A Genre Analysis of Patient Notes and Documentation Practices in the ICU

ALEXUS FORSHEE
Produced in Lissa Pompos Mansfield's Fall 2018 ENC 1102

Introduction

Day after day, my mother would come home after a twelve-hour shift and begin to unload her pockets on her scrubs. In her pockets were crumpled papers, gloves with writing on them, and napkins (Figure 1). I asked my mother what all of this stuff was and she told me that they were her notes. This confused and baffled me that nurses do not take structured and organized notes. My mother told me that there is not enough time to ensure that every note is in a nice format and on a clean sheet of paper in the ICU setting. This instigated my research because I felt that there should be an easier and better way for nurses to document about their patients.

Figure 1: The images that are provided show the manner in which nurses in the ICU of Southeastern Medical Center currently document their notes in the fast paced environment of this unit. The images include a sheet of copy paper, a paper towel, and a glove.

The Activity System of Nursing Documentation

The nurses of Southeastern Medical Center[1] are considered an activity system because there is a motive, subjects, a community, tools, rules, and a division of labor that all come together around a central goal. An activity system is a group that works together over time to come to a specific goal (Kain and Wardle 398). One of the main literate activities that nurses encounter throughout their

[1] Names have been changed to protect the confidentiality of research participants.

day is taking notes about their patients. They must record all of their patients' data, and they must be able to relay this information to the doctor when prompted to.

The motive of this literate activity is to ensure the safety and wellbeing of their patients. The intended outcome of this activity is to tailor the treatment plan to each patient. The community that engages in this activity is all registered nurses, but more specifically the nurses on the ICU unit at Southeastern Medical Center. These nurses must make sure they keep very detailed notes on their patients because the patients are so ill. The subjects of this literate activity are the nurses who write the notes and doctors that read the notes about the patients. Nurses use a variety of tools for this activity like computers, hand written notes, and verbal communication between the nurses to the doctors. These notes and conversations must be very professional and accurate for the safety of the patients. The members of this group must follow very strict rules when writing or reading the patient notes or the patient's chart, and they must ensure that all information is written correctly and in the right unit. For example, if a patient is supposed to receive 300 mg of a medication but the note says "3000 mg," this can be detrimental to the patient. The nurse must also write legibly to be sure that any doctor or nurse can read the patient note and understand the care plan. The patient notes are the nurse's personal chart about the patient, and they use this information to input data into the computer chart. Within the group of nurses, there is a Nurse Manager, a Charge Nurse, and floor nurses. The Nurse Manager is in charge of the entire floor of nurses all of the time. The charge nurse is a nurse that has more authority than the average floor nurse, and their job is to help floor nurses if they are extremely busy. On an ICU floor, the floor nurses typically only have 1-2 patients because the patients require very detailed care from the nurses. This hierarchy ensures that the entire floor works as a unit to care for the patients. Figure 2 is a visual breakdown of the different aspects of the activity system on the ICU unit of Southeastern Medical Center.

