eHealth: the future of health care

Royal College of Nursing position statement
Nursing staff form the largest group of health care professionals, and because of their particular role in co-ordinating as well as delivering care to patients, they are major generators and users of information. High-quality patient care and nursing practice have always relied on the effective management of information. They now increasingly rely on appropriate health information technology (IT) systems (eHealth applications) for effective communication, collaboration, monitoring and decision making.

Health IT systems are now an integral part of professional nursing practice. There is evidence to suggest they make a positive difference to the safety of patients, to their experience of health care and to the working lives of health professionals (Huryk, 2010; McQueen et al, 2011). They are key to quality improvement in health care.

The Principles of Nursing Practice (2011a) moves to empower patients and modernise services through the adoption of technology. New opportunities and new ways of working may require nursing staff to develop new skills and knowledge. The effective use of data challenges traditional approaches to service delivery. It is instrumental in helping nursing staff improve quality of care. Examples include clinical audit and real time outcome measurement. Telehealth technology can be used to support people in their homes, and extend access to specialist services.

The RCN believes that sharing information about patients across the health care service, subject to appropriate safeguards, is an integral part of nursing and multi-disciplinary care. Nursing staff have a responsibility to ensure that they are aware of confidentiality and data protection legislation, local policies and professional guidance and do not abuse their privileged access to patient information. Nursing and Midwifery Council (NMC) guidance and data protection legislation apply to both electronic as well as paper records. Electronic records have the added advantage of audit trails which can identify who accessed a patient’s record and when.

Personal health information systems allow patients online access to their own electronic health records and in some cases input to the record. It is acknowledged that access to good quality information helps people to understand their health situation, make informed decisions about their care and treatment, and manage their own health. Patients need to be confident that personal health information systems are secure and that vulnerable patient’s records are protected from misuse by others. Guidance for patients about how to access health records should raise awareness about how to keep downloaded records secure and provide advice about the risks of sharing their health information.

The RCN therefore welcomes the introduction of appropriate health IT systems and supports the overall aims and the direction of travel of health IT in all four countries of the UK. Nursing engagement and involvement at all levels are critical to success.

In the current economic climate, it is important that all public spending is closely monitored and the RCN welcomes a high level of scrutiny in terms of how national IT programmes are managed. However, the RCN remains committed to helping to deliver the health IT systems that frontline nursing staff want and need, and patients expect and deserve.

**Recording usage**

The widespread use of technology across mainstream society (email, texting, online banking and shopping, the internet) has changed people’s expectations of how quickly they can access services and how they will access them. Patients may well expect a practice nurse to be able to access
their details while on the phone, just as they would with an insurance company. They may also expect them to help access online sources of health information. However, studies have shown that clinicians are often slower than others in exploiting the potential of new information sources, such as the internet (NHS Evidence, 2011).

There is increasing evidence to show that technology can positively impact on quality of care: greater adherence to guidelines or protocols through decision support (reminders), enhanced surveillance and monitoring (adverse drug events, quality measurement, disease outbreak) and reduction in medication errors (Jamal et al, 2009).

From a regulatory point of view the NMC Code (NMC, 2008) requires nursing staff to keep clear and accurate records (this includes electronic records) and use the best available evidence in their practice. The NMC principles of good record keeping (NMC, 2010) requires them to know how to use information systems and tools and ensure that the systems (and the way they are used) are secure. Increasingly we are likely to see health IT competences as conditions of employment and as requirements in commissioning.

Given the inevitability of health care IT, it is important that nursing staff, from frontline workers to leaders, embrace the agenda and play a key role in it, meeting the needs of the profession, patients and health care.

**eHealth covers:**

- electronic patient records (including assessment and care planning, electronic nurse prescribing, patient scheduling, online laboratory requests/results, e-pharmacy, clinical communications such as discharge/transfer letters)
- electronic communication with patients/professionals (includes telephone support/advice lines, email, SMS text messaging)
- telehealth/telecare (e.g. remote monitoring, video consultations, including service redesign, equipment management, etc)
- information management (reusing data recorded for care purposes to improve care, run clinical services, health care research, patient informed decision making, etc)
- information governance (covers confidentiality, system security and data protection, data quality)
- Personal health records (a repository of information considered by the individual to be relevant to his or her health, wellness, development and welfare, and for which that individual has primary control over the record’s content).

**Examples of benefits:**

- patient safety – patients’ demographic and clinical information is more legible, accessible and shareable, thereby giving clinicians more accurate, timely and complete data on which to base decisions
- effectiveness – clinical pathways and decision support systems can be embedded in electronic patient systems to give easy access to best practice evidence
- efficiency – more efficient work processes due to increased availability of clinical information, for example electronic transmission of prescriptions direct to the pharmacy
- patient centred – information about patient’s preferences more easily available
- timeliness – access to up-to-date information on which to base clinical decisions
- equitable – ensuring that all people have the same level of access to services.
Examples from around the UK

Scotland
In NHS Lothian in Scotland midwives use a maternity patient management system to document maternity records. The system supports delivery of care and the extraction of information for multiple purposes including primary clinical decision making and assisting manpower planning and quality assurance. The new system replaces a variety of electronic and paper-based records in use across the health board. This multiplicity of pre-existing records was considered a risk to patient safety and confidentiality as well as being expensive to maintain.

Northern Ireland
In Northern Ireland the E-CAT product is a clinical tool developed by district nursing staff to support them in balancing demands on their service with finite staffing resources. The tool provides nurses, at all levels in the community, with a statistical tool to measure clinical need and nursing performance, thereby allowing them to analyse need in relation to the skill and distribution of the workforce.

Wales
Informing Healthcare is developing a Clinical Portal. This is a secure health space uniting key patient information from the many computer systems and databases used in NHS Wales, such as those found in pathology, radiology, cancer and primary care settings. The portal provides fast access to information about medication, referrals and discharges, allows health professionals to request tests and results from various sources and ultimately improves patient safety and a reliance on paper records. [Source: NHS Wales Informatics Service (NWIS)]

England
A nursing metrics system developed at Heart of England NHS Foundation Trust won the ‘excellence in health care information management’ category of the eHealth Insider Awards 2010. Using laptops and a wireless network senior nurses interrogate 10 patient records and enter data from the notes into the nursing metrics checklists. Feedback is given on the spot to the senior sister and the team. If results come up with a red or amber warning, the senior nurse assessing the ward can help staff focus on areas that need improvement. The indicators are measured across every ward, every month and the system is used to drive change (eHealth Insider, 2011).
References


The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

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