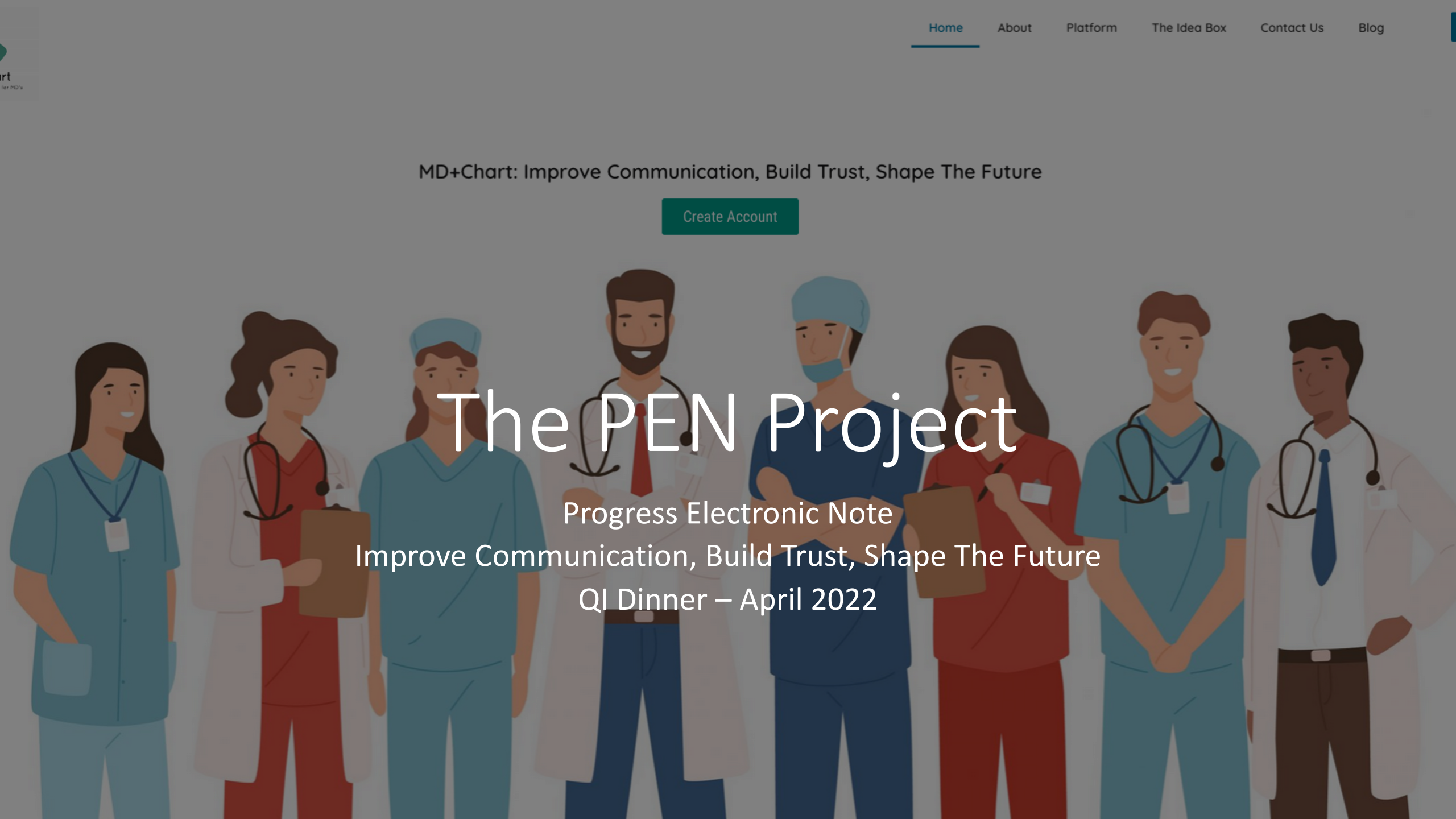


The PEN Project

Progress Electronic Note

Improve Communication, Build Trust, Shape The Future

QI Dinner – April 2022

Overview

- The PEN Project – Overview
- Recent PDSA cycle (after 6 months of free styling)
  - Study:
    - Current Practice
    - Template design and handovers
    - Processes
      - Meditech
      - Summary Section Utilization
      - Formatting
      - Copy and Paste
  - Change Ideas – based on feedback and study

THE PEN PROJECT

Improve communication, build trust, shape the future

PROJECT TEAM

Dr Johann Schreve

Project Participants:

- Kathy Derita - Dyad
- Caryl Harper - Consultant

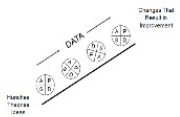
AIM STATEMENT

By July 2021, we, the Vernon Jubilee Hospitalist group, will improve handovers between hospitalists and communication with the multidisciplinary team by reducing handwritten progress notes by 40%. 95% of hospitalists will report satisfaction in taking over from their colleagues. 75% of the multidisciplinary team will report satisfaction in the communication of care plans.

PDSA Cycles

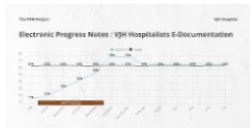
Small Test(s) of Change

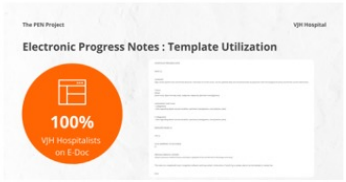
1. Template Development and standardization



DATA

1. Hospitalists using electronic documentation for progress notes – Chart Reviews
2. Adoption of the template – Chart Reviews
3. Billing Recovery – Data Analysis
4. Satisfaction with handovers and communication - Survey





BACKGROUND

Electronic documentation is the new standard of care, yet at Vernon Jubilee Hospital, 90% of hospitalists are doing handwritten progress notes. As hospitalists, our patients are often unknown to us and complex, so we rely on good documentation practices to care for them. Illegible handwritten notes and different documentation styles leads to fracture care, less efficient handovers and nursing uncertainty and will require a standardized and innovative approach to change.

INITIAL PROBLEM

1. Illegible handwritten notes
2. Fractured Care
3. Nursing Uncertainty with care plans

CHANGE IDEAS TESTED

- Vernon Jubilee Hospitalist Group
- Survey to identify need for change
- IMIT training
- Template Development – PEN template
- Website Technology to host e-templates

FINDINGS

- 78% of hospitalists voluntarily adopted electronic documentation after IMIT training. 68% continued to use MModal and pDoc at the end of the project
- 100% of hospitalists, who changed their practice adopted the PEN template
- 100% of hospitalists agreed that e-documentation and the template improves handovers.
- 90% of hospitalists agreed that electronic progress notes helps them do complex discharges
- The program saw a 2% increase in contract recovery with e-billing. The group managed to secure 100% of their billing incentive target for the last 3 quarters, which is an improvement.

