# Table of Contents

1. **The Pregnancy Workflow** ................................................................................. 2
   1.1. Finding the OB Workflow Pages .................................................................. 2
   1.2. **OB Specific Components** ....................................................................... 3
       1.2.1. Prenatal Visits ..................................................................................... 3
       1.2.2. Education and Counseling .................................................................. 4
       1.2.3. Fetal Monitoring .................................................................................. 4
       1.2.4. Birth Plan ............................................................................................. 5
       1.2.5. Consolidated Problems ......................................................................... 5
       1.2.6. Prenatal Labs and Tests ....................................................................... 6
   1.3. **Where do I find?** .................................................................................... 7
   1.4. **The First Visit** ....................................................................................... 7
       1.4.1. Open the Pregnancy ............................................................................. 7
   1.5. **New OB Visit History and Physical (Outpatient)** ................................... 8
       1.5.1. Documenting the Pregnancy History .................................................... 9
       1.5.2. Transcribed Prenatal Labs .................................................................. 12
   1.6. **The OB Clinic Visit** ............................................................................. 13
       1.6.1. Documenting an OB Visit/Exam: Documenting on the Pregnancy Workflow Page ........................................................................................................ 13
       1.6.2. Documenting in Interactive View (iView) ............................................ 14
       1.6.3. Documenting Education ..................................................................... 15
       1.6.4. EDD Maintenance .............................................................................. 16
   1.7. **Closing the Pregnancy** ............................................................................ 17
   1.8. ** Archived Pregnancy Summary** .............................................................. 18

2. **OB Notes** ........................................................................................................ 18
   2.1. **OB Admit/Clinic/TOLAC Notes** .............................................................. 19
       2.1.1. Dynamic Documentation .................................................................... 19
       2.1.2. Powernotes ......................................................................................... 19
   2.2. **Powernotes Basics** ............................................................................... 20
       2.2.1. Add a Note .......................................................................................... 20
       2.2.2. Launching Your Powernote ................................................................ 21
       2.2.3. Powernote Favorites ......................................................................... 21
       2.2.4. Creating Precompleted Notes ............................................................ 21
   2.3. **OB/GYN Smart Templates** ...................................................................... 22
   2.4. **Delivery Notes** ..................................................................................... 22
   2.5. **Fetal Well Being Powernote** .................................................................. 25
   2.6. **Discharge Summary** ............................................................................... 26
   2.7. **Postpartum Clinic Note** .......................................................................... 26

3. **OB/GYN Orders** ............................................................................................. 26
   3.1. **Quick Orders** ......................................................................................... 26
   3.2. **Powerplans** ......................................................................................... 27
   3.3. **Postpartum Orders** ................................................................................ 27
   3.4. **OB/GYN Order FAQs** .......................................................................... 28

4. **Related Records** ........................................................................................... 28

5. **OB Tracking Shell** ....................................................................................... 28
   5.1. Launching the Chart from the Labor Board .............................................. 31
   5.2. Reports/Birth Log ...................................................................................... 32
1. The Pregnancy Workflow

The Pregnancy Workflow is the flowsheet for the patient’s prenatal care. There are 2 versions, the OB Prenatal and OB Inpatient which are optimized for their respective location. You should be able to review all of their care relevant to their pregnancy care without navigating away from this screen.

Many of the components are common to other Workflow pages. There are a few components specific to OB. You should familiarize yourself with the information available on this page.

There are videos available that review each of these pages:

OB Prenatal
https://youtu.be/BpWWtz6iEzU?list=PL6psK6r4RFx0HT0sllnZVKDWe5BbwOSwB

OB Inpatient
https://youtu.be/-bLR5jOw68?list=PL6psK6r4RFx0HT0sllnZVKDWe5BbwOSwB

1.1. Finding the OB Workflow Pages
You can use both of these pages as a tab on your Acute Workflow.

Click on the + to find the pages you do not have visible:
Select the view you want to use:

You can drag and drop the tabs of the Acute Workflow to where you want them.

