Home care nurses have multiple goals at the patient admission visit. Electronic health records support some of these goals, including high-quality documentation, but nurses may not complete the electronic documentation at the point of care. To characterize admission nurses’ practices at the point of care and lay the foundation for design recommendations, this study investigates admission nurses’ documentation strategies with respect to entering electronic data and how nursing goals affect them. We conducted 10 observations of home care agency admissions with five admission nurses in rural Pennsylvania. We collected screenshots and recorded the admission process. We asked the nurses questions outside the point of care. We coded the nurses’ strategies at the data-entry screen level. Using thematic analysis, we investigated the influence of nursing goals on documentation strategies. Subject matter experts reviewed our findings. Several goals affect nurses’ documentation strategies: ensure data accuracy, reduce time in the patient’s home, and prevent infection. Home care admission nurses distribute the electronic documentation temporally due to their goals. Nurses developed memory aids to support completion of the documentation after leaving the patients’ homes. Design and training should support the distributed manner in which home care nurses document patient encounters.

KEY WORDS: Distributed documentation, Electronic health record, Home care admission, Nursing goals

Nurses have multiple goals, such as providing high-quality patient care, devoting attention to the patient, preventing infections and other undesirable outcomes, and completing high-quality documentation.1–4 These goals can affect how nurses complete their work. For example, to enhance nurse-patient interaction, including maintaining eye contact and reducing head-down time, a hospital floor nurse may take notes on paper when with the patient and then complete documentation in the electronic health record (EHR) after leaving the patient’s room.5

In home care, admission nurses face the challenge of managing multiple goals. During the first home visit, a nurse may need to perform direct care activities (eg, wound care) and may need to educate patients and caregivers on various topics (eg, disease knowledge, condition self-management, medication self-management). An important goal of the admission process includes documenting the Start of Care (SOC) that includes the care plan (problems and interventions addressed during the episode), inclusion of other disciplines (services needed, such as physical therapy and social work), future visit patterns (visits following the admission and total number of skilled nursing visits), and medication reconciliation (process of creating an accurate list of the patient’s medications by comparing discharge orders and medications in the home).6

Another important goal is to meet the documentation requirements of the Centers for Medicare & Medicaid Services. To support agency quality assessment and care reimbursement, each admission requires the answers to Outcome and Assessment Information Set (OASIS) questions.7 Also, the nurse may be required to document agency-requested data. The OASIS and additional patient-related data collection are very time consuming, taking at least 1 hour and requiring almost the entire first visit to complete.

Home care agencies have implemented healthcare information technologies to help nurses address some of their goals.8 Electronic health records can support critical thinking, decision making, and productivity, and enable accurate information capture, information sharing, and care coordination with those who have access to the EHR.9,10 However, a pilot study showed that one EHR only partially supports nurses’ decisions and their workflows.11 Another study at a different agency
showed that nurses may not complete EHR documentation for the admission at the point of care.12

Documenting after leaving the patient's home may introduce issues related to memory regarding details of the admission, enable errors and omissions, and increase workload.13 Although the impact has not been studied in home settings, the temporal distribution of documentation has affected other roles in ambulatory settings. For example, in ambulatory care, while physicians spent 37.0% of the time with patients in the examination room, they also spent an additional 1 to 2 hours completing EHR-related work.14 Thus, it is important to understand what home care admission nurses' point-of-care EHR documentation strategies are and whether the nurses' multiple goals influence these strategies.

Objective
In this study, we identify home care admission nurses' EHR documentation strategies and investigate how their goals affect these strategies. The results can inform recommendations regarding EHR design and opportunities for other technology and training to support nurses' goals and to mitigate potential risks of completing documentation outside the point of care.

METHODS
The Drexel University Institutional Review Board approved this study as part of a larger one intended to develop and disseminate design and implementation recommendations to support home care admission nurses' information requirements, decision making, and workflow. This study involved observations of nurses completing the admission to home care in patients' homes and afterward at the agency.

Setting and Sample
The small rural Pennsylvania home health agency participating in this study serves a majority white population with lower socioeconomic status. We reimbursed the agency at the nurses' standard hourly salary for participation. Five home care RNs, both home-visiting nurses and care managers, who admit patients were recruited using a convenience sampling strategy (based on interest, agreement, and schedule) by the agency's leadership. The five nurse participants were white, 25 to 47 years of age, and mostly females, with an average of 9.8 years of work experience in healthcare.

