BARRIERS THAT PREVENT NURSING STAFF ON A NON-CRITICAL CARE UNIT FROM EFFECTING INDIVIDUALIZED DOCUMENTATION OF PATIENT CARE PLANS

by

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ABSTRACT

Historically, patient care plans were introduced in the academic arena to teach a process that nursing students could use to identify and define a patient-centered problem. This method has evolved to a five step process known as the nursing process. The five steps include assessment, diagnosis, planning, implementation and evaluation. The nursing process is fundamental to providing quality, safe and individualized care that results in positive patient outcomes (Doenges, Moorhouse, & Murr, 2006). A major tool within the nursing process is the patient care plan. Patient care plans are multidisciplinary and are used to communicate and document patient care. They are required by government agencies, third-party payers and are part of hospital policy (Doenges et al., 2006). The impetus of this project was an audit by The Joint Commission of an acute care hospital. The audit revealed a deficit in compliance in regards to documentation of individualized care plans. Changes were instituted within the acute-care hospital however; it was felt by staff that these changes did not address the root cause of the problem. The purpose of this project was to identify barriers that prevent nursing staff on a non-critical care unit from effecting individualized documentation of patient care plans. Three focus groups assembled to discuss their insights regarding the barriers professional nurses face that prevent them from documenting on and making a patient's care plan individualized. This project proposed using the data from the focus groups for further investigation and research to develop nursing processes and technology that can truly benefit patient outcomes.

CHAPTER ONE

INTRODUCTION

Various forms of nursing care plans have been used since the 1930's. Ellen Buell, registered nurse and nursing educator, used case studies to teach nursing principles. As a nursing instructor who taught public health nursing, she introduced a "scientific attitude," as a way to recognize and define a problem, choose a solution, apply the solution and evaluate its success (Buell, 1930, p. 399). Buell was teaching her students to become nurses. She instilled in them the process that would eventually be known as the nursing process.

The nursing process consists of five steps; assessment, diagnosis, planning, implementation and evaluation. Assessment is the data collection step. The assessment includes both subjective data, information obtained from the patient and/or family and objective data which is observable and measurable. Diagnosis is a statement of the problem. Professional nurses take all the information that is collected and apply critical thinking and judgment to determine the problem. A nursing diagnosis is not the same as a medical diagnosis. Wording or language describing the nursing diagnosis is drawn from a list of potential diagnoses that have been reviewed and accepted by the North American Nursing Diagnosis Association (NANDA). The third step in the nursing process is planning. Planning identifies and describes patient-centered goals and the nursing interventions to achieve the goals. Implementation of the plan requires following through with the plan by way of communication to other care providers, delegation of

responsibilities as needed and finally documentation of activities. The final step, evaluation, requires continued review and assessment by all care providers. The nursing process is an ongoing and changing process. Goals and interventions are evaluated in relationship to the patient's response and improvement. The nursing process "combines all the skills of critical thinking and good nursing care because it creates a method of active problem-solving that is both dynamic and cyclic" (Doenges, Moorhouse, & Murr, 2006, p.7).

Critical thinking is used in each step of the nursing process as a systematic way to plan, implement and evaluate care for individuals, families and communities (Potter & Perry, 2009). Critical thinking is the cognitive and systematic process a nurse uses to provide safe, quality, evidence based care. It is the root of investigating and analyzing a problem (Heaslip, 1993). Critical thinking is the skill that separates the professional nurse from technical or ancillary staff (Potter & Perry, 2009).

A major tool used within the nursing process is the patient care plan. Historically, patient care plans were seen as an educational tool used in nursing school and frequently were not utilized by a nurse following graduation (Doenges et al., 2006). However, care plans are presently becoming a common method nurses use to "communicate and document client care" (Doenges et al., 2006, p. xvi). Patient care plans are also used and required by government agencies, third-party payers and to comply with hospital policy (Doenges et al., 2006). The transforming Institute of Medicine (IOM) paper, titled *Crossing the Quality Chasm*, states one of its visions is that health care should be "customized based on patient needs and values. The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual

patient choices and preferences" (2001, p. 61). If patient-centered care documentation is not complete, accurate and informative, the patient may not receive the effective nursing care they have a right to (Karkkainen, Bondas, & Eriksson, 2005).

