**Introduction to Health Information Technology:**

 **A Guide for Entry Level Healthcare Professionals**

**Module 3:**

**Electronic Health Record Documentation**

**Acknowledgements**

This curriculum was developed with grant funding from The Healthcare Workforce Transformation Fund through the Commonwealth of Massachusetts, Executive office of Labor and Workforce Development. The grant project was administered by Commonwealth Corporation and The Massachusetts eHealth Institute.



**Being an Effective Presenter:**

Knowing how to lecture well is a crucial skill to master. Effective lecturing is characterized by enthusiasm and expressiveness, clarity, and interaction (Murray in Perry & Smart, 1997). Consider using the tips below to introduce students to the subject and stimulate their enthusiasm about the course material.

* **Be Prepared**
	+ Outline clear objectives for your lecture—both what students should know after the lecture and why it is important.
	+ Develop a lecture outline and any audiovisuals.
	+ If you are nervous about the lecture, write out your introduction and rehearse it.
* **Keep Your Focus**
	+ Create effective visuals, analogies, demonstrations, and examples to reinforce the main points.
	+ Share your outline with students.
	+ Emphasize your objectives and key points in the beginning, as you get to them, and as a summary at the end.
* **Engage Your Audience**
	+ Focus attention early on using a quote, a dramatic visual, an anecdote, or other material relevant to the topic.
	+ Integrate visuals, multimedia, discussion, active learning strategies, small-group techniques, and peer instruction.
	+ Link new material to students’ prior knowledge, such as common experiences or previous coursework.
	+ Show enthusiasm for the topic and information. Remember, you are modeling your discipline.
	+ Give students time to think and genuine opportunities to respond.
	+ Plan for diverse learners. Use verbal, visual, and kinesthetic approaches such as hands-on exercises and simulations.
* **Get Feedback**
	+ Observe students’ non-verbal communication: notetaking, response to questions, eye contact, seating patterns, and response to humor. Are they “with” you?

**Module 3: Electronic Health Record Documentation**

**Introduction** (Slide #2)

 Documentation can be defined as material that provides official information or evidence that serves as a record. Electronic documentation simply adds a computer to this definition. When speaking in terms of healthcare, electronic documentation progresses to encompass the creation, gathering, and managing as well as the recording of health-related information (Quality, 2015). This module will focus on best practices of documentation as a means of recording, reporting, and communicating basic healthcare tasks and conditions.

**Instructor Teaching Points**

* **Healthcare Documentation:** The medical record is something that most people know exists. They may, however, not fully understand the magnitude of impeccable documentation as not only a form of communication, but also as a means of evidence that is subject to legal ramifications.
* **Electronic Healthcare Documentation:** A good number of people have been to healthcare providers that enter their information into a computer. *Ask the class if they know that EHRs are best practice for increasing safety in patient care.*
* **Handwriting Discrepancies:** *Ask the class what kinds of errors could be made if they could not read their patient’s chart or plan for care? Discuss handwriting vs. computer entry as a means to increase safety (medication names/doses, treatments, the ability to find out prior care and the patient’s response.)*
* **Decision Support:** The class may not know this term. *Explain in simple language that computers can help to give the best and most accurate information to healthcare providers so that their patients are getting the best care possible. Give examples: When to use cold vs. heat therapy, what lab work to order, which antibiotic will work the best for specific infections, how to clean around a catheter, and when specific treatments, tests, or medications* *are due.*
* **Data Collection:** Now that healthcare is moving toward computer documentation and EHRs, the ramifications of data collection as astronomical! *Give examples: Collection of statistics to improve medical care (infections caused by foley catheters, illnesses associated with smoking and other lifestyle interactions, response to medications such as vaccines and antibiotics.)*

**Module 3: Electronic Health Record Documentation**

**Learning Outcomes** (Slides #3)

Upon completion of this course the learner will be able to:

* Name three benefits of electronic health care documentation
* List three components of legal communication
* Define subject and objective documentation
* Name at least five conditions that are critical to report
* Give three examples of computer documentation entry selections
* Describe how the EHR contributes to safer patient care
* Identify at least three EHR best practices

**Module 3: Electronic Health Record Documentation**

**Syllabus**

**Electronic Communication of Health Information** Definition

* Legal Communication
* Barriers to Communication

**Subjective and Objective Documentation**

* Objective – facts & signs
* Subjective – quotes & symptoms

**Communication and Documentation**

* Verbal
* Non-verbal
* Using the senses

**Plan of Care Documentation in EHR**

* Patient Centered
* Individualized Directed Care
* Continuity of Care
* Communication of Care

