

5-31-2017

Tracking and Improving Bedside Procedures Through Standardized Documentation

N. Sich

Abington Jefferson Health

L. Gartner

Abington Jefferson Health

J. Sternlieb

Abington Jefferson Health

K. Noonan

Abington Jefferson Health

Follow this and additional works at: <https://jdc.jefferson.edu/patientsafetyposters>

 Part of the [Medicine and Health Sciences Commons](#)

[Let us know how access to this document benefits you](#)

Recommended Citation

Sich, N.; Gartner, L.; Sternlieb, J.; and Noonan, K., "Tracking and Improving Bedside Procedures Through Standardized Documentation" (2017). *House Staff Quality Improvement and Patient Safety Conference (2016-2019)*. Poster 37.

<https://jdc.jefferson.edu/patientsafetyposters/37>

This Article is brought to you for free and open access by the Jefferson Digital Commons. The Jefferson Digital Commons is a service of Thomas Jefferson University's [Center for Teaching and Learning \(CTL\)](#). The Commons is a showcase for Jefferson books and journals, peer-reviewed scholarly publications, unique historical collections from the University archives, and teaching tools. The Jefferson Digital Commons allows researchers and interested readers anywhere in the world to learn about and keep up to date with Jefferson scholarship. This article has been accepted for inclusion in House Staff Quality Improvement and Patient Safety Conference (2016-2019) by an authorized administrator of the Jefferson Digital Commons. For more information, please contact: JeffersonDigitalCommons@jefferson.edu.

Background

Abington-Jefferson Health (AJH) currently relies on hand written notes for all bedside procedures. This leads to a multitude of problems including:

- Illegibility
- Missed Elements of Standard Hospital Protocol
- Failures in Documentation
- Inability to Track Procedures
- Inability to Generate Outcomes Data from Procedures

ACGME's Clinical Learning Environment Review (CLER) has identified bedside procedures as an area of improvement for AJH that we suspect originated from poor documentation. CLER metrics targeted are:

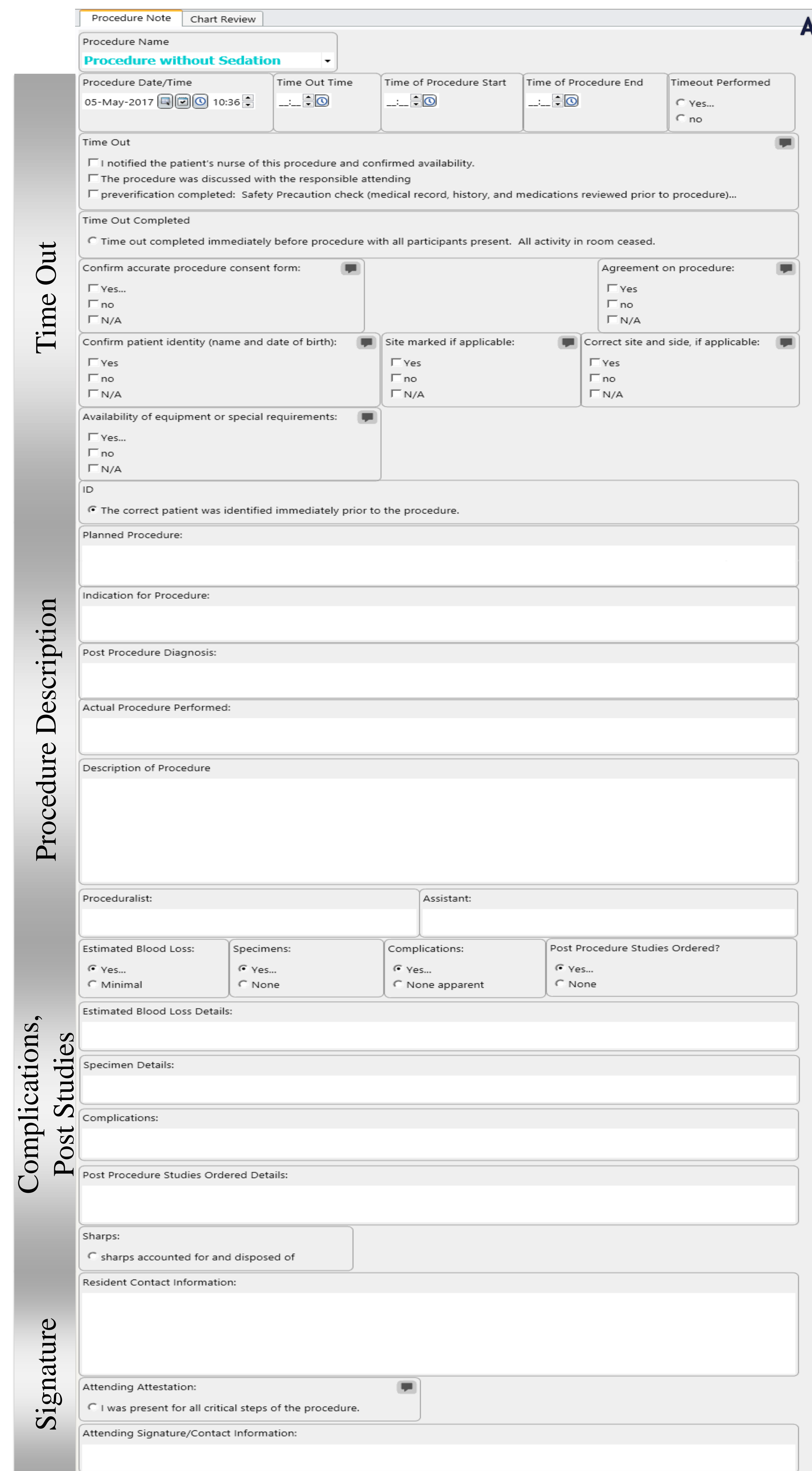
- Patient Safety
- Health Care Quality
- Supervision
- Clinical Experience

