



Parkland

Every Click Counts: Optimizing Electronic Health Record Documentation to Improve Nurse Satisfaction and Increase Nurse-Patient Interaction

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Background

In any given day, nurses and patient care assistants (PCAs) at our large, urban academic medical center, will spend a substantial amount of time charting in narrative notes and clicking through flowsheet rows within the Electronic Health Record (EHR). Assuming that each click on a flowsheet row takes about one second to complete, it is easy to see the time and dollars spent on documentation. Additionally, duplicative and repetitive documentation in the EHR has long been identified as a bedside nursing dissatisfier, contributing to a feeling among front line staff of more time spent charting than caring for patients. To evaluate documentation perception at our institution, a survey was created and distributed among direct care nurses and PCAs.

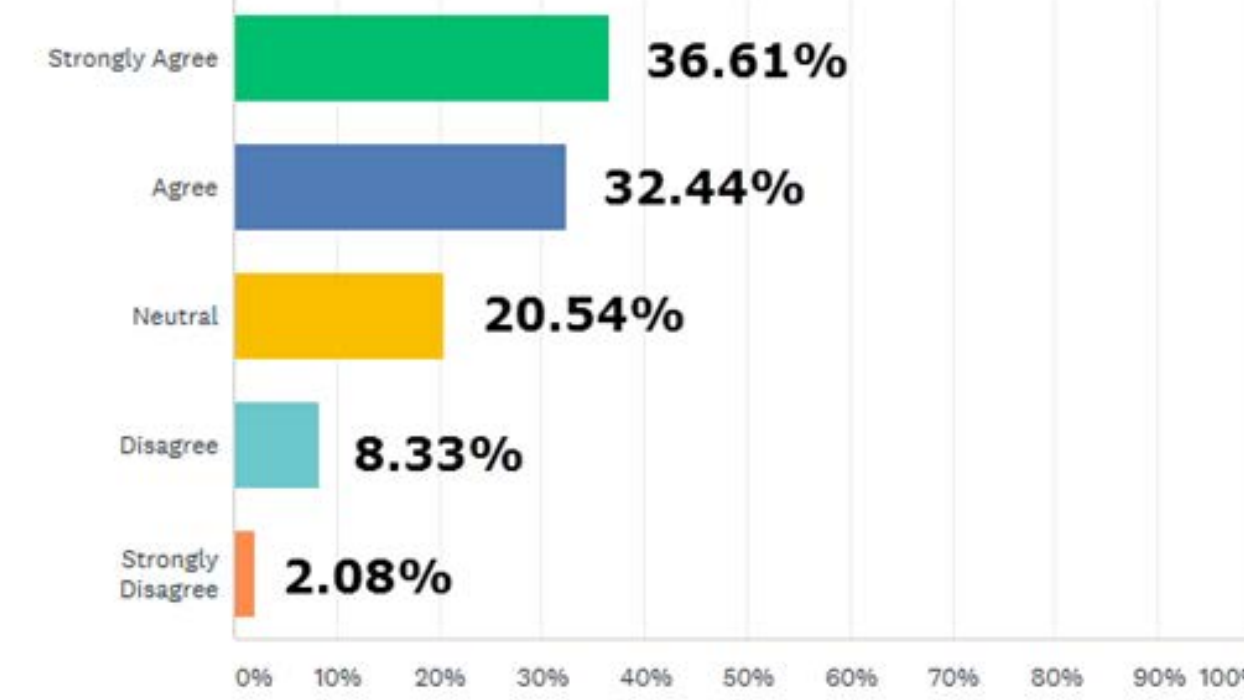
Methods

A ten question survey was sent via an internet service to direct care nurses and PCAs at our institution. The survey was open for eight days. A total of 336 respondents completed the survey at 100% rate of completion.

