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‘Paperwork’: its implications for Community Mental Health Nurses’ Practice

**Report for the participating Mental Health
NHS Trusts**

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Introduction

The growth of paper / documentary work within contemporary public sector organisations is of common concern. The study reported aimed to examine the real life documentary practices of Community Mental Health Nurses (CMHNs) to enable a better understanding of its impact on their nursing practice. Following ethical and organisational approval this type of work was investigated within two Mental Health NHS Trusts in Northern England. Twenty one nurses were interviewed about their documentary work and blank copies of the documents that they use were collected. 'Paper / documentary work' was defined as all nurses' activity related to written data, including that performed using information technology. Examples include patient assessment documents, correspondence, referral forms and records of clinical supervision.

The conduct and writing up of this study has coincided with growing professional and political concerns regarding the progress and failure of a national programme for IT in the NHS. Indeed one of the study's participating Mental Health Trust's is mentioned in the Commons Public Accounts Committee Report (2011). MPs concerns focused on the huge costs incurred for this programme at a macro level. They have not considered the practical ramifications and different types of costs and benefits involving paper work incurred by health professionals and their patients at a micro level. This study goes a small way to filling this gap.

Background

Nurses complain that organisational rules and expectations regarding the amount and completion of paperwork are consistently growing, and that this has negative implications for their work with service users (Vere-Jones, 2007; Royal College of Nursing (RCN), 2008). A particularly bitter complaint is that of much duplication of the information they provide and

the burden of paperwork has been negatively implicated in studies of mental health nurses' job satisfaction (Dallender and Nolan, 2002 and Robinson et al, 2005). Burnard et al. (2000) found that excessive paperwork was perceived as a cause of stress and burnout in their study of CMHNs in Wales.

Complaints of a growing tide of bureaucracy are a common contemporary feature of organisational life and this has been associated by some with the idea of audit culture and 'the audit society' (Power, 1997). It is argued that the practice of auditing is the fundamental driver for paperwork production, that is, that the paperwork must meet the needs of the distant auditor first and foremost. Auditing can be regarded as a positive process for making organisations rigorously accountable for their work (Munro, 2004). However, no matter what the interpretation of the purpose of paperwork is, it is largely regarded as an onerous burden that diverts resources away from other core areas of organisational work. Given that within the mental health sector national policy is premised on the basis of patient contact, it is imperative that activity that detracts from this needs to be carefully examined.

A survey by the Nursing Times (Vere-Jones, 2007: 16) opined that: 'Nurses are being crushed under a mountain of paperwork' and their report distinguishes between paperwork associated with patient care (understood as being necessarily undertaken by nurses) and that regarded as work that could be undertaken by another worker. A further survey commissioned by the RCN (2008:1) concluded that nurses were spending far too much of their time on 'non-essential paperwork'. Both surveys reported respondents' views on the reasons for the increase in paperwork but interestingly no one questioned its purpose and usefulness, or its place as a managed area of work activity. The solutions they proposed merely concerned finding other methods for getting the paperwork done, for example, by employing administrative support workers. There appears to be a resigned and pessimistic acceptance that the burden of paperwork is here to stay.

The indications suggest that organisational participants feel helpless in the grip of a rising tide of increasingly burdensome bureaucracy, driven by an ideological quest for accountability. From writing orders for mundane supplies to completing large and complex forms for service requests, paperwork is a ubiquitous and growing feature of nursing work.

Methods

CMHNs were invited to take part in the study following an oral presentation at several Community Mental Health Team meetings. 21 nurses volunteered and participated in a semi-structured, audio-taped interview within their work base. They worked within a variety of settings and included those who worked with working age adults and older people. Prior to the interview nurses were asked to consider what proportion of their working week they spent on documentary work (it was emphasised that only 'an estimate' was being requested) and to collect blank copies of the documentation that they used for collection by the researcher.

The interview sought data regarding two main matters: their documentary work and its relationship to nursing practice, and their perspectives on this work.

