DOCUMENTATION IN THE DELIVERY OF NURSING CARE: AN EXAMINATION OF NURSES' ATTITUDES ABOUT DOCUMENTATION IN INSTITUTIONAL SETTINGS

THESIS

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CHAPTER 1

THEORETICAL FOUNDATION

I have always had a fascination with nursing documentation, broadly defined as the written record of care provided by a nurse to a patient. From my early days as a nursing student learning my way through a patient's chart during clinical rotations, to my current work as a nurse analyst reviewing charts for indications of medical fraud and abuse, there is something about the variety of ways in which health information is collected, assembled, and presented that intrigues me. In fact, several years ago I told a nursing student classmate that I found as much challenge and interest in trying to piece together a clinical representation of the patient from the documentation in the chart as I did from performing a head-to-toe physical assessment. To me the content of patient's chart represents a window to discovery.

During my many years of clinical nursing practice I have been exposed to several different styles of written documentation, also know as "charting," in a variety of health care settings. Originally trained to document in a narrative manner, I enjoyed the challenge of trying to craft the perfect entry in a patient's chart and saw the blank page of nurses' notes as a canvas that provided the opportunity to paint a picture that reflected my observations and interventions. The fact that I was responsible for accurately recording a clinical snap-shot in time upon which others might base, or withhold, treatment was

something I did not take lightly; and rightly so. Although I did not have a grasp of discourse theory and analysis at that time, I have since learned how powerful language is.More specifically, when I apply the poststructuralist approach to language use, I recognize that the charting provided access to that patient's "reality." Events are ascribed meaning through our language use, and it is these meanings that constitute our world. Within the discursive practices of medicine and nursing, my choice of language constructed a story that contained content *and* function (Hardin 14).

As the nursing profession has evolved over time, methods of communicating the aforementioned clinical snap-shot have also evolved. When a certain method of charting reveals it is flawed in some way, a new method is instituted in its place in the hope. But do the problems associated with flawed documentation lie in the method of documentation or in the documenter? Institutions place blame on the documenter and in an effort to minimize the potentially damaging effects of imperfect documenters, they often adopt standards of documentation, typically dictating when and how nursing information is communicated. These standards include requirements such as how frequently an entry should appear in the chart, what information is important to document, and in what format. Nurses communicate both verbal and nonverbal information across inter-and multi-disciplinary ranks every day in the clinical workplace, and it is the charting to which they are held most accountable.

In theory, the role of written documentation in the practice of nursing is two-fold: first, to communicate what is happening with the patient along with the nurse's subsequent intervention and, second, to provide useful information that supports the inter-and multi-disciplinary continuum of care (Mohr 1). The documentation of nursing

interventions is the evidence of a nurse's contributory role in the overall provision of health care and is even one criterion by which the quality of that care is measured. In fact, a well-known maxim in the nursing profession is that, "If you didn't document it, you didn't do it." This maxim became mantra as a result of Kolesar v. Jeffries, a case presented before the Canadian Supreme Court in 1978 in which a hospitalized post-operative patient aspirated and died during the night (Chow 1). Because nothing had been charted on the patient between 2200 and 0500 hours, the Supreme Court concluded that nothing had been done. In other words, because there was no entry in the medical record, the assumption was that the patient had not been checked throughout the night. The lesson here was that failing to adequately document a finding or intervention can adversely impact a nurse, and that nurse's institutional employer, both professionally and legally.

The information nurses document ranges from objective, quantifiable measurements of a patient's condition, such as vital signs or telemetry readings, to more subjective assessments, such as cognitive awareness and compliance. The manner in which nurses document these findings and their interventions varies from institution to institution and even from specialty to specialty. The discursive practices of different nursing specialties often warrant different documentation methods and so a universal standardization of these practices across specialties has not yet been feasible, although standards do exist within particular specialties. This leaves it up to institutions to bear the responsibility of enforcing documentation practices that they decide would best suit each specialty, conform to the standards of accrediting bodies, and protect themselves and their staff from litigation.

The three most common types of charting nurses use to communicate are narrative, charting by exception, and electronic. Briefly, narrative charting consists of free-form writing and requires a certain degree of skill in composition in order to clearly communicate observations. For example, to document the simple assessment of a wound dressing the nurse might write, "The 3x5 dressing to the left anterior thigh surgical site is intact and approximately 30% saturated with new serosanguineous drainage. The margins of the drainage were marked at 2200 hours." In more comprehensive charting entries, the acronym "SOAP" guides the order in which the nurses' findings are recorded. "S" stands for Subjective – what the patient states (for example, "I'm in pain"). "O" is for Objective – what the nurse observes (e.g., the patient is grimacing and clutching his leg). "A" stands for Assessment – the nursing diagnosis (e.g., Alteration in comfort). "P" is for Plan – the plan the nurse has formulated to address the identified issues (e.g., administer pain medication as ordered). This charting entry is problem-specific. The information obtained during a head-to-toe assessment would be recorded under the objective section.

Charting by exception, on the other hand, primarily consists of structured check-boxes. This approach presumes the patient's review of physiological systems is normal unless otherwise noted. Charting by exception has been criticized as being fragmented and rigid because the standardized protocols inherent to this method are based upon a prediction of outcomes (Dumpel, et al.). What this means is the presumption that everyone's "normal" state is the same.

Electronic (computerized) charting, a technological approach to recording nursing observations and actions, is most often a blend of these two previous methods. Electronic charting software contains fields similar to checkboxes as well as fields suitable for

narrative comments. My experience with electronic charting has been that it can have limitations when a clinical situation does not fit the configuration of the software program.

A universal concern of nurses is that institutional documentation standards are often at the core of what keeps them focused on the paperwork rather than on the patient. One study showed that a nurse may spend as much as one-half of his or her workday completing or shuffling papers. At one New York City medical center, for example, nurses are required to fill out the same nine-page assessment form on all patients, regardless of whether the patients are staying 24 hours or 24 days. This translated into decreased time at patients' bedsides and decreased employee satisfaction. According to one spokesman for the New York State Nurse Association, nurses sometimes leave their positions because they are often buried in record-keeping and need to stay after their shifts completing paperwork (Trossman 2).

Another concern is that the specific manner of documentation enforced by institutions often leaves little room for independent decision making as it relates to what information is important to document. Although I might prefer to document my findings and patient interactions in a narrative format on paper, others may prefer to chart by exception on a computer screen. What I might view as my artistic and professional contribution to the clinical continuum of care another nurse may view as an exercise in composition simply to avoid litigation. The style of documentation is only at the surface of the dilemma, however.

Some argue that no matter what style of documentation nurses use, the documentation itself is of little value. As Marie Heartfield observes, "attempts to meet

ethical, legal, medical and institutional guidelines have influenced nursing records to the point whereby the records are often sufficiently sanitized barely to represent what has actually been done" for the patient. Heartfield argues that while nursing documentation serves to reveal nursing care to some, it is actually dismissed by others in the field as a misrepresentation of that care (98). Additionally, according to Trossman,

> Nurses blame excessive paperwork on the ever-growing list of state and federal mandates, some of which were put in place to reduce fraud and sub-standard care. They also fault: accrediting groups such as the Joint Commission on Accreditation of Healthcare Organizations, which reviews paperwork as part of determining an institution's quality; health care facilities, which can go overboard in trying to comply with various rules and regulations; and today's litigious society, which pressures nurses and health care providers into creating a detailed paper trail (4).

Trossman also found, for the most part, that nurses see paperwork merely as legal documents and not something that adds to their nursing practice. In nursing school we were taught to "nurse the patient, not the chart," but at this point there doesn't seem to be a way to satisfy that requirement because, in a sense, the chart is a symbol inextricably linked to the patient. What transpires in the nurse-patient interaction must be accurately reflected in a written format to document its occurrence and constitute its meaning.

A preliminary review of existing literature shows that there is a plethora of quantitative studies that examine the implications nursing documentation has on nursing practice, adherence to standards, and litigation. For example, Menke, et al., conducted a study to determine if implementing a computerized documentation system (CDS) in a

pediatric intensive care unit: 1) Decreased the amount of time nurses spent charting and, therefore, increased the amount of time at the bedside; 2) reduced the number of medication errors; 3) improved decision making in the clinical setting; 4) improved the quality of the nurses' documentation; and 5) improved the patient report exchanged during shift change. The researchers used a pretest-posttest design to measure outcomes and found, overall, the CDS improved these five aspects of care delivery. The evaluation of the change of shift report was measured using a Likert scale questionnaire on which the nurses rated their attitudes toward the shift report experience as well as the amount of time it took to complete the shift report (2).

Many studies such as that by Menke, et al., quantitatively assess a variety of elements related to nursing documentation; however, no substantive amount of qualitative research currently exists that specifically examines nurses' attitudes regarding this form of technical communication (charting), a situation that reflects the idea that nurses' attitudes about documentation are not important. In fact, no studies I have found thus far even distinguish nursing documentation as a form of technical communication when it is, in fact, a subset of technical documentation and, as such, is subject to the same measures of usability and effectiveness.

Because of my experiences with both the study of technical communication and nursing, I have developed an appreciation of the importance of the interplay between the discursive practices of nursing and the hands-on practice of nursing. My nursing experience tells me that it is not possible to capture the essence of nursing in documentation and yet the documentation is the evidence of our profession, the voice that we have to construct our competence. Further, my technical communication education

and experience has taught me that language is more than a string of innocuous words, but is, instead, the means by which we construct reality.

Because of the key role nursing documentation plays in the overall contribution to a patient's clinical picture, nurses' attitudes towards the various types of technical documents, as well as institutional documentation standards, warrants further examination. This qualitative study of nurses' attitudes about institutional standards of documentation addresses this gap in the research to-date.

I began with a review of the literature to explore nursing as a discourse community to define what constitutes its discursive practices. It was also important to me to establish charting as a form of technical communication and, consequently, to examine how those discursive practices might impact this type of technical communication and those who practice as technical communicators in the context of nursing. For the purposes of this study, I chose to perform qualitative interviews with six nurses (participants) and me in addition to a review of existing literature on the topic of nursing documentation. Throughout this study I will use the terms "nurses" and "participants" interchangeably.

I developed the following interview questions with the intent to elicit insight into how the nurses view their written contribution to the continuum of care, defined as uninterrupted treatment encompassing all aspects of care, as well as how their writing conditions and practices are influenced by institutional standards and formats.

Research Questions:

To better understand how mandated documentation practices affect nurses' attitudes, I developed the following research questions:

What attitudes and perceptions do nurses hold about institutional nursing documentation standards and formats?

