An Exploratory Study to Review Written Nursing Documentation

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Background

> Reviews of nursing documentation have often used audit methodology, evaluating the process against pre-determined standards.
> Less is known about the ways in which the content describes the contribution of nursing to patient care (De Marinis et al, 2010).
> The aim of this project was to explore the language, content and themes present in clinical nursing documentation.

Methods

> Content analysis (Hsieh and Shannon, 2005) was used to analyse anonymised written nursing records from two in-patient wards between July and October 2016. Nine patient records from each ward were reviewed, each record containing seven consecutive days of nursing documentation.
> An initial thematic framework based on the 'Activities of Daily Living' (Roper, Logan and Tierney, 1980) was developed, three researchers then independently analysed two sets of patient notes to establish a coding consensus, and refine the thematic framework.
> The analysis of clinically derived nursing records did not identify the presence of a shared, cohesive approach within nursing documentation.
> There was evidence that this may have contributed to poor documentation practice.
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Discussion

> An initial thematic framework based on the Activities of Daily Living (Roper, Logan and Tierney, 1980) was developed, three researchers then independently analysed two sets of patient notes to establish a coding consensus, and refine the thematic framework.
> The findings suggested that nursing does not have an agreed approach to documentation, unlike that which is seen in other healthcare professions, such as medicine and physiotherapy.

Results

> A high number of repetitive statements with an unclear or non-specific purpose were present; many of these replicated or referred to aspects of care documented elsewhere.
> Overall there was a lack of coherence regarding the style of writing and the objectives of the entries, for example whether they aimed to describe, evaluate or recommend care.
> A diverse range of subjects were identified within the nursing records.
> This resulted in 126 days overall, around 252 entries, and 19,622 words that were analysed.
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Next Steps

> The findings will be used to support the next phase of the project; working with nurses at a local and national level to achieve a consensus on exemplars of statements that make a positive contribution to patient care.
> Further analysis will be conducted to explore additional aspects of the data.

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Word Cloud Showing their Frequency of Use

Non-specific care catheter changes charted concerns documents drugs bedbowels

Maintaining a safe environment Communication Nutrition and hydration Elimination

Family support

Mobilising

Sleep

Care liaison

Organisational

Death and dying

Referral to other nursing documentation

Nutrition and hydration

Mobilising

Personal hygiene

Sleep

Communication

Elimination

Nursing Documentation Coding Framework