That Was Then, This Is Now: 
Electronic Nursing Documentation

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Purpose of Nursing Documentation

- Communication
- Continuity of care
- Evidence of quality of care
- Performance improvement, research, EBP
- Reimbursement
- Legal protection
The Good ‘Ol Days...Or Were They?

- Prior to EMRs...
  - Combination of electronic and paper
  - Multiple documentation systems
  - “Where’s my chart?”
  - Narratives frequently summarized data and interventions due to fragmented documentation systems

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Electronic Medical Records

- Supports real-time charting
- Easily retrieved from multiple locations by multiple users
- Provides structure and standardization
- Integrates devices (monitors, pumps, etc)
- Decision support, care prompts
- One-stop-shopping for information

“There’s a flowsheet for that!”
Nursing Documentation in an EMR

- Desired outcomes:
  - Standardize documentation throughout the hospital for ease of use and retrieval
  - Ensure nursing documentation is complete, concise, accurate, non-duplicative, and done by exception
  - Increase efficiency by eliminating duplicative documentation
Charting by exception: a method of documenting findings, based on clearly defined standards of practice and predetermined criteria for assessment findings and interventions. Only significant findings or exceptions to the predefined standards are documented in detail.

- Charting by exception may guide both flowsheet and narrative documentation
- Recognized a legally sound when done well
Framework

- Multiple narrative formats were critiqued
- Susan Lampe’s Focus Charting was selected
Focus Charting

- Process driven documentation format
- Supports outcomes based care
- Charting is done by exception
- Narrative documentation follows Data-Action-Response (DAR) format with a header
- Narrative documentation is concise
Data and interventions reflecting care delivered will be primarily documented in flowsheets
- Flowsheet charting is documentation

Narrative documentation will not routinely “summarize” data and interventions

Follow charting by exception principles
Required Note Types

- **Event**
  - An occurrence or situation during the patient encounter that is significant enough to warrant narrative documentation in the medical record
  - DAR format required

- **Progress**
  - Evaluation of the patient’s progress within the plan of care; includes the patient’s status and/or response to treatment
  - DAR format not required

- At least 1 event or progress note must be written for each patient within each shift, including 4 hour shifts
Transition

- Clearly define outcomes and expectations
  - Have the right stakeholders at the table
- Identify documentation exemplars and change agents
  - Monitoring tools are effective to a degree
  - No substitute for 1:1 coaching and mentoring
- Set goals and timelines
- Include all stakeholders – don’t forget providers
- Nursing practice should drive EMR evolution, not the other way around
Questions...

References: