

Interdisciplinary Collaboration and the Electronic Medical Record

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Purpose: To examine interdisciplinary collaboration via electronic medical records (EMRs) with a focus on physicians' perception of nursing documentation.

Design: Quality improvement project using a survey instrument.

Location: Tertiary care pediatric hospital.

Participants: Thirty-seven physicians.

Outcome Measure: Physicians perceptions of nursing documentation after EMR implementation

Key Findings: Physicians desire nursing documentation with greater clarity and additional information. Physicians indicate checklists alone for patient assessment and intervention data are insufficient for effective nurse/physician collaboration. Narrative nursing summaries are invaluable references that guide medical treatment decisions. Physicians see detailed assessments and well-described interventions of nurses' as critical to their ability to effectively practice medicine.

Key Conclusions: Health care technology is called to develop EMRs that enable nurses to document detailed patient data in a swift and straightforward manner. Joint collaboration between nurses, physicians, and technology specialists is recommended to develop effective EMR systems.

The future of health care documentation is found in information technology through use of electronic medical records (EMRs). In addition to enhanced accessibility, diverse formatting, and electronic imaging, EMRs are expected to increase the accuracy and precision of important patient data. Paper medical records are viewed as critical components of patients' hospitalizations, yet numerous problems are encountered, such as lost or damaged pages, illegible handwriting, and complex accessibility. Studies have repeatedly shown that "practicing medicine on paper leads to mistakes and poor care" (Stone, 2005, p. 84). Both nurses and physicians expect EMRs to solve many of the previously

noted problems found in traditional medical records (Langowski, 2005). However, nurses play the most critical role in documenting the totality of patients' care due to nurses' on-going presence with hospitalized patients (Langowski, 2005).

For five decades, a tertiary care pediatric hospital used a paper system of documentation that heavily relied on nursing narrative notes with minimal use of checklists. Recently the hospital shifted from an all-paper system of patient documentation to an EMR system. The process of selecting the EMR system was initiated by a multidisciplinary team visiting various health care organizations to examine a range of systems. The team was composed of staff nurses, ancillary department representatives, physicians, nurse executives, and other hospital administrators. The team selected a system based on its perceived ability to most accurately and efficiently meet the needs of the pediatric hospital. The system was introduced to each hospital unit by EMR training programs, and the EMR system was implemented throughout the hospital one service line at a time. The "Train the Trainer" model was used as the basis for training expected users of the system. Training was provided to all anticipated users of the system by a

team composed of EMR corporate representatives, hospital employed "super-users" who received advanced training, and associates from the nursing informatics department. An on-site command system was established to assist with troubleshooting and problem-solving. EMR users were given unlimited access to the command system during the first two weeks of conversion to the EMR system.

The EMR training provided to nursing staff focused on the use of checklists for nursing assessment and interventions. The checklist format did not provide a simple means to document additional information, such as patient-caregiver interaction, parental nurturing behaviors, or other important psychosocial information. The EMR training instructed nurses to use a separate *nursing addendum* form to document narrative data not included in checklists. The nursing addendum called for nurses to learn a new problem-oriented approach to patient documentation, known as *observation, intervention, and response*.

After the EMR system was implemented, physicians voiced concern that the nursing addendum form was frequently incomplete or not used. The hospital's chief nursing officer stated that staff nurses may have per-

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Objectives and the
CNE Posttest can be
found on pages 228-229.

ceived narrative data as no longer critical after initiation of the EMR checklist approach to documentation. Further, the risk manager noted negative consequences of insufficient nursing documentation because litigation was frequently settled out of court due to inability to mount effective legal defenses. Nurse leaders also expressed concern that nurses underestimated the significance of narrative patient information when collaborating with physicians. Therefore, the chief nursing officer requested a survey to determine if the EMR enabled nurses and physicians to collaboratively communicate about patient care issues.

Baggs et al. (1999) reported that successful collaboration between nurses and physicians is positively associated with patient outcomes. Effective communication, both written and verbal, between nurses and physicians is a key component of professional collaborations (Casanova et al., 2007; Nelson & Venhaus, 2005). In addition, the EMR is a focal point for nurse/physician communication (Kash, Gamm, Bolin, & Peck, 2005). Therefore, the purpose of this quality improvement project was to examine interdisciplinary collaboration via EMRs. Physicians' perception of nursing documentation is specifically discussed.

Methodology

Participants and setting. The hospital is located in a major metropolitan area in the southeastern United States. It is affiliated with a local academic health science center and serves as the primary pediatric teaching institution. The hospital also serves as the only pediatric tertiary care facility in the region.

The hospital provides a pediatric residency training program, and at the time of this project, seven pediatric faculty physicians supervised the training and education of 33 pediatric residency physicians. Permission to survey physicians was obtained from the chief attending physician's office and the office of the pediatric chief residents. Although the survey was a quality improvement project, the survey was granted exempt status from an Institutional Review Board, and by completing the survey, physicians implied consent to use their responses for data analysis.