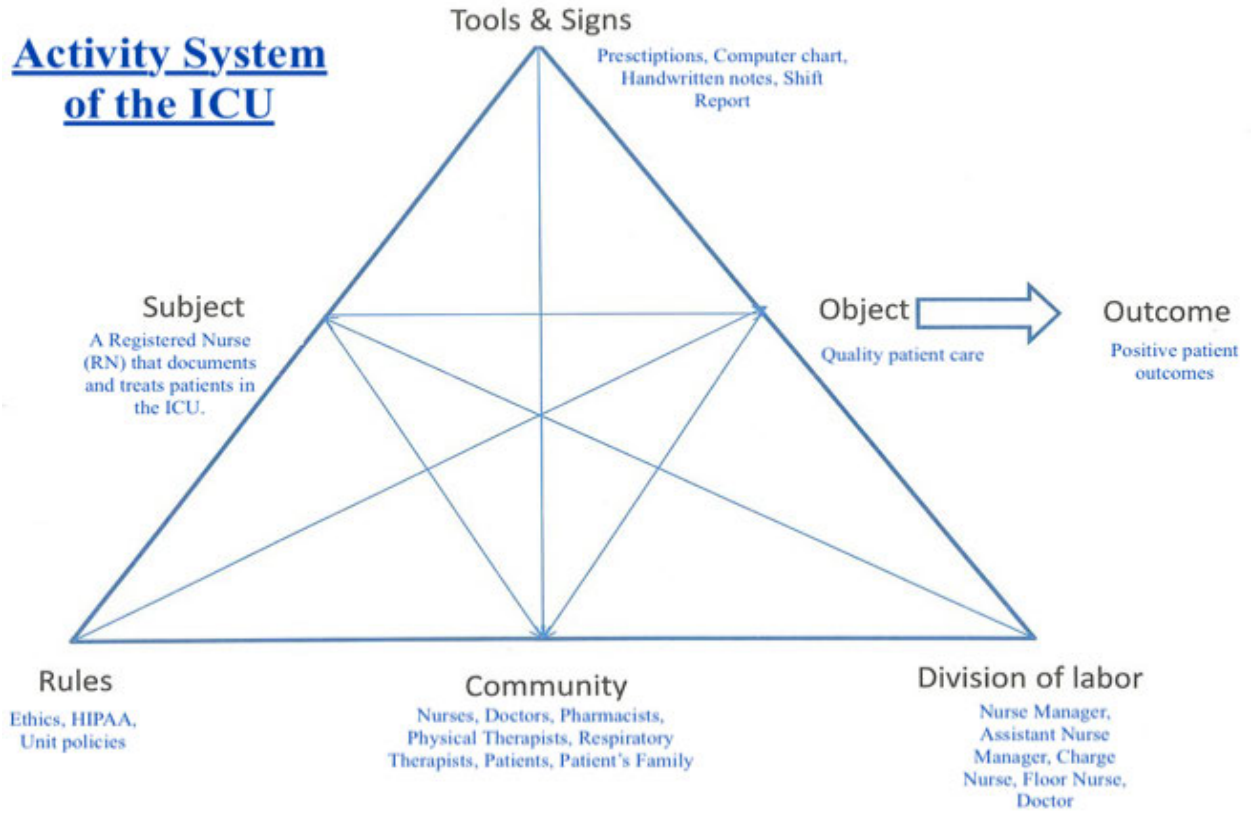

Figure 2: This diagram shows every aspect of the ICU unit, and it shows how these individual pieces are interconnected in the big picture.

Tools Used in the Documentation Activity

The nurses use many genres such as notes, charts, and reporting. The nurses use note-taking to quickly jot down the patient's information while doing rounds, and this information must be concise, correct, and legible. The nurses are very busy and use notes to save time while doing rounds on patients, and they transfer the informal notes into the official patient chart. The charts have to be completely accurate because the doctors use them to make decisions about the patients' medications and treatment plans. The charts are online and can be seen by all of the nurses and doctors. Nurses give reports to the oncoming duty nurse, and this time is vital because this is when the oncoming shift nurse gets the pertinent information about the patient from the last twelve hours. By relaying information, the nurses are able to discuss the possible treatment plans for that specific patient. The charts on the computer are on a server so that any doctor in the system of Southeastern Medical Center can see all of the official documentations and treatment plans for that specific patient. The nurses must input documentation about the patients' blood pressures, temperatures, test results, medications, wounds, and new orders for procedures or treatment plans. The nurses record this documentation throughout the day on their chosen tool, such as a napkin, a sheet of copy paper, or gloves. The nurses typically use whatever item is handy at the moment that they need it.

