

HOW TO DOCUMENT IN AN EHR TUTOR CHART

Use this guide to gain an understanding of how an EHR Tutor chart is organized, as well as how to use the chart's functionality to add new documentation.

- [Chart Organization](#)
- [How to Document Within Chart Tabs](#)
 - [Patient Summary](#)
 - [Patient Information](#)
 - [Notes](#)
 - [Flowsheets](#)
 - [Care Plan](#)
 - [Orders](#)

Chart Organization

EHR Tutor
zATI University

Ben Ivanos Male, 09/01/1998 (24 years old), 70 in, 167 MRN: 65157

Attending: William Smith, MD Code Status: Full Code

Allergies: NKDA Comments: none

Inpatient Chart

- Patient Summary
- Patient Information
- Results
- Provider
- Allergies & Home Medications
- Immunization Record
- Notes
- Flowsheets
- Screenings

Patient Summary

Primary Concern: Multiple fractures

The Patient Summary is read only! To add or edit data you must open another page by clicking the appropriate tab to the left.

Vital Signs

	08/29/2022 1135	08/29/2022 1535	08/29/2022 2335	08/30/2022 1135
Heart Rate	87	110	110	110
Blood Pressure	128/78 MAP: 95	145/87 MAP: 106	132/80 MAP: 97	132/67 MAP: 89
Respirations	16	22	20	22
Temperature		98.2°F (Tympanic)		
SpO2 (%)	98%	98%	98%	87%
Pain	8	10	10	9

The **Patient Header** is always available at the top of the page and displays important patient information. Use the arrow next to the patient name to collapse the bottom half of the header.

The **center of the page** is your main work area where you will view and enter patient data. The content of this area changes depending on which documentation tab you click.

Use the **left navigation menu** to move through the chart's documentation tabs. For more information about what is contained within each tab, see [Quick Guide to Documentation Tabs](#).

How to Document Within Chart Tabs

Now let's look at the functionality within the documentation tabs.

Patient Summary

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The **Patient Summary** provides an overview of important patient information, including the patient's primary concern, allergies, vital signs, orders, and lab results.

It is the first page you see when opening a chart. **The Patient Summary is read only!** Data entered in other tabs automatically displays in this tab.

Patient Information

Ben Ivanos Male, 09/01/1998 (24 years old), 70 in, 167 MRN: 65157

Patient Information UPDATE

Name
Ben Ivanos
Do not place any HIPAA PHI in this chart. Do not use the patient's real name, birthdate, Hospital, Hospital room number, etc...

Sex Assigned at Birth
Male

Gender Identity
Male

Pronouns
Pronouns

DOB
09/01/1998

Provider
William Smith, MD

Go to **Patient Information** to see the patient's name, sex, gender identity, pronouns, date of birth, provider, and code status. If you need to display newborn or pediatric documentation tabs, make sure that the patient age is correct. Depending on how your charting activity has been set up, you might not be able to edit this tab in the chart.

Notes

Ben Ivanos Male, 09/01/1998 (24 years old), 70 in, 167 MRN: 65157

Notes NEW NOTE

Show 10 entries Search: Next

Note Time	Note Type	Professional Role	Created By
01/03/2023 1504	Nursing Note	nurse	alaina40 denney
09/01/2022 1120	Nursing Note	nurse	RN - Behavioral Health
01/01/2022 0935	Nursing Note	nurse	RN
08/29/2022 1135	History and Physical	physician	William Smith, MD
08/29/2022 1135	Nursing Note	nurse	RN

Showing 1 to 5 of 5 entries Previous 1 Next

To see the text of an existing note, click the **Blue Plus** icon that appears to the left of the note.

Click **New Note** to enter your own note.

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Notes SIGN

Professional Role: Nurse

Note Type: Nursing Note

Edit Date/Time: 01/03/2023 1504

Formatting toolbar: Bold, Italic, Underline, Text Color, Background Color, Bulleted List, Numbered List, Indent, Outdent, Link, Unlink, Source Code, Help.

Select your **Professional Role** and the **Note Type**. Enter the text of your note and then click **Sign** to save your note. After signing, the note is added, with your name, to the list of notes.

Important: If you don't click sign, your note will be lost.

[Go back to the top](#)

Flowsheets

The flowsheets section of the chart contains documentation tabs that feature different types of entry fields used throughout the chart:

- [Text Entry](#)
- [Single Select](#)
- [Multi-Select](#)
- [Add Criteria](#)

Text Entry

Enter text or numerical values into a field.

Click on **Flowsheets** and then **Vital Signs**.

If there have been previous entries, they display in columns with the creation information (initials, date, time) at the top of the column.

Click **NEW ENTRY** to chart data in a new column with a current date and time stamp.

Click into the open field for Temperature and enter a value. Note that any values previously entered in this field will display in a list from which you can select.

Single Select

Select a single option from a dropdown list.

Single select fields, such as the one on the Temperature row, are designated with an arrow to the right of the field. Click on it to open the dropdown list and select a value.