Watch this video to view the customization of your Workflow tabs:
https://youtu.be/nePYKrTv9Lk?list=PL6psK6r4RFx2e0vgGgnQUhV_pkE8Mpxz2

1.2. OB Specific Components

1.2.1. Prenatal Visits

You can view and document your prenatal visits in this component. You can use either the card view or the flowsheet view and toggle between the two with the icon in the upper right.

Card View

Flowsheet View
When you hover over the details in the box, you can view all of the historical information for that detail for the pregnancy (this is particularly useful for reviewing blood pressure and weight gain trends):

Troubleshooting: If the OB exam box does not appear make sure that you are using a Clinic encounter and that the blood pressure was recorded on the correct encounter.

1.2.2. Education and Counseling

OB education is documented in Interactive View and populates this section.

1.2.3. Fetal Monitoring

The Fetal Monitoring tab will display the archived strips done in the hospital. If you click Show, it will launch a view-only version of Fetalink and you can review the archived strip:
1.2.4. Birth Plan

Birth plan requests are documented in Interactive View. If you click the + here, it will launch the birth plan form.

Birth Plan (0) +

No birth plans have been documented for this patient. Add a Birth Plan.

Here are the items that will display in this section if documented in this form:

Document who to call for delivery here.

1.2.5. Consolidated Problems

Make sure to keep this section up to date and complete as it is the most useful way to convey important problems relating to the pregnancy between providers and
between the outpatient and inpatient settings. Document dates of tubal and TOLAC forms in the comments section to make sure it can be easily retrieved in the hospital.

1.2.6. Prenatal Labs and Tests

Review prenatal labs here. They are separated by stage in pregnancy and the gestational age of the lab draw appears in the table.

You can also click on the lab and mark Decline when the patient declines a test:
Note: transcribed labs and HIV do not appear here, but you can find them in the Labs section. Not all of the labs will appear as “Ordered” when the order is placed, but the results will still appear if completed in our system.

1.3. Where do I find?

1.3.1.1. MSAFP results

Make sure your clinic scans these in as “Lab Report” then they will be viewable in the Documents section of the Pregnancy Workflow pages.

1.3.1.2. Ultrasounds Done in Clinic or Outside Facility

Make sure your clinic scans these in as “Ultrasound Report” then they will be viewable in the Diagnostics section of the Pregnancy Workflow pages.

1.4. The First Visit

1.4.1. Open the Pregnancy

Go to the OB Prenatal of OB Inpatient pages. Add a pregnancy by clicking where it says Add Pregnancy:

You will now see this window. Typically the onset date will be the LMP. You can then choose to use this as the LMP date and it will be used for initial dating calculations, you can also specify the number of gestations (it will default to 1 gestation).
The overview tab will now display the current pregnancy.

**Troubleshooting:** if the overview contains information about a pregnancy and you believe this is the first visit for this pregnancy, you will need to determine whether the information in the overview is from a previous pregnancy. If it is, you will need to first close the pregnancy, then add a new one. DO NOT make changes to the EDD until you have closed the pregnancy and added a new pregnancy (see section 1.5 on closing the pregnancy).

1.5. New OB Visit History and Physical (Outpatient)

To document the intake history, use the Antepartum Intake Form. If the Antepartum Intake form was started by your clinic staff, you can find it in the Form Browser:

Right click on it and select “Modify” to review and add your documentation as well.

If it was not already started, you can go to AdHoc charting on the banner bar (typically this form is started by the clinic CPSP/MA):

Choose the Antepartum Intake form
The advantages to using this form for your new OB visit are that it will contain the appropriate prompts for a complete history and the items in this form will populate to the Pregnancy Workflow (histories, genetic screen, pre-pregnancy weight) and the Pregnancy Report or Pregnancy Summary Document which is the printable version of the Pregnancy Workflow (including the Antepartum Note and the physical exam).

To save the documentation in the form, click the green check mark in the upper left hand corner.

1.5.1. Documenting the Pregnancy History

Go to Pregnancy History in the Antepartum Intake form, or to the Pregnancy tab in the Histories section:
Click on the +Add button to add a prior pregnancy.

