EHR Tutor Charting – Quick Guide to Documentation Tabs

For ATI Nursing Education Simulations

Click **CHART** in the simulation header; then drag the left edge of the Chart window until the Documentation tabs display. Note that some tabs might not be available for every activity.

Tab Name	Description
Patient Summary	Contains a limited overview of information such as Principal Problem, Vital Signs, Allergies, Orders, Lab results, *etc.*, and is the first page you see when opening a patient record. The information displayed is **read only**. Data is entered into flowsheets or other forms and then transferred automatically to the Patient Summary.
Patient Information	Edit the name, sex, date of birth, provider and code status for the patient. For newborn or pediatric charts, make sure that the patient age is correct.
Results	Enter results from the following to update the chart: • **Labs** – Hematology, Blood Typing, Hemoglobin A1c (HbA1c), Chemistry, Lipid Panel, Coagulation, Arterial Blood Gasses, Cardiac Enzymes, BNP, Other Labs, Urinalysis (UA). • **Imaging/Diagnostic Tests** – Imaging and Diagnostic Study Results.
Provider	Provides Provider documentation of patient status: • **Chief Complaint and History of Present Illness** – Admission Problems, History of Present Illness/ Injury. • **History** – Past Medical History, Surgeries, Pregnancies, Family History, Social/ Environmental Screening, Substance Use, Impairments. • **Review of Systems** – Constitutional, Eyes, Ears, Nose, Throat, Cardiovascular, Respiratory, Genitourinary, Gastrointestinal, Male Urinary, Gynecological, Musculoskeletal, Skin, Neurological, Psychological, Hematologic/Lymphatic.
Allergies & Home Medications	Enter all allergens and home medications.
Immunization Record	Enter vaccine administration information. Access Immunization Schedules from CDC.
Notes	Enter a free-form text note or view a previous note. Used by all members of interprofessional team, such as Providers, Nurses, Physical Therapists, Anesthesiologists, Dietitians, and Social Workers. Includes several types of notes, such as Progress Note, History and Physical, Procedure Note, Surgical Note, Consult Note, and more. **Important:** Be sure to click **Sign** after entering your note information; otherwise, your note will not be saved.
Flowsheets	Used for data entry. The tabs for data entry are: • **Admission** – Informants, Admission Problems, History of Present Illness/Injury, Allergies, Admission Data, Additional Demographic Info, Home Medications, Past Medical History, Past Surgical History, Family History, Immunization Screen, Social/Environmental Safety Screening, Substance(S) Used, Impairments. • **Vital Signs** – Vital Signs, Measurements. • **Assessment** – Head, Face, Anterior Fontanel, Neck; Eyes, Ears, Nose, Throat; Neurological Group; Glasgow Coma Scale; Respiratory; Cardiac; Peripheral Vascular; Integumentary; Braden Scale; Musculoskeletal; Morse Fall Scale; Gastrointestinal; Genitourinary; Pain Assessment. • **Other Screen/Scales** – Behavioral Health; Substance Use. • **Daily Care** – Safety/Environment, Mobility, Nutrition, Hygiene. • **Intake and Output** – Oral Intake, IV Intake, Intake/Output Totals, Output (mL), Unmeasured Output. • **Interventions (Lines, Drains, *etc.*)** – IVs/Lines, Urinary Catheters, Gastric Tubes, Drains, Chest Tube, Enema. • **Wounds/Incisions/Ostomies** – Wounds, Incisions, Ostomies.

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	• **Respiratory Interventions** – Ventilator, Endotracheal Tube, Chest Tube. • **Blood Administration** – Pre-Transfusion Information, Vital Signs, Transfusion Information. • **Stroke Scale –** National Institutes of Health Stroke Scale. • **Restraints** – Restraints, Assessment and Monitoring, CMS (color, motion, sensation), Discontinued Restraint. • **Behavioral Health** – Risk Status, Mental Status, Sleep Pattern, Safety, Family & Visitors, Behavioral Health Notes. • **Preoperative Checklist** – Preop Patient Information, Medical Documentation, Surgical Information, Preoperative Checklist. • **Patient Registration** – Patient Registration, Person Responsible for Bill, Emergency Contact Information, Primary Insurance, Secondary Insurance. **Important!** Before leaving a flowsheet, you must click **Submit** to save any new data you entered. If you are entering a large amount of data, try clicking **Submit** periodically to save data and then click **Edit** to continue with your entries.
Screenings	Screenings for: • **CAGE-AID Questionnaire** – Assess for alcohol and substance use disorders. • **Mood Disorder Questionnaire (MDQ)** – Identifies bipolar disorder. • **Fall Risk Assessment** – Assesses history of falls and current risk factors. • **Malnutrition Screening Tool (MST)** – Identifies risk for malnutrition, including weight loss, appetite, eating habits. • **Hamilton Anxiety Rating Scale (HAM-A)** – Measures level of anxiety as mild, moderate, or severe. • **Patient Health Questionnaire (PHQ-9)** – Identifies presence and severity of depression from minimal to severe. • **Suicide Assessment Five-step Evaluation and Triage (SAFE-T)** – Identifies level of suicide risk and suggests interventions. Five steps include risk factors, protective factors, suicide inquiry, risk level/interventions, document. • **Abnormal Involuntary Movement Scale (AIMS)** – Detect and measure severity of Tardive Dyskinesia. Includes facial and oral movements, extremity movements, trunk movements, global judgments, dental status, movement during sleep. • **Edinburg Postnatal Depression Scale (EPDS)** – Identifies postpartum depression by evaluating how the client has felt during the previous week. • **Alcohol Use Disorders Identification Test (AUDIT)** – Assesses alcohol consumption, drinking behaviors, alcohol-related problems. • **Smoking Cessation Questionnaire** – Assesses previous and current tobacco or other nicotine product use. • **Wound Assessment** – The physical characteristics of a wound and surrounding tissue, including edema and pain. • **Braden Scale** – Identifies risk for a pressure injury. • **Pediatric Coma Scale** – Assesses level of consciousness in pediatric clients.
MAR (Medication Administration Record)	View all ordered medications. Order information is automatically transferred to the MAR from a signed Order. Documentation of medication administered, withheld, or discontinued.
Orders	View, enter, or manage orders. Includes all orders such as admits, discharges, medications, diets, consults, activities.
Patient Education	Enter learner assessment, patient education documentation.
SBAR	Add giver and receiver of report using standard SBAR format (situation, background, assessment, recommendation).
Care Plan	Add all nursing diagnoses/problems. Enter Care Plan information in the Nursing Process text fields, Assessment, Diagnosis, Outcomes/Planning, Interventions, Evaluation, and a section for Additional Information. Also includes status of current care plan (ongoing or resolved).

Tab Name	Description

Obstetrics	General admission data can be documented on the Admission flowsheet tab.
	• **OB Admission**
	  ○ OB Admission – includes LMP, EDD, reason for admission, *etc*.
	  ○ Pregnancy History (GPTAL)
	  ○ Prenatal Labs – includes Type and Rh, STI screenings, GBS status.
	  ○ Fetal Assessment Test(s) – includes NST, BPP, Ultrasound, *etc*.
	• **Labor Assessment**
	  ○ Vital Signs – includes pain rating and blood glucose results.
	  ○ PIH Assessment – includes DTRs, and manifestations such as vision changes, headache.
	  ○ Fetal Assessment – includes monitor type, FHR data, ROM.
	  ○ Uterine Activity – includes monitor type, frequency and duration, MVUs.
	  ○ Cervical Exam – includes examiner, dilation, effacement, station, presentation, position.
	  ○ Interventions – includes pain management, oxygen, urinary status.
	  ○ OB Notes – free text entry for narrative notes, and note to refer to MAR for medication administration details.
	• **Delivery Summary**
	  ○ Delivery Information – includes EDD, gestational age, placenta information, location of birth.
	  ○ Vaginal Delivery – add information for method of delivery, episiotomy/laceration, EBL, anesthesia type.
	  ○ Cesarean Section – add information for reason for, type of, EBL, anesthesia.
	  ○ Other Procedures – add information for:
	  ▪ Tubal ligation, hysterectomy, dilation and curettage
	  ▪ Labor Times (enter times for each stage, birth, placenta)
	  ▪ Apgar (add information for time, score, examiner)
	  ▪ Newborn Information (includes respiratory interventions, umbilical cord and cord blood, blood glucose, medications, height and weight, measurements, output)
	  ▪ Delivery Personnel (includes nurses, delivery provider, pediatrician, anesthesiologist).
	• **OB-Post Partum**
	  ○ Post Partum – includes vaccines, assessment of breasts, emotional status, perineum, lochia, incision.
	  ○ Fundal Assessment – height, consistency, location.
	  ○ Peripheral Vascular – assessment of lower extremities.
	  ○ Postnatal Depression Scale (EPDS) – assesses for depression and suicidality.
	  ○ RhoGam – add information about Rh immune globulin.

Discharge	Enter information for: • **Discharge information** – includes date, time, condition, disposition. • **Summary of stay** • **Discharge orders/instructions** – includes activity, diet, when to notify provider, newly prescribed medications to take at home, medications to continue taking at home as previously prescribed, changes to previously prescribed home medications. • **Discharge medication reconciliation** -- discontinued medications and where/how new prescriptions were sent.
Barcode	Print barcodes from the chart and then scan the printed barcode from MAR or Patient Summary.