NURSE RECORD KEEPING AND DOCUMENTATION

Nurses’ experiences of and opinions about using standardised care plans in electronic health records – a questionnaire study

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Nurses’ experiences of and opinions about using standardised care plans in electronic health records – a questionnaire study

Aim. The aim of the present study was to investigate nurses’ opinions about using standardised care plans in electronic health record and quality standards for clinical practice.

Background. Following introduction of an electronic health record, use of standardised care plans and quality standards has increased among nurses at two hospitals in Sweden. Understanding nurses’ opinions is important to continued development in this area. There are few previous studies on nurses’ opinions about standardised care plans.

Design. Survey.

Method. The study was quantitative, descriptive and based on a questionnaire. The questionnaire included items on nurses’ knowledge of and opinions about standardised care plans and quality standards.

Results. The majority of the nurses were of the opinion that standardised care plans increase their ability to provide the same high-quality basic care for all patients. They also thought that a common standardised care plan across several professions would improve conditions for provision of high-quality care. The majority of the nurses also felt that the quality standards are a prerequisite of maintaining standardised care plans of high quality. There was no consensus on whether standardised care plans increase the risk of failing to notice patients’ individual problems. Most agreed that standardised care plans decrease documentation time as well as redundant documentation. The study showed that training is needed to teach nurses how to use standardised care plans in care provision.

Conclusions. The nurses in the study had positive attitudes towards use of standardised care plans and felt that they could facilitate nursing practice.

Relevance to clinical practice. Use of standardised care plans can improve nursing documentation and facilitate work for nurses. Moreover, it can support nurses in their use of evidence-based nursing methods. The present study shows that nurses have positive attitudes, which could facilitate continued use of standardised care plans.

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Introduction
The aim of the present paper is to report the results of a questionnaire study investigating nurses’ opinions about working with standardised care plans in electronic health records (EHR) in the context of practical nursing care at two hospitals in Sweden. Few studies have investigated nurses’ opinions about standardised care plans in EHR (Lee 2006).

Background
The background begins with a description of several concepts. Thereafter follows a short review of earlier studies, a description of Swedish Legislation on Health Records and of the setting for the present study.

‘Standardised care plan’, ‘quality standards for clinical practice’, ‘care pathway’ and ‘individualised care plan’
According to Carpenito (2000), a standardised care plan is a printed care plan that describes the nursing care to be provided for a patient, a family or a group. Carpenito described the standardised care plan as containing a diagnostic cluster, nursing diagnosis, collaborative problems and interventions. Thus, a standardised care plan could be considered a general action plan or a sort of guideline for care. The standardised care plan follows the nursing process and includes nursing diagnosis, goals and interventions. The overall aim of using a standardised care plan is to help nurses follow a common plan in caring for a specific group of patients (Forsberg & Edlund 2003, Willman et al. 2006). This could help to ensure that all patients receive the same high-quality care.

In the optimal case, a standardised care plan will be based on up-to-date, evidence-based knowledge. According to Willman et al. (2006), the overall aim of using standardised care plans is for nurses to follow a common plan in caring for a specific group of patients; an additional aim is that such plans should be based on scientific evidence. The overall goal is to ensure that all patients receive the same high-quality care. The ‘quality standards for clinical practice’ (in the following text called ‘quality standards’) are used together with the standardised care plan. The quality standards include accepted local clinical guidelines for interventions in the care plan and they should be based on the best available knowledge about nursing care for a specific patient group (Forsberg & Edlund 2003, Willman et al. 2006, Idvall E. red 2007). Care Pathway (CP) is a multi-professional tool for planning care for a specific group of patients. As the name indicates, an individualised care plan is a care plan that is adapted to a specific patient. According to Carpenito (2000), an optimal care-management system should include CP, standardised care plans and, if need be, an individual care plan for the patient.