The interview data were transcribed verbatim and analysed thematically. The documentary data were subjected to content analysis by two researchers. The blank forms collected have yet to be analysed.

There are clearly limitations to the study reported here. It was a small study conducted within two organisations in the North of England. The data was collected by a lone researcher. Inevitably it raises many areas of further interest to pursue. For example, it would be useful to replicate the study in another part of England to compare the findings. New projects such as observing paperwork in practice and comparing the documentary practices of CMHNs with other mental health practitioners would further our analysis of this contemporary problem.

Interview findings

Overall the CMHN participants were keen to offer a balanced account of their documentary work. Its importance for the effective continuity of patient care, and its methods for accounting for their work within the organisation were repeatedly stressed. They appreciated the Trusts' complex responsibilities for reporting on work activity and the relationship of this to its financial health and clinical reputation. However these positive understandings of the functions of documentary work were discussed within the context of largely negative experiences. Many of the participants were acutely aware of this and apologised for complaining and feared that I would regard them as being negative.

Paperwork was mostly experienced as an ongoing, sometimes threatening and highly taxing burden that mitigated their opportunities to work directly with their patients, this being the type of work that they believed they should be doing. Their estimates of how much of their working week was taken up with paperwork varied from 33% to 60%. Inevitably, they explained, this was contingent on the specific activities they were engaged in at any one time. For example first assessments of a new patient with serious mental illness, requests for long-term care funding and reports for Mental Health Act Review Tribunals were particularly paper heavy. Several participants were of the view that the paperwork they did was of more importance to senior managers within the Trust than the quality of the care they gave to patients. This perception followed from their experiences of what aspects of their work were scrutinised and managed / not managed. They perceived that the burden of paperwork just kept growing, that paperwork just bred more paperwork. New forms were frequently added but rarely taken out of use. Some linked this

growth to the systemic effect of changes to other services. As Geoff¹ told me:

'They shut down a welfare rights department, so we have to do all the welfare rights calculations now. They used to do the DLA forms but we have to do them now'

The CMHNs were asked to comment on their personal paperwork skills. There was evidence that some more experienced CMHNs had developed highly skilled organisational 'know-how' when it came to constructing documents. They aimed to do this in a way that was likely to succeed in getting patients what they needed and in working as efficiently as possible. Thus the forms to be completed both shaped the work of the CMHNs and the work of others was shaped by their documentary methods.

Six main themes were analytically distinguished across the 21 interviews: the advantages of paperwork, paperwork in the driving seat; systems not fit for purpose; feeling unprepared, paperwork and organisational politics and wondering what the point of all the paper produced was. These are discussed in turn.

Paperwork advantages

As practitioners, the participants recognised the value of paperwork that contributed directly to their care of service users. On the other hand, whilst they understood that data collection was important for their employing NHS Trust in various ways, actually doing it was a tedious, growing and never-ending burden. The advantages they described then were associated with service user records but were usually followed by a caveat. For example Jackson explained:

¹ Names of CMHNs are pseudonyms.

'...there is an appreciation that it is much better – compared with the old paper systems. I mean it's a very comprehensive system. But I guess that the flip side is that it's so time intensive so ultimately the emphasis of the role has changed quite considerably and that will have an impact on patient care.'

Access to a comprehensive electronic patient record was regarded as an important advantage. As Lauren explained:

'...it means that whatever's happening with your client, wherever they are, you can see it and that is brilliant, absolutely brilliant. If I've got a client who's in hospital on the mental health side I can see what's happening shift by shift over the in-patient case note that go on and that really is phenomenal. When a consultant's been out to see one of my clients and they've done a letter, I get an email as soon as the letter is finalised so I can see what went on in that review. If I wasn't there I can still see what is happening and that's brilliant that we've got access to that because when we had paper records it just didn't work like that. If you're working out of hours it doesn't matter because you can still get access to all that information. It also means that if we get phone calls about somebody else's clients or someone else in the team we can find out for them so we can offer a better service and that's just phenomenal because we're in this for the clients you know we're not here for the money so that's a really useful part of it. I think the frustration comes because sometimes the paperwork feels like its been put together by people who don't actually have to use it...'

