SCCC Workflow

The new SCCC 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 SCCC Workflow will open.
4. On the left is the Workflow.
5. Click on each item to jump to that section. You can also scroll down the page to review each section in the workflow.
Sections in SCCC Workflow

Documents

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

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

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

Documents (9)

<table>
<thead>
<tr>
<th>Note Type</th>
<th>Subject</th>
<th>Author</th>
<th>Time of Service</th>
<th>Last Updated By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress Note</td>
<td>Progress Note Basic</td>
<td>AI MD, Mohammed</td>
<td>04/31/14 13:29</td>
<td>04/31/14 13:33</td>
</tr>
<tr>
<td>Progress Note</td>
<td>Medicine - CHP</td>
<td>Uzelac MD, Giovanna L. (resident)</td>
<td>03/31/14 17:27</td>
<td>03/31/14 17:32</td>
</tr>
<tr>
<td>Progress Note</td>
<td>Progress Note Basic</td>
<td>MDPilot, Test</td>
<td>03/31/14 16:35</td>
<td>03/31/14 16:37</td>
</tr>
</tbody>
</table>

Pane View

Documents (9)

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.

Progress Note

Subjective

Objective/Physical Exam

Vital & Measurements

GENERAL: [awake], [well-developed, well-nourished], [comfortable]

HEAD/EYES: [normocephalic, straumatic], [normal lds and conjunctiva], [pupils equal], [extraocular muscles intact]

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

NECK: [supple], [full range of motion], [no masses], [no thyromegaly]

CARDIOVASCULAR: [normal S1/S2], [regular rate and rhythm], [no murmur/signs]

Lab Results

<table>
<thead>
<tr>
<th>Labs</th>
<th>Value</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>HGB 9.4</td>
<td>04/15/2014</td>
<td>13:30 EDT (Lex)</td>
</tr>
</tbody>
</table>

Patient Information

Display of most recent patient information.

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Sections in SCCC Workflow

Pertinent Clinical Data

Click the down arrow next to Pertinent Clinical Data. Click on SCCC Clinical Information Form.

Populate the following sections:
- CVP
- ScVO2
- Heart Rhythm
- Sedation goal
- Pupil Size Right
- Pupil Size Left
- Glasgow Coma Score
- Eye opening
- Best Verbal Response
- Best Motor Response

There is also a tab on the left to populate Vital Signs if not done by nursing or if you need to update vitals at time of progress note/exam.

Sign the form by checking the Green Check Mark.

The information you added will populate in the Pertinent Clinical Data section.

Vent Settings

If the patient is on a ventilator, the settings are here. Check for accuracy and when settings were last documented.

Vital Signs

Vital signs are populated by nursing once per shift. If not updated, you can use the PowerForm to enter vitals.

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

Hover over a specific result to see more information.
Sections in SCCC Workflow

Intake and Output (I&Os)

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

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

Click on the order name (in blue) to open the report.

<table>
<thead>
<tr>
<th>Status</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordered</td>
<td>Order placed but not yet completed</td>
</tr>
<tr>
<td>In Progress</td>
<td>Order currently processing</td>
</tr>
<tr>
<td>Unauth</td>
<td>Order completed but not yet resulted</td>
</tr>
<tr>
<td>Auth (Verified)</td>
<td>Completed order with dictated report available</td>
</tr>
</tbody>
</table>

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Sections in SCCC Workflow

Diagnostics

The Diagnostic Tests and Imaging Orders for the selected visit will be displayed, but the timeframe can be changed.

Clicking an Auth (Verified) report opens the Final report.

Clicking an Unauth report opens the Result Details window with more information about the order.

Highlight any specific section of the report and click Tag to insert this information into your Progress note.

Tagging can be used in:
- Documents
- Diagnostics
- Lab Results

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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

To complete reconciliation or view the med rec screens, click the status.

