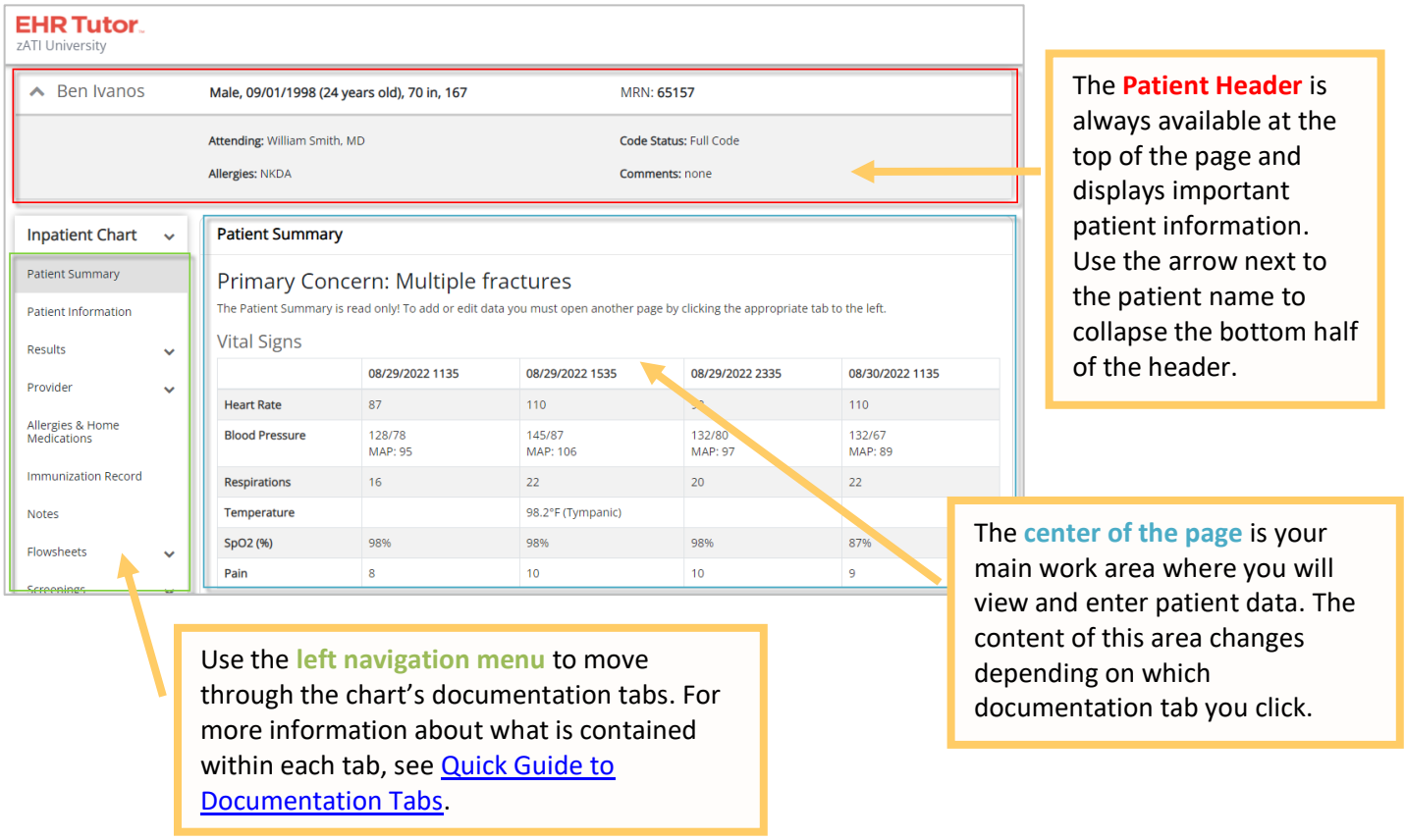
How to Document in an EHR Tutor Chart

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



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.

