Interview with Marilynn Doenges, Mary Moorhouse and Alice Murr

Transkription: Maria Müller Staub

Q: Maria Müller-Staub: **What was the start of your work or your vision to write the nurses pocket guide? Please tell us about the first edition - how was it perceived?**

A: Marilynn Doenges: We had written a care plan book and we had feedback that people would like to have a small book, a book that would help them learn nursing diagnoses. So we realized that the nurses did not know how to use the nursing diagnoses with just the related factors and defining characteristics. So we thought, writing interventions and outcomes would give the nurse - who was using it - an idea how to use nursing diagnoses. And so that's how we came about deciding to write the nurses pocket guide. It was received very well – the first edition - and all the editions since, the 11th will be coming out later next year.

Q: M. Odenbreit: **When and how did you three start to work together? From where did you know each other?**

A: **Mary Moorhouse**

Marylinn and I had worked together in the late nineteen-seventies in a large group on a project that was not published. And one of our colleagues was a professor and very much wanted to be published came to us and said: are you interested in helping me take this material and get it published? So we wrote the first book - as Marylinn mentioned , the care plan book- and the publisher came back and said we need something smaller and it turned out the pocket guide.

During that time I worked in critical care with Alice and she would see me writing at free moments at night when the patients were sleeping and I didn't have vital signs to do, and asked if she might be a part in the future. And so, in 1985 she came on as a contributor and worked her way up to an author with us. And she has been a very good asset, a good fit for us. Many people say that trying to get 3 women to work together on a project is almost impossible.

But we each bring something different to the table. Marilynn brings a psychiatric background, Alice brings critical care and good English skills, and I bring critical care and a logical, down to earth focus. So Alice keeps our spelling in line and Marilynn reminds us of psychiatric issues and we get along.

Q: M. Müller-Staub:

What was the first translation into a foreign language and into how many languages is your book translated by now? What are the reactions/feedbacks from around the world in using your book?

A: Alice Murr

The first translation was into French. Over the years, the pocket guide has been translated into 7 different languages. And we had a couple of other books that are also out in 9-11 languages. So it feels kind of strange to us, to realize that people actually around the world are starting to use nursing diagnoses and to use our book for that. It's (the book) been very well received and that's exciting to us … to see that the thoughts that we have and the thoughts that all nurses have and the way that we wanted to learn and to teach people is been well received.

Q: M. Odenbreit: **Why did you choose to include NANDA diagnoses?**

A: Marilynn Doenges:

We received a list of NANDA nursing diagnoses from one of our first partners, and we looked at it and said: **This is very important, this language of nursing. And we set a vision that nursing needs a language of its own. And we thought this was it!** And we would use it and not mix it with other languages. Some people who have written nursing diagnoses books, think "oh, I need to add this one" or "I need to change this one" but we decided in the very beginning that we would use the NANDA-diagnoses correctly as it was published and anything we wanted to add we would identify with brackets. So I think that has paid out well, that as we have gotten more nursing diagnoses we go forward with adding them to the books, particularly the pocket guide.

Q.: M. Müller-Staub: **Can you also say something about the advantage of using a structured taxonomy versus free text diagnoses or "patient problems?"**

Marilynn Doenges:

We think it gives a format and a logical understanding of what the patients' problem is. One thing that I like about nursing diagnoses is, that you get to the crucial problem.

For instance, if we said "well this patient has a weight loss problem" (= nursing problem in "free text"). Would you know what to do for this problem? How would you know what the real problem is? Or would it be better if you identified that nutrition was the underlying problem? Or perhaps the patient has a self-care deficit in feeding? Maybe the patient was not able to feed himself? So you get to the true problem, when you use nursing diagnoses, rather than just some generalized term like "weight loss".

Q.: M. Müller-Staub: **What is the reason to link each diagnosis with nursing goals/desired outcomes? What is your theory or reason for formulating outcomes in the way they are stated in the book? = "Client will…."** (Ziele sind aus Sicht des Patienten formuliert)

A: **Alice Murr**: **Our philosophy is that the patient drives everything we do!**
And we want to know that patients have outcomes that <u>they want</u>. If patients come to us they want their outcome to be that they get well because of what we do for them.