PQI LEARNING OUTCOMES

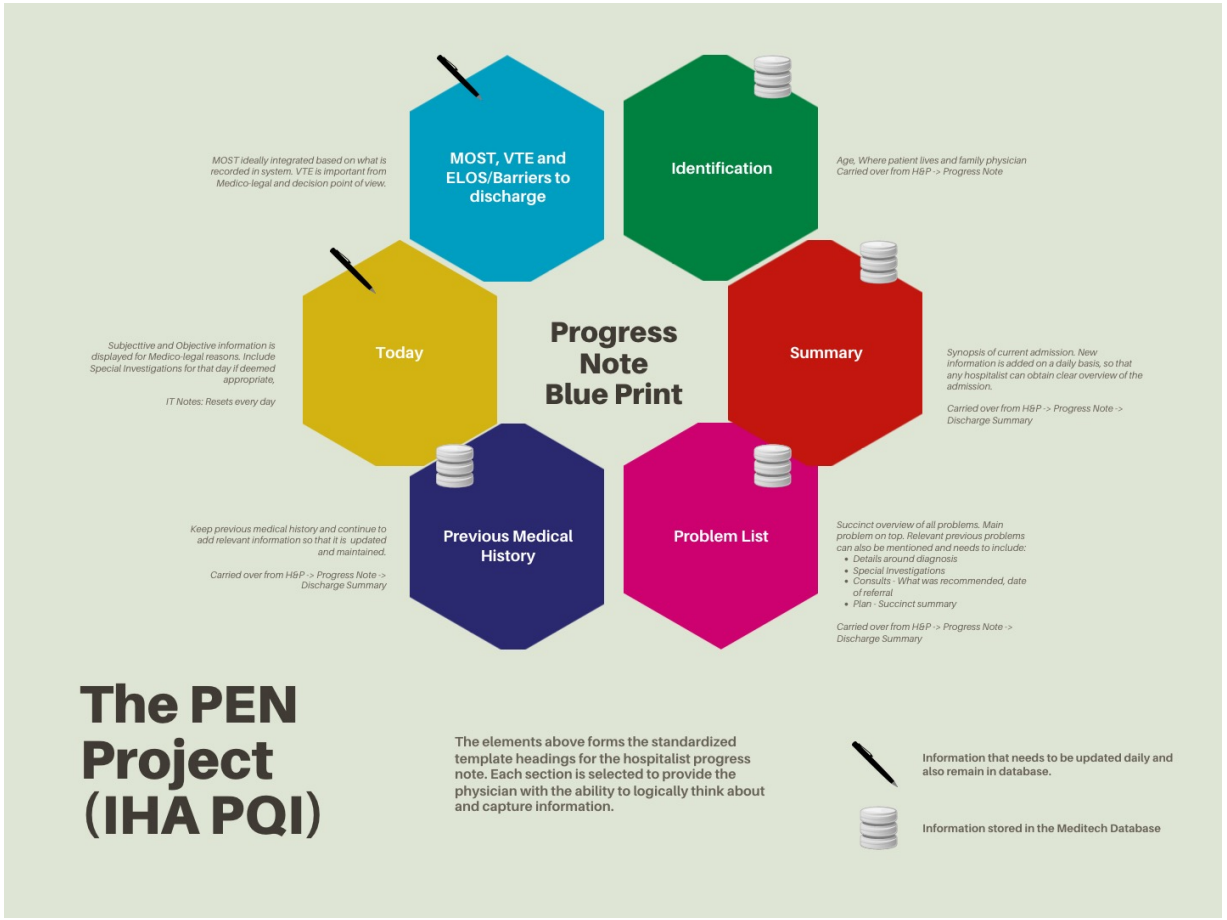
The PEN Project required a clearly defined goal to help determine if change led to an improvement. We wanted to use technology to improve technology, but after focusing on the handover component, it allowed us to better understand what elements of the progress note template required additional PDSA cycles that led to improvement. Engaging stakeholders, the members of our multidisciplinary team and our hospitalist group was paramount for success of this project.

PQI PHYSICIAN QUALITY IMPROVEMENT An SSC Initiative

The PQI Initiative provides training and support to physicians, to lead quality improvement (QI) projects of interest to them
This investment increases physician involvement in quality improvement and enhances the delivery of patient care.
Please see our website for more details: sscbc.ca

Partners in Quality
Interior Health
SSC SPECIALIST SERVICES COMMITTEE

Desire for uniform notes: Blue Print



ID: []

MOST: []

SUMMARY: []

TODAY: []

PROBLEM LIST: []

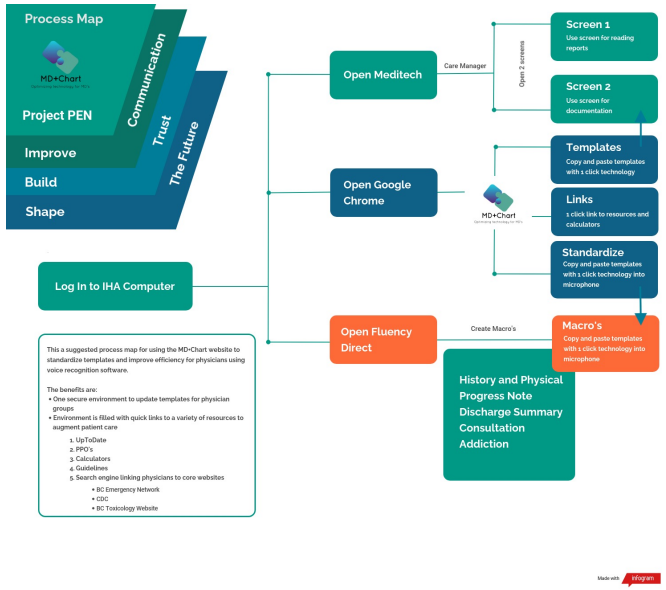
VTE: []

