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Walden University
2026

Executive Summary: Staff Education Project

The Importance of Timely Documentation of Updates on Patients' Records in Improving Documentation Accuracy and Reducing Clinical Errors at the Home Health Agency

by

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MS, Western Governor University, 2022

BS, Western Governor University, 2020

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Summary

Timely and accurate documentation is essential to patient safety, care coordination, and risk reduction in home health care. In this Doctor of Nursing Practice project, I implemented an evidence-based educational intervention to improve documentation practices among clinicians at a pediatric home health agency in the southwest United States. Guided by the analyze, design, develop, implement, and evaluate (ADDIE) instructional design model, I conducted the project to evaluate whether focused education would improve documentation accuracy, consistency, and timeliness. A targeted literature review on electronic health record (EHR) best practices, structured documentation, and patient safety informed the development of five training modules addressing knowledge, workflow integration, and accountability. The intervention included a blended approach combining in-person sessions, e-learning modules, case-based learning, and reflective activities. Baseline assessments revealed documentation delays and inaccuracies. I evaluated project outcomes using knowledge assessments, chart audits, error tracking, staff surveys, and reflective journals. Results showed a 50% reduction in medication discrepancies, greater than 95% documentation accuracy, and 89.3% of records updated within 24 hours. The project demonstrates that structured, multimodal education improves documentation quality in home health care. Sustainability strategies include integration into annual competencies, refresher training, routine audits, and ongoing leadership support, offering a scalable model for enhancing patient safety. Accurate, timely documentation promotes equitable care for vulnerable populations by reducing errors, supporting continuity, and minimizing disparities from fragmented records.

Background

Timely and accurate documentation is essential to patient safety, continuity of care, and effective communication across interdisciplinary teams particularly in home health settings, where clinicians frequently work independently and rely on up-to-date records to guide clinical decision-making. Delayed, incomplete, or inaccurate documentation contributes to medication discrepancies, missed interventions, and preventable clinical errors, all of which threaten patient outcomes (Demsash et al.,2023). Baseline data from the project site pediatric home health agency demonstrated inconsistent real-time charting practices, outdated medication lists, and gaps in assessment documentation that placed patients at increased risk for harm. Evidence from multiple studies supports that documentation delays and omissions lead to safety events and workflow inefficiencies, while structured documentation tools, EHR optimization, and education on best practices significantly improve accuracy and decrease error rates (Albagmi, 2021; Demsash et al., 2023; Ebbers et al., 2022).

Given the link between documentation quality and clinical outcomes, early intervention through staff education is critical. Ebbers et al. (2022) demonstrated that targeted training on EHR workflows, standardized templates, and documentation expectations improves clinical accuracy and reduces preventable errors. The purpose of the current project was to develop, implement, and evaluate an educational program aimed at strengthening staff knowledge, awareness, and competency regarding timely documentation. The practice-focused question asked whether educating home health clinicians on the importance of timely documentation would reduce medication

discrepancies by 25%, increase documentation accuracy to 95%, and ensure that 90% of patient records were updated within 24 hours of a visit.

The importance of timely documentation in improving documentation accuracy and reducing clinical errors in home health care is supported by a growing body of moderate-to-strong evidence. Multiple peer-reviewed studies have demonstrated that delays, omissions, and inaccuracies in EHRs are directly associated with medication discrepancies, communication failures, and increased risk of adverse patient outcomes. Albagmi (2021) and Ebbers et al. (2022) found that standardized documentation processes improved EHR use, and workflow integration significantly reduced documentation errors and enhanced clinical decision-making. In addition, Demsash et al. (2023) identified timely documentation as a key patient safety strategy, particularly in settings where care is delivered across shifts and by multiple providers, such as home health.

The findings of Portela Dos Santos et al. (2022) support education-based interventions as an effective and sustainable approach to improving documentation practices. Systematic reviews and quasi-experimental studies indicated that structured, multimodal education combining didactic instruction, case-based learning, and ongoing competency reinforcement leads to measurable improvements in documentation accuracy, timeliness, and staff accountability (Wilesmith et al., 2025; Strube-Lahmann et al., 2022). The interventions have been shown to reduce medication discrepancies and documentation-related errors while improving interprofessional communication and continuity of care. Overall, the strength of the evidence is moderate to high according to appendices G and H, with consistent findings across multiple studies supporting timely

documentation education as a best practice for reducing clinical errors and enhancing patient safety in home health care settings.

Staff Education Project Development

Participants included 123 home health clinicians employed at a pediatric home health agency in the southwest United States, consisting of 68 registered nurses, 40 licensed vocational nurses, and 15 allied health clinicians. The ADDIE instructional design model was used to guide the development, delivery, and evaluation of an evidence-based documentation training program for home health staff. The practice gap identified at the agency involved inconsistent documentation practices, limited formal training on documentation standards, and workflow challenges that contributed to delayed updates in the electronic health record. The ADDIE model provided the project with a structured, iterative framework, ensuring the educational intervention was grounded in current evidence, aligned with agency expectations, and feasible for clinicians working in the field.

