

**EVALUATING THE USE OF NURSING CARE PLANS IN
GENERAL PRACTICE AT A LEVEL 3 HOSPITAL IN THE
UMGUNGUNDLOVU DISTRICT OF KWAZULU- NATAL**

by

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ORIGINALITY DECLARATION

I, Priscilla Maharaj, hereby declare that this dissertation, submitted for examination, represents my own work, both in conception and execution, and has not been submitted for examination by any other university, or for review and publication by any research journal. Where I have made reference to the work of others, I have included such reference in the bibliography and as a citation in the text.

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ABSTRACT

Aim

The aim of this study was to evaluate the use of nursing care plans in the management of patient care and to recommend guidelines for improving the quality of planned nursing care at a level 3 hospital in the Umgungundlovu district of KwaZulu-Natal.

Method

The case study was based on the conceptual model of care planning and employed both quantitative and qualitative research designs. The quantitative phase involved a retrospective audit of charts, using an itemised checklist to determine whether items relating to the phases of the nursing process were in evidence within the charts. The qualitative phase consisted of face-to-face interviews with registered nurses, who were asked about their understanding and use of the nursing process. Data derived were analysed using Nvivo 10 and presented as graphs, tables and written text extracts.

Results

The results show that the use of the standardised care plans at the study hospital had an impact on the understanding of the importance of the nursing process and the successful implementation of the care plans. Factors that had an impact on this included the registered nurses who failed to nurture the junior nurses, lack of understanding of the care plans and what was expected of the staff, staff attitudes and the heavy workload.

Conclusions

It was suggested that nurse leaders support the implementation and continued use of individualised care plans in order to improve critical thinking skills of nurses by implementing teaching and in-service programs, employing knowledgeable registered nurses, by developing and enforcing adherence to policies that favour care planning and nursing documentation.

Keywords

nursing process, nursing care plan, nursing diagnosis, nursing care, nursing documentation, case study

DEDICATION

This dissertation is dedicated in loving memory of my dear friend and sister.



Neermala (Niri) Naicker

(1966 – 2013)

Niri inspired me to start the work represented by this dissertation, but sadly would never see me finish it. She taught me forgiveness and perseverance.

Thank you, Niri, for your love and support. For these I will always be grateful.

ACKNOWLEDGEMENTS

This dissertation would not have been possible without the support and assistance of the following people:

Professor Ashley Ross, for all the support, teaching, guidance, nurturing and mentoring for the duration of this study, from conception to write-up. I know how difficult it must have been for you. Your reassurance, patience, wisdom and support eventually paid off. I thank you for your time and humour, which kept me going, even when I thought I could not possibly go on.

Ms Sibongile Ngcobo, thank you for your assistance in the foundation phase of this dissertation; your support is valued.

Chris, my patient and wonderful husband, for your unwavering love and support, despite the odd hours, day and night. Thank you for your assistance with the technical aspects of the dissertation. I could not have done it without you.

Shanice, my niece, thank you for all your assistance, your input, your encouragement and support, especially when I was at my lowest.

Timika, my lovely daughter, thank you for your technical know-how and coming to my rescue whenever I needed it.

Thivesh, my son, thank you for your emotional support and patience.

My parents, Mr B. and Mrs E. Sithapersad, thank you for your unconditional love and support in any project I undertake. Thank you for your encouragement to keep on studying.

Sandy Chandramohan, for all your assistance and proof reading my work. It is appreciated.

Cookie Mathura and Shayna Jaenant Cattigan, thank you for your assistance and support in data collection and for your support during the study period.

My friends and colleagues at Grey's Nursing campus, thank you for the support, advice and all the assistance given during this period of study.

Grey's Hospital management, for allowing me to use the hospital as the study site.

Greys Hospital Nursing management, Mrs Sosibo, for your assistance and support.

All the registered nurses, for your participation in the study. Your contribution was huge, thank you.

Mrs Navina Parmanand and her staff at Medical Records, for being so co-operative and allowing us to use the charts according to our schedule. A big thank you.

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DEFINITIONS OF TERMS

Care

Care is nursing that is carried out correctly and without causing damage to keep someone healthy and safe (Webster, 2014).

Care Plan

Refers to a printed or electronic guide or programme of the care to be rendered to a patient. It includes both standardised and individualised care plans (Kozier and Erb, 2008:175). They add that the care plan deals with nursing management of the patient's health problems on a daily basis.

Critical Thinking

An intellectual method of actively and competently guides a nurse in applying, analysing, synthesising and appraising data in order to reach a conclusion when dealing with patients who need care (Kozier and Erb, 2008:163).

Diagnostic Tests

A term used for any test that is done to determine the kind and seriousness of a particular disease (The Free Dictionary, 2014).

Expected Outcomes/Patient Goals

An expected outcome is a statement in the care plan of what the nursing interventions are intended to accomplish (The Dictionary of Nursing, 2008).

Health

According to The World Health Organisation, health is a state of complete bodily, psychological and social wellbeing and not merely the absence of disease or infirmity (Dreyer, Hattingh and Lock, 1997).

Health Status

Is an all-inclusive perception that is determined by more than just the presence or absence of disease. It is often summarised by life expectancy or self-assessed

health and includes body functioning, physical illness and mental wellbeing (Male-Health, 2014).

Holistic Care

Medical/nursing care of the whole person considered as subject to personal, social and organic factors (The Free Dictionary, 2014).

Interdisciplinary

Involving two or more academic disciplines that are usually considered distinct (The Free Dictionary, 2014).

Interview Guide

Is a set of pre-planned questions that the nurse asks the patient during the assessment phase, in order to collect data. This tool was designed and is used by this study hospital (The Sage Encyclopedia of Social Research Methods, 2004).

Level 3 Hospitals

Refers to a major hospital that has a full complement of services, including paediatrics, obstetrics, general medicine, gynaecology, various branches of surgery and psychiatry. Patients will often be referred from smaller hospitals to a level 3 hospital for major operations, consultation with specialists and when sophisticated intensive care facilities are required (all nurses, 2004).

Medico-Legal Risk

A medico-legal risk refers to a hazard which is related to medicine and the law. There has been a swift development of the area of the law relating to healthcare because of the increasing number of court cases for accidents and injuries in the healthcare facilities, many of them seeking to be compensated for negligence (Oxford Concise Medical Dictionary, 2002: 417).

Nursing

Nursing is involved with the promotion of health, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human responses

and advocacy in the care of persons, families, communities and the general population (Nursing World, 2014).

Nursing Diagnosis

Meyer, Van Niekerk and Naude (2004: 40) have defined nursing diagnosis as an intellectual activity, in which critical thinking skills are used to identify the relationship between physiological, emotional and social variables, in order to draw conclusions.

Patient

A patient is a person who plays a special role in society, which carries social expectations regarding his/her behaviour. He/she is often sick or injured and in need of treatment (Vlok, 1988:5).

Profession

A group of people engaged in an occupation or calling. A vocation requiring special education, training and skills (Geyer, Mogothlane and Young, 2009:33).

Registered Nurse

A registered nurse is one of many different types of nurses, who has at least completed a nursing programme at a nursing school, college or university. The registered nurse's Scope of Practice is determined by the South African Nursing Council (South African Nursing Council, 2014).

Responsibility

Responsibility is being answerable. The nurse's basic responsibility is to promote health, prevent illness, restore health and alleviate suffering. The nurse is answerable for the way in which this responsibility is carried out (Geyer, Mogothlane and Young, 2009:78).

CHAPTER: ONE

1.1 INTRODUCTION AND BACKGROUND

The need for excellence in nursing care and the emergence of managed care has had a severe impact on clinical nursing practice. The South African Nursing Council has established a strategy towards ensuring that the nursing process is practised in all South African health institutions. This is based on a view of the nursing process as a means of ensuring a systematic provision of nursing care to all patients. Although some nurses are men, the researcher will be using the female gender for the 'nurse' throughout.

The nursing process is a systematic, rational method of planning and providing individualised nursing care. This process consists of five phases, *viz.* assessment, nursing diagnoses, planning, implementation and evaluation (Kozier and Erb 2008:175). Nursing care plans are part of the nursing process and are a written guide that organises information about a patient's care to meet the unique needs of individual patients. Such plans help the nurse to stay focused on each patient's health problems and ensures continuity of care, so that a patient-centred care, as opposed to routine care, is able to be rendered to patients, with the nurse focused at all times on the nursing needs of the specific patient (Vlok 2007:200). Individualised care plans are tailored to meet the unique needs of a specific patient. The care plan is important because it gives direction to what care is to be rendered to the patient. The nurse uses the nursing diagnosis to develop goals and nursing interventions, which result in an holistic, individualised plan of care (Kozier and Erb 2008:211).

According to Kozier and Erb (2008:197) the nursing diagnosis is a problem statement consisting of two components, the patient's health problem and the etiology (the cause/related risk factors). It is a reasoning process where the nurse uses critical thinking skills to interpret the data that is collected in the previous phase (assessment phase). The nursing diagnosis is important because it provides the

basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable. The nursing diagnosis must be specific and to the point.

Gulanick and Myers (2011:1) state that with nurses being the backbone of healthcare, quality of care and safety of the patient must be their business. They go on to say that nurses are well positioned to positively enhance patient outcomes and these efforts are shared by physicians and hospital management in their pursuit of high quality and safe patient care. Enhancement of patient care in any hospital is influenced mainly by the quality of nursing care that is able to be provided. Nursing care is enhanced by nursing care plans which outline the nursing activities to be provided by the nurse to the patient. Nursing care plans are a set of actions the nurse will implement to solve the nursing problem identified for a particular patient. The nursing process was developed as a way of providing holistic patient care and has globally been considered as a framework for nursing practice and nursing education (Mamseri 2012:9). This study sought to evaluate the use of nursing care plans at a level 3 hospital in the UMgungundlovu district.

The South African Nursing Council (SANC) states, in its Scope of Practice, that it is the responsibility of the registered nurse to ensure that the patient admitted to the ward has the correct factual information captured to allow for proper and accurate nursing diagnosis formulation. The plan of care must be based on the previous two steps and the plan must be complete. Plans are also made for the risk factors, as well to ensure the safety of the patient. The SANC further states that the registered nurse must delegate responsibly to nurses who are competent in the nursing duties required by the patient. The registered nurse must supervise the delegated duties to ensure they are carried out competently. The registered nurse is required to evaluate the nursing actions and the patient outcomes. All the steps of the nursing process are recorded. In SANC's draft Charter of Nursing Practice 2004, and standard practice guidelines for clinical practice, is a breakdown of the nursing process and what is expected of the registered nurse.

Once a patient is delivered into a nurse's care, the registered nurse must prepare a nursing care plan based on a correct identification, meticulous history-taking, careful physical examination, consideration of the medical diagnosis and treatment, and medical judgement. A clearly defined plan for an appropriate intervention, evaluation and recording of nursing activities is both necessary and essential.

Research has shown that, within current nursing practice, care plans are not being used effectively towards the delivery of quality nursing care and, as a result, nursing care standards are on the decline (Armstrong, Rispel, Penn-Kekana, Blaauw and Bell 2012). Professional nursing beliefs support the survival of the care plan in the hospital environment as it served as a reminder of the nursing care to be rendered to the patient (Lee and Chang 2004:35). One of the registered nurse's responsibility is to meet the patient's health care and nursing needs. This role of the nurse can be achieved by the correct application of the nursing process. This ongoing process involves assessing the patient, using critical thinking skills to make a nursing diagnosis, planning the care by selecting nursing interventions, implementing the interventions and evaluating the outcomes (Kozier and Erb 2008:1555). The media also informs the public, on a regular basis, that nurses appear not to be performing their duties the way that they should. In 2006, on the occasion of the 10th anniversary of the founding of Denosa, which was held in Durban, the then State President, Thabo Mbeki, thanked the nursing profession for 'occupying the moral high ground in the past' and he warned the nurses of deteriorating standards and corrosion of the ethos that once directed nurses for such a long time (Breier, Wildschut and Mggqolozana 2009:112). According to Mamseri (2012:31), the nursing care plan is a tool that collates data when a patient is admitted, improves the quality of care and forms a basis for discharge. Research has been conducted in the UK, USA, Australia and Switzerland (Bjorvell, Thorell and Wredling 2000; Lee and Chang 2004; Muller-Staub, Lavin, Needham and van Achterberg 2007), but the researcher has been unable to access any research regarding the use of care plans in South Africa, or indeed on the African continent. The research conducted overseas, within those respective countries' contexts, is likely to reflect the barriers to the use of care plans in those countries that may be very different to those of South Africa. The present research seeks to provide an insight into the current status, with regards to the use of care plans, in the South African context, the

effectiveness of such use and, if they are not being used, to identify the problems or barriers to their effective use (inasmuch as the research site is representative of the South African context).

1.2 PROBLEM STATEMENT

Nursing is principally concerned with assisting individuals through a range of activities that contribute to the restoration of health and recovery from illness. While nurses represent the core of the health care delivery system, their image remains that of individuals who are dependent on the doctor's supervision (Carpenito 1991: xi). Diers (as cited by Carpenito 1991:xi) reasons that nursing could be seen to be exceedingly complicated work due to it involving and requiring a range of different qualities from nursing personnel. These qualities include technical skill, a great deal of formal knowledge, the ability to communicate, critical thinking, sensitive timing and a willingness to become emotionally involved in the act of nursing. The thinking process is complicated and falls outside of the general public domain. The nurse has to consider the requisite knowledge and how she may best apply it technically; abstract information is transformed to reality, such as observation to action; from making a decision to the application of touch. There is much that happens in nursing, but a small proportion is formally described (Carpenito 1991: xi). One way of making the act of nursing overt and visible is for nurses to formally describe their often tacit reasoning, processes and strategies, all of which are incorporated within the plan of nursing care (Carpenito 1991: xi).

In April 2012, the Royal College of Nursing in London held a research conference. "Quality of care in nursing units in South Africa" (Armstrong *et al.* 2012) was one of the papers presented. This study measured the quality of care provided within a selection of South African nursing units in terms of the following focal areas: hand hygiene, record keeping and observations. A recommendation which emerged from this study was that there is an urgent need for an increased emphasis on developing nursing care plans within the South African context. Within the clinical area it has been found that there is a lack of care planning and, as a result, patients are often

subjected to routine care instead of holistic, patient-centred care (Greenwood 1996). The value of the nursing care plan cannot be overstated, as it is designed to ensure continuity of care, as well as to keep reminding the nurse to stay focused on the patient's individual needs. A study by Jansson, Pilhammar-Andersson and Forsberg (2009:611) showed that, when care plans are not used, the nurse fails to focus on patient problems, which results in longer hospital stays and a resultant increase in healthcare costs. When care planning is effective, however, patients are said to have rated their nursing care to be of higher quality and to have enjoyed participating in the decision-making pertinent to their care.

According to Booyens (2008:135) nursing record-keeping is done according to care plans and records are kept to ensure safe and high quality care to patients. Quality health care therefore depends on accurate and chronological evidence of the care provided. Ngidlana (as cited by Booyens 2008:132) states that a large number of the South African Nursing Council's disciplinary measures arise from inaccurate record-keeping. She further states that recording and record-keeping go hand in hand, since all the information obtained during the assessment phase of the nursing process constitutes the basis for subsequent care. If records are inaccurate, or not kept safely, the continuity of care is interrupted and may result in inefficient patient care. Inadequate record-keeping may also lead to medico-legal risks. Good record-keeping is the only tool that nurses have to provide proof of the care that they have provided to the patient. Vlok (2007:200) states that record-keeping is the tool by which nurses take responsibility for their scientific actions within a legal framework.

The responsibility for patient care, from the moment the patient is admitted to a health care facility, is that of the registered nurse and her team. It is the responsibility of the registered nurse to make sure that effective, vigilant care is upheld through accurate recording (Vlok 2007:200). In terms of the Nursing Act (Act 33 of 2005) the registered nurse in charge of the ward is fully accountable for all acts and omissions relative to patients under her care.

Muller-Staub *et al.* (2007:42) state that care plans improve the quality of care rendered to patients because care is planned and all essential data are within the reach of all nurses who are responsible for the patients' care. These, in turn, result

in the patients receiving specified and targeted care. Elf, Poutilova and Ohrn (2007:531) support this view when they state that care plans enhance the quality of care, as care plans are typically co-ordinated, safe and more effective. When nursing care plans are documented, the nurse is more focused on the care to be given to the patient. The nurse does not lose sight of the patient's health status and, as a result, the quality of care is improved (Bjorvell, Thorell and Wredling 2000:11).

Much research has been conducted in the UK, USA, Australia and Switzerland regarding the use of the care plans and the quality of nursing care rendered (Bjorvell, Thorell and Wredling, 2000; Lee and Chang, 2004; Muller-Staub *et al.* 2007) but the researcher was unable to find much published research conducted in the African or South African contexts. Against this backdrop, the present case study sought to evaluate the extent to which care plans are used to deliver care to South African patients (as evidenced within a specific Level 3 hospital in KwaZulu-Natal).

1.3 AIM OF THE STUDY

The aim of the study was to evaluate the use of nursing care plans in the management of patient care and to provide recommendations towards improving the quality of planned nursing care at a Level 3 hospital in the UMgungundlovu District of KwaZulu-Natal.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- determine the registered nurse's level of understanding of the nursing process, *viz.* assessment, nursing diagnosis, planning, implementation and evaluation, by using semi-structured interviews;
- determine whether or not the nursing care plans are being used according to the standard guidelines provided by the South African Nursing Council in its

Scope of Practice, by using an itemised checklist to determine if the nursing process is being applied correctly;

- identify the factors which impact on the preparation and use of care plans; and
- make recommendations on strategies for planned nursing care that may be adopted into nursing practice.

1.5 RESEARCH QUESTIONS

- How well does the registered nurse understand the nursing process?
- What differences exist between the standard guidelines that are provided by the South African Nursing Council in its Scope of Practice?
- What conditions influence the preparations of care plans

1.6 SIGNIFICANCE OF THE STUDY

The significance of this study is as follows:

-the study will assist in determining the knowledge limitations of the registered nurses in the use of the nursing process and nursing care plans and assist to develop training guidelines in view of in-service training for all nurses and to encourage nurse managers to support care planning strategies in nursing practice.

-nurse educators are at the centre of this study as the findings will inform curriculum development and preparing students to effectively internalise and operationalise the nursing process.

-The findings of this study are limited to the study site, but further research on the use of care plans at other institutions could expand on the findings. The information could be used to develop hypotheses to be tested more rigorously in subsequent studies.

- To be able to inform policy on how to more effectively use the care plan to deliver quality care. This study sought to benefit patients and the researcher anticipated that it would advance the understanding of the nursing process, shed light on

controversy that may exist with respect to the planning of care in the South African context and promote the delivery of quality health care.

1.7 LAYOUT OF CHAPTERS

Chapter One: the background, aims and objectives of the study. The general layout of the study will be covered in this chapter.

Chapter Two: an overview of the literature study will be given.

Chapter Three: the research methodology is described, including research design, data collection and ethical considerations.

Chapter Four: presentation of results, both qualitative and quantitative.

Chapter Five: the discussion of the results

Chapter Six: conclusion and recommendations based on the findings of the study.

1.8 CONCLUSION

Chapter one provided the motivation and scientific foundation for the research study. Within this brief motivation were included the background to the study of the use of the nursing care plans, the aims, objectives, perceived significance of the study and the problem statement. In the next chapter, the researcher will provide a review of the relevant literature and expand on the rationale for the study.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

The literature review for this study was conducted systematically, using the concepts of the nursing process in order to obtain a deeper understanding. The nursing process, its five phases (i.e. assessment, nursing diagnosis, planning, implementation and evaluation), nursing documentation and the requirements for nursing practice by the South African Nursing Council are discussed in detail. Nursing theories and the conceptual framework that underpins this study are discussed. Good nursing care depends extensively on access to high-quality data. Apart from the delivery of patient care, another urgent task for nurses is to discuss information about their patients' health and future plans. The major source of information for this is the nursing records or nursing care plan (Saranto and Kinnunen 2009:465).

The researcher did online searches using the following databases, Pubmed, Google Scholar, Dut Library, CINAHL, Healthsource: nursing, Medline, ProQuest: nursing, Sage Research and Science Direct. The search terms such as the nursing process, nursing care plans, nursing documentation, nursing records, nursing assessment, implementation, evaluation, nursing diagnosis, nursing care and case study. Only English literature was searched.

The nursing profession is built on a unique body of knowledge, which is a requirement of any profession. The nursing profession is responsible for creating and communicating this knowledge to members of the profession and student nurses through education. Various concepts, models and theories exclusive to nursing have been accepted, described and established in order to shape this knowledge base. A concept has been defined as a thought that has been envisioned in the mind. These are words that symbolise reality and improve the ability to communicate it. Theories are sets of interdependent concepts that signify a methodical way of viewing facts by stipulating relationships among the variables. In nursing, there is a general agreement that nursing is concerned with four major

concepts, i.e. the person (the patient), health, the environment and nursing. Together these concepts make up the meta-paradigm of nursing. In all of the nursing theories, each of the four concepts is included. Some theories speak overtly to these concepts, while others only suggest their presence.

2.2 THE NURSING PROCESS

The nursing process is the fundamental structure that provides order and direction to nursing care. It is the lifeblood, the instrument and methodology of the nursing profession (George, 1995).

2.2.1 HISTORY

From its earliest stages in the 1950s, the nursing process has grown progressively to become every nurse's daily activity (Yura and Walsh 1988:23). In 1955, Hall was the first to see nursing as a process (Kozier and Erb 2008:175). In 1960, Orlando defined the phases of the nursing process in terms of interpersonal relationships, while other nurses were exploring its philosophy and values (Yura and Walsh 1988:23). Knowles in 1966, described a model of activities of the nursing process and, a year later, a committee involved with curriculum development defined the nursing process as the activities between the nurse and the patient. It was in the same year that a group of nurses at a school of nursing identified the nursing process as assessing, planning, implementing and evaluating (Yura and Walsh 1988:23). It was in 1986 that the nursing diagnosis was added to the previously-existing four phases (Nanda-I 2012).

Just as architects make elaborate and detailed blueprints and models before building any structure, nurses seek to use the nursing process - a patient-centred, problem-solving, goal-oriented method of caring that enables the nurse to provide nursing care in an orderly, scientific manner (Carpenito 1991;xi) – to provide a scaffold and model for effective nursing care delivery. White (2003:4) described the nursing process as a process that inspires methodical thought, enquiry and planning

when working with patients, to select those things that need to be done. The nursing process is a scientific, goal-oriented and problem-based method of nursing the patient. The nursing process is made up of five phases which are assessment, nursing diagnosis, planning, implementation and evaluation. These phases of the nursing process occur in a sequence and are necessary to ensure holistic, individualised nursing care for the patient (Meyer, van Niekerk and Naudé 2004:175).

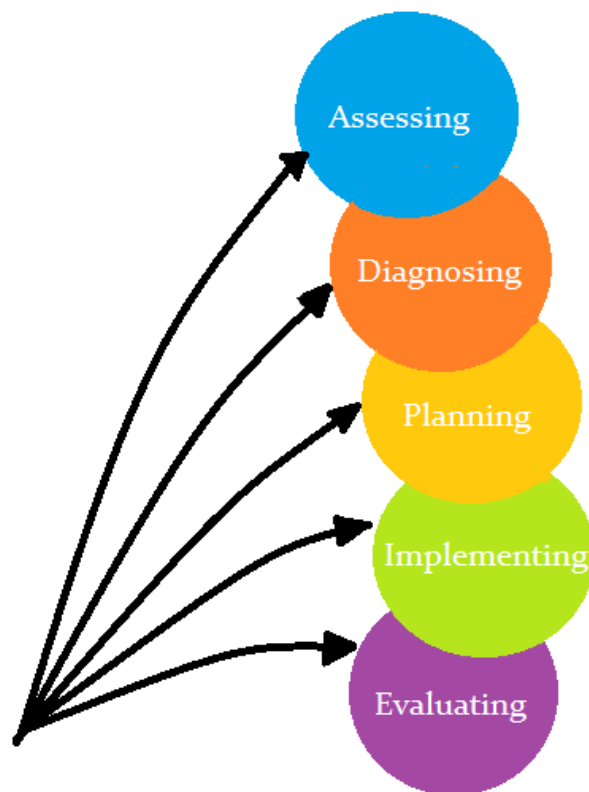


Figure 2.1: The Nursing Process (Kozier and Erb 2008:176)

According to Kozier and Erb (2008:175), the purpose of the nursing process is to determine the patient's health status, including the actual and potential healthcare needs or problems, to formulate plans to meet the problems and to deliver the nursing care to meet the needs. The characteristics of the nursing process include decision-making in each phase, patient-centred problem-solving, interpersonal skill, cyclic evaluation and adaptation and universal applicability. The nursing process is additionally a framework within which the nurse must function, as set out by the South African Nursing Council's Scope of Practice. This process further

ensures continuity and co-ordination of care by the nurses in charge of the patient's care and ensures quality in patient care (Geyer, Mogothlane and Young 2009:193).

2.2.2 ASSESSMENT

According to Kozier and Erb (2008:179), assessment, the first phase of the nursing process, is seen as an ongoing process that entails collection, organisation, validation and documentation of data. They further state that all phases of the nursing process rely on the complete and accurate collection of data during this phase. Intelligent judgement by the nurse is required in order for her to analyse the gathered information. All the information that the nurse collects regarding the patient makes up the assessment. Data is collected from the patient using a combination of methods, such as observing the patient, by conducting an interview with the patient and by performing a physical examination of the patient. Saranto and Kinnunen (2009:472) support this view by stating that data should be collected from the patient and family members in order to adequately evaluate nursing documentation. Nurses need a variety of critical thinking skills to successfully carry out this phase of the nursing process (Geyer, Mogothlane and Young 2009:193). To be useful, the data should be relevant to the health problem identified. Nurses should therefore think critically about data to be included. Meyer, van Niekerk and Naudè (2004:174) add that effective evidence-based nursing care must be built on accurate assessment and an ongoing monitoring of the patient. It is compulsory for every nurse to acquire expertise in the skills and methods of patient assessment. Failure to do this represents negligence.

2.2.2.1 Methods of Data Collection

Data collection begins at the first encounter with the patient, i.e. on admission, and continues to the point of discharge from the health facility (Geyer, Mogothlane and Young 2009:175).

a) *Observing*

This important means of data collection includes the physical and mental state and the ability to communicate and co-operate. The nurse's observation of the patient using all her senses, including sight, smell, touch and hearing (Geyer, Mogothlane and Young 2009:175).

b) *Interviewing*

In conducting an interview, it is essential that the nurse establishes a rapport with the patient and this must be done systematically. A questionnaire may be useful, as it is structured and based on the patient's functioning. However the interview is conducted, it is imperative that all relevant information is obtained. Interview data is necessarily subjective information given to the nurse by the patient (Geyer, Mogothlane and Young 2009:175).

c) *Physical examination*

A head-to-toe or body system approach may be used and it must be thorough and systematic. Objective data is obtained independently by a nurse through observation, physical examination and a range of diagnostic tests. This data is self-evident and can be obtained by any other member of the health care team when they examine the patient (Geyer, Mogothlane and Young 2009:175). The data is then validated and documented.

