Educational Interventions to Improve Clinician Documentation

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Educational Interventions to Improve Clinician Documentation

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Background

- Timely and accurate documentation is essential:
  - enhances shift communications
  - assists in evaluating the patient's clinical progress
  - evaluates the patient response to clinical interventions
- Accurate and timely documentation can have legal ramifications.

Departmental Policy

- A clinical note is required at the start and end of each clinician’s shift.
- The clinical note is to utilize the SBAR format:
  - S = Situation
  - B = Background
  - A = Assessment
  - R = Recommendation
- Documentation can occur between notes if warranted.

Study Design

- We collected fifty random pre and post shift assessment notes.
- We reviewed these notes to examine if they contained the elements of SBAR per our departmental policy.

Results

- Based on the review we required:
  - a SBAR format review session at our annual educational days.
  - staff to complete an on-line learning module focusing on the correct SBAR formatting.
  - A documentation presentation was provided by our institution’s legal/risk management team.

- Post education there was an improvement in SBAR documentation from 70% to 90%.
- Monthly QA was performed to insure that SBAR notes continued to be written per policy.

Conclusions

- Content education and vigilant monitoring insure precise and appropriate staff documentation.
- Precise documentation helps to provide clear clinical goals and optimizes patient outcomes.