will take you to the Documentation section of PowerChart.

Documents (13) +

2. Select the document from the list by single clicking on it. The options of Modify and In Error (Void) are available directly above the note.

Modify In Error

Choosing Modify will allow you to add an addenda as well as strike through existing documentation. Choosing In Error will allow you to completely strike through the entire note.

Notes that are entered on the wrong patient will need to be placed In Error and re-created in the correct record. They cannot be moved to the correct chart. You may choose to Copy the entire note and Paste it into a General — Free Text note within the correct chart to save time. Contact Clinical Informatics for assistance.

Creating Personal AutoText:

AutoText is a simple way of adding a redundant or large block of text that you use repeatedly. We have global Autotext, available to all users, however you can make AutoText which are all your own.

1. Click on the Manage AutoText icon, when creating a note, to begin creating a personal template.



2. To create a new template click on the "Create New" icon.



3. Enter an abbreviation, this will be what you type in to access the AutoText. It must have a repeated character at the beginning. We commonly use "//". You may enter a description as well.

| | |
|---------------|---|
| Abbreviation: | <input type="text" value="//autotext_name_here"/> |
| Description: | <input type="text" value="You may enter a description."/> |

4. Click on the Add Text button.



5. In the BOTTOM Dynamic Documentation box enter the text you want to call up using your AutoText.

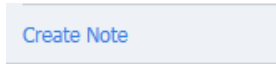
| | | |
|---|------|--|
| Auto Text as viewed in Dynamic Documentation (HTML) | | |
| Font | Size | |
| <input type="text" value="Enter text here."/> | | |

6. Click OK, then click Save and your AutoText is ready to use!

Accessing Global AutoText:

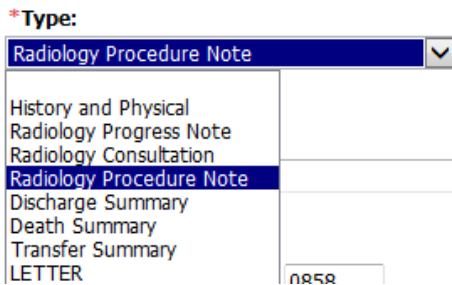
// " is used to access the majority of TMMC Global AutoTexts. You are encouraged to type "//" and review the existing list to explore your options.

Creating a Simple Radiology Procedure Note

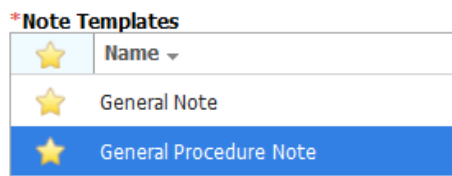


1. Click on Create Note

2. Choose a note "Type" of Radiology Procedure Note

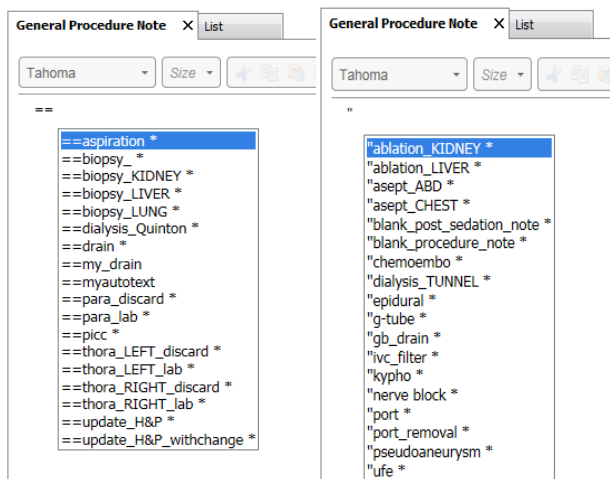


3. Choose a Note Template of "General Procedure Note", then click "OK" at bottom right to open note.



4. Insert procedure template by typing the prefix (== or ") then double clicking on the Template for the procedure you just completed. (ex. to do a PICC note enter == and choose ==picc template)

== for most Radiology Procedures / " (apostrophe, apostrophe) for Interventional Radiology



5. Modify the note where necessary.



6. Click Sign/Submit

Catalog of All Physician AutoText

| Anesthesia |
|--------------------------------|
| //anesth_Vitals_Measurements |
| Emergency Department |
| //ed_provider_attestation |
| //ed_scribe_attestation |
| //edadulthpishort |
| //edadultpe-basic8 |
| //edadultpe-eyedetailed |
| //edadultpe-trauma-basic8 |
| //edadultros-genmed |
| //edadultros-trauma |
| //edlabs_this_encounter |
| //edpedspe-adolescent |
| //edpedspe-child |
| //edpedspe-infant/toddler |
| //edpedspe-neonate |
| //edpedsros-child/adol |
| //edpedsros-infant/toddler |
| //edpedsocialhx-adol |
| //edpedsocialhx-child |
| //edtriage_vital_signs |
| Cardiology |
| //card_cath_angio_intervention |
| //card_cath_diagnostic |
| //card_pci_femoral |
| //card_pci_radial |
| //card_pe_complete |
| //card_pericardiocentesis |
| //card_radial_diagnostic_angio |
| //card_ros_complete |
| //ep_AVNRT_ablation |
| //ep_AVRT_ablation |
| //ep_BiV_implant |
| //ep_EPS&ILR |
| //ep_ICD_change |
| //ep_ICD_implant |
| //ep_IRL |
| //ep_PPM_gen_change |

| |
|------------------------------------|
| //ep_RF_PVI |
| //ep_aflutter_ablation |
| //ep_cryo_PVI |
| //ep_perm_pacer_implant |
| //ep_vtach_ablation |
| |
| Gastroenterology |
| //gi_colonoscopy |
| //gi_egd |
| //gi_egd_with_peg |
| //gi_ercp |
| //gi_eus |
| //gi_pe |
| //gi_rectal_eus |
| //gi_ros |
| General |
| //acs_timi_risk |
| //adult_I&O |
| //chadsvasc |
| //coreAMI |
| //coreCHF |
| //coreSTROKE |
| //curb65 |
| //pressure_ulcer_documentation |
| //rcri |
| Microbiology |
| //micro_1week |
| //micro_90days |
| //micro_encounter |
| Neonatology/Newborn |
| //neonate_PE_DischargeSummary_Boy |
| //neonate_PE_DischargeSummary_Girl |
| //neonate_PE_H&P_Boy |
| //neonate_PE_H&P_Girl |
| //neonate_PE_ProgressNote |
| //new_ros |
| //newborn_FollowUP_PE_Girl |
| //newborn_FollowUp_PE_Boy |
| //newborn_Initial_PE_Boy |
| //newborn_Initial_PE_Girl |

| |
|------------------------------------|
| //newborn_RN_resuscitation |
| //newborn_bilirubin |
| //newborn_screening |
| //newpe |
| //nicu_Apnea/Brady |
| //nicu_CRP |
| //nicu_Respiratory |
| Nephrology |
| //nephpe |
| //nephros |
| |
| |
| OB/GYN |
| //ob_Delivery_Data |
| //ob_History_of_Present_Illness |
| //ob_L&Dassessment |
| //ob_Maternal_History |
| //ob_PP_RN_AssessmentObjective |
| //ob_PP_RN_AssessmentSubjective |
| //ob_PhysicalExam_H&P |
| //ob_Pregnancy_History |
| //ob_Review_of_Systems |
| //ob_circumcision |
| Oncology/Hematology |
| //onc_brief_pe |
| //onc_brief_ros |
| //onc_full_pe |
| //onc_full_ros |
| //heme_brief_pe |
| //heme_brief_ros |
| //heme_full_pe |
| //heme_full_ros |
| Pediatrics |
| //peds_Birth_History_Immunizations |
| //peds_Discharge_Neo_Jaundice |
| //peds_H&P_Assessment/Plan |
| //peds_History_Of_Present_Illness |
| //peds_PE_Adolescent_FEMALE |
| //peds_PE_Adolescent_MALE |

