An Electronic Health Record Interface for Clinician Use in Inpatient Settings During Rounds

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Acknowledgements

I would like to thank my thesis advisor, Professor Barbara Grosz, for being so receptive of my wish to get involved with her research and for her continued mentorship, guidance, and encouragement. I thank Shiri Assis-Hassid for her feedback and support and for regularly dispelling my confusion about my own work. I would like to thank Dr. Jody Lin, Dr. Lee Sanders, Dr. Hermioni Lokko, Dr. Katherine Rose, Dr. Yoshio Kaneko, and Sheila Enamandram for providing feedback on my designs. I would like to thank my mother for her daily words of encouragement. I would also like to thank my friends for their moral support.
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Chapter 1

Introduction

1.1 Project Motivation & Definition of an EHR

In every sector, technology is changing the way people interact with each other. In medicine, electronic health records (EHRs) digitize paper patient records to prevent information loss, increase access to information, and improve clinicians’ understanding and retention of patient information. EHRs combine many elements of a patient’s medical record, such as medication and allergy lists, past test results, and consultant notes with the ability to prescribe medication, complete orders, and input new notes, ultimately, with the goal of enhancing a clinician’s ability to treat patients [1]. However, EHRs can only enhance a clinician’s ability to treat patients if their design is intuitive and reflective of specific clinician needs, which is not always the case.

The recent adoption of EHRs in the United States was motivated by forces external to clinicians. The Health Information Technology for Economic and Clinical Health (HITECH) Act, within the American Recovery and Reinvestment Act of 2009, took effect when only 10% of United States hospitals had basic EHRs. The goal of the HITECH act was to increase the adoption of EHRs by subjecting hospitals that had not adopted EHRs by 2015 to fines. As a result, by 2015, 84% of U.S. Non-Federal Acute Care Hospitals had basic EHRs [17]. However, adoption does not automatically translate into enhancement. Current EHRs adopted during this transition are difficult to navigate and do not account for clinicians’ needs. This incompatibility between the system’s requirements and clinicians’ needs overburdens clinicians in the patient room and encourages behavior that is antithetical to the EHR goals [18].
EHR interface designs that fail to support clinicians’ needs force them to find workarounds, such as handwriting notes on paper, and increase their chance of experiencing clinician burnout, all of which lead to patient safety issues [6, 9]. This potential for patient harm makes it vital to design an EHR interface that supports clinicians’ workflow. This thesis focuses on supporting clinicians through the use of EHRs in inpatient settings during rounds.

I decided to focus on EHR use during rounds, because many problems that clinicians encounter with EHR interface designs are exacerbated when clinicians are interacting with patients under time pressure. Rounds are a critical and short period for the care team and the patient to share results, patient status, and upcoming events. The goal of the thesis is to design an EHR interface for rounds that improves clinicians’ rounding experience.

1.2 Literature Review

In an effort to address the interface design issues in current EHRs, researchers in informatics and design have worked with medical professionals to identify specific problems resulting from the use of EHRs in hospitals [3-9]. These studies informed me of the problems with current EHRs.

Through surveys, interviews, and contextual inquiry, the studies pinpoint reasons why clinicians, medical students, nurses, and attending clinicians have trouble using EHRs. These reasons vary from physicality and location of the system, to unintuitive interface designs and lack of support. In terms of physicality of the system, most literature studies EHRs that are located on desktop computers [3-6] though a few use iPads [7]. As a result of desktop computers’ immobility, clinicians are required to allocate additional time at the end of their shifts to enter information into the EHRs [3,4]. Clinicians’ frustration in response to the isolated location of the EHRs is only
exacerbated by interface designs that force them to click through many pages to access relevant information [5]. Additional interface design problems include inflexible note taking and data input, resulting in clinicians resorting to handwriting notes on paper, increasing the likelihood of error if, and when, they are transferred to the EHR [6].

The problems that arise through the use of EHRs differ depending on the context in which they are used. The inpatient setting is complex by nature, with patients often staying several days or weeks, resulting in the accumulation of many clinical notes and test results. Within the inpatient setting, I focused on EHR interface design problems that occur during rounds. Understanding the workflow of a clinician during rounds—including the timeline, goals, and tasks—helped identify which usability problems were relevant to this thesis. EHRs are used by clinicians in the patient room mostly to share information with care team members and with the patient rather than to input new information [8,9]. As a result, the design solutions in this thesis focus heavily on information extraction.

Existing literature maps out the workflow of clinicians, with and without EHRs, during their rounds. Lin [8] studied the distribution of work between team members during rounds which allowed him to propose EHR interface design suggestions for specific moments in the workflow. Collins [9] focused on the use of EHRs before, during, and after rounds. By charting the clinician’s actions during rounds, without EHRs, I was able to understand the clinician’s responsibilities and work habits.

1.3 Problem Statement & Project Scope

Current EHR designs do not sufficiently support clinicians in the patient’s room. Specifically, EHRs disrupt the clinicians’ workflow and require them to allocate additional time
to input information into the system after rounds. Existing literature [8,9] reveals that when EHRs are used in patient rooms, they are used to share information and take quick notes rather than to enter or organize information, but current designs do not facilitate these tasks. The objective of this thesis is to present an EHR interface design that maximizes clinicians’ engagement with the patient by minimizing the time needed to extract information from the interface, accommodates clinicians’ existing practices, and dynamically integrates information. This thesis identifies several design choices that successfully reflect the design objectives by presenting a relevant subset of information, dynamically integrating data, and prioritizing visualizations when appropriate. This thesis builds on the work done by Assis-Hassid et al [24].
Chapter 2

Methods & Tools

2.1 Design Objectives

Current EHRs do not sufficiently support clinicians during rounds, because the systems are created to store structured patient information and do not account for clinicians’ rounding practices. I present three design objectives for this thesis which aim to change the clinician rounding experience through a novel EHR interface design. The objectives are to design an EHR interface for rounding that:

1. Maximizes the clinicians’ engagement with the patient by minimizing the time spent interpreting results.
2. Accommodates clinicians’ natural behaviors and desired actions.
3. Helps clinicians interpret and extract information by integrating traditionally separate components.