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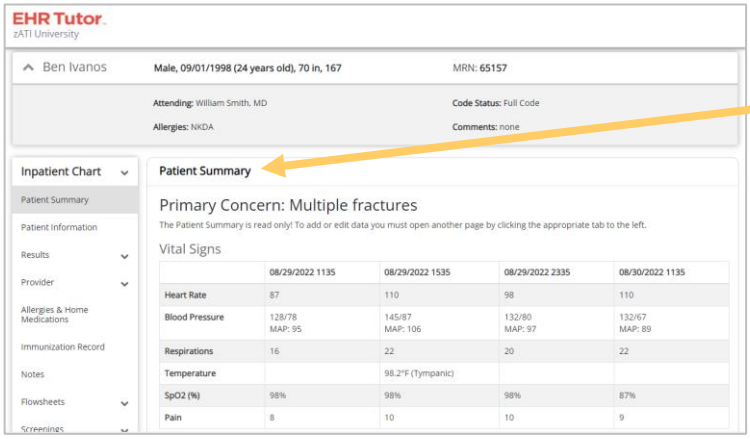
Patient Summary



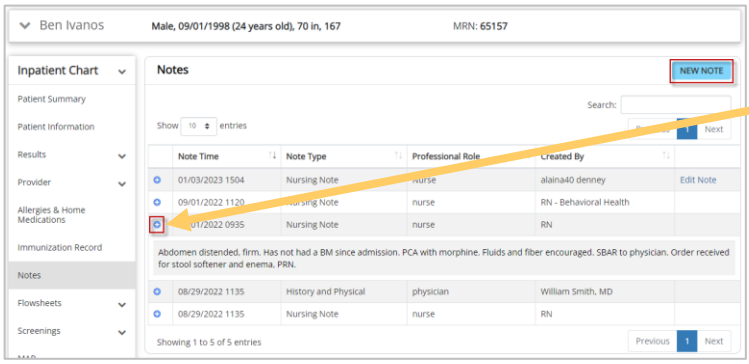
The **Patient Summary** provides an overview of important patient information, including the patient's primary concern, allergies, vital signs, orders, and lab results.

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

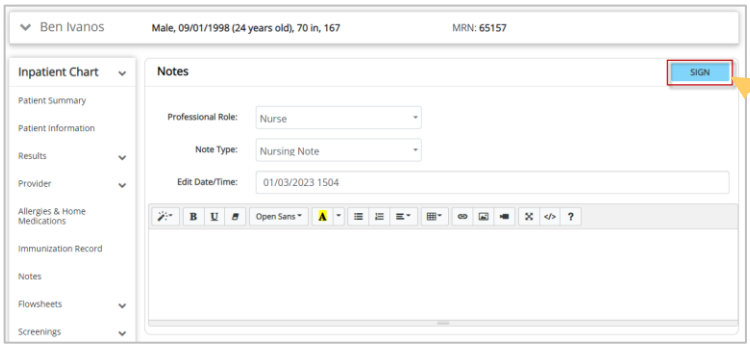
Go to **Patient Information** to see the patient's name, sex, gender identity, pronouns, date of birth, provider, and code status. If you need to display newborn or pediatric documentation tabs, make sure that the patient age is correct. Depending on how your charting activity has been set up, you might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

Notes



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.



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.

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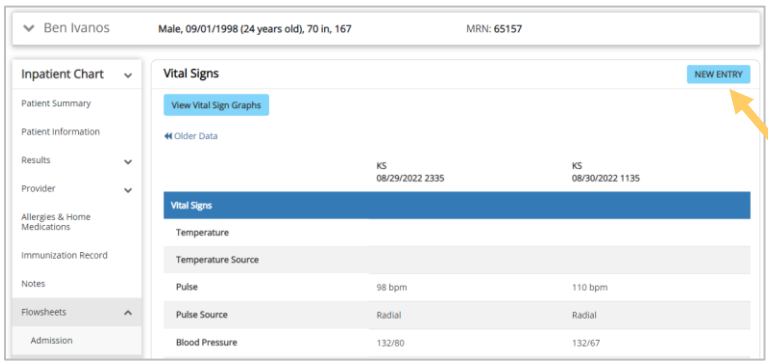
Flowsheets

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

Text Entry

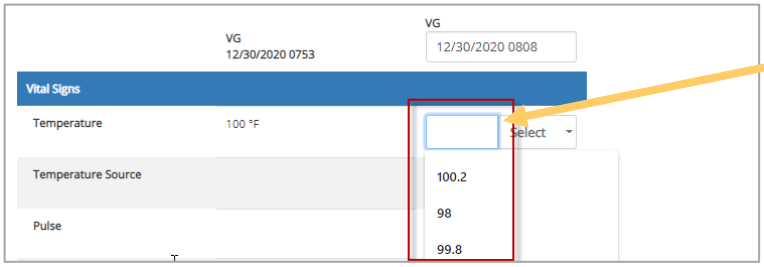
Enter text or numerical values into a field.



