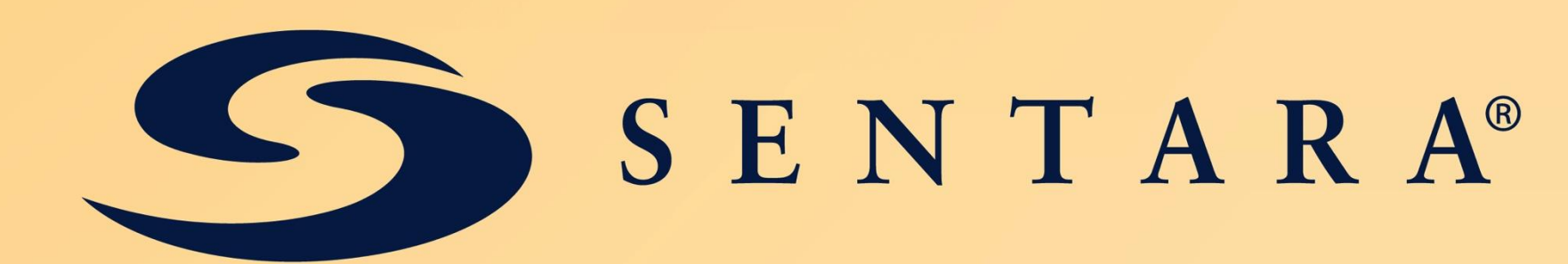




Improving Documentation Around Intake and Output

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Background

Proper assessment of a patient's fluid balance guides clinical decision-making and can reduce the risk of complications associated with dehydration, malnutrition, and electrolyte imbalances.² Recording the amount a patient has taken in and put out are important data points in the patient's care and can be dangerous if documented inaccurately.

Problem

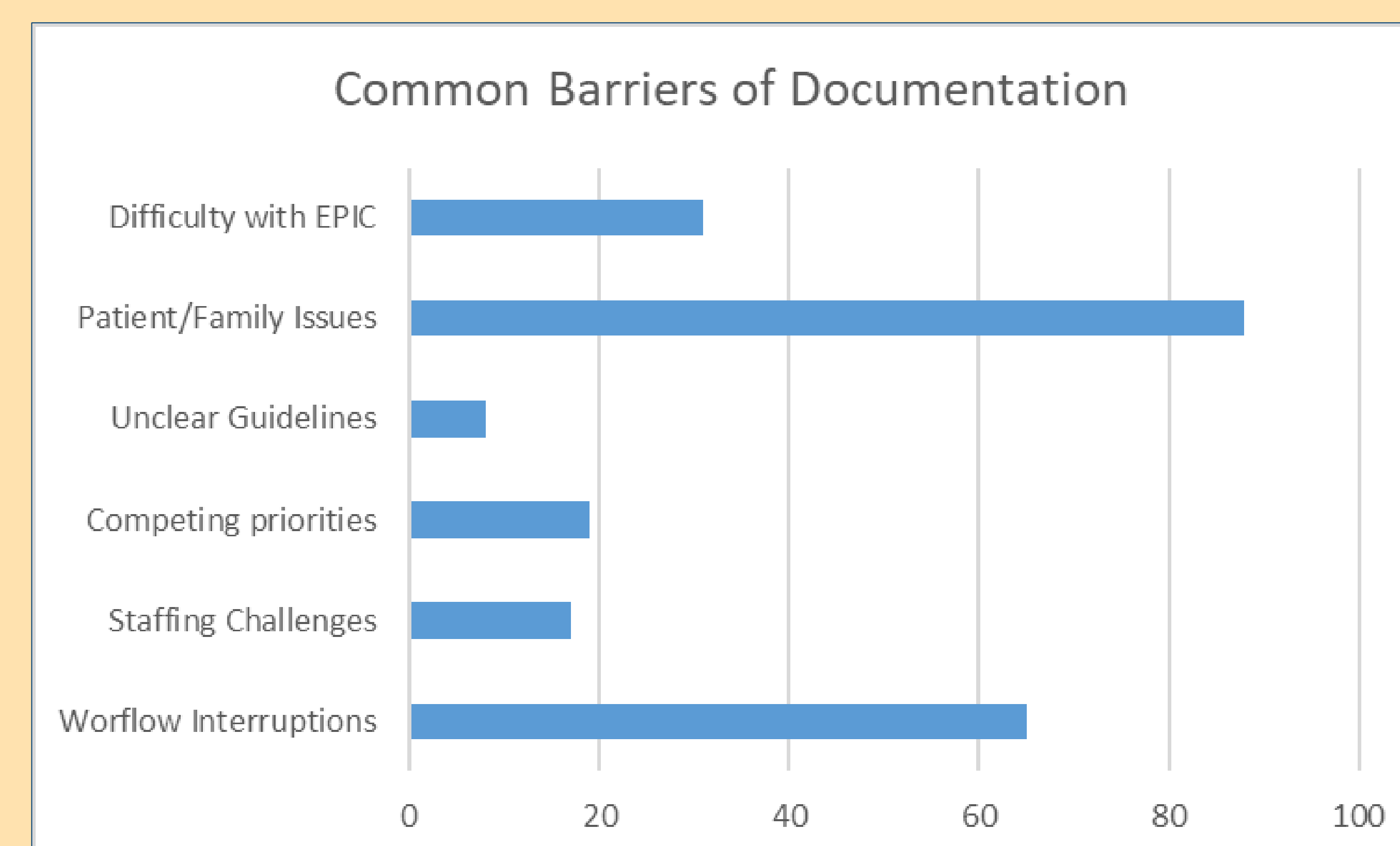
Through multiple case studies and reviews, the Nursing Peer Review committee at Sentara Virginia Beach General brought to light that accurate documentation for Intake and Output (I&O) was a consistent problem in providing quality care to patients at our hospital.

