COVID-19: Disaster Admission Navigator and Decreasing Documentation

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Partners eCare, Partners Healthcare
Learning Objectives

- List small changes within an EHR that can guide a decrease in documentation expectations
- Describe operational challenges of implementing a model of reduced documentation across a large health system
Agenda

- Background
- Challenges
- Process of Making a Changes
- The Changes
- Implementation
- What we’ve gained
Partners HealthCare System Members - Hospitals

- **BRIGHAM HEALTH**
  - Brigham and Women's Hospital
    - Boston, MA
  - Brigham and Women's Faulkner Hospital
    - Jamaica Plain, MA

- **MASSACHUSETTS GENERAL HOSPITAL**
  - Boston, MA

- **BRIGHAM HEALTH**
  - Newton-Wellesley Hospital
    - Newton, MA

- **MASSACHUSETTS EYE AND EAR**
  - Boston, MA

- **McLean Hospital**
  - Belmont, MA

- **NANTUCKET COTTAGE HOSPITAL**
  - Nantucket, MA

- **COOLEY DICKINSON HOSPITAL**
  - Northampton, MA

- **NORTH SHORE MEDICAL CENTER**
  - Salem and Lynn, MA

- **SPAULDING REHABILITATION NETWORK**
  - Boston, Cambridge, and Cape Cod, MA

- **WENTWORTH-DOUGLASS HOSPITAL**
  - Dover, NH
Challenges

- Documentation Burden
- Increased Patient Acuity
- Staffing changes
Governance - Nursing Informatics Advisory Committee

- Nursing Informatics leader from each hospital
- Partners eCare Clinical Informatics- Nursing
- Application team leadership
- Established governance body pre-dating first Epic go-live
- Highest governance body for nursing informatics decisions
Decreasing the Burden of Documentation

Operational
- Local policies & procedures
- Documentation practice

Technical
- EHR Changes
Technical Changes

Vendor

Vanderbilt model

CMS

Disaster build

Reduce Automation & Reminders

Streamlined Navigator Guides Input

Essential Documentation
<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Complete required screens: Travel Hx. &amp; Communicable Disease screen; Flu screen during flu season; Pneumovax screen for adults. Other screens only when patient presentation warrants.</td>
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<tr>
<td></td>
<td>• Assess Care Categories: Pain, Neuro, Cardiac, Respiratory, GI, Renal/UR, Safety; for adults, Vascular. Based on patient presentation, may need to assess other Care Categories. Documentation by exception: Problems, OEL</td>
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<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Beginning of Shift</th>
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<tbody>
<tr>
<td></td>
<td>• Assess required Care Categories and others as warranted by patient presentation. Document by exception (problems, OEL).</td>
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<tr>
<td></td>
<td>• Document Interventions performed by end of shift; document assessment and care of LDAs by exception (abnormals and care deviations)</td>
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<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Focused Re-assessment</th>
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<tbody>
<tr>
<td></td>
<td>• Perform assessment per standard for unit.</td>
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<td>• Document either “unchanged” or “unchanged except” &amp; denote changes for problems, OEL items by exception (only changes since initial shift assessment).</td>
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<tr>
<td></td>
<td>• ICU – at least once more during the shift</td>
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<td></td>
<td>• Acute Care – as appropriate to patient</td>
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<thead>
<tr>
<th>Inpatient</th>
<th>Post Procedure or Transfer</th>
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<tbody>
<tr>
<td></td>
<td>• Focused reassessment with documentation by exception (only new Problems, OEL)</td>
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<table>
<thead>
<tr>
<th>Inpatient</th>
<th>End of shift</th>
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<tbody>
<tr>
<td></td>
<td>• Summative documentation of ordered interventions completed</td>
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<td>• Clear IV Pump and enter I&amp;O totals</td>
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<td></td>
<td>• Summarize response to care and recommendations focused on Problems that are the focus of the current admission.</td>
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<td>• Ensure blood transfusion and med admin. documentation is up-to-date</td>
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<tr>
<th>Inpatient</th>
<th>Discharge</th>
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<tbody>
<tr>
<td></td>
<td>• Summarize response to care, focus on significant unresolved problems and action plan post discharge</td>
</tr>
<tr>
<td></td>
<td>• Document follow-up care and discharge teaching provided</td>
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</table>

Vendor

- Disaster Admission Navigator
- Disaster Shift Navigator
- Reduced Required Documentation
Put Patients Over Paperwork

CMS waived the provision at 42 CFR 482.23(b)(4), 42 CFR 482.23(b)(7), and 485.635(d)(4), which requires the nursing staff to develop and keep current a nursing care plan for each patient.

