Component III: Communication
Module B: Documentation
Topic 1: Written Documentation

I. **Statement of Purpose**

To enable the learner with basic principles and skills to communicate clearly and timely via written and different modes of communication including an electronic medical record.

II. Terminology

1. Electronic medical record
2. Telecommunication
3. ANA Nursing Code of Ethics
4. Nursing Minimum Data Set
5. Meaningful use
6. EMR (Electronic Medical Record)
7. Interdisciplinary plan of care documentation
8. Decision Support Systems
9. The Joint Commission
10. HIPAA (Health Information Portability and Accountability Act)
11. SBAR (Situation, Background, Assessment, Recommendation)
12. Nursing Minimum Data Set (NMDS)

III. **Performance Standards**

1. Define the terms listed in the vocabulary section.
2. Discuss the legal and professional responsibility in written communication.
3. Define the purpose and benefits of recorded documentation.
4. Discuss the legal and professional responsibility in verbal hand-off communication.
5. Define personal responsibility with system practices to ensure accurate documentation for billing and reimbursement.
6. Document appropriately and accurately in the medical record; paper or electronic.

IV. **References**

Books

Laughlin, C. (2006). Core Curriculum for Ambulatory Care Nursing, Second edition. Pitman, New Jersey: Anthony J. Jannetti, Inc.

Professional Journals

1. Brous, E. (2004). Seven tips on avoiding malpractice claims. *Nursing,* Jun, pg.16
2. Dunsford, J. (2009). Structured communication: Improving patient safety with SBAR. *Nursing Womens Health,* 5, 384-390
3. Dykes, C., DaDamio, R., Goldsmith, D., Kim, H., Ohashi, K., Saba, V., (2011) Leveraging Standards to Support Patient-Centric Interdisciplinary Plans of Care, *AMIA Annual Symposium Proceedings.* 2011: 356–363. Published online 2011 October 22.
4. Higuchi, KS, Davies BL, Edwards N, Ploeg J, Virani T. (2011). Implementation of clinical guidelines for adults with asthma and diabetes: a three-year follow-up evaluation of nursing care. *Journal of Clinical Nurse.* May; 20 (9-10):1329-38.
5. Pope BB, Spores, G. (2008). Raising the SBAR: How better communication improves patient outcomes. *Nursing,* Mar, 38, 41-43

6. Yocum, R. (2002). Documenting for Quality Patient Care. *Nursing*, Aug, 32, pg 58.

Websites

1. www.qsen.org_
2. https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage
3. Health Communication and Health Information Technology
   http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=18

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation
Objective 1 **Define the terms listed in the vocabulary section.** A. Give examples of each term. B. Discuss benefits and challenges of utilizing each term or process.	Discussion: Give each dyad one –two terms. Each dyad will describe the term, give an example of the term and explain one benefit and challenge of the term in the outpatient setting.
Objective 2 **Discuss the legal and professional responsibility in written communications** A. Medical terminology that describes a patient encounter must appear as a "source document". It can be: 1. Billing forms 2. Encounter forms 3. Emergency forms B. Health care professionals are accountable for ensuring a complete, transparent documentation 1. Meet coding standards 2. Reflect service provided 3. Failure could result in fraud and/or loss of license. C. Ambulatory Patient Classifications were adopted in 2000 by CMS for outpatient. 1. Based on procedure not diagnosis 2. Can allow for severity adjustment D. Nursing Minimum Data Set (NMDS) includes 16 data elements that must be collected by nurses for all encounters (not admissions) in ambulatory settings. 1. Age 2. Gender 3. Unique patient identifier such as medical record number 4. Payment mechanism; insurance coverage or reimbursement information 5. Medical diagnosis, this is typically coded in ICD9 coding 6. Facility; facility type or provider code 7. Dates of care 8. Unique provider identification; in some situations, nurses may have their unique provider code or sign on code in a computerized documentation system 9. Nursing care provided; nursing diagnosis, intervention, outcome and intensity	Lecture: Show examples of correct documentation. Discuss. Show examples of incomplete documentation. Ask students to identify omissions. Discuss. After NMDS section, show documentation that is missing some of the 16 elements. Ask for what is missing. Debrief. Discuss dangers of missing noted elements. Show charting examples of data collection that can be used for decision making. Examples • Pt with history of Congestive Heart Failure (CHF) has an irregular heart rate. • Pt with history of asthma exacerbation including number of times he has needed intubation • Pt with history of Chronic Obstructive Pulmonary Disease (COPD) who has

