Documentation Improvement

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Documentation Improvement

Leadership/Planning

The mission of Providence Medical Center (PMC) has long been "Quality healthcare in the spirit of Christ". Six years ago change came to PMC in the form of a new Chief Executive Officer, Chief Nursing Officer and electronic health record (EHR) all in the same year. With new leadership came a fresh look at our patient, provider and staff satisfaction and an update to our vision and values. PMC started to focus more on patient and staff satisfaction within all departments of the hospital by implementing a hospital of choice program with the help of Custom Learning Systems. Our facility goals at PMC shifted from mainly being financially focused to also being quality focused. A board quality committee was developed to closely monitor quality improvement goals within the organization, to determine strategic quality priorities and to hold administration, directors and frontline staff accountable for the highest quality healthcare possible and accomplishing the strategic goals of PMC.

Process of Identifying Needs

With processes in place to improve our patient, staff and provider satisfaction PMC evaluated other quality needs within the facility. In review of quality issues our quality care committee and administration found that documentation within the electronic health record seemed to be an ongoing theme. Concern related to documentation came from providers, insurance certification issues, difficulty locating documentation in the EHR and increasing portal usage requirements for patients.

PMC providers verbalized concern about information that was pulling from nursing documentation into their provider notes. They identified that notes had outdated info or were missing info that should be coming from nursing documentation and they asked to have note info evaluated. Insurance often dictated what documentation was needed to certify and approve

outpatient procedures or services. Utilization review nurses certifying for inpatient stays noted that info necessary to get an inpatient stay approved by insurance was sometimes missing or unable to be easily found or printed to send to insurance. Medical records and nursing staff identified that documentation was hard to find in the chart as one department documented information in a different place in the electronic health record than another department. Increased portal usage by patients and the goal for more provider notes to appear in the portal necessitated the need for a cleaner provider note to make it easier to read for patients in their portal. For all of these reasons the board quality committee at the recommendation of the quality care committee and administration decided that documentation improvement needed to be a strategic priority and improvement project for PMC.

Two PMC staff members took the Certified Documentation Improvement Practitioner (CDIP) class and got certified to assist us in driving improvement efforts from the provider side of documentation. They gathered providers to discuss specific issues with documentation, identifying issues such as note formatting, problems with patient history documentation and issues with dictation devices. Our CDIP staff worked with providers to update note formats and troubleshoot our dictation devices. PMC also developed a facility documentation improvement team to focus on documentation from the facility side.

Process Improvement Methods and Results

The current core documentation team is led by the director of quality assurance and performance improvement (QAPI) and includes the Chief Nursing Officer (CNO), Chief Operating Officer (COO), Utilization Review (UR), discharge nurse, informatics nurse, medical records/coding and billing. The team first met to develop a team charter, attachment 1, and to brainstorm facility documentation topics and other issues related to the EHR. Priority was given

to EHR issues that could affect patients and their safety. Documentation topics were then prioritized by using a priority matrix, attachment 2. Our matrix prioritized the topics based on frequency of use for a documentation topic and the number of departments that used the documentation. Priority was given to topics that would be documented on daily or by more than one department, such as clinician notification, EHR clinical alerts and intravenous (IV) documentation.

Our documentation team has seen results in many different ways throughout this whole project. Improvements have not only been in the form of numbers, but also include policy updates, improvement of patient discharge info, improvement of patient portal information, ease of finding information for staff in the EHR and standardization of various documentation topics.

Our initial PMC documentation team project was patient safety related and centered on orders within the EHR. We updated our policy related to orders for our EHR which included standardizing processes related to order entry and order communication type. We implemented a procedure facility wide for departments to clean up old outdated future orders so that only current future orders would be active and appear on patient discharge paperwork. This change allowed for a cleaner and more accurate list of future orders on patient discharge paperwork and within their patient portal. Cleaning up our future orders list monthly has allowed us to go from 50 pages of future orders facility wide initially, to 10 pages of future orders currently and has reduced the length of pages within some patient discharge paperwork.

