Improve Clinician Satisfaction and Compliance by Simplifying Documentation

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Documentation has always been a burden to clinicians, and it has increased exponentially in the last several years with the advent of the electronic health record (EHR). The Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services foundthat while an important part of the EHR, Computerized Physician Order Entry has reduced transcription-related medication errors, but it has also created an avalanche of new errors. Although EHRs geared to outpatient settings tend to work well, hospital inpatient EHR documentation is typically inaccurate and is poor for communicating the quickly changing status of hospital inpatients, contributing to clinician dissatisfaction and burnout.

What to do?

Hospitals typically have little time to address these issues because they are directly or indirectly threatened with loss of Medicare certification. They have no choice but to quickly improve clinical performance and associated documentation, which means they must make the right thing to do the easy thing to do and document.

First, hospitals must simplify their expectations (policies and procedures). Second, they must streamline navigation through the medical record, making it easier to input information and glean information from the EHR.

Simplifying Policies

Rule number one: “say what you do and do what you say”. Around 80% of regulatory citations are based on deviations from hospital policy rather than a direct regulatory violation. Yet policies and procedures have expanded in recent years for several related reasons:

1. Regulatory and accreditation surveys tend to focus on the content of policies and procedures since it is difficult for a surveyor to observe actual practice. Surveyor focus on policies has led hospitals to create longer, more complex policies on almost every topic. A highly scrutinized restraint policy grows from a page and a half to 10, 20 or even 30 pages, sometimes overflowing into separate policies for behavioral health vs. general medical settings.
2. Policies and procedures are often based on pure regulatory myths rather than the true requirements or clinical imperatives.

3. Hospitals often fail to leverage other ways of communicating expectations to clinicians, such as instructions for use, testing and maintenance forms, training material, or clinical record templates.
4. Hospitals tend to add pages to their policy and procedure as a means of correcting any regulatory or accreditation citation or when addressing an adverse event.

But before the hospital can reduce its documentation burden, it must first reduce its policy burden. Hospitals must:

1. Reduce the number of policies and procedures
2. Reduce the length of policies and procedures
3. Clearly specify when certain elements of a clinical process need not be documented
4. Reality test these expectations through a monitoring, implementation and reinforcement process called “care facilitation”

There are two recommended ground rules leadership should set to help guide the way:

1. All revised policies must reduce the total number of words by at least 25%
2. At least two polices or procedures must be retired for every new policy or procedure created

Streamlining Documentation: Less is More

It is not necessary to abandon any particular medical record product or “build” to streamline documentation: existing screens and reports can be simplified by the local EHR administrators. There is no time like the present to begin the following paradigm shifts:

1. Eliminate unnecessary “structured” data

Less than 15% of data entered by nursing into structured fields (check boxes, radio buttons, drop-down lists) will ever be aggregated. So adopt narrative notes for any necessary information that doesn’t fall into the vast minority of information that will never be aggregated.

2. Eliminate redundancy

Documentation screens are built around a multitude of workflows. Unfortunately a number of fields have been created to capture essentially the same information, emphasizing the necessity to define data carefully and find one and only one field to capture the information.

3. There is no substitute for critical thinking

A documentation template or a hard stop is no substitute for critical thinking. Therefore, hospitals typically adopt “care facilitation” as the method of implementing, monitoring and reinforcing practice. Care facilitation is done *during* the clinical process, reinforcing expectations and monitoring documentation only when the correct clinical process is validated.

This seems like a lot because it is. Although hospitals typically only have 30 days to make big changes in crisis mode, it takes much, much longer to undo the harm inflected by decades of policy and documentation overkill. So, start now. Focus. Simplify.

https://www.hitechanswers.net/improve-clinician-satisfaction-and-compliance-by-simplifying-documentation/