# Quality Improvement Through Improved Documentation

**Kenneth Lobe, BSN, RN, Swedish Ballard Emergency Department**

## Background

Nursing documentation provides key information describing a patient's hospitalization, telling a story of the patient's journey detailing patient concerns, interactions, interventions, and patient response.

Research shows that documentation in the ED has unique challenges due to the intensity of service and rapid patient turnover. The fast-paced environment requires focused strategies and structures to meet regulatory requirements aimed at optimizing patient outcomes.

Review of organizational standards led to creation of an ED documentation policy. A initiative targeted on dissemination of an updated standard and engaging frontline nurses to be accountable for their documentation practice. Education of new and experienced staff about documentation standards.

## Purpose

To optimize practice standards in accordance to regulatory requirements, the organizational policy for ED nursing documentation was created. The project focused on application of the policy, ensuring compliance and augmenting current nursing documentation to enhance communication of the patient's ED trajectory.

## Methods

An initial audit, staff education and post intervention audits were used in this project.

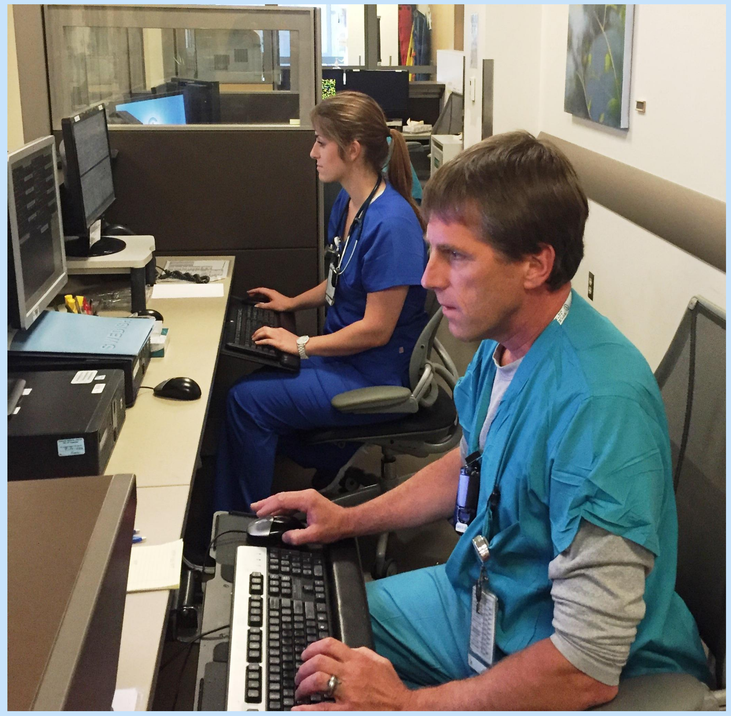
**Staff Education**

- Formal and informal presentations.
- New policy disseminated.

**Audits**

- 16 data points reviewed.
- Baseline established.
- Focused improvement in the 4 lowest data points, screening, hourly vital signs, ongoing evaluation and removal of PIV.

## Methods Cont.



**Staff Engagement**

- Staff completed 3 anonymous, random audits
- Ongoing evaluation/ feedback engaged staff to improve documentation and professional development.

## Data Collection

**Chart Audit of Current Practice**

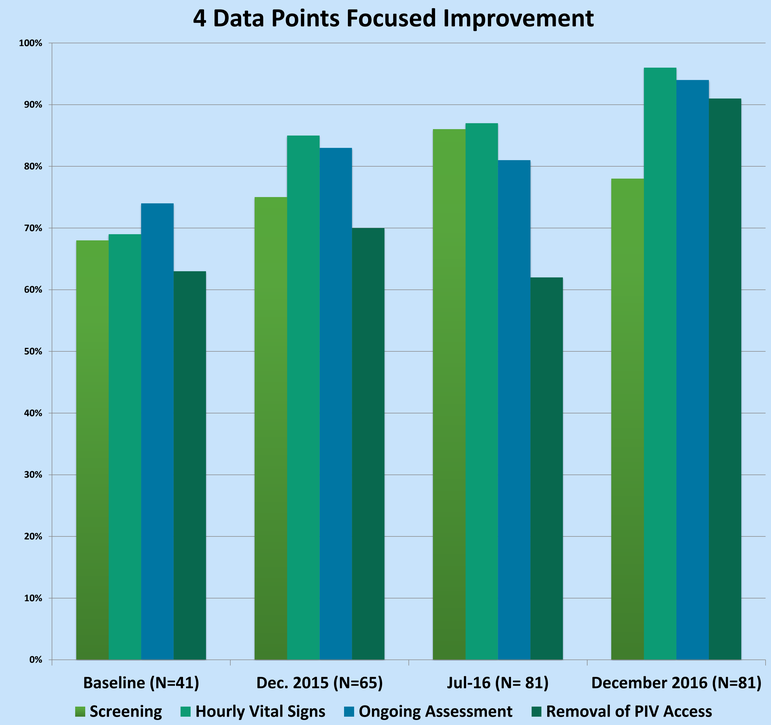
- Establish a baseline
- Post intervention establishing 4 data points for focused improvement.
- 6-month evaluations to evaluate improvement and sustainability.

**Audit Review**

- Review of strengths and areas for improvement
- Goal of 10% improvement in targeted areas

## Results

- Improvement in Screening, Hourly VS, Ongoing assessment and Removal of PIV access.
- Greater than 90% compliance in many of the 16 data points.
- Hourly VS went from 69% to 96% with improved documentation from RN's and ED techs.
- Focus on clear and concise documentation




## Conclusion

Nursing documentation standards are a challenge. The results of this project show that we can make improvements and ultimately impact patient outcomes through better telling of their story. Setting the standard, educating staff and having staff review documentation improves practice. The data further showed sustained and continued improvement. Future audit and monitoring will evaluate the extent of the engagement and commitment to nursing documentation and the integration of the standards into the department's culture.

Kenneth Lobe, kenneth.lobe@swedish.org