

# Clinical documentation and nurses: **the challenges and opportunities**



## About this report

Having commissioned a detailed and independent analysis of time spent by clinicians on clinical documentation, Nuance convened a roundtable to discuss the impact of clinical documentation on nurses.

This report was written following the roundtable event which was chaired by **Anne Cooper, Chief Nurse, NHS Digital.**

## We would like to thank the following for their input:

**Ian Bailey** - Senior Clinical Informatics Consultant, EMIS Health and Queen's Nurses Institute

**Gerry Bolger** - Nurse Clinical Lead for informatics & CCIO (Nursing), NHS England and Royal College of Nursing eHealth Forum

**Richard Cox** - Matron, Central Manchester University Hospitals

**Jo Dickson** - CCIO / Clinical Informatics Partner, Nuffield Health

**Lucy Harborne** - Ward Manager, Birmingham and Solihull Mental Health NHS FT

**Simon Noel** - Project Development Manager, Oxford Radcliffe Hospitals NHS Trust

**Sarah Newcombe** - Clinical Site Practitioner, Great Ormond Street Children's Hospital

**Ross Scrivener** - Knowledge and Resources Manager Education, Learning and Development, Royal College of Nursing

**Liz Watson** - Ward Manager, Northern Devon NHS Healthcare Trust

**Dan Wheeldon** - Ward manager, Birmingham and Solihull Mental Health NHS FT

**Lucy Wright** - Clinical lead, Waverly (Virgin Care)

**Karen Vernon** - Multiple Sclerosis Nurse Consultant, Salford Royal NHS Foundation Trust

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## Introduction

The effective use of information and digital technologies is a key enabler in delivering health and social care now and in the future. The impact of technology and the potential that it has to transform care is a professional issue touching on care delivery, practice, education and research.

But we are living in a period of transition. We are moving from one world into another. Paper records are characteristic of this passing world. Electronic Patient Records (EPRs) are characteristic of the new world.

Transition periods are painful because, for a time, these worlds co-exist. We can list the shortcomings of analogue systems at work but grow increasingly frustrated when we cannot immediately benefit from the spread of digital records and systems.

The new world needs to work for the benefit of citizens and patients and the staff who work within it. But it is difficult to abandon established ways of working. This publication documents a nursing documentation roundtable discussion. It is part of a conversation with nursing staff that needs to be heard more widely. We need more conversations like these where people can share their experiences of what is and is not working.

We need more spaces where nurses can make sense of the challenges arising from the transition period. Nurses and midwives will grow in confidence if they speak about the changes that affect them.

Nurses and midwives are not alone in feeling ill prepared or equipped to benefit from digital innovation. Nesta's study highlights that only 33 per cent of UK employees say they are offered basic digital training by their employers<sup>1</sup>.

The Royal College of Nursing (RCN) is running an initiative called: "Every Nurse an eNurse". Our ambition is to help develop a nursing workforce that has the confidence, tools and skills to thrive in this new world. We have worked with Health Education England to identify the digital skills required to make the transition<sup>2</sup>. We will need to do more if this mission is to succeed. The roundtable attendees provide valuable insight into the next phase of this agenda.

Ross Scrivener, Knowledge and Resources Manager,  
Education, Learning and Development, Royal College of  
Nursing

<sup>1</sup> Mocker V, Chapman O (2017). *Digital Pulse: how ready is the UK for the digital life?* Nesta.

<sup>2</sup> Health Education England, Royal College of Nursing (2017). *Improving digital literacy.*

## Nurse documentation - the challenge

Paper still plays a significant role in recording, storing and reviewing information in today's NHS. Nursing is no exception and recent research<sup>1</sup> shows that documentation takes up a significant proportion of nurses' clinical time. Nursing documentation needs to be high quality and timely with inbuilt levels of security, governance and control as appropriate for each patient scenario. In addition, nursing takes place in a range of different settings, via a range of NHS and non-NHS providers encompassing acute, primary, mental health and community care.

Documentation needs to reflect the healthcare needs of the ageing population. The changing nature of healthcare places particular demands on health and social care services to communicate, co-ordinate and to collaborate<sup>2</sup>.

At the same time the clinical documentation challenge is not solely a nursing issue. It is felt throughout healthcare and as such there are issues around the flow and availability of information across all parts of the system and in all roles. The Royal College of Physicians for example has invested in an iLab project<sup>3</sup> to raise awareness of how health information is managed and develop systems that better support working practices.

