Reducing Burden:
What Clinical Documentation is REQUIRED vs. Self-Imposed

Thursday, November 16, 2023

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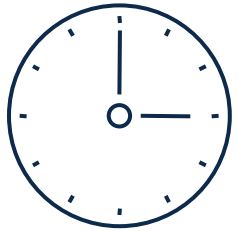

The webinar will start at the top of the hour.

Past Webinars Available for Streaming

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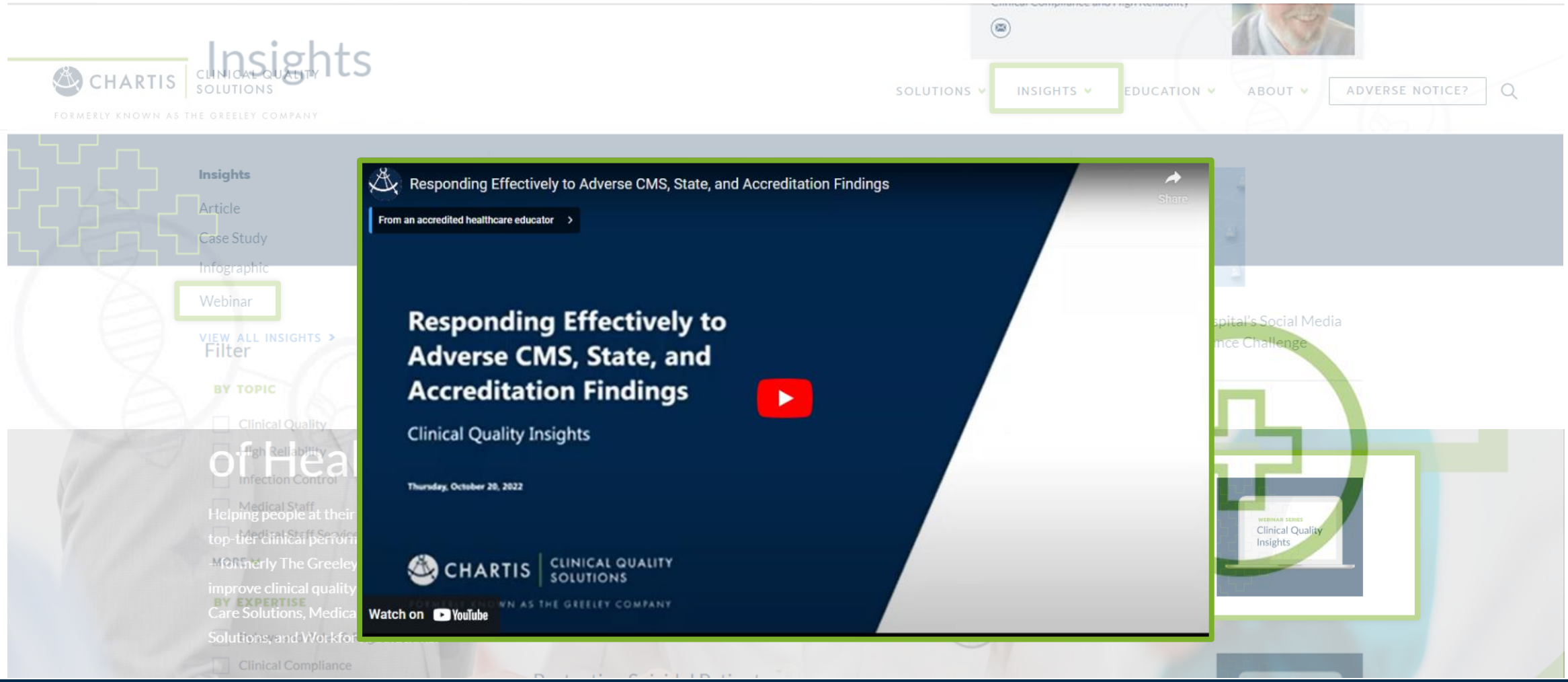