2.2.3 NURSING DIAGNOSIS

Geyer, Mogothlane and Young (2009:197) state that the nursing diagnosis is a statement of the patient's that needs nursing interventions in order to ensure that the patient's needs are met. Meyer, van Niekerk and Naudè (2004:40) have defined nursing diagnosis as an intellectual activity, in which critical thinking skills are used to identify the relationship between physiological, emotional and social variables, in order to draw conclusions. They add that the diagnosis of health needs provides the basis for individualised patient care. The nurse must be able to use high cognitive

reasoning in order to differentiate between those problems that need nursing interventions and those that have to be managed by a doctor. Effective diagnosis depends on the accurate assessment of the patient. Accurate diagnosis therefore facilitates individualised nursing care, enhances the planning of nursing interventions, promotes interdisciplinary communication and increases the nurse's autonomy and accountability. The Scope of Practice of the registered nurse (R2598) of the South African Nursing Council makes it clear that the registered nurse must assess, diagnose, provide care plans, intervene in patient care, and evaluate patient responses and record nursing care. Meyer, Mogothlane and Young (2009:197) describe the nursing diagnosis, the second phase of the nursing process, as a statement of the patient's health problems, both actual and potential, as these are linked to a cause that requires nursing interventions.

2.2.3.1 Actual Problems

These are health problems that are present at the time of assessment, e.g. a patient who is having chest pain (actual health problem). To convert this health problem to a nursing diagnosis, the nurse has to relate the chest pain to a probable cause. The nurse will identify the cause or aetiology while she is conducting the assessment phase of the nursing process (Kozier and Erb 2008:197).

2.2.3.2 Potential Problems

In contrast, a potential problem does not exist at the time of assessment, but the patient has risk factors that indicate that a problem is likely to develop, unless the nurse plans interventions to prevent it, e.g. a patient who is vomiting (actual problem) has a risk of becoming dehydrated, because he/she is losing body fluid. The nurse, in such a case, must plan to replace the fluid before the patient becomes dehydrated (Kozier and Erb 2008:197).

2.2.4 PLANNING

Kozier and Erb (2008:211) state that, in planning, the nurse uses data from the assessment phase and the nursing diagnosis as guides in determining the most

relevant and appropriate nursing interventions, in order to lessen the patient's problems. The nurse then formulates the expected outcomes/patient goals (the desirable patient responses the nurse hopes to achieve by implementing the nursing interventions) and decides on the most appropriate nursing interventions to eliminate the patient's problem. This view is shared by Meyer, van Niekerk and Naudè (2004: 43), who add that the nurse decides what can be done to help the patient, meets these identified needs and draws up a plan of care, depending on the identified needs. Planning is the nurse's responsibility, but the patient's input is of vital importance to ensure the effectiveness of the care rendered and adherence to this programme of care. Patient-centred care, as opposed to routine care, is made possible by high-quality care planning. The nurse needs to decide what requires immediate action and what can wait.

Planning can be both short-term and long-term (Mellish, Oosthuizen and Paton 2010:117). Searle (2004:200) states that the registered nurse must exercise caution when practising her independent judgement. She must adjust institutional policies, routines, standing orders and guides to the plan of care and not ignore them. Additionally the registered nurse should make environmental changes in order to maintain patient safety. In a study conducted by Perkins and Fisher (1996:275) 'beyond mere existence: the auditing of care plans', the aim of the study was to develop ways of auditing the quality of care plans and to improve the quality of care planning. It emerged from this study that the content of the care plan did not necessarily mean that an assessment was done; that all the problems identified did not receive equal attention; that the care that was outlined in the plan was not always delivered; and the patient's views did not appear on the care plan. Anderson and Mangino (2006:112), in their study, 'Nurse Shift Report: Who Says You Can't Talk in Front of the Patient?', found that market forces, financial constraints and consumer forces require that patients be more involved in their care and the bedside shift report was identified as one way of meeting this need. The bedside shift report ensures patient participation in decision-making and increases patient gratification.

In another study, by Colón, Lekan-Rutledge, Utley-Smith, Ammarell, Bailey, Piven, Corazzini and Anderson (2006:337), 'Connection, Regulation and Care plan innovation: A case study of four nursing homes', it was revealed that formally

creating occasions for connection among various nursing home staff was fundamental in setting the platform for effective patient care planning. Managers, it was pointed out should consider implementing regular opportunities, such as shift reports, meetings and rounds, which, in addition to inspiring informal staff interaction, was seen to enable effective care planning.

In a study by Radcliffe and Hegarty (2001:87), 'An audit approach to evaluating individual planning', it was clear that, although there were numerous discussions and evaluations of individual planning, there was no agreement on the best method of evaluating such planning. The suggestion was that the nurses/service providers do an appraisal on care plans against their own objectives.

2.2.4.1 The Planning Process

The planning process may be viewed as having five components, viz. setting priorities, establishing expected outcomes/patient goals, selecting nursing interventions, and two modes of intervention themselves, in the form of standardised care plans and individualised care plans.

a) *Setting Priorities*

At the outset, the nurse decides which nursing diagnosis requires attention first. In the determination of priorities, the urgency of each respective diagnosis, the availability of resources and the patient's beliefs, values and personal priorities must be considered and evaluated.

b) *Establishing Expected Outcomes/Patient Goals*

After setting priorities, the nurse proceeds to establish expected outcomes/patient goals/desired outcomes for each nursing diagnosis. The outcomes can be short- or long-term. The purpose of defining expected outcomes is to provide direction for care planning and serves as a standard for evaluation, helps determine when the problem has resolved and motivates the patient and the nurse by providing a goal to be accomplishment (Kozier and Erb 2008:221).

c) *Selecting nursing interventions*

Meyer, van Niekerk and Naudè (2004:44) state that nursing interventions are those actions that the nurse performs in order to achieve the expected outcomes/patient goals. The nursing actions chosen should focus on removing or decreasing the cause of the nursing diagnosis, which forms the second clause to the diagnostic statement. The interventions for potential problems should focus on ways to decrease the risk factors. Interventions are dated and reviewed at intervals, depending on the patient's health needs. Care plans are divided into two major groups, namely standardised and individualised care plans.

d) *Standardised care plans*

Kozier and Erb (2008:212) state that a standardised care plan is an official or formal plan that stipulates the nursing care for groups of patients with common needs (e.g. all patients with hypertension). It ensures that minimally acceptable standards are met and encourages the effective use of nurses' time by decreasing the need to rewrite activities that are done over and over for many patients in the ward. According to Meyer, van Niekerk and Naudè (2004:44), standardised care plans are compiled from knowledge of a particular disease/illness and therefore have an illness-based focus. These care plans are very useful as teaching tools and in busy clinical areas, where they ensure uniformity of care. Notwithstanding their inherent generalisability, standardised care plans should never be applied to patients without an initial, individual assessment (Geyer, Mogothlane and Young 2009:205).

From their study, 'Factors and Conditions that influence the Implementation of Standardised Nursing Care Plans', Jansson, Bahtsevani, Pilhammar-Andersson and Forsberg (2010:25), concluded that standardised care plans must be easy for the nurse to understand and implement and the facilitators must be supported by nurse leaders in order to ensure time and resources for the continuity of work. Resources should also be devoted to knowledgeable care plan developers.

e) Individualised care plans

Individualised care plans are designed to meet the unique needs of a specific patient that are not addressed by the standardised care plan. Nurses use the care plan for direction regarding what needs to be documented, as well as for the delegation and assigning of staff to care for patients. When nurses use the nursing diagnosis to develop expected outcomes and nursing interventions, the result is holistic, individualised care plans that meet the patient's unique needs (Kozier and Erb 2008:121). Meyer, van Niekerk and Naudè (2004:44) add that individualised care plans are based on knowledge with regard to the patients' specific needs or health problems gained through assessment.

Table 2.1: A Schematic Exemplar of a Care Plan
(Geyer, Mogothlane and Young 2009:205)

| Nursing diagnosis | Expected outcome | Nursing interventions |
|---|--|--|
| 1. The patient's problem requiring nursing intervention 2. Supporting documentation/database | 1. Objective of intervention/s 2. Evaluation criteria/parameters 3. Time factor <i>(if appropriate)</i> | 1. Nursing actions 2. Rationale and technique 3. Protocols and standing orders 4. Frequency |

2.2.5 IMPLEMENTATION

According to Kozier and Erb (2008:233) the phase of implementation represents the 'action phase' of the nursing process. Implementing consists of carrying out and documenting the activities that are the specific interventions that are needed to be carried out in the clinical area. The nurse carries out or delegates the activities for the interventions that were developed in the planning phase and concludes this phase by recording the activities and resulting patient responses. The first three phases of the nursing process, i.e. assessment, nursing diagnosis and planning,

provide the basis for the nursing actions performed during the implementation phase and implementation itself provides for the actual nursing activities and patient responses that are evaluated in the final phase, the evaluation phase. While implementing nursing care, the nurse continues to re-assess at every contact with the patient, she collects data about the patient's response to the nursing activity and any new problem or need that may arise.

The care plan must be checked for accuracy and validated before being implemented. The care plan must be written down and available to all staff taking care of the patient to ensure continuity of care (Geyer, Mogothlane and Young 2009:205). 'Factors and conditions that have an impact in relation to the successful implementation and maintenance of individual care plans' was a study conducted by Jansson, Pilhammar and Forsberg (2011), with the aim of determining the factors that played a role in care plan implementation and the results of this study indicated that nursing management was critically important because clear instructions from management regarding care planning and the roles the nurses play were seen to be necessary, for implementation to be effective. Well-informed and hands-on facilitators were also found to be important to the success of the implementation of individual care plans.

2.2.6 EVALUATION

Kozier and Erb (2008:233) describe evaluation, the fifth and final phase of the nursing process, to be a judgement or appraisal, and is a planned, ongoing activity in which the nurse and the patient determine whether the expected outcome/patient goals were achieved or not. The conclusions drawn from such an evaluation determines if the care plan should be terminated, continued or modified. Evaluation that is done immediately after an intervention enables a nurse to make on-the-spot changes to the care plan, and those evaluations done at longer intervals, i.e. once a week, provide a more overarching view of the extent of the patient's progress towards the expected outcomes. Evaluation is intended to continue until the patient achieves the expected outcomes or until discharge (Meyer, Mogothlane and Young 2009:206). In a study conducted by Voutilainen, Isola and Muurinen (2004:79), to gain more information on the quality of nursing care based on the comments in the

nursing records, it emerged that evaluation was the area that needed more attention.

2.2.6.1 The process of evaluation

Within the process of evaluation, the nurse collects data that is precise and measurable, so that conclusions can be drawn. The expected outcomes and the collected data are compared. The nurse draws a conclusion about the problem. There are two components to the evaluation: the conclusion and the supporting data. The nurse then determines if nursing activities have had any relation to the outcomes. The nurse must never assume that a nursing activity was the only reason for achieving the expected outcomes (Kozier and Erb 2008:236).

2.3 RECORDING/DOCUMENTATION

Kozier and Erb (2008:233) define recording as the process of making an entry onto a patient's chart. Geyer, Mogothlane and Young (2009:192) add that a record may be either written or computer-based. Recording is not a phase of the nursing process but is, rather, a very important part of every phase of the nursing process. Recording in the nursing records is the one way the nurse shows her accountability for the nursing action she has taken towards improving the patient's health status. This accountability and responsibility of the registered nurse is part of South African law. Searle and Pera (1995:320) stress that the recording of treatment, observations and other relevant data constitute a legal, formal record. It is very important that the nurse carries out this aspect of her duty with accuracy and diligence, because the patient trusts that the nurse will ensure his/her safety and protection through data contained in the written record. The nurse betrays the nurse-patient relationship when she does not record accurately or falsifies the record. Kozier and Erb (2008:246) state that communication among health care staff is vital in quality patient care and that such communication is effected through discussion, reports and recording. Recording further provides evidence that the patient received care. Darmer, Ankersen, Nielsen, Landberger, Lippert and Egerod (2004), in their study

entitled 'Introduction of a Swedish VIPS Model' (VIPS is an acronym for wellbeing, integrity, prevention and safety), it emerged that implementation of such programmes had a constructive influence on nursing documentation and the VIPS Model improved the nurse's awareness of the nursing process.

Different health care facilities use different methods of recording, e.g. computer-based or handwritten. According to Geyer, Mogothlane and Young (2009), documenting or recording is an integral aspect of the nursing process. The recording of the assessment and of the nursing interventions implemented, as well as the outcomes and patient's response to the interventions, provide evidence that the nurse did provide the care for which she is accountable (Mellish, Oosthuizen and Paton 2010:117).

In view of the the pivotal importance of nursing documentation, the study, 'Quality of nursing documentation and approaches to its evaluation: a mixed method systematic review', was conducted by Wang, Haily and Yu (2011:618). Their recommendations were that future research should pay greater attention to the accuracy of nursing documentation, the factors impacting on recording, and the effects that these have on nursing care as a whole.

2.4 RECORD-KEEPING

Record-keeping enhances quality patient care and recording is the legal and professional responsibility of every nurse (Meyer, van Niekerk and Naudè 2004:40). According to Geyer, Mogothlane and Young (2008:192), recording is an essential requirement for the effective use of the nursing process. Nurses must bear in mind that in the majority of the South African Nursing Council's disciplinary hearings, the accused's case stands or fails on the grounds of the patient's records. These are legal documents and must reflect accurately and honestly the nursing actions carried out for the patient. Records reflect accountability and proof that nursing care was carried out. This view is shared by Pera and van Tonder (2012:105), who feel that the significance of record-keeping cannot be over- stressed, keeping in mind

that legal claims can be instituted against a nurse months or even years after the fact. Inaccurate and incomplete documents are evidence of a nurse who is negligent. According to the South African Nursing Council's Acts and Omissions, a nurse may be disciplined if found negligent for not recording her nursing care rendered to the patient. Keenan, Yakel, Tschannen and Mandeville (2008:175) point out that, although it is said that record-keeping ensures continuity, compliance and quality of care, no link has been found between these variables. They noted that there are challenges when it comes to nursing documentation and cite the reasons for this as being, *inter alia*, time constraints and a lack of standardisation. The researchers further state that nursing documentation does not fulfil the purpose of being a communication tool that supports quality and safety of care. The observed negative attitudes of nurses towards record-keeping, in seeing nursing care plans as management requirements, did not contribute positively to the value of nursing documentation. In a study conducted by Uys and Booyens (1989:29) in which standards for nursing documentation in general hospitals in South Africa was studied, it was revealed that the factors that made a difference to the quality of documentation included the number of registered nurses and non-nursing support staff per nursing unit, as well as the bed occupancy rate, type of unit and type of hospital. The conceptual Model of Care Planning guided this study.

2.5 CONCEPTUAL FRAMEWORK

Elf, Poutilova and Ohrn (2007:530) state that a model or framework is fundamental to ensuring individualised care. Modern health care requirements, with new types of treatments and more professionals being added to the health care arena, increase the difficulties and the complexity of nursing. Comprehensive patient health problems and planned care is essential to ensure the safety, consistency and continuity of the care provided. They observed that there had been communication failures with the traditional care planning process. Time was wasted due to verbal messages, incomplete notes on patient records and there may have been consequent difficulties for other staff to follow planned interventions, which had a negative effect on the continuity and co-ordination of patient care. Elf, Poutilova and

Ohrn (2007:530) state that studies show that nursing records often lack care plans that were are based on patient needs. This may not only be caused by ignorance or lack of knowledge of the value of documenting the assessment accurately, but also the nurse's difficulties in identifying patients' health needs. This has been viewed as an obstacle to the ability to plan individualised care based on a patient's values, preferences, priorities and capacity. Studies also show that the entries on patients' records are seldom based on clinical guidelines or evidence-based recommendations about care which may affect the effectiveness and quality of care. Optimal care planning has been described as being critical in facilitating patient-centred care and avoiding routine care. Patient-centred care is a philosophy of care which defines the patient's needs as the primary factor for shaping the care practices. Patient-centred care includes respect for the patient's values, preferences and expressed needs and a shared decision between the patient and the nurse. The care plan must be documented, explicit and co-ordinated.

The Conceptual Model of Care Planning, developed by Elf, Poutilova and Ohrn (2007:530-538), will be used in the present study. This model was created to highlight the hypothetical links between structural, process and outcome factors, which are necessary to the quality of the process. The patient's health needs must be assessed accurately and form a prerequisite when making a nursing diagnosis and preparing the nursing care plans. Other factors that influence the quality of the process are the care culture and professional knowledge.

2.5.1 KEY VARIABLES IN THE MODEL

2.5.1.1 Health Status

In this model, the human being's functioning and disability can be described as a result of interaction between health conditions (diseases, disorders and injuries) and contextual factors. Functions and disabilities may be described as follows: body function (both physiological and psychological), body structure (anatomy of the body), activities and participation in life situations and environmental factors (design of space and support from others). This model strives towards teamwork in order to provide guidelines for the assessment of patient needs.

2.5.1.2 Quality of the Diagnosis

The nursing diagnosis is the summary statement of a patient's health status. The quality of the diagnosis is dependent on the nurse's efforts and ability to assess the patient's health status and needs accurately. The nurse should perform a thorough physical examination, as well as an interview, with the aim of summarising the problem in terms of the nursing diagnosis. The nurse should focus on the patient's health needs in order to address the needs. This is the thinking process, sometimes referred to as diagnostic reasoning or critical thinking.

2.5.1.3 Communication and Shared Decision

Care planning requires a deep understanding of the patient's health needs and shared decision-making among the nurse, patient and the other health care professionals. Shared decision-making yields some benefits for the patient, as the patient is given the opportunity to make decisions affecting his/her health. Effective communication is linked to patient recall of, adherence to, and satisfaction with information, i.e. patients who are well informed are more likely to adhere to treatment, are less anxious, are satisfied with care and have improved outcomes.

2.5.1.4 A Documented Care Plan

A care plan can be described as a written programme designed for an individual patient, highlighting the decision-making process. It is the guide that the nurse writes up for the patient's care after consulting the patient and others concerned with the patient's care. A care plan in the patient's records supports assessment, diagnosis, planning and delivery of patient care. The nurses who meet the patient throughout the care period are assisted in monitoring their contact with the patient. Patient information is always available to all nurses responsible for care and it is more likely that the patient will receive planned interventions with minimal variation.

2.5.1.5 Design of the Space

A supportive health care design (environment) should promote the patient's authority over decisions about his care and facilitate access to staff and relevant information, as the patient must be well-informed when he/she makes decisions regarding his/her care. During assessment, privacy must be promoted. The environment should include areas for private conversation as the patient and the nurse need to communicate about the patient's health status, so that the patient is comfortable and not afraid to share confidential information with the nurse. The staff also need space for discussions and reflection on care. When drawing up the care plan, it should be done in collaboration with the patient at his/her bedside. Comfortable furniture and an area for patient records and computers are additional spatial demands.

2.5.1.6 Professional Knowledge

Professional knowledge includes context-specific knowledge, skills and the ability to reflect. The nurse must possess critical thinking skills in order to make sound decisions about patient care and have a therapeutic relationship with the patient, which also includes ethics and values. Research shows that skilled professionals make more precise observations and assessments of the patient's health problems. They know what to assess related to their professional accountability and how to use various instruments in order to make precise judgements.

2.5.1.7 Care Culture

The culture of the nursing unit (what the professionals prioritise as important) is an important aspect in the quality of the care planning process. Such a culture determines the prevailing values, beliefs and assumptions about care. Clearly-defined and shared goals in the nursing unit are important for a successful work environment. Cultural factors such as learning organisation, a patient-centred philosophy and continuing education may support quality improvements in the organisation. A strong culture values individual staff and patients but, at the same time, promotes teamwork and relationships with others. Factors that may have an

impact on the quality of practice performance are a high nurse to patient ratio and decentralised decision-making, which are associated with job satisfaction, reduced failure to rescue and patient mortality rates.

2.5.1.8 Care Organisation

The organisation of work in the unit has an impact on the potential to assess the patient's needs. How the work or nursing activities are divided amongst the nurses in the nursing unit could have an impact on how well a nurse assesses the patient. Using the round model of nursing (which fragments the care), or the teamwork model (which divides the nurses and patients into smaller groups), nurses continue to work in a task-oriented way. Many care organisations have adopted a model for the total care of the patient, in which the one patient shares one nurse with a few other patients. This model supports patient-centred care.

2.5.1.9 Workload

Workload influences the professional's potential to assess accurately a patient's health status. Nurses often cite lack of time as the reason that care planning is not properly structured. This results in inadequate planning and lack of time prevents the nurse from going back to reflect on the care plan. This influences the quality of the care planning and the implementation thereof. Workload and lack of time influences the care planning process and may result in routine patient care instead of individualised care, as the nurses have limited time to make accurate assessment, or the workload may be reduced by an effective standardised care plan Elf, Poutilova and Ohrn (2007).

2.5.2 THE CONCEPTUAL MODEL OF CARE PLANNING REPRESENTED IN A CAUSAL FEEDBACK LOOP DIAGRAM (CFLD)

The interactions between key variables of the care planning model are represented in terms of a Causal Feedback Loop diagram. The aim of the model is to improve care quality and thus improvement of the patient, and to better understand how these variables influence care quality and the patient's health. The model is based

on the understanding that accurate assessment is a pre-requisite to nursing diagnosis and care planning.

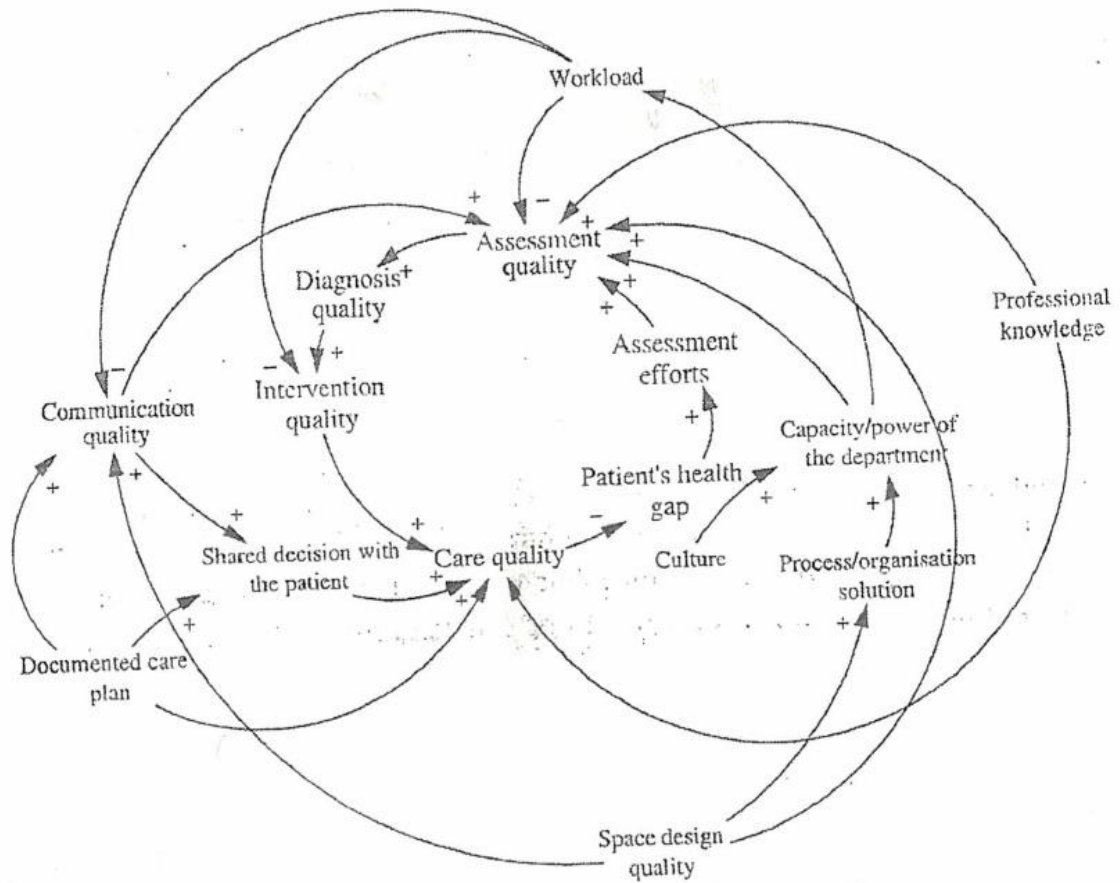


Figure 2.2: THE CONCEPTUAL MODEL OF CARE PLANNING REPRESENTED IN A CAUSAL FEEDBACK LOOP DIAGRAM (CFLD)

(Elf, Poutilova and Ohn 2007)

The patient's health status is the basis for nursing care activities. The patient enters the health care facility with perceived health status gaps, i.e. a 'gap' between their actual health status and their desired health status. As care quality and interventions improve, the patient's health gap will decline. As nurses make an effort to extract more information about the patient's health, the quality of the assessment improves, which leads to a more reliable diagnosis and, consequently, improved intervention quality, which, in turn, facilitates the health progress of the patient. Communication and the ability to share decisions with the patient has a positive effect on assessment. Increased communication quality with the patient improves

assessment quality and, similarly, enhances the quality of the diagnosis and interventions and subsequently improves the patient's health. Improved communication also facilitates the interaction and collaboration with the patient and leads to the possibility of shared-care decisions.

Greater professional knowledge improves the quality of assessment, which improves assessment quality and diagnosis. An improvement of professional knowledge increases the quality of care. Skilled professionals perform care activities more efficiently, safely and correctly. A documented care plan includes shared decision-making with the patient, thereby allowing the patient more say in his/her health care. The capacity in the health care organisation is strongly influenced by the care culture, the quality of the design of the space and how care is organised. A high-quality design of the space will have a positive effect on the quality of assessment and communication and, in turn, the ability to share decisions with the patient will strengthen or improve patient-centred care. The capacity of the health care facility influences workload. A lower capacity will increase workload and a heavy workload reduces the quality of care interventions and assessment, as time to assess the patient's health needs is reduced. A heavy workload also increases stress among the nurses and may result in care being omitted (Elf, Poutilova and Ohrn 2007).

2.6 GLOBAL TRENDS IN CARE PLANNING

The purpose of the nursing process is to diagnose and treat human responses to actual and potential problems, through effective communication between the nurse and the patient in a variety of settings (Kozier and Erb 2008:175). The nursing process is patient-centred and focuses on problem-solving, is universally applicable, uses critical thinking and encourages continuity of care (Kozier and Erb 2008:175). Notwithstanding these virtues, the nursing process, in terms of its design and implementation, can be time-consuming (Greenwood 1996).

Different researchers have provided different points of view when it comes to nursing care plans. Bott, Gajewski, Piamjariyakul and Taunton (2007:87) conducted a study to determine care planning efficiency for nursing facilities in the United States of America (USA). They stated that cost effective care planning and delivery that result in high-quality care are difficult to establish and that there is no evidence that planned care is actually rendered. The study was conducted in USA nursing homes and it established that 21 percent of nursing facilities have been cited for general quality of care deficiencies, 13.4 percent for poor resident assessment and 16 percent for failure to provide a comprehensive care plan. These researchers concluded by saying that having more people and more time devoted to the care planning process did not assure quality or efficiency (Bott *et. al.* 2007).

O'Connell, Meyers, Twigg and Entriken (2000:276) opine that nursing care plans are seen as a management tool for accreditation, as well as a good tool to teach student nurses about the nursing process, but are unsafe and ineffective in practice. O'Connell states that nursing care plans are difficult to use and update, due to the dynamic status of the patient and the problems associated with capturing this in a written form. This view is supported by Jansson, Pilhammar-Andersson and Forsberg (2009), Lee and Chang (2004) and Bott *et al.* (2007:86), who collectively argue that there is no evidence that the use of the nursing care plan improves patient outcomes and the quality of care rendered and the resources spent on development and implementation of nursing plans could be put to better use.