The record will be updated in the Gravida/Para box. DO NOT change the pregnancy count by entering numbers in to the Gravida/Para box (Add pregnancies ONLY by using the +Add button)

DO NOT CHANGE THE NUMBERS IN THIS BOX:

After you click on +Add, you can fill out the pregnancy details in this box:
To add information about a second twin, click on the + Add Baby icon:

You can then add the details for the additional baby:

Click OK, or OK & New until you are done adding all of the pregnancy history. The pregnancies will be viewable in the historical pregnancy table, and the count will be updated automatically in the pregnancy count box (again, do not edit the pregnancy count here).
If you need to make changes on the pregnancies you have documented, or if you need to delete a pregnancy you have recorded, click on the pregnancy within the table, then click modify:

![Image]

It will bring up this box and you can make changes to the pregnancy here, or delete the pregnancy:

![Image]

**Troubleshooting:** If the Gs and Ps are not correct in the Overview, try these tips:
Are the pregnancies documented in the Pregnancy History component? If not, then document them.

Is the gestational age documented for each pregnancy? If not, then modify the pregnancy to add the gestational age (an estimate is appropriate).

In some patients there may be an error with one or more of the pregnancies. If they are correctly documented, then you can try deleting the pregnancies and adding them again. If this does not correct the problem, please report it to the Helpdesk.

1.5.2. **Transcribed Prenatal Labs**

Labs that were done outside of the system (outside lab or transfer of care) can be documented in the Transcribed Prenatal Labs section on the Antepartum Intake form. When documented here, the labs will be available for review in the Labs section of the Pregnancy Workflow pages.
1.6. The OB Clinic Visit

View the OB clinic visit video here
https://youtu.be/BpWWtz6iEzU?list=PL6psK6r4RFx0HT0sllnZVKDWe5Bbw0SwB

1.6.1. Documenting an OB Visit/Exam: Documenting on the Pregnancy Workflow Page

Document your prenatal visit directly on to the Workflow page by clicking Chart. The Chart button appears at the bottom of both the Card view and the Flowsheet view.

When you are done adding results, sign with the green checkmark.
HINT 1: There is a 256 character limit for the comments section. For most OB patients, a short note in the comments section is adequate for the visit and you will not need a separate note. If you do need to complete a separate note, it is helpful to add the important details here and then create an OB clinic note (see below).

HINT 2: Your name will appear at the top of the card if you add visit comments, making it very easy to see who has been seeing the patient.

HINT 3: If you diagnose a patient with a multiple gestation, click where it says “Add Baby” to create an additional baby for documentation. ONLY do this ONCE.

1.6.2. Documenting in Interactive View (IView)
If you do not document on the day of your visit, to modify a result you have already charted, or to document Education and Counseling, you will need to document in IView.

You can access IView from the Pregnancy Workflow pages by clicking on Prenatal Visits.

For an office visit, use the MD office visit section:

HINT: Double click on the colored box at the top of the column you are going to use for charting and then you can click enter or tab after completing each section and it will move to the next undocumented box in the column.
To modify a result you have already charted, right click on that result and select Modify.

Sign using the green checkmark in the left corner:

HINT 1: If you need to modify the gestational age on a card (e.g. if you perform an ultrasound that re-dates the pregnancy after the visit was started), navigate to Interactive View and document a new gestational age in any column that is more recent than the one already documented:

1.6.3. Documenting Education

Document OB education performed under the OB Education tab in IView:
1.6.4.  EDD Maintenance

1.6.4.1.  Adding New Dating Criteria

If you have a new piece of dating information and wish to add it to this section, click the + to add a new EDD calculation:

Then, you can add the new item here:

Once you have entered the new information, you can choose to use this method to calculate the EDD by clicking the box on the lower right:

Click OK when you are done.

**HINT 1:** use the comments box only for items relating to the EDD (other details relating to the pregnancy should probably go in the problem list).

**HINT 2:** for LMP calculations, you can select Show Additional Details and add details on the cycle length, the details on cycle length will adjust the EDD calculations accordingly.

1.6.4.2.  Making Changes to an Existing EDD Calculation

To modify an existing EDD (e.g. if the patient tells you that she was mistaken about her LMP date), select “Modify EDD”
Do not use the modify function to change the calculation based on a new dating item.

