# Coordinating Care: The Literate Activity Systems of Hospital Nursing

Annie Hackett and
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Nurses serve a very important role in any hospital, providing much of the day-to-day patient care and coordinating between other service providers. With lives on the line, thorough documentation is critical. In this interview, Annie Hackett and David Giovagnoli discuss the complex literate activity system within the field of nursing with Alex O'Brien, a Registered Nurse at Carle Foundation Hospital in Urbana, IL.

**ANNIE:** Can you please start by introducing yourself and explaining what you do?

**ALEX:** I'm Alex O'Brien and I'm a Registered Nurse (RN) on a Neurology Unit with Carle Foundation Hospital in Champaign-Urbana.

**ANNIE:** Cool, and you're alum from Illinois State, right?

**ALEX:** Yeah, I got my BSN from Mennonite College of Nursing.

**ANNIE:** Oh, awesome. When was that, how recent?

**ALEX:** I graduated in August 2015.

**ANNIE:** Oh, wow.

**ALEX:** I've only been a nurse for about eight or nine months now. The unit I'm on is actually a brand new unit at Carle, too. So I'm a new nurse, on a new unit, and I'm new to the hospital.

**ANNIE:** Wow, that's really cool.

**ALEX:** Yeah, it's been an exciting transition.

**ANNIE:** Yeah, it seems like it. We'll just start by asking you about any kinds of writing you might do as part of your work as an RN. This doesn't just have to be writing that you physically do on a piece of paper, but it could be any visual or written ways that you communicate with patients, other people on your staff, anything like that.

**ALEX:** I think the bulk of my writing comes with assessments and care plans. Documentation with health care is really important, so you have to be thorough. We do what are called "head-to-toe" assessments, which involves assessing and documenting everything subjective and objective observed with your patient and making sure it is reflected accurately in the patient's chart. In addition to medication documentation, the nurse is also responsible for developing nursing care plans and providing patient education. Care plans establish nursing diagnoses and are useful when it comes to deciding the interventions that will help patients meet their health goals. We update them as we go so everyone is on the same page. We also document all the education we provide, which can be about any health topic, such as fall prevention, medications, and specific medical diagnoses. With these tools, we can help patients engage with their plan of care and understand the rationales for why the care team does what they do.

There are a lot of other communication avenues we use to keep everyone updated. Many people are involved with any given patient, and it's a whole multidisciplinary team that's working to help them get better. We have message boards in the rooms, all sorts of signage on walls, the patients' wrists, on medications, and on medical devices. We have a hospital-wide paging system, so we can text whoever we need. There is endless paperwork, such as consents, discharge orders, and transport forms. And there are just as many verbal avenues used for communication—it's pretty involved. And each discipline, whether it's nursing, doctors, speech therapy, physical therapy, etc., will add their own notes as they go, so the completed picture is well-rounded.

**ANNIE:** So there's multiple people that all contribute to one document, for lack of a better term?

**ALEX:** Exactly. It's a patient summary. There are tons and tons of notes you have to know how to navigate. Everyone can contribute, and each discipline is very specialized. It's nice being the nurse because I get to be a coordinator amongst them. I'm the one who's there with the patient all day. If a therapy service has a question or they want to see my patient, they call me, and I give them updates. You have to be concise, and you have to know how to convey what you're seeing and what the patient is going through. That way, everyone will understand and adjust the plan of care appropriately.

**ANNIE:** Interesting. So you were talking a little bit about being able to navigate that. Did you learn that while you were in school or is it more that you've just been learning as you're going?

**ALEX:** It's a little bit of both. School is a different kind of formal setting. It's also a generalized approach, whereas the unit I'm on is specialized. My instructors at the Mennonite College of Nursing wanted students to know how to put all the aspects of patient care into a chart. It's important not to leave out any pieces to the puzzle. In nursing school you learn assessment tools to help you remember what to look for. For example there's "OLD CART," which means onset, location, duration, characteristics, aggravating factors, relieving factors, and treatment. It's a goofy mnemonic used to produce a complete pain assessment and plan of care. However, in the hospital setting, we have a chart that will prompt all these questions and more. So the real world has systems in place that make every assessment standardized and reproducible. The system Carle uses is called Epic, but different hospitals use many different kinds of software to accomplish the same goal. Nursing school teaches you how to survive if you have nothing to tell you what to look for or what to do. So it's nice when you get out in the real world, because you have more communication resources available to you. Nursing school teaches the basics and the rules, and then you adapt that to the structure of whatever organization you end up working for. Every hospital will do things differently, so the beauty of nursing school is that it helps you understand what's going on regardless of the subtle differences between care facilities.

