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Improving the Quality of the Documentation System in a Health Care Environment

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Abstract

An effective documentation system in a managed care organization is complicated yet important in today's business environment. Being too busy taking care of patients, health care professionals often fall behind in paperwork and quality care provided. An action research model developed by Cummings and Worley (2001) was utilized to assess the organization's status. Data collection methods included survey questionnaires, group interviews, and secondary data. A collaborative team approach designed to reach a consensus decision was used in the evaluation, interpretation, and validation of the information collected. Three intervention methods relating to training and education, teamwork, and staff knowledge and skills were proposed with one of these recommended for implementation. This action research will bring the organization to greater success in the health care environment.

Improving the Quality of the Documentation System in a Health Care Environment

Effective management of documents and their content plays a fundamental role in assisting organizations in retaining both their knowledge and growth. A comprehensive and accurate documentation system is especially important in the managed health care environment (Mayer, 2001) because it is responsible for both the financing and delivery of quality care to patients. This cutting-edge business has become more and more competitive. In the last several years, medical costs and insurance premiums have increased at double-digit levels.

To succeed in today's managed care environment, Pacific Health Plans (PHP), a managed care company, must distinguish itself from others in both cost and quality of care. This must occur from the patients', payors' and providers' perspectives. As a result, new demands on both the medical professional staff and the administrative support team have been made. These demands can be observed from the strategic planning level to the most detailed operational levels.

The goal of this action research was to provide recommendations to improve the quality of documentation system practices in an existing company in the health care industry. The company was assessed by the collaborative team. Data collection methods used including written questionnaires (surveys), group interviews, and secondary data. Information from the analysis was compiled and analyzed, interventions were developed, and recommendations were proposed for improvement.

On the strategic planning level, accurate, efficient, and timely documentation systems allow the company to enhance revenue; control resources, and match case mix to the population treated. For example, payment for services to patients insured by Medicare is based on their documented need for nursing care and covers supplies and equipment used during that care. Continued payment depends on daily documentation demonstrating the patient's ongoing need

for skilled care. The quality of documentation in this area directly affects the amount of Medicare payments and other insurance reimbursements. Documentation must confirm that the nursing staff meets certain standards of care (Guido, 2006). On the operational level, the efficient flow of patients through the system as well as the availability of appropriate documentation and clinical data allows both administration and providers to improve communication, reduce costs and, most importantly, provide the highest level of care. For example, nursing documentation provides the data that examiners need to justify reimbursement for health care expenses. Besides reviewing the records to estimate revenues, examiners also use these records to calculate nursing care costs. Today, almost every health care organization has tried its best to ensure that there is a reliable and quality system in place to detect any potential problems that might impact either their services or financial situation. Organizations also continuously monitor their system and improve the quality of care. In the health care business, there is a lot of sensitive documentation required to support the coordination and delivery of patient care. These documents include the operating procedures, referral procedure, necessity of visits, diagnosis, treatment, and the billing processes. Many of the professional health care staff, especially physicians and nurses, view documentation as drudgery, a task that interferes with the time needed to provide quality patient care. Consequently, less attention is given to the documentation system, and therefore, an organized and complete documentation system is not always well maintained.

Background of the Organization

Pacific Health Plans (PHP) was established in 1989 and is owned by a group of primary care physicians (individual medical doctors who watch over all aspects of the care process) and specialty physicians (individual medical doctors with specialized skills). Located in Boulder, Colorado, PHP uses a managed care system that integrates the efficient delivery of medical care with payment for that care. In other words, the managed care system includes both the financing

and delivery of care responsibilities. PHP establishes formal, contractual relationships with physicians and hospitals, and uses a utilization management program that monitors the appropriateness of care before, during, and after the care is actually provided to members. Its foundation is in the skills of a Primary Care Physician (PCP), a professionally trained physician who provides a broad spectrum of care needed by patients from birth to death. This physician is not responsible for just a few medical conditions. The primary care physician is in the best position to know each patient as an individual. Patients are referred to a specialist (by their PCP) when unique or specialized care is required. However, their treatment is guided, managed and monitored by their Primary Care Physician. PHP relies upon collaborative relationships with a network of trusted specialists and ancillary service providers that share PHP's values and commitment to excellence. Currently, the PHP network consists of more than 400 primary and specialty care physicians associated with two Independent Physicians Associations (IPAs) that are involved in two risk-sharing contracts: Primary Physician Partners (PPP) and Colorado Pediatric Partners (CPP).

PHP's mission is "to maximize the efficiency of the delivery system. [They] must balance the needs of [their] patients, [their] physicians, and [their] payors through wisdom, creativity and dignity… to serve [their] employees with respect and good humor… and to serve [themselves] by growing, learning, and striving for excellence " (Pacific Health Plans Mission Statement, 2003). PHP was founded on the belief that physicians have the responsibility and the power to drive better and more cost-effective care for their patients. A market research study found that primary care physicians' control 75% to 80% of the dollars spent for health care. They order lab tests, CT scans, MRI scans, and dozens of other tests when diagnosing illnesses. The primary care physician determines whether a patient's condition requires the care of a specialist or whether a patient is sick enough to be referred to a hospital for inpatient care. PHP provides

the management leadership and services necessary to make this mission a reality. This small, non-unionized company employs roughly 65 individuals including health care professionals, office administrators and technical support personnel.

To maintain a competitive edge in the managed care business, Pacific Health Plans believes that performance excellence is a process that can be achieved and maintained only through continuous quality improvement. The primary function of PHP Quality Management is to use data and decision-support techniques to improve the performance and outcomes of PHP's clinical and operational processes. To ensure the success of PHP, the managers use various internal and external committees to communicate their activities. These include the Utilization Management Committee, Clinical Review Committee, and Quality Improvement Committee. Additionally, they act upon utilization indicators that encompass care delivered in inpatient, outpatient, home health, and ancillary environments. A final but equally important function is to facilitate and support Pacific Health Plans teams in learning and applying the principles of quality improvement methodologies and techniques. Quality management systems are an integral part of Pacific Health Plans. The mission of PHP is to provide the highest level of quality care to patients in a highly competitive industry. Without quality built into the system, PHP could quickly lose its position in the marketplace.

The Problem

Managed care was formed as a care delivery system that offered cost-effective services for subscribers at reduced or constant rates. Since the inception of this delivery system, a continuously changing concept of the form of managed care has evolved. Managed care is aimed at reducing national expenditures through the elimination of duplicate services. This works by curtailing unnecessary diagnostic tests and procedures as practiced for defense protection from litigation. The delivery system that most of the managed care companies would adopt is

complex, confusing, and often viewed as limiting needed and life-saving therapy and surgical procedures (Meiner, 1999).

History of the problem. As the current care delivery system continuously diversifies, documentation of the actual care delivered to patients becomes more critical. Malpractice litigation continues to increase, as do the monetary awards being given by the jury system. More and more health care professionals are being included in litigation, and sometimes in negligence cases too. Medical records provide both proof of communication with other team members and a written record of the care given to a patient. Since these are individualized for specific patients, the records must reflect the patient's needs, problems, limitations, and reactions to the medical intervention implemented following a medical diagnosis. Thus, the goal of the treatment should be easily identified in the patient's medical record. Proper documentation must also reflect current standards of medical practice.

Several years ago a critical analysis performed on the organization's documentation system discovered that it had an unorganized and disjointed documentation environment. Additionally there were very limited connections among principles, policies, procedures, current standards of medical practice, best business processes, and information technology. This disconnect may have occurred due to a combination of past factors that include: (a) organizational structure changes, (b) the deployment of networked desktop computers that enable authors to create documents quickly, and (c) the low priority given to documentation management.

This documentation environment leads to potential business integrity threats. Disjointed registration scenarios for physical files, reports, and electronic documents mean that employees are unable to determine the precise location and status of various types of information by accessing a single database. Consequently, most employees within PHP cannot access all

information relevant to a particular matter or service. Examples of this include objects that are typically not defined by searchable properties and are stored in diverse physical and electronic repositories. This discrepancy might be due to a number of factors, including training, varying levels of education and experience of employees, under-staffing, lack of teamwork, and leadership. Other integrity threats include multiple location stores for the same document, and the threat posed by simultaneous updates being performed on the same electronic document.