Methods

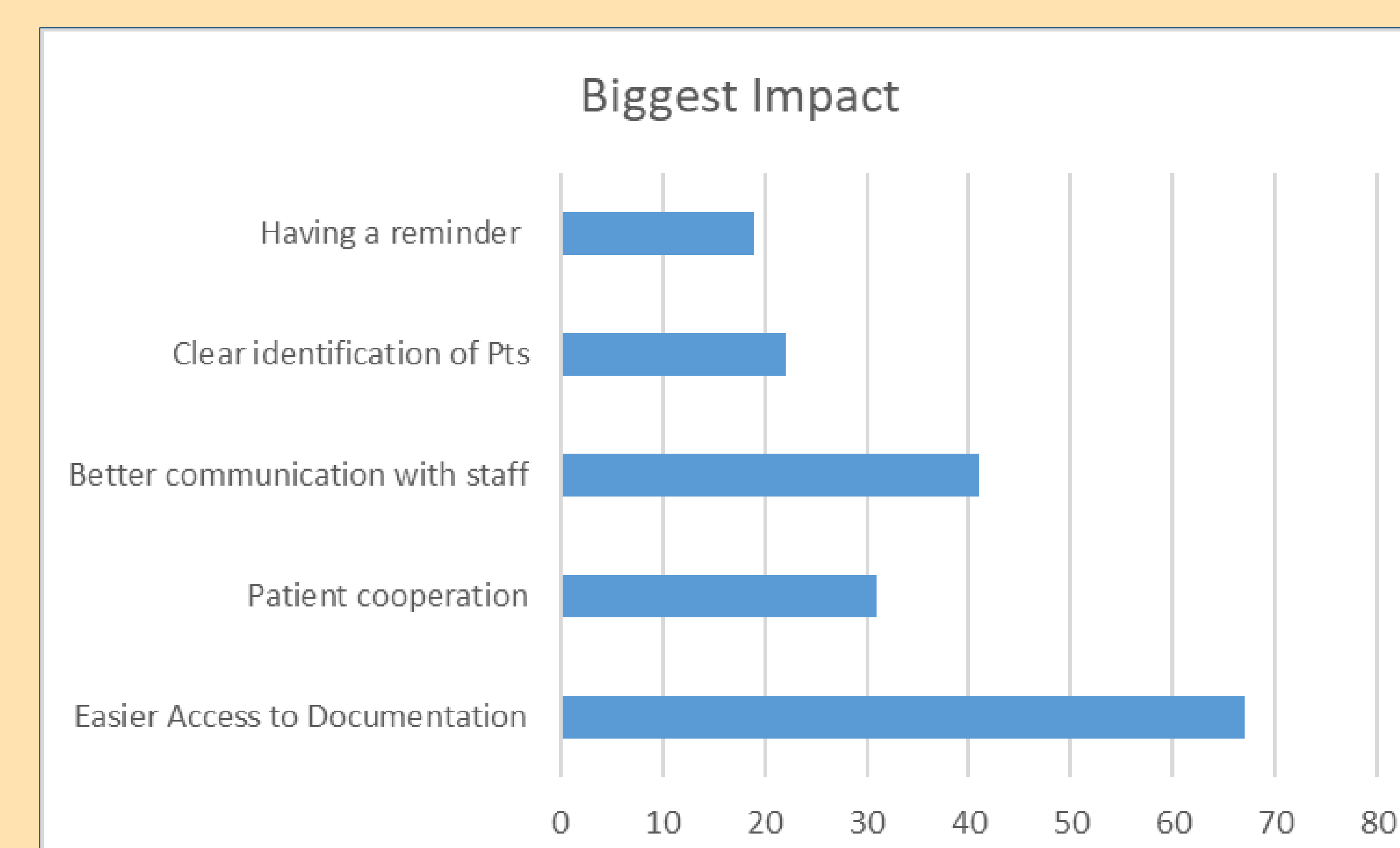
A Performance Improvement taskforce was created and made up of both leaders and bedside staff from the Operating Room, Emergency Department, and Inpatient Units. The purpose of this taskforce was to gain a better understanding of what was creating the difficulties around accurate I&O documentation and design an action plan for the Nursing Leadership to implement with their staff. The taskforce did a literature search to assist in defining the scope of the problem, the impact of the problem, and evidence-based solutions that have worked for other facilities. Next steps were to gain insight from the nursing community as to what the barriers to documenting I&O were and any proposed solutions. By involving staff in the problem-solving and decision-making aspects, the taskforce hoped to gain engagement from them into fixing the problem. The taskforce met every couple of weeks over the course of 4 months.

