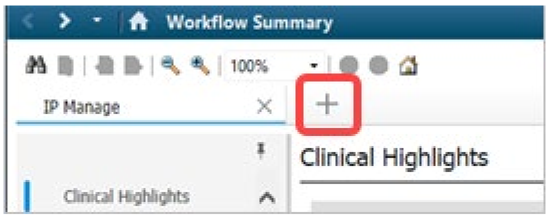
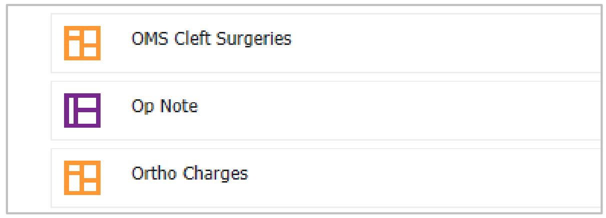
Op Note Workflow Summary Setup

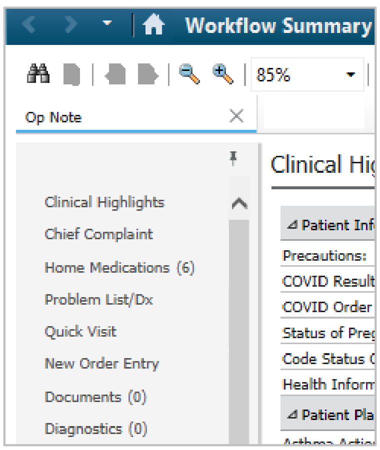
The Operative Procedure Report is a post-surgery requirement. If this note is not completed after the surgery or is dictated, an Immediate Post Op Note or brief note needs to be completed before the patient transfer of care. The link to this note can be found below the Operative Procedure Report note link on the Workflow Summary.

1. Click + and select **Op Note** to add the Workflow Summary.

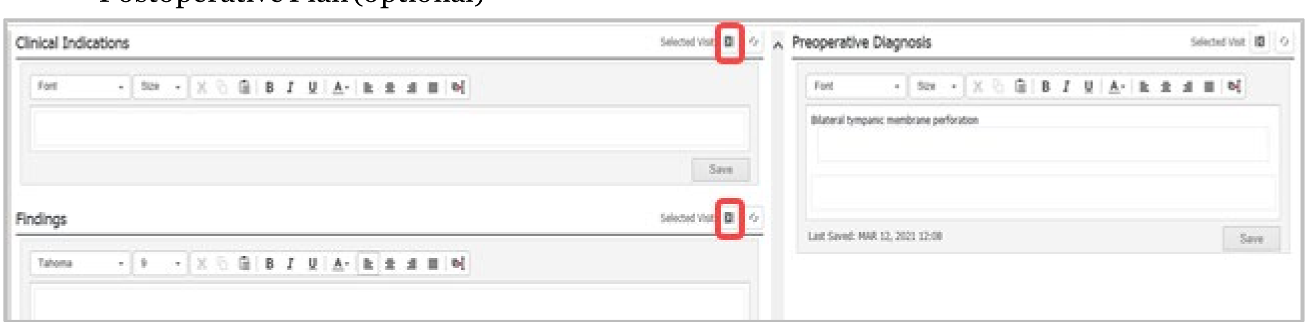




2. The **Op Note Workflow Summary** facilitates chart review and note creation. Rearrange the chart review components by dragging and dropping them into a preferred order. See suggested menu order below.



