

NURSING DOCUMENTATION IN
THE EMERGENCY DEPARTMENT:
NURSES' PERSPECTIVES

by

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Abstract

Nursing documentation is a required aspect of care, but for various reasons it can be curtailed. Nursing records are a critical aspect of communication and without them coordinated and safe care can be difficult to achieve.

Study aim: To explore emergency nurses' perspectives and practices about the quality, importance and value of emergency nursing documentation in relation to their personal beliefs, past experiences and preferred systems of documentation; the practical and contextual factors that influence documentation practices within an emergency department (ED); their interests in documentation tools or systems; and their interests in relation to further development of documentation practices and systems.

Methodology and design: A qualitative descriptive study (informed by Sandelowski). Ten emergency nurses from one ED in New Zealand were recruited. Participants were interviewed using interactive interview methods, and completed a Likert scale to identify the relevance of internationally recognised general influences on documentation to their own practices in the context of an ED.

Findings: The participants' practices were influenced by factors in the workplace including competing priorities for time e.g. care provision vs. documentation, competition for access to patient records, and extant culture in relation the purpose, content and frameworks for documentation. Documentation practices were influenced by the participant's own clinical histories, philosophies, familiarity with particular frameworks and education. The participants recommended routes to development through partnership, participation and process engagement. Recommended strategies included document development, knowledge advancement and support. These findings were reported qualitatively and reveal areas of agreement and divergence.

Contribution and consequences: These results compare well to the general literature regarding known influences on documentation. Importantly they provide insight and generate new knowledge into context specific influences and to the relevance of personal histories to documentation practices. A consequence of this research will be to better understand the context and practice of nursing documentation in ED, the factors that influence it and the potential means for development which support the legal and professional goals of optimal documentation.

Keywords

Nursing Records; Emergency Nursing; Qualitative Description; Nursing Documentation; Emergency Nurses' Perspectives; Interviews, Context Specific Influences; Facilitating and Inhibiting factors

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Table of Contents

Title Page	i
Abstract.....	ii
Acknowledgements	iii
Table of Contents.....	iv
List of Tables.....	viii
List of Terms.....	ix
List of Abbreviations	xii
Chapter 1: Introduction.....	1
Introduction.....	1
Research aim, objectives and focus.....	1
Contribution to nursing knowledge	2
Justification.....	2
Personal background and beliefs	3
Approach	4
Limitations in research foci	4
Presentation of this thesis	5
Chapter 2: Literature Review.....	6
Introduction	6
Search strategy	6
Part One: Documentation systems	7
Historical perspectives.....	8
Discussion of documentation frameworks	18
Summary	21
Part Two: Rationale for documentation.....	23
Introduction	23
National and international situations	24
Litigation.....	26
Communication and collaboration.....	27
Professionalism and visibility of practice	28
Research, best practice, professional autonomy and accountability	30
Consequences for patients.....	31
Summary	31
Part Three: Practical factors influencing documentation	33

Introduction	33
Identified gaps in the reviewed literature	39
Limitations of the literature review	41
Summary	42
Chapter 3: Method, Methodology and Design	44
Introduction	44
Research aim and questions	44
Method	45
Fundamental qualitative descriptive research	45
Methodology	47
Theoretical perspective and paradigm – Naturalistic inquiry	47
Ontological assumption – Relativism	47
Epistemological assumption – Naturalistic methods	48
Axiological assumption	50
Design	50
Overview of the study design	50
Context of the study	53
Data collection methods	54
Data storage	58
Method of analysis	58
Rigour	60
Ethics	62
Ethical considerations	62
Ethical principles	65
Management of other aspects of the research	67
Role change	67
Time constraints	68
Summary	68
Chapter 4: Findings	69
Introduction	69
Orientation of the study	70
Themes clustered according to concepts	72
Cluster 1: Current local practices and habits	73

Rationale for documentation.....	73
Quality standards.....	77
Cluster 2: Participants own practices and history	79
Justification of practice and line of reasoning	80
Strategies and processes	82
Cluster 3: Participants reading.....	86
Training and education.....	86
Literature.....	88
Cluster 4: International literature and influences	90
Environmental impacts	91
Other influences impacting on documentation.....	95
Referral and its consequences	98
Cluster 5: Future development, potential process of change.....	101
Route of change.....	102
Document development.....	106
Education.....	111
Summary.....	114
Chapter 5: Discussion and Implications	116
Introduction	116
Discussion in relation to the substantive findings from the literature review.....	117
Discussion in relation to the substantive findings from field study.....	119
Visibility, power and value	120
Expectations and priorities of practice	124
Quality assessment and standards.....	127
Communication, care-coordination, data gathering and leadership.....	129
Findings in relation to methodology.....	131
Method, methodology and design	131
Rigour.....	132
Limitations of this study.....	133
Reflections on the study and findings.....	134
Implications arising from the study.....	135
Recommendations in further studies	136
Recommendations for practice	137

Conclusion	138
Appendix A: Ethics Letter of Study Approval	141
Appendix B: Recruitment Poster	142
Appendix C: Participant Information Sheet	144
Appendix D: Participant Consent Form	147
Appendix E: Aide-memoire.....	149
Appendix F: Demographic Data Survey	153
Appendix G: Positive and Negative Influences Found in Literature.....	154
Appendix H: Influences Survey	155
Appendix I: Theoretical documentation frameworks and nursing frameworks	156
References.....	158

List of Tables

Table 2.1 Search terms.....	7
Table 2.2: Theoretical documentation frameworks	17
Table 2.3: Acronym based practical assessment frameworks and authors.....	20
Table 2.4: Nursing council standards as tools.....	24
Table 2.5: Summary of motives to document, with advocates	31
Table 2.6 Summary of inhibiting influences on documentation practice.....	33
Table 2.7 Summary of enabling influences on documentation practice.....	35
Table 3.1 Design features and principles of the method	50
Table 4.1 Types and incidence of participants' pre-registration nursing education	71
Table 4.2 Types and incidence of participants' post-registration nursing education.....	72

List of Terms

There are many facets to documentation and its fundamental position within nursing practice has led to a multitude of names for the same process, as shown as part of the literature search in the literature review. It has consequently been deemed necessary to provide some definitions and clarifications of some of the key terms utilised in this study. Within this thesis the term 'documentation' is utilised. These clarifications also reveal some of my personal knowledge and potential assumptions of knowledge.

According to convention, the organisations, role titles and frameworks referred to are given in full name in their first citation in the thesis and thereafter by their initials or acronym. The initials and full names of the organisations and titles referred to have also been placed, for the convenience of the reader, as a reference in Box 1.1 in the introduction. Likewise, the acronyms of the frameworks can be found in Appendix I. These are separate because they were a tool within the interview process.

Documentation:

College of Nurses of Ontario [CNO] (2005) define documentation as both the act of creating records of care and the actual records themselves. In a clinical context these may include nursing, medical, clinical records and incident reports, also care plans and writing that focus's on the patient experience. The Nursing Board of Tasmania [NBT] (2003) extends this definition to:

Include but not restrict to the following types of documentation: policies/procedures/protocols, rosters performance appraisals or assessments, personnel files, computer generated data, dependency studies, research data and documents required for health funding purposes (p4).

The board further states that nursing documentation comprises all written and/or computerised recordings of relevant data made by nurses to document care given or to communicate information relevant to the care of a particular client/patient (NBT, 2003). This concurs with publications from the College of Registered Nurses of British Columbia [CRNBC] (2005) who state that the principles underlying documentation remain the same whether nurses use traditional (e.g., paper) or electronically generated (e.g., computer, fax, video, voice recording and images) documentation methods. Lastly the National Library of Medicine Data describes documentation as data "recorded by nurses concerning the nursing care given to the patient, including judgement of the patient's progress" (1997, p.1-2). Therefore, documentation can be considered the creation of an authentic record of patient care (Navruli, 2001).

Document:

Noun: a document is a physical representation of a body of information designed with the capacity (and usually intent) to communicate. In general use it is understood to be a paper artifact, containing information in the form of ink marks although increasingly, documents are also understood as digital artifacts. Verb: to document is the action required to produce a document by collecting and representing information. The verb also refers to the practice of data provision to support statements, requests, plans and actions (Wikipedia, 2006).

There are various names for each patient's health documents; these most commonly include 'file', 'chart', 'record', and 'notes' among others. This thesis may refer to these using the terms interchangeably but always meaning the same thing.

Emergency Department (ED) document:

Within the setting of this study, the ED documentation record is a pre-printed pink sheet with a red border. The staff members refer to this variously as the: 'red sheet', 'pink sheet', 'ED chart', 'ED sheet' and 'MR2B' after its filing number. They also often refer to the ED chart as the 'notes' despite the fact that it is only one small section of the patient's record.

Patient:

For the purposes of simplicity this thesis will use the word 'patient' to encompass all recipients of nursing care whether they would be referred to by another name such as client, consumer etc.

Model:

The term model may refer to either a model of nursing or a model of documentation. It can also be referred to as a theoretical framework. Documentation models may also be referred to as a: 'tool', 'system' or 'method' and the model may be presented as an acronym or mnemonic and therefore it may be referred to as such.

Factors influencing the process of documentation:

These factors come in both positive and negative forms. The positive forms may be referred to as: 'helping', 'assisting', 'supportive', 'facilitating', 'beneficial' or 'enabling'. Negative forms include: 'hindering', 'inhibiting', 'stopping', 'constraining', 'restraining' and 'barriers' among others.

Culture:

Culture has been defined " ...the beliefs and practices common to any particular group of people" (NCNZ, 2002, p3) and comprises of several parts including a philosophical base, a way of living in the world, attitudes and behaviours, the individual's role in society and links / relationships with others" (Ramsden, 1992). Organisational culture has been described by Germain (1993) as consisting of three levels, of which "nursing is a professional culture, a hospital is a socio-cultural institution and a unit of a hospital [e.g. the ED] can be viewed as a subculture" (p.238). Schein (1992) developed a model to describe organisational culture; he said that artefacts are the primary level of culture and these are the visible organisational structures and processes that can be difficult to decipher, examples include documentation styles as well as language used. The second level includes espoused values, which include the organisation's published standards of practice and philosophy of practice. In the third level, he argues there are the underlying assumptions which are basic and unconscious; this would include the habitual practices of the department's nurses.

List of Abbreviations

Abbreviation	Name or title in full
AC:	Audit Commission – United Kingdom (UK)
ACC:	Accident Compensation Corporation – New Zealand (NZ)
ACENDIO:	Association for Common European Nursing Diagnoses, Interventions and Outcomes
ACHS:	Australian Council on Healthcare Standards
ACEM:	Australian Nursing and Midwifery Council
ANA:	American Nursing Association – United States of America (USA)
ANMC:	Australasian College for Emergency Medicine
BHC:	British Healthcare Commission
CDHFS:	Commonwealth Department of Health and Family Services – Australia
CNC:	Clinical Nurse Coordinator
CNO:	College of Nurses of Ontario – Canada
CRNBC:	College of Registered Nurses of British Columbia
CSCI:	Commission for Social Care Inspection – UK
DoH	Department of Health – UK
ED:	Emergency Department
EOA:	Emergency Observation Area
GP:	General Practitioner
ICN:	International Council of Nurses
JCAHO:	Joint Commission on Accreditation in Hospitals Organisation – USA
MoH:	Ministry of Health – NZ
NANDA:	North American Nursing Diagnosis Association
NAO:	National Audit Office – UK
NASN:	National Association of School Nurses – USA
NBT:	Nursing Board of Tasmania
NBSA:	Nurses Board of South Australia
NBWA:	Nurses Board of Western Australia
NCNZ:	Nursing Council of New Zealand
NHS:	National Health Service – UK
NMC:	Nursing and Midwifery Council – UK
NMDS:	Nursing Minimum Data Sets
NPA:	National Pathways Association – UK
NPC:	National Pathways Commission
NZNO:	New Zealand Nurses Organisation
QHNZ:	Quality Health New Zealand
QNB:	Queensland Nursing Board – Australia
QNC:	Queensland Nursing Council – Australia
RCN:	Royal College of Nurses – UK
RNABC:	Registered Nurses Association of British Columbia
SNBHW:	Swedish National Board of Health and Welfare
TNCC:	Trauma Nursing Care Course

Chapter 1: Introduction

Introduction

Documentation is the bond which holds patient care together; it provides written confirmation of discussions and actions that have occurred as well as of activities that have been omitted for specific reasons; so it becomes a record and a method of communication regarding the patient. Therefore, without accurate documentation the ability to communicate can be compromised.

The quality of documentation by nurses has often been found to struggle to reach the current standards, such as those set by Quality Health New Zealand (QHNZ) and individual hospital documentation standards (Ammenwerth, Kutscha, Mahler, Eichstader and Haux, 2001; McKerras, 2002; Sbaih, 1994; Schulz-Robinson, 1997). This is a matter of concern in all areas of health care, and for all of the health professionals because optimal quality of practice is critical. This is especially so in emergency care, as the need for accurate documentation to facilitate every aspect of care in constantly evolving situations is critical.

This thesis reports on a small-scale descriptive and exploratory qualitative study about nursing documentation in the emergency setting. The thesis reports on the imperatives for nursing documentation, contemporary and classical documentation frameworks, and the enabling and inhibiting factors to completion of documentation. The descriptive study explored the value that emergency nurses place upon these aspects, and asked them what they perceive could be done to improve documentation in the context of the Emergency Department (ED). This chapter provides an overview of the study by assisting the reader to understand the organisation of the study and to clarify the concepts and activities that occurred.

Research aim, objectives and focus

This research study aimed to describe emergency nurses' perspectives regarding their practices in nursing documentation. Four research objectives were identified in relation to this aim, including:

- Gathering textual information from emergency nurses about their documentation practices in relation to their personal beliefs, past experiences and preferred systems of documentation.
- Gathering textual information and personal perspectives from emergency nurses in relation to practical and contextual factors that influence documentation practices within an ED.
- Explore emergency nurses' interests in documentation tools or systems in practice.

- Discover the interests (content or process) that emergency nurses may have in relation to further development of documentation practices and systems.

Nursing documentation in the ED is the focus of this study, because there is an apparent absence of research into the documentation practices in short-care episodes. An aim of emergency care is to ensure that the episode is of as brief as possible (Department of Health [DoH]{England}, 2001). It is therefore, transient in nature with the plan to always move the patient on, whether to an inpatient destination, to outpatients, transferred to another inpatient facility including rest-homes, nursing-homes or respite care, discharged home for follow-up by their own general practitioner (GP) or Practice Nurse, district nursing, home-help networks or other support services or occasionally they die within the department. In addition, the patient is usually or often treated by various members of the multi-disciplinary team, who can themselves be transient providers of care. In every case, communication is paramount to ensure continuity of care. All care needs to be documented comprehensively, succinctly and contemporaneously (not at the end of the staff member's shift or the patient's transfer or discharge, as can occur on the wards) to ensure that care provision is complete.

Contribution to nursing knowledge

This research contributes to the larger collective research endeavour as findings may be integrated into the knowledge base already found and written about by other researchers and authors. This follows the concept of the mosaic model suggested by sociologists from the Chicago School as described by Crotty (1998). A consequence of this research will be to better understand the context and practice of nursing documentation in the ED, and the factors that influence it. This contribution to knowledge supports the legal and professional goals of optimal documentation.

Justification

Renfroe et al. (1990) found in their study that 15% of nursing actions were not documented while Suhayda and Kim (1984) similarly found that 19% of nursing actions were not documented. McKerras (2002) drew attention to the issue that nursing documentation in the ED setting is often inadequate but did not investigate the reasons for this. Notably, McKerras stated that "existing practice cannot change without understanding the underlying reasons for failing to document" (p.5). This is a notion that is consistent with the aim of this thesis. The apparent gaps in understanding are what sustain current inhibitory influences and practice difficulties regarding documentation and the failure to support the facilitating influences, thereby, imparting the justification for this research project.

The idea for the study arose as a result of a quality role I held in the department of nursing and my awareness of the findings from two audits on the standard of documentation practice among nurses held within the ED of one hospital. The first audit was part of an employees' study (McKerras, 2002) and the second was in preparation for national accreditation (Dean et al., 2003). This second audit raised eight systems recommendations including the development of an outline of the expectations of the standards of documentation and practice the nurses should fulfil and the ongoing monitoring of practice. Also five training or education recommendations were made such as an awareness of the standards that exist, an update of the teaching materials available and the document used by the health staff members to write upon, the development of learning opportunities for specific areas such as formalised health assessment to address a lack of practical skill which could be leading to poor written assessments and support with caseload management to facilitate documentation. A documentation committee was formed with the intent to upgrade documentation charts and attempt to improve documentation practices. This resulted in some small changes in the paperwork provided. In addition a set of teaching sessions occurred to highlight the issue and the standards of practice covering documentation and each nurse received a laminated card with expected standards of practice detailed on it to attach to their identity badge. The Clinical Nurse Coordinator (CNC) on duty checks the notes of discharged patients to ensure they were completed prior to filing, if the nurse concerned has finished the shift they receive a pre-printed note with the relevant data to help them retrieve the notes and complete them to the set standards. However, an informal repeat of the audit in early 2006 revealed little change in practice (Williams, personal communication, 12th February, 2007), and the results of a 2007 audit, as part of the now annual audit cycle, has yet to be published.

In addition to the audits there have been two significant New Zealand reports generated from industry investigations which have had consequences on practice: *Stent Report on Deficiencies at Christchurch Hospital in 1996* (Stent, 1998) known colloquially as "The Stent Report" and *The External Review of Emergency Department, Christchurch Hospital* (Brennan & Kennedy, 2004). In each of the investigations, the documentation that occurred for patients was scrutinised and commented upon. Likewise internationally, in the UK the National Audit Office [NAO] wrote "lost or poorly completed records are a major contributory factor to patient safety incidents" (2005, p.9).

Personal background and beliefs

I am a Registered Nurse with 16 years of clinical practice experience. I qualified in a large hospital in England serving a wide range of cultures and my qualification translated into that of a Registered Comprehensive Nurse when I migrated to New Zealand. Since my migration I have steadily furthered my education from that of Diploma Level to Masters Level and this thesis is the final part of this process. My

predominant and current field of practice has been emergency nursing. In addition, I maintain a regular role in the quality programmes of the ED, as a representative of the department on a hospital committee addressing all aspects of fluid and medication administration.

Out of this interest in quality in nursing I undertook a six-month secondment in the role of Quality Facilitator within the same hospital as this study occurs. During this time I assisted in the investigations of reported incidents. A significant proportion of the investigations relied on the documentation provided by the health care workers at the time of the incident. This role revealed to me how widely the practices of documentation within and between each health-care profession and between work settings in the same institution differed. Prior to this role I had viewed varying documentation practice solely from the perspective of an emergency nurse and I would explain the phenomenon away as the person "must have been too busy to document in full". Discovering inadequate documentation from the prior carers creates difficulties when assuming or assessing a patient's care and it became clear during my secondment that this issue affects a wider population than that of emergency nursing.

Regarding my own knowledge of documentation requirements and frameworks, I felt that my knowledge is empirical knowledge, dependent on experience or tacit personal knowledge (Polanyi, 1967). I have come to realise through reflection that much of my knowledge is taught to me by preceptorship and example, meaning my knowledge is empirical and explicit knowledge.

Approach

This study engaged with nurses from one very busy ED in a tertiary hospital, who have a range of past experiences informing their current practice. Previously published articles and books in relation to documentation involve nurses from medical, surgical or specialist wards or the community (Ehnfors, 1993b; Hardey, Payne & Coleman, 2000; Howse & Bailey, 1992; Kerr & Lewis, 2000; Tapp, 1990; Törnkvist, Gardulf & Strender, 1997).

A qualitative descriptive approach was chosen as the primary approach of the study because description with low-inference in relation to emergency nurses' perspectives on their documentation practices, the factors that influence this, and potential for development of practice would be helpful.

Limitations in research foci

While the literature review provided an overall description of the types of frameworks and systems available to facilitate documentation, no framework was preferred over another. While many of the

documentation tools identified may apply for nurses or as general multi-disciplinary tools, this thesis has not addressed the documentation of all disciplines, rather the focus is on emergency nurses as participants and nursing documentation. I chose to investigate nursing documentation only as each profession has its own requirements, and the scope of this inquiry was insufficient to encompass the documentation of other professionals involved in patient care.

Presentation of this thesis

This opening chapter provides overview of the study interests, a general rationale for the research and a description of my background as the researcher and the location of the study. In the following chapter, a summative analysis of the literature is presented. This review reveals pertinent information that further informs the design of the study. In Chapter 3 the methodological approach and the investigative methods of the study are discussed. The processes of the study are described and the rationale for the research procedures chosen is explicated. The qualitative descriptive findings of the study are presented in Chapter 4. The findings are discussed and the implications arising from them for future practice and research are presented in the final chapter (Chapter 5).

Chapter 2: Literature Review

Introduction

A literature review provides opportunity to “look again at the literature... in... an area not necessarily identical with, but collateral to, your own area of study” (Leedy, 1989, p.66). This literature review as presented affords a summative analysis of the theoretical (conceptual and research based) literature applicable to the study interests. It is a review which looks at the history of documentation, the processes influencing it such as practice and theoretical models, and the reasons and requirements for nursing documentation.

Discussion has been divided into three sections. The first describes the various systems of documentation that exist; the intent of this section is to provide an explanation of key terms, such as the nursing process, which are used in practice and are often implicit in the documentation frameworks as well as a brief synopsis of common frameworks in use. This section as a whole demonstrates the significant journey through change that documentation frameworks have made. The second section investigates and explains (through the literature) why documentation is a necessary part of nursing practice with reference to professional organisations and legislated standard setting requirements, litigation, communication and collaboration, professionalism and visibility of practice, research, best practice and professional autonomy and the consequences of documentation for patients. The third and final section reviews the identified facilitators and barriers to documentation including physical and psycho-social pressures, time and workload, access, repetition, knowledge, and language barriers.

Search strategy

The principal databases used were Cochrane, CINAHL, MedLine, EBSCO Host, ProQuest, Google, and Google Scholar. The search terms were adjusted as verbs and nouns to gain the widest response possible (e.g. impede, impediment etc). Using the various search-engines to find appropriate and useful literature 16,617,941 items were initially located by fit to the terms listed in Table 2.1. More have followed since, plus further articles and studies cited in the references of the original publications reviewed.

To reduce this extensive literature to a manageable size, only publications described by the database as research articles, study reports, systematic reviews, tools, guidelines or recommendations were accessed. This was followed by a review of the references in their cited sources if needed. As a consequence of this strategy, a total 117 articles, reports or books, in print and online were gathered, including: tools or models

of documentation (n=21), research articles, audit tools or systematic reviews of variable quality or depth (n=44), nursing council or college standards or guidelines (n=16), editorials or opinions (n=17) and non-professional/ organisational documentation recommendations (n=19).

Table 2.1 Search terms

Aspect	Terms
General	Documenting, charting, recording, record-keeping, note-taking and writing Records, notes, files, charts, information systems, – varying these terms by adding the terms nursing/medical/patient/client/clinical to each
Types	Models, theoretical frameworks, systems, methods, formats, checklists, flow-charts/sheets, clinical pathways, tools, algorithms, mnemonics, acronyms Incident report, (core) care planning, Kardex, assessment forms
Positive and negative influences:	Positive forms: helping, assisting, facilitating, beneficial or enabling Negative forms: hindering, inhibiting, impeding, stopping, impeding, constraining or restraining as well as barriers
Other aspects:	Critical care practice guidelines, practice parameters, accreditation, quality control/assurance, standards, legislation, accountability, clinical governance, practice guidelines, professional compliance, financial, fiscal

Part One: Documentation systems

Much has been written about documentation approaches, processes and methods to address the issues of documentation by researchers and scholars to improve and develop the quality, efficiency and usefulness of nursing documentation, for example, Lampe (1984, 1985); Lawler (1991a); Montemuro (1988); Navuluri (2000) and Weed (1969). Various approaches to documentation have developed over time and some of these approaches have become documentation theoretical frameworks in their own right. The focus of the following section is upon the theoretical frameworks for documentation rather than models of nursing with the exception of the nursing process which has, as will be seen, significantly influenced other frameworks.

Each framework would appear to have been developed to facilitate nurses' documentation knowledge and skills and each has a different philosophical basis. Coleman (1997) noted that documentation falls into two categories: documentation by exception and documentation by inclusion. Some of these approaches are so

long established it is difficult to trace their origins or original references or - this is particularly true in the case of critical care paths, which even a search through the National Pathways Association [NPA] literature does not reveal. In addition to the theoretical frameworks of documentation, models of nursing have been developed, which many healthcare providers use to frame their care and often their documentation too.

In the following sections I present a more detailed and summative overview of these systems of documentation. Around the world nurses and other health professionals use many different frameworks for documentation. These frameworks have a long history of development; sometimes they have been developed in practice and have become intrinsic to the practice of documentation, in other cases the initial ideas and frameworks were developed for practice and have then been adopted in part or modified by other groups. For this research study, I needed to trace the historical development of the frameworks and to understand how the aspects have been developed, used and may currently inform research into documentation practice, and the actual practices of clinical teams in the workplace. The results of this analysis were informative, and many of the frameworks that I present in the following sections are indeed referred to by authors whose work has been cited in the remainder of the review. A summary of common documentation frameworks is shown in Table 2.2 after the frameworks have been discussed.

Historical perspectives

Documentation of care has occurred since the time of ancient Egypt i.e.: 1500-1600BC on papyri and continued to take place through subsequent centuries including by the European religious orders who cared for the sick (Royle-Mansell, 1977). Apothecaries of that time also listed their patient's complaints and purchases (Benjamin, 1977). In contrast, in the 19th century documentation was advocated by Florence Nightingale (1860) only if it helped the nurse to recall observations, implying that routine care provision by her peers and herself was not documented. At that time the narrative processes would have been utilised for written documentation, with the oral tradition as the principle component of communication for transfer of care from nurse-to-nurse. Narrative documentation is a descriptive approach in which the patient status, nursing actions and outcomes are recorded in chronological order to reflect the care given during a particular time frame in the progress notes without an organising framework, with or without support by other tools, such as flow sheets (Registered Nurses Association of British Columbia [RNABC], 2003, CNO, 2005). Narrative documentation was the original form of nursing documentation in hospitals, initially in the ward book (James, 1997) then in the patients' notes first as a sub-section and more recently integrated into the whole.

The oral tradition

Parker and Gardener (1992) argue that the culture of oral nursing communication is traditional to nursing, describing it as “private and transient” (p.8). They reason it is private is because it frequently occurs away from the patient “behind closed doors” in “handover” (p.8). It can be inferred that the description of such communication is transient because no formal record of this communication occurs, although the authors do not clarify this. The oral tradition has been a core component of nursing communication, verbally passing from one nurse to another critical information for the patient’s care during the following shifts, not considered important enough to be written down, because traditionally it was nursing care not medical care (James, 1997). In the earliest writings, the oral tradition was often maintained in tandem with the narrative process, possibly giving rise to the origins of the old wives tales so often deplored by the health community, which contain elements of truth.

The oral tradition is best demonstrated during the handover time where records and care plans are often not formally referred to; instead informal notes are used to prompt nurses in verbally reporting to each other (Hardey et al., 2000). Verbal handovers, however useful to the receiving nurse, do not protect the providing nurse if an investigation occurs, unless that information has also been written down. Lawler (1991b), Parker and Gardener (1992), Pearson (2003) and Schulz-Robinson (1997) remind readers that the invisibility of nursing practice has been caused in part by communication following the oral tradition. In defence of the tradition, Parker and Gardener argue that the traditional handover time is not dedicated solely to imparting patient data from one shift to the next, but also it is an opportunity to learn from colleagues and to gather support for their practice. They assert that this private oral communication is an opportunity for nurses to construct an “every-day word out of their experiences” (p.8) to help them normalise their activities where such discussion would distress or disgust non-nursing friends or family. Savy (1997) highlighted another concern regarding the oral tradition, that it depends upon the effectiveness of spoken communication, and that the eradication or curtailment of ward handover time has interfered with this practice.

In summary, the oral tradition has advantageous and disadvantageous aspects. Oral communication is immediate and interactive with the listener; however, two problems there are caused by it. Firstly it contributes to the invisibility of areas of nursing practice (Lawler, 1991b). Secondly it fails to provide for recorded evidence of decisions and critical thinking that occurred and actions or omissions in care or assessment that transpired. An example of the oral tradition in the emergency setting is decision-making around triage.

Triage

The term “triage” originates from France and means to sort, pick out, classify or choose (Williams, 1992). It was originally used as a means of grading the quality of commercial produce (Marsden, 2007). The triage process was first used in medicine during the Napoleonic wars (1792 - 1814) when “for the first time, casualties were treated on the basis of medical need rather than rank or social status” (Marsden, 2007, p.567). The principle of triage in health care is to prioritise care to large groups of people and it has since been adapted from its military origins for use in the civilian context of initial ED care (Edwards, 1994; Mallett & Woolwich, 1990; Wilson, et al., 1995). In the civilian ED context, triage is a formal process of immediate assessment of all patients who present seeking emergency care (Commonwealth Department of Health and Family Services [CDHFS] & Australasian College for Emergency Medicine [ACEM], 1997; Williams, 1992). Triage assessment findings are then used to prioritise or classify patients on the basis of illness or injury severity and need for medical and nursing care (ACEM, 1993b, 2000a). An effective triage system aims to ensure that ED patients “receive appropriate attention, in a suitable location, with the requisite degree of urgency” with the most urgent patients seen first (George, et al., 1993, p.221). Triage aims to ensure that emergency care is initiated in response to clinical need rather than order of arrival, to promote the safety of patients by ensuring that timing of care and resource allocation is apposite to the degree of illness or injury (ACEM, 1993a; 1993b; 2000a; CDHFS & ACEM, 1997; Whitby, Ieraci, Johnson & Mohsin, 1997).

The majority of New Zealand EDs use the Australasian Triage Score (ACEM, 2000a), which is similar to the United Kingdom’s Manchester Triage Scale (Mackway-Jones, 1996). Triage scales utilise codes to order the patient assessment priority, they include a numerical or colour coding. The Australasian Triage Score like the Manchester Triage Scale uses five priorities: ONE denotes immediately life-threatening resuscitation level needs – for immediate interventions, TWO denotes Imminently life-threatening emergency level for assessment in less than ten minutes, THREE denotes Potentially life-threatening – urgent needs, to be seen within 30 minutes, FOUR denotes Potentially serious: semi-urgent needs, patient to be seen within one hour and FIVE denotes less or non-urgent: patient to be seen within two hours (ACEM, 2000a). By using one scale nationwide consistency is sought.

The nursing process and nursing diagnosis

The development of the nursing process as a framework of nursing practice began in 1967 and adapted as practice developed (Yura & Walsh, 1988). Moloney and Maggs (1999) contend that 1987 represented “the nodal year for the introduction of the nursing process across most western orientated countries” (p.3). The nursing process is an outcomes model, which initially involved four elements: **A**ssessment, **P**lanning, **I**mplementation and **E**valuation (Yura & Walsh, 1967). It later evolved into five elements with the

addition of a nursing **D**agnosis as the second element therefore: **A**ssessment, **D**agnosis, **P**lanning, **I**mplementation and **E**valuation (Yura & Walsh, 1973). This change occurred as a consequence of the conference of the inaugural North American Nursing Diagnosis Association [NANDA] in which it was agreed that there needed to be a conclusion or diagnosis after the process of assessment is completed. In medicine the place of diagnosis in practice is central. Fowler described it as: “the most important aspect of clinical medicine ... it depends more on skilled history taking than on examination or studying the results of tests [as] evidence-based medicine only follows when a correct diagnosis has been made” (Fowler, 1997, p. 153). Although Fowler was writing about medical practice, the concept is true for nursing practice also. A widely accepted definition of nursing diagnosis is that it is: “A clinical judgement about an individual, family or community response to actual or potential health problems/life processes. [It] provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable” (NANDA International [NANDA I], 2005, p.227).

Gordon (1994), Carnevali (1996) and Carpenito (2002) have separated nursing diagnosis into three components. Gordon described the PES structure, where the signs and symptoms validate the problem. This structure includes a health **P**roblem, related or aetiological (**E**tiological as in the American spelling) factors and the defining characteristics or cluster of **S**igns and **S**ymptoms. An example could be P = weight-loss secondary to E = dysphagia leading to S = pressure sores. However, Carnevali and Thomas (1993) qualified this definition arguing that the diagnostic statement does not always include all three parts providing an example as “sleep deprivation leads to irritability and fatigue” (p.171). Carnevali later developed an alternative tool for documenting the diagnosis, with the first two steps unchanged, replacing signs and symptoms with “concerns and consequences” or the patient’s response to the problem. An example of this tool could be “weight-loss [P] secondary to dysphagia [E] leading to low body weight and poor healing of pressure sore [consequence]”. Carpenito described nursing diagnosis as resembling to Gordon’s structure. The first part is to name the problem (diagnostic label), relate it to the aetiology (contributing factors), and evidence it by a symptom (signs and symptoms). Ehnfors (1993b) claimed that the nursing process is “the basis for good nursing care” (p.207) and Latimer (1995) described it as “both a technology and a set of artefacts through which nurses extend themselves in ways which help manage their interests and (re)constitute their identity” (p.213). Meanwhile, Kenney (1990) illustrated the nursing process as a tool with seven characteristics; these include that it is goal-orientated, patient-centred, logical, systematic, dynamic, applicable to individuals, families and communities; adaptable for use with its elements used either sequentially or concurrently. It is interpersonal, based upon the nurse-patient relationship and, finally, it can be used with any type of nursing model.

One may question why this one theory of nursing practice has been incorporated into a literature review of nursing diagnosis when other significant theories have been omitted. This is simply because later

documentation tools have been based upon it or it has been incorporated into the education programme instigated by those authors such as Siegrist, Dettor and Stocks (1985).

1960s-1970s developments

Three new approaches to documentation emerged within the 1960s including a clinical nursing tool (Smith, 1968), a problem orientated tool (Weed, 1969) and integrated care pathways. The establishment of NANDA and the advancement nursing process to include the concept of nursing diagnosis (Yura & Walsh, 1973) were the sole developments published during the 1970s found in this literature search. During the 1970s, these approaches were instilled into daily practice and education and have influenced the development of future approaches as evidenced further in this review.

Smith (1968) argued for the need for a systematic method and evidence of clinical thinking among nurses and claimed that her tool could provide a conceptual and procedural frame of reference. She developed a guide for the collection of a nursing history, which involved 14 “items” with the first seven representing the “history guide” and the latter eight to 14 facilitating clinical thinking processes, by asking the user questions about the goals for the patient’s care. Smith made an interesting point when she noted that what is not pertinent to medicine is pertinent to nursing and therefore reliance on the medical model may be insufficient to meet nursing needs. However, she may have overreached in her argument, as some elements may legitimately be within the domain of other practitioners, such as occupational therapists or physiotherapists whose disciplines emerged from nursing.

Perhaps the most influential documentation tool to be developed at this time was a problem-orientated tool by Weed (1969). He described medical records as “being sometimes irregular, diffuse, subjective and incomplete” (p.vi) when not problem-orientated. His thesis was that documentation could and should be ordered in a problem-orientated manner to make it “a dynamic, structured, creative instrument for facilitating comprehensive and highly specialised care” (p.vii). Weed argued that the problem-orientated record consisted of four phases of medical activity: the establishment of a data base, formulation of a list of all problems, initial plans for each problem and progress notes for each problem. Weed wrote of a system called the SOAP method, which is an acronym of the four elements of each of the patients’ problems. These elements are: **S**ubjective data, **O**bjective data, **A**ssessments made and **P**lans formulated. Alternatively, the first two elements are also sometimes described as: **S**ymptoms and **O**bservations by some nurses. Although Weed was writing from the physician’s perspective, it is now clear that his method has influenced generations of nurses since. Nurses found that the method reflected the nursing process and utilised it however they found a limitation in the tool, in that it did not allow for three other phases of practice including **I**mplementation of planned interventions, **E**valuation of interventions, or **R**evision of

plans. As a consequence the method has been extended to integrate these processes making it: SOAPIER (RNABC, 1999). Filmer (1997) refers to the use of another alternative adaptation of the SOAP tool with the addition of **E**ducation given, **R**eferrals made and evaluated **O**utcomes and known as SOAPERO; also noted by Lawler (1991a). Filmer claimed that the SOAPERO system was the tool of choice when working in isolated places as it enables documentation of autonomous practice.

The critical path and process mapping methodology was being developed in industry, particularly in the field of engineering from as early as the 1950s (National Health Service [NHS] National Library for Health, 2005) and was used in the health sector from the 1960s (Kowal & Delaney, 1996; Page, 1997). Integrated care pathways (ICP) are now used all around the world including Australia, Belgium, Canada, Germany, the Netherlands, New Zealand, United Kingdom (UK) and the United States of America (USA) (NHS National Library for Health). A definition of a critical pathway is that it is a: “multi-disciplinary patient-care tool used in case management models to coordinate and facilitate the efficient and effective management of various patient groups... [it] may be based upon diagnostic related groupings... patient condition... or elective surgical procedures” (Page, 1997, p.89). The National Pathways Association [NPA] claims a critical pathway forms “all or part of the clinical record, documents the care given, and facilitates the evaluation of outcomes for continuous quality improvement” (NPA, 1998, p.1). An integrated care pathway determines locally agreed multidisciplinary practice, based on guidelines and evidence where available for a specific patient/client group. The NHS National Library for Health also states:

[ICPs] may contain protocols and guidelines and they may start their developmental histories as a process map, flow chart or decision tree, but unless they have a mechanism for recording variations/deviations from planned care/activities when used as the record of patient care, then they are not a true ICP. (p.1)

The intention of critical pathways is to further integrate patients' clinical records into single records. Critical pathways enable an increase in the consistency of the care provided, based on current best practice models of care, to set a minimum standard for care. They enable the identification of core components of care appropriate to that pathway grouping; highlight patient progression and daily requirements and facilitate the discharge process. This has an impact on the individual patient and the flow of patients through the hospital system. The NHS state in their website that an ICP can also be known as: Anticipated Recovery Pathways (ARPs), Multidisciplinary Pathways of Care (MPCs), Care Protocols, Critical Care Pathways Pathways of Care, Care Packages, Collaborative Care Pathways, CareMaps® or Care Profiles (NHS National Library for Health, 2005).

