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GUIDELINE FOR HEALTH CARE INFORMATION MANAGEMENT

The Guideline for Health Care Information Management has been approved by the AORN Recommended Practices Advisory Board. It was presented as proposed recommendations for comments by members and others. The guideline is effective December 1, 2011. The recommendations in the guideline are intended to be achievable and represent what is believed to be an optimal level of practice. Policies and procedures will reflect variations in practice settings and/or clinical situations that determine the degree to which the guideline can be implemented. AORN recognizes the various settings in which perioperative nurses practice; therefore, this guideline is adaptable to various practice settings. These practice settings include traditional operating rooms (ORs), ambulatory surgery centers, physicians' offices, cardiac catheterization laboratories, endoscopy suites, radiology departments, and all other areas where operative and other invasive procedures may be performed.

Purpose

This document provides guidance to assist perioperative nurses in documenting and managing patient care information within the perioperative practice setting. Highly reliable data collection is not only necessary to chronicle the patient response to nursing interventions, but also to demonstrate the health care organization's progress toward quality care outcomes. Health care data collection and retention is rapidly transitioning from traditional paper formats to standardized electronic applications that incorporate criteria from statutes and regulations, accreditation requirements, and standards setting bodies. Whether patient data are captured using paper or electronic formats, the nursing process should be completed for each surgical or procedural intervention performed.[1,2] The nursing process is a formalized systematic approach to providing and documenting patient care and is embedded within perioperative patient care workflow (ie, clinical workflow). Comprehensive perioperative documentation accurately reflects the patient experience and is essential for the continuity of goal-directed nursing care and for effective comparison of realized versus anticipated patient outcomes.[3,4]

This document should be viewed as a conceptual outline that can be used to create a comprehensive documentation platform. It is not inclusive of all documentation elements, nor should it be seen as the only guideline that may be used when developing or revising a clinical documentation system.

Recommendation I

The patient's health care record should reflect the perioperative patient's plan of care, including assessment, nursing diagnosis, outcome identification, planning, implementation, and evaluation of progress toward the outcome.[1,3-5]

The nursing process provides the guiding framework for documenting perioperative nursing care. When the nursing process is used in perioperative practice settings, it demonstrates the critical-thinking skills practiced by the registered nurse (RN) in caring for the patient undergoing surgical and other procedural interventions.[1,3,6-8] Documentation includes related information about the patient's current and past health status, nursing diagnoses and interventions, expected patient outcomes, and evaluation of the patient's response to perioperative nursing care.[5,9,10]

I.a. The perioperative RN conducts a patient assessment (eg, physical, psychosocial, cultural, spiritual) and should record the findings in the patient health care record before the surgical or other invasive procedure.[1,4]

The patient assessment forms a baseline for identifying the patient's health status, developing nursing diagnoses, and establishing an individualized plan of care. Concurrent reassessment throughout the patient's perioperative experience contributes to continuity in the delivery of care.[1,3,5,10]

Intraoperative nursing interventions for inpatient and ambulatory settings are embedded within the delivery of care but are not consistently reflected in clinical documentation.[7] In a systematic review of nursing documentation literature, inadequacies in the use of nursing process structure within clinical documentation resulted in one or more deficiencies in the application of the assessment process.[11] Using the structured data elements (eg, Perioperative Nursing Data Set [PNDS]) that include nursing diagnoses, interventions, and outcomes in clinical documentation demonstrates nursing contributions to patient outcomes and represents professional nursing practice.[7,8]

I.b. The health care record should include the nursing interventions performed and the time performed, the location of care, and the person performing the care.[4,5,12,13]

Clinical judgments are based on actual or potential patient problems (eg, nursing diagnoses), which determine the nursing interventions to be implemented to achieve expected

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