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.

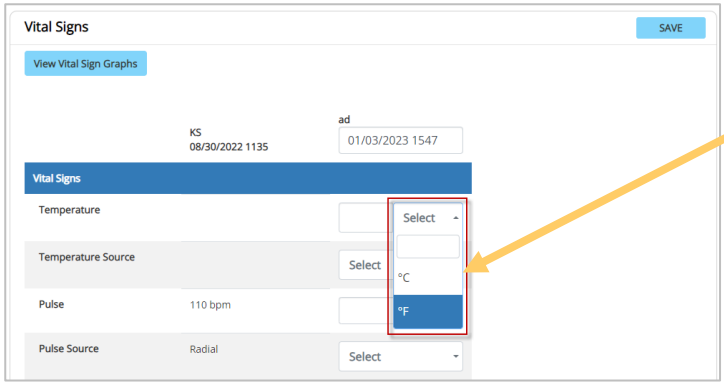
Click **NEW ENTRY** to chart data in a new column with a current date and time stamp.



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 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.

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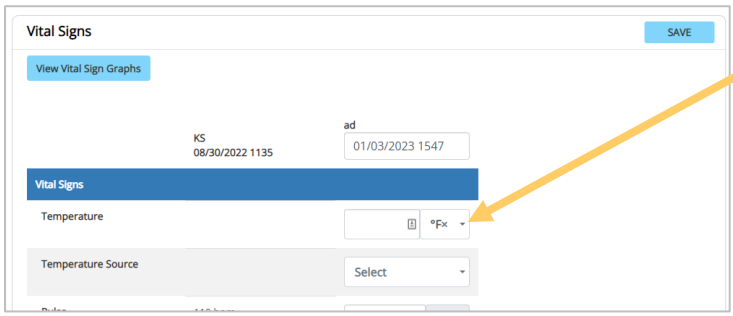
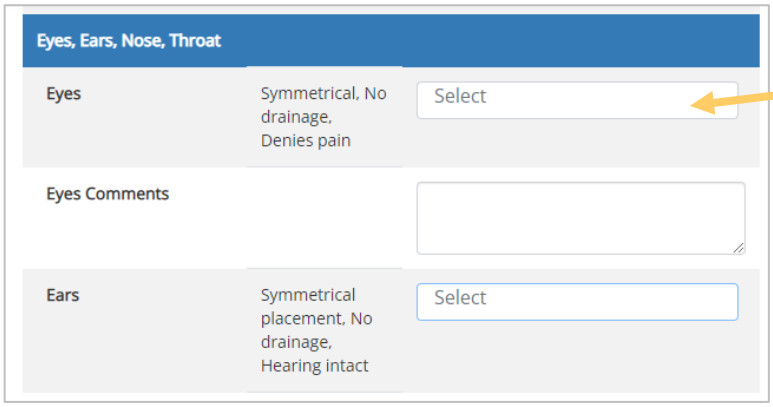


The list closes and your selection displays. To remove your selection, click the **X**.

Multi-Select

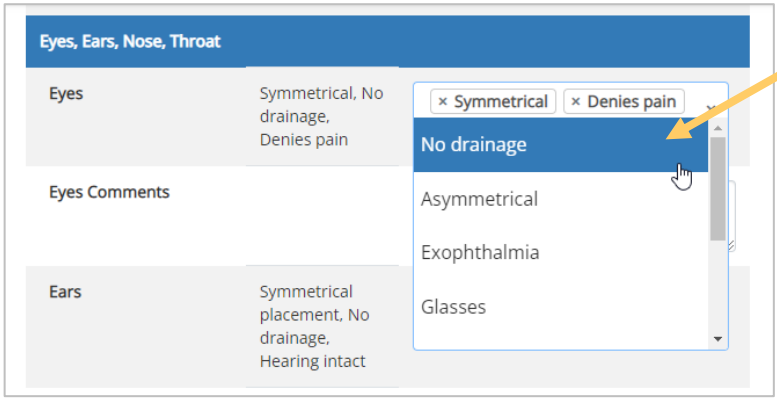
Select multiple options from a dropdown list.



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.

