Improving Consistency and Accuracy in Pressure Injury Documentation

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Introduction/Background

Hospital-wide chart reviews revealed difficulty in accurately determining the condition of a patient's pressure injury or injuries through available documentation. Information was inconsistent among various areas in the Epic electronic health record (EHR), including clinician notes and flowsheets. Staff focus groups identified human factors, variation in practice, and Epic functionality as contributing to this lack of consistency. In addition, no clear definition or guidance for where, how and when to document in Epic has been established. This inadequate or inaccurate documentation of pressure injury (PI) leads to confusion, impacting both treatment and reporting of PI, negatively impacting care delivery for the individual patient and resulting in missed opportunities for staff education. Regulatory reporting requirements and payor reimbursement are affected.

Methods

Meetings with staff nurses revealed that they considered Pressure Injury descriptors in the Epic "Lines/Drains/Airways" (LDA) to be the "source of truth" for PI identification and assessment. Chart reviews and consultation with Case Management Clinical Documentation Specialists and staff on two pilot units informed our decision to define (1) present on admission (POA), (2) staging, and (3) location of PI as three elements necessary to establish accurate documentation in the PI LDA. We measured the number of PI LDAs containing accurate data in all three elements compared to the total number of PI LDAs, on our pilot units. Brainstorming sessions with bedside nurses and nurse leaders led to development of interventions that might improve the measure. Staff nurses began to incorporate discussions of Pressure Injury into daily multidisciplinary rounds to focus the attention of the entire patient care team on PI treatment and documentation. After one month, the intervention was enhanced to include the addition of the Attending RN and/or Resource Nurse as guides for the discussion of PI during these rounds.

Results

At baseline, documentation in the PI LDA that included all three elements was only 45%. After both interventions, documentation in the PI LDA that included all three elements increased to 63%. POA was the element most often found to be inaccurate or missing in documentation (32%). When POA was excluded from the measure, accuracy of documentation for staging and location of PI reached 91%. Discussion with bedside nurses revealed that their awareness of PI documentation increased; they also expressed increased confidence related to staging of PI.

Discussion/Conclusion

Accurate documentation of PI in the EHR was improved on two inpatient units by incorporating daily discussion of PI into rounds and standardizing documentation requirements. Established guidelines, and increased focus on PI documentation during rounds, enabled staff to improve documentation. Barriers to accurate completion of the POA element have been identified and potential system changes are being evaluated. Next steps include identifying champions for a hospital-wide effort to leverage these interventions and implement the documentation recommendations into standard practice. Once adequate compliance is achieved, responding clinicians will be encouraged to incorporate the PI LDA in their progress notes to achieve consistent documentation across role groups and establish basis for reimbursement.

References:

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