Arthur pointed out the advantage of typed text over illegible handwritten text and the convenience of having documents in one place:

'It's infinitely better than the old system simply because you've got everything and it's all scanned in and you know- you can see letters. Whereas it used to be all in folders and in date order and now if you need to find something out really quickly its really good,

although having said that...if it's really old stuff you've got to get admin to phone up the storage place... as far as continuity and knowing what everybody else knows, it's much better.'

Arthur linked the importance of records with frustration about a lack of timely training (discussed further below):

'...it seems a bit daft. Because you know at the end of the day it's important stuff we're putting on there you know-if people don't know that if you don't press that button then it won't save – and then it's like “oh my god”...'

Further advantages of having a computerised system were discussed by Barry. He found the system reminders helpful and felt that the system made you more accountable as a CMHN. He explained:

'And I think it makes people think about the practice more. You've got to think about what you're putting and why you're putting it.'

These paperwork advantages were situated in the CMHNs lived experience of the place that paperwork played in their overall practice.

Paperwork in the driving seat

Virtually all aspects of the CMHNs practice involved paperwork. As Gaynor, who worked with older people explained:

'Nothing happens without any paperwork basically – we're always being told “if it's not written down it hasn't happened”.'

From a fast 'phone call to a complex case review, all patient related work had to be recorded. Given this organisational requirement, paperwork was central to how the participants organised their work. It was an ever present task waiting to be done and was rarely experienced as being under control. It was a matter of just how out of date it was, rather than it ever being completely up to date. Recording the work done usually took

longer than doing the work itself. The total amount of paperwork needing to be done resulted in it being a major organising feature of the CMHNs' work. As but one of many pressing priorities it took an important and frequent place in their planned schedule; a plan that frequently had to be abandoned and re-organised because of contradictory organisational expectations. For example, the need to respond to urgent patient needs and other, unpredicted, organisational work. Several participants gave examples of planning paperwork time into their diaries in the hope of trying to catch up with it, only for this plan to be scuppered by yet another 'priority'. This frequent experience reinforced a sense of their work being impossible to keep under control.

Organisational documents are designed to shape practice for different purposes, such as the promotion of good patient care and for the management of limited resources. The study's participants were largely positive about the construction of each Trust's patient care related documents but experienced their alteration as frequent and disruptive. Given the inevitable lack of fit between using a generic form and engaging in an individual patient encounter, the CMHNs learnt how to manipulate the form's management for their current purposes but some participants seemed worried about how the Trust would regard this. As Wendy explained when discussing the use of a form for a CPA review:

' ...the number of clients that say to me "oh please" – you know they lose the will to live, they don't want to fill in 18 pages. One gentleman that I spoke to last week – we were going through a CPA review and he said "look love, I don't want to answer them all"... I had to put that on and he didn't answer any of the questions, so yeah, and I can turn round to anybody and if any manager says to me that's not acceptable – well I'm very sorry but that's what he said and that's how he felt and I'm not pushing him to answer those questions because I think that's damaging to our sort of relationship...'

The CMHNs regarded the paperwork they produced as material through which they were subjected to a form of distant and vaguely threatening surveillance. Several used the 'big brother' metaphor when discussing this. On occasions some had received what they experienced as direct threats from service managers about paperwork. Wendy told me:

'I have been advised that if I don't get up to date then disciplinary action will follow within a period of time and I'm not the only one that's happened to.'

Several participants mentioned a recent drive to get all the paperwork up to date ready for an upcoming external review (nobody was clear exactly what this was). It was reported that they had explicitly been told to prioritise this over direct patient care otherwise there might be consequences for the security of team members' employment.