Well-written and factually accurate clinical records are a fundamental part of delivering quality healthcare. Increased documentation requirements reflect the increasing volume of patients, complexity of healthcare, the burden of regulation and greater interworking with multi-disciplinary teams and other health and social care organisations. These complex conditions and therapies across complex care pathways need to be documented and communicated.

### Nursing documentation – the pressure cooker environment

There are several factors at play that are increasing pressure on nurses when it comes to documentation such as the changing and broadening role. Nurses are playing a pivotal role in healthcare delivery working in many different settings, using a wide range of technologies to support patients in their care. They are running their own clinics, prescribing drugs and taking on some of the work of managers. Nurses are also taking on many of the roles that used to be undertaken exclusively by doctors.

Factor in the change in medical and nursing culture which makes patients, parents and carers partners and co-producers in their care, and there is more communication than used to be required in a paternalistic healthcare environment.

The drive towards a paperless records system and the Electronic Patient Record (EPR) has sparked an increasing focus on nurses and their readiness to use electronic systems, particularly when it comes to documentation. The RCN's 'Every nurse an e-nurse' initiative has been backed by NHS Digital. In its first publication with Health Education England on digital skills development the contributors from the RCN talk about the need for a workforce that is 'involved in the design, development and deployment of technology in healthcare'.

### Complete, correct and timely patient story

As the NHS becomes more sophisticated at using recorded data to produce useful and meaningful insight for quality improvement, it will become increasingly important that the data captured is accurate and timely. The starting point is often the EPR. The role of nurses in accurately recording data is therefore vital. They must also be able to access, review and update the most contemporaneous and relevant records from wherever they are working.

up to

# 40%

of the time is spent on clinical documentation

# 73%

go home late due to clinical documentation

At the same time, there are information standards which apply to all healthcare professionals including nurses. Healthcare organisations are bound by information governance requirements which form part of staffing induction training and operational policies. In addition, the Professional Records Standards Bureau (PRSB) is working to articulate information standards.

All nurses and midwives have to refer to the Nursing and Midwifery Council's Code. The Code [see Figure 1] presents the professional standards that nurses and midwives must uphold in order to be registered to practice in the UK.

#### **The impact on day-to-day nursing**

In a 2016 @WeNurses tweetchat<sup>4</sup> an online poll found 73 per cent of respondents said they went home late (171 responses) because of clinical documentation and 33 per cent of nurses said clinical documentation takes 20 to 40 per cent of their time. There is no doubt that meeting the daily documentation demands in line with the Nursing and Midwifery Council's code<sup>5</sup> and Figure 1 below has an impact on patient care.

The participants in the tweetchat suggested that clinical documentation is taking up a substantial amount of nurses' time but at the same time they understand its importance and the need to 'get it right' because it supports clinical decision making. They also had concerns about litigation and the requirement to record the rationale for taking particular action.

#### **Figure 1 Nursing and Midwifery Council's Code - record keeping guidance**

This includes, but is not limited to, patient records. It includes all records that are relevant to the scope of practice. To achieve this nurses must:

**Complete all records at the time or as soon as possible after an event, recording if the notes are written after the event.**

**Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.**

**Complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.**

**Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.**

**Take all steps to make sure that all records are kept securely.**

**Collect, treat and store all data and research findings appropriately.**

<sup>4</sup> Nursing Documentation Tweetchat, December 2016

<sup>5</sup> The Code, Professional standards of behaviour and practice for nurses and midwives, NMC, 2015

## Documentation and clinical practice

**The three pillars of nursing documentation:  
Accuracy. Quality. Completeness.**

**1** It provides an accurate reflection of nursing assessments, changes in conditions, care provided and patient information. This in turn is critical to good quality and timely care because it ensures good communication between clinicians and other health and care professionals. Documentation also helps to determine which interventions are working and ensures that changes to the patient's care plan are documented. The NMC's Code states nurses must ensure the health care record for the patient or client is an accurate account of treatment, care planning and delivery. "It should be written with

the involvement of the patient or client wherever practicable and completed as soon as possible after an event has occurred. It should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared."

**2** Clinical documentation ensures a patient's wishes are clearly recorded. It presents an opportunity for the patient to become involved in their care. Patients are able to become shared decision-makers and co-producers of their care. This in turn helps them manage their condition and reduce the risk

of exacerbation and emergency admission to hospital and reliance on out of hours services.