**Critical EHR Documentation and Reporting**

* Incident Reporting

**Documentation Basics**

* Computers & Accessories
* Software & Programs

**Entering Documentation**

* Text Box
* Text Fields
* Drop Down Menu
* Radio Button
* List Box
* Check Box

**Completing Documentation**

* Saving Information

**Increased Safety with EHR Documentation**

* Identifying abnormal values
* Alerts

**EHR Best Practice**

* Real Time Documentation
* Clear, Truthful, Succinct
* User/Documenter Identity
* Privacy & Security
* Not Documented Not Done

**Module 3: Electronic Health Record Documentation**

**Instructor Teaching Points**

**Electronic Communication of Health Information** (Slide #4)

Explain the premise of information exchange with EHRs.

* Ask the class if they have ever gone to a clinic or emergency room and gotten a phone call from their PCP the next day.
* Give Examples:
	+ The *Transition of Care Document* is something that is emailed to home care organizations, long term nursing facilities, rehabs, and other hospitals when a patient is discharged from one hospital to the care of another providing organization.
	+ Providers have the ability to look up information (lab work, hospital notes, etc.) on their patients.
	+ Providers get detailed notifications when patients are in clinics and hospitals.
* ***Care providers and organizations MUST be linked into the EHR network in order to have this information exchange.***

**Legal Communication**

* Stress the importance of the EHR as a legal document that automatically captures date, time, and documenter.
* Stress the importance of factual and objective content. Note that there will be more on this in following slides

**Barriers to Communication** (Slide # 5)

* Ask the class if they know of any other barriers to communication or if they have any examples to share.
* Relate to EHRs:
	+ Tell the class that some EHRs allow for documentation of communication barriers. Use example such as preferred language. Discharge and healthcare instructions can be printed out in multiple languages so that care providers know that their patients understand how to care for themselves.
	+ Being aware of the barriers to communication can alert care providers to alter the way in which they communicate so that patients will have a better understanding and also be more likely to put forth more complete and accurate information. Don’t forget, this information is being entered into a computer. It is permanent and used to provide care and also to collect data. Examples: Patients may not want to give information like admit that they smoke or that they are illiterate to a provider that is using a harsh tone or demonstrating impatience.

**Subjective and Objective Documentation** (Slide # 6)

**Objective Documentation:**

* Give Documentation Examples: Shortness of Breath, Lethargy (feeling tired), Vital Signs, Bruising, Pallor
* Also give examples of things NOT to document: Anything that is not directly involved with the care of the patient such as the weather, or what is on TV.

**Subjective Documentation:**

* Give Documentation Examples: “I have chest pain”, “I have no pain”, “I tripped over the rug and fell”, “I fell nauseous”.
* Again, it is not necessary to document things that are not directly related to patient care.
* Sum up by explaining the importance of brevity and also the importance of not documenting opinions.

**Communication and Documentation** (Slide # 7)

* Explain non-verbal documentation as being objective (factual).
* Give examples or ask the class to give examples of non-verbal documentation using the senses:
	+ *Sight:* Bruising, Cloudy Urine, Dark Tarry Stools
	+ *Hearing:* Wheezing, Gurgling
	+ *Touch:* A Lump, Crepitous (crackling skin around chest that indicates a pneumothorax)
	+ *Smell:* Foul urine or stool or a wound, fruity breath (high blood sugar)

**Knowledge Checkpoint** (Slides #8, #9, #10 & #11)

*The benefits of electronic healthcare documentation include:*

1. The elimination of handwriting discrepancies
2. Providing better organization of information
3. Decision support for ordering medications and treatments
4. Data collection to help identify best practices
5. All of the above

Answer: E

*Barriers to communication include:*

1. Language
2. Technical jargon
3. Culture
4. All of the above

Answer: D

*Important components of legal communication are:*

1. Fiction
2. Opinion
3. Timed, Dated and Signed
4. All of the above

Answer: C

*True or False:*

Subjective documentation is a direct quote; Objective documentation is observed fact.

 Answer: True

**Plan of Care Documentation in EHRs** (Slide #12)

* Explain the *Plan of Care*, also known as *Care Plans* as a means to define and document care.

**Patient Centered**

* Information is related to solely to the individual. Holistic, meaning the information encompasses all of the body systems including the psyche and also contains demographics (height, weight, address, insurance information).

