Table of Contents

How to View Notes
How to Start a Note
How to Expand Your Screen
Carry Forward Functionality
How to Remove/Replace Reference Data
Default Template List to Personal Favorite View
How to Free Text a Problem
How to See More Detailed Questions/Sections
How to Sign a Provider Query
How to Identify an Edited Note
Viewing Beyond the Last 10 Records
Printing a Single Progress Note
Macro Search Tip
Using the A/P Section for H&Ps and Consults
After clicking on patient chart from Soarian census view, you will be brought to the following screen:
Clinical Information System (CIS)

If this is your first time viewing patient notes in Soarian, you will need to select “Physician Clinical Summary w/ Provider Doc” from the dropdown circled above. This will remain your default view for all patients unless you change. So, if you want to toggle the view between the one above and the one below, you will need to use this dropdown to do so.

Selecting “Physician Clinical Summary w/ Provider Doc” from the dropdown will bring up the integrated Clinical Summary/Provider Doc view. Notes can then be viewed by expanding the SOAP or Provider Procedure Notes section as indicated above. You can then click on the selected note on the left to bring up the main note view on the right side of the screen. Clicking once on the desired note will then open for viewing.
After clicking on patient chart from Soarian census view, you will be brought to the following screen:

To start a new note, click on the paper icon with a plus next to it, which is circled in red in the above screenshot. This will open the “Add New Document” dialog box where you can select the note template you would like to use. Note templates can be filtered by Procedure or Progress by selecting from the circled drop down below.
The Physician Portal can be minimized so that the full screen can be utilized for Soarian. This is especially helpful when using PDoc. To expand the Soarian view and minimized the Physician Portal, click the icon as seen below. To restore to original state, simply click on the “Collapse” icon in the top left corner.
Clinical Information System (CIS)

**Carry Forward Functionality**  Back

Some template elements from other specialty specific templates may carry forward into a different specialty specific template. These elements will only become part of the note if you confirm them. In order to see who and when these elements were documented, simply hover over the element in question. It is important that careful attention is paid to information that is carried forward into a note, as it is the responsibility of the author to ensure it is up to date, accurate, and relevant.

If for some reason the previous A/P has not carried forward into a note, it is likely because the note was saved “In Progress” before the carry forward A/P was accepted into the note. To correct this, edit the note and then click the icon in the A/P section to replace the reference data.

**How to Remove/Replace Reference Data**  Back

Reference data can be removed by users in individual notes by clicking on the red “X” icon as seen below. Reference data includes vital signs, labs, cardiology results, radiology results, and active orders. This allows users to customize how their notes will appear, and will also drastically cut down on the length of progress notes. Of note, these settings will not be saved, and will need to be applied for each given note. To replace reference data, simply click on icon immediately to right of red “X” icon.

One useful workflow we have seen is to review the reference data for a given section and then copy the data you want to keep directly from the document. You can then paste this data into the free text field for the section. Using the screen shot below as an example, the user could copy just the most recent bilirubin level and then paste it into the “Addtl Lab Results” field of the Laboratory section. They could then remove the reference data for that section so only the most recent bilirubin level they had copied would appear.
Default Template List to Personal Favorite View

Users can select favorite templates by clicking on the star next to a given template. This will add that template to their personal favorites list. To remove a favorite from the list, simply click off of the star next to that template. Users can then select “Make This My Default Tab”, so that each time they open a new note they will be automatically directed to their personal favorites list.
How to Free Text a Problem

Free text problem will be the last selection available in the problem list box when typing in a problem. When adding a free text problem, make sure that the area you are adding to is at the top of the progress note window. If it is lower on the screen, you will not see the OK/Cancel buttons.

**Notice that you cannot see the OK button in this view**

Scroll up so that the field is at the top of your screen, and you will be able to see the OK button.
How to See More Detailed Questions/Sections

Some templates have certain questions hidden in some sections that may be apparent in other templates. For example, the Cardiology note has the “Care Plan Discussed With” element and “Discharge” element hidden while other templates have this expanded by default. This may also apply to other elements within a template. To see more detailed questions within a given section of a template, click on the icon as seen below. This will enable hidden elements such as Care Plan and Discharge. Once these elements are expanded and documented within a patient note, they will appear in future versions for that patient.

