Transforming Nursing Documentation

Looking Back: Early Work & Spin Offs

Ann O’Brien RN, MSN FHIMSS
Charlotte Weaver RN, MSPH, FAAN, FHIMSS
A Common Goal

- An urgent need for nursing data in EHRs be **shareable** and **comparable** for quality outcomes improvement, research and to demonstrate the **value of nursing care**.
- Nursing leaders from practice, academia, informatics, public policy, and industry/vendors committed to come together for a common goal.
Transforming Nursing Documentation WG

10 Working groups formed in 2014 – expanded in 2015 & 2016

WG #10 41 participants: CNIOs, Inpatient & ambulatory Informaticians, Researchers, CNEs, Clinical Content vendors, EHR vendors, leaders from practice, academia and government (TJC, ONC).
Current State of EHRs (2015)

- Current EHRs are not designed to guide the delivery of evidence based care.
- Data Silos create disconnects in care.
- Nursing documentation is primarily data entry.
- Lacks access to the right information at the right time within the nurse’s workflow and personalized to each patient.
- Clinical decision support relies on accurate and timely documentation but nurses may not have the tools or perceive the value.
- Volume of documentation is burdensome.
- Lack of meaningful & actionable information.

EHR Documentation
The Hype and the Hope for Improving Nursing Satisfaction and Quality Outcomes

Ann O'Brien, RN, MSN; Charlotte Weaver, RN, PhD, FAAN; Theresa (Tess) Setergren, MHA, MA, RN-BC; Mary L. Hook, PhD, RN-BC; Catherine H. Ivory, PhD, RN-BC

http://journals.lww.com/naqjournal/toc/2015/10000
Recommendations WG#10

• Streamline, simplify nursing documentation
• Link evidence based practice to the point of care within the EHR build;
• Decrease data entry by leveraging the EHR as a computer; use risk tools, groupers in the background
• Embed clinical decision support in workflow
• Collaborate with MDs, Pharmacy to design and use interdisciplinary user reports/ screens
• Improve data visualization: sidebar reports/dashboards
• Capture and display the patient’s story/ patient’s goals
AMIA EHR 2020 Task Force

Key Recommendations on the status and future direction of EHRs. *JAMIA Sept 2015*

1. Simplify & Speed Documentation
2. Separate Data Entry from Data Reporting
3. Incorporate research knowledge into Practice
4. Improve Usability to support Patient Safety
5. Foster innovation; use public standards
6. Support Person-Centered Care Delivery – social context & *Precision Medicine Initiative*

*Precision Medicine Initiative*
Precision Nursing

- “Evidenced Based, personalized care across the continuum”
- Create knowledge generation within nurses’ workflow for optimal decision making.
- Need to see the big picture; the patient’s story.
- Transform documentation to be simple, intuitive, knowledge-enabled with predictive models and CDS.
- Promote the value of nursing data and the need to document in real time.
Reinventing vs Sharing

How do we most effectively create, standardize and share best practices

Is a Repository for EHR clinical documentation best practices feasible?
Repository Explorative Spinoff

• Charlotte Weaver & Judy Effken Co-Chairs – 2016
  – with Kelly Cochran, Ida Androwich and Rebecca Freeman
  – Contributors: Jane Englebright, Susan McBride, P. Sengstack, L. B-Bolton/Tess Settergren, Sue Matney/Judy Warren

• **Purpose** -- to explore feasibility of creating a repository/ web resource for:
  – nursing documentation best practices,
  – evidence based content for assessment documentation
  – decision support exemplars to support nurses, team care and workflow optimization
  – Terminology mapping exemplars
STTI’s Henderson Library as Host

- e-Library
- Vendor Neutral
- No cost to users
- Tested Platform
- Pilot testing underway
- Looking for content
We Need Your Help

• Need Content
• Need Partners to test usability
• Volunteers for critical feedback

• COMMUNICATION Plan
  – Only as good as its used
  – Getting the word out
  – Multiple audiences

caweaver2011@gmail.com
Thank You!