Mission POSSIBLE: Reducing Nursing Documentation Burden

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Learning objectives:

- Discuss the impact of nursing documentation burden on the healthcare team and patients.
- Describe a strategic approach to reducing the documentation burden.
- Identify methods to improve charting efficiency for nurses.

Background

- Nurses spend approximately 40% of each shift documenting. [1, 2, 3]
- Time spent documenting has an inverse relation to time spent providing patient care[1, 2, 3]
- Documentation burden leads to:[1,2,3]
  - Decreased job satisfaction
  - Increased burnout
  - Increased cognitive load
- Health worker burnout causes:
  - Increased risk of medical errors
  - Increased hospital acquired infections
  - Decreased patient satisfaction[1]
- National efforts to reduce documentation identified:
  - Patient's Over Paperwork Initiative[4]
  - The Joint Commission[5]
  - The 25x5 Symposium[6]

Methods

- Created a Mission POSSIBLE team with representatives from inpatient, ED, Perioperative Services, and nursing informatics
- Reviewed similar documentation efficiency projects from other academic centers
- Established principles to guide documentation decisions. (See QR Code)
- Bedside staff feedback collected through interviews and daily observations to identify inefficiencies and pain points
- Implemented a phased go-live approach, including charting by exception using within defined limits (WDL's), flowsheet (FLT) cleanup, and optimization of lines, drains, airways and wounds flowsheets (LDAs)
  (See Figure 1)

Results

- 15% and 22% decrease in active flowsheet time for ICU and acute care areas, respectively (See Figure 2 & Table 1)
- 82% reduction in nurses reporting redundant charting (See Figure 3)
- 59% reduction in nurses reporting > 30% of shift spent documenting after implementation of WDLs
- 748 groups, rows, and options were removed from nursing flowsheets

Discussion

Nursing documentation burden is a critical problem to address for both nurses and patients. Development and use of guiding principles is a key strategy in performing this work. Achieving a reduction in time spent in documentation is possible through a phased approach led by an interdisciplinary team with heavy engagement from frontline staff.

References

1. Department of Health and Human Services. (2022) Addressing health worker burnout: The U.S. surgeon general's advisory on building a thriving health workforce. https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf.
2. Collins, S. et al. (2018). Quantifying and visualizing flowsheet documentation burden in acute and critical care. AMIA Annual Symposium Proceedings 2018: 3248-357.
3. Padden, J. (2019). Documentation Burden and Cognitive Burden. Computers, Informatics, Nursing; 37(2): 60-61.
4. Center for Medicare and Medicaid Services (CMS) (2018). Patients over paperwork initiative. https://www.cms.gov/Outreach-andEducation/Outreach/Partnerships/PatientsOverPaperwork.htm
5. The Joint Commission (TJC). (2023). Joint Commission announces major standards reduction to provide relief to healthcare organizations. Retrieved May 20, 2023 from https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/lab-focus/lab-focus-issue-1-2023/major-standards-reduction-to-provide-relief-to-healthcare-organizations/.
6. Rossetti, S. Et al. (2021). 25x5 Symposium Summary Report. Retrieved May 20, 2023 from https://www.dbmi.columbia.edu/wp-content/uploads/2021/12/25x5-Summary-Report.pdf

An annual increase of 30,000 hours available

for direct patient care by reducing nursing documentation burden

"I had 5 patients and was done charting by 10am. I was able to walk my patient around the unit. I wouldn't have had time to do that before. Thank you, Mission POSSIBLE!"

