Three great reasons (and the evidence) to speech-enable your clinical documentation

Many factors contribute to the need for healthcare organisations to improve the quality of clinical documentation. For healthcare professionals, high quality, accurate, up-to-date patient records enable better communication and clinical decision making. For patients, it improves the experience and the continuity of care leading to better outcomes and improved safety. For everyone in the NHS, complete clinical documentation delivers more accurate coding for commissioning and budgeting and better data for analysis and reporting to meet regulatory, legal and financial requirements. Good quality clinical documentation records the full patient story and is a rich source of data (once patient privacy has been assured) for medical research that will benefit us all in the future.

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Stay ahead of evolving healthcare

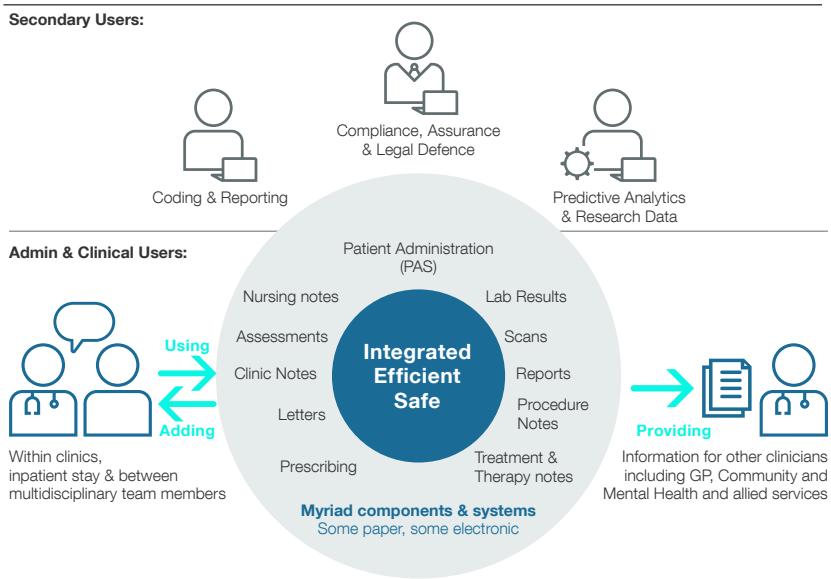
The NHS continues to see investment in clinical documentation as part of the government's vision for a paperless NHS by 2020[1]. Much of this investment has been in electronic health records (EHRs) but research[2] also indicates that many healthcare professionals are struggling to adopt this technology.

Challenge

How can we make it easier and quicker for doctors, nurses and other healthcare professionals to meet high clinical documentation standards and provide exceptional care to patients?

Today's healthcare demands innovation

On top of the existing pressures within the healthcare system; increasing prevalence of long term conditions, increased demand for services, fewer resources, greater complexity of treatments and rising patient expectations, the need for comprehensive and high quality documentation is loading pressure on today's healthcare professionals. Whilst they scroll and hunt through myriad screens within the EHR, navigating pull down menus or check boxes and labouring with one-fingered typing, there is a risk that the focus is on the system and the technology rather than the patient. This inevitably places constraints on the amount of time for communication leading to a fracture in the relationship between healthcare professional and patient. Factor in the effort needed to complete the regulatory requirements of basic structured information and the essence of the patient story – the narrative including the involvement e.g. of carers and relatives – becomes constrained or is even lost. The story of the patient journey disappears becoming instead a collection of unconnected data points.



Graph 1: Understand the clinical process impacts of documentation in acute care.
Source: Accuracy and completeness of clinical documentation Report[3] June 2015

Hospitals migrate to a paperless process

Automated speech to text solutions that work with (or complement) other technologies such as the EHR are a key part of making a paperless NHS a reality. Great strides have already been made in the quality, accuracy, performance and affordability of clinical speech recognition solutions and their use in healthcare is on a dramatic upswing.