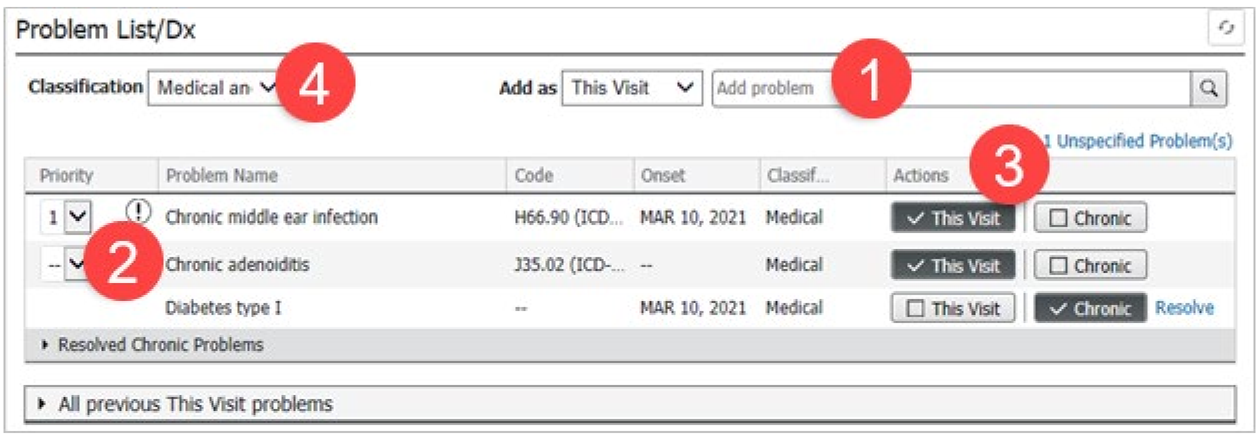
3. The **Op Note Workflow** offers a split screen view. To create the split screen, click the grey right arrow on the following scratchpads:
   - Preoperative Diagnosis
   - Indications (optional)
   - Findings
   - Description of Procedure
   - Postoperative Plan (optional)



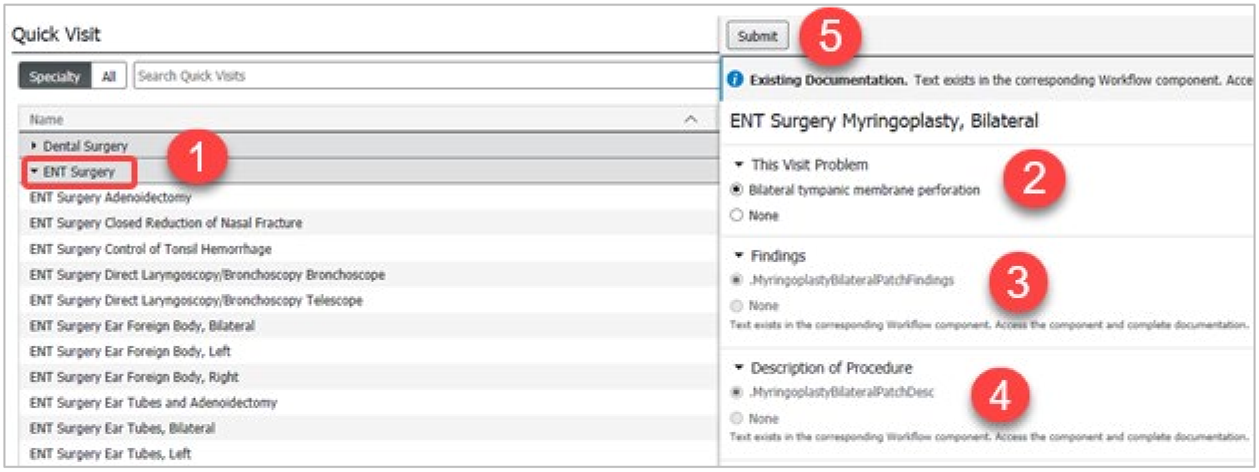
Questions or need assistance? Call Children's IT Service Desk 24/7 at 952-992-5000 or 4-5000 internally

