

## ARTICLE

# CHALLENGES OF NURSING DOCUMENTATION IN CORONARY CARE UNIT: A QUALITATIVE STUDY OF NURSES' EXPERIENCES

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## ABSTRACT

Evidence shows that there are challenges in nursing documentation in CCU. Studying nurses' experiences of documentation can help acquire a deep understanding about documentation-related challenges and develop strategies for promoting documentation. The purpose of the study was to explore nurses' experiences of documentation in CCU. This descriptive qualitative research was conducted in 2015 by using the conventional content analysis approach. A purposive sample of fifteen nurses was recruited. Unstructured interviews were held for data collection. Data analysis was done by using the Graneheim and Lundman's content analysis approach. Data trustworthiness was maintained through the criteria Lincoln and Guba. The study participants' experiences of documentation in CCU fell into three main themes including 'Documentation: an instrument for or a barrier to conscious and safe care', 'Reality-documentation-principles gap', and 'Dynamic management-person interaction and high-quality condition for documentation'. Nursing documentation has a contradictory nature for nurses and is perceived differently from 'an instrument for care provision' to 'a barrier to care provision'. However, the gap between realities and documentations diminishes the value of documentations. Managerial supervision and provision of necessary infrastructures for reality-based documentation can enhance the quality of nursing documentation in CCU.

## INTRODUCTION

The profession of nursing has become more specialized and more complex compared with the past decades and hence, nurses' legal liability has also increased [1]. Nursing reports show the flow of medical treatments and patients' reactions to care services [2] and enable healthcare providers to communicate with each other and evaluate the quality, type, and continuity of services [3]. Besides, nursing reports have significant roles in nursing education and research as well as in care auditing and evaluation [4]. The quality of documentation in critical care units is of greater importance due to the hospitalization of critically-ill patients in these units, critical situations, administration of certain medications which may produce major side effects, and high mortality rate. However, studies showed that most nursing care services in critical care units are documented and reported by using non-standard narrative methods [1]. Besides, the quality of documenting the findings of nursing assessment and care evaluation is also poor. Different studies reported the inadequacy of documents on clinical care evaluation [5], mismatch between documentations and patients' actual conditions [6], the poor quality of documentations, and nurses' poor-to-moderate documentation-related knowledge, attitude, and practice [7]. Therefore, considerable emphasis is placed on improving the quality of nursing documentation. There are numerous studies on the methods for improving documentation quality, most of which have been done using quasi-experimental designs and in general hospital wards such as medical-surgical units. These studies dealt mainly with developing and implementing a directed program to improve documentation quality [8], launching a peer evaluation program [9], providing in-service educations to nurses [10,11] and assessing the effects of different methods for writing nursing reports [12]. Evidence shows that nurses have negative attitude toward documentation [13]. Moreover, there is a knowledge gap regarding nurses' experiences of documentation in the Iranian socio-cultural context. This study was made in Iran to explore nurses' experiences of documentation in coronary care unit (CCU).

## METHODS

### Study design

This was a descriptive qualitative study which was conducted in 2015 by using the conventional content analysis approach [14].

### Setting and sample

This study was undertaken in the CCU of a teaching hospital located in X. A purposive sample of fifteen nurses was recruited. The selection criteria were having a minimum work experience of six months in

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critical care units, being interested in sharing experiences, and being psychologically stable for establishing communication.

### Ethical consideration

The approval for conducting the study was obtained from the Ethics Committee of X University of Medical Sciences (LUMS.REC.1394047). The study aims and methods were explained to the participants and they were requested to provide written consent for participation. All participants retained perfect right to withdraw from the study. They were also ensured that their information would remain confidential and that they could have access to the study findings.

### Data collection

In-depth unstructured interviews were held for data collection. All interviews were held personally in a private quiet room located in the study setting. The time of the interviews was determined according to the participating nurses' preferences. Initially, the interview questions were broad. For instance, 'What feelings do you have when documenting the care?' 'Would you please talk about your experiences of documentation?' 'In your opinion, what items should be documented in critical care units?' Interviews were recorded by a MP3 recorder. They ranged in length from 20 to 40 minutes. Data collection was performed in 2015 and ended once theoretical data saturation was achieved [15].

