



Introducing standardised care plans as a new recording tool in municipal health care

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Abstract

Aims and Objectives: To explore how nurses use standardised care plans as a new recording tool in municipal health care, and to identify their thoughts and opinions.

Background: In spite of being an important information source for nurses, care plans have repeatedly been found unsatisfactory. Structuring and coding information through standardised care plans is expected to raise the quality of recorded information, improve overviews, support evidence-based practice and facilitate data aggregation. Previous¹ research on this topic has mostly focused on the hospital setting. There is a lack of knowledge on how standardised care plans are used as a recording tool in the municipal healthcare setting.

Design: An exploratory design with a qualitative approach using three qualitative methods of data collection. The study complied with the Consolidated Criteria for Reporting Qualitative Research.

Methods: Empirical data were collected in three Norwegian municipalities through participant observation and individual interviews with 17 registered nurses. In addition, we collected nursing records from 20 electronic patient records.

Results: Use of standardised care plans was influenced by the nurses' consideration of their benefits. Partial implementation created an opportunity for nonuse. There was no consensus regarding how much information to include, and the standardised care plans could become both short and generic, and long and comprehensive. The themes "balancing between the old and the new care planning system," "considering the usefulness of standardised care plans as a source of information" and "balancing between overview and detail" reflect these findings.

Conclusions: Nurses' use of standardised care plans was influenced by the plans' partial implementation, their views on usefulness and their personal views on the detail required in a care plan.

Relevance to Clinical Practice: The structuring of nursing records is a fast-growing trend in health care. This study gives valuable information for those attempting to implement such structures in municipal health care.

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KEYWORDS

care plan, electronic patient records, ICNP, nursing documentation, standardisation

1 | INTRODUCTION

Globally, healthcare services are facing the challenges of an ageing population. As a result, primary healthcare services are increasingly taking over responsibility from hospitals for a growing number of patients with chronic conditions in need of complex care (OECD, 2013). Adding to the complexity of their care needs, a high number of these patients suffer from multi-morbidity and have cognitive impairments, which leaves them in a frail condition with a high risk of adverse outcomes (Bing-Jonsson, Hofoss, Kirkevold, Bjørk, & Foss, 2016). Access to accurate patient information is a prerequisite for ensuring patient safety and these patients' continuity of care, and a care plan is one of the principal sources of information for nurses (Saranto & Kinnunen, 2009). A care plan includes identified problems (nursing diagnosis), goals for the patient's desired outcome, and planning and evaluation of nursing interventions (Thoroddsen, Ehnfors, & Ehrenberg, 2011). Despite their importance, nursing care plans have repeatedly been found unsatisfactory both internationally (e.g. Tuinman, de Greef, Krijnen, Paans, & Roodbol, 2017; Voutilainen, Isola, & Muurinen, 2004) and in the Norwegian long-term care setting (e.g. Gjevjon & Hellesø, 2010; Johnsen, Ehrenberg, & Fossum, 2014).

The terms used to describe nursing diagnosis, interventions and outcomes vary greatly in traditional narrative nursing notes. This can lead to misunderstandings, put the patients' safety at risk and make systematic data gathering for quality improvement difficult (Jones, Lunney, Keenan, & Moorhead, 2010; Lee, Jeon, & Kim, 2019). To overcome this problem in Norway, the Norwegian Nurses Organisation has initiated the development of standardised care plans (SCPs) enabled by the International Classification for Nursing Practice™ (ICNP). ICNP consists of a dictionary of terms that can be used to describe and record nursing practices in a systematic way (Coenen, Kim, Bartz, Jansen, & Hardiker, 2012; International Council of Nurses, 2019). SCPs are evidence-based sets of preformulated nursing diagnoses and their related goals, resources, characteristics and interventions that nurses can select from when making a care plan. By using such a structure combined with standardised nursing language, documentation quality is expected to improve by easing the documentation of nursing care, facilitating communication across different settings and supporting systematic data gathering (Johnson, Edward, & Giandinoto, 2018; Park & Lee, 2015; Saranto et al., 2014; Strudwick & Hardiker, 2016). Initially, in 2016 five SCPs were implemented in the electronic patient records (EPR) system of three Norwegian municipalities. Previous research on structuring nursing records has, to a large extent, been conducted in the hospital setting (Saranto et al., 2014); thus, it is not clear how such standardised structures for recording fit into nurses' information practices in the municipal healthcare setting.

What does this paper contribute to the wider global clinical community?

- It provides an understanding of the complexities in the municipal healthcare setting that represent challenges to implementing SCPs.
- It points out the challenges of defining the appropriate amount of information to be included in a care plan.
- It sheds light on the fact that although SCPs can help nurses record more elements of nursing care, the amount of information provided depends on the preference of the individual nurse who is using the SCP.
- It points out the problematic issues of partially implementing a new tool for recordkeeping.

