PACU DOCUMENTATION: TRANSITIONING FROM PAPER TO THE ELECTRONIC RECORD

Team Leaders: Diane Fetterhoff BSN RN CPAN, Patricia Craig RN
Pennsylvania Hospital, Philadelphia, Pennsylvania
Team Members: Stephanie Setaro MSN RN ACNS-BC, Theresa McMunn BSN RN,
Jessica Friedman BSN RN, Francis R. Rinault BSN RN

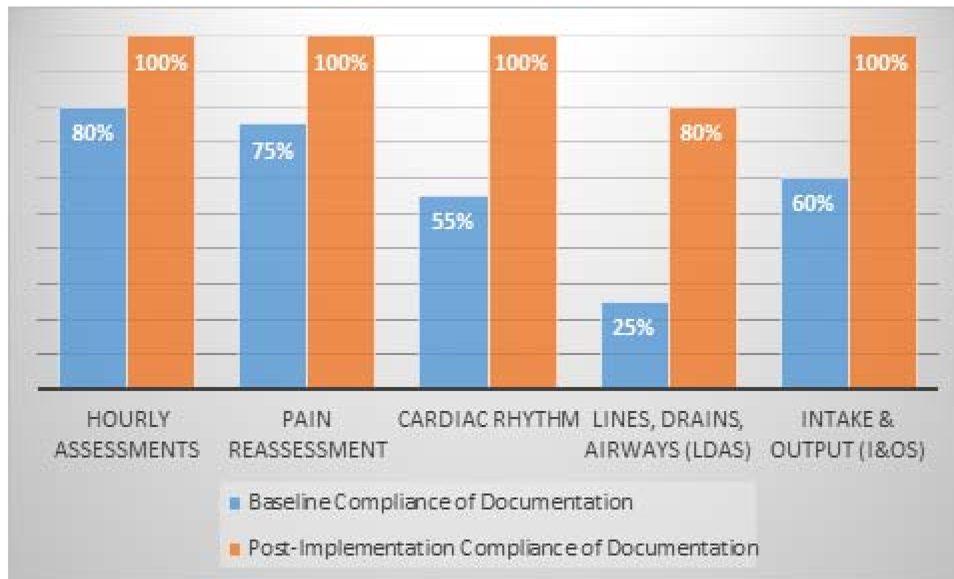
Background: The implementation of the electronic medical record (EMR) has dramatically changed the workflow and documentation practices in the Post Anesthesia Care Unit. Although eight hour education classes and two weeks of onsite support were provided, documentation in the EMR was inconsistent and did not consistently meet required standards. Nursing handoffs were also impacted by difficulty finding the information necessary to deliver safe care. Prior to our intervention, an electronic survey was completed by all PACU clinical nurses to obtain qualitative data on specific documentation criteria and the results were found to be very diverse. Chart audits were also conducted to determine the degree of variation in documentation practices.

Objectives of Project:

- Establish guidelines for PACU documentation in the EMR
- Promote standardization and decrease variation in the medical/health record
- Increase accessibility of pertinent information by the entire perioperative team

Process of Implementation: A committee was formed to establish guidelines for PACU documentation. After conducting a review of the current literature, including the ASPAN standards and The Joint Commission regulations, the committee developed guidelines based on the best available evidence and published standards. The guidelines were disseminated via email, “staff huddles”, staff meetings, and were posted on the intranet. Chart audits were performed monthly, and real time audits were performed at the bedside during handoffs to ensure documentation standards were being met. Education huddles were conducted to disseminate education on the audit findings and to answer process questions.

Statement of Successful Practice: The initial audits were used as the baseline data to measure improvement. Five specific areas of documentation were reviewed in twenty random records. The post-intervention audits showed a significant improvement in compliance and were collected monthly following implementation of the EMR guidelines.



Implications for Advancing the Practice of Perianesthesia Nursing: Hospitals throughout the country are converting to Electronic Medical Records, which create opportunities for clinical nurses to lead change and improve documentation practices, impacting other disciplines and the quality of patient care. Creating and implementing evidence-based guidelines for EMR documentation improved the consistency and comprehensiveness of nursing documentation at our institution. The interdisciplinary health care team can now locate data in standardized locations, thus promoting efficiency, reducing variations of care, and creating safer handoffs.