PMC documentation team has also focused on maintenance of patient chronic problem list. The problem list is patient health history that feeds into the provider's notes and can be important not only for care, but for insurance certifications, coding and billing. In discussion with our CDIP staff members providers had verbalized issues related to keeping the problem list

updated and utilizing the correct problem. Medical records and the informatics nurse reviewed the process of how various PMC departments enter chronic problems, what version (acute, chronic, history) of a problem is used, how resolved problems are removed from the problem list and where within the EHR things are entered. They then determined best practice for problem entry and educated staff which lead to a cleaner updated list within the provider note.

PMC documentation team explored options for using new workflow pages within the EHR to reduce documentation burden and standardize documentation for nurses caring for our specialty clinic outpatients. We utilized the EHR workflow pages that allowed us to access all patient info, change and add info and to generate a note relating to the visit. CDIP staff worked with specialty clinic nursing to develop note templates that pulled in the basic patient information, included basic assessment info and assessment info specific to their reason for visit. With minimal clicks nursing could pull in all the info they had just reviewed with the patient and could include the template specific to the patient visit and type in additional info. By using a note templated for a specific visit, such as cardiology, nursing could ensure that they assessed all necessary info and that fellow staff members were assessing the same thing. The process removed the need for numerous forms and locating them within the EHR. It also utilized the system for a one screen workflow with all patient info, gave a quicker and cleaner nursing intake process for patients and gave our nursing staff a way to standardize assessments from nurse to nurse in specific specialty clinics.

One of the more recent topics that the PMC documentation team focused on was IV insertion, assessment and discontinuation documentation. Our core documentation team identified all of the departments involved, we reviewed the documentation that was available within the EHR and determined what the minimum documentation for insertion, assessment and

discontinuation would be. Departments involved with IV documentation were then given the minimum info on IVs and brought to a documentation team meeting to review and discuss the info. After all info was presented to department leads and questions answered a power point education and test were developed and dispersed to all the involved department staff. Our initial review of IV documentation info was done by manual review of charts. However this left us reviewing only a small portion of the IV documentation, not gathering a large amount of data per staff member and was a very time consuming and tedious way to gather data. To improve the data review process we utilized the report writing capabilities of the EHR to pull large quantities of data. Data was then exported to excel and filtering and formulas were used to sort and compile percentages of appropriate documentation facility wide, per department and per staff member. Gathering and displaying data in this way not only let us know how we as a facility were doing, but also if there were specific departments or staff members that needed re-education or assist with their IV documentation.

At the beginning of our IV documentation project we did not have a report built in our EHR to pull information documented on a specific assessment. Lack of an EHR report to pull documented data left us with a tedious manual process to evaluate data and we were only able to review minimal IV insertion, assessment and discontinuation documentation. We invested about 10 hours of staff time into building an EHR report, testing that report and then writing formulas and doing color formatting in excel. Prior to our EHR report and excel spreadsheet it took approximately one staff member 12 full hours to pull up and manually review 40 insertions, 40 assessments and 40 discontinuations per month. This manual process comes out to be about 5 minutes to find each patient, find the correct visit, find the correct documentation and make sure that all minimum documentation was present and recorded for tracking. Now with excel and our

report capabilities of the EHR we review all insertions, all shift assessments and all discontinuations of IVs. This report increased our review capabilities from 40 of each for insertion, assessment and discontinuation to an average review of 200 insertions, 400 assessments and 200 discontinuations per month. This report can be set to run and be available whenever it is needed and with 30 minutes of work per month in the excel spreadsheet it can do what it would have taken a person more than 65 hours to do in a month. Also the report within our EHR can be easily modified to accommodate other documentation sets for easy review of another topic such as catheters, vital signs or blood documentation.