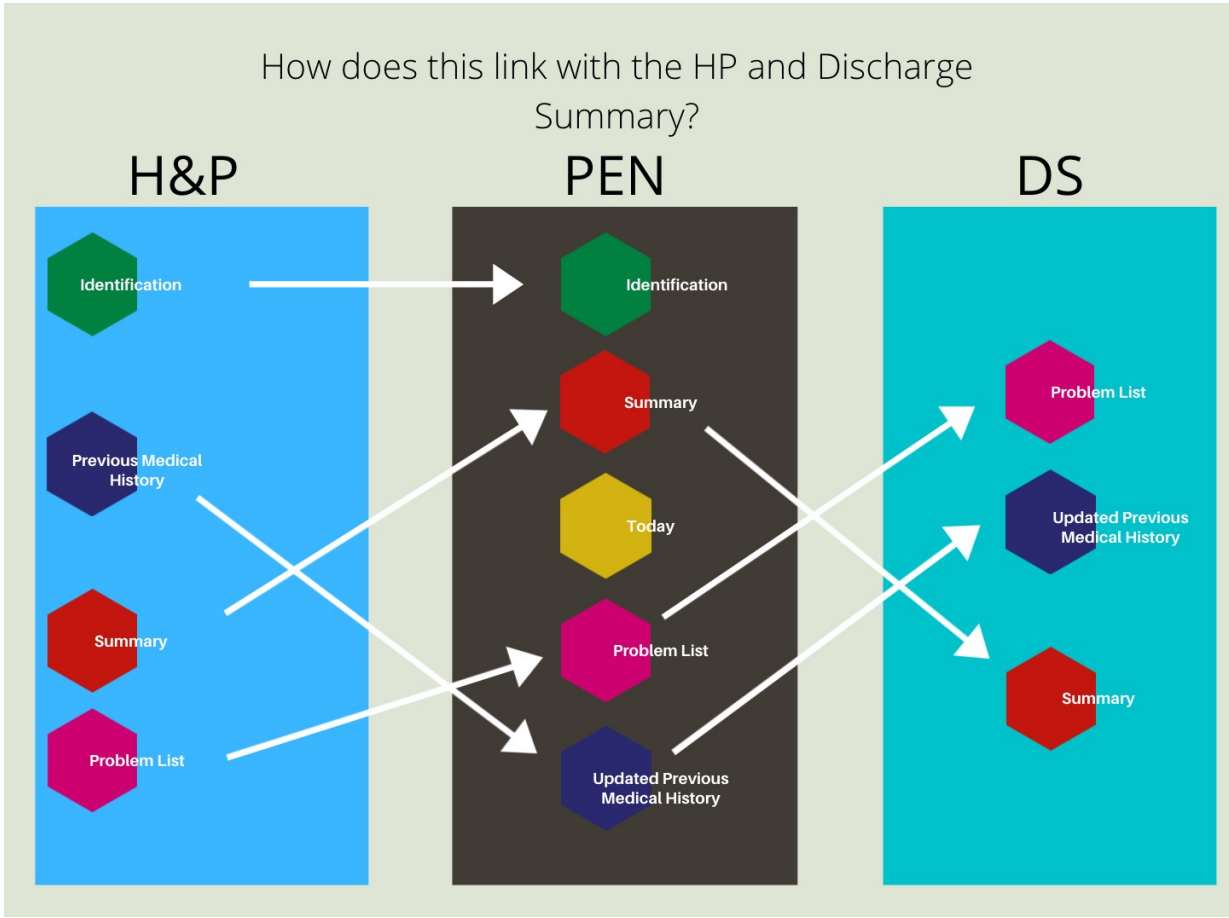
ELOS/Barriers/Disposition: []

Blue Print

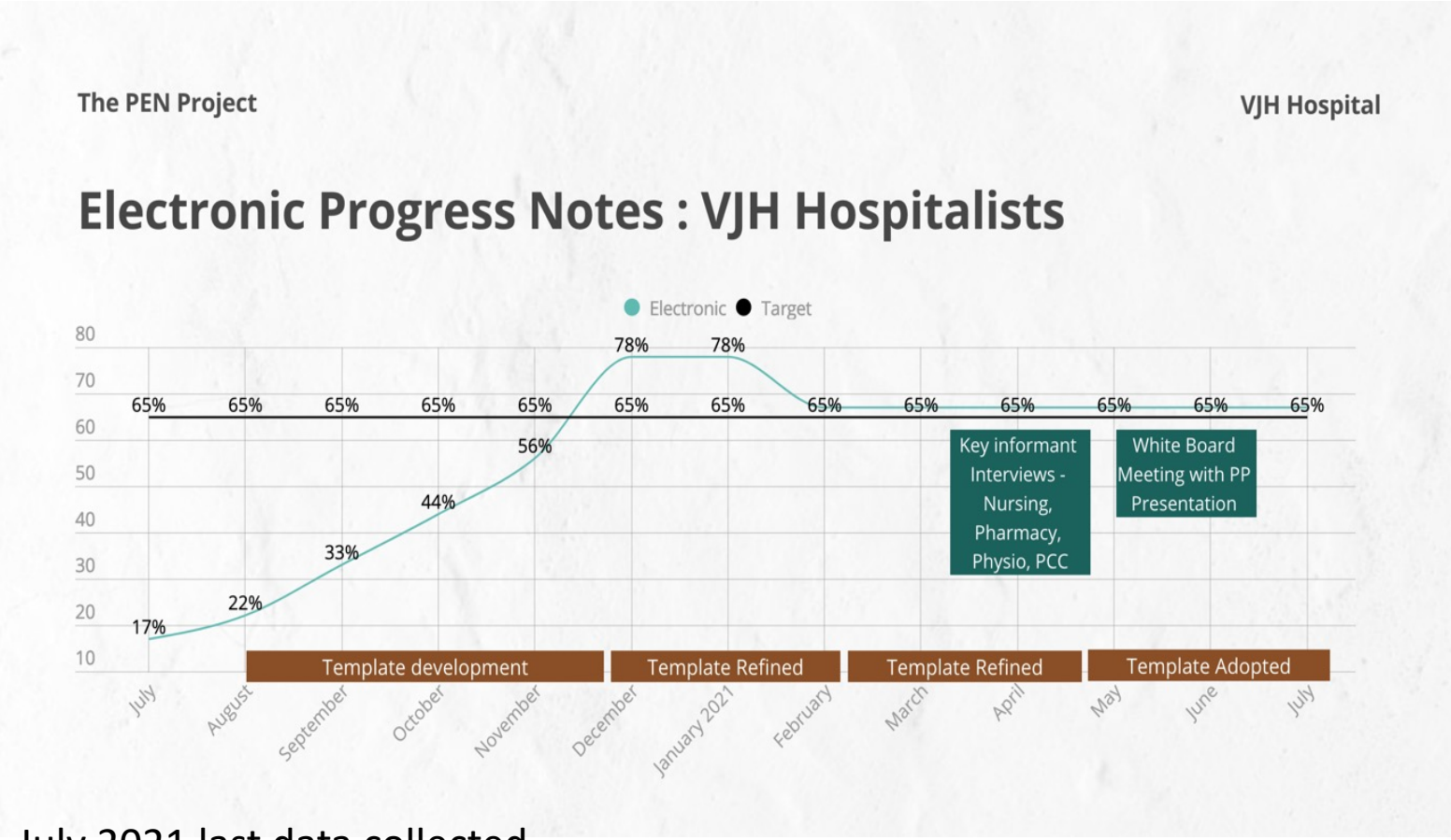
Could we design a template based blue print that could be adopted by IHA and lead to the development of Macro's for auto-population?