I collected evidence using a mixed-methods approach to comprehensively evaluate the effectiveness of the educational intervention. Quantitative data included pre- and posttest knowledge assessments, standardized chart audits, documentation timeliness reports, and medication discrepancy tracking. I used knowledge assessments to measure clinicians' understanding of documentation standards, EHR workflows, and patient safety implications. Chart audits were employed to evaluate documentation accuracy, completeness, use of required EHR templates, medication reconciliation, and compliance with the 24-hour documentation requirement. Documentation timeliness data and medication discrepancy reports were extracted from the EHRs and quality assurance

records at baseline and postintervention. In the analysis phase, I examined documentation practices, learning needs, and workflow constraints among clinicians at the pediatric home health agency. Through baseline EHR audits, leadership meetings, and informal staff feedback, recurring issues were identified, including delayed charting, incomplete assessments, medication discrepancies, and inconsistent use of EHR templates. Clinicians reported limited formal training on documentation standards and expressed a need for practical tools to support real-time documentation during home visits (see Ebbers et al., 2022).

I analyzed quantitative data using descriptive statistics and pre/postintervention comparisons to assess changes in participants' knowledge, documentation accuracy, timeliness, and error rates. The evaluation process was designed to determine the effectiveness of the educational intervention in improving documentation accuracy, timeliness, and patient safety outcomes. Evaluation measures included pre- and postknowledge assessments, standardized chart audits, documentation timeliness reports, medication discrepancy tracking, staff surveys, and reflective journals. Outcomes were compared to project goals of a 25% reduction in medication discrepancies, 95% documentation accuracy, and 90% of records updated within 24 hours.

Results

Postintervention findings demonstrated measurable improvements across all outcome measures. Medication discrepancies were reduced by 50%, exceeding the project goal of a 25% reduction. Documentation accuracy improved to 96.4%, surpassing the target of 95%. Documentation timeliness also increased substantially, with 89.3% of clinical records completed within 24 hours, closely approaching the 90% benchmark.

Participants' knowledge assessment scores improved significantly from a pretest mean of 68.4% to a posttest mean of 91.7%. Collectively, the results indicate that the intervention was effective in improving clinician knowledge, documentation accuracy, timeliness, and patient safety outcomes. Also notable was chart audits conducted after the training that revealed enhanced completeness of assessment fields, more accurate medication lists, improved use of required EHR templates, and more consistent documentation of patient changes and plan-of-care updates. Additionally, error reports showed a reduction in documentation-related issues, including fewer incomplete notes and decreased medication discrepancies. Staff surveys indicated positive changes in attitudes toward accountability and professional responsibility in documentation, with participants reporting increased confidence in performing real-time or near-point-of-care charting. Reflective journal entries further highlighted improved awareness of how documentation practices influence patient outcomes, communication, and workflow efficiency. Collectively, these results support that the structured, evidence-based training successfully improved documentation accuracy, timeliness, and overall quality within the home health agency.

The project had a substantial positive impact on the pediatric home health agency by strengthening documentation quality, medication safety, and regulatory compliance. Improvements in documentation accuracy and timeliness enhanced care coordination across interdisciplinary teams and reduced clinical risk associated with incomplete or delayed records (Sharma et al., 2024). The 50% reduction in medication discrepancies contributed to safer medication management and decreased the likelihood of adverse events, supporting the organization's patient safety goals and quality benchmarks. In

addition to clinical outcomes, the project positively influenced organizational culture and workflow efficiency. Staff demonstrated increased knowledge, confidence, and accountability related to documentation practices, resulting in more consistent EHR use and reduced documentation-related follow up by leadership and quality assurance teams. The structured, scalable education model established a sustainable framework for ongoing training, audit, and feedback, positioning the organization to maintain improvements, supporting continuous quality improvement initiatives, and strengthening long-term operational and patient safety outcomes (see Moon et al., 2022).

Several limitations may have influenced the project outcomes. The relatively short postimplementation evaluation period may not fully capture the long-term sustainability of documentation improvements, particularly documentation timeliness, which narrowly missed the 90% benchmark (89.3%). Additionally, reliance on EHR audit data and self-reported surveys introduces the potential for reporting and observer bias. Staffing shortages, variable internet access during home visits, and competing clinical demands may also have affected clinicians' ability to consistently document within 24 hours. Despite the limitations, the intervention produced clinically significant improvements, suggesting that the educational approach was effective even within real-world operational constraints (see Vigfússon et al., 2021).

