# EHR Tutor Instructor Tipsheet:
## Documenting Patient Data

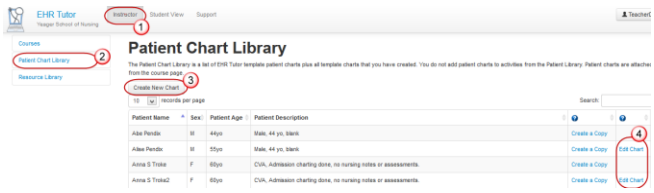
There are two different places and purposes for an instructor to enter patient data.

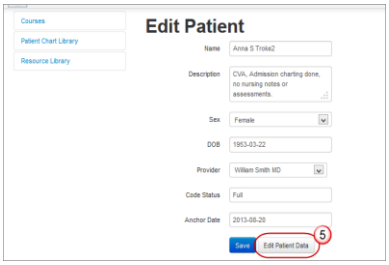
**1. Patient Chart Library**- Only instructors can create documentation that will be saved on a patient chart in the Library, which can be copied and added to activities. This is where you can modify or build new patient charts that will be used repeatedly in your lessons and activities. Students and instructors add documentation to a *copy* of the patient, but the chart saved in the Patient Chart Library remains unchanged, except when you edit the patient data by accessing the patient in the Library.

**2. Activities**- Students and instructors can add documentation to patient charts that have been added to an activity in an assigned course. This is where students gain experience using EMRs/EHRs. As an instructor, you are automatically assigned as a student to every Course that you create, so that you can view activities and chart as a student. Your charting within an activity may or may not be seen by students, depending on whether you set the activity for Individual Patients or Shared Patients. (Refer to the Tipsheet titled, *Shared or Individual Patients*, for more information related to the two types of patients.)

## *Where to go to Document*

### 1. For Patients in the Patient Chart Library

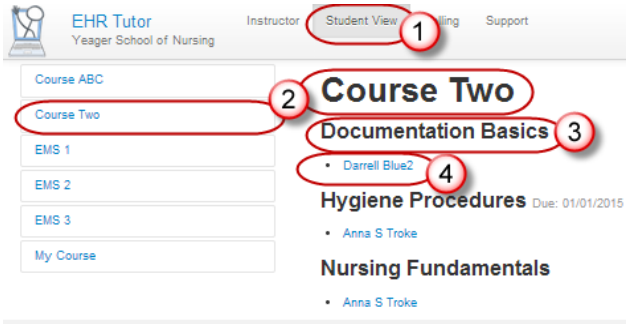



1. Click **Instructor** from the top menu.
2. Click the **Patient Chart Library** tab to the left.
3. If you want to start with a new blank chart, click the **Create New Chart** button.
4. If you want to edit an existing patient chart in the library, click the **Edit Chart** link to open the Edit Patient page.
5. From the Edit Patient page click the **Edit Patient Data** button at the bottom of the page.
The chart opens to the Patient Summary page.

The tabs along the left side of the Patient Summary page are used for documenting patient data as described later in this Tipsheet.

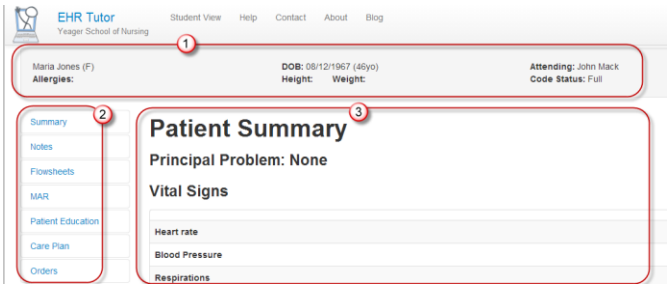
### 2. For Patients within an Activity




1. Click **Student View** in the top menu. (Students have *Courses* in the top menu instead of *Student View*.)
2. The Course tabs to the left of the page list all of your courses. The selected course name appears in bold at the top of the page.
3. Each activity created in a course will appear as a smaller bold sub heading beneath the course title.
4. If a patient chart has been attached to an activity, you will see the patient name as a blue hyperlink. Click on the patient name to open the patient chart described below.

## *The Patient Chart Overview*

You open a patient chart by following the steps above. The Patient Summary page opens first.
**Note:** Charting is done in exactly the same way for instructors and students from this point on.