Decrease duplication of information…





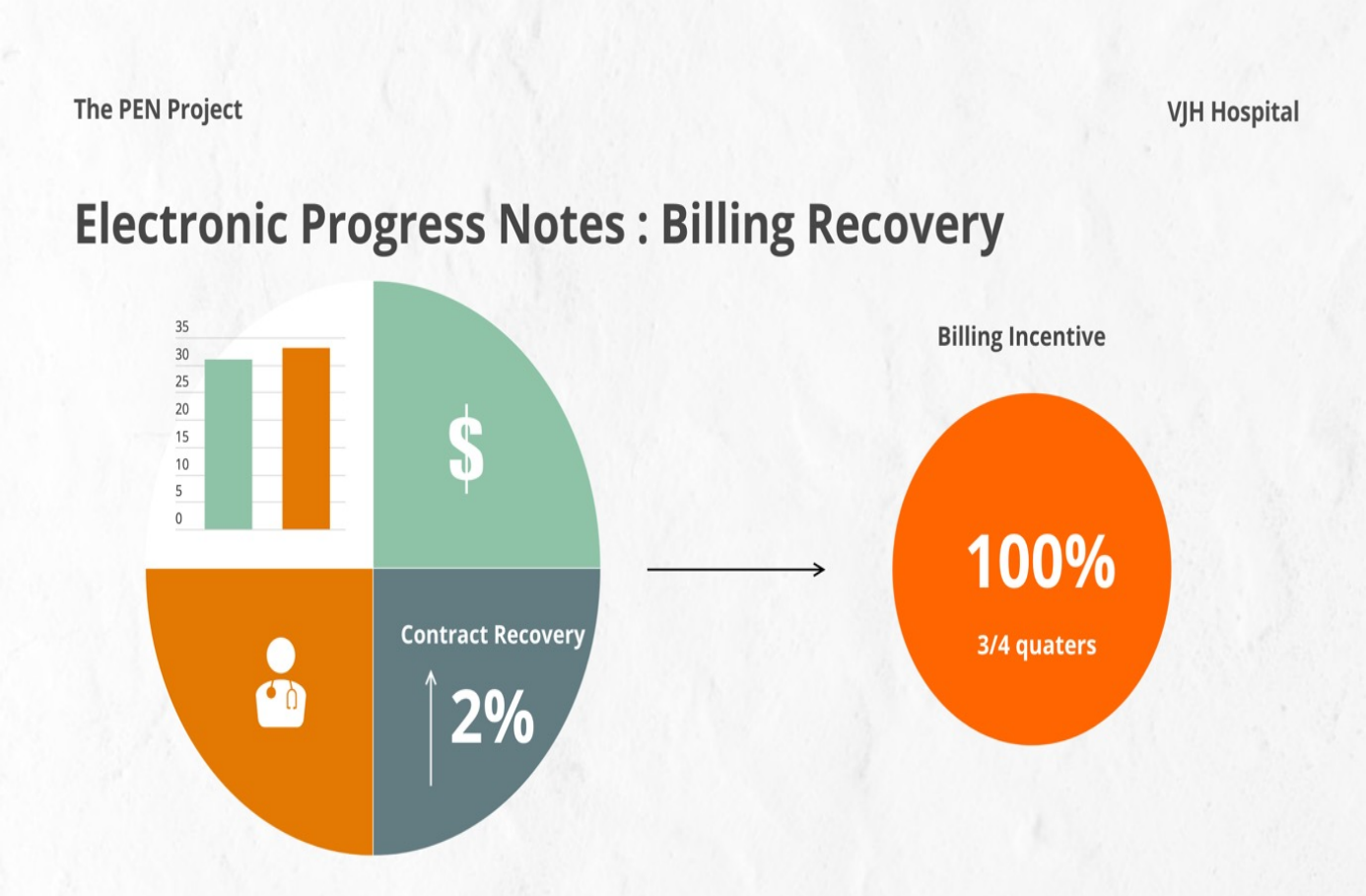
What did we achieve?



July 2021 last data collected.

April 2022
86% of contractees are currently using electronic documentation

Also…



100% of hospitalists indicated that they were more satisfied with handovers.

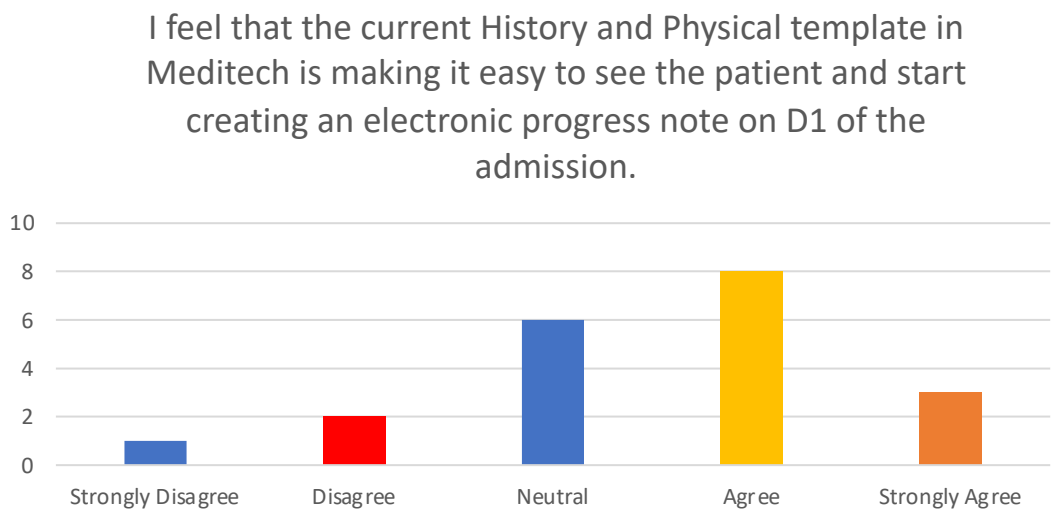
Nursing, allied health and pharmacy surveys indicated **80%** satisfaction with electronic notes compared to handwritten notes**.**