1980s developments

Four documentation methods were published in the 1980s, including the Focus Charting tool (Lampe, 1984, 1985; Lampe & Hitchcock, 1987), Charting by Exception (Burke & Murphy, 1988; Murphy, Beglinger & Johnson, 1988) the PIE System (Buckley-Womack & Gidney, 1987; Siegrist, Dettor & Stocks, 1985) and the CORE system (Montemuro, 1988).

Focus Charting was developed in 1981 in the USA in one institution as a response to perceived limitations to the SOAP system (Lampe & Hitchcock, 1987). The principle of the Focus system was to concentrate upon certain concerns (known as the focus) which the nurses and patients held in respect to the patient's conditions and care and then to organise the written report. The system involves three types of documents which include flow charts for vital signs and checklists for monitoring of activities and nursing tasks, then the nursing care plan and finally the patient care notes. The care plan is divided into three columns, the first is the focus followed by expected outcomes and nursing interventions. Each patient care note is then divided into three columns the first is the date and time the second is the focus and the third is for the findings or outcomes which are arranged into three fields: **D**ata: subjective and objective supporting information, **A**ction: interventions implemented and **R**esponse to those interventions or the DAR format. The patient care notes are written with the agreement that the nurse is not required to document there what has already been documented in the flow charts unless interventions occurred as a consequence of findings shown on the flow charts such as abnormal vital signs that required a therapeutic intervention. This agreement reduces the quantity of repetition in documentation which raises compliance and results in notes becoming more concise and pertinent.

Charting by exception (CBE) was developed in 1983 (Burke & Murphy, 1988; Murphy, Beglinger & Johnson, 1988). The intent of CBE is to simplify and streamline the writing process for long term care situations where daily care follows a set pattern and documenting every detail of normal daily living every shift would lead to repetition and any deviation from the norm could become obscured by the details of the daily care. Murphy et al. describe four record forms as the components of CBE. Three are kept at the patient's bedside these include the graphic record for vital signs, the nursing / physician order flow sheet based upon the SOAP system and the patient teaching flow sheet. In conjunction with these, a shift report highlighting any variables or exceptions written in longhand is present in the main clinical record with a carbon copy of the patient's vital signs for the previous day for the convenience of physician reviews. For this system to occur successfully a detailed care plan is developed on the patient's admission which is then updated at set regular intervals. By simply signing off the care plan each day to show that the routine practices had occurred and then documenting only the variable episodes in the patient's day accentuates differences and potentially important incidents (Burke & Murphy). A second consequence of CBE is the

reduction in the overall time spent by nurses documenting their care. CBE challenges the long-held legal belief: "if it was not charted then it was not done," and replaces it with a new premise: "all standards have been met with a normal or expected response unless documented otherwise" (CNO, 2005 p.21).

In 1984, Siegrist et al. (1985) developed an alternative documentation system: the PIE system. This system shares the same problem orientated approach as the SOAP tool. And is acronym based name for the tool, representing **P**roblems, **I**nterventions and **E**valuation. While this tool does not include the assessment process in the acronym, an assessment sheet is provided within the tool. The second redeveloped version by Buckley-Womack and Gidney (1987), integrated **A**ssessment findings to validate the stated problem as an additional primary step, renaming the steps to APIE for **A**ssessment, **P**roblems, **I**nterventions and **E**valuation. The PIE and APIE systems are clearly based upon four of the existing five steps of the nursing process although Siegrist et al. did not directly acknowledge this. In fact they reveal how aware they were of the nursing process when argue that this tool improves the nurses utilisation of the nursing process in their daily practice and they describe how staff members were taught the nursing process as the first step towards implementing the tool. Neither the PIE or APIE tool integrates the step of nursing diagnosis, yet the step was recognised in both versions, as the staff members using the original tool were "introduced [to] the accepted list of nursing diagnoses [published by Kim and Moritz (1982)]" (Siegrist et al., p.188) and they were and taught to integrate these diagnoses into their care planning formulation process. The development of this tool with nursing diagnosis delineated within the acronym would have been an ideal opportunity to remind nurses to develop standard diagnoses and formulate their plans upon them. The argument for the development of the tool was to simplify the narrative process in place at the time; it appears that they were also trying to integrate all the elements of the nursing process, yet simplify it by not adding all of the elements into the acronym for the tools name. The fact remains (as they have identified) this tool does "bridge the gap between the classroom and the real world of nursing practice" (Siegrist et al., p.189) by placing the nursing process into a working tool for nursing care provision and documentation.

Montemuro (1988) described the development of the CORE system based upon the nursing process. CORE is an acronym representing the conceptual aims of documentation: to be **C**oncise, **O**rganised, **R**esponsive and **E**valuative. It uses an admission assessment form to complete a patient database, and a care plan followed by flow sheets and narrative progress notes. The flow sheets are divided into sections headed: nursing diagnosis, expected outcomes and interventions. The progress notes are organised under three headings: **D**ata to support the nursing diagnosis, **A**ctions and **E**valuations made, referred to as the DAE format (Montemuro, 1988). This system also integrates a discharge summary to complete the nursing documentation, which is ideal, as discharge planning should occur from the patient's admission.

1990s developments

Developments published in the 1990s on documentation systems include three new systems. These included the VIPS model (Ehnfors, Thorell-Ekstrand & Ehrenberg, 1991, Ehrenberg, Ehnfors & Thorell-Ekstrand, 1996), the FACT tool (Warne & McWeeney, 1991) and the Health Care Focus Documentation model (Scoates, Fishman & McAdam, 1996).

The VIPS model was developed in 1991 then revised in 1996 (Ehrenberg et al., 1996) and is an acronym formed from its principle concepts using the Swedish words for **V** for Well-being, **I**ntegrity, **P**revention and **S**ecurity. The model involves keywords including nursing history / status / diagnosis / goal / intervention / outcome / transfer report / discharge note and it utilises “everyday nursing terms and internationally recognised, professional terms” (Ehnfors, Ehrenberg & Thorell-Ekstrand, 2002 p.146). This model is also based upon the full nursing process with terms in the model corresponding to phases of the nursing process, i.e. assessment corresponds to nursing history and nursing status, diagnosis with nursing diagnosis, planning with goals and nursing interventions, implementation with nursing interventions again and evaluation with nursing outcomes and discharge notes (Ehrenberg et al., 1996 p.15). The author's state that the model has two foci, the first is on patient care rather than the structure of the documentation however the intent is to provide a structure and vocabulary for all areas of care for which the nurse is responsible to do and to document, regardless of who prescribed them. The second focus given is towards the patient's functional ability in the activities of daily living rather than on pathophysiological problems (Ehnfors et al., 2002). This can lead to confusion or repetition of documentation because, as the authors point out, the same patient problems may need to be categorised under different keywords depending upon the context. This model is taught as a 3-day course to all registered nurses followed by varying degrees of mentorship and in all nursing schools. The course is known as “Vård 77” (Törnkvist et al., 1997, Ehnfors et al., 2002) and is described in detail by Björvell, Thorell-Ekstrand and Wredling (2002). The VIPS model was developed in Sweden as a result of legislative changes specifying the nature of nursing documentation (Ehnfors et al., 1991). Since its publication it has been integrated into nursing practice almost entirely throughout Sweden, in hospital and community settings, as well as in parts of Norway and Denmark (Darmer, et al., 2006).

The FACT tool (Warne & McWeeney, 1991) follows the acronym FACT representing **F**low-sheets, **A**ssessment, **C**oncise narrative notes and **T**imely entries. The flow-sheets are for data trending as the data is collected to avoid duplications of writing and to enable immediate analysis of the patient's situation in light of prior recorded data. Assessment involves using standardised medical surgical baseline parameters, with individual interventions planned for the patient listed below these parameters. Concise narrative notes follow with an emphasis on the use of an integrated record using the DAR format (Data, Action

and Response) of the Focus charting tool for all but mental health patients, where the SOAPIER model is used. These models are used to standardise the narrative process across the spectrum of health workers accessing and recording in the patients' clinical record, to enable easy retrieval of recorded information. Finally, the timeliness of documentation is imperative; to enable this many of the flowcharts designed for the model are intended to be kept at the bedside.

Scoates, Fishman and McAdam (1996) published a system developed in their hospital called "Health Care Focus Documentation" (p.1), which it involved the replacement of nursing diagnoses with 16 healthcare topics and five basic charts. This system and charts were developed with the future in mind; being paper-based but designed to be convertible to an electronic format. They rejected nursing diagnoses as a basis for documentation after analysing the current practices in their hospital which revealed inconsistencies within the notes, they "were categorised incorrectly, [cumbersome, lacked clarity and had]... multiple nursing diagnoses ... combined within [each] note" (p.1).

21st Century developments

This century has revealed two further processes for documentation. These include the Invocation Technique (Navuluri, 2000) and concept mapping (Taylor, 2007).

The Invocation Technique (Navuluri, 2000) involves the application of six questions to every item the nurse is considering documenting. The questions are simple and Navuluri argues that by writing the answers to all six questions within the entry being made in the clinical record a complete documentation entry is formed. The questions are: What? Why? Where? When? Who? How? The benefit of this framework is that it is applicable to narrative documentation and more importantly it facilitates critical thinking in the nurse.

Taylor (2007) introduced concept mapping as a method of health assessment that can be based upon a nursing paradigm. In this system, the nurse develops a visual map of the patient's needs and then writes client outcomes, nursing strategies, and an evaluation plan. However, the documentation of the strategy, plan and evaluation are not specified as following any system, so it can be inferred that narrative process is used.

These frameworks have been collated and summarised in Table 2.2 as follows.

Table 2.2: Theoretical documentation frameworks

Framework	Author or advocate
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Oral tradition	Advocated: Nightingale (1860)
Narrative	Records seen on Ancient Egyptian papyri: 1500-1600BC
Nursing process	Yura and Walsh (1988)
SOAP revised to SOAPERO and SOAPIER	Weed (1969) – revised Lawler (1991a), RNABC (1999)
Critical pathways / care paths	1960s – Advocated: Kowal and Delaney (1996), Page (1997)
Focus charting ®	Lampe, (1984, 1985), Lampe and Hitchcock (1987)
Charting by exception [CBE]	Burke and Murphy (1988)
PIE revised to APIE	Siegrist, Dettor and Stocks (1985) – revised Buckley-Womack and Gidney (1987)
CORE charting	Montemuro (1988)
VIPS Model	Ehnfors, Thorell-Ekstrand and Ehrenberg (1991) – revised Ehrenberg, Ehnfors and Thorell-Ekstrand (1996)
FACT tool	Warne and McWeeney (1991)
Invocation technique	Navuluri (2000)
Concept mapping	Taylor (2007)

Discussion of documentation frameworks

Nursing models rather than documentation models

Kerr and Lewis (2000) noted that some workplaces do not use a documentation model for writing, using instead a nursing theoretical framework to develop core care plans. The growth in the number of frameworks developed for nursing practice has been well documented since the development of the nursing process. Prior to this time there are also some notable theorists at work, for example Florence Nightingale, who could be called the first of the nursing theorist with her environmental model of nursing (Nightingale, 1859), Hall (1964) who first talked of the nursing process, Abdellah (1953, 1979) who developed a model based on 21 nursing problems and Henderson (1960, 1966) who is known for her definition of nursing. Other popular nursing models developed since the nursing process was introduced include the 12 activities of daily living model, commonly referred to as the “12 ADL’s” (Roper, Logan & Tierney, 1990) and the self-care deficit model (Orem, 2001). The benefits of using a theoretical framework to guide practice are that knowledge can be increased by the contribution of nursing theory which ultimately improves nursing practice through the explanation, prediction and control of phenomena (Marriner-Toomey, 1994). Although frameworks are adapted for use in ED, for example Roper et al.’s assessment of the 12 ADL’s model and Orem’s self-care deficit assessment model, Jones (2000) contends that emergency nursing lacks a speciality-specific framework and this assertion is reflected in the absence of an ED specific tool documented in the literature. Marriner-Tomey argues that nursing power is increased through theoretical knowledge which in turn leads to autonomy of practice by guiding the

practice, research and education functions of the profession. Therefore, an ED specific nursing model could be advantageous for effective ED care.

Alternative systems

As a supplement to the frameworks for documentation and nursing models, there are also practical tools for practice, often known by a mnemonic device or an acronym. Examples include the systems for trauma, pain assessment, triage assessment and collapse assessment. In Table 2.3 a series of acronym based practical assessment frameworks and authors (where known) are presented. The original authors of many of these systems have been obscured through absent or insufficient referencing in subsequent published citations, however, where possible the original authors have been cited.

Table 2.3: Acronym based practical assessment frameworks and authors

Framework / algorithm	Author
ABC DEF Resuscitation / Trauma Airway, B reathing, C irculation, D isability, E xposure & E nvironment, F ahrenheit/ temperature, G et & use G adgets, H ead to toe, I nspect posterior & wounds, J ot down data, Next of K in	
AMPLE Trauma assessment Allergies, M edications, P ast health history, L ast ate, E vents	
PQRST Pain assessment P rovokes & P alliative, Q uality & Q uantity, R egion & R adiation, S igns & S ymptoms, T reatment & T ime	Budassi-Sheehy and Miller Barber (1981)
CWILTED Manchester Triage – Health assessment C ondition, W itness, I ncident, L ocation, T ime, E scort, D escription of patient	Mackway-Jones (1996)
OLDCART Health assessment O bservations, L ocation, D uration, C omplaint, A llergies, R egion & R adiation, T ime & T reatment	
SAVE CHILD A Paediatric health assessment Skin colour, A ctivity & response, V entilation effort, E ye contact, A buse, C ry, H eat, I mmunisations, L evel of consciousness, D ehydration	Wiebe and Rosen(1991)
CIAMPEDS Paediatric health assessment C hief condition/ C omplaint, I njuries/ I llnesses/ I mmunisations, A llergies, M edicines, P ast health history E vents preceding the problem, D iet & elimination, S ymptoms associated with the problem	Emergency Nurses Association (1988)

Use of models, frameworks and tools

Core care plans are care plans that are often developed around the model of nursing utilised by the workplace. They are intended to be developed using an evidence-based approach for patients, who are admitted with certain conditions, to enable the assessing nurse to collect the appropriate care plan and base the initial patient assessment upon it, given that patients with certain disorders have certain similar characteristics. However, they have a critical drawback in that no two patients are identical. As early as 1979, Vasey emphasised that there was a need to make these core-care-plans patient-centred, rather than nurse-centred, for holistic individualised care. This reminder continues to be valid as the use of core care plans persist and as critical care pathways are now also being developed. The FACT tool addresses the issue of patient-centred-care by placing individualised patient intervention plans together with the assessment phase, while incorporating an element of the critical pathway. As a result, care given according

to the care plan is simply signed off with comments documented only if there is deviation or additional information specific to that goal.

Levels of documentation

Within all the different frameworks available there exist different levels of documentation. These have been described by Allen (1998); Hardey et al. (2000); Irving et al. (2006) and Perroud, Romsdal, Tzelil, Watercutter and Manager (2000). Hardey et al. describe three levels that include “formal” documents such as the care plan and clinical records, “semi-formal” documents such as ward diaries for patient appointments and disposable notes or “scraps” nurses write as aide-memoirs for the care to be delivered (2000, p.213). In contrast, Irving et al. found that nursing documentation of patient assessments can be divided into three distinct styles, that of the medical, nursing and informal styles, with each affecting the visibility of nursing. They noted that nurses utilise different styles of documentation to portray their practice in certain ways or to avoid committing their personal clinical judgement to a written record. Allen and Perroud et al. also describe three components to nursing documentation. Their levels however describe upon the sections of documentation rather than the formality or style of the documentation, including the “pro forma” for biographical data, patient history and nursing assessment, the nursing “care plan” with problems and agreed goals identified and the “Kardex” or “progress notes”, which document the patient’s progress in a contemporaneous form (Allen, 1998, p.1225; Perroud et al., 2000 p.591). Urquhart and Currell (2005) assert that there is a challenge for the nursing profession to understand the specific characteristics required for documentation (such as whether it includes structured, semi-structured or free-text attributes), match these to each workplace in relation to the type of care provided, and then to utilise a system that fits the technology to the task.

Summary

The key issue surrounding documentation frameworks is that they are tools only. They can be used exactly as they were developed or they can be adapted for maximum applicability for each situation. An example of tool adaptation and re-adaptation is that of the SOAP tool which was developed to meet the needs of medical assessment documentation. It was redeveloped to “SOAPIER” by nurses because it reflected the nursing process and then again to “SOAPERO” to meet the needs of a rural nurse practicing autonomously in an isolated location (Filmer, 1997). Critical pathways are another example of tool development. In health care these were initially developed to accompany the patient through their journey from initial admission for planned care (e.g. elective surgery) to their discharge. Some of these pathways now start in the ED rather than on the patient’s admission to the ward because the patients care commences from the time they arrive in hospital and continues through to their discharge by the consultant either on leaving the hospital or as an outpatient. Critical pathways may now involve

orthopaedic conditions e.g. treatment of neck of femur fractures or medical conditions such as cerebral vascular accidents or asthma or other surgical conditions e.g. pancreatitis as well as the elective treatments for which they were originally developed.

The tools vary in their aim and level of prescription, for example the guidelines: FACTUAL (QNC, 2005) and Ten C's (NBSA, 2006) are reminders to the practitioner of the qualities of documentation rather than a process to guide the content of the documentation. At the opposite end of this spectrum are the frameworks: charting by exception and critical pathways, where every step of the patient's progress needs to be signed off or commented upon. Between these approaches are the Invocation Technique (Navuluri, 2000), that while not leading the nurse to document on specific situations, ensures that documentation is complete and concise and the narrative approach that is not necessarily concise, complete and clear, with incidents obscured or omitted by too much information.

Each tool or system has its benefits to various fields of healthcare, to meet the needs of the practitioners involved. A question remains though as to whom the benefit is directed. As Vasey (1979) wrote, when writing a care-plan nurses need to remember that it should really be referred to as a "patient care-plan rather than a nursing care-plan" (p.68). When a tool is developed or adapted certain questions should be asked of it including: whether the new tool benefits the patient, the nurse, doctor or team as a whole, or whether it is a tool developed to enable the organisation to view the activities of its members for fiscal or political reasons. It is assumed that the reason any tool has been developed or adapted is to meet the needs of the practitioners involved at the time. However, when a tool is adapted, that adaptation needs to be communicated to all other users of the record to ensure that the information stored there is retrievable by all members of the team needing to find information on the patient's plan and progress. The strength of any given tool (or its adaptation) is that it needs to be understood and used consistently and completely by all who use it. More importantly, it needs to be chosen as appropriate for the care provision situation. It is imperative that the tool used is appropriate to the data for documentation and that it is linked to the level, style and characteristic attributes, to ensure that it meets the needs of all who may refer to the notes either during the current patient care episode or in the future.

The search for material on documentation frameworks needed to be undertaken for the reasons established earlier in this review. Working with material retrieved through the literature searches, I have been able to develop a summative overview of the key documentation frameworks used in nursing nationally and internationally. I was surprised by how robustly these frameworks (original and re-developed) have been sustained by the profession, and while reviewing them I often found myself thinking that I had used them in my clinical practice or knew of many of them. I wondered how familiar these documentation frameworks might be to nurses working in EDs. For example in relation to the ED

in which I work - I know we use the ABC mnemonic and the SOAP framework as well as the unstructured narrative style. We also debate amongst ourselves which models of documentation we should consider adding into our mix of practices. I speculated, if I interviewed the nurses working in our department, what preferences they might have for particular documentation frameworks and models, or which ones they believed to be most pertinent to the context of ED work. There are several ED specific frameworks which the participants might choose, such as the triage scales (ACEM, 2000a; Mackway-Jones, 1996) or the ABCDE resuscitation framework.

Having presented an overview of the documentation frameworks in this section, it is important to build up the literature review by identifying key professional and legal expectations in relation to documentation. This is presented in the next section.

Part Two: Rationale for documentation

Introduction

This section investigates and explains through the literature why documentation is a necessary part of nursing practice. Particular attention has been given to aspects of professional organisations and legislated standard setting requirements, litigation, communication and collaboration, professionalism and visibility of practice, research, best practice and professional autonomy and the consequences of documentation for patients.

Documentation is a critical and integral part of communication and the consequences of poor communication can lead to detrimental outcomes for both the patient and nurse (Hansebo, Kihlegren & Ljunggren, 1999; Moloney & Maggs, 1999; NCNZ, 2005; Nursing & Midwifery Council [NMC], 2004; Renfroe et al., 1990). Nurses can show evidence of a systematic, problem-solving approach to the care provision, by documenting the work that has been done, through all the stages of the nursing process (Sbaih, 1994). As a consequence members of the multi-disciplinary team have a reference to outcome of plans that have been implemented, which enable further assessments and planning. In addition, documentation facilitates retrospective investigations by researchers; such research, undertaken to investigate processes and outcomes of treatment and methods of care, can lead to evidence based results which contribute to raised standards and steam-lined care.

National and international situations

Efforts of professional organisations

Improvement of documentation in nursing has long been recognised internationally as an aspect of care that needs to be driven towards common goals of standardised high quality levels, and in some cases, of standardised terminology. In the United States of America (USA), Joint Commission on Accreditation in Hospitals Organisation [JCAHO] stressed the need for adequate patient records and standards of nursing documentation since its establishment in 1951 (Clark, 1998). Within the nursing profession there are four distinct, but interrelated groups, leading the way with guidance on the need for and content of documentation. These include international, national and state nursing councils, nursing unions and quality improvement bodies, as well as the evidence-based-practice organisations.

National nursing councils worldwide, as well as the multi-nation bodies such as the International Council of Nurses [ICN], publish guidelines in the forms of booklets, fact sheets and pamphlets. These councils include the NMC (2006) in the UK, the American Nursing Association [ANA] (2003), NCNZ (2005) in New Zealand and the Australian Nursing & Midwifery Council [ANMC] (2005) provide guidelines on acceptable documentation. The larger countries, such as Australia and Canada, also have individual state nursing boards to complement the national councils who also provide independent advice to their nurses. These boards include the Nurses Board of South Australia [NBSA] (2006), Queensland Nursing Council [QNC] (2005) and Queensland Nursing Board [QNB] as well as the NBT (2003).

Of these groups, the best-practice standards developed by of the two bodies stand out due to their comprehensiveness and clarity. These are summarised in Table 2.4. One is the QNC (2005) which has developed a framework of standards for high quality professional documentation arguing that there are seven key standards that must be met, linked to the acronym **FACTUAL**, which represent **F**ocused on the client, **A**ccurate, **C**omplete, **T**imely, **U**nderstandable, **A**lways objective and **L**egible. The NBSA (2006) has also developed a set of ten single word standards based upon alliteration each beginning with the letter C. These standards are – Concise, Clear, Complete, Contemporary, Consecutive, Correct, Comprehensive, Collaborative, Client Centred and Confidential. Both these sets of standards, while not useful as a practical tool for daily practice, are clear guidance summaries of best practice for documentation.

Table 2.4: Nursing council standards as tools

Council standards
FACTUAL Focused on the client, Accurate, Complete, Timely, QNC (2005)

Understandable, Always objective, Legible	
The ten C's	Concise, Clear, Complete, Contemporary, Consecutive, Correct, NBSA (2006) Comprehensive, Collaborative, Client-centred and Confidential

The professional unions provide guidelines and information to their members and include the New Zealand Nurses Organisation [NZNO] (2005), Canada's CNO (2005) and British Columbia's RNABC (2003) and CRNBC (2005). The quality improvement bodies consist of quality in care organisations, which assess health provider establishments on all aspects of care provision, of which documentation is a cornerstone, by evaluating set criteria practice standards for minimal acceptable documentation practice. Examples of this group are the American JCAHO (2005) in conjunction with the Health Insurance Portability and Accountability Act, the British Healthcare Commission in partnership with the Commission for Social Care Inspection and Audit Commission, and the New Zealand and Australian accreditation bodies: QHNZ (2001) and Australian Council on Healthcare Standards [ACHS] (2002). The final group are the evidence based practice organisations, which assess documentation by professional bodies in setting standards, and include the Cochrane Collaboration and the Joanna Briggs Institute.

Another trigger for increasing the quality and quantity of documentation were the industry investigations that have occurred in the past, such as The Stent Report on Deficiencies at Christchurch Hospital in 1996 (Stent, 1998) which is colloquially known as the "Stent Report", and two more recent reports: External review of Emergency Department, Christchurch Hospital (Brennan & Kennedy, 2004), and Independent review into the death of Dean Jared Carroll (McKeen, Freeman & McCrea, 2007). These have played a role in shaping the context in which nurses' practice, due to the growing scrutiny of the nurses' work environment.

Legislation

Internationally, countries have independently set legislated requirements for documentation. Within New Zealand there are two pieces of legislation that have an impact on documentation; these are the Health and Disability Commissioner Act (Ministry of Health, 1994 & 2004) and the Health Practitioners Competence Assurance Act [HPCA Act] (MoH, 2003). Sweden has detailed legislated requirements for documentation, where it is required that nurses document patient needs, planned and performed interventions, evaluations and discharge notes using the nursing process (Swedish National Board of Health and Welfare [SNBHW], 1993, tr. Björvell, Wredling & Thorell-Ekstrand 2003a). In the UK there have been a series of white papers published since 1989 each shaping documentation requirements differently (DoH, 2001). Likewise the USA has set requirements although it was only this year that it has

become a legal requirement to have the time documented for every entry written into the record (Emergency Medical Treatment and Active Labor Act [EMTALA] – Conditions of Participation [CoP] Regulations, US Code of Federal Regulations, 2007). Frew (2007) notes this need for documenting the time of each entry and registers the fact that in hospitals which do not use electronic forms of documentation this new requirement will have a significant impact on practice. He also comments that it will have implications for medical malpractice suits:

Ambiguities in treatment records caused by lack of timed entries might be fodder for a plaintiff's attack on the record's accuracy... The lack of timed entries will now be a potential standards level violation for medical records that could turn out to be an EMTALA 21-day Notice of Termination citation. (p.58)

In addition to the laws governing the content of documentation there are also laws addressing its storage and privacy, such as the Health and Disability Commissioner Act (MoH, 1994 & 2004) and Privacy Act (MoH, 1993) in New Zealand, Health Insurance Portability and Accountability Act [HIPAA] (US Congress, 1996) and the Data Privacy and Security Act (US Congress, 2005) in the USA and the Data Protection Act (DoH, 1998) in the UK.

Litigation

It has been shown that there is a growing tendency of patients or their families to take legal action and nursing is one of the few disciplines in which the complainant does not have to have the writer of the documents present during the court hearing – the notes alone are admissible evidence (Richard, 1995). This is contrary to the hearsay rule of evidence, which is the rule that prevents evidence from being admitted into court proceedings unless a witness can give first hand evidence of what occurred (NBT, 2003). Nursing documentation is recognised in a court of law as evidence of activity of the nurse, whether the documentation describes an act of commission or omission. If an activity is either carried out, observed or omitted and is not documented as such, it can be interpreted in court to have never been done or seen when it should have been, or conversely, to have been done or seen when it has not been. The quality of the documentation made during the patient's care process will be highlighted in court, and assumptions by the court of the nurse's capabilities are made based upon the available documentation. As complaints can take years to come to court, this is understandable, as nurses may see thousands of patients a year, and without written evidence the accuracy of memory can be questioned. This could mean that the absent nurses' ability and practice can be called into question if the quality of the documentation is less than ideal (Richard, 1995). There is recognition that "courts tend to give greater credibility to the accuracy of written, timely notes over verbal evidence reliant solely on memory" (NBT, 2003, p.9). By ensuring that all aspects of care are fully documented health care workers have a reliable defence and an

opportunity of recalling the care that was provided however long ago it occurred. Therefore, the nurse who provided the care should always undertake the documentation.

Inadequate documentation of healthcare practices is an internationally recognised problem. For example the British annual report of professional conduct by the NMC (2003), highlighted that issues regarding clinical practice, including failure to keep accurate records, were the biggest category of offence, accounting for 30% of all charges made. The Health Ombudsman of England criticised nursing documentation as demonstrating inadequate planning and coordination, inaccurate observations, and inaccurate content (Abraham, 2004). In the UK, the 2005-6 Parliamentary and Health Service Ombudsman's annual report identified 1425 health service-related complaints were accepted for investigation. To achieve the status of acceptance for investigation by the Ombudsman the cases had already been investigated internally within the practice arena in which the complaint occurred (Abraham, 2006). Oxtoby (2004) found that inadequate communication arising from unsatisfactory documentation was one of the main reasons for complaints in the UK. Abraham (2004, 2006) indicated that poor communication and poor documentation are recurring causes for complaints. In spite of this high level recognition of problems with documentation and communication, documentation is not always completed to an adequate standard and it can be inferred that the issue of inadequate documentation is of such concern to the professional bodies and nursing colleges worldwide that they publish guidelines with explanations and fact-sheets (NMC, 2005 & 2006; QHNZ, 2001; RNABC, 2003).

There is a well known maxim about documenting patient care that states that "if it has not been recorded, it has not been done" (NMC, 2004, p.9). One exception to this maxim is that of charting by exception, in which Richard (1995) contends that the fact that nothing is written in the notes does not necessarily indicate a lack of care. Cudmore (2000) argues that documentation of care given by nurses is the only evidence that nursing care has been provided and Sbaih (1994) likewise argues that if documentation is not completed there is limited evidence of a systematic approach to problem-solving in care issues. Therefore, when nurses rely on verbal rather than written communication, there is the risk of lack of evidence to support their practice and choices made.

Communication and collaboration

The health sector is a 24-hour, 7-day-a-week industry and within it the staff members work their time in varying lengths of duties, however there comes a time at the end of each shift in which staff members hand over their patients' progress and plans to their colleagues. At this time the quality of the prior health care workers' documentation makes a difference. Currell and Wainwright (1996) state "the personification of the nurse in providing twenty-four hour care, and in coordinating the care given by others means that

the transfer and exchange of information are a significant nursing activity” (p.1). This argument is supported by Perroud et al. (2000) who claim that the action of passing on all relevant information from one nursing team to the next forms a significant activity.

Teytelman (2002) argues that “documentation and communication are highly intertwined, and doing one facilitates the other” (p.122). It is not difficult to omit to verbally inform the next staff member of every single detail, in the limited time given to pass on all the necessary information of multiple patients, by documenting the assessments made, plans devised, activities carried out (or omitted with the reason for the omission), observations made and evaluations derived in the patients’ case notes, the succeeding health care worker has the opportunity to provide continuing care to the patient. Without communication nursing care and care provided by the doctors or allied health professionals cannot occur in a collaborative manner, so documentation is a pivotal element of communication. Documentation enables communication to occur to ensure that care is coordinated. The CNO (2005) notes that for effective communication to occur nurses must review prior documentation and do their own documentation in a timely manner. The nurse must understand what has been written previously and then document what has transpired since then, showing that consideration and action on that prior documentation has taken place. Schulz-Robinson (1997) argues that documentation defines the work carried out by nurses and that whether or not organisational goals are supporting or conflicting best practice, documentation must show the nurses’ work accurately.

Professionalism and visibility of practice

Rutty (1998) demonstrated by using the descriptions of Chinn and Jacobs (1987), Hall (1980), McKenna (1993), Sarvimaki (1988), Smith (1981), Styles (1982), Raya (1990) and Van Maanen (1990) that the dilemma regarding the struggle for professional status of nursing continues, in that it remains difficult to define the role of a professional nurse due to the diverse descriptions that have been published. Clark and Lang agree, arguing that "if we [nurses] cannot name it [nursing] we cannot control it, research it, or put it into public policy" (1992, p.111). Rutty argues that this inability to define nursing is a limiting factor towards the goal of professionalism, even when nursing already falls in the category of a profession if the characteristics described by Friedson (1983), Maloney (1986), Nicoll (1992) and Richman (1987) are accepted. These characteristics include that it is: a “learned vocation [that has a] unique body of knowledge, altruistic service, a code of ethics regulating practice, lengthy socialisation and autonomy of practice” (Rutty, 1998, p.243).

The oral tradition contributes to the invisibility of areas of nursing practice (Lawler, 1991b) and it seems likely that visibility of nursing practice has an impact on professionalism. Martin et al. (1999) argue that for

nursing contributions to be recognised and valued they need to effectively communicate to all stakeholders. Purkis (1999) and Heartfield (1996) argue that documentation of knowledge makes nurses work visible. As Purkis states, nurses continue to provide the majority of direct professional care, therefore, it is critical that their documentation is completed to make their work visible to others within and outside the workplace. Heartfield highlighted the fact that patient is visible within the patient's notes but the nurse is not. She calls to the reader's attention the fact that other professionals clearly document their clinical judgements, yet nurses avoid this and that it is through nurses' documentation that nursing knowledge can become known, and nursing can then be reflected upon. Documentation is a part of the reflection-on-action process described by Schön (1992), enabling the nurse to learn from incidents, procedures or actions. Heartfield also contends that nurses find it difficult to document their work, because much of that work is intimate for the patient, who may not want certain activities written down in a permanent form. Irving et al. (2006) found that nurses do not find it easy to express elements of caring and professional judgements in the objective and non-critical words required by the law and professional guidelines, which confirm Heartfield's contentions.

One of the reasons that nurses maintain the oral tradition is ironically triggered by governing bodies setting requirements for complete documentation which are contrary to the needs of the health providers. Heartfield (1996), Savy (1997) and Pearson (2003) suggest that the tradition of oral knowing is once more growing in value for nurses especially in relation to a growing dissatisfaction in written forms of documentation. Heartfield argues that the resurgence in oral communication is due to the minimisation or loss of the nursing voice in documentation. In agreement, Savy believes that the requirements of the professional bodies now make irrelevant much of what is pertinent in the written records, when it does not contribute to the financial bargaining position of the health facility. An example given is that of the documentation requirements set by Australia's Commonwealth Department of Human Services and Health [CDHSH] (1995), from which she provides an example of how nurses are advised not to document "normal" levels of interaction regarding emotional support of dementia patients. However if this support requires a financial input such as the cost of a telephone call, then this interaction must to be documented. Yet as Savy argues, "the management of distress and anxiety is an intrinsic part of nursing care, especially ... for dementia sufferers" (p.10). In face of the arguments by Heartfield, Parker and Gardener (1992), Savy it is not entirely surprising that the oral tradition of nursing communication is maintained and enjoying a resurgence.

Schultz-Robinson (1997) and Pearson (2003) wrote that poor documentation is a critical component of silencing of nursing practice, leading to the invisibility of aspects of care and a weakening in the professional role of nursing. Hardey et al. (2000) noted this invisibility leads to nursing marginalisation while the articulation of nursing practice remains confined to informal documentation or "scraps" and

verbal exchanges (p.213). Clark (1998) argued that the drive towards increased documentation for the sake of accountability has been driven partly to enable the visibility of nursing practice by nurses themselves and their managers, and partly for political expediency.

Research, best practice, professional autonomy and accountability

For a profession to maintain and develop its professional status it needs to maintain best practice standards and behaviours (Rutty, 1998). Two stages to achieve and then maintain the standard of best practice are a) research to establish the parameters and nature of best practice and then b) auditing of practice to assess whether this standard is achieved. Documentation also provides a sound practice on which to base professional autonomy while it facilitates research and auditing processes. The NCNZ requires that a nurse "articulates", "shows" and "demonstrates" a complex range of skills (2001, pp 21-22), these skills can be shown to have occurred when audited later if documented properly. Documenting all the work that has occurred, through all the stages of the nursing process, provides evidence of a systematic, problem-solving approach of the care that was given; as a consequence retrospective investigations and audits by researchers are enabled. Health care records are used as a data source for research (Hakim, 1993; McEvoy, 1999; Mohr & Noone, 1997; Reed, 1992). They are also increasingly studied as indicators of the standards of care given to an individual patient as it has been argued that the quality of care a patient receives is reflected in the quality of the documentation of that care, and that a direct relationship between the two exists (NBT, 2003). As a result of increasing professional and institutional requirements the quantity of documentation and accountability for care delivery has increased dramatically. This has led nurses to consider it a burden and to worry that it compromises quality patient care (Kirrane, 2001). This is ironic as documentation is a process that is intended to demonstrate the level, quality and quantity of care that has been provided (ANA, 2005). Research undertaken to investigate processes and outcomes of treatment and methods of care, can lead to evidence based practice, contributing to raised standards and steam-lined care, which benefits patients and practitioners. This demonstration of practice contributes to knowledge gains and therefore works towards the goals required for professional practice and autonomy.

Renfroe et al. (1990) and Clark (1998) agree that accountability and authentication arising from documentation of activities is essential. Clark argues that clinical nurses need to develop ways of recording their practice as a result of the increasing pressure to accept these concepts and thereby their effectiveness and provide a more comprehensive and accurate view of their activities. Renfroe et al. assert that completed nursing notes can show the application of theory to practice by demonstrating the nurse's judgements, evaluations, decisions and actions. Nursing judgements are important because they lead to the development of nursing diagnoses on which the patient's plan of care is based. Castledine (1998) argues

that documented actions and rationales authenticate the behaviour of the nurse which is essential for auditing institutional, departmental or individual practices. Heartfield (1996) meanwhile comments that nursing documentation connects nursing with “the worlds of law, medicine and economics” (p.102). That documentation enables accountability of nurses’ activities is not a new concept for example Boehm Steckel (1976) stated that documentation of interventions provides written evidence of the nursing process for which the nurse becomes accountable. Smith (1968) also argued that using her tool for health history collection and clinical decision-making created the ability to ensure care values were made operational; that the humanistic skills and values of nursing, like the scientific values of medicine, should be translated into “skills, knowledge and behaviours, by means of orderly and predictable procedures” (p.2388).

