Selecting and Implementing a Point-of-Care Clinical Documentation System

Electronic point-of-care clinical documentation can have a significant impact on the quality of care you provide. Your documentation will likely be more complete, and your clinical data is more easily measured. Furthermore, point-of-care documentation results in real-time data capture, which can, in turn, lead to better clinical outcomes, because well-informed decisions are made sooner rather than later. In addition, these systems push clinical data to the MDS coordinator. The ready availability of electronic data can also aid facility administrators in monitoring and managing care in their communities, via more efficient reporting.

Best-of-Breed Versus Integrated Platforms
There are two basic strategies for implementing a point-of-care clinical documentation system: You can use an integrated platform with a complete offering of clinical applications, or you can select a best-of-breed application, designed exclusively for the capture of ADL data at the point of care. Excellent best-of-breed products are available with established interfaces to other clinical systems. While scalability and centralization can be achieved with a best-of-breed model, a single integrated clinical documentation platform may be easier for larger organizations to support with a centralized back-end IT center.

System Selection
It is vital to use a standard process for selecting your point-of-care documentation system. Write out your requirements from both a user and an IT standpoint, and match them with available products, scoring and ranking each product by its ability to meet those requirements. Ask vendors to provide on-site demos, and check their references – particularly those not on their preferred client list, since speaking to only their most satisfied customers may not give you a real feel for how the system performs in the field. The selection process should be driven and led by the end users, as they can define system requirements outside of management’s business requirements.

Features and Functions
There are a number of features and functions to look for in your point-of-care clinical documentation system. First and foremost is the completeness of the clinical record. Comparing the product’s features set against all of the documentation you will perform at the point of care will help to clearly define your needs. An easy way to determine the items to include is to compare them to your current paper chart. Once you are confident the system will feed your medical record with complete information, consider the following:

**Assessments**: Does the system provide pre-configured assessments, as well allow you to modify the assessments to meet your business needs? Some organizations may be comfortable with a vendor’s “out of the box” assessments, while others will require user-defined assessments. For example, an organization may want to create an electronic customized assessment when incorporating a new approach to documenting a clinical condition.

**Clinical Content**: Does the system allow you to take clinical notes? If you are using an integrated platform, versus a best-of-breed program, does it enable e-prescribing and computerized physician order entry (CPOE) and provide electronic medication and treatment administration record (EMAR and ETAR, respectively) modules?

**Alerts**: In addition to offering preconfigured alerts, your system should also allow you to create custom alerts to notify the care team of key information points.

**Workflows**: The ability to customize the workflows to meet your business needs is the key to improving your users’ productivity.

**Reporting Features**: Does the system enable customized reporting, allowing your organization to write its own reports and easily display them in the application?

**Technology Concerns**: Select a software platform based on technology your IT organization is comfortable with. For organizations that use mostly Microsoft...
software, a SQL server and Windows-based platform may be best. During the selection process, you should also consider whether you prefer a Web-based or Client Server type application.

**Performance and Scalability:** For independently run facilities or smaller multi-facility chains, many point-of-care clinical documentation systems scale well to your operations. For larger multi-facility organizations with multiple care disciplines, performance and scalability are more important. Having the vendor provide an independent, third-party expert review of its performance and scalability can reduce the risk of your organization facing performance and scalability issues down the road. Also, if possible, speak with one of the vendor’s largest customers, in terms of usage, to determine how the software has met the needs of an organization larger than yours.

**Anticipating Your Future Needs**
It is also important to anticipate what your needs will be in the future – up to three or five years out, if possible. Look for a vendor that is committed to being in business for the long run. Does the vendor have a vision for the future and a roadmap for integrating the features you may want down the road? Implementing a clinical documentation system is a time-consuming and costly undertaking, but replacing it a few years down the road may be even more difficult.

**Hardware Selection**
Users have a variety of computing platforms to choose from, including touch-screen kiosks, tablet PCs, PDAs, and laptop or desktop computers. While Erickson Retirement Communities found touch-screen computers to be very intuitive and easy to train staff to use during our pilot of the hardware technology, we ultimately decided to use laptop computers with 15-inch screens for clinical documentation. Well received by our employees and equipped with a dual battery, the laptops have six to eight hours of battery life. We store back-up laptops on each floor, so if one runs out of power, a staff member can easily switch it for a fully charged computer. We purchased inexpensive carts, instead of more costly COWs (computers on wheels), because this flexible option allows us to easily replace hardware. This standardization of and consistency in our equipment has allowed our nurses and CNAs to better support each other in caring for our residents, as each staff member knows how to use another’s equipment.

