

UTILIZING CHART AUDITS TO IMPROVE AIRWAY DOCUMENTATION

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Background information related to problem identification:

Chart audits have been used in nursing for years. The audit we used reviewed the chart for completeness, i.e. assessments were documented at the correct times, but did not focus on the quality of the documentation. Nurses were not documenting necessary information about endotracheal tubes and tracheostomies as it was not prompted by the electronic document.

Objectives of project:

1. Improve patient care by creating an audit process to reflect deficits in documentation.
2. Identify areas of improvement related to patient care standards and the documentation of care.
3. Increase patient safety by directing care to specific high risk procedures and body systems.

Process of implementation:

Chart audits were created that assessed the documentation of endotracheal tubes, including questions such as where the tube was secured, the presence of breath sounds during intubation and post extubation, and the presence of an obturator for tracheostomies. Baseline data was evaluated, and reflected a need to change EMR enabling nurses to document a more thorough assessment. Audits were assigned to all nurses reviewing the completeness of documentation.

Statement of the successful practice:

The first month's audit showed that 0% of the nurses were documenting where the ETT was secured, tube size, and extubation criteria. After the initial audit a section was added to the form to help capture and prompt nurses to document this data. In 6 months documentation was at 100%.

Implications:

By changing the audit process the nurses' attention to detail has increased and with it improved patient safety, as well as improving overall documentation. Future audits will include topics such as neurovascular checks, pain control, and neurology status checks.