2 | BACKGROUND**2.1 | Nurse recordkeeping**

Recordkeeping is well recognised as an important part of nursing (Keenan, Yakel, Tschannen, & Mandeville, 2008). EPRs are expected to provide "the right information at the right place at the right time" by facilitating the continuity of care across time and space (Meum, 2013). In an EPR, there are designated spaces for nurses to record information, and one of these is the nursing care plan.

Studies have evaluated the quality of nursing records in terms of content, completeness, structure and accuracy (De Groot, Triemstra, Paans, & Francke, 2019; Wang, Hailey, & Yu, 2011). Because their quality has repeatedly been found unsatisfactory (e.g. Gjevjon & Hellesø, 2010; Tuinman et al., 2017), several studies have tested interventions aimed at improving the quality of nursing records (e.g. Fossum, Ehnfors, Svensson, Hansen, & Ehrenberg, 2013; Mahler et al., 2007; Muller-Staub, Needham, Odenbreit, Lavin, & van Achterberg, 2007). Even though these interventions have shown quality improvement in nursing records, the reasons why these documentation flaws repeatedly appear is not well understood (Wang et al., 2011). Previous studies have found that recording in EPRs is viewed as a less urgent task, that healthcare workers experience competing interests and that the EPR system does not support their workflow (Vabo, Slettebø, & Fossum, 2016). The EPR system is just one of multiple information sources used in long-term care and does not always support nursing practice due to availability at point of care (Østensen, Bragstad, Hardiker, & Hellesø, 2019). These are all factors that can influence the quality of nursing records and their ability to facilitate the continuity of care.

2.2 | Structuring nursing records

EPR content, including nursing records, has been criticised for being unstructured (OECD, 2014). In addition, different health-care providers use different EPR systems. This has resulted in fragmented information and created a barrier for information-sharing across settings (Ministry of Health & Care Services, 2012–2013). Standardising the systems' structure has been evaluated as a necessary solution. Structuring and coding the recorded information is expected to raise the information's quality, improve its overview, support evidence-based practices and facilitate information searches and report extractions for quality improvement and research (Kim, Coenen, & Hardiker, 2010; Mykkänen, Miettinen, & Saranto, 2016; Saranto et al., 2014). One way to structure the recorded information is to implement structured nursing language (SNL) in the EPR. Several studies have investigated the impact of SNL and found improvements regarding both the quality of the content and the completeness of the EPR (Park & Lee, 2015; Thoroddsen et al., 2011). Although SNL usage is expanding, it is still a great variation in European countries of how far the implementation process has come (Thoroddsen, Ehrenberg, Sermeus, & Saranto, 2012). In Norwegian municipal health care, this work is still in its infancy, with a gradual implementation of SCPs in EPRs. The term *SCP* has previously been used to describe both clinical pathways and care maps detailing phases of care for patients with a specific diagnosis or undergoing a specific procedure (Nussbaum et al., 2015). In this study, however, SCPs refer to nursing care plans in EPRs where the nursing diagnosis and its associated goals, resources, characteristics and interventions are predefined and can be selected according to applicability to the patient.

Using SCPs has been found to restrict recording, but simultaneously reduce redundant information and make the recording process both easier and quicker (Dahl & Wadensten, 2008; Jakobsson & Wann-Hansson, 2013; Jansson, Bahtsevani, Pilhammar-Andersson, & Forsberg, 2010; Svensson, Ohlsson, & Wann-Hansson, 2012). Previous research has found that whether SCPs are used and how they are used are dependent on organisational, professional and individual factors, such as the culture and traditions in the ward, the available time for recording, and personal opinions (Castellà-Creus, Delgado-Hito, Casanovas-Cuellar, Tàpia-Pérez, & Juvé-Udina, 2019; Conrad, Hanson, Hasenau, & Stocker-Schneider, 2012). None of these SCP studies were conducted in municipal health care, so the results are not directly transferrable to this setting. The SCPs at the time of this study were only pilot-tested and available for five nursing diagnoses: impaired ability to manage medication regime, risk of pressure ulcers, risk of malnutrition, risk of falls and risk of urinary tract infections. Before the SCPs are implemented in a large scale, then, it is important to identify how they are used and evaluated by nurses in this setting. This paper presents the results from a study exploring how nurses in municipal health care used ICNP-enabled SCPs as a new recording tool.

2.3 | Aim

The aim of this study was to explore how nurses use SCPs as a new recording tool in municipal health care, and to identify their thoughts and opinions.

