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Review

A systematic literature review of accuracy in nursing care plans and using standardised nursing language

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ABSTRACT

Background: Care planning is an essential part of nursing practice. Formulating nursing care plans within the framework of standardised nursing language warrants further examination.
Aim: The aim of this systematic review was examine the available literature related to nursing documentation and care plans, in relation to the impacts of using standardised nursing language.
Methods: The electronic databases of Medline and Cumulative Index to Nursing and Allied Health Literature were searched using predetermined search strategy. A narrative synthesis was undertaken.
Findings: Of the 198 articles identified 21 articles were included in the review.
Discussion: The examination of the available evidence suggests that a global and Australian difference in use of standardised nursing language in nursing care planning and documentation, including research related to nursing documentation exists.
Conclusion: There are major benefits for systematically integrating nursing classification systems and standardised nursing language. Standardised nursing language is essential for the successful integration of nursing documentation into contemporary healthcare where electronic health care records will be the norm.

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Summary of relevance

Problem or issue: Formulating nursing care plans, in many countries has not been thoroughly captured in research within the framework of standardised nursing language.

What is already known: Nursing care planning is an essential part of nursing practice that provides the framework for patient care. Currently in Australia standardised nursing language is not used in nursing documentation (Nursing and Midwifery Board of Australia, 2006).

What the paper adds: There exists a paucity of published Australian research that investigates the accuracy and quality of nursing care plan documentation. Available evidence suggests standardised nursing language is essential for the successful integration of nursing documentation into contemporary healthcare, including the use of electronic patient records which are quickly becoming common place.

1. Introduction

Nursing care planning is an essential part of nursing practice that provides the framework for patient care (Can & Erol, 2012). Quality of information in nursing care plans includes completeness, content and accuracy as essential characteristics. Completeness in health care records is a contextual concept that is determined through an understanding of specific data needs (Weiskopf, Hripcsak, Swaminathan, & Weng, 2013). Completeness when applied to a nursing care plan incorporates the evidence of the nursing process and legal documentation requirements (Thoroddsen, Asta, Sigurjónsdóttir, Ehnfors, & Ehrenberg, 2013). The content of nursing care plans must be comprehensive which is defined as "documentation according to the different phases of the nursing process", and accuracy pertains to the correctness of "correspondence between the data and reality" (Thoroddsen et al., 2013, p. 84).

2. Background

In many countries nursing practice associated with formulating nursing care plans has not been thoroughly explained in nursing literature. Standardized nursing language (SNL) is an established of terms used to label the clinical judgments involved in nursing assessment (Rabelo-Silva et al., 2017). Attempts to introduce SNL and capture the impacts are important to increase the visibility of nurses and improve nursing practice and communication as SNL enables the capture of holistic, individualised nursing care and defines the unique role of the nurse (Patiraki, Katsaragakis, Dreliozi, & Prezerakos, 2015). SNL also promotes continuity, improved decision making and increased accuracy of language in nursing documentation which in turn can minimise errors and more accurately track patient care planning (Jones, Lunney, Keenan, & Moorhead, 2010). The establishment of SNL also assists the development of evidenced based nursing practice and offers data for research purposes (Park & Lee, 2014).

Societal changes are increasing patient acuity and complexity; therefore research and evidenced based practice must remain current to reflect this changing health care environment. Based on the increasing acuity and complexity of patients presenting to hospitals, there is a current demand for nurses to be able to plan effective and safe patient care, and importantly to document this accurately; promoting patient safety through consistently written communication. However, the use of SNL in nursing care plans is not common place in nursing particularly in Australia.

3. Aim

We aimed to provide a detailed examination of the available literature related to nursing documentation and care plans, in addition to the impacts of using SNL in care planning. Specifically examining global trends and adapting this to the Australian context.

4. Objectives

The objectives were to

(1) Collate available evidence associated to the nursing documentation and care plans, in addition to use of SNL;

(2) Identify global nursing documentation trends; and

(3) Identify the impacts of SNL with the introduction of electronic medical records (EMRs). We are particularly interested in the Australian context since Australian nursing education related to the nursing process does not include diagnosis and SNL is not currently used in the profession.

5. Methods

5.1. Search strategy

Using a standard search strategy, the electronic databases CINAHL and Medline were used. The MESH search terms nurs* AND documentation AND care plan AND nursing diagnosis AND content were used. The references of retrieved articles were hand searched for further articles.

5.2. Inclusion and exclusion criteria

Articles included in the review were:

- Published in academic journals
- Written in English
- Published to end 2016 (this review was completed as part of a Master degree) and
- Reporting primary research.

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