The list closes and your selection displays. To remove your selection, click the **X**.

Multi-Select

Select multiple options from a dropdown list.

Click on **Flowsheets** and then **Assessment**.

Multi-select fields look like the single select field, but they do not have an arrow at the right.

Scroll down to the Eyes, Eras, Nose, Throat section and find the *Eyes* field.

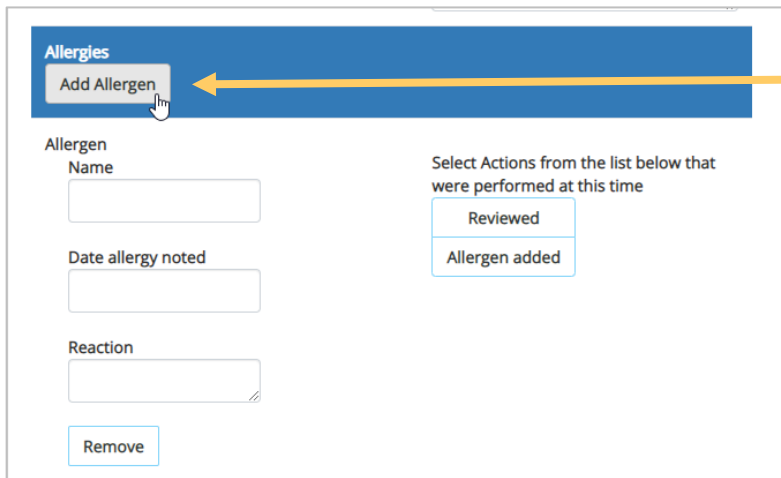
Click inside the field. The multi-select list expands. Select all items in the list that apply.

You can remove a selection by clicking the associated **X**.

Add Criteria

Another method of charting on the flowsheets is Adding Criteria. The Add Criteria functionality allows you to add criteria to the left hand side of a flowsheet and then document actions performed related to that specific criteria in a time and date stamped column to the right. Examples of this can be found in Allergies & Home Medications, Immunization Record, and certain sections the Admission flowsheet.

Let's look at an example.



Allergies

Add Allergen

Allergen Name

Date allergy noted

Reaction

Remove

Select Actions from the list below that were performed at this time

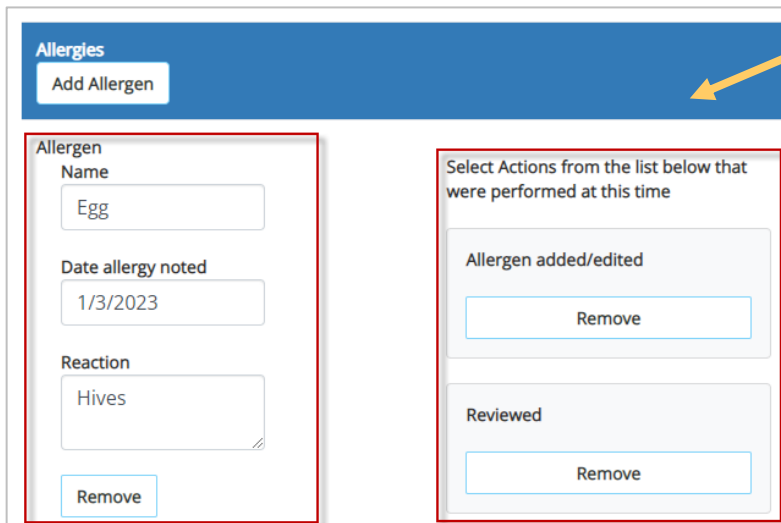
Reviewed

Allergen added

Click on **Flowsheets** and then **Admission**.

Click on **NEW ENTRY** and scroll down to the Allergies section.

Click **Add Allergen**.



Allergies

Add Allergen

Allergen Name

Egg

Date allergy noted

1/3/2023

Reaction

Hives

Remove

Select Actions from the list below that were performed at this time

Allergen added/edited

Remove

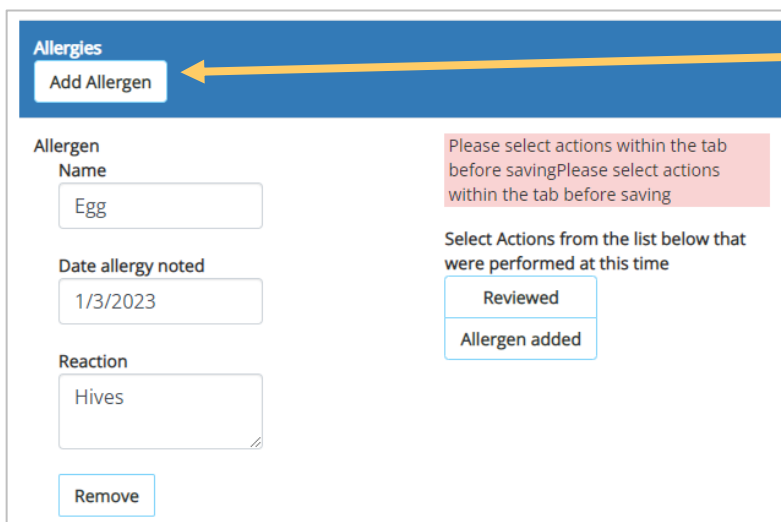
Reviewed

Remove

Two columns of options display.