In summary, paperwork was a central part of the CMHNs workload which had practical ramifications for all aspects of their practice, a point also previously raised by Munro (2004) in relation to Social Work practice.

Systems not fit for purpose

The participants were most evidently frustrated by the practicalities of actually doing the paperwork. Every CMHN talked about a large amount of duplication. This appeared to arise for two main reasons. Firstly, because they worked in a joint agency team (NHS and Local Authority) they were expected to 'feed' two incompatible IT systems, literally having to repetitively put the same data in twice (at least). Secondly the forms that needed completing were often repetitive, so they had to provide the same data over and over again for different purposes. What had led some to 'despair' was when CPA forms had been changed and they were expected to start again from the beginning, thus a CPA review form, for example, could no longer be electronically populated using the original assessment form.

Immediate access to computers was mixed across the different teams represented. Some had their own computer while others had to share, resulting in delays to getting the paperwork done. In some offices the telephone and the computer were located in different places, reducing their ability to multi-task. Using the available computer software was often experienced as time consuming and frustrating, for instance, having to move back and forward between numerous data fields and coping with the system 'on slow'. Nurses in one team had experienced frequent system disruption where the IT was not operational at all. Having prioritised paperwork the CMHN could not then actually get on with it.

Lauren clearly explained some of the difficulties:

'...you're going to write somebody's notes up. It might only take you 5 or 10 minutes to actually type those notes but you've got all the opening up the computer system, getting software loaded – if the software's running slowly because there's a lot of people using it at any one time, there's network problems, sometimes you might have written your actual notes but to move between different screens, it can take a couple of minutes for the screens to change and that's really frustrating because you're thinking, god if this was on paper I'd have just written and turned the paper over and it would be sorted. It just takes an inordinate amount of time... I think because we're using a computerised system there are glitches with it...'

In one of the Trusts the helpdesk service had recently been reduced from a 9 – 5 service. Arthur told me:

'I phoned up for something – now it's only open to 1 o'clock ... I actually sought help and got through, somebody took a message and somebody else was going to phone me back to talk me through it and it has just made what was essentially a really quick turn around service into a bloody nightmare now.'

The administrative support available to the CMHNs was highly variable. All the participants spoke respectfully about their administrative colleagues

and some were sensitive to their workload demands and did not want to place them under more strain. Some CMHNs were able to get handwritten records word processed by administrative colleagues but some had to do all of this work themselves. Others, who had good typing skills, chose to do most of their own work, believing this to be quicker. The growing burden of paperwork has not been matched by a growth in administrative support.

Feeling unprepared

Feeling unprepared for real world documentary work was located in three contexts by the participants: firstly, in relation to their pre-qualification education, secondly in relation to joining a community mental health team and the resources available for learning on the job and finally, becoming familiar with new forms and the new nursing practice that they represented.

Documentary work is addressed in nurses' initial education through theoretical learning about record keeping and in practice through clinical placements. The former tends to emphasise patient records and their legal, ethical and policy aspects, for example, discussion concerning the NMC Code (2008). The latter is inevitably limited by the nature of student nurse placements and their level of accountability. IT and form filling skills are gained through the education process and student nurses are implicitly coached in the documentary consequences of working within a highly regulated occupational field. Contemporary student nurses also enter their education with previously gained IT skills but their aptitude will vary. Experienced and older CMHNs have come to IT later in life and the participants described varying levels of computer literacy and typing skills. Lauren and Arthur, for example, had learnt how to touch type prior to becoming a student nurse, whereas Peter said:

'I mean I still count on an abacus!'

The NHS Trusts appeared to take it for granted that CMHNs were computer literate. In reality this was extremely variable and the less literate relied on their more literate colleagues to help them out when they were struggling. This time consuming learning and teaching 'on the job' did not appear to be formally recognised. Whilst the helpdesk staff (when available) were helpful, hands on support and situated 'know how' was the most reliable form of help. David explained:

'I'm not brilliant on computers but I can manage a word document and I can type. I wouldn't say fast...the difficulty is all the other things. Say if you've done a CPA review and stepping a case down or closing it, you can spend – well, the other Friday it took me half an afternoon to close 2 cases and I probably roped in 2 colleagues – it was 3 people's time for over an hour plus the helpdesk just to simply close a case.'