Literature review
Use of computers in nursing
The use of computers in nursing has been reported since the 1960s (Romano 1982). Computer use in nursing areas has increased as computers have become more common. Many studies have investigated nurses’ opinions about using computers, as Romano (1982), Rinard (1996), Barnard (1997, 2000), Darbyshire (2004) and Stricklin et al. (2003). However, results are equivocal. In their review Smith et al. (2005) concluded that it is not possible to find any demographic variable that can identify nurses who are more or less likely to have a positive attitude towards computerisation. Newton (1995) performed a very interesting study, namely the first implementation of a computerised care planning system in the UK. The implementation included both a new way of structuring work, using the nursing process and a new technology, i.e. computers. The results showed that it took more than a year after implementation until the nurses’ negative attitudes towards the system shifted to positive attitudes. The study also showed a significant improvement in the quality of care planning. In their review, Smith et al. (2005) found no conclusive evidence that could provide the foundation for an effective computer implementation strategy. However, the more common use of computers in society today has increased the use of computers in nursing and also made it possible to implement standardised care plans in EHR. Goorman and Berg (2000) called attention to problems associated with the design of structures in EHR and suggested that there is a risk that such structures will be difficult to work with in practice. Timmons (2003) described nurses’ resistance to using computerised systems for planning nursing care; their resistance did not entail direct refusal, but was instead quite subtle. They tended to...
minimise use of the system or postpone it to another time or to the next work shift. Timmons considered that the nurses’ behaviour was characterised by resistance to the nursing process and to the technology.

Smith et al. (2005) investigated charting time before and after computer implementation and found that no change had occurred. The advantage of using the software was observed when the technology and the concept brought together the care plans and subsequent documentation. This shows that use of the system improved the function and meaning of the care plan process.

Investigations of use of standardised care plans in Sweden
A national investigation was conducted in 2002 and aimed at analysing the content of Swedish standardised care plans. The investigation included 210 standardised care plans. It showed that such plans largely follow the nursing process and that the planned care for the patients was clear (Segersten Mårtensson 2002). This investigation also showed no obvious connection between standardised care plans and research-based knowledge. Only three (1%) of the analysed care plans had a clear scientific basis and none of them was evidence based.

Another national investigation, conducted by the National Board of Health and Welfare (SoS 2006) in a sample of hospitals, looked at the extent to which standardised care plans are used in hospitals settings and at the design and quality of these plans. The report showed that 23 of 25 hospitals used standardised care plans. However, only a few of these were based on quality standards and none were evidence based. No study has been found that investigates Swedish nurses’ opinions about working with standardised care plans in EHR.

International investigations of nurses’ opinions about using standardised care plans
Lee and Chang (2004) stated that many studies have investigated the outcomes or effectiveness of using different types of care plans, but that studies of nurses’ opinions about using such care plans in daily practice are few. Lee and Chang (2004) argued that better use of standardised care plans would improve nurses’ access to appropriate and accurate information in decision-making, thus improving the charting process and quality of care. Disadvantages of standardised or computerised care plans have been mentioned, including loss of nursing expertise (Harris 1990), increased paperwork requirements (Mason 1999, Lee et al. 2002) and the de-individualised content (Harris 1990, Lee et al. 2002). Lee (2005, 2006) found that nurses’ overall opinion was that computerised standardised care plans facilitate their work and enhance their knowledge, allowing them to improve the quality of care. Therefore, the review above shows the need of more studies on nurses’ opinions of standardised care plans in EHR.

Swedish legislation on health records
Since 1985, registered nurses (RNs) in Sweden are required by law to document nursing treatment in the health record. The Swedish legislation also states that the health record should include relevant information about: reason for care, nursing diagnosis, planned and performed interventions (SFS 1985:562). Moreover, nurses are responsible for ensuring that the nursing care is planned, performed, evaluated and coordinated with medical treatment (SOSFS 1993:17). The standardised care plan should be based on scientific knowledge and clinical practice norms (SoS 2006). It is also legislated that management systems for quality and patient security shall be established in all health systems (SOSFS 2005:12).

Settings – description of hospitals and organisation of nurses’ documentation
The study was performed in central Sweden at a university hospital and a county hospital associated with the university hospital. The hospitals together have 1227 patient beds and 8986 employees. EHR was implemented during 2004–2006. The system is an integrated electronic patient record intended for use by all authorised health professionals. Individuals from all the health professions participated in the process of developing and designing the EHR system. The work to improve the system is ongoing, as is the work with standardised care plans. The first standardised care plans, in paper size, were introduced in the hospitals in 1997. The introduction of EHR led to an increased interest in implementing standardised care plans.

