ATTITUDES OF REGISTERED NURSES WHO PRACTISE IN ACUTE CARE HOSPITALS IN AN URBAN CENTRE OF MANITOBA TOWARDS WRITING NURSING CARE PLANS

by

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A Thesis
submitted to the
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of the
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Abstract

The purpose of this descriptive correlational study was to describe the attitudes of general duty, registered nurses (RNs) who practise in acute care settings in an urban Manitoban centre toward writing nursing care plans (NCPs) and their self-reported NCP writing/revising behaviour. The relationship between the identified attitudes toward writing NCPs and the self-reported NCP writing/revising behaviours also was examined. It was anticipated that answers to these questions would assist in determining the degree of acceptability of the nursing care plan (NCP) as a communication tool to practising, general duty RNs and its utility to them. As well it would describe whether the RNs reported writing/revising NCPs as prescribed by both professional nursing and hospital accreditation standards.

A modified version of Shea's (1986) conceptual framework was used. A random sample of 350 general duty RNs was surveyed by telephone using a structured interview schedule. The interview schedule was comprised of a Nursing Care Plan Attitude Scale (Oetker Black, Taunton, Thomas & Krampitz, 1989; Thomas, 1984; Yurchuk, 1976); a self-reported NCP Writing/Revising Behaviour questionnaire; a professional and demographic characteristics questionnaire, and a few open-ended questions.

The use of the nursing process, described as the core methodology of nursing practice, and the documentation and use of a NCP for each patient by the professional nurse have

been incorporated into Canadian professional nursing and hospital accreditation standards (Canadian Nurses Association, 1987; Canadian Council on Health Facilities Accreditation, 1992). The literature reveals that historically the ideological and practical uses of both the nursing process and the NCP have been debated and that NCPs are not written consistently. Continuity of individualized nursing care is jeopardized when the RN is required to document and revise planning in a manner which is deemed ineffective by the RN. In addition, requiring the RN to document a plan of care, in a format that is not used by RNs in a clinical area, is an inefficient use of nursing time.

The results indicated that the RNs had positive attitudes towards writing/revising NCPs; however, NCPs were not written/revised for patients on a regular basis. A weak, positive linear relationship existed between the two variables (r = .2334 p =.01). Over 75% of the RNs used NCPs to help them provide patient care. Qualitative analysis revealed themes related to the RNs' thoughts about the NCP; how they used or why they did not use the NCP as a guide; and information desired on a NCP. Based upon these findings implications for nursing practice, education, research, administration and nursing were discussed.

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Chapter 1

INTRODUCTION

Since its introduction in the 1960s, the nursing process has been described as the very core of nursing practice because it was accepted as the methodology for the delivery of individualized nursing care to patients, and was applicable to any nursing situation (Kozier, Erb & Blais, 1992; Oermann, 1991; Shea, 1984b; Yura and Walsh, 1978; 1988. In 1988, Yura and Walsh stated that it was now accepted as the "mode of nursing practice on both the national and international levels" (p.ix). It comprises four or five steps or phases which include (1) assessment, (2) diagnosis, (3) planning, (4) implementation, and (5) evaluation. The four-step description includes diagnosis as the final component of the assessment phase (Kozier et al., 1992; Oermann, 1991). The steps are interrelated, interdependent, and recurrent (Kozier et al., 1992; Kozier, Erb, & Olivieri, 1991; Oermann, 1991; Ziegler, Vaughan-Wrobel, & Erlen, 1986). According to Aspinall and Tanner (1981) "the sequence of steps depicted in the nursing

process reflects the systematic use of problem-solving methods in clinical practice for the purpose of resolving, reducing or preventing health problems, and for promoting the client's adaptation to those problems" (p.1). Tucker (1994) stated that this clinical decision-making framework is the process of nursing care.

The Canadian Nurses Association (CNA) defines nursing as "a dynamic, caring, helping relationship in which the nurse assists the patient to achieve and maintain optimal health" (CNA, 1987,p.iii). The nurse applies nursing and related knowledge to the helping relationship through the use of the nursing process (CNA, 1987). The use of the nursing process is based on the following assumptions: the nursing process is the methodology for providing continuity to individualized nursing care; a written nursing care plan (NCP) is the tangible operationalization of the nursing process; and the use of the nursing process in the practice setting provides a framework for nursing accountability to the patient, to colleagues, to the clinical unit, to administration and to the professional statutory nursing body (Kozier et al., 1992; Shea, 1984b; 1986; Ziegler et al., 1986).

