Patients Not Paperwork – Bureaucracy affecting nurses in the NHS

“Bureaucracy is the death of all sound work”

Albert Einstein

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# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>2</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2. Objective and approach</td>
<td>5</td>
</tr>
<tr>
<td>3. Review of literature</td>
<td>5</td>
</tr>
<tr>
<td>4. Findings</td>
<td>7</td>
</tr>
<tr>
<td>4.1 Duplication</td>
<td>8</td>
</tr>
<tr>
<td>4.2 Data collection and audits</td>
<td>11</td>
</tr>
<tr>
<td>4.3 Clarity on essential/ non essential documentation – how the role of the nurse is being compromised by the level of non essential documentation</td>
<td>14</td>
</tr>
<tr>
<td>4.4 The Impact of the dwindling level of administrative support on the role of the nurses</td>
<td>16</td>
</tr>
<tr>
<td>4.5 Issues around use of technology</td>
<td>18</td>
</tr>
<tr>
<td>4.6 Ideas from NHS staff</td>
<td>21</td>
</tr>
<tr>
<td>5. Conclusion</td>
<td>26</td>
</tr>
<tr>
<td>6. Recommendations</td>
<td>27</td>
</tr>
<tr>
<td>7. Appendices</td>
<td>29</td>
</tr>
<tr>
<td>8. Acknowledgements</td>
<td>43</td>
</tr>
</tbody>
</table>
Executive summary

This report has been commissioned by The Nursing Quality and Care Forum and produced by the NHS Institute for Innovation and Improvement in response to the growing concerns that nurses expressed regarding the time spent on completing paperwork, to the detriment of delivering high quality nursing care.

The aim of the report is to explore the issues around the burden of paperwork affecting nurses and to help identify the key areas that need to be addressed. Additionally, there are numerous examples of organisational/regional good practice identified, as well as recommendations for further action so that such good practice can be consolidated nationally.

Information was gathered in a number of ways; literature search, focus groups, interviews and an online survey. The findings from these were analysed using a thematic approach, where the following key themes were:

1. Duplication
2. Data collection and audits
3. Clarity on essential/non essential documentation – how the role of the nurse is being compromised by the level of non essential documentation
4. Dwindling administration support
5. Issues around use of technology
6. Ideas from NHS staff

Nurses recognise that paperwork is an integral part of delivering care and an important method of communication and that some of the paperwork they complete is patient focused and essential. They also have a professional duty to provide information for quality improvement and managing services effectively. However, the current amount of paperwork they are expected to complete can result in nurses being unable to effectively prioritise and focus their energies on documents of real value and, most importantly, it reduces the time they have to care for the patient.

The findings of the online survey showed two particularly striking results. The overwhelming majority of nurses, 77.9%, confirmed that not only is paperwork time consuming and difficult to complete, but also add little value to patient care (68.1%).

The survey, focus groups and interviews highlighted duplication as the most frustrating issue for nurses when dealing with their paperwork; “duplication” was the word most commonly used in all forms of feedback.

Nurses found data collection and paperwork linked with audits to be most time consuming. There are a large number of measures that nurses are now required to provide on a regular basis in order to comply with regulatory standards, quality targets and financial measures. This is a source of ongoing frustration in the nursing community due to the overlaps of information required and the lengthy nature of the documents.

Many nurses who took part in the focus groups felt that the role of the nurse was being eroded by the focus on paperwork and that they were seen as ‘all things to all men’ and not appreciated as experienced and highly skilled care givers. There is widespread perception in the nursing community that most paperwork requiring completion is seen to fall within the remit of the nursing role, and furthermore, that certain documents have minimal value, which serves to compound frustration.
The reduction or absence of clerical support was a key issue for nurses who felt that they would be expected to bridge the administrative gap. The impact of the lack of clerical support is that basic administration duties which do not require a nurse’s expertise are being backfilled by highly skilled and expensive nursing staff. Consequently nurses are drawn away from caring for their patients which should be their primary focus. The subsequent effect of this is that nurses’ desire to stay within the nursing profession is being eroded. This is demonstrated in the survey responses where certain respondents discussed leaving their role due to the burden of bureaucracy.

Use of technology appears to hold the key to resolving many of the issues, enabling a reduction of the repetition that nurses find so frustrating. However, nurses report that many systems have not been designed with the end user in mind which, coupled with the lack of integration, means that many systems are not as effective as they could be. This is an area that needs sustained focus and investment as technology is potentially the nurse’s (as well as the organisation’s) greatest ally. The findings suggest there is a lack of investment in suitable technologies as the initial outlay is high and there is pressure on investors to demonstrate cost savings. However, if the executive team can see past the short term cost, and recognise the long term gain, this is an area that could significantly reduce bureaucracy.

There was a good deal of useful feedback on ideas from respondents and participants to the focus groups, interview and survey. Below is a summary, based on the online survey, of the main themes nurses perceive to hold the most potential to resolve issues around the burden of bureaucracy.

### What ideas do you have that could reduce bureaucracy and paperwork?

- **Electronic, paperless, improved infrastructure**: 24%
- **Dec. simplify, eliminate duplication, standardise, streamline**: 11%
- **More ward support**: 8%
- **Address the culture of the fear of litigation and the need to document practice, reduction in audits, targets**: 12%
- **Bottom up approach**: 6%
- **Fit for purpose, clinically relevant assessments**: 5%
- **MOT approach inc. admission and discharge**: 5%
- **More clinical autonomy, clinical judgement**: 5%
- **Other**: 3%

Conclusion

Bureaucracy is clearly an issue that resonates within the nursing community, and narrative responses to the survey, focus groups and interviews conducted by the NHS Institute were vociferous and indicated a sense of urgency.

There is ample evidence of innovative solutions in place in a number of organisations, and of technology being used to its best advantage in numerous “islands of excellence”. However, the solutions in place to reduce bureaucracy vary significantly region by region, organisation by organisation. This is something that will benefit from a central review.
There appears to be an urgent need to review the levels of administrative support staff available to ease the burden on nursing staff who are “currently drowning in paperwork”. This would alleviate the problem of highly skilled and specialist nurses undertaking clerical duties and being drawn away from the patient care they really need to focus on.

Furthermore, there needs to be a determined focus on streamlining all documentation used in order to reduce the number of hours spent per day by nursing staff in completing this paperwork. Documents need to be fit for purpose, only requesting information relevant to the patient and the purpose of their visit.

Finally, the use of technology represents one of the most significant opportunities to reduce bureaucracy, but only if technology is fully embraced, well co-ordinated and consistently used, with systems that link up effectively with other agencies/organisations.

**Recommendations**

The solutions recommended are realistic and pragmatic. They will appeal to NHS staff across the board, improving their efficiency and their experience in the workplace. The ultimate outcome of these solutions could be a dramatic improvement in patient care as direct care time could be increased and the morale of staff boosted.