3 | METHODS

3.1 | Design

As most previous SCP studies have been conducted in the hospital setting, little is known about how SCPs are received and used in municipal health care. Thus, we considered an exploratory design suitable for our study because of its ability to provide knowledge and provide understanding in an area where we have little current knowledge (Patton, 2015). In relation to the introduction of SCPs as a recording tool across three Norwegian municipalities, participant observations and semi-structured interviews were conducted with nurses who had access to the SCPs. In addition, a sample of the nursing care plans from patients' EPRs from all three municipalities was collected. These methods of data collection were chosen to generate knowledge on how the SCPs were used in practice in a new setting. This study complied with the Consolidated Criteria for Reporting Qualitative Research (see Appendix S1).

3.2 | Setting

The settings of this study were the three municipalities in Norway that had, at the time of the study implemented ICNP-enabled SCPs. In all municipalities, the implementation was partial because only five SCPs had been developed and pilot-tested at the time of this study. The study sites were limited to those where SCPs had been implemented, which included two nursing homes and two home healthcare districts. The SCPs offered predefined nursing diagnosis, goals, resources, characteristics and interventions. In traditional care plans, nurses formulate everything themselves, while in the SCPs, the only place for individual formulations was under the selected intervention, where the nurses could add an individualised description of what the intervention entailed.

In Norway, municipalities are responsible for the delivery of primary health and care services, including both home care services and nursing home care. In spite of the increased responsibility for patients with complex care needs, municipal health care employs a limited number of registered nurses (RNs) (Gautun & Syse, 2017). The largest group of healthcare workers in this setting are auxiliary nurses who represent up to 60% of the workforce, while approximately 30% of the healthcare workers are assistants without formal healthcare training (Romøren, Torjesen, & Landmark, 2011). Hence, there are many healthcare workers with low levels of education caring for patients.

3.3 | Participants

The participants in this study were recruited through convenience sampling within three Norwegian municipalities. We were granted access to the field through healthcare service leaders in the municipalities. The inclusion criteria were that RNs should hold 75%–100% positions and have been employed for over a year in the ward, which meant that they were familiar with the local EPR system. RNs that met our inclusion criteria received information about the study from a contact person, and 17 agreed to participate. The RNs ranged from 27–60 years in age (mean 40.9), and all but one RN were women. To protect the anonymity of the male participant, all nurses are described as female (she, her) in this article. The participants had used SCPs for a maximum of 8 months at the time of the study. Details regarding the working site of the participants are listed in Table 1. Working sites of participating RNs ($n = 17$).

3.4 | Data collection

The data were collected between May–October 2016 by the primary researcher (EØ, MSc) who is a female PhD candidate with 2 years of prior experience of conducting qualitative research. To collect data, the primary researcher approached the field by applying participant observations. First, RNs were observed during a normal dayshift, which lasted 7–8 hr, followed by an interview at the end of the shift. Knowledge gained through the observations was used to inform some of the questions the RNs were asked. After each interview, the primary researcher wrote down reflections and new elements to explore further in the following interviews. Data collection continued until all study sites were covered, and data saturation was reached (Patton, 2015). We also collected printouts of the care plans from the EPRs of volunteering patients ($n = 20$). The EPR content was collected to see examples of care plans where the SCPs were used and where they were not used. The care plans provided an understanding of how the SCPs differed from other care plans, how they were used, and provided a better understanding of the nurses' evaluations of the SCPs. The primary data source for the current article was the interview data.

3.4.1 | Interviews

The semi-structured interviews took place in a room close to the ward and lasted approximately 50 min. Because the SCPs

represented a new way to record information electronically, elements of the Unified Theory of Acceptance and Use of Technology 2 (UTAUT2) were, together with previous empirical findings, used as a framework guiding some of the interview questions (Venkatesh, Thong, & Xu, 2012). UTAUT 2 brings together alternative theories of technology acceptance and unifies them into one theory. The theory includes seven key constructs that predict behavioural intention: (a) performance expectancy, (b) effort expectancy, (c) social influence, (d) facilitating conditions, that is the resources and support available to perform the behaviour, (e) hedonic motivation, that is the fun or pleasure one experiences from using the technology, (f) price value (for consumers—not applicable in this study) and (g) habit. The users' age, gender and experience function as moderators (Venkatesh et al., 2012). According to our understanding of UTAUT2, whether and how nurses use SCPs were influenced by how they view the benefit and purpose of using them, the training and support they have received to change their habits, and their personal experiences in using them. In the interview guide, UTAUT2-guided questions included "Can you tell me about what training you have received regarding SCP?", "What are your experiences from using SCP?" and "How would you evaluate the usefulness of SCP?" The interview guide's themes covered topics regarding care plans in general and SCPs in particular. We used the interview guide as a reminder of topics to be discussed, but it neither bound nor structured the interviews. As new issues were discovered through the observations and interviews, the interview guide was dynamic and was continually developed to explore these emerging issues further. During the interviews, the primary researcher asked open-ended questions, listened actively to the participant, made notes of issues to explore further and asked follow-up questions to go deeper into the participants' responses, as described by Patton (2015).

