



**RCN/IHCS**

**eHEALTH WORKSHOP**

**CARDIFF**

**From Paper to electronic records –  
What is needed for nursing?**

**November 10<sup>th</sup> 2006**

**REPORT**

**Bernice Baker**, Committee Member ING, Lecturer Practitioner, IHCS  
Bournemouth University  
**Dr Bernie Edwards**, Practice Development Fellow, Centre for Practice  
Development, IHCS Bournemouth University

## **Acknowledgement**

The authors would like to thank the following people and organisations – without whose help and support the Workshop would not have been possible:

RCN Information in Nursing Forum  
RCN Ty Maeth Cardiff  
Angela Perrett, RCN Cardiff

eNWI Co-Ordinating Committee

Clive Andrewes, Head of Practice Development, IHCS, Bournemouth University  
Alison Jackson, Administrator, Practice Development, IHCS Bournemouth University

And of course all the nurses and midwives who attended the Workshop and gave of their enthusiasm and time so freely.

Thank you to you all.

## 1. Background

The Institute of Health & Community Studies (IHCS) at Bournemouth University are currently undertaking a collaborative project with the Information in Nursing Forum (ING) at RCN. This project involves running eHealth Workshops in each of the Four UK Countries. RCN provides the venues and hospitality for the Workshops and IHCS provides the administration, facilitation and write-up.

This report is as a result of the second of these workshops – that held in Cardiff on November 10<sup>th</sup> 2006.

The Workshop was attended by 20 delegates plus members of the eNWI Co-Ordinating Committee whose roles and interests reflected acute, community, midwifery, educational and nurse executive experience. A delegate list is included at Appendix 1

## 2. Aims

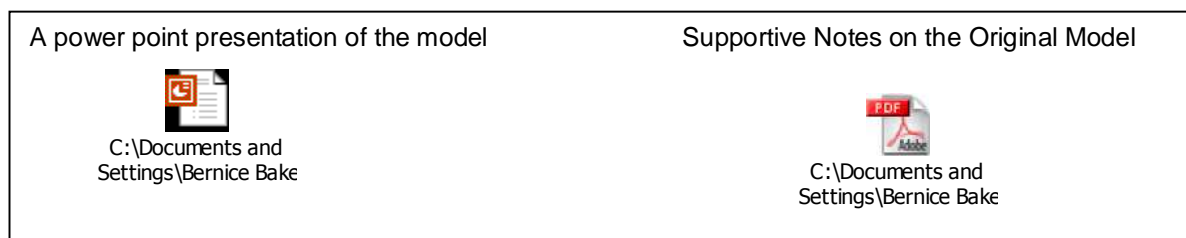
The generic aims of the four workshops are:

- to highlight the issues emerging from working in an e-health context
- to make recommendations for developments for the future.

## 3. Method:

The Cardiff Workshop was a 2 ½ hour, half day session, held immediately following an eNWI (2004) meeting at RCN Cardiff. Colleagues in North Wales had already established a 'Conceptual Model' (Hughes R 2005) as an example from which to critically investigate and develop a nurse understanding of what e-information is needed for nurses, nursing and clients in Wales. See Fig 1 for further information if viewing this Report in electronic form.

**Fig. 1 The North Wales Nurse Terminology Conceptual Model**



It was therefore decided to use this model as a starting point for focused discussion around the needs of nursing within the time limits of the Workshop. The following programme was therefore adopted:

1. Overview of the Conceptual Model: Dame June Clark
2. Further discussion and Selection of two areas of nursing practice to work on: Dr Bernie Edwards
3. Group work
4. Feedback Plenary/Next steps
5. Evaluation/Close

It had originally been intended that – in the limited time available - the focus of the group work would consider what 'models' of nursing would be relevant if applying the conceptual model in **two** discrete areas of care delivery. However the expertise 'spread' of the attendees made this option problematic and it was instead decided following the information from the first two sessions to generically brainstorm around the following question in order to establish a focus relevant to those present which would stimulate subsequent group work:

**‘What are the areas that attendees feel are most relevant to nurses following the sessions?’**

This generated the following

- Is there ONE model or more than one model?
- What are the BLOCKS to appropriate care delivery – should the e-record reflect/record these?
- Should the e-record record service shortfalls/other shortfalls?
- The e-record appears to be clinical oriented as opposed client oriented
- What is the information FOR (ie as a NURSE?)

