Taking a Deep Dive into Care Plans and Patient Education Documentation

Dana Dark, BSN, RN, PCCN; Bonnie Roth, BSN, RN; Kimberly Lutterloh, BSN, RN; Tara Dark, MSN, RN-BC
Cone Health Greensboro, NC

Introduction

- Care plan and patient education documentation is vital to demonstrating the use of evidence-based nursing care within the healthcare environment.
- Evidence shows that the quality of care delivered is often determined by evaluating documentation found within patient care plans and measuring the associated outcomes.
- Accurate and complete documentation of patient care and patient education is now a necessity for proving Meaningful Use, which must be achieved by organizations receiving federal reimbursement.
- Individualizing care, guided by care plan utilization, can positively affect patient satisfaction, patient/family participation, and length of stay.
- While documentation of care plans may be difficult to evaluate from a patient’s perspective, evidence indicates that care plan documentation can assist in ensuring the quality of nursing care provided.
- There are identified challenges associated with implementing electronic care plans, which is often associated with nurses’ having the time to organize thorough training programs.

Problem

- Clinical nurses on a 45 bed inpatient Intermediate Care/Urology department identified inconsistencies in the initiation, use, and documentation of care plans and patient education.
- Identified issues:
  - Incorrect selection of appropriate care plan to meet identified patient problems
  - Incorrect or incomplete documentation within care plans and patient teaching; documentation not reflective of care or education provided
  - Not using care plans to guide care to meet patient outcomes

Initial Assessment

- To assess care plan and patient education documentation compliance, the electronic medical record (EMR) of 51 nurses were audited.
- Compliance was defined as:
  - Correct care plan selection and implementation on admission
  - Care plan documentation completed every shift
  - Patient education assessment performed on admission
  - Patient education addressed every shift

Care Plan & Patient Education Compliance

- 56.9% for Care Plan
- 17.6% for Patient Education

Objectives of Project

1. Increase care plan initiation and documentation compliance to 85%
2. Increase patient education documentation compliance to 75%

Strategies and Implementation

- A one hour class was developed and taught by members of the project team.
- Seven sessions of the class were offered to facilitate attendance by all clinical nurses.
- Participants were able to practice documenting in a simulated patient care EMR environment utilizing patient scenarios and one on one training.
- Content addressed during class:
  - Selecting appropriate care plans which generated applicable patient education
  - Efficient methods to assist in decreasing charting time, while also ensuring accuracy
  - Documentation requirements of The Joint Commission
  - Importance of how care plan selection and patient education documentation affects healthcare reimbursement for organizations

Results

- 53 nurses, or 96.4% of nurses, attended one of the sessions.
- Auditing began 2 weeks after completion of the final class.

Project Team Members

Marissa Long, MSN, RN, PCCN; Melissa Brainnan, BSN, RN; Jessica Deutsch, BSN, RN-BC; Anne Blankenship, BSN, RN; Kellie Capes, BSN, RN, PCCN; Danyel Johnson, MSN, RN, CNN

References