Pitfalls in Perioperative Documentation, Compliance with the EMR

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Background Information

- In 2018, PeriAnesthesia nurses at Delnor Hospital embarked on a documentation quality improvement initiative.
- A team of nurses collaborated to promote consistency in standardized documentation to uphold the American Society of PeriAnesthesia Nurses (ASPAN) guidelines by enhancing electronic documentation.

- A workgroup was developed with representation from Pre-op, Phase I, Phase II, Professional Development, and Perioperative Leadership with both surgical areas within Delnor.
  - ❖ The team established documentation guidelines based on ASPAN standards
  - ❖ Education was developed along with an audit tool to measure compliance

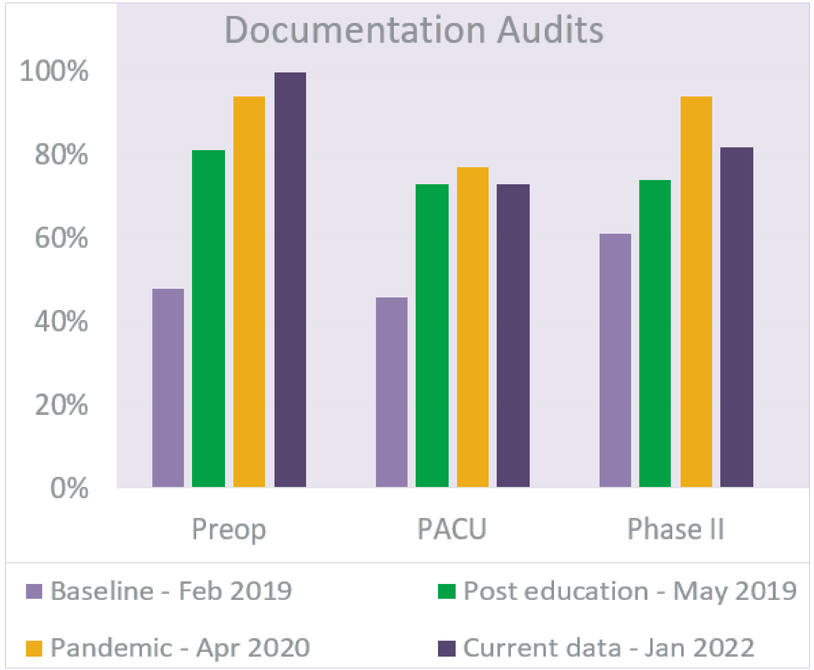
- Baseline data from the start of the project in 2018 identified documentation compliance was less than 62% for all areas.
  - ❖ To improve compliance a goal of 85% established
  - ❖ After three months of audits, all three areas exhibited significant improvement
  - ❖ With continued audits and peer coaching provided by the Documentation Committee compliance of 85% was achieved
  - ❖ After the COVID pandemic hit, sustainment of the goal decreased in compliance in PACU and Phase II

Objectives of Project

Goal: 85% Documentation Compliance

- Re-education of the team on the documentation guidelines
- 20 random audits completed monthly for each phase of care to identify compliance and expectation
- Peer coaching given to staff members when trends were identified

Figure 1:
Baseline Performance and Current Performance



Northwestern Medicine — Audit Form
PT MRN: _____ PROCESS: PRE-OPERATIVE DOCUMENTATION
PROCEDURE DATE/TIME: _____ DEPARTMENT: DELNOR SURGICAL SERVICES

Pre-Op Documentation

Step	Description:	Who	COMPLIANT?	NOTES:
1	Suicide/Abuse risk assessment under psychosocial assessment tab -Document in Baseline Assessment, each question needs to be answered	RN		
2	Braden Scale Completed includes nutrition and mobility - Document in Change in Status Assessments	RN		
3	Pain assessment completed (including comfort function goal where applicable)	RN		
4	Cognitive ability baseline assessed - Document in Neuro tab section of Complex Assessment	RN		
5	Lung sound assessment -Document in Respiratory Tab under complex assessment	RN		
6	Radial and Pedal pulse assessment - Document in Peripheral Vascular tab under complex assessment	RN		
7	Skin Assessment completed to include color and condition – Document in Integumentary Tab in complex assessment	RN		
8	Moderate Sedation pre-op education for conscious sedation patients- document under patient education	RN		