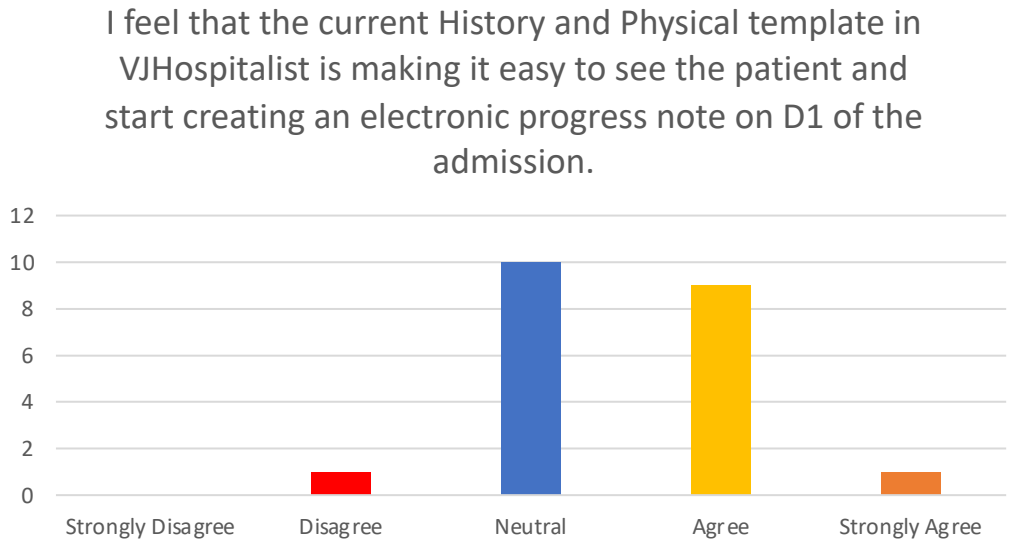
PDSA Cycle

- STUDY: Survey circulated to locums and contractees that worked with us in the past 1 year. 21 doctors completed the survey,
  - **90%** of hospitalists completing the survey is currently using pDoc, which is a significant improvement compared to only 17% in July 2020
  - **86%** of hospitalists experienced symptoms of burnout in the past 6 months (? Is electronic documentation contributing)
  - Only **28%** of hospitalists are using the templates on the website. **38% prefer to use their own template**. 29% is neutral when it comes to using a prescribed template and **33% indicated that would rather have a template provided to them**.

PDSA Cycle

- STUDY: Continued
  - **53%** of hospitalists indicated that the **History and Physical in Meditech** is making it easy to see the patient and start creating an electronic progress note on D1 of the admission.





PDSA Cycle

- STUDY:
  - Progress Note

ID: []

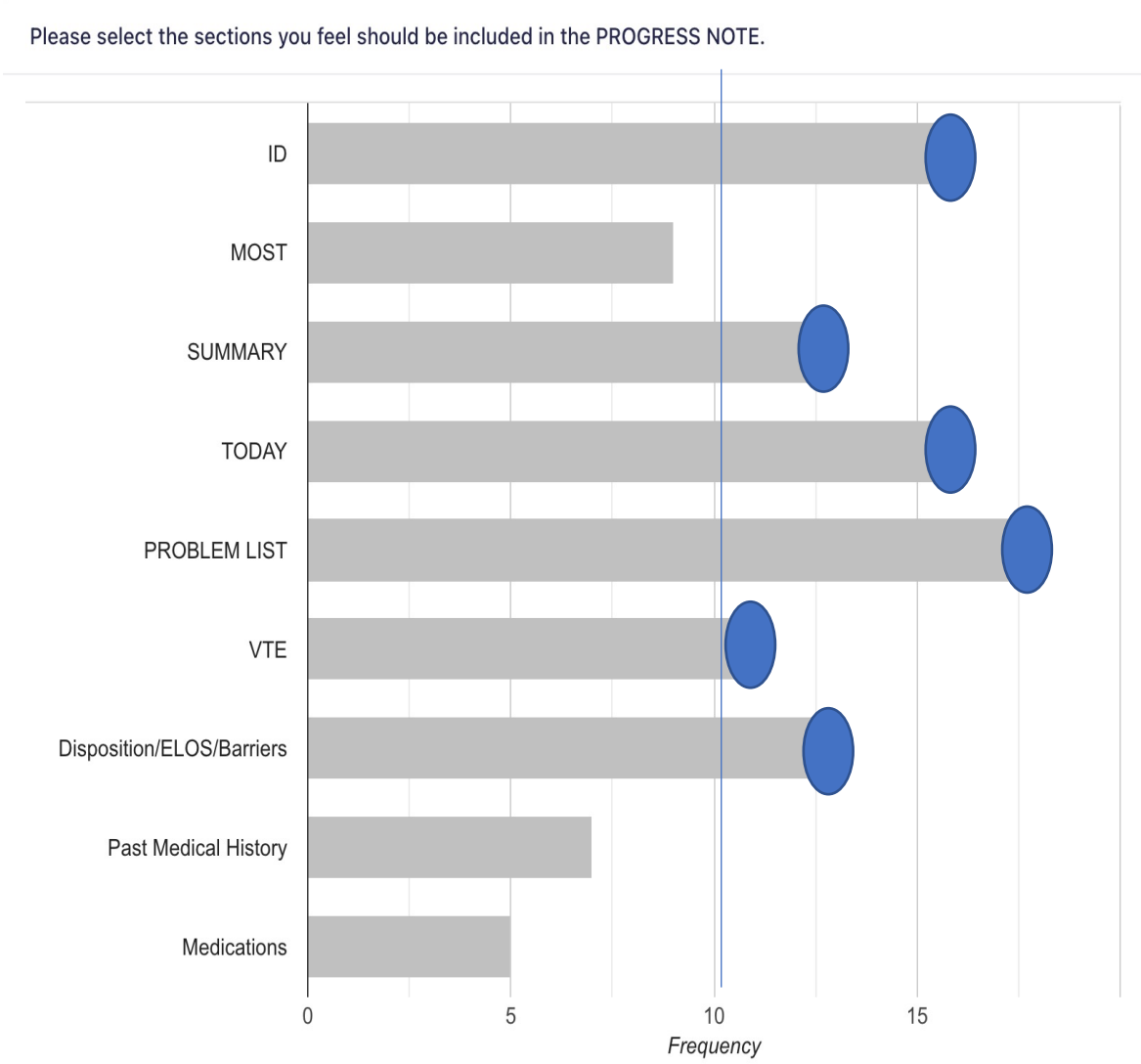
SUMMARY: [including presenting complaints and findings, resolved issues, specialists, complications during admission]

TODAY: []

PROBLEM LIST:
[]

VTE: []

DISPOSITION/ELOS/BARRIERS:
[]