Survey Details	
Staff Surveyed	Direct Care Nurses and PCAs
Total Number of Responses	336
Completion Rate of Survey	100%
Average Time Spent to Complete Survey	1 minute 53 seconds
Number of Questions	10
Dates Survey Open	August 22, 2017 – August 30, 2017

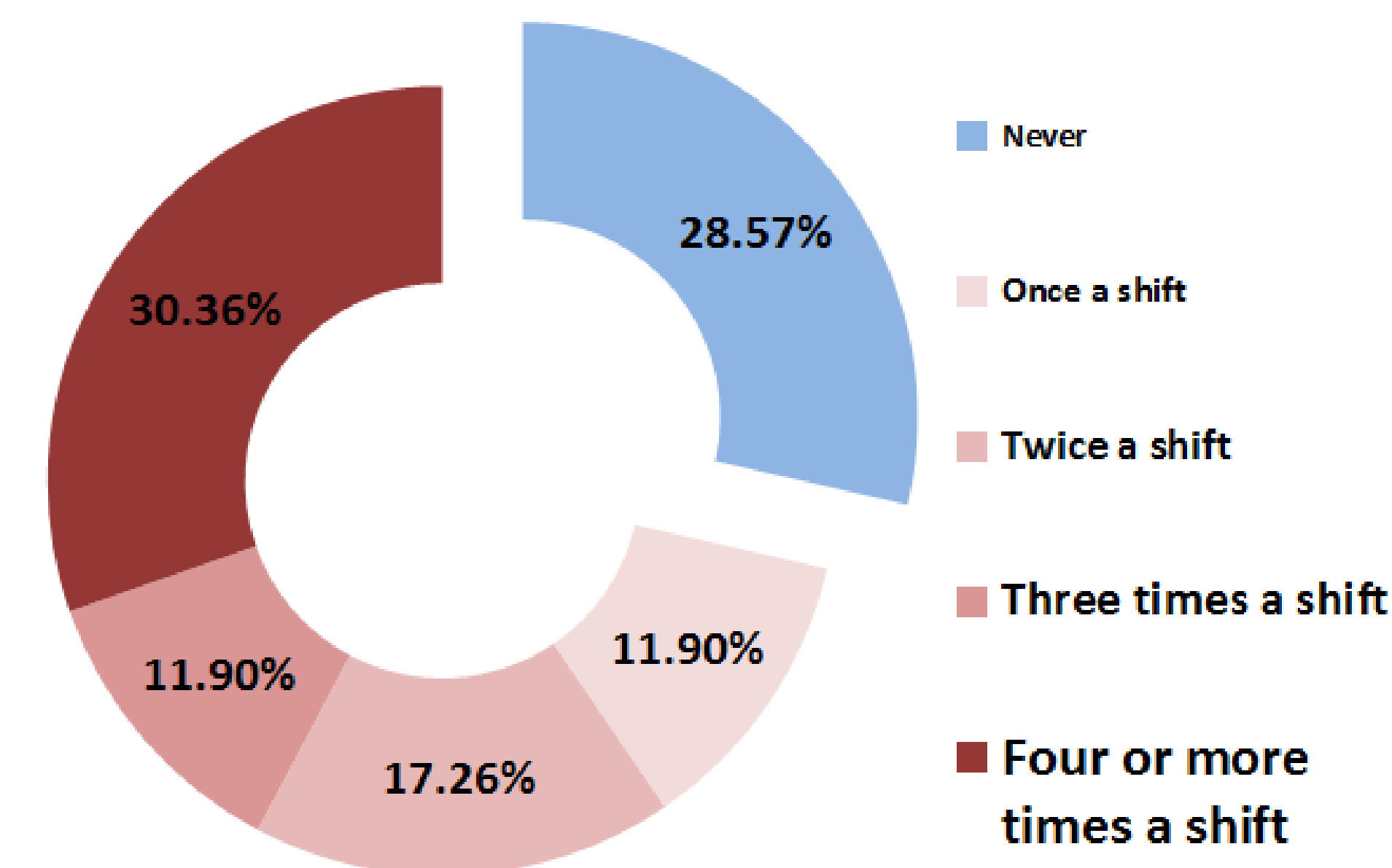
Survey Results

If my required charting was decreased, I would have greater job satisfaction.

