



## **Challenges and Opportunities in Documentation of the Nursing Care of Patients**

*A Report of the Maryland Nursing Workforce Commission,  
Documentation Work Group*

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## Executive Summary

An ongoing severe nursing shortage can be improved in a number of ways. One way is to decrease or eliminate work life dissatisfiers for nurses. One such dissatisfier is the current cumbersome nature of nursing documentation of patient care. Nurses routinely spend 15-25% of their workday documenting patient care, and in some cases considerably more. This is not an issue *per se*, but perceptions by nurses that much of this documentation is unnecessary or redundant, and most of all that it takes away from their ability to administer direct patient care, a significant issue for practicing nurses, makes issues surrounding nursing documentation of patient care important to nurses and therefore to all of us. A recent trend in nursing practice is the introduction of electronic documentation. Little is known about this significant trend or its impact on nursing documentation issues.

This report presents the results of the Maryland Nursing Workforce Commission, Workplace Committee, Documentation Work Group survey of 933 Maryland nurses on nursing documentation of patient care issues conducted in the fall of 2005. Among the many findings of significant concern to this sample of nurses were:

- Redundant documentation,
- Excessive time spent documenting, which takes the nurse away from direct patient care,
- More than 1/3 of the nurses reported routinely staying beyond their scheduled work hours to complete documentation and almost 2/3 of these were paid for the “stay over period,”
- Routinely documenting for reasons other than recording and communication of pertinent clinical information. (e.g. regulatory requirements and third party payors.)

Proportionally, almost twice as many hospital nurses than non-hospital nurses in the sample reported using electronic documentation; however, overall use of electronic documentation of this sample was low at 36%. Of those using electronic documentation, most felt that its use *increased* redundancy and time spent on documentation while also increasing completeness and quality of the documentation. These findings indicate that current nursing documentation processes are substantially sub-optimal and contribute to work life dissatisfaction.

Recommendations of the Committee include:

- Convene forums where nurse informaticians, nurse executives, nurse managers and direct care nurses can dialog about the issues identified in this survey, particularly issues regarding electronic documentation, for the purposes of identifying/ recommending best practices, and standards for improved/ streamlined documentation of nursing care.
- Encourage the involvement of nurse executives and direct care nurses as well as other users of the technology in the formulation of documentation policies, selection of software, planning, and implementation of electronic patient records in all health care facilities/agencies.
- Encourage developers of electronic documentation systems to improve the design and integration of their systems while producing systems that decrease documentation redundancy and save nurses' time.
- Include research and nursing patient care documentation principles as well as experience with electronic documentation in nursing education programs.

The Work Group has targeted two goals as feasible within 3 years. *First*, decrease documentation time per working nurse by 25%. *Second*, for institutions that incur nurse overtime for the purpose of patient care documentation, reduce overtime by ½ hour per week per nurse. Conservatively estimated, achieving these two targets would free up about \$94,000,000 per year in the state of Maryland. This would allow nurses to provide more direct care which would improve nurse satisfaction and result in retention of nurses.

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## Introduction

The shortage of nurses in the United States, currently estimated at 200,000, is projected to grow to 800,000 by 2020. (American Association of State Colleges and Universities, 2005) In addition to recruitment problems, there is difficulty in retaining individuals in the profession. To address retention of nurses, nurse leaders and policy makers are searching for ways to improve the work environment and to remove barriers to practice that increases indirect care time which subsequently “steals” from direct care time. Nurses working in most healthcare settings have identified the excessive burden of documentation as a source of dissatisfaction in their practice.

The Maryland General Assembly established the 55-member Maryland Statewide Commission on the Crisis in Nursing (renamed the Maryland Nursing Workforce Commission in 2006) to study issues related to the nursing shortage and to make recommendations for recruitment and retention of nurses. Its Workplace Committee investigated documentation, frequently identified by Maryland nurses as a concern. In focus group discussions, nurses indicated they believe an increasing amount of time is spent on documentation, time that could be more appropriately spent on direct patient care. In addition, nurses in the focus groups reported that documentation is often redundant and done primarily to benefit regulators and third-party payors.

These beliefs are consistent with findings in the literature. Despite some studies that reported nurses spend as little as 14-16% of their working time on documentation, more typical findings are that nurses spend from 25% of their time in the acute care setting--and up to 50% in home care environments--documenting care rather than delivering care directly to patients. (Korst et. al, 2003; Epps-Reaid, 2001; Pabst, Scherubel and Minnick, 1996) Studies further suggest that documentation is often driven by a host of governmental, accreditation and payor entities, resulting in excessive duplication or redundancy. (Collins and Malone, 2001) Indeed, one study found overtime of 1-2 hours per week attributed to documentation of patient care by nurses. (Smith et. al., 1998)

The Workforce Committee focused on documentation for three reasons:

- 1) Nurses voiced concerns about issues around nursing documentation of patient care,
- 2) Published literature indicated that nursing documentation of patient care is a sub-optimal process, and
- 3) Committee members expressed concurring knowledge of and experience with items 1 and 2.

To gain more insight into this important issue, the Documentation Work Group of the Workplace Issues Committee surveyed Maryland nurses to obtain findings that would guide the Nursing Workforce Commission in making recommendations to address specific nursing documentation of patient care issues.

## Survey Methodology

A nursing documentation of patient care questionnaire was developed based on the focus groups' results as well as the expertise of the Work Group. (See Appendix A for the survey and Appendix B for a list of Work Group members.) The questionnaire was administered in the fall of 2005 primarily through *The Maryland Nurse*, a quarterly publication that is distributed to all Maryland licensed RNs and LPNs. Respondents were asked to return the completed questionnaire to The Maryland Nurses Association. No envelope or postage was provided. Other nurses responded to an email request to submit the survey. A total of 933 responses were submitted by the combined methods.

The questionnaire included open-ended questions. Responses to these qualitative questions were examined for themes by two doctoral level researchers. The second researcher reviewed the responses and the themes initially identified by the first researcher. The two researchers were in agreement on the identified themes.

Because this was not a randomly selected sample of Maryland nurses, the specific values yielded by each survey question should not necessarily be considered representative of nurses in the State. Nonetheless, the results of the analysis are derived from a self-selected sample that required effort on the part of participants to be included in the study. The relatively large sample and respondent characteristics suggest that the direction, not necessarily the specific values, of the survey findings have validity.

## Findings & Discussion

### Quantitative Data

The quantitative data from the survey is presented in Respondent Demographics (figures 1 – 6) and Documentation Process (figures 7 – 21). Figures 22 – 28 are from data analysis which compares hospital nurses—who made up 59% of respondents—with all other nurses on select variables. Totals in all cases may not add to 100% due to rounding.

The findings presented in the form of tables or charts are briefly discussed in most cases immediately following the figure. Summary findings are discussed at the end of this section of the report.

### Respondent Demographics

**Figure 1. Age (n=925)\***

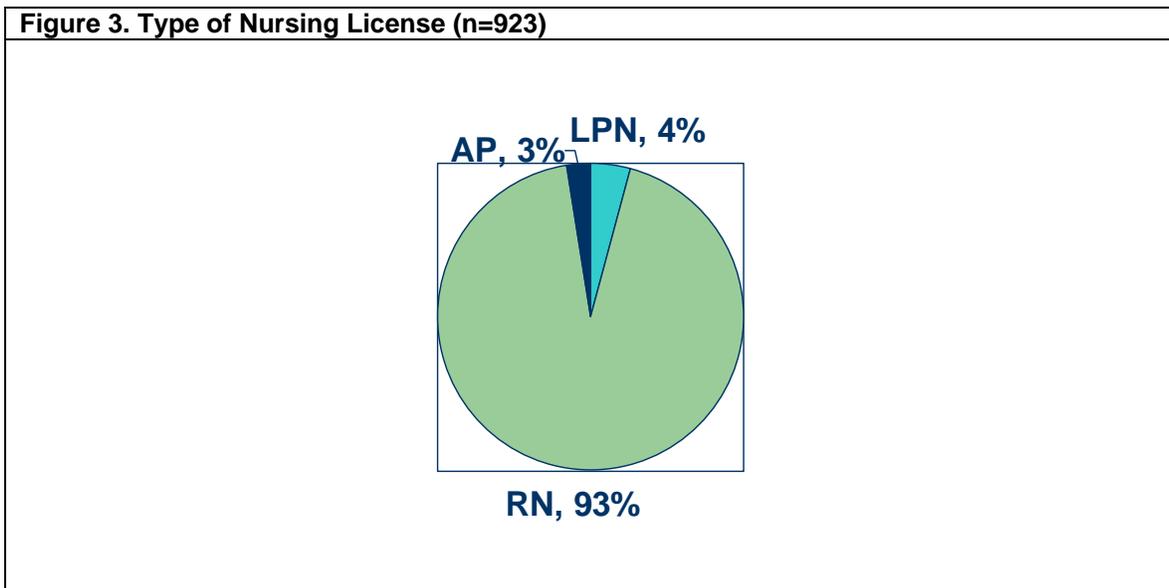
Age	N	Percent
18-27	51	5.5
28-37	159	17.2
38-47	249	26.9
48-57	336	36.3
58-67	120	13.0
68+	10	1.1
Total	925	100.0

**\* (n=925) means that 925 respondents answered this particular question.**

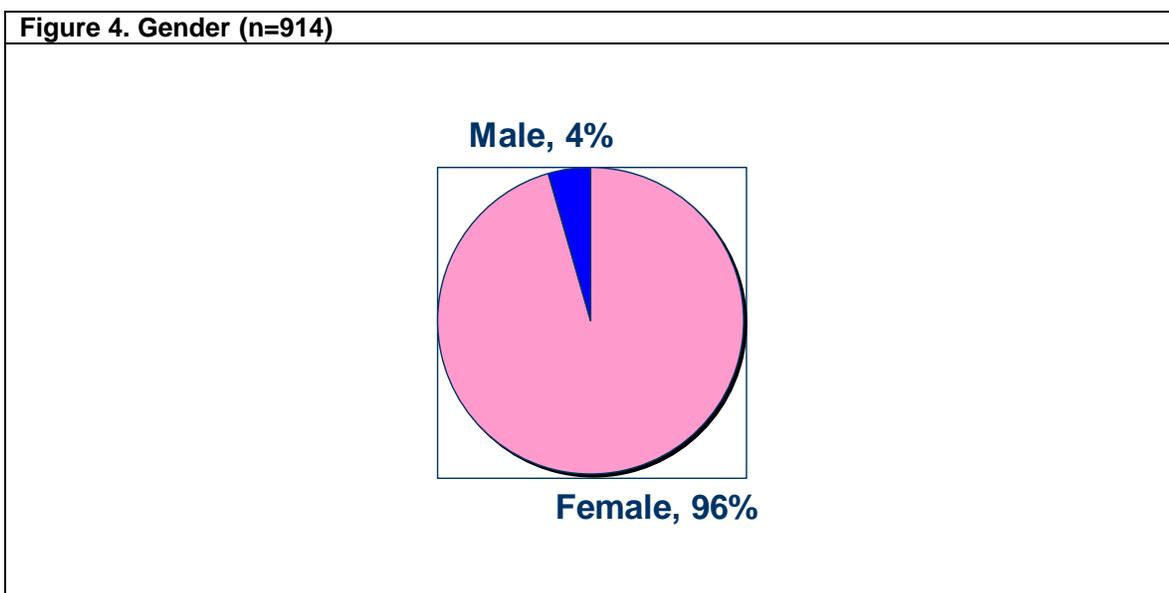
The survey asked nurses to report their age by selecting one of the age categories listed in the table. Only eight respondents either failed to report their age or gave an ambiguous response. More than half of the nurses (63%) reported their age as being between 38 and 57 years, which is consistent with the average age of 46.8 for the US RN population. (Health Resources and Services Administration, 2004)

<b>Figure 2. Years In Nursing (n=923)</b>			
<b>Years in Nursing</b>	<b>N</b>	<b>Percent</b>	
<5	123	13.3	
6-10	124	13.4	
11-19	191	20.7	
20-29	258	28.0	
30-39	197	21.3	
40+	30	3.3	
Total	923	100.0	

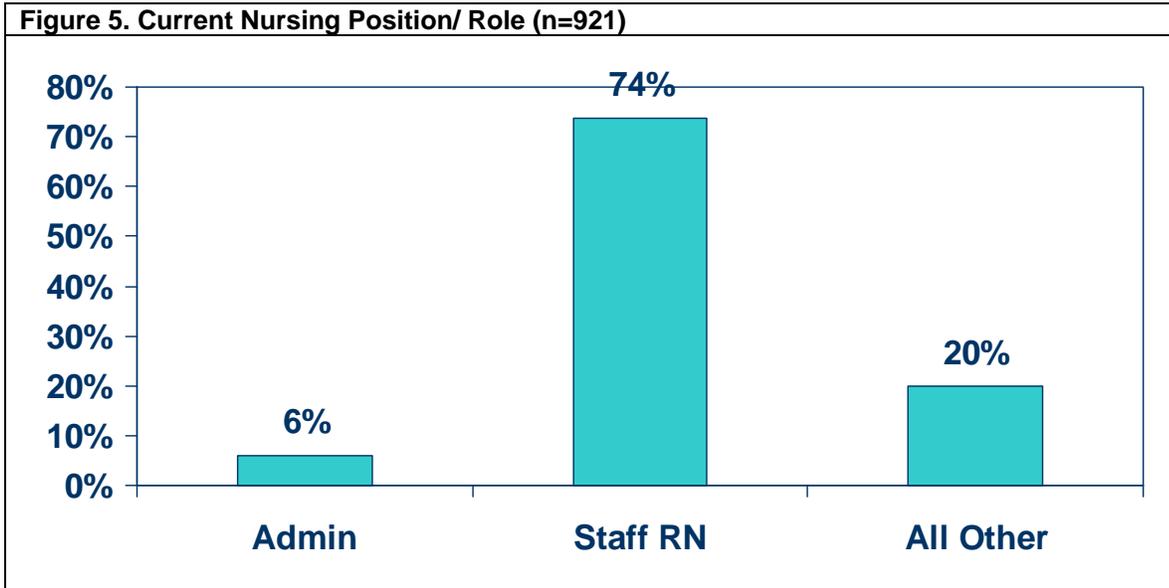
The majority of the nurses in this sample reported 20 or more years in nursing.



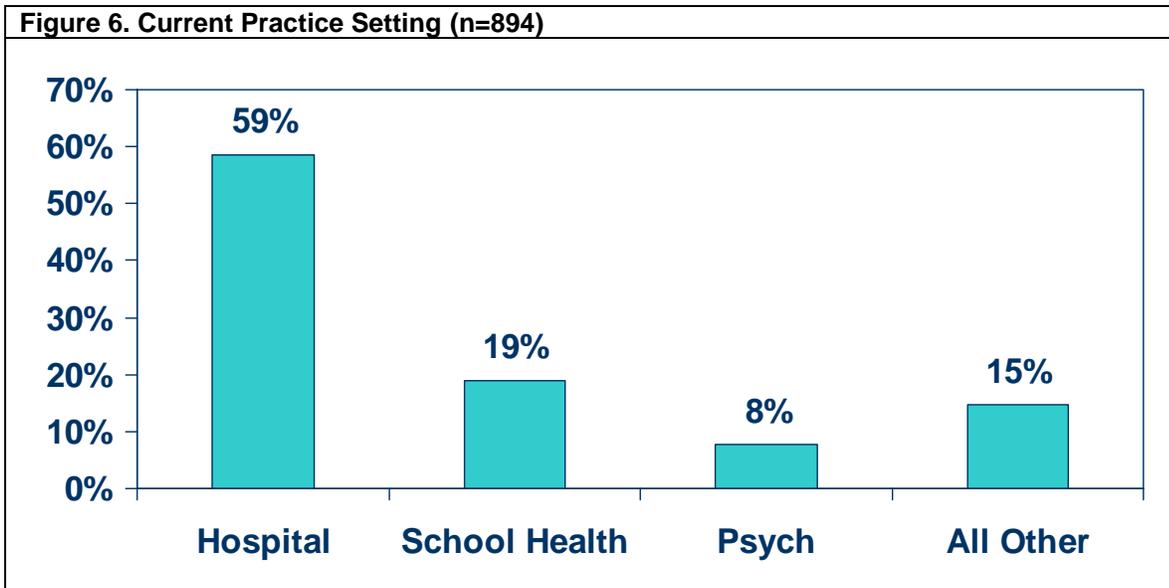
RNs made up 93% of the sample, while LPNs (equivalent to LVNs) constituted 4% and Advanced Practice (AP) nurses made up the remaining 3%.



Men constituted 4% of this sample, slightly less than the 5.7% estimated nationally from a large national survey. (Health Resources and Services Administration, 2004)



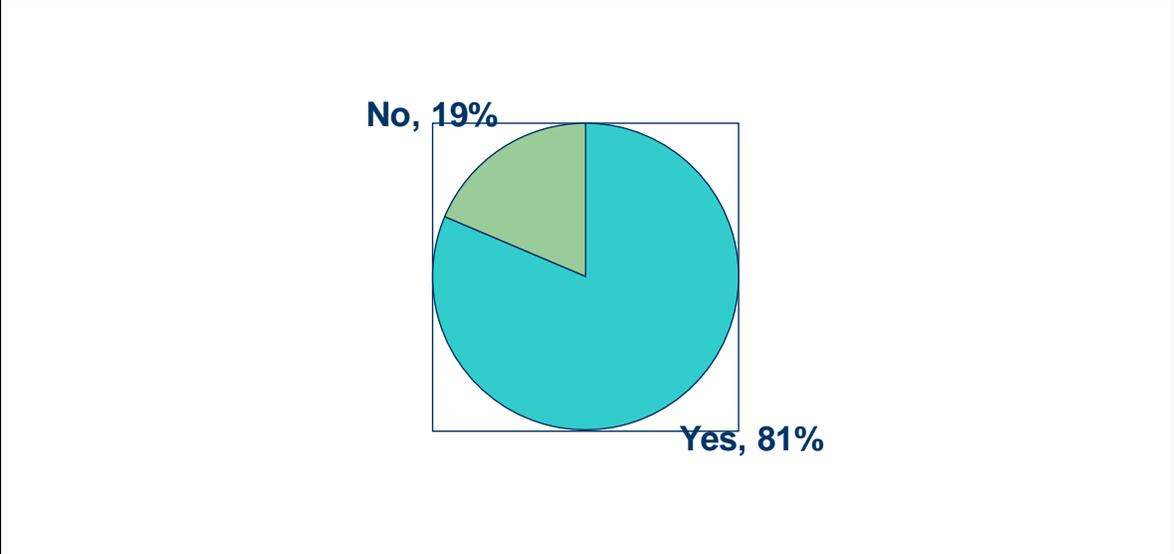
Almost 3/4 of the respondents (74%) identified themselves as staff nurses. 6% identified themselves as administrators, with the remaining 20% spread across 7 categories. None of the categories included in All Other had more than 5%.



The clear majority of respondents identified their current practice setting as a hospital. About a fifth (19%) identified their current practice setting as school nurse. This clearly represents a disproportionately high number of school nurses, most likely due to enthusiastic advocacy of completing this survey by school nurse opinion leaders in Maryland. Nonetheless, non-school nurses represent 81% of the sample so that any bias caused by the disproportionately high number of school nurses was attenuated.

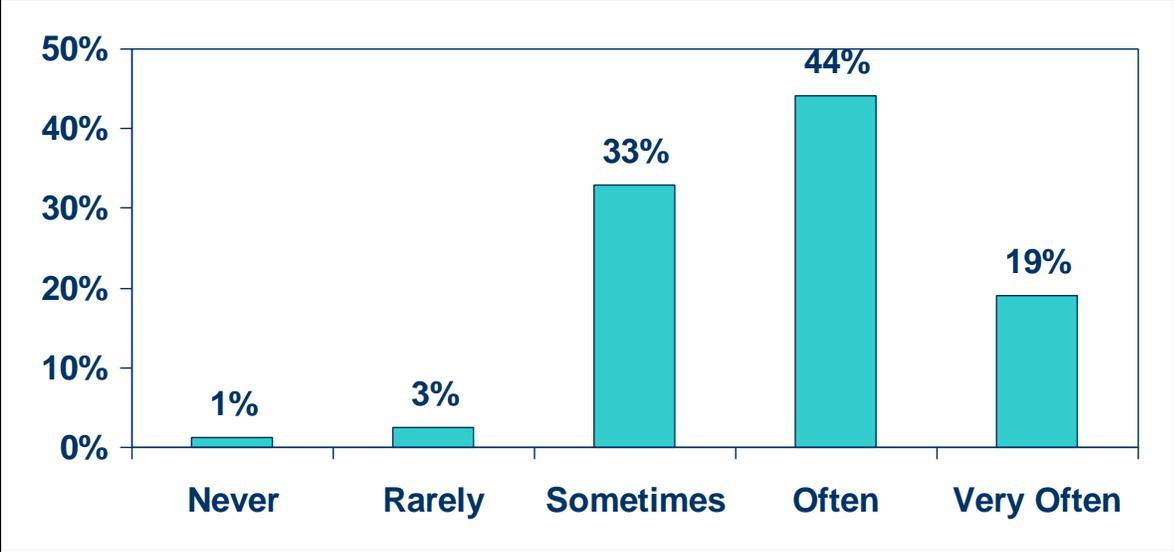
### Documentation Process

**Figure 7. 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?  
Figure 7 (n=919)**



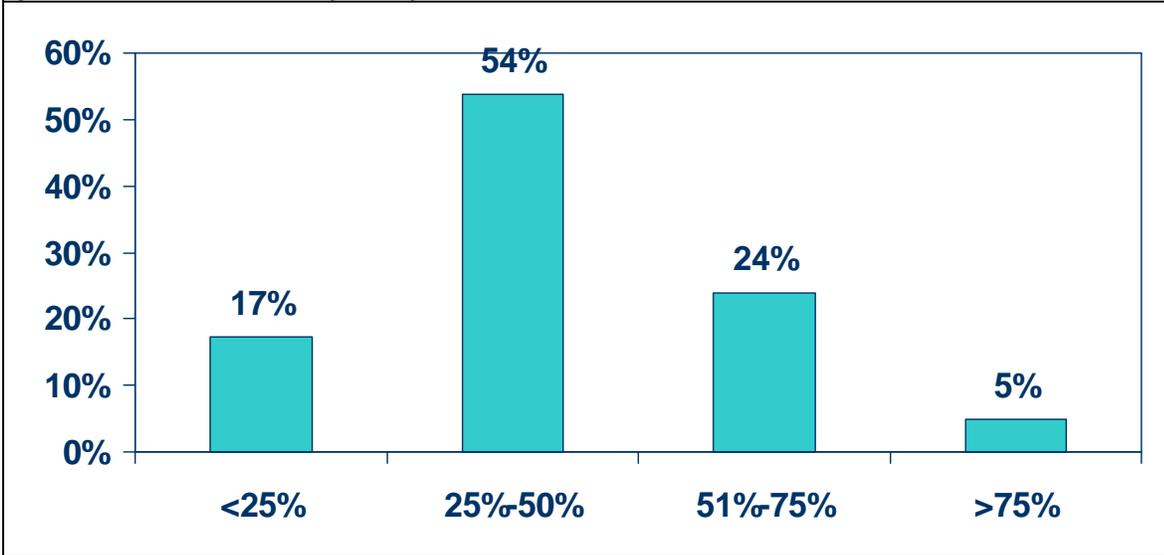
A strong and clear majority of nurses in this sample, 81%, indicated that documentation reduces and directly affects time spent in providing direct patient care.

**Figure 8. If yes to the above, to what extent does the documentation process prevent or keep you from spending as much time with patients as needed? (n=769)**



Of those who indicated that documentation reduces and directly affects time spent in providing direct patient care, 63% responded that they often or very often are kept from spending as much time with patients as needed.

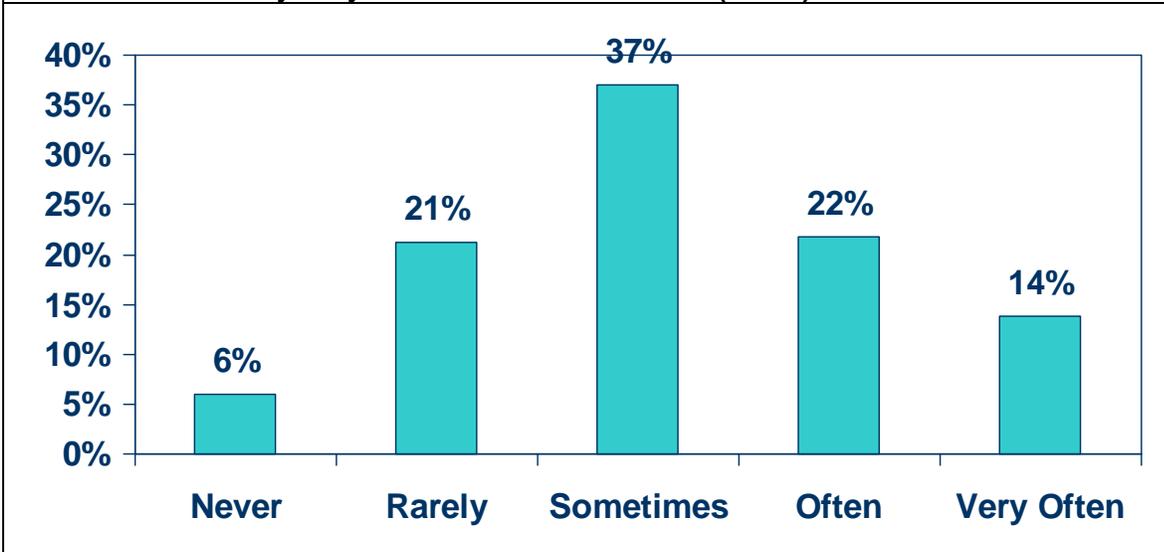
**Figure 9. What percentage of your shift or patient visit is actually spent in completing patient documentation? (n=915)**



A majority of respondents, 54%, indicated that the percentage of their shift or visit spent completing patient documentation was between 25% and 50%. 29% of the respondents reported completing patient documentation for greater than 50% of their shift or visit.

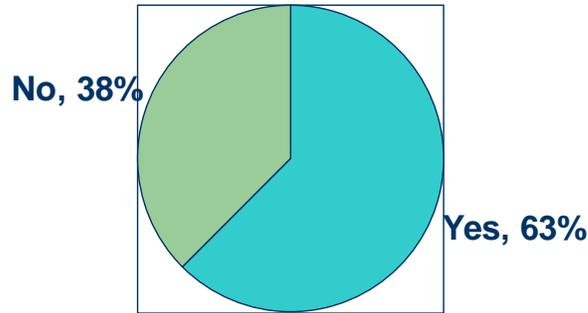
It is important to note that another independent survey of Maryland nurses conducted in 2005 with a response rate of 1,199 (630 RNs and 569 LPNs) had very similar results. When asked about percentage of shift spent performing nursing documentation, 18% reported <25%; 44% reported 25%-50%; 30% reported 51-75%; and 8% reported > 75%. This is powerful validation of the findings on one of the most important questions in this survey. (Maryland Statewide Commission on the Crisis in Nursing Workplace Survey 2005: Final Report, 2006)

**Figure 10. How often does the demand for completing patient documentation cause you to extend or work beyond your scheduled work hours? (n=919)**



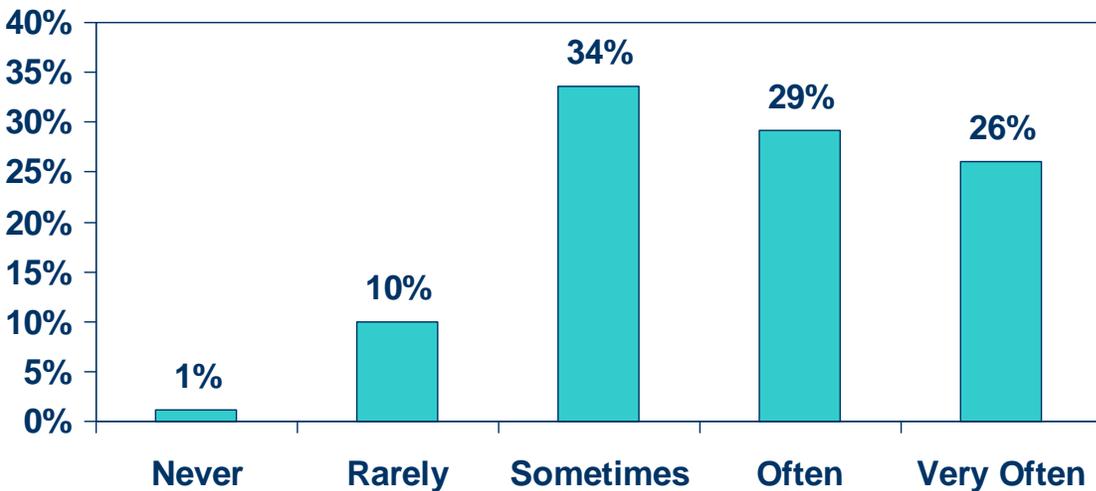
73% of respondents indicated that the demand for completing patient documentation caused them work beyond their work hours sometimes, often or very often. 36% of respondents indicated that this extension occurred often or very often.

**Figure 11. In instances where you work beyond your scheduled work hours to complete documentation, are you compensated for the duration of this “stay over period”? (n=897)**

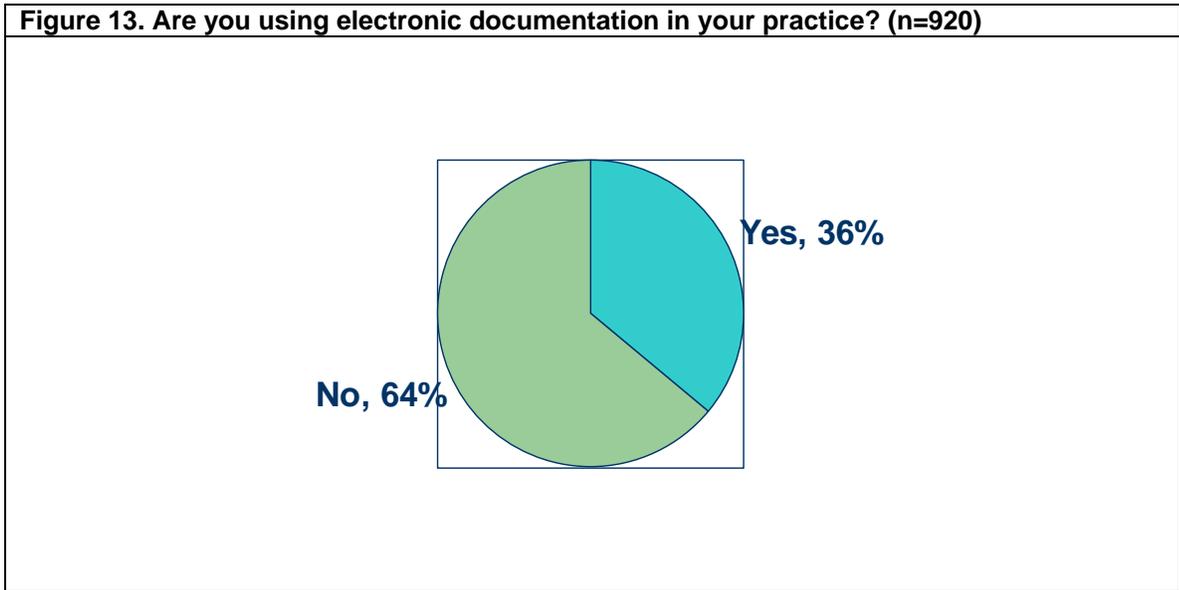


63% of respondents reported compensation for their “stay over periods”.

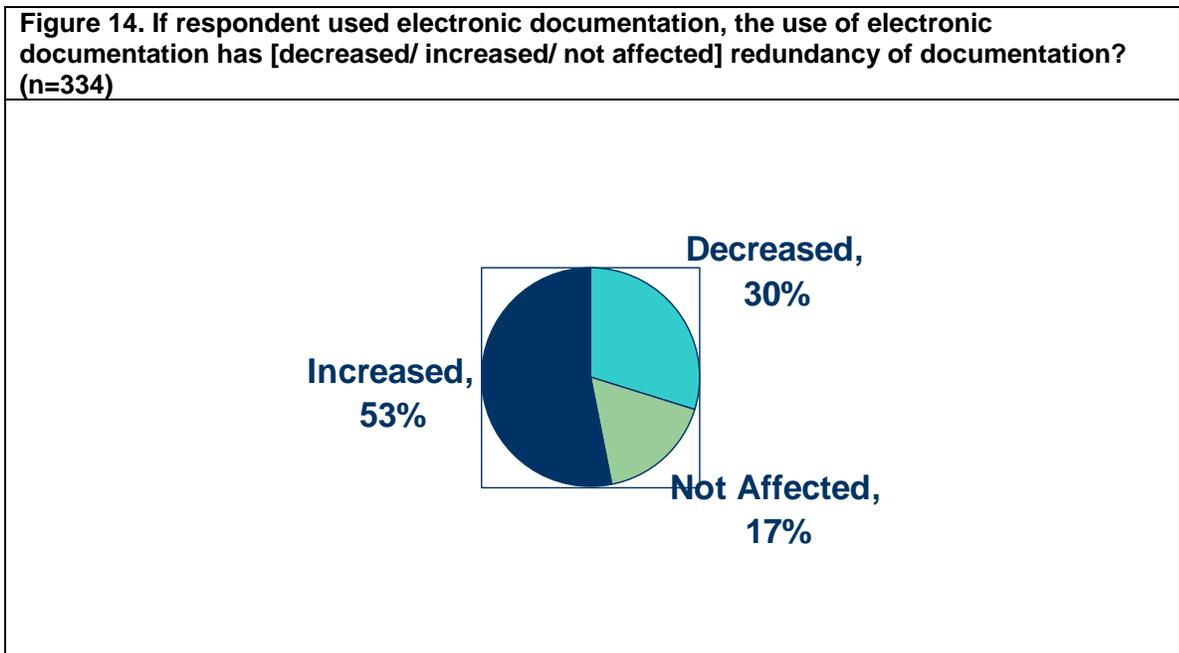
**Figure 12. Do you find the documentation process redundant where you are rewriting or duplicating the same information relative to patient care on several different forms/notes, etc.? (n=915)**



A very strong 89% of respondents indicated that they found the documentation process redundant sometimes, often and very often. A clear majority of 55% of respondents reported redundancy often or very often.

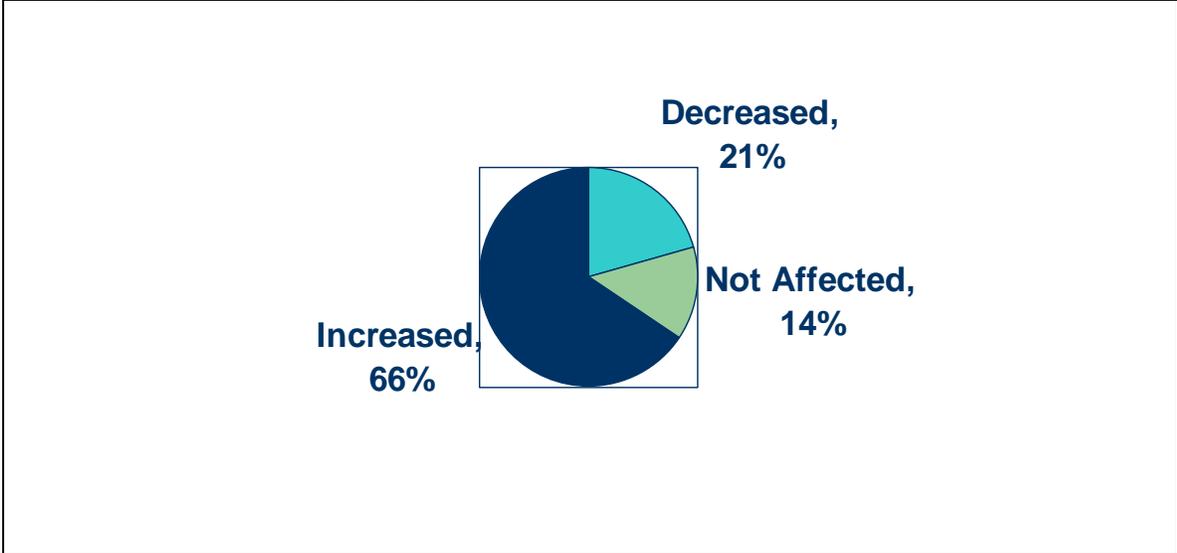


64% of respondents reported not using electronic documentation in their practice.



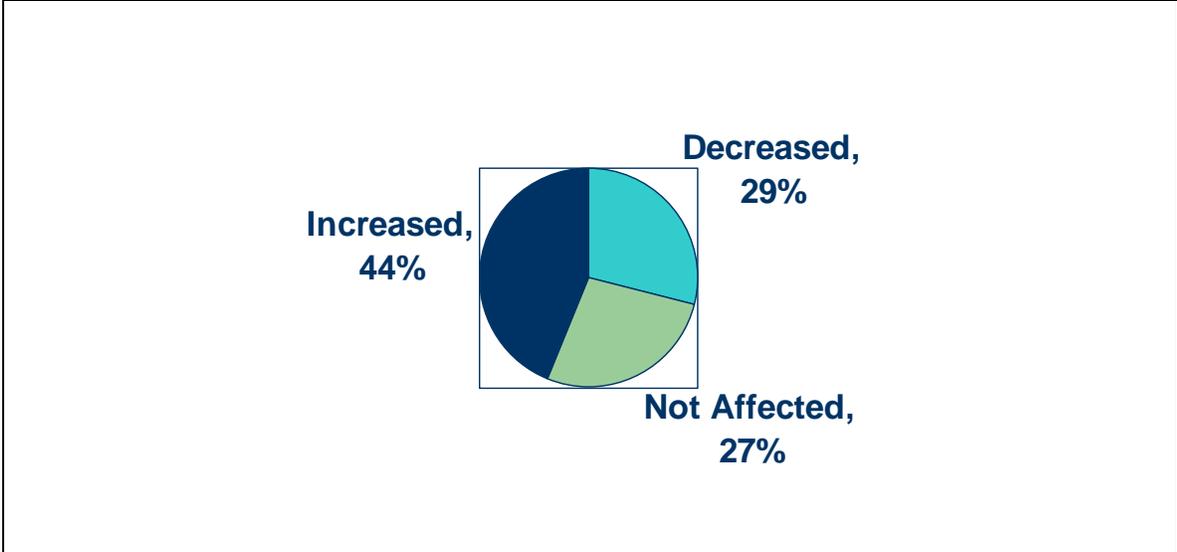
Of those using electronic documentation 53% indicated that electronic documentation *increased* redundancy. The use of electronic documentation increased reported redundancy by more than 20 % over those reporting its decrease

**Figure 15. If respondent used electronic documentation, the use of electronic documentation has [decreased/ increased/ not affected] the amount of time spent on nursing documentation? (n=334)**

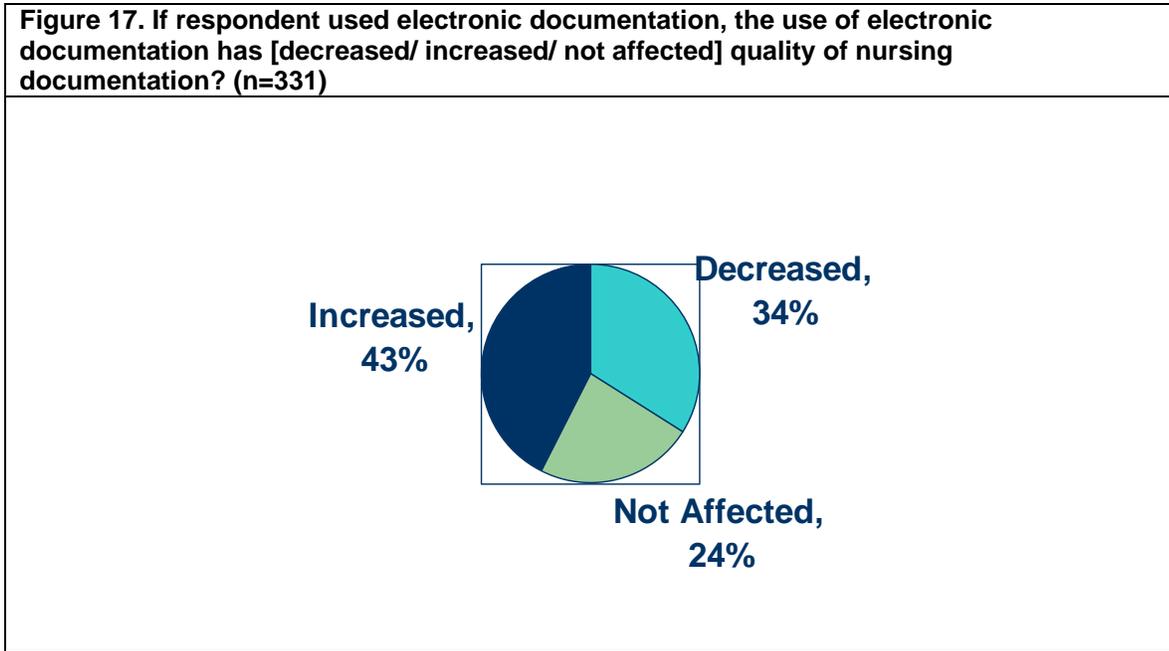


Of those using electronic documentation 66% indicated that electronic documentation *increased* time spent on documentation. The use of electronic documentation increased the reported amount of documentation time by more than 40% over those reporting a decrease in documentation time.

**Figure 16. If respondent used electronic documentation, the use of electronic documentation has [decreased/ increased/ not affected] completeness of nursing documentation? (n=328)**



Of those using electronic documentation 44% indicated that electronic documentation *increased* completeness of nursing documentation while 29% indicated decreased completeness and 27% indicated completeness was not affected. Reported completeness of documentation by respondents improved by 15% over those reporting a decrease in documentation completeness.



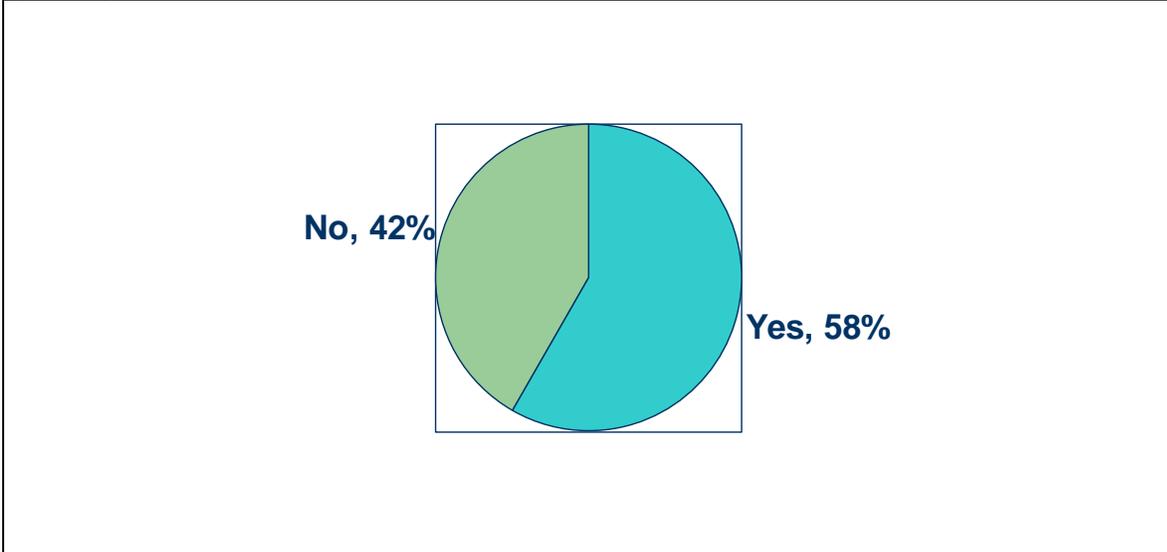
Of those using electronic documentation, 43% indicated that electronic documentation *increased* quality of documentation while 34% indicated it decreased quality; 24% indicated quality was not affected. Reported quality of documentation improved by 6% over those reporting a decrease in documentation quality.

**Figure 18. If respondent used electronic documentation, identify the system name for the electronic documentation system you currently use. (n=327)**

Blinded Company Name	N	%
2	13	4.0
7	8	2.4
1	6	1.8
9	4	1.2
3	2	.6
8	198	60.6
4	26	8.0
5	3	.9
10	67	20.5

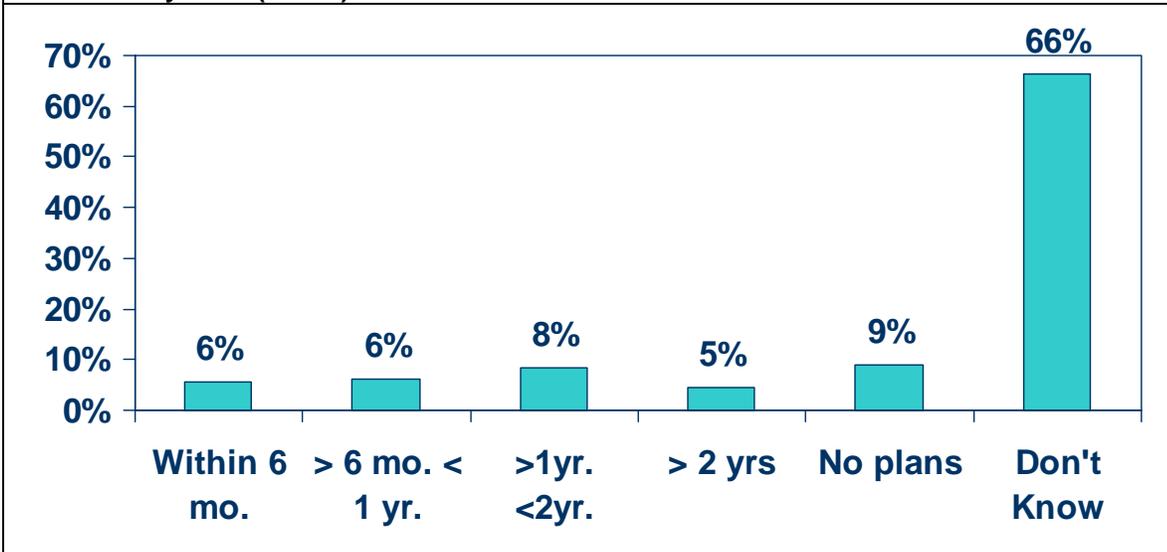
A significant majority, 61%, of respondents who used electronic documentation used one system. It should be noted that, according to Healthcare Information Management Systems Society Analytics (2006), in comparison this system has 44% of Maryland’s market and no other system had more than 22% at the time of this survey. As this was not a representative sample, the discrepancy between the percentage of this survey’s respondents and its market share as reported by HIMSS Analytics may not be highly significant.

**Figure 19. If respondent used electronic documentation, did direct care nurses have input into the development and use of the electronic medical record in your work setting? (n=324)**



58% of respondents reported having input into the development and use of the electronic medical record in their work setting. The survey did not solicit whether or not the involvement was in selecting the product or involvement after the selection process.

**Figure 20. If you are not currently using electronic documentation for your day-to-day patient data documentation, indicate when your organization is planning to implement an electronic system. (n=600)**

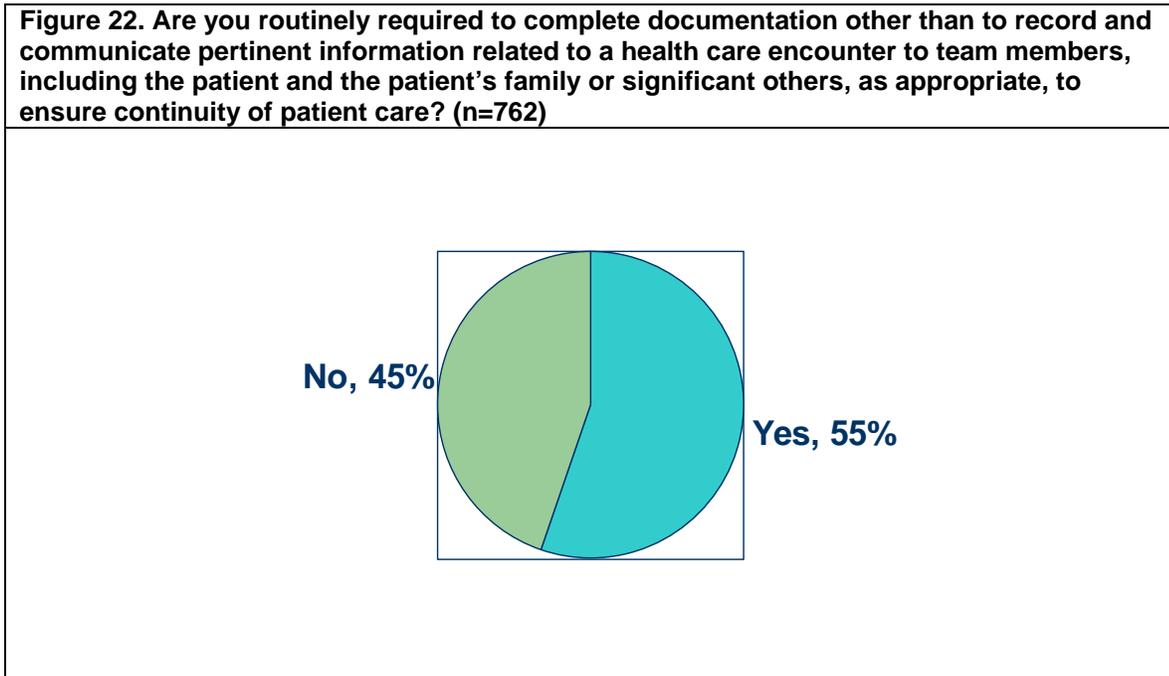


Of respondents not using electronic documentation for day-to-day patient data documentation, 2/3 (66%) did not know when their organization was planning to implement an electronic system.

**Figure 21. What framework does your organization use for nursing documentation? (n=744)**

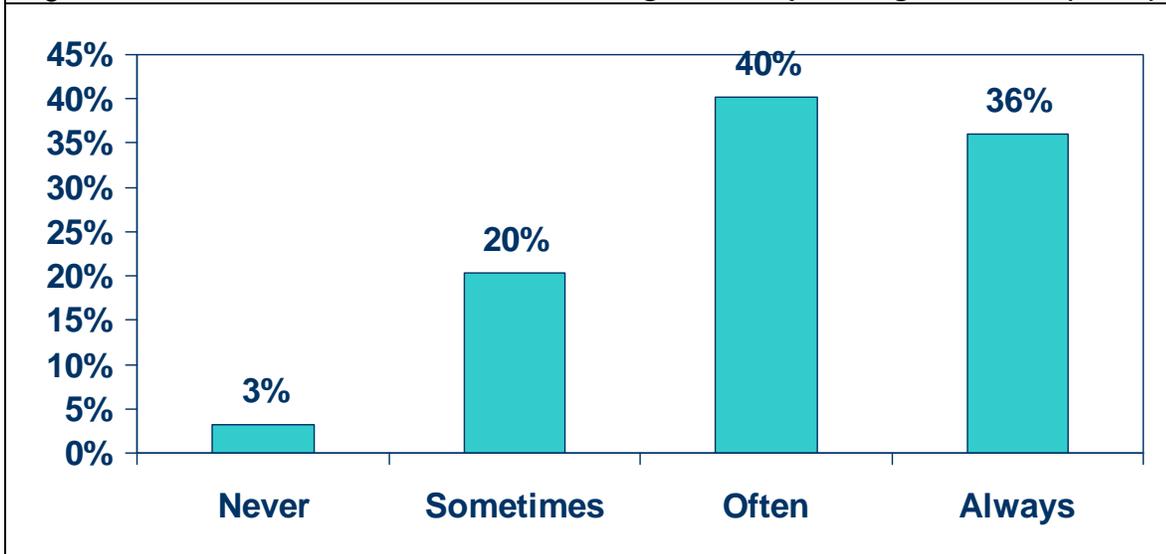
Framework	N	Percent
Critical pathways (CP)	96	12.9
Charting by exception (CBE)	168	22.5
SOAP	127	17.0
Charting to standards (CTS)	213	28.6
Other	90	12.0
CBE + CTS	8	1.1
CBE + CP	42	5.6
Total	744	99.7%

81% of respondents use Charting to standards, Charting by exception, SOAP or Critical pathways as frameworks for documentation.



55% of respondents reported being routinely required to complete documentation other than to record and communicate pertinent patient information.

Figure 23. Documentation is related to the nursing care I am providing at the time. (n=437)



Three-quarters (76%) of the respondents report that the documentation they do is related to the nursing care they provide.

### Comparison of Non-Hospital Nurses to Hospital Nurses

Since 59% of the respondents identified themselves as hospital nurses, cross tabulations were used to compare the responses of hospital nurses to all other respondents on select variables to see if there were any statistically or clinically significant differences between these two groups. The results of this analysis are reported here. Please note, the statistical tests assume random samples, which is not met by these data. Therefore, the results are only suggestive.

\* = statistical significance at the 0.05 level

\*\* = statistical significance at the 0.01 level

Figure 24- Documentation reduces time spent by nurse in providing direct patient care by groups. Groups = Non-Hospital Nurses vs. Hospital Nurses

DOCTIME		Non-Hospital Nurses Frequency	Non-Hospital Nurses Percent	Hospital Nurses Frequency	Hospital Nurses Percent	Chi-Square Value	df	P
	No	82	18.9	86	16.5	5.173	1	0.024*
	Yes	280	77.3	434	83.5			
Total		362	100.0	520	100.0			

A slightly higher proportion of hospital nurse reported that documentation reduces the time available to provide direct patient care. Although statistically significant, this *difference* is not practically noteworthy.

**Figure 25. Extent documentation keeps nurses from spending needed time with patients by groups. Groups = Non-Hospital Nurses vs. Hospital Nurses**

EXTENT		Non-Hospital Nurses Frequency	Non-Hospital Nurses Percent	Hospital Nurses Frequency	Hospital Nurses Percent	Chi-Square Value	df	P
Never		3	1.0	6	1.4	4.547	4	0.337
Rarely		11	4.0	8	1.8			
Sometimes		98	33.4	149	33.6			
Often		134	45.7	192	43.2			
Very Often		47	16.0	89	20.0			
Total		293	100.1	444	100.0			

There is no statistically significant difference on this variable, hence there is not likely any real difference in what is reported as the extent documentation keeps nurses from spending needed time with patients by hospital and non-hospital nurses.

**Figure 26. Percentage of shift spent in completing patient documentation by groups. Groups = Non-Hospital Nurses vs. Hospital Nurses**

PRCNTSHFT		Non-Hospital Nurses Frequency	Non-Hospital Nurses Percent	Hospital Nurses Frequency	Hospital Nurses Percent	Chi-Square Value	df	P
<25%		80	22.1	74	14.3	10.325	3	0.016*
25%-50%		177	48.9	297	57.6			
51%-75%		88	24.3	122	23.6			
>75%		17	4.7	23	4.5			
Total		362	100.0	516	99.9			

Although there is not much difference between the two groups in the proportion of individuals reporting 51% or more of their time on patient documentation, proportionally fewer of the hospital nurses report less than 25% of their time on documentation. This difference is statistically significant.

**Figure 27. Demand for completing patient documentation causes nurse to work beyond their extended work hours by groups. Groups = Non-Hospital Nurses vs. Hospital Nurses**

EXTNDHRS		Non-Hospital Nurses Frequency	Non-Hospital Nurses Percent	Hospital Nurses Frequency	Hospital Nurses Percent	Chi-Square Value	df	P
Never		30	8.2	26	5.0	23.093	4	0.000**
Rarely		66	18.2	121	23.2			
Sometimes		118	32.6	210	40.3			
Often		80	22.1	113	21.7			
Very Often		68	18.7	50	9.6			
Total		362	99.8	520	99.8			

Proportionally almost twice as many non-hospital nurses reported that they very often worked beyond normal hours because of documentation (18.7% compared to 9.6%). This difference is statistically significant.

**Figure 28. Compensated for “stay over period” by groups. Groups = Non-Hospital Nurses vs. Hospital Nurses**

EXTNDCOMP		Non-Hospital Nurses Frequency	Non-Hospital Nurses Percent	Hospital Nurses Frequency	Hospital Nurses Percent	Chi-Square Value	df	P
	No	209	59.2	114	22.4	120.101	1	<b>0.000**</b>
	Yes	144	40.8	394	77.6			
	Total	353	100.0	508	100.0			

Proportionally almost twice as many hospital nurses are compensated for staying beyond their shift to complete documentation than non-hospital nurses. This difference is statistically significant.

**Figure 29. Documentation process redundant by groups. Groups = Non-Hospital Nurses vs. Hospital Nurses**

REDUNDOC		Non-Hospital Nurses Frequency	Non-Hospital Nurses Percent	Hospital Nurses Frequency	Hospital Nurses Percent	Chi-Square Value	df	P
	Never	3	0.8	7	1.3	1.956	4	<b>0.744</b>
	Rarely	41	11.4	48	9.2			
	Sometimes	122	34.1	173	33.2			
	Often	104	29.1	154	29.5			
	Very Often	88	24.6	139	26.6			
	Total	358	100.0	521	100.0			

There is no statistically significant difference between what is reported by hospital and non-hospital nurses on documentation redundancy.

**Figure 30. Using electronic documentation by groups. Groups = Non-Hospital Nurses vs. Hospital Nurses**

ELECDOC		Non-Hospital Nurses Frequency	Non-Hospital Nurses Percent	Hospital Nurses Frequency	Hospital Nurses Percent	Chi-Square Value	df	p
	No	283	77.3	283	55.0	46.613	1	<b>0.000**</b>
	Yes	83	22.7	232	45.0			
	Total	366	100.0	515	100.0			

Proportionally twice as many hospital nurses report using electronic documentation than non-hospital nurses. This difference is statistically significant.

## **Qualitative data**

Writing space was provided on the survey for respondents' comments. A significant number of respondents took advantage of those spaces, and many respondents also wrote comments in non-designated comment places. This yielded rich and varied qualitative data. Only preliminary analysis of this qualitative data has been completed. One recommendation is to select an expert qualitative researcher to further analyze this promising information resource.

The three themes that emerged from preliminary analysis of the qualitative data were: 'systems not integrated', 'redundancy of documentation' and 'poorly designed systems'. Here are the three themes followed by one example from the data of each theme. See Appendix C for more examples.

1. Systems not integrated

"The greatest downfall in electronic documentation is in following the patients hospital care. Unlike in the days when nurses wrote their assessments, vitals, and plans in one note – in chronological order – electronic programs scatter this information into numerous bundles, i.e.; all vitals together, intake and output, mental status, physical therapy progress – the list can go on ad nauseum. All the information is there, just extraordinarily difficulty to bring together. It even has the potential to affect patient safety – when one cannot piece together the bits and bytes to resolve the patient's problem."

2. Redundancy of documentation

"Electronic system X' (name of system changed) can be very redundant; there is a lot of double-charting. It would be helpful to somehow streamline the charting and make it more user-friendly. It takes a while to learn it and become proficient at it."

3. Poorly designed systems

"The system is not user friendly. There are too many "off screen" occurrences of documentation needed. In our instance, too much information was started all at once; instead of doing it in a slower manner, when we could all get used to the big change, many areas were started all at once, ... with more to come!"

## Summary of Findings

- Although this was not a representative sample of Maryland Nurses, the large number of respondents, 933, lends substantial validity to the study's findings.
- Age, years in nursing and gender were substantially equivalent to US nursing demographics.
- Respondents were proportionally higher RNs, as opposed to LPN/LVNs or Advanced Practice nurses, than exist in US nursing population.
- Three quarters of respondents were staff nurses.
- 59% of respondents worked in hospitals.
- 81% of respondents believed requirements for patient care documentation reduced time spent with patients.
  - 63% felt this happens often or very often.
  - A slightly higher proportion of hospital than non-hospital nurses reported this.
- 54% believed they spent 25-50% and 29% believed they spent  $\geq$  51% of their shift documenting.
  - Fewer, in relative terms, hospital nurses reported spending less than 25% of their time on documentation.
- 36% of respondents said documentation often or very often caused them to work beyond their scheduled work hours.
  - 63% were paid for the "stay over period."
  - Statistically significant differences were found between hospital and non-hospital nurses.
    - Non-hospital nurses were proportionally almost twice as likely to report working beyond normal hours very often to complete documentation than hospital nurses.
    - Hospital nurses reported that they were almost twice as likely to be paid for working beyond normal hours to complete documentation.
- 55% reported redundancy often or very often in documentation.
- 64% did not use electronic documentation while 36% did.
  - Proportionally almost twice as many hospital nurses report using electronic documentation than non-hospital nurses.
- Of those using electronic documentation
  - 53% reported *increased* redundancy.
  - 66% reported *increased* time spent on documentation.
  - 44% reported increased completeness of documentation vs. 29% decreased completeness.
  - 43% reported increased quality of documentation vs. 34% decreased completeness.
  - One commercial system was used by 61% of respondents. It should be noted that this system had a high market share in Maryland at 44%.
  - 58% had input into the development and use of the electronic medical record.
- Of those *not* using electronic documentation, 2/3 did not know when their organizations might implement electronic documentation.
- 81% use one of the following frameworks for documentation: Charting to Standards, Charting by Exception, SOAP or Critical Pathways.
- 55% reported routinely documenting for reasons other than recording and communicating pertinent clinical information. (From the Documentation Work Group's deliberations and some of the comments on the surveys, these 'other reasons' include payor and regulatory requirements.)
- 75% reported that their documentation is related to the nursing care they provide.