1. Development of national guidelines to assist front line nurses and organisations in understanding what comprises essential and non essential documentation.

2. Creation of organisational multi professional forum to review, rationalise and streamline all documentation. This group would be responsible for considering any national guidance and for implementing a robust process to review and update documentation in a controlled manner to meet the need of the patient, nurses and service. Organisational forums would need strong guidance from a national source so that their nationally defined parameters regarding documentation can filter down through every region and every organisation, resulting in consistency and clarity.

3. Review of administration staff supporting nurses at ward level with a view to ensuring there is adequate resource and removal of all non clinical documentation that currently falls to nursing staff to complete.

4. Development and implementation of a patient care record that is multi professional and is designed for completion by all disciplines i.e. medical staff, nurses and physiotherapists, recording patient assessment and progress in the same document.

5. Review of training and education of nurses at an organisational level (including Healthcare Assistants) will be essential to ensure staff are clear about what should be documented and how this is best done. The quality of records of care is felt by many nurses to be affected by the desire for those completing the records to ‘cover their back’ due to the fear of litigation.

6. Set expectation, and put in place support, for all organisations to implement integrated e-systems with an ambition to become paper-light. Organisations should be creative in the use of new technology to aid nurses in documenting at the bedside/in patient homes and ensure that there is adequate hardware to support staff.

7. Formation of a national workstream to support the work of reducing bureaucracy. This workstream should oversee the multiple initiatives needed to address the issue and include the creation of national guidance, support for procurement and implementation of e-systems, and development of a sharing culture to ensure the ‘pockets’ of excellence are adopted and spread.
1. Introduction

The Nursing and Care Quality Forum has commissioned this report from the NHS Institute for Innovation and Improvement in response to the growing concerns that nurses have regarding the time spent on completing paperwork, to the detriment of delivering high quality nursing care. This is particularly topical in light of the Prime Minister’s comments in January 2012 on the need to review the bureaucracy that gets in the way of nurses performing their jobs properly. The Prime Minister stated that in order to guarantee patients are treated with dignity and respect, the multiple problems of ‘stifling bureaucracy’ rife in the system need to be addressed.

2. Objectives and approach

The purpose of this report is to:

- better understand the issues around the burden of paperwork affecting nurses
- identify specific areas that need to be addressed
- identify initiatives and good practice being implemented
- make recommendations for further action.

An initial review of literature was undertaken together with an online survey of nursing staff, for which 2035 responses were received. Twelve focus groups were held with acute, community and mental health organisations, as well as 12 interviews with Directors or Deputy Directors of Nursing.

The Royal College of Nursing (RCN) has been a valued external contributor and assisted greatly with distributing the online survey.

This report outlines a short literature review and findings from the research undertaken.

Sections 4.1 through 4.5 discuss the themes and provide feedback from the interviews and focus groups. Each section offers a number of possible solutions to address the issues discussed.

Section 4.6 is a summary of ideas for possible solutions from survey respondents.

Following the conclusion in this document there are a number of recommendations for central consideration. These recommendations are the culmination of all the findings of the work undertaken to complete this report. The recommendations suggest workable solutions based on positive examples given by organisations who took part in the research. Harnessing the benefits reaped in these ‘islands of excellence’ on a national basis, could deliver huge gains, both from the perspective of improved job satisfaction for nurses and in related improvements to patient care.

3. Review of literature

The crippling effect on staff that results from increasing bureaucracy is supported by a study commissioned by the Department of Health that took place in October 2005, aimed at investigating the amount of time senior nurses spent on clerical and administrative tasks. The results demonstrated that they were spending more time on administration, and the resulting reduction of time spent on delivering patient care has a negative impact on job satisfaction.¹

An RCN survey in 2008 found that nursing staff were spending more than one million hours on paperwork and clerical tasks each week with 88% of respondents feeling that there had been an increase in bureaucratic tasks they were undertaking.²

More than a quarter (28%) said they had no access to clerical support and only 22% believed administrative back-up had kept pace with the growth in bureaucratic chores.

The RCN survey showed that 170,000 full-time nurses in posts delivering hands-on care for patients spend an average 7.3 hours a week on paperwork and 100,000 part-timers spend 3.9 hours. This equates to approximately one fifth of their working week. Reviewing the wealth of feedback gained in the focus groups and interviews carried out for this review, it is clear that there has been a significant increase in the hours spent on paperwork.

Anne Milton, until recently shadow health minister and a former NHS nurse, said:

“**It is appalling to discover that nurses are spending over a million hours a week on paperwork. This is not the best use of these highly qualified and highly trained healthcare professionals.**”³

Christine Beasley, Chief Nursing Officer at the Department of Health 2004-12, said:

“Nurses should spend their time caring for patients, not having to carry out unnecessary administrative tasks”.

She stated although paperwork is necessary it should not be onerous.⁴

In her study *Smart Nursing: Nurse Retention & Patient Safety Improvement Strategies*, June Fabre RN MBA discusses how bureaucracy comes about in an organisation:

“**Every organisation has structure, but not all organisations have bureaucracy…We need structure to work efficiently and serve patients. But, structure should be our tool, not our master.”**

In this insightful quote from her book, Fabre states how critical it is that bureaucracy is avoided, as it stifles organisations and never benefits patients. She goes on to state that bureaucracy is expensive and adversely affects both staff morale and patient outcomes.

With the increasing demands upon the NHS it is imperative that nurses are freed from the requirement to complete bureaucratic documentation that is not an essential component of delivering care.

4. **Findings**

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² All statistics quoted the RCN 2008 survey are from John Carvel’s article ‘Nurses spend 1m hours a week on bureaucracy ’in the Guardian on Monday 28 April 2008

³ & ⁴ Quotations from John Carvel’s article ‘Nurses spend 1m hours a week on bureaucracy ’in the Guardian on Monday 28 April 2008

The findings from the survey, focus groups and interviews were analysed using a thematic approach, where the following key themes were identified:

4.1 Duplication  
4.2 Data collection and audits  
4.3 Clarity on essential/non essential documentation – how the role of the nurse is being compromised by the level of non essential documentation  
4.4 Dwindling administration support  
4.5 Issues around use of technology  
4.6 Ideas from NHS staff

When the results of the online survey, distributed across the nursing community by the Royal College of Nursing were analysed there were two particularly striking findings. An overwhelming majority of nurses confirmed that not only is paperwork time consuming and difficult to complete, but the perception was that it adds little value to patient care (see diagrams below).

