NURS 6051: Transforming Nursing and Healthcare through Information Technology
“Electronic Health Records” Program Transcript

[MUSIC PLAYING]

NARRATOR: Because patient data, research evidence, and best practices are central to health care, effectively managing information has become one of the key concerns for today's organizations. Electronic Health Records, or EHRs—also known as Electronic Medical Records, or EMRs—offer a valuable solution to information management. In this media segment, Katie Skelton, Richard Rodriguez, Carina Perez, Shannon Mori, and Carmen Ferrell outline the processes, considerations, and benefits related to implementing an electronic health record within an organization.

KATIE SKELTON: I think for a long time in health care, we've known that we need to get our arms around data in a much better, more organized, consistent, predictable way. And handwriting notes in a chart that you fight for with all the other disciplines to get access to is not the best way to do it. We've been pulling for an electronic medical record for many years, but have been grateful at those going before us to hopefully learn and avoid some of the pitfalls that other organizations have had to go through.

But I believe the electronic medical record is helping us do so much better with really addressing quality issues. Being able to look and identify trends, and either positive things that are happening or not so positive things that are happening on a broader scale. And then, really be able to make significant changes for populations of people, not just individuals.

We have had to make difficult choices as we've rolled out our electronic medical record. And lots of negotiations on timelines, and where we put the resources, and what software do we get to augment this versus holding off on the next project. We have felt it very important for nurses to be able to see trended information. And so, we have spent significant dollars investing in additional software that will make that easier for the nurses, because we think that that's
going to make a huge difference on a quality perspective, where you can see trended data over days.

So that was an important piece. While the nurses have been going up on the EMR, we've made investments in staffing to lighten their load. So to promote more fearless learning, knowing that they've got a buddy that can help them, teach them, and also support them with their patients. So, we've made some of those choices. I think staff really love the fact that they don't have to chase the chart, that everyone has access to the critical information that they need.

I think they're feeling a lot of pride in learning something and really seeing the across the board benefits, for patients being able to have better access to their own data, as we evolve into the personal health records for patients. Being able to have remote access to the data for our physicians, so they can check in and look real-time on what patient data looks like. It's huge, because then you can have a much more informed conversation around what's the best course of action that the nurses and the physicians can take for the patient.

It's important to have enough time to learn it and to be able to incorporate it into your practice. And that doesn't happen overnight, and I feel very strongly that nurses need to be supported to use it, to embrace it, to ask the questions, and have those mentors and teachers surround them so it's not so scary. And I believe certainly in the nurses that I work with, I think it has far exceeded their expectations.

RICHARD RODRIQUEZ: The main project we have is rolling out electronic documentation to the bedside. Which thankfully, we've done already, and it's been pretty successful. It took about, I want to say, a good year and two months in order to get everything finalized and rolled out to the bedside. And I'm glad to say that the nurses are really, very successful at the documentation.

My role initially, when I came into the department, was to help develop assessment. So we take a paper assessment, and we try to convert that into the old electronic format. And I'd say about a good six months after that, that's when the teaching started. So they want the subject matter experts to be the people teaching the staff. As it turns out, the people who built the assessments were the
subject matter experts, so we spent a good, I want to say, another six months teaching a total 1,000 nurses, I believe.

So my teaching involved having a class of 25 nurses every other day. So we would start with one aspect of documentation on one day, and then we'd go over to the medication documentation on the second day. After we were done teaching, we do what we call mentorship. So what you do is, you're assigned particular shifts within the day, and your responsibility as a mentor is to come up and work with the nurses side by side to answer any questions, maybe address anything that they might be doing wrong in the documentation.

The range of technical skills when from the extremely savvy-- so savvy that they were actually trying to tell me how to teach the class, or how the technology worked, and here, I was the expert. All the way down to the really unexperienced nurse who really had so much anxiety that they swore within two weeks they would end up quitting or retiring, because it was just too much for them to take.