From the above it was decided to focus Group Work on a ‘generic’ question:

**‘What information, in an ideal world, would I like to collect which reflect both nurse and client perspective?’**

**Fig 2: Group Work Flip Chart Feedback**

GROUP A	GROUP B
<p>Pt determines how far we go – levels Pt – What is it I want you to know about me? Who do you want to know what?</p> <p>Pictures – of wounds etc</p> <p>(LEVELS) BULD-IN (USE) Accumulative Record – capacity potential</p> <p>Functional ability</p> <p>Beliefs – views on death/dying/sexuality/function</p> <p>What goals have you got for your life?</p> <p>Intimate/close relationships</p> <p>Make-up a) Family life b) life at Home? Support Systems?</p> <p>What is their normal function?</p> <p>What would their ideal of health be?</p> <p>What do they want – ideally?</p> <p>Culture – Beliefs</p> <ul style="list-style-type: none"> <li>• What is health</li> <li>• ? value non traditional treatments?</li> <li>• Understanding of health system/who should do what</li> </ul> <p>Family – whose responsibility? How are decisions made?</p>	<p>Background information needed <u>before</u> we treat: Psycho-social/physiological-pathological Example: Pre-Op Assessments Past History plus psycho-social – are they fit – all this information needs integrating into record PRIOR to care</p> <p>Example from Midwifery: Primary/secondary care integration needed but needs to be standardized re</p> <ul style="list-style-type: none"> <li>- Quality of information recorded in other areas</li> <li>- Thus trusting the integrity/depth</li> <li>- Accountability issue – you duplicate if you can’t trust existing information</li> </ul> <p>Therefore design of assessment needs critical – tension between what is ‘coded’ and what code ‘covers’ Example from Breast Cancer counseling service: Counseling is coded and recorded – but difference between nurse and doctor counseling – needs clearly defining what code stands for</p> <p>There needs to be ‘levels’ of information/access rights to levels of appropriate information</p> <p>There is a need for an ability to clearly clarify and justify what you NEED to know</p> <p>What should clients take responsibility for in the e-records?</p> <p>What about clients carrying their own ‘health info’ memory stick/chip?</p>

<p>Non healthcare practitioners inputting?</p> <p>Should patients decide who writes in the record?</p> <p>Do you want to get better?</p> <p>What's their understanding of their issue?</p> <p>Past medical history and Social History</p> <p>Recent loss</p> <p>Nature of their home physical environment</p> <p><u>Lifestyle: Addiction</u></p> <ul style="list-style-type: none"> <li>- Smoking? Why? Do I want to give up? If not why not?</li> </ul> <p>Have you tried giving up and what happened?</p> <p><u>Medications?</u> Understand what they are taking and why?</p> <p>Cultural Issue – other therapies</p>	<p>Client input: what if a client wants to 'correct' the information recorded about them? Why shouldn't they?</p> <p>Who inputs clients information? Nurse on behalf client? Client themselves?</p> <p>Assessment only – confidentiality is key – justification for information collected</p> <p>Recognition of clients right NOT to take responsibility for recording</p> <p>Training needed to achieve e-record methods – plus TIME to 'play' to get expertise</p> <p>Dedicated computers – ACCESS!!!</p>
---	---

**Action Plan/Follow-up.**

At the Feedback Plenary Session the following recommendations with regard to what is needed now following experience of this Workshop generated the following:

- **Similar events in different locations**
- **Get people to present on work already done**
- **Focus on outcomes**

**4. Analysis, synthesis and discussion of delegates input at Workshop.**

For the authors of this report it was very interesting how the nurses at the workshop in Wales so closely reflected the values, interests and enthusiasm of the nurses at the corresponding workshop in Scotland – even though the approach undertaken at each event was completely different. In December 2005 we wrote in the Edinburgh Report:

“It was very apparent from the discussions amongst the nurse delegates present that nurses in Scotland recognise the potential of ehealth to transform the way care is delivered to their clients and exhibit a real willingness to make it work within a ‘whole systems’ understanding. This finding is entirely in line with recent RCN Surveys in the UK (RCN 2004, RCN 2005a) and the expressed vision of nurses at international level (ICN 1998).”

The paragraph above completely reflects the situation at the Cardiff Workshop nearly a year later and is now further underpinned by the latest RCN Survey (2006).