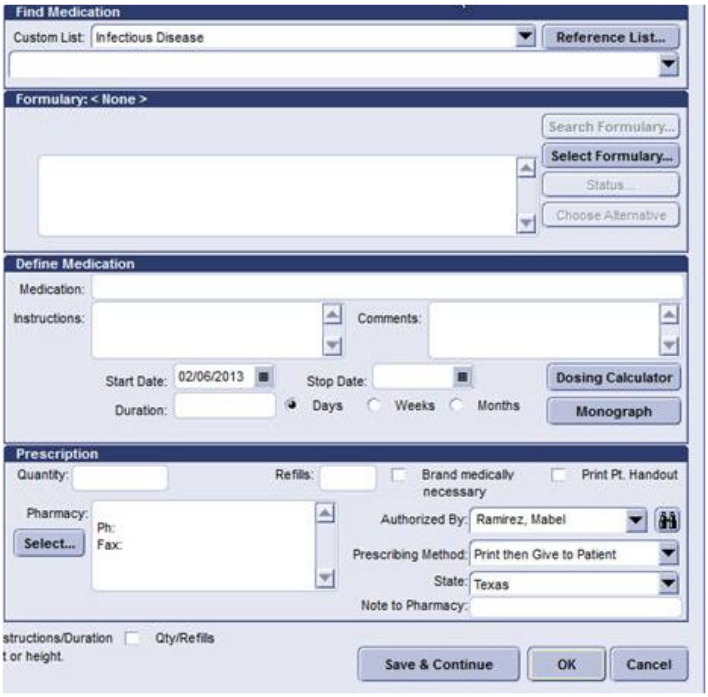

Figure 3: This image is an example of a blank Cerner PowerChart file on a patient. There are several tabs on the chart, but this image shows the medication list for a patient. The nurse would input the medication dosages and the time that they received that medication during the shift that they worked. It is imperative that the nurse includes the correct dosages and time that it was last taken because other nurses use this documentation on their shift to determine the correct time to administer the medication again.

Genre Sets of the ICU

A genre set is a selection of texts that are used by a group of people to achieve a common goal (Bazerman). This genre set is very important in the overall goal of treating the patient. By monitoring the patient's daily changes, a plan is being made and implemented in their care. The genre set of the nurses and the genre set of the doctors are reliant upon each other to get the job

done. Without the nurses' notes or charting, the doctor would not be prepared to speak with the patient and make a plan of action for the patient when they do rounds. If the nurses did not give a shift report to the other nurses, then the oncoming nurses would be clueless about the patient and what has happened with their case over the previous twelve hours. The doctors and nurses must communicate and bounce ideas off of each other to achieve their goal of treating the patient. Without the doctors and nurses working together, the patient would not receive adequate care and could possibly be put in harm's way by incorrect prescriptions and unnecessary procedures.