- How do nurses perceive the role of nursing documentation in practice?
- What problems do nurses perceive with specific types of nursing documentation?
- How do nurses address or resolve these problems?
- How do nurses bridge the gap between excessive documentation and falling victim to the maxim of, "If you didn't document it, you didn't do it?"

A complete list of the interview questions can be found in Appendix A.

After examining both my participants' responses to the questions and reflecting critically on my own experience with nursing documentation, my argument for this thesis is that the majority of nurses do not oppose institutional standards of documentation; rather, they view them as safety nets that protect them from litigation. What they do resent, however, is the fact that institutions choose standards based on what seems to be in the best legal interests of the institution, rather than the preferences of the nurses. In other words, the nurses appreciate the need for institutional standards, but they feel they shoulder the burden of protecting themselves *and* the institution in today's litigious clinical climate. The questionnaire responses revealed an underlying oppositional attitude toward the role nursing documentation realistically plays in institutional settings versus the role nurses feel it should play and the fact that the standards imposed by the institution dictate that role.

I also found something unexpected. The participants' responses revealed that while they did not generally oppose standards of documentation, their documentation preferences showed that they differed on how they viewed, and used, their writing. I will explore this idea further in subsequent chapters.

Research Methods

The choice of a research method should be determined by what one is trying to learn (Seidman 7). As Liebscher argues, "A quantitative research methodology is appropriate where quantifiable measures of variables of interest are possible, where hypotheses can be formulated and tested, and inferences drawn from samples to populations. Qualitative methods, on the other hand, are appropriate when the phenomena under study are complex, are social in nature, and do not lend themselves to quantification" (669). Quantitative research is based primarily on positivist thought while qualitative research is more constructivist in theory. Where quantitative research seeks to describe observations through a statistical analysis of measurable data, qualitative research seeks the elucidation and understanding of specific circumstances. The knowledge we glean from qualitative research is situational and conditional (Fierro 129).

For this phenomenological study I chose to engage the participants in the qualitative research method of interviewing. More specifically, I selected a two-prong strategy of a written questionnaire and follow-up telephone interviews. The written questionnaire was a feasible fit with the nurses' busy schedules and our established rapport was central to achieving what Seidman, in his book *Interviewing as Qualitative Research,* calls the "We" relationship in interviewing (80). According to Seidman, the goal of the interviewing relationship should be to go beyond an intersubjective

understanding of one another, known as the "I-Thou" relationship, but to stop short of creating a full "We" relationship in which the "I-Thouness" is mutual (80). Seidman argues for a balance between these two states in order to "preserve the autonomy of the participants' words and to keep the focus of attention on his or her experience rather than (the interviewers)" (80). In this respect, my rapport with the participants fit quite well with Seidman's recommendations. Although I had primarily professional associations with all of the nurses, I had not interacted with several of them in a couple of years. Additionally, some of the participants worked in specialties in which I had no previous professional experience. This also contributed to respect of their autonomy because I could not supplement the interviews with similar stories and, thus, risk distorting participant responses. Seidman warns that sometimes in the spirit of establishing rapport interviewers share their own experiences with the study topic. This practice can skew what the participant reconstructs in the interview (81).

Interviewing seemed to be the most logical method of inquiry in a study involving language. Additionally, I used a qualitative interview approach because I was more interested in collecting the nurses' *stories* about charting than I was in measuring their level of satisfaction or dissatisfaction in a quantitative way, as plenty of data of that nature already exists. It was more important to me to temporarily enter their worlds to capture and understand their experiences as it related to the study. Just as I had my personal opinions and preferences regarding documentation methods based on my experience in a clinical setting, it seemed only fitting to use a method that would reflect as closely as possible what the participants' attitudes and perceptions were in the context of their clinical experiences and the meanings they applied to those experiences. In this

way, I might validate the importance of nurses' perspectives on the work they are primarily responsible for.

After obtaining their consent to participate, I chose to e-mail the participants the questionnaire of open-ended questions. Open-ended questions establish "the territory to be explored while allowing the participant to take any direction he or she wants" (Seidman 69). Because my study was an examination of documentation methods, I chose to provide the participants a questionnaire on which they had to write their responses in a narrative manner. I decided to interview in this manner because, according to Seidman, "Recounting narratives of experience has been the major way throughout recorded history that humans have made sense of their experience" (2).

Seidman's qualitative research approach presents a format for in-depth phenomenological interviewing that provides a method for researchers to understand the meaning of participants' experiences. This three-interview series is designed to ensure that the researcher establishes and understands the participants' experiences "within the context in which it occurs" (11). This format dictates that three separate interviews are conducted with each participant: "The first interview establishes the context of the participants' experience. The second allows the participants to reconstruct the details of their experience within the context in which it occurs. And the third encourages the participants to reflect on the meaning their experience holds for them" (11).

Using this three-interview series as a guide, I modified the first interview approach of putting the participants' experience into context by only asking how long they had been nurses and their respective areas of specialty. I did not further explore their life histories or how they became involved in nursing as a profession. I did not think there

was a need to include these constitutive aspects of their lives for the scope of this particular study, although there is certainly the potential for examining how these events might direct one to the profession of nursing in the first place.

The purpose of the second interview, according to Seidman, is more concrete in nature. It is during this phase of interviewing that participants share the details of the experiences that constitute their opinions of the study topic (12). On the questionnaire provided, the nurses were asked open-ended questions ranging from how standards of documentation influenced their daily practices to how they felt about their documentation experiences. Qualitative interviewing is a valuable way of finding out what others feel and think about their worlds (Fierro 128).

Interview number three is reflective in nature. In it the participants are asked to try to make meaning of their experiences. In this phase of the research process, the researcher goes beyond what is directly and begins to find themes, relations of meaning not immediately evident in the text. In this third step I was able to explore in-depth the participants' experiences in a way that was tailored to their responses. I found that I rarely asked two nurses the same follow-up questions; rather, I used their selective events as springboards to investigate a variety of viewpoints. I found that the participants disclosed more information talking to me about their experiences than writing about them, which revealed to me a limitation of my approach that I had not previously considered.

Limitations

Many avenues of inquiry exist when conducting research, and there are limitations associated with any approach. While questionnaires are considered useful

collaborative tools when researchers also pursue other data collection strategies, I found that the convenience of e-mailing these tools also limited the data I got in return. This was apparent when I received the questionnaire responses and found that one nurse skipped two questions entirely, another was unclear about what I was asking in one of the questions, and a third provided an answer to a question that wasn't asked. Additionally, two of the nurses supplied fairly short written answers. These two nurses, incidentally, primarily use the charting by exception method.

I compensated for the questionnaire method by initiating follow-up telephone interviews with available participants, but I believe I would have received more complete answers on all questions had I conducted initial face-to-face interviews. According to Nelson and McGillon, there is no "pure space" from which voices speak, especially in the interview process. In their study examining contemporary narrative use in nursing, they cite research that suggests "the very engagement in a research project sets the parameters of the invoked narrative." Subjects come to the interview having had a range of discourse occasions from which "to select a model that seems most appropriate and with which they are most comfortable in the circumstances" (633). Unfortunately, the dilemma was finding a convenient time during which to interview participants who work shift work, often for 12 hours at a time.

The questions I explored during the telephone interviews were based on the participants' written responses and these issues and opinions did not seem overtly complex or especially well-thought out. That makes me wonder how well they understood the nature of this study. I'm curious how the nurses' initial responses would have differed had we engaged in a dialogic interview versus a written one because I'm

certain they would have shared more stories or reconstituted experiences in a different way. A face-to-face discussion would have enabled the nurses to ask me questions about the study and that perhaps would have given them a better frame of reference from which to frame their responses.

Last, I wonder how the nurses felt about having to write about their writing experiences. Did they answer my questions during work hours in between episodes of professional charting? Did they answer them at the end of the day when there were perhaps tired of charting? Or did they complete the questionnaire when they were off-duty? Face-to-face interviews may not have competed with their other writing obligations.

Initially I chose to have the nurses write their responses because I wanted to assess how they write and how they feel about their writing, but now I wonder if the questionnaire approach was more of an inhibitor than not. If I were to ever conduct a study of this nature again I would opt to conduct interviews in person because, again, the participants spoke more than they wrote. Perhaps this is also an indicator of how they feel about writing in the first place.

Informed Consent

According to Seidman, the intent of informed consent is the protection of both the researcher and the participant. By obtaining informed consent from study participants, researchers protect themselves against misunderstandings regarding the range and purpose of their study. The impetus to protect study participants originally stemmed from the atrocities suffered by human subjects at the hands of Nazi researchers during World War II (49). Today informed consent is legally necessary when research is federally

funded, but Seidman believes that seeking written consent to participate in research is both ethically and methodologically desirable (50). With that in mind, I used Seidman's guidelines below to develop my consent form:

- *Who, what, and for whom?* – Participants knew who was conducting the study, the purpose behind the study, and what they were being asked to do.
- *Risks* – The consent form indicated any risks or vulnerabilities (or lack thereof) the participant may face by participating in the study as well as how the researcher planned to minimize those risks.
- *Voluntary nature or participation* – Participants were free to agree or decline participation.
- *Anonymity* – I included a statement that indicated the results of the participation would be anonymous and would not be released with identifiable information.
- *Dissemination* – The consent form implied that the results might be published and that the study participants would receive an electronic copy of the study summary at the conclusion of the research.

A copy of the consent form can be found in Appendix B.

Participants

According to the Occupational Outlook Handbook, Registered Nurses constitute the largest healthcare occupation, with approximately 2.3 million nursing jobs in the United States. Professionally,

> Registered nurses (RNs) work to promote health, prevent disease, and help patients cope with illness. They are advocates and health educators for patients, families, and communities. When providing direct patient care, they observe,

> assess, and record symptoms, reactions, and progress in patients; assist physicians during surgeries, treatments, and examinations; administer medications; and assist in convalescence and rehabilitation. RNs also develop and manage nursing care plans, instruct patients and their families in proper care, and help individuals and groups take steps to improve or maintain their health. While State laws govern the tasks that RNs may perform, it is usually the work setting that determines their daily job duties.

RNs may earn a Diploma, an Associate's Degree, or a Bachelor of Science degree in Nursing. Additionally, nurses must pass a national licensing exam to obtain a license to practice. Nurses may also earn graduate and doctoral degrees in Nursing in a variety of areas, which range from clinical to administrative specialties.

Eight female RNs were contacted via e-mail to participate in this study. I considered contacting male nurses, but do not currently know any male nurses in clinical practice. The six nurses who volunteered to participate in this study are former co-workers in some capacity. Two contacts did not respond to my e-mail request to participate.

