Writing Nursing at University

GUIDES FOR WRITING IN SPECIFIC DISCIPLINES

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1 What is Nursing?

TERMCAT, the Catalan language terminology centre, defines **nursing** as the provision of personalised health care to an individual.

The International Council of Nurses defines the term more generically, underlining that of special concern to nurses are responses to actual or potential health problems faced by individuals, families, and groups. These responses range from reactions to health and recovery after an individual episode of illness, to the development of policies to promote the long-term health of a community.

The unique nursing perspective of caring for and understanding the needs of patients makes the practice of nursing a complex, dynamic, and changing discipline, and therefore highlights the relevance of nursing care in achieving better outcomes for the patient and for the health system.

2 General characteristics of writing in Nursing

The creation of nursing languages and vocabularies arose in the second half of the TWENTIETH CENTURY, in association with the theoretical development of nursing. These semantic tools structure and represent nursing knowledge. In healthcare practice, they are used to record the delivery of patient care and outcomes in the electronic (or paper) medical record of the patient. The objectives of writing in nursing include:

- Facilitating effective communication between professionals.
- Helping to obtain accurate and reliable data that guarantee the quality and continuity of care.
- Improving the clinical safety of patients.
- Facilitating the decision-making process for nurses.
- Contributing to the evaluation and continuous improvement in the delivery of patient care and health outcomes, thus producing reliable and clear data.

The American Nurses Association currently recognises twelve terminologies supporting nursing practice, and understands *terminology* as a structured organisation of concepts represented by their relationships, mappings, descriptions, and translations, which form the basis of knowledge in a discipline. These include the International Classification for Nursing Practice (ICNP), SNOMED Clinical Terms (SNOMED_CT), Logical Observation Identifiers Names and Codes (LOINC), Perioperative Nursing Data Set (PNDS), and Alternative Billing Concepts Codes (ABC Codes), among others. Mention should also be made of most frequently used nursing language using controlled vocabularies, such as the International Classification of Diseases and Health Problems (ICD-10), ATIC interface vocabulary (Architecture, Terminology, Information-Interface-Nurse

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and Knowledge), and the NANDA (North American Nursing Diagnosis Association), NIC (Nursing Interventions Classification) or NOC (Nursing Outcomes Classification) classifications.

The use of controlled languages in nursing allows professionals to clearly and precisely record complex health situations in a patient's medical record. Medical records must contain structured, orderly and coherent information related to: the assessment of the state of health, the nursing diagnosis based on signs and symptoms, planned procedures and expected outcomes, and assessment of procedures and outcomes of the care provided. All of these stages form the basis of the clinical evaluation or care process that the nurse develops, whether they work in a hospital, a primary care centre, a social health centre or other type of setting.

Articles are widely used in scientific writing and include the following sections: title, authorship and keywords, summary, introduction, objectives, methodology, results, discussion and conclusions. International guidelines are followed, including SQUIRE (Standards for Quality Improvement Reporting Excellence), CONSORT (Consolidated Standards of Reporting Trials) and SRQR (Standards for Reporting Qualitative Research).

However, nurses use a more simple, non-technical style of writing when providing health education and promoting activities related to health to individuals, groups and communities of various age groups.

Writing in nursing is also characterised by the constant presence of the nurse's core professional values in relation to patients, families and other significant individuals, groups, communities and society in general. These values also guide the relationship with students, colleagues and other professionals, as well as the nurse's own commitment. The advancement of the nursing profession is essentially linked to the development of the following values: nursing responsibility, self-autonomy, privacy and confidentiality, social justice and professional commitment. Therefore, nurses:

- Use all resources to establish a relationship of trust with the patient, using appropriate verbal and non-verbal language, in order to establish effective communication that allows them to respond to the patient's needs as an individual.