E. Common vocabulary is core to nursing practice and nursing informatics. An example of a unified language include is NANDA: North American Nursing Diagnosis Association's nomenclature. F. Decision Support Systems: Computerized data systems 1. An automated decision support system improves a nurse's decision- making The system contains: a. Prompts that trigger inquiries. b. Database contains expert information organized to promote decision-making c. Analytic modules can generate alterative solutions. d. Examples: "pop ups" when a visiting women's next Pap smear is due, next childhood immunization is due. 2. Benefits of an automated support system are: a. Large amounts of data can be organized and interpreted for use by professionals. b. Standardized decision making criteria result from large amounts of collected and interpreted data c. Best practices can result from large population studies G. Legal Requirement of Documentation in an EMR 1. Same as paper documentation 2. Authentic signature required 3. Secure password is required 4. "Downtime" policy and procedures required 5. HIPAA (Health Information Portability and Accountability Act) applies to all who use an electronic record	symptoms of upper respiratory infection • Pt with knee pain who recently had Total Knee Replacement (TKR) and last week had his teeth cleaned (no antibiotic coverage)
Objective 3 **Define the purpose and benefits of recorded documentation.** A. Documentation is a recorded account of care or service provided. 1. Complete, accurate and timely to improve patient safety and can minimize errors. 2. Words are clear, complete so no assumptions are made and misunderstanding is minimized. 3. Timely documentation so decisions are made with full picture of patient's care 4. Time is not lost in treatment plan 5. Documentation indicates outcomes of care and	Lecture Direct students to go to The Joint Commission website and find information about abbreviations in medical records. (See handout for your reference). If students work at an agency, ask them to bring in the agency's approved list of abbreviations and policy regarding approved abbreviations. Check and discuss

treatment. 6. Patient expectation of accountable care is met with accurate, complete, timely recorded communication of their care. B. Regulatory agency (The Joint Commission) has defined an acceptable standard for abbreviations in a medical record. 1. Any reasonable approach to standardizing abbreviations, acronyms, and symbols is acceptable. Examples include: a. Standardized abbreviations developed by the individual organization. b. Use of a published reference source. c. If multiple abbreviations, symbols, or acronyms exist for the same term, the organization identifies what will be used to eliminate ambiguity. C. Each professional is accountable for knowing the unapproved list and agency approved list of abbreviations.	date last reviewed. Use any case scenario below and practice writing the documentation for the nursing encounter.
Objective 4 **Discuss the legal and professional responsibility in verbal hand-off communications** A. Discuss RN responsibility in transferring patient centered care assessments to other health professionals. a. Hand-off communication occurs between all health care professionals and team members. Some examples frequent communication in the ambulatory setting include: i. RN- MD ii. RN-LVN iii. RN-PharmD iv. RN-MA b. Professional standards define one's responsibility to communicate effectively to ensure patient safe timely care. c. Standardized format for hand-offs: i. Ensures a clear message ii. Delivered in a concise format iii. That is complete with what is requested or recommended. d. SBAR is a "best practice" form that health professionals can use in their hand-off communication with each other. e. SBAR is a safety strategy that meets the QSEN competency of Teamwork and Collaboration (qsen.org)	Activity: In dyads, have students review ANA standards, "Code of Ethics for Nurses with Interpretive Statements" and identify which standards define accountability for accurate communication among health care team. This is an enclosed handout, but it is a PDF and I could not label it. Refer to SBAR in Module I. Role play and use SBAR to transfer assessment and plan of care to another health professional