77.9% of respondents disagreed with the statement that the paperwork they use is quick and easy to complete
68.1% of respondents disagreed with the statement that the paperwork they complete adds value to patient care

4.1 Duplication

Duplication is the word most commonly used by nurses when describing what frustrates them most about the paperwork they are required to complete. Duplication of information represents an avoidable waste of time and money, and this is highlighted in the narrative feedback received in the online survey.
This was also an issue discussed at length in the focus groups and in the responses from the online survey, examples of which are noted below.

“Personally I fulfil a quasi medical role so usually my documentation is entered straight into the patient’s case notes. It’s a long time since I worked "on ward", however recently I worked a bank shift on a trauma admissions unit. The patient I had to admit had sustained gunshot injuries (none life threatening). He was young and therefore without the usual cohort of medical co-morbidities and polypharmacy. To say I was horrified is an understatement when I had to fill in (hand write) a 22 page Admission document then at least ten separate documents for Waterlow, a MUST assessment, falls risk, comfort round chart, there was ENDLESS repetition. The demographics also had to be reproduced on each separate page, it was ridiculous. How the Ward Nurse copes filling this rubbish in when the patient they are admitting is ill, wet, in pain, confused or aggressive, is beyond me.”

Survey respondent

A participant in one of the focus groups highlighted the example of a patient’s weight being documented four times within the patient’s admission paperwork and subsequent assessment documents.

Another focus group participant noted that in the maternity unit a mother’s blood loss during labour was recorded seven times on different documents.

Focus group feedback

Below is a selection of statements made by survey respondents.

Thinking about documentation and paperwork, what frustrates you most around the issue of DUPLICATION?

- Reporting names, dates of birth, NHS number a dozen times on every document as labels are too expensive. We also have to write outcomes manually on case cards then repeat it all electronically for coding.

- Duplication, duplication, duplication. Having to complete irrelevant forms just for the purpose of an audit trail, which has no bearing on patient care whatsoever.

- That everything is repeated, what is put on the charts at the end of the bed, has to be input into the care plans and notes. This is a complete waste of nurses time and expertise and we are spending too much time duplicating paperwork and not enough time with the patients where we are needed most.

- There is duplication of information as I have to input information into different systems and they are not compatible.

- I feel a lot of the work is repetitive, not always necessary and is sometimes just a paper exercise...It has got so out of hand that we can’t get on with the work that we originally trained for.
Patient information is frequently duplicated during the patient’s episode of care. On being transferred to a ward from the Emergency Department, for example, they may be asked to provide the same information and have the same basic observations repeated even when they have been carried out just prior to transfer. This is merely in order to ensure compliance with regulation/documentation audits.

Furthermore, many departments have personalised their admission documentation to their specific clinical areas, necessitating the completion of new paperwork that would not be required if the paperwork followed the patient through their episode of care. Particularly frustrating for nurses is being required to re-document basic patient information that has previously been recorded. This also increases the risk of transcription error.

The limitations on information sharing between organisations, agencies and health professionals means that assessments are taken and records updated on several occasions even though the information is readily available.

The time involved in record taking can not only prove burdensome to nurses but is often seen as an irritant to patients and relatives. When an episode of care involves a patient being transferred within the hospital they become conscious of being asked for the same information on multiple occasions. Most often nursing notes and medical notes are recorded separately and used distinctly, whereas merging these two sets of notes would give a more complete picture of the patient’s health status. An added benefit of this is the improved communication between healthcare professionals.

The following quote from a survey respondent highlights a key impact of bureaucracy on nurses, who are on occasion working additional hours at the end of their shift in order to provide information which may have already been recorded in other areas of the hospital.

Some nurses take notes home, which represents an unacceptable risk to the confidentiality of patient information, as well as the potential loss of patient information and is a clear breach of Caldicott guidance.

“Too much of it [paperwork], too much repetition, no time to fill it in. Then stressed ..... knowing you are in breach of professional code bringing confidential documents home to complete, breaching data protection.”
Survey respondent

There is a perceived ‘culture of blame’ where nurses feel anxious about working extra hours to complete documentation, as they are deemed to be inefficient with their time. This could have a negative impact on their health and well being and in turn this has the potential to impact negatively on patient outcomes and safety.

“The fact is that I have no time to do paperwork during the shift so usually end up staying over my time (unpaid) to complete it, and you don't get the time back as you are considered to be bad at time management if you don't get it all written and done in your shift!!”
Survey respondent

Nurses develop a certain level of cynicism regarding the submission of safety information i.e. risk assessments, as they submit duplicated information to diverse organisations and receive little feedback about what this information is used for.
Solutions

There have been many innovative solutions rolled out in organisations around the issue of duplication, good examples of which were highlighted during the focus groups. The examples below give an indication of some of the ideas being explored and employed in organisations across the NHS.

- Portable notes that follow the patient through their episode of care. This would allow staff throughout the hospital to access results quickly and easily, thereby avoiding duplication.
- The use of technology could dramatically reduce the levels of duplication rife in the system. This is discussed in greater depth later in the report (see section 4.5).
- Establish forums in organisations where the content of all documents completed by clinical staff is challenged and rationalised.
- Multi professional care records where all disciplines contribute to a single record of assessment and progress reducing duplication and improving communication.
- Better links between organisations/agencies/professionals where the patient is treated in a variety of environments.
- Standardisation across an organisation in the common elements of admission paperwork so that basic information is not repeated subsequent to its initial capture.

4.2 Data collection and audits

There are a large number of measures that nurses are now required to provide regularly in order to comply with regulatory standards, quality targets and financial measures. This is a source of ongoing frustration in the nursing community due to the overlap of information required and the lengthy nature of the documents.

When asked which documents were most time consuming to complete nurses responded that data collection documentation, reports and paperwork linked with audits took up a high proportion of their time. The chart below details the survey responses.
Below are a number of quotes from survey respondents to demonstrate the impact data collection has on the nurses' everyday role and their ability to deliver patient care.

"Most of the data collected is to ensure that the trust is covered in case of a claim of neglect by patient. Reams of documents will be available to show we must have done all the care as the box is ticked. In one unit the care plan tick box is 26 pages…I would rather just write a small paragraph rather than tick 'dentures applicable or not applicable, cleaned, cleaned by client, if not cleaned why… You cannot tell anyone higher up as they are just happy that boxes are ticked and they are covered. 'Your mother was not left without a drink all day, look the boxes were ticked every hour to say she was offered a drink."
Survey respondent

"The amount of paperwork that we have to complete takes up a great deal of time that could be spent with patients, for example completing paperwork for ten patients per shift can take up to an hour and a half. Some of the paperwork does not appear to have any rationale behind it and appears to be a paper exercise without any positive outcome for the patient, for example the intentional rounding forms."
Survey respondent

There are overlaps in certain data returns, where information is duplicated due to a lack of co-ordination between the multiple agencies or organisations requesting the information. Audits required to provide evidence to the Care Quality Commission (CQC) and CQUIN schemes are widely considered as an onerous process and as a “tick box exercise”, ironically preventing nurses from delivering the quality care they are being evaluated on. The resulting cynicism can lead to the loss of focus on the importance of monitoring key measures as there is insufficient time for them to complete the task in a comprehensive manner. This is partly due to the lack of useful feedback. Feedback is either not given at all or if it is provided, it is in an unhelpful format following a data return, and feels like a fruitless exercise for the respondent who will often require guidance on ways to improve.
“We get criticised by the CQC for not spending enough time with patients, yet they are the ones who insist on most of this paperwork. With the attachment of money e.g. CQUIN targets the paperwork is where the priority is for managers.”
Survey respondent

This is also the case in general data collection which is often viewed with cynicism within the nursing network due to the lack of feedback following the submission of data. Specialist nurses are spending large amounts of time collecting data, drawing them away from their primary purpose, which should be advising staff and delivering expert patient care.