3.4.2 | Patient records

We collected data from the EPRs of 20 patients without cognitive impairments who were living in nursing homes or receiving home health care. The nurses in charge of the patients informed them about the study and asked for their consent to talk to the researcher about participation in the study. If the patient consented, the researcher then informed them about the study both orally and in writing. Twenty patients gave their oral and written consent to participate in the study. The data collected from their EPRs consisted of their care plans from the last 30 days or as long as the patient had been receiving care if less

	RNs in short-term wards	RNs in intermediary wards	RNs in long-term wards	RNs in home health care	Total RNs
Municipality 1	2	3	0	0	5
Municipality 2	1	0	4	3	8
Municipality 3	1	0	2	1	4
Total	4	3	6	4	17

TABLE 1 Working sites of participating RNs ($n = 17$)

than 30 days. In total, we collected 319 pages of printouts from the EPRs. The patient records were read to gain a better understanding of how the SCPs were used, how they differed from the traditional care plans, and were used to look for examples of issues mentioned by the nurses, to better understand their comments.

3.5 | Ethical considerations

This study has been noted by the Norwegian Centre for Research Data, project number 46,503. The primary researcher signed a confidentiality form in all three municipalities visited. In accordance with the Declaration of Helsinki, the participants, both nurses and patients, were informed that participation was voluntary and that they could withdraw their consent at any time without any negative consequences. The participating RNs decided which patients could be asked to share data from their EPRs based on their knowledge of the patients' cognitive abilities. No cognitively impaired patients were included. All data were anonymised before analysis.

3.6 | Data analysis

A digital voice recorder was used to audiotape the interviews. The interviews were then transcribed verbatim using the software HyperTRANSCRIBE. First, the transcribed interview data were read as a whole by the Norwegian-speaking researchers (EØ, LKB, & RH). Second, the data relevant to the aim of this paper were extracted. The text was then subjected to a conventional content analysis as described by Hsieh and Shannon (2005). Even though the interview guide was theoretically driven by its influence from UTAUT2, the analysis was inductive, without predefined categories. In the analysis process, the first author read the text several times, and the parts of the text that corresponded with this study's aim were marked, condensed and coded. Similar codes were grouped together in categories, and discussed with the other authors, and together we developed the categories into the final themes; for an example, see Table 2. An iterative process was applied, which meant that we moved back and forth between the interview text and the analysis, making sure that the final themes were representative of the data (Patton, 2015). The EPR printouts were searched for examples of the issues that the nurses brought up in the interviews. This provided a further understanding of how the SCPs were used and how they differed from traditional care plans in content. Through our analysis and after a careful consideration of relevance and accuracy, we found two overarching themes, which are presented in the results section.

3.7 | Trustworthiness

We addressed several quality criteria for qualitative studies to ensure the trustworthiness of our results (Patton, 2015). As all members of

the research team are healthcare personnel, and one (NH) has been active in ICNP's development, we were aware that both these issues influenced our preunderstanding of the municipal healthcare setting, the potential usefulness of ICNP, and subsequently how we interpret our data. However, in being aware that we in our preunderstanding may have had positive expectations of SCPs, we were also able to identify situations where our interpretations could have been influenced by this. To facilitate transparency and show how we interpreted our data, we have provided examples of the statements, codes, categories and themes in Table 2 and included quotes as examples in the presentation of our results. To further increase the legitimacy of our interpretation, three of the authors read through the data transcripts, and all four reflected on the interpretations and meaning of our results. These efforts together enhance the trustworthiness of the results we present.

4 | RESULTS

In this study, the nurses' descriptions of their experiences with SCPs were related to three overarching themes: "balancing between the old and the new care planning system," "considering the usefulness of SCPs as a source of information" and "balancing between overview and detail."

4.1 | Balancing between the old and the new care planning system

The first theme we identified was that the nurses had to balance between using the old care planning system and the new SCPs as a result of the latter's partial implementation. Using the SCPs required a new way of making care plans. Where the nurses previously had used narrative free text, the SCPs now allowed them to choose between preformulated problems, goals, resources, characteristics and interventions.

The participating nurses all had experience using SCPs, but to a varying and somewhat limited extent. They gave several reasons for this, such as that they forgot to use SCPs when applicable; insecurity on how to use SCPs; reluctance to change; that it was quicker to do it the old way; and not seeing a benefit in SCP use. Partial implementation meant that the nurses had the opportunity to make all care plans the old way, even in areas where they had SCPs available. Because most care plans were made the old way, it was easy to forget to use SCPs when one of the five nursing diagnoses was identified. As one of the nurses explained:

I wish we had it in all areas. When it's only a few, it is easy to forget that you've got it [the SCP].