Procedures. The survey was administered at a regularly scheduled supervision meeting of the faculty and resident physicians. Seven faculty physicians and 30 pediatric resident physicians attended the meeting and completed the survey.

The nurse leading the quality improvement project explained the purpose of the survey, and physicians were given the opportunity to ask questions about the project and survey instrument. The chief resident distributed the surveys to the physicians who were seated approximately 3 feet apart from each other in a hospital conference room. The nurse remained in the conference room during the administration of the surveys to answer questions and to collect the surveys after physicians completed them.

Instrument. Survey data were collected using a paper and pencil instrument developed by the nurse project leader, and it was composed of both closed and open-ended questions. The closed-ended questions were written in a format that required either "yes" or "no" responses. The purpose of the five close-ended questions was to obtain quantifiable information regarding physicians' perceptions of nursing documentation after EMR implementation. The intent of the open-ended question was to elicit richer, more complete data and provide physicians opportunity to cite situations that illustrated concerns.

Development of the survey resulted from both review of literature pertaining to EMRs and the nurse project leader's professional knowledge and experience. A panel of experts, including two university nursing faculty members and a nurse executive, determined the survey possessed face and content validity. The survey required approximately 10 minutes to complete.

Data analysis. The responses to the five closed-ended survey questions were analyzed by using a handheld calculator that yielded descriptive statistics. The narrative responses to the one open-ended question were examined by the use of content analysis. Similar data were grouped and eventually converged into three categories (Burns & Grove, 2002; Polit & Hungler, 1991) with all categories pointing to the over-arching concern that insufficient data were available on which to base medical treatment decisions.

Results

Quantitative analysis of closed-ended survey questions. Table 1 provides physicians' responses to the closed-ended survey questions. The responses to closed-ended questions indicated that physician-users of the EMR desired nursing documentation with greater clarity and additional information.

Analysis of physician narrative statements. Thirty-one (84%) physicians wrote additional narrative comments about the EMR nursing documentation. Physicians' narrative comments indicated that the EMR did not provide physicians the amount and type of patient data needed to make medical decisions. Elaboration of this core concern follows.

Incongruent views among physicians and nurses regarding pertinent patient data. Physician survey data indicated that differing views existed between physicians and nurses about what is considered pertinent patient data requiring documentation. Based on survey responses, pertinent patient data needed for successful nurse-physician collaboration were (a) antecedents to changes in patients status, (b) documentation of changes in patient status, (c) nursing interventions performed in response to changes in patients' status, (d) documentation of physician notification, and (d) outcomes of interventions.

Many physicians commented that changes in patients' statuses were often documented in the EMR, but details and circumstances surrounding status changes were not noted. Physicians used the initiation of supplemental oxygen as an example. In some instances nursing assessments reflected patients breathing adequately on room air, but sequential EMR nursing notations indicated oxygen therapy had been initiated for patients. Physicians were concerned about lack of information about the reason(s) patients required oxygen therapy. Some additional examples of missing patient data included (a) rationale for and results of PRN nursing interventions, such as suctioning, dressing changes, adjustments of oxygen levels, and PRN medications; and (b) information about physician and nurse communications about patients that resulted in physician orders. The perception that pertinent patient data were inadequate also raised concerns that documentation may be insufficient if the patients record was examined due to threatened or filed litigation.

Lack of a nursing narrative component. Another category that was incomplete or absent was the nursing narrative components of the EMR. Traditionally, nursing documentation provided physicians with summaries of detailed information about unusual or unexpected events that occurred in physicians' absences. Physicians viewed nursing summaries as invaluable references that guided physicians' treat-

Table 1.
Physicians' Perceptions of Nursing Documentation in Electronic Medical Records: Closed-Ended Survey Questions (N = 37)

	Frequency	Percent
1. Have you spoken with a nurse to clearly understand what occurred with a patient because of lack of clarity in the documentation in the EMR?	Yes = 29 No = 8	(78%) (22%)
2. Have you felt confused or unclear regarding the patient care provided and the patient events that occurred after reviewing the nursing documentation in the EMR?	Yes = 28 No = 8 *	(76%) (24%)
3. Have you read the EMR seeking patient care information that should have been documented but was not included in the record?	Yes = 27 No = 10	(73%) (27%)
4. Have you looked for patient care information in the EMR that was not documented that resulted in extra steps and/or time before a treatment decision could be made?	Yes = 26 No = 11	(70%) (30%)
5. Have you read the nursing documentation for information regarding a major patient event that was not documented in the EMR?	Yes = 26 No = 11	(70%) (30%)

* One non-response.

ment decisions. However, the EMR was largely a checklist system that only reflected patients' changes from normal physical states. Further, while the electronic nursing addendum form was available, it was rarely used. Although the checklist format was less time consuming for nurses, physicians clearly desired additional narrative information regarding patients' physical and psychosocial aspects of care. Nurses had the advantage of reviewing additional patient information during shift reports but these data were not accessible to physicians.

