Examining the impact of electronic care records on confidentiality and nursing practice

While electronic care records offer many opportunities, they also present practical and professional challenges, which the profession must be prepared to tackle.

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Electronic care records have significant implications both for frontline nurses and the wider profession. Two articles in last week’s issue discussed how the electronic care record (ECR) can support and bring benefits to frontline nurses’ role from a practical perspective. They also discussed the scope and complexity of the change management challenges underpinning implementation of ECRs in England.

This final article examines the issues nurses must consider when introducing and using this system. These include access and information governance, and matters such as confidentiality.

PROFESSIONAL IMPLICATIONS

Although electronic care records (ECRs) present significant opportunities to enhance nurses’ practice, practitioners will inevitably have concerns about the move from paper to electronic systems.

Professional associations such as the Royal College of Nursing have encouraged members to embrace the opportunities presented by e-health in all its forms, through discussion forums, research information and professional guidance (RCN, 2006).

However, in a joint report published with Bournemouth University, the college highlighted a number of professional concerns raised by nurses about working in electronic environments (Baker et al, 2007).

Along with practical concerns, such as access to hardware and the need for more training and engagement, the report raised issues about confidentiality and security of electronic systems and their ability to capture or follow the reality of nursing practice. It also examined more complex professional fears about data being used to covertly monitor individual performance, that standardisation may reduce professional management and that computers may divert nurses from direct care (Baker et al, 2007).

These concerns are neither new nor uncommon – similar issues have been raised in previous studies (Kossman and Scheidenhelm, 2008; Darbyshire, 2004; Kirshbaum, 2004; Timmons, 2003).

Given the main role that nurses have at the frontline of NHS services and their function as primary information managers, such concerns cannot and indeed must not be ignored if the potential benefits of ECRs for patients and clinicians are to be realised.

ACCESS TO HARDWARE

Access to computers and other hardware remains a barrier to nurses using the ECR. This is highly variable across the NHS, with some nurses using electronic records via highly portable and reliable hardware, while others remain frustrated by a single, static computer per team or inappropriate or unreliable mobile technology.

Nurse leaders must learn from organisations that have provided staff with the appropriate hardware so that they can participate more effectively in procurement.

INFORMATION GOVERNANCE

Making sure that frontline nurses and nurse leaders understand and demonstrate rigorous information governance will help tackle some practical concerns about the ECR. Information governance can be defined as “the structures, policies and practice of (nursing) to ensure the confidentiality and security of all records, especially patient records, and to enable use of them for the benefit of individual patients and the public good” (adapted from Cayton, 2006).

In common with other clinical groups, nurses have practised information governance as part of their professional codes of conduct and record keeping standards for many years. The obligations to maintain confidentiality and record security do not diminish with the ECR, but require adapting.

Nurses need to consider how this translates into action in ways that demonstrate clarity, accountability, transparency, coherence and consistency while being realistic, practicable, deliverable and measurable.

Some main elements of information governance are set out below.

Record content

Information governance requires that all nurses look at how the content of their existing records is set out, to consider the extent to which, if audited, this would be structured, prospective and actionable, unambiguous and measurable.

An Audit Commission (2009) report found that clinical records varied highly in quality, with many reported to be unauditable. This would be less likely with electronic records, particularly if nursing grasps this opportunity to build a clinical content library of generic and specialist predefined elements of assessment and care, based on best practice and evidence, that can be used to support assessment and care planning across multiple pathways.

Such a library could be supported by a system of professional assurance and governance that unifies the evidence base with access at the point of care. This requires greater collaboration within the profession, with clear lines of accountability, governance and contribution at all levels to ensure that the needs of nursing, as part of a wider clinical body, are clearly defined, consistent.
and seen as important and integral to a patient's shared electronic record.

The argument for professionally assured content systems that can be used in all nursing records becomes more crucial when we consider that electronic care records may be shared under tight control across a number of provider organisations. These would also support the reporting of outcomes and the achievement of quality indicators to commissioners and patients alike.