2.2 User-centered Design Process

Within the EHR interface design, the design objectives are realized through design choices. The design choices emerged from the design objectives through an iterative process of user-centered design. User-centered design (UCD) believes that users of a system, not the designers, are the most knowledgeable about the needs of the users. The UCD process allows designers to uncover the user’s needs and translate these into a design. The UCD process can be separated into
three phases: inspiration, ideation, and implementation [20]. This thesis focuses on the first two phases.

The design objectives were formed during the inspiration phase from existing literature on the usability problems in EHRs and a qualitative study conducted by Assis-Hassid [24]. Design choices were made, evaluated, and refined during the ideation phase. For this thesis, the ideation phase included an iterative process of prototype development and user feedback. Prototypes were used as a tool to simulate a scenario for users. Through this scenario, I was able to identify strengths and weaknesses of the design [20]. The form of each prototype differed depending on the stage in the process, but feedback on each prototype helped answer the following questions:

1. What patient information is relevant to the clinicians as they are rounding?
2. How should this information be visualized and integrated?
3. How do clinicians see this design fitting into their existing rounding routines and practices?

The answers to these questions helped justify design choices that bring the EHR interface closer to achieving the design objectives. Chapter 3 outlines the first two prototypes and the feedback for each prototype and Chapter 4 discusses the final design prototype and feedback on the final design.

2.3 Tools

I used PowerPoint to design Prototype 1 and Adobe XD (Experience Design) for Prototype 2 and the final design. I used Adobe XD to create interactions between buttons and screens. For each prototype, I used patient medical information from the MIMIC-III dataset of anonymized clinical records [21]. I developed an interview guide (Appendix A) for the first interview to understand the clinician workflow and get feedback on the prototype. The interviews for Prototype
2 and the final design focused only on design feedback. For Prototype 2 and the final design, the users performed different tasks (Appendix B) to help elicit feedback.
Chapter 3
Design Process

3.1 Prototype 1: Key Components of the Interface

Prototype 1 (Figures 1-3) presents multiple visualizations of various components. Components are individual pieces of patient information like medication list, clinical notes, and lab results, whose visualization affects a clinician’s ability to understand a patient’s health status. The components represented in Prototype 1 are repeated across Figures 1-3 with different visualizations, but each Figure does not represent a complete EHR interface screen. As a result, the prototype focuses on the functions and information that should be included in the design to accommodate the behaviors and actions of clinicians (Objective 2) and to understand how to organize components (Objective 3) before moving to a complete EHR interface screen in Prototype 2. All prototypes assumed that the clinician would be using a tablet to access the system.

3.1.1 Prototype 1: Design Walkthrough

Figure 1 is designed to highlight the difference between textual and visual representations of information and to consider the possibility of automating information organization. Figure 1 is divided into two halves. The top half shows text integrated with visuals, with an automatic selection of potentially important information. The visuals are intended to help the clinician synthesize information, so that he or she can spend less time on the screen (Objective 1). The bottom half includes only textual patient information to get feedback on the type of information that is relevant to display in this context (Objective 2).
The top half of Figure 1 shows a short summary of the patient demographic information, reason for hospital admission, and patient medical history. Below the patient summary, a blue header displays five buttons. These buttons represent a subset of patient documents and an automatically aggregated set of recommendations. Four of the buttons are grey to denote that the documents are displayed below the header. The documents are chosen based on perceived relevance, but the clinician can change which documents are automatically displayed. The automation aims to minimize the actions required of the clinician to maximize his or her ability to engage with the patient (Objective 1). Within the document display, the CT Scan is paired with the impression note about the CT Scan and the information in the Cranial Nerve Exam is separated based on body part and linked directly to that body part in the diagram. Both of these choices group related information to help the clinician synthesize results (Objective 3). Between the blue header and the Cranial Nerve Exam, there are three boxes that correspond to the Recommendations button. Recommendations automatically aggregates information from patient records to suggest a care plan for the patient.

The bottom half of Figure 1 contains multiple patient documents. There are three sections of notes: History of Present Illness, Most Recent Physical Exam (objective patient measures), and Pertinent Results (consultant notes and images). None of the files displayed are condensed or summarized and the clinician must click the graph icon or image icon to see graphs and images in a separate page. An integrated EHR interface design would not contain this much text, but this visualization helps get feedback on the amount of text that should be displayed and the importance of numerical and textual information when displayed with graphs and images (Objective 3).
**Patient Info & History**
- **Name:** John Doe
- **Age:** 62
- **Address:** 123 Main St, Anytown, USA
- **Phone:** 555-1234
- **Allergies:** None

**History of Present Illness:**
John Doe was admitted to the hospital with a complaint of left-sided headaches, nausea, vomiting, and difficulty with vision.

**Past Medical History:**
- Hypertension
- Diabetes
- Asthma

**Social History:**
- Smoker
- No alcohol consumption

**Family History:**
- Father: died of heart attack at 65
- Mother: alive, no health issues

**Chief Complaint:** Left-sided headaches, nausea, vomiting

**Chief Exam:**
- **Cranial Exam:**
  - Pupils: equal and reactive to light
  -
- **Neurological Exam:**
  - Motor: 5/5 both sides
  - Sensory: intact

**Physical Exam:**
- Blood Pressure: 120/80
- Pulse: 70
- Temperature: 98.6°F
- **Cranial Nerve Exam:**
  - I: Extraocular movements: full
  - II: Pupil: equal, reactive to light
  - III-VII: Grossly intact
  - VIII: Normal cerebellopontine angle
  - IX: Normal gag reflex
  - X: Normal phonation
  - XI: Normal neck flexion
  - XII: Normal neck flexion

**Relevant Tests:**
- **CT Head:**
  - Impression:
    - **Pre-operative:**
      - Status post left frontal craniotomy for resection of a 3 cm left parietal area dominant glioblastoma.
      - The tumor is moderate size with surrounding edema and mass effect.
    - **Post-operative:**
      - Status post left frontal craniotomy for resection of a 3 cm left parietal area dominant glioblastoma.
      - The tumor is moderate size with surrounding edema and mass effect.

