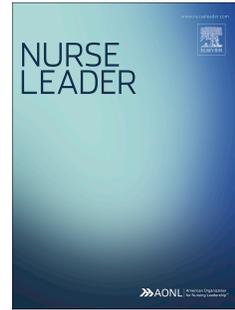


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Decreasing the Nursing Documentation Burden During the Covid-19 Surge

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## Decreasing the Nursing Documentation Burden During the Covid-19 Surge

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## Abstract

**During the Covid-19 pandemic, nurses requested a clean, streamlined, intuitive view of the adult nursing assessment(s) within the electronic medical record (EMR). We created a more efficient method during a *national disaster* to reduce duplicative efforts and allow additional time with patients. This project was added as part of the Clinically Led EMR Optimization (CLEO) strategy to eliminate unnecessary EMR assessment data elements in the adult medical-surgical and critical care areas. This was completed in a 5-month period and decreased 20% of the data points entered by nursing. 433 data points were excluded or relocated to achieve the desired result.**

## Article

Memorial Hermann Health System (MHHS) is an extensive academic healthcare system in Houston, Texas, and surrounding communities. There are 17 acute care hospitals, the largest being a 1000+ bed academic medical center in the Texas Medical Center. They are also comprised of many additional services from Cancer Care Clinics to Rockets® Outpatient Therapy sites, physician practices in the Memorial Hermann Medical Group (MHMG) practices, and many more. Among their many awards and accolades is a coveted spot on the "Most Wired" health systems list selected by Health & Hospitals Network (H&HN) in partnership with the American Hospital Association for several years. Most acute care hospitals in the system are Magnet® designated by the American Nurses Credentialing Center (ANCC); this is notable as only 9.4% of all hospitals in the nation are Magnet recognized. U.S. News and World Reports list the TIRR (The Institute for Research & Rehabilitation) Memorial Hermann facility as number two or three in the country as a top rehabilitation hospital.

## THE NEED FOR CHANGE

The onset of the Coronavirus pandemic globally began in 2019. The impact of the pandemic was felt in the United States in the early days of 2020. It was Spring of 2020 when it hit the Houston area. Like others in the country, the leadership of MHHS was learning and reacting as the Centers for Disease Control (CDC) and the World Health Organization (WHO) came into possession of the latest information. This time in healthcare history was chaotic, confusing, and full of uncertainty. MHHS prepared for the worst and hoped for the best. With the increasing census numbers, patients across the United States were placed in non-traditional spaces in the acute care environment. Post-anesthesia care units, outpatient observation units, and emergency rooms were called into service to house the rising volume of patients. In addition, the calls from across the nation at areas that were harder hit than others began to come in for registered nurses to "travel" to those locations. The fear and uncertainty of the times caused some nurses to opt out of acute care and leave the bedside arena. Increasing volumes and decreasing staff resulted in shifting care delivery models from primary care to team nursing. The team nursing model creates

a heavier documentation burden for the registered nurse at the bedside and requesting a more streamlined documentation system became imperative.

## **EMR OPTIMIZATION**

Consequently, MHHS was undertaking a Clinically Led Electronic Medical Record (EMR) Optimization strategy involving multiple disciplines (providers, nursing, therapy) to maximize the potential of the EMR and streamline documentation across the disciplines. The decision was made to speed up these efforts for nursing and undergo an urgent project to decrease the number of required data elements, thereby decreasing the length of time spent by nursing in the EMR. From beginning to completion, this initial emergency project lasted five months.

At the height of the first Covid-19 surge, the request came from nursing to use "emergency paper charting" to be more efficient and save time that they did not feel could be given to an EMR versus time at a patient's bedside. These thoughts came from the perception that "our competitors are doing it, and it could save us time with our initial and daily assessments." Staff did not recognize the processes that must accompany paper charting; the need to scan in the paper assessment, the lack of visibility in the EMR for continuity of care, and that paper documentation is a temporary solution when a more permanent solution may be available. Another significant driving factor was the realization that much younger nursing staff would have to be taught how to chart on paper. One of the many benefits of being a leader in an organization that is committed to redesigning and implementing workflows that improve quality, reduce costs, generate revenue, and achieve our strategic mission of improving health. One of the hallmarks of Magnet® and Most Wired® organizations is the ability and desire to listen to nurses, support them, and work to relieve barriers in the workflow. Leaders are empowered to find the best solutions for our teams that do the work, so the execution of solutions that improve the work environment and outcomes for patients and staff become the focus.

