Journal of Current Medical Research and Opinion
Received 15-09-2024 | Revised 17-09-2024 | Accepted 09-10-2024 | Published Online 12-10-2024

DOI: https://doi.org/10.52845/CMRO/2024/7-10-3 ISSN (O) 2589-8779 | (P) 2589-8760
CMRO 07 (10), 3678-3681 (2024) www.cmro.in

Review Article

A Short Review on Increase Burden of Documentation Vs Patient Care for Nursing

Sati Chakrabarti[1] | Jaba Dey[2] | Nupur Das[3] | Dr.Sayantan Ghosh[4*]

[1]Nursing Advisor, Medica Group Hospitals, Kolkata

[2]Assistant Nursing Superintendent Department of Nursing Medica Superspecialty Hospital Kolkata

[3]Nursing Controller Department of Neonatology & Pediatrics Medica Superspecialty Hospital Kolkata

[4]Clinical Pharmacologist (In charge) Department of Clinical Pharmacology Medica Superspecialty Hospital Kolkata

*Corresponding Author

Abstract:

In contemporary healthcare settings, nursing documentation plays a crucial role in ensuring the quality and continuity of patient care. However, the increasing burden of documentation on nurses has become a significant concern, affecting various aspects of their professional responsibilities and patient outcomes. This review examines the causes, consequences, and potential solutions to address the escalating demands of documentation on nursing practice, emphasizing the need for a balanced approach that prioritizes both documentation requirements and patient-centered care.

Keywords- Nursing, Nursing Care, Burden, Patient Safety, Nursing Documentation

Introduction:

Nurses are team players. They collaborate with a wide range of healthcare professionals to ensure the highest quality of patient care. The Royal College of Nursing emphasizes that "nursing should be central to reducing the effects of illness, encouraging health, and supporting individuals in managing their daily activities at home, work, and during leisure time"[1]. Improving public health should be seen as part of all nursing and midwifery roles. Nursing documentation serves as a comprehensive record of patient assessments, interventions, and outcomes, facilitating communication among healthcare professionals and supporting legal and regulatory requirements. While its importance cannot be overstated, the exponential growth in documentation demands has resulted in a considerable strain on nursing resources and time[2,3]. This review explores the factors contributing to the increase in documentation burden on nurses and its impact on patient care.

Nurses are essential to nearly every facet of healthcare. Their diverse duties vary based on their specialty, position, staffing availability, and skill set. Reports indicate that around 70% of a nurse's time is dedicated to coordinating care, in addition to other specific tasks[4]. While prospects detail the primary responsibilities of an adult nurse, the overall objectives of nursing encompass: Providing high quality patient care

- Educating patients and their families/carers
- Promoting a safe environment
- Evolving professionally

Nurses are vital to almost every aspect of healthcare. Their various roles differ depending on their specialty, position, staffing levels, and skills. Research shows that approximately 70% of a

nurse's time is spent on care coordination, along with other specific responsibilities. Although prospects highlight the key duties of an adult nurse, the broader goals of nursing include:

Responsibilities of a Nurse in healthcare settings

As a nurse, you'll need to:

- write patient care plans
- implement plans for tasks such as preparing patients for operations, treating wounds and monitoring pulse, blood pressure and temperature
- observe and record the condition of patients
- check and administer drugs and injections
- set up drips and blood transfusions
- assist with tests and evaluations
- carry out routine investigations
- respond quickly to emergencies
- plan discharges from hospital and liaise with GPs and other healthcare professionals
- reassure patients and their relatives and communicate effectively with them
- advocate on behalf of patients
- educate patients about their health - this may include running clinics and education sessions on topics such as diabetes, weight loss and quitting smoking
- organise staff and prioritise busy workloads
- mentor student and junior nurses
- maintain patient records
- make ethical decisions related to consent and confidentiality[5,6,7]

Factors Contributing to the Burden of Documentation: Several factors contribute to the escalating burden of documentation on nursing practice:

1. **Regulatory Requirements**: Increasingly complex regulatory requirements mandate detailed documentation to ensure compliance with standards of care, billing regulations, and legal obligations.
2. **Technological Advances**: While electronic health records (EHRs) offer numerous benefits, they also introduce additional documentation tasks, such as data entry, navigating multiple screens, and ensuring accuracy, which can be time-consuming.
3. **Quality Metrics and Performance Indicators**: Healthcare systems often utilize documentation data for quality improvement initiatives and performance evaluation, leading to additional documentation requirements.
4. **Litigation Concerns**: Nurses face the pressure to document thoroughly to mitigate legal risks, resulting in defensive documentation practices that prioritize legal protection over clinical relevance.
5. **Administrative Burden**: Non-clinical documentation tasks, such as scheduling, ordering supplies, and administrative duties, divert nurses' time and attention away from direct patient care[8].

Impact on Nursing Practice and Patient Care: The rising burden of documentation has profound implications for nursing practice and patient outcomes:

1. **Time Constraints**: Nurses spend a significant portion of their time on documentation tasks, limiting their availability for direct patient care and impeding meaningful patient interactions.
2. **Burnout and Stress**: Excessive documentation requirements contribute to nurse burnout and job dissatisfaction, affecting morale and retention rates within the nursing workforce.
3. **Quality of Care**: Documentation overload may compromise the quality of care by diverting attention from critical patient needs, increasing the likelihood of errors, and fostering a checkbox mentality rather than individualized care.
4. **Communication and Continuity**: Overly burdensome documentation practices can hinder effective communication among healthcare providers and compromise the continuity of care, leading to fragmented healthcare experiences for patients[7,8,9].

Addressing the Documentation Burden: To mitigate the adverse effects of documentation overload on nursing practice and patient care, several strategies can be considered:

1. **Streamlining Documentation Processes**: Simplifying documentation templates, utilizing voice recognition software, and optimizing EHR interfaces can reduce the time and effort required for documentation.
2. **Interprofessional Collaboration**: Collaborative efforts among nurses, clinicians, administrators, and policymakers are essential to identify documentation priorities, streamline workflows, and advocate for regulatory reforms.
3. **Training and Education**: Providing comprehensive training on documentation best practices, EHR utilization, and time management can enhance nurses' proficiency and efficiency in documentation tasks.
4. **Technology Integration**: Investing in interoperable health information technologies and artificial intelligence solutions can automate routine documentation tasks, allowing nurses to focus on high-value patient care activities.
5. **Policy Reforms**: Policymakers and regulatory bodies should review and revise documentation requirements to strike a balance between accountability and the provision of patient-centered care, while also considering the impact on nursing workload and job satisfaction[9,10,11].

Conclusion:

The increasing burden of documentation on nursing poses significant challenges to the delivery of high-quality, patient-centered care. Addressing this challenge requires a multifaceted approach that encompasses technological innovation, policy reform, interdisciplinary collaboration, and a renewed focus on the core principles of nursing practice. By prioritizing the reduction of unnecessary documentation tasks and promoting efficient documentation practices, healthcare organizations can empower nurses to allocate more time and attention to direct patient care, ultimately enhancing the quality and safety of healthcare delivery.

Conflict of Interest: There is no conflict of interest among authors

Funding: None

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