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Enhancing skills in patient care documentation and transfer of care: An example of intra-professional collaboration across pharmacy schools through video-conferencing

Sherilyn K.D. Houle[a,*], Theresa L. Charrois[b]

[a]School of Pharmacy, University of Waterloo, 200 University Avenue West, Waterloo, Ontario, Canada N2L 3G1

[b]Faculty of Pharmacy and Pharmaceutical Sciences, University of Alberta, 2-35 Medical Sciences Building, 8613 - 114 St., Edmonton, Alberta, Canada T6G 2H7

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Abstract

Documentation of care is a challenging skill to teach, especially when assessments are performed by individuals with familiarity with the case being documented. We designed an activity utilizing peer-review of documentation by students unfamiliar with the patient case, to better replicate real-life interprofessional communications. Pharmacy students from the University of Waterloo and the University of Alberta were provided anonymized notes from a group of students at the other institution. Groups met via video-conference to provide feedback and ask questions about the notes they received. Students were surveyed on their confidence and skills in documentation prior to and following the activity, and also submitted reflections on the experience, which were assessed using qualitative content analysis. Improvements in students' self-perceived documentation skills showed slight improvement after versus before the activity; however, student reflections were highly positive and showed a change in perspective from documentation being considered something to be done for the documenter's personal reference, to something that is invaluable to seamless care transitions between professionals and care settings. Students commonly receive feedback from peers and instructors; however, educators should consider the added benefit of offering feedback from the perspective of individuals unfamiliar with the patient case and from different institutions.

Keywords: Peer review; Feedback; Documentation

1. Introduction

While an important skill to acquire, the instruction and assessment of clinical documentation has been a challenge. Rubrics have been developed and validated [1-3]; however, a number of limiting factors remain. First, assessment is often performed by an individual who is familiar with the patient case. This may allow them to detect missing information that would not be known to an unfamiliar reader or, conversely, to assume the rationale for decisions and recommendations not described in sufficient detail. Second, instructor-performed assessment does not offer students the opportunity to be exposed to the work of others or to

*Corresponding author.

E-mail addresses: sherilyn.houle@uwaterloo.ca (S.K.D. Houle), tcharroi@ualberta.ca (T.L. Charrois).

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adopt the perspective of an assessor – strategies that have been found beneficial in health professional education.[4,5]

The objectives of this paper are to describe a multi-institutional approach for providing peer assessment of documentation as part of a pharmacy skills lab course, and to assess the impact of the activity on students' documentation skills and their recognition of the role of documentation in the transfer of care.

2. Material and methods

2.1. Educational context

Third-year pharmacy students at the University of Waterloo (UW) and the University of Alberta (UA) each complete a skills lab course scheduled in the winter term. These courses utilize patient cases and interactions with standardized patient actors to apply knowledge to practice. Peer assessment of these interactions occurs on a regular basis at each university; however, neither program had employed peer assessment of clinical documentation activities to date.

As one of the aims of documentation is to facilitate seamless care among health professionals, peer evaluation of documentation within the same institution can be problematic, as students may observe and/or discuss the case being documented. As notes in practice are often read by other health professionals not present during the interaction, this unawareness of the interaction would be most realistic to practice.

To address this challenge, course coordinators from UW and UA agreed to jointly conduct this learning activity across institutions. Students at each university could therefore still observe their peers' interactions in lab, while also being able to receive 'blinded' peer assessment of their documentation of those interactions.

2.2. Structure of the activity

Students at each university completed patient interactions as per usual course procedures in March 2017 and, in groups of 7–8 students, had approximately 1 day to submit a clinical documentation note to the course instructor. Each group was paired with a group from the other university, and were provided blinded electronic versions of the notes. Students were then provided approximately 3 days to review their peers' note and determine topics for clarification and feedback. They were advised to read the note from the perspective of another pharmacist newly assuming responsibility for that patient's care or follow-up.

Course instructors identified a block of time at each university when students were not scheduled to be in class, and arranged for feedback sessions at 15-min intervals during this period. Using generic Skype® accounts created by each university, students from each university met to provide feedback, ask for additional information on aspects of the note that were unclear, or discuss the rationale for clinical decisions made.

Following this interaction, students submitted a 250–500 word reflection on the overall experience, and were invited to complete a brief web survey and/or provide consent for the content of their reflections to be included in the qualitative analysis. The web survey consisted of six questions answered along a sliding Likert scale, as follows:

1. How would you rate your confidence with documentation prior to this exercise? (0 = not confident; 100 = confident)
2. This exercise improved my ability to decide which patient and/or clinical information is relevant to include in my documentation note. (0 = did not improve my ability; 100 = improved my ability)
3. This exercise improved my ability to write a concise documentation note. (0 = did not improve my ability; 100 = improved my ability)
4. This exercise improved my ability to document necessary changes as well as any recommendations posed. (0 = did not improve my ability; 100 = improved my ability)
5. This exercise improved my ability to provide seamless care with other healthcare professionals, and to include relevant monitoring and follow up. (0 = did not improve my ability; 100 = improved my ability)
6. How would you rate your confidence with documentation after completing this exercise? (0 = not confident, 100 = confident).

