Standardization of Nursing Electronic Documentation in Perianesthesia Area

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Background

In 2015 a multi-unit merger within the perianesthesia area created a wide variability in nursing documentation. Due to the implementation of electronic documentation and staff feedback a chart review committee was developed for standardization of documentation.

Objectives

- Ensure nursing electronic documentation standards across perianesthesia area
- Develop audit tool for nursing documentation in the perianesthesia areas
- Review/audit documentation and provide individual feedback to staff
- Educate staff on electronic documentation standards

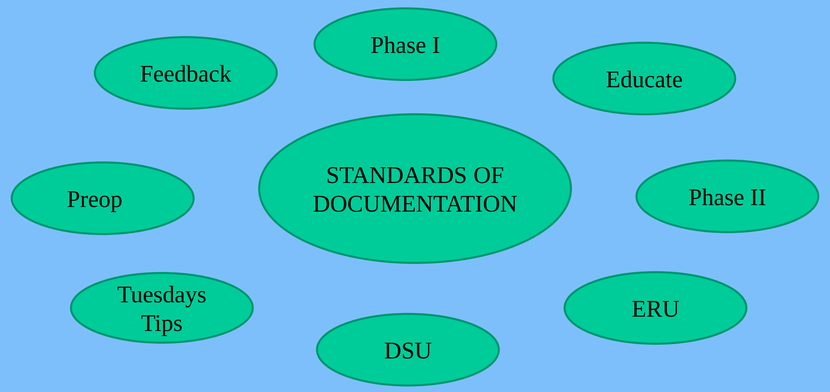
Pre-op assessment audit tool
MRN:_____
RN_____Date_____time_____

Pre-op checklist
1. Did nurse assign themselves as preop nurse yes____ no____
2. Allergies reviewed and completed yes___ no____
3. Med list reviewed with last dose documented yes__no__
4. Advanced care directive status assessed yes__no__
5. Complete VS recorded yes__no___
6. Pre-op level of pain documented yes__no__
7. If patient has pain, location documented yes__no__n/a__
8. Was VTE assessment done yes__no__
9. Time out done if pt had a block/epidural yes___ no___ n/a___
10. Morse Scale is documented in chart yes__no__
11. Is Braden Score documented in Chart yes___no__
12. Documentation in plan of care yes__no__
13. primary learner questions completed in ppe or pre-op yes__no__
14. Was "Pre-op care completed" documented in events yes__no__
15. Was the chart verified yes__no__
16. Care handoff for breaks yes____no____n/a____

PRE OP	2017	2018	
	August	August	
Allergies	100	100	
Advanced care directive status assessed	100	79	
Pre-op level of pain documented	100	73	
If patient has pain, location documented	100	57	
Documentation in plan of care	100	73	
primary learner questions completed in ppe or pre-op	100	60	
Complete VS recorded yes__no__ if no, missing items	100	95	
Morse Scale is documented in chart	100	55	
Is Braden Score documented in Chart	100	45	
Was VTE assessment done	100	60	
Med list reviewed with last dose documented	100	90	
"Pre-op care completed" documented in events	100	80	
Was the chart verified	100	90	
Care handoff for breaks	0	0	

Process of Implementation

- Creation of a chart review committee
- Developed audit tool for phases of care
- Provide ongoing feedback to individuals regarding documentation compliance
- Report out data at staff meetings
- Provide weekly "Tuesday Charting Tips"
- Incentives for improvement



Tuesday Tips

- Neuro check protocols (per ASPAN standards)
- Neuro check to be done upon arrival to PACU, q 2hrs and/or upon discharge (including motor strength, motor response and pupils)
- Pt's dressings should be documented upon arrival, discharge and prn
- Extended Recovery Unit (ERU) dressings should be documented upon arrival, q shift and prn
- ERU Morse falls score q 8hrs
- Braden Skin assessment q 24hrs

Implications for Advancing the Practice of Perianesthesia Nursing

- Developing standards for electronic documentation
- Promote consistent documentation methods for all staff nurses
- Provide individual feedback about electronic documentation
- Standards of documentation allowing for seamless extrapolation of information for all team members

Obstacles

- Compliance percentages fluctuate greatly
- A large influx of novice staff in the last 2 years
- A multi unit merger of perianesthesia areas greatly affects the results
- Motivation to improve is variable with some staff
- Lack of knowledge related to minimum documentation requirements

Statements of Success

- Electronic documentation standards are consistent and clear
- Initial resistance from staff has evolved into positive feedback
- Committee has expanded to accommodate work load
- Committee members also serve as a resource in the unit
- Instrumental in documentation policy changes