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Exploration and Description of Faith Community Nurses' Documentation Practices and Perceived Documentation Barriers.

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Cover Page Footnote

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The renewed emphasis of nursing practice in the community context and the targeted focus on improving population health provides faith community nurses (FCNs) with an ideal opportunity to support positive healthcare outcomes throughout the world. FCNs, as specialty professionals, provide various important services within community-based healthcare, specifically focusing on the integration of faith and healthcare (American Nurses Association [ANA] and Health Ministry Association [HMA], 2012). Accordingly, documentation is deemed necessary to “capture the essence of the FCN [faith community nursing] practice, not only as a professional obligation but also for the purposes of articulating the salient features of the (w)holistic specialty practice and accounting for the financial impact of the practice” (Dyess, Chase, & Newlin, 2010, p. 192). Ziebarth (2015) asserts in a FCN position paper for documentation that the use of a “standardized nursing language, documentation education, use of electronic documentation systems, application of nursing theory, and emphasis on standards of practice or guidelines” will support quality practice (p. 2). To be clear, in traditional practice settings, numerous regulatory standards mandate documentation for communicating patient clinical information and providing a legal account of the complete nursing process. In faith settings, the regulatory agencies are few; however, the professional standards for documentation remain.

Using information technology and electronic health records (EHRs) as part of standard documentation is believed to be an essential practice element that supports enhanced professional decisions and improved health outcomes (Westra, Delaney, Konicek, & Keenan, 2008; Westra, et al., 2010). Unfortunately, it is thought that the majority of FCNs are not using EHRs for documentation as part of their professional practice. Still, little is known about documentation practices within faith community nursing settings. Therefore, the aim of this research study was to explore and describe documentation practices for FCNs, and identify any perceived barriers to documentation.

Background

Meaningful use is a term often associated with activities related to professional documentation and EHRs. The meaningful use activities involve maintaining privacy while harnessing the documentation information to continually improve patient care quality and outcomes. While the passage of the Health Information Technology for Economic and Clinical Health Act of 2009 provided incentives for using electronic healthcare documentation, the financial and regulatory mandates only applied to professionals and healthcare organizations receiving government payments (Blumenthal & Tavenner, 2010). Most FCNs practice in settings and situations where the aforementioned mandates do not apply, therefore use of EHRs is not widespread.

Over one decade ago, researchers Burkhart and Androwich (2004) and Burkhart, Konicek, Moorhead, and Anrowich (2005) studied documentation practices of FCNs associated with a Mid-west health system by considering the domain completeness of Nursing Intervention Classifications (NIC) (Bulechek, Butcher, McCloskey Dochterman, &Wagner, 2013) and mapped the completed documentation from practice settings in congregations that use a computerized health record. At that time, conceptual issues for using NIC were noted, particularly for not capturing the fullness of spiritual care practice. A better understanding of the conceptual nuances within faith community nursing practice was called for but further research addressing this conclusion was not advanced.

During that same time period, Parker (2004) examined 81 surveys of self-reported documentation practices from FCNs in Kentucky and Ohio. These findings indicated that FCNs were in fact documenting, but, pointed out limitations in the capturing of outcomes. More research was suggested but not found within the literature. Miller and Carson (2010) emphasized the professional obligatory aspect of documentation for faith community nursing practice and offered a thorough and standardized form for FCNs to use that incorporated standardized language. Alas, the form was not widely adopted. Nonetheless, it was and is recognized that documentation is a mandatory aspect of FCNs professional practice (Church Health Center, 2014).

Method

This study utilized an exploratory, descriptive, mixed methods design over a 4-month span in 2016. Human ethics were considered and approved by the principle investigator's university. Consents were obtained from participants prior to any data collection. A convenience sample of FCNs was recruited within two targeted conferences (Westberg Symposium, April 2016, and Faith Community Nurse Network of the Greater Twin Cities, October 2016) and through electronic messaging of known list serves in the United States of America for practicing professional FCNs. Participant criteria for inclusion were ability to speak, read, write and understand English and current practice as a paid or non-paid Faith Community Nurse for a designated congregation or organization. Participants were invited to complete a researcher- developed survey. The participants then were given the option to participate in a focus group and/or a key informant interview.

