Patient Education Documentation: Is it Being Done?

Patient education is a key component to disease management, convalescence, and overall wellness maintenance. Documentation of patient education provides a means of monitoring the type of patient education performed, the patient response, and additional educational needs.

Patient education is a key to disease management, convalescence, and overall wellness maintenance. The medical and allied health literature identifies the important partnership of responsibility to be developed between the patient and health care provider in order to ensure proper health education (Epstein, Alper, & Quill, 2004; Salmon & Young, 2005). A person's entry into the acute care setting provides numerous opportunities for all members of the health care team to provide patient education. However, education is not effective for health and lifestyle change unless an appropriate approach is taken that considers both the learning needs of the patient and the necessary documentation to confirm teaching strategies (“How to Document,” 1999). Documentation serves to identify specific educational needs, possible barriers to education, previous education received, and patient and family response to education.

The health care system offers an intricate, potentially overwhelming environment that may be difficult for patients and their families to navigate. Among the concerns of patients admitted to the hospital and their families are a sense of loss of self-determination over personal needs, threat of self-control, depression, and anxiety (Coyne, 2006; McLaughlin et al., 2005; Tornqvist, Mansson, Larsson, & Hallstrom, 2006). In addition to psychosocial concerns, culture and literacy also must be considered. Numerous studies cite difficulties in communication between health care providers and patients with low-literacy levels (“Communication with Patients,” 1998; Mayeaux et al., 2004; Safeer & Keenan, 2005). The issue of provider education regarding cultural diversity and languages other than English likewise is encountered in the pertinent literature with regard to barriers of communication and sensitivity to the patient’s culture (Deyirmenjian, Karam, & Salameh, 2006; Flacker, Park, & Sims, 2004). In the context of poor language skills, the most important information must be the focus of the communication and presented in small segments to achieve the educational objective (Brucolieri, 2000).

Health care providers also need to consider the patient’s hearing and vision. Hospitalization may occur suddenly, and patients admitted without their hearing aids or glasses may be hindered in education. Providing patient education to patients with hearing loss requires facing them, speaking clearly and slowly, and possibly using written materials. For patients with vision loss, using educational materials with larger font on white paper in bright light will facilitate reading (Brucolieri, 2000).

Patient education also can decrease hospital length of stay and therefore health care costs (Merriman, 2008; Siggeirsdotir et al., 2005). It may be appreciated that the appropriate provision of care (using guidelines/instruction for disease and medication management) can have significant benefits for both the patient and health care system in terms of...
Incomplete documentation can result in loss of valuable patient education opportunities and provision of information during a hospitalization when the current health care system is focusing on shorter lengths of stay. Documentation of patient education also provides evidence that patients and families were given information about disease management and potential complications. This documentation offers some protection for the health care professional should complications arise and the patient denies receipt of this information. Adequate documentation entails consistent compliance from all providers involved in the patient’s care (Baker, 2000).

Despite Joint Commission standards, patient education often is under-documented in patient medical records (Leisner & Wonch, 2006). Research suggests several reasons why documentation may not be occurring with the use of electronic medical records. The reasons include negative perceptions from staff on electronic medical records systems (Ahn et al., 2006), limited training on computerized systems (Lindemauer et al., 2006), complexity of electronic medical record documentation format (Rinkus & Chitwood, 2002), and the failure to recognize the importance of documentation. Increase in use of electronic medical records also does not necessarily imply change in computer literacy or comfort (Lium, Laerum, Schulz, & Faxvaag, 2006). Despite the drawbacks, it is vital to maintain current and accurate patient medical records, particularly regarding patient education (Janousek, Heerman, & Eilers 2005; Rinkus & Chitwood, 2002). Nurses surveyed in one study indicated the electronic medical record decreased workload; in addition, almost two-thirds of nurses surveyed preferred bedside documentation. A corollary to this was that environment and system barriers, such as wireless connectivity, access to computers-on-wheels, battery pack longevity issues, and the presence of other patients, often prevented electronic medical record entries at the bedside (Moody, Slocum, Berg, & Jackson, 2004). Bedside entry may enhance documentation of patient education that occurred during the patient encounter and could be forgotten if documentation occurs at a later time.

**Purpose**

The purpose of this study was to assess the presence, frequency, and interdisciplinary nature of patient education documentation in the electronic medical record and determine if specific discharge instructions were provided at a 186-bed adult medical-surgical, suburban community hospital in the mid-Atlantic region of the United States.

**Design and Method**

Post-discharge review of 243 electronic medical records representing all inpatients was done for 1 week. The electronic medical record review was limited to the Interdisciplinary Teaching Intervention which serves as the central location of all documented patient education and review of the discharge instructions. A data collection tool was developed to obtain information from the Interdisciplinary Teaching Intervention and the discharge instruction form. Data collectors were hospital employees with access to the Interdisciplinary Teaching Intervention as part of their job responsibilities.

**Results**

The patients’ length of stay ranged from 1 to 40 days (M=4.14), with the most frequent length of stay being 1 day (n=69). Representing multiple departments, 599 entries were found on the Interdisciplinary Teaching Intervention of the electronic medical records. The number of patient education entries ranged from 0 to 20 (M=2.4), with most electronic medical records lacking any patient education entries (n=65; 26.7%) (see Table 1). Assessment of barriers to patient education showed that the patient’s disease process (n=6), cognitive ability (n=5), resistance to teaching (n=3), and language (n=2) (see Table 2) were most commonly identified.

