Improving Documentation in the Emergency Department

Jacqueline Wright-Cole, DNP, RN / Dr. Hedi Landry, DNS, RN

PRACTICE PROBLEM

Poor quality documentation is considered a key factor of delayed patient care and discontinuation of care at a local hospital emergency department.

Such mishaps have resulted in adverse events and unsatisfactory outcomes for all the stakeholders involved.

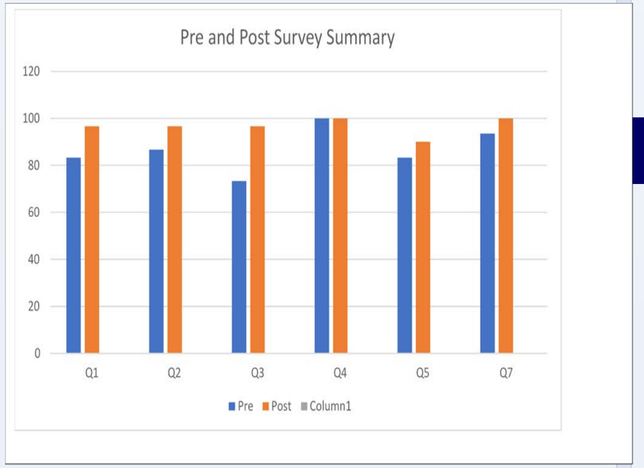
For nurses working in the emergency department at a local hospital, does the implementation of the Institute of Health Improvement SBAR guideline checklist compared to unstructured handoff forms help in improving documentation and handoff communication among the emergency department nurses in 8 weeks?

METHODOLOGY

- Settings: A local hospital Emergency Department
- A pre and post implementation design was utilized for collecting responses on the use of the IHI SBAR checklist for improving documentation and hand-off communications for a period of four weeks.
- A SBAR Assessment Evaluation tool adapted from Sears, Lewis, Craddock, Flowers, and Bovie (2014) was utilized to assess the nurses' perception of the tool.
- A sample of 30 nurses utilized the SBAR checklist phase 3 of the implementation process
- Descriptive statistics was performed using the IBM SPSS v25 to calculate the data.

RESULTS

- Post implementation significant finding indicated that 96.7% of the participants identified that good communication existed between healthcare providers, patients and families.
- While 50% of participants believed that the IHI SBAR checklist reminded them of important information to document and their message was fully received and understood.
- The Z- score and p-value were used to calculate the difference between the pre (73.3%), post (96.7%), Z -score/p-value (-2.53; .01**) intervention survey.



IMPLICATIONS

- Transformational leadership support, frequent auditing of charts, feedbacks, continuous education and visual reminders on the SBAR documentation tool are highly recommended to maintain change.
- The use of the SBAR checklist will help to inaugurate a culture of patient safety thus promoting an overall improvement in patient outcome and satisfaction for everyone.

CONCLUSIONS

Overall the project results indicate that utilization of a structured tool, such as the SBAR checklist continued to be a fundamental part for creating a culture of safety for the patients by reducing adverse events.

REFERENCES

Sears, K., Lewis, S. T., Craddock, M. D M., Flowers, B. R., & Bovie, L. C. (2014). The evaluation of a communication tool within an acute healthcare organization. Journal of Hospital Administration 3(5), 79.