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Electronic Health Record and Safe Nursing Documentation

Practical 01 / Clinical case or record exercise

Aim

Navigate a simulated electronic record, enter a nursing assessment and resolve a documentation discrepancy.

Principle

Accurate identifiers, time-stamped entries and an audit trail support safe coordination and confidentiality.

Articles and Materials

- Training EHR or paper mock-up and fictional patient records
- Approved terminology and documentation checklist

Procedure

1. Access the training system with the assigned student role and confirm the correct encounter and two identifiers before opening the patient's record.
2. Locate allergies, current orders, observations, nursing notes and relevant results. Check dates, entry source and whether more than one encounter is open.
3. Enter a new assessment with approved fields, units and time. Use consistent terms and record reported concerns separately from observed findings.

Continue with step 4 on the next page.

Procedure Continued

Electronic Health Record and Safe Nursing Documentation

4. Add the nursing action and response, including who was notified and planned review. Use the permitted local nursing terminology or taught code list.
5. Use the correction or addendum workflow when an entry is inaccurate. Keep the reason, author, date and original record traceable.
6. Review alerts and decision support against the case and notify the supervising nurse about discrepancies. Protect confidential details from unintended disclosure.
7. Prepare an authorised handover summary and verify that the correct encounter and pending results are visible.
8. Log out of the training account and report any access or privacy issue through the assigned process.

Precautions

- Use fictional data in training.
- Follow role-based access and retention rules.

Observations and Record

Electronic Health Record and Safe Nursing Documentation

Documentation

Item	What to record	Why it matters
Verification	Encounter, identifiers and role	Prevents wrong record
Entry	Data, time, correction and action	Maintains traceability
Follow-up	Alerts, handover and access	Supports continuity

Worked Example

Two training records share a surname. The student checks the second identifier and encounter before entering observations.

Result and Evaluation

Produce a complete, attributable case entry and demonstrate safe correction and access handling.

Viva Questions and Answers

Why keep an audit trail when changing a note?

It shows who changed the record, when and why.

What should happen to a wrong-chart warning?

Pause entry, verify identity and report according to policy.

Nursing Data Spreadsheet and Clinical Indicator Report

Practical 02 / Lab or data practical

Aim

Clean a fictional nursing dataset and calculate a defined service indicator.

Principle

Consistent coding, denominators and transparent formulas improve health information used for decision-making.

Articles and Materials

- Synthetic shift dataset and indicator definitions
- Spreadsheet application and audit worksheet

Procedure

1. Create a local copy of the training file and identify the respondent or event key. Confirm that identifiers are fictional and review the data dictionary.
2. Check column formats, units, allowable codes and dates. Mark absent readings as missing and review duplicate records without silently dropping valid entries.
3. Define the event and eligible population or time period from the indicator guide. Select and document the exact rows used for analysis.

Continue with step 4 on the next page.

Procedure Continued

Nursing Data Spreadsheet and Clinical Indicator Report

4. Calculate the numerator and denominator with transparent formulas. Verify a few entries and the total using an independent manual check.
5. Present the count, proportion or rate with unit and time period. Choose a suitable chart or table with labelled axes and summary labels.
6. Describe one pattern and a limitation such as missing entries or a short observation period. Avoid attributing a cause without supporting evidence.
7. Prepare a short nursing information system report and verify access and sharing permissions for any real use.
8. Save the calculation, inputs, revised fields and output with consistent names so the instructor can reproduce the result.

Precautions

- Use a de-identified or fictional dataset.
- Keep raw data and the transformed training copy traceable.

Observations and Record

Nursing Data Spreadsheet and Clinical Indicator Report

Documentation

Item	What to record	Why it matters
Dataset	Field definitions, quality and exclusions	Makes analysis reproducible
Indicator	Numerator, denominator and formula	Ensures correct calculation
Report	Result, chart and limit	Supports interpretation

Worked Example

Six simulated events among 120 eligible encounters give 5%. A missing date is documented and its effect on the eligible count checked.

Result and Evaluation

Deliver a clear, reproducible training indicator with a documented limitation.

Viva Questions and Answers

Why define the denominator before calculation?

It identifies exactly who or what the indicator describes.

How should missing values be handled?

