

Do Medical Surgical RNs Have More Time to Provide Direct Patient Care When Using a Point and Click Documentation System or an Evidence-Based Documentation System?.

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DO MEDICAL-SURGICAL REGISTERED NURSES HAVE MORE TIME TO PROVIDE DIRECT PATIENT CARE WHEN USING A POINT AND CLICK DOCUMENTATION SYSTEM OR AN EVIDENCE-BASED DOCUMENTATION SYSTEM?

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Abstract

- Medical-surgical Registered Nurses (RNs) cite clinical documentation as one of the many tasks that limit time for providing hands on patient care. The documentation is time consuming and cumbersome to the point that RNs perceive they are spending more time away from the patient. There is limited literature surrounding how electronic documentation impacts RN perception of time at patients' bedside.

Overview

- Time away from the patient to complete documentation meets the requirements of maintaining a medical record; however; there is limited literature addressing how electronic documentation impacts RN perception of time at patient's bedside (The Maryland Nursing Workforce Commission, 2007).

Statement of the Problem

- Documentation is an important focus in the day-to-day responsibilities and duties of a registered nurse. The RN is required to document the care provided; however RNs often cite clinical documentation as one of the many tasks that limit time for providing hands on patient care to the patients assigned to them.

Specific Aims

- This scholarly project intended to demonstrate that an evidence-based integrated documentation system offered RNs the ability to perceive that they provide more direct patient care than they were able to provide with the point and click non-integrated documentation system in place.

Literature Review

- The review of literature identified variability in documentation across numerous venues.
- Healthcare remains non-standardized in the application of documentation.
- Research identified areas that saw increased quality along with fewer errors when electronic documentation was in place.

Literature Review Cont.

- According to Langowski (2005) there is direction from many areas including the federal government, regulatory agencies, media, and consumers for health care facilities to recognize and implement electronic systems, as a needed resource of improving patient care and reducing costs.
- Current medical record documentation conforms to medical-legal requirements, regulatory requirements, and reimbursement (Cusack et al., 2013).

Literature Review Cont.

- The literature revealed that nursing documentation, whether paper or electronic, requires a significant amount of time for nurses.
- Finally, there is limited research that discussed electronic documentation and nurses' ability to provide more direct patient care.

Project Design

- A descriptive exploratory project using survey methodology pre-implementation and post-implementation of the evidence-based documentation system was utilized.
- Convenience sample of homogenous group.
- All subjects were registered nurses.

Sources of Data

👤 The “Nursing Documentation Survey Instrument” (The Maryland Nursing Workforce Commission, 2007).

👤 Consisted of 22 questions:

- Four yes/no questions.
- Five demographic questions.
- Three Likert-type scale.
- Four with responses from decreased to not affected.
- One with a scale of less than 25% to more than 75%.
- One for choice of electronic system.
- One for framework of nursing documentation.
- One with a scale of never to always.
- Two allowed for free response.

Sample Survey Questions

- Do you find the documentation process redundant where you are rewriting or duplicating the same information relative to patient care on several different forms/notes, etc.?

Response choices were: Never, Rarely, Sometimes, Often, or Very Often

- Does the process of and requirements for patient care documentation reduce and directly affect the amount of time spent by you in providing direct patient care?

Response choices were: Yes or No

Data Collection and Management

- Data collection took place at three separate points between July, 2015 and February, 2016.
- Data were anonymous with each survey response having a unique code retained by the respondent.
- Each survey was left open for completion for two weeks.
- Data was placed into an Excel Spreadsheet to facilitate statistical analysis.
- Data was maintained in a log-in and password protected non-public folder.
- All electronic data was deleted from authorized personnel hardware and software at the completion of the scholarly project.

Results

Table 1.
Demographic Characteristics of the Participants (“N = 35”).

Variable	Response	Frequency	Percentage
Gender	Female	34	97.1
	Male	1	2.9
Age	18-27 years	12	34.3
	28-37 years	12	34.3
	38-47 years	3	8.6
	48-57 years	8	22.9
Years in Nursing	0-5 years	17	48.6
	11-19 years	4	11.4
	20-29 years	1	2.9
	30-39 years	4	11.4
	6-10 years	9	25.7
Type of Nursing License	Advanced Practice	1	2.9
	RN	34	97.1
Current Nursing Position	Administrative Nurse	4	11.4
	Nurse	1	2.9
	Educator/Faculty	1	2.9
	Staff RN	30	85.7

Findings from the Analysis of the Survey Questionnaire

Results Cont.

Table 2.
Comparison of Maryland Nursing Workforce Commission Survey Tool Item #9 from Pre to 3-Month Post to 6-Month Post Follow Up After Implementation of New Electronic Health Record ("N = 35").

Variable	Responses	Before Implementation ("n = 34")		3-month Follow Up ("n = 18")		6-month Follow Up ("n = 35")	
		Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
How often does the demand for completing patient documentation cause you to extend or work beyond your scheduled work hours?*	Never or Rarely	4	12%	4	22%	8	23%
	Sometimes	13	38%	6	33%	18	51%
	Often to Very Often	17	50%	8	45%	9	26%
*Chi-square test (8, "N = 87") = 16.54, p = 0.04							

Results Cont.

Table 3.
Comparison of Maryland Nursing Workforce Commission Survey Tool Item #13 from Pre to 3-Month Post to 6-Month Post Follow Up After Implementation of New Electronic Health Record ("N = 35").

Variable	Responses	Before Implementation ("n = 34")		3-month Follow Up ("n = 18")		6-month Follow Up ("n = 35")	
		Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
The use of electronic documentation has _____ the amount of time spent on nursing documentation?*	Decreased	6	18%	5	28%	12	34%
	Increased	18	53%	12	66%	21	60%
	Not Affected	10	29%	1	6%	2	6%

*Chi-square test (4, "N = 87") = 10.04, p = 0.04

Results Cont.

Table 4.

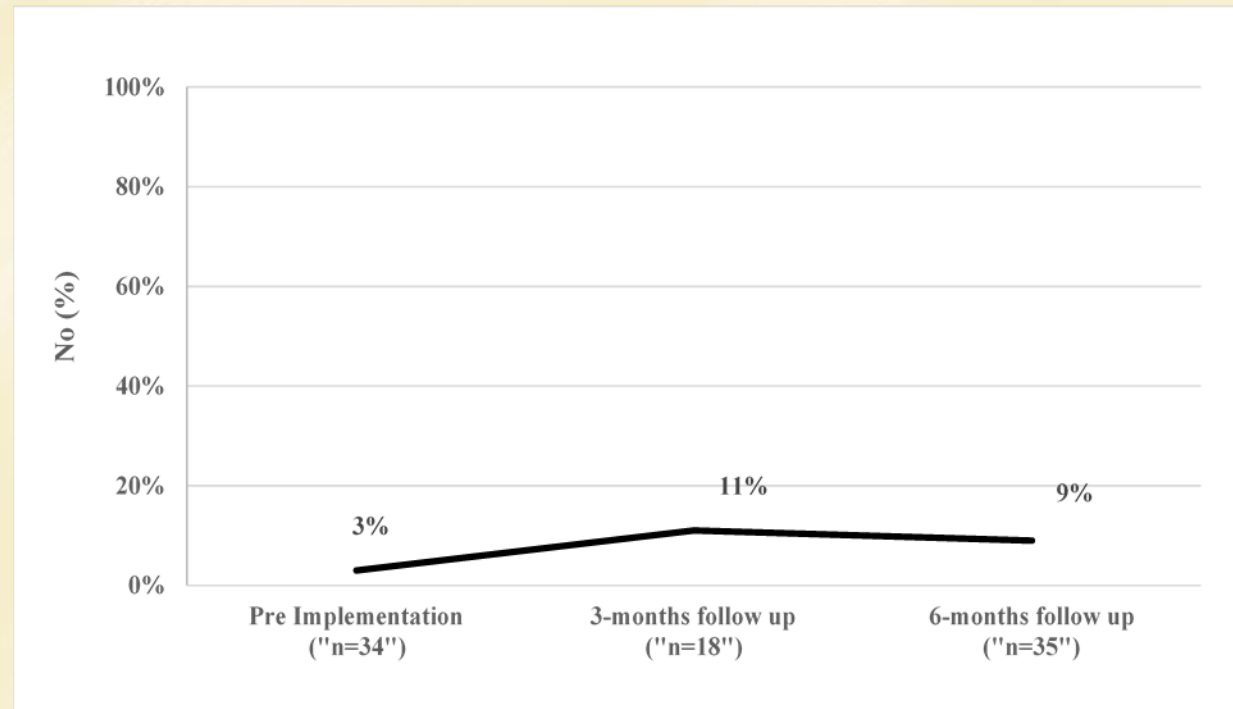
Comparison of Maryland Nursing Workforce Commission Survey Tool Item #19 from Pre to 3-Month Post to 6-Month Post Follow Up After Implementation of New Electronic Health Record ("N = 35").

Variable	Responses	Before Implementation ("n = 34")		3-month Follow Up ("n = 18")		6-month Follow Up ("n = 35")	
		Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Are you routinely required to complete documentation other than to record and communicate pertinent information related to a health care encounter to team members, including the patient and the patient's family or significant others, as appropriate, to ensure continuity of patient care?*	No	20	59%	17	94%	27	77%
	Yes	14	41%	1	6%	8	23%

*Chi-square test (2, "N = 87") = 8.07, p = 0.02

Results Cont.

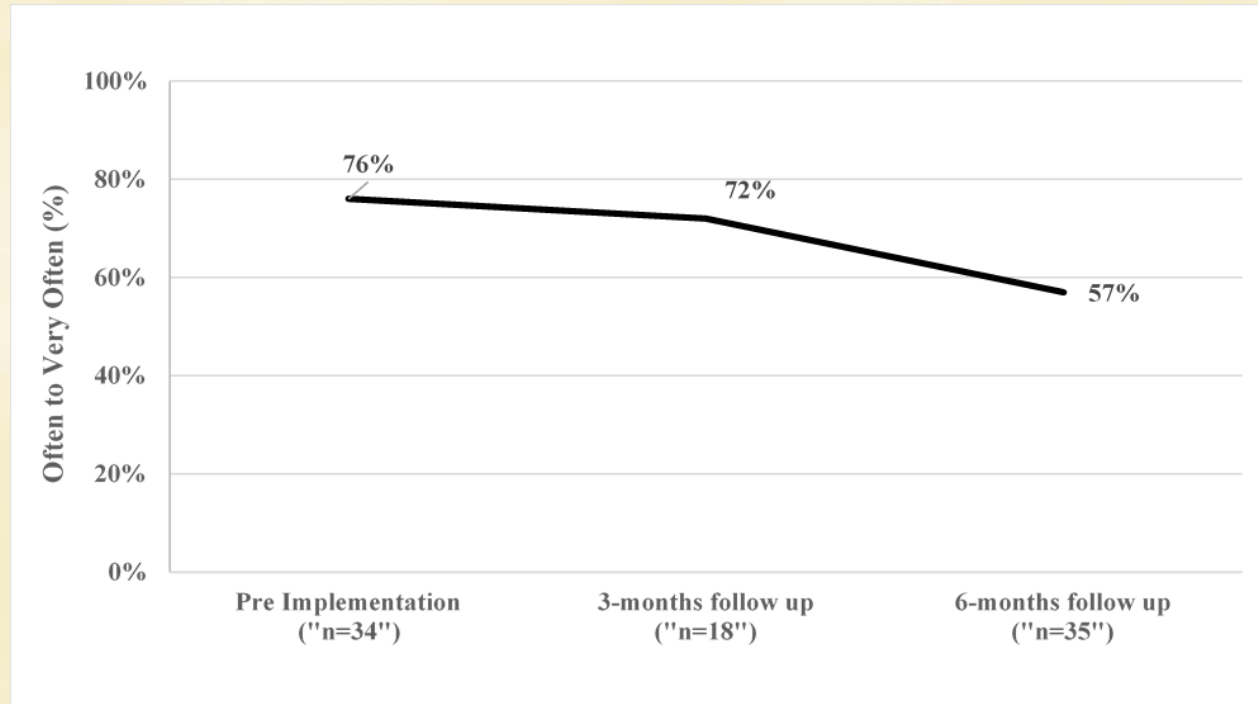
Figure 3.
Trend Graph of Responses Stating “No” to the Maryland Nursing Workforce Commission Survey Tool Item #6 from Pre to 3-Month Post to 6-Month Post Follow Up After Implementation of New Electronic Health Record (“N = 35”).



Results Cont.

Figure 4.

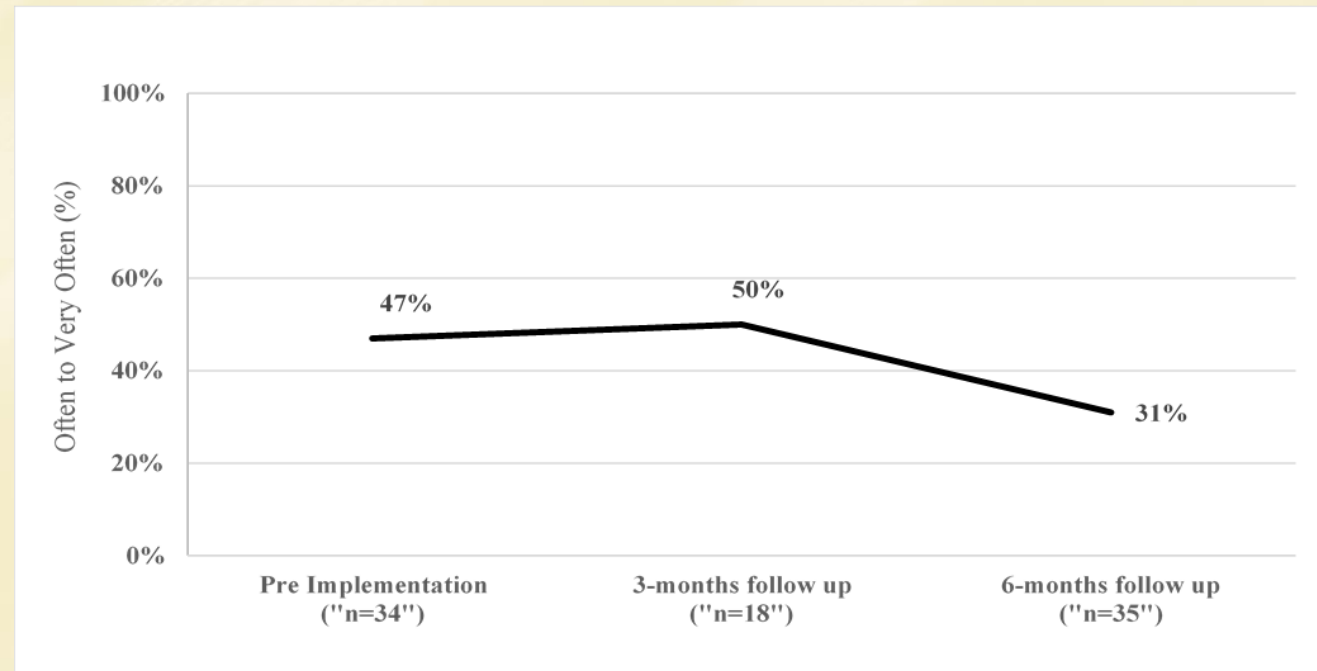
Trend Graph of Responses Stating “Often to Very Often” to the Maryland Nursing Workforce Commission Survey Tool Item #7 from Pre to 3-Month Post to 6-Month Post Follow Up After Implementation of New Electronic Health Record (“N = 35”).



Results Cont.

Figure 5.

Trend Graph of Responses Stating “Often to Very Often” to the Maryland Nursing Workforce Commission Survey Tool Item #11 from Pre to 3-Month Post to 6-Month Post Follow Up After Implementation of New Electronic Health Record (“N = 35”).



Themes

- Time spent in documentation.
- Redundancy of documentation.
- Completeness of nursing documentation.
- System utilized.
- Framework of documentation.
- Items not related to the patient or encounter.
- Suggestions for improved efficiency.

Discussion and recommendations

- Results of the study partially supported the inquiry question.
- Repeat the survey at 12-month, 18-month, and 24-month time frames.
- Organizational review of documentation policies and requirements.
- Education on documentation framework.

Discussion and recommendations Cont.

- Exploration of voice/verbal documentation.
- Survey if differences in perception present themselves based on FTE status i.e. full-time, part-time, and per-diem.

Conclusion

- Findings revealed a positive impact on overtime spent in documentation.
- Findings revealed a positive impact on time spent in documentation.
- Findings revealed a positive impact on documentation being related to the patient and the encounter.

Conclusion Cont.

- Additional areas demonstrated:
 - The new system is beginning to improve the ability to have time to provide hands on care.
 - The new system is not preventing the RNs from spending as much time with their patients as the old system did.
 - The new system offers less redundancy as perceived by the respondents.
 - The RNs perceived they had input into the system.
 - All information given to Nursing Informatics for further review.