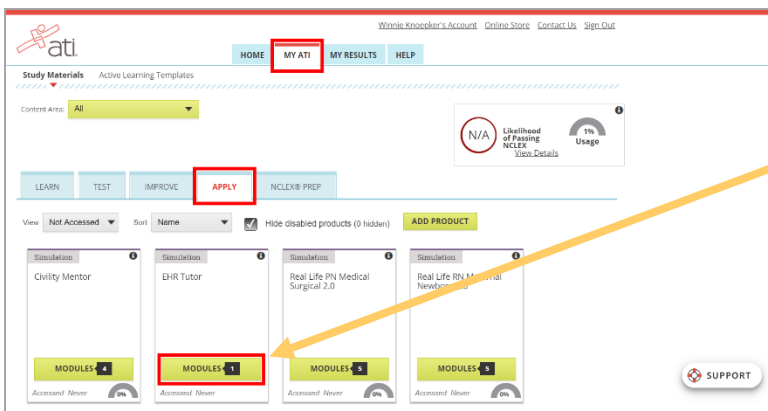


STUDENT INTRODUCTION TO EHR TUTOR

This guide contains the following:

- [Accessing EHR Tutor](#)
 - [Merging Accounts](#)
- [The Patient Chart Overview](#)
- [Documentation Tabs Overview](#)
 - [Patient Summary](#)
 - [Patient Information](#)
 - [Notes](#)
 - [Flowsheets](#)
 - [Care Plan](#)
 - [Orders](#)

Accessing EHR Tutor

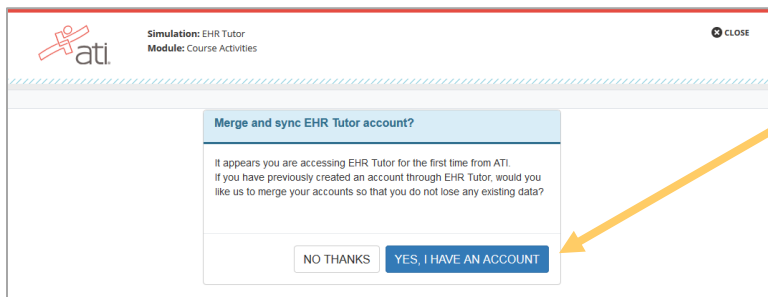


To get started with EHR Tutor, go to atitesting.com and log in to your ATI account.

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

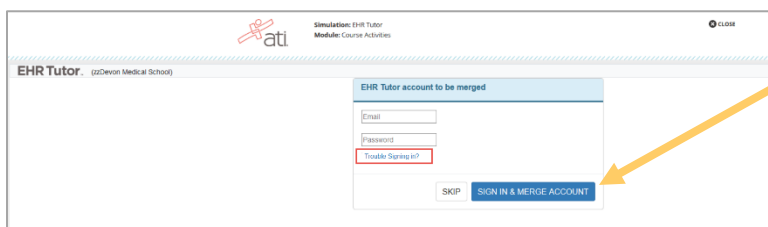
Merging Accounts

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**.

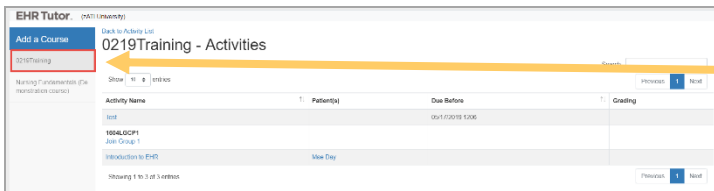


Enter the e-mail address and password associated to your EHR Tutor account and then click **SIGN IN & MERGE ACCOUNT** to complete the merging process.

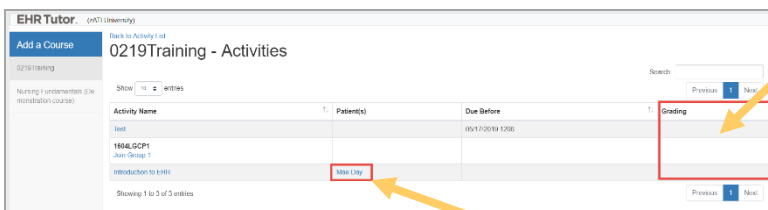
If you need assistance with your email address or password, click **Trouble Signing in?**

On the EHR Tutor student homepage, the menu to the left lists all the courses you have been added to.

- If you do not see your course, contact your instructor to be added.
- If you do not see your course, but the instructor has provided a course enrollment key and instructed you to enroll yourself into the course, click the **Add a Course** button and enter the code provided by your instructor.



To select a course, click the course name in the list on the left; the course opens with the course name displayed in bold at the top of the page.



