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No evidence support for intake/output documentation

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Parkview Health System

Objectives

- Upon the change of Dekalb hospital as a Parkview hospital, adoption of policies and standards were in process.
- The standard of care for intake/output (I/O) documentation was found to be every 8 hours at defined time periods of 6am, 2pm and 10pm in the hospital setting.
- The reality of nursing practice with electronic documentation facilitates 'real-time' documentation of I/O, so the question was raised as to why should we wait until 6a, 2pm, and 10pm do document I/O?

Purpose

- The purpose of this project was to determine best practice for documentation of I/Os comparing the current standard of q8hours (6am, 2pm and 10pm) to a more realistic measure of every 12 hours.

Problem

- Varied I/O documentation practices across the health care system.
- Inconsistency of nursing practice.
- Standards of care did not correlate with current nursing shifts and needs.

Background

- The accurate documentation of I/Os is imperative for quality patient care.
- Consistent standards of care provide clear guidance on required nursing practice.

Methods

- The clinical question was brought to Parkview Professional Practice Committee (PPC) to determine the need to change standard of care to an evidence-based approach. No one was aware of literature supporting either practice and felt current practice was based on tradition rather than evidence.
- A literature search was completed and found no research to support every 8hours I/O documentation.
- Only one study could be found and it focused on accuracy of I/O and raised the question if I/O was even necessary.
- Through our EBP fellowship class and collaboration with two Clinical Nurse Specialists at Parkview Regional Medical Center assisted with chart audits for I/O documentation on their units for 1 week

Collect data for 1 week

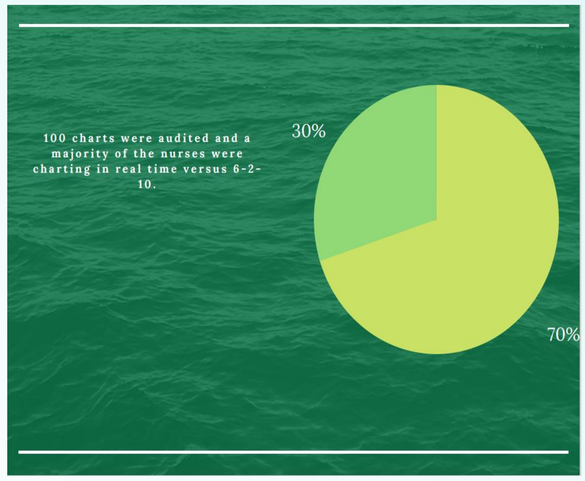
- Was I/O completed at 2-10-6 or at the end of shift

Units-

- ortho/trauma
  - Shifts 7-7
- Neuro
  - Shifts 7-7
- Med-surg 6
  - Shifts 3-3
- Med-surg 7
  - Shifts 3-3

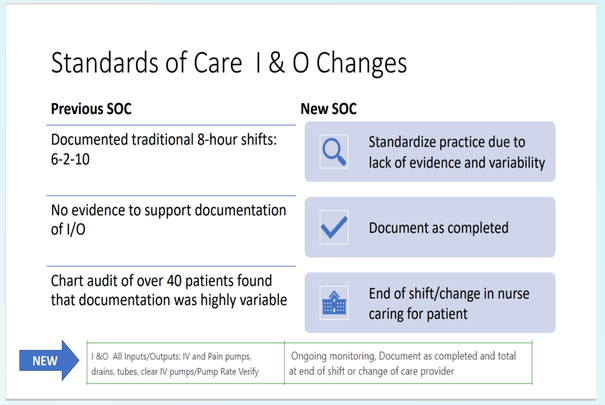
Results

- The audits were inconclusive and identified varying practices for documentation of I/O.
- Some were doing 6,2,10, but most were at end of the shift or not documented at all. Most audits identified documentation focused on pump rate verification.
- When PRV is taught to the nurses they were instructed to do this at the end of their shift.
- But audits identified nurses were doing them at different times, or not at all.



Conclusion

- Upon further discussion after presenting the data at PPC, it was determined that we would change our standard of care away from every eight hours, to end of shift
- The new standards of care changes are in progress and will state "Document as completed and total end of shift or change of care provider".
- Additional work is in progress to determine consistency with physician orders and epic view.



References

- Tonnessen, S., Scott, A., & Nortvedt, P. (2020). Safe and competent nursing care: An argument for a minimum standard? *Nursing Ethics, 27*(6), 1396-1407. https://doi.org.10.1177/09697330509137

Acknowledgements

- I added this is you wanted to put any