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Research Article

Meaning and Feelings in Relation to Standardized Care Plan Individualization Process in Acute Hospitalization Wards: A Grounded Theory Study

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Abstract

Introduction: The individualization of care and its inclusion in health records should both be considered a fundamental part of nursing care. Recording individualization through the use of Standardized Care Plans facilitates decision-making regarding the development of judgments about the patient's health status and care planning.

Aim: To understand the meaning given by nurses to the Standardized Care Plan individualization process in acute hospitalization wards.

Method: A qualitative study according to the Grounded Theory approach developed by Strauss and Corbin was carried out. Theoretical sampling with maximum variation was used to select nurses from medical, surgical and medical-surgical wards in three hospitals. The data were obtained by way of in-depth individual interviews, participant observation and a focus group discussion. The analysis consisted of constant data comparison. Open, axial and selective coding was performed until data saturation was reached.

Results: Thirty-nine nurses from the interviews and focus group discussion participated in the study and the researchers carried out 65 hours of participant observation. The core category emerged was 'useful as long as it is updated to the current patient's health status', from which two thematic categories are derived: 'Construction of meanings', which includes a meaning linked to the organizational context and another linked to the delivery of care. Together with 'Construction of feelings', which corresponds to the negative, ambiguous and positive feelings experienced by nurses as a result of the individualization process.

Conclusion: These results spotlight the importance of the updating the care plan and the influence of the organizational context in relation to individualization process.

Keywords: *Nursing Care Plan; Nursing Process; Nursing Records; Organizational Culture; Qualitative Research*

Abbreviations

SCP: Standardized Care Plan; EHR: Electronic Health Record; CP: Care Plan; COREQ: Consolidated Criteria for Reporting Qualitative Research

Introduction

The adoption of a patient and family-centered care model means that nurses provide individualized care, among other features [1,2]. Furthermore, this care must be evidence-based [3] in order to improve quality and safety [4]. Individualized care is when each patient is regarded as an individual person, whose care must be adapted according to their needs and priorities [4].

The individualization of care and its inclusion in health records should both be considered a fundamental part of nursing care. Recording individualization using Standardized Care Plans (SCP) that may be modified to adapt their content to a patient's requirements according to the nurse's assessment promotes decision-making regarding the development of judgements about patient's health status and care planning, thus facilitating nurses' work [5].

One way to evaluate individualization is by recording it in health records [6]. Given that paper-based health records have recently evolved into electronic records, due to the need to transform data into information and knowledge [7], it has been possible to implement electronic SCP. "An SCP determines the diagnoses and nursing interventions, so as to obtain health results in a set of patients defined according to the reason for care" [8]. Due to SCP structure, the individualization may be recorded adapting the diagnoses and interventions of the standards to a patient's needs [5]. For this purpose, the design of the Electronic Health Record (EHR) must essentially include a functionality that allows the care plan (CP) to be updated and modified, depending on the evolution of a patient's health status throughout their hospitalization [9].

Another important factor when creating an SCP and its individualization is the use of nursing languages [10]. Nursing languages allow naming and describing the body of nursing knowledge [11]. Within the nursing discipline, different vocabularies have been developed, such as interface terminologies. These terminologies are conceptual systems that act as a bridge between nurses' natural language and EHR code requirements. The ATIC terminology is one of them. This terminology is used by the nurses participating in this study and its name is the Catalan acronym for Architecture, Terminology, Interface, Information, Nursing (Infermeria) and Knowledge (Coneixement) [12].

Among other factors, the organizational context has been associated to the quality and individualization of care [13]. The organizational context refers to the features of an organization that have a negative or positive effect on nursing practice [14]. An appropriate organizational context facilitates a quality and safe delivery of care [15]. The features involved include using nursing diagnoses, updating each patient's CP according to their evolution, having enough time to discuss patients' care with other nurses, adopting a nursing care model and having a sufficient number of nurses to be able to provide quality care [14]. In accordance with this, adapting the nurse - patient ratio means respecting patients' values and needs, thus favouring care individualization.

Given that nurses spend a fifth of their time transmitting the care planned for patients either in writing or verbally [16], due to the importance of individualizing care and recording it [17] and, in the end, the fact that patients admitted to hospitals with favourable organizational environments acknowledge that they are more satisfied with the delivery of nursing care [18] it is deemed appropriate to conduct an in-depth study of the SCP individualization process in relation to the work context and clinical practice through nurses' experiences and feelings.