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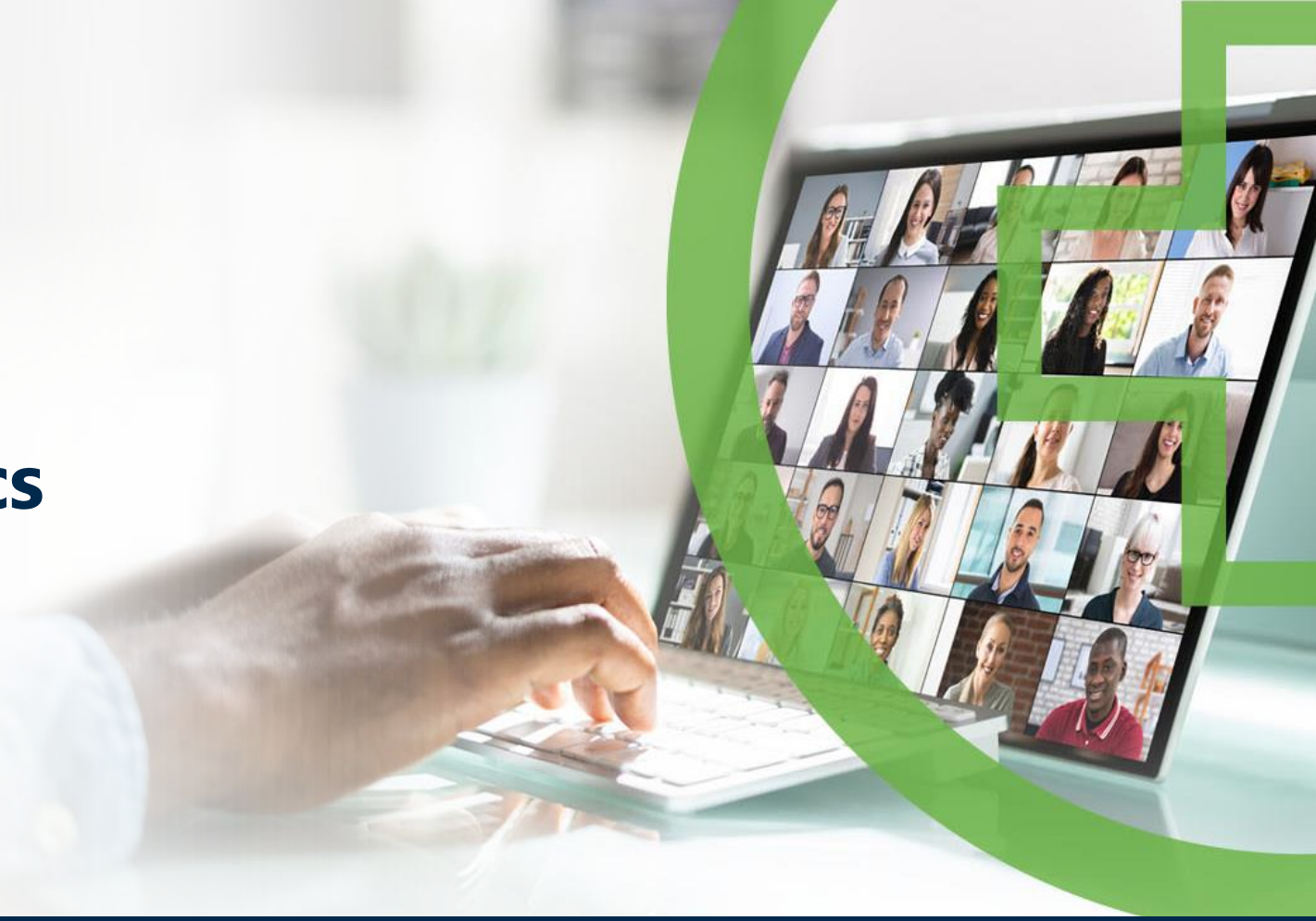

MONTHLY CLINICAL QUALITY INSIGHTS

Webinar Schedule & Topics

THE 3RD THURSDAY OF EVERY MONTH:

10AM Pacific, 1PM Eastern

TODAY

Reducing Burden: What clinical documentation is REQUIRED vs. Self-Imposed?

DECEMBER

A Simple Start to the New Year: Clear-cut Clinical Policies

Past W

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AVAILABLE FOR STREAMING

- Practical Approaches to Ace Regulatory and Accreditation Surveys
- EMTALA Made Simple
- Protecting Suicidal Patients
- Responding Effectively to CMS, State, and Accreditation Findings
- Avoiding Infection Prevention Survey Catastrophes
- Survey Smarts: Looking Forward to 2023
- Increasing Nurse Efficiency: Documentation Simplification
- Better Meetings Better Results
- Overcoming Persistent Challenges in the Physical Environment
- TJC's Emerging Model for New Standards
- New CMS Interpretive Guidelines for QAPI
- Putting Your Best Foot Forward During Survey
- Connecting Hospital Rankings to Outcomes
- Compliance and Safety Challenges for Psychiatric Hospitals and Units
- CMS and QAPI: A Deeper Dive
- Mid-Point Update … Focusing on Regulatory Changes
- High Risk Roundup: Restraint, Sedation, and Titrations
- Reducing Burden: What clinical documentation is REQUIRED vs. Self-Imposed

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- Environment of Care, Life Safety, and Emergency Preparedness
- Hospital-CMS Systems Improvement Agreements ...the National Leader
- Emergency Department/EMTALA
- Behavioral Health
- Infection Prevention
- Patient Safety
- Process/Policy Simplification
- Streamlined Health Records
- Process Implementation
- Quality Monitoring and Improvement

Integration with other best-in-class consulting services offered by Chartis

SIMPLIFY & COMPLY

What is your role?