Mark them explicitly and document whether the analysis includes them.

eHealth Communication and Evidence Search

Practical 03 / Supervised communication practice

Aim

Find a reliable resource and prepare a safe digital patient education or follow-up exercise.

Principle

Trustworthy sources, privacy and accessible communication protect patients when technology is used for care.

Articles and Materials

- Fictional inquiry, approved patient information resources
- Simulated telehealth or teaching channel and evaluation checklist

Procedure

1. Define the question and intended audience, identifying whether urgent symptoms require the supervised escalation route before education.
2. Search an approved official or clinical resource using key concepts and check currency, author and applicability. Record the source and date.
3. Compare the information with the patient's needs, available language and access to technology. Summarise one actionable message in plain terms.

Continue with step 4 on the next page.

Procedure Continued

eHealth Communication and Evidence Search

4. For telehealth simulation verify identity, consent, contact method and privacy before discussing health information.
5. Use only the approved channel and limit details to those needed. Explain how to get assistance if video or audio fails.
6. Present the task and request teach-back. Assess whether the patient can use the resource or needs another route or language.
7. Document the communication, source, result and follow-up. Record any technical, privacy or safety issue for supervised review.
8. Evaluate the plan by checking accessibility, clinical accuracy, and the clarity of escalation and next contact.

Precautions

• Use fictional details in the training system.

• Use an urgent clinical pathway for symptoms needing immediate care.

Observations and Record

eHealth Communication and Evidence Search

Documentation

Item	What to record	Why it matters
Source	Author, date and applicable guidance	Checks reliability
Contact	Consent, channel and privacy	Protects confidentiality
Evaluation	Teach-back and next contact	Confirms usability

Worked Example

A patient cannot open the approved online handout. The student provides an authorised accessible version and checks understanding verbally.

Result and Evaluation

Complete a verified teaching exercise and document the chosen safe communication plan.

Viva Questions and Answers

What makes a resource suitable for patient teaching?

It is reliable, current, accessible and relevant to the person's task.

What should happen if video follow-up is unavailable?

Agree a suitable authorised alternative and document it.

Nursing Terminology and Record Interoperability

Practical 04 / Lab or data practical

Aim

Map a fictional nursing observation to an approved structured record and check what the receiving system displays.

Principle

A standard concept code, clear units, time and encounter context preserve meaning when clinical data move between systems.

Articles and Materials

- Two fictional record layouts and a simulated export
- Faculty-approved terminology and field-mapping table

Procedure

1. Open the training records and verify the simulated patient, encounter, source observation and receiving record.
2. Select a nursing observation such as oxygen saturation. Identify the measurement, unit, observation time, device and respiratory support recorded with it.
3. Match the concept to the approved terminology table, using the supplied SNOMED CT mapping where assigned. Verify the selected concept and version, and retain the original wording.

Continue with step 4 on the next page.

Procedure Continued

Nursing Terminology and Record Interoperability

4. In the model exchange identify the patient, encounter, time, value, unit and context fields. Use the supplied HL7 FHIR Observation example where assigned and mark any required field that is empty.
5. Enter the information in the mock source record and map it to the receiving fields. Leave an unavailable value identified as missing.
6. Compare the receiving display with the source, checking numbers, units, time zone and clinical context. Test whether an incorrect unit would be rejected or flagged.
7. Resolve any ambiguous term or mapping with faculty. Record what the receiver can interpret and which information requires an explicit qualifier.
8. Save the coded example, reviewed mapping table, validation checks and correction reason without using real case identifiers.

Precautions

- Use a training system and fictional identifiers.
- Verify terms, units and versions against the authorised reference.

Observations and Record

Nursing Terminology and Record Interoperability

Documentation

Item	What to record	Why it matters
Concept	Original wording, approved code and version	Preserves clinical meaning
Exchange	Value, unit, time and encounter	Makes data reusable
Validation	Source and display comparison	Detects mapping errors

Worked Example

Oxygen saturation is displayed as 94 with the unit missing. The student restores the verified percentage unit and checks that the receiving record still shows the oxygen device and observation time.

Result and Evaluation

Produce a verified training exchange that preserves the observation and its clinical context.

Viva Questions and Answers

What makes records interoperable?

Different systems can exchange information with its intended meaning preserved.

Why preserve the original measurement context?

It lets the receiving team interpret and compare the value correctly.

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