Use of a Concurrent Audit Process and ED-Trauma Workgroup to Improve Trauma Resuscitation Documentation

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INTRODUCTION

- Our level I trauma center uses an electronic health record (EHR) to document trauma care.
- Nursing documents in an EHR, providing a real-time roadmap for documentation of required trauma elements.
- Documentation compliance was monitored and found to be less than 95% compliant in some areas.
- While various interventions were initially implemented, a study by D'Huyvetter et. al. (2014) shows that collaboration between departments can help improve documentation compliance and, thusly, a collaboration needed to be formed.

INTERVENTIONS

The initial interventions in 2016 included:

- EHR trauma documentation classes
- An "orange sheet" self-audit
  1. Alert/Activation status
  2. Physician arrival
  3. Initial vital signs – manual blood pressure, temperature, pulse, respiratory rate, pulse ox and GCS
  4. Repeat vital signs
  5. Mechanism/Primary/Secondary assessment
  6. Substance-abuse screening
  7. Documentation of fluids/blood products
- Direct RN feedback for fallouts

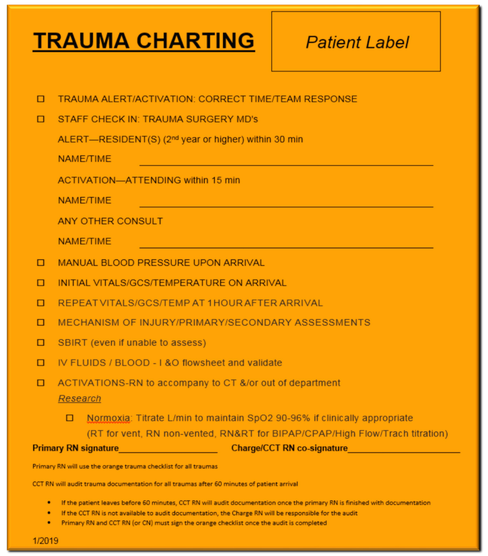
There was some improvement in documentation, but the goal of 95% was not met.

In 2017, interventions included:

- Quarter 1: Double RN audit verification with a nurse champion
- Quarter 3: ED workgroup formed
  1. EHR optimizations
  2. Trauma documentation champion to verify documentation compliance
  3. Positive reinforcement with use of a reward system for 100% documentation compliance

OBJECTIVES

- Improve trauma EHR documentation compliance with a goal of 95%
- Determine the best process to provide education, feedback and assistance to nursing in improving documentation
- EHR optimization to remove barriers to documentation



TRAUMA CHARTING *Patient Label*

- ☐ TRAUMA ALERT/ACTIVATION: CORRECT TIME/TEAM RESPONSE
- ☐ STAFF CHECK IN: TRAUMA SURGERY MD's
  ALERT—RESIDENT(S) (2nd year or higher) within 30 min
  NAME/TIME _____
  ACTIVATION—ATTENDING within 15 min
  NAME/TIME _____
  ANY OTHER CONSULT
  NAME/TIME _____
- ☐ MANUAL BLOOD PRESSURE UPON ARRIVAL
- ☐ INITIAL VITALS/GCS/TEMPERATURE ON ARRIVAL
- ☐ REPEAT VITALS/GCS/TEMP AT 1HOUR AFTER ARRIVAL
- ☐ MECHANISM OF INJURY/PRIMARY/SECONDARY ASSESSMENTS
- ☐ SBIRT (even if unable to assess)
- ☐ IV FLUIDS / BLOOD - I &O flowsheet and validate
- ☐ ACTIVATIONS-RN to accompany to CT &/or out of department
  Research
  - ☐ Normoxia: Titrate L/min to maintain SpO2 90-96% if clinically appropriate (RT for vent, RN non-vented, RN&RT for BIPAP/CPAP/High Flow/Trach titration)

Primary RN signature_____ **Charge/CCT RN co-signature**_____

Primary RN will use the orange trauma checklist for all traumas

CCT RN will audit trauma documentation for all traumas after 60 minutes of patient arrival

- If the patient leaves before 60 minutes, CCT RN will audit documentation once the primary RN is finished with documentation
- If the CCT RN is not available to audit documentation, the Charge RN will be responsible for the audit
- Primary RN and CCT RN (or CN) must sign the orange checklist once the audit is completed