| |
|------------------------------------|
| //peds_PE_Infant/Toddler |
| //peds_PE_Neonate |
| //peds_Review_Of_Systems |
| //peds_billing |
| //peds_hospital_course |
| //peds_lumbar_puncture |
| //peds_surgical_Patient_Male |
| //peds_surgical_patient_Female |
| Hospitalist |
| //hosp_pe_followup_pt |
| //hosp_pe_new_pt |
| //hosp_ros_followup_pt |
| //hosp_ros_new_pt |
| //internal_med_ros |
| //pecomplete |
| //peshort |
| //roscomplete |
| //rosinternalmedicine |
| //rosshort |
| |
| Infectious Disease |
| //idpe |
| //idreviewedrad |
| //idros |
| //idsocialhistory |
| Intensivists |
| //aline |
| //bronch |
| //bronch_ebus |
| //bronch_navigational |
| //icupe |
| //icuros |
| //intubation |
| //triple_lumen |
| History and Physical Update |
| //update_H&P |
| //update_H&P_withchange |
| Lab Results |
| //lab_encounter_most_recent |
| //lababg |

| |
|--|
| //laball_latest_36hours_this_encounter |
| //labbloodtype |
| //labbmp |
| //labbnp |
| //labcardiac |
| //labcardiacworkuped |
| //labcbc |
| //labcoags |
| //labcsf |
| //labddimer |
| //labesrcrp |
| //lablft |
| //lablipase |
| //labs18months |
| //labs1month |
| //labs24hours |
| //labs6months |
| //labserumketones |
| //labthyroid |
| //laburinalysis |
| //laburinedip |
| //laburinepregnancy |
| //laburineserumtox |
| //labvbg |
| |
| |
| |
| Radiology Results |
| //radall_36_hours |
| //radall_latest_36_hours |
| //radall_latest_90_days |
| //radall_latest_this_encounter |
| //radall_this_encounter |
| //radct_36_hours |
| //radct_latest_36_hours |
| //radct_latest_90_days |
| //radct_latest_this_encounter |
| //radct_this_encounter |
| //radcxr_36_hours |
| //radcxr_latest_36_hours |

| |
|--------------------------------|
| //radcxr_latest_90_days |
| //radcxr_latest_this_encounter |
| //radcxr_this_encounter |
| //radmri_36_hours |
| //radmri_latest_36_hours |
| //radmri_latest_90_days |
| //radmri_latest_this_encounter |
| //radmri_this_encounter |
| //radnm_36_hours |
| //radnm_latest_36_hours |
| //radnm_latest_90_days |
| //radnm_latest_this_encounter |
| //radnm_this_encounter |
| //radus_36_hours |
| //radus_latest_36_hours |
| //radus_latest_90_days |
| //radus_latest_this_encounter |
| //radus_this_encounter |
| //radxr_36_hours |
| //radxr_latest_36_hours |
| //radxr_latest_90_days |
| //radxr_latest_this_encounter |
| //radxr_this_encounter |
| Sleep Studies |
| //sleeplatency_multiple |
| //sleepstudy-full_night |
| //sleepstudy-split_night |
| Surgery |
| //surgpe_L2-3 |
| //surgpe_L4 |
| //surgpe_L5 |
| //surgros_L2-3 |
| //surgros_L4 |
| //surgros_L5 |

Radiology Procedure Specific AutoText

| Radiology AutoText | |
|-----------------------------------|---|
| ==aspiration | Aspiration |
| ==biopsy_ | Biopsy, generic |
| ==biopsy_KIDNEY | Kidney mass biopsy |
| ==biopsy_LIVER | Liver mass biopsy |
| ==biopsy_LUNG | Lung biopsy |
| ==dialysis_QUINTON | Quinton catheter placement |
| ==drain | Drain Placement |
| ==para_discard | Paracentesis, fluid discarded |
| ==para_lab | Paracentesis, fluid sent to lab |
| ==picc | Picc Line Insertion |
| ==thora_LEFT_discard | Left thoracentesis, fluid discarded |
| ==thora_LEFT_lab | Left thoracentesis, fluid sent to lab |
| ==thora_RIGHT_discard | Right thoracentesis, fluid discarded |
| ==thora_RIGHT_lab | Right thoracentesis, fluid sent to lab |
| ==update_H&P | H&P update text |
| ==update_H&P_withchange | H&P update text, with changes from original |
| Interventional Radiology AutoText | |
| "ablation_KIDNEY | Renal mass ablation |
| "ablation_LIVER | Liver mass ablation |
| "asept_ABD | Tunneled drainage catheter, abdomen |
| "asept_CHEST | Tunneled drainage catheter, chest |
| "blank_post_sedation_note | Generic Procedure Note - Post Sedation |
| "blank_procedure_note | Generic Procedure Note |
| "chemoembo | Chemoembolization of Liver mass |
| "dialysis_TUNNEL | Tunneled dialysis catheter placement |
| "epidural | Epidural steroid injection |
| "GB_drain | Cholecystostomy tube placement |
| "G-tube | G-tube placement |
| "IVC_filter | IVC filter placement |
| "kypho | Vertebral augmentation |
| "nerve_block | Transforaminal selective nerve root injection |
| "port | Port placement |
| "port_removal | Port removal |
| "pseudoaneurysm | Pseudoaneurysm ablation |
| "UFE | Uterine Artery Embolization |
| "update_H&P | H&P update text |
| "update_H&P_withchange | H&P update text, with changes from original |

List of OB Physician Notes for Dynamic Documentation

1. **Admission H&P**
 - a. Enter shortcuts from below list into proper sections
2. **Progress/SOAP Note**
 - a. Use for Labor checks, Antepartum patients or patients in labor as needed
3. **Post Vaginal Delivery Note**
 - a. Information will flow in from nursing or you can enter your own
 - b. Fill out Delivery Notes and Complications section
4. **Postpartum Progress Note**
 - a. Make sure to first fill out the [OB Physician Postpartum Assessment](#) form in 'Custom Links' in Postpartum tab
 - b. All information will be autofilled
 - c. You may use nursing assessment instead by using //ob_PP_RN_Assessment (see below)
5. **Operative Report**
 - a. Some Information will flow from nursing or you can enter your own
 - b. Use //ob_Delivery_Data for the 'Findings' section if desired
6. **General Note – use for Circumcision - **make sure to document in baby's chart***
 - a. Open general note and use //ob_circumcision or your own template
7. **Discharge Summary**

List of OB Shortcuts (auto-text) for Dynamic Documentation

1. **//ob_Delivery_Data**
 - a. Delivery Information
 - b. Use in Postoperative Report
2. **//ob_History_of_Present_Illness**
 - a. Use in H&P
 - b. Contains Gravida/Para etc. EDD/EGA, labor
3. **//ob_L&DAssesment**
 - a. Latest OB Assessment done (vaginal exam, FHR/US assessment, Bishop Score)
4. **//ob_PP_RN_AssessmentSubjective**
 - a. Nursing Postpartum assessment
 - b. Use in Postpartum Progress note if not using physician assessment
5. **//ob_PP_RN_AssessmentObjective**
 - a. Nursing PP Assessment
 - b. Use in PP Progress note if not using physician assessment
6. **//ob_PhysicalExam_H&P**
 - a. Use in Admission H&P or anywhere PE is needed
7. **//ob_Pregnancy_History**
 - a. Gravida/Para etc. information only
8. **//ob_Review_of_Systems**
9. **//ob_circumcision**
 - a. Circumcision template – use in General note in baby's chart
10. **Use any //lab***** shortcut for labs. E.g. //laburinalysis for UA etc.**