When we identify a nurse that's really having a hard time adapting to this new implementation, we go ahead and we communicate that down in our department, the Design For Perfect Care, and identify these people. Not necessarily put them on a list of bad employees, but people who really do require a little bit more help. And what you have to understand is that a lot of these nurses are excellent bedside nurses, and those are the type of nurses you would want taking care of you. It's just you've thrown this thing that they're really not familiar with, and it really throws them into a loop.

So for you to say these people aren't catching on let's, forget about them, is really an injustice, and it's to your benefit to really support them and walk them along the process. Because being that they're smart people, they're going to catch on eventually. They're just a little bit slower than the other crowd who's really savvy.

For electronic documentation to be successful, it has to address the majority of everybody's needs. So we can't work what we call in silos. We can't develop a system that's good for nurses but isn't good for physicians and ancillary care. It
has to be a system that's going to be good for everybody. Because ultimately, if it's not a useful tool, people are not going to use it.

Change is really difficult. It's not something that's going to happen overnight. But through persistence and patience, I feel that anybody can really accomplish what St. Joseph's is going through today. Multiple organizations have gone through it, and I know many more will go through it as well. It can be done.

CARINA PEREZ: When we first took a look at the paper documentation, we gathered all the data as a team, and then we developed these core teams that are comprised of subject matter experts from every single unit. And we looked at this data and said, how can we optimize this? How come we put it into the system? Removing the subjective information, defining it so it becomes objective data and discrete data to be used in meaningful use.

The second part of it was a really, we've now made the system, we're going to implement it house-wide. So those same people that were instrumental in building the information, the content, for the application has now become part of our support team when we go live. So they're the subject matter expert, go-to person in each unit that really supports that area.

Mentors are instrumental in your success, because they serve as ambassadors. And they're one of you, they're one of the unit. So they feel like if they can do it, I can do it. And they are the best people to translate the changes that are coming. They also help identify-- one thing we didn't anticipate is that they found those gaps that we didn't see as designers.

Our mentors served in both creating the documentation and the content, and their approval was essential in pushing that documentation out. And then, once we were ready to go live, they were key people. They were scheduled from each area. They knew to field the questions, answered the ones that were already resolved, and only gave to our team what really needed to be reevaluated. So they took away all the time wasters as well.
The general response-- and I was involved in their goal live-- is, I'm scared. How do I know what I'm doing is right? How do I know I got everything? So we've anticipated a lot of these fears that people may have. We need to cheat sheets. We made sure we had mentors to audits. We even proactively looked for people we knew were going to have challenges, and made sure that those people were targeted, and they had some kind of mentoring system while they were here for their first couple of shifts.

So those things we anticipated. But you really can't anticipate when somebody is going to be comfortable. So we continue to have support for that. So I think that's instrumental.

And communication. So as we're bringing up these documentation systems, there are other issues that may be brought up, or other requests, maybe, we should have done this differently. So communication of those requests coming back to our area and being reevaluated by our team.

A change agent is someone who propels, implements, change. And that begins at the bedside. If you want your outcomes to be better, your patients have to get better. If your patients have to get better, then the people who take care of those patients have to be better. And informatic systems, computers, apps-- these are all tools to help facilitate that change and the improvement in care.

One of the things that I wanted to touch on is, during our development and build phase, we really tried to improve our documentation system. And the paper documents we evaluated, are we using evidence-based data? Are we looking at policies and procedures that affect this particular documentation? And is this data objective?

If it's not objective, we can define that subjective data, and now we have discrete information. It's important because that discrete information now gets trended, and we can look at values, and determine as an institution how do we want to better care for these patients?
SHANNON MORI: The project we've been working on is taking all written documentation— that includes orders, nursing documentation, information we send the patient home with—and putting that into the computer. The development process is a very slow process, not only just a big learning curve, because a lot of our team members are nurses. They are bedside staff—respiratory therapists, nursing, case managers.

