

PROCEDURE FOR: Documentation: Perioperative Electronic and Paper Back-up

- POLICY:
1. The RN is responsible for documentation of all nursing care pre-, intra-, and postoperatively. Prior to beginning documentation, it is the first responsibility of the nurse to assure that s/he has opened the correct record for the patient about whom they intend to document.
  2. Paper back-up records will be used when the electronic system is not accessible. If paper back-up records must be used, information should be entered into the electronic record as soon as possible after the fact in order to support automated charging for time and materials; to assure defaulting of updated information from module to module and care event to care event; and to support accurate queries of information from records. A time notation / nurse's note should be entered explaining that information was originally recorded on a paper form and that the electronic record is being completed post-event. A monitor strip should be retained in lieu of entering a series of vital signs observations in Nursing PACU.
  3. A copy of the handwritten Nursing Intraop and Nursing PACU back-up paper records must be retained for billing purposes until all information has been entered into the electronic system.
  4. The RN is expected to document all aspects of the nursing process as it applies to the various phases of patient care and to document demonstrated critical-thinking skills practiced when caring for the patient. As appropriate for each phase of care, the patient record should reflect assessment, plan of care, interventions, and evaluation. Any significant or unusual occurrences pertinent to perioperative patient outcomes should be included.
  5. The RN is expected to use documentation wizards / scripts as designed to assure that all required aspects of patient care are addressed. If screens within wizards have any answer items pre-selected for the purpose of standardizing and / or expediting documentation (e.g., most common or expected answers), the RN must evaluate the accurateness of the selected items for each patient prior to approving the entry.
  6. The RN will be informed when changes to documentation wizards have been made; it is the responsibility of the RN to remain current about documentation changes by reviewing unit communications and by seeking clarification for any content about which questions or concerns arise.
  7. The RN is expected to identify any issues or problems related to documentation and to bring them forward to nursing leadership for discussion and possible resolution. If the issue is of multidisciplinary concern, the RN should collaborate with anesthesiology/surgery or refer the matter on, as appropriate.

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8. Documentation components will be identified through professional organization best practices (AORN, ASPAN, SGNA, ASA, etc.), regulatory (DPH, Joint Commission, CMS, etc.) requirements, JDH / UCHC performance improvement initiatives, etc.
9. Preoperative (preadmission and day of procedure) documentation should address, but is not restricted to:
  - a. patient surgical, medical, and anesthetic history
  - b. medication management (medication history; specific instructions about medications for diabetes control, anticoagulation therapy, and hypertension control)
  - c. preadmission patient / family education
  - d. risk of falls
  - e. skin condition and wound care
  - f. pain - acute and chronic
  - g. prep - skin, colon
  - h. preparation / administration of medications, especially preoperative prophylactic antibiotics
  - i. risk for venous thromboembolism formation
  - j. required paperwork such as informed consent, transfusion consent, history and physical
  - k. site marking
  - l. vascular access and pt. response
  - m. medications administered and patient response
10. Intraoperative documentation should address, but is not restricted to:
  - a. skin condition
  - b. positioning devices and supports and all personnel involved in the positioning process, including any immobilizing devices used
  - c. use of and related patient responses to equipment such as electrosurgery, tourniquets, lasers, fluoroscopes, etc.
  - d. specimens, cultures, dressings, drains, catheters, packing, casting materials, etc.
  - e. placement and location of implants, including all unique identifying and tracking information
  - f. skin preps and antimicrobial solutions
  - g. Time Out process and, as appropriate, site marking
  - h. wound classifications
  - i. documentation of all count outcomes, as appropriate
  - j. vital signs, pain ratings, and pulse oximetry values, if nursing monitoring only involved; if moderate sedation, other specific monitoring information such as oxygen flow rate, heart rhythm, and sedation value
  - k. medications administered and patient response
11. Postoperative documentation should address, but is not restricted to:
  - a. primary assessments of airway, breathing and circulation
  - b. secondary full assessments, as appropriate for patient and procedure performed

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- c. ongoing pain assessments
- d. medications administered and patient response
- e. intake and output for overall fluid balance
- f. postoperative patient / family teaching related to anesthetic and invasive / operative procedure(s) performed
- g. postoperative nausea and vomiting management
- h. medication reconciliation for ambulatory patients
- i. postoperative incision / puncture site management, with additional vascular, neurosensory, etc. checks as appropriate
- j. vascular access, with infiltration and phlebitis ratings at discharge

12. Once the record has been signed, an addendum note should be used for simple entries of additional or supplemental information that does not normally reside in specific fields. The addendum note should indicate the name of the person adding the notation and the time of the event about which the addendum is being entered.

If the missing information should reside in a specific field (eg, specimens, drugs, implants), the record should be re-opened by a Superuser to add the missing information into the appropriate field and to add a nurse's note explaining the circumstances about the record being accessed (eg, the record was accessed by which Superuser at the request of Nurse X for the purpose of completing documentation of specimens and medications administered).

13. If a record must be accessed after signing by a Superuser, a time notation will be entered to indicate the name of the Superuser, the date / time the record was accessed, and the reason for accessing the record
14. If a record was completed mistakenly for the wrong patient, the user must notify a system administrator to combine or delete modules and / or care events, as appropriate.
- a. incorrect record will be printed
  - b. perform record merge
  - c. print merged version
  - d. compare both versions and correct any erroneous entries of module level information; enter a notation as in #13 above if signed record must be modified
  - e. print final copy

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 4/09

REVISION DATE: 7/09