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Implementation of Charting Guidelines: The Impact on a Telemetry Unit

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Background

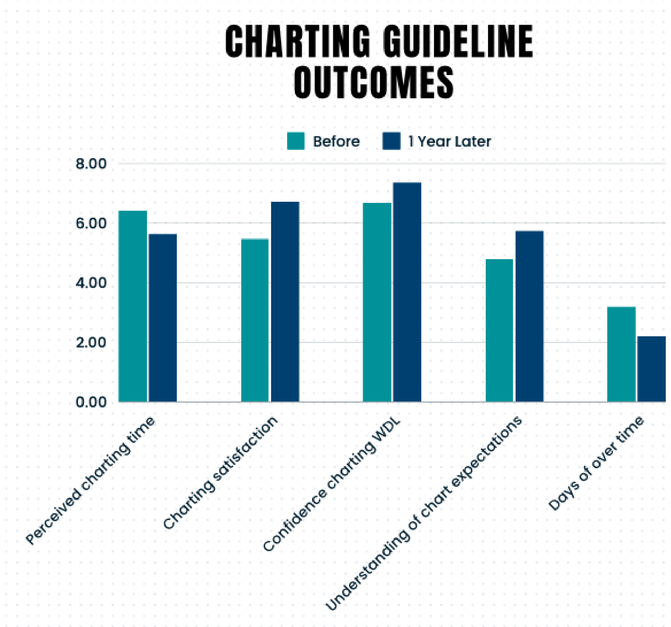
- New nurses and nurse residents did not have a clearly outlined policy of required documentation for the adult Head-to Toe Patient Care flowsheet
- Manzione, et al. (2020) revealed that 12% of nurses said a lack of proficiency and training in the EHR contributed to their burnout
- Nurses spend 19% to 35% of their time charting (Collins et al., 2018)
- Charting without clear expectations leads to over charting, decreased time for patient care, decreased nurse satisfaction

Purpose

- Improve charting efficiency
- Improve nurse satisfaction with charting
- Provide staff with clear charting expectations for a telemetry unit

Methods

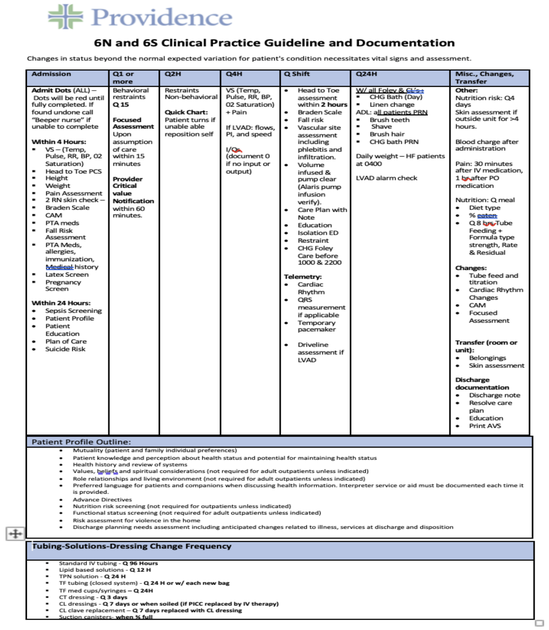
- Two reference guides were developed for nurses based on policy documentation standards
- The guidelines were delivered to nurses via email, shift huddle, and printed resource folders at the nurses' station
- Data was collected anonymous using a mixed-method survey served as the main source of data collection
- Pre and post implementation surveys were sent to nursing staff via email and QR code posters



Results

33 pre-guideline responses
51 post-guideline responses

- 80% of respondents who viewed the guidelines reported the intervention changed their charting practice
- Significant decrease in average perceived time charting in flowsheets (-2.23, p=0.02)
- Significant increase in charting satisfaction (2.74, p=0.008)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6N and 6S Clinical Practice Guideline and Documentation

Changes in status beyond the normal expected variation for patient's condition necessitates vital signs and assessment.

