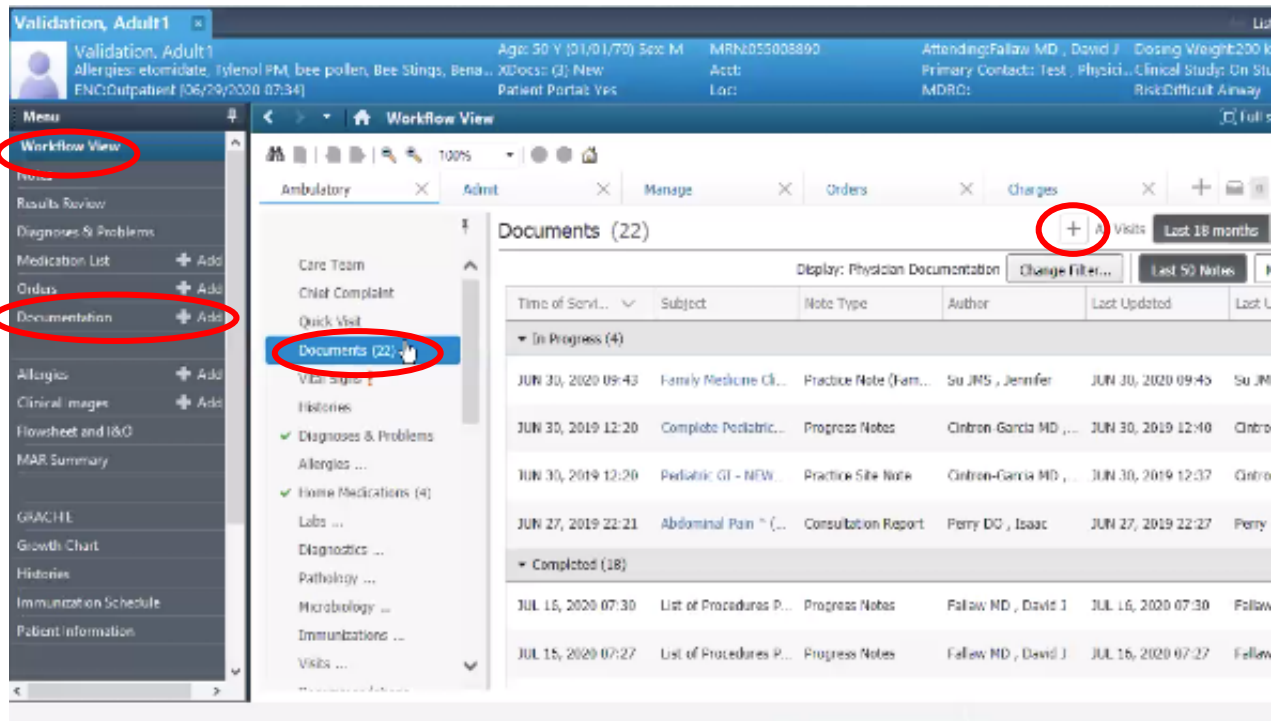


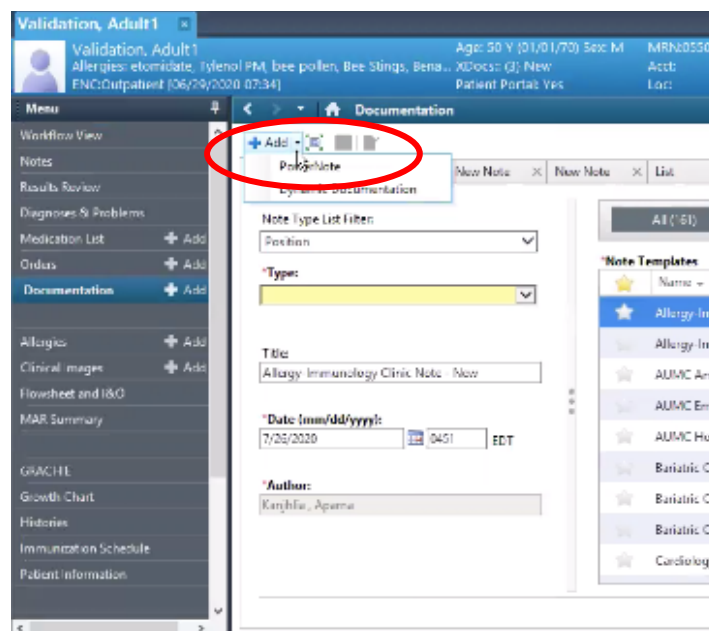
# Adding PowerNote Documentation to a Patient's Chart