Purpose of the Study

The purpose of this study is to understand the meaning given by nurses to the SCP individualization process in acute hospitalization wards.

Methods

Study design

Qualitative study according to the Grounded Theory approach developed by Strauss and Corbin [19]. The Grounded Theory methodology is used to explain and gain in-depth understanding of phenomena through data interpretation, involving the researcher in the study by way of a flexible process [20]. EQUATOR guidelines for qualitative research 'Consolidated Criteria for Reporting Qualitative Research' (COREQ) were applied.

Setting

The study was conducted in two large tertiary hospitals and a community hospital in the metropolitan area of Barcelona, Catalonia. The three hospitals fulfilled accessibility criteria for the principal investigator. The three hospitals use the same EHR for nursing records and the same SCP based on diagnoses and interventions of ATIC terminology [12].

Sample/participants

Nurses were selected using theoretical sampling with maximum variation [20], who had to meet the following criteria: a) they had worked for over 6 consecutive months in the same ward; b) they had worked with electronic care plans; c) they worked in a medical, surgical or medical-surgical acute hospitalization ward and d) they had the following years of experience working in hospitals, classified according to the professional career levels of the Catalan public health system: between 6 months and 10 years, between 11 and 17 years, between 18 and 24 years and 25 years or more. Paediatric units, day hospitals and home hospitalization were excluded. The sample included a total of 39 nurses. 90% were women aged between 23 and 59. 15 nurses (38.5%) worked on the morning shift, 10 participants (25.6%) worked in the afternoon, 8 (20.5%) at night and 6 nurses (15.4%) worked in the 12-hour shift. As regards the years of experience required at the levels of the nurses' professional career, 12 had between 6 months and 10 years (30.8%), 12 had between 11 and 17 years (30.8%), 7 had between 18 and 24 years (17.9%) and 8 had over 25 years of experience (20.5%). Of the total number of nurses, 15 had previously worked with paper-based care plans (38.5%).

The selection of participants concluded once data saturation had been reached. The unit nurse managers and knowledge and information system nurses acted as key persons and were responsible for asking the nurses to participate in the study and for putting them in contact with the principal investigator.

Data collection

Data were collected from September 2015 to October 2017. Three data collection techniques were included:

1. Individual in-depth interviews: 28 nurses (71%) from the sample participated in the interviews. They took place in meeting rooms provided by each hospital and were conducted by the first author. They lasted approximately 1 hour. They were recorded and transcribed verbatim. The initial interview script contained the following questions: What is your opinion of SCP individualization? What do you use the CP for in your daily practice? How do you feel about CP individualization?

2. Participant observation: 65 hours of observation were carried out in 11 hospitalization wards of the 3 participating hospitals: General Surgery, Trauma, Gynaecology, Vascular Surgery, Neurology and Neurosurgery, Cardiology and Cardiac Surgery, Nephrology and Urology, Respiratory and Internal Medicine. The unit nurse managers told the nurses that the observation was going to take place and explained the reason, but without going into details. The observation was carried out by the first author, except on two occasions, when two collaborating researchers also observed, with a different person attending each one of these joint observations. The researchers were allowed to talk to the participants during the observation. All the researchers took field notes for subsequent analysis.

3. Focus group: 11 nurses (29%) from the sample participated in the focus group. It was held in a meeting room in the head office of the hospitals and lasted for 2 hours. The principal investigator performed the duties of a moderator and another researcher acted as the observer. The latter took notes of the subjects she considered important, as well as of the interactions that took place between the participants. It was recorded and transcribed verbatim. The purpose was to validate the data that had been obtained in the previous data collection techniques and increase the information of the codes that had not reached saturation.

Data analysis

The data were collected and analysed simultaneously using constant comparison [20]. The texts of the interview transcriptions and focus group discussion were analysed, as well as the field notes of the participant observation. It consisted of open coding where codes were created based on the micro-analysis of the texts. Axial coding was performed in order to classify the codes into categories and subcategories and, finally, the selective coding process was completed to establish the core category and the thematic categories and explain their meaning. The analysis was performed by the first author with the contribution of the authors who provided the academic supervision of the study. Theoretical saturation was reached when the collected data did not provide new codes [20]. Nvivo v.10 software was used so as to facilitate the analysis.