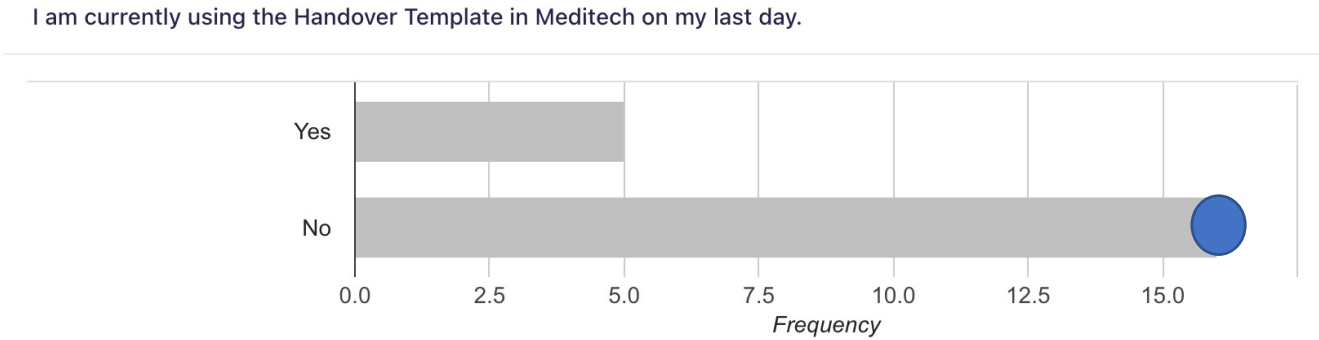


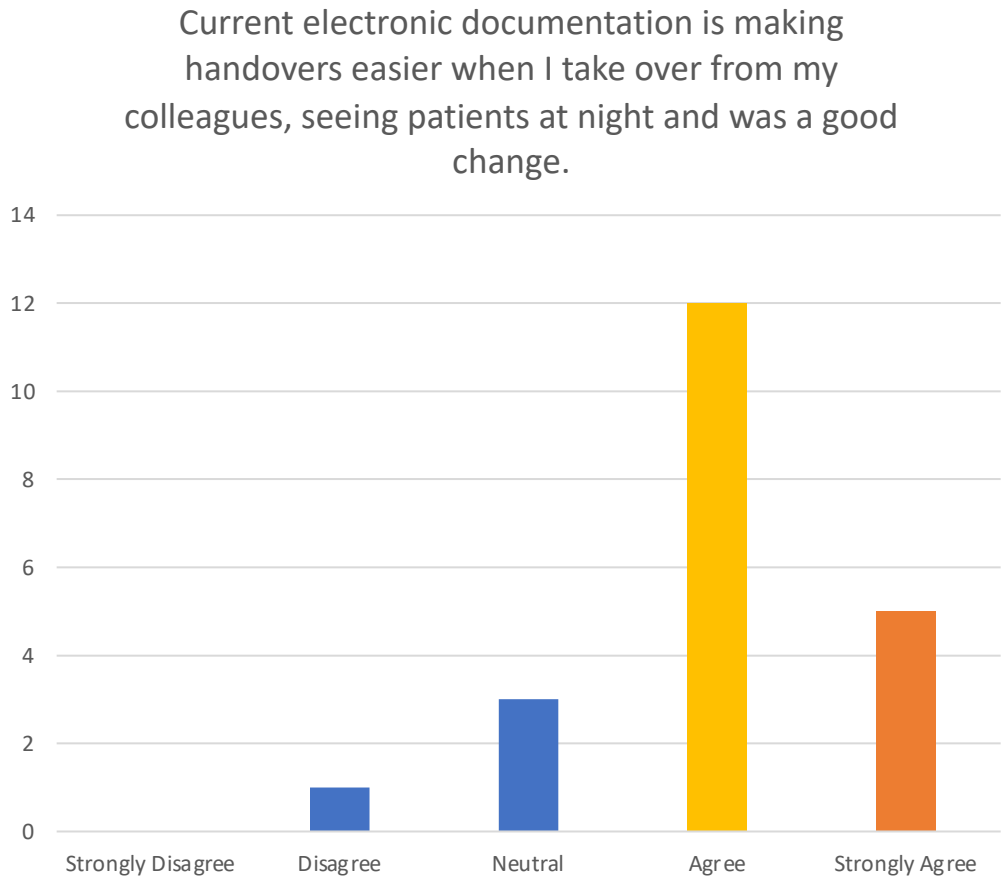
PDSA Cycle

- STUDY:
  - Handover Note

90% of hospitalists feel that electronic notes is making handovers easier, seeing patients at night easier and was a good change for the department after 1 year of implementing The PEN Project.

This was 100% in September 2021, so what changed?





PDSA Cycle

- STUDY:
  - Handover Note

ID: []

MOST: []

SUMMARY:
[]

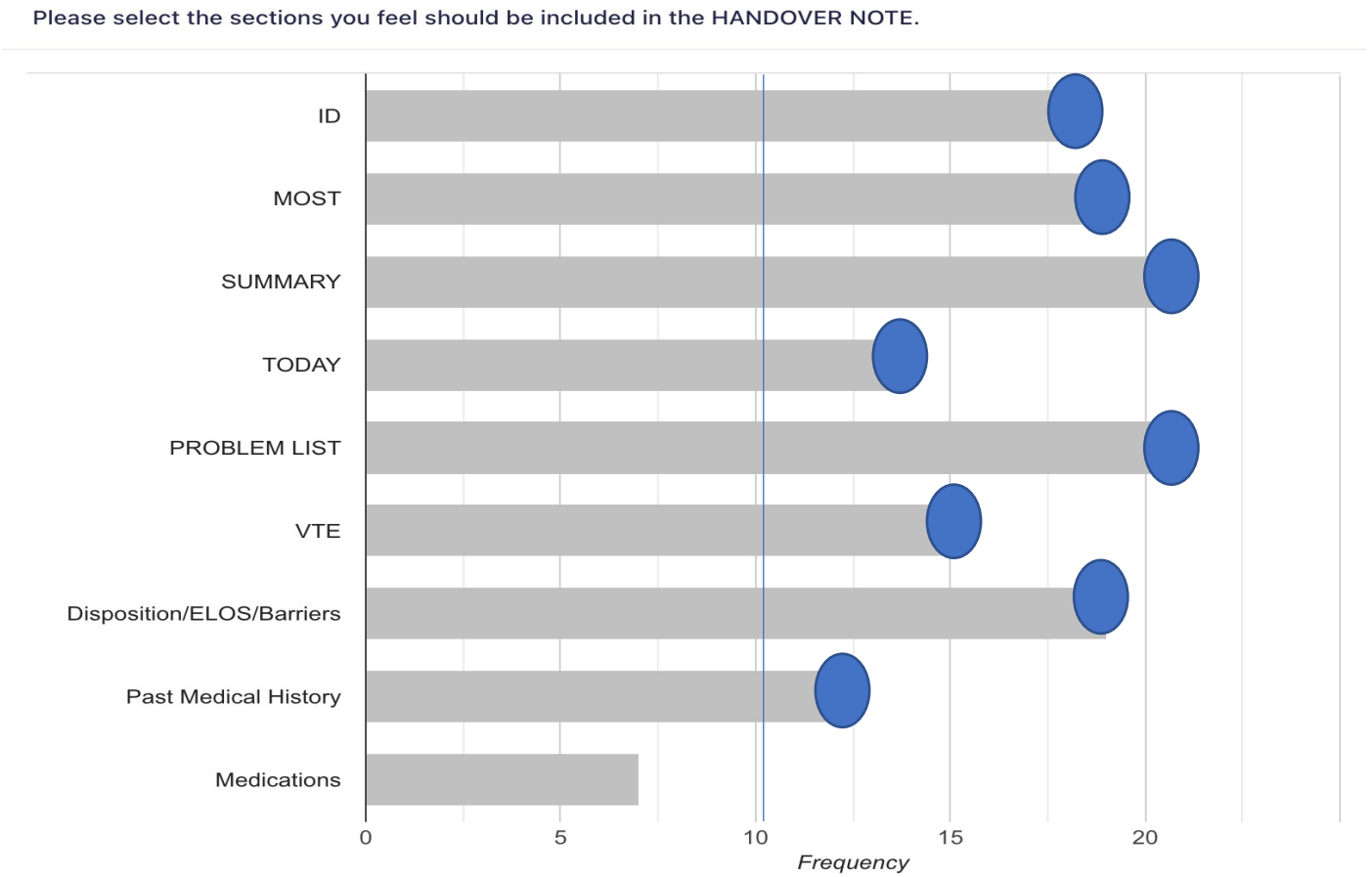
TODAY:
[]

