The average nurse spends < 30 seconds on > 50% of tasks upon observation (Cornell et. al., 2011). Patient care safety mandates an understanding of factors contributing to nursing work complexity that include but are not limited to evidence-based documentation. Shared governance enabling the voice of direct care nurses representing the Pre-Operative Care Unit (POCU) and Post-Anesthesia Care Unit (PACU) revealed ineffective documentation structures and patterns that enabled multiple charting pathways that increased nursing work burden and complexity. Additionally, documentation builds did not reflect professional nursing organization (ASPN) standards of practice. Shared decision-making among all levels of nursing helped determine that a consistent charting pathway should be designed and implemented to reflect ASPN standards of practice. Team members were selected for their expertise, creativity, innovation and determination to advance the practice of nursing while simultaneously easing the burden of documentation complexity. Energy generated by the shared decision-making team resulted in a formal research study. An IRB-approved, quasi-experimental study was developed to examine differences in documentation practice and perception and/or the impact of designing for excellence in electronic documentation. The study included two measurements: medical records audits performed 30 days prior to and 30 and 60 days after staff training; and a Likert scale perception survey that evaluated time spent charting, amount of duplicate charting and awareness of regulatory standards. The perception survey was administered 2 weeks prior (N=27) and 2 weeks post (N=18) staff training. Medical record audits measured data on a specific patient population and included five charting criteria. An educational intervention outlining the revised charting pathway was delivered in 2-hour classes over a period of 2 weeks per a consistent instructor. T-test analysis of the data derived from the perception survey and medical record pre- and post-intervention audits showed an increase in perception of additional time spent with patients, decreased time on the computer and an overall improvement in specific charting at 30 days, with a slight decline in compliance at 60 days.