Implementation of Plan of Care Documentation

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S
Faulkner Hospital

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

Purpose

The purpose of this performance improvement project was to improve compliance with the use of a multi-disciplinary plan of care within the Electronic Health Record (EHR) that is available for staff to document patient care and progress towards admission goals.

The project aim was to improve plan of care documentation for three specific problems; pain, infection, and Venous Thrombus Emboli (VTE).

Background

- Brigham and Women's Faulkner Hospital (BWFH) has used an EHR for many years. The previous system provided clinical nurses with a list of interventions that did not correlate with patient problems or a plan of care.
- In May 2015, BWFH implemented an integrated EHR based on the Epic clinical systems product.
- The new EHR provided nurses with a multidisciplinary plan of care based on evidence-based practice interventions including patient education content.
- Clinical nurses were not routinely using the new plan of care to document patient progress against identified goals.

Methodology/Process

Setting: The pilot project was conducted on a 24-bed general surgical/orthopedic adult unit.

Population: Post operative patients who were at least 24 hours post surgical procedure.

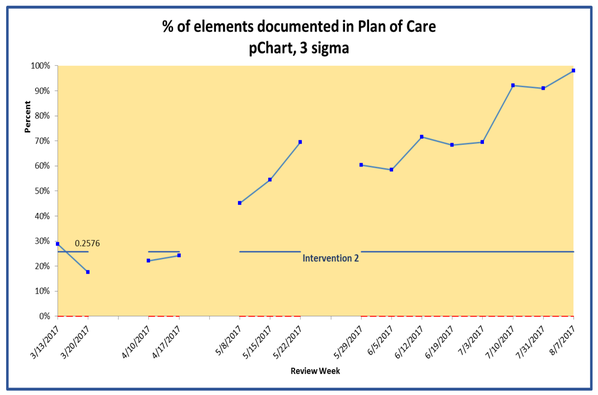
Process:

- A clinical nurse survey was conducted to identify barriers (knowledge, skill, attitude) to documentation in the plan of care.
- Baseline compliance data was obtained by manual chart audits revealing that only 23% of clinical nurses used/documented against the plan of care.
- Clinical nurses chose the plan of care template and selected problems to focus on.
- Plan-Do-Study-Act (PDSA)
  - Day 1: Two RN's documented on two patients for the three identified problems and completed an evaluation form to identify concerns.
  - Day 2: The two RNs documented on a full assignment for up to five patients.
  - Every three days at least two new clinical nurses were educated and expected to document on the plan of care.
  - Manual chart audits continued for eight weeks post implementation to monitor compliance.
  - An educational "tip sheet" was developed on the documentation process.
  - A Nursing Grand Rounds was held on the unit to discuss use of the plan of care and nursing's impact on care.

Outcome Measures

Success was measured as an increase in compliance with:

- Correct plan of care template utilized
- Problems on plan of care for pain, infection, and VTE prophylaxis
- Associated actionable goals to the problems
- Presence of a plan of care note



Results

- Compliance with documentation in the plan of care has consistently improved post implementation and remains between 90 - 98%.
- Feedback from clinical nurses was very positive. Participants in the project shared that documenting in the plan of care took less time than anticipated and provided a true picture of the patient story.

Practice Implications

The use of an interdisciplinary plan of care:

- Increases clinical nurse and patient satisfaction
- Eliminates duplicate documentation
- Promotes interdisciplinary collaboration
- Supports a coordinated plan of care to improve patient outcomes
- May potentially decrease the length of stay and prevent readmissions

The use of a multidisciplinary plan of care ensures that information about patient goals and progress towards specific goals is easily accessible to all members of the health care team.

Next Steps

- Implementation on all inpatient medical/surgical units.