**Wireless Networking and Infrastructure**
For electronic point-of-care documentation, wireless connectivity is key. First, perform a physical plant survey to identify areas in which wireless access may be dropped and where additional access points may need to be added. Each building will be different. For instance, structural steel can create wireless connectivity “dead zones” in older facilities. Post-implementation fine-tuning...
may also be necessary, and you may need to boost signals in certain areas to ensure the continuity of wireless network access.

Server Issues
For a multi-site organization like Erickson, centralized servers and data centers can ease the process of enterprise-wide reporting. Maintaining multiple servers in the field requires more work – and potentially, more money – than maintaining one centralized server. Network prioritization is also an important consideration. At Erickson, we have prioritized our network traffic so that our clinical and business applications' data receives the highest priority, and Internet traffic is on the lowest rung. We have also increased our bandwidth, and now use three T1 lines per campus.

Workflow Standardization
Technology has a tendency to amplify procedural weaknesses and make them more visible. With this in mind, prior to implementing a point-of-care clinical documentation system, it is advisable to review your standardized documentation procedures and identify opportunities for improvement. Simply replicating your current forms in an electronic format may not maximize the benefits of electronic documentation, such as increased workflow efficiency, that you stand to reap.

At Erickson, we improved our data capture rate after we implemented our clinical documentation system and streamlined our process for documenting assessments. We learned a significant lesson: Listen to the users, as they can easily identify inefficiencies. After making some improvements to our procedures, such as reducing the complexity and number of pages of the admissions assessment and linking our clinical workflows, we have seen a significant improvement in our employees' adoption of the system. In fact, in a January 2008 survey, 86% of our employees indicated, if given the choice, they would not go back to paper documentation. They have resolved that electronic documentation is the future and have begun to see its benefits throughout our organization.

Staff Training
While it requires a good deal of homework and due diligence, selecting the software and installing the related hardware and network infrastructure is not the hardest part of a point-of-care clinical documentation system implementation. Rather, you will likely spend more time on staff training and encouraging their adoption and appropriate use of the system. A significant number of your staff may have fewer computer skills than are necessary, and they should be trained in those functions before the implementation. You may find it helpful to offer a “Computers 101” class to educate people on using a keyboard and mouse, logging into software programs, and navigating the Web. With these basic skills mastered prior to implementation, you remove a significant impediment to system acceptance. Because our point-of-care clinical system is Web-based, we were satisfied that users with those basic skills were then ready for more platform-specific training.

Reaping the Benefits of Reporting
It is vital to pick the key metrics you want to measure through your point-of-care clinical documentation system's reports. While each facility will invariably have its own unique needs, any organization can benefit from running standard reports, including:
- ADL documentation and completion rates
- Compliance of documentation against the policies of the organization
- MAR documentation compliance

Management gains valuable insight into nursing staff practices through the use of a system's reporting features. Administrators and nurse managers are able to measure compliance against their organization's established documentation rates and proactively resolve any issues that arise. On paper, that kind of analysis is nearly impossible, due to its labor intensiveness. System reports can also highlight areas for improvement in the completion of ADLs per resident and per shift. Nurse managers can use reports to identify residents who have not received necessary services prior to the close of each shift, thereby ensuring that residents receive the care they need and deserve.
Implementation Advice

You must respond to your users' feedback and incorporate it— as quickly as possible— into your organization's software product and processes. Doing so will ensure that your end users are happy customers. You will always run into unanticipated problems, but what counts is how you react to them. To meet your end users' needs, consider conducting surveys after the implementation and any major upgrades to your system. By carefully reviewing your end users' responses, you will likely uncover opportunities for improvement in your clinical documentation system. Improvements directly into the product, for instance, Erickson's users requested the ability to perform a spell check before electronically signing off on their documentation system. In addition, after implementing a clinical notes feature in our clinical software system, our users provided feedback for improving the functionality with structured data points.

Calculating Your ROI

In determining the return on investment for a point-of-care clinical documentation system, it can be difficult to apply hard numbers to the benefits your facility will enjoy. For instance, it is challenging to quantify the cost savings associated with the reduced risk and legal liability that this kind of system can provide. That said, there are opportunities to identify clear financial returns from a system implementation. For instance, electronic point-of-care clinical documentation can lead to more complete CNA ADL documentation, and in turn, better documentation of the support your staff provides your residents can directly translate into more accurate billing and, in some cases, improved revenue as you are capturing data that may have slipped through the cracks before the implementation.

Conclusion

By taking the recommendations in this article under careful consideration, you can ensure your important decision is right the first time and begin benefiting from the variety of process and care improvements a point-of-care clinical documentation system can provide to you and your residents.

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