The nursing process and patient care plan continues to be a major focus and teaching tool in baccalaureate nursing programs. In spite of the long history and support from many nursing leaders and researchers, patient care plans outside of the academic environment remain under used or misused. According to Blair and Smith (2012) "nursing documentation should, but often does not show the rational and critical thinking behind clinical decisions and interventions" (p. 160). Nursing care plans lack the individualization that is needed for each patient.

Karkkainen et al., (2005) conducted a metasynthesis of fourteen research studies and concluded that within nursing documentation, individualized patient care is not readily evident. They identified four major areas that lead to the absence of individualized patient care. The four areas are:

1. the requirements of the organization;
2. the nurses' attitudes and obligations;
3. the lack of patients' involvement in their care; and
4. the use of standardized documentation forms;

Local Problem

The environment for this project is on a thirty-eight bed, non-critical care unit of an acute care hospital in a rural area of a western state. The impetus of the project was a result of a recent Joint Commission audit that identified a lack of compliance in regards

to patient care plans. The Joint Commission noted that the patient care plans did not fully address the individualized needs of the patient. The Joint Commission (2014) standard states,

> Planning for care, treatment, and services is individualized to meet the patient's unique needs. The first step in the process includes creating an initial plan for care, treatment, and services that is appropriate to the patient's specific assessed needs. To continue to meet the patient's unique needs, the plan is maintained and revised based on the patient's response. The plan may be modified or terminated based on reassessment; the patient's need for further care, treatment, and services; or the patient's achievement of goals. The modification of the plan for care, treatment, and services may result in planning for the patient's transfer to another setting or discharge (Standard PC.01.03.01).

It is expected that the care planning process starts upon admission of the patient to the non-critical care unit. Hospital policy states,

> A care plan directs a patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process… A nursing care plan should be written for each patient, preferably within 24 hours of admission. It's usually started by the patient's primary nurse or the nurse who admits the patient (Lippincott Procedures, 2014, p. 1).

The nursing diagnosis, a patient-centered problem, is the basis for the care planning process. The nursing diagnosis is formulated from assessment data obtained by the professional nurse. The nurse documents the patient assessment on the patient's electronic health record. As a result of the assessment data that is documented a standardized nursing diagnosis is attached to the electronic care plan. A single patient outcome is attached electronically to the nursing diagnosis. For each nursing diagnosis the same standardized patient outcome is generated. Nursing interventions and evaluation of the patient outcomes are documented by the nurse. Interventions and evaluations are

not standardized and should reflect individualized care of the patient. One of the major components of a patient's individualized care plan is the education they received. Patient education is required to be documented on the discharge plan to demonstrate that the care plan continues following discharge from the hospital. A patient's care plan is initiated upon admission and should be an active part of their care. It follows them to discharge and is a part of their medical health record. The patient care plan needs to be intelligible, relevant and specific to the patient (Paans, Sermeus, Nieweg, & van der Schans, 2010)

Hospital policy dictates that the nurse providing direct care for the patient must update the patient care plan every shift. Other disciplines such as Physical Therapy, Discharge Planning and Pastoral Care also document on the care plan, showing inter-disciplinary aspects of care. Figure 1 depicts the care planning process on the non-critical care unit.