**Plan:**
- Continue post-operative care
- Monitor for any signs of increased intracranial pressure
- Discharge planning

**Figure 1**
[Image of a smiling face with cranial nerves labeled]
The top half of Figure 2 shows Patient Information and History, Medication Timeline, Patient Vitals, and Patient Lab Results. The Patient Information and History is organized in a square box; this distinguishes itself less from the other components than the rectangular box used in Screen 1 did. Below Patient Information and History, the patient’s current medications are displayed graphically in Medication Timeline. Each medication is graphed starting from the prescription date and includes dosage information and side effects. The clinician can also search drug interactions between medications. Patient Vitals displays the last four days of five vital measurements, four are displayed numerically and one, blood pressure, is displayed both numerically and graphically which helps the clinician interpret the changes in measurements. Below Patient Vitals, Patient Lab Results charts recent lab results. The results are separated based on result type and, for each document, there are categories for images, values, and comments, so the clinician does not even need to open the document to understand the results (Objective 1).

The bottom half of Figure 2 includes two different visualizations of Patient Documents, an Imaging Result, and an open Clinical Note. The Patient Documents visualization in the top left corner lists the documents and includes an icon to show if a document is currently open (concentric circles) or has been opened (check box). The second Patient Documents visualization in the bottom left corner displays the documents graphically and separates them into different categories (e.g., notes, results, new diagnoses). The separation of documents into categories helps track the patient’s hospital journey. Clinical Note by Dr. Y formats the note by topic and synthesizes the information to make all the information visible in the allocated space.
Figure 2

Patient Info & History

Patient Name: [Redacted]
DOB: [Redacted]
Sex: [Redacted]
Chief Complaint: [Redacted]
Service: [Redacted]
Attending Name: [Redacted]

Major Surgical or Invasive Procedure: E.g., colonoscopy, bronchoscopy
History of Present Illness: 71F with history of CHF, CAD, with on abutment, ESRO on HD and COPD presenting with pain, swelling and edema in the left leg. Patient has had chronic ulcers at the left and right leg since last [Month] and had been seen by me for 2 weeks complicated on [Date] 10 days noted increased swelling and pain in the left calf which had changed from previous baseline...
Past Medical History: Hypertension, Hyperlipidemia, Obesity, Colorectal Polyps
Social History: Former tobacco [Date] pack per day x 25 years, previous alcohol use: quit 2 years ago, denies recreational drug use or other toxic habits; lives alone, is able to complete her ADLs.
Family History: Mother with 'heart trouble'

Medication Timeline

Pre-admission 3/10/16
3/10/16
3/11/16
3/13/16

Symp: dosage info, side effects

Diarrhea: dosage info, side effects

Query Drug interaction between: Sensa-Chek
Search of side effects

Patient Vitalis

<table>
<thead>
<tr>
<th>Date</th>
<th>Temperature</th>
<th>Blood Pressure</th>
<th>Pulse</th>
<th>Respiration</th>
<th>O2</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/10/16</td>
<td>98.2</td>
<td>80/130</td>
<td>65</td>
<td>26</td>
<td>98%</td>
</tr>
<tr>
<td>3/11/16</td>
<td>98.6</td>
<td>90/140</td>
<td>63</td>
<td>25</td>
<td>98%</td>
</tr>
<tr>
<td>3/12/16</td>
<td>98.0</td>
<td>80/130</td>
<td>72</td>
<td>25</td>
<td>98%</td>
</tr>
<tr>
<td>3/13/16</td>
<td>98.6</td>
<td>80/130</td>
<td>65</td>
<td>26</td>
<td>98%</td>
</tr>
</tbody>
</table>

Patient Lab Results

<table>
<thead>
<tr>
<th>Date</th>
<th>Imaging Values</th>
<th>Blood Values</th>
<th>Other Lab Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/10/16</td>
<td>Serum 13.0</td>
<td>Lactate 2.0</td>
<td>NEF 0.7</td>
</tr>
<tr>
<td></td>
<td>Calcium 8.9</td>
<td>Potassium 1.4</td>
<td>Mg 1.8</td>
</tr>
<tr>
<td></td>
<td>Fosfomycin 6.3</td>
<td>NEF 0.7</td>
<td>Lymph 10.2</td>
</tr>
<tr>
<td></td>
<td>Nevirapine 6.3</td>
<td>NEF 0.7</td>
<td>Monon 6.3</td>
</tr>
</tbody>
</table>

Clinical Note by Dr. T — 3/10/16

- Secondary to metastatic disease to the brain
- Patient evaluated by Radiation/Oncology, and it was decided that the patient would receive a total of seven treatments of whole-brain radiation therapy
- Maintained on Octreotide, as well as Dianetics, patient had no seizure activity while in the hospital; tolerated Octreotide well and tolerated whole-brain radiation therapy without any complications
- Discharged on a living wage, lansoprazole; weight increased to a total of 300 pounds a day, given that her Dilantin level (II) was 1400.0, I was only 18
- Will record her Dianetics level followed as an outpatient at next appointment.

Hyper tension

- BP 120/70 while in DR, once transferred to the floor, maintained well control Rx (Timolol, Hydrochlorothiazide, Minoxidil, Hydralazine, losartan 400 mg)
- BP remained in 160-160 systole – this was an appropriate range given that patient needed to have adequate perfusion in the face of an increased intracranial pressure.

Cellulitis

- Initially maintained on Vancocin, later changed to Kefax, did not develop any rash or other complications
- Kefax, cellulitis improved by time of discharge

Renal Insufficiency

- Creatinine remained at baseline: 1.4-1.5

Coronary Artery Disease

- Maintenance on oral coated Aggrenox, diltiazem, used for myocardial infarction, and electrocardiograms remain subnormal with no T wave changes

FEN

- Maintained on diet with fluids, tolerated w/o events
- Electrolytes followed daily and rested as needed with monitored therapy

Paremyxonic Atrial Fibrillation

- Patient is paced, rate controlled
- Held off all anticoagulants given her metastatic disease to the brain.