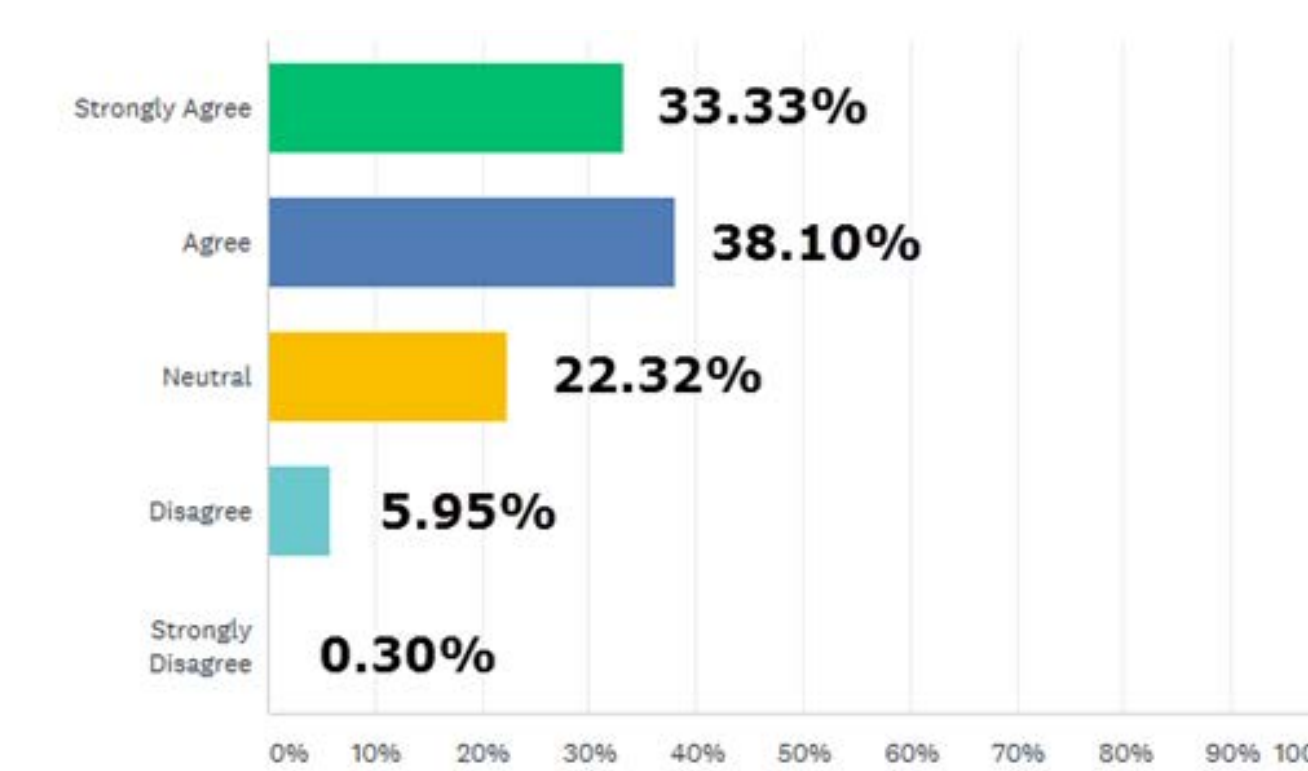


ANSWER CHOICES	RESPONSES
Strongly Agree	36.61% 123
Agree	32.44% 109
Neutral	20.54% 69
Disagree	8.33% 28
Strongly Disagree	2.08% 7
TOTAL	336

I duplicate charting the same elements...