## Navigation:

1. Start by selecting Workflow View in the main menu, clicking on Documents, and clicking on the + tab on the right side of the screen. You can also click on +Add next to Documentation in the main menu.



2. Click on the +Add button and change to PowerNote view.



3. Add the type of note you are writing by clicking on the drop-down menu next to Type and selecting a category.
4. Next to Date, log the date and time you are writing the note.
5. Next to Title, add a title for your note.

New Note x New Note x General H&P x New Note x New Note x L

Hide Note Details

\*Type: History and Physical Exam

\*Date: 07/26/2020 04:51 EDT

Title: General H&P

6. Under the Encounter Pathway tab, you can use the search function to search the type of note you are writing. Select the type of note you are writing and click OK, and a template will pull up to write a new note.

Encounter Pathway Existing Precompleted Catalog Recent Favorites

Search: general Contains Add to Favorites

Restrict display by:  Associated Diagnosis  Note Type

Name	Description
General Admission H&P *	*2G Admission H&P General Admission
General Complaint *	*2G General Complaint
General Complaint MCG	MCG *2G General Complaint
General Exam *	*2G General Exam

OK Cancel

7. Under the Existing tab, you can view the patient's previous notes. You can filter these notes using the filters under Encounter ID. You can select an existing note and click Make Correction to edit that note. You can also copy the information from an existing note to a new note by clicking Copy to new note, then OK.

Encounter Pathway Existing Precompleted Catalog Recent Favorites

Patient name: Validation, Adult 1

Encounter ID: 70147526.000000

Copy to new note

Current encounter  Unsigned notes only  My notes only

All encounters

Make Correction Delete

Perform/Service Date/Time	Author	Status	Title
6/26/2020 11:32:13 AM	Fowler MD, Teresa	AutoSaved	Abdominal Pain Admission H&P *
05/04/2020 08:22:00 EDT	Test NP Student	In progress	test

Encounter Pathway Existing Precompleted Catalog Recent Favorites

Patient name: Validation, Adult 1

Encounter ID: 70147526.000000

Copy to new note

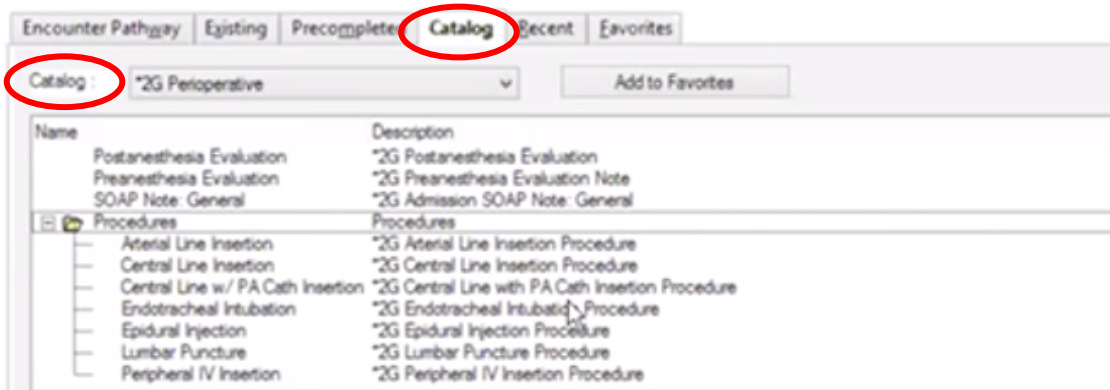
Current encounter  Unsigned notes only  My notes only