They were plucked from their department and put into our department, and we are now a project. The biggest challenge with that is just learning the computer system itself, and knowing what we can manipulate and what we can change to make it easier for the end user, as well as making it accessible and understandable to the patient.

The computer application itself was something that was handed to us from our health system or our executive team. The hardware and the technology that is hands-on use was something that we as a hospital had to do the research on and did the due diligence to say what really works in this particular unit. Because each department is different.

We also had to retrofit all the hardware into all of the patient rooms. So it wasn't a one solution fits all. It was more of what works in the ICU, or what works in mother-baby unit? Totally different units. At the same time, they’re going to be using the same documentation system, but everything is different.

For the hardware, when we made that decision to say, OK, will this work, we did the due diligence on the ergonomics. We had the ergonomics guy come in. We also had end users.

We had the staff trial it out, and let us know if this is really going to work with their workflow. Because while we can make the best decision on our end, we aren't the ones using it. Its the staff nurses, it's the doctors, that are really using it in the end.
The electronic chart that we are mandated to give to the patients has to be in a readable format, and it has to be readable in their language. So we send the patient home with very pertinent information. We don't want too much in there, because we don't want to confuse or overload the patient with more or less useless information.

We put a system together, we put the documentation together, that has medications, and followup questions, and followup answers, and physical therapy evaluations. At the same time, it needed to be in layman's terms. So a lot of the chart beforehand, before the electronic patient chart came around, was just a copy of the charts. It was pretty much abbreviations that most people have never heard of. It was lab values that they didn't know if that was normal or were irregular.

So what we've done now is made an electronic copy, and we're able to send them home. The nurses are able to explain to the patients what's going on, and they understand now what went on during their hospitalization.

The nice thing about our electronic patient record is that everyone gets the same. It is hard-coded data that what needs to be given to the patient is automatically given. So nothing falls through the cracks. It's the same no matter if you were here for an hour or if you were here for a month. You get the same information.

So we went live just a few weeks ago, and we've heard go-lives are always tricky. But we've been hearing a lot of good things about ease of finding data. So a patient was here probably for a few months, but they needed to know what happened 10 days ago.

So the chart, of course-- the paper chart-- was about this thick, but they had to pan through it, and it took forever to find the information. Once the electronic system came on board, it took a matter of seconds to find that information. You just click, you find it. Your clinical decisions go much faster, and it's just an easier system to find data.
CARMEN FERRELL: One of the projects that this hospital decided to take on is clinical information to essentially capture all the pieces that are going to be delivered to the patient, both from a nursing, a physician, a multidisciplinary kind of perspective. And we decided to adopt a program called Metatech in order to capture that.

So the way that this hospital started is they started with things that we normally do there kind of in the background. We implemented all the laboratory and radiology queries, and ability to order. Then we went through and did all the admitting, and all the medical record basic components. Things that for a nurse or doctor would not really make that big of a difference.

When we finally started to get to the clinical components, that's when it affects nursing and physicians. We sat down with our nursing and physicians, and tried to translate what does Metatech offer, this program, versus what we wanted to see in the medical record? And in that translation, we found out we needed to put a timeline together, because people didn't want to do any of it.

So as we put the timeline together, we put it together in a logical sequence that, I think, care is delivered. The broadest spectrum of care being documented is the nursing documentation. So we started with that. And then we added the multidisciplinary components of respiratory therapy, physical therapy, case management, and all of that, and put that together.

Lastly, we decided to put in the physician component, because we also felt that the physicians followed the nurses. So from an adoption perspective, we felt that if we got nursing involved first, and got them working with their systems, they could easily help us bring our physicians along.

We put that all on a timeline, and we looked at pieces of education, part of the timeline. Adoption time once it's been implemented. And then, optimization time. Once you implement something, you have to allow time to optimize things that are not working well.
It is a culture shift to add electronic medical record to any hospital. And if you
don't take that seriously, then you're not going to have a successful
implementation. So we kind of had to step back to be able to re-plan and have
the right amount of time to be able to do this correctly.