NICU/Newborn Dynamic Documentation**List of NICU/Newborn Physician Notes**

- 8. Newborn/NICU Admission H&P**
 - b. Most Information auto-populates from chart (if documented)
 - c. Enter EDD: if desired
 - d. Use appropriate shortcut in Physical Exam as listed below
 - e. Dictate or type Narrative, Plan
- 9. NICU Progress Note**
 - b. Use appropriate shortcut in Physical Exam as listed below
 - c. Dictate or type Interim History, Plan
 - d. Assessment pulls in some results (see other side), please dictate/type the rest
- 10. Newborn Progress Note**
 - c. Use appropriate shortcut in Physical Exam as listed below
 - d. Dictate or type Subjective, Assessment and Plan
- 11. NICU Discharge Summary**
 - d. Use appropriate shortcut in Physical Exam as listed below
 - e. Dictate or type other appropriate sections
- 12. Newborn Discharge Summary**
 - a. Use appropriate shortcut in Physical Exam as listed below
- 13. General Note – use for any note you don't need a template for**

List of NICU/Newborn Shortcuts (auto-text) for Dynamic Documentation

- 11. //neonate_PE_H&P_Boy**
 - c. NICU Physical Exam for Admission H&P for boy
- 12. //neonate_PE_H&P_Girl**
 - c. NICU Physical Exam for Admission H&P for girl
- 13. //neonate_PE_ProgressNote**
 - c. NICU Physical Exam for Progress Note
- 14. //neonate_PE_DischargeSummary_Boy**
 - c. NICU/Newborn Physical Exam for Discharge Summary for boy
- 15. //neonate_PE_DischargeSummary_Girl**
 - b. NICU/Newborn Physical Exam for Discharge Summary for girl
- 16. //newborn_FollowUp_PE_Boy**
 - d. Healthy newborn Physical Exam for Progress Note, Discharge summary or as needed - boy
- 17. //newborn_FollowUp_PE_Girl**
 - a. Healthy newborn Physical Exam for Progress Note, Discharge summary or as needed – girl
- 18. //newborn_Initial_PE_Boy**
 - a. Healthy newborn Physical Exam for H&P - boy
- 19. //newborn_Initial_PE_Girl**
 - a. Healthy newborn Physical Exam for H&P - girl
- 20. //newborn_bilirubin (all results for last 7 days – this visit only)**
 - a. Total Bilirubin
 - b. Direct Bilirubin
 - c. Hematocrit
 - d. Reticulocyte Count
 - e. Blood Type
 - f. Coombs
 - g. TCB
- 21. Use any //lab***** shortcut for labs. E.g. //labs6months for all labs in last 6 months etc.**

NICU Progress Note Assessment

- 1. Respiratory**
 - a. ABG, Vent settings
- 2. Cardiac**
 - a. CCHD Screening Result in the last 24 days
- 3. GI/Metabolic/Nutrition**
 - a. Feeding type
 - b. Sodium, Potassium, Chloride, CO2, Calcium, Phosphorus results
- 4. Bilirubin**
 - a. Total, Direct, TCB
- 5. Hematologic**
 - a. CBC, Differential, Retic. count
- 6. ID**
 - a. CRP result
- 7. Neuro**
 - a. US Newborn Skull
- 8. Ophthalmology**
 - a. Free text
- 9. Social**
 - a. Free text

Consolidated Problem List – Diagnoses

- 1. Maintain the Consolidated Problem List every day**
 - a. Enter each problem and mark as 'This visit', 'Chronic' or 'Historical'
 - b. These will be pulled into your notes as 'Diagnoses' and 'Chronic Problems'
 - c. These will also show up in the Assessment section of 'Newborn Progress Note'

2. Common Problems/Diagnoses

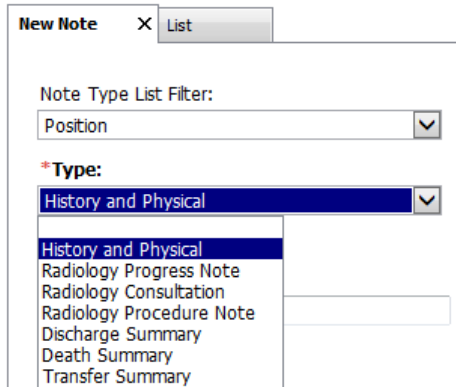
| Common Diagnosis/Problem | Type in Consolidated Problem | Type in a ICD code |
|--------------------------------|--|--------------------|
| Healthy/well newborn | Normal newborn (single liveborn) | V30 |
| Newborn delivered vaginally | Single liveborn infant delivered vaginally | V30 |
| Newborn delivered via cesarean | Single liveborn infant, delivered by cesarean | V30 |
| Newborn delivered with vacuum | Newborn delivered by vacuum extraction | 763.3 |
| LGA | Large for gestational age (or LGA) | 766.1 |
| SGA | Small for gestational age (or SGA) | 764 |
| IUGR | IUGR | 764.90 |
| IDM | IDM (or Infant of Diabetic Mother) | 775.0 |
| Hyperbilirubinemia | Hyperbilirubinemia | 782.4 |
| Suspected sepsis | Please enter symptoms, such as: Neonatal Fever Tachypnea, newborn Apnea of newborn etc. | |
| Sepsis | Neonatal Sepsis | 771.81 |
| Respiratory distress (RDS) | RDS (of newborn) | 769 |
| Hyaline Membrane Disease | Hyaline Membrane Disease | 769 |
| Pneumonia | Pneumonia | 486 |

| | | |
|------------------------------------|---|--------|
| Meconium Aspiration Syndrome | Meconium aspiration syndrome | 770.12 |
| Aspiration Pneumonia | Aspiration pneumonia in newborn | 770.18 |
| Transient Tachypnea of the Newborn | Transient Tachypnea of the Newborn (or TTN) | 770.6 |
| Perinatal Asphyxia | Neonatal Asphyxia | 768.9 |
| Perinatal Depression | Perinatal depression | 648.4 |
| Hypoxic Ischemic Encephalopathy | Hypoxic-Ischemic Encephalopathy | 768.70 |

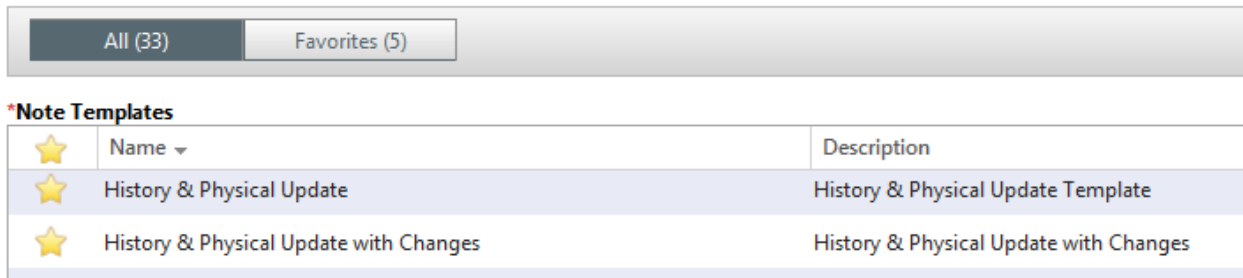
How to Document an H&P Update

1. Click on Create Note. 

2. Choose a note "Type" of History and Physical.



3. Choose a Note Template of "History & Physical Update" or "History & Physical Update with Changes", then click "OK" at bottom right to open note.



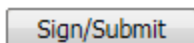
H&P Update inserts the following text:

The History & Physical and subsequent events were reviewed and a Physical Exam was performed. No significant change from the Admission History & Physical was found.

H&P Update with Change inserts the following text:

The History & Physical and subsequent events were reviewed and a Physical Exam was performed. Changes from the Admission History & Physical were noted, including: _

5. Make any needed additions. Then click Sign/Submit.



How to document a procedure where Moderate Sedation is used.

Step 1:

Document the pre-procedure Sedation Documentation / History & Physical Form

Custom Links

- 4 Additional Chart Links (4)
- 36 Hour Order Summary
- Facesheet
- Glycemic Monitoring
- Interdisciplinary Summary
- 4 PowerForms (2)
- Pre-procedure Sedation Documentation / History & Physical
- Pre-Induction Assessment

Use Green Check mark in upper left hand corner to sign forms.



