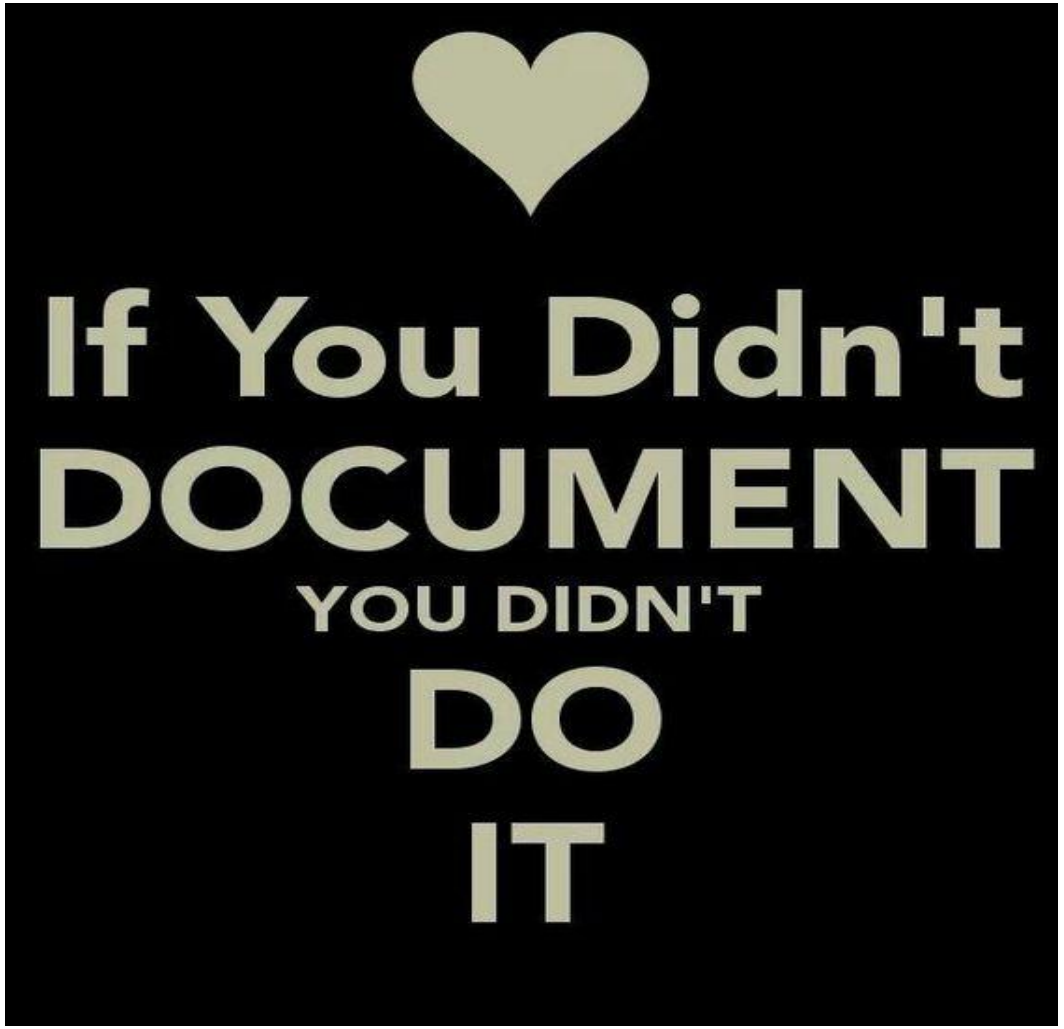
