Rehab Forum Query Summary-EPIC diet process and documentation-11/11/19

ORG A

For example, a patient who has participated in a Videofloroscopic Swallow Study (VFSS) or FEES and needs a feeding plan e.g. no thin liquids, thicken all liquids to a mildly thick IDDSI level 1, is admitted to an inpatient floor. ***Where is that information documented at your facility so that admit team, surgical team etc. can see this diet plan?*** ***Please see attached PP. We have this information flow through to a variety of resources in Epic. However, we do ask our SLPs to enter the diet orders directly as well.***

- At ORG A we file a VFSS/FEES report in EPIC but medical providers have a hard time locating it or don't track down the most recent report.
- We can, and have, added a dysphagia diagnosis to the problem list and entered it into the medical history section.
    - Feedback, however, has been that at times the patient's problem list and medical history list is long and this diet information is easily overlooked.
- Another suggestion was to use the "FYI" feature.
    - Feedback is that this feature is at times over used and leads to "FYI Fatigue" and as a result its content does not receive the attention it deserves.

Therefore, our team is wondering*:*

From your experience, what is best practice for a centralized location for documentation, and what are your processes to keep this information up to date?

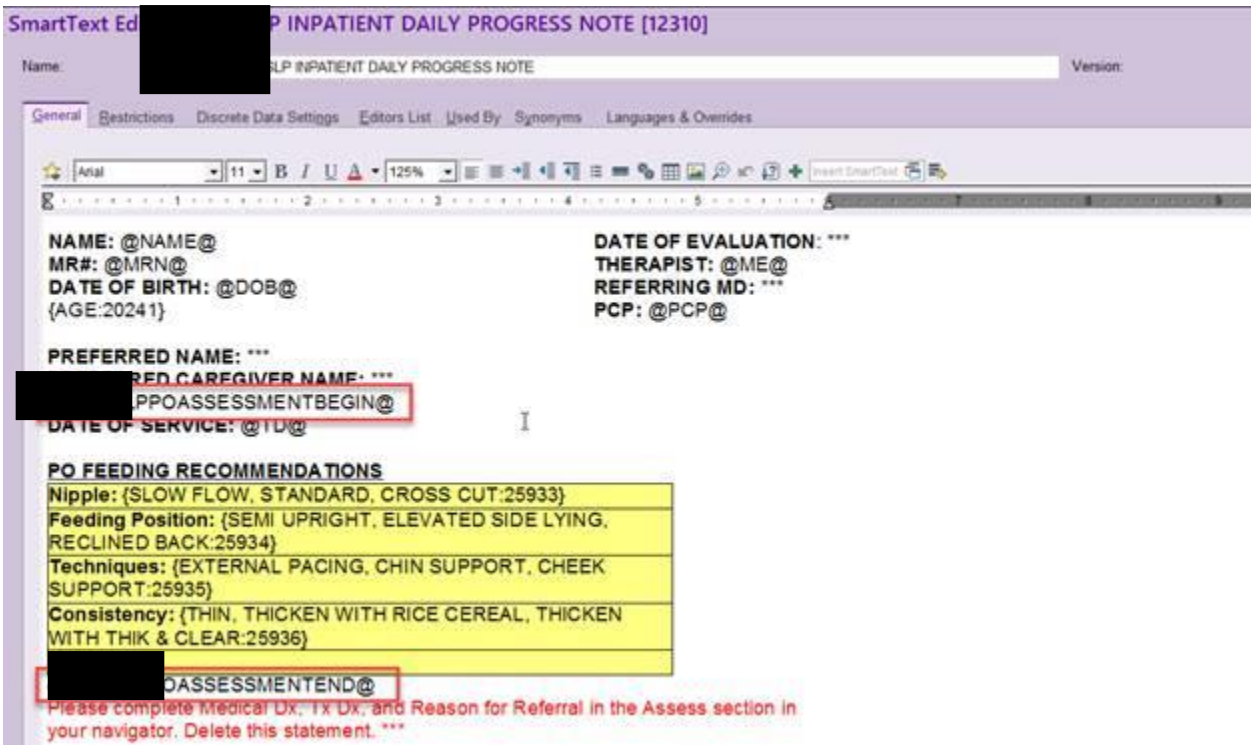
1. What is he best place to document a patient's feeding plan/swallow diet so that the current diet is ordered in the system **upon admission**? We have a report pull through of the last filed value from the SLP documentation. This obviously only works for patients who are seen within our system.
2. What is the best place to document a patient's feeding plan/swallow diet so that the current diet is ordered **status post-surgery**? Flowsheet documentation
3. Who documents the feeding plan/swallow diet and maintains this information (ensures most current)? SLP is in charge of any diet consistency/compensatory strategies.
4. If a child admitted has received a VFSS/FEES at another facility, who captures that information is EPIC for the medical providers? As long as the documentation was done in flowsheets, it should display in a report in the diet order if this patient was seen within our system.

