Utilizing Trauma Registry Data to Improve Emergency Department Documentation Practices

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Problem

Through trauma performance audits, we found there were documentation deficiencies identified for critically ill trauma patients after leaving the resuscitation bay and entering the main emergency department (ED). The deficiencies identified were consistent hourly vital signs (VS) and hourly neurological (neuro) assessments. The goal was to implement a process that would assist nurses in identifying the need for hourly assessments and documentation.

Barriers identified:

- Transition from paper charting in the resuscitation bay to electronic charting in the main emergency department.
- Transition to new electronic health record (EHR).

Interventions

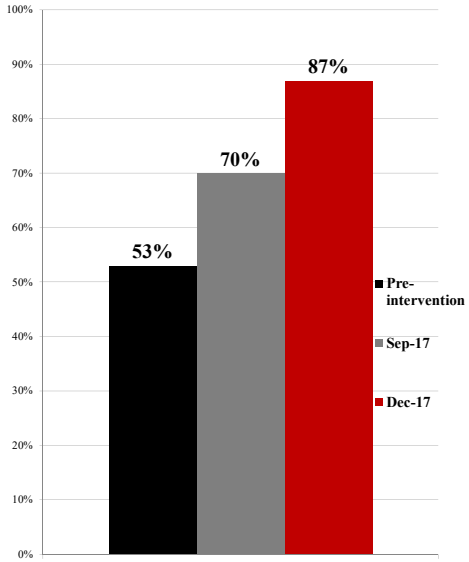
A chart audit of trauma intensive care unit (ICU) patients admitted through the ED was conducted. The audit included documentation of hourly vital signs on all ICU patients, and documentation of hourly GCS and pupil size on patients with a head injury. Education was provided to ED residents and nurses on ED policy requirements for charting on patients admitted to the ICU.

In July of 2017, a revision of the trauma resuscitation order set was completed to ensure patients that went through the trauma bay automatically received an order for hourly vitals until determined not to require ICU care. Nursing was then further educated to order hourly neurological checks on patients with signs of a head injury. Once the order was placed an hourly reminder populated in the nurse's activities tab in the new EHR.

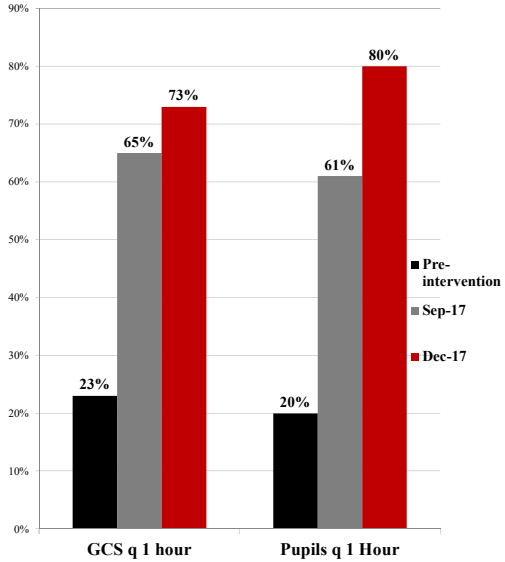
Results

- Over the span of three months, 283 patients went through the trauma resuscitation bay.
- Out of the 283 patients, 138 patients went to the main ED to await ICU admission.
- Out of the 138 patients awaiting ICU admission, 69 of those patients had a documented head injury.

VS documentation audit pre & post intervention



Neuro documentation audit pre & post intervention



Conclusion

By providing education during staff meetings and pre-shift huddles along with automated reminders, the nursing staff has improved documentation of critically ill trauma patients and head injury patients early in the resuscitation process. Findings include an increased compliance with our ED policy of hourly charting of vital signs, GCS, and pupil size for patients admitted to an ICU.

Limitations that occurred: familiarity of new charting system, inconsistency in where the staff documented information, and high turnover in nursing in the ED. Ongoing education is provided for the nursing staff.

Monthly audits will continue to be conducted, and the results provided to nursing and nursing leadership.

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