All units at the hospitals have nurses who are responsible for development in different areas, for instance, nutrition, pain management, prevention of pressure ulcers and nursing documentation. The nurses responsible for nursing documentation are part of a network covering both hospitals. Every unit is represented in the network, which includes a total of about 90 participants. The members of the network meet in seminars twice a year. At the time of the study, the network had been in place for 13 years. The network members had changed over the years owing to staff turnover. At these seminars, different work concerning nursing documentation and development of documentation is presented and discussed. Examples of nursing diagnoses, interventions, standardised care plans, individual care plans and quality standards from different types of units are discussed. Current information is provided in the form of news from studies and
articles, reports from conferences and new local guidelines on documentation. These meetings have become an important forum for distributing information and for discussion among nurses. Over the years, nursing documentation has developed and nurses’ interest in standardised care plans has increased.

The first standardised care plans with quality standards were introduced at the university hospital in 1997, after which time a great many standardised care plans were developed. Most of the standardised care plans are used by nurses, although some units have multi-professional standardised care plans, which are jointly used by nurses, occupational therapists and physiotherapists. At the hospitals under study, a project on implementation of an EHR had been in progress for four years during the present study. The standardised care plan is a part of the EHR and nurses could access the quality standards via a link from the EHR. However, this development has not yet progressed as far as hospitals using only evidence-based standardised care plans. Thus, standardised care plans are based on quality standards that include clear guidelines for the recommended interventions. Work is currently underway to make standardised care plans evidence based and the goal is to implement evidence-based standardised care plans at each unit.

Aim

The aim of the present study was to investigate nurses’ opinions about using standardised care plans and quality standards for clinical practice.

Method

Design and setting

The study was quantitative, descriptive and based on a questionnaire. The study was performed at a university hospital and at a county hospital in Sweden.

Data collection

Data collection was carried out using a web-based questionnaire to which nurses responded. The questions were formulated by the first author and were specific to this investigation. The questionnaire included items on their knowledge of and opinions about standardised care plans. All questions had fixed response alternatives, but also allowed respondents to make their own comments. Some questions were written as statements and based on literature claiming the advantages of working with standardised care plans. The questionnaire was tested by two nurses and modified before it was used.

Procedure and selection of participants

Permission to carry out the investigation was obtained from the head nurses at the units. A convenience sample was used. Seven units were chosen, they were: the adult medical, surgical and orthopaedic units at both hospitals. The selection was intended to include different kinds of hospital wards. On each of the seven units, 15 RNs were chosen to answer the questionnaire. The nurse in charge of documentation at each unit helped to register the first 15 nurses in alphabetical order at that unit. Then these nurses were sent, via e-mail, personal login information for accessing the questionnaire. In the same e-mail, the nurses also received a cover letter with information about the study; here they were informed that participation was voluntary. The questionnaire was sent to the RNs in March 2007 and one reminder was sent after 14 days. The questionnaires were sent to a total of 105 RNs and 85 questionnaires were answered. The nurses in charge of documentation at the departments did not participate in the study.

Data analysis

Data analysis was performed in a system for web-based questionnaires and the results are presented using descriptive statistics. Analysis of the collected data was carried out in April 2007.

Ethical considerations

All participants received information about the aim of the study and were informed that participation was voluntary. The data have been treated confidentially. Thus, the recommendations made by the Swedish Council for Research in the Humanities and Social Sciences (HSFR 2006) have been followed.

Results

The web-based questionnaire was sent to 105 nurses, of whom 85 responded. The response frequency was 80.9%. Not all questionnaires were answered completely.

Demographic data

Characteristics of the participants are presented in Table 1. The table shows that most of the nurses were between
20–40 years of age and had more than 2 years of nursing experience. Table 1 also shows that the number of standardised care plans at the units was quite variable. The majority of RNs felt they were very familiar with the standardised care plans used in their unit.