- Chief Quality Officer
- Other Executive Leader
- Quality Manager
- Patient Safety Officer
- Risk Manager
- Accreditation/Regulatory Compliance
- Consultant
- Other

TODAY'S DISCUSSION

Updating our community on clinical documentation misconceptions and providing a pathway to simplification

Cherilyn Ashlock DNP, RN, NE-BC

Advisory Consultant

Clinical Compliance and High Reliability

Kim Wilson, MS, BSN, RN

Senior Consultant

Clinical Compliance and High Reliability

Lisa Eddy MSN, MHA, RN, CPHQ

Vice President,

Clinical Compliance and High Reliability

"

Keeping up with Change

Planning for Tomorrow

"

Who is your primary accreditor?

- The Joint Commission
- The Accreditation Commission for Health Care (ACHC)
- Det Norske Veritas (DNV)
- Center for Improvement in Healthcare Quality (CIHQ)
- Non-Accredited
- Other

Objectives

We will focus on four prioritized areas that are commonly overburdensome and can be simplified to give nurses time back at the bedside. This includes the following areas:

- **Nursing Admission Assessment**
- **Restraint documentation by shift attestation**
- **PRN Medication assessment & reassessment**
- **Block Charting for Titratable Medications**

Handouts will be linked to the Chartis Website for post-webinar streamers.

Nursing Admission Assessments

the biggest bang for your buck….

Nursing Owns a SIGNIFICANT Amount of Documentation

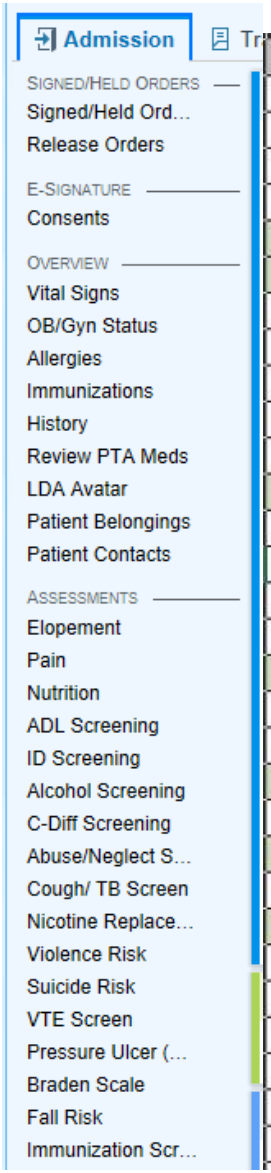
Admit Assessment:

- Allergies
- Advanced Directives
- Initiate Care Plan
- Domestic Abuse
- PTA Meds
- Patient Belongings
- Education
- Skin/Braden
- Suicide
- Travel
- Vitals
- Nutrition
- Fall/Morse
- DC Planning
- ……and MORE!

Admission Assessments: The Issues We See

- Policy doesn't align with EMR
- Taking the "standard build"
- The Kitchen Sink Methodology
- Misunderstanding the requirements
  - Don't create regulatory burden for yourself
- Nursing 24/7
  - Where to draw the line
  - Should nurses collect data for other disciplines?

EPIC Required Documentation (Admit)	Policy Requirements for Admit	Policy Requirements for Admit (ICU & INTERMEDIATE)
To be completed within 4 hours:	**To be Completed within 24 Hours**	**To be Completed within 24 Hours**
ADL Devices	Physical	Psychological
ADL Screening	Psychological	Social
C-Diff Screening	Social	Developmental disabilities
Domestic Abuse	Nutrition & Hydration Status	Safety
Nutrition	Functional Status	Cognitive disorders
Smoking History Documented	Learning Needs/Language	Patient/Family Personal Goals
Suicide Screening	Abuse, neglect, exploitation	**Within 1 hour of arrival to Unit:**
Violent Patient Screening	Safety	Vitals
Allergies Reviewed	Cognitive disorders	Height/Weight
CAGE Questionnaire	Patient/Family Personal Goals	Pain
Elopement Screening	Cultural and Religious factors	Sepsis
Fall Risk Assessment	Self-harm/suicide	Allergies
It Takes Two	Pain	**Within 4 hours of arrival to Unit:**
Pain Assessment	Skin Integrity/risk	Head to Toe
Skin/Braden	Fall Risk	LDA and Wound Assessment
To be completed within 12 hours:	Developmental disabilities	Skin (It takes Two Protocol)
Learning Assessment	Substance abuse/dependence/additive	Elopement
PTA Med List		Nutrition & Hydration Status
Valuables		ADL
Values/Beliefts		ID
Care Plan Started		Alcohol
Nurse Driven VTE Mechanical Contraindication Screening		C-Diff
Nurse Driven VTE mechanical prophylaxis screening		Abuse