### Data analysis

Data analysis was done concurrently with data collection by using the Graneheim and Lundman's five-step content analysis approach [14]. Immediately after holding each interview, it was transcribed, typed, and perused for several times. Then, primary codes were extracted, combined, and grouped based on differences and similarities among them. Finally, the latent content of the data was extracted. All codes were assessed, scrutinized, and grouped by authors in order to generate appropriate categories and themes.

Data trustworthiness was maintained through the criteria Lincoln and Guba. The credibility of the data was maintained through member checking, allocating adequate time to data collection, prolonged engagement with the data, and conducting the interviews according to the participants' preferences. On the other side, data conformability was ensured by sending the interview transcripts and the generated codes and categories to several reviewers and asking them to review the accuracy of data analysis. We also attempted to hold all interviews in a same place and to transcribe them immediately in order to establish the dependability of the data. Besides, the maximum variation sampling technique was deployed to enhance data transferability [16].

## RESULTS

The study participants were twelve staff nurses, a matron, and two educational and clinical nursing supervisors. On average, the participating nurses' age and work experience were respectively 29 and six years and most of them were female (64%) and married (64%). The study participants had been employed permanently (14%), conditionally (57%), temporarily (7%), or based on the national post-education service law (21%). The study participants' experiences of documentation in CCU came into three main themes including 'Documentation: An instrument for or a barrier to conscious and safe care', 'Reality-documentation-principles gap', and 'Dynamic management-person interaction and high-quality condition for documentation' [Table 1].

**Table 1:** Critical care nurses' experiences of nursing documentation in CCU

Theme	Category
Documentation: An instrument for or a barrier to conscious and safe care	1. Documentation: An instrument for obtaining information and making decisions 2. Documentation: A factor behind effective care provision and rights protection 3. Documentation: A barrier to care and peace 4. Documentation: A marginal tool and task
Reality-documentation-principles gap	1. Censorship due to lack of professional autonomy 2. Documentation without implementation due to lack of resources and equipment 3. Inadequate documentation of essential nursing care services 4. Imprecise documentation 5. Traditionalism and non-adherence to principles
Dynamic management-person interaction and high-quality condition for documentation	1. Managers' support and supervision 2. Personal and situational characteristics

Documentation: An instrument for or a barrier to conscious and safe care

The participating nurses had different and even contradictory ideas about documentation. Some of them had a positive attitude towards it, emphasized its importance, and considered it as an instrument for exchanging care-related information. Moreover, they had experienced its positive role in protecting patients' health, particularly in critical care units, and also in protecting their own rights. The participants' positive experiences of documentation fell into two categories which are explained in what follows.

#### 1. Documentation: An instrument for obtaining information and making decisions

Some participants noted that reading documents on patient assessment helps them obtain information about patients' conditions. Moreover, they referred to documentation as an instrument for exchanging information among healthcare professionals and making clinical decisions. On admission, I assessed the patient and documented his signs and symptoms such as ecchymosis. This helped my colleague in the next shifts consider the probability of bleeding. The attending physician also provided his orders based on our documentations (P. 3).

#### 2. Documentation: A factor behind effective care provision and rights protection

As most patients who are hospitalized in CCUs have vital organ dysfunction, the participating nurses greatly valued the documentation of nursing assessments, hemodynamic monitoring, and advanced life support for vital organs. Besides, they highlighted the necessity to document data on patients' basic needs. Cardiac patients' level of consciousness is an important parameter and should be documented. Their breathing pattern and cardiac rate and rhythm are also among the priorities and need to be documented. These parameters show whether a patient is still suffering problems or is achieving recovery (P. 6). The study participants' experiences showed that accurate documentation of patients' clinical conditions and their responses to treatments can play a significant role in establishing right diagnoses, administering effective treatments, and saving patients' lives.