Consequences for patients

There is substantial evidence to indicate that inadequate or inappropriate documentation concerning patient care can lead to negative outcomes for patients through impairing the continuity of care, the omission or duplication of treatment, and failing to observe and note signs of deviation in a patient’s health status. The impairment of the communication process can lead to increased lengths of stay for patients with a concomitant increase in risks associated with hospital stays, such as infection, falls, debilitation related to chronic conditions and psycho-sociological distress or inconvenience (Perroud et al., 2000). An increased length of stay also creates fiscal and political problems, due to creating longer waiting times for elective admissions and threatening the bed targets set for funding purposes. As Perroud et al. state “the nature of nursing must reflect the current political, social and environmental realities of the world in which we now live” (p.589).

Summary

The grounds for the importance of documentation identified in the literature are based upon practical, institutional, professional and legal requirements (see Table 2.5). These requirements include professional accountability for practice, legislation, litigation evidence and protection, financial reimbursement for internal organisational funding, external organisation funding such the Accident Compensation Corporation [ACC] in New Zealand and patient invoicing in private care. Other issues are internal quality control of departmental, and where necessary, an individual staff member’s practice as well as external audits such as those undertaken for accreditation of the facility, plus research facilitation and inter-disciplinary communication for continuous care.

Table 2.5: Summary of motives to document, with advocates

Practical, institutional, professional and legal requirements	
Fiscal reimbursement	Savy (1997); Yu, Richter & Shelton (2007)
Legislation	EMTALA (US Code of Federal Regulations, 2007); Health and Disability Commissioners Act (MoH, 1994 & 2004); HPCA Act, (MoH, 2003); NBT (2003); SNBHW (1993)
Litigation	Brent (1997); Buppert (1999); Coleman (1997); Iyer & Camp (1996); Nordensen (1997); Richard (1995)
Professional accountability	Clark (1998); Creighton (1981); NBSA (2006); NCNZ (2001); NMC (2004); Renfroe et al. (1990) RNBC (2003)
Professional autonomy	NCNZ (2001); Sbaih (1994)
Quality control	QHNZ (2001); Yu, Richter & Shelton (2007)
Research	Hakim (1993); Hardey et al. (2000); McEvoy (1999); Mohr & Noone (1997); Reed (1992)
Communication and collaboration	Currell & Wainwright (1996); Page (1997); Perroud et al. (2000); Teytelman (2000)
Visibility	Lawler (1991b); Pearson (2003); Purkis (1999)

In this section of the literature review I have presented key aspects of professional and legal expectations regarding the need for documentation and the practice of it. I found it worthwhile to systematically search for and analyse this material. As demonstrated in this section, internationally there is significant agreement about the need for documentation and the consequences of poor or inadequate documentation. Whether nurses work in acute or rehabilitation settings, in hospital or urban or rural community locations, with either long-term care or with short-care episodes the imperatives for documentation are the same. In my search I found no specific material that identified special circumstances in relation to emergency nursing in the context of ED apart from documentation frameworks such as the ABC tool and the health assessment tools. The imperatives discussed in the section, therefore form a basis of social and professional expectations for the documentation practices of nurses working in the ED. As an emergency nurse myself I found the sentiments expressed in this literature and the expectations of practice in relation to documentation had significant resonance for me; they were familiar to me and in the main reflected my own sense of expectation in relation my documentation practices. I wondered whether other nurses working in the ED would feel similarly to me, and what opinions they may have about these professional imperatives.

As was borne out by the audits that I had been involved with, I also knew that, whatever we believe, achieving such high ideals in the demanding conditions of the workplace is not easy. It was important then to look for literature and research into what helps and what hinders the practice of documentation in the workplace. The findings of this search are presented in the next section of the literature review.

Part Three: Practical factors influencing documentation

Introduction

This final section of the chapter reviews the identified facilitators and barriers to documentation including physical and psycho-social pressures, time and workload, access, repetition, knowledge, and language barriers, and it closes with a summary of the limitations of the literature reviewed.

It has been noted that nursing documentation is often seen as inadequate and this is supported by the wealth of writing found in this field (McKerras, 2002; Sbaih, 1994; Schulz-Robinson, 1997). The majority of the published literature tends to focus on the burden of documentation or the litigious aspects of not documenting, or providing hints, tips or guidelines on what to document, when and where. A number of research studies were found to have investigated documentation within the last 20 years. The authors include: Allen (1998), Björvell et al. (2003a), Ehnfors (1993a, 1993b), Hardey et al. (2000), Heartfield (1996), Howse and Bailey (1992), Kerr and Lewis (2000), Martin et al. (1999), Oxtoby (2004), Renfroe et al. (1990), Savy (1997), Tapp (1990), Törnkvist et al. (1997), Urquhart and Currell (2005). These studies principally reviewed how the use of models in nursing influence documentation or gathered data in the nurses perspectives of the models and the needs and benefits gained from documenting.

The inhibiting influences have been recognised in the writing of other authors (Anderson, 2001; Barber, 2001; Cudmore, 2000; Jamieson, 1997) and professional bodies worldwide. Overall, the authors do not contradict one-another's findings on the influences affecting documentation. As a consequence of these studies there is an extensive list of inhibiting and facilitating influences on the process of documentation and these have been collated and presented in as inhibiting influences in Table 2.6 and enabling influences in Table 2.7 (shown overleaf).

Table 2.6 Summary of inhibiting influences on documentation practice

Type	Factors
Physical issues	Difficulties in writing Lack of space to think and to write within the workplace Lack of space to write on the set forms
Psycho-sociological pressures	Negative attitude towards change Inability to see the benefits of nursing documentation Lack of support from supervisors and colleagues (peer pressure) Fear of qualitative evaluations of behaviour based on written performance

	<p>Negative connotation of the forms (e.g. incident reports)</p> <p>Organisational obstacles</p> <p>Workplace change processes</p>
Time and workload pressures	<p>Lack of time</p> <p>High patient acuity</p> <p>Work prioritisation</p>
Accessibility, multiplicity and integration of clinical records	<p>Inaccessibility of records</p> <p>Multiplicity and redundancy of forms</p> <p>Inappropriate forms</p> <p>Lack of consistent record systems and routines</p> <p>Lack of continuity</p>
Knowledge of expected content	<p>Lack of knowledge of the nursing process</p> <p>Lack of knowledge of patient conditions, medications or therapies</p>
Language barriers	<p>Indistinct terminology</p>

Table 2.7 Summary of enabling influences on documentation practice

Type	Factors
Models	Flow-charts Theoretical frameworks to enable rapid and accurate patient assessment Theoretical frameworks to improve analytical skills
Psycho-sociological	Positive reinforcements
Taxonomy	Standardised terminology
Physical	Time Access for contemporaneous documentation Patient activities and changes

Individual authors have not been attributed to each influence in Tables 2.6 or 2.7 because many of the authors list multiple influences in their findings. Some of the factors can be found in many of the studies such as time constraints, while others are found in fewer, such as fear of qualitative evaluations of behaviour based on written performance. These factors are referenced and reviewed in the following discussion, and suggestions for addressing these influences are sought from the research participants, therefore this issue is therefore addressed later in this thesis.

Physical pressures

Several physical issues were noted as significant constraints by Tapp (1990) and Törnkvist et al. (1997) when nurses attempt to complete patient care documentation. These authors highlighted that physical inhibitors occur in the form of noise, interruptions, lack of environmental space to sit and write in and a space limitations on the documentation charts provided. Howse and Bailey (1992) further described these constraints as extrinsic or environmental in nature. However, none of the authors make any suggestions to remedy these influences.

Psycho-sociological pressures

Another reason nurses fail to document may be peer pressure and senior influences. Heartfield (1996) argued that nurses resist revealing their knowledge and thereby being subject to examination and comparison. As a result, the documentation consists only of descriptions of observations and responses, unlike other professionals who write about their own judgements and examinations. Moving away from an oral approach to a written one where the preservation of nursing activities and knowledge is assured, is hampered by many barriers, but despite these it is essential that nurses document critical thinking that is a core resource to enable nursing assessment, planning and evaluation for patients. Allen (1998) noted that nurses' attitudes were contradictory, in that they linked documentation with the nursing process and that

they valued the nursing process as a means of demonstrating professionalism, but found it difficult to bring it into their work on the wards. The reason found, was that the nursing process is based on a private model of nursing with one-to-one nurse-patient relationships, whereas nurses in most hospital situations have multiple patient assignments. Allen, using the arguments of de la Questa (1983), also pointed out that in the UK the health service reforms of consumerism, purchaser-provider division and new managerialism have led to nursing records being used as a management tool and that nurses feel that consumerism and litigation consciousness of the consumer has distorted the purpose and content of documentation. She argues that documentation is no longer primarily for inter-professional communication but for protecting oneself or the organisation from accusations and litigation. Tapp (1990) argued that as a consequence certain types of documentation hold “negative connotations” (p.237). Such forms include accident or incident reports, which are perceived this way because the nurse knows that by completing such a form, an investigation into the incident or accident will occur. Tapp argues that the nurses believe this is a punitive process not a constructive one, hence their negative perception of these forms. Howse and Bailey (1992) concur; they found that there exists a disparity between the content which nurses value and the content valued by those who control it externally, such as managers and standard-writers. They describe this as an intrinsic barrier to documentation. Renfro et al. (1990) concluded their study by recommending that the nurses’ subjective norm or their perspectives of the pressure to perform or to not perform the task rather than their general attitudes are addressed to improve documentation.

Time and workload pressures

Documentation is a fundamental and integral part of nursing practice, so it should not to be left to the last moment, and it should not be considered an optional extra in nursing care; it is a specified requirement of the Code of Conduct (NMC, 2004, NCNZ, 2005). This is supported in the writings of Anderson (2001) Jamieson (1997), NBT (2003), Oxtoby (2004) and Wynn & Hargrave (2006). For documentation to be considered contemporaneous according to UK law it is required to be written within 24-hours of the event, however as some nursing boards have noted the higher the acuity or variability in a patient’s condition the more often the writer must document (CNO, 2005; Oxtoby, 2004; RNBC, 2003). By following these principles, documentation enables continuity of care to the patient improves collaboration between health professionals and with patients in certain circumstances, promotes consistency of nursing care, supports nurses to meet both professional and legal standards and becomes a record of the judgment and critical thinking used in professional practice (CNO, 2005; NBT, 2003; RNBC, 2003). In addition, documentation is an essential and component of the effective nursing care of a patient, integrated into that care provision, and is not to be considered as a distraction (NBT, 2003).

Authors agree that the process of documentation impinges upon nurses' time to provide practical care to their patients and that constant interruption and workloads create difficulties in completing the documentation (Howse & Bailey, 1992; Oxen, 2005; Oxtoby, 2004; Renfroe et al., 1990; Savy, 1997; Tapp, 1990; Törnkvist et al., 1997). Bryant (2005) concurs that nurses are prepared primarily for clinical practice and are frustrated by the excessive demands of documentation which take them away from their patients. Documentation of activities, interventions, assessments, plans and evaluations take an increasing amount of the nurses' time. Early studies found that nurses spent an average of 20.9% of their time and between 28 to 40 seconds per patient per shift documenting respectively (Stewart & Needham, 1957; Walker & Selmanoff, 1964). This has increased over the years with various researchers providing differing proportions of time spent documenting. In a stark contrast to 1957 and 1964 studies Murphy et al. (1988) described nurses as spending 25-44 minutes per shift documenting, while Moody and Snyder (1995) place this average as between 15-20%, Martin et al. (1996) described an average of 12% with some nurses spending as much as 25-50% (which equates to 15-240 minutes spent per shift) of their time documenting and Hendrickson, Doddato, and Kovner (1990) found that nurses spend on average 38% of their shift in activities that involve communicating data through documentation. Currell and Urquhart (2005) highlighted another aspect of time-consumption related to documentation. They reviewed five studies indicating that computerisation initially increased the time taken for documentation. This time then gradually reduced as familiarity with the system developed with an associated increase, then decrease, in workload dissatisfaction.

Repetition and integrated clinical records

Nurses question the relevance of documentation, implying that it is not referred to by other health professionals. This concern has been studied intermittently since the middle of the 20th Century with early investigators observing and timing the frequency and duration of referral to nursing notes, indicating a limited use of nursing documentation (Walker & Selmanoff, 1964). Since then, nursing documentation has in many situations been integrated into the clinical record, creating a multi-disciplinary record to encourage each of the specialities to read the observations of other members of the team. However, each speciality appears to have their own assessment sheet or care plan, which is then added to the clinical record, so, this leads to the generation of a multitude of additional pages of writing that need to be referred to in the multi-disciplinary record and can lead to repetition. Howse and Bailey (1992) describe this as an extrinsic or environmental barrier to documentation (p. 374). The tools that have been devised which require special forms on their own pages, such as the FOCUS Charting system and charting by exception, can lead to a lack of reference to them by non-nursing teams, as they are not integrated into the medical progress notes. Whereas, narrative documentation (with or without the use of a tool) follows through from the records of other discipline's, thus enabling true integration in the single clinical record. Critical pathways address some of the nurses' complaints regarding lack of referral to nursing notes, as

they are designed to be multi-disciplinary. However, like the tables, charts and flow-sheets used for the FOCUS and charting by exception systems, they are often developed alongside other current documentation forms and tools, which lead to the complaint of multiple documentations of single episodes of care or specific patient data. By creating single patient records, nurses have found a further problem hindering them from documenting. That is the absence of the records.

Accessibility and electronic records

Anecdotally, it is a common complaint of nurses that they cannot find the notes in which to document because the doctors have moved them or taken them away, Howse and Bailey (1992) only identify this as a concern in their study. Limited access to the clinical record is often caused because a member of the team such as the doctors or allied health staff has taken the clinical record away for some purpose either to read them or write in them. For this reason (among many others) the emergence of client-focused computerised nursing documentation systems might be precisely what contemporary nursing needs, although computerisation of the medical records has been developing for decades. Dr Weed, the author of the SOAP method of documentation, was a keen advocate for computerising medical records and was a director of the PROMIS (i.e. Problem Orientated Medical Information System) Laboratory in the 1960s. Considering the investment in the computerisation of clinical records it is surprising that these studies rarely mention the barrier of inaccessibility of the clinical records which certain types of computerisation can address, depending on the location of the care. Pearson (2003) argues that a computerised system must be sensitive to the complexities of nursing care delivery, to lay down evidence of activities and interventions, and the outcomes that result for clients. An issue raised by Urquhart and Currell (2005) was that paper records enable practitioners to make contemporaneous records whilst with a patient when there is a lack of bedside computer terminals. However, this assumes that the paper record is readily available and separable from the medical record; in reality it may not be, so the same inaccessibility complaints may persist with desk-top computers as for paper-records. Multiple mobile computers may prove suitable for taking to the bedside, where complete computerisation of records is planned for implementation.

Knowledge of expected content of documentation

A further influence found was that of the nurses' knowledge of what should be recorded and the nurses' ability to write all they wished to within the parameters set by whatever system they utilise. Doering (1992) argued that there is an expectation that nurses document objectively, omitting value judgements, but Ehrenberg et al. (1996) noted that nurses appear to be unfamiliar with expressing their actions in abstract terms. They argued that this could potentially be due to a traditional lack of autonomous care planning and management. Törnkvist et al. (1997) concurred; they noted that nurses recognised a lack of knowledge of how to express their understanding of the patients' needs. Ehnfors (1993b) commented on her

frustration on finding that elements of the nursing process continue to be invisible in patient documentation. Despite these authors revealing a lack of understanding by the nurses of expectations, there have been guidelines and expectations published by the nursing councils, nursing unions (JCAHO, 2005; NMC, 2005 & 2006; QHNZ, 2001; RNABC, 2003), as well as by individual hospitals in their internal guidelines.

Language barriers

To compound the problem of difficulty of expression of practice, there is also an inconsistency and deficit in a universally accepted language and terminology in clinical records by nurses. Hays (1989) argues that these language barriers compromise nurses' documentation. As a consequence nurses name clinical phenomena using medical and nursing diagnosis classifications to facilitate and standardise nursing communication. Efforts to classify nursing phenomena into a catalogue to promote the development of a professional nursing language have occurred since 1973 in the US by NANDA, this was followed in 1995 by Europe through the Association for Common European Nursing Diagnoses, Interventions and Outcomes [ACENDIO] and internationally since 1996 through the ICN with the first version of the International Classification For Nursing Practice (ICNP®) (Clark 2003; Ehnfors et al. 2002; ICN, 2005; NANDA, 1990). These classification catalogues have increasingly become referred to as Nursing Minimum Data Sets (NMDS).

Health regulations in a number of international locations require nurses to document utilising a data set for clinical, professional, managerial, research and policy purposes, such the establishment of comparability of statistics nationally and internationally or for budget planning (Clark & Lang, 1992; Sermeus & Delesie, 1994; Werley, 1988). However, limitations remain to this type of documenting, because it runs the risk of taking therapeutic caring out of the record as ordinary words or phrases do not fall into the nomenclature of the data set (Heartfield, 1996; Savy, 1997).

This third and final section of the literature review the identified facilitators and barriers to documentation including physical and psycho-social pressures, time and workload, access, repetition, knowledge, and language barriers.

Identified gaps in the reviewed literature

It was revealed through this literature review that there were significant gaps in the literature and one issue contended by some authors as absent. Of the first group the issues include studies investigating the perspectives of the nurses who document, New Zealand based publications and investigations into

documentation for either ED specific or short-care episodes. Into the second group is the issue of a dearth of published practice standards.

ED / short-care specific studies

The transient nature of emergency nursing requires that a rapport between the nurse and their support person or people is rapidly established. This is to enable a thorough assessment, diagnosis, plan and treatment, with an evaluation of outcomes and any relevant discharge planning and education, which needs to be fully documented prior to the patient's discharge, transfer or admission, which should occur as soon after their arrival in the ED as possible. It was noticeable in this literature review that the participants of the published studies found in this literature search were nurses who do not have a short-care episode in which to interact with the patient and their family such as ward nurses and community nurses (Ehnfors, 1993b; Hardey, Payne & Coleman., 2000; Heartfield, 1996; Irving, Treacy, Scott, Hyde, Butler and MacNeela, 2006; Kerr & Lewis, 2000; Kirrane, 2001; Lee & Chang, 2004; Lyngstad, 2002; Martin et al., 1999; Mason, 1999; Mohr & Noone, 1997; Renfroe et al., 1990). This imparts a further justification for this study.

Nurses attitudes and perspectives

Björvell et al., (2003a) and Kerr and Lewis (2000) described a lack of investigation into factors influencing nurses' attitudes towards documentation, considering its impact on practice and the size of the nursing population worldwide. Kerr and Lewis support their argument with a reference to Newton (1985). However, they appear to have overlooked multiple studies (Allen, 1998; Ehnfors, 1993b; Howse & Bailey, 1992; Martin, Hinds & Felix, 1999; Renfroe, O'Sullivan & McGee, 1990; Tapp, 1990; Törnkvist, Gardulf & Strender, 1997), who all summarised helping and hindering factors that influence documentation practice.

NZ articles

A significant finding of the literature search is a dearth of New Zealand specific research or articles, with only one published article (McKerras, 2002), one unpublished article (Richardson & McKerras, 2002) and guidelines provided by the New Zealand professional organisations (New Zealand Nurses Organisation [NZNO], 2005 Nursing Council of New Zealand [NCNZ], 2005) found. However, while the majority of the published work is not based in New Zealand, there are parallels between the issues and concepts that have been found internationally and are described in the literature and the New Zealand setting. The trends noted in New Zealand are shared with those internationally, and the New Zealand Nurses

Organisation works with the International Council of Nurses [ICN] to develop standardisation of intents and systems.

Lack of standards

The lack of standards or guidelines available to support and guide nurses has been argued by Griffith (2004). In fact many nursing councils (ANA, 2005; CNO, 2005; CRNBC, 2005; NBT, 2003; NMC, 2005; QNC, 2005) and independent authors (Austin, 2006; Bowen, Guido & Leone, 2006; Buppert, 1999; Carson-Smith, 2006; Tingle, 2002; Winn & Hargrave, 2006) have published guidelines or clarifications. This research attempts to address the first three of these issues by recruiting nurses who work in or with emergency patients such as emergency nurses to obtain their perspectives of nursing documentation. The study is based in New Zealand and will be published in New Zealand to add to the body of evidence.

Limitations of the literature review

Foreign language

A considerable number of studies have been carried out in Sweden, Norway and Denmark (Björkdahl, 1999; Björvell & Emlen, 1994; Engvall, 1994; Tunset & Øvebro, 1988) but not published in the English language; therefore, these studies could not be included in this review due to translation issues. These studies and articles were identified through the reference lists of studies that have been written in or translated into English.

Electronic documentation

There has been a large quantity published about electronic documentation, including the types available, its impact on practice during implementation, its longer term impacts on practice and the benefits it may confer to all parties once it is in place (Ammenwerth, Kutscha, Kutscha, Mahler, Eichstader & Haux, 2001; Currell & Urquhart, 2003; Korst, Eusebio-Angeja, Chamorro, Aydin & Gregory, 2003; Lyngstad, 2002; Mahler, Ammenwerth, Tautz, Wagner, Eichstader & Hoppe, 2003; Paterson & Soroka, 2006; Purkis, 1999; Smith, Smith, Krugman & Oman, 2005; Tornvall, Wilhelmsson & Wahren, 2004). This issue has not been reported or discussed in detail in this review for the sake of brevity, as electronic documentation and its impact is significant enough to require a study in its own right.

Summary

The literature review revealed a comprehensive list of reasons that help or hinder nursing documentation. It also attested to the need for further study into the practice of nursing documentation, particularly the nurses' perspectives, such as the effects of their departmental culture and environment, and their personal and professional histories on their current practices. In addition this literature review identified any tools available for documentation purposes and the rationale for documentation.

The search for material on documentation frameworks needed to provide a brief synopsis of common frameworks in use in nursing documentation, and explain the key terms, such as the nursing process, which are pivotal in practice. As a consequence of this review I have developed an overview of the key documentation frameworks used in nursing worldwide and I queried if I could find, through interviewing the nurses working in our department, what preferences and opinions they might hold for the various frameworks that influence documentation, and which ones they believed to be most pertinent to the context of ED practice.

It was important to develop this literature review through the identification of key professional and legal expectations in relation to documentation and the second section revealed why documentation is a necessary part of nursing practice with reference to a) professional organisations and legislated standard setting requirements, b) litigation, c) communication and collaboration, d) professionalism and visibility of practice, e) research, f) best practice and professional autonomy and the consequences of documentation for patients. There is considerable accord about the need for documentation and the consequences of poor or inadequate documentation. Regardless of the work settings, the imperatives that form a basis for social and professional expectations for the documentation practices are the same; however, I found no specific material that identified special circumstances in relation to emergency nursing in the context of ED in this literature search. I questioned what opinions the other nurses working in the ED may have about these professional imperatives in the context of the practical inhibiting influences present in their work environment and discussed in the final section of the literature review.

As this literature review progressed it was necessary to develop and alter its perspectives. Initially it was intended to find further facilitators and inhibitors that could be enabling or preventing nurses in ED to document fully. Part of my argument was that there was a lack of investigation on this subject. However a group of articles from Sweden (Björkdahl, 1999; Björvell & Emlen, 1994; Björvell et al., 2002; Darmer et al., 2006; Ehnfors et al., 1991, 1996; Engvall, 1994; Tunset & Øvebro, 1988), some of which were research based, dispelled this argument. By drawing together the influencing factors from the literature reviewed

into one table (see Table 2.5) it was clear that enabling and inhibiting factors had already been identified. Therefore focus of this thesis shifted to the nurses' perspectives of the influences on their documentation.

The literature has not only informed the foci in the study, but provides important information in relation to documentation frameworks, the rationale and requirements for documentation and factors that help or hinder the daily practice of nursing during documentation. Summative information gained from this review in relation to these areas will be used in the research design.

Chapter 3: Method, Methodology and Design

Introduction

The research aim, questions and design of this study were influenced initially by my interests; the process of reviewing the literature resulted in refinement of these interests to reflect what is known, knowledge gaps, as well areas associated with the topic that need stronger focus and elaboration. This chapter is commenced with an overview of the research purpose, research questions and a description of the method. The purpose of the method has been outlined by Crotty (1998) and Polit and Beck (2004) as a description of the techniques or procedures used to gather and analyse data relevant to the research question. The decision to commence with the method is so that the following sections become a clarification of the choice, rather than leaving the reader to wonder what directions the study took. The methodology follows the method, with an introduction to the theoretical perspective, the associated assumptions within which this research was placed and the contribution to knowledge of the results. Cohen and Manion (1994) described that the main aim of the methodology is to help the reader to understand, in the broadest terms possible, the process of the research itself rather than the outcome of the enquiry; while Silverman (2000) and Polit and Beck (2004) described it as the way in which research knowledge is obtained and the general approach taken.

In the following section the features in relation to the study design are presented, with particular attention to providing an overview and explanation of the processes of data collection, storage, coding and analysis. Polit and Beck (2004) summarised the purpose of the design as the overall plan for acquiring the answers to the study questions and the management of difficulties encountered during the research process. This chapter is concluded with a discussion of the ethical considerations and principles associated with the study. For ease of reading and consistency with the remainder of the thesis and to enable some reporting of movements in the research process during the study I have chosen to present the chapter in the past tense.

Research aim and questions

Overall research aim

Overall this research study aimed to describe emergency nurses' perspectives in relation to their practices in nursing documentation. In relation to this overall aim four research objectives were identified, these are stated as:

- To gather textual information from emergency nurses about their documentation practices in relation to their personal beliefs, past experiences and preferred systems of documentation.
- To gather textual information and personal perspectives from emergency nurses in relation to practical and contextual factors that influence documentation practices within an ED.
- To explore emergency nurses' interests in documentation tools or systems in practice.
- To discover the interests (content or process) that emergency nurses may have in relation to further development of documentation practices and systems.

Research questions

After developing these objectives it became clear that information in relation to the above could be explored by talking to emergency nurses about:

- What do they believe about the importance and value of documentation?
- What do they report about the relationship of their knowledge and past experiences to their current documentation practices?
- What influences do they believe organisational culture and peer practices have on practice?
- What (if any) strategies, tools or documentation frameworks are used - in their own practices specifically and in the ED generally?
- How do they manage workplace pressures and achieve quality documentation?
- When and why do refer to nursing notes made by other Emergency Nurses?
- What formal or informal education has influenced the participants' current documentation practices?
- Were they taught about any nursing theories or documentation frameworks?
- Had they experienced investigations or positive or negative feed back about their documentation?
- What do they perceive as key positive and negative influencing factors in relation to their practice of documentation?
- In their opinions, how could change and development of documentation in an ED occur?

Method

Fundamental qualitative descriptive research

The method chosen for this research was qualitative description. I leaned heavily on the work of Sandelowski (2000b) to ascertain the basic assumptions, design features, and methods of data collection and analysis associated with qualitative description. These ideas have also been supported by other influential writers (Denzin & Lincoln, 1998a; Guba & Lincoln, 1994; Morse, 1991), who in the main hold consistent views with Sandelowski and the method of qualitative description. The method of analysis in

this study has also been shaped by some work of narrative theorists Labov and Waltezky (1967) and Labov (1972). In the following sections I present information in relation to these theoretical and practical underpinnings, and to the expression of them in the design of this study.

Sandelowski (2000b) argues that qualitative descriptive research in its fundamental state is the foundation upon which most other qualitative descriptive methodologies (such as phenomenology, grounded theory, ethnography and narrative inquiry) are based. She also argues that in qualitative description the line between data exploration (finding out what is there) and description (describing what has been found) is less interpretive when compared to other qualitative research methods. Sandelowski also recognises that “although [fundamental qualitative description is] less interpretive than phenomenological or grounded theory description, [it] is more interpretive than quantitative description” (p.336). Sandelowski agrees with Denzin and Lincoln’s (1998a) contention that all research is interpretive, because it is “guided by a set of beliefs and feelings about the world and how it should be understood and studied” (p.26). Her arguments uphold the idea that in qualitative description everyday events can be described in everyday terms and that the art of the researcher is in keeping close to the surface of what is presented and shared and that the research concentrates on data and/or language as “a vehicle of communication, not itself an interpretive structure that must be read” (p.336).

In such qualitative inquiry themes and patterns are emerged inductively from interview and field note data and are not imposed prior to data collection (Denzin & Lincoln, 1998a; Janesick, 1998). This frequently depends upon the insights of the researcher and on the process of linking data with the argument. Sandelowski (2000b) wrote that fundamental qualitative description is:

unavoidably interpretive, in that it is “filtered through (human) perceptions” (Wolcott, 1994, p. 13), basic qualitative description is not highly interpretive in the sense that a researcher deliberately chooses to describe an event in terms of a conceptual, philosophical, or other highly abstract framework or system. (p.336)

In keeping with these general positions and with Sandelowski (2000b) specifically this research adopted qualitative descriptive study processes to pursue the research aims and questions. In the next section I place the assumptions of qualitative description under the general tenets of naturalistic inquiry; this is followed by an elaboration of the study design in relation to the overall method of qualitative description.

Methodology

Theoretical perspective and paradigm – Naturalistic inquiry

Denzin and Lincoln (1994) argue that the selection of the theoretical framework and the research methodology needs to be derived from the issue under investigation. Crotty (1998) describes a theoretical framework as a philosophical stance that informs the methodology by providing a context to ground its logic and criteria. Heron and Reason (1997) state “a paradigm is, by its very nature, beyond definition and the grasp of the human mind” (p.3). However, it has been described as sitting within the theoretical perspective establishing parameters and setting boundaries, as an “overarching conceptual construct, a particular way in which scientists make sense of the world or some segment of the world” (Crotty, 1998, p.35). Sandelowski (2000a) drawing on the works of Guba and Lincoln (1994) and Heron and Reason (1997) has synthesised descriptions of paradigms as:

...Worldviews that signal distinctive ontological (view of reality), epistemological (view of knowing and the relationship between knower and to-be-known), methodological (view of mode of inquiry), and axiological (view of what is valuable) positions. Indeed, paradigms of inquiry are best understood as viewing positions: ways, and places from which, to see. (p.247)

A paradigm is, therefore, a way of approaching study a phenomenon utilising a set of philosophical assumptions that direct the approach to the enquiry, and it includes a basic set of premises that guide actions taken involving the researcher's ontological, epistemological and methodological beliefs (Guba, 1990; Polit & Beck, 2004).

This research is a small-scale descriptive and exploratory qualitative study that is situated within the naturalistic paradigm. A naturalistic paradigm has been described as one that encompasses multiple, subjective realities that are “mentally constructed by individuals” (Polit & Beck, 2004, p.14). Another description of naturalistic inquiry offered by Sandelowski (2000b) which she acknowledges as being constructed from the works of Lincoln and Guba (1985) and Willems (1967), is that it “implies only a commitment to studying something in its natural state, or as it is, to the extent that this is possible in a research enterprise” (p.337).

Ontological assumption – Relativism

Ontology is the study of the nature of existence and the structure and basic elements of reality (Silverman, 2000). The ontological view of this study is that of relativism and it was chosen, because the participants' reality was being sought. The relativist ontology has been defined by Guba and Lincoln (1998) as:

...Realities that are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature (although elements are often shared among many individuals and even across cultures), and dependant for their form and content on the individual persons or groups holding the constructions. (p.206)

This relativistic ontological view of the naturalistic paradigm has been further described as a view that the social world is created within people's minds and that social interaction reinforces this (Denscombe, 2002). Denscombe argues that ontological relativism does not have physical qualities that are touchable, enabling it to be measured, touched or observed in some literal way. In response to this stance a relativist ontological view was assumed, because as already stated: the participants' reality was being sought out, and their social reality is something that is constructed by them and interpreted by them making it unique to them (Denzin & Lincoln, 1998b). Denscombe writes that researchers in the realm of relativism are open to the prospect that other researchers studying the same phenomenon or subject may hold different views and produce diverse results and conclusions. This is congruent with arguments of Polit and Beck (2004), who recognise that as human beings are the instrument of a naturalistic investigation, there is the potential that those results can be fallible and are dependent on the skills of the researcher as the information being sought is of a subjective nature. These arguments are compatible with the concept that there are findings from other studies and yet there remains the need for further investigation.

Epistemological assumption – Naturalistic methods

Epistemology, or the theory of knowledge, has been described by Polit and Beck (2004) as the relationship between the researcher and the participants and by Silverman (2000) as the "nature and status of knowledge" (p.77). Minichiello, Aroni, Timewell and Alexander (1990) explain it as being concerned with the decision of which statements we accept to justify our beliefs. The epistemological assumption of the naturalistic paradigm is that of the researcher interacting with the participants of research and that any findings established are created through an interactive process with the participants, discovering their knowledge and integrating this knowledge with that which is already known – to confirm, deny, develop and extend the body of knowledge in the field of enquiry (Guba & Lincoln, 1998). Polit and Beck (2004) write that the "naturalistic methods of inquiry attempt to deal with the issue of human complexity by exploring it directly" (p.16). They argue that these methods involve an emphasis on understanding the human experience as it is lived, and is subjective in nature. Polit and Beck argue that naturalistic methods involve evolving and flexible procedures occurring in the field, which in the case of this study was the workplace. These ontological and epistemological positions underpin the method of qualitative description as described by Sandelowski (2000b), and consequently the design and process of this study.

Sandelowski (2000b) argues that because the interest in qualitative description is about surfacing information and events in their everyday terms, that researchers can add or use methods and frameworks of their choice to elicit the descriptions of interest, without necessarily being constrained by the overarching principles of the paradigms with which the methods are frequently employed. This has been useful in designing this study. In this study I have used some principles of analysis derived from the work of Labov (1972) and Labov and Waltezky (1972) which are more usually associated with narrative methodologies; however, because the framework was suited to the type of data and the overall interests of this study I have been able to use the methods, without needing to adopt narrative as method, and still feel comfortable that the methods suited the research data and could be sustained under the overarching method of qualitative description.

There are also some elements in this study of the emancipatory epistemology, i.e. the study documents “aspects of reality and it takes a personal, political and engaging stance to the world” (Sarantakos, 2004, p.54). This is demonstrated in the results chapter where I have taken the opinions given by the participants and used them – sometimes verbatim, to illustrate arguments for or against current documentation practice, enabling their views to be integrated into the development of better working practices. Fleming (2004) describes an emancipatory stance in organisational studies as one that “champions freedom from arbitrary domination and exploitation” (p.42) although he questions the validity of emancipatory studies, because “subjects merely move from one set of dominating power relations to another” (p.43). By providing the participating nurses with a voice and encouraging them to express their beliefs on the need, purpose, benefits and limitations of documentation and then leading them to make suggestions about altering it, they will be given a opportunity to direct change in a way that they can own. This stance is consistent with the argument put forward by Sandelowski (2000b) when she stated “If studies were designed with overtones from other methods, they can describe what these overtones were, instead of inappropriately naming or implementing these other methods” (p.339). The presence of some elements of emancipatory epistemology can be acknowledged in descriptive research, such as this, without the need to subject them to stronger framing emancipatory framing as methodology.

A further aspect of this form of flexibility has been demonstrated in the design of the study. While remaining consistent with the tenets of qualitative description, I have been able to address some aspects of the data in quantitative terms. For instance, some aspects of the demographic characteristics of the participants were able to be considered in percentage terms, as this was useful for considering different signifiers and aspects of influence in relation to particular qualitative data sets. This usage is consistent with Sandelowski's (2000b) position that the researcher must decide what forms of data and framing of data are needed to best suit the task of description and portrayal of findings in everyday terms and with

her contention that “quantitative treatments of qualitative data can be used to extract more information from qualitative data” (Sandelowski, 2000a, p.253).

Acknowledging the framing of qualitative descriptive methods under the naturalistic paradigm also served as a helpful and functional point of reference for containing the small influences and some use of emancipatory epistemology, narrative method, and quantitative description for particular purposes in the study while sustaining overall congruence and consistency in research design.

Axiological assumption

Axiology has been described by Polit and Beck (2004) as the role of values in the study. They argue that subjectivity and participant values are both “inevitable and desirable” (p.14) in the axiological assumption of the naturalistic paradigm. As this study was designed to seek the participants’ values, their subjective opinions of what occurs at present and how they believe practice could or should alter this is entirely consistent with the axiological assumptions of the naturalistic paradigm. This is consistent also with the overall position of Sandelowski (2000a, 2000b) in relation to qualitative research generally and to purpose and concerns of qualitative descriptive method specifically.

Design

In this section the design of the study is reported. I present a general overview of the design, and then discuss the context of the study in relation to setting and participants, mechanisms of access, recruitment, obtaining consent, methods of data collection, methods of analysis, considerations in relation to rigour, and matters of ethics.

Overview of the study design

The research design is presented in a form of the following table (Table 3.1) with reference to design features and principles of the method. The Table was developed to reveal the congruence and coherence of the design features with the overall method and tenets of qualitative description.