Electronic Health Record
The agency used a laptop-based, commercial EHR (Allegheny Software Publishers, St Marys, PA), designed for the point of care. For patient admission, the SOC Assessment module incorporated (1) 80 OASIS questions (M questions); (2) 130 additional patient-related questions; (3) four clinical decision support tools (ie, two risk-of-fall tools [Missouri Alliance for Home Care 10,15 Timed Up and Go16], Braden Scale,17 and nutritional health screening); and (4) two graphical tools (ie, pain rating scale using FACES and integumentary status locator).

The EHR's SOC Assessment module was organized in a hierarchical fashion. Twenty-one vertical tabs identified the themes of patient assessment (see the left side of Figure 1). Selecting a vertical tab changed the data-entry area to include a horizontal tab tailored to the patient assessment theme. For example, the “sensory” patient assessment tab was associated with six horizontal tabs, including vital signs; eye, ear, nose, and throat; pain; vision; speech; and pain assessment, in addition to a free text “Notes” tab (Figure 1). The SOC Assessment module incorporated 65 horizontal tabs plus another 15 “Notes” data-entry tabs. The designed flow of navigation for the EHR was to select the vertical tabs from top to bottom. Within each theme, the flow included selecting the horizontal tabs from left to right.

Each horizontal tab had unique data-entry screen layouts and items. The human-computer interaction included multiple-choice questions, single-choice options (ie, check marks), and blank text fields associated with labels. Some data-entry screens had notes fields at the bottom. Data-entry screens employing check marks usually included a notes field in which check marks were used for clinical findings (such as an abnormality), while the notes field allowed further explanation. For example, the “Respiratory” tab included 52 check marks and a notes field about abnormal findings or other narrative texts. The nurse checked “WNL” (within normal limits) if a patient had no issues with respiration. The nurse checked “SOB” for shortness of breath. Other examples in the list included inhalation treatment; cough (frequent, occasional, or chronic); productive (thin, thick, clear, yellow, white, frothy, or hemoptysis); breath sounds (clear, crackles, wheezes, dyspnea, exertion, rhonchi, diminished, absent, or rales); anterior (right, left, upper or lower); posterior (right, left, upper or lower); pain (inspiration, expiration, resting, or exertion); tracheostomy; and other.

The EHR included some data validation checking. Missing data and contradictory answers across items were identified. For example, if M1011 (inpatient diagnoses) was not entered, the message “Missing M1011 Answer” was generated. For therapy need and plan of care (M2200) and current payment source for home care (M0150), the message “M2200 should be N/A if M0150 is not 1—Medicare: traditional fee for service” was displayed if the values for the two questions were not consistent with each other.

Data Collection
Two researchers (E.J.B. and P.S.S.) conducted observations of 10 home care patient admissions (five nurses were observed admitting two patients each). The observers met each
nurse at the agency and obtained informed consent, if needed. In the patient's home, they obtained informed consent from the patient and recorded audio and observed the nurse admitting the patient to home care. A nurse may conduct home visits consecutively and then complete a batch of documentation. For this study, the nurses were scheduled to return to the agency after visiting each patient. The observers recorded video of the nurse completing the admission at the agency and asked questions including "Why do you document these data at the patient's home?"; "Why do you document these data after visiting the patient?"; and "What are your strategies for documenting?"

In the patient’s home and at the agency, at least one observer stood behind the nurse and photographed each EHR screen as a backup.

Data Analysis

Based on a usability engineering perspective, the EHR documentation was analyzed at the data-entry screen level by Y.Y., who coded the nurses’ documentation strategies for each data-entry screen (ie, horizontal tab) by reviewing the video recordings and screenshots. This analysis identified where a nurse started and finished documentation for each data-entry screen (in the patient's home or at the agency). From the transcribed audio recordings, Y.Y. extracted nurses' statements related to the strategies and entered them into an Excel spreadsheet (Microsoft, Redmond, WA). Using thematic analysis, concepts that conveyed the essential meaning were organized and grouped as themes. This analysis addressed the influence of nursing goals on documentation strategies. The authors used research triangulation (analysis from multiple perspectives) to ensure validity of the coding and thematic analysis, and Y.Y. described the process in an audit trail. Each member (E.J.B., P.S.S., K.H.B.) reviewed the results and provided feedback, with priority given to input from the expert nurse (K.H.B.). The external advisory board comprised nurses, informaticists, and a human factors engineer; they reviewed the findings to further ensure validity.

