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**THEME: The IT – EHR Challenge**

**Representing Nursing Practice using ICNP®**

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**Abstract**

The International Classification for Nursing Practice® is a terminology and classification system developed by the International Council of Nurses to communicate nursing practice. This tool represents three specific areas of nursing practice: nursing phenomena or diagnoses, nursing actions, and nursing outcomes. The Canadian Nurses Association has endorsed the use of the International Classification for Nursing Practice® to communicate nursing data in Canada.

Implementation of this assessment tool was a significant change in practice. For most clinicians this assessment was also the first introduction to an electronic client record and to charting at point of care. Numerous barriers exist which challenge the adoption of the tool into clinical practice. Capitalizing on our health authority's ability to extract assessment data, an opportunity was created to initiate site-specific sharing of aggregate RAI-HC data and open dialogue regarding use and meaning of RAI outputs in clinical practice. This team approach supports integration and promotes data quality by empowering clinicians to use RAI data in clinical decision-making. The presentation will detail this innovative decision support strategy used to instill confidence in the tool by increasing relevance, utility and ownership of the information. Feedback received, lessons learned, processes developed, and next steps regarding ongoing support for integration will also be shared.

**Introduction**

This paper reports on Canadian research that explored the use of the International Classification for Nursing Practice® Beta 2 version to reflect nursing practice across multiple practice domains.

Many nurses believe that nursing, as a professional discipline, is invisible with regard to formal recognition in the health care system, and a central role in health care decision-making (Hannah, Ball, & Edwards, 2006; Weyrauch, 2002; CNA, 2000; Clark & Lang, 1992). Sidani, Doran, & Mitchell (2004) observe that increasing calls for accountability in the health care system have reinvigorated calls for investigations into nursing contributions. Hannah, Ball, & Edwards (2006) note that nurses' contributions to health care are not recorded in institutional or national databases representing essential elements of care provision. As a consequence, they argue that nurses lack a position of political agency or authority from which to exert control over their own nursing practice and influence systemic health care decision-making. Clark & Lang (1992, p. 109), noted that "if we cannot name it, we cannot control it, finance it, teach it, research it, or out it into public policy." This perspective, expressed by Clark & Lang, and other NI leaders (such as CNA, 2006; Hannah, 2005; CNA, 2000; Graves & Corcoran, 1989; Werley, 1988, etc.) is based on the acknowledgement that in order to give nursing visibility, the profession requires a standardized language to reflect what nursing is and what

nursing does. The absence of universal methods, data elements, or language to document nursing data is cited as one reason for the exclusion of nursing contributions from data summaries and a key antecedent to nursing invisibility (Hannah et al., 2006; White et al., 2005; Giovannetti, et al., 1999). Clark (1999, p. 42) advocated for a standardized nursing language using the argument that “without a language to express our concepts we cannot know whether our understanding of their meaning is the same, so we cannot communicate them with any precision to other people”.

At the 19th Quadrennial Conference in Seoul Korea, the International Council of Nurses passed a resolution to develop a unified nursing language to represent nursing practice (ICN, 2005). According to ICN (2005, p.19), ICNP® provides “a terminology for nursing practice that serves as unifying framework” to describe nursing practice and into which other nursing vocabularies and classifications can be cross-mapped. This proposed standardized representation is intended to enable comparison of nursing data across diverse practice and geographical settings. With a focus on nursing phenomena (assessments), nursing actions, and nursing outcomes, the ICNP® Beta 2 version was constructed as a multi-axial, combinatorial terminology which is used to create a statement about each nursing element in the classification system (ICN, 2001). CNA (2000) supports ICNP® as the foundational classification system for Canadian nursing.

Records from acute care, mental health, home-based care, and long term care were obtained using purposive sampling in eastern Canada. A retrospective qualitative analysis of nursing records was conducted on five random excerpts from each patient record. The nursing data was then abstracted to reflect Nursing Phenomenon, Nursing Actions, and Nursing Outcomes, resulting in 1500 data elements for analysis. The data elements were subjected to a matching process for terms in ICNP® that reflected these categories. The matching process involved identifying exact matches, conceptual matches, no match available, and no match due to insufficient data.

Overall, ICNP® performed well, matching the majority of terms in all four practice domains. Nursing documentation did not conform to ICNP® statement protocols in any nursing record, and records were coded using data available in each excerpt. The majority of Nursing Phenomenon (diagnoses) and Nursing Actions were abstracted and successfully coded, with the exception of Home-based Care. In this instance, almost 46% of excerpts contained no nursing assessments (Kennedy, 2005). Nursing Actions were also well represented by ICNP®, with the exception of Mental Health, where 36% of excerpts contained no record of nursing actions. Finally, Nursing Outcomes were a significant obstacle, as the domains of Acute Care, Mental Health, and Long Term Care failed to document outcomes in 70-78% of excerpts (Kennedy, 2005). The Home Care domain recorded ICNP® matches for almost 50% of excerpts but failed to record outcomes in approximately 20% of excerpts. ICNP® did not match 32% of outcomes recorded in the Home Care domain – which was the highest level of match failure in any category and for any domain. Instances of match failure tended to be recurrent among the excerpts, and included such examples as “stable”, “comfortable”, and “discharged from service” (Kennedy, 2005).

In considering the implications of using ICNP® to represent professional nursing practice, it is imperative to situate the analysis in the context of current trends in healthcare information management. Nursing data is not being recorded in hospital discharge reports, or provincial or national data repositories. However, as Hannah (2005, p. 49) notes, it is “essential in Canada that the nursing data elements constitute one component of a fully integrated health information”. ICNP® clearly performs very well in the presence of adequate data (Kennedy & Hannah, 2007). The question, then, becomes “What can be done to improve documentation to consistently include nursing outcomes?”

It is imperative that nurses recognize the necessity of document their nursing practice fully and completely. The value and necessity of nursing documentation is a matter for education – both basic nursing curricula and continuing education options. Not a matter exclusively for educators, education and policy can be a matter for continuing quality committees or nursing practice committees in health care agencies.

Additionally, nurses need to be involved, actively and intimately, with the design of health information systems, and how such systems are constructed to record nursing data. Nurses involved in the design and development of information systems are able to lobby for the inclusion of nursing data (such as Health Information: Nursing Components). Further, new approaches to stimulate complete documentation may require consideration. One such option that may contribute to greater consistency in documenting nursing outcomes is the use of prompters, such as those in clinical decision support tools. There is still room to debate inclusion of such tools and opportunity to initiate innovative solutions to ensuring nursing data is represented fully and effectively.

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