Perioperative Nurses' Attitudes Toward the Electronic Health Record

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Background: *The adoption of an electronic health record (EHR) is mandated under current health care legislation reform. The EHR provides data that are patient centered and improves patient safety. There are limited data; however, regarding the attitudes of perioperative nurses toward the use of the EHR.*
Purpose: *The purpose of this project was to identify perioperative nurses' attitudes toward the use of the EHR.*
Design: *Quantitative descriptive survey was used to determine attitudes toward the electronic health record.*
Methods: *Perioperative nurses in a southeastern health system completed an online survey to determine their attitudes toward the EHR in providing patient care.*
Findings: *Overall, respondents felt the EHR was beneficial, did not add to the workload, improved documentation, and would not eliminate any nursing jobs.*
Conclusions: *Nursing acceptance and the utilization of the EHR are necessary for the successful integration of an EHR and to support the goal of patient-centered care. Identification of attitudes and potential barriers of perioperative nurses in using the EHR will improve patient safety, communication, reduce costs, and empower those who implement an EHR.*

Keywords: *perioperative, attitudes, electronic health record, electronic medical record, research.*

HEALTH CARE REFORM IS A TOP PRIORITY in the United States, and the adoption of a standardized electronic health record (EHR) is a major reform component and cost saving tool.[1,2]

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Conflicts of interest: None to report.

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In 2004, President George Bush said in his State of the Union Address "…by computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care".[3] President Bush then established the Office of the National Coordinator for Health Information Technology (HIT). This office was charged to develop standards and certification for electronic charting systems. In addition to the president's initiative, the Agency for Healthcare Research and Quality launched its National Resource Center for HIT. And in 2007, the National Health Information Network was formed and funded, providing much momentum and attention on HIT from the federal government.[3]

The agency for Healthcare Research and Quality's HIT initiative is part of the nation's strategy to

put information technology to work in health care.[4] By developing secure and private electronic health records for all Americans and making health information available electronically when and where it is needed, HIT can improve the quality of care, even as it makes health care more cost-effective.[4] To achieve these advances in HIT, these agencies have intensely focused their initiatives on three goals

- Improve health care decision making
- Support patient-centered care
- Improve the quality and safety of medication management[4]

This early political momentum has crossed political differences and enjoyed continued support and funding, transforming the paper chart into an electronic health record across our nation in many health care organizations.[1]

The Patient Protection and Affordable Care Act, signed on March 23, 2010, is dedicated to providing affordable and quality health care to all Americans. The law also places additional focus on the growing recognition of health information technology as essential to health care reform.[3] As a component of this law, 19 billion dollars has been earmarked to aid the adoption of HIT and EHRs. The intent of these incentives is to assist health care providers in purchasing and implementing electronic systems. The act also clearly stipulates penalties for both hospitals and physician providers who fail to adopt an electronic record in a meaningful way.[3]

In this highly technological age, computer skills are no longer a nice addition to one's resume; they are an essential skill set needed to safely and efficiently care for patients.[1] Computers play an integral part in recording and disseminating information in the 21st century. Communication and information management are key elements in health care organizations as it relates to the quality of care provided. The quality of care that HIT enables can be directly related to the quality of information available to health care professionals.[5]

Use of the EHR can improve the quality of information available to the medical team caring for a patient in any institution. Electronic health records achieve this by transforming confusing and physically unwieldy masses of data to be instantly available, portable, and searchable. Computer-accessible records have the potential to save the cost-strangled American medical system billions of dollars in waste, repetition, and error.[6] Electronic systems also safely bridge one of the more perilous chasms in medicine: the transfer of care when patients move from one department to another and when they leave the hospital and potentially seek treatment from another health care providers.[6]

Use of the EHR in the perioperative setting offers tremendous advantages to the perioperative team through the creation of accessibility of all patients' information in one location. Additionally, for many patients, the perioperative arena is the initial entry point into the health care system, either through scheduled or unscheduled surgery. Correct and efficient use of the EHR can improve communication throughout the system and help create a safer and more efficient patient-centered experience.

Additional advantages of EHR use in the perioperative setting include clear communication of information to other departments and effectively capturing workload.[1] Patient care is enhanced and improved when information can be easily accessed. In addition, there is less repetition of patient information gathered and included in documentation.[7] These advantages aid in the provision of safe handoffs, leading to safe patient care and improved communication throughout the health care system. These advantages also address the perilous chasm involving the transfer of care that takes place every day as patients move in and out of the operative areas.

Literature Review

There is an abundance of literature describing nurses' attitudes and barriers in using the EHR in medical and/or surgical and critical care units. The literature reflects that documentation and review of the electronic record provide nursing staff with increased knowledge of the patient's current health status and has demonstrated a positive effect on the nurse's care of the patient. This positive effect on patient care is illustrated with improved patient and family involvement in care, efficiency of care, access to information impacting patient safety, improved communication, and independent decision making by the nurse.[8,9] Electronic health