Table 3.1 Design features and principles of the method

Design features	Specific aspects of design in the study	Rationale, theoretical derivation
Overall paradigmatic position	◦ Naturalistic Inquiry	

Overarching method	<ul style="list-style-type: none"> ◦ Fundamental Qualitative Description 	<ul style="list-style-type: none"> ◦ Sandelowski (2000b)
Research Aim and Objectives	<ul style="list-style-type: none"> ◦ Brief points ◦ This study seeks to learn from ED nurses about their perspectives, general practices in relation to documentation, things that they believe help or hinder documentation practices, how they view change and development in this area. 	<ul style="list-style-type: none"> ◦ There is an established gap in understanding of documentation practice from the perspective and context of ED nurses. ◦ There are multiple models and approaches to documentation theoretically and practically. ◦ Documentation is central to quality care and safety.
Research Approach	<ul style="list-style-type: none"> ◦ Fundamental Qualitative Description (Sandelowski, 2000b) 	<ul style="list-style-type: none"> ◦ Research findings offer a straight and summative description of ED nurses perspectives. ◦ The findings will provide a general platform for the participants and the ED unit as a whole to consider these multiple perspectives; and how they can be incorporated in to any developmental strategy regarding documentation in the ED. ◦ Sandelowski suggests that these designs are “typically eclectic, but [a] reasonable, well considered combination of sampling, data collection, analysis and re-presentational techniques” (2000b, p.337).
Data Sources and Methods	<ul style="list-style-type: none"> ◦ Setting: A tertiary ED in NZ ◦ Participants: ED nurses ◦ Scale: Large enough group to offer relevance, connectedness to the overall nursing population in the ED (approximately 6-10% of staff to be recruited to the study) ◦ Small masters project ◦ Interactive individual interviews -1 hour/ participant with use of aide-memoire (Appendix E) ◦ Practical perspectives in relation to known general models and theories of documentation, clinical realities, personal standpoints, and relevance of known factors that support or hinder documentation <ul style="list-style-type: none"> - Specifically probing issues in aide-memoire - Creating space and attention to support individual participants’ testimonio - Record and transcribe interviews - Researcher reflexive journaling. 	<ul style="list-style-type: none"> ◦ Purposeful sampling to obtain sufficient insider and professional perspective in relation to documentation practices, from those working in the ED, who hold the culture of documentation and who live and work in the context of ED service environment. ◦ Participants hold rich qualitative and contextually based knowledge. ◦ Small numbers to keep data generation manageable while ensuring adequate information collected. ◦ Interview processes which support individual expression and exploration of experience and practices, and that invite consideration and comment in relation to established literature and theory. ◦ Fits Sandelowski’s framing to obtain straight descriptive and low-inference answers that are minimally theorised or otherwise transformed to questions of special relevance to practitioners and policy makers. It conveys the facts

		and the meanings that participants give to those facts, and transmits them in a useful and coherent manner. (2000b, p.334-7)
Recruitment	<ul style="list-style-type: none"> ◦ Open advertisement ◦ Insider support for value of research and participation 	<ul style="list-style-type: none"> ◦ Open advertisement enabled access for all potential participants ◦ Needed open and transparent process ◦ Minimise any risk of coercion ◦ Wanted to research a topic that was of value to the group
Data Analysis	<ul style="list-style-type: none"> ◦ Systematic review of transcripts and field notes – content coding, thematic coding. ◦ Review of data in relation to research question and context of data gathering in field. ◦ Exploration of the themes and processes in relation to Labov's six functions of qualitative/narrative text. 	<ul style="list-style-type: none"> ◦ Analysis concerned with summarising the informational contents and themes of the data. ◦ Attention to variety of opinion and perspectives as well as shared values and beliefs across the group. ◦ Unable to achieve full data saturation due to small sample but sufficient numbers to warrant some consideration of trends in data. ◦ Attention to context/narrative testimonio/values/ emancipatory positioning of individuals expression in data as well as the contextual and embedded and collective understanding of the group that they represent.
Scientific Rigour	<ul style="list-style-type: none"> ◦ Readers are able to follow decision making trail. ◦ Participants recognise their information and the practice culture of the ED unit in relation to documentation in the research findings. ◦ Readers are able to transfer findings into meaningful context for them outside study setting. ◦ Study findings provide perspectives of ED nurses from one tertiary ED, while identifying aspects that need from further investigation, exploration or application. 	<ul style="list-style-type: none"> ◦ Careful gathering of data. ◦ Systematic method of working with data. ◦ <u>Dependability</u> -audit trail clear. ◦ <u>Confirmability</u>- participants verify findings are an accurate portrayal. ◦ <u>Credibility</u>- recognition of scope and single location/source of study participants. ◦ <u>Transferability</u>- data presented - qualitative and summative descriptive forms - substantive reasonableness and relevance balanced against strength of data generated across the participants.
Ethical Considerations	<ul style="list-style-type: none"> ◦ Key considerations: <ul style="list-style-type: none"> - Deontology and duty - Virtue ethics - Culture - Cultural safety ◦ Principles: <ul style="list-style-type: none"> - Accuracy and truth - Beneficence and non-maleficence - Fidelity - Respect and autonomy 	<ul style="list-style-type: none"> ◦ Consideration overall in relation to the positioning and content interests of the research ◦ Care in relation to ethics of data collection, gathering and reporting.

Context of the study

This study recruited Registered Nurses (RNs) from staff members who work within a 41-bedded ED in a 650-bedded hospital that serves approximately 65,000 patients per annum. The RN staff-base for the ED includes more than 140 RNs, of whom 91 were on permanent contracts, plus ED casual nurses, those on parental leave, varying numbers of permanent and casual hospital pool nurses, as well as clinical nurse educators, clinical nurse coordinators and clinical nurse managers. The ED only employs RNs either as its own permanent and casual nurses, or from the hospital's casual pool of nurses.

Access

Wolcott (1995) identified that obtaining access to participants in a study can be a potential obstacle for researchers, while Foster (1996) argued that research settings are frequently selected, because the participant has past or present contact with an institution or setting which facilitates access. Burgess (1990) described those who exercise control of access to participants as gate-keepers. In this study the formal gate-keepers were the Unit Nurse Manager of the ED, the National Ethics Committee, who cleared the application for ethical approval (authorisation in Appendix A), the Te Komiti Whakarite Committee for cultural safety approval and lastly, the General Manager of the hospital who was required to complete the authorisation of the locality assessment for the study. These last three gatekeepers held the greatest potential to cause a delay in commencing data gathering, however once the proposal and application were completed the process was completed smoothly and relatively swiftly compared to anecdotal reports by fellow students. Importantly, the nurse manager acted as a facilitative gatekeeper, who commended the value of the research, drew staff attention to it, while being careful not to apply coercive tactics.

Recruitment – inclusion and exclusion criteria

Sandelowski (2000b) argued that “virtually any of the purposeful sampling techniques ... may be used in qualitative descriptive studies” (p.337). Up to 10% of the nurses who work in the ED (approximately 10-15) participants were sought because of a combination of reasons including: the interest of gathering multiple perspectives and, the opportunity for the study findings to have relevance to the large ED, with the need to remain within the scale of study (master's constraints). The inclusion criteria included all RNs currently or recently working in the ED, regardless of their age, previous experience or qualification. The nurses were excluded if they have not been working in the ED for more than two years, due to changes in nursing documentation practice in that interval. Initial recruitment of the participants began with

convenience volunteer sampling and was purposive to the extent that it drew from a comparatively small population that was relatively homogenous (i.e. the RNs who worked in the ED).

Recruitment began with a poster advertising the study, which was placed in the tearoom of the ED and nurse's meeting-room in the casual pool, as well as in the two respective communication books (see Appendix B). In addition to these posters, the topic was raised in the start of shift group handovers in the ED to raise the awareness of the nursing staff of the project. This was combined with a meeting between the charge nurse of the pool nurses and me; this enabled a clarification of the study so that she could instigate a similar discussion during the pool nurses handover prior to their departure to their delegated workplace for that shift. In the communication books of both areas multiple copies of the information sheet (Appendix C) were deposited to allow the nurses to have some knowledge of the study processes and aims prior to approaching me.

Consent

When potential participants approached me, they were given a copy of the information sheet if they had not kept the ones from their communication book, and the study was discussed. Each participant was given one to two weeks to decide if they wished to participate. In practice, all of the participants agreed to take part immediately, having indicated that they had already decided prior to approaching me. As a result a suitable date and time was set at that point. Once agreement to participate had occurred, each participant was given a copy of the consent form (Appendix D) to read and sign, which was then kept by me, which additionally enabled me to ensure that those participants who requested a copy of the thesis summary report would get one. Additionally, participants were invited to share demographic information about themselves.

Data collection methods

Data collection methods were related to the use of an interview aide-memoire, individual interactive interviews, completion of a descriptive demographic survey and use of a reflective journal.

The aide-memoire concepts

The study explored participants' perspectives interesting relation to documentation practices within an ED. To support the interview process the orienting research questions and associated interests were noted in an aide-memoire (Appendix E). These were clustered around five interests 1) the current practices of nursing documentation in the contextual environment of ED - peer and organisational culture, 2) the

participants own practices and how these developed, 3) the participants views and use of documentation frameworks in everyday practice 4) practical influences that facilitate or inhibit documentation processes in everyday practice and 5) the potential for practice development and the routes such development could or should follow.

Individual interactive interviews

The primary source of data was gained through individual interactive face-to-face interviews. Morse (1991) describes an interactive interview as one in which the researcher “probes and explores concepts” (p.18). This is consistent with the fundamental qualitative descriptive research methodology, as described by Sandelowski (2000b). To facilitate the smooth running of the interview an aide-memoire was used (Appendix E). The social process and general flow of the interactive interviews involved individual interviews to generate in-depth data on the participants' views, opinions and approaches to nursing documentation using open-ended questions in conjunction with the aide-memoire. The plan was to elicit the perspectives of the individual participants, to gain an understanding of the context of their views, and understand their beliefs, while recognising that members across the group experience things differently and hold a range of beliefs. Face-to-face interviews also enabled the opportunity to gain a sense of the unspoken aspects and the professional and local assumptions regarding documentation practice for the individuals and the ED as a whole. The interviews were held in private to support individual participants' privacy to encourage them to express their own perspectives and values, and the aide-memoire and associated documents (Appendix G – the positive and negative influences found in literature, Appendix H – influences survey and Appendix I – theoretical documentation frameworks and nursing frameworks) were designed to stimulate the participants' thoughtfulness and sharing in relation to documentation.

Chase (2005) states, more people need to have their “testimonio” or “story which is politically based describing oppression and ... resistance to it” heard than is often recognised (p.652). Although Chase points out that a testimonio is generally associated with political suppression in Latin America it also has applicability to those who work within a large organisation, who lack power and who perceive barriers towards suggesting change and free speech. Many staff members, who are not in senior management positions within their respective organisations, often see the need for change, hold key values and beliefs, but may feel powerless to make any impact, or feel too threatened to speak up, or simply are too busy in everyday work to become involved. These staff members can therefore be effectively silenced either through methods by the organisation aiming to maintain the status quo or by self-censoring to ensure they do not make their work life difficult. This opportunity to give their stories enabled them to be freed of the concern of speaking what they perceive to be a truth. This concept created hues of the emancipatory epistemology within the research process.

The participants were given the option to nominate the venue for the interview. It was made clear during the recruitment discussion that the venue should not be the workplace to ensure that the interview could be completed undisturbed and support confidentiality imperatives. At the start of each interview I requested that external disturbances were minimised through turning off cell-phones. If the interview was interrupted, the plan was to either resume immediately the disturbance was resolved or at a new time and/or venue as agreed upon by both the participant and me. In reality, no interviews were disturbed. Each participant required only one interview and participants were given the option to have a support person I to the interview if they so wished, although no participant took this option. The interviews were audio-taped during the interview, and these were transcribed by me.

The interviews opened with a reminder of the aims and objectives of the study and the clarification of any questions that the participants held. The aide-memoire (see Appendix E) helped to focus our conversation and interaction, but as researcher I provided support for each participant to share their ideas and perspectives in relation to documentation practices as an ED nurse. Participants were encouraged to reflect on and to give their views on documentation practices generally, share their own documentation strategies and processes including the use of any tools, what knowledge of frameworks they have read about and any reflections of these. During the interview participants were shown a listing of various theoretical frameworks that either underpin documentation practices or are available to facilitate this process (see Appendix I) and they were encouraged to share their thoughts, knowledge, views and/or usage of any of these. Participants were also shown of list of helping and hindering influences identified in the literature (Appendix G) and asked about their impressions of the impact of these. They were given opportunities to engage in a ranking process, based upon a Likert scale that I developed from constructs exposed by the literature (Appendix H). The structured part of the interviews closed with a discussion of the participants views of whether practice in ED needs to change and how this could occur including education. As the final part of the interview each participant was offered the opportunity to raise any new issues or any issues they wished to discuss further.

Descriptive demographic survey

In recruiting participants to the study, I was interested in the demographics and professional qualifications of the participants across the group. Each participant completed a brief descriptive survey with closed questions to obtain demographic and other relevant professional data, such as, educational attainments in nursing, length of service, previous clinical or other experience related to nursing etc, to enable a description of participants' characteristics (see Appendix F). Gathering of this information was important to me, as researcher, as I wanted to gain a sense of each participant as I prepared to interview them and to

draw them out in conversations about their perspectives, experiences and thoughts in relation to documentation practice in the ED. I also wanted to have sense of the overall experience and diversity or commonalities across the group of participants. This was important to the careful working of each interview transcript, and to choices in the relation the coding, extraction and coalescing or differentiation of qualitative descriptive data across the data sets. Recruiting sufficient staff from one department had also the possibility of returning good descriptive and well founded information for the department as whole, which was not representative but which reflected sizable opinion and reasonable perspectives. Because of this understanding of the demographics of those who volunteered, it made it easier to think about whether those who were recruited to the study carried characteristics or not of the wider ED. Such information enhances clarity around the context of the source material and considerations of transferability of findings.

Tacit knowledge – Reflective journal

Tacit knowledge was defined by Polanyi (1967) as knowledge that is internal and difficult to describe, because people have a wider and deeper scope of knowledge about certain knowledge than they can say. One potential methodological problem in this study included the tacit knowledge of the workplace, held by me, because I shared a mutual background of emergency nursing, and there may have been concepts, values or language which I, with the participants, take for granted without recognising these assumptions. As a result, gathering the information about enculturated norms and values held by participant may have been difficult.

Certain assumptions of the researcher were acknowledged and considered thoroughly throughout the project, including the language of the culture, for example, the primary emergency documentation sheet can be referred to as the “MR2B” or the “pink sheet”, “red sheet” or the “ED sheet” or “ED chart”. Clarification of these terms for the analysis process ensured that this study can inform other researchers in the future. Acknowledged language assumptions have been defined in the summary of terms provided in the introductory pages.

To address the issues of tacit knowledge, an additional data collection tool was integrated into the design. This tool involved the use of a reflective journal to document my thoughts and ideas resulting from the interactions during the study process. Introspective reflection by me throughout attempted to identify my tacit knowledge, assumptions, pre-suppositions and beliefs. This journal was designed to identify any local cultural issues, such as the formal and informal terminology used. This process also facilitated the process of contextual completeness. Initially, these thoughts were simply documented and then they were examined using a tool of reflection such as Gibbs (1988) or Goodman (1984). In addition to the strategy

of journaling, dialogue and collaboration occurred with the university nominated supervisors to assist in the recognition of these assumptions as they appeared.

Data storage

The data, when not in use by me or my university supervisor, were kept locked away to ensure through security that confidentiality is maintained. When the research is completed, after discussion with the university nominated supervisor and the ethics committee, the hard copies can be destroyed through shredding the written transcripts and deleting the audio-tapes. Because this study has the potential to influence nursing practice and patient care, the data will first be kept for ten years as required by the hospital. Participant confidentiality was assured by refraining from using participant names or genders in the interviews or in the reporting of them.

Method of analysis

The method of analysis utilised were primarily those of content and thematic analysis. In relation to these processes the form and structure of the spoken texts were generally studied for relationships between structure and content. It is important in qualitative research and in naturalistic inquiry that the researcher attends carefully to the process of induction during analysis. In qualitative descriptive research attending to content and thematic analysis as inductive process is often core to the research and a significant aspect of achieving validity. Braun and Clarke (2006) argued that "thematic analysis should be seen as a foundational method for qualitative analysis" (p.78), which is a congruent concept for a fundamental qualitative descriptive study. DeSantis and Ugarriza (2000) described a theme as: "an abstract entity that brings meaning and identity to current experience and its variant manifestations. As such a theme captures and unifies the nature or basis of the experience into a meaningful whole" (p.362).

In this study each transcript was carefully read and the core content and overall structure of text were noted. Content analysis progressed to thematic analysis after sufficient attention had been paid to the descriptive data generated by the participants. The content and thematic data were considered in relation to the overall research aim and objectives. Once this had been centrally completed reflexive engagement of the ethical considerations, axiological assumptions, emancipatory epistemology, and the narrative framework for relevance and further insight and description was undertaken. The material presented in the following results chapter reflects the overall outcomes from these processes. In keeping with the method of research the data as presented is openly descriptive.

Although this thesis was not a narrative inquiry, the structures of the interview texts were also studied generally, utilising a framework that notes particular socio-linguistic features and order in oral narratives (Labov & Waletzky, 1997). Labov and Waletzky's model is used or quoted by many researchers who analyse texts, both in interview situations and in conversational contexts (Toolan, 1988). Labov's (1972) argument is that narratives have two central functions: a referential and an evaluative function. By the referential function it is meant that narratives recount events so that the order of events experienced is reproduced in the order of events in the narrative. By the evaluative function it is meant that the narrative presents a special occurrence, worth reporting, and that the speaker "uses various evaluative means to demonstrate this" (p. 359–362). Abrahamson (2004) contends that, according to Labov's model, during a narrative the participant solves a problem, crisis, or conflict. In fact, Labov differentiates different types of conversation, for example in an anecdote the teller does not solve a problem but rather presents his reaction to a problem, and in an exemplum the teller presents an event in order to use it as a background to make a moral point about how the world is or ought to be. Abrahamson argues, that "ultimately, [narratives] are not necessarily about a problem, [rather it is to] solely to retell events in order to assess the events together with the listener" (p.76). It is due to this argument that this study utilises this model.

Abrahamson (2004) noted that according to Labov and Waletzky (1967) and Labov (1972), texts consist of "six elements, which answer six different questions or perform six different functions in the narrative" (p.65) and she argued that the first and last elements – abstract and coda – "may be present, but are not necessary" (Abrahamson, 2004, p.65). The first element of Labov and Waletzky's (1997) model is the Abstract or what the principal point of the narrative is as introduction. The second element of the model is Orientation i.e. who or what is the narrative about? It informs the listener of the participants' time, place and situation. Information about me as the researcher, the participants and the study location enables the placement of this study into its context and has been described in the opening sections of Chapter 4: Findings and Analysis. The 4th chapter then reveals the participants responses made during their interviews, using the third element of the analysis model: Complication or what happened or occurred is the main body of the participants' narratives. These responses were then explored using the fourth element of the model which is Valuation or evaluation and is the meaning or the point of the story or why it is of interest and then the fifth element: Resolution i.e. outcomes or the participants views of what could potentially happen if the opportunity for change arose. These responses have been themed according to the concepts described in the aide-memoire (Appendix E). The final and sixth element of the model: Coda or the return of the listener to the current moment was evident in the transcripts as participants reflected upon the interview, summed up their ideas and volunteered other information that felt was pertinent. .

As stated previously, these textual movements and elements in the transcripts were observed and studied in relation to the content and themes, as the inductive process of determining results in relation to particular participant perspectives, across the group of participants and in relation to the research aim and objectives was undertaken. The method of qualitative description supported these processes and resulted in open themes and the explication of these through the voices and perspectives of participants as textual examples. These are reported in depth in the next chapter.

Rigour

This section of the chapter assesses the processes involved in the assessment of the quality of the data obtained in this study. It reviews the criteria of verification, validation and validity; and generally explores the influence of methodological concerns such as credibility, authenticity, criticality and integrity, and explicitness, vividness, creativity, thoroughness, congruence and sensitivity in relation to the data and the findings.

Verification, validation and validity

Meadows and Morse (2001) argue that there are three components to the assessment of quality in qualitative research, namely verification i.e. the confirmation of the data, validity or the “accurate accounting of events” (Sandelowski, 2000b, p.336) and validation or the efforts to assess the validity of the research with use of various techniques.

Denzin and Lincoln (1998c) describe verification as the description and credible explanation of the data. It has been argued also that verification can be “as brief as a fleeting second thought crossing the analyst’s mind during writing, with a short excursion back to the field notes, or ... thorough and elaborate, with lengthy ... review among colleagues” (Miles & Huberman, 1994, p.11). Although Wolcott (1990) rejected validity as a measure of rigour when he argued that there is no single correct interpretation in research; Sandelowski (2000b) has described two types of validity: descriptive validity or “the accurate accounting of events that most people (including researchers and participants) observing the same event would agree is accurate”, and interpretive validity, that is “the accurate accounting of the meanings participants attributed to those events that those participants would agree is accurate” (p.336). This study sought descriptive validity and interpretive validity which is consistent with this fundamental qualitative descriptive research methodology.

Sandelowski (2000a) argued that forms of triangulation can achieve or ensure corroboration of qualitative descriptive data. Validation occurred in this study through three triangulation techniques including:

method triangulation, person triangulation and analysis triangulation. Method triangulation, or the use of and analysis of multiple methods of data collection (Polit & Beck, 2004), involved the use of interactive interviews and a score based on a Likert scale (Appendix H) to gain comparable opinions about the impact influences have upon the participants' documentation. Person triangulation, which is the collection of data from levels of the population involved (Polit & Beck, 2004), was used to gain validating data through obtaining multiple perspectives on the same phenomena from different levels of nurses in the department. The opportunity to participate was open to all RNs of any level in the department and the casual pool, and this option was taken by staff from the most senior groups through to RNS with as little as two years experience. Analysis triangulation, which is the use of multiple analytical techniques on the set of data (Polit & Beck, 2004), occurred through content and thematic analysis of the interviews, the use of the Labov and Waltzky (1997) framework, analysis of the scores given in the influencing factors impact scale, and the ability to quantitate aspects of the demographic data.

Consideration in relation to the primary criteria of credibility, authenticity, criticality and integrity, and secondary criteria include explicitness, vividness, creativity, thoroughness, congruence and sensitivity, are also helpful (Sandelowski, 2000b; Whittemore, Chase & Mandle, 2001), within this overall framing of rigour. These terms are meant in their everyday usage. In this study the use of individual interactive interviews was intended to achieve credibility in the gathering of the participants' perspectives. The method of interviews facilitated the process of understanding the participants' realities making it a process that is congruent with the question and the participants. A part of interviewing is the drawing out of ideas and beliefs that the participants' hold, partly through a reflective process. The credibility criterion involves establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research.

For the criterion of thoroughness the size of the sample was approximately 10-15 nurses (6-10%) of the working population of registered nurses in the department. Audio-taping and transcribing the interviews meant that close attention to the content and themes of each interview could be paid. In addition immediately after each interview I listened to the interview once more and spent time writing notes about any significant non-verbal signs associated with specific sections of the interview. On the two occasions the tape recorder failed, field notes were written with the participant's permission. This step in the method was designed to facilitate the general qualitative descriptive processes of textual integrity and vividness.

The criterion of criticality, or the critical appraisal and reflexivity which is the critical self-reflection about my own biases, pre-conceptions and reflections, was intended to be addressed during the data generation stage by the use of the reflexive journal. Transcript rigour was maintained throughout with an exact transcription of all that was said during the taped interviews with clarifying data inserted into the

transcripts in brackets where required. I transcribed the data, and as a peer of the participants there was clarity and familiarity with terminology and contextual colloquialisms. Verbatim reporting was used as appropriate to enhance credibility, authenticity, explicitness and vividness; however, it was kept confidential to ensure sensitivity. The department is large, but the nurses know each other well enough that it was necessary to obscure the sources of the data to protect the identity of individuals. For this reason also there was no attempt to identify the cultural backgrounds of the participants. Integrity was demonstrated through the maintenance of comprehensive field notes and careful interview transcribing.

Verification occurred in this research by beginning the study with a literature review, on which to clarify the research questions and plan the design. This study sought descriptive and interpretive validity and validation was sought through the use of three triangulation techniques.

Ethics

Two forms of ethical concerns were considered in relation to the focus, design and conduct of this study. Firstly, there was a need for ethical consideration of the substantive basis and ethics of studying documentation practices in relation to emergency nursing and the ED. Secondly, ethical principles in relation to the design and conduct of research needed to be clarified to shape researcher conduct in the undertaking of the research. In this section reflections and actions in relation to both forms are presented.

Ethical considerations

There are regularly updated codes of ethics, which are developed and enforced by the international, national and local professional organisations to provide guidance to the practitioner. These codes are based upon the normative philosophy of ethics, which is what should occur or what is considered to be best practice (Rogers & Niven, 2003). This study, however, follows that of non-normative ethics because it is a descriptive study; it does not seek to pass a judgement on the participants' practices and beliefs, only reveal what is occurring and what is valued by the participants. By reporting the participants' responses, expressions have been given, of the participant's background sets of values, judgements, beliefs and convictions and these define the participant as a "moral agent" (Rogers & Niven, 2003 p.100); and which honour the "interpretive nature of moral experience" (p.99) because it sought the participants' responses to questions about their working lives and observed the textual form and descriptive interpretation of meaning in relation to their practices and beliefs.

Deontology and duty

From the selection of three traditional views of philosophical ethics of deontology, social contract theory and normative ethics, as outlined by Rogers and Niven (2003), this study falls predominantly under the theory of deontology, which is the focusing on the actions of a person involved in any given situation, who is predisposed by the duties perceived by that person. The theory of deontology accords well with the qualitative methodology, because it is an approach that is appropriate for the study of the phenomena of the social processes and structures present affecting nursing documentation including the duty the nurse has to record activities. Rogers and Niven (2003) outlined five groups, to whom nurses have a duty including the employer, profession, patient, society and dependants. Therefore, this study ethically speaking, tacitly incorporated aspects of duty by searching for the basis of the participants' actions in the context of daily work.

Virtue ethics

In a limited way this research also falls under the theories of virtue ethics, which are described as examining the character of those people involved in the situation, and social contract theory "acknowledging the sense of community and mutual responsibility" (Rogers & Niven, 2003 p.21). Virtue ethics are demonstrated in this study through revealing the values and standards held by the participants. These are of great importance in this study, because they are reflected in how the participants document the care that they provide. Social contract theory is likewise demonstrated in the practice of nursing documentation, because nurses accept the practice, even though it is an increasingly heavy burden to nurses due to its increasing volume. According to Barber (2002) they accept it in return for protection from the institution against litigation because they are aware of its potential benefits to the institution in fighting lawsuits while also providing a sound footing on which to base professional autonomy of actions, research and auditing by either institutional, departmental or individual processes.

Culture

This study involved the investigation of the participants' cultural values. Crotty (1998) argued that culture "is best seen as the source rather than the result of human thought and behaviour" (p.53) and that each person views the world "through lenses bestowed upon us by our culture" (p.54), leading us to endow certain aspects of our world with meaning and to ignore other aspects. Germain (1993) defined three levels within culture, she stated that "nursing is a professional culture, a hospital is a socio-cultural institution and a unit of a hospital [e.g. the ED] can be viewed as a subculture" (p.238). The links between these levels and this study are that within the first category are the professional and organisational policies and guidelines for practice and the legal requirements (MoH, 1993, 1999, 2003, 2004). Employee

relationships and requirements (e.g. the individual nurse's employment contract and job description) are found in the second level, and finally, the societal requirements set by the ED fit the category of sub-culture.

Schein (1992) described organisational culture; he defined it as having three distinct levels. Artefacts are the primary level and are the visible organisational structures and processes that can be difficult to decipher, such as the patient record document in the department. The espoused values, which include the organisation's published standards of practice and philosophy of practice, follow in the second level. Lastly in the third level, he argues there are the underlying assumptions which are basic and unconscious; this would include the habitual documentation practices of the department's nurses.

Cultural safety

The ethical philosophies bound into the Treaty of Waitangi require significant consideration. After a discussion with the Chair of the Te Komiti Whakarite Committee, who provide cultural advice on the cultural safety aspect of a study for the national ethics committee, this study design was simplified in its description of its aspects of cultural safety. The study followed the three principles set in the Treaty of Waitangi of Partnership, Participation and Protection utilising the steps of cultural awareness and cultural sensitivity to achieve cultural safety (NCNZ, 2002). Cultural awareness occurred through a reflection of my own culture including my ethnicity, faith, professional and social backgrounds. Cultural sensitivity was chiefly addressed through the recognition that every person is unique despite similarities that may be shared with others; recognising this fact rather than placing the onus onto the recipient to clarify their individual needs in relation to this study, facilitated cultural safety. To achieve the completion of this study, it was intended from the start that the participants became partners as well as participants in the resulting practice development. Their safety to be free to talk freely was critical, therefore, by using individual interviews rather than group interviews their privacy and confidentiality was ensured to provide their protection. Also for their protection, all quotes arising in the final written thesis are unidentifiable to any specific person.

These ethical considerations sat tacitly within the research inquiry and reside informally in the analysis of documentation practices and the perspectives of emergency nurses. Given opportunity to undertake a larger and more theoretical study of these practices at another time, it would be interesting to pursue these ethical considerations in relation to the practice of nursing documentation and workplace culture in more depth.

Ethical principles

Practically, the design of a research study requires consideration of an array of ethical principles. In this section of the chapter I report that ethical values adhered to in this study included accuracy and truth, beneficence, non-maleficence, fidelity, as well as respect and autonomy. In addition, three ethical rights were addressed in this study, these were the rights of justice, liberty and safety.

Accuracy and truth

Accuracy of reporting and analysis were high priorities as key components of the value of truth. To maintain accuracy, the conversations were audio-taped and transcribed and at the end of each interview. Reflective notes in relation to subject contents were also written and kept in a written journal. The unaltered relationship between me and the participants when not in the interview process was assured during the consent process, as a peer relationship was already in existence prior to the research. This relationship was not used as a form of duress to persuade possible participants to take part in the study. These safeguards link to the principles of informed consent and protection of vulnerable subjects.

Beneficence

Beneficence is the seeking to do good or the conferring of a benefit upon others (Rogers & Niven, 2003) yet the notion of improving the method of nursing documentation varies from nurse to nurse. These views may well be conflicting and range between reducing the documentation workload of nurses, to increasing it for the defensive standpoint; for "improvement" there cannot be a single definition for the entire population of ED nurses. This study explored the standpoints from which the nurses view their work and their documentation. Beneficence questions the rationale for an activity if it does not confer any benefit and it was demonstrated in this study. An objective of this study was to enable participation and partnership in practice development and to find a basis to launch this development from. This study gave the participants a voice in the role of documentation in relation to their practice. It provided them with the opportunity for them for dialogue and reflective consideration of their practices and offered potential personal and professional development through the reflections this interview process invoked.

Non-maleficence

Non-maleficence is the prevention of harm and the minimisation of harmful effects where harm cannot be avoided. This study involved specific strategies for non-maleficence; including transcribing the interviews my-self, to reduce the risk of the participants' voices being recognised. By utilising the method

of individual interviews each participant was assured of confidentiality as the only two people to have access to the transcriptions were me and the research supervisor.

Fidelity

Fidelity is the value which holds one person's agreement to another as a requirement to be held, thus, it is the faithfulness to that contract. During the consent to participate in this research I promised that the only personnel with access to the data would be me and my university supervisors. Also the interview data were locked in a secure environment during the study and for a further 10 years at completion of the study, as required by the university's research policy and the ethics committee and after this time they will be destroyed. As the researcher, I further promised that when the results of this study are published every attempt will be made to protect the participants' identities. Finally, the participants were offered a summary report of the findings, which will be fulfilled, to ensure the value of fidelity is carried out in relation to this offer.

Respect and autonomy

Respect for human dignity includes the issues of autonomy or self-determination and privacy (Noble-Adams, 1999b) by ensuring consent is informed and given freely, with whatever consultation the participant requires, for respect to be maintained. This is consistent with the idea that autonomy underlies the process of informed consent. Autonomy may be individual or group-family-whanau centred and is the right to express self-determination. Rogers and Niven (2003) contend that people rarely act alone; they may be considering the impact of their actions on current, future or previous relationships because their lives are interconnected with people who place values upon their actions. In this study, to support the autonomy of the participant, privacy was provided and confidentiality of the responses provided in the written thesis was assured in the consent process. Each participant was given an information sheet to read and keep (see Appendix C) outlining the aim and process of the study, providing the opportunity to discuss the study with me and with the support persons of their choice prior to giving written consent. This was done to ensure that consent was given freely and informed, as required by the Ethics committee. Within this information sheet the principles of confidentiality and the choice to withdraw were emphasised. The consent form (see Appendix D) offered the opportunity for the participant to request feed-back of the completed study in the form of a report. As this project was a qualitative study, some of the themes were illustrated with quotes as anecdotal evidence in the final publication, so these quotes were given using numbers, and any identifying details were suitably disguised to maintain the confidentiality of the participant, as suggested by Noble-Adams (1999b).

Justice, liberty, and safety

The right of liberty as described by Rogers and Niven (2003) was evident in this study, predominantly the right to justice, liberty and safety. Justice in the context of this study follows that of natural justice. This is because natural justice aims to enable the participant to have a fair hearing, with equality and non-preferential treatments for each of the participants and to enable the participants' voices to be heard. Each interview was of similar duration guided by the same aide-memoire, although each participant was unique and had different perspectives to offer. The right of liberty is to have the freedom to choose, either to do or not do something. The participants' choice to participate in the study, withdraw, or to not participate was emphasised through-out the research process, thereby conforming to the right of liberty. By participating, the nurses were being given the opportunity to have their voices heard. The right safety is linked with the right of liberty, in that there should be the right of liberty without the risk or fear of punitive results. No participants were directly approached and asked to participate, each responded to the poster advertisement (Appendix B). They were each given an opportunity to read and discuss the information sheet (Appendix C) prior to setting a time for their interview. At the start of each interview this opportunity to discuss participation was renewed, and the participant was then asked to sign a consent form (Appendix D) to participate. Each interview was private to ensure the participant felt safe to relate their views opinions and questions and the consent form reiterated the measures undertaken for data security and confidentiality.

In summary, I believe the ethical considerations undertaken in relation to this study were helpful to the overall position, pertinence and integrity associated with research the subject of nurses' practices in relation to documentation. I also believe that the ethical principles, in relation to research values and participant rights were sustained appropriately through-out the study.

Management of other aspects of the research

In this section of the chapter I offer a series of comments in relation to methodological tensions and choices that I made as preparation for the study and in undertaking the research. These are presented to reveal the care taken in making particular methodological choices and/or in responding to contextual aspects of 'doing' research.

Role change

During the time of this thesis I was given an acting role of Clinical Nurse Coordinator (CNC) for six months. This had the potential to influence the participants. I cannot tell if I obtained different data as a

result of my promotion and no participants declined to participate after it was announced. I do not think it affected the outcomes given to me, but I cannot confirm or deny this without further investigation.

Time constraints

Participant availability was the most difficult challenge to overcome, as many staff members were part-time and did not regularly attend staff meetings or shift handovers, because they had external responsibilities consuming their time. Availability was an issue for full-time staff also, as it was difficult to interview a participant working a full-time week as the working week is 40 hours long (of physically and mentally tiring work, plus the ordinary domestic duties every person must undertake) consequently time off is deeply appreciated. In addition, I continued to work a 36-40 hour week which necessitated planning interview times carefully. To address this, the venue and time of the interviews were to be the participants' choice with my agreement.

Summary

This chapter described the study's naturalistic paradigm, the method of qualitative descriptive research, the overall design including data collection methods and the methods of analysis. Processes to ensure rigour, ethical concepts and management of practical issues that arose also were identified.

The emphasis of this study was on the phenomenon of nursing documentation and emerging concepts grounded in the experiences described by the participants. The participating nurses explicated and described their current knowledge and the context of their practices, and they shared their ideas about the development of documentation practices. These are reported in the next chapter in ways that sustain the congruence of the qualitative descriptive method and the assumptions of the naturalistic paradigm, while emerging inductive understandings in relation to the research aim and objectives based on the perspectives of the participants' as emergency nurses.

Chapter 4: Findings

Introduction

In this chapter the findings of research study in relation to the field work are presented. In the presentation of the findings I have paid particular attention to the general tasks of qualitative descriptive method, as well as to the particular task of holding analytic description at the level of meaning intended by the participants and also to enable direct appreciation by consumers of the research findings and report.

As noted in the methodology chapter, the framework of qualitative description (Sandelowski, 2000b) encourages the use of the content of the participants' responses as descriptions enlarging upon the themes found through the analysis of the transcripts. Also as noted in the methodology chapter, analysis included use of Labov and Waletzky's (1997) framework for textual analysis. For ease of communication in the presentation of the overall results, I have chosen to report them using the headings from this framework and themed within a framework of clusters of concepts which have been described in the aide-memoire.

The chapter opens with the second element of the model: Orientation i.e. who or what is the narrative about? Therefore, information about me as the researcher, the participants and the study location has been described to enable the placement of this study into its context. The chapter then reveals the participants responses made during their interviews within each cluster of concepts, using the third element of the analysis model: Complication or what happened or occurred. These responses were explored using elements four and five of the model, which include Valuation of evaluation – the meaning or the point of the story or why it is of interest and Resolution i.e. outcomes or the participants views of what could potentially happen if the opportunity for change arose.

Due to my privileged position researching documentation practice in the organisation and setting in which I work, and interviewing my peers, throughout the research I have had to work hard to sustain appropriate researcher independence, and to consider the tacit knowledge and assumptions that I share with the participants because of this context. I have written parts of these chapters in the first-person narrative, to offer recognition of implicit knowledge relating to the content of the participants' responses and to reveal my considered readings of the topic.

Orientation of the study

The researcher

As the researcher I acknowledge that some knowledge of anecdotal data was in place prior to commencing the study. The second stage of Labov and Waltezky's (1997) method of analysis is "orientation". Chapter 1 of this study revealed the background information about me, while the demographic information of the participants and the location of the study follow next.

The department

The ED is part of a tertiary level hospital and there are three principal areas within it. From the patients' perspective they enter through one of two entrances, the first is the waiting room where they are met by the triage nurse and allocated a priority level (known as a triage code) and allocated a place to await further assessment and treatment. Alternatively they come in by ambulance to the resuscitation and monitoring area, known as the "Back" where they are also triaged by the nurse coordinating that area, who is often known as the "Sorting Nurse". This nurse also allocates a waiting place as well as a nurse if that place is within the Back. Treatment areas the patient can be allocated to consist of the resuscitation and monitoring area, the ambulatory area (known as the "Front"), and the Emergency Observation Area (EOA) whose name was changed to "Work Up and Clinical Decision Unit" during departmental reconfiguration mid-project and referred to as "WU" or "CD" by the participants.

The participants' experience and education

Ten to fifteen members of the nursing staff were sought to participate in this study and ten took the opportunity to share their knowledge; this represents 6% of the fulltime, part time and casual ED nurses. A further four nurses expressed an interest, but these nurses were unable to commit to a time that was outside of their employment (paid) time. The number of participants sought was limited to a maximum of 10% in an endeavour to gather multiple perspectives and strengthen the opportunity for the study findings to have relevance to the large ED, while remaining within the scale of study (master's constraints).