Waivers allow nurses increased time to meeting the clinical care needs of each patient and allows for the provision of nursing care to an increased number of patients.

Technical Changes

Drive users to streamlined documentation tools for essential documentation

Reduce automation and reminders for nonessential documentation
Goals of Technical Changes

- Low build complexity
- Bang for your buck
- Easy to backout
- Intuitive
- Maintain current tools
- Consistent with current UI
- Universal
Principles of Technical Changes

- Remove burden from nursing on shared elements
- Remove what isn’t pertinent during a crisis
- Remove what won’t impact the care outcome
- Keep vulnerability assessments that may be exacerbated during crisis
- Keep assessments that recommend services still supported
- Is this applicable across all populations?
Technical Changes: Decreased Required Documentation

Removed from Admission:
- ADL
- Discharge Planning
- Learning Assessment Filed
- Nutrition
- Patient Belongings
- Plan of Care Added
- Pressure Injury Present on Admission
- Smoking History Documentation
- Self-Harm

Preserved:
- Advance Directives
- Audit C
- Domestic/Intimate Partner Abuse
- Fall Risk
- PTA Medication List Review
- Pain
- Language Preferences
- Spiritual Care
- Suicide Risk
- Travel/Symptom Screening
- Vitals, Height and Weight

Required Daily (from Q shift):
- Braden/Q
- Fall Risk Assessment
Technical Changes: Disaster Admission Navigator

- Default within Navigators Activity
- Supports essential admission workflows
- Content aligns with reduced required documentation
- Sections condensed to support streamlined data collection
Technical Changes:
Patient Education and Plan of Care

Automation Turned Off

- First-Dose-Patient-Education
- Best Practice Advisories recommending Plans of Care

Automated text to progress notes

Nursing Progress Note

The plan for the day was reviewed with the multidisciplinary team. The plan and patient education was provided verbally to the patient and/or family during the shift. Patient and/or family were accepting of this information and verbalized understanding. Any additional details and/or outstanding concerns are listed below:
Partners eCare Inpatient Nursing Build Supports

- Med/Surg
- ICU
- Behavioral Health
- OB/Newborn/NICU
- Pediatrics-general care
- Pediatric ICU
- Post Acute-LTAC, Rehab, SNF

COVID 19 Impact varied
# Application of Changes Per Domain

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<thead>
<tr>
<th></th>
<th>Med/Surg &amp; ICU</th>
<th>General Pedi &amp; PICU</th>
<th>Behavioral Health</th>
<th>OB</th>
<th>Newborn/NICU</th>
<th>LTAC &amp; IP-Post Acute</th>
<th>SNF</th>
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<tbody>
<tr>
<td>Reduced Required Documentation</td>
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<td>Disaster Admission Navigator</td>
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<td>First-Dose-Patient-Education: Off</td>
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<tr>
<td>Plan of Care Best Practice Advisories: Off</td>
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<td>Default Text to Notes</td>
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Ready for Operations

- Iterative review with NIAC
- Input from site Quality leaders
- CNO Council endorsement
- Change Management processes
- Release Notes
Operational Considerations

- Variation across enterprise in COVID impact
- Local hospitals, units and users to determine appropriate level of documentation
- Already started Plan of Care and Patient Education
- Not about the patient’s diagnosis, but the staff/facility caring for the patient
Gains

- Inform us on decreasing burden of documentation
- Rapid deployment of innovative changes
- Maintain tools, change content
- End user satisfaction and relief!