Ethical considerations

The study was approved by the Clinical Research Ethics Committee of the participating hospitals (PI-15-089) and (PR234/15). The nurses participated voluntarily in the interviews and focus group discussion. First the purpose of the study was explained to them verbally and in writing, then the informed consent process was carried out. In accordance with applicable European legislation on data protection, alphanumeric codes were used to guarantee the confidentiality of the information provided and the participants' anonymity.

Rigour

Guba and Lincoln's criteria of dependability and authenticity were followed [21]. To increase the rigour of the study, the data and data collection techniques were triangulated. The transcription was sent by email to the people participating in the interview and focus group discussion so they could confirm its content. The analysis was supported by memorandums written during the entire analytical process. During the analysis, the researchers applied reflexivity so as to avoid biases related to their experience of the phenomenon under study [22].

Results

The core category that emerged from this study was 'useful as long as it is updated to the current patient's health status'. Nurses report that the updated record of the individualization in the CP is the key to consider them useful and reliable. Therefore, diagnoses and interventions must reflect the actual health status and care of each patient.

'With the care plan you have the opportunity to record the individualized care of the patient. But to trust the plan, its content must be updated according to the patient's evolution. On the contrary, they are not useful' (P3-Interview).

According to the participants, when individualization is poorly recorded, it can cause the quality of the care to diminish.

'If a patient has a pressure sore that needs to be treated every two days. If this treatment is not properly scheduled in the CP, there might be a nurse who does not treat it with this frequency and this prevents the proper ulcer healing' (P21-Interview).

There are two interrelated thematic categories. The first is 'Construction of meanings', which includes a meaning conditioned by the organizational context in which nurses develop their professional practice, as well as a meaning related to the delivery of care as a representation of the lived experience. The other thematic category, 'Construction of feelings', reveals the feelings expressed by nurses towards the individualization process of the SCP.

Construction of meanings

Meaning linked to the organizational context

This category refers to the way nurses orchestrate the individualization process of the CP within the organizational context in which the clinical practice is developed.

Delivery of high-quality and safe care with legal protection

The participants state that a CP improves quality and makes the care safer. They also consider that it is a document that provides nurses with legal protection.

'CPs provide quality and improve the care because they remind you of each patient's care' (P3-Interview).

'They're a tool for delivering safe care' (P38-Focus group).

'The CP is a legal tool and many nurses aren't aware of it. …It legally proves the care a patient has received' (P33-Focus group).

Improved communication between professionals

In the nurses' opinion, the CP is a tool for informing the different nurses and shifts the care that has to be delivered. In this way, they think that they reduce variability in clinical practice.

'…they facilitate the continuity of care. They are useful for unifying criteria among nurses and ensure the care is the same in each shift' (P31-Focus group).

An opportunity for progressing professionally

CPs are considered a career advancement and SCP individualization specifically is viewed as an opportunity to make progress, inasmuch as it gives visibility to the value and delivery of nursing care. They also consider that CPs should be given the relevance they deserve.

'CPs endow the profession with quality. …Being able to individualize an SCP gives you a very important element of creativity and it enables you to develop professionally' (P28-Interview).

'I don't suppose we realise the importance of CPs. And that's really the case' (P6-Interview).

Regarding different standardized nursing languages, the participants think that they distinguish them as a profession. When asked about the ATIC terminology, the nurses in this study consider that it is sufficiently specific to represent their observations, judgments and actions.

'In the same way physicians have their language, nurses can have ours. And the one we use (ATIC terminology) matches how we usually express ourselves quite well' (P1-Interview).

A tool for knowing which care a patient requires

The nurses perceive the CP as a work tool. Furthermore, they believe that because they include the diagnoses and interventions required by each patient, they could be used to adapt the wards' nursing resources.

'CPs are a good work tool and you should work with them as much as possible. …if the CP is individualized, it gives you the right information about the care a patient needs at that particular time' (P25-Interview).

'The CP reflects the patient's health status and the care they need. …it's a way of demonstrating that another nurse is needed because patients require all this care' (P11-Interview).