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

- Name
- Dosage
- Route
- Frequency

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Sections in SCCC Workflow

### Last 24 Hour Events

To add information about events in the last 24 hours, you can:
- Free text
- Auto text
- Dragon

### Resident Exam/Comments

Residents can add documentation by using:
- Free text
- Auto text
- Dragon

---

1. Use Dragon commands or auto-text to add information:
   - for example, say “S Triple C macro” or type `=sccc_plan`

2. Use the Dragon Tab Forward key (or say “Next field”) or the F3 key to move to each bracketed field and dictate your findings.

3. If you have to complete a selection field in the template or auto-text (by adding an X to select a choice), be sure to use a capital X.

4. When complete, press the Accept Defaults key on the Dragon mic to remove the brackets.

**I’m using Dragon to dictate 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.
Sections in SCCC Workflow

**Consolidated Problems**

Consolidated Problems list is a combined list of problems and diagnoses. This is where you’d enter this visit’s problems. Active Problems carry forward from day to day.

**Consolidated Problems**

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

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**.

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

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.
Sections in SCCC 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.

**Use caution!!**

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

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

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

As you make your selections, the Order Inbox in the upper right of the Workflow page turns green and counts the number of orders.

Click the Order inbox. The Orders for Signature window appears.

Remove the order by hovering over the order and clicking the X that appears.

Click Sign to complete the order.

Change order information by clicking Modify.
Sections in SCCC Workflow

Outstanding Studies & Consults

Outstanding Studies & Consults have a status of Ordered and have not been completed yet.

<table>
<thead>
<tr>
<th>Study/Consult</th>
<th>Status</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventriculostomy, Open</td>
<td>Ordered</td>
<td>04/30/14 20:35</td>
</tr>
<tr>
<td>Ventriculostomy, Left</td>
<td>Ordered</td>
<td>04/30/14 20:35</td>
</tr>
<tr>
<td>Ventriculostomy, Dressing</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>Ventriculostomy, Omm</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>TPN Solution 1900 mL + copper chloride 10 mL + rnitidine 150 MG</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>Consult Physician</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>Notify Nurse</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>Mouth Care: Soft Toothbrush</td>
<td>Ordered</td>
<td>04/22/14 11:34</td>
</tr>
<tr>
<td>Shave: Electric Razor Only</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>Shave: Electric Razor Only</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>Initiate OMS: Full Preventive, Evaluation and Treatment</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>Initiate OMS: Bleeding Provisions (Adult)</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>Precautions: Bleeding</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
<tr>
<td>Urine Culture</td>
<td>Ordered</td>
<td>04/30/14 20:34</td>
</tr>
</tbody>
</table>

Hover over a row to see more information, including who ordered the study or consult.

Create Note

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

Progress Note

To create your Progress Note, complete the following:

1. From the Type dropdown list, select Progress Note.
2. Under Note Templates, select Progress Note SCCC. The Title field will update with this name.
3. Click OK.

There are many Note Template types for you to choose depending on what you want to document. See page 15 for more types you will use.

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Progress Note

The Progress Note displays. This note is unique to SCCC. 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 day, the vitals and labs will be different.

SCCC Progress Note

Basic Information includes hospital day #, surgical procedures and code status if there was one.

The following information will pull into each system from the workflow:

Active/This Visit Diagnosis:
- List of problems and diagnosis prioritized in the workflow

I&O: Input/Output details

Medication List: active medications

Clinical Protocol in Use: use F3 or Dragon forward key to move from field to field. Place X under the Protocols that are in use.

The following information will pull into each system from the workflow:

- Neurologic: GCS, pupils, sedation level, ventriculostomy, c-spine precautions
- Pulmonary: RR/Spo2, Vent settings, ABG/VBG, chest tubes
- Cardiohemodynamic: HR/BP, CVP, SCV02, cardiac enzymes, H&H trend, pressor orders
- Abdomen/GI: GI labs, stress ulcer prophylaxis, diet order
- Renal/Electrolytes: weight/weight change, last 8 hr urine output, Foley orders/indication
- Hematology: Coags, VTE prophylaxis
- Wound Care: Free text box for comment
- Infectious Disease: Temperature, WBC count, active antibiotic order # of days on antibiotics, list of central line and # of days those lines have been present.