RESULTS

Across the 10 observations, the mean time in the patient home was 66.7 minutes. The mean time back at the agency was 68.6 minutes, including time for researchers to ask questions for clarification. The times spent at the agency were longer than is typical due to the questions.

Documentation at the Point of Care and After Leaving the Patients’ Homes

We identified six possible ways that nurses start and finish EHR documentation at the data-entry screen level. The first strategy is to start and finish documentation through the data-entry screen in the patient's home. For example, a nurse admitted a patient with an arm wound and completed the "respiratory" data-entry screen. The nurse listened to the...
patient's lungs. While still in the home but after completing other work, the nurse asked the patient about breathing, coughing, congestion, and respiratory diagnosis history. Although the nurse identified some wheezing, the patient denied having any issues related to respiration. Based on this information, the nurse documented in the notes field on the “respiratory” data-entry screen that there was an occasional expiratory wheeze in the left upper lobe and that the patient denied SOB, coughing, congestion, or any other symptoms.

The second strategy is to start documentation in the patient's home and review the data later. For example, one nurse answered questions on the “Pressure Ulcer” data-entry screen (M1322-1334) in the patient's home and reviewed the answers at the agency. Another nurse answered questions on the “Urinary and Bowel Incontinence” data-entry screen (M1600-1630) in the patient's home and reviewed the answers at the agency.

The third strategy is to start documentation in the patient's home and finish it by modifying the previously entered data afterward. For example, one nurse answered the M-1800 question (Groom: Current ability to tend safely to personal hygiene needs) as “0—Able to groom self unaided, with or without the use of assistive devices or adapted methods”; M-1810 question (Current ability to dress upper body safely) as “0—Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance”; and M-1820 question (Current ability to dress lower body safely) as “0—Able to obtain, put on, and remove clothing and shoes without assistance.” The nurse reviewed the documentation for “M1800-1820” at the agency, and after thinking about the patient's SOB, and its influence on the answers, raised the ratings one level. The rationale for the revision was: “Actually now that I'm just thinking shortness of breath-wise, I think I'm going to go with a 1. Just because he was short of breath just sitting there so I think it would be more appropriate and safety-wise, he'd be better off with having someone lay this stuff out for him at least.”

The fourth strategy is to start documentation on a screen in the patient's home and add and possibly modify data later. For example, a patient with back and wrist fractures due to a fall was admitted to home care. The nurse listened to the patient's lungs, asked about SOB, and observed the patient ambulate to the bathroom. The patient denied SOB; however, the nurse identified SOB as the patient moved. While in the patient's home, the nurse had documented “breath sounds: clear” and “posterior: right, left, upper, and lower” on the “Respiratory” screen. Back at the agency, the nurse also selected “SOB” and “diminished” and added information to the Respiratory notes field indicating that (1) the patient denied SOB, but it was evident during ambulation; (2) the breathing sounds were clear and diminished in the bases; and (3) the patient was not in acute respiratory distress.

The fifth strategy is to start and finish the documentation at the agency. For example, a patient in need of wound care was admitted, and in the patient's home, the nurse conducted an examination, asked about respiration (eg, issues such as SOB while walking, coughing, and congestion), and found no respiratory issues, so did not document respiration. Back at the agency, the nurse checked “breath sounds: clear” and wrote in the notes field that the patient denied SOB, cough, or congestion and that lung sounds were clear to auscultation.

The sixth strategy is to skip everything and document no data. Some screens may include items to be entered by other disciplines or care roles or may not be relevant for other reasons. For example, all nurses skipped the M-1017 (Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days) screen. At this agency, coders enter data about patient diagnoses. Also, most free-text notes screens were skipped; nurses added information in the notes field associated with the relevant data-entry screen, instead of using the standalone horizontal notes tab.

Memory Supports for Documentation Outside the Point of Care

Nurses utilized three external memory supports for EHR documentation outside the point of care. One support involved purposeful, partial, or incomplete documentation in the EHR in the patient's home. The idea was to sketch the solution in order to fill in the complete data later. In one case, a nurse did not know the exact spelling for a medication and entered “5 FE” in the notes field on the “infusion” screen. Back at the agency, this entry was sufficient to remind the nurse to review the referral documents and to enter the full name of the medication and exact dosage.

