Progress and Challenges in Nursing Documentation
Part II

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In a previous Nursing Informatics column in this journal, I asserted that there are areas with low-hanging fruit in which healthcare IT could be applied to make immediate and substantial gains in process improvement and increased patient safety in the delivery of nursing care. Two examples that were highlighted were barcode-assisted medication administration and vital sign collection technology implemented with vital sign documentation technology.

“After improving (medication administration and) vital signs documentation in the EHR and similar processes for which nurses are responsible, opportunities for improving nursing documentation will be more difficult to accomplish, but the payoffs are greater,” I wrote in that column. “Information technology is being used to improve flowsheets, assessment forms, plans of care, and other documentation approaches that nurses use.

“There are a variety of challenges facing attempts to improve these areas. They are often multidisciplinary in nature, adding complexity to the improvement process; there is tremendous variation and proliferation of documentation approaches within and across healthcare organizations; there are few, if any, standards and models integrating different documentation approaches; and organizations wish to incorporate standardized terminologies and evidence-based knowledge with these documentation approaches as they improve them.”

I delayed a further exploration of these issues because in the most recent issue of this journal I wrote about a convergence of forces entitled, “The Holy Grail: Cost-Effective Healthcare Evidence Transparently and Consistently Used by Clinicians.”

In that column, I asserted that increasing amounts of high-quality evidence are being produced by researchers; standardized clinical reference terminologies necessary for the application of evidence-based practice terms in EHRs are maturing; commercial clinical content providers are entering this space, rapidly pulling together large amounts of evidence-based clinical knowledge; and EHR companies are starting to pull all of this together in the form of plans of care, order sets, and other evidence-based practice manifestations, all of which are computable and interoperable on a large scale.

The convergence of these forces will enable clinicians to be guided by the evidence as they use information
systems to receive information, document care and to make and execute decisions. The convergence will facilitate the widespread use of updated evidence by making it transparent to users by having these resources embedded deep within their tools of practice.

**Survey Results to Consider**

In the past six months, nursing colleagues and I have been analyzing data from a survey on nursing documentation issues. The survey was conducted in late 2005 by the documentation workgroup of the workplace issues committee of the Maryland Legislature Commission on the Crisis in Nursing. Some 934 nurses, mostly registered nurses from Maryland, responded to the survey.

While this was not a random sample and findings from the survey should be cautiously applied, the survey found that nurses perceive that time spent documenting takes away from time that should be spent with patients; too much documentation is devoted to non-direct clinical concerns; and documentation is often redundant.

Other findings indicate that nurses perceive the nursing documentation process to be substantially suboptimal. Taken together, results suggest that the current state of nursing documentation of patient care is a potent work life dissatisfier.

Wow! That’s a splash of cold water on the face. But have EHR modules, like barcode-assisted medication administration, clinical documentation, and plans of care, which have been increasingly implemented in the past five years, helped improve nurses’ perceptions of care documentation?

About a third of the entire sample used such technology, and about a half of the hospital nurses used electronic documentation. Somewhat alarmingly, at least at first blush, nurses who used electronic documentation reported increased redundant documentation, increased time spent on documentation, and poor integration of information across systems.

Yikes! While it seems like this story is getting worse, the survey also revealed nurses perceived increased completeness and quality of documentation.

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One conclusion that may be drawn is that increased quality of documentation appears to come at a price of increased time spent on this critical function. One question that should have been asked was how long respondents had been using electronic documentation. Perhaps there is a significant perception of increased time spent on electronic documentation when a nurse is climbing the learning curve of electronic documentation. The task force wants to partner with other groups to conduct the survey again on a national level with improved questions and methods.

So it appears that healthcare IT is making gains in process improvement and increased patient safety in the delivery of nursing care. A variety of forces are beginning to facilitate a long-standing objective in nursing clinical practice, namely the widespread use of updated evidence-based knowledge, making the evidence transparent to the user in the information systems they use on a daily basis to plan, carry out and document care to patients. However, despite these positive developments, documentation in general and electronic documentation specifically is perceived as effectively a fractured process that takes too much time.

**Time Implications of Documentation**

Documentation of patient care by nurses is important because those professionals comprise 54 percent of the healthcare workforce. The survey of Maryland nurses revealed a majority of nurses spend a third of their shift documenting patient care, with a minority spending half or more of their time on documentation. Other research has demonstrated similar findings.

If 350,000 nurses, or those who report directly to nurses, are on duty at any given time in the U.S., that means that about 3 million hours per day are spent on documentation in the U.S. alone! If healthcare IT can increase the quality of nursing documentation and decrease the time spent on this process, huge gains can be made in the effectiveness and efficiency of nursing care.

There are efforts under way by knowledgeable and committed experts to tackle aspects of this issue. The HIMSS Nursing Informatics Task Force conducted a national survey to measure the impact of health information technology on the role of nurses and interdisciplinary communication...
in acute care settings. Their recommendations include using existing IT applications and tools in different, more effective ways and working to overcome barriers to interdisciplinary communication impacting acute care workflows.

The International Medical Informatics Association Nursing Informatics-Special Interest Group (IMIA/NI-SIG) has several working groups that are looking at documentation issues. Nurses from Scandinavia, Europe, Asia-Pacific, and other regions have a record of scholarship in nursing documentation, and many individuals involved in this scholarship belong to IMIA. Many countries besides the US have made more progress initiating the EHR, but not necessarily in electronic nursing documentation. The issues in nursing documentation of patient care are largely the same around the world and provide a golden opportunity for international collaboration.

Clinical terminology standards have attracted increasing effort. Nursing classification systems, terminologies, and “languages” have been developed, expanded, and aligned with broader healthcare reference terminologies, thesauri, and others. This essential work will enable nursing documentation to become more standardized and interoperable.

But standardization of terms and clinical expressions that nurses use in their documentation of patient care may not be enough because there are no consistent best practices and frameworks for the nursing documentation of patient care that I am aware of. There are a plethora of nursing documentation frameworks—structured notes, unstructured notes, POMR, charting to standards, clinical pathways, care maps, and charting by exception, just to name a few. More work needs to be done to identify best documentation practices, streamline documentation workflows and test documentation frameworks so that increasingly standardized clinical terms and expressions can appear in nursing documentation of patient care that is truly interoperable.

**Getting Involved**

For the most part, healthcare organizations have realized that they are not in the business of aggregating clinical content or building clinical information systems through which the content will be used by their clinicians. When choosing companies in this field—clinical content aggregators, and healthcare information system and EHR providers—healthcare organizations would be well advised to partner with companies that have depth of understanding and staying power, particularly in the area of the nursing documentation of patient care. Nursing applications are “hot.” This area is attracting more interest. Organizations should look for partners that are engaged in standards-setting efforts, thought leadership, and innovative initiatives in nursing documentation of patient care.

Also, healthcare organizations may substantially benefit by engaging in the nursing documentation movement to bring best practices back to their organization in a timely manner. Be aware of the HIMSS nursing informatics task force initiatives; have nurses participate heavily in the next survey; follow the promising developments of the IMIA/NI-SIG; attend the HIMSS and AMIA day-long nursing symposia or the MEDINFO in Australia in 2007 or NI 2009 in Finland. Be open to working with researchers and companies who are seeking partners to test and study new approaches for documenting patient care. In these and many other ways, healthcare organizations will shape the direction of this promising field.

Progress in nurse documentation of patient care in recent years has shed light on this promising area. Those who have been immersed in the field have been heartened by the interest in nursing documentation and the positive outcomes many have been able to demonstrate by applications such as barcode-assisted medication administration. This progress is only the tip of the iceberg, and nurses are substantially dissatisfied with the patient care documentation process. To extend the progress, the nursing and clinical informatics communities have their work cut out for them as healthcare organizations, vendors, and professional societies work together to overcome the challenges that exist in taking nursing documentation to new levels. It is worth the effort, as markedly improved patient care outcomes and greatly improved satisfaction by nurses are possible.

**About the Author**

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