The project is significant beyond the local pediatric home health agency because it addresses a widespread and persistent challenge in health care (see Olakotan et al., 2025), that of ensuring timely, accurate documentation to support patient safety, care coordination, and error reduction. Documentation delays, medication discrepancies, and inconsistent EHR use are common across home health agencies and other decentralized

care settings, where clinicians work independently and rely heavily on shared records (Olakotan et al., 2025). This staff educational project demonstrates that structured, evidence-based, and multimodal education can produce meaningful, measurable improvements in documentation quality even in complex, resource-constrained environments. Additionally, the project offers a scalable and adaptable model that can be replicated across diverse home health organizations, outpatient clinics, and community-based care settings. By using the ADDIE framework, standardized training modules, and measurable outcomes, the project provides a practical roadmap for nurse leaders and organizations seeking to improve documentation practices and meet regulatory and quality standards. Beyond improving operational efficiency, the project supports broader patient safety and equity goals by promoting consistent documentation practices that reduce preventable errors and disparities in care, making its implications relevant to nursing practice, health systems leadership, and policy initiatives nationwide.

Conclusions

The project had a meaningful impact on the project site pediatric home health agency by significantly improving documentation accuracy, timeliness, and medication safety. The intervention exceeded key benchmarks, including a 50% reduction in medication discrepancies and documentation accuracy above 95%, demonstrating stronger compliance with agency standards and regulatory expectations. Improved documentation practices enhanced care coordination, reduced clinical risk, and strengthened the organization’s culture of patient safety. In addition, increased staff knowledge, confidence, and accountability supported more efficient workflows and reduced the burden of documentation-related errors on leadership and quality assurance

teams. Together, the outcomes established a strong foundation for sustained quality improvement.

Building on the organizational gains, I have several recommendations that can further strengthen the long-term impact. Integrating documentation education into onboarding and annual competency requirements will help ensure consistency across staff and support new clinicians entering practice. Ongoing quarterly or semiannual chart audits with structured feedback can sustain improvements and identify emerging gaps. Expanding the program to include advanced EHR optimization strategies, real-time documentation tools, and peer documentation champions may further enhance efficiency and reinforce best practices. Aligning documentation metrics with organizational performance dashboards will also support data-driven decision-making and continuous improvement.

The findings have important implications for nursing practice. The project reinforces that timely, accurate documentation is a core nursing competency directly linked to patient safety, medication management, and care coordination. Structured, multimodal education enables nurses to integrate documentation best practices into daily workflows, strengthens professional accountability, and promotes consistent EHR use across disciplines. The results support nurse-led education and quality improvement initiatives as effective strategies for reducing preventable errors and improving care outcomes in home health settings. Beyond practice implications, the project also supports positive social change and advances diversity, equity, and inclusion. Accurate and timely documentation promotes equitable, high-quality care by ensuring that all patients, particularly medically complex and vulnerable pediatric populations, have complete and

reliable health records regardless of provider, shift, or setting. Improved documentation enhances continuity of care, reduces preventable errors, and minimizes disparities caused by fragmented or inconsistent records. By standardizing documentation practices and reinforcing accountability, the project contributes to safer, more transparent care delivery and fosters equity, inclusion, and patient advocacy within home health nursing.

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Appendix A: Pre-/Posttest Knowledge Survey

Documentation Survey

Pre-/Post-Test: Clinical Risks & Documentation Standards

Form Description:
Please complete the following 10-question quiz to assess your knowledge of clinical risk factors and documentation standards. This quiz is used both before and after the training session.

* Indicates required question

Email *

izisandy@yahoo.com

The phrase "If it wasn't documented, it wasn't done" emphasizes what principle? 1 point

- ( ) Staff accountability
- ( ) Charting for reimbursement
- (•) Legal and professional responsibility
- ( ) Organizational policy

Clear selection

Failure to document a medication administration could be considered: 1 point

- ( ) A minor oversight
- ( ) Acceptable if the patient didn't react
- (•) A medication error and legal risk
- ( ) Unnecessary unless audited

Clear selection

Which is the most appropriate time to document a significant change in a patient's condition? 1 point

- (•) At the end of the shift

Which is the most appropriate time to document a significant change in a patient's condition? 1 point

- (selected) At the end of the shift
- Immediately after the change is observed
- During weekly staff meetings
- After discussing it with the family

Clear selection

Which of the following increases the risk of clinical error in documentation? 1 point

- Standardized templates
- Real-time charting
- (selected) Copy-paste functions in EMRs without review
- Use of electronic reminders

Clear selection

Which documentation practice can **legally protect** a clinician during a dispute? 1 point

- Generalized notes
- Using abbreviations not approved by the facility
- Documenting only positive findings
- (selected) Accurate, timely, and complete notes

Clear selection

What is the primary purpose of timely documentation in patient care? 1 point

- To satisfy insurance requirements
- To protect healthcare staff from lawsuits
- (selected) To ensure continuity and safety of care
- To increase workload accountability

Clear selection

Which of the following is a common cause of medication errors in home health care? 1 point

- ○ Patient mobility
- ○ Incorrect documentation
- ◉ Overstaffing
- ○ Frequent home visits

Clear selection

Which of the following is considered objective documentation? 1 point

- ○ "Patient appears to be in pain."
- ○ "I think the wound looks infected."
- ◉ "Patient states pain level is 8/10."
- ○ "Wound measured 2.5 cm x 2.0 cm with purulent drainage."