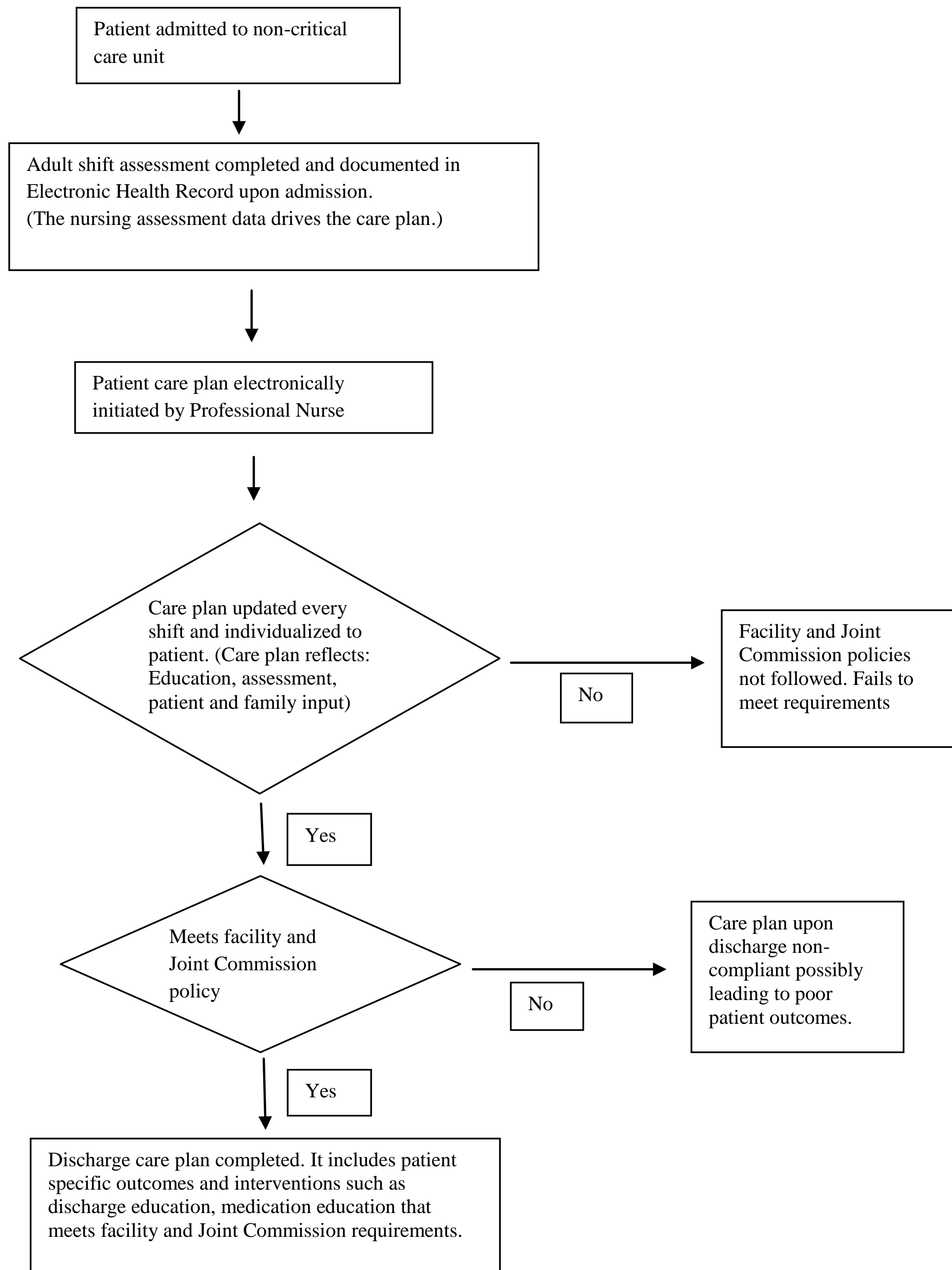

Figure 1. Care Plan Process.

The nursing leadership team and hospital compliance officers of the facility were committed to addressing the deficit cited by The Joint Commission (TJC). Compliance required by government regulations in relation to patient safety and quality care is a high priority for this organization. Following the documented deficit by The Joint Commission, the hospital Change Management Committee met regarding this problem. This committee consisted of the Chief Nursing Officer, the Magnet Program[R] Coordinator, the Accreditation Coordinator, the Surgical Unit Manager and a Nursing Informatics Registered Nurse (RN). This committee reviewed the patient care plan documentation process and identified four areas that led to inadequate care plan documentation and compliance. The areas in need of improvement included:

- Unclear documentation of patient specific education in the electronic health record (EHR).
- Lack of nursing staff knowledge regarding the facility's nursing care plan policy.
- Lack of nursing staff knowledge regarding The Joint Commissions' requirements concerning patient care plans.
- Lack of transferability of EHR data regarding patient education information to the patient care plan.