We have monitored percentages for minimum documentation complete for our facility and for our four departments that do IV documentation, related to insertion, assessment and discontinuation. In late July, early August of 2019 we presented mandatory education to all four departments on the minimum for IV insertion, assessment and discontinuations documentation. Before our education our manually collected data from the month of May showed that 49.2% of insertions, 48.8% of assessments and 53.7% of discontinuations had what we decided would be the minimum documentation. We did not figure stats for each department on this data. After developing the EHR report and excel spreadsheet we went back and used the EHR and excel to figure percentages on IV insertions, assessments and discontinuations for the month of May that we had previously done manually.

Comparing data from before the start of our project, with data soon after documentation education, to data from March of 2021 we have seen improvement in facility percentages for insertion, assessment and discontinuation, attachment 3. The only significant repeated declines in percentage from pre-education to September of 2019 to March of 2021 occurred in the inpatient nursing department related to discontinuation documentation. In review of causes for

the inpatient drop it was noted that there has been a large turnover of staff in the inpatient area over the past year and the IV documentation education was not being presented to new staff. We also identified that an experienced staff member was having significantly lower percentages for discontinuation and was re-educated on the minimum for discontinue documentation.

In the beginning of 2020 we started to distribute staff member specific percentages for insertion, assessment and discontinuation, attachment 4. Directors were made aware of their staff's numbers and able to give them feedback related to their documentation. Staff members were made aware of their specific percentages and percentages per facility and department. Next steps will be to disperse all staff member percentages to everyone in a department so they can see how they compare to fellow staff members.

Lessons Learned, Replicability, Sustainability

Our documentation committee learned many lessons related to documentation improvement including data collection, group membership, materials presented, people and goal development. Comparison of percentages from our manually collected data to our EHR data showed that the EHR collected data did not match our manual data. We learned many lessons with EHR data compared to manual data. One was that when using the EHR you may be investing 10 hours in the beginning of a project to build reports or write formulas, but the time it will save you month to month could be extraordinary. Over one year with our EHR report and excel spreadsheet we have spent 16 total hours on evaluating IV charting, 10 hours building the report and 6 hours over the year to evaluate the data. If this process had been done manually the same amount of data collection and review over the year would have taken an estimated 780 hours. The second lesson we learned with data was that due to time our manual process limited the amount of data we could review. Due to the time restraints we were limited to the review of

only 3 IV insertions per nurse for the month. With some nurses doing 3 IV insertions per week that would have only caught about 25% of their documentation over a month and for assessment that would have been an even lower percentage. As a documentation team we felt that only assessing 25% of their total documentation wouldn't give a true picture of how they were doing. In thinking about this we wanted to be fair and decided that it was necessary to pull as much data as the system could to get an accurate result, even if it meant some work up front with EHR reports and excel. The third thing we learned is that we could utilize the EHR report and excel spreadsheet for other topics. With a few hours of work to change a report and the excel spreadsheet we could collect documentation on catheter documentation, blood documentation, physical assessment documentation or virtually anything we documented in our check box charting.

At the beginning of our documentation improvement project out team was composed of our current core documentation group in addition to 2-3 staff members from each department involved in a topic. We found that this was about 20 people compared to our current group of 8. With many different departments at the table it was hard to truly assess all the different workflows and figure out what was actually needed for a topic. In December of 2020 we made the choice to revise our team membership. We brought to the table our core documentation group and discussed topics and what was needed from each one of the core group members related to the documentation topic. Then from there the departments were brought in separately to discuss the topic with the core group and give their workflow for the topic. After hearing from all departments involved the core group decided which workflow would be adopted at PMC and developed education to present to the departments. Reducing the core group to only 8 and identifying what was needed before the topic was discussed with departments, allowed a quicker

and easier process start to finish. This process also assured that the core group identified the minimum documentation that was needed from the very beginning.