Step 2:

Document the Pre Induction Assessment (immediately prior to sedation/procedure)

Custom Links

- 4 Additional Chart Links (4)
- 36 Hour Order Summary
- Facesheet
- Glycemic Monitoring
- Interdisciplinary Summary
- 4 PowerForms (2)
- Pre-procedure Sedation Documentation / History & Physical
- Pre-Induction Assessment

Step 3: Post Procedure Note

Create Post Procedure note, use the Procedure Note – Sedation Template

New Note [X] List

Note Type List Filter:
 Position [v]
 *Type: Radiology Procedure Note [v]

All (25) Favorites (1)

*Note Templates

| ★ | Name v | Description |
|---|---------------------------|------------------------------------|
| ★ | Procedure Note - Sedation | Procedure Note - Sedation Template |

Step 4: Insert procedure AutoText under “Post Procedure Information”

Post Procedure Information

Post Procedure Information
 //gi

"ablation_KIDNEY *
 "ablation_LIVER *
 "asept_ABD *
 "asept_CHEST *
 "blank_post_sedation_note *
 "blank_procedure_note *

-OR-

//qi_colonoscopy *
 //gi_egd *
 //gi_egd_with_peg *
 //gi_pe *
 //gi_ros *

Step 5: Verify and update procedure information and sign note.

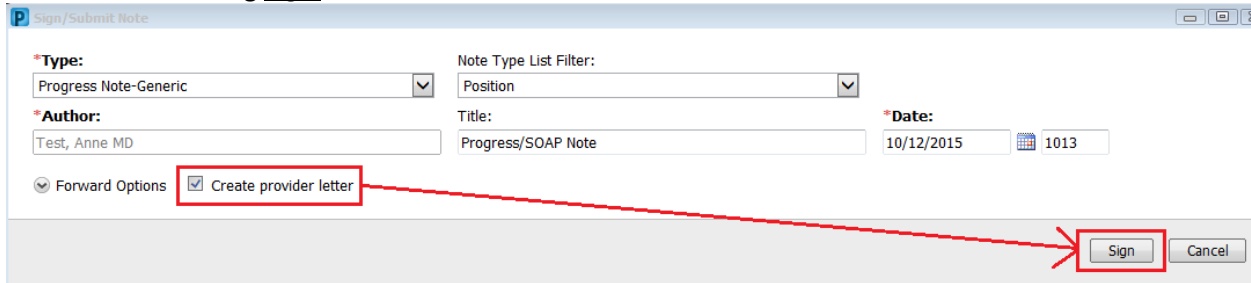
Sign/Submit

Provider Letter – Faxing a Note to Another Provider

Forwarding a document can be done two ways: 1. At the time of signing the document or 2. from Document Viewer (Documents).

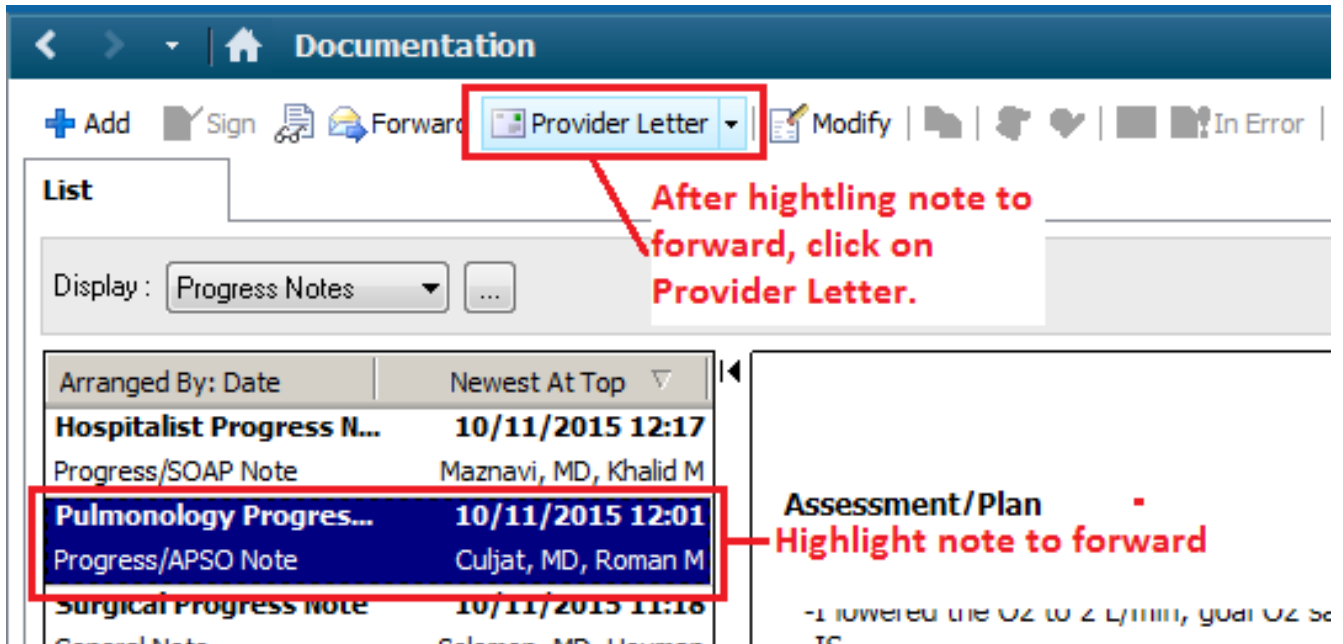
Accessing Provider Letter:

A. You can access Provider Letter at the time of signing the document by checking the Provider Letter box and then clicking Sign.



B. You can access Provider Letter for a document you have previously signed by going to Document Viewer (Documents), highlighting the document you want to forward, then click on Provider Letter in the viewer.

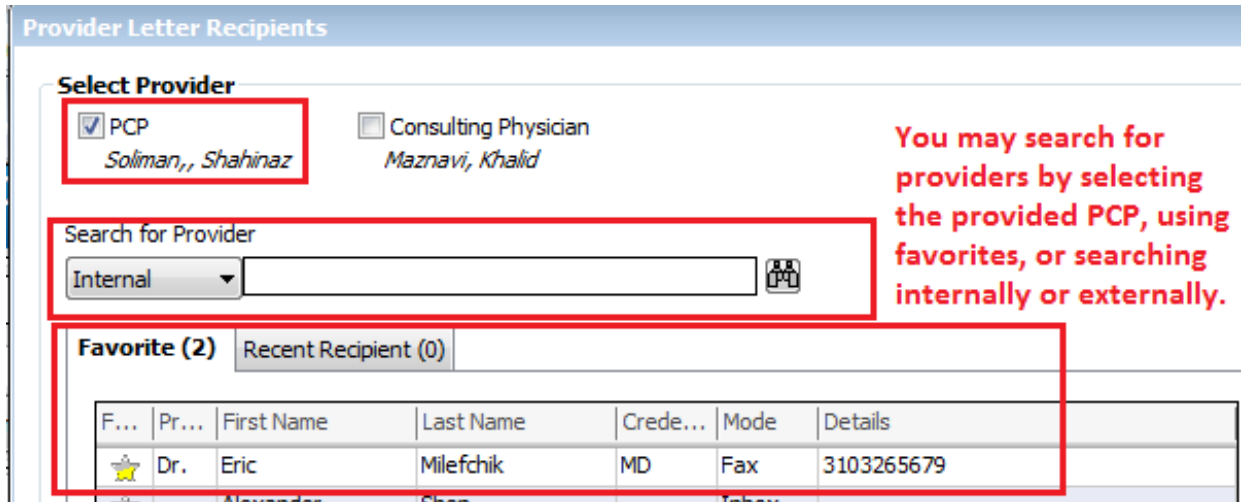
****Note:** If your button shows “Messages” instead of “Provider letter simply click on the little black down arrow next to Messages to locate Provider Letter. Message



Selecting Recipients:

You may simply select provided PCP, or search internally or externally for providers. Once you have chosen the appropriate provider and selected Mode of Fax, click OK.