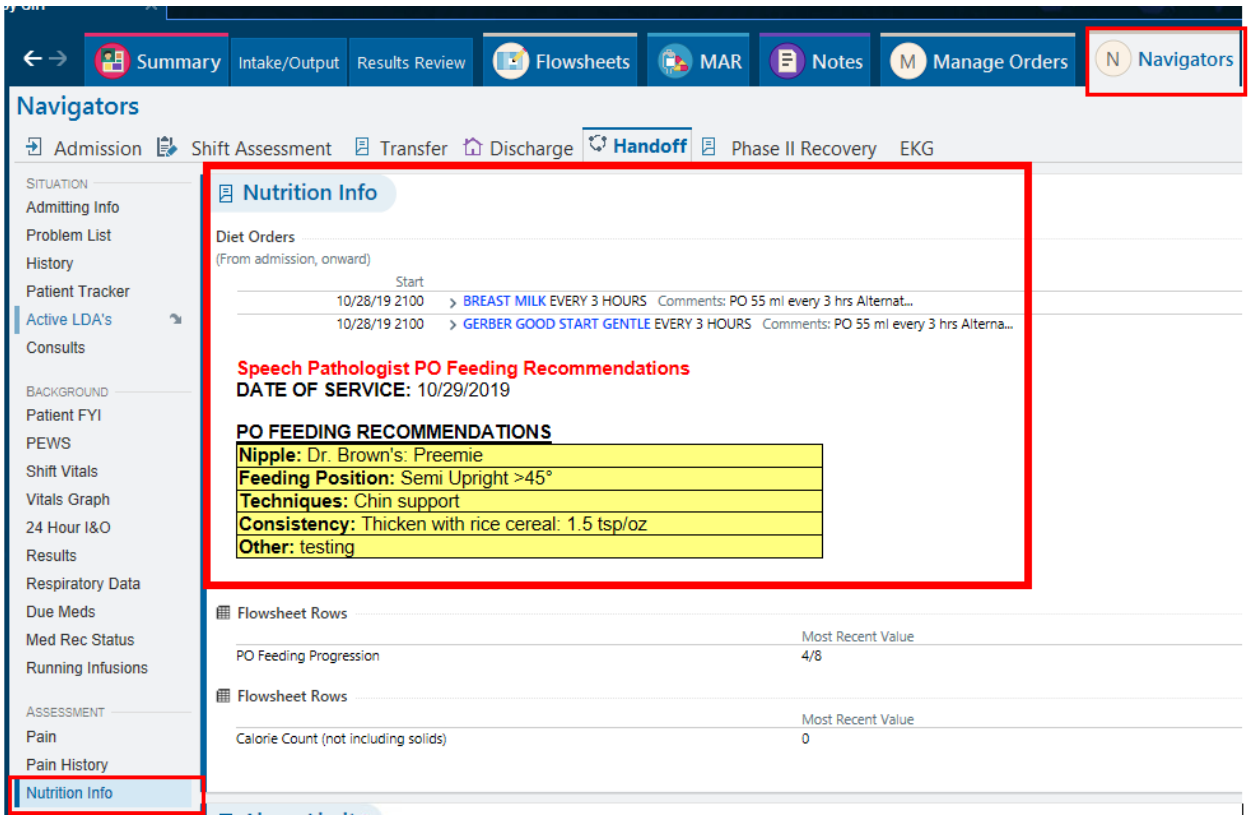
We have done a lot of work around this at our facility over the past year due to a few safety events that occurred. Our inpatient therapists' documents in flowsheets and they are instructed to fill out a specific section with the diet recommendations and compensatory strategies immediately following their evaluation if they are unable to complete the full report. That information then flows through to an

interdisciplinary plan of care, PCT and nursing hand-off tools, and the transfer to facility documentation. I have attached a brief PowerPoint that highlights the changes that we have made. It does not solve everything; however, it has made great improvements in our hand-offs and communication. We did a root cause analysis and polled our SLPs to ask them what "ideal state" would look like and then worked with our medical teams and Epic to make the requested changes. Let me know if you have any questions.

Here is how we are capturing it here at ORG B.