Record keeping standards

Poor quality records and documentation can lead to significant clinical and patient safety risks, so enabling nurses to maintain the highest levels of record keeping standards is a continuing objective.

There is a fundamental legal imperative for all nurses to maintain a comprehensive, accurate and accountable record. This is another area that would benefit from collaborative working between nurse leaders and professional bodies to ensure that professional guidelines reflect electronic working and to determine the policies and procedures required in a structured and integrated ECR environment. This approach is strongly advocated by the Royal College of General Practitioners and NHS Connecting for Health (2009) in guidance on shared professional records.

Confidentiality and security

The NHS Confidentiality Code of Practice is clear that record security and confidentiality remain the responsibility of all clinical practitioners (Department of Health, 2003).

The Care Record Guarantee reinforces the responsibilities and sets out obligations under which ECRs will be managed, to promote confidentiality among patients and the public (National Information Governance Board for Health and Social Care, 2009). These obligations include:

- How and when a record may be shared;
- The responsibilities of staff accessing a record, including ensuring that information is accurate;
- The audit trail that will link record access to practitioners;
- The contractual consequences for practitioners who breach their professional duty of confidentiality.

Nurses need to have a clear understanding of these obligations and be personally accountable for them. Part of this personal accountability includes being aware of policies that govern access to ECRs; this includes managing passwords.

As well as having a good understanding of service policies and procedures, nurses need a broad understanding of the main legislation around personal information. The Data Protection Act 1998 sets out principles that govern how personal and sensitive information may be processed, irrespective of whether it is held in a paper or electronic format (Office of Public Sector Information, 1998); this legislation covers clinical records. Nurses should ensure they are up to date with local management arrangements, including who the data protection officer is for their organisation and how the act supports patients’ access to their records.

In many healthcare organisations, the “Caldicott guardian” will work alongside the data protection officer (DH and the Caldicott Committee, 1997). The Caldicott guardian “should be, where practicable, a senior health professional with access to the most senior tier of management” (Cayton, 2006). This is very often the director of nursing or the medical director. The guardian “must be seen as separate from other management and sectoral influences; there by engaging in confidence in their independence and integrity” (Cayton, 2006). Their appointment must always avoid any conflict of interests.

The Caldicott guardian’s role is to ensure that local data sharing protocols are in place, which detail the standards that will apply when confidential information is disclosed or shared with other organisations and agencies. The Caldicott principles include justification to share, the minimum use of patient identifiable information, access on a “need to know” basis, and individual awareness and understanding of relevant legislation. These principles apply to both paper and electronic records.

As ECRs become seen as routine, adherence to such obvious principles will be much easier as they support new models of care delivery that depend on the sharing of integrated, structured, consistent and professionally assured content.

PROFESSIONAL ISSUES FOR NURSING

While access and good information governance will help tackle practical concerns, challenging questions remain about the effect of ECRs on areas such as clinical judgement, nursing practice, skills and identity (Greenhalgh et al, 2009; Baker et al, 2007; Darbyshire, 2004).

It is essential that these questions are debated openly by the profession and investigated through evaluation and research. Even then, the answers may not be clear, and such issues are resistant to the linear problem solving favoured in nursing. These complex issues will require new ways of conceptualising and working (Davis, 2000) and a willingness to learn from non-traditional practice areas.

Clinical judgement, decision making and nursing skills

At NHS Direct, nurses have been routinely using computerised decision support software and electronic records to support clinical practice for several years.

Despite initial concerns about diminishing clinical and professional skills, studies cited by Hunt (2008) have emphasised the nurses’ central role as active decision makers using professional judgement to seek consensus with the software and overriding it as required. Hunt (2008) points out that, rather than being deskillled by the technology, many NHS Direct nurses improve their levels of knowledge and judgement. The potential educational benefits of computerised systems for nurses in a face to face setting were highlighted by Lee (2006), who found that using ECRs improved descriptions of patient problems and care strategies.