Seidman cites several benefits of making initial contact via e-mail: It is informal and the participant can deal with the request if and when she wants. Additionally, "e-mail may seem less aggressive than the telephone and be more timely than conventional mail" (41). Seidman also points out that whatever the method of initial contact, it is important to be serious in your request but also maintain a friendly tone. I stated in my initial contact that I was requesting the participants' help because not only did I respect them as healthcare professionals, I considered them friends as well.

Although I did not work in the same clinical area at the same time with any of the participants, they all have clinical experience either in inpatient (hospital) settings or outpatient (clinic) settings. My initial focus was going to be on the attitudes and perceptions of nurses in a hospital setting, but as I further considered the scope of nursing documentation, I realized that nurses document wherever they practice and, as such, will hold perceptions and attitudes about the institutional standards to which they are held. Because of this, I was curious to see if any common themes would emerge among the various specialties. Following is a brief background on the nurses who participated in the study.

Nurse A has been an RN for 17 years. She holds an Associate's Degree in Nursing and brought to the study her viewpoints regarding institutional standards of documentation from home health and occupational health backgrounds. Home health nurses provide nursing services to patients at home and care for a broad range of patients. They must be able to work independently and may supervise home health aides. According to the *Occupational Health Outlook Handbook*:

> *Occupational health nurses*, also called *industrial nurses*, provide nursing care at worksites to employees, customers, and others with injuries and illnesses. They give emergency care, prepare accident reports, and arrange for further care if necessary. They also offer health counseling, conduct health examinations and inoculations, and assess work environments to identify potential or actual health problems.

Nurse B has been an RN for four years and holds two Bachelor degrees: one in psychology and one in nursing. Her clinical background includes inpatient labor and delivery as well as outpatient ophthalmologic services. This second style of nursing constitutes office nursing:

> *Office nurses* care for outpatients in physicians' offices, clinics, ambulatory surgical centers, and emergency medical centers. They prepare patients for, and assist with, examinations; administer injections and medications; dress wounds and incisions; assist with minor surgery; and maintain records. Some also perform routine laboratory and office work (*Occupational Outlook Handbook* - online).

Nurse C holds a Bachelor's degree and has been an RN for 10 years. She contributed input from her experience providing care in an inpatient setting, most recently on an orthopedic surgical unit at an Austin-based hospital. Her practice consists of providing bedside nursing care consistent with accepted treatment protocols according to the patient's diagnosis as well as carrying out medical orders for care written by physicians.

Nurse D has been an Intensive Care Unit (ICU) nurse for 10 years and currently works in an Austin-based hospital. ICU nursing, also called "critical care nursing," is a specialty within nursing that deals with managing patients who have life-threatening illnesses. ICU nurses primarily engage in charting by exception and typically chart on a patient's status at least every hour.

Nurse E has been an RN for 18 years, holds a Master's Degree in Nursing, has a background in nursing education, and currently works in an ICU setting in an Austin-based hospital. It was Nurse E who suggested I include in this study how long each of the participants has been a nurse. The thought behind this suggestion was that perhaps the attitudes and/or perceptions of institutional standards of documentation, and perhaps even the preference for various methods of documentation themselves, are influenced not only by specialty, but also by how long a nurse has been practicing. This proved to be a valuable observation.

Nurse F has been an RN for 11 years. She brings experience as a nurse who has managed a practice specializing in cosmetic procedures, such as vein sclerotherapy and Botox procedures. Additionally, she has as her most experience a unique form of telephone nursing. Telephone nursing in this context is one of reaching out to patients who are at risk of developing chronic health conditions. She talks with patients in a way that empowers them to make the necessary changes in their lives so chronic conditions don't develop or existing conditions don't worsen.

I included myself and my own nursing experience in this study. I have a Bachelor's Degree in Nursing and have been a nurse for 15 years. I began my career as an Army nurse and have practiced in medical/surgical, pediatric, home health, outpatient surgical, clinical education, and utilization review settings. I am no longer in clinical practice. I now review and analyze the practice of other health care providers in an attempt to identify fraud and abuse. My contributions to this study stem from my past experience in clinical practice.

I purposefully selected nurses who could bring to this study broad and varying perspectives based not only on practicing specialty, but also the amount of time they've spent in the profession and their respective academic experiences. The variation in sampling was done to allow for a wide range of experiences across the profession. As Seidman argues, "the range of people and sites from which the people are selected should be fair to the larger population. This sampling technique should allow the widest possibility for readers of the study to connect to what they are reading" (78). By including a wide variety of specialties, (home health, intensive care, inpatient, outpatient, occupational health, and telephonic), the results of this study will be of interest to a similar variety of readers.

The following chapters discuss my literature review, findings, and conclusions. The literature review will provide broader insight into the core of nursing, the relationship between technology and nursing, the discursive practices of nursing, and nurses' attitudes and perceptions regarding institutional standards of documentation. The overview of findings and conclusions will focus both on common threads in the nurses' responses to the survey questions as well as implications for future research. These threads include the notion that the majority of nurses view documentation standards primarily as protection for the institution, and that the role nursing documentation realistically plays in the delivery of patient care is not consistent with the role the nurses think it should ideally play.

CHAPTER II

REVIEW OF LITERATURE

Nursing and the Phenomenon of Caring

"Doctors cure and nurses care" was the message proudly displayed on the chalkboard when I walked into my "Fundamentals of Nursing" class on the first day of nursing school many years ago. While I don't recall whether it was written to evoke controversial discussion or as a preview of what the profession expected of us, I do recall feeling a slight wave of uneasiness as I took my seat in the lecture hall. After all, I had entered the profession because of an interest in science.

Nursing has been described as a noble profession and a terrible job. Jane Sumner and Judith Townsend-Rocchiccioli are nursing professors who authored an article on why nurses leave nursing. In it they describe nursing as emotional work that "traditionally has embraced the concept of duty and obligation, which involves self-abnegation" (168). Historically, nursing has been viewed as a form of women's work which was characterized by altruism, virtuosity, and a need for caring concern of others (Crowe 965). In her study on the nurse-patient relationship, Crowe quotes from a 1953 article on nursing and human relations that demonstrates how the literature reinforces the idea that caring is situated in the domain of nursing:

> Nursing is a calling and a mission – there is no higher mission in...life. In nursing a woman may not reach the ideals of her soul, she may fall far short of the ideals of her head, but she will go far to satiate the longings of the heart from which no woman can escape – Girls want to nurse because they have a great desire to help; instinctively they are drawn to protect the weak and the helpless, and they want to spend themselves in the service of others (965).

These comments construct women's "natural" preference for nursing, a construction that is perpetuated even today. Crowe cites comments from a 1995 article that provide insight into what the literature has put forth regarding the behavior expected of nurses:

> What is required is that the nurse acts in a reliable and disciplined way, if not carrying out explicit orders, then following set routines. A demeanour of deference rather than independence of mind and a questioning stance is what is called forth...the system is one that undermines the contribution she can make and sets up constant questioning about the quality of care delivered (967).

Certainly, caring is a key feature in nursing practice but this very attribute also constitutes a problem. How does one measure caring? How does one manage caring? In this sense, the caring aspect of an emotional profession is hardly quantifiable and when something cannot be measured, it can sometimes be rendered invisible (Crowe 966).

Is the emphasis on caring actually doing a disservice to nursing? John Paley explores the ideology of caring as a "slave morality" using an examination of Nietzschean themes in nursing ethics. Paley explains his genealogical approach, borrowed directly from Nietzsche's Genealogy of Morality:

> That book argues that the values associated with caring are the expression of a profound resentment, harboured by the slaves (weak, powerless, timorous) against the nobles (strong, powerful, self-confident). Caring represents an inversion, a sort of fantasy revenge, in which the nobles can be portrayed as evil, while the slaves portray their own weakness as good. Taking its cue from Nietzsche, (Paley's) paper shows that the Genealogy narrative can be transposed into a modern health care context, with nurses as the slaves and the medical profession as the nobles (1).

In other words, the caring paradigm that has been established as central to the practice of nursing, even one of its defining factors, is actually motivated by resentment against the depersonalizing, unfeeling, scientific stance of medicine. Strength (that derived from the domain of medicine) becomes evil and by the act of choosing not to engage in medicine, nurses voluntarily assume a position of weakness. Further, nurses use caring in an effort to feel superior to physicians and use their weakness as grounds for self-congratulation. In this manner, nurses essentially solidify their lower status in the health care hierarchy.

I witnessed a textbook example of this during an interaction between one of the nurses in the study and another healthcare professional when I met with her at work to pick up her survey responses. The nurse had gone down to purchase her lunch from the hospital cafeteria. When she returned she set her lunch down at the nurses' station (first mistake) and began to socially chat with me (second mistake) while another healthcare professional was in one of her patient's room administering care. Through these actions, she violated an unspoken rule in health care: if you're visible, you're available. The other

healthcare professional came out of the room, approached the nurses' station, and asked the nurse if she could help her move the patient. The nurse responded that she would help her, but when the other healthcare professional walked away she turned to me and said, "Gee…it's not like I wanted to eat or pee today anyway!" I excused myself so she could get back to work and mulled over that interaction on the way back to my car. Her resistance appeared to mirror Nietzsche's theory of caring as a slave morality. Her response also reinforced Sumner and Townsend's point; namely, nurses tend to have "an ideal of service and duty above self, tending to others regardless of personal need and deprivation" (164). Even though the nurse verbalized opposition to self-deprivation, she uses the opportunity to demonstrate to an "outsider" the extent to which she sacrifices, rather than delegating the request to someone else.

Paley goes on to call the caring paradigm "disingenuous" and "pathological," but he points out that while there is no objection to the act of caring itself, it is when caring is applied as an ideology that it becomes objectionable (9). In a fascinating study titled, "Troubling Distinctions: a Semiotics of the Nursing/Technology Relationship," Margarete Sandelowski, from the University of North Carolina School of Nursing supports Paley's assertion by arguing:

> The alignment of nursing with feminine caring serves to reduce nursing to what is generally conceived as a natural female attribute requiring no special knowledge or skill and thereby to undermine nurse' claims to special knowledge (202).

But nurses seem to care about caring. Sumner and Townsend, in their article on why nurses leave nursing, remark that it is the emotional intimacy nurses share with vulnerable patients that keeps them coming back in the face of day-to-day stressors. Their

comments indicate that nurses, although they would deny it, need to be recognized as heroes by the "highly stratified, gender segregated, hierarchically organized" system in which they, (excuse the term), slave every day. They state that while nursing embraces the concept of duty and obligation, nurses either consciously or subconsciously crave acknowledgment of how special they are and how special their role is (166).

