

Clinical Stories shared at handover compared with formal documentation by Child and Family Health Nurses

Jane Louise Kookarkin Ba App Sc (HIM), Ass Dip MRA

A thesis submitted for the degree of Master of Health Services (Honours) Thesis

University of Technology, Sydney

June 2012.

CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student

Production Note:
Signature removed prior to publication.

Acknowledgements

Firstly, I wish to thank the management and staff of the Tresillian Family Care Centres for supporting me throughout my study and allowing me to conduct this research within their organisation. Secondly, I would like to thank the academic and support staff at UTS who have assisted me to develop my research and academic writing skills; and the librarian at the Canterbury Hospital for her help using CIAP.

I have been very fortunate to have Maralyn Foureur and Cathrine Fowler as my supervisors. I wish to thank them for their encouragement and guidance in helping me along this journey and also thank them for their willingness to share their knowledge and vast experience in both the academic world and the nursing profession. I would like to give a special thank you to Cathrine for her patience and support over the past four years.

The opportunity to undertake this study has been a privilege, as it enabled me to work alongside many individuals who have taught me a variety of lifelong lessons. I wish to acknowledge all the people who I have come in contact with while undertaking this study. This journey has not been completed in isolation. A special thank you must be given to several friends, Jenny Seems, Hildegard Withers, Michael Ampoulos, Julie Maddox, Marie Dickinson and Anne-Lyse DeGuio who have assisted me by listening to my ideas, reading parts of this thesis and offering feedback at different stages.

Finally, I would like to thank my wonderful family, Michael, Alexandra, Elizabeth and Gabrielle for the unconditional support and love they have provided, and I would like to dedicate this work to them. Thank you.

Abstract

The impetus for undertaking this study arises out of the author's work as a Health Information Manager (HIM), employed within an Early Parenting Centre (EPC) with a predominant nursing workforce. To a HIM, quality documentation in the clinical record is of the utmost importance in ensuring that accurate clinical coding can be achieved with positive outcomes for clients, families and the organisation.

The aim of this study is to investigate nursing documentation and handover practices within a child and family health (CFH) setting. The focus is on the differences between what nurses write in the clinical records and what they communicate verbally in 'handover'. This study builds on the development of the ICD-10-AM Early Parenting Manual to examine the accuracy and quality of information collected in the clinical record. This study was conducted in three residential units of an EPC situated in Sydney, NSW. These EPC units provide early intervention for parents with young children through support and education. Nurses provide the majority of parenting intervention, support and education during a parent and child's stay.

A qualitative interpretive research approach was used employing several forms of data including case studies, interviews, field notes and questionnaires. The data analysis involved qualitative thematic content analysis in two parts; firstly the analysis of the transcripts of handover and the clinical record documentation through the use of a coding template; and secondly examination of the nursing interview transcripts using the themes identified from the verbal and written analysis. Demographic data collected from a nursing questionnaire and field notes were used to provide context to inform the analysis process and findings.

This study identified a number of positive outcomes: comments from the nurses echoed their desire to learn and improve their documentation practices; the demographic data identified a wealth of nursing expertise and knowledge; and the changing nature of CFH nursing acknowledged that the RNs are now expected to work at a much higher level than in the past. Conversely, there were some concerns related to the barriers that impact on the nurses' ability to accurately document their practice. They included confusion regarding who is the client, inconsistency of the parenting advice given, gaps in communication transfer of both written and verbal information, the changing and increasing educational needs of staff, the environment and the workload.

It has clearly been identified that the area of CFH clinical information collection and clinical coding would benefit from more research. For the clinical coding process to be improved,

more focused education for nurses is necessary to help them understand the need for quality documentation required by clinical coders. This stresses the importance of work place education and mentoring; and the importance of education about the role of clinical coding in undergraduate and post graduate nursing programs. Continuing professional development for nurses should include topics such as the importance of clinical documentation with regard to the introduction of Activity-Based Funding and the completion of clinical documentation using the eMR. Finally, further development should be undertaken in improving formal communication processes between all clinical staff.

Table of Contents

Certificate.....	i
Acknowledgement.....	ii
Abstract.....	iii
Table of contents.....	v
List of Tables.....	ix
List of Abbreviations	x
Chapter 1: Positioning the Study	1
1.1 Background	2
1.1.1 Location and setting of the study	3
1.1.2 Personal Perspective on the quality of documentation	4
1.2 Clinical coding is dependent on accurate documentation	5
1.2.1 Development of ICD-10-AM Early Parenting Manual	6
1.3 Model of Care and Care Pathway	7
1.4 Child Protection	8
1.5 Garling Report 2008	8
1.6 Handover	9
1.6.1 Communication skills needed for clinical documentation and handover	10
1.7 Electronic Medical Record	11
1.8 Activity Based Funding	12
1.9 Significance of the study	13
1.10 The thesis outline	13
Chapter 2: Literature Review	16
2.1 Introduction	16
2.1.1 Purpose and scope of review	17
2.1.2 Search terms	17
2.1.3 Reference lists	18
2.2 Review of the literature	18
2.2.1 Nursing documentation	19
2.2.2 Handover	19
2.2.3 Clinical coding and analysis	20

2.2.4	Best practice	21
2.2.5	Focus on patients needs	21
2.2.6	The loss of important data during handover	22
2.2.7	The missing link	22
2.2.8	Assumptions and beliefs about nursing clinical communication	24
2.3	Summary	24
Chapter 3: Study Design and Method		26
3.1	Qualitative Interpretative Research Approach	26
3.1.1	Setting and context	27
3.1.2	Ethical considerations	27
3.1.3	Recruitment of participants and consent process	28
3.1.4	Possible risks and the right to withdraw	29
3.1.5	Selection of the participants	29
3.1.6	Inclusion criteria	30
3.1.7	Exclusion criteria	30
3.2	Data Sources	31
3.2.1	Case studies	31
3.2.2	Nurses interviews	31
3.2.3	Researcher's field notes	32
3.2.4	Questionnaire	32
3.3	Data Management	33
3.3.1	Ensuring the right to confidentiality, privacy and anonymity	33
3.3.2	The study participants	33
3.4	Analysis	36
3.4.1	Template analysis	37
3.4.1.1	Definition	37
3.4.1.2	Development of a coding template	37
3.4.1.3	Analysis of nursing interviews	39
3.4.1.4	Validity	40
3.5	Summary	41
Chapter 4: Parallel Stories of Handover and Documentation using Clinical Coding of Case Studies		42
4.1	Introduction	42
4.2	Case study 1 – Elizabeth and Lily's story	43

4.2.1	Codes 1 and 2	45
4.2.2	Codes 10 and 11	47
4.2.3	Codes 8 and 16	47
4.2.4	Codes 18 and 19	48
4.2.5	Codes 7 and 19	49
4.3	Case study 2 – Alexandra and Sophie’s story	49
4.3.1	Codes 1, 2 and 3	51
4.3.2	Codes 4 and 11	53
4.3.3	Codes 2 and 6	54
4.3.4	Codes 7 and 8	54
4.3.5	Code 11	55
4.4	Case study 3 – Gabrielle, Tristan and Indigo’s story	58
4.4.1	Codes 1 and 4	60
4.4.2	Codes 6, 7 and 8	60
4.4.3	Code 2	60
4.4.4	Codes 7 and 8	61
4.4.5	Codes 3 and 10	61
4.4.6	Codes 7, 8, 9 and 10	62
4.4.7	Codes 11, 12 and 13	62
4.5	Summary	63
Chapter 5:	Nursing Semi-structured Interviews	64
5.1	Introduction	64
5.2	Client Focus	64
5.3	Communication and Information Sharing	66
5.4	Organisational Guidance, Policy and Education	71
5.5	Work Practices – Documentation and Handover	75
5.6	Summary	76
Chapter 6:	Discussion, Conclusion, Recommendations and Future Directions	77
6.1	Discussion of outcomes	77
6.2	Work Practices and Policy Guidelines	78
6.2.1	Documentation practices	78
6.2.2	Mismatch of information between handover and documentation	78
6.2.3	Handover practices	79
6.2.4	Informal handover	80

6.2.5	Organisational guidance	80
6.3	Education Needs	81
6.4	Client Identity	82
6.5	Communication Transparency	82
6.5.1	Working in silos	82
6.5.1	Inconsistency of parenting advice	83
6.6	Study Challenges and Limitations	83
6.7	Conclusion	84
6.8	Recommendations and Future Direction	86
Appendix A:	ICD-10-AM Coding Example	88
Appendix B:	Tresillian Model of Care Practice Principles	89
Appendix C:	Initial Coding Template	91
Appendix D:	Final Coding Template	94
Appendix E:	Nursing Interview Questions	95
Appendix F:	Information Sheet No: 1 – Child and Family Health Nurse	96
Appendix G:	Information Sheet No: 2 - Parent	98
Appendix H:	Consent Form No: 1 –Child and Family health Nurse	100
Appendix I:	Consent Form No: 2 – Parent	101
Appendix J:	Information Sheet No: 3 – Child and Family Health Nurse Interviews.....	102
Appendix K:	Consent For No: 3 –Child and Family health Nurse.....	104
Appendix L:	Nursing Questionnaire – Demographic Information.....	105
References	107

List of Tables

Table 1: Documentation & Coding Process	5
Table 2: Demographic description of nurse participants	34
Table 3: Example of Coding Template	39
Table 4: Coding Template for Case Study 1	43
Table 5: Coding Template for Case Study 2	50
Table 6: Coding Template for Case Study 3	58

Abbreviations

ABF	Activity-Based Funding
CNC	Clinical Nurse Consultant
CM	Centre Manager
CFH	Child and Family Health
DOCS	Department of Community Services (now FACS)
EDS	Edinburgh Depression Scale
EPC	Early Parenting Centre
EN	Enrolled Nurse
eMR	Electronic Medical Record
FACS	Family and Community Health Service (previously DOCS)
HREC	Human Research Ethics Committee
HIM	Health Information Manager
ICD-10-AM	International Classification of Diseases 10 th Revision. Australian Modification
MOC	Model of Care
NCCH	National Centre for Coding in Health (now NCCC)
NCCC	National Casemix and Classification Centre (previously NCCH)
NOS	Not elsewhere classified
NSW	New South Wales
NUM	Nurse Unit Manager
PND	Post Natal Depression
PNRQ	Post Natal Risk Questionnaire
RN	Registered Nurse
SW	Social Worker
UTS	University of Technology Sydney

Chapter 1

Positioning the Study

Stories are how we think. They are how we make meaning of life. Call them schemas, scripts, cognitive maps, mental models, metaphors, or narratives. Stories are how we explain how things work, how we make decisions, how we justify our decisions, how we persuade others, how we understand our place in the world, create our identities, and define and teach social values (Rutledge 2011).

The reporting of nursing care using clinical documentation and nursing handover is of crucial importance to enable safe, efficacious and timely health care. Clinical documentation and nursing handover tells the stories of both the clinicians and clients in a health care setting. These stories, in the same way as the stories described by Rutledge (2011) in the opening quote, explain how the health system works and how decisions regarding client care are made and justified. Increased understanding and knowledge in relation to these clinical documentation and verbal handover practices are needed to improve Nurse reporting mechanisms and in doing so improve client care.

The impetus for undertaking this study arises out of my work as a Health Information Manager (HIM), working within an Early Parenting Centre (EPC) with a predominant nursing workforce. To a HIM, quality documentation in the clinical record is of the utmost importance in ensuring that the HIM's work can be achieved with positive outcomes for clients, families and the organisation.

The aim of this study is to investigate nursing documentation practices within a child and family health (CFH) setting. The focus will be on the differences between what nurses write in the clinical records and what they communicate verbally in 'handover'. Variations between the verbal and written stories will be highlighted and explored.

The study will be carried out using understanding, knowledge and skills gained through working for many years as a Health Information Manager (HIM). One of the roles of a HIM is to design and manage information systems within the healthcare system. This includes the collection of patient data and generation of reports using the HIM's clinical knowledge of disease and surgical procedures, technical knowledge of computer systems and databases and management skills to set up and monitor these systems. HIMs also play a key role in the

security and legal use of clinical records and health information by establishing appropriate procedures, handling and protection systems for personal health data.

This chapter will provide a background to the study, including the study location and setting and a personal perspective on the importance of quality clinical information collected through clinical documentation and handover. An overview of clinical coding, the coding process and its uses for research, planning and future funding is discussed, highlighting the dependence of quality clinical data on the accuracy of nursing documentation. The history of the development of the ICD-10-AM Early Parenting Manual, the Tresillian Model of Care (MOC), and the importance of accurate documentation with regard to child protection and medico-legal issues are outlined with focus on the relevant issues to come out of the Garling Report. Finally, the new challenges for nursing documentation arising from the introduction of the electronic medical record (eMR) and Activity Based Funding (ABF) to the Australian healthcare setting are included.

1.1 Background

During the two past decades there has been an explosion in the amount of clinical information generated by the healthcare industry (Dulit 2002, Armstrong & Kelly 2010). Summary estimates from the University of California, Berkley School of Information Management (2003) show that the storage of new information has been growing at the rate of 30% a year. A more recent study by Gantz & Reinsel (2011), found the amount of information created and replicated has surpassed previous estimates and has grown by a factor of nine in just five years. The collection and management of clinical data is becoming an ever-increasing challenge to Australian health care facilities.

In 2008, Peter Garling SC led the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals. Garling (2008) noted that there is already a great reservoir of information available within NSW Health. He then emphasised that the problem is not in collecting the data but understanding its meaning and being able to interpret it. Through understanding and analysing clinical information accurately, significant improvements in health care can be achieved as asserted by Garling in the following words:

Information is the basis for knowing where the health care is at, where it has to go, and when it has arrived (Garling 2008, p.8).

This study aims to analyse clinical information in order to improve the understanding of communication and documentation practices in the Child and Family Health residential setting.

1.1.1 Location and Setting of the Study

In Australia, there are nine Early Parenting Centres (EPC) providing early intervention, support and education to parents with well young children (0-5 years). Infant feeding, sleep and settling problems and other parenting concerns are common reasons for admission to residential units of these EPCs. The focus is on working with parents, infants and other family members before problems have reached crisis point.

The role of an EPC as stated in the Tresillian Annual Report (2010, p.4.) is to:

- Provide holistic family care within a primary health care framework through a range of services responsive to community needs. Primary health care includes specialised nursing care, medical support, psycho-social interventions, family advocacy, health promotion and clinical assessment of the growth and development of infants and young children;
- Provide child and family health education and associated resources in child and family health to health professionals and the community;
- Develop Tresillian's advocacy and research role.

This study has been conducted in three residential units of an EPC situated in Sydney, NSW. The three residential units are geographically located in very different areas of Sydney; one unit is in a predominately culturally diverse area; the second is in a well-established middle income area; and the third is in a developing area with many young parents. The physical layouts of these units also vary with two modern purpose built units and one large federation-era house which is divided up into three units.

In these units, mothers, and/or other significant carers (e.g. fathers, grandparent) and infants can undertake a five day/ four night program to address issues such as the infant's unsettled behaviour, feeding problems and other concerns faced by the parents' transition into parenthood. Frequently the presenting parenting problem or difficulty is complicated by complex mental health or psycho-social issues such as eating disorders, perinatal depression and anxiety, domestic violence and experiences of childhood sexual or physical abuse and neglect.

Nurses provide the majority of parenting intervention, support and education during a parent and child's stay within the EPC's residential units. During their admission parents are also able

to access additional assistance from psychologists, social workers, paediatricians and psychiatrists. There are three groups of nurses working within the residential units. These are: registered nurses (RNs) with an additional qualification in child and family health nursing; mothercraft nurses¹ and enrolled nurses (ENs) with an additional qualification in parentcraft nursing.

EPCs have been keen to demonstrate the high level of care provided to families by its early parenting services. However, there has been minimal documented evidence to support the regular verbal feedback from parents of the high level of satisfaction with the services provided (Fisher & Rowe 2006; Barnett & Morgan 1996); or to demonstrate nursing practices used to work with families. This study may contribute evidence to support this goal of the EPCs.

1.1.2 Personal Perspective on the quality of documentation

As the Health Information Manager (HIM) employed by an EPC, I am aware of the importance of accurate and informative nursing documentation and have seen how inadequate documentation can potentially undervalue the complex work done by the nurses working in EPCs. As a clinical coder and an end-user of the information contained in clinical records, it has become evident through my work, that the quality of the clinical information collected in EPCs for research, planning, future funding, mandatory reporting to government agencies, medico-legal issues, child protection and custody, and to reflect 'best practice', is dependent on the accuracy of nursing documentation. The quality of clinical documentation is a key element in collecting useful data. The data are collected by coding the clinical record and must be accurate to be of benefit for healthcare planning and development.

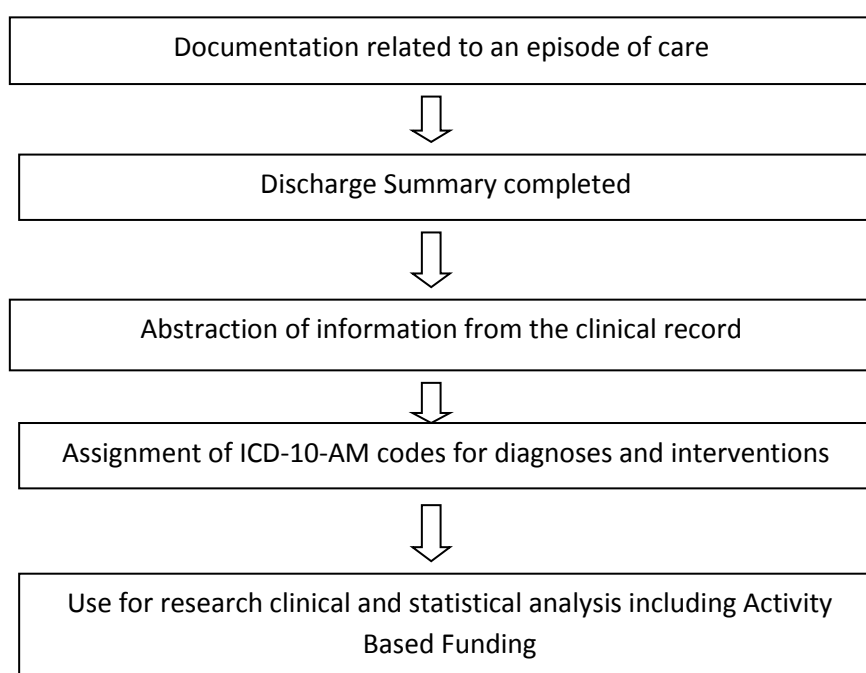
1.2 Clinical Coding is dependent on accurate documentation

Clinical coding is a method of translating a clinical description of a disease or procedure into a standard code (NCCH 2001). The coding classification used by NSW Health is the International Classification of Diseases, Tenth Revision, Australian Modification (ICD-10-AM). The clinical coding process is extremely complex.

¹ For the purpose of this thesis no distinction will be made between enrolled nurses and mothercraft nurses both will be referred to as ENs.

Clinical coding is a subjective activity. Often there is no direct match between what is written in the clinical record and what is in the alphabetic index of the ICD-10 AM classification. The clinical coder is dependent on the quality of the documentation completed by clinical staff and contained in the clinical records and often has to attempt to read between the lines' to understand what has been documented. The clinical coding process requires the clinical coder to find the best code match for the terminology used in the clinical record. Achieving an exact match between the code and the documentation in the clinical record can be problematic. Slight differences in wording or diagnostic semantics can lead to incorrect coding assignment. If the clinical record is incomplete, poorly documented or contains conflicting information the clinical coder may be forced to make clinical judgments in relation to the patient's diagnosis (NCCH 2001). Table 1 illustrates the relationship between the entry in the clinical record by the nurse and how this information is ultimately coded and analysed with the resulting data being used for clinical research and funding.

Table 1. Documentation and Coding Process



Inadequate, incomplete or missing facts in the documentation lead to frustration for the clinical coder and raises concerns regarding the quality of data. It can leave the organisation vulnerable to negative interpretation and may not reflect the excellent work being done by nurses in the CFH Services. This was the driving force for the development of the ICD-10-AM Early Parenting Manual which was a significant step forward in enabling the collection of accurate clinical data for EPCs.

1.2.1 Development of ICD-10-AM Early Parenting Manual

For many years, the collection of useful data and the reporting requirements of State jurisdictions to report diseases and interventions have posed some challenges for Australian EPCs. These services are unique in the Public Hospital System as they treat 'well' patients (without disease). All public hospitals are required to submit morbidity data to State and Federal Governments using ICD-10-AM codes. As ICD-10-AM classifies 'diseases', it was recognised by EPCs that using the ICD-10AM classification did not sufficiently describe the 'diagnoses' of the EPCs' clients, or adequately code the interventions that are performed by nurses and other health professionals. There was a definite need for EPCs to have an accurate coding classification and ICD-10-AM (the classification used at the time) was not meeting this need.

In August 2000 the National Centre for Classification in Health (NCCH)² and EPCs throughout Australia collaborated in the EPC's Coding Study. In this way the clinical records of EPC patients were examined using the International Classification of Diseases, Tenth Revision, Australian Modification (ICD-10-AM) codes. In 2001 the NCCH and Early Parenting Centre HIMs, produced a manual incorporating a list of terms extracted from the results of the Early Parenting Coding Study and the EP Classification (Randall 1999).

Working as a HIM at Tresillian I was part of the research and development team for the creation and development of the ICD-10-AM Early Parenting Manual in conjunction with the NCCH. This manual proved to be a significant step towards improving quality and consistency of data collected by EPCs, providing a common clinical and 'coding' language for staff by enabling improved reporting and measurement of health data. An example of this can be seen in Appendix A – ICD-10-AM Coding example.

The scope of the ICD-10-AM Early Parenting Manual with the NCCH did not include the way nurses and others, document their care and other critical incidents within the clinical record. Achieving an exact match between the code and the documentation is of the utmost importance in code assignment; differences in wording or terminology can lead to incorrect coding assignment, and subsequently affect future government funding and program development for EPCs.

² The contract for further development of the ICD-10-AM Classification changed from the NCCH to the National Casemix and Classification Centre (NCCC), University of Wollongong in 2010.

