2022 PACU documentation audits revealed a high variability in nursing practice documenting mandatory elements of postoperative care, such as Fall Risk, Care Plan, Education, Pain Assessment/Reassessment and Admission Assessments. This affects documentation compliance with the Joint Commission regulatory and professional standards. Furthermore, these inconsistencies affect the continuity of care and ultimately, postoperative patient outcomes.

"Nursing documentation is an important proxy of the quality of care, and quality indicators in nursing assessment can be used to assess and improve the quality of care in health care institutions" (Iula et al. 2020). Ensuring completion, accuracy, and timeliness of documentation by influencing nursing practice documenting is the main focus of our unit improvement initiative.

**Methods**

**Pre-Intervention**
- Retrospective chart review of mandatory PACU documentation elements as per NYP Policy.

**Intervention**
- Educational staff inservices emphasizing the importance of completeness, timeliness and accuracy of clinical documentation.
- Disseminated visual displays using screenshots of the EMR mandatory elements of documentation
- Being available on the unit as a resource for questions

**Post-Intervention**
- Retrospective and real-time chart review audit to evaluate intervention effectiveness.
- NYP documentation policies enforcement through emails and EPIC chat

**Results**

- **Nursing compliance with Fall Risk Assessment documentation**
  - Pre-Intervention: 80% Complete, 20% Timely
  - Post-Intervention: 100% Complete, 100% Timely

- **Nursing Compliance with Pain Assessment Documentation**
  - Pre-Intervention: 60% Complete, 40% Timely
  - Post-Intervention: 100% Complete, 100% Timely

**Key Findings**

- Demonstrated improvement in nursing compliance documenting mandatory elements of patient care, as evidenced in the completeness and timeliness of documentation.
- Real-time audit revealed the need to improve the usability of EMR, such as PACU Flowsheet.
- Nursing staff viewed documentation as a burden, that takes them away from the delivery care.
- Continuous chart audit reviews and reinforcement of NYP policies is required to achieve standardization.

**Scan me to view nursing compliance with documentation related to:**
- Pain Reassessment
- Patient Education
- Care Plan
- Admission & Ongoing Assessments

**References**