Another support included making electronic notes outside the EHR. Nurses sometimes used features on their computing devices such as the electronic equivalent of sticky notes or other notes-related applications while in the patient's home. For example, a patient with a hip fracture due to a fall was admitted to home care. The nurse stored patient contact information, wound measures, and other data on the computer's desktop. Back at the agency, the nurse added the data to the appropriate locations in the EHR.

A third support involved non-electronic methods. Sometimes nurses wrote notes on blank paper. At other times, they used patient-related paper documentation. For example, while conducting medication reconciliation in the home, one nurse marked up a paper copy of the discharge document with check marks where the medication was correct, question marks where there were questions about a medication, and notes where a medication was not in the patient's home or the
dosage was not consistent with the medication list. Such marks reminded the nurse to contact the physician for clarification; the paper document served as a reference when completing the “medication” screen and calling the physician while at the agency.

Impact of Goals on Electronic Health Record Documentation Strategies

There were three specific reasons for documenting outside the point of care: (1) ensure data accuracy, (2) reduce time in the patient's home, and (3) prevent infections.

Ensure Data Accuracy

The goal of ensuring data accuracy was a reason to review and/or modify the documentation after the home visit. Nurses made sure that the data were accurate. For example, one nurse explained, “[I am] just looking over my answers because sometimes I hit the wrong buttons.” Another said, “[I am] just double checking that I don’t need to add anything.”

Ensuring data accuracy was a reason to add data to the documentation afterward (Strategy 4). One nurse wrote incomplete phrases in the notes field on the “Endocrine” screen and completed the notes at the agency. Writing notes requires critical thinking, which may be disrupted by patients. The nurse stated, “Because I can’t think in the house, like if I’m thinking then, usually the patient will start talking because there is awkward silence, and then I can’t think about what I’m putting into the computer.”

Ensuring data accuracy was also a reason to start and finish the documentation after the home visit (Strategy 5). Data may be documented as collected in the patients’ homes (eg, flu shot history and vital signs) and entered in the EHR based on the patient’s answer or the assessment value. However, other data items require synthesis. In some cases, the nurses may need to apply critical-thinking skills to determine the appropriate information to enter (eg, OASIS item M-1034 overall status). For example, one nurse explained, “M-1034 is your nursing judgment on his overall prognosis. Since he has the COPD (chronic obstructive pulmonary disease) and a history of these frequent hospitalizations and things, that bases off of why you pick that. This is our opinion on the patient’s overall status outcome. And that’s just based off of our nursing judgment.”

In some cases, the value for one data item may be influenced by another. For example, safety measures data items are influenced by medication. One nurse stated, “I didn’t fill this in when I was there, [the safety measures], just because what I do, I come back here [the agency], and just what I want to make sure is, medication-wise, is he on any anticoagulants?”

Reduce Time in the Patient’s Home

Reducing time in the patient’s home was a reason to add data to the documentation after the visit (Strategy 4) and to start and finish documentation outside the point of care (Strategy 5). Two nurses specifically mentioned that they skipped some data-entry screens or only partially documented in the patient’s home, to reduce the time spent there. Therefore, for data entry that requires more time, the nurse may complete the documentation after the patient visit.

A home care admission visit is the first face-to-face encounter that the agency has with the patient for the current episode. Because the patient has recently transitioned from a hospital, skilled nursing facility, or similar location, the patient generally needs to rest. One nurse specifically mentioned not wanting to spend too much time because the patient might be tired: “It’s too much for me to sit and type and type and type, and you could tell she was getting tired.”

Nurses perceived the patients’ homes as private space in which it is not appropriate to stay too long. Therefore, they intentionally completed some screens later. One nurse said, “I don’t want to be there for hours and hours in this person’s home invading their space too much.”

Nurses knew which data-entry screens were good candidates for later completion. For example, they wrote medication data on paper and documented later to reduce visit time. One nurse stated, “It’s time consuming to type all the meds in there while I’m in the home. And it was already an hour and a half that we were there for.”

To shorten the visit, some nurses skipped a lot of the data-entry screens. For example, one admission nurse skipped 32 of the 65 data-entry screens (49.2%) in one visit and skipped 51 data-entry screens (78.5%) in another. This nurse mentioned another benefit of not documenting in the home: building a one-on-one nurse-patient relationship: “I like to have a more one-on-one patient experience. That’s more important to me than putting in this whole long assessment and making them wait between,” and “I can sit there and fiddle around on my computer, but if I’m sitting there between every question and typing something into my computer, people feel analyzed and not more one-on-one. Like that relationship—especially when I’ve never met a patient before and I’m trying to build that rapport with them, it’s hard when you’re constantly looking at your computer screen.”

However, not every nurse prioritized reducing time in the patient’s home. For example, one nurse who completed most of the documentation during the admission visit spent longer than average time there (95 minutes during the first observation and 75 minutes during the second). In the first observation, the nurse completed all documentation and later reviewed one screen (M1850-M1870, with questions related to transfer, ambulation, and eating). For this screen, the nurse wanted to consult with the supervisor before revising the answers. In the
second observation, the nurse completed all but five data-entry screens in the patient’s home.

Prevent Infections
Nurses mentioned the goal of preventing infections as a reason to start and finish the documentation outside point of care (Strategy 5). Admission nurses completed wound care and other clinical tasks during the visit. Many infections are preventable, and nurses strive to avoid them. As a nurse generally wears gloves while conducting the physical assessment and wound care, touching the keyboard during these procedures is not possible due to infection control practices. One nurse who provided wound care at a patient’s home wrote notes about the wound measurements on paper and documented them on the data-entry screen labeled as “Integumentary” back at the agency. The nurse explained, “Actually part of that is just for sanitation-wise. Like if you know I’m touching a wound, I’m not going to go and type.”

DISCUSSION
In this study, we observed home care admission nurses and characterized their documentation strategies during the admission visit in patients’ homes. We identified six strategies with regard to when (and thus where) nurses document in the EHR. We found that nurses use memory supports for documentation outside SOC. We identified three goal-related themes as the reasons for completing the documentation outside the point of care.

The Impact of Goals on Documentation Strategies
We examined how nurses’ goals influenced their strategies with respect to documentation in the patient’s home. Goal-related themes emerged: (1) ensure data accuracy, (2) reduce time in the patient’s home, and (3) prevent infections. Based on the nurses’ explanations, it was clear that these documentation strategies were a result of intentional decisions about how to address multiple goals. For example, to ensure data accuracy, a nurse may later review and modify data that are documented in the patient’s home. The process can help nurses identify missing, incorrect, or incomplete answers. Corrections based on the existing documentation improve the quality of documentation. Contrary to the positive impacts of distributed documentation in home care that we identified, delayed data entry in the hospital setting is often considered a potential risk because clinicians are not able to fully utilize clinical decision support embedded in EHRs.21 Also, delayed data entry in the hospital leads to wasted provider time due to unsuccessful data searching by other team members and increases the likelihood of adverse events.22

To reduce time in the patient’s home, a nurse may finish the documentation afterward. Research has shown that to complete OASIS at the start of care nurses have to spend a long time in the patient’s home (ie, 93.9-minute in-home time and 61.3-minute documentation time).23 In addition, some data-entry screens may take large amounts of time to complete due to the multiple data items required. For example, for each medication, the nurse needs to enter the medication name, dosage, frequency, route, and start and stop dates. The data-entry time may be extensive, because home care patients take a median of five medications, and 19% of patients take nine or more medications.24 Completing those screens outside the point of care reduces the time spent in the patient’s home, an important consideration on the first home care visit. This is consistent with a study of physicians, which revealed that EHR data were documented later, outside the exam room, because completing an electronic “diary” can be time consuming.14

To prevent infections while completing the patient assessment, a nurse may have to document the results, such as wound care measures, later in the day. Nurses may need to wear gloves while completing the physical assessment. Documenting afterward can avoid contamination of the keyboard and the opportunity to spread infections. This practice is consistent with hospital nurses’ goal to decrease healthcare-associated infections, as that is a primary cause of preventable death and disability of hospitalized patients.25

The nurses have two sets of different goals: patient care (eg, sterility) and administration (eg, efficient documentation). Sometimes the distribution of the documentation between the patients’ homes and the agency is a result of prioritizing goals related to patient care. For example, nurses apply their nursing knowledge and critical thinking to the patient assessment. This process may take time and require concentration and synthesis of information. To ensure data accuracy and reduce time in the patient’s home, nurses may document some data in the patient’s home and leave those data requiring critical thinking for later.