**Individualized and Directed**

* Each patient has a care plan that is specific to their needs. Give examples: treatments, tests (blood sugar), activity, diet, medications, etc..

**Continuity**

* Ensures that all caregivers are consistent withthe plan of care that the provider has outlined.
* Explain that care is not comprised of just tasks that need to be documented as completed. Questions: Is the treatment working? Is the wound better or worse or the same? How did the patient tolerate an activity? How much did the patient eat/drink? How did the patient respond yesterday with a different caregiver?
* The Plan of Care is continually being updated in the EHR, capturing the patient’s progress or lack thereof.

**Critical EHR Documentation and Reporting** (Slide #13)

* This ties directly into the legal aspects of documentation and adds the reporting criteria. It is important that the documentation in the EHR

match what is verbally reported. Again….data collection!

* *Incident Reporting* – specific to organization. EHR documentation should NOT include entry stating that incident report was completed. Just the facts of the incident. Incident reports are NOT part of the EHR. Incident reporting is one method that organizations use to improve care by reviewing issues that patients and staff experience.
* Ask the class if they have any other examples or experiences with critical situations and how documentation was done.

**Knowledge Checkpoint** (Slide #14)

*Information that is critical to report immediately includes all EXCEPT:*

1. Patient reports having chest pain
2. Noticing symptom of shortness of breath
3. Ate all of breakfast
4. Falls

Answer: C (Although it is not critical to report that the patient ate all of the breakfast, it is important to document.)

**Documentation Basics** (Slide #15)

* **Computers & Accessories:** This is a great opportunity to discuss the various types of computers and accessories. Ask the class for examples: desk top, smart phone, tablet, etc… printer, headphones, scanner, etc…
* **Software & Programs:** Not all EHRs look alike. They do, however, contain the same information; it just looks different. Compare this to online banking or shopping. They all look different, but the results are the same.
* **User Name & Password:** Stress the importance of user authentication for identification and security.

**Entering Documentation into the EHR** (Slide #16)

* **Textboxes & Test Fields**
	+ Ask if anyone has ever documented in a text box and what types of things were documented
* Explain how a text box/field can be limited to a specific number of characters
* Define characters as symbols & numbers
* Explain how spaces are also included in the field count

**Entering Documentation into the EHR** (Slide #17)

* **Drop Down Menu & List Box**
	+ Ask if anyone has used a drop down menu and discuss the purpose in selecting from a predefined list as a means to limit the documentation and make more efficient to save time.

**Entering Documentation into the EHR** (Slide #18)

* **Radio Buttons & Check Boxes**

Ask if anyone has ever used these types of documentation choices and discuss purpose of efficiency in documentation as well as specific data collection.

**Completing Documentation** (Slide # 19)

* Different computer programs and software have various icons to save information
* All entries are associated with the user – the person who signs on to the computer with a specific username and password.
* Ask what would happen if the information entered was not saved.

**Knowledge Checkpoint** (Slide #20 & #21)

*Various types of computer documentation are dependent upon:*

1. Type of computer used
2. Software / Program
3. User permissions
4. All of the above

Answer: D

*Some computer charting entries include:*

1. Text boxes and text fields
2. Check boxes and radio buttons
3. Drop down menus
4. Save icons
5. All of the above

Answer: E

**Increased Safety with EHR Documentation** (Slide #22)

* Computer documentation has the unique ability to alert the person who is entering or reading the documentation to abnormal values.
* Some EHR software contains required fields that must be filled out in order to save the information that is entered.
	+ Example: If you do banking or shopping on line, there is a pop up or warning when information is omitted or not valid such as credit card info or blank fields.

**Increased Safety with EHR Documentation** (Slide #23)

* Provider Orders are entered by physicians, physicians assistants, nurse practitioners, registered nurses, and others that are part of the healthcare team.
	+ The EHR sorts these orders into task lists for RNs, CNAs, and other care providers.
	+ Examples: Medication Records, Treatment Lists, etc..
* Because the items on these lists are then set at specific dates/times, the computer can communicate tasks that are due and warn of tasks that are overdue.