1.3 Model of Care and Care Pathway

Concurrently, there have been other projects within the Tresillian Family Care Centres, the EPC where this research is located that have highlighted the need for improved accuracy of documentation. In the 2005-2010 Strategic Plan, a need was identified for the development of a Model of Care (MOC). Supporting the MOC are practice principles (see Appendix B – Tresillian Model of Care Practice Principles) enabling the provision of consistent and high quality parenting services, including the development of an evaluation framework. The MOC development was informed by an investigation into international and national ‘best practice’ for working with parents and young children. The implementation of the MOC has led to the introduction of a ‘Care Pathway’ which has highlighted the need for nursing documentation to accurately reflect observations of the parents and communications between staff and parents (families). Unless documentation is appropriate, it does not allow evaluation of the success of the model or demonstrate the use of the practice principles.

This MOC establishes a collaborative relationship between parents and clinicians, as well as effectively engaging and preparing parents for positive and achievable parenting changes that work within their family and cultural context. The documentation of these mutually identified positive changes or parent goals, contrasts with the more traditional form of documentation in the clinical record, and this should be a major advantage to achieve accurate data collection and analysis for the EPC. The implementation of the Care Pathway within the EPC has been another step forward in validating the work done by this EPC and identifying types of parents that use the EPC services.

1.4 Child Protection

The escalating focus on child protection and Family Court issues in EPCs has increasingly resulted in clinical records being subpoenaed by the courts for child custody and child protection cases. In these situations the clinical records may be placed under scrutiny many years after the parent and child have had contact with the centre.

Unfortunately, health professionals do not always competently document care in a complete, legal and useful manner, ensuring that all reports and entries in the clinical records are correctly signed and dated. Inferior and insufficient documentation, gaps in documentation and a lack of consistency in the language used by nurses can have enormous repercussions on the children, families, the nurses and organisation.

1.5 Garling Report 2008

The Garling Report is the final report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, published on 27 November 2008. This inquiry was commissioned by the NSW Government as a result of public disquiet over the state of the NSW Hospital System. Commissioner Peter Garling SC and his team visited 61 public hospitals over a 10 month period; reviewed over 1200 submissions; held 39 public hearings and analysed over 30,000 documents. The final report made 139 recommendations including a focus on: education and training; workplace reform; clinical records and IT; and communication.

The documentation within clinical records has significant patient and child safety issues as well as legal and ethical issues for nurses. Peter Garling (2008) based his recommendations on the principle that the safety of the patients and the quality of their care is paramount.

Although, the Garling Report states that collecting and understanding written clinical information is of the utmost importance in hospitals; it also recommends that all communication needs to be improved. The Report goes on to say that everyone employed in a hospital environment needs to work on effective communication, otherwise there will be chaos and emphasises the importance of note taking, clinical records and documented handover between nursing shifts. The Report identifies that any one patient in a public hospital is likely to be seen by at least three teams of nurses and other health professionals in the course of 24 hours. Documentation in the clinical records must be clear and accurate as no one person will be able to remember all of this information and it must be available for all clinicians to use. Garling recommends that clinical information should be communicated in four ways: in clinical notes, during multidisciplinary ward rounds, at handover and by word of mouth at other times during the shift.

Correspondingly, the current practice of handover between one group of clinicians and the relieving team carries risks for the patient when information is not well communicated between the two groups. Useful handover is at the centre of communicating patient care within the health care system and is an important, efficient method of information sharing between clinicians. The report recommends that a mandatory shift handover policy be implemented immediately, with the rollout being accompanied by appropriate training for all staff (Garling 2008).

1.6 Handover

Handover is *'the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis'* (Australian Medical Association, 2006, p.8).

Documentation within clinical records and verbal handover have similar purposes as nurses use both practices to communicate information about clients to other nurses and health professionals. Nursing documentation has been identified as containing much more objective data about the client, while judgments about the patients' condition, psychological state and personality occur more frequently in verbal handover (Jefferies, Johnson, Griffiths & Clinical Development Group 2008). Together, these make up the links in the chain of continuity of patient care.

The contribution of knowledge in relation to understanding nursing documentation practices and verbal handover practices in EPCs will be an important input in improving clinical communication practices. In more particular terms, the outcomes will increase knowledge about nurse reporting mechanisms/process within EPC residential services; identify the differences between the reporting that occurs in the documentation and verbal handover; identify the required crucial elements within verbal and written reports to improve client care and ensure reports comply with legal requirements; and identify improvements that can be made to the quality of data within nursing reports to enhance data extraction for research and mandatory reporting purposes.

Handovers allow nurses to share their knowledge with other clinicians irrespective of team or role. The 'informational' function of handover according to Kerr (2001) includes the elements of patients' psychosocial needs including family problems. Handover enables nurses and clinicians to discuss the underlying emotional distress of the family and its impact on the patient's condition.

The British Medical Association (2004) reported that poor handover can lead to adverse patient outcomes. The constraints of time, staffing issues and work practices can result in a handover that is too brief, reducing the ability to pass on important information (Jenkins, Abelson-Mitchell & Cooper 2007).

1.6.1 Communication Skills needed for Clinical Documentation and Handover

In the same way that special skills and techniques are required for academic writing, particular skills and techniques are required to produce quality nursing documentation. All nursing documentation must be sensitive enough to show changes in the patients' conditions and care. It requires personal accountability to ensure that the nurse has accurately recorded the care they plan to provide, the care they have provided and the observed outcome of that care (McCrow 2010). The NSW Department of Health³ describes nursing documentation as data recorded by nurses concerning the nursing care given to a patient, including judgment of the patient's progress (Jefferies et al 2008).

The Australian Medical Association (2006) states that the aim of handover is to achieve the efficient communication of high-quality clinical information at any time, when the responsibility for patient care is transferred. Useful handover is at the heart of an effective healthcare system and stands alongside clinical documentation to make up the links in the chain of continuity of patient care. Handover requires systemic and individual attention and needs staff who receive education, support, facilitation and sustained effort to ensure it maintains a position of importance in an already full working day.

In the study of 'Modes of Rationality in Nursing Documentation', Hyde, Treacy, Scott, Butler, Drennan, Irving, Byrne, MacNeela, & Hanrahan (2005) discuss 'holistic' nursing and the theme of 'nursing documentation' versus 'biomedical documentation'. This study describes nurses as having excellent skills in documenting medical-technical information but their skills are not adequate for documenting psychosocial patient issues. It goes on to say that nurses are excellent verbal communicators but are not 'good' documenters.

Similarly, Manias & Street (2000) argue that although nurses learn to communicate through documentation in formal education programs, greater emphasis is placed on the oral practices of communication in healthcare institutions. This emphasis on oral communication, supports the belief that nurses 'know' what to do and, therefore, do not need to keep careful records of what has been done previously to guide them in their decision-making.

Historically, nurse education in the public hospital system has often been *ad hoc* rather than planned, and this will become an increasingly serious problem in circumstances where only junior nurses are available (Garling 2008). Garling (2008) argues that 22% of the NSW nursing

³ In 2011 the name of the NSW Department of Health was changed to the NSW Ministry of Health

workforce will have qualified for retirement in 2011; this will leave many junior nurses working in the public health system with insufficient senior nurses to provide supervision and mentoring. Reforms in undergraduate nursing courses are needed to create a modern, well-educated, flexible workforce.

In Documentation Workshops, it has been noted that many nurses, who are excellent verbal communicators, are not confident with all aspects of nursing documentation. These nurses are unsure about writing 'defensively', or in a manner that explains their decisions, so that this information can be used in legal proceedings for many years into the future. Also, they are confused about when to use documentation by 'variance', that is, when to document by exclusion, or only document changes in condition or care; and how to avoid repetition of data in different sections of the clinical record. Also to avoid writing 'what they think' or 'presumed' happened.

1.7 Electronic Medical Record

It is generally agreed that high-quality nursing care depends on access to high quality information. Saranto & Kinnunen (2009) identify in their work that evaluates nursing documentation, that the principal source of clinical information is the nursing notes or nursing care plan. Quality documentation and the use of standard terminology by nurses is a crucial element in assuring the continuity of patient care.

The Electronic Medical Record (eMR) is gradually being introduced to Australian healthcare institutions. NSW Health Department plans to replace the paper clinical record with an online record which tracks and details a patient's care during the time spent in hospital. Over the next three years, approximately 84,000 clinicians and scientific staff in up to 88 public hospitals in New South Wales will start using the eMR (NSW Health 2011).

The introduction of the eMR will help minimise opportunities for mistakes and misinformation in clinical information (Garling 2008). However, the introduction of the eMR will create new challenges for nursing documentation, as eMRs rely on the use of standardised terminologies by its users.

Nurses will be one of the main users of eMRs, and it is critical that further understanding of nurses' educational needs to competently transfer patient information through documentation is made available to educators, to create appropriate education in documentation using standard terminologies. As stated previously, there is already a great reservoir of information available within NSW Health; the problem is not in collecting the data

but understanding the meaning of the data and being able to interpret it accurately. Therefore the study described in this thesis is well justified and timely.

1.8 Activity Based Funding

Activity-Based Funding (ABF) is a central feature of the Australian hospital reform plan - '*A National Health and Hospitals Network for Australia's Future*' (2010). This plan proposes that, from 1 July 2012, the Commonwealth will progressively introduce ABF to Australian healthcare (Eagar 2010). Using ABF, healthcare facilities will be funded on the activity they undertake.

This activity will be identified through Casemix which literally means the 'mix of cases' that a health service treats. The Casemix data is collected by clinical coders from the clinical records through the use of classification systems. For this process to work efficiently, the importance of clear, timely, complete and accurate documentation in the clinical record cannot be undervalued. The clinical coder is dependent on the quality of the documentation in the clinical record and therefore the amount of funding allocated to a health care facility will also be dependent on the quality of the documentation in the clinical record.

1.9 Significance of the study

This study builds on my involvement as a HIM in the development of the ICD-10-AM Early Parenting Manual in 2002. This manual is a significant step towards improving quality and consistency of data collected by EPCs, providing a common clinical and 'coding' language for staff enabling improved reporting and measuring of health data. However, this manual did not address the actual documentation; or accuracy and quality of information collected in the clinical record.

This study aims to investigate nursing documentation practices within an EPC. The focus will be on the: differences between what nurses write in the clinical records and what they communicate verbally in 'handover'; and variations between the verbal and written stories will be highlighted and explored. The aim is to contribute to the existing knowledge about nursing reporting mechanisms; and to increase the understanding and accurate analysis of clinical information.

There has been minimal evaluation of EPCs; which leaves these services vulnerable to funding cuts if policy-makers do not recognise the positive outcomes of such essential early intervention. A systematic review of the literature completed by Fisher & Rowe (2006) found that there had been no formal investigation of the impact of Child and Family Health services.

This finding is reinforced by Barnett & Morgan (1996) who challenged secondary and tertiary level parenting services to provide evidence of service efficacy. Quality data is essential to validate the work done by EPCs and identify the types of parents that use the services provided.

1.10 The thesis outline

In this chapter I have provided a background to the study. This includes the study location and setting, my personal perspective on the importance of quality clinical information collected through clinical documentation and handover. An overview of clinical coding, the coding process and its uses for research, planning and future funding has been provided, highlighting the dependence of quality clinical data on the accuracy of nursing documentation. The history of the development of the ICD-10-AM Early Parenting Manual, the Tresillian Model of Care, and the importance of accurate documentation with regard to child protection and medico-legal issues is discussed as well as other relevant issues to come out of the Garling Report. Finally, the new challenges for nursing documentation arising from the introduction of the eMR and Activity Based Funding to the Australian Health Care setting are included.

The following chapter (Chapter Two) reviews the literature on nursing documentation and handover in Australia and Internationally. This review focuses primarily on the literature that deals with nurses' documentation and handover practices; the quality of written and verbal communication between clinicians; and the importance of collecting accurate and complete data from the clinical record for use in clinical coding to ensure the quality healthcare.

Chapter Three describes the study design and method that have been used to address the research question and aims of the study. The first section of this chapter includes a description of a Qualitative Interpretive research approach used in this study employing several forms of data collected about the same clinical experiences. Following this is a description of the setting and context, recruitment and participants involved in the study, inclusion and exclusion criteria and a description of the data management ensuring the right to confidentiality, privacy and anonymity. The final section describes the data collection and analysis including the development of a coding template and analysis of nursing interviews. The coded data collected from the coding template and the nursing interviews can then be used to identify important themes, organise them a meaningful manner and allow the analysis to identify issues of concern.

The analysis has been conducted in two parts.

In **Chapter Four**, the first part of the data analysis is discussed. This examines the handover transcripts and the clinical record documentation of three case studies through the use of clinical coding and the development of a coding template.

And secondly **Chapter Five** further examines the data collected from the nursing interview transcripts, using the themes identified in Chapter Four.

Chapter Six discusses the overall findings of the study. This includes a discussion of the emergence of four major themes from the analysis. These themes included client focus; communication and information sharing; organisational guidance; and varying work practices. Limitations of the study are included and discussed. This chapter concludes with a discussion on the future direction for clinical documentation practices within EPCs, identifying the new challenges for nursing documentation arising from the introduction of the eMR and Activity Based Funding to the Australian healthcare setting.

Chapter 2

Literature Review

2.1 Introduction

Nursing has a long tradition of eschewing the written word and a consequent over-reliance on handing down both information and knowledge by word-of-mouth. This oral tradition is best demonstrated during the still-prevalent handover ritual where records and care plans are often not referred to, and informal notes are used to prompt nurses in verbally reporting to each other. The result is an invisibility of the real work of nurses in the written records of health services (Pearson 2003, p.271).

Australian Healthcare Services, including Child and Family Health (CFH) Services are coming under increasing pressure by government and other agencies to demonstrate that the services they provide reflect international research findings and incorporate best practice (Garling 2008, Eagar 2010). These services are keen to demonstrate the high level of care provided to families for future government funding and support. There has been minimal documented evidence to support the high level of care given by CFH services; much of this information as stated in the opening quote by Pearson (2003) is communicated verbally between nurses, resulting in the invisibility of the real work carried out. There is a lack of correlation between nursing practice and documentation, that is, nurses' notes do not adequately reflect the actual work done as often nursing practice is not easily translated into words (Howse & Bailey 1992, Brooks 1998, Bjorvell, Wredling and Thorell-Ekstrand 2003, Pearson 2003, Hyde *et al* 2005, Davies & Priestly 2006). Recent work by Gogler (2010) reported that formal nursing documentation was poorly used and incomplete; there were inconsistencies in the use of assessment tools; and the unnecessary duplication of data lacked logic and structure.

Unwritten communication between nurses allows knowledge and information to be handed down with a wealth of nursing expertise being lost in verbal handover. Hopkinson (2002) argues that as nursing documentation is not well maintained and is not up to date with current practice and technology, verbal handover provides necessary backup. Her phenomenological study of 28 nurses identified two important functions of nursing handover. The first was a forum for discussing opinions and expressing feelings and the second was as a source of information on which to base nursing decisions and actions. She also argues that handover

reinforces a shared value system between nurses, and therefore is important to team-working and team-building.

This review of the literature will discuss the need for quality nursing data; the need to reflect 'best practice' by nurses; exploring the differences and identifying variations and disjunctures between the verbal and written stories; and highlighting the importance of high quality clinical data to ensure positive outcomes for clients, families and the Australian Healthcare System. The collection and understanding of accurate clinical information in CFH Services is of the utmost importance. Particularly as a means of communication for both staff and parents and therefore continually needs to be improved.

2.1.1 Purpose and scope of review

The aims of this review were to identify and evaluate themes in nursing documentation and handover in national and international literature, and to explore the need for quality nursing data collected through nursing documentation and verbal handover. A search of the literature was undertaken to determine if there was evidence that nurses have an overreliance on handing down both information and knowledge by word of mouth as stated by Pearson (2003), and if there is evidence that this results in invisibility of the real work carried out by nurses as reflected in their clinical documentation. It is these two questions that have guided the literature search and are the core of this review.

This review focuses primarily on the literature that deals with nurses' documentation and handover practices; the quality of written and verbal communication between clinicians; and the importance of collecting accurate and complete data from the clinical record for use in clinical coding to ensure the quality healthcare. It will bring to light the differences between what nurses write in the clinical records and what they communicate verbally in 'handover'; with the hope to enhance the knowledge about nursing reporting mechanisms; and increase the understanding and accurate analysis of clinical information through clinical coding so that improvements in health care can be achieved.

2.1.2 Search terms

Literature searches were made of databases containing scientific peer-reviewed articles, including MEDLINE and CINAHL. These searches have been progressing using key terms such as nursing documentation; hospital documentation; clinical information systems; medical records; care pathways; nursing culture; nursing practice; communication; verbal communication; clinical coding; activity based funding; . Additional searches were conducted

with direction from the UTS librarian using EBSCO, ProQuest, Ovid and Google Scholar; and recently searches using CIAP with the help of the Canterbury Hospital Librarian have been undertaken. These searches have been more systematic using additional key terms such as communication; health informatics; clinical coding; clinical analysis; clinical classification; handover; verbal handover; interprofessional relations; shift handover; handover practice; family; family health; and paediatrics. Articles retrieved from these searches that did not focus on the purpose or scope of this review were discarded. Articles were also excluded if they were directly associated with the use of clinical documentation research older than 1990 or were studies in languages other than English.

Research articles, discussion papers, conference papers, government, nursing and health information management association journals and web sites were also acknowledged and used. The search was mainly limited to articles published from 1990 to 2011 in an attempt to capture a representation of documentation and handover practices written about within the last 20 years. Numerous articles, texts and published works were analysed and critiqued to provide a basis for this research. New references and publications were reviewed and added to the reference list during the course of this study. This review is predominantly based on the research literature of ten main authors.

2.1.3 Reference lists

Reference lists obtained from retrieved literature were reviewed to identify relevant articles not yet considered. Some useful articles related to different aspects of this study were found in this way that did not include the study search terms.

2.2 Review of the literature

The review of the literature is provided in the following pages and will focus on the themes of nursing documentation, handover, clinical coding, clinical analysis, best practice, patients' needs and written versus oral communication, while determining the above mentioned questions that have guided this literature review. It will highlight the problems faced by nurses and reflect the work done and reveals why clinical information is being lost. Much of the literature suggests that nursing documentation and oral handover have similar purposes in that they are both used by nurses to communicate information about patients to other nurses. Nursing documentation contains much more objective data about the patient, while

judgments about the patient's condition, psychological state and personality occur more frequently during verbal handover (Jefferies *et al* 2008).

2.2.1 Nursing documentation

Nurses' documentation is a process in which the patient's experience from admission to discharge is recorded to enable the reader to understand what has occurred. Regulatory requirements from the NSW Department of Health (2005) state that the Health Care Record is required to be sufficiently detailed and comprehensive to provide effective communication to the health care team; to provide for a person's effective, continuing care; to enable evaluation of a person's progress and health outcome and to retain its integrity over time.

Research studies have found that nursing notes do not always provide an opportunity to demonstrate the high quality of their nursing practice and do not adequately reflect actual work done. Qualitative studies by Brooks (1998) and Bjorvells *et al* (2003) using questionnaires to investigate nurses' perceptions about clinical documentation, suggest that nurses do not clearly document their knowledge and practice.

Nurses believe that their area of expertise is unique and are not satisfied by the use of generic clinical record forms and standard documentation practices used by other health professionals (Gogler 2010). Brooks (1998) found that although nursing documentation was beneficial to nurses and their patients in their daily practice, nurses do not clearly document their knowledge regarding the patient and work practice issues. Behavioural issues that were considered of utmost importance to nurses, such as patient confusion, anxiety and frustration were **not** noted but rather communicated verbally to other staff. Some possible limitations of these studies were that the design was a one point in time measure and differences in nursing education and experience of participants was not explored.

2.2.2 Handover

Handover allows nurses to share their knowledge with other clinicians irrespective of team or role. The 'informational' function of handover includes the elements of patients' psychological needs including family problems. During handover nurses and other clinicians can discuss underlying emotional distress of the family and its impact on the patient's condition (Kerr 2001).

It is well accepted by nurses that handover is the 'exchange of information' about patient care. Kerr (2001) recognised that shift handover played a pivotal role in the continuity of patient

care. His quantitative study was set in two paediatric wards with handovers being audiotaped. Kerr divided handover practices into four main functions: *informational* – basic goal of patient reports and continuity of care; *social* – social/emotional support; *organisational* – plans for shift; and *educational* – explicit teaching through examples.

Handover is a highly complex communication event, with a range of social and technological practices and multiple functions. While it is argued that a 'wealth' of useful information is being lost at handover (Kerr 2001), many researchers agree that a good nursing handover process is a crucial part of providing quality nursing in a modern healthcare environment (Pothier, Monteiro, Mooktiar & Shaw 2005). However, there are limitations in how far these findings can be generalised into other nursing contexts and the possible effects of the researchers' presence must also be recognised. An important aim of this review is to identify what nurses write in the clinical records and what they communicate verbally in handover and discover if important information is being lost in handover due to inadequate nursing documentation processes.

While it is well known that nursing documentation does not adequately address patients' wishes and needs, the process of handover allows nurses to share their knowledge of patients' needs and wishes with other clinicians, irrespective of team or role. The 'informational' function of handover according to Kerr (2001) includes the elements of patients' psychosocial needs, for example providing information about family problems. Nurses and clinicians are able to discuss underlying emotional distress of the family and its impact on the patient's condition. The process of handover aims to ensure continuity of care by focusing on the transfer of key information as stated in the Tresillian Clinical Handover Policy (2009). It acknowledges that the continuity of client care is ensured by the provision of relevant client information during the handover process; clinical handover is focused on the transfer of key information; confidentiality of information concerning the client is protected at all times; clinical handover is delivered in a timely manner and communication and dialogue between staff results in a consistent approach to care. This policy puts into effect the premise that handover is an exchange of information about patient care which plays a pivotal role in the continuity of patient care. The Tresillian handover is a verbal process, this valuable information can be lost if it is not accurately documented in the clinical record.