The hospital Change Management Committee instituted three interventions to address the identified deficits:

1. The Nursing Informatics team was asked to develop the NANDA diagnosis of "Knowledge deficit" as a Nursing diagnosis and integrate it on the patient and family education documentation screen. This was established to meet The Joint Commission requirement of individualized patient education. The change to the electronic health record (EHR) went live October 6, 2014.

2. The non-critical unit nursing staff were educated by the unit nurse educator about the use of the EHR's newly developed "knowledge deficit" screen. She demonstrated, by way of video presentation, the use of the "knowledge deficit" screen, the hospitals' care planning policy and The Joint Commission policy regarding individualized care plan documentation during staff meetings. She also communicated these issues to the staff through email and newsletters.

3. Patient care plans were audited monthly by a non-critical unit staff nurse to address compliance with The Joint Commission policy.

The specific aim of the Change Management Committee was that the nursing staff on the non-critical care unit would improve compliance regarding patient care plan documentation. Individualized plan of care and patient specific medication teaching documentation would be noted in 92% of the nursing care plan audits completed by March 2015.

Following four months of chart audits, it was noted that the non-critical care unit attained 93.7% compliance. The Joint Commission returned to the facility and audited random charts for individualization regarding documentation of medication education upon discharge and was satisfied with the unit's compliance.

Even though compliance regarding governing agency requirements is important for a patient's care plan, it is only one area to be considered. According to Keenan, Yakel, Tschannen and Mandeville (2008) "nursing documentation in the medical record does not meet the espoused purpose of being a communication tool that supports the continuity, quality and safety of care" (p. 3) Keenan et al. (2008) stated that documentation is "limited and inadequate for evaluating the actual care given" (p. 3). Ehrenberg and Ehnfors (2001) noted in their study after completing chart audits and nurse interviews, there was little correlation between the care that was actually given and what was documented.

Purpose of Project

Nurses hold much of the responsibility for "managing and implementing the interdisciplinary team's plan for the patient, as well as documenting the care and progress toward goals" (Keenan et al., 2008, p. 1). However, care plans are generally poorly used in a patient's care and generally not reviewed prior to delivery of care to that patient (Karkkainen et al., 2005).

The purpose of this project was to identify barriers that prevent nursing staff on a non-critical care unit from effecting individualized documentation of patient care plans. It was anticipated this project would be a catalyst to change. It will start the process to truly identify the root cause of identified barriers.

Change Tool

The Golden Circle is a concept that is being used by companies such as Apple and FedEx. These companies are focusing on WHY they do what they do rather than HOW or WHAT. The Golden Circle concept was developed from the premise that companies, healthcare included, have forgotten WHY they are doing what they are doing (Sinek, 2009). Nurses know what a care plan is, they know how to write a care plan, but have they forgotten why care plans are used? Have they forgotten why care plans benefit the patient and lead to better outcomes? This is comparable to working through a root cause analysis asking the "why" question repeatedly. According to Sobek and Smalley (2008); "the most obvious cause (of the problem) is rarely the root cause" (p. 22).

To fully understand the root cause related to ineffective care plans, this author utilized the research technique of focus groups, which will be discussed in depth later in this paper. Focus groups are groups that are organized to collect data and identify issues (Reed & Payton, 1994). Before the focus group could or should identify “what” drives the nursing care plan process or “how” nursing care plan documentation should be done, the focus group attempted to answer the questions of “why”. Why do staff nurses use patient care plans? The second question was, why are the staff nurses having difficulty with individualizing a patient’s care plan and documenting that information? Figure 2 is an example of the very simple Golden Circle diagram by Simon Sinek (2009, p. 37) who developed this concept.

