Components of a good eBridge Progress note

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Guidelines for Nursing Documentation

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GENERAL PURPOSES OF DOCUMENTATION

• Informs health care planning
• Utilized for quality assurance/improvement
• Influences allocation of resources
• Think about this with EVERY note you write:
  
  • S → Source of truth
  • T → Tell the Patient’s Story
  • A → Accountability, Accuracy & Authorship
  • R → Reflect the nursing care YOU have provided
  • R → Resolve outstanding problems
The Electronic Health Record (EHR) is utilized by multiple disciplines caring for the patient and ultimately should accurately reflect individualized, patient-centered care.

Documentation should reflect actual care that is provided to the patient.

Information should be valid and reliable.

(Wang, Hailey & Yu, 2011)
TELLS THE PATIENT’S STORY

- Reflects individualized patient care
- Standardizes communication across providers

Content of Documentation should include:
- Diagnosis
- Current problems
- Nursing Interventions
- Up-to-date assessments related to each problem
- Outcomes
- Resolution of active problems

(Keenan, Yakel, Tschannen, & Mandeville, 2008)
Provision 4 of the Code of Ethics for Nurses states that:

“The nurse is responsible and accountable for individual nursing practice. In each instance, the nurse retains accountability and responsibility for the quality of practice and for conformity with standards of care”

- Illustrates critical thinking & decision making
- Reflects the nursing process
- Reflects actual nursing care provided during shift

(Day, 2014; AHIMA workgroup 2009)
What is it?

• Attributes the original creation of a unit of information to a specific individual at a particular time

• Clearly establishes the provider who authored a document

• Identifies the provider’s contribution to patient care

• Establishes ownership of information

(AHIMA workgroup, 2009)
Accuracy Provides for:

• Information that aids in decision making
• Documentation of actual nursing care provided
• Continuity of care
• Increased patient safety
• Improved communication around discharge planning

Consequences of Inaccurate Documentation:

• Increased LOS
• Incorrect plan of care
• Incorrect procedures
• Disruption in care coordination
• Inadequate information to provide care

(Wang, Hailey, & Yu, 2011; AHIMA, 2009)
Reflects your shift

- Reflects actual nursing care provided to the patient
  - Nursing assessment
  - Nursing interventions
  - Outcomes & evaluation of interventions
  - Current patient problems

Nursing problems should be resolved as soon as appropriate

- When a problem is no longer active (i.e. you are not performing an assessment or providing any intervention on the previously documented problem)
TIPS FOR A GOOD NURSING NOTE
OWNERSHIP OF INFORMATION

• In signing the note, the nurse attests that all information reflects the care provided, his/her clinical judgment, and is current and accurate.
  • Note is free of conflicting information.
  • Note reflects the care the you delivered or assessment that you made.
  • References to other notes or summaries include dates.

• Nursing notes are a component of clinician documentation that may also be reviewed by patients and/or families
• Evaluation of nursing note documentation during Annual Review with Nurse Director, based on criteria:

1. Notes are updated to reflect care provided and the patient’s current condition. The note contains evidence of updating and is accurate.
2. HPI is summarized to highlight information relevant to patient’s current condition. This may not change daily.
3. Patient problems include updated nursing assessment and are resolved when appropriate. The assessment contains accurate, current descriptions of the patient’s condition and response to interventions.
4. Evaluation/Impression provides a synthesis of patient’s overall progress.
“YOU ARE WHAT YOU WRITE”

- eBridge Admit/Progress/Transfer notes
  - **Plan of care**: Identify Goals & Interventions under each patient problem.
  - **Assessment**: Document patient response to interventions and progress towards goals, as of the current shift.
  - **Evaluation/Impression**: Describe pertinent changes in patient clinical status and overall progress towards goals.

- Note reflects care provided by the nurse and includes the information necessary for a safe hand-off between clinicians.
1. NOTES ARE UPDATED

“MAKE AN EDIT, TAKE THE CREDIT”

- **Carry-forward function**
  - Eliminates need to re-enter information that remains relevant to current patient status.
  - Requires nurse to **review, delete, change and add** information in each field to reflect the patient’s current status.
  - It’s important to **delete** information no longer relevant. It remains in the previous note.
2. HPI IS SUMMARIZED

- **Brief description** of patient condition leading to hospitalization
  - May include pertinent PMH or other related medical/psychosocial information.

- **If chronology of events included:**
  - Keep it succinct.
  - Edit/update to highlight events relevant to patient’s current condition.
  - Summarize course of events prior to transfer to another unit and throughout hospitalization.
3. PATIENT PROBLEMS

- Problems contain 3 components: goals, interventions and nursing assessments.

- Goals and Interventions are updated/removed when indicated.

- Nursing assessments describe patient’s response to interventions and progress towards goals. Compared to the previous note, the assessment must be a current reflection of the patient’s status.

- Problems are addressed each shift and resolved when appropriate.
4. EVALUATION/IMPRESSION IS A SYNTHESIS

- Compared to previous RN note, it provides an updated synthesis of patient’s overall progress towards goals.

- Reflects key changes in patient status.
  - Includes the “so what?” of the note
  - Includes readiness for discharge
WHAT RESOURCES ARE AVAILABLE?

• Excellence Every Day (EED) eBridge site
  • http://www.mghpcs.org/eed_portal/eBridge.asp#nurse

• eBridge Nursing Progress Note Worksheet
  • http://www.mghpcs.org/eed_portal/Documents/eBridge/Nursing_Progress_Note_Review_Tool.pdf

• Updated information communicated via:
  • Informatics Info Board (*Coming Soon* to every unit!)
  • “Informatics Update” Email
  • EED site resources
  • Unit Leadership