EPIC Required Documentation (Admit)	Policy Requirements for Admit
	Initial Physical Assessment
Allergies	
Annotated Image	
Integumentary LDAs	
Care Plan Initiated	Care Plan
Domestic Abuse Assessment	Psychological
PTA Med List Completed	
Patient Belongings Assessment	
Patient Education Documented	
Patient Safety Agreement Reviewed/Signed	
Skin/Braden Assessment	
Smoking History Documented	Social Status
Suicide Assessment	
Travel Screening	
Vitals, Height, Weight, Pain	
Discharge Folder Given to Patient	
ADL Assessment	Functional Satus
ADL Devices Assessment	
Consults Needed Assessment	
Discharge Planning Assessment	Discharge Planning
Infection Screen	
Learning Assessment Filed	Education
Notification of Admission Documented	
Nutrition Assessment	Nutritional Status
Pneumonia Vaccine Screen	
Values Assessment	
Visitation Support Person Designation	
Fall/Morse	
	Spiritual Needs
	Patient's Response to Illness/Treatment

Admission Assessments Solutions

- Inventory your admission assessment
- Determine WHO should be responsible for collecting information
- Understand the requirements – there are VERY few regulatory requirements for an admission assessment by nursing
- Eliminate redundancy
- Simplify your policy language

Admission Assessment Simplification	Recommendations:
***Discharge Planning**	
Admission info provided by:	
What brought you to the hospital? (free text)	There's an admitting diagnosis so what's the rationale for capturing this in a free text note? This is catpured through coding and H&P. Recommend removing. This same question is in the discharge planning section too.
Is there a physician you would like notified of this admission?	
Is there a family member or rep you would like notified of this admission?	
Emergency Contact verified?	What's the purpose of this? This should have already been done by registration. Eliminate
Clinical Information/Patient History - Have you been hospitalized within the last year?	This is not relevant to the bedside nurse - eliminate. This is likely screening for another department.
How long ago?	This is not relevant to the bedside nurse - eliminate. This is likely screening for another department.
What were you admitted for?	This is not relevant to the bedside nurse - eliminate. This is likely screening for another department.
At what hospital were you admitted?	This is not relevant to the bedside nurse - eliminate. This is likely screening for another department.
Visitation Support: Is there a family member or representative you would like to designate as your support person for purposes of visitation? (free text)	Duplicative. You have already asked about this. Eliminate
Living Arrangements (list of people)	Recommend have ONE question for DC Planning on admission: Are there any identified discharge needs at this time? If yes, a consult will be entered to SS/CM. Let CM/SS address the rest of this.
Support Systems (list of people)	
Current Residence Type (list of locations (private residence, group home, etc)	
Current Home Care Service (list of places)	
Current Residence Type	
Current Home Care Services	
Patient expects to be discharged to:	
Discharge folder given to patient? Yes/No/ CCH Nurse/ Christus St. Vincent Hospital Nurse = patient info given	
Allergies	
Gender History	
Is your gender now the same as at birth?	
What steps are you taking related to yor gender?	
HISTORY:	
Medical History	Duplicative to MD documentation - feeds into H&P, recommend eliminating from Nursing
PMH	
Pertinent Negatives	
Surgical History	

L&D Admission Assessment Simplification	Recommendations/Comments:
Triage Admit Overview Section	
Arrival Info	
*Arrival Info (arrival date/time, expected LOS, arrival date, room, etc.)	There's a MyChart Signup in this navigator that doesn't exist in any of the other navigators. Can this be removed? Staff aren't using it and don't know what it's for.
Visit Info	
* Reason for visit	There's an admitting diagnosis so what's the rationale for capturing this in a free text note? This is catpured through coding and H&P. Recommend removing.
ed automatically)	
of Conception, Ultrasound	
rview & Plan	
tuses, Delivery Plans, Planned Delivery Location, Plans for Adoption, etc.	Nursing doesn't use this. This is only completed by clinics and nurses can see it only if it's documented in the clinic.
re (same as others)	
ers (they can list their OB/Providers/Midwife, etc)	L&D staff do not complete or use this
(labs related to pregnancy) -	Nursing staff are transcribing all external lab values, one at a time, even though they have the paper documents. They do this so that providers don't have to look at a paper document. I've never heard of any other hospital doing this. This seems like a huge waste of time for a nurse to compelte and raises transcription error concerns. Recommend stopping this.
lted labs, a place where staff can enter orders, or input lab results.	
hey can order ultrasounds from here and view prior ones from here)	
vida, etc.)	
sk Assessment	
sment (AWHONN PP Hemorrhage (Shows Admit/Pre/Post birth)	Epic sweeps chart Q20 min for updated scores
cia Screen - fires BPA if positive	
istory	There's no family health history on this section like the adult. There is an entirely separate HISTORY tab that repeats the Medical/surgical histrory and has a Family History in it. Why? Duplicative to MD documentation - feeds into H&P, recommend eliminating from Nursing
type/type	
: Yes/Not Currently /Never, Birth Control Protection, Partners	
/No, Types, Uses/Week	
*Tobaco Use, Passive Exposure, Smokeless, Cessation Counceling	There's a separate HISTORY tab with "social determinants" that goes over substance use (again), sexual activity (again), e-cig/vaping (even though smoking questions already addressed, socioeconomic, PHQ (again), etc. Why is this all a separate tab? Recommend consolidating.

