BACKGROUND
It has been found that providing pre-procedure information to patients in written form increases the patients’ comprehension of the procedure. It has been further found that providing patients with incomplete information at discharge can result in patient harm.

OBJECTIVES
- Encourage patients to become active and informed participants in their own care.
- Provide for the ability to reprint individualized patient instructions if those documents become lost or misplaced.
- Enhance the process for determining patient discharge status and thus hospital bed availability.

METHODS
The Cleveland VA Medical Center employed an Automated Informed Consent Application (AICA) to add a patient signature block to various pre-operative (pre-op) instructions and discharge instructions. Patients would sign their instructions acknowledging receipt and understanding of the instructions using a digital signature pad. The patient would then receive a printed copy of the instructions containing their signature. The AICA would automatically post a note in the patient’s Electronic Medical Record (EMR) indicating that he or she received the instructions. The AICA would also place a digital image of the signed instruction document into the medical center’s Document Management System.

RESULTS
In 2008, the Cleveland VA Medical Center utilized the AICA to produce and distribute 6,682 sets of discharge instructions and 2,329 sets of pre-procedure instructions – increases of 246% and 18% over 2007, respectively.

CONCLUSIONS
Use of an AICA to prepare and document both pre-op and discharge instructions has improved patient care and process efficiency. Detailed instructions are helpful to families and to those care providers who may assist the patient at home. The AICA provides real-time information to the EMR and is thus instantly available to both members of the care team and to the Bed Control Staff. Patient reaction to the system has been very positive. Feedback has included comments such as, “Nobody told me that I had to do that.” Those types of comments help providers know what types of information they need to reinforce with certain types of patients. The ability to store signed instructions in a document management system is crucial when serving patients from a wide geographic area – lost or misplaced documents may be easily accessed remotely via the EMR and reprinted in the local, community-based outpatient clinic.

FUTURE DIRECTION
A tool for assessing patient understanding has been developed for use with any patient document made available via the AICA. Deployed in late 2008, the tool allows the provider to electronically complete an 11-step process documenting learning preferences and assessment of understanding. The utility of that assessment tool for better evaluating and documenting understanding of the printed materials received is presently being evaluated.

TEAM
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REFERENCES