22nd Annual HCCA's
Compliance Institute
April 15th - 18th, 2018
Las Vegas, NV

Transforming Clinical Care Through the Use of Nursing Documentation Audits

Aliya Aaron, MSHS, BSN, RN
Principal Consultant
AMR Healthcare Consulting, LLC

AMR HEALTHCARE CONSULTING
Transforming Healthcare

Agenda

- Welcome & Introductions
- Session Goals
- Overview: Nursing Documentation Audit
- I.Best Practice Considerations
- Common Findings
- Clinical Transformation
- Audit Review
- Group Discussion
- Q&A

Meet The Presenter!

Aliya Aaron, MSHS ,BSN, RN

- 16 years of clinical nursing practice
- 11 years of nursing informatics expertise
- Lead and advise multi-disciplined clinical information system projects
- Subject Matter Expert in designing, implementing, optimizing, and analyzing leading EHRs and Telehealth solutions for hospitals, vendors, and provider practices across the U.S. and Canada
- Master of Science in Health Systems Management
- Bachelor of Science in Nursing
- Registered Nurse, Nurse Leader of Sigma Theta Tau, member of the American College of Healthcare Executives, Hospital Management Systems Society, and American Nursing Informatics Association

Session Goals

1

Identify best practices for conducting internal nursing documentation audits

2

Discuss common findings from clinical documentation audits

3

Describe how clinical documentation audits help to transform clinical care and increase quality of care

Overview - Nursing Documentation Audit

What is Nursing Documentation?

- All written and/or electronic entries reflecting all aspects of patient care communicated, planned recommended or given to that patient.

What is a Nursing Audit?

- A review of the patient record designed to identify, examine, or verify the performance of certain specified aspects of nursing care by using established criteria. Often a nursing audit and a medical audit are performed collaboratively, resulting in a joint audit

  (Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier)

History of Nursing Audit

- One of first ever clinical audits was undertaken by Florence Nightingale during the Crimean war of 1853-1855.
- On arrival at the medical barracks hospital in Scutari in1854, Florence was pained by the unsanitary conditions and high mortality rates among injured or ill soldiers.

- She and her team of 38 nurses applied strict sanitary routines and standards of hygiene to the hospital and equipment, Florence's gift of statistic kept meticulous records of the mortality rates among the hospital patients.

  Following these changes the mortality rates fell from 40% to 2%. Her methodical approach, as well as the emphasis on uniformity and comparability of the results of health care, is recognized as one of the earliest programs of outcomes management.

Purpose of the Audit

- Evaluates Nursing care given to patients
- Focuses on care provided and not on the care provider
- Contributes to research
- Used as a defense tool that provides complete, accurate, and up-to-date documentation to prevent liability if nurses are involved in a lawsuit

A Case of Missing Documentation

- In *Susan Meek. V. Southern Baptist Hospital of Florida, Inc. d/b/a Baptist Medical Center*, the patient (plaintiff) was admitted to the hospital for a hysterectomy. She developed bleeding after surgery and was admitted to the radiology unit for uterine artery embolization (UAE) to stop the bleeding. Although the physician ordered the nurses to perform frequent leg examinations to mitigate the risk of diminished blood flow and nerve injury (a known complication of UAE), the patient claimed the exams were not performed, based on lack of documentation. The patient sustained nerve damage after a massive clot was removed in the external iliac artery. The case resulted in a $1.5 million verdict.[1]
- There is no way to know whether the nurse(s) responsible for the patient had in fact performed leg examinations, because the supporting documentation was simply not there.

1. Sources: https://www.medcomrn.com/index.php/articles/prevent-documentation-errors-nursing/

Types of Audit

Internal - a control technique performed by an internal auditor who is an employee of the organization

External - a control technique performed by an outside auditor who is not an employee of the organization

Methods of Audit

01

A concurrent nursing audit is performed during ongoing nursing care.

02

A retrospective nursing audit is performed after discharge from the care facility, using the patient's record.

03

In nurse **Peer Review,** nurses functioning in the same capacity as their peer's appraise the quality of care or practice performed by other nurses.

Characteristics of an Audit

- Written standards of care to evaluate nursing care
- Evidence that actual practice was measured against standards
- Examination & analysis of findings
- Evidence of corrective action being taken
- Evidence of effectiveness of corrective action
- Appropriate reporting of the audit program

Documentation for Auditing

- Nursing Care Plan
- Nurses Note
- Vital signs charts
- Medication Administration Records
- Patient's Condition
- etc.

Audit as a Tool for Quality Control

The audits most frequently used in quality control include outcome, process and structure audits.