According to Paley, one remedy to salvage the profession is for nursing to more readily embrace science rather than reject science (9). The authority of physicians and medicine's domination of health care rests on a framework derived from the scientific model. Nursing needs to build empirical knowledge on its own distinctive domain, but this will require a slave revolt of sorts. Perhaps because caring is so integral to the discourse of nursing, discourse is the most logical place to begin the revolt. Hardy, et al, cites research by Crowe arguing that because nursing practice is shaped by managerial discourse, "nursing discourses that promote caring and interdependency represent increasingly problematic constructs in a dominant culture of managed health-care" (201).

Changing the status quo will take a slave revolt from within because nurses themselves tend to value scientific/medical discourse over nursing's own discourse, particularly in critical care settings (Sumner and Townsend 167). I have been guilty of this practice as well. I always had an affinity for medicine's discourse and on my first nursing unit began a "Medical Word of the Day" program in which I referenced a medical dictionary and introduced a new medical term daily. Sometimes I would choose a word a doctor used that I didn't fully understand or one that a resident had misspelled in a patient's chart. My intent with this program was to help build the vocabulary and, thus,

the knowledge of the nurses on the unit. Even as a newly-graduated nurse I recognized the importance of being able to articulate one's knowledge.

Sumner and Townsend-Rocchiccioli support the opinion that there is a sort of "truth status" to medical/scientific discourse that has usurped nursing work, generally perceived as caring work. They state that as more "hard" knowledge about diseases and treatment has evolved, the physician has become the dominant power in this process. They argue that "this has meant medicine dominates nursing because society values the knowledge of processes of the body far more than the ability to care for the diseased body" (167). Nursing involves caring for the "whole" patient: his or her spiritual, emotional, and social needs. And while these aspects of care may be the very thing that draws some into the profession, it is, again, these very things that may not be evident in the process by which success in nursing is measured: documentation.

It should be possible for the ineffable qualities of caring and sound scientific discovery to coalesce. Nurses are in a prime position, by virtue of their exposure to the many aspects of health care, to contribute to the "knowledge economy" of the profession.

In broad terms, knowledge economy refers to the technological infrastructure of knowledge and the increasing shift in the treatment of knowledge itself. The creation and appropriation of knowledge becomes a commodity for the knower (Drummond 58). Nursing knowledge is fashioned when nurses take clinical risks, act outside standardized care practices and, thus, position themselves as "experts" (Hardy 200). Articulating expertise can be enhanced when nurses espouse science and technology but, traditionally, this relationship has been problematic. Following is a discussion on the sometimes troubling history of nursing's relationship with technology.

Nurses and Technology

Nursing became my profession of choice because, quite frankly, the math looked too hard to pursue marine biology as a major. I had assumed that both science and technology were inherent to nursing and thought the two disciplines would blend nicely. Luckily, I had entered nursing at a point in time when nurses began to recognize "the harmony and unity and technology (as a form of in-human care) and the humane care nurses provided by assimilating technology into nursing" – a sort of techno-nursing (Sandelowski 201).

Sandelowski makes this connection clear when she observes that, "nursing and technology have been 'inexorably linked' since the beginnings of trained nursing in the late nineteenth century. That is, technology – largely in its modes of manifestation as physical object and way of doing – has been integral to and has fundamentally (re) shaped nursing practice" (198).

Nurses have always used a variety of technological tools to assess, treat and comfort patients. The tools are the hardware, but the care is the soft side of the technology when we look beyond the notion of nursing as using technology to the notion of nursing *as* technology. Sandelowski goes on to discuss how the boundaries between nurses/nursing and technology has "served to reinforce the subordination and invisibility of nursing in the social hierarchy of healthcare professions" (198).

In her article, Sandelowski presents compelling arguments on the trouble with nursing as technology as well as the trouble with nursing as opposed to technology. On one hand, nurses liken themselves to technology because they are instruments whose interventions achieve certain ends. Depicting the work as such helps to solidify their

place in the medical hierarchy because they can perform technological work without the traditional mechanical drawbacks of a machine. On the other hand, however, "defining nursing as technology also reinforces the idea that nursing is nothing more than manual labour and the mindless application of medical science on orders from physicians" (200).

Interestingly, this is how many of us view nursing. Sandelowski argues that nursing is associated with soft technology, a link between sympathy and science. Nurses are the "interface" between physicians and patients, and patients and machines but possess very little decision-making authority or autonomy (199). They do what others (doctors, institutions, etc.) tell them to do, much like machines. Some documentation standards also reinforce this notion.

Whether nurses *are* technology or simply *use* technology would constitute a thesis of its own. I do submit, however, that because nursing and technology do co-exist and even depend on each other as a means to an end, the writing produced as a result of that relationship constitutes technical communication and, as such, qualifies nurses as technical communicators. In fact, technical communicators create and manage a variety of forms of technical communication, just as nurse do on a daily basis. Following is a discussion that situates nursing documentation as a subset of technical communication and nurses as technical communicators.

Nursing Documentation as Technical Communication

Mike Markel, in *Technical Communication*, states that "producing technical communication involves creating, designing, and transmitting technical information so that people can understand it easily and use it safely, effectively, and efficiently" (4).

This definition in mind, it is easy to see how nursing documentation is a sub-set of technical communication. Further, Markel notes that technical communication

- **Addresses particular readers** – Nursing documentation addresses other healthcare providers.
- **Helps readers solve problems** – Objective and subjective data documented helps to create a picture of illness, which leads to treatment and resolution of that illness.
- **Reflects an organization's goals and culture** – Institutional standards of documentation reflect an organization's commitment to a pre-defined standard of care.
- **Is produced collaboratively** – Documentation in the medical chart is multi-disciplinary. Also, nurses are sometimes requested to provide input regarding the documentation method that would best serve their specialties.
- **Uses design to increase readability** – The multiple formats on which to document nursing care speaks to this characteristic of technical communication.
- **Consists of words or graphics or both** – Various documentation formats are available in clinical settings.
- **Is produced using high-tech tools** – Electronic charting is the best example of this characteristic (7).

Based on the standards outline above, nursing documentation certainly meets the accepted definition of technical communication.

Technical communicators often describe their role as one of transferring information from those who have it to those who need it (Hughes 275). Using this definition, nurses are not only the technical professionals (those who have the information) but also the communicator who creates and delivers the information to the end user, who in this case is other health care professionals.

But do nurses merely transfer information in their documentation? Michael Hughes would argue that most technical communicators who focus their writing on end users actually cross the line of information transfer into the realm of knowledge transfer. "By reinterpreting technical information in user contexts they are creating new knowledge by presenting that information in actionable terms and by relating it to specific applications" (Hughes 276). The information recorded in a medical chart is one way in which knowledge is formulated in the clinical setting. Because language is epistemic, charting entries become more than the evidence of care; they become a contribution to a larger orientation and system of meaning (Mohr 7).

But when nurses select predetermined information to document, are they doing so simply because of the institutional standards in place, or are they thinking beyond the concept of documentation and in terms of creating and managing knowledge? A review of the literature on institutional standards and mandated documentation practices may help us answer this question. First, however, I want to further examine the essence of nursing documentation and how institutional standards fit into the overall discussion of nursing documentation; namely, what standards are, where they came from, and why they're in place.

Nursing Documentation as Power

Unequal power relations exist in healthcare. Physicians write orders that nurses are to follow when caring for a patient. Nurses then document that this care was provided because, as Heartfield reminds us, "nursing documentation exists as a daily reality of nurses' work" (98). Institutions create and implement the standards that dictate how and when that care is documented. And while the nurse-patient discourse that occurs in clinical settings can serve to negotiate power relations between nurses and patients (Candlin 173), nurses are essentially powerless in the context of these former relationships. More specifically, and more relevant to this study, standards geared toward the maintenance of healthcare institutions have, through their influence on discourse, created and shaped the experiences and discursive practices of nurses. Institutions actively participate in this constitution by mandating what ways of talking are available and, conversely, not available in a situation, such as a clinical setting. Language is not a neutral medium. "When one is in a position to influence the language used, one becomes an important source of power" (Bjornsdottir 162).

Indeed, there exist many sources of power when we examine the influence institutions and regulatory agencies have on nursing documentation. Jennie Dautermann, in *Writing at Good Hope: A Study of Negotiated Composition in a Community of Nurses* explains

> In addition to medical and nursing professional communities, state boards of health and hospital accreditation agencies, even third parties like Medicare inspectors and insurance companies, regularly inspected the records, activity, and local practice of the nursing department. All these professional surveyors required adequate local nursing regulations, but these requirements are not necessarily

> couched in the same terms. Local nursing regulation systems must conform to all these diverse regulators at once. Mediating among them often requires considerable imagination and the ability to interpret the regulations freely (65).

Dautermann suggests in her research that institutional authorship, in which there is a reliance on "bureaucratic norms of medical texts, nursing standards, and local legal jargon," leaves little creative space for authors to explore their ideas and agendas (119). Institutional authorship seems to only reflect the voice of regulatory texts. But, as Dautermann points out,

> Among the value systems that may impinge on the work of writing hospital nurses are a number of attitudes that promote a romantic view of writing and an ambiguous sense of the actual role of instrumental texts as they function in practice. Many of these values are complicated by the influence of medical and institutional regulators whose requirements provided a good deal of the motivation for keeping written records. As discussed in Chapter 3, a number of these values coalesce into the following community maxims about written discourse:
>
> - Paper is power.
> - Standardized paper will standardize practice.
> - Paper protects the practicing nurse.
> - Professional groups must prove themselves by writing.
> - Good writing equals good thinking (118).

In the next section I will discuss the history of standards of documentation, why they're in place and what role litigation plays in the development of standards.

Standards of Nursing Documentation

According to Morrissey, "the idea for nursing documentation standards took root in the 1980s, before the grip of managed care but after clinicians began realizing that increasing patient acuity was creating new demands for information" (Morrissey 2). The primary purpose of the movement to implement nursing standards seemed to be to address gaps often found in documentation in order to better capture billable charges in what was primarily a fee-for-service world for physicians (1). Other benefits of standardizing documentation protocols included ensuring that a record of the nurses' work existed and collecting easily retrievable medical data for research and trending.

Because the patient's medical record is both a legal document and a means of communicating information (or knowledge) between healthcare professionals, standards are necessary to provide a "reliable defense against allegations of negligence and violation of nursing standards. (They) may very well be the only reliable means for the healthcare team to prove that the care provided complied with the standards of care" (Dumpel, et al.)

