Personal Support Workers: From Paper to Computer Documentation

Traditionally, documentation of resident care in long term care homes has been recorded on paper using various forms, charts and flow sheets. The management of the paperwork related to this documentation is time-consuming and labour-intensive. In addition, the excessive use of paper is not environmentally friendly.

At Temiskaming Lodge, the registered staff, program staff and therapists document resident care using computers. Now, the next step toward a paperless resident record is being taken by having personal support workers (PSWs) also document via a computer.

Traditional documentation

Documentation is an essential part of resident care. Nurses are required to make and keep records of their professional practice. In the past, this documentation was recorded on various paper forms and stored in a chart at the nursing station. However, there has been a shift in the health care field toward using computers for documentation by all disciplines, including PSWs.

Temiskaming Lodge in Haileybury is an 82-bed CCHSA-accredited long term care rural facility with a 'home-like' atmosphere and continuous quality improvement programs. The journey from paper to computer documentation for PSWs at Temiskaming Lodge is a pilot project for the nursing homes within Jarlette Health Services.

Pre-implementation

PSWs must provide care and document the care that has been given. Previously, this was completed on paper forms designed as flow sheets to capture dressing, toileting, bathing, hygiene, mouth care, transferring, eating, bowel movements and fluid intake. The daily care forms were kept in binders stored in a drawer close to the nursing desk and the fluid intake forms were stored a separate binder, alternating between the nourishment cart and the dining room. At the end of the month, all forms were collected, compiled for each resident and filed in the resident chart.

PSWs provided care and then documented for 15 to 20 minutes at the end of each shift. The exception was the fluid intake records, which were completed after each meal in the dining room and following each nourishment pass. Each PSW was accountable for documenting care for 10 to 12 residents.

The concerns with this approach to documentation are that it is not completed in real time and it relies on the ability of the PSW to recall the time and the care provided

for individual residents. Standards of care for compliance review rely on the approach that 'nursing care documented is defined as the nursing care given.' Thus, if care is not documented, it is interpreted as not having been given.

In addition, information about the resident was kept in multiple locations: the chart at the nursing station, the care binder in a drawer and the intake binder that rotated between the nourishment cart and the dining room. Thus, members of the multi-disciplinary team had to retrieve information from multiple locations to obtain a complete picture of the care provided.

Furthermore, the management of paper documentation is labour-intensive. PSWs who worked nights printed flow sheets that were computer-generated monthly and filed these papers in the appropriate binders at the beginning of each month. They also removed the month-end records and filed them in each resident's chart. This was very time-consuming and records were often not filed for 30 days.

Lastly, it is very tedious to do audits from documentation on paper. The flow sheets were standard in format, but specific to each resident. To collate just one month's worth of data, it was necessary to work through multiple pieces of paper to answer formulated queries and to ensure documentation was complete.

The project

The transition from paper to computer documentation involved the PSWs, registered staff, the director of care, the administrator, staff educators, the resident family services coordinator, corporate information technology support and information technology support locally within the community. This project required a process change to real-time documentation and the use of computers instead of paper. Therefore, the project was divided into two stages.

Stage one

The purpose of the first stage was to familiarize PSWs with charting in real time. With the new process, they would be charting immediately after care was provided throughout the shift.

Lewin's basic change model of unfreezing, changing and refreezing[1] is very helpful when leading a process change and can be applied to the human response to change. In this particular project, the unfreezing stage was managed by holding meetings with all the PSWs and registered staff to discuss the shift to charting in real time. Staff suggestions were taken into account and forms were modified as required.

During the actual change phase, the binders with the flow sheets were moved from the drawer to the care carts so PSWs could chart as they gave care. Support was given during the change, with regular meetings for all shifts to ensure they had the tools required for the task.

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Refreezing is established when the new process becomes the norm for the individual and habitually replaces the old process. This takes time. Stage one was initiated in August 2008, with the intent to implement documentation via computer in January 2009.

Post-stage one

The new routine of PSWs charting care in real time was established. By working through stage one, PSWs did not have to experience a process change and a technical change simultaneously.