The goal of this action research was to assess the current situation of the organization's operating and documentation system and ultimately to develop and implement a systematic, cost-effective, and appropriate intervention to improve organizational productivity and effectiveness, as well as to bring the organization to a higher level of recognition and greater success in the health care market. A problem statement (Landfair-Mueller, 2003) was constructed, based upon the information collected from PHP, and summarized in the following paragraph.

Problem Statement. Several years ago, the company was experiencing a lack of consistency in format, and a lack of both accuracy and completeness regarding documentation of policies and procedures related to patient care management. This problem would both inhibit the company from growing in a highly competitive health care business and affect the level and quality of care and services provided to their members, providers, and health partners. The purpose of this action research was to find a way of improving the organization's documentation system, while at the same time maintaining a high level of patient care. This was to be accomplished using a cost effective action research approach.

Literature Review

Many years ago, everything most physicians needed to care for their patients was found either in their knowledge and experience as a physician or in their little black bag. Nevertheless, today, even the most conscientious, dedicated professionals cannot work effectively in isolation.

They need easy access to other professionals, specialized equipment, and the most current medical information (Zelman & Berenson, 1998). Electronic medical records (EMR) that suggest courses of treatment based on volumes of medical literature are being developed and installed around the United States. It has been a slow and difficult process, and one that many physicians resist. Ironically, while physicians have been slow to accept the information infrastructure, many patients have not because they know the values of outcomes. Through the Internet, as well as through television and the press, patients and their families are turning to the latest scientific journals in an effort to influence their own course of care. While one might not worry about doctors who fail to keep up with rapidly changing medical literature or for practicing medicine in accordance with the norms of the communities where they learned to be doctors, the record of preventable medical mistakes is impossible to excuse. In 1984, the Harvard Medical Practice study reviewed thousands of case records from 1984 in New York State and demonstrated that in 1 out of every 100 hospitalizations, patients were injured or died as the result of what physician reviewers thought to be overt clinical negligence (Brennan et al., 1991). These systems assume that, despite the best efforts and intentions of highly trained individuals, human and technological mistakes are inevitable.

Although most discussions about documentation focus on writing in the patient's chart, other types of documentation affect nurses and heath care staff. This documentation of policies and procedures is contained in health care organization employee and nursing manuals. Deviation from these rules suggest that an employee failed to meet the organization's standards of care.

Whether such policies establish a standard of care has been debated in some malpractice cases. However, in every nursing malpractice case, the actions of the nurses are compared with the appropriate nursing standard of care. The jury measures the nurse's actions or omissions

against the performance of a reasonable, prudent nurse with comparable training and experience. Accepted, regularly updated national standards are used as guidelines, although the defense can always challenge the presumption of the standard by introducing expert testimony or other methods. There is a distinction between goals and policies; if nothing was written down on paper, it is considered a goal and not a policy. This will not stand up in court if there is a disagreement.

It is important to distinguish between bad outcomes and malpractice. A bad outcome is not malpractice per se. Health care has many inherent risks, such as an adverse reaction to a blood transfusion received during surgery. If the medical record indicates that the blood was the correct type, that all policies and procedures were properly followed, and that the organization policy set is a reasonable standard, the patient has no cause for a claim – he simply had an unexpected reaction to the blood transfusion. On the other hand, if the policies are not clear in detailing the activities, the case might be considered malpractice. Some patients assume that a bad outcome is due to malpractice because they had unrealistic expectations or received an inadequate explanation of a condition or procedure.

The quality of medical documentation is a critical factor in efforts to prevent and control patient injuries, malpractice claims, and malpractice claim losses. Deficiencies in documentation can have significant consequences in three areas.

1. Causing patient injuries: Many patient injuries occur because of errors, omissions, illegible entries and other medical record problems that preclude physicians and other providers from rendering appropriate treatment.
2. Filing of claims: In determining whether or not to file a malpractice claim, plaintiff attorneys scrutinize the medical records for evidence of the appropriateness or inappropriateness of the case rendered. If the records are incomplete, inaccurate, or

cannot be deciphered, attorneys may be obliged to file a claim simply to get access to better information.

3. Defense of claims: Medical records are one of the primary sources of evidence used by the jury in deciding whether a physician is liable for malpractice. As far as the jury is concerned, incomplete records can be devastating to the defense of a claim. If it is not in the medical record, it simply did not happen. Sloppy or inaccurate documentation can create the impression that the medical care rendered was less than professional. The significance of the record becomes even more apparent when it is recognized that a medical malpractice suit will not come to trial for many years after the incident in question. At that point, physicians are unlikely to have any independent recollection of their treatment of a particular patient. The medical record is invaluable as contemporaneous documentation of the events at issue.

Since the 1990s, organizational quality management programs have been critically driven by performance data (Mangano, 1997). The demand for performance measures occurs both within organizations and from the outside. Two of the most important accrediting bodies in the United States are using performance data. They are the Joint Commission on Accreditation of Healthcare Organization (JCAHO) and the National Committee for Quality Assurance (NCQA). Many of these performance measures are based on clinical outcomes, and many care-delivery processes affect clinical outcomes. Today, many consumers purchase their health insurance benefits based on a health plan's "performance."

JCAHO routinely surveys health care facilities in the United States to make sure that they meet its standards as accredited health care providers. Health care facilities submit to these surveys mainly to demonstrate that they provide high-quality safe health care. They also seek JCAHO accreditation to qualify for reimbursement and other funding from governmental and

private insurance agencies. The government agencies require health care facilities to hold JCAHO accreditation before they are eligible to receive Medicare, Medicaid, or private payments.

Besides requiring that the documentation demonstrate a facility's measurable overall quality care and service, JCAHO also insists that the documentation meet certain quality standards. Specifically, reviewers examine medical records containing patient assessments, care plans, and personal records. Those include clinical nurse competence evaluations, nursing licenses and credentials, and nursing assignments.

Health plans look to their providers, physicians, and hospital to ensure that the plan's performance goals are met. Clinical documentation is the written record demonstrating the care process, patient's response to treatment, and movement toward achieving patient goals. It is often the key evidence that care was provided and that outcomes were met. The current clinical collaborative guidelines focus on quality improvement efforts. They create an atmosphere for the entire health care team to work together to achieve patient-centered care and outcomes. The clinical documentation is the written evidence of this collaboration. It can be seen in the form of team communications, meetings, conferences, or other activities (Iyer & Camp, 1995).

Documentation of care provided is often the key element in determining the outcome of a malpractice verdict. Careless, sloppy, and incomplete record keeping implies poor patient care. Although clinical guidelines have been controversial with those physicians and administrators who worry about the legal impact of making them a permanent part of the medical record, those guidelines have become one tool for preventing malpractice litigation. If developed in collaboration with physicians and experts from other disciplines, and updated regularly, clinical guidelines should reflect the current standard of care, improved by communication and continuity among all providers involved in the patient's care, as well as the transition to other

care settings. Clinical guidelines also provide a mechanism for ongoing, systematic evaluation of the patient's progress toward the desired outcome.

The old financing and care delivery system was recognized as having four major problems: (a) the excessive costs associated with the excess supply of hospital beds and specialists, (b) the overuse of medical care services, (c) the inadequate evaluation of new technologies, and (d) excessive variation in medical practice and quality (Haas-Wilson, 2003). Physicians varied greatly in how often and for how long they hospitalized patients with the same kind of medical problem. Given the many factors that might explain these differences in hospitalization rates and lengths of stay, accurate documentation can become critical evidence in providing an explanation of malpractice, negligence, fraud and abuse. This can ultimately lead to legal action. These legal situations can be stressful and detrimental to both physicians and health care professionals (Buppert, 2000).

The Department of Justice does prosecute for Medicare and Medicaid fraud at both the medical group and individual provider levels. Substantiated charges of fraud may result in loss of provider status, loss of employment, restriction of the medical practice license by the Medical Board Certification, a monetary fine, and a possible prison sentence (Buppert, 2000). Errors resulting in improper payment occur 46% of the time. These are due to either insufficient or complete lack of documentation (Harrison, 1999). Many health care professionals are not accustomed to such scrutiny of their documentation. Today, the roles of physicians and health care professionals require them to become experts on both the coding rules and regulations, and appropriate documentation in order to prevent billing errors. Miller (2000) advised health care professionals to "document well" to both minimize risk of liability, and to prevent charges of fraud and abuse.