In a recent research report from the Nuffield Trust[2] on delivering the benefits of digital healthcare, 'voice-recognition' technology is highlighted as one of the commonplace ways healthcare professionals of the future will spend less time on administrative tasks and routine communication.

Why does speech-enabled clinical documentation make sense now?

For the healthcare professional

The time healthcare professionals dedicate to interacting directly with patients can account for less than 13 per cent of their day[4]. Other research has shown that healthcare professionals spend more than 50 per cent of their working day creating, reviewing and updating clinical documentation[3]. In the US, research states that a busy doctor will produce enough clinical documentation to fill 40 books of 400 pages each year: the equivalent of 7.2 million words[5].

50%

or more is the time doctors and nurses spend with clinical documentation processes.[3]

Quality time with the patient

Speech recognition solutions allow healthcare professionals to capture patient data within the EHR and other clinical documentation more than twice as fast as typing, with greater accuracy and completeness, in real-time[9]. Using voice to text in the EHR and other clinical documentation the healthcare professional can also speed navigation within the clinical documentation and call up templates, examinations and reports and insert often repeated standard texts using voice commands.. Anecdotal estimates of time saving from clinicians in the UK using Nuance Dragon Medical speech recognition solutions are dependent upon the clinical setting and the individual. They range from a saving of 40 minutes for a nurse on an intensive care ward[6] to up to 2 hours in a typical day at the surgery for a GP[7].

Despite workload and time pressures healthcare professionals want the time to understand the complexities of each case, listening to and counselling patients, putting them back at the centre of their care. Patients value certain elements of their visit more than others such as time for discussion, advice and recommendations, privacy and engagement[8]. Healthcare professionals who focus on these factors will have greater success conveying their concern and interest in their patients' wellbeing. Speech-enabling clinical documentation supports this goal, not only freeing up time but also disentangling the healthcare professional from the keyboard and the screen, helping to sustain the relationship with the patient.

Quality documentation

The use of speech-recognition improves the quality of documentation, reduces repetition and the potential for introduction of errors and eliminates duplication of effort. Not only is the regulatorary required 'structured' information captured in the EHR in a streamlined manner but speech recognition also allows the healthcare professional to capture the patient story (narrative) with all its subtleties and uniqueness. Given that a recent study[3] found 68 per cent of the clinical documentation is narrative, the impact of speech recognition on improving quality time with the patient is clear. A complete, detailed patient record, including not just the basic facts but the story of the patients' care, helps healthcare professionals to share vital information quickly with colleagues and multidisciplinary teams,

during handovers and later, as the patient recovers. Higher quality clinical documentation can help to guide and speed the transfer of care of the patient as they move through the care pathway; being triaged, consulted, referred or discharged to social care.

Enjoyment and satisfaction at work
Studies have shown that 8 in 10 healthcare professionals find having good patient relationships is the most satisfying part of their job[4]. However, they are becoming de-motivated and frustrated with an overload of administration and the consequent lack of time spent with patients[4]. Speech-recognition helps to improve the day-to-day working lives of healthcare professionals because they know their documentation is more accurate and complete which in turn means they can provide better quality care. It puts them in control and gives them more freedom to practice in line with the evidence base[4]. The natural interface with an essential technology helps healthcare professionals use their time more effectively, create a more complete record of care and maintain focus on the patient.

"Speech recognition has raised the bar on the quality of our clinical notes. There is much more detail, the notes are easier to read and the quality of the information is so much better."

Peter White, Paediatric Intensive Care Unit Nurse
Alder Hey Children's Hospital[5]

For the patient

The relationship between healthcare professionals and patients is at the core of treatment and healing. This begins with hearing and understanding, but all too often technology and the pressure to capture the consultation within the EHR and other clinical documentation can get in the way. A patient survey[8] commissioned by Nuance to gain insight into what patients need and want from their doctors indicated that while patients are comfortable with the growing role health IT is playing in their care experience, they are less accepting of the technology if it distracts or interferes with their conversation time with their healthcare professional. 40 per cent of patients feel rushed during the visit with their doctor. For more than 30 per cent, this appointment lasts less than 10 minutes – the time it takes to hard boil an egg.