	while keeping patient involved as active member and decision maker of his/her care. Debrief and give feedback to team mates on role play. Was the message clear, concise and complete? If pt is present, was patient included in the communication? Assign students to look up QSEN competency on Teamwork and Collaboration (qsen.org). Select one knowledge, skill and attitude they will practice when transferring information to other health professionals. Handout 5 Develop own plan of action to perfect SBAR communication technique for verbal transfer of information.
Objective 5 **Define personal responsibility with system practices to ensure accurate documentation for billing and reimbursement.** A. Documentation is the written/visible method of communication. a. Meets professional standards of assessment, plan, implementation b. Meets professional and regulatory standards (DMS, CMS, TJC) c. Meets QSEN standardized competency of teamwork and collaboration. (qsen.org) d. Demonstrates adherences to approved protocols, orders, standards of care, evidence based guidelines. e. Records the level of service provided and who provided the care f. Enables health care organizations to seek reimbursement for services given g. Provides transparency and accountability to the public. Documentation must be accurate and complete in order to bill fairly and measure outcomes for the public's information.	Lecture Activity: Each nurse will bring his/her agency's policy and procedures for documentation: EMR, paper, email Share documentation methods and documentation policy used at own agency. In dyads, review the policies to see how the agency ensures accurate, complete and timely documentation to meet state and regulatory standards. Identify any gaps in documentation policies and explain the risks of identified gaps.

Objective 6 **Document appropriately and accurately in the medical record; paper or electronic.** A. SBARE is a format for documenting action and outcomes, which are required for billing and reimbursement. a. S= Situation, i. Concise statement of problem, "What is happening" b. B=Background ii. Pertinent data/database that paints the context of the situation c. A= Assessment, iii. Your assessment of the date/situation. iv. Begins with "I think". v. This part of SBAR is done by MD, RN d R = Actions, Interventions & Recommendation vi. What you did vii. Recommendations to be done e. E = Outcomes and evaluation viii. What outcomes were reached 1. response to treatment 2. patient understanding of plan 3. patient's willingness to follow plan Critical pathways/protocols are seen in electronic documentation. (Computerized Decision Support System)	With given scenario, (Handout 6) and guide students to document their care in SBARE format. Debrief, use answer sheet (in Handout 6) to guide teaching. Create additional scenarios and have students practice documentation in SBARE format. Share and debrief.
• Interdisciplinary approach to capture patient centric interventions for managed care services • Based on use of critical pathways or protocols to structure documentation • Standard MD or other order sets are included in pathways and are automatically processed. • System can track variances from the standard or anticipated critical pathway • Provides a feedback loop and information is used to improve care and patient outcomes.	Solicit an example from one of your affiliate agencies. Review with class and discuss if each pathway/protocol is evidence based, prompts safe quality practice, creates inter-professional communication and coordination. Discuss benefits, precautions and problems if any. Discuss article, Leveraging Standards to Support Patient Centric Interdisciplinary Plans of Care. This article has a futuristic approach on how the nursing care plan can individualize patient care across all disciplines.

SAMPLE CASE STUDIES

Case Study-Adult Medicine

Maria, a 28-year-old female, presents to your office approximately 5 weeks pregnant. Her first language is Spanish and she speaks only broken English. Her cousin came with her to translate. This is her first pregnancy. She believes she is current on her shots but has no vaccine or previous health records. She is living with a cousin and has good extended family support, but limited financial support and no transportation or phone. She is excited about the pregnancy and the prospect of being a mother. She reports having a few sexual partners with intermittent use of protection. Maria did mention that her previous doctor had her watching her diet and trying not to eat a lot of sugar but she is unclear as to why.
Vital signs: BP 124/82, Pulse 84, Resp Rate 12, Height 63", Weight 190 pounds. Blood sugar done in office was 174

