Informatics Innovations in Nursing Practice

Enhancing Care in Long Term Care with Clinical Informatics

CNIA Conference

September 14th 2005

Specialty Care

Overview

- LTC in Ontario – Nursing Informatics
- About Specialty Care
- Implementation of the clinical information system
- Lessons learned- successes and challenges
- Benefits
- Continuing the Journey

LTC in Ontario

- Over 600 Long Term Care Homes
- Approximately 74,000 residents
- RNs - 7,205, 65% over 45 (CNO, 2004)
- RPNs - 7,679, 64% over 45 (CNO, 2004)
- LTC highly regulated by MOHLTC compliance review process
  - Includes extensive MOH requirements for assessment, documentation, resident monitoring

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Clinical Informatics in LTC

- Adoption of clinical informatics in LTC is limited
- Overwhelming majority of homes have no or very limited capacity for nurses to do assessment, care planning and documentation on line
- Policies, procedures and other decision mechanisms in paper based format
- Limited, if any access to internet
- 2005- the implementation of MDS 2.0 for assessment and care planning started in LTC
  - 20 homes selected and have started implementation with support from MOHLTC

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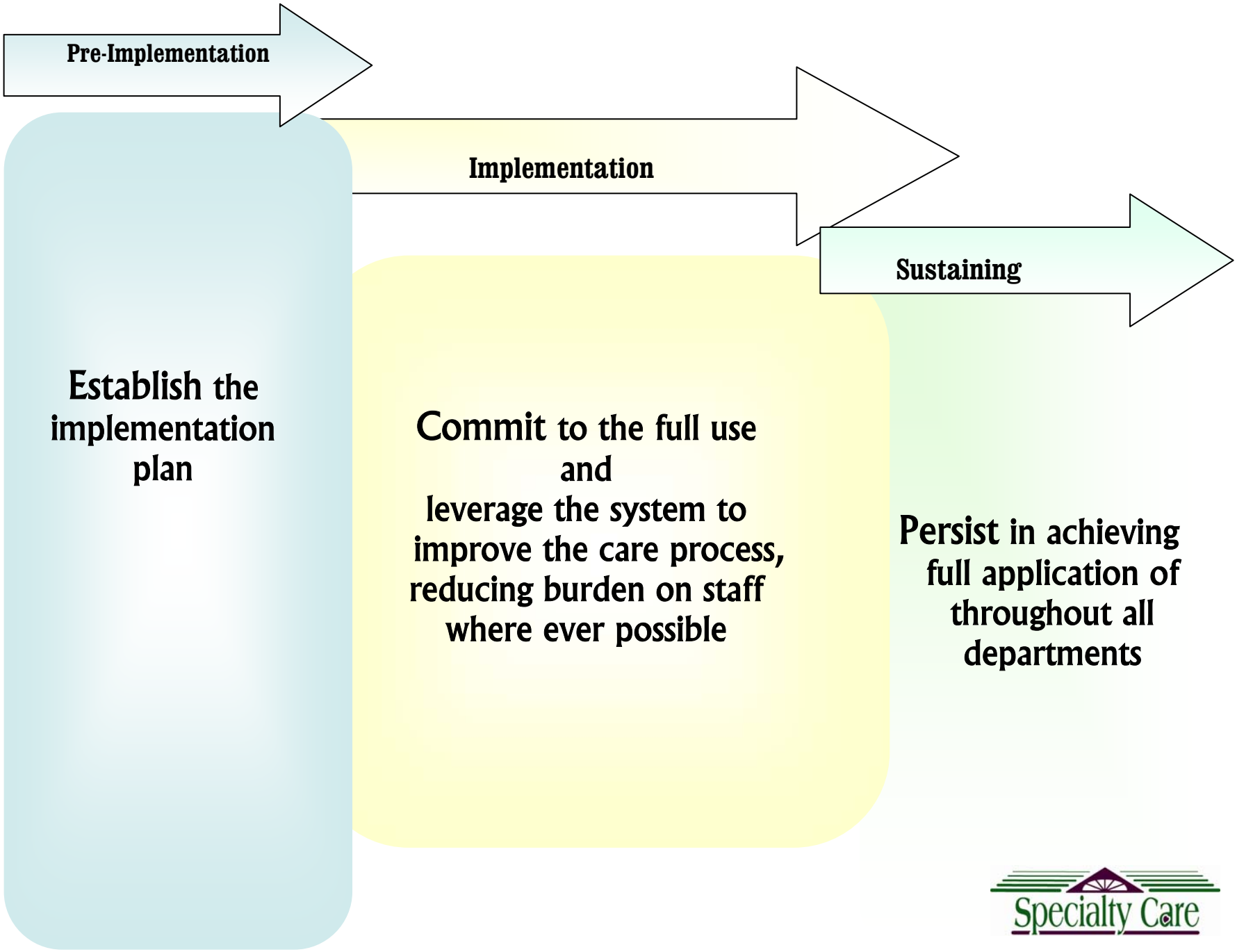
- Provider of Family Centered Long Term Care Services for 25 yrs.
- Manage 13 Long Term Care homes and 4 Retirement residences across Southern and Eastern Ontario
- Specialty Health Consulting provides consulting to Long Term Care homes, Community Care Access Centers, Associations and Hospitals