****Note:** Recommended MODE is Fax.

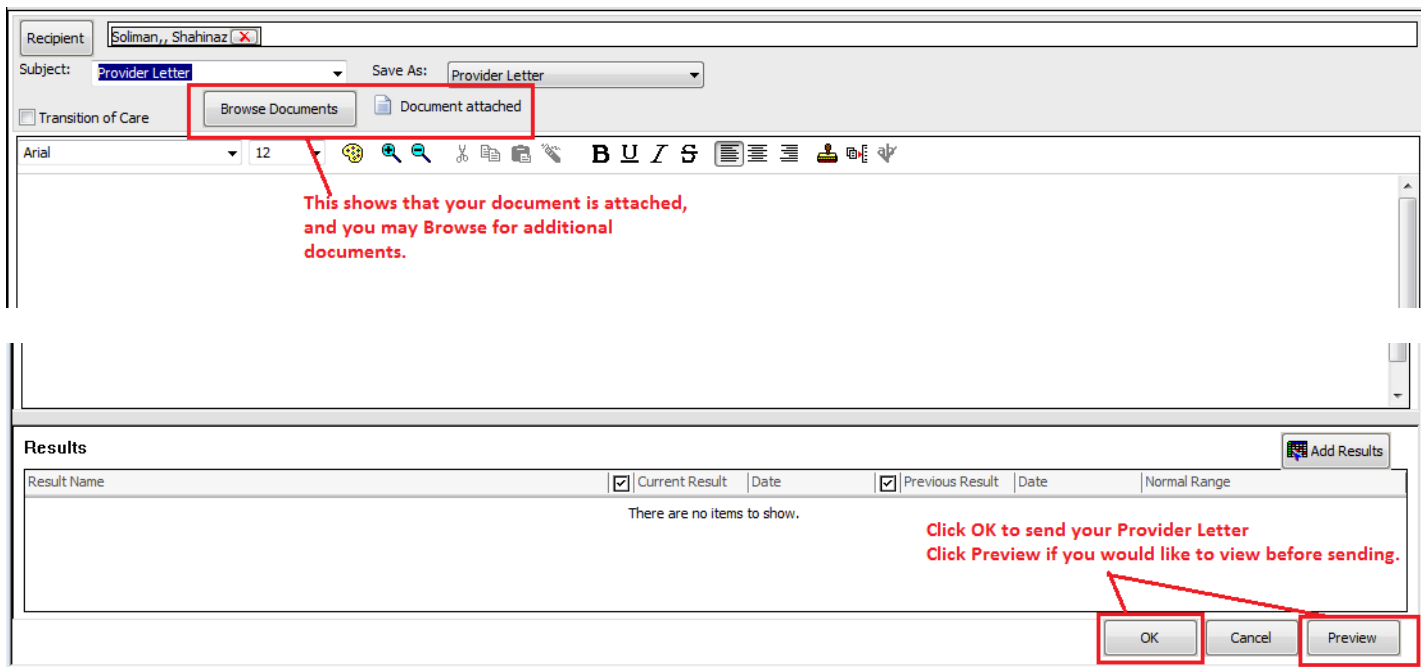


Sending your Faxed Provider Letter:

After clicking OK on the recipients screen take a moment to validate that your document is attached and click OK to send.

You may also choose to Browse and add additional documents.

You may choose to Preview the fax if you would like.

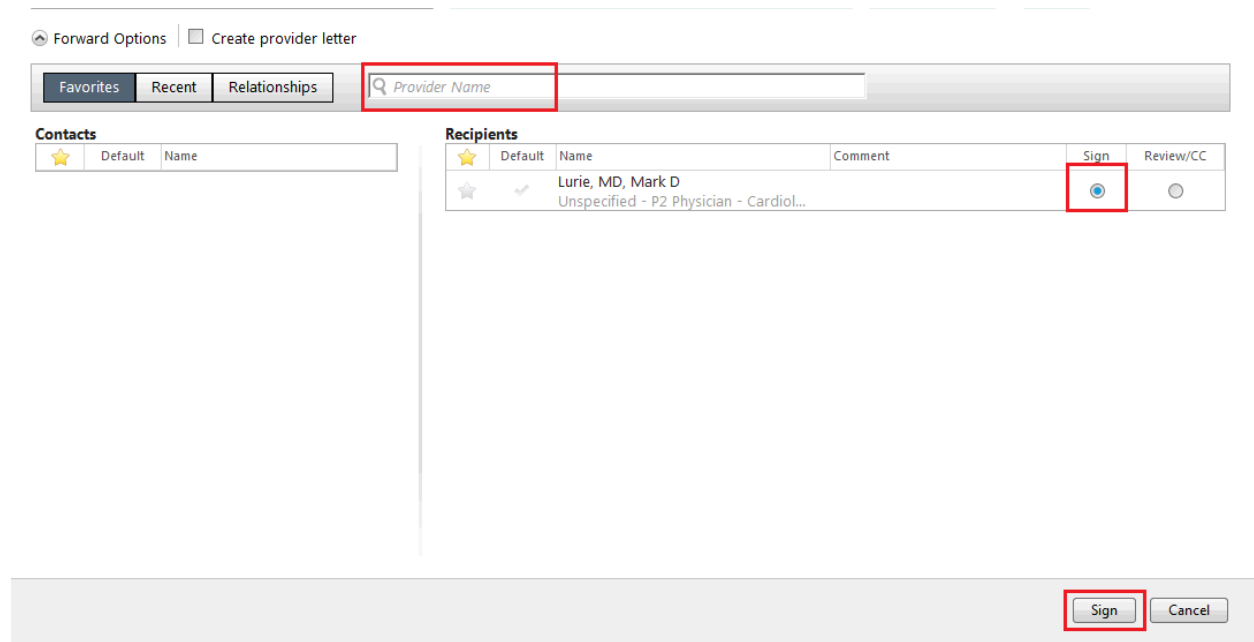


How to Forward a Note for Co-Signature

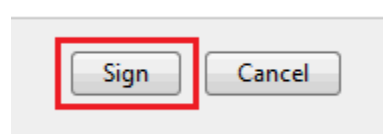
Step 1: Complete Note and Sign



Step 2: Search for provider's name, add them as a recipient. Ensure that it is marked for "Sign" and not Review/CC.



Then Click Sign:

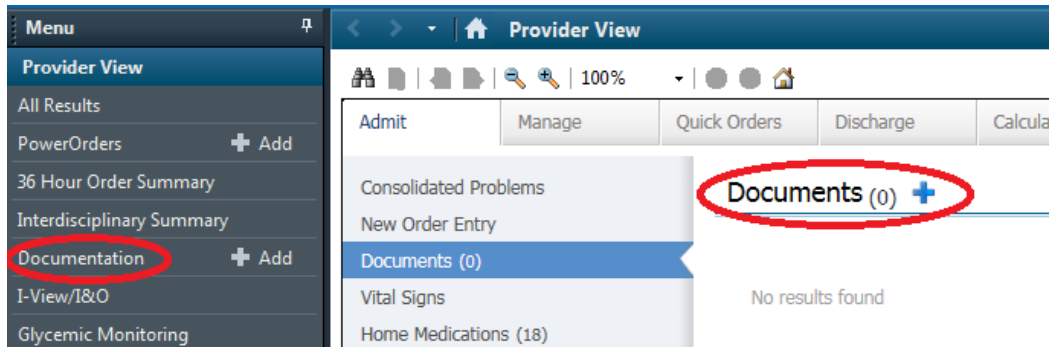


Hint: For physicians that you forward to a lot, add them to favorites by clicking on the star next to their name.