The American Nurses Association (ANA) includes discussion of documentation in its standards of nursing practice. According to the *Nurses' Legal Handbook*, "the ANA says documentation must be systematic, continuous, accessible, communicated, recorded, and readily available to all health care team members" (245). Regulatory standards set forth by the Department of Health Services (DHS) enforce the licensing and certification standards to which acute care facilities (hospitals) must adhere. According to Title 22, Division 5, Article 7, Section 70749 (a) (6) of the DHS standards, examples of what the nurses' notes of an inpatient medical chart must contain include:

- A concise and accurate record of nursing care administered
- A record of important and relevant physical and psychosocial observations
- The name, dosage, time and route of medication administration
- A record of the type and time of restraint application

The standards put forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) indicate that the medical record should be a complete and accurate reflection of the patient's contact with the healthcare system. JCAHO stipulates that the medical record should include a history and physical exam findings of the patient, the nursing assessment (which is similar to the physician's physical assessment but also includes psychosocial factors), what diagnostic tests were performed and their results, physician orders, and the patient's response to treatment. "Evidence of compliance with JCAHO standards is determined through interviews with staff members and review of hospital-wide and department policies and procedures at the time of JCAHO surveys" (Dumpel, et al. 3). The fact that no formal nationally-mandated documentation formats exist to meet these guidelines means that individual institutions must integrate laws, regulations, and specialty-specific standards into its policy and procedure manuals and because JCAHO does not specify a specific format in which care must be documented, the onus falls on individual facilities to implement documentation standards they perceive best reflect the perception, in both care giving and litigious contexts, that the standard of care was met. The search for documentation formats may result in implementing one or all of many different protocols, "from preprinted forms to handwritten reports to electronic format, which may include decision algorithms and care maps" all within the same institution. (*Nurse's Legal Handbook* 245).

Ideally, the medical record serves to enhance communication between health care professionals, as a tool for planning and evaluating patient care, as a source of collecting clinical data for research, as the basis for reimbursement of services rendered, and, lastly, as a legal document (Murphy 134). Unfortunately, both existing research and my study questionnaire show that the litigation aspect of care provided is really the most important driving force behind the "why" and the "how" of nursing documentation, as well as the choice of institutional documentation standards. A brief discussion on the prevalence of medical malpractice better situate the need for documentation standards in this history of legal action.

According to the National Practitioner Data Bank (NPDB), nurses and nursing-related practitioners accounted for 11,716 (4.4%) of the 264,065 reports of malpractice for all practitioner types between September 1, 1990 through December 31, 2000 (Miller & Glusko 1). While that may not sound like a high incidence compared with all practitioner types, consider that for nurses in 2000, "medication-related malpractice had the highest number of payments" (Miller & Glusko 1). A major part of the nurse's daily practice, especially in an inpatient setting, is medication administration.

The notion that litigation is the driving force behind how nurses approach documentation, whether voluntarily or because they are following institutional standards, is well-supported in the literature. In fact, the *Legal Handbook for Texas Nurses* devotes an entire chapter to defensive documentation. But while there exists plenty of caution in the literature that documentation of care is synonymous with care itself, at least one nurse consultant/lecturer has chosen to address the issue of the medico-legal aspect of nursing documentation in a slightly different way.

Jackie Palmer, RN, CEN, President and CEO of The EdCare Group, a consulting firm, says that while a lack of time and work overload are daily factors that do affect nurses' charting, "We must always bear in mind that caring for the patient is the most important thing. Documentation truly does become secondary to patient-care priorities" (Pyrek 1). Palmer teaches nurses to chart in the context of contributing to the continuum of patient care versus charting because they may one day end up in court. If nurses don't adequately record what they did while caring for the patient, how will the next caregiver know what was done? According to Palmer, "nothing in nursing is done in a vacuum; it is a continuum of care. If it begins without adequate information, that is going to impact the rest of the patient's care" (Pyrek 2). Palmer's approach emphasizing charting in a thorough, comprehensive and detail-oriented fashion ideally will, as a by-product, also protect the nurse from litigation. Under certain circumstances, she is quite critical of institutional standards of documentation. Palmer says that, ironically, the very methods institutions impose on their nurses to document patient-centered care can be obstacles to realizing those very same goals: "'A significant number of facilities utilize charting by exception, which is, from a legal viewpoint, the worst kind of charting because nurses never write down anything that's normal. It may be that what is normal is what is crucial to document'" (Pyrek 1).

Palmer also discusses the problems with specific nursing discourse as it relates to documentation. She has seen numerous examples of nurses using abbreviations or lingo specific to their specialties or facilities. This can be dangerous because the same abbreviation may not mean the same thing from one facility to another. The example Palmer provides is, coincidentally, the same example I used during a presentation on

nursing as a discourse community while enrolled in a course on language in institutional settings: The abbreviation "SOB" in charting can mean at least two things in a clinical context: "side of bed" or "short of breath." And there is a third meaning that, at least most of the time, exists outside of the clinical context. Because abbreviations are not necessarily communicable across a clinical continuum, Palmer further supports the need for clear and accurate charting; arguing institutions should keep this in mind when implementing standards of documentation.

Just as documentation is evidence of nursing practice, nursing practice is a powerful factor in developing documentation practices. Likewise, nursing discourse has been just as influential in shaping nursing documentation as documentation has been in shaping discourse. Next I will briefly discuss the communication practices of nurses and how their material and metaphorical characteristics guarantee their membership in a nursing discourse community.

Nursing as a Discourse Community

According to Dautermann, two social discourse groups, or communities, exist: metaphorical and material. Metaphorical communities represent associations where membership is voluntary and based on a "likemindedness" related to beliefs, purposes, goals, and interests. Material communities are primarily bound by common physical space which often translates into common life experiences (6). Nursing exists as a discourse community in both contexts: Metaphorically because of the overriding reason they were drawn to the profession (to care for others, guaranteed employment, etc.) and materially because of their practicing specialty (medical/surgical, ICU, home health, etc.).

The article by Hardy, et al., notes that every discourse community has its own rules, values, and preferred methods of describing things. A by-product of these factors is that it helps people make sense of the world in which they operate (197). Nursing is no exception to this rule. If language is viewed as a way to name or make visible an extra-linguistic reality (Allen 2), then the achievement of excellence in nursing practice is reflected in the quality of the nurse's discourse (Candlin 173). How nurses are conversationally positioned, or position themselves, determines what they access to constitute their interpretations, perceptions, and interactions in the world and, in this case, institutional settings. Over time, the resulting discourses become internalized and act as guides that create and shape identities and experiences (Allen 6), as responses to my own questionnaire indicated.

Unfortunately, however, Dautermann tells us that nursing has also fallen victim to competing discourses. Hospital nursing, in particular, "is subject to review by several regulatory agencies whose purposes do not always correspond" (Dautermann 64). Although the nursing profession is regulated by national guidelines developed by nursing organizations, they are also required to answer to the medical profession. The competing discourses within an organization will typically disqualify nursing from the competition and the resulting impact on discursive practices leave the nurses frustrated and powerless.

But perhaps the dichotomous nature of the discourses within a health care setting arises from a difference of intent. The intents of institutional discourses are to protect and profit, while the ideal intent of nursing discourse ideally is to express nursing care, in whatever framework the nurse chooses. Because the goals of the competing discourses are different, the two cannot peacefully co-exist. My study sought to establish how the

nurses viewed and responded to the discursive practices of nursing as they relate to institutional standards in practice settings.

Thus far I have provided the foundation on which I based this study. The following chapter details my findings in which I will address the themes that surfaced from the participants' responses.

CHAPTER III

FINDINGS

Institutional Standards – A Necessary Evil

In the previous chapter, I reviewed the literature related to nursing, nursing discourse, and documentation practices. In this chapter I will discuss the two primary themes that emanated from the findings of this study.

The first principle theme was that while nurses considered institutional standards bothersome they recognized that such standards are, inevitably, a necessary evil. On the whole, the nurses in this study did not mind having institutional standards as safety nets that could protect them from landing in court.

The nurses responded that institutional standards directly influenced the amount of time they spent charting, how they structured their day, and the fact that these standards could serve to make their workday either easier or harder, but they were willing to adapt to the institution's required charting styles. This allegiance did not come without a price, however. The institutional imperatives in place to avoid litigation, fueled by the very real potential for litigation in clinical settings, not only shaped the nurses' attitudes about documentation, but about the practice of nursing overall.

First I will address the benefits and drawbacks the nurses expressed about institutional standards of documentation and then transition the discussion into the

dichotomy that emerged between the theory and practice of nursing documentation; namely, how the documentation standards influence practice and the role the nurses feel documentation actually plays in the delivery of care, rather than the role they wished it played.

One beneficial aspect the nurses expressed about having institutional documentation standards in place was that the standards protect them by prompting proper writing. In fact, Nurse A said she felt "good" about having institutional standards in place. In her opinion, requiring everyone to chart in the same manner ensured that she would find others' documentation helpful in the workplace. She saw the standards as something that benefited her from a clinical perspective because if everyone is required to chart in the same manner, then she knew what to expect from others' charting. Nurse A preferred that the institution tell her and her co-workers what is important to chart rather than have to decide on her own and she doesn't mind charting according to "the standards set by the agency."

Nurse B viewed the benefit of institutional standards in a slightly different way. She stated that if according to the standards in place "everything had been covered in (her) charting" and "if the doctor was happy, then everyone was happy." In this sense, the adherence to the standards pacified those in power and provided a more immediate benefit in her clinical setting; namely, that those in power were placated.

Consistency and providing a safe level of care to patients was what Nurse C saw as benefits of the standards. She stated that she thinks "standards are good in that they assure everyone is at a minimum documenting the same thing." She gave the example that if vital signs are not documented every 4 hours then "how could one assure they were

done?" Nurse D echoed these sentiments in her comment that she charts in the manner that she does to ensure continuity of care and as "proof of care."

The nurses were keenly aware of the value institutions place on avoiding litigation and promoting fiscal health. For example, when I asked Nurse B during a follow-up interview why she thought institutional standards are even in place, she had three responses, in the following order: "Reimbursement, litigation, and quality of care." The underlying impact of the fear of litigation was evident when Nurse B commented that she charts according to standards in order to "cover her @*$!"