Specialty Care's Information System

In 2003 an integrated information system was selected to support:

- Administration
  - resident billing, trust accounts, occupancy
- Clinical
  - assessment, care planning, diagnosis, vital signs, immunization tracking, weights, ongoing documentation and reports
- Quality Management
  - Indicators, comparative reports, quality improvement tracking


Pre-Implementation
Implementation
Sustaining
Establish the implementation plan
Commit to the full use and leverage the system to improve the care process, reducing burden on staff where ever possible
Persist in achieving full application of throughout all departments

Prior to implementation

- All resident care related documentation was completed on paper
- Limited care planning ability available using initial computer application
- Assessments
  - Nursing, Dietary, Programs, Physiotherapy assessments hand written
  - Narrative, lengthy tools; filed in chart and infrequently viewed by other disciplines
  - Duplicate information collection by all disciplines: i.e.. diagnosis, history, functional status, financial information, vision, hearing, adaptive devices, family profiles
  - Completed at different times within first 6 weeks of admission prior to care conference

Pre-Implementation

- Plan business process changes (current state and desired state)
  - Security, Access, Down time, Printing, Review of forms, Resident Classification Process
  - Planning for the new process: assessment, care planning, documentation
- Adequate Hardware- computer access & technical support
- Implementation plan (tasks, times, responsibilities)
  - For all departments
- Roles
  - Appoint Corporate sponsor and project coordinator
  - Identify champions and leaders in all homes

Benefits

The entire care process has been enhanced and is more interdisciplinary

- Assessments
- Care Planning and Quarterly Reviews as a team effort
- Documentation
- Resident Classification – involving front line staff
- Reports
- Quality Management
- Auditing

Assessments

- One time entry of full assessment with ability to copy and update thereafter (MOH requires quarterly reassessment)
- Removal of duplicate items between disciplines
- Ability to identify scores from triggers i.e.. Fall risk, CMI
- Readily accessible for viewing
- Refer to each others assessments
- Triggers standardized Kardex & Care Plan items

Streamlining Care Planning Processes

- Benefits to the care process:
  - introduction of standardized format and process for care planning in all Homes
  - each discipline now participates in quarterly review with increased accountability
  - easy to maintain all historical information and revisions to the care plan, etc over time
  - easier to evaluate outcomes and changes over time by running reports rather than going back through tons of paper!
  - Reinforces the same logic and language of the annual resident classification process

Reducing duplication of data collection

- Previously duplicating information - infinite
  - Collect information once
  - Save nurses time in creating care plans, requisitions, shift report, lists, equipment tracking, other reports
  - Avoids repeatedly writing out the same resident information or creating Word and Excel tables
  - Health record readily accessible for repeat short stay admissions

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Improving Quality and Patient Safety

- Data Dictionary (definitions) and indicators set up in the system can be done from a central location
- Clinical indicators tracked by nursing staff
  - i.e. Falls, Medication errors, pressure ulcers
- Graphics created to view on line at professional practice meetings
- Run benchmarking reports to compare to other homes
- Improvement opportunities identified and benchmarks set

Interdisciplinary team work

- Resident Care Plan development has become a multidisciplinary approach
  - input from front line staff utilized to develop appropriate and individualized goals and interventions for resident
  - Increased sharing of information to enhance resident care

Lessons Learned

- Easing into the world of e health
  - Phased approach does not work
  - staff avoided using it, longer for staff to gain comfort
- Establish Principles at the outset
  - Minimal if any printing
  - Reduce burden on staff
  - Minimize duplicate data collection
  - Maximize system use to improve care process
- Most nurses not computer literate initially
  - super user role established to support staff
  - easy to use reference materials created; available on every unit

Lessons Learned

- Staff afraid to make errors in real data base
  - training data base set up with no unique identifiers and generic password access
  - proficiency checklists and certificates
- Strong nursing leadership required
- Committed resources for implementation and support
- Design the desired state, develop processes at front line to support it
- Physician acceptance
- Adequate number of computers and printers on the units

Continuing the Journey

- RAI-2.0 will further reduce duplication in assessment, data collection
  - Foster greater interdisciplinary team work
  - Will generate the clinical quality indicators for sector benchmarking
  - Clinical decision support and outcome measurement
- On line policies and procedures
- E- Learning
- Requires significant nursing leadership in the sector to make nursing informatics a priority

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