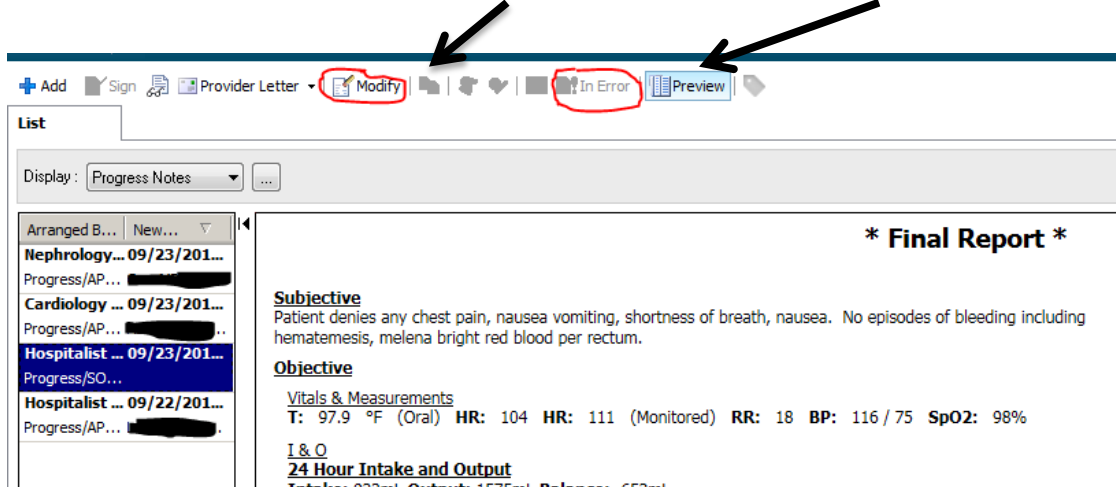


How to Addend or In-Error a Dynamic Documentation Note

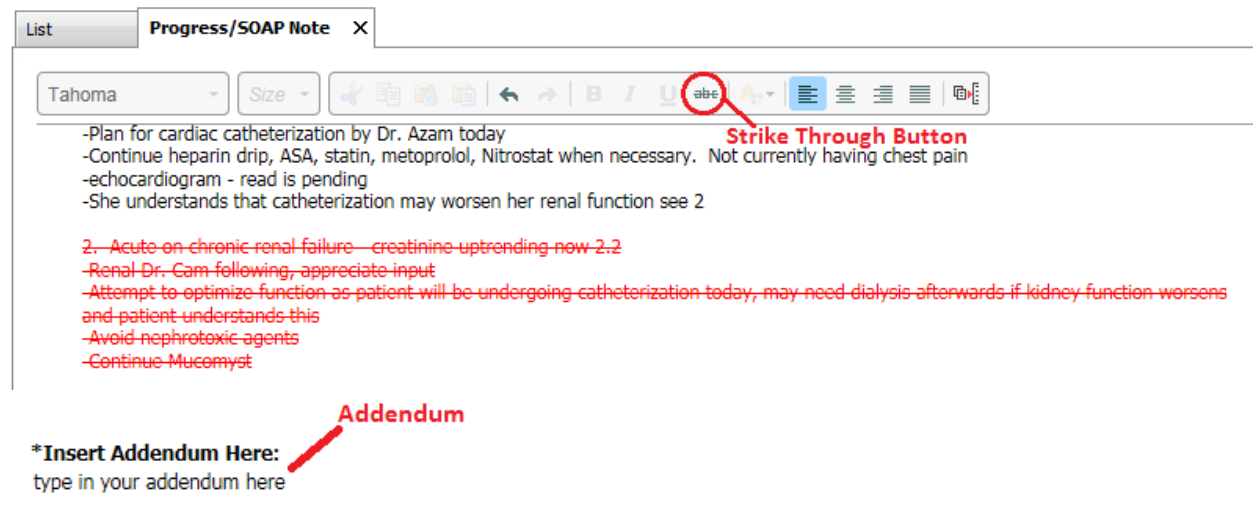
1. Access Document using “Documentation” or “Documents”



2. **Single Click** on the Note you need to Addend or In-Error. Here we have navigated to a Hospitalist Progress Note. Choose **Modify** to addend or choose **In Error**.



3. When you choose Modify the document allows you to add an addendum, or strike through existing text. When you are done, click Sign/Submit.



How To Order Labs

To understand how to order labs, you have to understand Lab Collection Priorities — **The Priority Drives Everything!**

The screenshot shows the 'Details for CBC with Auto Differential' section in the Laboratory PowerChart. The 'Collection priority' dropdown menu is open, showing the following options: AM Morning, Discharge Pending, ED STAT, Routine, Stat, and Time Collect. The 'AM Morning' option is currently selected. Other fields visible include 'Specimen type: Blood', 'Collection Date/Time: 01/13/2017 04:15 PST', and 'Label Comment'.

- 1. AM Morning:** Lab will be drawn next calendar day, in the morning.
Important: If you use AM Morning after Midnight, it will NOT be drawn that morning, but the next calendar day, in the morning.
- 2. Discharge Pending:** Indicates to the Lab that lab needs to be drawn ASAP.
STAT and Time Collect take priority over Discharge Pending.
- 3. ED STAT:** Used only in the Emergency Department for STAT orders. Labs default to ED STAT if they are ordered on non-admitted Emergency patients.
- 4. Routine:** For one time only labs. Lab will be drawn sometime today, added to an existing draw schedule.
Important: Cannot be ordered with a Frequency or Duration.
- 5. Stat:** For one time only labs. Lab will be drawn within the next 30 minutes.
Important: Cannot be ordered with a Frequency or Duration.
- 6. Time Collect:** Lab(s) will be drawn at the time(s) you indicate. Around the clock if ordered with a frequency.
Important: If you need the lab drawn within the hour, don't use Time Collect please order the lab Stat. If you are ordering a series starting within the hour, order the first lab Stat then use Time Collect to order the remainder if a series of labs is needed.

Frequency/Duration:

Frequency: For labs that allow frequencies (AM Morning, Time Collect) use this detail to document frequencies such as: daily, q6hrs, q2hrs, etc.

Duration: Indicates how long a frequency should be carried out using the two fields together (Duration & Duration Unit) document how many times a lab with a frequency should be drawn. Example: 3 dose(s)/time(s), 2 Day(s), 8 hour(s).

Medical Powerplans

| | |
|--|--|
| Activities | Hospice Admission (GIP) |
| Acute Coronary Syndrome (ACS) / NSTEMI | ICU - Admission |
| Acute Myocardial Infarction (AMI/ACS) / STEMI | ICU Electrolyte Replacement - Ordering Convenience |
| Alcohol/Drug Withdrawal (ETOH) | ICU Transfer-In |
| amiodarone - Loading Dose and Infusion | Inpatient Diabetes Medications Following Iodinated IV Contrast |
| Amiodarone Infusions Only (No Loading Dose) | Insulin - IV |
| Anemia - Common | Insulin - SQ |
| Antibiotics Adult CAP, Aspiration | Iron Supplements |
| Antibiotics Adult CAP, ICU | IV Fluids (IVF) |
| Antibiotics Adult CAP, Non ICU | Labs - Common |
| Antibiotics HCAP | Lumbar Puncture |
| Asthma - Adult | MD Notification Parameters |
| Atrial Fibrillation (Afib) | Mechanical Ventilation |
| Blood Cultures - 2 sets | Med/Surg - Admission (General Medicine) |
| Blood Pressure (BP) Medications - Common | Med/Surg/PCU Transfer |
| Blood Pressure (BP) Medications PRN | Medrol (methylPREDNISolone) DosePak |
| Bronchoscopy - Post | Nephrology - Common |
| Bronchoscopy - Pre | Neuro Checks - Stroke |
| Cardiology - Common | Neuromuscular Blocking Agents (NMBA) |
| Chest Pain - Low Risk (ACS) | NM Myocardial Cardiolyte |
| Chronic Obstructive Pulmonary Disease (COPD) | Obstructive Sleep Apnea Post Procedure Orders |
| Clostridium Difficile Associated Diarrhea Medication Convenience (Cdiff/CDAD) | Oncology Unit Admission |
| Code Status - Physician Only | Pain - Acute |
| Comfort Care | Pancreatitis |
| Congestive Heart Failure (CHF) | Pancreatitis Common Labs |
| Coronary Computed Tomography Angiography Protocol (CTA) | pantoprazole bolus and drip |
| Corticosteroids | Paracentesis |
| Cortisol Stimulation Test | Parenteral Nutrition (PN/TPN) - Adult |
| Critical Care Drips | PCU - Admission |
| CT Spine | Pneumonia - Adult |
| Deep Venous Thrombosis (DVT) Treatment | Pressure Ulcer Protocol |
| Diabetic Ketoacidosis - Adult (DKA) | PRN Medications |
| Diagnostic Tests | Pulmonary - Common |
| DIC Profile Labs | Pulmonary Embolism (PE) |
| Diets | Radiology - Common |
| Discharge | Radiology - Exam Ordering Guide |
| Discharge Orders for Bone Marrow Procedure | Renal Failure - Acute (ARF) |
| Discharge Planning | Respiratory |
| Duragesic (Transdermal Fentanyl) | Restraints |
| Gastrointestinal Bleed (GI Bleed) | scopolamine patch |
| Gastrointestinal Prophylaxis (GI Prophylaxis/PUD) | Sepsis - Adult |
| Head Injury | Sepsis Diagnosis - Common |
| Heparin Infusion Protocol - Acute Coronary Syndrome (ACS)/Higher Bleeding Risk | Sickle Cell - Adult |
| Heparin Infusion Protocol - Thromboembolism (VTE/PE) | Sickle Cell with Fever - Adult |