“Because of the fear of litigation, common sense has been relegated.”
Survey respondent

“The lack of common sense. Does a 21 yr old independent man really need a falls risk, a Braden score, a moving and handling chart and a MUST score?”
Survey respondent

Certain measures are not universally relevant so data collection can be wasteful i.e. three out of four of the “safety thermometer” measures do not apply to children or young people and there is the perception that this has been imposed upon nursing staff. Information from the safety thermometer and other audits that is returned is often perceived to be arbitrary. The results are presented as a short summary that does not give full context as some harm incidents are sustained outside the clinical area, have a negative impact on results and are outside of their control. To give a specific example of this a patient may be admitted with a pressure ulcer; this would be recorded as part of the audit and may be seen as the clinical area’s responsibility.
4.3 Clarity on essential and non essential documentation – how the role of the nurse is being compromised by the level of non essential documentation

Many nurses in the focus groups expressed that they felt that the role of the nurse was being eroded and that they were seen as ‘all things to all men’, and not appreciated as experienced and highly skilled care givers. There is a widespread perception that most paperwork requiring completion falls within the remit of the nursing role. Furthermore certain documents are perceived to have minimal value which only serves to compound frustration.

“Nurses became nurses to care for patients, not sit at a computer all day ticking boxes while untrained staff are left to provide care for complex patients who need our expertise - if I had wanted to this type of work I would have gone for an office job.”

Survey respondent

Nurses feel that much of the documentation completed is driven by the need to prove that they have achieved targets. This is a cause of frustration as the documentation is time consuming and draws them away from the high quality patient care they are tasked with delivering. As a consequence nurses feel they have to stay on after their hours to complete documentation so the team does not fail to reach their targets.

It would appear that nationally there is lack of clarity regarding what is “essential” paperwork and what is “non essential” paperwork. In addition, information completed on forms is not always seen by nurses as being clinically relevant. Prevalent in the majority of interviews, focus groups and in the narrative feedback in the survey was the outcry about this lack of national guidance which was felt to undermine the nurse’s ability to prioritise workload.

Solutions

- Streamline the number of data measures collected, particularly in the area of patient safety where duplicate data is provided to multiple organisations in different formats.
- A more dynamic link between frontline teams and regulatory bodies needs to be established in order to truly engage frontline teams in the process, and to foster a greater sense of understanding of the importance of certain measures. Improving this relationship would help combat cynicism about data collection that is currently rife in the nursing community.
- Comprehensive feedback for all audits should be provided to responding organisations to aid improvement
- Enhanced use of e-systems to collect audit/compliance data will be necessary to alleviate the significant problem of duplication and the lack of interface between concerned organisations.
- An organisational wide group to oversee, manage and streamline the type and quantity of documentation, specifically that relating to data collection and audit. The purpose of such a group would be to continually review all documents to ensure they are fit for purpose and pertinent to patient care as well as minimising the number of documents overall.
The Nursing and Midwifery Council’s (NMC) guidelines on record keeping are considered to be the blueprint regarding principles of good record keeping but there are limitations in how much clarity it provides. There is ample guidance on how to record information but nurses perceive that it lacks detailed guidance on what must or should be recorded, by whom and when.

In light of the culture of increasing litigation, nurses can be overwhelmed by issues around regulations and compliance, adding to the duplication in information submitted (safety or audit information provided several times and on different forms). Despite some of this information being of critical importance, there needs to be a rationalisation process to ensure that only measures that will be used to directly influence patient care are retained.

Admissions and discharge paperwork is universally acknowledged to be unnecessarily lengthy and repetitive causing frustration for nurses, patients and relatives. Although it is essential to document important patient information at the point of admission and discharge, it need not be exhaustive and should be streamlined to reduce the burden on nurses.

“Our organisation has reduced the time it takes to complete patient admission documentation by approximately 50%. This has been achieved by streamlining the admission assessments, so full in-depth assessments are only required for those patients that need them.”
Focus group feedback

Many nurses feel frustrated that regardless of the nature and the anticipated duration of a patient’s episode of care, they must still complete lengthy documents and provide information that is not always clinically relevant to the specific patient. For example, where there is a shorter than average period of time between admission and discharge, a patient being admitted for a short procedure may generate considerable paperwork that a nurse will struggle to complete within the time available. In most cases the standard documentation is unsuitable for short stay patients. This is an issue that nurses were most vociferous about in the focus group sessions.

“Waste of time and paper costs for very short term patients. Intensity of paperwork should be scaled to seriousness of patient condition and length of hospital stay. Much duplication still with paperwork - often no documents properly completed because of this or because of time constraints.”
Survey respondent

Nurses recognise that paperwork is an integral part of delivering care and an important method of communication and that some of the paperwork they complete is patient focused and essential. They also have a professional duty to provide information for quality improvement and managing services effectively. However, the current amount of paperwork they are expected to complete can result in them being unable to effectively prioritise and focus their energies on the documents that will be of real value and, most importantly, on the patient.

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6 NMC (2008) the code: Standards of conduct, performance and ethics for nurses and midwives. [www.nmc-uk.org/code](http://www.nmc-uk.org/code)
“I work in the recovery department and on many occasions the patients stay for a short period of time. Because there is so much paperwork to fill in, many times I do not find time to speak to the patient! That saddens me a lot because nursing is about talking and listening to people not filling paperwork!”
Survey respondent

“There is huge pressure to make sure everything is written down but the more paperwork there is to fill in, the less time I can spend with my patients. I am worried that I may miss something putting my patients at risk.”
Focus group participant

One of the main objectives is to separate what must be done, what can be delegated and what nurses should absolutely not be doing. There is a strong feeling that national guidance is needed so that a clear statement can be made on this, which would be very helpful for nurses. The RCN’s Information Standards Officer Anne Casey, is leading the College’s work on managing paperwork and made the following statement.