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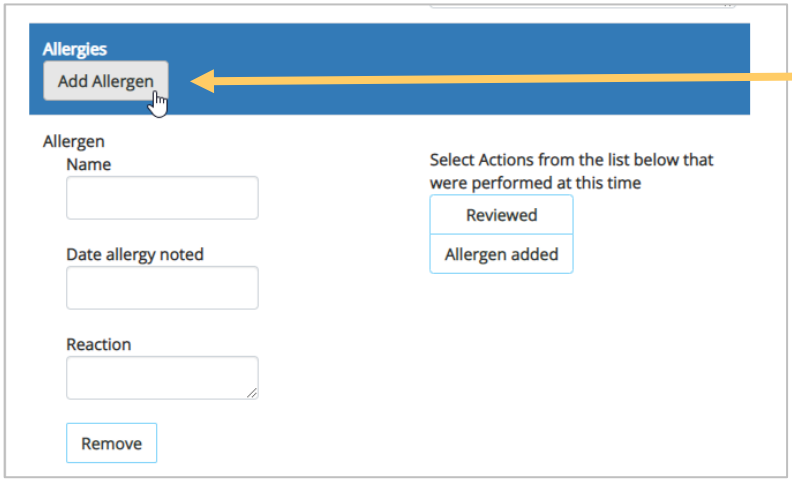
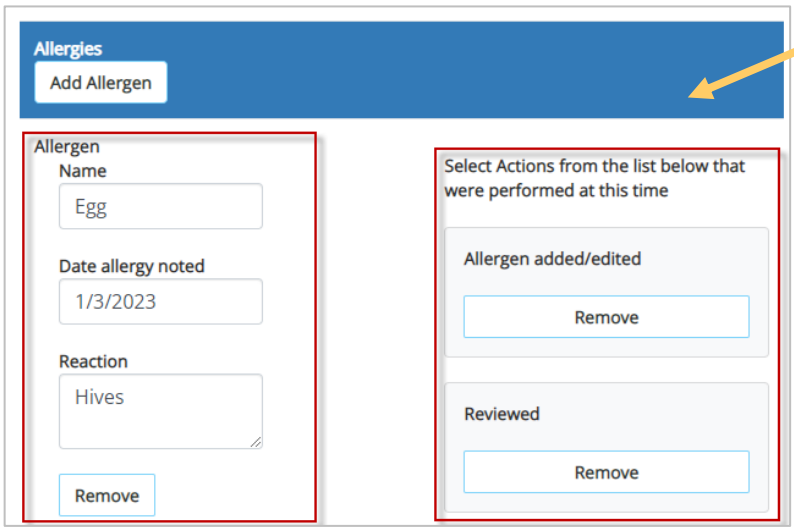


Click on **Flowsheets** and then **Admission**.

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

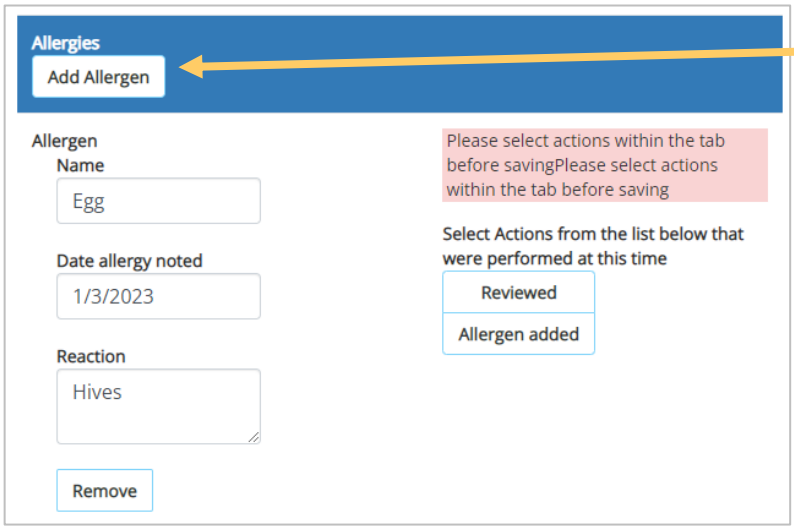
Click **Add Allergen**.



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.



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.