Multidisciplinary use of standardised care plans

Forty-eight RNs answered that only nurses use the standardised care plans and 30 RNs that other professionals used them, indicating that nursing assistants, occupational therapists and physical therapists used the same plans.

Table 1 Demographics and RN’s knowledge about standardised care plans at their units (n = 85)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Level</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses’ age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–30</td>
<td>29</td>
<td>(34)</td>
</tr>
<tr>
<td>31–40</td>
<td>22</td>
<td>(26)</td>
</tr>
<tr>
<td>41–50</td>
<td>20</td>
<td>(24)</td>
</tr>
<tr>
<td>51–60</td>
<td>9</td>
<td>(11)</td>
</tr>
<tr>
<td>&gt;60</td>
<td>5</td>
<td>(6)</td>
</tr>
<tr>
<td>Nurses’ experience (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 1</td>
<td>11</td>
<td>(13)</td>
</tr>
<tr>
<td>≥1–2</td>
<td>9</td>
<td>(11)</td>
</tr>
<tr>
<td>&gt;2–5</td>
<td>22</td>
<td>(26)</td>
</tr>
<tr>
<td>&gt;5–10</td>
<td>22</td>
<td>(26)</td>
</tr>
<tr>
<td>&gt;10</td>
<td>21</td>
<td>(25)</td>
</tr>
<tr>
<td>Number of standardised care plans at the units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–5</td>
<td>20</td>
<td>(24)</td>
</tr>
<tr>
<td>6–10</td>
<td>21</td>
<td>(25)</td>
</tr>
<tr>
<td>11–20</td>
<td>19</td>
<td>(22)</td>
</tr>
<tr>
<td>21–30</td>
<td>0</td>
<td>(0)</td>
</tr>
<tr>
<td>&gt;30</td>
<td>14</td>
<td>(16)</td>
</tr>
<tr>
<td>Do not know</td>
<td>11</td>
<td>(13)</td>
</tr>
<tr>
<td>How familiar are you with the content of the standardised care plans at your unit?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very familiar with all of them</td>
<td>18</td>
<td>(21)</td>
</tr>
<tr>
<td>Very familiar with most of them</td>
<td>49</td>
<td>(58)</td>
</tr>
<tr>
<td>Very familiar with a few of them</td>
<td>13</td>
<td>(15)</td>
</tr>
<tr>
<td>Not very familiar with any of them</td>
<td>5</td>
<td>(6)</td>
</tr>
</tbody>
</table>

Quality standards as the basis for standardised care plans

Responses to the question concerning whether standardised care plans are based on quality standards showed that more than half of the RNs did not know if they were; see Table 2. The RNs who knew that the standardised care plans were based on quality standards (n = 30) answered that they were familiar with most/all of the quality standards that form the basis for the standardised care plans.

RN’s opinions about and understanding of standardised care plans

The nurses had to respond to statements that all had the same response alternatives. The statements dealt with nurses’ opinions about how nursing care is affected by working with standardised care plans and quality standards. Table 3 shows the RNs’ answers to the statements about standardised care plans. The results show that the majorities were of the opinion that standardised care plans and quality standards increase their ability to provide the same high-quality basic care for all patients and that standardised care plans decrease redundant documentation and documentation time. There was, however, no consensus as to whether standardised care plans increase the risk of failing to notice patients’ individual problems (n = 79).

Some nurses made comments on some statements. These comments are included below:

Comments on statement 5:

Naturally, if the nurse lacks experience and knowledge, individual needs can be missed if she just follows the standardised care plan.

Comments on statement 6:

I agree, given that everybody knows how to use standardised care plans. Everybody here doesn’t know how and sometimes some information is missed because the nurse documents something incorrectly, or doesn’t know where to find the information.

General comments on the statements:

Documentation can never be perfect, but here on my unit it’s almost perfect. I’ve seen many systems, but none as good as this one.

Some colleagues document things unnecessarily, despite the standardised care plan, just to have something to document. We’re supposed to document deviations from the standardised care plan. Some standardised care plans aren’t ‘water tight’, I mean, some aren’t suited to the patient if maybe the patient’s operation is a mixture of several standardised care plans. You can’t have everything in detail, but have to be more general.