“Patient documentation is an important way of communicating - and much of the paperwork nurses complete is essential. However, what constitutes ‘essential’ and ‘non-essential’ paperwork needs urgent clarification”

Casey goes on to state that the principle of record-keeping should be based along the lines of ‘record once, use many times.’

**Solutions**

- A clear set of national guidelines required on what is essential paperwork and advice on prioritisation of paperwork.
- Tailored documentation for short-stay patients to reduce the pressure on staff working in these areas who feel they do not have the capacity to complete standardised nursing care plans, and clinical tasks within the timeframes available.
- Mobilise frontline nursing staff to take part in discussions to help determine what constitutes essential paperwork in their daily duties and, most importantly, assist in the design or redesign of documents (paper or electronic).
- During the focus groups one organisation discussed the idea of mobilising healthcare assistants to alleviate the burden on more senior grade nurses, although they recognised that HCAs do not feel sufficiently confident to write nursing notes. Currently accountability sits with registered nurses with all entries into the patient record requiring countersignature. However, HCAs are able to undertake vital signs and document observation charts, fluid chart and rounding charts without countersignature. A review of the paperwork that HCAs could complete, both clinical and otherwise, to support the registered nurses, together with the requisite education, may offer a possible solution.
4.4 The Impact of dwindling levels of administrative support staff on the role of the nurse

Nationally, there is published evidence that nursing staff are spending an increasing amount of time undertaking paperwork and additional duties. A study commissioned by the Department of Health (October 2005) was aimed at discovering the amount of time senior nurses spent on clerical and administrative tasks. The results demonstrated that they were spending more time than before on administration and the resulting reduction in time spent on delivering patient care was shown to have an adverse effect on job satisfaction.\(^7\) This finding was corroborated in the focus group sessions.

The study went on to suggest that one way of reducing the amount of non-essential paperwork completed by nurses was through the use of administrative support staff. However, even in 2005 there was an indication that this support was either not being put in place or was being taken away or reduced. In recent months there has been a continued reduction in administrative staff supporting nurses through initiatives such as the NHS Back Office Efficiency and Management Optimisation Programme.

The impact of the lack of clerical support is that basic administration duties which do not require a nurse’s expertise are being backfilled by these highly skilled and expensive nursing staff. Consequently nurses are drawn away from caring for their patients which should be their primary focus. This impacts staff morale as shown in the numerous examples from the focus groups and could have an impact on staff turnover.

“We are drowning in repetition and duplication in our paperwork. I might as well as have trained as a secretary as that's all I do. Type, type and even more typing. I hate the job so much now because of this and am desperate to get out.”
Survey respondent

Another survey conducted by Nursing Standard in 2009 found that almost one third of ward managers in the UK did not have a ward clerk. Subsequent surveys in Scotland indicate that this support is in decline. A 2010 survey of 550 senior charge nurses found that just fewer than 50% had no administrative support, despite 85% believing that help with clerical duties would mean they could spend more time caring for patients.\(^8\) Early analysis of a repeat of the survey, carried out by RCN Scotland in January this year, found that just 16% of respondents had administrative support. One third said that support had decreased in the intervening period.\(^9\)

“There is a real need for more administrative support in the ward area. I do a lot of paperwork that doesn’t need to be completed by a nurse. Most of the audit paperwork and some of the other audits could be done by admin staff. Documentation audits, for example, take hours to complete and take us away from the bedside.”
Focus group participant

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Nurses feel that even when administration support is present it is not seen as important by the organisation as there is regularly no annual leave or sickness cover and nurses are expected to pick up the burden.

“I dread being on duty on Sundays as there is so much paperwork organising the surgical admissions coming in and there is no one to pick up the phone. If I ignore the phone and prioritise patient care I feel guilty.”

Focus group participant

**Solutions**

- Recruitment of adequate administrative support staff to lift the burden from nurses of non essential paperwork. This would enable them to concentrate on care delivery which could potentially improve nurse and patient satisfaction, reduce the number and type of complaints and improve the quality of care. One organisation trialled the role of personal assistant to the senior sisters. The immediate effect was the senior nurse’s ability to have more clinical time and be available in the clinical area. The resultant increase in visibility at a clinical level had a positive impact on leadership for staff and patients, quality of care and showed improved length-of-stay statistics. The success of the trial was also seen in a reduction in patient complaints and an increase in positive comments about the service staff provided. Importantly, it demonstrated an improvement in the quality and timeliness of documentation.

- Use of volunteers or outside agencies to help with patient satisfaction surveys, menu completion and some audits where patient confidentiality is not an issue.

**4.5 Issues around use of technology**

Use of technology may hold the key to resolving many of the issues outlined in this report, particularly when the end user is empowered to influence the process of design, development and implementation. However, the general opinion conveyed was that the end user nurse who enters data onto the electronic system often finds the functionality of e-forms frustrating and the content just as repetitive as paper based systems. Furthermore, systems often do not interface with other systems in use. This is an area that needs sustained focus and investment as technology is potentially the nurse’s as well as the organisation’s greatest ally.

During the focus groups and interviews many examples of good use of technology were shared.
How e-health technology helps streamline processes and reduce bureaucracy

It is widely acknowledged in the nursing community that where patient information is entered onto a central system that can be accessed by all, this saves staff time and reduces frustration. There are also potential benefits to the patient who is empowered to consult with clinicians remotely, and provide results using devices from their own home. Pressure on the system is thereby reduced and the patient is allowed more independence and a better quality of life. If GP systems interface with other health and social care providers the level of paperwork required to ensure continuity of care can be dramatically reduced.

Example in practice

The trust uses a digital pen to enable them to improve the speed and efficiency with which staff collect data, which is then automatically transferred onto their systems

Four clinical teams in the occupational therapy and physiotherapy services used the pens and the pilot showed that their use could save clinicians 167 hours per month and administrative staff 83.5 hours per month


Example in practice

Several hospitals have purchased smart phones and tablets to support the VitalPAK programme to reduce the amount of paperwork that nurses need to complete around vital signs monitoring by up to 40%.* The programme interfaces with the Patient Administration system and has been shown to reduce the cost of care as staff are alerted early in the deterioration process and have algorithms available to follow.

*Based on feedback received in an interview with deputy director of nursing

Many organisations are using electronic solutions to implement Patient Status at a Glance and Shift Handover modules from The Productive Series programmes to assist nurses who look to quickly establish key pieces of information saving them time and paperwork.

Focus group example

One team has used simple technology in the form of a computer, large flat screen television and excel spreadsheet that enables the team to prioritise their documentation to meet deadlines for assessments. The tool has been designed to alert nurses to the status of patient assessments using a colour coding system and can be updated quickly and easily by the nursing staff.
Community nurses are also using mobile healthcare systems to have patient notes, appointment details and updates sent to handheld devices. This reduces the need for them to source and collect cumbersome files prior to their visits, saving them valuable time.