The options on the left define the criteria. In this case it is a specific allergy that we are documenting.

The options on the right enable you to indicate what *actions* you took regarding this particular allergy.



Allergies

Add Allergen

Allergen Name

Egg

Date allergy noted

1/3/2023

Reaction

Hives

Remove

Please select actions within the tab before savingPlease select actions within the tab before saving

Select Actions from the list below that were performed at this time

Reviewed

Allergen added

You can add another allergy by clicking **Add Allergy** again.

➡ **Important:** You must make edits to BOTH columns before saving. If you do not select actions in the right column, you will see an error message.

Care Plan

Ben Ivanos Male, 09/01/1998 (24 years old), 70 in, 167 MRN: 65157

Inpatient Chart Care Plan

NEW PROBLEM/NEED

Search:

Previous 1 Next

Last Updated	Diagnosis / Problem	Status
01/03/2023 1632	test	ongoing

Showing 1 to 1 of 1 entries

To create a Care Plan or to view or edit an existing Care Plan, click the **Care Plan** tab in the left menu.

Click **New Problem/Need**.

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Inpatient Chart Care Plan

SAVE

Last Updated: 01/03/2023 1633

Assessment

Open Sans

A form opens in which you can enter Care Plan information in text fields: Assessment, Diagnosis, Outcomes/Planning, Interventions, Evaluation, and Additional Information. Designate whether the issue is ongoing or resolved.

When finished, click **SAVE**. Like the Notes tab, saved Care Plans will appear in a table. To view an existing plan, click the blue plus (+) icon.

[Go back to the top](#)

Orders

EHR Tutor has an orders list that contains medications and orders you can add to charts.

Orders

SIGN

Select an Order Search for an order

Order Type Written order

Approving Provider William Smith, MD

All orders to be cosigned by the provider. Orders not signed will not be saved.

Be sure to also select the **Order Type**:

- Written – Provider gave written orders.
- Verbal – Provider gave orders face to face.
- Telephone – Provider gave order by phone.

And the **Approving Provider**. (Note that in a real nursing situation, the provider would receive a message to cosign the order that was entered.)

Click the **Orders** tab in the left menu and then the **New Order** button.

To select a specific order, click inside the field and enter at least three letters of the name of a medication, activity, or procedure. If you don't find the order you want, try different words that could be used for the order. Although EHR Tutor does not contain every order that you would find in a clinical EHR used in hospital systems, it does have over 2,000 of the most common medications and clinical orders available. **If you find that an order is not available, search for the word "other." Select the appropriate generic order.**

Remove Order

Select Order ☒

Imaging: X-Ray: Abdominal

Frequency

For How Long

Schedule

Start Date

End Date

Admin Instructions / Comments

Student Notes

The order form for a procedure contains the following fields:

- **Select Order** – Checked by default. If you have entered multiple orders, you can uncheck any that no longer apply before saving.
- **Frequency** – How often to perform the procedure.
- **For How Long** – Indicate duration
- **Schedule** – Select scheduled time, or times, for the procedure if there is one. (Note that PRN has no schedule.)
- **Start Date** – Pre-populated with the current date and time. The date/ time to begin the procedure.
- **End Date** – The date/time to end the procedure.
- **Admin Instructions/Comments, Student Notes** – Free-form text fields to enter additional notes.

Medication: ATORVASTATIN
TABLET; ORAL 10MG

Dose

Rate

Route

Frequency

For How Long

Schedule

Start Date

End Date

Admin Instructions / Comments

Student Notes

A slightly different order form opens if you are entering a medication. The following fields are specific to entering a medication order:

- **Dose** – The first field is for the number. The second field is for the unit from the list to the right.
- **Rate** (for IVs) – The first field is for the number. The second field is for the unit/time.

Click **Sign** to enter the order. Note by signing the order you are not authorizing it, as you do not have the legal authority. In a real situation, the provider must cosign the order.

Start Date	Order	Details	Status
12/30/2020 1541	ATORVASTATIN	Discontinue Add/Edit Student Notes	Active
12/30/2020 1603	Ice Pack	Discontinue Complete Add/Edit Student Notes	Active

After signing an order, the Orders page opens, displaying all orders entered. The Status column indicates the following:

- **Active** – The order is current.
- **Completed** – The order has been performed.
- **Discontinued** – The order has been cancelled without being performed.
- **Past End** – The order was active for a period of time; the end date has passed, and the order expired.

You have several options for signed orders:

- **Discontinue** – You cannot delete an order after it is signed. Click **Discontinue** to stop the order.
- **Complete** – This option is available if the order has been scheduled. Click **Complete** to mark an order as having been performed and finished.
- **Add/Edit Student Notes** – Add or change information attached to the order.

[Go back to the top](#)