- They leave a written and signed record of their observations, opinions, procedures and outcomes of the healthcare process in order to evaluate their care, help ensure the safety of the patient and the continuity of care, and facilitate teamwork.
- They avoid making value judgements about the thoughts, emotions, beliefs, and values of the patient that may influence the treatment they provide.
- They do not make false, fraudulent or misleading statements, nor do they misuse the media or social media.
- They pledge to honestly communicate the procedures, results, implications, limitations and conclusions of research studies and new professional knowledge.

3 Common written texts in Nursing

The nursing process is a methodology for identifying and solving (or preventing) problems which involves:

- Activating analysis and decision-making procedures based on an assessment of the patient's condition (data and information collection to identify problems and state of health).
- Establishing the nursing diagnosis (a short report containing the nurse's diagnosis of actual or potential health problems, based on clinical evaluation which requires patient care).
- Care planning (establishment of the care plan, stages of development, means and precautions to be taken into account).
- Delivery of care (start of nursing procedures outlined in the care plan).
- Assessment (the degree of effectiveness of the objectives established in the care plan).

As defined by Juvé-Udina, standardised care plans are tools for structuring nursing knowledge for care planning at the community or group level, based on the available scientific evidence. An individualised care plan involves assessing the patient and adapting the standardised care plan to the patient's state of health and lifestyle. Its

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purpose is reinforced by the legal framework established by Law 41/2002, which regulates patient autonomy and the rights and obligations in the field of clinical documentation, which establishes that the medical record must include care planning, among other documents. Care plans contain nursing diagnoses, which are clinical evaluations made by nurses after analysing data obtained during assessment, as well as procedures. A nursing procedure is the delivery of nursing care to achieve the prevention, resolution, or alleviation of a diagnosis. The care plan is a dynamic tool which sets out the reason for the procedure (diagnosis/results), as well as the planning and programming of the procedure, and the professional or caregiver who should carry out the procedure. Incorporating standardised care plans into nursing documentation speeds up the registration process. They also act as a routine care guide for new nurses. The individualised care plan includes nursing diagnoses and additional procedures not included in the standardised care plan.

Nurses routinely summarise discharge information in continuity of care documents. These are records which include the status of the patient, their most serious ongoing problems, the care that has been given and the state of their condition, as well as their basic needs and nursing diagnoses. They reflect the nursing duties that take place when a patient is discharged.

Being able to deliver safe, high-quality care is the goal of any health care organization. Defining nursing care indicators is a key aspect in verifying the impact of nursing procedures, not only on the patient and their caregivers, but also on the health system. A quality indicator is a quantitative/qualitative measure that reflects the quality of an activity or service. It is a tool that serves to monitor, evaluate and compare quality and allows us to assess means, actions and results.

Research shows that nurses have their own particular way of relating to people who face situations connected to health or disease. So they use various ways to discover and understand, and different theoretical and methodological frameworks to acquire knowledge. Of course, a physiological or biological knowledge of the body is essential, but it must be complemented with knowledge of social sciences (people are shaped not only by physical health, but also by the emotional, social, cultural, spiritual dimensions, etc.), because nursing focuses on human beings who live, breathe, speak, and feel. This is why it is common to use two types of scientific writing: one which derives from quantitative research and another which comes from qualitative

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research. The latter is very useful when we are concerned with trying to understand the needs of the patients and their families. In addition, in recent years there has been a growing interest in the use of methodologies called mixed methods and multi methods, which allow the combination of the two methodological approaches and more weight to be given to one or the other, or equal weight to both.

Infographics for non-experts are tools for visual communication and aim to help transform complex information into easier-to-understand information. The infographics created by nurses are associated with disease prevention and health promotion, as well as health and disease processes. Infographics are also created for nurses themselves, to improve their knowledge on certain topics.

4 Writing conventions in Nursing

The word *nurse*, used as an adjective, is widely used in nursing (nursing diagnosis, nursing ethics), and we can find it, for example, used as the name of subjects (Nursing Care in Old Age).