All encounters

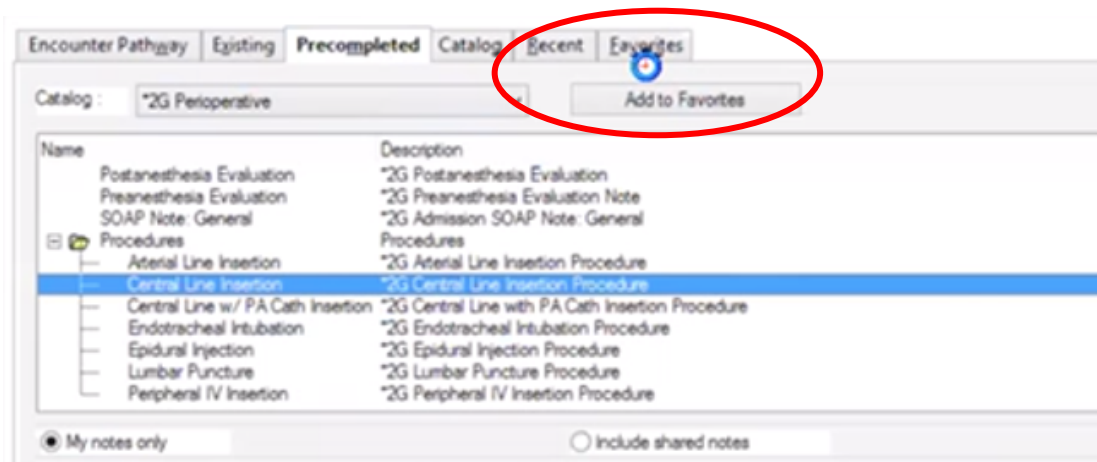
Make Correction Delete

Perform/Service Date/Time	Author	Status	Title
6/26/2020 11:32:13 AM	Fowler MD, Teresa	AutoSaved	Abdominal Pain Admission H&P *
05/04/2020 08:22:00 EDT	Test NP Student	In progress	test

8. Under the Precompleted tab, you will find notes completed by the provider for common procedures or disease processes. They are not for any particular patient. Similar to notes under the Existing tab, they can be filtered.
9. Under the Catalog tab, you will find that notes are categorized by specialty. Select your desired specialty under the Catalog drop-down menu, then click on the Procedures folder and double click on the procedure you wish to write a note for.

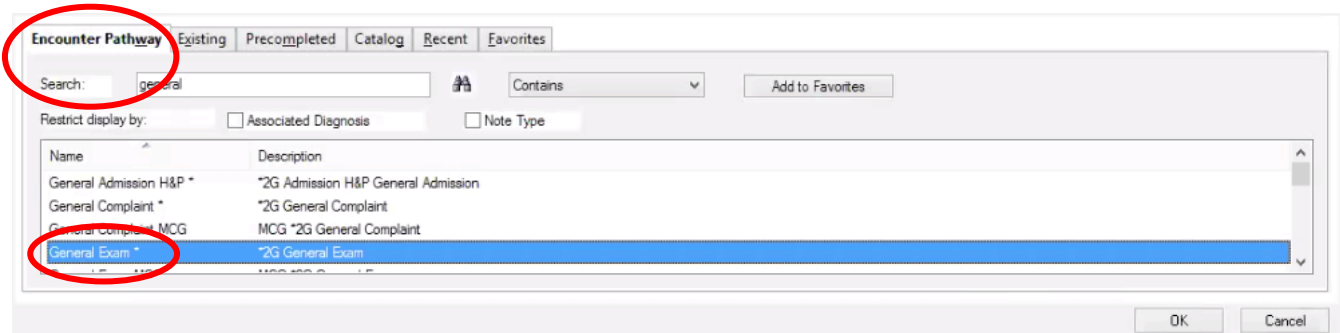


10. You can add a note to Favorites by selecting the note and clicking on Add to Favorites. You can access these notes under the Favorites Tab. You can view recently accessed notes under the Recent tab.