(INT NO. 10)

Like this participant, nurses could have a positive attitude towards SCPs but still forget to use them because they were

TABLE 2 Examples of codes, categories and themes from the analysis

Transcribed interview text	Code	Category	Theme
"A reason that they [the SCPs] have not been used that much is that they are only available in five areas. Sometimes you are supposed to use them, other times not, so we tend to forget about them." (INT NO. 3)	Forget to use SCPs because there are so few of them	Partial implementation limits the experience	Balancing between the old and the new care planning system
"I have made some SCPs, but not that many. I absolutely have a potential for improvement when it comes to using them." (INT NO. 13)	Have not made many SCPs; could be better at using them	It takes extra effort to use SCPs	
"There is a lot of useful information and observations [in the SCP] that you maybe had not come up with yourself. That the auxiliary nurses can use." (INT NO. 4)	SCPs provide information useful for auxiliary nurses	SCPs are seen as a source of information	Considering the usefulness of SCPs as a source of information
"If you are newly educated, it is perhaps easier with the SCPs to see that 'okay, this is common.' With experience you have more knowledge on what is typical for a condition." (INT NO. 14)	SCPs give useful information for those with less experience	SCPs' usefulness is connected to experience	
"It is perhaps a bit complicated that there are so incredibly many points that you can tick off [in the SCPs]. Because there are so many things that can be relevant, but that perhaps do not have significance right here and now, you have to choose the most important in a way." (INT NO. 1)	Many relevant interventions in SCPs have to choose the most important	SCPs can become too comprehensive because there are many relevant interventions	Balancing between overview and detail
"In general, care plans can be very long. All the problems are identified. Some problems are real, daily problems, while others are just written there. If you open one of those, then perhaps you do not bother to read it all. The SCP can also become very long." (INT NO. 7)	Care plans, including SCPs, often become too long; then, they are not read	Too long care plans are not used in practice	

so few. Not all participants were able to pinpoint why they had not used SCPs as often as they could and explained the non-use as unintentional. However, nonuse could also be intentional. Insecurity on how to use the SCPs properly raised the threshold for using them:

These templates that we have started with, they are still a little new and a little unfamiliar to many. So, they are maybe not used that much yet.

(INT NO. 1)

The nurses had received some initial training on how to use SCPs, but they still felt insecure. It was a challenge to change from using the old and well-known care planning system to using the unfamiliar SCPs. One super-user, trained to offer peer support in SCP use, explained how she experienced her co-workers' reluctance towards using the new care planning system:

It's one of those things you feel that you are pulling alone. Because it is hard, especially if you have used the system for a long time and you are used to make your own care plans. It is not easy to readjust the whole unit to suddenly use a template instead.

(INT NO. 5)

This nurse found it hard to motivate others to change their habits and start making care plans in a new way. A complicating factor was that the nurses themselves had not requested the implementation of SCPs. As one nurse explained:

Earlier, we made the care plans ourselves. I think that worked better. [...] I was actually pretty satisfied with the care plans we had.

(INT NO. 14)

Not considering the implementation of SCPs as necessary further affected how much they were used. The nurses struggled to see how using SCPs could be of benefit in their daily practice and were divided in their opinions and expectations of their usefulness. Regardless of their opinions, partial SCP implementation with the old and the new care plans functioning simultaneously led to limited SCP use.

4.2 | Considering the usefulness of SCPs as a source of information

It became apparent through our analysis that the nurses considered SCPs an information source. Whether they considered it beneficial

to use SCPs was evaluated against the individual knowledge of the person making the care plan. The nurses saw the SCPs as an information source where they could find suggestions for appropriate interventions and how to formulate a care plan, which provided a learning possibility. As one nurse explained:

I think that you learn something [from using the SCPs].
That you think in other directions, too.

(INT NO. 9)

As this nurse pointed out, the suggestions in the SCPs also made the nurses think in new ways. It was mentioned that SCPs helped them make care plans with interventions that they otherwise would not have come up with themselves or that they would not have remembered. Even so, for some, the decision regarding whether to use SCPs was connected to whether they believed the information in the SCPs would be useful to them personally. This is illustrated in the following quote:

I have considerable knowledge on this subject, and I think that what I know is just as good as what you can find in a standardized care plan. [...] Nevertheless, in other areas where my knowledge is lower, it could be that it is useful for me to use SCPs.

(INT NO. 2)

The SCPs were regarded as useful when making a care plan regarding a subject that was unfamiliar or where the level of knowledge was low. In that regard, it was suggested that the information the SCPs provided was perhaps more useful for healthcare workers with a lower level of healthcare education or newly educated nurses with less experience:

With the SCPs, you get alternatives so that it becomes easier for those who are not that used to making care plans.