Table 2 RNs’ knowledge about whether the standardised care plans are based on quality standard

<table>
<thead>
<tr>
<th>The standardised care plans we use have standard for quality for the recommended interventions</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Uncertain</td>
<td>52</td>
</tr>
</tbody>
</table>

Table 2 RNs’ knowledge about whether the standardised care plans are based on quality standard

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The questionnaire enquired about how RNs used standardised care plans in practical care. Their responses showed that they use the diagnoses, goals and interventions in the standardised care plans, but they do not always evaluate the goals. Only 19% (n = 15) of the nurses reported that they always evaluate the goals. Despite this, 46% (n = 36) responded that they use standardised care plans in an optimal manner. Only 18% (n = 14) reported making an individualised care plan when one is needed (see Table 4). Most nurses felt that both their theoretical and their technical knowledge regarding how to use standardised care plans in practical care are satisfactory.

Comments on the questions above:

I’m not familiar with our standardised care plans. I haven’t worked much with standardised care plans so far.

I haven’t been working so long and don’t understand why goals should be evaluated.

The problem is that there are only a few diagnoses. That’s why I don’t use standardised care plans in an optimal manner, there’s more double documentation when you can’t do it the same way every time.

I haven’t become familiar with the electronic records, so my knowledge isn’t satisfactory, which is why I can’t judge it either. But I do feel I have a lot to learn.

### Table 3 RNs’ opinions about and understanding of standardised care plans and quality standards

<table>
<thead>
<tr>
<th>Question</th>
<th>Agree completely, n (%)</th>
<th>Agree to some degree, n (%)</th>
<th>Do not agree at all, n (%)</th>
<th>Cannot judge, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Nursing care based on standardised care plans increases nurses’ ability to provide the same care for all patients (n = 79)</td>
<td>53 (67)</td>
<td>22 (28)</td>
<td>2 (3)</td>
<td>2 (3)</td>
</tr>
<tr>
<td>2 Nursing care based on standardised care plans increases nurses’ ability to provide high quality care (n = 79)</td>
<td>55 (70)</td>
<td>21 (27)</td>
<td>2 (3)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>3 Nursing care based on standardised care plans increases nurses’ ability to work using evidence-based methods (n = 79)</td>
<td>45 (57)</td>
<td>27 (34)</td>
<td>2 (3)</td>
<td>5 (6)</td>
</tr>
<tr>
<td>4 Having quality standards is a prerequisite of ensuring that standardised care plans are evidence-based (n = 79)</td>
<td>36 (46)</td>
<td>22 (28)</td>
<td>0 (0)</td>
<td>21 (27)</td>
</tr>
<tr>
<td>5 There is a risk that patients’ individual problems/needs will not be discovered when standardised care plans are used (n = 79)</td>
<td>8 (10)</td>
<td>42 (53)</td>
<td>28 (35)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>6 Redundant documentation decreases when standardised care plans are used (n = 79)</td>
<td>34 (43)</td>
<td>35 (44)</td>
<td>10 (13)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>7 Documentation time decreases when standardised care plans are used (n = 79)</td>
<td>45 (57)</td>
<td>25 (32)</td>
<td>8 (10)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>8 The conditions for providing high quality care improve when all professionals dealing with a patient work using a common standardised care plan (n = 79)</td>
<td>39 (49)</td>
<td>27 (34)</td>
<td>0 (0)</td>
<td>13 (16)</td>
</tr>
</tbody>
</table>