Nurses may aim to build a one-on-one relationship with patients during the admission visit. Thus, they may defer some data entry to after the home visits in order to reduce the amount of time focused on the EHR device. The patient may be unknown to the nurse during the first visit. Even if the nurse has seen the patient in the past, providing one-on-one attention to the patient is an important but time-consuming process at the home care admission.26

Studies of physicians found doctors were also conflicted between entering data in the EHR and paying attention to their patients in the exam room.27–29

Nurses’ Memory Supports for Distributed Documentation
We observed that nurses developed memory supports for the distributed documentation. To support remembering what to document, the nurses may use the EHR as intended (such as using the notes data-entry screen), may use other
electronic methods (such as electronic sticky notes on the device's desktop), or may use nonelectronic methods (such as paper). Regardless of the methods, memory-aid strategies are helpful in achieving multiple nursing goals. For example, taking notes of wound measures in the patient's home on paper and documenting afterward can help ensure data accuracy, reduce the time spent in the patient's home, and avoid infections. While each nurse developed individual preferred methods for creating memory aids, introduction of best practices for memory support may be helpful to provide for contingencies. These memory-support strategies were also used by emergency department physicians, who made handwritten notes (e.g., patient's and caretaker's names, bed number, and chief complaints) on paper at the bedside and used these as the basis for their official notes in the EHR.\textsuperscript{30}

**Electronic Health Record Design and Related Recommendations**

**Goal Management**

In our observations, not all of the nurses prioritized goals the same way. Some nurses appeared to prioritize the need to reduce time spent in the patient's home, while at least one nurse prioritized completion of the electronic documentation at the point of care. Agencies should consider developing policies and training programs and working with EHR vendors to both support nurses' awareness of multiple goals and build strategies to support data entry at the point of care. Training nurses how to document while engaging the patient or caregiver in the documentation process may be helpful.\textsuperscript{31}

**Memory Supports**

With respect to data entry, nurses have many reasons to enter data after the patient visit, such as checking with a supervisor or contacting the physician or other parties to get or share information (e.g., medication clarification). However, the nurses tended to revisit all of the pages (even ones deemed completed) because there was no mechanism to mark screens as finished or intentionally not completed. The EHR we observed did not provide any user-initiated methods for identifying data screens that the nurse wanted to review or skip. Such capabilities may enhance efficiency by supporting nurses who defer activities to after the patient visit.

**Infection Prevention**

Alternative data-entry devices (e.g., hands-free data entry) or augmentation of existing ones (e.g., keyboard covers) could help to reduce the risk of contamination while documenting. Future research should evaluate the effectiveness of such technologies.

**Supporting Critical Thinking**

Nurses may enter data that require critical thinking after the patient visit. Electronic health record design considerations include the ability to summarize the assessment findings to assist the nurse with decision making. Highlighting abnormal findings, patient goals, and inconsistent data may be helpful.

**Data Element Grouping**

In our observations, there were some data items that the nurses never addressed. These data items, which were intended for other disciplines, were intermixed with those the nurse did need to consider. We recommend organizing the screens by role so that nurses do not need to spend time skipping data irrelevant to them.

**Interoperability and Data Transfer**

Interoperability and data transfer across information systems can avoid doubled data entry and simplify local workflows.\textsuperscript{32} In the context of home care admissions, adequate interoperability and data transfer from referral facilities, such as an auto-filled medication list, may help nurses prioritize the goals related to patient care at the point of care.

**Limitations of the Study**

The limitations of this study include the sample. Only five nurses from a single home health agency using a single EHR system were observed. To enhance research transferability, future work should include additional observations at different agencies, with different nurse and patient populations, and with different EHRs at the point of care. Regarding data collection, we were not able to video record the home visit due to concerns for patient privacy. The data in the patient's home included audio recordings, field notes, and screen shots of the EHR. The documentation strategies were analyzed at the screen level. Some strategies across the data-entry screens might also be interesting to analyze (such as screens with fall risk assessments and the M code questions associated with fall risk). Regarding the proposed recommendations, while they are based on the research, they do require implementation and evaluation. Participation of the agency and its point-of-care EHR vendor is required to address the feasibility of such future work.

**CONCLUSIONS**

Home care admission nurses achieve multiple goals regarding both patient care and administration. To address these goals, which may sometimes conflict, nurses distribute the EHR documentation temporally. To support the management of goals and the distributed documentation, we proposed EHR design, other technologies, and training recommendations, which require further evaluation.
Acknowledgment
The authors thank the nurse participants and the home care agency.

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