Figure 2
Figure 3 has several of the same components as Figure 2. The new components are *Medical Paper Search*, *Patient Comparison*, *Blood Pressure by Day*, *Clinical Note by Dr. Y*, and *Hospital Course Timeline*.

*Medical Paper Search* displays the titles of two papers based on a medical query and includes a summary of each paper. This feature is based on work by Elhadad et al. [23] and would help the clinician quickly understand the queried information (Objective 3). *Patient Comparison* uses different patient features to determine similarity between patients to see how a change in medication might affect one patient based on how similar patients have reacted. Both *Medical Paper Search* and *Patient Comparison* offer desirable features to the clinician, but they might require too much time and thought (opposite of Objective 1) to be relevant during rounds.

*Blood Pressure by Day* presents a graph with relevant comments from patient notes embedded in the graph. The clinician can read comments related to a change in the patient’s vital signs while looking at the graph.

*Clinical Note by Dr. Y* differs from *Clinical Note in Screen 2*, because it is not summarized. The non-summarized note is separated into sections which the clinician clicks to expand. This change was made to see how important complete sentences are to a clinician when reviewing notes.

*Hospital Course Timeline* charts patient events by date. The timeline represents the patient journey by combining subjective and objective measures compiled during the patient’s stay. The patient event categories are complaints, procedure, medication change, lab results, and location. This timeline automatically combines different types of patient information for the clinician’s benefit (Objective 3).
3.1.2 Prototype 1: Feedback

I conducted an interview with Dr. A, a hospitalist, to get more information about the clinician’s rounding workflow and to get feedback on Prototype 1. The details of the interview process are outlined in Appendix A. Feedback on Prototype 1 helped measure the effectiveness of certain high-level design choices (e.g., patient information and features to include in the EHR) for creating an interface design that accommodates clinicians’ actions (Objective 2) and integrates patient information (Objective 3). The insights that emerged from the feedback are based on one interview with Dr. A, so they do not reflect all clinicians’ or all departments’ practices. I share three insights that emerged from the interview:

1. Clinicians check patient records before entering the patient room, so information displayed on EHRs during rounds should only show a relevant subset of information for clinicians to quickly scan.

   Dr. A reported taking time in the morning to go through each patient record before rounding, so Dr. A enters the patient room knowing the patient’s condition and has notes indicating the goals of the visit. Dr. A does not need to or have the time to look through all the patient’s information when Dr. A is in the patient room. As a result, not all patient data should be presented on the EHR screen during rounds, but the information that is presented should be interpretable at a glance and automatically selected based on relevance.

2. Graphical representations of patient data (e.g., lab results, vitals, document lists) help visualize the patient’s hospital journey and help clinicians quickly interpret patient information.

   By combining temporal and numerical data with visual cues, clinicians are able to more quickly interpret the relationship between data points (Objective 3). This is potentially relevant
for EHR components like patient vitals, lab results, and medication lists. An intuitive representation of these components increases the speed with which clinicians can interpret information in the patient room. *Medication Timeline* and *Hospital Course Timeline* received positive feedback on their concepts, because the visualization of the document lists has a dual purpose of conveying information about a patient’s stay and serving as a way to open the documents.

3. Unstructured, handwritten notes give clinicians the flexibility to record details and reminders as they appear, but they still require clinicians to structure the information as they enter it into the EHR after rounds.

   Dr. A handwrites comments prior to visiting the patient, continues writing on this list in the patient room and then refers to this list after completing rounds. Although this exact style of note taking is not generalizable to all clinicians, it does reveal an intuitive way of capturing information that should be supported in EHRs (Objective 2). In its current form, handwriting notes on separate pages increases the risk of losing information and requires clinicians to add notes into the system later. A digital mechanism that allows clinicians to quickly enter unstructured information would increase the amount of information recorded in the EHR and minimize repeated work (Objective 1).

   The feedback on Prototype 1 indicates that integrating and visualizing patient information (Objective 3) helps clinicians understand the patient’s journey. Clinicians enter the patient room knowing the patient’s medical updates, so they only need to skim results from the screen rather than take the time to interpret the results (Objective 2). Clinicians would benefit from being able
to take notes in an unstructured way on the EHR screen which could then be adapted to fit the structured needs of a clinical note (Objective 2).
3.2 Prototype 2: Interactive Prototype

Prototype 2 factors in feedback from Prototype 1 and presents integrated EHR screens for clinician use during rounds. The interactivity mimics the experience of using a functional EHR to understand how effective the integrated interface design is for quickly extracting and entering rounding information (Objective 1).

3.2.1 Prototype 2: Design Walkthrough

Screen 1 lists all the clinician’s patients for rounds. There are two patient list settings, one for preparing for rounds (Office View) and another for performing rounds (Rounding View). Screen 1 shows the patient list in “Rounding View”. Both settings list the same patients, but show different patient information to reflect the clinician’s needs for rounding and pre-rounding. The clinician clicks “Order Patients by” to order patients by room number, acuity, language, last name, or primary service. Each patient section includes basic patient information, relevant recent updates drawn from overnight notes, and recent results. The clinician can open a patient record by clicking “Open” on the patient’s section, clicking “Start Rounds”, or clicking an icon associated with a recent result.
### Patient List

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Service</th>
<th>Sex</th>
<th>Attending</th>
<th>Last seen by</th>
<th>Recent updates</th>
<th>Recent results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient experience X during the night. Check on Y when you visit.</td>
<td>3/9 Cardiologist Note by Dr. X, 3/9 Imaging Results, 3/9 Blood Results</td>
</tr>
<tr>
<td>Patient 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient experience X during the night. Check on Y when you visit.</td>
<td>2/25 Cardiologist Note by Dr. X, 2/25 Imaging Results, 2/25 Blood Results</td>
</tr>
<tr>
<td>Patient 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient experience X during the night. Check on Y when you visit.</td>
<td>2/25 Cardiologist Note by Dr. X, 2/25 Imaging Results, 2/25 Blood Results</td>
</tr>
<tr>
<td>Patient 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient experience X during the night. Check on Y when you visit.</td>
<td>2/25 Cardiologist Note by Dr. X, 2/25 Imaging Results, 2/25 Blood Results</td>
</tr>
</tbody>
</table>