Greenwood (1996:33) points out that nurses are reluctant to use care plans despite there being a need to ensure quality, and that there are good reasons why the care plan is still in use, albeit amidst great resistance. She indicates that knowledge of the nursing process and its application are a linked deficiency. Due to a lack of such an understanding, care becomes routine rather than patient-centred. She acknowledges that it is time-consuming to write up care plans. This position is evident in a study by Lee and Chang (2004:38) who state that nurses view nursing care plans as unnecessary and this serves to further undermine the care plan. They state further that care plans are not always a true reflection of the actual care rendered. They also note that nursing care plans represented an extra workload for the nurse and many nurses perceive care plans as another obstacle within their

busy workload schedule and thus devalue them (Lee and Chang 2004:38). This view is shared by Elf, Poutilova and Ohrn (2007:534), who found that there was a tendency for nurses, when they experienced a heavy workload, to render routine care rather than patient centred, individualised care, as there is no time to adequately assess a patient's individual health needs, and very often elements of personalised care are omitted.

Dellefield (2006:89) believes that care plans are nevertheless believed to be effective clinical processes. Nurses do not use them because of a lack of support for care plan activity, a lack of the requisite skills to produce care plans and the nurse's lack of belief in the care planning process itself. Some nurses saw the value of the care plans but did not use them effectively. In the Dellefield study in 2006, it emerged that some nurses believed that they knew how to take care of patients without having to look at care plans, but agreed that it is difficult to imagine how complex it could be for patient needs to be met by caregivers without the use of care plans. Amongst the recommendations that surfaced was that employers should invest in registered nurses with the intellectual skills required to perform care planning responsibilities competently and that registered nurses ought to be trained in critical thinking and care planning. Bjorvell, Thorell and Wredling (2000:6) have stated that when nursing care plans are documented, the nurse is more focused on the care to be given to the patient. The nurse does not lose sight of the patient's health status and, as a result, the quality of care is improved. They added that without an individualised care plan nursing care tends to become fragmentary and based predominantly on institutional routine and schedules. Their study also revealed that, when care planning occurs, the patient participates in decision-making regarding his/her care and that patients are happy to be part of this process as it enhances holistic and individualised care (Bjorvell, Ekstrand and Wredling 2000).

Care plans enhance care quality as it is co-ordinated, safe and more effective (Elf, Poutilova and Ohrn 2007:534). Muller-Staub *et al.* (2006) feel that care plans improve the quality of care that is rendered to patients. When care is planned, essential data is within the reach of all the nurses who are responsible for the patients' care and these results in the patient receiving specified and individualised

care. Elf, Poutilova and Ohrn (2007:533) believe that knowledge, as well as the care culture of an organisation, influences the quality of the care planning. Planned care ensures safety, competency and continuity of care. Nurses who possess professional knowledge on care planning are aware, precise and make sound judgements related to patients' health status as a detailed assessment of the patient is a pre-requisite for good quality nursing care planning. Muller-Staub, Lunney, Odenbreit, Needham, Lavin and van Achterberg (2009:70), in a study to develop an instrument to measure the quality of nursing documents, found that the instrument could measure a broad range in quality regarding nursing documentation and they were able to relate nursing intervention to reach desirable outcomes. In an earlier study by the same group of researchers (Muller-Staub *et al.* 2007:42) the results illustrated that after the establishment of nursing diagnosis effective nursing interventions were implemented and the documented nursing outcomes described improved nursing outcomes.

In a study by Lee and Chang (2004:33-40), in which they explored the experiences of nurses in Taiwan with regard to standardised care plans, data was collected in one-to-one structured interviews which were tape-recorded. The interviews lasted 30 to 45 minutes each and were conducted in a private room in the unit during lunch break or after work. Each interview was translated *verbatim* and presented to the participant to ensure accuracy. Similar and different themes were grouped. From the content analysis, the major themes were highlighted.

A study by Jansson, Pilhammar-Andersson and Forsberg (2009) evaluated documented nursing care plans through the use of nursing sensitive outcome indicators. The retrospective cross-section design took the form of a study in which patients were surveyed at the time of discharge from the stroke unit and two to three weeks after going home. The study compared two hospital units treating patients with strokes in a rural part in Sweden. The control unit A did not document care plans. The intervention unit B documented all steps of the nursing process. Postal questionnaires were sent to the patients two to three weeks after discharge. The data yielded descriptive statistics which were presented in tabular form. This study found that documented care plans may have an effect on patient satisfaction in the areas of individualised care, patient participation and how long a patient stays in

hospital. O'Connell *et al.* (2000:280) in a study on documenting and communicating patient care, used a questionnaire to rate care plans on 10 measures, using a four-point Likert Scale. A high score indicated an approval of the care plan. Respondents were asked to identify advantages and disadvantages of care plans. The statistical data was presented in a tabular form. The findings in this study indicated many difficulties with the use of the care plan, which was said to be outdated. A study by Karkkainen, Bondas and Eriksson (2005:123), focused on documentation of nursing care. The aim of this study was to understand the content that was documented on patients' notes and to determine whether or not the ethical principles relating to individualised care were included. The themes that emerged from the study were that: the organisation insisted on the documentation showing a measurable result of care that could have financial implications; nurses did not consider documentation as being important; and nurses only documented the physical function of the patient and seldom referred to the patient's views. The researchers concluded by saying that, although nurses advocate the need for individualised patient care, it is not visible in the nursing documentation.

Griffiths and Hutchings (1999:57-63) conducted a study called the wider implications of an audit of care plan documentation. The aim of the study was to find out if patient goals had been achieved. A selection of patient charts was audited. The results showed that there was room for improvement in the documentation of evaluation within nursing care plans. Another view was that poor documentation does not mean that the care is poor. The recommendation that was made was that nursing staff should receive training in the use of the nursing process. In her study, Clemow (2006:1463), 'Care plans as the main focus of nursing handover: information exchange model', found that there was an increase in the patient-nurse contact time, leading to better care, improved care plans and patient documentation, overall.

2.7 CARE PLANNING IN THE AFRICAN CONTEXT

All nursing records are legal documents and must comply with the country's requirements. Planning of care and accurate and complete documentation are very important components in determining the patient's progress. If a nurse does not document treatment and nursing intervention, then it is considered as not implemented. The application of the scientific Nursing Process in providing nursing care and accurate and comprehensively completed records can contribute to improving nursing outcomes and thus address patients' complaints about the quality of care that they receive.

Planning is a crucial component in nursing care. A care plan, also known as the plan of care, serves as a navigator that guides all nursing staff who are involved in the patient's care. Nursing care plans are expected to be holistic in terms of a patient's care and, using the nursing process through nursing documentation provides a possibility of knowing the patient well.

Many studies have demonstrated patient satisfaction due to improved care plans such as a study conducted by Hall (2009:4), which focused on the development and use of care plans for type-2 diabetes patients. It is continually stressed that patients should be included in their treatment planning process of their condition. The diabetic patients involved in this study demonstrated a sense of comfort and compliance and were free to call the nurses whenever a need arose, because they were involved in planning and agreed to the treatment plan for their own condition.

According to Mamseri (2012:1), patient care improvement depends on the quality of nursing care provided. The nursing process enhances the nursing care which directs the nurse towards the care to be given to the patient. Globally the nursing process has been used as a framework to provide holistic patient care. The nursing process serves both as a form of documentation of activities carried out for the patient, as well as evidence that care was rendered to the patient. The nursing care plans are part of the nursing process and must be done individually for each patient, or the care becomes routine, necessary treatment not being carried out and patients

being unhappy and disadvantaged, as the treatment required was not given. She adds that the Nursing Council of Tanzania has established strategies to ensure that the nursing process is practised by all health care centres. The Tanzanian Nursing Practice Model was formulated as guidelines by the Ministry of Health, which were based on the nursing process, to ensure that nursing care is provided systematically to all patients, with the purpose of ensuring uniformity in the provision of holistic nursing care in all health care facilities. Despite all these efforts to improve the quality of nursing care, reports have indicated that there have been incidents which have resulted in nurses losing their jobs for not implementing the nursing process and, as a result, not documenting the care actions carried out. If the situation is allowed to continue there could be difficulty in evaluating patients' responses to care and their progress and loss of continuity of care, resulting in loss of patient satisfaction and lack of evidence to support nurses in case of complaints or litigation.

2.8 CARE PLANNING IN THE SOUTH AFRICAN CONTEXT

There are acts and procedures that serve as a guideline and are mandatory for South African registered nurses to comply with. Among these acts is the nursing process, a framework by which the nurse is expected to nurse her patient. The nurse is reminded and advised that she, in her daily practice, remembers her Scope of Practice, to be able to carry out her duties legally and efficiently (South African Nursing Council Regulation 2598 as of 1982, Chapter 2). Searle (2004:200) states that, when a patient comes into the care of the registered nurse (not any other personnel), she must plan for nursing care based on correct identification, meticulous history-taking and careful physical examination, taking into account present treatment and medical diagnosis. The responsibility for patient care, from the moment the patient is admitted to a health care facility, is that of the professional nurse and her team. It is the responsibility of the registered nurse to make sure that effective, continuous care is maintained through accurate recording (Vlok 2007:200).

In terms of the Nursing Act (Act 33 of 2005) the registered nurse in charge of the ward is fully accountable for all acts and omissions relative to patients under her care. A clearly defined plan for the patient's intervention, evaluation and documentation is necessary. The registered nurse is then responsible for recording all the information such as observations, interventions, untoward reactions to treatment and patients' responses or decisions. The registered nurse must exercise caution when practising her independent judgement, as she must adopt institutional policy, procedures, routines and standing orders or guidelines and not disregard them. She must make environmental changes and improvise in order to meet a patient's needs, while maintaining patient safety.

In the regulations of the South African Nursing Council it is clearly stated that recording the course of the patient's health problem, the care received and the result of this care is the responsibility of the registered nurse (Regulation number 2598, of 30 November 1984). The nurse must have sound knowledge, a good attitude and experience, and use standards of nursing practice as set out by the South African Nursing Council. Nurses need complex thinking processes as well as technical and affective skills, in order to be expert clinical practitioners. Problem-solving is essential for nursing, as is teaching nursing students how to use the nursing problem-solving process (called the nursing process), so that the nurses can provide nursing care of a high quality to patients. In a study conducted by Brysiewicz and Lee (2009:22) on nursing students' evaluation of the introduction of nursing diagnosis-focused tutorials in a university degree programme, students in Year III Problem-Based Learning (PBL) tutorials (University of KwaZulu-Natal) were used in the study to measure their problem-solving skills and care planning abilities in the clinical area. (Third-year students have one more year at university, and emerge from university expected to function as registered nurses in the clinical area). The study revealed that the students were enthusiastic about the programme and felt competent in their assessment of the patients. The researchers stated that using a method in problem-solving helped the mind to be more focused and helped to shape ideas, raised the students' self-confidence and assisted in the application of learning. They concluded that problem-solving training can lead to greater positive effects, higher job satisfaction and higher life satisfaction.

The importance of record-keeping cannot be over-emphasized and caution must be exercised, as legal claims can be instituted against a nurse months or even years after the fact. A nurse must at all times document accurately and completely, because inaccurate and incomplete records are evidence of a nurse who is negligent. According to The South African Nursing Act 33 of 2005, a nurse may be disciplined if found negligent for not recording her/his nursing care. According to Booyens (2008:135), nursing record-keeping ought to be done according to care plans and records are kept to ensure safe and high-quality care to patients. Quality health care therefore depends on the accurate and chronological evidence of care provided. Ngidlana (as cited by Booyens 2008:132) states that a large number of the South African Nursing Council's disciplinary measures arise from inaccurate record-keeping. She states that recording and record-keeping go hand in hand, since all the information obtained during the assessment phase of the nursing process constitutes the basis for subsequent care. If records are inaccurate or not kept safely, the continuity of care is interrupted and may result in inefficient patient care. Inadequate record-keeping may also lead to medico-legal risks. Good record-keeping is the only tool that nurses possess to provide proof of the care that they have provided to the patient. Vlok (2007:200) states that record-keeping is the tool by which nurses take responsibility for their scientific actions within a legal framework.

Armstrong *et al.* (2012) sought to measure the quality of care provided within a selection of South African nursing units, in terms of the focal areas of hand hygiene, record-keeping and observations. One of the recommendations that emerged from this study was the urgent need for increased emphasis on developing nursing care plans within the South African context. In some South African hospitals the nurse-patient ratios are as high as 1:18 and in extreme conditions, can reach 1:44, which means that the nurse only has three minutes out of every hour to care for each patient (Aiken, Clarke, Sloane, Sochalski, and Silber 2009). The South African nurse may have a heavy workload, but the nursing process is a legal requirement by the South African Nursing Council. It is based on nursing theories and practices taught in nursing schools as part of the curriculum, as it appears in the Scope of Practice of the South African Nursing Council (SANC) of 1991.

2.8.1 REGULATION OF NURSING PRACTICE IN SOUTH AFRICA

The Constitution of the Republic of South Africa of 1996 is responsible for guiding the health professionals to uphold morality and honesty by the provisions made for human rights and freedom of conscience, religion, thought, belief and opinion [section 15 (1)], which stipulates that a nurse may refuse to participate in certain healthcare activities, such as abortion (Pera and van Tonder 2012:80).

2.8.1.1 The Nursing Act

In 1891, South Africa was the first country in the world to obtain registration for its nurses. The establishment of the South African Nursing Council and the declaration of the Nursing Act (Act 69 of 1944) ensured control and regulation of the profession by its members. The Act has since been amended several times. The Act represents the law governing the nurse's practice. Regulation of nursing practice ensures public safety. The regulation of practice is found in The Scope of Practice and Act and Omissions provided for in the Nursing Act (Act 33 of 2005), (Mellish, Oosthuizen and Paton 2010:97).

Nursing Regulations made in terms of the Nursing Act 50 of 1978 makes provision for Regulations that prescribe the conditions for the achievement of the purpose of the Act. Within this context the regulation of the practices of nursing and midwifery *“is about public welfare through the improvement of standards of education, standards of practice and care of patients by ensuring that those who nurse or practice midwifery, have the knowledge, skills and ethical preparation through appropriate education to provide the quality care the nation needs”* (Searle and Pera 1995:5). Such regulation serves to ensure the identification of those who meet the criteria for admission as a nurse/midwife, provides a means of disciplining those who wilfully or negligently harm the health of those entrusted to their care and ultimately empowers the profession to govern its own affairs (Searle and Pera 1995:5).

2.8.1.2 Scope of Practice

Briefly stated, the Scope of Practice regulations define the limits of the registered nurse's practice. These regulations are not intended to be restrictive, but rather to empower the nurse. The Scope of Practice directs the registered nurse to assess the needs of her patient, develop a care plan for the patient, implement the planned nursing interventions and evaluate the results of care within a specified range of autonomy (Geyer, Mogothlane and Young 2009:55). The registered nurse is expected to work within her Scope of Practice to assist the patient achieve his/her desired outcomes. Should the nurse fail to work within the scope of practice, the safety of the patient is compromised and the quality of care comes into question.

The regulations relating to the Scope of Practice of persons who are registered or enrolled under the Nursing Act of 1978, are the guides that nurses use to perform their nursing duties on a daily basis. They entail the following acts or procedures, which may be performed by scientific, physical, chemical, psychological, social and technical means applicable to health care practice. The present study is based on the following guidelines:

- a) *The diagnosis of a health need and provision and execution of a nursing programme of care to meet the needs of the patient.*
- b) *The carrying out of the prescription of treatment on orders of a registered person.*
- c) *The care and administering of medicines, including the monitoring of the patient for untoward outcomes.*
- d) *The preventing of disease and promotion of health and family planning through health education.*
- e) *Prevention of disease and promotion of health and patient reassurance.*
- f) *Promotion of exercise, rest and sleep.*
- g) *Prevention of deformities and facilitation of body mechanics.*
- h) *Supervision, supply and maintenance of oxygen to the patient.*
- i) *Facilitation of wound healing, healing of fractures and protection of the skin.*
- j) *Maintaining of fluid balance for the patient.*
- k) *Facilitation and regulating bodily function in a patient.*
- l) *Maintaining nutrition in a patient.*

- m) Maintaining of elimination by a patient.*
- n) Maintaining communication with the patient.*
- o) Maintaining optimum health for the patient, family and the community.*
- p) Establishing and maintaining an environment in which physical and mental health is promoted.*
- q) Preparation, assistance and care with diagnostic and therapeutic acts for the patient.*
- r) Provision of health care programmes provided by other health personnel.*
- s) Patient advocacy provision to enable the patient to obtain care.*
- t) Care of the dying and the deceased patient.*

2.8.1.3 Acts and Omission

In Chapter 2 of the South African Nursing Council Regulation 387 of 1985, there are Acts and Omissions set out in respect of which the Nursing Council can take disciplinary action against a registered nurse. These Acts and Omissions refer to the deliberate or negligent omission to carry out such acts in respect of diagnosing, treatment, care, collaborating, referral, co-ordination and patient advocacy as the Scope of Practice permits and, indeed, warrants (Vlok 2007:91).

2.8.1.4 Nursing Standards of Practice

Standards of practice (standards of care) are parameters used to regulate what a nurse should or should not do. Standards may be viewed as yardsticks of accomplishment which are based on anticipated levels of distinction. Standards of care determine the minimum levels of distinction in nursing care and serve to indicate a proficient level of nursing care (McMahon 2014). Also included are the competencies for clinical practice as they appear in the draft Charter of Nursing Practice.

2.8.1.5 Ethical Codes

One of the distinguishing features of a profession is the adoption of an ethical code, which serves to enforce a prescribed level of ethical behaviour by the members of

the specific profession. Numerous professional groups have developed codes of ethics that offer strategies for their members to practise (Mellish, Oosthuizen and Paton 2010:138).

2.8.1.6 Policies and Procedures

Policies and procedures are set in place to facilitate the achievement of institutional goals and objectives and to explain the steps to be followed towards accomplishing those goals. They should be all-inclusive yet adaptable. Procedures are a chronological guide for actions while helping to achieve regularity in the institution (Booyens 1998:200).

2.8.1.7 Accountability

Accountability is a crucial aspect of professional nursing practice because nurses have to be constantly assessing different situations and must accept accountability for the judgements they make. Nurses are accountable for all that happens to the patient while the patient is in the health care facility (Pera and van Tonder 2012:87).

2.9 CONCLUSION

The reviewed literature gives us different perspectives regarding the use of the care plan. One point of view is that the care plan has the capacity to improve the quality of care rendered to the patient because the nursing care plan guides the nurse in determining, effecting, recording and iteratively evaluating the care that she provides to the patient. A number of other studies, however, reveal that while the above may be true, the care planning process is time-consuming and nurses have a heavy workload and the time could be put to better use at the patient's bedside. Some researchers felt that the care plan was an excellent teaching and audit tool, but was unsafe for routine practical use on patients. The care plan is part of the nursing process. The nursing process is part of a legal framework within which South African nurses must work, as set out by the South African Nursing Council.

Within this context, and in light of the sparcity of prior research within the specific South African context, the present study sought to derive an understanding of the current South African use of nursing care plans through the analysis and comparison of qualitative and quantitative data derived from nursing charts and registered nurses' interviews. The specific details of the methodology adopted to carry out this study are described in the following chapter.

CHAPTER THREE: METHODOLOGY

3.1 INTRODUCTION

In the previous chapter the researcher focused on the literature review, examining what other researchers found in this area of study. In chapter three the researcher describes the research methodology adopted in this study. Research methodology refers to the techniques used to structure a study and to gather and analyse information in a systematic fashion. In the present study both qualitative and quantitative methods were used to gather information. The qualitative research is rooted in interpretive paradigm and the quantitative research is rooted in positivist paradigm. The descriptive single case study was concerned with the use of nursing care plans and sought to determine whether or not registered nurses used these care plans correctly. The conceptual framework of Care Planning (Elf, Poutilova and Ohrn 2007) guided this study. This framework describes the relationships among a number of variables, illustrating how these variables within the concept of care planning relate to each other.

As was explained in Chapter Two the Care Planning conceptual framework starts with the *patient*, who enters a health care facility because he/she has a *health problem*. The assessment process begins with the nurse collecting as much data from the patient as possible. The *assessment quality* depends on a number of factors, such as the *capacity or power of the department* (how well equipped and accepting the department is when it comes to care planning, as well as the value that it places on care planning). The *workload* that the registered nurse has to deal with will impact on the quality of the assessment (e.g. if the registered nurse has a heavy workload, the *assessment quality* may be poor, as he/she does not have the time to ensure adequate assessment). The *professional knowledge* that the nurse possesses will determine how well the nurse collects and interprets this data. Such professional knowledge would include context-relevant, nursing process knowledge and ethics. The *quality of communication* is just as important when it comes to the process of collecting data. The registered nurse must communicate effectively with the patient when he/she is collecting information about their health status, because,

if there is a misunderstanding, the information may be distorted and create inaccuracy which would negatively impact on their subsequent management.

Communication is affected by *space design quality* (i.e. the opportunity given to the patient to participate in his/her own care and the patient's ability to obtain information relevant to his health). The *quality of the diagnosis* will depend on the completeness and accuracy of the assessment. An appropriate *care plan* is dependent on the two preceding steps (*viz.* assessment and diagnosis).

The researcher used qualitative and quantitative research designs in this study to gain a deeper, more holistic, understanding of the use of nursing care plans. The researcher felt that by using qualitative and quantitative designs in this study, a rich source of information will be discovered. Patients' charts were used to collect data in the quantitative phase of the study and registered nurses were interviewed during the qualitative phase of the study. This is not a mixed methods study.

3.2 CASE STUDY

Polit and Beck (2012:512) explain that a case study is an intensive inquiry of a phenomenon of interest in its real-life context and the collection of data can be done using multiple sources. Yin (2012:17) adds that the boundaries between phenomenon and context may not be visibly obvious.

3.3 RESEARCH DESIGN

According to Maree (2012:70), research design is the blueprint of how a researcher will go about collecting data, analysing this data and how the entire research will be conducted. This research was designed as a descriptive single case study, in which research data were derived from respective quantitative and qualitative phases and analysed within the respective research paradigms. The conclusions of the

respective (quantitative and qualitative) analyses were subsequently cross-related and integrated towards addressing the research objectives.

3.4 THE RESEARCH SETTING

The case study was based at a level 3 hospital. The hospital is located in Pietermaritzburg, UMgungundlovu Health District, and is situated about seven kilometres from the Pietermaritzburg city centre. This hospital offers 100% tertiary services. The hospital provides regional services to UMgungundlovu districts which, have an approximate population of one million people. Tertiary services are on offer to the western half of KwaZulu-Natal – this includes five health districts, with a total population of 3,5 million. The hospital has 530 commissioned beds and at the time of the study was utilising 507 beds. This hospital has a staff complement of 2160 (Greys Hospital website, 2014). The present case study focused on the services in the form of nursing care that is provided by the nurses to the hospital's patients and their use of nursing care plans.

3.5 DESCRIPTIVE RESEARCH

Polit and Beck (2012:17) state that descriptive research is carried out to learn more about a phenomenon, when little is known about it. The aim of descriptive studies is to provide an in-depth description of a small number of cases (Mouton 2012:149). In the present work the researcher describes the use of care plans in the study hospital.

3.6 THE QUANTITATIVE RESEARCH

Quantitative research has been defined as 'a formal, objective, systematic process in which numerical data and deductive reasoning are utilized to generate predictions that are tested in the real world.' (Polit and Beck 2012:13). In this study, quantitative

data were derived from patient charts at the level 3 hospital, located in the UMgungundlovu District (Pietermaritzburg) of KwaZulu-Natal.

3.6.1 SAMPLING

Prior to the study, the researcher reviewed the admission and discharge books at medical records to determine the number of patients that are admitted per month. The charts were examined for completeness. Generally, the patients who were admitted for a short period of time appeared not to have a complete nursing process record to work from. Because of the short stay, perhaps there was not enough time to observe and record the patient's progress adequately and these charts lacked that vital information. This was discussed with the supervisor and it was decided that only those patient charts who were admitted for five or more days would be used in order to get a more realistic picture.

The number of staff who work over weekends and public holidays is greatly reduced when compared with the normal work days. School holidays also have an effect on the number of staff on duty, as parents often take this time off to be with their children. The researcher had to find a time of year when there were minimal disruptions in the ward, and the ideal number of staff were on duty, to get a true reflection of the use of the care plan. The three months of the year that had minimal disruptions were August, September and October.

Systematic sampling was used. In such sampling, a sample is drawn by systematically moving through the sample frame and selecting every third element, or chart in this case. The researcher met with the manager of medical records (registry) and was given access to the discharge book (all patients who are discharged from hospital are recorded in this book in chronological order). From this discharge book the researcher counted every third entry and recorded the name and number. This was done until the required number of charts were acquired. The charts to be used were approximated at 240, based on an average >5 day admission rate of 80 patients per month ($=80 \times 3 \text{ months} = 240 \text{ charts}$). The researcher recorded 250 names and numbers. A copy of the names and numbers

was made and the copy was handed to the manager of the registry and she then supplied two staff members with 50 of the identified patient charts at a time.

The two staff members, who were in no way connected to the research, were recruited to remove patient-identifying data before photocopying the chart, and to hand the completed set of copies to the researcher for data capturing. As each staff member completed photocopying the charts they were returned to the registry and the next allocation of charts was handed to them. This process was completed over a period of two weeks. A total of 220 charts was photocopied.

3.6.2 INCLUSION CRITERIA

- 1) Charts of patients who had been admitted for five days or more were included in the study.
- 2) Charts from the general wards, that is, all the surgical, medical orthopaedic and gynaecology wards, were included.
- 3) Charts from 1 August 2011 to 31 October 2011 were included.

3.6.3 EXCLUSION CRITERIA

- 1) Charts that did not have the admission and discharge dates were excluded.
- 2) Charts from specialised units, such as the Intensive Care Unit (ICU), Paediatric Intensive Care Unit (PICU), Neonatal Intensive Unit (NICU), all Paediatric Units, Maternity, Labour and Renal Units were excluded.
- 3) Charts that were incomplete, such as charts that did not have nursing notes or care plans, were excluded.

3.6.4 THE CHECKLIST

A checklist (Appendix A) was used in this study. A checklist is made up of a number of questions with a similar response pattern. A checklist has a two-dimensional design, with questions along the one side and responses at the other end (Polit and Beck 2012: 299-300). The checklist used in this study was adapted from the audit checklist that the level 3 hospital in which the study was done uses to conduct

monthly audits to determine the completeness of charts. The checklist used by the study hospital was developed by the quality improvement audit committee of this hospital, in line with the standard guidelines of COSASA in 2002. This checklist was inspected during accreditation of the study hospital in 2005 and was found to be valid and reliable, as it complied with the baseline survey for quality. The checklist is reviewed annually, with minimal changes.

The checklist was formulated with a set of questions relating to each phase of the nursing process on the left hand side of the page and space on the right hand side of the page for the researcher to record whether or not the items on the left hand side were in evidence within the chart, reflected in 'yes' and 'no' checkboxes. Included under the heading of each of the five phases of the nursing process was a set of more specific questions, allowing for a more detailed evaluation of the extent to which each element of the nursing process was in evidence, e.g. under the heading of 'assessment', the following questions were asked: is there a nursing and surgical history; was the interview guide completed and does it include the major complaint of the patient and is there evidence that a physical examination was carried out? Under 'nursing diagnosis', the questions asked were: were both actual and potential problems identified? In 'planning': is there a care plan and is it complete with the diagnosis/problem statement, are there expected outcomes/goals and are there appropriate nursing interventions and did the registered nurse sign the plan? Under 'implementation': is there any evidence that the nursing actions were implemented and what was the patient's response? In 'evaluation' the questions asked were: was the care evaluated? Was it linked to the nursing intervention? Was the care plan modified? At discharge was the care plan terminated?