PROBLEM LIST:
[]

VTE: []

DISPOSITION/ELOS/Barriers:
[]

PMH:
[]



Outstanding and pending results and consultations are useful in the problem list or summary.

PDSA Cycle

- STUDY:
  - Summary Section

Only **43%** of hospitalists agrees that the summary section is optimally utilized by fellow hospitalists.

62% of hospitalists agreed that the summary should contain presenting complaints, resolved issues, complications and name of consultants

- STUDY:
  - ELOS / Disposition / Barriers

Only **52%** of hospitalists indicated that they use this section and update it frequently.

Select information that is helpful to provide care, formulate a discharge summary and communicate with providers.

I think the summary should be updated more often to reflect what has gone on with the patient…often the summary is a copy and paste from the H & P and not updated during the week.

PDSA Cycle

- STUDY:
  - Formatting:

    71% of hospitalists agreed that shorter entries are preferred to long paragraphs.

    57% of hospitalists agreed that copy and paste processes amongst hospitalists requires review as it exposes individuals and the group to medico-legal risk.

We need to limit formatting in notes (bold, color, -:, bullets, boxes for PMH) This makes for unnecessarily editing changes which is time consuming

Formatting needs to be standardized.

My main concern with the copy and paste technique is the carry over of information that is out of date (eg old reports when there's a new study) and that it can be difficult to establish which day something happened (eg spoke to specialist/family)

I will probably never be perfect but we can aspire. Please ensure proper spelling and grammar.

PDSA Cycle

REPORT SECTION CLOGGING UP WITH REPORTS**!!**

- STUDY
  - Meditech

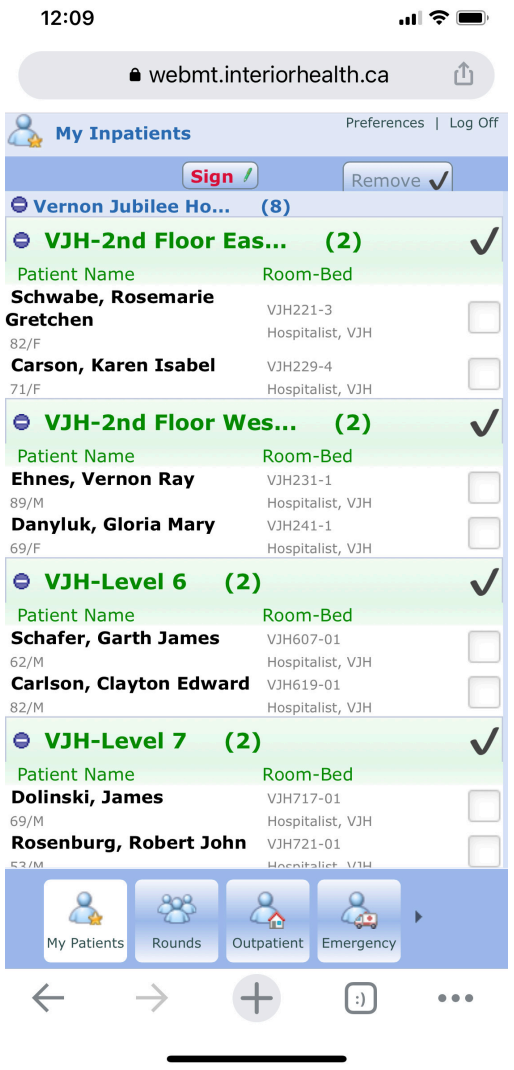
85% of hospitalists are not currently using the My Patients functionality in Meditech.

My Discharge List

App integration

Keep better track of movement in hospital

Keep better track of results



Before we go to Change Ideas…

- Dr Erica Remer wrote in 2020 in The Hospitalist after auditing notes in her US hospital, **Documentation Matters, Quality of Quantity**
- Documentation has always been part of a physician's job. Historically, in the days of paper records, physicians saw a patient on rounds and immediately following, while still on the unit, wrote a daily note detailing the events, test results, and plans since the last note. Addenda were written over the course of the day and night as needed.
- The medical record was a chronological itemization of the encounter. The chart told the patient's story, hopefully legibly and without excessive rehashing of previous material. The discharge summary then encapsulated the hospitalization in several coherent paragraphs.

Documentation Matters

- In the current electronic records environment, we are inundated with excessive and repetitious information, data without interpretation, differentials without diagnoses. Prepopulation of templated notes, defaults without edit, and dictation without revision have degraded our documentation to the point of **unintelligibility**. **The chronological storytelling and trustworthiness of the medical record has become suspect**.
- Having clinical documentation serve too many masters, including compliance, quality, medicolegal, utilization review, and reimbursement, is also to blame. The advent of the electronic medical record was just the straw that broke the camel's back.

Documentation Matters

- **Tell the story**:
  - The most important goal of documentation is to clinically communicate to other caregivers. Think to yourself: “What would a fellow clinician need to know about this patient to understand why I drew those conclusions or to pick up where I left off?” At 2 a.m., that information, or lack thereof, could literally be a matter of life or death.
- **Tell the truth**:
  - Embellishing the record or including invalid diagnoses with the intent to increase the severity of illness resulting in a more favorable diagnosis-related group – the inpatient risk-adjustment system – is considered fraud.

Documentation Matters

- **Documentation Time-Out**
  - You may like the convenience of copy forward, but do you relish reading other people's copy and paste? Consider doing a **documentation time-out.** Before you copy and paste yesterday's assessment and plan, stop and think: "Why is the patient still here? Why are we doing what we are doing?" If you choose to copy and paste, be certain to do mindful editing so the documentation represents the current situation and avoids redundancy. Appropriately editing copy and pasted documentation may prove more time consuming than generating a note de novo.