### Table 4 RNs’ practical use of standardised care plans and their opinions about their own knowledge (n = 78)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answer</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you evaluate the goals found in the standardised care plans?</td>
<td>Always</td>
<td>15 (19)</td>
</tr>
<tr>
<td>Do you think that you use the standardised care plans in an optimal manner?</td>
<td>Yes</td>
<td>36 (46)</td>
</tr>
<tr>
<td>What is your opinion about your theoretical knowledge of standardised care plans?</td>
<td>Completely satisfactory</td>
<td>22 (28)</td>
</tr>
<tr>
<td>What is your opinion about your technical knowledge of standardised care plans?</td>
<td>Completely satisfactory</td>
<td>25 (32)</td>
</tr>
<tr>
<td>Do you plan patient care in an individual care plan when one is needed?</td>
<td>Always</td>
<td>14 (18)</td>
</tr>
<tr>
<td>Do you plan patient care in an individual care plan when one is needed?</td>
<td>Most of the time</td>
<td>21 (27)</td>
</tr>
<tr>
<td>Do you plan patient care in an individual care plan when one is needed?</td>
<td>Seldom</td>
<td>27 (35)</td>
</tr>
<tr>
<td>Do you plan patient care in an individual care plan when one is needed?</td>
<td>Never</td>
<td>16 (21)</td>
</tr>
</tbody>
</table>

All this updating and these ‘newfangled’ things throw a spanner into the Works.

I was in charge of documentation at my latest job and I’ve taken several courses, so I feel I’m pretty well prepared.
Discussion

The present study showed that the majority of nurses were of the opinion that using standardised care plans in EHR increases their ability to improve the quality of care and provide the same basic care and also increases their opportunities to work using evidence-based methods. Their opinions were that multidisciplinary standardised care plans also increase the team’s ability to provide high-quality care and decrease time spent on documentation in the records as well as redundant documentation. Previous studies (Daly et al. 2002, Lee & Chang 2004, Lee 2005, 2006) have revealed the advantages of working with evidence-based standardised care plans and the nurses participating in the present study had the same understanding. The nurses felt that if standardised care plans, based on quality standards, are used in patient care, there are increased chances of providing high-quality basic care for all patients. Moreover, if such plans are also used across different professions, there are additional advantages with regard to quality of care. They also reported an increase in chances to work using evidence-based methods and thought that redundant documentation and time spent on documentation had decreased.

Standard care planning and individual care planning

With regard to the risk of disregarding patients’ individual needs and problems, there was little consensus; only a few respondents saw this as a great risk. Thus, the nurses generally did not perceive any great risk of failing to notice patients’ individual needs when using standardised care plans. The de-individualisation of care has been one criticism of standardised care plans (Harris 1990, Newton 1995, Lee et al. 2002, Forsberg & Edlund 2003, Lee 2005). Most of the nurses felt that it is necessary to have quality standards together with standardised care plans. However, many of them, 62%, had no knowledge of whether they have quality standards at their own unit. Thus, the present study also showed that there is a theoretical and practical need to teach nurses how to work with standardised care plans.

Quality standards as the basis for standardised care plans

In nursing care, written memoranda have always been used to indicate guidelines or local routines, for example different parts of examinations and treatments. These memoranda have mostly been confirmed by the heads of departments, but without any note of their basis in scientific findings. The development of evidence-based standardised care plans represents an effort to help nurses perform their work in accordance with the best scientific evidence and proven experience. In Sweden, the requirement to follow-up on the quality of care has increased during recent years (SOSFS 2005:12, SoS 2006). This has accelerated the development, such that more quality standards have been prepared at the hospitals under study, although today only a few standardised care plans are based on scientific evidence. Most of the present respondents felt comfort and very familiar with the standardised care plans at their units, but they were uncertain about whether their standardised care plans were based on quality standards or whether quality standards actually guided the care they provide. However, they were also of the opinion that standardised care plans and quality standards increase their ability to provide care of high quality. Many ongoing projects are addressing the quality standards at both hospitals. The results also indicate a current need for information and education. It is important to consider that the technology is simply an electronic way of doing what was previously performed using pen and paper. Thus, nurses must understand the nursing process: nursing diagnosis, goals, nursing interventions and evaluating goals. Their understanding must be theoretical, but also practical. Many reported that they do not evaluate goals and that individual care plans are seldom made, even though this is clearly necessary and something that additionally improves the quality of care. The nurses’ comments show that experience and knowledge are sometimes lacking and that the needs of individual patients can indeed be missed if nurses only follow standardised care plans.

