



Use of the SGNA Minimum Data Set in the Clinical Area

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Elements of the SGNA Minimum Data Set (MDS) are found in the procedure documentation gastrointestinal (GI) nurses complete about each patient. From the preprocedure intake until discharge, bits of information are collected that may be used to compare patients over a span of time, support efforts to improve the care delivered, and satisfy the requirements of regulatory bodies. Often the same information is collected at numerous institutions, though key elements may not always be called by the same name. The act of developing and defining those elements, however, has the potential to serve GI nurses and patients in efforts to standardize documentation, improve care, and provide benchmarks from facilities across the nation.

Standardized Documentation

Many institutions have used the Society for Gastroenterology (SGNA) standards for documentation to develop pathways that document the care a patient receives from admission to discharge. Using the SGNA Minimum Data Set will further standardize documentation because the same terms will be used to describe what is done “speaking the same language.” Frequently, different terms are used in different parts of the country to describe the same thing. The act of gathering these terms, identifying the similarities, and establishing a minimum term to describe that activity forms the foundation of the SGNA MDS.

Minimum Data Set and Electronic Documentation

As electronic documentation makes its way into an increasing number of healthcare facilities, the need for a MDS becomes more apparent, necessary, and critical. What does this mean to you as a nurse manager or staff nurse? Electronic documentation not only improves efficiency and decreases the potential for errors, but also allows nurses to collect data about the care they provide, the manner in which it is delivered, and variances which may occur. This information in turn allows us to determine important aspects of practice such as staffing levels, medication and

supply use, and trends. It also provides a language for quality indicators and activities directed toward quality improvement, outcome measurement, and benchmarking.

Standards for documentation and data collection, as well as thinking about what information is needed in the future, are important considerations for building an electronic documentation program. These uses include but are not limited to benchmarking, process improvement, scheduling criteria, and research. Data collection is even more important when working in a health system of several hospitals or clinics, or there is a desire to participate in benchmarking. The MDS forms the framework of the data you wish to collect.

The process of implementing electronic documentation software in an endoscopy facility involves considerable planning prior to the “go-live” date. Careful consideration should be given to the information one wishes to capture, mandatory elements for state licensure and JCAHO regulations, as well as meeting the requirements of the facility or health system. Also important are the SGNA standards for documentation and the SGNA MDS.

A Personal Implementation Experience in the Clinical Area

As nurse managers in a large health system consisting of several hospitals, each with an endoscopy department, my colleagues and I had already collaborated on the development of a standardized documentation pathway for the endoscopy department. When the information technology department decided to implement the software in stages across the system, we thought our task would be simple.

First, a software product designed specifically for the GI endoscopy department was selected. Prior to implementing the nursing documentation software, we spent several days working with the vendor to determine which information we felt most important and agreed upon a standardized set of criteria (e.g., minimum data set). For example, the criteria for the Aldrete scoring must all be the same. So what do scores of 0, 1, and 2 mean? Does administration of the medications or introducing the scope signify the procedure initiation? And is the end of the procedure indicated when the scope is removed or when the endoscopist walks out of the room? Verification of

the procedure to be performed, in accordance with the “Safest in America Program—Safe Site Determination” now required by the JCAHO (http://www.jcaho.org/accredited+organizations/patient+safety/05+npsg/05_npsg_hap.htm), would also be an important part of our data collection. These elements would be the framework for data collection for review and reporting to various regulatory bodies.

The most obvious information to be collected was included in our paper documentation pathway. We soon realized we had to determine how information such as equipment identification, Aldrete scoring, and medications for each individual procedure from admission to discharge would be captured. While the software vendor had already designed some of the basic fields, making our assignment much easier, it still represented a monumental task to our group. Access to SGNA’s MDS would have made our task much easier!

Data Collection

The data we collect from our daily practice facilitates continuity of care, assists in determining the relationship of cost to quality effectiveness, and supports calculation of management and reimbursement costs of clinical functions. Retrospective review of paper charts, however, is time consuming and tedious. As documentation software is introduced

into endoscopy departments, it is more important than ever to establish a standardized set of data elements that will facilitate collection of useful and necessary data. The advantage of using the SGNA MDS is that it establishes many of those standardized elements SGNA members already collect on paper.

From time to time, SGNA members have discussed benchmarking among facilities. These endeavors have produced some interesting results. To accomplish that task, however, the researchers had to first agree on what information they were looking for and then collected that data in a standardized manner. The SGNA MDS used these strategies at a national level to establish the minimum data set. The resulting information and recommendations will make comparing the care endoscopy nurses provide less complicated and more accurate.

Conclusion

The SGNA MDS has the potential to address some of those regional differences GI nurses often discuss. It creates a roadmap or framework for the development of the necessary requirements for a comprehensive clinical documentation pathway. It will also facilitate establishing elements that can be included in documentation software.