References to litigation were strewn throughout all of the initial questionnaire responses and follow-up interviews. Every single nurse at some point during the interviews made a point of mentioning the potential of legal action as having some influence on not only her documentation practices, but on her attitude about documentation as well. A prevalent response voiced by several of the nurses was that while they felt the need to chart excessively to protect themselves, the excessive charting often kept them away from the patient's bedside, which is where they wanted to spend the majority of their time. The alternative was to stay after the shift to complete charting so that it didn't interfere with care.

These responses echo Ellen Purkis' findings in a study of the writing practices of Canadian nurses. Purkis cites commentators' notes that "the demand for nurses to engage in elaborate and time-consuming writing exercises" has arisen because of the more litigious nature of health care in America (148). Further, Davina Allen cites research on nurses in England that found most nurses engage in excessive documentation as a defensive strategy against risk (7).

Conversely, however, one benefit of documentation standards for Nurse F included actually reducing the amount of information she had to record. She said she felt "pretty good" about standards because she doesn't "want to have to mess with unnecessary charting." She especially enjoys the documentation standards at her current telephone nursing job because she feels the documentation standard (electronic – some check boxes and an unlimited narrative field) captures the intent of the preventive medicine program in which she practices. In this case, Nurse F provides a workplace example of where the method of documentation is consistent with the goals of the clinical program. This is a rare success story and it's noteworthy that the leadership group in charge of creating and administering this particular nursing program consists primarily of nurses.

My own attitude is a bit different from the other nurses. I support institutional standards if they are consistent with how I want to chart – in a narrative fashion. When I was engaged in this style of documentation, I enjoyed the degree of creativity that came with expressing my findings in my own way. For example, even if a standard dictated I must document the findings of my neurological exam during my head-to-toe assessment at the beginning of my shift, I liked being able to verbalize those findings in my own way rather than select my findings from a series of check-boxes.

Nursing Documentation – Does It Really Represent Care?

The questionnaire responses revealed a dichotomy between the theory of nursing documentation and the practice of nursing documentation. Additionally, the responses indicated that ultimately shapes their nursing practice.

The nurses' replies reflected a belief that the realistic role documentation plays in the delivery of health care was inconsistent with what the nurses felt was its idealistic role. In other words, while most of the nurses felt that the purpose behind the documentation should be to communicate important clinical information between members of the immediate and ancillary health care team members, and that it should serve the interests of the patient, realistically they knew documentation was a tool that contributed to the maintenance of the organization. In this sense, the documentation standards influence the nurses' attitudes regarding their nursing practice in a way that equates adherence to standards, rather than documentation by choice or preference, with good, competent care.

For example, Nurse C said she believes "standards are needed to provide a safe level of care to patients." I found this comment intriguing. This told me that she subscribes to the maxim, "If you didn't document it, you didn't do it." In my opinion, a safe level of care can be provided even if it isn't necessarily documented.

Nurse D also spoke to standards more in the context of clinical guidelines versus the way care must be documented. She stated, "I think it is very important to have policies stating the need and timing of assessments." In other words, not only did the standards tell her how to chart, but also what and when to chart. In this respect, Nurse D saw the documentation standards as pragmatic in a clinical sense.

Perhaps the most compelling example of how documentation standards shape nursing knowledge and practice came from Nurse B, who said her care followed what she knew she had to document. For her, the writing prompted the care instead of the other way around. This phenomenon was perhaps the result of her level of clinical expertise at

that time in a clinical setting, but the fact is that she based her care on what she knew she later had to chart.

The impression that documentation standards shape practice, and not always for the good, is also evident in a related comment Nurse E made while discussing the challenges she associates with charting by exception. She wrote that she sometimes has a hard time making her care "fit" the documentation style she must use and cited psycho-social issues as an example of this. This statement corroborates what Helen Taylor discusses in her examination of the nursing attitudes that affected record-keeping.

In her study, Taylor cites research that suggests what is often documented by nurses may not accurately reflect the work done. For example, Taylor found that there are areas of care that are sometimes omitted from documentation, such as:

- The fulfillment of the patient's emotional needs
- The patient expressing his/her sexuality
- The fulfillment of the patient's spiritual needs
- The fulfillment of the patient's social needs
- Problems with verbal and non-verbal communication
- Efforts to maintain the patient's dignity
- The promotion of self (752).

While much of nursing documentation focuses on tasks completed, what Bjornsdottir refers to as "public talk," there is also a private discourse of nursing that attends to the impact illness has on patients' lives. According to Bjornsdottir, for many nurses "being able to relate to the patients as persons was what made nursing meaningful

work (but)...the private discourse was not apparent in the documentation of nursing care" (163). In this context, we are once again forced to recognize the uneven power relationships that exist in the healthcare system because the power of medicine is affirmed by documentation that references scientific information. If we explore the maxim of using written language to construct a clinical reality, the maxim, institutional standards, and legal guidelines send the message to nurses that what is important to the work of nursing is really identified by non-nurses. And, conversely, what nurses seem to value in terms of the care they bring to the practice is sometimes not given a voice.

Nurses are situated in between what is recognized and put forth by the institution as valuable discourse and the maxim that "if you didn't document it, you didn't do it." Even 20 years after its introduction, this maxim remains at the core of the nurses' documentation practices. They don't fight it. In fact, they use it as a tacit standard. I wanted to further explore the connection between action and recording that action because, as every nurse knows, it is impossible to document every single nursing action performed during a shift.

The nurses in the study bridge the schism of excessive documentation and falling victim to the maxim above by "charting according to standards," even if that means excessively. Nurse A expressed that she would rather chart too much than not enough and is willing to do so. Nurse B recommended an automated system be developed that would solve this problem for the nurse. Nurse C asks herself, "What would a lawyer look at?" and charts accordingly. She reads her charting and determines for herself if her documentation would protect her and show that she properly performed her nursing care. Nurse D responded that excessive charting holds up in court and she charts in a manner

such that if she is called back to court years after she has cared for a patient, she hopes her charting will prompt her memory of what she did for the patient.

Nurse E likes to pray that she doesn't see the chart again 5 years from now in court. On a more serious note, however, she responded that she does try to prioritize her charting and leaves the "pillow fluffing" things out. In other words, she uses her experience and education to decide what's important and what's not important to include within the constraints of the institutional standards. Nurse F was less descriptive in her response and just tries to balance each clinical charting episode as it happens.

While these responses spoke to the role nurses thought documentation realistically plays in the overall delivery of care, I was equally interested in assessing what role the nurses felt nursing documentation should play in the delivery of care.

The nurses' responses to this question were fairly consistent: documentation should serve as a thorough account of observations and treatments. Nurse F, in particular, expressed very specific ideas regarding the ideal role of nursing documentation. She stated that nurses should not have to chart in such an excessive manner that it interferes with the quality of patient care. She stated that in her outpatient cosmetic surgery clinical practice she would chart specifics regarding patient treatment responses versus in accordance with a standardized treatment protocol that addresses unnecessary information. She thought that this would translate into a higher quality of care because she was not spending unnecessary time charting and, thus, patient satisfaction would increase. Additionally, her example of patient-centered charting would be meaningful to the patient because in subsequent clinical interactions, the nurse would have referenced what was important to the patient and follow-up accordingly. Nurse F also made a point

of saying that her idea of patient-centered charting would not serve the liability interests of the practitioner.

I somewhat expected the nurses to believe that documentation should play a vital contributory role to the patient care continuum, and the majority of them do. What I did not expect, however, were the two responses that follow.

Nurse A responded that she felt nursing documentation should play "a huge role" in the delivery of nursing care because "documentation serves as a record of what is going on with a patient so that all nurses or providers that come behind you will know what is going on with the patient." Although that seemed like a complete answer, for some reason I felt prompted to ask the follow-up question, "And what's important about that?" Her response – "Tracking for OSHA – OSHA's tough! The consequence for not documenting is paying a fine." Even though her written response spoke to the theoretical reason for good nursing documentation, her intent still echoed the undercurrent of charting to meet a standard to avoid discipline and the institutional discourse from which it originated.

Further, Nurse C presented this rather disparaging view of documentation:

> I believe a patient could have the doctor's order, MAR *(Medication Administration Record)*, graphics *(vital signs)*, and just the nursing assessment at each shift and the care would remain the same. Most nurses never even read what the other nurses wrote and the doctors certainly do not read it nor really care what the nurses are writing.

Nurse C's sentiments are echoed in the study by Helen Taylor that examined factors that affect nurses' record keeping practices. Taylor argues that nurses simply do

not value the documentation process and may even view it as a practice distinct from nursing. In fact, "a study by Tapp (1990) suggested that while nurses often cite a lack of time as an inhibitor to effective documentation, respondents also stated that even if adequate time were available, their documentation would not necessarily be more comprehensive" because even having additional time did not impart value to the documentation process (752). The literature suggests that the act of translating an event into prose is, unfortunately, often perceived as a time-consuming and tedious act.

For Nurse C, the rationale behind how she charts is strictly mandated by the institutional standard in place. She does not view documentation in a constitutive or contributory manner; rather, she views it as something she has to do because "most facilities don't give you a choice." She went on to say, "I chart according to the institution and what they tell me I must chart." This is a perfect example of Sumner and Townsend's statement that, "It is the powerful in the hierarchy who make decisions, and this renders the nurse voiceless" (169).

In response to the question regarding the role nursing documentation should play in the delivery of care, Nurse C replied rather candidly that she does not believe nursing documentation should play a very large role at all because, realistically, all nurses do is "follow the doctor's orders and that is essentially the plan of care." In other words, the documentation does not reveal new information, only confirmation that the nurse followed the physician's orders. Nurse C went on to say that nursing interventions, such as turning patients in their beds, do not need to be in the patient's plan of care "because it is a nursing intervention and not an actual (doctor's) order."

Nurse C's sentiments are echoed by Marie Heartfield's findings in her phenomenal study of nursing documentation and nursing practice. Heartfield has this to say about institutional impact on documentation practices:

> The hospital is an examining mechanism, particularly through the use of documentation. Nursing documentation functions as a manifestation and ritual of power relations. Through the recording of nursing activities the patient and nurses are examined but communication occurs through only a limited language...The dominant discourses of nursing documentation are made problematic by considering discourses of resistance. Nurses' resistance strategies are evident in nursing documentation...nurses write about observations and responses in a manner that is passive. Such intentions leave the record devoid of meaning as anything more than a record of information that assists the other health care providers.....There is no apparent knowledge base that underpins what nurses are doing that differentiates them from assisting the doctor (102).

An interesting by-product of this phenomenon is the nursing care plan, a document developed by nursing to outline a nursing plan of care for the patient.