RN’s opinions about and understanding of standardised care plans

For the nurses in charge of documentation at the university hospital and general hospital under study, there is a long tradition of work with development of documentation and a forum for sharing documentation experience in the network. Development of standardised care plans has been underway for about 10 years and has caused increased interest in such plans. Subsequently, an electronic patient record was introduced and nurses recognised the additional advantages of this technique. Today, all parts of the hospital units under study have some standardised care plan and many units have a large number of standardised care plans for common diagnoses or common patient examinations. Before EHR was introduced, many nurses had been trained to use standardised care plans and now when the plans became a part of EHR, this presumably facilitated their work. This and the fact that computer use is more common has probably caused the nurses of today to have more positive attitudes towards both computers and using standardised care plans than has been shown in earlier studies,
Multidisciplinary use of standardised care plans

The development of multidisciplinary standardised care is driven by efforts to achieve coherent and common patient records, requirements to carry out evidence-based care and the ambition to develop standardised terminology in documentation of care (Willman et al. 2006). The nurses in the present study thought that a common standardised care plan across several professions would improve conditions for provision of high-quality care. Of the total group of respondents, 51% agreed completely with this statement and 35% agreed to some degree. One report from the National Board of Health and Welfare (SoS 2006) states that standardised care plans should increasingly be designed for multidisciplinary use. At the hospitals studied here, there are several examples of multidisciplinary standardised care plans in which physical therapists, occupational therapists and nurses carry out documentation together and there are several ongoing projects in this area. In this context, there are often discussions of the fact that physicians are not involved in documentation in the standardised care plan. There is, nevertheless, some degree of joint work, as the standardised care plan always includes the general medical prescriptions provided by the physician in charge. Moreover, creating a standardised care plan and quality standards also involves multidisciplinary co-operation among all professionals working with a patient group, including the physician responsible for the group. This co-operation involves multidisciplinary discussions of and decisions regarding what type of care will be provided to all patients in a given group.

Possible advantages of use of standardised care plans

In development work with standardised care plans, there are several effects that could be attended to and emphasised. The first, which is indicated in a report by the National Board of Health and Welfare (SoS 2006), is that the standardised care plan provides great scope for using the patient’s participation and self-determination, in that the course of care is described in detail, thus allowing goals and treatments to be discussed with the patient. It is important to point out that patient participation can be facilitated because plans for the patient’s care are specified in the standardised care plan and can thus be discussed with him/her. In this way, the patient is made aware of the main goals of the care being provided. If standardised care plans are available, nurses can choose a relevant care plan and use the plan to identify the suggested diagnoses and interventions, thus ensuring that all patients receive the same high-quality care.

One problem that remains is that we cannot develop standardised care plans that are entirely evidence based, because we do not have evidence supporting the efficacy of a large number of nursing interventions. Obtaining such evidence will require more research.

Methodological considerations

Using a web-based questionnaire was an easy way to collect responses and was probably appropriate for nurses who are used to using a computer. The selection was intended to include wards with different kinds of patient diagnoses. Naturally, it would have been interesting to include all of the nurses, but it was our judgement that the sample would be representative. Moreover, including all nurses would have taken too much time from their practical care. One limitation of the present study is that it did not include nurses’ skills in IT and examine whether this factor may have influenced care plan completion. This could be an area for further investigation.

Conclusions

Our study shows that nurses generally have positive attitudes towards standardised care plans, use of standardised care plans in EHR and quality standards for clinical practice. They considered that these procedures facilitate their work and improve the quality of care. Use of a network is probably advantageous in an ongoing innovation project.

Relevance to clinical practice

Understanding that nurses now have positive attitudes towards standardised care plans could facilitate continued implementation of such care plans in nursing care. Working with introduction of standardised care plans is one important way of implementing evidence-based knowledge and pursu-
ing high-quality work. It can also improve nursing documentation and facilitate work for nurses. However, it would seem that nurses need more knowledge about standardised care plans and that they need to better understand what evidence-based knowledge is.

Contributions

Study design: MFD, BW; data collection and analysis: MFD, BW and manuscript preparation: MFD, BW.

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References