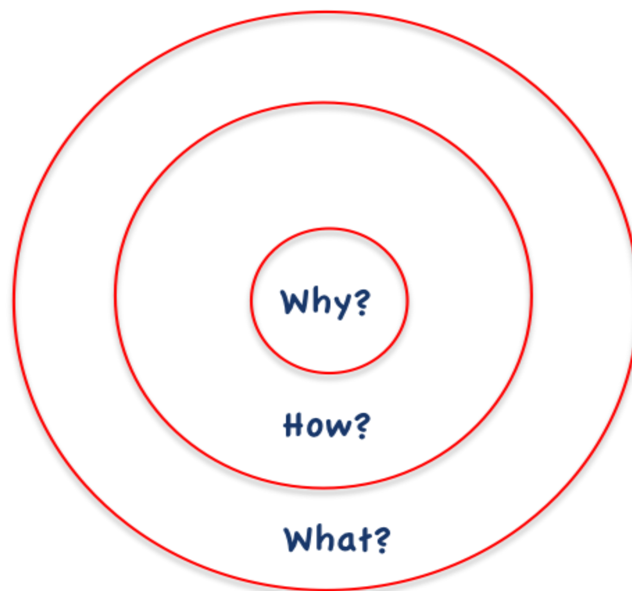

Figure 2. Golden Circle Diagram.

Change Theory

According to Nelson, Batalden and Godfrey (2007); “change concepts can help clarify your thinking about where in a process a change can be made …” (p. 333). The use of change concepts or theories can also bring about a new point of view. This improvement project implemented the initial steps needed for change. It answered the question, “What along with beliefs and values need to be changed?” The change theorists Lippitt, Watson and Westley, as cited in Mitchell (2013), developed a seven step theory that concentrates on the role and responsibility of those who are initiating the change (Kritsonis, 2004-2005). Change resulting from this project was initiated using Phase 1 of Lippitt’s theory to diagnose of the problem. It corresponds to finding the root cause of the problem or in relation to the nursing process, diagnosing the problem. Table 1 provides a representation of Lippitt’s theory and how it corresponds to the nursing process (Mitchell, 2013, p. 33).

Table 1. Nursing Process Compared to Lippitt’s Theory

Nursing Process	**Lippitt’s Theory**
Assessment	Phase 1. Diagnose the problem Phase 2. Assess motivation/capacity for change Phase 3. Assess change agent’s motivation and resources
Planning	Phase 4. Select progressive change objective Phase 5. Choose appropriate role of the change agent
Implementation	Phase 6. Maintain change
Evaluation	Phase 7. Terminate the helping relationship

CHAPTER TWO

METHODS

After completing a microsystem assessment through weekly chart audits over at four month period, the author determined further information was needed to address the lack of individualized documentation on a patient's care plan. It was determined that a focus group involving the nursing staff of this non-critical, medical unit would be helpful in gathering, identifying and understanding the barriers that were preventing useful and patient centered documentation on patient care plans.

Focus Groups

A focus group is a group discussion assisted by a facilitator. Focus groups have been accepted within research as a strong qualitative method. Doody, Slevin and Taggart (2012) stated, "They are particularly useful for exploring peoples' knowledge and experiences" (p.170). The goal of this method was to use the interaction between participants to better identify ideas, clinical observations and opinions from the nursing staff regarding the care planning process. Data were used to reveal themes and issues to clarify and understand the obstacles nurses are experienced when developing and implementing nursing care plans. Group dialog and discussion, directed by specific questions, was used to discover and dig deeper to identify various views and opinions of the participants.

According to Jayasefara (2012), "compared with other data collection methods, it can be concluded that the real strength of focus groups is not simply in exploring what

participants have to say, but in providing insights into the sources of complex behaviors and motivations" (p. 411). The focus group method is common in nursing research and is used to explore health care issues, collect further information and data and to validate findings (Jayasefara, 2012). The focus group questions (Table 2) along with a copy of the focus group consent form were submitted to the university Institutional Review Board (IRB) for approval. The IRB determined that the project received exempt status in accordance with Code of Federal regulations, Part 46, section 101.

Design and Participants

Over the months of March and May of 2015, the author conducted three focus groups. Table 2 includes demographic data for each focus group.

Table 2. Focus Group Demographics.

Date of Focus Group	**March 26, 2015**	**May 5,2015**	**May 13,2015**
Total number of Participants	10	4	5
Female	10	4	5
Male	0	0	0
Full-time Employee	7	0	4
Part-time Employee	2	2	1
Casual Call Employee	1	2	0
Day-shift	4	1	4
Evening-Shift	0	1	0
Night-Shift	5	0	1
Rotates Shifts	1	2	0

Each participant in the focus group signed a consent form. The consent form identified participation in the focus group was voluntary and would not in any way affect

their work or staff position. The discussion was strictly confidential and direct quotes or data would remain confidential.