Key points on the limitations of technology

Using electronic devices and automating the collection of key patient information represents an opportunity to reduce bureaucracy. However, the technology used varies from region to region, and from organisation to organisation. This makes for inconsistency and variation. Consequently it is harder to produce central standards or guidelines for the use of technology.

Systems developed by commercial companies often do a great job in automating lengthy processes for a given organisation, but do not always have the flexibility to link with other systems used in other organisations and agencies also involved in the patient’s care. The nature of the health service demands that systems should talk to each other, but this is often not the case and compounds the issue of duplication in particular.

Widely embraced is the concept of patients in the community with long term conditions taking ownership for recording their own information using electronic devices. This undoubtedly allows the patient more independence and aids greater quality of life. However, the implication of this is that the patient has to be relied upon for reporting changes in their symptoms and results, and in the event of them failing to do so there could be serious consequences. Often, the expert clinician observes changes in their symptoms quickly and has an idea of diagnosis long before test results are returned.

“The lack of interface between the systems means we have to enter the same information multiple times and log in to each individual programme which is so time consuming”
Focus group participant

“The vast majority of it [information] is firstly written then has to be put on to electronic format for sharing within the organisation.”
Survey respondents

From a resource perspective a variety of specialist IT support staff or co-ordinators would need to be recruited to work with the end user in order to ensure that innovations remain reliable, fit for purpose and that any new requirements are developed, implemented and staff trained. The findings suggest there is lack of investment in suitable technologies as the initial outlay is high and there is pressure upon investors to demonstrate cost savings. However, if the executive team can see past the short-term cost and appreciates the long term gain this is an area that could hold the key to significantly reduce bureaucracy and paperwork.

10 Using technology to complement nursing practice: an RCN guide for healthcare practitioners. RCN publications May 2012.
4.6 Ideas from NHS staff

During the focus group sessions, interviews, and in the responses to the online survey, there were many useful ideas either currently in discussion or being implemented in organisations. Below is a summary, based on the online survey of the main themes that nurses perceive to hold the most potential to resolve issues around the burden of bureaucracy.

![Pie chart showing ideas to reduce bureaucracy and paperwork]

- Doc. simplify, eliminate duplication, standardise, streamline 31%
- Electronic, paperless, improved infrastructure 24%
- More ward support 8%
- Address the culture of the fear of litigation and the need to document practice, reduction in audits, targets 12%
- Bottom up approach 6%
- Fit for purpose, clinically relevant assessments 5%
- MDT approach inc admission and discharge 6%
- More clinical autonomy, clinical judgement 5%
- Other 3%
4.6.1. Ideas from staff for reduction of bureaucracy

The examples below give fuller detail on the ideas provided by nurses responding to the online survey:

Many nurses feel their expertise is undermined by the lengthy tick box documents currently used, and would prefer to use their clinical judgement to write a brief summary of their patient’s day for handover to their colleagues:

“After a long 12 hour shift on a ward I should be able to provide a brief summary of my patient’s day to the next nurse, a short written guide to remind if there is any particular care needed for that person, and an acceptance that I will have given a full range of care as needed according to the training and experience of my 34 yrs without resorting to 26 pages of ticks.”

Online survey response

Another idea nurses discussed was streamlining the amount of information requested in risk assessments conducted, as the information is not always pertinent to the patient being treated. Furthermore, risk assessment documents are not only lengthy but they are repeated when the
The patient is transferred from emergency department to medical admissions unit then admitted to the ward. One nurse highlighted that doctors use a standardised form that captures all pertinent information, whereas a nurse is required to complete multiple documents:

“We need to get rid of the duplication, and get away from the current practice of completing an initial assessment and then a risk assessment document, crisis and contingency and CPA document even though there is no risk of wandering, fire or other. Interestingly enough the doctors have one document when they see a patient called the Medics Care Plan and this seems to suffice for the initial assessment, diagnostic, care plan, treatment plan and risk. My argument would be why can’t nurses have the same?”

“More portable electronic devices, a coherent approach so that all staff agree to use one system and sufficient initial outlay so that the best possible systems are purchased.”

Survey responses

Many ideas for how technology could help nurses combat bureaucracy were discussed. The most frequently mentioned was that of a central electronic record where all the pertinent patient information is recorded on admission, and subsequently all healthcare staff can update and view this information. This system would be populated with data sourced from electronic hand-held devices i.e. digi-pens, used by staff to obtain vital signs information. This type of system would have a number of benefits; a reduction in transcription errors from paper notes to electronic record; a reduction in duplication and the potential for a patient’s deterioration to be noticed and acted upon more quickly due to automatic alerts. Another benefit is that the notes follow the patient through their episode of care, reducing duplication. These are just a few of the benefits of such a system.

“Each patient should have a central electronic record that can be accessed/logged onto by healthcare staff. Staff should then be given hand-held devices e.g. tablets and then the record could be viewed, all documentation could be recorded at time and place and referrals/prescriptions etc could all be done from there.”

Survey response

“We already have the electronic clinical system, on which the observation charts and nursing notes for critical care can be placed. According to some IT people, it would cost no more than about £30,000 to move a 13-bedded critical care unit to fully electronic observation and nursing documentation. For a start, we wouldn’t have to record vital signs, ventilator parameters or renal replacement therapy data manually. That would free up about 10-15 minutes hourly - not to mention information accuracy and consistency.”

Survey response

Responses from the on-line survey indicate that the frequency and number of audits needs to be reduced as it is causing intense pressure in a culture where blame is constantly apportioned and increasing litigious being action taken. The added impact of these audits is to lead to a perception from nurses that they are being disenfranchised, with a constant need to prove their work is being done properly, undermining their skill and expertise:

“Surely the evidence speaks for itself, I work on a 23 bedded orthopaedic ward with many immobile, elderly unwell patients and we do not get any pressure ulcers and that is not an easy achievement and will only come with regular and intensive nursing care which is
carried by an excellent, thoughtful and conscientious team of nurses who are struggling with the volume of paperwork… I am ordering a new filing cabinet and I need space for 70 forms. Basically I have the training, the qualifications, the ethics, the NMC code, the honesty, my own integrity and trust of my colleagues so why isn’t my word good enough? In the past it was enough for nurses to simply evaluate and document the care given to each patient for the period of time that you were caring for them.”

