How To Document A Delivery Note

STEP 1
Allow the nurses to complete their documentation so that it will be included in your note.

STEP 2
Go to Physician Documentation to add a POWERNOTE. We have to use Powernotes in order to capture clinical data that you enter in your note.

Choose Encounter Pathway and search for “delivery”

The new notes are called OB C/S Cesearean Delivery Note and OB Vaginal Delivery Note. The C/S note, if completed with the surgical details can be used as both the operative note and delivery summary.

Choose one of these notes.

STEP 3
The first time you create each note, select all of the boxes on the pop up window
Then click OK. You only have to do this ONCE, but you HAVE to do it ONCE.

**STEP 3**

Click **Show Structure** after Procedure to open the documentation area.
You will need to do this EVERY time you use these notes.

**STEP 4**

Use the point and click documentation options for all of the portions included. This will allow what you put in your note to be retrieved for later data retrieval and reporting. You can add a narrative in each section, or at the end if desired. If all of the pertinent details are recorded as part of the point and click sections, a narrative note is not necessary for a vaginal delivery.

**NOTE**

There are a couple of places in the note where nursing documentation is pulled in:

Indications for Csections, Maternal and Neonate complications will show the nursing documentation if completed below the section like this:

```
Complications:
Baby B+ / Baby C+ / Baby D+
Maternal: no complications / abruption / anesthesia-related / blood transfusion ...
fever / fractured coccyx / placenta previa / pre eclampsia / pulmonary / retinal ...
       / uterine inversion / uterine rupture / CVA / seizure / maternal death
Singleton Baby A: no complications / anomalies / brachial plexus ... / cephalohemat ...
fractured clavicle ... / hypoxia / laceration / lesions / meconium aspiration / m

Nursing Documentation (ST)
Baby A - Neonate Complications: None (05/22/17 21:31:23)
```

If this is complete, you do not need to select any of the options above for your note, it will be included in the text. If there are clinical discrepancies, please review with the nurse as inconsistencies in documentation are frequent medico-legal pitfalls.

The QBL will also pull in to the note:

```
Quantitative Blood Loss
OTHER / QBL (ST)
Quantitative Blood Loss: 750 (05/24/17 13:41:26)
```

If it is already documented, do not add it again.

If it was not documented, it will appear like this:
Click where it says “OTHER” to add the QBL.

**STEP 5**

Sign your note and go back to bed!

You can also watch the video here about creating these notes:

https://youtu.be/gYg8tDLsV7s