**Screen 1: Patient List in Rounding View**
Screen 2 displays the patient list in the “Office View” setting. The only difference between Screen 1 and Screen 2 is the additional “Follow-up list” in Screen 2. The “Follow-up list” shows which items are still pending from previous visits.
The clinician arrives on Screen 3 by clicking “Start Rounds” or “Open” from an individual patient summary on Screen 1. The top of Screen 3 is Patient Information and History, which appeared originally in Figure 1 of Prototype 1. Screen 3 is otherwise divided into the left and right side. The left side leaves space to write reminders and the right side contains various patient data. Within Reminders, the clinician selects the pen icon to handwrite to-do items, general notes, and follow-ups on the page. The clinician can even use the pen to markup information outside of the designated Reminders section. The handwritten notes are automatically translated into text. The goal of the handwriting recognition technology is to allow the clinician to take notes as he or she naturally would and then translate the notes into text to improve legibility and keep notes in a format consistent with later documentation needs (Objective 2).

The right side of Screen 3 contains two distinct components: Patient Blood Pressure Information (Active Blood Pressure Medication & Patient Symptoms Potentially Related to Medication) and Recent Results. The clinician uses Active Blood Pressure Medication to see the length that an administered medication is active, as visualized by the blue rectangles that span the active time and contain the medication name, dosage information, and potential side effects. This adds temporal information to a previously static medication list to help the clinician understand more about the patient’s day (Objective 3). Patient Symptoms Potentially Related to Medication does as its title suggests and charts reported patient symptoms, pulled from various notes, across the day to provide additional insights into how a patient is responding to medication. The Patient Symptoms chart is placed below the medication timeline to signal a relationship between the two. Recent Results automatically populates with the latest results that have been added to the patient’s record, which are currently CT Scan and Blood Results. The automatic selection of results prominently presents recent information to minimize the time needed to find the results, since the
The clinician will be most interested in sharing these results (Objective 1). The complete displays of *CT Scan* and *Blood Results* are visible in Screen 4 and 5, respectively, and allow the clinician to compare values with earlier results, see larger images, and write comments.
The “click to compare earlier results” button in *Blood Results* on Screen 3 leads to Screen 4. The blood results displayed on Screen 3 show only a preview of the most recent values, but the clinician might want to know how each value compares to earlier results or normal ranges. As a result, Screen 4 shows the current blood concentration number for each chemical in green if it is in range and red if it is out of range with a supplemental graph for each chemical.

The clinician manually inputs a potential medication, dosage, and blood chemical in *Potential effect of medication change* to see how a change in dosage or a new medication might affect patient vital measurements.
The “click to compare earlier scans” button in *CT Scan* on Screen 3 leads to Screen 5. On Screen 5, the clinician can select multiple scans to view at once and see earlier comments about the scan, if there are any.

**Screen 5: CT Scan**

3/5 #1 Head CT/ce contrast: IMPRESSION:
Status post left frontal craniotomy changes with improvement of pneumocephalus and stable 3 cm left to right midline shift; focus of hemorrhage with/without residual tumor in the resection bed is similar in appearance to prior exam but now with more surrounding vasogenic edema.
Stable appearance of subarachnoid hemorrhage.
Followup to assess for residual tumor/interval change

3/9 #1 CT Head: IMPRESSION:
Expected post-operative changes with the left frontal craniotomy including subcutaneous air and soft tissue swelling, moderate pneumocephalus overlying predominantly the bilateral frontal lobes, and foci of hemorrhage in the surgical bed. No evidence of residual tumor on this non contrast CT.
Clicking the pen icon in *Reminders* on Screen 3 allows the clinician to handwrite notes.

Screen 6 shows an example of what a handwritten note would look like.
After writing a handwritten comment on Screen 6, the comment is automatically translated into text, shown in Screen 7.

Screen 7: Handwritten Reminder Translated into Text
The “Change Information Displayed” button in the bottom right corner of Screen 3 leads to Screen 8. The right side of Screen 8 displays a list of patient documents, so the clinician can manually select documents to be displayed on Screen 3, if the automatically chosen documents are insufficient.

Screen 8: Change Information Displayed
3.2.2 Prototype 2: Feedback

Similar to the interview for Prototype 1, Dr. A was my only interviewee for Prototype 2, so the feedback does not reflect all clinicians’ perspectives. This interview was conducted on Skype, so it was necessary for me to be the intermediary between Dr. A and the prototype as we walked through tasks (Appendix B). The feedback highlights high-level and low-level design choices and EHR component visualizations that affect the usability of the EHR interface design. The feedback is summarized by important EHR component.

Timelines

Timelines refer to components that visualize non-numerical information over time. The medication timeline is displayed alone in Prototype 2, but feedback indicates that integrating it with additional patient information would create a more cohesive view of the patient experience. Initial feedback on Prototype 1 suggested that the specific design of a Hospital Course Timeline might be hard to generalize across patients, but that the idea to visualize a patient’s upcoming and past schedule across different categories would help clinicians structure the visit (Objective 2). The feature could be brought back in a more generalized format as the patient schedule which would enable clinicians to understand the patient journey. A patient schedule, including medication schedule, procedures, and therapy appointments, combines non-numerical data to visualize the patient’s day.

Images

The EHR interface design aims to show, in as few screens as possible, all, and only, the information that the clinician would need during rounds (Objective 2). All features should be accessible from the patient record home screen, but some components require more space to be interpreted. As a result, CT Scan and Blood Results are previewed in Screen 3, but expand into
their own screens (Screen 5, 6). Prototype 2 shows a thumbnail image of the CT scan on Screen 3 and displays a full size image on Screen 5, if the clinician navigates to that screen. Including thumbnail images, from Dr. A’s perspective, is not an effective use of space, since clinicians need to see a larger image to interpret the results. Although the thumbnail image is not an effective way to convey the CT scan results, it could help the clinician if the purpose is to locate results. In this case, design Objective 1 and Objective 3 contradict each other since the thumbnail image inadvertently speeds up the locating process, but duplicates information and uses valuable space.

