Perianesthesia Orientation Redesign Phase I: Standardizing Minimal Documentation Across the PACUs

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Introduction

Standardizing orientation reduces confusion, increasing nursing safe practice. Nursing documentation remains the single largest area where differences exist and errors occur. Along with errors, issues with learning documentation accounts for increases in orientation cost due to extensions. It also accounts for a decrease in orientation satisfaction resulting in orientee and preceptor frustration. When surveyed, orientees reported their documentation differed daily based on which preceptor they were with. At times the variations orientees had to learn due to preceptor preference, lead to orientees either being extended for several weeks or failing orientation. Standardizing the documentation practices of both existing and new hire nurses showed an improvement in orientation outcomes.

Objectives

Standardizing perianesthesia documentation's aim was to :

- Develop a consistent standardized method of charting essential PACU data elements that reflected American Society of Perianesthesia Nursing (ASPAN) and the Joint Commission required documentation.
- Increase nurses' satisfaction and efficiency of care.
- Design training for new and existing RNs to the same standards so all staff charts within comparable guidelines.
- Reduce issues with orientees' learning clinical documentation requirements due to preceptor preferences.

Implementation

- Eight of the 11 PACUs at the East Baltimore Campus of The Johns Hopkins Hospital worked together via committee to design documentation guidelines based on goals aimed at improving compliance and decreasing confusion.
- Minimal documentation standards were designed and approved to be applicable to many different Prep and PACUs.
- Units identified one champion to manage unit superusers.
- In June, the superusers trained end-user groups. Nurses received classes on the standards then practiced in Epic play environment.
- New standards were piloted on nurses in orientation.
- Preceptors held their orientees to documentation guidelines.
- Audits were designed to track compliance of minimal documentation standards.
- Units were grouped based on their patient population. Each group contained two units. (ambulatory, procedural only, surgical only & surgical/procedural mix)
- Baseline audits were performed from dates prior to onset of education.
- Unit champions and superusers performed the audits first on their assigned end-user groups to gauge effectiveness of training.
- By July 2021, the audit data began to be collected and disseminated bimonthly to superusers to give real time feedback to their end-user group members.
- By August, end-users started auditing their team members twice monthly to reinforce minimal documentation training.
- As survey numbers and compliance improved, end user audits were decreased to once per month.

Minimal Documentation Bed Side Guides

Preop

PREP MINIMAL DOCUMENTATION FAST FACTS

UPON PATIENT ARRIVAL IN PREOP, THESE ITEMS MUST BE COMPLETED PRIOR TO THE PATIENT GOING INTO PROCEDURE/ SURGERY

Topic		Guidelines
Vital Signs	On Admission, PRN	TEMP, HR, BP,O2 SATS, RR, HEIGHT, & WEIGHT
Continuous monitoring		Rhythm, Rate, PR/QRS intervals, PRN ICD, MCS, & EXISTING CONT. MONITORING
TESTING		EKG, URINE HCG, LABS & UNIT SPECFIC TESTING
Sleep Apnea		Performs appropriate Sleep Apnea screening and CPAP machine inspection as needed
Infection Screening.		Performs all pertinent infection screening questions as needed
Pain		Record pain goal, current pain score, and characteristics
Assessments • Unit specific Assessments		Completes appropriate patient assessments per unit guidelines.
PREOP NAVIGATOR		COMPLETE PER UNIT SPECIFIC GUIDELINES
Consents		Consents are complete and accurate prior to patient's going to procedure/surgery
IV and wound sites		Placed and assessed prior to patient going into procedure/surgery
MOLST/DNR/Advanced Directives		Attending is made aware of restrictions to care, has consulted with patient, and entered MD note stating final outcome of that meeting.
Review/**Release** Orders		1. Release PREP orders on arrival 2. Release pertinent additional orders on admission
Education		Prep (3 topics): 1) Pain, 2) Infection Prevention, 3) Keeping yourself safe
PACU Nursing Relief Handoff		Flowsheet Handoff (RN to RN meal break/shift relief). Handoff to OR staff.
Preop Eventing		1) In Preop, 2) Preop RN complete, 3) Pre-procedure Complete