The demographic data tool revealed the following summative data in relation to the research participants. The participants were all emergency nurses, four of whom worked full-time and six worked 20-hours per week or more. Nine of the ten were female and eight placed their age between 25-45 years old, the remaining two as older. One consequence of this participant group is that in the text of the following chapters, the participants will be referred to in the feminine form regardless of the participant's gender, in order to protect the identity of the male participant.

A total of seven participants worked as staff nurses ranging between levels RN3-RN5, and three participants were from the senior nursing team. As the participants from the senior nursing team are more easily identifiable, the details of their positions have been withheld. Years of overall nursing experience ranged being between 8-27 years and the mean was 14 years. Years of emergency nursing experience ranged between 1.5-17 years, with the mean as 10 years. Seven participants had more than 10 years of emergency nursing experience, and of the three participants who had less than 10 years emergency experience, only one had less than five years experience. The overall nursing experience of the senior nursing team ranged between 14-27 years and their emergency experience between 11-14 years at this time.

It was important to ascertain the level of education and qualifications because different models of documentation and client management are advocated for in post-qualification education. Therefore, educational history may explain responses of the participants as individuals and across the group. For replicability of the study, future researchers need to be aware of the educational profile of the participants, consequently the participants' education background is described here.

Pre-registration training (Table 4.1) occurred in a training hospital for six of the participants who gained qualifications as either a registered general nurse or registered nurse or registered general and obstetric nurse dependant on their choice of course and country of training. Three nurses had gained a diploma in health studies or nursing studies, the title again being dependant on the country of origin while one nurse completed a Bachelor of Nursing (BN) for her pre-registration training.

Table 4.1 Types and incidence of participants' pre-registration nursing education

Award/qualification	Principal academic/education setting	Incidence (%)
RN, RGN or RGON	Hospital only	60
Diploma	Hospital base with university, polytechnic or college input	30
Bachelor Degree	University, polytechnic or college with clinical assignments	10

Eight of the participants stated that they had completed post-graduate education (Table 4.2). Post-graduate education varied in nature including post-graduate certificates in nursing or teaching, diploma in emergency nursing, and Bachelor of Science (BSc) of which one participant had been awarded two. When the participants described the nature of their studies, they did not include post-qualification courses, such as the trauma or triage courses as further education, even though these were admissible. I was aware that

they had attended these courses through their interview discourse, and/or because they are necessary qualifications for their role positions. However, due to a lack of explicitness in the survey tool this data was not adequately captured. In respect of the basic competency study days required by the hospital, all of the participants had attended these days, but only two had attended these and no other post qualification or post-graduate education courses.

Table 4.2 Types and incidence of participants' post-registration nursing education

Type	Example	Incidence (%)
Post-registration education (University/ Polytechnic/College)	Master Degree	Nil
	Bachelor Degree	20
	Diploma	10
	Post-Graduate Certificate - Nursing	40
	Graduate Certificate - Teaching	10
	Nil - Study days only e.g. basic required hospital competencies and preceptorship, leadership etc	20
Post-qualification courses	Triage course, Trauma course, Specialty courses: ED nursing, ICU nursing, High dependency nursing etc	Incomplete data

Themes clustered according to concepts

Summative data in relation to the themes derived from the interviews with the participants now follow in this chapter. Most of the participant responses reported in this section were gathered during the complication, valuation and resolution phases of the their interview texts (Labov & Waletzky, 1997) Analytically the 'complication' or what happened or occurred was carefully noted and then explored textually using elements four and five of the framework, 'valuation of evaluation' – the meaning or the point of the story or why it is of interest, and 'resolution' i.e. outcomes of the participants views and perspectives towards the future.

This section of the chapter has been themed and reported within a framework of clusters of concepts which have been described in the aide-memoire (Appendix E). These clusters of concepts begin with participants' insights into current, local, and contextualised nursing documentation practices occurring in the ED and their perceived rationales in relation to these. Summative reporting in relation the participants own practices from their own perspective are then revealed including details of any tools or strategies that

they employ. This is followed by an account of the participants' views about the influence of the working environment on their own documentation practices (and perceptions of this generally) and their concerns related to those practices. Next, summative and descriptive data is presented in relation to participants comments in relation to how reading or study that they may have undertaken had influenced their documentation practices. The participants' opinions of the helping and hindering influences found in literature as well as their opinions of the impact of these influences (as shown in Appendix I) are subsequently presented, followed by a discussion of the reasons and frequency of their referral to colleagues' notes. Lastly, qualitative description of the participants' beliefs and thoughts about means to improve documentation in the department is presented.

Cluster 1: Current local practices and habits

This cluster of questions was designed to clarify the practice influences on the nursing team as a whole, not the individual participants. The interview began with this cluster in an attempt to obtain a broader perspective general perspectives and perceptions of nursing documentation practices and culture in the department. I believed it would be useful to remind each participant, through the review of their perceptions of their colleagues' practices, of the global effect of documentation, as it is and as it could be, before focussing on the personal aspect of documentation practice. I felt it was important that the participants considered their perspectives in the context and culture of documentation practice because peer practices have a well-known impact on personal practice and is often referred to as peer-pressure, cultural integration and socialisation, submission to local practice or simply adaptation to circumstance. The intent of this line of the discussion was to gain the impressions that the participants' held as to how the culture within the department influenced practice. Commencing the interviews on the practice of the participants' colleagues facilitated the opening moments of the conversation, because for many people it is less confrontational to comment upon other peoples good and bad habits than it is for ones own habits. The findings in relation to this first cluster focuses upon the rationales given that influence documentation, including the visibility of nursing practice, cultural issues and peer pressure, prioritisation and the quality standards of practice.

Rationale for documentation

Visibility of practice

A key rationale given for documentation was that of the visibility of nursing practice. Visibility of nursing practice is a concept advocated in nursing literature and is regularly discussed in post-graduate education (Jones, 1999; Lawler, 1991a, Lawler, 1991b; Nelson & Gordon, 2006; Nelson & McGillon, 2004; Pearson, 2003; Schultz-Robinson, 1997; Schön, 1992). The concept of nursing visibility and more importantly

invisibility is that much of nursing practice remains invisible to non-nursing individuals or groups. One nurse mentioned this rationale as a factor for documentation “*I [recognise] that if you do write it’s a reflection on the practice that you are doing; although often people don’t always get the chance to write as much as they do*” (Participant 6, p.5). She recognised the value of visibility on practice, but commented on how pressures were adversely influencing nurses, curtailing their motivation to write when she said:

I’ve had a few charts thrown in front of me saying ‘Are you going to write anything?’ Which is a shame. Because actually we do quite a lot and we don’t always write it down, so it looks like you’ve done nothing. Unfortunately, the way we work sometimes it doesn’t allow you to actually document necessarily all that well either. You know, you’ve got a lot to do and... the other day I had somebody that was really sick and I actually was doing so much it was almost an hour before I got to document everything. (p.4)

This response also has ties with the environmental impacts adversely influencing documentation practice (as discussed in Cluster Four within this chapter) as well as the need to justify actions as discussed in Cluster Two when the participants discussed their own practices.

Culture, collegial influences and peer pressure

All participants were asked about the influence of culture upon documentation. Culture as a term was not defined, as each person holds different views of what culture is or is not and I wanted to gain their views and not mine on how they perceive what it is and its influence. As a consequence the responses to this issue varied greatly with only two participants referring to the term “culture” at all while other participants spoke of cultural influences indirectly. A number of nurses compared this ED in which they had worked nationally and internationally and they gave descriptions of contrasting behaviours.

Behaviour to consider within the ED culture is that of peer influence especially peer pressures. This is represented in the attitude score the participants were asked to complete and the discussions which consequently arose. Eight participants stated that peer influence had either a low or very low impact on their practice, while two participants placed it in the medium or high categories. Neither of these participants clarified this response, but it appeared to be linked to comments regarding orientation of new staff to the department. One of these participants narrated an episode that had been over-heard, during which a junior nurse new to the department in her orientation asked another nurse what to write and was told “*whatever you think is relevant*” (Participant 9, p.1). She further described her own orientation regarding departmental documentation as being shown the ED record and told:

“Right, here’s the red sheet.” And I looked at it and I asked “What MUST I write?” And they said “Well, whatever you need to.” And I thought: well that’s okay for me, but some people don’t know, especially the newly qualified [nurses]. (Participant 9, p.1)

This account highlights the possibility that a reasoned or structured documentation process is not being passed on to junior nurses.

The impact of working with nurses who have practiced overseas was discussed. One participant directly denied that culture influenced nursing documentation in the department, because of the diversity of the workplace experiences and origins of the nurses. She stated that: "*There aren't any cultural reasons because a lot of the nurses have worked in England, so they all know how it's expected in England*" (Participant 9, p.1). She then partially expanded upon her original statement and described how working in England to English standards impacts on nurses. She described the culture of litigation as being the driving force behind the current rationale for documentation processes and explained that nurses only document for a legal defence. This participant described how the relaxed attitude of New Zealand nurses had led to a reduction of documentation by the nurses accustomed to British attitudes.

It's more and more about legalities and the suing culture, and documentation is important from a legal point of view. But I notice that here [New Zealand] people don't seem to get that so much. In England we're getting sued left-right-and-centre, so it's much more important, whereas here they are much more relaxed. It's not quite so important. (Participant 9, p.1)

She believed that some staff members had become less careful in their documentation as a result of working in New Zealand, because previous workplaces had been stricter and had a more proscribed documentation format. This statement implies how the relatively non-litigious cultural norm of New Zealand has resulted in a reduced sense of importance for documentation in relation to this aspect for this participant.

Another participant also recognised that the experiences of overseas nurses may have an impact on their documentation; but she was not referring to this from a perspective of how these nurses may influence local nurses. She referred to the matter of diverse cultural influence when she discussed whether overseas nurses hold any training or specialist understanding on documentation and the impact they could have on document and practice development in New Zealand and whether New Zealand nurses should receive specific documentation education. She questioned whether overseas nurses work to any set standards at all. She said:

But then you see if we [in New Zealand] do [work to set standards], do the girls who come in from overseas (or the guys), do they just do it in their orientation with us? ... It would be very hard when you have such a variety of people coming from so many streams, because we have a lot of overseas staff here, each with their own ideas. (Participant 8, p.6)

Conversely, in opposition to this concern, this participant later described in detail how she had been influenced by an overseas nurse in the way she wrote her own personal disposable notes. She also

mentioned that overseas nurses need to be included in any change process *“because they have lots of ideas”* (Participant 8, p.7).

Another participant discussed culture in relation to how nurses devalue their contribution to care. She noted the fact that nurses are the first health-professionals the patient encounters on their arrival in an ED and that the nurse is very often the sole health professional caring for the patient for up to several hours until they are medically reviewed. She stated: *“I think that nurses don't value their role in the assessment and their contribution and don't understand that it is important that it should be documented”* (Participant 10, p.1). When asked her why she thought this she replied: *“I think it's just a nursing culture thing.”* On being asked to clarify this she stated *“I think there is a tendency for us to hide behind the doctors and I don't really know why, it's historical”*.

These varying responses reflect their professional and personal backgrounds. One participant is a junior nurse with knowledge of health-related court cases, the second has 19 years of experience without any post-graduate training and the third is a senior nurse with post-graduate education. As discussed in previous chapters, there is a great deal more to culture than the participants discussed. Participants' comments reflected their awareness of culture, but also reflected a lack of recognition of the impact of workplace culture on documentation practices. This may be related to a knowledge deficit about culture; perhaps the participants related it merely to race or religion, rather than it's much broader meaning; although no participants directly referred to culture in reference to race or religion. These perspectives may link with the New Zealand focus on cultural safety, and the fact that cultural safety and the Treaty of Waitangi are core competencies for practice (NCNZ, 2002, 2005).

Priorities - documentation versus care provision

In this study many of the participants acknowledged competing clinical priorities as influencing documentation practices and culture. Participant 8 described the setting of nursing priorities as: *“for most nurses ... it is just more important to do the nursing care, the nursing roles”* (p.1) and her own stated priority was: *“I think the patient comes first”* (p.1). This concept mattered most when they were caring for “sick” patients. Two participants concurred with this concept and said it occurred *“... particularly with a very sick patient”* (Participant 5, p.1), and *“... you haven't documented properly because you've been with someone that's been sicker”* (Participant 6, p.1). In addition to the thoughts expressed upon the practical priorities of care versus documentation, the concept of learning how to prioritise the content of the written notes was briefly raised by one participant who said: *“I think that it's trying to manage it in a positive way, so that people know what the priorities of documentation are”* (Participant 5, p.4).

Participant 1 stated that documentation held the same importance to care provision and said that: *"It has an equally high priority"* (p.5). However, the majority of nurses described the practice of placing nursing documentation low on the list of priorities for action, and two participants noted a complete lack of prioritisation of documentation. One explained that this is due to apathy: *"simply we're just lazy ... I think that's what it comes down to sometimes"* (Participant 7, p.1.)

Other participants expressed difficulty with the idea of documenting while attending patients. For example one participant said: *"part of [the ED] culture is that looking after the patient is very, very important and that the notes come second"* (Participant 5, p.1). The implication was that documentation was not "care" and that it should wait until the practical care was completed. For instance another participant said:

Generally as a nurse, you don't think documentation is the most important thing, because you want to deliver the care to the patient. If someone's always asking you to do something, like get a bedpan, that's more important than writing down, that you gave them a bedpan. So I think that it's just prioritising, and documentation is not very high up on the priorities for most nurses, because it is just more important to do the nursing care, the nursing roles. (Participant 9, p.1)

Within this statement she has acknowledged both needs: to give the patient relief with a bedpan and the need to communicate the outcome, yet this is a contradiction of her own argument. Her argument was that it was more important to give the bedpan than to write down the outcome while recognising the need to document data. Without accurate documentation it may appear that the patient has not passed urine while in the department, which would be an incorrect assumption. This is especially so when patients are given drugs to enhance micturition (diuretic drugs). For example:

With the frusemide [a diuretic drug], we don't record how much the person passes urine, which is a huge failing. But we are getting away with it. There should be an expectation that people should know. But for some reason a lot of it is slipping into the system. (Participant 5, p.4-5)

She expressed concern over this lack of documentation and recognised it as a slipping of the optimal quality standards for practice.

Quality standards

The quantity and quality of documentation by nurses was found to vary in the literature review and in the study's findings. Participant 3 indicated that the more experienced nurses know what to omit. In contrast, Participant 2 refuted this when she identified that a review of documentation and communication related incidents in the department did not demonstrate this; she said poor documentation was occurring among staff at all levels. Participant 5 recognised a lack of clarity of the expectations of documentation; she believed that the department needs to introduce clearer guidelines about what should be written thereby clarifying expectations.

Content – quantity versus quality

The overall impression given about the quality of the departmental nursing documentation was that it varied widely and that the nurses “do very much what they like”; from the majority of it being poor to certain groups of staff writing very protracted notes “in the tradition of [the novel] *War and Peace*” (Participant 3, p.1). This particular participant stated that when such notes are compared with those of senior nurses it is noticeable that the salient facts are still present within the notes of “more experienced nurses” who use their experience to decide what is necessary to write and what is not, because “the senior staff members recognise their experience and are more confident [in what to write]” (Participant 3, p.1). In other words this participant held the opinion that experienced nurses use their professional judgment to decide what to write and what to omit, although she did not verbalise this. The implication was that junior nurses write everything everywhere, whereas the senior nurses write only selected data in selected locations. Another participant said “I think a lot of that is in relation to the nurse and how much knowledge they’ve got on assessing patients and what they’ll do” (Participant 6, p.1). This links back to the sentiments expressed in which it was implied that the size of the documentation does not necessarily reflect the content (Participant 3).

A participant identified that “there is lots of useful information that can be put in nursing notes, that may or may not be there depending on who’s writing the notes” (Participant 5, p.2). These sentiments correspond to another participant’s comment, that different things are omitted from documentation, she said:

It is not always been the same things being missed. It’s been different things that people have missed although there is a tendency to certain areas of the chart to be ignored. (Participant 2, p.1)

In relation to nursing judgement, a positive reading could be that the sections of the documentation are omitted because they are not appropriate to that patient’s immediate needs. However, this participant quashed this idea noting: “It’s ... things that we should really have [been] written down,” although she did not state this occurred in every case of non-documentation. This comment reflects on staff members of all levels of experience, because it effectively rejects the argument of Participant 3 who implied that more experience led to more complete and concise notes. Participant 2 did not qualify what level of experience the nurses had, who left incomplete documentation, but said: “Even I can shortfall; and I know I can” (p.1) indicating that a very experienced and educated nurse can write incomplete documentation.

This cluster of concepts revealed the participants’ views about how documentation does or does not occur in the ED in general. The rationales given for documentation included the demonstration of thought in justification of practice as self defence for litigation and industry investigations, with, to a lesser degree, professional practice advancement. A second rationale was that of visibility of nursing practice to reveal the extent and level of nurses’ practice. While much of nursing practice remains invisible to non-nursing

individuals or groups, the profession of nursing cannot gain full recognition of its place and value in the patient's progress, treatment and care. A further rationale was that of culture, collegial influences and peer pressure. Four workplace perspectives emerged from the participants views in relation to aspects that sway nursing documentation practice. These were 1) the orientation of new staff to the ED, 2) the quality of overseas nurses' documentation practices they carry with them when they come to practice in New Zealand and the impact of New Zealand practices upon these overseas nurses, 3) the need for legal defence, and 4) the continuation of the historical culture of nurses devaluing their own work. Nurses prioritise their work and the culture of the department is likely to have an impact on the priorities a nurse chooses to follow. Nurses are trained to ensure their patients' safety and to maintain the continuation of basic needs for life support and then the improvement of whatever needs that make them a patient. It appears from the comments of the participants that the communication of these actions to colleagues is recognised as a necessary task but its priority is not as high as the literature implies that it should be, which corresponds to previous studies, such as Savy (1997), who revealed that some nurses begrudge the time necessary to document, believing that it reduces the time they can spend with their patients. Lastly, the issue of the content of documentation was raised. It appears that the participants have disparate views of who documents well and who does not. Some revealed the belief that experienced nurses complete documentation succinctly yet comprehensively, while others refute this argument to say that any nurse can fail to document fully. So what can assist nurses to document accurately and comprehensively, yet concisely in the minimum of time? A number of tools have been developed to assist this as described in Chapter Two: Literature Review. This following cluster begins to enquire into this question.

Cluster 2: Participants own practices and history

This second cluster emerged from the participants in relation to their own interests and practices, their philosophies and beliefs, as well as the strategies that they employ. In this section I also report responses to enquiries as to whether the participants had had any experiences where their documentation had been used in either in a positive or negative way. The participants were asked how they were influenced by these experiences and what strategies they have developed as a consequence. This section provides an additional powerful rationale for documentation to those identified previously. The participants were also asked what strategies or processes they follow for documentation, gained through formal or informal education or experience, and if they had been taught about any nursing theories or documentation frameworks. These questions were designed to enable the process of learning from experience, this is important as it is necessary that practitioners learn from one-another and develop practices which have a sound and clear rationale behind them. The intent of this set of questions was to provide the equivalent of an audit trail to how and why certain practices develop.

Justification of practice and line of reasoning

Several participants described the influence of formal investigation and adverse events in relation to professional practice (including documentation). Of these, three participants had experienced direct investigations of their practice; another mentioned witnessing the investigation of the 1996 report on the ED known as the "Stent Report" (Stent, 1998), and a third participant described off-the-record how she observed a court case when she supported a colleague. One participant who had not long qualified as a nurse when she went through an investigation said:

I have had an experience when a patient who died and they were trying to pin the blame on our ward (this was a surgical patient) and thankfully we'd documented so much that they couldn't do anything with us and it never went to court because it was all documented. ... They were trying to pin the blame on my colleague, and thankfully, we'd all had it drummed into us about documentation and we'd all documented everything, and they couldn't do anything because of it. (Participant 9, p.3)

This appears to show the benefit of education in relation to documentation methods and content. For those who either did not receive this education or those for whom significant time has passed since their qualification or last documentation education, their experiences of investigations gave notable impact on their practice and were clearly reflected in their beliefs for documentation. One participant commented that she had noticed that documentation had changed in recent years, from being "very scant" (Participant 4, p.1) to more in-depth and detailed documenting. One theory raised by the participants was the idea of justification of actions.

And then you have to justify yourself when you get your practice scrutinised. It's very difficult to a) recall, b) say "that's what I did but I just didn't write it down", "that wasn't what I heard and that wasn't my impression but I never wrote it down." It doesn't help you feel that confident. (Participant 10, p.1)

This change was principally identified by the participants as having being triggered by the increasingly litigious environment in which nursing practice now occurs and more than one nurse quoted variations of the nursing proverb: "If it's not documented it is assumed it has not been done" and that if nurses fail to document their practice "we leave ourselves wide open" (Participant 7, p.1) to legal attack should a problem or investigation occur. A participant said: "You read your notes and think 'Oh!' and you remember things, but you haven't written everything you needed to write" (Participant 7, p.1). Although a nurse may recall what was said or done during certain situations, if she failed to document it and a court case ensues in relation to that patient's care, that nurse has no defence; and it may be that she is judged in her absence by her documentation. Such an event was observed by one participant who described the event and its impact off the record. The recognition of the responsibility to document is reflected in the observations of another participant, who described a pressure of working in emergency as: "We are the front line and the first person to see the patient; we are taking an enormous responsibility" (Participant 10, p.1).

Another identified trigger for increasing the quality and quantity were the industry investigations that have occurred in the past such as the report by Stent (1998). A number of participants indirectly referred to how nursing documentation had either altered or could alter the complexion of investigations. They described how documentation had rescued them in past investigations. Participant 4 said of the Stent Report that it was *“a witch-hunt, they were out to find a scapegoat among one of the nurses, and it was our written work that saved us”* (p.1).

Practice advancement and widening of the nursing scope of practice is an area which post-graduate nursing education aims to meet and advocate, and the majority of the participants had taken part in post-graduate education. Despite the fact that several nurses acknowledged the nursing adage: *“if it has not been written it has not occurred”* and that the majority had completed post-graduate studies, it was interesting to note that only one of the participants directly commented on the role of documentation as part of nursing process, to reveal their line of reasoning or their clinical judgments to reach the potential diagnosis, and their responsibility for their patients. This participant revealed recognition of potential judgement on professional practice, knowledge, understanding and skill required in emergency nursing solely through the medium of documentation. As Renfroe et al. (1990) argued: completed nursing notes can show the application of theory to practice by demonstrating the nurse's judgements, evaluations, decisions and actions.

Justification of actions was a recognised rationale for documentation. This is affirmed by the criticism of the Health Ombudsman of England of inadequacy and inaccuracy in nursing documentation (Abraham, 2004). The increased tendency of patients and families towards seeking legal redress over health-care provision has led to a rise in the quality and quantity of documentation in the affected countries and will over time do so in all countries, regardless of whether the complainants are turning to the law or to bodies such as the Health and Disability Commissioner in New Zealand or the Health Ombudsman in Britain. It is critical that nurses migrating across the globe either maintain or improve their practices, and that they withstand voiced and unvoiced peer-pressure to reduce the quality of their documentation. The only industry investigation referred to was that of Stent (1998), however more recently there have been two further reports (Brennan & Kennedy, 2004, McKeen et al., 2007). Participants recognised that what is written can justify nursing actions and that nurses need to demonstrate in writing what they have done and their reasoning; however, the majority did not describe it as a rationale for their own or their colleagues' documentation.

Strategies and processes

Current documentation as a prompt sheet

Several participants had developed personal strategies in relation their documentation practices. One practice described by Participants 1, 3 and 8 was that of following the format laid out on the department's emergency sheet. One participant described this as having become second nature to use and now thinks of the assessment in that format. However, two of these participants stated they filled parts of it only, and one said she does all but the drug list "*because the patient's yellow card is so often out-of-date*" (Participant 1, p.2). The other participant generalised with only what was "*appropriate*" to either the situation or patient (Participant 3, p.1). The omissions described included commencing a fluid balance chart and the check-list section. This latter effectively reveals that the nurses do not routinely record significant negatives in the task list. The third participant described the use of all the areas including the check-list, however, this participant also described using the free-text area of the progress notes to corroborate the check-list, because there is no allocated space in the check-lists for the time of the activity, thereby double-charting this data. This participant explained her double charting resulted from the fact that there was no "*box*" for the time the task was accomplished or for repetition of tasks. She said:

...because you tend to not put the time in there. And it's a provision of your notes: that you're trying to keep up-to-date as you go really. And [the] ECG may be repeated, and you only have the one box to tick for it. (Participant 8, p.2)

This issue of documenting the time of activities and process is known as contemporaneous documentation and it is a concern shared by others: "*I like the tick boxes, but there's no [space for the] time ... so, people tick 'bloods', but we don't know what time they were taken. So, it needs to have a time there somewhere*" (Participant 9, p.1). During the last review of the documentation by the committee who developed the department's documentation audit (Dean et al., 2003) there was much argument about the need, size and style of this checklist. There was an argument forwarded that the department's nurses were professionals, who do not need reminders of what activities they need to document. Yet one participant described using the emergency documentation sheet as a tool, stating "*everything is there on the pink-sheet as a reminder*" (Participant 3, p.2), illustrating that the check-lists continue to have a place in documentation templates or strategies.

Acronyms and algorithms

Acronyms, mnemonics and algorithms are used as memory aides to health assessment, care provision or documentation. Although several participants described the tools for documentation that they choose to employ, none advocated for the widespread acceptance of the tool of their choice. Some of the participants expressed the opinion that nurses who use these systems do not always use them appropriately, accurately or effectively, while others adapt the tools to suit their needs. In illustration of

this a number of nurses recognised the SOAP acronym; while the majority correctly identified first two sections of the tool as “subjective and objective data” (Weed, 1969), several misnamed them as: symptoms and observations. Three participants described using the SOAP assessment. One participant described having used this in the past, but for documentation purposes only: “*I’ve used the SOAP, so that was the one of the formats we used in health assessment ... as far as writing it down. We used it as ‘symptoms and observations’*” (Participant 7, p.2). Participant 6 expressed a liking for this system:

I find I’m using more of the SOAP ... and I think that does actually help with the documentation, a lot. I think you do kind of put it a bit more lucidly ... I think you do kind of put it a bit more lucidly, a sort of round-up ... So when you actually forget to write something in relation to the [problem] ... you can just head back to it. (p.3)

This participant described a time when nurses were expected to write their entry then draw a line under their writing and sign so no-one else can add or amend anything. With the use of the SOAP system this she felt was no longer possible.

A commonly described strategy was the one linked to trauma and cardio-respiratory resuscitation – the ABC DEF algorithm. This algorithm along with others mentioned in this text is illustrated in the systems summary found in Appendix G. Six of the participants described using this system, although there is a range of reasons and extent of its use for each participant. These participants described learning this format of assessment and treatment through trauma courses and resuscitation courses and they have applied the principles generically rather than specifically.

Other participants described how they use other acronyms, algorithms and mnemonics in their actual practice and patient assessment, but choose not to use them for documentation. An example of this is:

AMPLE and PQRST and AEIOUTIPS: I use those on the ambulance, and I probably use them here too, I run through them as possible causes of things – and they are quite useful little mnemonics to remember. But I wouldn’t document according to those. I would use them as tools to ask questions. (Participant 7, p.3)

(These mnemonics and others have been summarised in Appendix I.) Likewise, one participant stated that while she followed the ABC assessment process, there were times when she did not: “... *tend to write ‘ABC’, but if I write alert and orientated, I am covering it*” (Participant 10, p.2).

Health assessment formats

Health assessment formats were also described as a system for documentation; however, there are numerous health assessment formats available (refer to Appendix G). Most of the participants learnt their chosen system through their various courses. Several described using a health assessment format based upon the medical model (Bickley & Szilagyi, 2003). Participant 7 said: “*I try to write it like a normal health*

assessment, so I'll start by writing the presenting complaint, history of the presenting complaint, past medical history, so I'll try and structure it to a set format" (p.1). Another who utilises the medical model expressed enthusiasm of it:

The doctors have a real systematic approach, so regardless of [the patient's presentation] the same things get written. Okay, it might be different because of their actual medical history. But they write the same things. And we were never taught that in nursing. And that's what I loved about the ... course, because the way you were taught was the way the doctors were taught. And you can't miss anything out. And if you almost put those headings down first – you fill them in. (Participant 2, p.2)

This participant then stated that the nurses who are qualifying at present are taught the medical model of assessment. She said: *"They have the whole health assessment process, so they probably go through that in their head"* (Participant 2, p.3). A different participant referred to the type of documentation she was taught as a student and said:

Nurses are wound up in writing ... [and] then drawing a line and signing the end of it so that no body can write in there. The doctors don't do that, no, the doctors just write ... everything and it keeps it much more orderly and if you look at even the way medical staff write, they document quite clearly and ... [it's] expected to flow and you can find information ... quite clearly. (Participant 6, p.3)

While a fifth concurred: *"[With] the doctor's notes, you know where to look for something"* (Participant 8, p.6). The recurring theme through all of these responses was the comprehensiveness of the medical model of assessment combined with the unchanging format of presentation. No matter what country these participants originated, all stated they know exactly where to look in the health assessment for the data they seek, suggesting that this format is used internationally as well as nationally, and that the model is used for all patients and adapted according to the patients condition. This theme implies that one standard tool can be used for the assessment of all patients, adapting it to the patient's needs but always documenting according to the same framework.

Context and appropriateness for choice of tool

There was a perception expressed by that no single stand-alone system is used for nursing practice or for the documentation of such practice. One participant described this as *"[each nurse uses] a different methodology; some people's methodology doesn't exist at all"* (Participant 5, p.1) while some nurses found one system works better for them than others. One participant recommended the use of a single tool for all patients. She argued that: *"if everybody used the same format, you would open up the notes and you would know exactly where to find things."* (Participant 8, p.6). However, another participant expressed the opposite belief and said that systems or more specifically acronyms and mnemonics *"need to [be adapted] to the situations. One set does not always fit all patients"* (Participant 5, p.1).

In contrast to the theme apparent in the health assessment format section above, the argument for one tool for all contexts was opposed by some participants who felt that one tool for all situations would be inappropriate. One participant questioned the appropriateness of the use of a single tool for documentation of all patient care in the ED. She stated: *"I'm just wondering about the context, [whether] we [should] always be commenting on the airway, breathing and circulation"* (Participant 5, p.2). She commented that assessment along this process is documented by some nurses even when it's not a situation that demands this level of assessment, such as minor injuries. This participant contended that: *"One set des not always fit all patients"* (p.1) and another agreed with:

It would be nice to have one, but that's not terribly realistic, so it would be helpful if there were versions of [tools], with different types to meet the need. With high acuity patients there is quite a lot you should really talk about and someone with a sprained ankle there is sort of less you need to talk about, so having different ones would be useful. (Participant 10, p.4)

She then clarified to say that she adjusted her practice so that when she works in an area assessing ambulatory patients she has: *"... a looser system, if it's orthopaedic, I'll do limb baselines instead of AB[C]"* (Participant 10, p.2). Another participant described that she generally commenced her documentation according to the ABC system and then adapted to circumstances, she said: *"A lot of my ED patients I'll tend the first notes in an ABCD [order] and then just ... [as] an on-need basis..."* (Participant 7, p.1). This participant however then implied that one tool for all patients could be used despite stating she only used tools *"on-need"* when she finished her sentence with *"... the only set tool is the format of the health assessment."* (p.1). another participant spoke of using separate strategies, dependant on the patient's presentation:

I use two different strategies. If I'm in a resus area I use ABC. If I'm in an area like the minors area I use more what I have been taught when I was a nurse practitioner, which is a more 'fuller' type history. I don't mean 'fuller', it's totally different in that you start with the presenting complaint, history, presenting complaint and you move through it like that. (Participant 2, p.1)

These strategies illustrate some of the nurses' habits for whom the algorithm had been used regardless of the reason for the patient's presentation. One participant expressed the feeling that there is an expectation to complete the ABC of trauma assessment in the department *"I think that needs to be clearer, because there is an expectation that you do that and people aren't doing it"* (Participant 5, p.2). She noted that the nurses do not write following this system and wondered if it indicated that they may not be assessing in this manner either. Of her own practice she said: *"I only tend to [follow the ABC mnemonic] when it is a problem for that patient or it they are a trauma patient and it is really important to know what their output status is"* (Participant 5, p.2). Her comment reveals her perception that there is an expectation to follow the ABC mnemonic for health assessment and it illustrates a cultural demand within ED to do so, and yet this participant, like others, has

described that it is not perceived as a consistently appropriate tool to use, one participant uses as the first step of assessment (Participant 7) while others use an alternative tool instead (Participant 10).

Justification of actions was a recognised rationale for documentation. Participants recognised that what is written can justify nursing actions and that nurses need to demonstrate in writing what they have done and their reasoning; however, the majority did not describe it as a rationale for their own or their colleagues' documentation. The participants describe using frameworks to demonstrate their line of critical thinking to justify their practice, and described the use of various tools, especially the health assessment format and mnemonics for support of practice and/or documentation. If one tool was introduced as part of the printed documentation, some of the nurses would inevitably follow it because as was seen some participants use the documentation chart as a prompt for their patient assessment. However, some participants questioned the appropriateness of a single framework of documentation for all patients presenting to the ED, providing arguments for and against such a plan.

Cluster 3: Participants reading

Anecdotally the influence of education on participants' documentation practices had varied impact. This cluster of data was generated by specific enquiry in relation to what education or support the participants had encountered in their careers that influence their practice. Some of this education may have come through self-learning processes such as the reading of literature. It is recognised that not all nurses read or follow literature on practice development; however, many of the participants will have read something at some-point. This set of data also reports on what (if any) of that reading has been about documentation, including issues of documentation in general or nursing specific documentation or more specifically emergency nursing documentation. During the interview it was clarified that comments in relation to reading could include nursing or documentation theories, reports of disciplinary hearings in the nursing council publications, newspaper articles or any other source. For those participants who had read literature regarding documentation, their opinions and reflections upon that reading were also sought.

Training and education

As described in the introduction to the chapter, the participants had for the most-part completed some form of further education, even though they did not include practical courses, such as trauma or triage courses. However, during the interviews, many participants mentioned the trauma course: Trauma Nursing Care Course (TNCC) as well the fact that they work in triage, which requires attendance at triage courses (only one participant specifically mentioned attendance to a triage course). These courses are designed to make the participant reconsider their process of patient assessment and documentation. Of

the practical courses several systems were alluded to, including the ABC of trauma, which was repeatedly spoken of, as well as health assessment processes and acronyms such as the OLDCART, CWILTED and PQRST systems.

For some participants, training in documentation occurred during their basic training one recalled:

... During my training [it was] through our tutors, so obviously [it was] on nursing, on clinical [practice], and that ... was pertaining to ward nursing. And ... we were really encouraged to write succinct and precise and relevant notes, and not to just guess, to keep it nice and short. (Participant 5 p.3)

However another expressed reservations about the quality of documentation education occurring with under-graduates, she described her own as: *"It was more about wording and language [than content]"* (Participant 10 p.4). Another participant stated she had learnt through shared experiences from her colleagues not through study:

I've never actually been sat down and said: "This is what you need to do." I've only been told [about] Manchester Triage by my colleagues, they have said: 'this is what you do with the Manchester Triage, and this is how you assess, and this is how you...' It's me just getting information from other people and then using it. I've never had a teaching session. (Participant 9, p.2)

One participant discussed how the practical courses had influenced her with the provision of three tools:

Paediatric emergency course and TNCC influenced [me with the] CLAMPEDS and ABCDE [tools respectively]. ... We did the ABC anyway, all the time ... But you tend to go that little step further again; it's quite like a quick in-ground thing. I find I'm using more of the SOAP, (that was from the advanced health assessment [paper]), and I think that does actually help with the documentation, a lot. I think you do kind of put it a bit more lucidly, a sort of round-up. (Participant 6, p.3)

Two participants spoke of their post-graduate study, one said her documentation practices were first developed on-the-job and then refined by study:

When I worked in Australia in ED and when I worked in ICU, we wrote our notes on a systems based approach and I've tailored that down here after I did some post-grad papers. So its still systems based – you know, renal, neuro whatever, and then before that on admission I'd use a health assessment format: PC [patient complaint] and the history of PC and health history. And it's kind of just because they're all good prompts. If I use a format, then I don't miss things, it jogs your memory. Initially it was taught as part of my orientation – my ICU and ED in Australia, but as far as the health assessment extras it was taught as part of my post-grad cert. (Participant 7, p.2)

Participant 10 also spoke of her post-graduate education; which included two courses that used the OLDCART health assessment mnemonic, and held reservations on their practicality:

The big assessments like OLDCART I find difficult, I find I forget what they are about; and when I've used them under pressure ... I didn't actually cover everything and I found if I'd actually thought about it I could have got everything, because I was using a mnemonic – I didn't, I wasn't able to think outside of the square under pressure, and that's not something I would practice so I decided mnemonics aren't my thing! (p.3)

She likewise disliked the use of a nursing theory as a basis for health assessment: "*Orem's self-care model: I covered that last year actually, though it's a little meaningless in terms of emergency*" (p.3). However, Participant 9 refuted this belief, she explained that in a previous role she had utilised Orem's Model (1991) extensively in a neurology rehabilitation unit and she found it useful as part of her health assessment in ED.

It was apparent from the interviews that the participants' mode of documentation and associated health assessment had been influenced through formal education which included frameworks for practice and informal learning through practice and observation. Of the frameworks cited, only the SOAP tool is a documentation model, the others have all been developed to assist nursing practice (as discussed in the literature review). No participants had taken part in an education session dedicated to how to document, only why, and even those who had been taught the SOAP tool had learnt it principally as a method to organise the assessment rather than the documentation of it. When coding the qualitative data, I was interested to note that across the participants there were multiple frameworks in use. This raises questions as to whether other nurses reading these forms of documentation are in a position to fully use the data generated through the actual models of documentation. The divergent beliefs between the uses of frameworks indicate that familiarity with a model is likely to have a greater impact of its benefits on practice and documentation than just knowledge of it.