**3** It is a valuable method for demonstrating that nurses have applied their knowledge, skills and judgment according to professional standards. It can be used as evidence in legal proceedings, coroners' inquests, and disciplinary hearings. It provides evidence of care and is an important professional and medico legal requirement of nursing practice.

### Documentation in practice versus theory

Despite the good reasons for good quality clinical documentation, there can be little doubt that in practice it is not always complete and accurate. One of the nurses on the roundtable panel said: "In our Trust there have been a few investigations into patient harm where documentation has been brought up as a contributory factor to the breakdown in communication. So, we are keen to standardise documentation processes, so we are doing the same thing everywhere in the trust."

Consistency in recording information is a challenge that many Trusts still face. Although there are processes in place, one ward may not record information in exactly the same way as another. This could be because nurses have adapted forms to make them more relevant to the ward they are working on. One of the roundtable panellists said that prior to an EPR implementation she had audited one ward and found 40 different ways of documenting care which resulted in a large volume of paperwork.

Another nurse characterised the challenge of balancing patient care versus the burden of documentation suggesting "sometimes it feels that everyone is so busy writing about doing it, but not doing it". The reality is that care takes precedent and documentation is often left until the end of the shift, or is completed at the right time, but quickly and sometimes inaccurately.

Researchers from Nottingham University Hospitals NHS Trust carried out in depth interviews with eight nurses in 2015 and found that patient care information is often being recorded by nurses in an "inaccurate, inconsistent, repetitive and incomplete" way, leading to potential safety concerns.

The study<sup>6</sup>, based on the interviews was published in 2016 and focused on gaps, mishaps and overlaps in documentation. Gaps refers to information that was missing, inaccurate or inconsistent. Mishaps refers to the consequences of these gaps and overlaps refers to the problem of duplication of this information.

<sup>6</sup> 'Gaps, mishaps and overlaps' Nursing documentation: how does it affect care? Liz Charalambous, Sarah Goldberg

It highlighted nurse exasperation over the time it took to complete the paperwork which they felt was repetitive and of no benefit to patients. All of those interviewed felt that the amount of time spent completing documentation was excessive and took them away from the patients, with evidence that, in some cases, the documentation itself was counterproductive to delivering safe and effective care.

It is to be welcomed that, long overdue, attention is now being paid to the design of records and the systems that produce them. However, Ross Scrivener, Knowledge and Resources Manager Education, Learning and Development, Royal College of Nursing, says: “We need to be careful that we are taking a person-centred approach to clinical documentation and not one that is based around systems. No amount of exhorting nurses to be more reliable can overcome poor system design.”

#### **An opportunity to re-design documentation**

Roundtable attendees were asked whether there was anything about nursing in particular that might contribute to gaps, mishaps and overlaps. One factor which could be having an impact on documentation is that, despite changes in technology, little has changed in the way information is documented. “I have been practising for over 25 years and the way we document is not very different from the way we did it as student nurses,” said one nurse. In other words, over two and half decades on, with better access to technology, the documentation process hasn’t kept pace. “We are still documenting the same things,” she said.

The issue can be compounded by the advent of electronic health records which often mirror the paper records. This means that even when an electronic patient record is implemented nurses are simply typing the same information that used to be written by hand. Instead of taking the opportunity to ask what information really needs to be recorded, the reality is that paper forms are duplicated electronically. One nurse said: “We need to make the most of this by asking, how much of this information do we need to document and how much do we actually use.”

Anne Cooper suggests one way to overcome this challenge is for “nurses to re-imagine the process of clinical documentation”. She added that if smart 21st-century documentation is going to work, then the output needs to be a natural by-product of the nursing process. However, there is an important caveat; work imagined can be different from the work actually being done.

The challenge of being able to retrieve factual information from the electronic patient record, which can often be long-winded and overly detailed, was highlighted by one nurse. “The bits that you really need that highlight potential risk can be buried,” she said. This begs the question about the amount of information recorded and whether there is a trade-off. In other words, too much information of little relevance can mean technology can sometimes make life more difficult for busy staff.

In Improving digital literacy<sup>2</sup> contributors from the RCN argue that many systems are developed with a fundamental misperception of what nursing is. The misperception, that nursing is a series of tasks, can be termed a ‘nursing is doing’ mindset. What is needed is a ‘nursing is knowing’ mindset, based on the recognition that nursing involves clinical decision making.