1.7. Closing the Pregnancy

After the patient delivers, the pregnancy should be closed. Typically this is done by the postpartum nurse on discharge from the hospital. If the patient has an SAB, delivers outside of our system or if the pregnancy was not closed, you will need to close the pregnancy.

Go to Close Pregnancy on the Pregnancy Summary under Overview:

It will prompt you to enter the details of the pregnancy, which will now be part of the patients Pregnancy History:

Troubleshooting: if you have trouble closing the pregnancy, make sure you have entered the details for all of the babies in the pregnancy. If an additional baby was added in error, you will need to inactivate that baby first in Interactive View, then go back and close the pregnancy.

If an additional baby was added, there will be more than one tab here:
1.8. Archived Pregnancy Summary

Once the pregnancy is closed you will no longer be able to view any of the pregnancy specific data in the Pregnancy Summary. You can review an archive of the Pregnancy Summary under Physician Documentation or Notes. It will be saved with the date that the pregnancy is closed.

**HINT:** this document is also viewable from the Pregnancy History section. Scroll to the right and you will see an icon in the column Summary under the closed pregnancy. Click on this and you can open and view the report from that pregnancy.

2. OB Notes

Most notes can be done using Powernotes, or Dynamic Docs depending on the provider preference. **Delivery notes should only be done in Powernotes.**
2.1. OB Admit/Clinic/TOLAC Notes

2.1.1. Dynamic Documentation
There are several phrases that will give you entire note templates for many of the OB notes:

```
.obTOLACconsult *
.obTOLACintrapartumcklist *
.obTOLACreferralcklist *
.obadmithistoryphysical *
.obadmithistoryrepeatcsection *
.obclinicvisit *
```

They are designed to be added to a free text note and will contain all of the pertinent chart details for OB patients. It is not recommended to use the standard note templates as these do not contain information related to the pregnancy.

HINT: select a note from the menu of the OB Workflow pages to launch directly into the correct note type and label.

**OB Inpatient:**

![OB Inpatient Menu]

**OB Prenatal:**

![OB Prenatal Menu]

2.1.2. Powernotes
There are several shared precompleted OB admission notes designed for labor, repeat csection, general OB admits, TOLACs, and OB clinic visits. They will contain most of the charted elements relevant to an OB admission and are very easy to use. See section 2.2 for more information on how to use these notes.
2.2. Powernotes Basics

2.2.1. Add a Note

Click on Physician Documentation, click the down triangle next to the + Add and select Powernote.

You can now choose a template for your note. Encounter pathway lets you type and search for a template. Under the Catalog tab you can browse the available templates by discipline. Under Precompleted, you can select shared or personal precompleted notes.
2.2.2. Launching Your Powernote

After you find your desired note and click OK you will get this screen. Here you can select already charted items to bring in to your note. Click only the items that you want your note to contain.

**HINT:** In general it is best to select fewer items for a more readable note. Powernotes will save your preference for the next time you launch that note template.

2.2.3. Powernote Favorites

Save notes that you use frequently as your favorites for easy launching from the Summary pages. Click Add to Favorites before you launch the note.

From the Workflow pages, you can now click on the downward triangle at the top of the Documents component and launch directly into that note (updates to your favorites in this drop down box often do not appear until the next time you log in).

2.2.4. Creating Precompleted Notes

You can customize your note templates by creating Precompleted notes. First launch the standard template you wish to use and make the changes you want to save for each notes. Smart templates (like vital signs) that you include will be updated with the current values for the patient you are documenting on.

To save the note, find Documentation on the top line and then Save As Precompleted Note.
2.3. OBGYN Smart Templates

There are several smart templates to assist you in creating OBGYN notes. These are available for use in either Dynamic Documentation or Powernotes.

.obduedatecalcs will bring in the EGA/EDD and basis for the calculations
.obpreghistory will bring in the details from the pregnancy history
.obgravipara will bring in the Gs and Ps documented in the pregnancy history
.obclinicvisit will bring in the info documented in Interactive View for the outpatient OB visit
.prenatal will bring in the prenatal labs (including the transcribed labs)
.labs.gyn will bring in many labs relevant to a gyn patient
.labs.std will bring in std screening labs

2.4. Delivery Notes

Use Powernotes for your delivery notes. There is a note for vaginal delivery and another for csection.