Aim: To create an Electronic Procedure Note with a multi-disciplinary team (Surgery, Informatics, Regulation, Compliance, Epidemiology, Safety/Quality) to improve documentation and tracking of all bedside procedures.

Proposal and Goals

1. We propose to create a standardized electronic procedure note that will replace all documentation for bedside procedures without sedation.
 - Makes notes legible and easily identified
 - Allows uniform tracking of metrics necessary to identify outcomes from a procedure (blood loss, specimens, post-procedure studies, complications)
2. The procedure note will be created in such a way as to allow specialized procedures to be added over time with minor customization to improve physician/nursing work flows and increase efficiency
 - Allows procedures to be sorted and tracked by type
 - Will be constructed to allow attaching CPT codes to patient charts via documentation
3. We propose using this procedure note to create a running database of all bedside procedures
 - Can be utilized by existing software (Qlik) to query all procedure notes to create large anonymized patient lists

Methods



The form is divided into several sections:

- Time Out:** Includes fields for Procedure Name (dropdown), Procedure Date/Time, Time Out Time, Time of Procedure Start, Time of Procedure End, and Timeout Performed (Yes/No). It contains checkboxes for notifying the nurse, discussing with the attending, and completing preverification.
- Procedure Description:** Includes fields for Confirm accurate procedure consent form, Agreement on procedure, Confirm patient identity, Site marked if applicable, Correct site and side, and Availability of equipment or special requirements.
- Procedure Description (continued):** Includes fields for ID, Planned Procedure, Indication for Procedure, Post Procedure Diagnosis, Actual Procedure Performed, and Description of Procedure.
- Complications, Post Studies:** Includes fields for Proceduralist, Assistant, Estimated Blood Loss, Specimens, Complications, Post Procedure Studies Ordered, and Estimated Blood Loss Details.
- Signature:** Includes fields for Specimen Details, Complications, Post Procedure Studies Ordered Details, Sharps, Resident Contact Information, and Attending Attestation/Signature.