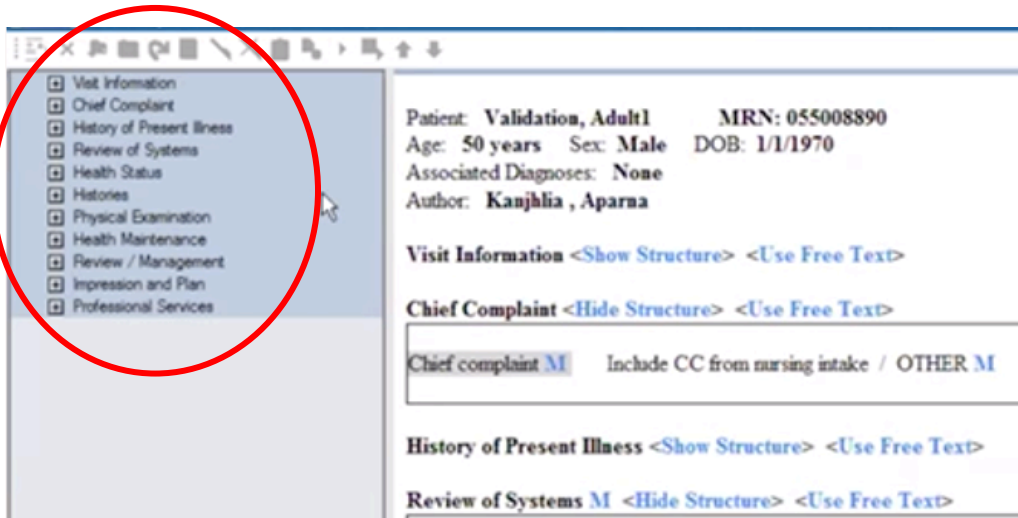


### Filling out a Note for a General Exam:

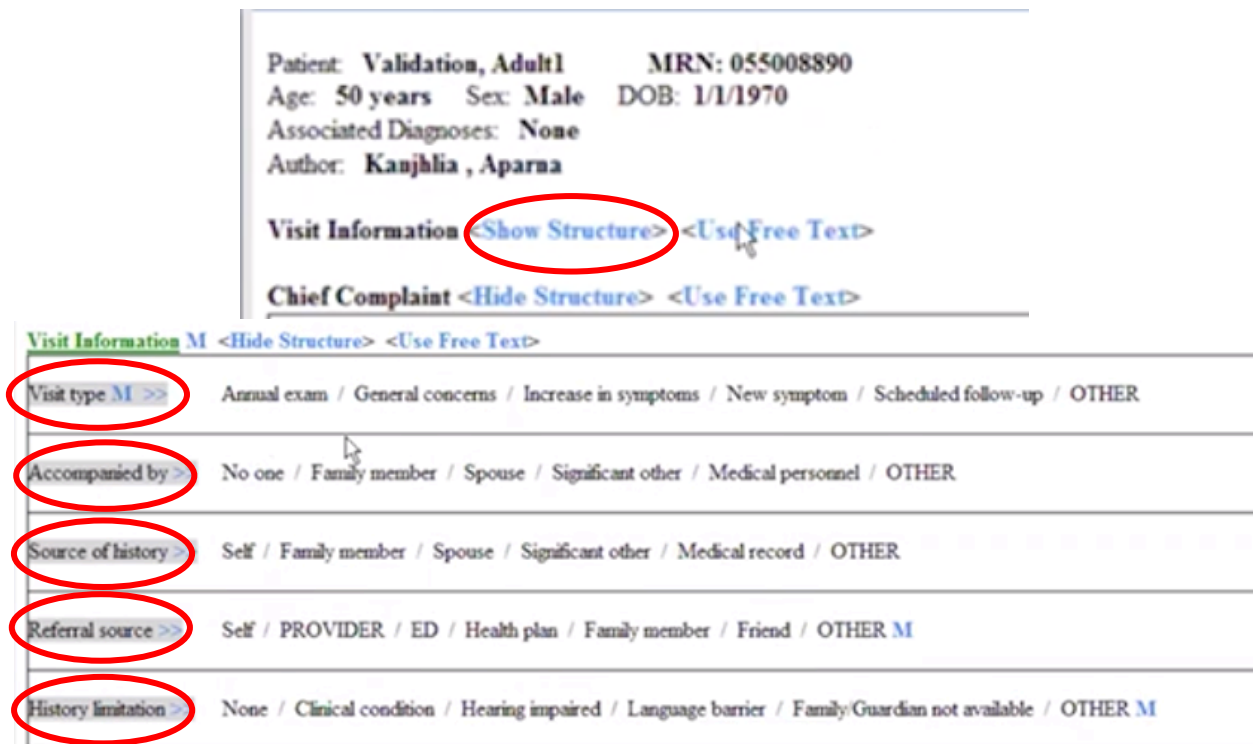
11. Create a new note by following steps 1-5. To access the template for a General Exam, search "General" under the Encounters pathway, select General Exam, and click OK.