Admission	Q1 or more	Q2H	Q4H	Q Shift	Q24H	Misc., Changes, Transfer
Admit Dots (ALL) – Dots will be red until fully completed. If found undone call "Beeper nurse" if unable to complete **Within 4 Hours:** • VS – (Temp, Pulse, RR, BP, O2 Saturation) • Head to Toe PCS • Height • Weight • Pain Assessment • 2 RN skin check – Braden Scale • CAM • PTA meds • Fall Risk Assessment • PTA Meds, allergies, immunization, Medical history • Latex Screen • Pregnancy Screen **Within 24 Hours:** • Sepsis Screening • Patient Profile • Patient Education • Plan of Care • Suicide Risk	Behavioral restraints **Q 15** **Focused Assessment** Upon assumption of care within 15 minutes **Provider Critical value Notification** within 60 minutes.	Restraints Non-behavioral **Quick Chart:** Patient turns if unable able reposition self	VS (Temp, Pulse, RR, BP, O2 Saturation) + Pain If LVAD: flows, PI, and speed I/O (document 0 if no input or output)	• Head to Toe assessment within **2 hours** • Braden Scale • Fall risk • Vascular site assessment including phlebitis and infiltration. • Volume infused & pump clear (Alaris pump infusion verify). • Care Plan with Note • Education • Isolation ED • Restraint • CHG Foley Care before 1000 & 2200 **Telemetry:** • Cardiac Rhythm • QRS measurement if applicable • Temporary pacemaker • Driveline assessment if LVAD	W all Foley & Sides • CHG Bath (Day) • Linen change AOX – all patients PRN • Brush teeth • Shave • Brush hair • CHG bath PRN Daily weight – HF patients at 0400 LVAD alarm check	**Other:** Nutrition risk: Q4 days Skin assessment if outside unit for >4 hours. Blood change after administration Pain: 30 minutes after IV medication, 1 hr after PO medication Nutrition: Q meal • Diet type • % eaten • Q 8 hrs Tube Feeding + Formula type strength, Rate & Residual **Changes:** • Tube feed and titration • Cardiac Rhythm Changes • CAM • Focused Assessment **Transfer (room or unit):** • Belongings • Skin assessment **Discharge documentation** • Discharge note • Resolve care plan • Education • Print AVS

Patient Profile Outline:

- Mutuality (patient and family individual preferences)
- Patient knowledge and perception about health status and potential for maintaining health status
- Health history and review of systems
- Values, beliefs, and spiritual considerations (not required for adult outpatients unless indicated)
- Role relationships and living environment (not required for adult outpatients unless indicated)
- Preferred language for patients and companions when discussing health information. Interpreter service or aid must be documented each time it is provided.
- Advance Directives
- Nutrition risk screening (not required for outpatients unless indicated)
- Functional status screening (not required for adult outpatients unless indicated)
- Risk assessment for violence in the home
- Discharge planning needs assessment including anticipated changes related to illness, services at discharge and disposition

Tubing-Solutions-Dressing Change Frequency

- Standard IV tubing – **Q 96 Hours**
- Lipid based solutions – **Q 12 H**
- TPN solution – **Q 24 H**
- TF tubing (closed system) – **Q 24 H or w/ each new bag**
- TF med cups/syringes – **Q 24H**
- CT dressing – **Q 3 days**
- CL dressings – **Q 7 days or when soiled (if PICC replaced by IV therapy)**
- CL clave replacement – **Q 7 days replaced with CL dressing**
- Suction canisters – **when ¾ full**

Discussion

Positives

- Nurses preferred resource folder format
- Improved charting satisfaction after guideline implementation

Barriers

- High nurse turnover rate
- Difficulty reading small fonts
- Competing priorities
- EPIC changes alter flowsheet layout
- Guidelines did not impact reported over time spent charting

Implications for Practice

- Include guidelines in orientation for new hires
- Adaptable resource for other MedSurg units
- Consider other methods for reducing over time related to documentation

Acknowledgments

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References and additional information available upon request, please email mckenna.freed@providence.org