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Featured Article

# Documentation in Contemporary Times: Challenges and Successes in Teaching

**Julia A. Greenawalt, PhD, RNC***

*Indiana University of Pennsylvania, 1010 Oakland Avenue, Indiana, PA 15701, USA*

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academic electronic health record;
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**Abstract:** Teaching documentation skills and concepts to the emerging professional is a new challenge for nurse educators as the infusion of meaningful use is implemented within nursing's affiliating agencies. Discipline mandates and accreditation requirements expect the emerging professional to be current in technology and communication as one prepares to care for patients in contemporary times. The purpose of this instructional opportunity was to examine issues contributing to the successful learning of electronic documentation within an undergraduate nursing course in western Pennsylvania. This article documents one approach to infusing documentation skills into an obstetrical clinical experience. However, the best method of instruction for teaching learning to undergraduate nursing students as relates to electronic documentation remains unclear at this time. Current inquiry and future research into evidence-based practice are needed as preparation gears toward workforce ready graduates who will be skilled and adept at documentation using current technologies. Teaching skills for information systems, particularly the electronic health record, requires identification of challenges and obstacles, which can be surmounted if academe and corporate culture work in tandem.

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Documentation skills and methods have become challenging in current times for emerging professionals within academia owing to the migration of paper/pencil charting and the evolution of information systems that are emerging as electronic health records (EHR) within health care agencies. Current trends have fostered the migration of handwritten chart notes in an unstructured and nonstandardized format to a rigidly structured record-oriented database, spurred on by the adoption of meaningful use. The challenges of access, security, privilege, availability, authentication, oversight, and technique are just a few of the obstacles noted that must be surmounted for future professionals to emerge from academia prepared and workforce ready upon graduation (Hammoud et al., 2012). Currently, a lack of evidence-based practice models is available to inform educators on best practices for teaching documentation concepts and skills to students in this emerging health information paradigm. This manuscript addresses one method in which electronic record entry and usage was taught to a group of undergraduate nursing students.

## Background

Accurate documentation of patient care is a component of services rendered that has evolved to be its own discrete task within the delivery of safe quality health care. Documentation serves multiple purposes within the health

* Corresponding author: jgreen@iup.edu (J. A. Greenawalt).

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care arena. The recording of a patient's clinical signs, symptoms, treatments, interventions, and responses is critical for effective and efficient treatment and recovery. If the legal recorded annotation is inaccurate, a patient may receive improper or potentially harmful care in the course of their treatment. Charting or documenting of patient status is a mechanism that fosters health care team cohesion. It is used by all health care team members (Barron, 1987; Hripcsak , Vawdrey, Fred & Bostwick, 2011). A common service that exemplifies accurate documentation is in the delivery of medications (Benoit, et al., 2012). Documentation is also noted by health care providers in the delivery of palliative care (Gunhardsson , Svensson, & Bertero, 2008). Documentation, whether via pen and paper or electronically, has provided a mechanism for research, particularly for demographic data, prevalence and epidemiological type data to inform health care providers and influence policy makers (Bostrom, et al., 2006; Hedemalm, Schaufelberger & Ekman, 2007). Historically, health care legal annotations have also been used to evaluate practitioner performance, to monitor resource usage and to determine reimbursement (King & Jenkins, 2008). Health care provider documentation may reduce any liability as services are rendered (Zierler-Brown, Brown, Chen, & Blackburn, 2007). In particular, patient teaching and education are documented within the patient chart to demonstrate delivery of content and to validate comprehension by the patient (Cook et al., 2008). Prevalent contemporary thought is that documentation should also be a mechanism that is used to record quality improvement of care (Tornvall & Wilhelmsson, 2008). To address this skill, nursing education programs infuse documentation/charting into didactic and clinical learning experiences. With the infusion of information systems within health care and their institutions this discrete task of documenting is endangered as a hands-on tool for the student and the emerging generalist practitioner. This article addresses one approach to teaching/learning with the EHR in an undergraduate nursing obstetrical course.

**Key Points**

- Teaching documentation skills has evolved as technology continues to evolve.
- The nature of recording patient care and assessments is vastly different in contemporary times.
- A current challenge for nurse educators is teaching documentation skills with emerging technology.

The Health Information Technology for Economic and Clinical Health (HITECH) provision was an outcome from the American Recovery and Reinvestment Act of 2009. The HITECH Act provides the Department of Health and Human Services with the authority to establish programs to improve health care through the promotion of health information technology, including EHRs and private/secure electronic health information exchange (Furukawa & Poon, 2011). Under HITECH, the Centers for Medicare and Medicaid established incentives for the adoption of EHRs with specified objectives. Four regulations have been released, of which two define "meaningful use" objectives that providers must meet to obtain their incentives. Meaningful use is the use of certified electronic record technology to improve quality, safety, and efficiency in health care; engage patients and families in their care; improve care and coordination of care; and foster privacy and security of patient information (U.S. Department of Health and Information Technology, 2013). The meaningful use objectives have been defined and operationalized by Centers for Medicare and Medicaid and are rolling out in three phases. Phase I will be completed in the fall of 2013. Phase II will continue through 2014 and Phase III conclude in 2016. For more information on meaningful use, see www.HealthIT.gov. Phase I health care agencies have EHR systems. Many affiliating agencies have limited non-employee access to the EHR because of safety, security, and privacy issues. This often results in limited or no documentation experiences for the student during a clinical experience. Some health care agencies have burdensome orientations to the HER, which detracts negatively from time allowed for students to interact with patients. Still other affiliating agencies are working closely with their academic cohorts to optimize the learning experience for students while providing documentation exposure for the student.

Unfortunately, this new technology has yet to be mastered and/or understood; often, the human response to the unknown is to say, "no." This negative response to allowing students to use this emerging technology is short sighted and will surely have a negative long term consequence when hiring of new fledgling professionals is needed to staff the health care agencies. In addition to nurse educators being influenced by HITECH is the mandate by accreditation bodies such as Joint Commission to verify compliance with proper documentation of services and care rendered (Radecki & Sittig, 2011). The American Association of Colleges of Nursing in Essential Competencies for Baccalaureate Education notes in Essentials II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety, Essential IV: Information Management and Application of Patient Care Technology and Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcomes that the skill of documenting is a necessary skill for the emerging professional in nursing (American Association of Colleges of Nursing, 2008). Nurse educators are continually challenged with providing students with experiential learning opportunities through documentation of activities as an integral part of the learning process.

## Resources

There are many options available to faculty to facilitate the instruction of documentation with the EHR. Some use apps,

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