**Graphical Displays**

Prototype 2 includes multiple graphs to help clinicians interpret changing information. Dr. A noted that the Blood Results measurements have such small variations and many clinicians have these ranges memorized, so graphs are not an effective way of helping clinicians interpret the changes. There are other, non-graphical representations (e.g., colors, arrows) that might be better suited for certain situations. The choice to include or exclude graphical displays, depending on context of the information will be important in creating an interface that clinicians can quickly use (Objective 1).

**Reminders**

*Reminders*, in Prototype 2, allows the clinician to take unstructured notes while he or she is in the room with the patient. Dr. A mentioned that Dr. A normally makes a patient comment or to-do list prior to rounding to bring in the patient room to continue taking notes. Dr. A suggests that this functionality could be replicated in the EHR interface design by pre-populating *Reminders* with notes that the clinician took on patient documents prior to rounding. Although one benefit of *Reminders* is its unstructured nature, Dr. A suggests that organizational features could add optional
structure. *Reminders* helps the clinician by accommodating existing behaviors (Objective 2) and minimizing the note entry work after rounds.

The feedback on Prototype 2 indicates that high-level design choices (e.g., Reminders) facilitate clinician EHR use (Objective 1), because clinicians’ existing behaviors are accommodated in the design (Objective 2). The design choices must now be refined to include dynamic visualizations depending on their relevance relative to other components (Objective 3).
Chapter 4

Final Design

4.1 Design Walkthrough

To understand the workflow and functionality of the EHR interface design for rounding, I will introduce a persona, Dr. James, who will help us navigate through the system in context. Dr. James is spending the morning visiting her patients in their rooms. She started her morning by looking through the EHR system to see what has happened to her patients since her last visit. For each patient, she checked the patient’s vital signs, took brief notes on new results, and made a to-do list relating to the patient’s care plan. Now, she is about to start rounding to check in with each patient, go over results, and share upcoming events and goals. We will walk through the prototype as if we are with Dr. James while she is in the room with a specific patient.

Dr. James opens the EHR to Screen 1 which displays the list of patients with basic information about their care team, recent results, and recent updates. The information paired with the patient name is selected to remind Dr. James about the patient’s history and current health status. Dr. James can also easily open recent results from the patient list. From Screen 1, Dr. James can click “Start Rounds” or “Start in Office View” which result in different visualizations of the same patient record. Dr. James used “Office View” when she was looking over patient information before rounds. Now that she is doing rounds, she can directly “Open” a patient file or she can use “Order Patients by” to choose an order to organize the patients by such as room number, last seen, attending name, or language spoken. Dr. James can also manually organize the patients or switch the ordering using the arrows on the left side of Screen 1.
After choosing an order, Dr. James selects “Start Rounds” and arrives on the patient record (Screen 2) for Tyler Pat, the first patient on her list. Dr. James can access all EHR features from this page which maximizes time spent focused on the patient (Objective 1). The top part of Screen 2 displays Tyler’s background information (e.g., date of birth, reason for admission, and allergies). On the lower right side of Screen 2, Vitals displays Tyler’s pulse, weight, temperature, and blood pressure in four quadrants. Dr. James can easily see Tyler’s most recent vitals, displayed in numerically in green (to indicate that it is in the normal range) and she can also use the graph to see how today’s values compare to previous values. This visualization combines graphs with numerical data and visual cues (colors) to help Dr. James quickly interpret information (Objective 1).

Dr. James looks at Tyler’s Calendar, above Vitals, to see any upcoming events for Tyler. This calendar combines different types of events like medicine schedule (including the duration
that the medicine is active), procedures, and therapies. The calendar allows the care team and the patient to visualize upcoming events and make plans for the day. Combining the patient medication schedule with other events shows a more complete picture of when the care team will be in contact with Tyler.

Next to Tyler’s Calendar, Dr. James sees a section called Recent Results. CT Scan (3/9/15) and Blood Results (3/9/15) appear in this section. The information contained in Recent Results changes dynamically when new information is added, so only a few documents appear in this section at a time. The information displayed for each document represents a preview of the newest information. The purpose of Recent Results is to group together information that clinicians will likely want to see at the same time (Objective 3). For each recent result, Dr. James can select “click to see X” to see a document-specific page with multiple images, results, or notes across different dates.
On the left side of Screen 2, Dr. James can view her Comments. This section is separated into pre-rounding and rounding comments. The pre-rounding comments were written by Dr. James while she was viewing the patient’s file in “Office View” (Objective 2). These comments might be linked to a specific patient document; if this is the case, then the left header for the specific comment will indicate the document on which the comment was made and Dr. James can select “open” to see the comment directly on the document. This EHR interface assumes that the user is using a digital pen to handwriting notes on the page. The system translates the handwriting into text, extracts it from specific documents, and places it in the pre-rounding comments section; this accommodates clinicians’ natural behavior of handwriting notes (Objective 2), but also considers the system’s need for structured input from rounds. The items written in the Rounding section are also automatically transformed from handwriting to text and are placed under the previous comment at the bottom of the section, so as not to disrupt the note-taking process (Objective 1).
Final Screen 3

Final Screen 4
In the CT Scan example in *Recent Results*, Dr. James must “click to see” the CT Scan images. In this scenario, *Recent Results* indicates that there are new CT Scans to view, without showing a preview image, and Dr. James can click to see the recent CT Scan as well as past scans, if she chooses (Screen 5). This CT Scan comparison easily displays scans which might reveal information about the most recent results (Objective 3).

In the Blood Results example in *Recent Results*, only the most recent test results are displayed on Page 2 (Objective 2), but if Dr. James wants to compare the values to previous days, she can “click to expand results” to see current and previous values (Screen 6). Now, Dr. James has the option of looking at blood results across different days. She is able to filter the results and search for specific dates or measurements. This comparison feature expands within the primary page (Screen 4) instead of opening in a new window. This expansion decreases the number of clicks that Dr. James needs to get from one function to the next and increases engagement with the
patient, because she can compare the Blood Results and then select another component from that screen.