The researcher checked the care plan in conjunction with the problem statement or nursing diagnosis or the problem that the patient needed assistance with. The care plan is checked to determine if the nursing interventions are acceptable for that problem. The researcher then read the nursing notes to check if the nursing interventions were carried out for that particular problem. If the nurse's notes did not mention that the intervention was carried out, the researcher took it that it was not done. According to the SANC, the nurse uses the nursing process as a framework

within which the nurse functions. The evidence of the work or the nursing interventions that the nurse has carried out is the record that the nurse keeps. If the nurse does not record all she does for the patient, it is not in keeping with the guidelines of the SANC.

3.6.5 DATA COLLECTION

The described checklist was used in reference to the photocopied charts. It sought to record whether or not the items relating to each phase of the nursing process was in evidence within the chart. This was indicated by ticks within 'yes' or 'no' checkboxes. The researcher read each chart and as she came across evidence within the chart that the items on the left hand side were carried out or otherwise in evidence, she ticked the 'yes' box and if no evidence was found in the chart, the 'no' box was ticked. This process was carried out on all 220 charts. Once all the charts were completed, a spreadsheet was created in *MSEXCEL*[®] and all this information was captured. The 'yes' and 'no' responses were counted for each question and the totals were captured. A total of each of the 'yes' and 'no' responses per question was recorded. The supervisor then checked the checklist with the researcher.

3.6.6 DATA ANALYSIS

These data were subsequently analysed using *SPSS*[®], *version 19*, and descriptive statistics were derived from the data and represented as clustered bar, combination and pie charts.

3.6.7 PRESENTATION OF DATA

The data was presented in the form of graphs (clustered bar and combination charts). Graphs for each phase of the nursing process were illustrated to give a summary of the data collected.

3.6.8 VALIDITY AND RELIABILITY

The checklist used in this study was adapted from the audit checklist that the level 3 hospital in which the study was done uses to conduct monthly audits to determine the completeness of charts. The checklist used by the study hospital was developed by the quality improvement audit committee of this hospital, in line with the standard guidelines of COSASA in 2002. This checklist was inspected during accreditation of the study hospital in 2005 and was found to be valid and reliable, as it complied with the baselinesurvey for quality.

The checklist represents all the components of the variables to be measured.

3.7 THE QUALITATIVE PHASE

Qualitative research explores the meaning of, or describes and promotes the understanding of, human experiences (Burns and Grove 2007:61). In the present study, semi-structured interviews were conducted with 17 registered nurses to explore their experiences of using nursing care plans. Open-ended questions dealing with the following broad areas of enquiry were asked by the researcher herself:

- Interpretation of the nursing process by registered nurses,
- Data collection during the assessment phase of the nursing process,
- Perception of the role of nursing diagnosis in the care planning process,
- Nurses' ability to develop care plans,
- Reflection of responsibilities between ranks with developing care plans,
- Personal roles during development of care plans.

In this phase of the study, objectives 1, 3 and 4 will be covered.

3.7.1 PARTICIPANTS

Polit and Beck (2012:739) state that a population is the entire number of individuals or objects that have certain common elements. In the present study the identified population was the registered nurses employed by the hospital in which the study was conducted. The level 3 hospital that served as the site for this study had a registered nurse population of 470. The researcher met with the Nursing Services Manager and more information regarding the interviews was shared. The researcher was granted permission by the Nursing Services Manager to conduct the interviews during on-duty time, as this study concerned nursing work. Registered nurses are nurses who have either completed a four-year diploma course or a two-year bridging course (after having trained as a staff nurse, a course that takes two years to complete). Registered nurses are required to renew their licence annually with the South African Nursing Council. The registered nurse is the person who is responsible for all the patients in the ward. They are required to work in wards and departments and work a variety of shifts within the hospital.

3.7.2 SAMPLING

Convenience sampling was employed. According to Polit and Beck (2012:276), convenience sampling refers to using those participants that are most conveniently found. The researcher advertised at central points in the hospital, such as in the lifts, in the passages and at the dining hall, as well as via the regional matrons, inviting registered nurses to participate in the study. Only nurses working in the general wards and not the specialised units were invited to the interviews. As registered nurses came forward to participate, the researcher drew up an interview schedule (Appendix F) with the registered nurses' names, date, time and place where the interviews would be held. This information was relayed to all professional nurses who volunteered to participate. Their names were kept in a safe place until the interviews were conducted.

3.7.3 INCLUSION CRITERIA

All registered nurses working in the general wards were invited to take part in the study.

3.7.4 EXCLUSION CRITERIA

Registered nurses working in specialised units such as ICU, CCU, Maternity, PICU, Renal unit, Paediatrics, Outpatient and Casualty were excluded from the study.

3.7.5 THE INTERVIEW

The researcher conducted face-to-face, semi-structured interviews with the participants between 6 October 2013 and 10 October 2013. Data analysis took place from October to early January 2014. The interviews took place in a doctor's room outside the respective ward. The room was private (each ward has a doctor's room attached to it and all lecturers have access to this room for student counselling). Permission was asked from the sister-in-charge to use the room. A 'Do Not Disturb' sign was placed on the outside of the door and the telephone was taken off the hook, to ensure that there were no disturbances. All interviews took place as per schedule. The interviews lasted between 15 and 30 minutes. During the interview open-ended questions dealing with the broad areas of enquiry were posed by the researcher in the order that the nursing process occurs. The researcher prepared a specific set of questions (Appendix E) that had to be covered by each participant, to ensure that all participants talked freely about all the topics in the guide (Polit and Beck 2012:537). The first question involved the registered nurse's understanding of the nursing process. The researcher encouraged the participants to talk about the data collection process. The participants were required to indicate their understanding of the importance of the nursing diagnosis. The participants were asked about their personal ability to create care plans, as well as their view of whose responsibility they believed such creation of care plans to be. The registered nurses were asked to discuss their role in the care planning process. The last question was of a more general nature and afforded the participant an opportunity to share any additional information regarding her/his experience with

care plans. The interview was audio-recorded on a tablet (a *Lenovo ideatab A2107A*).

3.7.6 DATA COLLECTION

All participating registered nurses were informed of the time and place where the interviews would be conducted. The sister-in-charge of each ward that the registered nurses came from, was first consulted on how busy the ward was and that releasing the registered nurse would not impact negatively on patient care. Each participant was welcomed to the interview and the researcher reiterated that participation in the interview was voluntary and if at any point she or he felt uncomfortable, the interview would be stopped, without prejudice. The participants were informed that the interview was to be audio-recorded on a mobile device, a tablet (*Lenovo ideatab A2107A*), for the researcher's convenience (to assist the researcher with the transcriptions) and that these recordings would only be heard by the researcher and her supervisor. Once the details of the research study and the interviews were explained and an opportunity was afforded to each participant to ask any additional questions, participants who were still willing to participate signed an informed consent form.

The participants were encouraged to relax and to answer as completely as they could. The semi-structured interviews, which consisted of a finite set of open-ended questions were recorded on the tablet and later transcribed into written text by the researcher herself. On the last day of interviews one registered nurse did not arrive at the scheduled time and the researcher was unable to reach him. The researcher subsequently also encountered difficulty in retrieving the first two interviews that had been recorded and the interview data was unable to be included. These interviews were then replaced with two additional interviews. A total of 17 interviews was conducted and only the 15 audio-recorded interviews that were able to be retrieved from the mobile device were transcribed into text by the researcher. The interviews were carried out until data saturation was reached; the participants were saying more or less the same things.

Transcription of written text was achieved by the researcher listening to each interview in three to five second sound-bites and verifying each line of manually transcribed text in an iterative line-by-line manner, listening to the audio-recording using headphones for increased clarity and focus. These manually transcribed texts were given to each participant for verification.

The verified manual transcriptions were typed into respective *MSWord*[®] files, with each file saved according to the coding scheme described in 3.7.7 below. When all the audio recordings had been typed, the researcher verified the accuracy of the electronic data captured by listening to the audio recordings against the typed text. These electronic files were subsequently imported into *NVivo*[®] *version 10* for data analysis. Each of the participants (and their electronic transcription files) was coded, so that the participants were not able to be identified by anyone other than the researcher at any subsequent point.

3.7.7 CODING OF PARTICIPANTS

During transcription of the interviews from audio to written text, the participants were coded in order to ensure anonymity and confidentiality during the study. The coding reflected each participant's designation, the sequence of the interviews, the ward or department that the participant was working in and the number of years that the participant was working as a registered nurse, post-graduation. The coding was effected according to the following schema:

| | | |
|---------------------------------|---|---|
| Registered Nurse | = | <i>RN</i> |
| Interview sequence | = | <i>01, 02, 03, etc.</i> |
| Ward or Department | = | <i>S(urgical), M(edical), C(linical)</i> |
| Number of years post-graduation | = | <i>01, 02, 03, etc.</i> |

Thus, a registered nurse ***[RN]***, who was interviewed fourth ***[04]***, and was working in a medical ward ***[M]***, and had been working as a registered nurse for the past nine years ***[09]***, would be coded as ***RN04M09***.

3.7.8 DATA ANALYSIS

Fifteen transcribed files were imported into *NVivo® version 10* and the researcher coded each transcript for major categories. The thematic coding framework was based upon objective 1, 3 and 4 of the study. Content analysis was used in the present study. According to Marree (2012:101) content analysis is a methodical approach to qualitative data analysis that recognises and reviews message content.

3.7.9 PRESENTATION OF DATA

The coded data were evaluated within their respective categories and presented against the respective objective. The frequency, scope and intensity of coded material were factors considered in deriving meaning and validity in addressing the qualitative exploration of each of the key questions encapsulated within each of the study objectives. These were revealed during the presentation of results and subsequent discussion of each stated objective.

3.7.10 DATA SYNTHESIS

Quantitative and qualitative data were analysed within each paradigmatic view and synthesised to determine whether or not conclusions demonstrated consistency and/or informed the interpretation of the other. The extent to which the conclusions were consistent indicated the inherent validity of the study.

3.7.11 Trustworthiness

Once the transcriptions were completed they were handed to the participants for verification (member checks). The transcripts were handed to colleagues of the researcher who are familiar with the nursing and research process to read the transcripts to find categories (peer debriefing). The interviews were done until there was data saturation (prolonged engagement).

3.8 ETHICAL CONSIDERATIONS

Permission to conduct the study was sought from DUT's Institutional Research Ethics Committee (IREC) and approval was granted on 6 September 2013 against the number IREC 075/13. Permission to conduct the study within a provincial hospital was obtained from the Provincial Health Research and Knowledge Management Secretariat. Permission to conduct the study within the specific site was obtained from the hospital CEO and the Nursing Services Manager. For the qualitative phase of the study, informed written consent was obtained from each participant. Participation was entirely voluntary and there was no coercion. The aim and the reason for the study was explained to each participant. All the participants were assured of anonymity and confidentiality. For the quantitative phase of the study, two staff members, who were in no way connected to the research, were recruited to remove patient-identifying data from the chart before photocopying the chart and then handing it to the researcher for data capturing. In this way, the researcher sought to minimise the possibility of personal reference to patients or nursing staff, either historically or in the future.

3.9 CONCLUSION

The two research methods used in this case study were outlined. The research designs, population, sampling, participant coding and the research process were discussed. The research objectives, research instruments, data collection, data analysis and ethical consideration for the study were highlighted. The results of the study are presented in the next chapter.

CHAPTER FOUR: THE RESULTS

4.1 INTRODUCTION

The implementation of the methodology revealed in the previous chapter yielded respective qualitative and quantitative results. These results are presented in this chapter. The results from the respective qualitative and quantitative phases are presented separately and compared. In the presentation of the quantitative data, graphs have been used as additional means of visually illustrating the completeness of patient charts at the level 3 hospital. By contrast, the presentation of the qualitative data consists of categories emerging from coded transcribed text and these are presented in line with the study objectives presented in Chapter 1.

4.2 THE QUANTITATIVE PHASE

In this phase of the research, patient charts were evaluated against a checklist. The results revealed that there were certain aspects of the nursing process that were carried out according to the level 3 hospital audit specification, while other areas were found to be lacking or, in specific instances, ignored. The results of this phase of the study are in line with study objective 2, which is to determine whether or not the nursing care plan is being used according to the standard guidelines provided by the South African Nursing Council in its Scope of Practice, by using an itemised checklist to determine if the nursing process is being applied correctly.

Figure 3, provides a summary of the collective findings of the quantitative phase of the research. The checklist recorded the presence of evidence obtained from 220 patient charts (n=220). The mean value for evidence across the entire checklist was

77.1%. The results of the quantitative evaluation of the specific elements of the five phases of the nursing process are described in details within 4.2.1 to 4.2.5 below.

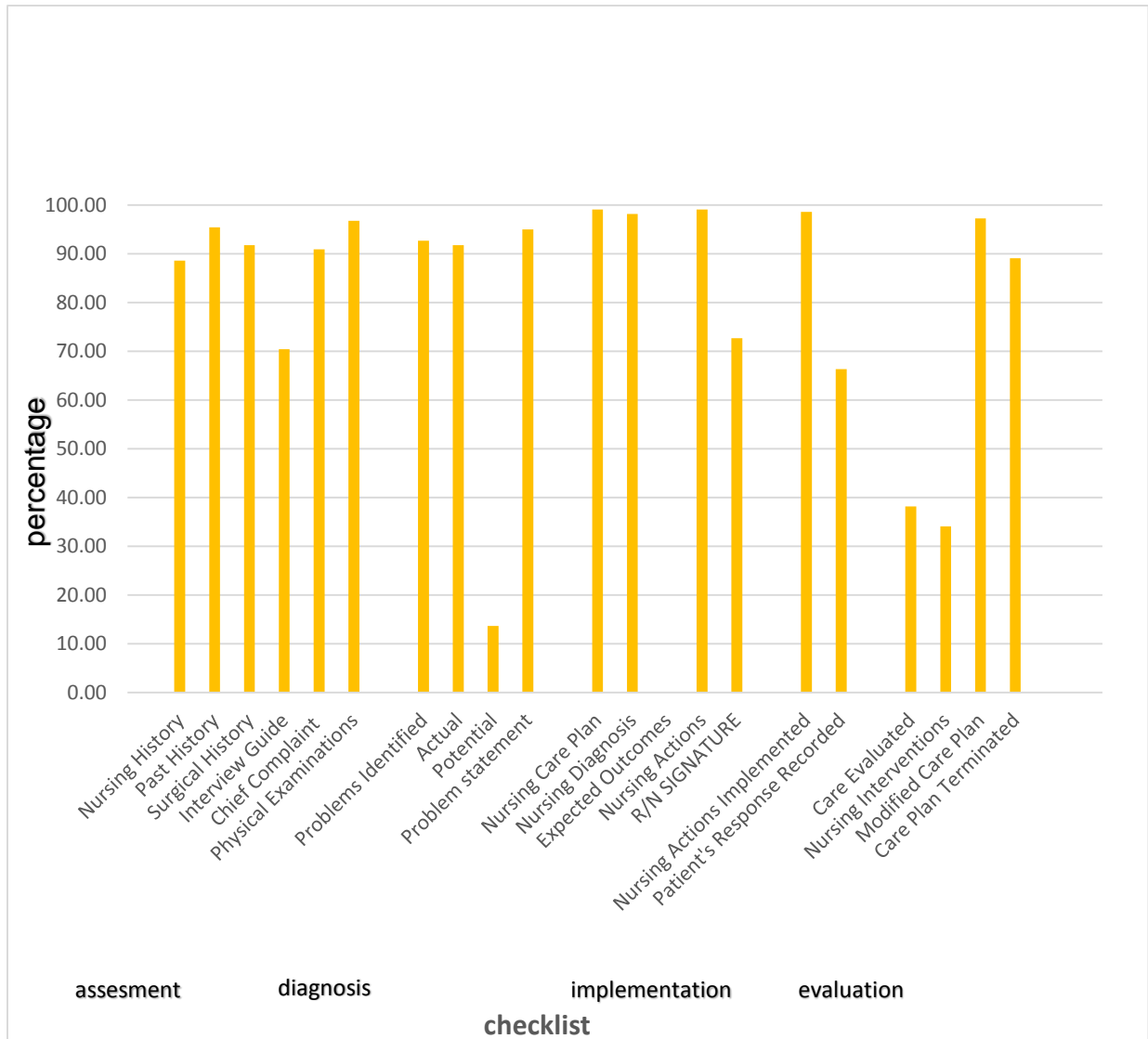


Figure 4.1: Summary of the Quantitative Findings

4.2.1 ASSESSMENT

The results of those elements of the checklist that relate to the ‘assessment’ phase of the nursing process indicate that nurses *did* ask about the patient’s past nursing and surgical history. Twenty-five (11.4% of total) charts did not have a nursing history (which is understood to encompass the reason the patient came to hospital). Ten charts (4.5%) did not have the patient’s past history, while 18 charts (8.2%) did not contain the surgical history. The interview guides in 65 (29.5%) charts were

incomplete. Twenty (9.1%) charts did not show the chief complaint (the specific reason the patient came to hospital) and seven (3.2%) charts had no evidence of a physical examination. The mean compliance (i.e. evidence of each element of the checklist in the patient chart) was 89.0%, with a range of 70.5% (complete interview guide) to 96.8% (physical examination).

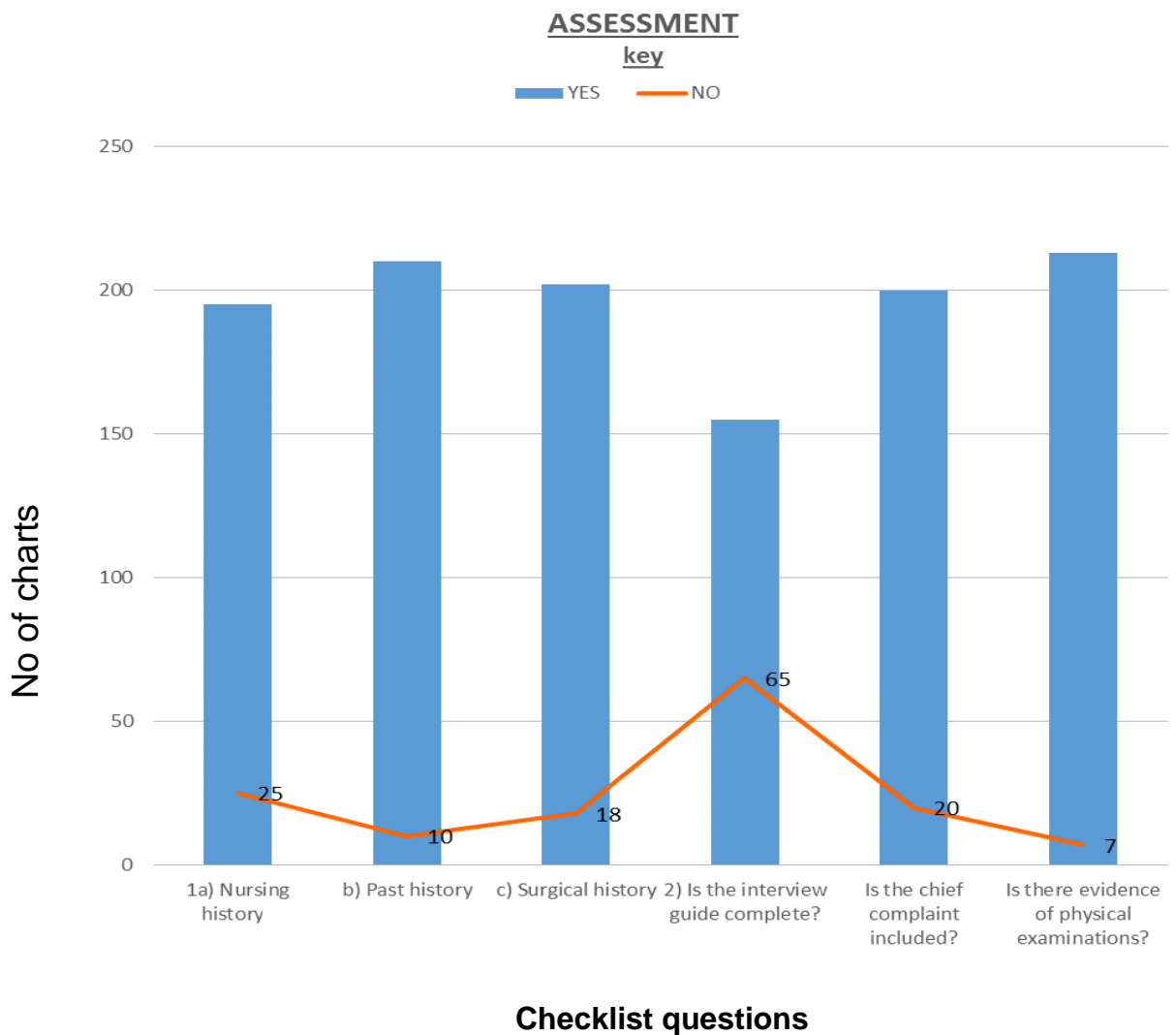


Figure 4.2: The 'Assessment' Results

4.2.2 NURSING DIAGNOSIS

In contrast to the relatively narrow range of compliance seen within the elements of the 'assessment' phase [stated above and which, aside from the 'complete interview guide' element (70,5%), indeed was between 88.6%-96.8%], the results of the 'nursing diagnosis' elements of the checklist indicated that potential problems were, to a very great extent, not identified, as 190 (86.4%) charts had no evidence of consideration and identification of potential problems. Eighteen (8,2%) charts had no actual problems identified and 11 (5.0%) charts did not have a nursing diagnosis/problem statement. The mean compliance was 73.3%, with a range of 13.6% (potential problems identified) to 95.0% (nursing diagnosis). It is of some interest to note that, aside from the identified general failure to identify potential problems, compliance within this phase (i.e. nurses identifying the patient's actual problems and making a nursing diagnosis) was within a very narrow range of 91.8-95.5%.

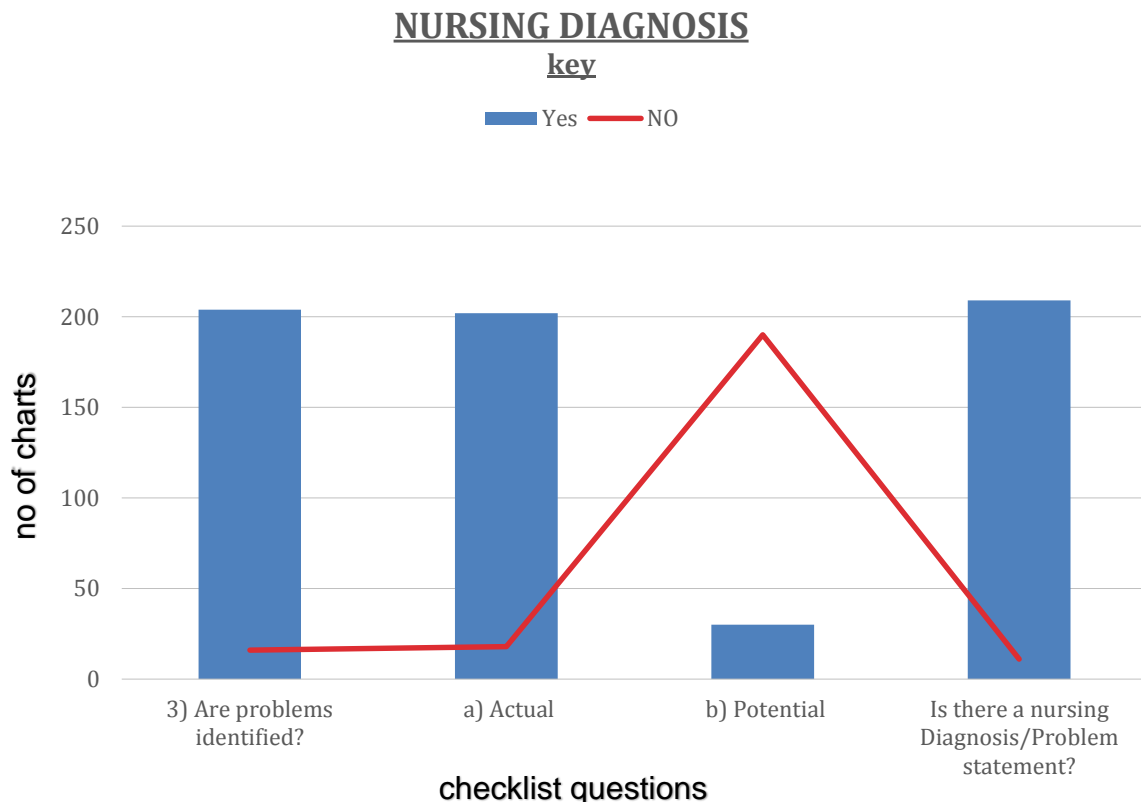


Figure 4.3: The 'Nursing Diagnosis' Results

4.2.3 PLANNING

Within the evaluation of the 'planning' phase of the nursing process it was found that patients' care was generally planned, but none of the care plans had expected outcomes and, in many cases (27.3%), the care plan was not signed by the registered nurse. Only two (0.9%) charts did not have a care plan. Four charts (1.8%) did not have a problem statement/nursing diagnosis contained within the care plan. As identified above, none of the charts referenced had an expected outcome, two (0.9%) charts had no nursing interventions and sixty (27,3%) care plans were not signed by a registered nurse, as is required. The mean compliance in planning was 73%, with a range of 0% (expected outcomes) to 99.1 (inclusion of a nursing care plan and nursing actions)

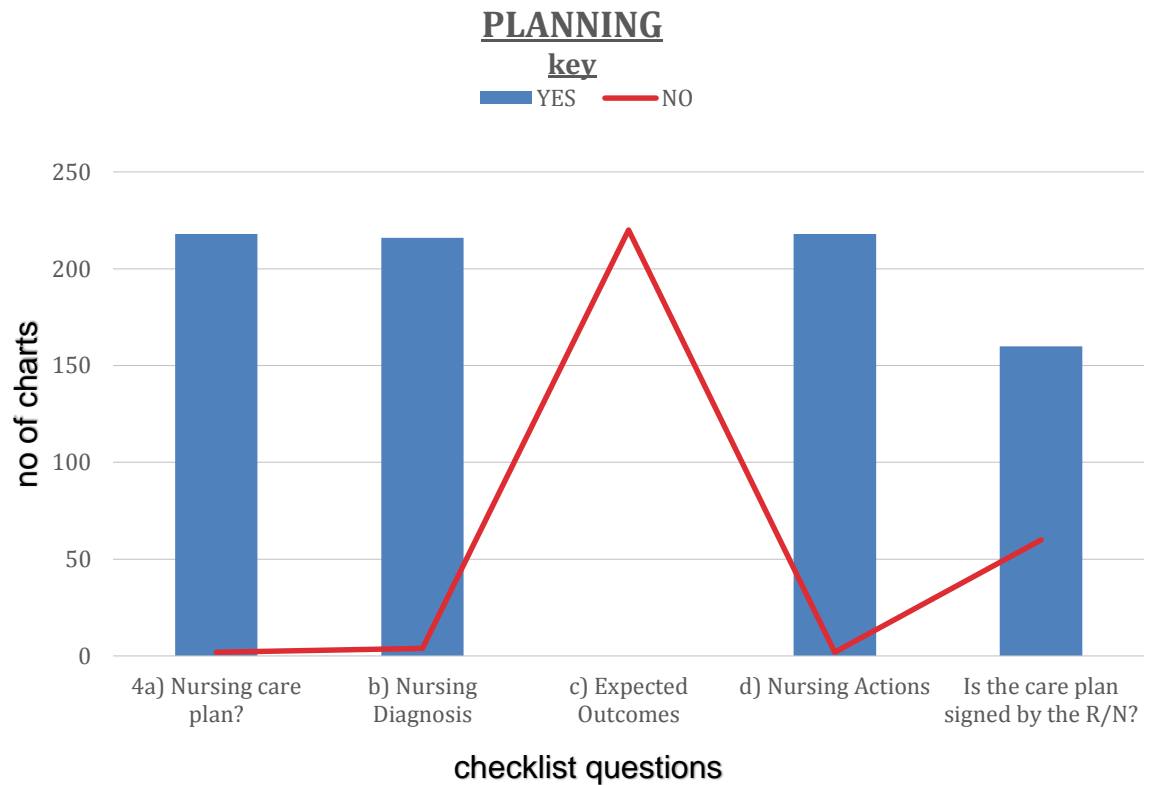


Figure 4.4: The 'Planning' Results

4.2.4 IMPLEMENTATION

The evaluation of the 'implementation' phase of the nursing process (n=2), indicated that nursing interventions were carried out, but that the recording of patient responses was lacking. Three (1.4%) charts did not have any evidence of implementation of nursing care and 74 (33.6%) of the charts did not include any record of the patient's response to nursing care. These results suggest a very high compliance with respect to implementations of nursing care plans (98.6%), but that nurses (in almost one-third of cases) are not recording the patient's response to care. This relatively low compliance of 66.4% would serve as some predictor of shortcomings in the 'evaluation' phase of the nursing process, since the iterative evaluation and modification of care planning is largely dependent on the record of patient response to nursing interventions.