Although the main purpose of documentation is first to serve the patient and to convey information, one should never lose sight of documentation's legal import. Depending on how well the organization administers care and records the organization's activities and observations, the records may or may not support a plaintiff's accusation of nursing malpractice. Legally, malpractice focuses on these four elements: (a) duty, (b) breach of duty, (c) causation, and (d) dangers. Good documentation can save a nurse in a credibility dispute. Lack of documentation does not always imply negligence, but juries often believe it does. "If it was not charted, it was not done." Juries may think that this statement applies to all situations, when in reality the organization cannot possibly document every word and action. Fair or not, this misconception can lead to a negative outcome in a malpractice case when no negligence occurred.

The health care business is a document-intensive business. It is a sensitive environment that involves records and reports about patients who are being treated by doctors and other health care professionals. A high degree of security and legal use of people's medical records and health information is required as are extensive procedures for handling and protecting information. An advanced technology approach, Integrative Document and Content Management (IDCM), has been applied in the health environment. This approach brings together many aspects of medical records management so that information about patient care may be aggregated according to need. For example, data concerning diagnosis, therapy, and medication on an individual case basis may be associated with administrative data, such as bed use or accounting. With appropriate permissions, data may be made available to all personnel through a common network interface. There are also many other opportunities for IDCM, including workflow management. Integrated forms and workflow can be utilized to support management of clinical case documentation. Information gathered during a workflow process can be added to a patient record using electronic forms. An examination of processes and the use of documents and

records within the business context may offer opportunities for business process improvement (Asprey & Middleton, 2003). Consequently, understanding the managed health care processes and the documentation system may offer good opportunities for process improvement.

Entering and Contracting

In determining how best to proceed, the VP of operations expressed interest in following up on these concerns and agreed to work through an action research project that would leverage the strength of a collaborative team toward examining the problems they had raised.

A summary of the problem was presented to senior management for review and approval, thereby ensuring that the expectations of the project's scope were agreed upon. Specific parameters for the completion of the project, including outcomes and deliverables, the timeframe and available resources, were all discussed.

After receiving formal approval from the senior management, a collaborative team composed of key organization members was established. Taking a team approach to this project was a way of marshalling other people's expertise and strengthening the project. Lee & Krayer (2003) noted the best way to choose team members is to inspire them to volunteer; the best candidates to work on the team are individuals who are favorably disposed toward improvement, and who succeed and thrive under situations that call for improvement. We asked interested employees to volunteer to participate in this project and ended up with the following team.

The collaborative team members, by position and area of relevant expertise were as follows:

1. VP of Operations, who is experienced with company operation process and team needs
2. In-patient Medical Management Manager, who is experienced with company operation process and current documentation system
3. Quality Manager, an expert in operation and documentation control system

4. Human Resource Manager, who is experienced in documentation improvement support
5. Project Assistant, who is experienced in documentation improvement support

Collaborative team members made a commitment to the project and took ownership of finding a solution to the problem. They were willing to participate in this action research and had a high level of interest in examining the current documentation system with a goal for improvement. Entry discussions established commitment to participate and confirmed availability during the project timeframe. The collaborative team participated in the design of the data-gathering instruments and the analysis of the resulting data. All resources and expenses were supplied by the organization.

Method

Action Research

Definition. Action research aims to contribute to the practical concerns of people in an immediate problematic situation and to simultaneously further the goals of social science (Reason & Bradbury, 2001). Action research has a dual commitment to both study a system, and concurrently, to collaborate with members of the system to make change in a desirable direction (Robbins, 1998). Accomplishing this dual goal requires the collaboration between researcher and client, and thus stresses the importance of co-learning as a primary aspect of the research process. Action research is used to solve this problem because, unlike traditional research approaches that aim only at creating knowledge, action research is an approach to research that aims at both taking action and creating knowledge or theory about that action (Coghlan & Brannick, 2001). Action research is problem-focused, context-specific and future-oriented. It is also a continuous process that cycles from research to action to further research and more action; it involves the participation of organization members in the study of their own behavior for the

purpose of changing or improving an aspect or aspects of the system and learning from the research process. The learning or knowledge obtained from action research is the result of participants' critical reflection on the research process itself. In other words, employees affected by the problem work in a collaborative manner to attack the problem.

Rationale. Action research is appropriate for this project for several reasons. First, a small committee can make decisions to implement a process change for the entire organization. Second, action research works well in a small corporate environment similar to PHP. The bureaucratic hurtles to implement a plan are low. Finally, action research provides benefits for the entire organization. As indicated by Patton (2002), action research is conducted on a more informal basis and the people involved in the system improvement process usually participate in collecting data and evaluating themselves. After initiation of the action research, execution and completion of the data collection process, I conducted follow-up interviews with all participants. Results were compiled and a summary of the findings was presented to the collaborative team for review, analyzed and discussion, three interventions were developed and recommendations for improvement were proposed.

Action research model. There are several different models of action research. The model selected for this project is the six-step action research model adapted from Pearce, Robinson and Sandberg (1989), which was described in the Regis University MSM 696 Applied Action Research, Models of Action Research (Regis University, 2005). Table 1 illustrates the action research model.

Table 1

Six-Step Action Research Model Adapted from Pearce, Robinson and Sandberg (1989)

Step number	Activity
1	Recognize the problem
2	Diagnose the situation
3	Involve members, gather data, confirm the problem, and gain ownership
4	Involved members select solution
5	Plan intervention and implement
6	Evaluate the change

Validity. Triangulation was used to enhance data validity. Triangulation is the result of the three diagnostic methods used in this project. Data gathered through the use of questionnaires, group interviews, and secondary sources were compared in order to arrive at a comprehensive list of problems requiring attention. The technique of using a combination of methodologies to explore research questions or to strengthen a study's design and results from different angles and perspectives is called triangulation (Patton, 2002). Triangulation mitigates the problems inherent in each type of method described and provides a cross-data validity check. Patton (2002) also noted the importance of ensuring data validity during research and suggested the use of triangulation to accomplish this. By gathering and analyzing data using various methods, sources or investigators, the collaborative team can reduce the effects of bias inherent in any single approach. In this case, methodological triangulation occurred using both quantitative questionnaires and qualitative group interviews. Together with data gathered from

archived secondary information sources, they produced a balanced representation of the situation being examined.

Data-gathering Methods

When considering the purpose of this project, to assess the current documentation system with the goal of identifying opportunities for improvement, several discrete methods to collect relevant data and three sources of data were chosen: (a) written questionnaires, a quantitative written survey administered to the Quality Department (Appendix 1); (b) group interviews, a method to facilitate group consensus-based decisions that respect the diversity of perspectives within the group; and (c) an examination of existing internal documents that provided relevant secondary data. According to Coghlan and Brannick (2001), a research approach that combines data from various sources and collects it a variety of ways can provide depth and scope to the inquiry. This approach facilitated the rigorous comparison necessary to fulfill the requirements for an action research study and permitted meaning and definition to emerge. These patterns ultimately came to light during analysis and discussion.

Written questionnaires. A questionnaire consisting of closed-ended questions is one of the most time-efficient methods for collecting data. These paper-and-pencil measures are administrated easily to all employees simultaneously, and the data can be analyzed quickly and given a quantitative comparison and evaluation (Morse & Field, 1995). This method is inexpensive, and results can be easily fed back to employees. These questionnaires are easier to analyze than an unstructured interactive interview (Fink & Kosecoff, 1998).

The purpose of the questionnaire was to find out how well the employees understood and applied the company policies and procedures. It also helped to identify if the organization is in compliance with the newly federal government Health Insurance Portability and Accountability Act (HIPAA) laws. Questionnaires were prepared and distributed to all 65 employees. The

survey was collected after one week. There were 24 employees who responded, which is equivalent to a 37% response rate. This rate is acceptable for statistical analysis and derived a meaningful conclusion.