In addition, the quality of the documentation improved post-stage one. The documentation was more complete and more accurate for the daily care records. One flaw was that the bathing section was still not completed at least one-third of the time. This was because the bathing section was kept with the daily care record in the binder on the care cart, while the actual care took place in the tub room. There was a working record in the tub room indicating who had a bath that shift, but the documentation was not always transferred to the paper record that went in the resident chart. Furthermore, the fluid intake record was still kept in a binder in the dining room.

Stage two

The implementation of computer use—stage two—began on March 1, 2009. The following preparations were made for this phase:

- Libraries in Point Click Care (the documentation system) were built by February 13.
- Kiosks were mounted in the third and fourth weeks of February.
- Training for PSWs took place from February 25 to 28.

The change process applied to this stage of the project as well. The director of care showed a kiosk to each PSW and talked about documenting via the computer. This was the unfreezing stage: preparing PSWs for the next stage of the project.

There were 15 full-time PSWs and 29 part-time PSWs. Only three PSWs indicated they were very nervous about using a computer for documentation and even these staff felt confident they could learn. The majority of the PSWs used computers at home and were very excited about the next stage. The night PSWs were particularly eager, as it was their responsibility to compile and file all of the paper records in the resident charts.

At each weekly PSW meeting, the second stage of the project was discussed to encourage questions and keep staff up to date about the project.

The cost of computerized versus paper documentation

The cost of shifting to computerized documentation included purchasing 12 kiosks with wall-mounted devices and recessed plugs and the labour to mount and wire them.

Minimal costs were associated with training, as it was conducted during regular working hours in small groups during all shifts by staff educators who adjusted their schedules accordingly.

The cost of paper documentation included approximately 10 pieces of paper each for 82 residents monthly. There was also the cost of replacing cartridges to print the forms. Moreover, there was a hidden labour cost related to compiling and filing the forms each month. Lastly, the time associated with audits can also be reduced.

With the greater efficiency of the computerized system, staff time can be used for other duties that are not completed in a timely manner or, even better, devoted to enhanced quality time with residents.

Benefits of computerized documentation

The use of computers by PSWs for documentation has had several benefits at Temiskaming Lodge. These include:

- an improvement in the quality of documentation;
- the entering of information into one source, at any kiosk;
- the implementation of a checks and balances system (PSWs can determine if they did not chart on a resident prior to the end of their shift to ensure that the documentation is complete); and
- the more manageable and timely auditing of documentation of care.

This process has also been implemented at Extendicare Nursing Home in Brampton. Senior administrator Carmen DiMauro has noted the following benefits of computerized charting:

- Information is available at your finger tips.
- Documentation is in real time.
- Charting is spread throughout the shift.
- Charting is objectified—the PSW who is charting can't see the charting from the day before, so charting is more objective (objectivity is pronounced with the Minimum Data Set [MDS]).
- The resident plan of care is accessible to less experienced staff.
- The need to print the resident plan of care has been eliminated, because it accessible by front-line workers.
- Documentation is legible.
- There is no missing documentation (there has not been one blank space in flow sheets since implementation).
- Auditing can be conducted immediately (e.g., showing missed and late charting).

Ms. DiMauro also commented on the back-end benefits, including:

- better structured care plans;
- improved tracking of quality indicators;
- improved ability to meet compliance standards (with appropriate charts more readily available);
- the triggering of MDS charting and care plans; and
- the availability of information to a multidisciplinary team (programs and therapies).

Recommendations

Five key recommendations have arisen from the Temiskaming Lodge pilot project for the transition from paper to computer documentation:

- Plan six to 12 months in advance to prepare for implementation.
- Identify a project leader.
- Review current documentation processes within the home and change them, if needed, prior to implementing any change related to technology.
- Engage staff in the change process and meet with them routinely and frequently to communicate changes in process and the introduction of computers for documentation.
- Learn from others who have implemented computerized documentation successfully in a long term care setting.

Having PSWs use computers for documentation supports quality documentation, efficiencies related to documentation and audits, objective charting and timely documentation. This can have both a direct and indirect impact on the quality of life and quality of care for long term care residents. **LTC**

References available upon request.