## **THE VOICE OF THE FRONT-LINE**

Healthy and engaged front-line nurses are necessary to improve health and outcomes for patients (Ulrich, et al., 2022). By voicing their thoughts and being listened to, they can create and improve the care they provide. It is essential to understand nurses' needs and survey teams to determine the next strategic steps. To achieve this, a community vendor annually administers a confidential, blinded, front-line clinician nursing survey. This vendor is a research firm that surveys healthcare organizations regarding satisfaction focused solely on the EMR and assists in getting the confidential voice of our nurses utilizing the EMR. There is a commitment to performing this survey to determine nurses' satisfaction with the EMR. This element of a healthy work environment is a crucial pillar affecting clinical engagement and satisfaction in an organization. This "Clinically led" approach is powerful as clinicians have the voice and build their workflows. Those that do the work create the workflows to best accomplish it. This approach requires buy-in at all levels, dedicated executive sponsorship, involvement of clinical end users, a developed governance structure, and the ability to implement organizational change management across the organization.

## **EXECUTIVE SUPPORT TO DRIVE CHANGE**

The authors of this article were the executive nursing co-sponsors for the CLEO inpatient nursing assessment documentation enhancements. Success would be determined by the ability to influence change and gain buy-in from peers. Sharing the short-term and long-term implications was critical in engaging other stakeholders to enable an informed decision in undertaking this project to streamline our inpatient admission and daily nursing adult assessments in the EMR. The case for the change needed to be made quickly to address the needs of a shrinking nursing staff quickly and efficiently during the Covid-19 pandemic.

This crisis led to the initiation of Lorenzi and Riley's (2010) cyclical model for managing technological change. This model consists of discontent, conceptualization; planning; development; testing; cutover, acclimation, acceptance, and discontent. Guided by the vendor's Blueprint to Model recommendations, the level of opportunity was reviewed. Executive support was crucial to the success of the project. Under the best circumstances, technology changes are cumbersome and time-consuming. In these circumstances, change was critical to the care and vital in meeting staff needs and, therefore, the patients. The two executive Chief Nursing Officers (CNOs) for this project supported the EMR vendor's Blueprint to Model recommendations, then partnered with the other 12 CNOs in the system and garnered buy-in and agreed on the necessity to create the time allotted for the nursing staff time to participate in this project during a national pandemic. The underlying theme of this project was speed. The pandemic had created a documentation crisis, and these actions needed to provide a clear, concise, and quick resolution of the documentation issue.

## **FOLLOWING THE VENDOR BLUEPRINT**

Assessment bands were adopted per blueprint, but the workflow had not been optimized compared to other like-facility users. It was learned from reviewing the recommended vendor data that MHHS had added significantly more essential clinical dataset fields than other EMR users with the same model. Making EMR changes has resulted in additional clicks, fields, duplicative documentation, frustration, and added time for nurses in the EMR. The MHHS matrix organization had been adding other data points resulting from system council requests without asking the question, 'what can we take away to balance these additional asks?' The time was now to seize the opportunity to make a much-needed change despite one of the busiest and most chaotic timeframes in healthcare delivery history.

## **SELECTING THE TEAM**

MHHS gathered names of high-functioning, passionate, diverse front-line nurses, and top nursing leaders to take part and drive this change. A nursing documentation task force that included thirty-seven bedside nurses from various MHHS hospitals, seven nursing leaders, and a representative from quality, legal, infection control, coding, and informatics departments was created. Again, this type of rapid timeline can only be successful with the full support of executive leadership. Following the selection of the task force, a series of Joint Application Design (JAD) sessions were conducted over six weeks to redesign the EMR with nurses from each campus and specialty that use the EMR. At the forefront of all this work was the knowledge

that time was of the essence, momentum needed to be maintained, and it was pivotal to keep all other nurses, and nursing leaders informed of progress. This group revised these nursing assessments, limiting them to essential data elements that meet quality and regulatory requirements by improving logic and cutting unnecessary documentation. The team removed duplicate fields, redesigned the face-up fields, and increased nursing efficiency and engagement. The meetings were carried out through live, interactive sessions sharing what our current assessment fields contained versus the recommendations of our blueprint to model and what other similar organizations were doing. The task force found that nursing could lead this charge of optimization for the organization and improve nursing engagement with the EMR.

## **ENGAGEMENT DRIVES CHANGE**

Even during the pandemic, there was an air of excitement to focus on something other than the Covid-19 surge. Staff was highly engaged when taking part via a virtual option as a method, allowing achievement of 100% participation at each session. Collaboration occurred between our informatics team, EMR vendor, nursing leadership, and front-line nurses. A safe space was created where each discipline felt respected and could speak up. One of the CNO sponsors attended each meeting to ensure that this safe space was present and that the project was on target.

