Nursing Practices and Perceptions in Code Documentation in the Electronic Health Record

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Introduction/Background

Accurate documentation of medical codes (i.e., cardiopulmonary arrest events) in real time contributes to appropriate delivery of life-saving interventions in the moment and provides a detailed record for later review to identify opportunities for quality improvement and to serve as legal documentation when medicolegal questions arise. Documentation that is clear, concise, honest, accurate, readable, and timely is essential if liability and cost are to be contained [1]. Few studies have examined nurses' knowledge, skill and attitudes towards code documentation [2]. To better understand the current perceptions and practices related to code documentation in the Electronic Health Record (EHR), we surveyed inpatient nurses across the hospital.

Methods

A 20-question, anonymous survey was distributed via email to 3,406 inpatient nurses employed at a single 900-bed, academic hospital. Voluntary completion of the survey served as implied consent.

Results

A total of 402 surveys were completed. 47% of the respondents had documented a real code in the Code Narrator. 74 % of these respondents had documented a code in real time using the Code Narrator. 64% of respondents did not feel comfortable using the Code Narrator. 25% had participated in a code not documented in the Code Narrator and 28% had participated in a code where the details of the event were not accurately recorded. Also, 91.5% nurses felt that more practice using the Code Narrator in a simulated environment would help them become more facile. All responders provided suggestions to improve Code Narrator functionality.

Conclusions

These findings suggest although most nurses feel comfortable using computers and the new EHR, few feel comfortable using the Code Narrator for code documentation in real time. Lack of practice navigating the Code Narrator and poor functionality significantly contribute to this discomfort. Future educational and technological interventions may provide nurses with the support needed to harness the power of real time code documentation in the EHR.

References

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