Specialty Requirements (example below)

PACU Phase I

PACU PHASE I MINIMAL DOCUMENTATION FAST FACTS

PRIOR TO ARRIVAL IF ABLE: REVIEW PT. HX, REVIEW ANESTHESIA & SURGICAL ORDERS/AVS & ATTACH DEVICE
AT PT. ARRIVAL: ATTACH MONITOR, CHECK PT. ID, CHECK SURG. SITE, ALDRETE, RASS
TEAM HANDOFF: ANESTHESIA, SERVICE, NURSING

Topic		Guidelines
Vital Signs	On Admission, PRN	Q15 x4 -> Q30 x 2 -> Q1 hr (until PACU Phase Criteria met)
Continuous monitoring		Rhythm, Rate, PR/QRS intervals, AND Q 12 HRS.
RASS		With vital signs. Q15 min if RASS is not -1 to +1
Modified Aldrete		& when criteria met or Q15 mins (when Rass score not 1 to -1)
I&O's		Q1 hr (IV site/type, amt, Foley amt/color, Drain amt/color)
Pain		*Pain score with each dose, PRN. Characteristics on admission, Q2 hrs & < 1 hr D/C*
Assessments • Systems: CV, Respiratory, Neuro/GI/GU/GYN/ HEENT • Wounds/Lines/Drains/IV site		Q4 hr, < 1 hr of transfer/discharge (D/C) (or per protocol/orders)
Regional/Blocks/Epidural PCA		Sensory and Block levels per unit guidelines or per surgical/procedural protocol/order
Review/**Release** Orders		1. Release PACU orders after handoff, within 15-30 minutes of arrival 2. Release pertinent Inpt orders < 60 mins of admission 3. Release ALL Inpt orders < 4 hrs of *patient becoming floor status*
Education		PACU Phase I - Additional as needed (PCA, Any patient teaching topics, Medications)
PACU Nursing Relief Handoff		Flowsheet Handoff (RN to RN meal break/shift relief) *Smart Script*: Review of Systems Stable, Focus on_____ during PACU Phase I care. PACU D/C handoff (transfer to Inpt/outside facility)
Phase I Eventing		Per policy and pertinent to patient's post op course.

Specialty Requirements (example below)

PACU Phase II

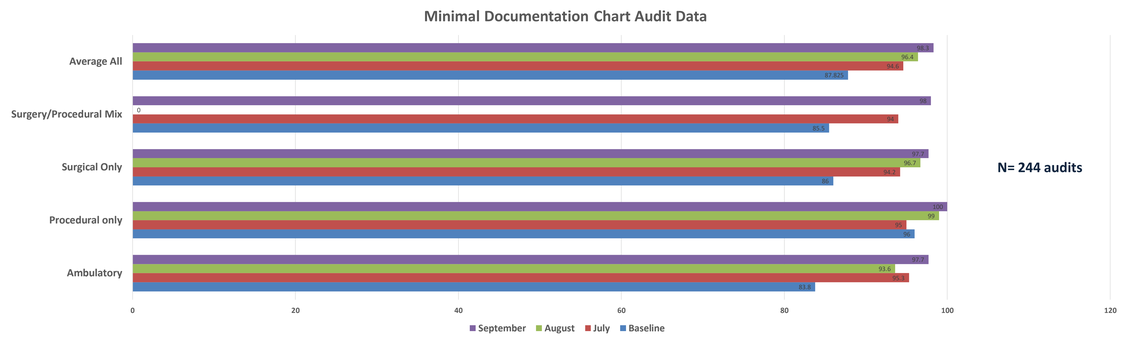
PHASE II MINIMAL DOCUMENTATION FAST FACTS

UPON PATIENT ARRIVAL IN OR CHANGE OF STATUS TO PHASE II, THESE ITEMS MUST BE COMPLETED PRIOR TO THE PATIENT BEING DISCHARGED TO HOME