(INT NO. 13)

The participating nurses had years of experience from making care plans. When they used the SCPs, they had to search for the interventions they had already planned to put in the care plan when they assessed the patient. If they did not find an intervention that fit, they chose not to use the SCP. If they did find it, however, they agreed that SCPs could be useful. The following quote illustrates this:

As long as you can find something that fits, I think it [the SCP] becomes concrete and useful.

(INT NO. 11)

The nurses considered the preformulated interventions up against their own knowledge of what best fit the needs of the patient. If they conflicted, they trusted their individual knowledge.

4.3 | Balancing between overview and detail

When the nurses recorded notes in the EPR, they made several deliberations concerning, for instance, meeting legal requirements, considering different readers, and making sure that the information was accurate and understandable. This also applied to making care plans, where they struggled between providing the reader with enough information but not so much that it became difficult to get an overview of the patients' needs. One participant explained:

There is often so much written in the care plan so that the real problem kind of drowns. I like it better when it is more precise.

(INT NO. 12)

In addition to selecting what is most relevant, all the other underlying considerations behind the written words in a traditional care plan complicated the writing process. The nurses thus considered formulating one in writing as time-consuming and difficult. In this regard, the SCPs were identified as a useful tool:

The interventions [in the SCPs] are well formulated, so when I know the patient I can just select what is relevant. [...] I use less time because I don't have to formulate the interventions myself.

(INT NO. 8)

For some nurses, the SCPs represented a convenient way to make care plans by just selecting preformulated interventions. Others, however, were concerned that this opportunity to tick off relevant interventions from a list created care plans with too little information. They stressed that the interventions should be individualised to fit the patients' individual needs:

I think it is wise to individualize because then you get to know exactly what applies to this patient. Because not everybody is standard. Not everybody fits with what is written there, then you can specify more accurately what applies to this patient.

(INT NO. 15)

Several nurses agreed that even though an SCP can function as a recording support, a care plan made from prewritten words and sentences will become superficial and generic if not individualised. One nurse explained that a care plan that is not individualised is "a care plan that is made just to be there [in the EPR] and not to be used actively in patient care" (INT NO. 10). To understand the difference between the SCPs that were individualised and those that were not, we searched the patient records. There, we found several examples of care plans of both categories. To illustrate, Table 3 provides an example of a care plan that has not been individualised.

From the care plan in Table 3, we can see that the person who made this care plan chose five interventions from the SCP. Several of

these interventions, such as “pressure ulcer prevention,” do not provide enough information to guide care because a description of how to perform the intervention is lacking. To create such a description, the user has to use her own words and her own knowledge of, for instance, how to prevent pressure ulcers. To illustrate the difference, Table 4 is an example of a care plan where the SCP is individualised.

As we can see in Table 4, the SCP’s individualisation is an explanation of what the person who made the care plan understands about, for example, what “pressure ulcer prevention” entails.

An issue the nurses were concerned about was how much information the care plan should contain. As we showed in Table 3, SCPs could provide an opportunity to make care plans with too little information, but the nurses also frequently mentioned the opposite. The list of possible resources, characteristics and interventions in the SCP were seen as suggestions, and the nurses were tempted to tick off many of these when they made a care plan. However, several nurses explained that SCPs contributed to very long and comprehensive care plans. They experienced that some of the elements that they ticked off in the SCP were redundant and could block the overview of what was important:

A care plan should give enough information, but it should also be precise and as short as possible. The content of the care plan should as far as possible be updated and sifted for unnecessary information. [...] The SCP can become long. It is not that the content is not applicable, but the really important parts disappear a little.

(INT NO. 13)

Like the nurse in this quote, many struggled to balance the amount of information in the care plan. A complicating factor was that the care plan users were healthcare workers with different information needs. Healthcare workers with different professions worked together with assistants with no education in health care, which meant that the individuals in the group using the care plans had a profoundly different basis for the understanding of a health problem. Hence, it was hard to reach an agreement on the level of detail needed in a care plan.

5 | DISCUSSION

The three main themes characterising how nurses used the SCPs were “balancing between the old and the new care planning system,” “considering the usefulness of SCPs as a source of information” and “balancing between overview and detail.” From these themes, we identified three main challenges to accepting and using SCPs as a new recording tool, namely partial implementation, individual consideration of usefulness and lack of consensus regarding use.

Partial implementation was a result of the development process, where only five SCPs were fully developed and pilot-tested at the time of the study. As a result, the nurses had to switch between the new SCP and traditional care plans and did not use the five fully

TABLE 3 Nonindividualised SCP from EPR NO. 11

Problem:	Risk of pressure ulcers
Goal:	No pressure ulcers
Interventions:	Pressure ulcer prevention
	Monitoring blood pressure*
	Care of skin
	Providing pressure-relieving mattress
	Assessing nutritional status

*This intervention is not a part of this SCP today.

implemented SCPs as much as they could have. This could be understood in light of habit, which UTAUT2 presents as a key condition for use. Here, habit is seen as an automatic function of doing what one is used to do. To change a habit, one needs a certain amount of repeated experience using the technology (Venkatesh et al., 2012). The participants in this study had limited experience using SCPs, and even though the nonuse was unintentional, the partial implementation made it challenging to form a new habit of using SCPs. Additionally, deliberate SCP nonuse could be understood in light of the implementation process because the nurses had received a limited amount of training and not taken part in the decision to implement SCPs in their workplace. These are factors likely to affect the acceptance and use of a new technology (Strudwick, 2015).

A well-known natural response to an innovation requiring a change of behaviour, such as the implementation of a new care planning system, is resistance, especially if people interpret the change as being imposed on them (André et al., 2008). Therefore, it is understandable that this study’s participants were sceptical, preferred the well-known and searched for a benefit of using the SCPs. Studies have suggested that prior to the implementation of a new technology, it is important to examine organisational readiness for change and address this first. If organisational readiness is low, the users have more of an “ought to” than a “want to” motive to use the new technology, which can create a barrier to use (Mogensen, 2019). In this specific study, partial implementation provided an easy opportunity for nonuse for those who were reluctant to use SCPs.

A second challenge identified was that the nurses’ decision of whether to use the SCPs or not often came as a result of an individual consideration of how SCPs could benefit them personally. Not seeing a personal benefit is known to make it harder to accept new technology, such as SCPs, and could thus explain deliberate nonuse (Strudwick, 2015). In UTAUT2, *performance expectancy* is a key predictor of intention to use. This has to do with the users’ perceived benefits of using the technology (Venkatesh et al., 2012). For their behaviour to change, that is for the nurses to use SCPs, they must be motivated and see use as more beneficial to them than nonuse. In the same way that negative experiences create barriers to use, positive experiences can facilitate use (André et al., 2008). Therefore, the training and support an individual receives in the implementation process is of great importance for the adoption and use of new technology (Kruse, Mileski, Alaytsev, Carol, & Williams, 2015). In this

TABLE 4 Individualised SCP from EPR NO. 17

Problem:	<i>Risk of pressure ulcers</i> Because of unilateral paresis, he does not turn in his sleep. He is also incontinent of urine, which means that he periodically is laying on moist skin
Goal:	<i>No pressure ulcers</i>
Interventions:	<i>Care of skin</i> After help with personal hygiene, one should use a barrier ointment on the skin around the genitals <i>Pressure ulcer prevention</i> Use a pressure-relieving mattress in bed, a pressure-distributing cushion in wheelchair and a uridom all day. To prevent pressure ulcers, we must avoid using a sliding cushion because he should sit directly on the pressure-distributing cushion, as he has a tendency to become red on his bottom

study, the participants explained that the initial training they received was limited to an initial course one evening. A few did, however, have a super-user in their department who they could ask for help.

In spite of limited experience, the participants identified that SCPs could function as a reminder of appropriate interventions, in addition to an information source for those with a lower level of healthcare education or experience. The main difference between SCPs and traditional care plans is that in SCPs, the user chooses from a selection of preformulated elements. These elements can raise awareness of the relationship between a problem and evidence-based interventions and thereby be educational. Whether or not the nurses regarded SCPs as a useful tool when making a care plan was influenced by their degree of individual knowledge on the subject. SCPs were regarded as most useful when the degree of knowledge was lower. One aim of structuring nursing records is to assist the development of evidence-based practice (Johnson et al., 2018). In Norwegian municipal health care, nurses are a minority in the workforce (Gautun & Syse, 2017). Hence, there are many healthcare workers with a lower level of formal competence who read and write what is commonly referred to as *nursing* records. Because this has been shown to negatively affect the content and coherence of nursing records in long-term care facilities (Paans, Nieweg, van der Schans, & Sermeus, 2011; Tuinman et al., 2017), recording tools that can contribute to knowledge among the staff are most useful. Even though SCPs raised awareness of appropriate interventions, they did not describe the interventions in further detail. It was thus up to the individual healthcare workers to seek additional information on what the intervention entailed, and the intervention's individualised description would necessarily reflect the knowledge of the person who made the care plan. Hence, SCPs alone cannot be expected to raise healthcare workers' competence or ensure evidence-based practice.

The third challenge we identified was the lack of consensus regarding how SCPs should be used. The nurses disagreed on the detail required in a care plan and struggled to find a balance between providing enough details without clouding the overview. This affected both the nurses' views on whether using SCPs would

benefit them (performance expectancy) and the degree to which they perceived whether or not using SCPs would be important to others (social influence). These are both described as important issues in predicting intention to use and actual use in UTAUT2 (Venkatesh et al., 2012). While some participants ticked off all relevant interventions, individualised them and ended up with comprehensive care plans, others narrowed down the interventions to the most essential. For yet another group, an SCP functioned as a recording aid, where they could quickly make care plans just by ticking off relevant interventions. The care plans' function and use in daily practice influenced the amount of detail the participants assessed as appropriate.