**EHRs Best Practice** (Slide #24)

* Real Time Documentation may be a new concept for some. Explain the benefits of documenting in real time vs. saving the documentation for the end of the shift:
	+ Forgetting
	+ Feeling rushed
	+ Getting busy and not leaving enough time
* Ask audience what kinds of responsibilities they should have when documenting
	+ User ID
	+ Logging off
	+ Facts not Opinions
	+ Complete
	+ Protection of information
* Discuss confidentiality and log off as a means to protect user and patient

**If it was not documented, it was not done!** (Slide #25)

* Explain the phrase: *If it was not documented, it was not done.*
* This is a common expression that is used frequently to make clear the importance of documentation, be it handwritten or computerized. If there is no record of care such as BP/HR checks, hygiene, skin care, or activity performed, then it is assumed that the care was not given. If nothing is documented, there is no proof of patient care.

**Knowledge Checkpoint** (Slide #26, #27 & #28 )

*EHRs contribute to safer patient care by:*

1. Alerting caregivers to abnormal vital signs and lab values
2. Reminding caregivers when treatments are due or past due
3. Providing decision support for best practice
4. All of the above

Answer: D

*Best practice includes:*

1. Leaving yourself logged onto the computer for convenience
2. Saving documentation for the end of the shift
3. Letting someone use your username and password because they forgot theirs
4. Documenting opinions
5. None of the above

Answer: E

*True or False:*

*If it was not documented, it was not done* means that there is no proof that care was given.

Answer: True

**Module 3: Electronic Health Record Documentation**

**Summary** (Slide #29)

You have learned about:

* Benefits of electronic health care documentation
* Components of legal communication
* Subject and objective documentation
* Conditions that are critical to report
* Computer documentation entry selections
* How the EHR contributes to safer patient care
* EHR best practices

**Module 3: Electronic Health Record Documentation**

**Exam with Answer Key**

*1. The benefits of electronic healthcare documentation include:*

1. The elimination of handwriting discrepancies
2. Providing better organization of information
3. Decision support for ordering medications and treatments
4. Data collection to help identify best practices
5. All of the above

Answer: E

*2. Important components of legal communication are:*

1. Fiction
2. Opinion
3. Timed, Dated and Signed
4. All of the above

Answer: C

*3. Barriers to communication include:*

1. Language
2. Technical jargon
3. Culture
4. All of the above

Answer: D

*4. True or False:*

Subjective documentation is a direct quote; Objective documentation is observed fact.

 Answer: True

*5. Information that is critical to report immediately includes all EXCEPT:*

1. Patient reports having chest pain
2. Noticing symptom of shortness of breath
3. Ate all of breakfast
4. Falls

Answer: C (Although it is not critical to report that the patient ate all of the breakfast, it is important to document.)

*6. Various types of computer documentation are dependent upon:*

1. Type of computer used
2. Software / Program
3. User permissions
4. All of the above

Answer: D

*7. Some computer charting entries include:*

1. Text boxes and text fields
2. Check boxes and radio buttons
3. Drop down menus
4. Save icons
5. All of the above

Answer: E

*8. EHRs contribute to safer patient care by:*

1. Alerting caregivers to abnormal vital signs and lab values
2. Reminding caregivers when treatments are due or past due
3. Providing decision support for best practice
4. All of the above

Answer: D

*9. Best practice includes:*

1. Leaving yourself logged onto the computer for convenience
2. Saving documentation for the end of the shift
3. Letting someone use your username and password because they forgot theirs
4. Documenting opinions
5. None of the above

Answer: E

10. *True or False:*

*If it was not documented, it was not done* means that there is no proof that care was given.

Answer: True

**Module 3: Electronic Health Record Documentation**

**Glossary of Terms**

**Best Practice:** The most up-to-date statistically proven methods to administer the best care possible.

**Critical Documentation & Reporting:** The documentation and reporting of information that can be harmful or life threatening.

**Decision Support:** Information that helps to determine the best option.

**Documentation**: Material that provides official information or evidence that serves as a record.

**Incident Report**: A detailed account of a patient care related issue that is used by healthcare organizations to improve patient care. Incident Reports are NOT part of the patient’s medical record or EHR.

**Legal Communication:** The documentation of factual, objective information that is timed, dated, and signed.

**Objective Documentation:** Facts or observations that are written or entered into a computer to communicate information.

**Plan of Care:** A holistic approach to caring for patients that includes the assessment and evaluation of specific treatments and activities with the goal of improving health and wellness.

**Subjective Documentation:** Direct quotes or symptoms that are written or entered into a computer to communicate information.

**Transition of Care Document:** An electronic document containing patient information that can be easily shared among care providers in order to communicate the most up-to-date patient related facts.