Group interviews. The second data-gathering method used in this research project was the group interview method. This method is a way to reach a consensus in a short period of time through a collective integrated thinking process. When consensus is reached, all participants feel that their ideas, insights, perspectives, and wisdoms have been honored and included in the consensus. No one feels that they have had "to give up something" in order for the group to move forward or in order to reach a decision. When a consensus is reached, each member of the group has ownership of the entire group's decisions, experiences his/her personal wisdom as having expanded, and can now operate in concert with the rest of the group (Krueger & Casey, 2000).

In this action research, it was feasible to conduct the group interviews during work hours, and flexible scheduling facilitated participation. All key discussion points were written down on flip charts, to be recorded at a later time. The meeting room setting was comfortable, which contributed to participants' willingness to share their thoughts and expand upon their statements. The questions were reviewed and deemed appropriate by collaborative team members for use. Four group sessions were conducted in the conference room, each lasting for about 1 hour. The group interviews yielded information and detailed comments that were later transcribed, and then categorized for data compilation and analysis purposes. All raw data was available to the collaborative team for review. Group interviews were initiated by asking 3 basic questions (See Appendix 3). The answers were agreed to by group consensus and these results were then compared to data from the other two sources to ensure its validity. The data was ultimately used to develop interventions and recommendations for improvement.

In order to obtain accurate information and to save time, the collaborative team adopted a more direct approach, the group interview method, one of the commonly used effective group facilitation methods. The collaborative team set up the consensus group interview session for five different departments, give employees another chance to provide additional input that they may not have considered before. We decided to conduct these group interviews by department in a small group environment of about 10 people. For departments with only 2 or 3 people, the employees were combined with other departments. Advantages of this approach included simplicity, directness, and brevity. The benefit of member involvement in this step is that employees can often become a source of internal pressure to change once they become involved in the feedback process (Robbins, 1998).

In this approach, the collaborative team was able to obtain a direct answer and probe more deeply into the areas of concern to each of the participants. During the interviews, the committee also attempted to clarify any information or concerns they may have had. The collaborative team had developed a set of parameters to gain participants' trust in the survey. The participants were guaranteed that their responses would remain confidential. There was over 90% attendance at all of the meetings. At the end of the session, the staff voiced their appreciation for having the opportunity to share their thoughts and feelings toward the company.

Secondary data. Secondary data was used as another source of information. Secondary data provides an indirect way to review, verify and confirm the information gathered by the previous data collection methods (Coghlan & Brannick, 2001). Secondary data is data gathered and recorded by someone else prior to and for purposes other than the current project **(**Coghlan & Brannick, 2001). Secondary sources were used because they can provide different ways of looking at an issue or problem. Paul and Elder (2001) advised that the inclusion of a secondary source should not be overused, especially for literature reviews. However, it can be valuable to

the beginning of document users' research. There are many advantages of using secondary data. These include (a) a low cost to obtain the data, (b) rapid obtainment, and (c) help in shedding light on the problem.

Secondary data was collected using a detailed examination of both internal and external business documents related to the operation of the organization. The collaborative team reviewed several documents including: (a) the administrative policy and procedures, (b) in-patient medical management procedures, (c) out-patient medical management procedures, (d) patient diagnosis medical records, (e) patient admission information, (f) patient discharge plans, (g) IT (Information System) department operating procedures, and (h) accounting and budgeting procedures.

In this action research, some of this information is considered confidential and has to be handled carefully in accordance with the Health Insurance Portability & Accountability Act (HIPAA). HIPAA is a new privacy rule that imposes restrictions on sharing medical information by doctors, pharmacists, insurance companies and others in the health care industry; and creates safeguards for consumers over their own health information. However, these items provided additional perspectives about key issues and concerns as well as solid evidence for cross checking the validity of the documentation system. Secondary data was further analyzed by the collaborative team to ensure its completeness and validity.

Results

Written Questionnaires

In March of 2004, a policy and procedure questionnaire that focused on the level of employee understanding and application of company documentation was developed by the collaborative team. The assessment contained 10 short questions. The response to each question had four levels, ranging from strongly agree to strongly disagree (Appendix 1).

The first survey was designed to evaluate the general knowledge of all employees at PHP toward the policies and the processes/procedures. The results are shown in Appendix 2. The data indicates that 90% of the employees agreed to Questions 2, 6 and 7. That means they believe that the organizational policies and procedures are current, easy to read and understand. About two-thirds of the employees agreed to Questions 3 and 9, meaning they agree that the Department's policies are current; however, an evaluation of the department policies, processes and procedures is needed. Only approximately 50% of the employees in the company are certain on Questions 1, 4, 5, 8, and 10 (see Appendix 1 for details of questions). The data indicates that less than 50% of the employees are aware of where their department's policies, processes, and procedures are located. They are also unsure of the process to update the information. These are obviously the areas that are confusing to the employees. Additionally, they are uncertain where the HIPAA documents are located.

Group Interviews

With the evenly split responses to these five questions (Question 1, 4, 5, 8 and 10) in the first survey, the collaborative team could not determine exactly what employees understood about the current organization's documentation system. Therefore, the collaborative team developed another set of questions that focused on five items where the employees did not have clear opinion. Since there was some similarity in the previous survey questions, the committee decided to combine the similar questions as a group, such as Questions 1 and 5 as A, Questions 4 and 8 as B, and rephrased Question 10 as C. Therefore, in the second round of data collection, we had a total of three group interview questions, namely A, B, and C (see Appendix 3).

Secondary Data

The results from detailed examinations of previous internal reports, policies and procedures were collected using the secondary data method. The results were brought back to the

collaborative team for review and discussion. Consequently, the team developed three interventions based upon the information in order to resolve the problems. The three interventions included facilitating continuing education and training, enhancing team development, and improving staff utilization.

Discussion

Interpretation of the Results

Our first step involved reviewing the results from the three data collection methods: written questionnaires, group interviews and secondary data. We took a critical look at each approach. With the written questionnaire method we recognized several concerns:

1. The survey was done under a tight schedule. Employees may not have had sufficient time to thoroughly think about the questions before answering.
2. The staff may not have recognized how important it was to accurately complete the survey.
3. Survey questions can be interpreted differently by various individuals. This is an inherent risk in any survey. Clearly there are issues surrounding this approach.

Secondary data also has areas of concern. They include:

1. Secondary data had to be retrieved from a variety of sources including e-mail, shared-drives and departmental offices. This negatively impacted the completeness of the data. It was easy to miss something.
2. Secondary data was written in various formats including soft copies, hard copies, notes and memos. This affects the overall consistency of the data.

Finally, the group interview environment, while not perfect, allowed us to more closely assess the employees' answers to questions. We could probe more deeply in areas of particular concern. Additionally, we could observe non-verbal cues and address those issues.

As a result, we determined that the most well-defined and detailed information came from the group interviews. An added benefit was the fact that the results from both the written questionnaires and secondary data collection methods also support our ultimate conclusions.

Since the beginning of the action research project, the collaborative team held twelve separate meetings to discuss all the concerns relating to the project. The collaborative team reviewed and analyzed data, which was collected from the questionnaires, group interviews and secondary data in an attempt to develop a better understanding of the documentation problems. The collected information provided the collaborative team with a clear understanding of both the employees' knowledge about the company's policies and procedures as well as the current documentation system. By collecting the comments and feedback from the group interviews, the collaborative team concluded the following: (a) every employee wants to have a good documentation system and provide high quality services to the customers; (b) employees want to standardize the policies and procedures system but do not know how to begin; (c) employees do not think there is sufficient cohesive teamwork. With over 50% of the employees working outside of the office, it is difficult to maintain a sense of team in striving for a common goal; (d) employees feel that they need a strong coach to guide them through this process; (e) employees are both eager and interested in learning new documentation processes and technology; (f) there is a wide range of employee knowledge and skill sets, and (g) a majority of the employees do not believe they have sufficient time and resources to successfully document the policies and procedures in an ideal manner.

Interventions

Based upon the results from the written surveys and group interviews, as well as an extensive literature research, the collaborative team proposes three potential interventions. These interventions should improve the quality of the health care documentation system by

emphasizing accuracy, accessibility, and shareability. The three interventions are: facilitate continuing education and training, enhance team development, and improve staff utilization.