Quantitative Data Collection and Analysis Method

A survey was developed to capture objective data related to FCNs' demographic characteristics as well as their basic documentation practices. The researchers

developed items in the survey guided by recent publications (Dyess, Chase, & Newlin, 2010; Miller & Carson, 2010; Slutz, 2011) because no previous researchers targeted a national sample to measure specific documentation practices. The items included general and FCN specific demographic questions as well as general and FCN specific documentation questions. Feedback was obtained from three FCN experts to establish face validity of the survey. Paper and on-line surveys were developed to accommodate the convenience sample participation. Eighty-four FCNs completed the paper survey and 69 FCNs completed the online survey for a total of 153 returned surveys. Of the returned surveys, the majority were fully completed and few contained omitted nonspecific items. Still all returned surveys were included in the descriptive analysis that was accomplished using SPSS 23 (Statistical Package for Social Sciences, 2015).

Qualitative Data Collection and Analysis Method

Qualitative inquiry was accomplished within three live focus groups and three telephonic key informant interviews (n=28). A set of standard questions guided interviews (Table 1). Focus groups and interviews lasted 20-42 minutes. Conventional content analysis was used to examine all qualitative data. This conventional content analysis approach to data was appropriate because as a phenomenon, FCN documentation required general description (Hsieh & Shannon, 2005). All qualitative data, including transcribed audio-recorded focus groups, interviews and field notes, were reviewed and independently coded by two experienced qualitative researchers. No preconceived codes or categories for the phenomena were applied.

Table 1 *Focus Group Question Guide*

Questions
1. Can you describe for me your documentation as a FCN?
2. What types of things do you document? What is easy and what is difficult to document?
3. How do you keep your documentation records?
4. What are barriers to documentation?
5. Can you describe your experiences with electronic documentation?
6. Are there aspects of your practice that you do not currently have a way to document and wish you did? Please describe?

Data were reviewed for initial impressions, then reviewed word by word to derive codes. General impressions and consensus was gained for an initial code key that guided further content and field notes analysis. Then, two researchers re-read data transcription and field notes while reflecting on codes. This step allowed for the identification of key textual information (Table 2) and the development of data clusters for both FCN documentation practices and perceived barriers.

Table 2 *Clusters*

Documentation Practices	Perceived Documentation Barriers
Capturing unique nature of faith community nursing practice	Lack of clarity for autonomous practice accountability
Outcome versus intervention	Time consuming
Storage of documentation	Reliance on others to develop best practices
How & What documentation differences	Knowledge deficit patient documentation

At that juncture, the basic standards for professional documentation that followed the nursing process provided a structured framework from which the researchers considered all data (American Nurses Association, 2015). The identified six phases of the dynamic nursing process included:

- (1) Assessing pertinent data;
- (2) Diagnosing patient problems and resources;
- (3) Setting goals;
- (4) Planning nursing responses;
- (5) Implementing the responses; and
- (6) Evaluating the nursing responses and patient encounter.

Through an iterative process of data reduction, the research team refined the clusters for the emergence of documentation practice and perceived documentation barrier categories. Exemplars were identified for reporting of the findings and discussed in the qualitative findings section below.

Findings

Quantitative Results

The sample completing the survey consisted of 130 females with 23 FCNs not reporting their gender. The age of this sample ranged from 32 to 80 with a mean of 61.9 for those completing this question. The majority of the sample who

reported their marital status and ethnicity were married (73.4%) and white (93%). Most FCNs who reported their highest level of education held bachelors and master degrees (71.4%). As for religious affiliation, the majority the respondents were Christian (88.5%).

All 153 FCNs answered the hours per week compensation question which indicated that 58.8% were not paid but 41.2% were paid. Compensated hours per week worked ranged from 1 to 40 with a mean of 21.4. Uncompensated hours per week worked ranged from 0 to 36 with a mean of 6.8. Most of these nurses were affiliated with a religious organization (77.1%) located in a suburban area (59.7%). Most of the FCNs who responded to the question of population served indicated that they most often served middle aged and older adults (92.8%). Roles assumed by the 153 FCNs completing the survey included integrator of health (64.1%); health educator (76.5%); health counselor (65.4%); referral agent (68.6%); facilitator of volunteers (46.4%); developer of support groups (32.7%); health advocate (64.1%); health screenings (60.1%); home visits (62.1%); transitional care (24.8%).

Of the respondents, 127 FCNs answered the question that focused on frequency and types of documentation (Table 3). Only 10.2% indicated they never document, 31.5% indicated sometimes, 26% indicated frequently, and 32.3% indicated they always document. The results in table 3 indicate the percent of FCNs that use the various documentation approaches.

