What can nurse leaders and staff nurses do to prepare to implement electronic care records?

With electronic care records being rolled out in England, nurse leaders, managers and frontline nurses need to prepare to change how patients’ records are kept.

LEADING IMPLEMENTATION
There are many challenges facing nurses involved in making the change from a paper-based to an electronic record system. Effective leadership plays a vital role in the process (see www.nhsicarecords.nhs.uk for more information).

Nurses leading the transition have to be able to translate the strategic vision for the electronic care records (ECRs) into a tangible product that will benefit frontline staff and they need to develop a workforce that understands the technological portal through which it is accessed.

UNDERSTANDING AND OVERCOMING BARRIERS
Mustain et al (2008) pointed out that fear, apathy and competing priorities were the three main barriers they faced when introducing electronic records to an acute facility in the US – factors that will no doubt resonate with nurse leaders in this country.

The fear may be related to the technology itself or the need to learn new working processes. Apathy, on the other hand, emerges during lengthy implementation projects which are inevitably delayed by organisational issues, equipment problems or minor to severe software glitches. This increases the chance of encountering the third barrier, that of competing priorities, as new policies, service demands or new projects compete for attention and resources.

These barriers may be at the root of change fatigue, a phenomenon that appears to be increasing in nursing. Change fatigue is often demonstrated by a lack of engagement, scepticism or frustration. These problems can result in the types of negative behaviour highlighted in a study of three hospitals implementing computerised care planning. Here, staff used various strategies to avoid writing and updating electronic care plans (Edmondson et al, 2001, cited by the National Nursing Research Unit, 2009). The study concluded that, despite the implementation plan being delivered and the organisation perceiving the change as successful, there was a failure to assimilate the system into routine practice long after the change had occurred. This study highlights the importance of truly effective change management in this process.

CHANGE MANAGEMENT
In the past, the management of change was often presented as a logical process comprised of a series of linear steps or actions to achieve a successful outcome. However, as Nadler (1998) pointed out: “Real change in real organisations is intensely personal and enormously political.” Change is a messy and complicated business, more akin to progressing through the grieving process (Turner, 2002) than a clearly staged journey with measurable milestones.

Reineck (2007) described an alternative approach to change that may be more appropriate given the evidence above. This approach would still have at its heart a well planned and resourced programme of activity but the management of change would take place through a multifaceted approach using power, reasoning and re-education and involving structural, behavioural and technological approaches. Table 1 outlines these principles and their potential application to implementing the ECR.

MAKING THE CHANGE
The issues that nurses need to address to ensure effective implementation of ECRs in their area tend to fall into four interconnected areas – partnerships, people, processes and technology (Fig 1).
PARTNERSHIPS
Implementation leads need to establish strong partnerships at all levels if they are to succeed. At the delivery end, key partnerships involve frontline staff, the IT team responsible for resourcing the equipment and the electronic record system developers (who may or may not be a commercial company).

It is likely that the organisation’s executive will have allocated a board sponsor who will be a key partner, along with the finance director, HR director and non-executive directors.

Partnerships should extend to units or teams that may have an interest in the change and those outside the organisation involved in the patient care pathway.

Education providers are useful partners as they can ensure the change is reflected in educational programmes and advise on issues such as evaluation and change management.

Lymbery (2006) described the vast differences in power and culture between various occupational groupings, and the inherently competitive nature of professions jostling for territory in the same areas of activity. He suggested that these issues cannot be resolved unless they are properly understood – a rhetorical appeal to the unmitigated benefits of “partnership” alone will not produce more effective joint working.

This is particularly pertinent to the partnership between clinical staff, trust IT employees and systems suppliers whose language, concerns and priorities are often different.

Mutual respect and understanding can be developed by building strategies such as action learning into the change process. Action learning is based on the relationship between reflection and action. The focus is on the issues and problems that individuals identify and planning action with the structured support of the partnership group. This approach helps people to learn from each other, and generates collective ownership and strong accountability for goals and risks.

PEOPLE
Who needs to be involved?
Clinical ownership is crucial (Mustain et al, 2008; Edmondson et al, 2001) and it is vital that nursing staff of all grades and any support staff are involved as early as possible in all aspects of implementation. It is this involvement that allows nurses to feel they have ownership of introducing the ECR.

They need clear leadership from their manager, who should ensure that each staff member knows what is expected of them and make use of existing skills and expertise. Visiting professionals also need to be involved, such as medical staff, diabetic specialist nurses and community psychiatric nurses, as they may have different needs from regular staff in terms of access.

What skills are needed?
It is likely that nurses involved in implementation will have different attitudes towards the ECR and vary in their knowledge about its purpose, structure and content. Developing a shared vision is essential.

Since levels of competence vary in relation to IT, each person’s level needs to be assessed to ensure appropriate training and support is offered. At this early stage, “buddies” and “champion users” can be identified to support less confident staff and ensure they do not become marginalised.

