The innovation of the Electronic Health Record (EHR) system presented many challenges throughout all departments. Although mandatory education was offered, multiple audits revealed the need for a drastic improvement specifically related to pain management, plan of care, and blood transfusion documentation prior to the Joint Commission Survey.

Strive to continuously advance standardized, evidence-based practice through ongoing development and review of the Electronic Health Record.

Promote effective communication and best practice through the use of the standard governance communication structure to all clinical employees related to standardized usage of the EHR.

Blood Transfusion Requirements
- Transfusion Consent
- PLT Transfusion Indication
- Plasma Transfusion Indication
- Blood Administration Documentation
- Preoperative Anemia Screening

Plan of care Requirements
- Patient safety
- Appropriate treatment
- Timely responses to patient incidence

Pain Requirements
- Appropriate assessment and management of pain
- Screen for pain during initial assessment with periodic reassessments
- Educate patients and families about pain management

Background
The hospital continued to sustain successful practice by maintaining above average patient satisfaction scores in hospital core measures.

Nursing Documentation had zero errors and exceeded all charting standards required by Joint Commission.

The EHR council continues to promote standardized evidence-based practices, advance quality improvements and support to all nurses so continuity of care continues to be can be achieve in order to sustain a patient centered culture.

Aim Statement
Develop an independent EHR council that implements a standard of charting and completes continuous audits to ensure continuity of the nursing documentation process.

Process of Implementation
- Educational resources made easily accessible
- Frequent informational in-services
- Utilized multiple avenues of communication
- EHR binder located on every unit as a reference
- Specific badge cards made for every nurse

HCAHP Scores During Implementation

Scores maintained above average

HCAHP Scores Post Implementation

Scores maintained above average

Implications for Advancing Practice
Strive to continuously advance standardized, evidence-based practice through ongoing development and review of the Electronic Health Record.

Promote effective communication and best practice through the use of the standard governance communication structure to all clinical employees related to standardized usage of the EHR.

Outcomes
The hospital continued to sustain successful practice by maintaining above average patient satisfaction scores. The overall facility observed an absolute zero decline in hospital core measures. Nursing Documentation had zero errors and exceeded all charting standards required by Joint Commission.

Results

PLAN:
Implement a specific EHR council to disseminate quality improvement updates, enhance quality of care, establish a consistent standard for charting, and audit staff performances

DO:
The committee leaders were identified, a council charter was approved, and project milestones were defined.

CHECK:
Leaders will facilitate council activities as necessary in order to meet identified goals

ACT:
Council Implementation date: March 17, 2013

Joint Commission Documentation Standards