Literature

All the participants were shown a Table of the theoretical frameworks for documentation to remind them of options available to assist in documentation (Appendix I). This Table included nursing theories as well as documentation models, as some nurses utilise these models rather than documentation specific frameworks. The participants were asked for their views of these frameworks and models, why they like or dislike them, why they use or do not use them. These issues are important as they provide an understanding of the influences by which the nurses are affected. These influences need to be clear and recognised before developing any form of practice development, because if changes are planned without taking account of the background of those affected by the proposed change, the change process will take longer with more resistance and potential antagonism shown by those affected by it. By understanding the current influences of practice, appropriate lessons can be learnt and it may be that the participants reveal a theme or structure for practice development themselves.

Although several of the participants referred to courses when describing their personal documentation practices, the majority (six) stated that they had purposely read literature on documentation; two participants had read articles without seeking them specifically and done so independently of any courses. These participants gave varied reasons for undertaking this reading. For one participant the article she had read had been published by a colleague, and the others she had read were about raising the profile of nursing visibility. This participant connected the idea of writing and publishing work with visibility of practice, she said: *"I ... think that if you do write it's [an opportunity for] reflection on the practice that you are doing"* (Participant 6, p.5). Another stated she had come across an article which she described as *"scare tactic"* in style, but she had not sought out such articles through intent (Participant 3, p.2). One participant commented indirectly about the time and effort required to find and read articles, she said: *"There are some good articles I think and I think that they do make you think a bit more about it [documentation], when you can be bothered to think"* (Participant 6, p.5). This comment again reveals the sentiment expressed by many of the participants, that the busy workplace discourages voluntary additional work-related practices such as reading nursing literature.

Participants 1, 4 and 10 stated that they had read about health assessment systems as part of their post-graduate courses, which were applicable to documentation, and Participant 9 described reading some articles during her staff nurse development programme. One participant conducted a literature review on documentation for patients who die in the ED from the cultural, forensic and police perspective as part of her post-graduate paper and that she had provided a presentation for post-graduate students on one occasion (Participant 1, p.3). One participant, when asked directly, said that she had not read anything on documentation, yet she had already spoken of reviewing a paediatric health assessment system and that she was discussing it as a suitable tool to employ for documentation (Participant 10, p.2).

Despite potential benefits for participants' practice, there were few independent attempts to investigate or clarify aspects of documentation among the participants. This lack of investigation on the subject was evident despite recognition by the participants of the value of optimal documentation, with some describing how good documentation had helped them or their colleagues in the past. The most likely reason for this is their belief that they already know enough for their needs. Howell (1982), a communications scholar, proposed a communication theory consisting of five levels of competence: unconscious incompetence, conscious incompetence, conscious competence, unconscious competence, and unconscious super-competence. The participants in this present study may believe that they possess sufficient knowledge regarding documentation skills and systems, and are at the stage of unconscious competence. This explanation is especially so if applying the description of this stage made by Sommerlad (2005) who argued this stage demonstrates knowledge through performance, even while being unable to fully explain reasons for action. However, knowledge deficits of differing frameworks of documentation

became evident when asked about models of documentation. Consideration of this in relation to Howell's framework would place the participants into a lower level of competence: either the second or third, when discussing the extensive range of documentation frameworks available. Nevertheless, of the documentation tools that they utilise they may perform at much higher levels, either the fourth or fifth stages of unconscious competence or unconscious super-competence.

Lack of purposive read about topics on documentation was not identified in the literature; however, Smith (1968) noted in her findings that there was a resistance to formalising the development of the assessment process and documentation of nursing practice, because it could raise accountability. This finding is also consistent with the findings of Ehrenberg et al. (1996) and Törnkvist et al. (1997) who found that writing down clinical judgements intimidated some nurses and in a number of cases some nurses appeared to lack an understanding of how to document abstract findings and concepts. Participants in this research may be reluctant to reveal to themselves their lack of knowledge on details of the documentation process, thus they avoid the issue of their knowledge deficit and the impact this could have upon their documentation.

Cluster 4: International literature and influences

The published literature provides a list of helping and hindering factors as shown in Appendix G. These factors have been compiled through the outcomes and recommendations of published audits, research and editorial-style literature. From this a list of these influences were developed into an attitude scale (as found in Appendix H). The participants were given a copy of this scale and asked to record what impact they felt each influence had upon their own work and to discuss what views they held on these factors. They were asked what they felt could be done to address the barriers highlighted and what (if any) inspirations these factors gave. Lastly in this section the participants were an explanation of the extent of training Swedish nurses are given for documentation and then the participants were asked if they thought that all nurses should receive training in documentation, as the Swedish nurses do, and why they thought this. Lastly, issues of referral to nursing notes were also raised. The intent of these questions was designed to reveal how often the participants referred to patients' notes to enable further research in the future.

The Kennedy Report (2005) highlighted the risks of workload and the pressures under which New Zealand emergency staff work. These pressures were raised repeatedly by the participants as patient acuity and the quantity of patients for whom they care. Different ways of working could address these pressures when associated with changes in the environmental structure. Such changes were already beginning to occur, as indicated by one participant who mentioned the reorganisation of the department (as described in the orientation of the study within the results chapter).

The issues raised in this cluster of question are of interest because they give the participants the opportunity to influence the process of development in their ED. The participants have a working knowledge of many of the needs for their specific genre of documentation; they hold opinions on how some of it can change and also what will not work, even if it works in other areas. This does not mean that this study gives them a veto to changes in certain direction, but this study does give the participants a chance to express their wishes and reservations for change.

Environmental impacts

Time, patient acuity and rate of turnover

The most commonly expressed concern was regarding the high patient turnover in every shift, associated with a high patient acuity. Some participants chose to view this as having a high number of patients in their workload, while others limited their descriptions of this concept as unstable patients; these varying views influenced their response to this attitude score. Participant 5 explained: *"I think the biggest pressure is time"* (p.1) and another stated *"I think in general, documentation is poor, and I think it has got a lot to do with the environment, as in the turnover, and how quickly [nurses] move from patient to patient"* (Participant 2, p.1)

Almost three-quarters of the participants cited time constraints as being a considerable constraint influencing documentation. Seven participants rated high acuity as either a very high or high cause for poor documentation, while two rated this as a medium influence. One participant spoke about the less experienced nurses, who continue to write exhaustive notes, as being most affected by time constraints. She argued that when the department is busy it is their documentation that *"gives [way to other priorities]"* (Participant 3, p.1). No participants classed this as a low influence on their documentation although one participant placed this as a very low influence with the explanation *"you make time to write, even if it's in the lift while escorting to theatre or wherever"* (Participant 4, p.2). Another participant similarly said: *"If it was that much of a problem and there was something you really needed to document, you could always follow the patient, wherever they needed to go; but if you've got other patients you can't do that"* (Participant 9, p.4).

To address the problem of inability to complete documentation, there is the option to request help or to share ones workload with colleagues. Only one participant acknowledged this option to enable documentation: *"The only thing you can do is say to somebody, "I need help – I need to finish my documentation, would you mind looking after such-and-such patient while I document everything" which I have done in the past"* (Participant 9, p.4). Another participant described the practice of offering colleagues help when they are busier than her and wished that they would reciprocate in similar circumstances. This participant excused her lack of

documentation on some occasions to the fact that she had *“been with someone that’s been sicker”* and couldn’t get back to her original patient to document the care she had provided intermittently (Participant 6, p.1).

The participants’ responses and the literature showed a correlation between time and patient-acuity and the pressure to document. A number of the participants complained about the lack of time to write all that they wanted to write, while others in rebuttal, said that they made time in which to document. As time cannot be produced it must be understood that that these participants altered their practice and processes to enable documentation. This practice differentiates quality from quantity. Do these nurses adjust the content of what they consider necessary to write or simply adjust how they write it? As one participant phrased it when she described the assessment and care of a patient with a minor injury: *“succinct documentation that doesn’t have to be complete, because it is a minor”* (Participant 5, p.4). This is counter to the advice published by professional health bodies that documentation should always be complete (CRNBC, 2005; NBT, 2003; NMC, 2005). However, this participant implied in her statement that she meant *“complete”* as in every section of the emergency record being completed rather than meaning the essential data requiring documentation being completed. Time constraints have been argued as holding a significant impact upon nursing documentation by many researchers and in the general nursing press (Bryant, 2005; Currell & Urquhart, 2005; Howse & Bailey, 1992; Martin, et al., 1996; Moody & Snyder, 1995; Oxtoby 2004; Renfroe, et al, 1990; Savy, 1997; Stewart & Needham, 1957; Tapp, 1990; Törnkvist, et al., 1997; Walker & Selmanoff, 1964).

Noise and interruptions

Noise and interruptions were considered frustrating constraints yet no participants chose to discuss these in-depth. The majority of the participants bore witness to this impact as given in the literature; half classed it as a high influence and one third as medium. Of the two participants who rated noise as holding a very low impact on their practice, one stated simply that she *“ignores it”* (Participant 9, p.4). These findings concur with the results published in the literature (Bryant, 2005; Howse & Bailey, 1992; Oxtoby, 2004; Renfroe et al., 1990; Savy, 1997; Tapp, 1990; Törnkvist et al., 1997). From the interviews I became aware that the participants have the desire to reshape the department to make it more practical and also to provide places in which they can sit and write uninterrupted and not be overheard, but within sight of the patients and their monitors. This lack of discussion in their interviews may well be based on the proposed upgrade of the department; it may be that they have hopes for a quiet area in the redeveloped workplace.

Space

Lack of space to write within the charts was raised by the participants and concurs with the findings of Howse and Bailey (1992), Tapp (1990) and Törnkvist et al. (1997). Six of the participants scored this as a medium influence or above, and four registered this as low or very low. Their comments were mainly in regard to the emergency record (Participants 1, 2, 4, 7, 9 and 10), the trauma sheet or fluid balance chart (Participant 6). One participant particularly complained about the difficulty of documentation in trauma situations. She noted that on the trauma chart there is not a proper fluid balance chart and as she pointed out: "...there is nowhere ... you can't sort of tally anything up on it there's no room is there? ... People often don't do a fluid balance chart in a trauma, when they should, but that's a huge job" (Participant 6, p.9).

Participants who described lack of space on the forms as having a low or very low impact on practice explained their rationale as simply, that in the event of running out of space, they would get more paper to write on, although one participant admitted to squeezing in information because she was sometimes "lazy" when it was for one more sentence (Participant 9, p4).

As another aspect on the issue of lack of space to document, one participant linked this issue to the value of nursing contributions to patient care. She described a feeling that nurses need to be encouraged non-verbally to document, by providing sufficient space within the document. She said of the emergency record sheet:

It doesn't give enough [space]. I tend to write a lot of history and it never fits into the space, particularly with sick people and I haven't actually got to my examination yet or my impression of patient on arrival yet and I have run out of room.
(Participant 10, p.3)

Accessibility and repetition

There was a strongly expressed link with the accessibility of the nursing record and repetition or multiplicity of documentation. On the influences ratings, the majority of the participants stated they felt inaccessibility of the record was a very high, high or medium influence on their documentation. This meant that almost three quarters of the participants felt this inaccessibility impacted upon their documentation compared to the remaining quarter who rated it as a low but not very low influence. The issue of inaccessibility to the record explains some of the findings of the audit by Dean et al. (2003) which demonstrated a lack of documentation by the nurses in the ED when it had been observed to occur by the auditors.

In this department the emergency doctor writes on the rear side of the emergency record form, and this means nurses cannot write concurrently with the doctor on the emergency record. A participant complained about her inability to write more than vital signs or complete the tick-boxes saying:

You know, you've got a lot to do and... the other day I had somebody that was really sick and ... I documented all my obs as I'd gone along and I ticked off some of the other things but to actually write down ... [my assessment and findings] ... because the doctor had taken off with the notes, I [couldn't] write it. (Participant 6, p.4)

This inaccessibility can lead to an element of repetition of documentation; with one nurse stating “*I mean how many times the doctors have got someone's notes and you've got ... frequent obs ... and your busy writing them on a piece of paper*” (Participant 8, p.5). Another participant agreed and expressed the wishful concept of separating nursing and medical documentation and described the trauma sheet which is a nursing record of activities during the resuscitation phase of a patient. This participant stated:

If you are using one of those trauma sheets its right there in front of you, no-one takes it away from you, it's all yours, you can write whatever you like. But when you've got the other sheet [emergency record chart] you can't do [it]... Even writing your obs down, how often do you still see nurses having to run away because the doctor's still writing on the back? And you can't actually write your obs down. (Participant 6, p.4)

Another reason given in the literature for repetition of documentation is that certain items for data are required to be written in a number of places within the patient's records. The concept of repetition arises in the comment of Participant 7 who stated that “*it's often that things are duplicated*” (p.1). The impact of repetition and multiplicity of records was described by the participants as being widely spread through the range of influences. Four of the participants stated that it had a medium influence on their practice; two each as very low or very high and one each as a low or a high influence. Of the two participants who scored this as very low one gave no explanation for this choice, while the other compared this workplace to her previous workplaces. She said repetition used to have a big impact on her practice: “*In [my country] that is very much so, especially in the medical assessment unit; but here I'd say absolutely not: because you've got the pink sheet*” (Participant 9, p.4). This demonstrates that nurses from other regions need to have an input when practice development occurs, because there is the otherwise the risk of the developers becoming institutionalised and following a narrow perspective.

Other influences impacting on documentation

Performance evaluation

Although the participants recognised that members of the senior nursing team refer to nursing notes for quality assessment processes, only one participant volunteered this data independently, the other participants conceded their knowledge of this practice only when directly asked to grade the influence this practice had upon their own documentation practice. Their responses to the question of the impact of this practice evaluation were confident. Eight of the participants stated this had either a very low or low impact upon their practice. Of the remaining two, one placed it as a medium impact and the last as very high, however, she did not elaborate upon this theme.

The participant who mentioned set practice standards (developed as a consequence of the audit by Dean et al., 2003) described how at the beginning of every shift during the team handover a number of items are supposed to be highlighted as routine reminders for the staff members for that day. One of these items is that of optimal documentation. This participant described the practice of “*eye-rolling*” by the nurses as a sign of boredom that they have been reminded yet again to document and that they then “*switch off*” (Participant 1, p.1). This is despite the fact that the findings of the audit by Dean et al. revealed a lack of documentation by these and other nurses, indicating the relevance of such reminders. No other participants mentioned standards as a rationale for documenting.

A quality improvement initiative was in place in the department during the study period and this was one of the reasons some of the participants gave for referring to their colleagues' notes. In this initiative, the shift coordinator on duty reviews the notes of discharged patients to check for completion and to encourage completion prior to filing. Participant 2 felt this practice might have halted, but Participant 1 confirmed this continued as time permitted. She stated that those nurses who document well, compared to those who do not, are now clear to her because she has reviewed notes on a regular basis; however, she continues to check all the notes she can to ensure it is a consistent practice – if somewhat “*discreetly*” in some cases (Participant 1, p.1). The participants were asked how they felt about their performance being analysed by colleagues, and their opinions of how the reviewers may be rating their performance, based upon their documentation. All of the participants were aware that the shift co-ordinators try to review all the patient charts and that their writing is scrutinised, despite this there was very little expressed concern about how their practice might be interpreted based upon their documentation, even among those who placed patient care ahead of documentation. The response was that the overwhelming majority were not concerned about the opinions that might be gained from their written work. Eight of the participants claimed that performance appraisal based on their documentation had very low or low impact on their practice, with the remaining two participants rating this as either medium or very high. These two

participants were both experienced nurses with more than 15 years and 10 years of experience between them, therefore it cannot be assumed that they lack confidence in their practice; although one of these participants reported involvement in several investigations of patient care during which her practice was scrutinised. These ratings of documentation reviews holding a low influence do not concur with the writings of Tapp (1990) or Howse and Bailey (1992). Tapp argued that analysis of written records as a reflection of the nurse's practice is feared and is therefore an inhibiting influence to documentation, while Howse and Bailey argued that feedback on documentation and positive reinforcement assist nurses to maintain an optimal standard of documentation.

Acknowledgement of the value and visibility of nursing

In addition to the reasons given for referral to documentation one participant also discussed the notion of multi-disciplinary and managerial acknowledgement of nursing contribution to care. She spoke extensively of how the scope of practice of the various professionals is increasing which is leading to an interconnection between the roles of each group. She argued that there appears to be a lack of recognition of this parity at present, but noted that it is beginning to occur. This participant, after having her practice scrutinised through her documentation, described herself as feeling undervalued by the health system, and that her contribution was unimportant:

[I was] getting the impression from all the people, senior management, senior nurses that really my role isn't that important. And while that isn't what people have said I've sort of felt a little bit: "Oh, but it was the doctor's decision at the end of the day". (Participant 10, p.5)

Her personal belief was in opposition to this, and she contended that:

... My personal view is that in emergency care that shouldn't be the case in that what we do as nurses has to support the decisions we make. And there is no reason when a person that's involved in ... who's being cared for by a team that any one of us can't say or we should be saying "we disagree" if we disagree and there should be ... and that should be: "and I said so" and not disregarded because of one person or more. (p.5)

She adds that the legal profession rightly ask what the nurse does and why, stating: "*Having had my practice scrutinised, in a legal sense it is acknowledged and in the [health system] culture it isn't*" (p.5). This participant then described a right and validity of the potential reviewer to ask certain questions such as:

... "You've been doing this job for however many years and learnt nothing?" "So you can contribute nothing, so you have no observations, you thought there was nothing wrong?"... I think they [the legal system] should and they do ask [these questions] that but we [the nurses] don't ask it of ourselves. (p.5)

She also questioned whether even the nurses themselves see the associated need for documentation, despite this role development she described how nurses do not value their true contribution to care. This returns to the subject of visibility of nursing practice, and one route to achieve such visibility is through

clear, concise and comprehensive documentation. It appeared that the participants felt the lack of space to record a full nursing history, assessment, plan and evaluation as a contributing factor towards silencing the voice of nursing. This lack of space was spoken of by one participant who said: “...*there's kind of the sense that you don't really need to write that much. [Yet] a proper assessment can take a whole page*” (Participant 7, p.4) which was again connected by the participants to the idea of separating the medical and nursing notes.

Negative connotation towards chart types and language

One aspect of attitude perception noted in the literature was the effect of negative connotations of certain types of documentation. An example of this is the type of wording used, which may be authoritarian or patronising. An alternative negative connotation of certain documents is towards those documents which may imply a complaint, either as the writer or respondent; and an example of this group includes incident reports. The participants were asked to score the perceived impact such documents had upon their practice. The largest response classed this as having a very low influence upon their practice while the remaining participants rated this equally as low, medium or high and no participants gave this a high score.

These responses link to the participants' interviews well, in that four participants refer to using documentation whenever an incident occurs or an incident form is tendered. Not one of these participants spoke negatively about their use, although one participant stated that she would prefer it if staff members faced the people that they were having problems with rather than escalating them always to incident levels (Participant 1, p.1). Another participant described her first reaction towards forms, such as incident reports, and the potential negativity of it, as unconcerned although she quickly qualified it as having some impact on her practice when she said: “*it doesn't really bother me actually, well to a degree, I wouldn't be petty about writing an incident form, it would have to be something reasonable*” (Participant 6, p.6).

In relation to the authoritarian discourse that some documentation employs, a participant also explained: “*I don't respond well to that and I'm sure I'm not the only one*” (Participant 1, p.2) and described the feeling that the language could be rephrased to be more positive such as suggesting rather than ordering appropriate actions. This conversation related to some of the care pathways present in the department. An opposing point of view was expressed by a second participant, who believed that the set documentation was not authoritarian, rather it was maternal with leading questions: “*Everything is there ... as a reminder [of what to document]*” (Participant 3, p.2). It is understandable how conflict could arise in the development of pre-printed documentation forms, with such divergent attitudes to language used.

Referral and its consequences

Frequency of referral

There were a number of reasons identified as causes to refer to other staff members' notes, as well as a range of frequencies. Frequency of referral varied with the participants' overall position for which they were employed, and for others, their role on any particular day. For example those participants who were part of the senior nursing team and the experienced nurses who on some shifts are in charge of an area referred to colleagues' notes regularly. Of this group of participants, two described the frequency of these referrals as "*all the time, maybe 4-5 times an hour*" (Participant 4, p.1) and "*probably 15 to 20 times in a 10 hour shift*" (Participant 7, p.1). Other participants were unable to place a figure on the frequency; however, they were able to give reasons for referral which demonstrated that they engaged in the practice of referral.

Participant 4 directly referred to a positive change towards referral of notes by co-workers when she spoke in the past tense of the fact that nurses had had a low expectation of their notes being referred to by colleagues, especially the medical team. Negative sentiments were expressed by two participants and the remaining participants made no direct or indirect reference to the issue. Of the two who spoke on the subject, one said: "*Half the time people don't even read [the notes]*" (Participant 7, p.1). While another wondered if it was worth documenting at all and saying:

The doctors don't read the nursing notes any way ... [they] say something like "Oh what's wrong with her?" Whereas if they'd actually read what I'd written ... It's a complete waste of my time! (Participant 6, p.7)

Yet the answer to this lies in a statement made another participant: "*It's hard to justify your actions or back yourself when you haven't had the opportunity to document or complete everything that was occurring*" (Participant 10, p.1). This argument was amplified by another who asked: "*How can we realistically recall what we were doing 8 months ago, let alone longer? ... Our documentation is our memory*" (Participant 1, p.3).

Communication, information collection and coordination

Reasons given for referral to notes included enabling the answering of patients', relatives' and colleagues' enquiries. Communication is clearly important to the participants, one participant said: "*We assume a role of ... clearly documenting so that even if the doctor hasn't; we know what's going on and the person taking over from us will know what's going on*" (Participant 5, p.2).

Participant 2 explained the reason that non-nursing staff members do not refer to nursing documentation was due to a lack of consistency of the content and location of data. She said:

You find that what you document the doctors don't go back and look at, because they don't even know where to go and find it. Whereas, if it was in a precise place and was very similar to the way that they document they'd find it. (p.5)

This line of reasoning fits well with the expressed enthusiasm for the medical model of documentation discussed in the strategies for documentation in Cluster 2 of this chapter.

Several participants expressed a concern relating to the incompleteness of much of the documentation. Two particular types of documentation were repeatedly highlighted: the trauma resuscitation record sheet and the fluid balance chart. These (among other forms of documentation) are frequently incomplete or incorrectly utilised. For example on the front page of the principal ED patient notes there is a box in which the patient's nurse should identify themselves and provide a specimen signature and time of taking up the care, but the participants stated this box is frequently left blank *"There is a lack of identification on the records, they do not write their own name, time seen and specimen signature on the record"* (Participant 1, p.1). In addition, other nurses may provide a brief intervention for the primary nurse and may document what they have done, but their signature is often illegible and the primary nurse is unable to identify who provided that care if an issue arises out of it.

Acceptance and data gathering on new patients

A second, and more commonly referenced reason among the participants for referral to colleagues' notes, was for the adoption of a patient's care, either for a short or prolonged duration. This includes receiving the patient at the start of a shift or relieving for meal break or emergency relief. Relieving for a meal break or during time when a patient's nurse is in an emergency such as trauma was spoken of by the majority of the participants (Participants 3, 5, 6, 7, 8, 9 and 10). One phrased it as: *"[to] try to find out what was going on ... [when]... filling in"* (Participant 6, p.2) and another simply said *"as often as need be"* (Participant 9, p.2). One participant asserted that referral to colleagues' notes probably occurred more often than these, stating that *"I tend to do so while going about activities rather than planning to refer to the notes"* (Participant 3, p.1). This links to the discussion of Participant 10 regarding the provision of one item of care for another staff member's patient, such as the provision of a bed-pan and the need to discover if a sample is needed or if the quantity needs recording in the fluid balance chart.

Participant 8 explained the reason for this type of referral is because: *"[When] I'm banded that patient I'll look at the notes. Because then it's my responsibility and I need to know all the things about them"* (p.1). Another participant said that she tended to principally refer to colleagues notes at patient handovers and that this happened more often when she worked in EOA than elsewhere (Participant 3). This is in line with another participant, who spoke of shift change handovers and referring to the notes:

I do that a lot. When taking over a patient I like to reflect back on what's happened, because when you accept several patients at a time, either you didn't hear the information or you have not been told the information of what's happened.

(Participant 5, p.1)

This is confirmed with an extending reason voiced by a participant who said: *"If I haven't been handed over to by the nurse who was actually looking after [the patient]"* (Participant 10, p.1). In my experience this occurs relatively frequently due to the nature of the ED; emergencies arrive, sometimes with little or no warning, and a nurse must be relieved of her patients immediately to care for this new patient, consequently the relieving nurse or nurses receive no handover or a minimal one only. To corroborate the idea of clarifying and substantiating verbal handover data, two participants stated that they referred for reflection and in-depth data collection, they said:

... just reflecting back on a previous presentation for that patient; people ... sometimes ... document the nuances about [the patient's] mood or the way that they behave towards other staff which is quite helpful and useful. (Participant 5, p.1)

I'd also look at [the patient's] retrospective notes ... I'd look at previous presentations that were similar and see what people had written then as well to see what the parallels [are present]. (Participant 7, p.1)

This is supported by another who said she referred to colleagues notes: *"Just to see what they've been doing, where the patient's at, getting their baseline in my mind"* (Participant 10, p.9).

Coordination and leadership

Leadership and preceptorship issues included the coordination of individual patients, involving data gathering on current patients through referral to and reflection of previous notes for temporary or ongoing assumption of care. Care coordination also involves that of individual areas of the department or of the department as a whole, and it includes the facilitating patient movement towards discharge, transfer, admission and or investigations and therapies. Leadership also requires knowledge of complex or challenging (and potentially challenging) patients or companions within the ED for risk minimisation and incident management. In illustration the participants spoke about the need for information to facilitate the coordination of transfers to wards, investigative imaging procedures such as computerised tomography (CT) scanning, ultrasound scanning and exercise tolerance testing and also the definitive treatments such as gastroscopy or operating theatre. As one participant stated:

I refer all the time, as [a coordinator] I don't carry a patient load but I constantly field telephone and face to face enquiries from family and colleagues – I'm dependant on the completed documentation for giving appropriate responses.

(Participant 4, p.1)

Likewise, members of the senior nursing team and the experienced participants said that they also reviewed their colleagues' notes for leadership reasons. One participant said at the beginning of a shift *"If*

a patient is handed over as a concern by the departing clinical nurse coordinator (CNC) or by an area's nurse-in-charge' (Participant 1, p.1), then this is a cause to refer to that patient's notes. This participant clarified the category of patients who are a concern or *"who have been an issue [to the previous shift]"* to include those who have been *"difficult to manage"*, such as patients and visitors who have been aggressive, patients who have been clinically challenging due to complexity and resources required, or patients who have been *"sexually abused"* (Participant 1, p.2).

A further reason given for referral by members of the senior nursing team was for whenever an incident report was generated. This was identified by four participants, two in general, one as preparation for handing-over to the oncoming shift coordinator and to record in the shift report, and one to evaluate the content of the notes to address the cause after the event had occurred. This response was not surprising in three of these participants, as they were members of the senior nursing team, the fourth holds a range of previous nursing experience, and this shows by her recognition of this reason for documentation.

A final reason given for referring to colleagues notes was that of collegial support through preceptorship and as the coordinator of an area within the ED for the shift. As one participant explained:

If you were overseeing someone, overlooking someone at work; if you had more [of the] less-experienced people [nurses] ... I would look at them if I thought there was something else ... [occurring] ... If I was concerned about them, I was worried about them; and I would question the nurse, or maybe help out the nurse. (Participant 6, p.2)

As explained previously, the literature review generated identification of 21 inhibiting and eight facilitating influences on the practices of documentation. The principal environmental impacts included time, space, patient acuity, noise, interruptions, access to records and the quantity and duplication of documentation. Other influences included evaluations of performance, acknowledgement of the value of nursing and visibility of practice and terminology employed in documents. The participants have suggested through their comments ways to address some of these influences and in most cases they agree with the literature, although not in every case, such as performance evaluation through documentation reviews. They also explained how often and why they refer to their colleagues' notes and the impact such referral upon documentation practice.

Cluster 5: Future development, potential process of change

This final section offers information derived from the interviews on a collection of issues. This data was generated by asking participants directly about what they want to have happen in the future practice of documentation and how they would like this to develop. I also probed to discover whether the

participants believed the other members of staff in the department or they themselves would be interested to work with these ideas for development. The participants were asked to clarify the steps for practice development from their perspective, including how forthrightly this process should occur. This section of the interview was important as it again gave the participants a voice in the future of practice development.

Participants were also offered an opportunity for a review of the interview and to comment any other aspects of documentation. This came in the form of asking the participants if there was anything else they wanted to discuss and whether they were comfortable for this data to be transcribed and used or whether they wanted sections omitted from the final report or treated with more care perhaps because it was particularly sensitive. If they did not want any part of the interview used they were asked to specify what part or parts they did not want to be taken further. Material derived from both these areas is reported in this section of the chapter.

Route of change

The route for change as advocated by the participants fell into two categories: consultation and participation as well as document development.

Methods

Once the initial idea of document development was suggested, the idea to reconvene the original staff documentation group or convene a new one was voiced: *"I do think it would be good to get the group who were dealing with the red sheet back up and running, and get that moving again"* (Participant 2, p.5). Another participant agreed, although she did not stipulate that the original group should reform. Instead she said: *"Begin with an open forum ... Give the staff members' ownership of the document"* (Participant 3, p.3).

Recommencing the documentation group as suggested by Participant 2, would include a number of users of the record such as some of the department's nursing, medical and reception staff. In addition this group could benefit from the input of other user's of the emergency record; examples would be the transit care nurses, the psychiatric emergency staff and the orthopaedic outpatient department staff. Also, an open forum could be made available in which any staff member could contribute their opinions. This forum could occur as a meeting, or offering the option for staff members to approach the current staff representatives to the senior nursing team, alternatively, that a list is made available to the staff, either in the communication books, or as a poster on the tearoom wall on which they can place their ideas.

Consultation and participation

A key aspect towards change as recognised by some of the participants was the need for consultation of the workers, as listed above, who presently use the document and to encourage participation in the development stages of the new document. Half of the participants directly recommended that collaboration and involvement of all members of the team are required to facilitate practice and document development. Their motives varied between two reasons, firstly to absorb the maximum range of ideas from the team members and secondly, to smooth the transition of the change process, because the staff members contributed to process. Participant 7 rationalised this as:

If people were consulted and it was talked about ... then people would probably feel a lot more open about it. I think if we involved staff and said "put some ideas together and submit them" ... if they felt like you actually care what they say, not that it's a token gesture, then I think that they'll be more willing to be apart of it as well ... (p.4)

Two participants agreed, describing the negative responses that transpire when a perceived lack of consultation occurs, even when the participants do not wish to take an operational role in the rest of the change process: "I think that they should be invited to propose things. People get annoyed if they're not asked. Even if their suggestions are not used they want to be heard" (Participant 8, p.7). "... You do hear about frustration about not being involved, though no one wants to [get] actively involved themselves" (Participant 10, p.4). Lastly, two participants called attention to the need for the change process to be constructive, including: "I think that it's trying to manage it in a positive way" (Participant 5, p.6) to encourage staff members to contribute to the process. This fits well with the idea of authoritarian practices and their lack of place in such a situation: "You know, I don't really think that some-one standing up and saying 'you must do this' will be that productive in the way of change" (Participant 7, p.4).

In the context of these beliefs, the participants were asked how they believed change could be commenced. Two participants proposed a general invitation, this included: "I think that a sheet should be put out in the tea-room and in the [communication] books, to provide a space and an invitation to participate" (Participant 8, p.4). Another recommended the involvement of the staff representatives: "... feedback – hand to [a staff rep] or [ask] a person 'what do you think?' [...of the staff]" (Participant 10, p.4). Similarly, a third participant said:

I think the best way is to ask the staff what they want or don't want. And they will give you such a clear starting step in the right direction ... possibly something we have never even thought of. But different people see different things that could work. (Participant 4, p.3)

Importantly, one of these participants recognised that nurses who have worked in other departments have a wealth of experience that could be applicable. She asserted the need to involve staff who had worked

abroad: “*We need to get overseas staff involved, because they have lots of ideas*” (Participant 8, p.4). She described being influenced by an overseas nurse in her own documentation and care planning:

One thing I found really [useful] I seen one of the guy’s sheets one day at handover; it was ... [so organised] ... and he had columns. In the first one was name and diagnosis, past medical history, plan – you know treatments and any plan, then I changed the end bit to put IV fluids, medications, allergies. So that you had that down, so when you read your patient’s notes, because they were significant things that you needed to know, and also needed to know to hand over to the ward, then I wrote those things down; and I just used a small sticker with their age and their team, and then the rest. And I found that absolutely fantastic. (Participant 8, p.6)

Anonymous contributions

No-one directly suggested that recommendations could be anonymous, although there is a system in place in the department where people can present suggestions to elected staff representatives and that these suggestions can be presented as anonymous contributions to the meeting or team. One participant included the option of the staff representative collecting suggested changes, but did not clarify if it should have the contributor’s name linked to it or remain anonymous. This lack of reference to anonymous contributions could mean that the participants had not recognised that some staff members prefer to contribute anonymously, or perhaps they felt that such an option would be inappropriate.

There are benefits and drawbacks to anonymous contributions. Staff members may feel threatened about offering contributions to change processes, they therefore self-censor. Reasons for this self-censorship may include an unwillingness to expose themselves to constructive or destructive criticism, or to appear to criticise current practices, especially if they are new to the department or to their current position. Additionally, potential contributors may perceive that they are in too junior a role to be recognised as holding a valid opinion that could be offered towards the change process. Others may prefer to hide behind the option of anonymity so that they may slow or stall the process (Schein, 1992).

Support, acknowledgement and recognition

One participant talked about the notion of multi-disciplinary and managerial acknowledgement of nursing contribution to care:

I think boundaries between medical and nursing staff are withering more and more, and I think nurses are learning way beyond the title ‘nurse’ and it’s not being acknowledged well yet. I think there’s a movement towards acknowledgement of it but it’s not really being acknowledged in an obvious sort of way. (Participant 10, p.5)

Encouragement to document and lack of space was spoken of by one participant who said: "... *there's kind of the sense that you don't really need to write that much - a proper assessment can take a whole page*" (Participant 7, p.4). This returns to the subject of visibility of nursing practice, and one route to achieve such visibility is through clear, concise and comprehensive documentation which can be supported through management by the provision of documentation that supports optimal documentation.

A further observation made by one participant related to peer and senior support. She complained that there was a lack of constructive and positive feedback regarding the quality of nursing documentation. She requested more helpful feedback and stated:

The only feedback we get is "you haven't written anything in the notes". It is negative feedback. You don't get feedback that those were good notes or those aren't good notes, so you don't actually know whereabouts you are sitting in the quality of those notes, so that you rely on self assessment that makes it very difficult. (Participant 5, p.3)

Expectations

Several participants felt that the nursing management needs to ensure that nurses receive clarification of both the principles and the content of optimal documentation. One participant stated that it might help if "*in their [the nurses] heads a desired emphasis or set of priorities for what's important [was provided]*" (Participant 5, p.1) and she argued that the department needs to introduce clearer guidelines about what should be written, clarifying "*what the expectations are*" (Participant 5, p.5). Another participant concurred when she said: "*[there is a] need to provide rules to follow, but loosely*" (Participant 3, p.2) which could imply that rules need to be established and or clarified and maintained. One participant expressed a concern a number of times over an apparent lack of documentation and associated quality expectations. She described how nurses fail to document the consequences of care, and stated that: "*there should be an expectation that people should know [what they should do]*" (Participant 5, p.5). She continued with the thought:

I do think we need to be bringing in a lot clearer guidelines about what we need to be written down, what the expectations are. In some ways what the consequences may be if it is not done, because it would be a way to motivate people to do it, to support people to do it. (Participant 5, p. 6)

Yet this is a basic requirement of nursing: to document consequences to enable evaluation. The nursing process is the basis of modern nursing; it describes four stages to care: assessment, plan, intervention and evaluation. Without the documentation of the outcomes of care evaluation cannot occur, and the nursing process has been taught in the primary stages of nurse training since its inception in 1967 (Yura & Walsh, 1988).

Each participant had an opinion on how practice could be developed, however, on enquiring the level of participation likely to occur from the nursing staff the response was unanimous – the response would be from one extreme to the other: enthusiastic participants to accepting individuals who would simply “conform” (Participant 2, p.4), to the passive obstructers and active objectors. As one participant pithily asked: “*How long is a piece of string?*” (Participant 4, p.2). Of the groups of individuals who may give a negative response, another participant said: “*Nurses can be resistant for the sake of it*” (Participant 3, p.3), and another participant succinctly described the whole uptake of change as:

Some would be very, very receptive, which would be quite a big group of people, but there would be other people who would be quite negative, because that is the way that they react to things. And then there would be the people who would take it on board, but it would be very slowly. (Participant 5, p.5)

The participants did not assert that staff members had to conform to changes, but they were agreed that the level of responsiveness to change would vary widely, that active encouragement would be necessary and that staff participation in the process with the option to contribute would be necessary. Overall the suggested route of change was through the option for all staff members using the documentation chart to have a say in how it should develop, either through group or individual involvement. It was also recommended that the chart should facilitate and support optimal documentation and recognise the endeavours of all staff who take part in the patients care, giving nurses the belief that their contribution is valued. Lastly when the charts are documented, there was a request for positive feedback to be given and any negative feedback to be given in a constructive manner.

Document development

Half of the participants identified the need to review and redevelop the emergency record chart. One participant recognised that the: “*red form [is] not used as well as they could be*” (Participant 4, p.2), and recommended that an investigation as to this cause should be made as a preliminary action. However, one participant disputed this and argued that the emergency record chart should be kept unchanged, because “*the majority of the staff are used to it*” (Participant 1, p.5). This argument for stability from this participant refers to the ideas expressed in the previous chapter, about the ability to find recorded data rather than resistance to documentation development; as this staff member stated she had been part of the forum that developed the documentation standards and audit.