At this point, if the resident is the one completing, click Save & Close. On rounds, this note can be reopened by Attending/Fellow from the workflow.

At that time, any elements which may have been resulted in the interim may be updated by refreshing; there is space for Fellow/Attending attestation statement and plan of care.

For example, use Dragon command "Attending Agree Macro".

Then click Sign/Submit to finalize the note.
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.

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.]

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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

1. On Documentation Workflow in the patient's chart, the Documents section will list the notes.
2. Click on the note you wish to modify. The note opens.
3. Right click and select **Modify**, or in the toolbar, click the **Modify** icon.
4. 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.**
5. Add your information.
6. 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?

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-signer. 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.
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.
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.

<table>
<thead>
<tr>
<th>Description</th>
<th>Dragon Command</th>
<th>Auto-text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Attestation Agree</td>
<td>Attending Agree Macro</td>
<td>=attending_attestation_agree</td>
</tr>
<tr>
<td>Attending Attestation Present</td>
<td>Attending Present Macro</td>
<td>=attending_attestation_present</td>
</tr>
<tr>
<td>Attending Attestation Except</td>
<td>Attending Agree Except Macro</td>
<td>=attending_attestation_except</td>
</tr>
<tr>
<td>Attending Attestation Reviewed</td>
<td>Attending Reviewed Macro</td>
<td>=attending_attestation_reviewed</td>
</tr>
<tr>
<td>Attending Attestation Split/Share MLP</td>
<td>Attending Split Macro</td>
<td>=attending_attestation_split</td>
</tr>
</tbody>
</table>

5. When finished, click Sign.
## Note Templates

<table>
<thead>
<tr>
<th>Type</th>
<th>In addition to Resident/ Exam Attending/Fellow Exam, Assessment Plan, also pulls in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress Notes SCCC</td>
<td>Vital Signs, CBC/BMP (Fishbone Labs)</td>
</tr>
<tr>
<td>Procedure Note</td>
<td>None; blank text field for free text</td>
</tr>
<tr>
<td>Procedure Note Bedside</td>
<td>None; blank text field for free text</td>
</tr>
<tr>
<td>Brief Consult Note</td>
<td>None; templated sections</td>
</tr>
</tbody>
</table>
| Progress Note Post Surgical | Vital Signs, CBC/BMP (Fishbone Labs), Post-op day, I&O  
*Does not pull in Subjective, Objective, Assessment Plan. |