Topic		Guidelines
Vital Signs	On Admission & PRN	TEMP, HR, BP,O2 SATS, RR – One set upon arrival to or within 1 hour of discharge
Pain		Current Pain Score/Characteristics on arrival to or within 1 hour of discharge
Assessments • Unit specific Assessments		Full assessment within 1 hour of discharge or PRN with changes.
Phase II Discharge Navigator		COMPLETE PER UNIT SPECIFIC GUIDELINES
IV removal		Document upon removal. Perform site assessment if needed (mod bruising or hematoma)
Wound/Drain assessment		Perform upon arrival to or within one hour of discharge
MOLST		Electronically attach MOLST to AVS if altered, or created within this hospital visit.
Review/**Release** Orders		Review discharge orders. Release any remaining discharge orders as needed
Education		Phase II (3 topics): 1) Pain med actions/side effects, 2) Discharge planning, 3) Miscellaneous Handouts. Add Qtips and Cane if pertinent. Add videos as needed. Teaching plan for narcotic safety. All pts going home with narcotics.
PACU Discharge Handoff Report		Provide handoff report to any outside facility or ambulance services as indicated.
Event per protocol		1) In Phase II, 2) Phase II Criteria Met, 3) Out of Phase II, 4) Periop Care Complete. 5) Discharge.

Specialty Requirements (example below)

Compliance Data Analysis



Nursing Satisfaction Survey Results

Question	Answer A	Answer B	Answer C	No Answer
#1 Minimum Documentation has reduced required documentation by:	Moderately, Removes duplications and lengthen time frames 25 (59%)	A little, hardly notice it. 12 (29%)	Not at all, more confusing than ever 5 (12%)	0
#2 Use of minimal documentation guidelines has:	Improved my compliance with Joint Commission standards 14 (34%)	Reduced the amount of documentation I usually do 19 (45%)	Has added to the documentation I usually do 9 (21%)	0
#3 Using the Smart Phrase for lunch and end of shift relievers has:	Made it easier to document to an unchanged assessment 23 (55%)	Is confusing and hard to find 8 (19%)	Not been used, I'd rather put my own assessment in fully 11 (26%)	0
#4 Completing monthly audits:	Helps remind me what the standards are 29 (69%)	Was made easier by the use of a phone application 5 (12%)	Isn't of any help at all 8 (19%)	0
#5 For orientees, the minimal documentation standards have:	Given them a set of criteria to follow, reducing differences based on preceptor practice 18 (43%)	Has helped them improve their documentation skills 12 (29%)	Has made them more confused 5 (12%)	7 (16%)

N= 42 responses

Response time was 2 weeks

RNs surveyed at month 4 of the pilot.

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Results

- Data showed an approximate increase from 87% to 98% compliance with ASPAN standards.
- Areas being missed differed from unit to unit. In some cases items missed were required but were not part of the unit's routine.
- Data demonstrated a need for re-education in those areas to harmonize over all PACUs.
- Areas for improvement were outpatient documentation, specialty assessments, and hospital required documentation (ex: belonging documentation), however some standard items were missed in Prep and in PACU Phase I.
- Orientees stated the review and bedside reminder pages were helpful in making documentation easier.
- Preceptors reported orientees demonstrated increased documentation competency.
- Removing duplication and standardizing the intervals, resulting in more time for patient care was the greatest benefit RNs reported.

Lessons Learned

- Collaboration within large groups proved at times to be challenging.
- Population specific Prep/PACUs demonstrated that the standards did not always apply to all areas.
- Finding consensus and adding avenues to recognize each unit's special needs allowed the group to come together.
- Piloting the program with nursing orientees proved beneficial in the data and real time feedback it provided.
- COVID caused a delay of 6 months in creating and implementing the standards due to low staffing and higher patient census/acuity.
- Adjustments in data collection needed to be made for appointment based areas due to differences in Epic access.
- Some RNs preferred to continue documenting more than needed. Will continue to audit to see if this affects compliance over the long run.

Implication for Practice

In minimizing documentation, we systematically reduced issues with orientation and lowered stress on nurses keeping up with their workload and throughput. In maintaining a standardized documentation practice, we reduced confusion regarding what should be documented and when. This program sparked interest from other JHH Health System Prep/PACUs. The standardized design of this pilot can be readily used by other perianesthesia units to meet both ASPAN and Joint Commission requirements for Epic documentation.

References

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