The lack of agreement on the comprehensiveness and detail needed in the care plans could have several explanations. One possible explanation is the multiple functions of the care plan. On the one hand, a care plan functions as a legal document describing what care the patient receives (Ministry of Health & Care Services, 2001). On the other hand, it is a tool facilitating continuity of care in providing a guide for the daily practices of nurses and other healthcare workers (Hayrinen, Saranto, & Nykanen, 2008). These two functions are not easily combined. From a legal point of view, all interventions should be documented; otherwise, it is hard to prove that they have been performed, and the general assumption is that they have not been done (Kärkkäinen & Eriksson, 2005). This implies that the care plan should be comprehensive, listing all relevant interventions. Moreover, in line with other studies, our study's results show that for a care plan to function as a care guide, it needs to be specific, that is individualised (Castellà-Creus et al., 2019). However, we also found that the nurses wanted a care plan to provide an overview of what was most relevant. Overview has also previously been described as something healthcare workers consider an important EPR feature (Mogensen, 2019). Hence, a comprehensive care plan describing all interventions for legal purposes does not fit well with nurses' needs in practice. Adding to this complexity, nurses have to consider individual differences in information needs and how the care plan is being used in practice.

The individual information needs of healthcare workers differ with experience, formal health education and familiarity with a given patient (Bing-Jonsson et al., 2016; Østensen et al., 2019). It is therefore difficult to decide what level of detail to put into a care plan. A prerequisite for dedicating time and effort to making detailed care plans is that they are read and used in practice. Due to familiarity with patients and other information sources in long-term care, a care plan is not always the preferred source of information (Østensen et al., 2019). This can explain why some nurses thought it unnecessary to individualise care plans and rather treated them as just a legal formality. This finding is similar to what a recent study described as a "lack of interest in individualisation" (Castellà-Creus et al., 2019). We argue that this lack of interest may be connected to the actual use of care plans in practice and the perceived usefulness of individualising them. Moreover, other studies have found that when it comes to decision-making, nurses prioritise their own experience over the care plans' contents

(Jakobsson & Wann-Hansson, 2013; Svensson et al., 2012). This could also affect the nurses' evaluations of how much information they should put in a care plan. A recent systematic review of other systematic reviews described that there is general uncertainty in nursing practice as to what criteria nursing documentation has to meet to be of high quality (De Groot et al., 2019). This could imply that there is a need for a discussion in nursing on how nursing care plans should be used and what information to include in them. If such decisions are left to individual healthcare workers, the large discrepancies that we see today will most likely continue.

6 | CONCLUSION

This study found that nurses' SCP use was limited due to partial implementation. Partial implementation contributed to both deliberate and unintentional nonuse. When deciding whether to use SCPs, the nurses first considered personal usefulness. Not identifying usefulness often led to deliberate SCP nonuse. In addition, this study identified a lack of consensus among the nurses on how to use SCPs and the detail required in a care plan. Lack of consensus was related to individual preferences, different information needs and different care plan use in general. A possible complicating factor related to the amount of detail in a care plan is its different functions as both a legal document requiring comprehensive recording and a working tool required to provide a patient overview. Together, this study's findings represent possible challenges to the use of SCPs as a new recording tool in municipal health care.

7 | LIMITATIONS

We acknowledge that the relatively low number of participants, patient records and municipalities limits our findings' transferability. However, the design, research method, data collection and analysis are described in detail to promote transparency and give the reader the opportunity to consider our results' transferability. Nurses are also a minority among healthcare workers in the municipal healthcare setting; thus, we acknowledge that we could have gained an even broader understanding of the use of ICNP-enabled SCPs by including other groups of healthcare workers in this study. ICNP was, however, created for the nursing profession, so we chose only to include nurses in our study. All interpretations made in the analysis will in some way reflect the researchers' perspectives, and we acknowledge that the translation of quotes from Norwegian to English may have been influenced by our interpretations.

8 | RELEVANCE TO CLINICAL PRACTICE

The standardisation of nurses' recording systems has previously been studied in the hospital setting. SCPs are recommended to

improve nursing documentation by facilitating recording for both standardised and individualised care, but previously, little research has focused on how they are used by nurses in the municipal healthcare setting. This study gives insight into the complexity of implementing new recording tools. The results show that partial implementation and a lack of consensus regarding the use and content of a care plan are challenges to the use of SCPs as a new recording tool. This knowledge is of relevance for SCPs' further development and implementation in this setting.

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CONFLICT OF INTEREST

None of the authors has any conflict of interest in this study.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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