IMPLEMENTING A NURSE LEADER TOOLKIT TO IMPROVE STAFF NURSING DOCUMENTATION

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Introduction

Nursing documentation is a communication tool for the patient's care team which assists in decision making and ensures effective, timely, safe and high-quality care is provided to the patient (Asmirajanti et al., 2019; Doody et al., 2018).

Nursing documentation reviews are used to assess the performance of the individual nurse, the organization's performance measures and compliance with regulatory standards (Asmirajanti et al., 2019; Cutugno et al., 2015; Nomura et al., 2016).

Nursing documentation is an important legal document that is reviewed to substantiate claims, hospital reimbursement, utilization management, and payment for services (Asmirajanti et al., 2019; Cutugno et al., 2015).

Nurses at all levels must be engaged with organizational leaders to revise, evaluate and improve documentation policies, procedures and systems (American Nurses Association, 2010).

Background & Significance

The Joint Commission (TJC) reports a top compliance issue healthcare organization's struggle with is demonstrating a consistent, complete and accurate record (Anderson, 2018).

The nurse leader is responsible for overseeing and maintaining the provision of safe, high-quality nursing care (Asmirajanti et al., 2019).

Lack of appropriate documentation can lead to significant patient harm events such as falls, decreased mobility, or clinical deterioration (Jungquist et al., 2016).

Nurse leaders need to have the knowledge, skills and tools to internally monitor and evaluate that safe, timely and effective patient care is provided.

Problem

The project site does not have an established record review process for unit nurse leaders nor education in their nurse leader orientation to know what to evaluate regarding nursing documentation accreditation and regulatory standards.

Nurse leaders are not educated on how to access and analyze EMR quality reports to guide decision making and drive performance.

The purpose of this project was to provide the nurse leader with the knowledge of how to evaluate nursing documentation via quality reports and implement a sustainable monitoring process with direct feedback to nursing staff to ensure accurate nursing documentation.

Methodology

Design: The pilot unit's EMR pain discrepancy report was analyzed to establish pre-intervention data.

The unit nurse leaders received education on the nurse leader toolkit components and weekly rounding with the project manager.

Post-intervention data analysis of the pain discrepancy report was analyzed for 4 weeks to determine if the interventions made a meaningful impact on nursing documentation.

Setting: 42 bed, in-patient, medical-surgical, orthopedic unit led by 4 nurse leaders.

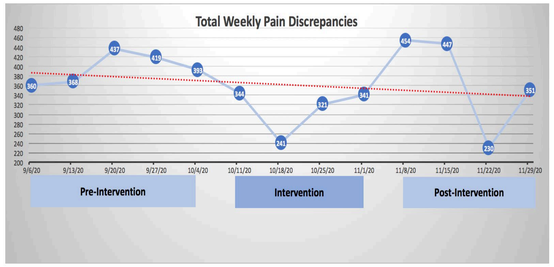
Intervention: The nurse leaders received education on the nurse leader toolkit components: documentation requirements, EMR quality report analysis and monitoring process, coaching, and documentation monitoring tools.

Weekly rounding with the unit nurse leaders and DNP project manager.

Measurable Outcomes: Reduction in pain assessment, pain reassessment and order adherence discrepancies.

Results

Reduction in the pain documentation discrepancies during the intervention phase.



Reduction in pain documentation discrepancies during the intervention and post-intervention phase compared to pre-intervention phase.

	Pre-Intervention Average	Intervention Average	Post-Intervention Average
Assessment	219	147	182
Reassessment	312	244	276
Order Adherence	48	23	22

Responses to the open-ended questions during the coaching sessions between the nurse leader and the DNP project manager validate that the nurse leader toolkit components and process are easy to use and valuable.

Findings

Increase in nurse leaders' knowledge in documentation standards, quality report analysis, performance improvement.

Nurse leaders need to provide consistent and timely feedback to staff to sustain results.

Organizational support and departmental collaboration with nurse leaders enhances unit performance.