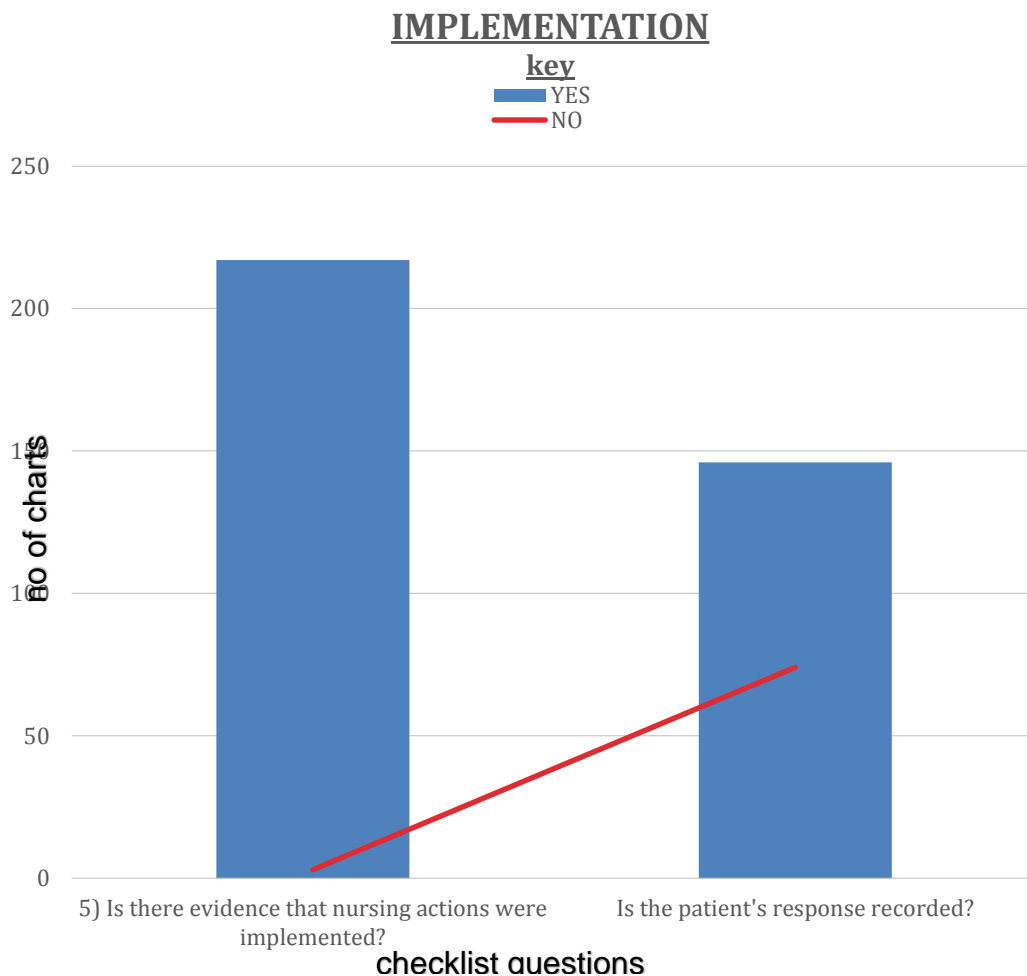


Figure 4.5: The 'Implementation' Results

4.2.5 EVALUATION

The checklist evaluation of chart evidence of the evaluation of nursing implementation and modification of care plans demonstrated a very broad range of compliance. As was predictable by the failure to record patient response to nursing care in 33.6% of charts, the majority of charts revealed that patient care was not evaluated (136 [61.8%] charts) and was not linked to nursing action (145 [65.9%] charts). Most of the care plans were modified or updated as the patient's condition changed, but 24 (11%) charts showed that, on discharge the care plan was not terminated. The mean compliance was 64.7%, with a range of 34.1% (link to nursing interventions) to 97.3% (modification of care plans).

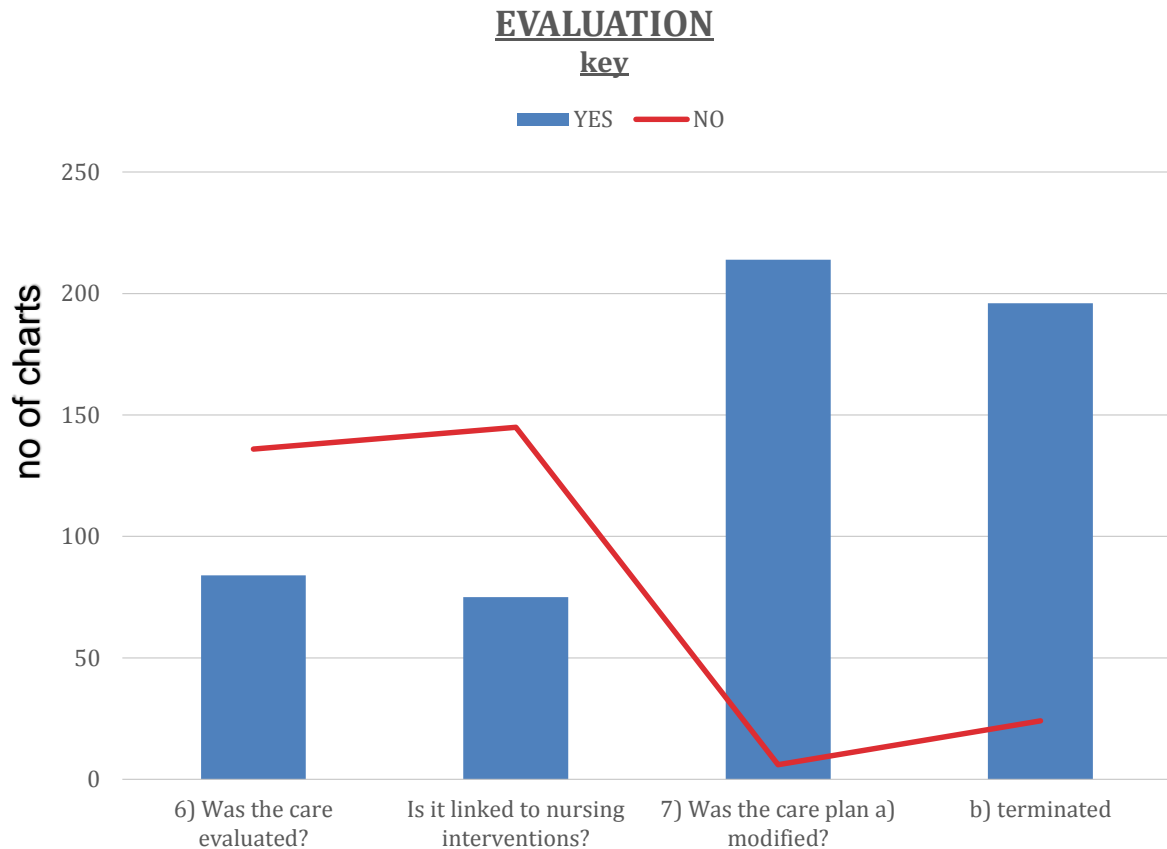


Figure 4.6: The 'Evaluation' Results

4.3 THE QUALITATIVE PHASE

In the qualitative phase of the research, interviews which were transcribed by the researcher into written text were used to categorise interview data into categories. The results are presented in line with the study objectives. For ease of reference within this chapter, the objectives of the study were: 1) to determine the registered nurse's level of understanding of the nursing process, 3) to identify the factors affecting the implementation of the nursing care plans by the registered nurse; and 4) to make recommendations on good, practical and effective strategies for planned nursing care that may be adopted into nursing practice.

Table 4.1 categories in line with objectives.

| OBJECTIVES | CATEGORIES |
|--|---|
| Objective 1 : to determine the registered nurse's level of understanding of the nursing process, by using semi-structured interviews | -the nursing process |
| | -assessment |
| | -nursing diagnosis |
| | -planning |
| | -implementation |
| | -evaluation |
| Objective 3: factors which impact on the preparation and use of the nursing care plan | -workload |
| | -bad staff attitudes |
| | -lack of understanding |
| | -use of standardised care plans |
| Objective 4: Recommendations on strategies for planned nursing care that may be adopted into nursing practice | -the use of standardised care plans |
| | -the registered nurse's ability to develop care plans |
| | -the registered nurse's role |

4.3.1 OBJECTIVE 1: TO DETERMINE THE REGISTERED NURSE'S LEVEL OF UNDERSTANDING OF THE NURSING PROCESS

In determining the registered nurse's understanding of the nursing process, reference was made to the number of interviewed nurses who produced coded information about their experiences while using the nursing process.

4.3.1.1 The Nursing Process

The nursing process was described by the participants to be a document that was completed, on admission, to help identify the patient's needs. The nursing process ensured continuity and guidance of nursing care. They explained that the nursing process helped to establish when, how, and how often something was to be done. The nursing process also guided the nurse in recording nursing care and determining whether the patient's condition was improving or not.

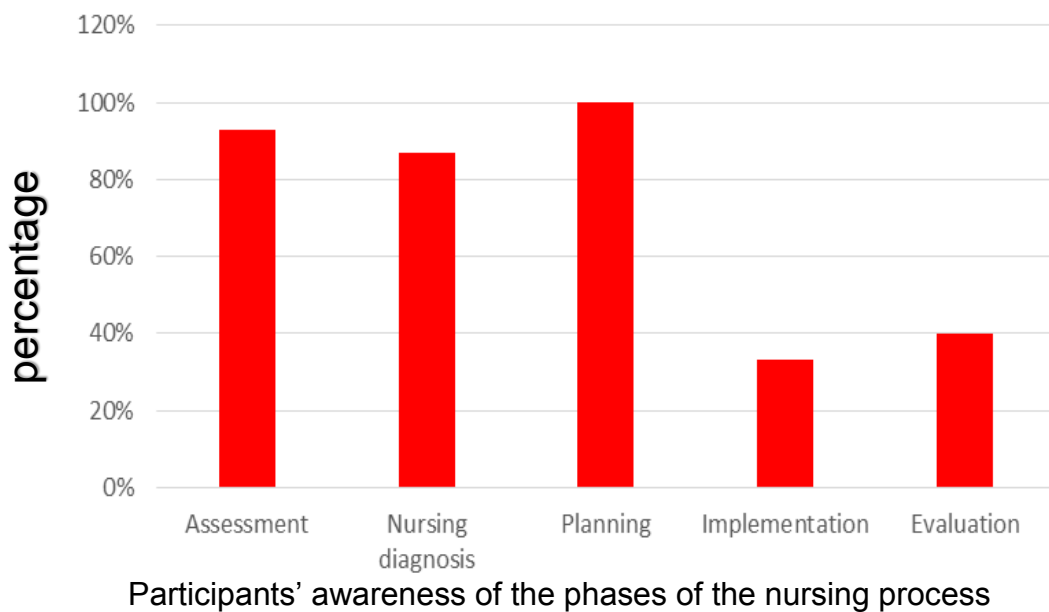


Figure 4.7: Nurses' level of understanding the Phases of the Nursing Process

'About the nursing process, what I understand is that, we use it as a guide to help us continue with nursing care and also with the doctors, so that whatever is happening we write it down in our nursing process.' [RN10M03]

'The Nursing Process is something that we formulate on admission of a patient where we identify our patient's nursing needs according to their diagnosis and their symptoms. We use the nursing process to guide our practice, we use it to, it's our daily guide as to how many times we may do something a day or what exactly needs to be done for the patient on a daily basis. It also is a guideline to how we report on that patient so, on a day to day basis it's going to tell us what we need to have reported on and help us establish if the patient is improving or worsening and obviously we are going to alter it as we go along.' [RN16C09]

The nursing process is used to record all the changes in the patient's condition and anything else that may happen to the patient while he/she is in hospital. All that is done for the patient is recorded as part of the nursing process. Five participants saw recording to be an important part of the nursing process.

'Our nursing process is done on admission and we record every time a patient's condition changes, or they leave the department, etc.' [RN06S14]

'OK, the nursing process is a record of everything we do for the patient.' [RN10M03]

'About the nursing process, I understand that it's the recording of everything that you do with the patient, it must include the time, the date, the patient's name, the patient's in-patient number, the diagnosis on top, and the page number.'
[RN13S01]

Five participants viewed the nursing process as a means of ensuring continuity of care from admission to discharge.

'About the nursing process, what I understand is that, we use it as a guide to help us continue with nursing care and also with the doctors, so that whatever is happening we write it down in our nursing process.' [RN08M02]

'I think the nursing process is like continuous nursing care of all the patients. The process is just nursing care, because it continues from admission until the patient is discharged, the patient is cared for.' [RN11S01]

4.3.1.2 Assessment

Fourteen participants mentioned assessment as being an important part of the nursing process. They also indicated that the full details of a patient are sourced from the patient and the family members during history-taking.

'By the full details, history-taking from the patient and from the relative of the patient, and then by checking the patient. Maybe the patient will come to me, and I can see the patient by the expression, when the patient is coming to me, I can see the patient is distressed. The patient is limping, now I can see that something is wrong. I can see the patient is on a stretcher, I am asking what is wrong, and the patient cannot walk. That's my assessment, even the skin of the patient; I will assess the skin, if the skin is dry, if there is a cut even if there is a scar, red, something like that. That's what I'm going to assess the patient with.' [RN08M02]

'I think so because when the patient initially comes, you nurse each patient individually, so you will initiate the care plan from there because you are assessing the patient and getting history from the patient and you are developing a care plan according to those patient needs.' [RN10M03]

The participants stated that data collection involved interviewing the patient (using the interview guide), history-taking, the physical examination and observing the patient for physical problems such as scars and deformities. Twelve participants saw data collection as being fundamental in the assessment phase.

'As far as medical details we ascertain their allergies, the medication that they are on, health, medical and surgical history and current problems. We assess their pain levels on admission; vital signs are done all vital signs, height weight, and oxygen saturation.' [RN06S14]

'We use the interview guide to collect data, so here at hospital name its already been prepared, it guides which questions to ask and although where you write presenting problem, the space sometimes is too small to write everything the patient tells you, ja, all these questions you ask the patient, social, previous history, surgical, medical, family history, even giving you space where you get to record the patients vital signs, even the contact numbers, whether the patient had X-rays or not.' [RN07S02]

'We collect data when we do the interview and also we do the interview and there are some other things we need to explain to the patient.' [RN09S10]

'Well we collect information from the patient, all of the history from the patient and you get all of that from the patient, so you collect the history and well that includes the social and the background of the patient, in the interview. The interview guide, you collect all the information from the patient and you also do a physical examination from head to toe and you will be able to see now on admission whether the patient has any scars, gashes or bruises, or comes with any deformities or whether the patient is mobile or immobile, whether the patient can use all four limbs, on admission as well if the patient is clerked, you can also read the doctors file, but you gather most of the information from the patient and according to the interview guide what is needed.' [RN10M03]

The participants acknowledged the fact that data collection required input from the patient on a one to one basis and involves the family members as far as possible.

'The data collection process, it's when you ask questions, like when the patient is admitted. On admission, you must ask questions, like when did she first see the signs that brought him or her to hospital.' [RN13S01]

'Data collection process, it is usually on a one to one basis where you ask the patient questions, if the patient is able to answer the question. You could also involve the family members to help you establish what routines ought to be.' [RN16C09]

One participant identified a problem with some nurses who would ask a patient 'what brought you to hospital today? The patient would respond by saying that he/she had an appointment at the cardiac clinic. The nurse would not then probe further to find out what the problem that led to the appointment being made in the first place was, and as a result important information regarding the patient's health status would be incomplete and not accurately captured. The interview guide was mentioned by nine participants as being a method of collecting data.

'Then we ask them using our interview guide from the beginning to get the reason why they came to hospital, so basically, the problems, presenting problems that they are experiencing, if they are on any medication, their past medical, surgical history and If patients cannot help us to get this information, if relatives are present, we ask them to assist in collecting the information.' [RN03S04]

'OK with the data collection we use the interview guide, it is the tool that we use to ask the patient all the questions that are there and then, the interview guide covers almost everything that we have to know about the patient, social history, surgical history, medical history, so that's where we get to know the patient.' [RN04S02]

The participants mentioned that, besides enquiring about the patient's present needs, there was a need to ask about the past, the patient's family and any present chronic illnesses.

‘They collect data according to the interview guide and most of the data is collected, first of all the presenting problem, now here most of the nurses make a mistake, they ask the patient why did you come to hospital and the patient says they came because they have an appointment at name of hospital and we have tried many times to educate nurses that the presenting problem is the actual problem the patient is having and you have to write down how long the patient has had the problem and when did the problem start.’ [RN05M24]

‘Most importantly you use the interview guide, where you are going to ask the patient questions about their first diagnosis, what was wrong and when did this start. Everything is there, medical history, surgical history and allergies. Everything is in the interview guide.’ [RN11S01]

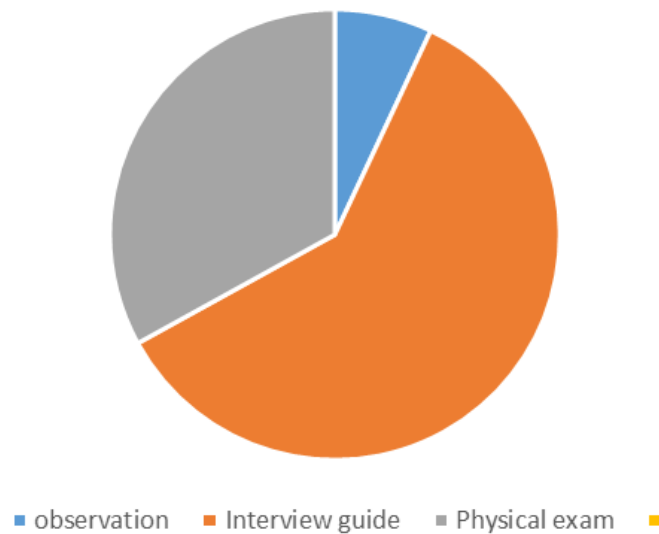


Figure 4.8: Summary of components of the assessment phase mentioned by the nurses

4.3.1.3 Nursing Diagnosis

The participants felt that the nursing diagnosis helped the nurse to identify and incorporate into planning some things that the doctor was unable to pick up, such as psychological issues. This empowered the nurse because she/he knew more about the patient and was thus able to prepare better care plans that ensured more

precise care for the patient. Three participants felt that being able to derive a nursing diagnosis empowers the nurse and allows her/him to exercise her/his independent function as they were better equipped to plan care according to the patient's health needs. Thirteen participants saw the nursing diagnosis as being the basis upon which to move to the next step of the nursing process, that of planning.

'I think it is of great importance because it helps to know how to nurse the patient firstly and also, what you should do and should not do for example if they are diabetic and stuff, you should know what diet to give them, you know what they should not be having and how to manage them in the ward, so like four hourly GRs and stuff, It helps you to manage your patient.' [RN03S04]

'Sometimes we just follow the doctors diagnosis, but I think the nursing diagnosis is good because we see the progress the patient makes, the patient initially was presenting with, this and this and this but now we did try to treat that, so ja, I think it is important in that way.' [RN04S02]

'The nursing diagnosis is important because the nurses get one to one information as to what is really wrong with the patient. She picks up things that the doctor does not pick up, like psychological care.' [RN05M24]

One participant felt that it was important to distinguish between the different types of diagnoses in order to understand its importance and when to use each one.

'It's important as nurses that we understand the diagnosis from a nursing perspective. Very often we have a nursing diagnosis, we have a doctor's diagnosis, and we have a post-op diagnosis. The diagnosis changes all the time, so as nurses we are taught how to assess patients and diagnose them and this is where we exercise our interdependent role in the health care team to diagnose patients, and ja it empowers the nurse also to say wow, I can diagnose a patient from my assessment and of course it's done in correlation with you, you have got the doctors

diagnosis to check, you have got X-rays, diagnostic tests, whatever you need, you got as a nurse.' [RN06S14]

'It's very important because sometimes if we use the doctor's diagnosis, half the time we don't even know what it is, but if we make our own diagnosis, the nursing diagnosis, we able to make the patient better, because, we create a care plan according to that diagnosis that we make, I think it's very important, the nursing diagnosis.' [RN07S02]

'It's important, it's important because before even the doctor comes, I will know that the patient is sick, maybe the patient is dyspnoeic, I have to put the patient on oxygen. I have to administer the oxygen by myself, without the doctor's order, and then after I will call the doctor, because this is an emergency, but I have to do something, I have to act before I call the doctor.' [RN08M02]

'It's the diagnosis that's going to help with the planning of the care for the patient.' [RN09S10]

The participants also felt strongly about the nursing diagnosis guiding the patients' care and directing the nurses to choose the appropriate nursing interventions.

'The nursing diagnosis makes you see what is wrong with the patient. Why the patient came.' [RN11S01]

'It is important because you're going to know how you are going to nurse your patient. If you know the diagnosis, you're going to give the best of nursing care, because you know what's wrong with the patient.' [RN11S01]

'... The nursing diagnosis is important so that you can do your care plan accordingly. The nursing diagnosis is important because, if you don't know the nursing diagnosis- you won't be able to take care of that patient, from what you have assessed from the patient.' [RN13S01]

The nursing diagnosis is based on the signs and the symptoms that the patient presents with on admission, and that is why it makes it easy for the nurse to care for the patient according to his/her needs.

'It's very important because you have to treat the patient according to the diagnosis that you've got. So, to prevent mistreatment it's important.' [RN15S04]

'... I think the nursing diagnosis helps us as nurses to understand exactly what is wrong with the patient, often a medical diagnosis is vague, and so with the nursing diagnosis you pretty much explain the patient's symptoms so in that way it does help to understand what is happening with the patient.' [RN16C09]

One participant viewed the nurse who was able to formulate a nursing diagnosis as exercising her/his independent role, which makes the nurse confident in making decisions with the patient, regarding his/her care.

'It's important as nurses that we understand the diagnosis from a nursing perspective. Very often we have a nursing diagnosis, we have a doctor's diagnosis, and we have a post-op diagnosis. The diagnosis changes all the time, so as nurses we are taught how to assess patients and diagnose them and this is where we exercise our interdependent role in the health care team to diagnose patients, and it empowers the nurse. Also to say, wow, I can diagnose a patient from my assessment and of course it's done in correlation with you. You have got the doctors diagnosis to check, you have got X-rays, diagnostic tests, whatever you need, you have got as a nurse. As an orthopaedic nurse you can also diagnose problems from the nursing point of view, looking at X-rays, MRIs, etc.' [RN06S14]

Three participants felt that the nurse is empowered when she/he creates a nursing diagnosis, as she has used the information that she collected from the patient, based on signs and symptoms. If nurses could change their lackadaisical attitude, they would realise how important the nursing process is and have the ability to empower themselves and build their confidence. There were a number of nurses

who were enthusiastic and showed an interest in the nursing process. These nurses were eager to share their knowledge with others.

'There are those nurses that are interested, they are empowered, they much more... sorry I cannot think of the word today, words don't want to come... they are more enthusiastic, they are more willing to teach and pass on information to others, because from that nursing process comes health education. And if you don't know yourself how to plan care and how to empower patients, how do you teach them when they are going home and health education is going back to grassroots level?'
[RN06S14]

4.3.1.4 Planning

The nurses are intended to plan care while the patient is in the ward and to re-assess every day or whenever the patient's condition changes, so that the patients are nursed appropriately. The care plan is intended to be devised on admission and evaluated throughout the patient's stay in hospital. The nurses ought to nurse the patient according to the plan, as the plan seeks to improve care and the nurse should reflect on the care plan when writing the patient's report.

It was found that not much emphasis was placed on the detailed implementation of nursing care plans, although this study showed that all participants understood the importance of the nursing care plan.

'We plan nursing care for the ward and for the admission period that they are in the ward and of course it's reassessed every day and every time the condition changes, so that patients are nursed appropriately and nursed according to policy in the department and procedures are carried out accordingly.' [RN06S14]

4.3.1.5 Implementation

The implementation step of the nursing process exists to make sure that orders are carried out. When the nurse has assessed and made a nursing diagnosis and

developed a care plan, she/he must put the plan into action. Implementation is ongoing. Five participants mentioned that implementation referred to the nursing activities that took place in the ward.

'To make sure it is carried out, to make sure that if there is certain orders that are carried out, that it's done and to also update the care plan, to evaluate on that. Well, the whole nursing process, to see whether that care plan is, we need to check whether that care plan is being implemented to see, monitor, we need to see whether it is working and re-assess if we need to. I know I am not going in order.'

RN10M03

'We implement, all of that is recorded on the care plan and what needs to be done for the patient, and we implement it and then we monitor the patient to see if whatever we documented, whatever we have implemented, is helping the patient.'

[RN10M03]

'Not just to develop and then, maybe there's a care plan that's developed and then we're going to leave it like that. I have to make sure that it is implemented in the ward, and that it's an ongoing process. So they must do the things. So just to make sure that what is developed is done, and going the way it should be going.'

[RN11S01]

Seven participants identified the nursing care plan as being responsible for the quality of care or lack thereof. The registered nurses are responsible for ensuring that the care rendered to the patient is of a high quality. Nurses plan care from admission, and review it as the patient's condition changes, so that the patient is nursed appropriately and according to departmental policy. The interviews further revealed that there was sometimes a delay in making appropriate changes to the care plan, and that some nurses simply ticked boxes without necessarily taking full account for the meaning of the tick and its relationship to the patient.

'Okay, the main problem that we have, that I've seen in the ward, is like when, okay, example, when a patient's post-operative: whoever is receiving the patient from OT they may not update that care plan and open specific needs, the new needs that the patient requires or maybe if the patient develops respiratory distress as well, the care plan is not updated immediately as this affects the nursing care. So that's the main problem that we have.' [RN03S04]

'We plan nursing care for the ward and for the admission period that they are in the ward and of course it's re-assessed every day and every time the condition changes, so that patients are nursed appropriately and nursed according to policy in the department and procedures are carried out accordingly.' [RN06S14]

'It improves care but it depends on the nurses that are using the care plan and I think it's with the trained staff that need to emphasize the importance of the care plan to the nurses because to them, it's just to tick, tick, tick. What are you ticking? Because sometimes they just tick something that does not apply to the patient, you know what I am saying. It is just to emphasize the importance of what you are ticking, does it correlate with what you do to your patient.' [RN09S10]

4.3.1.6 Evaluation

Only six of those interviewed felt that evaluation was an important step in the process.