Patient education was documented most frequently by staff from nursing (n=160), physical therapy (n=26), cardiology (n=22), respiratory therapy (n=22), nutrition (n=11), pharmacy (n=8), and occupational therapy (n=1) (see Table 3). Methods of providing patient education included verbal instruction (n=175), demonstration (n=16), verbal with a handout (n=15), Krames-on Demand® handout (n=6), handout (n=4), and demonstration and handout (n=3) (see Table 4). The patient was the most frequently taught person (n=173), with the patient and family (n=23) and family

---

**Table 1. Number of Interdisciplinary Teaching Intervention Entries**

<table>
<thead>
<tr>
<th>Number of Entries</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>65</td>
<td>27</td>
</tr>
<tr>
<td>1</td>
<td>40</td>
<td>16.6</td>
</tr>
<tr>
<td>2</td>
<td>41</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>28</td>
<td>11.6</td>
</tr>
<tr>
<td>4</td>
<td>16</td>
<td>6.6</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>5.4</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>3.3</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>9</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>11</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>13</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>20</td>
<td>2</td>
<td>0.8</td>
</tr>
</tbody>
</table>

---

MEDSURG Nursing—October 2008—Vol. 17/No. 5
(n=3) also included. Legal guardian as well as patient and interpreter each were identified once as other receivers of instruction/information (see Table 5).

A variety of educational topics were identified, including medications (n=97), other (n=81), activity (n=58), test/procedure (n=50), diet (n=40), treatment/therapy (n=40), pain (n=32), medical equipment (n=28), disease process (n=26), rehabilitation (n=25), special care (n=20), discharge planning (n=9), and spiritual care (n=3). The topic “other” included any subject not specified as a category on the Interdisciplinary Teaching Intervention, such as ostomy or wound care or use of the bed controls and call bell system (see Table 6).

Electronic medical records also were reviewed for the presence of specific discharge instructions. The most frequent specific discharge instructions were diet (n=110), other instructions (n=67), medication use (n=27), and activity (n=6) (see Table 7).

During the study, several issues were identified as possible contributors to the low number of patient education entries. The first was the number of medical records without patient education documentation. In an effort to represent fully the nature of patient education, the Interdisciplinary Teaching Intervention was developed as the site of documentation by all departments that have patient contact and provide patient education. Several clinically vital departments, such as the clinical laboratory and speech therapy, did not document in the Patient Education Intervention. Others, including the radiology/imaging department, did not have access to the Patient Education Intervention documentation screens.

The second issue was that the computerized nursing documentation module did not have an activated Interdisciplinary Teaching Intervention for three patients. The Interdisciplinary Teaching Intervention was programmed to be activated when the Nursing Interventions Set was added to the electronic medical record by the admitting nurse, but there was no indication why this had not occurred. During the admission process, the database requires an assessment of the patient’s educational needs and identification of whom among the family should be included in the educational process; this then translates to the Interdisciplinary Teaching Intervention. This flow of information facilitates the development of a teaching plan, but there are no means of establishing expected patient outcomes or goals without activation of the intervention.

The last issue involved poor patient education resource promotion. In each patient room, signs indicated several patient education channels available on the hospital’s closed-circuit television system. However, the signs did not reflect the current patient education channels, and the television system was not active in several patient rooms.

### Discussion

Study results were presented to the patient education and per-
Staff instruction regarding performing and documenting patient education must lead to increased awareness of this vital element of patient care.

At the time of the study, the radiology/imaging department did not have access to the Interdisciplinary Teaching Intervention. Many patients have diagnostic and therapeutic examinations and procedures every day within this department, but staff members are unable to document the education they perform.

This study focused on documentation of patient education, and no input was obtained from patients to gather information regarding their view of education, the need for education, and whether or not an acute care setting is the most appropriate setting for teaching about complex disease management regimens.

Comments

This study focused on the documentation of patient education. Patient education may be most meaningful when the patient is faced with numerous, complex health care needs, and is expected and required to make challenging lifestyle changes and choices. Consideration of the patient’s education and literacy level is often missing in the assessment and provision of patient education. Presently, little is being done to assess an individual’s educational level and reading ability on admission to the acute care setting. This assessment is vital to ensure provision of understandable information for the patient and his family.

Documentation describes the provision of health education and the patient’s response to it. Consistent patient education documentation provides a vital means of communication among health care professionals. Education often occurs in an informal manner during many patient interactions that may not be viewed by health care professionals as opportunities for documentation. Incomplete or nonexistent documentation of patient education can lead to replication of effort or omission of vital pieces of information (Taylor, 2003).
Patient education documentation is a vital component in the provision of comprehensive patient care.

Future Research

Further research needs to be conducted to identify factors that influence or prevent health care professionals from documenting patient education. A key unanswered question involves what is considered to be patient education by health care professionals. If discussing medications or treatments is patient education, do all health care providers view it as such and document the education?

With the increasing presence of electronic medical records, research needs to be done to identify factors that may increase ease of patient education documentation. Software typically allows using institutions to set fields as required and add pop-up window reminders. What effect do these capabilities have on the frequency of documentation?

Repeating the study in 6 months to evaluate progress in documentation of patient education would serve as an assessment of the effectiveness of staff education. Staff members of those departments previously not documenting have been approached about the need to document on the Interdisciplinary Teaching Intervention.

Conclusion

Patient education documentation is a vital component in the provision of comprehensive patient care. Patient education documentation serves as a means to ensure vital information is provided to and reinforced as needed with patients and their families who strive to achieve an overall state of well-being through complex regimens. Consistent documentation of patient education helps to identify specific educational needs and determine the ability of all members of the health care team to meet these educational needs collaboratively.

References


