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Adopting the National Structure of Nursing Documentation is Consequential in the Development of Care

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Abstract

When healthcare units adopt the national structure of electronic nursing documentation, the process requires managerial support in nursing development as well as theoretical education arranged prior to the implementation. According to the experiences of the pilot units in the Central Finland Health Care District, nursing core data documentation in accordance with the national structure promotes care planning, clarifies and constructs documentation and furthermore unifies the documentation system. The change process gives rise to juridical aspects of documentation as well as a critical evaluation of the documentation contents. The early period of implementing the new theoretical aspect and proceeding from paper-based to electronic documentation required learning, training and agreement on common policy. In health care practice, there is at present one collective structure and model for nursing documentation based on national guidelines. A documented nursing plan is available when a patient is transferred between units or even into extended care. The structured care plan is also helpful when new nurses are introduced to praxis. The continuity of care is at stake when employees are transferred between units to meet the demands of resource allocation.

Keywords:

Core data, Nursing, Information systems, User training

Introduction

The law on using electronic social and healthcare client data in Finland was passed on July 1, 2007. Accordingly, the information in electronic health records (EHR) must be structured in order to support decision making in patient care as part of health management and the acquisition of health policy information. [1, 2]

According to the legislation, every electronic patient record must follow core data structures. The core data structures consist of essential health and care documentation that must be coded as defined so that it can be archived nationally. [3, 4]

The Nursing Minimum Data Set (NMDS) is a part of the EHR core data set. The Finnish Ministry of Health and Social Affairs has set the core data structure as a national goal for nursing documentation. The core data in nursing includes nursing diagnoses, nursing interventions, intensity of care and summary on discharge. [4] Nursing documentation is done by choosing headlines under different phases of the nursing process that can be complemented with free text. The documentation is based on the nursing core data that comply with the Finnish Care Classification (FinCC). [5]

Structured Nursing Documentation – a Pilot Study in the Central Finland Health Care District

The Central Finland Health Care District participated in a national electronic nursing documentation project titled *HoiDok* in 2005–2007 and in the national development of structured nursing core data. The goal of this development was to unify and standardise nursing documentation and to connect it with interdisciplinary core documentation of patient history, the national code server and the national archive. [6, 7] Finnish nursing documentation is based on the nursing decision making process, the nursing core data (NMDS) and the Finnish Care Classification (FinCC). The FinCC includes the Finnish Classification of Nursing Diagnosis/Needs (FiCND), Nursing Interventions (FiCNI) and Nursing Outcomes (FiCNO). [5, 7] The participants of the pilot study were nine hospital units of different specialties. These represented psychiatric and somatic care, and both wards and outpatient departments. In addition, a technical application of nursing documentation titled *WHOIKE* was utilised as part of patient data recording. [7]

Both theoretical education and case-based training were arranged at the hospital while the electronic application of nursing documentation was prepared for implementation. Nursing documentation will generate an interdisciplinary document that consists of daily notes done by several professionals engaged in patient care. During the training sessions, nurses and care providers received theoretical education of the nursing process. The training focused on structured data models following the national guidelines as well as on the legal aspects of documentation. A theoretical model of the nursing process was also introduced and its use rehearsed. The FinCC was explored with the help of case studies and examples. The training content was tailored to the units' needs and expectations. Every unit had one person engaging with the manager to plan and enable the personnel's participation in the training sessions.

The units also appointed one or two super users to support the implementation and utilisation. The documentation training was arranged immediately before the implementation. [9, 10]

The implementation of nursing documentation was accomplished in phases in the nine units during a two–month period from December 2006 to February 2007. The units made accurate plans describing the implementation date, volume of users, the final date of completion and plans for user support. (*Fig 1).*

The assessment of the implementation revealed that seven units achieved their goals well. In two units, the preparation for electronic documentation was insufficient. In the wards, every patient had a structured nursing document within two months. In the outpatient departments the transfer phase took over six months.

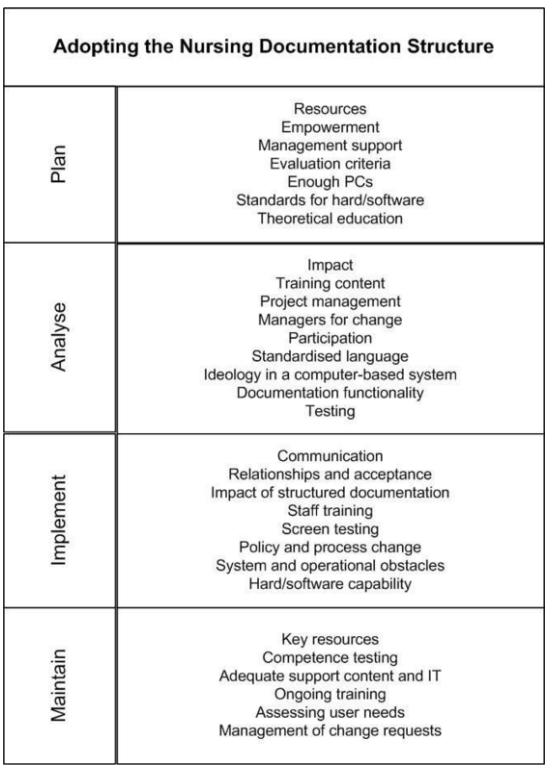

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Figure 1- The adoption model for structured nursing documentation [9, 10]

