

# Improving Care Plan Documentation Compliance and Sharing the Patient's Story

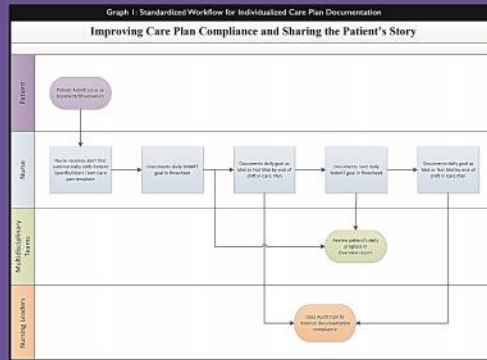
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## Introduction

To assure this organization meets regulatory standards, opportunities were noted in the EHR documentation to individualize careplans and share the patient's story. Communications to other multidisciplinary teams were also affected, since there was no care plan report to show the patients' daily goals or progress. Baseline data showed units having as low as 25% rate of any care plan documentation related to their patients' progress.

## Methods

A collaborative effort with nursing senior leadership, nursing education department, nursing staff, informatics, and information technology was used to explore solutions to help nurses complete their documentation easily and efficiently. Care plan meetings were held weekly with the team to design a viable solution where evidence based practice drove the technology to enhance nursing workflow and care plan documentation compliance. Standardized processes were developed including (see graph 1):

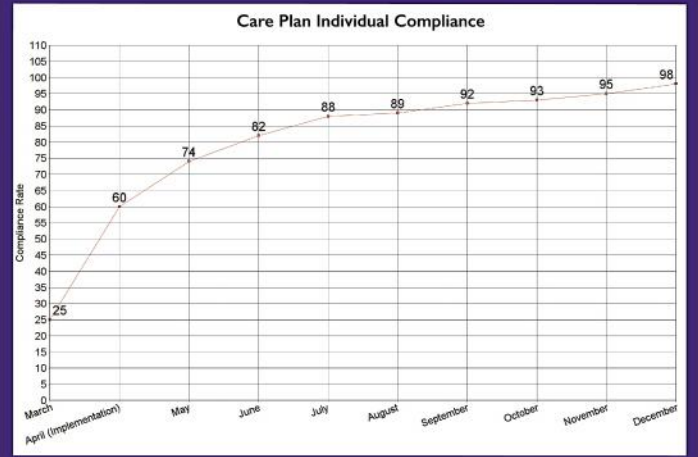


- Flowsheet documentation created for daily patient goals and to be documented on daily (leveraging current nursing workflow to document in flowsheets per shift)
- Short term/patient specific care plan template (pulls in flowsheet documentation)
- Best practice alert on newly admitted inpatients to automatically add the short term/patient specific care plan template to the patient chart
- Real time care plan report to view daily goals and progress provided to multidisciplinary teams
- Audit tool for real time monitoring on the Nursing Leader Dashboard

The image shows four screenshots from an EHR system:
 1. **Flowsheet**: A table for documenting patient goals and progress.
 2. **Best Practice Alert**: A notification box that appears when a patient is admitted.
 3. **Dashboard Report**: A summary table showing care plan compliance across different units.
 4. **Care Plan Report**: A detailed view of a patient's care plan, including goals and progress.

## Care Plan Individual Compliance

Results: 2018 data demonstrated an increase in compliance from 25% to 89% and sustaining.



## Conclusions

Utilizing a collaborative effort to implement standardized workflows has proven to be a successful methodology for improving individualized care plan documentation compliance and sharing the patient's story. This organization also met regulatory standards during the re-evaluation of care plan documentation.

## Clinical Implications

Continuous evaluation of informatics processes are needed to update and support the sharing of patient information that is vital to the patient's quality of care being provided as well as meeting regulatory requirements.