Streamlining Nursing Documentation – The Journey Continues

The Problem
Nursing Documentation in the inpatient Med/Surg areas is a paper-based process that is time consuming, uses multiple forms, has many redundant and/or unnecessary fields, has missing data elements and does not convey the patient story. As documentation moves to a computerized system, improvements to current documentation has been reviewed to mirror what the forms will translate into on the computer system.

Aim/Goal
To improve nursing documentation by creating a product that captures the patient's story through the nursing perspective, reduces redundancy, improves patient care, as well as workflow and continuity among caregivers, while increasing nurses’ satisfaction and meeting regulatory requirements.

The Team
Christine Bookbinder, RN
Jean Campbell, RN, MS
Erin Conti, RN
Emily Keenan, RN
Robert Lombardo, RN
Sarah Power, RN
Kimberly Sulmonte, RN, MHA, CSHA
Patricia Bourie, RN, MS
Janine Caruso, RN
David Grosso
Jaime Levash
Sharon O’Donoghue, RN, MSry
John Ryan, MSN, RN
Amanda Tjonahen, RN

The Interventions
- Monthly LEAN Documentation meeting for the team to continue reviewing Nursing documentation
- Roll out of a updated flowsheet which incorporates a new falls assessment (IHI Falls) and capturing new assessment information on patients: delirium – RASS and Test of Attention, O-CAT score and completion of oral care, and dyspnea assessment
- Created Medical Administration Record (MAR) signature form (one signature for multiple forms which is found at the bedside)
- Teaching model (one point lessons and video slide show) to educate staff how to document consistently and learn of the new assessment tools

The Results/Progress to Date

<table>
<thead>
<tr>
<th>Interventions</th>
<th>FY13 Q3</th>
<th>FY13 Q4</th>
<th>FY14 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall prevention interventions documented and in alignment with the patient's fall risk assessment?</td>
<td>92.9%</td>
<td>90.9%</td>
<td>95.4%</td>
</tr>
<tr>
<td>O-CAT score completed within the last 24 hrs?</td>
<td>42.6%</td>
<td>51.8%</td>
<td>63.1%</td>
</tr>
<tr>
<td>Oral care documented on flowsheet?</td>
<td>59.6%</td>
<td>59.4%</td>
<td>66.5%</td>
</tr>
<tr>
<td>The MAR Signature Log was signed by all RNs who administered medication, daily.</td>
<td>92.9%</td>
<td>97.4%</td>
<td>98.6%</td>
</tr>
</tbody>
</table>

MAR Signature Log Roll Out

<table>
<thead>
<tr>
<th>MAR Signature Log Roll Out</th>
<th>Pre-Data</th>
<th>Post-Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set of Initials</td>
<td>202</td>
<td>95</td>
</tr>
<tr>
<td>Corresponding signatures</td>
<td>171</td>
<td>94</td>
</tr>
<tr>
<td>Total Percent</td>
<td>84.7%</td>
<td>98.9%</td>
</tr>
</tbody>
</table>

Lessons Learned
- Having clinical nurses involved in every step is key to the success of this project
- Specialty units may need additional customization of the forms
- Initiatives that are a change in practice require separate education and roll-out strategies to effectively incorporate them into standard work

Next Steps/What Should Happen Next
- Work on updating Initial Patient Assessment (IPA) to mirror changes to documentation and add the new information that is being captured on patients
- Continue planning for electronic documentation
- Explore how to replace manual auditing with electronic capture of data

For more information, contact:
Patricia Bourie, RN, MS - Program Director, Nursing Informatics
tbourie@bidmc.harvard.edu