## Procedures

<table>
<thead>
<tr>
<th>Description</th>
<th>Dragon Command</th>
<th>Auto-text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Note CV Cath Internal Jugular Right</td>
<td><code>/cv_internal_jugular_right</code></td>
<td><code>/cv_internal_jugular_right</code></td>
</tr>
<tr>
<td>Procedure Note CV Cath Internal Jugular Left</td>
<td><code>/cv_internal_jugular_left</code></td>
<td><code>/cv_internal_jugular_left</code></td>
</tr>
<tr>
<td>Procedure Note CV Cath Subclavian Right</td>
<td><code>/cv_subclavian_right</code></td>
<td><code>/cv_subclavian_right</code></td>
</tr>
<tr>
<td>Procedure Note CV Cath Subclavian Left</td>
<td><code>/cv_subclavian_left</code></td>
<td><code>/cv_subclavian_left</code></td>
</tr>
<tr>
<td>Procedure Note CV Cath Femoral Right</td>
<td><code>/cv_femoral_right</code></td>
<td><code>/cv_femoral_right</code></td>
</tr>
<tr>
<td>Procedure Note CV Cath Femoral Left</td>
<td><code>/cv_femoral_left</code></td>
<td><code>/cv_femoral_left</code></td>
</tr>
<tr>
<td>Procedure Note Chest Tube Placement</td>
<td><code>/chest_tube_placement</code></td>
<td><code>/chest_tube_placement</code></td>
</tr>
<tr>
<td>Procedure Note Foley Catheter</td>
<td><code>/foley_catheter</code></td>
<td><code>/foley_catheter</code></td>
</tr>
<tr>
<td>Procedure Note Gastric Lavage</td>
<td><code>/gastric_lavage</code></td>
<td><code>/gastric_lavage</code></td>
</tr>
<tr>
<td>Procedure Note OG Placement</td>
<td><code>/og_placement</code></td>
<td><code>/og_placement</code></td>
</tr>
<tr>
<td>Procedure Note NG Placement</td>
<td><code>/ng_placement</code></td>
<td><code>/ng_placement</code></td>
</tr>
<tr>
<td>Procedure Note Endotracheal intubation</td>
<td><code>/endotracheal_intubation</code></td>
<td><code>/endotracheal_intubation</code></td>
</tr>
<tr>
<td>Procedure Note Cricothyroidotomy</td>
<td><code>/cricothyroidotomy</code></td>
<td><code>/cricothyroidotomy</code></td>
</tr>
<tr>
<td>Procedure Note Arterial Line Placement</td>
<td><code>/arterial_line_placement</code></td>
<td><code>/arterial_line_placement</code></td>
</tr>
<tr>
<td>Procedure Note IO Placement</td>
<td><code>/IO_placement</code></td>
<td><code>/IO_placement</code></td>
</tr>
<tr>
<td>Procedure Note IV Placement with Ultrasound Guidance</td>
<td><code>/IV_placement_with_US</code></td>
<td><code>/IV_placement_with_US</code></td>
</tr>
<tr>
<td>Procedure Note Ortho Joint Reduction</td>
<td><code>/ortho_joint_reduction</code></td>
<td><code>/ortho_joint_reduction</code></td>
</tr>
<tr>
<td>Procedure Note Ortho Fracture Reduction</td>
<td><code>/ortho_fracture_reduction</code></td>
<td><code>/ortho_fracture_reduction</code></td>
</tr>
<tr>
<td>Procedure Note Ortho Splinting</td>
<td><code>/ortho_splinting</code></td>
<td><code>/ortho_splinting</code></td>
</tr>
<tr>
<td>Procedure Note Ortho Arthrocentesis</td>
<td><code>/ortho_arthrocentesis</code></td>
<td><code>/ortho_arthrocentesis</code></td>
</tr>
<tr>
<td>Procedure Note Anesthesia Sedation/Conscious Sedation</td>
<td><code>/anesthesia_sedation_conscious_sedation</code></td>
<td><code>/anesthesia_sedation_conscious_sedation</code></td>
</tr>
<tr>
<td>Procedure Note Incision and Drainage</td>
<td><code>/incision_and_drainage</code></td>
<td><code>/incision_and_drainage</code></td>
</tr>
<tr>
<td>Procedure Note Wound Repair</td>
<td><code>/wound_repair</code></td>
<td><code>/wound_repair</code></td>
</tr>
<tr>
<td>Procedure Note Simple Wound Repair</td>
<td><code>/wound_repair_simple</code></td>
<td><code>/wound_repair_simple</code></td>
</tr>
<tr>
<td>Procedure Note Complex Wound Repair</td>
<td><code>/wound_repair_complex</code></td>
<td><code>/wound_repair_complex</code></td>
</tr>
<tr>
<td>Procedure Note Multiple Wounds</td>
<td><code>/wound_repair_multiple</code></td>
<td><code>/wound_repair_multiple</code></td>
</tr>
<tr>
<td>Procedure Note Nasal Packing</td>
<td><code>/nasal_packing</code></td>
<td><code>/nasal_packing</code></td>
</tr>
</tbody>
</table>