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.

Choose Precompleted 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 the appropriate note.

**STEP 3**
The first time you create each note, select all of the boxes on the pop up window (will be pre-selected if using the precompleted note)

Select ALL of these

Like this

Then click OK
You only have to do this ONCE, but you HAVE to do it ONCE.

**STEP 4**
You will need to do this EVERY time you use these notes.

**STEP 5**

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:

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:
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 6**
Sign your note and go back to bed!

You can also watch the video here about creating these notes: https://youtu.be/gYg8tDLsV7s

### 2.5. Fetal Well Being Powernote

NSTs, BPPs and simple OB triages can be documented using the Fetal Well Being Powernote.
There are a couple of shared pre-completed notes for common triage complaints, feel free to make more of your own.

For triage patients that are sent home by the RN, they will complete the Fetal Well Being Powernote and send it to the physician covering. When you receive these notes, you should review the note and the monitoring strip from the visit (see section 1.1.4 for an easy way to find and view the monitoring strip).
The note should contain the following in order to satisfy CMS requirements:

1. outcome of care
2. disposition
3. plan for follow up
2.6. Discharge Summary

Patients with minor or no complications who have been in the hospital for less than 48 hours regular inpatient or 72 hours for normal deliveries or normal newborns do not require a formal discharge summary. Instead the “final progress note” can be substituted for the discharge summary.

To fulfill CMS requirements, the note must contain the following:

1. Outcome of hospitalization
2. Disposition
3. Plan for follow up

2.7. Postpartum Clinic Note

To document a postpartum visit, use your favorite ambulatory clinic visit template (Dynamic Docs or Powernotes).

HINT: add the .obpreghistory smart template to your note to bring in the basic delivery info to your postpartum note.

3. OB/GYN Orders

3.1. Quick Orders

There is a Women’s Health Quick Orders tab that has many useful orders for your obgyn patients. The page has components for both the inpatient and outpatient settings. You can watch this video on using Quick Orders. 
https://youtu.be/WgLMiodtBpg

You should familiarize yourself with the orders available on this page.
3.2. Powerplans

Ob/Gyn Powerplans start with OBGYN. Subphases start with PHA OBGYN.

HINT: use the OB powerplans preferentially for OB orders as there are rules attached to the ordersets to help suggest orders and certain orders (like Pitocin and magnesium) are specifically designed for the OB unit and will not work well if you use the standard orders.

3.3. Postpartum Orders
After delivery, discontinue the Labor and Delivery Admit Powerplan, and any other subphases or orders that you do not plan to continue after delivery. Then, perform a transfer order reconciliation.

For post vaginal delivery patients, place the postpartum orders and initiate these orders.

For post csections, follow the OR workflow and leave orders in a planned state.

**HINT 1:** for all individual orders placed during the antepartum stay, remember to Add to Phase so that they are discontinued along with the admission plan.

**HINT 2:** use postpartum and post csection orders only for postpartum patients because there are rules that fire off of these ordersets that do not apply to GYN patients.

3.4. OBGYN Order FAQs

How do I place an order for an amnioinfusion? Order the desired fluid and rate with a route of “Intrauteral”

4. Related Records

You can bring up baby’s chart from mom’s chart by clicking on Related Records:

5. OB Tracking Shell

Click on Tracking Shell near the top of the screen.

This is what you will see:
You can hover over the items in the columns to see more details. Here you can see the details in the Allergies column:

Go through the columns to become familiar with what is available on the tracking shell.

Most of the columns (age, Gs and Ps, cervical exam) will populate automatically from documentation that you do elsewhere in the chart.

To Do and Notifications columns include icons for FSE, IUPC, and common labor diagnoses:
Anyone can add an icon by right clicking in the To Do, or Notifications box and it will bring up this screen, then, click on the appropriate boxes:

In the Comments column you can add a short free text comment that you want viewable on the labor board. This is typically where you would add the reason for admission (PTL, pyelo, IOL, etc). You can add a comment from any computer and it will be visible for everyone.