2.2.3 Clinical coding and analysis

In Australia, clinical coding is mandatory for all inpatient admissions (Bramley & Reid 2007) including residential admissions to EPCs. Health statistics generated from coded clinical data

which inform social and medical research and health policy development are used under the assumption that data sources are accurate and reliable. An audit study by Cheng, Gilchrist, Robinson & Paul (2009) identified the major problem in the miscoding of clinical information was related to the quality of the documentation. This study aimed to measure discrepancies in clinical coding and identifies the underlying causes of coding error by using a blind auditing method on 752 inpatient discharges from a hospital within a six month period. It was concluded from this study that whilst high level skills in clinical coding are important for accurate coding, the overriding need for improvement is in the clinical documentation. The outcome of coding of poor clinical documentation provides an incomplete record of care and can lead to misinformation being made available to health and outside agencies, hindering the developments and implementation of health projects.

2.2.4 Best practice

Quality data is essential to validate the work done by Child and Family Health (CFH) Services. There is a need to showcase 'best practice' through documentation to attract future government funding and support; and it is imperative that services such as Tresillian collect accurate data to identify the types of families that are using these services for future program development. The introduction of Activity-Based Funding to Australian Health Care from July 2012 emphasises the need for EPCs to accurately document the care provided, as health care facilities will be funded on the activity they undertake (Eagar 2010).

As stated in Chapter One, a systematic review of the literature completed by Fisher & Rowe (2006) found that there had been no formal investigation of the impact of CFH Services on the community. This finding is reinforced by Barnett & Morgan (1996) who challenged secondary and tertiary level parenting services to provide evidence of service efficacy.

2.2.5 Focus on patient needs

Many studies have been undertaken concerning nursing documentation. Karkkainen, Bondas & Eriksson (2005) in a qualitative metasynthesis of the results of fourteen qualitative research projects, highlight that nursing documentation does not meet the criteria of comprehensive and patient centred documentation, and although this has been known for many years, no change seems to have taken place. Karkkainen *et al's* (2005) metasynthesis established that although there were many studies about nursing documentation, there were not many studies that dealt with documentation of 'patient care', most dealt with methods of documentation or attitudes to documentation. This study also found that one of the shortcomings of

documentation was the small amount of written detail covering a patient's wishes and needs. A question was raised about nurses' education regarding their collection of documented information. This included the importance of educating nurses to be aware of documenting patient's needs, and increasing their ability to analyse and express, in writing, their knowledge of a patient's care and wishes. In other words, in order to provide an objective account of a patient's experience of health care from admission to discharge, the nurse should document the care given from the point of view of the patient (Jefferies *et al* 2008).

2.2.6 The loss of important data during handover

Nursing has a long tradition of handing down information and knowledge by word of mouth (Pearson 2003). This oral tradition is best demonstrated during the still prevalent handover. A good nursing handover process is a crucial part of providing quality nursing care. The conservation of patient data during the handover process is vital to ensure good continuity of care and safe practice. Pothier *et al* (2005) observed the handover of twelve simulated patients over five consecutive handover cycles between nurses, recording the loss of data, using three different styles of handover- verbal, note-taking and a typed sheet. Although this approach did not always reflect data collection in reality, the verbal group experienced more data loss than the others. Resulting in a significant loss of patient data impacting on patient care and an invisibility of the real work carried out by nurses in the healthcare setting (Pearson 2003).

2.2.7 The missing link

There are many reasons for the 'wealth' of information being lost in handover. These include a predominantly medical focus on documentation and handover; nurses' perceptions and attitudes of the value of their work; environmental factors such as charting formats; and the historic 'ritualistic activities' associated with nursing documentation and handover practices.

Many nurses maintain a predominantly medical focus in regard to their written documentation and it is unclear whether nursing issues are perceived as noteworthy or valuable by them (Brooks 1998). Findings from this study suggest that nurses do not clearly document their knowledge and practice issues. Behavioural issues that were considered of importance to nurses, such as confusion and anxiety, were not documented but rather communicated verbally to other nurses. One of the factors for pertinent nursing issues not being documented is that the charting format does not provide the appropriate cues from which to draw this information. Karkkainen *et al* (2005) confirms this idea in the previously

mentioned qualitative metasynthesis on documentation of individualised patient care. These results showed that the structure of nursing documentation and the organisational recording requirements inhibit the nurses' ability to adequately document patient care.

Similarly, Howse & Bailey (1992) in research into nurses' resistance to documentation supported the common belief that resistance to completing nursing documentation was influenced by environmental factors such as inflexibility of charting systems, and insufficient allocation of time. However, in this case study, using the views of a sample of four hospital nurses to determine the underlying causes of antipathy towards clinical documentation, additional factors surfaced as impediments to recording information. These were lack of confidence in written expression and difficulties with articulating nurses' practice. It was also noted that difficulty with cognitive processing and written expression; resentment of external control of documentation; and the effect of work group norms impacted on the quality of nursing documentation.

There is other evidence to suggest that the effectiveness of handover is not simply measured by time spent; rather it extends beyond the patient report and involves managing multiple and sometimes conflicting functions. While working as a student nurse on clinical placement, Davies & Priestly (2005) noted in a reflective evaluation of patient handover practices that the inflexibility of handover and the 'ritualistic' activities associated with nursing handover are essential for developing 'good' practice. These 'ritualistic' activities can maximise communication and may include being given a mass of information at the start of each shift about all the patients on the ward regardless of who is looking after them, or the information discussed can be related to human and resource management, housekeeping and administrative issues, and/or clinical and social function.

To a lesser extent, communication problems may also occur at handover, where the efficiency of the handover is entirely dependent on the skills and abilities of the person conducting the handover. Clarification of language can be minimised, bias can influence nurses coming on duty, and lack of time for questions may result in misunderstandings and adverse consequences for the patient (Davies & Priestly 2005). Accurate documentation and clear, concise handover work together to alleviate any communication problems between nurses and clinicians.

Collecting and understanding clinical information is of the utmost importance in hospitals. Communication between clinicians and hospital staff needs to be improved; everyone employed in the hospital environment needs to work on good communication, otherwise

there will be chaos (Garling 2008). Garling (2008) raised concerns that thousands of patients being treated using the 'old style' clinical records will not have the most important requirements for their care well documented. He has recommended the introduction within NSW of an electronic medical record to help minimise opportunities for mistakes and misinformation.

2.2.8 Assumptions and beliefs about nursing clinical communication

Nursing documentation and oral handover have similar purposes; however documentation contains more objective data about the patient while handover contains more judgmental statements about the patients' condition, psychological state and personality (Jefferies *et al* 2008). Nurses do not clearly document their knowledge of their patient's issues and nursing practice; behavioural issues such as patient confusion, anxiety and frustration are often communicated verbally to other staff (Brooks 1998; Bjorvell *et al* 2003; and Karkkainen *et al* 2005).

2.3 Summary

Handover is a highly complex communication event with a range of social and technological functions; and often this wealth of information is being lost (Pothler *et al* 2005; and Kerr 2001). Handover allows nurses to share knowledge on the needs of the family. The collection of this quality data is essential to validate the work done by EPC Centres. Information is being lost at handover because nurses' issues are not perceived as being noteworthy or valuable; charting formats are inflexible; there is lack of time for writing notes; lack of confidence in written expression and difficulties in articulation of nursing practice (Howse & Bailey 1992).

Nursing documentation does not meet the criteria of comprehensive and patient centred documentation, and although this has been known for many years no changes have taken place. Nursing documentation studies have not dealt with the patients' care, wishes or needs (Karkkainen *et al* 2005). Nursing notes do not provide an opportunity to demonstrate practice and do not adequately reflect actual work undertaken. Studies by Brooks (1998) and Bjorvell *et al* (2003) suggest that nurses do not clearly document their knowledge and practice issues. Historically, training for nurses in how to document patient care in hospitals has been ad hoc rather than planned (Garling 2008).

As highlighted in this review, there is an over-reliance by the nursing profession on handing down both information and knowledge by word-of-mouth. Problems with written

communication may be a consequence of the lack of correlation between nursing practice and the expectations of documentation. In the complex context of nurses' workplace, practice is confusing and not easily translated into written words. (Howse & Bailey 1992). Nurses believe that their area of expertise is unique and are not satisfied by the use of generic clinical record forms and standard documentation practices used by other health professionals (Gogler 2010).

There is a wealth of nursing expertise and knowledge that is lost in nursing handover. This information could be used to promote professionalism in nursing. Kerr (2001) concludes that handover is robust and adaptable as the effectiveness of handover extends beyond the patient report and involves managing multiple and sometimes conflicting functions. Handover allows nurses to share their knowledge with other clinicians irrespective of team or role.

Garling (2008) emphasises the importance of 'note taking, clinical records and handover'. He states that any one patient in a public hospital is likely to be seen by at least three teams of nurses and other health professionals in the course of 24 hours. Documentation in the clinical records must be clear and accurate as no one person will be able to carry all of this information in their head and it must be available for all clinicians to use. He recommends that clinical information should be communicated in 4 ways: clinical notes, during multidisciplinary ward rounds, at handover and by word of mouth.

This research will contribute to building knowledge around clinical documentation and handover practices in EPC Centres and provide documented evidence to support the high level of care provided by CFH Nurses.

In the next chapter I describe the research study design and methods that have been used to address the research question and aims of the study. The first section of this chapter includes a description of the Qualitative Interpretive research approach used employing several forms of data collected about the same clinical experiences. Following this is a description of the setting and context, recruitment and participants involved in the study, inclusion and exclusion criteria and a description of the data management ensuring the right to confidentiality, privacy and anonymity. The final section describes the data collection and analysis including the development of a coding template.

Chapter 3

Study Design and Method

This study has investigated nursing documentation practices and client information transfer within a child and family health setting using a qualitative interpretive research approach. The overall aim was to explore the differences between what nurses write in the clinical records about infants and their parents admitted to an EPC unit and what they communicate verbally in 'handover'. In this chapter the study design and method will be described. This will also include nurse participant characteristics, data management, ethical considerations and analysis approaches.

3.1 Qualitative Interpretive Research Approach

A qualitative interpretive research approach has been used to frame this research study. This research design has been chosen as it focuses on understanding the meanings, purposes and intentions people give to their own actions and interactions with others. Interpretivists believe that researchers should re-think the role of methods in the research process (Smith 2011).

Central to the interpretive framework is the notion of 'verstehen' or understanding. Max Weber (1864-1920) a German sociologist who profoundly influenced social theory was the first to discuss 'verstehen' (Elwell 1996). Weber stated there are two kinds of understanding. One, being the direct observational understanding of subjective meaning of a given act; and two, being explanatory understanding where the researcher understands the motive, or, what makes an individual do a particular thing in a particular circumstance. Since we (as researchers) are interested in the subjective meaning of action, we must place an action in the complex of meaning in which it took place (Elwell 1996). In more recent years, several social scientists such as Denzin & Lincoln (2011) have emphasised the inseparability of understanding from interpretation and concluded that all social research is interpretative because it is guided by the researcher's desire to understand and interpret social reality.

The actual inquiry procedures employed by interpretivists are similar to those used by other qualitative researchers, but there is a major difference in that interpretivists do not accept that specific techniques are essential and believe that analysis can vary from one situation to another (Smith 2008). As various methods can be used when conducting qualitative interpretative research, a range of sources and methods for the design of this research were

informed by knowledge, skills and understanding gained as a Health Information Manager (HIM), employed in the area of clinical coding and patient data management with many years of experience.

The qualitative interpretative approach used for this study employed several forms of data collected about the same clinical experiences. The methods of data collection included:

- observation of the handover process
- digital recording of the handover process,
- a review of documentation in clinical records.
- digitally recorded interviews with four nurses

Using these methods, variations between the verbal and written stories will be highlighted and explored to increase knowledge about child and family health nurse reporting mechanisms; and to increase our ability to understand, analyse and interpret clinical information accurately to enable improvements in health care.

3.1.1 Setting and context

This study has been set in three residential units of an Early Parenting Organisation situated in Sydney, NSW. This organisation provides early intervention, support and education to parents with well young children. Standard policies and procedures concerning handover and clinical documentation have been introduced and implemented for the organisation as a whole; although different practices for handover and clinical documentation in each unit have evolved over time. A detailed description of the location and setting of the study has been given in Chapter One.

3.1.2 Ethical considerations

When undertaking research with human participants, it is important for researchers to respect the participants' right to the protection of their privacy, to recognise the debt owed to those people who have agreed to be participants of research, and respect them accordingly (Australian National Health and Medical Research Council Act 1992). In this study, approval was granted by the Human Research Ethics Committee (HREC) of the University of Technology, Sydney. The EPC in this study uses the UTS HREC to approve research conducted within their services. The EPC supported this research and provided a supporting letter to the ethics committee to this effect.

3.1.3 Recruitment of participants and consent process

While the focus of this study is the documentation and handover practices of nurses, parents of infants who were the subjects of the documentation and handover were also recruited and provided consent for the use of their data. Therefore three groups of participants were recruited to the study:

1. a convenience sample of six parents of seven infants who were admitted to the EPC
2. a convenience sample of 22 nurses who provided care for the six parents and seven infants during the study period
3. a purposive sample of four nurses who were interviewed

The recruitment process is detailed below:

Nursing staff, working in the three research sites, were invited to information sessions prior to the commencement of the study. These information sessions were facilitated by an independent health professional working within the Early Parenting Centre (EPC) who had a thorough knowledge of the recruitment and consent processes of the study. The nurses were provided with an information sheet (see Appendix F – Information Sheet CFH Nurse). If they agreed to participate they were asked to sign the consent form providing consent to digitally record each handover session in relation to the six parents and their infants (see Appendix H - Consent form CFH Nurse). All the nurses agreed to participate. Nurses working at the three EPC's residential units consented to be involved in the study.

In the same way, the nurses asked to be involved in the semi-structured interviews were provided with an information sheet (see Appendix J – CFH Nurse Semi-structured Interviews) and given the opportunity to discuss their involvement in the study with an independent health professional working in the EPC. If they agreed to participate they were asked to sign the consent form providing consent to digitally record their involvement in a 20 minute semi-structured interview (see Appendix K - Consent form CFH Nurse Semi-structured Interviews).

The parents were approached by the Nurse Unit Manager (NUM), shortly after admission and prior to the afternoon handover, to be provided with information about the study (see Appendix G – Information Sheet Parent). If the parents consented to be part of the study then further verbal information was provided by the NUM. Written consent was obtained to record the verbal handover about their care and to review the documentation in their clinical

records. This process ensured that only data from parents who had consented was included in the data collection (see Appendix I – Consent Form Parent).

3.1.4 Possible risks and the right to withdraw

Participation in this study was entirely voluntary and the participants could withdraw from the study at any time with no negative implications. Parent participants were provided with information about the research study by the residential unit NUMs on admission, as well as, information being included on the research information and consent forms. These parents were informed that non-participation or withdrawal from the study would in no way be problematic and would not impact on their future involvement with the EPC.

Nurse participants were provided with information during an information session, as well as having information included on the research information and consent forms given to them. They were similarly informed that non-participation would not impact with their current or future employment at the EPC. If participants wished to discuss any concerns about the study, contact details of the study supervisor and the Research Ethics Officer were listed on the consent forms.

3.1.5 Selection of the participants

The participants were the parents admitted to the EPC during the data collection period who consented; and the nurses who were providing the handover report for these parents over the four day admission period. Parents who met the inclusion criteria and agreed to participate in this research study were included from admission to discharge. This was considered an appropriate approach for this study as all families were admitted to the EPC during a specific time period, had a similar casemix and was considered equally suitable for inclusion in the study.

3.1.6 Inclusion criteria

All nurses participating in the clinical handover during the designated period were eligible for inclusion in the study.

Parents who were admitted to the EPC Residential Unit for the first time on the day the data collection commenced were eligible if they met the inclusion criteria. The Centre Manager (CM) or NUM identified the potential parent participants using the selection criteria. The CM or NUM would speak to the parents and invite them to join the study. If consent was given,

these parents' afternoon handovers were recorded and the clinical documentation reviewed from admission to discharge.

The inclusion criteria for the nursing interviews were based on the need to speak to two Mothercraft nurses/ENs, and two RNs, one being a Clinical Nurse Consultant (CNC) with responsibility for clinical practice standards within the EPC. These nurse interviews would assist in understanding the nursing experience and skills of the CFH nurses.

3.1.7 Exclusion criteria

Non-English speaking parents who required an interpreter were excluded from the study. This was due to the difficulty in gaining access to the interpreter service to ensure the parent has provided informed consent. Others excluded were parents with known involvement with NSW Family and Community Services⁴ (FACS) due to the sensitive nature of their admission and possible future involvement with court proceedings.

Given the nature of the research and the inclusion and exclusion criteria identified above, it was anticipated that no harm or distress would be experienced by participants.

3.2 Data Sources

Data were collected from four sources for this qualitative interpretative research. The following sections will describe these four sources of data collection: case studies, interviews, field notes and questionnaires.

3.2.1 Case studies

These data were collected during the afternoon handover sessions over four days (from admission to discharge) in each of the three residential units. Two family admissions (discussing both parent and infant) in each residential unit were digitally recorded and transcripts were produced from the digital handover reports, with each handover taking approximately 20 minutes. A documentation review was conducted on the clinical records of the same family admissions involved in the handover report process. This resulted in six case studies of six parents and seven infants (one set of twins). Alternative names were given to the mothers and infants participating in the case studies to ensure they were not identifiable.

Clinical coding (a method of translating a clinical description of a disease or procedure into a standard code) was used to develop a coding template using the codes and themes from the

⁴ NSW Family and Community Services (FACS) was formerly known as Department of Community Services (DOCS)

ICD-10-AM Early Parenting Manual (2008) based on the ICD-10-AM (2008). The coding template was created to facilitate the analysis of the handover and clinical documentation data by examining the nursing practice descriptions, diagnoses and interventions provided as well as looking at the social aspects of the parent's and infant's issues. The clinical coding process is extremely complex, it requires the clinical coder to describe the best code match for the terminology used, achieving an exact match can be problematic, slight differences in wording or diagnostic semantics can lead to incorrect coding assignment.

3.2.2 Nurse interviews

In order to ascertain the nurses' perspective on clinical documentation and handover, semi-structured interviews were recorded with four nurses with varying educational backgrounds and experience. These interviews included direct questions, some statements and open-ended questions focusing on nurses' communication about clinical care, reasoning, decision-making and their education level (see Appendix E). For example, 'what factors influence your thinking when deciding what to write?' The answers to the questions assisted with the interpretation of the verbal and written data collected, by aiding with the understanding of the concerns and skills of the nurses, and exploring some of the subtle but important legal and cultural practices of the nurses.

3.2.3 Researcher's field notes

Field notes were made to provide context during the analysis process. These notes provided a recording of nurse participant's attitudes, humour, body language, the prevailing atmosphere, and any extra information occurring during handover. Additional information recorded included making a note of staffing levels and reporting on busy times of the week. For example:

Clerical support was away – sick, causing extra workload for nursing staff. Clients were not registered and the paper work was incomplete. Therefore it was difficult to get nurses together to start handover as they were occupied with clients and covering clerical duties.

Finally, a description of the memory aids used by the nurses during handover, such as, clinical records, pieces of paper and charts were noted. For example:

RN 3 was reading from a 'handover form'; RN 9 was writing things down on a similar form. RN 3 was reading information from the clinical record – looking at the progress notes, infant care plan and infant admission history.

3.2.4 Questionnaire

A questionnaire was developed for the nurses involved in the study (see Appendix J). The questionnaire asked for demographic information relating to the nurses. These data have been used to assist and interpret the verbal and written data collected by increasing the understanding of the CFH nurses' experience and skills.

3.3 Data Management

A variety of data collection methods were used in this study, with the data being organised and managed in the following ways. The consent forms and questionnaires were kept in a locked filing cabinet. The digitally recorded handover transcripts and nursing interviews were downloaded onto a secure computer using Digital Voice Editor. A separate folder was made for the nursing interviews and each of the six case studies. These folders were labelled accordingly. The recordings were then individually transcribed and filed numerically within the correct folder. All digital files were stored within a password protected computer file. Photocopies of the clinical records of each of the case studies were then filed in the appropriate folder along with the researchers' field notes.

3.3.1 Ensuring the right to confidentiality, privacy and anonymity

Considerable effort was taken to ensure that this study adhered to the UTS HREC guidelines, and that all information/data was recorded in accordance with the Privacy Principles defined in both the Privacy and Personal Information Protection Act 1998 (NSW) and in the Health Records and Information Privacy Act 2002 (NSW).

All data were de-identified during the review of clinical documentation and the transcript process to ensure confidentiality. Due to the size of the organisation, care was taken to ensure that participating nurses and the individual units would not be identified when discussing the findings. Participant anonymity was achieved during the transcription process of the digitally recorded data by giving pseudonyms to all individual participants.

The storage of all data was security controlled. The paper-based data were stored in a locked office filing cabinet at the EPC. All database information was stored on a computer that had restricted access and personalised log-on.

3.3.2 The study participants

In the handover component of this study there were 22 nurse participants. All the nurses were women and their ages ranged from 30 years to 65 years. The highest educational qualification of the RNs was a Masters Degree. While the Mothercraft/ENs highest qualification was a TAFE or Hospital Certificate. The number of years of nursing experiences was from one year to over 31 years.

Eighteen nurses were involved in the nursing handover report process (nine RNs and nine Mothercraft/ENs). The focus of the handover was on six parents and seven infants (two admissions from each of the three units with the infants including one set of twins).

To provide additional information four nurses (two RNs and two Mothercraft/ENs) were interviewed to ascertain their views about documentation processes, communication about clinical care, their reasoning and decision-making.

The demographic information results from the nurse participants' questionnaires are listed below:

Table 2: Demographic description of participants

Residential Units	Centre 1	Centre 2	Centre 3	Nursing Interviews
Gender				
Sample number	4	7	7	4
Male				
Female	100%	100%	100%	100%
Age in Years				
20-29				
30-39			14%	
40-49	75%	43%	43%	75%
50-59		43%	43%	
60-69	25%	14%		25%
Highest level of education attained				
Hospital Certificate		71%	57%	50%
Graduate Cert.	75%	29%	43%	25%

Residential Units	Centre 1	Centre 2	Centre 3	Nursing Interviews
Graduate Diploma	25%			
Masters Degree				25%
Employment Status				
Full-time		29%	43%	25%
Part-time	100%	71%	43%	75%
Casual			14%	
Years of work in current position				
< 1			29%	
1-2	25%		14%	
2-5	50%			25%
>5	25%	100%	57%	75%
Position/Designation				
Registered Nurse	100%	57%	43%	25%
Clinical Nurse Specialist				
Clinical Nurse Consultant				25%
Enrolled Nurse /Mothercraft		43%	57%	50%
Years since first qualification				
0-5		14%		
6-10				
11-15			14%	
16-20			14%	25%
21-25	75%	29%	29%	25%
26-30	25%	29%	29%	25%
>31		29%	14%	25%

3.4 Analysis

A qualitative content analysis approach with a focus on the identification of themes was predominately used in this research study. Graneheim & Lundman (2003) proposed that qualitative content analysis can be useful in nursing research and education as data collected from narratives, transcripts and observations can be interpreted in a number of ways.