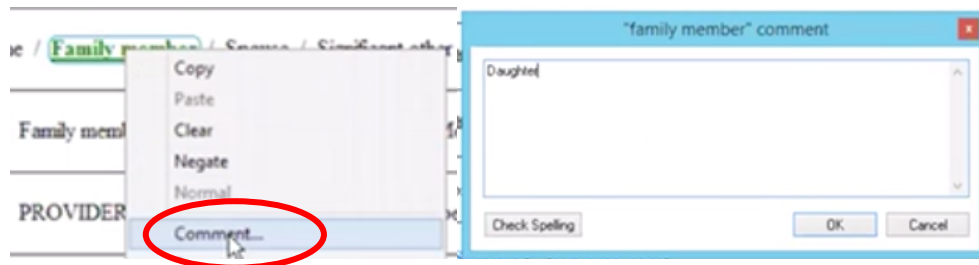
12. You can keep track of filling out the note in its entirety by following the menu on the left-hand side. You can also click on a tab in the menu to jump to that particular section.



13. **Visit Information:** To fill out this section, click on Show Structure and select from the options provided next to each subsection. Click on an option to select it, and click on it again to negate it.



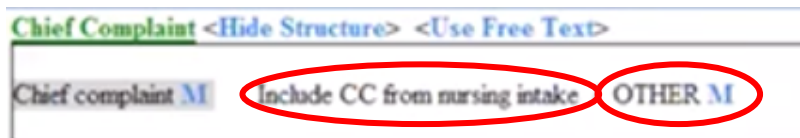
14. To add a comment under any option, right click on the option, select Comment, write the comment and select OK.



15. When you're done filling out the section, click on Hide Structure. All of the information you filled in will populate under that section, as seen below. A checkmark will appear on the left-hand side menu once a section is completed.

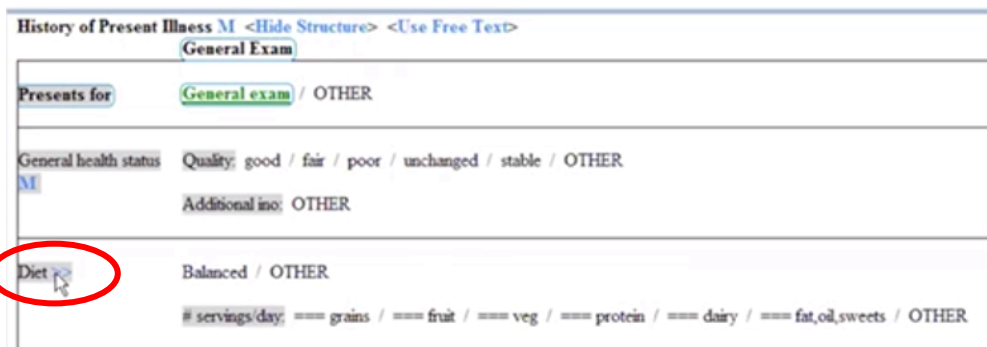


16. **Chief Complaint:** To fill out this section, you can fill it in from the nursing intake by clicking on Include CC from nursing intake and selecting the chief complaint. You can also click on OTHER and write your own.



17. **History of Present Illness:** Fill out this section similar to how you would fill out the Visit Information section (see steps 13-15)

18. When filling out a section, some subsections will have >> next to it: by clicking on it, it will reveal more options to choose from when filling out that subsection. To hide the options, click on <<.



