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ICNP® in Nursing Documentation – When Expectations Meet Reality

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Abstract

The International Classification for Nursing Practice (ICNP®) terminology was in 2016 implemented in three Norwegian municipalities through the introduction of five standardized care plans in the Electronic Patient Record (EPR) system. This poster provides results from an exploratory, qualitative study, investigating how nurses in these municipalities applied the care plans into their daily informational work.

Keywords:
Electronic Patient Records, Documentation, Terminology

Introduction

In Norway, over recent years the focus for standardization, including the introduction of standardized terminologies, has been on hospitals with little attention paid to community health care. In 2016, the International Classification for Nursing Practice (ICNP®) was for the first time implemented in Electronic Patient Record (EPR) systems for community health care through standardized care plans in five areas. ICNP®-enabled care plans were expected to make documentation more effective, by being precise, accessible and user-friendly. The terminology had in previous studies appeared to be well developed for various settings and populations [1]. The aim of this study was to explore how nurses in community health care applied ICNP®-enabled care plans, into their daily informational work.

Methods

The study had an exploratory design using a qualitative approach. It was conducted in three municipalities in Norway and used five standardized ICNP®–enabled care plans. Empirical data was collected through 124 hours of participant observation on 17 different registered nurses on regular day shifts. All participating nurses were also interviewed individually. The data were analyzed applying an integrative method in order to permit going back and forth between the different data [2].

Results

Three major themes emerged.

Balancing the new and the old: ICNP®-enabled care plans had been implemented in just five areas, so in all other areas nurses had to make care plans the old way. Hence, the old systems were not changed, and neither were existing care plans made prior to the implementation. It was observed that the ICNP®-enabled care plans were not always applicable to the patient at point-of-care, and even if they were, they were sometimes forgotten, resulting in limited use of ICNP®.

Balancing between overview and detail: Nurses described the standardized care plans as being too detailed, resulting in long lists getting in the way of the much needed overview. On the one hand they viewed short, not individualized care plans as less useful, but on the other hand too much information got in the way of what was important.

Balancing current limitations and future possibilities: Nurses expected that ICNP® would be a useful way of systemizing and standardizing nursing documentation in the future, even though they did not use it very much at the moment. For nursing documentation to become as effective as they would like it to be, they expressed a need for everyone to use both the same language, and the same EPR system.

Conclusions

Despite the limitations connected to the relatively small sample in this study, the results highlight issues with the evaluation of partial implementations. They also point to a need for further exploration about the optimal level of detail for nursing information. More significantly perhaps for the profession, they reveal that nurses appear to understand the advantages of appropriate standardization, particularly when this is accompanied by increased future adoption.

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