'It's obviously divided into assessing the patient and planning for the patient, implementing and monitoring the patient and evaluating everything that is done for the patient basically.' [RN10M03]

4.3.2 OBJECTIVE 3: FACTORS WHICH IMPACT ON THE PREPARATION AND USE OF THE NURSING PROCESS BY THE REGISTERED NURSE

The interviews revealed a number of factors that affected the implementation of the nursing process by the registered nurse:

4.3.2.1 Workload

The nurses were found to be too busy in the ward doing admissions. Often the registered nurses feel that they have a lot of work and going back to check on all the documentation does not happen because of time constraints. Sometimes nurses could not complete the nursing process, as they are supposed to, because of the workload. Five participants mentioned workload to be one of the important factors impacting negatively on nursing process implementation and evaluation. The conceptual model of care planning states that, due to a heavy workload, the care planning process cannot be completed successfully.

'People are too busy in the ward, just doing admissions, like, and want to finish and get to the next one.' [RN07S02]

'So if it was me, I was going to say "maybe", the RNs will say, "no, you giving us a lot of job", but if it was me I was going to say, we must do it as RNs and staff nurses, we must make sure that every day we check it, the nursing care plan is done properly.' [RN08MO2]

Shortage of staff was also seen as a reason why there was no time for the registered nurse to go back to check that all the nursing care plans were completed, nursing care was implemented, documented and evaluated.

'You are assisting them with the care plan and also teachable moments when you find something is not done, in the morning handover or whichever time you find, go to the staff and tell them and use it as a learning experience because, I mean, maybe sometimes, it's not even lack of care or lack of interest, sometimes we say we are

going back to certain things and we don't end up going because of time constraints and we are understaffed as well and all time is of importance as the effort of trying to do everything but as I said, priority as well. So on a daily basis when people are allocated to do the report, they need to reflect on the care plan. So it's also people who are allocated to their different wards, need to go back to the care plan and if they find something not right there, they go back to their supervisors and also supervisors need to go back and check as well. Because we are enough sisters for certain days and these nurses also are allocated to cubicles, so we go back and check if all documents are in order and things are done. So ja, I must admit to you that not much stress has been put into care plans, people do it, others don't and there is no stress and emphasis on the care plans, I don't know why.' [RN10M03]

'Well I think sometimes it's the workload that we have, we just like do what we can and you find that sometimes you don't have the time to really go back to what you have found and you just rather say, let me just ignore it because it's not a problem- I can see for now that it's not a problem. If it is a problem, then I will deal with it when the time comes - that's how we think.' [RN12S01]

'I'm not going to say any specific nurse, because you're a nurse, I think that as a nurse we were taught, everybody was taught about the patient. So, whatever you see - you can be an ENA - but we've got experience from, like let's say you've been an ENA for 20 years, so then you know, you've seen patients, so you can be able to say and to note what is noted on the patient and you can go and report to the registered nurse that I've seen this and this and this, from my experience, this is how we help the patient and it always works like that. So, I'm not going to say which category, because registered nurses have, sometimes we've got too much to do and there's no time to focus on one patient.' [RN12S01]

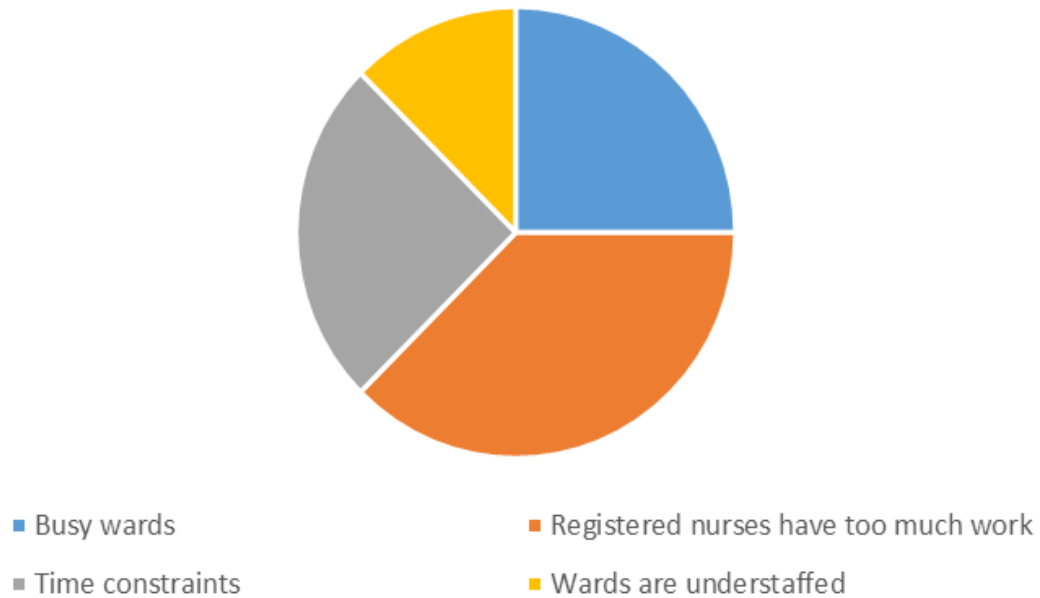


Figure 4.9: Contributors to heavy workload

4.3.2.2 Bad Staff Attitudes

Some participants felt that some staff had a careless attitude towards care plans, while other nurses were enthusiastic, empowered and more willing to teach others. Nurses did not want to take any responsibility and one participant stated that some nurses viewed nursing as just a job and, therefore, refused to be accountable. Participants went on to say that nurses have a ‘don’t care’ attitude towards care plans. One participant expressed concern about some nurses’ bad attitude, to such an extent that she felt sorry for the patients that were nursed by these student nurses. In general, nurses lack interest in what they do and often neglect their duties and their patients. Certain nurses are so careless, they do not care if the care plan is right or wrong.

‘Some nurses have a kind of lackadaisical attitude towards care plans, they don’t see how important it is from a nursing point of view, to assess the patient and they don’t see it as empowering themselves, they just see it as something that just got to be done, like it’s just routine, do the care plan and finish.’ [RN06S14]

'There are those nurses that are interested, they are empowered, they are much more... sorry I cannot think of the word today, words don't want to come they are more enthusiastic, they are more willing to teach and pass on information to others, because from that nursing process comes health education and if you don't know yourself how to plan care and how to empower patients, how do you teach them when they are going home and health education is going back to grassroots level.'

[RN06S14]

'People don't want to be responsible for something, you find that OK that nurse did the nursing care plan in her way that she was taught, but only to find that I don't want to sign for her that it was done. So now when you checking or when audits are done the things are not signed, so when I asked the sister and she was busy and she could not do it. Only to see we don't want to commit ourselves to that thing like that because sometimes you think that, O I'm going to go to jail with her if she writes something wrong and the other thing about the nursing care plan is that sometimes you find the patient has been in the hospital for almost a month but the nursing care plan is the only nursing care plan that was done on the admission of the patient.'

[RN08M02]

Some participants viewed some nurses as being negligent, as they will not carry out their duties fully. They rush to complete their tasks without putting any thought into the reasoning and importance of completing the task conscientiously.

'Sometimes people, what can I say? Because I do not want to say It's the time, because when you are with the patient, that is where you are supposed to waste your time with the patient, may be negligence because sometimes people, they just do things, because, I have done the obs, I have written the report post operatively, now I am finished, you know what I am saying, forgetting that your patient is here, you need to see to your patient OK, circulation, patient is not in pain, OK do basal observations and then come to your routine. You start with where you are supposed to start, with your observations, the report is written, care plan may be if, I am just thinking may be, we tried that also to tell them that the patient has come back from

theatre, you taking over, you checking the patient, OK you see that there is no bleeding, your catheters, your drips are running OK, the patient is comfortable, if he is in pain, give something for pain. Then you come to writing, you know what I am saying, on that day it won't happen.' **[RN09S10]**

'I can say that the attitudes of nurses, from students to nursing staff to trained staff, lack of, what can I say, not lack of knowledge but lack of I don't know, of care is the right word, lack of interest I can say lack, I can say ignorance with some of us and some of us feel it's not important. They feel it's not important so, sometimes only when, sometimes the patient is even discharged, they don't even have a care plan in the nursing process. And it also boils down to lack of supervision as well because, at the end of the day, we are accountable for our acts and omissions and even though it's such a big ward, according to the South African Nursing Council, we are all nursing that patient and our shift for that month and we all missed that the patient did not have a care plan so also it's a hazard and I would say it's attitude again, because now this one thinks that one has done it, that one did it instead of going and checking that okay fine, and that also tells you that they are not using the care plan if none was done.' **[RN10M03]**

'My feelings... because really it's not difficult to do that thing. That is carelessness of the nurses.' **[RN11S01]**

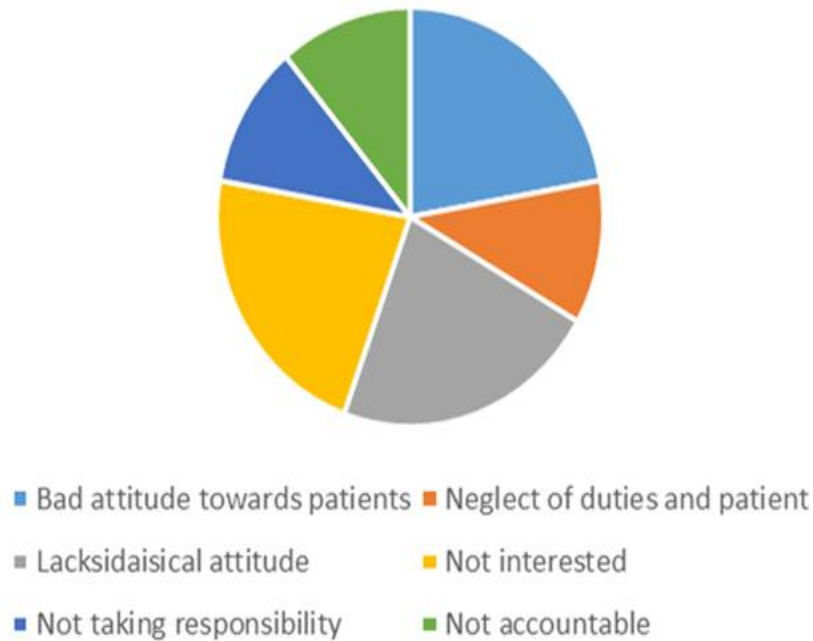


Figure 4.10: Summary of bad staff attitude factors

4.3.2.3 Lack of Understanding of the Nursing Process

Many participants identified a lack of understanding by the nurse to be one of the issues with standardised care plans. The participants added that some nurses did not know what was going on in the standardised care plans and did not know what to do in the care plans. Another reason for the lack of understanding could be the lack of supervision by the more senior nurses, such as the registered nurses. One participant said that registered nurses do not teach the younger nurses what should be done and how it should be done. The language barrier was also cited as being one of the factors that furthered the understanding of the care plan. Seven participants identified a lack of knowledge to be one of the impact factors. The model of care planning shows that a lack of knowledge by the registered nurse derails the correct application of the nursing process.

'The care plan, as I said, is a standard care plan but we have a lot of difficulties, nurses don't understand what goes on in the care plan, so to try and combat that, as I said we try and do an audit every Thursday and we teach the nurses what is

right and what is wrong, there is a new part to the whole admission which is the Morse fall and the Water low scales which is done for the patient and that seems to be a disaster when it comes to that.’ [RN05M24]

‘People are too busy in the ward, just doing admissions, like, and want to finish and get to the next one, might be they don’t know what to write because they don’t get enough orientation when they come, they don’t know where to put that extra problem.’ [RN07S02]

One participant stated that the nurses have a tendency, especially when they do not know what to do, to copy what the previous person did without understanding why it was done that way. This demonstrates a lack of understanding.

‘They are just copying what I did and then they continue with that thing without knowing that the condition has changed and without knowing when to change, what else to do, only ticking what I tick. They will tick as well until the patient is discharged, only to find that most of the things are not done because now they are only copying what I have done. We in nursing, have this tendency of copying whatever practice we did even the patient, maybe doctor ordered something, I did that thing, the other person will do just tick, you see, so, I will say sisters and staff nurses can do the proper one because we know the patient’s need. Sometimes these children don’t understand and they are just here for their jobs and to do their allocations, you see, but the purpose of doing that they sometimes don’t know, some of them don’t know, so I think we do need in-service and also to teach them they are here to learn.’ [RN08MO2]

‘Maybe to give them more knowledge about the care plan. More information about it, about how it is going to be done, more information about that. Or maybe audit, or maybe just to teach in the morning, every morning you have to tell them about the care plan. How important it is to do.’ [RN11S01]

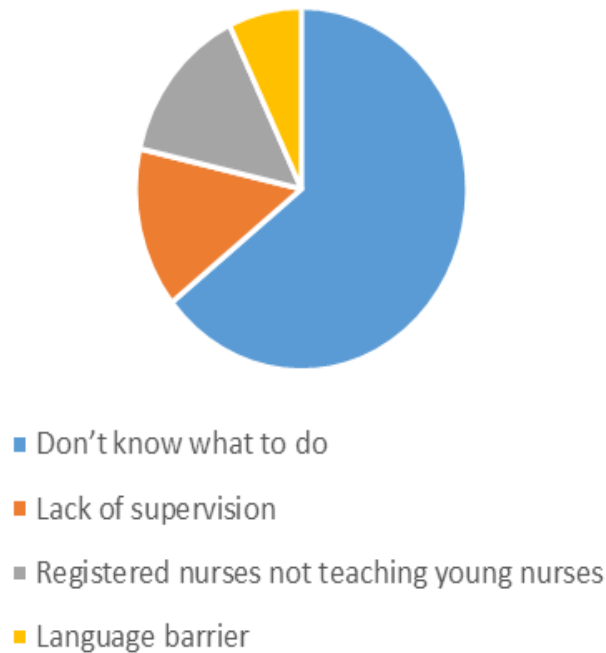


Figure 4.11: Reasons for lack of understanding of care plans

4.3.3 OBJECTIVE 4: RECOMMENDATIONS BY REGISTERED NURSES

4.3.3.1 Use of Standardised Care Plans

The weakness of the standardised care plan, according to the participants, stems from the fact that a standardised care plan is a generic care plan, meaning that all the patients use one care plan and, as a result, all patients are treated alike, even though each patient comes to hospital with his/her own individual problem. The standardised care plan made the nurse too dependent on the already-made care plan, not allowing her to use creative thinking skills and exercise the theoretical knowledge gained from college to formulate individualised care plans. Nurses expressed the need to be motivated to write care plans.

In general, nurses felt that writing care plans is a laborious and time-consuming task, which some nurses believed was unnecessary extra work. Nurses were found to not see the care plan as being holistic and its existence was taken for granted by

all staff. Staff attitudes were indifferent to the care plan and many failed to see its importance in nursing. The younger nurses were found to not learn to develop the care plan because the standardised care plans are available and it is the norm to use them within the institution.

Care plans were seen as routine, and as something that *had* to be done, and nurses tend to be careless when working with care plans. These care plans make the nurse lazy and make it difficult for the nurse to learn how to formulate individual care plans for the patient. Due to the fact that the standardised care plans are used, many nurses cannot write individualised care plans and they are unable to update/modify and review care plans to ensure that the care plans remain relevant. This results in appropriate care not being highlighted or reflected on the care plan.

One participant suggested that the institution stops using the standardised care plan and that nurses go back to writing their own care plans.

'The care plan as I said is a standard care plan but we have a lot of difficulties, nurses don't understand what goes on in the care plan.' [RN05M24]

'Recently I have noticed that nurses have become too dependent on the care plan that is already been standardised in the hospital. They are not exercising their creative thinking, creative thinking powers and their theoretical nursing knowledge that they have attained from college to try and plan care for a patient.' [RN06S14]

'They don't have the knowledge or because they are not getting good supervision from the registered nurse, because the registered nurse is supposed to check the care plan and counter sign it with students and so it is also up to the registered nurse to supervise them and fill in the gaps and assist them where necessary, because its problem solving you know, action plan and everything needs to be formulated.' [RN06S14]

'I find it difficult to motivate people to write care plans, because they feel that it is a laborious process and time-consuming and also people that do not have the creative thinking power and don't see things from a holistic point of view, have difficulties developing care plans and also the language barrier comes in because sometimes, you may

explain something, and they say yes they understand, but when they put it on paper, and they are writing it, then you see that this person did not catch a thing of what I said. And also some nurses have a kind of lackadaisical attitude towards care plans, they don't see how important it is from a nursing point of view, to assess the patient and they don't see it as empowering themselves, they just see it as something that just got to be done, like it's just routine, do the care plan and finish.' [RN06S14]

One of the strengths of the standardised care plan identified by the participants is that when the nurse uses the care plan it improves the patient's care, by reminding the nurse of the care that must be rendered to the patient. The standardised care plan gives the nurse guidelines to patient care, provided it is used correctly.

'It's a good care plan and if people use it correctly, they will never have a problem, if they know how to use it correctly, it basically covers everything even the interview guide, the only thing that is missing is the address, and we will have to find a space for that.' [RN05M24]

'Because, it's good, because at the end of the day you're going to do the care plan. The things you're going to tick there on the care plan, because it's already printed, you're just going to tick, is the nursing care you're going to deliver to the patient. The care plan is going to give you the guidelines.' [RN11S01]

'Yes, the standard care plan. It is OK, for that care plan, because you know what to do; you know, at least it will remind you what to do, sometimes so that you don't forget how to deal with that patient. But I feel there are things that can be added, although I cannot point it out now because for each patient there is a different thing.' [RN12S01]

4.3.3.2 The Registered Nurse's Ability to Develop Care Plans

The general feeling was that not all nurses were enabled to formulate individual care plans, because at the particular institution standardised care plans were used. This made the nurse lazy and incapable of planning and implementing care, as their

critical thinking skills were not developed. Some nurses lacked the competence to modify or update the care plans as the patient's condition required. Few nurses could assess the patient and create an individual care plan and one participant added that she/he found that the student nurses were better equipped to work with care plans, while other nurses were still learning.

'That's a difficult one, because you cannot say that only trained staff are more experienced to do it because not all are experienced, maybe it comes with experience as well as when you work in the ward. Some students... I think it depends entirely onto the individuals competence as well, because some students are quite capable of doing it and some trained staff as well, like RNs even ENs and then you get some that are not, it just depends on the individual.' [RN03S04]

'Recently I have noticed that nurses have become too dependent on the care plan that is already been standardised in the hospital. They are not exercising their creative thinking, creative thinking powers and their theoretical nursing knowledge that they have attained from college to try and plan care for a patient. If the care plan is standardised, they will just use what is there for example, in a basic care plan there is nothing there about an orthopaedic patient. They will not go back and institute a care plan and think of one and make up one. And yet, on the care plan, the care plan is designed for that, so that they can add to it. You can do an individual care plan.' [RN06S14]

'Yes, either because they are pushed for time or they don't have the knowledge or because they are not getting good supervision from the registered nurse. Because the registered nurse is supposed to check the care plan and countersign it with students, and so it's also up to the registered nurse to supervise them and fill in the gaps and assist them where necessary, because it's problem solving you know, action plan and everything needs to be formulated.' [RN06S14]

'Some nurses, they are. But some they don't have the ability to do a care plan. They don't care, they just tick, tick, tick, tick and then leave it. They don't have the ability

to do a care plan, the importance of nursing care; they don't know what that is, or how important the nursing care plan is. Maybe we should emphasise to them the importance of the nursing care plan, because some nurses they don't care, they just tick, tick, tick. They don't even care if it's right or wrong, and then leave it like that. Even writing the entry, they don't go according to the care plan. When you are writing the report for the patient, you have to go according to the care plan.'

[RN11S01]

One participant voiced his/her concern regarding the use of the standardised care plans, as the practice spoilt the nurses and they did not see the need to formulate an individualised care plan. These nurses will never learn how to plan care for a patient.

'From what I've seen at the two different hospitals that I have worked at, hospital name has far more the set care plan and helps the nurse learn to structure a care plan but at the same time, it makes her lazy, so she doesn't really have that ability to plan and implement so whereas the other hospital I worked at, we did not have standardised care plans and it was far more difficult for me when I started there as a new sister, to start thinking in that way, so yes, I think nurses also have the ability but sometimes we are fed with a silver spoon, so it makes us lazy in that we don't use critical thinking skills.' **[RN16C09]**

'That's a difficult one, because you cannot say that only trained staff are more experienced to do it because not all are experienced, maybe it comes with experience as well as when you work in the ward. Some students... I think it depends entirely onto the individuals competence as well, because some students are quite capable of doing it and some trained staff as well, like RNs even ENs and then you get some that are not, it just depends on the individual.' **[RN03S04]**

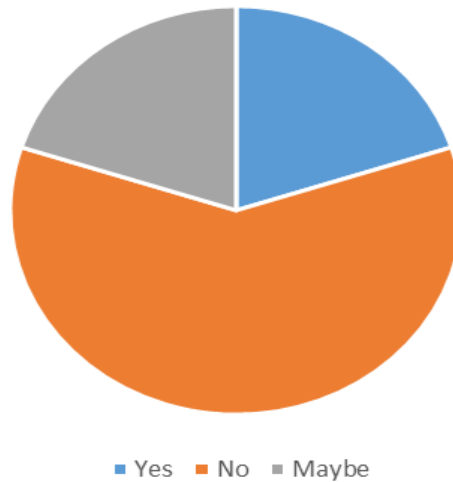


Figure 4.12: Summary of nurses' personal perceived ability to develop care plans

4.3.3.3 The Registered Nurse's role in Care Planning

The role of the registered nurse was understood by all the participants, in that the registered nurse was understood to be responsible for the total care of the patient, including assessment of the patient and formulating a care plan in line with the patient's health needs. It was also understood that, if other nurses did not understand the nursing process, it was the registered nurse's duty to teach and provide in-service training to fill the identified gaps. Some participants felt that the registered nurse already had a lot of work and that the other categories of staff should be more involved, with registered nurses merely supervising what they had done on the nursing process. Some registered nurses refused to commit themselves to certain tasks in the ward.

'My role as a registered nurse to just look at the patient from head to toe then develop the care plan according to the patient's needs, according to whatever nursing needs he may have. Also to teach other categories of staff how to actually do a care plan according to patient's needs. Also to find those gaps that are there and may be do in-service training and bring up whatever gaps are there to the Operational Manager, that I think there are gaps here and there, so that she can

take it to her supervisor. Maybe we can have an individualised care plan for that particular patient or patients that come in with the same problem.' [RN07S02]

'Sometimes these children don't understand and they are just here for their jobs and to do their allocations, you see. But the purpose of doing that they sometimes don't know, some of them don't know, so I think we do need in-service and also to teach them they are here to learn. But to do it in the ward when the patient is already there, I think we must start, and then sometimes if I'm doing it, I must call even maybe an ENA or a student, okay you said you know how to, because sometimes even maybe the OM doing the in-service in the morning, who knows how to draw care plan, no one knows now because, but every day they are doing it, you see. So if it was me, I was going to say "maybe". The RNs will say, "no, you giving us a lot of job", but if it was me I was going to say, we must do it as RNs and staff nurses, we must make sure that every day we check it, the nursing care plan is done properly.' [RN08M02]

'To make sure it is carried out, to make sure that if there are certain orders that are carried out, that it's done and to also update the care plan, to evaluate on that, well the whole nursing process, to see whether that care plan is... we need to check whether that care plan is being implemented to see, monitor, we need to see whether it is working and re-assess if we need to, I know I am not going in order.'
[RN10M03]

One participant said that it was the job of the registered nurse to ensure that all that had to be done for the patient was carried out accordingly and to supervise the junior staff, to identify the reasons why certain tasks are not carried out the way they should be. The registered nurse should also lead by example, by inviting junior staff to join him/her when he/she is performing certain duties, added another registered nurse.

'My role is to see that, if this care plan is done, it's to see that whatever plan we've got for the patient, I make sure that it is done. Whatever needs to be done for the

patient, it is done at the time it is supposed to be done. And if it's not done, to find out why was it not done, and to have a clue on what is going on with that particular patient, and the plan that was made for that patient. I think that's my responsibility.' [RN12S01]

'My personal role as sister, I think it's in-service training is very good in the ward, guidance of my juniors and my colleagues, so if I notice that something has not been done correctly, by just approaching that person, making them aware of how I would have done it and inviting staff to come with you for admission and to actually see how you are doing it, so I think that actual role play is very good, you know ja in-service training I think is an absolute must and must be done on a monthly basis because of staff rotation, sometimes a care plan in one unit will be very different to another unit and obviously from patient to patient its different as well, and it needs to be on-going and in-service and updates.' [RN16C09]

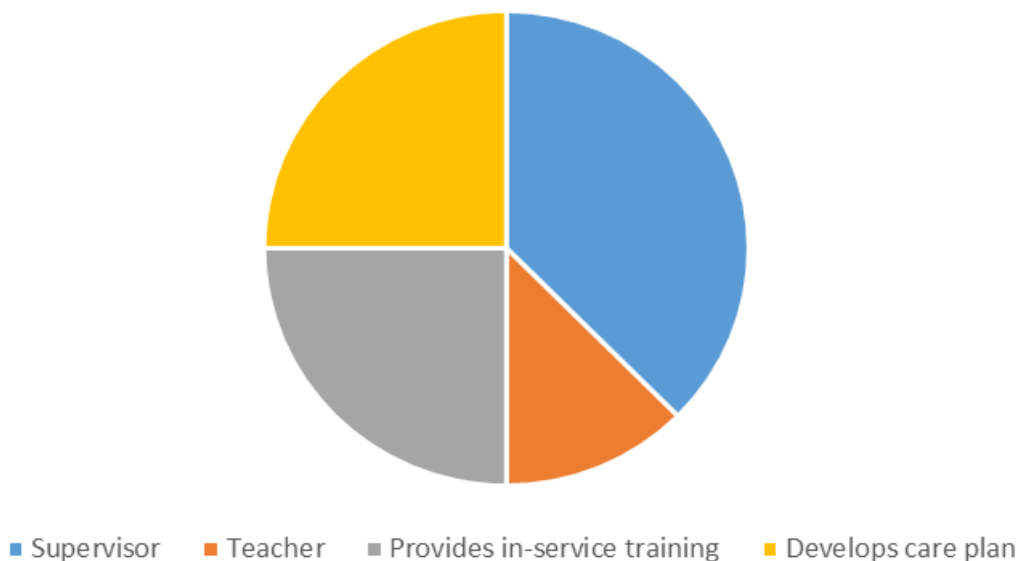


Figure 4.13: Summary of the registered nurses' perceived role

4.4 CONCLUSION

Both qualitative and quantitative results have been presented. In the presentation of the quantitative results, graphs were used to illustrate the deficiencies in the patient charts that were used in the study, and the semi-structured questions yielded valuable qualitative data that was coded according to the objectives of the study. Tables were derived from this information and preliminary overlaps between the qualitative and quantitative data sets were compared. The next chapter discusses these results in terms of their meaning and implications for the future use of nursing care plans in the South African context.

CHAPTER FIVE: DISCUSSION OF RESULTS

5.1 INTRODUCTION

The data that was presented in chapter four represents the use of the nursing care plan, the perceptions of the registered nurses working at the level 3 hospital where the study took place and the factors that impacted on the use of care plans. In this chapter the results will be discussed under the study objectives they answer. The quantitative aspect of the research will be discussed first, followed by the qualitative discussion and a comparison of both phases of the research designs. Conclusions will be drawn and limitations to the study, as well as recommendations, will be presented.

