Editorial

Maximize Valuable Nursing Time by Eliminating or Reducing "Stupid Stuff"

The title of the article "Stop Stupid Stuff to Prevent Burnout" in the March 2019 issue of *Bold Voices* resonated with me.[1] This article reviewed a *New England Journal of Medicine* article, "Getting Rid of Stupid Stuff," which focused on the amount of time spent on documentation in the electronic health record (EHR).[2] Author Melinda Ashton noted that the definition of *stupid stuff* is subjective. Ashton surveyed hospital staff from a variety of disciplines to assess sections of the EHR that were perceived as redundant or inefficient workflow. Several suggestions were submitted by nurses and resulted not only in changes to the EHR but also to nursing workload, such as decreasing the frequency of routine checks of vital signs. A global Stupid Stuff campaign was implemented throughout the health system because of the success of the EHR project.[2] According to Ashton,[2] "there is stupid stuff all around us," and small wins have been made in her organization by acknowledging and improving daily work. She says that her program is still too new to realize measurable improvement in staff satisfaction.[2]

As acute and critical care nurses, we have heard messages from the American Association of Critical-Care Nurses (AACN) presidents to be guided by why, find our voice, and be unstoppable.[3] Collectively we have a stronger voice. We must continue to ask questions about our practices and processes. As a novice intensive care unit (ICU) nurse, I noticed a routine practice in my ICU that did not make sense to me. This practice resulted in a flurry of activity every 12 hours and demanded a high level of resources: Every nurse in our ICU performed patient bed baths and linen changes each 12-hour shift. I remember asking, Why are we spending so much of our precious nursing time doing bed baths and linen changes at 3 PM? The middle of the afternoon was a busy time when patients returned from surgery, patient consultations were being completed, family members were visiting, and diagnostic tests and procedures were being performed. Did all patients require a complete bath every 12 hours? Where was the evidence to support this practice? I was still naive to the practice change process, so I could not take credit for the practice change that resulted a few months later. Maybe I got lucky by expressing my concerns to the right person. We quickly adopted our unit-wide practice change to stop all routine afternoon baths and linen changes because there was no evidence to support this frequency of bathing. What a huge win for nursing time!

Getting rid of "stupid stuff" also brings to mind the idea of appropriate delegation. What is the most appropriate use of nurses' time? Are registered nurses doing work outside of their scope of practice? Are processes working with maximal efficiency in your workplace? Are you performing tasks that are not directly related to patient care? As a student nurse working night shift during my acute care practicum placement, I witnessed nurses cleaning the dirty utility

Annette Bourgault is Editor of Critical Care Nurse. *She is an Assistant Professor at the University of Central Florida in Orlando and a Nurse Scientist with Orlando Health. Dr Bourgault can be reached at annette.bourgault@aacn.org.*

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room sink as part of their routine night duties. I am hopeful that the nursing profession has evolved since then and that none of our readers are performing this task in their current practice. When nurses delegate tasks, 2-way communication is key to ensure that the delegatee has the necessary competencies to accept the activity and that the nurse is available to provide guidance, evaluate outcomes, and maintain accountability.[4] The 5 rights of delegation include (1) right task, (2) right circumstance, (3) right person, (4) right directions and communication, and (5) right supervision and evaluation.[4] The ultimate goal is to provide safe, ethical, and effective care.[4] Employers and nurse leaders also have a responsibility to develop appropriate delegation policies for their workplace to promote a positive work environment.[4]

On a more formal level, some organizations have started addressing "stupid stuff," using more professional terminology such as *routine tradition-based practices* or *low-value care*. Many clinical practices likely originated from expert opinion or a "good idea"; however, over time some practices have become unnecessary, not cost-effective, or even harmful. As more research is performed, evidence supporting a specific practice may shift, demonstrating that the practice is no longer relevant or could be harmful. A recent example of this practice shift is the warning about routine use of prophylactic low-dose aspirin to prevent cardiovascular disease. In a systematic review, Huang et al[5] found that the risk for intracranial bleeding was higher in those taking low-dose aspirin compared with control groups, which may outweigh the benefit of this preventative therapy in certain populations.

Since its inception in 2012, the Choosing Wisely campaign, an initiative of the American Board of Internal Medicine Foundation, has identified more than 300 tests and procedures that are inappropriate or overused.[6] The American Academy of Nursing refers to the call to action list as "tests and procedures that clinicians and patients should question."[6] The American Academy of Nursing has partnered with more than 80 professional associations to promote their evidence-based recommendations. A couple of practices that are aligned with acute and critical care nursing and endorsed by AACN include (1) avoiding use of urinary catheters unless clinically indicated and (2) not waking patients for routine care unless their condition or care needs require it.[7] More information is available on the Choosing Wisely website and app, and on Twitter (#choosingwisely).

As we look for opportunities to get rid of the "stupid stuff," we may find free time that can be spent on important initiatives that can improve patient outcomes, including hourly rounding and patient-centered communication such as bedside shift report.[8] We do not have time to keep adding practices into our busy schedules. We need to work smart and incorporate practices that make a difference for patient safety, quality, and (human connection) experience of care.[8]

Let us make a pact to remove, reduce, and delegate the stupid stuff—those things that do not make a difference or fall outside of our scope of practice. Let us think about how we can work smarter. As nurse leaders (every nurse reading this editorial), let us challenge each other to see how we can improve processes or communication or how we can delegate more effectively. Let us question the underlying evidence of our clinical practices. There may be plenty of ways to save time if we look for efficiencies. What would you do with your saved time? Spend more time with patients and their families? Take a deep breath during a busy shift? Provide positive feedback to one of your nursing colleagues? In our quest for safe, appropriate, evidence-based practice, let us follow the advice of current and past AACN presidents to be guided by why, find our voices, and be unstoppable. CCN

Annette M. Bourgault, PhD, RN, CNL, FAAN
Editor

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