Restraint Documentation by Shift Attestation

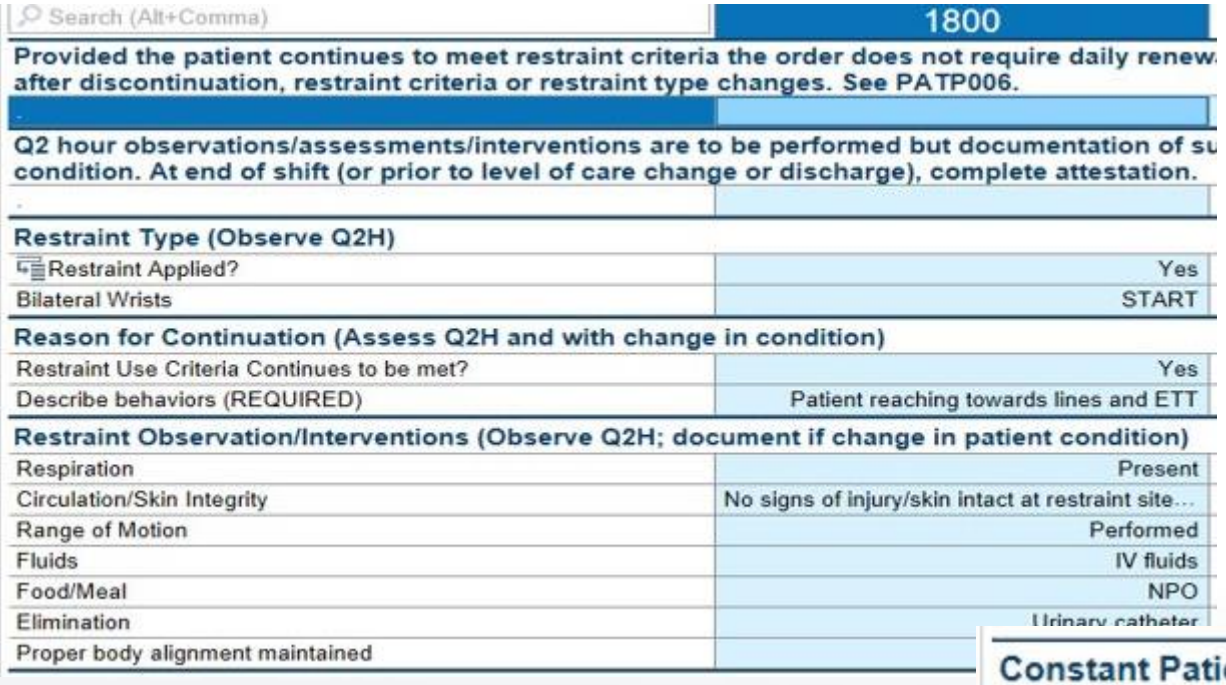
thinking outside the box…

Restraints: The Issues We See

- Policy doesn’t align with EMR
- Missing Q2H observations
- Missing restraint care plan
- Restraint Order “reason” doesn’t align with nursing “reason” for restraint
- No clear justification for why restraints are being used
    - RASS -4, staff documenting patient “unresponsive”, “comatose”

Restraint Solutions

- Consider an end-of-shift attestation that would eliminate Q2H documentation!



Search (Alt+Comma)	1800
Provided the patient continues to meet restraint criteria the order does not require daily renew after discontinuation, restraint criteria or restraint type changes. See PATP006.	
Q2 hour observations/assessments/interventions are to be performed but documentation of su condition. At end of shift (or prior to level of care change or discharge), complete attestation.	
Restraint Type (Observe Q2H)	
Restraint Applied?	Yes
Bilateral Wrists	START
Reason for Continuation (Assess Q2H and with change in condition)	
Restraint Use Criteria Continues to be met?	Yes
Describe behaviors (REQUIRED)	Patient reaching towards lines and ETT
Restraint Observation/Interventions (Observe Q2H; document if change in patient condition)	
Respiration	Present
Circulation/Skin Integrity	No signs of injury/skin intact at restraint site…
Range of Motion	Performed
Fluids	IV fluids
Food/Meal	NPO
Elimination	Urinary catheter
Proper body alignment maintained	

RNs completes the Non-Violent end of care attestation when their care of the patient is complete. Usually this occurs at end of shift, however, may occur if patient gets transferred to another level of care, if nursing assignments change mid-shift, or when restraints are discontinued.

Build your care plan INTO your restraint flowsheet!