The VCMC or SP labor board is the de-identified view that will be available as the labor board with only the patient initials visible.
5.1. Launching the Chart from the Labor Board

You can launch any tab of the patient’s chart by right clicking on the patient from the labor board:

You should always launch the chart from the Tracking Shell in order to ensure you are working on the correct patient and the correct encounter/visit.
5.2. Reports/Birth Log

Launch the delivery log from the tracking shell, by clicking on Reports.

Then, choose which type of report you want to run:

- Delivery Summary
- Extractable Birth Log Book
- Fetal Well-Being
- OB Activity Log
- Ongoing Pregnancy by EDD EGA
You can specify a date range, and location (delivery location)

The Delivery Summary shows totals, multiples, c/s rates, VBACs, inductions, epidurals, lacerations and instrumented deliveries.

The Extractable Birth Log report is similar to the written birth log and has many, many fields. You can search within the report, or save the file and import it to Excel and can search and sort and work with the data.
6. Customizing IView Bands

You may want to customize what is visible in IView. To add or remove a section from what you see in IView, go to View, then Layout, then Navigator Bands.

Highlight the section on the left that you wish to add and then click the right arrow to add. Then click OK.
Highlight the item on the right side that you want to delete, click the left arrow, then OK to delete. Highlight the item on the right, then click the up or down arrow to change the order of the bands.

You will need to exit and restart Powerchart to view the changes in the IVView bands.

7. Surgeries

7.1. Preop Visit

7.1.1. Preop Orders

Watch the Video instructions here: https://www.youtube.com/watch?v=JJaTN-9BS8I (5 minute video)

When you are ready to place your preop orders, they need to be placed on the PREADMIT encounter. This encounter will be created by pre-admitting when the surgery is scheduled. If you are doing the preop orders the same day you make the decision for surgery, you, or your clinic staff will need to call pre-admitting to have them create this encounter in order to enter preop orders.

1. Make sure you place the orders on the PREADMIT encounter (DO NOT use a PREREG or OUTPATIENT encounter).

To switch to the pre-admit encounter, click on the Loc in the Banner Bar.

Then click on your correct preadmit encounter in the list in the pop up window and click OK.
You will now see Preadmit under the patient name.

2. Preop orders have 3 phases, Pre Admission Test, Day Before Surgery and Day of Surgery, click on each phase in the View column to enter orders for that phase. First enter the orders for the preop testing phase. The preop testing phase will initiate automatically when you sign the orders.

3. Then enter the orders for the day before surgery phase. This phase contains the day of surgery medications per pharmacy request. If you want any medications that are not in the standard orderset, remember to Add to Phase. These orders are left in a PLANNED state (do NOT Initiate).

4. Then, enter the orders for the day of surgery phase. These orders are left in a PLANNED state. You will need to put an admitting physician in the orders and the name of your procedure. If you want to order any intraoperative medications (marcaine, pitressin, etc), add them to this phase. Select intraoperative orders from the surgery favorites folder (Folders->Surgery->Medications).

5. CHECK ALERTS

6. Save your orders as a favorite so you have to make fewer modifications next time.
7. SIGN the orders when you have completed all of the phases. If you have done your orders correctly, they should look like this:

7.2. Day Of Surgery

7.2.1. Before the case

Review your H&P. Double click on the H&P to add an addendum. Add the H&P update. If you can not add the addendum to your document, you can create a free text document and place the update there (TIP: label it H&P update so HIM can find it easily)

7.2.2. After the Case

7.2.2.1. Outpatient Cases

1. Add Follow up and postop instructions
2. Make sure your patient has a discharge diagnosis
3. Add disposition and plan for follow up to your operative note and it will fulfill the requirements for a discharge summary on outpatient surgeries.

7.2.2.2. Post op Orders

Same Day Admits

1. Perform an Admission Reconciliation. DO NOT Discontinue the PACU orders.

   Status: Mode History Admission Transfer Discharge

   [Image]

2. Select a post op admit Powerplan

   [Image]

3. Click on each phase (Initiate in PACU and Leave Planned Until Floor) to review and select all orders. Place any time sensitive orders & orders you want completed in the PACU in the first phase.

