

Short bio-sketch of the person or organization's experience in patient safety

Dr. Mary B. Killeen is a registered professional nurse with her BSN, MSN, and PhD in the field of Nursing . She is certified in Nursing Administration Advanced by the American Nurses Credentialing Corporation. She has been employed in multiple roles in her career primarily in the hospital setting. Currently, Dr. Killeen is a Research Fellow at the University of Michigan School of Nursing. Her experience in patient safety is based on her chairpersonship of a Patient Safety Committee when employed as an Associate Professor at the University of Michigan-Flint.

**Oral and Written Testimony of Mary B. Killeen, PhD, RN, CNAA, BC
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I am a registered professional nurse with my diploma, bachelor's degree, Master's degree, and PhD earned in the field of Nursing. I am certified in Nursing Administration Advanced by the American Nurses Credentialing Corporation. I have been employed in multiple roles: Clinical Nurse in Obstetrics, Clinical Nurse Specialist, Nurse Administrator, Associate Professor, and now as a researcher. Currently, I am a Research Fellow at the University of Michigan School of Nursing. In 2003-04, I served as the chairperson of a Patient Safety Committee when employed by the University of Michigan-Flint Department of Nursing.

I am speaking as a private citizen and registered nurse safety advocate concerned about the safety of my fellow citizens who, from time to time, find themselves in the health care system.

My focus of concern is the systemic, time consuming, ineffective process of documentation by nurses in all clinical settings. Documentation is the recording of pertinent patient data in the patient's medical chart. Specifically, I am talking about problems with both the process of documentation by nurses and with the documentation systems, written and computerized, that they use. Let me address each.

First, the process of documentation. There is a legal responsibility to document properly but not enough time for RNs to document properly. RNs are taught "if it isn't documented, it isn't done." This means the care the RN provides; assessment, reassessment, setting and evaluating goals, providing treatments, giving medications, and literally hundreds of other nursing interventions, must be recorded manually or electronically entered into the patient chart. If it isn't documented, it is as if the RN never provided the care and he/she may be legally liable for omission of care. As an educated professional, the RN is always legally responsible or liable for his/her actions. This is true for every setting in which RNs practice.

Documentation activity adds greatly to nurses' workloads – 20-30% of RN time is spent writing or electronically entering patient information into the patient chart. RNs feel compromised when they do not have enough time to provide safe care. Safe care requires that the patient's story, including initial and ongoing assessments, short and long term goals and their actual attainment, and interventions that are completed are entered in the patient's chart for all the health care team members to refer to. True, verbal communication occurs at shift change and other times when patient handoffs occur. But without a complete plan of care in the patient record, the team is uncertain on the details. Complete information in the patient chart is part of a safety culture that allows the oncoming shift RN to know exactly what each patient's previous status was, and the medications, treatments and other interventions that occurred during the previous shift. RNs feel torn between providing direct care in the presence of the patient or taking time to document for their own legal protection. Consequently, documentation often suffers because the RN usually cannot take the time to do it well. Charting is often a mindless

activity done to meet the requirements of regulatory agencies. The safety problem with the process of documentation is that necessary patient information for clinical decision making is often lacking in the patient's chart.

Second, I want to address the problem with documentation systems. I am referring to electronic systems now because they are the information technology being introduced today. For the most part, the present electronic documentation systems are cumbersome and time consuming. There is no consistent research evidence yet that computerized charting saves RN time. There is a need for more standardization in computerized documentation systems to enhance the ability for RNs to diagnose, plan, deliver and evaluate quality care. The American Nurses Association has recognized standardized nursing terminologies that could be used to gather consistent patient information, with consistent terms, in a consistent format. However, software vendors of computerized information systems do not routinely include complete standardized nursing terminologies in their systems. As commercial interests dictate, vendors design and sell their systems on the basis of customizing them to fit the requests of organizations. As a result, the health care industry is left without standardized nursing information in computerized documentation systems to support continuity of patient care across many settings.

Therefore, I am making the following recommendations to improve patient safety and reduce information errors in health care organizations:

1. Research monies be sought for demonstration studies focused on streamlining the documentation and care planning processes in organizations with the specific aim that documentation becomes a realistic component of the nurse workload.
2. ANA recognized, standardized nursing terminologies be used for information entry and retrieval in manual and computerized documentation systems in all clinical settings.
3. Monies be appropriated by the legislature to support the development and implementation of computerized information systems to streamline documentation of patient care.

In summary, RNs are the glue that hold health care systems together. They provide safe passage for patients through the system. Bottom line: They need better information technology to assist them to provide safe care. Thank you for the opportunity to testify.