Becoming a CMHN within a Community Mental Health Team mostly means becoming a care co-ordinator too. The CPA (implemented in 1990) has spawned a multitude of frequently changing forms and the burden of their completion falls heavily on the care co-ordinator. One participant opined that being a '*paper co-ordinator*' was part and parcel of being a care co-ordinator. In-house training for documentary work was hit and miss in terms of its timeliness. As Arthur stated:

'We've recently had kind of a refresher, a refresher course on the CPA and it kind of focussed me – I didn't have any formal CPA training when I started this job but I suppose with hindsight, having the 2 day refresher course, it would have been handy to have had that when I first started...'

Some CMHNs regarded the training available with some ambivalence because taking time out for training meant that their paperwork got even more behind.

New organisational initiatives *always* resulted in more forms to be completed by the CMHNs. The participants gave many examples of this

phenomena including Len who talked about the recent introduction of a 'parenting assessment form' and a 'child data collection form'. He understood well that these had been designed with the important matter of child safeguarding in mind but questioned the team's skills in parenting assessment and therefore the organisational assumptions that the form represented:

'...we were given the form and some of my colleagues – ok, I'm a parent but who's to say, parent or not, I mean some of my colleagues are parents but we haven't had any training – its just thrown in.'

Other than completing the documentation I asked Len if it had made any difference to his practice. He answered:

'No, not really – no. We'd have contacted a health visitor, the GP or social services...'

The practical experience of feeling unprepared for documentary work was an important feature of the data collected but its proper place within the CMHN role was a topic of stronger feeling.

Paperwork and organisational politics

Facets of organisational politics were intimately wrapped up with the CMHNs' experience of paperwork. A ubiquitous theme in the data was that CMHNs did not feel they were doing the job they were educated to do and were not doing the job in the way that they believed they should be doing. Whilst understanding the importance of record keeping (see above) the balance between paperwork and face to face contact with service users was seen as being seriously out of kilter. They understood their proper work as being with service users and were frustrated that paperwork took them away from this. Some of the participants had engaged in expensive therapeutic training but were not in a position to actually use the skills they had gained. Geoff talked about this at length ending with:

'I'm like an office worker who spends most of his time on the telephone or filling in paperwork. I probably spend about 15-20%² of my week actually visiting clients and even then the input I give is very limited, its very much about who I can refer them to... and that's so frustrating, its not the job I came to do you know – I'm one of these people now who just can't wait to get their pension.'

Suzanne, who worked with older people said:

'I think the sad bit for me is that the actual contact with the patient seems less and less important...'

There was a sense that aspects of paperwork both enabled and disabled good practice. The '*continuous slog*' (as Len called it) of the documentary work had pushed some features of good practice completely off the agenda. For instance Barry noted how shared work was a thing of the past. He used the example of how work with a long-term service user could become stale and formulaic and how the opportunity for live supervision could result in new and more helpful interventions and improved care quality.

A further political aspect of documentary work was how information was used by other agencies in an attempt to control finite resources. This was discussed mostly in relation to efforts to secure long-term/continuing care funding and decisions about who would bear those costs, either the PCT or the local authority. Gaynor explained this complex process in relation to a person with dementia requiring residential care. Firstly a lengthy screening document – 'a decision support tool' was completed by the CMHN. Using a set formulae, this resulted in the person being categorised as an appropriate candidate (or not) for continuing care. If they were an appropriate candidate they were then subjected to a full multi-disciplinary review. This meeting had to consist of at least 2 professionals and a social

² This is what is left of his working week after taking out the time for paperwork and meetings.