Lack of documented nursing observations of patients' psychosocial issue. Physicians noted that the psychosocial data addressed in the EMR checklists were minimal and did not give a full picture of patients' psychosocial situations. For example, patients were often admitted with diagnoses such as failure to thrive or a fracture secondary to suspected abuse. Physicians cited specific examples where patients' activity and interaction with parents, and feeding habits and parental nurturing behaviors were not documented in the EMR. When such behaviors occur, additional attention is required to promote the safety and quality of care for patients. Further, such behaviors are critical to the medical diagnosis in situations where abuse is suspected.

Over-arching message. All three categories pointed to the lack of suffi-

cient patient information to drive physician decisions regarding patient care. Physicians were dependent upon nurses to not only provide safe and effective patient care but physicians also required nursing-generated patient data to make appropriate medical judgments. Physicians viewed detailed assessments and well-described interventions of nurses as critical to their ability to effectively practice medicine.

Implications for Nurses and Effective Interdisciplinary Collaboration

Various factors have an impact on the need for effective interdisciplinary communication via the EMR. First, the EMR is a major vehicle that enables interdisciplinary collaboration resulting in safe, quality patient care. Further, data obtained by nurses are not only critical for thorough and comprehensive nursing care but are also frequently essential for correct medical diagnoses (Leonard, Graham, & Bonacum, 2004).

Issues concerning legalities also are at stake. Nurses are accountable for providing comprehensive narratives that clearly report patients' situations and accurately record all provided care and outcomes (Deese & Stein, 2004). The fundamental principle of documentation is "if it is not charted, it was not done" (Castonguay, 2001, p. 6) is well known to nurses. Recognizing the future of patient documentation re-

sides in EMRs, nurses are called to safeguard patients, colleagues, employers, and themselves by consistently implementing the fundamental principle of nursing documentation. Minimal legal documentation requires an audit trail beginning with 1) patients' baseline status, 2) changes in patients' status, 3) interpretation of changes in status, 4) interventions used to respond to changes in patients' status, and 5) responses to interventions. Incomplete nursing documentation results in hospitals being unable to defend themselves against threatened or actual malpractice litigation. Therefore, it is essential that EMR systems are developed that easily and quickly enable nurses to thoroughly document all aspects of patient care.

In March 2007, 11% of community hospitals had fully implemented EMRs, 57% of hospitals reported "partial" implementation, and 32% indicated no initiation of EMRs (Amednews.com, 2007). Technological transition to EMRs is inevitable due to the Joint Commission's support of an electronic health care infrastructure (Joint Commission, 2007; Stone, 2005). It is estimated that over the next five years, EMRs in hospital settings will become widespread (Runy, 2005). However, to be fully effective, EMR systems must enable nurses to rapidly and precisely document all aspects of patient care to provide safe, quality care for patients, successful collaboration with physicians, and legal protection of health care organizations (Cato, 2005; Drexler & Malloch, 2005).

Future Recommendations

The findings of the quality improvement project are similar to a study performed at Stanford University that found physicians experienced difficulty accessing patient information in 81% of cases reviewed (Stone, 2005). The challenge for the health care technology industry is to develop EMRs that enable nurses to document detailed patient data in a timely and straightforward manner. EMRs can enable nurses and physicians to deliver safe, quality patient care; therefore, it is essential that both nurses and physicians collaborate with technology specialists in developing effective EMR systems.

The creator of the current EMR system received the results of this project with the recommendation that survey findings guide improvement of the current system. The hospital leader-

ship team decided to trial the new EMR product in three different clinical areas before house-wide implementation occurs. The three areas include a critical care unit, a medical-surgical unit, and an ambulatory care unit. During the trial period, continuous feedback is encouraged from nurses and physicians about the upgraded EMR product. Once the trial and revision process is successfully completed, the new EMR product will be implemented throughout the organization.

This quality improvement study indicates that other health care organizations should critically evaluate EMR systems prior to adoption in their facilities to ensure that critical elements are not only available but are easily usable. There is a tendency to focus upon checklists as a panacea for decreasing the workload of nurses and streamlining patient care. However, further investigation is needed to determine if checklists can be modified to provide richer and more detailed data or if nursing narrative data should remain a continuing component of the nursing care of hospitalized patients.