Facilitate continuing education and training. This is the first intervention method. The questionnaire survey results indicate that 54% of the staff is unaware of departmental policies and procedures. 55% of the staff is uncertain of the location of both HIPAA and departmental policy documentation. Finally, 47% of the employees are unaware of how to update existing policies and procedures. These findings strongly support the need for continuing education and training for employees. Education and training has a great impact on the organization. This is particularly important for the leaders within the organization. An organization's success is also directly related to its leaders' education and training. If PHP wants to succeed in the health care market, it should have a comprehensive solid plan to continue educating and training employees in all departments and at all levels, instead of just relying on a few strong leaders at the top.

The main purpose of health care documentation is to communicate to other members of the health care team the nurse's contribution to the diagnosis, treatment, and care of the patient (Mayer, 2001). Accurate, accessible, and shareable health information is a well-accepted requirement of good health care. Yet, the health care system in the United States continues to accept illegible handwriting and other documentation practices that compromise the quality of this documentation. This problem reduces accuracy, accessibility, and shareability. These quality issues influence five main areas in the health care system: (a) patient safety, which is affected by inadequate information, illegible entries, misinterpretations, and insufficient interoperability; (b) public safety, a major component of public health, is diminished by the inability to collect information in a coordinated, timely manner at the provider level in response to epidemics and the threat of terrorism; (c) health care economics are adversely affected, with information capture and report generation costs currently estimated to be well over $50 billion annually; (d)

continuity of patient care is negatively affected by the lack of shareable information among patient care providers; and (e) clinical research and outcomes analysis are adversely affected by a lack of uniform and reliable information capture. This is needed to facilitate the derivation of data from routine patient care documentation.

Welsh (2003) emphasized the importance of training and education for documentation. If documentation is done with attention to detail, people will clearly show the quality of care their patient received, the outcome of that care, and the treatment the patient still needs. Therefore, all employees at the organization should receive the basic training of good documentation. They must be familiar with the meaning, process and overall importance of documentation, as well as how to prepare good documents. Documentation has two important parts: (a) information captures and (b) report generation. Information capture is the process of recording representations of human thoughts, perceptions, or actions in documenting patient care. It is a device to generate information that is gathered and/or computed about patients as part of their health care history. The challenge of attempting to standardize information capture is an overwhelming task. Although it merits continued attention to work, the more fruitful, near-term, practical goal should be the standardization of report generation, thus facilitating the exchange of information. The current documentation practice at the organization is inadequate in both parts.

People who come to the organization want to be successful, to be a part of the solution, and to make a difference in their life. The vast majority wants to continue on this path. They want to learn, grow, do things right for the people they serve, and remain well prepared for their daily work as well as for the next move. A majority of the staff is interested in expanding their knowledge by learning new skills and processes. Training can also benefit employees by improving their incomes, advancing their careers, and enabling them to grow as people. To ensure high quality and performance consistency, the organization will need to strengthen both

internal staff training and their professional development programs. A health care organization cannot maximize resources without focusing on its most important asset, the employees (Spath, 2002).

The current company policy does not have an educational reimbursement program to financially assist employees in advancing their career. Ultimately this could discourage employees from continuing their professional development. Continuing professional development is a complex concept; the definition and measurement of which should incorporate stakeholder perspectives (i.e., employer, regulatory agencies, and individual) in relation to specific learning contexts. Attributes of the professional identified in literature include knowledge, critical thinking ability, communication skills, leadership ability, participation and use of research in practice, involvement in professional nursing organizations, and reflection skills.

Factors influencing training from the perspective of the individual employee include learner motivation, learner defined needs, financial support, time, space, and peer and family support. Factors influencing professional development from the view of employers include organization-defined needs related to competence, flexibility, cost of provision, and cost effectiveness as an outcome related to patient-focused care and cross-training. More recently, the employer's perspective seems to be driven in part by the impact of restructuring the recruitment and retention of staff. Regulatory agencies, whose purpose is to protect the public, focus on competence and many emphasize mandatory hours of continuing education. Comprehensive understanding of training should incorporate the perspectives of all three stakeholders.

This first intervention includes facilitating on-going education and training programs to help employees to expand their knowledge, skills and improve their work performance for the company continued growth.

Enhance team development. This is the second intervention method. In the health care industry, a lot of job functions require that employees work together as a team. A team is a group of individuals organized to work together to accomplish a specific objective. A team cares about achieving common goals. Teams are formed with the understanding that improvement can be achieved using the skills, talents, and knowledge of appropriate individuals. The benefit of teamwork is available at any level of the organization. The executive team is one of the most visible while teams at the line-worker level may provide the best return on investment.

Teamwork is such a good quality that most groups simply do not reach the measure of a true team. People may work together to reach a goal or do a job, but how effective they are and how they treat each other along the way is always a concern. Working with the VP of Operations, it was determined that teambuilding would be the second focus of the project. To gain a stronger insight into organization change, several academic advisors, whose expertise was directly related, were consulted. This provided a tremendous benefit as faculty members could analyze individual experiences and help to determine a suitable intervention. The intervention was based on the faculty member's experience in the field. This allowed the project to derive a greater benefit from the knowledge and the talent of the faculty members' contribution. The guidance and leadership provided was helpful in engaging the staff of the organization and offering feedback to the VP of operations. Without her assistance, implementation of change would have been difficult. She was able to help prepare and transition the staff for changes and coordinate the meetings for implementation.

Effective care involves teams of health care professionals working together to bring their skills to bear on a particular health problem or patient in order to achieve care goals (Molnar Feiger & Schmitt, 1979). Teamwork has been assessed with multidimensional measures that target concepts such as communication, coordination, and decision-making. Additionally,

measures can be used that target one component of teamwork, such as questionnaires that access only coordination or communication. Understanding teamwork in patient care, finding methods to assess it, and effectively intervening to improve it are going to be increasingly important because of the complexity of patient care today.

The survey indicated that employees are unsure of what is expected of them, assigned members lack needed knowledge, skills, experience, or attitude, and the team process is ignored or improperly managed. During the group interview sessions, the following symptom were observed: (a) employees' roles are not clearly defined, efficient communication procedures do not exist or have not been developed, and administrative procedures either do not exist or are not supportive of the employees' effort, (b) 25% of the project team members are not qualified, professionally or socially, to contribute to the team and thus did not help it to achieve its goals, and (c) 35% of the project team members do not have the specific skills to meet their assigned task responsibilities so that problems faced by the team are not solved effectively nor efficiently.

Therefore, the following corrective action approach is recommended to enhance the awareness of team development: (a) train and implement team facilitators to help teams define roles and responsibilities, (b) take personal interest in the roles of individual team members, (c) initiate or expand a systematic process of skills analysis, training, and development in technical and communication skills for teams and leaders, (d) hold team leaders and facilitators accountable for addressing team problems, and (e) create dialogue on the documentation information.

Improve staff utilization. This is the third intervention method, which we have ascertained by looking at several important parameters including staffing, hiring, education and training. With appropriate adjustments to these components, we believe that PHP will be able to positively influence its future.

In the group interview sessions, we recognized a broad scope of answers to similar questions. For example, employees were asked how to access information regarding HIPAA documentation. Some respondents felt a training session was necessary to explain this. Others believed that placing the information on an intranet or shared drive would be the most effective. This alone is a good indication of a how varied employee skill sets are. To survive in the increasingly competitive markets, health care organizations need employees with highly developed skills (Anthony, 2002). Today's job descriptions for health care workers call for multi-skilled people who can adapt quickly to new technology and learn new ways of performing tasks. Every health care organization faces the challenge of hiring and retaining people who meet these job requirements. As work in health care becomes more complicated and as hierarchical structures give way to lateral organizations, all employees will need retraining and retooling (Irvine Doran et al., 2002). To ensure high quality and consistent performance outcome, the organization needs to strengthen both internal staff training and development programs. This intervention will attempt to address this issue.

On a similar note, the current staff has vastly different levels of knowledge and experience. Both staff knowledge and experience are important and valuable assets in any organization. Workforce development activities enhance employees' skills and help to achieve health service goals. Knowledge and experience are also critical components of successful staff hiring and retention strategies. As a result, widely different degrees in performance outcomes are expected. The level of education (e.g., certificate-prepared, diploma-prepared, baccalaureate-prepared) as well as the amount of experience (e.g., overall in, within an organization, on a particular unit, in a specific role) have emerged as important variables to consider when exploring the links between staffing and outcome achievement.

