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From Free Text to Standardised Nursing Language

-The National Development Project of Nursing Documentation in Finland

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Summary

The Council of State made a decision in principle in 2002 that Finland should have a nationally interoperable Electronic Health Record (EHR) by the end of the year 2007. Furthermore the decree launched in 2007 requires public healthcare organisations to join the national patient record archive by the end of the year 2011. The Ministry of Social Affairs and Health is in charge of the implementation of this decision and the specification of the EHR solution. The national nursing documentation mo del and the Finnish Care Classification (FinCC) were developed in the national nursing documentation project 2005- 2008 as a part of the national solution. FinCC has been implemented in CDA R2 format by Health Level 7 Finland. The information on nursing process and the nursing discharge summary can be transformed and stored in the national archive of EHRs. After the results of the national nursing documentation project, the nationwide implementation process started in Finland in October 2007 and will end in 2011.

Development Process

The national development process started in 2004 when the core data elements of the national EHR were introduced. The core data means health-related information required for data exchange between health information systems in a standardised format. In Finland, six IT suppliers representing the whole healthcare industry were initially involved in the national project.

The ratio of nurses to physicians is four to one in Finland. In clinical settings this means that nurses, being the largest group of healthcare professionals, constitute the most active users of patient data in hospitals. This dictates that tools and models adopted for daily practice must support nursing from philosophical, ethical and practical perspectives.

The Nursing Minimum Data Set (NMDS) is a part of the core data elements. The national NMDS and FinCC were integrated during 2005-2007 into eight health-recording systems in 34 healthcare organisations. Piloting was carried out as an action research in 106 units / wards in three university hospitals, 11 district hospitals, 19 healthcare centres, and in one private hospital.

Results

The developed systematic nursing documentation model is based on the nursing decision making process introduced by the World Health Organisation in the late 1970's. This international model comprises mainly four phases:

> Assessment and naming the nursing needs (nursing diagnoses);

> Planning and describing the outcomes of care;

> Description of interventions performed, and

> Assessment of nursing outcomes.

(Figure 1) An education model and an eEducation environment were also developed to support the implementation.

FinCC includes the Finnish Classification of Nursing Diagnosis (FiCND), Finnish Classification of Nursing Interventions

(FiCNI) and Finnish Classification of Nursing Outcomes (FiCNO). The FinCC is a translation of the Clinical Care Classification (CCC) (www.sabacare.com) and it was implemented after a cultural validation. The CCC is approved by the American Nurses Association (ANA) and is cross-mapped to the International Classification for Nursing Practice by the International Council of Nursing (ICN) and to the Unified Medical Language Systems. The CCC is also a part of the international Snomed CT classification and it can be used together with ICD-10.

Based on the experiences and evaluation results the Finnish Care Classifi cation can be implemented and used in all kinds of wards. Overall, the quality of the nursing documentation has improved. It is more uniform, patient centered,

based on guidelines accepted for care and in interdisciplinary use.

The length of oral reports has decreased, allowing more time for actual care-giving. Recording information

concerning the well-being of the patient throughout treatment until discharge improves the care process and pathway and, additionally, this data can be used for managerial and administrative purposes.

Conclusions

There is no desire to return to the old model of recording patient data among nurses. The users have begun to see the benefits of the systematic nursing documentation and use of EHR. The experiences of the systematic model of recording patient data are promising. Statistics and reports of nursing processes by systematic documentation have far-reaching benefits, including: Nursing management, planning, education, research and quality assessment. After the results of the national project, the nationwide implementation process started in Finland in October 2007 and will end in 2011.

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