19. If you see === next to an option, you can click on it to provide a numerical value (type in a number).



Balanced / Vegetarian / Vegan / Lactose free / Gluten free / Wheat free / Casein free / Soy free / Organic / Raw / OTHER  
 # servings/day   grains  fruit  veg  protein  dairy  fat,oil,sweets / OTHER

20. **Review of Systems:** To fill out this section, select Negative for a symptom if there is nothing wrong. If there are any abnormalities, you can selection the appropriate symptoms. You can also add comments for any of the symptoms by following step 14.

**Review of Systems M** <Hide Structure> <Use Free Text>  
 >>  M / Negative except HPI / Fever / Chills / Sweats / Weakness / Fatigue / Decreased activity / OTHER  
 >>  / Negative except HPI / Recent visual problem / Icterus / Discharge+ / Blurring / Double vision / Visual disturbances /  
 >>  / Negative except HPI / Decreased hearing+ / Ear pain+ / Nasal congestion / Sore throat / OTHER

21. **Health Status:** Fill out this section similar to the previous sections.  
 22. If an option has (ST) next to it, that means there is a Smart Template available. By clicking on it, it will pull the relevant information from the patient’s chart. To add any additional information, select Other and write it in.

**Health Status M** <Hide Structure> <Use Free Text>  
  (ST) M  / OTHER  
  
  /  /  M  
**Home Medications (4) Active**  
 acetaminophen-butalbital 300 mg-50 mg oral tablet 1 tab, PRN, PO, Q4HR  
 amLODIPine 2.5 mg oral tablet 5 mg = 2 tab, PO, Every Day  
 Colace 50 mg oral capsule 50 mg = 1 cap, PRN, PO, BID  
 Percocet 5/325 oral tablet 1 tab, PRN, PO, Q4HR

23. For the Problem List subsection, you can use the Smart Template to fill it out. You can also click on “Include problem list,” select a diagnosis, and choose from a list of problems.

M    
 Anhydrosis  
 Tobacco use  
 / OTHER

24. **Histories:** Fill out this section similar to the previous ones. You can also utilize the Smart Template function in this section.
25. Under the Past Medical History subsection, you can click on “Include past medical history” and select from the list. The same can be done for family history and procedure history.

**Histories M** <Hide Structure> <Use Free Text>

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Past Medical History Negative / Past Medical History/Problems (ST) **Include past medical history** /

26. **Physical Examination:** Fill out similar to previous sections. You can also utilize the Smart Template function in this section.
27. If an option is indicated with a +, there will be additional information to fill in. Fill in numerical values as outlined in step 19.

**VS/Measurements Vital Signs (ST)**  
 No qualifying data available.

/ Vital signs from flowsheet M / Inpt. Vital signs (ST) M / Measurements (ST) / Measurements from flowsheet / Hemodynamics from flowsheet / Document hemodynamics+ / OTHER

**Document vital signs+** OTHER /

Blood pressure: systolic == / diastolic == / mean == / supine ... / sitting ... / standing ... / site ... / cuff ... / method ... / OTHER /

Pulse: == beats per min / peripheral == / apical == / supine == / sitting == / standing == / regular / irregular / OTHER /

Respiration: == breaths/min ... / dyspneic / labored / tachypneic / wheezing / OTHER /

Temperature: febrile / Celsius ... / Fahrenheit ... / OTHER /

Oxygen saturation == %;  $\text{HbO}_2$  == % / == liters per min / room air / OTHER /