1) Identify primary health concerns for Maria.
   (Pregnancy; potential STDs; elevated blood sugar-potential diabetes…)
2) What tests do you anticipate being ordered?
   (HCG, fasting blood sugar, hemoglobin A1C, CBC, Chem panel, STD screening including HIV; varicella titer, rubella titer, Hep B antibodies)
3) Identify Maria's barriers to receiving medical care.
   (Health literacy challenges; language barrier; lack of transportation; limited income; limited communication means i.e.-no phone)
4) Identify teaching needs.
   (Pregnancy; expectations, s/s of concern-when to seek care/call office, visit intervals, need for prenatal vitamins, when to repeat blood work, weight gain expectations, medications to avoid, etc.; blood sugar management – possible meds, diet, checking blood sugars at home; safe sex practices)
5) Develop a teaching plan, including: consideration of learning barriers, time allotted for each teaching point, learning activities, and how to measure teaching success/retention.

Case Study – Staff Education Need

It has come to the attention of the office that there are inconsistencies in how blood pressures are being taken by all the medical staff. Cuff size, not taking BP on bare arm, using alternative extremity, and inability to perform proper orthostatic blood pressures are all items of concern. You have 25 medical assistants to educate, from very new to 18 years in practice. Two of the medical assistants have already stated they are not concerned with changing anything as they feel what they are doing is working.
You have a 30-minute slot at the staff meeting later this week to perform this education.

1) How will you prepare for this? (Printed materials, supplies, etc.).
2) How will you manage the resistance?
3) How will you organize your teaching? (Time breakdown, learning station, lecture, demo, etc.)
4) How will you assess effectiveness of education?

Case Study – Adolescent Medicine

Sam is a healthy 16-year-old athlete. He is having increasing reactions to bee stings including significant site swelling, site itching, and facial swelling with his most recent bee sting. Sam is being referred to an Allergist for workup and possible allergy shots for bee sting allergy. At his visit today, the PCP just prescribed an EpiPen 2-Pack to carry at all times. You have been given the job of educating Sam and his father about the EpiPen. Sam and his father are in a hurry to get back to school for practice and seem pre-occupied.

1) What information does Sam need to hear before he leaves the office?(How to recognize signs and symptoms of anaphylaxis; when to use EpiPen; how to use EpiPen)
2) What teaching tools could be used?
3) How will you measure the success of your teaching?

Case Study- Pediatric Medicine

Scenario #1

Call received from mother of 3-year-old child, stating that she is being "so bad". When asked what behavior the child was showing, mother stated that she was having little urinary accidents in her panties for the last week and was got getting to the bathroom in time to void. Was also having night time accidents. Child had been completely trained (day and night) for over 6 months without accidents. Child was only having urinary accidents and no trouble with bowel movements, was also complaining of "tummy pain".

1) What additional questions would be appropriate to ask mother regarding her concern?
2) What would be your considerations for the differential diagnosis for this patient? Mother was encouraged to make appointment to rule out urinary tract infection as children in this age group have atypical presentation, often with urinary accidents and tummy pain. On evaluation, urinalysis showed 4+ glucose as well as bacteria. Blood glucose found child's blood sugar to be 389. Child was immediately admitted to the hospital with the diagnosis of Type I diabetes.
3) Upon learning that her child would be admitted to the hospital, what information about the need for hospitalization would be important for the mother to have?
4) What emotions might the mother be experiencing upon learning the diagnosis and what an appropriate strategy is for the ambulatory care nurse.
5) What information could be provided to mother regarding expected toddler behavior vs. illness symptoms?

Scenario #2

Call from mother who reports that 15-month-old child had been seen in Urgent Care three nights previously for "bad cough". Was told there were no abnormal findings on examination at that time and he had a viral illness. Mother calls because she thinks "cough is getting worse".

1) What assessment questions would be important to ask to determine if this child is currently in any respiratory distress? (length of illness, fever, description of cough, s/s

of increased work of breathing, color, level of activity, counted respiratory rate while on phone with Advice Nurse)

2) What additional information would be important to know about the child's medical history? (any concurrent medical diagnoses, immunization status)
   Child is reported by mother to be having nasal flaring and substernal retractions. Mother was able to provide a counted respiratory rate of 60. Child had been having fever 103-104 degrees for past 24 – 48 hrs. Poor feeding, only one wet diaper in last 24 hrs. Mother advised to take child to nearest Emergency Room. Child in ER had O2 saturation of 88%, respiratory rate of 64, mild dehydration, chest x-ray showing bilateral pneumonia. Started on nebulizer treatment, IV antibiotics and admitted for evaluation. Discharged home after 72 hours improved and stable.
3) What education to mother would have been important regarding follow-up for continued concerns after initial evaluation in Urgent Care? What parameters could be given to mother to evaluate worsening condition?