**ANNIE:** How much of that training did you have to go through?

**ALEX:** Well, a lot. I graduated in August, and I started as a health care tech before I passed my NCLEX. I spent two or three months doing that while I prepared. After I passed my boards, then I went into a three or so month period of on-the-job training. That involved working with nurse preceptors who show you the ropes. They help you hone your skills, perfect your charting, and help you organize your mind so that you are less likely to leave anything out. It's an intense process because you essentially make decisions that may or may not harm somebody else, so you have to know what you're doing. And the truth is, we are all still learning. Even seasoned nurses learn something new every day.

**ANNIE:** Did you have any moments when you had a big realization about why you were writing a certain way for a patient, to another nurse, to a doctor, or anything?

**ALEX:** I would say I've had many. I can't think of, "on this day, at this time," but I have had moments like that especially when shift reporting, which is a transfer of care where a nurse hands off a patient to me or I'm handing one

off to someone else. During reporting you get a thorough and quick rundown of everything that patient is going through: their diagnoses, their history, their allergies, if they have an IV, their diet, and their activity. It's a whole patient picture. Reporting can be strenuous. I feel like when I started, I was writing as fast as I could, my hand was cramping, my writing just turned to chicken scratch, and I couldn't even read what I wrote. But eventually I got to a place where I can remember feeling like, "I've got this." When I started it was so stressful and crazy, and now I'm sitting there like, "Uh-huh, go faster" because I can keep up. You learn your own shorthand, and everything that you're hearing about your patient makes sense, especially with diagnoses and treatments, you're like, "Yes, I know exactly what to look for now." So I think new nurses don't really see themselves being on their own, doing it. They're like, "How am I ever going to get to that place where I'm comfortable?" and then eight or so months later when you're doing it on your own, you're just like, "I'm still not entirely comfortable, but I can do it." So there's a sense of self pride. Another thing that was kind of an epiphany for me was that no matter what I'm looking at, whether it is discharge information, or a doctor's note, or my own report sheet, each one is written differently and uses different vernacular, and each one can be interpreted in different ways. If I know a patient is going to see what I'm working on, I need to put it in a way that they will understand. So you just have to adapt to your audience all the time, whereas sometimes I'll read what a doctor has written, and it'll be totally over my head. It's interesting, I think, to see how I change depending on what I'm working on and who I'm working for.

**DAVID:** It seems like you're under a lot more pressure to be comprehensible more than people above you in the hierarchy are.

**ALEX:** Well, sometimes I do feel that way. I guess I won't speak for doctors because I know that they are extremely stressed and go through a lot, but I've had it happen many times where a doctor will come in and explain something and then walk out and then the patient will say something, and I can tell that they just don't get it. They don't understand what they were just told. So I have to either get the doctor to come back and redo the situation or do my best, if I understand the situation enough, to put it down. They teach us in school that everything we teach others needs to be at around a fifth-grade reading level.

**ANNIE:** Translating to normal-people speak?

**ALEX:** Yeah, you have to translate it. I work on a neurology unit so I deal with a lot of strokes and central and peripheral neurovascular issues, but sometimes, even with my understanding of basic anatomy, if you cut open a brain in front of me and told me to point to a certain area, I wouldn't

necessarily know where to go. But I have a general idea mostly of what they're talking about. So I understand both sides of it.

**ANNIE:** What kinds of tools do you use to communicate?

**ALEX:** Well, everything is technology driven. That's the way things are, and it helps with speed. I can put something in the Epic system, and then everyone can see it. It organizes things well for the care team, so that system is the primary mode of communication. Each nurse gets their own phone, we receive and send a lot of e-mails, there are tons of different message boards throughout patient rooms, and throughout the unit, so information is always readily available. If I need to call somebody, if there's an emergency, I can look up pretty much anywhere and see what number I need, and I can call it right there. Physical therapy or something will come in and work with my patient, and as the day goes on, they will update the board. They use different colored markers. I know purple is physical therapy, and they've been in here, this is what they did. Same with speech. There's all types of notices that they post like: swallow precautions over patients' beds—everything from fall risk signs to do-not-resuscitate wristbands. Hospital identifiers are some of the biggest things. Always double-checking to make sure that what you're doing is being done to the right person in the right way at the right time; it's all about safety. There are tons of alerts and it's overwhelming at first, but you get an eye for it. It's constant communication, I would say. Whether it's written or verbal, it seems like a lot but you get used to the information overload, and you learn to appreciate the resources.