5.2 QUANTITATIVE RESEARCH DISCUSSION

The discussion is based on study objective 2.

5.2.1 ASSESSMENT

The conceptual framework of care planning strives towards ensuring that correct and complete information is captured for adequate planning for the patient.

The nursing history or presenting history refers to all the information that is relevant to the patient's current situation, i.e. all the factors that are relevant to his/her admission. The researcher found that this information was vague and incomplete in 11.4% of the charts that were reviewed. A comprehensive assessment gives the nurse a large variety of data about the patient's health status, assisting in decisions about the patient's care (Mamseri 2012:29). One of the common reasons for this was that the nurse documenting the information did not clarify the detail of some of the patient's information. By way of example, a presenting problem may read, "patient came in for angiogram". The patient may well have been booked for the procedure, but the nurse admitting the patient should have asked the patient why

he/she was booked for the procedure, so that the complete history of the patient could be captured. All the nurses who would ultimately be looking after such a patient would need to know what had happened to the patient to necessitate the booked procedure. According to Chabeli (2007:78), it is the phase where the nurse collects all-inclusive, applicable, valid, trustworthy and complete patient data from the patient and other dependable sources, in order to bring forth health problems, make a diagnosis and then plan, implement and evaluate the nursing care given. The importance of collecting accurate and complete data, is a requirement of The South African Nursing Council, as set out in the Scope of Practice. Information, such as has been described for illustrative purposes, is incomplete and may not allow the nurse to plan adequately. she might subsequently render inappropriate care to the patient. Kozier and Erb (2008:179) state that all phases of the nursing process rely on the complete and accurate collection of data during this phase.

Past history refers to any medical problems that the patient may have suffered from in the past. This information, too, is important, as the patient's present condition may have a link to his/her past history. In 95.5% of the charts past history was captured. Five percent of the charts had no information in this column, although it is unclear whether the nurse asked the question and did not get a response, whether she got a response and did not record it, or whether the question was not asked at all. Similarly, the surgical history refers to all the surgical procedures or operations that the patient has been subjected to in his/her life, up to the present day. Eight percent (8.2%) of the charts did not have a response recorded, either due to omission to ask relevant questions, or failure to record patient responses. This information is important, as it may be linked to the patient's present health problems.

The interview guide is a structured questionnaire that is used by the level 3 hospital in which the study took place and is used to collect data from the patient on admission. Often a standardised questionnaire, which may be part of the patients' admission, is used. This enables the nurse to establish a rapport with the patient and family and begin to plan the care with the patient (Geyer, Mogotlane and Young 2012:193). The questions within the interview guide are important for complete data capture. In 29.5% of charts, the researcher found the interview guide to be incomplete. This means that the data collected was, in consequence, also

incomplete. Such a questionnaire is useful as it is structured and is based on the patient's functioning, and, provided it is completed correctly, ensures that all relevant information is obtained. The chief complaint refers to the one (or small number of) sign/s or symptom/s that are the reason the patient came to hospital. Somewhat disconcertingly, 9.1% of the charts did not have this information recorded. In such cases, it was found that the nurse would record that the patient was booked for surgery, for instance, but without providing an indication of the actual presenting problem. The lack of such fundamental information would be said to make it very difficult for the other nursing staff to nurse the patient appropriately. According to Potter and Perry (2005:289), the nurse must ask the patient what made him/her come to the health facility and ask questions about the symptoms e.g. when did the symptom start and what is the location. The omission of such a basic requirement indicates omission at a fundamental level.

By contrast, the evidence of a physical examination was found in 96.8% of the charts, indicating that, even in the absence of certain important subjective data, objective data was almost always collected from the patient. Three percent (3.2%) of the charts did not have this information, possibly because the person completing the questionnaire was not the same as the person who had performed the physical examination, or it is not recorded because it was not done. These omissions are important, because records reflect the nurses' accountability and provide proof that nursing care was carried out (Pera and van Tonder 2012:105).

5.2.2 NURSING DIAGNOSIS

The nursing diagnosis is developed from the signs and symptoms of the patient and their relationship to their cause. This level 3 hospital uses standardised care plans, which means that nurses simply tick the appropriate sections, without reference to the patient's actual problems. Because the problems are insufficiently described, the nursing interventions would be unspecific. Muller-Staub et al. (2006:9) agrees with this finding, stating that the nursing problems are often not accurately formulated and can lead to inappropriate nursing interventions. The researcher sought to identify a record of the patients' signs and symptoms, their actual and potential problems and checked the areas that were ticked on the standardised care

plan, where these matched. The researcher did not find a nursing diagnosis on the care plan in 5.0% of the charts. Such a diagnosis would include the signs and symptoms with an attached aetiology or, in the case of standardised care plans, a tick against the matching problem. Accurate diagnosis facilitates individualised nursing care, enhances planning nursing interventions, promotes interdisciplinary communication and increases the nurse's autonomy and accountability. In the study hospital, there was found to be no individualised planning of care because of the use of standardised care plans. The nursing diagnosis becomes fundamental if the nurse is to plan the programme of nursing care from scratch, because the care plan is based on the nursing diagnosis. The importance of the nursing diagnosis is lost to nurses operating within a 'standardised' institutional culture, and the nurse would consequently not fully appreciate the pivotal importance of the nursing diagnosis and why it should be made. The conceptual model of care planning accepts that the quality of the diagnosis is dependent on the nurse's ability to assess the patient's health status and needs accurately, in order to diagnose the patient's needs. This is a thinking process, or critical thinking.

5.2.3 CARE PLAN

A care plan can be described as a written programme for an individual patient, highlighting the decision-making process, as found in the model of care planning. Ninety-nine percent (99.1%) of the charts had a care plan attached and only 0, 9% of charts did not have a care plan, but care was nevertheless rendered to the patients, as evidenced by the nursing records. The researcher allows for the possibility that the care plan had been lost during chart compilation, but regrets that, were this the reason, such a loss would render the patient chart incomplete in terms of the South African Nursing Council requirements. Should there in the future be a case regarding that particular chart, there is no evidence that the patient's problems were identified and planned for. It was also found that a care plan may have been found within the nursing documentation, but the appropriate areas of the care plan had not been ticked, indicating that care was not planned for, or the appropriate care plan was not done (in this case, not ticked). A care plan in the patient's records supports assessment, diagnosis, planning and delivery of patient care (Elf, Poutilova and Ohrn 2007).

Expected outcomes or patient goals are what the nurse hopes to achieve after implementation of the nursing interventions. The expected outcomes do not exist on the standardised care plans at the specific level 3 hospital. Expected outcomes may be viewed as the tools a nurse uses to measure the degree to which the outcomes have been achieved. According to Arries (2006:69), the nurse devises a suitable individualised plan of care that stipulates approaches and options to reach written expected outcomes and objectives. Without the expected outcomes it becomes difficult for the nurse to evaluate or measure the success or effectiveness of the interventions. The South African Nursing Council, in its Scope of Practice, states that the nurse must evaluate the nursing care that was delivered. The signature of a registered nurse on the care plan serves to indicate that the signing registered nurse has approved the care plan (another requirement by SANC). In 27.3% of the charts a registered nurse omitted to sign the care plan, as an indication of accountability for care rendered to the patient.

5.2.4 IMPLEMENTATION

The nursing records indicate that nursing interventions were carried out. The general view is that if there is no documentation to indicate that something was done, then it was not done. Within this view of documentary accountability, the documentation in 1.4% of charts indicated that no nursing activities had taken place. Saranto and Kinnunen (2008:473) reported that inadequate and inaccurate nursing documentation presents a risk to patient safety and well-being and to the continuity of care. They add that the accuracy of documentation content in relation to a patient's actual condition, and the care given, is an important process of documentation quality. Such an instance may occur if a patient were admitted for a procedure or was awaiting transport to the referral hospital, in which case the patient's health status does not require immediate nursing interventions. Where nursing activities are conducted, the patient's response to treatment, or her/his involvement or decisions in the plan of care to be rendered, is very important if the patient is to adhere to his programme of care. In 66.4% of charts there was some response from the patient, either stating that his/her condition was improving or articulating concerns or some other input towards his/her care. When care planning occurs, the patient participates in decision-making regarding his/her care, and

patients are happy to be part of this process, as it enhances holistic and individualised care (Bjorvell *et al.*, 2000). The data suggest that such engagement existed in two-thirds of sampled patient charts. The model of care planning includes that a deep understanding of the patient's health needs and shared decision-making between the nurse and patient is a requirement.

5.2.5 EVALUATION

Evaluation was found to be poorly conducted, with only 38.2% of charts indicating evaluation of nursing interventions. In order to evaluate the patients' care, the nurse must have the expected outcomes/patient goals as the benchmark, something that she/he will measure against. Jansson, Bahtsevani, Pilhammar-Andersson and Forsberg (2010:33) state that, in general, evaluation was rare and, when carried out, it was the staff's experience that was recorded. The level 3 hospital in which the study took place uses standardised care plans with no expected outcomes, making it difficult to follow through with evaluation and in consequence the evaluation of care did not seem to be a priority. In order for a nurse to know that the nursing interventions that were implemented were responsible for the patient's improvement, she/he must be able to link an outcome to an intervention. A statement that indicated a linking of improvement in a patient's condition to a specific nursing intervention was found in only 34.1% of charts.

As the patient's condition improves and his/her health problems are resolved the nurse should terminate the care plans that are no longer needed, or as the patient's condition changes, the care plan should be modified. At the level 3 hospital, only 2.7% of the care plans were not modified, indicating that the nurses were updating the care plans as the need arose. On discharge, or before the patient is discharged, it would be reasonable to assume that the patient's problems have been resolved or minimised. The care plan would then be terminated, as an indication that there is no further use for the care plan or the patient would continue the care at home. The Scope of Practice directs the registered nurse to assess the needs of her/his patient, develop a care plan for the patient, implement the planned nursing interventions and evaluate the results of care (Geyer, Mogothlane and Young 2009:55). The researcher found that 10.9% of care plans were not terminated.

5.3 QUALITATIVE RESEARCH DISCUSSION

The participants that were targeted for this study were registered nurses, because it is their responsibility to ensure that the patient under her/his care receives continuous, safe and high-quality care. In terms of the Nursing Act (Act 50 of 1978, as amended by Act 33 of 2005) the registered nurse in charge of the ward is fully accountable for all acts and omissions relative to patients under her/his care. A clearly-defined plan for the patient's intervention, evaluation and documentation is necessary. The aim was to determine the registered nurses level of understanding of the nursing process, determine the factors that impacted on the implementation of the nursing process and highlight the recommendations by the participants. The interviews of 15 registered nurses were included for qualitative data analysis.

The participants were asked to respond to seven open-ended questions, based on the nursing process. The questions were grouped together to answer objective 1) to determine the registered nurse's level of understanding of the nursing process, 3) to determine the factors that impact on the implementation of the nursing process and 4) the recommendations by registered nurses.

5.3.1 OBJECTIVE 1: THE REGISTERED NURSE'S LEVEL OF UNDERSTANDING OF THE NURSING PROCESS

In Figure 9 (see Section 4.3.1.1) it was illustrated that the five phases of the nursing process enjoyed varied levels of understanding among the nurses interviewed in this study.

The term 'nursing process' appeared to have a dual meaning for the registered nurses that were interviewed, as most, if not all of them, indicated that they would record all of the nursing activities carried out for the patient on the nursing process. The nursing process is a method that inspires orderly thought, analysis and planning of a patient's care (White 2010:4). This would indicate that the nursing process is regarded as a document. Literature, however, suggests that the nursing process is a framework (i.e. it is abstract), within which the nurse must function as set out in

the Scope of Practice. This process (as a framework of care) further ensures continuity and co-ordination of care by the nurses in charge of the patient's care (Geyer, Mogothlane and Young 2009). The nurses' understanding of the utility of the nursing process was not entirely aligned with the literature. The literature views the nursing process as the fundamental structure that provides order and direction to nursing care. It is "the lifeblood, the instrument and methodology of the nursing profession" (George 1995:1). This idealistic and philosophical view was not shared by interviewees. All the nurses were able to distinguish among the phases of the nursing process.

The importance of recording patient information, the nursing care rendered to the patient and, importantly, the patient's response to treatment was only mentioned by five participants. This is worrying, because the literature, and indeed nursing regulation, insists that recording is a crucial part of the nursing process and should be a part of any discussion pertaining to this process. As cited in the review of the literature Geyer, Mogothlane and Young (2009:192) have stated that recording is not a phase of the nursing process but is an integral part of each phase of the nursing process. Recording in nursing notes is the one way the nurse shows her/his accountability for the nursing action she/he has taken towards improving the patient's health status. Searle and Pera (1995:320) stress that the recording of treatment, observations and other relevant data constitutes a legal, formal record. It is very important that the nurse carries out this aspect of her/his duty with accuracy and diligence, because the patient trusts that the nurse will ensure his/her safety and protection through data contained in the written record. The nurse betrays the nurse-patient relationship when she/he does not record accurately or falsifies the record.

Five participants saw the nursing process as a way of ensuring continuity of care by the nurse. Dellefield (2006) stated that the written care plan was a means of promoting the continuity of care. By contrast, 10 participants did not indicate that one of the purposes of the nursing process was to ensure continuity of care. The various phases of the nursing process are written down on a nursing document and this is available to all nurses that are responsible for the patient's care, expressly as a means of ensuring that the patient receives continuous, consistent care from any

nurse at any time. It would appear that this actual reason for using the nursing process is not well understood by the majority of registered nurses.

Fourteen participants viewed assessment to be a crucial aspect of the nursing process, in order to ensure appropriate nursing care. Assessment ensures that there is data out of which the nurse is able to determine the nursing diagnosis and nursing interventions. The registered nurses were found to possess an understanding of the nursing process and its phases, understanding that the nursing process commences with the first phase, which is the assessment phase. According to the assessment of Kozier and Erb (2008:179), the first phase of the nursing process is seen as an ongoing process that entails collection, organisation, validation and documentation of data. They state that all phases of the nursing process rely on the complete and accurate collection of data during this phase. Intelligent judgement by the nurse is required in order for him/her to analyse the gathered information. The methods of collecting data from the patient mentioned by the participants were interviewing the patient (mentioned by 10 participants) and conducting a physical examination (mentioned by five participants). Observing the patient was alluded to by only one participant. It would appear, therefore, that registered nurses are most familiar with interviewing the patient, and, somewhat alarmingly, an important aspect of data collection, by way of observing the patient, was evidently not considered important enough to be mentioned routinely as one of the methods of data collection. The researcher considers the possibility that observing a patient may have become so routine to some nurses that it has become something that is practised, but was not mentioned in the interview because it is done so regularly and so routinely. If this is indeed, a probable explanation for the omission in the interview, it would seem at odds with the almost universal mention of interviewing the patient, which should be equally routine.

The physical examination of the patient was mentioned by only five participants. In many cases the doctor would do the physical examination from head-to-toe, and for this reason the nurse may not see her/his examining of a swollen ankle or distended abdomen as being important to mention. Data are collected from the patient using a combination of methods, such as observing the patient, by conducting an

interview with the patient and by performing a physical examination of the patient, ought to be seen as a continuous and systematic process of gathering information about the patient (Kozier and Erb 2008:179).

One participant noted that some staff failed to ask more specific questions about why a patient presented to the hospital, and appeared to be content with a minimal indication of some purpose. Valuable historical and current health information was often lost in such cases, and this contextual information would affect the understanding of the patient's needs and the nursing care that would subsequently be provided. Such a 'missed opportunity' ultimately affects accountability and has a negative impact on all subsequent phases of the nursing process, since these rely on complete and accurate assessment data (Kozier and Erb 2008:179). The observed omission to actively seek additional information, on the part of the nurse, and to focus only on what is immediately apparent, finds a parallel in the subsequent 'nursing diagnosis' phase, in which it was observed that, whilst actual problems were generally identified, there was a notable lack of identification of potential problems and related etiology.

The nursing diagnosis should not be confused with the medical diagnosis. The latter is based on specific evaluations of physical signs and symptoms and the results of diagnostic tests, while a nursing diagnosis is a clinical judgement about a patient's response to actual and potential problems (Potter and Perry 2005:33). When a nurse describes a nursing diagnosis (from assessment data), she/he should have holistic information on which such decisions can be based, so it may be true that sometimes the nurse may discover information about the patient that was not elicited by the doctor. The ability of the nurse to correctly assemble a diagnostic statement (nursing diagnosis), is an achievement that makes the nurse feel good about herself and subsequently enables her/him, with some independence, to choose nursing interventions that are appropriate to the patient. Within this context, a knowledge of care plans amongst nurses would improve the quality of care, as well as give nurses the confidence to converse with doctors regarding the patient's health status. Care plans could also be used as guidelines or standards of care (Lee and Chang 2004).

All the participants regarded the care plan as being very important in the delivery of nursing care and recognised the guidance it afforded nurses in their daily activities. The hospital at which the study was conducted uses only standardised care plans, in which the nurse ticks the appropriate sections and ignores those that are not applicable to the patient. Concern was expressed that some nurses do not seem to understand what it is that she is ticking, or why is it applicable to one patient and not another. If a nurse were to tick an incorrect section that did not pertain to the patient, would the patient then receive incorrect nursing care or would the nurse even use the care plan as a guide? The question the researcher would ask, that many researchers, indeed, have asked, is: 'Does the presence of a care plan indicate that nursing care was rendered accordingly?'

One of the concerns that interviewed registered nurses raised was the lack of emphasis on the importance of the care planning process. If the registered nurses and their teams in each department were tasked with developing care plans from scratch, would this change the perception that care plans are not important, and rather have them viewed as part of the routine to be followed? The researcher's deliberations on the questions led her to contend that this might well be true. Towards this end, it was observed, however, that nursing management plays a major role in supporting and ensuring adherence to policies and procedures in any institution, and that the support of nursing management is extremely important, because clear instructions from management regarding care planning and the roles the nurses play are necessary, for implementation to be effective (Jansson, Pilhammar and Forsberg, 2011:66). Well-informed and hands-on facilitators were also found to be important to the success of the implementation of individualised care plans.

The implementation phase is where the plan of care is put into action. This is what the nurses do in the wards, carrying out nursing actions that were planned in the previous phase. Five participants recognised that care plans ensured that quality nursing care was rendered to the patient. Hoffman (2008, cited in Mamseri 2012:31) states that the nursing care plans were tools in a sense that they organise data when the patient is admitted, improve the quality of patient care and form the basis

for patient discharge. The implementation phase has previously been identified as a very important phase, as this is the phase that allows for the plan that was developed in the previous phase to be put into action and to be evaluated in the next phase. If collection of data were carried out accurately and completely, it is very possible that a correct diagnostic statement would be reached, leading to appropriate planning for care and diligent implementation of care. In this way, quality nursing care would be able to be achieved. Ellenbecker and Shea, cited in Lee and Chang (2004:37), caution that, although nurses were performing quality nursing care, some were unable to put into writing the interventions they had performed for a patient. The question remains whether the presence of a care plan means that the care rendered was of high quality. How would one measure such care? Bott *et al.* (2007:87) conducted a study to determine care planning efficiency for nursing facilities in the United States of America (USA) and found that cost effective care planning and delivery that result in high quality care are difficult to establish and that there is no evidence that planned care is actually rendered. During the patient's stay in hospital, it is the registered nurses' responsibility to ensure that the patient receives the care he/she requires in order for his/her health status to improve. The registered nurse is required by law to reassess the patient throughout his/her hospitalisation and to make changes to the care plan in accordance with his/her health status. This will ensure that the patient receives the appropriate care. Six of the interviewed registered nurses felt that evaluation was important, while the remaining registered nurses evidently did not see a need for evaluation. The failure to appreciate the importance of evaluation is important to note, because evaluation that is done immediately after an intervention enables a nurse to make on-the-spot changes to the care plan and those evaluations done at longer intervals indicate the patient's progress towards an expected outcome (Geyer, Mogothlane and Young 2009:206). This failure to recognise the importance of evaluation (as a means of working actively towards an ultimate goal) may be seen to link to the observation, within the quantitative data, that nurses universally did not describe expected outcomes in their patient charts.

All five steps of the nursing process are equally important. The observation that many nurses have collected data, produced a nursing diagnosis, planned care and

put the care into action and then not evaluated that care in terms of outcome, suggests that a lot of work has been done without a clear indication of whether it had all been worthwhile or not. The evaluation phase helps the nurse and the patient to enjoy a sense of accomplishment, at best, or gives an indication during the patient's hospital stay that the interventions are not suitable, prompting the nurse to seek alternative interventions. If evaluation is not done, it means that the nurse is not aware of the patient's progress and the patient could be receiving inappropriate care. This may result in a longer hospital stay for the patient and increase the financial burden for the hospital. Within the context of the study, this omission is considered to carry the most impact.

5.3.2 OBJECTIVE 3: FACTORS WHICH IMPACT ON THE IMPLEMENTATION OF CARE PLANS

5.3.2.1 Workload

The workload in the ward was cited as one of the reasons that the nursing process was not implemented the way it should be. This included too much work for the registered nurse to complete, wards being busy and the wards being understaffed and subject to time constraints. According to Holdt and Murphy (2006:1), most of the doctors and nurses they interviewed in South African public hospitals believe that staff shortages and management failures compromise patient care. Nursing care plans represented an extra workload for the nurse and many nurses perceive nursing care plans as another chore within their busy workload schedule and thus devalued the care plans (McElroy *et al.*, cited in Lee and Chang, 2004). Workload contributes to the nurses being stressed and has a negative effect on nursing activities, as there is insufficient time to complete nursing duties, e.g. patient assessment, which then leads to incomplete and inaccurate nursing records. In some South African hospitals, the nurse-patient ratios are as high as 1:18, and in extreme conditions, can reach 1:44, which means that the nurse only has three minutes of every hour to care for each patient (Aiken *et al.* 2009). The South African nurse may have a heavy workload, but the nursing process, nevertheless, is a legal requirement by the South African Nursing Council. It is based on nursing theories

and practices taught in nursing schools as part of the curriculum, as it appears in the Scope of Practice of the South African Nursing Council, SANC (1991). The model of care planning which underpins the present study, indicates that the workload influences the registered nurse's ability to assess accurately, and that care planning is not properly structured, leading to inadequate care of the patient.

5.3.2.2 Bad Staff Attitudes

Bad staff attitudes were another reason why care plans were incorrectly implemented. Jooste, van der Vyfer and van Dyk (2010:95) are of the opinion that the use of the nursing process requires scientific knowledge, clinical problem-solving skills and positive attitudes towards the nursing process. It became apparent that some nurses did not see the importance of care plans and carried them out as a routine that had to be done and not as a requirement of the profession. Some nurses had an indifferent approach to nursing and the care plans, carrying out nursing duties and interventions on the care plan just because they had to be done. They sometimes had no understanding of the role and purpose of the plan, from a position of rendering care. Keenan *et al.* (2008:175) have stated that the negative attitudes of nurses towards record-keeping, by seeing nursing care plans as management requirements, did not help the cause of the care plans. This could be a dangerous standpoint, when a nurse does not understand the implications of not carrying out her duties meticulously and with diligence. The bad attitudes of nurses are apparent and evident in the number of complaints from the patients and the public. People are admitted into nursing courses without any vocational calling or commitment to the job at hand. In some case it would appear, to the researcher that the person is passing time, while waiting for something better to come along and in the meantime ill-treats patients who need care. These attitudes see patients being neglected and the possibility that serious harm could come to them. Many of these nurses refuse to take responsibility or to be accountable. The participants mentioned that there are some nurses who are enthusiastic about the care plan and want to learn and see it work. These nurses are eager to teach those who are willing to learn.

5.3.2.3 Lack of Understanding

A lack of understanding was the third reason for the problems encountered with the use of care plans. The participants stated that many nurses experienced many challenges with the use of care plans and one of them was that the nurse did not know what to do with the care plan. Kim and Park, cited in Saranto and Kinnunen (2008:473), believe that nurses do not have enough time for patient assessment and documentation, or knowledge concerning how and when to assess the status of the patient. According to the participants, the nurses did not know what to do or the correct way of doing it and the reason they provided for this was a lack of supervision from the registered nurse. It was felt that when a nurse showed a lack of understanding, it would be ideal if the registered nurse could take the opportunity to teach the nurse and strengthen her nursing team, but this does not happen. Is it because she is not sure herself? Dellefield (2006) pointed out that classes on critical thinking, care planning and integrating these into basic supervision and management behaviours would be useful. Lack of understanding due to the language barrier was cited by one of the participants, who stated that if English was not the registered nurse's home language, it could create misunderstanding when teaching the student. Only when the care plan was implemented would one realise that the nurse understood little of the teaching. Greenwood (1996:33) points out that knowledge of the nursing process and its application is a linked deficiency. Due to a lack of such an understanding, care becomes routine rather than patient-centred. The model of care planning shows that skilled professionals make more precise observations and assessments of the patient's health problems.

5.3.3 OBJECTIVE 4: RECOMMENDATIONS

The recommendations were discussed by the researcher and the registered nurses under the following headings.

5.3.3.1 The role of the Registered Nurse in Care Planning

The role of the registered nurse with regards to the nursing process was adequately captured by the participants, who stated that it was the responsibility of the registered nurse to ensure appropriate nursing care for all the patients in her charge. It was also clear that the participants understood that, although it is stated in the Scope of Practice that the registered nurse has this function, the registered nurse on her own cannot take care of all the patients. The registered nurse can delegate to other nursing staff and supervise them to ensure that the appropriate nursing care is delivered. If the registered nurse delegates duties to nursing staff in the ward, it must be done according to their level of training or expertise, to ensure that no harm comes to the patient. It is also the registered nurse's responsibility to teach junior nurses and support them when carrying out nursing work. This is what is expected from the registered nurse in the ward setting. Some participants voiced concerns about the number of tasks that the registered nurse was expected to shoulder and felt that some of these duties should be shared amongst the other staff. The South African Nursing Council states clearly that the registered nurse is the person responsible for nursing care of the patient. It is then up to her how effectively she delegates to ensure all the work in the ward is completed. One of the participants noted that some registered nurses refused to carry out certain tasks, such as supervising students, by refusing to counter-sign nursing documents for the students.

'People don't want to be responsible for something, you find that, OK that nurse did the nursing care plan in her way that she was taught, but only to find that I don't want to sign for her that it was done. So now when you checking or when audits are done the things are not signed, so when I asked the sister and she was busy and she could not do it. Only to see we don't want to commit ourselves to that thing like that because sometimes you think that, O I'm going to go to jail with her if she writes something wrong and the other thing about the nursing care plan is that sometimes you find the patient has been in the hospital for almost a month but the nursing care plan is the only nursing care plan that was done on the admission of the patient.'

[RN08M02]

5.3.3.2 Ability to Develop Care Plans

Figure 11 (see 4.3.1.7, above) represents the registered nurses perceived ability to develop care plans. A large portion of the pie-chart indicates 7 participants saying that nurses do not know how to develop care plans. Searle (2004:200) states that when a patient comes into the care of the registered nurse, (not any other personnel), she/he must plan for nursing care based on correct identification, meticulous history taking, careful physical examination, taking into account present treatment and medical diagnosis. In Dellefield (2006) it states that although care planning and the written care plan were believed to be effective clinical processes, they continued to be characterised as processes that working nurses did not use. Reasons for this included a lack of the development of care plans as taught in the curriculum very early in nurse training. If follow-up in the clinical area does not occur, the young nurse is unable to learn and retain these vital, critical-thinking- and creative skills that are required to successfully develop a care plan. The hospital in which the study took place uses standardised care plans. Some participants blamed the standardised care plan for nurses not being able to develop care plans. One participant argued that the standardised care plan made the nurses lazy and unable to develop critical thinking. Only three participants felt that nurses had the ability to develop care plan, while the other 3 participants stated that they could not say whether or not nurses had the ability to create care plans.