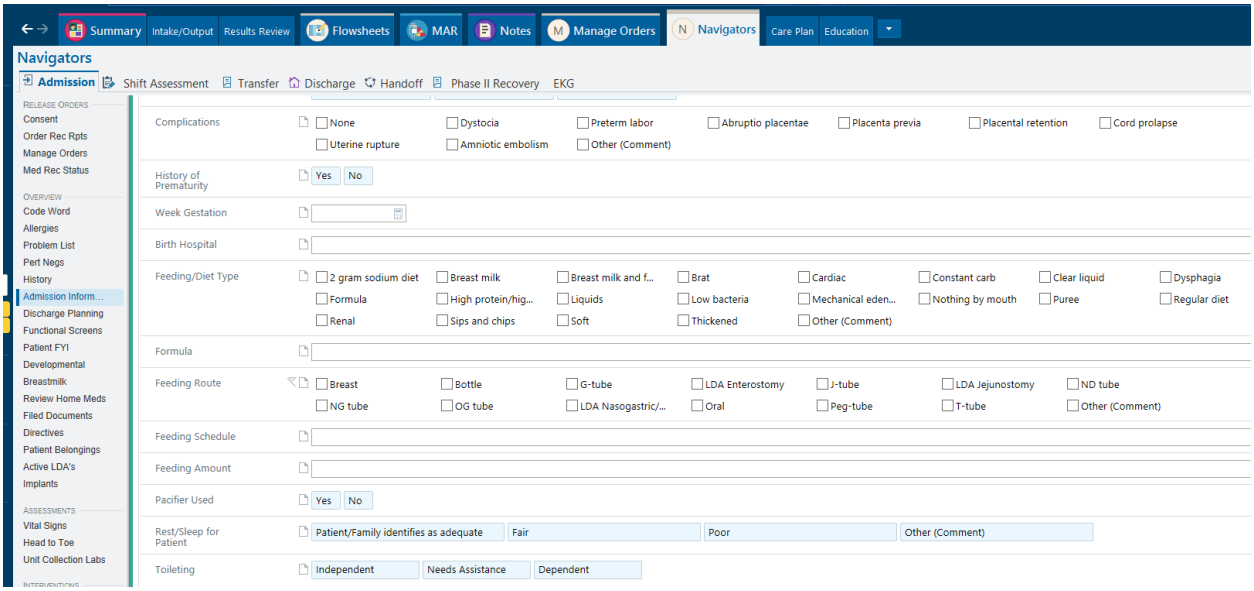
- IP speech team came up with feeding recommendations with drop downs (ELT).
- Speech therapists complete the PO Feeding recommendations table in the patient's daily treatment note smarttext (ETX).
- Smartlinks were created (HHS) beginning, text, and end. The beginning and and end HHS were included in the IP Daily treatment note smarttext.
- The text HHS was included in the nurses' handoff navigator in the nutrition info report. (Second screenshot)
- Every time the table is updated or changed in the SLP daily treatment note, it automatically updates in the handoff navigator.





From your experience, what is best practice for a centralized location for documentation, and what are your processes to keep this information up to date?

1. What is the best place to document a patient's feeding plan/swallow diet so that the current diet is ordered in the system **upon admission**? Upon admission, in the admission navigator, the nurse enters feeding/diet type, formula, feeding route, feeding schedule, feeding amount, pacifier used.



2. What is the best place to document a patient's feeding plan/swallow diet so that the current diet is ordered **status post-surgery**? PO feeding recommendations are documented in the speech's smarttext and it always pulls in to the nutrition info section in the handoff navigator
3. Who documents the feeding plan/swallow diet and maintains this information (ensures most current)? Speech therapist documents and maintains. We ensure that it is current by pulling in their feeding recommendations table into the nutrition info section in the handoff navigator
4. If a child admitted has received a VFSS/FEES at another facility, who captures that information in EPIC for the medical providers? If caregiver mentions this to a resident or SLP, they may include the information verbally given in to their note.

ORG C

From your experience, what is best practice for a centralized location for documentation, and what are your processes to keep this information up to date?

1. What is he best place to document a patient's feeding plan/swallow diet so that the current diet is ordered in the system **upon admission**? We document our MBS and FEES reports in epic as well but rely on the MD to be sure to read the most recent MBS/FEES report when the patient is newly admitted. Fortunately it hasn't really been a problem with our MDs missing the recent MBS/FEES notes and diet recommendations but I can completely see how errors could occur.
2. What is the best place to document a patient's feeding plan/swallow diet so that the current diet is ordered **status post-surgery**? We will often put comments specific to the feeding recommendations in the RN Sticky Note. The RNs are really good about checking that. Additionally, we write a note in epic with a recap of recommendations. We also communicate it to the MD and they often will document it in their notes under the FEN/GI/Nutrition section of their daily notes.
3. Who documents the feeding plan/swallow diet and maintains this information (ensures most current)? The SLP following the patient documents the feeding plan and diet recommendations. The MD puts diet orders in epic for all to see and they will be as specific as we want them to be when entering the orders (ex: they will write specific comments like "hold the infant in elevated sidelying and use a preemie nipple"). MDs also have comments on the feeding plan within their daily notes under the FEN/GI/Nutrition section.
4. If a child admitted has received a VFSS/FEES at another facility, who captures that information is EPIC for the medical providers? Typically that information is written in the HP completed by the physician with information be provided by the parent. If Speech is consulted, we also document that information in our notes as well.