Patient information at your fingertips: piloting an electronic assessment form in Sunrise Health Region

Sunrise Health Region and eHealth Services collaborated with 3sHealth to develop an electronic version of the Nursing Information System Saskatchewan© Daily Systems Assessment Form (DSA) for Medicine/Surgery. This electronic version (eDSA) was created for use with the Allscripts Sunrise™ Clinical Manager (SCM), a web-based electronic record program used by Sunrise Health Region.

The form was initially implemented in the medicine units of the Yorkton Regional Health Centre (YRHC). After trialing the form for 10 months, Sunrise Health Region staff members were asked to share their experiences with, and feedback on, the new electronic form in November, 2014.

The majority of the front-line nursing staff members who used the new form believed that the electronic DSA improved the quality of the documentation. However, respondents expressed some concern that a breakdown in communication can occur when some documentation is electronic and other documentation still remains on paper.
“Being able to complete the NISS DSA at the bedside has allowed nursing staff to spend more time with patients. Having a patient’s information available at your fingertips is very beneficial when it comes to patient care,” said Amanda Spelay, RN, Medicine Clinical Coordinator. “For me specifically, I find SCM to be a very valuable resource when following up on client safety reports, as I no longer have to pull charts to find what I am looking for. I can find it all on SCM, which saves me a lot of time.”

Those working in the units that piloted the eDSA believed the electronic form added value to their work. Positive comments were also received from staff working in areas outside the units since they also had access to information on the eDSAs though the Sunrise ™ Clinical Manager.

“I think the eDSAs are quite useful, says Scott Jacobson, an RPN working in long term care. “Previously, I would have called the floor nurse for an update. Now I can just review the electronic DSA, saving time for both of us. I think this is a big step forward to create a better picture of health for our residents.”

Multidisciplinary health professionals in the region, such as home care assessors, speech language pathologists and pharmacists access the DSA regularly to help form the basis for their own assessments.

“I find the electronic DSA a very helpful tool in providing important information about a patient. I can access details and accurate information that I require when I am investigating an infectious case”, says Jacqueline Byblow, RN, Infection Prevention and Control. “With the eDSA, I am able to follow the patient’s progress from the admission assessment and history to the discharge summary. The nursing staff provides valuable information on a daily basis using the eDSA, saving me valuable time when looking for information. Previously I would have to go to the patient’s unit or to the Health Records Department to look through paper files.”

Diane McDougall, Director of Health Service for the region believes the eDSA is the wave of the future and is central to Saskatchewan’s approach to patient care. “As I watch nursing staff using the computer at the bedside to complete the electronic daily systems assessment, I realize how much this one document has increased the time and interaction of nurse and patient”, said McDougall. “In the planning to go forward with more electronic implementation, I can’t help but think how well this fits with the lean philosophy of freeing time to spend with patients and families, but also the Patient First initiative our province endorsed and supports.”

McDougall noted that “documentation with the patient, at the bedside, can only strengthen the nurse-patient relationship and I look forward to future electronic documents that all members of the team including pharmacist, physician, dietitian, social work, therapies using this tool and also strengthening that connection in the best patient-centred care.”

With the positive feedback and support from the staff that piloted this new form, Sunrise Health Region is looking forward to working with eHealth Services and 3sHealth to develop other electronic NISS documents for 2015.”
NISS FORMS REVISIONS

In addition to the Clinical Record flowsheet, the NISS Standard Revision Committee and the NISS Long Term Care Working Group reviewed the Long Term Care forms with the following forms requiring revisions for this cycle:

Long Term Care

Admission Assessment and History – Long Term Care AALTC-021.8

Page 1
- ‘Proxy’ is replaced by ‘Medical Substitute Decision Maker’ and relocated to top of page 1.
- Nutrition care component:
- Malnutrition Screening questions considered best practice by the Canadian Malnutrition Task Force are added and the weight management program section is removed;
- Specific Diet reflects more common LTC diet orders and identifies residents requiring thickened fluids;
- Additions to the Meal Time Assistance section help users identify those residents who need help eating;
- Additions to the Eating/drinking difficulty section relate to amount consumed. Mobility care component: Sask-a-pole and raised toilet seat are added.

Page 2
- Observations & Measurements: Pain assessment includes PQRST method and added an area to record assessment tool used for non-verbal communication for pain.

Page 3
- added checkbox for ‘Facility/Unit specific Pressure Ulcer risk assessment completed’. Meds: added ‘PIP done’. Safety: checkbox to indicate a ‘facility/unit specific falls risk assessment’ has been completed.

Page 4

Admission Assessment and History – Respite/Day Program AARES-022.8

Page 1
- Added ‘Medical Substitute Decision Maker’ to top of page 1.
- Observations & Measurements: Pain assessment includes PQRST method and added an area to record assessment tool used for non-verbal communication for pain.

Page 2
- Meds: added ‘PIP done’ to Medication Reconciliation.
- Treatment and Procedures: added checkboxes for both Home Care and Adult Day Program.

Clinical Record CR-128.7
- The grid lines for charting Temperature and Pulse on this flowsheet have been modified for easier recording and reading.
- Blocks have been added to record blood pressure systolic and diastolic readings.
- Additional blank lines have been included for both Intake and Output to be filled in as needed.
NISS Standard Revision Committee and NISS Long Term Care Working Group

NISS would like to acknowledge and thank the NISS Standard Revision Committee and the NISS Long Term Care Working Group for their contributions and expertise in the revision of these forms.

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Please inform the Clinical Advisor, NISS of any accreditation requirements and/or health region concerns related to NISS documentation. If you wish to participate on the NISS Standard Revision Committee or the Long Term Care Working Group, please contact:

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**About NISS**

*Nursing Information System Saskatchewan© (NISS) is a 3sHealth program that facilitates the effective and efficient collection, organization and communication of relevant patient information by authorized care providers. The documentation system includes a methodology to determine nursing workload. NISS is a client based program provided to organizations who subscribe to this service.*