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355 EVALUATION OF AN ELECTRONIC SYSTEM FOR NURSING PROCESS DOCUMENTATION

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Introduction:
Electronic clinical nursing information systems should capture the nursing process and aggregate formal knowledge elements able to reflect nurses' clinical practice. The aim of this study was to evaluate functionality of an electronic system for nursing process documentation.

Methods:
A descriptive study conducted at the University Hospital from University of São Paulo, an academic hospital in São Paulo, Brazil. A purposive sample of 20 baccalaureate nurses, practing at all wards of the hospital, was trained to use an electronic system for nursing process documentation recently developed for the institution. Training program last two 4-hour sections, containing a short presentation of the system after which participants were guided through system functionalities. Simulated patient data were offered for each participant, who use the system to document patient data, generate nursing diagnoses hypotheses, state nursing diagnoses, nursing outcomes (as goals), nursing interventions, and nurses orders (nursing activities). All participants documented the admission assessment and care plan of at least three real patients in the next 30 days after the on-site sections. One month after the on-site training sections, all participants were invited to answer a questionnaire containing Likert-scale items (1=bad to 5=excellent) related to the functionality of the 11 modules of the system and 5 general features of the system. Additionally, there were items for self-assessment on digital fluency, accessing computer and internet frequency, knowledge on Information and Communication Technologies, internet and informatics skill level.

Results:
Sixteen nurses returned their questionnaires (female=100%; age range = 20 to 44 years; mean years of graduation = 13.4; highest professional degree were: baccalaureate (1); specialization (7); master (7); and doctoral (1). All participants reported having access to computers, and 15 used computers/internet daily. Nine nurses reported that they had never taken a distance education program; and familiarity with internet functionalities was: electronic mail (14); instant message services (12); and videoconference (11). Self-reported level of informatics knowledge and skills were basic (11), and moderate (5). Mean scores on modules functionalities ranged from 3.4 to 4.4 (average = 3.9). "Patient search" had the highest mean score (4.4), followed by "Assessment category" (4.2), and then by "Nurses-generated nursing diagnosis hypotheses" (4.1), "Nursing Interventions" (4.1), "System-generated nursing diagnosis hypotheses" (4.0); "Nursing diagnosis statements" (4.0); "Nursing outcomes" (3.9); "Nurses orders" (3.9); "Assessment data" (3.8); "Summary" (3.6); and "Reports" (3.4). Average score on 5 general features of the system was 3.9 (range = 3.7 to 4.5). "Clinical content" had the highest average score (4.5); "Directions" (4.1); "Comfort for user" (3.8); and "objective data" (3.7). Participants made relevant suggestions to improve the system feasibility and appropriateness.

Conclusion:
The evaluation data reported here informed decisions to improve functionalities of the system, and plan a training program as part of the system implementation.

References:
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356 ELECTRONIC SYSTEM FOR CLINICAL DOCUMENTATION OF STRUCTURED NURSING DIAGNOSIS, RESULTS, AND INTERVENTION: PROCENF - USP

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Introdution:
Electronic nursing documentation constitutes technical, scientific, legal, and ethical documents. The aim of this study was to develop an electronic system for nursing documentation supporting adult clinical and