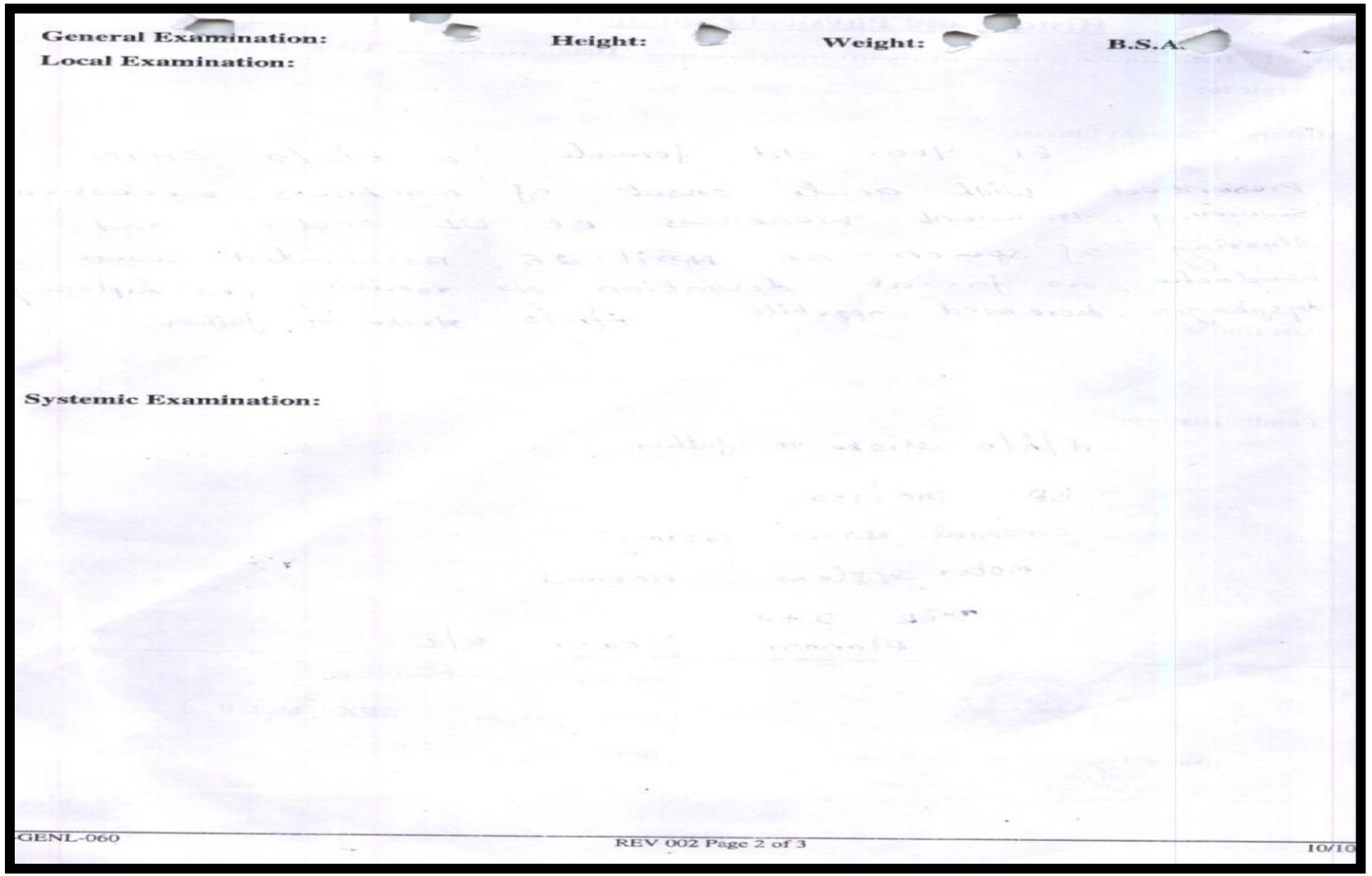
Debate
Documentation v/s Patient Care