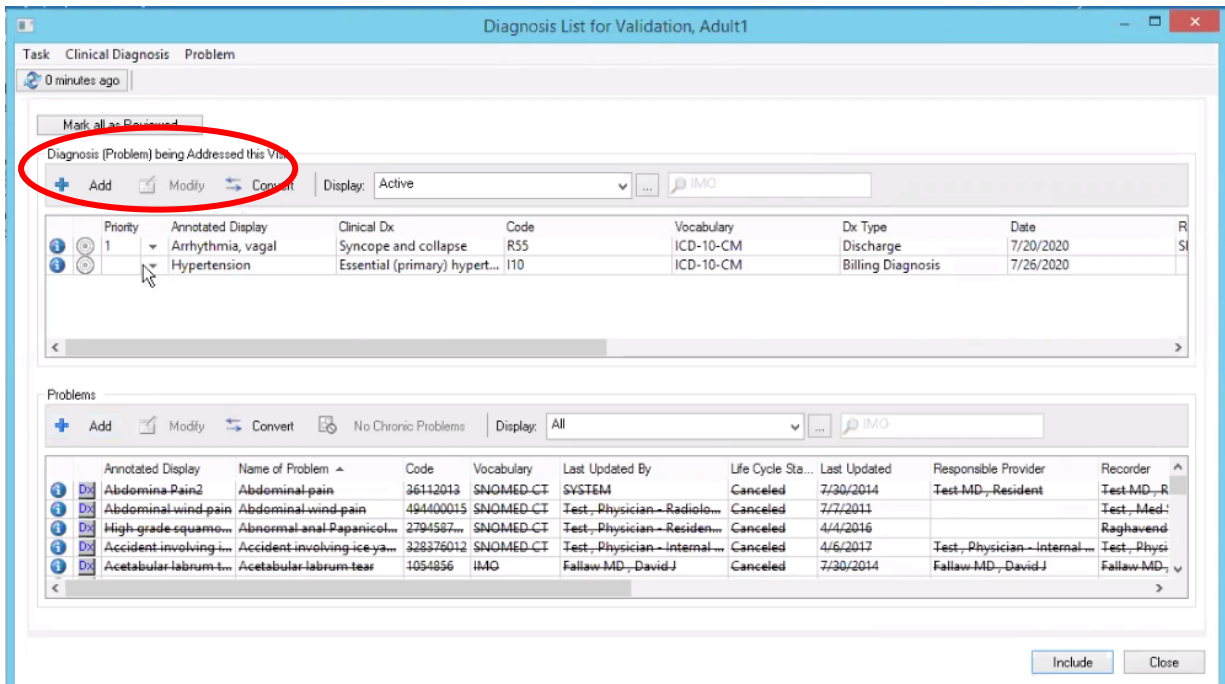
Height/length: dosing ... / measured ... / estimated ... / OTHER /

Weight dosing ... / measured ... / estimated ... / gain ... / change ... / refused / OTHER /

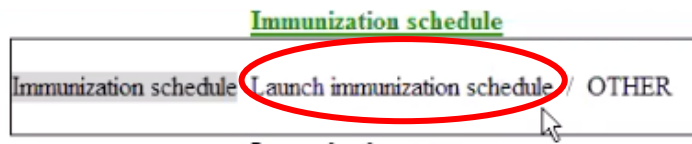
4 extremity B/P: LUE ... / RUE ... / LLE ... / RLE ... / OTHER

28. **Health Maintenance:** Fill out this section similar to previous ones.

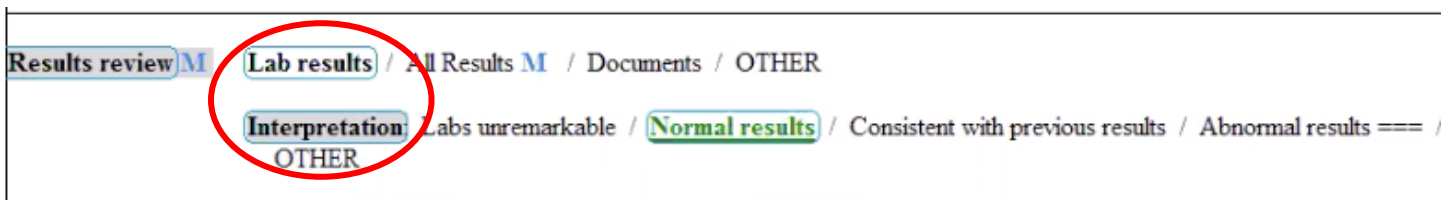
29. To fill out the Diagnosis, select “Dx Code Search.” You can select a pre-existing diagnosis and/or add a new one by clicking on the Add button under Problem.