It is therefore important to note that qualitative research based on data from narratives and observations, requires understanding and co-operation between the researcher and the participants. The presumption must be made that texts involve multiple meanings and can have varying interpretations. For that reason it is an essential to ensure the trustworthiness of all findings in qualitative content analysis (Graneheim & Lundman 2003). The uses of concepts for describing trustworthiness include validity and reliability as well as the concepts of credibility, dependability and transferability. Graneheim & Lundman (2003) emphasise that even though these concepts contain separate aspects of trustworthiness they should be viewed as connected, intertwined and interrelated.

As content analysis is designed to classify the words in a text into themes chosen because of their theoretical importance (Burns & Grove 2005), this technique provides a systematic means of measuring the frequency of occurrence of these themes. The process of undertaking qualitative content analysis, as outlined by Silverman (2007) has been followed. This process involves defining the research problem; deciding on the source of the material; identifying sample material if there is too much to analyse completely; identifying the categories that will be the focus of the research; constructing a coding frame that fits both the theoretical considerations and the materials; piloting and revising the coding frame; defining the coding rules; and counting the occurrence of the pre-established categories. This approach using an apriori template is frequently referred to as a Template Analysis (King, Carroll, Newton & Dornan 2002).

The data analysis used in this research involves qualitative thematic content analysis in two parts. Firstly to analyse the transcripts of handover and the clinical record documentation through the use of a coding template; and secondly to further examine nursing interview transcripts using the themes identified from the verbal and written analysis. Demographic data collected from a nursing questionnaire (see Appendix L) and field note data were used to provide context to inform the analysis process and findings.

3.4.1 Template analysis

3.4.1.1 Definition

Template analysis approach refers to a particular way of thematically analysing qualitative data. The data involved in this type of analysis are usually interview transcripts, but may be any kind of textual data, including diary entries, text from electronic 'interviews' (e-mail), or open-ended question responses on a written questionnaire (King *et al* 2002). The analysis involves the construction of a coding template representing themes identified in the data through careful reading and rereading of the text. Codes are categorised hierarchically so that the highest level codes represent broad themes in the data. These categories can be changed or added to if additional relevant data themes are identified during analysis and do not fit the previously identified categories. Once a final version has been defined, and all transcripts have been coded to it, the template serves as the basis for the interpretation of the data set, and writing-up of the findings (King *et al* 2002).

3.4.1.2 Development of coding template

For the first part of the analysis, an initial coding template was developed to guide the initial data analysis of the handover transcripts and the clinical records (see Appendix C). This initial coding template was developed to work with the clinical documentation data, handover data and the nurse interview data. This preliminary template did not adequately address the aim of the study to investigate nursing documentation practices and client information transfer within a CFH setting. For example, identifying information such as parent and infant names, age, admissions date and reason for admission was removed from the coding template as it was always accurately documented in the clinical record as part of the computerised admission process. In the same way, it was identified that the data collected from the nurses' interviews did not allow for analysis within the template design. The nursing interview data were therefore removed and later used to support the themes identified from the coding template.

A pilot was undertaken of the coding template to further develop and refine the template design by exploring the differences between what nurses wrote in the clinical records and what they communicated verbally in 'handover' through the use of ICD-10-AM (2008) codes. Some of the previously identified themes in the nurse handover were modified or dispensed with altogether, if they proved to be of little value or inappropriate. For example 'the parent's identified infant/child issues discussed during handover' were dispensed with; while some new

themes identified through the use of ICD-10-AM (2008) codes were defined and included in the final coding template (Appendix D). The similarities and differences between the primary and secondary diagnoses and the nursing interventions enabled exploration of the differences between the nurses' verbal and written communication. Once the design was decided, the analysis started by identifying themes in transcripts through the use of clinical coding.

Clinical coding was used in the development of this coding template including the codes and themes from the ICD-10-AM Early Parenting Manual (2008) based on the ICD-10-AM (2008). These ICD-10-AM (2008) codes give a common clinical and coding language to provide quality reporting and measurement of health data and have been used to identify important themes within these data sets, and to organise them in a meaningful and useful manner. For example:

Z63.0 Problems in relationship with spouse

Problems in relationship with spouse or partner. Discord between partners resulting in severe or prolonged loss of control, in generalisation of hostile or critical feelings or in a persisting atmosphere of severe interpersonal violence (hitting or striking). (ICD-10-AM 2008)

The data were coded by a researcher with many years of experience coding in CFH facilities and validated by a clinical coder with similar experience working within the EPC. The coded data from the handover transcripts and the clinical records documentation were categorised according to content and ranked according to the frequency of themes. The coding templates were used to analyse and explore the differences between what nurses wrote in the clinical records and what they communicated verbally in 'handover'. This technique provided a systematic means of measuring the frequency of occurrence of these themes.

The following example highlights the differences between the health information communicated verbally in handover and that documented in the clinical record about the same client. The handover transcripts states:

... is exhausted, she was diagnosed with PND three months ago.

This was coded as F53.0 which includes mild mental and behavioural disorders associated with the puerperium: Postnatal Depression (PND). The clinical documentation does not reflect these behavioural characteristics to the same degree. The code allocated from the clinical documentation is F41.9 Anxiety Disorder, unspecified. The allocation of the different codes

between the handover transcript and clinical documentation highlight the need for nurses to consider how information is provided both verbally and in writing.

Table 3: Example of coding template

ICD-10-AM CODES FROM HANDOVERTRANSCRIPTS	ICD-10-AM CODES FROM DOCUMENTATION IN THE CLINICAL RECORD
F53.0 PND Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified Depression: Postnatal NOS ⁵ Postpartum NOS	F41.9 Anxiety disorder Anxiety disorder, unspecified Anxiety NOS

3.4.1.3 Analysis of nursing interviews

Four nurses were interviewed to investigate their views on communication, handover and documentation. The data for this analysis came from the transcripts of the semi-structured nurse interviews. These interviews included direct questions, some statements and open-ended questions focusing on nurses' communication about clinical care, reasoning, decision-making and their education level. The interview data assisted with the interpretation of the handover verbal and documentation data collected. It increased my understanding of the concerns and skills of the nurses and identified the most frequently mentioned barriers to documentation and handover.

The interviews were read through several times to obtain a sense of the whole. Then the themes and sub-themes of the nurses' experiences were extracted. The themes from these nursing interviews were analysed acknowledging themes identified from the verbal and written analysis of the coding template.

The nurse participants completed a questionnaire to collect demographic data as a final data collection strategy. These data have been used to provide understanding and context about

⁵ NOS is an abbreviation for 'not otherwise specified', meaning 'unspecified' or 'unqualified'. (ICD-10-AM/achi Early Parenting Manual – Third edition (2008))

the verbal and written data collected from the nurse participants by increasing the understanding of the CFH nursing skills and education related to handover and documentation.

Finally, the coded data from the coding template and the nursing interviews has been used to identify important themes, organise them in a meaningful manner and allow the analysis to identify issues of concern.

3.4.1.4 Validity

To enable the analysis to have credibility, dependability and transferability (Hansen 2006), the above description of how data were collected and analysed has been included. Graneheim & Lundman (2003) advocate that research findings must be as trustworthy as possible throughout every step of the research procedure. The validity of the coded data in this study was ensured by having two clinical coders code the clinical documentation and the handover transcripts and a third clinical coder supervising the process.

Providing adequate description of the methods undertaken in any research process enables the reader to judge the dependability of the research (Hansen 2006). Such processes have been described as ensuring validity within a qualitative method of research (Pyett 2003) and are related to accuracy, relevance and reliability of measurement. Debate continues about the inclusion of the concept 'validity' in qualitative research, but many qualitative researchers support its relevance as an approach that ensures rigor (Silverman 2010).

3.5 Summary

In summary this study predominately uses a qualitative content analysis approach with data collected using observation and digital recording of a handover, review of clinical record documentation and nurse interviews. This analysis has been conducted in two parts: firstly the analysis of the transcripts from the handover and the clinical record documentation; and secondly an analysis of the transcripts from the nursing interviews. A demographic questionnaire has been used to provide a context and illustrate the experience and education of the nurses to further inform the analysis process. The method of qualitative content analysis that was used to organise and facilitate the data analysis has been described. In the following chapters, the findings of the analysis are presented.

In the next two chapters the findings are described. Chapter Four examines the handover transcripts and the clinical record documentation of three case studies through the use of clinical coding and the development of a coding template. Then Chapter Five further examines the data collected from the nursing interviews transcripts, using the themes identified in Chapter Four.

Chapter Four

Parallel Stories of Handover and Documentation using

Clinical Coding of Case Studies

4.1 Introduction

In Australia, clinical coding is mandatory for all inpatient admissions (Bramley & Reid 2007) including residential admissions to EPCs. Health statistics generated from coded clinical data are used under the assumption that data sources are accurate. The outcome of coding of poor clinical documentation provides an incomplete record of care and can lead to misinformation being made available. This can result in an undesirable situation where the clinical coder is dependent on the quality of the written information available and as a result has learnt to 'read between the lines' to understand what should have been documented. Slight differences in wording or diagnostic semantics can lead to incorrect codes being assigned (NCCH 2001).

As discussed in the previous chapter, a qualitative interpretive research approach has been used to frame this research study. The first part of the data analysis is discussed in this chapter, examining the handover transcripts and the clinical record documentation through the use of clinical coding and the development of a coding template. The second part of the data analysis is discussed in the following chapter. It further examines the data collected from the nursing interview transcripts, using the themes identified in this chapter.

As already stated, the focus of the data collection for this part of the analysis was on the handover transcripts and clinical record documentation of six parents and seven infants [one set of twins]. The data were coded by a researcher with many years of experience coding in CFH facilities and validated by a clinical coder with similar experience working within the EPC.

Once coded, the data were categorised according to content and ranked according to the frequency of themes in the coding templates. These templates were used to analyse and explore the differences between what nurses wrote in the clinical records and what they communicated verbally in 'handover'. It became clear that these 'stories' work in parallel, with multiple intersections and divergences. Three of the six case studies in the analysis have been chosen to highlight the similarities and differences through the use of codes allocated from the ICD-10-AM Coding Classification.

4.2 Case study 1 – Elizabeth and Lily’s story

Elizabeth is a 32 year old mother admitted to the residential unit, with her first child Lily who is seven months and three weeks old. Mother and daughter were referred by her community CFH Nurse. The table below lists the diagnosis and intervention codes allocated from the handover transcripts and the documentation in the clinical record concerning both mother and infant. Some explanations of the ICD-10-AM codes are included in the following tables. Explanations of the codes have only been included where the code has not been allocated to both the handover transcript and the clinical documentation.

A comparison of these codes highlights the parallels and differences between what nurses communicate verbally in ‘handover’ and what is written in the clinical records. In this case study the handover was given by RNs, with the documentation in the clinical record being completed by RNs, EN/Mothercrafts and Social workers (SW) with the Medical Officer’s Examination Form being completed by the Paediatrician.

Table 4: Coding Template for Case Study 1

TEMPLATE CODE NUMBER	ICD-10-AM CODES FROM HANDOVER TRANSCRIPTS	ICD-10-AM CODES FROM DOCUMENTATION IN THE CLINICAL RECORD
	MOTHER’S PRIMARY DIAGNOSIS	MOTHER’S PRIMARY DIAGNOSIS
1.	F53.0 PND Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified Depression: <ul style="list-style-type: none"> • Postnatal NOS⁶ • Postpartum NOS 	

⁶ NOS is an abbreviation for ‘not otherwise specified’, meaning ‘unspecified’ or ‘unqualified’. (ICD-10-AM/achi Early Parenting Manual – Third edition (2008))

TEMPLATE CODE NUMBER	ICD-10-AM CODES FROM HANDOVER TRANSCRIPTS	ICD-10-AM CODES FROM DOCUMENTATION IN THE CLINICAL RECORD
2.		F41.9 Anxiety disorder Anxiety disorder, unspecified Anxiety NOS
MOTHER'S SECONDARY DIAGNOSES		MOTHER'S SECONDARY DIAGNOSES
3.	R53 Malaise and fatigue	R53 Malaise and fatigue
4.	Z33 Pregnant	Z33 Pregnant
5.	Z86.5 History of mental disorders	Z86.5 History of mental disorders
6.	Z63.2 Inadequate family support	Z63.2 Inadequate family support
7.	Z39.1 Supervision of lactating mother Care and examination of lactating mother Supervision of lactation Early parenting assessment of lactation	
8.		Z63.0 Problems in relationship with spouse Problems in relationship with spouse or partner Discord between partners resulting in severe or prolonged loss of control, in generalization of hostile or critical feelings or in a persisting atmosphere of severe interpersonal violence (hitting or striking).
9.	Z76.8 Parent craft support	Z76.8 Parent craft support
10.	Z63.71 Alcoholism in family	
11.		Z63.79 Health problems within family Other stressful life events affecting family and household Health problems within family or disturbed family member Isolated family

TEMPLATE CODE NUMBER	ICD-10-AM CODES FROM HANDOVER TRANSCRIPTS	ICD-10-AM CODES FROM DOCUMENTATION IN THE CLINICAL RECORD
12.		Z73.8 Life management difficulties Other problems related to life-management difficulty
13.		Z91.6 Personal history of physical trauma
MOTHER'S INTERVENTIONS		MOTHER'S INTERVENTIONS
14.	96145-00 Skills training in parenting techniques	96145-00 Skills training in parenting techniques
15.	96169-00 Assistance with settling/feeding	96169-00 Assistance with settling/feeding
16.		96032-00 Psychosocial assessment Evaluation of a client's issue(s) or functioning within the context of their social situation. Includes exploration of psychosocial needs, coping capacity, adjustment and personal/situational resources
17.	95550-01 Seen by social worker	95550-01 Seen by social worker
INFANT DIAGNOSES		INFANT DIAGNOSES
18.	R68.1 Unsettled Behaviour	R68.1 Unsettled Behaviour
19.	R63.3 Feeding difficulties	R63.3 Feeding difficulties

4.2.1 Codes 1 and 2

Handover transcripts state:

Elizabeth is exhausted, she was diagnosed with PND three months ago [RN H1]

The code allocated from the handover transcript for the above statement was F53.0. This code covers mild mental and behavioural disorders associated with the puerperium – postnatal depression. A tension starts to appear between the handover and clinical documentation. The clinical documentation does not reflect the diagnosis and the mother's behavioural characteristics to the same degree. PND is not well supported by the clinical documentation. For example, the admitting nurse only noted the existence of PND once within the clinical record. The nurse wrote:

She was diagnosed three months ago with PND and currently sees a psychologist.

[RN3]

This has resulted in not enough information being available in the clinical record to support the assignment of F53.0 (PND).

The code allocated to this mother from the clinical documentation is F41.9 'Anxiety disorder, unspecified'.

The allocation of the different codes between the handover transcript and clinical documentation highlights a need for nurses to consider how information is provided both verbally and in writing. On first reading of these two coding items there are similarities and it would be easy to dismiss the variation in presentation as being of minimal concern. Here we can see that the differences in wording or diagnostic semantics can lead to incorrect coding assignment.

On Day 3 of the handover transcript, the RNs repeat a number of times that Elizabeth was 'quite an anxious lady'. There are a number of reasons for her anxiety. The nurse explains that Elizabeth sees a psychologist but finds it quite stressful getting to the appointments, as she does not have any one to help with the baby. She had a difficult labour due to foetal distress and an emergency Caesarean section. She has also recently discovered that she is six or seven weeks pregnant and is worried about her husband's thoughts about this.

I think that this has put the wind of fear up the husband's proverbial. [RN 4]

This statement about the husband alludes to concerns he has but there is no evidence of further exploration of this issue with the mother by the RN.

The handover transcript details the parentcraft interventions introduced in an attempt to help reduce Elizabeth's anxiety with the care of Lily. For example, allowing the mother to sleep all night without having to attend to Lily's feeds, and introducing new foods in Lily's diet using a 'no fuss technique'. The question is asked:

Has she had counseling yet? [EN 3]

And the RN replies

She hasn't yet but I think . . . said she will try to fit her in. . ."[RN 4]

Then in discussing Elizabeth on Day 4, the RN related at handover that:

. . . her thing is that she does have depression so she is forcing herself to be happy.

You can just feel there's some sort of undercurrent happening there. [RN 5]

The RN has come to this realisation after a discussion with Elizabeth about her goals for Lily and herself during the admission. It appears to be a subjective statement as this statement was not based on evidence and there was no mention of the outcome of a counseling session with the psychologist. This highlights a gap in the information sharing between nursing staff and social workers/psychologists and raises questions of whether nurses are using the social workers/psychologist's psychosocial assessment when caring for families. This is discussed further with regard to codes 8 and 16.

It was also emphasised by the RN that Elizabeth is 'just really different!' The nurses present at handover did not query what was meant or ask for any additional information to assist in the assessment of Elizabeth's maternal needs.

4.2.2 Codes 10 and 11

Through the admission interview documentation, Elizabeth disclosed to the RN that she was 'anxious about being so far away from home'; and that her parents were sick and elderly (Z63.79). Of significance, it was revealed in the handover that she has a relative suffering from alcoholism (Z63.71). It was briefly noted once in the handover that she was experiencing feelings of guilt about being so far away from her parents when they need her. This was the limit of discussion or acknowledgement of these issues as no further discussion occurred in the subsequent handovers. Crucially both of these issues have the potential to impact on Elizabeth's parenting ability. They were not documented in the clinical record and discussed in handover to the same degree, again bringing to light the convergence and divergence between the written and verbal transfer of information. It was not revealed during handover what level of support Elizabeth felt she was required to provide to her relatives. Interestingly the nurses listening to the handover did not request any further information.

4.2.3 Codes 8 and 16

On the other hand, the psychologist's comprehensively and systematically documented psychosocial assessment was not discussed at handover. This assessment documented the presenting issues; family composition and support; relationship issues; clinical impression; clinical care plan during admission; and discharge plan. The code assigned was Z63.0, which

covers problems in relationship with spouse: 'the discord between partners resulting in . . . , hostile or critical feelings or in a persisting atmosphere of severe interpersonal violence (hitting or striking)'. The code for the psychosocial intervention (96032-00) can only be assigned from the clinical documentation.

Again, this highlights a gap in the information sharing between nursing staff and social workers/psychologists and raises questions of whether nurses are using this information when caring for clients. This gap also highlights issues about boundary sharing and how the nurses might position themselves in regard to their role in accessing and using a family's psychosocial information to inform and develop nursing interventions.

4.2.4 Codes 18 and 19

The Medical Officer's Examination Form completed by the paediatrician regarding Lily, noted a healthy baby. The Infant/Child Care Plan in the clinical record recorded Lily's reasons for admission to be 'frequent night waking', 'breastfeed to settle' and 'co-sleeps in early am'. These two records reinforced the reason for admission as a parenting issue and appropriate for a residential stay. The goals on admission were to 'improve nights sleep', 'sleep longer in the day' and 'not breastfed to settle'. The Care Plan negotiated between the mother and RN consisted of a Modified Toddler Routine⁷.

The RN at the Day 1 Handover discussed 'the Plan' and informed other staff members that:

[the mother] . . . agreed to counseling [and] . . . timeout we will discuss later and we will support her with the routine, OK. [RN 3]

This information giving highlights a level of implied knowledge that is expected of experienced nurses working within the residential unit. Possibly, this practice is a form of talking in 'shorthand' enabling the handover to be given in a shorter period of time. Nevertheless, is there enough information being conveyed to ensure the safety of the mother and infant and the effectiveness of any nursing intervention that is to be implemented.

⁷ A modified toddler routine is a daily feed, play, sleep routine negotiated between the RN and mother to match the child's developmental stage

4.2.5 Codes 7 and 19

The code Z39.1 (Supervision of lactating mother) was allocated from the handover transcript but this was not coded in the mother's clinical record. One possible reason for not documenting this could be that it was 'assumed knowledge' by all nurses. Feeding difficulties R63.3 were identified as the infant's problem that was coded in both handover and clinical record. There is a strong connection between these two codes but each only illuminates one aspect of the clinical nursing work. This is a missed opportunity to demonstrate the quantity and quality of the nursing work.

A major theme emerging from this analysis is 'who is the client?' Historically, the infant has been the client at this EPC due to funding requirements. From the coding tables it is obvious that the mother has a more complicated range of issues and requires complex interventions, while the infant whose codes are less problematic indicates the need for a more straight forward set of nursing interventions.

4.3 Case study 2 - Alexandra and Sophie's story

Alexandra was admitted with Sophie, her 16 week old daughter. Sophie was identified by her mother as having unsettled behavior. Alexandra has an 11 year old son from a previous relationship; she is a childcare worker and will be returning to work in a couple of months. As with the previous case study the table below lists the diagnosis and intervention codes allocated from the handover transcripts and the documentation in the clinical record concerning both mother and infant. A comparison of these codes highlights the parallels and differences between what nurses communicate verbally in 'handover' and write in the clinical records. Explanations of the ICD-10-AM are included in the table where the code has not been allocated to both the handover transcript and the clinical documentation.

