

# 10 DO's & DON'Ts

## for Improving Documentation in the Cath Lab

Lead the Way in Quality Improvement at Your Cath Lab.



Many cath labs, despite providing excellent care to patients, struggle with documentation. A pair of studies reported on the first hospitals to undergo review by Accreditation for Cardiovascular Excellence (ACE) found that cath reports often contained insufficient information on patient risk and the appropriateness of percutaneous coronary intervention. Experts surveyed by SCAI said that the key to improving documentation is to make it quick, simple, and part of the routine. Try these tips in your cath lab.

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### DO Review your charts.

(You may be shocked by what you learn.) Pull some random charts. See if you can tell what the indication for PCI was, whether it was

an appropriate case, what treatment was rendered, and what the outcome was. "Every cath lab manager should do this," said April Simon, R.N., president of Cardiac Data Solutions in Atlanta, and an ACE nurse reviewer. "It's eye-opening how much information is missing." Once you know the specific weak points of your institution's documentation processes, you can begin to plan for improvement.

### DO Tame the AUC with the new SCAI-QIT online calculator.

Adhering to AUC doesn't have to mean carrying printed documents in your pocket. SCAI has developed an easier option: a free online AUC calculator on [www.SCAI-QIT.org](http://www.SCAI-QIT.org). A nurse or tech enters information on the patient's ischemic symptoms, anti-ischemic medications, and non-invasive test results. A click of a button shows whether the procedure is generally considered *Appropriate, Uncertain, or Inappropriate*. "That's a moment of pause, a time out to make sure you really should be doing this case," said Kirk N. Garratt, M.D., FSCAI, associate director of the Division of Cardiac Interventions, Lenox Hill Heart and Vascular Institute in New York City. Meanwhile, a copy of the AUC Data Reporting Sheet is printed for inclusion in the medical record.

### DO Make structured reports work for you.

Certain pieces of data—angina class, heart failure class, stress test results—are frequently missing from cath reports, said Kim Wright, R.N., director of clinical consulting at Cardiac Data Solutions, and a nurse reviewer for ACE. A good solution: Simplify documentation by creating structured reports on your EHR, using electronic templates and checklists with prompts for all the necessary data. "Just having an electronic health record doesn't solve every problem," Ms. Wright said. "You have to spend the time to build the templates, and then you have to use them."

You can model paper forms after their electronic counterparts. For example, a structured cath report can be created from a paper template that includes all of the same data prompts as those in an electronic template. And checklists, whether paper or electronic, are effective safety tools in any cath lab.

### DO Embrace electronic health records.

An EHR, including a cath lab database, is a great way to keep documentation from becoming a time-consuming chore. With a few clicks, you can record essential information on patient risk factors, presenting symptoms, procedural indication, stent implantation, final angiographic results, and safety information. "You can fill it out at the point of care, just as you're finishing the procedure," said Sunil Rao, M.D., FSCAI, an associate professor of medicine at Duke University Medical Center in Durham, NC. "It takes about 30 seconds—and your referring physicians get exactly what they need out of that note."

### DO Make the most of pictures.

Many hemodynamic systems include the option to create coronary diagrams. Investigate this capability in your hemodynamic system and take advantage of it. "We've seen coronary trees that have prompts for the TIMI flow pre- and post-, stenosis pre- and post-, the FFR results," says Ms. Wright. "You can make them as elaborate as you want them to be. It's all part of figuring out where you're missing information and how you can best capture it."

### DO Educate referring physicians about pre-intervention documentation.

Important details about a patient's clinical history and stress test results may be in the medical records of a referring physician, but unless they are also included in the cath report, the quality of documentation will fall short. Reach out to referring physicians, educate them about the need for complete documentation, and establish a procedure to make it happen on a routine basis.

### DO Make friends with your data coordinators.

Nurse data coordinators play an essential role in ensuring that clinical information is complete and accurate. "Data coordinators are our colleagues, and we've found it helpful to treat them as such," said Michael A. Kutcher, M.D., FSCAI, director of interventional cardiology at Wake Forest Baptist Medical Center in Winston-Salem, NC. "If your institution is serious about documentation, you'll designate a quality champion who will bond with the data coordinators."



### DON'T Fight it.

Face the reality of today's health-care environment and simply resolve to improve documentation for the benefit of everyone involved. "Don't try to wrestle this one to the ground," Dr. Garratt said. "Just try to go with it and sort out how to get it done as painlessly and effectively as you can. If you do this the right way, it's going to help you and your patients."

### DON'T Duplicate — it could create conflicts in the medical record.

No two people tell a story the same way. As a result, medical records are rife with inconsistencies in everything from lesion classification to procedural complications. The best way to avoid conflicts in data is to minimize duplication in the recording of data. "Decide who's going to be responsible for which piece of information and avoid redundancy," said Ms. Simon.

### DON'T Try to do it all yourself.

Why reinvent the wheel? SCAI's Quality Improvement Toolkit has several tools that can help you improve documentation in the cath lab, from pre-procedure checklists to advice on making the best use of benchmarking data.

"We've learned very clearly in the last handful of years that quality care doesn't just happen," Dr. Garratt said. "It only takes place when you have very clear systems in place."

