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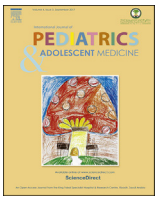

Original Article

Departmental collaborative approach for improving in-patient clinical documentation (five years experience)

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ABSTRACT

Introduction: Health care institutes are is cooperative areas where multiple health care services come together and work closely; physician, nurses and paramedics etc,. These multidisciplinary teams usually communicate with each other by documentation. Therefore, accurate documentation in health care organization is considered one of the vital processes. To make the documentation useful, it needs to be accurate, relevant, complete and confidential.

Objectives: The aim of this paper is to demonstrate the effect of the collaborative work in the Department of Pediatrics on improving the quality of inpatient clinical documentation over 5 years.

Methods: Improving clinical documentations went through several collaborative approaches, these include: Departmental Administration involvement, establishment of quality management team, regular departmental collaborative meeting as a monitoring and motivating tool, establishment of the residents quality team, Integration of quality projects into the new residents annual orientation, considering it as a part of the trainee personal evaluation, sending reminders to the consultants and residents on the adherence for admission note initiating and 24 h's verification, utilization of standardized template of admission note and progress note and emphasizing on the adherence to the approved medical abbreviation list only for any abbreviation to be used.

Results: During the period between the first quarter of 2012 to the fourth quarter of 2017; a significant improvement was noticed in the overall in-patient clinical documentation compliance rate, as it was ranging from lower 50% in 2012 and 2013, and increased gradually to reach upper 80% in the last quarters of 2016 and 2017. These figures are based on an independent audit that being done by the hospital quality management department and received by the department in a quarterly basis.

Conclusion: Despite multiple challenges for improving the compliance for clinical documentations, major improvement can be achieved when the collaboration and efforts among all stakeholders being shared and set as a common goal.

1. Introduction

The importance of clinical documentation has been recognized very early in the history of medicine. It goes back to the ancient time and has undergone several changes in its content and scopes since then. In the past two centuries, they called a variety of records that is generated by literate men, including medical profession, as “Casebooks”. Theodore de Mayerne, famous Huguenot and Royal physician, has probably the most extensive surviving casebooks which he called “observations medicine” [1]. The evolution, uses and development of these records over time can be observed over two centuries from the records of The New York Hospital [2].

Nowadays, clinical documents have become more complicated

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and detailed. It represents the thoughtful process of health care providers and their decision's rationale. It is the main vehicle to transfer and store patient's health conditions and their needs. Its importance and complexity have grown alongside the development of health care systems and information technologies [3]. Proper and accurate clinical documentation could improve the quality of care provided especially in those with chronic diseases [4,5]. If structured in templates, it may enhance the trainees' knowledge and early recognition of subtle conditions [6]. Moreover, legal clinical documentation is essential component of quality accreditation agencies surveys. Despite the doubts about its benefit, the interest in these accreditations has increased as a reflection of the increasing awareness of the public about medical errors and malpractice. The interest has switched to the hospital compliance to the accreditation requirements and their ability to maintain valid ones. Therefore, it will be of particular importance to health care institutions to develop and monitor appropriate documentations policies [7–9].

When it comes to the economic impact, appropriate clinical documentation plays critical role too. In the recent years, many health care institutions have linked the patient's visit cost to a specific coding system that requires appropriate documentation. Some physicians finds this coding system complicated and time consuming [10]. This issue becomes more complex in teaching hospitals where inadequate and inappropriate coding and documentation may result in loss of revenue, exaggerated cost or delayed reimbursements [11,12].

Other aspects that give the clinical documentation vivid challenges are the emerging information technologies. Electronic-based medical record (EMR) has dramatically replaced paper-based documentation in many institutions. Many other new information technologies are expected to improve the patient care and enhance the physician performance. It was shown that EMR would eliminate many concerns associated with paper-based medical records like illegible handwriting, ambiguous and incomplete data, data fragmentation, and poor availability [13]. However, the cognitive and social interactions between these emerging technologies, physicians and their patient have changed our reasoning, decision making and, of course, clinical documentation [14]. Also, EMR and the accessibility to it, especially for minors, have raised concerns about confidentiality and privacy [15]. The debate about its content and structure is still needed to be examined more to achieve a good quality and more user-friendly content [9,16,17].

King Faisal Specialist Hospital & Research Center (KFSH&RC) was officially opened by His Royal Highness King Khaled Ibn Abdulaziz Al Saud more than 40 years ago. It is a state-of-the-art Joint Commission International (JCI)-accredited tertiary care hospital and American Nurses Credentialing Center (ANCC) Magnet designation. KFSH&RC has over 18,000 employees, of 65 different nationalities working in different health care and administrative areas.

The facility is the national referral center for oncology, organ transplantation, cardiovascular diseases, neurosciences and genetic diseases. It also specializes in medical, surgical, pediatrics, perioperative, obstetrics/gynecology, research, education and outpatient and Health Outreach Services.

KFSH&RC's internship, residency and fellowship programs are organized in collaboration with Saudi Commission for Health Specialties.

The objective of the residency program in Pediatrics is to provide outstanding education in pediatric medicine while delivering the highest caliber of patient care. The program provides the residents with strong foundation in general pediatrics and allows excellent exposure to all subspecialty care at King Faisal Specialist Hospital and Research Center (Gen. Org.), which make the program have the broadest patient population.

Residents are the key people for clinical documentations in our hospital. They learn to treat common diagnoses and see diagnostic dilemmas that are presented in a tertiary center. In the core of their training is how to document clinical care properly. They are expected to write daily progress notes admission, discharges etc.

Poor documentation in both paper-based medical record and EMR has been an ongoing concern especially from faculty staff [18,19]. we have been facing this issue in our institution as well. Therefore, we have done several intra departmental steps to improve the compliance to our clinical documentation for both paper-based charts and EMR whenever applicable. Our goal was to educate our staff member about its importance and achieve the quality target that has set by our quality control committee. We will present here our efforts and findings.

2. Objectives

The aim of this paper is to demonstrate the effect of the collaborative work in the Department of pediatrics on improving the quality of inpatient clinical documentation over 5 years.

3. Methodology

We proposed improving clinical documentations through several collaborative approaches, which include:

3.1. Administration involvement

Improving staff performance and maintaining the highest level of quality, patient safety and experience will be achieved by continuous monitoring, feedback and coaching by health care administration.

Departmental administration ensures the availability of qualified manpower resources, proper training and education to achieve the desired goals that are measurable, attainable and aligned with the organization 's vision, mission and strategic priorities.

Clinical documentation is one of the measures to monitor the quality and the outcome of patient management. On a daily basis, patient care must be documented properly as per standards of national and international accreditation institutions and the administration provides constructive feedback and coaching once needed and participate in initiating and updating documentation standards and policies.

3.2. Establishment of quality management team

Establishment of quality management team, which started on January 2012, was a strategy to formulate a team who are receiving regular updated reports about the progression of quality improvement plan, evaluating the quality of documentation of the physician, emphasizing on the importance of timing in writing admission and discharge notes as well as reconciliation of medications, finding deficient area in documentation and creation of different solutions to overcome this deficiency.

3.3. Departmental collaborative meeting

Collaborative meetings started on July 2012. It involves a group of medical practitioners from different professions in the Department of Pediatrics who share patient care goals and have responsibilities for complementary tasks on an ongoing basis. The departmental collaborative meeting is held on a regular basis to discuss all quality measures and performance of the department,

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