



## **Preparing for Electronic Clinical Documentation**

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### **Looking Back. . .**

It's every nurse's nightmare. You're just about to finish your shift and you get a new admission and you know there's no way you're getting home any time soon. As a nurse in CCU or as a cardiac nurse there are the orders to check, the assessment to perform, the family to orient, treatments to carry out, and IVs to start. Then, after the patient is made comfortable and seems reasonably stable, the documentation begins. Fifteen years ago, the standards of care were to complete the cardiac and general assessment forms and write the highlights of both in a narrative format on the nursing notes. The cardiac assessment, to some degree duplicated the information on the general assessment. IV infusions that were running were documented on an IV Flowsheet and vital signs, height and weight, and intake and output values were entered on a graphic sheet so they could be trended. After the initial assessment and care plan were performed, ongoing observations, safety precautions, and nursing interventions were documented in a check list format. Another form, called a Kardex, was kept within the reach of all care providers and provided a snapshot of the patient. It contained contact numbers, activity level, diet, treatments to carry out, and lab and X-ray orders to track. The Kardex was used to communicate to the next shift and was updated as the patient's condition changed.

Care providers would have numerous forms to review to piece together what was going on with the patient condition. When the clinical system started to be implemented, nurses were hopeful that their documentation would be automated, but unfortunately what happened was the new system was customized to accommodate their existing practices and nurses found one more place to chart: the computer.

### **EMR Future Goals and Promises**

The concept of a total electronic medical record (EMR) has been a goal for many healthcare facilities for some time; providing physicians, nurses, and ancillary care providers with a totally integrated record with easy access to the information they need to deliver care. Patients would not have to explain their story repeatedly, or have to rely on their memory to provide details of their past medical or family history. Information could be written once and populate the same fields on all other forms requesting the same data entry. All the information gathered is easy to find, view and compare during the course of the patient's stay, and the data collected can be analyzed to improve patient outcomes. Are healthcare organizations taking the right steps to get there? Are they taking this opportunity to refine their processes or are they preparing to retrofit existing practices into their new system?

### **It Begins with Process Review**

Ideally, before selecting an EMR system, nursing should select a practice model that is in line with their philosophy and review their standards of practice. The standards of practice formulate the policies that provide direction to nurses on how they document the care provided the process for decision making, the frequency of assessment, process for late entry recording, acceptable abbreviations, HIPPA and other regulatory requirements, and handling the transmittal of client information. All of these practices and policies will be impacted by computerization.

### **Why Standardize?**

Decisions must also be made as to whether to incorporate a standardized nursing language into the new system. Without standardized terminology, nursing observations, interventions, treatments, and evaluations are not captured and submitted to government and health care agencies for use in health care planning. In essence, the practice of nursing is omitted from research and aggregate data. Since evidence-based practice starts with clinical documentation, it is pivotal to decide what constitutes nursing data, and what terminology will be used to represent that data so it can be validated and used to improve patient outcomes and manage cost.

Another reason may be to prepare for the current version of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act provides a monetary incentive to hospitals and physicians who can show that they are using the information extrapolated from the EMR to improve health care. 4

The table below lists the existing terminologies recognized by and sanctioned by the American Nurse Association (ANA) as of March, 2008

Table 1.1 – Standardizes Nursing Languages and Minimum Datasets

Standardized Term	Description
<b>NANDA</b> - North American Nursing Diagnosis Association, Inc.	Standardized nursing terminologies that supports documentation of the Nursing Process and the plan of care. Designed to be used in conjunction with NIC and NOC.
<b>NIC</b> - Nursing Interventions Classification System	Standardized nursing terminologies that supports documentation of the Nursing Process and the plan of care. Designed to be used in conjunction with NANDA and NOC.
<b>NOC</b> - Nursing Outcomes Classification System	Standardized nursing terminologies that supports documentation of the Nursing Process and the plan of care. Designed to be used in conjunction with NANDA and NIC.
<b>Omaha System</b>	A nursing terminology recognized by the ANA that focuses on nursing concepts of the client as an individual, family, or group and the interactive nature of nurse-client relationship. And served all ages, populations socio-economical status, education, spiritual beliefs and ethnicity. 1
<b>PNDS</b> - PeriOperative Nursing Dataset	Standardized nursing terminologies designed specifically for peri-operative nursing
<b>CCC</b> – Clinical Care Classification formerly HHCC) Home Health Care Classifications	
<b>SNOMED</b> (formerly SNOMED RT)	Systemized nomenclature of medicine that contains clinical terms that can be used for mapping to the nursing problems (diagnosis) for NANDA, the Omaha system, CCC formerly HHCC, and the PNDS.
<b>ICNP</b> International Classification for Nursing Practice (2000)	
<b>LOING</b> – Logical Observation Identifiers Names and Codes (2002)	
<b>Alternative Link</b> (2002)	Supports electronic and paper claims processing and fee structures for providers, health care payers, managed care organizations, and affiliate organizations. Although recognized by the ANA, it serves a different purpose than the other terminologies
<b>NMDS</b> - Nursing Minimum Data Set	Data elements organized for a specific purpose. US Nursing Minimum Data Set provides the vocabulary for NANDA to collect Nursing Dagnosis. .

Armed with a clear direction on the standards of care and how the standards should be documented, nursing is ready to begin identifying the specifications for the electronic document design. In order to identify specifications, the team needs to understand the capabilities and limitations of the selected system. Decisions need to be made early in the design process to minimize changes later on. The table below provides examples of the type of decisions that need to be made for free text notes, structured notes, and flowsheets specifically for the Eclipsys Sunrise™ Acute Care Documentation system, but may be appropriate for other clinical documentation systems as well.

