VANDERBILT School of Nursing

SINI 2019

Tackling Documentation Burden at Bon Secours and Beyond

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Objective

- Identify and discuss an organizational strategy used to help reduce documentation burden for nurses

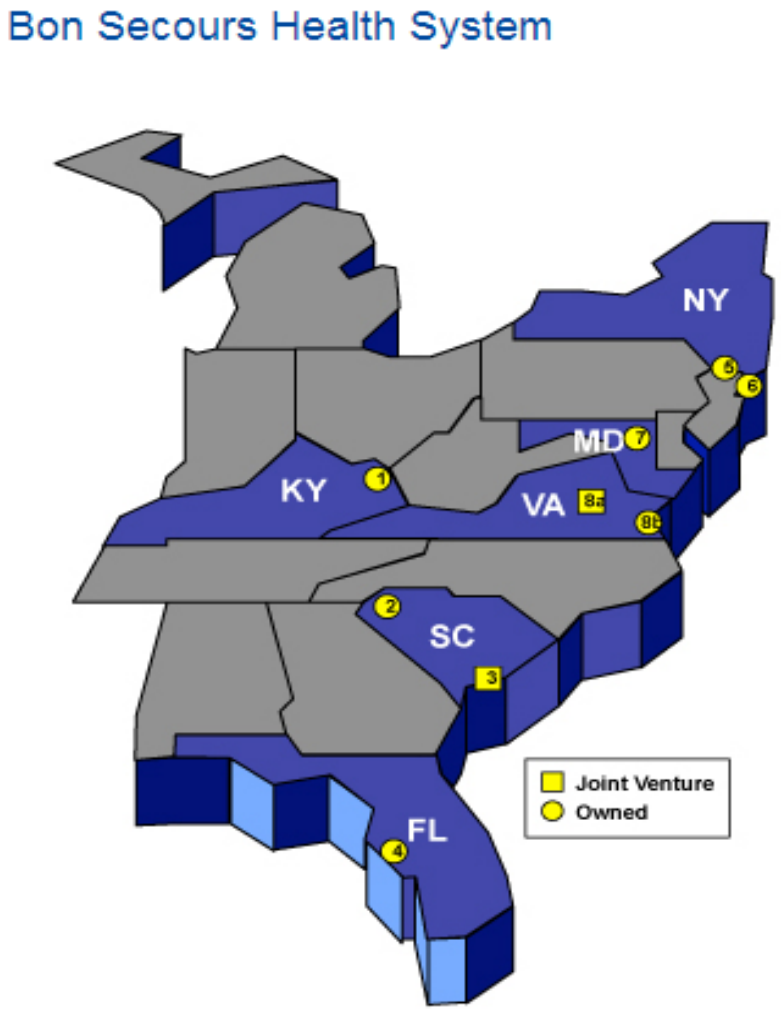
The Story Of 539 Of Clicks At Bon Secours

Nursing Admission Assessment Documentation

Socioeconomic	0	5	0	5
Surgical History	0	18	0	8
Subtotal including History:	**17**	**316**	**153**	**385**
Admission Physical Assessment	13	59	0	108
Vital Signs	1	36	0	46
Final Total including Physical Assessment and Vital Signs:	**31**	**411**	**153**	**539**

Bon Secours Health System (2016)

- Not-for-profit Catholic health system sponsored by Bon Secours Ministries
- 14 Acute Care Hospitals with associated ambulatory practices
- 5 LTC facilities
- 4 Assisted living facilities,
- 14 home care and hospice services
- More than 22,000 employees across six states



POLITICO

Morning eHealth

Your go-to report on the intersection of health care and technology, published every Monday, Wednesday and Friday

October 7, 2015

537 CLICKS: That's how many it took for the admissions nurse at Bon Secours Health System to enter in the EHR all the potentially required clinical, administrative, legal, ethical, spiritual, etc., data for a single patient, according to nursing informatics officer Patricia Sengstack, who watched this happen recently while a student counted the clicks. The story from Sengstack, a new member of the Health IT Standards Committee, raised all 74 eyebrows around the table at Tuesday's big advisory committee meeting. Expect "537 Clicks" T-shirts soon, and maybe a new song to the tune of that garage-band classic by ? and the Mysterians.