worker, all of whom had to provide a written report. Ideally it would also include a personal representative of the person under discussion (assuming that they lacked capacity). The CMHN also had to secure written reports from everyone involved in the person's care, including the GP and the occupational therapist for example. If this group agreed that continuing care was required then the CMHN had to compile all these reports along with a full raft of their assessment documentation (including a financial assessment) and send them to the PCT review panel for continuing health care funding. Gaynor's experience of this process was that the review panel *always* wanted more information which she would then have to acquire. If the panel eventually refused the request Gaynor would then need to follow a similar process for applying to the local authority forum. This forum was also the place she had to approach, using the right forms, to deal with matters such as getting a community care grant for household goods for people living in very deprived circumstances. She explained:

'So you complete the paperwork, you would justify why that person needs whatever. The only thing is they like you to give them a price so I would need to go and find the price of, usually use the Argos catalogue actually. The price of a fridge or washer, it's just to give them an idea of how much money you're wanting.'

Clearly an expert in managing very difficult and risky circumstances with extremely vulnerable older people, Gaynor demonstrated an incredible stock of knowledge about local private and commercial services and the complex processes engaged in securing those services. This senior nurse had learnt to keep an up to date Argos catalogue close to hand.

Chris had a specialist role, including the care of people with a long history of high risk behaviours. Like Gaynor his role often included funding matters. On top of the continuing care issues it also involved individualised budgets, for which the completion of a '*massive form*' was required. He reported:

'They will find a gap somewhere, so you might put down that this patient has difficulty swallowing so then they'd want a dysphagia assessment – so then I have to generate the referral and the health professional to get that...sometimes you get the feeling that these things are just delaying making a decision because they don't want to fork out the £800 per week funding.'

Over a long period Chris had developed expertise in manipulating the paperwork for the patient's benefit. He explained his system of recipient design, where he would construct the story for the people receiving it. Thus, he explained, he would not use highly technical terms but emphasise problematic behaviour if this seemed a strategy likely to secure what was needed.

Occupational hierarchy and organisational roles also played a political part in the world of paperwork. I learnt quickly from the CMHNs that medical and psychology staff were not subject to the same documentary requirements as them. My understanding was that at some point the psychiatrists had refused to co-operate and this was accepted. Because they were never care co-ordinators, clinical psychologists simply were not expected to undertake documentation associated with CPA. The participants reported this as a matter of fact, apparently accepting that the heaviest burden of paperwork fell on them and their mental health social work colleagues, particularly in the context of also being care co-ordinators.

Given that documentary work had such an important place in their role many of the participants wondered what the point of it all was (the positive points raised have been discussed above).

What's the point anyway?

This issue emerged in discussion concerning the responses of service users to paperwork and to questions about whether anybody actually read any of it.

Engaging individual service users in paperwork about them is taken to represent and encourage good practice. It provides a method for facilitating a therapeutic partnership; the service user and the practitioner can share in constructing an understanding of the person's needs and how the service can provide for them. Intuitively this seems to make good sense but it is not a topic that appears to have been examined through research within mental health services. The CMHNs who raised this issue discussed how service users' willingness to engage with paperwork was very variable. Some were largely not interested and weary of it, others found it useful. Len thought this might be connected to the person's current mental state and their psychiatric diagnosis. In this next example he is talking about a document called 'The wellbeing care plan':

'...this is my perception. It feels like those people with the severe and enduring that are quite unwell – I'm trying to think, the well being care plan – there's one or two pages asking them all about what wellness means to them and I don't think any of them have completed that... for the people on my caseload who haven't got severe and enduring I think I've probably filled in more – because they've wanted to write what that wellness means'.

Jon also reported varying levels of service user engagement:

'I think that the care plans are useful to some extent. I mean, it depends on the person. Some people – you give them a care plan and they just put it in the drawer and never look at it again. But some people are more interested in working out a package of care if you like.'