Survey response

There were many interesting and potentially beneficial ideas generated about streamlining current documentation so that the number of documents overall are reduced, but important information is still captured. Many nurses suggested that generic documentation is created, reducing bureaucracy and that if a specialist nurse needed to complete information there is a section specifically for this purpose:

“There should be a template care plan with sections for specialist nursing. The assessments, admission and discharge should be universal. This would mean all personnel could be trained and updated efficiently it would reduce the cost of documentation, be easier to audit and there would be no ambiguity. A fluid balance chart should include a diet section. Anyone needing to have their fluids assessed should also have their diet observed. This would reduce the need for food charts and assist in calculation of fluids as soups would be taken into the fluid balance equation.”

Survey response

Another idea frequently discussed was having a tailored document for short-stay patients i.e. for those patients who are in hospital for a minor surgical procedure, are low risk and expect to be discharged within 24/72 hours. This would solve the problems currently experienced by staff in short stay units as the standardised paperwork they are currently obliged to complete is not always clinically relevant:

“Develop a 72 hour short admission document that covers the very essentials i.e. risks, contact details, legal status, reasons for admission. After 72 hours if the patient stays then a full and comprehensive pathway.”

Online survey response

4.6.2. Ideas discussed during focus groups

During the focus groups there were many examples of innovative solutions being implemented in organisations around the country. A number of examples that were cited have been provided below.

- One organisation gave the example of ward staff managing sickness absence paperwork and return interviews. They suggest that HR should offer some form of administrative support to assist them in producing the sickness returns, roster updates, notes and letters required.

- A great example of using technology to offer quick access to vital patient information was given. One unit developed an interactive electronic system using an electronic spreadsheet, a computer and large screen TV. Working on a calendar format, colour coded and hyperlinked, the system centralised all pertinent information i.e. practice guidelines,
databases. A further benefit is that nurses are guided by the system on how to prioritise assessments.

- One organisation reviewed all nursing documentation and reduced paperwork from 50 pages to 14, creating a ‘Prescription of Care’ where everyone enters information. This was again cited in a second organisation involved in the focus group, and they created a Multi-Disciplinary Team notes pack, thereby reducing duplication.

- Another organisation suggested the following ideas to alleviate the burden of bureaucracy; streamlining admission/discharge documentation so that it is pragmatic and fit for purpose, using digi-pens and barcode notes, using portable devices, integrating systems so they talk to each other and gaining access to clerical support staff.

- 24 hour/72 hour admission pack for low-risk patients.

- The establishment of a Nursing Quality Group looking at the quality of nursing care. A dedicated focus is placed on reviewing documentation relating to the quality of nursing care. All suggestions for new documentation are evaluated to decide whether the new document is necessary and to ensure its design and content is clinically relevant, and existing documents are scrutinised to ensure that they remain fit for purpose and to establish if they need to be improved.

- Healthcare Assistants being able to document care they deliver. Currently in the majority of organisations HCAs need to have a registered practitioner countersign anything they note in the patient care record, and yet they do not require registered nurses to check or countersign any vital signs they take. As a result HCAs generally feel uneasy and lack confidence about writing in the care record and the net effect of this is more pressure on the registered nurse. Potentially empowering Healthcare Assistants and mobilising this resource could offer a solution to the bureaucracy rife in clinical areas.
5 Conclusion

Bureaucracy is clearly an emotive and important issue within the nursing community, and narrative responses to the survey, focus groups and interviews conducted by the NHS Institute for Innovation and Improvement were vociferous and indicated a sense of urgency.

There is ample evidence of innovative solutions in place in organisations, and of technology being used to its best advantage in numerous “islands of excellence”. However, the solutions in place to reduce bureaucracy vary significantly region by region, trust by trust. This is something that will benefit from a central review. There appears to be an urgent need to review the levels of administrative support staff available to ease the burden on nursing staff who are drowning in paperwork. Furthermore, there needs to be a determined focus on streamlining all documentation used in order to reduce the number of hours spent per day by nursing staff in completing this paperwork. Documentation needs to be fit for purpose, only requesting information relevant to the patient and the purpose of their visit.

Finally, the use of technology represents one of the biggest opportunities to reduce bureaucracy but only if technology is fully embraced, well co-ordinated and consistently used, with systems that link effectively with other agencies and organisations.
6 Recommendations

The solutions recommended are realistic and pragmatic. They will appeal to NHS staff across the board, improving their efficiency and their experience in the workplace. The ultimate outcome of these solutions could be a dramatic improvement in patient care as direct care time could be increased and the morale of staff boosted.

1. The development of national guidelines to assist front line nurses and organisations in understanding what comprises essential and non-essential documentation.

2. The creation of an organisational multi-professional forum to review, rationalise and streamline all documentation. This group would be responsible for considering national guidance and putting in place a robust process to review and update documentation in a controlled manner to meet the need of the patient, nurses and service. This group should include within its membership, staff currently working at ward/team level to help with staff engagement, but most importantly to ensure that all documentation is fit for purpose and that national guidelines are understood. Organisational forums would need strong guidance from a national source so that their nationally defined parameters regarding documentation can be filtered down through every region and every organisation, resulting in consistency and clarity.

3. The review of administration staff supporting nurses at ward level with a view to ensuring there is adequate resource and removing all non-clinical documentation that currently falls to nursing staff to complete.

4. The development and implementation of a patient care record that is multi-professional with all disciplines i.e. medical staff, nurses, physiotherapists et cetera, recording patient assessment and progress in the same document. Comments from staff who are working where this has been implemented highlight the resultant improvement in communication and teamwork.

5. The review of training and education of nurses (including Healthcare Assistants) at an organisational level to ensure that staff are clear about what should be documented and how this is best done. Many nurses feel that the quality of records of care is affected by the desire for those completing the records to ‘cover their back’ due to the fear of litigation. This could help to address the current situation where nurses often over-document or miss out pertinent information. In addition, this should help nurses feel confident that their record entries will be able to withstand scrutiny, should any investigation or litigation arise.

6. To implement integrated electronic systems with an ambition to become paper light. Organisations should be creative in the use of new technology to aid nurses in documenting at the bedside or in patient homes and ensure that there is adequate hardware to support staff.
7. The formation of a national work stream to support the work of reducing bureaucracy. This work stream should oversee the multiple initiatives needed to address the issue and include the creation of national guidance, support for procurement and implementation of e systems, and the development of a sharing culture to ensure the islands of excellence are adopted and spread widely.
Appendix

Survey question results

Question one: Please state your role within your organisation

Nearly half of the respondents to the survey were staff nurses with the second largest group of respondents being sisters and the third largest being community nurses.
Question two: What type of organisation do you work in?

The majority (nearly two thirds) of respondents work in an acute in-patient hospital setting.

Within the above categories, there were also responses from nursing homes, hospices, prisons, GP practices, private hospitals, SHA’s, ambulance, PCT’s, Social Enterprises and CCGs.
Question three: Generally the paperwork I use is quick and easy to complete - agree or disagree?