Table 3 *Types of Documentation Approaches most often used by 153 FCNs*

Documentation Approach	Percent of Sample
Daily Activity Log	32%
Monthly Activities Report	33.3%
Individual Interaction Form	40.5%
Computer Program	9.2%
Web-Based System	17.6%
Use of NANDA classifications	19.6%
Use of NIC classifications	20.3%
Use of NOC classifications	17.6%
Use of no standardized classifications	46.4%

Respondents who used a web-based documentation system were asked to provide the name of the program but only 12 of the 27 respondents did so. Seven of the 12 who responded indicated they used Henry Ford Macomb's program. The last two questions on the survey were Likert-type scales to quantify the FCNs' perceptions of their computer skills and their likelihood to use a tablet or phone application to document their FCN practice. The first question asked the FCN to indicate their level of computer skills using a scale ranging from no skill to expert

skills. Of the 128 respondents, only one stated no skill (.8%); 72 stated basic skills (56.3%); 46 stated very skilled (35.9%); and 9 stated expert skills (7%). One question asked the FCNs to indicate their likelihood to document their FCN practice if they had a user-friendly application for either a smart phone or tablet if one was developed specifically for FCNs. The scale ranged from 0 (not at all likely) to 10 (very likely). These scores ranged from 0 – 10 with a mean of 7.82.

Qualitative Results and Exemplars

Two categories of documentation practices and perceived barriers emerged from the data. In both identified categories of practices, the identified categories of perceived barriers were related. Therefore, the categories that emerged for both practices and barriers of documentation will be presented together; they include: 1) FCNs engage in professional mandate for documentation but lack clarity for autonomous practice and nursing process expectations and 2) FCNs attempt to capture the fullness of specialty encounters but lack supportive infrastructure and interprofessional communication (Table 4).

Table 4 *Categories*

Documentation Practices	Perceived Documentation Barriers
Engage in professional mandate	Lack clarity for autonomous practice and process expectations
Attempt to capture fullness of specialty encounters	Lack the supportive infrastructure and interprofessional collaboration

Many FCNs indicated their documentation accountability was to their program coordinator, pastoral committee, or funder without acknowledgment of their responsibility to Nursing Standards. This shared reporting sentiment is expressed in this participants' response; *"For grantors it's really whatever goals they have set out that we are going meet. That could vary based on the grant, but most generally they always want to know the number that you are reaching and demographics of the group and locations and that type and the service that's given"*.

The FCNs who articulated their documentation practices revealed a common approach that is inclusive of simply counting numbers. One FCN stated, *"So currently we just submit like a quarterly report. And so we documented how many people came to our education sessions. And if they happen to follow up for diagnostics and that was pretty much what we documented"*. This nurse, like so

many, believed they documented necessary information; however, no assessment, plan, educational intervention nor an evaluation of education was portrayed as typical elements for their documentation practices. While that particular project reached 586 people and crossed 9 counties the actual nursing process and true health outcomes were not recorded.

Another example of the mandate/lack of clarity was provided with the following explanation; *“We did a survey when they came to the education, what kind of self-care practices they did and after hearing the education what did they plan to incorporate. A pre- and post- or what they took away from the education”*. In this example, the FCN considered the baseline assessment of a group without noting an assessed need for an educational provision. Additionally, this participant omitted the diagnoses, plan and education intervention documentation.

An alternate approach that was common among FCNs included the thorough documentation of assessment without any documentation of the nursing diagnosis, plan, intervention and evaluative follow-up. This practice was expressed by the following comments from two different FCNs; *“the things we document are the vital signs, the chief complaint, we do the blood sugar, the pressure, and things like that”* and *“their age, marital status, their address, chief complaint type of thing, what I found on assessment.”*

For those FCNs who utilize an electronic documentation format there was common agreement that *“there is so much stuff to report”* and it takes *“too much time”*. Also noted with electronic documentation was a detached sense of responsibility from their actual nursing work voiced as *“it is a burden and I mostly go home to do the paperwork after I finish”*. It was clear that the participants believed the expectation of electronic documentation was too much *“on top of everything else”*. Moreover, the FCNs expressed frustration with the complexity of the electronic documentation categories with a comment, *“they say on-line is supposed to be easier, well it is not”*.

The second practice and barrier category that emerged incorporated the effort made by FCNs to reveal the often-hidden nature of the (w)holistic specialty practice but the frequent unsupported infrastructure that exists as well as the limited interprofessional collaboration. For example, when describing documentation this nurse explains,

“What I have available at my church, first of all, I took my foundation course probably 12 years ago, so at that time it was very rudimentary, so all I have would be, I call it a diary log and I put the date of the visit, who I visit, the reason, what the interactions were in the plan. So if it's a very lengthy visit I'll do more or like gerontological nurse assessment kind of thing”.