2.3. Data analysis

Results from the Likert-scale survey questions were analyzed descriptively using Microsoft Excel 2010. Two researchers independently performed conventional content analysis on the reflections. Qualitative content analysis is defined as "a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns."[6] In the conventional method of qualitative content analysis, themes are not pre-specified but rather derived from the data. In this study, major and minor themes arising from the

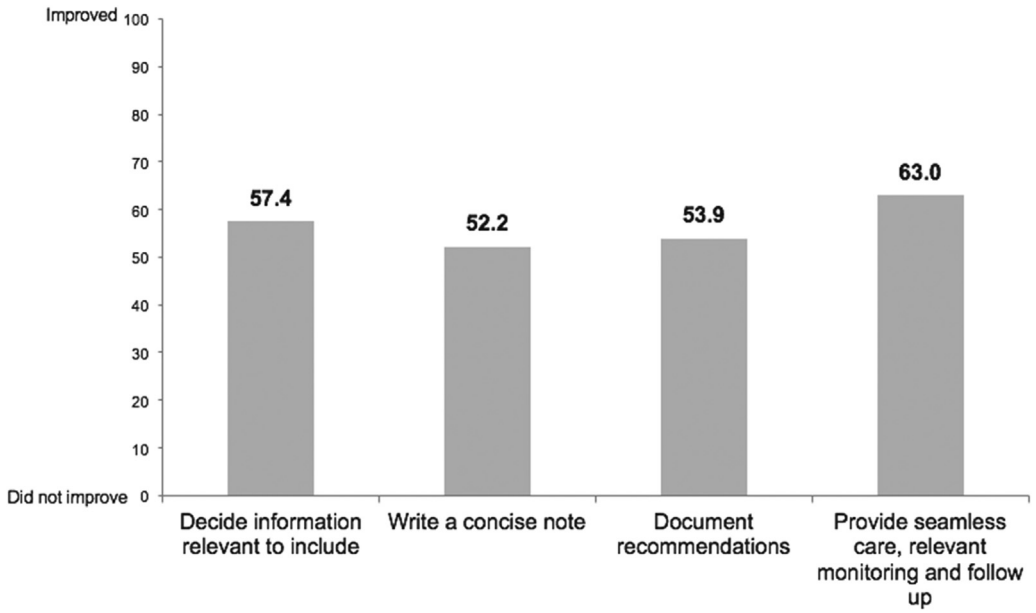

Fig. 1. Student self-report to the question: "The exercise improved my ability to…".

data were identified from examining a sample of 10 reflections and identifying themes, which were then organized and grouped into meaningful clusters where relationships between themes were identified. Coding structures were compared between researchers and consolidated into a final set of codes. Each investigator then independently applied the final coding structure to all reflections and survey comments, and compared results. Any disagreements in coding were resolved through discussion and consensus.

2.4. Ethics approval

Research ethics committee approval was obtained from each university, and consent was obtained from students for data collection.

3. Results

74 students completed the post-activity survey, for a response rate of 31%. Students self-rated their ability to document patient care activities at 79.7% (SD 11.8) prior to the activity, increasing slightly to 83.3% (SD 10.6) following the activity. Slight improvement in all aspects of documentation ability was reported, with the greatest benefit noted on their ability to provide seamless care, as shown in Fig. 1.

Consent for the contents of their activity reflections to be evaluated for research purposes was received from 104 students. Content analysis revealed the following themes and sub-themes:

3.1. Theme 1: Note structure and contents

3.1.1. Subtheme: Clear and detailed follow-up plan

Students reflected on the need for the follow-up plan to be written in sufficient detail for another health professional to be able to assume care. Some students referred to a complete follow-up section as one that clearly describes the 'who, where, what, when, and how' of the plan.

> 'A [follow-up] goal can be potentially compromised when the follow-up personnel is not specified, as readers might assume other people will take on the role of monitoring and thus choose not to follow up themselves' (Reflection 2)

3.1.2. Subtheme: Balance of conciseness and comprehensiveness

A number of students commented that this was their first time receiving a note written by someone else, and recognized it would be difficult to read excessively lengthy notes in practice within one's existing workload. However, they weighed this with a note being too short, missing information that is essential to ongoing care.

