12 Questions about Record-Keeping

Kris Deering is a lecturer in mental health nursing at the University of the West of England in Bristol. He has 15 years experience working in practice over various sectors, including as a senior practitioner within an intensive team and specialising in care for adolescents experiencing psychosis in an Early Intervention team. A key area of interest is the various effects of neoliberalism on mental health services, in particular how it's philosophical underpinnings are becoming symbiotic within recovery-based approaches. He is currently exploring how co-production may assist creating positive risk taking tools with service users. He is always happy to have chat with others who subscribe to CHMNN, so please do email him kris3.deering@uwe.ac.uk
Kris has written the following piece for the network about *record-keeping*. In it he raises and discusses a number of questions which we hope the network will find useful to open further conversations about something which nurses frequently talk about but is hitherto not addressed on this website. As ever, please feel free to comment or ask questions, which Kris will read.

When Bulwer-Lytton wrote that the pen is mightier than the sword, he could not have predicted that one day many nurses would gladly apply a sword to electronic record devices!

In contemporary mental health care communication does not exist without it being objectified through inscription – as the judicial adage goes – an event has not occurred unless it is written. How did such necessity occur? And what if the act of writing, in particular following instructions to fill the blank spaces of electronic records, is itself becoming the performance of our daily professional actions? We need to ask,

Question 1: Has record keeping about our nursing work replaced our nursing work?

Record-keeping has been around for millennia, famous texts such as the Domesday Day book saw records intrinsically related to the fiscal, in this case tax losses of William the Conqueror. Such practices assisted later with medieval feudalism (Mutch, 2006), whereby for military service, a person gained land that was divided and distributed to assist localised governing. The Bayeux Tapestry which depicted William's triumphs strengthened the trend to capture history, and perhaps to not allow the truth to get in the way of a good story. 'Truth' becomes dependent on which writings survive. As Walter Benjamin said, 'History is written by the Victors', suggesting the investigation of what is excluded is as important as what is read. We need to ask,

Question 2: As nursing records become increasingly framed through the boxes of computer databases, what is excluded and why?

What if 'how' history is written becomes more important? Critique of Westernised positioning on using specific knowledges to make sense of the world may have a bearing. The theory 'Coloniality of Power' originates from the work by *Anibal Quijano* (Quijano, 2000). Quijano argues that the dominance of westernised colonisation is still being felt today, especially as knowledge is constructed within hierarchies to enact power over others (Alcoff, 2007). Partly this originated from plantation owners need to categorise and ultimately dehumanise slaves to maximise profit. Slaves were not asked how they constructed themselves individually or culturally, but were observed and placed into categories that aided highest yield of crops (Quijano, 2007). Thus age, height and proficiencies were important, not slave's personal identities. We need to ask,

Question 3: Could record keeping ever be a politically neutral exercise?

Coloniality of Power also proposes that while colonisation increased so did the importance of impartial observation in health research – limiting knowledge to experts who have a supposed proficiency in being impartial (e.g. education at university), rather than those experiencing health concerns (Alcoff, 2007) – an explosion of empiricism. Less was noted on interpretation and more on objectifying experiences into tangible realities (Quijano, 2007). Understandably this was driven by suspicions about how human bias may affect health findings, hence the eventual work of Karl Popper and seeking information going against the hypothesis (Bolton, 2008).

Florence Nightingale proposed that nursing documentation assisted care by noting personal needs and was also a way to communicate the orders of doctors (Darmer et al. 2006), whilst Virginia Henderson, a prominent US nursing theorist in the 1930's, suggested documentation assists planning care (Darmer *et al.* 2006). It seems that not until regulation increased from the 1970s onwards that documentation become more important. There are many reasons to why this occurred, such as taking on the judicial view that experiences become realities once documented, or the need to professionalise nursing and have status with other disciplines.

Many of these themes of empiricism, status and shaping objective realities can be seen in the rise of evidence based practice; demonstrating a written process of reasoning on what helps a person, potentially demonstrating influence from higher education, for example Project 2000 in the UK (Brunt, 2000).

It appears that there has always been an influence of hierarchy in record keeping, yet justified as a way of helping a person, as Nightingale alluded – to assist the consistency of care. Also how knowledge is constructed to determine truth has a bearing on documentation, perhaps relating to the arguments of Coloniality of Power that in health care, there is emphasis on the objective of the categorising of people (Quijano, 2007). We therefore need to ask,

Question 4: Does increasing record-keeping increase hierarchy?

You will be forgiven for the assumption that I am staunchly against electronic records, however, their initial premise was one with great intentions, a record that is accessible by all regardless of time and place to help service users' holistic needs. The tool has the possibility of binding disconnected services of various disciplines and promoting innovation, and yet, this is not the apparent experiences of nurses using this tool. There are cries of 'death by documentation'; less time is spent with service users than documenting what occurred, to the detriment of care. It seems this is happening by the convergences of different systems (noted below) unwittingly battling each other for supremacy, though as proposed by Coloniality of Power the winners are those within hierarchies who determine how knowledge is constructed. We need to ask,

Question 5: Is record-keeping increasing divides between disciplines and fuelling the categorisation of persons ?

Question 6: Is record-keeping delivering what it promised?

