eHealth

technology in practice

Nursing content of eHealth records

Royal College of Nursing

Introduction

Record keeping is an essential element of nursing practice; it is an important method of communication, is used to monitor the quality of patient care, and serves as a legal record of a practitioner's care. Electronic patient records have become increasingly commonplace and nursing staff are key to the success of this new health care practice.

This booklet is aimed at nursing staff (nurses and other health care workers working in any sector within or outside the UK) and reflects the RCN's current understanding of factors that will ensure that the nursing content[1] of electronic patient records:

- supports effective clinical judgements, decisions, care and communication
- accurately represents the work of nursing and identifies the nursing contribution to patient outcomes
- reflects core nursing values such as patient focus, partnership working, confidentiality, respect and choice
- provides relevant data for commissioning, workforce planning, performance monitoring, quality improvement, and research.

Nursing content of eHealth records

The RCN believes that the following points are essential for ensuring that electronic records truly reflect nursing care.

As systems are deployed and upgraded and as new knowledge is gained, managers and system designers should continue to listen to the experience, evidence and advice of nursing staff, so that electronic systems evolve to truly support nursing staff in meeting the health needs of patients/ clients, carers and families.

1 Standards for the nursing content of electronic records are essential for patient safety, and to support best practice, reduce duplication of effort, and support the provision of nursing data for resource management, quality improvement, service planning, and research.

These standards must be based on the best available evidence/expert consensus and agreed by the relevant professional bodies.

2 Nursing staff must be able to record elements of the nursing process in a manner that reflects nursing practice including:

- the patient's views, expectations and preferences
- results of assessments
- judgments about the patient's needs and problems
- decisions made
- care planned and provided
- expected and actual outcomes
- communications (with patients and carers and other professionals/ agencies).

3 Nursing information in the record needs to be structured using national standardised terminology to enable, for example, links to decision support, the creation of messages, and the provision of data for analyses. Standardised terminology is essential to avoid ambiguity and to enable data to be aggregated and compared.

Standardised terminology will never capture the full richness of patient care and experience and there will always be a need for free text. However, the more information about nursing can be structured using standardised terminology, the more it can be shared to support of patient care and compared for quality improvement and effective management purposes.

Find out more and get involved

4 The primary driver for deciding on nursing content in electronic records must be patient care. Systems should enable 'record once, use many times for many purposes'. Data to support commissioning, workforce planning, performance monitoring, quality improvement and research ('measure and compare') should be derived wherever possible from record content defined for primary use ('care and share'), with appropriate safeguards.

5 The content of electronic records must be SAFER[2]. There are different risks associated with recording and using information in electronic records compared with paper records. Those undertaking quality assurance for systems or standards need to assure themselves that that the content represents faithfully the meaning intended by the person recording it, and that this meaning will be preserved. They also need to ensure that the systems and the way they are used are SAFER:

S conform to **STANDARDS**
A be **ACCEPTABLE** to patients, clients, carers and health care workers
F be **FIT** for purpose and practice
E be supported by **EVIDENCE**
R be **RISK MANAGED**

6 Multi-disciplinary records to which the patient/client has access and contributes to are the gold standard in most health care contexts. The RCN supports this concept but notes that the nursing contribution to care must always be identifiable.

The Royal College of Nursing supports the direction of travel of eHealth in each of the four UK countries. And we recognise that the people who use IT are key to realising its potential.

For more information on eHealth, and to discover how you can get involved, visit the RCN's eHealth and Information in Nursing (IN) Forum web pages at the RCN website **www.rcn.org.uk/ehealth**

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

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1 Nursing content: what is written or entered into the record that reflects the nursing contribution to patient care and outcomes of that care.

2 Royal College of Nursing (2010) *Making IT SAFER*, London: RCN. Available from www.rcn.org.uk

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