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Implementation of a Structured Nursing Documentation in a Special Care Unit

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Abstract. The purpose of this article is to describe the piloting of nursing documentation in accordance with the national model in the Oulu Univesity Hospital. The nursing documentation in Finland is based on the nursing process model and Nursing Minimum Data Set (NMDS). NMDS includes information on nursing diagnoses/needs; interventions, outcomes, patient care intensity and discharge summary. Nursing staff received education for documenting content which is consistent with the nursing process in the The Finnish Care Classification (FinCC). The new documentation model required time for all professional groups in the beginning. New documentation models is challenging, adequate time needs to be reserved for the staff in order to establish new documentation procedures. Successful implementation of the pilot necessitated the commitment of the nursing officers.

Keywords: Nursing documentation, Nursing minium dataset, Patient record

1. Introduction

Unification and standardization of electronic nursing document is a national challenge in Finland[1]. The electronic nursing document needs to be linked with the nationally recommended multiprofessional patient history core documentation and the national code server and archive.[2,3] In 2002, the Ministry of Social Affairs and Health decided that Finland should have a nationally interoperable patient record by the year 2007. This was driven by the fact that the nearly all public and private healthcare providers already utilize patient information systems of their own. In order to promote the development of this national initiative, Ministry of Social Affairs and Health has made funding available to IT-projects in the healthcare sector.[4] The nursing documentation is part of a patient record and the nationally defined Nursing Minimum Data Set (NMDS) includes information on nursing diagnoses/needs; interventions, outcomes, patient care intensity and discharge summary. The Finnish Care Classification (FinCC) includes the Finnish Classification of Nursing Diagnosis (FiCND), Nursing Interventions (FiCNI) and Nursing Outcomes (FiCNO).

Implementation of structured nursing documentation in the Oulu University Hospital (OUH) began in October 2006 and ended in September 2007. OUH was one of the many health care organizations which participated in the pilot project. Registered nurses and other nursing staff in six wards participated in the project and attendance was optional. A pilot documentation form was created to test structured nursing documentation in the OUH. The Paediatric Haematology Ward including outpatient activity, the Dermatology Ward including the Dermatology Outpatient Clinic, the Maternity Ward (Risk Pregnancies), the Department of Gynaecology and the Dialysis Ward participated in the implementation of this project. These pilot wards had criteria of their own and the patient data was documented to the pilot documentation form according to these specific criteria. None of the wards documented all patient data to the pilot documentation form.

2. Material and Methods

The purpose of this article is to describe the piloting of nursing documentation in accordance with the national model in the OUH. In this pilot, we have evaluated the Finnish Care Classification (FinCC) which is based on nursing process, the statistical information derived from FinCC and how FinCC supports the assessment of patient classification.

Nursing staff received education for documenting content which is consistent with the nursing process in the FinCC. Education included lectures, individual tutoring and guidance and case studies. Education sessions were also held in the wards and the registered nurse of the ward was relieved from her duties for the duration of two weeks in the beginning of the pilot. Successful implementation of the pilot necessitated the commitment of the nursing officers.

3. Results

The pilot has required careful planning and preparation. The use of the contents and the new documentation form of the Finnish Classification of Nursing Diagnosis (FiCND 2.0) and the Finnish Classification of Nursing Interventions (FiCNI 2.0) has required time and education of the nursing staff. It takes nurses about 3-6 months to learn structured nursing documentation. When the structured nursing documentation has been used for some months, it speeds up the recording process and nurses need less technical guidance.

The need for care was often erroneously recorded as a medical diagnosis or treatment in the OUH, furthermore, the goal of nursing care was often not adequately individualised and/or the patient's perspective was not heard. The goals were seldom discussed together with the patient. Nursing interventions were generally well documented, although the nursing staff gave negative feedback concerning breaking down the interventions into small parts. The nurses described the implementation of care well, although these descriptions sometimes included listing of tasks that the nurse had done. Evaluation was defined as a compulsory field in the pilot documentation form, and this prevented the update of care plans for the next day if the evaluation from the previous day was not done. The patient status evaluation table (better, unchanged, worse) was experienced as odd by some of the nurses. The use of the structured documentation has nevertheless decreased overlapping information and the documentation is more specific. The discharge summary included in the documentation was one of the nationally defined nursing core data, but it was not tested and evaluated in this project.

Statistical information concerning usage of FiCND and FiCNI revealed that between 1.11.2006 and 30.9.2007, a total of 3281 patients' need for care and 6274 patients' nursing interventions were documented to the pilot documentation form. The statistical nursing data has enabled examination of the nursing content and encouraged the staff during the pilot.[4]

The Oulu Patient Classification (OPC), the FiCND and the FiCNI have been cross-mapped. OPC has been developed to measure the patients' need for care and it is one of the pieces of core information in nursing. The OPC is constructed on the following areas of needs: 1) planning and co-ordination of care, 2) breathing, blood circulation and symptoms of disease, 3) nutrition and medication, 4) personal hygiene and

secretion, 5) activity/movement, sleep and rest and 6) teaching and instruction in care/follow-up care and emotional support. When a nurse documents a patient's care according to the nursing process model and uses the classification of needs and functions, these documentations are automatically recorded in the information system under OPC headlines based coding. In the future, the aim is to automatically define patient's dependency classification based on the implemented documentation without entering data into an indicator.

4. Conclusions

The documentation form must support the nursing decision-making process and one-time documentation. Education is needed concerning the nursing process and the contents of the classification of needs and functions. The case study examples were one of the most important implementation strategies as they enable the linking of abstract concepts with the real word of nursing. The new documentation model required time for all professional groups in the beginning, but with time the management of the classified content has markedly improved and individually. The new documentation form has been an increase in the professional discourse on care documentation.

Structural documentation of nursing enables development of evidence-based documentation and utilisation of information. The use of this standardized nursing documentation does not hinder individualization of nursing care any more than using the narrative format does. More discussion about the basic tasks of different professional groups and relevant matters in the documentation of a patient's care is needed in the wards. Structuralized documentation inevitably changes documentation practice. There is no longer need for conventional oral reporting, which can take up almost two hours per day.

Structuralized and classified information on clinical care enable processing of the information e.g. for statistics both for follow-up of the functional processes and the quality of the care. As the introduction of new documentation models is challenging, adequate time needs to be reserved for the staff in order to establish new documentation procedures.

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