Nurse C further expressed that she felt nursing care plans were "a waste of time." A nursing care plan is a plan of care that the nurse develops for a patient based on problems identified during initial and subsequent assessments. This is formulated in addition to the medical diagnoses assigned by the physician and is supposed to supplement the medical plan of care. The nursing care plan is considered a "road map" for all professionals involved in a patient's care. The problems identified are then assigned nursing diagnoses and a plan to correct or minimize the adverse effects of those

diagnoses is implemented. The nurse sets measurable, time-framed goals for the patient and, ideally, all members of the interdisciplinary team work toward resolving the identified problems.

Some research has shown, however, that nurses perceive care plans to be "superfluous" (Allen 4). According to Allen's study, care plans were regarded by the nurses as a secondary priority and something that needed to be completed for administrative purposes rather than practical ones.

I've never been a fan of nursing care plans, either. I tend to agree with Nurse C because I believe nursing care plans were developed in order for the profession to feel the sense of power that comes from creating something innate to the profession and then directing others on the healthcare team, with the exception of the physician, to adhere to what was created. Hardy et al, cite research by Crowe (2000) pointing out that from "a feminist post-structural perspective adherence to dominant and traditional discourses, such as those of medicine or management, places nursing practice in a subordinate and inferior position to other health professions" (200). I believe nursing care plans and nursing diagnoses are two ways the profession has asserted its opposition to this subordination.

Dautermann observes that the traditional role of nursing in hospital settings gives nurses little autonomy in the delivery of care because nurses deliver care and "significant treatments" that have been ordered by others. While nurses are permitted to act a bit more decisively in emergencies, in "day-to-day practice, (nurses) respect a rigid hierarchical decision-making system that comes both from the hospital administration and from the hospital's practicing physicians" (92).

Dautermann also addresses nursing care plans in her study as a professional and regulatory discourse. She writes that "choosing the language of nursing diagnoses, as opposed to medical diagnoses, represented an unresolved dissonance" in the group of nurses she studied because pre-existing medical discourses were so deeply imbedded in the community language (65). She cites other research that notes the trend toward the use of nursing diagnoses encourages nurses to no longer think in terms of medical diagnoses, "but rather to claim their authority over the nursing process."

This point is best illustrated by an example. Nursing diagnoses are different from and cannot be medical diagnoses because that domain has already been established. If a patient is admitted with the medical diagnoses of abdominal pain and dehydration, the corresponding nursing diagnoses would be "alteration in comfort" (pain) and "alteration in fluid/electrolyte imbalance" (dehydration). The medical plan of care for managing pain would be to administer prescribed pain medication and managing the dehydration would be to administer intravenous fluids that contain electrolytes and to monitor the amount of urinary output compared to fluid intake. From the nursing care plan perspective, however, the plan of care for managing the patient's pain would be to position the patient for comfort, administer prescribed pain medication, etc. The nursing plan of care for dehydration would focus on encouraging oral fluids and ensuring the patient's IV site is patent. The nursing care plan emphasizes those interventions that are non-medical in nature while reinforcing how the nurse will carry out the medical orders written by the physician. Although largely unpopular among the nursing students and clinicians who have to write them, nursing care plans are forms of documentation created by nurses and

for nurses, and exist almost exclusively in the domain of nursing. In this respect, the care plan ostensibly serves as a source of professional nursing power.

According to Heartfield, "the reality of documentation is that it provides a permanent record and as such takes on a power of its own, with the ethics of practice concealed or revealed in the language that describes nursing activity" (99). The resistance to having to chart to satisfy a standard is supported by what has been identified as a danger in documentation; namely, that power, such as that exercised by institutions, limits through discursive practices what is acceptable to be known. Foucault tells us that the procedures that dictate what can be said, who can say it, and what becomes of what is said to produce knowledge (Bjornsdottir 163).

In this section, I have presented the dominant themes I found regarding standards of documentation; namely, that the nurses in the study perceive institutional standards as unpopular, but necessary. Additionally there is an undercurrent of opposition that stems from the dichotomy of the role nursing documentation should play in the delivery of nursing care versus the role is realistically plays in the delivery of care.

In the following section, I will focus on the benefits and challenges the nurses have experienced utilizing the various types of documentation and how that has shaped their documentation preferences.

Documentation Preferences – You Are What You Write

As I examined the documentation preferences of the nurses in the study, I found that the amount of time a nurse had been in practice and her current clinical setting influenced her documentation preferences. These findings constitute the secondary theme of the study findings; namely, that charting preferences may indicate the degree to which

the nurses equate documentation practices to knowledge building and, thus, their particular understanding of nursing as a profession. In other words, the nurses' charting preferences not only seemed to be indicators of expertise, but also spoke to how the nurses viewed and valued the knowledge/expertise-building aspects of this documentation.

First, there was a correlation between the nurses' practicing specialty and the amount of charting necessary to meet institutional standards. Some of the participants worked in outpatient clinical settings where the exposure to the patient was relatively short-term and not recurring. In these cases, charting was minimal because care was minimal. In other settings, such as the ICU, the nurses manage a patient's care for 8 to 12 hours and some form of charting is typically required hourly. Charting is more voluminous because care is more intensive and comprehensive. In this respect, the clinical setting determined the level of competency that had to be proved and the discursive practices of the nurses, both verbal and written, served as indicators of their expertise.

Three of us in the study who have been nurses for 18, 17, and 15 years preferred narrative charting while the nurses who had been in practice for 12, 11, 10, and 4 years preferred either charting by exception or electronic charting. Certainly the point in time in which we received our training determined what documentation style we initially learned, with narrative being the oldest and electronic being the most recent. But even though the majority of us have had exposure to all three types, this pattern emerged where the more experienced nurses still preferred narrative charting.

My findings that the more experienced nurses preferred the more constructive methods of charting and the least experienced nurses preferred the least constructive methods of charting is what lead me to title this section "You Are What You Write." The title represents the various ways in which we construct knowledge systems. Narrative language in charting becomes less about the content and more about the function (Hardin 14). The more experienced nurses seemed most comfortable using words to construct a clinical reality using descriptions that held particular understanding to the immediate discourse community. Helen Taylor asserts

> A high level of cognitive processing is required in the translation of heard spoken words into a coherent response in either spoken or written prose...it is possible that some nurses' self-perceived or actual lack of literacy skills and dexterity with technical terminology will inhibit them. For example, a nurse may want to use a particular word to describe a patient and then realize that he/she does not know how to spell it. Rather than risk the embarrassment of misspelling the original word, he/she may select another. The substituted word may not have exactly the same meaning as the word originally selected, and may thus alter the whole meaning of the text (756).

What Taylor suggests here is that a certain degree of skill is required to craft a narrative charting entry and the more proficient a nurse is at composing narrative, the more likely he or she is to accurately describe nursing observations. This degree of skill comes with academic training and experience.

Nurse E has 18 years of experience as well as a Master's Degree in Nursing and works in the ICU. Nurse E and I were both trained in narrative charting and were in

clinical practice before charting by exception and electronic methods became as common as they are today. Nurse A also has a foundation in narrative charting.

To borrow from post structuralism – it seems the constructive aspects of language enabled us to position ourselves within a clinical system of meanings that helped us, through our storytelling, build knowledge systems and negotiate what was meaningful (Hardin 17). I should clarify at this point that liability was still a prevalent topic of discussion during our training and we certainly did chart defensively, but I think the difference is that because the wide variety of charting options were not available when we entered practice, engaging in narratives served to promote our competence, and vice versa. For example, I used to read the physicians' progress notes to learn to state my findings in different, more clinical ways. In other words, I used to go outside of the domain of nursing to build my nursing narratives and, thus, my nursing knowledge. This outcome was consistent with the following conclusion cited by Marie Heartfield.

According to Heartfield, the practice of documenting patient care is an everyday element of all nurses' work that "provides particular ways of understanding nursing and therefore nursing knowledge. Nursing documentation forms a permanent record through which nursing becomes known by others as well as by nurses themselves" (98). Constructing reality through narrative has been well established, but some of the nurses in the study either did not have the opportunity to experience this knowledge-building tool or simply did not share this perspective.

One of the nurses in the study had never practiced narrative charting in her career and Nurse C stated that she saw no benefits to SOAP charting because "many nurses

spend time just trying to figure out what they are suppose(d) to write and then the(y) put the subjective data in the objective part and vice versa." In other words, they get it wrong.

The other respondents stated this type of charting afforded the reader a more comprehensive clinical picture of the patient and allowed more space for individualized accounts of what was happening with the patient. Nurse E saw it as "widely accessible to other team members."

Even though several of the nurses in the study did not enjoy engaging in narrative documentation themselves, they did find benefit in reading what others had written. Nurse F stated that SOAP charting did not afford any benefits to the person charting but the nurse that reads the chart has a lot of "multi-aspect info about the pt."

The challenges with SOAP charting, however, outnumbered the benefits. Time available to compose clinical narratives was the most frequently cited challenge. I asked Nurse B during a follow-up interview if time were not a constraint, how she would feel about narrative charting. She responded that she would still try to use the scripts associated with charting by exception and "find a way to automate the process."

Other challenges associated with SOAP charting were handwriting issues (illegibility) and the fact that not all SOAP charting is created equal. Nurse A implied during the follow-up telephone interview that the freedom to chart without constraints inherent in the documentation method also gives nurses freedom not to chart. For example, Nurse A cited an incident in which another occupational health nurse on an earlier shift had simply charted "finger laceration" on a patient who had come to see her in her office. Nurse A was upset that the other nurse had not charted which finger had sustained the laceration, that there was no description of the laceration, and that there was

no description of what type of bandage was applied. Nurse A was concerned that when this patient returned for a wound check, she would not have a frame of reference from which to judge the healing process of the wound. In this example, the narrative nature of the charting was a disservice to Nurse A, who does prefer this style of charting "with standards so that everyone charts the same way."

Perhaps the more junior nurses preferred charting by exception and electronic charting methods over narrative because of discomfort with the aspect of storytelling. It's possible that this discomfort stemmed from a smaller portfolio of scripts from which to choose. I would have liked to have explored specifics about the use of narrative language with them a bit more because what they may not realize is that the type of charting they engage in may reinforce their status as knowledge-makers or transferors of knowledge.

The charting by exception method was the most popular among the participants and the overarching benefit was that it could be accomplished quickly. Charting by exception is a style of charting in which the typical findings of a physical exam are listed for the nurse and the nurse simply has to select which exceptional finding fits her assessment. The underlying theory behind this form of charting is that only abnormal findings are documented and, therefore, if nothing is documented as having been exceptional, everything was normal. Because CBE uses a check-box style format, one becomes fairly familiar with the "scripts" associated with findings.