The previous nurse acknowledged a magnanimous effort in compiling narrative notes but points to an under-developed mechanism for recording encounters that

neglects evaluation and/or follow up. Others resonated with expressed limitations to their current system for documentation with comments that were indicative of not knowing who to report to such as *“if we were doing testing, then I let the agency that was doing the testing handle all of the documentation for confidentiality. But otherwise we didn’t report to anybody”*. The work of that previous FCN was not recorded nor communicated to other professionals.

Likewise, another nurse, who elaborated that documentation is not really needed, stated, *“I might have a class on diabetes or something I don’t know how much documentation I need other than 10 people came and they participate.”* Another noted the experience of working alone *“when I work in the hospital I report off, in the community I am doing practice for who, who do I tell, no one understands the work? This limited interprofessional approach thwarts outcome reporting and certainly undermines any opportunity for collaboration.*

As the FCNs were given an opportunity to consider solutions to their perceived barriers, they all echoed a willingness and desire to comprehensively document if the “right system was developed”. This quote is a great summary of their readiness: *“Since the government is trying to streamline documentation like medical records portable, I think that will be a goal for us (FCNs) also something would be to have documentation kind of similar everywhere, so it’s easy for all the healthcare providers to understand and grasp what’s going on with an individual”*.

It was noted that all FCNs were not willing to work with electronic records as indicated by this voice response, *“I can tell you right now I am not a big computer person, I don’t have all the equipment, the church is small then we’ll not buy that kind of stuff. So that I would prefer for myself doing it in a written format”*. To summarize, the qualitative findings indicated that FCNs’ general practices recognize the professional mandate for documentation but lack clarity and system infrastructure for processes. These qualitative findings also acknowledged that FCN documentation practices were not capturing nor representing an accurate portrayal of the work and client outcomes accomplished.

Integration and Discussion

In mixed methods approaches, it is appropriate to integrate the qualitative and quantitative findings (Chaing-Hanisko, Newman, Dyess, Piyakong, & Liehr, 2016). These findings are complementary in that FCNs’ documentation practices, while recognized as imperative to professional standards, were found to be inconsistent and incomplete. During interviews, the nurses stated they documented mostly numbers of interactions and not the outcomes that were accomplished as a result of their interactions. The surveys also indicated that nurses used individual interaction forms or a daily/monthly activities log/report

that documents quantity and not necessarily the quality of interactions. So even though documentation is a standard of practice that must be met by all practicing nurses, the documentation sometimes is not occurring at all, and if it is occurring, not all care is being captured by the documentation method used by the nurses. Outcomes of care are one of the components of the nursing process that is missing from most documentation methods. From the interviews as well as the surveys, which identified the average age of the participants in the study to be 61.9 years old, use of technology in documentation could be a barrier resulting in FCNs choosing to omit documentation in their practices.

Limitations were present in this study and prevent broad generalization. While using a convenience sample was an acceptable method to target a particular sample, it was possible that the findings were not representative of all practicing FCNs and that sampling bias occurred. The limitations also included the possibility that more of the nursing process was and is being documented but it was not communicated through the focus groups or the interviews. Additionally, many of the paper surveys had incomplete information so it was possible that these nurses may have more complete documentation than was evident from the objective data provided. More robust sampling methods are warranted for future research.

Conclusion

Faith community nursing is a recognized specialty practice and holds promise for positively impacting healthcare for individuals and communities. Maximizing the articulation of FCNs' practice impact on individual and population health is predicated on demonstrating outcomes and meaning. The aim of this research was to explore and describe documentation practices for FCNs, and identify any perceived barriers to documentation. The evidence shows that documentation of the nursing process and client outcomes is limited and there is likely a correlation associated with a lack of standardized documentation. Challenges with adoption practices of using EHRs by FCNs may continue due to inadequate fiscal support, in addition to their exemption from regulatory mandates. Quality patient care requires continuity and communication of information that is augmented through accurate and timely documentation. For patients associated with faith communities and all populations, it is ideal that nursing documentation chronicles the entirety of a patients' journey, capturing the caring, nursing actions and nursing outcomes (Broderick & Coffey, 2013; Karkkainen & Erickson, 2004). Therefore, streamlining, standardizing and sharing documentation for FCNs and all nurses is a national action imperative that will support healthcare transformation (Westra, et al. 2015). Opportunities for the future include the development of user friendly, efficient, and mobile documentation technology that supports the tracking of patient outcomes and not merely the reporting of patient numbers and types of encounters.

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