The military nursing staff in the PACU is in a constant state of flux. The nature of the Air Force mission contributes an unusually high turnover rate in our small staff. Personnel frequently moving bases and consistent overseas deployments make continuity of documentation a challenge. New staff and negative documentation trends led to a reevaluation of the documentation process.

The objective is to create a documentation review program whereby the entire staff can participate, share input and learn from one another; while simultaneously maintaining an excellent standard of care.

Under the previous system, one nurse audited 10 charts per month and reported the results to the leadership. The new process requires each nurse to provide 5 charts each month, and review 5 of their peers’ charts against a set of established criteria. Much of the criteria remain constant month to month, but each quarter, a staff RN develops a peer review item that addresses an improvement opportunity or new evidence based practice.

Once implemented, we raised the standard of care provided in the PACU by improving the quality of documentation, and also by looking critically at the patient chart, eliminated waste such as redundant charting of vital signs and contradictory assessment information. Further improvements to the process have led to real-time evaluation of records rather than a retrospective audit.

This process has empowered our PACU RN’s to be accountable for their charting habits and created an avenue for them to be engaged with research and changing standards of practice.