Chart Review

Procedure: Procedure without Sedation
Proceduralist: Dr. Sich PGY-3
Assistant and/or Supervisor: Sherry Kessler, R.N.
Date and Time of Procedure: 05-May-2017 11:21

I notified the patient's nurse of this procedure and confirmed availability. The procedure was discussed with the responsible attending and preverification completed: Safety Precaution check (medical record, history, and medications reviewed prior to procedure). After obtaining informed consent, which is documented in the physical chart, the patient was placed in the correct position. The patient was prepped and draped in usual sterile fashion. A verbal timeout was performed with nursing present to confirm the correct patient, procedure, and site.

After prepping and draping in the supine position with the arm raised, the anatomic landmarks of the left 4th-5th rib space were identified between the anterior and mid-axillary lines. 1% Lidocaine was used to anesthetize the surrounding skin area, the periosteum of the rib, and the subcutaneous tissue from the skin to the pleural cavity. A small incision was made using a #15 scalpel down to subcutaneous tissue. Blunt dissection with a Kelly clamp was performed over the rib until the pleura was encountered. The left pleural cavity was then entered with a closed Kelly clamp and spread open. A finger sweep was performed to ensure no adherent lung parenchyma to the chest wall. The chest tube was inserted anteriorly and posteriorly into the chest and sutured in place. A sterile occlusive dressing was applied to the chest tube site and the chest tube was attached to a pleuravac and placed to wall suction.

CT Size: 36 Fr
Fluid Evacuated Upon Placement: 400cc Dark Thin Blood
Air Leak (Y/N): No

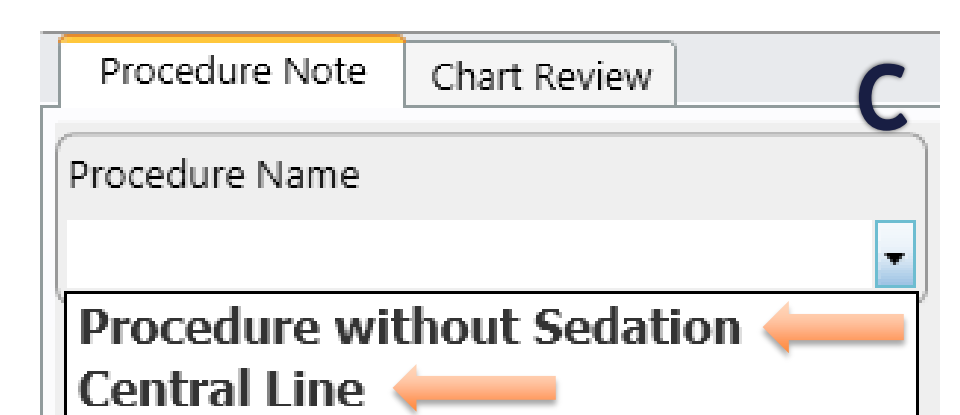
At the conclusion of the procedure all sharps and equipment were accounted for and properly disposed.

Resident Contact Information: Nicholas Sich M.D.
PGY-3 General Surgery
Pager# 0950

Figure A: Working Prototype of Note Input

Figure B: Example of Note Output

Figure C: Selecting Custom Procedures



The dropdown menu shows 'Procedure without Sedation' and 'Central Line' as options.

Future Direction, Next Steps

- Procedure Note to go live in Summer of '17
- Will need to build out custom procedures/named notes by Department in order to create easily queried lists/databases for each individual type of bedside procedure
- Once running can be used as a foundation/tool to address specific QI projects augmented by our own institutional data
 - Trialysis vs. Dialysis Catheters
 - ABx for Chest Tube Insertion
 - Surgery vs. Medicine Placing Central Access

Acknowledgements / Select Reference

Special thanks to the Department of Epidemiology, Patricia Renn, and Dr. Schneider for their assistance with implementing this project in compliance with CMS law and hospital policy. Special thanks to Holly Brilla for creation of the EMR note.

• Accreditation Council for Graduate Medical Education. CLER Pathways to Excellence. IL, USA, 2014. Accessed at: https://www.acgme.org/Portals/0/PDFs/CLER/CLER_Brochure.pdf