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Improving electronic health record (EHR) nursing documentation for blood draws

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Introduction: Blood draws are a common practice in Emergency departments (ED). Our current nursing ED practice of free texting the documentation in the blood draws was found to be insufficient and often times did not include some very basic elements such as gauge, venipuncture site, etc. Most of the nursing staff utilized free text documentation that often times did not provide clinically relevant data or no documentation was present.

Methods: We reviewed our current blood drawing practices, our current documentation section and through meetings with front line staff and nursing leadership decided to change our documentation template for IV/blood draws. Because changes affect all users of the EMR across our health system emergency departments all changes to ED Epic nursing documentation is reviewed by technical & clinical staff prior to implementing changes. A decision was made to transition from a free text note to a radio button documentation blood draw section. The radio button fields included routine blood drawing items such as anatomic site, needle gauge, tourniquet time, number of attempts, vacuum tube vs. syringe draw, IV angiocath vs. straight stick, and ultrasound use for placement. Documentation completed with this template is clearly displayed on the ED Encounter summary. The ability to report off of this documentation could be utilized to identify relationships and trends between pre-analytical lab collection events and lab results.

Results: After an initial roll out and education of staff an audit was performed to evaluate utilization rates of documentation of blood draws utilizing the new template. Education was performed using multiple modalities including: early adopters teaching others, an item about documentation was included on our nursing huddle white board and mentioned during daily rounding and through emails. After 3 months we reviewed 30 charts of patients who had blood drawn: 70% (21/30) had complete documentation utilizing the new template. Each case lacking appropriate documentation was reviewed by clinical nurse specialist to re-educate the front line staff about appropriate blood draw documentation practices.

Conclusion: We built and rolled out the new Epic EHR documentation template for nursing performed blood draws. Improved documentation of blood draws through a standardized template can result in better documentation than free text, improved tracking and improved care for patients requiring ablood draw in the ED. We have plans to validate our results and evaluate the effect of interventions on improving documentation as well as patient/provider factors associated with higher documentation rates.

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