Nordsjællands Hospital

There is no CHARM in gastrointestinal HARM...

Nurse documentation reveals hidden potential for quality improvement

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Problem

The profile of harm reveals that **gastrointestinal harm related (GI-harm) represents 25% of all harm**.
A problem easily overlooked and neglected by careworkers, but troublesome and maybe embarrassing for the patient.
In 2011 a careplan with flowchart for documentation and handling of in-patients bowel function had been developed, but spread to the Hospital it had no success. Looking at the patient's records it seems that nurse documentation was only done when there had been bowel movement, and not when there had not been any movement.

Patients could develop constipation without staff noticing it.

Background

Nordsjællands Hospital Hillerød, Denmark is a **590 bed University hospital** in the capital region of Denmark.
Since January 2010 the Hospital has been working with the campaign **"The Danish Safer Hospital Programme"** arising from The Danish Society for Patient Safety and The Institute for Healthcare Improvement (IHI).
The aim of the campaign is to reduce patients harm, due to care or treatment, by 30%. Working with this campaign, it is thereby necessary to identify harm.
To identify harm the IHI-Global Trigger Tool (GTT) is used.
Presenting data from IHI-GTT is done in run charts, but the Hospital has also found that valuable data is revealed in the profile of harm.

Lessons learned

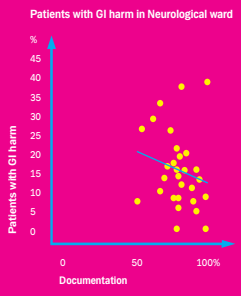
Change of nurses documentation takes more time and effort than expected, and nurse specialists are important in order to sustain the changes. Consistent nurse documentation can be an important factor in reducing GI-Harm.

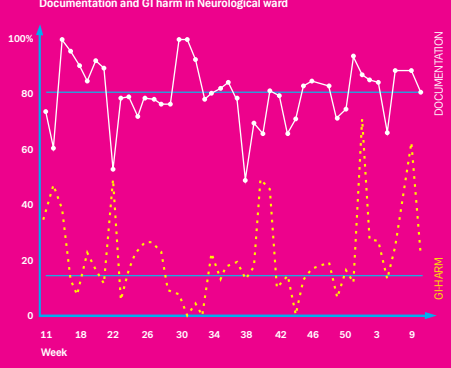
Assessment & analysis

Audit of patient charts shows a **lack of consistency** in nurse documentation and **variations in terms** used to describe bowel function.
For many years the demand for documentation seems to have increased, therefore it has been accepted for nurses, that they only document when something happens and do not document if nothing happens.
The result has been **"No bowel movement = no documentation".**
The careplan for patient bowel movement has not been implemented.

Effects

The control chart shows that **correct documentation is possible.** Special causes were detected during the summer vacation, when the nurse specialist was not present and the weeks she was present there was 100% correct documentation.
When focusing on correct documentation, the first result is increase in GI-Harm, but later on the harm rate decreases. The scatter plot shows a slight relation between correct documentation and the harm rate.





Conclusion

Correct nurse documentation shows potential for quality improvement. Data reveals that nurse documentation is more important than assumed.

Optimized nurse documentation leads to reduction in GI harm

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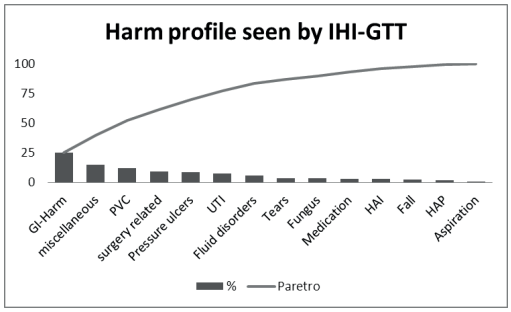

Context: Presenting data from IHI-GTT is done in run charts, but the Hospital is also found that valuable data is revealed in the profile of harm.

Problem: The profile of harm revealed that gastrointestinal harm related (GI-harm), represent 25% of all harm. A problem easily overlooked and neglected by care workers, but troublesome and maybe embarrassing for the patient. In 2011 a careplan, with flowchart for documentation and handling in-patients bowel function had been developed, but spread to the Hospital had no success. Looking at the patient's records it seems that nurse documentation, only were done when there had been bowel movement, and not when there hadn't been any movement. Patient could develop constipation without staff noticing it.

Assessment of problem and analysis of its causes: Audit of patient charts shows lack of consistency in nurse documentation and variations in terms used to describe bowel function.
For many years the demand for documentation has increased, therefore it has been accepted for nurses, that they only document when something happened, and no documentation if nothing happens. The result was "No bowel movement = no documentation". The careplan demanded documentation every day, but the careplan for patient bowel movement was not implemented.

Intervention: One ward was selected to be test ward for implementing the careplan with flowchart for documentation and handling bowel function.
A driver diagram was composed, in order to keep track of the need for tests and data collection. Flowchart were tested using PDSA, the Nurse Specialist introduced and taught the use of flowchart. Flowcharts were distributed to all staff in pocketsize.

Strategy for change: A clinical Nurse Specialist and the Head Nurse of the department met, and planned test and implementation of changes. Huddels at least once a week.

When focusing on correct documentation, the first result is increase in GI-Harm, but later on the harm rate decreases. The scatter plot shows a slight relation between correct documentation and the rate of Harm.
Lessons learnt:
Change of nurse documentation takes more time and effort than expected; therefore Nurse Specialist is important to sustain the changes. Consistent nurse documentation can be a factor in reducing GI-Harm.

Please declare any conflicts of interest below: There were no conflicts.