Improving Nutrition Productivity by Optimizing Nutrition Navigator and Nutrition Note in EPIC

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Background

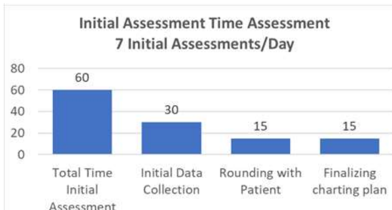
Clinical Dietitians are consistently being asked to optimize their patient care to ensure that maximum patients are seen while still providing excellent quality patient care.

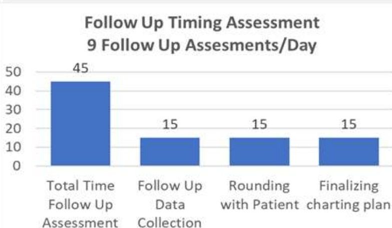
Historically the focus of the Clinical Dietitian was identifying if a patient was meeting nutrition needs and diet education. As inpatient dietitians have improved their skillsets to operate at the top of their scope of practice, RDs are now completing hands on physical assessments. The purpose of NFPE is to identify malnutrition when present as well as to analyze if nutrient deficiencies / toxicity signs and symptoms are present. RD's are the ideal clinician to perform these tasks.

Time needed to document is often listed as an employee dissatisfier and top reason listed for inability to assess more patients and participate in interdisciplinary activities.

The scope of this project was to analyze the current inpatient charting process to identify areas of opportunities to allow more face-to-face patient encounters and improved RD job satisfaction.

Figure #1: Time Assessments Current Process

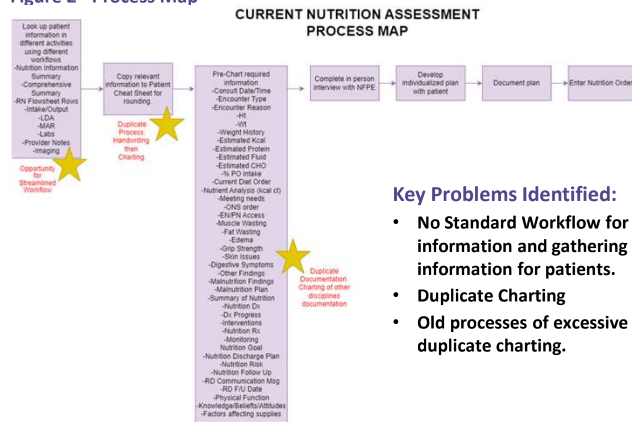




Methods

Utilized current process map, 5 why's analysis, and benefits / effect matrix to identify biggest areas of opportunity and plan for most impactful interventions.

Figure 2– Process Map



Key Problems Identified:

- **No Standard Workflow for looking up information and gathering rounding information for patients.**
- **Duplicate Charting**
- **Old processes of excessive paper duplicate charting.**

Figure #3: Interventions Implemented

ELIMINATED DUPLICATE DOCUMENTATION

Removed 14 flowsheet rows from Navigator documentation:

- Date of Assessment
- Time of Assessment
- Encounter Reason
- % of meals documented
- Diet Order
- ONS Order
- Estimated CHO intake needs
- EN/PN Access
- EN/PN RN documentation
- Edema Documentation
- Skin Breakdown
- GI documentation
- SLP Swallow Eval Documentation
- Food Insecurity Documentation
- Removal of documentation that is WNL.

ADDED DUPLICATE INFORMATION FROM NON-RD CLINICAL STAFF TO PULL DIRECTLY TO RD NOTE

- This allows staff to just pull smart phrase for patient note that pulls all clinical documentation (RD, RN, SLP, RT key information into 1 comprehensive note)
- Changed workflow process to analyze individual plan by scrolling up note with key information vs looking all over EMR activities for information.
- Changed RD Note to have no additional documentation in actual note / all nutrition documentation completed in navigator. (Improved time)

DEVELOPED KEY SMARTPHRASES FOR WORKFLOW ONLY INFORMATION:

1. Nutrition Navigator Smart Phrase

This smart phrase pulls data that is needed to directly fill out nutrition only information into the navigator. Information that pulls: Encounter Type, Weight Trends, Labs that effect estimated needs, % po intake documented by RN, Estimated needs (easy nutrient analysis), Malnutrition Findings to assess if malnutrition present.

2. Nutrition Rounding Smart Phrase.

This smart phrase pulls key information for easy RD rounding for patients on list so that no handwritten notes are needed. (pulls to 1 page per pt)

Information that pulls: Pt. Name, DOB, Room Number, Encounter Type, Reason for seeing patient, Nutrition Plan (Dx, Intervention, Goals, Monitoring), Intake Analysis, Diet Order, RN % meals eaten documentation, Orientation Level.

Results

Improvement in charting process allowed for:

1. More time for rounding with patients.
2. Allowed increased number of patients to be seen.
3. Increased identification of Malnutrition.
4. RD report of improved job satisfaction.
5. Increased time for areas of interest. (More time for quality improvement)

Figure #4: Post EMR Optimization

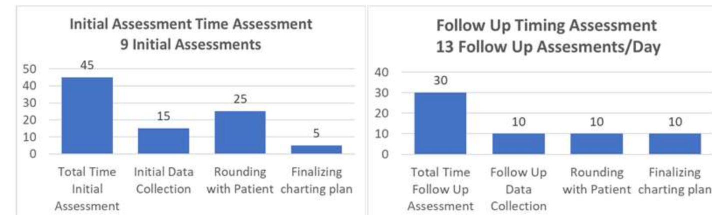


Table #5: Control Plan

Control Measurement							
Metric	Goal	Control Limit	Review Process	Frequency	Process Owner	Threshold for Action	Recommended Action Steps
Total Assessments seen per Day	100% of daily count 9-10)	95% above 9 assessments /day	CNM to report daily productivity to team.	Daily	CNM	2 consecutive months below the control limit	Pull together work group to identify barriers/opportunities
			Compares monthly data for trends	Monthly			

Conclusions

- **Eliminating documentation of information that is already in the EMR reduces time for RD and reduces charting errors.**
- **Building smart phrases that pull key non-RD clinical information prevents the need to hunt for information in different areas of the EMR and creates a standard workflow of the process for workflow.**
- **Build smart phrases for key workflows that RD's were previously writing down. This creates a consistent process for rounding and eliminates time spent looking up and writing this information.**
- **Create productivity reports that will eliminate your team needing to manually gather their productivity.**

Reference

Lindsay, M., & Lytle, K. S. (2022). Implementing Best Practices to Redesign Workflow and Optimize Nursing Documentation in the Electronic Health Record. Applied Clinical Informatics, 13(03), 711–719. https://doi.org/10.1055/a-1868-6431

Alissa, R., Hipp, J. A., & Webb, K. (2022). Saving Time for Patient Care by Optimizing Physician Note Templates: A Pilot Study. Frontiers in Digital Health, 3. https://doi.org/10.3389/fdgth.2021.772356

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