**Introduction to Health Information Technology:**

**A Guide for Entry Level Healthcare Professionals**

***Student Handout***

**Module 3:**

**Electronic Health Record Documentation**

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**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**

**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.

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**Module 3: Electronic Health Record Documentation**

**Exam**

*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

*2. Important components of legal communication are:*

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

*3. Barriers to communication include:*

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

*4. True or False:*

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

*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

*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

*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

*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

*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

10. *True or False:*

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