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Technology has changed the face of pediatric health care. Families today frequently "Google" or join online support groups for health care advice and support. Information is shared electronically within health care institutions and throughout the global community. Children and their families in remote areas are reached in ways unheard of even a decade ago. Keeping updated on technology issues in pediatric care broadens pediatric nurses' understanding of the exciting possibilities available today and stimulates thought for what is to come.

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ASSIGNMENT

- Sullivan, C. (2008). Cybersupport: Empowering asthma caregivers. *Pediatric Nursing*, 34(3), 217-224.
- Green, J., & Thomas, J. (2008). Interdisciplinary collaboration and the electronic medical record *Pediatric Nursing*, 34(3), 225-227, 240.

Earn 1.6 Contact Hours

OBJECTIVES

1. Discuss the importance of using available technology to meet the needs of children and their families.
2. Describe the experiences of members of an online asthma caregivers support group.
3. List three findings regarding physicians' perceptions of electronic nursing documentation.
4. Identify opportunities for pediatric nurses to keep current on the use of technology in pediatric health care.

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Statement of Disclosure

The authors reported no actual or potential conflict of interest in relation to this continuing nursing education series.

All *Pediatric Nursing* Editorial Board members reported no actual or potential conflict of interest in relation to this continuing nursing education series.

QUESTIONS

1. According to Ferguson, (1996) the largest proportion of online support messages are sent between the hours of ___?
 - a. 7:00 a.m. and 10:00 a.m.
 - b. Noon and 3:00 p.m.
 - c. 4:00 p.m. and 6:00 p.m.
 - d. 7:00 p.m. and 1:00 a.m.
 - e. 3:00 a.m. and 6:00 a.m.
2. The analysis in the article "Cybersupport: Empowering Asthma Caregivers" revealed several stressors and challenges encountered by caregivers of children with asthma. These included all of the following EXCEPT:
 - a. making sense of the illness.
 - b. coping with demanding treatment regimens.
 - c. role strain.
 - d. interacting with health care professionals.
 - e. peak flow assessment.
3. Which theme best reflected actions taken by the mothers to cope with the illness experience on a day-to-day basis, thus becoming intimately familiar with the details of their children's everyday lives?
 - a. Monitoring
 - b. Fitting the pieces together
 - c. Second-guessing
 - d. Sense of responsibility
 - e. Bonding
4. Which theme emphasized the overarching meaning associated with mothering a child with a chronic illness, having the opportunity to vent feelings and express frustrations in fulfilling the caregiver role?
 - a. Monitoring
 - b. Fitting the pieces together
 - c. Second-guessing
 - d. Sense of responsibility
 - e. Bonding
5. Which theme went beyond the experience of mothering and caregiving for a child with asthma and centered around the experiences of concerns with other women who were sharing similar life experiences? This theme emphasized the altruistic aspect of the online support group.
 - a. Monitoring
 - b. Fitting the pieces together
 - c. Bonding
 - d. Sense of responsibility
 - e. Second-guessing
6. Electronic medical records increase accuracy and precision of patient data for all of the following reasons EXCEPT:
 - a. enhanced accessibility.
 - b. diverse formatting.
 - c. electronic imaging.
 - d. increased buy-in by staff.
7. The purpose of the nursing addendum form is to document:
 - a. additional assessment data.
 - b. interactions with physicians.
 - c. narrative data not include checklists.
 - d. discharge plans.
8. Physician users of the electronic medical records desired nursing documentation with additional:
 - a. information and greater clarity.
 - b. patient-teaching data.
 - c. discharge planning.
 - d. details about nurse-physician communications.
9. The electronic medical record was largely a checklist system that reflected patient changes from normal physical states.
 - a. True
 - b. False
10. Which of the following is NOT considered minimal legal documentation?
 - a. Patient's baseline status
 - b. Patient's history prior to hospitalization
 - c. Changes in patient status
 - d. Interventions used to respond to changes in patient status

Answer Form: Technology in Pediatric Care

***PED J804**

Check the box next to the correct answer.

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Evaluation	Strongly disagree				Strongly agree
1. The objectives relate to the overall purpose/goals of the education activity.	1	2	3	4	5
2. The activity met the stated objectives.					
a. Discuss the importance of using available technology to meet the needs of children and their families.	1	2	3	4	5
b. Describe the experiences of members of an online asthma caregivers support group.	1	2	3	4	5
c. List three findings regarding physicians' perceptions of electronic nursing documentation.	1	2	3	4	5
d. Identify opportunities for pediatric nurses to keep current on the use of technology in pediatric health care.	1	2	3	4	5
3. Home study format was appropriate.	1	2	3	4	5
4. The content was relevant to my practice.	1	2	3	4	5
5. The content met my needs.	1	2	3	4	5
6. How much time was used to complete reading assignment and posttest:					
a. Less than 1 hour _____					
b. 1-2 hours _____					
c. 2-3 hours _____					
d. 3 hours or more _____					

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