A guide for the clinical practice of novice nurses

Novice nurses, who are often assigned to a different ward every day or they work in wards for short periods, state that the CP is a guide of the care they have to deliver. They also believe that it warns them of any complications the patient could develop. In the same way, these considerations are shared by expert nurses.

'For novice nurses it is a guide, so they know the care the patient requires. …when you're not an expert, the CP is useful because it forewarns you of the complications the patient could develop' (P2 novice nurse-Interview).

'It is a guide for new nurses. …with the CP, they can know the patient's risks' (P22 nurse with greater expertise-Interview).

Meaning linked to the delivery of care

This category refers to how nurses experience the SCP individualization process during clinical practice.

Transmitting information verbally using the EHR indirectly

Information is transmitted during the nursing handover without directly using the CP record in the EHR, although this does not prevent nurses from making implicit use of the CP and keeping the planned care in mind when information is exchanged at handover. The information is transmitted in the nurses' natural language and mainly consists in communicating the medical diagnosis, the devices connected to the patients, level of activity, treatment of wounds, diagnostic tests performed or pending, and changes in vital signs.

'A nurse on the morning shift gives the handover to another nurse on the afternoon shift. The information the nurse on the morning shift transmits to the nurse working in the afternoon contains information related to the individualized care of the CP, such as the patient can start ambulating or the treatment of the surgical wound has changed. Nurses use their natural language to communicate' (Participant observation 5).

"…The information transmitted at handover is the medical diagnosis, the devices connected to the patient, level of activity, treatment of wounds, diagnostic tests performed or pending, and changes in vital signs' (Participant observation 8).

Recording the planning and delivery of individualized care

Participants explain that they use the CP to record the planning and delivery of the individualized care of both the patient and their family members. They also state that with CP, the records of judgements made and nurses' actions have improved in quantity and quality.

'We use the CP to record the care the patient requires. …it's a way to reflect the care patients and their family members require' (P32-Focus group).

'CPs enable us to record each patient's individualized care' (P8-Interview).

'Since we started working with CPs, pressure sore records have increased and they are also more specific. Now we record the diagnosis of the sore and type of treatment, together with the dressing and necessary products to do it (by way of interventions)' (P6-Interview).

Construction of feelings

Negative feelings

Data analysis has brought to light some negative moods caused by doing or ignoring CP individualization.

Feeling frustrated and angry

In some participants, the situation of realising that a CP has not been updated to reflect the patient's health status and the care they require makes them feel frustrated, angry and uneasy. When this experience is often repeated, it produces extreme thoughts that make them change their behaviour and they stop individualizing the CPs temporarily. Once their anger has passed, these thoughts disappear and they start individualizing the CPs again.

'Whenever I find a CP that hasn't been individualized, it makes me feel a little frustrated and I'd like to see the nurse who hasn't individualized the CP to be able to tell her what I think' (P17-Interview).

'It makes you angry when you see that the patient's care hasn't been updated. Sometimes I've got so angry that I've told myself that I'm never going to individualize a CP again. But fortunately I'm only angry for a few days, and then I start individualizing again' (P32-Focus group).

Feeling disapproval

Some nurses state they have negative opinions of CPs and their individualization. This disapproval is based on the fact that some participants think that CPs are an obligation that do not benefit their work and they consider them to be secondary. They say that they select the SCP upon admission and then fail to continue with the subsequent individualizations that are necessary for keeping up to date with the evolution of the patient's health status. The reason is because they do not consider them to be particularly useful.

'I don't know what I gain with CPs. I can't bring myself to believe in them. …They're something that have been imposed on us. An obligation. We haven't been taught to think of CPs as something attractive' (P25-Interview).

'I don't find CPs useful. I never consult them. I think CPs are secondary. …I only use the CP when the patient is admitted' (P4-Interview).

'There are nurses who don't individualize CPs because they don't find them useful' (P19-Interview).

Ambiguous feelings

Some of the feelings that emerged in the analysis admit different interpretations, depending on how the participant experiences the individualization process.

Feeling an effort

Nurses explain that individualizing a CP is laborious and they have to make a special effort. They likewise point out that a non-individualized CP implies having to work harder as they need to spend more time on it than they had planned. Some participants have the feeling that it is always the same nurses who individualize the CPs.