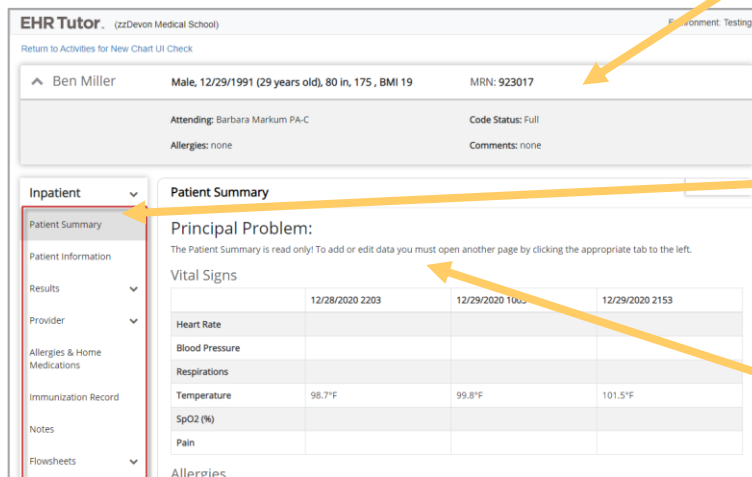
Each activity associated with the course displays in a list.

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

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

Click the patient's name. The chart opens and the **Patient Summary** page displays.

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

Ben Miller Male, 12/29/1991 (29 years old), 80 in, 175, BMI 19 MRN: 923017

Attending: Barbara Markum PA-C Code Status: Full
Allergies: none Comments: none

Patient Summary (selected tab)

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

	12/28/2020 2203	12/29/2020 1003	12/29/2020 2153
Heart Rate			
Blood Pressure			
Respirations			
Temperature	98.7°F	99.8°F	101.5°F

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

Ben Miller Male, 12/29/1991 (29 years old), 80 in, 175, BMI 19 MRN: 923017

Attending: Barbara Markum PA-C Code Status: Full
Allergies: none Comments: none

Patient Information (selected tab)

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

Sex: Male

DOB: 12/29/1991 2203

Provider: Barbara Markum PA-C

Code Status

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

Ben Miller Male, 12/29/1991 (29 years old), 80 in, 175, BMI 19 MRN: 923017

Attending: Barbara Markum PA-C Code Status: Full
Allergies: none Comments: none

Notes (selected tab)

NEW NOTE

Note Time	Note Type	Professional Role	Created By
12/29/2020 2203	History and Physical	Physician	Amalia Bayt RN
12/29/2020 2203	Daily Note	Nurse	Lisa Williams MD

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.

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 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.

Vital Signs

View Vital Sign Graphs

Enter the Patient's Vital Signs

AD 12/29/2020 0750 VG 12/30/2020 0753 EDIT

Vital Signs

Temperature 101.5 °F 102 °F

Temperature Source

Pulse

Click **NEW ENTRY** to chart new data.

Vital Signs

View Vital Sign Graphs

Enter the Patient's Vital Signs

AD 12/29/2020 0750 VG 12/30/2020 0753

Vital Signs

Temperature 101.5 °F 102 °F

Temperature Source Select

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.

Vital Signs

View Vital Sign Graphs

Enter the Patient's Vital Signs

AD 12/29/2020 0750 VG 12/30/2020 0753

Vital Signs

Temperature 101.5 °F Select

Temperature Source Select

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

Vital Signs

View Vital Sign Graphs

Enter the Patient's Vital Signs

AD 12/29/2020 0750 VG 12/30/2020 0753

Vital Signs

Temperature 101.5 °F 102 Select

Temperature Source Select °C

Pulse °F

Select a value from the list.

Vital Signs

View Vital Sign Graphs

Enter the Patient's Vital Signs

AD 12/29/2020 0750 VG 12/30/2020 0753


Vital Signs

Temperature 101.5 °F 102 °F

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

Multi-Select Fields

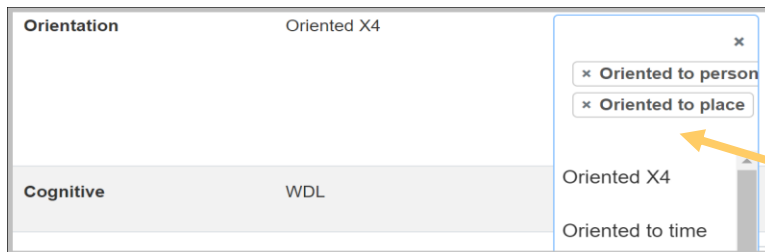
Now let's see a sample of multiselect field entry. On the left side of the chart, under Flowsheets, click the **Assessment** tab.



The screenshot shows a form with a label 'Orientation' and a value 'Oriented X4'. To the right of the value is a button labeled 'Select'. An orange arrow points to the 'Select' button.

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.