30. To fill out the immunization schedule, click on “Launch immunization schedule” to include previous immunizations.

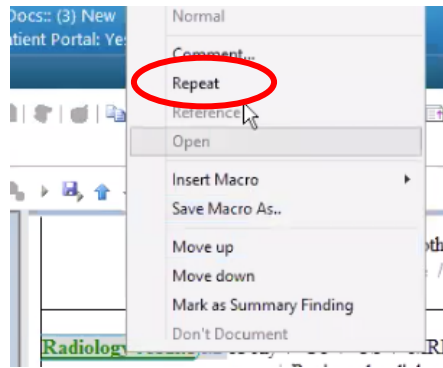


31. **Review/Management:** Fill out similar to previous sections. You can add lab results by clicking on Lab Results and selecting the ones you want to add, as well as add interpretations.

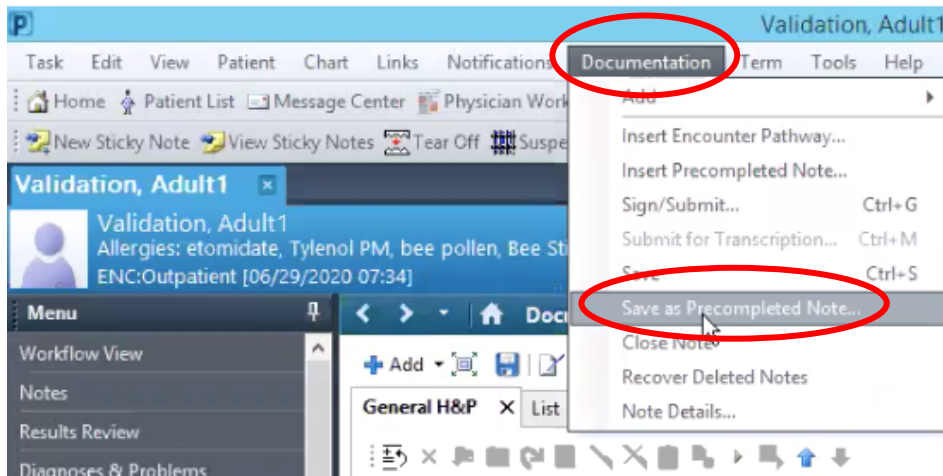


32. You can only add radiology results one at a time. If you have multiple radiology results to add, right-click on “Radiology results” and select Repeat.

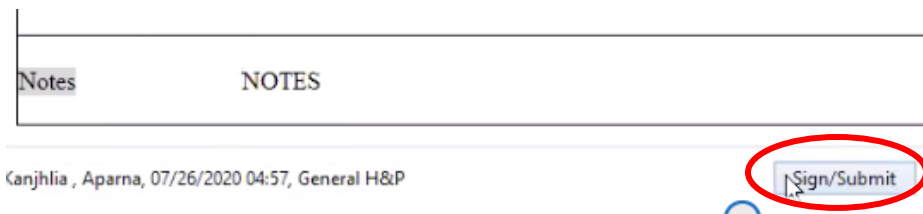




- 33. **Impression and Plan:** If you indicate the Course as “Unchanged” (under the Health Maintenance tab), then you do not need to fill out this section. Otherwise, you will fill it out similar to previous sections.
- 34. **Professional Services:** Fill out similar to previous sections.
- 35. Once you have continued filling out the note, select the Documentation tab at the top and click on Save as Precompleted Note. This way, you can use this template for future patients.



- 36. Click on Sign/Submit to submit the completed note. Review the type, title, and date. To add someone to review/sign your note (ex: an attending), select “Request endorsement,” search for your endorser, and select the type of endorsement you are seeking. You can also include a due date by which they need to review/sign the note, and any comments. Once you are done, click Submit.



### Reviewing the Note and Other Functions:

37. After you submit the note, it will appear in the Documentation list. You can preview the note, modify it, or forward it.

38. If the note was made in error, select the In Error button and write the error that was made. The note will update as “In Error Report.”

39. When filling out the note, the M next to many of the sections, subsections, and options stands for Macros. By clicking on it, you can select the appropriate Macro to add precompleted information to your note, and it will auto-populate. To remove an option that was selected by the Macro, just click on the option again.

40. To create a Macro for a section/subsection, select the desired options for that section, then right click on the section and select "Save Macro As." Name the Macro, and you can share it with others if desired.