'It's not easy to individualize a CP and you need to do your bit' (P8-Interview).

'A CP that hasn't been individualized increases my burden because I have to do the work my colleagues haven't done. And this means I'll have to spend more time to individualize the CP than I would if I only had to individualize the care of my shift' (P28-Interview).

'I think we're always the same nurses who update the CPs. …I spend more time on them than other nurses. I feel like the fool who's always individualizing the CPs' (P23-Interview).

Feeling indifference

Some participants say that they are not bothered if a CP has not been individualized because they think that their colleagues have either forgotten or were unable to do it. At the same time, they state that whenever this happens they do not get upset as they also sometimes fail to individualize the CPs; they do not give much thought to how this could affect the nurses on the following shifts.

'If a CP hasn't been individualized, it doesn't worry me because I think that my colleague has forgotten to do it or they didn't have time' (P12-Interview).

I don't complain if a CP hasn't been individualized. It doesn't bother me because sometimes I don't individualize them either' (P5-Interview).

'I don't know how it affects another nurse if I don't individualize a CP. I suppose they'll have to individualize it or they'll do the same as me and they won't individualize it' (P5-Interview).

Positive feelings

In the data analysis, other nurses have expressed positive moods in relation to CP individualization.

Feeling responsibility

Several nurses state that CP individualization produces a feeling of responsibility. They feel committed to either change the SCP selected for the reason for admission to another one that better suits the patient's current health status, or record patients' complications using diagnoses in the CP. They also add that in the event that they have not been able to individualize an SCP because the patient was admitted at the end of the shift, they tell the nurse working on the next shift.

'If a patient shows signs that they are nearing the end of their life, I change the SCP and select Last days of life because I think it's the one that adapts to the patient's new health status' (P26-Interview).

Patients' complications ought to be recorded in the CP. If respiratory failure exacerbates the patient's health status, I add Risk of respiratory failure recurrence/progression to the CP' (P13-Interview).

If I can't individualize the SCP because the patient is admitted at the end of the shift, I make sure I tell my colleague at handover' (P8-Interview).

Feeling satisfaction

Certain nurses say they are pleased and satisfied with CPs. In the same way, they state that the CP is useful and adds value to their work, although they stress that the usefulness depends on whether they have been individualized according to the patient's current health status.

'I like working with CPs. I think that the care required by the patient is very well specified in the CP' (P11-Interview).

'I enjoy working with CPs. I find it interesting' (P17-Interview).

'I think that the CP serves a purpose and is useful, but they have to be updated to the patients health status' (P6-Interview).

Discussion

The purpose of this study was to understand the meaning given by nurses to the SCP individualization process. The results show that the way nurses feel about the individualization process is conditioned by the organizational context and the experience lived during the delivery of care. Likewise, the study has revealed that there are contrasting feelings among the participants, which range from frustration or indifference to satisfaction [23]. These results are consistent with previous research, not only in relation to CPs, but also the Nursing Process in general [23,24].

The organisational context is associated to the quality of the care [25]. In this regard, the nurses taking part in this study consider that the use of CPs facilitates the delivery of quality and safe care [26,27]. Furthermore, like in scientific literature, they think that one of the functions of CPs is to provide legal protection in the event of possible claims [28].

In the same way, the participants consider that CPs make it possible to share information about patients with the multidisciplinary team, as well as among the different shifts and departments. As a result, CPs improve communication between professionals and ensure continuity of care [28,29]. They likewise consider that diagnosing and planning care using standardization reduces the variability of clinical practice [30].

A fundamental organizational factor is that nurses control their own professional practice [31]. Nurses participating in numerous studies state that the Nursing Process is an opportunity to develop their careers and autonomy [23,32]. Within the context of this study, the nurses believe that the CP individualization process, integrated into the Nursing Process, develops and provides value to their professional role, as well as boosting the profession image.

According to Carrington [33], standardized languages make it easier to plan individualized care, although this author warns that the content of some nursing language systems lack the capacity to suitably reflect the health status and evolution of patients. Nurses of this study state that the ATIC terminology makes it easier to represent the delivery of care and its outcomes in patients [34].