It is interesting to view the Cardiff nurse group work in relation to the early comment that the e-record appears to be 'clinical oriented as opposed client oriented'. The question arises, when nurses in Wales are left to think what they *would* like included – would these elements be classified clinical orient, client orient – or some both? The following table attempts to illustrate a basis for consideration of this:

**Fig: 3**

<b>Orient:</b>	<b>Clinical?</b>	<b>Client?</b>
Pt determines how far we go – levels		X
Pt – What is it I want you to know about me? Who do you want to know what?		X
Pictures – of wounds etc	X	
(LEVELS) BULD-IN (USE) Accumulative Record – capacity potential		
Functional ability	X	X
Beliefs – views on death/dying/sexuality/function	X	X
What goals have you got for your life?	X	X
Intimate/close relationships		X
Make-up a) Family life b) life at Home? Support Systems?	X	X
What is their normal function?	x	X
What would their ideal of health be?		X
What do they want – ideally?		X
Culture – Beliefs		x
• What is health		x
• ? value non traditional treatments?	X	x
• Understanding of health system/who should do what		x
Family – whose responsibility? How are decisions made?		x
Non healthcare practitioners inputting?	X	x
Should patients decide who writes in the record?		x
Do you want to get better?		x
What's their understanding of their issue?		X
Past medical history and Social History	x X	X X
Recent loss		

Nature of their home physical environment	X	X
<u>Lifestyle: Addiction</u>		
- Smoking? Why? Do I want to give up? If not why not?	X	X
Have you tried giving up and what happened?	X	X
<u>Medications?</u> Understand what they are taking and why?	X	X
Cultural Issue – other therapies		X
Background information needed <u>before</u> we treat: Psycho-social/physiological-pathological	X	X
Example: Pre-Op Assessments Past History plus psycho-social – are they fit – all this information needs integrating into record PRIOR to care	X X	X
Example from Midwifery: Primary/secondary care integration needed but needs to be standardized		
re		
- Quality of information recorded in other areas	X	X
- Thus trusting the integrity/depth	X	X
- Accountability issue – you duplicate if you can't trust existing information	X	
Therefore design of assessment needs critical – tension between what is 'coded' and what code 'covers' Example from Breast Cancer counseling service: Counseling is coded and recorded – but difference between nurse and doctor counseling – needs clearly defining what code stands for	X	X
There needs to be 'levels' of information/access rights to levels of appropriate information	X	X
There is a need for an ability to clearly clarify and justify what you NEED to know	X	X
What should clients take responsibility for in the e-records?	X	X
What about clients carrying their own 'health info' memory stick/chip?		X
Client input: what if a client wants to 'correct' the information recorded about them? Why shouldn't they?		X
Who inputs clients information? Nurse on behalf client? Client themselves?	X	X
Assessment only – confidentiality is key – justification for information collected		X
Recognition of clients right NOT to take responsibility for recording		X
Training needed to achieve e-record methods – plus TIME to 'play' to get expertise	X	

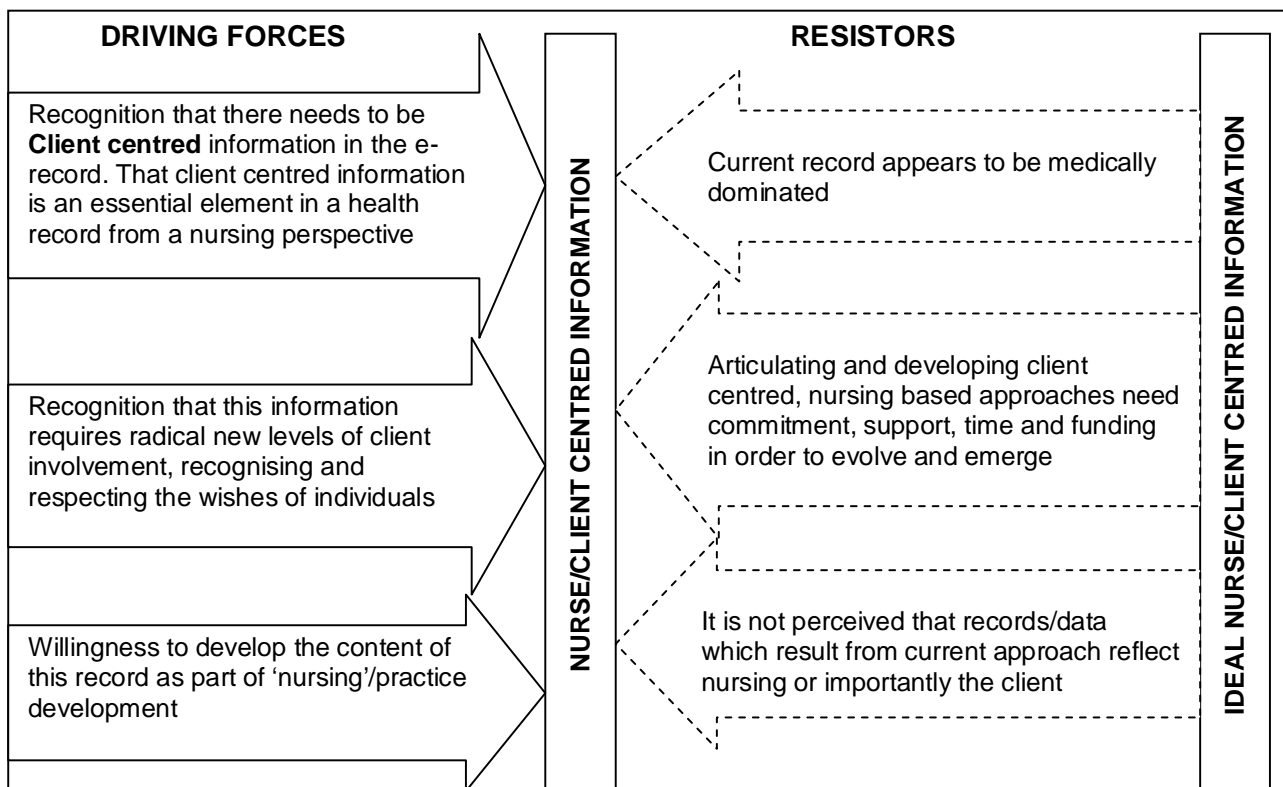
Dedicated computers – ACCESS!!!	X 27	43
---------------------------------	---------	----