Outcome audit

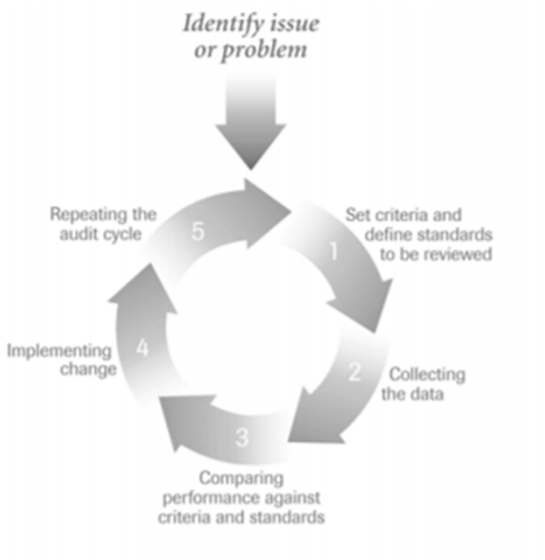
- Outcomes are the end results of care; the changes in the patients health status and can be attributed to delivery of health care services. Outcome audits determine what results if any occurred as result of specific nursing intervention for clients. Example of outcomes traditionally used to measure quality of hospital care include mortality, morbidity, and length of hospital stay.

Process audit

- Process audits are used to measure the process of care or how the care was carried out. Process audit is task oriented and focus on whether or not practice standards are being fulfilled. These audits assumed that a relationship exists between the quality of the nurse and quality of care provided.

Structure audit

- Structure audit monitors the structure or setting in which patient care occurs, such as nursing service, medical records and environment. This audit assumes that a relationship exists between quality care and appropriate structure.



Audit Cycle

The audit process is divided into 5 official steps and the cycle is only considered complete if all steps are performed. The five steps are as follows:

1. Set criteria and define standards to be reviewed
2. Collecting the data
3. Comparing performance against criteria and standards
4. Implementing change
5. Repeating the audit cycle

Sample Audit Tool

SAMPLE CHART AUDIT TOOL
Based on missing JCAHO standards when random audit conducted

Date of Audit: _____ **Auditor:** _____
Audit response codes: Yes =X No = O

Element/Criteria	MR#	MR#	MR#	MR#
Evidence of Resident/Patient rights discussed and given.				
Organ donor identification form present.				
Pain Assessment Tool Completed w/in 24 hr of admission.				
Pain Assessment Tool completed fully.				
Pain Management Flow Sheet completed per policy.				
Interdisciplinary Education Flow Sheet completed.				
Nursing Progress notes are dated and authenticated				

Best Practice Considerations

Best Practice Considerations

- Nursing Audit cannot be implemented where the Nursing process is not utilized for patient or client care because it appraises the outcome of the nursing process
- The literature review reveals that daily or weekly spot auditing of nursing forms is more effective than less frequent auditing *(Wong 2009)*
- Utilization of Spot audits by Nurse Unit Managers with results given to nursing staff to encourage compliance and improvement

Common Findings

Common Findings

The nursing documentation audit tool has proven to be valid for measuring information pertinent to the nursing process, and to possess a high degree of reliability when used by different auditors. Common findings of an audit include:

- Inconsistent Documentation
- Incomplete Documentation
- Inconsistent Processes
- Inefficient Workflows

Clinical Transformation

Transformational Vision

We are embarking upon a…***transformational journey*** to redesign the clinical practice model

Clinical Transformation

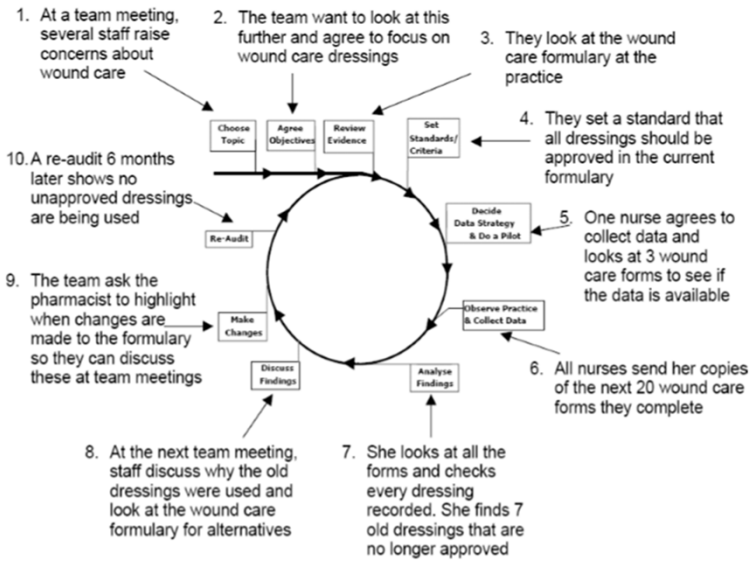
Benefits of Proper Documentation in Care Transformation:

- Improves compliance
- Improves patient care
- Improves knowledge of the regulatory requirements
- Identifies revenue opportunities
- Improves clinical data for research and education
- Protects the legal interest of the patient, facility, physician and staff
- Motivates nursing staff to become active contributors to efforts toward quality improvement and quality patient care

Audit Review

Practical View

The Story of a Wound Care Audit



Large Group Discussion

- What areas of improvement would you like to tackle?
- What audit tools/resources will you use?
- How will you help to educate your colleagues?

Questions

Contact Info

Aliya Aaron, MSHS, BSN, RN
Principal Consultant
AMR Healthcare Consulting, LLC
13762 W. State Rd. 84
Suite #73
Davie, FL 33315

(954) 541-4771
aaaron@amrhealthcare.com
www.amrhealthcare.com