
Medical Documentation: Fair Return on Time Investment?



The documentation of patient information can occupy as much as half of a clinician's working day, despite scant evidence that all of the collected information is valuable. Many medical records departments continue to use paper charts, which are more convenient for documenting a patient's story. Hospitals which have transitioned to electronic medical records (EMRs) may capture more data, but value is lost if clinicians find relevant information difficult to access.

A review in the *International Journal of Medical Informatics* argues that electronic medical records have done little to benefit physicians or patients. Neil Clynch and John Kellett, of the Dundalk Institute of Technology in Ireland and the Thunder Bay Regional Health Sciences Center in Canada, respectively, investigated the available evidence on the amount of time devoted to and the value of medical documentation. In addition to personal experience and discussion with colleagues, the authors conducted Medline searches of terms such as documentation, medical records, time and value.

Does Documentation Negatively Affect Patient Care?

Mandated documentation of patient visits, which was assumed to improve patient safety and assist physicians, may actually hinder patient care when it consumes clinicians' time without proportional benefits to the caregiving experience. The number of hours physicians devote to analysing and completing paperwork for a patient's chart detracts from the time which can be spent listening to patients at the bedside.

Besides taking physicians away from patients, documentation also limits the time which can be spent on clinical research and teaching, both of which ultimately affect more patients down the road. A survey by RAND revealed that the use of EMRs significantly and negatively impacts physician job satisfaction. It is not only the demands on time which are problematic, but the lack of reward when systems are difficult to use and fail to capture the patient narrative due to fragmented records.

It should be easier to have a more comprehensive view of a patient's predicament when there are accounts contributed by multiple caregivers, but this objective can be thwarted when important details are obscured or when elements within the record conflict with each other. Inter-observer disagreement must be minimised. Machines will perhaps never replicate the experience and wisdom of human observers, but they can generate recommendations for patient care when alerts are triggered.

Pluses and Minuses of EMRs

According to recent research, nurses in Australia and the United Kingdom spend about 20 percent of their time on documentation, while every hour of patient care delivered in the United States requires between 30 to 60 minutes of paperwork. There is some debate about whether entering data into EMRs is less or more time consuming than documenting patient visits using paper charts.

Despite the complaints, there are advantages to EMRs, including a movement toward standardised terminology and more structured data for easier reporting. In fact, as the authors argue, "use of a medical domain-specific language would allow the computer to recognise important medical issues as they appeared in a medical record without the need for standard data entry."

Bedside Documentation

Another aspect of EMR documentation that has the potential to be more rewarding is the ease of point-of-care documentation. Thanks to tablet computers patient information can be recorded at the bedside, remote members of a care team can be instantly informed of changes or updates to a patient's condition. Physicians and patients also benefit from the technology that allows the embedding of clinical guidelines into the EMR for advanced decision support.

Through point-of-care documentation, interventions can be automatically triggered using systems such as the National Early Warning Scores protocol which has been introduced in Ireland and the UK. A recent study showed that the approach has the potential to reduce in-hospital mortality.

The goal? Quick and easy EMR data entry that results in relevant clinical details being automatically pulled from a chart, prior to and during time spent in the hospital, so that clinicians can read a patient's "story" at a glance. In this way, documentation can pro-actively drive patient instead of being amassed without value.

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