Critical thinking skills in achieving these benefits are essential. Nurses using any electronic system in any setting must constantly question the content so that diligence is not lessened. Practitioners need to be aware of where the clinical information held for each patient comes from, and be ready and empowered to question, re-evaluate and modify it.

Technology and caring

Another concern is how technology affects the caring role, that is, the fear that electronic records may mean nurses spend more time with computers and less time with patients. The evidence is not conclusive either way. Greenhalgh et al (2009) suggested that, although electronic records may improve secondary functions, such as reporting and audit, primary clinical work may become less efficient. Kossman and Scheidenhelm (2008) reported that nurses working in a community hospital felt that care was safer but quality decreased due to the time spent on electronic records.

However, evidence from the field offers a different picture, with large mobile working initiatives such as the one in Lincolnshire PCT clearly demonstrating the potential of electronic systems to release time to care. Electronic systems and records inevitably affect the distribution and content of work tasks, so existing recording practices have to change. Once this is accepted, nurse leaders...
can stop nurses from trying to shoehorn their existing record keeping practices – some of which may be outdated and inefficient – into a new system, and help them adapt through training, supervision and providing updated operational policies.

**Nursing identity**

Much less tangible are the questions about the impact of technology on nursing identity. One recurring theme, which tends to emerge in the aftermath of high profile hospital failures and reports such as Hungry to be Heard (Age Concern, 2006), is that advancing technological care and medical substitution have somehow diminished nursing's traditional commitments to caring and human relationships.

As views are divided and the evidence is inconclusive (London Network for Nurses and Midwives, 2007), we might look again at NHS Direct nurses. While their work challenges the notions of traditional “hands-on” models of practice, it seems that they retain a strong sense of nursing identity and alignment to traditional values of nursing and holistic, empathetic practice. In addition, by learning new skills and adapting old ones, they add a significant cognitive element to their professional identity as a result of changing knowledge, analytical and communication skills (Snelgrove, 2009).

It is not disputed that caring must be at the centre of an e-enabled nursing world. All four UK Chief nursing officers reinforced this through Modernising Nursing Careers (DH, 2006) and in practice frameworks such as Confidence in Caring (DH, 2007), which stress the need for technical, interpersonal and caring competencies in equal measure. Provided that the profession is prepared to take ownership, there is a good chance that, by modernising working practices, securing our evidence base, realising our commitment to integrated multidisciplinary care, facilitating partnership working with patients and improving information giving, ECRs may serve to protect rather than detract from nursing’s core values.

The development of data standards will also make the caring elements of nursing much more visible and therefore subject to quality monitoring and commissioning (Baker et al, 2007).

**CONCLUSION**

The practical and professional issues presented here demonstrate the need for strong and coherent action nationally with high levels of nurse engagement – a conclusion that echoes the report by the Prime Minister’s Commission on the Future of Nursing and Midwifery (Central Office of Information, 2010).

Good governance could begin with professional assurance of the core components of clinical content in ECRs. Nurses must recognise that professional accountability is central to this, and mechanisms need to be put into place now to ensure dialogue with other clinical groups so we get it right. ECR confidentiality and security is down to us all, but our ability to bring compliance up to the highest standards is significantly easier in an electronic world. Leadership is essential. This will involve local and national partnership working with system providers, managers, educators, professional associations, policymakers and regulators to ensure that nurses are prepared, through education, research and policy, to practise safely and effectively.

As Dame Catherine Hall (1982), a pioneer in this field, said: “In all scientific and technological developments, man is and must remain the master. Man must never become the minion because his birthright is that of intellectual being. It is he who must solve the problems and identify the implications of technical marvels of this and every age and it is he who must make the moral judgements as to their usage. As nurses, it is for us to determine how we can use computer science appropriately and effectively in the facilitation and contribution of our profession in the provision of care.”

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