24 DR. SIMMER: Thank you. The Commission is
25 also pleased to welcome participant number five, Mary

1 Killeen.
2 MS. KILLEEN: Good afternoon. My name is
3 Mary Killeen. I'm a registered professional nurse
4 with my diploma, bachelor's degree, master's degree,
5 and Ph.D. earned in the field of nursing. I'm
6 certified in nursing administration advanced by the
7 American Nurses Credentialing Corporation. I'm a long
8 time member of the Michigan Nurses Association.
9 Currently I'm a research fellow at the University of
10 Michigan School of Nursing.
11 In 2003 and '4, I served as a chairperson of
12 a Patient Safety Committee when employed at the
13 University of Michigan Flint, Department of Nursing.
14 I'm speaking as a private citizen and a
15 registered nurse, safety advocate, concerned about the
16 safety of my fellow citizens who from time to time
17 find themselves in the healthcare system.
18 My focus of concern is the systemic
19 time-consuming, ineffective process of documentation
20 by nurses in all clinical settings. By documentation,
21 I mean the recording of pertinent patient data in the
22 patient's medical chart.
23 Specifically, I'm talking about problems with
24 both the process of documentation by nurses and with
25 the documentation systems, written and computerized,

1 that they use.
2 First, the process of documentation. There
3 is, of course, a legal responsibility to document
4 properly, but not enough time for RNs to document
5 properly.
6 RNs are taught if it isn't documented, it
7 isn't done. If it isn't documented, it's as if the RN
8 never provided the care, and he or she may be liable

9 legally for omission of care.
10 As an educated professional, the RN is always
11 legally responsible or liable for his or her actions.
12 This is true for every setting in which RNs practice.
13 Documentation activity adds greatly to nurses
14 work loads. 20 to 30 percent of RN time is spent
15 writing or electronically entering patient information
16 into the patient chart.
17 RNs feel compromised when they do not have
18 enough time to provide safe care. Safe care requires
19 that the patient's story, including initial and
20 ongoing assessments, short and long-term goals, and
21 their actual attainment and interventions that are
22 completed are entered into the patient's chart for all
23 the healthcare team members to refer to.
24 True, verbal communication occurs at shift
25 change and at other times when patient hand-offs

1 occur, and we know these hand-offs need to improve.
2 But without a complete plan of care in the patient
3 record, the team is uncertain on the details.
4 Complete information in the patient chart is part of a
5 safety culture that allows the on-coming shift RN to
6 know exactly what each patient's previous status was
7 and the medications, treatments, and other
8 interventions that occurred during the previous shift.
9 RNs feel torn between providing direct care
10 in the presence of the patient or taking time to
11 document for their own legal protection.
12 Consequently, documentation often suffers because the
13 RN usually cannot take the time to do it well.
14 Charting is often a mindless activity done to meet the
15 requirements of regulatory agencies.
16 The safety problem with the process of
17 documentation is that the necessary patient
18 information for clinical decision-making is often
19 lacking in the patient's chart.
20 Second, I want to address the problem with
21 documentation systems. I'm referring to electronic

22 systems now because they are the technology being
23 introduced today.
24 For the most part, the present electronic
25 documentation systems are cumbersome and

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1 time-consuming. There is no consistent research yet
2 that computerized charting saves RN time. There is a
3 need for more standardization and computerized
4 documentation systems to enhance the ability for RNs
5 to diagnose, plan, deliver, and evaluate quality care.
6 The American Nurses Association has
7 recognized standardized nursing terminologies that
8 could be used to gather consistent patient information
9 with consistent terms in a consistent format.
10 However, software vendors of computerized
11 information systems do not routinely include complete
12 standardized nursing terminologies in their systems.
13 As commercial interests dictate, they, vendors, design
14 and sell their systems on the basis of customizing or
15 tailoring them to fit the requests of their
16 organizations.
17 As a result, the healthcare industry is left
18 without standardized nursing information and
19 computerized documentation systems to support the
20 continuity of patient care across many settings.
21 Therefore, I'm making the following
22 recommendations to improve patient safety and reduce
23 information errors in healthcare organizations.
24 One, research moneys be sought for
25 demonstration studies focused on streamlining the

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1 documentation and care planning processes and
2 organizations with a specific aim that documentation
3 becomes a realistic component of the nurse workload.
4 Two, ANA-recognized standardized nursing
5 terminologies be used for information entry and
6 retrieval in manual and computerized documentation
7 systems in all clinical settings.

8 Three, moneys be appropriated by the
9 Legislature to support the development and
10 implementation of computerized information systems to
11 streamline documentation of patient care.
12 In summary, RNs are the glue that hold
13 healthcare systems together. They provide save
14 passage for patients through the systems. Bottom
15 line, they need better information technology to
16 assist them to provide safe care. Thank you for the
17 opportunity to testify.
18 DR. SIMMER: Thank you very much. Do we have
19 any questions? Okay. Thanks.