The roundtable also considered the issue of consistency in documentation and discussed the impact of the variation in style of narrative from ward to ward and even between nurses. One of the consequences of this variation is that handovers may take longer and where the narrative is constrained or not as detailed, a richness in the quality of the record is lost. There are also implications for the way information is shared. If clinical teams are recording information differently then the ability to monitor the patient journey effectively is hindered. One nurse said: “There is a lot of information that is collected, but it often feels like it doesn’t go anywhere or is used in the right way or shared effectively.

“We are in a watershed moment where we rely increasingly on electronic patient records and if we don’t get some of the fundamentals right, then the risk is we will build on sand. We need to reflect the reality of what is happening in practice. There have been times in my clinical practice where I have come onto a ward, looked at a patient’s notes and not been able to understand what had happened and what was going to happen next.”

– Anne Cooper, Chief Nurse,  
NHS Digital

“Documentation is a legal record of care delivery - it should not be an obstacle to care delivery.”

– @Bartontd David Barton, retired  
professor of nursing



## The role of the patient in clinical documentation

Interaction and communication with patients, carers or their families is fundamental to nursing and as a result nurses have an important part to play when it comes to encouraging patients to take more control and share decisions about their treatment and care.

Shared decision making appears in the NHS Constitution<sup>7</sup> and NHS England has made its commitment to shared decision making clear by developing resources and toolkits. In practice, encouraging patients to take a more active role requires a culture change and a shift from traditional models of care. There are few incentives and this is not promoted systematically at organisational, regional or national level.

Clinical documentation could be a catalyst to greater patient involvement. One nurse who attended the roundtable asked: “Why shouldn’t patients with long-term conditions be more involved in documenting their care and have the opportunity to supplement their own records?”

Patients with long-term conditions may have many interactions with nurses in a single year, but they live with their condition and manage it throughout the course of their lifetime. They become experts and are ideally placed to keep their health records up-to-date. The care planning process is at the heart of greater engagement and as one nurse said: “We have a unique opportunity to get the patient involved and that is when you get a truly personalised care plan.”

Enabling nurses to capture the care record closer to their patient inevitably helps when it comes to patient involvement. Roundtable attendees heard how community nurses in Surrey are using iPads to update clinical records as part of a mobile working initiative<sup>8</sup>. One of the challenges community nurses have faced in the past is the reliance on paper records and old IT systems. Inputting data multiple times takes up valuable time which clinical staff could be spending with patients. Processes involving paper forms and records are also open to error or loss affecting patient confidentiality and safety.

The Community Services Team in Surrey carried out its own research which found that only a third of a nurse’s average day was spent with patients; a third was spent on administration and the rest of the time was spent on travel and other tasks.

The mobile working initiative<sup>8</sup> has seen all nurses being provided with mobile tablets to manage their work including appointments, email and reporting. As a result, follow-up research has found there has been a 30 per cent increase in face-to-face time with patients and a 60 per cent improvement in the time it takes to complete clinical documentation. Other improvements such as a reduction in appointments missed and patients not attending appointments, point to better patient engagement in care and treatment plans.

“Digital capabilities are not only about the individual nurse. They open up the possibility of a new healthcare paradigm. The promise is for a true partnership. Patients and citizens engaged and involved in their health and healthcare management.”

– Improving Digital Literacy, health Education England, Royal College of Nursing

“Should we have patient held records - works well for women using maternity services.”

– @Liz\_HEE, Liz Fenton, nurse advisor, Health Education England

<sup>7</sup> NHS Constitution and Handbook

<sup>8</sup> Community nursing mobile initiative in Surrey

## Using technology to improve clinical documentation

The spectre of failed IT projects looms large in the NHS and nurses across acute, primary, community and mental health care are all wary of technology that is supposed to save time, but actually consumes more of their time. Either the user interface is not intuitive, or the way that the technology works does not fit around current working practices. The roundtable heard how nurses are very good at trying out new initiatives, but if it doesn't work for them they will 'slow walk it to death'.

There are also human and ergonomic factors at play when it comes to clinical documentation and the use of IT systems that aim to improve the documentation process. Research has found that improving the physical design of a medical device or the cognitive interface of health IT is important; but without understanding the organisational context in which these technologies are used, workers may develop work-arounds, the tools may not be used safely, and health IT may be usable but not useful. Technology can lead to new ways of working, but it has to be the right technology. The example of the adoption of mobile tablets by community nurses in Surrey is a case in point.

The roundtable heard examples from across the country where technology providers had come to the NHS with solutions which were not easy to use and were not adaptable to different NHS provider situations. Some of these companies have accepted that they need to offer flexibility, but finding a path that works for both the NHS and technology company can be tricky.

