

# Electronic Patient Specific Progress Note Templates to Reduce/Eliminate Documentation Errors

## The Problem

Random audits of general surgery documentation have shown poor compliance with documentation standards. Often notes lacked proper, legible signatures, dates, and/or time stamps with anywhere from 4% to 50% compliance. The current practice among surgical residents is to save an electronic progress note template on a single computer in the hospital which needs to be updated on a daily basis, leading to errors when data is not updated, incorrectly entered, or when this single file is lost.

## Aim/Goal

By linking general surgery progress notes to the existing online team census we are aiming to create a daily progress note template that will allow for better, more complete documentation while increasing efficiency and timeliness of work flow.

## The Team

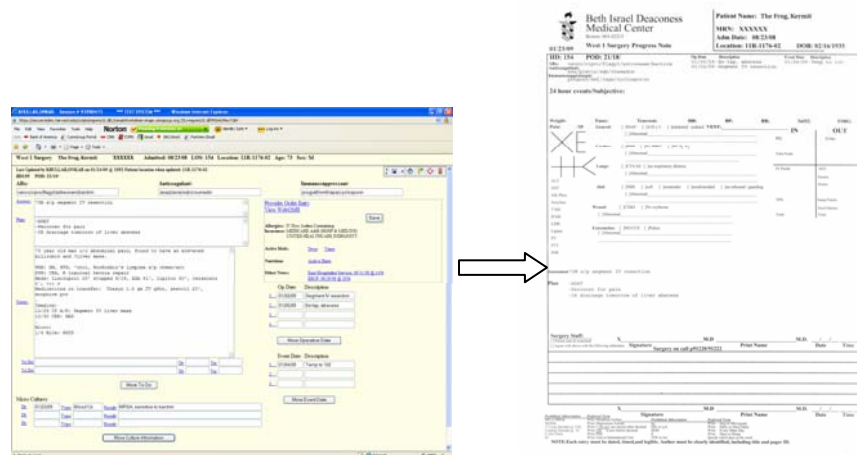
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- Donald Moorman, MD, Lisa DeAngelico/Office of Clinical Affairs, Safety, & Quality, Department of Surgery
- Jean Furbish, Kathleen Murray/Silverman Institute for Healthcare Quality and Safety
- Nan Zullo, Jean Hurley/Programmers
- Gerry Abrahamian/Health Information Management
- Lawrence J. Markson/Clinical Information Systems
- David Feinbloom MD, Julius Jong Yang MD/Department of Medicine

## The Interventions

We have created a system whereby information already entered into the team census program will be used to automatically generate a daily progress note. As the notes are computer generated the dates will be automated requiring the clinician to only time the note. This system was implemented on 1/20/09 with the transplant service and will soon be expanded to all surgical services.

## The Results/Progress to Date

A template for the transplant surgery progress note has been completed, approved by the forms committee, and implemented. Preliminary data after 1 week of usage on the transplant service shows 100% compliance with resident signatures, dates, and time stamps. While we do not yet know for certain how this system will effect our documentation compliance, our hypothesis is that more efficient system will lead to fewer errors in documentation.



## Lessons Learned

Interestingly, we have noted through this forms approval process that many of the abbreviations commonly used on surgical progress notes were not hospital approved. The note was taken to Michelle Micala from Health Information Management, who helped to replace all unapproved abbreviations with approved ones. This has allowed us to go from 0% compliance in the use of hospital approved abbreviations to 100%.

## Next Steps/What Should Happen Next

This system will be expanded to all of the surgical services within the next month. Random audits of surgical notes will be continued to assess for improvement in documentation practices.



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