5.3.3.3 Use of Standardised Care Plans

The use of standardised care plans was seen by many of the participants as lacking, in some areas. The standardised care plan is, by definition, generic, meaning that all the patients that are admitted to this level 3 hospital will use the same care plan. The nurse will tick what is applicable to that patient and leave the rest. The nurse could make a mistake on the care plan and tick something completely irrelevant to that patient. This means that the patient will get inappropriate nursing care. Each patient comes to hospital with unique health needs; the patient may be a cardiac patient, but his/her health issues may be very different from the cardiac patient in the next bed. Participants verbalised that the use of the standardised care plan was

being taken for granted and it made the nurse dependent on it and prevented her/him from using her/his critical thinking skills to develop individualised care plans.

The standardised care plan is such that the nurse only ticks the appropriate sections of the care plan. This could make the nurse careless and lazy. The nurse may not be fully aware of the patient's problems and tick the sections just because it has to be done. The nurse would have had to assess the patient, diagnose the patient and then choose what applies to the patient. If she/he is confronted with a problem that does not appear on the care plan, is it possible that she/he will choose to ignore the problem or manipulate the problem to suit the care plan? Care planning, in this case, is neither holistic nor individualised. It was also noted that the registered nurses felt that the completing of care plans was laborious and time-consuming for the nurse. Participants also felt that the use of standardised care plans robbed the young (student) nurses of the opportunity to practise in the clinical area to develop individualised care plans, so that critical thinking was well developed by the time the student nurse became a registered nurse and she would be proficient in care plan development.

'Recently I have noticed that nurses have become too dependent on the care plan that is already been standardised in the hospital. They are not exercising their creative thinking, creative thinking powers and their theoretical nursing knowledge that they have attained from college to try and plan care for a patient.' [RN06S14]

One strength that was identified by the participants is that the standardised care plan gave the nurse some direction as to what had to be done and how it should be carried out. The care plan has been said to be an excellent teaching tool. It gives guidance to student nurses and new staff or those staff members not familiar with a section of nursing. It reminds the nurse to stay focused on the patients' health problems, leading to a better quality of care.

'Yes, the standard care plan. It is OK, for that care plan, because you know what to do; you know, at least it will remind you what to do, sometimes so that you don't forget how to deal with that patient. But I feel there are things that can be added,

although I cannot point it out now because for each patient there is a different thing.' [RN12S01]

5.4 COMPARISON OF RESULTS

It is evident in both qualitative and quantitative discussion that the nursing process, as a whole, is not fully understood by the registered nurses in the study hospital, as there are gaps in the framework that forms their professional guide. Although the participants indicated the importance of the nursing diagnosis, it does not exist on the nursing care plan, nor do the expected outcomes. Most nurses have not been exposed to planning, as this study hospital uses standardised care plans. The nurses may know what the components of the nursing process are, but they have not had the opportunity to actually formulate the nursing diagnosis and then select the appropriate nursing interventions based on it. When working with the nursing process, the nurse is encouraged to use her critical thinking skills to formulate the nursing diagnosis from the assessment data. The nursing diagnosis then guides her to establish the expected outcomes and to select appropriate nursing interventions.

The evaluation of patient charts indicated five notable deficiencies in the current implementation of the nursing process within the level 3 hospital which served as the site of this study, *viz.* incomplete interview guides, a widespread failure to identify potential health problems, a universal failure to record expected outcomes of proposed nursing interventions, a common failure to record the patient's response to implemented nursing interventions and a pervasive failure to evaluate nursing interventions and to link patient responses to specific nursing interventions, as a basis for modification of the nursing care plan. The incomplete interview guide and failure to identify potential problems indicate incomplete data collected during the assessment phase of the nursing process, which undermines the importance of the process, as well as losing sight of the holistic care that is required by the patient. Due to the use of the standardised care plans, the nurses are not familiar with the expected outcomes, which should form part of the care plan. These deficiencies in the standardised care plan robs the nurse of the opportunity to develop her creative

and critical thinking skills. For the nurse to ascertain if the care that was rendered to the patient helped to resolve the identified problems, she must evaluate the care, by checking if the problems still exist. Evaluation assists the nurse to make immediate decisions regarding the next step in the patient's care. Qualitative data derived from interviews provided a more nuanced elaboration of the factors and dynamics that are to be considered in the evaluation of the identified deficiencies in the implementation of nursing care plans.

Amongst these were the observation that nurses were notably less familiar with the 'implementation' and 'evaluation' phases of the nursing process, which may account for implementation being poorly recorded, and that the cycles of evaluation-modification-implementation that are inherent to the nursing process were therefore also poorly in evidence in the charts. The qualitative data further indicated that the failure to record changes in nursing actions arose, additionally, from a lack of understanding of the process, the relationship of ticked boxes to the patient's actual status and a range of workload and attitudinal factors. The institutional use of standardised care plans was seen to hamper the development of creative and critical thinking skill in nurses and to negatively impact on both the perception and use of nursing care plans.

5.5 CONCLUSION

This chapter focused on discussing the findings of the evaluation of the use of care plans in general practice at a level 3 hospital. The findings satisfied the objectives of the study, which were to evaluate the use of care plans, determine the level of understanding of the nursing process by the registered nurses and identify the factors that impacted on care planning. The study sought to conduct an evaluation of the use of nursing care plans in the South African context. A case study was undertaken to gain specific scientific knowledge on various aspects of the nursing process, by comparing data derived from a quantitative analysis of 220 patient charts from a level 3 hospital in the UMgungundlovu district of KwaZulu-Natal and the qualitative data derived from interviews with 15 registered nurses.

Although the results are not generalizable, the researcher has provided an insight into the current use of nursing care plans, the registered nurses' level of understanding of the various phases of the nursing process and the factors that impact negatively on the correct and appropriate uses of nursing care plans. The evaluation of the qualitative data derived from interviews of 15 registered nurses, working within the hospital, provided possible reasons for the observed deficiencies in the patient charts selected for evaluation. The qualitative data suggested that nurses are evidently less familiar with the 'implementation' and 'evaluation' phases of the nursing process; that the failure to record changes in nursing actions arose additionally from a lack of understanding of the process, the relationship of ticked boxes to the patient's actual status, and a range of workload and attitudinal factors. The institutional norm of using standardised care plans was seen to serve a purpose counter to holistic patient-centred care. Whilst being able to make a nursing diagnosis was generally seen to be a positive element of the registered nurse's tasks and responsibilities, it was noted that interviewees were more focused on diagnosis of the main complaint, as opposed to the identification and management of further potential problems. There was found to be an almost direct correlation between completion of interview guides and the identification of interview guides as a useful tool in the initial assessment of patients (60% of interviewees identified the tool as useful and 70.5% of charts contained complete interview guides). High workloads and a perceived bad attitude to nursing care plans were identified, and discussed, as obstacles to the effective implementation and use of nursing care plans.

In this study, the researcher found the combined use of objective patient chart data and qualitative interview data to be both useful and informative. The reference to both data sets facilitated the interpretation of both the deficiencies observed in charts (against the interviews) and provided a concrete reference (charts) to the ideas expressed in the interviews. In this respect it was critical that the charts were from the same 'source' as the nurses' interviews.

5.6 RECOMMENDATIONS

The following recommendations are made for future research into the utility of nursing care plans in the South African context and as a means of informing educators, nurses and nursing management on the current deficiencies in use and possible means of improving outcomes.

5.6.1 NURSING EDUCATION

1. Nursing education appears to be at the centre of the use of nursing care plans and they play an important role in preparing the students to intelligently and effectively use the nursing process. The participants have suggested that a lack of understanding of the nursing process, as a whole, contributed to many of the problems that were identified. Nursing educators could mitigate this by actively teaching the nursing process to all nursing staff, indicating what is expected of each category of staff regarding each phase of the process. Regular updates, in-service training and audits by senior personnel and nurse educators would help the staff stay focused on care planning.
2. Current nursing staff should be updated on the nursing process. Within such updates, it would be crucial to reinforce the importance of the phases of the nursing process, especially the nursing diagnoses, as it is the basis upon which nursing interventions are built. If the nursing diagnosis is incorrect, then the nursing care rendered to the patient would be inappropriate. The concept of the nursing diagnosis is to be presented as including not only the presenting complaint, but consideration of potential problems which have some relationship to the presenting complaint. It should be indicated to each category of staff what is expected of them regarding the nursing process. Guidance by nurse educators or clinical facilitators on writing a care plan, including the expected outcomes, must take centre stage.

5.6.2 NURSING MANAGEMENT

1. Although the purpose of the study was to address the use of the nursing care plan, and to establish recommendations conducive to effective and efficient care planning, there were important factors that affected the registered nurses' ability to conduct their work. The researcher therefore recommends that these factors be investigated and addressed by management.
2. Care planning policies regarding supervision and guidance of junior nurses by registered nurses should be regulated, monitored and supported by management. This practice will assist in two ways: firstly, the nursing records will be correct and complete and, secondly, the junior nurse will have been supervised to follow the correct procedure and will be inducted into how to apply the nursing process correctly, and by doing so critical thinking skills will be developed.
3. The employment of registered nurses who are motivated and knowledgeable about the care planning process and nursing documentation, and those who show enthusiasm in this area, to be utilised as role models in the wards, may facilitate this process.
4. Nursing management to encourage individualised care planning, as these care plans ensure that the patient receives appropriate nursing care, that his/her stay in hospital is shortened, that the hospital benefits financially, and the nurse develops, in the process of planning, effective care for the patient.

5.6.3 NURSING RESEARCH

The findings of this study are limited to this level 3 hospital, but further research on the use of the nursing care plans at another level 3 hospital, which services a smaller catchment area, has a relatively smaller nurse-patient ratio, and does not utilise standardised care plans may yield a different set of conclusions, and may

provide additional insight into the role and value of nursing care plans within the South African context.

5.7 STUDY LIMITATIONS

A limitation that was identified in this study was that many of the participants who were interviewed were past students of the researcher. It is possible that these participants responded to the questions in a way that the researcher would have wanted them to, or in a way they *should* be doing things and not the way things are being done. If this is true then the results would not be a true reflection of what is actually happening. A way of carrying out such a study in the future could be to possibly get a researcher who is not known to the participants.

Another point of concern is the report writing by the nurses. It cannot be stated categorically that what is reflected in the nursing records is what actually happened and perhaps the opposite is true. The nurses could have implemented, but failed to record what was done. While reading the report we do not find what we are looking for, but the patient was given the care that he/she required. Recording is the only way the nurse makes known what she has done for the patient, but there are times when nurses record having done something without performing the nursing care. There appears to be limited research in this area, especially in South Africa, but the meagre findings suggest that more care planning is needed in practice.

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APPENDIX A: Checklist for Nursing Process

| | YES | NO |
|---|-----|----|
| <u>ASSESSMENT</u> | | |
| 1) Is there : nursing history | | |
| - past history | | |
| - surgical history | | |
| 2) Is the interview guide complete? | | |
| Is the chief complaint included? | | |
| Is there evidence of physical examinations? | | |
| | | |
| <u>NURSING DIAGNOSIS</u> | | |
| 3) Are problems identified? | | |
| - actual | | |
| - potential | | |
| Is there a Nursing Diagnosis/Problem Statement? | | |
| | | |
| <u>PLANNING</u> | | |
| 4) Is there: nursing care plan? | | |
| - nursing diagnosis | | |
| - expected outcomes | | |
| - nursing actions | | |
| Is the care plan signed by the R/N? | | |
| | | |
| <u>IMPLEMENTATION</u> | | |
| 5) Is there evidence that nursing actions were implemented? | | |
| Is the patient's response recorded? | | |

| <u>EVALUATION</u> | | |
|--|--|--|
| 6) Was the care evaluated? | | |
| Is it linked to nursing interventions? | | |
| 7) was the care plan : modified? | | |
| - terminated | | |

APPENDIX B: Permission Letter to CEO: Grey's Hospital

25 Helena Road
Newholmes
Pietermaritzburg
3201

27 August 2012

Dr B. Bilenge
Greys Hospital
Town bush Road
Pietermaritzburg
3201

Re- Permission to conduct research at Greys Hospital

Sir

I am a Master's student, studying through DUT, Nursing Department. I obtained my B Cur (management and education) through North-West University. I am interested in conducting research at Greys Hospital. My topic is: Evaluating the use of the Nursing care plan in General Nursing Practice at a Level 3 Hospital in the UMgungundlovu District of KwaZulu-Natal.

The aim of the study is to evaluate the use of the nursing care plans in the management of patient care, to determine the extent to which Professional Nurses are familiar with the nursing process, to determine whether nursing care plans are being used according to the guidelines provided by the South African Nursing Council and to implement guidelines for improving the quality of nursing care at a level 3 hospital in the UMgungundlovu District of KwaZulu-Natal.

The study is to be carried out at Greys Hospital. Qualitative data will be collected during semi structured interviews with Professional Nurses. The nurses will remain anonymous. An advert will be placed at central points in the hospital, inviting Professional Nurses to participate in the study.

The quantitative aspect of the study will entail using patient charts. 200-250 charts will be photocopied and all identifying data will be removed. The photocopied charts and an itemised checklist will be used to determine whether the items relating to each phase of the nursing Process are in evidence with the chart. The Hospital will in no way be expected to incur any expenses relating to the research.

The proposal has been reviewed by DUT Department of Nursing and IREC. Permission has been requested from the Health Research and Knowledge Management Secretariat.

Attached please find my Research Proposal.

Written permission will be highly appreciated.

Yours Faithfully

P. Maharaj (Mrs)

**APPENDIX C: Permission Letter to Grey's Nursing Services
Manager**

25 Helena Road
Newholmes
Pietermaritzburg
3201

27 August 2012

Mrs Sosibo
Greys Hospital
Town bush Road
Pietermaritzburg
3201

Re- Permission to conduct research at Greys Hospital

Sir

I am a Master's student, studying through DUT, Nursing Department. I obtained my B Cur (management and education) through North-West University. I am interested in conducting research at Greys Hospital. My topic is: Evaluating the use of the Nursing care plan in General Nursing Practice at a Level 3 Hospital in the UMgungundlovu District of KwaZulu-Natal.

The aim of the study is to evaluate the use of the nursing care plans in the management of patient care and to implement guidelines for improving the quality of nursing care at a level 3 hospital in the UMgungundlovu District of KwaZulu-Natal.

The study is to be carried out at Greys Hospital. Qualitative data will be collected during semi structured interviews with Professional Nurses. The nurses will remain anonymous. The quantitative aspect of the study will entail using patient charts. An itemised checklist will be used to determine whether the items relating to each phase of the nursing Process are in evidence with the chart. The Hospital will in no way be expected to incur any expenses relating to the research.

The proposal has been reviewed by DUT Department of Nursing and IREC. Permission has been requested from the Health Research and Knowledge Management Secretariat.

Attached please find my Research Proposal.

Written permission will be highly appreciated.

Yours Faithfully

P. Maharaj (Mrs)

**APPENDIX D: Permission to conduct research in the
Department of Health**

25 Helena Road
Newholmes
Pietermaritzburg
3201

27 August 2012

Dr Elizabeth Lutge
Health Research and Knowledge Management Secretariat
Private Bag X9052
Pietermaritzburg
3201

Re- Permission to conduct research in the Department of Health

Madam

I am a Master's student, studying through DUT, Nursing Department. I obtained my B Cur (management and education) through North-West University. I am interested in conducting research in the Health Department. My topic is: Evaluating the use of the Nursing care plan in General Nursing Practice at a Level 3 Hospital in the UMgungundlovu District of KwaZulu-Natal.

The aim of the study is to evaluate the use of the nursing care plans in the management of patient care and to implement guidelines for improving the quality of nursing care at a level 3 hospital in the UMgungundlovu District of KwaZulu-Natal.

The study is to be carried out at Greys Hospital. Qualitative data will be collected during structured interviews with Professional Nurses. The nurses will remain anonymous. The quantitative aspect of the study will entail using patient charts. An itemised checklist will be used to determine whether the items relating to each phase of the nursing Process are in evidence with the chart. The Hospital will in no way be expected to incur any expenses relating to the research

The proposal has been reviewed by DUT Department of Nursing and IREC. Permission has been requested from the Greys Hospital CEO, Dr B Bilenge and nursing management

Attached please find my Research Proposal.

Written permission will be highly appreciated.

Yours Faithfully

P. Maharaj (Mrs)

APPENDIX E: Interview Question Guide

- 1) What do you understand by the nursing process?
- 2) Tell me about the data collection process during the assessment phase.
- 3) Of what importance is the nursing diagnosis to you?
- 4) Discuss the nurses' ability to develop care plans.
- 5) In your opinion whose responsibility is it to develop care plans – Why?
- 6) Describe your role in the development of care plans?
- 7) Is there anything you would like to share about your experience with care plans?

APPENDIX F: The interview schedule

| DAY | TIME | DEPARTMENT | REGISTERED NURSE INTERVIEWED | VENUE |
|---------------------------------|-------|------------|------------------------------|--------------------|
| Monday 07 October 2013 | 08:00 | C2 | RN01S01 | Urodynamic room |
| | 09:15 | G2 | RN02S03 | |
| | 10:30 | G1 | RN03S04 | |
| | 13:00 | G1 | RN04S02 | |
| | 14:00 | D1 | RN05M24 | |
| Tuesday 08 October 2013 | 07:30 | B2 | RN06S14 | Doctors room B2 |
| | 08:30 | C2 | RN07S02 | |
| | 09:45 | H2 | RN08M02 | |
| | 10:30 | G1 | RN09S10 | |
| | 11:30 | H2 | RN10M03 | |
| | 13:00 | G1 | RN11S01 | |
| Wednesday 09 October 2013 | 08:00 | C2 | RN12S01 | Doctors room B2 |
| | 10:15 | G2 | RN13S01 | |
| | 11:00 | B2 | RN14S07 | |
| | 12:30 | B2 | RN15S04 | |
| | 14:00 | Clinical | RN16C09 | |
| | 15:30 | B1 | RN17S01 | |

APPENDIX G: Information letter



INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC)

LETTER OF INFORMATION AND CONSENT

Title of the Research Study: Evaluating the use of the nursing care plans in General Nursing Practice at a Level 3 Hospital in the UMgungundlovu District of Kwa-Zulu Natal

Principle Investigator/s/researcher: Mrs Priscilla Maharaj

Co-Investigator/s/supervisor/s: Dr A Ross and Ms S Ngcobo

Brief Introduction and Purpose of the Study: In 2012, at a research Conference held at the Royal College of Nursing in London, It emerged that there is an urgent need for increased emphasis on developing nursing care plans in South Africa. In the clinical area it has also been found that there is a lack of care planning. Some researchers have pointed out that where care planning is not done, the quality of care is on the decline. All of the research has been conducted overseas, and not much has been said about the South African context. I would like to determine the extent of this phenomenon in South Africa. This study will benefit patients and the researcher anticipates that it will advance the understanding of the nursing process, shed light on controversy that may exist with respect to the planning of care in the South African context, and promote the delivery of quality health care

Outline of the Procedures: This case study is based on the Conceptual Model of Care Planning and the researcher will employ both qualitative and quantitative designs to collect data.

Quantitative data will be derived from patient charts of Greys Hospital by doing a retrospective review of charts, and then analysed using *SPSS® version 19* and descriptive stats in the form of tables and graphs will be displayed.

Qualitative data will be obtained from semi- structured interviews with Professional Nurses. These interviews will take place at lunch time or after work. Open ended questions will be asked about the Profession Nurses interpretation of the nursing process and their involvement in care plan development. Audio recorded interviews from a mobile device will be transcribed into written text using Nvivo 10 for analysis. The participant will remain anonymous, the participants names will not be used during the interviews. The recorded interviews on a mobile device will be kept in a steel lock up cupboard at the researcher's home and the keys kept by the researcher.

Risks or Discomforts to the Subject: I do not foresee any discomfort to the participants

Benefits: The research will help the patients as the quality of care may improve

Reason/s why the Subject May Be Withdrawn from the Study: I do not foresee any reason why the participant may be withdrawn

Remuneration: There will be no remuneration for the participants

Costs of the Study: The participant is not expected to cover any costs related to the study

Confidentiality: Confidentiality will be maintained

Research-related Injury: I do not foresee the occurrence of any injury that is related to the study

Persons to Contact in the Event of Any Problems or Queries:

Supervisor: Dr A Ross, 0824586440 or

Co-Supervisor: Ms S, Ngcobo, 0722346969

Statement of Agreement to Participate in the Research Study:

I..... (Subject's full name), ID number
..... have read this document in its entirety and
understand its contents. Where I have had any questions or queries, these have
been explained to me by to my satisfaction. Furthermore,
I fully understand that I may withdraw from this study at any stage without any
adverse consequences and my future health care will not be compromised. I,
therefore, voluntarily agree to participate in this study.

Subject's name (print)

Subject's signature:

Date:

Researcher's name (print)

Researcher's signature:

Date:

Witness name (print)

Witness signature:

Date:

APPENDIX H: Transcript

RN06S14

Researcher: What do you understand by the nursing process?

RN06S14: well, the nursing process, err... is err... my assessment of the patient, it's my planning stage, assessment, planning, evaluation and recording as we were taught. But err.. Ok. So on admission, we use the nursing process to ascertain our nursing diagnosis by questioning patients, so there our assessment comes in. we plan nursing care for the ward and for the admission period that they are in the ward and off course its reassessed everyday and everytime the condition changes, so that patients are nursed appropriately and nursed according to policy in the department and procedures are carried out accordingly. Our nursing process is done on admission and we record everytime a patients condition changes, or they leave the department etc. and off course we review it at every opportunity and every time a patients condition warrants.

Researcher: thank you, ok tell me about the data collection process during the assessment phase.

RN06S14: ok on admission we ascertain the patients name, the diagnosis, we have to know what level hospital or clinic they are coming from, their personal details, like phone numbers, family err... contact details because lots of patients are referred from outlying clinics and they don't have contact details for them. So hence when the patient's condition changes or demises, theres no family contacts to, so that's the personal details. As far as medical details err... we ascertain their allergies, err... the medication that they are on, health, medical and surgical history and current problems. We assess their pain levels on admission, vital signs are done err... , all vital signs, height weight, oxygen saturation. I don't know how far you want me to go.

Researcher: it's up to you, if that is it...

RN06S14: what was the question again?

Researcher: I said tell me about the data collection process during the assessment phase.

RN06S14: ja, I think that's about it, its getting the personal, medical details.

Researcher: of what importance is the nursing diagnosis to you?

RN06S14: It's important as nurses that we understand err... the diagnosis from a nursing perspective. Very often we have a nursing diagnosis, we have a doctor's diagnosis, and we have a post op diagnosis. The diagnosis changes all the time, so as nurses we are taught how to assess patients and diagnose them and this is where we exercise our err.. our err... interdependent role in the health care team to diagnose patients, and ja it empowers the nurse also to say wow, I can diagnose a patient from my assessment and off course its done in correlation with you, you have got the doctors diagnosis to check, you have got err... X-Rays, diagnostic tests, whatever you need, you got as a nurse. As an orthopaedic nurse you can also diagnose problems from the nursing point of view, looking at X-Rays, MRIs etc,

Researcher: Can you discuss the nurse's ability to develop care plans.

RN06S14: recently I have noticed that nurses have become too dependant on the care plan that is already been standardised in the hospital. Err... they are not exercising their creative thinking,

creative thinking powers and their theoretical nursing knowledge that they have attained from college to try and plan care for a patient. If the care plan is standardised, they will just use what is there for eg in a basic care plan there is nothing there about an orthopaedic patient. They will not go back and institute a care plan and think of one and make up one and yet on the care plan, the care plan is designed for that, so that they can add to it. You can do an individual care plan.

Researcher: so you are saying that the actual planning is lacking?

RN06S14: yes, either because they are pushed for time or they don't have the knowledge or because they are not getting good supervision from the registered nurse, because the registered nurse is supposed to check the care plan and counter sign it with students and so it also up to the registered nurse to supervise them and fill in the gaps and assist them where necessary, because its problem solving you know, action plan and everything needs to be formulated.

Researcher: ok in your opinion whose responsibility is it to develop these care plans and why?

RN06S14: I think it's the individual department err... solely from the fact that err... each department is individualised , care is individualised and with specialised departments like ICU, orthopaedics, paediatrics, each specialist know their area well and should develop their own level of care for their patients and own expectations.

Researcher: so you are talking about a group of people who need to be nursed with similar problems, the department with their specialised expertise get together and formulate a care plan? What about the individual patients?

RN06S14: That will be the registered nurse on duty, who is supervising the students doing admission because they are training them to do admissions, and to assess, care planning and correlate their theory with practice, and this is the area that they need to exercise what they have learnt, so it is the nurses responsibility whose is doing the admission and the registered nurse who counter signs, who is checking, who is motivating , correcting the student and other members of staff, eg the staff nurses, who have not done admissions for a long time, and feel its a student nurses job, it's a junior responsibility and they tend to sit back and also miss out on opportunities to look and diagnose and check patients.

Researcher: ok describe your role in the development of care plans.

RN06S14: Generally we try and form a committee like (Ward and ward), have got a committee going for the orthopaedics. We felt that we had to try and individualise the care plan as I explained earlier for a simple fact that we know what to expect err... From our patients and we know what hazardous conditions to look out for, potential problems because this is lacking in the initial orthopaedic care plan which was designed by the nursing committee. So I felt we needed to individualise it although, it is standard for all patients in the ward, its individualised to orthopaedics, and off course there is blank spaces, so that you can add on because the patient may come in with with other issues, comorbidities, that we add on because all patients are now high risk, coming from other level hospitals, so it's a lot of other issues and comorbidities.

Researcher: Is there anything else that you would like to share about your experiences with care plans, it can be positive, negative, anything.

RN06S14: MMmm... err... I find it difficult to motivate people to write care plans, because they feel that it is a laborious process and time consuming and also people that do not have the creative

thinking power and don't see things from a holistic point of view , have difficulties developing care plans and also the language barrier comes in because sometimes, you may explain something, and they yes they understand, but when they put it on paper, and they are writing it, then you see that this person did not catch a wing of what I said. Err... and also some nurses have a kind of laxidaisical attitude towards care plans, they don't see how important it is from a nursing point of view, to assess the patient and they don't see it as empowering themselves, they just see it as something that just got to be done, like its just routine, do the care plan and finish.

Researcher: Having said that about staff attitude towards the care plan, it is a SANC requirement and it the framework within which we work, so why should we be motivating people to do what is required of them?

RN06S14: ja I guess so mm... That's about it.

Researcher: anything that is positive from you?

RN06S14: mm... There are those nurses that are interested, they are empowered, they mm... Much more mm... Sorry I cannot think of the word today, words don't want to come ummm... they are more enthusiastic, they are more willing to teach and pass on information to others, because from that nursing process comes health education and if you don't know yourself how to plan care and how to empower patients, how do you teach them when they are going home and health education is going back to grassroots level. We have to teach patients how to care for themselves in the community and especially orthopaedic patients go home with pins and external fixators and they need to know about infection and pin track care and all that. So If nurses are willing to learn and they are a bit more aflare with their theoretical knowledge then we are able to empower patients and we make better nurses, more rounded personalities shall I say and wanting to learn to improve care.