



Summer Institute in Nursing Informatics 2019  
Poster Presentation

**Optimizing Documentation for the Observation Class Patient**

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Our hospital system identified a need for streamlined documentation for patients held in an observation class status. These patients are considered outpatients, yet are treated on inpatient units or as boarder patients within the Emergency Department (ED). Despite shorter lengths of stay, the number of required documentation elements is the same as for inpatients and ED Boarders, placing an undue documentation burden on nursing staff. Nurses frequently complain about the amount of time spent documenting on these patients, with staff and patient satisfaction suffering. In addition, the EHR build for certain documentation items differs between ED and inpatient settings even though the documentation elements are the same. This causes patients to be asked some questions multiple times, which further impacts satisfaction for both patients and staff. To address the problem, Clinical Informatics staff first spent time observing nurses as they cared for these patients. The goal of the observation sessions was to quietly and unobtrusively see how nurses use the EHR in real-life without comment or guidance. In order to capture variances in workflow, we spent time in both ED and inpatient environments and at different facilities within the health system. Particular care was taken to determine which screens and tools within the EHR the nurses were using as they completed their documentation. We then assembled a work group consisting of bedside nurses and nurse managers from across the hospital system in conjunction with IS&T, Regulatory, Compliance, Clinical Informatics, and Project Management. With guidance from our executive sponsors from the health system's Chief Nurse Officer Council, the group was empowered to make decisions to reduce the documentation burden for observation patients. Our goals were to optimize documentation and reduce redundancy without compromising patient safety. The resulting design decisions led to a 75-item decrease in documentation elements, optimization of those elements shared between ED and inpatient settings, and enhancements to our existing flowsheet documentation to be more meaningful in the care of observation patients. A complete revision of our observation patient documentation has been targeted for a June 2019 release. In order to enhance usability, we will use existing documentation tools within the EHR that nurses at our system are already familiar with and are using on a daily basis. To evaluate the effectiveness of our efforts, we will be using our vendor's Workflow Analyzer tool to capture data such as keystroke-level model (KLM) time, screen switches, mouse wheel clicks and scroll distance, keyboard-mouse transitions, and key presses. We are currently in the process of gathering pre-implementation data and will compare these results with our data post-implementation. We will be able to speak to our findings, successes, and barriers as the project continues through July of this year and anticipate providing preliminary results as part of this SINI presentation.