Nurse leaders should consider updating or adapting record keeping skills of those staff who do not have the skills required to record contemporaneous information electronically, as they will not make best use of systems available to them (Timmons, 2001).

At the same time, leaders must be clear that the act of changing record systems cannot guarantee improvements in quality and safety (Urquhart and Currell, 2005). Therefore, staff must be clear about the part they play and their expectations managed to achieve progressive, continued implementation.

PROCESS
The two main areas that need to be addressed are process mapping and training.

1 Process mapping: this may be new for some nurses, but should be seen as part of reflective practice. It allows system users to identify the process “as is” and the process “to be”.

In “as is” mapping, it is important for staff to explore their current processes properly. They may find there are steps that are not fully understood or that are in place because of custom and practice rather than because they are necessary.

It is only when staff have had the opportunity to reflect on these process steps that they can begin to start to think about the “to be” process mapping.

This involves looking at how they plan to work once the ECR system is in place. Staff may be tempted to try to mould the system around existing practices, that is, the processes identified in the “as is” mapping.

| TABLE 1. POTENTIAL CHANGE STRATEGIES FOR IMPLEMENTING THE ECR |
| Change strategies (Reineck, 2007) | Application to implementing the ECR |
| Change through power | Empowering the team to build the ECR themselves |
| Change through reason | Using qualitative and quantitative evidence to highlight to staff the benefits and drawbacks of the old compared with the new system and to inform the change management process. Honest acknowledgment of potential problems is essential, for example, using the ECR will slow people down initially but they soon speed up again and there will be glitches. |
| Change through education | Providing education, information, knowledge and skills to effect a successful transition |
| Changing behaviour | Developing the team and then supervising and monitoring their performance in using the ECR |
| Changing structure | Anchoring change in culture by altering jobs, job descriptions, workflow and organisational design, as well as creating policies to support the safe and effective use of the ECR |
| Changing through technology | Using technology creatively in the change process to communicate progress and gather feedback. This will also help develop core skills |

FIG 1. AREAS OF ACTION FOR EFFECTIVE IMPLEMENTATION

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exercise. By spending time and creativity on the “to be” mapping, more benefit can be accrued by looking at all the possible options for working differently and more effectively following the ECR’s introduction.

An example of “as is” and “to be” process mapping could involve looking at how (general) assessments are undertaken. Information on the existing process may be gathered in separate documents at varying points in time, such as during nursing triage in A&E, followed by a medical assessment in the same place. A decision to admit is then made, and the ward may also carry out a nursing and separate medical assessment.

Using the ECR to best advantage is likely to involve having a single (comprehensive) assessment completed over time, with successive professionals adding to the technical data, reducing the potential for duplicate or, even worse, conflicting information. This example shows that process mapping must involve all relevant staff, not just nurses.

Training requirements: as mentioned earlier, system training alone is insufficient; individuals and teams must review record keeping practice and consider the practical, procedural and professional implications of the new approach. This section assumes this has already taken place.

System training needs to be driven by timing as much as anything else, in that staff must be trained on how to use the system as near to their “go live” date as possible. If training takes place too early, staff may need to spend time reading manuals during the going live phase since they may have forgotten elements of what they were taught.

Staff who have been trained on ECRs have often raised the same issue, that is, during training the system should reflect, as far as possible, how it will look when it goes live.

For example, its existing ward names could be used to create familiarity and to help gain system acceptance.

It is also important to involve staff in the “go live” planning so that education, training and confidence are there at the right time. Access control is one area where this can be useful. Most ECRs use role based access control, where access is based on need. For example, healthcare assistants may have read-only access to care plans, whereas registered staff all have read and write access to that area. Establishing early in the process who needs to access records, what kind of access they need, and then making sure they have it for training will do much to prevent some of those early glitches that so often frustrate and demotivate staff, and to ensure that information governance issues and system security are understood. This should include permanent and “visiting staff” such as students.

TECHNOLOGY

The technology used depends on the setting. Many models are available and staff should be involved in ensuring that a “best fit” approach is taken.

One criticism that frontline nurses have raised is that access to ECRs is often difficult when terminals are shared or when equipment is static. Nursing managers must recognise this problem because, if access is compromised, then the use of the ECR will also be compromised.

In a ward, this can be achieved through using mobile devices or having terminals at various points where a laptop can be connected, for example in a handover room or meeting room, or by having a wireless environment which can be accessed anywhere patients may be in the hospital. In community settings, mobile devices are required.

CONCLUSION

It is clear that effective leadership and sound change management processes are vital ingredients in making the shift from paper to electronic records.

Nurse leaders, managers and practitioners should not underestimate the complexity of implementation in a live setting, where the integrity of NHS services have to be maintained and where patient safety is paramount; nor the scope of this very fundamental change to professional nursing practice.

It is therefore essential that the DH, NHS, NHS Connecting for Health and professional organisations work in partnership with those involved in ECR implementation to capture and translate learning to national guidance that will support high quality care in all settings and excellence in nursing practice.

REFERENCES