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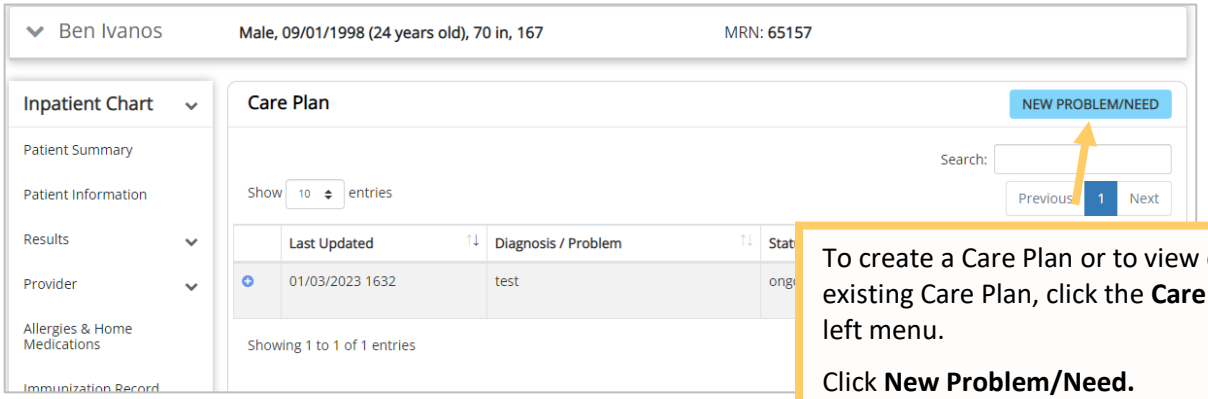
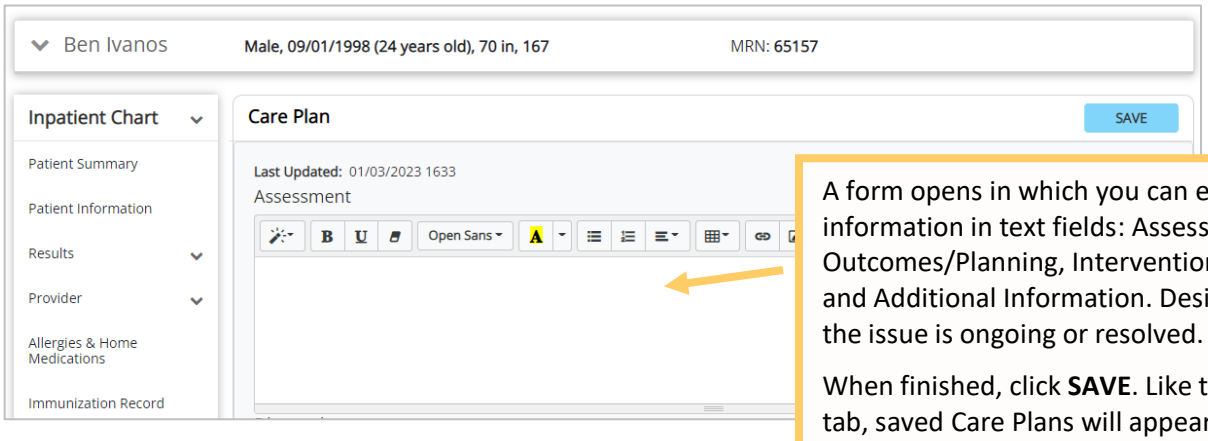
Care Plan



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.**



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.

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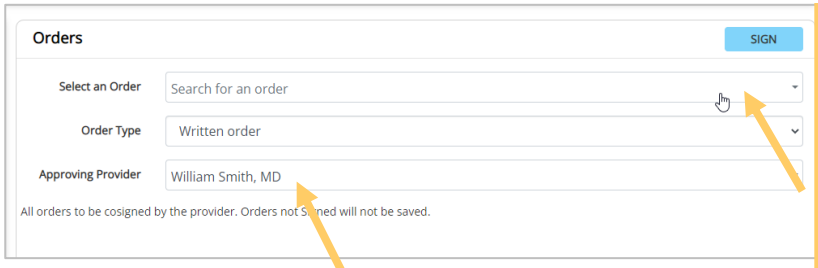
Orders