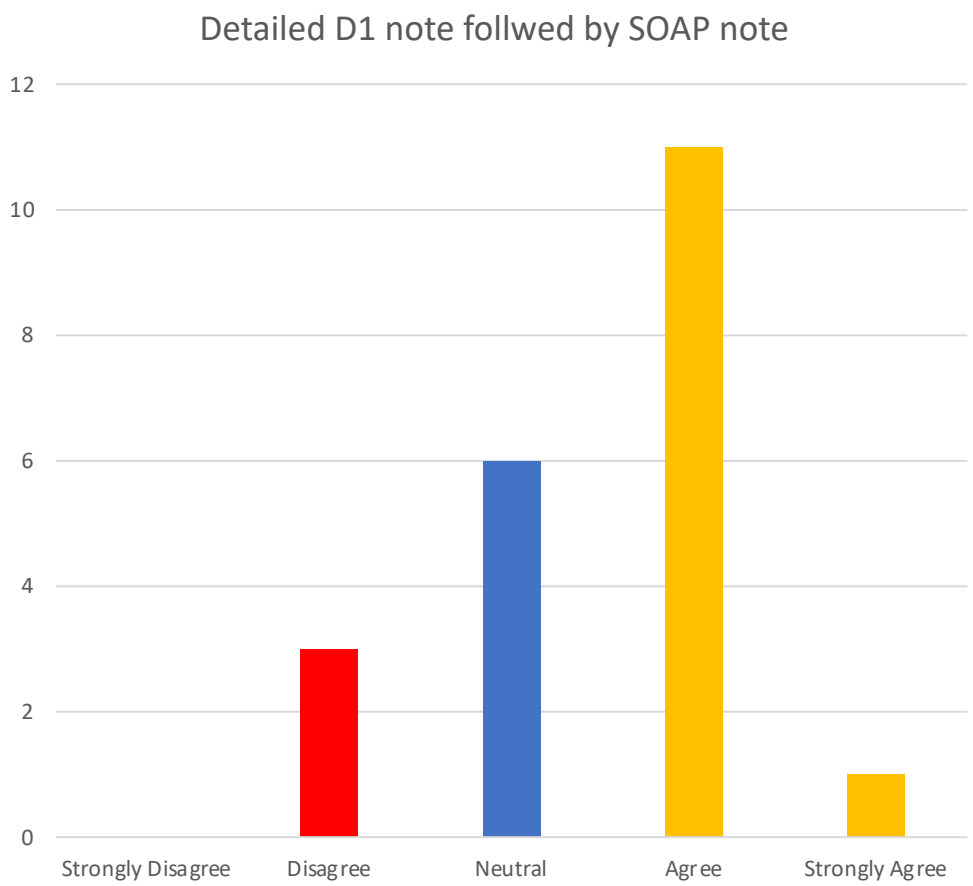
Documentation Matters

- **Evolve, resolve, remove, and recap.**
  - If an uncertain diagnosis is ruled in, take away the uncertainty. If it is ruled out, don't have 4 days of copy and pasted: "Possible eosinophilic pneumonia." You do not have to maintain a resolved diagnosis ad infinitum. It can drop off the diagnosis list but be sure to have it reappear in the discharge summary.
- **Keep a running summary**
  - If you have the capability to **keep a running summary** throughout the hospital stay, do so and keep it updated. A few moments of daily careful editing and composing can save time and effort at the back end creating the discharge summary. The follow-up care provider can reconstruct the hospital course and it is your last chance to spin the narrative for the lawyers.

Documentation Matters

- **Read your documentation over**
  - Ensure that it is clear, accurate, concise, and tells the story and the plans for the patient. Make sure that someone reading the note will know what you were thinking.
- **Set up a program to self-audit documentation**
  - where monthly or quarterly, you and your partners mutually review a certain number of records and give each other feedback. Design an assessment tool which rates the quality of documentation elements which your hospital/network/service line values (clarity, copy and paste, complete and specific diagnoses, etc.). You know who the best documenters are. Why do you think their documentation is superior? How can you emulate them?
- Documentation improves patient care and demonstrates that you provided excellent patient care. Put mentation back into documentation.

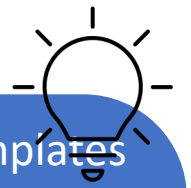
PDSA Cycle



- CHANGE IDEAS
  - In the survey we asked about a change in process and looking at doing a Detailed D1 note followed by a SOAP note and then a Handover Note to make life easier.
  - **57% of hospitalists agreed** that it will make their life easier.
  - **47% of hospitalists were neutral** about adding an addendum to a detailed D1 note, doing a billing note and then doing a detailed handover.

Change Ideas

- Formatting



WEBSITE: Central point to update templates based on group decision. Changing a template in Meditech requires a long and extensive process. Integrated is 1 button click technology, helpful links and does not require physicians to update the templates in their microphones.

Grammar and Spelling: Us ethe auto-correct functionality in Meditech

- Standardization and simply just using: – or bullets. Avoid color
- Copy and Paste important feature to carry information forward, but use it wisely and update it frequently
- Adopt a document structure as a group and let's ALL use it for 6 months -> H&P, Progress Note, Handover Note
- Shorter succinct entries rather than paragraphs

Change Ideas

- Template Development

Template: Based on the feedback of 21 hospitalists it is agreed that the minimum requirement for a progress note is ID, Summary, Today (subjective/objective), Problem List, VTE, ELOS/Barriers/Disposition

Summary: Can expedite the creation of a discharge summary.

Create a D1 complete note (template decided on by group), followed by a shorter SOAP note or template and a Handover Note.

Summary should include presenting complaints, progress in ward, resolved issues, consultants and complications. Requires optimization.

ELOS/Barriers/Disposition should be used and updated daily.

Change Ideas

- Handover

Template: Based on the feedback of 21 hospitalists it is agreed that the minimum requirement for the Handover note is ID, **MOST**, Summary, Today (subjective/objective), Problem List, VTE, ELOS/Barriers/Disposition, **PMH**

Summary: Update frequently

Create a D1 complete note (template decided on by group), followed by a shorter SOAP note or template and a Handover Note.

Ensure that Handover template is selected in Meditech as it is filed differently in the report section.

TODAY: Make sure that you tell the story for the whole week and update the summary section. Why is patient still in hospital?

Change Ideas

- Meditech

My Patients:
Reduce drafts in Meditech, track patients and results

Add patients to your My Patient List in D1

Consider adding patients to the list when you are on-call or lead.

View My Discharge List and ensure discharges are completed on time.

Change Ideas

- Other

Working Group: Establish to thoroughly work out the standardization of electronic documentation. Should include a 6 monthly feedback from the group to modify the document as a whole. Goal is uniform approach to documentation to **maximize efficiency**.

Ensure that you build enough information in the note to do a discharge summary

Consider adding MOST section and mention discussions with dates and people involved.

Add outstanding or pending results and consultations to the problem list.

Thank You!

- Improve communication
- Build Trust
- Shape the future

- Documentation improves patient care and demonstrates that you provided excellent patient care. Put mentation back into documentation.