Patient-centered Care		
Definition: Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.		
Knowledge	**Skills**	**Attitudes**
Integrate understanding of multiple dimensions of patient centered care: ○ patient/family/community preferences, values ○ coordination and integration of care ○ information, communication, and education ○ physical comfort and emotional support ○ involvement of family and friends ○ transition and continuity Describe how diverse cultural, ethnic and social backgrounds function as sources of patient, family, and community values	Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care Communicate patient values, preferences and expressed needs to other members of health care team Provide patient-centered care with sensitivity and respect for the diversity of human experience	Value seeing health care situations "through patients' eyes" Respect and encourage individual expression of patient values, preferences and expressed needs Value the patient's expertise with own health and symptoms Seek learning opportunities with patients who represent all aspects of human diversity Recognize personally held attitudes about working with patients from different ethnic, cultural and social backgrounds Willingly support patient-centered care for individuals and groups whose values differ from own
Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiologic models of pain and comfort.	Assess presence and extent of pain and suffering Assess levels of physical and emotional comfort Elicit expectations of patient & family for relief of pain, discomfort, or suffering Initiate effective treatments to relieve pain and suffering in light of patient values, preferences and expressed needs	Recognize personally held values and beliefs about the management of pain or suffering Appreciate the role of the nurse in relief of all types and sources of pain or suffering Recognize that patient expectations influence outcomes in management of pain or suffering
Examine how the safety, quality and cost effectiveness of health care can be improved through the active involvement of patients and families Examine common barriers to active involvement of patients in their own	Remove barriers to presence of families and other designated surrogates based on patient preferences Assess level of patient's decisional conflict and provide	Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care Respect patient preferences for degree of active engagement in

health care processes Describe strategies to empower patients or families in all aspects of the health care process	access to resources Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management	care process Respect patient's right to access to personal health records
Explore ethical and legal implications of patient-centered care Describe the limits and boundaries of therapeutic patient-centered care	Recognize the boundaries of therapeutic relationships Facilitate informed patient consent for care	Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care Appreciate shared decision-making with empowered patients and families, even when conflicts occur
Discuss principles of effective communication Describe basic principles of consensus building and conflict resolution Examine nursing roles in assuring coordination, integration, and continuity of care	Assess own level of communication skill in encounters with patients and families Participate in building consensus or resolving conflict in the context of patient care Communicate care provided and needed at each transition in care	Value continuous improvement of own communication and conflict resolution skills

Teamwork and Collaboration
Definition: Function effectively within nursing and inter-professional teams, fostering open

communication mutual respect and shared decision-making to achieve quality patient care.		
Knowledge	**Skills**	**Attitudes**
Describe own strengths, limitations, and values in functioning as a member of a team	Demonstrate awareness of own strengths and limitations as a team member Initiate plan for self-development as a team member Act with integrity, consistency and respect for differing views	Acknowledge own potential to contribute to effective team functioning Appreciate importance of intra- and inter-professional collaboration
Describe scopes of practice and roles of health care team members Describe strategies for identifying and managing overlaps in team member roles and accountabilities Recognize contributions of other individuals and groups in helping patient/family achieve health goals	Function competently within own scope of practice as a member of the health care team Assume role of team member or leader based on the situation Initiate requests for help when appropriate to situation Clarify roles and accountabilities under conditions of potential overlap in team member functioning Integrate the contributions of others who play a role in helping patient/family achieve health goals	Value the perspectives and expertise of all health team members Respect the centrality of the patient/family as core members of any health care team Respect the unique attributes that members bring to a team, including variations in professional orientations and accountabilities
Analyze differences in communication style preferences among patients and families, nurses and other members of the health team Describe impact of own communication style on others Discuss effective strategies for communicating and resolving conflict	Communicate with team members, adapting own style of communicating to needs of the team and situation Demonstrate commitment to team goals Solicit input from other team members to improve individual, as well as team, performance Initiate actions to resolve conflict	Value teamwork and the relationships upon which it is based Value different styles of communication used by patients, families and health care providers Contribute to resolution of conflict and disagreement
Describe examples of the impact of team functioning on safety and quality of care	Follow communication practices that minimize risks associated with handoffs among providers and across transitions in care	Appreciate the risks associated with handoffs among providers and across transitions in care

