Improving the Quality of Medical Record Documentation at

NYCHHC/Queens Hospital

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DNP 761: In Partial Fulfillment of the Requirements of the Doctor of Nursing Practice

Project

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2/1/2023

Abstract

Problem: In the Adult Primary Care Clinic at NYCHHC/Queens the problem list in EPIC was missing significant medical problems and chronic medical conditions.

Background: A poorly updated problem list in EPIC leads to ineffective communication within the healthcare team, incorrect linking of medications to the wrong diagnoses, insurance denials for medication coverage, and poor medication adherence, which compromises patient safety.

Methods. A quantitative design was utilized for this PI project. Pre- and post-tests were administered before and after the educational activity: "Medical Record Documentation Requirements". Thirty Participants (10 Nurse practitioners, 10 Medical Doctors, and 10 Medical Residents) participated in the educational activity and completed pre and post-questionnaires. Purposeful sampling was used. Thirty chart reviews were completed to analyze the effect of this intervention, 10 charts per provider type- Nurse Practitioners, Medical doctors, and Medical Residents. The SPSS program was used for statistical analysis.

Intervention. Education was provided about the Guidelines from the Center for Medicare and the National Committee on Quality Assurance. The training focused on 21 essential elements for medical record documentation, preferred documentation style- problem-based charting, and the techniques for updating the problem list in EPIC.

Results. The McNemar Test showed a statistically significant change (the p-value is 0.012) in the knowledge level following the educational program when compared with the knowledge level before the beginning of the educational program. Statistically significant changes in documentation practices were noted after the educational activity. Before the intervention, the problem list was updated in 17 charts out of 30, and after the intervention in 23

charts out of 30, leading to a P value of 0.030. Problem-based charting utilization significantly increased as well after the educational activity from 11 charts to 20 charts out of a total of 30 charts, P value of 0.022.

Conclusion

Significance to Practice Site and Systems. Provider education on medical record documentation requirements, evidence-based strategies, and the latest guidelines from the National Committee on Quality Assurance improves documentation practices and leads to accurate updates of problem lists in EPIC and utilization of problem-based charting.

Implications for Nursing Practice/Further Research. Ongoing provider education on proper documentation practices, evidence-based strategies, and the latest guidelines from the National Committee on Quality Assurance should be offered to medical providers to improve provider communication, medication adherence, disease management, and patient safety.

Keywords: Medical Record Documentation Requirements, EPIC.