Marie mentioned the well being care plan too:

I think that most service users I've talked to find it quite patronising – maybe I'm just meeting the wrong ones! ...it says things like "what does wellness mean to me? My goals and aspirations. Things important to me. Things I want to change." You know – it's a bit – very worthwhile things to discuss but people say to me "it sounds

really American and big words” – it just doesn’t fit really with the way, I guess, they work.’

Marie also talked about the relationship power imbalance when service users are subject to Community Treatment Orders and how this renders the freedom of service users redundant in relation to them stating their choices and goals (a matter that the document’s construction appears to take for granted).

The importance of inputting data did not seem to be organisationally reciprocated. With the exception of individual clinical records, the CMHNs did not appear to expect that the data base could give them any useful information either about, or for, their nursing practice. What feedback there was tended to be a critical consequence of record keeping surveillance. They would be informed when some documents were due to be completed and when they were late with their completion.

For some of the CMHNs there were broader questions to be posed: who read all the paper generated anyway? Did *anybody* actually read it at all? Chris argued:

‘My belief is that probably we generate lots of paperwork that’s not read by people.’

Chris went onto talk about being given huge records about individual service users when they were being resettled in the community. These included carefully constructed biographies. Chris could see their value in theory but said:

‘...and it comes out and it’s a book and do I read it? I’m afraid I don’t because I just haven’t got the time.’

Jenny’s real-life experience had taught her that other people did not read her paperwork:

‘We put a lot of information and time into care plans with clients and I can almost guarantee that nobody will ever look at them. If

my client went to A&E they wouldn't look at the care plan – they look at the risk assessment maybe...I've got a client I've had for 12 months and I was on duty and the GP rang to refer them to me and I was like "I've sent you 2 care plans, I've written to you about the medication yet you're referring them as a new client to me – it's staggering really!"

Barry often found himself questioning the point of all the paperwork he did and he described this as both alienating and as a barrier to getting the work down:

'...I suppose it's an added stress because if you're doing something and you think "I don't believe I really need to do it"... it makes everything a lot more remote for us as well. A lot of, we only put things on because the organisation wants that information but you don't know who in the organisation – you know? It can be really pointless'.

Despite these important questions, the CMHNs seemed to take it for granted that they would continue to comply with their employer's requirements as much as that was possible, despite their belief that paperwork would continue to grow. As Chris put it:

'...we're going to be suffocated. And I think the problem is that it suffocates good practice, because it stops you being innovative. It stops you taking risks and becomes very restrictive.'

Discussion

Like the CMHNs who participated in this study, I have been concerned that this report will be perceived as overly negative. My concern is that the CMHNs expression of negative experiences might be construed and trivialised as workplace carping. When collecting the data I was impressed by the CMHNs evident commitment to providing high quality care and noted their efforts at attempting to offer a balanced view of their

documentary work. Two categories of CMHN emerged through the data: those who loved their job despite the paperwork, and those who used to love their job but could not now wait to retire because of the paperwork and all that it represented for them.

Paperwork was discussed as having several main functions:

- Keeping effective patient records which contributed to good practice.
- Encouraging and organising good practice.
- Attending to paperwork that was designed to meet the needs of other organisations (and other parts of their own organisation).
- Doing paperwork on behalf of others (work that they perceived should be done by others and for service users who were unable to complete forms independently).
- Having their work kept under close but remote observation.
- Data collection for the organisational purposes of the NHS and the Local Authority.

There was very little explicit talk about the defensive function of patients' records in relation to providing evidence in cases of complaints and serious incidents. This may have been an unintended consequence of how the interviews were conducted or because this was a taken for granted phenomena. Fearing a backlash from records not kept up to date, or the failure to record every single patient related matter was evident. As David said about 'phone calls:

'...the one you don't log will always come back to bite you.'