Constant Patient Observation (Document on initiation, at discontinuation and with any change	
Constant Patient Observation Provided By	
Start and Stop of Constant Patient Observation	
Reason for continuation of constant patient observation	
Staff Observer Name	
estraint Attestation: At end of shift (or prior to level of care change or discharge), complete at	
ntervals for monitoring response to interventions used	Patient observations, assessments and inte…
riteria for continued use	Dislodgement of device/disruption of treatm…
escribe Behaviors (Required)	Patient reaching towards ETT/lines

Plan of Care (On initiation, daily and any change in patient condition)	
Goal 1: Patient remains free of injury from restraints	Initiate
Interventions	Determine that alternatives or other, less re…
Evaluations/Outcome	Progressing
Time Frame	As soon as clinically indicated or within the…
Goal 2: Discontinue restraints as soon as medically indicated	Initiate
Interventions	Assess and document the continuing need…
Evaluations/Outcome	Progressing
Time Frame	As soon as clinically indicated or within the…

Restraint Solutions: Chart TWICE a shift for Non-Violent Restraints

Search (Alt+Comma)	0300	0500	05	0800	1200	1652
Education (On initiation, daily and any change in patient condition)						
Initiation of Restraint Criteria Explained			Rationa	Rationale for ini...		
Discontinuation of Restraint Criteria Explained			Actions requ...	Actions require...		
Learner			Patient	Patient		
Readiness			Unable to partic...	Unable to partic...		
Method			Explanation	Explanation		
Response			Needs Reinforc...	Unable to return...		
Plan of Care (On initiation, daily and any change in patient condition)						
Goal 1: Patient remains free of injury from restraints			Initiate	Initiate		
Interventions			Determine that...	Determine that...		
Evaluations/Outcome			Not Progressing	Not Progressing		
Time Frame			As soon as clini...	As soon as clini...		
Goal 2: Discontinue restraints as soon as medically indicated			Initiate	Initiate		
Interventions			Determine that...	Determine that...		
Evaluations/Outcome			Not Progressing	Not Progressing		
Time Frame			As soon as clini...	As soon as clini...		
Constant Patient Observation (Document on initiation, at discontinuation and with any change in patient condition.)						
Constant Patient Observation Provided By						
Start and Stop of Constant Patient Observation						
Reason for continuation of constant patient observation						
Staff Observer Name						
Restraint Attestation: At end of shift (or prior to level of care change or discharge), complete attestation.						
Intervals for monitoring response to interventions used		Patient observa...				Patient observa...
Criteria for continued use		Dislodgement o...				Dislodgement o...
Describe Behaviors (Required)		Patient pulls on...				patient reaches...

1

2

PRN Medication Assessment & Reassessment

where definitions matter…

Pain Assessment & Reassessment: What We Typically See

- Policy doesn't align with EMR
- Unrealistic documentation requirements
- Overly complex EMR pain templates

11/2/2023	Times of Med Admin	Pre Assess	Post Assess	Assessment Details Other Than Score	Notes:
ORIF Ankle	1428	10	None	None	Morphine 2mg IV
	1629	10	None	None	Morphine 2mg IV
	2037	10	None	Yes	Morphine 2mg IV
	101	7	Gave more meds	None	Pain score severe, gave moderate pain med (Norco)
	207	7	None	None	Gave Tylenol and Morphine 2mg IV
	554	7	6	None	Pain score severe, gave moderate pain med (Norco)

11/2/2023	Times of Med Admin	Pre Assess	Post Assess	Assesment Details Other Than Score	Notes:
Patient w/ DX of Multiple Sclerosis	227	9	2	None	Dilaudid 1.5 IV
	600	8	None	None	Morphine 15 IR
	804	9	None	None	Dilaudid 1.5 IV
	1102	8	7	None	Morphine 15 IR
	1251	7	None	None	Dilaudid 1.5 IV

Pain Assessment	
Type of Pain Assessment	
Detailed Pain Assessment	
Patient's Stated Pain Goal	
Pain Scale 0-10	
Pain Level (0-10 scale)	
Pain Orientation	
Pain Location	
Pain Descriptors	
Pain Radiating Towards	
Pain Onset	
Clinical Progression	
Pain Intervention(s)	
Multiple Pain Sites	
Other Pain Descriptors	
Pain Frequency	
Pain Type	

Pain Assessment & Reassessment: Attestation Solutions

Problem: **Infection Risk**
Goal: **Stabilize- Infection Risk**
Description: Increased chance of contamination with disease-producing germs.
Outcome: **Stabilized**

Problem: **Injury Risk**
Goal: **Stabilize- Injury Risk**
Description: Increased chance of danger or loss.
Outcome: **Stabilized**

Problem: **Respiration Alteration**
Goal: **Improve- Respiration Alteration**
Description: Change in or modification of the breathing function.
Outcome: **Stabilized**

Problem: **Gas Exchange Impairment**
Goal: **Improve- Gas Exchange Impairment**
Description: Imbalance of oxygen and carbon dioxide transfer between lung and vascu
Outcome: **Improved**

Problem: **Communication Impairment**
Goal: **Improve-Communication Impairment**
Description: Diminished ability to exchange thoughts, opinions, or information.
Outcome: **Improved**

Problem: **Injury Risk**
Goal: **Stabilize- Injury Risk**
Description: Increased chance of danger or loss.
Outcome: **Stabilized**