Op Note Documentation Workflow

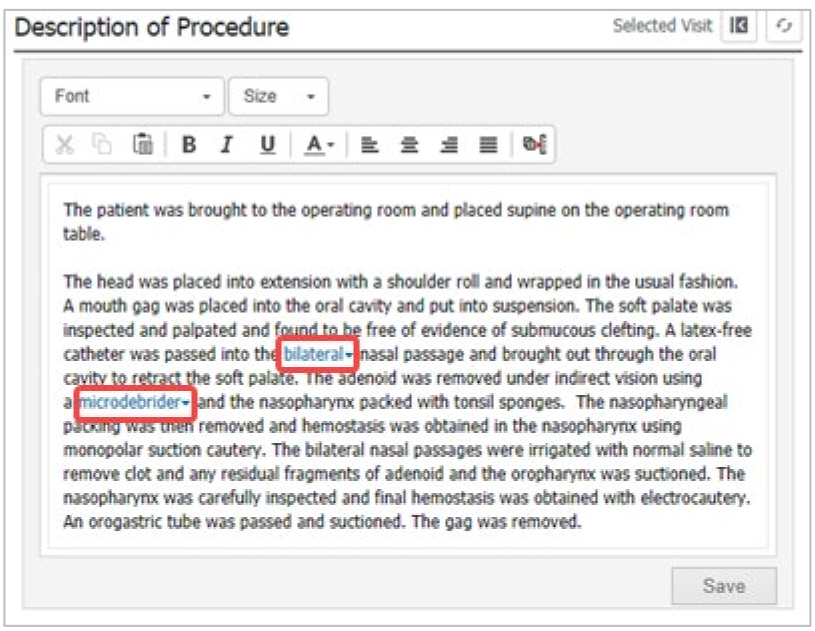
1. Use the **Problem List/DX** component to view and manage multiple problems/diagnoses.
   1. Add a new problem/diagnosis by entering the diagnosis name into the search field. Select the appropriate diagnosis name to add it to the problem list.
   2. Each clinician can create their own priority list by adjusting the priority of the diagnoses. The prioritized problems will flow into the **Operative/Procedure Report**.
   3. Click the action buttons to check/uncheck the type of problem
      - **This Visit**: The diagnosis is relevant for this visit only
      - **Chronic**: An ongoing problem that is not managed during this visit. Click **Resolve** if no longer active.
      - **This Visit and Chronic**: The diagnosis for this visit and an ongoing problem managed at this visit.
   4. Click the down arrow on **Medical and Patient State** and select **All** to view confidential problems (optional).



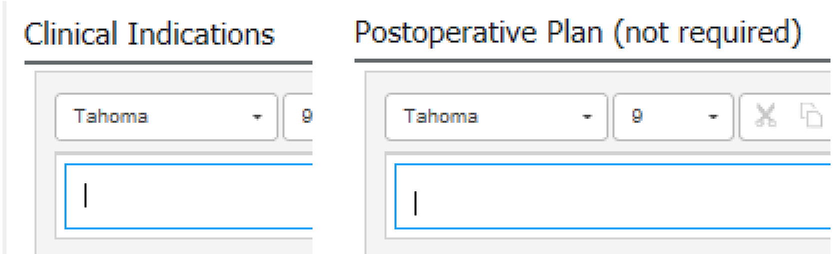
2. **Quick Visit** is a way to quickly add a diagnosis and documentation for your procedure.
    1. Locate your specialty and select the appropriate procedure.
    2. Select the appropriate This Visit Problem or select None to display only the prioritized problems on the problem list.
    3. Select the Findings.
    4. Select the Description of Procedure.
    5. Click Submit. The dot phrase templates will flow into their corresponding scratchpad.



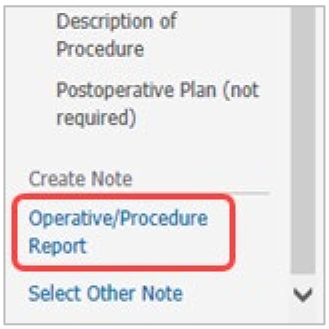
Note: On a desktop, using the F9 key will reposition the cursor from dropdown to dropdown to quickly complete documentation. Using the F3 key will cursor from underscore to underscore.



3. Free text to complete the optional component fields: **Clinical Indications** and **Postoperative Plan.**
   Note: Sections that are not required do not need to be removed. If there is no documentation, the header will not display on the signed note.



4. Select **Operative/Procedure Report** located on the bottom of the **Op Note Workflow**.



5. Review the note and click **Sign/Submit** if you are the surgeon of record.
   If you are an assistant resident, fellow, or NP, click **Save** and **Close** then **Forward**.
6. From the **Sign/Submit Note** window, the **Title** of the note can be changed to match the procedure name. Click **Sign.**