ORIGINAL ARTICLE

A Survey of Perianesthesia Nursing Electronic Documentation

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Purpose: *Electronic health records have become a common part of the perianesthesia care workflow, particularly for data gathering and documentation. The purpose of this survey of perianesthesia nurses was to examine patterns of adoption of electronic health records and their effect on clinical documentation and patient care.*
Design: *A survey was sent to nurses who are members of the American Society of Perianesthesia Nursing (ASPAN).*
Methods: *The electronic documentation survey was sent to the e-mail addresses of 13,339 ASPAN members representing various practice environments across the United States. Results were examined through descriptive statistics.*
Findings: *About two thirds (66.02%) of the respondents indicated that they could capture 80% of their clinical interactions with the patient. Few nurses indicated that adoption of the EHR was done using a standardized terminology. Respondents (63.99%) overwhelmingly indicated that they spent less time interacting with patients and families because of electronic documentation demands.*
Conclusions: *The results pertaining to the impact of the EHR on their practice were fairly mixed with some indication that there was greater access to important patient data, but with a trade-off of less satisfaction and efficiency. Improvements and evaluation of clinical documentation are being done, but ongoing optimization and improvements to the EHR based on the knowledge needs of nurses will help realize the promise of greater quality, safety, and access to data.*

Keywords: *electronic health records, documentation, clinical workflow.*

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THE HEALTH INFORMATION TECHNOLOGY for Economic and Clinical Health Act, as part of the American Recovery and Reinvestment Act,[1] required that all healthcare agencies adopt an electronic health record (EHR). The requirement has been a powerful catalyst for changes in many clinical practices and environments, particularly for registered nurses. To try and prepare the health care workforce for this massive digital conversion, multiple initiatives were set in motion to facilitate greater technology competence. The Technology Informatics Guiding Education Reform Initiative is an example of a grassroots educational effort

directed toward engaging and enabling nurses to thrive in the changing digital health care environment. The Technology Informatics Guiding Education Reform Initiative established competencies and standards for leaders, educators, and nurses in practice, while also specifically calling upon specialty organizations, such as the American Society of Perianesthesia Nurses (ASPAN), to promote specialty-focused informatics competencies and to lead its members toward the initiative's goals. The purpose of the survey administered as a part of this study was to evaluate progress toward meeting the goals of broader EHR adoption for perianesthesia nurses and the impact it is having on clinical practice documentation.

Background

Clinical documentation and access to information for clinical decision-making are critical aspects of the digitization of health care data that have a direct impact on perianesthesia nursing practice. Multiple factors play a role in how well EHRs and clinical information systems support the knowledge work of nurses. For example, usability or customization flaws in some of the current EHRs make completion of simple tasks challenging.[2,3] Furthermore, a lack of interoperability, even between systems within one clinical agency, can result in redundancy of data entry and inaccessible silos of potentially vital clinical data. Many clinical agencies have already started the process of replacing systems that may only have been adopted 5 years prior partially in response to these issues.

The nursing workforce has not always kept up with the competencies required to fully leverage all the data and functionality available within modern digital health care information systems. The insurmountable quantity of data may challenge a nurse's ability to sort, find relevance, prioritize, and act in a select context. It is also imperative that the demand for regulatory and institutional data does not increase the documentation burden already imposed on many nurses.[4] The nursing faculty shortage and a lack of informatics knowledge among nursing faculty affect the educational preparation of nurses for practice environments that are increasingly technology dependent.[5]

Studies examining the state of electronic documentation for perianesthesia nurses can help direct organizational education efforts including those of ASPAN. Nursing specialty organizations such as ASPAN have a primary role in promoting, advancing, and maintaining informatics competency for their members and the specialty as a whole.[6] They must not only promote computer and information literacy as a critical skill set for future and practicing nurses, but also be engaged in ensuring that their specialty practice knowledge is being represented in today's EHRs. These efforts will ensure that broader research and evidence-based practice initiatives are speaking to congruent perianesthesia care concepts.

Methodology

An online survey pertaining to the use of EHRs and electronic documentation was created to gauge EHR adoption in perianesthesia practice environments. The 16 survey questions were created and examined by a core group of ASPAN members whose practice focused on clinical documentation systems and informatics. The ASPAN National Office sent the survey in December 2014 to all ASPAN members with e-mail addresses. The message to members included an initial introduction to the survey and access to the survey questions. Electronic data were made accessible to the study team following the 2-week time frame during which the survey was open. No IRB approval was sought for this study due to the lack of identifying information for respondents and the secondary nature of data analysis.

In the first section of the survey, respondents indicated their credentials, primary work settings, job classification(s), and the number of years working in the nursing profession. The second section of the survey contained questions on EHR adoption, the application used in their facility, the number of times the application was updated, its interoperability with other software applications, and the use of standardized terminologies embedded in the documentation system. The last section of the survey included questions as to how quality of documentation was measured, the percentage of clinical interactions captured in electronic documentation, the length of time spent on nursing care, and the significance of having an EHR as it related to their role as a nurse.