Results

A 5 question survey was assigned to nursing staff via Survey Monkey (inclusive of RNs, LPNs, NCPs, ED techs, SAs) across both Sentara Independence and Sentara Virginia Beach General Hospital. This survey sought to gain an understanding of the staff's perspective of the barriers to documentation and what solutions would impact performance improvement. Over 330 responses were received and the data was reviewed.



Q4. What are the top 3 barriers that you consistently run into that inhibit your ability to document complete and accurate Intake and Output (I&O) consistently?



Q5. What would make the most impact to your workflow to support complete and accurate documentation of I&O on all patients in your department?

Conclusion

Using the most common reported barriers and improvement suggestions, the taskforce created an action plan to present to the nursing leadership team. Querying the staff helped to better understand the challenges they face everyday in accurately recording I&O. Providing an environment where staff have the opportunity to engage with both a problem and a solution will lead to successful achievement of compliance with accurate fluid balance documentation.

Action Plan Highlights:

- Promote patient and family involvement in understanding the importance of monitoring all intake and output for the care of the patient
- Analyze staff education tools and consider developing signage, posters, and huddle reminders
- Hold staff accountable through "Rounding To Influence"
- Evaluate EPIC documentation and make recommendations for streamlining

References

- ¹Fieler, V.K., Jaglowski, T., & Richards, K. (2013). Eliminating errors in vital signs documentation. *Computers, Informatics, and Nursing*, 31(9), 422-427.
- ²Georgiades, D. (2016). A balancing act: Maintaining accurate fluid balance charting. *Australian Nursing & Midwifery Journal*, 24(6), 28-31.
- ³Stevenson, J.E., Israelsson, J., Petersson, G., & Bath, P.A. (2017). Factors influencing the quality of vital sign data in electronic health records: A qualitative study. *Journal of Clinical Nursing*, 1-11.

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