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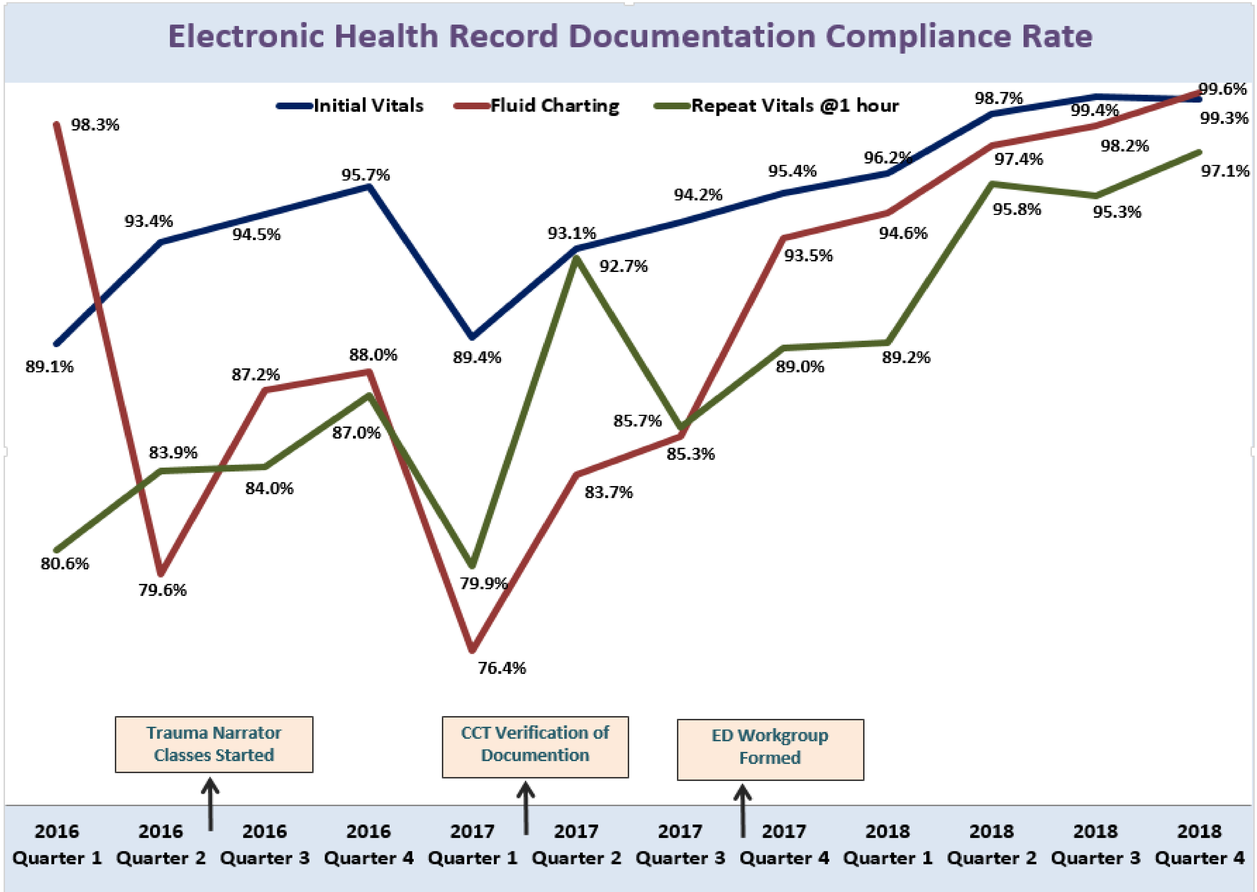

DISCUSSION/ NEXT STEPS

- In quarter 3 of 2017, a workgroup was initiated with trauma services and the emergency department. One focus of this group was to improve trauma documentation compliance in the EHR. We found that having the two groups collaborating and sharing ideas helped to generate solutions that would be meaningful to bedside staff. Subsequently, the goal of 95% charting compliance was consistently met.
- In addition, providing timely positive direct feedback related to clinical documentation was instrumental to the improvements made as a part of this project. The ED workgroup will continue to look for additional areas to improve system and patient care processes.

References

1. D'Huyvetter, Cecile; Lang, Ann M.; Heimer, Dawn M.; Cogbill, Thomas H. Journal of Trauma Nursing. 21(2):68-71, March/April 2014. Efficiencies Gained by Using Electronic Medical Record and Reports in Trauma Documentation

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