Where does the buck stops….



Doctors are complicating….more…..



General Examination: Height: Weight: B.S.A.

Local Examination:

Systemic Examination:

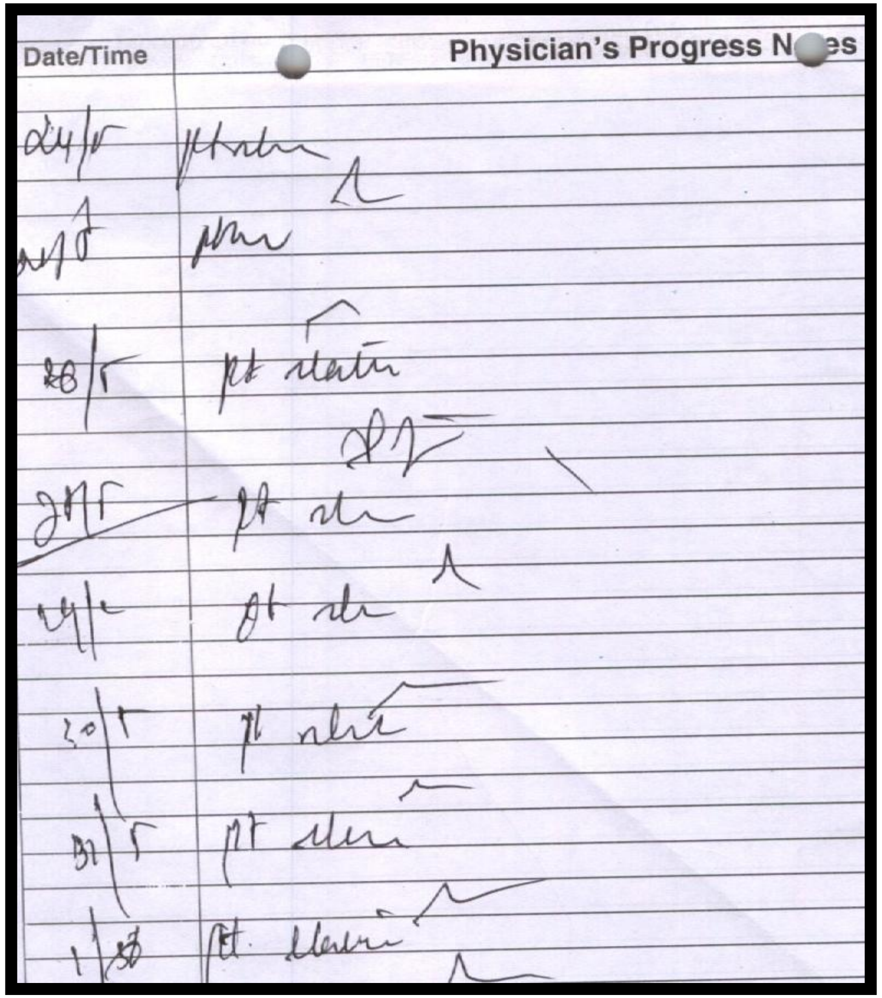
GENL-060 REV 002 Page 2 of 3 10/10

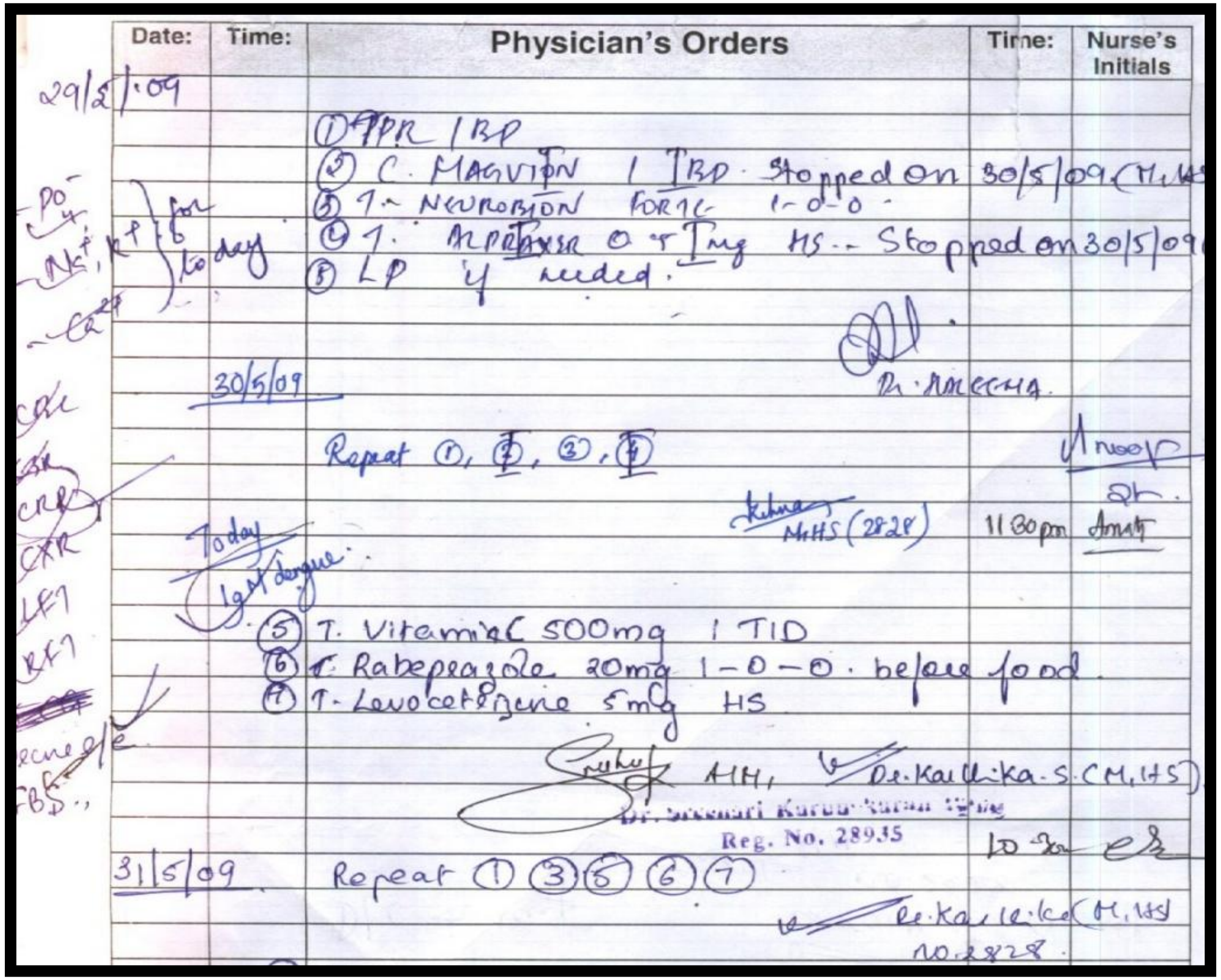
Date/Time	Physician's Progress Notes
23/12/09	S/P [illegible] [illegible] [illegible]
	[illegible] State:
	[illegible] [illegible] ([illegible] 37 [illegible]
	[illegible] [illegible] [illegible] [illegible] [illegible]
	[illegible] [illegible]
	[illegible] [illegible] [illegible] [illegible] [illegible]
	[illegible] [illegible] [illegible] [illegible]
	[illegible]