   [Image]

4. Sign orders. The first phase will initiate automatically.

Inpatients
1. **Discontinue** any prior Powerplans/orders that are no longer needed. **DO NOT** discontinue the PACU orders.

2. **Perform** a Transfer Reconciliation. This step is **REQUIRED**.
   
   Reconcile ALL orders with this reconciliation, not just medications. Resume any previous medication orders that you want to continue after surgery (they will default to resume). **DO NOT** Discontinue the PACU orders.

3. If you are not changing many orders, **add** the Transfer to: order individually.

4. If you need to place a new plan, **select** your post op Powerplan (see above). Click on each phase to review and select all of the orders. Orders that you want completed in the PACU go in the first phase.

5. **Sign** orders. The first phase will initiate automatically.

**Outpatients**

1. Place any orders that you want to be carried out during PACU recovery – **sign**

2. Place Discharge Orders for Home – **sign**

3. Perform a Discharge Reconciliation. You can add discharge medications directly to the Discharge Reconciliation.

**7.3. Viewing the Surgery Schedule**

Click on Case Selection on the top of the screen:

From here you can view the upcoming (or past) case schedule. You can find cases within a date range, for a specific provider, or search by name or MRN:
Change the location of your search by clicking location:

Select your desired location in this box:

A checkbox next to the name means the patient has arrived:

<table>
<thead>
<tr>
<th>Checked In</th>
<th>Status</th>
<th>Person Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>03-Jun-2013 13:02</td>
<td>FORTYTHREE</td>
<td>FORTYTHREE INT-THREE</td>
</tr>
<tr>
<td>03-Jun-2013 12:26</td>
<td>FORTYTHREE</td>
<td>FORTYTHREE INT-THREE</td>
</tr>
<tr>
<td>03-Jun-2013 11:24</td>
<td>FORTYTHREE</td>
<td>FORTYTHREE INT-THREE</td>
</tr>
<tr>
<td>05-Jun-2013</td>
<td>HAMPSTEAD, THOMAS TEST</td>
<td>HAMPSTEAD, THOMAS TEST</td>
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8. Partogram
The Partogram is available under the Acute Workflow tabs on the Menu.
You will find it under the down arrow:

(While you are managing labor patients, you could drag and drop to the first position so that the Workflow will open to that page).

The Partogram gives you a graphical representation and summary of the patient’s vital signs and progress in labor.
The graphs will appear when a labor onset date and time are charted in Interactive View. The labor nurses should all know how to do this step.

9. Fetalink

9.1. Strip Review

You can open Fetalink from any computer with access to Cerner. Without logging in you will be able to view the active monitoring strips and scroll back to the beginning of that monitoring session.

In order to search for older strips, you will first need to sign in.
Then click Patient Archive to search for other monitoring sessions.

9.2. Fetalink Alarms

Physicians can also address alarms when appropriate. Here are some tips on how to address the alarms.

9.2.1. What is Alarming?
The strip of the patient that is causing the alarms is highlighted in red.

The vital sign triggering the alarm will be highlighted in yellow.

9.2.2. Acknowledge the Alarm:
Acknowledging the alarm will silence that alarm unless the reason for the alarm recurs in 30 secs or more.

Step 1 Sign in!
Step 2 Click green check mark

OR Click paperclip to add annotation, signing your annotation will acknowledge the alert
9.2.3. Silencing the Alarm:
Silencing will stop the alarm temporarily for that user only, but it will start again after 30 secs even if the reason for the alarm has resolved.

To silence the alarms, click the bell

9.2.4. Set Alarm Thresholds for Individual Patients:
Example: a patient with chorioamnionitis with an elevated FHR baseline being treated.

Step 1 Sign in!
Step 2 Open patient specific view.

Step 3 Click Patient Alerting

Step 4 Set desired custom values, then click OK.

These values will remain stored for the patient for this monitoring session, unless you go back and reset to defaults. This icon will appear under the patient’s name.