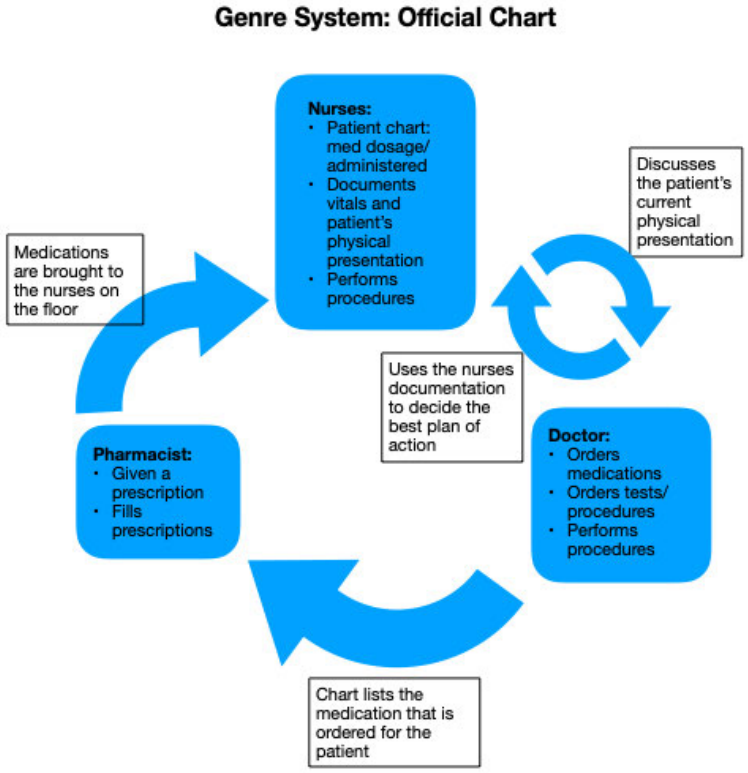

Figure 4: This diagram exemplifies the concept of the ICU unit as being a genre system. This diagram breaks down the various ways in which the official computer chart is used by several medical professionals for a single patient.

My mother is a nurse on the ICU floor of Southeastern Medical Center, and she has spoken to me about many different aspects of nursing from written notes, shift reports, and major rounds with the doctors. She has come home carrying napkins with writing all over them, front and back, and she explained that she was busy that day and could only find napkins to take her notes on. She would not save these notes; she would always shred them after each day that she brought them home to ensure the confidentiality of the patient.

Literature Review

The documentation that nurses take about their patients is one of the most important aspects of their job. Many different research studies have been conducted to understand the magnitude and importance that note-taking has on the outcome and overall well-being of the

patients. Research in an ICU on the sentiments that are included in the nurse's patient notes has correlated to the thirty-day mortality or survival rate of their patients. The nurses who documented more sentiments within their notes had better patient outcomes than the nurses who had fewer sentiments (Waudby et al.). Another research study in Ethiopia concluded that the amount of documentation that the nurses had led to better patient outcomes overall; nurses that had an excess amount of patient notes tended to have better patient outcomes (Kebede et al.). A study concluded that how the notes are written and communicated to the doctor was an important aspect of the nurse's job; if the notes cannot be read and understood, then they are not effectively doing their job (Doncliff). All of these articles focus on good documentation, legibility of the notes, and caring for the patient. These research studies align on the fact that nursing documentation on the patients are important regarding the outcome of the patient since the notes are a key part of the patient care plan and medication distribution.

While previous research has shown that the quality of nursing notes is important for the safety and well-being of the patients, more research needs to be done regarding the manner in which the nurses document the patients. We know that taking accurate and legible notes is necessary, but there needs to be more research about a different way to take the notes. The current manner in which notes are taken at Southeastern Medical Center is haphazard and rushed, so there should be a solution to the issue at hand. I saw a need for this research after witnessing my mother's notes when she came home from work. The notes would be written on napkins, scratch paper, and sometimes gloves. Although the notes may be understood by specific nurses, the notes should be written in a place and manner where any nurse can find and understand the information within a matter of seconds. Throughout this research project, I will focus on these questions: "How do nurses in the ICU Unit of Southeastern Medical Center currently take notes on their patients? What genre conventions are they following? How do they translate or repurpose these notes for other audiences? Is there a more efficient or useful process they could use instead?"

To answer the questions that I posed, I conducted interviews with some of the current nurses in the ICU unit of Southeastern Medical Center, and I conducted a genre analysis of the nursing notes in order to get a deeper understanding of the notes, what they included, and how the notes are currently taken. The interviews gave me insight about the environment that the nurses work in and how they feel about the manner in which they currently take notes. This information allowed me to further my investigation to see if there is a more efficient way for the nurses to take their patient notes.

