Discharge Documentation: Streamlining the Process

The Problem

Doctors and nurses prepare patient discharge documentation in two separate systems: MDs/ NPs /PAs use the "Discharge Worksheet" in POE and RNs use "Patient Discharge Plan" in Discharge Planning. This lack of integration created several problems:

- It is not always clear who is responsible for each section of the discharge paperwork.
- There is duplication of effort.
- Nurses have to copy and paste from two documents to create the final patient instructions, which poses the potential for patient safety errors.
- It is not obvious which parts of the discharge documentation are intended for the patient, the primary care doctor, or the accepting facility.
- Clinical documentation of patients' discharge status (mental and functional status) and disease specific discharge instructions are inconsistent and confusing.

As a result, the final patient discharge instructions may contain inaccurate or contradictory information, and may contain language that the patient cannot understand.

Aim/Goal

Eliminate the need for nurses to copy and paste information from the MD Discharge Worksheet into the Patient Discharge Plan. In addition, decrease redundancy, improve efficiency and decrease confusion of information for patients.

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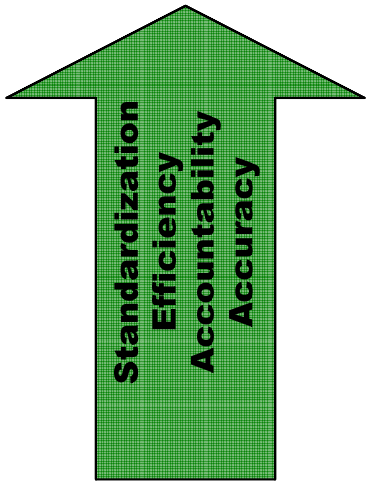
The Interventions

- Development of a multi-disciplinary team, Nursing, Physicians, and IS to identify specific needs to streamline documentation.
- Identified which clinician would own which data/information
- IS programming to utilize information directly from the Discharge Worksheet in POE to the Patient Discharge Plan, and updating nursing fields to eliminate redundant fields and display data and information written by discharging provider.

The Results/Progress to Date

The MDs/ NPs /PA "Discharge Worksheet" in POE and the RN "Patient Discharge Plan" are now combined into a single fully integrated system which clearly defines which fields are to be completed by MDs/ NPs /PAs or RNs and which sections are intended for the patient, the PCP, or for the page 1.



Other improvements include:

- Standardized "Danger signs"
- Structured "Condition at Discharge" fields.
- Elimination of printed copy of Discharge Worksheet; part of POE print in Medical Records at discharge
- Auto printing of 2 copies of the Patient Discharge Plan upon completion – one copy labeled for the patient and one copy labeled for the Medical Record

Lessons Learned

- Discharging patients is a high-risk, high complexity process, which requires the participation of the patient and multiple care providers. To insure this process is safe and provides relevant and accurate information to patients, accepting care facilities, and other providers, a systematic approach is required.
- By analyzing each step in the discharge documentation process, we were able to partner with information systems to identify and eliminate inefficiencies and potential sources of error.

Next Steps/What Should Happen Next

- Work with specialty areas such as Psychiatry to ensure the system supports the information needs of the Deaconess 4 discharges
- Integrate specific medical conditions to template patient discharge instructions
- Link to the Discharge Planning in POE
- Display home care and ECF information in Discharge Worksheet and fax to PCPs
- Pull appointments scheduled from the reminder system so that location and phone numbers are in patient friendly wording
- Improve Medication Reconciliation Process
- Push discharge information to multiple care providers

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