Finally, in a report of secondary analysis of study data obtained from two studies exploring nurse staffing and patient outcomes, the level of a nurse's experience was directly related to adverse patient occurrences. Patient care units that employed nurses who are more experienced were found to have lower medication errors and fall rates (Blegen, Vaughn, & Goode, 2001). Similar findings were also reported by McGillis Hall et al. (2004). They found that with a less experienced nursing staff, a higher number of wound infections could be expected on a unit. O'Brien-Pallas et al. (2002) reported that clients cared for by baccalaureate-prepared registered nurses (RNs) "had 1.8 times better odds of having improved knowledge scores and 2.2 times better odds of having improved behavior scores" in relation to their health condition. Doran et al. (2002) reported that baccalaureate preparation of nurses, the nurses' experience level, and team nursing were related to the documentation of nursing interventions, which in turn predicted improvements in functional status and symptom distress and patients' perceived health benefit from nursing care. In addition, Tourangeau et al. (2002) reported lower 30-day mortality rates on units where nurses had more years of unit experience. Most recently, Aiken et al. (2003) reported that hospitals with higher proportions of nurses with baccalaureate degrees had lower rates of surgical mortality and failure to rescue. Raising the educational level and experience of employees can help to implement the documentation system and enhance patient care.

In an effort to address all of these concerns, the third intervention proposes a multifaceted approach. First, level the knowledge of the current staffing. Continuing education is always important to an organization regardless of the staffing skill level. However, when there is a great disparity in skill sets among staffs, it becomes even more important to raise the bar for those with lesser qualifications. Second, improve the hiring process for new employees. This would facilitate the process of selecting the right long term candidates for PHP. Finally, while both

improving the educational standards and choosing the right employees are important, overall staffing numbers must also be appropriate for the patient load. By implementing these three components (raising the educational standards of the current staff, hiring the right employees and establishing appropriate levels of staffing) simultaneously, the company should accomplish the necessary changes to succeed.

In the following paragraphs, I will attempt to clarify some of the details of this intervention. Substantial studies suggest that staffing is an important parameter to capture in the study of outcome research. Measures of staffing should capture the proportion of RNs; the staff mixes; nursing hours per patient day; the proportion of full-time, part-time, and casual staff; and the level of education and experience of the staff. This can enable management to capture the full impact of staffing on patient clinical and system quality outcomes. Since today's business has become more competitive, the impact of staffing in relation to the intended effects of patient care should be examined. Once the initial assessment is complete, every effort should be made to stabilize the proportions of qualified personnel. This will probably require a greater number of employees with a higher level of education. Whether through training or recruiting, it is critically important to have adequately qualified staffing at all times. If a portion of the staff remains under qualified, it is critical to retain higher-level employees who can compensate for this education and experience shortfall.

A recurring theme in the group interview sessions was the lack of resources and time in the workplace. Nearly every department mentioned this was a barrier to success. In the long term, the best way to achieve substantial improvements in the quality of care would be to change the structure of the whole system. Each and every process would be evaluated for both efficiency and value. If properly managed, this could have positive ramifications on both staffing levels and morale.

Lastly, based upon the information collected in both the survey and group interviews, the company can improve the current hiring practice. Sometimes, a manager's life looks like a running battle, frequently fought with inherited troops of marginal competency. Negative employee attitudes can also play a role. Few ask for or are given the opportunity to clean house, and less than 20% are encouraged to attend a seminar or training in hiring practices. Bad hires affect the company, the individual, and the hiring manager. For this reason, the hiring managers should master techniques and methods to see below the surface of resumes. To do this, there are three important elements to consider in a good hire.

1. Ability to do the job: Often the hiring decision is on ability alone. While important, it is merely the first step in ensuring consistently successful hires.
2. Willingness to do the job: There can be a distinct gap between ability and willingness to do the job. Utilizing the last two years of hiring records at PHP; a 26% turnover rate has led to accusations of lack of professionalism. This lack is merely the symptom of a hiring problem. Many health care professionals are hired because they appear to have the ability to do the job. This does not always guarantee the self-confidence and determination necessary for success in this business.
3. Manageable once on the job: The third element of a candidate's evaluation should include a determination of whether the candidate is manageable. An individual, who is both willing and able, but not easy to manage, will not be an effective long-term employee. Additionally, this individual will not contribute to the team atmosphere PHP is trying to promote.

At some point, PHP may also need to engage external resources, such as hiring consultants. These experts will help them to solve problems, provide interim staffing, offer coaching to retain good employees, supply expertise in documentation development and

implementation, and develop a train-the-trainer program. Since these are short-term assignments that are very definable in scope and outcome, the cost would not be huge and can be controllable. After that, the company needs to monitor progress by paying attention to both the “burn rate” and the “return rate”. The burn rate is how quickly the fees are being incurred by the resources-billing speed. The return rate is how quickly the company starts to see a return on its investment in the resources. Iyer and Camp (1995) have strongly addressed professional responsibility and accountability as among the most important reasons for good documentation.

Recommendation. The collaborative team proposes the third intervention, improve staff utilization, as the best solution for this project. Currently, the organization has a rich resource of employees with both vast knowledge and experience. Each of the employees has an area of expertise and, in many cases, extensive work experience. The organization can expand its current brown bag education program to better utilize these assets. This program emphasizes the sharing of employee knowledge and encourages learning via the personal experiences of co-workers. This educational program will also provide multiple benefits as discussed by Huszczo (1996). It will motivate the facilitator to better prepare the teaching materials for sharing. At the same time, it will provide a learning opportunity for those employees who want to know more about the job function and ultimately want to advance their knowledge to better serve customers (Lee & Krayer, 2003). Using the same strategy, the organization should ask those physicians who are also employees to participate in this program and conduct educational seminars in their areas of specialization. Outside of the organization, PHP can work with pharmaceutical companies by asking them to join and/or to participate in this program. By supporting the program, they will be acting as partners working for the common goal of better patient care. Most of them already have a very rich educational program with well-prepared learning materials, so this will help the employees to advance their knowledge and provide some practical experience on how to

document the processes, and improve both internal and external communication. All of these activities should improve the working environment and employees' morale.

From the perspective of the company, PHP should start an educational reimbursement program. A limit can be set on the total amount of dollars available for employees who are interested in enrolling in college courses or training organizations. This can come with an agreement that after they complete their training, they will share the learning experience with the other employees. The company should establish the policy of allowing overtime for the seminars, workshops and other educational activities as a part of employee benefits.

Finally, the company should select a number of outstanding performers from its employees and prepare them to advance to a leadership role. The internal promotion concept should make employees realize that their contribution, hard work and effort will be recognized and appreciated by the company. Additionally, there should always be an opportunity for employees to advance their careers if their performance exceeds average expectations. These proposed recommendations should reduce the expensive burden of hiring additional full-time permanent personnel. It should also enhance the work environment, improve the employee morale, and ultimately help the company to keep in alignment with the future challenges of the business. In summary, the third intervention (raising the educational standards of the current staff, hiring the right employees and establishing appropriate levels of staffing) could be accomplished through a combination of the following initiatives. They include: leveling staffing knowledge to ensure adequate education and training levels, using best hiring practices to employ the best candidates and analyzing organizational performance to facilitate process improvements.

After presenting the recommendations to the management committee, I left the company for another opportunity. Later on, I learned from a former coworker that, due to the business decline, this action research project did not receive high priority for implementation.

Reflections

Evaluation and recommendations of the interventions were based upon the feedback from the survey questionnaires, the results from the group interviews, and extensive research literature. A detailed analysis of the action research experience is summarized below.

Collaboration of team members. Although some difficulties and conflicts were encountered throughout the action research project, no team member missed meetings or chose not to be on the team for any reason. Further into the project, it was evident that one of the collaborative team members, to some degree, lacked the skill and knowledge to go beyond having conversations about the organization's need to achieve a highly efficient documentation process. Members of the collaborative team consist of the VP of operations, In-patient Medical Management Manger, Quality Manager, Human Resources Manager and Project Assistant. Their thinking processes might be a little different from what was used in this project.