Methods

I found my secondary sources by using the online library database that is provided by the University of Central Florida. To find sources that were related to my study I used search terms such as "patient notes", "nursing notes", and "nursing documentation". These search terms provided an abundance of research regarding the importance of nursing documentation in relation to the outcomes of their patients, and it even detailed the most important aspects of how nurses write their notes. I chose three of the most pertinent sources to include in my Literature Review. I chose one source that detailed how nurses should take notes to ensure that they are able to be read and understood by everyone who reads them, and I chose two research studies that were conducted to determine how different aspects of the nurse's notes can affect the patient. To analyze these sources, I used the Kain and Wardle frame because it helped me to analyze the data and break it into separate sections, such as the motives/objectives, tools, rules, etc. This particular frame allows for me to pay attention to every aspect of the source that I analyzed. This framing concept affected the things that I investigated because it allowed me to draw conclusions based on how the nursing documentation is related to the system within the ICU unit.

To collect the data that I needed, I conducted interviews and a genre analysis of patient notes. The genre analysis was from patient notes that I was given for my research by my mother from one of her workdays. The identities of the patients were kept confidential because the patient names were marked out on one sheet of the notes, and the other notes referred to the patients by their room numbers. I analyzed these notes by coding them into different sections that were representative of the data. By coding the data, I was able to see similarities between the notes of different patients. I chose to complete a genre analysis of the notes because I felt that this would give me the most information regarding them.

Before conducting my interviews, I created a list of interview questions that I felt would give me the most comprehensive answers from my interviewees. The interviews for my primary sources were conducted in order to gain insight on how the actual nurse feels about the documentation practices. The interviews of these nurses allowed for me to see that the nurses also see a need for change within the ICU unit's method of note taking. I was able to obtain consent for these interviews by having both interviewees complete an "Informed Consent Form" prior to being interviewed. I chose to complete the interview in person because I felt that I would be able to gain more information from them, rather than an email interview where their responses could potentially be shorter and less detailed.

Findings and Analysis

The most important conclusion that I can draw from my data is that the nurses see a "need" for change within the practice and manner of taking patient notes. Another conclusion that I was able to draw was that the patient notes had similar trends in what they contained. Since the notes had a trend in what they contained, a worksheet with these main topics could drastically improve the manner in which patient notes are taken within the hospital setting. The framing concept that I used throughout my research project was the Kain and Wardle frame, which focuses on a group as an activity system. By referring to my group as an activity system, I was able to look at the different aspects that make up the group and study the different areas such as the subjects, tools, and rules within the community. Throughout this research project, I focused on these questions: "How do nurses in the ICU Unit of Southeastern Medical Center currently take patient notes? What genre conventions are they following? How do they translate or repurpose these notes for other audiences? Is there a more efficient or useful process they could use instead?"

Note-Taking Methods/Practices

The nurses on the ICU unit of Southeastern Medical Center currently take notes in a rushed and haphazard manner. Figure 1 clearly shows this practice; nurses take notes on napkins, gloves, and copy paper. One nurse stated, "I feel like we have no time to take proper notes; we are always rushing to the next patient," (Jones). The notes all contain the same information: medications, dosages, procedures, lab results, and an identifying number (such as the patient's room number). The genre conventions these notes follow are that they are informal, and they often use shorthand. Some nurses spend as little time as possible on these notes, which is why there are spelling errors. "As long as we can read and understand what we wrote, then it is fine," one of the interviewees said (Williams). The patient documentation follows the rules that the hospital follows, such as using military time and milligrams for dosages. This ensures that there are no errors when translating the patient notes into the official computer chart.

The images of the nursing documentation (Figure 1) show how the current practice of note taking is occurring. The notes are not organized in any particular way, they contain pertinent information to the patient's care, and they are taken on random pieces of papers or gloves.

Features of the Patient Note Genre

The patient notes are required to contain information regarding the patient's treatment. The organization and content of the notes are solely up to the nurses, but many choose to follow a similar layout. Many nurses group the patient's medications in one area of the note, test results in another area, and the plan of action in a separate area. This ensures that the nurse does not mix up test results, medications, or procedures between different patients. The actual aesthetics of the notes are completely the nurse's choice. The notes can be in sparkly pink pen or in black sharpie; it depends on the nurse and the circumstances surrounding the notes. For example, if a patient is coding, a nurse is not going to take extra time to write pretty notes; they would quickly jot down their notes and continue to help with the patient.

