Commentary

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Narrative Nursing Notes for Cardiac-Surgery Patients

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Description

The rise of Evidence-Base Practice (EBP) as a standard for care delivery is rapidly emerging as a global phenomenon that is transcending political, economic and geographic boundaries. Evidence-Based Nursing (EBN) addresses the growing body of nursing knowledge supported by different levels of evidence for best practices in nursing care. Across all health care, including nursing, we face the challenge of how to most effectively close the gap between what is known and what is practiced. There is extensive literature on the barriers and difficulties of translating research findings into practical application. While the literature refers to this challenge as the “Bench to Bedside” lag, this paper presents three collaborative strategies that aim to minimize this gap. The Bedside strategy proposes to use the data generated from care delivery and captured in the massive data repositories of Electronic Health Record (EHR) systems as empirical evidence that can be analysed to discover and then inform best practice. In the Classroom strategy, we present a description for how evidence-based nursing knowledge is taught in a baccalaureate nursing program. And finally, the Bench strategy describes applied informatics in converting paper-based EBN protocols into the workflow of clinical information systems. Protocols are translated into reference and executable knowledge with the goal of placing the latest scientific knowledge at the fingertips of front line clinicians. In all three strategies, Information Technology (IT) is presented as the underlying tool that makes this rapid translation of nursing knowledge into practice and education feasible.

Evidence-Base Practice

This study analyzed what nurses wrote in narrative nursing notes for cardiac-surgery patients. The nursing notes of 46 patients were analyzed based on the nursing process. Eight patterns were extracted according to different combinations of nursing process components, of which an assessment alone was the most frequent nursing phrase (45.8%), followed by assessment or diagnosis-intervention-outcome (25.9%). The content of the nursing notes was also classified into 15 categories, of which nursing outcomes were recorded more frequently in nursing care driven mainly by physician's order such as disease-related symptom management, insomnia care, respiratory care, and pain control, than in independent nursing care such as education and emotional care. A survey on the attitudes of nurses toward the nursing record revealed that they do not document nursing outcomes as much as they think they do. The main reasons for this discrepancy were insufficient time for recording and lack of knowledge about why, how, and what to evaluate. Even though there is room for improvement, nursing notes represent a useful resource for determining nursing contributions to patient outcomes.

The continuing increase in demands for health services and the associated healthcare costs have led both healthcare professionals and consumers to focus on the outcomes such as the effectiveness and efficiency of healthcare. At the same time, as evidence-based practice is emerging as an important method for clinical decision making, healthcare providers are required to demonstrate that their services are effective both clinically and financially.

The effectiveness and efficiency of nursing can be evaluated by assessing how patient outcomes are affected by Nursing Practice. Patient outcomes refer to observable and measurable changes in the health status or behaviors of patients as a result of nursing actions. Interest in nursing sensitive outcomes was stimulated by nurses’ beginning to assert them as an autonomous profession rather than having a subservient relationship to physicians. By demonstrating that nurses contribute positively to patient outcomes, a nursing component of care can be identified, a body of knowledge unique to nursing can be accumulated, and the foundation of their professional status can be developed.

It is difficult to quantify nursing unless a nursing activity, its rationale, and its outcome are recorded in letters or numbers, because nursing is a profession involving practice. Although nursing undoubtedly contributes to the curing of diseases and recovery of health, the effect of nursing cannot be proven unless it is documented. Thus, the nursing record can represent a significant body of evidence supporting the effectiveness of nursing care.

The nursing record contains various kinds of information acquired during the nursing process, including the condition of a patient, care that nurses provide, and the response of a patient to that care. The record is an important instrument with several purposes: to ensure continuity in patient care, as a tool for healthcare professionals, as a source of information for the

patient, for quality assurance, for self-evaluation, for audits of performance, for legal aspects, and for research. The importance of the nursing record has recently increased as more focus has been placed on patient outcomes in monitoring the quality of health care services.

However, studies in other countries have revealed that the nursing record is often unreliable and inaccurate, and have shown that nursing documentation does not always reflect the actual work of nurses and the effectiveness of nursing. Also in Korea, the nursing care provided is often not documented or the content of documentation is poor due to a lack of time, memory limitations, or nurses not being familiar with documenting in accordance with the nursing process. This leads to the nursing record exhibiting poor reliability and quality.