As far as we are concerned, it is the outcome that drives everything that nurses do. And therefore we want to link each nursing diagnosis with an outcome. For an example, if a patient has the nursing diagnosis "anxiety", we want to know that the anxiety has subsided when the patient leaves, and that we had done the right interventions to reduce that anxiety.
So we tied nursing diagnoses and outcomes together so that we can actually tell that what we did - our interventions - actually accomplished their goal. So nursing diagnoses and outcomes are tied to each other.

Q: M. Odenbreit: **The NANDA-taxonomy does not present diagnoses in a "care-plan-like setting" as you present them in your book, that includes nursing/goals and also nursing interventions and a documentation focus for each diagnosis.**
Why do you think it is important to put diagnoses into the framework of the nursing process?

Mary Moorhouse: Clinical nurses struggle to apply nursing diagnosis in their practice. They don't have a lot of time to sit and consider what it is they want to do. They have to move forward quickly. So we want to give them some examples of how to apply, how to choose appropriate interventions that will accomplish the outcomes that they have chosen.

And the documentation focus is added to remind nurses to show in the record what it is we did, that helped this patient to get better.

If we do not document, then no one can see our contribution to the overall wellbeing of the patient. And nursing then remains anonymous in the patient record.

So, we need to step forward, take responsibility for our practice, let everybody - including the patients and their families - know what it is we are doing for them and have an understanding with the patient and their families as to what the outcomes are, and that the outcomes are measurable, so that the patient knows what he is trying to achieve and what we are measuring.
And then document all of that for - in our country it is for reimbursement – if it's not documented than the insurance companies may not pay for it.
There are legal issues that you have not faced too much over here as we do.
And also to provide information within the record for research – to identify what interventions/outcomes really were most successful in dealing with a hundred patients in your hospital that have the same nursing diagnosis. **The reason is that we are moving toward evidence-based practice, and if we do not have some standardization in our naming of what it is we do, and the interventions that we choose, than it makes that research almost impossible.**

Q.: M. Müller-Staub: **What is the difference between the interventions in your book and the NIC-Interventions?**

A: Mary Moorhouse:

NIC-Interventions are a high level header, a classification or shorthand such us "selfcare assistance: bathing and hygiene". If I wrote that down as an intervention in the nursing documentation - what is it I'm doing?
What NIC did was: they took the books on the market - our care plan book and several others - took all the interventions out of the book, and devided them up underneath these headers, and then voted on which one was used most often…… a very interesting way of approaching a new product!
But we felt that was fine, we appreciate the work that was done on standardization.

The NIC-Interventions have a number of actions under each intervention, and those actions actually correlate to our interventions in the nurses' pocket guide.

Q: M. Odenbreit: **How came it that the interventions are prioritized in your book (eg. nursing priority 1-3. respectively 1-5)?**

A.: Marilynn Doenges:

We tried to group interventions in like-groups (or grouping similarities). **The first thing you want to do is the assessment: find out what this individual patient needs.** So we tried to group our interventions so that nurses can look up: "Oh, my patient needs first this intervention, than this intervention and later this intervention"; and **then we grouped interventions towards preventing and treating the patient. The final priority is for looking at when patients are going home at the discharge and what patients' needs are going to be as they get well - we hope patients will get well – so that's important to our prioritizing.**

Q.: M. Müller-Staub: **I like to add a question about NOC: What is the difference between your desired outcomes and NOC-outcomes?**

A.: Mary Moorhouse:

NOC is interesting in that way: It has very concise terms such as "ambulation" and a 5-point likert-scale, ranging from "very poor" to "somewhat poor" to "medium" etc., but that's all subjective. And what may be o.k. for one patient, is certainly not going to be o.k. for an other patient. So we **use outcomes that include actual, measurable descriptions and timeframes** - well, in the book, we don't include timeframes, because of course that's is part of your personalization of that care -. For instance, when we were talking about ambulation: if a patient has lung problems, I may be happy **to I get that patient walk from the bathroom and back, because that means when the patient gets home he will be able to cover that distance within his home.** Someone else, e.g. a new surgical patient, I may be concerned about them climbing their stairs, or whatever need the patient has, based on where their bedroom is situated in their home. **My outcome will change form person to person, than just simply having a single word just saying "ambulation"** (as in NOC) **does not give me a picture what that individual patient can do. That is why we are more specific in our outcomes, and this is how you show your individualization in the care that you plan and provide.**

