**Recommended Practices for Perioperative Health Care Information Management**

**Recommendations I-IV**

Overview: This document includes recommendations for practice that are meant to serve as achievable goals for optimal level of practice. Practice may vary depending on the setting. These are guidelines and are adaptable to different practices.

Purpose: To serve as guidance for perioperative nurses related to documentation and management of patient care information. This document is an outline that can be used to help create a complete documentation platform. It is not all inclusive and should not be seen as the only guideline that needs to be used.

* **Recommendation l**: The patient’s health care record should reflect the perioperative patient’s plan of care, including assessment, nursing diagnosis, outcome identification, planning, implementation, and evaluation of progress toward the outcome.
	+ Periop RN conducts a patient assessment (physical, psychosocial, cultural, spiritual) and should record the findings before the procedure
		- Concurrent reassessment throughout patient’s perioperative experience contributes to continuity of care
		- Using nursing process structure (PNDS) improves the application of the assessment process
	+ Record should include nursing interventions performed, the time performed, and the person performing the care
	+ Expected patient outcomes identified by perioperative RNs should be recorded in the record
		- Nurses who associate the patient diagnosis with planned interventions are more outcome focused than task oriented.
	+ The record should reflect continuous reassessment and evaluation of perioperative nursing care and the response to implemented nursing interventions
		- Patient data must be collected concurrently with each assessment, reassessment, or evaluation and recorded in the record
		- Continuous evaluation establishes a baseline
* **Recommendation ll**: Perioperative nursing documentation should be synchronized with the nursing work flow
* Nursing work flow is the cognitive process of nursing care activities
* Documentation of nursing activities is dictated by health care organization policy and it is necessary to inform other health care professionals involved in care
* Incorporating nursing process work flow into the framework of clinical documentation platforms has been shown to improve documentation completeness and compliance
	+ Clinical documentation should use a format that facilitates data capturing designed to support clinical work flow while eliminating redundancy
	+ Burden of documentation is associated with decreased nursing attention to patient care. Redundancy in documentation activities reduces the nurses ability to focus and can lead to adverse patient outcomes. **When processes are simplified and data capture is standardized and organized, there is reduction in the reliance on memory to complete tasks, thereby eliminating potential harmful events**
	+ A study that observed nurses switching between activities (patient care to documentation) with documentation being completed in intervals, showed nursing cognitive disruption, slower performance, and raised potential for error (35).
	+ A follow-up study: repeated clustering of patient care and documentation activities affected nursing work flow by increasing the amount of time dedicated to electronic documentation without negatively affecting direct patient care time
		- Clinical documentation should reflect patient-focused care. Patient focused interventions should be incorporated into the healthcare record
		- Perioperative RNs should evaluate electronic documentation systems for their effect on workflow and patient safety
			* Should address: clinical work flow, information needs of the patient care environment, patient population characteristics, clinician and provider usability requirements
		- Research has shown that changes in clinical work processes have both positive and negative influence on clinical work flow and patient safety
* **Recommendation lll:**  Electronic perioperative nursing documentation should use structured vocabulary (PNDS) inclusive of the nursing process work flow with discrete representation of each phase of the perioperative patient care continuum
	+ Structured vocabulary describes patient care using controlled and unambiguous terms
	+ The PNDS should be incorporated into the documentation platform
	+ Each phase of perioperative nursing documentation should incorporate nursing process workflow
		- Standardization of patient care information improves the quality of the data and can be used to support the extraction and interpretation of data (69)
	+ The health care organization should implement a documentation system that includes a standardized electronic framework
		- Promotes uniformity in comprehensive patient care data
		- Adoption of electronic medical record is important for quality of care
* **Recommendation lV:** Perioperative nursing documentation should be structured to meet professional and regulatory compliance requirements for a comprehensive representation of patient care
	+ Patient care information that is documented is a tool for monitoring and evaluating the patient’s health status and response to care, a resource to evaluate compliance with regulatory requirements, and a method to keep records for reimbursement
	+ Documentation should correspond to elements of regulatory statutes, national practice standards, and mandatory quality and reimbursement
		- **Components for clinical documentation should include the following**: assessments, clinical problems, **communications with other health care professionals regarding the patient, communication with and education of the patient (patient’s family members, designated support person, and other third parties**), medication records, orders, patient care interventions, patient clinical parameters, patient responses and outcomes, and plans of care reflecting social and cultural framework of the patient
	+ Documentation should correspond to professional guidelines and standards
		- (list of organizations with guidelines see pg 6-7) – includes AORN
	+ **Documentation should correspond to established recommended practices for nursing care**
		- Including: Aseptic technique maintenance, local anesthesia administration, medication administration, moderate sedation/analgesia, patient care considerations (latex allergy, dentures etc), patient positioning, patient information exchanges, specimens, sterilization, traffic control measures, and safety precautions
			* Safety precautions include electrical, environment of care prep (ex blanket warmer temps), equipment use (ex laser, MRI), fire prevention, human tissue procurement, infection prevention, tissue protection, radiation exposure prevention, retained surgical items prevention, correct procedure process, skin prep
	+ Documentation should adhere to local, state, and national regulatory requirements (see pg 9 for list)
		- **Criteria identified by national regulatory agencies include**:
			* Allergies, cultural variables, equipment used for care (with type, model number), names of patient support persons, nutritional considerations, ordered tests and services provided, patient family education, patient identifiers and demographics, patient attributes and status, safety precautions, surgical consents, and surgical implants/**explants**
	+ **Documentation should correspond to health care accreditation organization requirements**
		- Elements of this may include:
			* Blood and tissue tracking, compliance with joint commission’s patient safety goals, elimination of unacceptable abbreviations, hand off communication, identification of implantable objects, identification of designated support persons, infection control practices, medication reconciliation, patient care elements, pain management, patient and family member education, patient demographics, presence of current history and physical
	+ Documentation should include all patient care orders
		- All orders (verbal, standing, order on surgeon preference card, and order sets) must be dated, timed, and authenticated
		- Verbal orders must be documented when communicated
		- Standing orders (pref cards) should be reviewed frequently by the surgeon to ensure accuracy
	+ Patient care record must include informed consent for procedure unless designated as emergency
	+ **Individuals participating in perioperative care (including x-ray technicians**, observers, industry reps) must be documented with names, roles and credentials
	+ Clinical documentation platform should be tailored to its environment
		- Charting by exception should be well constructed and reviewed by risk management