Nurse C cited this as the most effective charting method because

> You only chart if something abnormal of exceptional happened. You do not then waste your time charting irrelevant information such as "the patient sat up in bed and ate 90% of breakfast" unless that would be considered an exceptional event

for the patient. I see to(o) many nurses chart information that is not even relevant to the patient's situation. Charting by exception saves time and is an easy method to understand.

An interesting response related to the benefit of charting by exception came from Nurse B, the youngest and least clinically experienced nurse in the group. She cited that one benefit of this style is that it provided "scripts in (her) head" for her to know what to say in her charting. As mentioned earlier, Nurse B had learned what aspects of care were on the documentation form and used that as a guide to manage the patient because she knew she would have to document it. Foucault might call this a "discourse of the self." We take up discourses of what we should be like and then compare ourselves to them (Allen 3). When the documentation style puts forth the performance expectation, Nurse B compared what she did to what was expected and adjusted accordingly.

I explored the notion of writing prompting care versus care prompting writing a little bit more because the idea of Nurse B relying on "the scripts" in her head to initiate action was fascinating to me. She borrowed the scripts from the documentation and in a sense I suppose we narrative authors do that as well. Scripts are a part of discursive practices. The difference to me, however, is that understanding and accessing a body of statements in the creation of narrative notes feels more constructive than using a checklist. In other words, I view narrative charting as the creation of information and charting by exception as a recording of information.

Charting by exception was not without its challenges, however. The most frequently cited issue with this documentation method was that it often does not present a full picture of what is happening with the patient. Two of the nurses responded that they

sometimes feel obligated to write something down even if the patient did not experience any exceptions during the shift. Nurse C stated that most nurses feel "they have to write something down for the shift and they end up wasting time doing that." Nurse D stated that some staff members "feel guilty that they haven't charted enough." This sentiment was supported by Nurse E, the most experienced nurse in the group, by her response that she feels like she is missing something because she perceives "gaps" in the charting if the patient is stable during the shift and there is nothing exceptional to chart.

Briefly, the benefits of electronic charting were similar to those of charting by exception; namely, the nurses in the group saw this method as quick and efficient. The challenges cited by the majority of the group included the learning curve associated with learning the documentation software, keyboarding skills, and application down time.

In this section I have explored charting preferences and how writing styles seem to be influenced by length of time in practice and clinical setting. I also speculate that documentation preferences could be indicators of clinical expertise as well as creators of clinical expertise. In the following chapter, I will discuss a summary of my findings and implications for future research and education.

CHAPTER IV

SUMMARY AND CONCLUSIONS

I approached this qualitative phenomenological study with the intent to collect data to examine nurses' attitudes and perceptions of institutional standards of nursing documentation. While there exists a plethora of studies that quantitatively explore nursing documentation, I performed qualitative interviews on 7 nurses and collected their stories regarding how they felt about nursing documentation as a clinical tool and the institutional standards in place that dictated when and how that tool was implemented and utilized. I usually opposed those standards when I practiced in a clinical setting unless they were consistent with how I wanted to chart and just assumed all other nurses felt the same way, which they did not.

Research of this nature is an important complement to quantitative data because it explores underlying resistance to documentation practices. Much of a nurse's work is mandated by others, such as physicians and the institutions for which they work. The literature suggests the idea that nurses do not enter the profession because they necessarily want to be decision makers anyway. Nurses typically enter nursing because they want to care for others and claim the emotional domain of that care as their own. The physical care is determined by physicians' orders and Nietzsche would say that the "caring" aspect of patient care is actually the nurses' revolt against the medical model.

Nursing documentation is something that is unique to nurses and even this aspect of the work is directed by others, some of whom are not even in the profession. Institutions and other regulatory agencies control the discursive practices of nurses and often do not include them in the decision-making processes that impact the various methods of documentation. Regardless of what happens during nurse-patient or nurse-physician interactions, the institutions and regulatory agencies direct what can and cannot be said about that interaction.

The reasons for standards of documentation are to protect the nurse and the institution from litigation, to ensure appropriate reimbursement for services rendered, and to enhance the quality of care the patient receives. Nurses are taught the theory that recording the patient status for optimal care and communication amongst health care professionals is the primary reason standards are necessary, which implies their documentation is valued as a tool they can use to articulate their expertise. The nurses learn, however, that the reality of the institutional standards of documentation seems to be geared toward protecting the practitioner and the institution from litigation. This being the case, the literature and my study both show that many nurses simply do not value nursing documentation and a frequent argument is that tedious documentation practices keep them from tending to the patient, which is how they would rather spend their time.

The primary finding of this study was that nurses perceive institutional standards of documentation as safety nets that not only protect them in the event of a lawsuit, but protect the institution that implements them as well. The institutional imperatives that

attempt to secure protection from litigation, however, also appear to shape the nurses' attitudes about documentation and, ultimately, the profession as a whole.

A second, and more fortuitous, finding was that the nurses' preferred documentation style seemed to correlate to how long the nurse had been in practice and may even be an indicator of expertise. The more senior nurses preferred narrative charting while the more junior nurses preferred charting methods that did not require a story-telling component. Whether this is an indicator of expertise or a contributor to expertise is something that could be explored with further research.

Implications for Further Research and Education

Institutional standards of documentation are here to stay and however nurses feel about them will not likely change that. What could change, however, is requiring nurses during their education to develop an appreciation for good writing skills and once in clinical practice to get involved in the institutional processes that regulate discourse in the clinical setting. Nursing research on writing practices indicates writing helps nurses improve their communication skills and develop critical thinking skills as well because they have to assimilate and organize large volumes of data (Dick and Wills 1).

Another possible area of investigation is the link between nursing documentation and technical communication and situating nurses as technical communicators. As mentioned earlier, I found no existing literature that directly establishes nursing documentation as a form of technical communication. Having had the experience of this graduate program has shown me that this link must be established, and there are benefits

to making this connection. My past experience on committees that review forms for nursing documentation enables me to say that those who review and revise these forms do not typically have technical writing experience. As a result, clinical documentation tools are not often user-friendly and frequently have errors that would not have occurred had a technical writer developed the form. If nursing documentation were established as a form of technical communication and if nurses received technical communication education during their nursing programs, they would bring a level of expertise to the field that typically does not exist. In other words, nurses should be required to have technical writing coursework during nursing school and then should be responsible for developing the forms they use in their daily clinical practice.

A third area that warrants further research is the subject of writing and expertise. Does writing prove expertise or help develop expertise in clinical settings? How is the subject of narrative writing addressed in nursing schools? With electronic charting methods and the current movement to an all electronic medical record for patients, it is unlikely that narrative in medicine and nursing will get much attention unless narrative composition correlated to development of expertise.

A fourth area of examination, though only briefly mentioned in this study, is oral communication versus written communication in nursing. The nurses in this study spoke more than they wrote regarding my study questions and oral communication is a large part of information transfer in the clinical setting. Many physicians do not write much of what they do during a clinical visit in a hospital. Some information is written but the majority of clinical information is recorded on tape and then transcribed by others. There

is an oral change of shift report that occurs to provide information from the nurse who is leaving to the nurse who is beginning the shift. This oral exchange happens in addition to the written documentation and contains much of the same information, but it also includes information that often does not make it into the chart, such as the psychosocial aspect of care that occurred during the shift. It would be interesting to examine how dictation might impact the discursive practices of nurses and the content of that discourse.

There are numerous areas of nursing documentation that can, and should, be explored in a qualitative manner. The constitutive and contributory characteristics of nursing discourse to clinical knowledge provide an unlimited number of research and educational opportunities and I believe nurses should be exposed to these attributes while still at the university. Nurses need to learn in their formative years that the language a profession chooses generally shapes that profession's values, habits, and standards of judgment and these qualities can have long-term, cumulative effects on the profession as a whole (Mohr 7).

APPENDIX A

Interview Questions

Institutional Standards of Documentation

How do institutional standards of documentation influence your daily nursing practice?

What is the source of your particular institution's standards?

How do you feel about having these standards in place?

What input, if any, have you had in your role as a nurse regarding your institution's documentation standards?

How was your input received?

Charting

What makes you chart in the manner that you do?

In your opinion, what role should nursing documentation play in the delivery of nursing care?

Based on your experience, what role does nursing documentation realistically play in the delivery of care?

What *benefits* have you experienced from using the following types of charting?

a. SOAP (narrative)

b. Charting by exception

c. Electronic charting

What *challenges* have you experienced from using the following types of charting?

d. SOAP (narrative)

e. Charting by exception

f. Electronic charting

Thinking about the challenges you've experienced with these various types of charting, what steps have you taken to address or resolve these problems?

What was the outcome?

How did you feel about the outcome?

Considering the maxim, "If you didn't document it, you didn't do it," how do you bridge the schism between excessive documentation and falling victim to this maxim?

APPENDIX B

CONSENT FORM

I, (participant's name), agree to participate in the research entitled Documentation in the Delivery of Nursing Care: An Examination of Nurses' Attitudes about Documentation Formats in Institutional Settings which is being conducted by Susan Vacula (512) 246-3875. I understand that this participation is entirely voluntary; I can withdraw my consent at any time and have the results of the participation returned to me, removed from the experimental records, or destroyed.

The following points have been explained to me:

- The reason for the research is to examine how mandated documentation practices affect nurses' attitudes toward documentation in institutional settings. I have had the opportunity to review the thesis proposal.

- The study consists of interviews as well as a review of literature.

1. The procedures are as follows:

    - Study Participants will complete a questionnaire via e-mail.

    - Depending on the responses to the questionnaire, the participants may be asked to engage in a telephone interview for clarification or further exploration of answers on the questionnaire.

2. The discomforts or stresses that may be faced during this research are: (if none, so indicate).

    - There are no anticipated discomforts or stresses for participants in this study.

3. Participation entails the following risks:

    - There are no anticipated physical, psychological, social, or legal risks associated with this study.

4. The results of this participation will be anonymous [or confidential] and will not be released in any individually identifiable form without the prior consent of the participant unless required by law. (Any special procedures regarding anonymity or confidentiality should be described here.)

Due to the nature of this study and the research questions, no confidential data is being collected. However, the researcher strives to adhere to high ethical standards and the ethical treatment of study participants, therefore will take the following precautions:

- Published study results will not associate names of interviewees and individual institutions in a unique way with particular data responses.
- Study participants will also receive an electronic copy of the study summary at the conclusion of the research.

Signature of Investigator	Signature of Participant [or authorized representative]

Date: _____

PLEASE SIGN AND RETURN TO THE INVESTIGATOR.

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