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Will you stay or will you go?

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With the paper deluge, it is no wonder over 70 per cent of nurses say they go home late after finishing patient documentation. Reviewing and adding to patient clinical documentation has become a significant task for any clinician working in the NHS today. However, there is an argument that too much time is being spent on clinical documentation that might otherwise be spent on face-to-face interactions with patients

Research carried out by UK analytics specialist Ignetica for Nuance has found that doctors and nurses spend up to 50 per cent on their time reviewing information and adding information to clinical documentation. The average time nurses spent adding to record keeping was 10.7 hours per week.

33% of nurses said Clinical Documentation takes up to 40% of their time

This is underlined by opinions raised during a tweet chat with WeNurses which gave us a very useful insight into the impact of patient documentation on nursing practice. During the tweet chat a snap poll of over 170 nurses found that 73 per cent of respondents said they go home late because of clinical documentation. Just as concerning is that 15 per cent said they rushed clinical documentation. Another snap poll during the tweet chat found that 36 per cent of nurses (over 220 respondents) said clinical

documentation took 40 – 60 per cent of their time.

Surely, if around a third of our nurses are spending on average half their day on clinical documentation, there is a need to redress the balance. Clearly the amount of documentation depends on the type of clinical practice and even the setting. However, one nurse added further context by saying that in 1980 it would have been around 20 per cent of the nursing day spent on documentation.

Among other feedback shared we found that duplication of notes is exacerbating the situation: "...write that you've done something then tick a box to confirm you have, human factor goes out of the window with documentation.... digitising seems like the most sensible answer".

Hitting the nail on the head

There must be a role for digitising clinical documentation and at the same time using software that can recognise speech. Some nurses are still understandably wary about speech to text, either because they have tried it in the past and it hasn't worked, or they simply don't believe it works.

However, we know it does work and nurses at Alder Hey have shown us how it can make a difference including time savings of up to 40 minutes per day. The latest speech recognition software has been designed specifically for the clinical environment. It understands the clinical nuances that might confuse other software. I would urge any nurse who is feeling overwhelmed by clinical documentation to give it a go. Speech to text can help you overcome the challenge.

Tags: Digitisation of the NHS, Electronic patient records (EPR), Clinical documentation, Nursing

More Information

Is it time to re-imagine nurse record keeping?

Download this new e-paper arising from a roundtable discussion chaired by Anne Coops at the Kings Fund: Clinical documentation and nurses: the challenges and opportunities

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About Dr. Simon Wallace

Dr. Simon Wallace is the Chief Clinical Information Officer (CCIO) of Nuance's Healthcare division in the UK and Ireland. Simon has worked as a GP, hospital and public health doctor in Brighton and London. His interest in health informatics began in the 90s when he spent a year at the King's Fund investigating the impact of the internet on shared decision making between patients and their healthcare professional. For the past 15 years, he has worked for a range of organisations including Bupa, Dr Foster, Cerner Corporation and GSK across a range of technologies which include electronic patient records, telemedicine, mobile health and lifestyle devices. Simon has a keen interest in the voluntary sector, recently completing a 7 year term as a Trustee for Fitzrovia Youth in Action, a children and young people's charity based in London.

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