The term *nursing* should be used when referring to the discipline, science or profession. In English, the name *nurse* refers to both women and men who practise nursing. However, a distinction is made for nurses who work in a supervisory or team leader role. In this case, female nurses are known as *sisters*, and their male counterparts as *charge nurses*.

Nurses are increasingly mindful of cohering to ethical care principals, and fight against the objectification of the people they care for. A patient refers to a person who is receiving healthcare services. However, in some settings, such as mental health services or residential care, it may be more appropriate to use alternative names, such as *service user*, *client* or *resident*.

Some abbreviations are linked to the same method of problem solving or nursing process, such as Dx (diagnosis), medical record (Mx), NIC (Nursing Interventions Classification), NOC (Nursing Outcomes Classification), SCP (standardised care plan), PIAISS (Interdepartmental Social and Health Care and Interaction Plan), ATDOM (Home Care Program). There are also others that refer to the different tests or health issues related to the patient, such as ECG (electrocardiogram), HR (heart rate), RR (respiratory rate), AMI (acute myocardial infarction), EN (enteral nutrition), SaO2 (oxygen saturation), PE (pulmonary thromboembolism), PrU (pressure sore), advanced chronic diseases (MACA).

5 Selected works and websites for writing in Nursing

1. *Principles of practice.* Royal College of Nursing.
https://www.rcn.org.uk/professional-development/principles-of-nursing-practice

A guide developed by the Royal College of Nursing, the Department of Health, and the Nursing and Midwifery Council, which describes what constitutes safe and effective nursing.

2. Grup de Recerca UB sobre Terminologies Infermeres (GRUBTI) (2015). *Glossary of nursing methodology and language terms.* Barcelona: Universitat de Barcelona.
http://diposit.ub.edu/dspace/bitstream/2445/63294/1/GRUBTI_S1_Romero%20et%20al_Glosario%28Definitivo%29.pdf

Document to help students and nurses explain the uniqueness and complexity of nursing care, and highlight how this group contributes to health outcomes. In addition to giving meaning and enriching disciplinary concepts related to nursing methodology and languages, this glossary also aims to be a starting point to stimulate debate and continue to build nursing knowledge as well as a challenge that helps to homogenise and organise professional practice.

3. Juvé-Udina, M. E. *Terminologia ATIC.*
http://www.atic.com.es

ATIC (Architecture, Terminology, Interface-Nursing Information and Knowledge) is a project on the architecture of nursing knowledge through an interface nursing language. It is a language system, supplementary to traditional classifications, which is characterised by terms based on natural language that professionals use in practice, which are subsequently subjected to theoretical refinement through procedures of development and analysis of concepts and scientific nursing production. ATIC is used in many hospitals, in all primary care and in social and health centres of various public and subsidised healthcare providers in Catalonia.

4. TERMCAT, terminology centre. *Nursing dictionary*.
https://www.termcat.cat/ca/diccionaris-en-linia/34

TERMCAT, the Catalan language terminology centre, has an indispensable terminology website. The Nursing Dictionary can be found online.

5. *Personalised care and support planning handbook: The journey to person-centred care. Core Information* (2016). NHS England.
https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf

A handbook for writing a personalised care plan, especially for people who require long-term, or end-of-life care.

6. *Writing Guide for Nurses* (2020). Nurse Journal.
https://nursejournal.org/articles/writing-guide-for-nurses/

A guide with information on the different types of writing nurses need to master during their studies, from personal statements to essays. It also includes a list of writing resources, information on citations, and common writing mistakes.

7. *Learning resources.* Royal College of Nursing.
https://www.rcn.org.uk/professional-development/learning-zone

Online resources for nursing essentials.

8. *Acronym Buster.* NHS Confederation.
https://www.nhsconfed.org/acronym-buster

A comprehensive list of more than 1,000 commonly used acronyms and abbreviations, to help understand healthcare jargon.

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