Problem: **Respiration Alteration**
Goal: **Improve- Respiration Alteration**
Description: Change in or modification of the breathing function.
Outcome: **Stabilized**

Problem: **Infection Risk**
Goal: **Stabilize- Infection Risk**
Description: Increased chance of contamination with disease-producing germs.
Outcome: **Stabilized**

Problem: **Fall Risk**
Goal: **Stabilize- Fall Risk**
Description: Increased chance of conditions that results in falls.
Outcome: **Stabilized**

Problem: **Gas Exchange Impairment**
Goal: **Improve- Gas Exchange Impairment**
Description: Imbalance of oxygen and carbon dioxide transfer between lung and vascular system.
Outcome: **Improved**

Problem: **Fluid Volume Alteration**
Goal: **Improve- Fluid Volume Alteration**
Description: Change in or modification of bodily fluid.
Outcome: **Improved**

Problem: **Respiration Alteration**
Goal: **Improve- Respiration Alteration**
Description: Change in or modification of the breathing function.
Outcome: **Improved**

Problem: **Physical Mobility Impairment**
Goal: **Improve-Physical Mobility**
Description: Diminished ability to perform independent movement.
Outcome: **Improved**

Problem: **Infection Risk**
Goal: **Stabilize- Infection Risk**
Description: Increased chance of contamination with disease-producing germs.
Outcome: **Stabilized**

Problem: **Skin Integrity Impairment Risk**
Goal: **Stabilize- Skin Integrity Impairment**
Description: Increased chance of skin breakdown.
Outcome: **Stabilized**

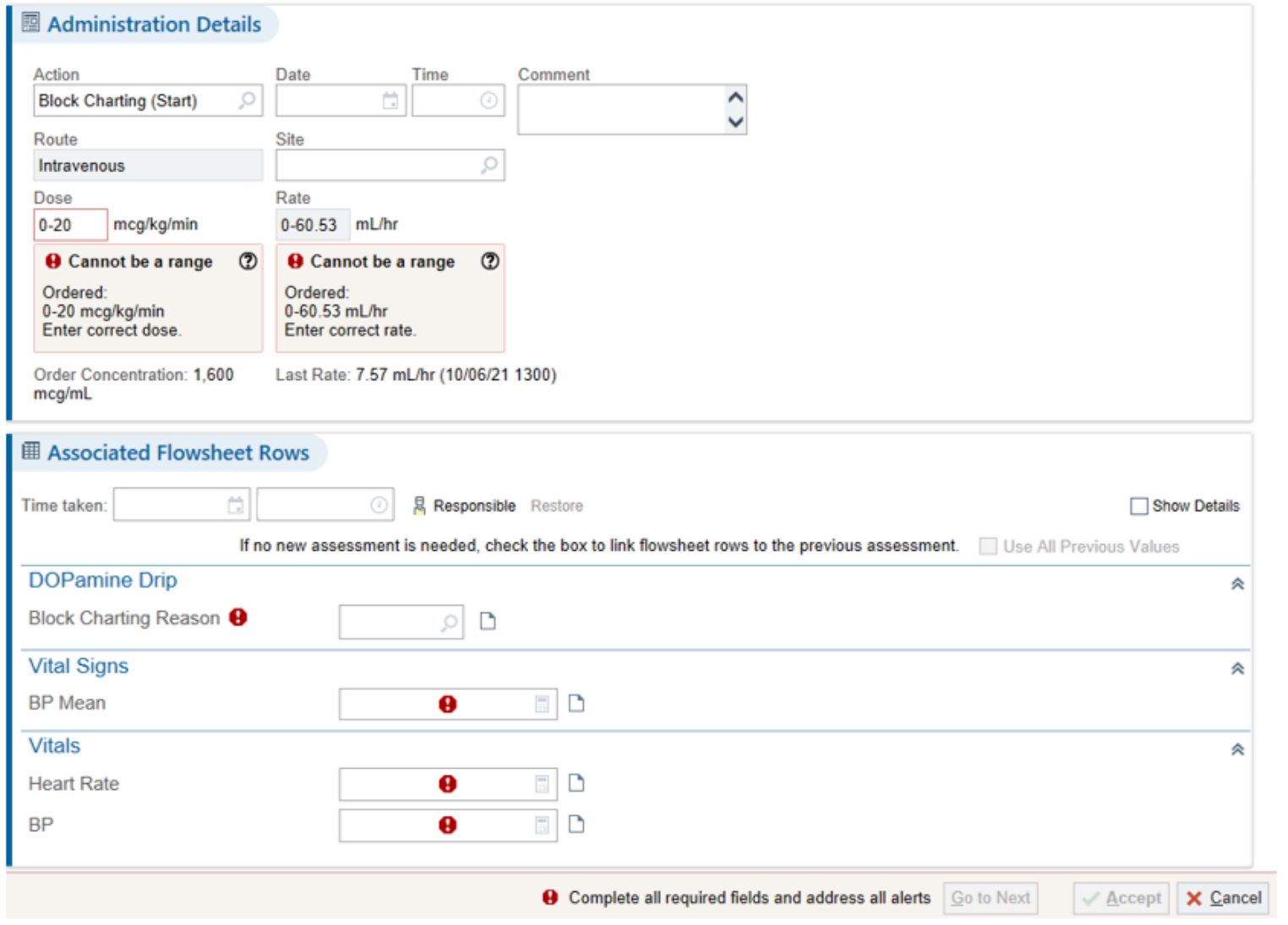
Problem: **Fall Risk**
Goal: **Stabilize- Fall Risk**
Description: Increased chance of conditions that results in falls.
Outcome: **Stabilized**