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



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.***

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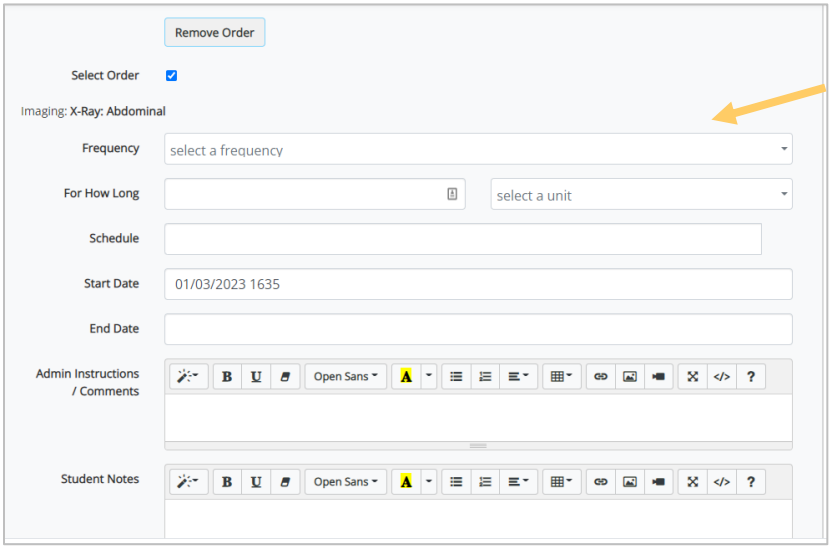
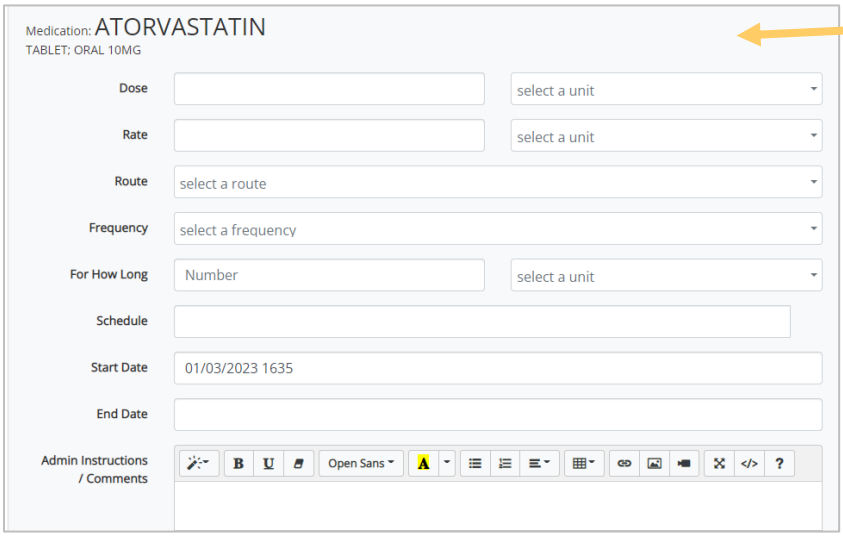


The order form for a procedure contains the following fields:

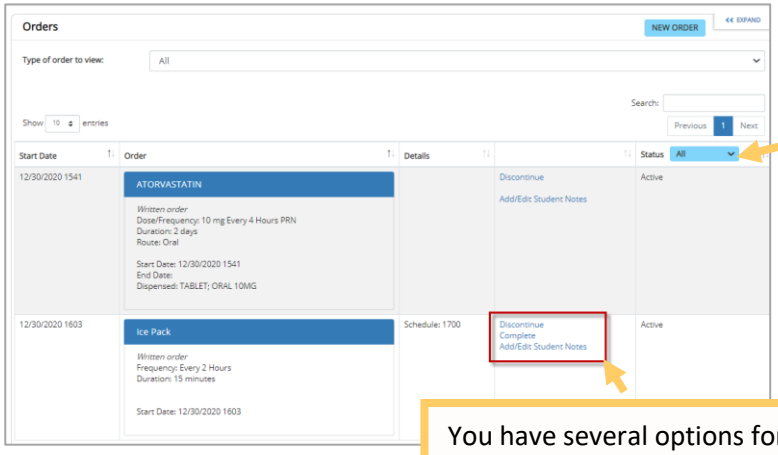
- **Select Order** – Checked by default. If you have entered multiple orders, you can uncheck any that no longer apply before saving.
- **Frequency** – How often to perform the procedure.
- **For How Long** – Indicate duration
- **Schedule** – Select scheduled time, or times, for the procedure if there 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.



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.



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.

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