

# Implementing Standards-Based Documentation to Optimize Electronic Nursing Documentation



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## Lessons Learned

Aligning the new electronic documentation screens with existing practices fostered a smooth transition for nurses and project leaders. SBD allowed nurses to optimize their documentation practices to prioritize patient care delivery.

## Description

In healthcare, documentation practices can be lengthy and vary greatly between practitioners. As a high reliability organization, Humber River Hospital prioritized the standardization of electronic nursing documentation. Aligned with best practices and evidence-based guidelines, HRH integrated standard-based documentation (SBD) within the electronic documentation screens. The SBD methodology includes a method for documenting grouped predefined normal findings based on an established standard definitions. Significant findings or exceptions to the predefined standard are documented in detail. Implementation of this SBD has reduced repetitive nursing documentation and ensured that clinician communications were standardized.

## Actions Taken

After a literature review, SBD was selected as it was aligned with best practices and existing workflows. Various stakeholders collaborated to design electronic documentation screens aligned with this methodology. Education sessions were provided to nurses prior to go-live. Staff feedback was received though a survey on the integration of SBD into their practice.

## Summary of Results

As SBD is aligned with existing workflows, 90% of nurses found it easy to integrate into their current practices. Furthermore, 83% of nurses believed that SBD would benefit their clinical practice as reduced time spent on documentation would allow for increased time providing patient care. Overall, 84% of nurses were satisfied with the new SBD electronic documentation in supporting efficient and standardized documentation.

Perceived Efficiency of SBD compared to Current Documentation Practices

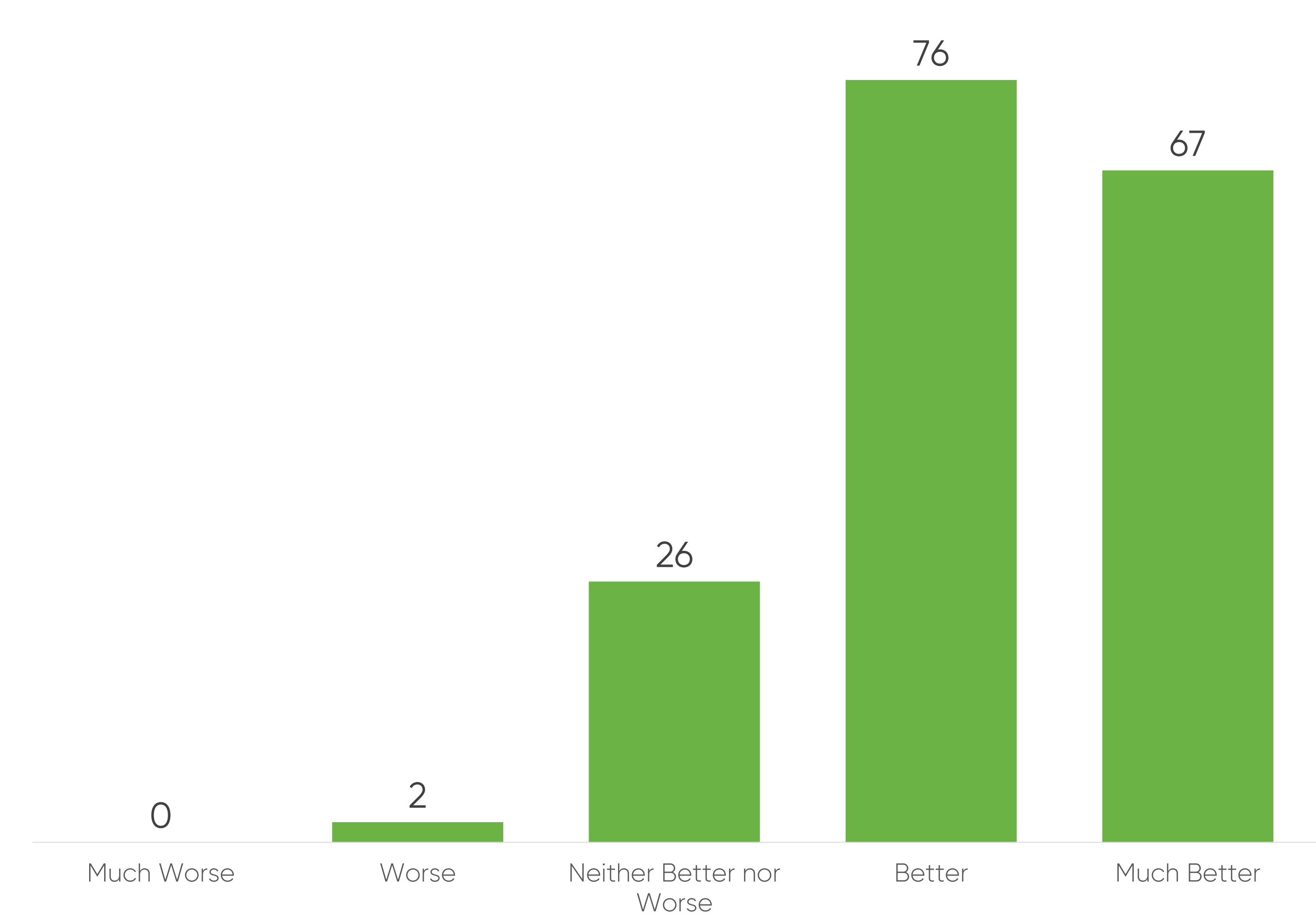


Figure 1. Out of 171 nurses, 83% of nurses believe that SBD is more efficient compared to current documentation practices.

The screenshot displays a digital form titled "Cardiovascular Assessment Parameters & Details". It includes a section for "Defined Standards" with text describing normal heart sounds, extremities, and capillary refill. Below this, there are two main sections: "Cardiovascular Assessment Parameters" and "Cardiovascular Signs & Symptoms". The "Parameters" section has a dropdown menu with options: "Within Defined Standards (WDS)", "Meets the standard, no further documentation required", "Not Within Defined Standards (NWDS)", "Does not meet the standard, detailed documentation required", and "Unable to Assess (UA)". The "Signs & Symptoms" section has a list of checkboxes for various conditions, including Anxiety, Bradycardia, Chest Pain at Rest, Chest Pain on Exertion, Cool Extremities, Cyanotic, Diaphoresis, Dizziness, Edema, Fatigue, Hypertension, Hypotension, Jugular Vein Distention (JVD), Light Headedness, Nausea, Palpitations, Petechiae, Purpura, Shortness of Breath at Rest, Shortness of Breath on Exertion, and Tachycardia.

Figure 2. SBD includes predefined normal parameters. Nurses can document Within Defined Standards if these parameters are met. Further documentation is only required if a patient's presentation is "Not Within Defined Standards".