Whilst some debate could be had about the categorisation in Fig 3 above, it is clear that one of the dominant themes for nurses coming out of this workshop is the need to consider – and *develop* – the client role in what information is collected – but **also** that the clients themselves are given the opportunity to become more actively involved in what information is relevant to *their* health status and therefore what is relevant to be recorded about them and their environment.

There was also emphasis on the need (if the information was to be of maximal use to the nurse and the client) for effective integration of access to information across traditional boundaries (eg Primary – Community – Acute – Midwifery – Mental Health) and of the need for nurses to justify and account for the information they feel they need to record in any given setting. In addition it was perceived that there was a need for the ‘health system’ to recognise that the method adopted for e-recording (maybe via coding) must truly represent what really happened and what was really needed. Several times attendees returned to the thought that the content of record could only be justified by consideration in relation to measurement of the outcome for the client.

The elements exposed by the workshop can be visualised in terms of a ‘Force Field’ Diagram (Lewin 1951); See Fig 3:

**Fig 4: ‘What information, in an ideal world, would I like to collect which reflect both nurse and client perspective?’**



This diagram should be viewed in the context of the focus of the day – which had started with a presentation around the North Wales Conceptual model. It naturally encouraged attendees to consider

**their** practice in relation to the model and to the clients for whom they care; it thus reflects application of the model to the practice areas of those present at the Workshop.

## 5. Recommendations

The nurses themselves made three recommendations in the final session:

- Similar events in different locations
- Get people to present on work already done
- Focus on outcomes

These recommendations are related to the possible content and approach required to maintain interest and action from the initial Workshop.

In relation to recommendations evolving from the discussions and sessions themselves, there is patently a need to investigate and research the wishes, rights and needs of clients in a newly empowered and informed health care environment underpinned and enabled by IT - recognising that this endeavour starts to address and expose core elements of a nursing model.

Within this several key themes emerged as requiring formal recognition and/or special focus:

- That this is and will remain **on-going and evolving** client centred model
- That there is a need for agreement on what is needed to support core **assessment** in any area but importantly that this should include the client's wishes
- That clients should be given the opportunity to determine levels of access to their own records
- That the client should have the opportunity to decide and record what is it that he/she wants the health service to know about them and that this should be valued
- Exposure of the tension between central standardisation and the requirements of professional judgement
- Recognition of the need for minimal levels of central standardisation which of itself must be subject to on-going development as the needs of client centred health care emerge

## 6. Conclusion

The Workshop exposed how nurses in Wales are advanced in their thinking around care records. It also demonstrated how nurses are naturally client centred when invited to think about e-records from a nursing perspective.

For key stakeholders - such as Informing Healthcare - the level of advanced thinking and insight from such a relatively short session from a relatively small number of nurses must serve to illustrate the latent and easily released expertise and knowledge waiting to be harnessed for the people of Wales. The nurses who attended the Workshop majored their recommendations on how they can continue to be involved we hope this report of their enthusiasm and knowledge adds some weight to their wish to continue with further supported work.

