

DOCUMENTATION: A LIMITING FACTOR IN CONDUCTING CLINICAL RESEARCH IN A HOSPITAL SETTING

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Chart Review, Charting by Exception

Purpose: This presentation describes the problems encountered in collecting patient data from medical records in which charting by exception was the method used to document care.

Methodology: The study, *Patient, Nurse, and Hospital Factors related to Ventilator Associated Pneumonia (VAP)*, is a retrospective chart review of patients admitted to one of several intensive care units (ICU) in a North Texas hospital between June 1, 2002 and June 1, 2003. A team of six data collectors reviewed 40 charts. Data points included elevation of head of bed, method by which oral care was provided and products used, condition of natural dentition, date of intubation/extubation and names of nurse providers. Data collectors, skilled critical care nurses holding a master's degree in nursing or enrolled in graduate study, were trained to criterion. Each chart was reviewed by a single data collector. Approval to conduct the study was obtained from both hospital and university IRBs.

Results: Two primary challenges in collecting data were encountered: illegible handwriting and incomplete/unclear or absent documentation. *Illegible handwriting:* To capture information about nurse factors required that nurse provider names be obtained from the record. In most instances, nurse identification could not be made as signatures were illegible or incomplete. Either the names could not be discerned or only an initial for first name rather than the full first name was entered. *Incomplete/unclear or absent documentation:* Critical care variables important to the study and the care of patients with VAP were absent or only partially documented. Examples of these variables include degree of elevation of patient's head of bed, how oral care was implemented, the products used in giving oral care, and changes in the condition of the mouth and oral mucosa.

Discussion: In this study retrospective review of nurses' notes and flow sheets revealed that they were not sufficiently detailed to permit evaluation of care factors associated with the development of VAP. The method of documentation and/or the evidence used in designing the forms appear to need reconsideration.

Conclusion: With hospitals working to achieve magnet status, regulatory agencies such as JACHO tightening patient safety requirements, and hospitals being asked to quantify outcomes through evidenced based practice, a paradigm shift in clinical documentation systems is needed. So that these systems can provide the data needed for clinical research, skilled nurse researchers should become engaged in their redesign.