# Standardizing the Words Nurses Use to Document Elements of Perinatal Failure to Rescue

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## ABSTRACT

**Objective:** To reach consensus for words used by nurses to document elements of a perinatal failure to rescue process measurement tool.

**Design:** Exploratory study with mixed methods.

**Setting:** Virtual. Participants were recruited through an online perinatal nursing discussion list and completed Internet-based electronic surveys.

**Participants:** Twenty-nine (29) labor and delivery nurses with at least 5 years of bedside nursing experience and additional expertise in fetal heart monitoring.

**Methods:** Modified Delphi study with three rounds. Qualitative methods were used to analyze study results for round one. Rounds 2 and 3 were analyzed quantitatively with a desired level of consensus of 75%.

**Results:** Twenty-seven of 29 participants completed all three study rounds. Seventy-six distinct data elements related to careful monitoring, timely identification of problems, appropriate intervention, and activation of a team response were defined by consensus. Because classification of maternal and fetal risk determines assessment frequency in labor, specific criteria for classifying a woman or fetus as high risk or low risk were included in the definitions for which participants reached consensus.

**Conclusion:** Achieving consensus about the actual words used to document perinatal nursing elements provides the foundation for incorporating paper-based process measurement tools, such as perinatal failure to rescue (P-FTR) into electronic documentation systems. Standardizing the words perinatal nurses use in documentation facilitates data retrieval and analysis and increases the usefulness of process measurement tools such as perinatal failure to rescue. Further, building process measurement tools into electronic systems may facilitate real-time rather than retrospective recognition of process deficiencies and improve perinatal outcomes.

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Note Figure 1 (tool) to be
published online only.

Perinatal nurses interact with data every day, and with more health care organizations and perinatal care providers implementing electronic health record systems, the amount of data entering these systems is staggering. The national focus on health care quality and patient safety, the ability to correlate perinatal nursing care to maternal and infant outcomes, and reporting requirements related to perinatal specific core quality measures suggested by the Joint Commission (2013) all require data. Across nursing specialties, specific quality indicators such as patient falls and pressure ulcers are categorized as "nurse-sensitive" meaning they may be influenced by nursing care. In labor, the perinatal nurse must properly assess maternal and fetal status, identify potential prob-lems, and appropriately intervene meaning patient outcomes for mother and infant are sensitive to perinatal nursing care. Analyzing the data captured and recorded by perinatal nurses and the rest of the care team during labor and delivery may help to demonstrate appropriateness of care or identify process deficiencies that need correction. However, the task of retrieving perinatal data, translating those data into meaningful information, and generating knowledge from that information is cumbersome and resource intensive.

Because more hospitals and health systems have implemented electronic documentation systems, there has been an increase in the capture of dis-creet data elements with the use of options such

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as predefined checklists and drop-down boxes. These discreet data fields may be used to collect data in a particular way for one unit, to capture the same data another way across health care systems, or even to capture data differently among separate units in the same system. An example of discreet data variability would be a data selection option for the perinatal nurse to document heavy bleeding. In another system, a perinatal nurse might have the choice to document bleeding with a second data field for heavy. Even with increased discreet data capture, much of perinatal nursing care is still captured on paper in narrative notes or into free text fields in electronic systems, a practice that makes data difficult to retrieve, contributes to data variability, and inhibits the ability of electronic systems to exchange information. All these factors support the need for retrievable, standardized perinatal data along with useful tools that assess clinical processes to quantify perinatal safety and quality outcomes.

An example of a process assessment tool for perinatal nursing is Simpson's (2005) paper-based perinatal failure-to-rescue (P-FTR) process measurement instrument. This validated perinatal nursing process measurement tool is endorsed by the Agency for Healthcare Research and Quality (AHRQ) (Simpson, 2006). The tool was created to retrospectively assess perinatal medical records to determine (a) if mother and fetus were appropriately monitored during labor, (b) if the correct nursing interventions occurred based on monitoring findings, and (c) in the case of nonreassuring fetal or maternal status, if the appropriate team was mobilized to accomplish either a timely cesarean birth or the timely transfer of mother and/or infant to a higher level of care (the tool is available online as Figure S1). In a validation study for P-FTR, Beaulieu (2009) reviewed the records of more than 50 women who underwent cesarean births because of nonreassuring fetal status. Beaulieu's findings supported using P-FTR as a process measurement instrument, but she noted significant difficulty locating the data elements in the medical record. Either important documentation was missing all together, or data elements were documented in a nonstandard way, making it difficult to correlate the elements of the medical record with P-FTR processes (Beaulieu, 2009). In-

corporating data elements from tools such as P-FTR into an electronic system may make it possible for the tool's data elements to be reliably and consistently retrieved and allow P-FTR to be used at the point of care to help guide perinatal nursing care decisions in real time. However, the first step in moving P-FTR or any paper-based tool into an electronic system is to decrease the data variability by standardizing the definitions (values) for P-FTR data elements.

Data standardization is a necessary step for meaningful data retrieval and data exchange. When perinatal electronic documentation systems were first introduced, standardized data were often overlooked in favor of customizable systems that could be adapted to an individual agency. Today, for any information system vendor to meet certification criteria as part of the meaningful use of health information technology (HIT), interoperability and the use of data standards must be considered (Department of Health and Human Services, 2012).

In terms of nursing visibility, when a nursing term is standardized, it can be assigned a code. Once coded, the term can be measured. Physicians and other care providers have been documenting medical diagnoses and corresponding treatment in a coded format since the late 1800s, when the International Statistical Classification of Diseases and Related Health Problems (ICD) began (Clark & Phil, 1999). The latest version of ICD (ICD-10) is being prepared for widespread implementation and consists of codes that are internationally recognized. The data elements for perinatal core measures, for example, are currently retrieved using ICD coded records. Similarly, coded nursing specific standard languages exist, such as the North American Nursing Diagnosis (NANDA) nomenclature, Nursing Intervention Classification (NIC), and Nursing Outcomes Classification (NOC).

Unlike ICD, none of the standard nursing terminologies has been widely implemented, perhaps because ICD is tied directly to billing and reimbursement, and nursing care has never been billed for or reimbursed in the same manner. Standard nursing languages are developed by consultation with expert sources, such as professional nursing organizations, and they incorporate the latest evidence, so using them increases the likelihood of adherence to practice standards (Rutherford, 2008). In all, the American Nurses Association (ANA; 2006) has approved 12 standard