Comprehensive changes of the emergency chart were sought by some of the participants. One declared a complete reconstruction would be useful of: “*The whole thing ... from the front cover, right through to the space that you have to document*” (Participant 2, p.4). Her justification of this was to make it: “*more user-friendly to medical staff, not just to the nursing staff*” (Participant 2, p.4). This again links back to the argument to facilitate the

search for information by all of the health care providers. Other participants requested critical, but less extensive alterations. At present the front page of the record has a Table in which to record the patient's vital signs, with each type of recording in a set row. One participant argued that this Table needs to be redesigned into a graph in-line with the rest of the hospital and many other emergency departments, with her rationale as: "*You can't show the trends on that [table]. You can sometimes mark it in red, but if you're in a rush, you're not going to and then you're going to miss [important trends]*" (Participant 9, p.5). Another suggested that staff add what changes they want and amalgamate the results, providing as an example: "*add diet type*" (Participant 3, p.3).

Prompt sheets and checklists

To address the strain of knowing what to document and how, several participants wished to have a printed document that provided prompts of what needed to be included as reminders. This could facilitate briefer documentation in that the context need not be written, only the answers to the headings that act as prompts. One participant argued that by developing a set format, it would enable all users of the chart to find data immediately. She argued:

It could all be changed to be more user-friendly to medical staff, not just to nursing staff. Because you find that what you document the doctors don't go back and look at, because they don't even know where to go and find it. Whereas, if it was in a precise place and was very similar to the way that they document, they'd find it. They'd find it easily. (Participant 2, p.4)

This could lead to arguments of what prompts to put in and whether they should follow a theoretical framework. The idea of a prompt-sheet as a basis for documentation was suggested by four of the participants. One gave her line of reasoning as: "*I would love to see an easy ... template for documentation... where you literally would fill in the blank spaces. I think that then people would not miss the essentials*" (Participant 2, p.3). A second participant limited the prompts to: "*things that are really important*" (Participant 6, p.8). A third participant concurred with the idea of prompts and recommended that it be based upon a tool such as the CWILTED acronym used by triage nurses in the UK: "*you used to write everything in those boxes, and then it was there*" (Participant 9, p.4). This participant also identified the role that the documentation can have to help support junior nurses in their practice to perform comprehensive assessments and complete necessary tasks to aid the patient's journey. She identified this role by its absence in this department's documentation chart (Participant 9, p.1). In line with these recommendations another agreed, stating:

I do think it would be really helpful to have our documentation guided to prompt you to remember things, like pre-hospital care; because that's something I might ask but forget to write down when I'm writing the notes. I think it would be really useful... It would be good to have like: subjective, objective big section and history, pre-hospital, list of medications that type of thing. (Participant 10, p.4)

The argument for the checklists was more divided. Two of the participants expressed the belief that there is a role for them, but that there are limitations also. Reasons for utilising them were simply because: *“they’re useful, because they bring stuff out of the text”* (Participant 9, p.5) and: *“I think some tick boxes to highlight certain things and narrative for [the rest]”* (Participant 10, p.4). She then said: *“I think that there is a limit to the amount of tick boxing you can do ... sometimes I think tick boxes are a little overwhelming”* (Participant 10, p.4). In effect, the participants described how some of the items and boxes on the list were useful short-cuts. An argument against their sole use was that there is a lack of a set space to insert the time an action is being signed for: *“it needs to have a time there somewhere”* (Participant 9, p.1). Another participant agreed and said: *“It’s a provision of your notes: that you’re trying to keep up-to-date as you go”* (Participant 8, p.2). Without a provision for recording the time of an entry, it is impossible to assess whether it is contemporaneous.

Critical care paths

Critical care paths are used for certain set conditions as prompts for treatment. This is especially so for nurse initiated treatments or admissions and are currently being extended by the department. Two participants expressed reservations about these pathways, one participant believed that there are too many in the department and that the nurses are becoming *“overloaded”* by them (Participant 1, p.5). Another expressed a liking for them, but was concerned about the degree of double charting they created, and suggested that they could replace the red sheet when appropriate. However, to do so, she said that they would also need to be reviewed to *“give more space”* for free-text (Participant 8, p.7). This corresponds with the requirement of the NHS National Library for Health (2005) that care paths must have a way for *“recording variations/deviations from planned care/activities?”*. Another reservation expressed was the lack of flexibility in some of the care paths; one said of one pathway: *“There is not a section of the pathway, where you can nurse initiate adequate analgesia”* (Participant 7, p.3) as opposed to waiting for a medical review for medically prescribed medications. This participant also amplified the first participant’s concerns regarding double-charting when she pointed out that much that is on the paths were: *“things that we routinely do”* (Participant 7, p.3). These pathways can act as prompts, which returns to the argument of Participants 2 and 9, in which less experienced staff can benefit from pre-printed assessment and treatment path forms. One participant again identified the terminology of these need to be carefully chosen to ensure that they are not authoritarian, rather they should be supportive (Participant 1, p.5).

Two other areas in which participants suggested improvements were discharge advice data and paediatric assessment. The former improvement was identified by one participant, who highlighted that patients often return to a health practitioner with problems due to a lack of knowledge of how to care for their condition. She described an incident where a patient had been prescribed a new medication without

education on its use and common side effects: *"I had a patient who had ... collapsed; he'd been prescribed it that morning, but had no education on its use. So he used it because he felt dizzy – and collapsed"* (Participant 8, p.7). She named the medication the patient had used, and it was clear it had been used inappropriately which exacerbated the condition leading to the collapse. The participant believed that the development of an extended range of discharge advice sheets could alleviate some of this type of attendances. The area of paediatric assessment and an inadequate level of assessment of children was a concern of one participant who said: *"... people don't fully assess them ..."* (Participant 6, p.7). She highlighted paediatric-specific health assessment models that are available, and that advice could be sought from specialist places such as paediatric hospitals, to develop a model that could be used in conjunction with the red sheet available in the department.

Access to documentation

An argument put forward by three participants to resolve the accessibility problem, was that nursing documentation could be separated from the medical. The integration of nursing notes into the main patient record began to occur in the 1960s. Previously, they had been kept separate from medical documentation but not for convenience sake, but because it was not intended for the benefit of the medical team, only for aiding the nursing care. The intent of integration was to increase multi-disciplinary referral to notes written by colleagues from other disciplines and to increase the recognition of the professional role held by nurses and allied health practitioners. However, this has led to problems with accessibility to the patient's record. This is particularly an issue in emergency healthcare, because the patient's journey is ideally transient (Department of Health [England], 2001), with the activities of the nursing process occurring in a continuous cycle. Each of these steps requires almost concurrent documentation by both the medical and nursing staff, but this does not mean that writing could not or should not occur on other documents instead.

The participants suggested that the nursing notes should once again be separated from the medical record within the emergency department, to enable access by all staff members to write the activities and outcomes occurring for the patient from their perspective concurrently with one another. One participant argued that once the medical and nursing were separated it would be much more difficult to lose all of the notes rather than just one section, and she believed that by separating the medical from the nursing notes, time would be saved for the nurses: *"Quite often you spend half the day chasing notes, rather than writing things down. So instead of chasing you can just lay your hands on them; it would be good"* (Participant 7, p.4). Another participant asserted:

There's no reason why we couldn't have the obs and medication sheet sort of ... separate, and just have some sort of system whereby they clip everything together ... Other ED's ... do it quite differently and they don't have some of this hassle. (Participant 6, p.7)

However, this participant then argued against the division of the nursing and medical notes, because in one of her previous workplaces where such a system existed, it was stopped due to losses of the nursing notes and the lack of medical referral to them. She said:

... It's tricky because you used to have a system where you wrote on something different. So the nurse would write on the nursing notes and the doctor[s] would be able to write on theirs, so you could actually write all the things down on the nursing page. And then what they did was they actually got rid of it, because it felt that they were always losing the nursing page or the doctors didn't read it because it wasn't on the same page. (Participant 6, p.7)

An alternative answer promoted by one participant could be that for the very sick patient, nursing and medical assessment generally occurs concurrently and in partnership; this can be stated in the nursing record with a comment to the effect "*refer to doctors [notes]*" (Participant 6, p.2). This participant's expressed belief was that by using this system the nursing notes can be task orientated, limited to the activities and responses occurring with the nurse and written as each occurs, with a review of the medical notes once they are written and any additional or alternative views documented. This system does not however provide much scope or recognition of the quality of the health assessment nurses now complete. In addition, one participant suggested that the location of the notes of current patients be reviewed. She recalled working in an area where some of the nursing notes, including the patient's vital signs, were kept at the patient's bedside, and she said of this system that it: "*was really useful*" (p.4).

Space

Arguments regarding the higher impact ratings related to two fields of opinion, that nurses need to write more than they used to in their past and that some nurses have large hand-writing. People's writing style varies enormously. The first argument is critical and it concurs with the arguments of Clarke (1998), who contends that there is a need to be able to compare nursing activities and performance - across locations and through time - by policy makers and managerial staff. This is to enable the addressing of issues of powerlessness associated with invisibility of practice and the need to address the effectiveness of care for accountability; and is advocating a drive to increase the quantity as well as the quality of documentation to enable review of nurses practice. Nurses are required by their employers, unions and legislation to include certain basic details within their documentation and one participant felt that nurses need to be non-verbally encouraged to document by providing sufficient space for this.

The participants made two suggestions to improve the inhibitor of lack of writing space. The first was to either increase the space in the chart in which nurses write their contributions, through reorganisation of the documentation form, with or without the use of prompts and without any reference to the location of the medical team's documentation. Participant 7 said: "*[make it] bigger ... more room for the progress notes ... a proper assessment can take a whole page*" (p.4). Participants 8 and 10 agreed with this wish "*more room ... Yeah, I think ... definitely more room*" (Participant 10, p.3). One participant also recommended a review of the trauma and resuscitation chart with the development of a fluid balance chart on the back saying: "*... you never use the whole [rear] side of the ... chart and that would be helpful in a trauma*" (Participant 6, p.9). The second suggestion was to separate the nursing from the medical notes. By removing the medical notes from the ED chart, there would be more space available for the nurses' written observations.

It can be seen that documentation development could help patient flow, which is a worldwide issue of importance to all ED staff members. There is the potential that supportive discharge data can reduce patient attendances and returns while practical assessment formats can facilitate patient assessment, by a) potentially minimising the need to return to each patient for additional data and b) reduce the possibility of missing important health information, thereby improving the speed and quality of patient care. This issue of speed was raised again when the participants suggested that the nursing and medical notes are divided. The nurses complained of the time sometimes required to either find and / or gain access to the notes to enable them to document, especially on the occasions when the doctors had taken the patients' records away.

Education

The level and extent of education about documentation varies enormously. In Sweden for example, nurses are taught the extensive VIPS framework as part of their training. In addition when the framework was introduced nationally all nurses received education and support to facilitate its introduction ranging from a 3-day course known as "Vård 77" (Törnkvist et al., 1997, p.23) which most nurses complete, followed by varying degrees of mentorship from a two-year comprehensive intervention programme comprising supervision, conferences and seminars, specialist support, leadership support and document development, to no follow-up (Björvell et al., 2002, p.12). Among the participants the level of education regarding documentation also varied as shown in the findings of cluster three. In this cluster the participants were asked how they believed the effect of the organisation's expectations impacted on practice, what the priorities for documentation should be and how they felt documentation education could or should occur.

Training

Education development was suggested to improve documentation practice by several participants. One participant said: *"I do think maybe it would be beneficial to have more on documentation"* (Participant 6, p.6) while another contended:

I think it ... needs to be reflected upon in an educational capacity. You can make ... improvements through education, [by] making people think about what they should be documenting. At the least they should know that they should be doing this. (Participant 5, p.6)

There was a range of responses to the placement and content of documentation education sessions. As one participant said: *"... [at present there is a] lack of consistency"* (Participant 3, p.2). Participants 3, 5, 7 and 8 all expressed the opinion that it should be introduced during nursing training in a *"more applied way than an ad-hoc way"* (Participant 5, p.4). Regarding the content, some participants described how they would like the opportunity to learn different tools and how to apply them (Participant 10, p.4) while another contended that one tool should be taught to standardise documentation.

There were mixed responses to the idea of training specifically related to documentation. The principal response was that it was a good idea, and very necessary to practice. One participant said:

As the nurse becomes more experienced, because you are able to improve and enhance upon your practice, you are able to pick up on the finer details. You get your gross motor skills and then you get your fine motor skills – don't you? It applies to everything that you do. So there does need to be ongoing in-service education. (Participant 5, p.4)

However, the participants implied that they felt such sessions or days would in all probability be *"dry"* (Participant 6, p.6) at best and said: *"I don't think I'd like to do three days of it"* (Participant 6, p.7). Only one participant voiced the opinion that a specific course for qualified nurses was unnecessary, she said: *"I don't think that you need a specific course on documentation. Each practitioner has to take responsibility [for their practice development]"* (Participant 7, p.3). She justified her case by expressing the belief that nurses absorb the specific needs of the workplace into their documentation strategy and that documentation education only: *"needs to be part of the orientation plan to [the specific workplace] and something that your preceptors cover"* (p.3). However, she endorsed the principle that nurses should *"we should all leave our undergraduate courses with the basic knowledge of what we need to document when we're looking after our patients"* (p.3).

One participant suggested that methods of documentation should be integrated into current courses. Some participants described of learning various acronyms or mnemonics as assessment formats through these courses. The participants then described how they applied the principles generically rather than

specifically, even though the courses do not emphasise that the documentation of the situation should be written in this way. As one participant illustrated:

I was just remembering some of the courses that I've done, a lot of them are done and they sort of teach you these things, but still don't even at the end of it talk about the documentation – like you don't necessarily get a documentation part at the end of it either do you? So it would probably be a good bonus to add on to those things. ... I mean they teach you and you do the ABCDE, but at the end of it you don't actually get a sort of ... this is ... [how] ... you sit down and document that, which would be quite good. (Participant 6, pp.6-7)

This participant recognised the need to understand what is happening to the patient and why, before the documentation can reflect this information, which would fit with the suggestion that appropriate documentation is taught during practical courses. She said:

Of course, there are a lot of people who can document, but you've got to have that basic understanding. You know, like, you still need to know what you're documenting, so you're not going to be able to document unless you understand what you're documenting. So I guess it's sort of a flow on effect isn't it? (Participant 6, p.6)

An additional subject for inclusion in courses was that of referral to colleague's notes. This was proposed by participant 6 as: "I think that's an education thing to get doctors and nurses to read each other's notes any way" (pp.7-8).

A further method of documentation practice education suggested by the participants was through the orientation process of staff to a new area of the department, (or ward or unit of an organisation). Participant 5 contended that: "Each specific area has its own aides [systems or tools], that need to be part of the orientation." (p.6). Participant 7 agreed and stated:

I think... as far as specialised documentation for areas whether that's ICU [intensive care unit], ED, orthopaedics, vascular, whatever, then I think that needs to be part of the orientation plan to those units and something that your preceptors cover. Because they're all the same, but they have little differences for each area that you need to be aware of. (p.3)

Diverse feelings were expressed about the adoption of further training. One participant spoke of making further documentation training mandatory. She recognised that it may appear somewhat authoritarian, but she held the belief that it would still be beneficial:

I think they'll probably groan and say another training day; and they'll probably think: 'we know all of this' – as everyone does for manual handling and fire safety and things like that – everyone always groans. But ... I'm sure they'll find it quite helpful, it will change documentation as a rule because it always does. They'll probably groan, but if you make it mandatory ... (Participant 9, p.5)

While the other participants avoided making such a commitment, their generally expressed perception was that education should be available but that take-up would be difficult to ensure if voluntary. For example as one participant described it: *"You can lead a horse to water, but you can't make it drink"* (Participant 7, p.3). Another agreed, she implied however that it needed to be limited to prevent the nurses' becoming tired or bored of it and said: *"But not so much as that people object to have to adopt this – you'll get a lot of rolling of eyes. I've got to do it again!"* (Participant 5, p.4)

The participants held a range of views on documentation education, from one extreme of a) making it a regular mandatory update, b) a section added to current education programmes or sessions, or c) leaving it to be a self-directed activity. They also recognised that the uptake of voluntary sessions would be variable. It would be fair to say however, from the responses in this study that further education does not necessarily alter the nurse's perception or practice of documentation. For example, the participants who described both positive and negative sentiments and rationale regarding the doctor's lack of referral to nursing notes had all taken part in either post-graduate education or education provision.

Summary

The chapter began with descriptive information about me as the researcher, the participants and the study location to enable the placement of this study into its context. The participants distilled the rationale for documentation into five principal groups including a) the need for practice to be visible, b) the influences of colleagues and organisational culture, c) priorities of practice, d) organisational standards and e) justification of actions. The participants described the strategies that they employ in their daily practice and they recalled how they acquired these strategies, how they employ them, as some participants follow certain systems strictly while others adapt tools to their needs, and their beliefs for and against some of the common frameworks. The participants reviewed the influences published in the nursing literature that are known to effect nursing documentation practice and they discussed the environmental impacts such as time constraints, noise, lack of space, access and repetition of documentation. They also revealed their beliefs about the impact of documentation being reviewed as part of quality improvement or as part of an investigation and the value of documentation especially linked with multi-disciplinary referral to nursing documentation. They also described the reason that they refer to colleagues' notes citing a range of reasons including data gathering and coordination of care – either for individual patients or for areas of the department and communication. Finally the participants shared their views on how practice could develop to improve documentation. Suggestions included the route to change, such as methods of collaboration, professional and organisational expectations, support and recognition of the value of practice and document development, including types of charting and space, as well as dividing nursing from medical notes. This chapter closed with the participants' views on how education could have an

impact on documentation and included a range of options such as: regular mandatory updates, pertinent documentation methods added to current education programmes or, to continuing with the self-directed process.

In the following chapter these issues and findings in respect of the overall research aims and objectives are discussed, the chapter concludes with consideration of how to take the findings further in practice and options for further research.

Chapter 5: Discussion and Implications

Introduction

In this chapter the research is drawn to closure via a discussion of the findings and implications arising from these; and some final reflections in relation to the method and design of the study, and study outcomes are offered.

The discussion of the findings involves three different elements. The first part of the discussion is focused in relation to the substantive question of the research, the findings in relation to the literature review and the emergency nurses' perspectives on nursing documentation in an ED. The second part comments on these in relation to the research design and methods, and the third part offers some reflections in relation to the findings and the overall research aim and objectives.

Relevance

New knowledge was generated in respect of this study in relation to emergency nursing and a consequence of this research is the better understanding of the context and practice of nursing documentation in the ED, the factors that influence it and the potential means for development which support the legal and professional goals of optimal documentation.

This study is timely in that documentation is a contemporary issue that affects all nursing and multi-disciplinary care provision and communication. The findings offer new insights in to the documentation practices of emergency nurses, and they have potential to help practice development regarding documentation processes in the ED. The information collected contributes to the body of knowledge already published internationally in relation to the documentation practices of nurses.

The significance of the qualitative descriptive data and themes derived from the study participants are discussed in the following section of the chapter. For each theme there are some opening remarks made in relation to issues of documentation practices; these are followed by discussion of the issues and an exploration of the participant-based recommendations.

Discussion in relation to the substantive findings from the literature review

Synthesis of the information revealed in the literature review led to the building and refinement of the research questions, foci, strategy and design. It provided a consolidation of data in three areas. These areas were the systematic search and review of a) the practical and theoretical frameworks influencing documentation, b) the rationale for documentation, including the professional organisations and legislated standard setting requirements, litigation, communication and collaboration, professionalism and visibility of practice, research, best practice and professional autonomy and the consequences of documentation for patients and c) the practical factors influencing documentation.

Practical and theoretical frameworks influencing documentation

Discussion of the history and details of the theoretical frameworks was useful because it gave a summative account of developments and transitions of these across time. Practically this useful summary will be a help for other researchers and clinicians who have an interest in the theoretical frameworks. In terms of this study this synthesised knowledge enabled exploration and consideration of where the actual practices documentation practices of the nurses who were interviewed fitted in relation to these historical and contemporary theoretical contexts. For example the history of the location of nurses' documentation has altered through the years, from a time when it was recorded and stored separately from the patients' records, not referred to by the other healthcare team members, to the stage where is integrated into the record, where all team members write together and it is available to be referred to by one-another. This referral to colleagues' notes has several benefits: it facilitates care provision and communication; it clarifies actions, confirms responses and provides the care providers with a sense of achievement and self-worth. Another example was that of the utilisation of documentation frameworks. Frameworks enable the standardisation of data transmission which supports collaborative practice and can prompt the care-provider to complete set aspects of assessment or care.

The functions and outcomes of this part of the literature review enabled an appreciative assessment of which frameworks remain useful in practice and those that have slipped away which could still be useful. Features of this literature have been incorporated into this study with the construction of tables of frameworks available which were presented to the participants (Appendix I) to support the interview process when discussing the subject. The effort of tracing the history of the frameworks into a summative form has developed a new appreciation in me of the abundance and quality of the systems available and it has assisted me to make this information made available to others.

Rationale for documentation – Organisational and collegial cultural influences

The second area identified in the literature was the framing of practice from the perspective of legal, professional and organisational viewpoints. The literature identified best practice and presented background knowledge and strategies to achieve this. This derived data is relevant to ED, because it highlights contemporary knowledge which is potentially useful for practice development and enables the understanding of the requirements and scope of practice especially in the fields of education, preceptorship and support and environmental development – as examined further in the discussion in relation to the substantive findings from field study.

The knowledge gained from this section of the literature review was the identification of the regulatory authorities and it enabled the clarification of the requirements for documentation. This familiarity with the rational and guidelines available influenced my responses while interviewing the participants, in that it enabled me to understand and support fuller discussion of the contextual arguments surrounding documentation, by raising the visibility of the guidelines already published. The resulting summative knowledge of this review can facilitate the development of pertinent guidelines for the department in association with the participants' responses and recommendations.

Practical factors influencing documentation

The third area of the literature identified in the literature were the practical factors influencing documentation involving the identified facilitators and barriers to documentation including physical and psycho-social pressures, time and workload, access, repetition, knowledge, and language barriers. The benefit of this part of the literature review has been the collation of the influencing factors; this enabled the development of summative tables (Tables 2.6, 2.7), the content of which was combined for participant use (Appendix G). The most relevant of these influences facilitated the construction of a basic tool to measure the impact of these influences from the participants' perspectives (Appendix H) and were brought to the attention of the participants. While these elements were related to general factors they are still pertinent to ED therefore it remains helpful to consider these to help build the tool for assessment.

Findings from the literature review generated information in relation to existing research, theoretical and practical models of documentation used by nurses generally, and clarified the identification of factors which can help or hinder nurses' practices in documentation. The knowledge gap and key aspects of information from the literature were used to inform the design process of this study including the framing of an aide-memoire, and interview strategy.

Discussion in relation to the substantive findings from field study

The findings from this research revealed that the participants' documentation practices were influenced by factors in the workplace such as extant departmental and organisational culture, competing priorities for time such as the provision of direct care against time for documentation, competing with other staff to access patient records, and peer culture in relation the purpose, content and frameworks for documentation. Documentation practices were also influenced by the participants' own clinical histories, philosophies, familiarity with particular documentation frameworks and education. The participants recommended routes to development of documentation practices through partnership, participation and process engagement. Recommended strategies included document development as well as knowledge advancement and collegial support. The results compared well with the general literature regarding known influences on documentation; importantly they added insights into context specific influences and to relevance of personal histories to documentation practices.

New knowledge in relation to objectives

This research study sought to describe emergency nurses' perspectives in relation to their practices in nursing documentation. in relation to: their personal beliefs, past experiences and preferred systems of documentation; the practical and contextual factors that influence these within an ED; their professional interests in documentation tools or systems in practice, and the interests that they have in relation to further development of documentation practices and systems.

The findings from this research revealed that the participants' documentation practices were influenced by factors in the workplace such as extant departmental and organisational culture, competing priorities for time such as the provision of direct care against time for documentation, competing with other staff to access patient records, and peer culture in relation the purpose, content and frameworks for documentation. The participants described their personal philosophies, which influence their practice, were consequent upon their practice histories, through personal experiences and observations of their colleagues. The findings in relation to document development and practice development are addressed later in this chapter.

New and practical insights emerging from qualitative description

This study was commenced in the absence of literature revealing nurses talking about their practices and perceptions. One of the gifts of qualitative description is that because it does not work at a highly interpretive level it allows access into the practical thinking and insights of the real world of documentation as expressed by the participants.

The next few pages of this chapter offer considerations that relate to the pertinence of this knowledge and information. These issues are organised in relation to four interests. The first is the need for practice to be visible, this involved recommendations to facilitate documentation through enabling space and ease of access to documentation as well as a discussion about the use of documentation frameworks. The second interest is connected to the influences of organisational and colleagues' culture, including issues of priorities of practice; this involves recommendations for education and practical support in the form of mentorship and preceptorship. The third interest relates to quality assessment and organisational standards, this includes commentary on the participants' beliefs about the impact of documentation being reviewed as part of quality improvement or as part of an investigation and how the documentation does not always reflect the actual care given or the patient's condition and acuity or intensity of care. Recommendations include adjustment of processes in the department used for auditing. The fourth interest considers the need for communication and coordination of care provision and the recommendations involve document development and education regarding certain aspects of documentation to facilitate these needs.

There was congruence between many of the participants' responses and the published literature; however, there were some notable exceptions, such as, the impact of quality control and practice investigations based upon documentation contents. There was almost universal agreement about the impact of many of the physical and psycho-social pressures influencing documentation, to which the participants offered useful recommendations although in some instances some of these conflicted with those proposed by other participants, for example the use of a universal framework of documentation and assessment. These recommendations and conflicting views are valuable to policy makers and document and practice development teams. The conflicting opinions held by the participants were given with pertinent arguments and these require addressing before new strategies for either document or practice developments are introduced. It was clear that the participants appreciated the acknowledgment of their contributions and the demonstration of appreciation of nursing documentation. The participants' recommended practical changes that could facilitate documentation which can be utilised by the development coordinators during the change process. As a result of the findings of this study I have gained an appreciation of the importance and recognition of contribution of practice is to the participants, to this end, their role and activities need to be acknowledgement in any development that occurs.

Visibility, power and value

The participants mentioned the lack of perceived value and recognition of the nursing contribution to care as an issue, and several participants discussed how they consider themselves and their colleagues to be

stretched to the point of wondering how little documentation they can get away with, and how they consider documentation a burden of practice. These findings concur with the writing of authors such as Clarke (1998); Lawler, (1991a, 1991b) and Mallison (1987) who argue that feelings of powerlessness, of being under-valued and invisible are linked with lack of documentation. Tapp (1990) argues that the quantity of nursing work and the associated lack of time or their "busyness" (p.235) exacerbates non-documentation. There was an argument expressed by both the participants and these authors that nurses should value their contribution to care more.

This issue of value arose from a discussion on one practical inhibiting factor: a lack of space to document in the chart. Multiple methods need to be employed to address this need for visibility, power and value. Effective and comprehensive documentation can address the first two, but there are multiple barriers present, as seen in Appendix G. Three of the participants' recommendations were the provision of more space in the ED chart, improved access to the ED chart and the review of the format of the ED chart.

Space and access

Two of the reasons most commonly expressed by the participants for nurses not documenting were the lack of space on the ED chart and lack of access to the chart. Of the first influence regarding lack of space to write in there was a recommendation by the participants to provide more space to write in. Two routes to achieve this were suggested, the first was to review the ED chart and develop it to create prompts for brief comments. Whichever system or tool utilised by the nurse or organisation, it is imperative for there to be sufficient space in the document for the nurse to chart each of the stages of the nursing process. Whether the document is a prompt for a certain system or a more generalised location for unstructured narrative, without provision of sufficient space nurses are less likely to see a requirement to document all the aspects of the care that they provide.

The second option recommended to achieve more space was to divide the nursing from the medical notes. There are both advantages and disadvantages to the proposition for dividing the nursing notes from the medical. Separating the medical from the nursing documentation could have the power to both improve and impede communication between the professions. The suggestion to divide could create space; by removing the medical notes from the ED chart there would be more physical space available for the nurses' written findings. A second gain from this division would be to increase nurses' access to the charts and to therefore potentially facilitate an improvement in the quantity and contemporaneousness of the nursing documentation. By separating nursing and medical documentation the participants believed that they would find the process of documentation easier, and by enabling the completion of documentation, there would be the potential of an increase in the visibility of nursing contributions as a consequence.

However, the difficulties attendant upon this option include the fact that the participants already complain that doctors do not read their notes, and they questioned the value of documenting if no one refers to what they have written. Dividing the medical from the nursing notes could potentially exacerbate this criticism further. Once chosen, the decision to divide the records would potentially require review in the doctors' orientation every six months, for each intake of new doctors to the ED, and also during the orientation for all new nursing staff, to ensure an ongoing agreement to refer to the notes written by co-workers. This would be necessary to ensure the recognition of the contribution and value of nursing documentation in the patient's treatment and to raise the awareness of the concept of collaborative care.

An alternative third option for coping with the lack of space to document was to omit the documentation of the health assessment in the nursing record and instead simply state a comment to the effect "*refer to doctors [notes]*" (Interview 6, p.2). This, however, would open up comments and concerns regarding the risk management and inability to assess the quality of the nursing assessment, especially as there can be hours of waiting for the patient between the nurse's and the doctor's health assessments. I believe that this suggestion would only be a safe option if the nursing health assessment occurred simultaneously and in conjunction with a doctor's assessment; and even then it would be wise to check what the doctor has written before signing such a comment, as it is anecdotally well known that the patient often tells one story to the first clinician and another to the next.

Frameworks or systems

All the participants opted for a review of some or all of the documents in the ED, yet this when it occurs will be complex due to the diverse wishes of the document users. Some participants argued for the division of nursing and medical notes while other participants suggested more fundamental or more generalised changes of the ED chart. Some participants argued for the creation of further checklists, yet others requested the removal of them and others desired either the increase or decrease in the patient pathways with arguments for each option. Several participants expressed a concern relating to the incompleteness of much of the documentation. Three particular types of documentation were repeatedly highlighted: the ED chart, the trauma resuscitation record chart and the fluid balance chart. An additional suggested change was that a separate paediatric documentation form should be developed, with prompts unique to child health assessment needs. The same recommendations for routes of change stand for this development as for other documentation, as discussed later in this chapter, in addition to the technical needs for printing. Overall the participants' arguments regarding these charts concurred with one another, and they stated that these (among other forms of documentation) are frequently incomplete or incorrectly utilised.

A number of researchers have commented that the use of a theoretical framework is beneficial. For example Ehnfors (1993) and Tapp (1990) argued that the utilisation of specific terminology leads to standardisation and frameworks which enable clarity through organisational structure. These authors were arguing this from a documentation perspective; however it is probable that it may benefit the nurse's individual organisation also. Participant suggestions ranged from implementing the use of a health assessment framework, a triage framework or a documentation framework. It was proposed by the participants that in ED a single framework would be unlikely to be appropriate for all the potential patient conditions; although the basic framework of the nursing process upon which the range of nursing models have been based could be utilised, and the staff members then could use whichever tool that is most appropriate to the patient's needs within that framework.

A different recommendation was the increased use of care pathways. Each patient that attends the ED has a unique combination of needs, yet their individual problems can be similar. Care pathways are designed to address these set care needs utilising evidence-based knowledge. But there could be potential problems with the care pathways because they are generally developed to address certain conditions and many patients now have multiple health conditions due to the aging worldwide population. Following and completing the documentation for all of the appropriate care-pathways on each patient could easily lead to repetition of documented data, which would reduce the likelihood of staff members complying with their proper use.

Although some participants recommended the development of prompts, there were reservations about the prompts already available in the check-list format. There were comments from participants about the practical issues of no designated prompt printed for the time interventions occurred. As a peer I recognise that it could be said that there is also no associated set space for a signature either, but there is space beside each task where this data could be written. It is possible that this non-compliance is due to lack of consideration of this option. Arguments that occurred during the previous documentation development drive were spoken of by a participant, who recalled that there was a question about whether all expected elements should be printed as prompts out on the form so that the nurses' need only to write in the space available to make it complete documentation, or whether there should solely be teachings provided about the department's specific documentation as well as general requirements of optimal documentation. She said one of the arguments given was that nurses are professionals, with common sense: that they will know how, what and when to document. Having revealed poor outcomes, the as-yet unpublished results of the repeat audit seem to contradict this (Williams, personal communication, 12th February, 2007).

The provision of more space and access to enable nurses to write comprehensive health assessments, that reveal the quality and extent of the nurses' practice, would have the potential for the doctors and other

members of the multidisciplinary team to increase their referral to the nursing documentation. Likewise there is the potential for improvement in the quality of documentation through the use of frameworks, which would again potentially improve the likelihood of collegial referral to the records. However there were conflicting arguments regarding the choice of frameworks available. Increased reference to the nursing notes may, in part, increase the feeling of value the nurses would experience and potentially develop a positive cycle of increased self-worth and the encouragement to document fully.

Expectations and priorities of practice

A number of participants recommended that the organisation clarifies its position and expectations to its staff members and ensures that nurses receive clarification of both the principles and the content of optimal documentation. The participants were discussing the priority that many nurses place upon documentation and that they recognised many nurses place it below other demands upon their time. Their comments agree with the literature, for example Tapp (1990) describes five other demands nurses place as holding a higher priority on their agenda including patient distress, medications, patient problems, planned treatments and condition monitoring and ward management. Documentation was described as the sixth priority – when time permitted.

An argument was made for the introduction of clearer guidelines which would motivate and support nurses to document. This claim, however, lacks force, as these expectations were summarised on a card as a consequence of the Dean et al. (2003) audit. These guidelines been laminated as a card the size of the staff ID badges and designed to be carried with the ID badge; and all nurses in the ED have been given one of these cards. Therefore, staff members being given the expectations does not necessarily mean that they will be followed. As the participants continue to believe that expectations are not clear enough, perhaps these guidelines need to be reviewed, either simplified or made more detailed. Part of the process of practice development will need to ensure all document users understand the standards of practice. These guidelines could need to be reiterated and advocated for by the preceptors and senior nurses. This advocacy for effective documentation is congruence with the argument of Renfroe et al. (1990) who recommended the “communication of high ideals and expectations ... to the staff nurse in order to improve the quality of documentation” (p.47).

Education, mentorship and preceptorship

Many of the participants recommended some form of education in documentation. This concurs with the literature. For example Martin et al. (1999) described an axiom that “documentation is only as good as the person doing it” (p.348) reflecting that the nurse may be very skilled yet document poorly, but a nurse

who is not knowledgeable in areas of practice, cannot document well in those areas. It was a common suggestion that it should involve all student nurses, and potentially all nurses returning to nursing after an absence from the profession during their return-to-nursing training period. Another recommendation was that all the nurses who do not attend training programmes as students could update their documentation knowledge through orientation programmes to hospitals when they change their jobs and also to their specific workplace. A further option for documentation training could be as part of the practical courses nurses attend to advance their knowledge on specific subjects, such as advanced life support training, trauma nursing, advanced health assessment, triage and advanced competency training and possibly within the fundamental annual updates along with basic life support and fire training. A specified objective of every course would be to document the actions or the findings related to whatever practice was the topic of the course, to demonstrate the ability to document their new practice effectively and accurately. However it was noticeable that there was a general lack of enthusiasm to attend documentation courses which links well with the writings of Törnkvist et al. (1997) who noted that that nurses who had a higher level of satisfaction in their own documentation practices tended to be less enthusiastic towards education in nursing documentation.

I believe however, that training in documentation should take more than a brief session if it is to be comprehensive. The legalities and rationales for documentation could indeed be covered in brief session, but this will not teach nurses how to document, only why. Furthermore, preparing the training would be complex in itself. Once the “why” has been discussed and before the “how” is taught to the nurses, there would need to be an agreed consensus of what system, framework or method is to be taught to ensure the same things are taught to all for standardisation of knowledge and practice development. In the literature Renfroe et al. (1990) questioned whether nurses know what they should be writing and they identified that nurses documented their assessment actions only 85% of the time, and they questioned whether nurses were either not assessing or unaware of the need to document the information. Meanwhile, Perroud et al. (2003) also demonstrated nursing knowledge deficits in the realm of the nursing process and the tools available to apply it, as well as a lack of knowledge on the care planning tools available leading to poor compliance in the tool use during patient assessments.

Once the training sessions or courses are complete there is the opportunity for ongoing support. This has been identified in the introductory process of both the PIE and the VIPS models, whereby the new users were given a range of support, from a shared facilitator to individual mentoring (Björvell et al., 2002; Buckley-Womak & Gidney, 1987; Siegrist et al., 1985). In association with this idea is that of preceptorship of nurses new to a department or ward to ongoing mentoring through team practices. Several participants nominated collegial support, either through preceptorship or as a coordination of an area within the ED for the shift as a route for documentation improvement. Several participants gave the

opinion that department specific documentation training should be taught through preceptorship during a nurse's orientation. This could be an effective method of reaching all new members of staff, but is dependant upon the preceptors own skills and beliefs. For example one senior member of the nursing team noted that she sometimes failed to document optimally, and I believe if documentation training is left to the preceptors the range of quality of documentation training has the potential to vary extensively. Howse and Bailey (1992) noted that nurses develop beliefs about documentation from their early years as students and after qualification, they argued that nurses "may be 'socialised' into a negative pattern of thinking about documentation from the outset" (p.372). Preceptors need to break rather than perpetuate this negative trend through "positive reinforcement" (Tapp, 1990, p.238). Effective preceptorship and mentorship has been identified as contributing to the integration and transition of staff into a workplace and for the new nurses' attainment of their role expectations (Andrews & Chilton, 2000; Fox, Henderson & Malko-Nyhan, 2006; Usher, Nolan, Reser, Owens & Tollefson, 1999). For documentation training to be improved by this route, all preceptors and mentors need to review of how and why they document and how they need to lead and support preceptees in their documentation.