Explain how authority gradients influence teamwork and patient safety	Assert own position/perspective in discussions about patient care Choose communication styles that diminish the risks associated with authority gradients among team members	
Identify system barriers and facilitators of effective team functioning Examine strategies for improving systems to support team functioning	Participate in designing systems that support effective teamwork	Value the influence of system solutions in achieving effective team functioning

Evidence-based Practice (EBP)
Definition: Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Knowledge	Skills	Attitudes
Demonstrate knowledge of basic scientific methods and processes Describe EBP to include the components of research evidence, clinical expertise and patient/family values.	Participate effectively in appropriate data collection and other research activities Adhere to Institutional Review Board (IRB) guidelines Base individualized care plan on patient values, clinical expertise and evidence	Appreciate strengths and weaknesses of scientific bases for practice Value the need for ethical conduct of research and quality improvement
Differentiate clinical opinion from research and evidence summaries Describe reliable sources for locating evidence reports and clinical practice guidelines	Read original research and evidence reports related to area of practice Locate evidence reports related to clinical practice topics and guidelines	Appreciate the importance of regularly reading relevant professional journals
Explain the role of evidence in determining best clinical practice Describe how the strength and relevance of available evidence influences the choice of interventions in provision of patient-centered care	Participate in structuring the work environment to facilitate integration of new evidence into standards of practice Question rationale for routine approaches to care that result in less-than-desired outcomes or adverse events	Value the need for continuous improvement in clinical practice based on new knowledge
Discriminate between valid and invalid reasons for modifying evidence-based clinical practice based on clinical expertise or patient/family preferences	Consult with clinical experts before deciding to deviate from evidence-based protocols	Acknowledge own limitations in knowledge and clinical expertise before determining when to deviate from evidence-based best practices

Quality Improvement (QI)
Definition: Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.

Knowledge	Skills	Attitudes
Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice	Seek information about outcomes of care for populations served in care setting Seek information about quality improvement projects in the care setting	Appreciate that continuous quality improvement is an essential part of the daily work of all health professionals
Recognize that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patients and families Give examples of the tension between professional autonomy and system functioning	Use tools (such as flow charts, cause-effect diagrams) to make processes of care explicit Participate in a root cause analysis of a sentinel event	Value own and others' contributions to outcomes of care in local care settings
Explain the importance of variation and measurement in assessing quality of care	Use quality measures to understand performance Use tools (such as control charts and run charts) that are helpful for understanding variation Identify gaps between local and best practice	Appreciate how unwanted variation affects care Value measurement and its role in good patient care
Describe approaches for changing processes of care	Design a small test of change in daily work (using an experiential learning method such as Plan-Do-Study-Act) Practice aligning the aims, measures and changes involved in improving care Use measures to evaluate the effect of change	Value local change (in individual practice or team practice on a unit) and its role in creating joy in work Appreciate the value of what individuals and teams can to do to improve care

Safety
Definition: Minimizes risk of harm to patients and providers through both system effectiveness and individual performance.