Table 5: Coding Template for Case Study 2

Template Code Number	ICD-10-AM CODES FROM HANDOVER TRANSCRIPTS	ICD-10-AM CODES FROM DOCUMENTATION IN THE CLINICAL RECORD
	MOTHER'S PRIMARY DIAGNOSES	MOTHER'S PRIMARY DIAGNOSES
1.	F41.9 Anxiety disorder Anxiety disorder, unspecified Anxiety NOS	
2.		F43.2 Reaction to severe stress, and adjustment disorders Adjustment Disorders States of subjective stress and emotional disturbance, usually interfering, with social functioning and performance arising in the period of adaptation to a significant life change Or a stressful life event...becoming a parent...
3.	F43.8 Reaction to severe stress, and adjustment disorders Other reactions to severe stress	
4.	R53 Malaise and fatigue	R53 Malaise and fatigue
	MOTHER'S SECONDARY DIAGNOSES	MOTHER'S SECONDARY DIAGNOSES
5.	Z76.8 Parent craft support	Z76.8 Parent craft support
6.		Z59.8 Problem related to housing and economic circumstances Other problems related to housing and economic circumstances Foreclosure on loan Isolated dwelling Problems with creditors

	MOTHER'S INTERVENTIONS	MOTHER'S INTERVENTIONS
7.	96145-00 Skills training in parenting techniques	96145-00 Skills training in parenting techniques
8.	96169-00 Assistance with settling/feeding	96169-00 Assistance with settling/feeding
9.		96032-00 Psychosocial assessment evaluation of a client's issue(s) or functioning within the context of their social situation. Includes exploration of psychosocial needs, coping capacity, adjustment and personal/situational resources
TEMPLATE CODE NUMBER	ICD-10-AM CODES FROM HANDOVER TRANSCRIPTS	ICD-10-AM CODES FROM DOCUMENTATION IN THE CLINICAL RECORD
10.	95550-01 Seen by social worker	95550-01 Seen by social worker
	INFANT DIAGNOSES	INFANT DIAGNOSES
11.	R68.1 Unsettled Behaviour Nonspecific symptoms peculiar to infancy Excessive crying Irritable infant	R68.1 Unsettled Behaviour Nonspecific symptoms peculiar to infancy Excessive crying Irritable infant
12.		92001-00 Physical Examination

4.3.1 Codes 1, 2 and 3

Codes F41.9 (anxiety disorder) and F43.8 (reaction to stress) assigned from Day 1 of the handover transcript cover the degree of stress and anxiety Alexandra is currently experiencing.

[Sophie] has to be rocked to sleep with this often taking 30 minutes; she then will only sleep for 30 minutes; she is quite loud and mum cries as soon as she hears her, and becomes quite anxious.[RN 6]

The nurse during the handover provides the following information by stating:

Alexandra doesn't describe herself as depressed; normally she is not anxious and copes really well. She is sleep deprived and is finding hard to cope. She has attended

sleeping classes⁸, contacted MSN⁹, she's done several things but nothing seems to actually be resolving anything . . . she's really in a bit of a mess. [RN 6]

The information provided in this component of the handover reflects the sharing of predominately non-judgmental information and provides a clinical profile of the mother as sleep deprived and not coping. The report provides the mother's actions and the outcome. The final statement "a bit of a mess" is a judgmental statement based on the objective information provided by the mother.

The information provided in this next section of the handover discusses the mother's parenting skills in greater detail. The striking change in the following text is the subjective judgment that is being made about Alexandra.

She is a childcare worker; she should know how to do all this . . . [RN 6]

This statement is a form of criticism of the mother that could influence the way the nurses interact with this mother. This is not the empathic response you would anticipate for a mother who is struggling to manage her infant's behaviour and from both the clinical documentation and handover has been identified as fatigued.

The tone of the handover then shifts to raising concerns:

She's probably a bit difficult to interpret sometimes. [RN 6]

The nurse then provides an example:

. . . she's come in with glass bottles, doesn't want to use milk but will because she has to. [RN 6]

There is no exploration of why the mother is concerned about the use of milk or why she feels she has no option. The nurse continues by providing an example of drawing on her clinical judgment or interpretation of the situation:

[she is] quite specific about certain things and I think it's part of her anxiety . . . it's actually quite hard to get somewhere! [RN 6]

⁸ Sleeping classes refer to the parenting groups held regularly at Tresillian covering sleep and settling strategies for babies under the age of four months.

⁹ MSN refers to Tresillian Live Advice which is a free service where parents can ask for parenting advice from a CFH Nurse on line.

This sharing of the nurse's clinical judgment 'I think it's part of her anxiety' would potentially alert the other nurses to the possible need to work in a different way or use alternative strategies to support this mother. A complex clinical situation is starting to be described by the nurse, yet there continues to be no questioning or interaction from the nurses receiving the handover.

This important information was not recorded in such specific terms in the clinical record, identifying the convergence and divergence between the written and verbal transfer of information. The nurse reports in the clinical notes that: Alexandra is seeking help with 'sleep and settling', and that she is very anxious. The documentation does not go into the same amount of detail as the handover transcripts; the nurse's perceptions of mother's attitudes to parenting are not documented. All that is documented in the progress notes is that 'strategies' were explored and 'options' discussed but these were not defined.

4.3.2 Codes 4 and 11

The admission interview in the clinical notes confirms the handover transcript regarding Alexandra's partner's lack of involvement with the baby. It states:

[he is] on the computer/TV all the time . . . doesn't help much with baby. [RN 6]

It is also documented that Alexandra is 'exhausted' (R53 malaise and fatigue) and is anxious regarding baby's 'sleeping issues' (R68.1).

These codes are reinforced by the RN handover report on Day 3. She discussed the care plan with the nurses and described incidents that happened during her shift. Both transcript and clinical record stated that Alexandra 'feels a little stressed and anxious' when Sophie starts to cry and:

[Alexandra] needs to move herself away and distract herself when Sophie is settling.
[RN 6]

There is no report of the action the nurse is taking to support the mother or interventions that have been devised to assist the mother manage her stress and anxiety.

4.3.3 Codes 2 and 6

The Social Work (SW) interview was documented in the progress notes after the nurse's discharge entry. This is a detailed three page report: discussing Alexandra's reason for

admission; the relationship with her husband; her support network; emotional and mental health status; and the social worker's clinical impression.

Using this information in the clinical record the following codes F43.2 (reaction to severe stress and adjustment disorders) and Z59.8 (problem related to housing and economic circumstances) have been allocated. The SW documentation has clearly identified the mother's issues and concerns but does not provide the actions taken to address these issues. The handover transcripts do not mention any of this information and as this information was documented in the clinical record **after** the discharge entry by the nurse and **after** the mother had gone home, it highlights the two separate streams of care –nursing and social work – not interwoven and appearing to work independently of each other. There is no evidence that a case discussion has occurred to enable the SW to contribute to an integrated approach to working with Alexandra.

4.3.4 Codes 7 and 8

Alexandra's goals during her stay as documented on Day 1 of the Care Pathway were to learn the differences in Sophie's cries; to learn to juggle her needs; to feel less anxious about Sophie's crying; and be less anxious that she will wake quickly. The negotiated Care Pathway between RN and mother documented that staff will support and encourage the mother to settle Sophie in her cot when putting her down for sleeps. The intervention codes 96145-00 (skills training in parenting techniques) and 96169-00 (assistance with settling/feeding) have been assigned to both the handover transcripts and the documented information in the clinical record.

The handover transcripts bring to light the informality of the handover process, and the ease with which nurses can verbally communicate with each other. This can be seen by the nurse conveying to staff that Alexandra told her that:

[her partner] doesn't do much. He's on the TV and on the computer. This is his first baby. He is coming in on Thursday and he is going to stay Thursday and Thursday night and Friday so hopefully he can get a bit more involved so she will be pleased at that. He will help if she asks and that's fine but she has to ask so she wants some help to be able to even get on and get out and do things like that [RN 6].

Within this transcript there is a sense of the nurse understanding the feelings of the mother when the nurse says 'she will be pleased at that'. This segment of transcript can be broken into

two parts the first is a description of the situation and what is happening. The second part is a message about what type of intervention is needed to assist the mother.

On Day 4 of the handover transcript the results of the parenting skills given to the father by nursing staff are evident by the nurse's comments:

. . . husband has been here all day and he actually did the settling at lunchtime and went really well. [RN 6]

This statement highlights the emphasis placed on the oral practices of communication in healthcare institutions where there is assumed knowledge of work practices. There is no mention of this parentcraft education given to the father in the clinical record. This supports the belief that nurses 'know' what to do in many instances and, therefore, do not rely on written records. This is a lost opportunity to document that the nurses work with fathers as well as the mother and baby.

4.3.5 Code 11

A consistent picture of the infant's reason for admission exists between the various aspects of the admission documentation. For example, the Medical Officers Examination Form completed by the paediatrician identifies a diagnosis of Unsettled Behaviour (R68.1); a problem with day and night sleeps; and general health – nil problems. The Infant/Child Care Plan recorded the reason for admission as a very 'unsettled infant, difficulty to settle and waking frequently'. The baby's goals on admission further supported the reason for admission: 'to learn to settle and resettle in the cot' and 'to see if dummy can be challenged and to sleep for longer periods.' The missing component covers details of the intervention used to work with the mother and infant. Nevertheless, the intervention is provided in the handover information where the nurse states that:

[Sophie] has to be rocked to sleep with this often taking 30 minutes; she then will only sleep for 30 minutes; she is quite loud. [RN 6]

It is interesting to note that during handover Day 2 it was reported that Alexandra had been given:

three different stories from three different staff members and she's feeling it's too confusing for her because we keep giving her different information. [RN 7]

This once again brings to light the importance of the Infant Care Plan and nursing notes in the clinical documentation. It may be that the care plan had not been documented in sufficient detail to ensure that Alexandra's care plan was adhered to by nurses caring for the mother and infant. Another possibility is that the nurses do not read the care plans prior to working with the mother or do not use them as a tool when working with the mother.

Alexandra's distress at being given conflicting advice was explained in great detail during the handover, to stop any differing information being given to the mother. The RN emphasized in the handover that she had documented clearly in the notes:

To make it simple . . . will make up bottles and write on them in red . . . also only has water on nappy liners to wipe her bottom when her nappy is changed. [RN 7]

Problems with the conducting of handover were acknowledged when the Day 4 handover started late due to short staffing issues. The emergency alarm went off in the middle of the handover and two of the nurses left immediately; then a mother interrupted and came into the handover room to ask if she should get her baby up. Because of all the interruptions the handover ran out of time. A 'handover form' was completed with relevant information and placed in the client's folder for the next shift to read. The 'handover form' is an unapproved form that has been designed by staff at this centre to be used when there is insufficient time to complete handover. This use of a handover form could be construed, as a questionable practice as it reinforces that the nurses recognise information provided in their nursing notes as inadequate or incomplete. The other concern is the information provided at handover is construed by the nurses to be too sensitive or irrelevant to be written in the nursing notes.

Before the Day 4 handover was interrupted, the nurse giving handover stated that:

[it was Alexandra's] review today and mum said that she ticked 'strongly agree' for both her goals and she seemed quite happy. She is still gaining confidence but she is confident to go home and continue at home. And husband has been here all day and he actually did the settling at lunchtime! [RN 8]

From this statement, the nurse reassures the next shift that although the mother has been 'difficult to interpret sometimes', she is gaining confidence, her husband has finally realised that he needs to help with the care of Sophie, and the mother feels that she has achieved the goals she set on Day 1 with the admitting nurse.

The same nurse documented this on the Day 4 Care Pathway in the Clinical Record writing:

[Alexandra has] achieved her goals and gained strategies. Alexandra is happy with progress and confident to continue at home. [RN 8]

There was no mention of a nursing discharge plan during the handover or in the clinical documentation even though the family was being discharged the following day. Once again there has been a missed opportunity to demonstrate the quantity and quality of the work successfully carried out by the nurses. It is the policy of this EPC for the mother's discharge summary to be completed by the Social Worker/Psychologist. It is common practice for the nurse to contact the community CFH nurse by phone to discuss the discharge plan, however, without a documented record of a nursing discharge plan the achievements of the admission may not be followed up after discharge.

A major theme emerging from this analysis is lack of 'communication and information sharing'. From this case study it has become evident that there are two separate streams of care identified – nursing and social work – which are not interwoven and appear to work independently of each other. The social worker's report in the progress notes was not documented until after the nurse's discharge entry. There was no report of the action taken by the nurse to support the mother in managing her stress and anxiety, and the nursing discharge plan was not discussed or documented.

Here again it can be seen, that this gap in the information sharing between nursing staff and social workers/psychologists raises questions of whether nurses are using this information when caring for clients. It also highlights additional issues: about boundary sharing; how the nurses might position themselves in regard to their role in accessing and using a family's psychosocial information; and the implications for safe clinical practice if important information is not passed from one health professional to another in a timely fashion.

4.4 Case study 3 –Gabrielle, Tristan and Indigo's story

Gabrielle was admitted with her 14 week old twins, Tristan and Indigo. The twins are the first children for Gabrielle. The twins were admitted to the residential unit as they do not have any particular routine, they 'catnap' during the day. As with the previous case studies, the table below lists the codes allocated from the handover transcripts and the documentation in the clinical record. A comparison of these codes highlights the parallels and differences between what nurses communicate verbally in 'handover' and what is documented in the clinical records. Explanations of the ICD-10-AM are included in the table where the code has not been allocated to both the handover transcript and the clinical documentation.

Table 6: Coding Template for Case Study 3

TEMPLATE CODE NUMBER	ICD-10-AM CODES FROM HANDOVER TRANSCRIPTS	ICD-10-AM CODES FROM DOCUMENTATION IN THE CLINICAL RECORD
MOTHER'S PRIMARY DIAGNOSIS		
1.	F41.9 Anxiety disorder Anxiety disorder, unspecified	
TEMPLATE CODE NUMBER	ICD-10-AM CODES FROM HANDOVER TRANSCRIPTS	ICD-10-AM CODES FROM DOCUMENTATION IN THE CLINICAL RECORD
2.		R53 Malaise and fatigue Lethargy Tiredness
	MOTHER'S SECONDARY DIAGNOSES	MOTHER'S SECONDARY DIAGNOSES
3.		Z63.0 Problems in relationship with spouse Problems in relationship with spouse or partner Discord between partners resulting in severe or prolonged loss of control, in generalisation of hostile or critical feelings or in a persisting atmosphere of severe interpersonal violence (hitting or striking).
4.	Z86.5 History of other mental and behavioural disorder	Z86.5 History of other mental and behavioural disorder
5.	Z76.8 Parent craft support	Z76.8 Parent craft support
6.	Z64.1 Twins- Problems related to multiparity	Z64.1 Twins- Problems related to multiparity
MOTHER'S INTERVENTIONS		
7.	96145-00 Skills training in parenting techniques	96145-00 Skills training in parenting techniques
8.	96169-00 assistance with activities related to parenting	96169-00 assistance with activities related to parenting
9.		96032-00 Psychosocial assessment evaluation of a client's issue(s) or functioning within the context of their social situation. Includes exploration of psychosocial needs, coping capacity, adjustment and personal/situational resources

10.		95550-01 allied health intervention, social work
	INFANT DIAGNOSES (TWIN 1)	INFANT DIAGNOSES (TWIN 1)
11.	R68.1 Unsettled Behaviour	R68.1 Unsettled Behaviour
	INFANT DIAGNOSES (TWIN 2)	INFANT DIAGNOSES (TWIN 2)
12.	R68.1 Unsettled Behaviour	R68.1 Unsettled Behaviour
13.	K21.9 Reflux	K21.9 Reflux

The handover at this centre was conducted differently to the two previous case studies. On Day 1 of the handover the admission nurse, an RN gave the handover to four nurses with one nurse sitting with a huge board called the 'floor sheet', on which she collected information for the food room¹⁰. The RN mainly read from her own notes and the clinical record.

4.4.1 Codes 1 and 4

The RN stated that Gabrielle has a history of depression (Z86.5) that has also been documented in the clinical record. The nurse continued with her report to say that the mother feels she hasn't bonded with Indigo and is 'quite anxious'. This has been coded as F41.9 Anxiety disorder. Her report was short with only selected information being provided. After her report was given she got up and left the room. This seemed an odd practice as the RN has supervisory responsibility for the EN¹¹.

4.4.2 Codes 6, 7 and 8

The EN then took over and spoke in great detail about the implementation of the twin babies' routine. It would appear that the ENs are working within their scope of practice¹² however, there is a disconnection between the work of the EN and the RN. This family appears highly

¹⁰ Food room – is where the formula and babies' meals are prepared

¹¹ EN- refer to Description of an EN from the Australian Nursing & Midwifery Council National, Competency Standards for Enrolled nurses October 2002

¹² Scope of practice – refer to Tresillian Discussion paper: Scopes of Practice for Nursing staff CNC 2011 1

complex yet the focal point is on the interventions and other tasks necessary to care for the twins. The missing dimension is the interventions that address the parent's distress and difficulties encountered caring for the twins.

4.4.3 Code 2

The clinical documentation in the admission interview states that Gabrielle is well at present but 'sleep deprived and exhausted' this can be coded as R53. Although these terms are similar in meaning, the code allocation is totally different, with F41.9 (Anxiety Disorder) belonging to the chapter of the ICD-10-AM Classification on Mental and Behavioural disorders and R53 belonging to the chapter on symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. Once again, the allocation of the different codes between the handover transcript and clinical documentation highlight the need for nurses to consider how information is provided both verbally and in writing. The differences in wording and diagnostic semantics have led to the assignment of different codes.

4.4.4 Codes 7 and 8

On Day 2, the handover was given by an EN, who again discussed in fine detail the implementation of the twins' routine.

OK, they're on Nan HA Gold 1. Little Tristan is on 150, 3-4 hourly by 5 to 6 feeds and little Indigo is on 120 with the same 3-4 hourly and 5 to 6. So they had a feed over night ... so we changed it to two pats, the third time she goes in she can either give them another pat or a dummy [EN 4]

The only new information given about the mother was in relation to the implementation of the twins' routine. In this handover the nurse was speaking in a 'shorthand' language, assuming a level of implied knowledge that may be expected of nurses who are experienced working within this specific residential setting. A nurse from another unit or who is new to the unit may have difficulty interpreting the information being provided.

4.4.5 Codes 3 and 10

The social worker interview was documented in the progress notes on Day 2. This is a detailed report discussing Gabrielle's reason for admission; relationship with her husband; her support network; and her emotional and mental health status; clinical impression; clinical care plan during admission; and discharge plan. This report supports the admission interview documentation with the allocation of the code R53 Malaise and fatigue. However, the detail of

the SW report brings to light other issues that can be covered by the code Z63.0: Problems in relationship with spouse. The handover transcripts do not mention any of this information. Here again there are two separate streams of care identified – nursing and social work – these are not interwoven and appear to work independently of each other.

4.4.6 Codes 7, 8, 9 and 10

Gabrielle's goals during her stay as documented on Day 1 of the Care Pathway are to get support to establish a routine for the twins and to get some sleep. The negotiated Care Pathway between RN and mother was left blank. The intervention codes 96145-00 (skills training in parenting techniques) and 96169-00 (assistance with settling/feeding) have been assigned to both the handover transcripts and the documentation in the clinical record. The codes regarding the social work intervention (95550-01) and the psychosocial assessment were assigned from the social work report in the clinical record.

On Day 3 the handover started late as the nurses had a prior meeting. The RN gave a brief overview of the twin's progress.

They have been really unsettled again today... This morning mum took them for a walk in the pram [RN 9]

At the end of her report she left the room and once again an EN discussed the feeding and sleeping routine in more detail with the other nurses.

Historically, the baby has been the client at this EPC. It is evident from the documentation in the clinical record that the focus of care at this EPC unit is on the infants. However, from the coding table it is obvious that the mother is experiencing a complex range of issues and potential multifaceted interventions are needed. There appears to be an imbalance between the focus on the twins in comparison to their mother within the documentation. This major theme continues to emerge from this analysis – 'who is the client?'

4.4.7 Codes 11, 12 and 13

The Medical Officers Examination Form completed by the Paediatrician regarding Indigo, noted a diagnosis of Unsettled Behaviour (R68.1); GOR (Gastro-oesophageal reflux K21.9) and poor routine. The Infant/Child Care Plan recorded the reason for admission as 'catnapping during the day, unsettled behaviour'. The mother's goals for her babies on admission were 'to learn to self settle in the cot' and 'sleep longer during the day'. The negotiated Care Plan

documented '4/24 twin routine . . . pat, pat, cuddle, pat, OP (dummy) last resort'. These codes can be seen in both the handover and clinical record table.

Questions have to be raised about the utilisation of an expensive residential service and the family disruption when the baby related issues may be adequately managed in a community setting or via home visits. Nevertheless, if interventions for the mother's complex needs were more carefully addressed and integrated into the residential program it would seem an appropriate use of resources. This integration may have been occurring but due to a lack of consistent and coherent written reporting in the clinical documentation this level of advanced nursing practice cannot be acknowledged.

4.5 Summary

The focus of the data collection in this chapter was on the handover transcripts and clinical record documentation of the case studies of six parents and seven infants [one set of twins]. The analysis of three of these case studies were chosen to highlight the similarities and differences through the use of codes allocated from the ICD-10-AM Coding Classification and the development of a coding template.

This analysis involving qualitative thematic content analysis has identified the major themes with these 'stories' working in parallel, with multiple intersections and divergences. Firstly, the theme of client focus identifies the need to answer the question 'who is the client, mother or infant?' Historically, the infant has been the client at this EPC due to funding requirements. It is obvious from the coding tables that the mothers have a more complicated range of issues and requires complex interventions, while the infants codes are less problematic and require a more straight forward set of nursing interventions.

Then, the theme of communication and information sharing highlights a lack of integration between the work of the nurses and the social work staff. Two separate streams of care have been identified – nursing and social work – they are not interwoven and appear to work independently of each other.

Of equal importance, the theme of organisational guidance and policy is identified brings to light the varying practices between units, such as the use of unauthorized forms at handover; a lack of consistent and coherent written reporting in the clinical documentation; and a disconnection between the role of the EN and RN.

The second part of the data analysis is discussed in the next chapter. It further examines the data collected from the nursing interview transcripts, using the four main themes identified in this chapter.