The education and materials we presented for departments to review related to a topic were only what was absolutely needed. If a policy is not needed related to a documentation topic then one is not developed. Frequently we develop a cheat sheet for steps or location of documentation within the EHR instead of writing a policy. When a policy is needed we develop that with input of departments that are involved with the policy. Recently we revised a policy related to blood product administration and did mandatory education on changes to the policy, as well as a refresher on minimum documentation for blood product administration for our nursing staff. When we develop a power point and test to assess knowledge of the subject, we have learned to evaluate our slides and test by allowing a few select members of departments involved to review and give feedback on the slides and test before distribution to all staff. This process has led to elaboration or clarification of points before info goes out.

Lessons we learned related to our people include giving the why, standardizing from the beginning and not everyone sees things in the same way. Our staff, like many others, do better when they are given the reason for doing something in a particular way or for changing a workflow. When we were able to tell them why something needed to be done, they were more likely to remember it and adopt it. We learned that people remember the initial way they are taught something so if you can standardize something and teach it that way from the beginning then people will be more likely to remember it and do it the way you want them to. We also learned that not everyone sees everything in the same way, literally. The EHR looks different and acts different depending on the permissions each staff member has. This means that you can't always develop education or step by step instructions in one way and expect another

department's staff to be able to follow it. The best way to avoid problems is to have an informatics person that can test documentation with different permissions. Our EHR allows one staff member to switch between permissions in something called "My Experience", therefore making it easier to evaluate and test workflow for different departments when needed.

Knowing what the end goal is before starting at the beginning is an important part of any quality project. If you don't know where you are trying to get to then you can't evaluate how you might get there. You need to have a shared mental model with your group to make sure you are all working to the same endpoint or goal. We are doing this by discussing documentation topics first with our core group and making sure we all had what was needed related to documentation from the UR, nursing, medical records, coding and billing viewpoints.

Documentation Improvement and the process we used to determine projects and bring our team together is something that can be replicated in any department or at any facility. Our project used materials, skills and team members that any healthcare organization should have access to. We worked with what we had and adjusted as needed.

PMC will sustain its documentation improvement project and IV documentation project by continuing to give feedback to staff for achievements and where improvement is needed. We will use peer to peer quality data to show staff the high achievers and what high levels can be reached and to identify where re-education is needed. With the support of our board and board quality committee holding staff, directors and administration accountable through our strategic goals, we will continue to improve our documentation and the care we give the patients of Providence Medical Center.

Attachment 1

Documentation Committee Charter

Mission Statement

To improve documentation throughout the facility

Purpose

a) Standardize documentation throughout the facility
b) Ensure that documentation reflects the patient clinical course and is accurate
c) Ensure that documentation reflects services provided and allows for accurate coding, billing and certification of testing or services
d) Ensure compliance with statutory requirements and state/federal regulations.
e) Reduce medical malpractice and general liability.

Responsibilities

With direction from the Quality Care Committee, we are expected to create and maintain a culture of clinical documentation improvement:

a) Identify issues related to documentation throughout the facility
b) Prioritize issues related to documentation that are referred to the committee
c) Work together to standardize documentation throughout the facility
d) Educate staff in your departments on any documentation changes
e) Hold staff in your department accountable to document in the standardized way
f) Review records for appropriate documentation and submit QI data
g) Report to administration reasons for not following standardized documentation
h) Develop minimum standards of documentation for certain episodes of care (ER, Inpatient, Outpatient) or certain forms (admission forms) and educate staff on them
i) Develop training guides for your department related to documentation
j) Write a downtime documentation plan for your department
k) If more than 1 representative from a department you are expected to communicate issues/decisions from previous meeting with each other
l) Report to the Quality Care Committee at minimum of quarterly

Membership

a) Director of QAPI
b) Director of Medical Records-CDIP
c) Utilization Review Coordinator-CDIP
d) CNO and/or COO
e) Director of financial services (billing)
f) Discharge Nurse
g) Clinical Informatics Nurse
h) Departmental directors and staff as needed and as per invitation