Source https://www.politico.com/tipsheets/morning-ehealth/2015/10/the -day-the-documents-dropped-meaningful-use-and-more-more-more-210586

Results of Click Count

Name	#Clicks	#Fields	#Fields Required	Child Screens
Total Admission Database (includes basic patient information, advance directives, readmission info, screenings, regulatory fields, etc.)	**149**	**136**	**98**	**28**
Braden Scale	**6**	**6**	**6**	**6**
Schmid Fall Risk	**5**	**5**	**5**	**1**
Recommended Fall/Safety Interventions	**8**	**2**	**0**	**0**
SAD Persons	**11**	**11**	**0**	**0**
Assistive Devices	**2**	**1**	**0**	**0**
Class Information/Consults	**2**	**1**	**0**	**0**
General Education	**84**	**40**	**40**	**6**
Allergies	**13**	**6**	**2**	**0**
PTA Home Medications	**9**	**2**	**2**	**0**
Past Medical History	**25**	**25**	**0**	**2**
Family History	**16**	**16**	**0**	**2**
Family Status	**8**	**8**	**0**	**0**
Social Hx/Substance Use/ Sexuality	**20**	**20**	**0**	**0**
ADL/Other Concerns	**14**	**14**	**0**	**0**
Socioeconomic	**5**	**5**	**0**	**0**
Surgical History	**8**	**18**	**0**	**0**
Admission Physical Assessment	**108**	**59**	**0**	**13**
Vital Signs	**46**	**36**	**0**	**1**
Final Total :	**539**	**411**	**153**	**31**

Impact of the Burden

Nurses and physicians spend as much as

30 – 50%

of their day performing documentation activities

- Munyisia EN, et al. The impact of an electronic nursing documentation system on efficiency of documentation by caregivers in a residential aged care facility. JClin Nurs. 2012.
- Oxentenko AS, West CP,Popkave C, Weinberger SE,Kolars JC. Time spent on clinical documentation: a survey of internal medicine residents and program directors. Arch In Med. 2010;170:377–380.
- Block L, Habicht R, Wu AW, et al. In the wake of the 2003 and 2011 duty hours regulations, how do internal medicine interns spend their time? J Gen Intern Med. 2013;28(8):1042–1047.
- Kelley TF, Brandon DH, Docherty SL. Electronic nursing documentation as a strategy to improve quality of patient care. J Nurs Scholarsh. 2011; 43(2):154–162.

Information Nurses Document

- Assessments
- Clinical problems
- Communications with other health care professionals regarding the patient
- Communication with and education of the patient, family, and the patient's designated support person and other third parties
- Medication records (MAR)
- Order acknowledgement, implementation, and management
- Patient clinical parameters
- Patient responses and outcomes, including changes in the patient's status
- Plans of care that reflect the social and cultural framework of the patient

Source: ANA's Principles for Nursing Documentation Guidance for Registered Nurses (2010).
http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingStandards/ANAPrinciples/PrinciplesforDocumentation.pdf

The Purpose of Documentation Today

- Capture the clinical care provided to patients
- Communication with other professionals
- Reimbursement
- Regulation and legislation
- Quality processes and performance improvement
- Accreditation
- Legal purposes
- Research

Identifying What is Really Needed

- What should stay?
- What should go?
- Why?