In the Assessment and Plan section, this will increase the number of problems available to up to 20. Unfortunately, these problems cannot be reordered at this time.

In the Radiology section, this will expand the fields available to allow for more customized entry of results.
Provider queries and other documents requiring signature or completion can be viewed by the provider by clicking on the Provider Documentation tab located on the left hand side of the main Census/Worklist view. Notes requiring co-signature will have the pencil icon as indicated by the red arrow. To enter the note, click on the document title for the patient in question as shown below.

This will take you directly into the document requiring co-signature. Answer the query within the “Physician Response” field, and then click “Cosign.” The query has now been successfully completed.
How to Identify an Edited Note  

Notes that have been edited by the author can be identified by the presence of an orange triangle icon in the top left corner of the note. This indicates that the author has made a change from their original note.

Viewing Beyond the Last 10 Records  

By default, Soarian PDoc will only show the last 10 notes on a patient so as not to clutter the electronic patient chart. If there are more notes than what is listed, this will be indicated next to the section header as shown by the red circle below next to “SOAP” on the left. There are several ways to change the viewable notes as shown by the red circles on the right. The first way is through the “10 Documents” dropdown menu. Click on this dropdown will allow you to either change to a specific date range or the last 7 days of notes. The other option is to click the right arrow which is circled in red below.
Clinical Information System (CIS)

As shown below, when this arrow is clicked it will show notes previous to the most recent 10 documents which are currently being displayed. If you look at the range of dates of the notes as indicated by the red circle on the left, it has now changed to reflect this.

Printing a Single Progress Note

In some cases, it may be necessary to print a single progress note for office or billing purposes. To do so, you will need to access the patient’s record in HPF. Notes cross to HPF in near real time however there may be a slight delay for them to appear in the HPF record. If you cannot find the record you’re looking for, wait a couple minutes and then try again.

To enter the patient’s record in HPF, click on the icon circled below in red from the patient’s Soarian chart and select “Previous Medical Records”. 
Clinical Information System (CIS)

This will take you to the screen below where you will need to select the encounter you want to print the note from. It is important to be sure you chose the appropriate encounter by checking the dates. Although the most recent encounter is typically at the top, this can include encounters which the patient is preregistered for.

Once the encounter has been selected, expand the Progress Notes section on the left until you find the specific note you want to print. Click on the note so it’s highlighted as shown below, and then click on the print icon.
Macro Search Tip

When creating macros, we recommend all users start the macro name with a prefix such as their initials or department. This will make it much easier to search for macros if you forget which macros you have created. A quick and easy way to search for macros is to type the prefix you use into a free text field that accepts macros and then hit F12. This will then automatically bring up the Text Block Editor along with all macros that feature the prefix you typed in. In this example, we’ve used macros created for the NICU.
Using the A/P Section for H&Ps and Consults

After dictating an H&P or Consult, most providers will leave a brief note on the chart indicating the encounter has been dictating and detailing a brief assessment and plan. One useful workflow we’ve seen used is to enter this in the specialty specific template you will be using instead of the blank progress note. This way the information will pull into your note the following day when you see the patient. Any section not documented on will simply not appear, so the output below is produced.

Subjective: Patient seen and examined by me. H&P dictated.
Assessment: 
Plan:
1) Fever: Details: Rule Out Septic. Details: Well appearing. No other symptoms. Plan: Will admit to pediatric floor on Ampicillin. Ceftriaxone and Acyclovir per CHOP protocol. Will continue to follow blood, urine, and CSF cultures in addition to HIV PCR from CSF. May receive treat as needed for fever. Will remain inpatient until cultures are negative for 48 hours.
2) FN: Details: Plan: Breastfeeding well with normal urine output. Will closely monitor I/O.

Care Plan: NW Family, Nurse, PCP
Primary Care Provider Details: Provider Name/Group: Gambling, James David MD - Internal Medicine

Electronically signed by Adam Glauser, MD on 07/15/2015 14:43