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PT MRN: _____ PROCESS: PHASE I DOCUMENTATION
PROCEDURE DATE/TIME: _____ DEPARTMENT: DELNOR SURGICAL SERVICES

Phase I Documentation

Step	Description:	Who:	COMPLIANT?	NOTES:
1	Vital signs Q 15 (x3), more frequent if needed. Q 30 (x2) then Q 1 hour or until phase I care complete per aesthesia d/c criteria	RN		
2	Assess Temperature upon admission	RN		
3	Assess Temperature upon discharge	RN		
4	Pain assessment completed (including comfort function goal)	RN		
5	Sedation Scale: Baseline Pasero Score documented with narcotic administration and as needed.	RN		
6	Oral airway removal documented by RN if applicable (either Aldrete or respiratory)	RN		
7	Lung sound assessment completed upon admission (Complex Assessment)	RN		
8	Lung sound assessment completed upon discharge (Complex Assessment)	RN		
9	Radial and Pedal pulse assessment (other procedural specific pulses assessed) (Complex Assessment) On arrival, discharge and PRN if indicated.	RN		
10	Skin assessment including condition and color documented (Complex Assessment) On arrival, discharge and PRN if indicated.	RN		
11	Neurological function (to include LOC/orientation) (Complex Assessment) On arrival, discharge and PRN if indicated.	RN		
12	Psychosocial/emotional status completed (Complex Assessment) On arrival, discharge and PRN if indicated.	RN		

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PT MRN: _____ PROCESS: PHASE II DOCUMENTATION
PROCEDURE DATE/TIME: _____ DEPARTMENT: DELNOR SURGICAL SERVICES

Phase II Documentation

Step	Description:	Who	COMPLIANT?		NOTES:
1	Vital signs Q 15 (x3), more frequent if needed. Q 30 (x2) then Q 1 hour or until Phase II care complete per aesthesia d/c criteria	RN	Y	N	
2	Assess Temperature upon admission	RN	Y	N	
3	Assess Temperature upon discharge Assess temperature within 30 minutes of d/c	RN	Y	N	
4	Sedation assessment completed if opioids are administered- Pasero Opioid Sedation Scale (POSS) Document before/at time of opioid interventions. Reassess 30min with IV opioids Reassess 1 hr with PO opioids	RN	Y	N	
5	Pain assessment, sedation comfort level, emotional status, and pain reassessment completed on arrival and within 30 minutes of d/c. Document before/ at time of opioid interventions. Reassess 30min with IV opioids Reassess 1 hr with PO opioids	RN	Y	N	
6	Pain assessment , comfort level, and emotional status completed (located under pain tab)	RN	Y	N	
7	Lung sound assessment completed upon admission (Complex Assessment)	RN	Y	N	
8	Lung sound assessment completed upon discharge (Complex Assessment)	RN	Y	N	
9	Radial and Pedal pulse assessment on admission and discharge (other procedural specific pulses assessed) (Complex Assessment)	RN	Y	N	
10	Neuro assessment/ LOC completed (Complex Assessment) On admit/discharge and PRN if indicated	RN	Y	N	
11	Skin assessment completed On arrival/discharge, and PRN if indicated (Complex assessment/condition and color or skin)	RN	Y	N	

Process of Implementation

Initial Project – a pre-learning audit was completed to determine baseline data and where education was needed.

Phase II of the Project– the education was disseminated to the staff again in the three phases of care.

Phase III of the Project – documentation guidelines and education were added to the orientation binder for new staff.

Statement of Successful Practice

- After nearly four year of developing and enhancing documentation in the EMR, the committee realized that accomplishing the goal is important but identified that sustainment is the most crucial aspect of the project.

Implications for Advancing the Practice of PeriAnesthesia Nursing:

- The documentation group will continue to:
  - ❖ Monitor documentation through audits
  - ❖ Provide additional education for compliance
  - ❖ Focus next on case-specific assessment and documentation
- Additional next steps:
  - ❖ Work with Health System Clinical Collaboratives (HSCC) for Periop to enhance EMR to simplify documentation

References

- American Society of PeriAnesthesia Nurses, 2017-2018 PeriAnesthesia Nursing Standards, Practice Recommendations and Interpretive Statements. ASPAN. 2016; pp. 49-55.