



An Exploratory Study to Review Written Nursing Documentation

Elizabeth Lumley¹, Clare Warnock² and Dan Wolstenholme³

1. Research Associate /RGN, Sheffield Teaching Hospitals and NIHR CLAHRC Yorkshire and Humber, Health Services Research, ScHARR, University of Sheffield, SheffieldS1 4DA 2. Practice Development Nurse, Weston Park Hospital, Sheffield Teaching Hospitals, NHS Foundation Trust, Sheffield, S10 2SJ 3. Core Project Manager and Theme Manager, Sheffield Teaching Hospitals and NIHR CLAHRC Yorkshire and Humber, D Floor Royal Hallamshire Hospital, Sheffield, S10 2JF

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.
- 1. De Marinis, M. G., Piredda, M., Pascarella, M. C., Vincenzi, B., Spiga, F., Tartaglini, D., Alvaro, R. & Matarese, M. (2010) "If it is not recorded, it has not been done!"? consistency between nursing records and observed nursing care in an Italian hospital.' Journal of Clinical Nursing; 19 (11-12) 1544-52. doi: 10.1111/j.1365-2702.2009.03012.x.

Methods

> Content analysis (Hsieh and Shannon, 2005²) 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, 1980³) was developed, three researchers then independently analysed two sets of patient notes to establish a coding consensus, and refine the thematic framework.

> Following the initial coding, and discussion amongst the research team, a finalised thematic framework was agreed upon; coding on a further 16 sets of notes was then conducted by a single researcher using Nvivo QSR v.11.

2. Hsieh, H.F. & Shannon, S.E. (2005) 'Three approaches to qualitative content analysis.' Qualitative Health Research; 15(9) 1277-88. doi: 10.1177/1049732305276687. 3. Roper N., Logan W.W. & Tierney A.J. (1980). The Elements of Nursing. Churchill Livingstone. ISBN 0-443-01577-5.

Results

- > 18 sources of anonymised nursing notes each incorporating 7 days of nursing documentation with an average of 2 entries per 24-hour period were obtained.
- > This resulted in 126 days over all, around 252 entries, and 19,622 words that were analysed.

Findings

- > A diverse range of subjects were identified within the nursing records.
- > 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 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.
- > A small number of statements that reflected nursing activity more effectively were present.

Word Cloud Showing their Frequency of Use

amounts appears areas assistance bed bowels

Care catheter changes charted Concerns

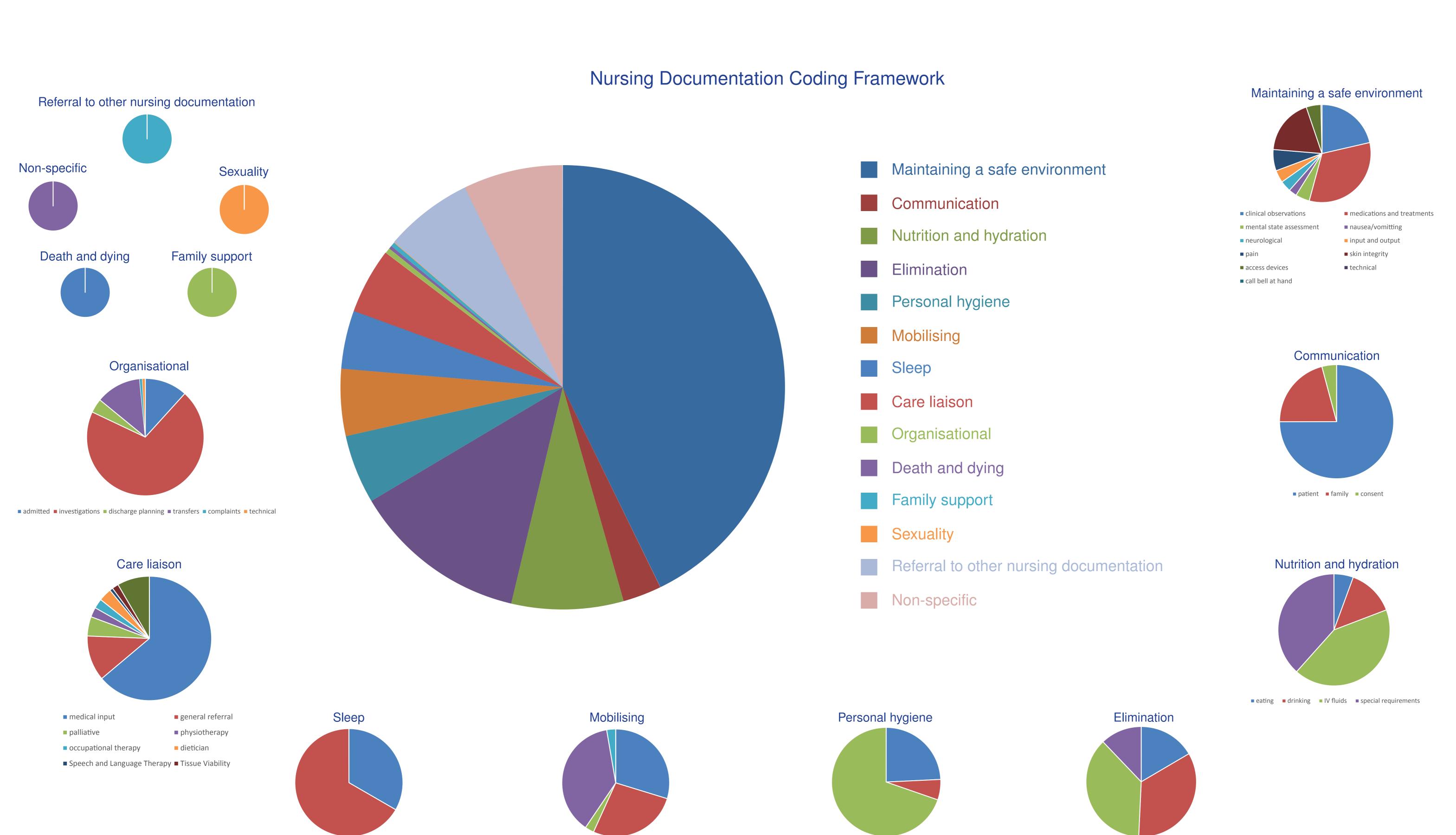
continues diet documentation prdraining due feed

maintained Medications morning needs

nursing observations opened overnight

pain patient per periods prescribed present

pressure recorded remains score settled shewslept SN stable taken urine ward



Discussion

> The analysis of clinically derived nursing records did not identify the presence of a shared, cohesive approach within nursing

■ disturbed ■ rested

- documentation. > There was evidence that this may have contributed to poor documentation practice.
- > The findings suggest that nursing does not have an agreed approach to documentation, unlike that which is seen in other healthcare professions, such as medicine and physiotherapy.

Next Steps

- > This objective analysis of nurses' written records provides useful insights into current practice in nursing documentation.
- > Further analysis will be conducted to explore additional aspects of the data.

■ bathing ■ dressing ■ oral care

> 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.

passing urine bowels catheterised incontinent



sitting in chair bed wheelchair equipment needed falls risk assessment