## Content Macros

<table>
<thead>
<tr>
<th>Description</th>
<th>Dragon Command</th>
<th>Auto-text</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCCC Plan for systems</td>
<td>S Triple C Macro <code>=sccc_plan</code></td>
<td><code>=sccc_plan</code></td>
</tr>
<tr>
<td>Description</td>
<td>Dragon Command</td>
<td>Auto-text</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Post-op Day# and procedures</td>
<td>Insert Post-op Day</td>
<td>.post_op_day</td>
</tr>
<tr>
<td>VTE Risk, Medications ordered, contraindications to Px</td>
<td>Insert VTE Prophylaxis</td>
<td>.vte_prophylaxis</td>
</tr>
<tr>
<td>Stress ulcer prophylaxis medication orders</td>
<td>Insert Stress Ulcer prophylaxis</td>
<td>.stress_ulcer_prophylaxis</td>
</tr>
<tr>
<td>Most recent vent settings charted by resp</td>
<td>Insert Vent Settings</td>
<td>.vent_settings</td>
</tr>
<tr>
<td>ABGs in the last 12 hrs (one set)</td>
<td>Insert ABG</td>
<td>.abg_last_12hrs</td>
</tr>
<tr>
<td>ABGs in the last 24 hrs (one set)</td>
<td>Insert ABG Last</td>
<td>.abg_last_24hrs</td>
</tr>
<tr>
<td>ABGs last 3 results (3 sets)</td>
<td>Insert ABG Last Three</td>
<td>.abg_last_3_results</td>
</tr>
<tr>
<td>VBGs in the last 12 hrs (one set)</td>
<td>Insert VBG</td>
<td>.VBG_last_12hrs</td>
</tr>
<tr>
<td>VBGs in the last 24 hrs (one set)</td>
<td>Insert VBG Last</td>
<td>.VBG_last_24hrs</td>
</tr>
<tr>
<td>VBGs last 3 results (3 sets)</td>
<td>Insert VBG Last Three</td>
<td>.VBG_last_3_results</td>
</tr>
<tr>
<td>Post void residual volume</td>
<td>Insert Post Void Residual</td>
<td>.post_void_residual</td>
</tr>
<tr>
<td>Intake and Output</td>
<td>Insert I and O</td>
<td>.io</td>
</tr>
<tr>
<td>Urine output last 8 hours</td>
<td>Insert Urine Output 8 hours</td>
<td>.urine_output_last_8hrs</td>
</tr>
<tr>
<td>Last 3 Hemoglobin &amp; Hematocrit results</td>
<td>Insert H and H trend</td>
<td>.hh_trend</td>
</tr>
<tr>
<td>Serum lactate level</td>
<td>Insert Lactate</td>
<td>.lactate_labs</td>
</tr>
<tr>
<td>Cardiac enzymes + BNP within last 12 hours</td>
<td>Insert Cardiac Labs</td>
<td>.cardiac_labs_12hrs</td>
</tr>
<tr>
<td>Cardiac enzymes + BNP last this encounter</td>
<td>Insert Cardiac Labs Last</td>
<td>.cardiac_labs_last</td>
</tr>
<tr>
<td>List of active inotrope or pressor orders</td>
<td>Insert Pressors</td>
<td>.pressors</td>
</tr>
<tr>
<td>For each antibiotic, # of hrs,days for admin</td>
<td>Insert Antibiotic Orders</td>
<td>.antibiotic orders</td>
</tr>
<tr>
<td>PT, INR, PTT, DIC, Fibrinogen, Thrombin Time within last 12 hrs</td>
<td>Insert Coags</td>
<td>.coags_12hrs</td>
</tr>
<tr>
<td>PT, INR, PTT, DIC, Fibrinogen, Thrombin Time last this encounter</td>
<td>Insert Coags Last</td>
<td>.coags_last</td>
</tr>
<tr>
<td>WBC only</td>
<td>Insert WBC</td>
<td>.wbc_only</td>
</tr>
<tr>
<td>WBC Differential in last 24hrs</td>
<td>Insert Differential</td>
<td>.differential_24hrs</td>
</tr>
<tr>
<td>WBC Differential most recent for this encounter</td>
<td>Insert Differential Last</td>
<td>.differential_last</td>
</tr>
<tr>
<td>Number of days a central line has been present</td>
<td>Insert Central Line Days</td>
<td>.central_line_day</td>
</tr>
<tr>
<td>Weight change from previous charted weight</td>
<td>Insert Weight Change</td>
<td>.weight_change</td>
</tr>
</tbody>
</table>
### 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**.

### 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**.

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**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.
- Do not use special characters like: *`, @, #, $, %` or `_`.