The evaluation from the units shows that successful implementation of structured nursing documentation requires managerial support, commitment to development and intense co-operation with managers and super users. Implementation must be executed with a careful design, realistic schedule and organised support. [10] It is important to immerse profoundly in the nursing process, classifications and the ideological significance. All professionals participating in patient care must determine both the meaning and relevance of documentation. Learning a new method of documentation takes time and is dependent on a well-operating application.

In May 2007, a survey was carried out in two of the pilot units after five months' use of electronic nursing documentation. Based on the results, some amendments were made in both the classifications and the application. A renewed application was implemented in February 2009. The pilot projects in structured documentation continued until September 2007. Based on some critical issues raised in user comments and requests, both operational and user interface usability alterations were implemented in January 2008. [9, 10]

Increasing the Use of Structured Nursing Documentation

Before increasing the use of structured nursing documentation, several information events were arranged for nursing managers and leaders. The units also received general directions on how to prepare for the implementation. During the lessons in the wards, theoretical studies were organised for both the super users and support persons. The actual training sessions for the application use were held from February 2008 to April 2008. Two training facilities with PCs were in constant use. Over 2000 nurses attended the training sessions.

Every unit made their own implementation plan that was executed immediately after the training. At present, structured nursing documentation has been adopted in all the psychiatric and other hospital wards as well as in the outpatient departments. A regional training program and implementation are under process. For example in the health care in Jyväskylä, a gradual switch is being made to structured nursing documentation.

The Impact of Structured Nursing Documentation

The impact of documentation in nursing has increased considerably in recent years. In previous years it was enough to record some of the interventions to be made, and nursing documentation lacked a legal function. Nowadays the demand for precise documentation is increasing, and the central function of documentation is to serve patient care planning, intervention and assessment and promote the continuity of care. Documentation also provides information to patients and establishes legal protection for both the patients and the personnel. With daily documentation, it is possible to explain and estimate how appropriate the treatment a patient receives is.

Developing structured nursing documentation has clarified and firmed the content of documentation. Some outpatient departments have considerably increased the volume of their documentation following the nursing process. Structured nursing documentation has enabled the units to also develop other functions. Through nursing documentation, change-of-shift reporting has taken the form of silent reporting. Orders can be prescribed in EPR by doctors, and the information is forwarded to the nursing documentation.

Nursing intensity is measured by a national system called *Rafaela*. Nursing documentation notes about ward intensity are available when workload is measured. A search engine enables patient information to be available to all users. Information can be retrieved according to the nursing sector, nursing process or the nursing period.

The implementation of structured nursing documentation increases the time consumed in storing data. However, it is obvious that in the long run, when the personnel have become familiar with the structure and the classification, documentation becomes precise and quality ameliorates. Structured nursing documentation accumulates significant patient data.

Discussion

The application of nursing documentation (*WHOIKE*) does not yet fulfil the structured nursing documentation standards completely. The structure of documentation is efficient but the user interface requires improvements to the usability. Some doctors are not satisfied with the use of the components and the terminology in the classifications. The documentation following the nursing process can appear abstract when implemented, and it takes time to visualise the new way of updating patient care.

Now it is time to confer, further develop patient care and make records to serve interdisciplinary documentation. It is important to find a common understanding of the consequential information documented into the nursing care plan. This means specific demands for the software application, user interface and usability.

Nowadays nurses read or retrieve doctors' documentation from different forms. At the same time, doctors inspect nursing data from a Nursing View frame or Nursing Plan frame. In the future, all information can be retrieved by similar search methods. The new nursing application includes a Daily Monitoring frame as well as a Medication frame; this will additionally enhance the significance of integrated software. Adopting a single recording principle for the patient records will improve visibility and usefulness and benefit patients in nursing planning, intervention and assessment. During the care period, the nursing document is vital for an individual patient's care.

A national study revealed that it takes about 3–6 months to learn the nursing documentation structure. When structured nursing documentation is carried out for a few months, it speeds up the recording and also guides documentation. Overlapping documentation has decreased, and documentation is more specific. The quality of the nursing documentation content has improved, and it has become more uniform and patient-orientated. Information is up to date, and the continuity and security of nursing care have improved. [7]

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