

Improving Nursing Documentation of Surgical Site Wounds: A Collaborative Effort to Promote Safe Patient Care Between OR and PACU

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Background Information: When patients transition from the Operating Room (OR) to the Post Anesthesia Care Unit (PACU), the absence of complete documentation in the electronic medical record (EMR) can result in significant adverse events leading to poor patient outcomes (bleeding, infection, delay of care). Lack of proper documentation of surgical site/wounds creates gaps in the handoff communication between the phases of care, from OR to PACU, and to the inpatient units.

Objectives of Project: The goal of this project is to fulfill RNs (for both OR and PACU) professional responsibility and 100% documentation compliance to prevent errors of omission related to surgical site/ wound documentation.

Process of Implementation: From January to March 2017, data was collected regarding missing surgical site/wound documentation in the EMR, on admission to PACU. Results showed that only 50% of patients were admitted from the OR with complete surgical site /wound documentation. The same audit showed that patients being transferred from PACU (discharged home or transfer to inpatient unit), had 100% completed documentation of surgical sites and wounds.

From March to April 2017, the implementation of assessment and documentation of surgical site/wound documentation was incorporated in the training of new hires, preceptors and float RN's for both OR and PACU departments. A taskforce of OR and PACU RN's were created to provide real time feedback and in-services regarding documentation review for staff and trainees.

Statement of Successful Practice: Compare data pre and post implementation. Data was evaluated and missed documentation was addressed in real time with the OR staff involved.

The results of this study indicated that the compliance of surgical site/wound documentation increased from 50% to 95% from implementation (March and April 2017) to present time. We currently sustain 90-100% completed documentation. We continue to reinforce and reeducate during our annual competency and as needed for new hires.

Implications for Advancing the Practice of Perianesthesia Nursing: Evaluation of the results prompted us to apply this process to other OR and PACU areas in the hospital. The overarching goal was to have 100% of our patients being admitted to the PACU with complete documentation. This can be accomplished by promoting a safe environment throughout the different phases of care, via proper assessment and accurate documentation.