I.H.D.

Date:	Time:	Physician's Orders	Time:	Nurse's Initials
22/12/08		① – T. Isordil. 10 1 – 1 – 1.	– ECG	
		② – T. Metolar 50 ½ – ½ – ½	– GMT/Echo	
		③ – T. Aspirin 75 – 1 – 0	– FLP	
		④ – T. [illegible] 150 IBP STOPPED ON 23/12/08 at 9:15 AM	– S. Creatinine	
		(Dr. Gnesh)	– Cardiology 7 am	&
			CBC	ESR,
			Na K.	
			URE	
			~~[illegible]~~	ICT
			CXR,	FBS,
23/12/08. 9:00 AM.		Continue ① ② ③ ④		
		(Dr. Ashok M. HS ON CALL – 2828)		
		TPR / BP CHART.		

To top it all....


Date/Time
Physician's Progress N


Date:
Time:
Physician's Orders
Time:
Nurse's Initials

Dilemma…..


The Adventures of Mighty Nurse
A NEW OLYMPIC EVENT...
THE CALL-LIGHT- ATHLON!
NURSE...
Oh, NURSE!
NNn-URSSSE!
NURSE!!
www.mightynurse.com


The Rising Importance
of Patient Satisfaction
in a Value-Based Environment

NABH guides us…

Chapter 1

Access Assessment and Continuity of Care (AAC)

Intent of the chapter:

Patients are well informed of the services that an organisation provides. This will facilitate in matching the patients with the organisation's resources in an appropriate manner. Only those patients who can be cared for by the organisation are admitted to the organisation. Emergency patients receive life-stabilising treatment and are then either admitted (if resources are available) or transferred appropriately to an organisation that has the resources to take care of such patients. Out-patients who do not match the organisation's resources are similarly referred to organisations that have the matching resources.

INTENT

We are here not for fault findings …….but for fact finding

What Assessors says….