Implications

Clinical Practice:
The project findings show promise in using the toolkit to support the nurse leaders in monitoring adherence to an accurate patient record. The EMR, documentation expectations for the end-user, data gathering and analysis can be overwhelming for both the staff nurse and unit nurse leader (Wisner et al., 2019). The nurse leader toolkit components and process provided focus for the nurse leader and staff.

Implications

Healthcare Policy:
The project site has Magnet designation, therefore the support structure, resources and multiple avenues for all nurses to influence healthcare policy, procedures and system change is available and highly encouraged. The staff nurse driven unit practice councils is a forum where nurses can engage in producing change where the results and findings of this project can be shared to advance the efforts of improving nursing documentation. The project site's organizational culture, mission, vision and values fosters collaboration to produce change with the goal of providing a safe environment for all patients, visitors and employees.

Quality & Safety:
The project interventions align with the regulatory and accrediting bodies recommendation of conducting ongoing patient record reviews, tracers and/or audits to ensure the delivery of safe patient care and compliance with accreditation standards (Anderson, 2018). EMR reviews are a proactive approach that assists healthcare professionals in identifying opportunities for performance improvement with the over-arching goal of providing safe patient care (Madden et al., 2018).

Education:
This project increased nurse leaders' knowledge in documentation standards. An organization that fosters knowledge and competency development, shared learning and mutual feedback amongst team members promotes professional development and fortifies relationships (Lunden et al., 2017).

References

American Nurses Association. (2010). *ANA's principles for nursing documentation: Guidance for registered nurses.* Silver Spring, MD: Nursesbooks.org.

Anderson, S.C. (2019, March 27-28). *Record of care, treatment, and services (RC)* [Conference Session]. The Joint Commission Hospital Accreditation Essentials, Las Vegas, NV, United States.

Asmirajanti, M., Hamid, A.Y.S., & Hariyati, R.T.S. (2019). Nursing care activities based on documentation. *BMC Nursing 18*(32). doi: 10.1186/s12912-019-0352-0

Cutugno, C., Hozak, M., Fitzsimmons, D.L., Ertogan, H. (2015). Documentation of preventive nursing measures in the elderly trauma patient: Potential financial impact and the health record. *Nursing Economics, 33*(4), 219-226.

Doody, O., Bailey, M.E., Moran, S., & Stewart, K. (2018). Nursing documentation in palliative care: An integrative review. *Journal of Nursing, 5*(3). doi: 10.7243/2056-9157-5-3

Jungquist, C., Correll, D.J., Fleisher, L.A., Gross, J., Gupta, R., Pasero, C., Stoelting, & R., Polomano, R. (2016). Avoiding adverse events secondary to opioid-induced respiratory depression: Implications for nurse executives and patient safety. *JONA: The Journal of Nursing Administration, 46*(2), 87-94. doi: 10.1097/NNA.0000000000000301

Lunden, A., Teras, M., Kvist, T., & Haggman-Laitila, A. (2017). A systematic review of factors influencing knowledge management and the nurse leaders' role. *Journal of Nursing Management, 25,* 407-420. doi:10.1111/jonm.12478

Madden, C., Lydon, S., Curran, C., Murphy, A.W., & O'Connor, P. (2018). Potential value of patient record review to assess and improve patient safety in general practice: A systematic review. *European Journal of General Practice, 24*(1), 192-201. doi: 10.1080/13814788.2018.1491963

Nomura, A.T.G., Barragan, M.S., & Almeida, M.A. (2016). Quality of nursing documentation before and after the hospital accreditation in a university hospital. *Rev. Latino-Am.Enfermagem, 24*(e2813). doi: 10.1590/1518-8345.0686.281

Wisner, K., Lyndon, A., & Chesla, C.A. (2019). The electronic health record's impact on nurses' cognitive work: An integrative review. *International Journal of Nursing Studies, 94*, 74-84. doi: 10.1016/j.ijnurstu.2019.03.003