Chapter Five

Nursing Semi-structured Interviews

5.1 Introduction

An over-reliance by the nursing profession on handing down both information and knowledge by word-of-mouth has been identified by many researchers and others as problematic¹³. In Chapter two the comparison between handover information and nursing documentation provided a snapshot of the discrepancy in clinical information provision. Howse & Bailey (1992) suggested that problems with written communication might be a consequence of the lack of correlation between nursing practice and the expectations of documentation. He further suggests that the complex context of the nurses' workplace, practice can be confusing and not easily translated into written words (Howse & Bailey 1992). The outcome of the nursing interviews on clinical documentation and handover clearly supports Howse's notion of a lack of ability to translate clinical practice into the written word in nurses' clinical documentation. The interviews however, also identify other barriers that impact on the nurses' ability such as confusion regarding who is the client,¹⁴ gaps in communication transference of both written and verbal information, changing educational needs of staff, the environment and the workload.

An analysis of data collected from semi-structured interviews with four nurses will describe the nurses' views on communication, handover and documentation. In this Chapter the four major themes identified in the nurses' interview data will be discussed: client focus; communication and information sharing; organisational guidance, policy and education; and work practices concerning documentation and handover.

5.2 Client Focus

The first crucial documentation within a clinical record is the admission to the unit. This valuable insertion into the clinical record indicates the reason for the admission, the clinical assessment of the physical and emotional well-being of the infant and the mother¹⁵. The

¹³ For an example of knowledge by word-of-mouth refer back to Chapter Two.

¹⁴ The EPC acknowledges the client to be the infant/child however the focus is on providing care to the family unit with the mother also being admitted as a border.

¹⁵ For the purpose of this document mother is regarded as the primary carer.

admitting nurse (RN) helps the mother identify her goals and commences the first process of negotiating a care plan for the infant and the mother. This entry must therefore be an accurate account of the infant and the mother's admission to the residential unit in order to develop a clear care plan that meets the individual needs of the family. A clear care plan ensures that the care provided is consistent with what was negotiated during the admission. The nurses reflected this process when they answered the first interview question – *what factors influence your thinking when deciding what to write?* One nurse described the admission documentation process as:

Issues that needed to be disclosed were . . . how the carer emotionally was at the time of admission... the health related issues of the child and the management plan.
[RN 1]

In this extract the nurse provides a list of issues and activities that are documented as part of the admission process. These cover both the mother's and infant's physical and emotional health. She finishes her statement with *the management plan*, an outcome of the admission process.

The nurses indicated that the issue of who is the client hinders the process. All nurses interviewed seemed to struggle with the notion that the client was the infant when the information gained and the care provided was mainly aimed at supporting the mother to care for the infant. The nurses were conflicted as to the separation of the infant and mother's issues throughout the admission documentation. The admission of the infant is based on a physical assessment and information gained from the mother during the interview process. The admission of the mother is usually more complex as it involves not only the physical assessment but also a psychosocial assessment aimed at gaining information about the emotional health and well being of the mother and the family as a whole. This is highlighted by the following quotes:

The admission documentation is mostly about . . . the mother/carers, baby and family all integrated [EN 1]

. . . indicating that the admission documentation is . . . both carer and baby. [EN 2]

The historical view and current government funding of EPCs positions the infant as the client, and the mother is admitted as a boarder. Similarly, it can be seen from the coding tables in the previous chapter, that the mother often has a more complicated range of issues and interventions identified than the infant. The infant's codes are, in most instances, less

problematic and indicate that more straight-forward nursing interventions are needed. The infant's behavior could be constructed in part as a response to the distress of the parent and/or their lack of parenting knowledge and skills. It was consistently stated by the nurses being interviewed that the primary nursing issues discussed were related to the mother rather than the client (infant). The infant care plan was developed from information gained from the mother and discussion with the mother identifying goals for the admission. In the same way, the question of 'who is the client?' is evident in the previous chapter. This question surfaces repeatedly, in the representation of either the mother or infant as the primary focus during the admission. In the above quotes, the nurses are clearly acknowledging the impossibility of caring for an infant in isolation and that in Australia there will be a primary caregiver for the infant.

Nurses also identified that the admission process itself had become more comprehensive and required a higher level of knowledge and skills for the nurse to move beyond just completing the physical assessment, identifying the problem or issue for the admission. During interactions with parents and their families, nurses are expected to have skills to consider psychosocial, environmental and safety needs. This documentation includes parent child interaction:

All the mother, infant, baby interaction stuff! [RN 2]

This acknowledgement of parent/infant interaction as a focus for documentation demonstrates a more advanced level of practice than a purely task focused role. The RN is stating that the family must be viewed as a whole for the admission to be of benefit.

5.3 Communication and Information Sharing

Nursing documentation and verbal handover have an identical main purpose in that they are both used to communicate information about clients to other nurses and, in some instances, other health workers. Communication is a central theme threaded throughout the interviews. The subthemes of formal and informal communication appear when asked how the primary nursing issues were communicated to other staff.

I do it three ways . . . I handover to the nurse that actually is going to be the prime carer and that can be an informal discussion. The team gets handover . . . there is a handover process and then I have to document. [RN 1]

It was made clear by the nurses being interviewed that the client's information is discussed with colleagues. This nurse provided the three ways she communicated about her experience with the client and her understanding of the client's needs. Within her comment she confirms that documentation occurs in the clinical record and her participation in a formal handover. However, a third method is an informal handover to the nurse who will be the prime carer. The informal handover may also signal the nurse finding a space to handover more intimate knowledge about the parent or family's circumstances; information the nurse has identified as potentially very sensitive, but important enough that it needs to be shared in a restricted manner. The informal handover may also provide an opportunity to clarify ongoing management or other concerns that have been raised by the parent or family. This once again demonstrates how much of nursing communication and work has the potential to remain invisible.

Client information transfer was noted in my field notes as occurring throughout the day in an informal manner. This approach was evident during informal communication between nurses and other clinical staff, and was observed during morning tea breaks. For example:

Day 4 Morning Tea Break: Nurses and Social Worker sat informally over coffee discussing suggested discharge options for mothers and babies [field notes].

The subtheme of formal and informal information is again highlighted when one of the nurses is asked how she communicates nursing issues with other staff:

We do that in handover as well and then amongst ourselves with the same shift and the same nurses. We would have a dialogue most of the time between each other about how things are going or where that person is on a scale or whether we are pushing her too much . . . we have a running dialogue most of the shift. [EN 1]

The importance of ongoing informal information sharing should not be underplayed. This ongoing dialogue enables nurses to have current information about the client, improving the consistency of information about the client and care provided, and it reinforces the agreed parenting practices being given by staff. Crucially, this dialogue enables the registered nurses to supervise the work of the enrolled nurses.

A common complaint of parents is inconsistency of parenting advice. The RN in the following statement raises the importance of transparency in the discussion content.

It is very important to disclose the discussion you have had with the person and how she is feeling at the moment so that the next person can come in and continue on that continuum rather than starting again and asking the same questions . . . [so that] the mother feels like she has not been listened to in the first place. [RN 1]

The explanation this nurse provides reinforces the importance of documentation to ensure continuity of care, reduction of duplication of information gathering and crucially that the mother *feels like she has not been listened to in the first place*. The difficulty here is the ability to accurately capture the emotional content of any discussion with the mother.

Some health professionals can see documentation as a waste of time. This attitude did not appear to be the situation with the nurses in this study. The nurses were asked when writing in the nursing notes: who do you think reads the notes; and what do they look for? All the nurses agreed that other professionals will read the notes during the admission. However, it was not mentioned that the clinical notes could be used at a later date for clinical coding or medico-legal issues until a further question was asked. This identified the nurses' potential lack of awareness of the importance of communication between other health workers, clinical coders, HIMs and potentially the legal system. This is concerning to those who work from the information documented in the clinical record. In further exploring this issue I asked the nurses to demonstrate some knowledge of the potential use of the clinical records – so you think that it's more for other professionals rather than the Department of Health?

The following replies provide two different views, one from an RN and one from an EN regarding the readers of clinical records:

Yeah, oh sometimes DOCS¹⁶, yeah I have to be careful because they might read it too.
[RN 2]

No . . . I haven't even thought of that. [EN 1]

The first reply by a registered nurse provides some insight into who will read the notes. The RN is highlighting but not saying that she recognizes the potential danger for the family and even herself as a nurse if the notes are not carefully constructed. In contrast the EN appears to have limited insight into the implications of her actions. Understanding the needs of the various readers of the nurse's documentation audience is an essential requirement to enable

¹⁶ DOCS is often used as an abbreviation for NSW Department of Community Services, now known as Family and Community Services (FACS).

the clinical records to become a coherent, valuable and relevant document. The sub-theme of 'who are the nurses writing for ' resurfaces as in the previous chapter where it was identified that the allocation of the different codes between the handover transcript and clinical documentation highlight the need for nurses to consider how information is provided both verbally and in writing. The differences in wording or diagnostic semantics can lead to incorrect coding assignment.

Of equal importance is the sub theme identifying the 'gaps in information sharing' between staff. When the nurses being interviewed were asked to agree or disagree on the following statement – 'Nursing notes are an accurate reflection of the actual work done'. The nurse's use of *I have to be careful because they might read it too* is of interest it provides the impression that this is the motivation for being careful in the documentation of nursing care.

The issue of being careful in the documentation of care is often hindered by the inability to find accurate ways of capturing the subtlety of nursing care and the frequent emotional content of the family's experience. All the nurses recognised the difficulty of this aspect of documenting. For example:

It's really hard to capture in words the subtlety of what we do. [RN 1]

This statement provides an insight into the complexity of trying to document feelings and emotions. It is revealed that it is difficult to commit feelings and emotions to a written nursing report. The text that is created within the nursing notes often appears simplistic due to the inability to include such attributes as tonal variations and body language that are part of the provision of verbal information. This may assist in providing an explanation for some of the discrepancies between handover and written nursing reports.

You have to actually have that skill of looking at the picture as a whole and you use all those other things as a tool . . . clinical impression [RN 2]

Alternative reasons were also provided by some nurses about why communication and information sharing was problematic. One of the participants provided her thoughts:

There are a lot of nurses I believe that don't really showcase what they do . . . I think it's a learning thing that we're still on [RN 1]

Much of the ability to put into practice knowledge and skills frequently requires mentoring and modeling of required behaviours. This stresses the need for work place education and training to enable nurses to have the confidence to document and articulate current nursing practice,

and it reinforces the importance of nurses feeling capable and self-confident to document and provide a handover in an accurate and professional manner as stated by RN 1 in the following statement:

... I also feel that it's nurses feeling capable, confident ... because when it comes to psychosocial aspects ... a lot of nurses feel that's Allied Health (the social worker's role) [RN1]

This statement also raises a number of issues that were explored in the previous analysis chapter. During the analysis of the handover transcripts and the clinical documentation it became evident that there are two separate streams of care identified – nursing and social work – these are not interwoven and appear to work independently of each other. In case study two the social worker's report in the progress notes was not documented until after the nurse's discharge entry, and there was no report of the action taken by the nurse to support the mother in managing her levels of stress and anxiety.

5.4 Organisational Guidance, Policy and Education

Shifting to another theme concerning organizational guidance, policy and education, it can be seen from the case studies in the previous chapter that handover structure and process differs between the three residential units. In case study two (Alexandra and Sophie) an unapproved form was in use for when there was insufficient time to complete handover. On the other hand, in case study three (Gabrielle, Tristan and Indigo) there appeared to be a separation between the work of the RN and the EN. Documentation practices and legal requirements are a significant and ongoing concern for HIMs and coders to enable a comprehensive and accurate record of the client's stay within a health facility. HIMs are often involved in providing continuing professional development for nurses; so understanding where learning deficits exist is essential to the content development process. The participants were asked to discuss the information and education they may require to meet their learning needs. The interview participants seemed to be unsure of their needs, with one declaring:

I don't know what I want because I don't know what I need. Does that make sense? I need for people to read them [clinical notes] and troubleshoot them, and then I will know what I want. [RN 2]

In this extract the nurse demonstrates her reflective capacity even though she is unable to identify her knowledge and skills deficits. She has realised there are things that she does not

know but should know. This may indicate the deficits in the current documentation teaching practices and the need to provide more experiential approaches to documentation knowledge and skills development. In the past, documentation training for nurses within this EPC organisation has been inconsistent and at times unplanned. The nurse then continues by saying:

But I want to improve I know that. Yes how to write carefully . . . how to make observations without incriminating the mother. [RN 2]

This nurse *wants to learn*! This statement shows her ability to not only reflect on her practice but also be motivated to improve her documentation practices as she seems to be aware of the implications of careless documentation on the family. This study highlights that there is a need for work place education to enable the current workforce to have the appropriate knowledge and skills in this area of nursing practice. This need for continuing education was reinforced in the following statement:

It's important to have updates . . . it's very valuable because you can get a little bit forgetful . . . and it's always good to brush up on it. [EN 2]

Within this quote the nurse identifies that the issue of forgetfulness and how a *brush up* is necessary. Through her words the nurse is inferring that education provides a means of refocusing and reviewing knowledge. Similarly, the changing nature of nursing is brought to light by the following statement:

I think the other barrier is that historically nurses haven't been trained appropriately to write . . . historically we have come from a background where it's temperature, pulse, medication, allergy, you know a medical model . . . now . . . we are expecting that nurses are at a higher level . . . exploring issues . . . whereas before we never did that as much. [RN 1]

This RN highlights the changing nature of CFH nursing and the expectation that the nurses work at a much higher level. Importantly, RNs within an EPC work in an autonomous manner as there are only visiting doctors within the residential units. The RNs are responsible for all aspects of the infant's care beyond acute medical care. The RN makes the decision with the parent about the care and parenting management that will be provided to the infant while in the residential unit.

One of the participants provided the following views about documentation and handover skill development:

I think the first thing with any practice is to give clear guidance to nurses and not have this idea that nurses have this unforeseen knowledge that they don't necessarily have. The first step is practice guidelines . . . and linking it into skill development in a very non-threatening way like case review. Many nurses have this wonderful knowledge but it is not reflected in the notes . . . if it's not transferred across on the handover it could be lost. Documentation is very important because even though I often believe that nurses do very good, possibly overkill on handover, if that nurse isn't going to be the one that looks after the client . . . and the notes don't reflect the handover the next person is behind in that knowledge that could be gained. [RN 1]

In order to acknowledge the clinical aspects of documenting in clinical records the quote above has identified a number of issues that warrant attention. Staff writing appropriate information within the progress notes need to provide concise handovers that match the progress notes. As indicated the quote acknowledges that clinical staff need clear guidance – education about writing progress notes and a challenge is posed to the assumption that a nurse automatically has the skills to do so. It must also be recognised from the demographic data that the majority of nurses participating in this study worked part-time, were aged between 40 to 49 years, and held hospital certificates or were educated as RNs before nursing became a university degree.

In reference to the quote “over kill” the nurse is alluding to unnecessary information that is given in handover. In reviewing the handover process it was very evident that the handover information was often a long dialogue between the nurses (not concise) and information discussed during the handover was not reflected in the client's progress notes. The review of the clinical documentation undertaken for this research study supports this view. It was often difficult to highlight what care had been provided and if the care provided matched the care plan negotiated with the family.

In reviewing how documentation practices could be improved another nurse provided an example of her learning style preference:

From my experience I have learnt from case studies, reading sets of notes and looking at them. [RN 2]

Further exploration of this statement occurred during the interview. The nurse indicated that her clinical documentation skills were only minimally developed during her tertiary education.

Her post graduate education in relation to developing documentation skills has not been by formal education or clinical guidance but by reviewing other professionals work and case studies.

In case review and with clinical supervision it can be asked 'OK, how do you translate that?' and the nurse can gain some confidence in deciding what is important to write in the notes 'It doesn't have to be a three page document. [RN 1]

Supporting the views of the previous statement regarding the need to provide education and support to nursing staff in order to improve and or develop their skills in clinical documentation. It cannot be assumed all staff have the same levels of knowledge or skill, the following quote used previously also supports the need for education and support in developing clinical documentation skills:

Probably my lack of literacy . . . that historically nurses haven't been trained appropriately to write ... historically we have come from a background where it's temperature, pulse, medication, allergy, you know a medical model. . . now . . . we are expecting that nurses are at a higher level . . . [RN 1]

The identification of literacy issues highlights the changes in expectation in nursing education standards. The nurse highlights the shift in focus from a task focus approach to expectation of a higher level of nursing functioning. This has the potential to place additional demands on RNs.

Another nurse discussed her previous experiences of working on night duty and was looking forward to being involved in the weekly case review. She described her learning style preference for developing skills in clinical documentation as:

To be given a situation and have to write on it . . . sitting and listening is not that effective. [EN 1]

This highlights the concept that adults have different learning styles. For example, reading other's work-as exemplars; while others need to practice skills (be provided with a case review and practice under supervision); and other nurses may prefer a more formal approach (in-service programs). If an education program is designed in order to improve documentation a range of learning styles need to be considered.

Both nurses during the interview indicated that they are aware of the need for good documentation, oral handovers and standards. This awareness highlighted their identified need for more educational support.

5.5 Work Practices- Documentation and Handover

A final theme from the data was work practices and, in particular, the barriers that impact on the nurses' documentation practices. Nurses again indicated that their lack of skills could be attributed to a lack of education and support. However, when asking about barriers, the nurses clearly identified time restraints placed on them due to heavy workloads and the expectation to be more descriptive in their writing. Nurses indicated that they now needed to provide a more comprehensive assessment including a clinical impression that was not taught during their nursing education. They also indicated that the physical environment can hinder the process of writing progress notes. For example, environments that are too noisy, and have lots of distractions with phone calls and client interruptions.

Time, appropriate space, like workspace and quietness . . . [RN 2]

Time is often a hindrance . . . we are expecting that nurses are at a higher level . . . exploring issues . . . whereas before we never did that as much.[RN 1]

The second statement elaborates the issue of time and links it to the increasing expectations being placed on RNs. This is further reinforced by the knowledge that nursing practice has changed and the demands on the RN are far greater than when many nurses commenced their nursing education.

At the conclusion of the interviews the question was asked 'Do you think nursing notes demonstrate the complexity of your nursing work?' Interestingly all answered 'No' but one nurse asserted:

I think we are working towards it. [RN 2]

And another nurse summed up her views on written communication in a very positive way by saying:

I think that we are starting to move . . . I think it is a nursing issue . . . we have come from this medical model and now overnight we are expected to be out of the medical model and start writing bigger and better stories. . . I think it is a change for all of us and we need to support nurses to do that change and not just anticipate that they

know and have this knowledge of how . . . the fact that we're even doing things like this to me means that we are moving and progressing. [RN 1]

In this statement the RN foresees the change in practice that is occurring within the nursing profession and identifies the reasons behind the need for change. She highlights the importance of the nurses' 'stories' in conveying their knowledge about the care of the client, both verbally and in writing to other health professionals. She also indicates that in order for these positive changes to occur in the nursing profession there needs to be organisational support and education.

5.6 Summary

The nurses' responses in the semi-structured interviews, have endeavoured to reinforce the issues raised in the previous chapter regarding the four major themes of client focus; communication and information sharing; organisational guidance, policy and education and work practices concerning documentation and handover. Many of the nurses' statements in this chapter discuss the lack of correlation between nursing practice and the expectations of documentation; and that in the complex context of the nurses' workplace, practice can be confusing and not easily translated into written words.

The next chapter discusses the overall findings of the study, including a discussion of the emergence of the four major themes from the analysis, concluding with a discussion on the future direction for clinical documentation practices within EPCs.

Chapter Six

Discussion, Conclusion, Recommendations and Future Direction

Clinical documentation and handover play a pivotal role in telling the clinical stories of both the nurses and clients in a health care setting. It is through these stories that an explanation of how the health system works and how decisions regarding client care are made and justified. This study has investigated nursing documentation and reporting practices within a CFH setting, looking at the differences between what nurses write in the clinical records and what they communicate verbally in handover.

This chapter focuses on the outcomes collected from this research, by discussing and understanding the meanings, purposes and intentions of the verbal and written communication contained within the study. Firstly, this chapter highlights the positive outcomes. These include the nurses' enthusiasm to learn, their wealth of experience in working with young families and the developing and changing role of the CFH nurse. The chapter then reviews the outcomes and results emerging from the following themes: work practices, education needs, client identity and communication transparency. Finally, the study's challenges, achievements and recommendations, for future direction and research, have been provided in the hope of advancing communication practices within the EPC. These challenges highlight the need for clear communication between all EPC staff in order to provide effective care.

6.1 Discussion of outcomes

It is clear from the analysis of the individual nurses' interviews that the nurses are keen to learn. This was identified when the nurse interview participants were asked to discuss their education and learning needs. Comments from the nurses, during the individual interviews, echoed their desire to learn and improve their documentation practices. They identified the implications of incomplete clinical documentation and reporting practices.

Similarly, it must be recognized from the demographic data of the nurse participants that there is a wealth of nursing expertise and knowledge held by nurses working within the residential units. The majority of nurses have worked in the area of CFH for many years. Equally important, is the changing nature of CFH nursing, where the RNs are expected to work at a

more complex level than in past decades. These nurses are working with families who are identified as presenting with more complicated domestic circumstances and risk factors that are impacting on their ability to parent. The RNs, in particular, are expected to have the nursing skills to consider the family's psychosocial, environmental and safety needs; and explore issues such as depression, maternal anxiety and relationship dysfunction. In the past the focus of care has been predominantly on procedural parenting tasks (Fowler & Briggs 2011). The nurses also identified that the admission process has become more comprehensive and requires a higher level of knowledge and skills for the nurse to move beyond just completing the physical assessment, identifying the problem or issue for the admission. These statements correspond with the nursing practice requirements in the Tresillian Clinical Guidelines (2007).

6.2 Work Practices and Policy Guidelines

The theme of work practices with regard to documentation and handover highlight the varying, and at times, inconsistent practices between EPC residential units. Documentation practices have been clearly demonstrated, through this analysis, as lacking in many areas. This deficiency results in diminishing the quality of nursing care being provided to parents and their infants by EPC residential nursing staff.

6.2.1 Documentation practices

Clinical documentation resulting from missing information and inadequate documentation practices also impacts on the quality of clinical coding in EPCs. Government agencies and funding organisations are becoming more reliant on the clinical data produced from the clinical coding of EPC inpatient documentation, to plan and implement future projects and funding.

The very existence of EPCs can be questioned when client information is not adequately documented in the clinical record as there is potential for the complexity of nurses' work to remain hidden and undervalued. The introduction of Activity Based Funding (ABF) from 1 July 2012 (Eagar 2010) complete, accurate and timely clinical documentation will be of the utmost importance. An inability of EPCs to demonstrate clinical effectiveness and 'value for money' may result in a withdrawal or decrease in funding.

