STUDENT INTRODUCTION TO EHR TUTOR

This guide contains the following:

Accessing EHR Tutor

To get started with EHR Tutor, go to atitesting.com and log in to your ATI account.

From the ATI Home page, click **MY ATI** and then **APPLY**. Locate the EHR Tutor product card and click **MODULES**.
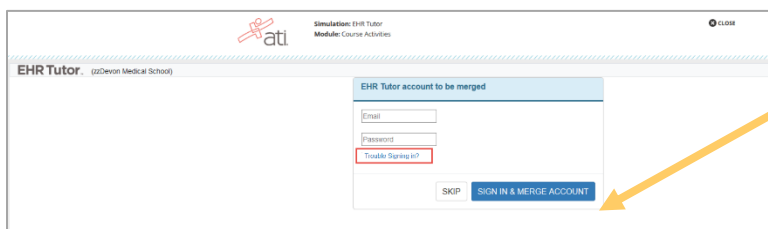
Then, click **BEGIN**.

Merging Accounts

If you are accessing EHR Tutor from ATI for the first time and already have an EHR Tutor account, you will want to merge your accounts to make sure you don't lose any work previously completed.
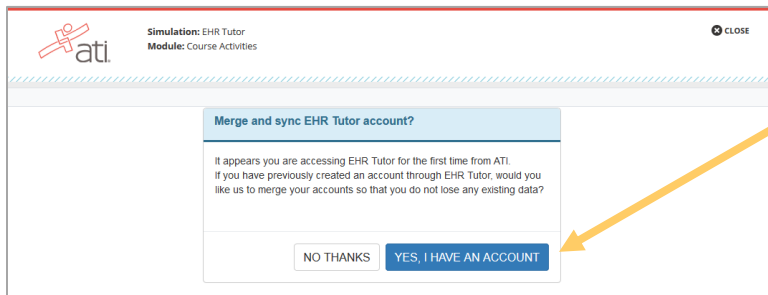
After clicking **BEGIN**, the Merge and sync EHR Tutor account window displays.

Click **YES, I HAVE AN ACCOUNT**.

Enter the e-mail address and password associated to your EHR Tutor account and then click **SIGN IN & MERGE ACCOUNT** to complete the merging process.

If you need assistance with your email address or password, click **Trouble Signing in?**

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Accessing Courses and Activities

On the homepage, select a course from the Course Name dropdown. The activities associated with that course will then display below under Course Activities.

Select a course from the Course Name dropdown.

Activities associated with the selected course will display in a list below Course Activities.

If a patient chart is attached to an activity, the patient name appears as a blue hyperlink. Click the link to access the chart.

When an instructor has graded or commented on your charting, you will see when their comments are available for you.

If you do not see your course in the Course Name dropdown, but the instructor has provided a **course enrollment key**, click the **Add a Course** button, and enter the code provided by your instructor. If you do not have a course enrollment key, contact your instructor to be added to the course.

The Patient Chart Overview

The **Patient Header** is always available at the top of the page with basic information related to the patient. Using the arrow next to the patient name, you can collapse the bottom half of the patient header.

Documentation tabs display on the left side of the page. Use these tabs to navigate to different sections in the patient chart.

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

Documentation Tabs Overview

Now let's look at the various tabs found along the left side of the page and the functionality of each.

Patient Summary

The **Patient Summary** tab 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 tab is read only!** Data entered in other tabs transfers automatically to the patient summary.

Patient Information

In some charts, you will be able to use the **Patient Information** tab to edit the name, sex, date of birth, provider, and code status for the patient. If you need to display newborn or pediatric documentation tabs, make sure that the patient age is correct. Depending on how your instructor has set up the activity, you might not be able to edit this tab in the chart.

Notes

To enter a free form text note, or to view a previous note, click the **Notes** tab.

To view an existing note, click the **Blue Plus** icon that appears to the left of the note you'd like to view. This expands the note.

To view or edit a note you created, click **Edit Note** to open the note and make changes. You can also change the Date/Time.

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

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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.

Flowsheets

The flowsheets section of the chart contains several documentation tabs. All flowsheets use the same types of data entry. Once you learn the methods for entering data, you will be able to use all of the documentation tabs.

There are four methods of data entry in a flowsheet:

- Single Select Field – Selecting a choice from a single select list
- Multi-Select Field – Selecting multiple choices from a multi-select list
- Text Entry Field – Typing an entry into a text field
- Add Criteria Field – Adding criteria to the flowsheet.

Let's visit several flowsheets to examine how to use these various methods.