Documentation needs to be incorporated into nursing training; it could also be built into nursing orientation programme when commencing employment within an institution. Additionally it should also be integrated into all advanced practical courses as well as within the fundamental annual competency updates such as basic life support and fire training. I do not think documentation education should be limited to the dry rationale or requirements, I believe it should integrate the advantages and disadvantages of different ways of documenting and practical sessions addressing recognised and perceived difficulties with the various types of documentation used within the workplace. Included in the session should be a forum for discussion about nursing priorities and the place of documentation in these priorities.

Environmental issues

Three influences described by the participants and in the literature which affect documentation and could legitimately be claimed to have an impact in the emergency setting are noise; interruptions occurring in such an environment and space in which to write. For the first and third influences, there is little that can be done to facilitate documentation by noise reduction that does not require building renovations. A quiet place convenient to the patients but with privacy, quiet and workspace would be required to mitigate this issue. As it is, with the aging population, there is a steady increase in patient presentations to the ED and until all the patient flow initiatives are in place and effective, there will continue to be crowding and consequently noise in the workplace. Interruptions could be reduced to a certain extent by nurses clearly documenting their name on the patient's chart, to enable other team members identifying the nurse they need, rather than continuously interrupting other nurses to enquire if they are caring for the patient they

are enquiring about. Space in the documents has been discussed with the issues of visibility, power and value, as already noted the development of the documents could facilitate more than just documentation, but also the elevate respect and value nurses hold for their work.

A major barrier recognised and commented upon by the participants, and in accordance with the literature, was the lack of time to document and overall workload (Bryant, 2005; Howse & Bailey, 1992; Oxen, 2005; Oxtoby, 2004; Renfroe et al., 1990; Savy, 1997; Tapp, 1990; Törnkvist et al., 1997). However this issue, although significant, has not been discussed in this chapter simply because the participants' did not proffer any recommendations.

Quality assessment and standards

The requirements for minimum documentation are set along with all other practice standards by the District Health Board (DHB) in collaboration with national requirements (QHNZ, 2001). These have been developed for hospital accreditation and the DHB is measured by the effectiveness and enforcement of many of these standards. Standards of practice need to be reflected in the documentation of the patient's care, from the initial assessment and triage category assigned, to any and all changes that reflect the patient's condition. As already mentioned, the participants of this study spoke of how they sometimes document only the minimum necessary for patients. This raises two questions: 1) what is the bare minimum? 2) Does the documentation in ED truly reflect the activities occurring? The first question has been answered by the standards set by the Canterbury DHB (2007), by the national accreditation board (QHNZ, 2001) and by some of the nursing councils or unions (NBT, 2003; NMC, 2005). The second question is larger than it initially seems. For this study I have reviewed only one aspect of this through looking at triage scores.

Auditing, waiting times and the consequence of triage scores

Two regular forms of auditing in ED involve the impact the patients' triage score. In the ED in which this study is set, the patients' waiting times are monitored as an indicator of quality of the care provided and of how busy the department is: these include time of arrival to time of treatment and to time of departure. However, there have been a number of studies and articles that question whether the triage score reflects the department's acuity to the patients' level of stability (Beveridge, Ducharme, Janes, Beaulieu & Walter, 1999; Fernandes, Wuerz, Clark & Djurdjev, 1999; Hollis & Sprivulis, 1996; Richardson, 1998). Yet this ED, like other's, continues to use triage scores as a basis for performance assessment. The second form of assessment of care provision is that of documentation through annual audits of random selections of patient notes. The documentation is audited with reference to the patient's triage score, because the higher

ratings on the triage scale merit a higher frequency of monitoring of vital signs with an associated higher frequency of recording of progress in the notes. These audits found that although the triage score is changeable as the patient improves and deteriorates, this altered score is not documented on the chart and also once the patient has been seen their score is never altered yet the patient's condition frequently alters (Williams, personal communication, 12th February, 2007). For example, a patient with a relatively minor condition, but who requires urgent pain-relief, is often set as a higher triage score than the injury itself warrants, facilitating the process of initiation of nurse- or doctor-led pain-relief; although the patient does not necessarily require the measurement and recording of their vital signs consistent with the requirement set by the triage scale. I believe the triage score given needs to reflect the patients' ongoing needs, not just their initial needs and any change to the score needs to be reflected on the written chart.

During the interviews there was no argument regarding the chances of being set-up to fail by the triage process, although several participants mentioned the appropriateness of some standards, and I understand through my shared background and conversations extra to the interviews, that they were referring to issues such as the frequency of vital signs recording according to the triage scale. During many shifts, it is not feasible to continue with observations that are consistent with the initial triage scale, yet the quality of nurse's work is being measured according to the standards as set such as the triage scale. As patients progress along their treatment path in the emergency the urgency of their assessment or reassessment and treatment needs vary. Part of the document development needs perhaps to address altering triage codes, to make them more visible as a written score for when auditing of practice occurs. At present after the patient has been medically assessed it is very unusual to up or down-grade triage scores although the standards of practice are measured against this score, not according to the patients' later condition in the department. If patient records are to continue to be audited based on their triage score, then the process of re-scoring on the triage scale needs to be instigated and maintained as a standard and documented so that the ongoing measurement of the vital signs and associated documentation is appropriate; this would then reflect and explain changes in the frequency of monitoring of patient's vital signs.

Addressing the documentation of triage score alterations would lead to increased accuracy in the annual audits; it could also lead to nurses increased use of the triage score to reflect their patients changing condition and to raise the awareness of patients' triage scores and the responsibilities they confer onto nurses, especially among nurses with less ED nursing experience.

Routes to change

The participants demonstrated openness and creativity when they provided recommendations for ways to develop documentation. Their key recommendations to enable successful change were collaboration and

communication, or partnership and participation, for ownership of the changes and improved engagement in the process, with protection and support to enable those who are nervous of expressing alternate opinions to contribute. Routes to change included staff forums, committees made up of representatives of all who would be using or handling the records and suggestion boards, books or boxes. Processes to change included that of document development including physical space, access and use of documentation frameworks discussed earlier in the chapter. Additionally the participants recommended knowledge advancement could occur through education and practical support as discussed in preceptorship and environmental issues above.

The third area reviewed the key impacts of the known influences in context of ED. The discovery of these enabled their consolidation into a list. These influences upon practice were incorporated into the design features of the study. The relevance of this information was sought by presenting this list of key factors to the participants and this information led to development of an assessment tool in the form of a likert scale which enabled a more focussed investigation into the practices in their setting. This was not a primary focus of this study, however, this assessment tool could be developed tested and used in practice and further research.

Communication, care-coordination, data gathering and leadership

Several participants expressed the desire to have their notes read and valued by their colleagues. One reason, revealed by the study, that nurses document more now compared to the past, was that nurses previously had no expectation of their notes being referred to by other health professionals. This argument was revealed by a comment of a participant when she was discussed how documentation has changed over the years; she spoke in the past tense of the fact that nurses had a low expectation of their notes being referred to by others (Participant 4, p.1). The implication was that nurses now expect their professional colleagues to refer to their notes. This idea could equally apply to the allied health professionals as well as the doctors. However, it was noticeable that no other participants directly or indirectly referred to this positive change towards referral of notes by co-workers; in fact the opposite belief was expressed.

The participants all recognised that communication for data gathering was the principal rationale for reading notes although the majority of the participants neglected to state it as a reason for writing notes. They listed the reasons for referring to their colleagues' notes as a) a route to learn more about a patient's condition and outcomes through reflection of previous notes, and b) for the assumption of patient care either when a shift change occurred or for temporary relief such as meal breaks or when assisting a

colleague with a task. The participants who directly referred to communication as a critical cause for documentation asserted this concept clearly, with comments along the lines of their dependence on colleagues written notes to enable care coordination and continuity, as well as to enable collaboration. It was noticeable that these staff members were all from the senior nursing team. This concept of documentation facilitating communication is visible in the literature, with authors such as Currell and Wainwright (1996) and Perroud et al. (2000) who argue that action of transmitting all relevant information from one member of the multidisciplinary team to the another forms a significant activity.

Care coordination in ED involves that of specific patients, individual areas within the department or of the department as a whole. It includes the process patient flow, and leadership requires knowledge of complex or challenging (and potentially challenging) patients or companions within the department for risk minimisation and incident management. No participants directly spoke of the process or concept of patient flow although this is an issue high on the current agenda for patient care development for many ED's (Ardagh, 2006; DoH, 2001, 2006; MoH, 1999, 2007). However, they indirectly referred to the issue when they spoke about the need for information to facilitate the coordination patients, staff and activities.

Nurse identification and specimen signatures

Several participants expressed a concern relating to the incompleteness of documentation. One section of the ED chart commented upon as incomplete, which would facilitate communication, was the section for the identification of the nurse(s) caring for the patient. I am aware that in this box the patient's principal nurse(s) should identify themselves and provide a specimen signature and the time of taking up the care. In addition, other nurses may provide a brief intervention for the primary nurse and may document what they have done, but their signature is often illegible and the primary nurse is unable to identify who provided that care if an issue arises out of it. However, the participants complained that this box is frequently left blank. The participants recommended that there should be a drive to get nurses to complete this. Again from my own experience as a coordinator, this causes constant interruptions because doctors (a proportion of whom are not familiar with all the ED nurses) repeatedly enquire which nurses are looking after their patients.

Not knowing who is caring for who has inconvenience issues for the nurses and doctors; it consumes the coordinator's time and can damage the communication between the teams. By addressing this single section of the ED chart, communication between members of the multidisciplinary team could be improved.

Findings in relation to methodology

This study used qualitative description as the primary research method. In the following section of the chapter the methods and design are discussed, in relation to the overall findings, and a summary of research limitations is presented.

Method, methodology and design

The study adopted fundamental qualitative descriptive research as method with aspects of a narrative framework being used as an adjunctive method in the analysis of the descriptive data, in that the study intended to gather information about perspectives and experiences of the participants while probing for information about the everyday knowledge and context of emergency nurses practices in and beliefs in relation to documentation. I contend that the study method and research processes that were adopted provided a sound basis for the study; and that the major components of the design are congruent with the statement of research findings and subsequent discussion. The basis of this confidence is presented in the following paragraphs.

Qualitative description drawn mainly from Sandelowski's (2000b) work was used as an overall method and design for the study as low-level interpretation of nurses' experiences was sought. Sandelowski contended that the main qualitative research approaches (e.g. phenomenology, grounded theory, ethnography and narrative) use qualitative description as basic premises, but that these approaches drive the analyses of phenomena under investigation to deeper interpretive interrogation. She argued that there are good reasons for qualitative description to be used as an approach in its own right and she stated "qualitative descriptive study is the method of choice when a straight description of phenomena is desired" (p.334). Consequently, a qualitative descriptive study approach was chosen as the primary method approach of the study within the naturalistic paradigm, because a straightforward description of the revealed phenomenon with low-inference was sought.

Sandelowski suggested that these qualitative research approaches designs are "typically eclectic, but [a] reasonable, well considered combination of sampling, data collection, analysis and re-presentational techniques" (2000b, p.337). The research design involved the use of individual interactive moderately structured interviews which supported individual expression and exploration of experience and practices, and invited consideration and comment in relation to established literature and theory while it provided privacy and security to speak. The participants' voices revealed the presence of some elements of emancipatory epistemology while maintaining the descriptive research methodology of the naturalistic paradigm, this was consistent with the argument put forward by Sandelowski that "... qualitative

descriptive studies tend to draw from the general tenets of naturalistic inquiry” (p.337). This methodology was congruent with the naturalistic paradigm because it encompassed the multiple, subjective realities of the various participants and while being committed to studying the issue in its natural state, or as close as this is possible (Sandelowski).

Sandelowski (200b) wrote that “qualitative content analysis is the least interpretive of the qualitative analysis approaches in that there is no mandate to re-present the data in any other terms but their own” (2000b, p.338). The design allowed the data reporting to follow a structure based upon a narrative analysis framework (Labov & Waltezky, 1967) that notes particular socio-linguistic features and order in oral narratives. The framework directed the study process through the six elements of the framework from the key points, to the orientation and location of the study, on to the main body of the participants’ comments, the evaluation of the participants’ responses, recommendations arising through the analysis of the resulting gathered data and a return to the current moment. The analysis followed three processes, including content analysis followed by thematic analysis with the rudiments of the narrative analysis, already described, to arrange the contents into themes with their component contexts to synthesise new knowledge.

This study planned to explore and reveal the perspectives and practices in relation to documentation, of Emergency Nurses working in a tertiary ED in NZ, through the eyes and voices of the participants and this has been achieved. I believe that the research design and the combination of analysis frameworks worked effectively.

Rigour

The veracity of the findings and the process were revealed in the careful organisation for the gathering and analysis and reporting of the data which followed a systematic manner. Dependability was sought through the provision of a clear audit trail to enable readers to be able to follow decision making processes. Confirmability was sought by planning for participants to be able to verify that the findings are an accurate portrayal. The report has been written so that the participants can safely recognise their information in the research findings. The participants’ opinions illustrated arguments for and against various aspects of current documentation practice, which has enabled their views to be integrated into the recommendations for alternative working practices. Credibility was revealed through the description of the size and scope and single location/source of study participants’ of the study (refer to the orientation description in the findings and analysis chapter) and the discussion of the limitations of the study.

Transferability of knowledge gained was planned through the design as many departments share similarities in many aspects. It was useful to recruit from one organisation, with sufficient numbers to deliver diversity of opinions and experience, and to carry some weight of opinion and knowledge of current practices and the context of documentation. By recruiting nursing staff from one ED, resulted in clear pertinence of the suggestions for the department, because the participants possessed detailed, experienced, contextual knowledge of the positive and negative issues effecting documentation in this study location and this understanding has been applied to inform their recommendations to make them relevant to the needs of the department. Their recommendations have the strength to apply to change for individual areas of practice and potentially to the ED as a whole on completion of the research report. The findings of this study provide perspectives of ED nurses from one tertiary ED, while identifying aspects that need from further investigation, exploration or application. Readers should be able to transfer findings into meaningful context for them outside the study setting.

The data has been presented qualitatively, using the participants' voices to demonstrate their perspectives and recommendations in qualitative and summative descriptive forms. Substantive reasonableness and relevance was balanced against the strength of data generated across the participants. The study provided the participants a safe platform to promote their ideas regarding practice and document development, thereby providing them with a voice in the potential progress plans for the department.

Limitations of this study

A number of limitations are present throughout this study; these include limitations of the literature review and the report of it, as discussed in Chapter Two, and the management of other aspects of the research discussed in Chapter Three. The limitations revealed here are restricted to the issues of the science of the research, the method, the data sources, the terms of interpretation and the limits to extraction of data clusters.

The method was constructed within descriptive enquiry science assumptions utilising the framework described by Sandelowski (2000b). The data sources were 10 nurses from a range of levels of employment and educational backgrounds from one ED. The participants took part in semi-structured individual interactive interviews lasting between 45-90 minutes and they discussed and completed a ratings scale of the impact of influences upon their practice. A demographic survey was the final tool to enable an accurate description of the participants and the correlation between the participants' backgrounds and their responses. The data was analysed using a content and thematic analysis process and it was reported upon using a narrative framework by Labov and Waltezky (1967) while sitting within the overall framework described by Sandelowski (2000b). Interpretation followed Sandelowski's recommendations

for minimally transformed data with a “straight descriptive summary of the informational contents of data organised in a way that best fits the data” (2000b, pp.338-9) and reported upon using the Labov and Waltezky’s framework to reveal textural outcomes.

The data has not been overly interpreted and there are resonances in the findings of this study with other nursing settings. By only having 10 participants from one ED, it is for reader to assess the applicability of the findings to their own department; the reader needs to consider how true the recommendations resulting from this study apply to own fields of practice and work settings. There remains the choice for the reader to apply relevant elements of the findings of this study to their own workplace, or to develop a tool based on the one developed for this study for the assessment of the impact of the influences on documentation in their own departments. Due to the small sample size, this research was unable to achieve full data saturation; however, sufficient numbers participated to warrant consideration of some of the trends in the data.

Analysis was concerned with summarising the informational contents and themes of the data. Attention to a variety of opinions and perspectives as well as shared values and beliefs across the group. Attention was given to the participants’ values and the emancipatory positioning of individuals expression in data, as well as the contextual, embedded and collective understanding of the group that they represent.

Reflections on the study and findings

This study planned to explore and reveal the perspectives and practices of emergency nurses working in a tertiary ED in NZ in relation to documentation, through the eyes and voices of the participants. This was important because of the critical imperatives of effective documentation and because so little is known about documentation practices of emergency nurses and about their perspectives in relation to this.

Overall this research study aimed to describe emergency nurses’ perspectives in relation to their practices in nursing documentation. In relation to this overall aim four research objectives were identified. The first objective included the textual information from emergency nurses about their documentation practices and the perspectives the nurses’ held regarding nursing documentation in relation to their personal beliefs, past experiences and preferred systems of documentation. The second objective endeavoured to gather textual information and personal perspectives from emergency nurses in relation to the practical and contextual factors that influence documentation practices within an ED such as the effect of departmental and organisational culture, environment and resources. The third objective included an exploration of the participants’ knowledge and/or use of documentation tools or systems in practice,

and the fourth objective sought to discover any interest by staff members in the ED who might wish to work together to participate in practice development and to uncover the potential routes and processes to change practice development.

This study revealed that participants in this cohort were keen to consider a review of the documentation processes, and held wide ranging views that were yet compatible with how change could be accomplished. It was noted that the majority of the participants had never been asked to articulate their personal perspectives on this subject, yet each described valid and useful information and recommendations for practice. They expressed what they thought needed development and they revealed an energy and enthusiasm for the idea of advancing practice in the ED and they exposed the topics of most importance to those in the context of their ED. It was good to use a consultative process that can lead to strategies that are practical and congruent with the setting. Ideas of how to change the format (and if it should at all) were diverse and likely to cause extensive and interesting discussions.

The participants revealed that their histories and experiences shaped their practices and their beliefs about documentation, these influenced their views on the importance of nursing documentation and what strategies they use, how they use them and why. In some participants these histories also revealed why they strongly identified with the need to develop both practice and the documents themselves. The history, reasons and benefits to document were exposed as was the important issue of the value of the contribution of nursing to patient care and visibility of nursing as a profession. It became increasingly apparent that change will need to address all the aims and needs of documentation. As this study has revealed, in line with the work already published, it is a complex issue with extensive ramifications for the patients and their families, the health care providers and educators, the health care organisations and financial providers, the legal profession and the quality assessors and authorities.

Implications arising from the study

The published literature and many of the participants' responses held congruence which leads to a confidence in highlighting these findings and recommendations. The expressed views were sometimes consistent and on other occasions different and this is valuable to policy makers and document and practice development teams. These views were given with pertinent arguments which require addressing before new strategies for either document or practice developments are introduced.

In the previous sections of this chapter I have discussed the significance and the reasonableness of the findings, the following section reviews and summarises some of the recommendations for further studies, and the recommendations for practice changes.

Recommendations in further studies

Use of a framework or theory

Several questions occurred to me as a consequence of the interview discussions regarding documentation and nursing frameworks. If it was decided to follow a set framework to facilitate documentation, which one would be chosen? Each has its benefits and drawbacks. Does the record need to follow a nursing theory? Two theories described by participants were the Activities of Daily Living (Roper, Logan and Tierney, 1990) or Patient Self-Care Deficits (Orem, 1991). Other options include the documentation frameworks discussed in the literature review such as those shown in Table 2.2 including SOAP (Weed 1969), care pathways, Focus (Lampe, 1984) and PIE/APIE (Siegrist, Dettor & Stocks, 1985; Buckley-Womack & Gidney, 1987). Alternatively there are the health assessment systems such as the acronym based practical assessment frameworks, shown in Table 2.3 including the resuscitation algorithm ABC DEF. There are no shortage of theories, each with advantages and disadvantages, however these questions were not answered in this study and would merit further investigation.

Impact of helping and hindering influences

A second area of interest for further study would be a more extensive investigation of the impacts of the positive and negative issues influencing documentation. The tool that was developed for this study, based upon a Likert Scale (Appendix I), could be further developed, including more or all of the known influences and the opportunity for free text comments by the respondents, to gather a wider range of quantitative and qualitative information of the nurses' perspectives in an alternative and/or larger group and/or setting.

Participant population information

For increased understanding of the personal backgrounds of the participants, when collecting demographic data, I recommend listing the varying types of post qualification education. This would be to encourage those nurses who had participated in post qualification practical courses as well as those who had participated in post graduate study to document their level of study.

Study size

Given another opportunity to undertake a larger piece of research, I would like to interview a larger number of participants to obtain richer data. In the current study several of the ideas and options (other

than electronic documentation) held resonance with findings of other research studies that have been previously published were raised by the participants; however, several ideas were raised by a few participants and these need further investigation. Potentially new ideas could yet be found and confirming or contrasting views would strengthen the findings of the study. An example of this would be visibility of practice and acknowledgement of the value of nursing are areas to be explored further.

Electronic documentation

There was no plan in this study to specifically investigate in-depth electronic documentation. I was surprised however that the participants did not discuss this option in their current or future practice development. As a peer I had anticipated a greater reference to this form of documentation. As a consequence, much of the literature focussing on electronic documentation tools has been omitted from the account of this study for the sake of brevity and relevance. This is an aspect of documentation that is increasing its role, and needs to be reviewed and considered by any practice setting that is considering documentation practice development.

Recommendations for practice

The routes recommended to change include the ways to involve the documentation users in the development of documentation and the process to develop documentations as a practice as recommended by the participants. Several recommendations have been discussed in detail earlier in the chapter.

The recommendations included addressing the issue of space in the paperwork and access to it and the use of documentation frameworks. Other recommendations included the encouragement of identification of contributing nurses, document development, positive reinforcement and quality assessment development are further issues with recommendations.

By increasing the quantity of the space and enabling access there was a general consensus that documentation would improve as a consequence. This space and access could be obtained through the redevelopment of the chart or it could occur through dividing the nursing from the medical documentation.

The participants also discussed the merits of using a set framework or theory to base documentation and indeed nursing practice upon in ED. These frameworks can act as memory prompts on which to structure health assessments and practice which would lead to the documentation of a more comprehensive health assessment and nursing practice, consequently improving the accountability of practice.

The ED chart has a section for self identification on it, of which several participants recommended there was encouragement of all nurses to complete this. The advantage to this would be the potential for an improvement in communication between team members while again recognising the accountability of each nurse and his or her actions.

A review to clarify the department's documentation requirements was also suggested. The principle driving this recommendation was to help guide nurses and reinforce their adoption of the standards. Likewise, the provision of positive reinforcement of optimal documentation, with ongoing support as part of the education and preceptorship processes, was strongly recommended.

For quality assessment, documentation development could also involve alterations to documentation of the triage score so that it reflects the patients' ongoing condition making retrospective audits more accurate and to create a more accurate reporting of practice documented according to the patients' triage score, when compared to any other ED using the same triage scale.

Conclusion

This study offered qualitative description of the emergency nurses' perspectives of ED nursing documentation and it revealed five themes including a) the need for practice to be visible, b) the influences of colleagues and organisational culture, c) priorities of practice, d) organisational standards and e) justification of actions. These themes underlie the need and nature of ED nursing documentation, and each theme requires addressing or practical support to facilitate comprehensive accurate and timely documentation.

The findings powerfully revealed the struggles of nurses and the context factors that influence the processes and practicalities of nursing documentation in ED. These perspectives led to constructive recommendations, as well as clarity of understanding that merit further investigation as well as support.

By integrating the recommendations of the participants in practice and document development programmes with safe and appropriate acknowledgement of the source of the recommendations the nurses would gain a sense of collaboration and achievement which would facilitate the process of change. Recognition of nursing contributions is also likely to occur as a consequence of improved documentation. The recognition of contribution from either cause can increase nurses' sense of self-value which in turn encourages continued participation and comprehensive documentation, thus creating a self-fulfilling

continuum benefiting the patient, the nurses, the multi-disciplinary team, the organisation and the profession.

The participants were generous with their time, support and confidence, without them this study would hold little value or validity. The study attained its aims through their input and can contribute to the future development of ED nursing documentation as a consequence.

Appendix A: Ethics Letter of Study Approval

Letter of approval from the Health Research Council Ethics Committee



Upper South B Regional Ethics Committee

Ministry of Health
4th Floor, 250 Oxford Terrace
PO Box 3877
Christchurch
Phone (03) 372 3018
Fax (03) 372 1015

12 March 2007

Paula Grainger
61 Evesham Crescent
Spreydon
Christchurch

Dear Ms Grainger

Nursing documentation in the Emergency Department setting: The factors and influences perceived by the nursing staff effecting nursing documentation
Investigator: Paula Grainger
Locality: Christchurch Hospital
Ethics Ref: URB/07/02/006

The above study has been given ethical approval by the **Upper South B Regional Ethics Committee**.

Approved Documents

Information sheet dated 24 February 2007
Consent form (as attached)

Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Final Report

The study is approved until 31 October 2007. A final report is required at the end of the study and a form to assist with this is available from the Administrator. If the study will not be completed as advised, please forward a progress report and an application for extension of ethical approval one month before the above date. Report forms are available from the administrator.

Amendments

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study

Yours sincerely

Di Rutledge
Upper South B Regional Ethics Committee Administrator

What do you think of the nursing documentation in the Emergency Department?

Paula Grainger (*who you may know as Polly*) is conducting interviews as part of a thesis towards a degree for Masters of Nursing (Clinical). If you are a Registered Nurse who currently works in ED or who has worked there in the last 2 years – I am interested in your views including:

- ⇒ Do you use any tools for documentation?
- ⇒ Do you base your writing on a nursing model?
- ⇒ What helps and hinders you in your documentation?
- ⇒ How would you like to see ED documentation develop?
- ⇒ Or, would you prefer it to stay as it is?
- ⇒ If we were to change it, would you like to take part in development of the processes?

Appendix C: Participant Information Sheet

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui



Nursing documentation in the Emergency Department setting: The factors and influences perceived by the nursing staff effecting nursing documentation

PARTICIPANT INFORMATION SHEET for participants of an interview

Thank you for your interest in this project. Please read this information sheet before deciding whether or not to participate in this study. If you decide not to participate, I thank you for considering participation. There is no penalty for not participating or for withdrawing from participation at any stage.

Your participation is entirely voluntary

Researcher: Paula (Polly) Grainger: Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington (also senior staff nurse - Emergency Department of Christchurch Hospital)

I am a student in the Masters programme at Victoria University of Wellington to attain a degree in Masters of Nursing (Clinical). As part of this degree I am undertaking a research project leading to a thesis which will aim to:

- a) share and discuss the practices and beliefs regarding nursing documentation and the effect of the departmental culture, environment and practices
- b) explore nurses' interest in documentation tools or systems in practice
- c) to discover interest by any staff members in the Emergency Department who might wish to work together to participate in practice development in the department and examine what could the process of change involve in further developing documentation

This study is timely in that documentation is a contemporary issue that affects all nursing and multi-disciplinary care provision and communication. The findings will be used to help practice development regarding documentation processes in the Emergency Department. Information collected will be added to the body of knowledge already published internationally.

Nursing documentation in the Emergency Department setting: The factors and influences perceived by the nursing staff effecting nursing documentation

INFORMATION SHEET

The researcher Paula Grainger (*who you may know as Polly*) is seeking Registered Nurses who are currently working in the Emergency Department or have worked in the department within the last 2 years to volunteer for an interview lasting up to 90 minutes that involves an open-question semi-structured conversation which can develop according to the responses given. The interview is designed to enabling you to reflect on your practices and views on nursing documentation and to express these current practices, views and beliefs and the potential for the future for processes of nursing documentation.

In order for the researcher to concentrate on what you are saying the interview will be audio-taped. The audio-tape will be transcribed by an independent secretary to prevent voice recognition of the interviewee to maintain confidentiality. Transcribing the interview means that it will be typed onto paper to enable responses to be grouped into similar themes and to highlight differences.

The only personnel who may have access to this data includes the researcher, research supervisor and transcriber. Interview data will be locked in a secure environment during the study and for a further 10 years at completion of the study, as required by the university's research policy and the ethics committee. After this time it will be destroyed.

Results of this research may be published. There will be every attempt to protect your identity and minimise identifiably in the process of analysis and reporting of the research. You are most welcome to request a summary report of the findings should you wish.

If you would like to participate, or have any questions about this interview, please contact the researcher to register your interest by:

Telephone: 03 981 6252 or e-mail: pollygrainger@cdhb.govt.nz

Thank you for your help with this research

This research has been reviewed and approved by the Upper South Ethics Committee and noted by the Victoria University of Wellington Ethics Committee

Appendix D: Participant Consent Form

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui



Consent Form

Nursing documentation in the Emergency Department setting: The factors and influences perceived by the nursing staff effecting nursing documentation

I have read and I understand the information sheet dated 24/02/07 for registered nurses taking part in the study designed to assess the practices and beliefs held regarding documentation in the emergency department.

I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

- I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future employment.
- I understand that any information I provide will be kept confidential to the researcher, the research supervisor and the person who transcribes the tape recordings of our interview. The published results will not use my name, and that no opinions will be attributed to me in any way that will identify me in any reports on this study.

I have had time to consider whether to take part.

I know who to contact if I have any questions about the study.

I _____ (full name) hereby consent to take part in this study

Signature: _____ Date: _____

I wish to have a report of the findings of this study: yes no

Project explained by: Paula Grainger Signature: _____ Date: _____

Full names of Researchers: Paula (*Polly*) Grainger

Contact Phone Number for researchers: 03 3640 270

Appendix E: Aide-memoire

Individual perspective, of nursing staff: descriptive & exploring seeking to probe 4-5 key areas as cluster related concepts

Start with thanks

Colleagues practices

Current practices in this ED: Seek team's influence despite lit, audits etc answers

What do the nurses do in general? – Culture / environment / practices

What are their perceptions of these practices? – Insights into practices, basis of opinions

What concerns or comments have they about documentation?

What reasons would make you refer to other nurses notes or they to yours?

How often would referral to other nurses' notes occur in an average shift?

Participants own practices & history

What are the participants own practices within this team? – Strategies & processes – current

What led to theses practices? – Issues, philosophy, strategy, beliefs for ED documentation, key influences

Have they had any experiences where their documentation has been used in some way either in a positive or negative way?

Participants reading & reflection

Participants reading & reflection & thinking about documentation: Component interest re context, literature

What extent have they read in this area in a) general b) nursing or c) ED?

Have they seen any systems which have / will influence them?

Show a selection of systems – choose 3 then: Individual perspective, of nursing staff: descriptive & exploring seeking to probe 4-5 key areas as cluster

What beliefs held for these systems?

Literature published

Literature published provides a list of enabling and hindering factors compiled through audits, research & commentary literature

Provide a diagram or table of some of these factors – Influences score:

What views do they hold on these factors? (Work a modified attitude scale – to obtain a brief overview – three factors and 5 questions on each? – Appendix G)

What are their insights of these factors?

What (if any) inspirations do these this give?

Do you think nurses should receive training in documentation as Norwegian nurses do?

Future Development:

What changes would you wish to see introduced to help in documenting?

To what extent do the participants believe staff in ED or they themselves would be interested to work with these to lead to development?

How would you instigate change in the documentation process in this department?

Summary in future practices:

What should we do next if anything?

How aggressive should we be?

Follow up:

Is there anything else they want to discuss?

Are they comfortable for this data to be transcribed and used – if not specify what not to be taken further – particular sensitive, more care taken

Is there any-one who you think would wish to participate in this study, and would be happy for me to approach them? (If purposive sampling required due to lack of respondents)

Conclude – with thanks

Details – when given

Appendix F: Demographic Data Survey

All questions are voluntary

Demographic data:	
1	What type of training did you have and what qualifications do you hold? _____ _____
2	What age group most nearly applies to you? 25 – 45: <input type="checkbox"/> >46: <input type="checkbox"/> Decline: <input type="checkbox"/>
3	Which gender are you? Male: <input type="checkbox"/> Female: <input type="checkbox"/> Decline: <input type="checkbox"/>
4	Term of employment: Full time: <input type="checkbox"/> Part time >0.5: <input type="checkbox"/> Part time <0.5: <input type="checkbox"/> Casual – varying: <input type="checkbox"/>
5	How many years of nursing experience have you? Overall: _____ Emergency: _____
6	What level nurse are you currently employed as? 1 2 3 4 5 Other: _____ Decline: <input type="checkbox"/>

Filter questions:	
1	Do you feel that you spend a lot of your time documenting? Yes: <input type="checkbox"/> No: <input type="checkbox"/>
2	What priority do you assign your documentation in relation to your workload? High: <input type="checkbox"/> Medium: <input type="checkbox"/> Low: <input type="checkbox"/>
3	Do you feel you document as well as you would wish? Yes: <input type="checkbox"/> No: <input type="checkbox"/>

Appendix G: Positive and Negative Influences Found in Literature

INHIBITING INFLUENCES:	FACILITATING INFLUENCES:
<p>Lack of time</p> <p>High patient acuity</p> <p>Work prioritisation</p> <p>Difficulties in writing</p> <p>Lack of space to think and to write within the workplace</p> <p>Lack of space to write on the set forms</p> <p>Multiplicity and redundancy of forms</p> <p>Inappropriate forms</p> <p>Inaccessibility of records</p> <p>Lack of consistent record systems and routines</p> <p>Lack of continuity</p> <p>Indistinct terminology</p> <p>Negative connotation of the forms (e.g. Incident reports)</p> <p>Lack of knowledge of the nursing process</p> <p>Negative attitude towards change</p> <p>Inability to see the benefits of nursing documentation</p> <p>Lack of support from supervisors and colleagues (peer pressure)</p> <p>Limited institutional barriers</p> <p>Fear of qualitative evaluations of behaviour based on written performance</p> <p>Organisational obstacles</p> <p>Workplace change processes</p>	<p>Flow-charts</p> <p>Time</p> <p>Access for contemporaneous documentation</p> <p>Positive reinforcements</p> <p>Patient activities and changes</p> <p>Theoretical frameworks enable rapid and accurate patient assessment</p> <p>Theoretical frameworks encourage and improve analytical skills</p> <p>Theoretical frameworks standardise terminology</p>

Appendix H: Influences Survey

INFLUENCES	IMPACT SCORE				
	1:low / 5:high				
Time constraints	1	2	3	4	5
High patient acuity	1	2	3	4	5
Multiplicity of forms (repetition of documentation)	1	2	3	4	5
Inaccessibility of records (absent with patient in CT etc, doctor writing in them, computer screen locked)	1	2	3	4	5
Negative connotation of the forms (e.g. Incident reports, authoritarian terminology)	1	2	3	4	5
Peer pressure (writing too much, not enough, why bother, patient care first, lack of support etc)	1	2	3	4	5
Concern of evaluations of behaviour based solely on written performance	1	2	3	4	5
Background noise / interruptions	1	2	3	4	5
Insufficient space to write – on the set forms	1	2	3	4	5
Other: Please describe:	1	2	3	4	5

Appendix I: Theoretical documentation frameworks and nursing frameworks

THEORETICAL FRAMEWORKS FOR DOCUMENTATION	
Oral tradition	Verbal handovers
Narrative	Unstructured information
SOAP, SOPIER and SOAPERO	S: Subjective data <i>or Symptoms</i> , O: Objective data <i>or Observations</i> , A: Assessments made, P: Plans formulated SOAP+ I: Implementation of care, E: Evaluation, R: Revision SOAP+ E: Education given, R: Referrals made, O: Outcomes evaluated
Critical pathways / care paths	
Focus charting ®	D: Data – subjective or objective supporting information, A: Action – interventions implemented R: Response – the patient's response to the interventions
Charting by exception [CBE]	
PIE and APIE	P: Problems, I: Interventions and E: Evaluation. Revised with: A: Assessment + PIE
VIPS Model	Swedish words for: V: Well-being, I: Integrity, P: Prevention and S: Security
FACT tool	F: Flow-sheets, A: Assessment, C: Concise narrative notes, T: Timely entries
Invocation technique	What? Why? Where? When? Who? How?

PRACTICAL ACRONYM FRAMEWORKS	
ABC DEF etc (Resuscitation / Trauma)	A: Airway, B: Breathing, C: Circulation, D: Disability, E: Exposure & Environment, F: Fahrenheit, G: Get & use Gadgets, H: Head to toe, I: Inspect posterior & wounds, J: Jot down data, K: Kith & Kin
AMPLE (Trauma)	A: Allergies, M: Medications, P: Past health history, L: Last ate, E: Events
AEIOUTIPS (Collapse assessment)	

PQRST (Pain assessment)	Provokes & Palliative. Quality & Quantity. Region & Radiation. Signs & Symptoms. Treatment & Time
CWILTED (Manchester Triage)	C: Condition W: Witness I: Incident L: Location T: Time E: Escort D: Description of patient
OLDCART (Health Assessment)	O: Observations L: D: C: Complaint A: Allergies R: Region, Radiation T: Time & Treatment
SAVE A CHILD (Child assessment)	S: Skin colour, A: Activity & response, V: Ventilation effort, E: Eye contact, A: Abuse, C: Cry, H: Heat, I: Immunisations, L: Level of consciousness, D: Dehydration
CIAMPEDS (Paediatric health assessment)	C: chief condition/complaint, I: injuries/illnesses/immunisations, A: allergies, M: medicines, P: past health history E: events preceding the problem, D: diet & elimination, S: symptoms associated with the problem
DOPE (Airway troubleshooting)	D: Displaced tube. O: Obstructed tube. P: Pneumothorax. E: Equipment

NURSING COUNCIL STANDARDS

FACTUAL standards	F: Focused on the client, A: Accurate, C: Complete, T: Timely, U: Understandable, A: Always objective, L: Legible
The ten C's alliteration standards	Concise, Clear, Complete, Contemporary, Consecutive, Correct, Comprehensive, Collaborative, Client Centred and Confidential

NURSING THEORETICAL FRAMEWORKS

Yura and Walsh	Nursing Process - Four stages of care
Roper, Logan and Tierney	Activities of Daily Living
Neuman	Health Care Systems (stress reduction)
Roy	Adaptation theory (integration process)
Orem	Self-care model

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