In November of 2011, Adventist Hinsdale Hospital (AHH), implemented an electronic version of the interdisciplinary plan of care (IPOC) that incorporated clinical, department specific plans of care into a single, comprehensive, evidence-based patient centered plan of care that would accommodate cross-population of documentation within the electronic medical record (EMR).

The Clinical Close Dashboard (CCD) is a corporate tool which tracks key CMS-reported metrics. After identifying that our facility was not meeting the recommended percent compliance scores relating to the IPOC in accordance with best practice per the CCD, we implemented this project in November of 2012 to increase standardization of knowledge and improved documentation into the patient’s IPOC. As our hospital embarked on the journey towards obtaining Magnet status, we began to incorporate our professional practice model, which included elements of the Quality and Safety Education/Evaluation for Nurses (QSEN) and an Evidence Based Practice/Quality Improvement (EBP/QI) model to help identify issues. After applying Lean Six Sigma methodology to our preliminary data, we identified that the p-value was less than <0.05, which validates that the retraining on our pilot unit significantly impacted our metric related to the initiation of an IPOC within 4 hours of admission. We continue to move forward on encouraging why IPOCs are so important to the patient’s plan of care.

Current metrics used to evaluate progress:
1. Every patient has an IPOC
2. Every patient has one IPOC initiated within 4 hours
3. Every discharged (DC) patient has an IPOC related to the DC diagnosis
4. Every goal in the patient’s plan of care (IPOC) reassessed q shift (15 hours)

In October of 2012, our Clinical Informatics team started to gather data as to why IPOCs were not being used consistently, and why our percentages remained low. Initially, we did not utilize a formal Fish diagram exercise.

Upon completion of the hospital wide training, we chose the Medical unit as our pilot site. Within two days of auditing, our data revealed that the initial reeducation was not specific enough, and did not meet the enduser’s needs. At that point, we utilized a FISH diagram with our point of care nurses, ancillary staff, and superusers who identified the following key issues:

- Limited understanding of the correlation between IPOC and the patient’s main diagnosis/problem
- General knowledge deficit on the documentation requirements
- Inconsistent hand off / review

Based on the above findings, we determined it was necessary to reeducate all of the RNs on our pilot unit to promote standardization of knowledge on the above issues.

Next steps were as follows:
- Improved education guideline tool and competency based on enduser feedback
- Started initial training with the lead RNs, educator, and manager of that unit
- Retrained all of the RNs on the Medical floor with individualized (1 on 1) training
- Worked with manager and educator to create an audit team that could sustain the ongoing audits to help hardwire the process and increase staff accountability
- Met with ancillary departments and received input on their issues related to usage of IPOCs
- Used Lean Six methodology to determine if there was any statistically significant impact from our training

RESULTS AS OF 04/24/13

LESSONS LEARNED
- Created IPOC Multidisciplinary Task Force
- Updated the RN competency material
- Created the ‘Readmission Risk List’ card
- Not enough time to document 3 times a week to managers and task force members
- Created a IPOC poster on all units with unit specific information
- Created a 30 minute in-service focusing on the specific issues in Pareto chart; mandatory for all nurses with attendance by ancillary staff strongly encouraged
- Created a symbol and motto; ‘Great Patient Care Guided by IPOCs’ to illustrate the importance of the multidisciplinary team approach

RESULTS AS OF 01/13

Chart audits revealed that our endusers were still having issues with:
- Not choosing the appropriate diagnosis or problem related IPOC
- Not initiating an IPOC within 4 hours of admission.
- Goals not being reassessed and documented against every shift

Since November, our pilot unit data has continued to trend up and is currently maintaining above our goal on 2 of our metrics. We continue to struggle on metric 3, related to initiating IPOC within 4 hours of admit time.

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REFERENCES