He had chest pain and was not responsive to oxygen therapy and we had documented this fact. The attending physician read it and prescribed more advanced diagnostic techniques for the patient. It was then revealed that the patient had severe coronary artery stenosis and hence, a stent was placed for him (P.11). During the process of documentation, our participants had clearly understood that documentation not only ensures patient safety, but also protects nurses' safety and rights and can strongly support them in lawsuits. At patient discharge, the patient's family members asserted that the staff nurse has not administered streptokinase to their patient. However, the nurse had documented the preparation and the administration of the medication and hence, family members' complaint was rejected (P. 1).

#### 3. Documentation: A barrier to care and peace

Contrary to the above mentioned findings, some participants referred to documentation as a barrier to care provision which disturbs nurses' peace through creating a sense of insecurity and boredom. They found it as a fruitless repetitive and time-consuming task which hinders effective care provision. All of our reports are repetitive and alike and hence, I feel that writing reports is a time-consuming and boring task. It wastes our time and thus, we can't effectively care for patients. I become really tired of writing reports. I think that it isn't beneficial to patients (P. 2).

Besides considering documentation as fruitless and boring, some participants had a negative attitude towards it because of being scared of its potential legal consequences. When documenting, I always feel fear because some patients are critically-ill and hence, I may forget documenting one care measure and thereby, be punished or experience legal problems due to such failure to document (P. 5).

#### 4. Documentation: A marginal tool and task

Some participants believed that documentation is important neither to nurses nor to physicians and has no pivotal role in clinical decision making. Nurses don't value their reports. Clinical care is more important [than documentation]. Nurses' decision making is even based on patients' clinical conditions. I haven't ever seen physicians to check vital signs charts and make their decisions based on them (P. 12).

#### Reality-documentation-principles gap

Two main findings of the study were the gap between the contents of documentations and what had been happened in real practice as well as violations against the principles of careful and accurate documentation. Such gaps have been perceived by the study participants in different ways which are explained below.

##### 1. Censorship due to lack of professional autonomy

One of the study participants' experiences was screening and selective documentation which was related to their sense of insecurity and lack of professional autonomy. In other words, although the participating nurses implemented some measures for patients in critical situations where physicians were inaccessible, they avoided documenting such measures because of having fear over potential prosecution or punishment. For example, we had a patient who suffered from chest pain. There was no medical order for

administering opioid analgesics for him and I couldn't contact the attending physician at midnight. Therefore, I was compelled to administer an opioid analgesic without physician's order. However, I avoided documenting it due to the likelihood of physician's anger and subsequent punishment (P. 9). The solution is to delegate some sort of authority to nurses in the form of protocols. Then, nurses would not be compelled to avoid documenting their care services (P. 7).

## 2. Documentation without implementation due to lack of resources and equipment

The study participants' experiences showed that the availability of resources, workforce, and medical equipment also contributed to the quality of documentations. One of the participants referred to the impact of access to physiotherapy services on the accuracy of documentations by saying, Suppose that chest physiotherapy has been prescribed for a patient while there is no physiotherapist in the hospital. The prescribing physician also knows this fact; however, he prescribes physiotherapy due to the possibility of negative legal consequences for himself. Therefore, we will have no option but not to perform physiotherapy; however, we write in patient's records, 'Chest physiotherapy was provided' (P. 8).

## 3. Inadequate documentation of essential nursing care services

Most participants noted that essential care services such as therapeutic relationship, patient and family education, and patient support by nurses are not documented. Most of the times, patients are anxious and are scared of death. We, the nurses, attempt to support and calm these patients and their family members. However, we don't document such nursing care services at all (P. 6).

## 4. Imprecise documentation

One of the study participants' concerns and experiences was a lack of precision in documentation due to the shortage of resources and equipment. The monitor displays of the cardiac monitoring system do not work properly, have too much artifacts, and do not trace patients' cardiac rate and rhythm properly. Sometimes, sphygmomanometers also function improperly and hence, we're compelled to document blood pressure inaccurately (P. 15).