The nursing process has been incorporated into professional nursing associations' standards for practice, education, administration and research (de la Cuesta, 1983). Standard II of the Canadian Nurses Association's Standards

for Nursing Practice was formulated to state that "Nursing practice requires the effective use of the nursing process" (CNA, 1987,p.1). The expansion of Standard II confirms that the registered nurse (RN) is responsible for the communication of the NCP to other nurses and to other health care professionals. The plan for nursing action is based upon identified actual and potential patient problems. These statements imply that a NCP is written for each patient.

The CNA's Nurse Registration/Licensure Examination Committee (1993), in the development of the Blueprint for The Criterion-Referenced Nurse Registration/Licensure Examination, approved a list of 238 competencies which a "beginning nurse is required to possess in order to practice safely and effectively" (p.3). These competencies are to provide the content domain for the examination. Two competencies, labelled very important and important respectively, are that:" the nurse documents the plan of care" (p.24) and "the nurse revises the plan of care as indicated" (p.31) by the evaluation.

As of March, 1994 the Manitoba Association of Registered Nurses' Standards of Nursing Practice: Direct Care Provider state that the RN is to develop a plan of care for each patient and to ensure that the plan is revised. The RN is to plan and provide safe, reasonable care through the use of a problem solving approach (Process Standard I,

MARN, 1994). Prior to the 1994 MARN Standards publication the nursing process was the first of three dimensions upon which the Manitoba Association of Registered Nurses Standards of Nursing Care was based (MARN, 1983). Through the inclusion of the nursing process in the standards it was clearly implied that a NCP would be written for every patient. The 1994 standards do not limit the RN to the use of one problem solving methodology, but do hold the RN responsible and accountable for a plan of care for each patient and the documentation and revision of the plan. The use of the term 'plan of care' rather than NCP also deemphasizes the use of the nursing process as the sole methodology for planning and providing safe, reasonable nursing care. The current study being described was completed prior to the publication of the 1994 Standards and was based upon the 1983 Standards which prescribed the use of the nursing process and the documentation of a NCP for each patient by the professional nurse. Furthermore, a written NCP for each patient is a requirement for hospital accreditation by the Canadian Council on Health Facilities Accreditation (CCHFA, 1992; Shea, 1986) and this plan is to be maintained as a separate document in the patient's clinical record according to CCHFA (1992). This requirement, according to Shea (1986), implies that NCPs "have a basic role to play in the delivery of nursing care" (p.149).

As part of the planning phase of the nursing process the professional nurse, in collaboration with the patient, develops and writes a plan of care based upon the nursing assessment and nursing diagnosis(es) (Kozier et al., 1991; Shea, 1986; Ziegler et al., 1986). The NCP documents nursing's decision making and problem solving processes as well as changes in planning over time (Kozier et al., 1992; McCloskey & Grace, 1990; Shea, 1986). According to Niziolek (1991) it has become "the cornerstone of clinical practice" (p.145).

The format of the prototype written NCP and its storage method may vary from agency to agency. The format usually has categories or columns which denote nursing diagnoses, goals, nursing interventions and outcome or evaluation criteria (Kozier et al., 1992; Oermann, 1991). The NCP may be stored in a central Kardex system, in the patient's chart, in a computer, or in the medical record (Kozier et al., 1992; Oermann, 1991; Ziegler et al., 1986). Regardless of the format or storage system of the NCP, it remains the central source of information about the patient's nursing needs (Oermann, 1991). It contains the details of, and facilitates the organization of, independent and interdependent (or collaborative) meaningful holistic nursing interventions required by the patient (Kozier et al., 1992; Oermann, 1991). Consequently, the written NCP serves as a communication vehicle for nurses in the

direction of individualized nursing care, and aids in the maintenance of continuity in the patient's nursing care (Christensen & Kenny, 1991) because as Christensen and Kenny state "a well-developed plan can prevent the use of time consuming trial and error, avoid duplication of effort, and alleviate costly and timely omissions of care" (p.209). The plan serves as a blueprint for the evaluation of care (Taptich, Iyer & Bernocchi-Losey, 1994). Measurement (evaluation) criteria, the expected outcomes of the specified nursing interventions and hence measures of the quality of the nursing care (Kozier et al., 1992; Oermann, 1991; Shea, 1986) are clearly delineated in the plan. Hodges and Icenhour (1990) claim that evaluation of the process and the outcomes of the nursing care (whether to individuals or to groups) serves to substantiate the effectiveness and to solidify the value of nursing to society. Clearly, a current, well documented, permanent NCP for each patient would assist the nurse researcher in substantiating the effectiveness of nursing interventions. This, in turn, would enhance the profession's ability to demonstrate the impact of nursing interventions on a system wide basis.