3	Turnaround time for the tests have been defined in the policy. However, there was no display of TAT in the labs.	AAC 6 f

5	Mock drills have been conducted twice however the CAPA	AAC 9 f

15	CPR Protocols have not been displayed in ER dept and in some of the ICUS's	COP 5 a

Evidence of proper cold chain maintenance of blood bags was lacking as temperature monitoring of refrigerator was inaccurate. COP 8 b

Though the HCO has an Infection Control Officer but there is no appointment letter for the same HIC 1e

The batch number and serial number of the implantable prosthesis and medical devices are being recorded in the patient medical record, however the records were not available at the discharge summary MOM 12 d

BMJ

BMJ 2012;344:e1717 doi: 10.1136/bmj.e1717 (Published 20 March 2012)

RESEARCH

Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States

Too busy for patients... nurses spend FIFTH of their time on paperwork

By JO MCFARLANE
PUBLISHED: 02:23 BST, 21 April 2013 | **UPDATED:** 02:23 BST, 21 April 2013

View comments

Nurses are being forced to spend more time on 'tick-box' paperwork and less with patients despite a Government pledge to crack down on unnecessary NHS bureaucracy.

The Royal College of Nursing says staff spend nearly a fifth of their working day filing, photocopying and ordering basic supplies because of a chronic lack of investment in administrative staff and the failure of expensive new IT systems to reduce their workload.

The scandal at Mid Staffordshire NHS Trust has also forced nurses to record more information on basic care and treatment and to document how often they speak to patients.

Documentation: You've got a lot to lose

September 2014 Vol. 9 No. 9
Author: Leah Curtin, RN, ScD(h), FAAN

According to the Centers for Medicare & Medicaid Services, fraud is "the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person." Misstatements or omissions found by auditors are not necessarily fraud. In fact, they're usually errors. Errors aren't deliberate; fraud is. Fraud requires the intent to mislead.

Then there are situations like this: *Mary Jane Howe (not her real name) was certified in OB/GYN and had 18 years of experience working in labor and delivery. After a particularly busy night, she "approximated" the blood pressures for an eclampsic patient—graphing them "pretty close to what she remembered." A random retrospective audit caught the discrepancies between the monitor's readout and the charting.*

Then we say.....

Community Eye Health. 2002; 15(41): 1–3.

PMCID: PMC1705904

HOW CAN WE IMPROVE PATIENT CARE?

Monitoring Editor: Gullapalli N Rao, MD
Gullapalli N Rao, L V Prasad Eye Institute, Hyderabad – 500 034, India;

Community Eye Health

Improving patient care has become a priority for all health care providers with the overall objective of achieving a high degree of patient satisfaction. Greater awareness among the public, increasing demand for better care, keener competition, more health care regulation, the rise in medical malpractice litigation, and concern about poor outcomes are factors that contribute to this change.

The quality of patient care is essentially determined by the quality of infrastructure, quality of training, competence of personnel and efficiency of operational systems. The fundamental requirement is the adoption of a system that is 'patient orientated'. Existing problems in health care relate to both medical and non-medical factors and a comprehensive system that improves both aspects must be implemented. Health care systems in developing countries face an even greater challenge since quality and cost recovery must be balanced with equal opportunities in patient care.

Nursing Practice
Research
Nursing care

Keywords: Observations/Nursing time/ Productive ward

●This article has been double-blind peer reviewed

Nurses have faced criticisms that they do not spend enough time giving direct patient care, however observations of their practice challenge this view

How much time do nurses spend on patient care?

TABLE 1. **INTERACTIONS BY AREA AND STAFF GROUP**

Rank	Area	Patients observed (*n*)	Staff observed (*n*)	Band 2	Band 5	Band 7	Other staff	Total length of interaction
1	4	4	3	00:16:18	00:49:03			01:05:21
2	1	6	5	00:09:55	00:15:40			00:25:35
3	3*	2	2	00:15:40	00:09:00			00:24:40
4	2	5	4	00:09:00	00:04:20	00:04:30		00:17:50
5	5	5	4	00:06:57	00:03:40		00:01:40	00:12:17
Total		22	18	00:57:50	01:21:43	00:04:30	00:01:40	02:25:43

*One observation only

TABLE 2. **ACTIVITIES AND DURATION BY STAFF GROUP**

	Rank	Activity	Band 2	Band 5	Band 7	Other staff	Length of interaction
	1	Nursing procedure	00:04:50	00:22:08			00:26:58
	2	Hygiene	00:14:18	00:08:15			00:22:33
	3	Toileting	00:12:35	00:06:30			00:19:05
	4	Patient communication	00:07:55	00:04:55	00:03:05		00:15:55
	5	Medicine round		00:12:40			00:12:40
	6	Other: transferring patient*	00:05:40	00:02:50			00:08:30
	7	Other: discharge information*		00:06:30			00:06:30
	8	Documentation (at bedside)	00:00:30	00:03:35			00:04:05
	9	Bed making	00:01:50	00:01:45			00:03:35
	10	Handovers		00:03:00			00:03:00

According to a study of how 1,000 nurses spend their time at work, more than one-third of nurses spend at least one full hour per shift finding items of equipment! That translates into 40 hours per month for a full time nurse.