Make your CARE PLANS RELEVANT! Use those end-of-shift care plan notes to capture relevant information, not just a repeat of care plans.

Block Charting for Titratable Medications

for those rough days…

Block Charting Solutions



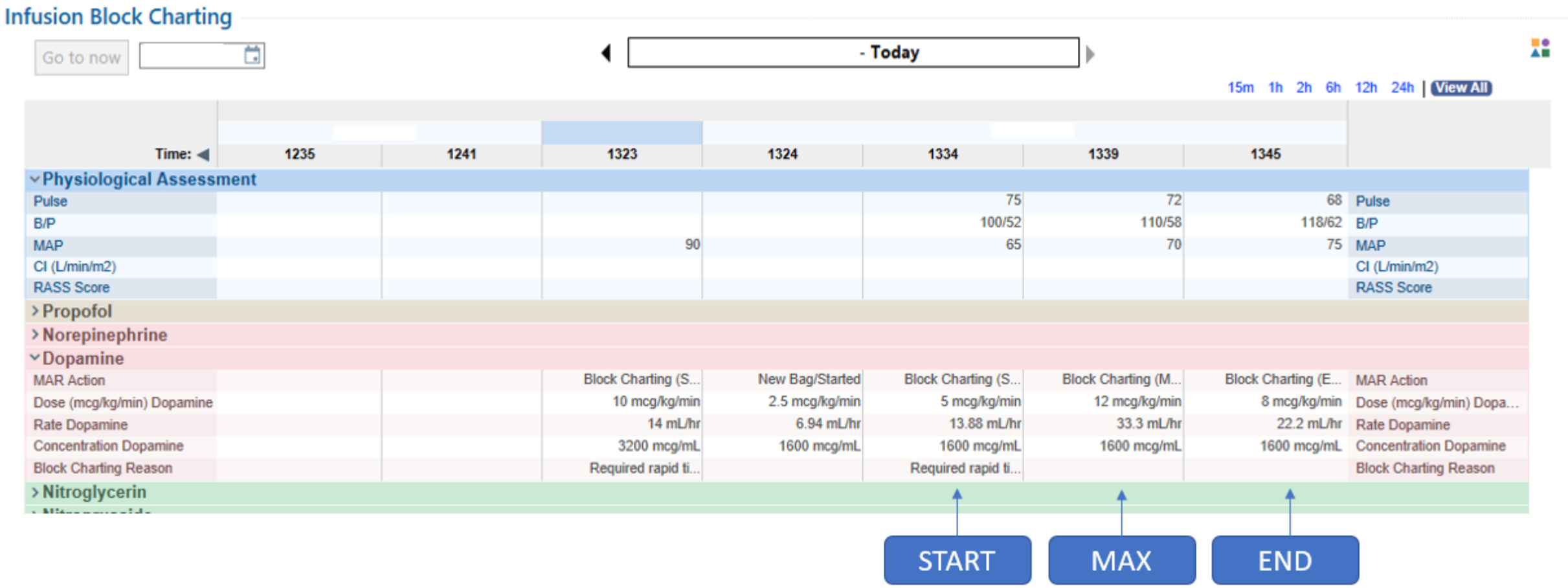
Block charting can be used when rapid titration of medication is necessary in specific urgent/ emergent situations <u>defined in organizational policy</u>.

The following information is required in all block charting documentation:

- **Block charting reason**
- **Time block started**
- **Starting dose**
- **Ending dose**
- **Maximum dose**
- **Time block ended**
- **Clinical parameters**

Block Charting Solutions

A single "block" charting episode does not extend beyond a four-hour time frame. If a patient's urgent/emergent situation extends beyond four hours and block charting is continued, a new charting "block" period must be started.



Other EMR Simplification Opportunities

Just a few of the other opportunities you likely have:

- Nursing Care Plans
- Head-to-Toe Assessments
- Fall Risk Assessments
- Wound Documentation
- Daily Cares (Activities)
- Suicide Assessments
- Triage

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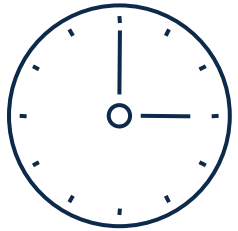

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