The ISD team at MHHS is large enough to meet the daily technology needs of the organization, with additional project teams to manage the never-ending list of project requests. For this project, they committed substantial resources and realigned priorities to achieve the timeline. The entire system was collaborating to make this a successful project. The project included a nursing leadership kick-off focused on leader buy-in and change management. A first build followed these sessions in June 2021, demonstration sessions July-August 2021, localization sessions August-September 2021, integration testing in September-October 2021, end-user testing in October 2021, and go live in November 2021. The nurses reviewed each field within these assessments and redesigned their workflow. Nurses designing nurses' workflow enabled us to create a more efficient process with strong outcomes that we were able to achieve. We followed this process with a benefits review session in December 2021 to realize our gains and review opportunities. This rapid-fire change process highlighted the organization's ability to achieve change rapidly when priorities align across multiple stakeholders. We have an annual nursing engagement and technology evaluation in the fall of 2022 to continue and ensure that we are moving positively by streamlining nursing documentation to allow more time to focus on their patients and less time in the EMR.

## **CONCLUSION**

The commitment to CLEO and the achieved improvements were strong during Covid-19. The fact that the project was focused on "Clinically led" change was pivotal in achieving acceptance as the project progressed and not having to "sell" the change at the project conclusion. The front-line nurses redesigned their assessment EMR bands and decreased the number of data points by 20% within each assessment form. We also realized a 21% decrease in total sections within each assessment band and increased the conditional logic by 33%. We excluded or moved 433 data points (see attachment A). Since completing this project in November of 2021, we have moved

on to enhance other areas of nursing documentation within the EMR utilizing this successful CLEO model. The nursing view was cleaner and more intuitive, and user-friendly. An example of the pain management band, pre, and post-CLEO, is below (see attachment B).

The plan is not to stop here but continue with added phases of CLEO to decrease the burden placed upon nurses with EMR documentation. Ongoing improvements are planned and prioritized, dependent on feedback from our confidential technology survey. Outcomes are shared with all system nurses through campus-based town halls and individual campus shared governance nurse-led councils.

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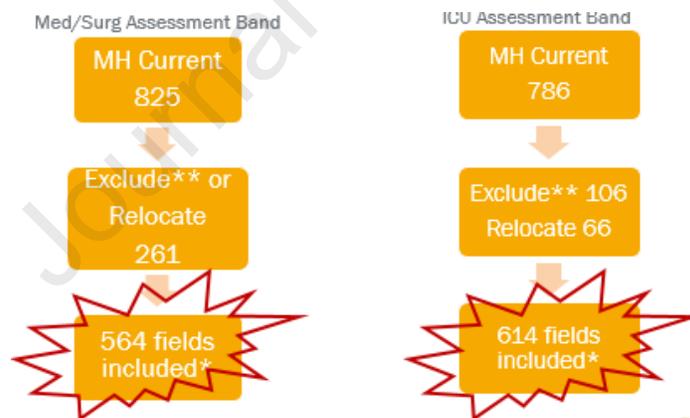
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**Attachment A**



**Attachment B**

## Pain Assessment – Current vs Future State

These changes impact other areas outside of ICU and Med/Surg. Communication going out to various councils in October.

**Current**

10/01/2020	
10:30	
Pain Assessment	
Pain Present	Yes actual or suspected
Preferred Pain Tool	DYHCS Pain Rating Scale
Current Pain Rating Scale	3
Pain Tool: AHA	10
Pain Score Total: AHA	
Reason for pain assessment	
Pain Associated Symptoms	
Pain Communicated by	
Pain Description	
Personalized Pain Goal	
Pain Onset Date	
Additional Pain	Yes
Primary Pain Assessment	
Primary Pain Location	Abdomen
Primary Pain Abdominal Location	
Primary Pain Location Laterality	
Primary Pain Quality	
Primary Pain Duration	
Primary Pain Time Pattern	
Primary Pain Radiation Location	
Primary Pain Radiation Characteristics	
Primary Pain Onset	
Primary Pain Aggravating Factors	
Primary Pain Alleviating Factors	
Primary Pain Associated Symptoms	
Primary Max Pain Level (W) intervention	
Nausea	
Diarrhea	
Primary Pain Intervention	

➔

**Future**

Pain Assessment	
Pain Present	Yes actual...
Preferred Pain Tool	DYHCS Pa...
DYHCS Pain Rating Scale	3
Personalized Pain Goal	
Primary Pain Assessment	
Primary Pain Location	
Primary Pain Location Laterality	
Primary Pain Quality	
Primary Pain Duration	
Primary Pain Time Pattern	
Primary Pain Onset	
Primary Pain Interventions	

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This quality improvement project did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors

### **Key Points**

1. A need to revise nursing assessment documentation, limiting it to essential data elements allowing more time at the patient's bedside.
2. Increasing utilization of conditional logic features, removing duplicate fields, and redesigning face up fields leads to increased efficiency.
3. Clinically led EMR optimization represents a commitment to increase bedside nursing engagement and is a best practice.

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