6.2.2 Mismatch of information between handover and documentation

The handover and clinical documentation processes, identified in this study, are in need of review as the analysis has highlighted a mismatch of information between verbal handover

and the written clinical documentation. This diminishes the accuracy and completeness of both methods of information collection. For example, in case study one (Elizabeth and Lily) the clinical documentation does not reflect the mother's diagnosis to the same degree as that discussed during handover, thus resulting in different codes being allocated between the handover transcript and the clinical documentation. Tresillian has an organisation wide Clinical Handover Policy (Tresillian Family Care Centres- Clinical Handover Policy 2009) stating that: the continuity of client care is ensured by the provision of relevant client information during the handover process; clinical handover is focused on the transfer of key information; confidentiality of information concerning the client is protected at all times; clinical handover is delivered in a timely manner and communication and dialogue between staff results in a consistent approach to care. This policy requires handover to be an exchange of information about client care. Handover is a verbal process that is pivotal in ensuring the continuity of patient care. This verbal process needs to be accurately reflected in the written clinical documentation otherwise valuable information may be lost.

6.2.3 Handover practices

A significant finding of this study is that different practices for handover occurred in each of the residential EPC units. These differences in some instances were in contradiction to the organisations existing clinical handover guidelines. For example, in case study two (Alexandra and Sophie) an unapproved form was in use when there was insufficient time to complete verbal handover. The differences were attributed by staff as being due to: the varying physical layout of the units; changeable staffing numbers due to staff shortages; the differing RN/EN ratios between the units; the high part-time RN ratios; the varying length and quality of nursing experience; and the commitment or lack of commitment to using evidence based/informed nursing practice. Regardless of these differences it could be argued that the principles of documented clinical information and handover are transferrable across different settings enabling safe and consistent clinical practice.

In reviewing the handover process as a component of this study it became evident that the efficiency of the handover is entirely dependent on the skills and abilities of the nurse providing the report. Both the findings from this study and recent changes to the government policies acknowledge the need for nurses to decide about what information is necessary to be shared with the mother as part of the report; and what information is more appropriate for discussion between nurses.

6.2.4 Informal handover

The practice of informal handover was identified during this study. Informal handover is when the nurse hands over more intimate knowledge about the parent or family's circumstances in an often unstructured and *ad hoc* manner with other nurses during tea breaks and other less formal settings, such as, at the nursing station or in a corridor. This reinforces the potential for nursing communication and work to remain invisible if it has not been adequately documented in the clinical record. Furthermore, there are significant issues related to these informal discussions in terms of client confidentiality. For example: what is the purpose of the information provision; who is present; and are people from outside the team present? It could also be purported that this sharing of client information infringes on other workers' rights to relax and distance themselves from work related activities during their breaks.

6.2.5 Organisational guidance

Organisational policy requires review to ensure the nurses are provided with: guidelines enabling them to decide on the relevance of the information being shared; an appropriate physical environment to share client information (not in corridors or outside client's rooms); and the allocation of sufficient time to enable the sharing of essential client information. Garling (2008) provides a salient reminder that communication needs to be improved. Everyone employed in the hospital (or EPC) environment needs to work on effective communication, otherwise there will be chaos.

Shifting to another outcome concerning organisational guidance, it can be seen from the case studies (see Chapter Four) that the handover structure and process differs between the three residential units. In some situations this resulted in a lack of adherence, by the nurses, to the accepted principles of documentation and handover. A match is crucial between information provided within the clinical record and verbal handover to ensure safe and consistent clinical practice is provided to families with young children. Staff guidance, education and skills development are necessary components to support safe and effective clinical documentation and handover practices. This research has challenged the assumption that a nurse regardless of her years of experience, automatically has the skills to comply with the requirements identified in the Special Commission of Inquiry into Child Protection Services in NSW (Wood 2008).

6.3 Education Needs

The nurses involved in this study have many years of experience working in the area of Child and Family Health. Yet, this research has demonstrated that it cannot be assumed that these nurses have up-to-date skills in documentation and handover practices. It is of the utmost importance that nurses are competent in the use of necessary documentation and handover practices to provide a safe clinical experience for families admitted to the residential unit. To achieve this competence clear guidance, education and mentoring are required to ensure there is accuracy and consistency.

The nurses interviewed in this study clearly identified their expectation of sharing information about their nursing care, and agreed they need to be more detailed and meticulous in their writing with regard to the health interventions, clinical assessments and the parenting education. As stated earlier, these nurses are now working with families with complex clinical presentations, and are expected to have developed their clinical skills to a high level of competency. The nurses also indicated that they were now required to provide a more comprehensive assessment, including a clinical impression, and that was not taught during formal nursing education.

Similarly, the study identified the nurses' lack of awareness of the importance of communication between other health workers, clinical coders, HIMs and potentially the legal system. A lack of skill in documentation is of significant concern for those who are required to respond to requests from the legal system and government bodies for information contained in the clinical records. Insufficient documentation, incomplete documentation and a lack of consistency in the language used by nurses can have enormous legal and financial repercussions for the organisation. The potential for diminished or unsafe care being provided may place families admitted to EPCs at risk of clinical harm.

Improvement in the quality of the clinical coding process requires education for nurses to help increase their skills to record accurate, complete and timely information. The introduction of improved mentoring programs, using case presentations and reviews, will support and enhance the nurses' ability to accurately describe and document clinical information, and develop skills in oral presentation.

Yet education alone will not result in improvements in practice. Several additional actions are required. Clinical leadership is necessary to model expected behaviours and assist in translating the required documentation and handover practices into the clinical setting. A management commitment is required to review guidelines to ensure they meet accepted Government requirements, while engaging staff in reviews to ensure that these guidelines are practical and can be translated into the clinical setting.

6.4 Client Identity

Regularly throughout the study the question arises of 'who is the client?' The historical view places the infant as the client with the mother being admitted as a boarder. It is clear from this study that the answer to this question is changing in EPCs. As has been identified the mother often has a more complicated range of issues and requires more interventions than the infant. All nurses interviewed seemed to struggle with the notion that the client was the infant when the information gained and the care provided was aimed at supporting the mother to care for the infant.

6.5 Communication Transparency

6.5.1 Working in 'silos'

This research study identified a lack of integration between the work of the allied health workers(including SWs) and nursing staff which results in inconsistency between clinical work practices and EPC policy. An example of this occurs in case study two (Alexandra and Sophie). The SW's report in the progress notes was not documented until after the nurse's discharge entry, and there was no report of the action taken by the nurse to support the mother in managing her levels of stress and anxiety. This example highlights the lack of timely formal communication processes between nurses and SWs potentially creating a significant risk for the mother in particular if the SW had identified threatening behaviours, such as domestic violence or neglect.

This disparate approach was further emphasised by the differing skill focus of the EN and RN. That is, the EN's focus was on the infant, whereas the RN appears to expand the focus to both the infant's needs and the psychosocial needs of the mother (and her partner). The positive aspect is that the EN and RN are both working within their scope of practice (Australian Nursing and Midwifery Council 2007, Tresillian Family Care Centres- Discussion Paper Scope of Practice 2011). On the other hand a less than desirable outcome for a family's care being allocated to an EN, may be the limitation of only receiving parentcraft interventions rather

than the higher level psychosocial care provided by an RN. This is further compounded if the RN does not provide adequate supervision of the EN during the shift. This was demonstrated in case study three when the RN did not stay for the EN's report.

6.5.2 Inconsistency of parenting advice

The inconsistency of parenting advice given by nurses was identified in case study two (Alexandra and Sophie) where the Care Plan did not contain sufficient information for the nurses working with this mother. This reinforces the importance of workplace education to enable well documented continuity of care.

In addition, nurses face a significant challenge to increase their ability to accurately capture the emotional content of any interaction with the parent and record it in the clinical record. This emotional component is often difficult to put into words and when documented can easily become one dimensional and task focussed. Much of this ability to put this knowledge into practice frequently requires modelling of required behaviours by more skilled nurses. This highlights the need for work place education and mentoring to enable nurses to have the confidence to document and articulate emotional interaction, and it reinforces the importance of the provision of handover in an accurate, professional and well documented manner.

6.6 Study Challenges and Limitations

Minor problems were experienced while designing the methodology due to the varied geographical locations of the EPC units throughout Sydney, the different physical layouts, and dissimilar work practices and staffing ratios (RNs to ENs) in each of these units.

The most significant limitation was that only the afternoon handover reports were recorded each day. The morning and evening handover were excluded. This potentially restricted gaining a complete 24 hour picture of the handover practices in each unit. Similarly, the impossibility of capturing the informal reporting between staff was identified as a limitation.

The families and nurses involved in this study were part of a convenience approach which fitted the required study timeframe, with ease of availability and accessibility. The available participants in this study were the families admitted to the EPC during the data collection period who consented, did not need an interpreter and were not known to have involvement with FACS. The nurses involved were those who were providing the handover report for these

families over the four day admission period. It is worth noting that all the families admitted to the EPC had a similar casemix and were considered equally suitable for inclusion in this study.

6.7 Conclusion

This study identified a number of positive outcomes from the analysis. Comments from the nurses, during the individual interviews, echoed their desire to learn and improve their documentation practices; the demographic data collected from the nurse participants identified a wealth of nursing expertise and knowledge. The majority of these nurses have been working in the area of CFH for many years, and the changing nature of CFH nursing acknowledged that the RNs are now expected to work at a much higher skill level than in the past.

The recent introduction of the eMR into EPCs has created new challenges for nurses with regard to clinical documentation. The structured format of the eMR will require nurses to use standard terminology. This is anticipated to reduce the potential negative outcomes of inaccurate clinical coding, resulting from clinical coders working with poorly construed or incomplete clinical documentation. It may be concluded from this analysis, in accordance with a study by Cheng *et al* (2009), that while high levels of education, knowledge and experience in clinical coding are essential for correct coding, the fundamental requirement for accurate, complete and timely coding lies in the quality of the documentation.

There were some negative outcomes identified throughout the study. These were related to the barriers that impact on the nurses' ability to accurately document their practice. These included confusion regarding who is the client, inconsistency of the parenting advice given, gaps in communication transfer of both written and verbal information, the changing and increasing educational needs of staff, the environment and the workload.

The historical view and current Government funding of the EPC places the infant as the client, and the mother as a boarder. All nurses interviewed in this study seemed to struggle with this notion when the information gained and the care provided was mainly aimed at supporting the parent to care for the infant. Similarly, it could be seen from the coding tables that the parent often has a more complicated range of issues and interventions than the infant. This clearly identifies the impossibility of caring for an infant in isolation and that the family must be viewed as a whole for the admission to the EPC to be of benefit. This has implications for the future and the EPCs ability to provide services within the existing allocated budget.

This study has brought to the surface a common complaint from the parents; the inconsistency of parenting advice given by different nurses. Results from the Tresillian Family Satisfaction Survey (2011) support this finding, by reporting that families ‘sometimes received conflicting information’ 31.9% of the time. This reinforces the importance of documentation to ensure continuity of care, reduction of inconsistency of advice and ensures that the parent *‘feels like they have been listened to’*. It appears to be a practice, depending on the residential unit, that there are ‘silos’ or a lack of integration between the work of the allied health workers (SWs) and the nursing staff. The analysis identified that many handover transcripts did not mention or include the detailed allied health reports that chronicled concerns regarding the functioning of the family, such as relationship issues. These findings confirm that there are two separate streams of care operating – nursing and allied health (SW) – they are not interwoven and appear to work independently of each other. This is a significant result as it has the potential to compromise the care provided and outcomes for families.

It was observed that the documenting of care can be hindered by the inability of the nurses to find accurate methods or descriptions to capture the subtlety of nursing care and the frequent emotional content of the family’s experience. One nurse’s statement emphasises this:

It’s really hard to capture in words the subtlety of what we do. [RN 1]

providing an explanation for some of the discrepancies between verbal handover and written nursing reports. Again, highlighting the need for increased organisational guidance.

This study identified that many of the nurses have a lack of awareness of the importance of their clinical documentation and its use as an information tool for communication with other health workers, clinical coders, HIMs and the legal system. This is a concern to those who work from the information documented in the clinical record.

As was expected the qualitative analysis used in this study has confirmed that handovers are an important exchange of information about patient care with the use of this information playing a pivotal role in the continuity of patient care (Kerr 2001). It identifies that there is an over-reliance by the nursing profession on handing down information by word of mouth (Howse & Bailey 1992, Pearson 2003).

6.8 Recommendations and Future Direction

Early Parenting Centres offer a unique service in the Public Hospital System. The literature review establishes that the majority of texts that discuss the transfer of information through

handover and clinical documentation refer to a more hospital orientated, medical model of care rather than that of CFH environments. Clearly this study identifies that more research is required in the area of CFH where there is a wellness and early intervention focus.

The proposed introduction of Activity-Based Funding to Australian Health Care from July 2012 emphasises the need for EPCs to accurately document the care provided, as health care facilities will be funded on the activity they undertake. It is recommended that nurses be made aware of these changes to hospital funding; told of the requirements for complete, accurate and timely clinical documentation and made aware of its importance. This will assist EPCs to ensure they receive adequate funding to continue offering high quality residential care.

It is recommended that HIMs and clinical coders are involved in providing continuing professional development for nurses to enhance their skills to accurately describe and document handover information. Clinical leadership should be supplied through improved mentoring programs using case presentations and reviews to enable nurses to develop their skills in oral presentation and documentation. It is important that nurses feel capable and self-confident to document and present handover in an accurate and professional manner.

Through educating students currently participating in undergraduate and post graduate nursing programs, about the importance of documentation, and its crucial role in clinical coding and health care, improvements in clinical communication may be made in the future.

The demographic data collected from the nurse participants, as part of this study, demonstrated that the majority of the nurses were educated as RNs before nursing became a university degree and they may not have had the opportunity or motivation to develop their documentation skills. Documentation practices and legal requirements are a significant and ongoing concern for HIMs and coders to enable a comprehensive and accurate record of the client's stay within a health facility.

Continuing professional development for CFH Nurses could give the opportunity for them to create a distinctive image as a specialists in this area of nursing practice with clear principles based on their CFH knowledge base, using documentation to reflect the practice/service provision provided; care and progress of the client; and discharge information.

In addition, nurses need to continue to develop their computer skills as NSW Health plans to replace the paper clinical record with an online record which tracks and details a patient's care during the time they spent in hospital (NSW Health 2011). The introduction of the electronic

medical record (eMR) currently occurring in EPCs is creating new challenges for nursing documentation. It has been acknowledged that many of the nurses involved in this study completed their formal education before the widespread introduction of computers into the work environment and many have had minimal exposure through their nursing career. Many of the nurses involved in this study may need to develop their computer skills as the workplace for nurses is changing in line with the rest of the world. As nurses are one of the main users of eMRs, it is critical that further understanding of nurses' learning needs are made available to educators, to create appropriate education interventions to support the use of standard terminologies when completing clinical documentation. It is recommended that the HIMs, clinical coders and senior nurses develop guidelines to assist nurses in using standard terminologies for completing clinical documentation using the eMR.

It is recommended that further development be undertaken in improving formal communication processes. A review of the handover process is recommended; formalising the structure with the use of a written handover report form; integrating allied health staff into the handover process and introducing a post discharge audit program, to be undertaken by the NUMs and Centre Managers, designed to draw attention to any discrepancies.

Finally, the organisation needs to ensure guidelines are easily available (eg on-line) to enable the nurses: to decide on the relevance of the clinical information to be shared; to be given clear guidance on their role as an EN or RN with regard to clinical documentation; and to encourage and develop improved formal communication processes between nurses and allied health.

Appendix A

ICD-10-AM Coding Example

The infant's diagnosis was 'unsettled baby' and the help given classified as 'parenting skills' and 'sleep management'. The notes also recorded that the new mother was stressed and exhausted and the baby had eczema.

	Diagnoses from Clinical Documentation	ICD-10-AM Code
Parent – Diagnoses	Adjusting to parenthood	F43.2
	Family Discord	Z63.8
Interventions	Mothercraft skills	96145-00
	Sleep management	96169-00
	Counselling	96080-00
Infant - Diagnoses	Irritable infant	R68.1
	Eczema	L30.9

Appendix B

Tresillian Model of Care

Practice Principles

The following practice principles are the core component of the Tresillian Model of Care providing a framework for all aspects of practice.

- ***Strengths-based***

Interactions focus on and promote the strengths and attributes of the family, parent and child. Interactions between Tresillian staff reflect and facilitate a strengths-based approach.

- ***Flexible***

The needs of each child and family are recognised and responded to in a flexible manner. Staff members work in a flexible manner with their colleagues while ensuring it does not adversely impact on service provision.

- ***Self-efficacy***

Staff interactions with families, parents and children, and other staff members aim to promote the development of self-efficacy and a sense of competence and capability. Self-efficacy is recognised as a predictor of positive practices by parents, children and staff.

- ***Social connectedness***

Parents are supported and encouraged to connect with appropriate community supports. This social connectedness enhances parenting capacity. Staff are supported and encouraged to network internally with other Tresillian staff and externally with appropriate professional and community organisations at a local, state, national and international level.

- ***Partnership***

Relationships between Tresillian staff members, families, communities and other professionals are underpinned by an approach that facilitates a partnership. This partnership recognises the importance of fundamental concepts of trust, respect, honesty and collaboration.

- ***Attachment-focused***

Interventions focus on enhancing the child and parent attachment relationship in recognition that the quality of this relationship is a major predictor of long-term outcomes for the child.

- ***Child-focused***

Work with families is focused on achieving better outcomes for children through facilitating and strengthening the relationship between the child and parent(s).

- ***Equity***

Tresillian staff will promote equitable access for all children and their families. Tresillian management will promote equitable staff access to employment opportunities, support and education

- ***Early Intervention***

Whenever possible Tresillian takes an early intervention approach assisting parents identify potential protective and risk factors, and appropriate intervention and support strategies.

- ***Reflective Practice***

Reflective practice is achieved through:

- Supporting staff implement their skills appropriately and to the best of their knowledge and abilities
- Encouraging staff to take responsibility for reflection in practice
- Encouraging self-evaluation of performance
- Providing an opportunity for the development of additional skills and ideas
- Providing a forum to explore complex or challenging situations
- Allowing debriefing and reflection following critical incidents.

- ***Best Practice***

Tresillian staff [strive to] ensure they use management, clinical and education best practice drawing on current research, expert opinion and practice evaluation. This is achieved by working with the “best available evidence modified by patient [parent/family] circumstances and preferences, is applied to improve the quality of clinical judgments” (The Centre for Clinical Effectiveness 2005).

- ***Quality***

Quality underpins all Tresillian services and activities. All Tresillian staff are encouraged to participate in continuous quality improvement practices in their everyday work.

Appendix C

Initial Coding Template

This template focuses on the content of nursing documentation in relation to the information provided in handover. Criteria have been taken from the TFCC Handover Policy 2009. One form is to be completed for each day of families stay.

Record No. _____ Audit Reviewers Name: _____

Facility: _____ Day: _____

Checklist items	Provided in handover	Reflected in the medical record	Not applicable
<p>Parent</p> <p>1. The nurse provides:</p> <ul style="list-style-type: none">• Name/s of Parent/carer• Age• Admission date and/or day of admission (e.g. day 4)• Reason for admission/referral• Alerts [allergies food and or drug reactions]• Medications• Any relevant information from other health providers – [e.g. DoCS /Worker] <p>2. Outcomes of assessments [e.g. EDS, PNRQ]</p> <p>3. The parent’s identified issues discussed during handover</p> <ul style="list-style-type: none">• Social• Psychological• Needs			

<ul style="list-style-type: none"> • Support Networks <p>4. The nurse provides information in relation to:</p> <ul style="list-style-type: none"> • Care provided during shift • Variation to care during the shift • On going care plan [including referrals] • Any incidents during the shift [e.g. related to mother emotional status] <p>5. Discussed discharge planning</p> <ul style="list-style-type: none"> • Follow up <p>ICD-10-AM</p> <p>Primary Diagnosis</p> <p>Secondary Diagnoses</p> <p>Interventions</p>			
Checklist items	Provided in handover	Reflected in the medical record	Not applicable
<p>Infant</p> <p>1. The nurse provides:</p> <ul style="list-style-type: none"> • Name/s of Infant/ child • Age • Reason/s for admission/referral • Alerts [allergies food and or drug reactions] • Medications • Any relevant information from other health providers – [e.g. Paed] • Outcomes of assessments [e.g. physical examination- breastfeeding] <p>6. The parent's identified Infant child issues discussed during handover</p>			

<ul style="list-style-type: none"> • Physical • Developmental • Feeding • Weight • Sleeping • Behaviour • Vulnerability <p>7. Infant child's progress during the shift</p> <ul style="list-style-type: none"> • Changes • Variations to care plan • Incidents during shift <p>[behaviour , no progress with strategies]</p> <p>ICD-10-AM</p> <p>Primary Diagnosis</p> <p>Secondary Diagnoses</p> <p>Interventions</p>			
--	--	--	--

Appendix D

Final Coding Template

This template lists the diagnosis and intervention codes allocated from the handover transcripts and the documentation in the clinical record concerning both mother and infant. Explanations of the codes are included where the code has not been allocated to both the handover transcript and the clinical documentation.

A comparison of these codes highlights the parallels and differences between what nurses communicate verbally in 'handover' and what is written in the clinical records.

TEMPLATE CODE NUMBER	ICD-10-AM CODES FROM HANDOVER TRANSCRIPTS	ICD-10-AM CODES FROM DOCUMENTATION IN THE CLINICAL RECORD
	MOTHER'S PRIMARY DIAGNOSIS	MOTHER'S PRIMARY DIAGNOSIS
	MOTHER'S SECONDARY DIAGNOSES	MOTHER'S SECONDARY DIAGNOSES
	MOTHER'S INTERVENTIONS	MOTHER'S INTERVENTIIONS
	INFANT DIAGNOSES	INFANT DIAGNOSES

Appendix E

Nursing Interview Questions

In order to ascertain the nurses' perspective on clinical documentation and handover, semi-structured interviews were recorded. These interviews included direct questions, some statements and open-ended questions focusing on nurses' communication about clinical care, reasoning, decision-making and their education level.