Eight questions were developed by the author to facilitate discussion and to obtain information, participant ideas and opinions. All focus groups used the same eight questions. The author used, at her discretion, tools to redirect the discussion as needed.

The focus groups were held in the education rooms within the acute care hospital between the hours of 7-8 pm. Participants were asked on a voluntary basis to stay following a Unit-based Council meeting and two Medical Unit staff meetings. The first focus group data was documented by hand but the following two groups were digitally recorded and then transcribed.

CHAPTER THREE

RESULTS

In all, nineteen staff nurses participated in the focus group. The non-critical care unit employs a total of sixty-seven professional nurses. Twenty-eight percent of the nurses on the unit were represented in the focus groups. All participants were female. At the time of the study, their years of experience ranged from less than one year to 24 years. Day shift, evening shift and night shift staff were all represented.

To initiate the focus group, participants were thanked for attending and were provided an overview of the focus group process. Each participant was given a list of the eight questions that would be used (Table 3).

Table 3. Focus Group Questions.

1.	What are your thoughts regarding the nursing care plans used on the medical unit?
2.	Do you feel nurses struggle to document on patient care plans? Why or why not?
3.	Do you feel patients are involved with their plan of care?
4.	Do you feel that unit nurses understand how to utilize and document on a patient’s care plan?
5.	What are some of the challenges nurses may have with utilizing and individualizing patient care plans that you have experienced?
6.	Do you feel that medical unit nurses know the importance of individualizing a patient’s care plan?
7.	What recommendation do you have for developing useful, individualized patient care plans?
8.	What do you believe would be the barriers to the above recommendations?

Outcomes

The focus group facilitator started the interaction by asking the nurses to generally voice their thoughts regarding the patient care plans that are used on the non-critical care unit. In all three focus groups, the interaction between the respondents was respectful. Each participant was allowed to voice her opinion and observations fully. There were no obviously dominant participants. Clear ideas and discussion were evident to the facilitator. Table 4 provides a summary of the themes, sub-themes, and participant quotes obtained from focus group transcripts.

Table 4. Summary of themes, sub-themes and participant quotations.

Themes	Sub-themes	Participant quotations
Present care plans at this facility are not beneficial to professional nurses in providing patient care	Do not provide useful information	"We do them because they are mandatory." "They're short, have little information and are not very useful."
Nurses struggle to document individualized care on the patient's care plan.	Time consuming	"I am so busy giving care that documenting that care on the care plan when I have already documented it in the nurses notes is a waste of time."
	Redundant/duplicate information	"I feel what you write in the nurses notes is written again in the care plan." "They're not useful at all, it's redundant charting."
Care plan individualized for each patient	Patient focus	"Care plans do not reflect patient involvement in care. There's no place to chart that." "I feel patients are involved in their plan of care but not the formal care plan." "Care plans were very individualized in school, we learned a lot from them. Now it's just something that takes our time." "They [care plans] don't feel very individualized."

Respondents were a hundred percent in agreement that care plans were not useful in relation to the care they provide their patients. The focus group participants discussed the fact that they documented on the patient's care plan because it is a requirement of the facility policy. They also stated that "after being told" they now know it is a requirement of The Joint Commission. Participants reported they read what the previous nurse documented on the care plan, but all participants agreed that the documentation was not helpful in planning or providing care to the patient. Seventeen out of nineteen participants stated they documented on the patient's care plan as one of the last things they did before ending their shift. One participant stated, "I don't even look at the care plan until right before I go home." Two participants stated that they do it earlier in their shift "just to get it done" but denied completing it earlier in their shift was more helpful in providing individualized patient care.

All participants were in agreement that the most significant reason they found it difficult to document on the patient care plan was the lack of time. One participant stated, "Why should I spend time documenting on something that doesn't matter?" Similar comments were voiced during each focus group. They felt the difficulty of maneuvering through the current process and the duplicate documentation, was too time consuming to be beneficial.