Identifying What is Really Needed – Bon Secours

- Is this something that is appropriate to ask EVERY patient?
- Is this information needed in first 12 - 24 hours of care?
- Is this information needed for discharge planning?
- Will this information improve the patient's experience/care of the patient?
- Is this something that needs to be captured so all care providers are aware (multi-disc team) ?
- Does an RN need to collect this?
- Is this information documented elsewhere in the chart?
- Required for Core Measure/MU/CMS/TJC other?
- Is this information displayed in the pt Header?
- Are there any legal implications if not documented?
- Is it being pulled into a report of any kind?
- Does this information trigger an alert or reminder?

Assessment of Nursing Admission Items – Bon Secours (174 items)

B	E	F	G	H	I	
Area Detail	**Number of Clicks in this section**	**Is this something that is appropriate to ask EVERY patient?**	**Is this info needed in first 12 hours of care?**	**Is this info needed in first 24 hours of care?**	**Is this information needed for discharge planning?**	**Will this in patient's e of th**
Admission						
Patient Profile/ acknowledge orders	1	Yes			No	N
Care Everywhere	1-2 with text possible	No (only applicable)				
Allergies/Contraindications	1-numerous with text	Yes				
Vital Signs	6 with text	Yes				
Pain	2-7+ with text possible	Yes				
POSS	1	No (only applicable)				
Oxygen therapy	1 with text	No (only applicable)				
Patient observation	0-10	No (only applicable)				
Height/Weight	1 with text	Yes				
Airway clearnace	0+ with text possible	No (only applicable)				
History: Medical	1-27 with text possible	Yes	Yes	Yes		
History: Surgical	1-19 with text possible	Yes	Yes	Yes		
History: Obstetric	1-3 with text possible	No (only applicable)	No	No		

Transitioned from Maryland to Tennessee

- Moved to Nashville, TN – Oct 2017
- DNP student interested in same work
- Marguerite Swietlik DNP, CNIO at hospital in Washington State

Project Setting

- Acute care adult 280 bed hospital in Seattle, WA
- EHR since 2004
- Fully integrated system

Analyze the Nursing Admission Assessment Data Elements

Is it imperative or required to document the data element for:

- Clinical care of the patient?
- Communication of patient information to the care team?
- A regulatory agency? (TJC, CMS, MU, Core Measure – that requires documentation)
- Does it trigger an alert?

Analyze the Nursing Admission Assessment Data Elements

- Is it documented elsewhere in the chart?
- Is an RN required to document?
- Is it required in the first 8 - 12 hours of admission?
- Is it something that EVERY patient must be asked?
- Is it pulled into the patient header?
- Is it needed for a report?

Scoring for Each Data Item

Criteria	Required regulatory field?	RN documentation required?	Ask EVERY patient?	Required within 24 hours?	Needed for discharge planning?	Displayed in patient header?	Required for CDS?	Communicate with care provider?	Reported data element?	Documented elsewhere?
Weight	9	5	1	9	9	1	9	5	5	9
Description	A “yes” response requires RN to identify the regulatory agency.	Only an RN can complete documentation of this field.	Ask patient or delegated caregiver.	Must be completed within 12 hours following the admission of the patient.	Question helps inform the discharge planning process.	A “yes” response triggers information to display in the patient header.	Currently informs clinical decision support in the EHR. Removal will have a downstream impact.	Providers rely on this information to support decision making and care processes.	Currently included in reports. Removal has a downstream impact.	A “yes” response = 0, a “no” response =9. Consider the best location for this information.

Table 1: Documentation decision support tool criteria details. Weights were determined during the focus group by the site-based team and reflect their perceived value of the information

Item Scoring

Each item got a total score

- Lowest score possible = 0
- Highest score possible = 62

Total scores divided into 3 categories:

- 1. Retain = 25 - 62
- 2. Review = 15 - 24
- 3. Remove = 0 - 14

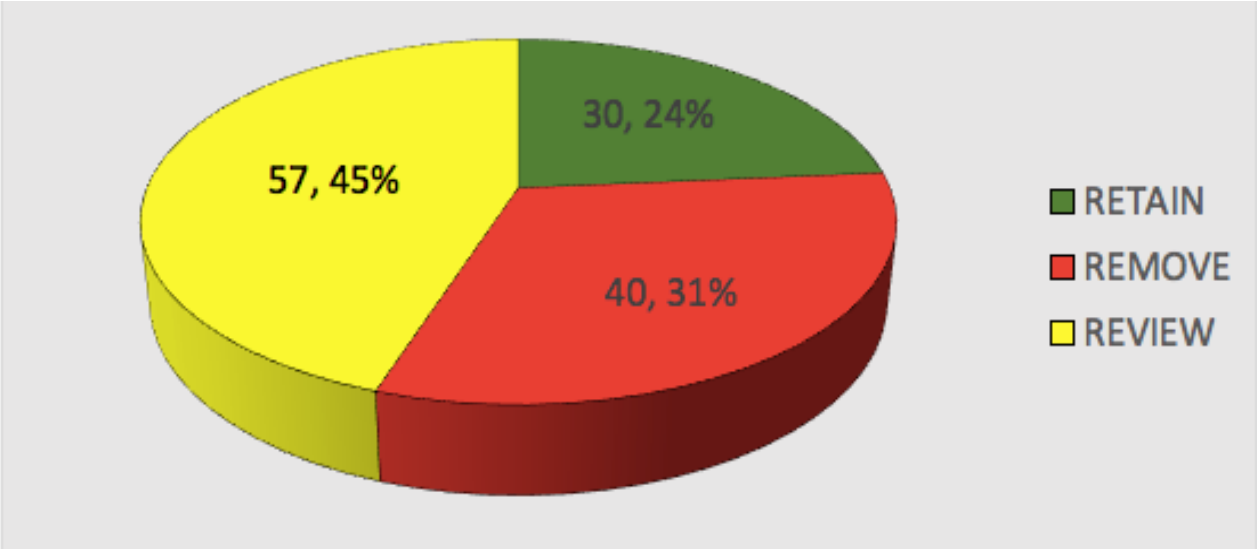
Evaluate What's Currently in the System

ADMISSION ASSESSMENT	Required regulatory field: Yes/No	If yes, list agency	"RN" required: Yes/No	Ask EVERY patient?	Required in first 12 hours?	Needed for discharge planning?	Displayed in patient header?
Would you like information (required if answer to 33 is "no")	N		Y	Y	N	N	N
Pamphlet given to patient (required if answer to 34 is "no")	N		N	N	N	N	N
If advance directive: Has your AD info changed since we last saw you (required if answer to 33 is "yes")	N		N	Y	Y	Y	N
Type of advance directive (required if answer to 34 is "yes")	Y		Y	Y	Y	Y	N
Medical durable power of attorney name and phone number (required if answer to 34 is "yes" - free text)	N		N	Y	Y	N	N
Where is your advance directive	Y		Y	N	N	N	N
Reason copy cannot be obtained (free text)	N		N	N	N	Y	Y
Health History							
Admitted with IV	N		N	N	N	Y	Y
Date and time of insertion (required if answer to 42 is "yes")	Y		Y	N	N	N	Y
RN reviewed health history via:	Y		Y	Y	Y	Y	Y