**Do not sign Post-Op
Orders until Surgery is
OVER!**

Done!

Finished!

Just wait.

Please.

Surgical Powerplans

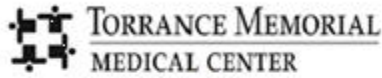
| | |
|---|---|
| Alvimopan (Entereg) Usage Criteria and Post-Op Order Set for ERAS | Laparoscopic Cholecystectomy Post-Op |
| Alvimopan (Entereg) Usage Criteria and Pre-Op Order Set for ERAS | Laparoscopic Radical Nephrectomy/Partial Nephrectomy Post-Op |
| Ambulatory GYN Postop | Lower Extremity Revascularization or Carotid Endarterectomy Pre-Op Orders |
| Ambulatory GYN Surgery Orders | Lower Extremity Revascularization Post-Op Orders |
| Bariatric Surgery Hernia + Abdominal Wall Reconstruction Post-op | Mastectomy with Expander Placement Breast Reconstruction Post-op |
| Bariatric Surgery Hernia + Abdominal Wall Reconstruction Pre-op | Mastectomy with Flap Reconstruction Post-Op |
| Bariatric Surgery Pre-op | Oncology Surgery Post-Op Orders |
| Burn Center Adult Admission Orders (13 years and older) | On-Q Pump Orders |
| Cardiothoracic Surgery Post-Op | Open Gastric Bypass Post-Op |
| Cardiothoracic Surgery Pre-Op Orders | Outpatient Bariatric Surgery Post-op |
| Carotid Endarterectomy Post-Op Orders | Outpatient General Surgery Post-Op |
| Craniotomy Post-Op Orders | PACU Drips |
| Craniotomy Pre-Op Orders | PACU Orders - Common |
| Dialysis Access Pre-Op Orders | Patient Controlled Analgesia (PCA) |
| Endoscopy Center Post Procedure Orders | PCU Transfer for Cardiac Surgery |
| Endoscopy Center Pre-Procedure Orders | PCU Transfer of Transcatheter Aortic Valve Replacement (TAVR) Orders |
| Endovascular or Open Abdominal Aortic Aneurysm Post-Op (AAA) | Peripheral Intervention Post-Procedure Orders |
| Epidural Continuous and PCEA Infusion Orders | Peripheral Nerve Block Infusion |
| ERAS Colorectal Surgery Post-Op | Peripheral Thrombolytic Infusion Orders **PILOT** |
| ERAS Colorectal Surgery Pre-Op | Post Anesthesia Care Unit - Adult (PACU) |
| ERAS Pain Management | Post Anesthesia Care Unit - Pediatric <=13yo (PACU) |
| Esophageal Surgery Post-Op | Post-Op Intraspinal Opiate Analgesia Orders (Main OR) |
| General Surgery Inpatient Post-Op | PreOp Orders - Common |
| GYN Oncology Pre-Op Orders | Pre-Procedure/Surgical Anesthesia Protocol |
| Gyn Oncology Surgery Post-Op Orders | Robotic-assisted Radical Prostatectomy Post-Op Orders |
| Gynecology Surgery Post-op Orders | Spine Surgery Multimodal Pain Management Orders |
| Inpatient Bariatric Surgery Post-op | TCU Joint Replacement Multi-Modal Pain Management |
| Laminectomy/Discectomy/Fusion or Disc Replacement Post-Op | |

Cardiology Powerplans

| | |
|--|--|
| Acute Coronary Syndrome (ACS) / NSTEMI | Chest Pain - Low Risk (ACS) |
| Acute Myocardial Infarction (AMI/ACS) / STEMI | Congestive Heart Failure (CHF) |
| amiodarone - Loading Dose and Infusion | Heparin Infusion Protocol - Acute Coronary Syndrome (ACS)/Higher Bleeding Risk |
| Amiodarone Infusions Only (No Loading Dose) | Impella Percutaneous VAD - ICU |
| Atrial Fibrillation (Afib) | MitraClip - Post |
| Cardiac Catheterization (PCI) - Post | MitraClip - Pre |
| Cardiac Catheterization (PCI) - Pre | NM Myocardial Cardiolyte |
| Cardiac Device / EP Radiofrequency Ablation - Post | TR Band Post-Procedure |
| Cardiac Device / EP Radiofrequency Ablation - Pre | warfarin (Coumadin) Initiation |
| Cardiology - Common | Watchman - Post |
| Cardioversion Post-Procedure | Watchman - Pre |
| Cardioversion Pre-Procedure | |

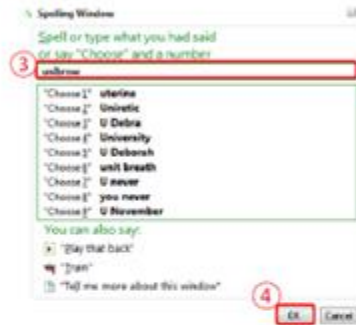
Radiology Powerplans

| | |
|--|--|
| Heparin Flush Protocol for Insertion of Temporary Dialysis Catheter (Dialysis Flush) | IR tPA Abscess Lysis Infusion |
| IR DOXOrubicin Chemoembolization | IR tPA Clearance of Dialysis Catheter with Heparin Flush |
| IR Dual Catheter Directed Venous Thrombolysis | IR tPA Clearance of PORT-A-CATH |
| IR Post Chemoembolization of Hepatic Tumor | IR tPA Clearance of Tunneled Catheter |
| IR Post Chest Port Insertion or Removal | IR tPA Loculated Pleural Effusion Lysis Infusion |
| IR Post Chest Tube | Peripheral Thrombolytic Infusion Orders **PILOT** |
| IR Post Femoral IVC Filter | Heparin Flush Protocol for Insertion of Temporary Dialysis Catheter (Dialysis Flush) |
| IR Post Gastric Tube Placement | IR DOXOrubicin Chemoembolization |
| IR Post Generic Biopsy | IR Dual Catheter Directed Venous Thrombolysis |
| IR Post Jugular IVC Filter | IR Post Chemoembolization of Hepatic Tumor |
| IR Post Kidney Biopsy | IR Post Chest Port Insertion or Removal |
| IR Post Liver Biopsy | IR Post Chest Tube |
| IR Post Lumbar Puncture | IR Post Femoral IVC Filter |
| IR Post Lung Biopsy | IR Post Gastric Tube Placement |
| IR Post Myelogram | IR Post Generic Biopsy |
| IR Post Nephrostomy | IR Post Jugular IVC Filter |
| IR Post Neuro Intervention Stroke Rescue | IR Post Kidney Biopsy |
| IR Post Procedural Drainage Generic | IR Post Liver Biopsy |
| IR Post Procedure Generic | IR Post Lumbar Puncture |
| IR Post Pseudoaneurysm Thrombin Ablation | IR Post Lung Biopsy |
| IR Post Tunneled Dialysis Catheter | IR Post Myelogram |
| IR Post Tunneled Peritoneal Drain | IR Post Nephrostomy |
| IR Post Tunneled Pleural Drain | IR Post Neuro Intervention Stroke Rescue |
| IR Post Uterine Fibroid Embolization (UFE) | IR Post Procedural Drainage Generic |
| IR Post Vertebral Augmentation | IR Post Procedure Generic |
| IR Pre-Procedure Orders | IR Post Pseudoaneurysm Thrombin Ablation |
| IR Prevention of Contrast Induced Nephrotoxicity (CIN) | |
| IR Single Catheter Directed Venous Thrombolysis | |
| IR tPA & DNase Loculated Pleural Effusion Lysis Infusion | |



