Text Responses

7B. What other ED(s) do you work in?

ONLY Park City and Heber Valley EDs, NOT Garfiled as selected above
Park City, Heber Valley
Heber and park city- not bear river
2 different in az
Heber
only heber and park city... not listed above
Park City / Heber Valley
Heber
Not intermountain
Heber
Heber
Heber. but I only do PC and Heber prn. mostly work outside of IHC
Heber

8B. Where else do you work?

Clinic
inpatient, clinic, administration
Clinic
BRVH as hospitalist and WorkMed
Revere Health clinic, Delta
All areas of hospital and clinic.
Clinic and inpatient
Clinic, inpatient
Clinic, obstetrics and hospice care
Clinic, Inpatient
Inpatient and Clinic
Hospitalist in Logan
Inpatient and Clinic
Wayne Community Health Center in Bicknell Utah
non IHC
Urgent Care

11B. Please tell us why you have never used ePNa.

I think this is a new, with in the last yr app. I am currently serving a Mission for the Church of Jesus Christ of Latter Day Saints, and do not remember being exposed to this application

It's more of a maybe.... I'm not really sure if I have used it. Certainly have not used much. I am worried about this because I'm not terribly familiar with the workflow. I feel that I can get the right antibiotics started fairly quickly by just using current iCentra. I use the pneumonia order set when admitting and that seems to cover well (at least this is my assumption)

I have not worked a shift with a pneumonia complaint since

No recent opportunity.

I have not had any patients with pneumonia recently, or rather since its introduction.

Have not had patient where it applied

I rarely work at PC or Heber

29. What ideas do you have for improving the ePNa tool?

Get rid of it

Clearly show what will show up on my note (autopopulate) before I sign anything related to the ePNa tool.

It still is somewhat cumbersome to use. Sometimes, I am not sure if it has all the information it needs to make a complete assessment

Give more options for certain allergies (e.g. PCN allergic but tolerates doxy) in Mod Outpt.

Regarding question 6, my ED was not an option, so it forced me to choose one that was incorrect.

It has become better over time, but still would like to have less "clicking" and for the windows to flow better.

I would love to know more about the criteria used, or if I could insert values. For example, if my initial evaluation did not include bloodwork, I am missing data points. I would love to be able to put in false numbers to determine anticipated treament assuming a certain value (or if treament options were based on ranges clearly defined and associated with treatment plans)

Combine it with inpatient admission process. I no longer work in the ER but receive patients often for admission through the ER. I would love to see it useful for admissions, as well. (I admitted someone yesterday with pneumonia but the tool didn't apply to my portion of the care, which is typical.

Include antibiotic recommendations based off local antibiogram data for resistance, including recommendations based off patient comorbidities and allergies.

Since it is not a part of our normal workflow it is just hard to remember and follow.

My biggest concern is that multiple times, it has recommended treatment in a patient that does not have pna. I've had several patient with relatively normal labs, atelectasis which radiology has noted to be unlikely for pna but then ePNA recommends treatment. Sometimes the order set is hard to use. I sometimes find myself just ordering treatment from the quick orders tab.

Can we scrap it and just use pneumonia ordersets instead?

Does not account for deviations in practice, such as recent atbx use, how sick or clinically looks, etc

30. What changes, features or information would help you use the ePNa tool on more of your patients with suspected pneumonia?

If we have to have it, make the program straight forward and not so time consuming as it is interfering with patient care, as all of these e warnings, are making it more dangerous for the patient in the long run, more time spent clicking thru a very awkward user unfriendly program instead of taking care of the patient. this happens to the nurses too, more busy trying to get blood cultures address time protocols instead of trying to resuscitate them and address abnormal vital signs.

None. I always use it.

Automatic pop up

Having the tool flow between ED and Admission order sets. As a courtesy we will write the admission orders for the admitting physician, and use the pneumonia HOS set. In doing both, the orders make it look like we are doubling the orders for Abx.

the green P is small. oh, so small. can it flag as a critical value (like I get critical d-dimer, etc)?

Nothing new

Include antibiotic recommendations based off local antibiogram data for resistance, including recommendations based off patient comorbidities and allergies.

Somehow make it more in line with regular workflow. How to do this I don't know.

It needs to be more accurate.

This needs to be streamlined and work more smoothly. Half the time I need to go into ePneumonia because it doesn't pick up on pneumonia cases, and it also frequently wants to send home a hypoxia patient who clearly needs hospitalization.

None

31B. Please explain what kind of clinical decision support tools you would be interested in.

UTI treatment Cellulitis treatment

Asthma, DKA, CHF

HEART score for chest pain

For all CPMs relevant to the ED

Sepsis

I now use pediatric head injury. I am open to many, but publicizing them will be key.

Chest pain, cellulitis, abdominal pain

It really depends on if they are easy to follow and flow well. Any decision support took has to be intuitive to use and flow well with regular work.

Stroke, MI, Sepsis, Trauma

Dizziness / Vertigo in the ED

Curb 65, PESI score

PE, cardiac syndromes, syncope

Clinical decision tools are best for rare but critically important things, such as toxins, radiation exposure, preeclampsia/ eclampsia, or intracranial hemorrhage. Pneumonia seems a bit bread-and-butter.

As long as clinical judgement continues to trump the tool and we are not ding'd for nonadherence.

31C. Please explain why you are not interested in more clinical decision support tools.

As stated above, not supportive, just one more straw on the camel's back.

I suppose it would be nice to have more decision support tools but it seems like there are many different sources of information including care process models and also other literature searches such as up-to-date or the Sanford Guide that make it somewhat cumbersome to find the best protocol. If the absolute best protocol was integrated into a Sentra for the majority of conditions we encounter that might be useful.

Our push to use LR instead of NS ...in the past 2 months I have had 6 patients with hyponatremia. I have stopped using LR first while I wait for labs...massive fluid resuscitations sure

Clinical decision support tools can be a beneficial resource, but need improved recognition for prompts as they are more helpful the closer they actually pertain to the clinical picture.

I want something that is more useful.

Cumbersome and more to worry about

Not looking to replace physician judgement any further, is aim of IHC to staff care environments with less qualified and cheaper staff (ie PA, NP vs MD) by having them rely on DS tools instead of training? Probably