Team dynamics play an important role in this project. Under the current work circumstances, two of the collaborative team members spent a great deal of time working in hospitals and clinics to support the health professionals including doctors and nurses. The rest of the team members were working in an office building. Even though the daily face-to-face interaction was not common and only occurred during meetings and special occasions, the team could still communicate efficiently through e-mail, pages, phones and faxes to share information, coordinate work efforts, and make joint decisions. Overall, the collaborative team functioned well and each of the members offered insights into the process and assisted the effort to facilitate the group interviews.

Leadership. Effective leadership of the change process in the health care environment requires reducing resistance to change, activating positive actions on the part of the health care teams, and improving performance through staff participation. In this action research project, I discovered my leadership skills and style. At the beginning of the project, I wanted to play the role of being the resource person for the team. Soon I discovered this approach was not working well because most of the collaborative team members did not have experience writing policies and procedures. They peppered me with all kinds of questions. They were very concerned about how to do the document and whether they had the ability to complete such a challenging task successfully. They asked questions about what format to use, how much to write, how much detail is enough, font size, and font style. These never-ending questions seemed rather basic in nature. One member seemed most concerned about the effects of the outcome. For example, this member asked whether everyone would use the documents when finished, whether the documents had any value, and whether we should put those documents on-line. Basically, this member seemed to want assurances from me that he was doing the "right" thing. Therefore, I changed my leadership style to become more closely involved in all the daily activities. I routinely held meetings to discuss problems—if a staff member could not perform a particular job, I would show him or her how. For those who were uncertain of their competencies, I provided reassurance. I tried to spend time teaching individuals and helping them on their assignments and, at times, I reminded people of the correct ways to do their work. My goal was to see, in the future, that all documents were clearly spelled out and employees could follow step-by-step procedures clearly.

At the first meeting, I noticed that a few members felt resistant to change. As stated by Carter (2005), one of the most challenging obstacles to overcome in any organizational transformation effort is the resistance encountered during change. Resistance can be due to any

combination of factors, including psychological, technological, or cultural fears; security or economic concerns; or fear of the unknown (Napolitano & Henderson, 1998). Fear affects all team members in specific ways (Marquis, 2006). Members who were generally supportive accepted change more readily if they saw that it would bring about new benefits for the patients, the company, and the individual team members. Therefore, in my presentation to the team, I focused on the benefits instead of processes to gain interest and confidence.

In this action research project, I also learned that my behavior had some influence on the team members. For example, traditionally PHP employees had a tendency to be late for meetings. Since this project started, most employees changed their habits to be punctual to all meetings. As I spoke with other team members, they all felt that punctuality favorably impacted the organization meeting style. I knew my job was to accomplish the documentation functions by motivating the team. According to Northouse (2001), "The two critical leadership functions are to help the group accomplish its task and to keep the group functioning. Teams are organizational groups composed of members who are interdependent, who share common goals, and who must coordinate their activities to accomplish these goals" (p. 161).

A number of constantly challenging issues that exist in the health care industry have been identified such as the rapidity of change, workforce shortages, the free-agent mentality, increasing diversity in the workplace, the need for new organizational structures, the turbulent business environment, and the need for managing one's own energy capacity.

Learnings. If the project were to be repeated, I would make a couple of changes to the process. They would include: (1) allocating time and resources to improve the quality of the documentation system, and (2) educating the collaborative team.

Management must remember that sufficient time and resources must be allocated in order to achieve the high quality documentation system. A standardized document template should be

developed for the employee to follow in the preparation of various documents, such as patient admittance procedure, patient care procedure, patient discharge plan, etc. Once documentation processes are developed, a formal process should be implemented for approval and release of each document. The greatest benefits of a comprehensive documentation system would include maintaining consistency among documents and better support evidence during regular external agency audit reviews.

The organization must also realize that a consensus is a conservative process. Because it takes a new consensus to change an existing directive, directives tend to stand once made. Some people were not comfortable with this conservatism because it can be so hard to change the process or ways for doing things. To address this new change, we put a review period on some of the proposals, requiring that the directive be renewed after time has passed. This encouraged the group to experiment with new ideas without fear of being blocked into a risky or unfamiliar path. It also provided an easy mechanism for incorporating new learning over time.

The organization has complex, yet undocumented, hierarchies that employees are expected to understand and respect. These are the political aspects of the organization that employees learn by experience working in the organization. It is important to understand the political nature of an organization, as it impacts how, why, and when employees do their work.

A strength derived from this project involves the group interview method. The group interview method was used in this research project to require a consensus decision. Consensus decision-making is a powerful tool for building nonhierarchical teams that can produce the best possible collaborative thinking. It is not suggesting leaderless teams and open-ended processes with no controls; rather, it suggests well-led processes that invite, engage, and expand capability and that lead to an effective and just way to make decisions, develop initiatives, and solve problems. Consensus is the process of synthesizing the wisdom of all participants into the best

decision possible at the time. It is not unanimous agreement, and in fact, participants may consent to a decision that they disagree with, but one they recognize meets the needs of the group or the situation. The goal of consensus is to come to a decision that everyone will agree to. Supporters of a decision usually include true supporters of that position, those who do not really care either way, and those who do not fully support the position but do not wish to stand in the way. The PHP business philosophy strongly supports group consensus decision-making. By utilizing the group interview method, our team was able to meet this underlying need of the organization.

Implications. The action plan chosen for a good documentation system and its successful implementation stemmed from the action research conducted in this project. Whyte (1989) suggested that action research explicitly and purposely becomes part of the change process by engaging the people in the organization in studying their own problems in order to solve those problems. These changes affect the organization's culture, processes, and learning.

If this action research were implemented, this would help the organization both to prepare for the future and to meet new challenges head on. As predicted, by the end of the 20th century, sky-high medical costs had broken the back of the health care system and managed care has arrived, which puts the business of health care primarily in the hands of insurance companies and regulatory agencies. As a result, there are now increased demands from payers and regulators for stricter adherence to governmental and third party payer rules and regulations.

Conclusion

Documentation is a vital tool for communication among health care team members. Frequently, decisions, actions, and revisions related to the patient's care are based on documentation from various team members. A well-prepared policy and procedure or medical record shows the high degree of collaboration among health care team members. Proper

documentation is also important for many other reasons. One of the most compelling reasons for professionals to develop good documentation practices is to establish individual professional responsibility and accountability.

In this action research, three interventions were developed to address these issues. The third intervention of improving staff utilization was recommended for implementation. The selected proposed solution was developed based upon current health care business needs, market trends, and goal and objectives of the organization.

Documentation technology will continue to change rapidly, which makes it all the more essential for one to understand and explore new approaches as documentation systems become more efficient and communication improves among health care personnel. New technology and new ways of organizing one's observations should help save time, eliminate confusion and, most importantly, improve patient care. With a proper implementation process and closely monitored and analyzed outcomes, we believe the action research would bring the organization to a higher level of recognition and greater success in the health care environment.

This action research project has assisted me as I seek to integrate my final coursework into my work life. Additionally, it has given me a forum in which to articulate concepts of active leadership.

References

Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silbur, J. H. (2003). Educational levels of hospital nurses and surgical mortality. *Journal of the American Medical Association, 290(12)*, 1617-1623.

Anthony, W. P., Kacmar, K. M., & Perrewe, P. L. (2002). *Human resource management: A strategic approach* (4th ed.). Mason, OH: South-Western (Thomson).

Asprey, L., & Middleton, M. (2003). *Integrative document and content*. Hershey, PA: Idea Group Publishing.

Blegen, M. A., Vaughn, T., & Goode, C. J. (2001). Nurse experience and education. *Journal of Nursing Administration, 31(1)* 33-39.

Brennan, R., Leape, L., & Laird, M. (1991). Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice study. *New England Journal of Medicine*, 324, 370-376.

Buppert, C. (2000). *The primary care provider's guide to compensation and quality*. Gaitherburg, MD: Aspen Publisher.

Carter, L., Ulrich, D., & Goldsmith, M., (2005). *Best practices in leadership development and organization changes.* San Francisco, CA: Pfeiffer Publishing.

Coghlan, D. & Brannick, T. (2005). *Doing action research in your own organization.* Thousand Oaks, CA: Sage Publications.