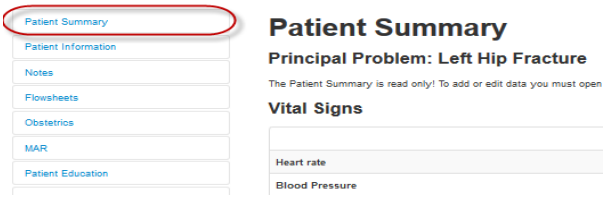

1. The Patient Header is always available at the top of the page with basic information related to the patient.
2. Documentation tabs to the left side of the page are like the tabs in the paper chart. Each tab opens a specific type of patient chart content. This is where

documentation will be done as described later in this Tipsheet.
3. The center of the page is your main work area. The content of this area will change depending on which documentation tab you click. You will read and/or enter information in this area.

## Documentation Tabs Overview

Now let's look at the various documentation tabs and the functionality associated with each.

### Patient Summary




This is a summary of important information such as Vitals, Orders, Lab results, etc. **It is read only**. Certain data is automatically transferred to the patient summary from flowsheets or other forms. This would be a foundation for giving report. This is the first page you see when you open a patient's chart.

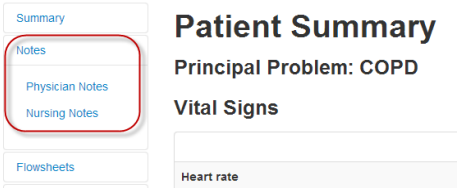
### Patient Information

This is where you can edit the name, sex, date of birth, provider and code status for the patient.

### Notes

1. Click the Nursing Notes tab.

   The menu expands and two note types appear.



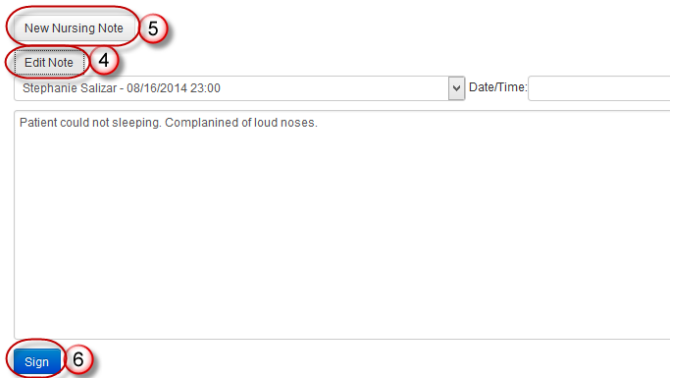

   The menu expands and two note types appear. You can create or edit your own nursing notes, but Physician notes are read only.

2. Click Nursing notes.

   The Nursing notes open.


3. To see a list of all nursing notes previously written, click inside the narrow text box or on the arrow. The list drops down. Then click on a selected note and the entire note will appear in the note text field with a gray background.

4. Click the **Edit Note** button and the background of your own note will change to white, indicating that you can now edit the note within the text box. You can also change the Date/Time. You can only edit your own notes.




5. Click the **New Nursing Note** button to enter a new nursing note.

6. Click **Sign** to save your note or it will be lost. The note will be added with your name to the notes list after signing.

### Flowsheets

Important! *Before leaving a flowsheet, you must click the **Submit** button to save any new data you entered. If entering a large amount of data, it may be helpful to **Submit** after a period of time to save data already entered, and then click **Edit** to continue entering more data.*

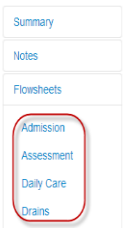
Most documentation is done in flowsheets. There are four methods of data entry:

- Selecting a choice from a single select list
- Selecting multiple choices from a mute-select list
- Typing an entry into a text field (short entry)
- Typing an entry into a text area (longer entry)

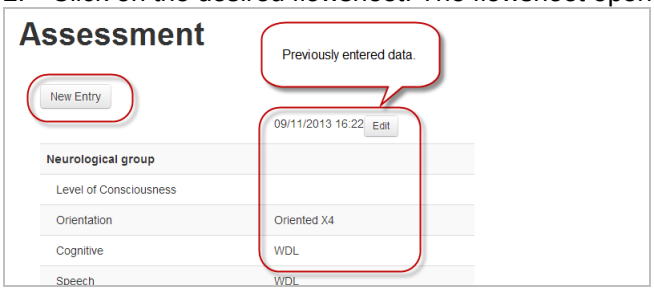
Let's see how each method works.