The screenshot shows the 'Orientation' field with 'Oriented X4' selected. A multi-select list is expanded, showing options: 'x Oriented to person', 'x Oriented to place', 'Oriented X4', and 'Oriented to time'. An orange arrow points to the 'x' next to 'Oriented to place'.

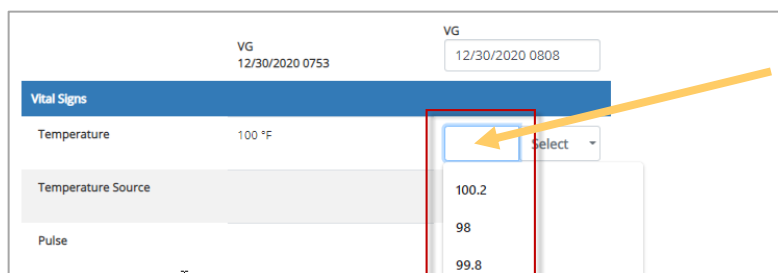
Click inside the field. The multi-select list expands. Select an item from the list. It displays above the list with a shaded background. Select all items that apply.

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 Fields

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



The screenshot shows a 'Vital Signs' section with a 'Temperature' field containing '100 °F'. Below it is a 'Temperature Source' field. To the right, a 'Select' dropdown menu is open, showing a list of previous values: '100.2', '98', and '99.8'. An orange arrow points to the 'Select' dropdown.

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 Fields

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.

Ben Miller Male, 12/29/1991 (29 years old), 80 in, 175 , BMI 19 MRN: 923017

Attending: Barbara Markum PA-C Code Status: Full
Allergies: none Comments: none

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

Immunization Record

Immunization Schedules from CDC - Click Here

VG 12/30/2020 0810

Vaccine Administration Information

Add Vaccine

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**.

Immunization Record

Immunization Schedules from CDC - Click Here

VG 12/30/2020 0813

Vaccine Administration Information

Add Vaccine

Vaccine Select

If not on list, add vaccine here

Is this a new administration?

Administration/Refusal Date

Remove

SAVE

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

Add administration details

Add refusal details

Add historical details

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.

Immunization Record

Immunization Schedules from CDC - Click Here

VG 12/30/2020 0813

Vaccine Administration Information

Add Vaccine

Vaccine Select

Hepatitis B (HepB)

If not on list, add vaccine here

Is this a new administration?

Administration/Refusal Date

Remove

SAVE

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

Add administration details

Add refusal details

Add historical details

Facility/Location where immunization was given:

Comments:

Remove

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**.

Care Plan

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

The screenshot shows the EHR interface for a patient named Ben Miller. The left sidebar has the 'Care Plan' tab selected. The main area shows the 'Care Plan' section with a 'NEW NURSING DX/PROBLEM' button highlighted in the top right corner. The table below it is empty, showing 'No data available in table'.

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.

The screenshot shows the EHR interface for a patient named Ben Miller. The 'Care Plan' tab is selected, and the 'Assessment' field is highlighted with a yellow arrow. The 'Diagnosis' field is also visible below it.

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.

The screenshot shows the EHR interface for a patient named Ben Miller. The 'Care Plan' tab is selected, and the table shows one entry. The 'Edit' and 'Delete' links for this entry are highlighted with a yellow arrow.

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.

[Go back to the top](#)

Orders

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

Ben Miller Male, 12/29/1991 (29 years old), 80 in, 175, BMI 19 MRN: 923017

Orders

Type of order to view: All

Show 10 entries

Search: [] Previous Next

Start Date Order Details Status All

No data available in table

Showing 0 to 0 of 0 entries Previous Next

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

Orders SIGN << EXPAND

Select an Order Search for an order

Order Type ICE

Approving Provider Admit to Hospice

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

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.

Orders SIGN << EXPAND

Select an Order Ice Pack

Order Type Written order

Approving Provider Barbara Markum PA-C

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

- **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.

Orders SIGN << EXPAND

Select an Order Lipid Panel

Order Type Written order

Approving Provider Barbara Markum PA-C

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

Remove Order

Select Order ☒

Lab: Lipid Panel

Frequency Once

For How Long [] select a unit

Schedule

Start Date 12/30/2020 15:41

End Date

Admin Instructions / Comments

Student Notes

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.

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 Written order Dose/Frequency: 10 mg Every 4 Hours PRN Duration: 2 days Route: Oral Start Date: 12/30/2020 1541 End Date: Dispensed: TABLET; ORAL 10MG	Discontinue Add/Edit Student Notes	Active
12/30/2020 1603	Ice Pack Written order Frequency: Every 2 Hours Duration: 15 minutes Start Date: 12/30/2020 1603	Discontinue Complete Add/Edit Student Notes	Completed

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.

[Go back to the top](#)