Effectiveness

1st and 3rd Thursday of the month from 12-1

Code of Conduct and Ground Rules

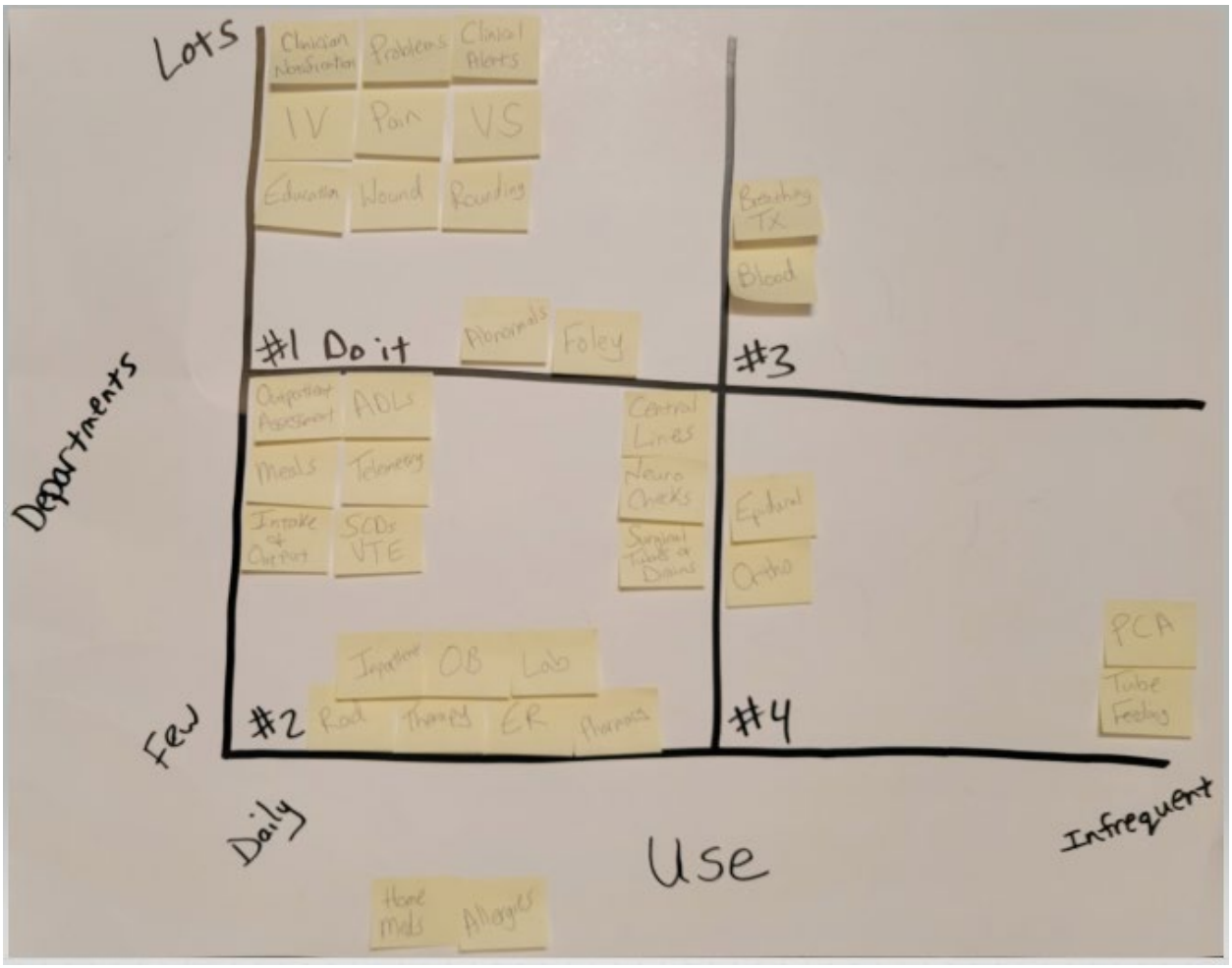
a) We commit to always be timely to meetings
b) We commit to having positive attitudes
c) We commit to listening when others are speaking and not having side conversations
d) We commit to give 100% participation
e) We commit to be accountable to each other and the documentation committee
f) We commit to address conflict within the group by discussing, determining the why and having a majority agreement in the decision making
g) We commit to hold departments accountable for documentation and QI related to documentation
h) We will use the word CAT as our committee accountability tactic if we feel that others are not following the code of conduct or ground rules.