40%

of patients feel rushed during the visit with their doctor.

Quality time

Freed from the burden of administration by using speech-enabled clinical documentation the healthcare professional has more time to observe, listen and interpret the patient story and put the patient back at the centre of care.

Speech enablement also supports the more complete capture of not only the required or 'structured' data but also the patient story - the narrative. For complex patients requiring multiple treatment protocols and the support of multi-disciplinary teams, the more information available to healthcare professionals, the more accurate is the picture of the patient and their care needs and the greater the likelihood of co-ordination and delivery of better care.

68%

of the clinical documentation is narrative and difficult to capture in the standard templates and click boxes of an EHR.

Continuity and quality of care

Not only does speech–enabled clinical documentation free up healthcare professionals' time and their ability to focus on care, it can improve quality of care. By hearing what is being said and entered into the notes during a consultation patients become more involved in their care. More time, better communication, empathy and involvement in the process of their own care will improve concordance with medical treatment and is likely to improve quality of care outcomes.

For the NHS

NHS trusts and commissioners have the considerable challenge of aligning the vision of a paperless NHS with the achievement of improved patient outcomes and other performance and quality objectives. The ongoing investment in EHRs across UK healthcare demonstrates the commitment to this vision and has the potential to transform the medical landscape. However, in a tough financial environment the pressure is on to demonstrate how these investments are paying off.

Accelerate adoption of the EHR

There are technical and cultural barriers to the uptake and adoption of the EHR but simplifying and naturalising the user interface by speech-enabling the EHR removes the greatest barrier of all – that of overloading the healthcare professional with yet another tedious administration overhead. Speech recognition technology is fast becoming one of the most used tools in the quest for EHR adoption and clinical documentation improvement, anywhere, at any time, and on any device. It puts healthcare professionals back in control and ensures that there is faster and greater take-up of the EHR to more quickly return the investment.

Improve efficiency, productivity and turnaround times

Although research has found that healthcare professionals spend up to half their day creating and updating clinical documentation, the same research found they also spend up to 52 minutes per day[3] searching for information that they cannot find in the clinical record. The cost of this lost time is equivalent to more than three outpatient clinics per doctor per week, or up to £20,000 in time value of a senior doctor's salary wasted per year in this activity.

Speech-enabled clinical documentation supports the creation of a more complete, more accurate patient record at the point of care.[4,6,8] From this it is logical to conclude that its use to improve the overall quality of the clinical documentation will also reduce the incidences of missing information, save healthcare professionals' time and reduce the impacts described above.

The use of speech-recognition integrated into the EHR and other clinical documentation also improves the individual productivity of each healthcare professional, freeing them from the burden of administration to focus on more patient-centred, higher value tasks.[6,7,8]

Speech-enabled EHRs and other clinical documentation also help eliminate documentation backlogs because referral letters, discharge letters etc. can be created, signed and forwarded by the healthcare professional at the point of care. This enables the organisation to achieve turnaround targets and avoid missed targets relating to clinical documentation and the communication between healthcare organisations and patients.

High quality clinical documentation delivers more accurate coding for commissioning and reimbursement and data for reporting to meet regulatory, legal and financial requirements. For medical research, high quality clinical documentation provides a rich source of data (once patient privacy is assured).

Employee satisfaction

Speech-recognition integrated into clinical documentation can help to avoid burnout. Healthcare professionals begin to feel better about documentation, more in control and more satisfied. They feel more confident about technology and have a better working experience. Now the 80% of healthcare professionals who find patient relationships are the most satisfying part of their job[4] are free to get back to practicing the art of medicine.

£20,000

a year is the cost per senior doctor of time consumed searching for or rechecking information which isn't available or sufficiently clear in the notes.

3.5

Estimated outpatient clinic appointments per clinician week not utilised effectively due to information not being available.

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