1. Click the **Flowsheets** tab.

The tab expands allowing you to see many flowsheet options.



2. Click on the desired flowsheet. The flowsheet opens.



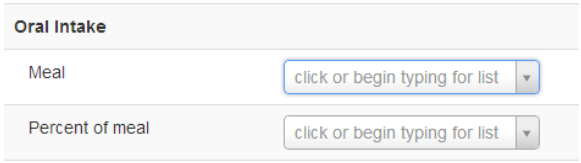

If there have been previous entries, you will see them in columns with the time indicated for the entry. Note that there is an **Edit** button if you want to make changes to previously saved documentation

3. Click the **New Entry** button to chart new data.

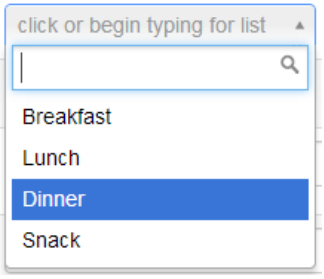
The Flowsheet updates with a new column of data shown with the current time. If you are back timing, you can change the time on this column. Fill in the information for each criteria using one of the three methods explained below.

### Single Select field

Single select fields are designated with an arrow to the right of the field.



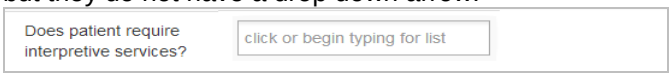

1. Click in the field. The list expands.




2. Select your entry and the list will collapse and display your selection.

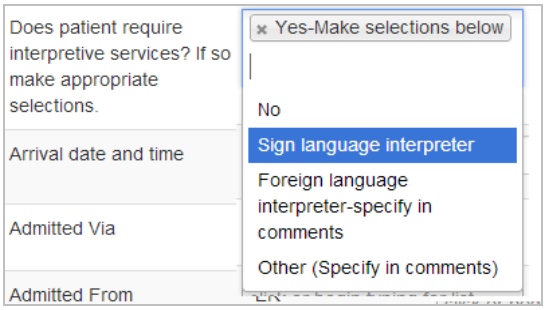
### Multi-select fields

Multi-select fields look similar to the single select field, but they do not have a drop down arrow.




1. Click inside the field.

The multi-select list expands.




2. Select an item from the list and it will move to the top of the box with a shaded background.

3. Continue to select any other choices that apply.

4. After selecting all your choices from this list, click the **Tab** key on your keyboard to move to the next field. (You can also click in the next field.)

   Your selections now appear on the flowsheet in the appropriate field.

***Note:*** *If you select an incorrect response and have not yet saved this flowsheet, you can delete the selection by clicking the* ***x*** *next to it before continuing.*

### Short text entry field

Short Text Entry fields are used for short responses such as vital sign entries, names, numbers etc.


Enter your information from the keyboard and press the **Tab** key on the keyboard to move to the next field.

### Long text entry areas

These areas are larger than the Short Text Entry field to allow for better visualization of longer entries. This field will expand as needed.


Enter your information from the keyboard and press the **Tab** key on the keyboard when you are done.

***Important!*** *Remember that even though it is easy to make changes in an electronic health record, there is always an audit trail of all changes (by whom and at what time). It is not visible to all users, but is part of the legal record and discoverable. Before submitting/saving any documentation in an EHR, make sure that you review it for accuracy. Any changes before submitting the form are not seen on an audit trail.*

## *Patient Education*

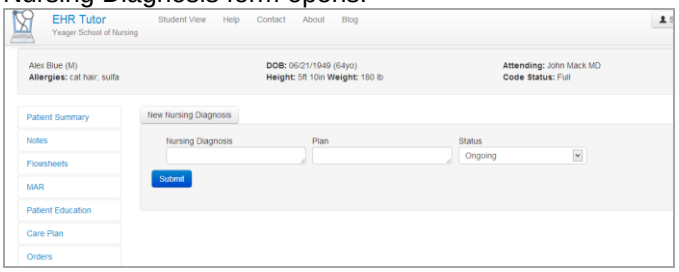
Documenting patient education is done like all other flowsheets. (See the flowsheets section of this Tipsheet.)