Repurposing Notes

The nurses translate these notes for different audiences by taking their handwritten patient notes and relaying this information into the online computer chart. Any doctor, nurse, or pharmacist within the Southeastern Medical Center's servers can access these online charts. Doctors use the online charts frequently to determine the plan of action for the patient's procedures and medication changes. The computer charts must be completely accurate at all times to ensure that the patient does not receive an operation or medication that they do not need. "I always triple check what I am putting into the computer chart because that is the most important information; sometimes the computer chart is the only thing the doctor will look at when making a decision about the patient's treatment" (Jones). These computer charts also contain information regarding the patient's religion and allergies, which may affect what the patient can receive as far as medications or potential treatments for their ailments.

Suggestions for the Revision of the Genre

From all of the research that I conducted, I am able to conclude that there needs to be a new manner in which nurses take patient notes. A new process such as an outlined worksheet could be more useful and efficient for the nurses. Figure 4 is a mock worksheet that was created using Microsoft Excel, and it includes the different categories that were found to be the most used by the nurses. The nurses do not have a lot of time to spend writing notes, so if they had a sheet that already had most of the general topics that they would need to write about, then it would take even less time to write their patient notes. When interviewing the nurses, they both agreed that a worksheet could be a solution to the problem at hand. However, one nurse stated, "I feel like if there's a worksheet to fill out, then people won't fill in any extra information," (Williams). The only way to determine if a worksheet will solve the issue at hand is to implement the practice and observe if it will help the process of documentation within the nursing field.

Nursing Documentation

Patient Name	Patient Room #	Date		Patient ID label
Medications	**Medication Name**	**Dosage**	**Time Administered**	**Next Dosage Time**
	Medication #1	0 mg	12:00	12:00
	Medication #2	0 mg	12:00	12:00
	Medication #3	0 mg	12:00	12:00
Patient Stats	**Vitals**	**Blood Glucose**	**Pain Level**	**Level of Arousal**
	###/###	###	#/10	Awake
	###/###	###	#/10	Asleep
	###/###	###	#/10	Non Responsive
Procedures	**Procedure Type**	**Ordered by who?**	**Date of Procedure**	**Time of Procedure**
	Procedure #1	Dr. Doe	1/1/19	12:00
	Procedure #2	Dr. Doe	1/1/19	12:00
	Procedure #3	Dr. Doe	1/1/19	12:00
Results	**Test Type**	**Results**	**Report to who?**	**Comments**
	Test #1	Positive/Negative	Dr. Doe	
	Test #2	Positive/Negative	Dr. Doe	
	Test #3	Positive/Negative	Dr. Doe	
Other				

Figure 4: This graphic is an example of a worksheet that could be used by the nurses to record their documentation in an organized manner. This document could make the task of taking patient notes simpler and more efficient.

Discussion

While nurses may not initially care about changing their habits of note taking, they should because their notes are directly linked with the treatment and outcomes of their patients. The activity of note-taking impacts the patients because the quality of the nurse's documentation is linked with the quality and accuracy of care that they receive from the doctors and nurses. This research is needed because it can help us to better understand how the documentation from the nurses can be detrimental to the patient if certain things are not documented correctly. Readers can use this information to discuss and implement a new format of nursing documentation that will enable the nurses to write detailed, accurate notes while also being quick and efficient. My research can be used to implement a new and different way of taking patient notes within the ICU unit of a hospital; the new manner of note taking could be in the form of a worksheet to make it easier and streamlined for all of the nurses on the unit. The stakeholders of my research project are the nurses and the patients. Both of these groups' lives can change because this research will help to ensure that both are informed on how the documentation is necessary and important. The research that has been conducted has challenged nurses to reconsider the manner in which they document patient notes, and this research also may need additional research for other units of Southeastern Medical Center or other hospitals to see if the same issue is occurring there.

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