

EFFECT OF ELECTRONIC CHARTING ON PAIN DOCUMENTATION IN THE POST ANESTHESIA CARE UNIT

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Identification of the problem: Electronic documentation standardizes communication to capture nursing interventions and influences the quality of care provided to patients. Current methods of pain documentation include paper and electronic however information in the literature is limited as to which method completely captures nursing interventions for patients who are in the Perianesthesia Care Unit following a surgical procedure.

Evidence-based project objective: The question to be answered by this project is: What is the effect of using electronic charting on nursing compliance for pain assessment and pain reassessment in the Perianesthesia Care Unit?

Methods: Chart audits for pain documentation were performed on a convenience sample of thirty patients who had hernia repair surgery and were recovered in the Perianesthesia Care Unit at a 150 bed community hospital. Fifteen charts were audited using the previous method of paper documentation and fifteen charts were audited using the currently utilized method of electronic charting. Charts were audited for assessment of initial pain following the surgical procedure and presence of pain reassessment following pain medication. Patients who did not experience pain following surgery were excluded.

Significance of findings: Audits revealed initial documentation for pain following surgery was 100% for both paper and computer charting methods. Documentation of reassessment of pain after administration of medication was 80% using the paper method and 93% using the computerized method.

Implications: Findings indicated the computerized charting method had a higher level of nursing documentation compliance for pain reassessment following administration of pain medication. Additional research is needed to examine the effects of electronic documentation on further nursing interventions to enhance communication between healthcare providers and to promote patient safety and comfort.