77.9% of respondents disagreed with the statement that the paperwork they use is quick and easy to complete (77.9% is the sum of “strongly disagree” and “disagree”).
Question four: The paperwork I have to complete always adds value to patient care - agree or disagree?

68.1% of respondents disagreed with the statement that the paperwork they complete adds value to patient care (68.1% is the sum of “strongly disagree” and “disagree”).
Question five: In my role I generally spend a lot of time completing the following paperwork (list of types of paperwork provided for an agree/disagree response)?

Clinical Assessment documents reported to be the most time-consuming to complete, followed by Nursing Care Plans, Admissions Documents and General Reports/Incident Reports.

Figures above the columns in green are the sum of “agree” and “strongly agree” responses i.e. allowing us to ascertain those documents which take the most time to complete.
There were many more types of documents cited in the “Other” category, with comfort or intentional rounding, risk assessments (both clinical and workplace), staff development, general administration and continuing care documents mentioned frequently and the documents below.

<table>
<thead>
<tr>
<th>Daily diary &amp; work allocation</th>
<th>Tribunal reports</th>
<th>Timesheets</th>
<th>Business cases</th>
<th>Bed state forms</th>
<th>Blood results transcribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfort rounding</td>
<td>Social work reports</td>
<td>Timesheet authorisation</td>
<td>Appraisals</td>
<td>Occupational health referrals</td>
<td>Diagnostic requests - i.e. X-rays, Blood tests etc.</td>
</tr>
<tr>
<td>GP letters</td>
<td>Health &amp; safety &amp; workplace risk assessments</td>
<td>Handover sheets</td>
<td>Student nurse assessments</td>
<td>Case report forms</td>
<td>District nurse referrals</td>
</tr>
<tr>
<td>Patient referrals</td>
<td>Equipment request forms</td>
<td>Finance reports</td>
<td>CQC reports</td>
<td>Recruitment paperwork</td>
<td>Maintenance requests</td>
</tr>
<tr>
<td>Budget reports</td>
<td>Travel forms</td>
<td>Bed state</td>
<td>Mandatory training request</td>
<td>Emails</td>
<td>Clinical supervisions sheets for staff</td>
</tr>
<tr>
<td>Complaints</td>
<td>Travel form authorisation</td>
<td>E-learning</td>
<td>Mandatory training request authorisation</td>
<td>Court reports</td>
<td>Duty roster - then transcribe into e system (a workload)</td>
</tr>
<tr>
<td>Clinical coding</td>
<td>Expense forms</td>
<td>Competencies</td>
<td>Root Cause analysis</td>
<td>Policies</td>
<td>Clinic schedules</td>
</tr>
<tr>
<td>Team meeting minutes</td>
<td>Expense form authorisation</td>
<td>Research and Trial documentation</td>
<td>ICNARC data</td>
<td>Equipment repair forms</td>
<td>CRB</td>
</tr>
<tr>
<td>CPA documentation</td>
<td>PHQ scores</td>
<td>External letters - other agencies</td>
<td>Activity data (time &amp; motion)</td>
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<td></td>
</tr>
</tbody>
</table>

34
Question six: Do you capture any of the following electronically (documents listed)?

With the exception of Incident Reports, documents captured electronically are in the minority, demonstrating that there is a significant opportunity to use technology to alleviate the paperwork burden and the resulting Bureaucracy.
Question seven: Thinking about documentation and paperwork, what is it that frustrates you most? Analysis of 100 responses, organised into thematic areas

Out of a sample of 100 responses analysed, and out of the 141 separate points raised, 60% related to nurse frustration over duplication in documents and the reduced time they get to spend with the patient as a result of the paperwork they are required to complete.
Question eight: Are you aware of any work that has been done to improve the situation?

In the 2035 free text responses to the question “what frustrates you the most?” (regarding paperwork), words connected with Duplication and Repetition are mentioned 788 times, showing this is by far the largest area of concern and frustration in the nursing community.

Use of “Patient Care” and “Takes” also high…when responses analysed in detail the point was often made that the time paperwork takes results in less time on Patient Care.
In the narrative responses provided, many nurses confirmed they felt excluded from discussions during the development of new documents, with the resulting document not being fit for purpose. This leads us not to question whether the work is being done…but whether it is being done without the participation/awareness of the nurse.

Are you aware of any work that has been done to improve the situation?

- Yes: 26.7%
- No: 73.3%
Do you have evidence to support the fact that work is being done to improve the situation?

Only a quarter of respondents could provide evidence that work is being carried out in their organisation to improve the situation as regards Bureaucracy.
Question nine: What ideas do you have that could reduce bureaucracy and paperwork?

Out of a sample of 100 responses analysed, and out of the 111 separate points raised, 25% related to the need to improve use of technology to alleviate the paperwork burden, and the other most popular ideas were to eliminate duplication, recruit additional support staff and simplify documents.
Chart showing analysis of all 2035 responses.

**What ideas do you have that could reduce bureaucracy and paperwork?**

- Electronic, paperless, improved infrastructure: 24%
- Doc, simplify, eliminate duplication, standardise, streamline: 31%
- Address the culture of the fear of litigation and the need to document practice. Reduction in audits, targets: 12%
- More clinical autonomy, clinical judgement: 5%
- Bottom up approach: 6%
- More ward support: 8%
- Fit for purpose, clinically relevant assessments: 5%
- MDT approach inc admission and discharge: 6%
- Other: 3%
- Other ideas: 3%
- What ideas do you have that could reduce bureaucracy and paperwork?
Conclusions

The large majority of respondents feel that the documents they are required to complete are NOT quick and easy to complete, and do NOT add value to patient care.

Clinical Assessment documents were reported to be the most time-consuming to complete, followed by Nursing Care Plans, Admissions Documents and General Reports/Incident Reports.

With the exception of general reports/Incident Reports, documents captured electronically are in the minority, demonstrating that there is a significant opportunity to use technology to alleviate the paperwork burden and the resulting Bureaucracy.

Reviewing the wealth of narrative feedback on what frustrates the nursing network most regarding paperwork, it is clear that duplication/repetition is the biggest concern, followed by the time taken away from direct patient care due to the paperwork completed.

There is a widespread lack of awareness of improvement work being carried out. Coupled with the fact that only a quarter of respondents could provide evidence of improvements, this suggests that there is a major opportunity to improve all documents/systems used.

There is a need to ensure communication/staff involvement is improved within the network (based on narrative feedback). Many nurses stated they felt excluded from the process of improving documentation.

Reviewing the multiple different types of documents cited in the “other” category in the question which asks about the types of document completed, it is clear that there is widespread variation in the documents completed by trust/region and a lack of consistency through the network in the use of technology.

Thank you to the Royal College of Nursing for their support in distributing the online survey.
Acknowledgements

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