**DAVID:** So you mentioned the shift change reports when you're talking with another nurse about what these patients' deals are and you mentioned shorthand. Can you talk a little bit about your system? Do you have a notebook that you keep these things in?

**ALEX:** Well, it's really nice because Carle has made up a ton of different report sheets that are all formatted differently, so each nurse, depending on how they operate, can choose whatever works for them, or you can even make your own. In terms of shorthand, it comes from my experience, not just with nursing school, but from my academic process of learning shorthand when you take notes in a class—that's what I've used for years, that's just what I use. If I was going to write a note or something in a patient's chart, I have to cut out all of that and use only what I know is accepted by the American Medical Association (AMA) or whatever people will understand across the board, no matter what institution they go to. I will say that there are times where doctors will use shorthand and I won't know what it means, so sometimes things can get blurred. A lot of speed and accuracy depends on being able to be quick. You have to keep going, so you can't get hung up on getting everything spelled

out. Shorthand is big in the hospital, and everyone makes it their own and follows the rules as much as they can. Nursing school helped with this because it teaches the rules so you can then break them responsibly.

**ANNIE:** Are there any terms or phrases that are uniform within your hospital that you use with each other that everyone knows what it means?

**ALEX:** Oh, yeah. I could read a line that says, "VSS, NPO, DNR" and know that it's "vital signs stable, nothing by mouth, do not resuscitate." Those are just a handful of examples that really everyone in every facility should know.

**ANNIE:** Besides the AMA, are there any other outside influences that control the way you write while you're at work?

**ALEX:** Yeah, there are a lot of regulatory bodies within the health care profession. I mean there's the American Nurses Association, American Medical Association, regulatory bodies that deal with health research and quality assurance. There's the Joint Commission, the DNV—they actually just came and visited us—and they're all accrediting bodies that make sure we are doing what we need to be doing. Carle is what's called a Magnet hospital, which means that there are certain qualities Carle has that makes it act like a "magnet" so that it attracts workers and patients. Reimbursement for insurance also depends on the reports of many of these accrediting bodies. Carle is working to become a Comprehensive Stroke Center. Right now we're a Primary Stroke Center, and there is an accrediting body we're working with to show that we have all the capabilities to do what we say we can do. If we can't show our ability to provide that level of care each year or so, we will lose that accreditation. Quality in what we do for our patients is really the driving force behind that. There are many other organizations that govern what we do. There's OSHA (Occupational Safety and Health Administration), the CDC (Center for Disease Control), Medicare, Medicaid—all of that deals with everything from public health to personal health. It's a very complex network, and it requires a lot of communication to keep everyone up to date.

**ANNIE:** The organizations you were just talking about seem more like umbrella "this applies to everyone all the time" type situations. Are there certain things that are specific to your facility, or is it mostly just that?

**ALEX:** Well, a lot of them are umbrella organizations, and they kind of have to be because, ideally, someone should be able to go to a hospital anywhere in our country or another country even and receive the same quality of care. Now that's not a reality; that just doesn't happen. Not every facility can do for you what my facility can, and my facility maybe can't do for you what RUSH or Wash U. can do for you. There is a standardization that everything is working towards depending on your accreditation and what you've been

identified as being able to give to your patient, so different places have different certifications depending on how they match up with the established standards. In that way, every hospital is unique.

**DAVID:** Will the charts you make at Carle travel with a patient to another hospital? Or when you get a patient, do they come with charts?

**ALEX:** Yeah. For example, I do discharges a lot since I'm on day shift so I'll admit patients and I'll discharge patients as they come and go, and not every patient is discharged home. Some patients go to what we call an ECF, or an extended care facility, and I have to go over with the patient everything not only about their care, what's to come, therapy services that they can expect, medications, but I also have to call and give a hand-off report to the nurse who's going to be taking care of them at that facility. So I do a whole report with them and then I print a summary of care so that they can take it to that facility and take it to their doctor or their primary care provider. Everyone from large hospitals to small clinic settings should be able to get the same documents, read the same thing, and understand what's going on and what's been done for that patient.