The roundtable found that the best technology implementations followed an approach where the technology provider was, at the outset, willing to listen to the challenges faced at the frontline and have the flexibility to work with NHS staff.

In addition, the best technology was not dependent on a particular platform or device. This echoes the recommendations made by Health Education England in *Barriers to Access for Technology Enhanced Learning*<sup>9</sup>. "Where possible, any newly commissioned products should be developed so that they are device independent, i.e. working responsively across multiple devices, platforms and manufacturers," it says.

One nurse who works in mental health highlighted the success of an app that enables therapeutic observations to be carried out on the move and the results fed back into the electronic patient record in real-time. Therapeutic observations in mental health can take place every five minutes, fifteen minutes or every half an hour depending on the client.

The app creates a virtual ward which allows nurses to see which observations are due and what the latest observations have found. There is a red, amber, green (RAG) rating attached to each report so staff can see at a glance whether any intervention is needed.

"It works well and the only issue we have is with the WIFI signal dropping out from time to time, but otherwise this is the sort of technological innovation that has helped enormously," said the nurse.

Another example of technology improving documentation came from a nurse who had experience of using speech recognition software. "Timeliness of entering data is important whether you are on a ward or in the community. The speech recognition software is better than having to type in information and it saves you time," she said.

Anne Cooper is a firm believer that technology should not constrain the answer. In other words, the solution has to work at the frontline and not be dictated by what is available. "Technology can enable a different way of working, but it has to be the right technology and nurses have to say what they need," she said.

"We are lucky to have clinical staff working within ICT who support software development."

- @Ann-MarieRiley10, Ann-Marie Riley, deputy chief nurse, Nottingham University Hospitals

## Roundtable highlights

- Nursing documentation is complex, laborious to complete, not always shared amongst the right teams, sometimes ignored and does not always contribute to improved clinical outcomes and patient safety.
- Nursing documentation needs to be high quality, and timely with inbuilt levels of security, governance and control as appropriate for each patient scenario
- On the journey to a paperless NHS, attempts to digitise the clinical documentation process has led to a 'digital mountain of documentation'
- An array of technologies is arriving that will shape the production of clinical documentation. These include: apps that capture therapeutic observations and feed into the patient record; biometrics for identification and authentication of individuals; the power of the cloud for capture, access to and sharing of data; the use of speech recognition as a user interface and the prospect of digital assistants.
- Smart creative technologists from leading digital technology companies could shadow the nursing fraternity and help them re-imagine clinical documentation. However, the technology must support the nurse, not the other way around.
- There is a real opportunity to involve the patient in patient record keeping and sharing; particularly those with long-term conditions.

## Conclusion

The clinical documentation challenge is not specific to nursing and should be considered as a system-wide issue. However, by bringing together frontline nurses from the acute, primary and mental health sectors we have discovered there are unique aspects of nursing documentation that need to be addressed. As well as considering the role of documentation our roundtable discussed ways in which nurses can help re-design, or re-imagine, the documentation process.

There is no doubt that with so much time being taken up on nursing documentation, there is an impact on face-to-face nursing. More time spent dealing with frustrating systems, means less time spent with patients. Given that we are moving further towards healthcare that sees the patient as co-producer in treatment and care, the imperative for change is overwhelming.

Our roundtable examined the role that technology can play in helping to reduce the documentation burden and ways in which it has been applied successfully. One point that surfaced time and time again was that technology solutions have to work for nurses, not the other way around and they should not be a replication of paper documentation.

## Key recommendations

### **Nurse involvement in technology solutions**

Clinicians need to be involved in developing technology solutions. Without their involvement, they are less likely to successfully adopt the solution. Nurses won't engage with it unless it fits their purpose. They know what they need from the technology and it is up to suppliers and providers to listen.

### **Nursing input into digital transformation**

Nurses need to be provided with the opportunity and support to articulate what is important to them in their working lives. Every organisation should take their views seriously and ensure they are not distorted by one or two powerful voices.

### **Digital records**

Paper records should not be transferred to a digital platform for the sake of it. The creation of electronic documentation is an opportunity to re-imagine the workflow process to get the most out of digital technology.

### **Usability**

Usability is much more than ease of use. A product should be: effective (user goals are met successfully), efficient (speed with accuracy required for tasks), engaging (satisfying to use), error tolerant (helping the user recover from errors that occur) and easy to learn. Technology providers need to work with clinicians on these characteristics. They provide a framework for testing and evaluation from a user perspective.



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