Several studies conceptualize the SCP as a useful, evidence-based tool [27,32]. Likewise, a favourable work context contemplates updating each patient's CP [14]. Unlike what Pinzur [35] expresses in his opinion piece, in which he advocates clinical practice based solely on standardization, the nurses of this study consider that the SCP is a tool whose relevance is linked to proper individualization, which is updated to a patient's requirements [28]. Furthermore, they add that they could be used as an instrument for measuring the necessary care for each patient [28,36] and contribute to the allocation of human resources. According to Juvé-Udina [37] the nursing diagnoses of the ATIC terminology are capable of measuring the complexity and intensity of the care; it is therefore possible to adapt patient-centered nursing resources.

Numerous papers agree that standardized care plans are considered a guide for clinical practice [27,28]. This is confirmed by the nurses participating in this study, although they are viewed as a guide for novice nurses. This would suggest that novice nurses or those who have recently joined a hospitalization ward conceptualize CPs as a learning tool that makes it easier for them to plan care and informs them of the possible risks that could lead to a deterioration of a patient's health status. Unlike expert nurses, who tend to rely more on the knowledge they have acquired throughout their clinical practice [27,28].

On the other hand, participants say that the individualized diagnoses and care should be suitable for the health status and needs of patients and their family members. Nevertheless, this is not always the case and there are inconsistencies in the diagnoses or planning [38]. In the international study by Aiken., *et al*. [39] the nurses alleged that the lack of time was a restriction when it came to recording the care. Furthermore, in certain countries, nurses considered that the nurse to patient ratio was too low. The majority of nurses in all countries thought that the existing proportion of nurses did not guarantee quality care. In fact, the study by Juvé-Udina., *et al*. [37] carried out in our context, suggests that given the variability of profiles of patients who require different intensities of care in hospitalization wards and the average ratio, patients are probably not receiving the hours of care they require. According to the study by Lake., *et al*. [40], the second

most missed care by nurses is the planning and individualization of care. The results of that study show that in hospitals where nurses frequently omit care planning, at the same time they omit the delivery of care more often, which could have consequences for patients in terms of adverse events, quality and the safety of care [13]. In addition, according to literature, care individualization is also influenced by attitude, beliefs about roles and responsibilities and each nurse's ethical values [41].

As regards using the EHR while verbally transmitting the information, our results are consistent with previous studies [42]. Nurses communicate the CP verbally at handover by indirectly using the CP recorded in the EHR. Regarding the use given to CPs, they are used for recording the planning and delivery of care [28].

With respect to the feelings created by care individualization, a wide variety have emerged. There are nurses who express negative feelings because in their opinion, CPs are an obligation and are not useful. These results are consistent with those obtained by other authors [24,43]. Other nurses feel that recording individualization requires extra effort, especially if it has not been done by their colleagues on previous shifts or they just do not think it is important enough. Finally, like some nurses of the study by Rodrigues-Alves., *et al*. [23], a group of nurses participating in this study feel frustrated and angry when a CP has not been updated. In spite of this, these same nurses also feel responsible for ensuring the CP reflects the appropriate diagnoses and interventions, together with feelings of satisfaction when they use CPs and they individualize them according to each patient's health status and care.

Limitations of the Study

The selection of the participants by the unit nurse managers or knowledge and information system nurses of each hospital could have influenced the selection process, despite the fact they were given exact instructions about the criteria the nurses had to meet. While reading the results of this research, it is necessary to bear in mind that they emerge from a qualitative study conducted within a specific context; to better understand the phenomenon, similar studies should be conducted in different environments.

Conclusion

By applying the Grounded Theory in this study it has been possible to carry out an in-depth analysis of the meaning nurses give to SCP individualization process. The results show that the SCP individualization process is related to the continuous CP updating to the evolution of the patients health status. Along with, the organizational context in which nurses work and to the delivery of care as a representation of the lived experience, as well as the feelings caused by the individualization process. A set of factors that could play an influential role, inasmuch as the CP resulting from individualizing the SCP could be more or less consistent with the patient's health status and the care they need. Nurse managers should establish strategies to improve the organizational context of hospitals with respect to the establishment of ratios according to patients' requirements, ensure diagnoses are accurate and that the necessary care is planned, and also ensure that patients and their families receive a quality and safe delivery of care.

Conflict of Interest

No conflict of interest has been declared by the authors.

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