Since the introduction of the nursing process and the written NCP into the practice setting, the utility of the written NCP has been diverse and multidimensional. In addition to serving as a communication channel among nurses

to enhance the quality of care and ensure its continuity, the written NCP has served as a guide for: the documentation of patient care; the allocation of nursing resources (staffing and scheduling of nursing care personnel); costing of nursing services through the linkage of patient classification systems with nursing diagnoses and/or independent nursing interventions; the provision of information for accreditation and quality control (Fischbach, 1990; Hinshaw, 1989; Karshmer, 1991; Kozier et al., 1992; McCloskey & Grace, 1990; Oermann, 1991; Shea, 1984a; Sliefert, 1990; Turner, 1991). Clearly, the written NCP is being utilized by nurses and by health care institutions to deal with issues of professional and institutional accountability as well as fiscal responsibility.

In 1987 Henderson stated that the NCP was originally devised as an educational tool and was introduced into the practice arena as a means of demonstrating nursing's autonomous holistic model of care. It was a communication tool which assisted practising nurses to provide continuity to planned, individualized nursing care. Its usefulness in the measurement of the outcomes of nursing care and its effectiveness in the determination of the time required for optimum patient service was and is hailed by nurse educators, nurse administrators, and nurse researchers according to Hodges and Icenhour(1990) and McCloskey and

Grace (1990). McCloskey and Grace (1990) contend that ultimately, the description of these outcomes of nursing care and their cost effectiveness to society will firmly establish the value of nursing's method of clinical service in the health care delivery system of tomorrow. Institutions ought to, and are, linking patient classification systems with nursing care plans (Karshmer, 1991). The NCP is becoming the key 'building block' in patient classification (Karshmer, 1991). In turn, these classification systems are being used to determine nurse staffing needs and to forecast nursing departments' requirements for health care dollars (Hinshaw, 1989; Karshmer, 1991; Shea, 1984b). Additionally, institutions are assuming that the presence of a written NCP is synonymous with the provision of optimal patient care by the nurse (McCloskey & Grace, 1990). Therefore, the written NCP appears to lie at the core of nursing service as well as professional and institutional accountability. The evaluation of nursing care, an ongoing process, determines whether the goals of planned care have been achieved (Kozier et al., 1992). Thus, the measurement of the effectiveness and efficiency of nursing care is closely linked to information documented on the written care plan. McCloskey and Grace (1990) assert that the demonstration of optimal and efficient nursing activity is the newest challenge for nursing. If the written NCP is to serve these identified

needs then it must constitute a current, concise and complete document.

The nursing profession has allocated the responsibility and accountability for writing/revising the NCP to the practising registered nurse (CNA, 1987; MARN, 1987, 1994). The nurse must first write the NCP stating the nursing diagnoses, expected outcomes, and nursing interventions, and then, must utilize the NCP for its identified purposes. The plan is begun following the first contact with the patient and should be readily accessible and kept current (Taptich et al., 1994). Sovie (1989) emphatically wrote that if this does not happen, requiring a written NCP for each patient is a ritual which must cease. The utility of the NCP, as the operationalization of the methodology of nursing, as well as the professional and accreditation standards which require a written NCP as evidence of delivery of high quality nursing care, require scrutiny.

Statement of the Problem

The literature review supports the finding that despite seemingly positive attitudes towards the nursing process, nurses either write incomplete NCPs or fail to write and employ NCPs to organize care (Kerfoot, 1990; Moss,1988; Nolan & Burgoyne, 1990; Shea, 1986; Sovie, 1989; Turner,

1991). According to Brider (1991), McCloskey and Grace (1990), McHugh (1991), and Sovie (1989) more time is spent today trying to get nurses to write or complete care plans and problem lists in order to comply with hospital accreditation requirements and nursing standards than any other activity. Yet, the nursing process and NCP have been accepted, by nursing, as a means of demonstrating nursing's unique role in today's dynamic health care delivery system in addition to being a systematic approach to nursing care. If practising nurses do not totally subscribe to this systematic approach and do not write or revise NCPs for every patient, the nursing process and NCP will serve as vehicles by which nursing can achieve these objectives.

