From Paper to Electronic Nursing Documentation in the NICU

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Introduction/Background

Electronic documentation has become the standard for recording nursing care. South Shore Hospital had implemented electronic documentation in all of the inpatient units, including critical care using the Meditech 5.X platform. All nursing care was electronic with few exceptions, such as critical care infusions. The 30-bed Level III NICU was the last unit to document all care using a paper flowsheet. Electronic NICU provider documentation and CPOE were well established as was BMV (Bedside Medication Verification). Use of paper documentation was an issue when staff floated to the Newborn Nursery or Pediatrics and were unable to document. It was a challenge for Nursery and Pediatric staff floating to the NICU to use the paper flowsheet. NICU staff was very invested in having electronic documentation.

Methods

A small group of nurses from NICU, Clinical Informatics and management met to develop a pilot project. With a large Meditech upgrade due in the near future, it was decided to limit interventions (e.g. vital signs, I&O) to those already in use in the Parent Child Division. A group would convene after the upgrade to work on developing documentation specific to the NICU. A group of four NICU nurses, three nurse informaticists experienced in nursery, pediatrics, pediatric ICU and NICU with support from NICU management and education would meet for four hours biweekly for 5 months. A go live date was set for month six. Various resources were used including the paper documentation forms, documentation used in the hospital's other units (including critical care) and standards from professional organizations. The neonatal provider group was consulted. A Standard of Care which included all the interventions and outcomes necessary for electronic documentation of the NICU patient was developed.

Results

Staff was required to attend a four- hour documentation class. Ten classes were held over a 2-week period. Every staff nurse was able to attend a class and successfully complete the competency. Go-live 24-hour Super User support was provided during the first two weeks. After the first week, most staff were comfortable and did not need support. The group met after 3 months to evaluate the process and make some changes to the documentation for clarity.

Discussion/Conclusion

The initial rollout of only a few interventions caused difficulty as nurses had to switch back and forth between paper and the computer. Some staff documented their care in both places. The major implementation was much more successful. Some of the nursing documentation was made to flow onto the provider documentation. Electronic documentation has enhanced the already collaborative process between nursing and providers.

References

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