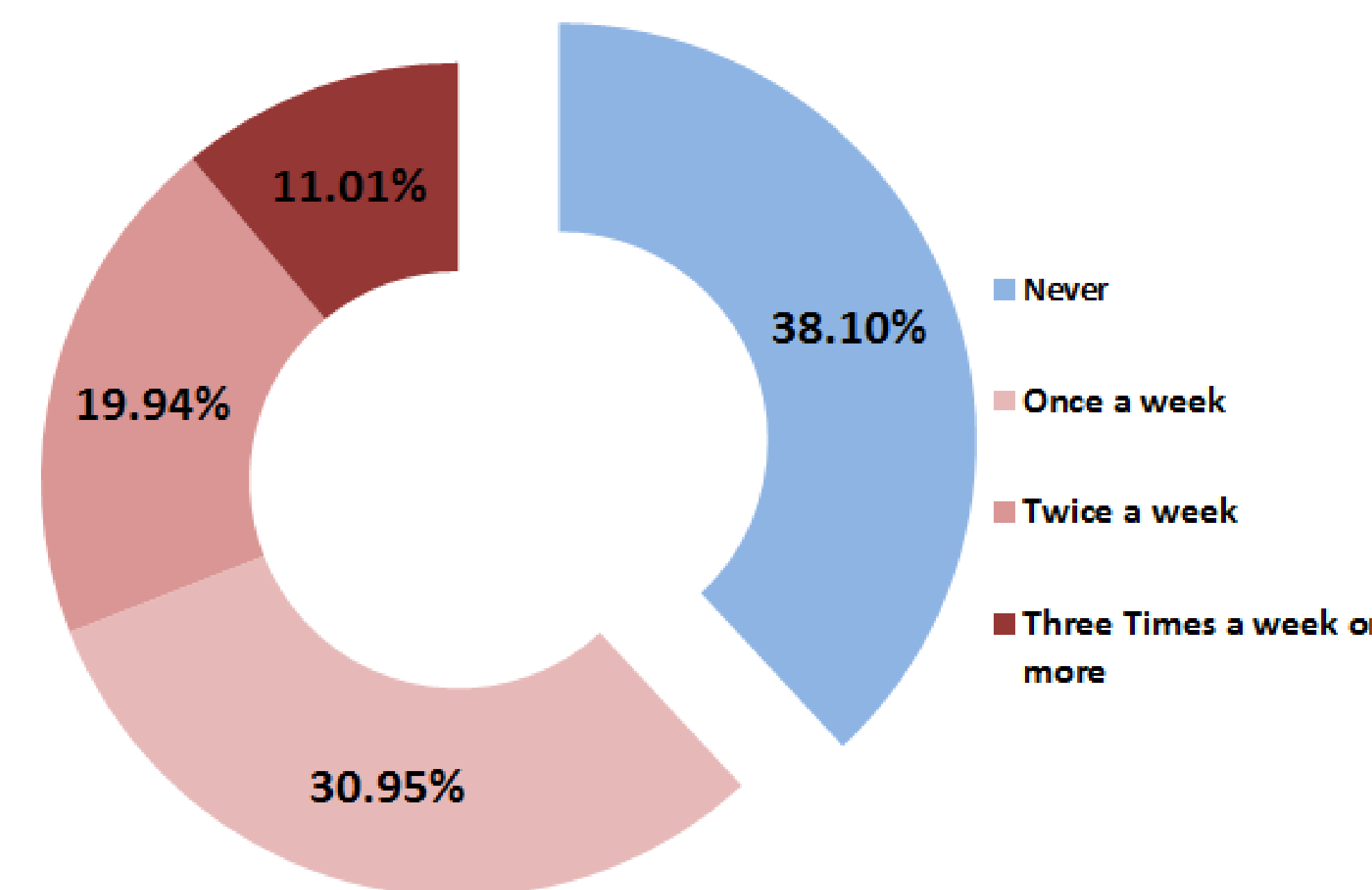


Documentation requirements are always added and never taken away.