Q: M. Odenbreit: **Where should a hospital/institution start when implementing nursing diagnoses into practice? What do you think should be the role of nursing managers?**

A.: Mary Moorhouse:

First, the hospital has to make a commitment to do this. They have to be willing to spend the time, the money, and the energy to support this process, because it doesn't happen over night and it doesn't happen without resistance.… let's face it!
Nurses are very busy people and they try to change as little as possible. **So the hospital needs to put forward to present the value of using nursing diagnoses within their system - the benefits to the nurse and to the patient.**

2) **Managers need to be positive**, they need refrain from saying "we will try this" because if you put that into that context (e.g. "well, o.k. we will try it for a week then we are done, thank you very much") **you need a sustained effort!**

3) **Use examples from other institutions, that have implemented and evaluated nursing diagnoses, and show what the benefits and outcomes were.**

4) **You need to determine the general staff knowledge of nursing diagnoses**. In my country we have been talking nursing diagnoses since the late Seventies, and it became more visible in the 1980' ies, and so a lot of students were introduced to it but once they get out of the school settings, in other hospitals the older nurses did not know about nursing diagnoses. So, you need to know what the level of your staff is.

5) **You need to identify "super users" - those are generally younger people who are fresh out of school, who are more familiar with the concept and know how to use it**. Who can serve as role models and support other staff members. It's the same concept as when you bring in new computers: you identify who is really good with that program and that process and then they help drag on all the other nurses along with them.

6) **Encourage research or evaluation as the process goes along, so that you can identify what roadblocks may be popping up and deal with them in a timely fashion, so that you do not loose "momentum".**

7) **Managers themselves need to identify – together with their staff –fifteen or twenty nursing diagnoses that are most frequently used within their setting** because you do not use the entire book in your particular practice. That are **some diagnoses that keep coming back over time and those are the ones you start with.** We would post a "nursing diagnosis of the week" on the board and we all became familiar with that one diagnosis and how possibly to apply it.

8) **Providing time to perform the activity of planning care.** How many times does someone look at you as you are sitting there trying to decide what nursing diagnosis and say: "Don't you have something to do?" Or: "There is a light on", or: "Are you really doing anything?"

We need to value the planning time and the creation of a plan of care. If that is not valued, it will not be done! We will be busy doing the baths and whatever else that needs to be done. Well, I would not sit and plan care while someone is in pain and needs a medication, but I would get that taken care of and come back, and we would do have to prioritize. **But we do have to recognize the importance of simply sitting and thinking.**

Finally: **Review the nurses' ability and skill level at the early performance evaluations** (jährliche Mitarbeiter-Qualifikation). Some of our hospitals have merit races or promotion ladders, and we would be instructed to bring two or three copies of our best care plans we had done over that past year to demonstrate our skill level. And with that care plans we would bring along the outcomes, so we had the opportunity to pick the very best care plan; and then that would be part of our success during the year and also be used to help us identify areas that we could improve in.

Q.: M. Müller-Staub: **How do you see the connection between the use of nursing diagnoses and the electronic health record or the electronic nursing documentation?**

A.: Alice Murr

Well, this is the real nut, or the whole thing we are trying to get to now. In the research I have done, it looks like you are long ways ahead of the United States in solitifying how to use nursing diagnoses in the electronic care plans, so congratulations to all of you!
I'm going to try to learn form you today. I think part of that may be simply the size of our country…. we are so large, we have a huge area – if I'm right our State of Colorado alone is six times larger than Switzerland. And in population we have over a hundred and three million people in the USA. That means a lot of people who think in different ways - we have a lot of trouble coming together and say "do it this way". And we have a lot of vendors of electronic products that want <u>their product</u> to be the product that we use. Therefore it's very difficult to say: "No, it's going to be done this way and it must be done this way".

