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Abstract Title:	Developing Burn Specific Documents In Electronic Medical Record
Author and Co-authors:	Kari Gabehart, RN, MSN, David Roggy, RN, Sara Tuvell, RN, BSN, Christina Cook, RN, Rajiv Sood, MD, FACS Richard M. Fairbanks Burn Center at Eskenazi Health, Indianapolis IN
Objective:	1) Discuss the importance of dedicated Clinical Informatics Specialists in the creation of burn specific documents in the electronic medical record.
Abstract:	<p>Introduction: The challenge with burn documentation needs in electronic medical record systems is recognized and often limited in the foundation of commercial electronic systems. In October 2016, our institution transitioned to a new all-inclusive electronic medical record. Prior to this transition, providers would use four different systems, which did not communicate with each other, to access patient information in order to coordinate and provide care. The transition to this new Electronic Medical Record (EMR) afforded us the opportunity to develop and build burn specific documentation needs in the new EMR system. In this paper, we share our experiences and the keys to our successful builds to streamline burn patients' documentation and information.</p> <p>Methods/Design: In January 2013, the EMR build team was composed of corporate contractors, dedicated clinical staff from all areas of the hospital that transitioned to the build team, and private contractors experienced in the EMR build process. To our great fortune, our burn team was provided access to four dedicated build team members that worked specifically on meeting our burn team documentation needs. With high level collaboration our team was able to assess foundation abilities of the new system, identify gaps to burn care and collaboratively create and build automated documents to meet our burn needs. In October 2016, the EMR system was implemented with our burn specific documents, flowsheets, and reports.</p> <p>Results/Findings: Through working with our dedicated build team, we were able to create an electronic Lund-Browder Chart with an avatar that is completed with each admission by our medical team. A burn progress notes as well as burn rounding sheets for the providers were built. We developed a fluid resuscitation flowsheet that is documented in real-time; displays fluid resuscitation goals; displays urine output goals; and in the near future will give alerts to the nurse on the need to notify the physician during fluid resuscitation. The creation of a</p>

standardized wound care note template was necessary as the wound template within the existing EMR system was too cumbersome to document larger TBSA burns. This wound care note allows for photodocumentation to be incorporated. Our tracking of tissue in the burn operating room is tracked electronically with the EMR rather than on paper prior to implementation. Burn wound photo-documentation to include inpatient, outpatient, intra-operative and emergency department needs automatically uploads into the patient's medical record from an encrypted portable handheld device connected to the EMR. Burn specific reports were developed with the help of our dedicated build team but can be edited and altered to meet the specific needs of inquiry whether it is for performance improvement or research. Additionally, the same EMR is used in all phases of care to include the burn clinic which allows for ease and continuity of care.

Conclusion: An EMR that is all-inclusive has benefitted our team and patient safety by streamlining the review and documentation of information. Having specific and dedicated EMR build specialist allocated to focusing on the needs of the burn unit was invaluable in the build, implementation, and maintenance phases. We continue to work with our EMR specialist to improve processes and documentation practices that impact patient outcomes. Our burn EMR specialist meets with the burn team on a monthly basis to evaluate and assess ongoing needs to further outcomes.