Paula Wolski, MSN, RN, Mary Anne Barry, MBA, BSN, RN, Jessica Loescher BSN, RN, Erica Ricci, BSN, RN

Brigham and Women's Faulkner Hospital, Boston, MA

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Introduction/Background

Historically Brigham and Women's Faulkner Hospital (BWFH) had an Electronic Health Record (EHR) that provided a list of nursing interventions that did not correlate with patient problems or an organized plan of care. In 2015, BWFH implemented an integrated EHR (Epic clinical systems product). Epic provided an evidence-based plan of care and patient education product. Staff were unable to successfully utilize the EPIC system to its fullest and often documented only "progressing" or "not progressing" without meaningful context. Upon chart review it was difficult to follow the patients' progress as there was a lack of documentation against the plan of care. Staff's perception was that the process was timeconsuming and diverted them from patient care. The nurses' contribution to patient care appeared to be missing in chart audits.

Methods

A manual chart audit showed 23% of charts had a plan of care that was patient-specific or showed evidence of progress towards goals. An audit tool was utilized daily by project team members to review the presence of specific problems to this population of patients. Two weeks of baseline data were obtained via manual chart audits. Staff champions chose common problems and goals for their unit's patient population. Rapid-cycle change process was used to educate and reinforce the use of the plan of care as important and relevant to nursing's contribution to care. Process issues around documenting were reviewed and adjustments made to educational materials to clarify steps to be taken. Staff were added to the project every 3 days until the entire staff was included. Manual audits were completed weekdays on patients that were at least one day post-admission. There were two educational interventions: a Nursing Grand Rounds, and tips sheets.

Results

Success was measured as an increase in documentation on the plan of care as evidenced by the presence of the identified problems and associated measurable goals and a plan of care note daily. Initial audits performed in April 2017 demonstrated compliance with the plan of care at 23%. Post intervention audits show continued improvement with increased compliance to 93%.

Discussion/Conclusion

The use of an interdisciplinary plan of care allows all clinicians to see what the impact of each discipline's contribution to the patient's care is. With the evolution of EHR's the entire team has the capability of documenting and seeing all disciplines' assessments in one place with easy reference to support the progression toward the next level of care [1]. Enhancing staff's ability to utilize and document against the plan of care has the potential to improve staff satisfaction, patient satisfaction, and decrease duplication of efforts.

We believe this project was successful because end-user staff were involved and engaged from the beginning of the project. Their assessment of issues, identifying reasons for lack of use, and solutions to solve them, in the form of tipsheets, helped all see how they can impact change. Addressing concerns regarding how to use the product, in an efficient manner, early in simple terms with clear examples helped to make this project a success. Once the project started, the fear of this being a time consuming process dissipated. Ongoing work will begin to include patient engagement in this work as well.

References

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