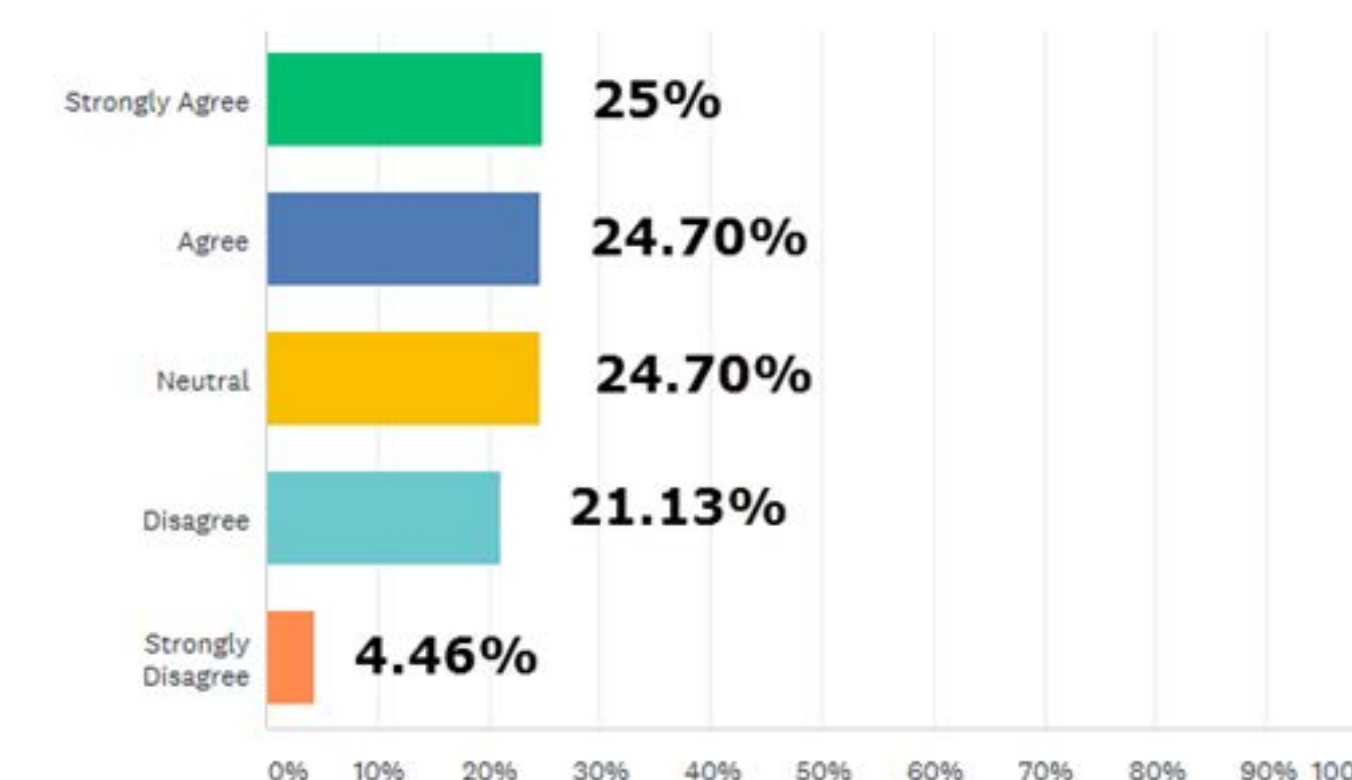


ANSWER CHOICES	RESPONSES
Strongly Agree	33.33% 112
Agree	38.10% 128
Neutral	22.32% 75
Disagree	5.95% 20
Strongly Disagree	0.30% 1
TOTAL	336

I stay after my shift is completed to chart.