## APPENDIX 1

<b>SURNAME</b>	<b>FORENAME</b>	<b>INSTITUTION</b>
<b>Beddoe</b>	Anne	UHW
<b>Davies</b>	Julie	Bro Morgannwg NHS Trust
<b>England</b>	Christine	Royal Glamorgan Hospital
<b>Evans</b>	Carla	UHW
<b>Harding</b>	Michelle	UHW
<b>Hooi</b>	Sam	Cardiff & Vale NHS Trust
<b>James</b>	Helen	Bro Morgannwg NHS Trust
<b>Jenkins</b>	Julie	Gwent Healthcare NHS Trust
<b>Manley</b>	Jane	Informing Health Care/Carmarthenshire NHS Trust
<b>Rees</b>	Patricia	Carmarthenshire NHS Trust
<b>Ryley</b>	Nicola	Cardiff & Vale NHS Trust
<b>Tang</b>	Pauline	Cardiff University School of Nursing & Midwifery Studies
<b>Thomas</b>	Janet	Carmarthenshire NHS Trust
<b>Thomas</b>	Karen	Carmarthenshire NHS Trust
<b>Waring</b>	Rose	Cardiff University School of Nursing & Midwifery Studies
<b>West</b>	Nicola	Cardiff & Vale NHS Trust
<b>Williams</b>	Marie	Carmarthenshire NHS Trust

## APPENDIX 2

### EVALUATIONS

eNWI Evaluation Forms From eHealth Conference November 2006 Wales					
QUESTION	1=strongly agree	2=Agree	3=Neither agree or disagree	4=Disagree	5=Strongly Disagree
The content of the day was relevant to my area of practice	11	4			2
The environment encouraged learning	11	3	1	2	
There was sufficient opportunity to discuss my own experiences and I was encouraged to voice my opinions	9	5	3		1
The day enabled me to reflect on my experiences	6	6	2	2	
I found it easy to book a place at this event	10	4		3	
I found the information sent to me prior to the event informative	4	7	5	2	
I enjoyed the food and refreshments	6	6	1	1	
I found the facilities comfortable	7	8		2	
I found the event good value for money overall	7	2	1		2
<b>TOTAL</b>	<b>71</b>	<b>45</b>	<b>13</b>	<b>12</b>	<b>5</b>
<b>COMMENTS</b>					
Very appropriate - it's a shame more people didn't take the opportunity to attend.					
Hang in there!					
The challenge is to widen this debate.					
A fruitful day for sharing. We should have more of these to encourage nurses to get together to discuss such issues.					
<p>Interesting but some comments made me think about possible ethical and legal implications in the situation of NOT divulging information. If health is not only about the absence of disease, certainly agree the electronic record will provide ongoing information of a persons' health developments. As a prior medical ward sister, patients arrive into hospital for a given health problem and not just arrive for a cup of tea and a talk. A nurse not only needs to know what are the actual and/or potential problems of the patient but can never ignore the social/psychological/spiritual/economic factors which often interplay with the patients' nursing management. Would like to see how the electronic records will engage in all of these factors.</p>					

## REFERENCES/READING LIST

eNWI (2004) *Welcome to eNWI* e-Health Nursing Wales Web site:  
<http://www.ehealthnurses.org.uk/wales/index.html>

HUGHES R (2005) *Nurse Terminology Model* North Wales Nursing Terminology Group available on line at <http://enwi.blogspot.com/>

INFORMING HEALTHCARE <http://www.wales.nhs.uk/ihc/home.cfm>

LEWIN K. 1951 *Field Theory in Social Science*, Harper and Row, New York.

ROYAL COLLEGE of NURSING 2004 *Speaking Up; Nurses and NHS IT developments* RCN London available on line at <http://www.rcn.org.uk/publications/>

ROYAL COLLEGE of NURSING 2005a *The information needs of nurses* RCN London; available on line at <http://www.rcn.org.uk/publications/>

ROYAL COLLEGE of NURSING 2005b *E-Health and the RCN: towards organisation wide integrated action* RCN available on line at <http://www.rcn.org.uk/aboutus/policy/ehealth/> last accessed 13<sup>th</sup> January 2006

ROYAL COLLEGE OF NURSING (2006) *IT Survey 2006: Nurses and NHS IT developments* RCN London available on line at <http://www.rcn.org.uk/publications/#i>

THE INTERNATIONAL COUNCIL of NURSES, 1998 *ICN's Vision for the Future of Nursing* ICN; available on line at: <http://www.icn.ch/visionstatement.htm> Last accessed January 12<sup>th</sup> 2006