

Standardized Nursing Data and the Oncology Nurse

Jenny Alderden, APRN, MN, CCRN, CCNS, and Mollie Cummins, RN, PhD, FAAN

Oncology nurses are experts in conducting comprehensive assessments of symptoms and patient responses to treatments, but documentation in electronic health records frequently results in data that cannot be readily shared or compared because of a lack of standardization of the terms. Standardized nursing terminology can enhance communication among nurses and between nurses and other members of the healthcare team. It can improve care coordination and may enable nurses to capture and make visible the unique, holistic perspective that they provide to patient care. Standardization also is important for large-scale data aggregation, which will enable healthcare teams to learn about particular subsets of patients so that care can be tailored to individual characteristics and responses.

At a Glance

- In 2015, the American Nurses Association (ANA) published a position statement that reaffirmed support for the use of ANA-recognized terminologies in an effort to facilitate interoperability of the data collected by nurses.
- Within individual healthcare organizations, immediate benefits of standardization include improving communication, capturing the value of what nurses really do, and improving patient care.
- Nurses need to understand the importance of standardized nursing documentation and, where necessary, gain the knowledge and skills necessary to champion the inclusion of nursing data in standardization efforts.

Jenny Alderden, APRN, MN, CCRN, CCNS, is a PhD candidate in the College of Nursing and Mollie Cummins, RN, PhD, FAAN, is an associate professor in the College of Nursing and Department of Biomedical Informatics, both at the University of Utah in Salt Lake City. The authors take full responsibility for the content of the article. The study was supported, in part, by awards (T32NR01345 and F31NR014608) from the National Institute of Nursing Research of the National Institutes of Health. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. No financial relationships relevant to the content of this article have been disclosed by the editorial staff. Alderden can be reached at jenny.alderden@gmail.com, with copy to editor at CJONEditor@ons.org.

Key words: electronic health record; standardized nursing terminologies; nursing documentation
Digital Object Identifier: 10.1188/16.CJON.336-338

Although electronic health records (EHRs) are in common use, the data that nurses record in EHRs rarely are used to their full potential. Customization of commercially available EHR systems or development of propri-

etary EHRs for specific health systems frequently results in data that cannot be readily shared or compared because of a lack of standardization of the used terms (Scherb et al., 2013; Westra et al., 2015). For example, a nurse who charts

that a patient has severe nausea in one organization's EHR may be using different criteria than a nurse who charts severe nausea in another organization's EHR, or even in a different clinical unit within the same organization. However, if the nurse documenting severe nausea does so using agreed-upon standardized nursing terminology, then the information will have the same definition across clinical settings.

Standardization of clinical nursing data is particularly important in oncology because oncology nurses are experts in conducting comprehensive assessments of patients' symptoms and responses to treatments. The detailed patient-level data that oncology nurses produce have the potential to transform oncology care by allowing clinicians and researchers to learn from the care being provided on a routine basis, and to evaluate outcomes and make adjustments in care processes (Corwin et al., 2014). This type of "virtuous cycle," in which routinely collected data are used to continually build knowledge and improve patient care, depends on adequately structured data collection. If the data also are standardized and coded in a way that enables their aggregation and interpretation alongside data from other healthcare organizations, nurses are able to learn from routinely collected clinical data across organizational boundaries. This interoperability, or the ability of disparate information systems to share and use data, is the key to creating such a learning health system.

The potential of a learning health system to lower costs and improve outcomes in the U.S. healthcare system is widely recognized among thought leaders and