Peer Reviewed

Burnout, Exhaustion, and … It Is Not Just COVID

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I'd been waiting for the Email for days…. And there it was: The subject line, " IT would like your feedback on your recent interaction with tech support." My chance to be heard! There better not be any character limits on this one! My IT guy was a dream. [He} had me back in the system in no time. It's just that….. every other day I came to work, I had to call IT to sort out some new befuddlement with my access. Whether access to log on to the computer, the blood gas machine, or access to a patient's chart so I could document or Pyxis, this was taking time away from patient care every time I had to sit on hold while IT was experiencing higher-than-normal-call-volume. In the comments section, I wrote:

"Once, just once, I would like to come to work, log in to my computer, and get on with my day. As it is, I spend my first one to 2 hours each shift on the phone with someone to get me logged in. I find this an insane waste of time".

I sent a copy to administration with a gentle explainer that I am still expected to perform patient care whether on hold with or interacting with IT those first 2 hours.

CoVid has done a number on all of us in healthcare, no matter what our specialty. But the insidious increase in time stolen by our computers in the name of patient care has been going on for years. And we are not equipped to fight it. Or are we? As bedside patient care clinicians, can we fight back or otherwise revolt against this system and put things back the way they ought to be: Patients come first, with thorough documentation of only pertinent information. What is the correct protocol for the rebellion?

For example, if I make a ventilator change, I should also know what other parameters need to be accounted for as a professional. If I change the PIP, I should also document returned tidal volume, any change in O_2 saturations or $ETCO_2$, and chest rise or breath sounds. The system often requires that I document the entire ventilator check and allows a very dangerous practice of copying and pasting the last entry. Can we band together and let Clinical Informatics know this is not working for us? Several articles have shown that even 'mature' EHR's require that we spend approximately 1.5-time units documenting for every 1.0 time unit in actual patient care. But no one is factoring this into our workloads. (1, 2)

I read accounts by my fellow CoVid RT's in adult capacities of crazy workloads, constant codes being called, non-stop intubations, and HFNC and BiPap setups. When do they chart all of this? Did someone perhaps ingeniously develop a minimum documentation protocol for when things get crazy? Think 24-week triplets, and you are the only MD or RT on the unit. Or, a baby crumps requiring an oscillator, which needs to be found, set up, calibrated, and vents moved around. Then we must titrate to optimal settings and wait 20 min to draw the ABG. If I get called to a crash C-section in the middle of this, that will surely take priority over finishing documenting every change we made on the "crumping" baby.

Patient care always comes first, but staying late every shift to complete documentation on every last detail of every baby in the unit does not allow us the time off we need to reset and regroup.

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I am reminded of my last hospital, where a critical result on a CBG required 65 (yes, that is sixty-five) clicks of the mouse to enter a result per The Joint Commission (TJC) and College of American Pathologist (CAP) standards. I could have run to the MD and showed him the slip of paper and run back ten times by the time I met the requirement -- Not to mention the delay in care. This delay was not TJC or CAP's fault; this situation occurred because the modern ABG machine could not make a way to interface with our old, pieced-together, and patched-up EHR.

How can we get back to patient care truly being our focus? Can we talk IT into giving us a SOAP button for those days when we need to focus on what the baby is doing or not doing and lose extraneous charting parameters that, although they may be related, are not affected by the changes we made?

Many healthcare personnel left the field in the Spring when the pandemic calmed down, understandably so. Nevertheless, the undercurrent of a different pandemic – the need for more information and to cover us and our health systems in case of lawsuits- presents a different level of exhaustion and burnout. Instead of just allowing MDs, RNs, and RTs to leave in droves, why not start

a conversation about building a better (more straightforward) system. We built it; we can un-build it. Moreover, we MUST convince administration, IT, and insurance carriers that clicking boxes is not patient care.

References:

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Disclosures: The author is President of the Academy of Neonatal Care, A Delaware 501 C (3) not for profit corporation.

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