## 5. Traditionalism and non-adherence to principles

The study participants' experiences revealed that care services provided to patients are usually documented without performing careful patient assessment, critical thinking, and paying close attention to observational findings. Rather, documentation is performed traditionally and based on previous nursing reports and old routines. Nursing reports are written through imitating senior nurses' documentation styles. Freshman nurses may even never pay attention to patients' conditions and the data presented by monitoring systems and just copy other nurses' reports (P. 14). We document a series of repetitive and routine patient education materials about dietary regimen and physical activity without assessing patients' real educational needs. However, the sound practice is to document only the educations that are provided based on patients' unique educational needs, underlying conditions, and literacy levels (P.10).

## Dynamic management-person interaction and high-quality condition for documentation

According to the study participants, nursing managers' attention to nurses' documentation practice, nurses and patients' personal characteristics, and the general atmosphere of CCU can considerably affect the quality of documentation. This main theme consisted of two categories which are explained below.

### 1. Managers' support and supervision

One of the main factors behind the quality of documentations was managers' support and supervision. Education, control, quality assessment, and feedback provision were among the most important experiences of the study participants regarding managers' role in documentation. Our manager used encouragement technique and introduced quality nursing reports to other nurses. Sometimes, hospital administrators held report writing workshops and reminded us of the importance and the legal consequences of documentation (P. 8).

### 2. Personal and situational characteristics

According to the study participants, nurses and patients' personal characteristics as well as the general atmosphere of CCU can also affect the quality of documentation. Participant 8 referred to nurses' professional characteristics as an important factor behind documentation quality by saying: Differences in nurses' personal characteristics such as knowledge, disciplined practice, conscience, interest, motivation, feeling of responsibility, and self-confidence can affect documentation quality. For instance, more knowledgeable or more accountable nurses usually write more comprehensive reports (P. 15). Other factors behind documentation quality were patients' health status and the severity of their problems. Once there is a critically-ill patient in the unit, all staffs attempt to write more detailed nursing reports to avoid being affected by legal consequences (P. 13).

Another patients' characteristic which can indirectly affect the quality of documentation is their cultural backgrounds which determine their behaviors. In our cultural context, some patients feel ashamed of expressing their chest pain. Therefore, a staff nurse may not notice patient's pain and does not document it (P. 9).

Finally, the general condition of CCU such as heavy workload and greater priority of care procedures may affect the possibility and the quality of documentations. When we have heavy workload due to great number of patients in the unit, we spend our time mainly on providing clinical care and hence, don't devote adequate time to reports writing (P. 4).

## DISCUSSION

The study participants' experiences of documentation fell into three main themes of 'Documentation: an instrument for or a barrier to conscious and safe care', 'Reality-documentation-principles gap', and 'Dynamic management-person interaction and high-quality condition for documentation'. The theme of 'Documentation: an instrument for or a barrier to conscious and safe care' showed that the participants had perceived appropriate documentation as care and peace and found it beneficial. One of the benefits of the documentation of patient assessment data was to become aware of patients' conditions. Moreover, it is an instrument for exchanging information among healthcare professionals, making clinical decisions, and guaranteeing patients, physicians, and nurses' safety. Previous studies also reported the same findings [2, 3]. Irajpour et al. found that taking and documenting patients' past health history at the time of hospital admission help nurses understand patients' background and legally protect patients and nurses [17]. Besides, Kinnunen et al. reported that standardized wound assessment and documentation significantly affect the quality of wound care [18]. Ahmadi, Habibi Koolae also noted that real-time patient assessment and documentation in each working shift help nurses rapidly identify patients' problems, implement appropriate nursing interventions, and prevent cardiac emergencies [19]. Besides, Considine et al. reported nurses' abilities and documentations as significant factors in identifying, interpreting, and managing physiologic health problems and reducing mortality rate [20].