	26	Mobilising		00:00:25			00:00:25
	27	Meal rounds	00:00:10				00:00:10
	28	Other: doctor with patient so staff member left*	00:00:05				00:00:05
	29	Assessments					
	30	Relative liaison					
	31	Responding to call bells					

*Activities marked "other" were not listed on the observation schedule but were observed

Discharges are also a pain….

Majeed *et al. BMC Health Services Research* 2012, **12**:410
http://www.biomedcentral.com/1472-6963/12/410

BMC
Health Services Research

RESEARCH ARTICLE Open Access

Delay in discharge and its impact on unnecessary hospital bed occupancy

Muhammad Umair Majeed[1*], Dean Thomas Williams[1,2], Rachel Pollock[1], Farhat Amir[1], Martin Liam[1], Keen S Foong[1] and Chris J Whitaker[2]

Abstract

Background: Elderly patients are potentially more vulnerable to prolonged hospital stay as they frequently require additional resources to facilitate their discharge. In an acute hospital setting, we aimed to quantify and compare length of stay (LOS) for all patients over and under the age of 65, and identify the number and cause of days lost under the care of a single surgical unit.

Methods: Over a 4 month period from January to April 2010, data on the management and source of potential delay was collected daily on consecutive patients admitted and discharged under the care of one consultant surgeon at a district general hospital. Statistical analysis was then performed with particular focus on actual delays affecting elderly patients.

Results: A total of 99 complete inpatients episodes were recorded. There were 30 elective and 69 acute admissions. 10 (33%) elective vs. 42 (61%) acute patients encountered delays, losing 39 and 232 days respectively (χ^2 [1, N = 99] = 6.36, p = .012). 23 of a total 39 elderly patients admitted acutely required specialist care of the elderly opinion and placement in community hospitals resulting in delays of 188 days. vs. 36 days for the 16 discharged home and 8 days for 30 patients under 65 (χ^2 (2, N = 69) = 26.54, p = <.001).

Conclusions: Elderly patients experiencing acute surgical admission and discharge to community hospitals had prolonged LOS due to significant delays associated with care of the elderly provision. The financial considerations behind bed capacity in primary and secondary care and the provision of care of elderly services need to be balanced against unnecessary occupancy of acute hospital beds with its associated health and economic implications.

Keywords: Surgery, Elderly, Length of stay, Bed occupancy, Community care

Antibiotic Use

Table 14.1. Before-after studies of practices to improve antibiotic use*

Study Setting and Intervention	Outcomes	Results: before vs. after practice
Elderly care unit of a large teaching hospital in England, 1984-85; Changes in empiric antibiotic regimens[29]	Level 1	*C. difficile* infections decreased from 37 to 16 cases (p=0.002).
Chronic care facility in Baltimore, 1985-86; multifaceted intervention[21]	Level 1	Patients with *C. difficile* toxin decreased from 28% to 24% (p=NS); Patients with *C. difficile* culture increased from 33% to 42% (p=NS)
Veterans Affairs Medical Center in Arizona, 1990-92; restriction of clindamycin use[28]	Level 1	*C. difficile* infections decreased from 7.7 to 1.9 cases/month (p<0.001)
660-bed Veterans Affairs hospital in California, 1992-94; removal of antibiotic restrictions[30]	Level 1	Monthly incidence of *C. difficile* infections per 1,000 admissions increased from 3.4 to 6.2 (p<0.05)
703-bed Veterans Affairs Medical Center in Virginia, 1993-94; restriction of clindamycin use[7]	Level 1	*C. difficile* infections decreased from 11.5 to 3.33 cases/month (p<0.001)

Clinical Pharmacist

Table 7.1. Studies of clinical pharmacists' impact on ADEs and medication errors*