Organisational documents are orientated to as accurate representations of the real world but they can only ever be limited representations, no matter how good they are. Managers had often said to Gaynor *'if it's not written down, it hasn't happened'*. This, of course, does not hold up in

reality. The majority of what we do is not recorded but this does not mean that it has not taken place, nor can it be argued that existing records are definitively truthful or accurate. This is not intended to suggest that records are routinely made incorrectly, more that at best they can only offer a perspective on complex social matters. The CMHNs were well aware of this; after all it was them who were spending a large proportion of their work on constructing those records, so when senior and remote organisational managers only showed an interest in their documentary work it felt to them as if their *real* work was of no interest. Despite this scrutiny however, the CMHNs did not believe that remote managers had an accurate and detailed knowledge of the totality of their documentary work. Some of the participants were extremely complimentary about their local manager and their appreciation of their work.

The remote paperwork designers, no doubt responding with the best of intentions to a whole variety of organisational drivers, make assumptions about practice that are problematic for the paperwork completers. For example, they assume that all patients are willing and able to divulge personal information and to co-operate with documentary work. They assume that rigid rules about the timing of certain events will promote best practice and, most importantly, that complex records are absolutely necessary. However, despite the continuing and growing organisational emphasis on record keeping and data collection the practicalities of getting it done were highly troublesome. The temptation is to continue to work towards a technological nirvana rather than rigorously analyse the basis of paperwork and its relationship to effective care. As Darbyshire (2004:17) has argued:

‘Technological ‘solutions’ to health care problems are endlessly seductive and easily entrance policy and decision makers.’

Collecting data from practitioners may also be ‘endlessly seductive’; there is undoubtedly always more important information to be found out by policy makers and researchers. Whilst a new form may, in theory at least,

'only take 5 minutes', all these small parcels of time add up to become a larger and larger part of CMHNs work. A series of powerful metaphors with much in common were often used by the study's participants in relation to their experience of paperwork and their fears for their future as a CMHN. These were 'suffocation', 'being snowed under', 'drowning' and 'an avalanche'. Peter captured this well:

'I think I can speak for most of my colleagues, is that it wears you down and you feel that you've lost the essence of what the job was all about in terms of contact with clients and now you're sat behind your desk either pushing a pen or typing away on a computer... It's very much shaping our practice and there has been concerns for years about loss of identity in terms of what we do now...'

Power (1994: 39) (an economist) in his seminal work titled 'the audit explosion' argues:

'Audits are not passive practices but strongly influence the environments in which they operate. Instead of involving direct observation, audit is largely an indirect form of 'control of control' which acts on systems whose role is to provide observable traces. In a number of areas this results in a preoccupation with the auditable process rather than the substance of activities. This in turn burdens the auditee with the need to invest in mechanisms of compliance, a fact which has produced a consistent stream of compliant (sic). Concepts of performance and quality are in danger of being defined largely in terms of conformity to auditable process. Indeed, the construction of auditable environments has necessitated record-keeping demands which only serve the audit process.'

Further, he argues that this form of remote control produces 'regulatory comfort' but this can only ever be transitory, as audit is a logic that can never be satisfied. After all, if we cannot trust those delivering services to

carry out their work conscientiously, how can we trust those who audit their work and, in turn, those who police the auditors? Power (1994: 40) makes a strong case for change:

'This will require a broad shift in control philosophy: from long distance, low trust, quantitative, disciplinary and ex-post forms of verification by private experts to local, high trust, qualitative, enabling, real time forms of dialogue with peers. In this way we may eventually be in a position to devote more resources to creating quality rather than just to policing it.'

Finally, rather than make recommendations which may be organisationally inappropriate I will pose a series of questions that the Trusts may find helpful to address.

Questions for consideration

- 1) What is a reasonable proportion of a CMHNs working week to be spent on paperwork?
- 2) Is the differential burden of paperwork on practitioners taken into account when setting work targets for different occupations?
- 3) Are paperwork skills included in person specifications designed for employee recruitment?
- 4) Is there an effective strategy in place for IT training?
- 5) Is there a relationship between the volume of records and their usefulness for good practice?
- 6) Does a Board level manager have responsibility for controlling this important area of practice?
- 7) What is the evidence for using forms for assuring good practice?

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