Training Words

1. Highlight incorrect word
2. Dictate "Correct That"
3. Use the keyboard to type in correct spelling of the word
4. Click OK



TIP: For better recognition, try training the pronunciation of the word as well

1. Continuing from the previous step, after typing in the correct spelling, say "Train That" instead of clicking OK in Step 4.



2. WITHOUT clicking the Record button on mic, Click Go with mouse and say the word.

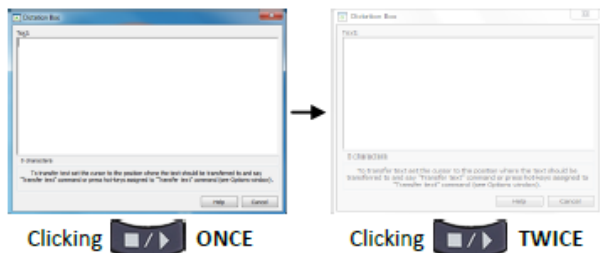


1. Click Go again.
2. Say the word again. (light flashes green)
3. Click Done

Dictation Box




Clicking **ONCE**: Opens the Dictation box
 Clicking **TWICE**: Opens the Dictation box to transparent "ghost" mode enabling it to stay on top at all times

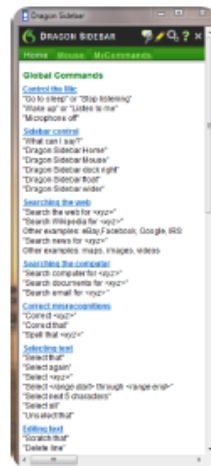


The ghost mode acts as a dual screen allowing the user to navigate around the patient's chart while dictating simultaneously.

TIP: The ghost mode is useful when needing to review other parts of the patient's chart while writing a note.

1. Navigate to the section which you need to review
2. Open dictation box into the ghost mode
3. Begin dictating. Anything dictated while in ghost mode will automatically appear in the dictation box.
4. Return to current note. Place cursor in appropriate section.
5. Click transfer text . This will transfer the text from the dictation box into the note.

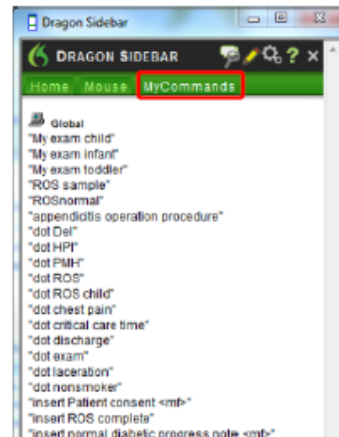
Dragon Sidebar



The Dragon Sidebar has a list of commands to remind you what you can say. You can also dictate "What Can I Say" to open the Dragon Sidebar

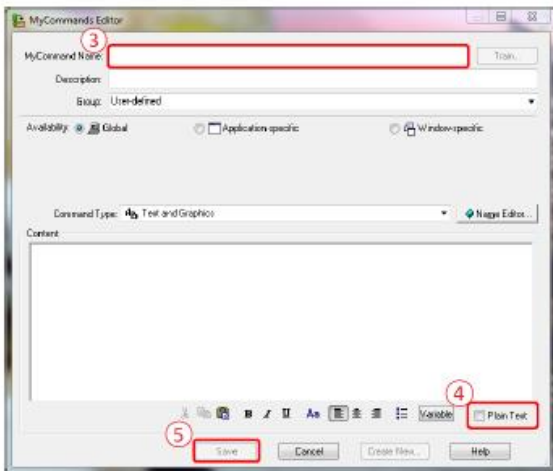


TIP: A list of your templates can be found in the Dragon Side Bar under the My Commands tab



Creating a Template

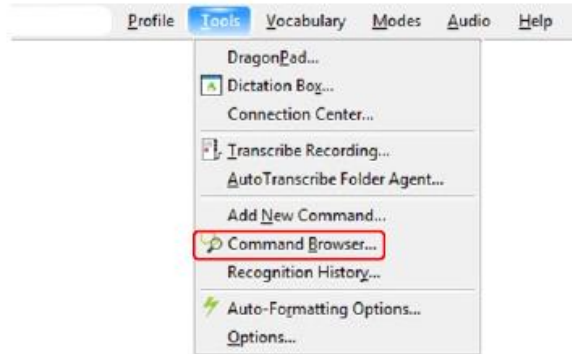
1. Highlight the text you want to make into a template
2. Dictate “**Make That a Shortcut**”
3. Create a name for this template
4. Check the **Plain Text** checkbox
5. Click **Save**



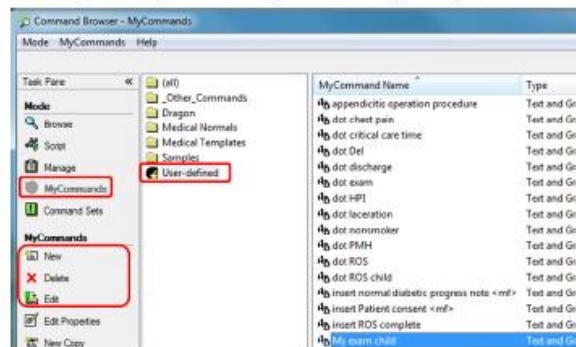
TIP: You can see a list of your templates in the Dragon Side Bar under the My Commands tab

Managing Templates

1. On the Dragon Toolbar, click on **Tools>Command Browser**



Under the Task Pane menu items, you are able to create, modify or delete your existing templates





Program Evaluation

Program Title Physician PowerChart Orientation

Date(s) _____ Time(s) _____

Specialty: _____ Position _____

Circle the most applicable number to rate the program using the following scale:

1=poor 2=average 3=good 4=very good 5=outstanding

| | | | | | |
|---|---|---|---|---|---|
| 1. Extent to which the material met the course objectives | 1 | 2 | 3 | 4 | 5 |
| 2. Relevance to current practice | 1 | 2 | 3 | 4 | 5 |
| 3. Overall teaching methods | 1 | 2 | 3 | 4 | 5 |
| 4. Knowledge of subject matter | 1 | 2 | 3 | 4 | 5 |
| 5. Clarity of presentation | 1 | 2 | 3 | 4 | 5 |
| 6. Environment (sound, lighting, room temp.) | 1 | 2 | 3 | 4 | 5 |

Identify how you will utilize the learning in your practice:

Rate the instructor(s) on the following utilizing the above mentioned scale:

| Name | Clarity | Knowledge | Relevance | Methods |
|----------|---------|-----------|-----------|---------|
| 1. _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ | _____ |

Would you like additional programming on this topic? Yes ___ No___

Additional Topic Suggestions / recommendations:
