Everything Needed but Nothing Else - A Successful Nursing Documentation Reduction Process

Nicole Callender, RN, BSN; Heather Knott, RN, BSN
Angela Swinger-Lockridge, RN, BSN

Problem Statement: Nursing documentation was estimated to consume 35% of the bedside nurse's shift at a 1000 bed University Teaching Hospital. In August 2015, implementation of changes focused on reducing the nurse's documentation time began. System Support Services, a group of RNs focused on supporting the inpatient EHR users, was charged with planning, education, and implementation of these changes. Using the Saba Clinical Care Classification, modified charting by exception documentation was implemented and resulted in reducing documentation by 30 minutes per nurse per shift. This presentation will discuss the process for education and implementation support- the strategies that worked and those that did not. **Methods:** Various education methods were used in the implementation. Voice Over PowerPoints were distributed to all bedside nurses via a learning management system. Unit specific super users were assigned and attended an interactive class. Unit specific practice scenarios were developed by the unit specific nurse educator. A phased rollout was scheduled for the fall of 2015 with System Support Services providing 24/7 support to provide one-on-one education and support to bedside nurses. Unit-Based Super Users (one per shift per unit) and Unit Educators were also part of the support plan. **Results:** PowerPoints, super user classes, and unit practice scenarios served as a good introduction to the changes, but did not prove to be the most effective. Staffing constraints severely limited the ability of units to supply out of staffing Super Users and consequently the rollout had to be extended. Due to varied adult learning styles and time constraints, one-on-one in person education on the units on the week of go-live proved to be the most effective method of education. With one- on- one time spent with each nurse, System Support Services was able to answer questions in live situations and comprehension appeared to increase. Chart audits were also performed while providing positive constructive feedback to the bedside nurse. **Significance:** Modified charting by exception using the Clinical Care Classification has been a success reducing documentation time by an average of 30 minutes per nurse per shift. While it is important to offer various learning methods, interpersonal interactions in real time proved to be the most effective in bedside nurses comprehending the new requirements and changes.