Overall Results

Assessment Results

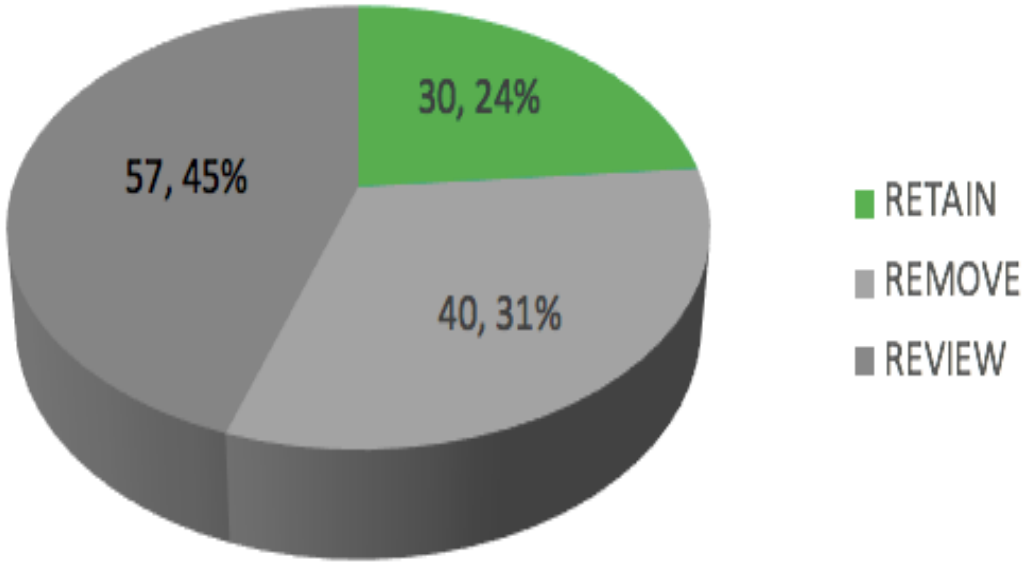
- 127 assessment elements reviewed
- 30 (24%) retain
- 57 (45%) review
- 40 (31%) remove



Retain = 25 – 62
Review = 15 - 24
Remove = 0 - 14

Items to Retain

- Patient education needs
- Have you had a flu vaccine this flu season?
- Qualifies for flu vaccine?
- Patient's preferred language
- Pain on admit
- Unintentional weight change
- When discharged, is it safe for you to go home?
- Are you being hurt, hit or frightened by anyone at home or in your life?
- Physical signs of abuse noted
- Behavioral signs of abuse



Retain = 25 – 62
Review = 15 - 24
Remove = 0 - 14

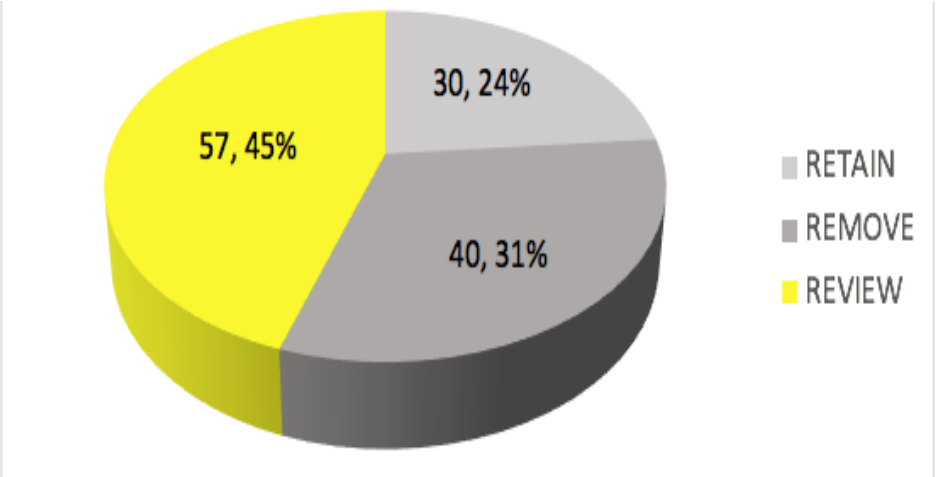
Items Needing Further Review

Top 5

- Little interest or pleasure in doing things?
- Feeling down, depressed or hopeless?
- Tobacco use
- Have you EVER had a pneumonia vaccine?
- Diabetes history?