Health organisations drive towards uniformity to demonstrate homogeneous good practice to those who commission services. These rely on data envelope analysis, which are evaluating or auditing processes of tools used to govern organisational mechanics, such as policies and managers. The Griffin report (Department of Health, 1983) instigated senior managerial positions detached from 'shop-floors' to enable more effective cost making decisions. Record keeping in this context becomes the evidence that managerial processes use to assess care and quell nursing dissent by using reprimands in the form of performance management. However, as shown by numerous historic events – e.g. Stalinism in Russia – there can be no uniformity which does not also contain oppression.

It could be suggested that the above contributes to surveillance emphasising the 'management' of health departments, whilst senior managerial detachment from actually experiencing or observing care increases the need for other methods of monitoring. Knowledge becomes constructed that eases the operations of an organisation from a hierarchal perspective perhaps superseding other types, for example interpretive experiences from service users. It is understandably within such a context that documentation becomes the focal point of monitoring care rather than actual care itself.

Electronic records ask questions in specific ways easing answers seeking causality, clear examples are risk assessments and need to document specific histories that increase risk, such as previous self-harm; this has been transposed to digital care plans which offer specific

needs/problems alongside interventions. Indeed interventions may be evidence-based, but may generalise and reduce choices, or at least influence that there are limitations possibly reducing enquiry on the service users' personal needs. We need to ask,

Question 7: As records are required to become increasingly uniform, is the service increasingly oppressive?

Question 8: Do management and records exist mainly for their mutual self-perpetuation?

Question 9: Is it enough to claim that the information collected by records is 'evidenced-based'?

Arguably 'Performativity of Economics' may be relevant to the above – the theory suggests all performances regard some economics (Callon, 2006) – for example limiting care options guides nurses to what interventions are available while the format of electronic records instructs how nurses use their time (Bar- Lev, 2015; Halford *et al.* 2010). Perhaps similarly to the arguments of Coloniality of Power, service users are becoming merely assets that require processing through electronic records, comparable to the ledgers used by plantation owners to measure and influence crop yield. Equally how and what data is collected for electronic records perhaps involves mostly the views of those in hierarchical positions, rather than views of those accessing and providing care.

Question 10: How do records extend the reach of market ideologies into nursing work?

Which leads us to two inescapable further questions:

Question 11: Have records, which began as part of a therapeutic process to assist quality and consistency of care, now become a 'manual' for nurses to follow?

Question 12: Who gains most through nurses keeping records?

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Published by cmhnursing

November 23, 2015

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5 thoughts on “12 Questions about Record-Keeping”

Add yours

1. **Ed Lord**says:

   November 23, 2015 at 4:27 pm

   Excellent piece. You raise some really pertinent issues about the construction of knowledge and ‘governmentality’ enacted through record keeping. This has long been a bone of contention for nurses but as a group we tend to lack the narratives to effectively critique these trends.
   The use of post/de-colonial theory can be really helpful in opening up these kind of radical debates, it is good to see you explore some of these theories.
   I have been looking at some of these angles in a research thesis I have recently completed. I posted a blog entry on this very website a few months ago – https://criticalmhnursing.org/2015/06/03/an-investigation-of-mental-distress-and-modernity/
   I think we can find many points of agreement.

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2. **cmhnursing**says:

   November 23, 2015 at 5:17 pm

   Dear Ed – we also saw the similarities! And we are also reminded that Karen Taylor made the hint of a suggestion in the conclusion to her piece that perhaps nurses should make a stand when it comes to this paperwork: https://criticalmhnursing.org/2015/05/21/karens-story/ . Bit of a theme emerging?

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3. **Kris**says:

November 23, 2015 at 7:25 pm

Thank you Ed and CMHN, I will certainly look at your links above; I do think performance of nurses is particularly guided by managerialism and within this are long histories of eurocentric thinking e.g. power base of subjugating knowledge, alternatively wouldn't be wonderful if a person accessing mental services could write their own records, in the manner they wished, rather than what is instructed? I believe to some extent Participatory Action Research in developing care is easing the possibility of expertise not being those with 'health positions' but with lived experience. Will empiricism allow for experiential knowledge?

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1. **cmhnursing**says:

November 23, 2015 at 8:42 pm

The CMHNN has some unfinished business with a trip made to Sheffield in August 2015 to see the Hearing Voices Network working in alliance with the NHS to produce (a) a different kind of ward and (b) differently skilled community teams. Interestingly, documentation was the major change on the ward – they talked about other changes too, but documentation was central. We are still looking for a way to write about that visit – Peter Bullimore (HVN) and Dr Simon Mullins (cons psy and member of the Critical Psychiatry Network) are key players in that effort, along with some terrific peer support workers. The result within both ward and community teams was a growing awareness of the importance of trauma.
What we need is someone within one of the teams to write about their experiences, and maybe someone with some expertise about documentation to meet up and write a bit about what they have achieved too. We have good contacts there and could easily arrange another visit. Are either of you guys interested?

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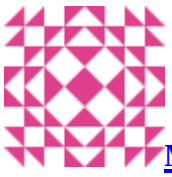
4.  **Michael Finn**says:

   January 13, 2016 at 6:35 am

   If it isn't recorded, then it didn't happen! It's not the recording of information that is brought to question but rather the quality of the information recorded. I've seen rubbish notes and I've seen novels. The best notes are brief factual observations that convey meaningful information to assist in the provision of support.

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