Knowledge	Skills	Attitudes
Examine human factors and other basic safety design principles as well as commonly used unsafe practices (such as, work-arounds and dangerous abbreviations) Describe the benefits and limitations of selected safety-enhancing technologies (such as, barcodes, Computer Provider Order Entry, medication pumps, and automatic alerts/alarms) Discuss effective strategies to reduce reliance on memory	Demonstrate effective use of technology and standardized practices that support safety and quality Demonstrate effective use of strategies to reduce risk of harm to self or others Use appropriate strategies to reduce reliance on memory (such as. forcing functions, checklists)	Value the contributions of standardization/reliability to safety Appreciate the cognitive and physical limits of human performance
Delineate general categories of errors and hazards in care Describe factors that create a culture of safety (such as, open communication strategies and organizational error reporting systems)	Communicate observations or concerns related to hazards and errors to patients, families and the health care team Use organizational error reporting systems for near miss and error reporting	Value own role in preventing errors
Describe processes used in understanding causes of error and allocation of responsibility and accountability (such as, root cause analysis and failure mode effects analysis)	Participate appropriately in analyzing errors and designing system improvements Engage in root cause analysis rather than blaming when errors or near misses occur	Value vigilance and monitoring (even of own performance of care activities) by patients, families, and other members of the health care team
Discuss potential and actual impact of national patient safety resources, initiatives and regulations	Use national patient safety resources for own professional development and to focus attention on safety in care settings	Value relationship between national safety campaigns and implementation in local practices and practice settings

Informatics
Definition: Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.

Knowledge	Skills	Attitudes
Explain why information and technology skills are essential for safe patient care	Seek education about how information is managed in care settings before providing care Apply technology and information management tools to support safe processes of care	Appreciate the necessity for all health professionals to seek lifelong, continuous learning of information technology skills
Identify essential information that must be available in a common database to support patient care Contrast benefits and limitations of different communication technologies and their impact on safety and quality	Navigate the electronic health record Document and plan patient care in an electronic health record Employ communication technologies to coordinate care for patients	Value technologies that support clinical decision-making, error prevention, and care coordination Protect confidentiality of protected health information in electronic health records
Describe examples of how technology and information management are related to the quality and safety of patient care Recognize the time, effort, and skill required for computers, databases and other technologies to become reliable and effective tools for patient care	Respond appropriately to clinical decision-making supports and alerts Use information management tools to monitor outcomes of care processes Use high quality electronic sources of healthcare information	Value nurses' involvement in design, selection, implementation, and evaluation of information technologies to support patient care

References

[1] Institute of Medicine. Health professions education: A bridge to quality. *Washington DC: National Academies Press*; 2003.

[2] Cronenwett, L., Sherwood, G., Barnsteiner J., Disch, J., Johnson, J., Mitchell, P., et al (2007). *Quality and safety education for nurses*. Nursing Outlook, 55(3)122-131.

Documentation Scenario for service provided using SBARE

Michael Morales is a 32 year old male recently discharged from the hospital. He was in the hospital due to his new medical diagnosis, Diabetes Type II. He has returned to the clinic to see the doctor, share his blood sugar log and discuss the possibility of adjusting his medication. His blood sugar log shows AM blood sugar of 110-125. He does not check it in the PM. You check both feet for possible diabetic neuropathy, take vital signs and schedule him for a diabetic class, all part of the new diabetic standard of care. He is unsure about attending the class but you secure his agreement. You want to make certain he will take his oral medication, Metformin 500 mg, twice daily and follow the 1800 cal ADA diet. You explain his medication, its purpose and mode of action. You emphasize why he needs to eat small meals at regular times. You discuss possible side effects of medication and ask how he is tolerating the medicine. You ask him to tell you what he thinks he can do.
Document this encounter in SBARE format.

S	Pt presents with new diagnosis DMII
B	Recently discharged from hospital with DMII diagnosis. Here to follow up with MD for blood sugar check and possible medication adjustment
A	Pt monitors blood sugar daily. No change in Metformin dosage ordered.
R	Scheduled for DM Class series. Instructed to eat 4 small meals and eat food recommended in ADA 1800 cal diet.
E	Pt agreed to attend 3 DM classes next month. Pt able to explain sample 4 meal day. Pt agreed to try. Pt able to state when to seek medical attention

5)
6)
7)

1)

6)

7)
8)

4)