Previous studies showed that nurses' attitudes towards documentation affect its quality. For instance, Okaisu et al. reported that instead of considering it as a necessity for professionalization, nurses referred to documentation as a massive and second-hand task which distanced them from care delivery [13]. Another key finding of the present study was 'Reality-documentation-principles gap'. This finding is somewhat supported by the findings of previous studies. For instance, the results of a systematic review by Wang et al. indicated that despite the importance of documentation quality and attempts to its improvement, documentation is still performed inconsistently, inadequately, and dishonestly because of having limited information and understanding about health, quality of life, and psychosocial, cultural, and spiritual aspects of care. Besides, they found that despite using the nursing process in some studies, nursing diagnoses and interventions were documented inaccurately and items such as pain, cognitive problems, palliative interventions and evaluations, and heart failure assessment, treatment, and prevention were not documented et al. [21]. Gunningberg and Ehrenberg also reported that the documentation of pressure ulcers is not performed completely, adequately, precisely, and based on patients' real conditions [6]. Although nursing is a professional practice which needs precision, consciousness, and a sense of responsibility and it can significantly affect the quality of healthcare services [22].

The findings of the present study also indicated dishonest nursing documentation due to nurses' lack of functional autonomy. The participants highlighted that delegating the authority over managing some kinds of patients' problems to nurses would enhance nurses' honesty in documentation and the quality of their documentations. The prerequisites to this delegation are specialization of nursing, particularly in critical units, recruitment of competent and qualified staffs to nursing, developing more independent job descriptions for critical care nurses, and obtaining permissions from hospital administrators for more independent nursing practice. Toulabi et al. also noted that care quality in CCUs can be improved through providing patient-centered care, delegating some authorities to nurses, and developing protocols for giving more authorities to critical care nurses [23].

Another finding of the study was the documentation of patient education activities irrespective of patients' unique conditions or patient-centered care. In other words, patient education was documented routinely and monotonously without assessing patients' real educational needs. Sultani et al. also reported that the main barriers to patient education were poor planning for patient education, considering patient education as a routine nursing task, nurses' limited access to educational materials, poor managerial supervision and encouragement, low nurse-patient ratio, nurses' inability to provide patient education due to their heavy workload, their indifference toward their educational roles, their inability to communicate with patients, and their inability to develop educational programs. Therefore, patient education by nurses can be promoted through allocating one or two independent nurses to patient education, conducting educational programs and workshops for enhancing nurses' interest and competence in patient education, removing organizational barriers, assessing nurses' ability to perform their educational roles, and providing constructive feedbacks by administrators and managers to nurses to provide patient education [24]. Howse and Bailey also attributed nurses' disinterest in accurate documentation to psychological factors such as nurses' low self-confidence, poor writing skills, and negative attitudes toward documentation[25].

The third main theme of the study was 'Dynamic management-person interaction and high-quality condition for documentation'. This finding reflects the necessary conditions for accurate documentation and shows nursing managers' performance, access to resources, and an appropriate environment for direct care provision as factors affecting documentation. In line with our findings, the results of a study in Thailand on the complexities of nursing documentation also revealed that the main factors behind nurses' poor documentation practice were lack of managerial supervision, limited managerial and organizational support, and healthcare professionals', particularly physicians', indifference towards nursing reports [26]. Our findings also indicated nurses and patients' personal characteristics as well as nurses' lack of motivation for and indifference towards documentation as factors behind low-quality documentation.

One of the study limitations was that it was conducted in a local hospital and hence, the study findings may have limited transferability. It is recommended to explore nurses' experiences of documentation in other clinical settings such as general hospital wards, emergency departments, and intensive care units.

## CONCLUSION

Three main themes were generated in this study, which were 'Nursing documentation: an instrument for or a barrier to conscious and safe care', 'Reality-documentation-principles gap', and 'Dynamic management-person interaction and high-quality condition for documentation'. These findings indicate that for nurses, documentation has a contradictory nature and is perceived differently from 'an instrument for care provision' to 'a barrier to care provision'. However, the gap between realities and documentations diminishes the value of documentations. Managerial supervision and provision of the necessary infrastructures for reality-based documentation can enhance the quality of nursing documentation in CCUs.

### CONFLICT OF INTERESTS

The authors declare no conflicts of interest.

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