Clinical Documentation Standards – Promise or Peril?

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Imagine a future of integrated clinical information systems that transcend the physical boundaries of clinical units, institutions and community care, providing nurses with comprehensive access to information and knowledge to support the delivery of care to individuals and families. Imagine not having to gather the same information repeatedly, ask the same questions over and over again, or struggle to assimilate information from multiple sources and informants. Better yet, as a person needing the services of the healthcare system, imagine not having to rely on memory for details of family health history or repeatedly provide the same information to numerous caregivers over the course of a single encounter (or multiple encounters) to satisfy the requirements of their specific data collection forms. The future lies in the electronic health record – but are we taking the right steps to get there? In particular, are we sufficiently challenging the status quo of the documentation structures associated with clinical information management?

Recently, I have had many moments to consider why it is that we need to create multiple variations of documentation tools. In the world of paper records, our propensity for propagating new forms is mind-numbing; a new form for this and for that – yet there are already six, seven or more variations of that form currently in use. Think of the amount of time spent designing, configuring, formatting and approving this montage of forms for clinical record keeping. Multiply that effort as it is enacted repeatedly within every care provider organization in this

country. Notwithstanding the unique assessment and monitoring associated with specific populations and disease entities, why does every single organization need to design its own version of commonly used tools? Could we not contemplate the adoption of documentation standards that go beyond the requirements of our respective regulatory bodies? How about an admission profile and discharge summary that incorporates a consistent set of data and information that supports continuity of care from sector to sector and continuity of information from provider to provider?

Infoway has made a considerable investment in the advancement of technical and clinical standards to support the acceleration of electronic health records across Canada. Clinical vocabularies, such as the Systematized Nomenclature of Medicine – Clinical Terms (SNOMED-CT), have been endorsed for consideration in the Canadian context. However, much work needs to be done to ensure that nursing is appropriately reflected in the context of this and other standards. (The details of this work and the supporting structures are beyond the scope of this column, but more information can be found at http://www.infoway-inforoute.ca/en/home/home.aspx.) Although nursing has been participating in this work at the national level, much dialogue is needed within the profession.

As we move to online information systems, there is an opportunity to rethink our approaches to the documentation of nursing practice. Too often, organizations have migrated to a version of clinical documentation that sadly replicates the compendium of flow sheets and forms found in paper records. Subsequently, promises of increased efficiency, elimination of redundancy and less time spent managing the records of care remain unrealized. I have heard the lament of nurses using these online replications; they are spending as much if not more time completing documentation. What is wrong with this picture? There is still an opportunity to reverse this emerging burden, as only a minority of organizations and providers have actually made the transition to online documentation. Rethinking the structure of documentation within your organization(s) and region(s), and by collaborating within and across sectors, could well pave the way for greater consistency and, in the long term, support clinical continuity.

Standardizing the way in which we describe and document nursing practice has potential benefits on a number of fronts. The use of a consistent vocabulary to describe clinical phenomena, actions and outcomes that are the preoccupation of nurses would provide the foundation to view and analyze these elements across and within clinical populations and sectors. To this end, the International Council of Nurses has significantly invested in efforts to develop the International Classification of Nursing Practice (ICNP). In recent years, the Canadian Nurses Association has supported the adoption of ICNP by the Canadian nursing

community. (Details of this classification system and its structure can be viewed at http://www.icn.ch/icnp.htm.) Three Canadian jurisdictions have deployed a small suite of outcome measures (Health Outcomes for Better Information and Care – HOBIC) for which there is substantial evidence to support nurses' contributions to same. The intent of HOBIC is to realize a consistent capture of these measures across care sectors, using common language and metrics. The adoption of these measures is currently being embedded in the clinical documentation practices in acute care, long-term care, complex continuing care and home care. (Further information about HOBIC and its origins can be accessed at http://www.health.gov.on.ca/english/providers/project/nursing/nursing_mn.html.)

HOBIC's work has unveiled the difficulties associated with the wide array of documentation tools used by nurses in provider organizations. This work has raised the question of whether it is possible to achieve consensus in defining the constituent data and information about clients and families gathered at the time of each nursing encounter. Moreover, can agreement be reached in defining the design of the documentation tools used for online recording? I would suggest that we have an unprecedented opportunity to unify the language of nursing practice through the adoption of clinical data standards that can be codified into clinical information systems. Some nurse leaders would vehemently argue against the adoption of such standards, claiming that we cannot possibly describe the human experience of illness and health within the confines of specific data elements. My position is not to suggest that there is no room to capture narratives and the unique experiences of individuals. Rather, I am suggesting that there is an opportunity to minimize the sheer volume of documentation and the degree of redundancy and variation that preclude continuity of information across the continuum of care in the world of clinical information systems.

Achieving consensus and coherence in the language of nursing practice can serve the profession well. As stated by Clark and Lang (1992: 109): "If we cannot name it, we cannot control it, finance it, research it, teach it, or put it into public policy." The time has come to embrace the concept of clinical data standards. If we do not take a definitive and unified stance, there are a couple of possible scenarios: (1) nursing practice will remain invisible in national clinical databases because of disparate and diverse documentation practices and/or (2) the profession will be subject to imposed vocabularies that do not resonate with nurses.

The delineation of nursing data and documentation standards will in part be informed and guided by Infoway's work. But simultaneously, we need to tackle this issue in a tangible way within the profession. We need to reopen and extend the discussion that was started during the CNA minimum data set consensus conference in 1992. Collaborating on regional documentation redesign efforts

can leverage collective thinking and reduce the time-intensive burden of creating solutions in isolation. Further, I believe that there is value in seeking funding for a regional, cross-sectoral demonstration of the benefits and challenges associated with developing and deploying standardized clinical documentation. Consider the promise of standards; consider the peril of none. Is the issue worthy of worry? If so, the time for action is now.

References

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