**Table 1.2 Decisions for General Flowsheet Design**

General Flowsheet	Issue	Considerations
General Flowsheet for documenting observations that repeat on a regular basis, need to display in a grid format, and allow for summarization and graphing	Should the parameters on the Flowsheet be visible when the Flowsheet opens or collapsed and opened manually when the user needs to chart?	Expanded parameters increase the size of the Flowsheet and increase the need for scrolling while collapsed parameters require the user to open the observation before they can chart in it.
	Should the columns auto generate and if so how far in advance?	This can be individualized for each Flowsheet version.
	Will future charting be allowed? If so, how much time in minutes will be allowed up to 4 hours.	A warning will display to the user if attempting to document farther into the future that the number of minutes allowed.
	Should a field within a parameter be mandatory?	Mandatory fields must be charted on or the user cannot save their work. Configuring mandatory fields can promote compliance
	Can a parameter be added more than once?	Examples of when parameters need to be added more than once are: to document wounds, pressure areas, and IVs
	Should the data charted in one Flowsheet be configured to populate to another Flowsheet with the same parameter such as temperature on it.	This is termed “fan out” and can be turned off for the entire Flowsheet or allowed for a single observation.
	Should the Flowsheet build include the parameters that most units would use and then be pared down for other areas?	This format may be easier to maintain
	Do you want the user to be able to document that a task was done from the Worklist and have it complete in the observation cell of the Flowsheet?	In some cases, this would prevent duplicate charting.
	Should the user be allowed to use the “auto enter” feature which means the value from one column is copied to another. And if so, which fields would you want to have configured to allow this feature.	Standards of practice may circumvent using this but if allowed it can save the user considerable time.
	Will flowsheets display in the Documents tab?	Since entries are made in flowsheets multiple times per day, many organizations elect to not have them display in the Documents tab
	Should observations display as a group and be deleted as a group?	Can mimics the format accepted by care providers for certain observations such as BP 120/80
	Will evaluation and management (E&M) coding values be assigned to the observations and lists?	E&M values added to observations within a structured note can assist with reporting purposes and the Suggested Diagnosis from the Assessment and Plan section of the note. They should be added when the observations are created.
	Will CPT 4 or ICD 9 or ICD 10 coding schemes be utilized? Will Vocabulary Manager be loaded?	Coded values can be added manually or via the Vocabulary Manager module of the Sunrise Acute Care Documentation component

**Table 1.3 Decisions for Intake/Output Flowsheet Design**

Intake/Output Flowsheet	Issue	Considerations
Deciding this upfront supports standardization and minimizes user confusion.	Do you want blood transfusions to be included and calculated separately from other intake components?	Easier to track number of units transfused.
	Naming conventions for outputs	
	Will you be using orders to Flowsheet capability?	Medications given in IV infusions would be automatically updated on the Intake/Output Flowsheet. Otherwise, the row label must be modified to reflect the current order which can be labor intensive for the nurse.
	Will nursing be allowed to modify the parameters?	This capability allows the nurse to change the drug concentration and rate.
	When should the Flowsheet perform a 24 hour total? What constitutes a shift?	
	What values should be included in the Grand Totals column?	This is an opportunity to exclude fluids discarded from diasolate and/or irrigations.

**Table 1.4 Decisions for Structured Note Design**

Structured Note	Issue	Consideration
Structured notes can be configured to include: <ol style="list-style-type: none"> <li>1. Free text only</li> <li>2. Question and answer statements</li> <li>3. Discriminate lists, Prose writer -paragraph format</li> <li>4. Pull data in the note</li> <li>5. Push data out to other sections of the chart</li> <li>6. Show reference data, Initiate an order</li> <li>7. Reference a standard</li> <li>8. Allow observations to display in groups</li> </ol>	Decide the format to include in the note depending upon the type of data that needs to be documented and how it will be viewed.	A structured note can be designed for a physician and modified so it only contains items that are typically documented by the nurse or ancillary care providers. It can be modified for all instances or for a selected patient.
	What department will own the document?	This decision effects how documents are filed and retrieved in order, result, and document browse.
	If data such as results and orders are pulled into a note, what time frame should be allowed?	
	Will the note allow data to be copied forward to a new note?	The “copy forward” feature copies like data from one note to another according to how it is configured.
	Will data be transferred from a monitor device?	
	Will complex calculations be needed to accommodate complex orders?	
	Are any fields to be mandatory, or significant?	Both are delineated to the user as a required entry, or mandatory if another field is documented with a specific result.
	Can the users modify the template once configured?	A structured note can be designed for a physician and modified so it only contains items that are typically documented by the nurse or ancillary care providers. It can be modified for all instances or for a selected patient.

After some familiarity of the features and functionality of the selected system, the next step is to perform a thorough analysis of workflow for **all** care providers who will interact with the system and a review of existing documentation in an attempt to get consistency and standardization.

In summary, evidence-based practice must include elements from the nursing assessment. The data elements must be standardized to ensure the quality and reliability of the information. The planning phase for implementing electronic documentation begins with a systematic review of existing practices before defining the specifications for designing the templates to use for documenting electronically. This phase, if conducted properly can be a critical step to the success of the project.

For more information about preparing your organization for clinical documentation please contact us at [vcs@getvitalized.com](mailto:vcs@getvitalized.com) or call us at 610.444.1233. You can also learn more about our services and solutions by visiting our website at [www.getvitalized.com](http://www.getvitalized.com).

## References

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