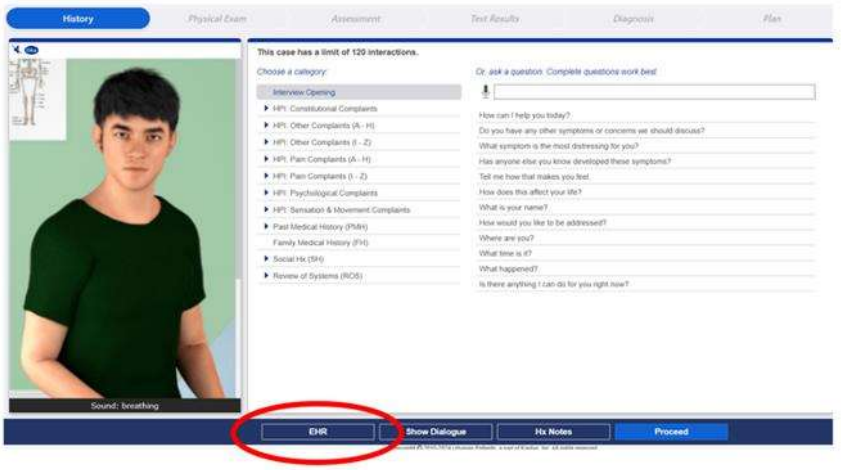
iHuman Documentation Guide

Purpose: Use this guide to help complete documentation within the iHuman Virtual Patient Encounter.
NOTE: All documentation must be entered into the iHuman Electronic Health Record (EHR).



EHR Button

EHR Documentation Tips

History:

- **You** may ask up to **120 questions** but must determine relevant questions. Questions should be focused on the present illness and associated body systems. Asking extraneous questions does not earn credit.
- **Findings** do not auto-populate in the EHR, so document as you go.
- **Document** information in the appropriate EHR sections of the patient history and enter abnormal findings under Key Findings.
- **Document** subjective information ONLY in the history.
- **Suggested approach:**
  - **Start** by asking two open-ended questions: "How can I help you today?" and "Any other symptoms or concerns?"
  - **Next,** obtain an HPI. Practice using the OLDCARTS method to document the HPI.
  - **Obtain** previous medical, family, and social histories and review the systems.

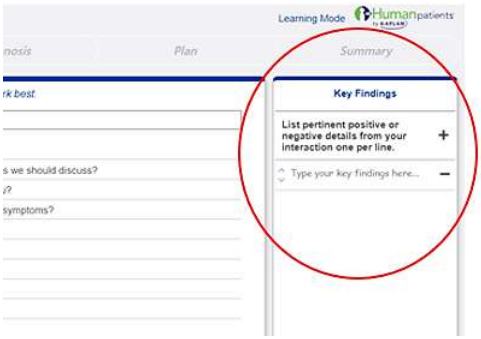
Physical Exam:

- **Open** and view the patient's record to receive credit for obtaining vital signs.
- **Click** on appropriate physical exams of the present illness and associated body systems to determine findings for the patient.
- Utilize the **iHuman Auscultation Tips** sheet to earn credit for pulses and breath sounds.
- **Document** physical exam information in the EHR in the appropriate sections of the Physical Examination and enter abnormal findings under **Key Findings**.

- **Document** objective information ONLY in the Physical Exam.
- **Avoid** ambiguous terms like “normal”. What is normal? Document what you found; interpret the findings later when you begin diagnosing the findings.
- **If** you did not assess a body system, document “Not assessed” rather than “Negative”. You do not want to infer findings that you did not assess inadvertently.

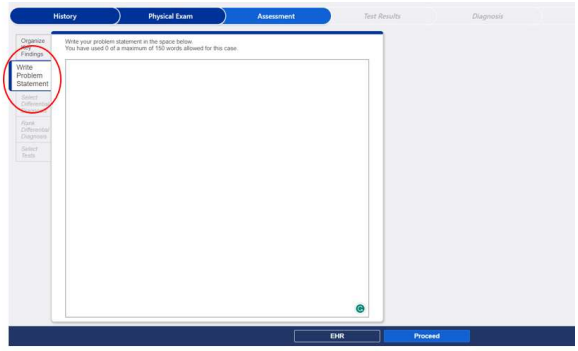
Key Findings

Add key findings at any time during the history or physical exam by clicking the plus (+) sign. Key findings may be organized using the up (^) and down (v) arrows. Remember that key findings should include everything that is out of the ordinary about this client, even when it does not appear to be a “problem”.



Key Findings

Problem Statement



Problem Statement

The problem statement must be sufficiently detailed, precise, succinct, and no more than 2-3 sentences. You must include the patient’s initials, chief complaint, epidemiology, risk factors (if relevant), pertinent history and physical examination findings, and results of any diagnostic testing (if known). It should not include extraneous details that better belong to other parts of the medical record, like the PMHx or ROS. For example, “*H.T. is a 57-year-old man with congestive heart failure and a 35-pack-year smoking history presenting with acute, severe, exertional, retrosternal pain and associated shortness of breath. His examination is notable for a new S3 gallop, bibasilar crackles, and bilateral lower extremity edema*.”

Management Plan

Create a comprehensive treatment plan using professional language**. Use headings and address all six parts of the comprehensive treatment plan**. If you do not wish to order an intervention for any part of the treatment plan, write "None at this time" but address each area. No intervention is self-evident. Provide a rationale and evidence-based in-text citation for each intervention. Include at least one appropriate, evidence-based, scholarly source to support your management plan decisions. Include the full reference for all in-text citations used. You will not be able to use italics for the title of your journal article within iHuman documentation. Do **not** submit a SOAP note.

- **Diagnostic tests:** For the iHuman case studies, assume that the test results you reviewed in the case are those you ordered for your patient during this encounter and include them as part of the management plan. It is important to develop an appreciation for when, why, and how diagnostic tests are ordered. Provide a rationale for the tests ordered and reference citations.
- **Medications/treatments:** Write out all medications like a prescription, including OTC medications. Include the name of the drug, dosage, route, frequency, duration, quantity to be dispensed, and refills. Include "continue other medications" if appropriate.
- **Consults/referrals:** Provide a list of appropriate referrals if needed. Include a rationale for each and provide support from scholarly literature with an in-text citation.
- **Client education:** Provide documentation of appropriate client education. Include a rationale and provide support from scholarly literature with an in-text citation.
- **Follow-up:** Indicate the time interval when the patient should return (2 days, 1 week, etc.) and provide detailed symptomatology ("Red Flags") indicating if the patient should return sooner or seek immediate attention.
- **Reference(s):** Include at least one scholarly source per the NP Program Expectations for Scholarly Sources.

Additional Resources

- iHuman H&P+Dx Case Play Webinar Lesson
- iHuman: Heart Auscultation Lesson
- iHuman: History Taking Lesson
- NR509 Week 1: iHuman Orientation
- NR509 Week 2: i-Human Pre-Brief Videos
- NR509 iHuman: "Ask the Professor" live or recorded webinar