Cummings, T. G., & Worley, C. G. (2001). *Organizational development and change (7th ed.)*. Mason, OH: South-Western College Publishing.

Doran, D., McGills Hall, L., Sidani, S., O' Brien-Pallas, L., Donner, G., Baker, G., et al. (2002). Nursing staff mix and patient outcome achievement: The mediating role of nurse communications. *The Journal of International Nursing Perspectives, 1(2-3)*, 74-83.

Fink, A., & Kosecoff, J. (1998). *How to conduct surveys: A step-by-step guide* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Guido, G. W., (2006). *Documentation in action*, Ambler, PA: Lippincott Williams &Wilkins.

Haas-Wilson, D. (2003). *Managed care and monopoly power*. Cambridge, MA: Harvard University Press.

Harrison, D. (1999, October), *Evaluation and management service codes criteria for billing medicare*. Paper presented at Kansas State Nurses Association, Wichita, KS.

Huszczo, G. E. (1996). *Tools for team excellence: Getting your team into high gear and keeping it there*. Palo Alto, CA: Davies-Black Publishing.

Irvine Doran, D., Baker, G., Murray, M., Bohnen, J., Zahn, C., Sidani, S., et al. (2002). Achieving Clinical Improvement: An interdisciplinary intervention. *Management Review, 27*, 42-56.

Iyer P., & Camp N. (1995). *Nursing documentation: a nursing process approach*. St Louis, MO: Mosby Year Book.

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Landfair-Mueller, S. (2003). *MSM 621 Constructing the problem statement.* Denver, CO: Regis University. CD

Lee, W., & Krayer, K. (2003). *Organizing change*. San Francisco, CA: John Wiley & Sons.

Mangano, J. (1997) Getting real with outcomes, *1998 Medical outcomes & guidelines sourcebook*, New York, NY: Faulkner & Gray.

Marquis, B., (2006). *Leadership roles and management functions in nursing: theory and application.* Philadelphia, PA: Lippincott Williams &Wilkins.

Mayer, B., (2001). *ChartSmart*: *the A-to-Z guide to better nursing documentation*. Springhouse, PA: Springhouse.

McGillis Hall, L., & Doran, D. (2004). Nurse staffing, care delivery model and patient care quality. *Journal of Nursing Care Quality, 19(1),* 27-33.

Meiner, S. (1999). *Nursing documentation*. Thousand Oaks, CA: Sage Publication.

Miller, S. (2000). *Patient care for the nurse practitioner*, 4(1) 48-51.

Molnar Feiger, S., & Schmitt, M. H. (1979). Collegiality in interdisplinary health teams: Its measurement and its effects. *Social Science and Medicine, 13A,* 217-229.

Morse, J., & Field P. (1995). *Qualitative research methods for health professional*. Thousand Oaks, CA: Sage Publications.

MSM 696 (2005) Model of Applied Action Research Module, Regis University.

Napolitano, C. S., & Henderson, L. J. (1998). *Leadership odyssey: A self-development guide to new skills for new times*. San Francisco: Jossey-Bass.

Northouse, P. G. (2001). *Leadership: Theory and practice* (2nd. ed.). Thousand Oaks, CA: Sage Publications.

O'Brien-Pallas, L., Irvine Doran , D., Murray, M., Cockerill, R., Sidani, S., Laurie-Shaw, B. et al. (2002). Evaluation of a client care delivery model, Part 2: Variability in client outcomes in community home nursing. *Nursing Economics, 20,* 13-23.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Paul, R. & Elder, L. (2001). *Critical thinking: tools for taking charge of your learning and your life,* Upper Saddle River, NJ: Prentice Hall.

Pearce, J. A., II, Robinson, R. B., Jr., & Sandberg, M. E. (1989). *Change and organization development.* Boston: Irwin.

Reason, P., & Bradbury, H. (2001), *Handbook of action research*, Thousand Oaks: CA: Sage Publications.

Robbins, S. (1998). *Organizational behavior*. Upper Saddle River, NJ: Prentice Hall.

Spath, P. L. (Editor). (2002). *Guide to effective staff development in organizations: a systems approach to successful training*. Francisco, CA: Jossey-Bass AHA Press.

Tourangeau, A. E., Giovannetti, P., Tu, J. V., & Wood, M. (2002), Nursing-related determinants of 30-day mortality for hospitalized patients. *Canadian Journal of Nursing Research, 33(4)*, 71-88.

Welsh, W. (2003). *Complete guide to documentation*, Springhouse, PA: Lippincott Williams &Wilkins.

Whyte, William F. (1989). *Advancing scientific knowledge through participatory action research*. Sociological Forum, 4, 3: 367-85.

Zelman, R., & Berenson, R. (1998). *The managed care blues and how to cure them*, Washington, DC: Georgetown University Press.

Appendix 1

Policies & Procedures Survey Questions

MY DEPARTMENT (Check one)

□ Administration □ Accounting □ Case Management
□ Contracting □ Executive □ Information Systems
□ Medical Management □ Practice Quality □ Provider Relations

Please review the following statements and rate each one by using a X in the box

	Strongly Disagree	Disagree	Agree	Strongly Agree
POLICIES	1	2	3	4
1. I am aware of where my department's policies are located				
Additional Comments:				
2. My department's policies are easy to read and understand				
Additional Comments:				
3. My department's policies are current				
Additional Comments:				
4. I am aware of the process to update my department's policies				
Additional Comments:				
PROCESSES/PROCEDURES	1	2	3	4
5. I am aware of where my department's processes and/or procedures are located				
Additional Comments:				

6. My department's processes and/or procedures are easy to read and understand				
Additional Comments:				
7. My department's processes and/or procedures are current				
Additional Comments:				
8. I am aware of the process to update my department's processes and/or procedures				
Additional Comments:				
GENERAL	1	2	3	4
9. An evaluation of my department's policies, processes and procedure is needed				
Additional Comments:				
10. I am aware of where HIPAA documents are located				
Additional Comments:				

OPTIONAL:

11. Please check the appropriate box for your length of employment.

□ <6 months □ 6 months but < 1 year

□ 1 year but < 3 years □ Over 3 years

Appendix 2

Policies & Procedures Survey Results

	% Agree	% Disagree	% Response
POLICIES			
1. I am aware of where my department's policies are located	41.7	58.3	36.9
Additional Comments:			
2. My department's policies are easy to read and understand	91.7	8.3	18.5
Additional Comments:			
3. My department's policies are current	71.4	28.6	21.5
Additional Comments:			
4. I am aware of the process to update my department's policies	55.0	45.0	30.8
Additional Comments:			
PROCESSES/PROCEDURES			
5. I am aware of where my department's processes and/or procedures are located	50.0	50.0	36.9
Additional Comments:			
6. My department's processes and/or procedures are easy to read and understand	92.9	7.1	21.5
Additional Comments:			

7. My department's processes and/or procedures are current	92.9	7.1	21.5
Additional Comments:			
8. I am aware of the process to update my department's processes and/or procedures	55.0	45.0	30.8
Additional Comments:			
GENERAL			
9. An evaluation of my department's policies, processes and procedure is needed	65.0	35.0	30.8
Additional Comments:			
10. I am aware of where HIPAA documents are located	45.5	54.5	33.8
Additional Comments:			

OPTIONAL:
11. Please check the appropriate box for your length of employment.
□ <6 months □ 6 months but < 1 year
□ 1 year but < 3 years □ Over 3 years

Appendix 3

Group Interview Questions

A. I am aware of the locations of my departmental policies and procedures.

a) What keeps you from knowing of the location of your departmental policies?

b) What are the ramifications of not knowing the location of your departmental policies?

c) What is the best way to ensure that everyone knows the location of the location of the policies?

B. I am aware of the process to update my departmental processes and/or procedures.

a) Can you describe the process used to update your departmental processes and/or procedures?

b) Why do you think you should be aware of the process to update your departmental processes and/or procedures?

c) What would help you to better learn the process to update your departmental processes and/or procedures?

C. I am aware of where HIPAA documents are located.

a) How was information concerning the HIPAA document communicated to you?

b) What would help you to learn the location of the HIPAA documents?

c) How did you receive your training on HIPAA documentation?