The majority of participants understood why a patient's care plan needed to be individualized. They verbalized understanding the connection between individualized care and patient outcomes; however, they felt care plan documentation did not reflect individualized care. One participant stated, she now knows the importance of individualizing a patient's care plan "because of The Joint Commission recommendations

and being told about it in staff meetings." One nurse stated "When I went to nursing school, I don't even remember [doing care plans]. I've forgotten why they are supposed to be useful." Nurses in each group reported, "I know what to do for a patient" but as previously addressed, documentation was difficult.

Analysis

The results of the focus group confirmed that documentation on a patient's care plan was time consuming, the electronic health record was cumbersome to maneuver, and caused duplicate documentation. The focus group participants realized a well-documented care plan could be useful, if it was less time consuming to complete. The nurses feel that they were providing good, individualized care but found it difficult to document that care using the present care plan format. Focus group participants stated that the biggest frustration was having to document their plan of care and interventions multiple times within the system. Participants felt the format did not allow for "easy" or individualized documentation. A recommendation from one of the participants was to "get rid of the present format" and have the patient notes and care plan combined to alleviate double charting. All participants agreed that a better process was needed. Comments regarding making the care plan a "snap-shot about what's going on with the patient" were suggested. One participant stated that "it would make me think a little more about my care when I read in the care plan what someone before me wrote about what they did for a patient problem." Nurses in the focus groups agreed that a care plan is important for good patient outcomes. They also believe they are giving good patient care and they are addressing problems. One hundred percent of the focus group participants

agreed individualizing or documenting on a patients care plan does not affect their delivery of patient care.

CHAPTER FOUR

DISCUSSION

Summary

The purpose of this project was to identify barriers that prevent nursing staff on a non-critical care unit from effecting individualized documentation of patient care plans. It was noted during a facility review by The Joint Commission (TJC) that documentation in this area was not being completed to TJC recommendations. A four month chart review along with short group and individual educational sessions were completed to improve compliance. Following the four month chart audit, it was revealed that compliance improved to greater than the desired 92%. During this process, it was noted that staff made comments such as "care plans are so time consuming," "it's the last thing I do," and "you know that after The Joint Commission comes it will go back to the same way." This information led the author to question "why". Further investigation regarding the care planning process and obtaining data regarding the root cause associated with individualized care plan documentation was needed.

Registered nurses participated in one of three focus groups to obtain qualitative data that allowed insight into the root of the problem. The focus groups revealed several important findings:

1. Documentation on the patient's care plan is very time consuming and thus is not a high priority in regard to patient care;

2. The present computerized care plan format is difficult to use;

3. The information within the care plan is redundant to patient information documented in other areas of the patient's medical record;

4. The information documented in the patient's care plan is not reflective of the care that is given;

Limitations

Focus groups, as with other methods, have limitations. Some researchers believe that focus groups are not a good choice for sensitive discussion topics. They also believe that group interaction can be limited by personality, social factors and power (Jayasekara, 2012). There were several limiting factors within this study. The first identified limitation was the focus group questions. Focus group questions must be precise and clear in their meaning (Jayasekara, 2012). During the focus groups, the different questions seemed to lead the discussion in the same direction and needed to be clarified by the facilitator. The second limitation was that the focus groups were difficult to arrange. Voluntary participation was limited. To improve participation, the focus groups were held after other required medical unit meetings.

Financial Considerations

During this project, there was no financial cost to the facility or medical unit. Focus group participation was voluntary as was the facilitator time. This author would expect as the project moves forward, an improvement committee would be formed and

members would be financially compensated for their involvement. Presently this rural acute hospital compensates professional nurses at their normal hourly wage for committee participation. A professional nurse would also be hired to audit and evaluate compliance with TJC recommendations.

Presently this facility is upgrading its computer system and its electronic health record system. Patient care plans will be a small part of that system. It is yet to be determined if the new system will benefit the nurses in relation to the care planning process.

Conclusion

It is well known that patients are individuals. Even though their diagnoses may be the same, they vary in not only physical but also in their psychosocial and spiritual needs. Planning individualized care and documenting that care is essential to achieve desired patient outcomes. The care planning process combines both critical thinking skills and the full use of the nursing process. This project described how care plans are intended to be utilized, the gap between intention and reality and barriers leading to this gap. This project is an opening to go further, to develop a process that will use a patient centered care plan as a working, fluid, document that will truly benefit the patient.

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