1. The primary nursing issues with the patient's I cared for today were:

☐ Mother related ☐ Baby related ☐ Family related ☐ All 3

2. How did you communicate this?

☐ Discuss informally with other staff ☐ Discussed at Handover

☐ Wrote in the medical record ☐ Discussed at handover and wrote on medical record

☐ Didn't communicate with others

3. Was there anything that might be important to convey in writing eg. domestic violence, drug use, DoCS involvement?

4. What factors influence your thinking when deciding what to write?

5. When you write in the nursing notes, who do you think reads the notes and what do they look for?

6. I think nursing notes are valuable.

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

7. For whom is it valuable?

☐ Other nurses and clinicians ☐ EPC Services ☐ DoCS ☐ Dept of Health

8. What are the barriers preventing you from writing the way you want?

9. Are your nursing notes an accurate reflection of the actual work done?

Appendix F

INFORMATION SHEET

No: 1 Handover and Documentation

Child and Family Health Nurses

‘Clinical stories’ shared a ‘handover’ compared with formal documentation

(UTS Human Research Ethics Committee Ref.No.2009-225R)

Who is doing the research?

My name is Jane Kookarkin, I am completing a Masters of Health Services (Hons) at the University of Technology, Sydney. My supervisors are Professor Maralyn Foureur and Professor Cathrine Fowler from the Faculty of Nursing, Midwifery and Health, University of Technology, Sydney.

What is the research about?

This research will analyze the differences between the ‘clinical stories’ given by Child and Family Health Nurses during verbal handover and documented reports throughout a families’ admission to a Tresillian Residential Unit.

This research will contribute to the development of new knowledge in relation to a number of questions about the nursing traditions and practice; the differences between written and verbal handover communication; increase understanding about the complexity of the work of Child and Family Health Nurses in health system; and contribute to knowledge in the area of Child and Family Health nursing practice.

Why have I been asked?

You have been asked because you are working with the family who has agreed to participate in this research project.

What will participation involve?

Your participation will allow the recording of your involvement in the afternoon verbal handover over a 5 day period.

Are there any risks?

Given the nature of the research and the inclusion criteria identified above, we do not anticipate any harm will be caused or experienced by participants. All information will be de-identified prior to the commencement of analysis process.

Do I have to participate?

Participation is entirely voluntary. You have a right not to participate. Information about your participation/non-participation will only be known to the research team. There will be no negative implications deriving from a choice not to participate.

If I agree to participate, can I change my mind later?

You can change your mind at any time. No reason is required. There will be no negative implications deriving from a choice not to participate.

What if I have concerns or a complaint?

If you have concerns about the research please feel free to contact Professor Maralyn Foureur on 9514 4847 .

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research you cannot resolve with the researcher, you may contact the Ethics Committee through the Ethics Research Officer (ph: 02 95149615. Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed by the outcome.

Appendix G

INFORMATION SHEET

No: 2 Handover and Documentation

Parent

**‘Clinical stories’ shared a ‘handover’ compared with formal documentation
(UTS Human Research Ethics Committee Ref.No.2009-225R)**

Who is doing the research?

My name is Jane Kookarkin, I am completing a Masters of Health Services (Hons) at the University of Technology, Sydney. My supervisors are Professor Maralyn Foureur and Professor Cathrine Fowler from the Faculty of Nursing, Midwifery and Health, University of Technology, Sydney.

What is the research about?

This research will analyze the differences between the ‘clinical stories’ given by Child and family Health Nurses during verbal handover and documented reports throughout a families’ admission to a Tresillian Residential Unit.

This research will contribute to the development of new knowledge in relation to a number of questions about nursing traditions and practice; the differences between written and verbal handover communication; increase understanding about the complexity of the work of Child and Family Health Nurses in health system; and contribute to knowledge in the area of Child and Family Health nursing practice.

Why have I been asked?

You have been asked because you are an inpatient at the Tresillian Unit where the research project is being conducted.

What will participation involve?

Your participation will allow the recording of verbal and written reports about your care and progress by Tresillian staff in the afternoon verbal handover over a 5 day period.

Are there any risks?

Given the nature of the research and the inclusion criteria identified above, we do not anticipate any harm will be caused or experienced by participants. All information will be de-identified prior to the commencement of analysis process.

Do I have to participate?

Participation is entirely voluntary. You have a right not to participate. Information about your participation/non-participation will only be known to the research team. There will be no negative implications deriving from a choice not to participate.

If I agree to participate, can I change my mind later?

You can change your mind at any time. Providing reasons is not required. There will be no negative implications deriving from a choice not to participate.

What if I have concerns or a complaint?

If you have concerns about the research please feel free to contact Professor Maralyn Foureur on 9514 4847

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research you cannot resolve with the researcher, you may contact the Ethics Committee through the Ethics Research Officer (ph: 02 95149615. Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed by the outcome.

Appendix H

CONSENT FORM

No: 1 Handover and Documentation - Child and Family Health Nurses

**‘Clinical stories’ shared a ‘handover’ compared with formal documentation
(UTS Human Research Ethics Committee Ref.No.2009-225R)**

I _____ agree to participate in the research project *Clinical Stories’ shared at ‘handover’ compared with formal documentation by Child and Family Health Nurses* (UTS Human Research Ethics Committee Ref. No. 2009-225R) lead by Professor Maralyn Foureur, Faculty of Nursing , midwifery and Health, University of Technology, Sydney.

I have read and understood the Information sheet provided. I understand that this research will contribute to the development of new knowledge in relation to a number of questions about the nursing traditions and practice; the differences between written and verbal handover communication; help justify the role of Child and Family Health Nurses in health system; and contribute to knowledge in the area of Child and Family Health.

I understand my participation will involve the medical record documentation of 6 to 9 infants and parents from admission to discharge and the verbal handover reports for these admissions. I understand that the handover report will be audio-recorded. I also understand that these recordings will be de-identified, transcribed and used only by members of the research team to develop their analysis. I understand that the recordings and transcripts will be securely kept for seven years and then destroyed in accordance with University data storage and management guidelines.

I also understand that my participation is entirely voluntary and that I can withdraw from the study at any time with no negative implications. I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

I am aware that if I have a concern or complaint I can contact Professor Maralyn Foureur on 95144847. Alternatively, if I wish to talk to someone who is not connected with the research, I may contact the Research Ethics Officer on 02 95149615, and quote this number (2009-225R)

_____ / /

Signature (participant)

_____ / /

Signature (researcher or delegate)

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research you cannot resolve with the researcher, you may contact the Ethics Committee through the Ethics Research Officer (ph: 02 95149615. Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed by the outcome.

Appendix I

CONSENT FORM

No: 2 Handover and Documentation - Parent

**‘Clinical stories’ shared a ‘handover’ compared with formal documentation
(UTS Human Research Ethics Committee Ref.No.2009-225R)**

I _____ agree to participate in the research project *Clinical Stories’ shared at ‘handover’ compared with formal documentation by Child and Family Health Nurses* (UTS Human Research Ethics Committee Ref. No 2009-225R) lead by Professor Maralyn Foureur, Faculty of Nursing , midwifery and Health, University of Technology, Sydney.

I have read and understood the Information sheet provided. I understand that this research will contribute to the development of new knowledge in relation to a number of questions about the nursing traditions and practice; the differences between written and verbal handover communication; help justify the role of Child and Family Health Nurses in health system; and contribute to knowledge in the area of Child and Family Health.

I understand my participation will involve the use of my family’s medical record documentation from admission to discharge and the verbal handover reports for this admission. I understand that the handover report will be audio-recorded. I also understand that these recordings will be de-identified, transcribed and used only by members of the research team to develop their analysis. I understand that the recordings and transcripts will be securely kept for seven years and then destroyed in accordance with University data storage and management guidelines.

I also understand that my participation is entirely voluntary and that I can withdraw from the study at any time with no negative implications. I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

I am aware that if I have a concern or complaint I can contact Professor Maralyn Foureur on 95144847. Alternatively, if I wish to talk to someone who is not connected with the research, I may contact the Research Ethics Officer on 02 95149615, and quote this number (2009-225R).

_____ / /

Signature (participant)

_____ / /

Signature (researcher or delegate)

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research you cannot resolve with the researcher, you may contact the Ethics Committee through the Ethics Research Officer (ph: 02 95149615. Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed by the outcome.

Appendix J

INFORMATION SHEET

No: 3 Semi-structured Interviews

Child and Family Health Nurses

‘Clinical stories’ shared a ‘handover’ compared with formal documentation

(UTS Human Research Ethics Committee Ref.No.2009-225R)

Who is doing the research?

My name is Jane Kookarkin, I am completing a Masters of Health Services (Hons) at the University of Technology, Sydney. My supervisors are Professor Maralyn Foureur and Professor Cathrine Fowler from the Faculty of Nursing, Midwifery and Health, University of Technology, Sydney.

What is the research about?

This research will analyze the differences between the ‘clinical stories’ given by Child and Family Health Nurses during verbal handover and documented reports throughout a families’ admission to a Tresillian Residential Unit.

This research will contribute to the development of new knowledge in relation to a number of questions about the nursing traditions and practice; the differences between written and verbal handover communication; increase understanding about the complexity of the work of Child and Family Health Nurses in health system; and contribute to knowledge in the area of Child and Family Health nursing practice.

Why have I been asked?

You have been asked because you are a nurse working for Tresillian Family Care Centres.

What will participation involve?

Your participation will allow the recording of your involvement in a 20 minute semi-structured interview.

Are there any risks?

Given the nature of the research and the inclusion criteria identified above, we do not anticipate any harm will be caused or experienced by participants. All information will be de-identified prior to the commencement of analysis process.

Do I have to participate?

Participation is entirely voluntary. You have a right not to participate. Information about your participation/non-participation will only be known to the research team. There will be no negative implications deriving from a choice not to participate.

If I agree to participate, can I change my mind later?

You can change your mind at any time. No reason is required. There will be no negative implications deriving from a choice not to participate.

What if I have concerns or a complaint?

If you have concerns about the research please feel free to contact Professor Maralyn Foureur on 9514 4847 .

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research you cannot resolve with the researcher, you may contact the Ethics Committee through the Ethics Research Officer (ph: 02 95149615. Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed by the outcome.

Appendix K

CONSENT FORM

No: 3 Semi-structured Interview - Child and Family Health Nurses

**'Clinical stories' shared a 'handover' compared with formal documentation
(UTS Human Research Ethics Committee Ref.No.2009-225R)**

I _____ agree to participate in the research project *Clinical Stories' shared at 'handover' compared with formal documentation by Child and Family Health Nurses* (UTS Human Research Ethics Committee Ref. No. 2009-225R) lead by Professor Maralyn Foureur, Faculty of Nursing , midwifery and Health, University of Technology, Sydney.

I have read and understood the Information sheet provided. I understand that this research will contribute to the development of new knowledge in relation to a number of questions about the nursing traditions and practice; the differences between written and verbal handover communication; help justify the role of Child and Family Health Nurses in health system; and contribute to knowledge in the area of Child and Family Health, in particular documentation.

I understand my participation will involve participating in a 20 minute semi-structured interview which will be audio-recorded. I also understand that these recordings will be de-identified, transcribed and used only by members of the research team to develop their analysis. I understand that the recordings and transcripts will be securely kept for seven years and then destroyed in accordance with University data storage and management guidelines.

I also understand that my participation is entirely voluntary and that I can withdraw from the study at any time with no negative implications. I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

I am aware that if I have a concern or complaint I can contact Professor Maralyn Foureur on 95144847. Alternatively, if I wish to talk to someone who is not connected with the research, I may contact the Research Ethics Officer on 02 95149615, and quote this number (2009-225R)

_____ / /

Signature (participant)

_____ / /

Signature (researcher or delegate)

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research you cannot resolve with the researcher, you may contact the Ethics Committee through the Ethics Research Officer (ph: 02 95149615. Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed by the outcome.

Appendix L

Nursing Questionnaire-Demographic Information

1. Your gender (*Please tick **one** box only*)
☐₁ Female ☐₂ Male
2. Your age (*Please tick **one** box only*)
☐₁ 20-29 years ☐₄ 50-59 years
☐₂ 30-39 years ☐₅ 60-69 years
☐₃ 40-49 years
3. What is the highest level of education you have attained?
(*Please tick **one** box only*)
☐₁ Hospital Certificate ☐₅ Graduate Certificate
☐₂ Associate Diploma ☐₆ Graduate Diploma
☐₃ Diploma ☐₇ Masters Degree
☐₄ Bachelors Degree ☐₈ PhD
4. How would you describe your employment status at the moment?
(*Please tick **one** box only*)
☐₁ Full-time
☐₂ Part-time
☐₃ Casual
5. How long have you worked in your present position? (*Please tick **one** box only*)
☐₁ < 1 year
☐₂ 1-2 years
☐₃ 2-5 years
☐₄ > 5 years

6. What is your position/ designation? *(Please tick **one** box only)*

☐₁ Registered Nurse

☐₂ Clinical Nurse Specialist

☐₃ Clinical Nurse Consultant

☐₄ Nurse Unit Manager

☐₅ Nurse Manager

7. How many years since your first professional qualification?

_____year

References

- Armstrong, K and Kelly, E 2010, 'Translating knowledge into practice and policy: the role of knowledge networks in primary health care.' *Health Information Management Journal* Vol. 39 No 2. Pp. 9-17.
- Australian Medical Association Ltd. 2006 '*Safe handover: Guidance on clinical handover for clinicians and managers.*' Australia p. 8.
- Australian National Health and Medical Research Council Act 1992.
- Australian Nursing and Midwifery Council. 2007 *The National Decision-making Framework*. ACT.
- Australian Nursing and Midwifery Council. 2002 *National Competency Standards for Enrolled Nurses* (ANMC) ACT
- Barnett, B and Morgan, S 1996, 'Postpartum psychiatric disorder: who should be admitted and to which hospital?' *Australian and New Zealand Journal of Psychiatry*, Vol. 30, pp.709-714.
- Bjorvell, C, Wredling, R and Thorell-Ekstrand, I 2003 'Prerequisites and consequences of nursing documentation in patient records as perceived by a group of Registered Nurses.' *Journal of Clinical Nursing*. Vol.12 No.2 March 2003 pp.206-214.
- Bramley, M and Reid, B 2007 'Evaluation standards for clinical coder trainer programs.' *Health Information Management Journal* Vol 36 No 3 2007 ISSN 1833-3583
- British Medical Association 2004 '*Safe Handover: Safe Patients, guidance on Clinical Handover for clinicians and Managers.*' British Medical Association, London.
- Brooks, J T 1998 'An analysis of nursing documentation as a reflection of actual nurse work.' *Medsurg Nursing*, Vol.7 No.4. pp.189-196.
- Burns, N and Grove, S 2005 *The Practice of Nursing research: Conduct, Critique, and Utilisation* (5th ed) St. Louis: Elsevier Saunders, 2005.
- Cheng, P, Gilchrist, A, Robinson, KM and Paul, L 2009 'The risk and consequences of clinical miscoding due to inadequate medical documentation: a case study of the impact on health services funding.' *Health Information Management Journal* Vol 38 No 1 2009 p 35 ISSN 1833-3585

Council of Australian Governments 2010 'A *National Health and Hospitals Network for Australia's Future*' Commonwealth of Australia.

Davies, S and Priestly, M 2006 'A reflective evaluation of patient handover practices.' *Nursing Standard*, Vol. 20 No. 21 pp. 49-52.

Denzin, NK and Lincoln, YS Eds. (In press, 2011). *Handbook of Qualitative Research*, 4th Ed. Thousand Oaks, CA: Sage Publications

Dulit, R 2002 'Patient Care and the Information Explosion.' *Psychiatric Services* Vol. 53 p. 657.

Eagar, K 2010 'What is activity-based funding?' *ABF Information Series No.1* Centre for Health Service Development University of Wollongong March 2010

Elwell, F 1996 *The Sociology of Max Weber*, Retrieved June 1, 1999.
<http://www.faculty.rsu.edu/~felwell/Theorists/Weber/Whome.htm> Accessed 29.10.2011

Fisher, J and Rowe, H 2006 'Building and evidence base for practice in early parenting centres: a systematic review of the literature and a report of an outcome study.' Tweedle, Child & Family Service, Melbourne.

Fowler, C and Briggs, C 2011 'Are you ready for the increasing challenge of working with families?' *CAFHNA Journal* Vol 22 No 1 April 2011

Gantz, J and Reinsel, D 2011 'The 2011 Digital Universe Study: Extracting Value from Chaos.' June 2011, sponsored by EMC. http://www.emc.com/digital_universe. Accessed 25.10.2011

Garling, P 2008 'Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals.'

Granehein, U and Lundman, B 2003 'Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness' *Nurse Education Today* Vol. 24 No. 2 pp. 105-112 Feb 2004

Gogler, J 2010 'Understanding a nurse's perspective: the chaos of nursing documentation.' Paper presented to *the Clinical Coding and Documentation and Analysis Conference*, Melbourne, March 2010.

Hansen, E 2006 *Successful Qualitative Health Research; a practical introduction*. Sydney: Allen and Unwin.

Health Records and Information Privacy Act 2002 NSW.

Hopkinson, J 2002 'The hidden benefit: the supportive function of the nursing handover for qualified nurses caring for dying people in hospital.' *Journal of Clinical Nursing*, Vol. 11 pp. 168-175.

Howse, E and Bailey, J 1992 'Resistance to Documentation - a nursing research issue.' *International Journal of Nursing Study*, Vol. 29 No.4. pp. 371-380.

Hyde, A, Treacy, M, Scott, P, Butler, M, Drennan, J, Irving, K, Byrne, A, MacNeela, P and Hanrahan, M 2005 Modes of Rationality in Nursing Documentation: Biology, Biography and the 'voice of Nursing'. *Nursing Inquiry*, Vol. 12 No.2. pp., 66-77.

Jefferies, D, Johnson, M, Griffiths, R and Clinical Development Group 2008 *Guidelines for Patient-focused Nursing Documentation*. Centre for Applied Nursing Research.

Jenkins, A, Abelson-Mitchell, N and Cooper, S 2007 'Patient Handover: Time for a change?' *Accident and Emergency Nursing* Vol.15. pp. 141-147.

Karkkainen, O, Bondas, T and Eriksson, K 2005 'Documentation of Individualised Patient Care: A qualitative metasynthesis.' *Nursing Ethics*, Vol. 12 No. 2 pp. 123-132

Kerr, M P 2001 'A qualitative study of shift handover practice and function from a socio-technical perspective.' *Journal of Advanced Nursing*, Vol. 37 No. 2. pp. 125-134.

King, N, Carroll, C, Newton, P and Dornan, T 2002 'You can't cure it so you have to endure it: The experience of adaption to Diabetic Renal Disease' *Qualitative Health Research*, Vol. 12 No. 3. Pp. 329-346

Manias, E and Street, A 2000 'The handover: uncovering the hidden practices of nurses.' *Intensive and Critical Care Nursing*, Vol.16. pp. 273-383.

McCrow, C 2010 'Clinical analysis of Coded data and the effect on Quality of Care.' Paper presented to the *Clinical Coding and Documentation and Analysis Conference*, Melbourne, March 2010.

National Centre for Classification in Health (NCCH) (Ed.). 2001 *Australian Coding Benchmark Audit (ACBA)*. Sydney.

National Centre for Classification in Health (NCCH) 2008 ICD-10-AM/ACHI *Early Parenting Manual*. 3RD Ed 1 July 2008. Sydney

National Centre for Classification in Health (NCCH) 2008 *The International Statistical Classification of diseases and Related Health Problems, Tenth Revision, Australian Modification* ICD-10-AM 6th Ed 1 July 2008. Sydney

NSW Department of Health 2011 *eMR*, NSW Health, Sydney 28 OCT 2011

NSW Health 2005 *Principles for Creation, Management, Storage and Disposal of Health Care Records*, NSW Health, Sydney.

Pearson, A 2003 'The role of documentation in making nursing work visible.' *International Journal of Nursing Practice*, Vol. 9, pp. 271.

Pothier, D, Monteiro, P, Mooktiar, M and Shaw, A 2005 'Pilot study to show the loss of important data in nursing handover'. *British Journal of Nursing*, Vol. 14 No. 20 pp. 1090-1093.

Privacy and Personal Information Protection Act 1998 NSW

Pyett, P 2003 'Validation of Qualitative Research in the "Real World".' *Qualitative Health Research*, Vol. 13 No. 8. pp.1170-1179.

Randall, A C 1999: Development of a classification (ICD) system for early parenting centres. *Thesis submitted in fulfilment of Masters in Public Health*, La Trobe University.

Rutledge, P 2011 'Transmedia Storytelling: Meaning Comes from the Ability to Share, Explore, and Discover.' *Media Psychology Matters*, December 3, 2011.

Saranto, K and Kinnunen, UM 2009 'Evaluating nursing documentation - research designs and methods: systematic review.' *Journal of Advanced Nursing*, Vol. 65 No. 3 pp. 464-476.

Silverman, D 2010 'Doing Qualitative Research' 3rd Ed. Los Angeles, A: Sage Publications

Smith, JK 2008 'Interpretive Inquiry.' *The Sage Encyclopedia of qualitative research Methods*. 2008 SAGE publications

Tresillian Family Care Centres – Royal Society for the Welfare of Mothers and Babies (2009) Clinical Handover Policy 2009.

Tresillian Family Care Centres– Royal Society for the Welfare of Mothers and Babies (2011) Discussion Paper Scope of Practice CNC 2011.

Tresillian Family Care Centres– Royal Society for the Welfare of Mothers and Babies 2011
Family Satisfaction survey

Tresillian Family Care Centres – Royal Society for the Welfare of Mothers and Babies 2010
Tresillian Annual Report 2010

Tresillian Family Care Centres – Royal Society for the Welfare of Mothers and Babies 2007
Tresillian Clinical Guidelines 2007.

Wood, J 2008 *Special Commission of Inquiry into Child Protection Services in NSW*,
NSW Special, Published November 2008 ISBN 978-1-921301-86-5

University of California Berkley's School of Information Management. 2003 'How much
information?' Available: <http://www.sims.berkeley.edu/how-much-info/>. Accessed 7.5.2009