There are two groups of criteria. The first group is related to the learners. The second group is related to what is taught, how they are taught and outcomes.

## *Care Plan*

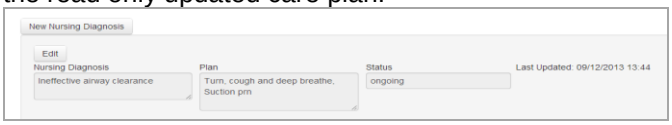
The Care Plan allows you to add all nursing diagnosis/problems.

1. Click the New Nursing Diagnosis button. The New Nursing Diagnosis form opens.




Enter the Diagnosis, plan and the status.

2. Click the Submit button. The page updates to show the read only updated care plan.



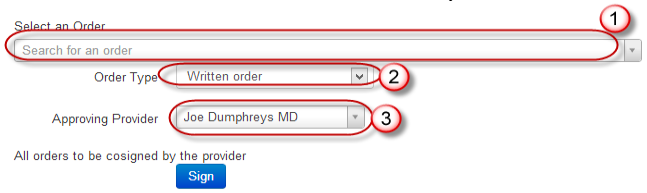

3. Click the **Edit** button to update or change the status for the existing Nursing Diagnosis. The background changes from gray to white to indicate you can now make changes within the text box. Continue Adding Nursing Diagnosis as needed.

Note the date on each diagnosis changes as updates are made.

4. Click **Submit** to save your work or it will be lost.

## *Orders*

Click the **Orders** tab. The Order form opens.



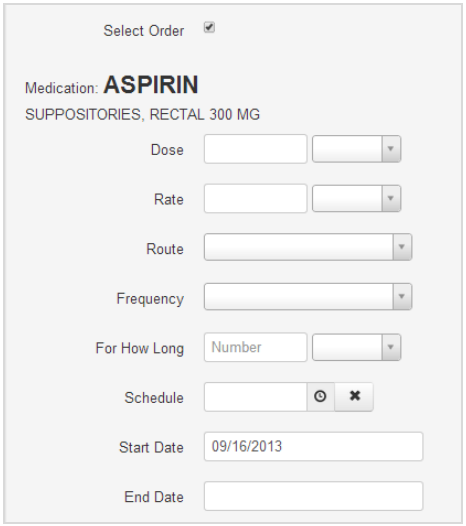

When entering orders, you search and select from the orders database. Click inside the text box and start typing the name of a med or activity. Every order containing the sequence of letters entered will appear on a dropdown list. If you don't find the specific order you want, try different words that could possibly be used for the order. Click on an order from the list to select that specific order.

1. When entering orders at the direction of a provider, it is required that you enter the method in which the direction was given:

*Written*: Provider gave you written orders for you to enter using the computer.
*Verbal*: Provider gave orders face to face.
*Telephone*: Provider gave order by phone.

2. The name of the Provider must be entered. In a real nursing situation, the provider would receive a message to cosign the order that was entered.

3. When you select your order from the search field, an order form opens to enter details related to the orders. Below is the form for a medication order.




- The Select Order checkbox is checked by default.
- The name of the Order and dispense information appears.
- Enter the Dose-The first field is for the number the second field is for the unit.
- Enter the Rate- (for IVs) The first field is for the number, the second field is for the unit/time.
- Enter the Frequency.
- Enter "How Long". This allows you to specify such things as number of doses, number of days etc.
- Enter the scheduled time or times, if there is a schedule. (PRN has no schedule)
- Enter the start date and end date.

4. Click **Sign**. This does not mean that you are authorizing this order, as you do not have the legal right to authorize the order. Remember, the provider would need to cosign the order in a real nursing situation. You are signing to record that you entered the order.

EHR Tutor does not have every order that you would find in hospital systems. EHR Tutor does have over 1400 of the most common medications and clinical orders available.

If you find that an important order is not available to you, search for the word “other”. Then select the appropriate type of order. Complete the order as you would any other order.

**Note:** If there is a particularly important or commonly used order that is not listed, you can send an email to information@ehrtutor.com to request that the order be added to our list.

## *MAR*

The MAR (Medication Administration Report) shows all ordered medications and IVs. Order information is automatically transferred to the MAR from a signed Order. Refer to the Tipsheet titled **Medication Administration with or without Barcode Scanning** for more information related to documenting medication actions including the administration of medications.