Five Time Saving Documentation Tips For

A plan for five time-saving documentation tips to help nurses efficiently manage charting while ensuring accuracy and compliance.

Outcome Measurement

To ensure these practices are effective, conduct monthly evaluations using documentation audits, peer reviews, and personal reflection on time saved and accuracy. Gradually integrate each tip and adjust based on feedback and evolving clinical needs.

1

Use Standardised Templates and Checklists

Objective: Reduce time spent on repetitive charting by using consistent templates and checklists.

Implementation Steps:

- Identify commonly documented information that can be structured into templates (e.g., vitals, medication logs).
- Collaborate with the healthcare team to create standardized forms for frequent documentation needs.
- Store templates in an easily accessible, organized manner in the electronic health record (EHR) system.

Tip: Colour-code or highlight high-priority fields for quick scanning and input.

2

Leverage Voice-to-Text or Dictation Tools

Objective: Minimize typing by using dictation or voice-to-text software for lengthy notes.

Implementation Steps:

- Ensure voice-to-text tools are enabled and set up for ease of access.
- Train on specific medical terms to improve the accuracy of dictation recognition.
- Establish a habit of reviewing and editing dictation entries immediately for clarity and accuracy.
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Tip: Use dictation for narrative notes but reserve precise entries (like medications) for manual input to avoid errors.

3	**Prioritize Real-Time Documentation** **Objective**: Reduce end-of-shift backlog and improve documentation accuracy. **Implementation Steps:** - Set a goal to document immediately after patient interactions whenever possible. - Break down documentation tasks (e.g., vitals, medication administration) and complete them in stages if real-time comprehensive entry isn't possible. - Identify specific cases where immediate charting is required and create a checklist for these instances. **Tip**: Use quick notes on mobile devices if available and finish documentation within the hour to maintain continuity.
4	**Batch Non-Urgent Documentation** **Objective**: Increase focus and speed by grouping similar documentation tasks together. **Implementation Steps:** - Identify non-urgent documentation tasks (e.g., non-critical vitals or progress notes). - Dedicate specific time blocks in your shift to handle these items in batches. - Communicate with colleagues to avoid overlapping interruptions during batch-documenting periods. **Tip**: Set reminders to review batch entries at the end of the shift to ensure all details are entered.

5

Use Abbreviations and Shortcuts Judiciously

Objective: Save time by using approved abbreviations and EHR shortcuts without sacrificing clarity.

Implementation Steps:

- Familiarize yourself with approved abbreviations specific to your facility.
- Create a list of common shortcuts and ensure they align with documentation standards.
- Train in EHR system-specific shortcuts (such as auto-populated text fields) to speed up repetitive entries.

Tip: Avoid over-relying on abbreviations for complex details where patient safety could be impacted