QR Code: Mission POSSIBLE principles and references

Tables and Figures

Figure 1: Phased Go-Live Timeline

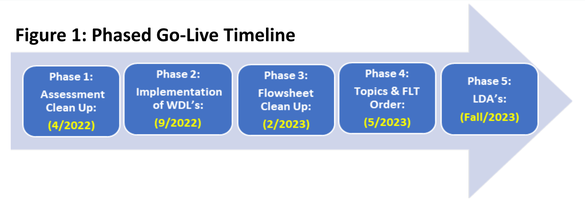


Figure 2: Average Head-to-Toe Flowsheet Activity Time Per Shift

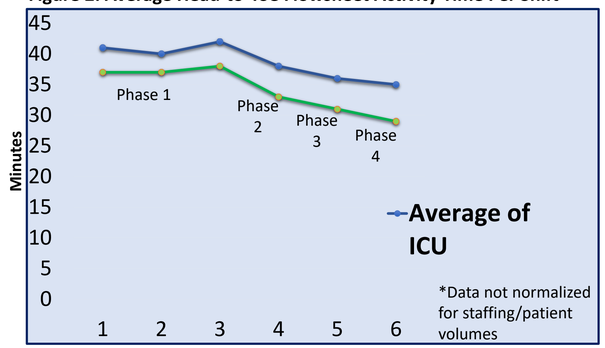
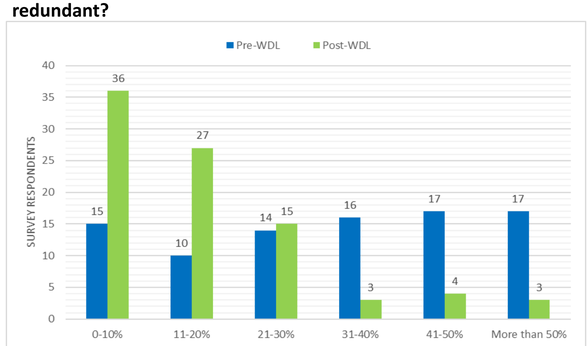


Table 1: Time Savings Calculation

	Average Nurses per Shift	Minutes Saved per Shift	Minutes saved per year	Hours saved per year
ICU's	86	4	251,120	4,185
Acute Care	175	12	1,533,000	25,550

Figure 3: RN Survey-What percentage of your charting feels redundant?



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Disclosure: No one in a position to control the content of this educational activity has relevant financial relationships with ineligible companies.

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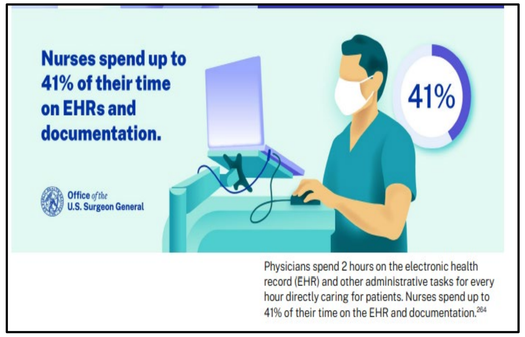
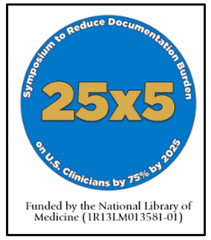
Background





Implement strategies and approaches developed by the 25x5 Symposium to reduce administrative burdens by 75% by 2025 so that health workers can spend more time with patients.

Figure 4: Definition of ANIA Six Domains of Documentation Burden (59)

Domain	Definition
Reimbursement	Documentation, coding and administrative charting required for reimbursement, by payors such as: CMS, Blue Cross/Blue Shield, United Healthcare, Aetna, Anthem, Cigna, Humana.
Regulatory	Accreditation agency documentation requirements such as: The Joint Commission, Healthcare Facilities Accreditation Program and State Regulatory Agencies.
Quality	Documentation required to demonstrate that quality patient care has been provided. This includes documentation requirements by the healthcare organization itself, as well as by governmental and regulatory agencies.
Usability	Insufficient use of human factors engineering and human-computer interface principles. EHRs are not following evidence-based usability/human factors design principles.
Interoperability	Insufficient standards requiring duplication and re-entry of data even though it resides elsewhere, either internal to the organization or in an external system.
Self-Imposed: "We've done it to ourselves"	Organizational culture's influence on what should be documented can exceed what is needed for patient care, including fear of litigation, 'we've always done it this way,' and misinterpretation of regulatory standards. Includes insufficient education on system use.

(Rosetti et al., 2021; Padden et al, 2019)

Methods

Guiding Principles:

- *Documentation accurately captures/supports relevant information about the clinical picture and clinical care*
- *Documentation is in alignment with organizational policies, procedures, and is clinically accurate using evidenced based literature.*
- *Practicing clinicians must be engaged in review of the content*
- *Maintains patient centered care and avoids excessive documentation to keep the time and attention of nurses about the patient at the bedside*
- *Regulatory experts evaluate content for compliance to standards*
- *The individual components of defined policies and procedures do not need to discretely documented, i.e. handwashing*
- *Additions to the medical record will be evaluated for evidence of effectiveness*

Modified from the University of Colorado, Project Joy

Criteria for Inclusion of a Documentation Element:

- It is needed to provide patient care, is reviewed by other care team members, or by the patient
- The nurse is the best or only person to document it
- Flowsheet entry is the best or only way to document it, and it is not documented elsewhere
- It is required by reporting mandate or regulatory compliance
- It triggers required actions for certain workflows, such as a consult
- It is required for billing or reimbursement
- It is required to document that the patient refused care