> 'In our attempt to write a succinct note, we may have missed including some information and this feedback has reinforced for me that documentation notes

do not necessarily need to be short, but rather complete regardless of length' (Reflection 89)

'In practice, I will not have infinite amounts of time to analyze documentation, and other practitioners who will read my documentation do not either. As such it is vital for documentation to be as organized and clear as possible' (Reflection 82)

3.1.3. Subtheme: Missing information of relevance to an external reader

Specific information deemed to be of value to an unfamiliar reader included the patient's height, weight, social history, previous medications tried, adherence, comorbid conditions not specifically addressed in the interaction, and the reason for the encounter. Additionally, students commented on the importance of clearly stating if a particular piece of information did not apply (e.g., not taking any non-prescription drugs, or drug interactions were checked for with no concerns identified) or was within normal limits (e.g., lab values) rather than omitting mention of these, as this could be interpreted as an oversight by the reader.

3.1.4. Subtheme: Rationale for decisions and recommendations made

Some reflections commented on the importance of providing a rationale for the action plan presented, such as references consulted, preferences stated by the patient, cost or drug coverage considerations, and adherence.

'What factors led to this conclusion? Why was it important for the patient? These are questions that I answer internally when making the assessment, but others, who simply see the documentation note, do not have the benefit of having had the interaction with the patient' (Reflection 29)

'If I had to explain to a patient why [the other pharmacist] chose this therapy, I would not be able to do so fully' (Reflection 82)

3.2. Theme 2: The role of documentation in supporting seamless care

Students expressed a change in perspective on the role of documentation in supporting transitions in care. Students commented on how documentation activities completed to date in their training focused on documentation for internal purposes (for example, for legal purposes and planned monitoring/follow-up by the writer), while this activity demonstrated that documentation should also consider the perspective of another healthcare provider.

'I was full of confidence – thinking surely the [other] students will completely understand the rationale and therapeutic decisions. I was so wrong. Even our own instructor knows the case and subconsciously fills in details. This interaction has drastically changed the way I look at describing patient interactions. Prior to this, I have essentially been writing documentation notes as if it was solely for me – in case I had to remind myself about what happened. I have been missing the point.' (Reflection 29)

4. Discussion

This activity aimed to establish a multi-institutional collaborative approach for providing peer assessment of documentation, and to assess the impact of the activity related to students' documentation skills. Through videoconferencing, students at two universities were able to engage with peers in order to practice the skills of documentation, seamless care, and providing feedback. This is the first known published report of peer feedback across institutions specific to the development of clinical documentation skills.

Student reflections demonstrated a deeper understanding in how they constructed their notes, and the importance of completeness of all elements following the activity. By reading notes for patients that they were unfamiliar with, students could better understand how the structure and completeness of documentation was so important. This was something both universities had struggled with prior to this activity. Usually all students and lab instructors are familiar with the patient cases, or students discuss cases with their peers; as such, they can make inferences and assumptions that would not be possible if they were 'blinded' to the case being documented. The lack of familiarity with these cases added to the authenticity of the activity simulating transferring care of a patient. While a similar activity can be undertaken within the same institution, efforts should be taken to ensure that students do not speak with each other about their cases prior to reviewing peers' documentation.

There are some limitations that need to be considered. First, the time limitation of 15 minutes for feedback by each group seemed to hinder some discussions, as they had to be cut short in order to allow the next group to provide their feedback. In addition, there were some technical issues that led to some discussions being cut short. Other instructors considering adopting this approach are encouraged to schedule a transition break between

groups, to allow the entire 15 min available for the interaction, and some potential space to accommodate discussions that run over the allocated time. Second, the timing of our activity was not ideal, as it occurred at the end of the semester, and the students seemed fatigued and potentially distracted by upcoming exams. While it was apparent that students reviewed the other group's notes in detail and came up with thoughtful items for discussion, we recommend holding this activity earlier in the semester when there are fewer competing demands for their time and attention. Some students did express that this activity would be more ideal earlier in the program as well (i.e., in first or second year), as some students felt that their documentation skills were already well-developed by the end of third year. As such, this activity may not have been as useful as it could have been. Finally, the aim of this activity was to write and review documentation intended for intraprofessional use; however, a similar activity performed across multiple professions may be even more impactful. In addition to focusing on the comprehensiveness and clarity of notes, the discussion and feedback can then expand into profession-specific norms related to documentation style and format, preferred methods for communication and integration of note writing and review within existing workflow, and identifying information deemed as most valuable considering the knowledge needs and scope of practice of the other profession.

5. Conclusion

Peer feedback across institutions by video-conference can provide a valuable perspective for students on documentation compared to feedback from peers in the same program or course instructors. To be most effective, this activity should be conducted multiple times over the course of a program, to both introduce the role of documentation in the transfer of care early on in a student's training, and also to accommodate changing documentation styles based on patient complexity and practice experience over time.

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Declarations of interest

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