Nursing care plans are written by staff nurses only about 50 percent or less of the time, and of those written, only about 50 percent are actually used by nurses in to help provide care (Shea, 1984b, 1986). Shea (1984b; 1986) also noted that the number of NCPs written increases at audit time. Anecdotal evidence from acute care nurses employed in Manitoba indicates that written NCPs are incomplete, often not current and are frequently perceived as not being important. As recently as 1991, Turner (1991) pointed out that this NCP writing problem will not go away. In a spot-check for written NCPs on patients' charts (N=21) Turner (1991) found that "only 16 (76 percent) had a NCP and only 9 (43 percent) had care plans that used nursing diagnoses"

(p.240). Turner (1991) contended that this lack of written NCPs jeopardizes the hospital's accreditation standing, makes the quality of nursing care questionable, and severely weakens nursing administration's information system foundation. Furthermore, it has been suggested (Koch, 1992; Shea, 1984a) that practising registered nurses do not value the NCP as a necessary tool for the provision of quality nursing care but view it an as administrative tool.

Without a written or current plan of care, the plan cannot be clearly and purposively communicated to all other nurses and health team members, therefore resulting in the compromise of continuity of planned nursing care. In addition, incomplete, outdated, or unwritten plans have the potential for camouflaging the value of nursing's contribution to the promotion of health for Canadians. As well, intended outcomes of the nursing process for the patient, nurse, administration, clinical unit and for nursing as a whole may or may not be realized. Shea (1984a; 1984b) and Turner (1991) alleged that if not documented, these outcomes cannot be purposefully validated. Therefore, in order to enhance and maximize the utility of the NCP as the operationalization of nursing's methodology, the NCP must be scrutinized. The utility of the NCP to the patient, the care giver and the institution must be clearly evident.

According to Brider (1991) and McHugh (1991) evidence of the NCP's usefulness to the nursing practitioner as a

mode of planning and communicating the developed nursing strategies to provide individualized care is limited. If this is so, then one must question why the care plan remains a component of professional and accreditation standards. One must also question how nurses do communicate with each other in order to promote the continuity of individualized care. It may be that nurses are using tools other than the NCP which are serving the purposes for which the NCP was intended.

Appropriate standards or interpretation of the standards must be established so that the nurse is able to provide nursing care based on each patient's needs unencumbered by tools that are ineffective and inefficient. Kerfoot (1991) stated that a major source of dissatisfaction for nurses was bureaucratic regulations that "do not appear from the nurse's perspective to guarantee quality" (p.275). Institutional accrediting standards need to be melded with a nursing system so that the whole makes sense to the nurses, facilitates patient care, and is valued by the institution (Kerfoot, 1990). Nurses need to be key players in the development of these standards.

Clearly, a thorough evaluation of the written NCP is timely. A positive evaluation of a health care innovation/ service/technology requires that the innovation is efficacious, effective and efficient (Tugwell, Bennett, Feeny, Guyatt & Haynes, 1986). Efficacy requires that the

innovation work (Drummond, Stoddart, & Torrance, 1989). Effectiveness mandates the acceptance of the innovation by the parties who will use it, and to whom it will be offered, as well as its practical utility (Drummond, Stoddart & Torrance, 1989). To date, there is a paucity of research regarding the acceptance of the NCP as the operationalization of nursing's methodology or of the NCP writing/revising behaviour of the registered nurse (Shea, 1984b). The lack of consensus between the practising nurse's NCP writing behaviours and nursing practice and administrative standards which require a written NCP for each patient as evidence of the operationalization of the nursing process caused questions to be asked. What are Manitoba nurses' attitudes towards writing/revising NCPs? What are their NCP writing/revising behaviours? What is the relationship between the nurses' attitudes towards NCPs and their NCP writing/revising behaviours?

Purpose of Study

The purpose of this descriptive correlational study was to identify practising, general duty, registered nurses' attitudes towards writing nursing care plans and to describe their self-reported NCP writing/revising behaviours. It was anticipated that answers to these questions would delineate

whether nurses accept the NCP as a useful communication tool and whether nurses write/revise NCPs as prescribed by both professional nursing and hospital accreditation standards.

A further purpose of this study was to determine the relationship or correlation between the two variables. A weak positive or negative correlation between the attitude of nurses towards writing/revising NCPs and NCP writing behaviour would suggest that other variables, for example, in the nurses' work environment or associated with the NCP system, were impacting upon the NCP writing/revising behaviour of nurses. These, in turn, could be studied so as to effect changes that would facilitate the writing/revising of NCPs by nurses.

The description of nurse attitudes, self-reported NCP writing/revising behaviour and the correlation between these variables would facilitate the identification of desired changes required by nursing administration, educators, and clinicians in order to optimize the utility and efficiency of the written NCP. It was possible that this study would also indicate that the written NCP, as currently formatted, was not written and was not a valued adjunct by the practising nurse to the provision of nursing care. The standards may be inefficient and they may not guarantee high quality nursing care. The standards might need revision in order to reflect the current reality of acute care nursing. Further research would be required to determine how nurses