Bottom 5

- Immunization Schedule Status
- Delirium risk
- Pregnant?
- Feeding ability
- Home diet



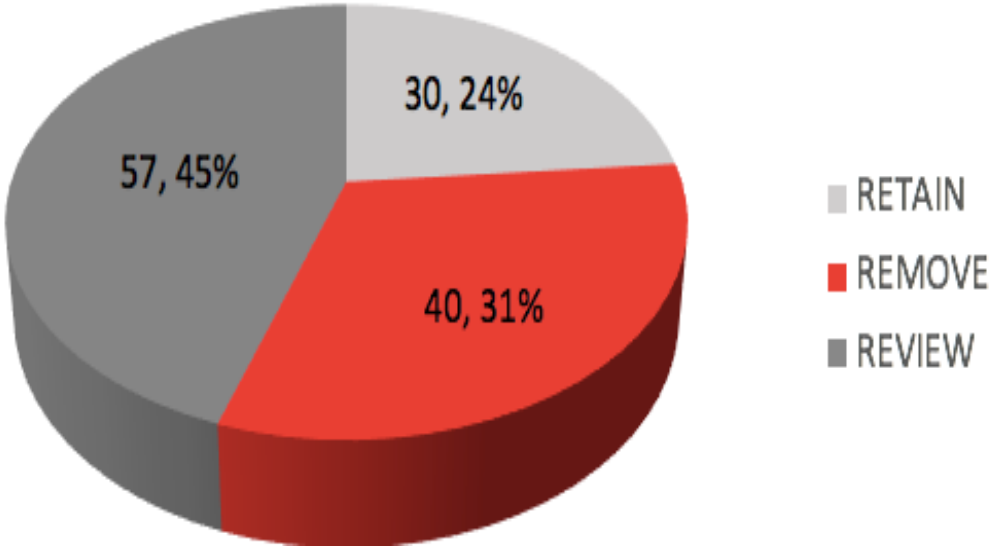
Retain = 25 – 62

Review = 15 - 24

Remove = 0 - 14

Items to Remove

- Patient level of activity on Admission
- Affect/behavior
- Stressors
- Methods for reducing stress
- Referral: Safety/suicide risk
- Support person available
- Alcohol last use - (date)
- Frequency of alcohol use?
- Interested in quitting alcohol?
- Interested in quitting recreational drugs?



Retain = 25 – 62
Review = 15 - 24
Remove = 0 - 14

Analysis of the Nursing Admission Assessment Data Elements

- Of the forty elements recommended for removal:
  - Their scores fell below a pre-determined threshold of 15 (0 – 14)
  - Ten of the 40 had total scores of **ZERO** - and they are documented elsewhere in the EHR
  - None of the 40 identified were required by a regulatory agency
  - Removing all 40 items recommended for removal decreases the admission assessment by 31%. Total potential click reduction = 39%
  - Raising the lower threshold from 0 – 14 to 0 - 15 results in an increase of elements recommended for removal by 25. Each of these additional elements are documented elsewhere in the record.

Source: Swietlik, M. (2019). Vanderbilt University School of Nursing . DNP Scholarly Project. A Decision Support Tool to Evaluate Nursing Documentation for Burden Reduction Opportunities. Committee Chair: Sengstack, P.

Limitations

- Single site
- Thresholds were selected based on sample of data
- Thresholds may need to be adjusted to avoid overstating or understating number of assessment elements for removal
- Consensus-driven responses vs. true interrater reliability

Follow-up work

- Remove items deemed non-value added
- Evaluate redundant elements in order to determine best location to capture this information
- Consider personnel other than nurses to collect admission information
- Partner with vendors to evaluate how nurses are spending their time in the patient chart and look for opportunities for improvement

Conclusions

- Limited number of studies objectively evaluating the impact of the burden of nursing documentation
- Most are survey-based and focus on perception of burden
- Burden continues to increase while little is being done to reduce volume
- Unnecessary
- Non-value added
- Limited quality research in this area
- NEED MORE RESEARCH!

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