Recommended Practices for Documentation of Perioperative Nursing Care

The following recommended practices were developed by the AORN Recommended Practices Committee and have been approved by the AORN Board of Directors. They were presented as proposed recommended practices for comment by members and others. They are effective January 1, 2000.

These recommended practices are intended as achievable recommendations representing 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 recommended practices can be implemented.

AORN recognizes the numerous types of settings in which perioperative nurses practice. These recommended practices are intended as guidelines adaptable to various practice settings. These practice settings include traditional operating rooms, ambulatory surgery units, physicians' offices, cardiac catheterization suites, endoscopy suites, radiology departments, and all other areas where operative and other invasive procedures may be performed.

Purpose

These recommended practices provide guidelines to assist perioperative nurses in documenting nursing care in the perioperative practice setting. Documentation using the nursing process should be completed for each surgical and other invasive procedure. The nursing process is a formalized systematic approach to providing and documenting patient care. Perioperative documentation is essential for the continuity of goal-directed care and for comparing achieved patient outcomes to expected patient outcomes.

Recommendation I

The patient's record should reflect the perioperative patient's plan of care, including assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

1. Documentation should include information about the status of the patient, nursing diagnoses and interventions, expected patient outcomes, and evaluation of the patient's response to perioperative nursing care. The nursing process provides the governing 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 nurse in caring for the surgical patient.[1]
2. The patient's record should reflect an assessment (ie, physical, psychosocial, cultural, spiritual) performed by the perioperative nurse before surgical or other invasive procedures. A documented assessment forms a baseline for developing nursing diagnoses and planning patient care. Continuing this assessment throughout each subsequent phase of the patient's care (ie, intraoperative, postoperative) contributes to continuity of care.[2]
3. The patient's record should reflect the plan of care. The planning process begins when the perioperative nurse identifies nursing interventions that will address the patient's actual or potential risk for health problems (ie, nursing diagnoses). Documentation facilitates communication among health care team members, promotes continuity of care, and serves as a legal record of care provided.[3] Identifying desired patient outcomes that are individualized, prioritized, measurable, realistic, and obtainable aids in developing the plan of care.[4]
4. The patient's record should specify what nursing interventions were performed and when, where, and by whom during each phase of perioperative care.[5] The implementation process is a result of assessment and planning using nursing judgment and critical thinking skills. The goals of nursing interventions are to prevent potential patient injury or complications and to intervene/treat actual patient problems. Documenting nursing interventions promotes continuity of patient care and improves communication between health care team members.[6]
5. The patient's record should reflect a continuous evaluation of perioperative nursing care and the patient's response to applied nursing interventions. The nursing process directs perioperative nurses to evaluate the effectiveness of nursing interventions toward attaining desired patient outcomes. The evaluation process provides information for continuity of care, performance improvement activities, perioperative nursing research, and risk management. Documentation provides a mechanism for comparing actual versus expected outcomes.[7]