All Records, initially displayed on Screen 2, contains all the past clinical, nursing, and consultant notes, imaging results, and lab results, organized by record type. If Dr. James wants to see any number of Tyler’s records, she can simply select the desired ones and click “view selected.” This opens a new page where she can see the records side by side and take notes on this page or on the records themselves (Screen 7).
## Final Screen 7

### Back to Patient List

| Patient Info & History | Patient Name: Tyler Pat  
Attending: Dr. Jones  
RN: Ann Prince  
Room #: 312  
DOB: 03/12/1963  
Sex: Male |
|------------------------|-------------------------------------------------|
| Reason for Admission: neurological problem, couldn’t stand  
Last seen by: Attending Clinician X on 3/8/15 |
| Allergies: No known allergies  
Family History: NC  
Social History: Lives with his wife. Retired, works parttime driving a school bus. |
| Past Medical History: Cardiac arrhythmia, pacemaker in place, prostate cancer with prostatectomy, and hypertension |
| | **View Selected** |

### Rounds 3/6/15

**Acute on chronic systolic heart failure:** The patient was hypovolemic on exam with elevated JVP and increased abdominal distention at presentation. Given the patient had been refractory to diuretic therapy requiring intravenous inotropic support during her last hospitalization and was oliguric and hypotensive on admission, ultrafiltration was initiated rather than diuretic therapy. She experienced significant muscle cramping and hypotension while on ultrafiltration requiring dopamine. CVP was discontinued on HD2 and she was diuresed with IV lactate and metronidazole. Pressure improved and she was weaned off of dopamine. It was noted that urine and blood pressure improved when the patient was in atrial fibrillation with second degree atrioventricular block. Therefore the patients pacemaker escape rate was lowered to allow for increased native rhythms and the mode was changed to AAI. Despite this change urine output remained poor and she was therefore started on a lasix drip ultimately requiring milrinone to augment diuresis. On HD5 patient underwent placement of a tunneled dialysis catheter, and on HD6 she continued HD using the tunneled line (see below). Lactate and metronidazole were discontinued as patient will be HD dependent.

Handwritten notes here

### Final Screen 8

### Back to Patient List

| Patient Info & History | Patient Name: Tyler Pat  
Attending: Dr. Jones  
RN: Ann Prince  
Room #: 312  
DOB: 03/12/1963  
Sex: Male |
|------------------------|-------------------------------------------------|
| Reason for Admission: neurological problem, couldn’t stand  
Last seen by: Attending Clinician X on 3/8/15 |
| Allergies: No known allergies  
Family History: NC  
Social History: Lives with his wife. Retired, works parttime driving a school bus. |
| Past Medical History: Cardiac arrhythmia, pacemaker in place, prostate cancer with prostatectomy, and hypertension |
| | **View Selected** |

### Rounds 3/6/15

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Handwritten notes here

### Final Screen 8
4.2 Final Design Feedback

I conducted three final evaluation interviews, all of which lasted between 30 and 45 minutes. Dr. B was the first interview, Dr. C was the second interview, and Dr. D and E were interviewed together in the third interview. I refer to all interviewees as Dr. X to preserve their anonymity, although one interviewee was still in medical school. Each interviewee has varying experience using EHRs in an inpatient setting; some use it daily in their interactions with patients, while others used it during their residency, or have only used it in a learning capacity. I asked the interviewees to use the prototype to try to accomplish different tasks (Appendix B). I asked the interviewees questions about the design choices throughout the interaction and asked for their overall impression and feedback on the design after completing all the tasks.

The feedback relating to graphical displays, comments (previously reminders), and the document comparison functionality highlight the design choices that work to achieve the design objectives. Future iterations of these components will contribute to improving the clinician’s rounding experience. I explain the principles and considerations that make these effective choices for maximizing clinician engagement with the patient, accommodating clinicians’ behaviors and actions, and integrating information dynamically.

Graphical Displays

Although graphical displays often make numerical data easier to interpret, they also attract attention and require more space to convey information. To highlight only the most relevant information in the record, not everything that can be displayed as a graph should be; the presence of a graph should signify to the clinician that there is something noteworthy to discover.

This claim is supported by feedback on *Vitals*. Dr. B said that the vitals are the first thing that the clinician would want to see, but he or she only needs to notice the abnormal values. Dr. B
suggested positioning *Vitals* in the top left corner (where eyes naturally wander first) or highlighting *Vitals* with color to attract the clinician’s attention without taking up too much space. Dr. D suggests only automatically displaying the graphs for abnormal values in *Vitals* and simply displaying the number for normal values. These suggestions highlight the benefit of using graphical displays to alert clinicians to pertinent information.

Additionally, graphs are not always the most effective way to highlight changes in numerical data. Numerical data impedes clinicians’ ability to quickly interpret results, but additional visual cues can help convey information without being displayed as prominently as graphs. For blood results, visual cues could be distinct colors or exclamation marks (to signal abnormal values) or arrows (to show direction of change). These provide hints for clinicians to interpret changing values (Objective 3). Non-numerical data, such as the medication list, could use visual cues to convey information about when the medication was prescribed, as suggested by Dr. E.

**Comments**

*Comments* supports clinicians’ natural, unstructured note taking process during rounds, but needs a consistent placement across EHR screens to focus clinicians’ attention on the patient and not the location of the notes.

Dr. B and Dr. D liked how *Comments* functions as a to-do list and incorporates notes taken before rounds, respectively. Both of these comments emphasize *Comments*’ accommodation of clinicians’ natural behaviors through its functionality (Objective 2), however, Dr. B and Dr. E suggested relocating and consistently placing *Comments* to create stability that would ultimately help the clinician focus on the patient. The location of *Comments* within the screen must consider its relation to other components.
Document Comparison

The document comparison functionality, for *CT Scans* (Screen 5) and *All Records* (Screen 8), facilitates custom document section to accommodate clinicians’ proclivity for synthesis. All interviewees enjoyed these features for their flexibility. The document comparison functionality directly responds to Objective 2, because the design helps integrate separate information. Opening multiple documents in the same screen can also help clinicians create a map of the patient’s experience.