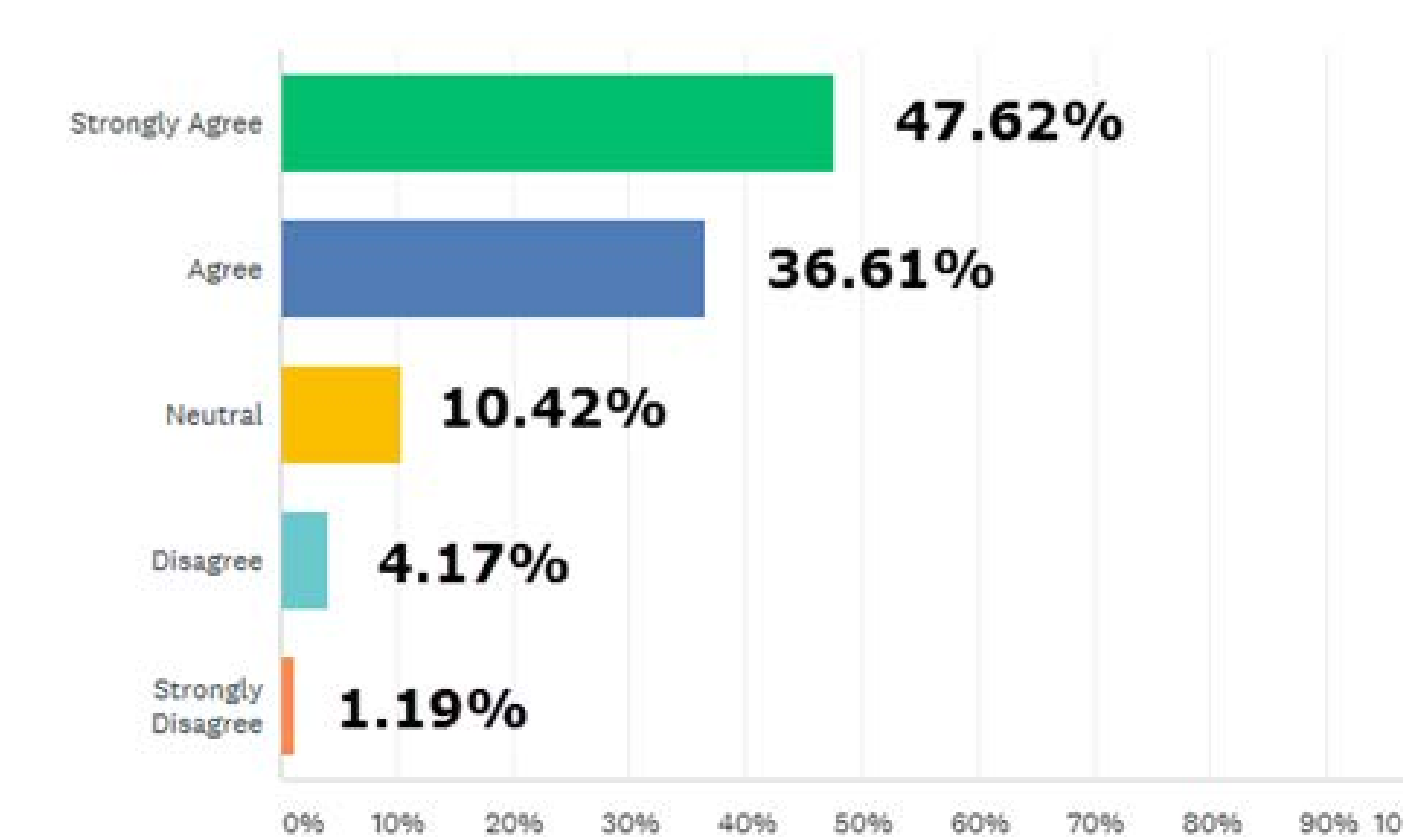


I spend more time charting than hands-on care of my patient.



ANSWER CHOICES	RESPONSES
Strongly Agree	25.00% 84
Agree	24.70% 83
Neutral	24.70% 83
Disagree	21.13% 71
Strongly Disagree	4.46% 15
TOTAL	336

Decreasing charting requirements means more time at the bedside.



ANSWER CHOICES	RESPONSES
Strongly Agree	47.62% 162
Agree	36.61% 123
Neutral	10.42% 35
Disagree	4.17% 14
Strongly Disagree	1.19% 4
TOTAL	336

Lessons Learned

The survey showed 78% of respondents reported learning documentation habits from their preceptors during unit-based training. While some charting habits were appropriate, many were discovered to be unsuitable. Additionally, individual units were found to have created their own documentation standards, causing confusion amongst staff. In an effort to diminish false notions surrounding documentation, "Myth Busters" was created for dissemination to all direct care staff.

Myth Busters

Myth #1 - "I must chart Critical Lab details in the flowsheet and in my Nurse Notes."

MYTH BUSTED

Critical lab results do NOT need to be documented in both the flowsheet AND nurse notes. These details need to be documented in the "Critical Lab Results" section of the flowsheet. You may reference Critical lab in your Nurse Notes if you wish, but this is not required.

Myth #2 - "I must chart pulse checks in the flowsheet and in my Nurse Notes."

MYTH BUSTED

Pulse checks do NOT need to be documented in both the flowsheet AND nurse notes. These details need to be documented in the flowsheet. You may reference pulse checks in your Nurse Notes if you wish, but this is not required.

Myth #3 - "I must chart Vital Signs in the flowsheet and in my Nurse Notes."

MYTH BUSTED

Vital signs do NOT need to be documented in both the flowsheet AND nurse notes. These details need to be documented in the flowsheet. You may reference vital signs in your Nurse Notes if you wish, but this is not required.

Myth #4 - "I must complete blood documentation before printing an AVL."

TRUTH

The blood documentation completion (BAC) link is not required. If you are printing the AVL, you must complete the blood documentation (BAC) link. The only thing that will prevent the AVL from printing is a missing Completed Blood Draw error.

NOTE - Documentation in the Nurse Notes on these items does not affect the BAC link. These details need to be documented in the flowsheet. You may reference these details in your Nurse Notes if you wish, but this is not required.

Solutions

The Nursing EHR Optimization Committee was formed with representatives from every nursing division within our institution with the goals of -

- Establishing best practices for nursing documentation
- Optimizing workflow
- Increasing efficiency
- Prioritizing and expediting optimization requests
- Brainstorming alternative solutions to optimize workflow

Conclusion

Collaboration from direct care staff is invaluable in the optimization process, since it is their increased satisfaction with documentation that we use to measure our success. Additionally, the survey showed 40% of direct care nurses and PCAs do not know who to contact if they have a suggestion about optimizing documentation, a number the Committee hopes to drastically change. The Nursing EHR Optimization Committee has the potential to impact far beyond the EHR, as optimized documentation leads to increased nurse-patient interaction, subsequently leading to increased patient satisfaction as more time is spent at the bedside. Furthermore, these improvements have the potential to increase nurse well-being at work and create overall increased job satisfaction.