Clear selection

What is the primary purpose of timely documentation in patient care? * 1 point

- ○ To satisfy insurance requirements
- ○ To protect healthcare staff from lawsuits
- ◉ To ensure continuity and safety of care
- ○ To increase workload accountability

Which is the most appropriate time to document a significant change in a patient's condition? 1 point

- ◉ At the end of the shift
- ○ Immediately after the change is observed
- ○ During weekly staff meetings
- ○ After discussing it with the family

Clear selection

Appendix B: Chart Audit Checklist

Chart Audit Tool – Completeness, Timeliness, and Accuracy Evaluation

Audit Element	Criteria	Met (✓)	Not Met (X)	Comments
Patient Identification	Full name, DOB, and MRN on each page/entry			
Documentation Timeliness	Entries recorded within 24 hours of patient encounter or event			
Accurate Date & Time Stamps	Each entry includes correct and complete date and time			
Provider Signature & Credentials	Signature, title/role, and date are included in each entry			
Completeness of Assessment	All required assessment fields completed (e.g., VS, physical exam)			
Medication Documentation	All administered medications documented with name, dose, route, and time			
Plan of Care	Clear documentation of clinical plan, interventions, or goals			
Incident/Change Documentation	Any critical changes or incidents documented promptly and thoroughly			
Objective & Subjective Data	Use of appropriate S (subjective) and O (objective) descriptors			

Corrections Made per Policy	Errors corrected per protocol (e.g., single line, initialed, dated)			
Use of Approved Abbreviations Only	No unapproved, ambiguous, or unclear abbreviations			
EMR Use (if applicable)	Documentation is completed using appropriate fields and workflows			
Consistency with Orders.	Documentation aligns with physician/provider orders			
Patient Education	Education provided is clearly documented with topic and response			
Discharge or Transfer Documentation (if applicable)	Completed appropriately with all relevant information			

Audit Outcome Summary (Optional):

Total Criteria Met: ___ / 15

Audit Result: ☐ Satisfactory ☐ Needs Improvement ☐ Unsatisfactory

Auditor Name: ___________________________

Date of Audit: ___________________________

Appendix C: Reflective Journal Review

Reflective Journal Review Rubric: Use this rubric to evaluate reflective journals based on depth, clarity, and connection to practice.

Criteria	Exemplary (4 pts)	Proficient (3 pts)	Developing (2 pts)	Beginning (1 pt)
Critical Thinking & Depth of Reflection	Demonstrates deep, insightful reflection; analyzes experience and connects with theory, personal growth, or practice.	Thoughtful reflection with some analysis; some connection to theory or personal learning.	Limited depth; mostly descriptive with minimal analysis or connection to learning.	Superficial or no reflection; lacks analysis or connection to personal/professional development.
Connection to Experience	Strong, clear connection between journal content and real-world experience; specific examples included.	Good connection to experience; examples used to support points.	Some connection to experience; examples may be vague or limited.	Weak or unclear connection to real experience; lacks supporting details.
Application to Practice or Learning.	Clearly links reflection to future practice or learning; identifies areas for improvement or goals.	Some effort to apply insights to practice or learning; goals are present.	Limited application to practice or future learning; goals are vague.	No clear application to future practice or learning.
Organization & Clarity	Well-organized and clearly written; flows logically with minimal errors.	Mostly well-organized; few grammar or structure issues.	Somewhat disorganized; noticeable grammar or clarity issues.	Poorly organized; difficult to follow; frequent grammar issues.
Personal Insight & Growth.	Demonstrates self-awareness,	Shows awareness of personal	Some insight into self;	Lacks personal insight; little

	growth, and understanding of self and others.	beliefs, attitudes, or behaviors.	lacks depth or clarity.	evidence of growth or reflection.

Total Score: ____ / 20
Scoring Guide:

- 18–20: Outstanding – Exceptional reflection and application
- 14–17: Competent – Meets expectations with minor issues
- 10–13: Needs Improvement – Some reflection, but lacks depth or clarity
- Below 10: Inadequate – Minimal reflection or connection to learning