Study	Study Design	Study Outcomes	Results
Beney, 2000.[18] Systematic review of the roles and impacts of pharmacists in ambulatory settings; reviewed studies included 16,000 outpatients and 40 pharmacists	Level 1A (systematic review)	Levels 1-3 (variety of patient outcomes, surrogate outcomes, impacts on physician prescribing practices and measures of resource use)	Improvement in outcomes for patients with hypertension, hypercholesterolemia, chronic heart failure, and diabetes
Gattis, 1999.[16] 181 patients with heart failure due to left ventricular dysfunction followed in a general cardiology clinic	Level 1 (RCT)	Level 1 (mortality and other clinical outcomes related to heart failure)	16 versus 4 deaths or other heart failure events ($p<0.005$)
Leape, 1999.[13] Medical and cardiac intensive care unit patients at Massachusetts General Hospital, a tertiary care hospital in Boston	Level 2 (prospective before-after study with concurrent control)	Level 1 (ADEs)	66% decrease in the rate of preventable ADEs ($p<0.001$)

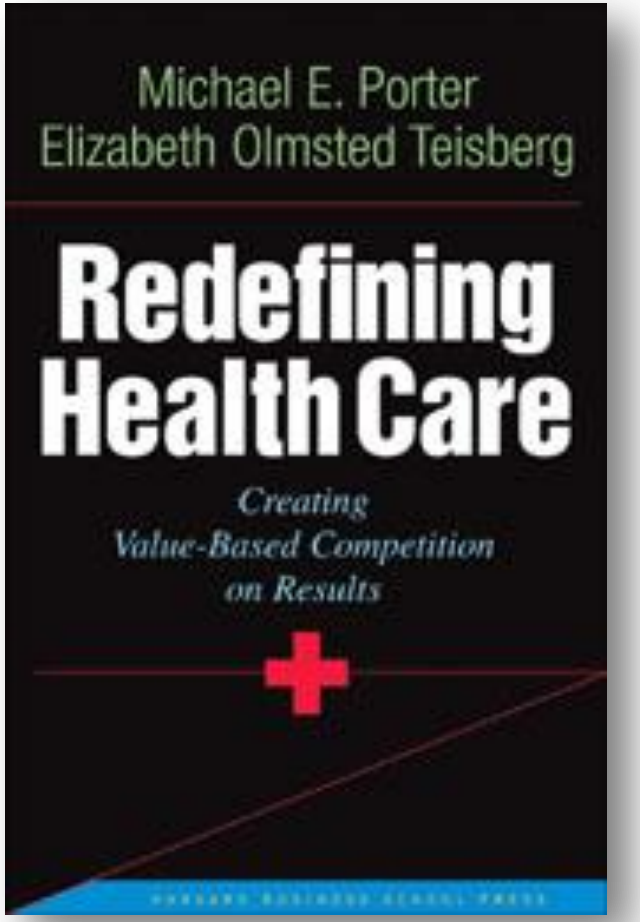
Bates et al, Harvard School

CPOE with CDSS (Bates..Harvard)

Table 6.1. Studies of computerized physician order entry (CPOE) with clinical decision support systems (CDSSs)*

Study	Study Design	Study Outcomes	Results
Overhage, 1997.[21] Impact of faculty and physician reminders (using CPOE) on corollary orders for adult inpatients in a general medical ward at a public teaching hospital affiliated with the Indiana University School of Medicine	Level 1 (RCT with physicians randomized to receive reminders or not)	Levels 2 & 3 (errors of omission in corollary orders)	25% improvement in ordering of corollary medications by faculty and residents ($p<0.0001$)
Bates, 1998.[22] CPOE with CDSSs for adult inpatients on medical, surgical, and intensive care wards at BWH, a tertiary care center affiliated with Harvard University	Levels 2 & 3 (two study designs)	Level 1 (ADE rates) and Level 2 (serious medication errors)	55% decrease in non-intercepted serious medication errors ($p=0.01$) 17% decrease in preventable ADEs ($p=0.37$)
Bates, 1999.[23] CPOE with CDSSs for adult inpatients in 3 medical units at BWH	Level 3 (retrospective time series)	Level 1 (ADEs) and Level 2 (main outcome measure was medication errors)	81% decrease in medication errors ($p<0.0001$) 86% decrease in non-intercepted serious medication errors ($p=0.0003$)

Patient Centered Care



"By default if not by design, the consumer is emerging as the locus of priority setting in healthcare."

James C. Robinson, Ph.D., M.P.H.
Chair, Berkeley Center for Health Technology,
University of California, Berkeley
The end of managed care. *JAMA* 2001 May

Please help us to provide

Patient Care

Please….