So, what I feel passionate about though is, that nurses have to help make these decisions (about nursing diagnoses in the electronic record). Because up to now in the US at least until very recently, the health records were an accumulation of doctors orders, laboratory orders, pharmacy orders and perhaps ordering of supplies and making appointments ... And nurses were left no place to put their notes, that means I could get on a computer and go to the RNs notes, that has not been the case. So nursing diagnoses gives as a way to have a label, and a code and have means, so that we can actually document and find what the nursing contribution to the health of patients is. That's why nursing diagnoses have to be embedded in the electronic record.

M. Müller-Staub (zwinkernd): Were you just talking about Switzerland or about the USA?

M. Moorhouse: I need to add why I'm so very, very passionate about nursings' contribution in the record. Because once we can identify what it is we (nurses) are doing, and can charge for what we are doing, we are no longer part of housekeeping maintenance or the dietary or whatever doing group. And once we start charging for our services, as part of the regular billing process, with that goes power. In our country, money and power are synonymous!

The doctors come to the table and say: “I bring you so many patients, and I want this piece of machinery, and I want this consideration”. Nursing sits at the table and says: “Well, we take care of people”…. But when we start really itemizing and demonstrating what it is we are doing, then we can say: “This is what we bring to the table, and this is what we want in return - we want this piece of lifting equipment so that our older nurses don’t have back problems”, “or we want to change our staffing ratios”, “we want to have more thinking time to create our plans of care”. With that comes the power in nursing and we will become a more powerful group.
As Alice mentioned, we have two million nurses, try to get two million people in general to agree on anything and that’s honestly part of our problem, we have so many choices of different roads to take and we all like to take our own different paths. So we envy smaller countries who can get it together and have more consensus.

Q.: M. Müller-Staub: **Do you think that using standardized language precludes nurses form giving individal care to patients?**

A.: Alice Murr

Well, my answer to that is a resounding NO, because I do not see it as an either or. Standardized language is simply a way to say something, it’s not a way to dictate or provide care, and it’s not a way to restrict care, it’s simply a way to identify and document what we are doing. Its not the *doing* of care that standardized language is about, but it’s about the documenting and the visibility of it. It has nothing really to do with the care per se, because the individual care is chosen by help of the classification that gives a whole range of theory based interventions and individualized outcomes to a certain nursing diagnoses.

Q.: M. Odenbreit: **What is your vision for the further development of nursing diagnosis and your book? What is your vision about future nursing generations relating to your work?**

A: Marilynn Doenges: I think that students now are learning nursing diagnoses and so, when they come out as graduates (out of school) and go to work on the floors, they have this knowledge and they help teach the older ones (that are somehow resistant to change) but I think that as our books are used more and more, that **absolutely it’s going to become our language, the nursing language - and we will all benefit from that.**

A.: M. Moorhouse:

My view and expectation is that Europe and Brasil and some of these countries who are very much vested in nursing diagnoses, are going to drive the US, and bring us into a better place. Nurses are willing to sit back and say: „Well, nursing diagnoses will die, we don’t have to worry about it because it will go away“. But the success that you all are having with it, is making some people sit back and say: Oh rats, it’s not going away, we are going to need to deal with this. So I look to you all to help drag us along.

A. Murr:

What I wanted to add: our vision is to be able to explain to the nurse out in a tiny little town, who might be one of five nurses or maybe she is by herself in an intensive care unit, what she is doing and why she is doing it. And so the learning that we wanted to bring (by the book) is in simple enough thoughts, in simple enough concepts that when I’m out there by myself, **I know what I’m doing, I know that it’s meeting my practice standards and I know that it’s offering good and proper nursing care.** Well, that goal and that vision remains, it is still the same one we had and is still the one we want to grow; and the fact that we are all here today it is something that we agree on and that is becoming more global, and that is thrilling to me, I cant’ believe... I’m a little gal from Colorado sitting here in Switzerland talking to you, thank you very much.