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CONCURRENT SESSIONS THEME 1: Informatics Innovations in Nursing Practice

Transforming a community hospital from paper to electronic documentation while implementing CPOE

by Debra M. Wolf, MSN, RN

ABSTRACT

OBJECTIVES:

1. Identify critical steps needed to initiate computerized documentation
2. Identify key factors which will impact the success of computerized documentation
3. Describe the multidisciplinary approach utilized in implementing computerized documentation
4. Provide statistical data revealing the impact the computerized system has on a community hospital.

SUMMARY:

This presentation will provide information on the methodology used to convert a 259 bed community hospital from paper documentation to computerized documentation while implementing computerized physician order entry (CPOE) within a rigid 18 month timeline, resulting in 98% compliance by physicians.

The content of the presentation focused on establishing operationally:

- a strategic plan
- a timeline,
- a communication process, and
- a committee of dedicated employees to complete the project successfully

QUANTITATIVE OUTCOMES:

When strategically planning the transformation of UPMC St. Margaret from a paper health record to an electronic health record (EHR), several quantitative activities were utilized to assess the impact the EHR would have on the healthcare facility. Several measurement tools were developed and utilized such as a readiness assessment, a pulse survey, and a post implementation assessment. In addition, several benchmarking indicators were identified prior to implementation to assess the impact the initiative would have on the overall hospital performance.

Examples of benchmarking indicators include:

- Cost measurement of selected surgical procedures, pre and post implementation of an electronic intra-operative documentation and charging system
- Time studies to assess the amount of time nurses use when completing the admission physical assessment electronically vs. on paper,
- Compliance of hospital wide required documentation by nurses and physicians pre and post implementation.
- Cost of printing laboratory and diagnostic test results pre and post implementation, identifying yearly savings. (At present all test results are only viewable within the EHR, results are no longer printed on paper post go live).
- Comparing the number of drug errors, drug order clarifications, transcription errors, etc., pre and post implementation.
- Time studies to assess the amount of time pharmacist use to enter medications electronically (old paper chart) vs. physicians' entry of medications directly into the EHR

ABOUT THE AUTHOR

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Debra M. Wolf, MSN, RN is the Director of Clinical/Operational Informatics at UPMC St. Margaret in Pittsburgh, Pennsylvania. Over the past 18 months, Debra has assessed, evaluated, organized, and planned for the transformation of a 259 bed community hospital to a computerized health record, in addition to implementing computerized physician order entry hospital wide. Prior experience includes Clinical Coordinator of Nursing, Nurse Counselor, Nurse Clinician, Nurse Recruiter, and Nursing Instructor within a BSN program. Courses taught include nursing leadership and healthcare for women. In addition, Debra acts as a mentor to nursing students enrolled within the graduate and undergraduate programs at the University of Pittsburgh School of Nursing.

Debra's nursing experience began as a Licensed Practical Nurse at a local community college and is presently a graduate of La Roche College where she obtained her Masters degree in the Science of Nursing in Nursing Administration. Debra is presently enrolled at the University of Pittsburgh were she is working toward her PhD in Nursing