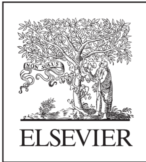

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Nursing documentation: How meaning is obscured by fragmentary language

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ABSTRACT

This article looks at the effect of using fragmentary language in nursing documentation. Fragmentary language is defined as phrases and abbreviations found in records of nursing care that are understood at the local ward level but would make it difficult for anyone reading the documentation beyond this local level to construct meaning. Sixty-seven entries of nursing documentation were investigated using textual analysis. Each entry was examined to determine how grammatical and linguistic features of the text could impede meaning. Three entries are discussed in detail to demonstrate possible difficulty for readers in understanding the patient's condition and care. Education programs that encourage nurses to view their documentation as a crucial aspect of care are recommended. Writing nursing documentation in a manner that allows readers from both within and outside the profession to understand the patient's condition and care required is supported. If readers cannot understand what is written in nursing documentation, there is a danger that misinterpretations could lead to clinical errors and adverse events.

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The nurse's documentation of a patient's condition and the outcome of care in the healthcare record are crucial to quality health provision.[1-3] If these aspects of care are recorded, nursing documentation ensures vital information about the patient is communicated to all members of the health care team[4-6]; provides evidence of the care delivered in the legal setting; builds a database of nursing knowledge that can be used for research and quality assurance purposes; and justifies the cost of nursing in the health care system.[7] With all these functions in mind, nursing documentation can be seen as an opportunity for nurses to showcase what they actually do for the patient.[8] Furthermore, nursing documentation is an essential component of patient safety if it presents patient information in a "clear, reliable and accurate"

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manner.[9] However, if nursing documentation is to showcase nursing and increase patient safety, the documentation must be written so that it is meaningful to all readers. This includes readers from within and outside the profession.

Nursing is described as an oral culture because nurses have a preference to transfer patient information orally rather than in a written form.[10,11] An inclination towards oral communication has been highlighted in current research undertaken by the authors.[12] Textual analysis of transcripts of clinical handover and of nursing documentation showed that clinical handover contained much greater detail about the patient's condition, care and response to that care, than the instances of nursing documentation examined. Nursing documentation tended to present a series of descriptions that the nurse had observed about the patient or about the tasks that the nurse had performed for the patient.[13,14] However, patient information found in the transcripts of clinical handover was drawn from a variety of sources and produced a much richer picture of the patient. Issues about the patient's condition and care could be clarified through questioning.[15] Nevertheless, there is a risk that important information concerning patients is omitted during clinical handover—this emphasizes the importance of the written record in nursing.[16,17] Another consequence of relying on oral communication systems to communicate clinical information about patients is that written communication systems become devalued and can be seen as burdensome.[18] There is a possibility, then, that nursing documentation is a devalued aspect of nursing care.[19]

The devaluation of nursing documentation as an important aspect of care has consequences for the introduction of the electronic medical record (eMR). Recent literature regarding safety issues with the implementation of the eMR reports that certain types of errors in documentation can result in harm. The authors recommend that healthcare leaders should be involved in the planning, design, and development of the eMR to avoid these unintended consequences to patient safety.[20] Part of that involvement should include ensuring that nursing documentation is presented in the eMR in a manner that is meaningful to all readers.

This article presents example of current practices in nursing documentation showing the use of fragmentary language.[21] This fragmentary language is evidenced by phrases and abbreviations that are understood at the local level of the clinical setting by a select group of nurses but are not meaningful to other readers. These other readers could include other health professionals, patients or carers, other interested parties, and members of the legal profession: coroners, judges, magistrates, lawyers, and non-medical jurors.[6] Although abbreviations can facilitate the storage of large amounts of written information in a prescribed space, only abbreviations found on a standardized list with their precise meaning should be used in nursing documentation to prevent misunderstanding and communication breakdown.[22] Nurses often use abbreviations not found on official lists, impeding the intended meaning.[3,23]

The Linguistic Background

Meaning in written communication relies on a set of agreed symbols and structures represented in spelling, sentence construction, punctuation, and the use of paragraphs. Although differences in each of these symbols and structures can exist, a general community-wide agreement about meaning, often established through education, allows anyone who is familiar with the written communication system to construct their own understanding.[24,25] An agreed meaning exists at the level of any speaker of a language who has learned the basic principles of reading and writing. However, smaller groups can construct meaning as a speech community utilizing their own symbols and structures. One feature of a speech community is to define its identity through the common use of symbols and structures of language at a social, cultural, political, or ethnic level. This definition serves to differentiate one speech community from another.[26] When written language is examined from this perspective, it becomes possible to view the use of fragmentary language in nursing documentation as a case of nurses defining themselves in terms of a speech community by using their own symbols and structures to identify themselves as nurses. They become a group set apart because their documentation is written often in a manner that is easily understood by nurses in individual clinical settings, but is misunderstood by any reader outside the profession.

A localized expression that may be seen as an example of fragmentary language and is often found in nursing documentation is the expression "nil complaints." A meaning of this expression among nurses may be that the patient has not complained of anything during a certain period of time, usually a shift, or it may be a convention used to express that there is nothing to report. Other examples of fragmentary language reported in the literature include "pleasant on approach or isolative,"[27] "alert," "well," "the same," "better," or "she's not going to make it,"[15] and "nothing new," "no change," or "about the same."[28] Nurses understand these expressions among themselves. Yet, to those outside the nursing context, it may be difficult to know what this expression means and to whom or to what it is referring. Grammatically, most of these expressions are difficult to understand because they do not fulfill the correct requirements for sentence structure, as they do not have a subject, verb, and object. Furthermore, each expression does not produce an accurate description of the patient's condition because

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