Creating Documentation "Best Practices" Following a Large Scale EHR Implementation

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Introduction/Background
Electronic health record (EHR) use has increased dramatically in recent years after the passing of the Health Information Technology for Economic and Clinical Health Act (HITECH) which provided financial incentives to health care organizations to support the adoption of an EHR. Patient safety concerns have been of paramount importance in institutions where EHRs are in use. Nurses, as end users of such a product, are in a unique position to identify workflow challenges and suggest improvements to enhance process standardization.[1] A recent EHR implementation resulted in the loss of inpatient documentation standardization across the nursing department. This abstract describes the effort to identify where standardization would be critical to insure patient safety and to implement a mitigation strategy.

Methods
Clinical Nurse Educators and Nursing Informatics Leadership, identified aspects of nursing care and documentation where streamlining and structure would promote consistency and standardization of documentation, compliance with institutional nursing policies and procedures, and improve nursing workflow. Smaller work groups reviewed applicable nursing policies, procedures, nursing work flow and the EHR to create "best practice" documentation guidelines (BPGs). Each BPG was vetted with all relevant multidisciplinary content experts before it was disseminated to Super Users during a monthly update meeting and to the entire nursing community via email. Nurse Educators took the lead to educate unit based staff on the guidelines. All BPGs are made available from within the online electronic Nursing Clinical Practice Manual.

Results
Initial efforts focused on high volume, high priority, high risk areas of nursing documentation. Intake & Output documentation fell into this category and became the focus of our first BPG. Within the EHR there were many different "places" on the flow sheet where I&O data could be entered and it became clear that this could cause miscommunication or misunderstanding of the patient's overall fluid balance as well as balance from specific output locations and implements. Once completed, the team prioritized additional areas in need of standardization within the EHR (Table 1).

Table 1: Documentation Best Practice Guidelines

• Intake and Output	• Nursing Notes
• Nasogastric Tubes and Tube Feedings	• Pressure Ulcer Staging
• Drains, Ostomies, Urine, Stool	• Nurse Driven Protocol for IUC removal
• Code & Rapid Response Documentation	• Critical lab Results
• Pain Assessment	• Continuous Renal Replacement Therapy

Discussion/Conclusion
Best Practice nursing documentation guidelines were developed to promote consistency and standardization of nursing documentation in an EHR They are designed to ensure that nursing documentation is accurate, complete, timely, organized and compliant with accepted standards. BPGs are designed to reflect nursing knowledge, judgment and skills. They can serve as a source of data for nursing research, to assess nursing interventions, evaluate outcomes, and determine the efficiency and effectiveness of care. They can reduce inaccuracies in documentation. They are designed to strengthen collaboration between members of the interdisciplinary team. Best Practice documentation guidelines facilitate hand off between nurses because, when followed accurately, the EHR will provide accurate and complete information for the seamless delivery of safe, competent and ethical care.[2]

References
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