- Qualitatively, respondents report that:
  - Electronic systems used in their work settings are not integrated.
  - Redundancy of documentation is a frustrating challenge for them.
  - Electronic documentation systems are poorly designed.

## Limitations

This research, like most self-reporting survey research, is susceptible to respondent bias. Survey items were constructed in a way to attempt to minimize “loaded questions”, and there was a large number of responses to the survey. These two things likely mitigated but certainly did not remove all the potential bias of self-report.

Many of the concepts and terms were purposefully devoid of operational definition in this exploratory research. For example ‘quality of nursing documentation’ was not defined for the respondent. The strength of this approach is that broad concepts like ‘quality of nursing documentation’ can mean many different things to a diverse group of nurses such as the population for this survey. Leaving terms like ‘quality of nursing documentation’ not operationally defined necessitated that nurses use their own definition of quality of nursing documentation. The weakness in this approach is that it limits generalizability.

Using a survey that is primarily distributed through a periodical, even one that is distributed to all people who would be included in the sampling frame, will not provide a sample from which unquestionably valid estimates can be derived. This approach results in a non-random sample self-selected from individuals who read the periodical. Furthermore, the self-selection process required effort on the part of participants who had to mail in the survey at their own expense. Other respondents responded to e-mail requests to complete the survey and return it by fax. It is possible that these methods resulted in a sample that disproportionately included nurses who had issues with documentation, rather than a sample that reflected nurses in Maryland. There is no way to determine this from the survey data alone.

Also, the survey targeted nurses in general, rather than those nurses for whom documentation is relevant.

This report blinded the names of the companies/products identified by respondents in question 12 of the Documentation Process section of the survey (see figure 18). In the absence of a random sample and an *a priori* power analysis, responses could not be ascribed to any one company or product. The responses suggest variability across ten companies’ products, but the fact that 60% of the respondents use one company’s product limits the generalizability of this finding. Because respondents were not asked to identify their work sites, it is possible that they represent relatively few sites. There is no way to know whether this is the case or to determine whether variability in the way sites implement systems impacts system performance and end user satisfaction.

## Conclusions

Although not randomized, this sample, which does not differ on important demographic characteristics from the US registered nurse population, is sufficiently large to draw conclusions about important patient care documentation issues in Maryland workplaces and perhaps beyond.

Of significant concern to this sample of nurses were:

- Redundant documentation,
- Excessive time spent documenting, time that takes away from needed direct patient care,
- More than 1/3 of the nurses routinely stayed beyond their scheduled work hours to complete documentation and almost 2/3 of these were paid for the “stay over period,”
- Routinely documenting for reasons other than recording and communicating pertinent clinical information.

This survey and others have demonstrated that a very high amount of a nurse’s day is spent documenting patient care. This, by itself, is unremarkable, but combined with the other findings of significant concern--a) time spent documenting takes away from time spent with patients; b) too much documentation is devoted to non-direct clinical concerns; c) documentation is often redundant, and d) other findings--indicate the nursing documentation process is substantially sub-optimal. This leads to the conclusion that the current state of nursing documentation is a strong work life dissatisfier. As such, the current state of nursing documentation is a factor in the turnover of nursing positions and loss of nurses from the profession, which is also a likely contributor to the present nursing shortage.

A significant trend in nursing documentation, especially in hospitals, is electronic documentation. Although about 2/3 of the sample did not use electronic documentation, almost half of *hospital* nurses, who constituted 59% of the sample overall, did. It was hoped that electronic documentation would alleviate nurses’ concerns with and frustration about documentation of patient care. The data from this survey lends support for a mixed ‘report card’ for electronic documentation. *Nurses who used electronic documentation reported increased:*

- Redundant documentation
- Time spent on documentation

But, at the same time, reported *increased*

- Completeness of documentation
- Quality of documentation.

The majority of nurses using electronic documentation had input into the development or use of the systems in their workplace, but there was substantial sentiment that the systems were poorly designed and not integrated with the many other systems in use.

The Work Group believes it is feasible to reach two goals in 3 years:

- (1) Decrease documentation time per working nurse per shift by 25% and
- (2) For nurses and institutions that incur overtime for the purpose of documentation of patient care, reduce that overtime by ½ hour per week per nurse.

Using data based on full-time equivalent (FTE) Maryland direct care hospital nurses *only*--who would more plausibly benefit, despite the likelihood that many more nurses could also benefit—we conservatively estimate that these two improvements would free up about \$94,000,000 per year in the state of Maryland, monies that could fund more nurses or in some way, more direct nursing care. This could be a significant contribution to relieve the nursing shortage, as suggested below.

**Basis of Estimate for Savings Attributable to Streamlined Nursing Documentation:**

- 2.5 = hours freed up per full-time nurse per week if the time spent on documentation was decreased by 25%.
- 45 = number of weeks a nurse actually works in a year.
- 112.5 = annualized hours freed up per full-time nurse per week if the time spent on documentation was decreased by 25%.
- \$40.72 = median expected hourly base wage plus benefits for a typical RN staff nurse - (Maryland Health Services Review Commission).
- \$4,581 = annualized cost per full-time nurse per week documenting 2 hours per shift instead of a more optimum 1.5 hours per shift.
- 17,446 = full-time equivalent (FTE) hospital nurse direct caregivers in Maryland, in 2005. (Maryland Health Services Review Commission).
- \$79,920,126 = annualized cost of FTE nurse direct caregivers in hospitals in Maryland documenting 2 hours per shift instead of a more optimum 1.5 hours per shift.
- \$14,547,150 = annualized savings of a ½ hour per week from reduction in overtime to document patient care per FTE hospital nurse direct caregiver in Maryland for ½ of those nurses. (Not all nurses incur overtime due to documentation of patient care.)

Clearly there is a significant need for improvement in the process of documentation of patient care by nurses, which currently takes up a substantial portion of nurses' time. New, relevant, streamlined, non-redundant, time-saving documentation approaches are needed. Electronic documentation approaches are welcome, but they must be effectively integrated with other systems and designed to make nurses' workloads lighter or at least more manageable. If documentation of patient care by nurses, who constitute 54% of the healthcare workforce, is made significantly more efficient, nurses can look forward to more satisfying work environments. Healthcare consumers can look forward to more direct nursing care that should equate to improved quality of nursing care. Moreover, putting substantial and sustained effort into improving the process of documentation of patient care by nurses holds the potential to decrease healthcare costs.

## Recommendations

1. After complete implementation of an electronic documentation system, target a reduction of 25% of nurse time spent on documentation within 3 years.
2. After complete implementation of an electronic documentation system, target a reduction of overtime by ½ hour per week per nurse within 3 years for nurses and institutions that incur overtime for the purpose of documentation of patient care.
3. Support research on best practices for implementation of and use of electronic systems.
4. Encourage the involvement of nurse executives and direct care nurses as well as other users of the technology in all planning and implementation of electronic patient records and formulation of documentation policies in all health care facilities/agencies.
5. Convene forums where nurse informaticians, nurse executives, nurse managers and direct care nurses can dialog about the issues identified in this survey, particularly issues regarding electronic documentation, for the purpose of identifying/recommending best practices and standards for improved, streamlined documentation of nursing care.
6. Encourage developers of electronic documentation systems to improve the design and integration of their systems while producing systems that decrease redundancy of documentation and save nurses time on documentation.
7. Nurse leaders should communicate/dialog with nurses in their organizations about plans for electronic documentation more substantially than at present.
8. Include research and content about nursing documentation in nursing and clinical informatics educational programs as well as continuing education for direct care nurses to more effectively use and contribute to the development of electronic documentation systems at their places of employment.
9. Publish the final version of this report on a web site for download.
10. Publish the results of this survey in a national peer reviewed journal.
11. Present the finding of this survey at local, state and national conferences.
12. Partner with researchers and interested parties to improve the methods of this survey and replicate it nationally. Obtain funding to do this.
13. In future studies:
  - a. Address the length of time that nurses were using electronic documentation. This variable was not addressed in this study.

- b. Add nursing education as a variable as well as subjects experience with electronic documentation during nursing school.
  - c. Include more questions to explore the relationship between nursing documentation and patient safety.
  - d. Explore more explicitly costs of current approaches and potential for cost saving of more effective approaches.
  - e. Test the effect of electronic nursing documentation on such variables as nurse satisfaction, documentation redundancy, time spent with patients and patient outcomes.
  - f. Obtain objective measures of quality of documentation in tandem with measures of nurse perceptions, which are subjective, at least for subsets of the samples, whenever possible.
  - g. Explore in more depth questions about frameworks for nursing documentation and how specific frameworks can contribute to increased documentation efficiency and effectiveness.
  - h. Explore in more detail the types of hardware and supporting equipment used in electronic documentation, such as computers on wheels and PDAs and how different types of equipment enhance compliance with use and accessibility.
  - i. Contrast known exemplars of nursing practice, such as magnet hospitals, with other institutions in future studies.
  - j. Explore nurse perceptions of the critical role, or lack thereof, that nurse informaticians play in designing, educating users, implementing and evolving electronic documentation solutions.
14. Analyze qualitative data collected in this survey more substantially.

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# Appendix A – Nursing Documentation Survey instrument as published in The Maryland Nurse

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AUGUST, SEPTEMBER, OCTOBER 2005

## Nursing Documentation Survey

Nurses attending the *Commission on the Crisis in Nursing* meetings have identified documentation of patient data and nursing interventions as issues. Therefore, the Workplace Committee and the Technology Workgroup of the Commission, have requested more specific information from direct care nurses relative to the practices associated with patient documentation.

The goal of this survey is to solicit information related to the nature and extent of current problems experienced during the process of nursing documentation from direct patient care nurses. As a direct care nurse, your participation in this statewide survey will provide first hand information and important data for the Commission to better evaluate the current issues related to Nursing Documentation and subsequently provide recommendations for change. All responses are CONFIDENTIAL, ANONYMOUS, and will be analyzed as Group data.

Please take ten (10) minutes right now and complete this survey and return this survey by mail or fax to:

Maryland Nurses Association  
21 Governor's Court, Suite 195  
Baltimore, MD 21244-2721  
Fax number: 410-944-5802

**Completed surveys must be received no later than October 21, 2005**

For Questions regarding this survey, call the Maryland Nurses Association at 410-944-5800 or email info@marylandnm.org

### Nursing Documentation Survey

Only one response is appropriate for each of the following:

#### Part I—Documentation Process

1. 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?

YES	
NO	

2. If you answered YES to #1, to what extent does the documentation process prevent or keep you from spending as much time with patients as needed?

Never	
Rarely	
Sometimes	
Often	
Very Often	

3. What percentage of your shift or patient visit is actually spent in completing patient documentation?

Less than 25%	
25% to 50%	
51% to 75%	
More than 75%	

4. How often does the demand for completing patient documentation cause you to extend or work beyond your scheduled work hours?

Never	
Rarely	
Sometimes	
Often	
Very Often	

5. In instances where you work beyond your scheduled work hours to complete documentation, are you compensated for the duration of this "stay over period?"

YES	
NO	

6. 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.?

Never	
Rarely	
Sometimes	
Often	
Very Often	

7. Are you using electronic documentation in your practice?

YES	
NO	
If NO, go to #14	

If you answered YES to #7, please complete 8-13 and then move to Part II of the survey

If you answered No to # 7 then please move to question 14 and complete questions 14-7 then move to Part II of the survey

8. The use of electronic documentation has \_\_\_\_\_ redundancy of documentation.

DECREASED	
INCREASED	
NOT AFFECTED	

9. The use of electronic documentation has \_\_\_\_\_ the amount of time spent on nursing documentation.

DECREASED	
INCREASED	
NOT AFFECTED	

10. The use of electronic documentation has \_\_\_\_\_ completeness of nursing documentation.

DECREASED	
INCREASED	
NOT AFFECTED	

11. The use of electronic documentation has \_\_\_\_\_ quality of nursing documentation.

DECREASED	
INCREASED	
NOT AFFECTED	

12. Identify the system name for the electronic documentation system you currently use.

CERNER	
ECLIPSYS	
EPIC	
GE	
IDX	
MEDITECH	
McKesson	
VISTA/CPRS	
Other, please specify	

13. Did/Do direct care nurses have input into the development and use of the electronic medical record system in your work setting?

YES	
NO	

14. If you are not currently using electronic documentation for your day-to-day patient data documentation, indicate when your organization is planning to implement an electronic system:

Within the next 6 months	
More than 6 months and less than 1 year	
More than 1 year and less than 2 years	
More than 2 years from now	
My organization has no plans for implementing the use of an electronic system	
I don't know	

15. What framework does your organization use for nursing documentation?

Critical Pathways	
Charting by Exception	
SOAP	
Charting to Standards	
Other, Please specify	

16. 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?

YES	
NO	

If Yes is selected, please provide an example of the documentation and check the box that most closely aligns to the reason that it is not relevant.

Example:

<input type="checkbox"/>	Documentation is NEVER related to the nursing care I am providing at the time
<input type="checkbox"/>	Documentation is SOMETIMES related to the nursing care I am providing at the time
<input type="checkbox"/>	Documentation is OFTEN related to the nursing care I am providing at the time
<input type="checkbox"/>	Documentation is ALWAYS related to the nursing care I am providing at the time

17. Provide suggestions or comments that you believe can improve the efficiency and effectiveness of nursing documentation.


### Nursing Documentation Survey

Only one response is appropriate for each of the following:

#### Part II—RESPONDENT DEMOGRAPHICS

1. Age

18-27	
28-37	
38-47	
48-57	
58-67	
68+	

2. Years in Nursing

Less than 5	
6-10	
11-19	
20-29	
30-39	
40+	

3. Type of Nursing License

LPN	
RN	
Advanced Practice	

4. Gender

Female	
Male	

5. Current Nursing Position/Role

Administration	
Staff RN	
Staff LPN	
Nurse Case Manager	
Nurse Educator/Faculty	
Agency Nurse	
Advanced Practice Nurse *	
Clinical Nurse Specialist **	
Other, Please Specify	

\* Nurse specifically authorized by the Board of Nursing to practice as nurse anesthetist, nurse mid-wives, nurse practitioners, nurse psychotherapist.

\*\* Nurses with a Master's degree in a nursing specialty, practicing in a clinical area.

6. Current practice setting

Hospital/Acute Care	
Rehabilitation	
Public Health	
School Health	
Occupational Health	
Home Health	
Long Term Care	
Assisted Living	
Adult Day Care	
Hospice	
Psychiatric setting	
Ambulatory Care/Outpatient	
HMO	
Physician Office Practice	

## **Appendix B – Membership of the Documentation Work Group of the Workplace Issues Committee of the Maryland Statewide Commission on the Crisis in Nursing**

Victoria B. Navarro, MAS, MSN, RN, Chair

Stephanie S. Poe, MScN, RN, Co-Chair

Mary Beachley, MS, RN, CNAA

Thomas Craven, BSN, RN

Brian Gugerty, MS, DNS, RN

Wahnita Hawk, LPN

Judy Karp, RNC, OCN

Steven Morrison, JD

Linda Thornton, MSN, RN

## Appendix C – Sample Comments

607 v25 I am used to 'electronic system Y' (name of system changed) and can choose to chart as much or as little as possible. I believe the deficit in charting comes from the nurse's knowledge level, not from the vehicle used to document. Nurses in Maryland do not have required yearly CEUs, big mistake!

606 v25 Input in selection process by more than VP patient care. All systems must be integrated before nursing documents – LAB, pharmacy, radiology, etc. All documentation in medical record by all providers should be mandatory. Nursing is often bearing the brunt of the limitations of the various systems. Require a Masters prepared informatics RN to be a part of designing and implementing systems.

603 v25 systems do not speak to each other [ ] help needed for non nurses.

532 v25 My institution has a lot of unnecessary forms that have to be filled out for most nursing care actions. For examples, just to document a glucometer reading, it has to be documented in the glucometer reading book, on a lab slip for the physician, in the patient's chart for lab tests, in the medication administration book, and in the running report. I suggest having less forms that have to be filled out.

503 v25 For school nurse – Each state school should have a uniform charting system with the SAME information required for all counties, then when a student is transferred, the chart does not have to be reproduced. In addition, a more accurate flow of where the student was will be obtained. V31 School health nurse.

476 v25 Electronic notes. Duplicate documentation: Pain management and flow sheets, Mar, critical flow sheets – All say the same thing.

415 v25 Multiple documentations of the same encounter should not be required. More standardized methods needs to be in place so that the RN is not completing several forms and making several phone calls all for the same encounter. Current documentation demanded is not efficient practice and definitely affects nurse's ability to render the best care possible.

377 v25 Detailed flow sheets – "Check off". Quick-portable electronic systems - (live in a poor county which limits our ability to access modern technology due to lack of funding.)

328 v25 The charting can be a nightmare for new graduate nurses and it can become overwhelming to older nurse too! Much documentation.

251 v25 The computer record is time consuming and hard to quickly retrieve PT. info. It was so much easier to use simple paper record. Also the computer has encouraged a huge increase in useless info being recorded.

204 v25 Delete and redundancy,. In another facility i work we use electronic charting, but the area for nursing to make comments is very small and we can't always legally protect ourselves. I can write a small sentence, then have to log out and log back in to complete the thought, action, or describe a scenario. Aside from assessments, it is very difficult to

make comments. In the facility that uses paper charting, the nurses notes are not contiguous with the progress notes other HCP are using. I've worked in several hospitals over the years where nursing notes were part of the progress notes and ALL HCP used exactly the same sheets. Interestingly physicians found information they weren't always aware of... imagine that!

201 v25 I like the open-ended forms to document on daily flow sheets because i can tailor them to my needs. This is true for MED forms too. Any form is OK – the factor that determines its efficiency is the nurse who uses/abuses it. For example, a document system may be ingeniously designed, but if the assessment is incomplete or the handwriting/ notation sloppy or incorrect, the system will fail.

181 v20 ICU collaboration v25 Have an attached nursing progress not sheet attached to daily flow sheets. All nurses note would stay together would help monthly chart checks to see all nursing documentation all on one sheet. Care maps – treatments – procedures – assessments, notes, teaching, discharge all together on one form.

123 v25 Working in PACu I find having paper documentation at bedside that is often scanned into the computer is most efficient. We have not found a system that works better using electronic documentation.

0084 v25 we use our word processors as typewriters. Develop templates for assessments and care plans are glacially slow. I am forced to review documentation of immunizations for errors that a well written program would detect in the input phase.

0083 v25 State and Federal regulations plus JCAHO certification have lead to the increase in documentation in home health. A typical SOC is 36 pages. The electronic documentation is a lot of check boxes but still takes time to go through. We have to complete orders 465. medication profile, classify the medications, verify interactions and send to MD if there are, create a plan of care for home health aide, get the contract signed including verification of DNR status.

0079 v25 go back to paper

0074 v25 Not having to document on things such as providing dry clothes for bathroom accidents, providing feminine hygiene products, for providing tooth chests for children who have lost a tooth;

0061 v25 I would like to see immunizations computerized – but actual notes not computerized. Unless the program is specific for school nursing I think it will take longer to use computer for notes. Now time spent with students is NOT taken away because I can care for them and write the note later in the chart. But I do spend more time charting then I spend caring for the student. Lots of time spent charting after duty day;

0058 v25 Document via checklist – standard nursing care with a few lines for narrative report as needed;

0057 v25 Check off boxes would save time instead of having to write everything;

0031 v25 Official agencies need to reduce the many different ways the require organizations to document care. Only one form for each care event provided. Transfers

within a larger system do not need to start collecting the same information all over again, as was already done in another part of the system;

0008 v18 Narrative v25 allow more time at the end of shift for charting. Charting on energy patient took care for the shift when nothing new is going, on with them is being redundant;

0002 v25 stop duplicating documentation. –when pt admitted from PACU, most information on nursing assessment can be gotten from perioperative report. I.e. Hx, meds, charting pain meds;



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