**ANNIE:** Can you explain where you fit into the hierarchy of your facility? Just some things to get you thinking: Who do you report to? Who, if anybody, reports to you, on the other hand. You talked about patients and having to translate for them, but what other people are affected by what you write? Whose writing do you have to deal with while you're at work?

**ALEX:** There's definitely a hierarchy. Not just among doctors and nurses, but also health care techs, and every discipline, as well as within each discipline. If I need help with something, I'm going to talk to what I call my charge nurse, or UNL (Unit Nurse Leader), and then there's going to be a unit manager that I would talk to, and then there's going to be the house officer. They deal with patient transfers and patient issues—troubleshooting any patient problems. There's a hierarchy in terms of going up the chain of command. With doctors for example, you start at the lower rung with medical students, then you have interns, then residents, and then you get to the attending provider. I have paged an attending provider prior to paging an intern before and was promptly informed that I had done the wrong thing. It's not that anyone is mean about it or anything, it's just that there is a protocol that you're supposed to follow, and it does feed into that hierarchy. In terms of education and responsibility with the patient's care and safety, you have all your services: speech therapy, physical therapy, occupational therapy, respiratory therapy; and then you get into health care techs, and all of them will ask me how things are for the patient before they see my patient. They need to know if my patient is OK to be seen or if I've noticed any changes.

So a lot of my job is collaboration and working to coordinate the day's events as they progress. It's an ongoing thing. I don't really feel hierarchically above them, though. It's more responsibility driven at that point. Even though there are so many services working with each patient, they're not the ones who are at the bedside; they're not the ones keeping a continuous eye on the situation. The job is rewarding in that respect because I feel my opinions and judgments are heard and valued.

**ANNIE:** Can you talk a little bit more about things you learned here at the Mennonite College of Nursing that have transferred to the work you do now, in terms of writing?

**ALEX:** Like I was saying, they build you from the ground up with your education. You take a health assessment class and so the whole class is about assessing somebody from head to toe and then writing down your assessments. Some people are really fluffy writers, some people don't put down enough, so it's training you how to write appropriately so that you don't leave anything out. Because when you leave something out, even if it's something really small, down the road that could become something potentially life-threatening. In school you don't have the programs that prompt you like, "Hey, did you assess this?" which is nice when you actually get into the workplace. Here at Mennonite College it was good because they put so much emphasis on muscle memory with your brain, learning to put everything down and to know to stay focused so you can cover all your bases. So I would say clear, concise, and complete communication was the most important thing, in terms of writing, that I learned here at ISU.

**ANNIE:** Is there anything, in terms of writing, that you wished you would have learned while you were here?

**ALEX:** Not to sound like I'm plugging something, but I would say that Mennonite College of Nursing is an extremely good school. They do a really good job and we have phenomenal professors. I've never really felt like I didn't get my money's worth out of any educational experience after coming here, and I don't feel like on the job I've ever had a moment where I was like, "Man, I wish they would have covered this a little more in school because now I'm really struggling." You'll always learn, there are always improvements that can be made. I tend to be kind of a fluffy writer anyways, and so I know that there's always room for improvement.

**ANNIE:** Finally, if you were talking to new nursing students, or students at the Mennonite College right now, what kind of writing would you want them to learn to do or really pay attention to? Any advice or tips that you could give?

**ALEX:** We do something called SBAR which stands for Situation, Background, Assessment, and Recommendation. When you page a doctor, you're supposed to stick to the SBAR format. I will admit that I have paged before saying, "Hey, Doctor So-and-so, how are you?" and they'll respond, "Tell me what's wrong with your patient." They usually don't have time for pleasantries.

I would say that new nurses should first and foremost work toward learning how to be OK with where you are. The job is stressful, you will always be a student, and some days will be harder than other days. And I've talked about this a lot, but new nurses should focus on being straightforward, clear, and concise. I would say focus on those because it's really what's going to matter when you actually get out into the workforce. All the time I'm filling out a careplan and I'm like "How do I say this?" about something I've seen, and my charge will say, "Just write down what you saw, that's it. Just give the facts. Learn how to tell it how it is because that's really important."

**ANNIE:** Well, thank you so much for meeting with us!

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