Revisions

a) Developed 4/4/19
b) Revised Team members 12/27/2020

Attachment 2

Priority Matrix



Attachment 3

Providence Medical Center
IV Documentation

	2019 May Pre-education manual data	2019 May Pre-education EHR data	2019 September	2021 March	Trend Lines
Insertion					
All Facility	49.2%	87.4%	94.3%	97.2%	
Inpatient		86.4%	92.7%	95.5%	
Outpatient		90.1%	97.8%	98.7%	
Radiology		69.2%	89.1%	99.4%	
Surgery		91.4%	98.6%	98.3%	
Assessment					
All Facility	48.8%	82.9%	84.7%	95.5%	
Inpatient		82.8%	88.2%	94.1%	
Outpatient		78.9%	65.4%	92.5%	
Radiology		96.3%	80.0%	93.3%	
Surgery		81.3%	82.9%	99.3%	
Discontinuation					
All Facility	53.7%	85.3%	88.4%	90.9%	
Inpatient		84.3%	84.6%	80.5%	
Outpatient		82.5%	91.0%	98.3%	
Radiology		78.4%	85.0%	100.0%	
Surgery		88.6%	95.3%	98.7%	

Attachment 4

	Insertion percentage complete	Assessment percentage complete	Discontinuation percentage complete
Facility Wide	**97.2%**	**95.5%**	**90.9%**

Inpatient	**95.5%**	**94.1%**	**80.5%**
Allen, Lexi RN	97.6%	100.0%	79.5%
Andrade, Maria RN	95.8%	96.7%	75.0%
Bauer, Jason RN	100.0%	#DIV/0!	75.0%
Briner, Wayne RN	83.3%	93.3%	91.7%
Clausen, Lisa RN	97.6%	#DIV/0!	75.0%
Cook, Amanda RN	#DIV/0!	97.1%	#DIV/0!
Haglund, Nicole	#DIV/0!	100.0%	#DIV/0!
Hangman, Valerie RN	#DIV/0!	100.0%	#DIV/0!
Keating, Tracy LPN-C	41.7%	95.5%	41.7%
Korth, Regina RN	#DIV/0!	100.0%	96.4%
Lunz, Nancy LPN-C	#DIV/0!	81.5%	90.6%
Marshall, Candice RN	95.8%	100.0%	75.0%
Melby, Brittany	100.0%	#DIV/0!	75.0%
Nelson, Michele RN	#DIV/0!	100.0%	#DIV/0!
Nissen, Sydney RN	#DIV/0!	#DIV/0!	#DIV/0!
Nissen, Tegan RN	91.7%	100.0%	#DIV/0!
Quanbeck, Cortney RN	#DIV/0!	100.0%	#DIV/0!
Pretzer, Tanna RN	100.0%	97.6%	91.7%
Shultheis, Nichole RN	100.0%	98.8%	100.0%
Sievers, Elizabeth RN	100.0%	100.0%	#DIV/0!
Sokol, Megan RN	96.9%	92.0%	100.0%
Spahr, Marcia RN	#DIV/0!	#DIV/0!	#DIV/0!
Swanson, Hannah LPN	95.0%	#DIV/0!	85.7%
Thies, Mackenzie RN	66.7%	92.7%	75.0%
VonSeggern, Courtney RN	95.1%	100.0%	81.3%
Wimmer, Melissa RN	#DIV/0!	#DIV/0!	#DIV/0!
Wragge, Abby RN	#DIV/0!	40.0%	100.0%