The feedback suggests that the individual design of the components considers visualization techniques and functionality that make the components easy to interpret and use, but that the cohesion of the components must be improved to purposefully guide the clinician through the information on the screen. Through this cohesion, which considers the order in which components should be viewed and the relative importance of each result, the design will help clinicians use the EHR screen to easily extract information, quickly record information, and thoughtfully engage with the patient.
Chapter 5

Discussion and Limitations

The feedback on the final design highlights specific successes and failures of the EHR interface design that influence how clinicians are able to engage with patients and retain information. The entire design process helped identify specific components and design choices that can improve the clinician experience during rounds, however, there are several limitations to this project. The prototypes relied on anonymized patient data, but this data was a summary at discharge rather than individual documents collected over the course of the patient’s stay. As a result, the prototypes did not contain as much data as would actually be contained in a patient’s file. This sparseness of data made it harder for users to imagine how the EHR interface would translate to their own patients. Although this thesis was based on a qualitative study in which the researchers watched clinicians use EHRs, I did not participate in this study, so I was unable to directly observe the clinicians. As a result, my insights are based on second-hand experience. Despite these limitations, the thesis still presents high-level principles that can be applied to EHR interface design across departments. These principles and considerations account for general clinician workflow, supported by studies and feedback on Prototypes, which can be refined in future design iterations.
Chapter 6
Conclusions and Future Research

This thesis aimed to design an EHR interface for rounding that maximizes clinicians’ engagement with the patient, accommodates clinicians’ natural behaviors and actions, and helps clinicians interpret information by integrating traditionally separate components.

Throughout the design process, I identified three component design choices that should be included in an EHR interface design to achieve the design objectives. These components are the graphical displays, comments sections, and document comparison functionality. The comments section helps clinicians naturally capture critical patient information without preemptively imposing structure on the notes (Objective 2). The document comparison functionality and graphical displays both convey and combine information to help clinicians easily understand a patient’s experience (Objective 3). In future design iterations, these design features can create an interface that maximizes the clinician’s engagement with the patient (Objective 1) by considering how the components should fit together based on the relative importance and flow of information.

This thesis shows several design components that move towards realizing the design objectives, however, there is still much to be done to create an EHR interface design that will fundamentally change and improve clinicians’ rounding experience. The next step would be to redesign the interface based on the feedback on the final design. This iteration would focus on the dynamic visualization of components and could also include patient-facing elements, so that the clinician could use the EHR as an educational tool with the patient. Further improvements could
work to expedite formal note taking processes after rounding. As evidenced by ongoing and past research, EHRs can be improved in many ways to fit into clinicians’ workflow before, during, and after rounds. Any future research that occurs must consider how to create a system that augments the clinicians’ ability to interact with and care for their patients without overburdening them with data.
Appendix

Appendix A

Interview Guide

The goal of this project is to design an EHR interface that will support clinicians’ workflow in the inpatient setting during morning rounds. In preparation for this interview and as a part of the design process, I have spent time reviewing literature on existing usability problems in EHRs. I have discussed findings from Shiri Assis-Hassid’s qualitative study at BWH and I have prepared initial designs of information that might be useful to have in an EHR while doing rounds. By understanding the goals of the clinician and the existing problems clinicians encounter in EHRs, I want to work towards creating a design that does not overburden the clinician while they are in the room and instead allows them to easily access relevant information. At this point in the process, I want to speak to you, as a clinician, to get a first hand understanding of how you prepare for and conduct morning rounds. Additionally, I would like to get your feedback on my initial design ideas. This information and feedback will help me ground my future designs in insights that will allow me to design for the clinician in this specific context.

I would like to use your experience to influence the design of an EHR interface that would help clinicians easily review patient information in real time, and make decisions pertaining to the patient’s plan of care. I would like to use visualization and summarization techniques to transform a patient record into a clinician-friendly dashboard. At the end of the interview, I’d like to share some ideas with you and would like your feedback. Can I ask for your permission to record this interview? Before we get into discussing any EHR systems, I would like to get a general sense, without relation to the EHR, of how you work.

<table>
<thead>
<tr>
<th>Question</th>
<th>Prompts</th>
</tr>
</thead>
</table>

48
1) Can you walk me through your workflow? Starting from when you begin your rounds, and including your interaction with a patient and everything that follows that interaction.  

What decisions do you make during the encounter?  
What do you need to accomplish?

### Workflow & Patient Record

<table>
<thead>
<tr>
<th>Question</th>
<th>Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) What information do you bring with you to the encounter?</td>
<td>i.e., notes about suggested plan of action? Patient lab results? Info about patient?</td>
</tr>
<tr>
<td>3) If you take notes before meeting with the patient, how do you do so?</td>
<td>i.e., do you take notes by hand?</td>
</tr>
<tr>
<td>4) As you are meeting / discussing with the patient, what information do you refer to?</td>
<td>i.e., patient history? Drug interactions/side effects?</td>
</tr>
<tr>
<td>5) If handwriting is used for note taking: What types of information do you handwrite?</td>
<td></td>
</tr>
<tr>
<td>6) How do you keep track of/stay updated on: special events, tasks that need to be carried out regarding the patient?</td>
<td>i.e., do you use a special calendar? Special events = upcoming surgeries, etc.</td>
</tr>
<tr>
<td>7) Is there any information in the patient record that is unnecessary to see while you are in the patient’s room?</td>
<td>I noticed while looking through patient records that info like family history always appears – curious how often certain info is used.</td>
</tr>
</tbody>
</table>

### System Ideas

**Questions**

8) Which features of the proposed interface do you like/find useful?  

9) Which features would not be helpful/would you not use and why?  

10) Are there changes that can be made to the helpful or unhelpful features that would make them more useful/easier to use?

### General Ideas & Feedback

**Question**

11) Do you have ideas for things you would like to see in the system interface?  

12) Anything else you think would be helpful for me to know when designing this interface?
Appendix B

Tasks

You are a clinician doing rounds and are currently in patient X’s room…

- Open a patient’s record.
- Compare their blood magnesium level to the previous week’s and write down any comments.
- Write a comment.
- Compare recent CT Scan to past CT Scans.
Bibliography