Single Select Field

Click the **Flowsheets** tab on the left of the chart. The tab expands allowing you to see many documentation tab options. Click the **Vital Signs** tab.
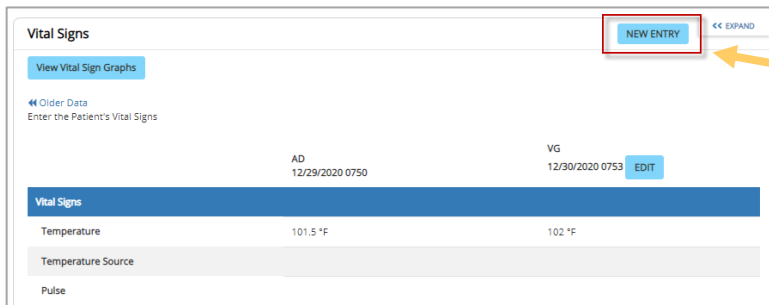
If there have been previous entries, they display in columns with the timestamp at the top of the column. If you have documented and saved an entry you will see an **Edit** button, enabling you to make changes to documentation created by you.

Click **NEW ENTRY** to chart new data. A new column opens for data entry.

Click **View Vital Sign Graphs** to view the data in graphs.

Click the button again to close the graphical view.

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Click **New Entry** to chart new data.

If you are back timing, you can change the time at the top of this new column.

When you are finished entering data, click **SAVE** to save the information.

Single select field are designated with an arrow to the right of the field. Click in the field to open the list of possible selections.

Select a value from the list.

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

Multi-Select Field

Now let's see a sample of multiselect field entry. On the left side of the chart, under Flowsheets, click the **Assessment** tab.

Orientation	Oriented X4	Select ▼

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

Scroll down to the Neurological section and find the *Orientation* field.

Orientation	Oriented X4	✕
		✕ Oriented to person
		✕ Oriented to place
Cognitive	WDL	Oriented X4
		Oriented to time

Click inside the field. The multi-select list expands. Select an item from the list. It displays above the list with a shaded background. Select all items that apply.

If you have not yet saved your flowsheet, you can remove a selection by clicking the associated **X**.

After making all your selections from all the fields, click **SAVE** to save your entries.

Text Entry Field

Text Entry fields enable you to enter text or values into a field.

	VG 12/30/2020 0753	VG 12/30/2020 0808
Vital Signs		
Temperature	100 °F	Select ▼
Temperature Source		100.2
Pulse		98
		99.8

Click in the field and enter your information. Note that any values previously entered in this field will display in a list from which you can select.

Add Criteria Field

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.

Click **Immunization Record**.

When you are in the "New Entry" mode, there are Add _____ buttons. In this case, it is an **Add Vaccine** button.

Click **Add Vaccine**.

Two sets of fields display. The options on the left define the criteria. In this case it is a specific vaccine that we are documenting.

> From the *Vaccine* list, select **Hepatitis B**.

> Note that you enter basic information into the fields on the left: type of vaccine, new or historical administration, and administration date.

The options on the right enable you to enter details about the criteria on the left.

Let's say you have historical details of a previous Hepatitis B vaccination. Click **Add historical details** to display the entry fields. Enter the information in the expanded fields.

When you have finished entering information for the selected vaccine, you can add another vaccine by clicking **Add Vaccine**.

When you have added all vaccines, click **SAVE**.

Hint: To display immunization documentation fields such as expiration dates, manufacturer, vaccine information sheets, *etc.*, click **Add administration details**.

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Care Plan

The Care Plan tab enables you to add all nursing diagnoses/problems.

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

Click the **New Nursing DX/Problem** button to enter a new nursing problem.

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

When finished, click **SAVE** .

Submitted Nursing Problems will appear in the table.

To view an entry, click the plus (+) sign.
To Edit or Delete an entry, click the links at the right.

Note: If the chart is not a group/shared patient activity, you can edit/delete problems you have entered.
If the chart is a group/shared patient activity, you cannot edit; you can only delete.

➡ **Important!**   Before leaving a flowsheet, you must click **SAVE** to save any new data you entered. If you are entering a large amount of data, try clicking **SAVE** periodically and then clicking **Edit** to continue entering more data.

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Orders

EHR Tutor has an order database containing medications and common orders you can add to charts.

Click the **Orders** tab in the left menu. Click the **New Order** button. The Order Search window opens.

To search the orders database, click inside the text box and enter at least three letters of the name of a medication or activity. Orders matching your search display. If you don't find the specific order you want, try different words that could possibly be used for the order.

Click an order from the list to select it. An order form opens where you can enter details related to the order.

- **Order Type** – You must enter the method in which the Provider communicated the order:
  - **Written** – Provider gave you written orders.
  - **Verbal** – Provider gave orders face to face.
  - **Telephone** – Provider gave order by phone.
- **Approving Provider** – You must select the Provider.

In a real nursing situation, the provider would receive a message to cosign the order that was entered.

The order form for a procedure contains the following:
- **Select Order** – Checked by default.
- **Frequency** – How often to perform the procedure.
- **For How Long** – Details such as number of doses, number of days, *etc*.
- **Schedule** – The schedule 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 where the provider and student can enter notes.

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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. 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.

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.

Although EHR Tutor does not contain every order that you would find in a Clinical EHR used in hospital systems, it does have over 1,400 of the most common medications and clinical orders available.

If you find that an order is not available to you, search for the word "other." Select the appropriate generic order and complete the order as you would any other order.

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